Maria Hecht: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, research content editor, Maria Hecht, talks with Christopher Miller, clinical psychologist and investigator with the Center for Healthcare Organization and Implementation Research. They’re discussing his work conducting qualitative interviews to understand more about both providers and veterans’ experiences of care in the community.

Christopher Miller: Chris Miller, clinical psychologist by training. I'm at the Center for Healthcare Organization and Implementation Research, or CHOIR, at VA Boston.   
  
So, one of the coins; I'm doing health services and implementation research, and my academic affiliation is with the Department of Psychiatry at Harvard Medical School.

Maria Hecht: Great, thanks so much. The first thing I’d like to get is a little bit of background of people and how they came to VA and, particularly, how they got into health services research. It’s an interesting field. It covers a lot of breadth and depth; everything from health economics to clinical care delivery. So, how did you get into it?

Christopher Miller: Sure. As a clinical psychologist, I did do part of my practicum, actually, at the VA Miami on the inpatient unit and so, came to VA Boston for my internship in General Mental Health and Substance Use Treatment.  
  
It’s really at that point that kind of contemplating postdoctoral fellowships. I started at CHOIR as a fellow, really kind of being interested in some of the more kind of systems perspectives on delivering good clinical care, thinking about all of the stuff that goes into getting the right patients into the right clinical experiences at the right time. And that’s really what led me to work with Dr. Mark Bauer and the other folks at CHOIR.

Maria Hecht: You’re at VA now. Why do you stay? You could probably go and do some research work and maybe be in private practice. But what keeps you here?

Christopher Miller: Yes, I think part of what I appreciate about doing this kind of research at VA is just that there is such a great infrastructure in place for doing health services research, for doing implementation science work, that isn’t necessarily present even at other really good academic settings.  
  
So, I do love working with veterans. I love being able to have a small clinical caseload with veterans while doing this research. And I like working within a system where we can really have access to data we might not otherwise have access to. And also, hopefully, kind of move some of the policy levers that might have impacts across the largest integrated health system in the US.

Maria Hecht: As somebody once put it, “Instead of just tossing the research over the fence and hoping somebody picks it up, there’s a gate in the fence and they can walk through it and hand it to someone and know that that research will be taken to the next level.”  
  
With this particular work, how did you come to this question? And tell me a little bit about the actual study itself.

Christopher Miller: When I first actually came into looking at VA and non-VA or community care coordination back in 2017, initially interviewing providers, both on the VA and the community side, about the current state of care coordination, as well as what they were hoping for out of care coordination.   
  
Then, got some additional funding from VA’s Office of Rural Health to extend that work, talking to veterans in the same geographic areas as the clinicians and administrators to whom we’d spoken the year before to really try to get kind of a more complete picture about, again, the current state and desired future state for this kind of care coordination.

Maria Hecht: I would imagine that you were, given the Mission Act has some pretty significant impacts. Is there a relationship right now that you see as a care provider with the Mission Act and your research work?

Christopher Miller: The Choice Act was obviously in place when we started this research.

Maria Hecht: Right.

Christopher Miller: The Mission Act went live right when we were in the middle of interviewing the veterans for the second half of the project.   
  
So, while it’s unclear exactly how that implementation might affect our results, we do think that the things we learned in talking to, again, clinicians and administrators, as well as veterans themselves, could certainly have implications for how the Mission Act continues to go over the coming years.

Maria Hecht: That’s a great segue into what exactly did you learn in your work?

Christopher Miller: From interviewing – I mean, doing kind of general direct qualitative analysis, both with providers and with veterans, we really found going in without necessarily a particularly stringent framework or model in mind, we found results in five broad domains in terms of things that impacted perceptions or experiences of community and VA care coordination.  
  
So, when it comes to this first domain that we found of external and veteran context, there are some things that I think anybody working in this space should already be aware of in terms of just being struck by the geographic distances involved, the amount of time it may take to get appointments.   
  
But one of the big things that we found in that domain is simply that in the geographic areas of the country where certain services aren’t available in VA, in many cases, those same services are likely to not be available outside of VA either. We found this to be especially the case for substance use and mental health services.   
  
So, we think the implication there might be that at least in certain geographic areas, the basic logic of the Choice and Mission Acts – namely, that community care can fill in gaps where VA access might fall short – might kind of break down, at least for certain services.

Maria Hecht: That’s really interesting. Do you think that, based on what you’ve done so far, is there any indication it’s the geographic area, less populous areas, that may not be a draw for the kinds of service providers?

Christopher Miller: Right. Absolutely, yes. I guess it goes without saying but I’ll say it anyway. You’re absolutely right; that the areas where there is that kind of double shortage, both within and outside of VA, seem to be the more rural areas.

Maria Hecht: Okay.

Christopher Miller: And obviously, there are exceptions. But we did talk to folks across eight different geographic areas relatively reasonably spread across the country. So, that seems to be relatively robust, at least the possibility that if you can’t get it in VA, then, for some things, looking outside of VA simply takes up more time.

Maria Hecht: I would imagine there might be sort of slight changes or differences that would probably be more of an anomaly. For example, if you have a rural area that hosts an academic medical center like Dartmouth, which is in a very rural area of New Hampshire, maybe you have people who go there and practice and they really enjoy that area. So, there might be clusters, I would imagine, of places.

Christopher Miller: Of course, yes. I mean, you know, part of the context here is that with these qualitative interviews, we want to acknowledge the limitation. We don’t want to over-generalize from this.   
  
But I would imagine, at least based on our results, based on the interviews that we’ve conducted, the situation you spelled out, for example, at Dartmouth, absolutely may occur but would probably be seen as the exception rather than the rule.

Maria Hecht: Right. So, again, the implication being that the things that Mission and Choice were trying to fix may not be fixable simply by this broad policy change because there’s a bigger endemic issue at work.

Christopher Miller: Certainly, none of the solutions in this space are going to be simple.

Maria Hecht: Right. Was there an outcome from this work that particularly surprised you that you just were not expecting and you went sort of, “Wow, didn’t think that was going to happen?”

Christopher Miller: Sure. I mean, one of the other domains – again, we have five broad outcome domains or five broad kind of qualitative codes that we applied – one of the findings related to relational practices we found to be particularly surprising; specifically, there’s kind of a dialectic going on where on the one hand, community providers really value having that one contact person at VA, that one relationship they had with an individual where they knew if they had a question about shared care for a veteran, they could reach out to that person, get their direct line, get them on the phone. That was seen as incredibly valuable. And that certainly is consistent with other research about the value of kind of boundary-spanning staff, right? People who know both systems.  
  
But the flipside of that was that when that one person retired or moved on to a different position, it could set back care coordination literally years. And given that in rural areas, the average turnover for healthcare providers is somewhere on the order of one to two years, this unfortunately seemed to be a situation that kept coming up, right?   
  
So, there’s this incredible emphasis placed on having that one key contact. But that setup ended up setting things back when that contact – maybe not inevitably but likely – moved on to a different position.

Maria Hecht: Well, that speaks to the larger issue of in any organization, it has a broad application of the loss of resident knowledge. When you have institutional resident knowledge and you’re either not creating redundancies in that organization with that to increase the knowledge spread or you’re not cultivating a younger generation to host that resident knowledge. So, that has really broad application.

Christopher Miller: Yes. And you know, from other research outside of the stuff that we found out directly, certainly, there’s a body of work on the importance of having good succession plans. But there are certainly situations, whether it’s abrupt departures or health issues or something, where there’s staffing issues or maybe there isn’t a person available to succeed somebody who leaves. In those situations, it’s going to be tough.  
  
But it certainly seems that finding a way to preserve that institutional knowledge and, even more difficult, preserve the relational knowledge, is going to be a key part of kind of cutting down on the discontinuities that we’ve seen.  
  
So, when it came to organizational mechanisms – another one of our kind of key themes – there was another dialectic or interesting finding there. Namely, that we interviewed several sites on the VA side that instituted these new care coordination offices, frequently staffed by nurses and support staff. And we saw that work really well in some situations and then, work not so well in other situations.   
  
And it seemed like one of the fundamental challenges there is that at its heart, care coordination is really about getting the right people to talk to each other in service of shared care for, in our case, a veteran.  
  
But by creating a separate office staffed by additional people, we’re essentially putting more folks in between, more middle men or middle women, in between the people that we wanted to be connecting.   
  
Again, it could work out really well if those offices were able to address that issue. But in many situations, it seemed that adding additional cooks in the kitchen, so to speak, merely complicated an already complicated question.  
  
Now, acknowledging there’s another kind of group in the middle, of course, here, which is the third-party administrators, the TPAs. That was another whole realm of findings. Certainly, we found a lot of challenges relating to coordinating care with the TPAs involved, particularly around scheduling and billing. That wasn’t necessarily the primary focus of our interviews but I’d be remiss not to mention it, given how involved they, I think, are going to be moving forward.

Maria Hecht: Right. And I think that that is an interesting thing for you to mention because the third-party administrative aspect is not something that VA patients have had to typically deal with. So, if they are getting care in the community, that may come as kind of a surprise to them so, that might have implications for satisfaction from the veteran perspective.

Christopher Miller: Absolutely. And I think it is a difficult thing to study because based on our veteran interviews, there were certainly some veterans to whom we spoke who had knowledge of the role of the TPAs, of these third-party administrators. But in many cases, it certainly seemed like veterans viewed the TPAs as simply part of VA, right?   
  
So, I think part of the takeaway there is that it’s maybe not a great ask to expect veterans to keep straight all these different administrative offices. From their perspective, they don’t want to have to work with VA and this other third party and so, they tend to attribute a lot of the problems with the TPAs to VA. And getting good information about what’s being done by VA versus what’s being done by the third parties from these veterans who just want to get their care delivered in a timely manner and reimbursed without them getting billed, I think that’s going to be an ongoing challenge.

Maria Hecht: Yes, that’s another research question for another day.

Christopher Miller: Indeed.

Maria Hecht: So, if there’s, in an ideal world, a long-term policy or practice outcome that you’d like to see, what would that be?

Christopher Miller: Well, I think there are a few takeaways here from the interviews. One is – and this is something I didn’t talk about in great detail before – but another finding that our respondents really hit on were kind of cultural differences between community providers and VA. So, VA was perceived as more kind of insular, more bureaucratic. Maybe VA clinicians are seen as having a harder time establishing therapeutic reliance – therapeutic alliance, excuse me.   
  
So, I think one kind of policy question moving forward is; How better to align cultures or, at the very least, help VA and community providers work together in the service of shared patients despite cultural differences.  
  
I think another policy implication is just being aware of the unintended consequences. Again, examples included establishing separate care coordination offices complicated an already complex picture; involving the TPAs, again, complicated an already complex picture.  
  
I think another policy question that, hopefully, this work kind of brings to light is just the fundamental challenge of patient ownership, right? Who ultimately is responsible for the veteran’s care? Is this about VA outsourcing just certain services to community providers where there’s a short-term gap? Or is this about community providers serving as the medical home for these veterans who are getting only particular specific services from the VA?  
  
In the absence of that kind of answer, it really exacerbates all of the kind of too-many-cooks-in-the-kitchen-type situations.

Maria Hecht: So, you do see veterans in clinic.

Christopher Miller: Yes.

Maria Hecht: So, what does that bring to you on a professional level and a personal level. These are people who’ve had a very unique set of life experiences; something that not the majority of the population would bring to a therapeutic relationship.   
  
So, what is it about veterans, in particular, that really is meaningful for you and your work?

Christopher Miller: Well, I think the first level of that is just acknowledging family members who themselves are veterans. So, on a most fundamental level, it feels good to be connecting to that population who have served and given so much.  
  
I think a second piece of it, both in terms of my small clinical caseload, as well as talking to veterans in the context of this research, is just that I do think that it grounds our research findings to make sure we are getting the frontest of front-line views on exactly how things are going down. It’s absolutely important to get the system level, the provider level, the clinic, the facility level, what have you.   
  
But hearing directly from veterans who’ve experienced this care who have had to reach out to TPAs or been unable to reach people at VA about the challenges they’ve faced I think, hopefully, can leave us more confident in the real-world applicability of our results, which I think is going to be important anytime we’re looking to influence policy.

Maria Hecht: The views and opinions expressed in the preceding podcast are concerned with the scope recently concluded or ongoing VA HSR&D-funded research and do not necessarily reflect current or to-be-implemented VA policy.   
  
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