John Fortney: Good morning everybody. My name is John Fortney, I am a Professor of Psychiatry at the University of Washington and a Research Career Scientist at the Seattle HSR&D Center. My colleagues on this project are Evan Carey, from the Denver COIN or Sister COIN; Suparna Rajan from the Seattle COIN; Peter Rise from the Seattle COIN; Elise Gunzburger from the Denver COIN and Bradford Felker our clinical expert from the Seattle COIN. The title of the talk today is “Veteran Reported Outcomes for VA Regional Tele-Meatal Health Hubs Compared to Community Care Providers”. The official name of the Tele-Mental Health Hub is the Clinical Resource Hubs-Mental Health but since that does not really roll off the tongue, I am just going to say Tele-Mental Health Hubs.   
  
This work was supported by a grant from HSR&D QUERI our Virtual Care QUERI Program. this one of the small QI projects we did as a part of that program. It is also supported by the VA Office of Primary Care, Primary Care Analytics Team headed by Karin Nelson. The views expressed of those are us, the authors and do not necessarily reflect the position or policy of the University of Washington or the VA.   
  
A little bit of background. Everyone is familiar with the 2008 MISSION Act. Part of that Title 1 Section 101 enables eligible VA enrollees to receive Community Care paid for by the VA. Consults for Community Care providers are authorized if any of the following conditions are met: The Veteran needs a service that is not available at their facility (e.g., obstetrical care); VA cannot provide care within certain designated access standard so less than 30 minute drive time or less than a 20 day wait time for a mental health appointment; or the VA service line does not meet certain quality standards; or the provider, the veteran’s VA provider determines it is in their best medical interest. Surprisingly approximately 25% of Veterans enrolled in VA Care have used Community Care paid for by the VA.   
  
Also part of the MISSION Act is Title IV Healthcare and Underserved Area section 402 required the VA to conduct a three-year pilot program to address the problem of underserved facilities. By that they mean Community Based Outpatient Clinics or CBOCs. In response to that, the VA established Clinical Resource Hubs (CRHs) in Fiscal Year 2019 and they did this by combining and expanding two existing programs – the Regional Tele-Primary Care Hubs with the Regional Tele-Mental Health Hubs. These Hubs serve multiple states in VISN’s so there is one in each VISN, there is supposed to be one in each VISN and this was furthered by another clause in the MISSION Act which allowed tele-providers to practice across state lines with a single state license.   
  
In a sense these two parts of the MISSION Act prompted the VA to revisit many of its “make or buy decisions”. Many have argued that mental health should be considered a core service provided by VA so that it should not be bought, it should be made because of the high volume of mental health. A large number of Veterans have mental health diagnoses and needs. The VA has certain expertise with mental health especially around the areas of PTSD. The VA is very well staffed in mental health compared to many communities around the country. The argument has been made and I will admit I kind of bought into it, that mental health should be something that the VA is making and delivering to Veterans themselves rather than buying it out in the community. However, this issue has not really been examined empirically and that is what we set out to do here.   
  
The objectives of this evaluation is to compare the patient-reported, Veteran-reported outcomes for those Veterans with approved consults to Community Care and consults to the Clinical Resource Hubs Mental Health, so Tele-Mental Health Hubs. We hypothesized even though this is kind of quality improvement work, we did hypothesize that compared to Veterans with Community Care consults, those with Tele-Mental Health Hub consults would report fewer barriers to care; greater number of encounters to care; better satisfaction with the patient-centeredness of care they received; and greater reductions in symptom severity.   
  
Turning now to methods, we identified consults from the VA Corporate Data Warehouse, that is the National Database, and the inclusion criteria for us to identify potential consults was: it was placed between October, 2019 and May, 2020 and yes, the COVID-19 epidemic started near the end of that which influenced our design. The consult originated from a Community Based Outpatient Clinic in VISNs 10, 19, 20, and 22. Finding the origin of the consults was a little tricky, consults can get forwarded from one facility to another. So, we used the CBOC where the Veteran was getting the majority of their primary care, we defined that as the originating source of the consult. We kept it if the consult type was for Community Care or Tele-Mental Health Hub. For example, if the consult said for Western Regional Tele-Health Network, we knew that was a Tele-Mental Health Hub. We only included those with a provisional diagnosis of depression or PTSD. These consults come with the diagnosis that the primary care team thinks is the most important problem for the Veteran. There is only one diagnosis in this field and often is not the diagnosis that the referring mental health provider ends up treating, but it is called the provisional diagnosis. We excluded consults if it had been discontinued or cancelled before we sampled it. We actually downloaded these consults every Monday. So, every week between October and May, we downloaded it and by the time we went to sample it it had been discontinued or cancelled we did not bother sampling it. We also excluded those that had the same consult or what we considered to be a very similar consult that had been requested and completed in the past 13 months. What we were trying to do here is not sample Veterans who were getting continuation of an existing consult, in particular the Community Care consults have to be renewed every year. So, there are a lot of consults out there which are simply an extension of an existing Community Care. We wanted to assess the experience of Veterans who had a new episode of care.   
  
The sampling is really interesting. We originally had hoped to sample equal numbers of Veterans with Community Care consults and Tele-Mental Health consults from each CBOC. If the CBOC had 100 consults over the period we wanted to sample half Community Care and half Tele-Mental Health. That would kind of keep things constant in terms of the local providers and local community, etcetera. That turned out to be impossible for a very interesting reason which is of the 76 CBOCs we ended up sampling from, 71 of them either referred Veterans entirely to Community Care or entirely to a Tele-Mental Health Hub. This kind of baffled us at the time, we quickly gave up on trying to sample that way. We have subsequently done some qualitative work which is not yet complete, but is also perplexing because many of the people we have been talking to at the CBOCs say that they basically give the Veteran a choice – do you want to go Community Care or do you want to go to Tele-Mental Health Hub. It seems unlikely to me that 100% of Veterans at a CBOC would all have the same preference. Something interesting is going on there that I have not quite figured.   
  
We quickly pivoted to a different sampling method and what we did was we created a stratified sampling frame where again we wanted to get equal numbers of Community Care and Tele-Mental Health Hub consults. We wanted to divide those evenly between PTSD and depression so we got 50% PTSD and 50% depression. We wanted to do that so it remained the same, those percentages as 50/50 percentages were the same in each one of the four VISN’s that we were looking at. I guess I forgot to point out that the four VISN’s we are sampling from is because that is where the clinical resource hubs were the most established and had the most consults to them at the time. They were kind experienced hubs; they were well staffed and they were well functioning. We did not want to evaluate a brand-new program that was still staffing up.   
  
This is our consort diagram if you think of it as a clinical trial. We sampled of about the 6,000 consults that we downloaded over the course of the months we sampled about 1,000 of them and we excluded 222. Mostly we ended up excluding the Community Care consults. Eleven of those were excluded because the consult was actually declined so it was never approved. What we would do is when we downloaded the consult, we would check it periodically in the electronic health record in CPRS and then go on to do a survey once it was approved and 11 of them never got approved, they actually got declined. The vast majority of those we excluded in Community Care consults were because they were what we briefly called a SAR or SAR-like which just means it was a continuation of an existing episode of treatment with the same provider. That was kind of determined through chart review because the VA would put information in even about the Community Care consults, who the provider was, what kind of care they were getting, etcetera. We excluded a lot of Community Care consults mostly because they were not new episodes of care. A few people did not have a telephone; 35 by the time we were done sampling patients, they were still on hold because of COVID-19. A few consults were still open they had not been declined but they had not been approved. A few others were ineligible for other reasons. We had about 800 patients with eligible consults, 250 of those were excluded before we were able to do a baseline survey. What we did was every week, we got the consults, we would review them, determine which ones were eligible and we would send out a batch of opt-out cards and wait seven to ten days for Veterans to send us an opt-out card saying I do not want to participate in the survey. One hundred and nineteen out of 800 opted out that way either by calling us or just returning the card and 133 we were unable to contact them so we called them a few times and they never answered the phone. We had a pretty decent baseline survey completion rate at 68.4%. Importantly, we had a lot of information about all of the eligible Veterans 797 from the Corporate Data Warehouse. We had their age, gender, race, ethnicity, marital status, service connected, diagnoses, medications, all those kinds of things. Veterans who completed the survey, the 545 who completed the survey were not significantly different than the 252 people that did not complete the baseline survey. We did 545 baseline surveys and then four months later we did a survey with them. We were able to complete, we have a follow-up rate of follow-up 85.5% with 466 completed follow-ups. Very few people in follow-up declined to participate but 66 we were unable to contact them.   
  
Here is what our final sample looks like. Because so many of the Community Care consults were ineligible because they were not really for a new episode of care, we ended up with fewer Community Care consults than Tele-Health Hub consults. Not a lot fewer, but 242 versus 303. We could have stopped enrolling or sampling Tele-Mental Health Hub consults altogether and made those two numbers the same, but that would have resulted in greater proportion of the Community Care consults sampled being post-COVID versus greater proportion of the Tele-Mental Health Hubs being pre-COVID and we did not want to do that because we thought that would bias the experience of Veterans. So, we continued to enroll though at a slightly slower rate Tele-Mental Health Hubs post-COVID so that we would balance that out. We were able to balance out the number of PTSD and depression diagnoses pretty well. Even within each VISN we were able to do a decent job with that, not perfect but pretty decent.   
  
What is the survey? The survey was very short, baseline it consisted of a PHQ-8. Most of you are familiar with the PHQ-9, this is a depression/severity rating tool that is used for screening in the VA and measurement-based care in the VA. We chose not do to the ninth question about suicide ideation because we were not really in a clinical setting and our surveyors were not clinicians and we did not want to…want to follow suicide safety protocol for Veterans with suicide ideation because we expected that to be very prevalent. For those Veterans who had the provisional diagnosis of PTSD, we also administered the PCL-5. The reason we administered the PHQ-8 for those with a provisional diagnosis of PTSD is because depression is so highly comorbid with PTSD it is probably 90% of Veterans with PTSD also have depression diagnosis. That was applicable to everybody. But the PCL was only applicable to the subset with a provisional diagnosis of PTSD. We also had a few questions about satisfaction with appointment scheduling, we just made up that question. At the four-month follow-up, we readministered the PHQ-8 for depression and the PCL-5 for PTSD symptoms. Then a relatively new instrument developed by Dr. Jeff Pine called the Perceived Access Inventory, this assesses perceived barriers to care which many of us believe is the best way to measure access to care is to get the Veterans perceptions about it on various dimensions. You will see what those dimensions are in a bit. This instrument was developed in a very rigorous way, it started out with qualitative interviews with Veterans about what their barriers to care were. We then had a Delphi panel with VA clinicians and policy makers to determine which of those barriers were considered to be influenced by the VA and therefore considered to be access and not more of an attitudinal barrier. We did not keep things like stoicism and self-reliance which certainly are barriers to care but which the VA has very little control. We also had Veteran’s kind of help choose questions and wordsmith questions so it is a really a very rigorously defined instrument. That instrument was developed for VA Care and then the process was repeated for Community Care. There are two versions of the PAI or the Perceived Access Inventory, one for VA Care and one that also has some Community Care specific items to it that you will see in a minute. We also measured self-reported encounters. Because we did not have access to claims data from Community Care, we could not actually use administrative data to count encounters so we relied on patient self-report for Community Care. We also asked patients whether they got care over interactive video. Then, the last instrument we administered at follow-up was the Office of Mental Health and Suicide Prevention (OMHSP) Veteran Satisfaction Survey. This has two subscales to it, one of them is the Patient Centered Care subscale which is really nice and it also included some Tele-Mental Health specific items that I will report on.  
  
It really is kind of a nice comprehensive measure of the Veterans experience; what their satisfaction was with appointment scheduling; what their barriers to care were and how many encounters they had; what their satisfaction with those encounters was and then how much their symptoms improved or not improved.   
  
Looking at the demographic results, this is not a randomized control trial so we were not randomizing people to two groups which would have balanced them on all their characteristics. One of the things I was worried about is that the Community Care and Tele-Mental Health Veterans would be different on things that would make a big difference in their experience to care. For the most part that was not the case so it was a nice surprise. Average age was about 50; 78%/77% male; 12%/13% Hispanic; 86% White; 7%/5% Black; 3% American Indian; about 50% married. The one thing that really differed between the two groups is the percent that were rural or highly rural. Community Care is designed to serve Veterans that live both far away from services so greater than a 30-minute drive time and those with a longer wait time. So, it was really designed to serve those rural Veterans. But only one-third of them ended up coming from a rural area. Not everybody that has to drive more than 30 minutes comes from a rural area but that is a high correlation there. On the other hand, over half of the Veterans who got a Tele-Mental Health consult were from a rural area.   
  
Clinical characteristics were also very similar. The provisional diagnosis of PTSD or depression is about 50% in each group; about 50% wee already on an anti-depressant when they got the consult; about 7%/8% were on anti-psychotic; about 5% are anxiolytic; 5%/6% on Benzodiazepine; the PHQ-8 and PCL-5 scores were virtually identical, so 13% on the PHQ-8 which suggests moderately severe depression and 45% on PCL-5 which also indicates moderately severe PCL. The PCL goes from 0 to 80 and the PHQ-8 goes from 0 to 27 if it was a nine so a little bit less than that.   
  
Let’s look at what type of Veterans are reporting to us. This is the question about their satisfaction with scheduling an appointment and Veterans were significantly more satisfied with scheduling their Tele-Mental Health appointment than the Veterans with a Community Care consult. Just to remind folks, if there is a Community Care consult that is authorized there is a third-party administrator. So that is TriWest Healthcare Alliance in the West and Optimum Public Sector Solutions in the East. They are responsible for finding a provider who is accepting new patients and facilitating appointment scheduling. If the consult is authorized, that third party administrator reaches out to the Veteran, tells them what providers are available in their community and are taking appointments and are contracted with the VA and they help schedule that appointment. Overall, 40% were very satisfied and 15% were somewhat satisfied so that is not terrible, it is not great either. In contrast with the Tele-Mental Health consult what will happen is that the Tele-Mental Health Hub folks will try to call the Veteran three times to schedule that appointment. If the Veteran does not answer or then declines the appointment for some reason, the consult gets discontinued. For the Tele-Mental Health Hubs, 50% were very satisfied and 15% were somewhat satisfied. Better than Community Care, certainly not perfect and that was statistically significant, the difference there.   
  
Here are the barrier domains that were assessed by the Perceived Access Inventory. PAI actually has a two-part structure to it. They look at travel and long distance is an example here. The question will be – do you have to travel a long distance to get to your VA provider or your Community Care provider? Then if the Veteran answers yes, then there is a second part that asks how much that interfered. As you can see there are not that many people endorsed each one of these barriers so there was not a large enough sample to look at how much each of these potential access barriers interfered with care. I am just reporting the first part. Virtually identical numbers of Veterans, about 12%/13% told us they had to travel long distance to their VA or Community Care provider. Community Care is here in blue, Tele-Mental Heath is in orange. A greater number of Community Care providers patients said their Community Care provider appointments were at an inconvenient time so that was about 14% versus 7%. That is not statistically significant ‘p<0.06’. Greater number of Veterans with Community Care Consults, again in blue said that the appointment they had was too short so that is about 16%/17% compared to about 15% of ‘p<0.06’ not statistically significant. In terms of the providers not being readily available that was actually a barrier that more people endorsed, about 22% for Community Care and 16% for Tele-Mental Health Hub that is not statistically significant of ‘p<0.07’.   
  
There was a statistically significant and much larger difference between Veterans saying their provider lacked knowledge of military culture. That was above 25% in Community Care, normally about 12%/13% for Tele-Mental Health Hub. That was statistically significant, that is a pretty small odds ratio, we typically do not see a 0.3 so that was a big difference, not to be unexpected. A greater number of Veterans said they lacked trust in their Community Care provider 20% versus about 16% for Tele-Mental Health, not statistically significantly different. More Community Care providers for Veterans said they got stuck in red tape, so 17% versus about 12% for Tele-Mental Health, not significant. Lastly a large number, 30% of the Veterans with Community Care consults said they were unaware of available services versus about 22% of Tele-Mental Health Hub Veterans. Again, not statistically significant. We actually hypothesize that on each one of those domains the Tele-Mental Health would do better than Community Care. As you can see none of our hypotheses, we had to reject all of those hypotheses.   
  
There was obviously a clear trend and so we did ad hoc tests, this is not a pre-planned test, this is after we saw those previous results, that just counted up the number of barriers to see if Veterans with Community Care consults reported more barriers than Veterans with Tele-Mental Health Hub. The average was above 1, about 1.3/1.4 for Community Care and less than 1 for Tele-Mental Health a 0.8/0.9, that was statistically significant. Ad Hoc hypothesis test after looking at the data did indicate that Veterans reported fewer barriers if they got a Tele-Mental Health consult compared to a Community Care consult. I think that is an important finding.   
  
Here are the results of the Perceived Access Inventory questions that are specific to Community Care. Some of them are concerning so the first one about 37% said that the VA, there as a delay with their authorization so that is a problem with the Community Care Program that is caused by the VA. It is true, we would watch these consults in CPRS, once they were submitted, they would often take a while to be approved, weeks. Another concern is that 35% of Veterans with a Community Care consult said there was a lack of coordination between the VA and Community Care providers. This has been a concern of VA providers that they referred their patients out to the community they would not know what was going on and the Community Care Provider would not know the Veterans treatment history. This is something that VA providers have worried about and apparently over a third of Veterans are worrying about it as well. Veterans did not seem so concerned about the problems with VA paying their Community Care providers. That might be different if you ask the Community Care providers. Veterans were not concerned about problems with the VA and Community Care providers sharing their records which has also been a concern of the VA. The VA, My Healthy Vet has what is called a ‘blue button’ where Veterans can download an electronic copy of their records to give to their Community Care providers. Maybe that is what is causing Veterans not to be concerned or maybe they are just not concerned about record sharing. Without record sharing there is potential for duplicate testing which is a problem if it is invasive, there is a problem with duplicate prescribing because people can get prescribed contraindicated medications or the same medication which would double their dose. That potentially is a concern.   
  
The really good news I think here in our results is that a large number of Veterans with both types of consults got at least one visit. Somewhat more for Tele-Mental Health than Community Care so 82% of those with a Tele-Mental Health Hub consult attended at least one appointment compared to 75% of those with a Community Care consult. That difference 82% versus 75% is not statistically significant when you control for case mix. The number of encounters over a four-month period is pretty high. So, 6.2 for Community Care and just under 6, 5.9-something for Tele-Mental Health. That is six visits in four months, that is pretty good, it could be better especially if it was a protocol psychotherapy want to see weekly care but this is pretty good.   
  
Looking at the orange box, the Tele-Mental Health box, obviously 100% of those were done over interactive video. Amazingly 70% of those were done with VA Video Connect. That is where the Veteran stays in their home and the Tele-Mental Health provider delivers care to the Veteran in their home either on their own device, laptop, desktop, etcetera, or through a web-enabled tablet that is sent to the Veteran by the VA. Veterans are getting a lot of home-based care here. Community Care we all saw it happen, they shifted to tele-health after March 17th and so ended up 36% of the encounters in the Community Care ended up being delivered by interactive video to their home as well.   
  
For people who had at least a visit what their satisfaction was with how patient centered it was. This is a summary score of about 15/20 questions about patient centeredness. Are you and your provider on the same page? Question’s kind of like that. For Veterans with encounters both groups agreed on average so that is what a four is, about satisfaction with patient centeredness. Slightly higher with Tele-Mental Health but not significantly so. Those are pretty good results; people are on average agreeing that their providers are providing patient centered care. I think that is good news for Veterans.   
  
Here are the Tele-Mental Health Hub specific patient centeredness questions. These also look really good for the VA. These are just Veterans with a VA Tele-Mental Health consult. Eighty percent agreed that their meeting by interactive video went smoothly; 78% said the meeting by interactive video was just as helpful as in-person and over 90% said they were satisfied with the quality of care during the interactive video encounter. Good news there.   
  
There is the really bad news. This is the PHQ-8, it goes actually from 0 to 24 since we left off the ninth question. It started out at about 13 both groups were identical and it dropped very little, this dropped it looks like from a 13 to a 12 in Tele-Mental Health and a 13 to maybe a 10/10.5 or something in Community Care. This was statistically different between the two groups, but the difference was only 1.4 points which is not clinically meaningful. Five-point difference is clinically meaningful so there is really no difference in outcomes here. The bad news is there is no difference because both sets of outcomes were poor. Again, a five-point decrease in the PHQ-9 would be noticeable by the Veteran, and they are not, they are getting a 1.5 to 2.5 decrease. The care they were getting was not improving their symptoms. That is a full sample for depression.   
  
This is the subset of those about half the sample that had provisional diagnosis of PTSD this is their PCL-5 score. They started out in the medium moderately severe range about a 45. The difference in the groups here is 4.3, it is not significant and not clinically meaningful. You need a 10-point difference here to be clinically meaningful so there is not clinically meaningful difference between the two groups. Unfortunately, not a clinically meaningful decline on average for Veterans in either group, they started out at about 45 and they end up at about a 40 to 38 range. Surprisingly with all the experience the VA has in treating PTSD, the outcomes are really not statistically different between the two groups.   
  
We did a sensitivity analysis on all these results with regard to whether the baseline survey was done pre or post COVID. That would be I think March 17th or 18th when we chose that date because that is when Medicare started reimbursing for tele-health regardless of the Veterans location, sorry regardless of the patient’s location. That is kind of when it became…all the barriers to tele-health disappeared. We actually thought that the VA would do a better job than Community Care post COVID and what we found here I think are kind of small, mostly non-significant differences between groups with Tele-Mental Health doing slightly better than Community Care. We expected that post COVID we would see greater differences with Tele-Mental Health doing much better than Community Care but, it looks like when we did that sensitivity analysis, the adding whether the baseline was done post COVID as a dichotomous variable that was not significant in any of the results. The interaction term between the group comparisons was not significant in any of the results. Things did not get worse or better post COVID for the Veteran experience and the difference between Community Care and Tele-Mental Health did not change post COVID. It appears that Community Care pivoted, the VA pivoted really fast in terms of providing care to Veterans in their homes. A nice article about that in *JAMA* a while back about how many Veterans were treated with VA video connect but it appears the Community Care healthcare system also pivoted quickly and effectively.   
  
To summarize I would say that the referral success rate for both Tele-Mental Health and Community Care was very high 80% to 75% of people having at least one visit and six visits in four moths is pretty darn good. When you look within the VA, in-person care when you refer somebody from primary care to especially mental health or PTSD clinic or substance abuse clinic, the referral rates are not very good. Often, we are hovering around 25% because Veterans just do not want to shift from primary care to specialty mental health and stigmatizing with lots of concerns about it. Here we are getting 80%/75% success rate I think that is great.   
  
Both programs appear to be effective at engaging Veterans in the encounters. There was significantly greater satisfaction with appointment scheduling and Tele-Mental Health so that is something Community Care can work on. There was somewhat greater perceived access for Veterans with a Tele-mental Health consult compared to a Community Care consult. We rejected, the hypotheses within each domain but when we counted the number of barriers that was statistically significant, not a big difference, but statistically significant. There were concerns about coordination between VA and Community Care providers that currently need some work. There was a high satisfaction with the Tele-Mental Health encounters so that is really good news for the clinical resource hubs. There were no differences in the number of encounters, patient centeredness. No differences in symptom reductions and symptom severity, there were no reductions in symptom severity essentially.   
  
Just to conclude, it seems that the results indicate that when given a choice as opposed to being randomized, these results may have differed if Veterans were randomized to Community Care versus Tele-Mental Health. In this case, they chose or their provider helped them choose which type of consults they wanted. Overall, when people are given a choice, going to the Hub or going to the Community Care, service utilization, satisfaction, patient centeredness, all these things look good and about the same in both groups. It is possible and what it seems to me that the Community Care Program and the Clinical Resource Sub-Mental Health Program they may complement one another. In particular the Tele-Mental Health Hubs seem to be filling a need in the rural communities that are not being served by Community Care. There are much higher proportions of Veterans getting Tele-Mental Health Hub consults from rural areas, 50+% compared to only about a third in Community Care Program. The Tele-Mental Health Hubs which are partially funded by the Office of Rural Health may be completely funded, I am not sure, they are doing their job in terms of serving rural Veterans. That does not look like it would be solved completely by Community Care. That is likely because if there are not VA services in rural areas, there are also likely not Community Care providers in those rural areas, at least not those that sign up to contract with the VA.   
  
Going back to the choice issue, it is likely that the Veterans and their providers are choosing the option that works best for their context and their local community context. Going back to the issue about why are 100% of Veterans in some CBOCs referred to Community Care versus 100% in other CBOCs going to Tele-Mental Health Hub. It may be that the CBOCs that are referring 100% to the Community they just have good community network, network of community providers in their area, around that CBOC. Whereas the CBOCs that are referring all to the Tele-Mental Health Hub are in areas probably more rural areas, that do not have very many Community Care providers contracted with the VA. I think in terms of going back to revisiting the “make or buy” decision I think what this indicates to me anyway is that is “make and buy”. These are complementary programs, they are probably serving different communities well, but not the same community well. I think the conclusion here is that we should continue to make mental health services available to Veterans via the Tele-Mental Health Hubs and to buy them from the community. The big concern here is the poor clinical outcomes suggest that in both groups, they need more intensive treatment then they are getting. We were not able to compare quality of care, we could have done so perhaps in the Tele-Mental Health Hubs by doing chart review and seeing what kind of care they were getting. Were they getting evidence-based psychotherapy; were they getting high enough doses of medications, etcetera? We cannot do that for Community Care. At the time we did the study the claims data were not available and claims data does not have the information we need to assess quality anyway for the most part. We do not know the difference in quality but I would conclude that quality needs improvement in both groups. One option for Tele-Mental Health Hubs anyway is to do what we call Tele-Psychiatry Collaborative Care which is an extension of Primary Care Mental Health Integration model PCMHI. One of the services that PCMHI delivers is collaborative care case management. They tend mostly to do that with in-person but it certainly is possible to provide collaborative care management virtually where their care managers are doing telephonic or even interactive video encounters with Veterans every week or every two weeks to assess their symptoms; provide psycho education; help them navigate the system; help them stay engaged and activated, not drop out of treatment and have the tele-psychiatrist or tele-psychologist delivering care every three weeks or so. So, something probably the clinical resource hub may think about doing something more intensive to try to improve outcomes.   
  
For future directions, we certainly need to examine the quality of care that is something I think a lot of people have known that we need to examine quality of care for the community, it is provided in the community, it is difficult to do. You really cannot do it by asking Veterans questions, you can get a sense of their satisfaction and their barriers, etcetera, but it is really hard to assess quality by asking the patient questions. Something we can do though there are caveats to it, is compare the cost of care. So going back to the “make or buy” decision, I said “make and buy”, but I do not know that really the cost is the same for the two types of services. It is quite likely that the Community Care costs quite a bit more and therefore we should be doing Tele-Mental Health Hubs instead because it is less expensive. The difficulty there is that they way of measuring costs in the two groups is going to be fundamentally different and Tele-Mental Health Hubs there will be a cost accounting method where the total salaries of the providers and the mental health hubs and the fixed costs of the facilities they are in get added up and then divided across the encounters. That determines the cost to providing Tele-Mental Healthcare versus Community Care where the cost is essentially how much claims were paid. Those are two different ways of assessing costs which makes them difficult to compare. It is something that I have alluded to earlier was there may be some substantial geographic variations in how well the Community Care and Tele-Mental Health programs are doing. Both rural and urban we could look at with I think more specifically, certainly different geographic reasons. Maybe Community Care is doing great in one VISN and terrible in another VISN so we need to examine that. Then lastly, we need to look at health disparities. Not only rural/urban differences and experience but also race; ethnicity; sexual orientation; gender, etcetera.   
  
I think I will stop there, and take questions. Rob if you have accumulated any in the chat box.

Rob: We have, yes most of them are in the chat box, unfortunately it is a little bit difficult for me to navigate the chat box I will do my best. We do have one that came in to the Q&A panel so I will read that one first. Anybody if you want to submit questions at this point, please do use the Q&A panel. If you do not see that click on the three dots in the lower right-hand corner and Q&A should be an option there, click on it, it will turn blue, and then it will be a panel on the right-hand side, as I said I will do the best I can with the ones that came into chat. First this person asked – I may have missed this, but how did you administer the survey questions to the participants?

John Fortney: I forgot to say that. We telephoned people; it was a telephone survey.

Rob: Okay. Could COVID isolation and stress possibly explain the declines in PCO and PTSD?

John Fortney: A good question not declines, probably the lack of improvement is what the person is asking. Yeah, that could have contributed to it. I would have to go back and see what proportion of our four-month follow-ups were done pre-COVID and that is something that is a great suggestion. I think I will go do that. I cannot report that to you now, but it is possible that we would have seen greater declines in symptom severity for those four-month follow-ups that were done before March 17th compared to those that were done after March 17th. It is a little tricky because some people were half the four-month period was half pre-COVID and half post-COVID it is kind of complicates the analysis. That is an interesting question and I will follow-up on that. Thank you.

Rob: Thank you Dr. Fortney. Do you think these results would differ if there was a balance between the portion of VA and portion of Community Care in tele-health and in-person?

John Fortney: Originally that question, I would not have considered relevant because what the VA was doing was either making tele-mental health services for Veterans or buying in-person services for Veterans. That was just was the comparison and the question would not have been – what if the Community Care ones were tele-health. With post-COVID, that is a tough question to answer. I am not sure I can do that one justice. It is just something we originally could not control for because 100% of the tele-mental health were tele-mental health and 100% of Community Care were in-person. We could not have even statistically analyzed that. We could try that now and that is another good question that I could follow-up with in terms of and doing subsequent analysis.

Rob: Thank you. Thank you for a great topic. Did you collect any data on the type of treatment received? For example, were there differences between CC and TMH in terms of receiving evidence-based psychotherapy? EG/CPT/PE versus less structured supportive psychotherapy?

John Fortney: That is a question that I wish I could answer yes to but I cannot answer yes to that question. Here is why it is because we could have chart reviewed the Tele-Mental Health Hub encounters and classified them as PE or CPT or CBT or were some evidence-based psychotherapies. We could have used natural language processing therapy to do that but with the sample size we probably could have done it by hand and I would have felt good about those results. We have done that in the past. With Community Care there is no way to do that. Even with the claims data, it is just going to be 45 minute/50-minute psychotherapy session with no indication of what type of psychotherapy it was. People have tried myself included to ask patients what kind of psychotherapy they got and it just it cannot really do it. There is one study, I cannot remember the citation where they were able to do a chart review to assess what kind of psychotherapy, they got CBT in that case is what they were looking for. They asked patients a very kind of clever set of questions to try to figure it out whether they were getting CBT. Thirty percent of the chart review patients indicated they were getting CBT and 85% of the patients were saying they were getting CBT. It is just not something that we can get at with patient self-report, we did not try to do it because I knew it would be questionable, the results would be questionable.

Rob: It looked like participants received about five to six encounters during this review. Could it be that the lack of improvement is due to only completing half of the typical course of psychotherapy?

John Fortney: Yes, that is absolutely true, if it is psychotherapy. The other thing is it was difficult to tell whether they were getting even medications versus psychotherapy. Yes, if they were getting psychotherapy and I expect a lot of it was psychotherapy they are clearly not getting it frequently enough. Something like PE or CPT is supposed to be done once a week. So, over the course of four-months you would have completed the 12 sessions even if you got a late start, you can complete 12 sessions in three months which is why we kind of chose the four-month timeframe. If it is a medication, you can do two medication trials in four months. You can try one medication and see if it works after two months if not switch them and do another trial and improve outcomes by four months. I think four months is enough time for the provider to improve outcomes, or should be able to be enough time. I do not think they were getting…either they were not getting intensive enough treatment or they were not getting frequent enough encounters or both.

Rob: Thank you. Who determines the future direction that you suggested?

John Fortney: [Chuckles] There is a Clinical Resource Hub Evaluation Team and they report to the Director and the Director reports to the Chief of \_\_\_\_\_ [00:55:05]. They are the folks that are making the policy choices here certainly not me.

Rob: Thank you. There are a few questions that I can pull out of the chat. Were all consults sent to Community Care scheduled by TPA? This may have changed, but currently depending on the CAN Score consults sent to Community Care can either be scheduled by the TPA if basic or by CT…TITC staff (I am sorry) if greater than basic?

John Fortney: TITC Staff…That is news to me. I think that during our evaluation it was all by the third-party administrators, the TPA’s. I am actually not familiar with the other way of scheduling. I am not surprise there is another way of scheduling because there was a lot of dissatisfaction with the TPA’s. I am glad to hear that there are alternatives to that.

Rob: Thank you. You have one more into the Q&A. Within the population of all Veterans receiving mental health services, about what percent are receiving all in-person mental health visits and what percent are receiving at least some tele-mental health visits at least before COVID-19?

John Fortney: I do not have that figure off the top of my head. I think that pre-COVID I think about five percent of Veterans were getting some tele-mental health or maybe it is even five percent of the encounters were tele-mental health. I do not know what percentage it is today or has been over the last year. I imagine it is closer to 80 but that is a guess.

Rob: Thank you. Were the Veterans studies novel to free care? Those that used it in the past may be more negative.

John Fortney: Can you read that one more time Rob?

Rob: Yeah, I am sorry. I think the question is – were the Veterans in the study new to free care, new to fee care f-e-e. Those that used it in the past may be more negative.

John Fortney: Yeah, these are all new episodes of treatment. That does not mean that they are all Community Care naïve, but what we did was we were very careful about doing a chart review on the part of the consult to make sure that it was not a continuation with the same provider that they had already been seeing. The person is absolutely right, that would have biased the results if half the Community Care sample were just signing up to get to see their provider in the Community Care provider for another year that would have indicated that they were satisfied. We worked really hard to make sure that we were excluding those. Those were the SARs, the 150 SARS that we ended up excluding which it was why the sample was not balanced out because so many of the consults with Community Care were actually continuations.

Rob: Thank you. This person actually found their own answer.

John Fortney: Oh good.

Rob: But since we have about a minute left, I will ask it and it is the last thing we have here. Was there a difference in the number of appointments between CC or TMH? Did the VA or CC offer more appointments in a certain timeframe.

John Fortney: It was both about 6; like 6.1 and 5.9.

Rob: Thank you sir, that was the last question that we had queued up in either the chat or the Q&A. If you would like to make closing comments, now would be the time.

John Fortney: I just want to thank everybody’s attention these zoom webinars are getting old these days so thank you for listening. Take care.

Rob: Thank you Dr. Fortney, there was one question about recordings. You will receive an email in approximately two days with a direct link to the recording and slides and all communication materials from this webinar except for the transcript which will come a little bit later. When I close the webinar momentarily, you will be presented with a webpage that opens up with a few questions, please take a few moments to answer those questions. We do count on them to continue to bring you high quality cyber-seminars such as this one. Once again thank you Dr. Fortney and with that…

John Fortney: Thank you.

Rob: …have a good day everyone.