Summer 6-27-2022

Evaluating the Effectiveness of Veterans Affairs Care in the Community Program

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EMPA 396

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6-27-2022

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Abstract

This research paper focuses on the effectiveness of the Veterans Affairs (VA) Care in the Community (CITC) program. This program is derived from the Mission Act of 2018, which allows Veterans to seek outside care through community providers if the VA cannot provide a primary or specialty care appointment within the established guidelines or if the Veteran lives farther than 40 miles from a VA facility. Recent studies surrounding this topic guided the literature review to discover the known issues and successes within the VA's community care history. The research was conducted using a mixed-method approach in which qualitative and quantitative data was collected and analyzed to accept the hypothesis. Based on the findings of this study, the results validated the theory of change and assumptions. The data also displayed the high potential to negatively impact a large percentage of the 2 million CITC users the VA already has approved to use this program.

Keywords: Veterans Affairs, Veterans Health Administration, Community Care, Veterans

Chapter I: Introduction

Background

The United States has taken great pride in providing care and additionally community care to its Veterans since the 1920s. This is based on the Veterans Affairs mission statement that aligns with President Lincoln's promise of "To care for him who shall have borne the battle, and for his widow, and his orphan, by serving and honoring the men and women who are America's Veterans" (VA, 2021). As the Veteran population has grown, there have been many attempts to satisfy this requirement of fulfilling adequate care needed for this increase.

Most recently was the signing of the newly designed law "VA Mission Act of 2018", in which the Care in the Community (CITC) program was rolled out to encompass the previously mandated community care programs of the Veterans Health Administration (VHA). The CITC consolidated programs the VA had been rolled out previously, such as the Veterans Choice Program (VCP), which was part of the previous public law "The Veterans Access, Choice, and Accountability Act of 2014, P.L. 113-146" (Bass et al., 2021).

With the current population of Veterans reaching over 9 million in recent years, there is an increasing effort to ensure the VHA provides the most adequate health care possible. With aging infrastructure and facilities, the federal government has partnered with its community counterparts to offer service. In a recent study completed by the Congressional Budget Office, Bass et al. (2021) provide data that shows 2.3 million Veterans were authorized for community care in 2020. This number represents nearly a third of the Veteran population. To fulfill the great demands of this population, great care and effort must be taken to ensure those who protected and served this country honorably receive the necessary care they deserve.

Statement of the Problem

The goal of the proposed capstone is to explore how to make the VA CITC program more effective. Further research needs to be conducted to determine what deficiencies if any are involved with current Medical Support Assistant (MSA) training, care coordination between the VA and community providers, and accessibility barriers within the underserved populations of rural and aged 65 and older Veterans. Therefore, to make the VA CITC more effective, MSA training needs to be expanded, coordination between VA and providers needs to be improved, and more access options need to be enhanced for the underserved populations.

Purpose of the study

This study aims to determine if the effectiveness of the CITC program can be linked to the VA's internal processes of employee training and readiness, utilization of the current Care Coordination model, or the access to community care services by those Veteran populations considered to be underserved.

Significance of the study

"The Veterans Health Administration (VHA) is the country's most extensive health care program, which currently serves over nine million Veterans that served in our country's conflicts of World War II (WWII), Korean War, Vietnam, Desert Storm/Shield, Iraq, and Afghanistan" (McVicker, 2021). As many as 69.6% of these Veterans are currently enrolled in VA health care (NCVAS, 2017). These numbers alone define the significance of conducting such a study. Since recent legislation has changed the policy and procedures of providing Veterans with non-VA healthcare by using community-based partnerships, the program's effectiveness needs to be evaluated to determine if the legislation's goals are being met. This research should provide the

necessary evidence to address any problems or issues that have been exposed during the last four years since the program's inception. In doing so, the hope is to create awareness within the VA and VHA leadership to make the appropriate adjustments for the program's effectiveness.

Main research question and sub-questions

The main research question is:

1. What changes can be made to the current VA Care in the Community program to increase the effectiveness of the medical staff and increase patient satisfaction?

The sub-questions are:

2. What improvements to the Medical Support Assistants (MSA's) training would result in greater effectiveness and efficiency?
3. What specific improvements to the Care Coordination model are needed?
4. How can the VA's Care in the Community program increase options for access for the underserved populations of Veterans?

Theory of change and Assumptions

The theory of change for this research study is: if training for Medical Support Assistants (MSA's) is expanded, if the existing VA Care Coordination model is improved, if more options for access are enhanced for underserved Veterans populations, then the VA's Care in the Community program will be more effective. Based upon the theory of change presented, the following assumptions are made:

Assumption 1 (A1): If training for Medical Support Assistants (MSA) is expanded, then the VA's Care in the Community program will be more effective.

Assumption 2 (A2): If the existing VA Care Coordination model is improved, then the VA's Care in the Community program will be more effective.

Assumption 3 (A3): If more options for access are enhanced for underserved populations, then the VA's Care in the Community program will be more effective.

Limitations

The limitations surrounding this study will revolve around the targeted population of respondents comprised of nearly 80 CITC department members, numerous local Veteran Service Organizations, and nearly 31 thousand Veterans in the Ventura County area. The survey targeted population are those Veterans in the age group of 65 and older, along with those that live outside the commuting distance from the local VAMC. Due to the time constraints around this research the sample population will not be at the appropriate size to determine the health of the entirety of the program. This study is also not intended to explore further causes of Veteran medical/psychological needs that may attract or detract them to the CITC program. Furthermore, this study does not intend to determine the efficiencies of operations provided through VAMC services.

Definitions of terms

Veterans Affairs and Veterans Health Administration use many terms, phrases, and acronyms when describing their programs and initiatives. Some of these terms and phrases overlap internally and can be applied to multiple areas within the VA.

Community Care refers to non-VA health care that is provided cost-free for Veterans who are outside the average drive time to a specific VA medical facility. This health care can also consist of primary or specialty care that cannot be provided by the local Veterans Affairs Medical Center (VAMC) in a timely manner.

Medical Support Assistants (MSA's) refer to administrative clerks within the VA's various Patient Aligned Care Teams (PACT) and other sub-teams that are formed. They handle the scheduling of appointments, determination of type and level of care, and other patient interactions either in person, over the phone, or online.

Expected Impact of the Research

This study has the potential to identify any training deficiencies, gaps within the Care Coordination model, and patient access barriers that may be unknown to the VA. Since this study is only a regional study, other VA regions and community providers could utilize these findings and apply them to other regions across the United States.

Chapter II: Review of Literature

Introduction

Within this chapter of the study, the focus will be on utilizing both professional and academic literature to address the main research question and sub-questions proposed in chapter 1. The main research question revolves around the effectiveness of the CITC program, whereas the sub-questions revolve around training, internal processes, and access barriers for underserved populations. This literature review will attempt to explain what has been previously studied in a close relationship to the current study while providing connections to the research questions. This will be done by discussing the following themes: The role of MSA training, the VA Care

Coordination Model, and access to care for Veterans. During this review of literature, there were no intentional source exclusions applied.

The Role of Medical Support Assistant Training

The MSA job within the VA is known for being an entry-level position in which many individuals are brought in at lower pay grades. The current standardized training coincides with low pay grades, given that most receive approximately three days' worth of onboarding before learning their actual position through on-the-job training. A recent study on *The unrecognized role of VA Call Center and Primary Care Clerical Staff in assisting patients with obtaining needed care* focused on the roles, responsibilities, training, and job satisfaction. McGown et al. (2021) revealed three significant findings of MSA's roles as more than just scheduling appointments for Veterans, training does not prepare them well enough to assist Veterans in obtaining the needed care, low salaries, and lack of recognition contributes to dissatisfaction and high turnover rates.

In a similar study, *The Future Role of Receptionist in Primary Care*, Litchfield, Burrows, & Greenfield (2017) revealed how often receptionists in the primary care setting are overlooked and undervalued even though they are considered the gatekeeper to controlling access for patients to primary care services. They further elaborate that personal experience and professional intuition lead the decision-making process in determining the type of care a patient may receive.

In Poorani's (2021) study *Veteran Patient Experience Academy: Putting Veterans First*, the focus was on employee training and integration of new tools to enhance Veterans' experience with the VHA. The results indicated that all levels of staff needed additional training to increase their effectiveness and customer satisfaction.

Before the CITC was formed, these shortcomings in training and refined processes were discovered in the VCP. The 2017 study *Adaptation of lean six sigma methodologies for the evaluation of veterans choice program at 3 urban veterans affairs medical centers* focused on introducing Lean Six Sigma (LSS) principles to the healthcare setting to improve the processes of all personnel working within the Veterans Choice Program (VCP). Ball et al. (2017) explained that while LSS processes would be beneficial, the current LSS language is not intuitive in the healthcare world and would need to be tailored to fit the language and goals within healthcare. This study doesn't exactly match the assumptions in chapter 1. Still, it does provide analysis concerning the effectiveness of how individual VA Medical Centers (VAMC) and Community Based Outpatient Clinics (CBOC) provide services as each of these sites provide a different level of efficiency and variations of the types of service they provide.

The VA Care Coordination Model

Assessing and providing the necessary care for Veterans has long been a concern for the VA. In the attempt to mitigate any lapse in care, the VA (2022) developed the five-step Care Coordination Model, which is described as receiving requests for community care, assessing Veteran needs, developing care coordination plans, implementing care coordination plans, and follow-up and complete episode. The article *Standardizing Care Coordination within the Department of Veterans Affairs* outlines two new initiatives by the VA to address and mitigate the risks of improper coordination of care for Veterans. Within these initiatives led by the VA's Office of Community Care, the Care Coordination and Integrated Case Management (CC&ICM) initiative adopts a Veteran's whole health approach. It encompasses the following core elements: Care Coordination Review Team (CCRT), care stratification methodology, and a Lead Coordinator (LC)" (Greenstone et al., 2019). Establishing these specialized teams and

coordinators will allow for Veterans to be managed individually and by diagnosis. The initiative is expected to leverage the other existing areas across the VHA.

In the study, *Recommendations for the evaluation of cross-system care coordination from the VA state-of-the-art working group on VA/non-VA care* focused on care coordination between VA and non-VA care providers. It was discovered that three specific areas were of concern and needed to be addressed. Mattocks et al. (2019) explain that the three areas were developed through workgroups: Identifying Veterans who benefit most from care coordination, delivery of care coordination services, and care coordination measurement systems. This approach does align with the study's assumptions of the necessary improvements needed in the Care Coordination model.

As Veterans decide to move their healthcare to the community setting, they must be aware of the inherent risks surrounding non-VA healthcare settings. In the study, *A mixed-methods study of the Association of non-Veterans Affairs Care with Veterans' and clinicians' experiences of care coordination* reported that Veterans who received both VA and non-VA care had significantly worse care coordination experiences than Veterans who only received care at the VA. Benzer et al. (2020) reveal that the VA should put more effort into prioritizing coordination of care while also increasing the levels of access for Veterans.

Innovations to streamline care coordination for Veterans seems to be a common theme among researchers today. In the *Practical use of process mapping to guide implementation of a care coordination program for rural veterans*, the approach of utilizing Lean Six Sigma (LSS) process mapping tools for streamlining new programs. Lean processes in the business and manufacturing industries have shown to be quite beneficial in eliminating wasteful actions. The LSS process mapping "can be used before and during program implementation and provides

insights into processes, role variations, and process inefficiencies, thus informing and customizing the design and implementation of clinical quality improvement interventions" (McCreight et al., 2019). Given that these processes will have mixed results at various sites, they justify attempting to change the Care Coordination model.

One commonality from these previous research studies is that patient satisfaction is high on the list of known issues pertaining to the program. These different satisfaction levels may be one reason for Veterans using both VA and non-VA care. In the study *VA-community dual care: veteran and clinician perspectives*, the study focused on identifying the perceptions behind the perceived benefits and challenges of using dual care within the system. "Veterans reported that community and VA providers were informed about the others' care more than half the time" (Schlosser et al., 2020). This would leave less than half the time of coordination of care as adequate or unfulfilling to what the VA is striving to achieve. Thus, "raising the potential for significant patient safety and Veteran satisfaction concerns" Schlosser et al., 2020).

Access to care for Veterans

With all these opportunities and choices, why is access to care still an issue across the country? In a recent study *Ready or not?: Assessing the capacity of New York State Health Care Providers to meet the needs of veterans*, discovered that community-based providers in New York state are not equipped to handle the various backgrounds and medical issues specific to Veterans. This deficiency of readiness for Veteran patients contributes to the accessibility problems that Veterans may face when trying to be seen by community providers.

Since specialty care services are among the most prominent participants of the CITC program, there will be greater demand for items such as mental health services for those outside

the normal commuting distance established by the VA. One recent study, *Development of a perceived access inventory for community care mental healthcare Services for Veterans,* focused on identifying barriers unique to community care and comparing those most frequent barriers reported by Veterans. One of the most reported barriers of this report was the long wait time to receive care. "The average time for veterans to receive routine care … was 51 days" (Payne et al., 2019). While these wait times are nothing new, they propose a high chance of risk for the Veteran to have additional medical episodes before being seen by a provider, which may hinder further access to care.

Rural Veterans have a high risk of being excluded from access depending on the part of the country they live in. In particular, those Veterans living in low population areas that do not have established community medical facilities create commuting issues so they can receive the necessary care. However, one study *Rural Veterans' Experiences With Outpatient Care in the Veterans Health Administration Versus Community Care* discovered that Veteran experiences with specialty care through community providers were just as good as inhouse VA specialty care services. However, primary care through community care was still lacking compared to their VA counterpart. Through recent investments in "community provider training on military culture and posttraumatic stress disorder, more expansive care coordinator functions, and infrastructure to support health information exchange might have contributed to improvements in Veterans' ratings of CC providers and their experiences with CC access and coordination" (Davila et al., (2021). While these investments haven't solved every issue with community care, "this suggests that there remains room for further improvement" in the access and coordination model (Davila et al., (2021).

Conclusion

Many of the issues brought to light during the literature review revolve around one central topic of patient satisfaction and then branch out to the other notable themes of this chapter. Within the theme of "The Role of the MSA Training", the authors conclude that training is a vital role in preparing MSA's for their role within the VA healthcare system which would increase patient satisfaction. Also, by giving recognition where needed would solve some dissatisfaction amongst employees. Throughout the theme of "The VA Care Coordination Model" a common trend of improving and developing additional safeguards for Veterans was noted by the authors. It was concluded that due to the poor levels of communication between VA and non-VA care, determined the overall level of care a Veteran may receive. In the theme of "Access to care for Veterans" the authors highlighted the main barriers that non-VA providers created for Veterans through their lack of understanding the military cultural and long wait times. The also authors noted that by improving the patient experience, accessibility, and coordination would solve many of the known problems.

With the continual increase of eligible Veterans authorized to use the CITC, the system needs to figure out the best solution to run and maintain the program. The best tactic would be to take a more simplistic approach to solve problems at the local level and then apply the successful methodologies to the much more significant issues. Regardless of the action taken, steps to mitigate the current issues will need to be addressed in the near future.

Chapter III: Research Methods

Introduction

The study's objective was to determine whether there is adequate data to support the realignment of employee training, reevaluation of the Care Coordination model, and increase in access to community care that will change the overall effectiveness of the CITC program. The research model allowed for an in-depth view of the behind-the-scenes actions within the CITC department. The study also allowed Veterans to voice their opinions on the satisfaction and effectiveness of the federally mandated program.

Research Question and Sub-questions

The main research question posed for this study is: What changes to the VA's current Care in the Community program can be made to increase the effectiveness of the medical staff and increase patient satisfaction? The research attempted to answer these sub-questions: What improvements to the Medical Support Assistants (MSA's) training would result in greater effectiveness and efficiency? What specific improvements to the Care Coordination model are needed? How can the VA's Care in the Community program increase options for access for the underserved populations of Veterans?

Theory of Change and Assumptions

The theory of change for this research study was: if training for Medical Support Assistants (MSA's) is expanded, if the existing VA Care Coordination model is improved, if more options for access are enhanced for underserved Veterans populations, then the VA's Care

in the Community program will be more effective. Based upon the theory of change presented, the following assumptions are made:

Assumption 1 (A1): If training for Medical Support Assistants (MSA) is expanded, then the VA's Care in the Community program will be more effective.

Assumption 2 (A2): If the existing VA Care Coordination model is improved, then the VA's Care in the Community program will be more effective.

Assumption 3 (A3): If more options for access are enhanced for underserved populations, then the VA's Care in the Community program will be more effective.

Operational Definitions

For the purpose of this study, the following Operational Definitions have been established to provide a clear understanding and minimize any confusion with similar terms concerning the research topics.

Medical Support Assistants: For the purpose of this study, MSA's represent VA personnel that handle the scheduling of appointments and determine what type of care is needed for individual veterans using Care in the Community to seek care outside the VA health care system.

Training expansion: For the purpose of this study, training expansion represents the increase in standard training practices that MSAs currently receive from the VA when appointed to their position.

VA Care Coordination Model improved: For the purpose of this study, improvement of the VA Care Coordination Model represents any reorganization of the existing model that would result in streamlining current processes within the model.

Access Options enhanced: For the purposes of this study, access options enhanced represent the various options provided to Veterans through the Care in the Community program to access non-VA health care.

Underserved populations: For the purposes of this study, underserved populations represent veterans over the age of 65 and Veterans that are considered rural or outside the 40-mile criterion to receive non-VA specialty and primary care.

Effectiveness increased for VA Care in the Community Program: For the purposes of this study, the effectiveness increase represents a 10% or greater increase in the Care in the Community Programs' ability to provide adequate and timely health care service to the Veterans that use the program. This increase change will be measured by the current participation of Veterans utilizing the CITC program and the future participation levels based on the findings from this study.

Population Sampling Strategy

The population sampling strategy for this study consisted of using rapid online surveys and key informant interviews. For this study, the population sample will come from the VA CITC department members located on the Sepulveda Ambulatory Care Center campus. Other population samples will include Subject Matter Experts (SME) from California Veteran Service Officers (CVSO). The goal was to have at least ten key informant interviews, however; only eight were able to be accomplished. Lastly, the Veteran population of Ventura County was sampled for their use of non-VA care through the CITC program, however, due to poor participation the parameters were opened up to Northern California, Oregon, and Washington. The initial goal was to reach at least 100 Veterans with these surveys, due to poor participation

rates there were only 50 surveys completed. These three separate populations comprise the population that was sampled for this study.

Procedure

Data received from this study was collected from the rapid online surveys, and key informant interviews. The surveys were deployed using "Survey Planet" to be distributed through local Veteran Facebook pages, Veteran Service Organization membership emails, the Nextdoor app, and through email to friends and colleagues. The same survey was also distributed as a hard copy to the local Veteran Service Organizations (VSO) such as the American Legion, Veterans of Foreign Wars, Disabled American Veterans, Marine Corps League, and Gold Coast Veterans Foundation to capture potential respondents during monthly meetings and events at their place of business. Key informant interviews were conducted with VA MSA's and Leads that currently work in the Care in the Community department. Other key informant interviews will be conducted with the Subject Matter Experts (SME) residing in the local VSOs. The online were deployed during weeks one through six during EMPA 396, while the interviews were conducted during weeks two through four of the course.

Data Processing and Analysis

Once all data was gathered from the surveys and interviews, it was consolidated on spreadsheets for further calculations. Consolidation of the data in this manner allowed for better organization of the data retrieved and to be appropriately analyzed. Survey responses were tabulated and distributed to visual charts like pie charts or bar graphs. Interview responses were consolidated in the same manner to determine common trends amongst the questions asked. Both

surveys and interviews were used to determine if the initial assumptions of this research problem are valid. All additional information or feedback gained from the interviews will be used for future recommendations or possible future studies on this topic.

Internal and External Validity

Within the design of the study there are some unknown factors that could threaten the internal validity. One possible threat is the unknown effects created by the COVID-19 pandemic that changed healthcare protocols for working environments and also appointment protocols for new and existing patients. Another factor that is unknown is the targeted population's reaction to the survey, in which they might have "survey fatigue". This may be due to increased surveys that were launched during the pandemic.

The use of convenience and voluntary response sampling methods tend to contain some bias among the target population. Therefore, utilizing this study's results to determine the larger populations general opinions might not create a clearest picture of the results. So, this study would best be used for initial investigations surrounding the research area and topic.

Limitations

As with most research studies, anticipated and unanticipated limitations will expose themselves throughout the data collection process. One of the anticipated limitations is the willingness of VA employees to participate in the personal interviews and surveys. Another limitation was getting truthful information about the training and Care Coordination Model established within the VA. When gathering data through surveys of the target population, one limitation finding enough participants to fall within the desired parameters, i.e., older than 65 and

living far enough away from the local VAMC. The last anticipated limitation concerned the local Veteran Service Organizations and their knowledge of internal VA processes that would provide adequate information for this study.

Conclusion

This study used a mixed-method approach to collect all necessary quantitative and qualitative data. This study aimed to relate the independent variables to real problems that could increase or improve the dependent variable if the correct changes are made. While this study may not encompass other independent variables that possibly affect the dependent variable, the data might highlight additional avenues of research for the future.

Chapter IV: Results and Findings

Introduction

Through the research process of this study, qualitative and quantitative data were gathered through semi-structured interviews and rapid surveys. The interviews were conducted with six "Care in the Community" VA employees and two County Veteran Service Officers. The Veteran surveys were deployed utilizing the social media sites Facebook and Nextdoor, along with email distribution to members of local Veteran Service Organizations (American Legion, Veterans of Foreign Wars, Marine Corps League, and Gold Coast Veterans Foundation). There were 50 Veteran respondents for the survey.

The purpose of the interviews was to gain information concerning MSA training, the Care Coordination Model, and access options for underserved populations of Veterans. The purpose of the Veteran survey was to gather age and distance from VA demographics, along with patient experience information. Initially, the survey was deployed only to the local area of

Ventura and Los Angeles counties. However, there was minimal participation, so the survey was opened to Washington state, Oregon, Central, and Northern California. This chapter analyzes the qualitative data gathered from the interviews and the quantitative data retrieved from the Veteran surveys in relation to my Theory of Change and original assumptions.

Assumption 1 (A1): If training for Medical Support Assistants (MSA) is expanded, then the VA's Care in the Community program will be more effective.

Quantitative Results:

Survey questions were deployed to the Veterans regarding their patient experience with MSA's and if they felt the MSA's were adequately trained to access their needs. The majority of the respondents, 76.8%, were satisfied with their interactions with MSAs (Figure 1).

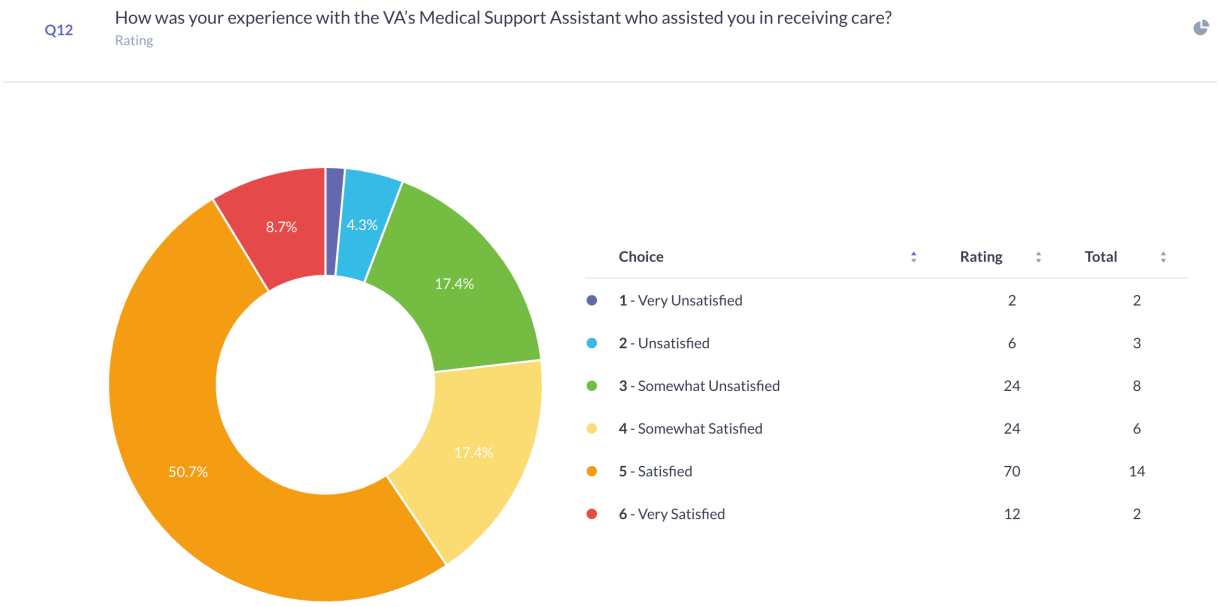

Figure 1

Despite the satisfaction concerning their overall experience, there were mixed results of the Veteran's view of MSA's being adequately trained to access their needs; 54.1% answered

"yes" and 45.9% answered "no" (Figure 2). These results do not validate that additional training is needed to properly assess Veterans' medical concerns or needs.

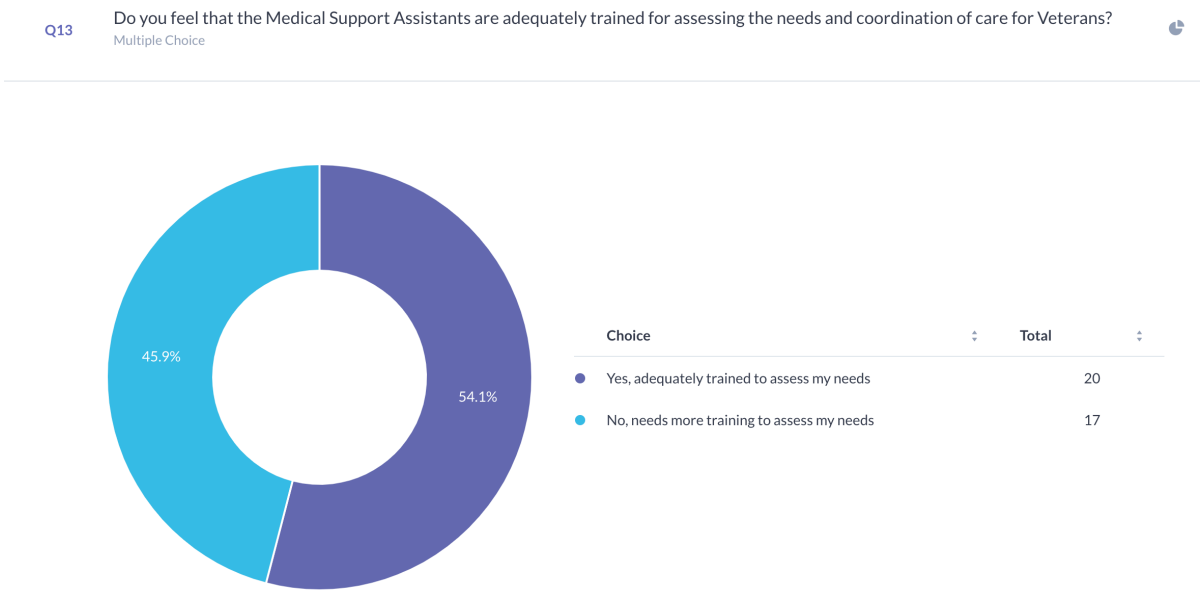

Figure 2

These results align with the Litchfield et al. (2017) study where personal experience and professional intuition are significant factors in how well MSA's can determine the appropriate care for Veterans.

Qualitative Results:

Six Key Informant Interviews (KII) were conducted with MSA's within the CITC Department located on the Sepulveda Ambulatory Care Center campus to capture the data on current training practices from the ground level. The MSA's that were interviewed were from Lead MSA's to MSA's still on probation. In the semi-structured interview, questions 1-4 pertain to Assumption 1. Question #1 in the interview was, "Is the current training regimen adequate for the current role of MSAs"? Five out of the six confirmed that the training was subpar, which left them vulnerable to not being able to perform their duties adequately. MSA #1 stated that the

training is geared toward administrative tasks and not for adequately accessing the needs of the Veterans (MSA #1, Personal Communication, June 6, 2022).

Question #2 of the interview was, “How well does this training prepare the MSAs to deal with the multitude of medical issues and concerns Veterans have”? Again, all interviewees commented that their training is orientated on accomplishing administrative tasks through multiple computer programs and finding appropriate providers to meet the Veteran’s needs. Another common theme was that because every Veteran medical condition is different, many of them have to learn on the go because every case is different. To further elaborate on this topic MSA #5 stated, “sometimes leadership doesn’t know how to address certain matters” (MSA #5, Personal Communication, June 6, 2022). This comment displays the complexities of what MSA’s may encounter on any given day.

Question #3 was, “If MSA training was expanded, what positive impacts would emerge”? All interviewees expressed that the positive impacts would enable them to handle situations better, be more productive and proficient, and be less stressed overall. Figure 3 describes the sentiments of the positive impacts the MSA’s describe.

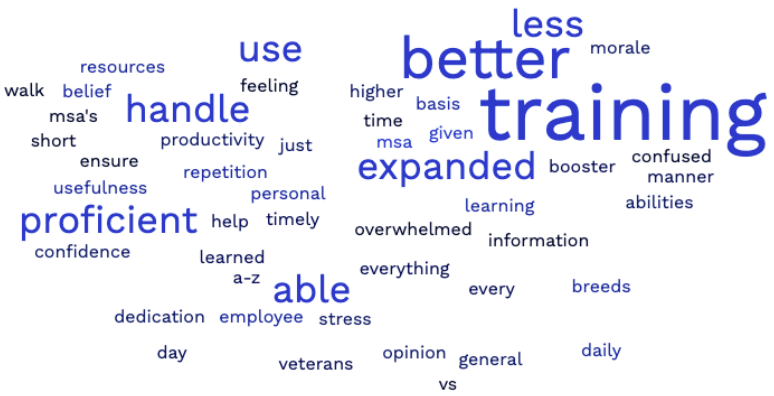

Figure 3

Question #4 was geared towards the opposite of question #3 "If MSA training was expanded, what negative impacts would emerge"? The negative impacts listed by the interviewees were how the proficient workers would receive larger workloads. This is due to the management not taking the time to address MSA's that are not meeting the basic standards of their job duties. In return, this would increase burnout within the ranks of the MSA's, leading to a higher turnover rate. MSA #3, a Lead in her section, stated:

"The expectations for the good workers are higher, and they are expected to do more and more work. Eventually, they get burned out and start not to care. While the not-so-good MSA's are not held accountable, and because they can't perform at an average level, they are given easier work, and expectations are a lot lower for them. Good workers get punished, and bad workers get rewarded" (MSA #3, Personal Communication, June 6, 2022).

After conducting these interviews and analyzing the qualitative data, I feel that my Assumption #1 (A1) has been validated. The majority of the interviewees mentioned that the current training standards and practices do not prepare MSAs for their duties within the CITC. Furthermore, they expressed that expanding their training would lead to more proficient, productive, and confident MSA's at the CITC.

The qualitative findings of Assumption #1 (A1) from the interviews align with the theme of "The Role of Medical Support Assistant Training." The McGowan et al. (2021) study reveals that current training practices do not prepare MSAs for their duties to assist Veterans and contribute to high turnover rates. The interviews also confirm Poorani's (2021) study that improved training would increase effectiveness and overall customer satisfaction. Both points were stated multiple times by the interview respondents, which assist to validate the original assumption.

Assumption 2 (A2): If the existing VA Care Coordination model is improved, then the VA's Care in the Community program will be more effective.

Quantitative Results:

In the survey for Veterans, two questions addressed the care coordination topic. Question #11, "Did you experience any problems in obtaining or receiving care through Care in the Community such as." In answering this question, 62.8% responded that communication issues with the VA and non-VA providers, nonavailability of appointments, long wait time for appointments, and non-VA providers not having the Veteran's medical records. The responses in Figure 4 suggests that the VA is not providing adequate coordination of care for its Veterans.

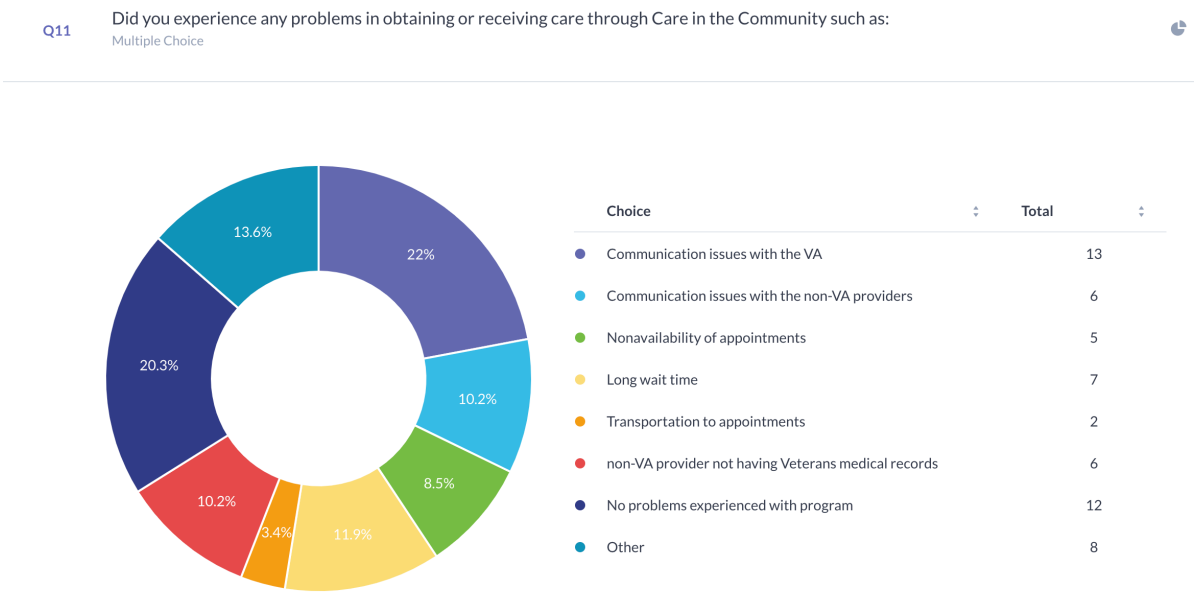

Figure 4

In Question #14, a Likert scale was used to ask Veterans, "How well do you feel the VA handles the coordination of care for Veterans"? The question received an average rating of "average," and 67.2% of the Veterans had rated the VA average or below. In contrast, 32.7% provided an above-average or excellent score. In Figure 5, the data reveals Veterans' negative

attitudes and perceptions concerning how well they are being taken care of and validates Assumption #2 (A2).

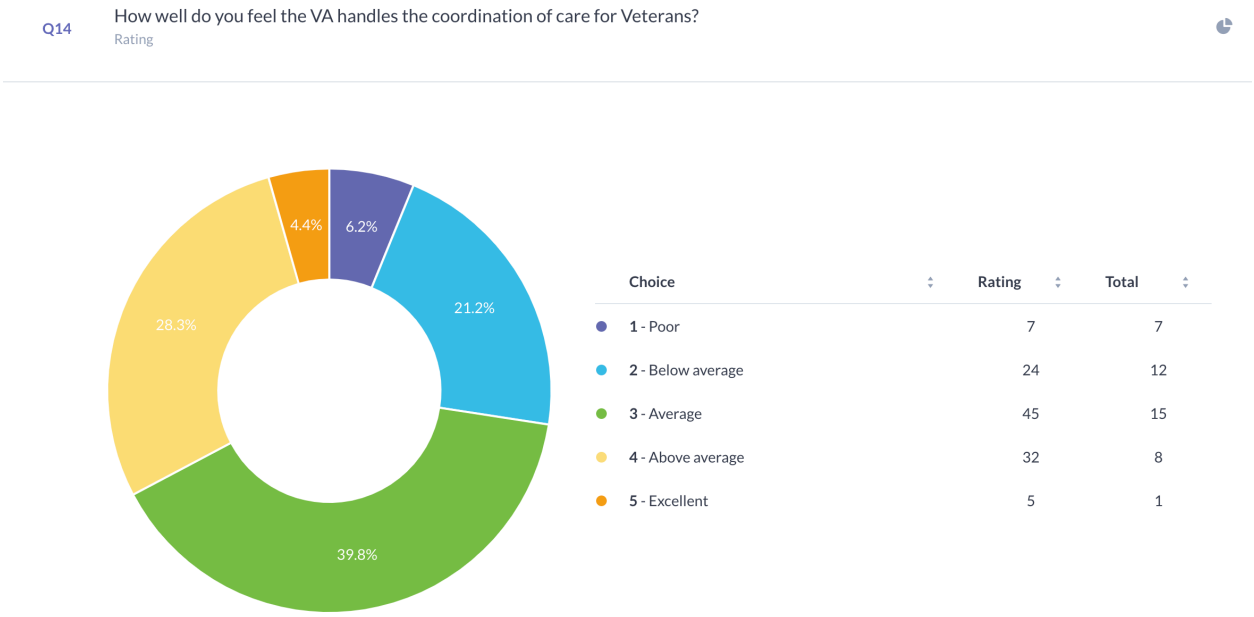

Figure 5

The quantitative findings of Assumption #2 (A2) from the surveys align with the theme of "The VA Care Coordination Model." The responses from the survey align with the Benzar et al. (2020) study, where it was revealed that the VA needed to increase its effort in prioritizing the coordination of care for Veterans. Mattocks et al. (2019) also discovered that the delivery of care coordination services needed vast improvements, which would likely increase Veteran's perceptions of how well the VA is coordinating their care.

Qualitative Results:

Six Key Informant Interviews (KII) were conducted with MSA's within the CITC Department located on the Sepulveda Ambulatory Care Center campus to capture the data concerning the Care Coordination model. In the semi-structured interview, questions 8-12

pertain to Assumption #2 (A2). In question #8, they were asked, “Out of these 5 step care coordination processes, which is the most difficult to fulfill or maintain? Why”? The responses were a mixed bag and varied from individual to individual. The most popular response revolved around “Access Veteran’s needs,” step two of the process. The MSA’s said that getting in contact with the Veteran is a difficult task. Because they need to be able to obtain preferences so that the appropriate provider can be contacted for the scheduling of appointments. MSA #6 stated the following:

“This step …is the most difficult because we need to ask the right questions with the Veterans and access their records properly to send them to the correct provider. If that doesn’t happen, they might be sent to a provider who is doing a completely different category of care altogether, which would delay their care. (MSA #6, Personal Communication, June 6, 2022).

Question #9 asked, “How difficult is it to maintain positive contact with Veterans that you are trying to provide appointments for”? Most of the responses concluded that Veterans do not answer their phones, nor do they return phone calls. In Question #10, they were asked, “How difficult is it to maintain positive contact with the various non-VA providers”? The responses were similar in that non-VA providers were either too busy to answer the office phones or the staff wasn’t large enough to have that administrative support in-house. MSA #5 stated that “It is a hit and miss, usually email works best as far as communication goes. Trying to get them on the phone is challenging because they don’t always answer or return your calls” (MSA #5, Personal Communication, June 6, 2022).

Question #12 asked the interviewees, “What changes to the current care coordination model would you suggest”? Only two respondents provided relevant answers which revolved around the training of MSA’s in the various categories of care so that teams could be developed

for each category. MSA #3 stated, “I would suggest assigning specialties to each staff and work on the same Veteran from beginning to end. That way, the staff can take responsibility for their own work and not pass the problem to someone else” (MSA #3, Personal Communication, June 6, 2022).

Two additional interviews were conducted with County Veteran Service Officers (CVSO) from Central California. They were asked, “What could the VA do better to ensure a Veterans care coordination is properly established and followed through with”? R. Pal, former Merced County CVSO, stated, “Allow the non-VA providers to read and write in VA Medical Chart notes. This way, the VA provider can pick up where the non-VA provider left off” (R. Pal, Personal Communication, June 10, 2022). His answer directly relates to step number five of the Care Coordination model. Throughout these interviews, Assumption #2 (A2) was validated that the Care Coordination model needs improvement.

The qualitative findings of Assumption #2 (A2) from the interviews align with the theme of “The VA Care Coordination Model.” In the Greenstone et al. (2019) article, there were new initiatives put in place by the VA to mitigate the unsuitable coordination of care for Veterans. The interviewees proposed many of the same themes of that study. In the Benzer et al. (2020) study, Veterans who received both VA and non-VA care had significantly worse experiences in the coordination of their care. This was again echoed by the interviewees, which displays an evident disconnect between the VA and community care providers.

Assumption 3 (A3): If more options for access are enhanced for underserved populations, then the VA’s Care in the Community program will be more effective.

Quantitative Results:

The Veteran survey contained three questions related to Assumption #3 (A3). Question #1 asked, “What age group do you fall in”? From the responses, there were 26% in the 65 and older group. While this population did not make up the majority of the survey, they did have the second-largest response rate participating in CITC. In Figure 6, the data displays the future will likely yield a larger population of older Veterans participating in community care programs.

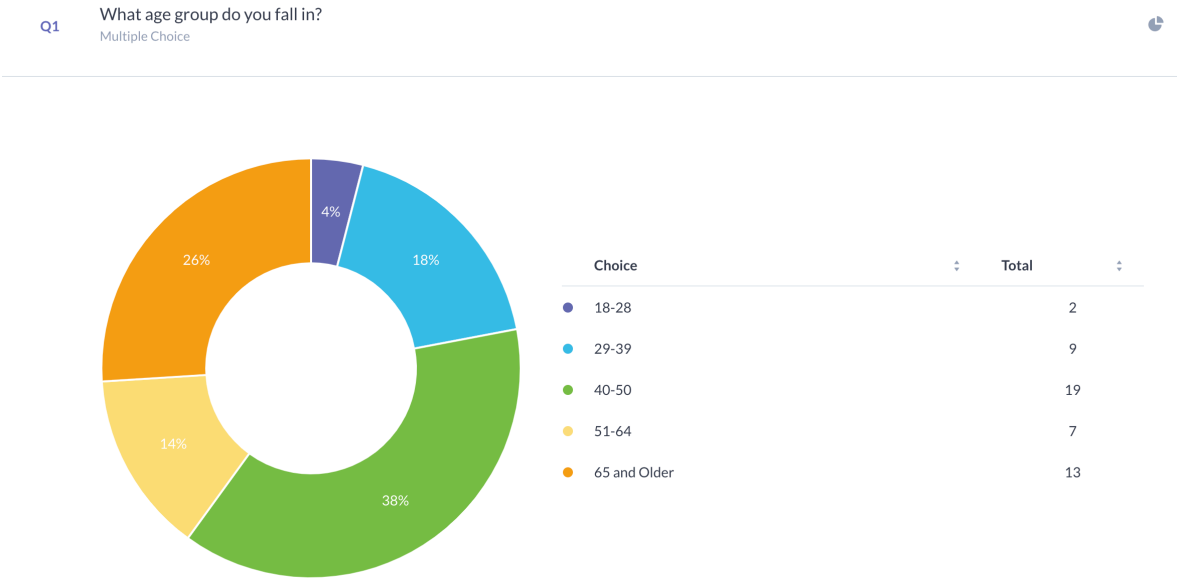

Figure 6

To determine the number of Veterans that lived outside the normal commuting, they were asked in Question #2, “How far do you live from West Los Angeles VA Medical Center or your local VA Medical Center. The response rate for those that lived 46 miles or farther was 48%. This suggests that long commuting times could create barriers for Veterans to receive care at their local VAMC. Increased access to local providers would eliminate many barriers Veterans face. Figure 7 displays that the majority of Veterans (60%) live close to the VA’s commuting distance of 41 miles to utilize CITC providers. These results suggest that with the current inflation and rising fuel prices, Veterans will likely opt to use CITC providers in the near future,

which will cause an influx of patients and a shortage of providers, possibly creating additional access barriers.

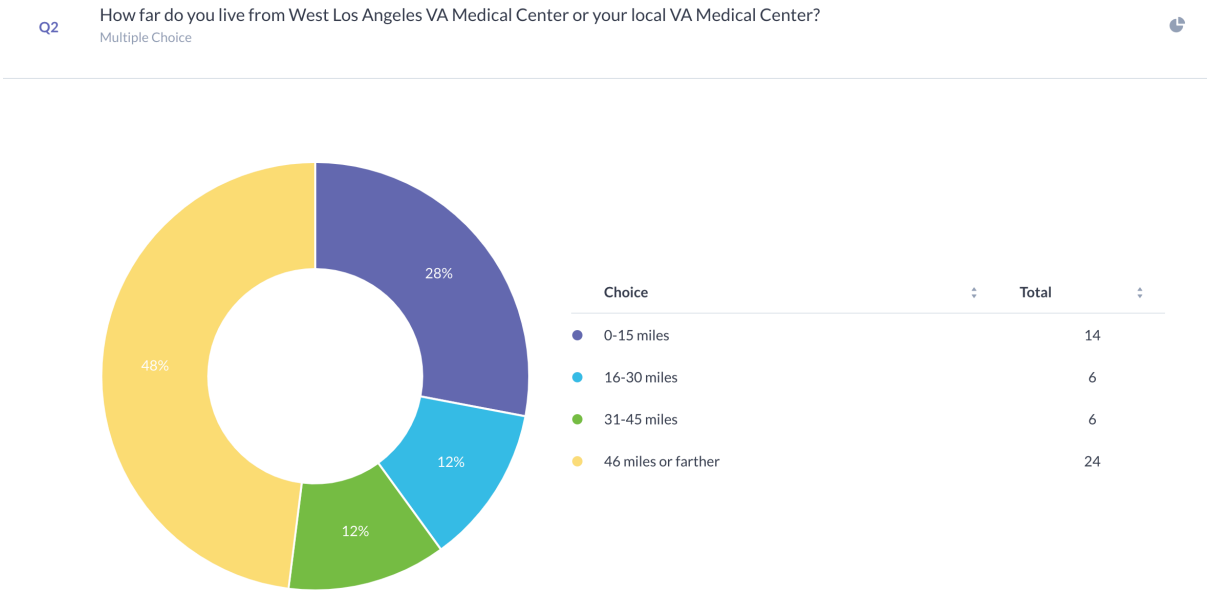

Figure 7

The next question was Question #8 “How long did you have to wait to be seen for your appointment”? This question had 13 unanswered responses due to unknown circumstances. Out of the 37 Veterans that did respond, Figure 8 displays that 54% waited 15 days or longer to be seen by a community provider. Many variables may have attributed to these more extended wait periods since the country has been in a global pandemic for the last two years, which aligns with Assumption #3 (A3).

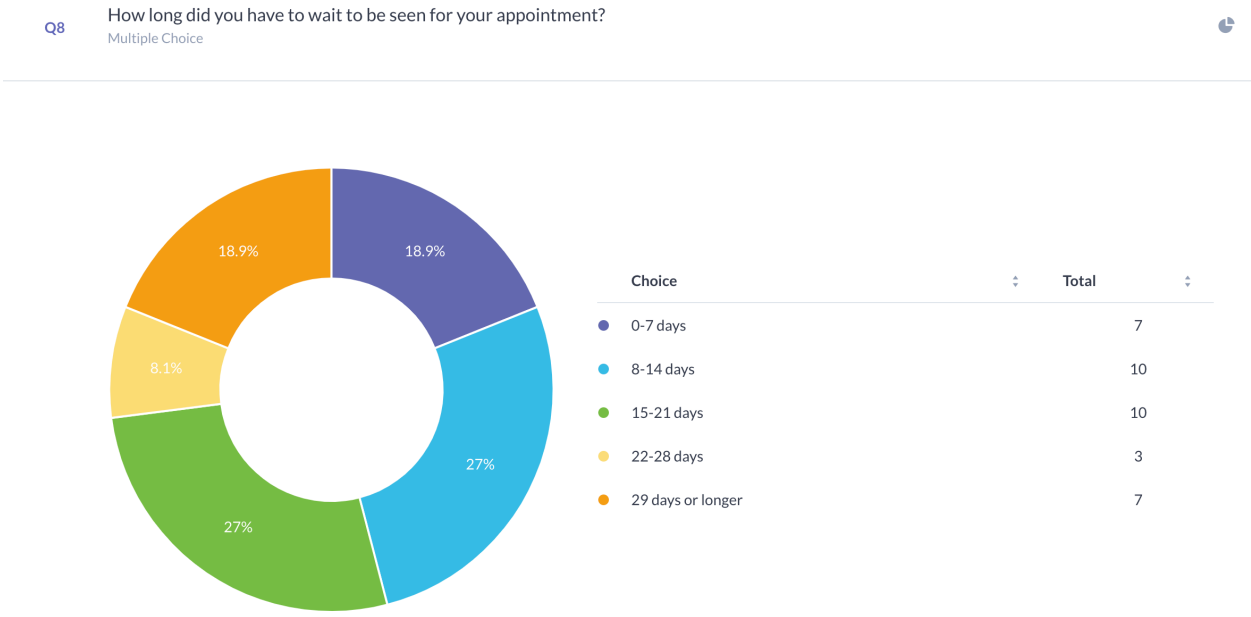

Figure 8

The quantitative findings of Assumption #3 (A3) from the surveys align with the theme of "Access to care for Veterans." The study conducted by Payne et al. (2020) describes that long wait times were one of the most frequent barriers Veterans face in community care services. While this study didn't reach the average wait times of the Payne et al. study, the Veterans did experience longer than average wait times, which aligns with the theme of the Literature Review.

Qualitative Results:

Six Key Informant Interviews (KII) were conducted with MSA's within the CITC Department to capture the data concerning the access to care for Veterans. In the semi-structured interview, questions 13 and 14 pertain to Assumption #3 (A3). Question #13 asked the MSA's, "What are some challenges you see with Veterans that participate in Care in the Community program"? MSA #3 suggests a lack of trust between the Veterans and the VA because the rules and regulations lack the transparency needed for Veterans to understand how everything works (MSA #3, Personal Communication, June 6, 2022). MSA #1 thoughts about the challenges were

"Not being able to get an appointment sooner than later and having to travel out further than the 28 miles from their local VA" (MSA #1, Personal Communication, June 6, 2022). Other answers that were received were "lack of providers within the Veterans area," "Veterans missing calls from MSA's and a broken call center system that makes it hard for Veterans to connect with the MSA's," and "mental health patients not being able to be seen in a timely manner."

In Question #14, the interviewees were asked, "Are there any populations of Veterans that struggle with gaining access to Care in the Community"? From this question, the answers ranged from those who suffer from mental health, non-ambulatory, and older Veterans identified as the populations within the Veteran community that have the most issues with gaining access to care. MSA #2 responded, "those who aren't ambulatory or lack their own transportation, or quite simply, may not have spouses, siblings, or other family and friends to assist in their care" (MSA #2, Personal Communication, June 6, 2022). This statement describes Veterans from various populations, including young, elderly, homeless, combat wounded, or those suffering from mental health issues. MSA #6 responded, "Older Veterans have the worst time because they feel as though they are not being heard... If an MSA's name and number isn't given to the Veteran… they have a tough time reaching the right MSA to address their open consultations" MSA #6, Personal Communication, June 6, 2022). These responses reflect the alignment with Assumption #3 (A3).

Two additional interviews were conducted with County Veteran Service Officers (CVSO) from Central California and were given separate questions. Question #1 asked, "What are some barriers that Veterans face when trying to obtain care from non-VA providers using the VA's Care in the Community program"? J. Christopherson, Madera County CVSO, responded, "The biggest barrier we see is the difficulty navigating the often-complex rules/regulations that

govern VA Community Care. Veterans often forego/delay care or end up with bills they cannot afford" (J. Christopherson, Personal Communication, June 10, 2022). R. Pal, former Merced County CVSO, answered, "Non-VA providers are sometimes not privy to the Veteran's needs, and the VA is slow at times in paying the non-VA providers, which puts the Veteran in financial problems" (R. Pal, Personal Communication, June 10, 2022). While these responses don't necessarily validate Assumption #3 (A3); however, they do express other potential issues that will need to be addressed by the VHA in the future.

In Question #2, the CVSOs were asked, "Which Veteran population do you feel is most affected by these barriers"? J. Christopherson replied, "Difficulties are faced by all Veterans; however, we find that older Veterans (typically Vietnam era and older) struggle most while attempting to navigate the VA system" (J. Christopherson, Personal Communication, June 10, 2022). A similar answer was provided by R. Pal in which he described:

"I feel like the Vietnam Veterans are affected the most by these barriers. They fought two wars; one aboard and one at home. To make matters worse is that most Vietnam Veterans did not seek VA benefits because of the way they were treated. And now, Vietnam Veterans are retiring and have more time, which may give them more time to think about their time in service. Lastly, navigating the VA healthcare system is a challenge for everyone, especially for the elderly generation" (R.Pal, Personal Communication, June 10, 2022).

These responses from the CVSOs clearly validate Assumption #3 (A3) in that specific underserved populations have access to care problems.

The qualitative analysis of the interview responses relating to Assumption #3 (A3) reveals similar findings within the literature review. In the study conducted by Tanielian et al. (2018), they describe that many community-based providers are not equipped to handle

Veteran's various medical histories and injuries. This can create barriers between the Veterans and providers when they don't feel they are being taken care of. The Payne et al. (2019) study reported long wait times, which could possibly allow Veterans to have multiple episodes before they could be seen. These findings align with the multiple responses from the MSA's in which they said that finding mental health providers with open appointments can take some time due to the lack of that specific specialty care provider in the community.

Conclusion

The quantitative and qualitative data presented in this chapter positively correlated the assumptions, literature, interviews, and survey responses. Significant issues have been identified by both Veterans and KIIs that further strengthen the theory of change. MSA training and appointment scheduling issues were some of the most noted problems throughout the study. The Care Coordination process appears to be a constant problem with both VA and non-VA providers, with some of the problems revolving around Veterans responding to telephone calls and other communication issues. Lastly, the data revealed that the older Veteran population has issues with navigating through the VA's complex healthcare system, which could be their primary barrier to gaining access to the VA CITC program. The research has also exposed other topics of concern that can be addressed in follow on studies due to being outside of the initial scope of this research.

Chapter V: Conclusions and Recommendations

Introduction

Within this study, the research included a literature review of academic journals, studies, and relevant materials that examined the training problems of MSAs, the disconnect of the Care Coordination model, and the hardships and barriers Veterans face when attempting to receive

care in the community setting. The primary data was collected through rapid response surveys to Veterans and Key Informant Interviews (KII) of MSAs and CVSOs. The survey results support the theory of change and assumptions proposed at the beginning of the research. While Veterans generally had pleasant interactions with MSA's, they did not have the same sentiments regarding communication with the VA.

The interviews with the KIIs also support the theory of change and assumptions. They provided a closer look into how poorly the department trains and readies its employees to deal with a diverse group of patients and their needs. Their insights also delivered detailed sticking points within the Care Coordination model. The CVSO interviews provided additional information on problems that Community Care users could possibly face when the VA doesn't pay the medical bills. The combination of the literature review, rapid survey results, and KII's allowed this study to formulate recommendations for the VA, as delineated below.

Conclusions

Assumption 1 (A1): IF training for Medical Support Assistants (MSA) is expanded, THEN the VA's Care in the Community program will be more effective.

VALIDATED

Throughout the interview process for MSAs, it was made evident that training and coaching play a big part in being successful within the department. With the onset of the COVID-19 Pandemic, MSAs were forced to telework and miss valuable one-on-one coaching sessions and on-the-job training with their leadership teams. Data revealed that "shadowing experienced MSAs" was lost in this process, where the new MSAs learned many skills necessary to perform their duties. The VA's initial onboarding training was scaled back to meet the minimum requirements established by the VA during the pandemic. All of these minor issues

combined created an environment that is destined to fail. The lack of actual job performance training has led to a higher turnover rate within the department, which has been attributed to the MSAs' low morale and job satisfaction. Both long and short-term implications surrounding these findings will ultimately result in the Veterans suffering at the expense of the poor service they receive.

Assumption 2 (A2): IF the existing VA Care Coordination model is improved, THEN the VA's Care in the Community program will be more effective.

VALIDATED

This research question examined the Care Coordination model and how effective it was. The data derived from the survey and interviews pointed out some flaws of the model and those working within the standard guidelines. Communication between the Veteran and VA / non-VA providers appeared to have the most considerable negative impact on both MSAs and Veterans. This communication barrier creates confusion and frustration for the Veteran, which leads to a distrust of the system. Another impediment of the model is the lack of continuity Veterans experience with the MSAs arranging their care. The continuity issue creates gaps in the Veteran's progress of care. The long-term implications related to the effectiveness of the Care Coordination model will result in the reduced continuity of care of Veterans between the VA and non-VA providers, which affects the probability of recovery of the Veteran.

Assumption 3 (A3): IF more options for access are enhanced for underserved populations, THEN the VA's Care in the Community program will be more effective.

VALIDATED

The research question was initially intended to identify the perceived underserved population of Veterans aged 65 and older and those who live outside the normal commuting

distance (41 miles plus) from their local VAMC. The data retrieved provided a small-scale snapshot of the age groups using CITC and the number of Veterans that did live outside the normal commuting distance, which validated the assumption. Additional access barriers included a poor network of specialty providers such as mental health and pulmonary. Long wait times and having the means to reach the appointment were also listed as barriers that prevent Veterans from being seen in a timely manner. One problematic Veteran era identified is the Vietnam Veterans. Many of these Veterans seeking treatment have foregone help from the VA for many years because of the country's previous stigmatisms associated with the Vietnam War. This has created a need for intervention and outreach to assist them in navigating the complex VHA system. The long-term effect surrounding the access barriers to care can lead Veterans to forego treatment and lose faith in a system for which they sacrificed their lives.

Recommendations

The below recommendations are composed in a narrative form utilizing the SMART Criteria (Specific, Measurable, Achievable, Realistic, and Timely).

Recommendation #1

The VHA needs to create standardized training for MSAs across the entire organization. The intent of the training is to produce MSAs that are confident in their abilities and be able to address the needs of the Veterans they serve. The goal should be to not only train the MSAs on how to use the multiple systems that house medical records and appointment scheduling but also focus on the interpersonal skills they will need to succeed. Soft skills, de-escalation techniques, and crisis intervention, along with clinical care categories, should be introduced to the training. This could be incorporated by using quarterly training events to address these skills and other problem-solving exercises to increase interaction with leadership and employees. To avoid

potential backlogs of work, the training hours can be blocked off throughout multiple days that will allow everyone to participate. Providing meaningful training will not only assist in producing better employees but can also assist in defeating high turnover rates and employee burnout. A new training curriculum should be developed within the next year and deployed at the agency's earliest convenience. Continual curriculum development will need to be kept relevant to the organization's mission.

Recommendation #2

The VHA needs to adopt new practices concerning the Care Coordination model in how the follow-up or continuity of care is handled for Veterans as they transition between VA and non-VA care. A checklist needs to be developed for each patient as they transition through the care process. Such a procedure would ensure that patients complete the care process as initially intended. While taking ownership of the patients will ultimately increase patient satisfaction, it will also eliminate the instances where care was never provided to the Veteran. In reality, this recommendation could be initiated immediately by holding MSAs, VA doctors, and community care providers responsible for maintaining positive contact with their patients. There needs to be some form of responsibility placed on the MSAs and leadership to ensure the Veterans receive the appropriate levels of care.

Recommendation #3

The VA needs to conduct outreach training with Veterans about the CITC program, how it works, and the benefits of using community providers. Initial training can start with Veterans already enrolled and then transition to those initially entering the program. The training can be conducted through already established VA outreach teams and Non-Governmental Organizations (NGO) already performing outreach for the VA. Due to the constant change in public law and

rules surrounding Veteran benefits, this type of training is necessary to establish transparency within the agency and programs. Outreach teams should be deployed within one year; however, training could start earlier with training videos attached to the VA website and the use of Veteran town hall meetings.

Areas for Further Research

While this study focused on a relatively small scope of the entirety of the program, additional surveys and interviews could be deployed agency-wide to determine other factors or reasons that contribute to training deficiencies, care coordination model issues, and access barriers that pose a threat to underserved populations of Veterans. This approach could further validate or challenge all three assumptions posed in this study. The additional deployment of surveys to Veterans utilizing CITC that further captures their concerns about the quality of care and additional barriers that restrict access to community care would help clarify and identify further needs within the program.

From the data captured, a few new discussion areas were brought to light. The billing practices of the VA and non-VA providers revealed that Veterans are receiving bills for their treatments directly due to the VA not paying community providers in a timely manner. This issue needs to be further researched, and appropriate action is taken to mitigate the problem. Another potential topic to be further investigated is the "Digital Divide" disparity amongst the aging Veteran population. With the increase of e-Government within the VA, an unnatural barrier has been created with the aging Veteran population. The topic needs to be further researched to determine how this digital divide affects Veterans and their ability to successfully navigate through the increased use of digital platforms to conduct medical appointments, schedule appointments, pharmacy orders, and maintain their medical records.

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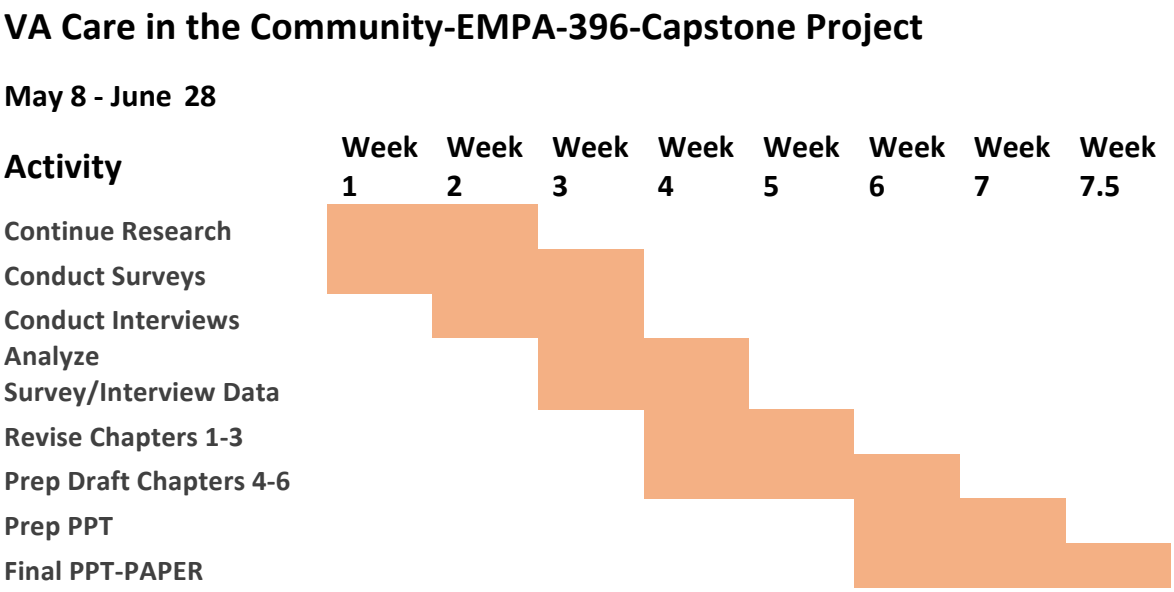
Appendix A



Appendix B

Interviews:

Informed Consent: My name is Christopher McVicker, and I am an Executive Master of Public Administration candidate at Golden Gate University. My capstone project is a case study on "Evaluating the Effectiveness of the Veterans Affairs Care in the Community Program". Your responses are confidential if you wish. This interview will only take 20 minutes or less to complete. If you have further questions, please email me at: cmcvicker@my.ggu.edu

Semi-structured key informant interviews (VA Employees)

1. Is the current training regimen adequate for the current role of MSAs?
2. How well does this training prepare the MSAs to deal with the multitude of medical issues and concerns Veterans have?
3. If MSA training was expanded what positive impacts would emerge?
4. If MSA training was expanded what negative impacts would emerge?
5. What areas of concern within the duties of an MSA are currently a hot topic within the department?
6. Is adequately assessing Veterans for specific needs a concern pertaining to newly indoctrinated MSAs?
7. What changes to the training would you recommend?
8. Out of these 5 step care coordination process, which is the most difficult to fulfill or maintain? Why?
9. How difficult is it to maintain positive contact with Veterans that you are trying to provide appointments for?
10. How difficult is it to maintain positive contact with the various non-VA providers?
11. Are there issues or concerns with continuity of care from non-VA providers?
12. What changes the current care coordination model would you suggest?
13. What are some challenges you see with Veterans that participate with Care in the Community program?
14. Are there any populations of Veterans that struggle with gaining access to Care in the Community?

Informed Consent: My name is Christopher McVicker, and I am an Executive Master of Public Administration candidate at Golden Gate University. My capstone project is a case study on "Evaluating the Effectiveness of the Veterans Affairs Care in the Community Program". Your responses are confidential if you wish. This interview will only take 20 minutes or less to complete. If you have further questions, please email me at: cmcvicker@my.ggu.edu

Semi-structured key informant interviews (Veteran Service Organizations)

1. What are some barriers that Veterans face when trying to obtain care from non-VA providers using the VA's Care in the Community program?
2. Which Veteran population do you feel is most affected by these barriers?
3. In your experience, how well does the communication flow between VA providers and non-VA providers concerning the care coordination for Veterans?
4. What could the VA do better to ensure a Veterans care coordination is properly established and followed through with?
5. What changes would you like to see concerning the VA's Care in the Community program?

Survey:

Informed Consent: My name is Christopher McVicker, and I am an Executive Master of Public Administration candidate at Golden Gate University. My capstone project is a case study on "Evaluating the Effectiveness of the Veterans Affairs Care in the Community Program". The sole purpose of gathering and analyzing your responses is to determine what issues and barriers Veterans face when utilizing the VA's Care in the Community program outside of the local VA

healthcare services available. This survey should only take 5 minutes or less to complete. Your responses are anonymous and you can opt out at any time during the survey. Your participation and cooperation are greatly appreciated. If you have further questions, please email me at: cmcvicker@my.ggu.edu

Survey for Veterans receiving care through the Care in the Community Program

1. What age group do you fall in
   ☐ 18-28 ☐ 29-39 ☐ 40-50 ☐ 51-64 ☐ 65 and older

2. How far do you live from West Los Angeles VAMC?
   ☐ 0-15 miles ☐ 16-30 miles ☐ 31-45 miles ☐ 46 miles or farther

3. Which county do you reside in?
   ☐ Ventura ☐ Los Angeles ☐ Santa Barbara ☐ Kern ☐ San Luis Obispo ☐ Other

4. Which conflict did you serve in?
   ☐ WWII ☐ Korea ☐ Vietnam ☐ Gulf War ☐ OIF/OEF

5. Are you currently enrolled in the Veterans Health Care System? Y or N

6. If Yes, have you seen an outside Non-VA provider utilizing the Care in the Community Program in the last year? Y or N

7. How did you make your appointment for this Non-VA provider?
   ☐In person ☐Over the phone ☐Online ☐Non-VA provider contacted you ☐Other

8. How long did you have to wait to be see for your appointment?
   ☐0-7 days ☐8-14 days ☐15-21 days ☐22-28 days ☐29 days or longer

9. What was your experience with using a Care in the Community Non-VA provider?
   ☐Very Unsatisfied ☐Unsatisfied ☐Somewhat unsatisfied ☐Somewhat satisfied ☐Satisfied ☐Very satisfied

10. What medical services did you receive at the Care in the Community Non-VA provider? Please select all that apply
    ☐ Dermatology Service ☐ Pulmonary Specialist ☐ Addiction Treatment Services
    ☐ Neurology/Neurosurgery ☐ General Surgery Services ☐ Dental Clinic
    ☐ Nuclear Medicine ☐ Gastro Intestinal Specialist ☐ Radiology Imaging

☐ Occupational Therapy ☐ Orthopedic Surgery Service ☐ Emergency Room Services
☐ Spinal Cord Injury and Disorders Center ☐ Trauma Recovery Services (PTSD/Mil. Trauma)

11. Did you experience any problems in obtaining or receiving care through Care in the Community such as:
☐Communication issues with the VA
☐Communication issues with the non-VA providers
☐Nonavailability of appointments
☐Long wait time
☐Transportation to appointments
☐Non-VA provider not having Veterans medical records
☐No problems experienced with program
☐Other: _____

12. How was your experience with the VA's Medical Support Assistant who assisted you in receiving care?
☐Very Unsatisfied ☐Unsatisfied ☐Somewhat unsatisfied ☐Somewhat satisfied ☐Satisfied ☐Very satisfied

13. Do you feel that the Medical Support Assistants are adequately trained for assessing the needs and coordination of care for Veterans?
Yes, adequately trained to assess my needs
No, needs more training to assess my needs

14. How well do you feel the VA handles the coordination of care for Veterans?
☐Poor ☐Below Average ☐Average ☐Above Average ☐Excellent
15. How likely are you going to use Care in the Community in the future instead of receiving care at the VA medical center?
☐Not at all likely ☐Not so likely ☐Somewhat likely ☐Very likely ☐Extremely likely