Program Evaluation of Veteran Outcomes and Project Implementation

Program Evaluation and Resource Center (PERC)
Mental Health Operations
Part 1: Monitoring Veteran Outcomes

**WHO:** Veterans being referred from VA to pilot partnerships with community–based providers.

**WHAT:** A structured interview about current mental health symptoms, their impact on Veteran’s functioning, and experience with community-based partnership.

**WHEN:** Trained call center staff contact eligible Veterans by telephone within 6 weeks of Veteran’s referral to community-based partnership for baseline assessment. All Veterans are re-contacted 3-5 months later for a follow-up assessment. A portion of Veterans were only assessed once, 3 months or more after referral.

**WHY:** To evaluate patient outcome data of Veterans participating at pilot sites. To provide feedback to VA facilities about the status and experience of Veterans participating in the pilots, including suicide risk assessment. To guide clinical operations and policy development regarding partnerships. To evaluate the quality and effectiveness of this pilot initiative.
Aims

1) **Identify strengths and weaknesses** of the pilot programs in terms of effect on Veterans mental health and functional status, and patient experience of care.

2) Provide facilities with independent **feedback** about referred patient health status, including suicide risk and function.

3) Describe the **co-morbidity, functional status, and severity of symptomatology** among Veterans being referred to community-based partnerships.

4) Examine Veteran **perceptions of benefit from treatment, and the recovery-orientation, timeliness and receipt of mental health care** as delivered in the pilots.

5) **Estimate change in mental health symptom and functioning** in the first 3-6 months after referral to community-based partnership.
Survey Measures

Functional Impairment
- Sheehan Disability Scale

Mental Health Symptoms
- AUDIT-C
- Substance Use
- Short form of PTSD Checklist (PCL-6)
- Patient Health Questionnaire (PHQ-9) with P4 Screener
- Veteran Recovery Assessment

Perception of Care
- Treatment Satisfaction
- Perceived Improvement
Partnership Models

Veterans referred to community-based partnerships receive:

• Services from a community provider (fee-basis or contract)
• Services by VA staff delivered via telemental health (TMH) to Veterans at a community provider location
Part 2: Qualitative Implementation Evaluation

**WHO:** Key VA leadership staff (at VACO, VISN, and facility levels) involved in set-up and implementation of pilot projects nationwide.

**WHAT:** Interview designed to identify lessons learned from the pilot program for use as part of the formal evaluation of the Executive Order.

**WHEN:** Interviews were conducted January through April 2014.

**WHY:** To evaluate the quality and efficiency of this pilot initiative. To provide feedback to VACO, VISN and facility leaderships about potential pitfalls and successful strategies for establishing partnerships with community-based providers.
Interview Protocol

BACKGROUND
• Selection of partner site and partnership model

ROLES AND RESPONSIBILITIES
• How VHA and community partner figured out who was doing what

COORDINATION OF CARE
• Challenges and solutions to delivery of coordinated patient care across VHA and community providers

QUALITY OF CARE
• Processes for ensuring that care is of the highest quality possible

LESSONS LEARNED AND BARRIERS
• Barriers and facilitators to setting up community collaboration
Lessons Learned: Early findings from VA’s ongoing program evaluation

BACKGROUND

• Most facilities consulted information about the geographic location of Veterans to narrow down locations for possible partnerships.
• Some community-based providers identified Veterans in their own clinical population who may not be enrolled with VHA.
• Community-based providers who already employ Veterans may be more open to partnering with VA.

ROLES AND RESPONSIBILITIES

• Facilities able to meet gaps in local needs by seeking specific services from community-based providers
  – Residential substance use treatment for a VAMC facility w/o a lot of residential capacity
  – Supportive treatment, so VA providers focus on providing evidence-based PTSD therapy
  – Providing care in certain geographical areas which are difficult to access/lack VA services
Lessons Learned: Early findings

COORDINATION OF CARE

• Partnership model affects amount of coordination and monitoring required.
  – Non-VA care requires more planning and communication with community-based provider to comply with VA directives (e.g. new patient evaluations, no-shows, risk assessment evaluations).
• May require development of standard procedures between several VA services, like Mental Health, Contracting/Business Office, and Medical Records.

QUALITY OF CARE

• Many VA staff felt the partnership with VA increased the quality of care at community-based providers due to compliance with common VA directives.
• A number of VA staff in non-VA care partnerships, felt the partnership was a necessary stop-gap measure but hoped to expand internal capacity due to the high quality of VA providers and care standards.
Lessons Learned: Early findings

BARRIERS

• Some rural areas have a dearth of any mental health providers, particularly those that can see new patients within 14 days. A variety of telemental health models may be necessary to cover such areas.

• Some partnerships are successful due to a few engaged (VA or community-based) staff members, but these partnerships can falter when staff/roles change.

• Sharing records or sending encrypted emails between VA and community-based providers is still exceedingly difficult.
  – Some community providers willing to give VA staff access to their medical records.
  – State Health Information Exchanges may offer opportunities to share pertinent records.

• Existing telemental health equipment at community-based provider may not be compatible with VHA equipment and/or IT security requirements.
Lessons Learned: Early findings

LESSONS LEARNED

• Consult with Contracting and IT Services as soon as possible to assess a potential proposal. Most serious implementation hurdles came from one of these areas.

• Most VA staff recommended partnering with a community-based provider who is excited about partnering with the VA. Reported indicators of engagement:
  – Site visits by leadership and/or treatment teams (to both VA and community sites).
  – Outreach activities by community partner to engage Veterans not enrolled in VHA.
  – Attendance at VA mental health summit or stakeholder meetings.

• Community-based provider fees (e.g. to lease space, provide admin support, etc.) varied widely from one provider to another.

• Embedded VA liaison staff are helpful in monitoring, tracking, and managing large non-VA care arrangements. They’re particularly helpful in reducing communication barriers between Veterans, VA staff, and community-based providers.
Future Directions

• Continue to collect Veteran outcome and satisfaction survey data through end of FY2014. Anticipating adding an additional facility utilizing TMH partnership model.

• Draft national and site specific summary reports of analysis on the effectiveness of the pilots on mental health outcomes, patient use, and satisfaction with care.
Questions or Comments?

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