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Women's Health CREATE

Overview

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Women's Health CREATE Director

Spotlight on Women's Health Cyber Seminar

VA HSR&D Service • January 27, 2014

Women Veterans in VA

- **Women Veterans (WVs) fastest growing segment of new VA healthcare users**
 - Legislative changes opened military careers to women (e.g., 20% of new recruits now women) and mandated VA to deliver gender-specific care
 - ↑ efforts to enroll returning Veterans from Iraq and Afghanistan (OEF/OIF) into VA care (>50% enrolled vs. 11%)
 - Women veteran VA users doubled in past 10 years
 - Projected to be 10% (or higher) of total user population by 2018
- **Rapid increase in #s in childbearing years** (42% of WVs vs. 12% of MVs <45 years old)
- **Complexity of care demands changing (rapidly)**



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Women Veterans in VA

- **Significant comorbid physical and mental health conditions among VA users**
 - Higher disease burden than female non-Veterans
 - Comparable disease burden to male Veterans
 - Greater mental health burden compared to male Veterans
 - High rates of sexual harassment, abuse, assault histories
- **Numerical minority creates challenges for VA**
 - Historical predominance of men in VA settings
 - Gaps in safety and privacy for women (GAO)
 - Limited gender-specific service availability (GAO)
 - VA providers with little/no exposure to women

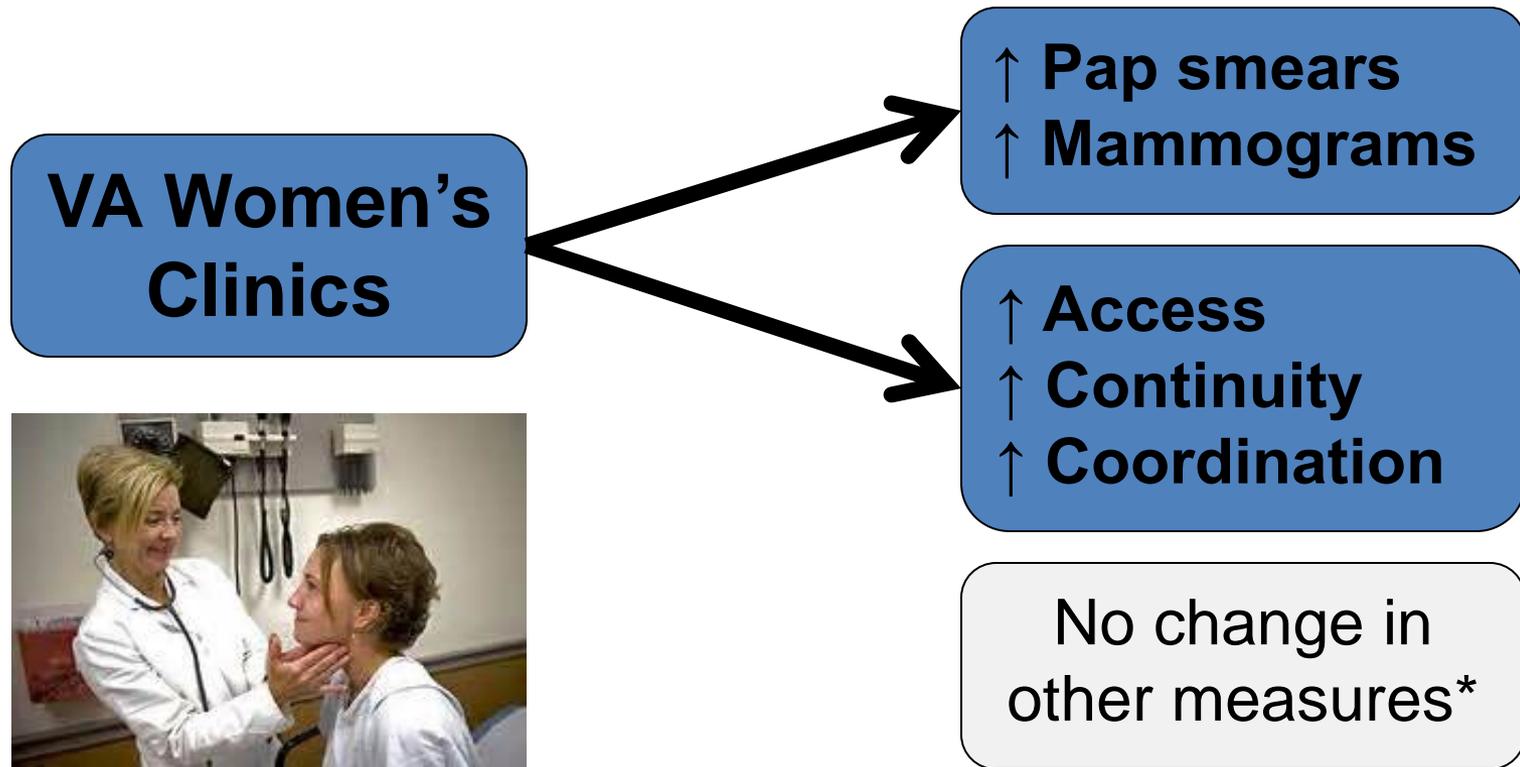


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Determinants of Women Veterans' Quality of Care in VA



*Gender-neutral (aka general PC clinics) better *or* worse depending on measure



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Source: Yano EM, Washington DL, Bean-Mayberry B. Impact of Practice Structure on the Quality of Care for Women Veterans. VA HSR&D Project #04-036 (2005-07).

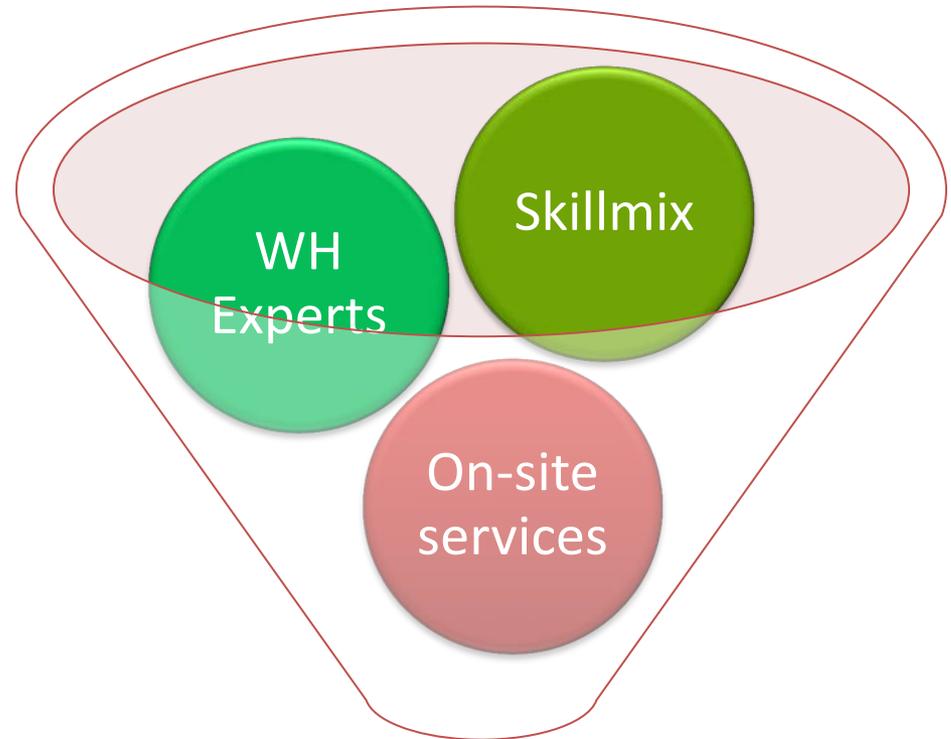


In a nutshell, *what worked?*

VA Women's Clinics



Comprehensiveness



Quality



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Research-Clinical-Policy Partnerships

- **Under Secretary for Health → tasked a work group**
 - *Established acceptable women's clinic models*
- **Women's Health Services (WHS) developed new VHA Handbook and field-based assessment tools**
 - *Health Care Services for Women Veterans (1330.01) (May 2010)*
 - *Women's Assessment Tool for Comprehensive Health (WATCH)*



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Key Focal Point Statements in VHA Handbook 1330.01

- “...each VA facility must ensure that eligible women Veterans have access to comprehensive medical care, including care for gender-specific and mental health conditions...comparable to care provided for male Veterans.”
- “...all enrolled women Veterans need to receive comprehensive PC from a designated WH PC provider who is interested and proficient in the delivery of comprehensive PC to women, irrespective of where they are seen” and “regardless of the number of women Veterans utilizing a particular facility.”
- Environments sensitive to women Veterans’ needs, safety, and dignity



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VA Women's Health CREATE

- **What is a CREATE?** = Collaborative Research to Enhance & Advance Transformation & Excellence*
 - Group of coordinated research projects conducted in a focused high-priority area in partnership with VA leaders
- **Women's Health CREATE goal:** *Use research to accelerate implementation of comprehensive care for women Veterans*
 - Principal partner: Women's Health Services (Hayes)
- **Focus on fundamental issues in how VA delivers care to women Veterans *in context of national VHA policy***
 - Ensure access to comprehensive healthcare services
 - Within environments that preserve privacy, dignity, safety



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*All CREATES described at
www.hsrp.research.va.gov/create



Women's Health CREATE Aims

1. To examine patient, provider, and organizational barriers and facilitators to implementation of comprehensive care delivery for women Veterans;
2. To assess determinants of these factors underlying delivery of comprehensive care for women Veterans and implications for their quality and experiences of VA care; and,
3. To evaluate the effectiveness and impact of alternate models of delivering comprehensive care to women Veterans

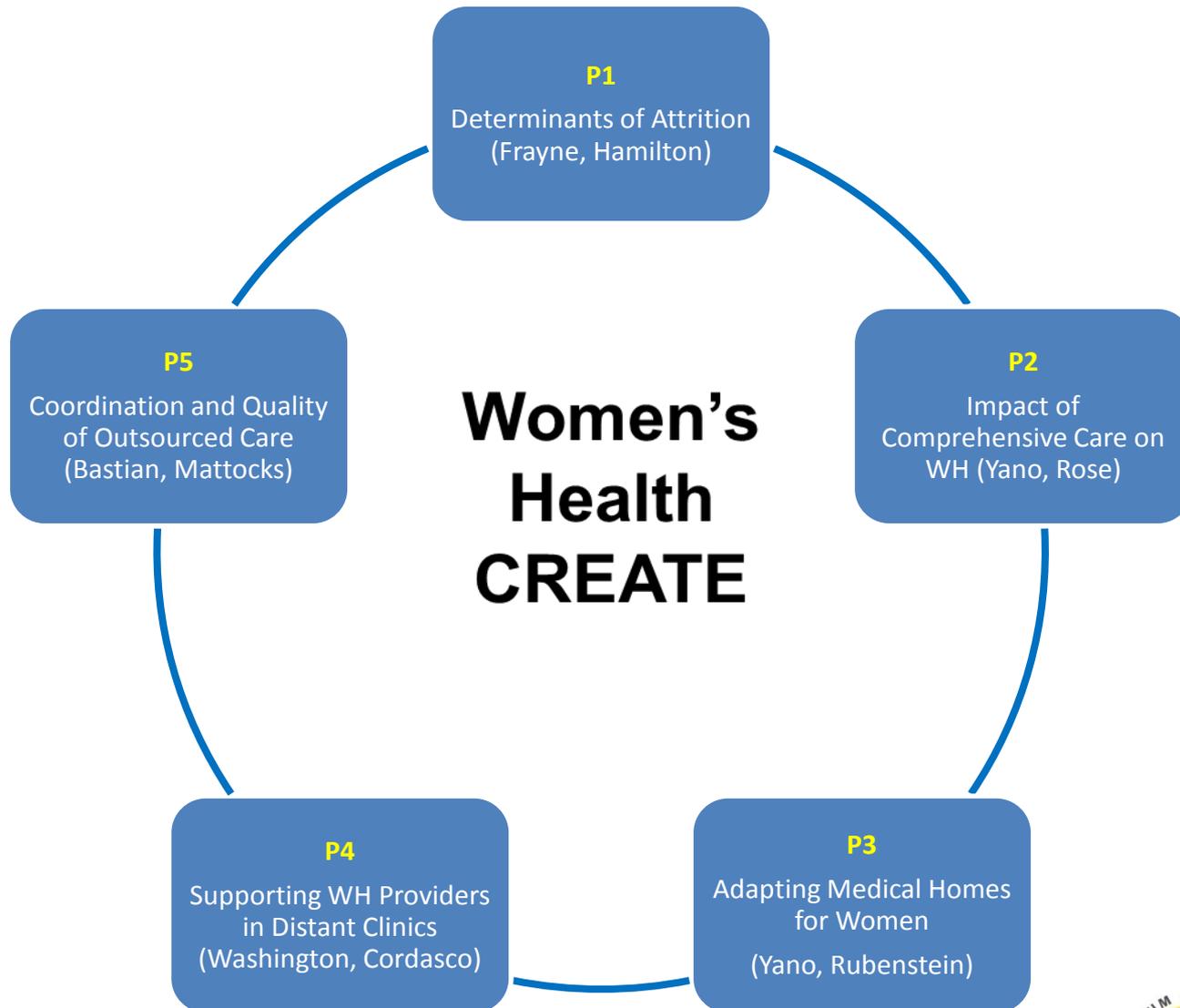


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Five Component Projects (P1-P5)



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Overarching CREATE Partners

- **Veterans Health Administration (VHA)**
 - **Funded by VA's Office of Research & Development (ORD) Health Services Research & Development (HSR&D) Service**
 - **Women's Health Services (WHS)**
 - Patricia Hayes, PhD (Chief Consultant)
 - Sally Haskell, MD (Deputy Chief Consultant for Clinical Operations and Director of Comprehensive Women's Health)
 - **Mental Health Services (MHS)**
 - Susan McCutcheon, EdD, RN (Director, Family Services, Women's Mental Health, and Military Sexual Trauma)



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(CREATE Program Manager) at angela.cohen2@va.gov.



Overarching CREATE Partners Continued

- **Also benefits from additional project-specific partners**
 - **Examples:** National Primary Care/PACT Program Office, Office of Specialty Care Services, National Radiology Program, VISN Leaders
- **WH CREATE Executive Steering Committee**
- **National Women Veterans Council**



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Women's Health CREATE "P1"

Lost to Care:

Attrition of Women Veterans New to VHA

Susan Frayne, MD, MPH

Center for Innovation to Implementation (Ci2i)

VA Palo Alto Health Care System

Alison Hamilton, PhD, MPH

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VA Greater Los Angeles Healthcare System

Background/Study Rationale



Many women are new to VHA

- Among WV using VHA outpatient care in FY09:
 - 14% new (no use in prior 3 years)
 - 56% had joined VHA since FY03
- Geographic variability in distribution of new WV

Friedman S (2011) *Women's Health Issues* 21(4S)



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Number of New Women Veteran Patients by Home Facility - FY09



Background/Study Rationale

Attrition: Common in New WV

- Definition:

- No use of VHA outpatient care in subsequent 2 years

- Attrition among WV using VHA outpatient care in FY06:

- 30% of new WV patients
- 8% of ongoing WV patients

Friedman S (2011) *Women's Health Issues* 21(4S)



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Project #1 Goals & Study Design

- Project goals:
 - To assess whether and how patient experiences of VHA care contribute to attrition
 - To recognize patient subgroups at risk for attrition
 - To identify promising, patient-centered remedies
- Study design:
 - Mixed methods convergent parallel design
 - concurrent timing of quantitative and qualitative strands
 - methods prioritized equally
 - results mixed during the overall interpretation
 - Conceptual model incorporating
 - Andersen Behavioral Model of Health Service Use
 - Consumer Choice Theory



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Project #1 Specific Aims: Quantitative

- **Aim 1: To identify predictors of attrition**
 - *using existing data to model predictors of VA attrition among a FY11 national cohort of new WV VHA patients (N~50,000)*
- **Aim 2: To characterize patterns of attrition over time**
 - *using existing data to examine longitudinal trends in attrition rates (FY03-FY11)*



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Project #1 Specific Aims: Qualitative

- **Aim 3: To understand perspectives of attriters and non-attriters.**
 - *telephone interviews with a national stratified sample of women primary care patients new to VHA in FY10 (N~125)*
 - *attriters and non-attriters from high/low attrition facilities*
- **Aim 4: To explore plans for future VHA use among current VHA users.**
 - *focus groups with recent (FY15 Q1-2) new WV VHA users (N~36) at two facilities*

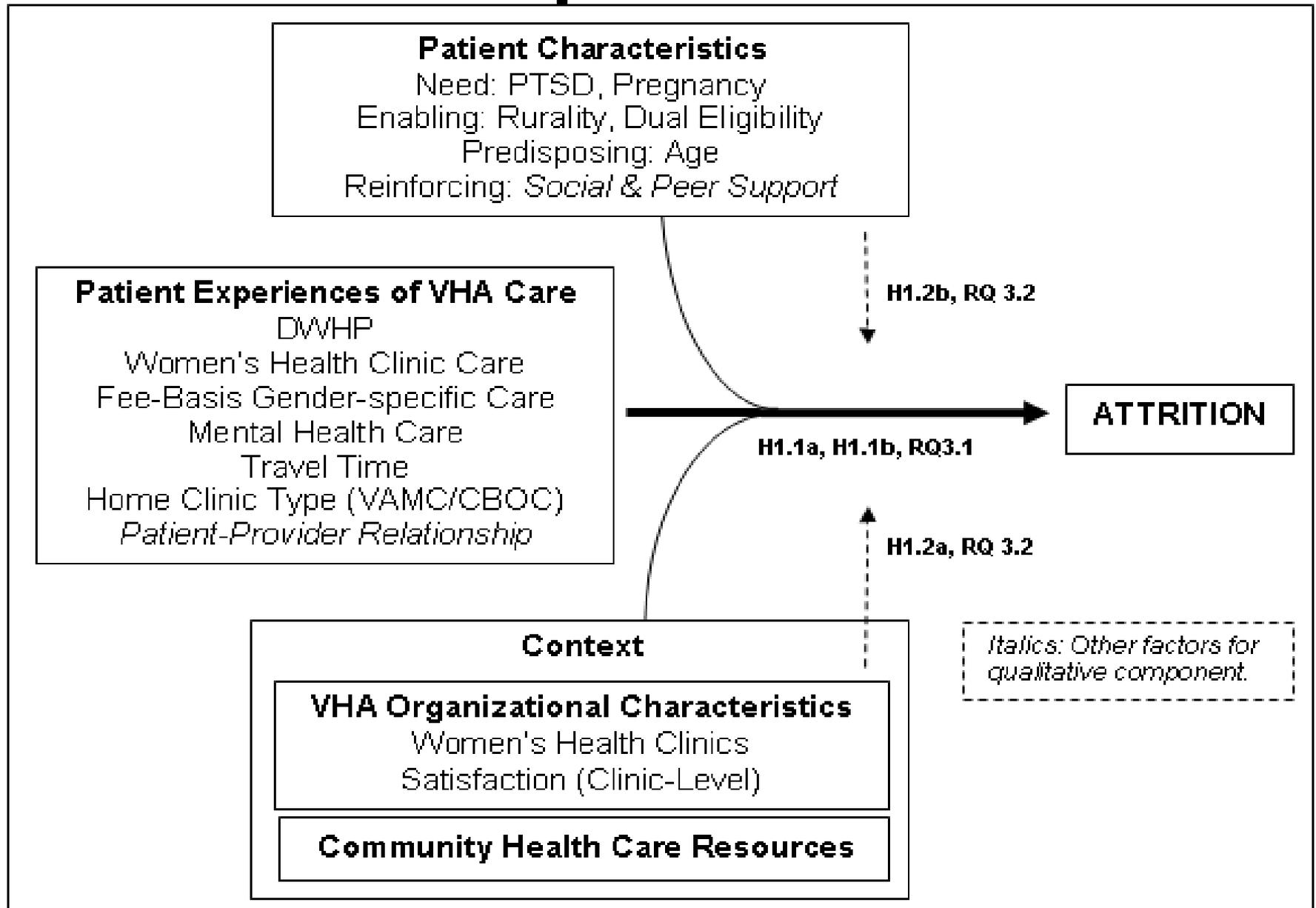


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Conceptual Model



Aims 1 & 2 Key Variables

- Cohort
 - Women Veterans new to VHA (*WHEI-M; OEF/OIF/OND Roster for subcohort*)
- Dependent variable
 - “Attriter” if no VHA outpatient use and no fee basis outpatient use in the “2nd year” and “3rd year” after her index visit (*WHEI-M*)
- Predictor variables
 - Receipt of DWHP Care (*Designated Women’s Health Provider Assessment of Workforce Capacity (DAWC)*)
 - Patient Experiences of Care (*WHEI-M*)
 - Contextual Factors & Community Resources (*PCMM, WATCH, Area Resource File, American Hospital Association Annual Survey of Hospitals*)
 - Patient Characteristics (*WHEI-M, Medicare/Medicaid*)



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Aim 3 Phone Interview Domains

Stratified national sample, WV new to VHA in FY10 (n=125)

- **RQ3.1: How do patient experiences influence women's decision to attrit from VHA?**
 - Patient experiences (e.g., with DWHP, in women's clinic, with travel time, with patient-provider relationship)
- **RQ3.2: How do contextual factors (VHA organizational characteristics/community health care resources) and patient factors influence women's decision to attrit?**
 - VHA organizational characteristics (e.g., women's health clinic, satisfaction), community health care resources and patient characteristics (e.g., PTSD, pregnancy, rurality, dual eligibility, social and peer support)
- **RQ3.3: What are patient-centered perspectives on organizational or policy improvements that would reduce attrition?**
 - Contextual factors, especially VHA organizational characteristics that could be modified

Aim 4 Focus Group Domains

Current new users in LA/Iowa City (n ~ 36)

- Current experiences of health care in VHA and in the community
- Plans to return to VHA for future healthcare, with probes about factors that would encourage them to return
- How services and policies could be changed or developed to prevent attrition and outreach to women who have not returned or who have never used VHA
- Priorities re factors that would prevent attrition, i.e., what do they want the VHA to do for them that would encourage them to return
 - Marketing theory: focusing consumers on “desired outcomes”



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Women's Health CREATE "P2"

Impact of Delivery of Comprehensive Women's Health Care in the VA

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Danielle Rose, PhD & Ann Chou, PhD (Co-PIs)

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VA Greater Los Angeles Healthcare System

Background/Study Rationale

- **Delivering comprehensive care to women Veterans can be a challenge in VA**
 - Rapid growth in VA use, yet no changes in on-site availability of services
 - Wide variations in how local VA facilities achieve comprehensiveness
 - General primary care/PACT clinics and women's health clinics
 - Integrated mental health care vs. referral to outpatient MH specialty
 - Different levels of in-house reproductive health/gynecology services
- **VA ↑ policy guidance on comprehensive care, ↑ WH provider training, ↑ quality x gender reporting**
 - Implementation varies, local barriers/facilitators vary



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Project #2 Specific Aims

- **Aim 1: To assess determinants of variations in the delivery of comprehensive care to women Veterans**
- **Aim 2: To study the impact of comprehensive care delivery on women Veterans' quality and experiences with VA care**



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Comprehensive Care

- **Comprehensive care**
 - *First contact care* (i.e., the usual and preferred route for entry into the healthcare system, including assessing and sorting out needs and making appropriate referrals)
 - *Subsequent care* of “any health problem at any given stage of a patient’s life cycle” (adapted from IoM)
- **Range of services** available/provided considering population needs – problem-related
 - *Primary care, subspecialty care, mental health care, gender-specific care organized from VA entry through care journey*
- Requires **personal relationship** with provider and **coordination** to achieve **timely care** per standards

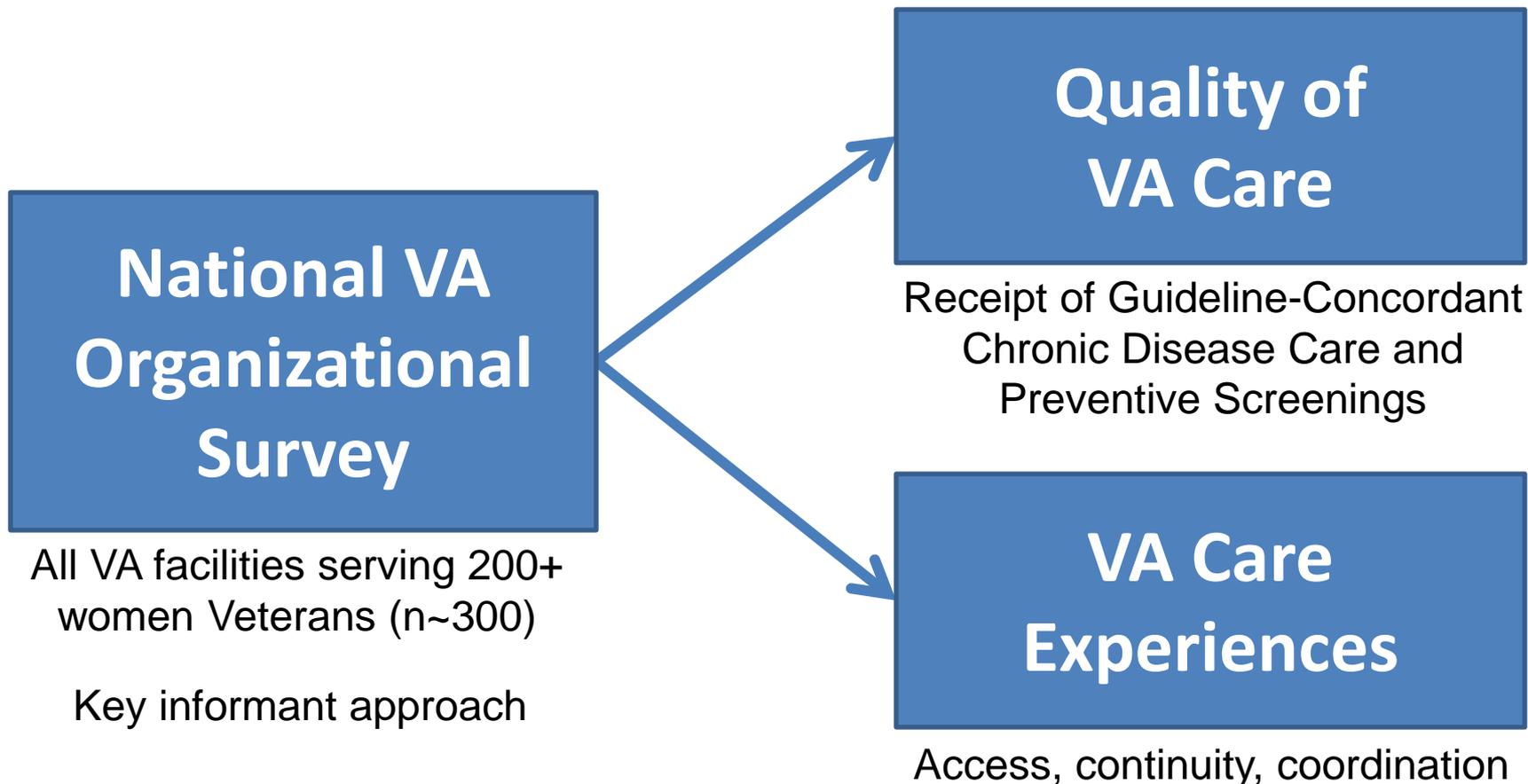


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Study Design and Sampling Plan



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Determinants

- **Organizational determinants**
 - **Practice characteristics** (e.g., primary care and women's health program features, coordination, quality improvement, environmental management)
 - **Facility characteristics** (e.g., size, academic affiliation, complexity, context within which care is delivered)
- **Area determinants**
 - **Location** (e.g., urban/rural, Census region)
 - **Area demographics** (e.g., poverty level)
 - **Health care area resources** (e.g., primary care shortage area)



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Quality & Experience Measures

- **Quality of VA Care measures**
 - Corporate Data Warehouse (CDW) derived quality indicators
 - Chronic disease (e.g., diabetes, ischemic heart disease)
 - Prevention (e.g., receipt of cancer screenings, immunizations and vaccinations)
- **Care Experience measures**
 - Access measures (PACT Compass/CDW)
 - Survey of Healthcare Experiences for Patients (SHEP)



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Women's Health CREATE "P3"

Implementation of VA Women's Health Patient Aligned Care Teams (WH-PACTs)

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VA Greater Los Angeles Healthcare System

Background/Study Rationale

- **VA undertaking patient-centered medical homes**
 - Non-VA PCMH associated with ↑ quality, ↑ patient and provider/staff satisfaction, while ↓ costs and ↓ disparities
- **VA's PCMH model—Patient Aligned Care Teams (PACTs)—holds promise for ↓ WVs' gaps in care**
 - Teamlets include PC providers, nurses, admin support
 - Larger PC team of pharmacists, social workers, dietitians, health coaches, integrated mental health
 - Links to medical home “neighborhoods” (specialists, hosps)
 - Goal ↑ access, continuity, coordination, comprehensiveness using team-based care that's patient-driven, pt-centered



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Background/Study Rationale

- **How VA should adapt PACT to meet the needs of WVs not part of original initiative**
 - No specific accommodations for gender-specific care or gender-sensitivity
 - No specific guidance on WH clinic-based programs
 - WH clinic models vary in delivery of comprehensive PC
- **VHA Handbook on comprehensive care delivery for WVs (1330.01) fills key policy gaps**
 - Aligns with PACT, requires comprehensive PC in one-stop visit, attention to gender-specific care and sensitivity
 - Specifies range of acceptable care models/attributes



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So what to do?

- We have national strategic priorities in hand
- We have evidence of PCMH effectiveness and early evidence of PACT promise and value
- We have evidence of PC features in general PC and WH clinics that contribute to quality
- We have national expert panel consensus on gender-sensitive comprehensive care features
- ***We needed an approach to tailoring PACT to evidence and women Veterans' needs***



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Project #3 WH PACT Specific Aims

- To assess the **effectiveness of evidence-based quality improvement (EBQI) methods** for developing a WH-PACT model using a cluster RCT
 - PACT features (accessible, continuous, team-based, patient-driven and patient-centered);
 - Comprehensive care (PC, gender-specific care, integ MH);
 - Gender-sensitive care delivery
- To examine **impacts of receipt of WH-PACT concordant care on women Veterans' outcomes**
 - Chronic disease care, prevention, health status, use, costs



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WH PACT Specific Aims (cont'd)

- To evaluate the **processes of EBQI-supported WH-PACT implementation**
 - Better understand influences of practice context
 - Document EBQI methods and WH-PACT implementation
 - Examine barriers/facilitators to EBQI-supported WH-PACT implementation using mixed methods (e.g., interviews)
- To **develop implementation/evaluation tools** for use in EBQI-supported WH-PACT model adaptation, implementation, sustainability, spread to other VAs



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So what is the intervention?

- **Intervention = *evidence-based quality improvement (EBQI)***
 - An implementation strategy for adapting/tailoring research evidence into routine practice and policy
 - We are **NOT** evaluating whether PACT works
 - Although under Aim #2, we will explore whether WH PACT concordant care improves WVs' outcomes
 - We are **NOT** evaluating whether it's better to deliver PC to women in general PC or WHCs
 - Participating VAMCs span all care model types



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What is EBQI?

- Multi-level research-clinical partnership QI approach
- Uses top-down/bottom-up features to engage local organizational senior leaders and QI teams
 - National strategic directives serve as guides
 - Regional expert panels set innovation design priorities
 - Local interdisciplinary QI team design and implement local activities in context of prior evidence and change methods
- Researchers serve as technical experts and guides
 - Train in QI, help teams structure QI (aims and measures), provide formative feedback
 - Provide practice facilitation to support implementation and across-site collaboration (data sharing, lessons learned)

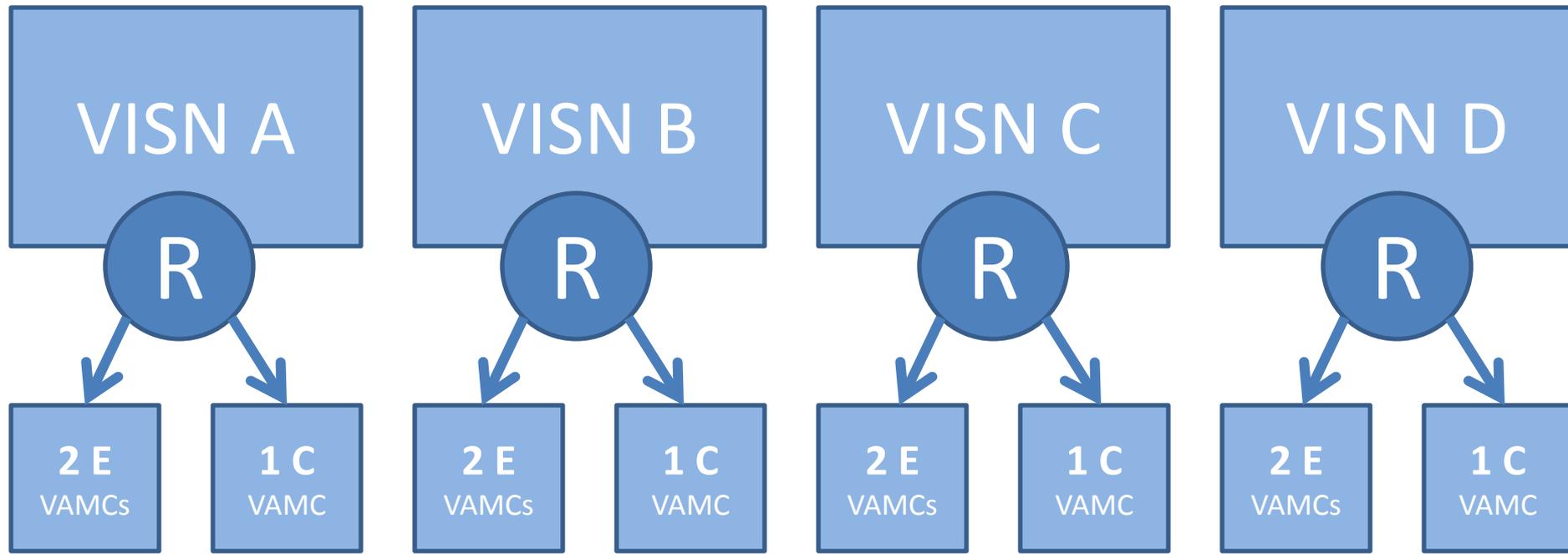


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Study Design: *Cluster Randomized Trial*



- 2:1 allocation (8 intervention + 4 control VAMCs)
- Supports appraisal of variations in implementation processes in intervention VAMCs
- Capitalizes on VA WH Practice Based Research Network



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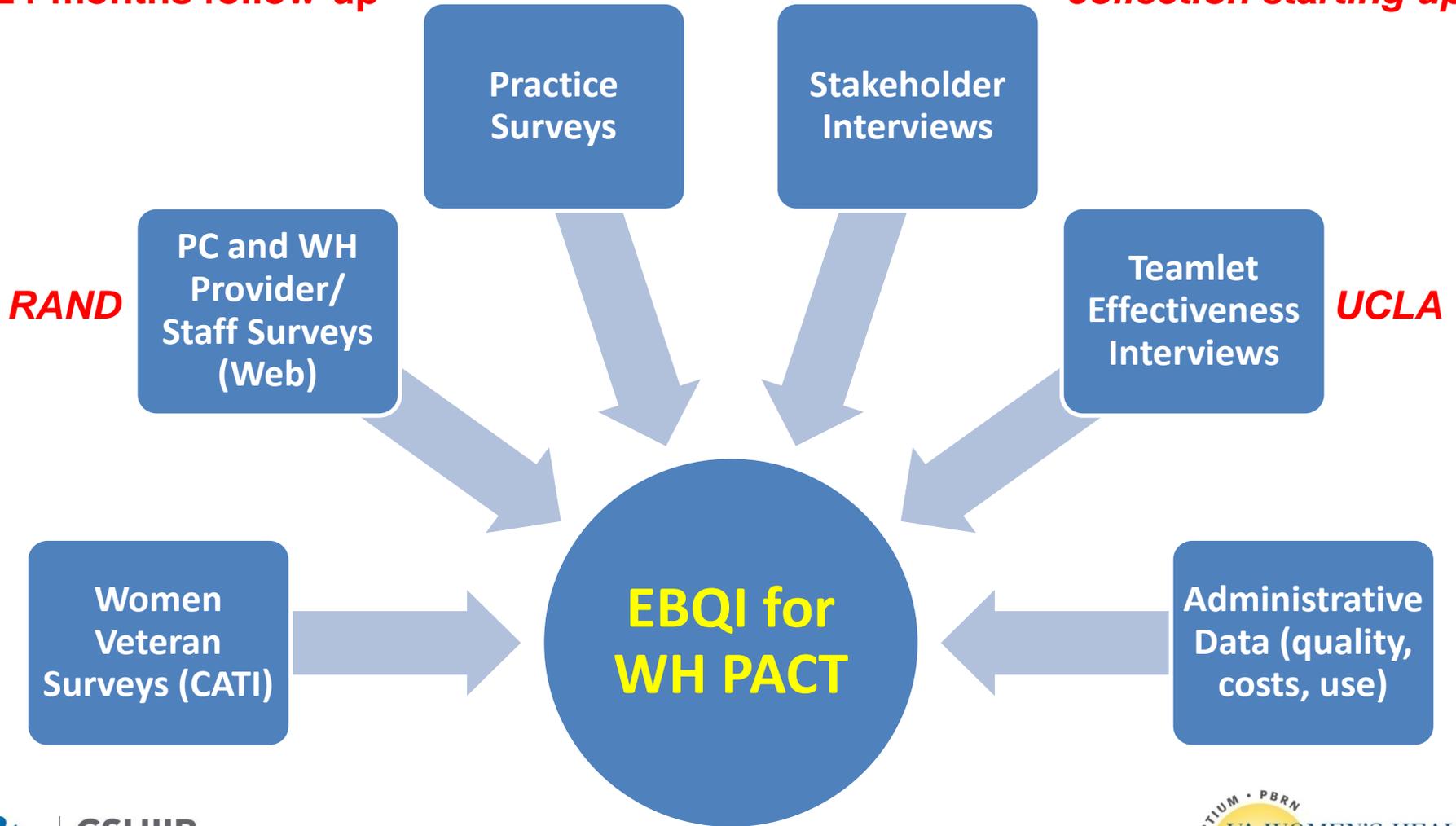
= random assignment



Formative & Summative Evaluation

Baseline, 12- and 24-months follow-up

Baseline data collection starting up



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Women's Health CREATE "P4"

Controlled Trial of Tele-Support and Education for Women's Health Care in CBOCs

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VA Greater Los Angeles Healthcare System

Background

- VA primary care workforce's exposure to and expertise in managing women's gender-related care is variable
- To ensure quality care, VA mandated designated women's health providers (DWHPs) in every VA facility and instituted intensive training opportunities – WH mini-residencies
- Continuous education, with re-enforcement of learning points, is needed to produce and maintain long-term gains in knowledge



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Background (cont'd)

- In a VISN 22 operations initiative, we launched
 - The 1st VA WH SCAN-ECHO: series of primary care provider (PCP)-specialist clinical tele-videoconferencing sessions for didactic education & discussion of patient cases
 - WH electronic (e-) consults: secure electronic communications between PCPs & specialists, w/ specialists reviewing charts to provide care recommendations
- Together we call WH SCAN-ECHO & e-consults *“DWHP Support”*
- This research project will evaluate the effectiveness of *DWHP Support*



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Project #4 Specific Aims

- **Aim 1:** To evaluate the effect of *DWHP Support* on WH care quality and efficiency
 - Quality assessed by guideline adherence
 - Efficiency assessed by specialist referral patterns
- **Aim 2:** To explore the impact of *DWHP Support* in changing DWHP behavior and self-rated WH knowledge, skills, and self-efficacy



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Project #4 Specific Aims (cont'd)

- **Aim 3:** To assess attitudes about *DWHP Support* and its use, specialist time for its implementation, and other features that could influence *DWHP Support's* effectiveness, sustainability and spread
- **Aim 4:** To develop tools to measure quality of WH care in VA



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Study Design

- 4-year mixed methods study with *DWHP Support* being rolled out one healthcare system at a time (“stepped wedge design”)
- Quantitative Methods
 - Chart review: quality & efficiency of care
 - Surveys of DWHPs: perceptions of program elements / events; self-efficacy delivering WH care
- Qualitative Methods
 - Semi-structured interviews with DWHPs and specialists, assessing needs, attitudes, perceptions

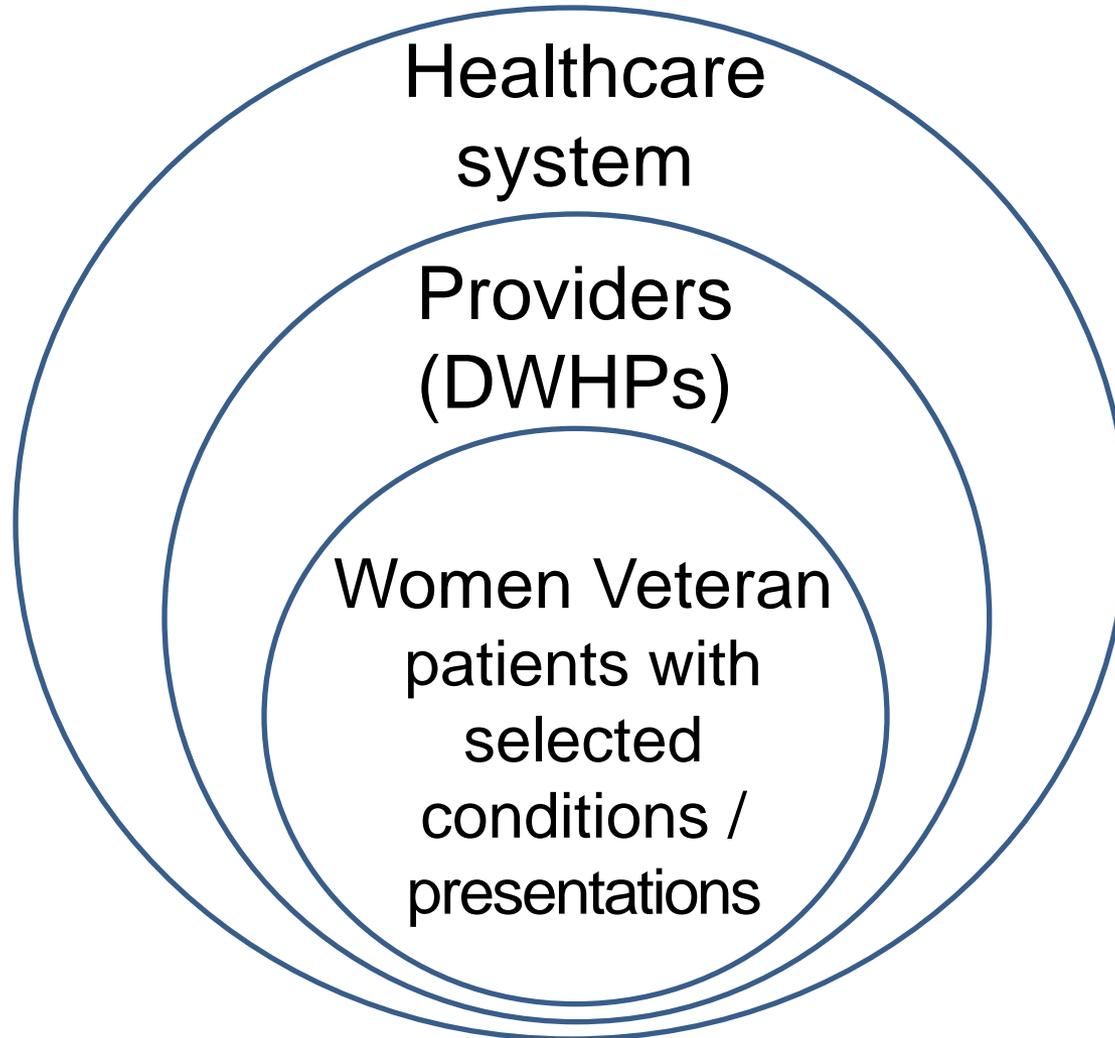


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Sampling Plan



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Data Sources and Measures

- Quality assessment tool development
 - Literature review; Expert panel methods
- Quality assessment
 - Administrative data (CDW); Chart reviews (CAPRI)
- DWHP self-assessment, attitudes, perceptions
 - Self-assessment tool; Survey instrument; Interview guide



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Women's Health CREATE "P5"

Evaluation of Quality and Coordination of Non-VA Care for Women Veterans

Lori Bastian, MD

VA Connecticut Healthcare System

Kristin Mattocks, PhD

VA Central Western Massachusetts Healthcare System

Background

- The VA relies on outsourced (non-VA) care to provide specialized health services not provided within the VA (i.e., mammography and prenatal care) to women Veterans (WVs)
- 34% of WVs in VA care also utilize some fee basis care and the number continues to increase on an annual basis. Despite increasing numbers of WVs relying on non-VA care, little is known about the quality of non-VA care.
- A majority (75%) of VA facilities contract with hospitals and other facilities for diagnostic mammograms
 - Facilities are not monitored for quality according to standards set forth in the Mammography Quality Standards Act of 1992 (PL 102-539)
- Given that mammography is the highest-volume gender-specific care for women (51,396 mammograms in FY09), understanding the quality of this type of care is of utmost importance to the VA



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Project #5 Specific Aims

- **Aim 1**

- To understand providers' and fee basis managers' strategies for provision, coordination, and quality oversight of non-VA care

- **Aim 2**

- To understand perceptions and experiences with non-VA care among women Veterans

- **Aim 3**

- To evaluate the quality of gender-specific services for women Veterans using a case example mapped to VHA Handbook priorities (e.g., Do VA facilities utilizing non-VA care for mammography meet key quality standards compared to VA facilities providing in-house mammograms?)



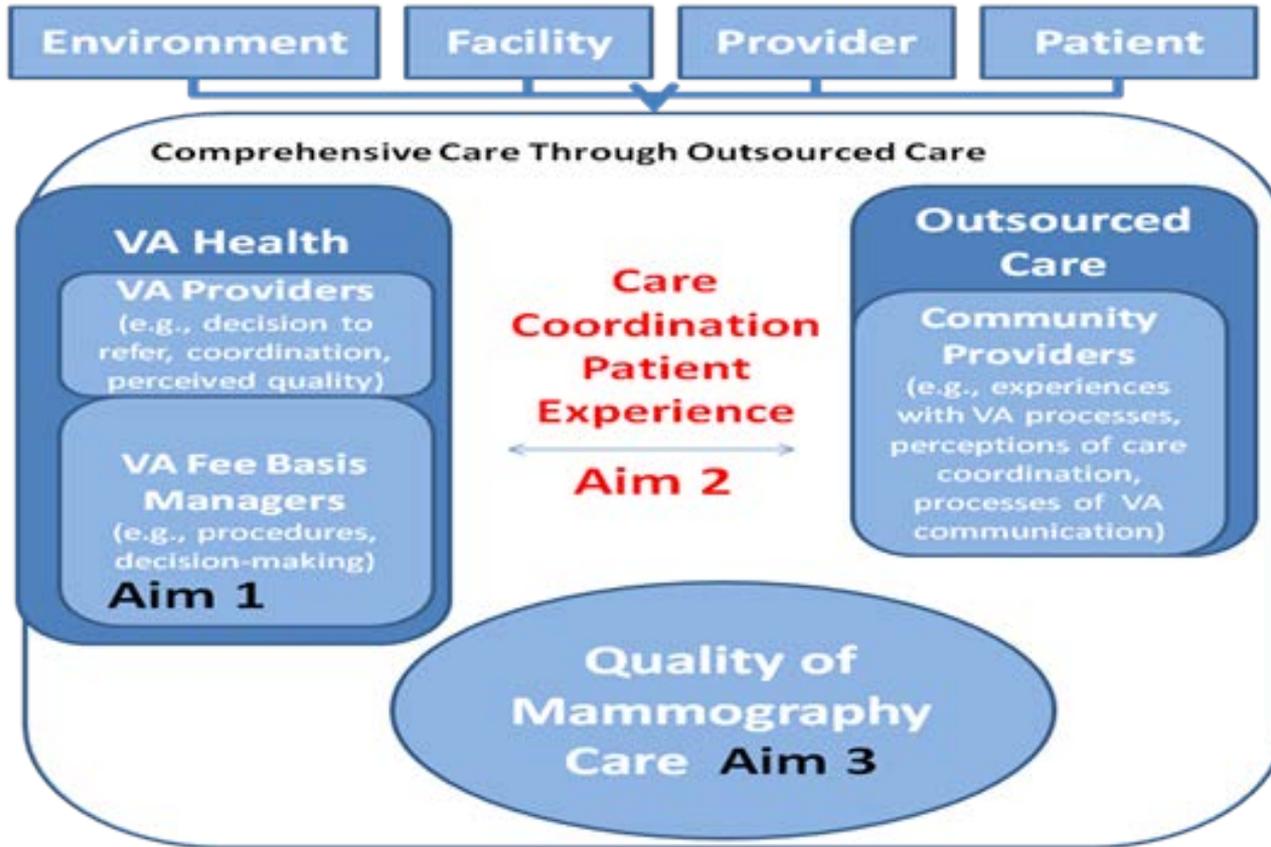
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Study Design

Conceptual Model of Care Coordination & Quality of Outsourced Care for Women Veterans *Determinants of Care Coordination & Quality*



Adapted from Sofaer et al. (2009) patient navigation and Rogers' diffusion of innovation (1995) models.



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Sampling Plan

Select twenty sites nationally with low, medium, and high use of non-VA care among women Veterans

Aim 1

- Conduct telephone interviews with 2-3 providers and 1-2 fee basis managers at each site focusing on the challenges of referrals to and coordination with non-VA care, with a particular focus on challenges of incorporating mammography results back into VA care

Aim 2

- Conduct telephone-based interviews with 6-8 women Veterans at each site focusing on their use of non-VA care. As an inclusion criterion, 50% of women that we will interview will have received a mammography from a non-VA care provider in the past two years. The remaining 50% of the women will have received some type of non-VA care in the previous two years.

Aim 3

- Conduct medical record reviews of women Veterans at the same 20 sites (ages 40-74) with either non-VA or in-house mammograms in FY12

Data Sources and Measures

Aim 1 Research Questions	Conceptual domains {"Q"=Question number in Appendix 5}
<p>RQ#1A: What are the processes (clinical decision-making, practice supports) underlying how providers utilize non-VA care for their female patients? What are providers' experiences with non-VA care? How is non-VA care coordinated with ongoing VA care? How are the barriers/facilitators to using non-VA care? How could the process to refer patients to non-VA care be improved?</p>	<p>Perceived availability & sufficiency of VA services (Grand Tour Question--Provider) Clinical processes (Question 1—Provider) Coordination of care (Question 2—Provider) Perceived quality of non-VA services (Question 3—Provider)</p>
<p>RQ#1B: What are fee basis managers' experiences with non-VA care? How are contracting decisions made? How is the quality of non-VA care monitored and evaluated?</p>	<p>Perceived availability & sufficiency of VA services (Grand Tour Question—Fee Manager) Organizational decisions regarding fee/contract (Question 1—Fee Manager) Payment of care (Question 2—Fee Manager) Perceived quality of non-VA services (Question 3—Fee Manager)</p>
Aim 2 Research Questions	Conceptual domains {"Q"=Question number in Appendix 5}
<p>RQ#2A: What are women Veterans' experiences (coordination, perceived quality, satisfaction,) with non-VA care (both fee basis and contract services)?</p>	<p>Experiences with Care (Question 1—Patient) Satisfaction (Questions 2 & 4--Patient) Coordination of care (Question 3—Patient)</p>
<p>RQ#2B: How can access to, and coordination of, non-VA care be improved for women Veterans?</p>	<p>Access (Question 3—Patient) Coordination of care (Question 3—Patient) Satisfaction (Questions 2&4—Patient)</p>



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Data Sources & Measures (cont'd)

AIM 3:

- Administrative Data (CDW, DSS, TIU text notes, Vital Status)
- Chart Reviews (CPRS/CAPRI)
 - Phase 1 is to determine whether or not mammogram results are appropriately acknowledged in the medical record
 - Phase 2 is to measure the number of days after an abnormal mammogram (defined as BIRADS 0, 4, or 5) that results are evaluated and followed up
 - We will also collect patient's age, race category (Asian, African American, Caucasian, other); service connectivity (non-service connected, 0, 1-49% service connected, 50-100% service connected); body mass index (BMI) and breast density



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WH CREATE Contact Information

- For more information contact:
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 - Angela Cohen, MPH, CHES (WH CREATE Program Manager) at angela.cohen2@va.gov

Thank you for your time and interest

QUESTIONS???



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