Prepared by:

RAND Corporation

A Product of the CMS Alliance to Modernize Healthcare
Federally Funded Research and Development Center
Centers for Medicare & Medicaid Services (CMS)

Prepared for:
U.S. Department of Veteran Affairs

At the Request of:
Veterans Access, Choice and Accountability Act of 2014
Section 201: Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs

Assessment B (Health Care Capabilities) Appendices E-I

September 1, 2015

Prepared for CAMH under:
Prime Contract No. HHS-M500-2012-00008I
Prime Task Order No. VA118A14F0373

This page intentionally left blank.

Preface

Congress enacted and President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) ("Veterans Choice Act"), as amended by the Department of Veterans Affairs (VA) Expiring Authorities Act of 2014 (Public Law 113-175), to improve access to timely, high-quality health care for Veterans. Under "Title II – Health Care Administrative Matters," Section 201 calls for an Independent Assessment of 12 areas of VA's health care delivery systems and management processes.

VA engaged the Institute of Medicine of the National Academies to prepare an assessment of access standards and engaged the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH)[1] to serve as the program integrator and as primary developer of the remaining 11 Veterans Choice Act independent assessments. CAMH subcontracted with Grant Thornton, McKinsey & Company, and the RAND Corporation to conduct 10 independent assessments as specified in Section 201, with MITRE conducting the 11th assessment. Drawing on the results of the 12 assessments, CAMH also produced the Integrated Report in this volume, which contains key findings and recommendations. CAMH is furnishing the complete set of reports to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care.

The research addressed in this report was conducted by the RAND Corporation, under a subcontract with The MITRE Corporation.

[1] The CMS Alliance to Modernize Healthcare (CAMH), sponsored by the Centers for Medicare & Medicaid Services (CMS), is a federally funded research and development center (FFRDC) operated by The MITRE Corporation, a not-for-profit company chartered to work in the public interest. For additional information, see the CMS Alliance to Modernize Healthcare (CAMH) website (http://www.mitre.org/centers/cms-alliances-to-modernize-healthcare/who-we-are/the-camh-difference).

This page intentionally left blank.

Table of Contents

Appendix E Summary of Qualitative Interview Results E-1

Appendix E.1 Results by Domain E-1

Appendix F Access F-11

Appendix F.1. Geographic Access to VA Services for Overall Population F-11
Appendix F.2: Geographic Access to VA Services for Illustrative Clinical Populations..... F-23
Appendix F.3 Access to Non-VA Hospital Types by VISN F-103
Appendix F.4: Access to Non-VA Services by VISN F-113
Appendix F.5 Access to Non-VA Specialists F-143
Appendix F.6 Veteran Responses to Access Questions F-156
Appendix F.7 Veteran Wait Times F-156

Appendix G Quality G-1

Appendix G.1 Evidence Table for Quality Review G-1
Appendix G.2 Quality Measure Definitions G-25
Appendix G.3 VA and Non-VA Performance Rates for Quality Measures G-25

Appendix H Projections H-1

Appendix I Survey Data Tables and Participant Comments I-1

Appendix I.1 Tables I-1
Appendix I.2 Survey Participant Comments I-174

This page intentionally left blank.

List of Figures

Figure F-1. Responses to Access Questions on VA Survey of Enrollees, 2010–2014. 156

Figure F-2 Maps of Wait Time Performance at VA Facilities across the United States, First Half FY2015 and Change from First Half FY2014 to First Half FY2015 160

List of Tables

Table E-1. Fiscal resources domain: code count by facility-level interview 9

Table E-2. Workforce and human resources domain: code count by facility-level interview 33

Table E-3. Physical infrastructure resources domain: code count by facility-level interview 61

Table E-4. Types of Interview Questions by Interviewee Type 73

Table F-1. Total and VISN Veteran Population by Enrollee and User Status 1

Table F-2 Geographic Access to VAMCs 2

Table F-3 Geographic Access to VAMC Complexity Level 1 or 2 4

Table F-4. Geographic Access to VAMC Complexity Level 1A , 1B, OR 1C 7

Table F-5 Geographic Access to VAMC Complexity Level 1A or 1B 10

Table F-6 Geographic Access to VAMC Complexity Level 1A 12

Table F-7 Geographic Access to Health Care Centers 15

Table F-8 Geographic Access to Multi-specialty CBOCs 18

Table F-9 Geographic Access to Primary care CBOCs 20

Table F-10 Mapping of Clinical Inventory Profiles and Services to the Seven Clinical Conditions 23

Table F-11 Geographic Access to VA Facilities providing ED care 26

Table F-12 Geographic Access to VA Facilities with a Coronary Care Unit 29

Table F-13 Geographic Access to VA Facilities with Telemetry 31

Table F-14 Geographic Access to VA Facilities providing Non-invasive cardiology services 34

Table F-15 Geographic Access to VA Facilities providing diagnostic cardiac catheterization 37

Table F-16 Geographic Access to VA Facilities providing interventional cardiology 39

Table F-17 Geographic Access to VA Facilities providing cardiac surgery 42

Table F-18 Geographic Access to VA facilities providing primary care 44

Table F-19 Geographic Access to VA Facilities providing colonoscopy 47

Table F-20 Geographic Access to VA Facilities providing CT scans 50

Table F-21 Geographic Access to VA Facilities providing Surgical Services 52

Table F-22 Geographic Access to VA Facilities providing Oncology Services 56

Table F-23 Geographic Access to VA Facilities providing Palliative/Hospice Care 58

Table F-24 Geographic Access to VA Facilities with Primary Care 61

Table F-25 Geographic Access to VA Facilities with a specialty or endocrinology clinic 64

Table F-26 Geographic Access to VA Facilities with a podiatry clinic 66

Table F-27 Geographic Access to VA Facilities with an ophthalmology clinic 68

Table F-28 Geographic Access to VA Facilities with a Polytrauma support clinic team 71

Table F-29 Geographic Access to a hospital with a polytrauma network site 73

Table F-30 Geographic Access to VA Facilities with a Polytrauma rehabilitation center 76

Table F-31 Geographic Access to VA Facilities providing TBI Specialty Care 79

Table F-32 Geographic Access to VA Facilities providing Domiciliary Mental Rehabilitative Treatment Program 81

Table F-33 Geographic Access to VA Facilities providing Mental Health Services 84

Table F-34 Geographic Access to VA Facilities providing psychotherapy 87

Table F-35 Geographic Access to VA Facilities providing Residential treatment for SUD 90

Table F-36 Geographic Access to VA Facilities providing Methadone 92

Table F-37 Geographic Access to VA Facilities providing Outpatient specialty care for SUD 95

Table F-38 Geographic Access to VA Facilities providing Inpatient detoxification for SUD 98

Table F-39 Geographic Access to VA Facilities providing Gynecological surgery services 100

Table F-40 Access to Any Non-VA Hospital 104

Table F-41 Access to Teaching Hospitals 106

Table F-42 Access to Academic Hospitals 108

Table F-43 Distribution of enrollee-level drive time differences between VA vs. non-VA facilities 110

Table F-44 Distribution of enrollee-level drive time differences between VA facilities with interventional cardiology vs. non-VA facilities with interventional cardiology 112

Table F-45 Access to Emergency Department within 40 mile and 60 minute driving distances 114

Table F-46 Access to Interventional Cardiology (PCI) within 40 mile and 60 minute driving distances 116

Table F-47 Access to Coronary Care Unit within 40 mile and 60 minute driving distances 119

Table F-48 Access to Diagnostic Cardiac Catheterization within 40 mile and 60 minute driving distances 122

Table F-49 Access to Cardiac Surgery within 40 mile and 60 minute driving distances 124

Table F-50 Access to Surgery within 40 mile and 60 minute driving distances 127

Table F-51 Access to Chemotherapy within 40 mile and 60 minute driving distances 130

Table F-52 Access to Oncology within 40 mile and 60 minute driving distances 132

Table F-53 Access to Palliative care within 40 mile and 60 minute driving distances 135

Table F-54 Access to Inpatient Palliative care within 40 mile and 60 minute driving distances 138

Table F-55 Access to Hospice care within 40 mile and 60 minute driving distances 140

Table F-56 Access to Cardiologists 144

Table F-57 Access to Endocrinologists 145

Table F-58 Access to Gastroenterologists 146

Table F-59 Access to General Surgeons 147

Table F-60 Access to Hematologists-Oncologists 148

Table F-61 Access to Mental Health Providers (Psychologists and Psychiatrists) 149

Table F-62 Access to Neurosurgeons 150

Table F-63 Access to Neurologists 151

Table F-64 Access to Obstetricians & Gynecologists 152

Table F-65 Access to Physical Medicine & Rehabilitation Specialists 153

Table F-66 Access to Primary Care Physicians 154

Table F-67 Access to Thoracic Surgeons 155

Table F-68 Number of Appointments Completed Within 0-14, 15-30, 31-60, and 61+ Days of Preferred Date, by Appointment Type, First Half FY2014 and First Half FY2015 158

Table F-69 Number of Days Waited at VA Facilities, by Appointment Type, First Half FY2015 159

Table F-70 Performance on Patient-Reported SHEP PCMH Access Measures by VA Facility, FY2014. 166

Table F-71 Percent of Veterans in VA Facilities Responding that They "Always" Got Appointment for Routine or Urgent Care as Soon as Needed on SHEP PCMH FY2014, by Facility Performance on Wait Times in First Half FY2015. 168

Table G-1. Variation in VA Facility-Level Performance on Quality Measures for Outpatient Setting, FY2014 25

Table G-2. Performance on Outpatient Quality Measures, VA Compared to Non-VA, 2013 30

Table G-3. Variation in VA Facility-Level Performance on Quality Measures for Hospital Inpatient Setting, FY2014 32

Table G-4. Comparison of Mean Facility-Level Performance of VA and *Matched Non-VA Facilities* on Measures for Inpatient Setting, FY2014 37

Table G-5. Variation in Facility-Level Performance of *Matched Non-VA Hospitals* on Quality Measures for Hospital Inpatient Setting, FY2014 41

Table G-6. Comparison of Mean Facility-Level Performance of VA and *All Non-VA Facilities* on Measures for Inpatient Setting, FY2014 46

Table H-1. Projected Demand and Supply in FY19, Under Supply Scenario Two, By Specialty 1

Table H-2 Projected Demand and Supply in FY19, Under Supply Scenario Two, By VISN and Specialty 1

Table H-3. Projected Demand and Supply in FY19, Under Supply Scenario Three, By Specialty 4

Table H-4. Projected Demand and Supply in FY19, Under Supply Scenario Three, By VISN and Specialty .. 4

Table I-1. Chief of Staff: Question 1 2

Table I-2. Chief of Staff: Question 2 2

Table I-3. Chief of Staff: Question 3 3
Table I-4. Chief of Staff: Question 4 3
Table I-5. Chief of Staff: Question 5 4
Table I-6. Chief of Staff: Question 6A 5
Table I-7. Chief of Staff: Question 7 6
Table I-8. Chief of Staff: Question 6B 7
Table I-9. Chief of Staff: Question 8 8
Table I- 10. Chief of Staff: Question 9 9
Table I-11. Chief of Staff: Question 10 9
Table I-12. Chief of Staff: Question 10D 9
Table I-13. Chief of Staff: Question 11 10
Table I-14. Chief of Staff: Question 12 10
Table I-15. Chief of Staff: Question 13A 10
Table I-16. Chief of Staff: Question 13B 11
Table I-17. Chief of Staff: Question 14 11
Table I-18. Chief of Staff: Question 15 11
Table I-19. Chief of Staff: Question 16 12
Table I-20. Chief of Staff: Question 17 12
Table I-21. Chief of Staff: Question 18 12
Table I-22. Chief of Staff: Question 19/20 13
Table I-23. Chief of Staff: Question 21 13
Table I-24. Chief of Staff: Question 22 14
Table I-25. Chief of Staff: Question 23 14
Table I-26. Chief of Staff: Question 24 14
Table I-27. Chief of Staff: Question 25 15

Table I-28. Post-Traumatic Stress Disorder: Question 1 16
Table I-29. Post-Traumatic Stress Disorder: Question 3A 17
Table I-30. Post-Traumatic Stress Disorder: Question 3B 18
Table I-31. Post-Traumatic Stress Disorder: Question 3C 19
Table I-32. Post-Traumatic Stress Disorder: Question 3D 20
Table I-33. Post-Traumatic Stress Disorder: Question 3E 21
Table I-34. Post-Traumatic Stress Disorder: Question 4 22
Table I-35. Post-Traumatic Stress Disorder: Question 6A 23
Table I-36. Post-Traumatic Stress Disorder: Question 6B 24
Table I-37. Post-Traumatic Stress Disorder: Question 6C 25
Table I-38. Post-Traumatic Stress Disorder: Question 6D 26
Table I-39. Post-Traumatic Stress Disorder: Question 6E 27
Table I-40. Post-Traumatic Stress Disorder: Question 6G 28
Table I-41. Post-Traumatic Stress Disorder: Question 6H 29
Table I-42. Post-Traumatic Stress Disorder: Question 6I 30
Table I-43. Post-Traumatic Stress Disorder: Question 6J 31
Table I-44. Post-Traumatic Stress Disorder: Question 7 32
Table I-45. Post-Traumatic Stress Disorder: Question 8A 32
Table I-46. Post-Traumatic Stress Disorder: Question 9 33
Table I-47. Post-Traumatic Stress Disorder: Question 8B 34
Table I-48. Post-Traumatic Stress Disorder: Question 10 35
Table I-49. Substance Use Disorders: Question 1 36
Table I-50. Substance Use Disorders: Question 3A 37
Table I-51. Substance Use Disorders: Question 3B 38
Table I-52. Substance Use Disorders: Question 3C 39

Table I-53. Substance Use Disorders: Question 3D 40
Table I-54. Substance Use Disorders: Question 3E 41
Table I-55. Substance Use Disorders: Question 3F 42
Table I-56. Substance Use Disorders: Question 3G 43
Table I-57. Substance Use Disorders: Question 3H 44
Table I-58. Substance Use Disorders: Question 4 45
Table I-59. Substance Use Disorders: Question 6A 46
Table I-60. Substance Use Disorders: Question 6C 47
Table I-61. Substance Use Disorders: Question 6F 49
Table I-62. Substance Use Disorders: Question 6G 50
Table I-63. Substance Use Disorders: Question 6H 51
Table I-64. Substance Use Disorders: Question 6I 52
Table I-65. Substance Use Disorders: Question 6J 53
Table I-66. Substance Use Disorders: Question 6M 54
Table I-67. Substance Use Disorders: Question 6N 55
Table I-68. Substance Use Disorders: Question 6O 56
Table I-69. Substance Use Disorders: Question 7 57
Table I-70. Substance Use Disorders: Question 9A 58
Table I-71. Substance Use Disorders: Question 9B 59
Table I-72. Substance Use Disorders: Question 9C 60
Table I-73. Substance Use Disorders: Question 9D 61
Table I-74. Substance Use Disorders: Question 9E 62
Table I-75. Substance Use Disorders: Question 9F 63
Table I-76. Substance Use Disorders: Question 10 64
Table I-77. Substance Use Disorders: Question 11A 65

Table I-78. Substance Use Disorders: Question 12 66

Table I-79. Substance Use Disorders: Question 11B 67

Table I-80. Substance Use Disorders: Question 13 68

Table I-81. Traumatic Brain Injury: Question 1 69

Table I-82.Traumatic Brain Injury: Question 2 69

Table I-83. Traumatic Brain Injury: Question 3 70

Table I-84. Traumatic Brain Injury: Question 4 71

Table I-85. Traumatic Brain Injury: Question 6A 72

Table I-86. Traumatic Brain Injury: Question 6B 73

Table I-87. Traumatic Brain Injury: Question 6C 74

Table I-88. Traumatic Brain Injury: Question 6D 75

Table I-89. Traumatic Brain Injury: Question 6E 76

Table I-90. Traumatic Brain Injury: Question 6F 77

Table I-91. Traumatic Brain Injury: Question 6G 78

Table I-92. Traumatic Brain Injury: Question 6H 79

Table I-93. Traumatic Brain Injury: Question 6I 80

Table I-94. Traumatic Brain Injury: Question 7 81

Table I-95. Traumatic Brain Injury: Question 8/9 81

Table I-96. Traumatic Brain Injury: Question 10 81

Table I-97. Traumatic Brain Injury: Question 12A 83

Table I-98. Traumatic Brain Injury: Question 12B 84

Table I-99. Traumatic Brain Injury: Question 12C 85

Table I-100. Traumatic Brain Injury: Question 12D 86

Table I-101. Traumatic Brain Injury: Question 12E 87

Table I-102. Traumatic Brain Injury: Question 12F 88

Table I-103. Traumatic Brain Injury: Question 12G 89
Table I-104. Traumatic Brain Injury: Question 12J 90
Table I-105. Traumatic Brain Injury: Question 13 91
Table I-106. Traumatic Brain Injury: Question 14A 91
Table I-107. Traumatic Brain Injury: Question 15 92
Table I-108. Traumatic Brain Injury: Question 14B 93
Table I-109. Traumatic Brain Injury: Question 16 94
Table I-110. Acute Coronary Syndrome: Question 1 95
Table I-111. Acute Coronary Syndrome: Question 3A 96
Table I-112. Acute Coronary Syndrome: Question 3B 97
Table I-113. Acute Coronary Syndrome: Question 3C 98
Table I-114. Acute Coronary Syndrome: Question 3E 99
Table I-115. Acute Coronary Syndrome: Question 4 99
Table I-116. Acute Coronary Syndrome: Question 6A 100
Table I-117. Acute Coronary Syndrome: Question 6B 101
Table I-118. Acute Coronary Syndrome: Question 6C 102
Table I-119. Acute Coronary Syndrome: Question 6D 103
Table I-120. Acute Coronary Syndrome: Question 6E 104
Table I-121. Acute Coronary Syndrome: Question 6F 105
Table I-122. Acute Coronary Syndrome: Question 7 105
Table I-123. Acute Coronary Syndrome: Question 9A 106
Table I-124. Acute Coronary Syndrome: Question 9B 107
Table I-125. Acute Coronary Syndrome: Question 9C 108
Table I-126. Acute Coronary Syndrome: Question 9D 109
Table I-127. Acute Coronary Syndrome: Question 10 110

Table I-128. Acute Coronary Syndrome: Question 12A 111
Table I-129. Acute Coronary Syndrome: Question 12B 112
Table I-130. Acute Coronary Syndrome: Question 12C 113
Table I-131. Acute Coronary Syndrome: Question 12D 114
Table I-132. Acute Coronary Syndrome: Question 12E 115
Table I-133. Acute Coronary Syndrome: Question 12F 116
Table I-134. Acute Coronary Syndrome: Question 13 117
Table I-135. Acute Coronary Syndrome: Question 14 117
Table I-136. Acute Coronary Syndrome: Question 15 118
Table I-137. Acute Coronary Syndrome: Question 17A 119
Table I-138. Acute Coronary Syndrome: Question 17B 120
Table I-139. Acute Coronary Syndrome: Question 17C 121
Table I-140. Acute Coronary Syndrome: Question 17D 122
Table I-141. Acute Coronary Syndrome: Question 17E 123
Table I-142. Acute Coronary Syndrome: Question 17F 124
Table I-143. Acute Coronary Syndrome: Question 18 125
Table I-144. Acute Coronary Syndrome: Question 19A 125
Table I-145. Acute Coronary Syndrome: Question 20 126
Table I-146. Acute Coronary Syndrome: Question 19B 127
Table I-147. Acute Coronary Syndrome: Question 21 128
Table I-148. Colon Cancer: Question 1 129
Table I-149. Colon Cancer: Question 2 129
Table I-150. Colon Cancer: Question 3 129
Table I-151. Colon Cancer: Question 4 130
Table I-152. Colon Cancer: Question 5 130

Table I-153. Colon Cancer: Question 6 131

Table I-154. Colon Cancer: Question 8 132

Table I-155. Colon Cancer: Question 9 133

Table I-156. Colon Cancer: Question 11A 134

Table I-157. Colon Cancer: Question 11C 135

Table I-158. Colon Cancer: Question 11D 136

Table I-159. Colon Cancer: Question 11E 137

Table I-160. Colon Cancer: Question 11F 138

Table I 161. Colon Cancer: Question 11I 140

Table I-162. Colon Cancer: Question 12 141

Table I-163. Colon Cancer: Question 13 141

Table I-164. Colon Cancer: Question 14 142

Table I-165. Colon Cancer: Question 15 143

Table I-166. Colon Cancer: Question 16 144

Table I-167. Type 2 Diabetes: Question 1 145

Table I-168. Type 2 Diabetes: Question 3A 146

Table I-169. Type 2 Diabetes: Question 3B 147

Table I-170. Type 2 Diabetes: Question 3C 148

Table I-171. Type 2 Diabetes: Question 3D 149

Table I-172. Type 2 Diabetes: Question 3E 150

Table I-173. Type 2 Diabetes: Question 3F 151

Table I-174. Type 2 Diabetes: Question 3G 152

Table I-175. Type 2 Diabetes: Question 3H 153

Table I-176. Type 2 Diabetes: Question 4 154

Table I-177. Type 2 Diabetes: Question 6A 155

Table I-178. Type 2 Diabetes: Question 6B 156
Table I-179. Type 2 Diabetes: Question 6C 157
Table I-180. Type 2 Diabetes: Question 6D 158
Table I-181. Type 2 Diabetes: Question 6E 159
Table I-182. Type 2 Diabetes: Question 7 160
Table I-183. Type 2 Diabetes: Question 8A 160
Table I-184. Type 2 Diabetes: Question 9 161
Table I-185. Type 2 Diabetes: Question 8B 162
Table I-186. Type 2 Diabetes: Question 10 163
Table I-187. Gynecologic Surgery: Question 1 164
Table I-188. Gynecologic Surgery: Question 2A 165
Table I-189. Gynecologic Surgery: Question 2B 166
Table I-190. Gynecologic Surgery: Question 2C 167
Table I-191. Gynecologic Surgery: Question 3 168
Table I-192. Gynecologic Surgery: Question 4A 169
Table I-193. Gynecologic Surgery: Question 4B 170
Table I-194. Gynecologic Surgery: Question 4C 171
Table I-195. Gynecologic Surgery: Question 5 172
Table I-196. Gynecologic Surgery: Question 6 173
Table I-197. Gynecologic Surgery: Question 7 173
Table I-198. Gynecologic Surgery: Question 8 173
Table I-199. Gynecologic Surgery: Question 9 174

Appendix E Summary of Qualitative Interview Results

This appendix provides a descriptive summary of the results from the expert and facility-level interviews conducted as part of Assessment B. The methods used are described in Chapter Two and Appendix A. Below, we present a descriptive summary of the qualitative interview data for the following domains:

Fiscal and economic resources
Workforce and human resources
Physical infrastructure resources
Information resources
Access/quality
Policy options

Appendix E.1 Results by Domain

Appendix E.1.1 Fiscal and Economic Resources

In 11 qualitative interviews with VAMC leadership (Directors and Associate Directors), the questions for the fiscal and economic resources domain focused on the effects of decentralization on the ability to allocate resources at the facility level, potential drivers of costs, and perspectives on the process for contracting to outside providers. Table E-2 at the end of this section provides the code counts by interview for each fiscal and economic resources domain code.

Budget and Budget Process

VAMC administrators were asked whether there were disconnects between the projection model, which helps develop the budget submitted to Congress, and the VERA model, which allocates money from the VISN to facilities. Most respondents indicated that the VERA distribution model worked well at efficiently allocating resources from the VISN to the VAMC based on workload and population factors at the facility level. However, respondents noted different issues with the process, including time lags in the data used in the VERA model or delays in receiving the allocation itself (four facilities) and the need to document and code accurately to reflect actual workload (two facilities). Several respondents noted that after being initially underfunded through the VERA allocation process the VISN was able to supplement their budget to bridge the gap.

> …there's actually a two-year lag between what data that methodology looks at, so there can be some significant population and/or workload shifts that take place. [F-005]

> In as far back as I can remember, we haven't gotten a budget allocation for several months into the fiscal year. Sometimes we've gone till six months into the fiscal year before we have a budget, so that's sort of a very difficult question to respond to when we're dealing with such a vacuum of information.[F-064]

> Probably about five years ago we started looking at a lot of the things that impact VERA to make sure that we were maximizing…or we were documenting correctly, we were coding correctly, we were getting everything completed within the amount of time to capture the appropriate workload. [F-061]

Respondents at five facilities also commented on whether the reallocation process was flexible enough to allow for redistribution based on changes in the patient population with some indicating the VISN had

flexibility (four facilities) while others described constraints on the ability to redistribute funds (two facilities).

> ….so, again, you may have a base allocation that's provided, but then as things change during the year there's enough flexibility in that the funds both to the facility and then within the facility can be redistributed or reallocated without really going into a VA cost accounting. [F-005]

> If the VISN holds a reserve, which they do, you're halfway through the year and you see a big shift, then some money can shift with it out of the reserve. The problem is that, again, we have created rules that all of your reserve needs to be out—all of your projects need to be obligated in the first six months of the year, all of your equipment has to be purchased in the first six months of the year, which doesn't leave you any room to have emergencies or make shifts as the environment shifts. [F-044]

Administrators at all facilities described different challenges to using allocated funds, including the time it takes to acquire new space (three facilities), mandates that have to be funded out of the allocation (three facilities), the inability to move funds between categories at the facility level (two facilities), and the burden of maintaining physical infrastructure no longer used for patient care (one facility).

Time to acquire new space

> … that we are in a huge space crunch and so right now I'm being told that you've got to bring 150-some mental health staff onboard. And in order to do that we're putting up modular buildings until once the space is available. Then we can start bringing the people onboard. But you can't recruit until you have that space to accommodate that staff. So it works great when the money comes at the beginning of the fiscal year. You have time to plan well and you've got the space. But when it comes at a very restricted time or the timeline is very short it makes it a challenge. [F-084]

Mandates and special programs

> I think it's a lot of the mandates or all of the sudden something new comes from a program office that then it's thrown back at you and you have to then fund it with the money that you've been allocated from the beginning. And then it becomes a challenge. [F-084]

Inability to move funds between categories

> If we're spending more than it was originally budgeted in a certain category, we would need to go to our network to try to get approval to move money from one account to another. Generally we're not allowed to do that. [F-064]

> In addition is all the special funding that comes out of central office. So they decide what your needs are, they decide that you need 15 mental health providers and say, "Here you go. You can only spend this money on this." And then at the end of the year if you didn't necessarily need that, you can't use the money for different operations somewhere else. You would have to return that money to central office. [F-041]

Need to maintain physical infrastructure

> The problem is that for this facility here, it's a pretty significant bill that we pay every year that the funding methodology does not compensate for, to maintain these buildings and the grounds that are really no longer needed for healthcare. So that has

> an impact on our budget, a direct impact on our budget, because we still have to manage these buildings and maintain them and the infrastructure to support them, but it generates no revenue for us in workload or anything else. And so that puts us—is a handicap right away in our budget methodology. [F-024]

Respondents at most facilities offered suggestions for improving the allocation process, including using a long-term budgeting process, allowing flexibility to move funds between categories at the facility level, and developing a performance-based model that goes beyond assessing prior workload.

> VA has been attempting to go more toward a planning-based or performance-based model that would, again, truly based on—and this would be more at the local or the market level—based on needs of the specific, unique population of the area and based on the capacity, not only in the VA but the capacity in the community resources, that those kind of be reconciled, to make sure that optimal treatment is given and services provided based on what is available in the budget. [F-005]

In terms of overall adequacy of the budget allocated through the VERA process, there was variation across facilities, with some starting out positively while others begin the fiscal year in a deficit. One administrator noted that the overall budget was constrained by centralized programs that required a lot of resources, while another commented that these centralized programs did not appear to be coordinated by the central office.

> Currently and for the last several years has been a positive VERA in terms of—that our allocation is, at the onset, sufficient to take care of our operational needs. That is not the case with all of the medical centers in our network. Some of them start with a projected deficit with regard to what they've been allocated. [F-064]

> Of course, we never have enough to go around everywhere. Actually this year we faced a pretty substantial projected budget deficit. So we had to take some steps locally to deal with that and delayed some funding of programs, that type of thing, to make sure we were going to close the year out—and we'll do fine now. [F-024]

> For instance, a lot of money comes out of the budget to support centralized programs both at the big VA level and at the VHA level and there's been tremendous growth in those programs that take money – there's only a fixed pot of money – that take money out – well, so there's less to be distributed to the field to provide the care to the Veterans. [F-044]

> then you have a lot of mandates, either…and from different program offices, that I believe in the sense throughout the organization is that a lot of these mandates that come from the different program offices are not coordinated through the leadership at central office. [F-084]

Hiring

Administrators at four facilities noted that there was discretion at the facility level to hire physicians, nurses, and other clinical staff as necessary to meet local demand.

> We do have to ability to do that locally. That's a local decision. Again, it is based on funding availability. And so the way we do it here, we have a physician management committee that looks at all new positions and recurring positions that have come open. And they go through the process of looking at that and looking at our budget projections

> and our supportable FTE levels, and then make recommendations to the director on which positions to fill or not fill. [F-024]

Purchasing

Respondents were asked about purchasing drugs and medical supplies. Generally, facilities had fairly good processes in place to meet their needs. One respondent, however, in describing the purchasing process in more detail, emphasized the layers of tasks and processes that needed to be accomplished despite centralized contracting.

> We have the national contracts and the idea was originally that [those] would streamline the process, but since they don't negotiate best pricing, that still has to be done at the regional or local level which then adds a substantial amount of lead time to the average procurement. So anything over $3,000, over the micropurchase threshold, still has to go through a fairly labor intensive and time consuming procurement process to validate [that] we're getting best value. That has a major impact on your efficient supply distribution methodologies because then you have to build that procurement process or that best value analysis process into your lead time. And so when you're trying to go to a just-in-time model of supply support at your facilities so you're efficiently using space and people and everything else, that is counter to that. That causes major, major problems. [F-024]

Contracting to External Providers

Respondents were asked about how they developed budgets for and made the decision to refer to non-VA care. Several themes emerged about the infrastructure and processes for non-VA care.

<u>Developing budgets for non-VA care</u>

Respondents described budgeting for non-VA care as part of the annual budgeting process. Like other parts of the budget, services or segments of the facility are asked to estimate needs for the coming year and provide justification. Given the somewhat unpredictable nature of demand for non-VA services, and the variability in staffing and other resources that might affect the site's ability to provide care in-house, respondents freely admitted that budgeting was only an "educated guess" at what they might need. When demand for non-VA care outstrips the budget, as was commonly true in one site, facilities need to go back to the VISN for more funds.

> We do our budget call, each individual service, medical service, or surgery, or whatever else, they would analyze what they feel they need for fee or non-VA care, so that would be part of the annual budget call. They would try to project what that requirement would be and then of course adjustments are made throughout the year based on actual patient needs. But that is part of the budget call that we do annually with all the services. And it's an educated guess, as things shift. [F-024]

> [To determine the budget for non-VA care] You look at what you did last year…. I say [that] kind of tongue in cheek, but really a lot of it is based upon previous experience. [F-081]

> It's a yearly cycle of being allocated a certain amount and knowing going in that you've executed more money the year before than you started out with the current year—you know you're going to have to go back in for more money. So that's the situation we face. [F-104]

Making referrals to purchased care

Respondents discussed the reasons that purchased care would be used. They emphasized that use of purchased care is based first on clinical need and what is best for the patient, not on cost.

> Those decisions are primarily based on clinical need and we try to keep it that way, that we don't—we try not to bias, if you will, the clinical decision due to funding. So if the need is there, the clinical need is there, we don't have the specialty in-house, then yeah, they are free to fee that out. That is what drives that decision, not the money. [F-024]

> You go through the third party administrator and, to be patient-friendly, you want to get that care as close to the Veteran's home as you can. For instance, if they need PT three times a week for some rehab, you don't want them coming all the way into [central city] for that. Then you'd just bring them to the medical center. You want to do that close to where they live. [F-044]

> Here at the facility level, we can take individuals on an individual basis and kind of do some research on their particular situation and make an exception to that rule [of when to refer to non-VA care]. There is a clause written for the geographical burden; however, the parameters of that decision-making process can be left for very vague interpretation. So our philosophy here is to err on the side of the Veteran and that's taking into account all the geographical barriers, the weather, the road conditions, all these factors that preclude them from being eligible and making an informed decision on that, and so that's kind of given that population of Veterans some hope. [F-005]

Respondents also described the tension between the benefits of providing care through VA and the cases in which non-VA care makes more sense for Veterans. VAMC leadership were attentive to the need to analyze the business case for either model of care, and the importance of periodically re-evaluating to identify the best solution.

> We would always prefer to have people working for us because we feel that provides better continuity of care, continuity of services, when somebody works for you, as opposed to a contract. However, sometimes a contract is better because we don't do enough of that work in-house here to justify having our own staff to do it. Case in point, mammographies. We don't have enough workload to justify the equipment and the personnel to run that equipment on a full-time basis, so we contract for that. And we have sufficient resources in the area to do that. [F-064]

> I feel like we have the authority to look into the demand for health services, and for example, one of the initiatives we're looking at now is, we don't have magnetic resonance imaging or an MRI machine. In the past, they've had contracted services for a service provider could bring a tractor trailer that has the MRI for certain days a week or a certain number of days per month, and so pay a contract fee for imaging onsite. A couple of years ago, it was decided that that was no longer what management wanted to do—instead, they were going to fee out or purchase the MRI services in the local communities. So as we take a fresh look at it, it appears that there's probably a blended approach that's more financially advantageous, so we're working on a contract to bring an MRI vehicle back to our central facility [F-104]

> When we are looking to staff or send something out on contract or bring in a fee provider or somebody on an intermittent basis, we need to look at the workload, we need to make sure that we're doing a make [or] buy analysis and do the best for the

> facility. So if we have the space and we're bringing people in, that's great. If we've got mammography and we know that we can't take care of that and that that's over at [academic partner]; great. But that workload has to be there. That data has to be there and that analysis is done appropriately. [F-041]

Use of contracts

Respondents commented on the challenges of using established third-party administrators (TPA) to refer patients to purchased care. Some facilities described the workflow required to interface with the TPA is duplicative and onerous. Respondents also complained about the limited networks of the TPA, how this affects patients, and how it creates more work for the sites, who must find an out-of-network fee provider when the TPA "fails."

> I can no longer just fee something to the dermatologist across the street unless it's an affiliate, and we have all these other issues we have to jump through. We created this third party administrator that's going to get all the providers for us and you know it sounds great on paper except they can't perform, so I send people out on fee and I can't get the work done because unless we go through this third party administrator. They fail and then I can send it out and get the care done, but I have to prove that the third party administrator can't perform the service first and that is not good patient care and it certainly is not good for patient satisfaction. [F-044]

Choice Cards – Utilization and Challenges

Respondents reported generally low utilization of the Choice Act option for obtaining purchased care. When asked about low demand, respondents surmised that many patients preferred receiving care within VA, and that wait times for community facilities were similar or worse than at VA.

> [The low utilization of the Choice Act is] for multiple different reasons. We could actually have an appointment that's earlier than they can find in the community—which happens a lot. Most of our veterans really love the VA here. We have an inner city population, we've got a high homeless population, and they connect with the VA. They want to be here. They don't want to go outside. … In addition, … for Choice the VA has also contracted with HealthNet. So the veterans just can't go to anybody that they want to go to. They have to go to the HealthNet providers. And if they don't have a good provider network, why are they going to go on the outside? [F-041]

> I've been asking for hard numbers and I haven't been able to get much information, much data yet. So I can only give you anecdotal data that yeah, we're not seeing much use of the Choice Card. And anecdotally, we're getting, again, from patients that, you know, even though they may have to wait a little longer, they'd rather just stay with their VA provider. [F-024]

Respondents also commented on the importance of education around the Choice Act for patients and providers outside VA. Several facilities were making efforts to engage their patients and communities to raise awareness about what the Choice Act does—and does *not*—provide.

> We have had some success where community providers have reached out to us and we've provided them with the literature and the information and the mechanisms to apply for the program and so we've seen some success with that. On the flip side of that, we've also seen where the providers read the details and has opted not to become partnered under that program, so that's one thing that the Veteran has to take and

> account for, too, is that the card in itself isn't a key to that access. It relies heavily on the community partnership, on educating both the Veteran and the provider about the Choice program, so we're doing that on a daily basis.
> [F-005]

Finally, respondents discussed administrative challenges with Choice, including the 40 mile "as the crow flies" distance (which was since been changed) and the paperwork overhead for facilities.

> Another piece pertaining to that 40-mile radius is that a lot of these folks live in mountainous terrain or there's a canyon separating them or big conservation reservations that they can't cross, and so under that law, "as the crow flies," and whether we agree or disagree with that, it is misleading in the fact that when a Veteran has to drive 90 miles around something, but yet if they were to be able to fly across the mountain they'd be there in 12 minutes, so those are issues that, again, are being taken up with the congressional channels to kind of rewrite that law and take into account the geographic burdens that the Veterans face in the rural communities and, again, we're not any different than other rural communities, but we are subject to quite a mountainous terrain here. [F-005]

> It is a tremendous amount of work for our front line people who do scheduling to make the appointment for the Veteran within our own system, which we know he's going to keep and do this work to put him on the Choice Act, and then we have to go in and the [staff who handle fee service referrals] have to upload all of this information when it's not going to be used. [F-044]

Comments on VA bureaucracy

Throughout the discussion of the budget and contracting processes for non-VA care, respondents emphasized the challenges of contracting within VA. Whether contracting for space, supplies, services, or providers, respondents complained that the contracting process was time-consuming and non-responsive.

> We have some contract CBOCs. So actually we contract for service and we do have some of our CBOCs that are VA run that are in leased space. So yes, that is a very viable program although again that is a very lengthy approval process, to go through that whole lease process as well.
> [F-024]

> The ability to [experience saving by purchasing non-VA care] is dependent on your ability to do the analysis, to navigate and negotiate the contracting world to actually accomplish what it is you're trying to set out, and there are sometimes obstacles, certainly in the contracting environment, that delay those kinds of projects for many months. [F-104]

> There is an entire process for contracting which is extremely challenging for the medical center. We don't do it. Somebody else does it for us. And it's become—and this is a general comment from my part—it has become so convoluted and so complex over the last couple of years that it is a constant problem for us. It takes too long to be able to accomplish anything with regard to—I'm not using hyperbole—it is just an exasperating process to do anything by contracting. So that's another reason why we would rather do it in-house because we don't want to get involved with contracting. It's the way the government is. [F-064]

Respondents suggested reasons that the VA contracting process might be as bad as they thought it was. They believed that a remoteness from the day-to-day responsibility of patient care kept them removed from the mission of VA, and that the reporting structure—in that contracting reports to Central Office—was not conducive to engaging contracting staff in the goals of a given facility. Other respondents explained the burdensome requirements by acknowledging that VA was part of the federal government, and therefore held to a higher standard for rules and procedures, regardless of the effect on efficiency.

> Our contracting staff are in [another regional city]. I've been there. They sit in a little office park and sometimes they're there, sometimes they're not there. And there's no real incentive for them to hurry the process up…. I should not need to get on the phone or go up there and go through every single thing and say "Why is this not done? Why are you not meeting your deadline on this? Why do you not need this?" If they were under my supervision, fine, because I am generally a tough manager, I'm going to make sure that you meet your deadlines and I want you to understand the whole picture, and by delaying the process, how it's affecting patient care. But since I have no control over those individuals, I sit there and I have my hands tied behind my back a lot of the time. [F-041]

> We are part of the federal government and there are a lot of bureaucratic processes that we're bound by law and regulation to follow. The simpler the process can be made to be, the better our veterans will benefit. So as we go to pay bills, as we enter into contracts, the magnitude of things we have to do to expend that money on behalf of our veterans sometimes slows the process and gets in the way. But we understand we're a public entity with a trust and that we have to do our due diligence to ensure that we're following the law, but that comes at an expense of the speed and volume of care we're able to translate that budget into execution, if that makes sense. [F-104]

> [Contracting is] one of those centralized programs that's beefed up its staffing by about three times, yet the service has gone through the basement, and it's all because one or two people make stupid purchasing decisions so we overreact and create this monster organization, train people – and I'm not exaggerating – one month out of the year, so they're not providing the service and then you centralize them so they are not connected to the mission or to the organization, and you just paralyze. [F-044]

Table E-1. Fiscal resources domain: code count by facility-level interview

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B1.1 Budget and budget process	1 Disconnect in budget process	2 Reallocation of budget	1 Reallocation process	2 Proposed reallocation fixes	3 Role of VISN	3 Problems with VERA allocation process	1 Time lag	2 Need to document services to insure future allocation	3 Maintaining older facilities	4 Increases in CO staff	4 Adequacy of budget	5 Constraints in using allocated funds	1 Medical care appropriation not flexible across domains	2 Takes time to get new space	3 Lack of incentive to save or plan for capital expenditures	4 Centralized processes take resources from patient care	6 Funding special programs	7 Role of CO staff in budget process	B1.2 Hiring	1 Degree of discretion in hiring	2 Ability to create new positions
F-002	VAMC	Leadership	F1	small-med metro	small	less complex	1	1		1								1										
F-004	VAMC	Leadership	F1	small-med metro	small	less complex																						
F-005	VAMC	Leadership	F1	small-med metro	small	less complex	1	1	1	1	1															1	1	
F-021	VAMC	Leadership	F2	large metro	large	complex		1	1				1											1	1			
F-023	VAMC	Leadership	F2	large metro	large	complex																						
F-024	VAMC	Leadership	F2	large metro	large	complex	1	1	1	1			1	1		1		1	1	1	1					1	1	
F-029	CBOC	Clinical staff	C2	large metro	large	complex																						
F-032	VAMC	Leadership	F2	large metro	large	complex																						
F-041	VAMC	Leadership	F3	large metro	medium	complex	1	1	1	1	1													1				
F-043	VAMC	Leadership	F3	large metro	medium	complex																						
F-044	VAMC	Leadership	F3	large metro	medium	complex		1				1							1		1			1		1	1	
F-050	CBOC	Leadership	C3	large metro	medium	complex																						
F-052	VISN	Leadership	V4																									
F-054	VISN	Leadership	V4																									
F-060	VAMC	Leadership	F4	small-med metro	medium	complex																						
F-061	VAMC	Leadership	F4	small-med metro	medium	complex		1				1	1	1	1													
F-062	VAMC	Leadership	F4	small-med metro	medium	complex																						
F-063	VAMC	Leadership	F4	small-med metro	medium	complex																						
F-064	VAMC	Leadership	F4	small-med metro	medium	complex	1		1	1		1	1		1			1	1	1				1		1	1	
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex																						
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex																						
F-070	CBOC	Leadership	C4	small-med metro	medium	complex																						
F-073	VISN	Leadership	V1																									
F-074	VISN	Leadership	V1																									
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex																						
F-081	VAMC	Leadership	F5	small-med metro	large	complex	1	1						1	1			1	1	1				1				

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B1.1 Budget and budget process	1 Disconnect in budget process	2 Reallocation of budget	1 Reallocation process	2 Proposed reallocation fixes	3 Role of VISN	3 Problems with VERA allocation process	1 Time lag	2 Need to document services to insure future allocation	3 Maintaining older facilities	4 Increases in CO staff	4 Adequacy of budget	5 Constraints in using allocated funds	1 Medical care appropriation not flexible across domains	2 Takes time to get new space	3 Lack of incentive to save or plan for capital expenditures	4 Centralized processes take resources from patient care	6 Funding special programs	7 Role of CO staff in budget process	B1.2 Hiring	1 Degree of discretion in hiring	2 Ability to create new positions
F-083	VAMC	Leadership	F5	small-med metro	large	complex																						
F-084	VAMC	Leadership	F5	small-med metro	large	complex		1		1	1								1		1					1	1	
F-094	VISN	Leadership	V3																									
F-100	VAMC	Leadership	F6	rural	small	less complex																						
F-102	VAMC	Leadership	F6	rural	small	less complex																						
F-104	VAMC	Leadership	F6	rural	small	less complex	1		1			1		1				1	1	1								
F-106	VAMC	Clinical staff	F6	rural	small	less complex																						
F-113	VISN	Leadership	V6																									
F-115	VAMC	Leadership	F6	rural	small	less complex																						
F-122	VISN	Leadership	V5																									
F-141	VISN	Leadership	V2																									
F-142	VISN	Leadership	V2																									
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex																						
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex																						
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex																						
F-164	VAMC	Clinical staff	F2	large metro	large	complex																						
F-171	VAMC	Clinical staff	F2	large metro	large	complex																						
F-182	VAMC	Clinical staff	F3	large metro	medium	complex																						
F-184	VAMC	Clinical staff	F3	large metro	medium	complex																						
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex																						
F-217	VAMC	Clinical staff	F2	large metro	large	complex																						
F-248	CBOC	Clinical staff	C2	large metro	large	complex																						
F-250	CBOC	Leadership	C2	large metro	large	complex																						
F-251	CBOC	Clinical staff	C2	large metro	large	complex																						
F-255	CBOC	Clinical staff	C2	large metro	large	complex																						
F-256	CBOC	Leadership	C2	large metro	large	complex																						
F-257	CBOC	Clinical staff	C2	large metro	large	complex																						
F-304	VAMC	Clinical staff	F2	large metro	large	complex																						
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex																						
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex																						
F-307	VAMC	Clinical staff	F2	large metro	large	complex																						

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	3 Ability to hire into open slots	4 Space limitations	B1.3 Purchasing	1 Systems for centralized purchasing	2 Purchase cards - how fit in budget	3 Purchase cards - limit	B1.4 Contracting to external providers	1 Budgets for contract care	2 Referrals to non-VA care	B1.5 Choice Cards	1 How CC change demand for contract care	2 Relationship CC and contract providers	3 Demand for CC	4 Perspective on changes to CC program elig	B1.6 Other/Unsure	B1.7 Complaints about VACO, bureaucracy
F-002	VAMC	Leadership	F1	small-med metro	small	less complex																
F-004	VAMC	Leadership	F1	small-med metro	small	less complex																
F-005	VAMC	Leadership	F1	small-med metro	small	less complex	1		1				1	1	1	1		1	1	1	1	
F-021	VAMC	Leadership	F2	large metro	large	complex																
F-023	VAMC	Leadership	F2	large metro	large	complex																
F-024	VAMC	Leadership	F2	large metro	large	complex			1	1		1	1	1	1	1			1			1
F-029	CBOC	Clinical staff	C2	large metro	large	complex																
F-032	VAMC	Leadership	F2	large metro	large	complex																
F-041	VAMC	Leadership	F3	large metro	medium	complex			1	1			1	1	1	1	1		1		1	1
F-043	VAMC	Leadership	F3	large metro	medium	complex																
F-044	VAMC	Leadership	F3	large metro	medium	complex			1	1	1	1	1	1	1		1	1	1			1
F-050	CBOC	Leadership	C3	large metro	medium	complex																
F-052	VISN	Leadership	V4																			
F-054	VISN	Leadership	V4																			
F-060	VAMC	Leadership	F4	small-med metro	medium	complex																
F-061	VAMC	Leadership	F4	small-med metro	medium	complex			1			1										
F-062	VAMC	Leadership	F4	small-med metro	medium	complex																
F-063	VAMC	Leadership	F4	small-med metro	medium	complex																
F-064	VAMC	Leadership	F4	small-med metro	medium	complex	1		1	1			1		1							1
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex																
F-070	CBOC	Leadership	C4	small-med metro	medium	complex																
F-073	VISN	Leadership	V1																			
F-074	VISN	Leadership	V1																			
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-081	VAMC	Leadership	F5	small-med metro	large	complex							1	1	1	1			1			
F-083	VAMC	Leadership	F5	small-med metro	large	complex																
F-084	VAMC	Leadership	F5	small-med metro	large	complex		1					1									

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	3 Ability to hire into open slots	4 Space limitations	B1.3 Purchasing	1 Systems for centralized purchasing	2 Purchase cards - how fit in budget	3 Purchase cards - limit	B1.4 Contracting to external providers	1 Budgets for contract care	2 Referrals to non-VA care	B1.5 Choice Cards	1 How CC change demand for contract care	2 Relationship CC and contract providers	3 Demand for CC	4 Perspective on changes to CC program elig	B1.6 Other/Unsure	B1.7 Complaints about VACO, bureaucracy
F-094	VISN	Leadership	V3																			
F-100	VAMC	Leadership	F6	rural	small	less complex																
F-102	VAMC	Leadership	F6	rural	small	less complex																
F-104	VAMC	Leadership	F6	rural	small	less complex							1	1		1			1		1	1
F-106	VAMC	Clinical staff	F6	rural	small	less complex																
F-113	VISN	Leadership	V6																			
F-115	VAMC	Leadership	F6	rural	small	less complex																
F-122	VISN	Leadership	V5																			
F-141	VISN	Leadership	V2																			
F-142	VISN	Leadership	V2																			
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex																
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex																
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex																
F-164	VAMC	Clinical staff	F2	large metro	large	complex																
F-171	VAMC	Clinical staff	F2	large metro	large	complex																
F-182	VAMC	Clinical staff	F3	large metro	medium	complex																
F-184	VAMC	Clinical staff	F3	large metro	medium	complex																
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-217	VAMC	Clinical staff	F2	large metro	large	complex																
F-248	CBOC	Clinical staff	C2	large metro	large	complex																
F-250	CBOC	Leadership	C2	large metro	large	complex																
F-251	CBOC	Clinical staff	C2	large metro	large	complex																
F-255	CBOC	Clinical staff	C2	large metro	large	complex																
F-256	CBOC	Leadership	C2	large metro	large	complex																
F-257	CBOC	Clinical staff	C2	large metro	large	complex																
F-304	VAMC	Clinical staff	F2	large metro	large	complex																
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-307	VAMC	Clinical staff	F2	large metro	large	complex																

Source: Authors' analysis of interview data collected and coded for this project

Appendix E.1.2 Workforce and Human Resources

Twenty-six qualitative interviews with VAMC leadership (Associate Directors and Chiefs of Staff) and VAMC and CBOC clinical staff (providers) included questions for the workforce and human resources domain focused on capacity constraints related to the number of providers and provider productivity. Table E-3 at the end of this section provides the code counts by interview for each workforce and human resources domain code.

Provider numbers and staffing

Findings from qualitative interviews at six facilities indicate that staffing shortages are common across VA. Representatives from all facilities could identify at least two areas in which they experience shortages. (Five facilities [83 percent] are short-staffed in primary care and all facilities [100 percent] are short-staffed in at least one specialty). Shortages by specialty are largely idiosyncratic, though a few specialties were identified by multiple respondents: mental health (10), urology (5), orthopedic surgery (3), physical therapy (4), and hospitalists (3) were among the most often mentioned.

Respondents attribute struggles with staffing shortages to non-competitive salaries relative to the private sector (five facilities; 83 percent), national shortages in certain specialties (four facilities; 67 percent), geographic isolation (five facilities; 83 percent), insufficient funds to hire and provide support resources for new providers (four facilities; 67 percent), and insufficient space to add staff (e.g., exam rooms, ORs) (five facilities; 83 percent).

National shortage:

> it's not easy when now, across the board a variety of positions are being recruited by VA when, frankly, nationally we don't have enough providers for the population in this country. [F-063]
>
> I'd say we're not replacing physicians who leave patient care at the rate at which we need them, considering the demand has increased, both within VA and nationally with the Affordable Care Act, so that's a challenge that we will have [F-063]

Geography:

> It's also very difficult to get specialists into small clinics because they prefer to live in the city where they have potential for income and their families want to live, etc. [F-032]
>
> In the case of the eye care in the northern clinics, they're relatively rural areas, where we've had two instances of people accepting the position, driving out there with their spouse and then going, "Aw, no, I don't want to move there." [F-021]
>
> The barrier chiefly for us, aside from being an extremely rural location is that though it's extremely rural, they have an oil boom in our area. So when you have an oil boom, the price of things, everything just went up, it shot, skyrocket. So the people that are coming in for oil, which is one of the major factors that's driving the veterans in as well, because of the job opportunity in the oil field. It's making housing very expensive. So people are not able to afford it and just the cost of living's gone way high and then the amount of accommodations that you have, the demand and supply, so it's not catching up with the level of influx of people. So that is the major factor for us. [F-115]

Salary:

> When you're talking about physicians, the pay scale. You've probably heard this from other people, but when you get into dermatology, neurosurgery, those kinds of things, the top of our top our pay scale is sometimes at best half of what they would make in the private sector.

Insufficient funds to hire:

> We are constrained by budget, I guess I should say. And the ability to… If you have an increase in your demand coming in…demand for services, you have to also be able to increase your full-time equivalent to be able to address that demand. For us for several years we've been under an FTE cap which has prevented us from being able to bring in and grow the number of people that we need to grow. [F-081]

> When you talk about expanding providers, and talking about extra space, then you're also talking about hiring additional environmental management staff, you're talking about extra burden on pharmacy, lab, pathology, radiology. All of those other services also have an impact. And when we do things like our VACAA funding and so forth it's basically just considered the primary care staff, or specialty care staff. It didn't talk about the extra workload that would be generated for lab, radiology, environmental management with a new space, SCS with demand in surgeons, dental. I mean, all of these areas have an impact outside of their small area that they work. [F-094]

Insufficient space:

> Certainly just not having enough space in general is an issue. We are bringing on several new positions and providers and support staff through the VACAA funding, and I have a small group that looks at our physical space and we're doing our very best to utilize every inch that we have and we still don't have enough space to provide everything that we need to provide and to house everyone we need to house, so we're looking at leasing space.
> [F-002]

> We need to hire our providers and I can tell you right now in mental health … I have a meeting later today actually on this very issue. They're holding off on hiring a couple of RN positions and provider – I can't remember if it's a psychologist or a psychiatrist position, some of those, because they don't have the space and I'm saying, no, you need to move forward with the recruiting and we'll figure this out. [F-002]

> The last analysis that we did about six months ago show that easily they need at least two and a half to three providers in that facility. But a concern we have in their facility is that there's nowhere to expand, there's nowhere to put a third provider. And we can't move out because there's no other thing in town that we can put. [F-115]

Respondents named a few sources of benchmarks for determining staffing levels including top-down mandates from program offices, panel sizes (for primary care), and comparison to similar facilities.

> A big chunk of that really came in through mandates from our program offices. And I'm sorry, at that level I don't know the exact models that they use. But they did use some

> types of algorithms or models to look at our demand, look at our volume and predict the number of providers that we needed. [F-081]
>
> Primary care is formulaic in that we now determine capacity based on panel size and your number of providers. So we know for a nurse practitioner, they get x amount of patients. A primary care physician gets y amount of patients. [F-023]
>
> Because we use our sister facility, XXXX, as a benchmark and we had something like 40-some FTE and radiology and they had 88. Now they see a few more patients than we do, but not that many more. So we do a business case analysis when we look at these things. [F-043]

Some respondents (50 percent) described difficulties with assessing requisite staffing, including challenges with complexity in treatment modalities (especially in mental health), a lack of ideal or recommended panel sizes in many specialties, and challenges presented by utilizing contract providers.

> In terms of capacity, mental health capacity is extremely difficult to figure out. It's not like primary care, where it's by panel. Mental health capacities are many, many different models and the issue with mental health is, unlike primary care which gives you a single therapeutic modality that pretty much everybody agrees with… Mental health has many therapies that are incorporated as part of mental health, including behavioral cognitive therapy, individual psychotherapy and other mental health modalities that you are never going to have enough staff to do. [F-023]
>
> It's not so clear in specialty care. There is no set ratio, so service chiefs for surgery, medicine, PM&R [physical medicine and rehabilitation, etc., have a combination of things that they have to use to determine the number of staff at your site and workload is one, productivity is another. [F-032]
>
> I kind of got in trouble because I was told I had too many providers. But when we did the analysis for medicine, which is our largest service, I asked my chief of medicine to find chiefs of medicine at other 1B facilities and see how many they had, and it turns out they were doing contracts and things like that, which doesn't count in the end number. So we actually had fewer when we did it on a per thousand patients. We had fewer FTE than the other facilities that were like us had because they were doing contracts. [F-043]
>
> As a result, staffing models only account for part of the equation, and about half of respondents (50 percent) indicated that they used additional metrics to determine if changes in staffing were necessary. Access and quality metrics (e.g.,. SPARQ and SAIL data) were used to determine if patients were waiting or quality was slipping; at that point, facilities would devise ways to acquire additional FTE.
>
> Basically we look at all the quality data. We look at SAIL, we look at the 30, 60, 90 days, we also look at panel sizes and try to project. We look at vacancy rates that are coming up and try to make sure that we have those announcements out so that a provider will come in within a reasonable period of time. [F-041]
>
> Well, decisions about adding would be if we're struggling to get patients seen then we're looking at all of the possibilities, are there things we can do to make them more efficient, is there a way to schedule additional clinics using either fee or part-time. [F-083]

Respondents discussed a variety of approaches to acquiring and maintaining FTE at their facilities, including hiring and retaining full time employees, using contract employees, and fee-basis and intermittent staff. All respondents (100 percent of facilities) mentioned that they were actively recruiting for vacancies at their facilities. Hiring decisions were made using a business case analysis, in many cases, and respondents from one facility (17 percent) indicated that they had established a committee to make and execute hiring decisions. For the most part, respondents indicated that they preferred to try to fill vacancies by hiring, especially in primary care where full time providers are virtually required, and that full-time employees tended to be more accountable than contractors.

> So if they do a cost benefit analysis, they've got the workload there and they show the labor mapping of where that physician is actually a map to, you know, whether they're mapped to research and actually doing research, we can find some more capacity within the system so we require them to do an analysis when they go to submit for a position. [F-041]

> Generally speaking if we've identified a demand our preference would almost always be to hire. If then we've been recruiting for a period of time and we can't fill the position we would start looking at fee providers, part-time providers, contracts with the community. We do use a business case planning model that goes through our resource board where if we've identified and people feel reasonable that this is a need that we have, then we begin our recruiting efforts. But we look at workload data, wait times, all of those kinds of things. [F-061]

> The way we do it here, we have a physician management committee that looks at all new positions and recurring positions that have come open. And they go through the process of looking at that and looking at our budget projections and our supportable FTE levels, and then make recommendations to the director on which positions to fill or not fill. And of course they make that decision based on our strategic goals, our issues with access, that type of thing. So all that is in a committee structure, is vetted, analyzed, and then the recommendations are then sent forward to the director. [F-024]

> I just think that we are considering [hiring] more in primary care because primary care here is normally going to be a full position, except with the residents coming over. So again, with the specialty care, we're sharing physicians with the different affiliates, so again, if we need a .2 or a .3, they're going to be able to find someone on their staff and send them over. [F-041]

> Even though you can put items in a contract that you hold people accountable to, they're not as accountable as people who actually work for you and are long term and are devoted to XXXX and its veterans. [F-043]

Barriers to hiring were common (six facilities; 100 percent) and were similar to the reasons for provider shortages described above, but also included a long HR process, and other VA regulations related to the approval process (privileging, credentialing, salary approval, etc.).

> Every time I have an open position I'm amazed by the number and the quality of the applicants that I get. But the HR process is in a state of utter paralysis. They can't move the ball down the field. [F-150]

> The VA is trying to address [shortages] to try to hire, but seems like our HR department is not very efficient and so between the selecting the candidates to getting on board it takes between three to six months. [F-251]
>
> Probably the biggest barrier [to hiring] is that our senior leadership understandably watches everyone that's hired and looks at the numbers, and looks at why do we need to hire this person. Why do we need to replace this social worker who just left? And so, this also drags out the process of hiring new staff. And this may actually be one of the major barriers actually, is the attempts by a senior leadership to make absolutely sure that we can justify all of the people that we're hiring, even if these are positions that previously had a demonstrable workload and functioning within the organization. [F-182]
>
> It depends on the specialty, but there are specialties which require approval at the facility level, above the facility, at the VISN level and above the facility at central office level. [F-004]

Other barriers included challenges presented by the culture of the VA (especially among support staff and facility-level administrators) and VA regulations that limit facilities' ability to expand service hours:

Culture of VA:

> We have no trouble finding highly trained, highly motivated professional staff. It's just that the efficiency of the place is undermined by not having administrative support commensurate with the professional effort being made. And just a tolerance of, I won't even say mediocrity, worse than mediocrity, in things like HR, contracting. [F-150]

VA regulations

> We need more providers. But if we hire the providers and we have nowhere to put them then it's a waste of resources. And we can't just hire providers to work evening hours without their support staff. We can't get past the labor partners to have support staff work those hours. [F-094]
>
> Our full-time docs, they're paid on a 40 hour week but there's no way to pay them for working extra. And while there may be some that would be willing to work extra hours or take a weekend a month, there's no way to pay them for that, other than to rearrange their work week so that they're off other days. But that doesn't give you any net increase. [F-083]

In order to address some of these barriers, respondents at all facilities (100 percent) described a number of strategies utilized to recruit providers, including raising salaries as much as possible within designated tiers, promoting other VA employee benefits, relocation packages, promoting affiliations with universities and other medical centers, utilizing recruiters, attending job fairs, advertising, and promoting unique aspects of practicing in a VA setting (e.g., slower pace at smaller clinics, lack of paperwork and payment processing that comes with private practice). Some respondents also indicate that these strategies could be utilized more effectively.

> **Pay:** Now that's not entirely fair because our pay table recently was raised from just around $200[,000]—maybe a little higher—up to $240[,000] as the top of the pay table, so we are more competitive. What I don't think that we promote as strongly as we could

> is that that $240[,000], if we give the top of the pay table—and I have to justify that—if we give that $240[,000] that comes along with other benefits that you don't necessarily get in the private sector like a pension plan, the matching components on the 401k equivalent and lots of various other benefits that the government and civil service provide. So that $240[,000] and equivalent value is probably higher, but to the applicant that's not always clear. [F-004]
>
> **Affiliations:** In XXXX we are very heavily integrated with the XXXX and XXXX medical schools, particularly XXXX. And so there are a lot of docs that have part-time appointments at VA and at XXXX. And that's actually been an enormously helpful recruiting tool for some of the scarce and more highly paid specialties. [F-083]
>
> **Traditional:** HR has gone out the last year or so on a regular basis doing job fairs in the different universities around us and different clinics and attending public…like big city of XXXX job fair and stuff like that, just to announce to us for recruitment. No one told me update on that. We've gone into the journals, you know, placed advertisement in the journals, in the local newspapers, especially the weekends so that people are able to read it. [F-115]
>
> **Intensity:** The other advantage that we offer is that when you work at either of these other two [non-VA] facilities, you are at a much higher level of intensity when you are working. Our facility is small, our facility has a lower average daily census and a lower level of acuity, so the demands placed on the provider are less and sometimes providers are looking for a less intense position.
> [F-004]

Comparison to private practice:

> I saw an Air Force ad not long ago that I think embodies a really excellent recruitment tool. And the ad basically said, "If you come and work for us you'll take care of patients, we'll take care of the administrative work." And to the degree that that can be realized, that is an area where the VA could be really attractive, particularly to the docs in practice who have gotten tired of interfacing with insurance companies that require preapproval for everything, and more and more forms to fill out, and delays in getting things paid for, and the hassles of running an office and all of that. I think that is a recruiting tool that is probably…not probably, has been grossly underutilized. [F-083]
>
> And we've asked the staff that are currently student that are rotating with us to, even word of mouth, anybody they know. They may know a doctor that is saying okay he's tired because of all these changes in the healthcare outside in non-VA community, that he may want to just transition to the VA. [F-115]

Retention challenges were also common among facilities, with respondents from only one facility (17%) explicitly stating that they had no issues with retention. (The other 5 facilities (83%) did experience provider turn-over). The most common area in which retention was discussed was primary care: While provider turn-over in primary care was often mentioned, recruitment of primary care providers was not a challenge for most facilities.

> I think we are in primary care. The only issue is that we do have an influx and outflux of physicians. It's turnover, so making sure that those physicians are adequately

> compensated for what they're doing would help with that. But overall, I think primary care is running well. [F-041]

Respondents described struggles with retention due to a number of factors that relate to pay and provider burn-out.

Pay:

> The second a provider or someone else like a mental health professional walks on board in XXXX, they're immediately looking for their next job down south where they can increase their pay and automatically get that higher geographic adjustment down in the XXXX area, so we have extremely high turnover in areas where the geographic pay is not matched out in the rest of the system. [F-032]

> XXXX is right across the street; seriously, literally across the main XXXX. XXXX is across the street, and I think that there are instances where people will go across the street to XXXX because the pay is better. [F-021]

> **Technology-based challenges:** "why is that, what is it that we're seeing, why is it we're not bringing more patients in, what is this, why does it take 30 minutes for one of these appointments," and a lot of it I'm being told it's the complexities of the CPRS tool and managing and getting through it today. It's also the mandates from all the various program offices that it can take you up to 12 minutes to just get through all of the health factor screenings and all the different questions to get through that; which is also something that has been a problem with maintaining physicians and keeping them onboard, because it's a big drag on them to have to do all of those. [F-081]

Issues with VA culture and process:

> And most docs and clinical people really want to provide excellent care and they just get frustrated when they can't do it, when something is getting in the way of it. And it's also I guess part of the sense of, can we trust clinical people or do the clinical people have to be regulated and managed in the sense that, we will give you this and only this, and we're going to expect you to achieve with only what resources we give you. And it's almost like on the administrative side we don't trust that the clinical folks will do the right thing. And again, that seems like an engrained institutional impediment to success. [F-083]

> The other problem is that you're working in a VA system and in the VA, there's a lot of frustrations. There's your team. It takes forever to replace when a team member leaves. Computers are clunky. Our beautiful medical records system is no longer state of the art. We kind of lag on that now. And there's provider burnout, particularly in primary care. In mental health, I assume it's the same issues. [F-023]

Just as facilities struggle with keeping providers on payroll, they also implement strategies to enhance retention. Representatives of all facilities (100 percent) identified specific retention strategies. These strategies were primarily financial: increasing salaries, improving debt reduction benefits, and offering pay-for-performance.

> The only issue is that we do have an influx and outflux of physicians. It's turnover, so making sure that those physicians are adequately compensated for what they're doing would help with that. [F-041]

> We're looking at the new EDRP. I've got to try to fund that out of my budget, so right now central office gave us some resources for EDRP if we found certain positions either that we wanted to recruit or retain… So right now we are looking at funding that out of our budget with, again, I mean I have a very, very tight budget to begin with but I'm seeing what I can piece together to try to influence these individuals to stay. [F-041]

> We do as much as we can with recognition awards and retention incentives. On the front end we're using recruitment incentives wherever we can. In rare circumstances if we're looking into a physician from out of the area we may offer a move package. Also, when you're talking the physician providers, we have pay-for-performance, so they have an opportunity to maximize their earnings there. [F-061]

Respondents also described the importance of the "mission" of the VA and maintaining transparency when it comes to retaining providers

> However, the flip side of that is that there are providers who stay because (a) they resonate with the mission or (b) VA is not profit-driven as it were, so some people have left XXXX and come to us because that drive for the almighty dollar is different here. Yes, we have productivity standards, but that concept of the more surgeries you do, the more money you get is a little bit – it's not the same, you know what I mean? [F-021]

> I meet them once a week during journal club just so we are sure to update them on where we are at, what, if anything's in the pipeline, how many interviews have been done so they know that the administration is just not saying okay…they don't think administration is just saying, yeah, we are 50 percent or so providers shorted, so the rest of you get on with it. When they work we appreciate what you're doing. This is what administration is doing. We're very transparent so that they know where we're at and what constraints. Once we get providers that accept we let them know, too, and then the same backpedaling because they can't get any accommodations. You know what I mean? So we let them know that, too. So that way they're in the know and once they know that we're continuously trying they—so far at least—they've been very understanding. And they've really got together and rallied together to help to assist. [F-115]

As described above, respondents indicated that their facilities used a variety of methods to maintain and increase FTE. Contract arrangements were common, with all facilities (100 percent) reporting that they used contract providers in-house, or that they contracted out certain complex or specialized procedures to affiliate facilities. Among the provider positions filled by contractors were difficult-to-recruit specialties (e.g., stroke neurology) or critical specialties (e.g., emergency department providers, hospitalists). Among the procedures that were mentioned as contracted out were mammography, complex surgeries, labor and delivery, and bariatric treatments.

> We've done other creative avenues to increase access. We're currently a standard level complexity facility and we've contracted with our local community hospital to use their OR, for our general surgeons to do intermediate complexity surgery in their facility, so we do creative things and we definitely use contracts. We use fee for service on a

> regular basis and we do contract for our, like I had said before, for our overnight hospitalists. [F-002]
>
> We're in an active partnership that's close to being consummated with a DOD facility that in many ways is a mirror image of us. They have multiple specialty physicians who are relatively underutilized because of a relatively healthy population and a medical facility that's relatively underutilized. And so we're in the final stages of completing a sharing agreement that will allow us to refer patients there, as well as even put some VA care teams in that site to take care of VA patients. That's one that we are utilizing. [F-083]
>
> As for sending care out, we would normally do that for things that we could not take care of and it wouldn't be necessarily something that comes up all the time like mammography. [F-041]

Among the reasons cited to use contracts were that they were often cost-effective solutions to access problems, they could quickly begin filling staffing holes more quickly than new-hires, and they improve access, particularly in rural areas.

> We use contracts, we use fee basis, we even use intermittent staff, depending on the gaps that we actually have is how we choose to do that and when we're looking or a contract, a make buy analysis is really going to have to be completed and we definitely do that, say, for mammography. We've decided here that it is better for our patients' continuity of care as well as from a financial perspective to send that care to one of our affiliates here at University of XXXX. [F-041]
>
> So the one contract I have was one FTE, is now a .5. I said I was willing to do it if it was cost neutral. So that's a cost neutral contract. It would have been the same if I was paying a .5 stroke neurologist and just had one. [F-043]
>
> We've been very successful with locus tenens because we stay in really close contact with the folks. It tends to be more paperwork that slows it down, waiting for signatures, but from the national office perspective, the office that runs this, we've had a very good relationship… They're already pre-credentialed, they already have everything ready to go and we get our paperwork, and once it gets out of our own site, they tend to move very quickly the locus tenens procedure. We're very pleased at the support we get there. [F-032]
>
> It's actually a contract that we've done with the community hospital… what it allows us to do is, like I said, our facility is a standard complexity and so we can do our intermediate complexity level procedures at that facility, which is beneficial. It gives our surgeons the ability to keep up on some of those skills and it gives access to our patients who otherwise would have to drive at least 250 miles or be transported to another VA. That's how far they would have to go and so it's been a very positive thing that we've done, and we have a good relationship with the local community hospital. [F-002]

On the other hand, two facilities (33 percent) indicated that they did not use contract providers, and many used fee-based or intermittent providers (five facilities; 83 percent). Reasons cited for using fee-based providers were often presented in contrast to using contract providers, including relative time to begin work, relative cost, relative administrative burden, and provider accountability. Provider

productivity among fee-based providers was also seen as a benefit. Much like contract providers, fee-based providers were often used to fill vacancies in difficult to hire, or rarely utilized specialties.

> **Time to begin work:** Fee is much quicker. Contracts are difficult, often taking months to get through the contracting process. That's a theme that you've probably heard before, and which relates to a lot of the support services. One thing that you… And I guess with fee you can turn it on and off quickly, if needed. [F-083]

Relative cost:

> We have quite a few of those, particularly in surgery because we can pay them higher and they're intermittent, and it doesn't make sense to hire a full time person. [F-023]
>
> The provider can get paid more than if they were part-time and it makes more sense for intermittent roles. And if I'm going to have 400… well, we can't pay 400. We can pay 380,000 is our top salary. If I have some surgeon that's worth 380, but they're only doing 1 surgery a month, I think I probably want to hire him or her intermittently, fee-basis employed, and have them come from XXXX and do the one-a-month surgery here. [F-023]
>
> It's also usually more expensive to do a contract. So the one contract I have was one FTE, is now a .5. [F-043]

Productivity:

> Fee is more of a productivity model. So folks tend to be productive if they're working in a fee arrangement versus a salaried arrangement. [F-083]

Accountability:

> There's a lot of issues with contracts in that they require monitoring very closely to make sure you get your money's worth. If they're sole source with your affiliate, they get another level of scrutiny. And affiliate is now getting more and more reluctant to enter into these contractual relationships because of that. [F-023]
>
> Even though you can put items in a contract that you hold people accountable to, they're not as accountable as people who actually work for you and are long term and are devoted to XXXX and its veterans. [F-043]

Respondents also described a few reasons why patients may be sent out into the community for care. Five facilities (83 percent) indicated that they used community-based care to some degree. Reasons for outsourcing care included issues with patient access due to geography, insufficient capacity, or the need for complex procedures. However, the preference of facilities was largely to keep patients in house, or at lease within the VA system.

Geography:

> And another issue is if they don't live within a reasonable drive to the VA, that it's very, very hard for somebody to come to a physical therapist that is not by their home. So we will send a lot of that care out to the community because if they have to come here every day or every other day for physical therapy—that's onerous. [F-041]

> Well, CBOCs don't have large physical therapy activity areas, so when we look at backlogs in PM&R, and physical therapy particularly, we have to really balance bringing a patient all the way in from a long distance into the VA Medical Center, where physical therapy is available versus putting them out into the community like my Veterans Choice or a non-VA care facility, so that is one where we have a very large amount of work trying to balance success. [F-032]

Capacity constraints:

> Those patients, when we can't accommodate them, they do get diverted, they do go to the local facilities. We luckily have a good constructive relationship with both local facilities but the patients aren't happy because if they get diverted without preapproval, they carry more of a financial burden, depending on their level of service connectedness. And I have no control over that. That is Congress, that is legislated, how those patients are handled. [F-004]

Complexity:

> I mean, there's certain surgeries that we don't perform so they go to the community. And, other than that, PET scans we send to one of our network facilities. [F-061]

Preference for network over community:

> I think there's some cases where we couldn't hire somebody and say XXXX could so we used them… So we look to the network as a resource first. And if it's something that we can't resolve within our sister facilities then that's when we go out into the community. [F-061]

Productivity

The qualitative interview also explored provider productivity issues and their causes. The most common issues affecting provider productivity related to different kinds of staffing shortages. Shortages related to clerical or administrative staff and clinical support staff were each cited by respondents at four facilities (67 percent).

> And so in many of those areas you'll have a doc that's working without an assigned nurse, with a rotating clerk who may or may not be very familiar with how to be scheduling patients in that area. And it may be a different person the next week. There's clinics where the docs have to be the ones to go out to the waiting room to find the patients to bring them back to check their vital signs, etcetera. And it's not that they can't do it or that it's work that's beneath them to do, that's not the point. It's just that's not an efficient way to be able to utilize very expensive staff and it keeps them from being able to see the volume of patients that they could see. [F-083]

> The problem is not having people to organize it, people like the schedulers, and the intake staff and that kind of thing [F-150]

> We have almost no administrative support…none. So all those people I mentioned to you, in excess of 50 clinical staff, we have one GS5 secretary. [F-150]

> We have all these appointments that we have with thousands and thousands of tests and procedures. We have no scheduler up here. The clinical staff is doing scheduling, calling the patients, licking the envelopes with the appointment letters. [F-150]

> And then you need a clerk obviously for scheduling, and you need the medical assistant, the LVN, to help you with the flow of your patients. So all those things have to be present to be productive and if you have disruption in your team, it just makes you a lot less productive. [F-023]

Respondents at four facilities (67 percent) also discussed how the lack of clerical and clinical support staff means that providers are spending their time on these activities rather than direct patient care.

> Well, the major barriers to doing anything, as I mentioned, is that it's hard to make providers productive if they're not working at the top of their license. So somebody like me, which I think in a way, it's pretty funny. I spend enormous amounts of time doing—I don't have enough clerical help. So I do a lot of clerical work. I mean, I'm a very highly paid clerk but I mean, do they want me doing that? And same with providers. They spend far too much time doing what is done in an office, in the private sector, by clerks or by somebody else. [F-023]

Respondents at four facilities (67 percent) cited infrastructure issues such as lack of exam and operating room space that negatively affected a provider's efficiency.

> But we don't have enough rooms. If you really want to see patients efficiently, you have two rooms for the physician so that you can move patients in and out more easily. [F-164]

> Surgery, we're impacted by the number of OR rooms that are available and have to schedule around there, which sometimes can be challenging when you've got five specialties that all want to operate on the same day and we don't have rooms available. [F-061]

Respondents at all facilities (100 percent) noted issues related to information technology that negatively impact provider productivity. For example, facility administrators indicated that providers spend a lot of time navigating the complex electronic record system. Also, some respondents discussed how there were assumptions that telehealth visits were more efficient and would increase productivity, but in practice these patient encounters take the same amount of time as face-to-face visits.

> What I hear from a lot of the individual docs, is that a lot of their time is spent on view alerts and other…many of which are not really relevant or necessary in the process of taking care of a patient, or on completing various paperwork electronically that, for one reason or the other in the VA system it's not allowed for someone else to do that work.to complete. [F-083]

> But the bottom line is in primary care, each patient generates gazillions of alerts that go onto your computer that you have to respond to in some way, shape or form. It's a terrible provider burnout problem and it's something we have to work on. [F-023]

> When I look into that and "why is that, what is it that we're seeing, why is it we're not bringing more patients in, what is this, why does it take 30 minutes for one of these appointments," and a lot of it I'm being told it's the complexities of the CPRS tool and managing and getting through it today. It's also the mandates from all the various

> program offices that it can take you up to 12 minutes to just get through all of the health factor screenings and all the different questions to get through that; [F-081]
>
> And I don't think it's been clearly recognized that it takes at least as much time to do a Tele visit as it does to do an in person visit. [F-083]
>
> Let's say I order a lab work or an X-ray on a person or a consult or whatnot. From the day I do it, anything else that happen to that thing, I get a view alert on it. That's why the five day doesn't really concern me… I get that all the time. What has been driving them nuts. It's on CPRS. View alert on CPRS, so if nationally you guys can help work on actually improving that so that what is succinctly needed by the provider is what comes to the provider; ah, absolutely the providers would love you. But's the main thing they find they're having to work hard on. [F-115]

According to respondents at two facilities (33 percent), issues related to the Choice Act produce inefficiencies that impact staff and provider productivity.

> So right now we are wasting so much of our time because we schedule a patient, then we have to put them on the Veterans Choice list, then if the veteran decides to call, they can call, but our staff has to upload all of the medical records and then they may or may not call in. If they call in and they find out on the outside that it's way longer, then we've done a lot of the work that we don't really have the staffing for and it's just wasted work here. [F-041]

Respondents at all facilities identified other factors that negatively impact provider productivity, including the complexity of the patients, and the teaching responsibilities that come with academic resident training programs.

> So, one is that the patients that we work with have a very high level of need. They've got usually multiple problems, medical as well as psychiatric. [F-182]
>
> So residents also slow everything up, but we have to supervise them. So that's another limitation of productivity, but if we get rid of the residents to improve our productivity, then you don't really have a VA. [F-023]
>
> So those that run residency programs will have less time in clinic. And then there's those that have administrative time, like a department chair or myself, who have administrative time to actually carry out the business of delivering healthcare. If you cut all that out, there will be nobody to make decisions because we'll be busy all seeing patients. So that does effect productivity in terms of seeing patients. [F-023]
>
> To maintain those appointments, you have to do some academic. So we give them an extra four hours a week in primary care, the ones that have academic appointments. We give everybody four hours a week to do their catch-up and their education, and we give them an extra four hours to have some sort of a chance at an academic career. So that cuts down on productivity right there in terms of seeing patients. [F-023]

Respondents at four facilities (67 percent) described issues with the culture of the VA, including the regulations and restrictions employees must operate under.

> But in addition, a lot of them like to maintain control, so they may want to be scheduling their own appointments instead of sending it out to the clerk to do that, or…I get it as a

> control issue.
> [F-041]
>
> And often in the VA with a unionized workforce, with very specific prescribed job duties and position descriptions, it's much more of a "no, that's not my job" or "no, you're not my boss" or whether it's said overtly or not, there's that whole sense that we're working together to get, together as a team, get the patients seen that need to be seen. That kind of a team based esprit is often not present and really contributes to a lot of physician frustration that have come from the private sector. [F-083]
>
> And it's also I guess part of the sense of, can we trust clinical people or do the clinical people have to be regulated and managed in the sense that, we will give you this and only this, and we're going to expect you to achieve with only what resources we give you. And it's almost like on the administrative side we don't trust that the clinical folks will do the right thing. And again, that seems like an engrained institutional impediment to success. [F-083]
>
> So there's a lot of concern that we're cluttering up everything to the point that a provider can't work anymore because there's just too many things that you have to address regarding one patient, much of which has nothing to do with their health. [F-023]
>
> They've seen a set number of patients or had a way of working that was very flexible, possibly, for them for lack of a better term, and so there's kind of a cultural shift that has to take place in order to get everyone to try to get the same level of productivity from each, struggling with some providers want 45 minutes for their patient per appointment and where others are okay with a 30-minute or shorter or longer, you know, so those are some of the things that we do struggle with and that we are working on, and I think it's just a different way of thinking, a different way of doing that and it's a challenge for those providers to not feel micromanaged and certainly leads to some dissatisfaction as we move forward in this area. [F-002]
>
> It's also an issue, too, with new consults coming in, having the time to review those consults and make a recommendation for whether they should be scheduled in that specialty or whether that's something that can be done as an e-consult or another form. So working through that, but that takes time, too, so it requires the physicians to do that. [F-041]
>
> But the contrast to that is there's some patients that tend to just walk in—I'm sure you must have heard about the walk in issues with the VA—where if they call, they phone in and nobody's answering them—they just walk in and once this habit get developed that they know that once they walk in they'll get seen, they'll keep doing the walk in instead of actually keeping their own appointment. [F-115]

Respondents at all six facilities (100 percent) described specific efforts undertaken to improve provider productivity, including checking the accuracy of the labor mapping, forming a scheduling committee to review scheduling procedures across the facility, creating group clinics for conditions such as Hepatitis C, utilizing hospitalists so that primary care providers do not have to provide inpatient care, developing consistent care teams, holding phone clinics, improving access to same-day lab work in rural areas, providing training to patients and schedulers to reduce no-shows and walk-ins, and developing clear productivity expectations and monitoring them over time.

> We used to—talking about supply and demand—one of our access issues had to do with the fact that primary care providers were providing inpatient care and when that happened, they'd have to cancel their clinic. So now that we have hospital based individuals doing it, we opened up more slots in primary care. [F-043]
>
> That's part of what we're doing with the VACCA and the ACI funding, is going back and really trying to put in place teams of docs and support staff that can get used to working together and can be more efficient together. [F-083]
>
> But what we do here is I was the first mental health provider to get a phone clinic, which to me is very, very helpful. My panel is big enough that there's no way I can get people back in the time frame that I would think they need to have some kind of a touch base appointment in to check, say, if I change the medication; sometime in the next two or three weeks there ought to be some kind of a contact made, and there's simply no way that I can bring people back in two to three weeks for an office visit. And no reason to, for the most part. So it turns into a phone clinic visit. [F-106]
>
> We've made an improvement in that before some of the CBOCs don't have the capability to do lab for those kind of patient that same day, and when we…made sure that the labs can be done any time when that clinic is open now. [F-115]
>
> We've educated the providers, the staff, chiefly, that any of those patients like that that show up even though when we're trying to book them for the appointment ask how long and try not to put those kind of patients for morning appointment, it is going to take them a long time to get to you. We can use the afternoon slots. So to reorganize. But sometimes these things fall through the crack and we've educated staff that when patients show up it is not for you to turn them away. They need to be seen. They may have to wait slightly longer because somebody is in the slot because they didn't show up on time. At least they still get seen. But the contrast to that is there's some patients that tend to just walk in—I'm sure you must have heard about the walk in issues with the VA—where if they call, they phone in and nobody's answering them—they just walk in and once this habit get developed that they know that once they walk in they'll get seen, they'll keep doing the walk in instead of actually keeping their own appointment. So we're trying to tackle both ways to reeducating patients to use their clinic appointment times and reeducating staff that look, patients. [F-115]
>
> When we run into particular productivity issues, service chiefs set up what they call provider agreements when they bring a provider on board and it describes exactly how many patients the provider is expected to see, how much administration time they get, how many slots they will have per day, and then the clinical services have an administrative officer in each of their services, along with the business council that's monitoring it, that follows up with the providers and gives the service chiefs a heads-up when it looks like productivity has changed or the provider is out too much time. [F-032]

Administrators at three (50 percent) of the six VAMC's described how the physician productivity cube was used to look at labor mapping and scheduling grids.

> You basically compare the labor mapping to the grids that they have and see whether they're appropriate. And by grids, I'm being a little bit more technical, but when you go into the scheduling package, each clinic and provider will have a grid of the

> appointments that they have and just being able to look in that and see that that is accurate and that matches what the labor mapping is. [F-041]
>
> We went through and looked at them and reviewed all their clinics and all their scheduling practices. Going forward it's something that the chief of staff works with the physician executive groups. They have weekly meetings and it's a standing agenda item that they discuss. [F-061]
>
> …that whole provider productivity cube was developed for departments, but interestingly enough, as I knew it would, headquarters is using that to monitor individual provider productivity. So it's a tool that everybody uses across VA and we use it extensively here. What we're finding is that there are far too many people that are doing administrative work that probably should be doing more clinical work. So we have been slowly but surely relentlessly cracking down on that. [F-023]

Respondents at all facilities (100 percent) described other processes used to assess and measure staff productivity, including routine monitoring of RVUs and other measures by committees or teams, using the OAA and SPARQ tools, and developing other measures of productivity.

> And using Medicare work RVUs has finally provided something that the majority of the physicians understand and accept as a way to provide comparability between and among facilities within the same specialty. But even with that as a productivity metric we find that not uncommonly a productivity metric in the private setting is higher than what it is, or at least what the mean is in the VA, and likely related to some of those things that I mentioned earlier, as well as some of the care that's provided and expectations are more intensive than in other settings. [F-083]
>
> Well, there actually are some guidelines that come from OAA and other sources. So we looked at those but then we made some modifications based on we saw our needs are. [F-043]
>
> So we're working on trying to figure out how to measure productivity differently, not just by the number of encounters, but by the patients' level of satisfaction and their improvement in their functioning and moving out of care, rather than just staying stagnant in it. And again, this is a thing that doesn't reflect well when you just look at the numbers. The patient satisfaction and their functional improvements as individuals really matters a lot when you look at "productivity". [F-195]
>
> Knowledge management was set up to constantly monitor all the reports, workload, help us run reports to dig down deeper into particular clinics that seemed to be struggling on access or having problems with longer backlogs, so at the business council we have presentations by groups who have been set up to look at specific areas. We look at productivity, we look at RVUs for clinicians, we monitor panel sizes for providers and every month they have to report back on where they find gaps, why the gaps are happening, what their stop-gap solutions are. Knowledge management is constantly providing senior executives with reports to help us balance the staffing, etc. [F-032]

As noted above, respondents at four facilities (67 percent) described a number of issues with assessing productivity related to labor mapping.

> We need to make sure that the chief of staff is watching the physicians and that they are actually having their schedules built on what time they should actually be doing that, so

> there can be a lot of variability in that with inpatient consults and whatnot, but we have to make sure that their outpatient clinics are built to really show their real capacity. So that would be an ongoing issue, just making sure that again, that their clinics and their capacity measure truly what their real capacity is. [F-041]
>
> We're also doing a lot of labor mapping and we're finding that our labor mapping is not accurate and that some people have been credit for doing things that they really shouldn't get credit for doing in terms of admin time, education time and so forth. [F-043]
>
> I'll find that that person who I wanted mapped 90 percent to patient care is only mapped 60 percent to patient care because the doctor themselves told the DSS (Decision support systems) person that it takes them a long time to write their notes. [F-004]
>
> Right now I think it's the group practice manager is what will be installed at all of our facilities, but in the private sector people who are group practice managers are paid a heck of a lot more than they're going to get paid in VA, so the current plan is for VA to train these people and then put them in place at each setting. Well, I'm slightly skeptical that we're going to come up with a position description that will adequately pay people to do what we want them to do, and that's absolutely necessary if we're going to be successful, so having, again, knowledgeable, skilled people across the board who are looking at productivity for each provider, for each team, who have the capacity for making adjustments so that resources move to where the patients are would also help so that we don't get into the situation in which we currently find ourselves. [F-063]
>
> Well, we measure the number of nontraditional encounters. We measure of the number of secure messaging, folks that are utilization secure messaging. But there isn't a link between those and access. So by using those the providers are really not getting any credit for their access. So they're just picking up another modality. And many of them have said, "It's a lot more difficult to see my patient, try to answer all my text messages in-between, answer all my phone calls in-between and continue to see the same number of patients. So we really haven't helped and that's part of that provider dissatisfaction. Again, we're worried about the numbers, not worried about the care we're actually delivering and that's what we need. [F-094]

Other capacity constraints

Respondents noted other issues that put a strain on their facilities, outside of or broader than workforce numbers and productivity. The most often-mentioned barrier to providing patients access to timely care was the large, and growing, patient population for most facilities, especially in specialties such as physical therapy, orthopedics, and mental health, without commensurate increases in facility budgets to care for these patients. (Representatives of five facilities [83 percent] described this challenge.)

> It is not asking for sufficient resources to meet the increasing number of veterans coming to VA, particularly with the increased eligibility; that is to say veterans of OIF and OEF all had automatic five-year full eligibility for all care and they had, I think it's a year for dental care, so that really increases the volume significantly. It's amazing… so with a lot of folks leaving service or having been activated in the Guard or Reserves, their

> eligibility for VA, which was full and unrestricted for an extended amount of time, that represented a large volume of increased users and whatever budget increases came really didn't adequately match their demand for services. [F-063]
>
> I'd say we're not replacing physicians who leave patient care at the rate at which we need them, considering the demand has increased, both within VA and nationally with the Affordable Care Act, so that's a challenge that we will have, as we have seen with mental health. [F-063]
>
> And the specialty care…oh, and I guess in mental health as well, there's been this push to hire into mental health because of the various initiatives that have been going on. And even though our facility still is pretty significantly behind getting all of those hired, some of which is just due to the enormous scope of the patient base that we have, but specialty care has really suffered. [F-083]
>
> And we do a lot of hip and knee replacements, shoulder surgeries, and that need is very high and so I'm ramping up anesthesia and ramping up orthopedics. [F-004]

Representatives from five facilities (83 percent) also described assorted other capacity constraints, which include issues with Choice Act-imposed access requirements (including wait time benchmarks and service provision requirements), geography-based barriers, issues resulting from telehealth and other IT-initiative implementation, VA regulations that impede facilities from taking on intermittent and contract providers, and implications of the Affordable Care Act.

Wait times*:*

> So we haven't had a huge problem such as other medical centers here, but again, if you look at the 30 day time limit to be placed on the Veterans Choice Act, that's a little stringent, and if you look out in the private sector, you're not going to have wait times that are even close to that, regardless. So my input would be is that really reasonable and should we really be going for that level of access? [F-041]
>
> I think the way VA defines it is you have to be able to see any new or follow-up mental health patient within 30 days. But the way we're measured by CNN—you may have noticed lately—is that we have to provide behavioral cognitive therapy to everybody within 30 days and that's just not possible [F-023]

Service provision requirements:

> I think the mental health requirement is that we have a provider or mental health access at all of our locations, and that's problematic. That means that I have to, in a very small clinic like XXXX, I have to have some sort of mental health presence. You can do it by Telemedicine, which we are trying to do, having stations in the clinic or taking care of mental health patients at home via computer. That's our so-called Telemedicine mental health programs. But we also have people driving to get to these more remote locations. [F-023]
>
> Mental health has many therapies that are incorporated as part of mental health, including behavioral cognitive therapy, individual psychotherapy and other mental health modalities that you are never going to have enough staff to do. If everybody wanted individual psychotherapy, can you imagine? I'd have 23,000 mental health

patients here. Imagine, I'd have to have how many psychiatrists? You can probably see, what, 10, 12 of these patients. You'd have a tough time seeing all these patients if they all required individual psychotherapy. [F-023]

Physical therapy, PM&R [physical medicine and rehabilitation], there was a point where we have a really fine balance in trying to provide access and enough staff because one of the things you'll find out about physical therapy is it could be unlimited demand. People would like to go to physical therapy the rest of their lives. They would love to have chiropractic constantly, two, three times a week, and so VA has had to say, you know, we're going to look at every episode of care and design a treatment plan and say this is not necessary or appropriate and then cut that off because it would just be constantly growing and growing and growing. [F-032]

Geography-based barriers:

And another issue is if they don't live within a reasonable drive to the VA, that it's very, very hard for somebody to come to a physical therapist that is not by their home. So we will send a lot of that care out to the community because if they have to come here every day or every other day for physical therapy—that's onerous. [F-041]

Telehealth and IT:

Say, for example, I have a primary care doc, maybe a family practitioner who has a face to face clinic and a telehealth clinic. And that person, then their face to face clinic is divided into two sections: new patients and established patients. And when within the established patients there's some that are put in a walk-in clinic versus a scheduled clinic. So here you're already down to—you're at four stop codes per one provider, then you add in that person has telehealth and the telehealth is divided into new patients and established patients, so now you're up to six stop codes. And then I have one doc who also does employee health so that goes into another stop code. So here you got one doc with seven stop codes and he just wants to look at his schedule for the week. [F-004]

However, in rural health when you have remote sites where you cannot get specialties out there, then obvious. [F-024]

It is beneficial financially because you've got to move the patient or you've to get a provider out there. So when you're dealing with your rural areas, yes, there is a benefit. If you're dealing with areas within commute distance, not so much. But it does help, I think, financially for—support rural areas. [F-024]

VA regulations:

Manpower is very easier to get [in the private sector] at as compared to the VA where you have to go with the people that you only have contracts. Sometimes it's a very small locum tenens company that do not have widespread; their catchment is very small so we've utilized that. And we haven't been able to build as quickly as we really would like. And of all the positions that we have now, we have one locum that took maybe about four months to get here. But is already here. He got here last week so we're working on it. Because I affect physician if I get all these national locum companies that send me e-mails almost every day. That if I want to go and work here, let me work there. So the VA

can at least improve it so that they don't just have the contract with one or two small, you know…broaden it. Maybe you give the contract to five people so that if I need—especially in these extremely rural areas—if we need, we can send to all the five companies instead of sending to one. [F-115]

ACA:

We don't have enough providers within the country while other things are going on outside VA, like the Affordable Care Act, that is making care more readily available to people to whom it has not been available before. [F-063]

Table E-2. Workforce and human resources domain: code count by facility-level interview

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.1 Prov_shortage	1 Yes_PC	2 Yes_Specialty	3 Yes_Inpatient	4 No_PC	5 No_Specialty	6 No_inpatient	7 No_General	B2.2 Prov_shortage_reason	1 Natl_shortage	2 Salary	3 Geographic	4 Insuff_funds	5Insuff space to add	B2.3 Assessing_capacity
F-002	VAMC	Leadership	F1	small-med metro	small	less complex															
F-004	VAMC	Leadership	F1	small-med metro	small	less complex															
F-005	VAMC	Leadership	F1	small-med metro	small	less complex															
F-021	VAMC	Leadership	F2	large metro	large	complex															
F-023	VAMC	Leadership	F2	large metro	large	complex	1		1		1										
F-024	VAMC	Leadership	F2	large metro	large	complex															
F-029	CBOC	Clinical staff	C2	large metro	large	complex															
F-032	VAMC	Leadership	F2	large metro	large	complex		1													
F-041	VAMC	Leadership	F3	large metro	medium	complex															
F-043	VAMC	Leadership	F3	large metro	medium	complex		1	1						1		1	1			
F-044	VAMC	Leadership	F3	large metro	medium	complex			1			1			1					1	
F-050	CBOC	Leadership	C3	large metro	medium	complex			1						1		1				1
F-052	VISN	Leadership	V4						1						1		1		1		
F-054	VISN	Leadership	V4				1		1	1											1
F-060	VAMC	Leadership	F4	small-med metro	medium	complex	1		1												
F-061	VAMC	Leadership	F4	small-med metro	medium	complex	1		1												
F-062	VAMC	Leadership	F4	small-med metro	medium	complex	1		1						1				1	1	1
F-063	VAMC	Leadership	F4	small-med metro	medium	complex	1	1				1									
F-064	VAMC	Leadership	F4	small-med metro	medium	complex	1					1									
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex															
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex															
F-070	CBOC	Leadership	C4	small-med metro	medium	complex															

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.1 Prov_shortage	1 Yes_PC	2 Yes_Specialty	3 Yes_Inpatient	4 No_PC	5 No_Specialty	6 No_inpatient	7 No_General	B2.2 Prov_shortage_reason	1 Natl_shortage	2 Salary	3 Geographic	4 Insuff_funds	5Insuff space to add	B2.3 Assessing_capacity
F-073	VISN	Leadership	V1				1	1	1						1			1		1	1
F-074	VISN	Leadership	V1																		
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex	1				1										
F-081	VAMC	Leadership	F5	small-med metro	large	complex															
F-083	VAMC	Leadership	F5	small-med metro	large	complex															
F-084	VAMC	Leadership	F5	small-med metro	large	complex															
F-094	VISN	Leadership	V3																		
F-100	VAMC	Leadership	F6	rural	small	less complex															
F-102	VAMC	Leadership	F6	rural	small	less complex	1	1	1						1		1		1	1	1
F-104	VAMC	Leadership	F6	rural	small	less complex	1	1	1	1					1	1	1		1	1	1
F-106	VAMC	Clinical staff	F6	rural	small	less complex															
F-113	VISN	Leadership	V6																		
F-115	VAMC	Leadership	F6	rural	small	less complex															
F-122	VISN	Leadership	V5																		
F-141	VISN	Leadership	V2						1												
F-142	VISN	Leadership	V2																		
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex															
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex	1	1	1						1	1	1	1	1	1	1
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex															
F-164	VAMC	Clinical staff	F2	large metro	large	complex	1	1	1		1				1		1	1			1
F-171	VAMC	Clinical staff	F2	large metro	large	complex															
F-182	VAMC	Clinical staff	F3	large metro	medium	complex															
F-184	VAMC	Clinical staff	F3	large metro	medium	complex															

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.1 Prov_shortage	1 Yes_PC	2 Yes_Specialty	3 Yes_Inpatient	4 No_PC	5 No_Specialty	6 No_inpatient	7 No_General	B2.2 Prov_shortage_reason	1 Natl_shortage	2 Salary	3 Geographic	4 Insuff_funds	5Insuff space to add	B2.3 Assessing_capacity
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex															
F-217	VAMC	Clinical staff	F2	large metro	large	complex															
F-248	CBOC	Clinical staff	C2	large metro	large	complex	1		1		1				1				1		1
F-250	CBOC	Leadership	C2	large metro	large	complex	1		1		1	1		1	1			1			1
F-251	CBOC	Clinical staff	C2	large metro	large	complex	1		1		1				1		1	1		1	1
F-255	CBOC	Clinical staff	C2	large metro	large	complex		1													
F-256	CBOC	Leadership	C2	large metro	large	complex															
F-257	CBOC	Clinical staff	C2	large metro	large	complex	1	1	1			1			1	1		1			1
F-304	VAMC	Clinical staff	F2	large metro	large	complex	1		1		1				1		1	1			1
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex															
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex	1		1	1		1			1		1	1			1
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1		1	1	1				1	1		1		1	1

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.3 Assessing_capacity	1 Staff_needs_bench	2 Staff_change_bench	3 PPC_how	4 Process_oth	5 Prod_assess_issues	6_Staffing_assess_issues	B2.4 Prov_staffing	1 Hiring	1 Hire_no	2 Hire_yes	3 Hiring_reas	4 Hire_Yes_decisions_who	5 Hiring_chall	6 Recruit_strat	1 Staff_needs_bench
F-002	VAMC	Leadership	F1	small-med metro	small	less complex																
F-004	VAMC	Leadership	F1	small-med metro	small	less complex																
F-005	VAMC	Leadership	F1	small-med metro	small	less complex																
F-021	VAMC	Leadership	F2	large metro	large	complex																
F-023	VAMC	Leadership	F2	large metro	large	complex								1	1		1			1	1	1
F-024	VAMC	Leadership	F2	large metro	large	complex																
F-029	CBOC	Clinical staff	C2	large metro	large	complex																
F-032	VAMC	Leadership	F2	large metro	large	complex														1		
F-041	VAMC	Leadership	F3	large metro	medium	complex																
F-043	VAMC	Leadership	F3	large metro	medium	complex														1	1	
F-044	VAMC	Leadership	F3	large metro	medium	complex																
F-050	CBOC	Leadership	C3	large metro	medium	complex	1				1									1		
F-052	VISN	Leadership	V4																			
F-054	VISN	Leadership	V4				1						1							1	1	
F-060	VAMC	Leadership	F4	small-med metro	medium	complex																
F-061	VAMC	Leadership	F4	small-med metro	medium	complex								1								1
F-062	VAMC	Leadership	F4	small-med metro	medium	complex	1				1											
F-063	VAMC	Leadership	F4	small-med metro	medium	complex								1						1		1
F-064	VAMC	Leadership	F4	small-med metro	medium	complex								1						1		
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex																
F-070	CBOC	Leadership	C4	small-med metro	medium	complex																
F-073	VISN	Leadership	V1				1	1			1			1	1		1	1		1	1	1

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.3 Assessing_capacity	1 Staff_needs_bench	2 Staff_change_bench	3 PPC_how	4 Process_oth	5 Prod_assess_issues	6_Staffing_assess_issues	B2.4 Prov_staffing	1 Hiring	1 Hire_no	2 Hire_yes	3 Hiring_reas	4 Hire_Yes_decisions_who	5 Hiring_chall	6 Recruit_strat	1 Staff_needs_bench
F-074	VISN	Leadership	V1																			
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-081	VAMC	Leadership	F5	small-med metro	large	complex																
F-083	VAMC	Leadership	F5	small-med metro	large	complex																
F-084	VAMC	Leadership	F5	small-med metro	large	complex																
F-094	VISN	Leadership	V3																			
F-100	VAMC	Leadership	F6	rural	small	less complex																
F-102	VAMC	Leadership	F6	rural	small	less complex			1		1			1	1		1	1		1	1	1
F-104	VAMC	Leadership	F6	rural	small	less complex		1						1	1		1			1		1
F-106	VAMC	Clinical staff	F6	rural	small	less complex	1															
F-113	VISN	Leadership	V6																			
F-115	VAMC	Leadership	F6	rural	small	less complex	1															
F-122	VISN	Leadership	V5																			
F-141	VISN	Leadership	V2														1					
F-142	VISN	Leadership	V2				1															
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex																
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex						1	1	1	1		1			1	1	1
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex																
F-164	VAMC	Clinical staff	F2	large metro	large	complex	1	1		1	1			1	1		1	1		1	1	1
F-171	VAMC	Clinical staff	F2	large metro	large	complex																
F-182	VAMC	Clinical staff	F3	large metro	medium	complex																
F-184	VAMC	Clinical staff	F3	large metro	medium	complex																
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex																

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.3 Assessing_capacity	1 Staff_needs_bench	2 Staff_change_bench	3 PPC_how	4 Process_oth	5 Prod_assess_issues	6_Staffing_assess_issues	B2.4 Prov_staffing	1 Hiring	1 Hire_no	2 Hire_yes	3 Hiring_reas	4 Hire_Yes_decisions_who	5 Hiring_chall	6 Recruit_strat	1 Staff_needs_bench
F-217	VAMC	Clinical staff	F2	large metro	large	complex																
F-248	CBOC	Clinical staff	C2	large metro	large	complex	1	1	1		1	1	1	1	1		1	1		1	1	
F-250	CBOC	Leadership	C2	large metro	large	complex	1		1	1	1	1		1	1		1	1	1	1		1
F-251	CBOC	Clinical staff	C2	large metro	large	complex	1	1			1	1	1	1	1					1	1	1
F-255	CBOC	Clinical staff	C2	large metro	large	complex						1					1			1		
F-256	CBOC	Leadership	C2	large metro	large	complex																
F-257	CBOC	Clinical staff	C2	large metro	large	complex	1	1	1	1			1	1	1		1			1		1
F-304	VAMC	Clinical staff	F2	large metro	large	complex	1	1				1		1	1		1				1	1
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex																
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex	1	1				1		1	1		1			1	1	1
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1	1			1			1	1		1			1	1	1

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	Retent_prob_No	Retent_prob_yes	Retent_strat	4 Retent_chall	Using outside providers/services	Contract	Contract_No	Contract_how	Contract_reas	Fee basis providers	Fee_Yes	Fee_No	Fee_reas	Comm_care_reas
F-002	VAMC	Leadership	F1	small-med metro	small	less complex														
F-004	VAMC	Leadership	F1	small-med metro	small	less complex														
F-005	VAMC	Leadership	F1	small-med metro	small	less complex														
F-021	VAMC	Leadership	F2	large metro	large	complex														
F-023	VAMC	Leadership	F2	large metro	large	complex		1												
F-024	VAMC	Leadership	F2	large metro	large	complex														
F-029	CBOC	Clinical staff	C2	large metro	large	complex														
F-032	VAMC	Leadership	F2	large metro	large	complex														
F-041	VAMC	Leadership	F3	large metro	medium	complex														
F-043	VAMC	Leadership	F3	large metro	medium	complex														
F-044	VAMC	Leadership	F3	large metro	medium	complex														
F-050	CBOC	Leadership	C3	large metro	medium	complex														
F-052	VISN	Leadership	V4																	
F-054	VISN	Leadership	V4																	
F-060	VAMC	Leadership	F4	small-med metro	medium	complex														
F-061	VAMC	Leadership	F4	small-med metro	medium	complex			1	1										
F-062	VAMC	Leadership	F4	small-med metro	medium	complex														
F-063	VAMC	Leadership	F4	small-med metro	medium	complex	1			1										
F-064	VAMC	Leadership	F4	small-med metro	medium	complex														
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex														
F-070	CBOC	Leadership	C4	small-med metro	medium	complex														
F-073	VISN	Leadership	V1						1		1	1		1						

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	Retent_prob_No	Retent_prob_yes	Retent_strat	4 Retent_chall	Using outside providers/services	Contract	Contract_No	Contract_how	Contract_reas	Fee basis providers	Fee_Yes	Fee_No	Fee_reas	Comm_care_reas
F-074	VISN	Leadership	V1																	
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-081	VAMC	Leadership	F5	small-med metro	large	complex														
F-083	VAMC	Leadership	F5	small-med metro	large	complex														
F-084	VAMC	Leadership	F5	small-med metro	large	complex														
F-094	VISN	Leadership	V3																	
F-100	VAMC	Leadership	F6	rural	small	less complex														
F-102	VAMC	Leadership	F6	rural	small	less complex		1	1	1	1	1	1	1	1	1	1		1	1
F-104	VAMC	Leadership	F6	rural	small	less complex				1	1	1		1	1	1	1		1	1
F-106	VAMC	Clinical staff	F6	rural	small	less complex														
F-113	VISN	Leadership	V6																	
F-115	VAMC	Leadership	F6	rural	small	less complex														
F-122	VISN	Leadership	V5																	
F-141	VISN	Leadership	V2																	
F-142	VISN	Leadership	V2																	
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex														
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex		1	1	1	1					1	1			
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex														
F-164	VAMC	Clinical staff	F2	large metro	large	complex			1		1	1		1	1	1	1		1	1
F-171	VAMC	Clinical staff	F2	large metro	large	complex														
F-182	VAMC	Clinical staff	F3	large metro	medium	complex														
F-184	VAMC	Clinical staff	F3	large metro	medium	complex														
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex														

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	Retent_prob_No	Retent_prob_yes	Retent_strat	4 Retent_chall	Using outside providers/services	Contract	Contract_No	Contract_how	Contract_reas	Fee basis providers	Fee_Yes	Fee_No	Fee_reas	Comm_care_reas
F-217	VAMC	Clinical staff	F2	large metro	large	complex														
F-248	CBOC	Clinical staff	C2	large metro	large	complex					1	1		1	1	1	1		1	
F-250	CBOC	Leadership	C2	large metro	large	complex		1	1	1	1	1		1	1	1	1			1
F-251	CBOC	Clinical staff	C2	large metro	large	complex		1		1	1	1			1	1	1		1	1
F-255	CBOC	Clinical staff	C2	large metro	large	complex														
F-256	CBOC	Leadership	C2	large metro	large	complex														
F-257	CBOC	Clinical staff	C2	large metro	large	complex		1		1	1	1	1			1	1		1	
F-304	VAMC	Clinical staff	F2	large metro	large	complex		1	1	1	1	1		1	1	1	1		1	
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex		1		1	1					1	1		1	1
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1		1		1	1		1	1	1	1			1

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.5 Prov_Productivity	Prod_Issues_No	Prod_reasons	Infrastructure_issues	Shortage_Clerical	Shortage_tech_clin_support_staff	Cultural_issues	IT_Challenges	Choice_Card_issues	Providers_clerical	Other_issues	Prod_Impr	B2.6 Capacity_Const_Oth	Large_pt_pop
F-002	VAMC	Leadership	F1	small-med metro	small	less complex														
F-004	VAMC	Leadership	F1	small-med metro	small	less complex														
F-005	VAMC	Leadership	F1	small-med metro	small	less complex														
F-021	VAMC	Leadership	F2	large metro	large	complex														
F-023	VAMC	Leadership	F2	large metro	large	complex	1		1		1									
F-024	VAMC	Leadership	F2	large metro	large	complex														
F-029	CBOC	Clinical staff	C2	large metro	large	complex														
F-032	VAMC	Leadership	F2	large metro	large	complex	1									1	1			
F-041	VAMC	Leadership	F3	large metro	medium	complex														
F-043	VAMC	Leadership	F3	large metro	medium	complex					1	1								
F-044	VAMC	Leadership	F3	large metro	medium	complex						1					1	1		
F-050	CBOC	Leadership	C3	large metro	medium	complex											1			
F-052	VISN	Leadership	V4									1								
F-054	VISN	Leadership	V4														1			
F-060	VAMC	Leadership	F4	small-med metro	medium	complex											1			
F-061	VAMC	Leadership	F4	small-med metro	medium	complex			1	1	1	1						1		
F-062	VAMC	Leadership	F4	small-med metro	medium	complex												1		
F-063	VAMC	Leadership	F4	small-med metro	medium	complex												1		
F-064	VAMC	Leadership	F4	small-med metro	medium	complex	1		1		1					1		1		
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex														
F-070	CBOC	Leadership	C4	small-med metro	medium	complex														

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.5 Prov_Productivity	Prod_Issues_No	Prod_reasons	Infrastructure_issues	Shortage_Clerical	Shortage_tech_clin_support_staff	Cultural_issues	IT_Challenges	Choice_Card_issues	Providers_clerical	Other_issues	Prod_Impr	B2.6 Capacity_Const_Oth	Large_pt_pop
F-073	VISN	Leadership	V1				1	1	1					1				1	1	
F-074	VISN	Leadership	V1	small-med metro	medium	complex	1	1	1								1	1		
F-076	VAMC	Clinical staff	F4	small-med metro	large	complex														
F-081	VAMC	Leadership	F5	small-med metro	large	complex														
F-083	VAMC	Leadership	F5	small-med metro	large	complex														
F-084	VAMC	Leadership	F5																	
F-094	VISN	Leadership	V3	rural	small	less complex														
F-100	VAMC	Leadership	F6	rural	small	less complex	1	1	1	1	1	1	1	1		1	1	1	1	1
F-102	VAMC	Leadership	F6	rural	small	less complex	1		1		1	1		1		1	1			
F-104	VAMC	Leadership	F6	rural	small	less complex														
F-106	VAMC	Clinical staff	F6																	
F-113	VISN	Leadership	V6	rural	small	less complex														
F-115	VAMC	Leadership	F6																	
F-122	VISN	Leadership	V5														1	1		
F-141	VISN	Leadership	V2																	
F-142	VISN	Leadership	V2	small-med metro	small	less complex														
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex	1		1					1				1	1	1
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex														
F-154	VAMC	Clinical staff	F1	large metro	large	complex	1	1	1	1								1	1	
F-164	VAMC	Clinical staff	F2	large metro	large	complex														
F-171	VAMC	Clinical staff	F2	large metro	medium	complex														

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B2.5 Prov_Productivity	Prod_Issues_No	Prod_reasons	Infrastructure_issues	Shortage_Clerical	Shortage_tech_clin_support_staff	Cultural_issues	IT_Challenges	Choice_Card_issues	Providers_clerical	Other_issues	Prod_Impr	B2.6 Capacity_Const_Oth	Large_pt_pop
F-182	VAMC	Clinical staff	F3	large metro	medium	complex														
F-184	VAMC	Clinical staff	F3	large metro	medium	complex														
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-217	VAMC	Clinical staff	F2	large metro	large	complex														
F-248	CBOC	Clinical staff	C2	large metro	large	complex	1	1	1	1	1	1					1	1	1	1
F-250	CBOC	Leadership	C2	large metro	large	complex	1	1	1		1	1	1	1	1	1	1	1	1	1
F-251	CBOC	Clinical staff	C2	large metro	large	complex	1		1			1					1	1	1	1
F-255	CBOC	Clinical staff	C2	large metro	large	complex				1		1								
F-256	CBOC	Leadership	C2	large metro	large	complex														
F-257	CBOC	Clinical staff	C2	large metro	large	complex	1		1	1	1	1	1	1	1	1	1	1	1	1
F-304	VAMC	Clinical staff	F2	large metro	large	complex	1		1								1	1		
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex														
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex	1		1			1	1	1		1	1		1	1
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1		1		1		1					1	1	

Source: Authors' analysis of interview data collected and coded for this project.

Appendix E.1.3 Physical Infrastructure Resources

In 27 qualitative interviews with VAMC leadership (Associate Directors and Associate Directors for Patient Care Services), VISN leadership (Chief Medical Officers), and VAMC and CBOC clinical staff (providers), interview respondents were asked about the physical infrastructure at their sites, which we defined as non-personnel resources that enabled patient care, such as medical equipment and supplies, diagnostic capabilities, exam rooms, and inpatient facilities. Most interview findings addressed the topics in the interview protocol, including medical equipment and supplies and space (e.g., adequacy of, lack of). Questions focused on challenges posed by infrastructure and strategies used by sites to address any infrastructure challenges, when they occurred. In addition, three interviews with VA experts touched on physical infrastructure topics so that information is also included in this summary. Table E-3 at the end of this section provides the code counts by facility-level interview for each physical infrastructure domain code.

Space

On the topic of adequacy of the physical plant, most respondents reported that lack of space was a challenge to optimal functioning. In addition to general comments about lack of space, respondents noted challenges particular to ED, inpatient, and outpatient care; challenges related to parking; costs and challenges of maintaining old and outdated infrastructure; and the relationship of space to staffing.

<u>General Lack of Space</u>

Respondents made general comments on the state of infrastructure at their facilities. Most respondents described lack of space as an annoyance or inconvenience more than an issue that affected patient access; they would enjoy more space or could imagine better configurations, but most did not consider infrastructure to be their site's most pressing problem. However, several respondents affirmed that they would be able to see more patients if they had more space.

> Yes, there are problems because of our lack of space. For instance [in one region], we've got a [huge] void, or gap, just in our physical infrastructure. We are in an old strip mall that has been cobbled together into this very non-efficient facility to enable us to get our patients seen. So that in itself provides hindrances to patient care. [F-081]

> The [challenges] I was talking about related to the space, we still get people in, in a timely manner. It would make things a lot easier for us if we had more exam rooms -- we could see more patients at the same time -- but [it's] nothing that's going to cause a harm in delaying their care. As I mentioned, if it's access issues, it's usually not related to the infrastructure. [F-061]

> Well, there has been a problem for space for the VA from the beginning. … Multiple services are working to provide [care]. Like cardiology was not at [our] VA before, but then in the last five or six years they have just come in because they want to provide [cardiology services here]. So we work very closely with other services, but it's a limitation. I have to go run around, "Could you please? Can I use this room? Can I do this?" So there has to be all this running around… Of course we need more space, better equipment, and more doctors so we can spread out more…. We will never compromise taking care of the patient, period. But again, it's stressful for us. [F-171]

The stress placed on facilities due to limited space was also described by a respondent who felt that his facility was already operating near capacity, and another who spoke to how demand for VA services within his geographic areas was growing faster than VA could obtain space.

> I think our access numbers are good. It's because we're managing it, alright? But to say can we really expand with one or two more staff folks maybe to provide different services at a higher degree, the answer is no, we're limited by space. We're shackled by limits of space. But for all the probably 80% to 90% of all the services that VA Central Office wants us to provide, we can certainly do that. But if they send another mandate out we're sunk. [F-154]

> We are having such a difficult time getting the space to improve that access. There are some opportunities that we can fine tune and tweak but in certain areas, especially here in our [region] …there are only so many things we can tweak and still not have enough room and access to do what we need to do, just because of the sheer increase in volume that we've had with folks relocating to our area. It really wasn't all just backlog. It's just new demand and not being able to increase the resources and the other things that go along with that. [F-094]

Some respondents described the physical infrastructure of their facilities as being good or excellent. Comments about to adequate or ample space were commonly made in tandem with discussing recent construction or renovation projects.

> Yeah, from what I see, we have everything [we need with regard to infrastructure]. We have the high-level technology and we had—oh, it's probably already ten years or even more, time flies—we had a new hospital built. The old space takes an incredibly long time to be renovated, so certainly there is still competition for space and for rooms, but that is, I would say, minor. Otherwise, from my standpoint, it's very good. [F-184]

> The clinic here is great. It's fairly new. It's fairly large, so we don't really have structural problems here, but the [other clinic I work at] is too small and they actually have been on 4/10 schedules there because they don't have enough rooms for the providers. Access is also a huge problem in [the other region]. They are understaffed. They need a bigger facility or another facility in order to improve access and to keep growing like they are growing. [F-029]

> Well, I think we could take on additional workers in our [newly opened specialty care facility] and not have to expand the physical space. We've got the physical availability which is what we're looking at now, is we're hiring more staff so that we can take on more patients. [F-062]

Space Issues in the Emergency Department, Inpatient, and Outpatient Settings

Providers were generally satisfied with ED facilities. Similar to statements about the challenges of old or outdated infrastructure, one respondent described how standards and expectations have changed for how an ED is organized, which has led to the need for additional space and modifications to existing facilities. Another respondent highlighted the relationship between ED capacity and capacity of and flow to the inpatient unit.

> I would say that in the Emergency Department where some would say that we may be delivering some primary care, emergency department care has changed, so, again,

> where you would go into an ER [years ago] where there were basically curtains in between every bed. You'd have 16 beds and there'd be curtains in between, so that if you're lying in an ER bed, the guy next to you is just simply separated by the curtain while they're doing whatever it is they're doing, unless of course they're dealing with a trauma or something and ERs have a room for that. The new standard is, ERs should each have, again, an individual room with a door, I mean, with a big open door, but the idea is, you're separated by hard walls, again, to provide patient privacy, patient satisfaction and to minimize the risk of cross-contamination, so things change, and that makes a difference with respect to what you can provide, so what I've seen over the past few years is a lot of VA facilities are remodeling from the inside out, so you're square that not many facilities are going to get a brand-new, knock it down and build a new building, so the way that VHA and facilities have handled it is, they put in a request for a project and they remodel their ER or they remodel their general medicine ward to have individual rooms, private rooms with private baths for their patients, and that's sort of the process that we've gone through over time in order to address these changes in what we know now versus what we knew then. [F-021]

> The ER is totally inadequate in terms of the number of patients that it takes in. I mean, they often have patients backing up in the ER, boarding in the ER, because they can't turn over at the beds upstairs. Some of that has to do with nursing shortages and not having enough nurses upstairs. But some of it just has to do with the physical bed situation, so everything backs up. This place should have an ER that's twice the size than it is now... That causes a very big obstruction. [F-164]

Respondents reported varying levels of satisfaction and difficulties relating to inpatient infrastructure, including operating rooms, general inpatient bed, and specialty care programs. There was also some concern specifically that there would be increased need for inpatient care due to the aging of the population and the high needs for substance use treatment among Veterans. On this topic, one respondent discussed the need for inpatient treatment programs for addiction and acute mental health issues.

> We don't probably have enough OR space to adequately accommodate all of the surgeries we need to do. We are looking at shifting some ambulatory surgeries, all of our eye surgeries down to XXXX or wherever they can do an ambulatory surgery. [F-081]

> Surgery, we're impacted by the number of OR rooms that are available and have to schedule around there, which sometimes can be challenging when you've got five specialties that all want to operate on the same day and we don't have rooms available. Sometimes it's kind of an artifact of our own system where we start digging down and realize that their clinics were set up incorrectly so they're not schedule appropriately. [F-061]

> Another concern is that I've seen some data from some planning committees about what will happen in the future and as far as the number of patients in this area and also nationally, and it seems like there's a sense there's going to need to be an expansion of some type but more specifically for the issue it relates to geriatric patients. I foresee that there's going to be a very much increased need for inpatient geriatric type services like combo geri-psych units, nursing home level assisted living…I'm not sure. But we're getting a lot of patients that are somewhere, for example, in between needing medical

> and nursing home care, or in between needing inpatient psychiatric and nursing home. [F-195]

> A lot of what was needed [in inpatient care] was not necessarily 24-hour nursing service, but a safe place for people to go and to be treated for co-morbidities at the same time, in other words, alcohol substance abuse and particularly among the younger vets, if they're addicted, they're poly-addicted. So it's not just alcohol and it's not just drugs. And a lot of what's driving it is PTSD. And so there finally is a pretty good residential program up at [one of our facilities], and then they started at first six beds and now it's 18 beds of inpatient intensive therapy that is 21 days long. [V-16]

On the other hand, respondents at several facilities were relatively happy with the state of their inpatient infrastructure.

> There are enough facilities in the general area that we can access an inpatient level of care as we need it and when they're discharged, we so far haven't had any problems getting them in in the time—certainly not in the VA mandated time frame—and what we want to do is usually shorter than that. So no, we haven't had a problem with [inpatient capacity]. [F-106]

The comments about limits of primary care and outpatient specialty care space centered around the need for more exam rooms.

> There are some isolated instances [of infrastructure being a problem], like, I have an office and across the walkway is my LVN… It really works well when we're in close proximity so that if she sees a patient and my door is open, she'll walk the patient right into my office and when I'm done with my patient and her door is open, I can walk the patient right across the way. So I think if there was some more space maybe we could have a better design and have all the providers close to their LVNs. [F-248]

> The first that occurs to me is we're space challenged, as I'm sure probably some other facilities you've spoken with. So in PACT, for example, ideally we'd like to have three exam rooms per provider. We're just now to the point where I think we've gotten pretty much two across the board. So that impacts their productivity to some degree. [F-061]

<u>Parking</u>

Respondents discussed challenges with parking at facilities.

> Parking problems are big. I know you don't think about that when you think about medical care but it's a huge. [A nearby VA] medical clinic finally got a parking garage… Three years ago—of course I didn't jump the curb with my car—but there were some people [who would] literally create their own parking spot to make [it to their] appointment that they otherwise would have to wait three more months to reschedule [if they missed]. [V-09]

> Just being where we are, traffic is always an issue… just getting here is a problem for many people… We're at one of the busiest intersections in the world... Our parking is insufficient. …Once you do fight [through] the traffic, there's delays in actually physically parking. [F-257]

> They don't even have parking for the vets. … They decided it was bad form to build a garage because it gave the wrong impression to build a parking structure where we really needed clinic space and other stuff. So they didn't build a parking structure. So you come there and there are handicapped people, have to schlep … to get to the clinic or to get to any place. It's a totally absurd situation. [F-164]
>
> It still seems there are times when parking is a huge issue for patients. We've also had some new construction. That's made it a little more difficult to get into my clinic. [F-153]

Relationship between Space and Staffing

In relation to questions on infrastructure and site capacity, respondents described how lack of available space slowed or prevented hiring because facilities did not have rooms available for providers to see patients.

> There's a definite relationship [between hiring new providers and building new space]. We need to hire our providers and I can tell you right now in mental health … I have a meeting later today actually on this very issue. They're holding off on hiring a couple of RN positions and a provider – I can't remember if it's a psychologist or a psychiatrist position, but one of those -- because they don't have the space and I'm saying, "No, you need to move forward with the recruiting and we'll figure this out." They're really nervous about it and we don't have the space for them, but I have someone working on it and so it is an issue and they're not comfortable… so, yeah. We do have that [problem] and it's a good example of what I'm dealing with today. Those positions have not been opened because of space but I'm trying to push them forward. [F-002]
>
> We are a million square feet short of space in just one of our facilities. We can't recruit and hire without having that space. And the lease thing is absolutely lethal. We couldn't expand our leases sufficiently to accommodate some of the demand, so you recruit people and have no place to put them. That really impacted the hiring process. [F-141]
>
> It's been very difficult to convince leadership that we need [some specialist] positions [like psychiatry] because of budgetary constraints and certainly space. Space is our nemesis, and I'll refer to space problems the whole telephone call if you let me. [F-154]
>
> There're all of these doorstops everywhere we turn. We need more space. We need more providers. But if we hire the providers and we have nowhere to put them then it's a waste of resources… And it's all of the things that happen in the background. I mean, just getting a physician and a nurse and a clerk to work on a weekend would be okay. I mean, we could probably get over that hurdle. But if you're talking about a specialty clinic that has reusable medical equipment that needs SCS to turn that around quickly then we have to talk about SCS. We have lab. We have radiology. We have all of these other ancillary services that support those clinics as well and so the ripple effect isn't just opening a clinic for a few extra hours, you're talking about expanding services across the board. And then when you talk about expanding providers, and talking about extra space, then you're also talking about hiring additional environmental management staff, you're talking about extra burden on pharmacy, lab, pathology, radiology. All of those other services also have an impact. And when we do things like our VACAA funding and so forth it's basically just considered the primary care staff, or specialty care staff. It didn't talk about the extra workload that would be generated for lab, radiology, environmental management with a new space, SCS with demand in surgeons, dental. I

> mean, all of these areas have an impact outside of their small area that they work. That's why we have these huge systems. [F-094]

Other respondents described how a lack of adequate staffing caused the site's infrastructure to be underutilized.

> I don't think the number of beds is as much of an issue [in creating bottlenecks or delays in patient care] as efficiencies in our—the flow, that deal with the flow and the effective use of staff. So I think that has an issue. [F-024]

> They often have patients backing up in the ER, boarding in the ER, because they can't turn over at the beds upstairs. Some of that has to do with nursing shortages and not having enough nurses upstairs. But some of it just has to do with the physical bed situation, so everything backs up. [F-164]

> We have struggled to find social workers to support our primary care teams and we have been doing major recruiting efforts to try to do that, so the providers can let the social workers help take care of some of the social needs and placement needs and we have not had social work, so now we're suddenly getting social workers on board without space. We need space for social workers, pharmacists and mental health. That's where our biggest struggle has been so our expansions are primarily space expanding. [F-032]

> I would say [our facility's problem with inpatient capacity is] 90 percent physical, 10 percent staffing. We do have a problem, as you heard me talking about, having the trained and experienced nursing staff, and getting staff onboard to make sure that we have that percentage of staffing. But the other is that we just physically don't have the beds. And ideally we'd like to be like regular industry and have single occupancy rooms. But we don't; we have double occupancies. Luckily we've reduced all of our quadruple occupancy rooms. But we run right now at about… I think when we actually count the patients we turn about 50 patients a day. That means how many coming in and going out. And we run about 90… I think I saw it was 97 to 98 percent occupancy. So right now I think this morning we had somewhere between 50, I've heard it up to 60 patients a day, that are out in the community in beds because we can't get them in here to the [VAMC]. We have to monitor very closely our surgeries and our catheterizations to make sure that we have a bed for these patients as soon as they're done with their procedure. [F-081]

> I think we're appropriately resourced to see patients in clinic and inpatients who have cardiac disease in the hospital. So for the most part, like I said, I think the clinical resources are, for the most part, adequate. I think there might be some isolated areas where we need more. But again, it's this hospital-wide management disconnect, where you would say, of course we need to have nurses on reserve call, so that if someone calls in sick we don't have to close a bed and spend tens of thousands of dollars sending a patient to a private hospital because we didn't have someone to serve as the nurse. It's like the airline industry. They always have crews. They don't cancel flights because someone has the flu. They have a crew on standby. And they're not doing it out of altruism. They're doing it because it's good business. And this kind of thing doesn't happen here. If a couple of nurses call in sick, the beds get closed, patients have to get sent to an outside hospital, taxpayers have to pay a huge amount for that….I have been told, has a budget for fee basis medical care currently that exceeds 100 million dollars a

> year. And some of that is needed because we could be responsible for a patient who has a service connected disability and has an emergency hospitalization 100 miles away. We're obligated to pay for the care at another facility. But much of it is because of poor use of the capacity that we have. So getting patients in and out of the hospital is too slow of a process. There is frequently closure of beds because of quote-unquote, "nursing staffing issues." And as a consequence if a bed is closed and, not because of physical availability the bed isn't there, but because there isn't a nurse to staff it, a patient might come into the emergency room, need hospitalization and has to get sent to another facility at VA expense: Huge, huge waste of money and also disruption in the continuity of care between different health care systems, where it's very likely that things will fall between the cracks…very poor use. [F-150]

Old/outdated infrastructure

Several respondents described ways in which old or outdated infrastructure hindered the optimal functioning of their medical centers. Some comments came from a large, older VAMC that felt burdened by maintaining their physical plant, which was no longer suited to their current needs. In general, respondents generally affirmed the idea that equipment was adequate, but that the physical space at many VA facilities is not sized or configured in most contemporary medical settings. This was attributed to the continually changing standards and requirements for health care. One respondent made the analogy:

> All the hospitals in the VHA are competing for a finite number of dollars.… I think they try very hard to ensure that the most critical needs are met first, but it's kind of like painting the Golden Gate Bridge: by the time you get to the one end, you've got to turn around and start all over again at the other end because infrastructure-wise, new technology changes the way that a footprint needs to be done. [F-021]

Another respondent echoed the need for continual renovation to keep up with standards.

> I would say in general the space is inadequate, the facilities are old, but because material or the equipment, we can turn over and it has a lifetime, our equipment is fairly new, up to date, state of the art… There's been such a big change in the size of operating rooms and the toys that are in the operating rooms and the need for computers and cabling and electricity, even back to the late '80s, early '90s. If you haven't redesigned your operating rooms since the mid-'90s or the late '90s, your operating rooms are too small and they don't have the infrastructure to support towers and video and all those other types of things because they haven't kept up with medicine. [F-073]

Finally, a related anecdote from a VA leader illustrates the challenges of down-sizing or "right-sizing" VA facilities, a theme we heard from multiple respondents who struggled to maintain facilities that were no longer suited to the local demand.

> Their average daily census in [the hospital that we closed] was running between two or three. So there were far more staff than there were patients. And it made absolutely no sense. It had not been closed largely because the veteran community was so against it. But there was a local critical access hospital which was also struggling …We made a decision we were going to close the VA, keep it as a clinic but transfer all the inpatient care to the critical access hospital, which was a mile down the road and it basically was a

> win/win for everybody. Veterans were still able to be hospitalized in their local community, it helped the critical access hospital with having a higher volume. [V-10]
>
> The problem that we have with major construction nationally, because there's not a big enough budget to take care of all the needs of all VA Medical Centers nationwide that are an aging infrastructure. We were fortunate to have one of those [major construction projects], but we don't believe it's possible that they can replace all of the buildings fast enough to take all the needed construction. There's going to need to be a major infusion of national funding into the VA construction process to support all the needs to repair and to replace our infrastructure. [F-032]

Strategies to Address Space Challenges

Respondents described different challenges to address space challenges that helped provide more space for patient care, programs, and staff, and are often used in combination to expand sites' capabilities.

Evaluating and monitoring space needs. When asked about strategies used to address space challenges, respondents described institutional planning and decisionmaking processes that were in place to monitor usage and respond to bottlenecks when they arose. Sites also referred to the importance of leadership being aware of facility constraints and proactive in addressing them, whether related to space, staffing, or other infrastructure.

> So we look at their current [volume], their [projected] growth. We look at their CBOCs, if they plan an expansion of course we take that into consideration. We also look at by location how many uniques do you have in your CBOC? If you are dropping your CBOC, what are you doing with that space… So we not only look at the data over the past two years from 2012 to 2014 and deal with specific facilities, but we also project which ones are going to drop. So when anything comes in like people asking for a lease or build out, we take [that] into account … So we build that into our decision making process to make recommendations of yea or nay. [F-141]
>
> [If patient volume increased rapidly, under the current director, this particular VAMC] would be morphing and getting providers as needed. Because they've got space, I mean they've got space that they could alter or incorporate, because it used to be an inpatient facility. So they watch their flow very closely, like daily, Monday through Friday, so I think they would just expand as needed. I don't think they'd have a problem facility-wise. [F-102]
>
> I have a small group that looks at our physical space and we're doing our very best to utilize every inch that we have and we still don't have enough space to provide everything that we need to provide and to house everyone we need to house, so we're looking at leasing space. [F-002]
>
> When there is a shortage, it's something that you just feel like, "Okay, we have the right amount of space. We need to hire somebody." Maybe we need to figure out where we're going to put this person but you get a feeling like it was planned out well enough for the current state, and when there's changes it'll have to be worked through in some way, but it's reasonable, yeah. Any facility

would have that issue. You don't want to have just caverns of offices that are unused just in case you hire more people later on. Typically it's not an issue. [F-195]

A: I think our access numbers are good. It's because we're managing it, alright? But to say can we really expand with one or two more staff folks maybe to provide different services at a higher degree, the answer is no, we're limited by space. We're shackled by limits of space. But for all the probably 80% to 90% of all the services that VA Central Office wants us to provide, we can certainly do that. But if they send another mandate out we're sunk.

Q: So if you have to provide something much more specialized, for example, and you don't currently have a person in-house that does that, you just can't hire someone else because there's nowhere to put them.

A: Bingo. And we've been struggling with that for probably four or five years. [F-154]

Reconfiguring to maximize use of existing space. Many sites described efforts to make the best use of their existing resources. At the facility level, they implemented space use arrangements that served as stopgap measures, to expand capacity in the short-term while awaiting new leases or new construction. In an effort to ensure adequate rooms for patient care and staff, sites discussed dividing office space, shifting people around, and being creative about how they used spaces, like having providers use a conference room for office space when there are no offices available. Because of the delays in establishing leases or securing a construction commitment from VA, respondents also described a spirit of self-sufficiency within their facility; they emphasized their commitment to patient care, and how they would make do or find a way, although ultimately, most respondents wished that their facility could have more space. Respondents talked about unconventional ideas that their sites had considered for how to maximize patient care capacity within their limited space. They discussed increasing clinic hours in order to run more clinics over the course of the day, only running clinics on certain days to enable space to be efficiently shared between services, and incentivizing telehealth providers and other staff who could to work from home.

We're doing our very best to utilize every inch that we have and we still don't have enough space to provide everything that we need to provide and to house everyone we need to house…we're dividing offices that we can into two if they're larger… [F-002]

We don't have enough space for everybody; so we're constantly moving people around. [F-248]

There's a constant refrain that there's a shortage of rooms in the clinic to see patients. Well, if you only use your clinic rooms seven hours a day, yes, there could be a shortage. But there's an inability or unwillingness to consider what I would say is obvious solution to that; which is, instead of running two clinics a day in a given room, making use of it. Perhaps seven hours out of the day, run three clinics and make use of it 11 hours out of the day. And that would also expand access to patients who work early in the morning or into the evening. [F-150]

Some of the things we're doing for space issues is we're looking at we have after hours clinics, weekend clinics and so forth, so opening up more capacity. Looking at kind of

> what I call "hot bunking" exam rooms, where we don't have enough exam rooms for services to have their own so we bring in clinics on certain days. [F-081]

Using the various existing mechanisms to connect Veterans with non-VA care. Another common strategy that sites used to deal with lack of space for patient care was to send patients to other VA and non-VA facilities. To many respondents, lack of space was something to be addressed in the short-term by "feeing out" patients to community facilities. Respondents noted that this practice is expensive, but did not seem hopeful that facility expansion was realistic in the near term. A few respondents suggested that the cost of non-VA care was a barrier to this strategy, or at least that facilities lament that fact that it is so costly, despite their obligation to provide and pay for care when indicated. Another non-monetary cost to using fee or contract care as a strategy to address lack of infrastructure is the challenge of coordinating care for patients who receive care outside VA.

> Certainly the ED gets congested, especially now with flu season. And we've been on diversion from time to time. But we send them to another hospital. [F-061]

> When we go out and conduct our site visits at hospitals, what we're seeing and hearing is that yes, they have resource or staffing issues, but in those situations, if they don't have the resource or staffing available to meet the immediate needs of veterans at the local facility, they have no choice but to refer them outside the VA to get timely care. But they're reluctant to do that because of the cost. But cost should not be a barrier. [V-05]

> I think every CBOC in the country does exactly what we [with regard to when to use non-VA care]. They look for the most critical patients. Most patients can come to the VA Medical Center [to receive diagnostic or specialty services]… We provide a bus transportation system to bring them in from those sites and to get their CT scans and their MRIs. They don't have to pay for [transportation]… however, you don't want a frail, 96-year-old man or woman in our most furthest outlying area coming in on a bus to go all the way to the Medical Center, so those types, we look individually and we get [the care] out into the community whenever there's a critical need to get them in, so somebody who is compromised in their immune system, somebody who has gone through chemotherapy, somebody who can't tolerate the trip down, we approve those on a case-by-case basis, fee for service clinical service, so we prevent those most frail patients from having to come all the way in, but the majority of our patients, we try to bring into the VA Medical Center rather than having them go out in a very costly [way in the] community when they're healthy enough to come in with the VA transportation system we provide. [F-032]

> I think this morning we had somewhere between 50, I've heard it up to 60 patients a day, that are out in the community in beds because we can't get them in here… we don't have, in reality, an adequate number of beds in order to take care. We're "feeing out" a lot of the inpatients because our facilities are full…. But when we send people out for surgery for a procedure, [we need to make] sure that we're aware of when they're going to schedule their procedure, when all that is going to happen, so that we can make sure that the DME [durable medical equipment] and the care plans, so the DME and all the other things that are available for them, immediately postoperatively. … There have been instances where patients have gone out and had the surgery and they never let us know when that surgery was going to happen. They went ahead with the

> surgery and none of the after care, or none of the equipment that they needed, was available for them. And that doesn't happen overnight. [F-081]

Leasing commercial space to increase capacity. Many respondents mentioned leasing additional space as a solution to space challenges, but few discussed leases without describing what they felt were burdensome and time-consuming administrative processes that needed to be navigated before a lease could begin.

> We're working on a proposal for a comprehensive pain clinic and we'd ideally like to find dedicated space to house enough people in there to make it a one-stop shopping, and just logically right now we haven't been able to identify that space. So we're hoping to have that pretty resolved shortly. But we've done things like we moved our outpatient mental health program to an offsite location. Our dental clinic is an offsite location. We moved our human resources out of the building to provide more clinical space. So we're pretty proactive about that. But our preference is not to have anything go outside. [F-061]

> One of the barriers to telehealth expansion is from a contractual standpoint because right now we, of course, in contracting for a new service or new area that might enhance telehealth care, we have the federal acquisition regulations that must be adhered to and sometimes the timeline for that is kind of stretched. For example, it took almost two years of planning for us—and going through the contractual end of things to get a new community-based outpatient clinic. [F-005]

> It takes a very long time, so it's not an easy nor a smooth process and it involves more than contracting and so, no, it takes a very long time to get a lease in place. I do have one potential small site in town that is currently leased by our VISN contracting office and they have sat there and that lease will be up in May and we're trying to do something faster than a normal lease process, to where we could, like, take over that lease…but, yes, timeframes of getting that in place, it is a very big issue and a big constraint. [F-002]

Establishing agreements to use other facilities. Although less common, some sites mentioned coordination or agreements made with non-VA medical facilities that were not leases, per se, but that still expanded VA capacity. These arrangements were made with military treatment facilities, academic medical centers, and community hospitals.

> [Our facility] does not provide intermediate surgery because we don't have the infrastructure that you would need to do that in a safe manner and that's from a lot of things, not just the specialty providers that we may not have but that's also the support staff, as well, and, in theory, sometimes the space capacity so that capacity does exist at [our local community hospital]. What we have is a very unique relationship and this is all done through a Memorandum of Understanding or agreement and, of course, when it was done it went through Legal and was blessed both at the VISN and national levels, but our doctors—and they're privileged to do this—will go over to the [community hospital] and will use their operating room space and infrastructure. [F-005]

> There was an opportunity [to sublease from an nearby academic medical center] on a time-limited [basis]… Well, orthopedics, which was one area that was significantly

> backlogged and that was restrained by the OR capacity at the VA Medical Center, made a pitch to lease property for ambulatory surgery that was available that was excess to the medical school's needs at the time, so VA did that. We did not have to go through the – another problem – cumbersome leasing process, and obtained space where they could do off-site surgery. It was using VA staff but it was giving them additional OR capacity than they had at the Medical Center and that allowed them to go through their backlog and reduce their backlog for orthopedic surgery. [F-063]

Constructing new facilities. Construction was frequently mentioned by sites as a strategy that resolved past space issues, and as a strategy they are pursing to address current infrastructure challenges. Renovation and expansions usually increase room for both staff and patient care space. However, respondents also noted the challenges to completing construction projects, including the bureaucratic process and lengthy time frames. Additionally, the VA's limited budget and high demand for construction among sites increases competition for funding and thus may prevent sites from being able to carry out their construction plans.

> We just opened up our new women's health clinic and it's got more space and much nicer space than they had before. But again, that was something that was planned to do several years ago as part of the strategic planning. So in cardiology it would be the same kind of thing. There's some things that we want to do to expand for the future and we're looking at how to make that happen but so far [infrastructure has] not been an impediment to providing care. [F-062]

> Every single site has a construction project or a lease expansion going on as we speak today because we've anticipated that we have to do that to deal with having access to bringing the system, bringing in that 30-day timeline to get everybody in in 30 days and try to take care of our patients closer to home. So every single one of our CBOCs is doing that right now. [F-032]

> To be able to lease space or build space you have to submit a request through central office. That has to be funded through Congress, so you can't just decide that you have a need here at the facility. You have to compete with all the other facilities across the country and then Congress decides what they're actually going to fund for that year and it may be two to three years down the line. … If we had more space and it was easier to get space, easier to build space, that we could actually use our money on capital projects without going through this bureaucratic process and having to deal with the pots of money, we could definitely improve the patient's experience of care as well as the productivity. [F-041]

> Now we're going to go for a "major", which means adding two floors at once. But we're talking a couple years in the future. [F-043]

> We have issues in our ED. Matter of fact, we have a couple projects on the books to solve that problem. … At this facility here actually, we were just approved at least for the design of a replacement facility… Of course, that will take probably—that's about an eight or nine year process to go through design and construction. [F-024]

> We also have construction going on which creates more space issues in that timeframe. We're building a new physical medicine and we have building, so parking is difficult; it's difficult for patients, it's difficult for staff and we're building a new parking garage and so that construction is ongoing so that will alleviate that, once that's [complete]. [F-002]

Medical Equipment and Supplies

Respondents spoke to the challenges and strategies around medical equipment and supplies. Overall, respondents were generally satisfied with medical equipment, although this varied across facilities and according to specific types of equipment.

Facility type, complexity, and volume of care. Respondents spoke about the limitations of medical equipment at their sites, which was sometimes related to the complexity level of or type of site rather than indicating unmet need. However, respondents reflected on the tension between having all the equipment or capabilities they might want and the need to provide care in a cost-effective way, which sometimes requires utilizing VA network facilities and non-VA care for lower volume or more specialized services.

> Some things [diagnostic equipment and laboratory infrastructure] are [sufficient] and some things aren't. They can do basic phlebotomy. Flat-plate x-rays, screening mammograms, and screening ultrasounds are done through contract or through non-VA care, but there are some things that I wish we could do. I mean, we don't have the appropriate refrigeration, and for some reason we can't give shingle shots here. And…the phlebotomy area, if you want to do a QuantiFERON gold, which is a test for TB, I think it has to be processed appropriately so a patient has to go up to [regional VAMC] or to [regional non-VA hospital]. So those are common tests and vaccinations that are inconvenience to the patient. But, you know, we're primary care, there's not a whole lot of sophisticated equipment that we actually have to have. I do a primary care derm[atology] and we seem to have a mess of equipment for that. We have women's health, [and our clinic] seems to be appropriately stored for that. [F-248]

> We hear about it [from providers] if we don't [have sufficient screening and diagnostic equipment and lab facilities]! Basically, they submit it through the equipment committee and our equipment is prioritized based on the money that we receive. Are some a "need" and some a "like"? Yes, absolutely, but if we had more resources to devote towards equipment, that would absolutely help. [F-041]

> We hear this all the time—why do a lot of the VA clinics not have 24 hour CAT scans, colonoscopies? You can essentially call a civilian hospital and say hey, I need to come in for a CAT scan and they say well, we can see you next Thursday at 11:30 at night. That is very common where I come from, where there's a large teaching hospital. Why can we not do that? It doesn't make any sense at all. The resources are there, they can rotate docs through. You don't even need a doctor to do the scan, you just need a tech. So exploratory and testing types of options should not have a backlog. [V-05]

> The frustration for patients is that the diagnostics typically are at what I call "the mother ship" or at a larger independent CBOC. For example, if you have a simple test X-ray that needs to be done they'll have to travel in order to get that, as opposed to us being able to just go out into the local area. And that's limited by the space in the clinic and also by the expense when you have performance measures that measure the amount of dollars per unique for radiology tests or for lab tests or whatever that measurement may be. [F-081]

> [This VAMC] does not provide intermediate surgery because we don't have the infrastructure that you would need to do that in a safe manner and that's from a lot of

> things, not just the specialty providers that we may not have but that's also the support staff, as well, and, in theory, sometimes the space capacity so that capacity does exist at [our local community hospital]. [F-005]

VA specialized infrastructure not available in non-VA settings. Several respondents highlighted the strengths of VA medical equipment and infrastructure for certain types of specialty care. For example, as counterpoint to the discussion of deficiencies in VA infrastructure, one respondent spoke about areas of care at which VA excels and around which it has built up impressive clinical infrastructure.

> Well, by and large the VA has experts in the types of service-connected wounds that we have been seeing over the past 100 years, not only with PTSD, traumatic brain injuries, certain types of cancer, you know, [but other things, like] reaction to toxic wounds, and now prosthetics. So the level of care that [Veterans are] able to get—specialized care specifically, like for spinal cord injuries—at the VA would really be cost prohibitive outside the VA. As a matter of fact, we recently toured [a new facility] only to find that they make a lot of their prosthetics on campus. They don't even contract out for it anymore. They have their own machine labs where they machine their own prosthetics and replacement parts. They can do it right there on site. You're not going to be able to get that type of focused care [anywhere else]… I mean where are you going to get that kind of service? [V-05]

Relationship between space and medical equipment. The physical space available for medical equipment was often a consideration when trying to upgrade machines or make efficient use of existing equipment.

> The next thing is the diagnostic services. We do EMG, we do muscle biopsy, we do nerve biopsy in the neuromuscular program. I have a problem. My machine is kind of kaput, although I requested it [be fixed]. Hopefully it will be…we will be able to get a replacement, but there is a problem [in the meantime]. If I have to do a muscle biopsy, I have to beg dermatology to give us their small OR where they do surgery. But I don't have any space to do any surgical procedures…. So diagnostic equipment, [having] the room for doing diagnostic procedures, they happen to be problems. [F-171]

> Infrastructure-wise, new technology changes the way that a [facility] footprint needs to be done. New inspection control requirements change the way an OR should be designed and the need for humidity control and all of those types of things affect-- for example, here we have ten OR suites. … They were state of the art when they were built, but as things change, they have infrastructure issues that we have to try to retrofit into those existing spaces, which is sometimes a challenge. You know, CT scanners are smaller, believe it or not, now, and they have different MRIs now that you can actually stand in instead of lie down, so I think with respect to infrastructure, there's always going to be a challenge, to be able to provide it in such a way that it meets the needs. [F-021]

<u>Strategies to Address Challenges Related to Lack of Medical Equipment or Supplies</u>

Although most respondents reported that medical equipment, lab services, and supplies were available and adequate at their facilities, they also described two strategies they used to meet patient needs when their sites did not have needed services or supplies.

Sending Veterans to other VA or non-VA facilities that had the needed medical equipment or capabilities. Utilizing other facilities that offered needed diagnostic or medical services, either other VA facilities or non-VA facilities, was a common strategy to address a lack of medical equipment. Respondents discussed their reliance on the capacity available in the wider VA network as a resource for providing certain types of care to patients. For lower-complexity facilities that were sometimes distance from other VAMCs, establishing agreements with non-VA hospitals to allow VA staff and patients use their facilities was a less common but still important strategy to addressing patient needs locally. The types of services offered through these arrangements were usually low volume or highly specialized laboratory services or diagnostic equipment (e.g. mammography, PET scan). Mobile MRI, for example, was mentioned by several sites as a strategy for increasing access to this service for their patients.

> Generally speaking, no, [we don't send out lab and diagnostic services]: we do all of that here. I mean, there's certain surgeries that we don't perform so they go to the community. And, other than that, PET scans we send to one of our network facilities. [F-061]

> There are mobile CTs and MRIs that you can contract with. And so, to improve the access for a short period of time while, you know, maybe a provider is being hired or we work on extending hours, extending hours over weekends and evenings, you know, while that's being worked out. So maybe in the short-term—so that's one of the things we were just batting around. [F-074]

Replacing or constructing medical equipment or infrastructure. Respondents also described replacing or constructing medical equipment or infrastructure to address facility needs. The process of requesting medical equipment, however, was not always a smooth or easy one, as it involved interfacing with the contracting process.

> We're adding to meet the demand. And it's an open demand for eye [care services] and that's one of our greatest demands. And we're actually building more eye lanes here. Our national facility just added four eye lanes down in our [sister] facility. [F-081]

> We've just gotten approval for all of our equipment that would become a patient safety issue if that was not replaced and so we will be getting that equipment. [F-002]

> I will tell you that regardless even if we did have the resources and we were able to buy everything that the physicians would like to take care of the patients, we still have the VA contracting process, which is extremely onerous and will take a long, long time. So as the local medical center, we do not have control over the contracting process. So all the documentation [of equipment needs] is done here and then it's submitted and it may be submitted into a black hole. [F-041]

According to some respondents, assessments and decisions about medical equipment were happening in an ever-changing environment of patient care needs, demand for services, and what technology or equipment was considered adequate or up-to-date. Like in the example above, the growing demand for eye care services seen by one respondent site was in part due to patient demographics (i.e. older patients needing more frequent eye exams), but also a result of a recent clarification of VHA policy on preventative eye services, which respondents belief has increased the volume of Veterans seeking eye care. We heard a similar example about audiology that spoke to how the interplay of changing technology and changing demands affects the strategies sites could use to meet patient needs. At

another site, respondents described how advances in telehealth technology have obviated the need for their site to have an audiology booth.

> …the problem with audiology has been, in the past the requirement for the audiology booth which is, oh, my gosh, construction needs to occur around it, so it's a big constraint. We're able now to do tele-audiology without that big booth. I mean, that was a game stopper right there, and as veterans are aging and there are changes to their hearing ability, the increased demand, and that's likely to continue for audiology. Well now we can do it via telehealth without even having to bring the person to the booth… [F-063]

Table E-3. Physical infrastructure resources domain: code count by facility-level interview

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B3.01 General Space Issues	B3.1 Med equip/supplies	B3.2 ED	B3.3 Inpatient	B3.4 Outpatient	1 Primary Care	2 Speciality Care	1 Specialty Care - Space	2 Specialty Care - Other	3 Other Outpatient	B3.5 Administrative Space and Other Infrastructure	B3.6 Strategies - Lack med equip/supplies	B3.7 Strategies - Lack of space	1 Strategy, space - Business arrangement	2 Strategy, space - Creative use of existing resource
F-002	VAMC	Leadership	F1	small-med metro	small	less complex															
F-004	VAMC	Leadership	F1	small-med metro	small	less complex															
F-005	VAMC	Leadership	F1	small-med metro	small	less complex															
F-021	VAMC	Leadership	F2	large metro	large	complex															
F-023	VAMC	Leadership	F2	large metro	large	complex	1	1			1			1	1						
F-024	VAMC	Leadership	F2	large metro	large	complex															
F-029	CBOC	Clinical staff	C2	large metro	large	complex															
F-032	VAMC	Leadership	F2	large metro	large	complex	1	1				1				1	1		1		
F-041	VAMC	Leadership	F3	large metro	medium	complex															
F-043	VAMC	Leadership	F3	large metro	medium	complex	1	1	1		1					1		1	1	1	1
F-044	VAMC	Leadership	F3	large metro	medium	complex				1	1		1	1		1					
F-050	CBOC	Leadership	C3	large metro	medium	complex	1		1	1	1		1	1	1	1			1	1	1
F-052	VISN	Leadership	V4				1	1	1		1					1			1		
F-054	VISN	Leadership	V4				1										1				
F-060	VAMC	Leadership	F4	small-med metro	medium	complex	1	1											1		1
F-061	VAMC	Leadership	F4	small-med metro	medium	complex	1		1										1	1	
F-062	VAMC	Leadership	F4	small-med metro	medium	complex	1	1	1	1			1		1				1		
F-063	VAMC	Leadership	F4	small-med metro	medium	complex				1	1		1	1					1		
F-064	VAMC	Leadership	F4	small-med metro	medium	complex		1	1	1	1					1			1		1
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex															
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex	1												1	1	1
F-070	CBOC	Leadership	C4	small-med metro	medium	complex															
F-073	VISN	Leadership	V1								1		1		1					1	
F-074	VISN	Leadership	V1							1									1	1	

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B3.01 General Space Issues	B3.1 Med equip/supplies	B3.2 ED	B3.3 Inpatient	B3.4 Outpatient	1 Primary Care	2 Speciality Care	1 Specialty Care - Space	2 Specialty Care - Other	3 Other Outpatient	B3.5 Administrative Space and Other Infrastructure	B3.6 Strategies - Lack med equip/supplies	B3.7 Strategies - Lack of space	1 Strategy, space - Business arrangement	2 Strategy, space - Creative use of existing resource
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex	1	1	1	1	1		1	1		1		1			
F-081	VAMC	Leadership	F5	small-med metro	large	complex					1	1	1	1							1
F-083	VAMC	Leadership	F5	small-med metro	large	complex	1	1	1	1				1	1				1	1	1
F-084	VAMC	Leadership	F5	small-med metro	large	complex	1	1			1	1	1		1						
F-094	VISN	Leadership	V3				1	1			1		1	1							
F-100	VAMC	Leadership	F6	rural	small	less complex	1	1						1							1
F-102	VAMC	Leadership	F6	rural	small	less complex															
F-104	VAMC	Leadership	F6	rural	small	less complex	1	1	1	1	1	1	1	1				1	1	1	1
F-106	VAMC	Clinical staff	F6	rural	small	less complex															
F-113	VISN	Leadership	V6				1	1										1			
F-115	VAMC	Leadership	F6	rural	small	less complex	1	1		1	1	1				1			1		
F-122	VISN	Leadership	V5																		
F-141	VISN	Leadership	V2				1	1													
F-142	VISN	Leadership	V2																		
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex	1														
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex		1			1		1	1				1	1	1	1
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex	1	1	1	1	1	1	1	1		1		1	1	1	1
F-164	VAMC	Clinical staff	F2	large metro	large	complex	1	1	1	1	1	1	1	1			1	1	1	1	
F-171	VAMC	Clinical staff	F2	large metro	large	complex															
F-182	VAMC	Clinical staff	F3	large metro	medium	complex															
F-184	VAMC	Clinical staff	F3	large metro	medium	complex															
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex															
F-217	VAMC	Clinical staff	F2	large metro	large	complex	1												1		1
F-248	CBOC	Clinical staff	C2	large metro	large	complex	1				1		1	1					1		
F-250	CBOC	Leadership	C2	large metro	large	complex		1	1		1	1	1		1				1	1	
F-251	CBOC	Clinical staff	C2	large metro	large	complex	1	1			1	1	1	1				1	1	1	
F-255	CBOC	Clinical staff	C2	large metro	large	complex					1					1					

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	B3.01 General Space Issues	B3.1 Med equip/supplies	B3.2 ED	B3.3 Inpatient	B3.4 Outpatient	1 Primary Care	2 Speciality Care	1 Specialty Care - Space	2 Specialty Care - Other	3 Other Outpatient	B3.5 Administrative Space and Other Infrastructure	B3.6 Strategies - Lack med equip/supplies	B3.7 Strategies - Lack of space	1 Strategy, space - Business arrangement	2 Strategy, space - Creative use of existing resource
F-256	CBOC	Leadership	C2	large metro	large	complex			1		1		1	1	1				1		
F-257	CBOC	Clinical staff	C2	large metro	large	complex					1	1									
F-304	VAMC	Clinical staff	F2	large metro	large	complex	1	1	1		1	1	1		1						
F-305	VAMC	Clinical staff	F4	Small-med metro	medium	complex					1	1	1		1				1	1	
F-306	VAMC	Clinical staff	F4	Small-med metro	medium	complex															
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1	1		1	1	1	1	1	1		1	1	1	1	1

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	3 Strategy, space - Construction	B3.8 Rel of space and staffing	B3.9 Old/outdated infrastructure	B3.91 Other/Unsure
F-002	VAMC	Leadership	F1	small-med metro	small	less complex				
F-004	VAMC	Leadership	F1	small-med metro	small	less complex				
F-005	VAMC	Leadership	F1	small-med metro	small	less complex				
F-021	VAMC	Leadership	F2	large metro	large	complex				
F-023	VAMC	Leadership	F2	large metro	large	complex				1
F-024	VAMC	Leadership	F2	large metro	large	complex				
F-029	CBOC	Clinical staff	C2	large metro	large	complex				
F-032	VAMC	Leadership	F2	large metro	large	complex		1		1
F-041	VAMC	Leadership	F3	large metro	medium	complex				
F-043	VAMC	Leadership	F3	large metro	medium	complex		1		1
F-044	VAMC	Leadership	F3	large metro	medium	complex				1
F-050	CBOC	Leadership	C3	large metro	medium	complex		1		1
F-052	VISN	Leadership	V4				1	1		
F-054	VISN	Leadership	V4					1		
F-060	VAMC	Leadership	F4	small-med metro	medium	complex		1		
F-061	VAMC	Leadership	F4	small-med metro	medium	complex	1	1		1
F-062	VAMC	Leadership	F4	small-med metro	medium	complex	1	1		
F-063	VAMC	Leadership	F4	small-med metro	medium	complex	1	1		1
F-064	VAMC	Leadership	F4	small-med metro	medium	complex		1		
F-065	VAMC	Clinical staff	F4	small-med metro	medium	complex				
F-069	CBOC	Clinical staff	C4	small-med metro	medium	complex		1		
F-070	CBOC	Leadership	C4	small-med metro	medium	complex				
F-073	VISN	Leadership	V1							
F-074	VISN	Leadership	V1							1
F-076	VAMC	Clinical staff	F4	small-med metro	medium	complex				1
F-081	VAMC	Leadership	F5	small-med metro	large	complex	1			

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	3 Strategy, space - Construction	B3.8 Rel of space and staffing	B3.9 Old/outdated infrastructure	B3.91 Other/Unsure
F-083	VAMC	Leadership	F5	small-med metro	large	complex	1	1		1
F-084	VAMC	Leadership	F5	small-med metro	large	complex				1
F-094	VISN	Leadership	V3					1		
F-100	VAMC	Leadership	F6	rural	small	less complex		1		
F-102	VAMC	Leadership	F6	rural	small	less complex				
F-104	VAMC	Leadership	F6	rural	small	less complex	1	1		1
F-106	VAMC	Clinical staff	F6	rural	small	less complex				
F-113	VISN	Leadership	V6							
F-115	VAMC	Leadership	F6	rural	small	less complex	1	1		
F-122	VISN	Leadership	V5							
F-141	VISN	Leadership	V2							
F-142	VISN	Leadership	V2							
F-150	VAMC	Clinical staff	F1	small-med metro	small	less complex				
F-153	VAMC	Clinical staff	F1	small-med metro	small	less complex				
F-154	VAMC	Clinical staff	F1	small-med metro	small	less complex	1	1		
F-164	VAMC	Clinical staff	F2	large metro	large	complex				
F-171	VAMC	Clinical staff	F2	large metro	large	complex				
F-182	VAMC	Clinical staff	F3	large metro	medium	complex				
F-184	VAMC	Clinical staff	F3	large metro	medium	complex				
F-195	VAMC	Clinical staff	F4	small-med metro	medium	complex				
F-217	VAMC	Clinical staff	F2	large metro	large	complex				
F-248	CBOC	Clinical staff	C2	large metro	large	complex	1			
F-250	CBOC	Leadership	C2	large metro	large	complex	1			1
F-251	CBOC	Clinical staff	C2	large metro	large	complex	1	1		1
F-255	CBOC	Clinical staff	C2	large metro	large	complex		1		
F-256	CBOC	Leadership	C2	large metro	large	complex	1	1	1	
F-257	CBOC	Clinical staff	C2	large metro	large	complex				

Interview ID	Interview type	Respondent type	Facility ID	Facility urbanicity	Facility size	Facility complexity	3 Strategy, space - Construction	B3.8 Rel of space and staffing	B3.9 Old/outdated infrastructure	B3.91 Other/Unsure
F-304	VAMC	Clinical staff	F2	large metro	large	complex			1	1
F-305	VAMC	Clinical staff	F4	small-med metro	medium	complex				
F-306	VAMC	Clinical staff	F4	small-med metro	medium	complex				
F-307	VAMC	Clinical staff	F2	large metro	large	complex	1	1	1	1

Source: Authors' analysis of interview data collected and coded for this project.

Appendix E.1.4 IT Resources

Twenty-two interviews were conducted with VA leadership (15 VAMC leadership, 1 Central Office staff) and clinical staff (6 respondents) to gain insight into how telehealth is utilized within VA, what barriers exist, and what VA staff think about the potential for telehealth to expand access to healthcare for Veterans.

Telehealth and Access

In discussing the various aspects of telehealth that were the focus of interview questions, respondents directly and indirectly described many ways in which telehealth affects access to care for Veterans, such as by improving "reach" of specialist services and reducing travel burden. Respondents also described challenges to providing and expanding telehealth.

> Anecdotally I heard that an audiologist would get in car and do a circuit of helping people with their hearing aids going from CBOC to CBOC in traffic. If that were happening, they'd be able to see more patients. I've also heard anecdotally that there are no-shows when there is bad weather. I would think telehealth would help with that. [R-536]

> We provide reimbursement for mileage. If we can bring care closer to home then the patient is not on the road and there is less wear and tear on the car. There is also more chance of keeping the appointment. The money saved for travel can be used to care for more patients. There is better use of resources because of telehealth… Think about patient X who lives 398 miles away and needs a cardiology appointment. He is eligible for travel benefits and gets paid $147 for his visit to his VAMC but he lives across the street from a CBOC. If he can go to the CBOC for that care, that is $147 that will not be paid to him… This means more visits for those who are asymptomatic or not willing to drive. More visits, but the costs per visit go down. What is being paid for the patients travel is part of the budget for VA. The dollars not in the beneficiary travel line can be used to provide more care. [R-553]

> Telehealth impacts the no show rate. Although there is a no show rate still with CVT, it is lower than the no show rate for physical face to face visits. Vets are older and they rely on their kids to bring them in. [R-553]

> To be honest most of the time a telehealth visit will require more provider time. More resources are needed than compared to a face-to-face appointment. For example, if you have a provider at a main facility who wants to do a cardiology visit and you have a patient in a remote facility, you do not only need a provider available, but next to the patient you need someone to administer that visit. Sometimes that can be done by a non-technical person that can just connect the equipment. But if it is a follow-up of a cardiac surgery, they may need to have the physician that is following that patient present in the telehealth visit…*with* telehealth, by the time things are set-up it can be more complex. It is patient centered where savings are accrued to them rather than to the providers…To provide the services, you would need to divert resources in the way of taking over exam rooms used for face-to-face care. There is constant competition over space and each site has to determine how to manage this. [R-502]

We are down two positions in a four-position clinic in one of my clinics. At another, we're at full staff, five providers, in really a four-empaneled clinic, so that means there's excess capacity. So we use telehealth to see primary care patients from when the patient's presented in the xxxx clinic, our provider in xxxx sees that patient remotely and then documents that encounter. We do that several days a week as the imbalance of supply and demand surfaces for unforeseen and foreseen reasons throughout our service area…. This load balancing comes at the expense of continuity, so I'm not real happy about that. [F-104]

So we just hired a psychiatrist about six weeks ago—we brought him out here for a month of training… he is brand new to the VA. We trained him up on CPRS and VistA, and then boxed up all his stuff and sent it to Michigan and sent him back home to his home where he is now seeing our patients via telehealth. [F-104]

It's much less a technology issue and much more about the burden and the continuity of care that our veterans receive. And so I think it depends on how you use that technology—there are always pluses and minuses, and again, if you're using it as we are, as a level of supply and demand, I think that is an issue for the use of that technology, if that's how it's being employed. And so I think there's great benefits to access, but it comes at the altar of sometimes continuity, where our veterans have to tell their story or their medical history more frequently than they would otherwise. [F-104]

So on the far end at the CBOC, you need to pull a nurse or someone out of a PACT team to help take care of the vital signs, get the patient prepped and ready. And that's always a challenge because we're already having struggles with access. So we need to figure out some way to have the resources available to support the actual placement of the patient in the room, the scheduling that XXXX mentioned, and then completing the visit…The other time that is precious is the professional time and the specialist time. It turns out that it's actually not a super-efficient way of delivering care because basically the specialist is tied up for the entire time of that visit with that one patient. That's not the way it happens in our face-to-face clinics where you might have a professional, you may have residents, trainees, who are seeing patients and then they present to the attending. The attending goes in and spends like 15 minutes with the patient, as opposed to the full 30 minutes or 40 minutes that it might take for—or even longer—for a telehealth evaluation. So our providers who are doing this, and some of them are scarce professions, right, like a neurosurgeon, might be able to see 6 telehealth patients in a morning, as opposed to 26 in the clinic. So it's really nice from the veteran point of view because they don't have to travel, but we have to somehow realize some of the efficiencies that we get in face-to-face visits. Even if a neurosurgeon were seeing one patient at a time in-clinic, probably that neurosurgeon would be able to see 50% more patients in a standard face-to-face clinic than in a telehealth clinic. [F-024]

And it's a basic thing. I mean, for telehealth, you occupy two exam rooms automatically at different locations. So the organization consumes two exam rooms for one visit. It inevitably is more convenient for veterans. But it's not that efficient, it's not at reduced cost to the system…However, in rural health when you have remote sites where you cannot get specialties out there, then obviously it is beneficial financially because you've got to move the patient or you've got to get a provider out there. So when you're dealing with your rural areas, yes, there is a benefit. If you're dealing with areas within

commuting distance, not so much. But it does help, I think, financially for—support rural areas. [F-024]

For us to survive, we have to make people want to stay in VA and get VA services, and not send everything out. This is one way for us to help to improve our survivability. So it's probably critical to that in many instances. The other thing is that when veterans have to travel very far to see a specialist, even if we can get them in within 30 days, it may be a hardship for them and they may therefore tell their provider, "Please request non-VA care for me because I can't travel down to [the closest VAMC]." And that's very expensive for us, to send people out. And so there could be a business case for telehealth as well. [F-024]

You're going to have a provider doing telehealth, that's great. That reduces the travel time on it. But it still takes the time to do that, so it's still a half an hour slot, say, for the care. So if you can expand the number of veterans who want to and can utilize telehealth, you still have to have the provider here at the medical center to be able to interact with the patient. [F-064]

Telehealth can help in that you become more efficient at using your space and your providers, but the time is not going to change. You still need a half an hour to an hour per patient. If it's a new patient, they claim to need up to an hour. And if it's a follow-up patient, they need to have it up to a half an hour. [F-064]

So but one of the challenges with televisits has been that there's almost been this assumption that it in some way it will either make docs more productive or overcome some of the staffing challenges. And I don't think it's been clearly recognized that it takes at least as much time to do a televisit as it does to do an in person visit. But there's still somebody on the other end that's having to be there for that appointment. And they often take more time than it does to do a face-to-face… We've been told, that you can't mingle televisits with face-to-face visits. You either have a clinic where you're having telehealth encounters, or you have a clinic where you're doing face-to-face. For some of the docs that's a little bit of a challenge because it means that instead of taking existing clinics and putting televisits into open slots, now they've got to find another half a day to set aside as a teleclinic. [F-083]

For example, we have a physician that worked in [one of our urban CBOCs], whose parent is quite ill and [the physician] lives in [farther-out] suburbs of [that city]. And what we have done, because he's providing the care for his elderly parent, is we're allowing him to do telemental health from his home. [F-043]

They go to the CBOC. There's this room set aside. [The telehealth provider is] actually more efficient because he doesn't have the commute and he doesn't have to worry about the weather. XXXX gets a lot of snow. And the patients are happy. They know him. [F-043]

Right now, our transplant program, we used to bring the patients all from different parts of the country to get their initial evaluation. Now we do it all through telehealth. So they stay wherever their facility is. We have a MOU for those facilities. We set it up and we have a technician dedicated to helping the providers at both ends to set up the communication and the equipment, and the patient doesn't have to travel all the way over here just to see if they quality for the program, they meet the clinical needs of the program. That's been huge. [F-084]

They [patients] like it a lot. They like it. They say, "Wow, I didn't know that you could do this." There was one clinic that we started in XXXX. It's a prosthetic clinic and before the patients had to, in order to get their prosthetics equipment or what they needed, they had to drive all the way into XXXX just to get an education. And now we have a technician and a person down in XXXX and the person is over here in XXXX, and they connect through telehealth and the Veteran doesn't have to get on the road for two hours. [F-084]

The most challenging obstruction is the coordination of the telehealth schedule into the schedule of a provider who has other responsibilities such as face to face—it doesn't sync well. So for example, if you're in your face to face clinic, you can walk from room A into room B. But if you've seen three face to face and now you're supposed to see three via telehealth, to be in sync with that remote location and keep things moving in a correct fashion is an extreme challenge. [F-004]

I don't know if that saves the facility a lot of trouble. It saves the patient a lot. So I don't know if it's going to be cheaper. I can't say that. It may be more expensive but when you think about overall, from the economics in the country, we are all going to a big national healthcare system. I think patients are pretty happy to not have to drive 200 miles for care…We pay the patients to travel. You know that. We pay for mileage and travel. [F-023]

Telemental health is great. They like the idea of the remoteness, to kind of help them be more frank in opening up. [F-063]

We've pushed so much onto our primary care providers with the implementation of the PACT model, using telehealth, using My HealtheVet. I've not done a time and motion study, but if a primary care provider was maximally utilizing these models, they would see patients half of the time. Their nurse in their clinic would be seeing most of the patients that have chronic issues. They would be doing a lot of messaging with their panels, their nurses would be doing a lot of messaging, we'd have a lot of group clinics set up for chronic diseases, but we're not there yet. [F-044]

Our guys can read [the teledermatology image] within the next 48 hours, which could mean they can read it at midnight and send the results back, so if you could get your providers, I guess in an ideal world you could have providers seeing patients all day long in the space and then bring in a cadre of other providers that wanted to moonlight or something, do all the readings for your own CBOCs and all the other places after hours, and you would improve the efficiency of the space utilization. I don't know if we have that much volume yet, but we do that with radiology, where radiologists read films at home at night rather than coming in and having to access the data on campus. So it's good for the patient because you have faster turnaround. You could become more efficient instead of having someone reading a tele-slide during the day, they could do it at night so you could have that office space to see patients during the day if you have the providers, so I guess that's a good idea. [F-044]

We recently had a psychiatrist who needed to go home and take care of his ailing mother, and rather than him quit, we set him up so that he could see patients through tele-mental health, so he's still providing care to his patients, but not at the clinic. [F-044]

I've got a mental health patient [at one site] right now who is just a real difficult patient. He threatened the social worker at one of my clinics and so he's barred from coming to the clinic and he's not going to come all the way in here, so he's just constantly on the phone. I mean, 50 times a day, making phone calls to our providers. We tried to use telemental health with him, but he doesn't have a computer and we can't do it, so one thing that would be helpful is … and actually the hospital down the street put in an innovation grant and was funded to provide the hardware to Veterans with, like, hot spot cards or something to Veterans so they can receive their care, especially mental health patients, so they can receive their care without coming into the medical center....We need to provide the care. The VA is obligated to provide the care, but sometimes it's very, very difficult. In the private sector, they say, "You're off my panel," get away from me. We don't have that opportunity. We've got to provide the care, but [the patient I was talking about], he can't go into the clinic because he's threatened to do very bad things to the staff. He won't come in here because our police will escort him around, so using telehealth will give him the care that he needs to, hopefully, stabilize him, but he doesn't have the infrastructure to receive the care. [F-044]

Our Nephrology program…they had a 10.8% no-show rate in the renal clinic and through use of telehealth the rate dropped to 4.4%. [R-525]

Telehealth is not tremendously efficient. I mean, it's great for the patient because they don't have to drive someplace. And I guess it's efficient for physicians because they don't have to drive to someplace. But it's not necessarily a tremendously efficient way to have an office visit. [F-164]

Telehealth gives isolated veterans a bridge to the outside world. Some of my patients in remote areas became confident enough from virtual care and then would start to come in. [R-518]

The facilities use telehealth tools to encourage communication with their spoke facilities when they have medical needs that surpass their capabilities. It is mainly a communication tool in order to do a warm hand-off of patients. [R-532]

And then other issues have been that it takes a provider or mid-level or nurse or someone to bring the person to the room to sit them in there, and this requires staff. [F-195]

I don't know how it goes in other divisions. I can tell you in Cardiology we're not ready for it because it's adding on a service where physicians are already stretched and it's not an efficient service…it would have to add to another timeslot in addition to the times that we're already spending…so if you wanted to do that, you would hire more clinic physicians so that the work was spread around instead of trying to put more work on the same group of people. [F-164]

And telehealth is excellent—I think the patient themselves may not know it can happen. If you ask me, it sort of takes so much of my time, much more than when patient comes in, so I don't like it. Not much more, but more—like, the patient will take 20 minutes and here it will take 30 minutes, which is substantial. Then it means that per hour, in-person I can see three patients instead of two patients, and then it multiplies, so from that standpoint, I don't like it. But from a patient standpoint, I think it's excellent. [F-184]

Telehealth is not a replacement for care; it's an enhancement to, and I think it's kind of, like, high tech, high touch. [F-005]

Telehealth impacts access in two ways. There is the convenience of it. Not having to drive two hours but rather 30 min instead…It offers convenience for specialty care not offered on site but also for things offered at your local CBOC…you can redirect locations that have access to those that don't. For example, primary care and mental health. With teleprimary care or telemental health you can get more timely access when services not available right away available at local site because of staffing… this allows for more efficient use of existing resources… this started first with specialty side and now we are moving to more and more primary care. [R-501]

Well, at my old site we were going to lose a provider. …He got tired of the commute. He lived close to [another city]. He just [said], "I'm done. I can easily get a job [closer to where I live]." We said, "No, we want you," so we used it as a retention tool. We allowed him to see patients from his house so he wouldn't quit…[telehealth] can be used as a retention tool or even a recruitment tool… [F-044]

Telehealth offers the opportunity for more continuous care – can track BP, oxygen saturation – I get an alert every month. If perfect, can make visits every 6 months instead of 3. This is home monitoring types of telehealth. So now my well controlled diabetics are being seen 6 months, opening up slots for other diabetics. [R-519]

Appendix E.1.5 Access/Quality

In this Appendix section, we augment the main Assessment B findings on access and quality, with supplemental information from VA interviewees. The access and quality VA interviews were conducted with administrative staff members and clinical staff from VISNs, VAMCs, and CBOCs.

Table E-4. Types of Interview Questions by Interviewee Type

Interviewee Category	Number of interviews conducted	Basic provider questions (eligibility & initial access, coordinating care within & outside of the VA)	Question on making & attending appointments	Question on measurement (important domains of access)	Question on the domains of access	FULL Access and quality measurement questions
Healthcare Workers						
CBOC providers (5 physicians and 1 nurse)	6	6		6		
VAMC providers	10	10		10		
VAMC chief nurse executives for patient care	1	1	1		1	
VAMC paraprofessionals (3 social workers, 2 medical support assistants; 1 business office)	6	6	6		6	
Administrators						
VISN quality management officers	5					5
VISN Chief Medical Officer	5					5
VAMC Associate Director	3					3
CBOC Director / Medical Director	2					2
CBOC Site Manager	3	3			3	
Total (by column)	41	26	7	16	10	15

These interviews do not reflect the perspective of the Central Office, or VA leadership. Since the majority of the interview content focused on access, we will primarily discuss access to the VA in this section.

How VA Staff Report on Overall Access to the VA for Veterans

A range of reasons was given as to why veterans do and do not enroll in the VA. Interestingly, “word of mouth” and the physical proximity of a Veteran to a VA facility served as both a reason to enroll as well as a reason to seek private health care. For example, living close to a VA facility was cited as a reason to seek VA care, while for others it led to them looking for alternative health care options closer to where

they lived. Once a veteran is enrolled in the system, VA staff indicated that in most places, most of the time, access to care is pretty good where they work.

> There are enough facilities in the general area that we can access an inpatient level of care as we need it and when they're discharged, we so far haven't had any problems getting them in in the time—certainly not in the VA mandated time frame—and what we want to do is usually shorter than that. So no, we haven't had a problem with that. [F-106]

There were problems with providing access in certain locations or at certain facilities, and VA staff we spoke with a very aware of them. Specifically, geographic barriers provide a clear and obvious set of challenges, but one that is difficult for VA staff to overcome. However, some additional services are available for rural veterans in many of the areas we spoke to (more on geographic barriers below).

> There's also … volunteer drivers who pick veterans up at specific locations and bring them to the VA. And then even within the VA we have a transportation system with a few shuttles that go out to specific areas like XXXX and XXXX and will bring patients into the VA [F-076]

A smaller group of respondents were asked about the factors that help or hinder access to the VA. With respect to timely access, the availability of appointments and staffing was referenced as a challenge whereas efforts to extend clinic hours and schedule subsequent appointments were viewed as helpful steps forward. The lack of transportation, traffic, and parking were mentioned as geographic barriers, but voucher programs and specifically the Choice Act were viewed as concrete steps to address these challenges. Regarding financial access, some reported it was difficult to understand if and how income status impacted eligibility and determine the cost of services, though the majority of respondents noted that VA care was far more affordable compared to private sector care. To address digital access, a lack of familiarity with specific programs such as MyHealthVet or telehealth more generally was noted as a barrier among providers whereas respondents listed a lack of access to technology (e.g., among homeless Veterans) or knowledge about how use technology (e.g., among older Veterans) as challenging. Despite this, respondents generally felt that efforts to improve digital access (e.g., through training for providers and help desks for patients) were important. Finally, regarding cultural access, some noted that while efforts are being made to ensure providers as sensitized to the unique experience of Veterans, more should be done to increase their awareness to a range of things such as military-specific language and slang, as well as the changing demographics among Veterans.

For VA staff and patients, access isn't just about providing care within a timeframe. Access is also ensuring trust and confidence that a veteran's provider or health care system will be there when they need it.

> I mean, my experience prior to VA as well with primary care delivery is that if you demonstrate to patients that they can get access to you pretty much whenever they feel like the need to, then the urgency with which they try to get it drops, because they're not panicked all the time about "Oh, my gosh, something terrible's happening, and if I don't start now and press hard, I'm going to get delayed." If they know that they can call or they can send a secure message or they can be seen briefly to get a question answered, then suddenly a lot of that pressure goes away. And except for those few outliers who have what I think are usually psychological issues about fear and about

> whatever, if you carve out those few, the vast majority of patients just feel much more comfortable that if they need a question answered, it's going to get answered and it's going to get answered in a timely way, so "I don't need to be calling six times, I don't need to be demanding to be seen, 'cause if I ask to be seen, I'll be seen." [F-070]

Everyday Efforts to Measure and Improve Access

To focus first on the measurement of access, respondents reported that a range of measures was used to evaluate access to care. All respondents reported using measures required by the VA and many mentioned challenges associated with using measures that did not appear to be evidence-based. Relatedly, many acknowledged the need to evaluate patient preference but noted the difficulty in reconciling any gaps between clinically indicated guidelines and patient preference Respondents noted the need to more systematically collect data on patient experiences and satisfaction—recognizing that access and quality are so closely linked—they highlighted that the intense focus on access often means patient experiences are overlooked and that improving patient experience could really impact access.

> … sometimes that 14-day measure isn't realistic based on the patient's needs … sometimes you're striving to meet a measure instead of providing care for the patient results in adverse things, so I would just be cognizant of when we put measures in place, are they for the right reasons? What's the intent of the measure and are we capturing the appropriate thing? [F-060]

> It used to be access had to be within 14 days and seven days and now they've relaxed it to 30 days. Again, it's all about communication. I'll just repeat: if our providers schedule—I mean we can look at the 30 day, no, that's fine, it's 30 days within your desired appointment date or your return date. But really, if we have a patient and they want to be seen sooner, that's what we're here for. We work as a team and whatever it takes to get the patient in, we're committed and we do it and whether that performance measure's there or not, we have 30 days now but if somebody wants to be seen within a week, we pretty much see them within a week because that's just how we are. That's just how we operate. [F-250]

Additionally, several noted challenges around standard measures being able to accurately evaluate the local context.

> So I think in an ideal world, right, you would sort of have the big measure. Central office would give you the big measure, right? …And, here's the things we're going to look at for access, let's say. And you would have the freedom to figure out how that works for you, and what you need to measure for yourself to make it work for your own individual setting. So the problem… Here's what I think happened in the system. What happened in the system was when there was more flexibility at the local level, when there were big national requirements but there was more flexibility at the national level, the organization got into sort of this making excuses model, right? I know that's the measure, right, but here's what's going on locally and therefore we can't meet that. And here's why we can't meet that. Not… It wasn't, "We're unique. Here are the unique things we have to do to meet that." It was, "We're unique and therefore we can't meet that." [F-113]

Further, respondents mentioned either developing additional measures and/or processes (e.g., monthly meetings to discuss access issues at the specific facility) to better understand factors impeding access to

care. Finally, a few respondents indicated that they would like to have more input into the process of measure development.

> One thing that's missing is once they develop a measure of access, run it by the field to see if it makes sense. We've got a ton of smart people who really know what they're doing. They're never asked. And when you give it to them after the fact then they change the measure and then we get into this trouble. [F-141]

Facilities engaged in a variety of day-to-day activities to improve or sustain access for veterans. While a few programs appeared linked to larger, nationally coordinated efforts (e.g., diabetes control), many programs and activities geared toward access improvement were local initiatives. From developing unique partnering arrangements with local providers, to developing innovations in customer service for veterans, we found the range of activities and programs varied greatly by location.

> It's actually a contract that we've done with the community hospital… so we can do our intermediate complexity level procedures at that facility…. It gives our surgeons the ability to keep up on some of those skills and it gives access to our patients who otherwise would have to drive at least 250 miles or be transported to another VA. That's how far they would have to go and so it's been a very positive thing that we've done, and we have a good relationship with the local community hospital. [F-002]

> I think we've all experienced [that frustration]—with large organizations where you call and you're either put on hold for a long period of time or you have to leave a message and you wonder am I really going to be called back… So what they've done is they have created a gigantic call center down in [X-Location]… …And at that point they are able to track how many lost calls come in, how long it takes to answer each call, how many minutes per veteran. … Those patients are automatically routed to the call center where they should be able to speak directly to the veteran and get them—if they can't help them—they get them to where they need to be. Eventually our clinic when they dial our general number which would be XXXX, eventually our general operator line will be transferred automatically to the call center … WE do something a little bit special here in [Y Location] because again, we're a smaller clinic and we have given all our veterans—I have made business cards for each team—and so we give our veterans the option, so for each team—I make them right here in the clinic, they're homemade but they look very professional, and we have the number for the nurse, the number for the scheduler, the telecare nurse, and so they do have the option of once the call center is in effect, and if they dial XXXX, they won't talk to anybody here, but we have these business cards so if they still want to call and talk to their scheduler or talk to the nurse, they will have the direct line to call into our clinic. [F-250]

Access to Coordinated Care within and outside of the VA System

Overall Care within the VA System

Among Veterans who seek care only within the VA, respondents noted that care was very well coordinated, especially as the VA has been at the forefront of electronic medical record implementation, which has streamlined communication between the services provided. Patient Aligned Care Teams (PACT) was highlighted as further contributing to the provision of well-coordinated care. Further, it was noted that VA has made substantial advances in the provision of care to certain groups such as homeless

Veterans and female veterans, alongside those with particular health concerns such as mental health and substance use and abuse. In general, respondents reported that high quality care is provided to all Veterans. It was noted by a small number of participants that the current public and political challenges faced by the VA sometimes lead to pressures in decision making on access issues that may not otherwise exist.

It's kind of political now, how does the Secretary approve closing a CBOC when on the front page of every paper there's access issues. So at this point the veterans groups are on board, the local politicians are all on board, the local elected officials, the veteran's service organizations are onboard and we still are not able to close it. So it's a money pit. [F-073]

Providing Access Outside of the VA is Complex and Unpredictable

The importance of local autonomy and the need for centralized processes were referenced as consistent tensions that persist among efforts to improve access.

> They're certainly dependent on how well we're using the scheduling package. I think the scheduling process… And I'm not all that down on the package. I don't think the package is fabulous, and I think we need a new package and it leads to all kinds of difficulties, but I really think our process is unnecessarily complicated and I think we just invite people to do it wrong. Sometimes I guess sometimes deliberately wrong, although I don't seem to run into that very much. Sometimes deliberately… Let's see. What's the best way to say this? Deliberately doing different from what you've been told in the scheduling package but in an attempt to do the right thing for the patient. [F-113]

> Well, I can give you a great example that we do here in XXXX and it really took an act of Congress, actually, to finally allow the business office to allow us to do it. We do not have radiology services here, so we have…our clinic is like two blocks from, it's called XXXX Radiology. It's a very large group that has several locations all over town and so we have built a rapport over the number of years with them that we would send our patients there and before, it was a contract, and so they would contract them. And easy access (inaudible @ 38:01) if there was a question with the order, they call us direct. The providers have a direct link to look up the result in…it's a secure website. If they send somebody for a hand X-ray, then the provider here has access to it. So it was a great relationship. So what happened when the non-VA care and VA Choice, they changed it all around and so all of a sudden, non-VA care, we couldn't have a contract anymore. And so it was horrible, I mean it was a nightmare. July 31 they said XXXX, you can't send your patients to XXXX Radiology anymore. We don't have a contract, it's all going to non-VA care. And so we—oh, gosh, it just gives me chills when I think about it—so anyway what happened was at the beginning, this shows you how things did get straightened out but at the beginning it was terrible because XXXX Radiology were told they would not get paid. The VA actually told them if you do an X-ray for XXXX, you're not going to get paid unless you have this authorization and all this. So we worked till midnight trying to get authorization forms and get a consult set up in the computer. And it was going pretty smooth and all of a sudden Tri-West came in which a third party administrator and they would see our radiology consult and start calling patients and telling them to go other places. Well, an example would be a mammogram. So if I had a

> women's health provider and we have our mammograms done at XXXX Radiology and we know the patients are going there, and Tri West calls and says we're going to send you to [another radiology provider]. We don't know if the picture went there, and we don't know if we're going to get the records. I mean we're talking it was like a major nightmare. And finally we got an agreement through the business office that the third party administrator was not to touch our consult to XXXX Radiology, and that made a huge difference for us so that we were able to continue that relationship. But that's all non-VA care but the way it was set up before with the contracts it was a little bit smoother. We've finally got it smoothed out now. And then on top of it, they didn't pay XXXX Radiology, the fee basis department for care didn't pay Radiology for probably at least 500 denials for claim denials. And at that point XXXX Radiology called me and said I'm not sure we can continue to do business with you because we haven't been paid for like 500 imaging studies. And so I begged. As the manager here I said, oh, I beg you, I beg you, send them to me. I will work on it. I had to look up 500 patients. It was new to our providers, they weren't used to putting in the consult for each one, but instead of the fee basis department, simply looking to see that there was a result there, they just started denying all these claims. So these are the type of things that can really affect the access for the veterans and also affects good patient care. The good news is it's straightened out now after three years, and they have promised us that they will not deny any claims for XXXX Radiology unless they look at it first and then they come to me and if we need a consult, I take care of it and make sure it gets in the computer. But that's just an example of how things can get really out of whack if you don't provide the services on site. [F-250]

A Constantly Changing Process

The constant changing of processes was also referenced as challenges to improving access.

> It's been a real struggle for them to know if they're eligible or not, and the training of the people answering the Tri-West or the VA Choice, whoever—I do not even actually know—who mans that. I don't know if it's a third party administrator manning the call center or if it's actually the VA administering the call center. But that really has to improve. The veterans get a lot of misinformation and the runaround and it's not good because it adds extra stress. So an example is the other day I had a patient call, and he was real upset because he lives probably 45 miles from our clinic, he's an elderly gentleman and it's a hardship for him to drive. He lives past XXXX, which means he has to drive…it's a busy XXXX highway. It's just busy. There's a lot of trucks, he's elderly, and I can completely understand why he may choose to want to go with VA Choice to see a provider in his town, which is a mountain town. And when he called the VA Choice line, first they said you're not eligible, then they said he was eligible, then they said well, you have to drive to XXXX and get a consult for that. That's all wrong. So that is one issue that I think is hurting the VA. If they're going to offer that, they need to make sure that it is well staffed and that people are educated, number one; number two, non-VA care is a huge…it's such a bad thing for our veterans. They go through so much. It's so frustrating, you know, the non-VA care, they need to—if this isn't on the topic, then I'll stop, so I don't want to take you off, but here's the problem, if you want problems, this is the problems we see. [F-250]

> And I'll tell you why I'm not sure. WE changed the system so much, I'm not sure who's happy anymore. When patients got the appointment they wanted, and then there wasn't access there, we measured that. Then all of a sudden we went into recall and now we're not giving them appointments and they're not happy because we're not giving them appointments, we're denying them that until they call in. So I don't know if they're happy or unhappy with the access or happy or unhappy with the process. The telephone lines don't work, so they can't even get calls. So recall doesn't work for that reason. We have 78,000 pending recall appointments in one facility; 78,000. And that's not our biggest one. So you've got a bunch of people trying to call in on phone lines that don't work and are they happy? No. I think they feel they don't have access. [F-141]

A Complicated Process

Not only are the processes constantly changing but they can be complicated, leaving lots of opportunities for things to simply fall between the cracks. For example, some veterans have had problems because they didn't realize that multiple authorizations were needed for multiple trips. Relatedly, some say it results in 'piecemeal' care and doesn't result in the provision of comprehensive care. Notes from one interview highlighted the fact that sometimes, it a patient has Medicare, it can be easier to say "use Medicare" just because it will be a more simple process and the patient may get seen sooner (Notes from F-031). The following illustrates come of the complications faced by Veterans seeking care.

> A lot of it would be with the non-VA care and with the VA Choice, the way that was rolled out. That's been a real…I think it's been a nightmare for many of our veterans. But we are small enough that we work—another we do at our clinic, too—actually monitor to keep tabs on all the different services because we offer audiology, optometry, dental, kinesiotherapy, a large mental health portion with psychiatrists, psychologists, social workers, counselors. We're integrating primary care with mental health. At our clinic once a month we actually meet with every service representative and although we may not be their direct supervisor, as the manager, we meet as a team. And as a team we work to make sure that our veterans are getting what they need, and this may be something might be a little bit unique to our facility, but if our kinesiologist says I need 10 more overbook slots because I'm going to have a group come in, immediately I'll be able to go in and I'll adjust the clinic and add those slots to them. We have such a great working relationship with all the services that we really pay attention to the needs of our veterans here. [F-250]

Going forward, respondents made suggestions regarding how VA access could be improved:

> The only thing with access is that when and if Congress continues to change things, that there be a good time frame to actually educate and train their staff so that when it gets rolled out, it gets rolled out as it was intended and there's not so much ambiguity. .. But when something is thrown out there to happen and—my wife got her Choice card before I even fully understood it as an employee—when things are done that way for political gain it really hurts the VA and it hurts their veterans. [F-102]
>
> I think that by and large, the culture was "We are not really primary care providers, we're a secondary backup system, we're a safety net, and we really need you to

> acknowledge our needs as a system and work yourself around those if you're the patient." I think a culture that says "We're here to do our best to meet your needs, tell us what those are, and we're going to try to help. We're going to try to do that quickly, efficiently, and even if you're being unreasonable, we're going to try to respond to you in a reasonable way." [F-070]

The Mission of the VA is Important and Matters to Veterans

The end of every access interview guide included a question where respondents could indicate anything about access not discussed to that point. Our research team was surprised to note how often respondents took this unstructured moment (or others) to tell us what they thought was most critical about access at the VA:

First, VA staff are committed to veterans, and willing to do more (even for less) to provide access to care for them.

> We take care of some amazing people… (Notes from F-031]
>
> We can do anything in VA and we have a very strong health care system and we've got some very talented people who get paid way less than the community that are dedicated to serving our veterans and there's no greater mission [F-102]

Second, VA staff and facilities are in routine contact with their constituents, providing another layer of access to the system. Certain types of VA facilities are required to have regular meetings, and …

Finally, VA staff indicated that veterans within the VA system have access to something 'special.' We did not come into this analysis prepared to measure—and indeed this may be inherently intangible—the 'specialness' of the VA.

> Well, I'll just lead with one thing that's different when a veteran comes to a VA clinic and it is really different, is that they're treated special. They're just not a patient in a waiting room. They're a veteran. And I think eventually even if the patients decide to use Choice—and I think it's really…my personal opinion—it is nice for the veteran. Some of our veterans have to drive down winding mountain roads. I drive myself because I'm from this area so I pretty much know each route to get here and where the patients live. And so I think that there is a purpose for the VA Choice … But there's nothing like coming to the VA. There's nothing like coming when you are with your fellow veterans, and all the different programs that we offer right on site, and all the activities. We have so many activities here for our veterans. We have our welcome home event. We have popcorn in the lobby, we have snow-cones. Our veterans service organizations throughout the city are so supportive of us. And it's just so nice for our patients because I believe that we really do treat them special.
> [F-250]

But more than anything else, what VA staff wanted *us* to hear is that Veterans aren't accessing *any* health system when they go to the VA. This is a community, dedicated to their well-being.

Appendix E.1.6 Policy Options

Policy Options

Our interviews with VA Central Office leadership, VA providers, VISN directors, Congressional staff, Veterans Service Organization representatives, third party administrators were focused on identifying perceived challenges to VA's capabilities and resources for providing timely and accessible care, and potential approaches to addressing those challenges and improving VAs ability to provide timely and accessible care to veterans. Respondents consistently identified issues and solutions across the categories of **workforce, information technology, private sector care, physical infrastructure, and standardization.**

WORKFORCE

Respondents described various challenges to maintaining an adequate workforce to sustain timely and accessible care, including non-competitive physician salaries, difficulty recruiting providers to rural areas, lack of support staff, national workforce shortages, a burdensome hiring process, and a funding system that lags behind actual demand.

Non-competitive salaries

> But the market… The pay is not comparable in all to the private sector. So I think it's still very difficult to recruit good people with the salary and limitations. [V-74]
>
> It's going to be an issue for VA to attract those types of providers, particularly because of salary rates, special salary rates and etc. that they have. But I think that in order for VA to be a key player in that big arena they're going to have to enhance their salary authorities to be competitive with the private sector. [V-01]
>
> …there are some specialties that we're just not going to be competitive in the recruitment process. So, what's an example? We're not going to be able to pay a neurosurgeon or an orthopedic surgeon what they're making in the private sector. [V-25]

Recruitment difficulties

> Right. And also we had trouble and still have trouble under the Choice Act finding providers in rural areas. And so, it's sometimes, you just can't find anybody to provide the type of care you need within the limits of the mileage that they're trying to provide or closer to home. So that's another issue. [V-74]
>
> And so right now there was five million dollars in the Choice funding to provide for staffing and resources, and so the problem that VA is facing, though, with that issue, they're competing with the private sector for the same resources. And so in rural areas it's a very big issue. Metropolitan cities where—particularly in the specialty care arena—where you have a lack of specialized care; a psychologist, psychiatrist and so forth. [V-01]

Inadequate support staff

> So that our physicians may not have three rooms per physician when they're in clinic they may not have the support staff that allows us to optimize three rooms so we can

move people in and move people out as they're seeing a third patient. So I think that's really the first area I would look at is I think we may have a number of physicians, they may be working X number of hours a day but they may not be as efficient in those eight hours as someone who has more examining rooms or a greater staff to support them. [V-25]

National workforce shortages

Well, there's a shortage…psychiatry is, in terms of the medical professions, psychiatry, it can be difficult to recruit specialty…actually, in the report that was done by VA in terms of looking at its own staffing shortages, psychology was also noted as a difficult to recruit profession. However, more importantly than broad statements like that is the fact that it's really a local problem. There are some markets and areas in the country where it would be fairly easy to recruit a psychologist or psychiatrist of other mental health provider, but there are other markets and the boundaries are probably geographic where it's very difficult. There aren't mental health providers in the community and so when VA tries to either recruit or as we may talk about later when we try and send out veterans or provide veterans through the Choice Act with opportunities to get mental health care in the community, there just aren't the resources. [V-39]

But, you know, it's not easy when now across the board a variety of positions are being recruited by the VA when, frankly, nationally we don't have enough providers for the population in this country. So at some point when VA does pull on additional providers' staff, I think it will be way more difficult to find replacements for people who retire or leave for whatever reason, simply because we don't have enough providers within the country… [V-17]

And because if you look at the overall stats of clinicians in America, it's not just military VA coming into a real shortage, you're coming into a big shortage in a society. There aren't going to be enough providers. [V-16]

Burdensome hiring process

The hiring process takes long everywhere and you do miss some really – you have an opportunity where you miss out on really talented folks because they get tired waiting and then they go elsewhere. So that's very real everywhere. [V-19]

But it takes a while to get awhile to get people on board and spun up, etc. [V-39]

Lagging funding system

So today we get funding, for example, to hire staff or to purchase care or to do whatever, but the fact is those things require a year or two to execute. The budget cycle…when somebody comes in in June and gives you three billion dollars, let's say—I'm just making that number up. I think the number was five billion—and they say, "Oh, by the way, you should execute this by October"…even though you may need that, the responsible person can't do that in a responsible way. So I think some of the dilemma at this point is not that the VA has been slow to respond; I think the VA has been very active and very aggressive in responding, but it takes a while to get things in place to really start to affect a change, which I think there has been some changes made. [V-39]

> We use Verifunding, so your funding is a population based funding that trails by, I think, two years. So you have a growing population but that growing population, you don't get the funding for that for two years. If you had the funding for it, you can't hire the people you need there, and you have a growing demand. [V-39]

Overall Issues

> What about our systems that... You know, it's not that we can't necessarily recruit, can we successfully recruit? So, how long does it take to get a primary care provider credentialed and privileged in the VA? How long does it take them to get appointed? And are they out there? Are we paying them? We each got a small increase in primary care across the country for physician pay. Can we pay them the market value? That has to be fought locally, because we're geographic. It's based on the market. I think the idea that staffing comes into play and can support access is critical and it can't go away. That's a critical aspect. [V-43]

> So we knew we had some problems the VA's been struggling with for a long time. Lack of providers in the system and the challenges in recruiting and retaining providers in VA, lack of providers, period, in the country. That definitely makes it a challenge. And also the lack of space and those kinds of… the infrastructure and the sort of supporting considerations that make it more difficult to get folks in. [V-14]

Possible solutions to addressing workforce challenges described by our respondents include:

Use of partnerships to augment VA workforce

> I think there are some opportunities for us to partner with academic medical centers and our academic affiliates to help recruit qualified and competent specialists, but specialists who may be interested in education or research, and may not be able to get that protected time if they're in the private sector. So one option is to look at your partners and see how you can leverage partnership and what we have, which is the combination of clinical care, research and education with a specialist interest. [V-25]

> I think one of the things we haven't looked at, we've focused on our academic affiliates in larger communities but I think one of the things we haven't done is look at are there ways we can partner with community hospitals in facilities, in towns that don't have an academic affiliation so that much like we partner with an academic affiliate, we partner with a community hospital and maybe between us we could buy somebody that neither of us individually can buy alone. And I think for some of our smaller facilities, and for some of the smaller communities, that's a real opportunity, it's win-win for both. [V-25]

Use of non-physician providers to augment VA capacity

> We in some facilities, in some clinics, there might be or there might have been usage when it was more difficult to get physicians to hire nurse practitioners or physicians assistants, and that tends not to be the case in VISN XXXX because we can hire physicians. But at times in some of our locations we will also utilize nurse practitioners and physicians assistants. [V-17]

> There aren't going to be enough providers… Particularly the nurses, and that's why many states are now giving much wider range of practice to nurse practitioners. Many will probably follow with PAs, giving them a wider scope of practice. [V-16]

Raising salaries to be market-competitive

> But I think that in order for VA to be a key player in that big arena they're going to have to enhance their salary authorities to be competitive with the private sector. [V-01]

> We've pushed them to make special exceptions so that they can increase the base salary for psychiatrists and so we can recruit more psychiatrists. [V-14]

Respondents also noted that even with increased hiring of providers, optimal provider productivity is dependent on other factors; e.g.: enough space, enough support staff, etc.

> Staffing has a downstream cost, right, so you hire more staff; you have to have more computers, right? You have to have, for higher, faster access. You have to have more buildings. So it creates another host of things. But I like the idea of thinking about measures as signals for the organization to keep tabs of what's going on. [V-39]

> I'm going to start with space because as we have looked at comparisons with the private sector, we have been told, "you're only seeing 10 patients a day but the private sector can see 33 patients a day." I think that ties to the fact that we are not set up as a fee-for system, fee-for-service system, we are set up as an accountable care organization so that we don't necessarily staff to optimize our productivity. So that our physicians may not have three rooms per physician when they're in clinic they may not have the support staff that allows us to optimize three rooms so we can move people in and move people out as they're seeing a third patient. So I think that's really the first area I would look at is I think we may have a number of physicians, they may be working X number of hours a day but they may not be as efficient in those eight hours as someone who has more examining rooms or a greater staff to support them. [V-25]

INFORMATION TECHNOLOGY

Respondents described various challenges to leveraging VAs IT infrastructure to support timely and accessible care. These relate to an outdated and unnecessarily complicated IT systems, particularly related to scheduling software, lack of interoperability of the electronic medical record, and separation of the IT organization from VA healthcare delivery and operations. Tele-health was consistently raised as a potential solution to increasing VA's capability to provide timely and accessible care, although some issues such as ensuring IT support and budget were raised as considerations salient to the success of tele-health.

Outdated IT systems

> One not surprisingly, and one that I'm sure you have heard from others, is the totally outmoded and inadequate scheduling package, as well as some other IT packages that we are using that need to be upgraded.[V-17]

> There's no good excuse that at a higher level in our organization, the upgrading and modernizing our IT systems has not occurred. [V-17]

> You know, I didn't think I needed a person to walk me through the system. So we just need to simplify it. The same with the scheduling package. Make it such that, you know, a not very bright person could figure out how to do it. And we in VA seem to do just the reverse of that. [V-17]

Our scheduling package is, you know, 25 years old. When XXXX talks about multiple modalities care, what you might not realize is that in the VA every single modality has to have a different scheduling grid. We can't see all of them together. So, if you're a clerk and your provider has telephone care and they do some Telehealth and they have secure messaging time or whatever, all of that is on a different scheduling screen. You can't mesh and see an overlay. So the work of primary care, the sheer work of it locally, is almost overwhelming. [V-43]

Lack of interoperability

I used to believe that we should have an integrated medical record, but now that I am dealing with the DOD, I understand. Think about this. In today's atmosphere, where the Department of Defense computer systems are the last think I want to have hacked. Then you have an insecure, it has time and time again been proven that the VA's Internet is not secure. Time and time again. We actually briefed the Secretary on this. So, I sit there and say, "No wonder DOD doesn't want us to have direct access." [V-28]

We have a hard enough time sharing electronic medical records within the VA. Only recently has it become somewhat seamless. But now when we try to expand that between DOD and VA, we're having a huge problem which reflects primarily on the claims side of the house. But it also reflects on the healthcare side. So if we can't get two sister government organizations that are funded by the same funding source, to get on the same electronic health care record system, there's not going to be possible to get the civilian population to work in a comprehensive manner, in a seamless way. [V-01]

Organization of IT accountabilities

Well, I think that one of the barriers is several years back, I don't remember exactly when, there was a reorganization when IT was separated from VHA. IT is a separate silo in VA and I think that, quite frankly, had the IT community were divorced from the healthcare mission in VHA. It's noticeable at facilities. Just the development of the electronic health record, which occurred in VHA, occurred with developers in medical center settings working with clinicians to pull together an electronic medical record that met that needs of clinicians, and that was enormously successful. That ability to work directly with developers has been eliminated. The organizational separation has cast IT out of its support role. IT is a support service, it's not its own entity, and the separation that we have currently, like it's a separate entity and it's not in support of the agency mission, certainly for VHA it's not in support of the VHA health care mission. [V-17]

They don't get it that healthcare mission trumps all, and that's manifest in ways like shutting down a service without adequately consulting with all of the people who are involved, so that you might have patients coming in who are scheduled for care, and the clinicians will find that, oops, that service has been shut down or, you know, utilities have been shut down without recognizing that when work needs to be done, it's done after hours, so that part of your goal is to minimize or eliminate disruption to actual healthcare service. But now with organizational lines being what they are, there isn't that kind of collaborative working together. [V-17]

I don't know a lot about what we're doing with IT. IT, as you know, it's separate from VHA now. When it went separate, we kind of seemed to lose control over what—that's actually one of the barriers. When it used to be under VHA, it seemed like we could do

things more locally, and yet, when you talk to IT, they're saying that VHA, this is what they sent us as their priority. So we do send up our priorities but it seemed like that at like a VISN level or medical center level, you lost any kind of ability to get any IT projects done. It has to a roll up at the VA level. So it was quite challenging. [V-74]

Tele-Health as a solution

I think one of the things as an overall system that maybe we're a little slow in doing but is a tremendous opportunity is our use of tele-health, tele-medicine, which is something that I've been in discussion with that office in terms of how do we develop a better set of business rules and processes, so, for example, if you're in a part of the country that can't hire a provider or find a provider, if that examination can be done via tele-health with, let's say, a part of the country like our part of the country. We can even buy the provider, if you will, and then develop that tele-health relationship, so I think we need to do more of that. [V-19]

One is that it's hard to hire dermatologists. They're expensive, and I think a lot more people need to see them almost like primary care. I don't know about you, but I know when I was growing up we used to slather baby oil all over ourselves, put ourselves out in front of the sun, and there was probably a lot of skin cancer lurking out there. But they're pretty expensive. There's some dermatologists who are largely involved and build a very lucrative practice just around doing cosmetics related things. So dealing with some serious skin illnesses, they're not that easy to recruit; Q - Right. Okay. Excellent. So telehealth also potential in places where you're slightly understaffed. [V-17]

We just did our first C&P exam through tele-health and it was really tremendous because this was one of the most longstanding wait for a C&P exam for mental health for a homeless veteran, and part of the reason was because of having to track down the veteran and then get having to get him to a provider, a C&P provider. It's a difficult population sometimes to engage, but we were able to get the veteran to the medical center. It happened to be here in the XXXX and then do the whole exam through tele-health and the exam was done and completed with results within just a couple of hours. [V-19]

Our goal in thinking about access is to make sure that the veteran has access to the care that he or she needs in the time that they need it. And so the challenge then is to look at things like telemental health. There may be a mental health provider in the clinic, but maybe they don't provide the kind of service that the veteran needs, so it's not just looking at if there's someone on site, but if there's someone on site who can provide the care that the veteran needs. [V-39]

So I think there's a lot of opportunity in virtual care. It has the advantage that I don't need to have a capital infrastructure in a lot of cases. I don't need to have three rooms per patient. And so it makes the use of my resources more efficient. And it's more convenient for the patient and in some cases they can be handled by individuals who don't have to be a doctor. So you've got the advantage of being able to effectively use differing levels of resource. Nurse, physician, nurse practitioner. You've got the ability to use your capital infrastructure in a different way and you've got the ability to provide services at different levels. And maybe they just want to ask a question and you've got the answer in some sort of reading material and that's all they want. [V-25]

> I think the second prong is the expanded use of telemedicine. If I'm remembering correctly, I think close to 40 percent of our patients now, we're touching, if you will, with some mode of electronic communication, be it clinical video telehealth or secure messaging with their providers. And that's, I think, going to continue to be a critical part of the process or the solution to providing more accessible care to people. [V-18]

Enthusiasm from our respondents for tele-health as an opportunity to provide timely and accessible care was tempered by various considerations to ensure success of tele-health, including the need to sort out coding/billing and workload issues, ensuring adequate IT support, and training, space and equipment needs.

Coding/Billing and Workload

> I don't think it's clear for folks how do we establish these maybe service agreements between two networks or two facilities? One is we have to make sure that whoever the provider is doesn't have … that's there's no insurance issues for providing to another state or to another facility. I think there's still some question about that, that they have capabilities to get into the CPRS record, so most of it is technological processes, but in addition that, the provider, there's no problem with the provider being boarded and whatever competencies that they have is transferable across state lines and across another facility, capturing the patient. How does that impact VERA allocations, for example, in cases where we buy the provider, meaning that we hire a provider for another facility? How do we work out those cost transfers? None of this is insurmountable and it's certainly being done; it's just if we could do it in one sort of standardized way, it wouldn't be so onerous every time you want to set it up. And I think that if there was these standard processes, sort of just a rule book to this, then facilities would be more inclined to get it started. [V-19]

> So just the fact that we might not be able to bill for these services because their coding structure's still being developed is one thing. Another thing is, say you're seeing a patient. You're in Atlanta and the patient is four hours away in a different state, and you're not credentialed. The credentialing and privileging has been a real challenge because, even though we're a federal system and our docs do not have to be credentialed in the state—so they don't have to have state credentialing and privileging done—they do have to have it at the facility that they work. And so they may be a seeing patient that's not in their facility, and we run into issues with that. So how do we have that provider have the credentialing and privileging. Those are things they're working out. [V-74]

> Coding and billing issues is a big issue. We need to develop some sort of, you know, there has to be coding that's developed in a streamlined way that would enable workload credit to be accurately obtained for providers, whether it's in a medical center or a CBOC clinic or a home. [V-19]

> They're looking at the stock codes with the decision-support folks to try to get the workload issues resolved and being able to keep track of the workload. To me, like even if we can't track our workload and we can't bill for it, we can still provide it. It's just the VISN directors and the facility directors I was going to say, but where we going to get the money for it if we don't have a way to get VERA, which is our payment allocation

system. If there's no credit in VERA, we're not going to get that reimbursement. So yeah, there are a lot of issues that still need to be worked out. [V-74]

IT support

The challenge with it, frankly, I think, is IT, first of all, and making sure that we have good IT support and good IT budget. [V-18]

I think some the barriers that we still run into is having enough bandwidth, you know. I went out for a visit to XXXX, so they're very rural areas, and I complimented them for their work with Telehealth because they really started to use it and increase it. And they said, "You know, if you could get us more bandwidth, it would really help." And I had not realized they would be struggling with something like that, because everybody has a cell phone and cellular FaceTime. But people, like all across the world, have it, so you wouldn't think about in the United States we still have areas where they don't have—they can't reach in some of these isolated areas. So those are challenges, but they certainly can be overcome. [V-74]

Training, space and equipment needs

Not all providers are trained in the use of tele-health, although I think some of the younger providers have been and the more we use tele-health and normalize it, including with our medical students, the more buy-in we will get. In some cases there's a lack of space so you still need space to provide tele-health, like an office with the equipment, but in terms of the challenges, we need sort of a – this one was interesting. A tele-health help desk for Veterans particularly because we could do video to home which provides an alternative to in person clinic care, particularly for Veterans who can't, you know, for a variety of reasons, do a far distance to get to a facility or to a provider, but they just would need, like, a Help desk in order to help them set it up. We need more clinical engineering support. We've had some great support here in VISN XXXX, but we need to build it into our engineering support so that when we develop office space, for example, it supports tele-health and the equipment. We need to invest some resources for virtual care if we want to move out of bricks and mortar, and some of that would be a greater focus on the business aspects of tele-health through data analysis. [V-19]

PRIVATE SECTOR CARE

Respondents also discussed a range of challenges to efficiently utilizing the private sector to provide care to Veterans, including whether or not there was adequate capacity outside VA, the lack of standardization in rules, processes and utilization of existing community care programs such as PC3 and CHOICE, and the fact that community providers often were not reimbursed in a timely manner, reducing their participation in the network and therefore reducing overall capacity. The most consistently raised issue was the lack of standardization across community care program.

Lack of standardization in the use of existing programs

But right now you have these different methods of non-VA care which are actually competing against each other. You've got the local contracts, some of them that are paying extremely high rates, Medicare plus 140%—a high rate of coverage. And then you've got PC3 which, you know, the contractors are negotiating with individual

providers, so it's Medicare usually plus a discount based on the population of providers, the availability of providers. I guess XXXX they can get a higher—a better discount rate versus XXXX or something like that. And then you've got Choice which is also kind of wrapped into PC3, network versus non-network. You know, network is at the PC3 rate, non-network is Medicare rate. And then you've got your one-off individual referrals which we don't know what those are going at. So they're all competing against each other and some medical centers, like, well, we've always contracted with this facility, we use them all the time. Why should we go with this other provider? And then you look at the providers in the communities, well, why should I go PC3 if I can stay here on this contract that pays significantly more? So there's got to be kind of a one pathway forward that compensates providers adequately to encourage them to participate, but then is also fiscally responsible on the VA side. [V-08]

So there's just a confusing process system, there's no standardized process across—every medical center is different. Sometimes VA uses that as a point of pride that everyone's different but in some ways that lack of standardization on just some basic business processes allows for just a lot of blocks and a lot of (instances [inaudible] @ 0:31:02) and a lot of frustration on the vets' part especially if the veterans are just (inaudible @ 0:31:06) or things like that. And I understand the need for flexibility and diversity between the medical centers, you know, different regions have a different flavor and they also provide different services. But if the skeleton of the system is consistent across the system then there aren't so many opportunities for confusion or not—you know, just—I don't know—manipulation is (the only word that [inaudible] @ 0:31:43). [V-08]

VA begrudges the existing contracting authorities. They don't like PC3, they don't like the ARCH program, they're resistant to use it, and we're angry about that because we consider it to be a great program. They consider it to be an inconvenience. But what we're finding is they are exuberant about the Choice card. So we're a little confused about that and if it's nothing more than from a sales position, we have to get VA to buy into using their contracting authority. [V-01]

Confusion regarding existing programs

And through our whole, non-VA care, PC3 and Choice, the communication process has really been a challenge. My perception, this is my opinion, we have focused more on the business aspect of that model than we have on the clinical aspect of that model. So that is, how do I get somebody out? How do I get information and appointments scheduled? How do I get a bill from that person? How to I pay that bill and how do I close that encounter? The concept of actually getting something back and getting it to a provider as a useable piece of information isn't always something that's been stressed. [V-25]

So yeah, I can think of a few things that really, really make it difficult. For instance, to get the care referred in the community, there's a bureaucratic piece to that, so the veteran just can't go, even with the Choice Card, and go and just say, "Here's my insurance card. Take it." There has to be a list generated that says that this veteran is eligible and you'd have to check all the rules and the mileage. [V-74]

One of the biggest barriers is how they apply the 40 mile rules, the criteria which we all know. But then if they live close to a CBOC and they're directed to that CBOC, when they call the CBOC and they need some care other than primary care and they can't

provide that care, then they're directed to the parent facility and the parent facility in some situations can be a three hour drive one way. [V-01]

One of the veterans also—they're confused on all of that stuff as well. What we've seen is the episode of care component is so in the weeds that they haven't even gone past the first several layers of confusion. No, I'm serious; like they haven't. I'm just going to rattle off some stuff; this is not scientific, not just because it's printed off on a piece of paper. So we had—these are confirmed members of our—so they're confirmed veterans, 226—this will roll over and I can provide this later. But 44% of our roughly 227 folks that have done this said the current eligibility requirements for Choice don't apply to them. Two of three said they had received a Choice card in the mail. Ten percent didn't know. And I can go anecdotally as well across the VSOs as well as veteran friends and neighbors; it's just so confusing. [V-09]

Community provider reimbursement

The reason also, it needs to be directly connected to immediate payment. A lot of docs won't go anywhere the Choice program because they've had the experience with fee basis of having to wait forever. And they're cash flow, they're still paying their people, and so they're just not going to deal with it. They won't take them because VA's sorry, sorry record of not paying, and I'll use as an example something that's gone on for a very long time. [V-16]

If you're service connected disabled, and/or you're just part of VA and you're nowhere near a VA hospital and you have an episode like you're having a heart attack and you go to the nearest hospital and they get you through the first 48 hours and then transport you by ambulance to a VA hospital, and they send the bill to VA, VA doesn't pay it, eight times out of 10. So what happens is ambulance services don't want to transfer for you anymore because they run on an even thinner margin than the hospital. The hospitals don't want to take you unless you have private insurance, because they're already swamped with indigent people in their emergency room. [V-16]

VA's reputation for payment stinks and it has…it's gotten no better over the last 30 years and it's something we've come back and come back to the Congress and the VA [V-16]

So, I would say that the biggest problem now with purchased care, across, is that a lot of the people who are providers and have been for some time are backing out because they have not been receiving their money, their reimbursement, in a timely manner. And why that happens, I do not know. [V-28]

STANDARDIZATION/CENTRALIZATION

Respondents also highlighted the lack of standardization of administrative processes and lack of centralization of authority as a key challenge to efficient delivery of care.

Specific to the VA, I mean, having been in DoD and VA I think it's that lack of the skeleton, that lack of underlying standardization that really kind of feeds this, you know, the one-off. And I know probably—"Well, if you've seen one VA you've seen one VA," that whole statement I find very offensive. It's like why do you have to keep buying into this idea that every medical center has to be different and when it's that different, there is no chain of reporting, there is no clear cut line of authority. I mean, you go around

> asking who's in charge of the homeless program here? At one VA it's the mental health director, one of them it's the chief of staff, another one—so you never know who's in charge. Who's in charge? Who do I talk to? Having been in DoD, you go to an Air Force Base, doesn't matter what airplane is on the ramp or what the mission is, I can go on base, I know exactly where base ops is, I know exactly who's in charge of the landscaping, I know exactly who's in charge of the control tower, I know exactly where the flight (kitchen is in relation to… I mean, it doesn't matter what's going on; that base is all skeletons there, that kind of standardization. And when directives come down or things like that then everyone at least follows them. And then you have latitude to be flexible, actually you have more latitude to be more creative around the edges, so you're not worried about all the kind of minutia. I think that's probably in my mind one of the biggest challenges with VA, is it's too many—152 little VAs that aren't reporting to each other. [V-08]

> Let me just say this. There is no standardization in VHA. No. There is a lot left to the discretion of the medical center director and/or the chief of staff. That's probably the biggest problem in VA because if you are thinking that you're going to get the same care in the XXXX VA that you're going to get in XXXX, they are both VA MCs, but the care if very different. [V-28]

> So when you contract for services you have to abide by contracting rules and VA some years ago centralized this contracting process. So through that centralized process, it's limited local contracting officials' abilities to meet the needs of the local health care facility. And so it has to follow all the way up through central office. And it doesn't follow the principle of health care is local. And so they need to reexamine their contracting process to minimize it and ensure that local contracting officials have the ability to do what they need to do within the confines of law to meet the needs of local veterans. [V-01]

PHYSICAL INFRASTRUCTURE

Respondents commonly described the lack of physical space, particularly exam space for provider to see patients in and a lengthy and burdensome leasing and contracting process, as key challenges related to VA's physical infrastructure for providing timely and accessible care.

Lack of space

> And also the lack of space and those kinds of… the infrastructure and the sort of supporting considerations that make it more difficult to get folks in. [V-14]

> You know, VA says we don't have the space. They have space. If you go to some of their facilities they have an awful lot of admin space. Their executive suites are rather grand. And I understand the need for having multiple exam rooms where a doctor doesn't have to wait until that exam room is empty before they can go back in there, I get that. And that's why we gave $2.5 billion for that kind of improvement. I'm a little concerned that VA is not utilizing even kind of immediate solutions, you know, mobile exam rooms, kind of like the schools. [V-08]

> So the challenges, of course, with our infrastructure is that many of our buildings are old. And whether we want to rebuild, renew buildings that are... A lot of them were built before the 50s, and so they're needing a lot of care if we're going to continue with

> those buildings. The other thing that folks I know in the field have said there was some sort of limit on being able to lease space too, so there was like we had to decrease our leasing of space, footprint. We have a declining infrastructure... [V-74]

Space in the context of provider efficiency

> And they said it could be much more efficient if each physician had two rooms so they could see the patient, and the next patient is getting ready, go to the next room. We don't have that. I don't know anywhere that actually has that model because of our limited space. They normally have one room and they have to wait for the new patient to get in there and get ready. So space has been a real constraint with access, and I don't know the clinical people talk to the space people. I'm really not sure about that, because those are two very separate areas in Central Office. [V-74]

> I'm going to start with space because as we have looked at comparisons with the private sector, we have been told, "you're only seeing 10 patients a day but the private sector can see 33 patients a day." I think that ties to the fact that we are not set up as a fee-for system, fee-for-service system, we are set up as an accountable care organization so that we don't necessarily staff to optimize our productivity. So that our physicians may not have three rooms per physician when they're in clinic they may not have the support staff that allows us to optimize three rooms so we can move people in and move people out as they're seeing a third patient. So I think that's really the first area I would look at is I think we may have a number of physicians, they may be working X number of hours a day but they may not be as efficient in those eight hours as someone who has more examining rooms or a greater staff to support them. [V-25]

Difficulties with leasing/contracting space

> But I was saying, okay, maybe it would be better than rather us trying to build a crumbling building, that we rent a floor in the local hospital. You know, we lease space there and we take care of our patients there, but in a brand-new community hospital. And they said there had been a limit to leasing any new space, and they were very challenged by that, the people who, even to start a new clinical outpatient... It has to all be approved. Well, it has to be approved by the capital assets management group here. [V-74]

> I mean, a real difficulty is that it takes us so long for getting anything through contracting. It's just crazy when you look at trying to expand. When you look at the need for an additional clinic space, it's several years before you can open it. And, you know, right now that's particularly frustrating because here we've been given the dollars, we've been given to hire additional staff and in many cases people think, where am I going to put them. I need leased space if just to move some administrative activity out of the medical center, so I can then sort of fix the space, convert the space for clinical use, and it just doesn't happen because of the need to go through contracting. [V-17]

I would start with our leasing program, which again, impacts our plans for our community outpatient clinics. It really needs a fresh look. It's a very cumbersome process that takes a lot of time. It's a very layered process from all the multiple approvals. Each takes time to get through. It creates, in essence, a multi-year planning cycle, so you need to know what it is that you want and you need to start working for it at least three years ahead of time in order to get through the process. [V-18]

This page intentionally left blank.

Appendix F Access

Appendix F.1. Geographic Access to VA Services for Overall Population

Tables F-1 through F-9 show various measures of access to the VA health care system. After a total count of Veterans, enrollees, and health care users (defined as enrollees who have used the VA health care system) in Table F-1, we show access to all VAMCs (Table F-2), to VAMCs by complexity level (Tables F-3 through F-6), to health care centers (Table F-7), to multi-specialty CBOCs (Table F-8), and primary care CBOCs (Table F-9). The access tables all show access by enrollees and health care users, with access defined as a 40-mile driving distance or 60-minute drive time. All tables show summary figures as well as by VISN.

The source for Table F-1 was the VA Planning Systems Support Group (PSSG) Enrollee file. Tables F2-F9 contain RAND estimates produced from VA Planning Systems Support Group (PSSG) Enrollee file and an April 2015 extract from the VA Site Tracking (VAST) system.

Table F-1. Total and VISN Veteran Population by Enrollee and User Status

	Veteran Pop. (N)	Enrollees (N)	Users (N)
U.S.	21368522	9026767	5786669
VISN			
1	959743	367854	237294
2	450596	204941	123698
3	764042	302953	152623
4	1216068	469282	296206
5	702133	241306	125886
6	1261715	536919	346029
7	1350711	605367	390548
8	1596447	762264	531237
9	925532	418979	280337
10	810589	331940	217645
11	1147262	418686	272889
12	894325	361127	238743
15	820654	349577	231933
16	1628522	731008	479801
17	1017808	461462	286190
18	857342	386064	251107
19	709427	298056	188666
20	1082702	430210	277572

	Veteran Pop. (N)	Enrollees (N)	Users (N)
21	980468	390830	246195
22	1243889	513541	302547
23	948547	444401	309523

Table F-2 Geographic Access to VAMCs

VISN	Choice Eligibility	VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	163	55.3	60.9	53.8	59.4	41.4(39)	51.9(45.3)
	Eligible for choice	163	0	0	0	0	91.7(38.6)	117.3(45.7
	Not Eligible for choice	163	59.6	65.1	58.3	63.7	16.5(10.5)	25.3(14.9)
1	All	11	72.6	79	72.1	78.2	28.1(26.3)	36.4(30.8)
	Eligible for choice	11	0	0	0	0	97.5(42.1)	119.2(46.2
	Not Eligible for choice	11	75.4	81.6	75.3	81.2	17.1(10.9)	25.6(14.9)
2	All	6	65.2	71.8	66.3	72.8	35.9(32.6)	46(36.8)
	Eligible for choice	6	0	0	0	0	97.4(36.2)	122.1(45.5
	Not Eligible for choice	6	67	73.6	68	74.4	18.3(11.5)	29.1(16.5)
3	All	9	88.5	91.8	87.5	90.9	13.7(14.5)	19.4(17.3)
	Eligible for choice	9	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	9	88.6	91.9	87.5	91	10.7(8.9)	16.8(12.1)
4	All	11	64.2	75.7	64.5	75.9	30(22.9)	39.3(28)
	Eligible for choice	11	0	0	0	0	63(20.4)	83.9(28.4)
	Not Eligible for choice	11	65.5	76.8	65.8	77	17.1(11)	28.1(16.6)
5	All	4	82.7	85.1	80.5	83	23.7(22.7)	32.8(29.7)
	Eligible for choice	4	0	0	0	0	52.2(12.3)	64.8(17.9)
	Not Eligible for choice	4	83.6	85.5	81.3	83.5	16.2(10.4)	23.7(13.7)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	10	45.9	49.9	46.1	50	51.4(35.5)	65.6(43.2)

VISN	Choice Eligibility	VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	10	0	0	0	0	73.3(21.4)	96.5(28.7)
	Not Eligible for choice	10	50.1	53.7	50.4	53.9	17.9(10.7)	27.6(15.3)
8	All	7	44.6	48.5	44.1	48.1	49.3(40)	57.8(43)
	Eligible for choice	7	0	0	0	0	96.9(35.6)	126.4(38.7)
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	8	43.4	50.8	44	51.2	55.8(41.6)	67.7(46.9)
	Eligible for choice	8	0	0	0	0	92.7(29.4)	115(32.8)
	Not Eligible for choice	8	49.3	57.1	50	57.5	15.9(10.4)	25.9(16.1)
10	All	4	52.3	60.5	51.5	59.9	36.4(26.2)	47.1(31.3)
	Eligible for choice	4	0	0	0	0	55(12.1)	79.5(16.8)
	Not Eligible for choice	4	52.7	60.9	51.8	60.2	17(11.3)	27.4(16.1)
11	All	8	49.6	55.3	48.7	54.1	46.4(37.7)	56.7(42.6)
	Eligible for choice	8	0	0	0	0	84(37.8)	102.4(44.5)
	Not Eligible for choice	8	53.3	58.2	52.2	56.9	18.3(11)	27.5(15.6)
12	All	7	61.2	67.9	58.6	65.2	33(33)	42.2(42.3)
	Eligible for choice	7	0	0	0	0	86.1(32.3)	125.3(49.2
	Not Eligible for choice	7	64	70.8	61.6	68.4	15.8(10.6)	22.6(14.2)
15	All	9	53.5	57.6	51.4	55.5	46.3(41.5)	59(50.8)
	Eligible for choice	9	0	0	0	0	94.9(36.1)	123.2(46)
	Not Eligible for choice	9	59.6	63.4	57.5	61.4	15.8(10.3)	23.4(14.9)
16	All	10	36.7	40.9	36	40.4	63.6(45.5)	76.9(51.6)
	Eligible for choice	10	0	0	0	0	87(30.3)	112.2(40.3
	Not Eligible for choice	10	41.2	44.8	40.6	44.4	17.4(10.5)	27.3(15)
17	All	6	57.1	65.1	56.8	64.2	49.2(42.7)	59.3(47.2)
	Eligible for choice	6	0	0	0	0	91.2(38)	116.1(43)
	Not Eligible for choice	6	62.7	70.5	62.5	69.7	20.9(10.5)	30.5(13.9)
18	All	6	55	57	54.4	56.4	50.2(54)	62.9(60.5)
	Eligible for choice	6	0	0	0	0	110.5(46.1	137.9(51.5)
	Not Eligible for	6	60.9	62.8	60.4	62.2	15.7(9.3)	24.6(13)

VISN	Choice Eligibility	VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	choice							
19	All	6	41	46.5	40.6	45.8	58.7(55.6)	69.1(60.2)
	Eligible for choice	6	0	0	0	0	131.5(49.5	154(53.6)
	Not Eligible for choice	6	48.7	54.5	48.7	54.1	16.1(10.3)	27.2(15.1)
20	All	10	61.1	65.4	60	64.2	40.6(40.2)	53.6(50.9)
	Eligible for choice	10	0	0	0	0	94.2(35.1)	126.8(48)
	Not Eligible for choice	10	70.3	73.8	69.2	72.8	15.5(9.7)	24.3(13.9)
21	All	7	60.6	65.2	58.4	62.8	33.5(33.5)	45.7(39.8)
	Eligible for choice	7	0	0	0	0	96.8(48)	130.1(54.2)
	Not Eligible for choice	7	62.9	67.6	60.8	65.4	16.7(9.8)	26.9(14.4)
22	All	6	79.3	85.5	78.4	85	26.1(27.6)	32.5(32.9)
	Eligible for choice	6	0	0	0	0	95(34.2)	122(42)
	Not Eligible for choice	6	81.6	88	80.6	87.4	16.6(8.8)	22.8(11.5)
23	All	10	40.6	44.1	39.6	43	59.2(48.1)	74(56.9)
	Eligible for choice	10	0	0	0	0	95.5(38.6)	123.2(45.9)
	Not Eligible for choice	10	51.8	54.7	50.8	53.6	15.4(10.4)	24.1(15)

Table F-3 Geographic Access to VAMC Complexity Level 1 or 2

VISN	Choice Eligibility	Level 1 or 2 VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC complexity level 1 or 2	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	129	50.9	56.6	49.3	54.9	44.8(42.7)	54.9(48)
	Eligible for choice	129	0	0	0	0	97.6(42.2)	122(47.7)
	Not Eligible for choice	129	54.9	60.5	53.3	58.9	16.6(10.6)	25.4(15)
1	All	8	60.3	72.2	60.2	71.5	33(27.9)	41(32.1)
	Eligible for choice	8	0	0	0	0	97.5(42.1)	119.2(46.2)

VISN	Choice Eligibility	Level 1 or 2 VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC complexity level 1 or 2	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	8	62.7	74.5	62.9	74.2	17.7(11.5)	27.5(16)
2	All	5	60.2	65.6	61.3	66.4	38.8(34.4)	50.4(40.7)
	Eligible for choice	5	0	0	0	0	106.8(31.4)	135.3(40.5)
	Not Eligible for choice	5	61.8	67.2	62.8	68	18(11.5)	28.6(16.7)
3	All	7	82	86.2	80.4	84.8	15.7(17.7)	21.3(20.3)
	Eligible for choice	7	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	7	82	86.2	80.5	84.8	10.7(9.1)	16.8(12.4)
4	All	7	55.6	65.6	54.8	64.5	36.2(29)	46.1(34.2)
	Eligible for choice	7	0	0	0	0	69.6(25.1)	91.7(33.6)
	Not Eligible for choice	7	56.7	66.4	55.9	65.4	17.6(11.1)	28.6(16.6)
5	All	4	82.7	85.1	80.5	83	23.9(23.3)	32.9(29.9)
	Eligible for choice	4	0	0	0	0	53.1(13.6)	66.2(19.3)
	Not Eligible for choice	4	83.6	85.5	81.3	83.5	16.2(10.4)	23.7(13.7)
6	All	7	50	59	48.5	57.7	49(34.8)	61.3(41.7)
	Eligible for choice	7	0	0	0	0	70(24.6)	93.7(33.4)
	Not Eligible for choice	7	54.6	63.5	53.3	62.3	20.9(11.1)	33.2(15.8)
7	All	8	43.6	48	43.5	47.8	55.1(37.5)	70.2(46.8)
	Eligible for choice	8	0	0	0	0	82.3(28.2)	108.1(37.2)
	Not Eligible for choice	8	47.7	51.6	47.6	51.6	18(10.6)	27.8(15.3)
8	All	7	44.6	48.5	44.1	48.1	49.3(40)	57.8(43)
	Eligible for choice	7	0	0	0	0	97.9(36)	126.6(38.8)
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	8	43.3	50.5	44	50.9	56.1(41.9)	67.9(47.2)
	Eligible for choice	8	0	0	0	0	93.4(29.3)	115.6(33)
	Not Eligible for choice	8	49.2	56.8	49.9	57.2	15.9(10.3)	25.7(16)
10	All	4	52.2	58.8	51.3	58.1	37(26.7)	47.6(31.5)
	Eligible for choice	4	0	0	0	0	55(12.1)	79.5(16.8)

VISN	Choice Eligibility	Level 1 or 2 VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC complexity level 1 or 2	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	4	52.6	59.2	51.7	58.4	17(11.3)	26.6(15.6)
11	All	6	42.1	47	41.1	45.8	56.2(46.9)	64.7(48.7)
	Eligible for choice	6	0	0	0	0	99.9(48.8)	113(50.9)
	Not Eligible for choice	6	45.2	49.6	44.1	48.4	17.5(10.6)	26.7(15.6)
12	All	4	52.9	62.8	49.9	59.5	37.1(39.4)	43.3(43.1)
	Eligible for choice	4	0	0	0	0	106.7(44)	131.2(46.2)
	Not Eligible for choice	4	55.3	65.5	52.5	62.5	16.2(11)	23.6(14.9)
15	All	8	51.7	56.1	49.4	53.8	48.9(44.1)	61.3(53.5)
	Eligible for choice	8	0	0	0	0	98.6(37.7)	126.4(47.6)
	Not Eligible for choice	8	57.6	61.8	55.2	59.6	15.6(10.2)	23.3(14.8)
16	All	7	31.1	34.7	30.2	33.8	75.6(54.2)	88.1(58.8)
	Eligible for choice	7	0	0	0	0	100.1(39.6	124.6(49)
	Not Eligible for choice	7	34.9	37.9	34	37	17.7(10.3)	27.4(14.8)
17	All	6	57.1	65.1	56.8	64.2	49.3(42.9)	59.5(47.4)
	Eligible for choice	6	0	0	0	0	91.5(38.4)	116.4(43.3)
	Not Eligible for choice	6	62.7	70.5	62.5	69.7	20.9(10.5)	30.5(13.9)
18	All	4	51.4	52.6	50	51.4	55.3(62.1)	67(66.7)
	Eligible for choice	4	0	0	0	0	122.7(53.9)	149.5(55.3)
	Not Eligible for choice	4	56.8	58.1	55.6	56.9	15.9(9.2)	24.3(12.5)
19	All	5	40.1	45.5	39.5	44.5	55.9(54.5)	66.1(58.8)
	Eligible for choice	5	0	0	0	0	131.5(50.3)	153.5(53.9)
	Not Eligible for choice	5	47.7	53.5	47.4	52.8	16.2(10.3)	27.3(15.1)
20	All	5	45	48.8	43.2	46.9	49.6(55.8)	59.2(59.3)
	Eligible for choice	5	0	0	0	0	110.8(48.9)	133.8(50.6)
	Not Eligible for choice	5	51.7	54.8	49.8	52.8	15.8(9.4)	24.5(13.8)
21	All	6	52.3	56.8	51.4	55.8	34.2(32.9)	46.7(38.7)
	Eligible for choice	6	0	0	0	0	99.5(53.7)	135.2(55.8)

VISN	Choice Eligibility	Level 1 or 2 VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest VAMC complexity level 1 or 2	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	54.2	59	53.5	58.1	17.2(9.9)	27.9(14.4)
22	All	6	79.3	85.5	78.4	85	26.1(27.6)	32.5(32.9)
	Eligible for choice	6	0	0	0	0	95(34.2)	122(42)
	Not Eligible for choice	6	81.6	88	80.6	87.4	16.6(8.8)	22.8(11.5)
23	All	7	34.6	38.5	32.7	36.6	62.4(49.9)	76.8(58.5)
	Eligible for choice	7	0	0	0	0	98.6(39.1)	125.5(46.6)
	Not Eligible for choice	7	44.2	47.5	42.1	45.5	14.9(10)	23.6(14.7)

Table F-4. Geographic Access to VAMC Complexity Level 1A , 1B, OR 1C

VISN	Choice Eligibility	Level 1A, 1B, or 1C VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A, 1B, or 1C VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	97	44	49.3	42.1	47.3	52.9(50.7)	62.4(54.7)
	Eligible for choice	97	0	0	0	0	109.3(46.9)	131.9(49.6)
	Not Eligible for choice	97	47.4	52.8	45.6	50.9	16.6(10.5)	25.3(14.8)
1	All	5	48.6	62.2	47.7	60.8	46.6(48.3)	54.7(51.5)
	Eligible for choice	5	0	0	0	0	191(33.3)	201.3(28.3)
	Not Eligible for choice	5	50.5	64.6	49.8	63.5	18.9(11.8)	29.6(16.1)
2	All	5	60.2	65.6	61.3	66.4	39.4(36)	50.8(41.8)
	Eligible for choice	5	0	0	0	0	107.3(32.3	136.9(42.9)
	Not Eligible for choice	5	61.8	67.2	62.8	68	18(11.5)	28.6(16.7)
3	All	7	82	86.2	80.4	84.8	15.7(17.9)	21.4(20.4)
	Eligible for choice	7	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for	7	82	86.2	80.5	84.8	10.7(9.1)	16.8(12.4)

VISN	Choice Eligibility	Level 1A, 1B, or 1C VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A, 1B, or 1C VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	choice							
4	All	3	38.9	47.1	37.4	45.5	51.3(40.8)	60.4(44.7)
	Eligible for choice	3	0	0	0	0	117.1(39.5)	135(43.3)
	Not Eligible for choice	3	39.6	48	38.2	46.5	17.7(11.2)	28(16.2)
5	All	3	73.4	75.7	69	71.1	28.4(30.8)	37.2(36.6)
	Eligible for choice	3	0	0	0	0	64.6(31.5)	76(31.6)
	Not Eligible for choice	3	74.3	76	69.7	71.5	15.4(9.9)	22.8(13.3)
6	All	5	27.6	36.9	28.9	38.1	64.2(41.1)	76.1(46.4)
	Eligible for choice	5	0	0	0	0	78.7(35.6)	101.5(43.1)
	Not Eligible for choice	5	30.2	39.4	31.8	40.9	21.7(11.7)	35.8(16)
7	All	6	39.8	43.9	39.8	43.9	63.6(44.8)	77.1(51.7)
	Eligible for choice	6	0	0	0	0	97.2(36.2)	121.6(41.9)
	Not Eligible for choice	6	43.5	47.5	43.6	47.6	18.2(10.6)	28.2(15.3)
8	All	7	44.6	48.5	44.1	48.1	49.4(40.3)	57.8(43)
	Eligible for choice	7	0	0	0	0	99(37.7)	126.6(38.8)
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	7	39.5	45.6	40.1	46	64.3(48.8)	75.5(53)
	Eligible for choice	7	0	0	0	0	102(35.3)	123.7(40.9)
	Not Eligible for choice	7	44.9	51.2	45.5	51.6	15.8(10.3)	24.9(15.6)
10	All	3	47.9	54.1	46.7	53.1	46.2(37.2)	53.6(39.4)
	Eligible for choice	3	0	0	0	0	62.2(15.2)	85.5(18.3)
	Not Eligible for choice	3	48.3	54.4	47.1	53.4	16.4(11)	25.6(14.9)
11	All	3	32.2	37.2	30.5	35.5	67.1(51.1)	74.4(52.3)
	Eligible for choice	3	0	0	0	0	121(41.2)	132(42.7)
	Not Eligible for choice	3	34.6	39.6	32.7	37.7	16.8(9.8)	26(15.2)
12	All	4	52.9	62.8	49.9	59.5	37.1(39.5)	43.3(43.1)
	Eligible for choice	4	0	0	0	0	107.7(43.3)	131.7(45.8)

VISN	Choice Eligibility	Level 1A, 1B, or 1C VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A, 1B, or 1C VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	4	55.3	65.5	52.5	62.5	16.2(11)	23.6(14.9)
15	All	6	43	46.2	40.5	43.6	65.4(55.1)	76.3(60.8)
	Eligible for choice	6	0	0	0	0	113.5(43.9)	139.9(49.6)
	Not Eligible for choice	6	47.9	50.8	45.3	48.2	16(10.1)	23(14.2)
16	All	5	27.1	29.1	25.4	27.4	86.4(60)	97.6(63.4)
	Eligible for choice	5	0	0	0	0	111.7(43.8)	134.2(50.3)
	Not Eligible for choice	5	30.4	31.8	28.7	30.1	16.9(9.8)	24.6(12.9)
17	All	6	57.1	65.1	56.8	64.2	49.3(42.9)	59.5(47.4)
	Eligible for choice	6	0	0	0	0	91.5(38.4)	116.4(43.3)
	Not Eligible for choice	6	62.7	70.5	62.5	69.7	20.9(10.5)	30.5(13.9)
18	All	3	48.8	50	47.2	48.5	50.2(62.6)	60.4(64.9)
	Eligible for choice	3	0	0	0	0	148.4(60.9)	168.4(56)
	Not Eligible for choice	3	54	55.3	52.4	53.7	16.3(9.1)	24.8(12.3)
19	All	2	33.3	37	31.6	34.8	53.2(55.1)	63.3(59.3)
	Eligible for choice	2	0	0	0	0	142.3(51.6)	160.3(51.5)
	Not Eligible for choice	2	39.6	43.8	37.8	41.6	16.7(10.2)	26.9(14.2)
20	All	4	39.7	42.8	37.1	40.2	50.7(58.1)	60.1(61)
	Eligible for choice	4	0	0	0	0	111.7(50.6)	133.9(50.4)
	Not Eligible for choice	4	45.6	48.4	42.8	45.6	15.9(9.3)	24.6(13.7)
21	All	4	38.9	43.1	37	41	53(51.5)	67(57.7)
	Eligible for choice	4	0	0	0	0	123.7(52.2)	154.1(50.9)
	Not Eligible for choice	4	40.4	44.8	38.5	42.7	17.9(9.3)	28.7(13.5)
22	All	5	66.3	72.5	64.6	71.2	44.7(63.4)	50.1(62.7)
	Eligible for choice	5	0	0	0	0	102(41.7)	126.9(42.4)
	Not Eligible for choice	5	68.2	74.6	66.4	73.2	17.2(8.9)	23.3(11.7)
23	All	4	26.2	29.4	24.4	27.6	74.4(57.4)	88.5(64.3)

VISN	Choice Eligibility	Level 1A, 1B, or 1C VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A, 1B, or 1C VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	4	0	0	0	0	112.7(47.7	139.8(50.5)
	Not Eligible for choice	4	33.4	36.7	31.3	34.7	15.4(9.6)	24.4(14.6)

Table F-5 Geographic Access to VAMC Complexity Level 1A or 1B

VISN	Choice Eligibility	Level 1A or 1B VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A or 1B VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	64	34.3	39	32.4	37	66(60.5)	75.1(63.4)
	Eligible for choice	64	0	0	0	0	122.2(50.8)	142.3(51.7)
	Not Eligible for choice	64	37	41.8	35.1	39.8	17(10.4)	25.7(14.6)
1	All	5	48.4	61.5	47.4	60.1	48.8(52.1)	56.1(53.9)
	Eligible for choice	5	0	0	0	0	196.3(29.2)	201(28.5)
	Not Eligible for choice	5	50.3	63.9	49.5	62.8	19(12)	29.5(16.1)
2	All	NA	0	0	0	0	175(38.9)	178.8(38.5)
	Eligible for choice	NA	0	0	0	0	185.6(24)	206.3(22)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
3	All	3	68.7	80.1	67.2	78.8	23.4(21.3)	29.5(24.1)
	Eligible for choice	3	0	0	0	0	99.5(7.3)	125.4(16.6)
	Not Eligible for choice	3	68.7	80.2	67.3	78.8	14.7(10.6)	22.8(14.6)
4	All	3	38.7	45.5	37.3	44	54.5(45.1)	63.1(48.2)
	Eligible for choice	3	0	0	0	0	126.5(33.9)	144.3(36.8)
	Not Eligible for choice	3	39.5	46.4	38	44.9	17.5(11.1)	27.1(15.7)
5	All	3	73.4	75.7	69	71.1	28.7(31.5)	37.4(37.1)

VISN	Choice Eligibility	Level 1A or 1B VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A or 1B VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	3	0	0	0	0	64.6(31.5)	76(31.6)
	Not Eligible for choice	3	74.3	76	69.7	71.5	15.4(9.9)	22.8(13.3)
6	All	2	13.9	17.9	13.5	17.2	100.4(55.4)	110.4(58.3)
	Eligible for choice	2	0	0	0	0	109.5(50.9)	129.1(54.4)
	Not Eligible for choice	2	15.2	18.9	14.9	18.1	19.2(10.9)	30.9(15.6)
7	All	4	27.8	31.1	27.5	30.6	83.3(55)	96.4(59.8)
	Eligible for choice	4	0	0	0	0	105.7(38.7)	131.2(44.9)
	Not Eligible for choice	4	30.4	33.6	30.1	33.2	18.7(10.5)	28.9(15.2)
8	All	6	37.2	42.7	36.6	42.2	54.5(41.9)	62.5(44)
	Eligible for choice	6	0	0	0	0	103(34.5)	130.2(35.1)
	Not Eligible for choice	6	37.8	43.3	37.2	42.8	17.8(11.1)	27.7(15.9)
9	All	3	18.8	22.3	18.2	21.5	97.6(62.2)	107.3(63.3)
	Eligible for choice	3	0	0	0	0	123.5(45.9)	141.6(46.8)
	Not Eligible for choice	3	21.4	24.9	20.6	23.9	15.6(9.9)	24.8(15.4)
10	All	2	36.4	46.7	36.7	46.6	57.2(43.5)	63.7(44.5)
	Eligible for choice	2	0	0	0	0	96.3(25.8)	114.5(27.4)
	Not Eligible for choice	2	36.7	47	37	46.9	16.6(11.3)	28.2(16.4)
11	All	3	32.2	37.2	30.5	35.5	67.6(51.8)	74.8(52.8)
	Eligible for choice	3	0	0	0	0	121.8(41.9)	132.5(42.9)
	Not Eligible for choice	3	34.6	39.6	32.7	37.7	16.8(9.8)	26(15.2)
12	All	4	52.9	62.8	49.9	59.5	37.1(39.5)	43.3(43.1)
	Eligible for choice	4	0	0	0	0	107.7(43.3)	131.7(45.8)
	Not Eligible for choice	4	55.3	65.5	52.5	62.5	16.2(11)	23.6(14.9)
15	All	2	19.5	20.9	16.7	17.9	99.6(69.7)	120.6(77.2)
	Eligible for choice	2	0	0	0	0	137.6(54.9)	156.7(54.3)
	Not Eligible for choice	2	21.8	23	18.7	19.8	15.6(10.1)	22.8(13.7)
16	All	3	21.9	23.5	20.4	22.1	106.6(73.6)	114.7(73.1)

VISN	Choice Eligibility	Level 1A or 1B VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A or 1B VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	3	0	0	0	0	129.3(54.6)	147.9(55.9)
	Not Eligible for choice	3	24.5	25.7	23	24.1	17.2(9.6)	24.5(12.4)
17	All	4	46.5	52.3	45.3	50.7	58.7(47.8)	68.2(51.6)
	Eligible for choice	4	0	0	0	0	100.5(37)	124.5(43.1)
	Not Eligible for choice	4	51.1	57.1	49.9	55.4	21.1(10.2)	30.1(13.3)
18	All	2	20.7	21.1	21.4	21.9	104.3(60.9)	109.1(60.1)
	Eligible for choice	2	0	0	0	0	157.4(60.3)	173.3(56.1)
	Not Eligible for choice	2	22.9	23.3	23.7	24.2	12.7(7.7)	21.4(11.7)
19	All	2	33.3	37	31.6	34.8	53.2(55.1)	63.3(59.3)
	Eligible for choice	2	0	0	0	0	142.3(51.6)	160.3(51.5)
	Not Eligible for choice	2	39.6	43.8	37.8	41.6	16.7(10.2)	26.9(14.2)
20	All	4	39.7	42.8	37.1	40.2	50.7(58.1)	60.1(61)
	Eligible for choice	4	0	0	0	0	111.7(50.6)	133.9(50.4)
	Not Eligible for choice	4	45.6	48.4	42.8	45.6	15.9(9.3)	24.6(13.7)
21	All	3	25.2	27.6	24.1	26.5	70.9(61.7)	82.8(64.6)
	Eligible for choice	3	0	0	0	0	145.4(40.9)	173.8(37.5)
	Not Eligible for choice	3	26.2	28.6	25.1	27.5	18.2(9.6)	27.9(13.5)
22	All	5	66.3	72.5	64.6	71.2	44.7(63.5)	50.1(62.7)
	Eligible for choice	5	0	0	0	0	102.2(42.8)	126.9(42.4)
	Not Eligible for choice	5	68.2	74.6	66.4	73.2	17.2(8.9)	23.3(11.7)
23	All	1	15.3	16.4	14.2	15.3	94.1(72.7)	113.7(79.9)
	Eligible for choice	1	0	0	0	0	132.7(55.3)	157(56.2)
	Not Eligible for choice	1	19.5	20.5	18.3	19.3	15.9(8.6)	23.3(11.7)

Table F-6 Geographic Access to VAMC Complexity Level 1A

VISN	Choice Eligibility	Level 1A VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	47	26	29.8	24.8	28.5	80.9(65.1)	88.8(66.3)
	Eligible for choice	47	0	0	0	0	128.1(50.7)	148.7(51.9)
	Not Eligible for choice	47	28	32	26.8	30.7	17.4(10.5)	26.5(14.7)
1	All	5	48.4	61.5	47.4	60.1	48.8(52.1)	56.1(53.9)
	Eligible for choice	5	0	0	0	0	196.3(29.2)	201(28.5)
	Not Eligible for choice	5	50.3	63.9	49.5	62.8	19(12)	29.5(16.1)
2	All	NA	0	0	0	0	173.3(38.1)	175.1(36.6)
	Eligible for choice	NA	0	0	0	0	178.9(17.8)	202.1(20.6)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
3	All	3	67.7	79.1	66.3	77.8	23.8(21.8)	29.9(24.5)
	Eligible for choice	3	0	0	0	0	102.9(4.4)	128.6(13.8)
	Not Eligible for choice	3	67.7	79.2	66.3	77.9	14.4(10.3)	22.7(14.6)
4	All	2	13.3	16.7	13.6	17	98.9(49.5)	104.3(50.1)
	Eligible for choice	2	0	0	0	0	139(42.3)	157.5(44.4)
	Not Eligible for choice	2	13.6	17	13.8	17.4	15.4(11)	27.6(16.9)
5	All	NA	0	0	0	0	133.5(24.7)	135.6(25.6)
	Eligible for choice	NA	0	0	0	0	120.9(23.9)	136.6(24.4)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
6	All	2	13.9	16.8	13.5	16.4	100.7(55.4)	110.6(58.2)
	Eligible for choice	2	0	0	0	0	110.1(50.9)	129.5(54.2)
	Not Eligible for choice	2	15.2	17.7	14.9	17.3	19.2(10.9)	30.1(15.3)
7	All	2	22.8	25.9	21.9	25	99.9(68.2)	108.5(68)
	Eligible for choice	2	0	0	0	0	128.8(47.9)	147.6(50.2)
	Not Eligible for choice	2	24.9	28	23.9	27	19.4(10.4)	29.5(15)
8	All	5	28.4	31	29	31.7	73(60.2)	83(60.8)
	Eligible for choice	5	0	0	0	0	114.3(43.6)	143.2(46.3)
	Not Eligible for choice	5	28.9	31.4	29.5	32.1	17.3(11.3)	28.2(16.8)

VISN	Choice Eligibility	Level 1A VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
9	All	3	18.8	22.3	18.2	21.5	102.4(66.8)	111.8(66.8)
	Eligible for choice	3	0	0	0	0	121.4(48.8)	140.8(50.3)
	Not Eligible for choice	3	21.4	24.9	20.6	23.9	15.6(9.9)	24.8(15.4)
10	All	1	20.4	24.9	20.2	24.7	90.8(54.5)	94.3(52.7)
	Eligible for choice	1	0	0	0	0	132.4(33.6)	148.6(30.8)
	Not Eligible for choice	1	20.6	25.1	20.3	24.9	17.3(11.8)	27.5(15.7)
11	All	1	11.5	13.3	11.5	13.3	143.6(60.7)	144.1(56.3)
	Eligible for choice	1	0	0	0	0	140.3(46.4)	146.6(45.6)
	Not Eligible for choice	1	12.3	13.9	12.4	14	14.6(9.9)	25.3(15.4)
12	All	2	46.4	57	43.3	53.7	44.6(43.9)	50.1(47)
	Eligible for choice	2	0	0	0	0	137.6(33)	159.2(39.9)
	Not Eligible for choice	2	48.5	59.6	45.6	56.4	18.5(10.1)	26.1(13.7)
15	All	2	19.5	20.9	16.7	17.9	87.8(67)	112(78.2)
	Eligible for choice	2	0	0	0	0	121(50.8)	143(53.5)
	Not Eligible for choice	2	21.8	23	18.7	19.8	15.6(10.1)	22.8(13.7)
16	All	1	13.5	14.4	12.3	13.2	118.3(79.2)	130.5(80.6)
	Eligible for choice	1	0	0	0	0	152.6(50.4)	179.2(48.5)
	Not Eligible for choice	1	15.1	16.1	13.9	14.9	18.9(9.6)	26.6(12.4)
17	All	4	46.5	52.3	45.3	50.7	58.7(47.8)	68.2(51.6)
	Eligible for choice	4	0	0	0	0	100.2(36.7)	124.3(42.9)
	Not Eligible for choice	4	51.1	57.1	49.9	55.4	21.1(10.2)	30.1(13.3)
18	All	2	20.7	21.1	21.4	21.9	102.6(59.8)	107.4(58.8)
	Eligible for choice	2	0	0	0	0	143.1(58.8)	162.3(56.3)
	Not Eligible for choice	2	22.9	23.3	23.7	24.2	12.7(7.7)	21.4(11.7)
19	All	1	21	22.6	19.7	21	50.1(50.4)	61.2(56.5)
	Eligible for choice	1	0	0	0	0	135.9(44.7)	154.6(50.3)
	Not Eligible for choice	1	24.9	26.7	23.6	25.1	15.1(9)	24.2(12.6)

VISN	Choice Eligibility	Level 1A VAMC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Level 1A VAMC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
20	All	4	39.7	42.8	37.1	40.2	48.2(55)	57.9(58.6)
	Eligible for choice	4	0	0	0	0	108.1(48.9)	131.3(50.1)
	Not Eligible for choice	4	45.6	48.4	42.8	45.6	15.9(9.3)	24.6(13.7)
21	All	3	25.2	27.6	24.1	26.5	70.9(61.7)	82.8(64.6)
	Eligible for choice	3	0	0	0	0	145.4(40.9)	173.8(37.5)
	Not Eligible for choice	3	26.2	28.6	25.1	27.5	18.2(9.6)	27.9(13.5)
22	All	3	47.8	57.7	45.8	55.4	41.2(36.6)	45.2(38.5)
	Eligible for choice	3	0	0	0	0	133.6(44.9)	155.9(40.5)
	Not Eligible for choice	3	49.2	59.3	47.1	56.9	19.2(9.9)	27.7(13.9)
23	All	1	15.3	16.4	14.2	15.3	94.3(75.9)	112.5(80.8)
	Eligible for choice	1	0	0	0	0	133.5(56.8)	156.8(57.4)
	Not Eligible for choice	1	19.5	20.5	18.3	19.3	15.9(8.6)	23.3(11.7)

Table F-7 Geographic Access to Health Care Centers

VISN	Choice Eligibility	HCCs (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest HCC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	14	5.4	6.2	5.4	6.3	117(66.8)	126.8(68)
	Eligible for choice	14	0	0	0	0	145.3(51.5)	167.5(48.6)
	Not Eligible for choice	14	5.8	6.7	5.9	6.8	19(11.1)	30.6(15.6)
1	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
2	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA

VISN	Choice Eligibility	HCCs (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest HCC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
3	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
4	All	NA	0	0	0	0	191.2(24.5)	189.8(24.1)
	Eligible for choice	NA	0	0	0	0	178(26.8)	197.4(18.6)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
5	All	NA	0	0	0	0	.(.)	233.3(.)
	Eligible for choice	NA	0	0	0	0	.(.)	233.3(.)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
6	All	1	8.7	10	9.4	10.8	113.4(63.7)	124.2(64.6)
	Eligible for choice	1	0	0	0	0	138.4(49)	153.6(47.6)
	Not Eligible for choice	1	9.5	10.9	10.3	11.8	20.5(10.2)	31.7(13.4)
7	All	NA	0.9	1.2	1	1.3	158.1(53.3)	173.2(53.5)
	Eligible for choice	NA	0	0	0	0	154.3(42.7)	182.1(41.9)
	Not Eligible for choice	NA	1	1.3	1.1	1.4	33.5(4.2)	43.8(7.6)
8	All	3	18.6	20.5	18.4	20.4	102.2(53.4)	108.9(50.5)
	Eligible for choice	3	0	0	0	0	137.8(56.6)	174.8(49.4)
	Not Eligible for choice	3	18.9	20.9	18.7	20.7	18.2(10.3)	31.2(14.8)
9	All	NA	0	0	0	0	199.1(30.4)	205(17.6)
	Eligible for choice	NA	0	0	0	0	156(44.3)	179.7(26.8)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
10	All	1	14.3	16.1	13.9	15.7	102.8(47.7)	106.1(44.7)
	Eligible for choice	1	0	0	0	0	104.1(29.8)	121.8(30.7)
	Not Eligible for choice	1	14.4	16.2	14	15.8	15.3(10.1)	25.5(15.9)
11	All	NA	0	0	0	0	182.5(26.8)	204.4(28.1)
	Eligible for choice	NA	0	0	0	0	165.7(39.5)	193.1(35.7)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
12	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA

VISN	Choice Eligibility	HCCs (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest HCC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
15	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
16	All	2	8.2	8.9	7.4	8.1	88.9(69.4)	97.9(68.4)
	Eligible for choice	2	0	0	0	0	155.9(59.3)	170.5(46.5)
	Not Eligible for choice	2	9.2	10	8.3	9.1	11.6(10.2)	19.6(16)
17	All	2	3.3	4.2	3.8	4.9	86.1(62.6)	107.9(77.2)
	Eligible for choice	2	0	0	0	0	131.4(37.4)	165.6(42.5)
	Not Eligible for choice	2	3.6	4.7	4.2	5.4	23.1(10.7)	35.1(14.6)
18	All	1	8.4	9.2	8.9	9.6	53.3(64.4)	71.4(75.3)
	Eligible for choice	1	0	0	0	0	166.4(49)	182.8(48.3)
	Not Eligible for choice	1	9.3	10.2	9.9	10.7	14(8.1)	26.3(14.2)
19	All	2	4	4.1	4.6	4.6	103.1(67.7)	120.6(72.7)
	Eligible for choice	2	0	0	0	0	107.4(51.2)	133.3(54.7)
	Not Eligible for choice	2	4.8	4.7	5.5	5.4	9.7(10)	15.7(13)
20	All	NA	0	0	0	0	191.2(18.8)	189.4(20.8)
	Eligible for choice	NA	0	0	0	0	179.4(33.8)	213.7(30)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
21	All	2	31.2	39.4	29.3	37.4	67.2(54)	75.6(58)
	Eligible for choice	2	0	0	0	0	138.8(57.3)	162.6(50.7)
	Not Eligible for choice	2	32.4	41	30.5	38.9	22.9(10.6)	34.8(14.3)
22	All	NA	0	0	0	0	211.8(8.2)	231.1(5.6)
	Eligible for choice	NA	0	0	0	0	216.4(21.2)	225.6(10.8)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
23	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA

Table F-8 Geographic Access to Multi-specialty CBOCs

VISN	Choice Eligibility	Multi-specialty CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Multi-specialty CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	185	45.9	51.9	44.5	50.4	49.2(43)	60.2(48.4)
	Eligible for choice	185	0	0	0	0	88.2(41.3)	115.5(47.4)
	Not Eligible for choice	185	49.5	55.5	48.2	54	19.1(10.6)	29.3(14.9)
1	All	6	46.8	62.7	44.9	61.2	40.1(30.7)	47.9(35.2)
	Eligible for choice	6	0	0	0	0	76.2(37.5)	104.6(46.5)
	Not Eligible for choice	6	48.6	64.5	46.9	63.2	18.5(12)	29.6(16.7)
2	All	4	34.3	39.3	34.6	40.1	52.9(31.3)	65.3(34.5)
	Eligible for choice	4	0	0	0	0	67.7(16.9)	104.5(30.1)
	Not Eligible for choice	4	35.2	40.3	35.5	41.1	16.9(11)	31.2(17.7)
3	All	9	91.1	99.3	91.3	99.4	21.7(9.9)	27.7(10.7)
	Eligible for choice	9	0	0	0	0	42.4(1.2)	65.7(9.8)
	Not Eligible for choice	9	91.2	99.4	91.4	99.4	20.4(8.5)	27.5(10.4)
4	All	15	66.6	77.2	65.6	76.3	30.8(21.1)	40.3(24.6)
	Eligible for choice	15	0	0	0	0	52.4(17.1)	73.3(22.8)
	Not Eligible for choice	15	67.9	78.1	67	77.3	20.4(10.4)	31.3(14.3)
5	All	9	90.3	92.2	89.8	91.9	20.6(13.9)	29.6(18.3)
	Eligible for choice	9	0	0	0	0	46.6(6.6)	59.2(16.4)
	Not Eligible for choice	9	91.3	92.5	90.7	92.3	17.8(9.7)	26.1(12.5)
6	All	5	17.1	21.4	18	22.5	78.9(39.7)	96.1(46.5)
	Eligible for choice	5	0	0	0	0	80.6(36.1)	106.3(40.5)
	Not Eligible for choice	5	18.7	22.4	19.8	23.7	22.9(11.4)	35.9(15.8)
7	All	7	20.6	24.2	21	24.7	72.1(36.2)	89.1(42.9)
	Eligible for choice	7	0	0	0	0	78.6(26.3)	107.6(34.8)
	Not Eligible for choice	7	22.5	25.9	23	26.5	20.4(11.2)	33.4(16.3)
8	All	13	63.4	72.1	63.2	71.5	38.2(25.1)	47.1(27.3)
	Eligible for choice	13	0	0	0	0	68.8(22.8)	97.5(29.4)

VISN	Choice Eligibility	Multi-specialty CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Multi-specialty CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	13	64.4	73.2	64.2	72.7	21.9(11.3)	33.5(14.8)
9	All	6	31.9	39	30.5	37.4	79.3(57.3)	91.4(60.1)
	Eligible for choice	6	0	0	0	0	103.5(51.2)	129.1(53.6)
	Not Eligible for choice	6	36.2	43.2	34.6	41.5	17.8(10.8)	30.7(17.2)
10	All	26	96.1	95.6	96.1	95.5	16.6(11.2)	25.1(16)
	Eligible for choice	26	0	0	0	0	44.7(4)	61.4(8.9)
	Not Eligible for choice	26	96.8	96	96.8	95.9	15.5(10)	23.4(13.8)
11	All	6	34.3	42.7	33	40.7	49.8(29.9)	61.2(34.5)
	Eligible for choice	6	0	0	0	0	64.5(22.2)	80.1(25)
	Not Eligible for choice	6	36.8	44.2	35.4	42.2	21.1(10.6)	33.2(14.3)
12	All	7	44.9	57.2	44.2	54.9	48.9(29.2)	58.2(35.1)
	Eligible for choice	7	0	0	0	0	92.5(38.1)	132.6(50.2)
	Not Eligible for choice	7	47	59.7	46.5	57.5	24.5(11.5)	37.4(14)
15	All	1	3.5	4.3	3.8	4.7	145.2(46.2)	161.5(49.6)
	Eligible for choice	1	0	0	0	0	112.2(41.1)	145.3(50.4)
	Not Eligible for choice	1	3.9	4.5	4.3	4.9	14.7(11.2)	27.9(18.4)
16	All	18	42	47.6	40.9	46.3	54.5(38.8)	66.4(45.1)
	Eligible for choice	18	0	0	0	0	79.6(37.2)	106(45.7)
	Not Eligible for choice	18	47.2	51.8	46.1	50.6	19.5(11.1)	28.7(14.5)
17	All	7	55.9	65.4	55	64	39.5(29.6)	49.2(36)
	Eligible for choice	7	0	0	0	0	79(28.6)	103(36.6)
	Not Eligible for choice	7	61.4	71.4	60.6	70	18.3(11.1)	29.7(15.4)
18	All	9	50.4	50.6	48	48.2	43.5(51.3)	57.5(58.2)
	Eligible for choice	9	0	0	0	0	114(59.3)	143(61.2)
	Not Eligible for choice	9	55.7	55.6	53.3	53.2	16.2(9.3)	26.1(12.5)
19	All	5	42.1	43.3	38.8	40.1	38.5(53.9)	48.6(57.9)
	Eligible for choice	5	0	0	0	0	115.3(45.7)	138.4(51.2)

VISN	Choice Eligibility	Multi-specialty CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Multi-specialty CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	5	50.1	51.3	46.5	47.8	16.2(9.7)	23.8(13)
20	All	6	27.4	31.1	27.9	31	69(52.4)	80.2(58.8)
	Eligible for choice	6	0	0	0	0	95.7(45.3)	125.7(48.8)
	Not Eligible for choice	6	31.5	35.3	32.2	35.3	18.9(10.8)	31.7(15.9)
21	All	10	47.4	53	47.4	52.8	41.6(41.8)	52.2(47.3)
	Eligible for choice	10	0	0	0	0	92.6(34.5)	126.6(40.8)
	Not Eligible for choice	10	49.2	55	49.3	54.9	17.8(10.2)	26.9(15.2)
22	All	7	62.9	68.6	60.8	66.8	25.9(24.5)	31.4(27.6)
	Eligible for choice	7	0	0	0	0	92.5(31.9)	122.7(38.3)
	Not Eligible for choice	7	64.7	70.5	62.6	68.5	15.5(9.2)	22.1(13)
23	All	9	24.7	29.3	24.7	28.5	68.1(44.2)	87.1(50.3)
	Eligible for choice	9	0	0	0	0	100.7(41.5)	131.3(43.7)
	Not Eligible for choice	9	31.6	36.8	31.7	36.1	23.9(11.3)	38.5(15.3)

Table F-9 Geographic Access to Primary care CBOCs

VISN	Choice Eligibility	Primary Care CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Primary Care CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	509	67.7	73.8	66.7	72.8	30.2(25.1)	40.8(31.7)
	Eligible for choice	509	0	0	0	0	66.8(26.7)	94.7(36)
	Not Eligible for choice	509	73	78.9	72.2	78	17.5(11.1)	26.9(15.5)
1	All	30	88.4	91	87.4	90.3	22.6(18.1)	31.4(23)
	Eligible for choice	30	0	0	0	0	70.1(26)	99.5(36.1)
	Not Eligible for choice	30	91.8	94.5	91.3	94.1	18.4(10.2)	26.5(13.2)

VISN	Choice Eligibility	Primary Care CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Primary Care CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	22	70.9	73.1	70.2	72.6	28.5(22.1)	39.6(27)
	Eligible for choice	22	0	0	0	0	50.8(11.3)	79.8(24.1)
	Not Eligible for choice	22	72.7	74.6	71.9	74	16.2(11.3)	26.1(16.2)
3	All	16	96.7	98	96.5	97.8	9.5(9.1)	14.8(12.4)
	Eligible for choice	16	0	0	0	0	49.1(8.5)	77.2(25.2)
	Not Eligible for choice	16	96.8	98.1	96.5	97.9	8.7(7.1)	14(10.3)
4	All	25	77	81.5	76.6	81.1	27.6(19)	36.9(22.5)
	Eligible for choice	25	0	0	0	0	62.2(21)	83.8(25.1)
	Not Eligible for choice	25	78.5	82.8	78.2	82.5	19.9(10.1)	29.1(13.5)
5	All	8	78.8	83.9	75.3	80.2	25.3(19.2)	33.2(20.8)
	Eligible for choice	8	0	0	0	0	54.1(21.7)	68.2(23.1)
	Not Eligible for choice	8	79.6	84.2	76.1	80.7	18.4(9.5)	27.3(13.1)
6	All	18	51.5	62.2	49.1	60	38.5(21.4)	50.8(26.9)
	Eligible for choice	18	0	0	0	0	55.2(11.4)	79.1(19.3)
	Not Eligible for choice	18	56.3	66.6	54	64.4	21(11.3)	34(16.3)
7	All	33	74.4	78.7	73.5	77.9	28.5(20.3)	43(28.3)
	Eligible for choice	33	0	0	0	0	56.5(13.8)	83.1(21.6)
	Not Eligible for choice	33	81.3	84.8	80.4	84.1	18.5(11)	30.2(15.9)
8	All	31	78.8	87.6	78.5	87.1	25(16.2)	34.6(20.4)
	Eligible for choice	31	0	0	0	0	55.5(11.6)	86.4(17)
	Not Eligible for choice	31	80	89	79.8	88.6	18.8(10.8)	29.6(15.1)
9	All	30	61.5	69	62.2	69.6	35.2(23.1)	48.2(28.6)
	Eligible for choice	30	0	0	0	0	55.8(12.7)	80.3(18.8)
	Not Eligible for choice	30	69.9	76.2	70.6	76.9	19.7(12.1)	32(17.4)
10	All	6	64.2	75	64.8	75.5	30(20)	38.5(24.9)
	Eligible for choice	6	0	0	0	0	57.8(11.8)	87.6(18.3)
	Not Eligible for choice	6	64.7	75.6	65.3	76	18.6(10.7)	28.6(15.9)

VISN	Choice Eligibility	Primary Care CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Primary Care CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	24	49.7	60.8	50.9	61.7	42.3(22.3)	52.8(23.9)
	Eligible for choice	24	0	0	0	0	56.2(12.6)	75.1(15.7)
	Not Eligible for choice	24	53.4	64.4	54.6	65.2	21.7(12.4)	36.8(17.3)
12	All	25	83.5	86.2	82	84.9	20.2(16.4)	29.5(22.2)
	Eligible for choice	25	0	0	0	0	56.5(15.2)	86.4(22.2)
	Not Eligible for choice	25	87.3	89.8	86.2	88.9	15.9(11.1)	24.2(15.1)
15	All	40	80.2	80.8	79.4	79.9	25.7(19.9)	37.7(27.8)
	Eligible for choice	40	0	0	0	0	57.8(15)	83.1(22.9)
	Not Eligible for choice	40	89.3	88.4	88.9	87.8	17.1(10.5)	25.6(14.7)
16	All	38	38.6	47.9	38.8	47.9	47.2(25.4)	61.1(31.4)
	Eligible for choice	38	0	0	0	0	60.2(16.4)	87.8(24.9)
	Not Eligible for choice	38	43.4	52.4	43.8	52.6	23.7(11.7)	36.1(15.2)
17	All	11	52.3	66.3	50.7	64.5	42(32)	51.4(37.6)
	Eligible for choice	11	0	0	0	0	76.4(34.4)	103.5(40.6
	Not Eligible for choice	11	57.4	72.4	55.8	70.7	23.4(10.9)	33.7(13.3)
18	All	27	69.3	73.1	68.7	72.1	35.8(33.7)	49.9(46.4)
	Eligible for choice	27	0	0	0	0	83.9(35.5)	121(49.8)
	Not Eligible for choice	27	76.7	80.3	76.2	79.5	17.7(11.2)	26.4(14.4)
19	All	22	50.5	54.8	50	53.6	41.9(39)	53.1(48.2)
	Eligible for choice	22	0	0	0	0	93.1(37.5)	119.9(48.4
	Not Eligible for choice	22	60	63	59.9	62.1	14.8(9.4)	21.9(12.6)
20	All	20	66.4	73.6	65.9	72.7	34.7(31.1)	45.3(40.1)
	Eligible for choice	20	0	0	0	0	75.9(29)	106.1(44.1
	Not Eligible for choice	20	76.3	82.9	76	82.1	18.5(11)	26.8(14.4)
21	All	24	76.5	79.2	74.4	77	25.9(21.4)	36.7(30.4)
	Eligible for choice	24	0	0	0	0	73.7(32.3)	113.4(40)
	Not Eligible for choice	24	79.4	82.2	77.5	80.2	18.3(10.3)	26.8(15.1)

VISN	Choice Eligibility	Primary Care CBOC (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest Primary Care CBOC	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	22	91	95	91.3	95.1	16.7(15.2)	22.3(18.7)
	Eligible for choice	22	0	0	0	0	67.1(29.8)	97.7(43.5)
	Not Eligible for choice	22	93.6	97.4	93.9	97.4	13.8(9.7)	19.4(11.4)
23	All	37	48.2	49.7	47.4	48.9	44.3(32.7)	61.7(43.4)
	Eligible for choice	37	0	0	0	0	70(25.9)	101(35.7)
	Not Eligible for choice	37	61.5	61.4	60.9	60.8	17.4(10.8)	25.7(15.2)

Appendix F.2: Geographic Access to VA Services for Illustrative Clinical Populations

Tables F-10 through F-39 show various measures of access to the services required to treat various medical conditions. First, Table F-10 summarizes the services required to treat patients with each of the clinical conditions, based on VA's clinical inventories of profiles and services. These are the basis of the analyses in the remainder of this appendix. Then, each following table shows the number of facilities where the service is available and the percent of enrollees and health care users who are within either a 40-mile driving distance or a 60 minute drive, by VISN. Two tables also include additional measures: the percent of enrollees whose closest hospital provides a service, and the median driving distance and time to the nearest facility with such services (Table F-11 for EDs, Table F-16 for interventional cardiology). The tables are organized by the illustrative conditions: acute coronary syndrome (Tables F-11 through F-17), colon cancer (Tables F-18 through F-23), diabetes (Tables F-24 through F-27), traumatic brain injury (Tables F-28 through F-31), Post-Traumatic Stress Disorder (Table F-32 through Tables F-34), substance use disorder (Tables F-35 through F-38), and gynecological surgery (Table F-39).

Data in Tables F11–F39 are RAND estimates derived from the VA Planning Systems Support Group (PSSG) Enrollee file, the VA Clinical Inventory Facility Profile Report, and the VA Clinical Inventory Facility Services Report.

Table F-10 Mapping of Clinical Inventory Profiles and Services to the Seven Clinical Conditions

	Clinical Inventory Profile	Clinical Inventory Services
Acute Coronary Syndromes		
Emergency department	ED (Emergency Department) or EDUCC (Emergency Department combined with Urgent Care Center)	

	Clinical Inventory Profile	Clinical Inventory Services
Coronary care unit	ICU level > 0 (Intensive Care Units with a complexity level of 1-4)	
Non-invasive cardiology services		Cardiac Stress Testing On Site
Telemetry (If CCU/ICU not available	Acute Telemetry On Site	
Diagnostic cardiac catheterization		Cardiac Catheterization-Diagnostic On Site
Interventional cardiology		Cardiac Catheterization-Interventional On Site or Cardiology-Interventional On Site
Cardiac Surgery		Cardiac Surgery Services On Site
Colon Cancer		
Primary Care Clinic		Primary Care General On Site or Primary Care Group On Site
Colonoscopy		Colonoscopy On Site
CT Scan		CT Routine On Site
Surgical Services		General Surgery Services On Site
Oncology Services		Chemotherapy Clinic On Site or Oncology-General On Site or any type of Radiation Oncology On Site
Traumatic Brain Injury		
Polytrauma Support Clinic Team	Polytrauma Support Clinic Team	
Polytrauma Network Site	Polytrauma Network Site	
Polytrauma Rehabilitation Center (Program)	Polytrauma Rehabilitation Clinic	
TBI Specialty Care		If any 3 or more of the following 6 services are present On Site: Audiology, Balance Assessment, Occupational Therapy, Physiatrist / PM & R Services, Physical Therapy, Vocational Rehabilitation Therapy
Type 2 Diabetes Mellitus		

	Clinical Inventory Profile	Clinical Inventory Services
Primary care clinic		Primary Care General On Site or Primary Care Group On Site
Diabetes specialty or endocrinology clinic		Diabetes Clinic On Site; Endocrinology On Site
Podiatry clinic		Podiatry Foot Care On Site
Opthamology clinic		Opthamology On Site
Post Traumatic Stress Disorder		
Domiciliary Mental Rehabilitative Treatment Program	PTSD_RRTPDOM or No-Acute Specialized PTSD	
Mental Health Services		Mental Health Integrated Care On Site, or Mental Health Outpatient Individual and Group Services On Site, or Psychiatry Services-Individual/Group On Site, or Psychology Services-Individual/Group On Site
PTSD psychotherapy		PTSD Group On Site, or PTSD Individual On Site, or PTSD Teams On Site, or Services Related to Military Sexual trauma On Site
SUD		
Residential SUD treatment	Substance Abuse DOM/RRTP	
Methadone	Opiod/Methadone Maintenance Program	Opiod Substitution On Site or Substance Use Disorder Medication Clinic On Site
Outpatient specialty SUD care		Substance Use Disorder Intensive Counseling - Individual / Group On Site or Substance Use Disorder Treatment - Individual / Group On Site
Inpatient detoxification	Acute Medical, or Acute Psychiatric, or Acute Substance Abuse	

	Clinical Inventory Profile	Clinical Inventory Services
Mental health services		Mental Health Integrated Care On Site, or Mental Health Outpatient Individual and Group Services On Site, or Psychiatry Services-Individual/Group On Site, or Psychology Services-Individual/Group On Site
Gynecological Surgery		
Gynecological Surgery services		Gynecology Surgery Services On Site

Appendix F.2.1 Services for Populations with Acute Coronary Syndrome (ACS)

Table F-11 Geographic Access to VA Facilities providing ED care

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	114	50.2	56.1	48.6	54.4	45.9(42.3)	55.8(47.7)
	Eligible for choice	114	0	0	0	0	97.9(41.2)	122(46.7)
	Not Eligible for choice	114	54.1	60	52.7	58.4	16.9(10.5)	25.8(14.8)
1	All	5	50.3	63.7	50.4	63.2	39.6(28.3)	47.4(31.6)
	Eligible for choice	5	0	0	0	0	97.8(42.2)	119.5(46.2)
	Not Eligible for choice	5	52.3	65.7	52.6	65.5	19.9(11.1)	31(15)
2	All	4	49.4	57.3	49.8	57.6	43.6(34.2)	52.5(37.9)
	Eligible for choice	4	0	0	0	0	97.7(36.3)	122.3(45.5
	Not Eligible for choice	4	50.7	58.7	51	58.9	15.9(11.5)	27.4(17.7)
3	All	5	80.5	85.9	79.1	84.5	17.6(17.8)	23.3(20.2)
	Eligible for choice	5	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	5	80.6	86	79.2	84.6	12.2(9.4)	18.9(13)
4	All	6	54.9	63.9	54.1	62.9	36.8(29.4)	46.6(34.3)
	Eligible for choice	6	0	0	0	0	71.1(26.9)	92.7(34.3)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	56	64.7	55.2	63.8	17.6(11)	28.2(16.3)
5	All	2	73.4	75.7	69	71.1	28(28.6)	36.6(34.2)
	Eligible for choice	2	0	0	0	0	59.4(22.4)	71(25.6)
	Not Eligible for choice	2	74.3	76	69.7	71.5	15.8(10.2)	23.1(13.5)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	7	43.9	48.5	43.9	48.5	54.1(36.5)	67.8(44)
	Eligible for choice	7	0	0	0	0	77.2(23)	100.2(30.6)
	Not Eligible for choice	7	47.9	52.4	48	52.5	18.2(10.7)	28.5(15.7)
8	All	7	44.6	48.5	44.1	48.1	49.3(40)	57.8(43)
	Eligible for choice	7	0	0	0	0	97.5(36.6)	126.4(38.7)
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	7	43.4	50.7	44	51.1	56(41.8)	67.9(47)
	Eligible for choice	7	0	0	0	0	92.9(29.6)	115.1(32.8)
	Not Eligible for choice	7	49.2	57	49.9	57.4	16(10.3)	26(16.1)
10	All	3	48.1	54.2	46.9	53.2	44(33.6)	52.1(36.4)
	Eligible for choice	3	0	0	0	0	57.1(12.5)	81.6(16.8)
	Not Eligible for choice	3	48.4	54.6	47.3	53.5	16.5(11.1)	25.6(14.9)
11	All	4	36.3	41.6	34.8	40.1	60.9(49.6)	68.9(50.9)
	Eligible for choice	4	0	0	0	0	112.9(47.6	124.1(48.4)
	Not Eligible for choice	4	38.9	44.1	37.4	42.5	16.6(10.1)	25.9(15.4)
12	All	6	59.4	64.8	56.6	61.8	35(36.2)	43.7(44.2)
	Eligible for choice	6	0	0	0	0	93.3(32.6)	130.6(47.4
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	7	51.2	55.6	49	53.3	49.5(44.1)	61.7(53.2)
	Eligible for choice	7	0	0	0	0	98.7(38.5)	125.8(47.2

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	7	57.1	61.3	54.8	59	16.1(10.2)	23.6(14.6)
16	All	8	35.3	39.6	34.5	39	69.1(51.5)	81.6(56.5)
	Eligible for choice	8	0	0	0	0	95.6(36.8)	118.2(44.1)
	Not Eligible for choice	8	39.6	43.4	38.9	42.8	17.6(10.4)	27.5(15)
17	All	3	53	61.7	52.1	60.3	52.7(44.3)	62.3(48.7)
	Eligible for choice	3	0	0	0	0	103.2(37.5	125.4(43.1
	Not Eligible for choice	3	58.1	66.9	57.3	65.6	21.4(10.4)	30.9(13.6)
18	All	5	54.5	55.5	53.8	54.9	53.3(61.7)	65.2(66.4)
	Eligible for choice	5	0	0	0	0	119(51.5)	147.1(53.8)
	Not Eligible for choice	5	60.3	61.3	59.7	60.7	15.8(9.2)	24.2(12.5)
19	All	5	40.1	45.5	39.5	44.5	56.9(55.4)	67.1(59.5)
	Eligible for choice	5	0	0	0	0	132.1(50.1)	154.2(53.7)
	Not Eligible for choice	5	47.7	53.5	47.4	52.8	16.2(10.3)	27.3(15.1)
20	All	5	46.9	54	46.1	52.7	51.4(48.3)	62.7(56.3)
	Eligible for choice	5	0	0	0	0	103.9(38.7)	133(47.3)
	Not Eligible for choice	5	53.9	61.1	53.2	59.9	17.7(10.4)	26.9(14.4)
21	All	5	50	54.6	49.2	53.6	36.9(34.7)	49(40.2)
	Eligible for choice	5	0	0	0	0	105.6(52.6)	136.6(52.1)
	Not Eligible for choice	5	51.9	56.7	51.3	55.8	17.4(10.2)	27.7(14.3)
22	All	5	79	84.7	78.1	84.1	27.7(28.4)	33.8(33.6)
	Eligible for choice	5	0	0	0	0	97.4(35)	124.5(42.8)
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	7	35.6	39.4	33.8	37.6	65.1(52.6)	79.2(60.4)
	Eligible for choice	7	0	0	0	0	102.6(41.3	128.8(48.4
	Not Eligible for choice	7	45.5	48.8	43.4	46.8	15.1(10.1)	23.8(14.7)

Table F-12 Geographic Access to VA Facilities with a Coronary Care Unit

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	112	50.1	56	48.5	54.3	46(42.4)	55.9(47.8)
	Eligible for choice	112	0	0	0	0	98(41.4)	122.1(46.9)
	Not Eligible for choice	112	54	59.9	52.5	58.3	16.9(10.5)	25.8(14.8)
1	All	5	50.3	63.7	50.4	63.2	39.6(28.3)	47.4(31.6)
	Eligible for choice	5	0	0	0	0	97.8(42.2)	119.5(46.2)
	Not Eligible for choice	5	52.3	65.7	52.6	65.5	19.9(11.1)	31(15)
2	All	3	44.3	51.9	44.5	52	47.8(37)	57.6(42.7)
	Eligible for choice	3	0	0	0	0	109.7(32.8	136.5(41.4)
	Not Eligible for choice	3	45.5	53.2	45.6	53.3	15.1(11.2)	26.5(17.7)
3	All	5	80.5	85.9	79.1	84.5	17.6(17.8)	23.3(20.2)
	Eligible for choice	5	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	5	80.6	86	79.2	84.6	12.2(9.4)	18.9(13)
4	All	6	54.9	63.9	54.1	62.9	36.8(29.4)	46.7(34.4)
	Eligible for choice	6	0	0	0	0	69.7(25)	91.7(33.6)
	Not Eligible for choice	6	56	64.7	55.2	63.8	17.6(11)	28.2(16.3)
5	All	3	82.7	85.1	80.5	83	24.2(23.3)	33.1(29.9)
	Eligible for choice	3	0	0	0	0	53.4(13.7)	66.2(19.3)
	Not Eligible for choice	3	83.6	85.5	81.3	83.5	16.6(10.6)	24(13.9)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	7	43.9	48.5	43.9	48.5	54.1(36.5)	67.8(44)
	Eligible for choice	7	0	0	0	0	77.2(23)	100.2(30.6)
	Not Eligible for choice	7	47.9	52.4	48	52.5	18.2(10.7)	28.5(15.7)
8	All	7	44.6	48.5	44.1	48.1	49.3(40)	57.8(43)
	Eligible for choice	7	0	0	0	0	97.5(36.6)	126.4(38.7

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	7	43.4	50.7	44	51.1	56(41.8)	67.9(47)
	Eligible for choice	7	0	0	0	0	92.9(29.6)	115.1(32.8)
	Not Eligible for choice	7	49.2	57	49.9	57.4	16(10.3)	26(16.1)
10	All	3	48.1	54.2	46.9	53.2	44(33.6)	52.1(36.4)
	Eligible for choice	3	0	0	0	0	57.1(12.5)	81.6(16.8)
	Not Eligible for choice	3	48.4	54.6	47.3	53.5	16.5(11.1)	25.6(14.9)
11	All	4	36.3	41.6	34.8	40.1	60.9(49.6)	68.9(50.9)
	Eligible for choice	4	0	0	0	0	112.9(47.6	124.1(48.4)
	Not Eligible for choice	4	38.9	44.1	37.4	42.5	16.6(10.1)	25.9(15.4)
12	All	6	59.4	64.8	56.6	61.8	35(36.2)	43.7(44.2)
	Eligible for choice	6	0	0	0	0	93.3(32.6)	130.6(47.4)
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	7	51.2	55.6	49	53.3	49.5(44.1)	61.7(53.2)
	Eligible for choice	7	0	0	0	0	98.7(38.5)	125.8(47.2)
	Not Eligible for choice	7	57.1	61.3	54.8	59	16.1(10.2)	23.6(14.6)
16	All	8	35.3	39.6	34.5	39	69.1(51.5)	81.6(56.5)
	Eligible for choice	8	0	0	0	0	95.6(36.8)	118.2(44.1)
	Not Eligible for choice	8	39.6	43.4	38.9	42.8	17.6(10.4)	27.5(15)
17	All	3	53	61.7	52.1	60.3	52.7(44.3)	62.3(48.7)
	Eligible for choice	3	0	0	0	0	103.2(37.5	125.4(43.1
	Not Eligible for choice	3	58.1	66.9	57.3	65.6	21.4(10.4)	30.9(13.6)
18	All	4	51.4	52.6	50	51.4	55.2(62.6)	66.7(66.9)
	Eligible for choice	4	0	0	0	0	121.4(53.1	148.1(54.7)
	Not Eligible for choice	4	56.8	58.1	55.6	56.9	15.9(9.2)	24.3(12.5)
19	All	5	40.1	45.5	39.5	44.5	56.9(55.4)	67.1(59.5)
	Eligible for choice	5	0	0	0	0	132.1(50.1	154.2(53.7

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	5	47.7	53.5	47.4	52.8	16.2(10.3)	27.3(15.1)
20	All	4	45	51.9	43.7	50.2	51.9(50.3)	63.2(57.6)
	Eligible for choice	4	0	0	0	0	105.3(40)	133.7(48.4)
	Not Eligible for choice	4	51.7	58.7	50.5	57	17.8(10.4)	26.9(14.4)
21	All	5	50	54.6	49.2	53.6	36.5(34)	48.6(39.8)
	Eligible for choice	5	0	0	0	0	99.5(53.7)	135.3(55.7)
	Not Eligible for choice	5	51.9	56.7	51.3	55.8	17.4(10.2)	27.7(14.3)
22	All	5	79	84.7	78.1	84.1	27.7(28.4)	33.8(33.6)
	Eligible for choice	5	0	0	0	0	97.4(35)	124.5(42.8)
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	7	35.6	39.4	33.8	37.6	65.1(52.6)	79.2(60.4)
	Eligible for choice	7	0	0	0	0	102.6(41.3	128.8(48.4)
	Not Eligible for choice	7	45.5	48.8	43.4	46.8	15.1(10.1)	23.8(14.7)

Table F-13 Geographic Access to VA Facilities with Telemetry

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	77	35.2	40.2	33.8	38.7	63.5(55.7)	73(58.3)
	Eligible for choice	77	0	0	0	0	113.9(49.3)	137.9(51.1)
	Not Eligible for choice	77	37.9	43.1	36.6	41.6	17.8(10.6)	27.3(15)
1	All	4	44	58.4	43.7	57.6	49.5(43.5)	57.2(45.6)
	Eligible for choice	4	0	0	0	0	144.8(60.5)	166(50.1)
	Not Eligible for choice	4	45.7	60.6	45.6	60	21.3(11.5)	33.1(14.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	1	13	17.7	13.9	18.7	96.1(48.4)	103.6(49.4)
	Eligible for choice	1	0	0	0	0	124.6(31.1)	156.7(39.2)
	Not Eligible for choice	1	13.3	18.2	14.3	19.2	15.6(12.5)	31.9(19.6)
3	All	4	81.5	89.5	80.8	88.7	21.4(16)	28(17.7)
	Eligible for choice	4	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	4	81.6	89.6	80.9	88.8	16.7(10)	24.9(13.1)
4	All	6	55.1	63.7	54.3	62.6	39.3(35.2)	49(39.1)
	Eligible for choice	6	0	0	0	0	71.9(28.5)	93.7(36.2)
	Not Eligible for choice	6	56.2	64.5	55.4	63.5	17.6(11)	28.1(16.2)
5	All	3	73.4	75.7	69	71.1	27.7(28.6)	36.4(34.2)
	Eligible for choice	3	0	0	0	0	59(22.5)	71(25.6)
	Not Eligible for choice	3	74.3	76	69.7	71.5	15.4(9.9)	22.8(13.3)
6	All	5	29.9	32.6	28.8	31.2	88.2(55.7)	100.6(59.6)
	Eligible for choice	5	0	0	0	0	98.3(38.7)	126.5(44.4)
	Not Eligible for choice	5	32.7	35.4	31.6	34	17.9(10.3)	26.4(14.6)
7	All	5	35.5	39.5	35.6	39.6	66.4(45.3)	77.9(50.2)
	Eligible for choice	5	0	0	0	0	92.7(36.3)	114.9(41.6)
	Not Eligible for choice	5	38.8	42.6	38.9	42.8	18.8(10.7)	29.2(15.6)
8	All	5	35	42.5	35.5	42.9	60.3(42.1)	69.3(44.1)
	Eligible for choice	5	0	0	0	0	114.9(49.5)	147.9(48.4)
	Not Eligible for choice	5	35.5	43.2	36.1	43.7	18.1(11.4)	30.7(16.9)
9	All	NA	0	0.5	0	0.5	138.3(40.8)	146.5(42.2)
	Eligible for choice	NA	0	0	0	0	154.7(37.5)	175.7(34.5)
	Not Eligible for choice	NA	0.1	0.6	0	0.6	36.9(.)	53.9(6.2)
10	All	2	20.1	26.7	21	27	78.2(44.3)	87.1(42.3)
	Eligible for choice	2	0	0	0	0	68.7(20.7)	96.8(26.6)
	Not Eligible for choice	2	20.2	26.9	21.1	27.2	17.2(11.4)	31.2(17.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	7	45.8	52.2	44.4	50.7	47.5(37.9)	57.8(43)
	Eligible for choice	7	0	0	0	0	84.7(38.2)	102.8(44.6)
	Not Eligible for choice	7	49.1	54.9	47.7	53.3	17.9(10.8)	27(15.4)
12	All	3	52.1	58.3	49.1	55	42.2(45.4)	48.1(49)
	Eligible for choice	3	0	0	0	0	133.9(34.5)	158(41.5)
	Not Eligible for choice	3	54.5	61	51.7	57.8	16.5(10.5)	23.1(13.9)
15	All	4	29.6	31.8	27.3	29.4	97.6(68.5)	106.6(67.7)
	Eligible for choice	4	0	0	0	0	113.2(45.5)	138.1(50.7)
	Not Eligible for choice	4	32.9	35	30.5	32.5	16.3(10.4)	24.3(14.9)
16	All	4	21.7	24.9	21.4	24.7	88.5(67.1)	102.8(71)
	Eligible for choice	4	0	0	0	0	124.3(51.5)	145.5(50.7)
	Not Eligible for choice	4	24.3	27.7	24.1	27.6	19.5(10.4)	30.1(15.1)
17	All	2	33	40.8	32.3	39.6	67.9(51.1)	76.5(52.9)
	Eligible for choice	2	0	0	0	0	107.1(42.6)	129.6(46.8)
	Not Eligible for choice	2	36.2	44.1	35.5	42.8	23.7(10)	33.5(12.9)
18	All	2	14.8	15	15.6	15.8	93(48.2)	107.4(49.5)
	Eligible for choice	2	0	0	0	0	150.8(57.3)	177.2(46)
	Not Eligible for choice	2	16.4	16.6	17.3	17.5	12.2(7.1)	20.8(11.9)
19	All	2	14.1	16.1	14	15.9	73.4(65.5)	85.2(71.4)
	Eligible for choice	2	0	0	0	0	149.8(51.9)	172.4(49.2)
	Not Eligible for choice	2	16.8	19.1	16.8	19	19.4(11.7)	31.1(15.4)
20	All	2	7.9	8.2	8.3	8.7	138.7(62.3)	144.2(59.5)
	Eligible for choice	2	0	0	0	0	141(55.7)	168.4(50.7)
	Not Eligible for choice	2	9.1	9.5	9.6	10	14.7(11.2)	24.6(14.7)
21	All	4	43	51.6	42.5	50.6	43.7(36)	55.7(41.1)
	Eligible for choice	4	0	0	0	0	107.6(53.5)	139.9(53.4)
	Not Eligible for choice	4	44.6	53.5	44.2	52.6	18.5(11.2)	32.4(16.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	4	66	71.6	64.3	70.3	45.9(62.5)	51.5(62.7)
	Eligible for choice	4	0	0	0	0	102.2(40)	129.9(42.9)
	Not Eligible for choice	4	67.9	73.7	66.1	72.3	18.4(8.6)	24(11)
23	All	8	35.9	39.7	34.2	38	64.5(52)	78.7(60)
	Eligible for choice	8	0	0	0	0	100.9(40.1)	127.1(47.1)
	Not Eligible for choice	8	45.9	49.2	43.9	47.3	15.1(10.1)	23.8(14.7)

Table F-14 Geographic Access to VA Facilities providing Non-invasive cardiology services

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	170	58.3	64.2	57.1	62.9	39.3(37.7)	49.5(43.9)
	Eligible for choice	170	0	0	0	0	92.6(39.7)	117.6(45.9)
	Not Eligible for choice	167	62.9	68.7	61.8	67.5	16.6(10.5)	25.3(14.8)
1	All	10	71.3	79.2	70.6	78.1	28.8(26)	37.3(30.1)
	Eligible for choice	10	0	0	0	0	96.5(42.7)	118.2(47)
	Not Eligible for choice	10	74.1	81.8	73.7	81	17.6(10.5)	26.6(14.2)
2	All	4	50.8	58.8	51.1	59	42.4(33.7)	51.5(37.4)
	Eligible for choice	4	0	0	0	0	93.1(38)	119.9(46.3
	Not Eligible for choice	4	52.1	60.2	52.3	60.3	16.2(11.5)	27.6(17.5)
3	All	12	88.8	92.6	88.1	91.8	14.8(14.2)	20.6(16.7)
	Eligible for choice	12	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	11	88.8	92.7	88.2	91.9	11.8(8.8)	18.3(12.3)
4	All	8	62	72.9	61.9	72.9	31.4(23.4)	40.9(28.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	8	0	0	0	0	62.3(21)	83.6(28.5)
	Not Eligible for choice	8	63.2	73.9	63.2	74	17.6(11.2)	28.6(16.6)
5	All	4	82.7	85.1	80.5	83	23.7(22.7)	32.8(29.7)
	Eligible for choice	4	0	0	0	0	52.2(12.3)	64.8(17.9)
	Not Eligible for choice	4	83.6	85.5	81.3	83.5	16.2(10.4)	23.7(13.7)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	7	43.9	48.5	43.9	48.5	53.3(35)	67.1(42.5)
	Eligible for choice	7	0	0	0	0	76.2(21.8)	99.5(29.5)
	Not Eligible for choice	7	47.9	52.4	48	52.5	18.2(10.7)	28.5(15.7)
8	All	14	71.6	75.2	71.7	75.3	28.4(22.5)	38.1(27.9)
	Eligible for choice	14	0	0	0	0	69.6(23.5)	100.9(31.6)
	Not Eligible for choice	13	72.7	76.4	72.9	76.5	18.1(10.9)	27.2(14.9)
9	All	6	34.6	41.6	35.4	42.1	74.2(52.1)	85.4(54.4)
	Eligible for choice	6	0	0	0	0	107.5(37.9	130.2(38.9)
	Not Eligible for choice	6	39.3	47	40.2	47.4	16.4(10.5)	27.4(16.5)
10	All	5	64.8	71.5	63.4	70.3	29.9(23.7)	38.4(27.4)
	Eligible for choice	5	0	0	0	0	53(8.1)	76.4(13.7)
	Not Eligible for choice	5	65.3	71.9	63.9	70.8	16.2(10.9)	25.2(14.8)
11	All	8	49.8	55.5	48.6	54.1	44.8(37.9)	55(43.1)
	Eligible for choice	8	0	0	0	0	81.4(38.8)	99.6(45.4)
	Not Eligible for choice	8	53.5	58.2	52.1	56.7	17.4(10.8)	25.7(14.8)
12	All	8	67	74.2	64.9	72	28.4(27.3)	37.1(36)
	Eligible for choice	8	0	0	0	0	75.3(28.9)	110.4(44.9)
	Not Eligible for choice	8	70.1	77.5	68.3	75.5	16.1(10.7)	23(14.3)
15	All	9	56.6	61.3	54.9	59.6	41.5(38.1)	54.1(47.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	9	0	0	0	0	92.5(37.8)	120.5(46.8)
	Not Eligible for choice	9	63	67.4	61.4	65.8	16.2(10.3)	24.1(15)
16	All	12	45.3	50.2	43.8	48.9	50.3(38.7)	63.6(47.2)
	Eligible for choice	12	0	0	0	0	84.5(29.6)	109.3(38.8)
	Not Eligible for choice	12	50.8	55.2	49.4	53.8	16.4(10.7)	25.9(15.5)
17	All	3	53	61.7	52.1	60.4	52(43.3)	61.8(47.9)
	Eligible for choice	3	0	0	0	0	100.9(36)	124(42.6)
	Not Eligible for choice	3	58.1	67	57.3	65.7	21.4(10.4)	31(13.6)
18	All	7	63.5	66.2	63.3	66	45.7(48.3)	58.3(55.8)
	Eligible for choice	7	0	0	0	0	106.5(41.7	135.1(50.4)
	Not Eligible for choice	7	70.2	73	70.3	72.9	15.6(9.2)	24.8(13.1)
19	All	7	40.5	46.2	39.4	44.7	58.5(56.4)	69.5(61.5)
	Eligible for choice	7	0	0	0	0	133.5(50)	153.6(52.8)
	Not Eligible for choice	6	48.1	53.9	47.2	52.5	16.2(10.4)	27.4(15.2)
20	All	8	54.4	62	54.6	61.7	45.6(46.1)	57.3(54.1)
	Eligible for choice	8	0	0	0	0	99.8(39.6)	128.7(47.7)
	Not Eligible for choice	8	62.6	70.3	63	70.2	17.3(10.5)	26.6(14.6)
21	All	11	71.2	73.7	69.3	72	26(26.2)	37.3(35.4)
	Eligible for choice	11	0	0	0	0	84.7(44)	121(54)
	Not Eligible for choice	11	74	76.5	72.1	74.9	14.9(9.7)	23.7(14.3)
22	All	9	79	84.7	78.1	84.1	27.2(28.5)	32.8(31.9)
	Eligible for choice	9	0	0	0	0	96.1(34.8)	122.6(41.4)
	Not Eligible for choice	9	81.3	87.1	80.3	86.5	17.1(9.1)	22.7(11.3)
23	All	10	41.1	44.5	39.8	43.1	58.6(48.8)	73.1(56.9)
	Eligible for choice	10	0	0	0	0	97.4(40.5)	124.6(46.8)
	Not Eligible for choice	10	52.4	55.2	51.2	53.9	15.2(10.3)	23.7(14.8)

Table F-15 Geographic Access to VA Facilities providing diagnostic cardiac catheterization

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	76	42	47.6	40.2	45.7	54.2(49.9)	63.3(53.8)
	Eligible for choice	76	0	0	0	0	110(45.5)	132(48.7)
	Not Eligible for choice	76	45.3	51	43.6	49.2	17.2(10.3)	25.9(14.4)
1	All	3	35.8	54.4	35.1	53.6	49.5(39.1)	56.2(41)
	Eligible for choice	3	0	0	0	0	113.5(61.4	125(61.2)
	Not Eligible for choice	3	37.2	56.1	36.7	55.6	21.1(11.4)	34.1(14.8)
2	All	3	44.3	51.9	44.5	52	47.8(37)	57.6(42.8)
	Eligible for choice	3	0	0	0	0	109.7(32.8	136.5(41.4)
	Not Eligible for choice	3	45.5	53.2	45.6	53.3	15.1(11.2)	26.5(17.7)
3	All	4	78.1	83.6	76.7	82.1	20.7(17.9)	27.5(20.4)
	Eligible for choice	4	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	4	78.1	83.7	76.7	82.1	14.9(9.6)	22.5(12.7)
4	All	3	41.5	51.8	39.7	49.9	46(35.1)	54(38.8)
	Eligible for choice	3	0	0	0	0	89.3(37.8)	108.3(45.9)
	Not Eligible for choice	3	42.4	52.4	40.5	50.5	17.4(11)	27.8(16)
5	All	2	71.8	75.3	67.1	70.7	29(30.9)	37.8(36.8)
	Eligible for choice	2	0	0	0	0	67.2(31.5)	78.3(33.5)
	Not Eligible for choice	2	72.6	75.7	67.8	71.1	15.6(10.2)	23.2(13.6)
6	All	4	21	25.7	21.6	26	75.1(40.7)	85.4(45)
	Eligible for choice	4	0	0	0	0	83.3(33.7)	105.9(40.7)
	Not Eligible for choice	4	23	27.3	23.8	27.7	19.4(11.3)	30.7(15.9)
7	All	5	39.8	43.8	39.8	43.9	64.2(45.8)	77.7(53)
	Eligible for choice	5	0	0	0	0	100.7(40.1	125.5(46.1)
	Not Eligible for choice	5	43.5	47.4	43.6	47.5	18.3(10.5)	28.2(15.2)
8	All	6	43.6	47.7	43	47.3	51.6(43.7)	61.3(47.2)
	Eligible for choice	6	0	0	0	0	123.8(50.6	150.5(48.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	44.3	48.5	43.7	48.1	18.2(11.1)	26.5(15)
9	All	5	33.3	40.4	34.1	40.8	77.1(52.8)	87.1(54.6)
	Eligible for choice	5	0	0	0	0	110.8(37.4	131.7(38.1)
	Not Eligible for choice	5	37.8	45.6	38.7	46.1	17(10.8)	27.6(16.4)
10	All	3	48.1	54.2	46.9	53.2	44.8(34.8)	52.4(37)
	Eligible for choice	3	0	0	0	0	62.2(15.2)	85.5(18.3)
	Not Eligible for choice	3	48.4	54.6	47.3	53.5	16.5(11.1)	25.6(14.9)
11	All	3	32.2	37.2	30.5	35.5	67.1(51.1)	74.4(52.3)
	Eligible for choice	3	0	0	0	0	121(41.2)	132(42.7)
	Not Eligible for choice	3	34.6	39.6	32.7	37.7	16.8(9.8)	26(15.2)
12	All	4	52.9	62.8	49.9	59.5	37.1(39.5)	43.3(43.1)
	Eligible for choice	4	0	0	0	0	107.7(43.3	131.7(45.8)
	Not Eligible for choice	4	55.3	65.5	52.5	62.5	16.2(11)	23.6(14.9)
15	All	5	47.1	52	44.6	49.4	53.4(46.2)	65.1(54.7)
	Eligible for choice	5	0	0	0	0	104.1(38.7	130.2(46.8)
	Not Eligible for choice	5	52.5	57.5	49.9	55	16.3(10)	24.2(14.8)
16	All	5	28.6	31.3	27.2	29.9	90.9(68.9)	101.1(70.3)
	Eligible for choice	5	0	0	0	0	108.4(44)	129.5(49.4)
	Not Eligible for choice	5	32.1	34.2	30.7	32.9	16.9(9.9)	24.7(13.2)
17	All	2	43.2	49.4	41.5	47.4	61.5(49.3)	70.2(52.6)
	Eligible for choice	2	0	0	0	0	110.5(36.9	132(43.5)
	Not Eligible for choice	2	47.4	54	45.7	51.8	20.9(10.1)	29.9(13.1)
18	All	3	48.8	50	47.2	48.5	50.9(62.4)	61.7(65.8)
	Eligible for choice	3	0	0	0	0	139.5(57.3	163.3(53.3)
	Not Eligible for choice	3	54	55.3	52.4	53.7	16.3(9.1)	24.8(12.3)
19	All	2	33.3	37	31.6	34.8	54.4(55.6)	64.2(59.3)
	Eligible for choice	2	0	0	0	0	142.9(50.8	159.8(50.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	2	39.6	43.8	37.8	41.6	16.7(10.2)	26.9(14.2)
20	All	2	33.7	39.8	31.7	37.4	55(57)	64.1(60.1)
	Eligible for choice	2	0	0	0	0	116.1(47.7	138.4(48.2)
	Not Eligible for choice	2	38.7	45.2	36.6	42.6	18.4(10.2)	27.5(14.3)
21	All	3	29.3	31.4	29.1	31	70(59.3)	81(63.4)
	Eligible for choice	3	0	0	0	0	125.1(46.4	159(51.4)
	Not Eligible for choice	3	30.4	32.6	30.3	32.3	18.1(10.2)	26.9(13.5)
22	All	5	79	84.7	78.1	84.1	28.2(30.6)	33.9(33.7)
	Eligible for choice	5	0	0	0	0	99.5(37.3)	124.9(43.5)
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	4	29.3	32.7	27.1	30.5	68.8(58)	83.1(65)
	Eligible for choice	4	0	0	0	0	112(50.2)	137.4(52.9)
	Not Eligible for choice	4	37.4	40.7	34.9	38.3	15.2(9.8)	24(14.5)

Table F-16 Geographic Access to VA Facilities providing interventional cardiology

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	79	43.4	49	41.5	47	53.4(48.7)	62.7(52.9)
	Eligible for choice	79	0	0	0	0	111.4(46.1	133.6(48.9)
	Not Eligible for choice	79	46.8	52.5	45	50.6	17.2(10.4)	26.1(14.4)
1	All	2	33.7	51.7	32.8	50.5	55.6(47.6)	62.6(50)
	Eligible for choice	2	0	0	0	0	197.4(35.3	208.4(26.5)
	Not Eligible for choice	2	35.1	53.7	34.2	52.8	21.1(11.4)	33.9(14.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	3	45.4	53.2	45.5	53.3	47.6(38.4)	57.5(43.9)
	Eligible for choice	3	0	0	0	0	109.8(33.7	140.7(45.9)
	Not Eligible for choice	3	46.6	54.6	46.6	54.5	15.3(11.2)	26.6(17.5)
3	All	5	86.4	91.6	85.6	90.7	18.7(14.7)	25.3(16.9)
	Eligible for choice	5	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	5	86.5	91.7	85.7	90.8	15.4(9.9)	22.9(12.7)
4	All	2	36.4	45.1	35	43.7	53.1(41.1)	60.9(44.3)
	Eligible for choice	2	0	0	0	0	111.9(37)	128.3(40.9)
	Not Eligible for choice	2	37.2	46	35.7	44.6	17.3(11)	27.6(16)
5	All	3	81.1	84.7	78.6	82.6	24.9(24.9)	33.8(31.8)
	Eligible for choice	3	0	0	0	0	59.1(23.5)	71.9(27.8)
	Not Eligible for choice	3	82	85.2	79.4	83.1	16.5(10.6)	24.1(14)
6	All	5	29.6	34.3	29.8	34.3	70.1(39.9)	80.5(43.7)
	Eligible for choice	5	0	0	0	0	81.1(34)	103.9(40.4
	Not Eligible for choice	5	32.4	36.7	32.8	36.8	19.4(11.4)	31(16)
7	All	5	39.8	43.8	39.8	43.9	64(45.4)	77.4(52.5)
	Eligible for choice	5	0	0	0	0	100.2(39.6	124.8(45)
	Not Eligible for choice	5	43.5	47.4	43.6	47.5	18.3(10.5)	28.2(15.2)
8	All	6	43.6	47.7	43	47.3	51.6(43.7)	61.3(47.2)
	Eligible for choice	6	0	0	0	0	123.8(50.6	150.5(48.4
	Not Eligible for choice	6	44.3	48.5	43.7	48.1	18.2(11.1)	26.5(15)
9	All	4	29.5	35.5	30.1	35.9	85.7(56.1)	95.1(58)
	Eligible for choice	4	0	0	0	0	120.5(39.7	140.9(42.6)
	Not Eligible for choice	4	33.5	40.1	34.2	40.5	16.9(10.8)	26.8(16)
10	All	3	47.9	54.1	46.7	53.1	46.2(37.2)	53.6(39.4)
	Eligible for choice	3	0	0	0	0	62.2(15.2)	85.5(18.3)
	Not Eligible for choice	3	48.3	54.4	47.1	53.4	16.4(11)	25.6(14.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	3	32.2	37.2	30.5	35.5	67.1(51.1)	74.4(52.3)
	Eligible for choice	3	0	0	0	0	121(41.2)	132(42.7)
	Not Eligible for choice	3	34.6	39.6	32.7	37.7	16.8(9.8)	26(15.2)
12	All	4	52.9	62.8	49.9	59.5	37.1(39.5)	43.3(43.1)
	Eligible for choice	4	0	0	0	0	107.7(43.3	131.7(45.8)
	Not Eligible for choice	4	55.3	65.5	52.5	62.5	16.2(11)	23.6(14.9)
15	All	5	47.2	50.8	44.7	48.1	57.9(52)	69(59.2)
	Eligible for choice	5	0	0	0	0	102.4(40.1	127.8(47.5)
	Not Eligible for choice	5	52.6	55.8	50	53.2	16.1(10.2)	23(14.2)
16	All	7	33.2	37.5	31.9	36.4	71.5(52.3)	84.2(57.9)
	Eligible for choice	7	0	0	0	0	99.5(39)	121.9(45.4
	Not Eligible for choice	7	37.3	41	36	39.9	17.5(10.4)	27.3(15)
17	All	2	43.2	49.4	41.5	47.4	61.4(49.2)	70.1(52.5)
	Eligible for choice	2	0	0	0	0	110.3(36.8	131.8(43.2)
	Not Eligible for choice	2	47.4	54	45.7	51.8	20.9(10.1)	29.9(13.1)
18	All	3	48.8	50	47.2	48.5	50.9(62.4)	61.7(65.8)
	Eligible for choice	3	0	0	0	0	139.5(57.3	163.3(53.3)
	Not Eligible for choice	3	54	55.3	52.4	53.7	16.3(9.1)	24.8(12.3)
19	All	2	33.3	37	31.6	34.8	54.4(55.6)	64.2(59.3)
	Eligible for choice	2	0	0	0	0	142.9(50.8	159.8(50.4)
	Not Eligible for choice	2	39.6	43.8	37.8	41.6	16.7(10.2)	26.9(14.2)
20	All	2	33.7	39.8	31.7	37.4	55(57)	64.1(60.1)
	Eligible for choice	2	0	0	0	0	116.1(47.7	138.4(48.2)
	Not Eligible for choice	2	38.7	45.2	36.6	42.6	18.4(10.2)	27.5(14.3)
21	All	4	43	47.1	42	45.7	52.3(53.9)	65.6(60.1)
	Eligible for choice	4	0	0	0	0	114.8(56.3	146.6(57.7)
	Not Eligible for choice	4	44.6	48.9	43.7	47.6	17.9(9.8)	28(13.6)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	5	79	84.7	78.1	84.1	28.2(30.6)	33.9(33.7)
	Eligible for choice	5	0	0	0	0	99.5(37.3)	124.9(43.5
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	4	26.9	30	25	28.1	77.5(58.3)	90.4(64)
	Eligible for choice	4	0	0	0	0	116.7(47)	142.7(49.5)
	Not Eligible for choice	4	34.3	37.5	32.1	35.4	15.1(9.6)	23.9(14.5)

Table F-17 Geographic Access to VA Facilities providing cardiac surgery

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	75	39.7	46.2	38	44.4	58.3(51.2)	67.6(54.6)
	Eligible for choice	75	0	0	0	0	112.3(45.7)	134.9(48.9)
	Not Eligible for choice	75	42.8	49.6	41.1	47.7	17.8(10.7)	27.5(15.1)
1	All	3	38.6	56.3	38.1	55.6	49.2(38)	57.5(42)
	Eligible for choice	3	0	0	0	0	141.7(57.9)	167.1(49.6)
	Not Eligible for choice	3	40.1	58.4	39.8	57.9	21.2(11.2)	34.1(14.8)
2	All	3	44.3	51.9	44.5	52	48.4(38.5)	58.2(44)
	Eligible for choice	3	0	0	0	0	110.2(33.6)	141.1(45.8)
	Not Eligible for choice	3	45.5	53.2	45.6	53.3	15.1(11.2)	26.5(17.7)
3	All	5	79.5	84.9	78.2	83.6	18(18.6)	23.7(21)
	Eligible for choice	5	0	0	0	0	93.9(6.8)	121.6(3)
	Not Eligible for choice	5	79.5	85	78.2	83.7	11.9(9)	18.7(13)
4	All	2	27.8	40.5	27.4	39.5	59.6(37.8)	69.1(40.6)
	Eligible for choice	2	0	0	0	0	109.2(29.9)	125.8(36.1)

	Not Eligible for choice	2	28.3	41.3	27.9	40.3	22.1(12)	35.4(15.4)
5	All	2	66.6	82.1	63	80.1	32.7(23.9)	42.2(29.3)
	Eligible for choice	2	0	0	0	0	56.9(22.7)	69.2(24.5)
	Not Eligible for choice	2	67.3	82.5	63.7	80.6	20.7(11.6)	32.7(15.7)
6	All	6	43.4	47.9	41.3	45.6	62.7(42.8)	74.6(47.8)
	Eligible for choice	6	0	0	0	0	76(27.7)	100.1(35.5)
	Not Eligible for choice	6	47.4	51.5	45.3	49.1	19.4(10.7)	29(15)
7	All	3	28	31.5	27.3	30.7	78.3(49.8)	90.3(54.6)
	Eligible for choice	3	0	0	0	0	118.7(40.8)	139.7(45)
	Not Eligible for choice	3	30.6	34.1	29.9	33.3	18.8(10.4)	28.8(15)
8	All	6	43.6	47.7	43	47.3	51.6(43.7)	61.3(47.2)
	Eligible for choice	6	0	0	0	0	123.8(50.6)	150.5(48.4)
	Not Eligible for choice	6	44.3	48.5	43.7	48.1	18.2(11.1)	26.5(15)
9	All	5	36.3	43.9	36.8	44.1	64.5(44.3)	75.4(49)
	Eligible for choice	5	0	0	0	0	102.2(33.8)	123.5(35.7)
	Not Eligible for choice	5	41.2	49.5	41.8	49.6	16.4(10.2)	26.5(16.1)
10	All	3	49	62.5	46.7	60.7	38.2(25.9)	46.1(28.9)
	Eligible for choice	3	0	0	0	0	62(13.2)	84.9(16.1)
	Not Eligible for choice	3	49.4	63	47	61.1	17.3(11.4)	30.1(16.8)
11	All	2	23.9	32.2	23.1	31.1	77(50)	85.1(49.8)
	Eligible for choice	2	0	0	0	0	125(41.7)	136.7(43.5)
	Not Eligible for choice	2	25.6	34.3	24.8	33	24.1(11.7)	37.9(14.9)
12	All	3	50.7	61.9	47.8	58.7	39.4(38.6)	45.7(42.1)
	Eligible for choice	3	0	0	0	0	108.7(43)	132.5(45.4)
	Not Eligible for choice	3	53	64.6	50.2	61.6	18.3(10.2)	26.1(13.9)
15	All	2	6.6	7.7	7.2	8.4	112.5(43.7)	120.7(46.9)
	Eligible for choice	2	0	0	0	0	134.1(41)	159.5(43.4)
	Not Eligible for choice	2	7.3	8.3	8.1	9.1	18(13.9)	30.7(20.2)
16	All	8	36.7	41.4	35.6	40.4	65.9(55)	76.6(58.3)
	Eligible for choice	8	0	0	0	0	106.2(44.6)	126.6(46.9)
	Not Eligible for choice	8	41.2	45.5	40.1	44.5	16.7(10.6)	26.1(15.4)
17	All	3	53	61.7	52.1	60.3	52.9(44.5)	62.4(48.8)

	Eligible for choice	3	0	0	0	0	103.7(37.9)	125.4(43.1)
	Not Eligible for choice	3	58.1	66.9	57.3	65.6	21.4(10.4)	30.9(13.6)
18	All	3	23.2	23.7	24.2	24.8	102.3(60.8)	108.1(60.7)
	Eligible for choice	3	0	0	0	0	129.7(58.5)	151.5(57.9)
	Not Eligible for choice	3	25.7	26.1	26.9	27.4	12(7.8)	20.3(11.9)
19	All	2	33.3	37	31.6	34.8	55.4(57.5)	65.4(61.3)
	Eligible for choice	2	0	0	0	0	142.8(51)	161.2(51.4)
	Not Eligible for choice	2	39.6	43.8	37.8	41.6	16.7(10.2)	26.9(14.2)
20	All	3	39.6	45.9	37.7	43.5	53.1(52.3)	64.4(59.1)
	Eligible for choice	3	0	0	0	0	105.9(41.1)	134.2(48.3)
	Not Eligible for choice	3	45.6	52.4	43.5	49.7	18(10.4)	27.2(14.3)
21	All	3	36.6	40.9	34.8	38.7	58(56.3)	71.5(62.5)
	Eligible for choice	3	0	0	0	0	126.3(53.8)	157.9(52.1)
	Not Eligible for choice	3	38	42.5	36.3	40.3	18.2(9.6)	28.5(13.3)
22	All	4	66	71.6	64.3	70.3	46.4(63.5)	51.5(62.7)
	Eligible for choice	4	0	0	0	0	105.5(43.4)	130.2(43.3)
	Not Eligible for choice	4	67.9	73.7	66.1	72.3	18.4(8.6)	24(11)
23	All	4	23.7	25.5	22.6	24.3	87.8(59.8)	101.4(64.9)
	Eligible for choice	4	0	0	0	0	113.4(44.9)	140.4(53)
	Not Eligible for choice	4	30.2	31.3	29	30.1	15(9.5)	22.4(12.7)

Appendix F.2.2. Services for Populations with Colon Cancer

Table F-18 Geographic Access to VA facilities providing primary care

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	895	91.8	92.1	91.4	91.6	15.8(16.1)	24.5(23)
	Eligible for choice	895	0	0	0	0	58.3(21.4)	83.2(31.7)
	Not Eligible for choice	839	99	97.8	99	97.6	12.3(9.3)	19.1(12.9)
1	All	50	96.2	96.2	95.8	95.8	12(11.1)	18.9(16.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	50	0	0	0	0	52.9(12.6)	76.2(22)
	Not Eligible for choice	47	100	98.9	100	98.9	10.7(8)	16.5(11.3)
2	All	33	97.4	95.2	97.6	95.3	12.5(10.7)	21.8(17.8)
	Eligible for choice	33	0	0	0	0	48.3(7.1)	75.4(19.2)
	Not Eligible for choice	32	100	97.2	100	97.3	11.5(9)	19(13.4)
3	All	35	99.9	99.9	99.9	99.9	6.3(5.1)	11(8)
	Eligible for choice	35	0	0	0	0	42.4(1.2)	65.7(9.8)
	Not Eligible for choice	32	100	100	100	100	6.2(5)	11(7.8)
4	All	55	98.1	98.3	98	98.2	12.3(9.3)	19.6(13.5)
	Eligible for choice	55	0	0	0	0	45.2(5.3)	64.5(13.2)
	Not Eligible for choice	51	100	99.4	100	99.4	11.7(8.3)	18.5(11.6)
5	All	21	98.9	99.5	99	99.4	13(9.9)	20.4(13.6)
	Eligible for choice	21	0	0	0	0	43.4(3.8)	55.6(11)
	Not Eligible for choice	20	100	99.8	100	99.8	12.7(9.4)	19.9(12.9)
6	All	28	81.8	84.1	81.7	84.1	23.1(16)	34.4(23.4)
	Eligible for choice	28	0	0	0	0	49.5(10)	72(20.2)
	Not Eligible for choice	28	89.4	89.2	89.8	89.5	17.9(10.7)	26.5(14.4)
7	All	48	90.8	90.7	90.6	90.3	19(15.9)	30.2(22.8)
	Eligible for choice	48	0	0	0	0	51.1(10)	73.9(16.9)
	Not Eligible for choice	47	99.2	97.1	99.1	96.9	14.5(10)	23.1(14.2)
8	All	57	98.4	97.9	98.3	97.8	12(9.1)	19.7(14)
	Eligible for choice	57	0	0	0	0	50.5(8.2)	76.7(12.5)
	Not Eligible for choice	54	100	99.4	100	99.3	11.4(7.7)	18.4(11.2)
9	All	45	88	88.8	88.1	88.8	21.1(16)	32.3(23.2)
	Eligible for choice	45	0	0	0	0	51.6(9.6)	74(16)
	Not Eligible for choice	42	99.9	97.7	99.9	97.6	16.4(10.7)	24.6(15)
10	All	33	98.4	98	98.4	98	11.7(9.5)	18.9(13.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	33	0	0	0	0	43.3(1.8)	60.2(7.8)
	Not Eligible for choice	33	99.1	98.5	99.1	98.5	11.2(8.7)	17.9(12.4)
11	All	36	92.6	93.9	92.6	93.8	17.4(12.7)	26.3(17.6)
	Eligible for choice	36	0	0	0	0	48.1(7.5)	64.5(12.9)
	Not Eligible for choice	36	99.4	98	99.3	97.9	15.3(9.9)	23.1(13.9)
12	All	38	94.2	93.9	93.6	93.1	12.2(11.6)	19.4(17.2)
	Eligible for choice	38	0	0	0	0	51.8(12.2)	79.6(19.8)
	Not Eligible for choice	38	98.6	97.7	98.4	97.3	10.6(8.5)	16.8(11.8)
15	All	57	89.8	89.5	89.4	88.9	18.8(17.4)	28.7(24.9)
	Eligible for choice	57	0	0	0	0	55.8(13.9)	79(21.6)
	Not Eligible for choice	50	100	97.7	100	97.4	13.8(10.4)	20.8(14.4)
16	All	66	88.4	89.3	88	88.8	19.6(15.7)	29.4(22.5)
	Eligible for choice	66	0	0	0	0	51(11.1)	73.1(19.4)
	Not Eligible for choice	65	99.3	97.1	99.2	96.9	15.3(10.5)	22.6(14)
17	All	30	91.1	91.4	90.9	91.1	20(17.8)	29(24.6)
	Eligible for choice	30	0	0	0	0	60.5(24.7)	85.2(34.5)
	Not Eligible for choice	25	100	98.7	100	98.7	15.7(9.6)	22.6(12.5)
18	All	47	90.4	90.3	90.1	90	17.9(22.3)	28.7(32.5)
	Eligible for choice	47	0	0	0	0	67.9(27)	99(42.5)
	Not Eligible for choice	42	100	98.7	100	98.7	10.9(8.3)	18.2(11.6)
19	All	42	83.9	85.2	83.2	84.4	24.7(32.4)	35.3(42.4)
	Eligible for choice	42	0	0	0	0	81.8(33.2)	107.7(46.3)
	Not Eligible for choice	34	99.7	98.3	99.7	98.2	11.3(8.9)	17.7(11.9)
20	All	38	87	87.9	86.7	87.5	19.5(21)	29.7(31)
	Eligible for choice	38	0	0	0	0	65.1(23.7)	95.6(39.9)
	Not Eligible for choice	36	100	98.1	100	98	13.1(9.8)	19.9(12.8)
21	All	41	95.2	94.5	94.8	94.2	13.2(13.2)	21.2(19.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	41	0	0	0	0	63.5(25.6)	97.2(32.9)
	Not Eligible for choice	39	98.8	98.1	98.8	98	11.2(8.1)	18(11.8)
22	All	35	97.2	97.4	97.3	97.5	9.5(10.1)	15(14.5)
	Eligible for choice	35	0	0	0	0	63.2(29.7)	92.5(43.6)
	Not Eligible for choice	35	100	99.8	100	99.8	8.6(6)	13.5(8.1)
23	All	60	77	76.9	76.4	76.1	25.7(24.8)	39.1(35.3)
	Eligible for choice	60	0	0	0	0	63(21.8)	90.9(31.9)
	Not Eligible for choice	53	98.2	95.1	98.1	94.8	14.5(10.9)	22.1(15.3)

Table F-19 Geographic Access to VA Facilities providing colonoscopy

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	167	58	63.5	56.6	62.2	40(38.8)	50.3(44.9)
	Eligible for choice	167	0	0	0	0	93.1(39.8)	118.5(46.1)
	Not Eligible for choice	165	62.5	68	61.4	66.8	16.2(10.4)	25(14.9)
1	All	8	62.1	72.7	61.6	71.8	34.2(27.2)	41.8(30.9)
	Eligible for choice	8	0	0	0	0	96.5(42.7)	118.2(47)
	Not Eligible for choice	8	64.6	75.1	64.3	74.4	19.2(11.6)	28.7(15.4)
2	All	3	45.4	53.2	45.5	53.3	47(36.9)	56.9(42.6)
	Eligible for choice	3	0	0	0	0	109.4(32.9	136.3(41.5)
	Not Eligible for choice	3	46.6	54.6	46.6	54.5	15.3(11.2)	26.6(17.5)
3	All	7	88.4	91.8	87.3	90.9	15.3(14.5)	21.1(17.1)
	Eligible for choice	7	0	0	0	0	92.2(5.4)	118.4(5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	7	88.4	91.9	87.4	91	12.3(9.3)	18.5(12.3)
4	All	8	61.3	73.6	61.3	73.5	31.5(23.5)	41(28.6)
	Eligible for choice	8	0	0	0	0	63(20.4)	83.9(28.4)
	Not Eligible for choice	8	62.5	74.6	62.5	74.6	17.6(11.2)	29.1(16.9)
5	All	3	82.7	85.1	80.5	83	24(22.7)	33(29.7)
	Eligible for choice	3	0	0	0	0	52.6(12.5)	64.8(17.9)
	Not Eligible for choice	3	83.6	85.5	81.3	83.5	16.6(10.6)	24(13.9)
6	All	9	57	64	56.2	63.2	43.6(34.2)	56.2(41.4)
	Eligible for choice	9	0	0	0	0	67(22.1)	91.1(31.1)
	Not Eligible for choice	9	62.4	68.8	61.8	68.3	20(10.7)	30.7(15)
7	All	8	47.6	52.6	47.6	52.6	50(34.7)	63.6(42.4)
	Eligible for choice	8	0	0	0	0	74.9(22.8)	97.3(29.6)
	Not Eligible for choice	8	52	56.8	52.1	56.9	18.2(11)	28.5(15.8)
8	All	13	68	71.7	67.7	71.5	32.1(29.7)	41.6(33.7)
	Eligible for choice	13	0	0	0	0	95.8(37.9)	125.1(40.3
	Not Eligible for choice	12	69	72.7	68.8	72.6	16.3(10)	25.8(14.8)
9	All	6	34.6	41.5	35.4	42	74.5(52.1)	85.6(54.4)
	Eligible for choice	6	0	0	0	0	108.3(37.3)	130.9(38.2)
	Not Eligible for choice	6	39.3	47	40.2	47.4	16.4(10.5)	27.4(16.5)
10	All	5	64.8	71.5	63.4	70.3	30(23.8)	38.5(27.6)
	Eligible for choice	5	0	0	0	0	53(8.1)	76.4(13.7)
	Not Eligible for choice	5	65.3	71.9	63.9	70.8	16.2(10.9)	25.2(14.8)
11	All	6	42.5	48.8	41.1	47.2	53.5(43.9)	62.7(47.2)
	Eligible for choice	6	0	0	0	0	88.5(38.4)	106.8(45.7
	Not Eligible for choice	6	45.6	51.5	44.1	49.8	17.6(10.8)	26.8(15.5)
12	All	6	59.4	64.8	56.6	61.8	35.2(36.6)	44(44.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	6	0	0	0	0	92.4(32.2)	129.8(46.3)
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	8	53	57.1	51	55	46.8(41.5)	59.5(50.6)
	Eligible for choice	8	0	0	0	0	95.1(37)	122.7(45.7)
	Not Eligible for choice	8	59.1	62.9	57.1	60.9	16.3(10.3)	23.8(14.7)
16	All	16	48.2	53.4	46.5	51.8	48(38.3)	61.5(47.2)
	Eligible for choice	16	0	0	0	0	83.7(29.3)	108.7(38.6)
	Not Eligible for choice	16	54.1	58.7	52.5	57.2	16.5(10.8)	26.2(15.5)
17	All	6	62.8	69.1	62.2	68.4	46.3(41.1)	56.3(47.1)
	Eligible for choice	6	0	0	0	0	91.5(32.2)	115.2(40.2
	Not Eligible for choice	6	69	74.7	68.5	74.2	19.1(10)	27.6(13.8)
18	All	6	63	64.8	62.7	64.5	49.2(55.8)	61.3(61.9)
	Eligible for choice	6	0	0	0	0	121.2(52)	149.4(54.2
	Not Eligible for choice	6	69.6	71.5	69.6	71.4	15.6(9.1)	24.4(12.7)
19	All	9	45	50.6	45.2	50.5	54.8(53.3)	65.4(58.1)
	Eligible for choice	9	0	0	0	0	123.2(51.6	145.1(54.8)
	Not Eligible for choice	8	53.4	59.2	54.2	59.5	15.8(10.4)	26.7(15.2)
20	All	10	58.1	62.5	57.3	61.6	40.2(40.4)	52.7(50)
	Eligible for choice	10	0	0	0	0	91.4(35.2)	123.3(47.2)
	Not Eligible for choice	10	66.8	70.8	66.1	70	15.9(9.5)	25(13.9)
21	All	9	62.9	65.4	62.3	65	28(25.8)	40.1(33.6)
	Eligible for choice	9	0	0	0	0	88.1(44)	124.2(53.1
	Not Eligible for choice	9	65.3	67.8	64.8	67.7	16.5(9.6)	26.2(13.7)
22	All	11	79.3	85.5	78.4	85	23.8(28.2)	29.5(31.9)
	Eligible for choice	11	0	0	0	0	93.7(33.9)	120.1(40.5
	Not Eligible for choice	11	81.6	88	80.6	87.4	13.9(9)	19.9(12.2)
23	All	10	41.1	44.5	39.8	43.1	59(49.2)	73.8(57.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	10	0	0	0	0	97.7(40.5)	125.1(46.9
	Not Eligible for choice	10	52.4	55.2	51.2	53.9	15.2(10.3)	23.7(14.8)

Table F-20 Geographic Access to VA Facilities providing CT scans

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	175	60	65.7	58.8	64.5	38.3(36.6)	48.6(43.1)
	Eligible for choice	175	0	0	0	0	89(39)	114.6(46)
	Not Eligible for choice	174	64.7	70.2	63.7	69.1	16.6(10.5)	25.3(14.7)
1	All	7	59	70.4	58.7	69.6	35.5(27.9)	43.1(31.6)
	Eligible for choice	7	0	0	0	0	97.8(42.2)	119.5(46.2
	Not Eligible for choice	7	61.3	72.6	61.3	72.2	19.2(11.6)	28.9(15.6)
2	All	5	62.5	70.3	63.5	71.2	36.7(32.5)	47.1(36.8)
	Eligible for choice	5	0	0	0	0	97.4(36.2)	122.1(45.5
	Not Eligible for choice	5	64.2	72	65.1	72.8	18.5(11.7)	29.8(17)
3	All	6	86.9	91.6	86	90.7	15.9(15)	21.7(17.5)
	Eligible for choice	6	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	6	87	91.7	86.1	90.8	12.5(9.5)	19(12.8)
4	All	10	62.2	73	62.3	73.1	31(23.5)	40.3(28.6)
	Eligible for choice	10	0	0	0	0	63.1(20.4)	83.9(28.4)
	Not Eligible for choice	10	63.5	73.9	63.6	74.1	17(11)	27.8(16.5)
5	All	4	82.7	85.1	80.5	83	23.7(22.7)	32.8(29.7)
	Eligible for choice	4	0	0	0	0	52.2(12.3)	64.8(17.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	4	83.6	85.5	81.3	83.5	16.2(10.4)	23.7(13.7)
6	All	9	57	64	56.2	63.2	43.5(34.1)	56.2(41.3)
	Eligible for choice	9	0	0	0	0	66.9(22)	91(31)
	Not Eligible for choice	9	62.4	68.8	61.8	68.3	20(10.7)	30.7(15)
7	All	9	46.9	51.3	47.1	51.4	49.7(33.8)	64(41.5)
	Eligible for choice	9	0	0	0	0	69.3(19.7)	93.2(28.5)
	Not Eligible for choice	9	51.2	54.9	51.5	55.2	18.3(10.9)	28(15.3)
8	All	15	72.7	76.1	72.6	76.1	28.4(25.1)	37.9(29.6)
	Eligible for choice	15	0	0	0	0	69.6(23.5)	100.9(31.6
	Not Eligible for choice	14	73.8	77.2	73.9	77.3	16.2(10)	25.5(14.7)
9	All	8	45.5	53.7	45.6	53.6	59.7(50)	71.5(53.6)
	Eligible for choice	8	0	0	0	0	92.8(38.6)	116(42.3)
	Not Eligible for choice	8	51.7	59.9	51.8	59.7	16.8(10.5)	27.3(16)
10	All	6	67.3	74.4	66	73.3	28.3(23.3)	36.3(27)
	Eligible for choice	6	0	0	0	0	53(8.1)	76.4(13.7)
	Not Eligible for choice	6	67.8	74.9	66.5	73.8	15.6(10.9)	24.3(15)
11	All	8	49.6	55.3	48.7	54.1	46.3(37.6)	56.6(42.5)
	Eligible for choice	8	0	0	0	0	83.8(37.8)	102.1(44.4
	Not Eligible for choice	8	53.3	58.2	52.2	56.9	18.3(11)	27.5(15.6)
12	All	7	61.2	67.9	58.6	65.2	33(33)	42.2(42.3)
	Eligible for choice	7	0	0	0	0	86.1(32.3)	125.3(49.2
	Not Eligible for choice	7	64	70.8	61.6	68.4	15.8(10.6)	22.6(14.2)
15	All	9	56.6	61.4	54.9	59.7	40.2(35.5)	52.3(44.7)
	Eligible for choice	9	0	0	0	0	84.2(32.6)	110.9(41.8
	Not Eligible for choice	9	63	67.4	61.4	65.8	16.2(10.3)	24.1(15)
16	All	17	52.5	58.2	51.3	57.2	43.3(34.5)	56.3(43.2)
	Eligible for choice	17	0	0	0	0	79.5(29.3)	103.7(38.8

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	17	58.9	63.4	57.9	62.5	16.7(10.9)	26.1(15.6)
17	All	5	55.2	64.1	54.7	63	48.9(41.9)	59.2(46.8)
	Eligible for choice	5	0	0	0	0	91.2(37.8)	117.6(43.7
	Not Eligible for choice	5	60.6	69.5	60.2	68.4	20.7(10.5)	30.6(14)
18	All	7	63.5	66.2	63.3	66	45.9(48.4)	58.5(56.1)
	Eligible for choice	7	0	0	0	0	106.5(41.7	135.1(50.4
	Not Eligible for choice	7	70.2	73	70.3	72.9	15.6(9.2)	24.8(13.1)
19	All	7	43.2	48.9	43.3	48.6	56.1(54.2)	66.4(58.7)
	Eligible for choice	7	0	0	0	0	127.7(50.4	150(54.4)
	Not Eligible for choice	7	51.4	57.2	51.9	57.3	15.9(10.4)	26.9(15.2)
20	All	8	60.1	64.2	58.8	62.9	45.5(46.8)	57.7(55.3)
	Eligible for choice	8	0	0	0	0	101.2(38.9	131.2(47.6
	Not Eligible for choice	8	69	72.7	67.8	71.5	16.2(9.4)	25.1(13.7)
21	All	8	66.5	69	64.3	66.9	30.7(28.8)	41.9(37.1)
	Eligible for choice	8	0	0	0	0	89.9(44.1)	125.5(53.3
	Not Eligible for choice	8	69.1	71.5	67	69.6	16.2(9.5)	24.8(13.1)
22	All	9	79	84.7	78.1	84.1	27.2(28.6)	33.2(33.8)
	Eligible for choice	9	0	0	0	0	96.4(35)	123.6(42.6
	Not Eligible for choice	9	81.3	87.1	80.3	86.5	17.1(9.1)	22.7(11.3)
23	All	11	43.1	45.4	42.1	44.2	57.7(48.7)	72.6(57.5)
	Eligible for choice	11	0	0	0	0	94.2(39.2)	122.1(46.3
	Not Eligible for choice	11	55	56.2	54.1	55.2	15(10.4)	22.7(14.2)

Table F-21 Geographic Access to VA Facilities providing Surgical Services

VISN	Choice Eligibility	Hospitals with the service	Enrollees	Users	Mean (SD) drive distance and time to closest facility with the service

		(N)	(%)		(%)			
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	130	54.3	60.4	52.9	59	42.4(39.8)	52.5(45.8)
	Eligible for choice	130	0	0	0	0	94.9(39.8)	119.8(46)
	Not Eligible for choice	130	58.6	64.6	57.3	63.3	16.9(10.5)	25.7(14.8)
1	All	7	58.9	70.2	58.7	69.5	35.5(27.9)	43.2(31.7)
	Eligible for choice	7	0	0	0	0	97.8(42.2)	119.5(46.2
	Not Eligible for choice	7	61.2	72.5	61.3	72.1	19.1(11.6)	29(15.7)
2	All	3	44.3	51.9	44.5	52	47.8(37)	57.6(42.7)
	Eligible for choice	3	0	0	0	0	109.7(32.8	136.5(41.4
	Not Eligible for choice	3	45.5	53.2	45.6	53.3	15.1(11.2)	26.5(17.7)
3	All	5	80.5	85.9	79.1	84.5	17.6(17.8)	23.3(20.2)
	Eligible for choice	5	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	5	80.6	86	79.2	84.6	12.2(9.4)	18.9(13)
4	All	7	58	68.2	57.6	67.8	34.5(27.5)	44.4(32.9)
	Eligible for choice	7	0	0	0	0	69.7(25)	91.7(33.6)
	Not Eligible for choice	7	59.2	69.1	58.8	68.7	17.4(11)	28.2(16.5)
5	All	3	82.7	85.1	80.5	83	24.2(23.3)	33.1(29.9)
	Eligible for choice	3	0	0	0	0	53.4(13.7)	66.2(19.3)
	Not Eligible for choice	3	83.6	85.5	81.3	83.5	16.6(10.6)	24(13.9)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	7	43.9	48.5	43.9	48.5	54.1(36.5)	67.8(44)
	Eligible for choice	7	0	0	0	0	77.2(23)	100.2(30.6
	Not Eligible for choice	7	47.9	52.4	48	52.5	18.2(10.7)	28.5(15.7)
8	All	10	63.2	68.8	62.4	68.2	34.3(29.4)	43.4(33.5)
	Eligible for choice	10	0	0	0	0	95.6(37.7)	124.6(39.3
	Not Eligible for choice	10	64.2	69.8	63.5	69.3	18.2(10.9)	27.4(15)
9	All	7	43.4	50.7	44	51.1	56(41.8)	67.9(47)
	Eligible for choice	7	0	0	0	0	92.9(29.6)	115.1(32.8
	Not Eligible for choice	7	49.2	57	49.9	57.4	16(10.3)	26(16.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
10	All	4	62.4	69.2	60.8	67.9	30.8(24.2)	39.5(28.6)
	Eligible for choice	4	0	0	0	0	54.9(8.9)	78(14)
	Not Eligible for choice	4	62.9	69.7	61.3	68.3	16.2(10.9)	25.1(14.8)
11	All	6	42.5	48.8	41.1	47.2	53.5(43.9)	62.7(47.2)
	Eligible for choice	6	0	0	0	0	88.5(38.4)	106.8(45.7
	Not Eligible for choice	6	45.6	51.5	44.1	49.8	17.6(10.8)	26.8(15.5)
12	All	6	59.4	64.8	56.6	61.8	35.3(37)	44.2(45.1)
	Eligible for choice	6	0	0	0	0	92.8(33)	130.2(47.6
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	7	51.2	55.6	49	53.3	49.4(44)	61.7(53.2)
	Eligible for choice	7	0	0	0	0	98.7(38.5)	125.8(47.2
	Not Eligible for choice	7	57.1	61.3	54.8	59	16.1(10.2)	23.6(14.6)
16	All	10	40.5	45.4	39.5	44.5	55.5(44.1)	68(50.9)
	Eligible for choice	10	0	0	0	0	87.5(30.8)	112.3(40.5
	Not Eligible for choice	10	45.5	49.8	44.6	49	16.4(10.7)	25.8(15.5)
17	All	4	56.3	65.9	55.9	65.2	50.6(41.4)	60.8(47.1)
	Eligible for choice	4	0	0	0	0	100(33.3)	123.1(40.1
	Not Eligible for choice	4	61.7	71.5	61.5	70.9	21.5(10.5)	31.4(13.8)
18	All	4	51.4	52.6	50	51.4	55.2(62.6)	66.7(66.9)
	Eligible for choice	4	0	0	0	0	121.4(53.1	148.1(54.7
	Not Eligible for choice	4	56.8	58.1	55.6	56.9	15.9(9.2)	24.3(12.5)
19	All	6	42.4	47.9	42.2	47.3	56.8(54.9)	67(59.2)
	Eligible for choice	6	0	0	0	0	128.8(50.1	150.9(54)
	Not Eligible for choice	6	50.4	56.2	50.6	56	15.9(10.4)	27(15.2)
20	All	6	50.8	58.1	49.7	56.5	50.5(48)	61.9(56.1)
	Eligible for choice	6	0	0	0	0	103.8(38.6	133.4(47.5
	Not Eligible for choice	6	58.4	65.8	57.3	64.2	17.5(10.5)	26.7(14.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
21	All	6	55.5	57.6	54.2	56.5	34.6(34.8)	45.8(40.1)
	Eligible for choice	6	0	0	0	0	105.3(52.8	136.3(52.3
	Not Eligible for choice	6	57.7	59.8	56.4	58.8	16.7(9.5)	25.7(13.1)
22	All	5	79	84.7	78.1	84.1	27.7(28.4)	33.8(33.6)
	Eligible for choice	5	0	0	0	0	97.4(35)	124.5(42.8
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	9	39.4	42.7	38.1	41.4	62.1(51.3)	76.7(59.2)
	Eligible for choice	9	0	0	0	0	98.9(41)	125.8(47.2
	Not Eligible for choice	9	50.2	53	49	51.7	15.3(10.3)	23.9(14.9)

Table F-22 Geographic Access to VA Facilities providing Oncology Services

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	168	55.3	61.2	53.7	59.5	42.1(41.1)	52.4(47.2)
	Eligible for choice	168	0	0	0	0	96.5(41.2)	122.1(46.9
	Not Eligible for choice	163	59.7	65.4	58.1	63.9	16.4(10.5)	25.2(14.8)
1	All	9	65.3	73	64.9	72.2	32.3(26.6)	40.6(30.8)
	Eligible for choice	9	0	0	0	0	94.1(42.9)	117.7(46.3
	Not Eligible for choice	9	67.9	75.3	67.7	74.9	18.7(11.5)	27.8(15.4)
2	All	14	58.4	64.4	57.6	63.7	36.4(32.3)	45.8(37.3)
	Eligible for choice	14	0	0	0	0	72.4(34.3)	100.6(40.2
	Not Eligible for choice	13	60	65.7	59.1	64.9	13.9(11.2)	23.9(17)
3	All	6	87.4	91.8	86.5	90.9	15.8(14.6)	21.6(17.3)
	Eligible for choice	6	0	0	0	0	83.2(21.1)	114.6(3.6)
	Not Eligible for choice	6	87.4	91.8	86.5	90.9	12.5(9.5)	19(12.8)
4	All	12	64.8	72.1	64.6	71.7	30.9(25.6)	40.9(31.3)
	Eligible for choice	12	0	0	0	0	68.6(25.5)	89.3(33.2)
	Not Eligible for choice	12	66.1	73	65.9	72.7	16.9(10.9)	26.7(16.1)
5	All	3	82.7	85.2	80.5	83.1	23.8(22.4)	32.9(29.5)
	Eligible for choice	3	0	0	0	0	51.3(11.5)	64.6(18.5)
	Not Eligible for choice	3	83.6	85.6	81.3	83.6	16.6(10.6)	24(13.9)
6	All	7	43.2	52.5	42.4	51.8	52.3(38)	64.7(44.9)
	Eligible for choice	7	0	0	0	0	70.1(25.6)	94.4(34.7)
	Not Eligible for choice	7	47.2	56.4	46.6	55.9	21(11.1)	33.2(15.8)
7	All	5	39.8	43.9	39.8	43.9	63.4(44.2)	77.4(51.8)
	Eligible for choice	5	0	0	0	0	97(36.2)	122.6(42.9
	Not Eligible for choice	5	43.5	47.5	43.6	47.6	18.3(10.5)	28.2(15.3)
8	All	8	52.9	59.6	52	58.9	43.2(39.8)	52.9(44)
	Eligible for choice	8	0	0	0	0	123.6(49.6)	151.3(48.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	7	53.8	60.5	52.8	59.9	18.1(11)	27.1(15.2)
9	All	6	34.6	41.6	35.4	42.1	74.9(52.8)	85.6(54.7)
	Eligible for choice	6	0	0	0	0	108.1(38.4	130.2(38.9)
	Not Eligible for choice	6	39.3	47	40.2	47.4	16.4(10.5)	27.4(16.5)
10	All	4	64.6	73.7	63.2	72.5	29.3(22.5)	38.2(27.4)
	Eligible for choice	4	0	0	0	0	54.9(8.9)	78(14)
	Not Eligible for choice	4	65.1	74.1	63.6	73	16.6(11.1)	26.2(15.3)
11	All	7	43	47.8	41.5	46.2	55.3(48.1)	64.4(50.2)
	Eligible for choice	7	0	0	0	0	100.3(40.7	117(44.6)
	Not Eligible for choice	7	46.1	50.6	44.5	48.9	15.7(10.1)	25.2(15.1)
12	All	6	59.4	64.8	56.6	61.8	35.2(36.7)	44(44.5)
	Eligible for choice	6	0	0	0	0	92.9(31.9)	130.1(46.1)
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	7	54.2	59.5	52.2	57.6	45.3(42.3)	57.3(52)
	Eligible for choice	7	0	0	0	0	96.9(39)	124.8(49.6)
	Not Eligible for choice	7	60.4	65.4	58.4	63.5	16.2(10.3)	24.2(15)
16	All	18	49.9	55	48.3	53.4	45.9(37.3)	59.7(46.4)
	Eligible for choice	18	0	0	0	0	83.1(29.3)	108(38.4)
	Not Eligible for choice	18	56.1	60.5	54.4	58.9	16.6(10.8)	26.2(15.6)
17	All	3	53.3	62.6	52.4	61.2	50.6(42.6)	60.7(47.4)
	Eligible for choice	3	0	0	0	0	97(37.9)	121.8(43.4)
	Not Eligible for choice	3	58.5	67.9	57.7	66.6	21.5(10.5)	31.3(13.8)
18	All	9	63	65.1	62.3	64.5	47.8(54.3)	61.5(63.1)
	Eligible for choice	9	0	0	0	0	106.4(45.6	138.5(53.3
	Not Eligible for choice	8	69.7	71.7	69.1	71.2	15.2(9.5)	23.9(13.2)
19	All	7	40.7	46.4	40.1	45.4	56.9(55.4)	67.6(60.1)
	Eligible for choice	7	0	0	0	0	132.4(51.6	151.7(53.5

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	48.4	54.2	48	53.4	16.2(10.3)	27.3(15.1)
20	All	5	48	56	47	54.5	50(50.3)	61.4(57.2)
	Eligible for choice	5	0	0	0	0	100.4(39.3	129.6(47.1)
	Not Eligible for choice	5	55.2	63.3	54.3	62	17.3(10.5)	26.7(14.6)
21	All	9	65	67.8	62.2	65.4	31.3(33.1)	42.7(38.9)
	Eligible for choice	9	0	0	0	0	106.7(60)	139.7(57.7
	Not Eligible for choice	8	67.5	70.4	64.8	68	16(9.3)	25.3(13.5)
22	All	10	79.3	85.5	78.4	85	25.6(27.8)	31.8(33.1)
	Eligible for choice	10	0	0	0	0	94(34.1)	121.1(41.8)
	Not Eligible for choice	10	81.6	88	80.6	87.4	16(9.2)	22.1(11.8)
23	All	13	45.2	47.4	44.1	46.3	54.9(46.6)	70.1(56.2)
	Eligible for choice	13	0	0	0	0	93.2(38.4)	121.9(46)
	Not Eligible for choice	13	57.6	58.8	56.7	57.8	14.5(10.2)	22.2(14)

Table F-23 Geographic Access to VA Facilities providing Palliative/Hospice Care

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	138	52.3	58.1	50.8	56.6	45.1(44.6)	55.2(49.8)
	Eligible for choice	138	0	0	0	0	100.1(42.7	124.7(47.5)
	Not Eligible for choice	137	56.4	62.2	55	60.8	16.6(10.4)	25.4(14.8)
1	All	9	61.1	71.1	60.8	70.3	33.8(28)	41.6(31.7)
	Eligible for choice	9	0	0	0	0	97.5(42.1)	119.2(46.2)
	Not Eligible for choice	9	63.5	73.3	63.5	72.8	17.7(11.5)	27.6(15.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	5	59.7	65.5	60.7	66.3	36.7(35.6)	47.4(41.8)
	Eligible for choice	5	0	0	0	0	106.8(31.4	134.8(40.3)
	Not Eligible for choice	5	61.3	67.2	62.2	67.9	14.4(10.8)	24.5(16.6)
3	All	6	82	86.2	80.4	84.8	16.9(17.4)	22.8(19.9)
	Eligible for choice	6	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	6	82	86.2	80.5	84.8	12.1(9.1)	18.4(12.4)
4	All	8	60.4	71.2	60.2	70.9	33.3(26.6)	43.1(32.1)
	Eligible for choice	8	0	0	0	0	69.6(25.1)	91.6(33.6)
	Not Eligible for choice	8	61.6	72.2	61.4	71.9	17.5(11)	28.5(16.5)
5	All	3	82.7	85.1	80.5	83	24.2(23.3)	33.1(29.9)
	Eligible for choice	3	0	0	0	0	53.4(13.7)	66.2(19.3)
	Not Eligible for choice	3	83.6	85.5	81.3	83.5	16.6(10.6)	24(13.9)
6	All	8	44.7	53.5	44.3	53.1	51.3(38.1)	64(45)
	Eligible for choice	8	0	0	0	0	70(25.6)	94.3(34.8)
	Not Eligible for choice	8	48.9	57.5	48.6	57.2	21.1(11.1)	33.2(15.7)
7	All	5	40.7	45	40.8	45.1	62.3(45.2)	76.5(52.6)
	Eligible for choice	5	0	0	0	0	100.2(39.5	124.7(45)
	Not Eligible for choice	5	44.5	48.7	44.7	48.9	18.8(10.8)	29(15.6)
8	All	8	52.9	59.6	52	58.9	43.3(40.3)	53(44.2)
	Eligible for choice	8	0	0	0	0	123.7(50.6	150.4(48.5
	Not Eligible for choice	7	53.8	60.5	52.8	59.9	18.1(11)	27.1(15.2)
9	All	6	34.6	41.5	35.4	42	75.1(52.8)	85.8(54.7)
	Eligible for choice	6	0	0	0	0	108.8(37.8	130.9(38.2
	Not Eligible for choice	6	39.3	47	40.2	47.4	16.4(10.5)	27.4(16.5)
10	All	5	64.9	73.2	63.6	72.1	29.7(23.6)	38.1(27.2)
	Eligible for choice	5	0	0	0	0	58.2(13.6)	80.2(16.8)
	Not Eligible for choice	5	65.4	73.6	64	72.6	16.3(10.9)	25.9(15.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	4	35.5	40.6	33.9	38.9	59.1(45.2)	68.5(48.5)
	Eligible for choice	4	0	0	0	0	110.3(41.3	124.5(44.5
	Not Eligible for choice	4	38.1	43	36.3	41.2	17.1(10)	26.3(15.2)
12	All	6	59	67	56.4	64.3	34.9(31.4)	44(40.4)
	Eligible for choice	6	0	0	0	0	87.5(32.2)	126.2(48.8
	Not Eligible for choice	6	61.7	69.9	59.4	67.5	17.7(9.9)	25(13.4)
15	All	9	52.7	56.7	50.3	54.3	48.5(45.8)	60.8(54.5)
	Eligible for choice	9	0	0	0	0	98(39.4)	125.5(48.4
	Not Eligible for choice	9	58.7	62.4	56.2	60.1	14.7(9.8)	22.4(14.5)
16	All	14	42.5	47.1	41.6	46.2	52.7(42.1)	65.4(49.2)
	Eligible for choice	14	0	0	0	0	86.4(32.7)	110.8(40.3
	Not Eligible for choice	14	47.7	51.6	46.9	50.9	16.4(10.6)	25.6(15.3)
17	All	3	53	61.7	52.1	60.4	52.1(43.7)	61.9(48.3)
	Eligible for choice	3	0	0	0	0	100.9(36.9	123.7(42.7
	Not Eligible for choice	3	58.1	67	57.3	65.7	21.4(10.4)	31(13.6)
18	All	8	56.3	56.6	55.6	55.9	50.2(64.3)	61.7(69)
	Eligible for choice	8	0	0	0	0	122.2(55.4	149.2(56.5
	Not Eligible for choice	8	62.3	62.4	61.7	61.9	11.7(7.4)	19.6(10.9)
19	All	5	38.4	44	37.4	42.6	58.6(56.5)	69.6(61.6)
	Eligible for choice	5	0	0	0	0	135.9(50.8	156.4(53.2
	Not Eligible for choice	5	45.7	51.5	44.8	50.2	16.4(10.3)	27.6(15)
20	All	6	52.6	56.6	51.2	55.1	48.5(48.8)	60.2(56.7)
	Eligible for choice	6	0	0	0	0	101.5(39.4	130.6(47.5
	Not Eligible for choice	6	60.5	64	59.1	62.6	16.3(9.3)	25.2(13.6)
21	All	6	55.5	57.6	54.2	56.5	34.6(34.8)	45.8(40.1)
	Eligible for choice	6	0	0	0	0	105.3(52.8	136.3(52.3
	Not Eligible for choice	6	57.7	59.8	56.4	58.8	16.7(9.5)	25.7(13.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	5	66.3	72.5	64.6	71.2	44.2(62.6)	50.1(62.7)
	Eligible for choice	5	0	0	0	0	99(38.4)	126.6(41.9
	Not Eligible for choice	5	68.2	74.6	66.4	73.2	17.2(8.9)	23.3(11.7)
23	All	9	39.4	42.7	38.1	41.4	61.6(50.8)	75.9(58.5)
	Eligible for choice	9	0	0	0	0	98.4(40.7)	125.2(47.1
	Not Eligible for choice	9	50.2	53	49	51.7	15.3(10.3)	23.9(14.9)

Appendix F.2.3 Services for Populations with Diabetes

Table F-24 Geographic Access to VA Facilities with Primary Care

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	895	91.8	92.1	91.4	91.6	15.8(16.1)	24.5(23)
	Eligible for choice	895	0	0	0	0	58.3(21.4)	83.2(31.7)
	Not Eligible for choice	839	99	97.8	99	97.6	12.3(9.3)	19.1(12.9)
1	All	50	96.2	96.2	95.8	95.8	12(11.1)	18.9(16.5)
	Eligible for choice	50	0	0	0	0	52.9(12.6)	76.2(22)
	Not Eligible for choice	47	100	98.9	100	98.9	10.7(8)	16.5(11.3)
2	All	33	97.4	95.2	97.6	95.3	12.5(10.7)	21.8(17.8)
	Eligible for choice	33	0	0	0	0	48.3(7.1)	75.4(19.2)
	Not Eligible for choice	32	100	97.2	100	97.3	11.5(9)	19(13.4)
3	All	35	99.9	99.9	99.9	99.9	6.3(5.1)	11(8)
	Eligible for choice	35	0	0	0	0	42.4(1.2)	65.7(9.8)
	Not Eligible for choice	32	100	100	100	100	6.2(5)	11(7.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
4	All	55	98.1	98.3	98	98.2	12.3(9.3)	19.6(13.5)
	Eligible for choice	55	0	0	0	0	45.2(5.3)	64.5(13.2)
	Not Eligible for choice	51	100	99.4	100	99.4	11.7(8.3)	18.5(11.6)
5	All	21	98.9	99.5	99	99.4	13(9.9)	20.4(13.6)
	Eligible for choice	21	0	0	0	0	43.4(3.8)	55.6(11)
	Not Eligible for choice	20	100	99.8	100	99.8	12.7(9.4)	19.9(12.9)
6	All	28	81.8	84.1	81.7	84.1	23.1(16)	34.4(23.4)
	Eligible for choice	28	0	0	0	0	49.5(10)	72(20.2)
	Not Eligible for choice	28	89.4	89.2	89.8	89.5	17.9(10.7)	26.5(14.4)
7	All	48	90.8	90.7	90.6	90.3	19(15.9)	30.2(22.8)
	Eligible for choice	48	0	0	0	0	51.1(10)	73.9(16.9)
	Not Eligible for choice	47	99.2	97.1	99.1	96.9	14.5(10)	23.1(14.2)
8	All	57	98.4	97.9	98.3	97.8	12(9.1)	19.7(14)
	Eligible for choice	57	0	0	0	0	50.5(8.2)	76.7(12.5)
	Not Eligible for choice	54	100	99.4	100	99.3	11.4(7.7)	18.4(11.2)
9	All	45	88	88.8	88.1	88.8	21.1(16)	32.3(23.2)
	Eligible for choice	45	0	0	0	0	51.6(9.6)	74(16)
	Not Eligible for choice	42	99.9	97.7	99.9	97.6	16.4(10.7)	24.6(15)
10	All	33	98.4	98	98.4	98	11.7(9.5)	18.9(13.9)
	Eligible for choice	33	0	0	0	0	43.3(1.8)	60.2(7.8)
	Not Eligible for choice	33	99.1	98.5	99.1	98.5	11.2(8.7)	17.9(12.4)
11	All	36	92.6	93.9	92.6	93.8	17.4(12.7)	26.3(17.6)
	Eligible for choice	36	0	0	0	0	48.1(7.5)	64.5(12.9)
	Not Eligible for choice	36	99.4	98	99.3	97.9	15.3(9.9)	23.1(13.9)
12	All	38	94.2	93.9	93.6	93.1	12.2(11.6)	19.4(17.2)
	Eligible for choice	38	0	0	0	0	51.8(12.2)	79.6(19.8)
	Not Eligible for choice	38	98.6	97.7	98.4	97.3	10.6(8.5)	16.8(11.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
15	All	57	89.8	89.5	89.4	88.9	18.8(17.4)	28.7(24.9)
	Eligible for choice	57	0	0	0	0	55.8(13.9)	79(21.6)
	Not Eligible for choice	50	100	97.7	100	97.4	13.8(10.4)	20.8(14.4)
16	All	66	88.4	89.3	88	88.8	19.6(15.7)	29.4(22.5)
	Eligible for choice	66	0	0	0	0	51(11.1)	73.1(19.4)
	Not Eligible for choice	65	99.3	97.1	99.2	96.9	15.3(10.5)	22.6(14)
17	All	30	91.1	91.4	90.9	91.1	20(17.8)	29(24.6)
	Eligible for choice	30	0	0	0	0	60.5(24.7)	85.2(34.5)
	Not Eligible for choice	25	100	98.7	100	98.7	15.7(9.6)	22.6(12.5)
18	All	47	90.4	90.3	90.1	90	17.9(22.3)	28.7(32.5)
	Eligible for choice	47	0	0	0	0	67.9(27)	99(42.5)
	Not Eligible for choice	42	100	98.7	100	98.7	10.9(8.3)	18.2(11.6)
19	All	42	83.9	85.2	83.2	84.4	24.7(32.4)	35.3(42.4)
	Eligible for choice	42	0	0	0	0	81.8(33.2)	107.7(46.3
	Not Eligible for choice	34	99.7	98.3	99.7	98.2	11.3(8.9)	17.7(11.9)
20	All	38	87	87.9	86.7	87.5	19.5(21)	29.7(31)
	Eligible for choice	38	0	0	0	0	65.1(23.7)	95.6(39.9)
	Not Eligible for choice	36	100	98.1	100	98	13.1(9.8)	19.9(12.8)
21	All	41	95.2	94.5	94.8	94.2	13.2(13.2)	21.2(19.7)
	Eligible for choice	41	0	0	0	0	63.5(25.6)	97.2(32.9)
	Not Eligible for choice	39	98.8	98.1	98.8	98	11.2(8.1)	18(11.8)
22	All	35	97.2	97.4	97.3	97.5	9.5(10.1)	15(14.5)
	Eligible for choice	35	0	0	0	0	63.2(29.7)	92.5(43.6)
	Not Eligible for choice	35	100	99.8	100	99.8	8.6(6)	13.5(8.1)
23	All	60	77	76.9	76.4	76.1	25.7(24.8)	39.1(35.3)
	Eligible for choice	60	0	0	0	0	63(21.8)	90.9(31.9)
	Not Eligible for choice	53	98.2	95.1	98.1	94.8	14.5(10.9)	22.1(15.3)

Table F-25 Geographic Access to VA Facilities with a specialty or endocrinology clinic

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	379	72.2	76	71.3	75.1	29.8(32.7)	40.1(39.7)
	Eligible for choice	379	0	0	0	0	79.5(36.5)	105.6(43.9
	Not Eligible for choice	373	77.9	81.1	77.2	80.4	14.4(10)	22.4(14.3)
1	All	26	86.8	89.6	86.1	88.7	20.2(22.2)	27.8(26.6)
	Eligible for choice	26	0	0	0	0	73.6(33.7)	96.7(38.5)
	Not Eligible for choice	26	90.2	92.4	89.9	91.8	14.2(10.2)	21.4(13.6)
2	All	8	69.5	72.3	70.6	73.1	30.9(33.2)	42.2(39.5)
	Eligible for choice	8	0	0	0	0	91.3(35.6)	125.2(42.9
	Not Eligible for choice	8	71.4	74.2	72.4	74.9	14.5(10.4)	23.8(15.4)
3	All	20	98.8	99.2	98.6	99.1	8.5(7.4)	13.8(10)
	Eligible for choice	20	0	0	0	0	42.4(1.2)	65.7(9.8)
	Not Eligible for choice	20	98.9	99.2	98.7	99.1	8.2(6.1)	13.5(8.7)
4	All	19	78.8	85.4	79.6	86	23.3(19.4)	32.6(24.8)
	Eligible for choice	19	0	0	0	0	51.7(12.4)	72.6(19.6)
	Not Eligible for choice	19	80.4	86.5	81.2	87.1	15.6(10.2)	25.5(15.6)
5	All	10	91.6	92	91.5	91.8	19.1(18)	27.7(25.7)
	Eligible for choice	10	0	0	0	0	46(6.4)	57.3(14.9)
	Not Eligible for choice	9	92.6	92.3	92.4	92.2	15.4(10)	22.2(12.8)
6	All	18	70.2	75.6	69.7	75.2	31.5(22.5)	43.6(30.5)
	Eligible for choice	18	0	0	0	0	54.1(13.4)	77.4(23.7)
	Not Eligible for choice	18	76.7	80.3	76.6	80.2	18.6(11.4)	28.9(16)
7	All	10	52	56.2	52	56.1	45.3(31.2)	59.1(38.3)
	Eligible for choice	10	0	0	0	0	66.6(18.8)	91.8(28.3)
	Not Eligible for choice	10	56.8	60.3	56.9	60.3	18.4(11.3)	28.1(15.8)
8	All	37	91.5	95.9	91.8	95.9	16.7(12.8)	25.5(17.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	37	0	0	0	0	51.9(10.1)	79.9(15.2)
	Not Eligible for choice	36	92.9	97.3	93.4	97.4	14.2(9.7)	23.6(14.5)
9	All	11	47.7	56.1	47.8	55.8	48.8(36.9)	64.7(46.6)
	Eligible for choice	11	0	0	0	0	81.5(28.4)	108.7(37.5
	Not Eligible for choice	11	54.2	62.5	54.2	62.2	16.5(10.8)	27.1(16.4)
10	All	24	94.5	96	94.4	95.9	14.5(11.9)	21.8(15.9)
	Eligible for choice	24	0	0	0	0	46.2(4.3)	63.8(9.6)
	Not Eligible for choice	24	95.2	96.5	95	96.4	12.9(9.7)	20.1(13.5)
11	All	7	47.9	53.5	47.4	52.9	49.7(41.7)	60.6(46.8)
	Eligible for choice	7	0	0	0	0	89.4(45.2)	105.9(49.5
	Not Eligible for choice	7	51.4	56.5	50.8	55.9	18.4(10.8)	28.4(16.1)
12	All	13	66.7	69.2	63.9	66.2	27.1(30.7)	36.9(39.3)
	Eligible for choice	13	0	0	0	0	73.8(24.7)	110(36.8)
	Not Eligible for choice	13	69.8	72.2	67.2	69.4	12.4(9.8)	19.1(13.2)
15	All	11	60.5	65.4	59	63.9	37.9(34.7)	49.6(43.2)
	Eligible for choice	11	0	0	0	0	82.1(37.5)	109.1(47.2
	Not Eligible for choice	11	67.4	71.7	66	70.4	16.5(10.5)	24.5(15.3)
16	All	30	65.1	69.3	63.7	68	34.9(31.2)	46.8(39.5)
	Eligible for choice	30	0	0	0	0	67.7(25.5)	90.7(34.4)
	Not Eligible for choice	30	73	75.3	71.8	74	15.9(10.7)	24(14.4)
17	All	7	71.2	75.3	70.4	74.5	40(40)	50.9(46.5)
	Eligible for choice	7	0	0	0	0	86(33.4)	111.7(40.9
	Not Eligible for choice	7	78.2	81.6	77.4	80.9	18.5(9.9)	26.6(13.2)
18	All	20	73.8	75.9	73.7	75.7	31.8(40.1)	45(51.1)
	Eligible for choice	20	0	0	0	0	96(39.9)	126.9(50.1
	Not Eligible for choice	19	81.7	83.4	81.8	83.4	11.7(8)	20.4(12.6)
19	All	18	70.8	71.2	68.7	69.1	40.2(51.4)	51.4(57.6)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	18	0	0	0	0	109.5(49.7	134.7(53.3
	Not Eligible for choice	18	84.1	83.2	82.3	81.4	12.2(8.6)	19.2(11.7)
20	All	16	68.2	72.2	67.5	71.3	40.5(45.3)	52.4(53.2)
	Eligible for choice	16	0	0	0	0	95.3(38.3)	126.3(47.4
	Not Eligible for choice	16	78.4	82	77.8	81.2	15.5(9.4)	24.3(13.7)
21	All	30	89	88.9	88.4	88.5	17.1(17.2)	26.7(24.7)
	Eligible for choice	30	0	0	0	0	66.1(26.6)	101.1(36.5
	Not Eligible for choice	29	92.3	92.3	92	92.1	12.7(8.4)	20.4(12.5)
22	All	11	79.3	85.6	78.4	85.1	23.4(27.2)	29.3(31.4)
	Eligible for choice	11	0	0	0	0	92.6(31.5)	123.6(43.7
	Not Eligible for choice	11	81.6	88.1	80.6	87.4	13.9(9)	20(12.2)
23	All	33	58.9	61.4	57.5	59.9	40.5(42)	54.5(50.1)
	Eligible for choice	33	0	0	0	0	79.4(37.2)	106.5(42.9
	Not Eligible for choice	31	75.1	75.9	73.9	74.6	13.9(10.5)	22.2(15.2)

Table F-26 Geographic Access to VA Facilities with a podiatry clinic

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	323	70.3	74.6	69.1	73.4	30.7(33.2)	40.8(40)
	Eligible for choice	323	0	0	0	0	81.9(38.4)	107.4(45)
	Not Eligible for choice	314	75.8	79.6	74.8	78.6	14.8(10)	23(14.3)
1	All	12	68.7	79.3	68.1	78.3	28.4(25)	36.4(29.8)
	Eligible for choice	12	0	0	0	0	88.5(45.4)	113.8(49.4)
	Not Eligible for	12	71.4	81.7	71.1	81.1	16.5(11)	26.2(15.8)

	choice							
2	All	10	80.2	83	80.9	83.5	22.8(20.2)	33.7(27.4)
	Eligible for choice	10	0	0	0	0	63.9(16.8)	97(32.1)
	Not Eligible for choice	10	82.4	85.1	82.9	85.4	15.1(10.7)	24.2(15.4)
3	All	18	98.5	99.1	98.5	99.2	10.2(8.5)	15.8(11.2)
	Eligible for choice	18	0	0	0	0	56.5(25.6)	81.2(36.6)
	Not Eligible for choice	17	98.5	99.2	98.6	99.2	9.8(7.5)	15.5(10.2)
4	All	32	90.2	92.7	89.6	92.2	16.6(14.1)	24.7(18.7)
	Eligible for choice	32	0	0	0	0	49.9(12.6)	70.2(19.2)
	Not Eligible for choice	32	92	93.9	91.4	93.5	13.6(9)	21.3(13)
5	All	12	93	93.7	92.8	93.6	16.8(13.7)	24.8(18.2)
	Eligible for choice	12	0	0	0	0	44.3(4.2)	55.6(11)
	Not Eligible for choice	12	94.1	94	93.8	93.9	14.5(9.8)	21.8(13.1)
6	All	12	62.6	67.2	61.7	66.2	37.4(29.3)	49.7(36)
	Eligible for choice	12	0	0	0	0	58.3(18.4)	82.5(26.2)
	Not Eligible for choice	12	68.4	71.8	67.8	71	19.6(10.7)	28.9(14.4)
7	All	13	55.2	58.8	55.1	58.7	45.4(33.6)	58.9(40.3)
	Eligible for choice	13	0	0	0	0	66(17)	89.2(23.5)
	Not Eligible for choice	13	60.3	63.4	60.3	63.3	18.1(10.9)	27.5(15.2)
8	All	21	77.5	87.6	78.2	87.6	22.8(19)	31.8(23.9)
	Eligible for choice	21	0	0	0	0	61.6(19)	89.8(25)
	Not Eligible for choice	20	78.7	89	79.5	89	15.5(9.6)	26.3(15.3)
9	All	8	43.8	51.5	44.5	51.9	55.3(41.5)	67.2(46.7)
	Eligible for choice	8	0	0	0	0	91.6(30.1)	113.9(33.8)
	Not Eligible for choice	8	49.8	57.7	50.5	58.1	16(10.4)	26(16.2)
10	All	31	98.1	97.5	98.1	97.4	12(9.7)	19.3(14.2)
	Eligible for choice	31	0	0	0	0	44.3(3.6)	61(8.6)
	Not Eligible for choice	30	98.8	97.9	98.8	97.8	11.4(8.7)	18.2(12.3)
11	All	10	59.4	66.1	58.5	65	36.9(30.2)	46.6(35)
	Eligible for choice	10	0	0	0	0	62.3(26.5)	77.7(30.2)
	Not Eligible for choice	10	63.7	69	62.8	67.9	18.6(11.1)	27.9(15.6)
12	All	11	75.4	80.4	73.6	78.4	23.7(25.9)	32.9(35.6)
	Eligible for choice	11	0	0	0	0	72.6(30.5)	108.1(47.6)

	Not Eligible for choice	11	78.9	83.9	77.4	82.3	14.5(10.5)	21.5(14.2)
15	All	9	54	58.6	52	56.6	42.2(37.4)	54.7(46.5)
	Eligible for choice	9	0	0	0	0	88.8(35.5)	117.1(45.5)
	Not Eligible for choice	9	60.2	64.5	58.2	62.6	16(10.4)	24.1(15.2)
16	All	23	61.4	65.2	60	64	35.9(32.8)	48.2(41.8)
	Eligible for choice	23	0	0	0	0	71.4(28.4)	93.8(36.8)
	Not Eligible for choice	23	69	70.9	67.7	69.7	15.4(10.2)	23.2(13.9)
17	All	13	80.9	83.5	80.5	82.9	27.5(25.1)	38.1(33.2)
	Eligible for choice	13	0	0	0	0	70.9(28.6)	96.3(36.5)
	Not Eligible for choice	13	88.8	90.4	88.6	90.1	17.6(10.1)	25.3(13.3)
18	All	10	68.9	70.5	68.7	70.2	46.3(52.2)	60.5(62)
	Eligible for choice	10	0	0	0	0	104.3(46.3	138.7(54.9
	Not Eligible for choice	10	76.3	77.7	76.2	77.6	15.4(9.4)	24.2(13.1)
19	All	20	68.3	70.5	67	69.1	44.5(53.2)	54.9(57.6)
	Eligible for choice	20	0	0	0	0	117.5(52.5)	141.5(53.3)
	Not Eligible for choice	15	81.1	82.7	80.3	81.7	14.5(10.1)	23.4(14.1)
20	All	14	66.5	71.2	65.5	70.2	40.9(45.6)	53(53.8)
	Eligible for choice	14	0	0	0	0	95.4(39.4)	125.8(47.8)
	Not Eligible for choice	14	76.4	80.6	75.6	79.7	15.3(9.7)	24.2(14.1)
21	All	18	75.5	78.3	73.8	76.9	21.7(22.2)	31.6(29.9)
	Eligible for choice	18	0	0	0	0	74.1(35.8)	108.9(44.3)
	Not Eligible for choice	17	78.4	81.2	76.9	80	12.9(9.2)	21.3(14.6)
22	All	14	83.9	87.8	83	87.2	21.2(24.5)	27.5(29.2)
	Eligible for choice	14	0	0	0	0	82.3(34.9)	108.2(40.1)
	Not Eligible for choice	14	86.3	90.2	85.4	89.5	14(8.7)	20(11.4)
23	All	12	43.9	46.1	42.9	45	56.1(47.9)	71.5(57)
	Eligible for choice	12	0	0	0	0	93.7(41)	120.5(46.5
	Not Eligible for choice	12	55.9	57.2	55.2	56.3	15.1(10.4)	23.1(14.5)

Table F-27 Geographic Access to VA Facilities with an ophthalmology clinic

VISN	Choice Eligibility	Hospitals with the	Enrollees	Users	Mean (SD) drive distance and time to closest facility

		service (N)	(%)		(%)		with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	169	53.8	59.1	52.9	58.2	43.9(41)	54(46.5)
	Eligible for choice	169	0	0	0	0	92.8(38.9)	118.1(45.3)
	Not Eligible for choice	167	58.1	63.2	57.3	62.4	15.8(10.6)	24.7(15.1)
1	All	8	63.7	73.3	63.4	72.6	32.1(27.7)	40.5(32.1)
	Eligible for choice	8	0	0	0	0	97.8(42.2)	119.5(46.2)
	Not Eligible for choice	8	66.2	75.6	66.2	75.3	17.9(11.3)	27.2(15.5)
2	All	6	63.6	70.3	64.7	71.3	34.6(34.1)	43.9(38.5)
	Eligible for choice	6	0	0	0	0	97.7(36.3)	122.3(45.5)
	Not Eligible for choice	6	65.3	72	66.3	72.9	14.8(10.9)	25.2(16.7)
3	All	7	81.8	86.4	80.3	85	15.9(17.6)	21.5(20.2)
	Eligible for choice	7	0	0	0	0	82.9(2.8)	111.4(10.7)
	Not Eligible for choice	7	81.8	86.5	80.4	85.1	10.9(9.4)	17.2(12.9)
4	All	10	58.5	65.8	57.2	64.5	33.4(30.6)	42.7(34.7)
	Eligible for choice	10	0	0	0	0	76.4(33.3)	94.3(39.7)
	Not Eligible for choice	10	59.7	66.6	58.3	65.4	15(10.1)	24.9(15.4)
5	All	10	2	4.5	2.3	4.7	102.3(25.5)	107.3(27.7)
	Eligible for choice	.	0	0	0	0	124.7(37.8)	131.2(32.1)
	Not Eligible for choice	.	2.1	4.5	2.4	4.8	28.9(8.4)	47.2(10.3)
6	All	10	51.4	57.4	49.6	56.1	48.9(33.5)	60.5(36.9)
	Eligible for choice	10	0	0	0	0	68.2(27.5)	91.8(33.7)
	Not Eligible for choice	10	56.2	61.3	54.4	60.1	20.8(11.2)	33.1(16)
7	All	12	54.1	59.2	53.7	58.7	43.8(31.3)	57.7(39.2)
	Eligible for choice	12	0	0	0	0	72.3(22)	97.4(28.4)
	Not Eligible for choice	12	59.2	63.8	58.8	63.5	18.1(11)	28.3(15.6)
8	All	15	70	74.5	69.9	74.5	27.7(25.3)	37.3(30.1)
	Eligible for choice	15	0	0	0	0	80.9(28.3)	112.4(33.3)
	Not Eligible for choice	14	71.2	75.6	71	75.6	16.3(10.1)	25.6(14.7)
9	All	6	37.8	45	38.3	45.1	61.8(43)	73.6(48.3)

	Eligible for choice	6	0	0	0	0	99.6(33.1)	122.6(36)
	Not Eligible for choice	6	43	50.7	43.5	50.8	16(10)	26.3(16.1)
10	All	5	64.9	73.2	63.6	72.1	29.8(24)	38.2(27.5)
	Eligible for choice	5	0	0	0	0	58.2(13.6)	80.2(16.8)
	Not Eligible for choice	5	65.4	73.6	64	72.6	16.2(10.9)	25.9(15.4)
11	All	3	25.8	34.5	25.2	33.4	70.4(44.1)	79.2(45)
	Eligible for choice	3	0	0	0	0	109.5(43.7)	122.6(46.1)
	Not Eligible for choice	3	27.7	36.5	27	35.3	24.2(11.8)	37.7(15)
12	All	6	59.4	64.8	56.6	61.8	35(36.2)	43.6(44.2)
	Eligible for choice	6	0	0	0	0	92.9(32.9)	130.2(47.6)
	Not Eligible for choice	6	62.1	67.7	59.5	64.9	15.7(10.5)	22.2(13.9)
15	All	7	51.2	55.6	49	53.3	49.5(44)	62(53.7)
	Eligible for choice	7	0	0	0	0	99(38)	127.2(48.3)
	Not Eligible for choice	7	57.1	61.3	54.8	59	16.1(10.2)	23.6(14.6)
16	All	17	52	55.4	49.6	53.1	47.3(40.1)	60(47.6)
	Eligible for choice	17	0	0	0	0	82.4(30.5)	106.2(37.8)
	Not Eligible for choice	17	58.3	60.9	56	58.6	15.6(10.4)	23.7(14.3)
17	All	5	57.8	68	57.7	67.5	47.1(37.6)	57.6(43.4)
	Eligible for choice	5	0	0	0	0	87.2(29.2)	111.5(37.8)
	Not Eligible for choice	5	63.5	73.7	63.5	73.3	21.6(10.5)	31.6(13.9)
18	All	7	36.9	39	38.9	41	75.1(48.3)	90.6(54.6)
	Eligible for choice	7	0	0	0	0	105.1(43.2)	134.1(51.6)
	Not Eligible for choice	7	40.8	42.8	43.2	45	12.1(8)	22.2(13.8)
19	All	4	27	30.3	26.4	29.3	58(56.7)	70.2(61.9)
	Eligible for choice	4	0	0	0	0	123.1(48.8)	142.7(53)
	Not Eligible for choice	4	32.1	35.4	31.6	34.6	14.7(9.3)	25.4(14.5)
20	All	8	58.5	62.4	57	60.9	46.2(46.8)	57.5(53.7)
	Eligible for choice	8	0	0	0	0	100.3(39.4)	130.8(48.3)
	Not Eligible for choice	8	67.2	70.7	65.7	69.2	16.1(9.4)	25.1(13.7)
21	All	10	58.5	61.8	57.7	61.2	30.4(30.2)	40.8(38.7)
	Eligible for choice	10	0	0	0	0	93.1(44.2)	128.1(52.4)
	Not Eligible for choice	9	60.7	64.1	60	63.7	14.6(9.9)	22.6(14.1)

22	All	13	82.5	86.3	81.9	86	23.1(28.3)	29.4(33.7)
	Eligible for choice	13	0	0	0	0	94(35.1)	122(43.1)
	Not Eligible for choice	13	84.9	88.8	84.2	88.4	13.7(8.9)	19.5(11.8)
23	All	10	40.6	42.3	39.5	41.1	67.7(56.7)	82.5(63.9)
	Eligible for choice	10	0	0	0	0	102.3(44.1)	130.6(51.1)
	Not Eligible for choice	10	51.8	52.5	50.8	51.4	14.5(10.1)	21.9(13.6)

Appendix F.2.4. Services for Populations with Traumatic Brain Injury

Table F-28 Geographic Access to VA Facilities with a Polytrauma support clinic team

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	88	36.9	42.7	35.9	41.4	59.7(50)	69.4(54)
	Eligible for choice	88	0	0	0	0	106.2(44.3)	130.2(48.2)
	Not Eligible for choice	88	39.9	45.7	38.9	44.5	18.4(10.9)	28.3(15.4)
1	All	7	64.8	75.9	64.5	75.2	34.5(25.1)	43(29.2)
	Eligible for choice	7	0	0	0	0	97.8(42.2)	119.5(46.2)
	Not Eligible for choice	7	67.3	78.4	67.3	78	22.2(10.2)	31.8(13.7)
2	All	4	49.9	54.8	49.9	54.7	48.9(39.4)	59.8(43)
	Eligible for choice	4	0	0	0	0	106.1(45.5)	130.9(53.8)
	Not Eligible for choice	4	51.2	56.1	51.1	55.9	19.4(11.5)	30.3(16.5)
3	All	7	86.9	90.7	85.8	89.6	16.2(15)	22.7(18.2)
	Eligible for choice	7	0	0	0	0	93.9(6.8)	121.6(3)
	Not Eligible for choice	7	87	90.7	85.9	89.7	12.9(9.1)	19.7(12.8)
4	All	8	52.5	69.5	53.3	69.7	39.4(26.6)	48.8(29.8)
	Eligible for choice	8	0	0	0	0	74.9(32.4)	93.2(39.2)
	Not Eligible for choice	8	53.5	70.5	54.3	70.7	21.9(11.9)	35.1(15.7)
5	All	2	53.2	70.3	57.7	72.3	40(24.4)	47.9(29.8)
	Eligible for choice	2	0	0	0	0	71.2(14.1)	84.1(14.3)
	Not Eligible for	2	53.8	71	58.3	73	22.6(12.7)	35.3(16.3)

	choice							
6	All	4	30.3	37.5	28.7	36.1	65.1(39.5)	76.9(45.2)
	Eligible for choice	4	0	0	0	0	79(29.8)	103.4(38.5)
	Not Eligible for choice	4	33.1	40.1	31.5	38.8	22.7(10.7)	35.4(15.2)
7	All	5	36	39.6	35.7	39.2	68.5(47.8)	81.1(53.9)
	Eligible for choice	5	0	0	0	0	108.3(42.8)	130.6(46.7)
	Not Eligible for choice	5	39.4	42.8	39.1	42.4	18.4(10.5)	27.9(14.9)
8	All	5	32.1	36.4	31.3	35.7	61.1(47.1)	72.3(50.2)
	Eligible for choice	5	0	0	0	0	124.4(50.1)	151.6(47.7)
	Not Eligible for choice	4	32.6	36.9	31.9	36.3	20.6(11.3)	29.1(15.3)
9	All	6	37.6	44.9	38.1	45	62.3(43.5)	74.1(48.7)
	Eligible for choice	6	0	0	0	0	100.1(33)	123.1(35.8)
	Not Eligible for choice	6	42.7	50.5	43.2	50.7	15.9(9.9)	26.2(16.1)
10	All	2	27.7	31.3	26.9	30.6	73.1(41.7)	79.5(41.7)
	Eligible for choice	2	0	0	0	0	62(21.1)	88.2(26.9)
	Not Eligible for choice	2	27.9	31.5	27.1	30.7	15.7(10.3)	25.7(15.5)
11	All	4	26.9	30.9	25.7	29.6	65.4(45.9)	74.3(47.8)
	Eligible for choice	4	0	0	0	0	108.9(43.5)	122.4(46.1)
	Not Eligible for choice	4	28.9	32.9	27.5	31.4	18.6(10.6)	28.1(16)
12	All	5	58.2	66.2	55.6	63.4	34.2(35.2)	41.1(40.2)
	Eligible for choice	5	0	0	0	0	97.3(45.1)	125.4(49.6)
	Not Eligible for choice	5	60.9	69.1	58.4	66.5	16.5(10.7)	23.6(14.4)
15	All	3	24.6	27.1	24.6	27.1	90.9(56.9)	100.2(60.3)
	Eligible for choice	3	0	0	0	0	119.4(39.1)	143(42.3)
	Not Eligible for choice	3	27.4	30.1	27.5	30.2	15.6(10)	23(14.9)
16	All	8	23.1	26.4	23.6	27.1	81.3(50.3)	99.4(61.3)
	Eligible for choice	8	0	0	0	0	93.1(36.6)	119.5(47.4)
	Not Eligible for choice	8	25.9	28.5	26.6	29.4	16.4(11.1)	28(16.8)
17	All	1	9.8	12.2	10.6	12.9	124.5(39.2)	129.2(39.8)
	Eligible for choice	1	0	0	0	0	129.7(43.3)	160(42.7)
	Not Eligible for choice	1	10.8	12.9	11.6	13.7	27.3(11.9)	40.6(14.9)
18	All	2	37.1	38	35.4	36.2	59.9(61.3)	70(64.1)
	Eligible for choice	2	0	0	0	0	137.1(54)	164.4(51.9)

	Not Eligible for choice	2	41.1	41.9	39.3	40.1	17.1(9.3)	25.7(12.3)
19	All	1	12.3	14.4	11.9	13.8	65.1(65)	72.3(65.6)
	Eligible for choice	1	0	0	0	0	150.6(55)	165.9(50)
	Not Eligible for choice	1	14.6	17.1	14.2	16.5	19.6(11.6)	31.3(15.4)
20	All	2	19.8	22.5	21.1	23.8	112.3(74.1)	117.1(71.9)
	Eligible for choice	2	0	0	0	0	119.8(47.9)	141.3(52.2)
	Not Eligible for choice	2	22.8	24.8	24.4	26.5	14.6(8.8)	24(13.9)
21	All	2	29.6	37.9	28.1	35.7	65.4(56.3)	78.7(62)
	Eligible for choice	2	0	0	0	0	134.7(57.8)	163.6(52.8)
	Not Eligible for choice	2	30.7	39.3	29.2	37.2	19.8(10.6)	34.2(15.2)
22	All	4	74.1	82.3	73.5	82	34.9(33.6)	40.6(36.1)
	Eligible for choice	4	0	0	0	0	103.9(41.3)	130.3(47.3)
	Not Eligible for choice	4	76.3	84.7	75.5	84.3	20.8(9.5)	28.2(11.8)
23	All	6	21.8	24.8	21.5	24.4	78.9(46.5)	93.5(54.3)
	Eligible for choice	6	0	0	0	0	105.7(41.6)	132.7(46.7)
	Not Eligible for choice	6	27.9	30.6	27.7	30.4	15.1(11.9)	25.8(17.8)

Table F-29 Geographic Access to a hospital with a polytrauma network site

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	23	20.8	24.7	19.2	22.8	86.8(66.8)	93.9(67.6)
	Eligible for choice	23	0	0	0	0	136.9(53)	156.9(52.2)
	Not Eligible for choice	23	22.4	26.5	20.8	24.6	19.3(10.4)	28.5(14.3)
1	All	1	22	36.4	20.7	35.1	70.1(51.4)	75.8(51.9)
	Eligible for choice	1	0	0	0	0	205.4(28.9)	208.4(26.7)
	Not Eligible for choice	1	22.9	37.8	21.6	36.6	20.5(11.2)	35.1(14.8)
2	All	1	11.9	15.6	12.9	16.7	104.4(50.2)	110.3(49.9)
	Eligible for choice	1	0	0	0	0	130.4(25)	161.4(37.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	1	12.2	16	13.2	17.1	14.8(12.5)	30.1(19.9)
3	All	1	65	78	63.5	76.5	28.1(20.4)	32.7(22.3)
	Eligible for choice	1	0	0	0	0	102.6(12.6)	127.7(20.4)
	Not Eligible for choice	1	65.1	78	63.5	76.5	18.7(9.5)	25.8(13.3)
4	All	1	23.4	27.4	21.8	25.6	86.3(59.8)	92.6(60.5)
	Eligible for choice	1	0	0	0	0	147.2(44.1)	157.6(48.4)
	Not Eligible for choice	1	23.8	27.9	22.2	26.1	17.9(11)	26.2(15)
5	All	1	55.3	69	49.2	64.3	38.7(32.3)	47.7(36.4)
	Eligible for choice	1	0	0	0	0	71.9(41.1)	83.2(42.2)
	Not Eligible for choice	1	55.9	69.2	49.7	64.6	19.8(11.5)	31.9(15.8)
6	All	1	7.3	9.1	7.2	8.7	146.9(64.7)	151.4(63.1)
	Eligible for choice	1	0	0	0	0	139.5(60.9)	155(57.3)
	Not Eligible for choice	1	7.9	9.9	7.9	9.4	14.5(9.3)	26.2(16.1)
7	All	1	5.1	5.1	5.6	5.7	138.3(45.8)	155.1(46.5)
	Eligible for choice	1	0	0	0	0	137.5(60.3)	166.9(55.2)
	Not Eligible for choice	1	5.5	5.5	6.1	6.2	14.1(10.7)	24.2(15.8)
8	All	2	23.2	24.4	23.3	24.6	89.9(70.4)	96.9(68.5)
	Eligible for choice	2	0	0	0	0	163.4(45.3)	189.3(39.8)
	Not Eligible for choice	2	23.5	24.8	23.7	25	20.1(11.5)	30.2(16.1)
9	All	1	5.7	6.2	5.9	6.4	133.4(66.2)	145.5(67.5)
	Eligible for choice	1	0	0	0	0	142.3(50.7)	166.3(49.6)
	Not Eligible for choice	1	6.5	6.9	6.7	7.1	16.5(12.5)	26.4(17)
10	All	1	20.5	24.8	20.2	24.6	87.6(53.1)	92.4(52)
	Eligible for choice	1	0	0	0	0	128.1(29.1)	144.9(27.3)
	Not Eligible for choice	1	20.6	24.9	20.3	24.8	17.3(11.9)	27.4(15.6)
11	All	1	11.5	13.3	11.5	13.3	143.9(60.6)	144.5(56.2)
	Eligible for choice	1	0	0	0	0	141(46.7)	147.3(46)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	1	12.3	13.9	12.4	14	14.6(9.9)	25.3(15.4)
12	All	1	35.1	43.5	31.8	39.9	64.2(58.3)	68.1(59.1)
	Eligible for choice	1	0	0	0	0	162.8(45.5)	177.4(48.5)
	Not Eligible for choice	1	36.7	45.5	33.4	41.9	19.7(9.4)	27.1(12.8)
15	All	1	18.5	20.3	15.9	17.4	95.7(70.5)	113.3(77)
	Eligible for choice	1	0	0	0	0	130.8(55.3)	152.2(55.8)
	Not Eligible for choice	1	20.6	22.6	17.8	19.5	21.1(9.7)	29(12.4)
16	All	1	13.5	14.4	12.3	13.2	105.2(85.6)	111.8(83.2)
	Eligible for choice	1	0	0	0	0	147.3(55.8)	167.4(52.1)
	Not Eligible for choice	1	15.1	16.1	13.9	14.9	18.9(9.6)	26.6(12.4)
17	All	2	43.2	49.4	41.5	47.4	61.6(49.4)	70.3(52.7)
	Eligible for choice	2	0	0	0	0	110.7(36.9)	131.8(43.4)
	Not Eligible for choice	2	47.4	54	45.7	51.8	20.9(10.1)	29.9(13.1)
18	All	1	11.7	12.1	11.8	12.3	111.1(54.6)	114.9(54.1)
	Eligible for choice	1	0	0	0	0	153.6(58.1)	170.1(49.9)
	Not Eligible for choice	1	12.9	13.3	13.2	13.6	12.3(6.8)	21(11.9)
19	All	1	21	22.6	19.7	21	49.9(50.2)	61.1(56.3)
	Eligible for choice	1	0	0	0	0	135.9(44.7)	154.6(50.3)
	Not Eligible for choice	1	24.9	26.7	23.6	25.1	15.1(9)	24.2(12.6)
20	All	1	19.2	23.3	16.7	20.3	97.9(75.9)	102.6(72.6)
	Eligible for choice	1	0	0	0	0	125.7(47.5)	153.5(47.9)
	Not Eligible for choice	1	22	26.8	19.2	23.4	21(10.5)	29.7(14.3)
21	All	1	15.6	19.1	15	18.3	85.8(58.6)	95.3(62.3)
	Eligible for choice	1	0	0	0	0	155.9(38.5)	183.6(37)
	Not Eligible for choice	1	16.2	19.8	15.6	19	24.3(10.5)	34.6(12.9)
22	All	1	26.5	34.3	24.8	32.3	58(46.3)	60.8(46.7)
	Eligible for choice	1	0	0	0	0	146(39.5)	166(36.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	1	27.2	35.3	25.5	33.2	21.3(9.4)	29.1(13)
23	All	1	15.3	16.4	14.2	15.3	93.8(75.9)	112.1(80.7)
	Eligible for choice	1	0	0	0	0	131.6(57.2)	154.1(56.8)
	Not Eligible for choice	1	19.5	20.5	18.3	19.3	15.9(8.6)	23.3(11.7)

Table F-30 Geographic Access to VA Facilities with a Polytrauma rehabilitation center

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	5	4.4	4.7	4.4	4.7	118.2(70.3)	126.3(69.8)
	Eligible for choice	5	0	0	0	0	133.8(52.6)	155.1(52.4)
	Not Eligible for choice	5	4.7	5	4.8	5.1	20.2(10.8)	29.8(14.4)
1	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
2	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
3	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
4	All	NA	0	0	0	0	222.1(13.2)	223.3(12.5)
	Eligible for choice	NA	0	0	0	0	217.5(20.9)	233.3(2.6)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
5	All	NA	0	0	0	0	135.9(28.5)	138.2(29.7)
	Eligible for choice	NA	0	0	0	0	136.6(49.3)	154.2(46.2)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
6	All	1	7.3	8	7.2	7.9	131.8(67.7)	137.6(66.3)
	Eligible for choice	1	0	0	0	0	133.1(58.5)	148.1(54.5)
	Not Eligible for choice	1	7.9	8.7	7.9	8.6	14.5(9.3)	24(14.7)
7	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
8	All	1	17.6	18	17.6	17.8	106.7(70.9)	113.7(68.1)
	Eligible for choice	1	0	0	0	0	163.4(45.3)	189.3(39.8)
	Not Eligible for choice	1	17.9	18.2	17.8	18.1	24(10.7)	34.9(14.7)
9	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
10	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
11	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
12	All	NA	0	0	0	0	179.3(28.4)	199.1(29.3)
	Eligible for choice	NA	0	0	0	0	151.7(30.4)	170.6(46.6)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
15	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
16	All	NA	0	0	0	0	209.1(15.2)	203.7(15.3)
	Eligible for choice	NA	0	0	0	0	166.2(24.7)	184.9(32.4)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
17	All	1	19.9	20.8	19.8	20.7	93.3(64)	102.2(67.8)
	Eligible for choice	1	0	0	0	0	132.8(46.7)	156.6(48.6)
	Not Eligible for choice	1	21.9	22.8	21.8	22.8	14.8(8.9)	22.7(12.7)
18	All	NA	0	0	0	0	202.1(2.2)	233(2.8)
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
19	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
20	All	NA	NA	NA	NA	NA	NA	NA
	Eligible for choice	NA	NA	NA	NA	NA	NA	NA
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
21	All	1	15.6	19.1	15	18.3	83.3(57.5)	92.8(61.5)
	Eligible for choice	1	0	0	0	0	155.6(38.9)	184.5(37.2)
	Not Eligible for choice	1	16.2	19.8	15.6	19	24.3(10.5)	34.6(12.9)
22	All	NA	0	0	0	0	191.8(13.4)	219.7(13.8)
	Eligible for choice	NA	0	0	0	0	188.2(25.1)	216.6(13)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
23	All	1	15.3	16.4	14.2	15.3	76.3(70.8)	97.6(80.2)
	Eligible for choice	1	0	0	0	0	120.6(53.1)	144.8(55)
	Not Eligible for choice	1	19.5	20.5	18.3	19.3	15.9(8.6)	23.3(11.7)

Table F-31 Geographic Access to VA Facilities providing TBI Specialty Care

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	207	62	67.5	60.6	66.1	36.6(36.8)	46.9(43.2)
	Eligible for choice	207	0	0	0	0	89.3(39.4)	115.1(46.1
	Not Eligible for choice	203	66.9	72.2	65.6	70.9	15.9(10.4)	24.5(14.7)
1	All	9	67.9	76.7	67.6	75.9	30.4(27.1)	38.5(31.4)
	Eligible for choice	9	0	0	0	0	97.8(42.2)	119.5(46.2)
	Not Eligible for choice	9	70.6	79.2	70.6	78.7	17.8(11.2)	26.7(15.2)
2	All	8	70.3	74.6	71.4	75.5	30.4(32.6)	40.7(37.6)
	Eligible for choice	8	0	0	0	0	87.5(37.5)	117.6(46.9)
	Not Eligible for choice	8	72.2	76.4	73.2	77.2	14.7(10.5)	24.3(15.5)
3	All	10	96.6	98.1	96.4	97.9	11.6(10.5)	17.2(13)
	Eligible for choice	10	0	0	0	0	56.5(25.6)	81.2(36.6)
	Not Eligible for choice	10	96.7	98.1	96.5	98	10.8(8.6)	16.4(11.2)
4	All	11	64.8	76.3	65	76.4	29.8(22.7)	39.1(27.9)
	Eligible for choice	11	0	0	0	0	62.8(20.4)	83.7(28.4)
	Not Eligible for choice	11	66.1	77.3	66.3	77.5	17.1(11)	28.2(16.6)
5	All	7	86.6	88.9	85.6	88	21.1(19.9)	30.1(27.3)
	Eligible for choice	7	0	0	0	0	46.8(7.6)	58.2(15.4)
	Not Eligible for choice	7	87.5	89.1	86.5	88.3	15.7(10.5)	23.2(13.9)
6	All	8	51.7	61.1	50.7	60.2	47(33.2)	59.4(40.3)
	Eligible for choice	8	0	0	0	0	67.1(22)	91.1(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	13	53.1	57.2	53.4	57.5	44.6(34)	58.6(42)
	Eligible for choice	13	0	0	0	0	69.2(20.6)	93.6(28.3)
	Not Eligible for choice	13	58	61.5	58.4	61.9	17.5(10.8)	27.1(15.3)
8	All	15	66	70.4	65.5	70.1	31.1(30.1)	40.4(34.1)
	Eligible for choice	15	0	0	0	0	69.8(23.9)	100.9(32.1

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	14	67.1	71.5	66.6	71.2	15.6(9.7)	24.5(14.3)
9	All	7	34.7	41.7	35.4	42.2	73.5(51.3)	84.8(53.9)
	Eligible for choice	7	0	0	0	0	106.8(37.4)	130(38.9)
	Not Eligible for choice	7	39.4	47	40.2	47.5	16.3(10.5)	27.2(16.5)
10	All	6	64.9	73.2	63.6	72.1	29.4(23)	38.1(27.1)
	Eligible for choice	6	0	0	0	0	53(8.1)	76.4(13.7)
	Not Eligible for choice	5	65.4	73.6	64	72.6	16.3(10.9)	25.9(15.4)
11	All	9	54.9	61.2	54	60.1	41.4(34.7)	50.8(38.6)
	Eligible for choice	9	0	0	0	0	74.8(32.8)	89.7(34.5)
	Not Eligible for choice	9	58.9	64.4	58	63.2	18.4(11.1)	27.6(15.6)
12	All	8	64.1	69.5	61.4	66.7	31.5(32.9)	41(42.3)
	Eligible for choice	8	0	0	0	0	83.7(33.6)	123.1(50.8)
	Not Eligible for choice	8	67	72.5	64.5	70	15.2(10)	22(13.7)
15	All	10	57	61.8	55.3	60.1	40.8(37.8)	53.3(47.5)
	Eligible for choice	10	0	0	0	0	91.3(36.9)	119.8(47.1)
	Not Eligible for choice	10	63.5	67.9	61.8	66.3	15.8(10.4)	23.7(15.2)
16	All	16	51.9	55.7	50.2	54.1	44.4(37.7)	57.6(46.6)
	Eligible for choice	16	0	0	0	0	81.1(29.7)	105.6(38.3
	Not Eligible for choice	16	58.2	61.2	56.6	59.7	15.6(10.4)	23.7(14.3)
17	All	6	63.9	70.8	63.2	69.7	43.2(41.9)	54.4(47.2)
	Eligible for choice	6	0	0	0	0	88.2(38.8)	115.7(44)
	Not Eligible for choice	6	70.2	76.8	69.6	75.8	20.3(10.4)	29.6(13.4)
18	All	8	65.9	68.8	65.8	68.7	42(46.2)	54.4(54.3)
	Eligible for choice	8	0	0	0	0	102.2(41.7	130.7(51.1)
	Not Eligible for choice	8	72.9	75.6	73.1	75.7	15.4(9.3)	24.5(13.3)
19	All	9	58.8	63.3	56.2	60.8	50.7(56.9)	61.5(62.1)
	Eligible for choice	9	0	0	0	0	128.6(51.4	152.4(54)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	9	69.8	74.4	67.3	72	14.7(10)	24.6(14.3)
20	All	11	65.3	70	64.6	69.2	40.6(45)	52.5(52.6)
	Eligible for choice	11	0	0	0	0	96.1(40.2)	126.4(48.7
	Not Eligible for choice	11	75.1	79.2	74.6	78.6	15.3(9.7)	24.3(14.1)
21	All	12	68.8	72.3	66.6	70.4	27.3(26.3)	38.9(35.4)
	Eligible for choice	12	0	0	0	0	87.3(43.1)	123.3(53.7
	Not Eligible for choice	10	71.4	75	69.4	73.3	15.3(9.5)	24.7(14.2)
22	All	12	83.2	89.7	82.3	89.2	21.3(19.2)	26.9(21.8)
	Eligible for choice	12	0	0	0	0	81.7(34.8)	106.9(39.7)
	Not Eligible for choice	12	85.6	92.2	84.6	91.6	15.9(9.3)	22.1(12)
23	All	12	44.1	46.4	43	45.2	57.2(47.5)	72.5(57.4)
	Eligible for choice	12	0	0	0	0	94.4(38.5)	122.9(46.6)
	Not Eligible for choice	12	56.2	57.5	55.2	56.3	14.9(10.4)	22.5(14.2)

Appendix F.2.5: Services for Post-Traumatic Stress Disorder (PTSD)

Table F-32 Geographic Access to VA Facilities providing Domiciliary Mental Rehabilitative Treatment Program

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	45	17.5	22	16.9	21.2	88(57.7)	98.5(60.7)
	Eligible for choice	45	0	0	0	0	125.2(49.8)	149.3(50.9)
	Not Eligible for choice	43	18.9	23.5	18.3	22.8	23.3(11.5)	35.2(14.7)
1	All	3	41.7	55	41.1	53.9	55.1(47.6)	61.2(48)
	Eligible for choice	3	0	0	0	0	180.6(36.2)	185(35.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	3	43.4	57.1	42.9	56.3	25.2(9.6)	35.4(13.2)
2	All	1	18	29.5	18.8	30.7	94(50.3)	102.2(51.6)
	Eligible for choice	1	0	0	0	0	158(31.2)	183.5(26.6)
	Not Eligible for choice	1	18.4	30.3	19.2	31.4	33.4(7.6)	43.2(8.3)
3	All	3	74.8	88.9	74.3	87.8	34.9(12.9)	42.1(14.1)
	Eligible for choice	3	0	0	0	0	100.1(12.2)	127(4.1)
	Not Eligible for choice	3	74.9	88.9	74.4	87.9	29.4(8.7)	39.4(9.5)
4	All	1	14.3	25.5	14.2	24.9	86.1(48.2)	97.6(48.9)
	Eligible for choice	1	0	0	0	0	125.3(52.3)	145.2(51.7)
	Not Eligible for choice	1	14.5	26	14.5	25.4	30.1(8.4)	46.2(9.6)
5	All	1	10	11.2	12.4	13.7	78.3(22.1)	95(26.5)
	Eligible for choice	1	0	0	0	0	77.5(18.3)	96.3(18.5)
	Not Eligible for choice	1	10.1	11.3	12.5	13.9	28.5(9.8)	42.2(13)
6	All	3	23.6	29.2	22.3	28.2	82.6(49)	95.4(54.6)
	Eligible for choice	3	0	0	0	0	101.4(41.8)	127.6(45.3)
	Not Eligible for choice	3	25.8	31.7	24.5	30.7	22.4(10.8)	36.3(15.8)
7	All	4	6.5	9	6.6	9.4	117(48.6)	130.8(49.7)
	Eligible for choice	4	0	0	0	0	110.4(49.6)	134.5(48.5)
	Not Eligible for choice	4	7.1	9.5	7.2	9.9	16.9(12.3)	35.2(19.1)
8	All	3	21.8	26.5	20.8	25.3	77.2(57.9)	89.9(63.6)
	Eligible for choice	3	0	0	0	0	120(29.9)	167(39.9)
	Not Eligible for choice	2	22.2	26.9	21.1	25.7	20.7(11.3)	31(15.9)
9	All	2	14.2	15.5	14.3	15.6	123.9(69.9)	134(70)
	Eligible for choice	2	0	0	0	0	128.8(48.3)	150.2(51.7)
	Not Eligible for choice	2	16.2	17	16.2	17.1	15.8(10.7)	23(14.7)
10	All	4	47.9	53.8	46.7	52.8	47.6(39.4)	55.1(41.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	4	0	0	0	0	62.2(15.2)	85.5(18.3)
	Not Eligible for choice	3	48.3	54.1	47.1	53.1	16.4(11)	25.4(14.8)
11	All	1	3.3	4	3.3	4.1	120(40.7)	128.1(38.8)
	Eligible for choice	1	0	0	0	0	133.3(47.6)	144.6(46.1)
	Not Eligible for choice	1	3.5	4.1	3.6	4.1	22.2(10.3)	36.7(15.3)
12	All	3	30	48.5	29.1	46.4	53.9(34.3)	59.9(38.6)
	Eligible for choice	3	0	0	0	0	112(40.8)	142.6(44.1)
	Not Eligible for choice	3	31.4	50.6	30.6	48.6	23.2(12.3)	36.8(15.2)
15	All	1	3.5	4.4	3.8	4.6	125.9(58.7)	133.4(62.3)
	Eligible for choice	1	0	0	0	0	150.8(49.4)	172.5(49.4)
	Not Eligible for choice	1	3.9	4.6	4.2	4.9	16.5(13.6)	29.3(19.9)
16	All	4	9.5	10.6	9.7	10.9	133.4(63.2)	153.7(69.1)
	Eligible for choice	4	0	0	0	0	125.6(48)	154.9(54.2)
	Not Eligible for choice	4	10.6	11.6	10.9	12	15.3(10.9)	25.8(15.8)
17	All	3	12.8	14.7	13.9	15.7	94.1(38.5)	107.4(39.9)
	Eligible for choice	3	0	0	0	0	104.7(47.7)	136.9(47.4)
	Not Eligible for choice	3	14	15.6	15.3	16.7	21.8(12.9)	35.7(18.3)
18	All	NA	0	0	0	0	229.2(15.8)	224.3(12.9)
	Eligible for choice	NA	0	0	0	0	226.1(19.9)	228.6(14.8)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
19	All	2	21.8	23.6	20.7	22.4	56.7(53.8)	68.5(60.7)
	Eligible for choice	2	0	0	0	0	133.8(42.5)	155.3(49.7)
	Not Eligible for choice	2	25.9	27.7	24.9	26.4	15.1(9)	24.1(12.6)
20	All	2	18.1	22.5	17	20.9	91.8(53.3)	98.5(53.9)
	Eligible for choice	2	0	0	0	0	136.4(49)	160.4(45.9)
	Not Eligible for choice	2	20.8	25.8	19.6	24.1	23.2(10.6)	39.2(14.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
21	All	2	24	27.4	22	25.2	78.5(59)	88.9(64)
	Eligible for choice	2	0	0	0	0	157.8(35.6)	180.7(35.4)
	Not Eligible for choice	2	24.9	28.5	22.9	26.2	21.7(11.1)	31.5(14)
22	All	NA	0	0	0	0	191.8(13.4)	219.7(13.8)
	Eligible for choice	NA	0	0	0	0	188.2(25.1)	216.6(13)
	Not Eligible for choice	NA	NA	NA	NA	NA	NA	NA
23	All	2	4.7	4.9	4.6	4.8	145(50.2)	151.2(48.3)
	Eligible for choice	2	0	0	0	0	143.9(49.6)	168.3(51.3)
	Not Eligible for choice	2	6	6.1	5.9	6	14.3(12.1)	22.3(15.2)

Table F-33 Geographic Access to VA Facilities providing Mental Health Services

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	848	90.4	91.1	90.1	90.6	16.4(17.3)	25.3(24.3)
	Eligible for choice	848	0	0	0	0	59.6(23.2)	84.7(33.7)
	Not Eligible for choice	810	97.6	96.7	97.5	96.6	12.4(9.4)	19.3(13.1)
1	All	47	96.1	96	95.7	95.6	12.3(11.3)	19.2(16.7)
	Eligible for choice	47	0	0	0	0	52.9(12.6)	76.2(22)
	Not Eligible for choice	46	99.9	98.8	99.9	98.8	10.9(8.2)	16.8(11.5)
2	All	33	97.4	95.2	97.6	95.3	12.5(10.7)	21.8(17.8)
	Eligible for choice	33	0	0	0	0	48.3(7.1)	75.4(19.2)
	Not Eligible for choice	32	100	97.2	100	97.3	11.5(9.1)	19(13.4)
3	All	34	99.9	99.9	99.9	99.9	6.3(5.2)	11.1(8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	34	0	0	0	0	42.4(1.2)	65.7(9.8)
	Not Eligible for choice	33	100	100	100	100	6.3(5.1)	11(7.9)
4	All	49	97.1	97.4	96.9	97.2	12.7(10.1)	20(14.4)
	Eligible for choice	49	0	0	0	0	46.7(8.6)	66.2(17.4)
	Not Eligible for choice	47	99	98.6	98.9	98.4	11.8(8.4)	18.6(11.7)
5	All	19	96.8	97.1	97.4	97.6	14.1(10.7)	21.4(15)
	Eligible for choice	19	0	0	0	0	43.5(3.9)	55.6(11)
	Not Eligible for choice	18	97.9	97.4	98.4	98	13.4(9.8)	20.3(13.1)
6	All	27	80.7	83.1	80.6	83.1	23.9(17.4)	35.4(25.1)
	Eligible for choice	27	0	0	0	0	51(11.2)	73.8(21.5)
	Not Eligible for choice	27	88.2	88.2	88.6	88.5	17.7(10.7)	26.4(14.4)
7	All	43	86.1	86.6	85.6	86	20.8(17.9)	32.4(25.4)
	Eligible for choice	43	0	0	0	0	52.1(10.5)	74.7(17.5)
	Not Eligible for choice	43	94.1	92.7	93.7	92.2	14.6(10)	23.1(14.2)
8	All	54	95	97.1	95.4	97.1	13.3(10.6)	21.2(15.1)
	Eligible for choice	54	0	0	0	0	50.7(8.4)	77(12.7)
	Not Eligible for choice	51	96.5	98.6	97	98.6	12(8.4)	19.8(12.5)
9	All	43	85.8	87.2	85.9	87.2	21.8(16.9)	33.2(24.2)
	Eligible for choice	43	0	0	0	0	52(9.8)	74.3(16.3)
	Not Eligible for choice	41	97.5	95.9	97.4	95.8	16.2(11)	24.4(15.4)
10	All	38	99.2	99	99.3	99	10.8(8.5)	17.8(12.8)
	Eligible for choice	38	0	0	0	0	43.3(1.8)	60.2(7.8)
	Not Eligible for choice	37	100	99.4	100	99.4	10.5(8.1)	17.2(11.9)
11	All	38	93.2	94.3	93.2	94.2	17.2(12.5)	26.1(17.4)
	Eligible for choice	38	0	0	0	0	47.7(7.4)	63.9(12.6)
	Not Eligible for choice	38	100	98.3	100	98.2	15.3(9.9)	23.1(13.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
12	All	39	95.6	94.9	95.1	94.3	11.9(11)	19.1(16.6)
	Eligible for choice	39	0	0	0	0	50.9(10.2)	78.7(17.7)
	Not Eligible for choice	39	100	98.7	100	98.5	10.6(8.5)	16.8(11.9)
15	All	50	88.3	88.4	87.9	87.6	20.7(22.4)	31.1(30.9)
	Eligible for choice	50	0	0	0	0	63.8(30.8)	89.1(41.1)
	Not Eligible for choice	45	98.3	96.5	98.3	96.2	14.2(10.6)	21.2(14.7)
16	All	67	88.3	89.2	87.9	88.8	19.7(16)	29.6(22.9)
	Eligible for choice	67	0	0	0	0	51.6(13.3)	73.7(21.8)
	Not Eligible for choice	65	99.1	97	99.1	96.8	15.3(10.4)	22.6(14)
17	All	20	86.7	87.7	86.2	87.2	22.8(20.2)	32.8(28.3)
	Eligible for choice	20	0	0	0	0	63.2(24.9)	88.5(34.8)
	Not Eligible for choice	20	95.1	94.8	94.9	94.5	16.3(9.8)	23.4(12.8)
18	All	42	90.1	90	89.8	89.7	18.3(23)	29.2(33.4)
	Eligible for choice	42	0	0	0	0	68.9(27.7)	100.3(43.5
	Not Eligible for choice	41	99.7	98.4	99.7	98.4	10.9(8.3)	18.2(11.6)
19	All	37	81.9	83.3	80.9	82.3	26.7(35.9)	37.5(45.9)
	Eligible for choice	37	0	0	0	0	84.1(35.6)	110.4(49.2)
	Not Eligible for choice	30	97.3	96	96.9	95.6	11.3(8.9)	17.7(11.8)
20	All	37	87	87.9	86.7	87.5	19.5(21)	29.7(31)
	Eligible for choice	37	0	0	0	0	65.1(23.7)	95.6(39.9)
	Not Eligible for choice	36	100	98.1	100	98	13.1(9.8)	19.9(12.8)
21	All	40	95.2	93.8	94.7	93.3	13.1(13.4)	21.2(20.5)
	Eligible for choice	40	0	0	0	0	64(26.1)	98.5(34.8)
	Not Eligible for choice	38	98.8	97.3	98.6	97.1	11.2(8)	17.7(11.5)
22	All	32	94.6	95.8	94.7	95.9	10.7(12.2)	16.3(16.6)
	Eligible for choice	32	0	0	0	0	64.8(30.1)	94.9(44.5)
	Not Eligible for	32	97.3	98.1	97.4	98.1	8.8(6.4)	14.1(9.3)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	choice							
23	All	59	75.9	76.1	75.3	75.3	26.3(25.4)	39.7(35.9)
	Eligible for choice	59	0	0	0	0	63.6(22)	91.6(32.2)
	Not Eligible for choice	51	96.8	94.1	96.7	93.7	14.3(10.9)	22(15.3)

Table F-34 Geographic Access to VA Facilities providing psychotherapy

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	672	84.7	86.6	84.1	85.9	20.3(22.2)	29.6(29.2)
	Eligible for choice	672	0	0	0	0	64.4(28.1)	89.9(37.3)
	Not Eligible for choice	649	91.4	92	91.1	91.6	13.2(9.8)	20.5(13.7)
1	All	36	88.9	90	88.1	89.1	16.4(21.2)	23.8(26.3)
	Eligible for choice	36	0	0	0	0	82.6(45.4)	106(49.6)
	Not Eligible for choice	36	92.4	92.9	92	92.4	11.5(8.8)	17.9(12.8)
2	All	27	93.5	92.3	93.7	92.5	15.1(14.9)	25(22.1)
	Eligible for choice	27	0	0	0	0	50.2(9.4)	76.8(20.7)
	Not Eligible for choice	26	96	94.3	96	94.3	12.4(9.9)	20.3(14.5)
3	All	28	99.8	99.6	99.7	99.6	6.7(5.7)	11.6(8.8)
	Eligible for choice	28	0	0	0	0	47.5(9.9)	75.5(26.6)
	Not Eligible for choice	28	99.8	99.7	99.8	99.7	6.6(5.4)	11.4(8.2)
4	All	31	88.8	92.7	88.2	92.2	16.5(14.3)	24.4(18.6)
	Eligible for choice	31	0	0	0	0	48.3(9.3)	68.7(18.8)
	Not Eligible for	30	90.6	93.8	90	93.3	13(9.2)	21.1(13.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	choice							
5	All	14	96	98.1	95.3	97.6	14.9(11.1)	22.8(14.7)
	Eligible for choice	14	0	0	0	0	44.1(4.7)	55.8(11)
	Not Eligible for choice	14	97	98.4	96.3	98	13.9(9.4)	21.9(13.2)
6	All	24	78.9	82	78.8	81.9	24.7(17.9)	36.3(25.6)
	Eligible for choice	24	0	0	0	0	51.7(11.7)	74.7(22)
	Not Eligible for choice	24	86.3	87.1	86.5	87.3	17.9(10.8)	26.8(14.5)
7	All	38	82.2	83.1	81.7	82.5	23.6(21.1)	35.3(27.9)
	Eligible for choice	38	0	0	0	0	55.1(14.6)	78.2(21.4)
	Not Eligible for choice	38	89.8	88.9	89.4	88.5	15(10.1)	23.8(14.5)
8	All	36	86.5	91.5	86.3	91	20.1(19.8)	28.2(22.8)
	Eligible for choice	36	0	0	0	0	51.1(8.7)	77.2(12.8)
	Not Eligible for choice	34	87.8	92.9	87.8	92.4	13.6(8.9)	22.2(13.1)
9	All	27	63.4	67.5	63.9	67.8	36(28.6)	50.6(37)
	Eligible for choice	27	0	0	0	0	60.1(18.9)	85.5(24.8)
	Not Eligible for choice	26	72	74.6	72.5	74.9	16.8(11)	26.1(15.9)
10	All	32	95.5	95.9	95.3	95.7	12.2(10.8)	19.7(15.7)
	Eligible for choice	32	0	0	0	0	44.9(3.9)	63.1(9.7)
	Not Eligible for choice	31	96.2	96.4	96	96.2	10.9(8.5)	17.9(12.7)
11	All	31	86.2	89.9	86.2	89.6	21.3(15.2)	30.1(19.8)
	Eligible for choice	31	0	0	0	0	49.3(9.6)	65(13.8)
	Not Eligible for choice	31	92.5	93.7	92.5	93.4	17.2(11)	25.3(14.9)
12	All	29	91.9	92.9	91.6	92.4	16.7(13.7)	24(18.4)
	Eligible for choice	29	0	0	0	0	50.9(10.2)	78.7(17.7)
	Not Eligible for choice	29	96.1	96.6	96.4	96.6	14.3(10)	21(13.4)
15	All	40	80.8	82.7	80.1	81.8	24.9(24.7)	35.7(33.6)
	Eligible for choice	40	0	0	0	0	67.6(31.8)	93(41.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	35	90	90.2	89.6	89.7	15.3(10.8)	22.8(15.1)
16	All	58	83.9	85.2	83	84.3	22.7(21.2)	33.1(28.4)
	Eligible for choice	58	0	0	0	0	55.6(17.7)	78(25.6)
	Not Eligible for choice	56	94.1	92.5	93.6	91.9	15.1(10.3)	22.5(13.9)
17	All	17	82.4	85.1	82	84.6	25.3(23)	35.6(30.9)
	Eligible for choice	17	0	0	0	0	66.5(26.8)	91.7(35.6)
	Not Eligible for choice	17	90.5	92.2	90.3	91.9	16.7(10.1)	24.6(13.4)
18	All	32	84.4	84.1	84.3	84	24(31.5)	35.8(42.1)
	Eligible for choice	32	0	0	0	0	78.9(31.5)	112.3(47.5
	Not Eligible for choice	32	93.3	92.3	93.6	92.5	11(8.1)	18.3(11.4)
19	All	29	78.5	80.7	77.6	79.7	31(39.5)	41.3(46.8)
	Eligible for choice	29	0	0	0	0	90(42.3)	114.5(50.2
	Not Eligible for choice	26	93.3	93.4	92.9	92.8	12.3(9.6)	20.2(13.8)
20	All	32	83.8	84.9	83.1	84.2	22.6(26.2)	33.3(36.2)
	Eligible for choice	32	0	0	0	0	70(28.4)	100.2(45)
	Not Eligible for choice	31	96.3	94.9	95.9	94.4	13.4(9.9)	20.3(13)
21	All	34	91.5	90.2	90.7	89.3	16(16.5)	24.5(23.5)
	Eligible for choice	34	0	0	0	0	71.6(33.8)	105.2(40.7)
	Not Eligible for choice	32	95	93.5	94.5	93	12.5(8.8)	19(12.3)
22	All	27	87.6	89	87.5	88.9	15.6(23.6)	22.1(30.4)
	Eligible for choice	27	0	0	0	0	73.9(28.1)	104.4(39.3
	Not Eligible for choice	27	90.1	91.5	90	91.3	8.9(6.1)	14.2(9.4)
23	All	50	72.2	72.6	71.5	71.7	29.4(29.9)	43.3(40.4)
	Eligible for choice	50	0	0	0	0	67.8(27.4)	96(36.6)
	Not Eligible for choice	46	92.1	89.8	91.9	89.3	14.2(10.8)	22(15.2)

Appendix F.2.6: Services for Substance Use Disorder (SUD)

Table F-35 Geographic Access to VA Facilities providing Residential treatment for SUD

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	64	29.2	34.6	28	33.3	73.9(58.7)	83.2(61.2)
	Eligible for choice	64	0	0	0	0	121.2(49.3)	144.1(51.1)
	Not Eligible for choice	61	31.5	37.1	30.3	35.9	19(10.7)	29.1(15.3)
1	All	3	30.7	42	29.8	41	57.7(41.2)	66.7(44.1)
	Eligible for choice	3	0	0	0	0	112.7(58.9)	124.5(59.8)
	Not Eligible for choice	3	31.9	43.3	31.1	42.4	19.7(12.6)	32.3(16.9)
2	All	1	19.5	20.7	20.2	21.4	97.9(55.3)	106.4(56.7)
	Eligible for choice	1	0	0	0	0	149.5(22)	178.9(27.2)
	Not Eligible for choice	1	20.1	21.2	20.7	21.9	13.6(10.3)	21.6(15.5)
3	All	4	84.9	89.5	84	88.5	21(14.8)	26.9(17.5)
	Eligible for choice	4	0	0	0	0	93.9(6.8)	121.6(3)
	Not Eligible for choice	4	85	89.5	84	88.6	17.2(8.8)	23.5(11.8)
4	All	4	35	49.1	34.9	48.6	51.8(32)	62.6(35.1)
	Eligible for choice	4	0	0	0	0	92.4(46.8)	111.8(51.8)
	Not Eligible for choice	4	35.7	49.7	35.7	49.2	23.5(11.1)	38.6(14.5)
5	All	2	18.1	32.8	21.1	38	65.9(23.2)	77.5(28.2)
	Eligible for choice	2	0	0	0	0	73.3(18.5)	92.1(14)
	Not Eligible for choice	2	18.3	33.1	21.3	38.4	28.8(10.2)	45.5(10.6)
6	All	5	34.7	41.3	33.9	40.9	66.9(47.7)	79.3(53.5)
	Eligible for choice	5	0	0	0	0	86.7(37.3)	109.6(40.9)
	Not Eligible for choice	5	38	44.8	37.3	44.5	20.4(11.1)	33.1(16.3)
7	All	2	2.6	4.9	3	5.4	123.9(44)	138.6(46.3)
	Eligible for choice	2	0	0	0	0	126.8(47.3)	150.4(44.5)
	Not Eligible for choice	2	2.8	5.3	3.3	5.9	18.6(13.6)	42.7(17.7)
8	All	5	24.7	30.5	23.9	29.8	67.6(47.6)	78.5(50.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	5	0	0	0	0	114.6(41.5)	148.1(38.8)
	Not Eligible for choice	3	25.1	31	24.3	30.3	20.6(11.5)	31.2(16.2)
9	All	3	23.7	26.6	23.8	26.7	106(69.4)	114.3(69.3)
	Eligible for choice	3	0	0	0	0	123.8(45.8)	142.9(48.8)
	Not Eligible for choice	3	26.9	29.7	27	29.7	15.3(10.1)	22.7(14.7)
10	All	4	48	55.7	46.9	54.7	45.7(37.2)	53.4(39.5)
	Eligible for choice	4	0	0	0	0	59.4(12.4)	85.3(18.1)
	Not Eligible for choice	3	48.4	56	47.2	55	16.4(11.1)	26.4(15.5)
11	All	2	7.5	8.6	7.9	9	105.4(38.5)	114.6(37)
	Eligible for choice	2	0	0	0	0	121.9(43.6)	134.4(44.9)
	Not Eligible for choice	2	8	9	8.5	9.4	25.3(10.9)	40.6(15.1)
12	All	5	54.7	65.8	52	63	34.6(35.2)	41.3(40.2)
	Eligible for choice	5	0	0	0	0	98(44.7)	125.8(49.4)
	Not Eligible for choice	5	57.2	68.7	54.6	66	16.3(11)	23.9(15)
15	All	2	34.7	38.6	31.8	35.4	80.7(63.8)	90(67.5)
	Eligible for choice	2	0	0	0	0	128.7(43.8)	153.3(48.5)
	Not Eligible for choice	2	38.7	43	35.6	39.6	18.8(9.7)	26.3(13.4)
16	All	2	5.2	5.6	5.3	5.8	153.1(59.1)	162.5(56)
	Eligible for choice	2	0	0	0	0	143.1(51)	167.9(52.9)
	Not Eligible for choice	2	5.8	6	5.9	6.1	14.9(10.5)	24.4(14.9)
17	All	3	45.4	51.3	43.9	49.5	61.3(51.4)	69.8(54.1)
	Eligible for choice	3	0	0	0	0	105.2(39)	127.7(43.8)
	Not Eligible for choice	3	49.8	56	48.4	54.1	21.1(10.2)	30.2(13.2)
18	All	3	48.8	50	47.2	48.5	47.7(60.4)	57.7(62.6)
	Eligible for choice	3	0	0	0	0	134.6(57.2)	156.9(54.4)
	Not Eligible for choice	3	54	55.3	52.4	53.7	16.3(9.1)	24.8(12.3)
19	All	2	13.1	15.4	13	15.1	71.2(66.7)	79.9(68.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	2	0	0	0	0	148.4(55.9)	166.4(51.9)
	Not Eligible for choice	2	15.6	18	15.5	17.8	19.4(11.7)	31.1(15.4)
20	All	6	42.1	49.4	42.1	48.9	61.1(50.2)	73.8(60.1)
	Eligible for choice	6	0	0	0	0	103.7(36.6)	136.9(48)
	Not Eligible for choice	6	48.4	55.5	48.5	55.1	18.9(10.5)	31.2(16.1)
21	All	1	15.6	19.1	15	18.3	86.4(59.1)	97.1(63.6)
	Eligible for choice	1	0	0	0	0	158.1(35.3)	180.1(35.2)
	Not Eligible for choice	1	16.2	19.8	15.6	19	24.3(10.5)	34.6(12.9)
22	All	2	47.5	56.8	45.5	54.5	43(36.5)	46.7(38.5)
	Eligible for choice	2	0	0	0	0	131.6(29.1)	153.8(33.8)
	Not Eligible for choice	2	48.9	58.4	46.8	56	20.8(9.2)	28.6(13)
23	All	3	12.8	14.6	11.8	13.7	122.9(64.8)	130.5(63.2)
	Eligible for choice	3	0	0	0	0	133.2(54)	157.1(53.9)
	Not Eligible for choice	3	16.3	18.1	15.2	17.1	12.8(10.5)	23.5(17.1)

Table F-36 Geographic Access to VA Facilities providing Methadone

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	347	68.9	73.1	67.5	71.6	32.5(35.3)	42.5(41.8)
	Eligible for choice	347	0	0	0	0	81.5(37.5)	108(45.9)
	Not Eligible for choice	334	74.4	77.9	73.2	76.7	14.8(10.1)	22.8(14.2)
1	All	17	76.7	83.2	76.4	82.4	25.1(24.6)	32.8(29)
	Eligible for choice	17	0	0	0	0	85.3(44.4)	108.1(48.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	16	79.7	85.8	79.8	85.4	16.2(11.2)	24(15)
2	All	9	74.1	77.8	75.2	78.7	28.5(31.2)	39(36.6)
	Eligible for choice	9	0	0	0	0	85.4(38.1)	116(47)
	Not Eligible for choice	9	76	79.7	77.1	80.5	15.2(10.8)	24.8(16)
3	All	9	90.5	93.8	89.5	93	13.9(12.4)	19.9(15.1)
	Eligible for choice	9	0	0	0	0	51.8(13.3)	77.2(25.2)
	Not Eligible for choice	9	90.5	93.9	89.5	93.1	11.7(8.6)	18.1(12)
4	All	23	78.8	84.3	77.6	83	22(23.4)	29.9(26.6)
	Eligible for choice	23	0	0	0	0	62.6(25.2)	83.4(31.9)
	Not Eligible for choice	23	80.4	85.4	79.2	84.2	13.2(9)	21.8(13.7)
5	All	6	86.3	89	84.8	87.6	21.1(19.2)	29.3(23.2)
	Eligible for choice	6	0	0	0	0	52.7(18.7)	65.2(21.4)
	Not Eligible for choice	6	87.3	89.4	85.7	88.1	16(10.4)	23.8(13.9)
6	All	14	67.5	72.9	66.4	71.9	33.5(23.2)	46.2(30.3)
	Eligible for choice	14	0	0	0	0	59.6(16.3)	83.6(24.6)
	Not Eligible for choice	14	73.8	78.1	73	77.3	19.1(10.7)	29.7(15.2)
7	All	20	63.2	66.7	63.6	66.9	36.7(28.7)	49.2(35.2)
	Eligible for choice	20	0	0	0	0	61.8(16.8)	83.8(23.3)
	Not Eligible for choice	20	69	71.4	69.6	71.8	17.3(10.6)	26.4(14.9)
8	All	24	76.1	82.5	75.9	82	27.6(27.5)	36(31.1)
	Eligible for choice	24	0	0	0	0	74.7(24)	104.1(28.2)
	Not Eligible for choice	22	77.3	83.7	77.2	83.3	14.8(9.2)	23.9(13.9)
9	All	10	46.6	54.7	46.7	54.6	51.9(40.2)	66.3(48.7)
	Eligible for choice	10	0	0	0	0	89.5(33.9)	114.3(40.1
	Not Eligible for choice	10	52.9	61.1	53	61	16.7(10.6)	27.1(16)
10	All	31	92.9	93.9	92.9	93.9	13.9(13.5)	21.4(18.1)
	Eligible for choice	31	0	0	0	0	51.1(9.7)	70.7(13.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	30	93.6	94.5	93.6	94.5	11.1(8.6)	18.1(12.5)
11	All	8	48	52.5	46.4	50.7	46.2(37.8)	56.8(43)
	Eligible for choice	8	0	0	0	0	83.3(36.6)	101.2(42.5)
	Not Eligible for choice	8	51.5	55.4	49.8	53.4	17.6(10.7)	26(14.8)
12	All	19	74.4	77.6	72.9	76	24.5(22.8)	32.5(28.5)
	Eligible for choice	19	0	0	0	0	58.7(17.9)	90(27.6)
	Not Eligible for choice	19	77.8	80.9	76.6	79.5	14.9(10)	21.6(13.8)
15	All	8	49.4	52.9	46.9	50.3	51.2(45.2)	63.1(52.6)
	Eligible for choice	8	0	0	0	0	88.5(33.9)	116.1(43.4
	Not Eligible for choice	7	55	58	52.4	55.5	15.6(10.3)	22.7(14.4)
16	All	25	62.3	66.7	60.7	65.2	37.8(34.6)	49.6(41.9)
	Eligible for choice	25	0	0	0	0	75.9(31.5)	99.3(38.7)
	Not Eligible for choice	25	69.9	72.7	68.5	71.2	15.8(10.6)	24.2(14.8)
17	All	16	81.1	83	80.4	82.5	29.4(31.5)	39.7(37.7)
	Eligible for choice	16	0	0	0	0	70.5(30.6)	96.3(39.4)
	Not Eligible for choice	16	89	89.7	88.5	89.4	16.7(9.7)	24.1(12.9)
18	All	19	70.9	71.3	69.9	70.2	33.2(43.2)	45.2(51.2)
	Eligible for choice	19	0	0	0	0	90.3(43)	120.3(52.3)
	Not Eligible for choice	18	78.5	78.1	77.5	77.1	14.7(9.7)	22.5(13.1)
19	All	28	77.9	79.5	76.5	78.1	31.3(39.5)	43.3(50.2)
	Eligible for choice	28	0	0	0	0	90.3(37.9)	118(52.9)
	Not Eligible for choice	23	92.6	91.7	91.7	90.8	12.8(9.1)	19.8(12.1)
20	All	24	74.2	77.7	72.8	76.2	28.3(30.8)	40.6(43)
	Eligible for choice	24	0	0	0	0	77(30.8)	110.4(48.1
	Not Eligible for choice	23	85.3	87.4	84	86	14.2(9.6)	22.2(13.4)
21	All	14	62.1	67.3	59.4	64.8	35.2(34.2)	45.1(41.3)
	Eligible for choice	14	0	0	0	0	95.1(46.6)	132.6(54)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	13	64.5	69.8	61.9	67.5	15.6(11.1)	24.5(15.4)
22	All	13	79.3	85.8	78.4	85.3	22.7(27.1)	28.8(32.9)
	Eligible for choice	13	0	0	0	0	84.7(31.8)	114.1(44.9)
	Not Eligible for choice	13	81.6	88.1	80.6	87.5	13.2(9)	19.3(12.4)
23	All	10	36.2	37.3	35.4	36.4	77.2(64.6)	93.4(71.5)
	Eligible for choice	10	0	0	0	0	106.5(49)	137.1(52.9
	Not Eligible for choice	10	46.2	46.6	45.5	45.8	14.8(9.8)	22.4(13.9)

Table F-37 Geographic Access to VA Facilities providing Outpatient specialty care for SUD

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	549	81.8	84.5	81.3	83.9	22.5(23.5)	31.9(30.5)
	Eligible for choice	549	0	0	0	0	66.8(29.5)	92.2(38.9)
	Not Eligible for choice	534	88.3	89.9	88.1	89.5	14.2(10)	21.7(13.9)
1	All	29	89.8	93.8	89.5	93.2	19.4(13.7)	27.1(18.4)
	Eligible for choice	29	0	0	0	0	53.8(13.5)	77.5(24.7)
	Not Eligible for choice	29	93.3	96.4	93.4	96.3	16.3(9.7)	24.1(13.4)
2	All	10	77.9	81.7	79	82.5	24.9(24.3)	36.1(31.5)
	Eligible for choice	10	0	0	0	0	73.5(22.1)	106.3(34)
	Not Eligible for choice	10	80	83.7	81	84.4	15.5(11)	25.5(16.3)
3	All	11	90.7	94	89.8	93.2	13.4(12.8)	18.7(15.6)
	Eligible for choice	11	0	0	0	0	51.8(13.3)	77.2(25.2)
	Not Eligible for choice	11	90.8	94.1	89.8	93.3	11.2(9.1)	16.9(12.6)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
4	All	35	93	95.1	93.1	95.1	16.7(13)	24.4(17)
	Eligible for choice	35	0	0	0	0	47.3(6.9)	67.7(14.8)
	Not Eligible for choice	34	94.8	96.3	95	96.3	14.4(9.6)	22(13.4)
5	All	14	96.9	98.3	96.5	97.9	15(11.3)	22.4(14.8)
	Eligible for choice	14	0	0	0	0	44.2(4.1)	55.6(11)
	Not Eligible for choice	14	98	98.6	97.5	98.2	14(9.8)	21.3(13.1)
6	All	22	76.9	80.8	76.9	80.8	25.7(18.3)	37.3(25.9)
	Eligible for choice	22	0	0	0	0	51.9(11.5)	74.9(22)
	Not Eligible for choice	22	84.1	85.9	84.5	86	18.2(10.9)	27.2(14.6)
7	All	23	70.9	74.7	70.5	74.2	31.1(23.5)	43(30.1)
	Eligible for choice	23	0	0	0	0	58(13.6)	79.7(20)
	Not Eligible for choice	23	77.4	80.1	77.2	79.7	17.1(10.9)	26.2(15.1)
8	All	39	90	94.2	90.4	94.2	16.7(13.2)	25.1(17.8)
	Eligible for choice	39	0	0	0	0	51.4(8.6)	77.4(12.7)
	Not Eligible for choice	36	91.4	95.6	91.9	95.7	14(8.9)	22.3(13)
9	All	24	66.5	72.4	66.9	72.5	31.8(25.6)	44.5(33.7)
	Eligible for choice	24	0	0	0	0	59.7(14.4)	83.4(22.6)
	Not Eligible for choice	24	75.5	79.8	75.9	79.9	15.9(10.8)	25.2(16)
10	All	28	94	94.5	93.7	94.2	13.3(11.9)	20.8(16.8)
	Eligible for choice	28	0	0	0	0	44.4(3.7)	61(8.6)
	Not Eligible for choice	27	94.8	94.9	94.4	94.6	11.6(9.2)	18.5(13)
11	All	26	79.8	83.1	79.6	82.7	25.2(20.9)	33.8(24.2)
	Eligible for choice	26	0	0	0	0	51.6(11.9)	68(17.3)
	Not Eligible for choice	26	85.7	86.7	85.3	86.3	17.2(10.8)	25.1(14.8)
12	All	30	92.3	92.8	92	92.2	15.3(13.3)	22.6(18.3)
	Eligible for choice	30	0	0	0	0	51.4(10.2)	79.4(17.2)
	Not Eligible for choice	30	96.6	96.6	96.7	96.5	13(9.5)	19.6(12.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
15	All	24	67	70	65.9	68.7	32.6(30)	44.4(39.2)
	Eligible for choice	24	0	0	0	0	73.7(33.6)	99.4(42.1)
	Not Eligible for choice	21	74.6	76.3	73.7	75.3	15.9(10.6)	23.2(14.7)
16	All	53	82.7	84.4	82.1	83.8	22.8(20.2)	33.1(26.8)
	Eligible for choice	53	0	0	0	0	55.9(20.6)	77.7(27.2)
	Not Eligible for choice	52	92.8	91.9	92.6	91.5	15.3(10.4)	22.9(14.1)
17	All	12	76.1	79.4	75.6	78.9	32(30)	43.3(38.1)
	Eligible for choice	12	0	0	0	0	70.4(28.2)	96.4(37.5)
	Not Eligible for choice	12	83.5	85.9	83.2	85.6	18.2(10)	26.1(13.4)
18	All	24	78.6	80.4	78.5	80.3	28.1(38.7)	39.7(48.6)
	Eligible for choice	24	0	0	0	0	92.4(40.5)	122.2(50.9
	Not Eligible for choice	24	87	88.3	87.1	88.4	10.9(7.8)	19.1(12.2)
19	All	26	76.8	79.1	75.8	78	33.1(39.7)	44.6(48.8)
	Eligible for choice	26	0	0	0	0	93(40.6)	120(52.7)
	Not Eligible for choice	23	91.3	91.6	90.9	91	13.2(9.6)	21.6(13.6)
20	All	30	83.1	84.6	82.5	83.9	22.6(24.7)	33.6(35.8)
	Eligible for choice	30	0	0	0	0	69.1(26.4)	100.2(43.9
	Not Eligible for choice	29	95.5	94.5	95.2	94.1	13.8(9.9)	20.8(13)
21	All	32	91.2	90.6	90.7	90.2	15.5(16.2)	24.1(23.3)
	Eligible for choice	32	0	0	0	0	69(34.3)	103.4(40.9
	Not Eligible for choice	31	94.7	94	94.5	93.9	12.2(8.9)	19.2(12.8)
22	All	23	87.7	90.4	87.5	90.3	16.2(22.2)	22.4(27.8)
	Eligible for choice	23	0	0	0	0	73.3(32.9)	102.4(44.4
	Not Eligible for choice	23	90.3	92.9	90	92.6	10.6(7.4)	16.2(10.4)
23	All	34	62.6	64.3	62	63.5	36.7(35.5)	51.3(45.6)
	Eligible for choice	34	0	0	0	0	74.3(31.7)	103(40.2)
	Not Eligible for choice	33	79.9	79.7	79.7	79.3	14.8(10.9)	22.8(15.3)

Table F-38 Geographic Access to VA Facilities providing Inpatient detoxification for SUD

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	146	52.4	57.9	51	56.5	44.2(40.7)	54.4(46.4)
	Eligible for choice	146	0	0	0	0	94.1(39.9)	119.3(46.3
	Not Eligible for choice	145	56.6	61.9	55.3	60.6	16.6(10.5)	25.4(14.8)
1	All	10	67.5	77.3	67.1	76.5	30.7(26.2)	38.9(30.6)
	Eligible for choice	10	0	0	0	0	97.5(42.1)	119.2(46.2
	Not Eligible for choice	10	70.2	79.9	70.1	79.4	18.3(11.5)	27.7(15.4)
2	All	4	50.5	58.6	50.8	58.9	42.8(34)	51.8(37.7)
	Eligible for choice	4	0	0	0	0	97.4(36.2)	122.1(45.5
	Not Eligible for choice	4	51.8	60	52.1	60.2	16.1(11.5)	27.5(17.5)
3	All	8	88.5	91.8	87.5	90.9	15(14.3)	20.9(17)
	Eligible for choice	8	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	8	88.6	91.9	87.5	91	12(9)	18.3(12.1)
4	All	9	62.1	73.9	62.1	73.9	30.9(23.3)	40.3(28.4)
	Eligible for choice	9	0	0	0	0	63(20.4)	83.9(28.4)
	Not Eligible for choice	9	63.3	75	63.3	75	17.2(11)	28.5(16.7)
5	All	3	73.4	75.7	69	71.1	27.1(27.2)	35.9(33.2)
	Eligible for choice	3	0	0	0	0	54.9(15.4)	66.4(19.6)
	Not Eligible for choice	3	74.3	76	69.7	71.5	15.4(9.9)	22.8(13.3)
6	All	8	51.7	61.1	50.7	60.2	47.1(33.3)	59.5(40.4)
	Eligible for choice	8	0	0	0	0	67.3(22)	91.4(30.9)
	Not Eligible for choice	8	56.6	65.8	55.6	65	20.9(11.1)	33.2(15.8)
7	All	10	45.9	49.9	46.1	50	51.4(35.5)	65.6(43.2)
	Eligible for choice	10	0	0	0	0	73.3(21.4)	96.5(28.7)
	Not Eligible for choice	10	50.1	53.7	50.4	53.9	17.9(10.7)	27.6(15.3)
8	All	7	44.6	48.5	44.1	48.1	49.3(40)	57.8(43)
	Eligible for choice	7	0	0	0	0	96.9(35.6)	126.4(38.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	7	45.3	49.2	44.8	48.8	18.2(11.1)	26.5(15)
9	All	7	43.4	50.7	44	51.1	55.8(41.6)	67.8(46.8)
	Eligible for choice	7	0	0	0	0	92.7(29.4)	115.1(32.7)
	Not Eligible for choice	7	49.2	57	49.9	57.4	16(10.3)	26(16.1)
10	All	4	52.2	58.8	51.3	58.1	37(26.7)	47.5(31.5)
	Eligible for choice	4	0	0	0	0	55(12.1)	79.5(16.8)
	Not Eligible for choice	4	52.6	59.2	51.7	58.4	17(11.3)	26.6(15.6)
11	All	8	49.6	55.3	48.7	54.1	46.4(37.7)	56.7(42.6)
	Eligible for choice	8	0	0	0	0	84(37.8)	102.4(44.5)
	Not Eligible for choice	8	53.3	58.2	52.2	56.9	18.3(11)	27.5(15.6)
12	All	7	61.2	67.9	58.6	65.2	33(33)	42.2(42.3)
	Eligible for choice	7	0	0	0	0	86.1(32.3)	125.3(49.2
	Not Eligible for choice	7	64	70.8	61.6	68.4	15.8(10.6)	22.6(14.2)
15	All	9	53.5	57.6	51.4	55.5	46.3(41.6)	58.8(50.6)
	Eligible for choice	9	0	0	0	0	95(37.1)	122.5(45.6)
	Not Eligible for choice	9	59.6	63.4	57.5	61.4	15.8(10.3)	23.4(14.9)
16	All	10	36.7	40.9	36	40.4	63.8(45.7)	77(51.9)
	Eligible for choice	10	0	0	0	0	88.1(31.3)	113.2(41.5)
	Not Eligible for choice	10	41.2	44.8	40.6	44.4	17.4(10.5)	27.3(15)
17	All	3	30.5	33.7	31.3	34.3	89.4(45.4)	96.4(47.5)
	Eligible for choice	3	0	0	0	0	110.7(40.5	137.8(44.2)
	Not Eligible for choice	3	33.5	36.4	34.4	37.2	16.1(10.4)	26.3(15.8)
18	All	6	55	57	54.4	56.4	50.2(54)	62.9(60.5)
	Eligible for choice	6	0	0	0	0	110.5(46.1	137.9(51.5)
	Not Eligible for choice	6	60.9	62.8	60.4	62.2	15.7(9.3)	24.6(13)
19	All	6	41	46.5	40.6	45.8	58.7(55.6)	69.1(60.2)
	Eligible for choice	6	0	0	0	0	131.5(49.5	154(53.6)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	48.7	54.5	48.7	54.1	16.1(10.3)	27.2(15.1)
20	All	6	52.6	56.6	51.2	55.1	48.5(48.8)	60.2(56.7)
	Eligible for choice	6	0	0	0	0	101.5(39.4	130.6(47.5
	Not Eligible for choice	6	60.5	64	59.1	62.6	16.3(9.3)	25.2(13.6)
21	All	7	58.4	62.9	56.2	60.5	35.2(34.1)	46.8(39.7)
	Eligible for choice	7	0	0	0	0	105.6(52.6	136.6(52.1)
	Not Eligible for choice	6	60.6	65.3	58.5	63	16.9(10)	26.7(14.2)
22	All	5	79	84.7	78.1	84.1	27.7(28.4)	33.8(33.6)
	Eligible for choice	5	0	0	0	0	97.4(35)	124.5(42.8)
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	9	39.4	42.7	38.1	41.4	61.7(51)	76(58.6)
	Eligible for choice	9	0	0	0	0	98.6(41)	125.2(47.1)
	Not Eligible for choice	9	50.2	53	49	51.7	15.3(10.3)	23.9(14.9)

Appendix F.2.7: Gynecological Surgery Services

Table F-39 Geographic Access to VA Facilities providing Gynecological surgery services

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	98	48.4	54.4	46.6	52.5	46.8(43.9)	56.2(48.8)
	Eligible for choice	98	0	0	0	0	104.4(44.5	127.6(47.8
	Not Eligible for choice	98	52.3	58.3	50.5	56.5	16.7(10.4)	25.5(14.7)
1	All	5	49.7	62.7	49.3	61.9	43.6(39)	51.7(43.3)
	Eligible for choice	5	0	0	0	0	139.7(55.6	164.2(47.6

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	5	51.6	65	51.4	64.5	19(11.8)	29.5(16.1)
2	All	3	44.3	51.9	44.5	52	48.4(38.4)	58(43.6)
	Eligible for choice	3	0	0	0	0	110(33.5)	137.8(43.6
	Not Eligible for choice	3	45.5	53.2	45.6	53.3	15.1(11.2)	26.5(17.7)
3	All	5	80.5	85.9	79.1	84.5	17.6(17.8)	23.3(20.2)
	Eligible for choice	5	0	0	0	0	92.2(5.4)	118.4(5)
	Not Eligible for choice	5	80.6	86	79.2	84.6	12.2(9.4)	18.9(13)
4	All	5	46.9	55.4	45.4	53.9	40.7(31.8)	49.9(36.2)
	Eligible for choice	5	0	0	0	0	77.4(33.8)	99(40.7)
	Not Eligible for choice	5	47.8	56	46.4	54.5	16.4(10.7)	26.5(15.9)
5	All	2	73.4	75.7	69	71.1	28.1(28.8)	36.7(34.3)
	Eligible for choice	2	0	0	0	0	61.5(26.9)	72.6(28.2)
	Not Eligible for choice	2	74.3	76	69.7	71.5	15.8(10.2)	23.1(13.5)
6	All	7	50	59	48.5	57.7	49(34.8)	61.3(41.7)
	Eligible for choice	7	0	0	0	0	70(24.6)	93.7(33.4)
	Not Eligible for choice	7	54.6	63.5	53.3	62.3	20.9(11.1)	33.2(15.8)
7	All	6	40.8	45.1	40.9	45.3	60.1(42.4)	72.9(48.6)
	Eligible for choice	6	0	0	0	0	89.4(34.8)	111.8(39.3)
	Not Eligible for choice	6	44.5	48.7	44.8	49.1	18.4(10.6)	28.7(15.6)
8	All	7	52.9	59.6	52	58.9	43(39.7)	52.8(43.9)
	Eligible for choice	7	0	0	0	0	109.8(45.7	143.1(44.6)
	Not Eligible for choice	7	53.8	60.5	52.8	59.9	18.1(11)	27.1(15.2)
9	All	6	37.6	44.9	38.1	45	62.4(43.6)	74.2(48.9)
	Eligible for choice	6	0	0	0	0	100.2(33.2	123.1(35.9
	Not Eligible for choice	6	42.7	50.5	43.2	50.7	15.9(9.9)	26.2(16.1)
10	All	3	50.9	62.9	50.8	62.5	36.1(26.9)	44.4(30.7)
	Eligible for choice	3	0	0	0	0	86(24.6)	104.9(29.3)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	3	51.3	63.4	51.2	62.9	16.3(11.1)	27.6(16.3)
11	All	4	34.2	39.5	32.6	37.8	63.4(49)	71.3(50.7)
	Eligible for choice	4	0	0	0	0	108(45.1)	121(47.4)
	Not Eligible for choice	4	36.7	41.8	35	40	17.1(10.2)	26.2(15.3)
12	All	5	58.5	63.9	55.4	60.6	35.3(39.7)	41.9(43.3)
	Eligible for choice	5	0	0	0	0	106.9(43.9	131.2(46.2)
	Not Eligible for choice	5	61.2	66.7	58.3	63.6	15.7(10.5)	22.2(13.9)
15	All	3	40.6	44.2	37.4	40.8	64.8(53.1)	75.1(60.2)
	Eligible for choice	3	0	0	0	0	110.5(39)	133.7(45.3)
	Not Eligible for choice	3	45.3	48.8	41.9	45.3	15.9(9.7)	22.8(13.7)
16	All	8	37.4	40.7	35.9	39.3	62.7(48.5)	73.9(53.5)
	Eligible for choice	8	0	0	0	0	98.8(37.7)	120.2(42.7)
	Not Eligible for choice	8	41.9	44.8	40.5	43.4	16(10.3)	23.9(14)
17	All	3	53	61.7	52.1	60.3	52.7(44.3)	62.3(48.8)
	Eligible for choice	3	0	0	0	0	103.4(37.7)	125.6(43.4)
	Not Eligible for choice	3	58.1	66.9	57.3	65.6	21.4(10.4)	30.9(13.6)
18	All	2	39.8	41	37.7	38.9	47.6(59.9)	58(63.3)
	Eligible for choice	2	0	0	0	0	147.3(58.)3	171.9(48.6)
	Not Eligible for choice	2	44.1	45.3	41.8	43.1	16.8(9.1)	25.3(12.4)
19	All	5	40.1	45.5	39.5	44.5	55.8(54.4)	65.9(58.6)
	Eligible for choice	5	0	0	0	0	131.4(50.3)	153.3(53.7)
	Not Eligible for choice	5	47.7	53.5	47.4	52.8	16.2(10.3)	27.3(15.1)
20	All	3	39	45.7	37.8	44.1	53.6(54.8)	62.9(58.5)
	Eligible for choice	3	0	0	0	0	114.6(46.5)	137.6(48.7)
	Not Eligible for choice	3	44.8	51.6	43.6	49.9	18.1(10.3)	27.2(14.4)
21	All	6	55.5	57.6	54.2	56.5	34.2(34.1)	45.4(39.7)
	Eligible for choice	6	0	0	0	0	99.3(53.8)	135(55.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	6	57.7	59.8	56.4	58.8	16.7(9.5)	25.7(13.1)
22	All	5	79	84.7	78.1	84.1	27.7(28.4)	33.8(33.6)
	Eligible for choice	5	0	0	0	0	97.4(35)	124.5(42.8)
	Not Eligible for choice	5	81.3	87.1	80.3	86.5	17.6(8.7)	23.4(10.9)
23	All	5	30.3	33	28.9	31.6	75.2(58.3)	88.8(64)
	Eligible for choice	5	0	0	0	0	114.4(48)	141.7(50.3)
	Not Eligible for choice	5	38.6	41.3	37.2	39.8	15.4(9.8)	24.1(14.7)

Appendix F.3 Access to Non-VA Hospital Types by VISN

This section contains tables showing access to non-VA hospital types for enrollees and health care users, for the 40-mile driving distance and 60-minute drive time, by both all enrollees and users and those who are eligible for VA Choice because they live outside the 40-mile boundary. These tables show such access for all non-VA hospitals (Table F-40), for teaching hospitals (Table F-41), and academic hospitals (Table F-42).

All three tables also show the mean driving distance (in miles) and driving time (in minutes), along with the standard deviation for each. The mean driving distance is defined as the mean distance along the existing road network (as opposed to straight-line distance) for all enrollees in that VISN to the hospital nearest where they live. For all enrollees and those who are eligible for Choice, we used a cutoff of 240 miles or 240 minutes, meaning that we took the mean distance to the nearest hospital within 240 miles and the mean driving time to the nearest hospital within a 240-minute drive. For enrollees who are not eligible for Choice (because they already live within 40 miles of a VA medical facility), we used a cutoff of 40 miles, assuming that since they were already 40 miles or less from a VA medical facility they would be unwilling to travel a longer distance. The driving time cutoff remained at 240 minutes.

In many cases the standard deviation is larger than the mean distance or driving time. This suggests that the distribution of mean distances and driving times skews to the right, meaning that a few enrollees live quite far from the nearest hospital. This would tend to be the case in more rural areas.

Tables F-43 and F-44 show the distribution of differences in drive times to VA vs. non-VA facilities across the population of VA enrollees. Mean differences (in minutes) are reported, as are 25th, 50th, and 75th percentiles. Also shown are the proportions of enrollees for whom VA facilities are less than 15 or 30 additional minutes of drive time, as compared to non-VA facilities. Tables F-46 and F-47 are similar, except that F-46 shows the differences between any VA facility vs. any non-VA facility, whereas F-47

shows the differences between the nearest VA facility with interventional cardiology capability vs. the nearest non-VA facility with interventional cardiology.

Data in Tables F40–F55 are RAND estimates derived from the VA Planning Systems Support Group (PSSG) Enrollee file and the American Hospital Association's 2011 Annual Survey of Hospitals.

Table F-40 Access to Any Non-VA Hospital

VISN	Choice Eligibility	Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest non-VA hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	6300	99.7	99.4	99.7	99.4	5.8(6.3)	11.2(11.3)
	Eligible for choice	6300	96.2	94.4	96.2	94.2	12.5(13)	23.6(23.4)
	Not Eligible for choice	6300	100	99.8	100	99.8	5.3(5.1)	10.2(9.1)
1	All	255	99.9	99.8	99.9	99.8	5.4(5.4)	10.2(9.6)
	Eligible for choice	255	98	95.4	98	95.2	14.8(11.4)	28.4(21.5)
	Not Eligible for choice	255	100	100	100	100	5.1(4.8)	9.6(8.3)
2	All	103	99.9	99.9	99.9	99.9	7.5(6.9)	14.1(12.2)
	Eligible for choice	103	94.3	94.3	94.5	94.5	15.4(14.2)	30.4(26.9)
	Not Eligible for choice	103	100	100	100	100	7.3(6.4)	13.7(11.2)
3	All	191	100	100	100	100	2.8(2.8)	5.7(5.1)
	Eligible for choice	191	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	191	100	100	100	100	2.8(2.7)	5.6(5)
4	All	306	100	100	100	100	5.4(5.2)	10.3(9)
	Eligible for choice	306	100	99.5	100	99.4	14.4(8.2)	25.3(13.8)
	Not Eligible for choice	306	100	100	100	100	5.2(4.9)	10(8.6)
5	All	111	100	100	100	100	5(4.4)	9.7(7.7)
	Eligible for choice	111	100	100	100	100	9.1(5.6)	17.2(9.5)
	Not Eligible for choice	111	100	100	100	100	4.9(4.3)	9.6(7.6)
6	All	251	99.8	99.8	99.8	99.7	7.8(6.4)	14.7(11)
	Eligible for choice	251	98.4	97.6	98.4	97.6	12.3(8.9)	22.8(15.4)
	Not Eligible for choice	251	100	100	100	100	7.4(5.9)	13.8(10.1)
7	All	351	100	99.9	100	99.9	7.4(5.9)	14(10.1)
	Eligible for choice	351	99.8	99.8	99.8	99.8	10.3(7.9)	19.4(13.5)
	Not Eligible for choice	351	100	99.9	100	99.9	7(5.5)	13.4(9.4)
8	All	314	99.9	99.7	99.8	99.6	5.4(4.7)	10.7(8.8)
	Eligible for choice	314	90.4	88	89.5	86.9	11.7(11.1	21.5(19.2)
	Not Eligible for choice	314	100	99.9	100	99.9	5.3(4.4)	10.5(8.4)

VISN	Choice Eligibility	Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest non-VA hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
9	All	341	99.9	99.9	99.9	99.9	7.4(6.1)	14.4(11.1)
	Eligible for choice	341	99.3	99.2	99.2	99.2	10.1(7.1)	20.1(13.4)
	Not Eligible for choice	341	100	100	100	100	7(5.9)	13.5(10.5)
10	All	199	100	100	100	100	5.1(4.4)	10(8)
	Eligible for choice	199	100	100	100	100	10.1(3.8)	19.6(8)
	Not Eligible for choice	199	100	100	100	100	5.1(4.4)	9.9(8)
11	All	341	100	99.8	100	99.8	5.9(5.5)	11.4(9.9)
	Eligible for choice	341	100	98.8	100	98.6	9.3(7.4)	18.1(14.1)
	Not Eligible for choice	341	100	99.9	100	99.9	5.7(5.3)	11(9.4)
12	All	268	99.8	99.6	99.8	99.6	4.6(5.1)	9.1(9.2)
	Eligible for choice	268	96	92.9	95.7	92.5	13.3(11.1	25.5(20)
	Not Eligible for choice	268	100	100	100	99.9	4.3(4.5)	8.6(8.2)
15	All	352	99.7	98.7	99.7	98.5	6.8(7.1)	12.9(12.4)
	Eligible for choice	352	97.5	93.3	97.4	92.8	10.5(10.1	19.9(17.7)
	Not Eligible for choice	352	100	99.3	100	99.2	6.3(6.4)	12(11.2)
16	All	761	100	99.8	100	99.8	6(6.1)	11.8(10.8)
	Eligible for choice	761	99.8	99.1	99.8	99	10.2(8.9)	19.4(16.2)
	Not Eligible for choice	761	100	99.9	100	99.9	5.5(5.4)	10.9(9.5)
17	All	341	99.8	99.8	99.8	99.8	6(6.4)	11.2(10.4)
	Eligible for choice	341	97.9	97.8	97.8	97.6	12.2(11.8	21.4(18.2)
	Not Eligible for choice	341	100	100	100	100	5.3(5.1)	10.1(8.5)
18	All	280	98.5	97.7	98.4	97.5	7.2(10.1)	13.7(17.5)
	Eligible for choice	280	84.6	82.2	84.2	82	18.4(20.1	33.3(35.3)
	Not Eligible for choice	280	99.9	99.3	99.9	99.3	5.6(6.3)	11(10.7)
19	All	267	98.6	97.8	98.4	97.6	7.1(10.2)	13.5(18.2)
	Eligible for choice	267	91.1	87.4	90.7	86.7	15.5(18.6	28.7(33.3)
	Not Eligible for choice	267	100	99.7	100	99.7	5.1(5.2)	9.9(9.1)
20	All	236	98.8	97.8	98.9	97.8	7.1(9.5)	14(17.8)
	Eligible for choice	236	90.8	86.6	91.5	87	16(19.7)	31.3(37.2)
	Not Eligible for choice	236	100	99.5	100	99.5	5.7(5.5)	11.3(10)
21	All	228	99.7	99.1	99.6	99	5(6)	10(11.3)
	Eligible for choice	228	92.4	86.2	92.3	86.1	17.9(16.3	35.9(31.9)
	Not Eligible for choice	228	99.9	99.5	99.9	99.5	4.6(4.7)	9.1(8.7)

VISN	Choice Eligibility	Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest non-VA hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	272	99.7	99.5	99.6	99.5	3.7(4.5)	7.4(8.3)
	Eligible for choice	272	88.1	87.1	86.4	85.2	17.7(17.6	33.5(33.6)
	Not Eligible for choice	272	100	99.9	100	99.9	3.5(3.4)	7(6.1)
23	All	532	99.7	98.9	99.7	98.8	7.1(7.6)	13.7(13.9)
	Eligible for choice	532	98.6	96.3	98.5	96.2	10.8(10.9	21.1(19.9)
	Not Eligible for choice	532	100	99.6	100	99.5	6.1(6)	11.7(10.7)

Table F-41 Access to Teaching Hospitals

VISN	Choice Eligibility	Teaching Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest teaching hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1132	77.4	80	76	78.7	21.6(27.5)	31(35.4)
	Eligible for choice	1132	14.9	21.6	14.4	20.8	66.4(34.2)	91.4(43.8)
	Not Eligible for choice	1132	82.3	84.6	81.1	83.5	10.8(10)	26.5(30.3)
1	All	75	85.8	89.8	84.8	88.8	16.3(21.4)	23.4(27.5)
	Eligible for choice	75	4.6	18.8	4.5	17.4	70.4(32.5)	96.4(40.9)
	Not Eligible for choice	75	88.9	92.6	88.4	91.9	10.4(9.8)	20.9(23.2)
2	All	26	74.3	78.4	74.7	78.9	24.8(25.1)	36.3(33)
	Eligible for choice	26	22.8	15.7	21.7	15	65.1(31.3)	100.6(40.9)
	Not Eligible for choice	26	75.6	80.1	76.1	80.5	14(12.3)	34.6(31)
3	All	93	97.5	97.8	97.3	97.6	5.7(8.8)	9.7(12.8)
	Eligible for choice	93	0	0	0	0	54.2(16.2)	88.1(25.4)
	Not Eligible for choice	93	97.6	97.8	97.3	97.6	4.9(6.6)	9.7(12.6)
4	All	74	85.2	88.6	84.8	88.5	16.4(18.7)	24.4(24.9)
	Eligible for choice	74	51	56.6	47.7	53.5	41.6(15.2)	61.3(25.2)
	Not Eligible for choice	74	85.8	89.3	85.5	89.2	10.6(10.3)	23.7(24.4)
5	All	45	90.2	89.9	88.6	88.5	14(19)	21.8(26.8)
	Eligible for choice	45	83	88.5	78.2	84.5	27.3(9.2)	42.6(15.8)
	Not Eligible for choice	45	90.3	89.9	88.7	88.6	9.5(9)	21.5(26.8)

VISN	Choice Eligibility	Teaching Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest teaching hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
6	All	46	75.8	78	74.4	77.2	24.8(22.5)	36.3(30.8)
	Eligible for choice	46	26.4	38.6	25.1	37.8	48.2(18.8)	70.7(28.2)
	Not Eligible for choice	46	80.5	81.7	79.3	81	14.3(11.1)	32.6(28.7)
7	All	55	77.3	80.7	76.7	80.1	25.6(22.1)	37.3(30.1)
	Eligible for choice	55	32.7	39.3	32.5	38.2	44.4(19.2)	65.7(28)
	Not Eligible for choice	55	81.4	84.5	80.8	84.1	14.3(11.1)	33.8(28.5)
8	All	60	80.4	83.6	79.9	83.2	20.6(23.8)	29.1(28.6)
	Eligible for choice	60	22.8	23.6	23.6	24.4	49(25.1)	73.8(35)
	Not Eligible for choice	60	81.3	84.5	80.8	84.2	11.9(9.4)	28.3(27.9)
9	All	56	72.1	76.4	71.5	75.7	27.2(23.2)	39.3(31.2)
	Eligible for choice	56	15.3	22.8	14.9	22.5	54.2(17.9)	75.7(24)
	Not Eligible for choice	56	79.8	83.6	79.2	82.9	14.3(11.3)	33.6(28.3)
10	All	36	84.1	87.9	83.1	87.2	17(17.7)	24.5(22.5)
	Eligible for choice	36	44.5	49.1	45.1	50.6	37.4(16.7)	57.2(23.9)
	Not Eligible for choice	36	84.4	88.2	83.4	87.4	11.6(10.1)	24.3(22.3)
11	All	68	82.6	85.1	81.8	84.3	18.3(20.1)	27.7(27.7)
	Eligible for choice	68	27.9	47.2	26.7	45.3	48.3(18.8)	63.6(24.9)
	Not Eligible for choice	68	86.6	87.8	85.8	87.1	11.5(10.2)	25.4(26.2)
12	All	67	83.7	85.6	82.1	84.1	15.6(21.7)	23.8(30.2)
	Eligible for choice	67	4.1	8	3.9	7.7	65.5(25.1)	101.1(39.9
	Not Eligible for choice	67	87.3	89.2	86.1	88.1	9.5(9.8)	21.3(26.4)
15	All	42	67	70	65.2	68.1	30.3(30.6)	42.3(40.1)
	Eligible for choice	42	18.2	19.7	18.6	19.5	63.6(24.5)	88.1(33.5)
	Not Eligible for choice	42	72.6	75.7	70.7	73.9	12(10.3)	36.1(36.8)
16	All	86	70	72	67.9	70	28(30.2)	39.6(39.7)
	Eligible for choice	86	16.3	24.2	15.8	23.4	64(30)	87(39.9)
	Not Eligible for choice	86	76.6	77.8	74.6	76	11.3(10.1)	33.6(35.4)
17	All	41	85.1	85.8	84.4	85.1	23.5(29.7)	32.6(36.7)
	Eligible for choice	41	18.1	23	18.4	23.2	67.6(32.8)	93.1(42.2)
	Not Eligible for choice	41	91.7	92	91.1	91.3	12.2(9.3)	26.2(29.5)
18	All	43	68.8	71.4	68	70.6	33.4(44.6)	45.1(54.7)
	Eligible for choice	43	7.2	12.2	6.5	11.7	85.8(39.5)	115.4(52.9)
	Not Eligible for choice	43	75.3	77.6	74.7	77.1	9.8(8.4)	35.8(47.7)

VISN	Choice Eligibility	Teaching Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest teaching hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
19	All	22	47.6	56.9	46.4	54.2	42.7(50.5)	53.1(57.6)
	Eligible for choice	22	0.8	5.8	0.7	5.5	111.3(44.9	135.1(53.5)
	Not Eligible for choice	22	56.4	66.5	55.4	63.8	13(11.3)	37.2(42.9)
20	All	33	65.5	66.9	63.7	65	32.1(36.6)	44.9(47.6)
	Eligible for choice	33	4.3	10.6	4.5	10.5	80(30.7)	111.4(46.2)
	Not Eligible for choice	33	74.7	75.3	72.8	73.3	11.7(9.1)	36.1(40.2)
21	All	48	82	82.2	80.6	80.8	16.6(23.4)	25.4(33)
	Eligible for choice	48	3.7	3.9	3.4	3.5	77.7(41.5)	113.3(50.1)
	Not Eligible for choice	48	85	85.2	83.8	84	10.1(9.3)	22.8(28.4)
22	All	51	87.9	90.3	87.1	89.7	13.3(20.2)	18.8(24)
	Eligible for choice	51	3.4	5	3.1	5	79.7(34.8)	105.7(39.9)
	Not Eligible for choice	51	90.4	92.8	89.5	92.1	8.2(7.7)	17.3(20.7)
23	All	65	64.3	66	62.6	64.3	33(36.4)	47.4(48.6)
	Eligible for choice	65	7.2	13.3	7	12.9	72.6(32.1)	100.9(41.6)
	Not Eligible for choice	65	80	80.5	78.4	78.9	10.6(10.7)	32.4(38.9)

Table F-42 Access to Academic Hospitals

VISN	Choice Eligibility	Academic Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest academic hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	247	50.1	54.7	47.7	52.5	43.5(46.5)	52.9(51.4)
	Eligible for choice	247	2.8	7.3	2.5	6.8	97.2(46.5)	121.7(50.3)
	Not Eligible for choice	247	53.8	58.5	51.5	56.3	14.2(10.4)	48.4(48.2)
1	All	26	71.5	80.3	70.5	79.2	26(28.9)	32.9(33.4)
	Eligible for choice	26	3	12.6	2.6	11.2	104.7(53.3	128.2(58.5)
	Not Eligible for choice	26	74.2	83	73.5	82.2	14.6(10.9)	29.9(27.4)
2	All	5	54.6	58.1	54	57.4	40.5(35.5)	53.2(41.9)
	Eligible for choice	5	18.9	11.8	18	11.3	74.3(46.4)	112.3(54.1)
	Not Eligible for choice	5	55.6	59.3	54.9	58.5	16.2(11.7)	51.6(40.3)
3	All	43	93.1	96.1	92.5	95.8	10.1(13.1)	14.7(16.2)

VISN	Choice Eligibility	Academic Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest academic hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	43	0	0	0	0	66.1(7.1)	96.4(18.3)
	Not Eligible for choice	43	93.1	96.2	92.6	95.9	8.3(9.3)	14.7(16.1)
4	All	20	63.6	70	62.5	69	30.6(28.5)	40.1(33.5)
	Eligible for choice	20	22.2	22.4	20.2	20.4	61.7(25.1)	85.5(32.4)
	Not Eligible for choice	20	64.4	70.9	63.3	69.9	14.5(10.9)	39.3(32.9)
5	All	8	76.1	77.8	71.5	73.4	22.5(24.5)	30.6(30.8)
	Eligible for choice	8	36.8	54.9	29.2	44.4	50.2(19)	61(22.7)
	Not Eligible for choice	8	76.6	78	71.9	73.7	12.8(9.6)	30.2(30.7)
6	All	10	51.5	55.9	49.8	54.2	42.1(35.2)	55.5(43.6)
	Eligible for choice	10	11.3	20.4	10.6	20	64.9(27.4)	90.2(37)
	Not Eligible for choice	10	55.3	59.2	53.7	57.6	17.8(10.9)	51.8(42.6)
7	All	8	29.9	33.1	30.4	33.8	73.6(42.2)	88.9(48.4)
	Eligible for choice	8	2.8	8.1	2.8	7.9	80.2(27.1)	109.6(35.2
	Not Eligible for choice	8	32.4	35.4	33	36.3	16.4(10.6)	86.3(49.2)
8	All	8	38.1	43.8	36.1	42	53.8(43.4)	61.6(45.3)
	Eligible for choice	8	0	0	0	0	93.1(33.9)	131.2(41.4)
	Not Eligible for choice	8	38.7	44.5	36.7	42.7	17.4(10.2)	60.2(44.3)
9	All	6	40.7	48.2	40.3	47.4	58.8(45.8)	71.5(52.5)
	Eligible for choice	6	1.6	4.9	1.6	5.1	89.6(29.4)	112.2(35.6)
	Not Eligible for choice	6	46	54.1	45.5	53.1	16.3(10.5)	65.2(51.9)
10	All	9	70.2	79.8	68.9	78.9	25.1(21.9)	32.8(26.3)
	Eligible for choice	9	0	10.4	0	10.5	59.3(13.2)	80.5(16.1)
	Not Eligible for choice	9	70.8	80.3	69.4	79.4	14.4(10.3)	32.5(26)
11	All	23	47.4	54.3	45.1	52	44.5(44.2)	52.7(47.2)
	Eligible for choice	23	8.2	25.8	7.6	23.9	79.3(42.6)	91.6(43.8)
	Not Eligible for choice	23	50.2	56.3	47.9	54	11.9(9.4)	50.2(46.4)
12	All	15	60	65.5	56.9	62.2	31.9(39.4)	38.7(43.1)
	Eligible for choice	15	0.5	2.4	0.5	2.4	103.8(42.9)	129.3(46.4)
	Not Eligible for choice	15	62.8	68.4	59.8	65.3	12.9(10.7)	36.7(40.8)
15	All	6	41.8	45.1	38.8	42	66.5(55)	76.6(60.7)
	Eligible for choice	6	0.7	3.6	0.6	2.9	117.3(48.3)	142(52.7)
	Not Eligible for choice	6	46.5	49.8	43.3	46.6	16.3(10.3)	68.9(56.8)
16	All	10	30.7	33.2	28.9	31.4	78.3(66.9)	90.4(69.4)

VISN	Choice Eligibility	Academic Hospitals (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest academic hospital	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	10	0.2	5.5	0.2	5.5	110.6(51.5)	136.6(54.1)
	Not Eligible for choice	10	34.4	36.6	32.6	34.7	15.5(10.3)	84.8(69)
17	All	7	69.2	71.3	67.7	69.8	40.6(44.8)	49.6(49.8)
	Eligible for choice	7	5.8	8.6	5.8	8.3	94.3(37.9)	116.9(44.2)
	Not Eligible for choice	7	75.4	77.4	73.9	76	16.2(9.6)	42.3(44.7)
18	All	7	40	42.5	38.5	41	59.9(56.3)	71.7(62.3)
	Eligible for choice	7	0	2.9	0	2.9	115.9(47.3	143.1(52)
	Not Eligible for choice	7	44.2	46.7	42.7	45.2	14.5(8.9)	63.5(58)
19	All	2	13	14.6	12.5	14	61.7(64.5)	67.6(65.5)
	Eligible for choice	2	0	0.1	0	0.1	151.1(56.7	164.7(51.8
	Not Eligible for choice	2	15.4	17.4	15	16.8	19(12)	44.1(42.9)
20	All	9	45.8	48.7	43.9	46.8	48.6(55.4)	59.1(58.7)
	Eligible for choice	9	0.7	6.7	0.7	6.4	108.1(48.9)	132.2(49.9)
	Not Eligible for choice	9	52.5	55	50.5	53	15.5(9.2)	50.5(53.4)
21	All	8	50.5	55.8	48.8	54.1	35.6(41.5)	44.2(45.4)
	Eligible for choice	8	0	0	0	0	108.8(54.8)	140.4(47.9)
	Not Eligible for choice	8	52.4	57.9	50.8	56.3	13.7(10.2)	42(42.9)
22	All	11	77.4	84.5	76.4	84	25.5(29.4)	31.9(34.7)
	Eligible for choice	11	0	0.6	0	0.6	96.8(35.1)	123.6(43)
	Not Eligible for choice	11	79.7	86.9	78.6	86.3	14.6(9.4)	30.3(32.4)
23	All	6	31.3	35.3	29.1	33.1	65.8(59)	77.2(63.8)
	Eligible for choice	6	1	4.1	1	3.8	107.9(50.5	133(53.9)
	Not Eligible for choice	6	39.7	43.9	37.1	41.4	14.6(10.2)	66.9(60)

Table F-43 Distribution of enrollee-level drive time differences between VA vs. non-VA facilities

	Distribution of differences across population of enrolled Veterans					
VISN	Mean difference in minutes (SD)	25th Percentile difference (minutes)	50th Percentile (minutes)	75th Percentile (minutes)	Proportion of beneficiaries with <15 minute difference	Proportion of beneficiaries with <30 minute difference
Overall	13.0 (19.2)	1.7	7.0	17.1	71.8%	87.2%
1	9.7 (13.3)	1.4	6.0	13.6	78.0%	93.4%

	Distribution of differences across population of enrolled Veterans					
VISN	Mean difference in minutes (SD)	25th Percentile difference (minutes)	50th Percentile (minutes)	75th Percentile (minutes)	Proportion of beneficiaries with <15 minute difference	Proportion of beneficiaries with <30 minute difference
2	7.7 (13.5)	0.3	2.4	9.5	81.5%	91.9%
3	5.4 (6.2)	1.3	4.5	8.1	94.1%	99.1%
4	9.3 (11.2)	1.8	5.9	14.4	76.4%	93.9%
5	9.7 (11.4)	1.7	6.5	15.5	74.4%	93.5%
6	14.9 (16.3)	3.0	8.8	24.7	62.8%	82.8%
7	13.7 (17.6)	1.7	7.5	19.1	67.8%	84.5%
8	8.6 (11.0)	1.2	6.2	12.5	80.7%	96.5%
9	16.7 (19.4)	2.0	10.3	26.3	59.0%	79.3%
10	7.9 (10.8)	1.0	4.8	11.3	83.4%	94.5%
11	15.6 (15.5)	3.6	11.0	24.6	59.1%	81.5%
12	11.3 (14.8)	2.5	6.8	14.6	75.7%	90.0%
15	14.0 (20.0)	1.2	6.4	19.1	69.2%	83.2%
16	16.7 (18.2)	3.5	10.7	23.9	60.7%	81.0%
17	16.3 (21.2)	1.9	10.0	23.6	62.2%	81.7%
18	11.8 (22.5)	0.2	5.2	13.2	78.1%	90.0%
19	18.8 (34.0)	1.3	5.3	17.9	70.8%	82.2%
20	17.0 (30.3)	1.3	7.4	19.2	69.7%	84.1%
21	10.8 (17.4)	1.6	6.3	14.3	76.3%	91.9%
22	7.8 (14.0)	1.7	5.2	9.5	89.0%	95.8%
23	24.1 (30.0)	2.9	10.6	38.9	57.5%	68.7%

Table F-44 Distribution of enrollee-level drive time differences between VA facilities with interventional cardiology vs. non-VA facilities with interventional cardiology

	Distribution of differences across population of enrolled Veterans					
VISN	Mean difference in minutes (SD)	25th Percentile difference (minutes)	50th Percentile (minutes)	75th Percentile (minutes)	Proportion of beneficiaries with <15 minute difference	Proportion of beneficiaries with <30 minute difference
Overall	55.3 (57.0)	10.9	34.2	85.7	31.2%	46.9%
1	54.8 (50.0)	20.4	38.1	73.6	17.1%	36.1%
2	29.4 (36.8)	1.5	9.1	54.6	55.7%	62.4%
3	18.7 (15.5)	8.3	17.1	23.2	43.2%	86.7%
4	50.2 (38.4)	16.6	46.7	74.3	22.9%	39.3%
5	21.4 (26.4)	7.1	12.6	27.0	56.3%	83.1%
6	53.9 (40.5)	13.6	56.0	85.4	25.6%	35.6%
7	51.9 (48.8)	11.4	41.7	83.9	30.2%	44.6%
8	50.9 (43.5)	11.3	38.4	85.9	29.8%	44.6%
9	61.9 (53.9)	6.3	50.3	115.5	32.4%	40.7%
10	40.5 (35.9)	7.8	32.2	68.9	33.2%	48.8%
11	63.6 (50.2)	17.4	56.2	94.9	21.7%	33.7%
12	43.8 (45.3)	9.5	27.1	66.7	33.7%	54.3%
15	49.0 (51.8)	9.7	26.0	85.4	34.4%	53.9%
16	66.4 (57.5)	14.6	54.7	106.4	25.4%	36.4%
17	60.1 (60.7)	11.0	35.9	93.4	30.1%	43.7%
18	80.5 (85.7)	9.6	31.8	162.8	33.8%	47.9%
19	79.3 (75.8)	13.2	57.6	110.0	28.0%	35.4%
20	93.7 (86.6)	15.8	49.4	190.9	24.4%	37.8%
21	69.6 (75.3)	14.4	37.7	102.4	26.4%	45.3%

	Distribution of differences across population of enrolled Veterans					
VISN	Mean difference in minutes (SD)	25th Percentile difference (minutes)	50th Percentile (minutes)	75th Percentile (minutes)	Proportion of beneficiaries with <15 minute difference	Proportion of beneficiaries with <30 minute difference
22	23.6 (31.4)	7.8	15.0	25.1	50.0%	79.3%
23	67.8 (59.4)	11.7	57.4	103.4	29.7%	36.9%

Appendix F.4: Access to Non-VA Services by VISN

Tables F-45 to F-55 are similar to those in Appendix F.2, except they show access to services at non-VA facilities, and they break out access by whether enrollees and users are eligible for the VA Choice program. These do not exactly match the tables in Appendix F.2 because comparable information was not always available. Information is provided for EDs (Table F-45), interventional cardiology (Table F-46), coronary care units (Table F-47), diagnostic cardiac catheterization (Table F-48), cardiac surgery (Table F-49), surgery (Table F-50), chemotherapy (Table F-51), oncology (Table F-52), palliative care (Table F-53), inpatient palliative care (Table F-54), and hospice care (Table F-55).

All tables show the mean driving distance (in miles) and driving time (in minutes), along with the standard deviation for each. The mean driving distance is defined as the mean distance along the existing road network (as opposed to straight-line distance) for all enrollees in that VISN to the hospital nearest where they live. For all enrollees and those who are eligible for Choice, we used a cutoff of 240 miles or 240 minutes, meaning that we took the mean distance to the nearest hospital within 240 miles and the mean driving time to the nearest hospital within a 240-minute drive. For enrollees who are not eligible for Choice (because they already live within 40 miles of a VA medical facility), we used a cutoff of 40 miles, assuming that since they were already 40 miles or less from a VA medical facility they would be unwilling to travel a longer distance. The driving time cutoff remained at 240 minutes.

In many cases the standard deviation is larger than the mean distance or driving time. This suggests that the distribution of mean distances and driving times skews to the right, meaning that a few enrollees live quite far from the nearest hospital. This would tend to be the case in more rural areas.

Table F-45 Access to Emergency Department within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	3907	99.1	98.8	99.1	98.6	7.3(8)	13.4(13.4)
	Eligible for choice	3907	92.2	89.8	92.1	89.5	16.2(16.1	29.1(27.3)
	Not Eligible for choice	3907	99.7	99.5	99.7	99.4	6.6(6.3)	12.2(10.8)
1	All	153	99.8	99.7	99.7	99.6	7(6.5)	12.3(10.6)
	Eligible for choice	153	96.1	94.5	96	94.3	16.2(13.3	29.8(22.5)
	Not Eligible for choice	153	99.9	99.9	99.9	99.9	6.6(5.8)	11.7(9.4)
2	All	66	99.5	98.7	99.5	98.7	9.3(8.7)	16.7(14.7)
	Eligible for choice	66	94.3	86	94.5	87	20(15.4)	37.7(28.4)
	Not Eligible for choice	66	99.6	99	99.6	99	8.9(8)	16.2(13.8)
3	All	119	100	100	100	100	3.5(3.6)	6.8(6.2)
	Eligible for choice	119	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	119	100	100	100	100	3.5(3.6)	6.7(6.2)
4	All	181	100	100	100	100	6.5(5.8)	11.9(9.7)
	Eligible for choice	181	100	99.5	100	99.4	15.3(8.8)	26.3(14.2)
	Not Eligible for choice	181	100	100	100	100	6.3(5.7)	11.6(9.4)
5	All	76	100	100	100	100	5.8(5.3)	10.8(8.4)
	Eligible for choice	76	100	100	100	100	11.8(4.9)	21(7.4)
	Not Eligible for choice	76	100	100	100	100	5.7(5.2)	10.7(8.4)
6	All	160	99.6	99.1	99.6	99.1	9.2(7.9)	16.8(13.1)
	Eligible for choice	160	97.6	96.1	97.8	96.2	14.5(10.1	26.3(16.9)
	Not Eligible for choice	160	99.8	99.4	99.8	99.4	8.5(7.1)	15.7(12.2)
7	All	194	99.8	99.3	99.8	99.2	9.6(8.1)	17.3(13.1)
	Eligible for choice	194	98.5	95.1	98.5	94.9	14.7(11.5	26.3(18.8)
	Not Eligible for choice	194	99.9	99.7	99.9	99.6	9(7.3)	16.2(11.8)
8	All	138	99.4	99	99.4	98.9	8.3(7.3)	14.9(12.1)
	Eligible for choice	138	87.5	79.6	86.3	78	18.6(13.9	31.5(22.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	138	99.6	99.3	99.6	99.3	8(6.6)	14.6(11.6)
9	All	192	99.6	99.3	99.6	99.2	10.4(8.6)	18.6(14.2)
	Eligible for choice	192	98.2	96.5	98.2	96.5	13.9(9.8)	26.1(17)
	Not Eligible for choice	192	99.8	99.6	99.8	99.6	9.8(8.2)	17.4(13.4)
10	All	117	100	100	100	100	6.3(5.5)	11.6(9.3)
	Eligible for choice	117	100	100	100	100	10.2(3.8)	19.7(8)
	Not Eligible for choice	117	100	100	100	100	6.3(5.5)	11.6(9.2)
11	All	217	99.4	99.1	99.4	99	7.1(6.8)	13.2(11.4)
	Eligible for choice	217	98.8	97	98.6	96.6	11.6(9.4)	21.4(15.9)
	Not Eligible for choice	217	99.5	99.2	99.4	99.1	6.7(6.1)	12.7(10.8)
12	All	192	99.6	99.3	99.6	99.2	5.1(5.4)	10(9.7)
	Eligible for choice	192	91.7	87.6	91.3	87	14.7(12.6	27.8(22.9)
	Not Eligible for choice	192	100	99.9	100	99.9	4.8(4.7)	9.5(8.3)
15	All	268	99.7	98.6	99.7	98.4	7.5(7.5)	14.1(12.9)
	Eligible for choice	268	97.5	93.2	97.4	92.7	11.4(10.7)	21.2(18.5)
	Not Eligible for choice	268	100	99.2	100	99.1	7(6.8)	13.1(11.7)
16	All	436	99.7	99.4	99.7	99.3	7.6(7.4)	14(12.4)
	Eligible for choice	436	98	95.9	98	95.7	13.5(11.4)	24.3(19.2)
	Not Eligible for choice	436	99.9	99.8	99.9	99.8	6.8(6.1)	12.7(10.5)
17	All	236	99.8	99.8	99.8	99.8	6.5(6.6)	11.9(10.7)
	Eligible for choice	236	97.9	97.8	97.8	97.6	12.8(11.9	22.3(18.5)
	Not Eligible for choice	236	100	100	100	100	5.8(5.4)	10.8(8.8)
18	All	159	96.3	95.6	96.1	95.3	9.6(13.1)	17.1(21.8)
	Eligible for choice	159	73.5	72.5	73.4	72.4	24.7(25.3	42.6(43.8)
	Not Eligible for choice	159	98.8	98	98.6	97.9	7(7.1)	13.5(13)
19	All	182	97.1	96.8	96.9	96.5	9.1(12.4)	16.1(20.1)
	Eligible for choice	182	83.5	82.6	83.3	82	20.7(21.3	35.5(35.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	182	99.6	99.5	99.5	99.4	6.3(6.4)	11.6(10.1)
20	All	165	96.9	97	97.1	97	8.9(11.2)	16.3(19.3)
	Eligible for choice	165	84.4	81.3	85.6	82	18.7(21.1	34.9(38.6)
	Not Eligible for choice	165	98.7	99.3	98.9	99.3	7.1(7)	13.5(12)
21	All	130	97.5	96.3	97.3	96	7(8.8)	12.8(14.7)
	Eligible for choice	130	73.8	59.4	73.5	59.1	30.7(20.8)	53.3(34.2)
	Not Eligible for choice	130	98.4	97.7	98.3	97.5	6.1(6.4)	11.5(11.5)
22	All	145	99.6	99.4	99.6	99.4	4.8(5.7)	9(9.5)
	Eligible for choice	145	86.2	85.1	84.4	83.9	21.9(25.8)	38.7(42.2)
	Not Eligible for choice	145	100	99.8	100	99.8	4.5(3.9)	8.4(6.5)
23	All	381	97.6	96.7	97.4	96.5	9.3(11.1)	17.1(18.6)
	Eligible for choice	381	90.6	88.4	90.3	88.2	16.1(16.5)	29.1(27.6)
	Not Eligible for choice	381	99.5	99	99.4	98.9	7.3(7.4)	13.7(13.4)

Table F-46 Access to Interventional Cardiology (PCI) within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1560	90	90.3	89.3	89.6	14(19.5)	22.1(27)
	Eligible for choice	1560	32.1	36.5	31.4	35.6	52.4(31.4)	75.9(42.8)
	Not Eligible for choice	1560	94.6	94.5	94.1	94.1	8.9(8.8)	18.1(20.4)
1	All	52	89.5	91.7	88.7	90.7	14.6(20.1)	21.9(26.1)
	Eligible for choice	52	16.6	27.4	16.3	25.8	65.7(33.7)	91.8(41.5)
	Not Eligible for choice	52	92.3	94.2	91.9	93.5	9.9(9.2)	19.6(21.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	23	85.6	85.9	85.8	86.2	19.2(21.1)	29(28)
	Eligible for choice	23	25.9	22.3	24.3	21	54.9(27.3)	84.5(35)
	Not Eligible for choice	23	87.2	87.6	87.3	87.8	13.4(11.3)	27.5(26.2)
3	All	67	98.9	99.2	98.9	99.1	5.1(6.2)	9.1(9.3)
	Eligible for choice	67	42.7	42.7	42.3	42.3	46.6(24)	71.8(39.5)
	Not Eligible for choice	67	99	99.2	99	99.2	4.8(5)	9(9.2)
4	All	91	96	96.5	95.5	96.1	10.8(11.5)	17.6(16.6)
	Eligible for choice	91	58.3	57	54.9	54	34.3(17.7)	52.7(28.8)
	Not Eligible for choice	91	96.7	97.3	96.4	97	9.4(8.9)	17(15.6)
5	All	40	97.4	96.7	97.5	96.8	8.1(8.8)	14.3(13.7)
	Eligible for choice	40	79.6	80.1	74.5	74.8	23.9(13.2)	38(20.7)
	Not Eligible for choice	40	97.6	96.9	97.8	97	7.4(7.2)	14(13.4)
6	All	72	91	91.2	90.5	90.9	16(15.9)	25.6(22.9)
	Eligible for choice	72	57.1	61.3	57.2	61.7	36.9(19.2)	56.1(28.5)
	Not Eligible for choice	72	94.2	94	93.8	93.8	11.3(9.7)	22.3(19.5)
7	All	79	90.9	91.6	90.4	91.1	16.8(16.2)	26.8(23.2)
	Eligible for choice	79	58.3	60	57.3	58.6	34.3(19.6)	52.5(29)
	Not Eligible for choice	79	93.9	94.5	93.5	94.2	12.1(9.8)	23.6(20.2)
8	All	82	95.3	96.1	94.9	95.8	12.2(14.1)	19.7(19.9)
	Eligible for choice	82	22	15.3	20.8	13.9	49.4(18)	75(25.4)
	Not Eligible for choice	82	96.4	97.4	96.1	97.2	9.7(8.1)	18.8(18.4)
9	All	70	86.9	86.8	87.1	87	18.9(16.2)	30(24)
	Eligible for choice	70	52.3	54.4	52.4	54.5	37.7(14.2)	57.4(21.1)
	Not Eligible for choice	70	91.7	91.2	91.8	91.3	13.3(11)	25.7(21.5)
10	All	58	97.7	97.8	97.6	97.7	10.1(9.9)	16.5(14.4)
	Eligible for choice	58	15.5	49.8	14	47.7	43.1(4.7)	60.8(9.9)
	Not Eligible for choice	58	98.3	98.2	98.2	98	9.4(8.8)	16.2(13.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	94	93.5	93.4	93.2	93.1	12.7(13.6)	20.7(19.9)
	Eligible for choice	94	55.8	62	53.7	60.4	34.1(18.6)	49.6(24.9)
	Not Eligible for choice	94	96.3	95.8	96.1	95.5	10.1(9.8)	18.8(18)
12	All	107	89.9	90	88.6	88.8	10(17.1)	16.8(25.2)
	Eligible for choice	107	24.4	23.1	23.6	22.2	56.7(24.9)	89.4(38.7)
	Not Eligible for choice	107	92.9	93.1	92	92.2	6.1(7.1)	14.5(20.9)
15	All	86	89.1	87.7	88.6	87	16.7(18.5)	26.5(26.6)
	Eligible for choice	86	38.6	36.5	38.7	36.3	45.5(21.1)	66.6(29)
	Not Eligible for choice	86	94.9	93.5	94.5	93	10.6(10.6)	21.1(21.1)
16	All	161	89.9	89.9	89.4	89.3	14.7(16.4)	23.6(23.8)
	Eligible for choice	161	40.9	46.9	41	46.5	41.2(18.2)	60.8(26.7)
	Not Eligible for choice	161	95.9	95.1	95.6	94.7	9.6(9.3)	18.9(18.6)
17	All	92	92.4	92.4	91.9	91.9	13(18.6)	20.6(25.8)
	Eligible for choice	92	35.6	39.9	35.1	39.4	51.7(30.3)	74.6(40.8)
	Not Eligible for choice	92	97.9	97.5	97.6	97.1	8.1(8.2)	14.9(14.9)
18	All	57	85.1	84.6	84.8	84.2	20.6(31.9)	30.7(42.6)
	Eligible for choice	57	15	15.9	14.6	15.6	71.1(36.8)	99.8(50.7)
	Not Eligible for choice	57	92.6	91.9	92.5	91.8	7.7(7.6)	21.2(31)
19	All	54	80.2	81	78.7	79.4	25.1(40.3)	35(50.4)
	Eligible for choice	54	17	25.8	16.1	24.3	75.3(46.7)	101.3(61.9
	Not Eligible for choice	54	92.1	91.4	91.1	90.4	7.3(7.4)	20.5(32.9)
20	All	55	82.6	84.1	81.8	83.2	18.8(25.2)	29.1(35.8)
	Eligible for choice	55	13.4	21.8	13.5	21.7	64.4(28.4)	94.9(43.4)
	Not Eligible for choice	55	92.9	93.4	92.3	92.7	9.4(8.7)	20.1(23)
21	All	65	88.1	87.3	87	86.2	11.3(17.1)	18.4(24.6)
	Eligible for choice	65	4.8	8.5	4.4	8.7	69.8(37.7)	102.8(46)
	Not Eligible for choice	65	91.2	90.3	90.4	89.4	7.7(8)	15.9(18.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	80	96.2	96.3	96.2	96.2	7.2(9.8)	12.2(14.2)
	Eligible for choice	80	11.8	19.1	12.4	20.1	54.3(20.2)	83.3(36.8)
	Not Eligible for choice	80	98.7	98.5	98.6	98.4	6(5.4)	10.9(9.7)
23	All	75	69.2	70.6	67.7	69.2	28.9(33.2)	42.4(45.7)
	Eligible for choice	75	11.5	16.9	11	16.4	68.2(32)	96.1(43.2)
	Not Eligible for choice	75	85.1	85.4	83.9	84.2	10.2(10.6)	27.3(33.4)

Table F-47 Access to Coronary Care Unit within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1027	84.1	85.6	83.1	84.7	18.3(23.7)	27.2(31.2)
	Eligible for choice	1027	26.3	31.1	26	30.6	58.8(34.9)	82.8(45)
	Not Eligible for choice	1027	88.6	89.9	87.9	89.2	10.8(9.7)	23.1(25.4)
1	All	43	90.8	91.7	89.6	90.6	15.3(19.7)	22.6(25.8)
	Eligible for choice	43	5	19.5	4.7	18	69.7(32.5)	96(41.3)
	Not Eligible for choice	43	94.1	94.5	93.3	93.8	11.2(9.2)	20.2(21.1)
2	All	27	91	89.7	91.4	90	15.9(14.7)	26(22.7)
	Eligible for choice	27	45.5	41.5	48.2	43.5	41.9(19.9)	71.8(34.4)
	Not Eligible for choice	27	92.2	90.9	92.4	91.1	13.1(10.7)	24.8(21)
3	All	73	99.8	99.9	99.8	99.9	5.2(6.3)	9.2(9.3)
	Eligible for choice	73	100	42.7	100	42.3	32.6(0.6)	53.2(7.6)
	Not Eligible for choice	73	99.8	99.9	99.8	99.9	5.2(6.2)	9.2(9.3)
4	All	70	93.4	96.1	92.6	95.6	12.7(12.4)	20(17.3)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	70	68.5	64.2	66.6	62	31.4(16.4)	50(27.5)
	Not Eligible for choice	70	93.9	96.7	93.1	96.3	10.8(9.6)	19.5(16.6)
5	All	29	96.8	95.9	96.8	95.9	12.1(11.1)	18.5(16)
	Eligible for choice	29	71.9	76	66.1	70.8	34.6(7.7)	47(15.2)
	Not Eligible for choice	29	97	96.2	97.1	96.2	11.2(9.7)	18.2(15.7)
6	All	45	85.5	88.2	85.3	87.9	19.7(17.4)	29.8(24)
	Eligible for choice	45	43.3	54.7	43.1	54.8	41.2(17.6)	60.8(26)
	Not Eligible for choice	45	89.5	91.3	89.4	91.1	13.5(10.6)	26.5(21.2)
7	All	55	85.7	86.9	85	86.4	21.1(18.9)	32.1(26.1)
	Eligible for choice	55	36.7	42.8	35.3	41.2	45.6(21)	66.3(29.1)
	Not Eligible for choice	55	90.2	90.9	89.8	90.6	14.1(10.7)	27.9(22.4)
8	All	61	92	93.2	91.3	92.7	14.1(13.7)	22.1(19.4)
	Eligible for choice	61	24.5	18.7	22.7	16.8	44.9(21)	69(30.6)
	Not Eligible for choice	61	93	94.4	92.5	93.9	11.2(9.3)	21.3(18.1)
9	All	49	76.5	81.5	76.6	81.4	25.2(22.4)	36.8(30.3)
	Eligible for choice	49	29.5	36	29.7	36.4	50.9(23)	72.3(29.5)
	Not Eligible for choice	49	82.8	87.7	82.9	87.5	14.6(11.1)	31.3(26.4)
10	All	43	96.9	97	96.7	96.9	12(11.2)	18.9(15.9)
	Eligible for choice	43	10.4	41.5	9.4	39.9	44.7(3.7)	63.3(9.7)
	Not Eligible for choice	43	97.5	97.4	97.3	97.3	11.2(10)	18.6(15.5)
11	All	61	89.3	89.8	88.7	89.3	15.5(16.1)	24.4(22.9)
	Eligible for choice	61	63.9	71.6	62.6	70.4	29.4(17.9)	43.8(25.3)
	Not Eligible for choice	61	91.2	91.2	90.6	90.6	11.7(10.5)	23.1(22.2)
12	All	37	79.8	82	78	80.1	16.8(21.2)	24.8(28.4)
	Eligible for choice	37	10.8	10	10.1	9.3	67.3(21.5)	99.3(32)
	Not Eligible for choice	37	83	85.4	81.5	83.8	9.9(9.6)	22.4(24.8)
15	All	31	64.1	66.4	62.6	64.8	31.4(30.8)	43.2(40.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	31	15.7	21.1	16.5	20.9	69.1(36)	94.7(46.7)
	Not Eligible for choice	31	69.6	71.5	68	70	13.2(10.9)	36.3(33.8)
16	All	89	78.2	80.1	78.1	79.8	20.9(21.6)	31.3(29.9)
	Eligible for choice	89	33.1	38.1	33.3	38	46.4(23.3)	67.3(32)
	Not Eligible for choice	89	83.7	85.2	83.8	85.1	11.7(10.3)	26.7(26.2)
17	All	38	86	86.6	85.3	85.9	23.2(29.3)	32.2(36.2)
	Eligible for choice	38	23.4	25.9	23.1	25.4	63.4(33.5)	86.6(42.8)
	Not Eligible for choice	38	92.2	92.6	91.5	92	12.4(9.6)	26.5(30.1)
18	All	36	75.5	75.9	75.3	75.8	31.9(45.4)	43.4(56)
	Eligible for choice	36	3	7.2	3.1	7.3	92.7(41.8)	122.9(56.2
	Not Eligible for choice	36	83.2	83.2	83.2	83.3	9.2(7.9)	32.9(46.8)
19	All	24	68.1	72.7	65.6	70.4	35.1(45.2)	45.4(53)
	Eligible for choice	24	9.2	15.7	9.6	15.6	91.1(47.5)	114.1(54.4)
	Not Eligible for choice	24	79.2	83.4	76.7	81.3	11.3(8.7)	30.5(39.1)
20	All	34	71.8	72.8	71.3	72.2	25.7(31.9)	37.8(44.8)
	Eligible for choice	34	19	25.5	19.7	25.9	64.6(35.3)	95.1(51.4)
	Not Eligible for choice	34	79.7	79.8	79.2	79.3	11.3(9)	30(37.6)
21	All	50	89.9	89.1	89	88.1	13.8(18.3)	22.1(27)
	Eligible for choice	50	3.9	8.8	4	9	72.5(38.5)	107.7(48.4)
	Not Eligible for choice	50	93.1	92.1	92.6	91.4	9.9(9.4)	19.5(21.2)
22	All	68	92.3	94.8	92.1	94.7	9.2(14.4)	14.4(18.2)
	Eligible for choice	68	8.8	9.7	9.3	10.1	69.8(31.5)	94.8(39.7)
	Not Eligible for choice	68	94.8	97.2	94.5	97.1	6.7(6.1)	13(14.1)
23	All	64	65.4	67	64.2	65.6	31.6(30.9)	45.3(42.1)
	Eligible for choice	64	26.7	27.2	26.7	27	59.2(30.6)	86.6(42.4)
	Not Eligible for choice	64	76	77.9	74.9	76.7	11.8(10.8)	33.8(34.1)

Table F-48 Access to Diagnostic Cardiac Catheterization within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1814	92	91.9	91.3	91.3	12.7(18)	20.5(25.4)
	Eligible for choice	1814	40.2	43.3	39.5	42.4	48(30.5)	70.8(42.4)
	Not Eligible for choice	1814	96	95.7	95.6	95.3	8.4(8.4)	16.7(18.8)
1	All	72	93.3	93.8	92.5	92.9	11.8(14.8)	18.6(21.1)
	Eligible for choice	72	17.4	29.3	17.2	27.7	58(21.4)	83.3(31.4)
	Not Eligible for choice	72	96.3	96.3	95.9	95.8	8.9(8.2)	16.4(16.7)
2	All	28	91.9	91.1	91.8	91.1	15.6(14.1)	25(21.4)
	Eligible for choice	28	25.9	22.3	24.3	21	45(15.3)	74.9(26.2)
	Not Eligible for choice	28	93.6	92.9	93.4	92.8	13.1(11.1)	23.7(19.6)
3	All	81	99	99.2	99	99.1	4.6(5.9)	8.4(9)
	Eligible for choice	81	42.7	42.7	42.3	42.3	33.9(33.7)	58(51.5)
	Not Eligible for choice	81	99	99.2	99	99.2	4.3(4.7)	8.3(8.9)
4	All	114	98.4	98	98.2	97.8	9(9.4)	15.5(14.4)
	Eligible for choice	114	66	65.1	63.4	62.3	31.7(15.7)	49.4(26.2)
	Not Eligible for choice	114	99	98.7	98.9	98.5	8.3(8.1)	14.9(13.4)
5	All	52	99	98.3	98.7	98	7.5(8.1)	13.2(12.4)
	Eligible for choice	52	79.6	80.1	74.5	74.8	23.9(13.2)	38(20.7)
	Not Eligible for choice	52	99.2	98.5	98.9	98.2	7.1(7.1)	12.9(12)
6	All	88	92.6	92.6	92.3	92.3	14.4(14.7)	23.7(21.5)
	Eligible for choice	88	65.8	69	65.9	69.3	32(16.9)	49.6(24.4)
	Not Eligible for choice	88	95.1	94.8	94.9	94.6	10.3(9.1)	20.9(19.1)
7	All	101	94.7	94.9	94.3	94.6	14.2(13.7)	23.5(20.4)
	Eligible for choice	101	68.1	72.3	67.2	71.3	30.6(19.6)	47.2(28.5)
	Not Eligible for choice	101	97.2	97	96.9	96.8	11.1(9.1)	20.6(17)
8	All	96	95.8	96.3	95.4	96	11.3(13.4)	18.6(19.2)
	Eligible for choice	96	27.5	23.2	26.2	21.7	42.9(21.8)	66.2(31.3)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	96	96.8	97.5	96.6	97.3	9.1(7.6)	17.8(17.9)
9	All	85	91.8	91.3	91.9	91.3	16.8(14.4)	27.2(21.7)
	Eligible for choice	85	74	71.9	74	71.8	31.2(14.4)	49.2(21.4)
	Not Eligible for choice	85	94.2	93.9	94.3	93.9	12.7(10.7)	23.8(19.6)
10	All	79	99.2	98.6	99.1	98.5	8.4(8.4)	14.4(12.8)
	Eligible for choice	79	69.1	69.2	67.7	67.4	27.9(14.3)	47.7(19.3)
	Not Eligible for choice	79	99.4	98.9	99.3	98.8	8.1(7.8)	14.2(12.5)
11	All	112	96.4	95.8	96.2	95.5	11.1(11.7)	18.7(17.6)
	Eligible for choice	112	75.7	76.2	74.5	75.1	27(17.9)	41.4(24.7)
	Not Eligible for choice	112	97.9	97.2	97.7	97	9.4(9.3)	17.2(16)
12	All	110	90.6	91	89.4	89.7	9.7(16.9)	16.4(24.9)
	Eligible for choice	110	27.4	27.9	26.7	27.3	56.2(25.2)	88.2(39.3)
	Not Eligible for choice	110	93.5	93.9	92.6	93	5.9(6.8)	14.1(20.5)
15	All	92	90.7	89	90.3	88.4	15.7(17.4)	25.3(25.4)
	Eligible for choice	92	43	42	43.1	41.6	42.8(21)	63.5(29.2)
	Not Eligible for choice	92	96.1	94.4	95.9	94	10.4(10.5)	20.1(19.9)
16	All	176	92.1	91.8	91.7	91.3	13.6(15.1)	22.3(22.3)
	Eligible for choice	176	50.7	54.7	50.8	54.3	37.3(18.8)	56.3(27.7)
	Not Eligible for choice	176	97.2	96.3	96.9	96	9.5(9.1)	18(17.2)
17	All	103	95.6	95.3	95.4	95.1	11(14)	18.1(20.1)
	Eligible for choice	103	57.8	59.5	57.4	59.2	38.3(20.5)	57(28.1)
	Not Eligible for choice	103	99.3	98.8	99.2	98.7	7.6(7.6)	14(13.6)
18	All	59	85.4	84.8	84.9	84.3	19.7(31.2)	29.8(41.9)
	Eligible for choice	59	14.4	17.3	14	17	71.2(36.7)	100.9(51.1
	Not Eligible for choice	59	92.9	92	92.7	91.7	7.7(7.6)	20(29.1)
19	All	59	81.4	82.2	79.9	80.7	23.5(38.4)	33.1(48.1)
	Eligible for choice	59	19.6	28.5	18.6	26.8	70.3(45)	95.5(60.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	59	93	92.3	92.1	91.4	7.1(7.2)	19.4(31.4)
20	All	63	83.8	84.9	83.1	84.1	17.5(24.1)	27.7(35.3)
	Eligible for choice	63	15.3	20.1	15.2	19.7	63.2(27.6)	94.8(43)
	Not Eligible for choice	63	94	94.6	93.5	94	8.8(8.5)	18.6(21.6)
21	All	75	90.6	89.9	89.7	89	10.6(16.2)	17.8(24.4)
	Eligible for choice	75	5.3	8.5	5	8.7	66.5(29.8)	100.5(42.1
	Not Eligible for choice	75	93.8	93	93.2	92.3	7.3(7.3)	15.2(18.4)
22	All	91	96.4	96.3	96.3	96.3	6.8(9.7)	11.6(14.3)
	Eligible for choice	91	15.3	19.1	15.8	20.1	55.2(21.1)	85.1(38.1)
	Not Eligible for choice	91	98.7	98.6	98.6	98.4	5.6(5)	10.3(9.5)
23	All	78	70	71.3	68.6	69.9	28(32)	41.5(44.5)
	Eligible for choice	78	14.9	19.3	14.5	18.9	65.1(30.3)	92.9(41.9)
	Not Eligible for choice	78	85.2	85.6	84	84.4	10.1(10.4)	27(33)

Table F-49 Access to Cardiac Surgery within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1125	85.6	86.8	84.7	85.9	16.9(22.3)	25.6(29.9)
	Eligible for choice	1125	20.7	27.5	20.2	26.6	60.1(33.1)	84.2(43.3)
	Not Eligible for choice	1125	90.7	91.4	90.1	90.9	10.1(9.4)	21.2(23.3)
1	All	40	88.7	91.4	87.7	90.4	16.4(20.1)	23.8(26.1)
	Eligible for choice	40	5	18.5	4.7	17	69.6(32.5)	95.9(41.2)
	Not Eligible for choice	40	92	94.3	91.4	93.7	11.8(10)	21.4(21.6)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	14	78.4	80.2	78.5	80.4	22.6(24.4)	33.6(32.5)
	Eligible for choice	14	25.9	22.3	24.3	21	61.5(30.6)	95.3(42.5)
	Not Eligible for choice	14	79.8	81.7	79.9	81.8	13.9(11.5)	32(30.5)
3	All	38	97.9	98.4	97.7	98.3	7.3(8.5)	12.1(11.9)
	Eligible for choice	38	0	0	0	0	56.9(15.1)	82.9(29.9)
	Not Eligible for choice	38	98	98.5	97.8	98.3	6.8(6.7)	12(11.8)
4	All	73	91.7	93.7	90.8	93	13(14.2)	20.3(19.3)
	Eligible for choice	73	49.7	47.4	46.8	43.9	39.2(20.8)	58.2(30.8)
	Not Eligible for choice	73	92.5	94.6	91.7	94	10.2(9.5)	19.6(18.4)
5	All	18	90.7	93.5	90.2	93.4	14.6(13.7)	21.3(18.4)
	Eligible for choice	18	61.6	69.1	53.5	61.9	37.2(10.2)	48.6(16.2)
	Not Eligible for choice	18	91.1	93.8	90.6	93.7	12(10.1)	21(18.2)
6	All	44	86.1	86.9	85.1	86.2	19.8(18.6)	30.1(25.4)
	Eligible for choice	44	38.6	48	38	47.6	44.2(18.4)	65.7(26.9)
	Not Eligible for choice	44	90.5	90.5	89.8	89.9	13.5(10.6)	26.3(22.1)
7	All	54	85.1	87.3	84.6	86.8	21.2(19.5)	31.6(26.2)
	Eligible for choice	54	29.3	38.4	29.7	37.9	49(19.7)	68.9(27.1)
	Not Eligible for choice	54	90.3	91.8	89.8	91.4	13.7(10.5)	27(22)
8	All	56	94.1	94.8	93.7	94.4	14.2(15.4)	22.4(21.6)
	Eligible for choice	56	8.6	3.5	8.3	3.2	56.1(17.1)	85.1(23)
	Not Eligible for choice	56	95.5	96.2	95.1	95.9	11.1(8.8)	21.4(19.9)
9	All	44	75.9	81.6	76.1	81.5	23.8(18.7)	35.1(26)
	Eligible for choice	44	37.5	43.3	37.4	43.2	42.4(15.6)	62.4(22)
	Not Eligible for choice	44	81.1	86.8	81.3	86.6	15.2(11.5)	30.9(24)
10	All	48	97.6	97.4	97.5	97.3	10.8(10.3)	17.4(14.9)
	Eligible for choice	48	20.2	50.5	21.1	49.5	42.3(6.7)	60.1(10.3)
	Not Eligible for choice	48	98.2	97.8	98.1	97.7	10.1(9.2)	17.1(14.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	71	91.3	91.5	90.8	91	14.8(15.8)	23.3(22.6)
	Eligible for choice	71	49.4	60.5	47	58.8	35.5(20.6)	50.4(27.4)
	Not Eligible for choice	71	94.3	93.8	93.9	93.4	11.3(10)	21.6(21.1)
12	All	80	87.5	88.3	86.1	86.9	11.6(18.4)	18.9(26.6)
	Eligible for choice	80	16.6	16	15.7	15.2	59.3(23.9)	92.1(37.5)
	Not Eligible for choice	80	90.8	91.6	89.8	90.6	7.1(8.1)	16.6(22.6)
15	All	58	78.9	78.7	78.5	78.1	21.7(22.2)	32.4(30.6)
	Eligible for choice	58	20.1	22.4	20.6	22.1	52.9(20.6)	75.7(29.1)
	Not Eligible for choice	58	85.6	85.2	85.3	84.7	11.8(11)	26.6(25.8)
16	All	124	82.8	83.9	82.7	83.7	18.2(20.6)	28(28.6)
	Eligible for choice	124	29.7	37.8	30.1	37.8	47.3(20.2)	67.9(27.6)
	Not Eligible for choice	124	89.3	89.6	89.4	89.5	10.2(9.7)	22.9(24.4)
17	All	76	90.2	90.4	89.7	89.8	14.6(20.2)	22.6(27.6)
	Eligible for choice	76	22.1	27.9	22	27.4	57.5(29.7)	80.6(40.1)
	Not Eligible for choice	76	96.9	96.5	96.5	96.1	8.8(8.7)	16.5(16.7)
18	All	42	79.4	80.3	79	80	24.2(35)	34.7(45.2)
	Eligible for choice	42	8.1	12.9	7.6	12.3	80.4(38.7)	108.4(52.4
	Not Eligible for choice	42	87	87.5	86.9	87.5	8.5(7.8)	24.6(33.1)
19	All	36	75.5	76.4	73.3	74.2	30.2(44.4)	40.4(52.9)
	Eligible for choice	36	8.8	17.5	8.1	16.2	87.9(46)	113.8(57.3
	Not Eligible for choice	36	88.1	87.5	86.3	85.7	8.7(7.6)	24.5(35.7)
20	All	36	73.4	74.7	73	74.3	23.1(30.5)	34(41.4)
	Eligible for choice	36	8.2	16.3	7.9	15.8	71.3(33.6)	102(47.7)
	Not Eligible for choice	36	83.1	83.5	83	83.3	10.1(8.2)	24.7(30.3)
21	All	53	88	87.1	87	86.1	12.4(17.3)	19.8(25)
	Eligible for choice	53	4.1	8.4	4	8.6	72.1(38.2)	105.6(46.5
	Not Eligible for choice	53	91.2	90.1	90.4	89.3	8.8(8.3)	17.3(18.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	73	96.2	96.2	96.1	96.2	7.6(10.6)	12.6(14.8)
	Eligible for choice	73	10.2	17.5	10.7	18.3	60.6(26)	87.7(37.8)
	Not Eligible for choice	73	98.7	98.5	98.6	98.4	6.4(5.7)	11.4(10)
23	All	47	61.2	63.9	59.5	62.2	35.5(38.5)	49.9(50.7)
	Eligible for choice	47	5.1	11.2	4.9	10.7	78.7(35)	107.1(45)
	Not Eligible for choice	47	76.7	78.4	75	76.9	10.8(10.6)	34(39.4)

Table F-50 Access to Surgery within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	4022	99.2	98.8	99.1	98.7	7.3(8)	13.3(13.4)
	Eligible for choice	4022	92.4	89.9	92.3	89.6	16.1(16)	28.9(27.3)
	Not Eligible for choice	4022	99.7	99.5	99.7	99.4	6.5(6.3)	12.1(10.7)
1	All	156	99.8	99.7	99.7	99.6	6.9(6.5)	12.2(10.6)
	Eligible for choice	156	96.1	94.5	96	94.3	16.2(13.3	29.8(22.5)
	Not Eligible for choice	156	99.9	99.9	99.9	99.9	6.6(5.8)	11.6(9.4)
2	All	69	99.5	98.7	99.5	98.7	9.3(8.7)	16.7(14.7)
	Eligible for choice	69	94.3	86	94.5	87	20(15.4)	37.7(28.4)
	Not Eligible for choice	69	99.6	99	99.6	99	8.9(8)	16.2(13.8)
3	All	123	100	100	100	100	3.5(3.6)	6.7(6.2)
	Eligible for choice	123	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	123	100	100	100	100	3.5(3.6)	6.7(6.2)
4	All	193	100	100	100	100	6.4(5.8)	11.8(9.7)
	Eligible for choice	193	100	99.5	100	99.4	15.3(8.8)	26.3(14.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	193	100	100	100	100	6.2(5.7)	11.5(9.4)
5	All	78	100	100	100	100	5.8(5.3)	10.8(8.4)
	Eligible for choice	78	100	100	100	100	11.8(4.9)	21(7.4)
	Not Eligible for choice	78	100	100	100	100	5.7(5.2)	10.7(8.4)
6	All	163	99.6	99.1	99.6	99.1	9.2(7.9)	16.8(13.1)
	Eligible for choice	163	97.6	96.1	97.8	96.2	14.5(10.1	26.3(16.9)
	Not Eligible for choice	163	99.8	99.4	99.8	99.4	8.5(7.1)	15.7(12.2)
7	All	204	99.8	99.4	99.8	99.3	9.6(8.1)	17.2(13.1)
	Eligible for choice	204	98.5	95.1	98.5	94.9	14.7(11.5)	26.3(18.8)
	Not Eligible for choice	204	100	99.8	100	99.7	8.9(7.3)	16.1(11.7)
8	All	144	99.4	99	99.4	98.9	8.1(7.2)	14.7(12)
	Eligible for choice	144	87.5	79.6	86.3	78	18.6(13.9)	31.5(22.5)
	Not Eligible for choice	144	99.6	99.3	99.6	99.3	7.8(6.5)	14.4(11.5)
9	All	198	99.6	99.3	99.6	99.2	10.3(8.6)	18.5(14.2)
	Eligible for choice	198	98.2	96.5	98.2	96.5	13.6(9.9)	25.7(17.2)
	Not Eligible for choice	198	99.8	99.6	99.8	99.6	9.7(8.2)	17.4(13.4)
10	All	121	100	100	100	100	6.2(5.4)	11.5(9.2)
	Eligible for choice	121	100	100	100	100	10.2(3.8)	19.7(8)
	Not Eligible for choice	121	100	100	100	100	6.2(5.4)	11.5(9.1)
11	All	228	99.4	99.1	99.4	99	7(6.7)	13(11.3)
	Eligible for choice	228	98.8	97	98.6	96.6	11.2(9.2)	21(15.9)
	Not Eligible for choice	228	99.5	99.3	99.4	99.2	6.6(6)	12.5(10.7)
12	All	193	99.6	99.3	99.6	99.2	5.2(5.4)	10.1(9.7)
	Eligible for choice	193	91.7	87.6	91.3	87	14.7(12.6	27.8(22.9)
	Not Eligible for choice	193	100	99.9	100	99.9	4.8(4.7)	9.5(8.3)
15	All	281	99.7	98.6	99.7	98.4	7.5(7.5)	14(13)
	Eligible for choice	281	97.5	93.2	97.4	92.7	11.4(10.7)	21.2(18.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	281	100	99.2	100	99.1	6.9(6.8)	13(11.7)
16	All	453	99.7	99.4	99.7	99.3	7.4(7.2)	13.8(12.2)
	Eligible for choice	453	98	96.1	98	95.9	13.2(11.4)	23.9(19.1)
	Not Eligible for choice	453	99.9	99.8	99.9	99.8	6.6(6)	12.5(10.3)
17	All	228	99.8	99.8	99.8	99.8	6.5(6.6)	11.9(10.6)
	Eligible for choice	228	97.9	97.8	97.8	97.6	12.8(11.9	22.3(18.5)
	Not Eligible for choice	228	100	100	100	100	5.8(5.4)	10.8(8.8)
18	All	165	96.3	95.4	96.1	95.1	9.5(13.2)	17(22)
	Eligible for choice	165	73.5	71.6	73.4	71.6	24.8(25.3	42.8(44)
	Not Eligible for choice	165	98.8	97.9	98.6	97.7	6.9(7.2)	13.4(13.1)
19	All	187	97.4	96.9	97.2	96.6	8.9(12.1)	15.9(19.9)
	Eligible for choice	187	85.9	83.1	85.4	82.4	19.8(20.8	34.6(35.1)
	Not Eligible for choice	187	99.6	99.5	99.5	99.4	6.2(6.4)	11.5(10.1)
20	All	162	96.9	97	97.1	97	9(11.3)	16.3(19.3)
	Eligible for choice	162	84.4	81.3	85.6	82	18.9(21.1	35.2(38.6)
	Not Eligible for choice	162	98.7	99.3	98.9	99.3	7.1(7.1)	13.5(12.1)
21	All	141	97.6	96.6	97.4	96.4	6.7(8.5)	12.5(14.4)
	Eligible for choice	141	73.8	64.8	73.5	64	29.8(21.2)	51.7(34.7)
	Not Eligible for choice	141	98.5	97.8	98.4	97.7	5.9(6.1)	11.2(11.2)
22	All	154	99.6	99.4	99.6	99.4	4.7(5.6)	8.9(9.5)
	Eligible for choice	154	86.2	85.1	84.4	83.9	21.7(24.9	38.7(42.1)
	Not Eligible for choice	154	100	99.8	100	99.8	4.4(3.9)	8.4(6.5)
23	All	381	97.5	96.7	97.3	96.5	9.4(11.1)	17.1(18.7)
	Eligible for choice	381	90.6	88.4	90.3	88.1	16.1(16.5	29.2(27.7)
	Not Eligible for choice	381	99.4	99	99.4	98.9	7.3(7.3)	13.7(13.4)

Table F-51 Access to Chemotherapy within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	2389	94.9	94.7	94.6	94.4	10.6(13.8)	17.8(20.3)
	Eligible for choice	2389	60.2	61.1	60.2	60.9	34.1(26.5)	52.8(38.1)
	Not Eligible for choice	2389	97.6	97.4	97.5	97.2	8(8)	15.1(15.3)
1	All	126	99.1	99	98.9	98.8	7.9(7.9)	13.6(12.3)
	Eligible for choice	126	76.9	76.3	76.2	75.7	24(19.5)	39.9(27.7)
	Not Eligible for choice	126	99.9	99.9	99.9	99.8	7.4(6.5)	12.7(10.3)
2	All	47	97.7	96.6	97.9	96.8	11.8(10.8)	20.2(17.5)
	Eligible for choice	47	76	69.8	76.4	71.2	29.5(15.7)	53.6(29)
	Not Eligible for choice	47	98.3	97.4	98.5	97.4	10.9(9.6)	19.3(16.2)
3	All	109	100	100	100	100	3.7(3.8)	7.1(6.4)
	Eligible for choice	109	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	109	100	100	100	100	3.7(3.8)	7(6.4)
4	All	132	99.5	99.4	99.4	99.3	8.4(8.4)	14.5(12.8)
	Eligible for choice	132	89	84.3	87.9	82.8	22.3(14.2)	35.8(22.7)
	Not Eligible for choice	132	99.7	99.7	99.7	99.7	8.1(7.9)	14.1(12.2)
5	All	64	99.2	98.9	98.9	98.4	6.6(6.9)	12(10.6)
	Eligible for choice	64	94.7	94.7	93	92.5	15.2(10.2)	25.7(13.8)
	Not Eligible for choice	64	99.3	98.9	99	98.5	6.3(6.1)	11.8(10.4)
6	All	112	97.2	96.4	97.1	96.4	11.5(10.8)	19.9(16.7)
	Eligible for choice	112	84.1	84.7	84.2	84.6	22(14.4)	36.1(21.5)
	Not Eligible for choice	112	98.4	97.5	98.4	97.5	9.9(8.6)	18.2(15.1)
7	All	94	93.6	93.1	93.4	92.8	14.9(14)	24.6(21)
	Eligible for choice	94	59.7	64.1	59.3	63.4	32.8(19.8)	50.1(28.9)
	Not Eligible for choice	94	96.7	95.7	96.6	95.6	11.5(9.4)	21.4(17.5)
8	All	103	95.6	95.5	95.2	95.1	11.1(12.5)	18.8(18.8)
	Eligible for choice	103	33.3	27.2	31.5	25.6	37.9(16.2)	59.8(24.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	103	96.6	96.6	96.3	96.3	9(8)	18.1(17.9)
9	All	92	89.8	91.1	90.3	91.3	16.5(14.3)	26.6(21.1)
	Eligible for choice	92	75.8	73.3	75.8	73.2	29(14.1)	47.2(21.7)
	Not Eligible for choice	92	91.7	93.5	92.2	93.7	12.5(10.3)	23.4(19.1)
10	All	94	100	99.7	100	99.7	7.4(6.7)	13(10.7)
	Eligible for choice	94	100	100	100	100	11.3(6.2)	21.9(11.7)
	Not Eligible for choice	94	100	99.7	100	99.7	7.4(6.7)	13(10.7)
11	All	167	98.6	98.4	98.5	98.2	8.7(8.9)	15.4(13.8)
	Eligible for choice	167	91	90.3	90.2	89.3	16.4(15.3)	27.3(21.6)
	Not Eligible for choice	167	99.1	99	99.1	98.9	7.9(7.4)	14.6(12.7)
12	All	150	98.7	97.6	98.5	97.3	6.2(7.3)	11.6(12.3)
	Eligible for choice	150	73.2	65.8	72.6	65	23.9(15.3)	42.2(25.1)
	Not Eligible for choice	150	99.9	99	99.9	99	5.6(6)	10.7(10.3)
15	All	134	97.1	95.4	96.8	94.9	11.8(12)	20.1(18.6)
	Eligible for choice	134	77.4	72.7	76.4	71.2	24(16.7)	39.1(25.4)
	Not Eligible for choice	134	99.3	98	99.3	97.7	9.8(9.4)	17.5(15.9)
16	All	168	92.6	92.6	92.1	92.1	13.9(14.4)	22.6(21.2)
	Eligible for choice	168	55.9	60.1	55.9	59.9	33.7(17.8)	51.8(26.3)
	Not Eligible for choice	168	97.1	96.6	96.7	96.2	10.2(9.5)	18.8(17.2)
17	All	75	91.7	91.4	91.4	91.1	14(18.5)	22.1(25.8)
	Eligible for choice	75	24.6	29.3	24.9	29.1	55(27.3)	77.9(37.3)
	Not Eligible for choice	75	98.2	97.5	98.1	97.3	9.1(8.8)	16.2(15)
18	All	61	84.1	84.6	83.6	84.3	19.6(29.8)	29.6(40.1)
	Eligible for choice	61	9.2	14.7	9	14.6	70(31.9)	99.1(45.2)
	Not Eligible for choice	61	92	92.1	91.9	92	7.8(7.5)	19.9(28)
19	All	108	90.2	90.4	89.5	89.7	14.1(21.4)	22.3(29.6)
	Eligible for choice	108	53.1	57.1	52.1	56	36.4(32.1)	54.5(45.8)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	108	97.1	96.6	96.9	96.3	7.2(7.5)	14.7(17.2)
20	All	98	90.4	91.1	90.6	91.1	13.1(17.4)	21.8(26.8)
	Eligible for choice	98	49.4	53.7	50.2	54	37.6(30.2)	60.6(48.5)
	Not Eligible for choice	98	96.6	96.7	96.8	96.7	8.7(8.4)	16(14.8)
21	All	95	95	94	94.5	93.5	9(12.3)	15.6(19.1)
	Eligible for choice	95	26.7	25.2	25.7	24.7	53.9(24.3)	82.8(34.4)
	Not Eligible for choice	95	97.6	96.6	97.4	96.3	7.2(7.5)	13.5(13.9)
22	All	105	95.5	96.4	95.5	96.4	6.6(10.4)	11.5(15.1)
	Eligible for choice	105	24.2	25.7	25.2	27	56.6(29)	83.9(43.2)
	Not Eligible for choice	105	97.6	98.4	97.5	98.3	5.1(4.8)	10.2(10)
23	All	255	93.1	92.7	92.8	92.4	13.1(16.5)	22.4(25.9)
	Eligible for choice	255	77	74.6	76.8	74.3	26.2(24.8)	43.5(38.3)
	Not Eligible for choice	255	97.5	97.7	97.4	97.5	8.4(8.4)	16.4(16.9)

Table F-52 Access to Oncology within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	2382	94.8	94.7	94.5	94.3	10.6(14.2)	17.8(20.9)
	Eligible for choice	2382	59.1	59.9	59.1	59.7	36.2(28.4)	55.6(40.2)
	Not Eligible for choice	2382	97.6	97.4	97.4	97.2	7.9(7.9)	15(15.2)
1	All	133	98.8	98.7	98.6	98.5	7.8(8.8)	13.4(13.7)
	Eligible for choice	133	77.4	76.3	76.6	75.7	24.4(20.6)	40.3(28.8)
	Not Eligible for choice	133	99.6	99.6	99.6	99.5	7(6.3)	12.5(11.9)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
2	All	47	97.8	97	98	97.1	11.7(10.7)	20.2(17.4)
	Eligible for choice	47	76	69.8	76.4	71.2	29.5(15.7)	53.6(29)
	Not Eligible for choice	47	98.4	97.7	98.6	97.7	10.9(9.6)	19.3(16.1)
3	All	118	100	100	100	100	3.5(3.7)	6.8(6.3)
	Eligible for choice	118	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	118	100	100	100	100	3.5(3.7)	6.8(6.2)
4	All	139	99.4	99	99.3	98.9	7.8(7.9)	13.8(12.5)
	Eligible for choice	139	86.5	77	85.1	74.7	24.9(14.8)	40.2(24.4)
	Not Eligible for choice	139	99.7	99.4	99.6	99.3	7.4(7.1)	13.4(11.7)
5	All	64	99.2	98.9	98.9	98.4	6.7(7)	12(10.7)
	Eligible for choice	64	94.7	94.7	93	92.5	15(9.9)	25.7(13.8)
	Not Eligible for choice	64	99.3	98.9	99	98.5	6.4(6.1)	11.9(10.5)
6	All	114	96.4	96.2	96.3	96.1	12(11.4)	20.4(17.1)
	Eligible for choice	114	82.3	83.5	82.1	83.3	22.9(14.7)	37.3(21.4)
	Not Eligible for choice	114	97.7	97.4	97.7	97.4	10(8.8)	18.6(15.5)
7	All	96	93.4	93.7	93.2	93.4	14.6(13.7)	24(20.5)
	Eligible for choice	96	64.5	70.4	64	69.6	30.3(19.6)	46.7(28.8)
	Not Eligible for choice	96	96.1	95.8	96	95.7	11.3(9.1)	21.2(17.2)
8	All	105	95.6	95.3	95.2	94.9	11(12.4)	18.7(18.8)
	Eligible for choice	105	30	22.2	28.3	20.7	39.7(16.3)	61.9(24.3)
	Not Eligible for choice	105	96.6	96.5	96.3	96.1	8.9(7.7)	18(17.8)
9	All	97	90	91.4	90.4	91.5	16.3(14.6)	26.3(21.3)
	Eligible for choice	97	81.2	78.1	80.9	78	27.7(14.9)	44.9(22.2)
	Not Eligible for choice	97	91.2	93.1	91.7	93.3	12.2(10.2)	23.5(19.7)
10	All	96	100	99.9	100	99.9	7.2(6.5)	12.8(10.5)
	Eligible for choice	96	100	100	100	100	11.6(6.4)	22.3(11.9)
	Not Eligible for choice	96	100	99.9	100	99.9	7.2(6.5)	12.8(10.4)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
11	All	167	98.5	98.2	98.3	98	8.7(9.1)	15.4(14.1)
	Eligible for choice	167	89.7	89.7	88.9	88.7	17.3(15.9)	28.2(22.3)
	Not Eligible for choice	167	99.1	98.8	99	98.7	7.8(7.4)	14.5(12.9)
12	All	148	98.2	97.6	97.9	97.3	6.5(8)	12(13)
	Eligible for choice	148	81.5	75.8	81.3	75.4	22.3(15.4)	40(26.6)
	Not Eligible for choice	148	98.9	98.6	98.8	98.4	5.8(6.4)	11.1(11.3)
15	All	130	96.4	94.9	96.2	94.5	12.2(13.1)	20.6(19.9)
	Eligible for choice	130	73.3	68.9	72.7	67.8	27.5(19.7)	43.7(28.6)
	Not Eligible for choice	130	99	97.9	98.9	97.6	9.7(9.6)	17.5(16.1)
16	All	177	93.1	92.8	92.7	92.3	13.6(14.4)	22.2(21.4)
	Eligible for choice	177	58.3	58.9	58.6	58.9	33.7(18.2)	52.5(27.5)
	Not Eligible for choice	177	97.3	96.9	97	96.6	10(9.5)	18.4(17)
17	All	94	94.5	94.3	94.4	94.2	12.1(17.3)	19.6(24.2)
	Eligible for choice	94	47.5	49.9	48	50.2	48.1(31.5)	69.2(42.2)
	Not Eligible for choice	94	99.1	98.7	99.1	98.6	8(7.8)	14.3(13.2)
18	All	60	85.5	85.3	85.1	85.1	18.6(27.4)	28.5(37.5)
	Eligible for choice	60	12.6	15.9	12.9	16.3	69.4(32.5)	98.1(46.1)
	Not Eligible for choice	60	93.2	92.7	93.1	92.6	8.2(7.8)	18.9(23.4)
19	All	94	88.4	88.9	87.6	88.1	16.5(27)	24.9(35.5)
	Eligible for choice	94	41.2	46.8	40.5	45.8	48.1(40.7)	68.1(54.4)
	Not Eligible for choice	94	97.2	96.8	96.9	96.5	7.3(7.7)	14.9(18.4)
20	All	92	90.6	91.3	90.6	91	13.2(18.4)	21.9(27.5)
	Eligible for choice	92	43	47.3	44	48	42.2(31.4)	65.9(48.2)
	Not Eligible for choice	92	97.7	97.9	97.7	97.6	8.2(8.2)	15.7(15)
21	All	98	94.6	93.9	94.1	93.3	9.1(13.4)	15.8(20.5)
	Eligible for choice	98	25.7	30	24.4	29	54.1(29.9)	83.4(41.1)
	Not Eligible for choice	98	97.2	96.3	97	96	7.1(7.5)	13.6(15.2)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
22	All	109	95.4	96.2	95.4	96.2	6.6(10)	11.4(15.1)
	Eligible for choice	109	17.8	19.8	18.4	20.8	55(23.7)	85.2(41.7)
	Not Eligible for choice	109	97.7	98.4	97.5	98.3	5.1(4.8)	10.1(9.9)
23	All	204	89.7	89.4	89.4	88.9	15.5(20.1)	25.7(30.4)
	Eligible for choice	204	63.9	63.2	63.7	62.8	35.2(29.3)	55.6(43.3)
	Not Eligible for choice	204	96.9	96.7	96.7	96.4	8.8(8.9)	17.4(18.4)

Table F-53 Access to Palliative care within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	1664	88.9	89.1	88.2	88.4	14.3(19.1)	22.5(26.4)
	Eligible for choice	1664	45.8	47	45.7	46.7	44.7(30.3)	66.9(41.9)
	Not Eligible for choice	1664	92.3	92.4	91.8	91.8	9.3(9)	19.1(21.2)
1	All	100	96.6	95.1	96.5	95	10(10.6)	16.8(17.2)
	Eligible for choice	100	70.2	67.9	69.3	66.9	29.1(20.5)	49.9(34.4)
	Not Eligible for choice	100	97.7	96.2	97.7	96.2	8.7(8.1)	15.6(15.1)
2	All	36	89.7	89.4	89.7	89.6	15.2(14.9)	24.5(22.1)
	Eligible for choice	36	48.2	44.7	46.5	43.3	36.4(19.8)	61.8(31.7)
	Not Eligible for choice	36	90.8	90.6	90.8	90.7	11.9(10.8)	23.5(20.9)
3	All	106	99.7	99.7	99.6	99.7	4(4.6)	7.5(7.3)
	Eligible for choice	106	100	100	100	100	18.9(7.7)	35.3(12.4)
	Not Eligible for choice	106	99.7	99.7	99.6	99.7	3.9(4.2)	7.4(7.3)
4	All	99	96.7	97.1	96.6	96.9	10.7(11.1)	17.5(15.8)
	Eligible for choice	99	58.3	60.2	57.9	58.9	32.5(17.1)	49.8(25.5)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	99	97.5	97.8	97.4	97.7	9.5(9)	16.9(15)
5	All	57	97.3	97.4	96.5	96.6	7.8(9.2)	13.5(12.9)
	Eligible for choice	57	80.5	91.3	74.8	88.7	20.3(12.6)	31.7(17)
	Not Eligible for choice	57	97.5	97.5	96.7	96.7	6.8(6.6)	13.2(12.7)
6	All	66	90.3	89.9	89.8	89.6	16.6(15.6)	26.3(22.5)
	Eligible for choice	66	58.4	60.3	58.4	60.7	35(18.5)	53.3(27)
	Not Eligible for choice	66	93.3	92.7	92.9	92.4	12.3(10.3)	23.4(19.8)
7	All	65	85.4	86.2	84.7	85.7	21(18.6)	32(25.7)
	Eligible for choice	65	46.1	47.4	45.3	46.4	40.7(21.4)	60.8(30.7)
	Not Eligible for choice	65	89	89.8	88.4	89.5	13.9(10.5)	28.5(22.6)
8	All	62	83.1	84.1	81.7	82.8	13(13.4)	21.1(19.7)
	Eligible for choice	62	21	18.9	18.9	17.3	48(17.2)	73.1(25)
	Not Eligible for choice	62	84	85.1	82.8	83.9	10.6(8.9)	20.1(18.1)
9	All	68	81	82.4	80.6	82.1	21.8(19)	33.4(27)
	Eligible for choice	68	55.6	54.1	55	53.3	37.4(19.8)	57.5(26.8)
	Not Eligible for choice	68	84.4	86.3	84.1	85.9	13.7(10.8)	29.7(25.1)
10	All	62	98.9	98.6	98.8	98.4	9.5(8.7)	15.9(13.1)
	Eligible for choice	62	77.2	78.3	74.1	75.4	27.5(11.8)	44.7(17)
	Not Eligible for choice	62	99.1	98.7	99	98.6	9.1(8)	15.7(12.8)
11	All	99	92.5	92.6	92.1	92.2	13(14.7)	21.2(21.6)
	Eligible for choice	99	76.1	75.3	75.5	74.4	26.2(18.7)	40.5(27)
	Not Eligible for choice	99	93.7	93.9	93.3	93.5	9.9(9.4)	19.9(20.6)
12	All	106	95.6	95.2	95	94.6	8.9(12.8)	15.1(18.3)
	Eligible for choice	106	83.6	76.9	83.2	76.2	24.5(19.6)	42.8(31.6)
	Not Eligible for choice	106	96.1	96.1	95.6	95.6	6.9(7)	14.2(17)
15	All	90	91.4	89.8	90.9	89.1	16.6(19)	26.6(27.6)
	Eligible for choice	90	54.4	52.5	54.9	52.5	43.7(30.1)	65.6(42.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	90	95.6	94	95.2	93.5	11.2(10.5)	21.3(19.9)
16	All	99	82.4	83.2	81.9	82.7	20.1(21.2)	30.5(28.7)
	Eligible for choice	99	30.4	35.6	30.9	35.9	47.5(20.7)	69.4(29.2)
	Not Eligible for choice	99	88.8	89.1	88.4	88.7	11.5(9.9)	25.5(24.5)
17	All	53	88	87.7	87.9	87.5	21.4(29.2)	31.3(36.9)
	Eligible for choice	53	46.7	45.6	46.7	45.5	46.2(27.8)	67.1(37.1)
	Not Eligible for choice	53	92.1	91.8	92	91.7	11.3(8.9)	27.5(34.8)
18	All	45	81.7	82.6	81.3	82.3	21.5(28.6)	32.2(38.8)
	Eligible for choice	45	14.6	18.3	13.9	17.7	69.1(35.7)	98.4(49)
	Not Eligible for choice	45	88.8	89.4	88.8	89.4	9.8(8.6)	23(26.2)
19	All	66	77.1	77.8	74.9	75.5	27.1(41.3)	37.6(50.5)
	Eligible for choice	66	24.5	31.6	24.3	31	67.7(45.3)	93.4(57.3)
	Not Eligible for choice	66	87	86.5	84.9	84.4	7.9(7.6)	24.9(38.9)
20	All	79	84.2	84.6	84.5	84.8	14.1(19.2)	23.2(29.5)
	Eligible for choice	79	36	40.4	36.3	40.1	46.2(32.1)	73.1(50.4)
	Not Eligible for choice	79	91.4	91.2	91.8	91.6	8.5(8)	15.8(14)
21	All	89	93.4	92.6	92.9	92.1	10.3(15.1)	17.3(22.7)
	Eligible for choice	89	38.8	38.7	38.5	38.5	55.4(41.4)	85.6(53.2)
	Not Eligible for choice	89	95.5	94.7	95.1	94.3	7.9(8.1)	15.1(17)
22	All	88	95	96	94.9	95.8	7.8(11.8)	12.9(16.4)
	Eligible for choice	88	23.4	28.8	21.8	27.4	58.1(33.3)	85.8(48.5)
	Not Eligible for choice	88	97.1	97.9	97	97.8	6(5.6)	11.6(11.5)
23	All	129	84.1	83	83.7	82.6	20(23.7)	31.9(34.7)
	Eligible for choice	129	57.2	55.2	56.8	54.6	39.9(27.6)	62.6(41.7)
	Not Eligible for choice	129	91.5	90.6	91.4	90.5	10.7(10.3)	23.2(26.7)

Table F-54 Access to Inpatient Palliative care within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	459	64.6	68.9	63	67.3	30.4(32.8)	41(40.5)
	Eligible for choice	459	17.1	20.5	17	20.1	70.7(37.9)	97.5(47.6)
	Not Eligible for choice	459	68.3	72.7	66.9	71.2	13.7(10.6)	36.8(36.7)
1	All	30	85.4	87	84.9	86.4	20.1(17.1)	28.8(23)
	Eligible for choice	30	43.6	45.9	42	44.3	48.6(33.5)	70.3(44.1)
	Not Eligible for choice	30	87.1	88.6	86.8	88.2	15.2(10.1)	27.4(20.5)
2	All	13	71	77.6	71.7	78.4	27(25.5)	36.6(31.2)
	Eligible for choice	13	0	6.4	0	6.1	73.5(22.2)	101.6(29.9)
	Not Eligible for choice	13	72.9	79.5	73.5	80.1	14.1(11.3)	34.8(29.3)
3	All	41	98.3	98.9	98.3	98.9	6.8(7.9)	11.2(11)
	Eligible for choice	41	42.7	42.7	42.3	42.3	50.1(30.1)	72.7(41.1)
	Not Eligible for choice	41	98.4	98.9	98.4	98.9	6.4(6.6)	11.2(10.9)
4	All	20	72.3	82.2	71.3	81.4	26(19)	34.8(22.3)
	Eligible for choice	20	30.5	45	29.9	43	45.2(18.1)	65.7(23.3)
	Not Eligible for choice	20	73.2	83	72.1	82.1	17.2(11.6)	34.3(21.9)
5	All	13	89.2	90	87.3	88.4	15.9(15.7)	23.4(20.7)
	Eligible for choice	13	56.6	65.7	45.8	57	38.6(14.8)	51.1(20.7)
	Not Eligible for choice	13	89.6	90.2	87.8	88.7	12.2(9.1)	23.1(20.5)
6	All	20	64.3	69.7	63.6	69.2	32.7(24.8)	45.7(34.4)
	Eligible for choice	20	29.7	32.5	29.4	32.5	50.5(22.8)	74.7(33.2)
	Not Eligible for choice	20	67.5	73.2	66.9	72.8	16.4(10.8)	42.6(33.1)
7	All	13	49.3	53.3	48.7	52.7	44.6(33.4)	57.9(40.4)
	Eligible for choice	13	8.5	12.7	8.2	12	67(25.5)	92.7(33.9)
	Not Eligible for choice	13	53.1	57.1	52.6	56.6	17.8(11.2)	53.6(39.1)
8	All	20	53.7	58.3	51.6	56.1	35.4(34.9)	45.6(40.3)
	Eligible for choice	20	0	0	0	0	82.5(29.9)	117.1(35.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	20	54.6	59.2	52.4	57.1	13.5(9.9)	44.1(39.1)
9	All	18	56	62.4	55.6	61.8	38.3(30.2)	51.2(38.5)
	Eligible for choice	18	18.2	19.3	17.6	18.7	65.2(29)	88.9(38.3)
	Not Eligible for choice	18	61.1	68.3	60.8	67.6	16.9(10.7)	45.4(35.1)
10	All	28	95.1	95.2	94.8	94.9	14.3(11.7)	22(16.5)
	Eligible for choice	28	62.2	71.9	57.7	67.9	32.5(10.6)	51.5(13.1)
	Not Eligible for choice	28	95.4	95.4	95.1	95.1	13.1(9.9)	21.8(16.3)
11	All	31	67.4	76.2	66.2	75.2	29.3(29.1)	39.2(34.7)
	Eligible for choice	31	41.3	53	40.9	51.6	49.6(33.5)	64.8(38.5)
	Not Eligible for choice	31	69.3	77.9	68	76.9	15(11.2)	37.6(33.8)
12	All	25	81.7	86	80.7	84.8	19.8(20.6)	28.6(28.7)
	Eligible for choice	25	51.8	45.9	52	45.7	47.1(33.5)	74.8(49.3)
	Not Eligible for choice	25	83.1	87.8	82.2	86.8	14.1(11.4)	27.1(26.5)
15	All	20	59.8	62.2	58.8	60.8	38.3(31.3)	51.9(41)
	Eligible for choice	20	14.5	10.7	15.3	11.6	74(25.8)	101.3(31.4
	Not Eligible for choice	20	65	68.1	63.9	66.6	16.6(10.9)	45.2(37.5)
16	All	30	48.5	51	47.6	50	45.6(43.3)	58.8(50.9)
	Eligible for choice	30	13.5	18.2	13.6	18.2	80(41.6)	106.2(49.2
	Not Eligible for choice	30	52.8	55	51.9	54.1	14(10.6)	52.8(47.9)
17	All	6	34.4	42.6	34	41.5	60.6(44.5)	75.5(52.8)
	Eligible for choice	6	14.4	16.2	14.6	16.2	81.2(41.5)	110.1(49.9
	Not Eligible for choice	6	36.4	45.2	35.9	44.1	23(11.8)	72.3(51.9)
18	All	16	68	69.3	67	68.3	36.6(41.7)	51.1(53.7)
	Eligible for choice	16	13.1	15	12.8	14.8	81.8(40.2)	114.1(54.4
	Not Eligible for choice	16	73.8	75.1	72.9	74.2	13.5(8.7)	42.4(47.4)
19	All	16	45.9	54.5	44.6	52.1	46(48)	57.4(56.9)
	Eligible for choice	16	10.4	14.6	10.1	13.7	103.3(53.7)	124.9(62.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Not Eligible for choice	16	52.6	62	51.5	59.7	14(11)	44.5(45.6)
20	All	25	63.4	67.4	62.2	66.3	29(30.2)	41.6(42.6)
	Eligible for choice	25	12.4	19.3	13.2	19.8	65.6(31.5)	97.4(46.8)
	Not Eligible for choice	25	71.1	74.6	69.7	73.5	12.8(9.5)	33.9(35.6)
21	All	21	73.8	75.1	72.2	73.2	23.7(29.3)	33.1(36.9)
	Eligible for choice	21	11	7.3	10.3	7	83.1(46.7)	121(54.3)
	Not Eligible for choice	21	76.2	77.7	74.7	75.9	13(10)	30.6(33)
22	All	21	81.6	86.1	80.4	85.2	19.9(25.4)	25.9(29.2)
	Eligible for choice	21	2.5	9.5	2.5	10.1	79.3(27.5)	114.3(40.3)
	Not Eligible for choice	21	83.9	88.3	82.6	87.3	11.3(8.8)	24.4(26.6)
23	All	32	52.7	54.8	51.1	53.1	42.1(39.1)	58.2(51.1)
	Eligible for choice	32	13.5	16.9	13.3	16.4	70.2(34.4)	100.9(46.7)
	Not Eligible for choice	32	63.5	65.2	61.9	63.6	13.6(10.7)	46.7(45.9)

Table F-55 Access to Hospice care within 40 mile and 60 minute driving distances

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
All	All	962	77.2	79.9	76.2	78.9	22.7(25)	32.4(32.3)
	Eligible for choice	962	41.3	42	41.4	41.7	49.4(32)	72.7(43.5)
	Not Eligible for choice	962	80	82.9	79.1	82	12.8(10.5)	29.4(29.1)
1	All	49	88	89.6	87.6	89.2	16.1(15.9)	23.8(21.8)
	Eligible for choice	49	39.5	45.4	38.6	44.1	46.2(18.4)	68.1(26.8)
	Not Eligible for choice	49	89.9	91.4	89.7	91.2	11.7(9.5)	22.3(20)
2	All	17	75.2	79.8	75.7	80.2	24.3(21.7)	35.3(30.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	17	12.3	13.2	12.7	14	60.9(16.3)	95.6(29.1)
	Not Eligible for choice	17	76.9	81.6	77.2	81.8	14.4(11.6)	33.7(28.4)
3	All	47	98	98.5	97.8	98.4	6.6(7.7)	11.3(11.1)
	Eligible for choice	47	42.7	42.7	42.3	42.3	33.9(33.7)	58.5(52.3)
	Not Eligible for choice	47	98	98.5	97.9	98.4	6.1(6.4)	11.3(11)
4	All	55	94	93.4	94.1	93.6	15.9(13.6)	24.7(19.7)
	Eligible for choice	55	72.3	58.9	69.9	55.5	34.7(16.8)	53.1(25.4)
	Not Eligible for choice	55	94.4	94.1	94.6	94.4	13.8(10.6)	24.2(19.2)
5	All	24	88.2	89.8	85.3	87.2	13(14.2)	20.4(19.1)
	Eligible for choice	24	80.7	84.4	76.8	79.8	27.2(13.5)	38.8(16.5)
	Not Eligible for choice	24	88.3	89.9	85.4	87.2	9.7(8.4)	20.2(19)
6	All	43	76.6	78.9	76.1	78.6	26.9(26.1)	38.7(35.2)
	Eligible for choice	43	60	60.9	60.6	61.2	38.5(23.1)	59.4(35.5)
	Not Eligible for choice	43	78.1	80.6	77.7	80.3	15.4(11)	36.4(34.5)
7	All	34	71.8	73.9	70.5	72.7	31.8(27.6)	44.7(35.3)
	Eligible for choice	34	38.7	39.8	37.4	38	45.1(23.7)	67.8(34.5)
	Not Eligible for choice	34	74.9	77.1	73.6	76	16.4(10.7)	41.8(34.4)
8	All	24	58.2	61.5	56.8	60.1	34.7(31.8)	45.8(37.7)
	Eligible for choice	24	15.3	14.5	14	13.3	66(35.1)	96.5(48.9)
	Not Eligible for choice	24	58.9	62.3	57.6	60.9	14.5(10.2)	45(36.9)
9	All	37	69.1	76.4	69.1	76.1	30.3(22.2)	43(29.7)
	Eligible for choice	37	36.1	34.9	35.5	34.2	51.6(24.2)	74.3(32)
	Not Eligible for choice	37	73.6	82	73.7	81.7	18.2(11.8)	38.2(26.2)
10	All	46	97.8	97.2	97.6	97	11.6(9.9)	18.7(14.7)
	Eligible for choice	46	77.2	79	74.1	77.2	24.5(12.6)	42.4(17.2)
	Not Eligible for choice	46	97.9	97.3	97.8	97.2	11(8.9)	18.5(14.6)
11	All	68	89.3	90.1	88.9	89.6	17.5(16.3)	27.1(23.1)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	68	67.5	71.8	68.1	71	30.9(19)	45.9(24.9)
	Not Eligible for choice	68	91	91.4	90.4	90.9	13.7(11)	25.8(22.4)
12	All	55	81.7	87.3	80.3	86.1	17.7(16.7)	26.3(23)
	Eligible for choice	55	61.4	53.7	60.4	52.9	31.3(22.5)	54.2(38.9)
	Not Eligible for choice	55	82.7	88.8	81.3	87.8	12.9(11.4)	25.4(21.8)
15	All	52	79.1	79	78.3	78	24(20.3)	35.3(27.9)
	Eligible for choice	52	52.2	49.7	53.2	50	39.3(20.3)	60.1(28.1)
	Not Eligible for choice	52	82.1	82.3	81.3	81.3	14.9(11.3)	32(26.2)
16	All	47	59.8	63.3	59.9	63.2	34.4(29.8)	46(36.7)
	Eligible for choice	47	23.1	27.2	23.3	27.6	55.3(24.1)	79.4(33.1)
	Not Eligible for choice	47	64.2	67.7	64.6	67.7	14(10.5)	41.7(34.9)
17	All	25	69	79.9	68.9	79.6	30.9(27.3)	41.2(35.3)
	Eligible for choice	25	42.6	38	41.8	37.2	49.4(27.5)	70.6(35.2)
	Not Eligible for choice	25	71.6	84	71.7	83.9	18(11.8)	38.1(33.9)
18	All	35	69.5	73.9	69.2	73.1	36.1(37.6)	49.1(47.8)
	Eligible for choice	35	17.5	19.2	17.5	19.4	64.8(37.1)	96.2(53.7)
	Not Eligible for choice	35	75.1	79.8	74.9	79	16.2(12)	42.7(43.1)
19	All	50	59.3	62.1	59.6	61.9	38(43.8)	48.6(52.3)
	Eligible for choice	50	21.9	26.9	22.5	27.3	78.9(45.5)	105(57)
	Not Eligible for choice	50	66.3	68.7	67	68.8	11.7(10.1)	36(41.8)
20	All	47	78.3	81.8	77.9	81.5	21.3(20.7)	31.4(30)
	Eligible for choice	47	38	45.8	39.3	46.8	46.5(30.7)	70.9(47.9)
	Not Eligible for choice	47	84.3	87.2	83.8	86.8	13.7(10)	25.6(20.9)
21	All	38	79.2	79.7	77.9	78.7	18.5(20.8)	28.4(30)
	Eligible for choice	38	20.1	19.3	21.4	20.8	64.3(40.8)	97.1(49.7)
	Not Eligible for choice	38	81.4	82	80.3	81.1	11.2(10)	26.3(26.5)
22	All	30	88.6	90.4	88	89.8	15(19.2)	21.1(23.7)

VISN	Choice Eligibility	Hospitals with the service (N)	Enrollees (%)		Users (%)		Mean (SD) drive distance and time to closest facility with the service	
			40 miles	60 min.	40 miles	60 min.	Miles	Minutes
	Eligible for choice	30	33.7	33.1	31.4	30.6	66.3(41.9)	93.4(55.2)
	Not Eligible for choice	30	90.2	92.1	89.6	91.5	9.8(8.1)	19.8(20.5)
23	All	139	86.8	86.2	86.1	85.4	19(22.4)	30.2(32.3)
	Eligible for choice	139	61.1	57.4	60.5	56.7	39.5(31.4)	61.1(44)
	Not Eligible for choice	139	93.9	94.1	93.4	93.6	11(10.1)	21.5(21.3)

Appendix F.5 Access to Non-VA Specialists

This section, Tables F-56 to F-67, provides more limited information for non-VA physician services from our analysis of the SK&A physician database. For each service, the tables show the mean distance in miles and the mean travel time in minutes for all enrollees, enrollees eligible for Choice, and enrollees not eligible for Choice. The percent of enrollees and users with access is not included. The physician services include cardiologists (Table F-56), endocrinologists (Table F-57), gastroenterologists (Table F-58), general surgeons (Table F-59), hematologists-oncologists (Table F-60), mental health providers (psychologists and psychiatrists((Table F-61), neurosurgeons (Table F-62), neurologists (Table F-63), obstetricians and gynecologists (Table F-64), physical medicine and rehabilitation specialists (Table F-65), primary care physicians (Table F-66), and thoracic surgeons (Table F-67).

All tables show the mean driving distance (in miles) and driving time (in minutes), along with the standard deviation for each. The mean driving distance is defined as the mean distance along the existing road network (as opposed to straight-line distance) for all enrollees in that VISN to the hospital nearest where they live. For these analyses we used a cutoff of 40 miles, meaning that we took the mean driving distance and mean drive time to the nearest non-VA providing within 40 miles.

In some cases the standard deviation is larger than the mean distance or driving time. This suggests that the distribution of mean distances and driving times skews to the right, meaning that a few enrollees live quite far from the nearest physician office. This would tend to be the case in more rural areas.

Data in Tables F56-F67 are RAND estimates derived from the VA Planning Systems Support Group (PSSG) Enrollee file and the SK&A Office-Based Physician, Nurse Practitioner, and Physician Assistant Database.

Table F-56 Access to Cardiologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	8.7(8.5)	12.9(9.4)	19.1(10.7)	22.9(11.1)	8.4(8.2)	12.6(9.2)
1	8(8)	11.8(8.8)	18.5(10.8)	20.3(9.8)	7.9(7.9)	11.7(8.7)
2	11.6(9.6)	16.3(10.5)	20.9(11.6)	27.6(12)	11.5(9.5)	16.2(10.4)
3	3.1(3.7)	6.1(5.9)	18.5(10)	26.4(3.7)	3.1(3.6)	6.1(5.9)
4	8.7(8.2)	13.3(9.7)	17.6(11.2)	22.9(10.1)	8.6(8.1)	13.3(9.7)
5	7.4(7.5)	11.8(8.7)	14(8.9)	19.9(8.3)	7.3(7.5)	11.7(8.7)
6	12.4(9.4)	18(10)	16.7(9.3)	23.5(10.6)	12.1(9.3)	17.6(9.9)
7	12.1(9.4)	17.2(9.6)	20.6(10.5)	24(10.2)	11.5(8.9)	16.8(9.4)
8	7.4(6.9)	12.4(8.2)	15.7(11.2)	17.9(11.9)	7.3(6.7)	12.3(8.1)
9	12.6(9.7)	17.2(10.2)	19.5(9.9)	24.8(9.9)	11.9(9.3)	16.6(10)
10	8(7.4)	12.7(8.9)	17(7)	26.2(7.8)	8(7.3)	12.7(8.9)
11	10(8.8)	14.8(10.2)	16.1(10.2)	20.9(11.8)	9.7(8.6)	14.5(10.1)
12	7.3(8.2)	10.9(8.9)	21.2(9.8)	22.7(12.7)	7.2(8)	10.8(8.8)
15	11.8(10.5)	14.8(10)	19.4(11)	23.4(11.7)	11.4(10.3)	14.4(9.8)
16	10.4(9.3)	14.7(9.7)	21.2(10.8)	23.8(11.5)	9.7(8.8)	14.4(9.4)
17	9.2(8.4)	13.7(8.9)	21.2(10.8)	24.5(11.2)	8.6(7.7)	13.3(8.5)
18	8.2(8)	12.9(8.5)	13.5(12.6)	14.9(10.4)	8.1(7.8)	12.9(8.5)
19	8.6(8)	13.2(8.8)	15.7(12.4)	16.4(11.3)	8.1(7.4)	13.1(8.6)
20	9.6(8.5)	14.4(9.2)	18.4(10.4)	22.6(10.8)	9.2(8.3)	14.2(9)
21	7.2(7.3)	11.1(8.1)	21(8)	29.1(7.4)	7.1(7.2)	11(8)
22	5.6(5.5)	9.7(6.7)	15.9(10.1)	23.1(10.4)	5.5(5.4)	9.7(6.6)
23	11.9(10.4)	14.8(10.3)	23.2(10.3)	25.8(10.8)	10.9(9.7)	14.2(9.9)

Table F-57 Access to Endocrinologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	9.8(9)	13.8(9.2)	24.2(11.2)	24.2(10.9)	9.6(8.8)	13.7(9.2)
1	8.9(8.2)	13(9.1)	36.2(5.2)	0(0)	8.8(8.1)	13(9.1)
2	13(10.3)	16.2(10.4)	14.4(7.4)	19.1(13.4)	13(10.3)	16.2(10.4)
3	4.5(5.1)	8(7)	18.5(10)	26.4(3.7)	4.5(5.1)	8(7)
4	10.7(9.4)	15(9.9)	22.9(11)	24.5(7.8)	10.6(9.3)	14.9(9.9)
5	8.2(7.6)	13(8.6)	16.3(7.9)	24.1(7.8)	8.1(7.6)	12.9(8.6)
6	14.3(10.5)	18.4(9.8)	20.7(12.8)	20.2(11.7)	14(10.3)	18.3(9.7)
7	13.8(10.2)	17.9(9.8)	21.3(11.5)	19.7(9.7)	13.6(10.1)	17.9(9.8)
8	8.9(7.5)	14.1(8.4)	24.4(12.6)	10.7(4.6)	8.8(7.4)	14.1(8.4)
9	15(11.4)	17.2(10.3)	24.2(9.8)	27.7(9.4)	14.5(11.2)	16.8(10.2)
10	10.4(9.1)	14.5(9.4)	30.2(9.9)	28.1(0.7)	10.3(9)	14.5(9.4)
11	11.7(9.7)	15.5(9.5)	26.8(11.2)	26.1(12.5)	11.3(9.4)	15.3(9.4)
12	8.1(8.2)	12(8.8)	26.6(8.5)	30.1(13.6)	8.1(8.1)	12(8.7)
15	11.8(9.9)	14.9(9)	28.6(12)	21.4(17.2)	11.5(9.7)	14.9(8.9)
16	11.1(9.4)	15.4(9.3)	25.5(10.7)	24.3(9.2)	10.8(9.1)	15.3(9.3)
17	10.8(9)	15.3(9.4)	25.5(10.9)	23.2(12.9)	10.5(8.7)	15.2(9.4)
18	9.3(7.3)	15(8.5)	16.2(13.1)	19.9(11.4)	9.3(7.2)	15(8.4)
19	9.8(8.7)	14.4(8.9)	17.3(12.5)	18.3(12)	9.7(8.6)	14.3(8.9)
20	10.3(9)	15.1(9.3)	23.1(8.5)	29.1(5.7)	10.1(8.9)	14.9(9.2)
21	9.3(8.4)	13(8.8)	27.9(8.7)	29.7(10.4)	9.2(8.3)	13(8.8)
22	6.9(6)	11.3(7)	28.8(11.2)	33.7(5.5)	6.9(5.9)	11.3(6.9)
23	10.3(9.4)	13.7(9.2)	28.7(6.8)	33(5.4)	9.8(8.9)	13.6(9)

Table F-58 Access to Gastroenterologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	9.2(8.8)	13.2(9.4)	20.3(11)	22.6(10.9)	8.9(8.6)	13.1(9.3)
1	8.2(8)	12(8.7)	21.3(10.1)	23.5(10.2)	8(7.8)	11.9(8.6)
2	12.6(9.9)	17.2(10.8)	22.3(9)	30(9.9)	12.5(9.9)	17.2(10.7)
3	3.6(4.3)	6.8(6.4)	18.5(10)	26.4(3.7)	3.6(4.3)	6.7(6.4)
4	10(9)	14.5(10.1)	21.5(11)	25.9(10.8)	9.9(8.9)	14.4(10.1)
5	7.8(7.8)	12.4(9)	13.3(9.3)	18.8(9.2)	7.8(7.8)	12.3(9)
6	13(10.1)	17.5(10.2)	18.1(10.5)	22.1(11)	12.6(10)	17.3(10.2)
7	12.3(9.7)	16.9(9.7)	19.5(10.5)	23.5(10.6)	11.9(9.5)	16.6(9.5)
8	7.8(7)	13(8.3)	23.5(9.6)	23.7(11.8)	7.7(6.7)	12.9(8.3)
9	13.1(10.1)	17.2(10.2)	21.2(9.8)	25.7(9.8)	12.4(9.8)	16.7(10.1)
10	9.6(8.5)	14(9.3)	23.9(11.7)	24.5(6.9)	9.5(8.5)	13.9(9.3)
11	11.8(10.1)	15.4(10)	19(11.7)	21(12.1)	11.5(9.9)	15.2(9.9)
12	7.2(7.6)	11.2(8.6)	24.6(8.2)	28.1(10.6)	7.1(7.4)	11.1(8.6)
15	11.3(10.3)	14.5(9.8)	28.6(9)	30.1(6.9)	11(10)	14.4(9.7)
16	10.9(9.3)	15.3(9.4)	22(11.1)	20.8(8.7)	10.4(8.9)	15.2(9.4)
17	9.5(8.6)	13.8(8.9)	22.7(9.9)	25.2(10.6)	9.1(8.3)	13.6(8.8)
18	7.9(7.2)	13.2(8.2)	13.8(12.9)	15.5(7.3)	7.9(7.2)	13.2(8.2)
19	8.8(8.5)	13.4(9.1)	15.3(13)	15.9(11.2)	8.4(8.1)	13.3(9)
20	9.7(8.9)	14.4(9.3)	16.2(10.4)	20(10.4)	9.5(8.8)	14.3(9.2)
21	7.8(7.6)	11.7(8.6)	23.1(8)	31.8(6.2)	7.7(7.4)	11.7(8.5)
22	6.6(6.4)	10.7(7.1)	19.2(13.8)	21.2(12.5)	6.5(6.3)	10.6(7.1)
23	12.3(10.8)	14.8(10.3)	23.2(10.3)	24.8(11.6)	11.7(10.5)	14.5(10.1)

Table F-59 Access to General Surgeons

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	VISN	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	8.7(8.5)	12.9(9.4)	18.4(10.7)	22.3(11.3)	8.3(8.1)	12.6(9.2)
1	8.1(8)	11.9(8.9)	18.4(9.2)	23.7(10.3)	7.9(7.8)	11.8(8.8)
2	11.2(9.6)	15.7(10.8)	20.7(10.8)	27.2(11.5)	11.1(9.6)	15.5(10.7)
3	3.8(4.6)	7(6.6)	18.5(10)	26.4(3.7)	3.8(4.6)	7(6.6)
4	8(7.7)	12.7(9.4)	17.4(10)	23.3(9.7)	7.9(7.6)	12.7(9.4)
5	7.5(7.4)	12(8.6)	14.1(8.5)	19(6.1)	7.4(7.4)	11.9(8.6)
6	12.4(9.2)	17.9(10)	17.5(9.6)	23.5(10.3)	12(9.1)	17.5(9.9)
7	11.9(8.9)	17.5(9.9)	18(9.8)	23.2(10.2)	11.3(8.6)	17.1(9.7)
8	7.5(6.7)	12.7(8.5)	17.1(9.5)	23.2(11.5)	7.4(6.6)	12.6(8.4)
9	12.6(9.8)	17.1(10.4)	18.5(10)	23.8(10.2)	11.9(9.5)	16.5(10.2)
10	8.1(7.6)	12.7(9)	20.1(8.5)	25.4(6.3)	8.1(7.6)	12.6(9)
11	9.5(8.5)	14.2(10)	15(9.9)	20.4(11.4)	9.2(8.4)	13.9(9.8)
12	7(7.5)	11(8.8)	19.3(10.5)	23.3(12.7)	6.8(7.2)	10.9(8.7)
15	11.6(10.3)	14.9(10.2)	20(11)	23.3(12.1)	11(10)	14.4(9.9)
16	10.8(9.4)	15(9.7)	20.9(10.3)	23.7(10.9)	10(8.9)	14.6(9.5)
17	9(8.4)	13.2(8.8)	20.9(11)	22.8(12.1)	8.2(7.6)	12.8(8.5)
18	8.3(8)	13(8.7)	14.4(13.2)	15.1(13)	8(7.6)	13(8.5)
19	8.8(8.7)	12.9(9.1)	17(12.8)	17.4(11.6)	7.9(7.7)	12.5(8.8)
20	9.9(9.3)	14.3(9.3)	15.7(10.5)	21.2(11.3)	9.5(9)	13.9(9.1)
21	7.4(7.4)	11.2(8.3)	20.9(9.1)	28.3(9.8)	7.2(7.2)	11.1(8.2)
22	5.5(5.4)	9.5(6.7)	15.6(12.3)	20(12.6)	5.4(5.3)	9.5(6.6)
23	11.6(10.4)	14.4(10.6)	20.5(10.6)	23.5(11.9)	10.3(9.8)	13.6(10.1)

Table F-60 Access to Hematologists-Oncologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	9.7(8.8)	13.9(9.4)	19.6(10.9)	22.6(11)	9.4(8.6)	13.8(9.3)
1	8.8(8)	12.9(8.9)	21.3(10.4)	23.5(10.3)	8.6(7.8)	12.9(8.8)
2	13(10.2)	16.7(10.5)	22.6(9.1)	30.8(5.9)	13(10.2)	16.6(10.4)
3	4.5(5)	7.9(6.9)	18.5(10)	26.4(3.7)	4.4(5)	7.9(6.9)
4	9.8(8.8)	14.4(9.8)	19.9(11.4)	22.5(10.2)	9.7(8.7)	14.3(9.8)
5	8.3(7.4)	13.2(8.6)	13.3(9.3)	18.8(9.2)	8.2(7.3)	13.1(8.5)
6	13.2(9.5)	18.5(9.9)	17.4(9.6)	23(10)	12.9(9.4)	18.2(9.8)
7	12.9(9.2)	18.2(9.7)	19.3(11)	23.8(10.6)	12.5(8.9)	17.9(9.6)
8	8.1(6.9)	13.4(8.2)	22.8(10.2)	21.9(11.4)	8(6.7)	13.4(8.1)
9	14.1(10.3)	18.2(10.4)	20.2(10.6)	23.5(10.7)	13.5(10)	17.8(10.2)
10	9.9(8.5)	14.4(9.3)	20.1(8.2)	27(8.5)	9.8(8.4)	14.4(9.3)
11	11.6(9.3)	16.2(10)	17.3(9.9)	22.2(11.6)	11.4(9.2)	15.9(9.8)
12	7.7(7.7)	11.9(8.8)	20.6(10.7)	21.6(11.7)	7.6(7.5)	11.9(8.8)
15	13(10.7)	15.9(10.3)	19.6(11.7)	21.8(13)	12.6(10.5)	15.7(10.1)
16	11.4(9.7)	15.4(9.5)	22.3(10.5)	23.2(9.7)	10.9(9.3)	15.2(9.4)
17	10.9(9.1)	15.5(9.6)	21.1(11.3)	23.5(11.9)	10.4(8.8)	15.3(9.5)
18	8.9(7.7)	14.4(8.5)	10.7(11.9)	13.6(10.5)	8.9(7.6)	14.4(8.5)
19	9.4(8.2)	14.3(9.2)	14(11.2)	17.2(9.8)	9.2(8)	14.2(9.2)
20	10(8.9)	14.5(9.1)	18(11.1)	22.4(12)	9.6(8.6)	14.2(8.8)
21	8.4(8)	12.3(8.8)	23.8(8.1)	32.2(8.1)	8.3(7.9)	12.3(8.7)
22	6.6(6.6)	10.7(7.1)	16.8(11.5)	23.4(12.3)	6.6(6.5)	10.6(7)
23	12.6(10.6)	15.1(10.3)	23.4(11.1)	23.6(11.8)	11.5(9.9)	14.6(10)

Table F-61 Access to Mental Health Providers (Psychologists and Psychiatrists)

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	7.7(8.2)	11.6(9.3)	18.5(10.6)	22.5(11.2)	7.2(7.8)	11.3(9)
1	6.4(6.9)	10.4(8.4)	16.6(10.3)	21.4(11.2)	6.2(6.6)	10.2(8.3)
2	9.3(8.3)	14.2(10.6)	18.4(7.5)	28.6(9.5)	9.1(8.3)	14(10.5)
3	3(3.6)	5.9(5.7)	14.5(3.1)	30.1(6.9)	3(3.6)	5.9(5.7)
4	7.3(7.6)	11.7(9.4)	17.1(9.3)	23(10)	7.2(7.5)	11.6(9.3)
5	6.2(6.9)	10.4(8.2)	12.2(7.5)	19(8.2)	6.2(6.8)	10.4(8.2)
6	11(9.2)	15.9(9.9)	18.4(9.3)	24.1(10.4)	10.3(8.9)	15.4(9.6)
7	10.6(9.2)	15.5(10)	19.3(10.5)	23.9(10.2)	9.8(8.7)	15(9.7)
8	6.7(6.5)	11.5(8.2)	21.8(9.7)	25(10.3)	6.5(6.3)	11.5(8.1)
9	11.7(9.7)	16.4(10.6)	19.4(9.7)	25(10.3)	10.8(9.2)	15.7(10.3)
10	7.5(7.7)	11.7(9)	21.4(9.2)	22.8(5.4)	7.4(7.6)	11.7(9)
11	8.6(8.7)	12.7(10)	15.3(10.1)	21.1(11.8)	8.3(8.5)	12.4(9.7)
12	6.1(6.9)	9.9(8.7)	18.5(9.6)	25.3(12.2)	5.9(6.7)	9.7(8.5)
15	11.3(10.5)	14(10.4)	20.1(10.1)	25(12.1)	10.7(10.3)	13.4(10)
16	10.1(9.5)	14.1(9.9)	19.5(10.8)	22.4(10.3)	9.3(9)	13.7(9.6)
17	8.7(8.6)	12.7(9)	21.2(11.7)	22.1(12.5)	8(7.9)	12.4(8.7)
18	7.1(7.6)	11.5(8.7)	13.1(12.4)	14.2(11.1)	6.9(7.4)	11.4(8.6)
19	7(7.8)	11(8.4)	13.1(11.8)	15.4(10.6)	6.5(7.1)	10.7(8.2)
20	8.1(8.3)	12.5(9)	16.7(11)	20.2(11.4)	7.6(7.8)	12.1(8.7)
21	5.7(6.4)	9.6(8)	19.6(10.3)	26.3(9.9)	5.5(6.1)	9.4(7.9)
22	4.4(4.8)	8.2(6.3)	18.6(10.2)	24.6(12)	4.3(4.6)	8.1(6.2)
23	10.7(10.3)	13.6(10.7)	20.7(10.7)	23.3(11.7)	9.5(9.6)	12.9(10.3)

Table F-62 Access to Neurosurgeons

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	11(9.2)	15.1(9.4)	23.6(11.3)	24(10.8)	10.8(9.1)	15(9.3)
1	11.4(9)	15.6(9.5)	27.9(4.7)	35.4(0.7)	11.4(8.9)	15.6(9.5)
2	12.8(10.5)	15.9(10.2)	26.6(11.9)	28.6(.)	12.8(10.5)	15.9(10.2)
3	7.1(6.8)	10.8(7.6)	36.8(0.9)		7.1(6.8)	10.8(7.6)
4	11.3(9.6)	15.7(10.2)	18.8(11.8)	22.2(11.4)	11.2(9.6)	15.7(10.2)
5	9.8(8.1)	14.5(9.1)	26.4(5.4)	33.1(2)	9.6(8)	14.4(9)
6	15(10.6)	18.8(9.7)	23.3(12.2)	22.8(10.7)	14.8(10.5)	18.7(9.7)
7	14(10.2)	18.2(9.7)	19.6(10.4)	24.2(9.1)	13.9(10.2)	18.1(9.7)
8	9.9(7.6)	15.2(8.5)	30.1(1.9)		9.8(7.6)	15.2(8.5)
9	15.9(10.9)	19.2(10.6)	24(10.7)	26.1(11.6)	15.5(10.7)	19.1(10.5)
10	11.8(9.6)	15.8(9.5)	21(14.5)	28.9(10)	11.8(9.6)	15.8(9.5)
11	12.3(10.2)	16(9.8)	23.3(10.4)	24.7(11.5)	12(10)	15.8(9.7)
12	9.5(8.7)	13.3(9)	22.4(10.8)	21.2(15.3)	9.4(8.7)	13.3(8.9)
15	12(9.8)	15.3(9.2)	22.9(12.4)	23.9(14)	12(9.7)	15.3(9.2)
16	12.1(9.7)	16.6(9.6)	24.1(11.9)	23(10.3)	11.7(9.4)	16.5(9.6)
17	11.9(9.2)	16.5(9.2)	28.8(10.4)	27.7(6.8)	11.7(9.1)	16.4(9.2)
18	10(7.3)	16(8.4)	39.7(0.1)		9.9(7.2)	16(8.4)
19	10.8(9.1)	15.7(9.6)	20.1(13.1)	19.3(10.4)	10.5(8.8)	15.7(9.6)
20	11.4(9.1)	15.9(9.3)	17(10.9)	21.7(11)	11.3(9.1)	15.9(9.3)
21	10.7(9.2)	14.5(9.3)	33(4.1)		10.7(9.2)	14.5(9.3)
22	8(6.7)	12.6(7.7)	35.9(3.1)	35.8(.)	8(6.7)	12.6(7.7)
23	11.5(10.1)	14.1(9.5)	31.1(7.9)	28.7(17.3)	11(9.7)	14(9.4)

Table F-63 Access to Neurologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	9(8.7)	13(9.3)	20.4(10.9)	23.1(10.9)	8.7(8.4)	12.8(9.1)
1	8(7.7)	12(8.8)	18.8(10.1)	23.3(9.5)	7.9(7.5)	11.9(8.7)
2	12(10.1)	16(10.6)	19.8(7.8)	30.4(10.7)	11.9(10.1)	15.9(10.6)
3	3.9(4.6)	7.1(6.8)	18.5(10)	26.4(3.7)	3.9(4.6)	7.1(6.8)
4	9.7(8.9)	14.1(10)	20.9(11.7)	23.1(10.5)	9.5(8.8)	14(10)
5	7.7(7.6)	12.1(8.4)	15.3(7.5)	21.5(6.1)	7.6(7.6)	12.1(8.4)
6	12.8(10.1)	17.5(10.1)	17.4(10.2)	22.6(11)	12.5(10)	17.2(10)
7	12.4(9.4)	17.4(9.6)	20.5(10.8)	22.7(9.9)	11.9(9.1)	17.2(9.5)
8	7.4(6.8)	12.3(7.8)	24.1(11.2)	17.4(11.5)	7.2(6.6)	12.3(7.8)
9	13(10.4)	16.6(10.1)	21.9(10.5)	25(10.5)	12.2(10)	16.2(9.9)
10	9.6(8.5)	14(9.4)	22.5(8.9)	25.8(6.7)	9.5(8.4)	14(9.3)
11	10.8(9.5)	14.9(9.9)	18(10.5)	22.4(12.1)	10.5(9.3)	14.6(9.7)
12	7.4(7.9)	11.3(8.8)	19.9(8.7)	26.5(10.2)	7.3(7.7)	11.2(8.7)
15	11.4(10.3)	14.2(9.5)	24.6(10.9)	25.4(11.4)	11.1(10)	14(9.4)
16	10.7(9.4)	14.9(9.4)	22(11)	23.5(10.4)	10.2(9.1)	14.7(9.3)
17	9.3(8.4)	13.9(8.7)	24.4(10)	27.1(8.6)	9(8)	13.8(8.6)
18	7.9(7.6)	12.8(8.3)	11.5(11.5)	12.5(7.5)	7.8(7.5)	12.8(8.3)
19	8.1(7.8)	12.6(8.5)	17(12)	18.9(11.6)	7.7(7.4)	12.4(8.3)
20	9.2(8.8)	13.7(9)	17.3(11.8)	19.9(11.8)	9(8.6)	13.5(8.9)
21	7.8(7.8)	11.7(8.4)	25.8(8.8)	30.7(6.5)	7.8(7.7)	11.6(8.4)
22	6(6.2)	9.9(7)	26.5(10.6)	26.9(11.5)	5.9(6.1)	9.9(7)
23	11.2(10)	14.2(10)	25.1(9.6)	27(9.9)	10.4(9.5)	13.9(9.8)

Table F-64 Access to Obstetricians & Gynecologists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	7.9(8.3)	12(9.2)	18.5(11.1)	21.8(11.5)	7.5(7.9)	11.7(9)
1	7.2(7.4)	11.1(8.6)	19.2(9.7)	24.3(9.7)	7(7.1)	10.9(8.4)
2	10.2(9.5)	14.6(10.9)	19.4(9.5)	28.3(10.3)	10.1(9.5)	14.4(10.8)
3	3(3.7)	5.9(5.7)	18.5(10)	26.4(3.7)	3(3.7)	5.9(5.7)
4	7.7(7.6)	12.3(9.3)	16.3(11.1)	19.2(9.4)	7.6(7.5)	12.3(9.3)
5	6.3(6.8)	10.6(8.2)	12.7(8.5)	19.9(9.8)	6.3(6.7)	10.5(8.1)
6	11.1(9.1)	16.5(9.9)	17.4(10.1)	22.6(10.5)	10.6(8.8)	16.1(9.7)
7	11(9.1)	16(9.9)	18(10.3)	22.6(10.5)	10.4(8.7)	15.5(9.7)
8	7.2(6.7)	12.2(8.4)	18.6(10.7)	20.6(13.6)	7.1(6.5)	12.2(8.3)
9	12.2(9.9)	16.4(10.2)	18.6(10)	24(10.5)	11.5(9.6)	15.8(10)
10	7.8(7.2)	12.5(8.9)	15.7(7)	23.3(6.7)	7.7(7.2)	12.4(8.9)
11	8.7(8.4)	13.3(10)	15.7(10.4)	20.5(12)	8.3(8.1)	12.9(9.8)
12	6.2(7.4)	9.8(8.6)	20.2(9.8)	25.8(13.1)	6.1(7.2)	9.7(8.5)
15	11.4(10.6)	14.1(10.2)	20.3(11.9)	22(13.1)	10.8(10.3)	13.8(10)
16	10(9.5)	13.9(9.7)	20.6(11.5)	22(11.4)	9.2(8.9)	13.6(9.4)
17	8.3(8.3)	12.5(8.8)	21.1(11.4)	22.7(12.2)	7.6(7.5)	12.2(8.5)
18	7.1(7.5)	11.7(8.3)	13.8(13.9)	12.1(10)	6.9(7.2)	11.7(8.3)
19	7.9(8.6)	11.7(9)	16.8(13.1)	16.3(11.1)	7(7.5)	11.4(8.7)
20	8.8(8.5)	13.4(9)	16.3(10.6)	21(11.6)	8.3(8)	13(8.7)
21	6.5(6.7)	10.5(8.1)	20(9)	26.7(9.9)	6.3(6.5)	10.3(8)
22	4.4(4.9)	8.2(6.4)	18.5(12.6)	20.4(12.8)	4.3(4.6)	8.2(6.3)
23	11.2(10.5)	13.8(10.5)	21.5(10.9)	23.6(12.2)	10(9.8)	13.2(10)

Table F-65 Access to Physical Medicine & Rehabilitation Specialists

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	9.4(8.9)	13.4(9.4)	21.4(11.7)	22.1(11)	9.2(8.7)	13.4(9.3)
1	9.5(8.2)	13.8(9)	21.2(11.4)	23(10.4)	9.4(8.1)	13.7(9)
2	12.7(10.6)	16.1(10.6)	19.5(13.1)	21.7(11.7)	12.7(10.6)	16.1(10.6)
3	4.1(5.3)	7.3(7.2)	19(0.9)	35.3(3.7)	4.1(5.3)	7.3(7.2)
4	9.3(8.8)	13.6(9.8)	19.9(13)	18.8(8.3)	9.3(8.7)	13.6(9.8)
5	7.9(7.3)	12.5(8.3)	20.8(9)	22(3.5)	7.8(7.2)	12.5(8.3)
6	12.8(9.9)	17.3(9.6)	20.2(11.7)	22.4(10.4)	12.4(9.7)	17.1(9.5)
7	12.4(9.9)	16.6(9.7)	21.3(12.1)	20.4(9.6)	12.1(9.8)	16.5(9.7)
8	8.5(7.4)	13.8(8.6)	22.8(10.8)	19.4(11.4)	8.4(7.3)	13.8(8.6)
9	14.2(10.1)	18.4(9.9)	24.7(9.5)	28.2(8.2)	13.6(9.8)	18.1(9.8)
10	9.6(8.3)	14.1(9.3)	23.1(9.5)	23.3(7)	9.5(8.3)	14(9.3)
11	10.9(9.8)	14.8(10)	18.1(11.6)	20.7(12.2)	10.7(9.7)	14.6(9.9)
12	8.2(8.5)	11.8(8.9)	25.9(9.3)	26.2(11.5)	8(8.4)	11.7(8.9)
15	11.6(10.2)	14.4(9)	28.6(12.1)	23.4(14.2)	11.4(10)	14.3(9)
16	11.4(9.6)	16(9.8)	21.9(12)	23.1(9.8)	11.1(9.4)	15.9(9.8)
17	10(8.7)	14.5(9.1)	26.5(9.6)	26.2(10.2)	9.7(8.4)	14.4(9)
18	8.6(7.4)	14.3(8.7)	36.3(.)	--	8.6(7.4)	14.3(8.7)
19	8.5(8.6)	12.3(8.6)	15.6(12.6)	16.2(11.1)	8.1(8.1)	12.2(8.4)
20	9.9(8.9)	14.4(9.4)	20.8(7.2)	27.7(8.5)	9.6(8.8)	14.2(9.3)
21	8.8(8.7)	12.1(8.8)	25.3(8.9)	31.8(4.8)	8.7(8.6)	12.1(8.8)
22	7.3(6.7)	11.5(7.6)	37.3(2.4)	39.8(.)	7.2(6.6)	11.5(7.5)
23	11.3(10.3)	14.1(10.1)	25.3(11.7)	19.8(14)	10.8(9.9)	14(10)

Table F-66 Access to Primary Care Physicians

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean(sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	5.8(6.5)	10.2(8.8)	14.9(9)	21.8(10.7)	5.2(5.9)	9.6(8.2)
1	5(5.2)	9.2(7.7)	14.5(7.5)	23.2(9.5)	4.7(4.8)	8.8(7.3)
2	6.7(6.6)	12.1(9.3)	13.6(6.9)	24.9(10.5)	6.6(6.5)	11.8(9.1)
3	2(2.5)	4.2(4.3)	9.1(5.2)	18.6(9.1)	2(2.5)	4.2(4.3)
4	4.8(5)	9.1(7.6)	12.1(7.6)	20.2(8.4)	4.6(4.8)	9(7.5)
5	4.3(4.6)	8.4(6.8)	10.2(6.4)	18.6(8.9)	4.2(4.6)	8.3(6.7)
6	7.8(6.8)	13.9(9.1)	13.1(7.5)	21.5(9.7)	7.3(6.4)	13.2(8.7)
7	7.9(6.7)	14.2(9.2)	13.7(7.7)	21.8(9.6)	7.2(6.2)	13.4(8.8)
8	4.8(5)	9.3(7.2)	13.4(8.8)	19.2(9.9)	4.6(4.8)	9.2(7.1)
9	9(7.5)	15.2(9.8)	14.1(7.8)	22.6(9.6)	8.2(7.2)	14.2(9.5)
10	5(4.9)	9.8(7.8)	11.8(4.9)	21.7(6.6)	5(4.9)	9.8(7.8)
11	6.1(6.1)	11.4(9.1)	11.2(7.9)	19.3(11.1)	5.8(5.8)	10.9(8.8)
12	4.6(5.6)	8.5(8.2)	15.6(8)	24.6(10)	4.4(5.3)	8.2(7.9)
15	8.6(8.2)	13.7(10.5)	16.8(9.1)	23.5(10.9)	7.7(7.6)	12.8(10)
16	7.6(7.6)	12.7(9.9)	15.7(8.8)	22.6(10.9)	6.7(6.9)	11.7(9.2)
17	6.2(7.2)	10.2(8.4)	16.9(10.2)	21.8(11.2)	5.3(6.1)	9.5(7.6)
18	6.3(7.8)	9.6(8)	16.2(11.7)	17.8(12)	5.4(6.8)	9.1(7.4)
19	6(7.3)	9.7(8.3)	14.5(11.5)	16.2(10.6)	4.8(5.6)	9.1(7.7)
20	6.5(7.1)	11(8.9)	14.4(9.2)	21.2(11.4)	5.7(6.3)	10.1(8.1)
21	4.5(5.3)	8.3(7.4)	15.4(7.8)	23.3(9.8)	4.3(5)	8.1(7.2)
22	3.1(3.8)	6.3(5.4)	14.5(11.1)	18.5(10.3)	3(3.4)	6.2(5.2)
23	9.6(8.9)	14.5(11.4)	17(8.8)	25.1(10.6)	7.9(8)	12.6(10.4)

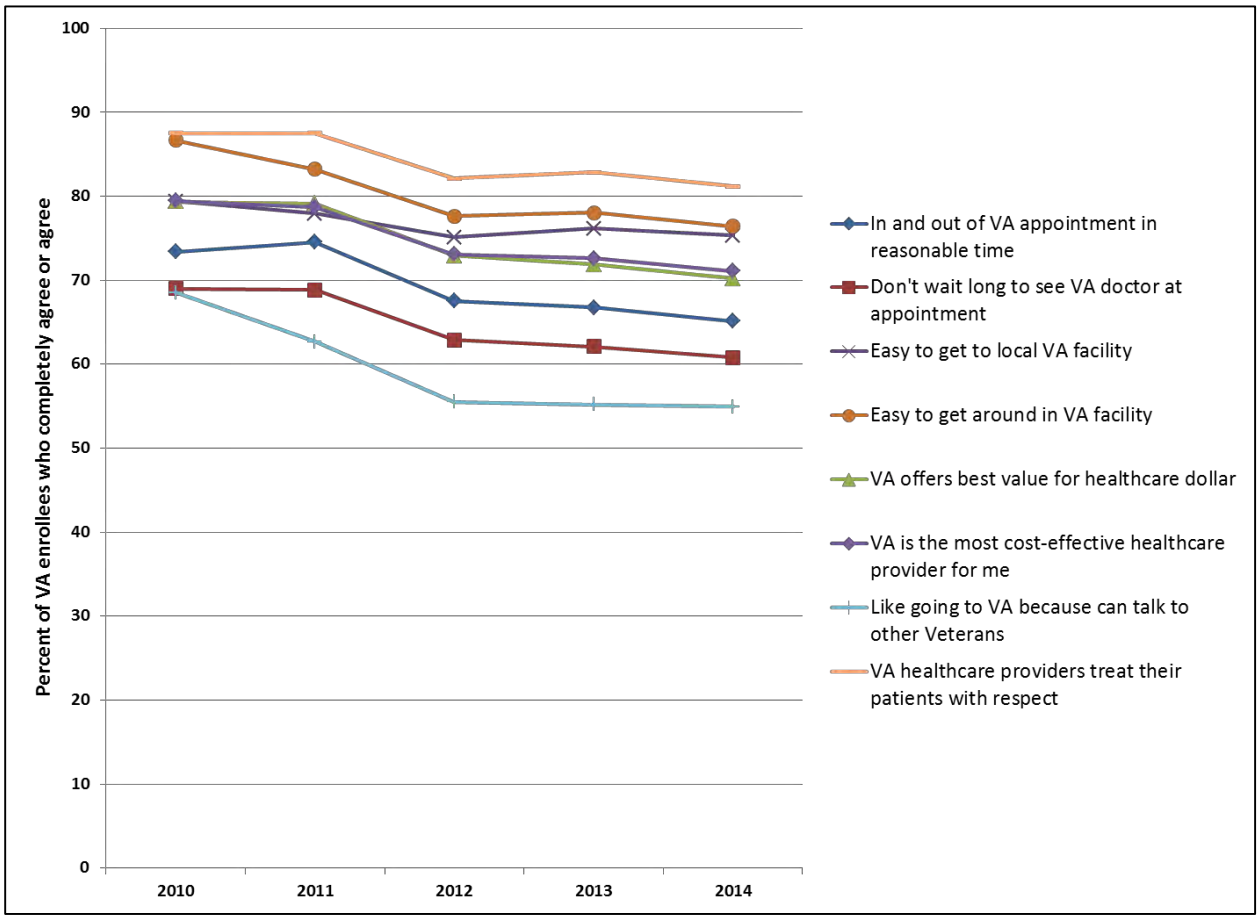
Table F-67 Access to Thoracic Surgeons

	All Enrollees		Eligible for Choice		Not Eligible for Choice	
VISN	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes	Mean (sd) distance in miles	Mean (sd) time in minutes
Overall	11.2(9.3)	15.3(9.4)	24.9(11.1)	25.7(10.5)	11.1(9.2)	15.3(9.4)
1	12.9(9.7)	16.6(9.8)	32.4(7.5)	31.5(0.7)	12.8(9.6)	16.6(9.8)
2	14.6(10.9)	17.3(10.3)	22(15.1)	24.5(10)	14.6(10.9)	17.3(10.3)
3	6.3(6.4)	10.1(7.6)	.(.)	.(.)	6.3(6.4)	10.1(7.6)
4	12(9.7)	16.1(10.3)	19.9(13.6)	17.9(9.7)	11.9(9.7)	16.1(10.3)
5	12(9.9)	15.9(10.1)	29.7(2.6)	34(2.6)	11.9(9.8)	15.8(10.1)
6	15(10.6)	19(9.8)	22.9(11.9)	23.5(11.2)	14.9(10.5)	18.9(9.8)
7	15.1(10.7)	18.9(10.1)	21.6(12)	22.4(10.7)	14.9(10.6)	18.8(10.1)
8	11(8.3)	16.2(8.9)	28.4(.)	.(.)	11(8.3)	16.2(8.9)
9	14.3(10.3)	17.7(9.8)	23.4(10.4)	27.1(10.5)	13.8(10.1)	17.4(9.6)
10	11.6(9.5)	15.6(9.5)	.(.)	.(.)	11.6(9.5)	15.6(9.5)
11	12.8(10.5)	16.1(9.8)	30.9(6.9)	34.4(6)	12.3(10.2)	15.9(9.7)
12	9.4(8.4)	13.8(8.8)	24.9(8.4)	27.2(11.8)	9.3(8.4)	13.8(8.8)
15	11.9(9.6)	15.4(8.9)	24.9(8.7)	32.1(5.7)	11.8(9.5)	15.3(8.9)
16	11.6(9.1)	16.3(9.3)	23(10.8)	23.8(8.3)	11.4(8.9)	16.3(9.3)
17	12.1(9.2)	16.5(9.2)	27.6(13)	15(15.8)	12(9.1)	16.5(9.2)
18	9.8(7.2)	15.7(8.5)	14(12.7)	19.9(11.4)	9.8(7.2)	15.6(8.5)
19	11.4(8.7)	16.6(9.3)	18.1(12.7)	18.6(12.4)	11.3(8.6)	16.6(9.3)
20	11.9(8.3)	16.6(8.8)	20(7.7)	28(5.8)	11.8(8.3)	16.5(8.7)
21	10.8(8.9)	14.5(9.1)	30.2(6.9)	.(.)	10.8(8.9)	14.5(9.1)
22	8.5(6.6)	13.1(7.7)	28.1(10.3)	33.7(5.5)	8.4(6.5)	13.1(7.7)
23	11.8(10)	14.7(9.4)	34.9(3.5)	36.9(.)	11.5(9.7)	14.7(9.4)

Appendix F.6 Veteran Responses to Access Questions

Figure F-1 summarizes Veteran responses over time to survey questions about access. All questions show a significant decline in the proportion of respondents who agree or strongly agree with the statements.

Figure F-1. Responses to Access Questions on VA Survey of Enrollees, 2010–2014.



Source: RAND analysis of data from VA Survey of Enrollees, 2010 – 2014.

Appendix F.7 Veteran Wait Times

The tables and figures in this section show wait times for different types of appointments. Table F-68 shows number of appointments completed within 0-14, 15-30, 31-60, and 61 or more days of the preferred date by appointment type for two time periods, the first half of FY 2014 and the first half of FY 2015, while Table F-69 shows average performance and variation in performance of VA facilities with regard to wait times for each of these appointment types, including mean performance of the best-performing facilities, in the first half of FY 2015.

Figure F-2 displays maps of wait time performance at VA facilities across the United States, measured as the percent of appointments of each type that were completed within 30 days of the preferred date. The color coding indicates the facility's performance against a benchmark of the best-performing VA

facilities, and the shape of the icon represents whether wait times improved or worsened from the first half of FY2014 to the first half of FY 2015. Performance benchmarks were calculated as the average proportion of appointments completed within 30 days of preferred date at the best-performing VA facilities, defined as the top 10 percent of facilities with regard to wait time for each appointment type. The performance of each facility was then classified into one of three categories relative to the benchmark: "near the benchmark" (within 0.5 standard deviation above or below the benchmark), "below the benchmark" (>0.5 to 2.0 standard deviation below the benchmark), or "far below the benchmark" (>2.0 standard deviation below the benchmark).

During the first half of FY 2015, for primary care appointments for new (established) patients, the benchmark was 99.95 percent (99.74 percent), and facilities were categorized as near benchmark if the percentage of appointments completed within 30 days of preferred date was above 95.98 percent (98.22 percent); below benchmark if between 84.05 percent and 95.98 percent (93.68 percent and 98.22 percent); and far below benchmark if below 84.05 percent (93.68 percent). The corresponding benchmark was 99.16 percent (98.97 percent) for specialty care appointments for new (established) patients, and thresholds were above 96.90 percent (97.73 percent) for near benchmark, between 90.13 percent and 96.90 percent (94.00 percent and 97.73 percent) for below benchmark, and less than 90.13 percent (94.00 percent) for far below benchmark. The corresponding benchmark was 99.96 percent (99.62 percent), and thresholds for mental health appointments for new (established) patients were above 99.02 percent (98.51 percent) for near benchmark, between 96.21 percent and 99.02 percent (95.19 percent and 98.51 percent) for below benchmark, and less than 96.21 percent (95.19 percent) for far below benchmark.

Changes in wait time performance over time were classified as improved, same, or worsened according to the standardized difference between the first half of FY 2014 and the first half of FY 2015. We calculated the standardized difference as the change over time in wait time performance divided by the standard deviation of the wait time performance for that appointment type across all VA facilities. Changes were deemed worsened if the standardized difference was -0.8 or smaller, same if between -0.8 and 0.8, and improved if 0.8 or greater.

Finally, the last two tables show survey responses about access to timely appointments, care and information. Table F-70 shows the average performance and variation in performance of VA facilities with regard to patient-reported measures of timely appointments, care and information, such as getting responses to medical questions or time spent in the waiting room. Table F-71 reports the percent of survey respondents at VA facilities who reported "always" getting needed appointments as soon as needed for urgent and routine care, by the wait time performance of those facilities for each appointment type.

Table F-68 Number of Appointments Completed Within 0-14, 15-30, 31-60, and 61+ Days of Preferred Date, by Appointment Type, First Half FY2014 and First Half FY2015

Appointment Type	First Half of FY2014				First Half of FY2015			
	0-14 days	15-30 days	31-60 days	61+ days	0-14 days	15-30 days	31-60 days	61+ days
Primary Care – New Patients	301,548	17,019	13,167	9,054	286,586	34,394	19,117	6,718
Primary Care – Established Patients	5,255,453	154,542	74,287	22,978	5,201,950	292,703	144,195	45,167
Specialty Care – New Patients	1,681,236	123,733	61,947	27,857	1,670,772	195,631	93,765	33,039
Specialty Care – Established Patients	6,955,341	260,556	124,571	47,292	7,192,459	421,311	218,015	96,413
Mental Health – New Patients	159,563	7,668	1,521	285	162,696	14,037	3,348	589
Mental Health – Established Patients	2,815,521	70,126	31,082	10,109	2,891,925	117,394	57,077	20,695

Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.

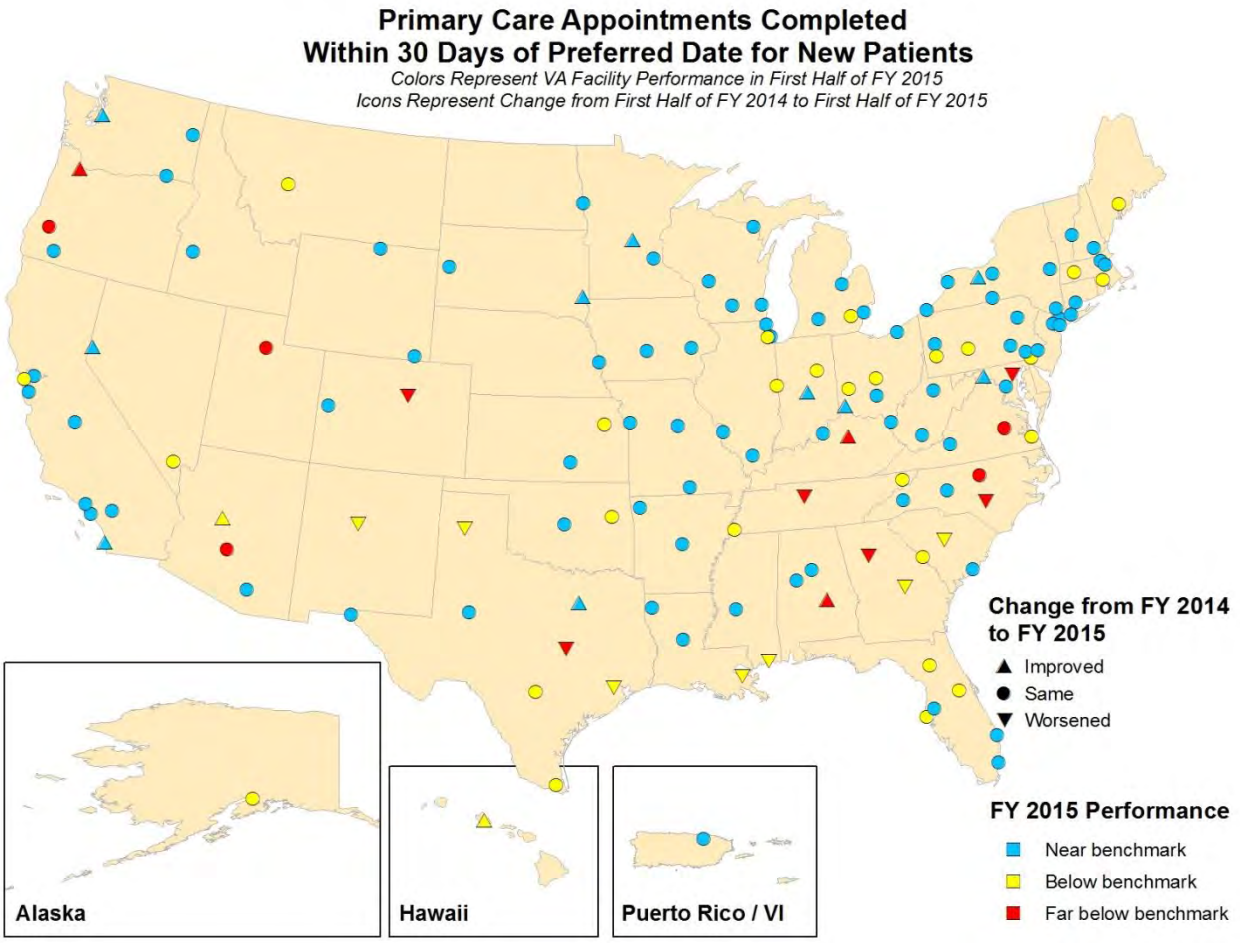
Table F-69 Number of Days Waited at VA Facilities, by Appointment Type, First Half FY2015

Appointment Type	Number of Reporting Facilities	Mean	Median	Lowest	Highest	10th Percentile	90th Percentile	Difference between 90th and 10th	Mean of Best Performing* VA Facilities
Primary Care – New Patients	141	6.5	4.8	0.4	40.7	1.2	14.0	12.8	0.9
Primary Care – Established Patients	141	3.8	3.5	0.4	14.8	1.5	6.6	5.1	1.0
Specialty Care – New Patients	141	6.6	5.9	0.3	21.7	2.8	11.3	8.5	2.1
Specialty Care – Established Patients	141	4.5	3.9	0.3	10.8	2.4	7.4	5.0	1.9
Mental Health – New Patients	141	3.5	3.2	0.4	9.5	1.0	6.9	5.9	0.7
Mental Health – Established Patients	141	3.0	2.7	0.5	12.2	1.1	5.4	4.3	0.9

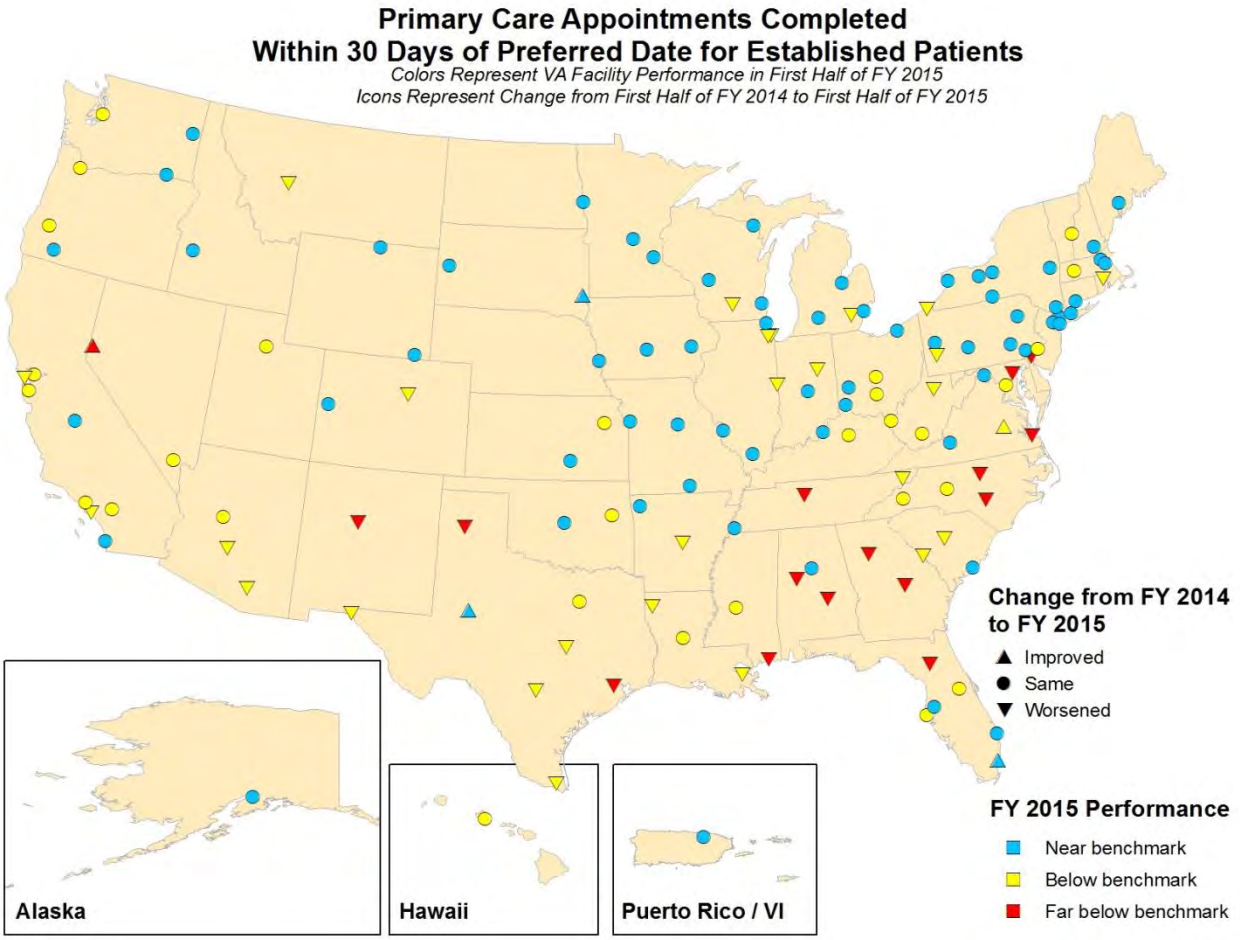
*Mean of average wait time in days for best-performing 10% of VA facilities.

Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.

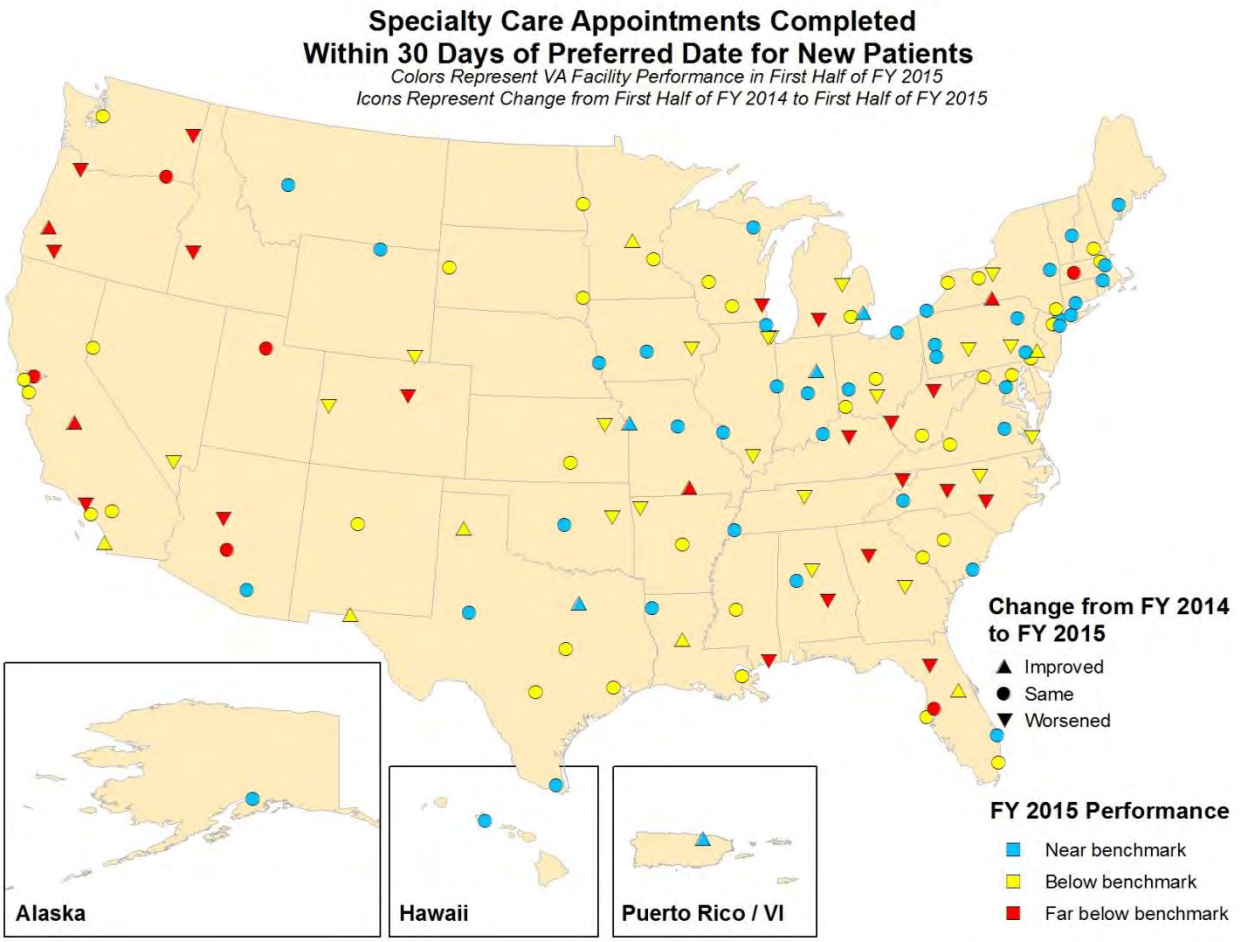
Figure F-2 Maps of Wait Time Performance at VA Facilities across the United States, First Half FY2015 and Change from First Half FY2014 to First Half FY2015



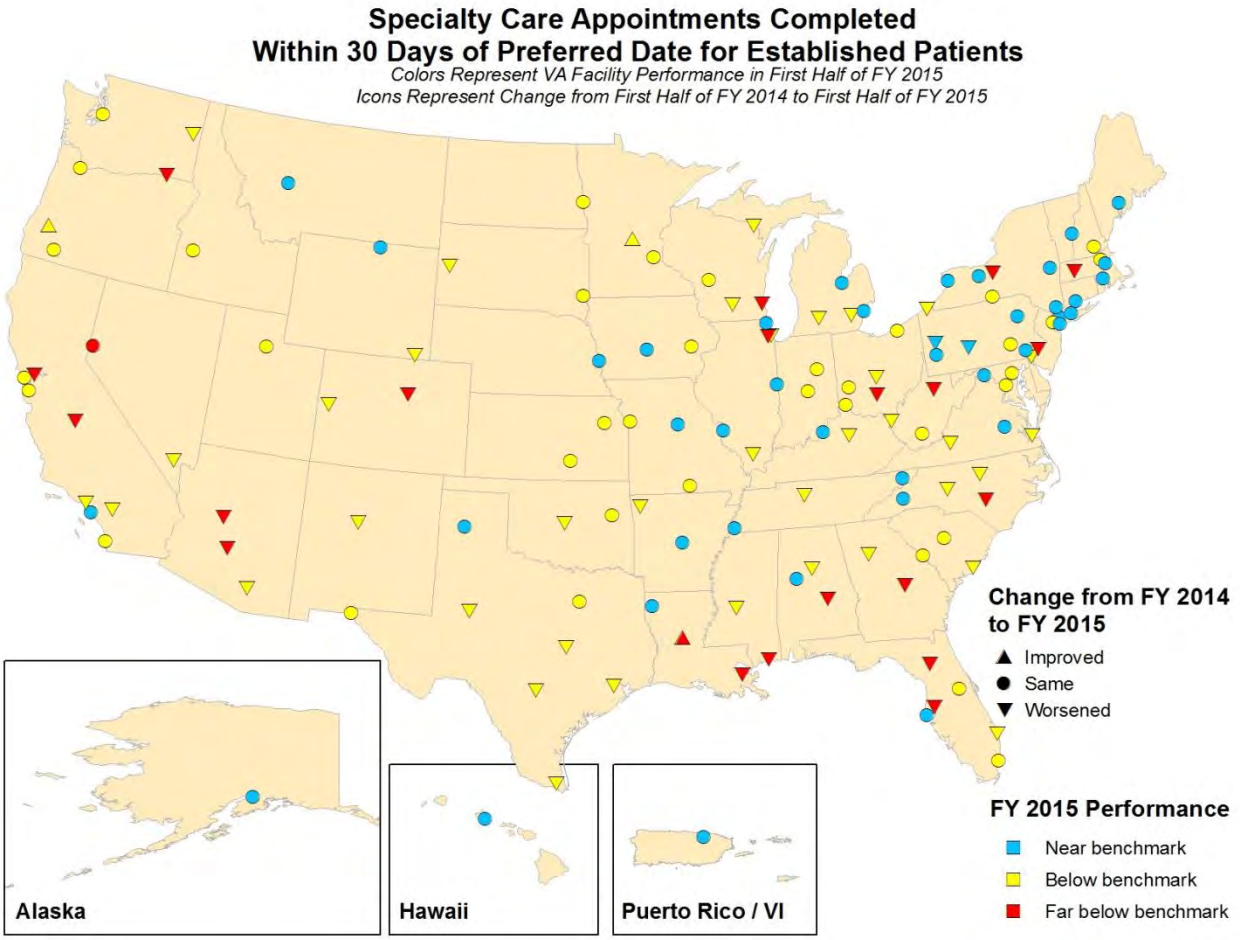
Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.



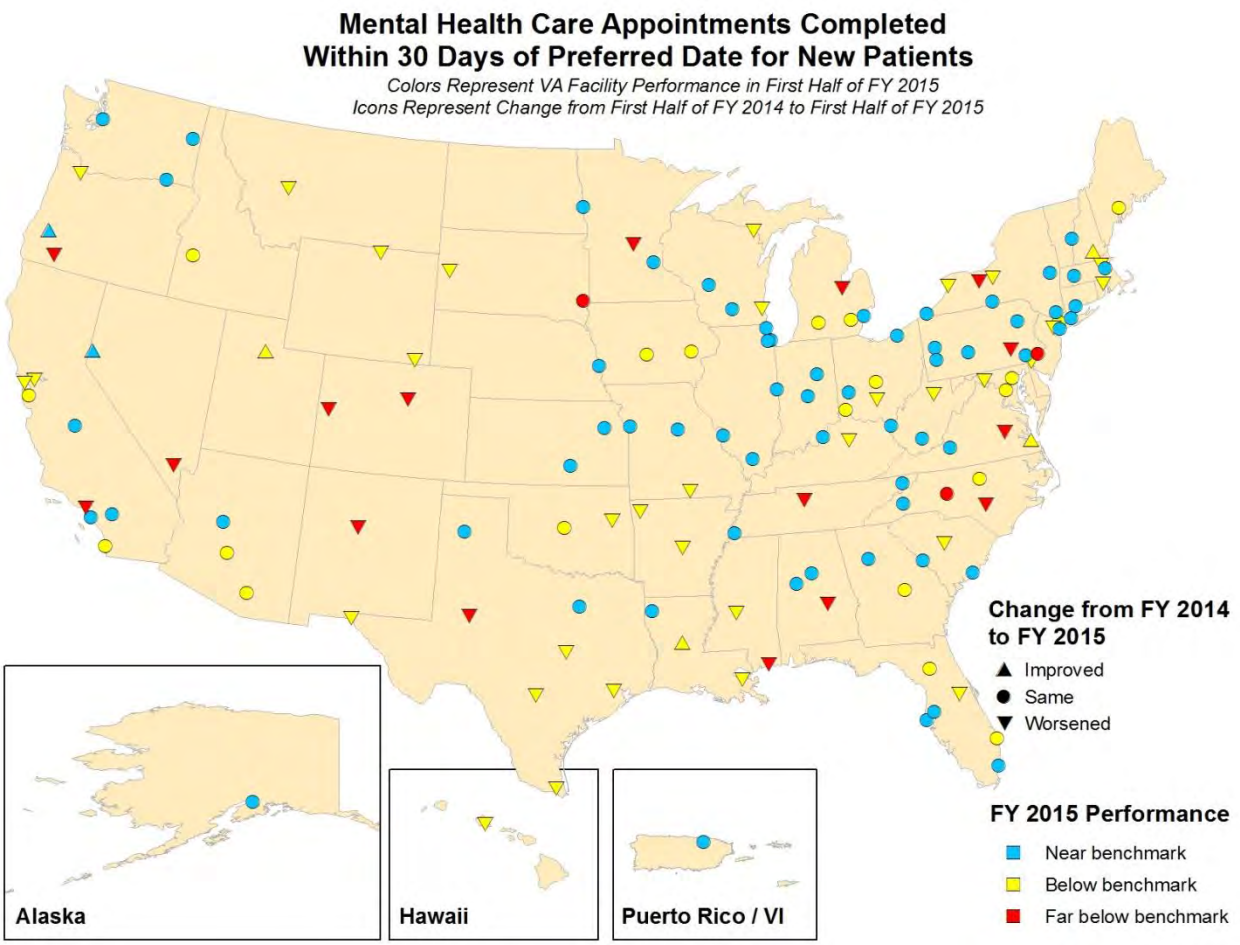
Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.



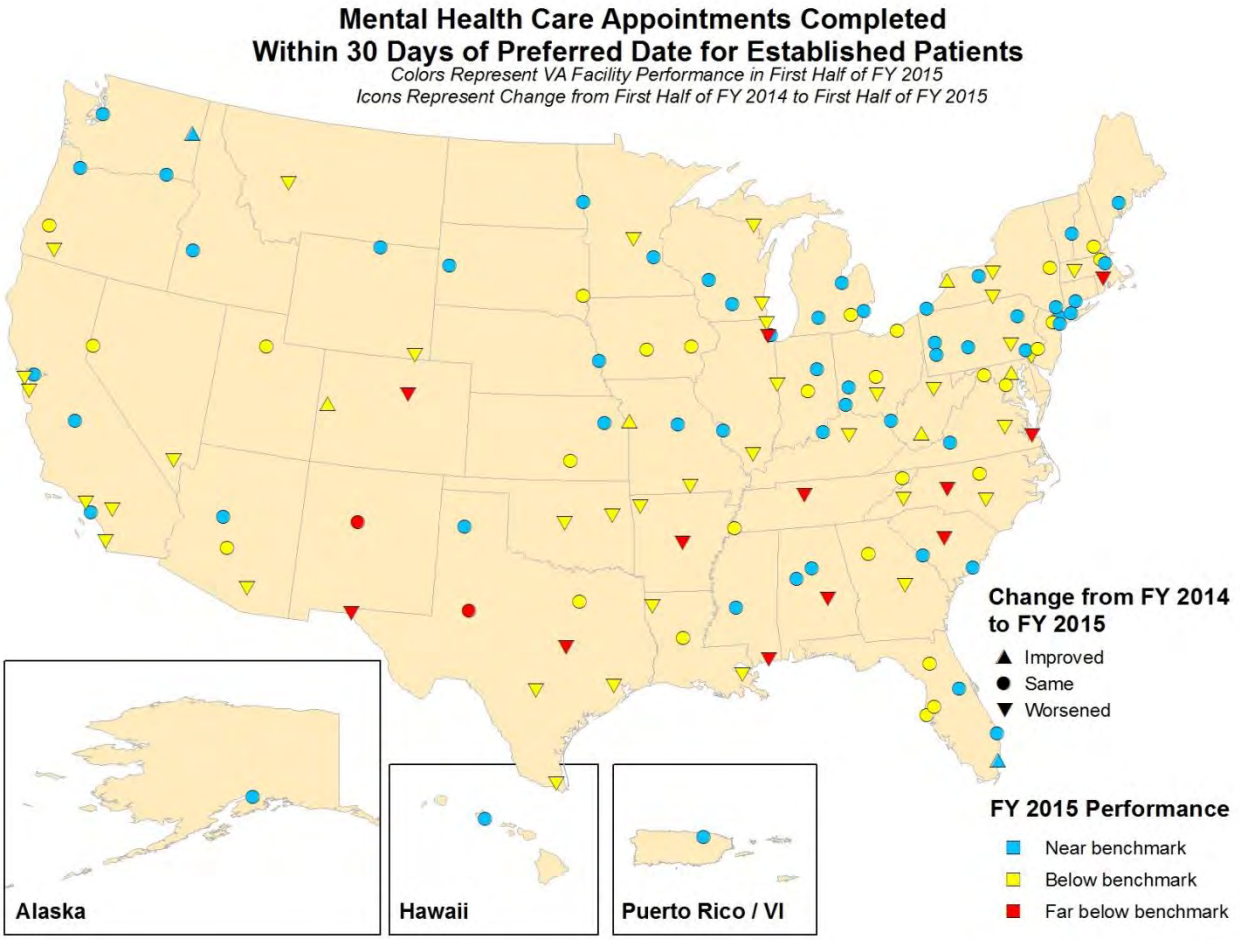
Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.



Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.



Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.



Source: RAND analysis of VA wait time data for FY2014 and the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation.

Table F-70 Performance on Patient-Reported SHEP PCMH Access Measures by VA Facility, FY2014.

Measure	Number of Reporting Facilities	Mean	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th	Mean of Best Performing VA Facilities*
% reporting that in the last 12 months, when phoned the provider's office to get an appointment for care needed right away, ALWAYS got an appointment as soon as needed	140	45.8	46	21.3	68.5	35.0	57.5	22.6	61.2
% reporting that in the last 12 months, when made an appointment for a check-up or routine care with the provider, ALWAYS got appointment as soon as you needed	141	54.6	55.2	31.2	75.1	43.6	65.1	21.5	68.5
% reporting that in the last 12 months, when phoned this provider's office during regular office hours, ALWAYS got an answer to medical question that same day	141	45.1	45.4	11.2	64.8	35.5	55.6	20.2	59.1
% reporting that in the last 12 months, when phoned this provider's office after regular office hours, ALWAYS got an answer to medical question as soon as needed	140	37.1	37.1	16.4	65.3	24.4	50.3	25.9	54.5

Measure	Number of Reporting Facilities	Mean	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th	Mean of Best Performing VA Facilities*
Wait time includes time spent in the waiting room and exam room. % reporting that in the last 12 months, ALWAYS saw this provider within 15 minutes of appointment time	141	32.6	32.7	16	52.1	21.8	42.9	21.1	46
% reporting that in the last 12 months, ALWAYS able to get the care you needed from this provider's office during evenings, weekends, or holidays	140	21.8	21.2	7.1	48	13.2	30.8	17.6	35.6

*Mean of measure rates for best-performing 10% of VA facilities.

Source: Facility-level patient experience data for VA patients from the Survey of Healthcare Experiences of Patients Primary Care Medical Home in FY2014 were obtained from the VA Office of Performance Measurement.

Table F-71 Percent of Veterans in VA Facilities Responding that They "Always" Got Appointment for Routine or Urgent Care as Soon as Needed on SHEP PCMH FY2014, by Facility Performance on Wait Times in First Half FY2015.

Appointment Type	Percent reporting ALWAYS got routine appointment as soon as needed	Percent reporting ALWAYS got urgent appointment as soon as needed
Primary Care – New Patients		
Wait Times Near Benchmark	57.0	48.9
Wait Times Below Benchmark	51.8	43.0
Wait Times Far Below Benchmark	45.2	36.1
Primary Care – Established Patients		
Wait Times Near Benchmark	58.5	50.0
Wait Times Below Benchmark	52.3	44.2
Wait Times Far Below Benchmark	45.2	36.3
Specialty Care – New Patients		
Wait Times Near Benchmark	56.1	48.1
Wait Times Below Benchmark	54.7	46.4
Wait Times Far Below Benchmark	51.5	42.2

Appointment Type	Percent reporting ALWAYS got routine appointment as soon as needed	Percent reporting ALWAYS got urgent appointment as soon as needed
Specialty Care – Established Patients		
Wait Times Near Benchmark	58.4	50.4
Wait Times Below Benchmark	53.4	44.7
Wait Times Far Below Benchmark	51.0	42.7
Mental Health – New Patients		
Wait Times Near Benchmark	56.4	48.3
Wait Times Below Benchmark	53.2	44.8
Wait Times Far Below Benchmark	51.9	42.9
Mental Health – Established Patients		
Wait Times Near Benchmark	57.5	48.6
Wait Times Below Benchmark	53.6	45.6
Wait Times Far Below Benchmark	47.0	38.7

Notes: During the first half of FY 2015, for primary care appointments for new (established) patients, the benchmark was 99.95 percent (99.74 percent), and facilities were categorized as near benchmark if the percentage of appointments completed within 30 days of preferred date was above 95.98 percent (98.22 percent); below benchmark if between 84.05 percent and 95.98 percent (93.68 percent and 98.22 percent); and far below benchmark if below 84.05 percent (93.68 percent). The corresponding benchmark was 99.16 percent (98.97 percent) for specialty care appointments for new (established) patients, and thresholds were above 96.90 percent (97.73 percent)

Appointment Type	Percent reporting ALWAYS got routine appointment as soon as needed	Percent reporting ALWAYS got urgent appointment as soon as needed
for near benchmark, between 90.13 percent and 96.90 percent (94.00 percent and 97.73 percent) for below benchmark, and less than 90.13 percent (94.00 percent) for far below benchmark. The corresponding benchmark was 99.96 percent (99.62 percent), and thresholds for mental health appointments for new (established) patients were above 99.02 percent (98.51 percent) for near benchmark, between 96.21 percent and 99.02 percent (95.19 percent and 98.51 percent) for below benchmark, and less than 96.21 percent (95.19 percent) for far below benchmark. Source: Benchmark categories were established by RAND analysis of VA wait time data for the first half of FY2015 that were obtained from the VHA Support Service Center (VSSC) by the MITRE Corporation. Facility-level patient experience data for VA patients from the Survey of Healthcare Experiences of Patients Primary Care Medical Home in FY2014 were obtained from the VA Office of Performance Measurement.		

Appendix G Quality

Appendix G.1 Evidence Table for Quality Review

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
New articles abstracted for this review											
Bean-Mayberry et al., 2007	Effectiveness [Mixed]	Mult ctrs	VA comprehensive Womens Health Centers [N= 8]	2003	Nat'l	Department of Health and Human Services National Centers of Excellence [N=13]	2003	None	Availability of services	Preventive cancer screening and general reproductive services were uniformly available at all centers, although DHHS centers offered extensive reproductive services on-site more frequently, and VA centers more often had on-site mental health care.	B
Belote et al., 2012	Patient Centeredness [Better]	Nat'l	Veterans at VA-staffed community-based outpatient clinics [N=2838]	2007-2008	Nat'l	Veterans at contract staffed community-based outpatient clinics [N=941]	2007-2008	None	Patient satisfaction, unadjusted	VA had significantly better satisfaction scores for continuity of care (mean % difference = 8.603, p<0.001), education and information (mean % difference = 1.111, p<0.001), emotional support (mean % difference = 0.847, p=0.014), overall coordination of care (mean % difference: 1.682, p<0.001), patient preferences (mean % difference: 1.083, p=0.002). No significant differences for patient access, courtesy, or visit coordination.	B
Berke et al., 2009	Efficiency [Worse]	Nat'l	Veterans in VA Hospitals [N=3,232,196 total patients; sample size not broken down by VA/non-VA]	2000	Nat'l	Medicare-eligible Veterans in non-VA Hospitals [N=3,232,196 total patients; sample size not broken down by VA/non-VA]	2000	None	Difference between length-of-stay and the expected length-of-stay based on DRG weight, for patients 65 or older, adjusted by complexity	VA hospitals had much longer than expected lengths-of-stay when compared to non-VA hospitals (6.5 days vs. 3 days in urban hospitals, 5 vs. 2 days in rural hospitals, and 3 vs. 1 days in highly rural hospitals; no statistical tests).	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Boitano et al., 2012	Safety [Same]	Single ctr	Veterans at a VA hospital [N=322]	2006-2009	Single ctr	Patients at Northwestern Memorial Hospital [N=269]	2006-2009	Vascular Surgery	Post-operative outcomes (morbidity and mortality), risk-adjusted	Multivariate analysis showed that hospital setting was not an independent predictor of complications, major adverse events, or death, suggesting no difference in outcomes between the VA and private sector.	A/B
Bond et al., 2008	Effectiveness [Better]	Nat'l	VA hospitals [N=84]	2006	Nat'l	Non-VA hospitals [N=1041]	2006	None	Clinical pharmacy services offered	Eight of 15 clinical pharmacy services were more commonly provided in VA hospitals. In-service education was higher by 25% (p=0.003), clinical research by 154% (p<0.0001), drug protocol management by 28% (p<0.0001), drug therapy counseling by 80% (p<0.0001), participation on rounds by 38% (p=0.001), and admission drug histories by 310% (p<0.0001).	A
Borzecki et al., 2010	Safety [Better] Effectiveness [Mixed]	Nat'l	IQI-related discharge at VA [N=403828]	2003-2007	Nat'l	HCUP-NIS IQI-related discharges [sample size not reported]	2003-2007	CHF, IHD, Pulm, TIA, Hip fracture, gastrointestinal hemorrhage, Surgical (General,Cardio, Ortho, Oncology, Other)	Inpatient quality indicators	Comparing VA and NIS risk-adjusted rates from 2003 through 2007, slope estimates differed significantly for AMI, acute stroke, hip fracture and pneumonia mortality, hip replacement, and all 3 utilization indicators. AMI, stroke, hip fracture, pneumonia and hip replacement mortality rates, and incidental appendectomy utilization rates declined more rapidly in the VA. Laparascopic cholecystectomy rates rose more steeply, whereas bilateral catheterization rates decreased more slowly, in the VA compared with NIS.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Chakkera et al., 2005	Safety [Worse] Equity [Same]	Nat'l	VA patients who received pretransplant care in VA or paid by VA [N=1646]	1991-2001	Nat'l	Non-VA patients who did not receive pretransplant care in VA or paid for by VA [N=77715]	1999-2001	Kidney Transplant	Graft and patient survival after kidney transplant, adjusted	African-American race was associated with poorer allograft survival even after adjustment. The relative risk (RR) of graft failure by race was similar among VA users and non-VA users and VA users who received a transplant within and outside the VA. Among all recipients, VA users had a 20% higher risk for graft failure (RR 1.21; 95% CI 1.12-1.30) and 14% higher risk of mortality (RR 1.14; 95% CI 1.07-1.22) compared with non-VA users. There was no interaction of race with VA user status in graft failure (P = 0.32) or patient survival (P = 0.63), no difference in graft (RR for VA users who received a transplant within the VA 0.86; 95% CI 0.68-1.10; P = 0.23) or patient (RR 0.97; 95% CI 0.74-1.26; P = 0.82) survival among VA users who received a transplant within versus outside VA, and interaction of race with VA user status was not significant for graft (P = 0.79) or patient (P = 0.97) survival.	A
Choi et al., 2009	Safety [Same]	Single ctr	VA patients [N=682]	2002-2006	Nat'l	Non-Veteran non-VA patients [N=34572]	2004	Cardio	In-hospital mortality rate after CABG, unadjusted	No significant difference in in-hospital mortality rate for male patients (1.6% versus 2.4%, P=0.20).	B
Fihn et al., 2009	Safety [Same]	Nat'l	VA patients [N=27494]	2000-2005	Nat'l	Medicare patients in private sector hospitals [N=789400]	2000-2005	IHD	Adjusted 30-day mortality following AMI, overall relative odds of death following AMI	From 2000-2005, overall unadjusted 30-day mortality was 16.0% in VA hospitals and 16.2% in private sector hospitals. After adjusting for patient characteristics and hospital effects, the overall relative odds of death were not significantly different for VA or private sector hospitals (OR 1.02, 95% CI 0.96-1.08). No differences were observed in separate analyses using patients discharged during 2000-2001, 2002-2003, and 2004-June 2005, or when non-VA hospitals were restricted to those located within a market that contains a VA hospital.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
French et al., 2012a	Safety [Worse]	Nat'l	Patients in VA database [N=20191]	2007	Nat'l	Patients in Medicare database [N=137726]	2007	Cataract surgery	90-day rates of routine and complex cataract procedures, odds ratios complications	The 90-day overall rate of secondary procedures was greater for patients having cataract surgery through VA (37.2 per 1000 surgeries) than Medicare (18.2 per 1000 surgeries). Adjusted results resulted in significant odds increases of corrective procedures for routine cataract surgeries performed in VA (OR 1.70; 95% CI 1.58–1.82) and for complex cataract surgery (OR 2.68; 95% CI 2.24–3.20).	A
French et al., 2012b	Safety [Better]	Nat'l	Patients in VA database [N=19721]	2007	Nat'l	Patients in Medicare database [N=129302]	2007	Cataract surgery	All-cause mortality following cataract surgery, adjusted	Mortality risk did not differ significantly between the two cohorts at time points within six months following cataract surgery. At 270 and 365 days postoperative, death hazard among the Medicare routine cataract extraction group exceed VA by 13% and 17% (HR 1.13, 95% CI 1.03–1.23; HR 1.17, 95% CI 1.09–1.27). Similar trends of excess mortality at 270 and 365 days were observed for complex cases (HR 1.16, 95% CI 1.06–1.29; HR 1.17, 95% CI 1.08–1.27).	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Gellad et al., 2013	Efficiency [Better]	Nat'l	VA patients [N=510485]	2008	Nat'l	Medicare patients [N=1061095]	2008	DM, high cholesterol	Proportion of patients who filled at least 1 prescription for a brand-name medication (or insulin analogue) for each medication group, adjusted	Medicare used more brand-name drugs than VA (5th to 95th percentile). Percentage of patients using any brand-name: oral hypoglycemics (Medicare: 25.1%-42.4%; VA: 5.1%-21.9%), insulin analogues (Medicare: 68.3%-85.4%; VA: 10.6%-46.9%), statins (Medicare: 41.0%-58.3%; VA: 6.2%-38.2%), ACE inhibitors or ARBs (Medicare: 31.1%-51.1%; VA: 12.7%-31.0%). In each group, the hospital referral region (HRR) at the 95th percentile of brand-name drug use in the VA was lower than the HRR at the 5th percentile in Medicare. Use of brand-name drugs was greater in Medicare than in the VA in 298 of 306 HRRs. Per capita volume of prescriptions filled among users in each medication group, was slightly lower in Medicare than in the VA.	A
Gonzales et al., 2006	Effectiveness [Worse]	Mult ctrs	Patients at VA ED [N=1125]	2003-2004	Mult ctrs	Patients at matched non-VA EDs [N=1138]	2003-2004	Pulmonary	Antibiotic prescribing patterns in ARIs	Clinical setting (VA vs. non-VA) was not independently associated with antibiotic prescribing. In four cities, VA and non-VA EDs were very similar, whereas in others, the two hospital types were far apart. In every case in which the VA and non-VA ED sites were discordant within city, the VA ED sites showed higher adjusted rates of antibiotic treatment.	B
Hausmann et al., 2009	Patient Centeredness [Same]	Nat'l	VA users [N unweighted= 362; N weighted = 140 672]	2004	Nat'l	Veteran VA nonusers [N unweighted= 3058; N weighted= 1406880]	2004	None	Perceived racial discrimination, adjusted for respondent characteristics	Likelihood of reporting perceived discrimination was not significantly different for VA users and nonusers (OR 1.30; 95% CI 0.54-3.13).	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Hynes et al., 2006	Effectiveness [Better]	Mult ctrs	VA hemodialysis patients [N=177]	2001-2003	Mult ctrs	Private sector hemodialysis patients [N=131]	2001-2003	ESRD	Compliance with erythropoietin administration guidelines, adjusted	Erythropoietin was administered predominantly subcutaneously for 52% of patients in VA versus 15% in private-sector facilities (P < 0.0001). For patients dialyzing in VA facilities, hemoglobin levels were 11.55 +/- 1.09 (SD) g/dL (115.5 +/- 10.9 g/L) for the subcutaneous group and 11.38 +/- 1.13 g/dL (113.8 +/- 11.3 g/L) for the intravenous group. For patients dialyzing in private-sector facilities, hemoglobin levels were 12.34 +/- 1.22 g/dL (123.4 +/- 12.2 g/L) for the subcutaneous group and 11.91 +/- 1.03 g/dL (119.1 +/- 10.3 g/L) for the intravenous group. Analysis of variance result indicated a significant difference (P = 0.0002).	B
Hynes et al., 2012	Efficiency [Worse]	Mult cts	VA hemodialysis patients [N=170]	2001-2003	Mult cts	Private sector hemodialysis patients [N=164]	2001-2003	ESRD	Utilization, adjusted	VA dialysis patients had more non-dialysis outpatient visits, emergency room visits, and 30-day supplies of prescriptions (P = 0.02, 0.04, and 0.02, respectively). The overall number of inpatient admissions for acute medical or surgical care was higher for VA than private sector dialysis patients (2.7 vs. 1.9, respectively; P = 0.02), and VA dialysis patients had more hospital days (25.8 vs. 10.7; P < 0.001). However, nonacute admissions and days of care were similar between the dialysis groups.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Keating et al., 2010	Effectiveness [Better] Equity [Worse]	Nat'l	Male VA patients [N=2913]	2001-2005	Nat'l	Propensity-matched male Medicare patients [N=2913]	2001-2005	Lung cancer, colorectal cancer	End of life indicators (last dose of chemotherapy within 14 days of death, admission to ICU within 30 days of death, more than 1 ER visit within 30 days of death), propensity matched and adjusted for residual differences	Men treated at VA were less likely than men treated in the private sector to receive chemotherapy within 14 days of death (4.6% vs. 7.5%, P < .001) or to be admitted to an ICU within 30 days of death (12.5 vs. 19.7, P < .001), and similarly likely to have more than 1 emergency room visit within 30 days of death (13.1 vs. 14.7, P = .09). Black patients did not differ from white patients in use of chemotherapy within 14 days of death whether they received care from VA (3.6% for blacks, 5.1% for whites, P = .21) or Medicare (6.0% vs. 8.6%, P = .06). Black and white Medicare and VA patients did not differ in rates of ICU admissions at the end of life (P = .67 in VA and .82 in Medicare). Black VA patients were more likely than white patients to have more than 1 ER visit in the last month of life 17.5% vs. 12.9%, P = .03), but this difference was not observed among Medicare patients (16.2% vs. 15.4%, P = .68).	A
Keating et al., 2011	Effectiveness [Better]	Nat'l	VA patients [N=50573]	2001-2005	Nat'l	FFS Medicare patients [N=143504]	2001-2005	Colorectal, lung, or prostate cancer; lymphoma; or multiple myeloma	Process measures to reflect receipt of high-quality cancer care, adjusted with propensity scores	For colon cancer patients, VA had higher rates of diagnosis at earlier stage (p<0.001), resection (p=0.010), but similar rates of adjuvant chemotherapy. For rectal cancer patients, VA had higher rates of diagnosis at earlier stage (p=0.007), but similar rates of resection or adjuvant chemotherapy/radiation. Lung cancer process outcomes were non-significant. Outcomes were mixed for prostate cancer and hematologic cancer patients.	A/B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Landrum et al., 2012	Safety [Better]	Nat'l	Males over 65 diagnosed/treated for certain cancers at VA [N=26718]	2001-2005	Nat'l	Males over 65 with certain cancers using Medicare FFS [N=118195]	2001-2005	Colorectal, lung, or prostate cancer; lymphoma; or multiple myeloma	Survival rates (time to all-cause death and time to cancer-attributable death), adjusted using standardized mortality ratio propensity weights.	VA patients had higher survival rates of colon cancer (HR 0.87; 95% CI 0.82-0.93) and non–small-cell lung cancer (HR 0.91; 95% CI 0.88-0.95) and similar survival rates of rectal cancer (HR 1.05; 95% CI 0.95-1.16), small-cell lung cancer (HR 0.99; 95% CI 0.93-1.05), diffuse large–B-cell lymphoma (HR 1.02; 95% CI 0.89-1.18), and multiple myeloma (HR 0.92; 95% CI 0.83-1.03) versus similar FFS Medicare patients.	A
Liu et al., 2008	Effectiveness [Worse] Efficiency [Worse]	Nat'l	Veterans who are primary care users at 76 VA-staffed community clinics [N=17060]	2000-2001	Nat'l	Veterans who are primary care users at 32 non-VA contract community clinics receiving capitation [N=6842]	2000-2001	DM, Pulmonary	Utilization of outpatient services and receipt of primary care services, adjusted	Contract community clinic patients had 4% fewer primary care visits and 16% fewer laboratory visits; there were no significant differences in numbers of visits for specialty care, mental health care, radiology, or inpatient admission. Odds ratios for the proportion of contract and VA-staffed clinic diabetic patients receiving a retinal exam were (OR 0.72, 95% CI 0.55-0.93) and COPD patients receiving a flu shot (OR 0.73, 95% CI 0.55-0.99).	A
Liu et al., 2009	Efficiency [Better]	Mult ctrs	Veterans using VA care [N=303]	2003-2004	Mult ctrs	Veterans using both VA and non-VA care (dual users) [N=247]	2003-2004	Depression	VA and non-VA outpatient utilization for physical and emotional health problems in prior 6 months, adjusted	Dual users had higher odds of any ER visit for physical health (OR=7.41, $p<0.001$) and emotional health (OR=14.64, $p<0.001$) and any inpatient admission for physical health (OR=2.34, $p<0.01$) or emotional health (OR=5.38, $p<0.001$) than VA-only users.	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Lu et al., 2010	Effectiveness [Better] Patient Centeredness [Better]	Mult ctrs	Veterans who died in a VA facility [N=520]	NR	Mult ctrs	Veterans who died in a non-VA facility [N=89]	NR	None	Perceptions of the care and services that patients and families received during the patient's last month of life	Patients who died in VA facilities (n = 520) had higher mean satisfaction scores compared to those who died in non-VA facilities (n = 89; 59 versus 51; rank sum test p = 0.002), which persisted after adjusting for medical center (p = 0.004), as was the domain measuring care around the time of death (p = 0.001). Patients who died in the VA were more likely to have had a palliative care consult (67% vs. 21%; p < 0.001). They were also more likely to have died in a dedicated palliative care or hospice unit (47% vs. 16%; p < 0.001). However, patients who died in VA facilities were more likely to die in an ICU (26% vs. 13%; p = 0.01) and less likely to die in a nursing home (0% vs. 26%; p < 0.001).	B
Lynch et al., 2010	Effectiveness [Better]	Nat'l	Veterans who had used VA facilities in the last year [N=1342]	2003	Nat'l	Veterans who had not used VA facilities in the last year [N=3159]	2003	DM, Preventive care	Quality of diabetes care: biannual provider office visits, hemoglobin A1c testing, foot exam, dilated eye exam, aspirin use, and influenza and pneumonia vaccination; adjusted	VA users were more than twice as likely to have received foot exams by a provider (OR 2.59, 95% CI 1.76–3.83), ever had a pneumonia shot (OR 2.30, 95% CI 1.68–3.14), and had a flu shot (OR 2.05, 95% CI 1.44–2.92). In addition, VA users had a 60–70% greater likelihood of having a dilated eye exam (OR 1.68, 95% CI 1.14–2.49), two or more hemoglobin A1c tests (OR 1.65, 95% CI 1.19–2.28), and two or more provider visits (OR 1.61, 95% CI 1.08–2.39) in the previous 12 months.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
McGuire et al., 2011	Patient Centeredness [Same]	Mult ctrs	Veterans in Domiciliary Care for Homeless Veteran (DCHV) Program [N=477]	2002-2005	Mult ctrs	Veterans in one of two community based programs: Grant and Per Diem Program (G&PD) and Health Care for Homeless Veterans (HCHV) [N=526]	2002-2005	Mental health	Perception of program, environment and satisfaction with program, adjusted residential treatment outcomes	No significant differences in overall social climate score between Veterans in each program the three program types. On the subscale addressing support for personal growth DCHV and HCHV program veterans reported higher ratings than veterans in the G&PD programs.There were no differences on the summary score of program satisfaction, but DCHV veterans were more likely to specifically report that they would choose their program again, if offered the choice, than were HCHV veterans. Program type was not significant for any outcomes after correction for multiple outcomes.	B
Mooney et al., 2007	Efficiency [Worse]	One VISN	Female Veterans admitted to VA hospital [N=718]	1998-2000	One VISN/ State	Female Veterans admitted to a private sector hospital [N=904]	1998-2000	None	Mean length of stay, adjusted	Mean length of stay was longer for musculoskeletal admissions (9.4 vs. 5.2 days; $p < .001$) and when examining all admissions (8.7 vs. 6.0 days; $p < .001$).	A
Nelson et al., 2011	Effectiveness [Same]	Mult ctrs	VA patients [N=150]	2009	Mult ctrs	Patients at an academic medical center [N=150]	2009	IHD	Appropriate use of stress/rest myocardial perfusion imaging (MPI) studies, unadjusted	The majority of the studies were ordered for appropriate indication (67.3% in VA vs. 74% in academic practice) ($P = .272$). In VA, non-physicians requested more inappropriate studies than physicians (26.8% vs. 20.1%; $P < .048$). Within the academic practice non-cardiologists referred more patients for inappropriate indications than cardiologists (23.9% vs. 10.1%; $P = .001$).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Parikh et al., 2011	Effectiveness [Same]	Mult VISNs	VA patients [N=378]	2005-2006	Mult VISNs	Medicare patients [N=25534]	2005-2006	ESRD	Method of vascular access for first outpatient dialysis (arteriovenous fistulas [AVF] preferred in guidelines)	Adjusting for patient demographics and comorbidities only, VA patients had greater likelihood of AVF (OR=1.70; 95% CI 1.31-2.20), but after accounting for pre end-stage renal disease care, the significant difference between the presence of AVFs in VA compared to non-VA hemodialysis patients was removed (OR 1.28; 95% CI 0.98–1.66), suggesting that the higher likelihood of starting hemodialysis with an AVF may be mediated by pre-ESRD care within the VA system.	A/B
Richardson et al., 2013	Safety [Worse] Timeliness [Worse]	Nat'l	VA users [N=9308]	2002-2008	Nat'l	Veterans at non-VA hospitals [N=1881]	2002-2008	Orthopedic surgery	Time between hospital admission and surgical repair, 1-year patient mortality	Relative hazards of surgery in non-VA hospitals within 2 days were 2.63 times greater (95% CI 2.47–2.81; $p < .001$); within 2 to 5 days there was no significant difference between the two hospital types, and more than 5 days after the initial fracture the relative hazards of surgery in non-VA hospitals were 51% smaller (95% CI 0.35–0.68; $p<.001$). Likelihood of death within 1 year of admission was 21% less for Veterans admitted to non-VA hospitals (RR=0.79; 95% CI 0.71-0.88; $p<0.001$).	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Rivard et al., 2010	Safety [Worse]	Nat'l	VA hospitals [N=116]	2003-2004	Nat'l	Non-VA hospitals (HCUP-NIS) [N=992]	2003-2003	None	Patient Safety Indicators (PSIs), adjusted	VA had higher composite PSI (VA: 1.118, 95% CI 1.071-1.164, NIS: 0.987, 95% CI 0.977-0.997), higher foreign body left in during procedure (VA: 0.14, 95% CI 0.10-0.17, NIS: 0.09, 95% CI 0.07-0.10), iatrogenic pneumothorax (VA 1.34, 95% CI 1.14-1.53, NIS: 0.78, 95% CI 0.72-0.83), postoperative hemorrhage (VA: 3.00, 95% CI 2.46-3.55, NIS: 2.13, 95% CI 1.98-2.28), postoperative wound dehiscence (VA: 4.80, 95% CI 3.41-6.19, NIS: 1.55, 95% CI 1.19-1.90). NIS had more postoperative sepsis than VA (9.41, 95% CI 7.61-11.21, 12.63, 95% CI 11.15-14.11), with a small overlap of confidence intervals. No significant differences for death in low mortality DRGS, failure to rescue, selected infections due to medical care, accidental puncture or laceration, postoperative physiologic and metabolic derangements, postoperative respiratory failure, postoperative pulmonary embolism/deep vein thrombosis.	A
Rosen et al., 2005	Safety [Mixed]	Nat'l	VA users [N=281423]	2000-2001	Nat'l	Non-VA (HCUP and MedPAR) [sample sizes not reported]	2000-2000	None	PSI rates, risk-adjusted	VA-risk adjusted rates are lower than HCUP-NIS and Medicare event rates for 4 indicators: decubitus ulcer, infection due to medical care, postoperative respiratory failure, and postoperative sepsis. VA PSI event rates were higher than HCUP-NIS and Medicare event rates for 2 indicators: postoperative physiologic and metabolic derangements and technical difficulty with procedure. VA PSI event rates were higher than HCUP-NIS event rates, but lower than Medicare event rates, for the remaining relevant indicators.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Selim et al., 2010	Safety [Better]	Nat'l	VA users [N=35876]	1999-2003	Nat'l	Medicare Advantage cohort [N=71424]	1999-2003	None	2-year mortality, probability of being alive with the same or better physical health or mental health at 2 years; adjusted	2-year mortality rates were 11.8% and 9.9% for the Medicare and VA, respectively, with a higher hazard for mortality in Medicare compared with VA (HR 1.26; 95% CI 1.23–1.29). Probability of being alive with the same or better physical health at 2 years higher VA compared to Medicare (69.2% vs. 63.6%); same or better mental health at 2 years was also significantly higher at VA than in Medicare (76.1% vs. 69.6%). Propensity score matched analyses had comparable results.	A
Tarlov et al., 2012	Safety [Same]	Nat'l	VA users [N=1465]	1999-2001	Nat'l	Medicare FFS users [N=1042]	1999-2001	Colon cancer	Overall and event-free survival to 36 months, adjusted	Overall survival hazard ratios were similar. Among VA users, hazard ratios were 0.50 (95% CI 0.35–0.71) compared to 0.63 (0.43–0.91) for Medicare users for stage 1, 0.72 (0.52–0.99) and 0.79 (0.57–1.11) for stage 2, and 0.71 (0.53–0.96) and 0.80 (0.59–1.09) for stage 3. Event-free survival hazard ratios were also not significantly different.	A
Trivedi et al., 2011	Effectiveness [Better] Equity [Better]	Nat'l	VA patients [N=293554]	2000-2007	Nat'l	Medicare Advantage (MA) enrollees [N=5768573]	2000-2007	DM, IHD, HTN, Preventive care	Health Employer Data Information Set (HEDIS) or External Peer Review Program (EPRP) indicators	The VA had higher aggregate performance than MA for 10 of 11 measures in the initial year of assessment, and all 12 measures in the final year. Adjusted differences range from 4.3 percentage points (95% CI, 3.2-5.4) for cholesterol testing in CHD to 30.8 percentage points (95% CI, 28.1-33.5) for colorectal cancer screening. In adjusted analyses, the VA had significantly narrower income and educational disparities for 9 of 12 measures.	A/B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Vaughan-Sarrazin et al., 2007	Safety [Worse]	Nat'l	Male VA users [N=139331]	1996-2002	Nat'l	Male Medicare patients [N=1212729]	1996-2002	Cardio	30, 90, 365 day mortality, adjusted	Adjusted mortality after CABG was higher (p<.001) in VA users compared with nonusers at 30, 90, and 365 days: OR 1.07 (95% CI 1.03-1.11), 1.07 (95% CI 1.04-1.10), and 1.09 (95% CI, 1.06-1.12), respectively. For PCI, adjusted mortality at 30 and 90 days was similar (p>.05), but was higher for VA users at 365 days (OR 1.09; 95 percent CI, 1.06-1.12).	A
Wang et al., 2005	Effectiveness [Better]	Nat'l	VA users [N=3391]	2000	Nat'l	Non-VA users [N=178735]	2000	Overweight/ Obesity	Association between being an obese VA user and weight control advice, adjusted	Obese VA users were twice as likely to have received professional advice to lose weight (OR 2.06; 95% CI 1.64 to 2.59) and as likely to have received professional advice to maintain weight (OR 1.72; 95% CI 0.75 to 3.97).	B
Wang et al., 2013	Safety [Same] Efficiency [Worse]	Mult VISNs	VA dialysis users [N=381]	2007-2008	Mult VISNs	Veterans who received outpatient dialysis exclusively in VA-outsourced settings [N=659]	2007-2008	ESRD	Adjusted all-cause hospitalization at 1 y, adjusted all-cause mortality at 1 y, adjusted	There was no difference in mortality outcomes among veterans who received outpatient dialysis exclusively in VA-outsourced compared to VA dialysis users (OR 0.80, 95% CI 0.48-1.3). Veterans who received outpatient dialysis exclusively in VA-outsourced settings were also less likely to be hospitalized within a year (OR 0.35, 95% CI 0.24-0.51, p<0.001) and, if hospitalized, had shorter length-of-stay (β= −0.37, p<0.05).	A
Weeks et al., 2009	Effectiveness [Better]	Nat'l	VA patients [sample size not reported]	2005-2006	Nat'l	Medicare FFS patients [sample size not reported]	2005-2006	CHF, DM, IHD, Pulm, Preventive care, general anc cardiovascular surgery	Quality measures of outpatient and inpatient care	The VA outperformed Medicare fee-for-service performance in one measure of mammography and two measures of outpatient diabetic management. In addition, in 2005 and 2006, the VA uniformly performed better than hospitals contributing to Hospital Compare.	B
West et al., 2006	Effectiveness [Better]	Nat'l	VA users [N=1928]	2000	Nat'l	Veteran VA non-users and non-Veterans [N=12461]	2000	None	Routine checkup within last 2 years	VA patients reported the higher rates of seeing a doctor for a routine checkup within the past 2 years (91.6% vs. other groups [data not reported]; P < .0001).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Articles from previous review (with additional information abstracted as necessary)											
Bansal et al., 2005	Effectiveness [Better]	Single ctr	VA patients [N=117]	2002	Nat'l	Registry not further described [sample size not given]	2002	IHD	Use of aspirin, beta blockers, ace inhibitors, heparin, gp2a3b inhibitors among pts with MI	Use of all these agents were higher in the Little Rock VA compared to the rest of Arkansas and the entire US.	B
Barnett et al., 2006	Effectiveness [Better]	Nat'l	VA patients [N=123633]	2002-2003	Nat'l	Medicare HMO patients [N=157517]	2000-2001	Other safety	Use of potentially inappropriate medications among the elderly	Compared with private sector patients, VA patients were less likely to receive any inappropriate medication (21% vs. 29%, P <0.001), and in each classification: always avoid (2% vs. 5%, P <0.001), rarely appropriate (8% vs. 13%, P<0.001), and some indications (15% vs. 17%, P <0.001).	B
Berlowitz et al., 2005	Safety [Mixed]	One VISN	Veterans in VA nursing homes [N=3802]	1997-1999	Lrg geo area	Veterans in contract nursing homes [N=961]	1997-1999	Other medical/ nonsurgical condition	Risk-adjusted rates of pressure ulcer development, functional decline, behavioral decline, and mortality	Veterans in VA nursing homes were significantly (P<.05) less likely to develop a pressure ulcer (OR 0.63), but more likely to experience functional decline (OR1.6) than veterans in community nursing homes. Veterans in VA nursing homes were also less likely to die but more likely to experience behavioral decline, but these differences did not achieve statistical significance after risk adjustment.	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Bilimoria et al., 2007	Safety [Same]	Nat'l	VA patients [N=513]	1985-2004	Nat'l	Academic hospital patients [N=12756] Community hospital patients [N=18299]	1985-2004	General surgical, Surgical Oncology	60-day and 3-year mortality	Unadjusted and adjusted mortality rates at 60 days and 3 years were comparable between VA, academic and community hospital settings for resection of stage I and II pancreatic cancer.	B
Campling et al., 2005	Safety [Worse]	One VISN	Male VA patients [N=862]	1995-1999	Lrg geo	Male non-VA patients [N=27936]	1995-1999	Cancer	Survival following diagnosis of lung cancer	The median survival was 6.3 months for VA patients compared with 7.9 months for patients in the rest of the state, and the 5-year overall survival rate was 12% for VA patients compared with 15% for patients in the rest of the state. The Cox model showed a hazard ratio for VA patients compared with non-VA patients of 1.22 (P< 0.001) after adjusting for age, disease stage, and race.	B
Chi et al., 2006	Effectiveness [Better]	Nat'l	VA users [N=3265]	2003	Nat'l	Veteran non-VA users [N=10677] Non-veterans [N=40331]	2003	Preventive Care	Influenza and pneumococcal vaccination	Among veterans, influenza and vaccination rates higher for VA users compared to non- users. For veterans, VA care was independently associated with influenza vaccination (adjusted OR 1.8, 95% CI1.5-2.2) and pneumococcal vaccination (adjusted OR 2.4, 95% CI 2.0-2.9).	A
Cox et al., 2005	Patient Centeredness [Better]	Mult VISNs	VA patients [N=151]	2000-2003	Mult ctrs	Private practice patients [N=79]	2000-2003	Other medical/ nonsurgical condition	Satisfaction with hearing aid fitting	Three weeks after the fitting, VA patients reported more satisfaction with their hearing aids. On some measures VA patients reported more benefit, but different measures of benefit did not give completely consistent results.	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Fink et al., 2007	Safety [Better]	Nat'l	Female VA patients [N=5157]	2001-2004	Mult. Ctrs	Female private sector patients [N=27467]	2001-2004	General surgical	30 day postoperative morbidity and mortality	Risk adjusted mortality rates are comparable between PS and VA patients, although setting of care did not enter the mortality regression model. Risk adjusted morbidity was higher in the PS compared with the VA OR 0.8 (CI 0.71-0.90).	B
Gill et al., 2007	Effectiveness [Worse]	Nat'l	VA patients [N=7395]	1995-2004	Nat'l	Privately insured patients [N=144651] Medicare/Medicaid patients [N=357345]	1995-2004	Other surgical	Time to treatment	Both VA-insured and Medicare/Medicaid-insured patients were approximately 35% less likely to receive transplants than patients with private insurance (HR 0.65; 95% CI 0.60 to 0.70; P < 0.0001). Most of this difference was explained by the fact that VA patients were less likely to be placed on the wait-list (HR 0.71; 95% CI 0.67 to 0.76), but even listed VA patients received transplants less frequently than those insured privately (HR 0.89; 95% CI 0.82 to 0.96).	A
Glasgow et al., 2007	Safety [Worse]	Nat'l	VA patients [N=377]	2001-2004	Mult. Ctrs	Private sector patients [N=692]	2001-2004	Other surgical	Postoperative outcomes (primarily morbidity and mortality)	Adjusting for case mix differences, postoperative morbidity and mortality rates for pancreatectomy were higher in the VA compared with the PS (OR 1.581, 95% CI 1.084-2.307 and OR 2.533, 95% CI 1.020– 6.290, respectively).	A/B
Hall et al., 2007	Safety [Same]	Nat'l	VA patients [N=2814]	2001-2004	Mult. Ctrs	Private sector patients [N=4268]	2001-2004	General surgical, head and neck	30 day morbidity and mortality; specific adverse event rates, LOS	Overall 30-day morbidity and mortality do not differ significantly in the VA vs. PS in risk adjusted model. Mortality event rate is too low to accurately evaluate, odds ratio for morbidity associated with VA care is 1.25 (95% CI 0.87-1.78).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Henderson et al., 2007	Safety [Worse]	Nat'l	Male VA patients [N=9409818]	2001-2004	Mult. Ctrs	Male private sector patients [N=18399]	2001-2004	General surgical	30-day postoperative morbidity and mortality	After risk adjustment for patient comorbidities and severity of illness, the odds of mortality at 30days were higher in the VA compared with the PS (OR 1.23, 95% CI). There was no significant difference in morbidity at 30days among the sites.	A/B
Hutter et al., 2007	Safety [Better]	Nat'l	Male VA patients [N=30058]	2001-2004	Mult. Ctrs	Male private sector patients [N=5174]	2001-2004	Vascular	30-day postoperative morbidity and mortality	Risk adjusted mortality was comparable among the two groups, although hospital site/type did not enter the stepwise regression model. Accounting for comorbidities and severity of illness, postoperative morbidity rates were lower in the VA population, OR 0.84 (95% CI 0.78-0.92).	A/B
Jha et al., 2007	Effectiveness [Better]	Nat'l	VHA patients [N=33504-74250]	1995-2003	Nat'l	Representative community sample [sample size not given]	1995-2003	Preventive Care	Vaccination rates	Trends in influenza and pneumonia vaccination rates were significantly different in the VA compared to those reported in the Behavioral Risk Factor Surveillance System (BRFSS) ($P < 0.001$). Pneumonia hospitalization rates decreased by 50% among elderly VA enrollees but increased among Medicare enrollees by 15% (P for difference in trend < 0.001).	B
Johnson et al., 2007	Safety [Better]	Nat'l	VA patients [N=458]	2001-2004	Mult. Ctrs	Private sector patients [N=3535]	2001-2004	Vascular	30-day postoperative morbidity and mortality	After risk adjustment, no significant difference in 30-day mortality rates among VA and PS female vascular patients. After adjusting for severity of illness, 30-day complication/morbidity rates were significantly lower in the VA compared with the PS (OR 0.60, 95% CI 0.44-0.81).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Keyhani et al., 2007	Effectiveness [Better]	Nat'l	Veterans receiving VHA / VHA and FFS MC/ VHA and MC HMOs [N=171/ 1009/145]	2000-2003	Nat'l	Veterans receiving FFS MC / MC HMO [N=3552/576]	2000-2003	Preventive Care	Self-reported use of influenza vaccination, pneumonia vaccination, serum cholesterol screening	Veterans receiving care through VA reported 10% greater use of influenza vaccination (P<.05), 14% greater use of pneumococcal vaccination (P<.01), and a nonsignificant 6% greater use of serum cholesterol screening (P=.1), than did veterans receiving care through Medicare HMOs. Veterans receiving care through Medicare FFS reported less use of all 4 preventive measures (P<.01) than did veterans receiving care through Medicare HMOs.	B
Krein et al., 2007	Safety [Better]	Nat'l	VA hospitals [N=]	2005	Nat'l	Non-VA hospitals [N=421]	2005	Other medical/ nonsurgical condition	Regular use of specific prevention modalities and a composite measure	Adjusted findings revealed that VA hospitals were significantly more likely to use chlorhexadine gluconate (OR 4.8, 95% CI 1.6-15.0) and/or to use a composite approach (OR 2.1, 95% CI 1.0-4.2) as compared with non-VA hospitals.	B
Lancaster et al., 2007	Safety [Same]	Nat'l	Procedures at VA hospitals [N=237]	2001-2004	Mult. Ctrs	Procedures at university hospitals [N=783]	2001-2004	General surgical	Post-operative morbidity and mortality at 30 days; also evaluated LOS, need for re-operation and occurrence of 18 specific postoperative events	Risk adjusted outcomes suggest that 30-day post-operative morbidity and mortality rates in the VA compared with the PS for hepatic resections do not vary significantly; after risk adjustment, morbidity rates and mortality were comparable in VA and PS. Comparing morbidity of VA with PS, OR was 0.94 (95% CI 0.62-1.42) and Mortality OR was 1.623 (95% CI 0.61-4.32)).	A/B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Lautz et al., 2007	Safety [Worse]	Nat'l	VA patients [N=374]	2001-2004	Mult. Ctrs	Private sector patients [N=2064]	2001-2004	Other surgical	30-day postoperative outcomes: morbidity (overall, specific adverse events, number of complications), mortality, LOS	No significant difference in postop morbidity or mortality among women in the VA versus non-VA settings (16.07 vs. 12.02 % p =0.21 and 0.89 vs. 0.42%, p=0.47). Unadjusted and adjusted morbidity rates were higher among men treated at the VA versus non-VA (OR 2.77, 95% CI 1.78-4.31 unadjusted and OR 2.29, 95% CI 1.28-4.10 adjusted). Unadjusted mortality rates significantly higher among men treated at VA versus non-VA (1.91% vs. 0.25% p=0.03).	A/B
Nelson et al., 2005	Effectiveness [Better]	Nat'l	Veterans with some VA care [N=254] Veterans with all VA care [N=281]	2000	Nat'l	Adults with other insurance types [N=10632]	2000	DM	Five self-reported measures of diabetes self-management and preventive care practices	Persons who received care through the VA were more likely to report taking a diabetes education class and HbA1c testing than those covered by private insurance.	B
Neumayer et al., 2007	Safety [Same]	Nat'l	VA patients [N=644]	2001-2004	Mult. Ctrs	Private sector patients [N=3179]	2001-2004	General surgical	30-day postoperative morbidity and mortality, LOS	After adjusting for comorbidities and preoperative factors, there was no significant difference in 30-day morbidity or mortality in female patients at the VA compared with the PS (OR 1.404, 95% CI 0.894-2.204).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Polsky et al., 2007	Equity [Same]	Nat'l	VA hospitalizations [N=369155]	1995-2001	Lrg geo	Non-VA hospitalizations [N=1509891]	1995-2001	CHF, IHD, Pulmonary Disease, TIA/Stroke	30-day mortality (for white and black males after hospital admission for any of the above conditions)	After risk adjustment, racial (black vs. white) differences in 30-day mortality rates after admission for 6 medical conditions were similar among VA and non-VA care settings.	B
Rehman et al., 2005	Effectiveness [Better]	One VISN	VA patients [N=12366]	2001-2003	Lrg geo	Non-VA patients [N=7734]	2001-2003	HTN	Control of blood pressure below 140/90	Blood pressure control to below 140/90 mmHg was comparable among white hypertensive men at VA (55.6%) and non-VA (54.2%) settings (P=.12). In contrast, BP control was higher among African American hypertensive men at VA (49.4%) compared with non-VA (44.0%) settings (P<.01), even after controlling for age, numerous comorbid conditions, and rural-urban classification. Being in a non-VA site was negatively associated with blood control adjusted OR 0.839 (0.742-0.949).	A

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Ross et al., 2008	Effectiveness [Better]	Nat'l	Adults receiving care at VAMCs [N=10007]	2000, 2004	Nat'l	Adults receiving care elsewhere [N=393873]	2000, 2004	DM, IHD, HTN, Preventive Care	Self-reported use of 17 recommended health care services including cancer prevention, cardiovascular risk reduction, diabetes management and infection prevention.	VA care was associated with greater use of recommended services in both years of study (6/17 services more used in 2000, 12/17 more used in 2004).	B
Selim et al., 2007	Safety [Better]	Nat'l	VHA patients [N=16725 at baseline and 12177 at follow-up]	1998-2000	Nat'l	Medicare Advantage (MA) Program patients [N=62614 at baseline and 26225 at follow-up]	1998-2000	None	Risk-adjusted 2 year mortality, change in physical and mental health status	Lower risk-adjusted mortality in the VA compared to MA (2 year mortality 7.6% in VA vs. 9.2% in MA); There were no significant differences in the probability of being alive with the same or better physical health except for the South (VA 65.8% vs. MA 62.5%, P = .0014).VA patients had a slightly higher probability than Medicare patients of being alive with the same or better mental health (71.8% vs. 70.1%, P = .002).	B
Selim et al., 2006	Safety [Better]	Nat'l	VHA patients [N=420514]	1999-2004	Nat'l	Medicare Advantage Program [N=584294]	1998-2004	Other medical/ nonsurgical condition	Risk-adjusted mortality	After adjusting for case-mix, the HR for mortality in Medicare was significantly higher than that in VA (HR, 1.404; 95% CI = 1.383–1.426).	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Selim et al., 2009	Safety [Better]	Nat'l	Medicaid-eligible VHA patients [N=2361]	1999-2000	Nat'l	Medicaid-eligible Medicare Advantage patients [N=1912]	1999-2000	Other medical/ nonsurgical condition	3-year risk adjusted mortality rate	The adjusted HR of mortality in the MA dual enrollees was significantly higher than in VA dual enrollees (HR, 1.260 [95% CI, 1.044–1.520]).	B
Turrentine et al., 2007	Safety [Same]	Nat'l	VA patients [N=178]	2001-2004	Mult. Ctrs	Private sector patients [N=371]	2001-2004	Other surgical	30-day morbidity and mortality	Unadjusted morbidity and mortality rates were higher in VA compared with PS (16.3% vs. 6.7%, p=0.003 and 2.8% vs. 0.4%, p=0.0074). Mortality event rate was too low for adjustment. Adjusting for comorbidities, the 30-day postoperative morbidity ratio in VA versus the PS was no longer significant (adjusted OR 1.33, 95% CI 0.49-3.6 compared with unadjusted OR 2.75, 95% CI: 1.55-4.91).	B
Weeks et al., 2008	Efficiency [Worse]	One VISN	Admissions inside VA system [N=107026]	1998-2000	Lrg geo	Veteran admissions outside VA system [N=159843]	1998-2000	None	Length of stay, readmission within 30 days	Across conditions, the length of stay was longer for VA admissions compared with non-VA admissions. In logistic regression, VA care was not a significant predictor of 30day readmission for veterans <65years old, however for veterans >=65 years of age initial VA admission was associated with a significantly higher odds of readmission within 30 days than non-VA index admission (OR 2.79, 95% CI 1.4-5.6).	B
Weeks et al., 2008	Safety [Mixed]	One VISN	Male VA enrollees receiving care within VA [N=50429]	1998-2000	Lrg geo	Male VA enrollees receiving care outside VA [N=74017]	1998-2000	Patient Safety Indicators (PSIs)	Risk-adjusted rates of non-obstetric patient safety indicators	Rates similar for 9 of 15 PSIs, ulcer, sepsis, iatrogenic infection, postoperative respiratory failure, postoperative metabolic derangement lower in VA, mortality higher in VA for low-risk DRGs.	B

Author, Year	Quality Dimension(s) [Assessment*]	Data Level	VA Sample [Sample Size]	Years Collected	Data Level	Non-VA Sample [Sample Size]	Years Collected	Conditions	Outcomes	Primary Findings**	Final Grade†
Weiss et al., 2006	Safety [Same]	One VISN	VA patients [N=140]	1997-2002	Lrg geo	Private sector patients [N=6949]	1997-2002	Vascular	Perioperative mortality, stroke and cardiac complications	After risk adjustment, having surgery at the VA was not a significant predictor of death (OR 2.98, 95% CI 0.51-17.6), stroke (OR 0.95, 95% CI 0.3-3.4) or cardiac complications (OR 1.07, 95% CI 0.37-3.1).	B

*We assessed each study in the review according to the statistically significant differences in performance on quality of care measures for VA care relative to a non-VA comparison group. If the VA quality of care was shown to be better than quality for non-VA care, the study was classified as "VA better." If VA quality of care was better in some instances and the same in other instances compared to non-VA care in the same study, the study was also classified as "VA better". If multiple quality measures were reported in the study and VA care was better than non-VA on some and worse on others, the study was classified as "mixed." If the quality of care in the VA and non-VA did not differ, the study was classified as "same." If the VA quality of care was shown to be worse than non-VA, the study was classified as "VA worse" (as were studies where the quality of care was worse in some instances and the same in other instances).

**The Primary Findings text has been drawn directly from the reviewed articles, and in some cases may be similar or identical to the article's text.

†Each article was given an overall assessment of quality shown in the Final Grade column. This assessment was based on the following criteria: time frames; samples (both VA and non-VA); quality measurements; outcomes; importance of measures; and statistical methods. Each of these factors was assigned a grade (A, B, or C) based on the data abstraction grading guidelines developed in the original systematic review. The overall assessment was predicated on the global assessment of the article considering the individual components, but was not an average. Thus an article that had, for example, a critical flaw in methodology would be a "C," even if other issues were satisfactory. Articles that received an overall grade of "C" were rejected from the review.

Table abbreviations: Acute myocardial infarction (AMI), confidence interval (CI), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery bypass graft (CABG), diabetes mellitus (DM), diagnosis-related group (DRG), emergency department (ED), emergency room (ER), end stage renal disease (ESRD), fee-for-service (FFS), hazard ratio (HR), Healthcare Cost and Utilization Project-Nationwide Inpatient Sample (HCUP-NIS), health maintenance organization (HMO), hemoglobin A1c (HbA1c), hypertension (HTN), inpatient quality indicator (IQI), intensive care unit (ICU), ischemic heart disease (IHD), length of stay (LOS), Medicare Advantage (MA), myocardial infarction (MI), not reported (NR), odds ratio (OR), private sector (PS), relative risk (RR), transient ischemic attack (TIA), Veterans Affairs (VA), Veterans Integrated Service Network (VISN).

Appendix G.2 Quality Measure Definitions

Available upon request

Appendix G.3 VA and Non-VA Performance Rates for Quality Measures

Table G-1. Variation in VA Facility-Level Performance on Quality Measures for Outpatient Setting, FY2014

Measure	VA Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Facilities**
Patient-Centeredness										
Communication (How Well Providers Communicate with Patients)	AdjComm	140	76.5	76.3	64.2	85.6	71.1	82.0	10.9	83.1
Office Staff (Helpful, Courteous, and Respectful Office Staff)	AdjOfficeStaff	140	71.8	72.0	59.0	82.9	65.1	78.5	13.4	80.1
Comprehensiveness (Providers Pay Attention to Your Mental or Emotional Health)	AdjComprehensiveness	140	63.1	63.3	52.9	73.5	56.8	68.6	11.7	70.5
Self-Management Support (Providers Support You in Taking Care of Your Own Health)	AdjSelfManagement	140	56.1	56.0	44.8	63.9	50.4	61.8	11.4	62.6

Measure	VA Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Facilities**
Providers Discuss Medication Decisions	AdjMedDecision	140	62.5	62.4	50.6	72.2	57.8	67.5	9.6	69.0
Patients' Rating of the Provider	OverallRatingOfProvider	140	70.0	70.4	54.6	83.8	63.4	76.5	13.0	78.4
Follow-up on Test Results	CoordinationQ27	140	62.4	62.7	40.3	80.1	54.0	71.3	17.3	74.8
Provider was informed and up-to-date on care received from specialist	CoordinationQ34	140	59.3	59.4	45.5	72.2	52.1	65.4	13.4	68.3
Talked about prescription medicines at each visit	CoordinationQ38	140	83.7	83.9	74.0	91.5	79.0	87.7	8.7	88.9
Provider's office gave information on what to do if care needed on evenings, weekends, or holidays	InformationQ10	140	70.9	70.9	58.3	81.4	64.5	76.5	12.0	78.3
Got reminders from provider's office between visits	InformationQ17	140	79.1	79.1	61.9	87.2	74.9	83.4	8.5	84.9
Effectiveness of Care: Process Measures										
Screening, Prevention and Wellness										
Tobacco Use: Advising Smokers and Tobacco Users to Quit	smg8	140	95.3	96.7	70.9	100.0	89.0	99.8	10.8	99.9

Measure	VA Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Facilities**
Tobacco Use: Discussing Cessation Strategies	smg9	140	95.3	96.5	78.6	100.0	89.4	99.8	10.4	99.9
Tobacco Use: Discussing Cessation Medications	smg10	140	93.8	95.4	68.8	100.0	87.5	99.5	12.0	99.9
Flu Shots for Adults Ages 50–64	p22h	140	65.0	64.5	45.0	79.0	58.5	74.0	15.5	75.8
Influenza Immunization 18-64 (OP)	p26h	140	57.7	58.0	44.0	79.0	50.0	64.5	14.5	68.4
Flu Shots for Older Adults (65+)	p25h	140	75.5	76.0	57.0	89.0	66.5	83.0	16.5	85.1
Pneumococcal Vaccination Status for Older Adults	p1	140	91.3	91.6	82.9	97.6	87.1	94.7	7.6	95.4
Breast Cancer Screening (50-74)	p31h	140	86.6	87.0	72.0	95.0	81.0	91.0	10.0	91.9
Cervical Cancer Screening (21-64, every three years)	p41h	140	91.7	91.9	81.4	99.4	86.7	96.0	9.3	97.2
Colorectal Cancer Screening (50-75)	p61h	140	81.6	81.4	70.2	93.3	77.1	86.5	9.4	88.9
Chronic Condition Management										
Persistence of Beta-Blocker Treatment After a Heart Attack	ihd20h	134	92.4	100.0	0.0	100.0	80.0	100.0	20.0	100.0
Comprehensive Diabetes Care										

Measure	VA Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Facilities**
Blood Pressure Control (diagnosis of DM and hypertension, 18-85 years, and <140/90 mm Hg)	dmg27h	140	77.9	78.4	66.8	88.6	71.8	84.3	12.5	85.7
Eye Exams	dmg31h	140	90.1	90.5	76.9	98.1	85.2	94.7	9.5	96.2
HbA1c Screening	c9h	140	98.5	98.6	94.9	100.0	97.3	99.6	2.4	99.8
Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	dmg23h	140	19.3	18.8	11.0	30.4	14.9	24.7	9.8	13.5
LDL Cholesterol Screening	dmg32h	140	96.9	97.4	91.5	100.0	93.8	98.9	5.0	99.3
LDL Cholesterol Control (<100 mg/dL)	dmg25h	140	67.4	67.3	51.3	82.3	60.0	75.3	15.3	77.5
Medical Attention for Nephropathy	dmg34h	140	94.8	95.2	86.0	99.3	91.7	98.1	6.3	98.5
Controlling High Blood Pressure (Diagnosis of hypertension, 18-85 years and <140/90)	htn9h	140	75.3	75.4	65.4	83.5	69.3	81.0	11.7	82.1
Cholesterol Management for Patients With Cardiovascular Conditions										
LDL Cholesterol Screening	ihd16h	140	95.7	96.0	87.9	100.0	92.0	98.5	6.6	99.1
LDL Cholesterol Control (<100 mg/dL)	ihd18hn	140	69.7	69.9	50.4	85.7	60.2	76.8	16.6	79.5

Measure	VA Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Facilities**
Antidepressant Medication Management										
Acute Phase	mdd43h	140	72.4	73.0	50.9	91.3	57.5	85.3	27.8	88.2
Continuation Phase	mdd47h	140	56.8	57.4	35.6	73.8	44.3	68.7	24.4	71.1

*National means based on VA facility-level data may differ from national measure rates in VA publications, which are based on patient-level data.

**Mean of measure rates for best-performing 10% of VA facilities.

Source: VA facility-level data for FY2014 was obtained from the VA Office of Performance Measurement.

Table G-2. Performance on Outpatient Quality Measures, VA Compared to Non-VA, 2013

HEDIS Measure	VA Measure ID	VA Facility-Level Mean, FY2013*	Non-VA Commercial HMO, 2013	Non-VA Medicare HMO, 2013	Non-VA Medicaid HMO, 2013	P-value for Difference Between VA and Commercial HMOs	P-value for Difference Between VA and Medicare HMOs	P-value for Difference Between VA and Medicaid HMOs
Tobacco Use: Advising Smokers and Tobacco Users to Quit	smg8	95.9	77.3	84.6	75.8	<0.001	<0.001	<0.001
Breast Cancer Screening (50-74)	p31h	86.6	74.3	71.3	57.9	<0.001	<0.001	<0.001
Colorectal Cancer Screening (50-75)	p61h	81.4	63.3	64.3	--	<0.001	<0.001	-
Chronic Condition Management								
Persistence of Beta-Blocker Treatment After a Heart Attack	ihd20h	91.7	83.9	90.0	84.2	<0.001	0.25	<0.001
Comprehensive Diabetes Care								
Blood Pressure Control (diagnosis of DM and hypertension, 18-85 years, and <140/90 mm Hg)	dmg27h	78.9	65.0	65.6	60.4	<0.001	<0.001	<0.001
Eye Exams	dmg31h	90.0	55.7	68.5	53.6	<0.001	<0.001	<0.001
HbA1c Screening	c9h	98.5	89.9	92.3	83.8	<0.001	<0.001	<0.001
Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	dmg23h	19.0	30.5	25.3	45.6	<0.001	<0.001	<0.001

HEDIS Measure	VA Measure ID	VA Facility-Level Mean, FY2013*	Non-VA Commercial HMO, 2013	Non-VA Medicare HMO, 2013	Non-VA Medicaid HMO, 2013	P-value for Difference Between VA and Commercial HMOs	P-value for Difference Between VA and Medicare HMOs	P-value for Difference Between VA and Medicaid HMOs
LDL Cholesterol Screening	dmg32h	97.1	84.9	88.9	76.0	<0.001	<0.001	<0.001
LDL Cholesterol Control (<100 mg/dL)	dmg25h	68.2	46.7	53.8	33.9	<0.001	<0.001	<0.001
Medical Attention for Nephropathy	dmg34h	95.3	84.5	91.1	79.0	<0.001	<0.001	<0.001
Controlling High Blood Pressure (Diagnosis of hypertension, 18-85 years and <140/90)	htn9h	76.1	64.4	65.5	56.5	<0.001	<0.001	<0.001
Cholesterol Management for Patients With Cardiovascular Conditions								
LDL Cholesterol Screening	ihd16h	96.0	86.7	89.6	81.1	<0.001	<0.001	<0.001
LDL Cholesterol Control (<100 mg/dL)	ihd18hn	69.7	57.5	58.6	40.5	<0.001	<0.001	<0.001
Antidepressant Medication Management								
Acute Phase	mdd43h	70.3	64.4	66.8	50.5	<0.001	<0.001	<0.001
Continuation Phase	mdd47h	53.6	47.4	53.3	35.2	<0.001	0.73	<0.001

*National means based on VA facility-level data may differ from national measure rates in VA publications, which are based on patient-level data.
Source: Facility-level data for VA patients for FY2013 was obtained from the VA Office of Performance Measurement. National data for CY2013 for non-VA subgroups of patients (commercial HMO, Medicare HMO, and Medicaid HMO) was obtained from the following report: National Committee for Quality Assurance. 2014. *The State of Health Care Quality 2014.* Available as of March 20, 2015 at www.ncqa.org.

Table G-3. Variation in VA Facility-Level Performance on Quality Measures for Hospital Inpatient Setting, FY2014

Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Hospitals**
Patient-Centeredness†										
Communication with Nurses	COMMNURSE_adj_t		121	74.7	60.7	87.2	67.7	80.9	13.2	82.7
Communication with Doctors	COMMDOC_adj_t		121	76.6	60.7	84.7	72.3	81.6	9.3	82.6
Communication about Medicine	COMMRX_adj_t		117	62.7	51.6	75.0	54.7	69.5	14.8	71.6
Shared Decision Making	SDM_adj_t		121	74.4	60.7	84.4	69.2	79.9	10.7	81.4
Responsiveness of Hospital Staff	NURSESVCS_adj_t		115	61.5	45.3	84.1	51.8	71.2	19.4	74.3
Discharge Information	DSCHRG_adj_t		121	83.5	76.0	92.6	79.2	88.3	9.1	89.7
Pain Management	PAINMGMT_adj_t		115	63.8	52.8	73.0	57.0	70.7	13.7	71.8
Care Transition	CTM_adj_t		121	50.9	40.6	61.0	44.6	56.1	11.5	58.4
Cleanliness of the Hospital Environment	CLEANHOSP_adj_t		121	71.6	52.9	91.1	62.3	81.4	19.1	84.5
Quietness of the Hospital Environment	QUIETHOSP_adj_t		121	58.3	41.1	80.2	47.8	70.8	23.0	73.6
Overall Rating of Hospital	INPTOQ_adj_t		122	63.6	40.6	80.6	53.2	72.3	19.1	76.1
Effectiveness of Care: Process Measures										

Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Hospitals**
Acute Myocardial Infarction										
Timing of receipt of primary percutaneous coronary intervention (PCI)	-	AMI-8a	8	85.3	64.0	100.0	64.0	100.0	36.0	100.0
Aspirin prescribed at discharge	-	AMI-2	70	99.4	91.0	100.0	98.0	100.0	2.0	100.0
Statin prescribed at discharge	-	AMI-10	69	99.0	89.0	100.0	97.0	100.0	3.0	100.0
Heart Failure	-									
Discharge instructions	-	HF-1	116	95.9	81.0	100.0	89.0	100.0	11.0	100.0
Evaluation of LVS function	-	HF-2	118	99.8	97.0	100.0	99.0	100.0	1.0	100.0
Medication (ACEI or ARB) for LVSD	-	HF-3	109	96.2	65.0	100.0	91.0	100.0	9.0	100.0
Pneumonia	-									
Initial antibiotic for community-acquired pneumonia (CAP) in immunocompetent patient	-	PN-6	117	94.7	78.0	100.0	89.0	100.0	11.0	100.0
Surgical Care	-									
Prophylactic antibiotic received within one hour prior to surgical incision	-	SCIP-Inf-1a	98	96.3	62.0	100.0	91.0	100.0	9.0	100.0

Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Hospitals**
Prophylactic antibiotics discontinued within 24 hours after surgery end time	-	SCIP-Inf-3a	98	97.1	74.0	100.0	94.0	100.0	6.0	100.0
Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	-	SCIP-VTE-2	98	98.1	88.0	100.0	95.0	100.0	5.0	100.0
Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period	-	SCIP-CARD-2	94	96.0	74.0	100.0	90.0	100.0	10.0	100.0
Prophylactic antibiotic selection for surgical patients	-	SCIP-Inf-2a	98	98.2	81.0	100.0	96.0	100.0	4.0	100.0
Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose	-	SCIP-INF-4	38	93.3	82.0	100.0	88.0	98.0	10.0	98.8
Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero	-	SCIP-INF-9	96	98.0	85.0	100.0	95.0	100.0	5.0	100.0
Surgery patients with perioperative temperature management	-	SCIP-INF-10	95	99.1	93.0	100.0	98.0	100.0	2.0	100.0
Patient Safety										

Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Hospitals**
Complication/patient safety for selected indicators (composite) (observed:expected)***	PSI-90-SAFETY		131	0.9	0.4	1.5	0.6	1.1	0.5	0.5
Death rate (per 1,000) among surgical inpatients with serious treatable complications***	PSI-4-SURG-COMP		101	96.5	0.0	286.7	0.0	159.9	159.9	0.0
Iatrogenic pneumothorax (per 1,000)***	PSI-6-IAT-PTX		130	0.4	0.0	2.1	0.0	1.0	1.0	0.0
Postoperative pulmonary embolism or deep vein thrombosis rate (per 1,000)***	PSI-12		124	3.2	0.0	14.6	0.0	6.7	6.7	0.0
Postoperative wound dehiscence (per 1,000)***	PSI-14		113	1.8	0.0	14.2	0.0	5.2	5.2	0.0
Accidental puncture or laceration (per 1,000)***	PSI-15		130	1.6	0.0	5.7	0.0	3.3	3.3	0.0
Outcome Measures										
Readmission										
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized readmission rate***		READM-30-AMI	80	18.6	16.1	21.0	17.4	19.8	2.4	16.9
Heart failure (HF) 30-day all-cause risk-standardized readmission rate***		READM-30-HF	121	23.4	19.0	28.6	21.1	26.3	5.2	20.3

Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing VA Hospitals**
Pneumonia (PN) 30-day all-cause risk-standardized readmission rate***		READM-30-PN	121	18.1	14.6	22.1	15.9	20.1	4.2	15.5
Mortality										
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized mortality rate***		MORT-30-AMI	86	14.3	11.5	17.8	13.1	15.5	2.4	12.7
Heart failure (HF) 30-day all-cause risk-standardized mortality rate***		MORT-30-HF	120	10.9	7.4	15.3	9.0	12.9	3.9	8.5
Pneumonia (PN) 30-day all-cause risk-standardized mortality rate***		MORT-30-PN	121	11.6	6.9	16.2	9.3	14.0	4.7	8.8

*National means based on VA facility-level data may differ from national measure rates in VA publications, which are based on patient-level data.

**Mean of measure rates for best-performing 10 percent of VA facilities.

***For this measure, a lower rate indicates better performance.

† To assess variation in inpatient SHEP scores across facilities within VA, we used inpatient SHEP scores that the VA adjusted using VA's internal patient mix adjustment model, which includes the following variables: age, sex, priority group, urban/rural residence, hospital service line (surgical/medical), self-reported health status, self-reported mental health status, education, and race/ethnicity.

Sources: VA facility-level data for patient experience measures for FY2014 was obtained from the VA Office of Performance Measurement. VA facility-level data for patient safety indicator measures for FY2014 was obtained from the VA Inpatient Evaluation Center. VA facility-level data for all other measures was obtained from the CMS Hospital Compare website for Quarter 4 of FY2014.

Table G-4. Comparison of Mean Facility-Level Performance of VA and *Matched Non-VA Facilities* on Measures for Inpatient Setting, FY2014

Measure Name	VA Measure ID	Hospital Compare Measure ID	FY2014 VA Sample Size	FY2014 VA Mean*	FY2014 Matched Non-VA Sample Size	FY2014 Matched Non-VA Mean	P-value for comparison of 2014 VA vs. Non-VA Means (t-test)	Cohen's D Effect Size for FY2014 Difference
Communication with Nurses	COMMNURSE_adj_t	H_COMP_1_A_P	114	74.1	321	77.8	< 0.001	-0.65
Communication with Doctors	COMMDOC_adj_t	H_COMP_2_A_P	114	77.1	321	80.3	< 0.001	-0.59
Communication about Medicine	COMMRX_adj_t	H_COMP_5_A_P	110	65.1	309	63.0	0.001	0.30
Responsiveness of Hospital Staff	NURSESVCS_adj_t	H_COMP_3_A_P	109	63.0	306	64.8	0.024	-0.20
Discharge Information	DSCHRG_adj_t	H_COMP_6_Y_P	113	85.9	318	85.8	0.852	0.02
Pain Management	PAINMGMT_adj_t	H_COMP_4_A_P	108	63.3	304	69.9	< 0.001	-1.11
Care Transition	CTM_adj_t	H_COMP_7_A	114	53.7	320	43.3	< 0.001	1.72
Cleanliness of the Hospital Environment	CLEANHOSP_adj_t	H_CLEAN_HSP_A_P	114	72.8	321	71.2	0.031	0.20
Quietness of the Hospital Environment	QUIETHOSP_adj_t	H_QUIET_HSP_A_P	114	55.4	321	58.9	< 0.001	-0.34
Overall Rating of Hospital	INPTOQ_adj_t	H_HSP_RATING_9_10	114	67.1	321	70.3	< 0.001	-0.35
Timing of receipt of primary percutaneous coronary intervention (PCI)		AMI_8A	8	85.3	17	96.5	0.001	-1.12
Aspirin prescribed at discharge		AMI_2	64	99.6	156	98.9	0.055	0.10
Statin prescribed at	-	AMI_10	64	99.0	156	97.8	0.088	0.09

Measure Name	VA Measure ID	Hospital Compare Measure ID	FY2014 VA Sample Size	FY2014 VA Mean*	FY2014 Matched Non-VA Sample Size	FY2014 Matched Non-VA Mean	P-value for comparison of 2014 VA vs. Non-VA Means (t-test)	Cohen's D Effect Size for FY2014 Difference
discharge								
Discharge instructions	-	HF_1	112	95.8	304	94.5	0.213	0.08
Evaluation of LVS function	-	HF_2	115	99.8	315	98.5	0.043	0.10
Medication (ACEI or ARB) for LVSD	-	HF_3	102	96.3	264	96.8	0.427	-0.06
Initial antibiotic for community-acquired pneumonia (CAP) in immunocompetent patient	-	PN_6	114	94.8	313	95.4	0.396	-0.06
Prophylactic antibiotic received within one hour prior to surgical incision	-	SCIP_INF_1	96	96.3	266	98.5	< 0.001	-0.36
Prophylactic antibiotics discontinued within 24 hours after surgery end time	-	SCIP_INF_3	96	97.1	266	97.8	0.113	-0.11
Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	-	SCIP_VTE_2	96	98.1	268	98.5	0.127	-0.05
Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period	-	SCIP_CARD_2	92	95.9	251	96.8	0.46	-0.10

Measure Name	VA Measure ID	Hospital Compare Measure ID	FY2014 VA Sample Size	FY2014 VA Mean*	FY2014 Matched Non-VA Sample Size	FY2014 Matched Non-VA Mean	P-value for comparison of 2014 VA vs. Non-VA Means (t-test)	Cohen's D Effect Size for FY2014 Difference
Prophylactic antibiotic selection for surgical patients	-	SCIP_INF_2	96	98.2	266	98.8	0.059	-0.12
Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose	-	SCIP_INF_4	28	92.6	57	92.1	0.791	0.10
Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero	-	SCIP_INF_9	93	98.1	259	97.4	0.173	0.08
Surgery patients with perioperative temperature management		SCIP_INF_10	93	99.1	261	99.8	< 0.001	-0.18
Complication/patient safety for selected indicators (composite)**	PSI-90-SAFETY	PSI_90_SAFETY	118	0.9	316	0.9	0.588	0.00
Complication/patient safety for selected indicators (composite)**	PSI-4-SURG-COMP	PSI_4_SURG_COMP	81	100.6	191	118	< 0.001	-0.94
Iatrogenic pneumothorax**	PSI-6-IAT-PTX	PSI_6_IAT_PTX	117	0.4	311	0.4	0.177	0.00
Postoperative pulmonary embolism or deep vein thrombosis rate**	PSI-12	PSI_12	111	3.3	286	4.6	< 0.001	-0.69
Postoperative wound dehiscence**	PSI-14	PSI_14	100	1.7	258	1.9	0.354	-0.30
Accidental puncture or	PSI-15	PSI_15	117	1.7	311	2.0	0.002	-0.42

Measure Name	VA Measure ID	Hospital Compare Measure ID	FY2014 VA Sample Size	FY2014 VA Mean*	FY2014 Matched Non-VA Sample Size	FY2014 Matched Non-VA Mean	P-value for comparison of 2014 VA vs. Non-VA Means (t-test)	Cohen's D Effect Size for FY2014 Difference
laceration**								
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized readmission rate**		READM_30_AMI	73	18.6	178	17.8	< 0.001	0.52
Heart failure (HF) 30-day all-cause risk-standardized readmission rate**		READM_30_HF	115	23.4	319	22.6	< 0.001	0.40
Pneumonia (PN) 30-day all-cause risk-standardized readmission rate**		READM_30_PN	117	18.1	323	17.5	< 0.001	0.39
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized mortality rate**		MORT_30_AMI	80	14.3	201	14.7	0.066	-0.27
Heart failure (HF) 30-day all-cause risk-standardized mortality rate**		MORT_30_HF	114	11.0	310	11.8	< 0.001	-0.52
Pneumonia (PN) 30-day all-cause risk-standardized mortality rate**		MORT_30_PN	117	11.6	323	11.7	0.482	-0.05

*National means based on VA facility-level data may differ from national measure rates in VA publications, which are based on patient-level data.
**For this measure, a lower rate indicates better performance.
Sources: VA facility-level data for patient experience measures for FY2014 was obtained from the VA Office of Performance Measurement. VA facility-level data for patient safety indicator measures for FY2014 was obtained from the VA Inpatient Evaluation Center. VA facility-level data for all other measures and all non-VA facility-level data for Quarter 4 of FY2014 were obtained from the CMS Hospital Compare website. For patient-centeredness measures derived from the inpatient SHEP and HCAHPS, results for both VA and non-VA facilities are adjusted for patient characteristics, mode of survey administration, and national mean hospital performance using guidance provided by CMS.

Table G-5. Variation in Facility-Level Performance of *Matched Non-VA Hospitals* on Quality Measures for Hospital Inpatient Setting, FY2014

Measure	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing Non-VA Hospitals**
Patient-Centeredness										
Communication with Nurses	H-COMP-1-A-P	350	77.6	78.0	56.0	95.0	72.0	83.0	11.0	85.2
Communication with Doctors	H-COMP-2-A-P	350	80.2	80.0	25.0	100.0	75.0	86.0	11.0	88.2
Communication about Medicine	H-COMP-5-A-P	349	62.8	62.0	43.0	88.0	56.0	69.0	13.0	72.1
Shared Decision Making	N/A									
Responsiveness of Hospital Staff	H-COMP-3-A-P	349	64.6	64.0	40.0	87.0	57.0	74.0	17.0	77.6
Discharge Information	H-COMP-6-Y-P	350	85.7	86.0	27.0	95.0	81.0	90.0	9.0	91.0
Pain Management	H-COMP-4-A-P	350	69.7	70.0	33.0	85.0	64.0	75.0	11.0	76.8
Care Transition	H-COMP-7-A	349	43.4	44.0	20.0	60.0	38.0	49.0	11.0	51.1
Cleanliness of the Hospital Environment	H-CLEAN-HSP-A-P	350	71.1	71.0	52.0	100.0	62.0	79.0	17.0	82.4
Quietness of the Hospital Environment	H-QUIET-HSP-A-P	350	58.9	59.0	0.0	83.0	49.0	69.0	20.0	72.5
Overall Rating of Hospital	H-HSP-RATING-9-10	350	70.0	71.0	40.0	95.0	59.0	78.5	19.5	83.4
Effectiveness of Care: Process Measures										

Measure	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing Non-VA Hospitals**
Acute Myocardial Infarction										
Timing of receipt of primary percutaneous coronary intervention (PCI)	AMI-8a	218	95.3	97.0	64.0	100.0	88.0	100.0	12.0	100.0
Aspirin prescribed at discharge	AMI-2	275	98.9	100.0	71.0	100.0	97.0	100.0	3.0	100.0
Statin prescribed at discharge	AMI-10	275	97.9	99.0	57.0	100.0	95.0	100.0	5.0	100.0
Heart Failure										
Discharge instructions	HF-1	332	94.3	97.0	0.0	100.0	87.0	100.0	13.0	100.0
Evaluation of LVS function	HF-2	342	98.7	100.0	42.0	100.0	98.0	100.0	2.0	100.0
Medication (ACEI or ARB) for LVSD	HF-3	301	97.1	99.0	64.0	100.0	91.0	100.0	9.0	100.0
Pneumonia										
Initial antibiotic for community-acquired pneumonia (CAP) in immunocompetent patient	PN-6	346	95.5	97.0	37.0	100.0	91.0	100.0	9.0	100.0
Surgical Care										
Prophylactic antibiotic received within one hour prior to surgical incision	SCIP-Inf-1a	342	98.4	99.0	64.0	100.0	96.0	100.0	4.0	100.0

Measure	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing Non-VA Hospitals**
Prophylactic antibiotics discontinued within 24 hours after surgery end time	SCIP-Inf-3a	342	97.8	99.0	66.0	100.0	95.0	100.0	5.0	100.0
Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	SCIP-VTE-2	343	98.5	99.0	85.0	100.0	97.0	100.0	3.0	100.0
Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period	SCIP-CARD-2	332	96.9	99.0	5.0	100.0	93.0	100.0	7.0	100.0
Prophylactic antibiotic selection for surgical patients	SCIP-Inf-2a	342	98.8	99.0	83.0	100.0	97.0	100.0	3.0	100.0
Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose	SCIP-INF-4	168	94.2	96.0	55.0	100.0	86.0	100.0	14.0	100.0
Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero	SCIP-INF-9	336	97.3	99.0	64.0	100.0	93.0	100.0	7.0	100.0
Surgery patients with perioperative temperature management	SCIP-INF-10	344	99.8	100.0	92.0	100.0	99.0	100.0	1.0	100.0
Patient Safety										
Complication/patient safety for selected indicators (composite) (observed:expected)***	PSI-90-SAFETY	327	0.9	0.9	0.5	1.9	0.6	1.2	0.6	0.6

Measure	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing Non-VA Hospitals**
Death rate (per 1,000) among surgical inpatients with serious treatable complications***	PSI-4-SURG-COMP	245	118.6	118.7	62.3	186.4	94.4	143.8	49.4	85.6
Iatrogenic pneumothorax (per 1,000) ***	PSI-6-IAT-PTX	325	0.4	0.4	0.2	0.7	0.3	0.5	0.2	0.3
Postoperative pulmonary embolism or deep vein thrombosis rate (per 1,000) ***	PSI-12	311	4.6	4.2	1.4	15.1	2.6	6.9	4.3	2.3
Postoperative wound dehiscence (per 1,000) ***	PSI-14	297	1.9	1.8	0.9	3.6	1.5	2.3	0.8	1.4
Accidental puncture or laceration (per 1,000) ***	PSI-15	325	2.0	1.9	0.6	6.3	1.2	3.1	1.9	0.9
Outcome Measures										
Readmission										
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized readmission rate***	READM-30-AMI	280	17.8	17.8	14.3	21.6	16.4	19.2	2.9	15.8
Heart failure (HF) 30-day all-cause risk-standardized readmission rate***	READM-30-HF	342	22.6	22.6	16.6	29.7	20.3	25.0	4.7	19.3
Pneumonia (PN) 30-day all-cause risk-standardized readmission rate***	READM-30-PN	347	17.5	17.4	14.4	22.2	15.6	19.3	3.7	15.1
Mortality										

Measure	Hospital Compare Measure ID	Number of Reporting Facilities	Mean*	Median	Minimum	Maximum	10th Percentile	90th Percentile	Difference between 90th and 10th Percentiles	Mean of Best Performing Non-VA Hospitals**
Acute myocardial infarction (AMI) all-cause risk-standardized 30-day mortality rate***	MORT-30-AMI	290	14.6	14.6	9.4	20.0	12.9	16.4	3.5	12.3
Heart failure (HF) 30-day all-cause risk-standardized mortality rate***	MORT-30-HF	334	11.8	11.7	7.9	17.1	9.9	13.7	3.8	9.2
Pneumonia (PN) 30-day all-cause risk-standardized mortality rate***	MORT-30-PN	347	11.7	11.5	7.4	21.6	9.5	14.1	4.6	8.9

*These represent national means based on facility-level data.

**Mean of measure rates for best-performing 10 percent of VA facilities.
***For this measure, a lower rate indicates better performance.

Source: Data for matched non-VA facility-level data for Quarter 4 of FY2014 was obtained from the CMS Hospital Compare website.

Table G-6. Comparison of Mean Facility-Level Performance of VA and *All Non-VA Facilities* on Measures for Inpatient Setting, FY2014

		VA Facilities			All Non-VA Facilities			
Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 VA Mean*	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 Matched Non-VA Mean	P-value for comparison of FY2014 VA vs. Non-VA Means (t-test)
Patient-Centeredness								
Communication with Nurses	COMMNURSE_adj_t		114	74.1	H-COMP-1-A-P	4065	79.1	< 0.001
Communication with Doctors	COMMDOC_adj_t		114	77.1	H-COMP-2-A-P	4065	81.8	< 0.001
Communication about Medicine	COMMRX_adj_t		110	65.1	H-COMP-5-A-P	4058	64.3	0.255
Responsiveness of Hospital Staff	NURSESVCS_adj_t		109	63.0	H-COMP-3-A-P	4063	67.8	< 0.001
Discharge Information	DSCHRG_adj_t		113	85.9	H-COMP-6-Y-P	4063	85.7	0.787
Pain Management	PAINMGMT_adj_t		108	63.3	H-COMP-4-A-P	4058	70.8	< 0.001
Care Transition	CTM_adj_t		114	53.7	H-COMP-7-A	4063	43.5	< 0.001
Cleanliness of the Hospital Environment	CLEANHOSP_adj_t		114	72.8	H-CLEAN-HSP-A-P	4065	73.6	0.325
Quietness of the Hospital Environment	QUIETHOSP_adj_t		114	55.4	H-QUIET-HSP-A-P	4065	61.4	< 0.001

		VA Facilities			All Non-VA Facilities			
Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 VA Mean*	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 Matched Non-VA Mean	P-value for comparison of FY2014 VA vs. Non-VA Means (t-test)
Overall Rating of Hospital	INPTOQ_adj_t		114	67.1	H-HSP-RATING-9-10	4065	70.8	< 0.001
Effectiveness: Process Measures								
Acute Myocardial Infarction								
Timing of receipt of primary percutaneous coronary intervention (PCI)	-	AMI-8a	8	85.3	AMI-8a	1506	95.5	< 0.001
Aspirin prescribed at discharge	-	AMI-2	64	99.6	AMI-2	2132	98.9	0.051
Statin prescribed at discharge	-	AMI-10	64	99.0	AMI-10	2115	97.6	0.024
Heart Failure	-							
Discharge instructions	-	HF-1	112	95.8	HF-1	3353	93.3	0.017
Evaluation of LVS function	-	HF-2	115	99.8	HF-2	3724	96.4	0.001
Medication (ACEI or ARB) for LVSD	-	HF-3	102	96.3	HF-3	2615	96.5	0.837
Pneumonia	-							
Initial antibiotic for community-acquired pneumonia (CAP) in immunocompetent patient	-	PN-6	114	94.8	PN-6	3834	93.9	0.319
Surgical Care	-							

		VA Facilities			All Non-VA Facilities			
Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 VA Mean*	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 Matched Non-VA Mean	P-value for comparison of FY2014 VA vs. Non-VA Means (t-test)
Prophylactic antibiotic received within one hour prior to surgical incision	-	SCIP-Inf-1a	96	96.3	SCIP-Inf-1a	3383	98.0	0.001
Prophylactic antibiotics discontinued within 24 hours after surgery end time	-	SCIP-Inf-3a	96	97.1	SCIP-Inf-3a	3376	97.4	0.572
Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery	-	SCIP-VTE-2	96	98.1	SCIP-VTE-2	3434	97.8	0.575
Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period	-	SCIP-CARD-2	92	95.9	SCIP-CARD-2	3062	96.9	0.158
Prophylactic antibiotic selection for surgical patients	-	SCIP-Inf-2a	96	98.2	SCIP-Inf-2a	3379	98.4	0.631
Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose	-	SCIP-INF-4	28	92.6	SCIP-INF-4	1029	94.0	0.332
Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero	-	SCIP-INF-9	93	98.1	SCIP-INF-9	3239	96.8	0.045
Surgery patients with perioperative temperature management	-	SCIP-INF-10	93	99.1	SCIP-INF-10	3419	99.6	0.114
Patient Safety								

		VA Facilities			All Non-VA Facilities			
Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 VA Mean*	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 Matched Non-VA Mean	P-value for comparison of FY2014 VA vs. Non-VA Means (t-test)
Complication/patient safety for selected indicators (composite)**	PSI-90-SAFETY		118	0.9	PSI-90-SAFETY	3271	0.9	0.248
Complication/patient safety for selected indicators (composite)**	PSI-4-SURG-COMP		81	100.6	PSI-4-SURG-COMP	1856	118.5	< 0.001
Iatrogenic pneumothorax**	PSI-6-IAT-PTX		117	0.4	PSI-6-IAT-PTX	3254	0.4	0.009
Postoperative pulmonary embolism or deep vein thrombosis rate**	PSI-12		111	3.3	PSI-12	3051	4.4	< 0.001
Postoperative wound dehiscence**	PSI-14		100	1.7	PSI-14	2640	1.9	0.004
Accidental puncture or laceration**	PSI-15		117	1.7	PSI-15	3246	1.9	< 0.001
Outcome Measures								
Readmission								
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized readmission rate**		READM-30-AMI	73	18.6	READM-30-AMI	2262	17.8	< 0.001
Heart failure (HF) 30-day all-cause risk-standardized readmission rate**		READM-30-HF	115	23.4	READM-30-HF	3820	22.7	< 0.001
Pneumonia (PN) 30-day all-cause risk-standardized readmission rate**		READM-30-PN	117	18.1	READM-30-PN	4132	17.3	< 0.001
Mortality								

		VA Facilities			All Non-VA Facilities			
Measure	VA Measure ID	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 VA Mean*	Hospital Compare Measure ID	Number of Reporting Facilities	FY2014 Matched Non-VA Mean	P-value for comparison of FY2014 VA vs. Non-VA Means (t-test)
Acute myocardial infarction (AMI) 30-day all-cause risk-standardized mortality rate**		MORT-30-AMI	80	14.3	MORT-30-AMI	2488	14.8	0.001
Heart failure (HF) 30-day all-cause risk-standardized mortality rate**		MORT-30-HF	114	11.0	MORT-30-HF	3724	12.0	< 0.001
Pneumonia (PN) 30-day mortality all-cause risk-standardized rate**		MORT-30-PN	117	11.6	MORT-30-PN	4116	12.0	0.012

*National means based on VA facility-level data may differ from national measure rates in VA publications, which are based on patient-level data.
**For this measure, a lower rate indicates better performance.

Sources: VA facility-level data for patient experience measures for FY2014 was obtained from the VA Office of Performance Measurement. VA facility-level data for patient safety indicator measures for FY2014 was obtained from the VA Inpatient Evaluation Center. VA facility-level data for all other measures and all non-VA facility-level data for Quarter 4 of FY2014 were obtained from the CMS Hospital Compare website.

Appendix H Projections

Table H-1. Projected Demand and Supply in FY19, Under Supply Scenario Two, By Specialty

VA Specialty	Milliman National RVU/Year Forecast		% RVU/Year Increase from FY14 to FY19	RVU/Provider/Year FY14 Percentiles			National FY14 RVU Capacity if Providers Operated at least at the Following RVU/Provider/Year Percentiles within their Specialties (shading indicates if capacity is sufficient for FY19)		
	FY14	FY19		25th	50th (median)	75th	Prodcutivity Level 1: 25th Percentile	Productivity Level 2: 50th Percentile	Productivity Level 3: 75th Percentile
allergy.and.immunology	80,052	94,709	18%	1,913	2,515	3,741	84,626	93,739	186,881
cardiology	2,458,361	2,841,646	16%	3,576	4,255	5,254	2,516,834	2,650,712	3,426,482
chiropracty	132,684	157,526	19%	1,903	2,547	3,446	136,585	147,577	227,124
critical.care...pulmonary.disease	1,125,446	1,351,647	20%	1,610	2,304	3,446	1,175,606	1,303,273	1,979,495
dermatology	1,131,318	1,456,154	29%	4,878	7,192	9,094	1,179,059	1,319,580	2,144,952
endocrinology	393,177	472,830	20%	1,513	1,881	2,612	417,884	450,568	660,979
gastroenterology	2,231,936	2,777,841	24%	4,323	5,943	7,466	2,307,570	2,607,686	4,135,758
hematology.oncology	791,544	940,054	19%	1,783	2,472	3,190	815,961	900,372	1,288,247
infectious.disease	300,312	307,092	2%	861	1,336	1,826	317,628	361,397	579,989
internal.medicine	12,629,558	14,200,389	12%	2,124	2,326	2,626	12,913,103	13,284,748	15,756,790
nephrology	890,821	1,078,947	21%	1,466	2,643	3,704	910,271	996,913	1,801,782
neurological.surgery	284,916	316,500	11%	2,396	3,458	6,060	293,964	315,597	889,062
neurology	1,103,627	1,358,149	23%	2,009	2,501	3,124	1,174,235	1,290,376	1,928,073
obstetrics...gynecology	201,264	289,813	44%	1,956	2,643	3,237	206,864	229,819	357,279
ophthalmology	2,455,210	3,048,800	24%	5,974	7,674	10,207	2,533,009	2,747,480	4,323,505
optometry	3,007,464	3,623,840	20%	3,805	4,390	5,297	3,070,423	3,202,339	4,304,883
orthopaedic.surgery	1,469,225	1,757,782	20%	4,044	4,912	6,063	1,524,852	1,627,152	2,635,070
otolaryngology	741,631	914,182	23%	3,711	4,720	6,241	764,449	819,828	1,249,250
pain.medicine	137,860	153,928	12%	2,028	2,571	3,249	145,419	156,125	227,201
physical.medicine...rehabilitation	997,135	1,236,369	24%	1,303	1,981	2,556	1,015,150	1,121,175	1,478,384
plastic.surgery	289,755	364,239	26%	3,145	4,138	5,015	307,638	336,580	439,952
podiatry	1,510,056	1,934,881	28%	3,187	4,044	4,879	1,558,557	1,678,621	2,641,304
psychiatry	6,765,438	8,089,661	20%	2,466	2,833	3,291	6,982,331	7,307,580	8,987,955
psychology	6,627,594	8,268,017	25%	1,630	1,765	2,045	6,757,420	6,918,289	8,031,008
rheumatology	300,139	375,624	25%	1,613	2,156	2,986	316,983	354,931	521,420
surgery	1,714,422	1,990,617	16%	2,753	3,561	4,320	1,764,827	1,911,424	2,354,307
thoracic.surgery	409,685	428,621	5%	2,228	3,329	5,813	419,203	451,409	745,370
urology	1,281,601	1,545,369	21%	3,837	5,187	6,396	1,331,997	1,466,598	2,239,703
vascular.surgery	707,639	768,457	9%	3,460	4,716	6,633	728,326	790,869	1,223,258
Total	52,169,870	62,143,684	19%				53,670,775	56,842,756	76,765,464

Sources: Milliman, Inc. August 8, 2014; 2014 VA Enrollee Health Care Projection Model - Base Year 2013 - 2014 Model Documentation & Analysis; Milliman Health Practice Seattle; RAND analyses of VA provider supply; RAND analyses of VA productivity data.

Table H-2 Projected Demand and Supply in FY19, Under Supply Scenario Two, By VISN and Specialty

The table below shows the following:

1. FY14: # of RVUs forecasted by Milliman for FY14
2. FY19: # of RVUs forecasted by Milliman for FY19
3. 50th: RVUs at the 50th percentile with forecasted FY19 provider FTEs and under Sensitivity Analysis Productivity Level 2

The cell shading indicates how well Sensitivity Analysis Level 2 50th percentile performs relative to forecasted FY19 RVU demand given the forecast provider FTE change in FY19:

1. Red: Less than 10% below FY19 RVU
2. Yellow: Within 10% of FY19 RVU
3. Green: Exceeds FY19 RVU

	VISN										
VA Specialty	V01	V02	V03	V04	V05	V06	V07	V08	V09	V10	V11
allergy and immunology	FY14: 2,270 FY19: 2,721 50th: 2,717	FY14: 2,895 FY19: 3,618 50th: 2,895	FY14: 2,811 FY19: 3,364 50th: 3,474	No FY14 Data	FY14: 1,922 FY19: 2,281 50th: 1,922	No FY19 Data	FY14: 2,184 FY19: 2,980 50th: 2,381	FY14: 8,805 FY19: 9,928 50th: 12,260	FY14: 2,603 FY19: 3,153 50th: 2,832	FY14: 3,561 FY19: 4,642 50th: 3,732	FY14: 2,050 FY19: 2,503 50th: 2,442
cardiology	FY14: 103,682 FY19: 117,420 50th: 128,160	FY14: 63,314 FY19: 70,767 50th: 63,314	FY14: 75,439 FY19: 81,198 50th: 82,668	FY14: 104,604 FY19: 120,913 50th: 116,079	FY14: 52,652 FY19: 61,604 50th: 63,962	FY14: 140,120 FY19: 170,147 50th: 159,470	FY14: 118,863 FY19: 143,625 50th: 128,228	FY14: 289,186 FY19: 321,632 50th: 294,972	FY14: 142,645 FY19: 168,790 50th: 154,915	FY14: 107,721 FY19: 130,152 50th: 112,965	FY14: 99,369 FY19: 117,080 50th: 106,721
chiropracty	FY14: 7,474 FY19: 9,104 50th: 11,287	FY14: 16,186 FY19: 19,770 50th: 16,186	FY14: 391 FY19: 483 50th: 2,224	FY14: 2,590 FY19: 3,344 50th: 2,590	FY14: 2,303 FY19: 2,841 50th: 2,303	FY14: 1,578 FY19: 1,949 50th: 2,157	FY14: 2,875 FY19: 3,551 50th: 2,875	FY14: 12,239 FY19: 12,662 50th: 12,833	FY14: 2,604 FY19: 3,223 50th: 2,604	FY14: 8,749 FY19: 10,196 50th: 9,184	FY14: 4,569 FY19: 5,848 50th: 5,381
critical care pulmonary disease	FY14: 64,444 FY19: 75,934 50th: 65,661	FY14: 34,466 FY19: 41,843 50th: 34,466	FY14: 74,733 FY19: 83,259 50th: 78,545	FY14: 64,684 FY19: 77,480 50th: 79,117	FY14: 20,577 FY19: 24,465 50th: 28,114	FY14: 68,902 FY19: 87,801 50th: 76,056	FY14: 38,183 FY19: 48,551 50th: 49,207	FY14: 143,554 FY19: 160,759 50th: 151,343	FY14: 46,708 FY19: 58,471 50th: 65,788	FY14: 48,806 FY19: 62,216 50th: 59,821	FY14: 42,153 FY19: 51,742 50th: 44,642
dermatology	FY14: 60,954 FY19: 76,579 50th: 67,947	FY14: 9,685 FY19: 11,200 50th: 9,685	FY14: 61,141 FY19: 73,590 50th: 67,733	FY14: 47,883 FY19: 62,240 50th: 49,025	FY14: 32,366 FY19: 34,424 50th: 42,119	FY14: 37,270 FY19: 51,541 50th: 60,733	FY14: 53,350 FY19: 73,252 50th: 60,690	FY14: 153,963 FY19: 189,978 50th: 157,844	FY14: 54,519 FY19: 73,690 50th: 59,692	FY14: 52,926 FY19: 72,701 50th: 52,926	FY14: 46,855 FY19: 61,999 50th: 51,422
endocrinology	FY14: 15,487 FY19: 17,643 50th: 18,212	FY14: 7,544 FY19: 9,380 50th: 7,834	FY14: 23,005 FY19: 26,913 50th: 23,106	FY14: 24,021 FY19: 28,121 50th: 24,431	FY14: 13,090 FY19: 15,589 50th: 13,090	FY14: 24,397 FY19: 30,364 50th: 27,542	FY14: 24,362 FY19: 30,139 50th: 27,154	FY14: 48,264 FY19: 55,300 50th: 48,264	FY14: 15,590 FY19: 19,699 50th: 22,081	FY14: 11,825 FY19: 14,884 50th: 13,912	FY14: 11,598 FY19: 14,467 50th: 12,440
gastroenterology	FY14: 101,251 FY19: 124,865 50th: 134,496	FY14: 38,843 FY19: 48,071 50th: 43,421	FY14: 90,271 FY19: 107,332 50th: 103,053	FY14: 100,200 FY19: 125,213 50th: 110,383	FY14: 51,650 FY19: 65,398 50th: 65,135	FY14: 154,623 FY19: 203,190 50th: 154,623	FY14: 118,906 FY19: 153,627 50th: 129,836	FY14: 253,113 FY19: 301,432 50th: 268,508	FY14: 104,187 FY19: 134,312 50th: 137,556	FY14: 88,763 FY19: 114,162 50th: 97,071	FY14: 123,592 FY19: 155,470 50th: 129,751
hematology oncology	FY14: 46,372 FY19: 54,159 50th: 51,932	FY14: 14,522 FY19: 17,378 50th: 14,522	FY14: 32,054 FY19: 35,601 50th: 40,311	FY14: 43,015 FY19: 50,131 50th: 45,169	FY14: 22,875 FY19: 28,879 50th: 29,898	FY14: 46,369 FY19: 57,271 50th: 52,342	FY14: 34,515 FY19: 42,738 50th: 39,729	FY14: 96,746 FY19: 106,762 50th: 96,746	FY14: 35,162 FY19: 43,074 50th: 46,844	FY14: 40,082 FY19: 50,613 50th: 40,303	FY14: 33,107 FY19: 40,214 50th: 33,107
infectious disease	FY14: 17,241 FY19: 18,409 50th: 17,473	FY14: 11,161 FY19: 11,966 50th: 11,161	FY14: 21,734 FY19: 20,698 50th: 21,734	FY14: 10,796 FY19: 11,145 50th: 12,180	FY14: 11,274 FY19: 10,947 50th: 12,301	FY14: 22,830 FY19: 25,536 50th: 23,685	FY14: 18,340 FY19: 20,017 50th: 18,781	FY14: 31,242 FY19: 30,256 50th: 32,254	FY14: 16,768 FY19: 16,897 50th: 23,643	FY14: 8,581 FY19: 9,128 50th: 17,481	FY14: 8,784 FY19: 7,417 50th: 9,534
internal medicine	FY14: 486,989 FY19: 533,710 50th: 511,109	FY14: 238,661 FY19: 269,157 50th: 238,661	FY14: 432,388 FY19: 450,795 50th: 449,202	FY14: 529,362 FY19: 582,908 50th: 596,177	FY14: 285,297 FY19: 330,384 50th: 303,311	FY14: 778,831 FY19: 900,726 50th: 818,746	FY14: 830,199 FY19: 973,491 50th: 841,402	FY14: 1,430,541 FY19: 1,559,703 50th: 1,465,279	FY14: 640,164 FY19: 727,774 50th: 655,389	FY14: 539,558 FY19: 616,082 50th: 542,654	FY14: 537,334 FY19: 614,584 50th: 569,979
nephrology	FY14: 32,597 FY19: 36,159 50th: 36,659	FY14: 17,601 FY19: 18,949 50th: 17,601	FY14: 80,393 FY19: 95,305 50th: 84,089	FY14: 38,732 FY19: 46,415 50th: 40,222	FY14: 20,087 FY19: 24,971 50th: 20,703	FY14: 63,415 FY19: 75,470 50th: 65,844	FY14: 41,629 FY19: 54,782 50th: 50,229	FY14: 74,315 FY19: 88,563 50th: 79,975	FY14: 32,810 FY19: 39,163 50th: 51,357	FY14: 29,978 FY19: 37,392 50th: 38,234	FY14: 22,318 FY19: 29,762 50th: 33,553
neurological surgery	FY14: 11,053 FY19: 11,791 50th: 11,716	No FY14 Data	FY14: 10,021 FY19: 11,702 50th: 10,021	FY14: 12,648 FY19: 13,983 50th: 13,796	FY14: 6,869 FY19: 8,343 50th: 6,869	FY14: 29,596 FY19: 35,791 50th: 29,596	FY14: 14,372 FY19: 16,399 50th: 18,044	FY14: 24,344 FY19: 25,565 50th: 25,766	FY14: 13,858 FY19: 15,790 50th: 15,113	FY14: 2,738 FY19: 3,453 50th: 2,738	FY14: 5,700 FY19: 5,921 50th: 5,700
neurology	FY14: 59,507 FY19: 70,271 50th: 68,063	FY14: 19,307 FY19: 24,120 50th: 19,307	FY14: 47,857 FY19: 56,763 50th: 56,886	FY14: 34,318 FY19: 41,362 50th: 39,860	FY14: 45,769 FY19: 55,604 50th: 67,652	FY14: 72,186 FY19: 93,272 50th: 81,385	FY14: 55,535 FY19: 69,915 50th: 65,425	FY14: 106,425 FY19: 124,907 50th: 110,037	FY14: 43,475 FY19: 54,080 50th: 50,845	FY14: 40,122 FY19: 50,942 50th: 49,949	FY14: 41,238 FY19: 50,962 50th: 47,171
obstetrics gynecology	FY14: 6,836 FY19: 9,989 50th: 7,204	FY14: 6,529 FY19: 10,088 50th: 6,529	FY14: 7,851 FY19: 11,722 50th: 10,157	FY14: 5,481 FY19: 8,192 50th: 9,307	FY14: 507 FY19: 670 50th: 579	FY14: 12,349 FY19: 18,519 50th: 13,673	FY14: 15,073 FY19: 20,496 50th: 15,671	FY14: 34,395 FY19: 46,997 50th: 37,522	FY14: 5,646 FY19: 8,764 50th: 7,421	FY14: 8,582 FY19: 12,440 50th: 9,097	FY14: 7,542 FY19: 10,843 50th: 7,542
ophthalmology	FY14: 96,371 FY19: 116,307 50th: 105,430	FY14: 69,071 FY19: 82,453 50th: 69,071	FY14: 68,974 FY19: 78,481 50th: 87,398	FY14: 76,123 FY19: 94,297 50th: 84,603	FY14: 73,745 FY19: 92,068 50th: 73,745	FY14: 153,585 FY19: 202,361 50th: 169,105	FY14: 169,673 FY19: 220,231 50th: 186,893	FY14: 281,771 FY19: 324,602 50th: 318,847	FY14: 115,081 FY19: 148,979 50th: 131,422	FY14: 60,954 FY19: 80,720 50th: 64,258	FY14: 102,065 FY19: 130,548 50th: 102,065
optometry	FY14: 229,002 FY19: 265,484 50th: 240,073	FY14: 53,810 FY19: 63,660 50th: 53,810	FY14: 126,110 FY19: 139,535 50th: 132,363	FY14: 139,235 FY19: 165,427 50th: 152,226	FY14: 55,598 FY19: 67,029 50th: 64,558	FY14: 167,299 FY19: 213,510 50th: 190,432	FY14: 184,217 FY19: 227,493 50th: 202,694	FY14: 308,720 FY19: 356,730 50th: 335,514	FY14: 132,934 FY19: 164,358 50th: 136,280	FY14: 200,532 FY19: 251,528 50th: 212,350	FY14: 143,465 FY19: 176,390 50th: 155,433
orthopaedic surgery	FY14: 58,932 FY19: 66,580 50th: 70,728	FY14: 30,736 FY19: 36,451 50th: 30,736	FY14: 47,644 FY19: 58,774 50th: 47,648	FY14: 61,291 FY19: 74,207 50th: 74,023	FY14: 42,826 FY19: 53,210 50th: 43,661	FY14: 108,888 FY19: 138,976 50th: 132,368	FY14: 52,131 FY19: 63,654 50th: 64,009	FY14: 153,786 FY19: 178,261 50th: 165,145	FY14: 59,486 FY19: 70,238 50th: 65,367	FY14: 52,889 FY19: 66,081 50th: 61,641	FY14: 42,942 FY19: 48,772 50th: 46,996
otolaryngology	FY14: 32,933 FY19: 39,373 50th: 38,069	FY14: 13,105 FY19: 16,637 50th: 13,105	FY14: 38,597 FY19: 46,589 50th: 40,325	FY14: 28,432 FY19: 35,320 50th: 34,053	FY14: 19,841 FY19: 25,103 50th: 24,130	FY14: 40,050 FY19: 53,771 50th: 51,874	FY14: 40,569 FY19: 51,920 50th: 44,887	FY14: 74,012 FY19: 87,682 50th: 76,195	FY14: 36,549 FY19: 45,857 50th: 36,549	FY14: 22,536 FY19: 29,637 50th: 24,066	FY14: 36,715 FY19: 45,432 50th: 39,134
pain medicine	FY14: 7,802 FY19: 8,941 50th: 8,391	No FY19 Data	FY14: 2,014 FY19: 2,651 50th: 2,561	FY14: 3,812 FY19: 4,841 50th: 5,888	FY14: 2,475 FY19: 891 50th: 3,885	FY14: 10,941 FY19: 6,666 50th: 13,620	FY14: 11,108 FY19: 11,741 50th: 13,338	FY14: 27,691 FY19: 33,998 50th: 27,691	No FY19 Data	FY14: 5,279 FY19: 4,396 50th: 5,451	FY14: 4,271 FY19: 4,967 50th: 4,271
physical medicine rehabilitation	FY14: 27,988 FY19: 33,925 50th: 28,752	FY14: 14,286 FY19: 17,631 50th: 15,534	FY14: 71,773 FY19: 84,324 50th: 72,128	FY14: 32,842 FY19: 40,314 50th: 37,940	FY14: 18,179 FY19: 21,469 50th: 21,428	FY14: 43,051 FY19: 57,349 50th: 60,451	FY14: 60,643 FY19: 79,964 50th: 71,580	FY14: 140,491 FY19: 160,386 50th: 146,759	FY14: 34,974 FY19: 42,923 50th: 35,355	FY14: 36,099 FY19: 46,805 50th: 42,154	FY14: 48,237 FY19: 60,574 50th: 51,315
plastic surgery	FY14: 10,941 FY19: 13,654 50th: 11,883	FY14: 8,242 FY19: 10,527 50th: 8,242	FY14: 9,632 FY19: 11,357 50th: 11,614	FY14: 3,206 FY19: 4,335 50th: 3,677	FY14: 7,477 FY19: 9,620 50th: 10,527	FY14: 19,330 FY19: 25,724 50th: 26,647	FY14: 17,212 FY19: 21,452 50th: 18,227	FY14: 46,090 FY19: 58,084 50th: 47,073	FY14: 15,332 FY19: 20,034 50th: 18,875	FY14: 10,204 FY19: 13,535 50th: 10,605	FY14: 18,757 FY19: 23,784 50th: 18,757
podiatry	FY14: 60,716 FY19: 75,298 50th: 75,135	FY14: 35,864 FY19: 46,688 50th: 35,864	FY14: 87,462 FY19: 107,283 50th: 104,795	FY14: 102,145 FY19: 132,288 50th: 109,430	FY14: 43,028 FY19: 55,562 50th: 48,536	FY14: 58,496 FY19: 78,959 50th: 67,744	FY14: 88,020 FY19: 117,052 50th: 93,949	FY14: 154,220 FY19: 188,989 50th: 174,508	FY14: 61,112 FY19: 79,105 50th: 70,682	FY14: 120,090 FY19: 162,056 50th: 126,907	FY14: 51,257 FY19: 67,418 50th: 60,302
psychiatry	FY14: 312,175 FY19: 361,881 50th: 391,802	FY14: 142,459 FY19: 170,003 50th: 142,459	FY14: 289,505 FY19: 339,332 50th: 322,335	FY14: 331,142 FY19: 394,945 50th: 343,674	FY14: 155,373 FY19: 185,331 50th: 164,418	FY14: 340,802 FY19: 426,715 50th: 434,100	FY14: 407,418 FY19: 495,278 50th: 470,677	FY14: 872,051 FY19: 991,201 50th: 878,181	FY14: 299,680 FY19: 365,739 50th: 311,429	FY14: 277,381 FY19: 342,128 50th: 282,070	FY14: 235,243 FY19: 278,589 50th: 246,803
psychology	FY14: 318,188 FY19: 380,946 50th: 362,921	FY14: 130,486 FY19: 160,423 50th: 130,486	FY14: 229,896 FY19: 276,038 50th: 258,061	FY14: 372,610 FY19: 459,771 50th: 376,067	FY14: 182,795 FY19: 226,782 50th: 186,362	FY14: 343,143 FY19: 445,694 50th: 376,378	FY14: 413,736 FY19: 524,653 50th: 429,090	FY14: 676,536 FY19: 822,341 50th: 676,536	FY14: 308,430 FY19: 386,784 50th: 328,316	FY14: 306,961 FY19: 386,032 50th: 314,269	FY14: 301,164 FY19: 371,534 50th: 312,520
rheumatology	FY14: 26,595 FY19: 33,266 50th: 27,814	FY14: 8,615 FY19: 10,833 50th: 8,615	FY14: 10,736 FY19: 12,607 50th: 12,129	FY14: 14,591 FY19: 17,963 50th: 16,758	FY14: 9,908 FY19: 12,440 50th: 10,656	FY14: 12,844 FY19: 17,402 50th: 13,482	FY14: 16,530 FY19: 21,350 50th: 23,116	FY14: 24,084 FY19: 28,806 50th: 27,911	FY14: 10,455 FY19: 12,723 50th: 11,732	FY14: 11,834 FY19: 15,633 50th: 17,026	FY14: 7,981 FY19: 10,045 50th: 10,688
surgery	FY14: 65,908 FY19: 74,645 50th: 70,107	FY14: 31,675 FY19: 36,075 50th: 31,675	FY14: 45,683 FY19: 50,867 50th: 68,260	FY14: 92,367 FY19: 109,380 50th: 102,074	FY14: 29,406 FY19: 34,190 50th: 35,311	FY14: 117,707 FY19: 144,626 50th: 137,488	FY14: 114,615 FY19: 138,157 50th: 123,242	FY14: 152,455 FY19: 168,114 50th: 157,954	FY14: 100,842 FY19: 117,969 50th: 108,292	FY14: 45,477 FY19: 54,794 50th: 60,715	FY14: 80,017 FY19: 92,304 50th: 87,933
thoracic surgery	FY14: 32,347 FY19: 33,319 50th: 32,347	FY14: 8,969 FY19: 9,708 50th: 8,969	FY14: 3,191 FY19: 3,393 50th: 4,002	FY14: 20,823 FY19: 22,647 50th: 23,834	FY14: 10,667 FY19: 11,213 50th: 12,270	FY14: 24,953 FY19: 27,339 50th: 28,641	FY14: 12,551 FY19: 13,449 50th: 15,290	FY14: 43,463 FY19: 45,143 50th: 46,843	FY14: 17,276 FY19: 18,278 50th: 28,444	FY14: 20,816 FY19: 22,510 50th: 24,771	FY14: 12,422 FY19: 12,908 50th: 12,429
urology	FY14: 64,156 FY19: 75,945 50th: 76,450	FY14: 28,820 FY19: 35,389 50th: 35,579	FY14: 60,715 FY19: 71,371 50th: 82,857	FY14: 42,607 FY19: 51,318 50th: 67,708	FY14: 33,498 FY19: 41,775 50th: 38,711	FY14: 76,985 FY19: 97,343 50th: 89,598	FY14: 72,773 FY19: 92,096 50th: 74,046	FY14: 171,048 FY19: 194,921 50th: 178,964	FY14: 64,480 FY19: 79,325 50th: 69,184	FY14: 34,973 FY19: 45,127 50th: 45,157	FY14: 33,110 FY19: 41,302 50th: 40,327
vascular surgery	FY14: 46,996 FY19: 50,323 50th: 52,726	FY14: 27,639 FY19: 30,371 50th: 27,639	FY14: 29,219 FY19: 31,292 50th: 30,688	FY14: 28,807 FY19: 31,120 50th: 35,050	FY14: 22,087 FY19: 25,329 50th: 27,002	FY14: 19,340 FY19: 18,880 50th: 23,442	FY14: 26,423 FY19: 29,479 50th: 33,917	FY14: 68,015 FY19: 69,917 50th: 68,015	FY14: 38,663 FY19: 42,132 50th: 40,042	FY14: 31,758 FY19: 36,446 50th: 34,144	FY14: 40,011 FY19: 44,932 50th: 40,011
Grand Total	FY14: 2,407,207 FY19: 2,788,641 50th: 2,725,264	FY14: 1,085,350 FY19: 1,283,156 50th: 1,098,355	FY14: 2,081,240 FY19: 2,372,619 50th: 2,310,366	FY14: 2,368,367 FY19: 2,809,620 50th: 2,605,340	FY14: 1,274,141 FY19: 1,528,412 50th: 1,423,159	FY14: 2,990,201 FY19: 3,706,892 50th: 3,381,543	FY14: 3,056,005 FY19: 3,761,532 50th: 3,314,608	FY14: 5,901,565 FY19: 6,743,619 50th: 6,119,738	FY14: 2,452,146 FY19: 2,961,324 50th: 2,688,248	FY14: 2,229,775 FY19: 2,746,431 50th: 2,375,652	FY14: 2,143,866 FY19: 2,578,311 50th: 2,288,368

	VISN										
VA Specialty	V12	V15	V16	V17	V18	V19	V20	V21	V22	V23	Grand Total
allergy and immunology	FY14: 3,168 FY19: 4,005 50th: 4,686	FY14: 7,065 FY19: 8,824 50th: 7,208	FY14: 2,906 FY19: 3,723 50th: 5,326	FY14: 4,312 FY19: 5,512 50th: 4,312	FY14: 17,911 FY19: 19,435 50th: 19,558	FY14: 692 FY19: 924 50th: 692	FY14: 1 FY19: 1 50th: 174	FY14: 1,382 FY19: 1,656 50th: 1,382	FY14: 10,033 FY19: 12,123 50th: 10,283	FY14: 3,160 FY19: 3,316 50th: 5,140	FY14: 80,052 FY19: 94,709 50th: 93,739
cardiology	FY14: 126,943 FY19: 148,770 50th: 137,820	FY14: 118,592 FY19: 136,207 50th: 118,592	FY14: 213,498 FY19: 244,635 50th: 222,515	FY14: 119,328 FY19: 141,275 50th: 128,191	FY14: 103,938 FY19: 121,000 50th: 108,368	FY14: 59,196 FY19: 69,805 50th: 67,958	FY14: 71,936 FY19: 84,959 50th: 76,775	FY14: 111,497 FY19: 123,612 50th: 123,475	FY14: 136,290 FY19: 151,266 50th: 143,676	FY14: 99,548 FY19: 116,789 50th: 111,889	FY14: 2,458,361 FY19: 2,841,646 50th: 2,650,712
chiropracty	FY14: 4,944 FY19: 6,011 50th: 6,013	FY14: 8,194 FY19: 10,159 50th: 9,085	FY14: 1,808 FY19: 2,352 50th: 3,161	FY14: 16,830 FY19: 21,494 50th: 17,915	No FY14 Data	FY14: 3,052 FY19: 2,943 50th: 3,349	FY14: 8,386 FY19: 10,258 50th: 8,386	FY14: 6,979 FY19: 8,172 50th: 6,979	FY14: 14,948 FY19: 17,201 50th: 15,896	FY14: 5,985 FY19: 5,965 50th: 7,168	FY14: 132,684 FY19: 157,526 50th: 147,577
critical care pulmonary disease	FY14: 36,060 FY19: 45,182 50th: 51,082	FY14: 40,017 FY19: 48,534 50th: 40,970	FY14: 83,615 FY19: 101,281 50th: 105,804	FY14: 57,728 FY19: 72,625 50th: 57,728	FY14: 27,276 FY19: 33,345 50th: 33,424	FY14: 34,374 FY19: 39,753 50th: 40,036	FY14: 38,816 FY19: 49,351 50th: 60,768	FY14: 41,263 FY19: 48,212 50th: 50,391	FY14: 87,957 FY19: 103,484 50th: 90,454	FY14: 31,130 FY19: 37,359 50th: 39,856	FY14: 1,125,446 FY19: 1,351,647 50th: 1,303,273
dermatology	FY14: 52,063 FY19: 68,303 50th: 54,934	FY14: 53,619 FY19: 70,322 50th: 55,516	FY14: 69,710 FY19: 89,041 50th: 80,053	FY14: 65,596 FY19: 88,614 50th: 68,815	FY14: 33,689 FY19: 44,043 50th: 44,236	FY14: 25,505 FY19: 34,219 50th: 32,146	FY14: 35,409 FY19: 47,248 50th: 44,498	FY14: 64,505 FY19: 80,954 50th: 118,888	FY14: 80,210 FY19: 100,704 50th: 99,657	FY14: 40,100 FY19: 51,512 50th: 41,023	FY14: 1,131,318 FY19: 1,456,154 50th: 1,319,580
endocrinology	FY14: 21,642 FY19: 26,369 50th: 22,304	FY14: 10,010 FY19: 12,090 50th: 10,702	FY14: 21,869 FY19: 26,538 50th: 33,598	FY14: 20,590 FY19: 25,468 50th: 24,457	FY14: 9,810 FY19: 12,202 50th: 14,839	FY14: 8,731 FY19: 11,104 50th: 10,286	FY14: 8,248 FY19: 9,620 50th: 11,354	FY14: 26,371 FY19: 30,881 50th: 32,033	FY14: 32,123 FY19: 39,183 50th: 34,186	FY14: 14,600 FY19: 16,876 50th: 18,743	FY14: 393,177 FY19: 472,830 50th: 450,568
gastroenterology	FY14: 83,880 FY19: 105,357 50th: 103,204	FY14: 99,483 FY19: 122,358 50th: 104,273	FY14: 158,104 FY19: 193,137 50th: 221,889	FY14: 105,125 FY19: 135,602 50th: 133,666	FY14: 100,415 FY19: 127,118 50th: 102,203	FY14: 38,312 FY19: 48,935 50th: 50,927	FY14: 73,520 FY19: 93,957 50th: 117,222	FY14: 134,850 FY19: 161,017 50th: 157,837	FY14: 149,242 FY19: 178,121 50th: 170,625	FY14: 63,606 FY19: 79,167 50th: 72,008	FY14: 2,231,936 FY19: 2,777,841 50th: 2,607,686
hematology oncology	FY14: 32,852 FY19: 40,592 50th: 38,445	FY14: 35,756 FY19: 43,098 50th: 35,756	FY14: 56,417 FY19: 67,051 50th: 68,201	FY14: 34,075 FY19: 41,644 50th: 40,566	FY14: 15,250 FY19: 18,926 50th: 20,656	FY14: 20,703 FY19: 25,726 50th: 21,345	FY14: 29,764 FY19: 37,617 50th: 33,064	FY14: 39,881 FY19: 46,392 50th: 57,622	FY14: 44,433 FY19: 50,767 50th: 49,235	FY14: 37,594 FY19: 41,421 50th: 44,581	FY14: 791,544 FY19: 940,054 50th: 900,372
infectious disease	FY14: 8,228 FY19: 8,881 50th: 14,090	FY14: 14,702 FY19: 14,729 50th: 16,433	FY14: 19,060 FY19: 19,089 50th: 27,006	FY14: 12,632 FY19: 13,582 50th: 14,552	FY14: 7,767 FY19: 8,042 50th: 11,568	FY14: 7,093 FY19: 7,457 50th: 9,666	FY14: 6,759 FY19: 7,491 50th: 12,385	FY14: 15,485 FY19: 15,497 50th: 16,976	FY14: 22,672 FY19: 22,118 50th: 24,201	FY14: 7,163 FY19: 7,790 50th: 14,292	FY14: 300,312 FY19: 307,092 50th: 361,397
internal medicine	FY14: 593,948 FY19: 653,697 50th: 627,706	FY14: 473,004 FY19: 527,622 50th: 473,004	FY14: 993,528 FY19: 1,125,065 50th: 1,033,629	FY14: 707,251 FY19: 814,073 50th: 707,251	FY14: 439,129 FY19: 505,381 50th: 503,344	FY14: 360,324 FY19: 418,256 50th: 364,645	FY14: 492,541 FY19: 585,302 50th: 561,836	FY14: 563,289 FY19: 626,971 50th: 659,658	FY14: 684,149 FY19: 730,276 50th: 746,117	FY14: 593,071 FY19: 654,432 50th: 615,649	FY14: 12,629,558 FY19: 14,200,389 50th: 13,284,748
nephrology	FY14: 45,912 FY19: 57,024 50th: 50,970	FY14: 33,523 FY19: 42,648 50th: 33,523	FY14: 33,104 FY19: 40,207 50th: 51,816	FY14: 81,074 FY19: 103,478 50th: 81,139	FY14: 22,043 FY19: 26,128 50th: 22,549	FY14: 15,354 FY19: 17,628 50th: 15,492	FY14: 15,014 FY19: 19,628 50th: 20,019	FY14: 40,923 FY19: 45,265 50th: 42,541	FY14: 97,771 FY19: 115,096 50th: 99,013	FY14: 52,228 FY19: 64,914 50th: 61,386	FY14: 890,821 FY19: 1,078,947 50th: 996,913
neurological surgery	FY14: 17,598 FY19: 19,542 50th: 18,725	FY14: 10,871 FY19: 11,323 50th: 11,569	FY14: 17,812 FY19: 19,725 50th: 26,407	FY14: 14,289 FY19: 16,823 50th: 14,849	FY14: 16,744 FY19: 19,103 50th: 16,744	FY14: 5,734 FY19: 4,508 50th: 5,734	FY14: 15,710 FY19: 17,076 50th: 16,086	FY14: 14,309 FY19: 14,844 50th: 21,623	FY14: 22,414 FY19: 24,908 50th: 26,204	FY14: 18,236 FY19: 19,910 50th: 18,297	FY14: 284,916 FY19: 316,500 50th: 315,597
neurology	FY14: 62,412 FY19: 77,620 50th: 70,328	FY14: 42,545 FY19: 53,229 50th: 42,545	FY14: 119,332 FY19: 148,290 50th: 133,699	FY14: 47,008 FY19: 58,957 50th: 47,008	FY14: 31,969 FY19: 40,430 50th: 33,060	FY14: 23,710 FY19: 30,767 50th: 32,155	FY14: 30,873 FY19: 38,027 50th: 43,158	FY14: 55,000 FY19: 65,274 50th: 83,928	FY14: 66,684 FY19: 79,433 50th: 81,353	FY14: 58,355 FY19: 73,924 50th: 66,562	FY14: 1,103,627 FY19: 1,358,149 50th: 1,290,376
obstetrics gynecology	FY14: 6,968 FY19: 10,169 50th: 9,912	FY14: 1,999 FY19: 2,740 50th: 2,510	FY14: 13,188 FY19: 19,141 50th: 14,247	FY14: 13,758 FY19: 19,525 50th: 13,758	FY14: 9,368 FY19: 13,549 50th: 12,657	FY14: 9,043 FY19: 13,259 50th: 10,206	FY14: 5,509 FY19: 7,762 50th: 6,425	FY14: 11,389 FY19: 16,891 50th: 12,646	FY14: 14,629 FY19: 20,648 50th: 17,508	FY14: 4,622 FY19: 7,409 50th: 5,247	FY14: 201,264 FY19: 289,813 50th: 229,819
ophthalmology	FY14: 127,297 FY19: 159,906 50th: 152,753	FY14: 76,375 FY19: 95,016 50th: 86,497	FY14: 244,337 FY19: 301,745 50th: 256,340	FY14: 116,540 FY19: 148,178 50th: 136,772	FY14: 92,312 FY19: 115,633 50th: 119,079	FY14: 67,077 FY19: 85,899 50th: 93,574	FY14: 91,707 FY19: 119,965 50th: 95,755	FY14: 110,613 FY19: 132,135 50th: 145,686	FY14: 154,316 FY19: 185,391 50th: 160,252	FY14: 107,223 FY19: 133,885 50th: 107,934	FY14: 2,455,210 FY19: 3,048,800 50th: 2,747,480
optometry	FY14: 110,298 FY19: 134,091 50th: 123,002	FY14: 116,145 FY19: 140,735 50th: 117,927	FY14: 215,203 FY19: 263,161 50th: 230,076	FY14: 90,932 FY19: 112,352 50th: 103,546	FY14: 121,059 FY19: 148,063 50th: 121,180	FY14: 31,515 FY19: 39,885 50th: 42,356	FY14: 157,791 FY19: 197,487 50th: 159,031	FY14: 150,904 FY19: 173,708 50th: 153,253	FY14: 167,036 FY19: 194,891 50th: 167,271	FY14: 105,659 FY19: 128,323 50th: 108,965	FY14: 3,007,464 FY19: 3,623,840 50th: 3,202,339
orthopaedic surgery	FY14: 62,966 FY19: 74,445 50th: 68,061	FY14: 65,250 FY19: 76,483 50th: 67,094	FY14: 92,133 FY19: 113,298 50th: 117,374	FY14: 54,303 FY19: 68,603 50th: 55,563	FY14: 84,972 FY19: 102,121 50th: 85,409	FY14: 71,736 FY19: 88,006 50th: 80,360	FY14: 60,628 FY19: 74,124 50th: 65,412	FY14: 81,612 FY19: 91,556 50th: 91,532	FY14: 101,474 FY19: 115,201 50th: 111,423	FY14: 82,600 FY19: 98,741 50th: 82,600	FY14: 1,469,225 FY19: 1,757,782 50th: 1,627,152
otolaryngology	FY14: 35,865 FY19: 43,883 50th: 38,458	FY14: 26,331 FY19: 32,066 50th: 26,331	FY14: 67,506 FY19: 84,494 50th: 86,826	FY14: 23,065 FY19: 29,708 50th: 24,737	FY14: 21,260 FY19: 26,344 50th: 23,501	FY14: 16,377 FY19: 21,133 50th: 18,489	FY14: 35,824 FY19: 45,398 50th: 36,194	FY14: 41,710 FY19: 47,561 50th: 45,703	FY14: 56,225 FY19: 67,206 50th: 61,303	FY14: 34,129 FY19: 39,068 50th: 35,897	FY14: 741,631 FY19: 914,182 50th: 819,828
pain medicine	FY14: 4,315 FY19: 5,790 50th: 4,485	FY14: 10,141 FY19: 8,669 50th: 10,994	FY14: 9,409 FY19: 12,132 50th: 10,461	FY14: 5,609 FY19: 7,290 50th: 5,609	FY14: 4,658 FY19: 6,224 50th: 4,757	FY14: 6,237 FY19: 8,519 50th: 8,174	No FY14 Data	FY14: 4,564 FY19: 5,537 50th: 7,513	FY14: 13,391 FY19: 16,629 50th: 13,974	FY14: 3,171 FY19: 4,046 50th: 3,876	FY14: 137,860 FY19: 153,928 50th: 156,125
physical medicine rehabilitation	FY14: 47,066 FY19: 58,648 50th: 64,262	FY14: 39,232 FY19: 49,722 50th: 39,232	FY14: 58,634 FY19: 74,513 50th: 70,723	FY14: 62,657 FY19: 80,808 50th: 69,101	FY14: 20,691 FY19: 26,312 50th: 29,001	FY14: 29,225 FY19: 37,035 50th: 29,335	FY14: 46,215 FY19: 59,385 50th: 48,979	FY14: 23,252 FY19: 28,202 50th: 34,193	FY14: 113,004 FY19: 138,740 50th: 114,704	FY14: 28,596 FY19: 37,340 50th: 38,248	FY14: 997,135 FY19: 1,236,369 50th: 1,121,175
plastic surgery	FY14: 11,773 FY19: 14,527 50th: 14,529	FY14: 9,735 FY19: 12,012 50th: 9,735	FY14: 15,379 FY19: 18,792 50th: 16,206	FY14: 13,948 FY19: 17,939 50th: 15,286	FY14: 9,557 FY19: 12,343 50th: 10,104	FY14: 5,616 FY19: 7,098 50th: 6,899	FY14: 13,783 FY19: 17,750 50th: 13,783	FY14: 20,072 FY19: 24,437 50th: 20,642	FY14: 20,056 FY19: 23,661 50th: 38,626	FY14: 3,413 FY19: 3,574 50th: 4,644	FY14: 289,755 FY19: 364,239 50th: 336,580
podiatry	FY14: 82,110 FY19: 106,049 50th: 86,430	FY14: 33,620 FY19: 42,846 50th: 35,020	FY14: 66,673 FY19: 83,610 50th: 82,805	FY14: 55,379 FY19: 72,144 50th: 59,188	FY14: 74,602 FY19: 95,193 50th: 81,390	FY14: 56,827 FY19: 74,616 50th: 63,729	FY14: 54,002 FY19: 70,257 50th: 58,041	FY14: 82,397 FY19: 101,196 50th: 90,782	FY14: 78,574 FY19: 96,201 50th: 87,742	FY14: 63,462 FY19: 82,071 50th: 65,640	FY14: 1,510,056 FY19: 1,934,881 50th: 1,678,621
psychiatry	FY14: 327,346 FY19: 393,636 50th: 358,174	FY14: 253,363 FY19: 306,559 50th: 253,363	FY14: 472,691 FY19: 568,801 50th: 501,249	FY14: 384,537 FY19: 473,734 50th: 384,537	FY14: 241,917 FY19: 295,932 50th: 250,576	FY14: 168,005 FY19: 208,142 50th: 202,893	FY14: 284,062 FY19: 345,014 50th: 300,345	FY14: 304,572 FY19: 355,279 50th: 369,442	FY14: 455,516 FY19: 529,942 50th: 455,516	FY14: 210,200 FY19: 261,480 50th: 243,538	FY14: 6,765,438 FY19: 8,089,661 50th: 7,307,580
psychology	FY14: 295,421 FY19: 366,636 50th: 315,552	FY14: 266,529 FY19: 338,701 50th: 275,508	FY14: 487,992 FY19: 620,126 50th: 506,133	FY14: 377,526 FY19: 479,906 50th: 377,526	FY14: 221,479 FY19: 282,657 50th: 245,625	FY14: 154,973 FY19: 200,754 50th: 168,365	FY14: 286,152 FY19: 360,638 50th: 294,557	FY14: 323,739 FY19: 389,080 50th: 339,851	FY14: 377,461 FY19: 458,556 50th: 377,461	FY14: 252,377 FY19: 329,965 50th: 266,704	FY14: 6,627,594 FY19: 8,268,017 50th: 6,918,289
rheumatology	FY14: 15,850 FY19: 19,798 50th: 20,019	FY14: 10,136 FY19: 12,678 50th: 10,136	FY14: 16,608 FY19: 20,502 50th: 22,436	FY14: 14,557 FY19: 18,835 50th: 15,964	FY14: 12,645 FY19: 15,978 50th: 13,475	FY14: 9,537 FY19: 12,655 50th: 12,673	FY14: 22,755 FY19: 27,938 50th: 25,758	FY14: 13,878 FY19: 16,838 50th: 20,617	FY14: 15,372 FY19: 18,589 50th: 17,130	FY14: 14,628 FY19: 18,745 50th: 16,796	FY14: 300,139 FY19: 375,624 50th: 354,931
surgery	FY14: 64,246 FY19: 74,683 50th: 82,519	FY14: 88,940 FY19: 100,577 50th: 88,940	FY14: 141,405 FY19: 166,995 50th: 147,592	FY14: 61,356 FY19: 74,131 50th: 64,811	FY14: 82,502 FY19: 93,709 50th: 88,073	FY14: 60,999 FY19: 73,603 50th: 65,533	FY14: 58,131 FY19: 67,684 50th: 75,162	FY14: 64,176 FY19: 69,725 50th: 79,016	FY14: 102,795 FY19: 113,855 50th: 118,120	FY14: 113,720 FY19: 134,534 50th: 118,606	FY14: 1,714,422 FY19: 1,990,617 50th: 1,911,424
thoracic surgery	FY14: 27,467 FY19: 29,157 50th: 30,887	FY14: 18,307 FY19: 18,083 50th: 20,997	FY14: 38,368 FY19: 42,436 50th: 39,997	FY14: 1,972 FY19: 2,179 50th: 3,081	FY14: 25,808 FY19: 26,503 50th: 26,311	FY14: 7,647 FY19: 7,893 50th: 7,647	FY14: 20,168 FY19: 21,477 50th: 20,168	FY14: 30,437 FY19: 29,869 50th: 30,437	FY14: 29,400 FY19: 28,210 50th: 29,918	FY14: 2,633 FY19: 2,907 50th: 4,126	FY14: 409,685 FY19: 428,621 50th: 451,409
urology	FY14: 58,191 FY19: 68,958 50th: 63,405	FY14: 55,787 FY19: 66,051 50th: 55,787	FY14: 80,657 FY19: 97,836 50th: 95,620	FY14: 64,195 FY19: 79,609 50th: 64,195	FY14: 46,463 FY19: 55,817 50th: 60,035	FY14: 39,233 FY19: 48,752 50th: 42,597	FY14: 54,327 FY19: 67,064 50th: 63,006	FY14: 62,590 FY19: 72,445 50th: 70,629	FY14: 84,282 FY19: 97,608 50th: 100,032	FY14: 52,711 FY19: 65,317 50th: 52,711	FY14: 1,281,601 FY19: 1,545,369 50th: 1,466,598
vascular surgery	FY14: 36,293 FY19: 39,786 50th: 45,147	FY14: 25,354 FY19: 26,730 50th: 27,761	FY14: 40,970 FY19: 44,423 50th: 48,768	FY14: 36,027 FY19: 40,871 50th: 38,988	FY14: 20,442 FY19: 22,028 50th: 23,260	FY14: 15,411 FY19: 17,343 50th: 21,710	FY14: 31,057 FY19: 35,338 50th: 31,166	FY14: 49,793 FY19: 52,832 50th: 57,347	FY14: 42,275 FY19: 45,277 50th: 52,106	FY14: 31,059 FY19: 33,608 50th: 31,940	FY14: 707,639 FY19: 768,457 50th: 790,869
Grand Total	FY14: 2,403,122 FY19: 2,861,515 50th: 2,677,905	FY14: 2,044,625 FY19: 2,430,811 50th: 2,087,008	FY14: 3,851,916 FY19: 4,612,139 50th: 4,259,956	FY14: 2,662,199 FY19: 3,264,959 50th: 2,773,110	FY14: 1,915,676 FY19: 2,313,559 50th: 2,124,982	FY14: 1,352,238 FY19: 1,656,617 50th: 1,528,971	FY14: 2,049,088 FY19: 2,517,816 50th: 2,299,507	FY14: 2,491,432 FY19: 2,876,038 50th: 2,942,623	FY14: 3,274,732 FY19: 3,775,285 50th: 3,513,987	FY14: 2,134,979 FY19: 2,554,388 50th: 2,304,066	FY14: 52,169,870 FY19: 62,143,684 50th: 56,842,756

Sources: Milliman, Inc. August 8, 2014; 2014 VA Enrollee Health Care Projection Model - Base Year 2013 - 2014 Model Documentation & Analysis; Milliman Health Practice Seattle; RAND analyses of VA provider supply; RAND analyses of VA productivity data.

Table H-3. Projected Demand and Supply in FY19, Under Supply Scenario Three, By Specialty

VA Specialty	Milliman National RVU/Year Forecast		% RVU/Year Increase from FY14 to FY19	RVU/Provider/Year FY14 Percentiles			Forecasted FY19 RVU if Provider Trends Continue with No Productivity Improvement	National FY14 RVU Capacity if Providers Operated at least at the Following RVU/Provider/Year Percentiles within their Specialties (shading indicates if capacity is sufficient for FY19)		
	FY14	FY19		25th	50th (median)	75th		Level 1: 25th Percentile	Level 2: 50th Percentile	Level 3: 75th Percentile
allergy.and.immunology	52,258	61,232	17%	1,913	2,515	3,741	90,477	93,611	100,854	182,264
cardiology	2,399,197	2,775,160	16%	3,576	4,255	5,254	2,770,434	2,838,024	2,988,224	3,860,146
critical.care...pulmonary.disease	1,024,015	1,234,833	21%	1,610	2,304	3,446	1,149,754	1,205,160	1,342,355	2,045,983
dermatology	989,391	1,281,753	30%	4,878	7,192	9,094	1,125,476	1,177,455	1,333,943	2,212,634
endocrinology	322,331	388,743	21%	1,513	1,881	2,612	360,841	382,167	412,183	595,746
gastroenterology	2,072,646	2,582,884	25%	4,323	5,943	7,466	2,439,245	2,528,372	2,864,753	4,580,969
hematology.oncology	665,848	793,679	19%	1,783	2,472	3,190	733,481	757,509	845,493	1,224,356
infectious.disease	247,704	254,310	3%	861	1,336	1,826	277,920	296,122	342,662	564,246
internal.medicine	12,505,890	14,062,159	12%	2,124	2,326	2,626	14,385,014	14,712,437	15,138,080	17,991,543
nephrology	718,160	873,480	22%	1,466	2,643	3,704	815,853	834,979	913,990	1,662,343
neurological.surgery	201,019	226,432	13%	2,396	3,458	6,060	230,161	238,496	259,360	792,070
neurology	1,027,688	1,269,969	24%	2,009	2,501	3,124	1,146,489	1,223,465	1,351,039	2,034,635
obstetrics...gynecology	146,695	210,358	43%	1,956	2,643	3,237	163,684	167,034	185,897	289,676
ophthalmology	2,339,681	2,906,777	24%	5,974	7,674	10,207	2,651,203	2,732,721	2,957,816	4,666,593
orthopaedic.surgery	1,373,201	1,641,308	20%	4,044	4,912	6,063	1,597,914	1,659,577	1,774,159	2,884,602
otolaryngology	671,878	831,785	24%	3,711	4,720	6,241	732,470	754,405	811,167	1,254,129
pain.medicine	64,496	82,970	29%	2,028	2,571	3,249	75,386	75,987	81,203	125,784
physical.medicine...rehabilitation	921,624	1,144,832	24%	1,303	1,981	2,556	1,061,976	1,078,238	1,194,767	1,580,191
plastic.surgery	218,928	278,587	27%	3,145	4,138	5,015	249,738	263,725	288,743	380,655
psychiatry	6,692,270	7,998,904	20%	2,466	2,833	3,291	7,932,023	8,183,893	8,565,015	10,536,698
rheumatology	253,793	319,803	26%	1,613	2,156	2,986	291,558	309,965	349,079	516,215
surgery	1,555,503	1,809,837	16%	2,753	3,561	4,320	1,732,279	1,786,223	1,948,585	2,413,767
thoracic.surgery	243,352	255,230	5%	2,228	3,329	5,813	309,860	316,772	342,149	569,962
urology	1,087,103	1,310,019	21%	3,837	5,187	6,396	1,212,362	1,264,375	1,403,545	2,200,070
vascular.surgery	559,583	610,837	9%	3,460	4,716	6,633	648,938	669,713	729,959	1,124,096
Grand Total	38,354,254	45,205,881	18%				44,184,537	45,550,427	48,525,022	66,289,374

Sources: Milliman, Inc. August 8, 2014; 2014 VA Enrollee Health Care Projection Model - Base Year 2013 - 2014 Model Documentation & Analysis; Milliman Health Practice Seattle; RAND analyses of VA provider supply; RAND analyses of VA productivity data.

Table H-4. Projected Demand and Supply in FY19, Under Supply Scenario Three, By VISN and Specialty

The tables below show the following:

4. FY14: # of RVUs forecasted by Milliman for FY14
5. FY19: # of RVUs forecasted by Milliman for FY19
6. 50th: RVUs at the 50th percentile under Sensitivity Analysis Productivity Level 2
7. Incr: Forecasted RVUs resulting from forecasted FTE increase with FY14 productivity per FTE (i.e., no productivity increase)

The cell shading indicates how well Sensitivity Analysis Level 2 50th percentile performs relative to forecasted FY19 RVU demand:

8. Red: Less than 10% below FY19 RVU
9. Yellow: Within 10% of FY19 RVU
10. Green: Exceeds FY19 RVU

	VISN										
VA Specialty	**V01**	**V02**	**V03**	**V04**	**V05**	**V06**	**V07**	**V08**	**V09**	**V10**	**V11**
allergy and immunology	FY14: 1,798 FY19: 2,153 Incr: 3,199 50th: 3,199	No FY14 Data	FY14: 1,998 FY19: 2,370 Incr: 2,156 50th: 2,556	No FY14 Data	No FY14 Data	No FY14 Data	FY14: 2,184 FY19: 2,980 Incr: 31,234 50th: 31,500	FY14: 8,805 FY19: 9,928 Incr: 9,271 50th: 12,796	No FY14 Data	FY14: 2,551 FY19: 3,338 Incr: 3,607 50th: 3,607	FY14: 1,143 FY19: 1,503 Incr: 1,468 50th: 1,497
cardiology	FY14: 102,671 FY19: 116,293 Incr: 110,547 50th: 139,482	FY14: 63,314 FY19: 70,767 Incr: 79,229 50th: 79,229	FY14: 60,515 FY19: 65,439 Incr: 59,108 50th: 66,678	FY14: 104,604 FY19: 120,913 Incr: 117,325 50th: 130,159	FY14: 41,899 FY19: 49,482 Incr: 47,405 50th: 59,688	FY14: 140,120 FY19: 170,147 Incr: 165,581 50th: 188,577	FY14: 118,863 FY19: 143,625 Incr: 135,520 50th: 144,985	FY14: 289,186 FY19: 321,632 Incr: 318,959 50th: 324,393	FY14: 142,645 FY19: 168,790 Incr: 164,598 50th: 179,601	FY14: 107,721 FY19: 130,152 Incr: 121,275 50th: 127,792	FY14: 99,369 FY19: 117,080 Incr: 114,224 50th: 123,783
critical care pulmonary disease	FY14: 59,088 FY19: 69,384 Incr: 68,443 50th: 68,895	FY14: 34,466 FY19: 41,843 Incr: 39,964 50th: 39,964	FY14: 42,230 FY19: 46,793 Incr: 46,440 50th: 49,451	FY14: 58,724 FY19: 70,224 Incr: 75,960 50th: 91,390	FY14: 20,577 FY19: 24,465 Incr: 20,774 50th: 29,059	FY14: 67,019 FY19: 85,438 Incr: 69,943 50th: 78,243	FY14: 27,799 FY19: 35,304 Incr: 30,982 50th: 42,845	FY14: 143,554 FY19: 160,759 Incr: 162,805 50th: 169,723	FY14: 46,708 FY19: 58,471 Incr: 51,158 50th: 73,599	FY14: 41,313 FY19: 52,395 Incr: 47,528 50th: 58,458	FY14: 42,153 FY19: 51,742 Incr: 42,195 50th: 44,380
dermatology	FY14: 36,899 FY19: 46,659 Incr: 46,598 50th: 54,853	No FY14 Data	FY14: 61,141 FY19: 73,590 Incr: 66,680 50th: 74,264	FY14: 44,703 FY19: 58,184 Incr: 44,492 50th: 45,946	FY14: 26,746 FY19: 34,424 Incr: 28,386 50th: 38,014	FY14: 34,921 FY19: 48,285 Incr: 41,509 50th: 62,964	FY14: 53,350 FY19: 73,252 Incr: 56,581 50th: 64,185	FY14: 140,046 FY19: 172,516 Incr: 167,653 50th: 173,888	FY14: 38,859 FY19: 52,572 Incr: 39,070 50th: 42,778	FY14: 52,926 FY19: 72,701 Incr: 62,642 50th: 62,642	FY14: 46,855 FY19: 61,999 Incr: 58,933 50th: 64,463
endocrinology	FY14: 15,487 FY19: 17,643 Incr: 17,575 50th: 20,904	No FY14 Data	FY14: 17,232 FY19: 20,246 Incr: 17,971 50th: 18,073	FY14: 20,625 FY19: 24,124 Incr: 23,914 50th: 23,914	FY14: 10,288 FY19: 12,292 Incr: 13,089 50th: 13,089	FY14: 21,785 FY19: 27,057 Incr: 23,566 50th: 26,608	FY14: 11,857 FY19: 14,836 Incr: 13,662 50th: 15,999	FY14: 42,936 FY19: 50,766 Incr: 47,701 50th: 47,701	FY14: 13,675 FY19: 17,352 Incr: 16,053 50th: 19,771	FY14: 3,389 FY19: 4,210 Incr: 3,787 50th: 4,050	FY14: 9,856 FY19: 12,428 Incr: 8,805 50th: 9,554
gastroenterology	FY14: 101,251 FY19: 124,865 Incr: 125,284 50th: 167,857	No FY14 Data	FY14: 73,152 FY19: 87,106 Incr: 68,024 50th: 73,871	FY14: 99,974 FY19: 125,213 Incr: 128,993 50th: 143,362	FY14: 51,650 FY19: 65,398 Incr: 65,184 50th: 81,798	FY14: 154,623 FY19: 203,190 Incr: 188,120 50th: 188,120	FY14: 118,906 FY19: 153,627 Incr: 139,332 50th: 150,191	FY14: 253,113 FY19: 301,432 Incr: 294,987 50th: 312,740	FY14: 104,187 FY19: 134,312 Incr: 119,520 50th: 158,945	FY14: 88,505 FY19: 114,162 Incr: 102,321 50th: 110,768	FY14: 109,870 FY19: 137,818 Incr: 130,678 50th: 137,616
hematology oncology	FY14: 46,372 FY19: 54,159 Incr: 53,240 50th: 59,202	No FY14 Data	FY14: 29,345 FY19: 32,599 Incr: 27,614 50th: 34,648	FY14: 41,864 FY19: 48,776 Incr: 39,362 50th: 39,919	FY14: 17,492 FY19: 22,081 Incr: 18,436 50th: 26,493	FY14: 36,536 FY19: 44,942 Incr: 38,740 50th: 44,140	FY14: 30,473 FY19: 37,801 Incr: 32,530 50th: 36,781	FY14: 75,084 FY19: 83,125 Incr: 81,269 50th: 81,269	FY14: 35,162 FY19: 43,074 Incr: 40,628 50th: 53,678	FY14: 22,831 FY19: 28,538 Incr: 29,678 50th: 29,968	FY14: 33,107 FY19: 40,214 Incr: 38,681 50th: 38,681
infectious disease	FY14: 14,115 FY19: 15,225 Incr: 14,996 50th: 15,229	No FY14 Data	FY14: 18,095 FY19: 16,875 Incr: 20,040 50th: 20,040	FY14: 10,796 FY19: 11,145 Incr: 10,183 50th: 11,522	FY14: 9,136 FY19: 8,818 Incr: 9,377 50th: 10,447	FY14: 22,830 FY19: 25,536 Incr: 21,968 50th: 23,007	FY14: 15,849 FY19: 17,456 Incr: 17,183 50th: 17,183	FY14: 29,898 FY19: 28,844 Incr: 35,602 50th: 36,641	FY14: 6,875 FY19: 7,127 Incr: 7,050 50th: 14,000	FY14: 7,122 FY19: 7,380 Incr: 7,977 50th: 17,375	FY14: 6,249 FY19: 6,261 Incr: 6,548 50th: 7,365
internal medicine	FY14: 486,989 FY19: 533,710 Incr: 500,871 50th: 522,428	FY14: 238,661 FY19: 269,157 Incr: 269,857 50th: 269,857	FY14: 432,388 FY19: 450,795 Incr: 469,128 50th: 487,058	FY14: 529,362 FY19: 582,908 Incr: 584,841 50th: 659,713	FY14: 285,297 FY19: 330,384 Incr: 337,765 50th: 358,129	FY14: 778,831 FY19: 900,726 Incr: 974,417 50th: 1,017,955	FY14: 830,199 FY19: 973,491 Incr: 1,004,511 50th: 1,012,974	FY14: 1,430,541 FY19: 1,559,703 Incr: 1,627,194 50th: 1,669,665	FY14: 640,164 FY19: 727,774 Incr: 729,958 50th: 743,915	FY14: 539,558 FY19: 616,082 Incr: 594,254 50th: 596,900	FY14: 537,334 FY19: 614,584 Incr: 636,327 50th: 671,875
nephrology	FY14: 29,664 FY19: 32,877 Incr: 31,509 50th: 32,132	No FY14 Data	FY14: 43,316 FY19: 48,433 Incr: 46,201 50th: 46,201	FY14: 38,063 FY19: 45,652 Incr: 45,583 50th: 46,819	FY14: 14,770 FY19: 18,670 Incr: 15,089 50th: 15,089	FY14: 45,076 FY19: 52,955 Incr: 56,863 50th: 58,472	FY14: 41,629 FY19: 54,782 Incr: 44,336 50th: 55,389	FY14: 66,993 FY19: 81,404 Incr: 73,493 50th: 79,456	FY14: 15,511 FY19: 18,249 Incr: 17,203 50th: 39,423	FY14: 23,992 FY19: 30,057 Incr: 27,634 50th: 33,444	FY14: 21,594 FY19: 28,890 Incr: 25,653 50th: 37,789
neurological surgery	FY14: 11,053 FY19: 11,791 Incr: 10,811 50th: 11,472	No FY14 Data	No FY14 Data	FY14: 2,778 FY19: 3,049 Incr: 3,668 50th: 4,003	FY14: 6,869 FY19: 8,343 Incr: 7,390 50th: 7,390	FY14: 29,596 FY19: 35,791 Incr: 34,606 50th: 34,606	FY14: 14,372 FY19: 16,399 Incr: 19,403 50th: 23,636	FY14: 12,268 FY19: 13,370 Incr: 14,274 50th: 15,599	FY14: 9,858 FY19: 11,344 Incr: 11,189 50th: 12,630	No FY14 Data	FY14: 5,700 FY19: 5,921 Incr: 9,315 50th: 9,315
neurology	FY14: 57,136 FY19: 70,271 Incr: 65,684 50th: 71,689	FY14: 19,307 FY19: 24,120 Incr: 16,913 50th: 16,913	FY14: 47,857 FY19: 56,763 Incr: 50,613 50th: 59,690	FY14: 34,318 FY19: 41,362 Incr: 38,174 50th: 44,549	FY14: 45,769 FY19: 55,604 Incr: 52,130 50th: 74,810	FY14: 72,186 FY19: 93,272 Incr: 85,137 50th: 97,369	FY14: 45,072 FY19: 56,397 Incr: 52,404 50th: 65,469	FY14: 91,409 FY19: 109,517 Incr: 105,869 50th: 109,503	FY14: 34,613 FY19: 42,881 Incr: 40,737 50th: 50,176	FY14: 31,821 FY19: 40,368 Incr: 36,620 50th: 47,230	FY14: 38,959 FY19: 48,159 Incr: 43,839 50th: 49,891
obstetrics gynecology	FY14: 1,287 FY19: 1,915 Incr: 1,263 50th: 1,263	No FY14 Data	FY14: 7,851 FY19: 11,722 Incr: 8,406 50th: 11,087	FY14: 4,588 FY19: 6,815 Incr: 5,382 50th: 8,022	No FY14 Data	FY14: 9,538 FY19: 13,691 Incr: 10,977 50th: 12,244	FY14: 14,801 FY19: 20,128 Incr: 18,308 50th: 18,621	FY14: 25,263 FY19: 34,761 Incr: 25,150 50th: 27,825	FY14: 3,092 FY19: 4,866 Incr: 2,685 50th: 3,474	FY14: 3,863 FY19: 5,426 Incr: 5,366 50th: 6,117	FY14: 6,121 FY19: 8,974 Incr: 7,247 50th: 7,247
ophthalmology	FY14: 96,371 FY19: 116,307 Incr: 122,531 50th: 133,301	FY14: 69,071 FY19: 82,453 Incr: 66,582 50th: 66,582	FY14: 68,974 FY19: 78,481 Incr: 72,386 50th: 91,238	FY14: 66,330 FY19: 81,755 Incr: 74,307 50th: 82,206	FY14: 59,707 FY19: 74,811 Incr: 74,193 50th: 74,193	FY14: 153,585 FY19: 202,361 Incr: 167,437 50th: 185,560	FY14: 168,450 FY19: 218,664 Incr: 215,507 50th: 235,019	FY14: 281,771 FY19: 324,602 Incr: 328,706 50th: 370,522	FY14: 115,081 FY19: 148,979 Incr: 116,414 50th: 131,837	FY14: 60,954 FY19: 80,720 Incr: 74,932 50th: 78,818	FY14: 99,642 FY19: 127,376 Incr: 124,545 50th: 124,545
orthopaedic surgery	FY14: 52,002 FY19: 59,147 Incr: 52,762 50th: 65,583	FY14: 30,736 FY19: 36,451 Incr: 40,869 50th: 40,869	FY14: 47,644 FY19: 58,774 Incr: 56,693 50th: 56,698	FY14: 45,065 FY19: 55,592 Incr: 51,971 50th: 65,463	FY14: 25,354 FY19: 31,676 Incr: 27,687 50th: 28,621	FY14: 108,888 FY19: 138,976 Incr: 132,871 50th: 158,676	FY14: 52,131 FY19: 63,654 Incr: 61,617 50th: 76,567	FY14: 153,786 FY19: 178,261 Incr: 165,721 50th: 176,773	FY14: 59,486 FY19: 70,238 Incr: 68,440 50th: 74,157	FY14: 52,889 FY19: 66,081 Incr: 59,368 50th: 68,841	FY14: 37,510 FY19: 42,700 Incr: 45,070 50th: 49,056
otolaryngology	FY14: 32,159 FY19: 38,389 Incr: 38,552 50th: 43,690	No FY14 Data	FY14: 34,546 FY19: 41,721 Incr: 40,188 50th: 41,970	FY14: 28,432 FY19: 35,320 Incr: 29,720 50th: 35,727	FY14: 19,841 FY19: 25,103 Incr: 18,019 50th: 22,434	FY14: 40,050 FY19: 53,771 Incr: 46,719 50th: 60,213	FY14: 40,569 FY19: 51,920 Incr: 45,492 50th: 50,292	FY14: 74,012 FY19: 87,682 Incr: 78,741 50th: 81,426	FY14: 30,080 FY19: 37,618 Incr: 29,577 50th: 29,577	FY14: 22,536 FY19: 29,637 Incr: 22,982 50th: 24,610	FY14: 36,715 FY19: 45,432 Incr: 45,766 50th: 48,341
pain medicine	FY14: 2,599 FY19: 3,372 Incr: 2,649 50th: 2,649	No FY14 Data	FY14: 2,001 FY19: 2,651 Incr: 2,527 50th: 3,059	FY14: 2,387 FY19: 3,035 Incr: 3,861 50th: 4,193	No FY14 Data	FY14: 3,419 FY19: 4,483 Incr: 3,673 50th: 3,673	FY14: 7,839 FY19: 10,186 Incr: 10,174 50th: 12,753	FY14: 9,433 FY19: 11,931 Incr: 13,507 50th: 13,507	No FY14 Data	FY14: 3,230 FY19: 4,396 Incr: 3,877 50th: 4,184	FY14: 4,271 FY19: 4,967 Incr: 4,661 50th: 4,661
physical medicine rehabilitation	FY14: 16,364 FY19: 20,239 Incr: 20,240 50th: 21,164	No FY14 Data	FY14: 65,401 FY19: 76,885 Incr: 73,315 50th: 73,656	FY14: 31,389 FY19: 38,332 Incr: 35,130 50th: 41,013	FY14: 18,179 FY19: 21,469 Incr: 24,014 50th: 28,058	FY14: 39,838 FY19: 53,137 Incr: 47,512 50th: 62,028	FY14: 56,572 FY19: 74,937 Incr: 62,340 50th: 73,390	FY14: 140,491 FY19: 160,386 Incr: 144,518 50th: 151,054	FY14: 33,847 FY19: 42,923 Incr: 38,722 50th: 39,234	FY14: 36,099 FY19: 46,805 Incr: 40,843 50th: 48,203	FY14: 37,984 FY19: 47,662 Incr: 47,232 50th: 50,464
plastic surgery	FY14: 4,496 FY19: 5,587 Incr: 5,749 50th: 6,330	No FY14 Data	FY14: 5,385 FY19: 6,202 Incr: 5,936 50th: 8,378	FY14: 3,206 FY19: 4,335 Incr: 3,772 50th: 4,326	FY14: 7,477 FY19: 9,620 Incr: 7,437 50th: 10,766	FY14: 19,330 FY19: 25,724 Incr: 25,544 50th: 35,358	FY14: 14,307 FY19: 18,574 Incr: 15,788 50th: 16,055	FY14: 38,056 FY19: 48,608 Incr: 41,480 50th: 42,207	FY14: 9,006 FY19: 12,204 Incr: 10,946 50th: 12,663	FY14: 10,204 FY19: 13,535 Incr: 11,158 50th: 11,702	FY14: 14,916 FY19: 18,919 Incr: 17,171 50th: 17,171
psychiatry	FY14: 312,175 FY19: 361,881 Incr: 348,529 50th: 438,396	FY14: 142,459 FY19: 170,003 Incr: 168,720 50th: 168,720	FY14: 289,505 FY19: 339,332 Incr: 321,459 50th: 356,067	FY14: 331,142 FY19: 394,945 Incr: 382,167 50th: 396,576	FY14: 155,373 FY19: 185,331 Incr: 167,396 50th: 177,507	FY14: 340,802 FY19: 426,715 Incr: 390,556 50th: 497,702	FY14: 407,418 FY19: 495,278 Incr: 491,205 50th: 573,035	FY14: 872,051 FY19: 991,201 Incr: 1,092,154 50th: 1,099,974	FY14: 299,680 FY19: 365,739 Incr: 377,809 50th: 393,707	FY14: 251,941 FY19: 310,465 Incr: 289,112 50th: 294,562	FY14: 235,243 FY19: 278,589 Incr: 266,448 50th: 277,961
rheumatology	FY14: 23,981 FY19: 29,986 Incr: 26,424 50th: 27,432	No FY14 Data	FY14: 10,736 FY19: 12,607 Incr: 10,345 50th: 11,777	FY14: 11,369 FY19: 14,203 Incr: 14,960 50th: 17,348	FY14: 9,908 FY19: 12,440 Incr: 10,296 50th: 11,198	FY14: 7,769 FY19: 10,495 Incr: 8,941 50th: 9,027	FY14: 16,530 FY19: 21,350 Incr: 19,404 50th: 27,269	FY14: 22,221 FY19: 27,110 Incr: 32,015 50th: 36,931	FY14: 9,692 FY19: 11,765 Incr: 11,415 50th: 12,818	FY14: 11,834 FY19: 15,633 Incr: 13,179 50th: 19,511	FY14: 7,981 FY19: 10,045 Incr: 7,008 50th: 9,406
surgery	FY14: 65,908 FY19: 74,645 Incr: 75,145 50th: 79,507	No FY14 Data	FY14: 43,651 FY19: 48,421 Incr: 51,183 50th: 78,079	FY14: 89,386 FY19: 105,583 Incr: 95,358 50th: 107,249	FY14: 29,406 FY19: 34,190 Incr: 30,312 50th: 35,232	FY14: 95,766 FY19: 118,229 Incr: 114,032 50th: 136,593	FY14: 114,615 FY19: 138,157 Incr: 129,769 50th: 140,096	FY14: 152,455 FY19: 168,114 Incr: 147,524 50th: 151,672	FY14: 100,842 FY19: 117,969 Incr: 97,511 50th: 105,111	FY14: 34,996 FY19: 42,500 Incr: 42,636 50th: 59,529	FY14: 80,017 FY19: 92,304 Incr: 82,654 50th: 89,798
thoracic surgery	FY14: 32,347 FY19: 33,319 Incr: 39,749 50th: 39,749	No FY14 Data	No FY14 Data	FY14: 20,823 FY19: 22,647 Incr: 54,716 50th: 58,373	FY14: 1,300 FY19: 1,533 Incr: 1,246 50th: 2,783	FY14: 12,812 FY19: 14,022 Incr: 11,307 50th: 12,932	FY14: 6,389 FY19: 6,855 Incr: 6,409 50th: 9,094	FY14: 19,680 FY19: 20,004 Incr: 20,678 50th: 20,678	FY14: 15,350 FY19: 16,303 Incr: 17,782 50th: 29,261	FY14: 20,816 FY19: 22,510 Incr: 22,407 50th: 27,805	FY14: 11,078 FY19: 11,519 Incr: 12,983 50th: 12,991
urology	FY14: 48,858 FY19: 57,926 Incr: 42,298 50th: 54,229	FY14: 28,820 FY19: 35,389 Incr: 35,055 50th: 43,276	FY14: 45,544 FY19: 53,538 Incr: 48,631 50th: 73,542	FY14: 30,631 FY19: 37,813 Incr: 30,726 50th: 56,371	FY14: 22,915 FY19: 28,674 Incr: 24,656 50th: 30,182	FY14: 74,169 FY19: 93,661 Incr: 86,264 50th: 97,469	FY14: 63,412 FY19: 80,264 Incr: 73,458 50th: 74,586	FY14: 143,147 FY19: 163,789 Incr: 153,626 50th: 161,853	FY14: 39,173 FY19: 48,585 Incr: 47,332 50th: 50,922	FY14: 33,511 FY19: 43,208 Incr: 34,044 50th: 44,345	FY14: 27,319 FY19: 33,641 Incr: 39,302 50th: 48,297
vascular surgery	FY14: 43,869 FY19: 46,717 Incr: 51,640 50th: 56,106	No FY14 Data	FY14: 23,315 FY19: 24,551 Incr: 28,534 50th: 29,656	FY14: 20,803 FY19: 22,430 Incr: 34,772 50th: 37,134	FY14: 16,759 FY19: 19,206 Incr: 18,844 50th: 25,810	FY14: 15,453 FY19: 18,880 Incr: 17,793 50th: 20,936	FY14: 19,231 FY19: 21,159 Incr: 19,582 50th: 26,699	FY14: 58,964 FY19: 61,078 Incr: 59,583 50th: 59,583	FY14: 34,506 FY19: 37,580 Incr: 39,261 50th: 39,261	FY14: 28,765 FY19: 32,960 Incr: 34,372 50th: 37,097	FY14: 30,808 FY19: 34,966 Incr: 42,393 50th: 42,393
Grand Total	FY14: 1,694,939 FY19: 1,944,460 Incr: 1,876,289 50th: 2,136,740	FY14: 626,834 FY19: 730,183 Incr: 717,189 50th: 725,410	FY14: 1,471,822 FY19: 1,655,894 Incr: 1,593,577 50th: 1,767,738	FY14: 1,671,362 FY19: 1,954,355 Incr: 1,929,338 50th: 2,155,297	FY14: 896,712 FY19: 1,074,014 Incr: 1,019,126 50th: 1,160,791	FY14: 2,324,942 FY19: 2,861,484 Incr: 2,764,077 50th: 3,112,473	FY14: 2,292,817 FY19: 2,801,076 Incr: 2,746,732 50th: 2,994,611	FY14: 4,575,163 FY19: 5,170,523 Incr: 5,242,481 50th: 5,427,378	FY14: 1,838,092 FY19: 2,196,715 Incr: 2,095,057 50th: 2,310,539	FY14: 1,493,367 FY19: 1,813,259 Incr: 1,691,596 50th: 1,817,559	FY14: 1,581,794 FY19: 1,883,693 Incr: 1,859,150 50th: 1,978,544

	VISN										
VA Specialty	V12	V15	V16	V17	V18	V19	V20	V21	V22	V23	Grand Total
allergy and immunology	FY14: 3,168 FY19: 4,005 Incr: 4,334 50th: 6,245	No FY14 Data	FY14: 2,906 FY19: 3,723 Incr: 2,693 50th: 4,560	FY14: 2,991 FY19: 3,820 Incr: 3,317 50th: 3,317	FY14: 17,817 FY19: 19,325 Incr: 20,931 50th: 22,865	No FY14 Data	No FY14 Data	No FY14 Data	FY14: 6,897 FY19: 8,087 Incr: 8,265 50th: 8,712	No FY14 Data	FY14: 52,258 FY19: 61,232 Incr: 90,477 50th: 100,854
cardiology	FY14: 126,943 FY19: 148,770 Incr: 150,681 50th: 162,927	FY14: 118,592 FY19: 136,207 Incr: 161,550 50th: 161,550	FY14: 213,498 FY19: 244,635 Incr: 249,318 50th: 258,721	FY14: 112,859 FY19: 134,113 Incr: 140,417 50th: 150,916	FY14: 99,166 FY19: 115,478 Incr: 117,233 50th: 120,491	FY14: 54,283 FY19: 63,844 Incr: 66,684 50th: 77,604	FY14: 69,024 FY19: 81,385 Incr: 81,726 50th: 87,298	FY14: 111,497 FY19: 123,612 Incr: 120,035 50th: 134,061	FY14: 136,290 FY19: 151,266 Incr: 143,054 50th: 149,937	FY14: 86,138 FY19: 101,530 Incr: 105,965 50th: 120,354	FY14: 2,399,197 FY19: 2,775,160 Incr: 2,770,434 50th: 2,988,224
critical care pulmonary disease	FY14: 36,060 FY19: 45,182 Incr: 38,209 50th: 54,592	FY14: 27,398 FY19: 35,049 Incr: 30,919 50th: 30,919	FY14: 83,615 FY19: 101,281 Incr: 74,078 50th: 97,285	FY14: 54,662 FY19: 68,995 Incr: 65,450 50th: 65,450	FY14: 16,802 FY19: 20,195 Incr: 21,749 50th: 30,207	FY14: 31,771 FY19: 39,753 Incr: 38,549 50th: 45,011	FY14: 38,500 FY19: 48,934 Incr: 48,885 50th: 72,818	FY14: 34,786 FY19: 40,613 Incr: 38,563 50th: 49,370	FY14: 87,957 FY19: 103,484 Incr: 100,122 50th: 102,586	FY14: 28,833 FY19: 34,529 Incr: 37,039 50th: 48,110	FY14: 1,024,015 FY19: 1,234,833 Incr: 1,149,754 50th: 1,342,355
dermatology	FY14: 42,103 FY19: 55,434 Incr: 44,884 50th: 48,345	FY14: 22,253 FY19: 28,569 Incr: 22,478 50th: 24,394	FY14: 60,708 FY19: 78,367 Incr: 68,331 50th: 78,483	FY14: 61,562 FY19: 83,516 Incr: 76,190 50th: 77,338	FY14: 33,689 FY19: 44,043 Incr: 37,176 50th: 49,567	FY14: 16,308 FY19: 21,845 Incr: 20,261 50th: 28,512	FY14: 35,409 FY19: 47,248 Incr: 34,651 50th: 45,772	FY14: 61,838 FY19: 77,576 Incr: 73,374 50th: 138,411	FY14: 80,210 FY19: 100,704 Incr: 89,266 50th: 112,803	FY14: 38,865 FY19: 50,269 Incr: 46,320 50th: 46,320	FY14: 989,391 FY19: 1,281,753 Incr: 1,125,476 50th: 1,333,943
endocrinology	FY14: 21,642 FY19: 26,369 Incr: 22,199 50th: 22,792	FY14: 5,469 FY19: 6,500 Incr: 5,837 50th: 5,837	FY14: 15,456 FY19: 18,693 Incr: 16,958 50th: 30,792	FY14: 20,590 FY19: 25,468 Incr: 25,224 50th: 29,954	FY14: 9,810 FY19: 12,202 Incr: 10,013 50th: 14,254	FY14: 8,731 FY19: 11,104 Incr: 11,255 50th: 13,273	FY14: 8,248 FY19: 9,620 Incr: 9,549 50th: 13,229	FY14: 22,705 FY19: 26,369 Incr: 26,885 50th: 29,675	FY14: 29,261 FY19: 36,186 Incr: 32,504 50th: 33,979	FY14: 13,289 FY19: 15,278 Incr: 14,292 50th: 18,733	FY14: 322,331 FY19: 388,743 Incr: 360,841 50th: 412,183
gastroenterology	FY14: 83,880 FY19: 105,357 Incr: 86,534 50th: 106,574	FY14: 99,483 FY19: 122,358 Incr: 121,882 50th: 127,145	FY14: 130,980 FY19: 160,451 Incr: 160,346 50th: 238,600	FY14: 99,145 FY19: 128,182 Incr: 121,783 50th: 155,991	FY14: 95,711 FY19: 121,129 Incr: 115,458 50th: 117,327	FY14: 38,312 FY19: 48,935 Incr: 45,137 50th: 60,216	FY14: 52,299 FY19: 66,920 Incr: 64,502 50th: 118,319	FY14: 104,757 FY19: 125,141 Incr: 111,683 50th: 137,531	FY14: 149,242 FY19: 178,121 Incr: 187,334 50th: 209,085	FY14: 63,606 FY19: 79,167 Incr: 62,143 50th: 68,699	FY14: 2,072,646 FY19: 2,582,884 Incr: 2,439,245 50th: 2,864,753
hematology oncology	FY14: 23,350 FY19: 28,714 Incr: 22,285 50th: 27,996	FY14: 26,092 FY19: 31,611 Incr: 24,116 50th: 24,116	FY14: 56,417 FY19: 67,051 Incr: 61,750 50th: 74,757	FY14: 34,075 FY19: 41,644 Incr: 42,824 50th: 50,884	FY14: 11,933 FY19: 14,900 Incr: 11,730 50th: 16,448	FY14: 20,703 FY19: 25,726 Incr: 21,408 50th: 22,069	FY14: 29,764 FY19: 37,617 Incr: 35,824 50th: 39,642	FY14: 39,881 FY19: 46,392 Incr: 45,731 50th: 66,429	FY14: 38,653 FY19: 44,586 Incr: 49,958 50th: 54,033	FY14: 16,714 FY19: 20,129 Incr: 17,677 50th: 24,338	FY14: 665,848 FY19: 793,679 Incr: 733,481 50th: 845,493
infectious disease	FY14: 8,228 FY19: 8,881 Incr: 9,184 50th: 15,876	FY14: 5,594 FY19: 5,671 Incr: 7,218 50th: 9,451	FY14: 18,631 FY19: 18,652 Incr: 22,687 50th: 29,346	FY14: 12,632 FY19: 13,582 Incr: 14,039 50th: 15,750	FY14: 7,767 FY19: 8,042 Incr: 8,177 50th: 12,455	FY14: 7,081 FY19: 7,446 Incr: 9,421 50th: 13,409	FY14: 3,590 FY19: 4,204 Incr: 4,436 50th: 9,592	FY14: 14,474 FY19: 14,384 Incr: 17,563 50th: 19,198	FY14: 21,579 FY19: 20,991 Incr: 25,510 50th: 27,051	FY14: 7,163 FY19: 7,790 Incr: 8,763 50th: 17,726	FY14: 247,704 FY19: 254,310 Incr: 277,920 50th: 342,662
internal medicine	FY14: 562,538 FY19: 619,603 Incr: 668,133 50th: 709,460	FY14: 473,004 FY19: 527,622 Incr: 542,642 50th: 542,642	FY14: 993,528 FY19: 1,125,065 Incr: 1,131,693 50th: 1,179,992	FY14: 645,449 FY19: 744,097 Incr: 682,936 50th: 682,936	FY14: 408,673 FY19: 471,221 Incr: 436,827 50th: 503,288	FY14: 360,324 FY19: 418,256 Incr: 442,958 50th: 448,666	FY14: 492,541 FY19: 585,302 Incr: 587,074 50th: 675,154	FY14: 563,289 FY19: 626,971 Incr: 691,145 50th: 812,897	FY14: 684,149 FY19: 730,276 Incr: 776,529 50th: 849,820	FY14: 593,071 FY19: 654,432 Incr: 695,953 50th: 722,756	FY14: 12,505,890 FY19: 14,062,159 Incr: 14,385,014 50th: 15,138,080
nephrology	FY14: 45,756 FY19: 56,842 Incr: 50,495 50th: 54,503	FY14: 18,110 FY19: 22,696 Incr: 24,653 50th: 24,653	FY14: 29,041 FY19: 35,402 Incr: 31,111 50th: 47,415	FY14: 80,840 FY19: 103,197 Incr: 87,974 50th: 87,974	FY14: 22,043 FY19: 26,128 Incr: 23,736 50th: 24,280	FY14: 15,351 FY19: 17,628 Incr: 16,836 50th: 16,920	FY14: 15,014 FY19: 19,628 Incr: 15,374 50th: 21,794	FY14: 40,923 FY19: 45,265 Incr: 44,310 50th: 45,871	FY14: 58,442 FY19: 69,811 Incr: 76,739 50th: 76,739	FY14: 52,032 FY19: 64,914 Incr: 61,059 50th: 69,627	FY14: 718,160 FY19: 873,480 Incr: 815,853 50th: 913,990
neurological surgery	FY14: 17,598 FY19: 19,542 Incr: 17,057 50th: 19,006	No FY14 Data	FY14: 7,342 FY19: 8,477 Incr: 6,509 50th: 11,505	FY14: 10,244 FY19: 11,966 Incr: 12,814 50th: 12,814	FY14: 16,744 FY19: 19,103 Incr: 21,911 50th: 21,911	FY14: 4,164 FY19: 4,508 Incr: 5,001 50th: 5,001	FY14: 15,710 FY19: 17,076 Incr: 20,007 50th: 20,527	FY14: 14,309 FY19: 14,844 Incr: 14,669 50th: 24,066	FY14: 22,414 FY19: 24,908 Incr: 21,539 50th: 25,879	No FY14 Data	FY14: 201,019 FY19: 226,432 Incr: 230,161 50th: 259,360
neurology	FY14: 62,412 FY19: 77,620 Incr: 71,221 50th: 80,716	FY14: 42,545 FY19: 53,229 Incr: 46,776 50th: 46,776	FY14: 107,815 FY19: 134,267 Incr: 117,797 50th: 133,565	FY14: 47,008 FY19: 58,957 Incr: 49,989 50th: 49,989	FY14: 16,167 FY19: 20,294 Incr: 19,033 50th: 20,171	FY14: 23,710 FY19: 30,767 Incr: 25,367 50th: 34,470	FY14: 30,291 FY19: 37,490 Incr: 30,374 50th: 42,594	FY14: 55,000 FY19: 65,274 Incr: 61,808 50th: 95,368	FY14: 66,684 FY19: 79,433 Incr: 72,521 50th: 88,010	FY14: 57,609 FY19: 73,924 Incr: 63,483 50th: 72,091	FY14: 1,027,688 FY19: 1,269,969 Incr: 1,146,489 50th: 1,351,039
obstetrics gynecology	FY14: 5,305 FY19: 7,663 Incr: 7,086 50th: 11,043	No FY14 Data	FY14: 10,021 FY19: 15,035 Incr: 9,719 50th: 10,432	FY14: 13,758 FY19: 19,525 Incr: 15,304 50th: 15,304	FY14: 8,551 FY19: 12,340 Incr: 9,902 50th: 12,246	FY14: 4,322 FY19: 6,577 Incr: 3,754 50th: 4,326	FY14: 3,762 FY19: 5,266 Incr: 4,677 50th: 4,677	FY14: 11,389 FY19: 16,891 Incr: 12,597 50th: 13,933	FY14: 10,513 FY19: 14,591 Incr: 13,242 50th: 15,418	FY14: 2,670 FY19: 4,172 Incr: 2,617 50th: 2,617	FY14: 146,695 FY19: 210,358 Incr: 163,684 50th: 185,897
ophthalmology	FY14: 127,297 FY19: 159,906 Incr: 159,295 50th: 193,606	FY14: 41,620 FY19: 52,874 Incr: 38,394 50th: 38,394	FY14: 236,259 FY19: 291,718 Incr: 263,059 50th: 276,503	FY14: 103,277 FY19: 132,622 Incr: 97,770 50th: 116,660	FY14: 78,554 FY19: 98,024 Incr: 87,287 50th: 116,446	FY14: 67,077 FY19: 85,899 Incr: 85,762 50th: 119,560	FY14: 86,251 FY19: 113,276 Incr: 99,228 50th: 102,645	FY14: 102,524 FY19: 122,527 Incr: 110,187 50th: 146,911	FY14: 153,050 FY19: 183,811 Incr: 181,564 50th: 181,564	FY14: 103,836 FY19: 129,611 Incr: 91,118 50th: 91,705	FY14: 2,339,681 FY19: 2,906,777 Incr: 2,651,203 50th: 2,957,816
orthopaedic surgery	FY14: 54,680 FY19: 65,117 Incr: 63,610 50th: 68,583	FY14: 65,250 FY19: 76,483 Incr: 81,352 50th: 83,657	FY14: 87,343 FY19: 107,119 Incr: 113,446 50th: 145,095	FY14: 53,369 FY19: 67,416 Incr: 62,645 50th: 63,438	FY14: 79,542 FY19: 95,109 Incr: 91,395 50th: 91,967	FY14: 71,736 FY19: 88,006 Incr: 89,548 50th: 100,605	FY14: 43,115 FY19: 51,807 Incr: 45,717 50th: 49,486	FY14: 81,612 FY19: 91,556 Incr: 94,461 50th: 106,893	FY14: 101,474 FY19: 115,201 Incr: 117,011 50th: 127,473	FY14: 69,589 FY19: 81,944 Incr: 75,659 50th: 75,659	FY14: 1,373,201 FY19: 1,641,308 Incr: 1,597,914 50th: 1,774,159
otolaryngology	FY14: 35,865 FY19: 43,883 Incr: 35,661 50th: 38,388	FY14: 14,129 FY19: 17,827 Incr: 12,351 50th: 12,351	FY14: 52,308 FY19: 65,627 Incr: 56,871 50th: 76,742	FY14: 13,809 FY19: 17,891 Incr: 11,325 50th: 11,444	FY14: 21,260 FY19: 26,344 Incr: 27,457 50th: 29,875	FY14: 15,103 FY19: 19,498 Incr: 18,543 50th: 19,887	FY14: 35,824 FY19: 45,398 Incr: 39,931 50th: 40,409	FY14: 40,857 FY19: 47,561 Incr: 45,708 50th: 48,879	FY14: 52,218 FY19: 62,095 Incr: 57,045 50th: 62,511	FY14: 31,565 FY19: 39,068 Incr: 31,821 50th: 32,398	FY14: 671,878 FY19: 831,785 Incr: 732,470 50th: 811,167
pain medicine	FY14: 1,535 FY19: 2,115 Incr: 1,673 50th: 1,858	No FY14 Data	No FY14 Data	No FY14 Data	FY14: 4,658 FY19: 6,224 Incr: 5,366 50th: 5,366	FY14: 5,716 FY19: 7,909 Incr: 4,124 50th: 4,329	No FY14 Data	FY14: 1,617 FY19: 2,098 Incr: 1,734 50th: 2,481	FY14: 13,391 FY19: 16,629 Incr: 15,248 50th: 16,042	FY14: 2,400 FY19: 2,974 Incr: 2,312 50th: 2,448	FY14: 64,496 FY19: 82,970 Incr: 75,386 50th: 81,203
physical medicine rehabilitation	FY14: 40,260 FY19: 50,205 Incr: 49,592 50th: 69,772	FY14: 39,232 FY19: 49,722 Incr: 49,749 50th: 49,749	FY14: 49,584 FY19: 62,838 Incr: 57,463 50th: 70,176	FY14: 62,657 FY19: 80,808 Incr: 70,203 50th: 77,788	FY14: 20,691 FY19: 26,312 Incr: 24,047 50th: 34,250	FY14: 26,675 FY19: 34,228 Incr: 28,442 50th: 28,442	FY14: 43,623 FY19: 56,151 Incr: 50,363 50th: 53,478	FY14: 23,252 FY19: 28,202 Incr: 30,634 50th: 44,460	FY14: 113,004 FY19: 138,740 Incr: 135,738 50th: 137,771	FY14: 26,482 FY19: 34,851 Incr: 31,880 50th: 40,618	FY14: 921,624 FY19: 1,144,832 Incr: 1,061,976 50th: 1,194,767
plastic surgery	FY14: 10,953 FY19: 13,514 Incr: 14,007 50th: 17,520	No FY14 Data	FY14: 8,764 FY19: 10,671 Incr: 8,778 50th: 9,263	FY14: 13,948 FY19: 17,939 Incr: 15,122 50th: 16,621	FY14: 9,557 FY19: 12,343 Incr: 11,888 50th: 12,416	FY14: 2,729 FY19: 3,506 Incr: 2,796 50th: 4,100	FY14: 13,783 FY19: 17,750 Incr: 14,645 50th: 14,645	FY14: 20,072 FY19: 24,437 Incr: 22,102 50th: 22,750	FY14: 12,739 FY19: 15,119 Incr: 15,420 50th: 26,474	No FY14 Data	FY14: 218,928 FY19: 278,587 Incr: 249,738 50th: 288,743
psychiatry	FY14: 327,346 FY19: 393,636 Incr: 405,248 50th: 443,884	FY14: 253,363 FY19: 306,559 Incr: 300,994 50th: 300,994	FY14: 472,691 FY19: 568,801 Incr: 550,727 50th: 585,092	FY14: 364,734 FY19: 450,168 Incr: 452,929 50th: 452,929	FY14: 224,562 FY19: 274,728 Incr: 274,614 50th: 283,460	FY14: 157,435 FY19: 193,818 Incr: 193,103 50th: 236,057	FY14: 284,062 FY19: 345,014 Incr: 339,182 50th: 355,833	FY14: 304,572 FY19: 355,279 Incr: 349,274 50th: 423,831	FY14: 455,516 FY19: 529,942 Incr: 541,494 50th: 541,494	FY14: 210,200 FY19: 261,480 Incr: 228,902 50th: 267,232	FY14: 6,692,270 FY19: 7,998,904 Incr: 7,932,023 50th: 8,565,015
rheumatology	FY14: 15,850 FY19: 19,798 Incr: 17,497 50th: 21,632	No FY14 Data	FY14: 11,696 FY19: 14,518 Incr: 14,990 50th: 18,628	FY14: 12,556 FY19: 16,317 Incr: 12,679 50th: 14,352	FY14: 11,167 FY19: 14,104 Incr: 12,192 50th: 13,076	FY14: 9,495 FY19: 12,606 Incr: 12,357 50th: 16,100	FY14: 19,711 FY19: 25,874 Incr: 26,038 50th: 29,497	FY14: 13,878 FY19: 16,838 Incr: 16,325 50th: 24,511	FY14: 14,585 FY19: 17,668 Incr: 13,749 50th: 15,018	FY14: 12,834 FY19: 16,446 Incr: 11,748 50th: 13,549	FY14: 253,793 FY19: 319,803 Incr: 291,558 50th: 349,079
surgery	FY14: 64,246 FY19: 74,683 Incr: 78,306 50th: 100,489	FY14: 46,374 FY19: 55,299 Incr: 58,283 50th: 58,283	FY14: 105,356 FY19: 123,585 Incr: 124,218 50th: 131,030	FY14: 58,716 FY19: 70,839 Incr: 66,702 50th: 66,702	FY14: 80,773 FY19: 93,709 Incr: 94,732 50th: 101,124	FY14: 60,999 FY19: 73,603 Incr: 59,958 50th: 65,715	FY14: 58,131 FY19: 67,684 Incr: 66,984 50th: 87,204	FY14: 57,351 FY19: 61,934 Incr: 68,999 50th: 83,929	FY14: 102,795 FY19: 113,855 Incr: 120,311 50th: 138,317	FY14: 113,720 FY19: 134,534 Incr: 127,662 50th: 132,926	FY14: 1,555,503 FY19: 1,809,837 Incr: 1,732,279 50th: 1,948,585
thoracic surgery	FY14: 18,742 FY19: 20,193 Incr: 20,305 50th: 21,511	No FY14 Data	FY14: 10,046 FY19: 10,556 Incr: 14,999 50th: 16,638	FY14: 1,972 FY19: 2,179 Incr: 1,322 50th: 2,065	FY14: 4,798 FY19: 4,892 Incr: 6,051 50th: 6,686	No FY14 Data	FY14: 20,168 FY19: 21,477 Incr: 25,674 50th: 25,674	FY14: 17,723 FY19: 17,530 Incr: 19,651 50th: 19,651	FY14: 26,675 FY19: 26,784 Incr: 31,691 50th: 31,726	FY14: 2,633 FY19: 2,907 Incr: 2,891 50th: 4,530	FY14: 243,352 FY19: 255,230 Incr: 309,860 50th: 342,149
urology	FY14: 58,191 FY19: 68,958 Incr: 61,014 50th: 66,630	FY14: 55,787 FY19: 66,051 Incr: 70,382 50th: 70,382	FY14: 74,042 FY19: 89,651 Incr: 87,963 50th: 102,786	FY14: 37,551 FY19: 46,390 Incr: 38,394 50th: 38,394	FY14: 37,450 FY19: 44,411 Incr: 36,750 50th: 46,287	FY14: 31,429 FY19: 38,865 Incr: 40,786 50th: 44,132	FY14: 43,912 FY19: 53,786 Incr: 43,154 50th: 52,274	FY14: 55,865 FY19: 64,536 Incr: 58,855 50th: 67,469	FY14: 84,282 FY19: 97,608 Incr: 102,150 50th: 122,597	FY14: 51,095 FY19: 63,275 Incr: 57,522 50th: 57,522	FY14: 1,087,103 FY19: 1,310,019 Incr: 1,212,362 50th: 1,403,545
vascular surgery	FY14: 36,293 FY19: 39,786 Incr: 39,877 50th: 50,340	No FY14 Data	FY14: 18,808 FY19: 19,257 Incr: 23,568 50th: 30,132	FY14: 36,027 FY19: 40,871 Incr: 38,169 50th: 41,834	FY14: 20,442 FY19: 22,028 Incr: 18,675 50th: 21,909	FY14: 15,411 FY19: 17,343 Incr: 18,298 50th: 25,604	FY14: 31,057 FY19: 35,338 Incr: 33,574 50th: 33,687	FY14: 49,793 FY19: 52,832 Incr: 60,381 50th: 69,217	FY14: 41,153 FY19: 44,051 Incr: 48,148 50th: 60,125	FY14: 18,126 FY19: 19,804 Incr: 21,476 50th: 22,436	FY14: 559,583 FY19: 610,837 Incr: 648,938 50th: 729,959
Grand Total	FY14: 1,830,241 FY19: 2,155,776 Incr: 2,138,386 50th: 2,414,290	FY14: 1,354,295 FY19: 1,594,327 Incr: 1,599,575 50th: 1,611,293	FY14: 2,856,855 FY19: 3,375,440 Incr: 3,269,070 50th: 3,657,538	FY14: 1,954,431 FY19: 2,380,502 Incr: 2,205,519 50th: 2,300,845	FY14: 1,358,327 FY19: 1,622,628 Incr: 1,544,329 50th: 1,728,369	FY14: 1,048,865 FY19: 1,271,670 Incr: 1,260,346 50th: 1,434,008	FY14: 1,473,789 FY19: 1,794,245 Incr: 1,721,570 50th: 1,996,249	FY14: 1,843,964 FY19: 2,108,662 Incr: 2,136,675 50th: 2,627,792	FY14: 2,563,173 FY19: 2,923,947 Incr: 2,976,154 50th: 3,215,162	FY14: 1,602,470 FY19: 1,893,028 Incr: 1,798,301 50th: 1,952,394	FY14: 38,354,254 FY19: 45,205,881 Incr: 44,184,537 50th: 48,525,022

Sources: Milliman, Inc. August 8, 2014; 2014 VA Enrollee Health Care Projection Model - Base Year 2013 - 2014 Model Documentation & Analysis; Milliman Health Practice Seattle; RAND analyses of VA provider supply; RAND analyses of VA productivity data.

Appendix I Survey Data Tables and Participant Comments

Appendix I.1 Tables

In the following tables, we present survey results for each survey question by survey module, starting with the Facility module for which the Chief of Staff was the intended respondent, followed by the modules for each of the seven clinical conditions. The clinical modules were designed to be answered by the most appropriate service chief. Results with fewer than ten respondents are not presented.

The survey questions first elicit respondents' perceptions about the existence of *clinically meaningful* delays. Specifically, respondents were asked to "*Consider delays which might put a patient at risk for adverse outcomes, slow resolution of symptoms, or which are not compliant with VA/DoD guidelines."* Respondents who indicated that delays sometimes exist were asked to formulate a solution for reducing delays and then to rate the importance of various components to that solution.

Each module also contained a question that asked respondents to identify issues that affect provider and system efficiency, and several questions intended to determine if respondents had difficulty recruiting and retaining clinicians with expertise in the clinical condition of interest, or in the case of the facility module, staff in categories that spanned multiple conditions. In facilities reporting difficulties with recruitment and retention, respondents were asked to identify barriers that caused these problems.

Appendix I.1.1 Chief of Staff

2015 Survey of VA Capabilities and Resources
Section 1: General Facility Questions for the Chief of Staff

1. In the PAST 90 DAYS**, what percentage of patients trying to obtain a new primary care appointment experienced a *clinically meaningful delay*?**

Table I-1. Chief of Staff: Question 1

Service		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%	n	%
New primary care appointment	115	63	54.8	45	39.1	5	4.3	1	0.9	0	0.0	1	0.9

2. Think of the most effective way to reduce the number of *clinically meaningful delays* for patients trying to obtain a **new** primary care appointment. Now, **in your solution, how important are each of the following elements**?

Table I-2. Chief of Staff: Question 2

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	49	22	44.9	13	26.5	12	24.5	1	2.0	1	2.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	49	21	42.9	25	51.0	3	6.1	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	49	11	22.4	28	57.1	8	16.3	2	4.1	0	0.0
d. Acquire and/or improve availability of equipment	49	1	2.0	11	22.4	20	40.8	12	24.5	5	10.2
e. Implement or increase the availability of telehealth services	49	2	4.1	20	40.8	20	40.8	6	12.2	1	2.0
f. Improve information technology (e.g., scheduling system, electronic health record).	48	21	43.8	16	33.3	8	16.7	2	4.2	1	2.1
g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	49	19	38.8	17	34.7	8	16.3	4	8.2	1	2.0
h. Improve personnel supervision, management, or incentives.	49	9	18.4	24	49.0	12	24.5	4	8.2	0	0.0
i. Increase weekend and evening availability of services	49	1	2.0	14	28.6	25	51.0	8	16.3	1	2.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	49	5	10.2	17	34.7	15	30.6	11	22.4	1	2.0
k. Some other solution(s).	49	7	14.3	9	18.4	2	4.1	1	2.0	30	61.2
This question (question 2) is based on respondents who indicated that patients experienced delays (n=51) in obtaining a new primary care appointment (question 1).											

3. In the **PAST 90 DAYS**, what percentage of patients trying to obtain a **follow-up** primary care appointment experienced a *clinically meaningful delay*?

Table I-3. Chief of Staff: Question 3

Service		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%	n	%
Follow-up primary care appointment	113	58	51.3	46	40.7	8	7.1	0	0.0	0	0.0	1	0.9

4. Think of the most effective way to reduce the number of delays for patients trying to obtain a **follow-up** primary care appointment. Now, **in your solution, how important are each of the following elements?**

Table I-4. Chief of Staff: Question 4

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	N	n	%	n	%	n	%	n	%	n	%
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	53	19	35.8	16	30.2	14	26.4	4	7.5	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	53	20	37.7	28	52.8	5	9.4	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	52	10	19.2	32	61.5	7	13.5	3	5.8	0	0.0
d. Acquire and/or improve availability of equipment.	52	4	7.7	12	23.1	14	26.9	19	36.5	3	5.8
e. Implement or increase the availability of telehealth services	53	1	1.9	18	34.0	21	39.6	13	24.5	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	52	13	25.0	26	50.0	8	15.4	5	9.6	0	0.0
g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	53	19	35.8	15	28.3	12	22.6	6	11.3	1	1.9
h. Improve personnel supervision, management, or incentives.	53	8	15.1	18	34.0	23	43.4	4	7.5	0	0.0
i. Increase weekend and evening availability of services	53	0	0.0	9	17.0	31	58.5	13	24.5	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	53	6	11.3	14	26.4	12	22.6	20	37.7	1	1.9
k. Some other solution(s).	52	8	15.4	6	11.5	2	3.8	3	5.8	33	63.5
This question (question 4) is based on respondents who indicated that patients experienced delays (n=54) in obtaining a follow-up primary care appointment (question 3).											

Issues that Affect Provider and System Efficiency

5. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency?

Table I-5. Chief of Staff: Question 5

		None		A little		A fair amount		A lot		Not Applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Providers performing clinical activities that could be performed by individuals with less training	112	5	4.5	30	26.8	43	38.4	33	29.5	1	0.9
b. Providers performing administrative activities that could be performed by others	112	4	3.6	14	12.5	44	39.3	50	44.6	0	0.0
c. Residency training/teaching requirements	112	35	31.3	42	37.5	17	15.2	5	4.5	13	11.6
d. Insufficient clinical/administrative support staff	112	3	2.7	26	23.2	36	32.1	47	42.0	0	0.0
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	112	1	0.9	19	17.0	29	25.9	62	55.4	1	0.9
f. Unnecessary documentation requirements or inefficient CPRS interface	112	3	2.7	17	15.2	33	29.5	58	51.8	1	0.9
g. Patient no-show rates	112	2	1.8	56	50.0	41	36.6	13	11.6	0	0.0
h. Poor patient flow management (room/bed turnover, appointments)	112	12	10.7	42	37.5	40	35.7	18	16.1	0	0.0
i. Too many administrative requirements (Initiatives/Policies/Programs)	112	3	2.7	11	9.8	29	25.9	67	59.8	2	1.8

Workforce

6A. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-6. Chief of Staff: Question 6A

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Primary Care Providers	112	86	76.8	26	23.2	0	0.0
b. General Surgeons	111	39	35.1	52	46.8	20	18.0
c. Hospitalists	112	56	50.0	46	41.1	10	8.9
d. Intensivists	112	54	48.2	28	25.0	30	26.8
e. Pathologists	112	17	15.2	66	58.9	29	25.9
f. Radiologists	112	24	21.4	73	65.2	15	13.4
g. Dermatologists	112	69	61.6	23	20.5	20	17.9
h. Anesthesiologists	111	27	24.3	60	54.1	24	21.6
i. Advanced practice providers (Nurse Practitioners, Physician Assistants)	112	43	38.4	66	58.9	3	2.7
j. Nursing (RN, LPN, clinical nurse specialist)	112	56	50.0	55	49.1	1	0.9
k. Social Workers	112	10	8.9	102	91.1	0	0.0
l. Psychologists	112	27	24.1	85	75.9	0	0.0
m. Specialized support staff (lab or imaging technicians)	111	65	58.6	45	40.5	1	0.9
n. Inpatient support staff (clerical)	112	20	17.9	86	76.8	6	5.4
o. Administrative support staff (e.g., schedulers)	112	42	37.5	70	62.5	0	0.0
p. Therapists (Occupational Therapists, Physical Therapists, Speech Therapists)	112	54	48.2	53	47.3	5	4.5
q. Pain Management Specialists	112	61	54.5	40	35.7	11	9.8
r. Telehealth clinical technicians	112	24	21.4	85	75.9	3	2.7

Reasons for Staff Recruitment/Hiring Problems

7. Please enter the **top two** reasons why there were problems **RECRUITING AND HIRING** these personnel types.

Table I-7. Chief of Staff: Question 7

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Positions	N	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Primary Care Providers	86	1	1.2	41	47.7	4	4.7	0	0.0	3	3.5	1	1.2	3	3.5	8	9.3	1	1.2	40	46.5	35	40.7	34	39.5
b. General Surgeons	39	1	2.6	26	66.7	3	7.7	0	0.0	2	5.1	2	5.1	4	10.3	6	15.4	0	0.0	10	25.6	10	25.6	10	25.6
c. Hospitalists	56	1	1.8	37	66.1	11	19.6	0	0.0	2	3.6	1	1.8	3	5.4	5	8.9	2	3.6	18	32.1	14	25.0	17	30.4
d. Intensivists	54	1	1.9	40	74.1	10	18.5	0	0.0	1	1.9	2	3.7	5	9.3	3	5.6	1	1.9	12	22.2	10	18.5	21	38.9
e. Pathologists	17	0	0.0	12	70.6	0	0.0	0	0.0	0	0.0	1	5.9	2	11.8	1	5.9	2	11.8	3	17.6	5	29.4	7	41.2
f. Radiologists	24	1	4.2	16	66.7	2	8.3	1	4.2	0	0.0	1	4.2	0	0.0	3	12.5	1	4.2	10	41.7	7	29.2	6	25.0
g. Dermatologists	69	1	1.4	58	84.1	0	0.0	3	4.3	2	2.9	2	2.9	2	2.9	3	4.3	0	0.0	21	30.4	11	15.9	32	46.4
h. Anesthesiologists	27	1	3.7	21	77.8	3	11.1	0	0.0	0	0.0	1	3.7	0	0.0	4	14.8	1	3.7	6	22.2	7	25.9	9	33.3
i. Advanced practice providers (Nurse Practitioners, Physician Assistants)	43	2	4.7	31	72.1	1	2.3	1	2.3	1	2.3	1	2.3	0	0.0	5	11.6	0	0.0	15	34.9	18	41.9	11	25.6
j. Nursing (RN, LPN, clinical nurse specialist)	56	5	8.9	36	64.3	7	12.5	0	0.0	2	3.6	2	3.6	0	0.0	2	3.6	0	0.0	13	23.2	25	44.6	18	32.1
k. Social Workers	10	3	30.0	5	50	0	0.0	0	0.0	0	0.0	1	10.0	0	0.0	0	0.0	0	0.0	3	30.0	6	60.0	2	20.0
l. Psychologists	27	0	0.0	13	48.1	0	0.0	0	0.0	1	3.7	2	7.4	0	0.0	1	3.7	1	3.7	10	37	9	33.3	17	63.0
m. Specialized support staff (lab or imaging technicians)	65	1	1.5	47	72.3	7	10.8	0	0.0	2	3.1	0	0.0	0	0.0	2	3.1	1	1.5	11	16.9	28	43.1	31	47.7
n. Inpatient support staff (clerical)	20	3	15	9	45.0	3	15.0	0	0.0	1	5.0	1	5.0	1	5.0	0	0.0	0	0.0	1	5.0	12	60.0	9	45.0
o. Administrative support staff (e.g., schedulers)	42	6	14.3	21	50.0	3	7.1	1	2.4	2	4.8	1	2.4	0	0.0	0	0.0	0	0.0	4	9.5	29	69.0	17	40.5
p. Therapists (Occupational Therapists, Physical Therapists, Speech Therapists)	54	3	5.6	42	77.8	4	7.4	0	0.0	3	5.6	1	1.9	1	1.9	0	0.0	1	1.9	16	29.6	18	33.3	18	33.3
q. Pain Management Specialists	61	2	3.3	47	77.0	1	1.6	2	3.3	4	6.6	1	1.6	3	4.9	4	6.6	0	0.0	14	23.0	13	21.3	28	45.9
r. Telehealth clinical technicians	24	0	0.0	10	41.7	0	0.0	0	0.0	3	12.5	0	0.0	2	8.3	0	0.0	0	0.0	8	33.3	13	54.2	12	50.0

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring. This question (question 7) is based on respondents who indicated that their local health care system had problems recruiting or hiring certain personnel categories (question 6A). Question 7 was asked for each personnel type marked "yes" in question 6A.

6B. IN THE PAST YEAR, did your local health care system have problems **RETAINING t**he following personnel categories?

Table I-8. Chief of Staff: Question 6B

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Primary Care Providers	111	72	64.9	39	35.1	0	0.0
b. General Surgeons	111	15	13.5	81	73.0	15	13.5
c. Hospitalists	111	36	32.4	66	59.5	9	8.1
d. Intensivists	110	24	21.8	54	49.1	32	29.1
e. Pathologists	110	7	6.4	77	70.0	26	23.6
f. Radiologists	111	7	6.3	95	85.6	9	8.1
g. Dermatologists	111	22	19.8	65	58.6	24	21.6
h. Anesthesiologists	111	11	9.9	82	73.9	18	16.2
i. Advanced practice providers (Nurse Practitioners, Physician Assistants)	111	33	29.7	77	69.4	1	0.9
j. Nursing (RN, LPN, clinical nurse specialist)	111	49	44.1	60	54.1	2	1.8
k. Social Workers	111	9	8.1	99	89.2	3	2.7
l. Psychologists	111	21	18.9	87	78.4	3	2.7
m. Specialized support staff (lab or imaging technicians)	111	46	41.4	63	56.8	2	1.8
n. Inpatient support staff (clerical)	111	26	23.4	77	69.4	8	7.2
o. Administrative support staff (e.g., schedulers)	111	56	50.5	53	47.7	2	1.8
p. Therapists (Occupational Therapists, Physical Therapists, Speech Therapists)	111	26	23.4	83	74.8	2	1.8
q. Pain Management Specialists	111	19	17.1	74	66.7	18	16.2
r. Telehealth clinical technicians	111	19	17.1	90	81.1	2	1.8

Reasons for Staff Retention Problems

8. Please enter **top two reasons** why there were problems **RETAINING** these personnel types.

Table I-9. Chief of Staff: Question 8

Staff Positions	N	01 Lack of opportunity for professional growth/promotion		02 Dissatisfaction with supervision/management support		03 Dissatisfaction with support staff		04 Dissatisfaction with physical demands of the job		05 Dissatisfaction with workload		06 Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		07 Organizational culture that does not prioritize/ encourage productivity		08 Administrative/ Program Demands		09 Lack of professional autonomy		10 Dissatisfaction with pay		11 Work schedule		12 Inadequate equipment/ resources/office space		13 Burnout	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Primary Care Providers	72	1	1.4	25	34.7	18	25.0	2	2.8	27	37.5	1	1.4	11	15.3	15	20.8	2	2.8	16	22.2	2	2.8	4	5.6	16	22.2
b. General Surgeons	15	3	20.0	4	26.7	3	20.0	0	0.0	2	13.3	0	0.0	1	6.7	4	26.7	0	0.0	7	46.7	1	6.7	5	33.3	0	0.0
c. Hospitalists	36	4	11.1	18	50.0	8	22.2	2	5.6	7	19.4	0	0.0	4	11.1	4	11.1	1	2.8	10	27.8	5	13.9	3	8.3	6	16.7
d. Intensivists	24	4	16.7	10	41.7	7	29.2	2	8.3	4	16.7	1	4.2	2	8.3	3	12.5	2	8.3	5	20.8	3	12.5	3	12.5	2	8.3
e. Pathologists	7	1	14.3	2	28.6	0	0.0	0	0.0	2	28.6	0	0.0	0	0.0	3	42.9	0	0.0	2	28.6	1	14.3	2	28.6	0	0.0
f. Radiologists	7	1	14.3	4	57.1	2	28.6	0	0.0	1	14.3	0	0.0	0	0.0	2	28.6	1	14.3	2	28.6	0	0.0	0	0.0	1	14.3
g. Dermatologists	22	2	9.1	8	36.4	3	13.6	2	9.1	4	18.2	0	0.0	1	4.5	5	22.7	2	9.1	9	40.9	2	9.1	3	13.6	1	4.5
h. Anesthesiologists	11	2	18.2	3	27.3	0	0.0	1	9.1	2	18.2	0	0.0	1	9.1	1	9.1	1	9.1	6	54.5	1	9.1	2	18.2	1	9.1
i. Advanced practice providers (Nurse Practitioners, Physician Assistants)	33	2	6.1	20	60.6	6	18.2	3	9.1	5	15.2	0	0.0	4	12.1	3	9.1	1	3.0	12	36.4	1	3.0	3	9.1	5	15.2
j. Nursing (RN, LPN, clinical nurse specialist)	49	4	8.2	28	57.1	14	28.6	2	4.1	5	10.2	4	8.2	3	6.1	7	14.3	0	0.0	13	26.5	8	16.3	1	2.0	8	16.3
k. Social Workers	9	5	55.6	2	22.2	1	11.1	1	11.1	1	11.1	0	0.0	2	22.2	1	11.1	0	0.0	2	22.2	1	11.1	0	0.0	2	22.2
l. Psychologists	21	4	19.0	10	47.6	5	23.8	2	9.5	4	19.0	0	0.0	1	4.8	4	19.0	0	0.0	7	33.3	1	4.8	3	14.3	1	4.8
m. Specialized support staff (lab or imaging technicians)	46	3	6.5	27	58.7	11	23.9	3	6.5	2	4.3	1	2.2	1	2.2	4	8.7	0	0.0	22	47.8	7	15.2	8	17.4	1	2.2
n. Inpatient support staff (clerical)	26	6	23.1	14	53.8	7	26.9	0	0.0	2	7.7	0	0.0	2	7.7	3	11.5	0	0.0	10	38.5	2	7.7	3	11.5	2	7.7
o. Administrative support staff (e.g., schedulers)	56	12	21.4	28	50.0	10	17.9	2	3.6	8	14.3	1	1.8	4	7.1	4	7.1	0	0.0	15	26.8	8	14.3	12	21.4	5	8.9
p. Therapists (Occupational Therapists, Physical Therapists, Speech Therapists)	26	5	19.2	14	53.8	8	30.8	0	0.0	2	7.7	0	0.0	1	3.8	3	11.5	1	3.8	12	46.2	0	0.0	2	7.7	3	11.5
q. Pain Management Specialists	19	1	5.3	11	57.9	2	10.5	1	5.3	2	10.5	0	0.0	3	15.8	1	5.3	0	0.0	11	57.9	0	0.0	2	10.5	2	10.5
r. Telehealth clinical technicians	19	5	26.3	6	31.6	3	15.8	0	0.0	4	21.1	0	0.0	0	0.0	3	15.8	0	0.0	8	42.1	1	5.3	5	26.3	1	5.3

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention. This question (question 8) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 8B). Question 10 was asked for each personnel type marked "yes" in question 6B.

Use of fee-basis or contracted care

9. How frequently do you refer Veterans to fee-basis or contracted care?

Table I- 10. Chief of Staff: Question 9

	n	%
N	111	
1% or less of the time	18	16.2
2-4% of the time	31	27.9
5-10% of the time	33	29.7
11-100% of the time	29	26.1

10. On a scale from 1 to 3 where 1 is the **most important** reason and 3 is the **least important** reason, please rank which of the following are the most important reasons for referring veterans to fee-basis care.

Table I-11. Chief of Staff: Question 10

		Ranking (1 - 3) Where 1 = most important		
	N	n (%) ranked #1	n (%) ranked #2	n (%) ranked #3
a. Lack of clinical services available at VA facilities	111	86 (77.5)	14 (12.6)	11 (9.9)
b. Veteran travel distance to VA facilities	111	12 (10.8)	51 (45.9)	48 (43.2)
c. Veteran wait times at VA facilities	111	15 (13.5)	46 (41.4)	50 (45.0)
Some individuals ranked more than one reason for referral as “the most important reason” or the “least important reason.” As a result, the columns do not add up to 111.				

10D. Are there other important reasons why your local health care system refers veterans to fee-basis or contracted care?

Table I-12. Chief of Staff: Question 10D

	n	%
	111	
Yes	37	33.3
No	74	66.7

11. Please mark 'YES' or 'NO' for the following questions.

Table I-13. Chief of Staff: Question 11

		Yes	No
	N	n (%)	n (%)
a. Has your local health care system implemented the Non-VA Care Coordination (NVCC) internal referral management program?	111	106 (95.5)	5 (4.5\)
b. At your local health care system, are veteran priority ratings and the service-connection of the injury or illness considered when scheduling appointments?	111	45 (40.5)	66 (59.5)
c. Does your local health care system "bump" a veteran from a scheduled appointment to accommodate the appointment needs of a veteran of a higher priority group?	111	2 (1.8)	109 (98.2)

12. How often does your local health care system do the following things?

Table I-14. Chief of Staff: Question 12

		All of the Time	Most of the time	Some of the time	None of the time
	N	n (%)	n (%)	n (%)	n (%)
a. Share records with non-VA health care providers in electronic format?	110	5 (4.5)	10 (9.1)	43 (39.1)	52 (47.3)
b. Collect data about how long veterans wait for appointments at non-VA health care providers?	111	15 (13.5)	23 (20.7)	45 (40.5)	28 (25.2)

13A. If you have to refer veterans out for non-VA care, and the care requires more than one visit, do they need a referral for each visit?

Table I-15. Chief of Staff: Question 13A

	n	%
	111	
Separate referral for each visit	9	8.1
One referral will cover all related visits to this specialist within 60 day timeframe	51	45.9
Other	51	45.9

13B. What if the veteran requires more than one visit to this specialist for his/her broken leg, but the care is anticipated to span a period longer than 60 days (e.g., 7 months)-do they need a referral for each visit?

Table I-16. Chief of Staff: Question 13B

	n	%
	111	
Separate referral for each visit	23	20.7
One referral will cover all related visits to this specialist regardless of timeframe	41	36.9
Other	47	42.3

Information Technology

14. WIFI Access: Is there wireless Internet access in your Administrative Parent for the following people at your VAMC(s) and CBOC(s)?

Table I-17. Chief of Staff: Question 14

		Yes, everywhere and reliable	Yes, everywhere but spotty	Yes, some places reliably	Yes, some places and spotty	No, no wireless Internet
	N	n (%)	n (%)	n (%)	n (%)	n (%)
VAMC (s) Wireless Internet Access						
a. For patients and guests?	111	13 (11.7)	8 (7.2)	33 (29.7)	14 (12.6)	43 (38.7)
b. For VA staff?	111	31 (27.9)	9 (8.1)	21 (18.9)	12 (10.8)	38 (34.2)
CBOC(s) Wireless Internet Access:						
c. For patients and guests?	111	9 (8.1)	3 (2.7)	9 (8.1)	10 (9.0)	80 (72.1)
d. For VA staff?	111	15 (13.5)	5 (4.5)	12 (10.8)	8 (7.2)	71 (64.0)

15. Do facilities in your local health care system send radiology exams for **remote reading**?

Table I-18. Chief of Staff: Question 15

	n	%
N	111	
Yes, both day and night	38	34.2
Yes, only at night	62	55.9
No, neither day nor night	11	9.9

16. Where is the remote reading done? Please mark all that apply.

Table I-19. Chief of Staff: Question 16

	n	%
N	100	
At a VAMC within this Administrative Parent	14	14.0
At a CBOC within this Administrative Parent	4	4.0
At a VA facility **outside** this Administrative Parent	58	58.0
At a **non-VA facility**	47	47.0
This question (question 16) is based on respondents who indicated that facilities in their local health care system send radiology exams for remote reading (question 15).		

17. In the PAST YEAR, what percentage of radiology exams were read remotely? Just your best guess.

Table I-20. Chief of Staff: Question 17

	N	Mean	Median	Standard Deviation	Range
Percent of radiology exams were read remotely	99	15.4	10	17.9	0 - 100
This question (question 17) is based on respondents who indicated that facilities in their local health care system send radiology exams for remote reading (question 15).					

Tele-Medicine Technology

18. What kind of tele-medicine technology is used for the following conditions in your local health care system? **Please select all that apply for each medical condition listed.**

Table I-21. Chief of Staff: Question 18

		Clinical Video Tele-Health (CVT) *provider to patient*		Clinical Video CVT- Virtual Consultations *provider to provider*		Home Telehealth/ Remote monitoring technology		Store and Forward Technology- storage of images or other data for later processing		None of these technologies are available at this Administrative Parent	
	N	n	%	n	%	n	%	n	%	n	%
a. Post-Traumatic Stress Disorder (PTSD)	111	101	91.0	25	22.5	43	38.7	13	11.7	8	7.2
b. Substance Use Disorders (SUD)	111	81	73.0	21	18.9	23	20.7	3	2.7	27	24.3
c. Traumatic Brain Injury (TBI)	110	62	56.4	25	22.7	18	16.4	4	3.6	38	34.6
d. Colon Cancer	111	32	28.8	16	14.4	4	3.6	3	2.7	73	65.8
e. Type 2 Diabetes	111	72	64.9	25	22.5	60	54.1	17	15.3	16	14.4

19/20. Within your local health care system, where are **providers and patients** located when using CVT? This includes CVT use for any medical condition. Include only CVT provider to patient. Just give us your best guess.

Table I-22. Chief of Staff: Question 19/20

Percentage of Clinical Video Telehealth (CVT Provider to Patient)						
		N	Mean	Median	Standard Deviation	Range
19. What percentage of the time is the PROVIDER at a:						
a.	VAMC?	101	77.3	80.0	23.3	0.0 – 100.0
b.	Small or medium CBOC?	101	11.2	5.0	15.3	0.0 – 70.0
c.	Large or very large CBOC?	100	6.3	0.0	10.9	0.0 - 75.0
d.	Other locations	100	5.3	0.0	15.9	0.0 – 100.0
20. What percentage of the time is a PATIENT at a:						
a.	VAMC?	101	27.8	10.0	30.7	0.0 – 100.0
b	Small or medium CBOC?	102	51.4	50.0	31.8	0.0 – 100.0
c.	Large or very large CBOC?	102	15.6	10.0	20.5	0.0 – 95.0
d.	Other locations	101	5.1	0.0	12.1	0.0 – 80.0
These questions (questions 19 and 20) are based on respondents who indicated that CVT provider to patient is used for any condition (question 18). Note % for a+b+c+d = 100% in Q19 and Q20						

Home Telehealth (HT) (Remote Monitoring Programs)

21. What is the average amount of time that a patient is part of a home telehealth monitoring program at your local health care system?

Table I-23. Chief of Staff: Question 21

	n	%
N	74	
Less than 1 month	1	1.4
1-3 months	12	16.2
4-6 months	21	28.4
7-12 months	19	25.7
More than 12 months	21	28.4
This question (question 21) is based on respondents who indicated use of a home telehealth monitoring program (question 18).		

22. What is the primary reason patients stop being part of a **home telehealth monitoring program**? Select ONE reason.

Table I-24. Chief of Staff: Question 22

	n	%
N	76	
Death	7	9.2
Improvement in health	34	44.7
Decline in health	4	5.3
Inpatient Admission	1	1.3
Transfer to nursing home or long-term care	7	9.2
Technical issues (such as Internet/phone issues)	3	4.0
Some other reason	20	26.3
This question (question 22) is based on respondents who indicated use of a home telehealth monitoring program (question 18).		

23. What is the **largest** number of patients enrolled in a **home telehealth monitoring program** at any given time from your local health care system?

Table I-25. Chief of Staff: Question 23

	n	%
N	76	
Less than 100	7	9.2
101 – 500	41	54.0
More than 500	28	36.8
This question (question 23) is based on respondents who indicated use of a home telehealth monitoring program (question 18).		

24. What is the **smallest** number of patients enrolled in a **home telehealth monitoring program** at any given time from your local health care system?

Table I-26. Chief of Staff: Question 24

	n	%
N	76	
Less than 100	21	27.6
101 – 500	37	48.7
More than 500	18	23.7
This question (question 24) is based on respondents who indicated use of a home telehealth monitoring program (question 18).		

25. Where do the providers who oversee the **home telehealth monitoring program** at your local health care system **work**? Select all that apply

Table I-27. Chief of Staff: Question 25

	n	%
N	76	
At the patient's primary CBOC	40	52.6
At a different VA facility within the local health care system	27	35.5
Oversight provided by an external vendor company	0	0.0
Some other place	26	34.2
This question (question 25) is based on respondents who indicated use of a home telehealth monitoring program (question 18). Respondents were permitted to select all answer choices that applied.		

Appendix I.1.2 PTSD

Section 2: Post-Traumatic Stress Disorder (PTSD)

PTSD Diagnosis and Assessment

1. Please think about patients who need a **referral for an evaluation** for PTSD.
IN THE PAST 90 DAYS, how often were there *clinically meaningful delays* in getting these patients an **evaluation** leading up to either a diagnosis or initial treatment plan? Indicate the percent of patients that experienced delays for whom the service was required.

Table I-28. Post-Traumatic Stress Disorder: Question 1

Service		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%	n	%
a. Evaluation in general mental health within your local health care system	117	54	46.2	49	41.9	8	6.8	2	1.7	2	1.7	2	1.7
b. Evaluation by the PTSD clinical team	117	53	45.3	33	28.2	8	6.8	6	5.1	4	3.4	13	11.1
c. Evaluation using telehealth in CBOCs (all sizes)	117	47	40.2	33	28.2	11	9.4	7	6.0	2	1.7	17	14.5
d. Evaluation for mental health services in CBOCs (all sizes)	117	36	30.8	42	35.9	20	17.1	7	6.0	6	5.1	6	5.1
e. Getting appointments when patients are self-referred for an evaluation in general mental health	117	55	47.0	44	37.6	7	6.0	2	1.7	2	1.7	7	6.0

2. Think about those PTSD patients who experienced *clinically meaningful delays* getting an **evaluation. IN THE PAST 90 DAYS**, which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q1 in order to identify their top three delays for Q3.

Reducing Delays in Obtaining a Diagnostic Assessment

3A. **Your solution for delays in getting an:** Evaluation in general mental health within your local health care system. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction? Now, **in your solution, how important are each of the following elements**?

Table I-29. Post-Traumatic Stress Disorder: Question 3A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**N**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	36	13	36.1	12	33.3	7	19.4	3	8.3	1	2.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	36	20	55.6	10	27.8	6	16.7	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	36	11	30.6	14	38.9	8	22.2	3	8.3	0	0.0
d. Acquire and/or improve availability of equipment.	36	3	8.3	5	13.9	10	27.8	10	27.8	8	22.2
e. Implement or increase the availability of telehealth services.	36	3	8.3	9	25.0	15	41.7	7	19.4	2	5.6
f. Improve information technology (e.g., scheduling system, electronic health record).	36	14	38.9	9	25.0	6	16.7	6	16.7	1	2.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	36	8	22.2	14	38.9	7	19.4	5	13.9	2	5.6
h. Improve personnel supervision, management, or incentives.	36	8	22.2	14	38.9	9	25.0	3	8.3	2	5.6
i. Increase weekend and evening availability of services.	36	3	8.3	4	11.1	15	41.7	12	33.3	2	5.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	36	6	16.7	4	11.1	13	36.1	12	33.3	1	2.8
k. Some other solution(s).	34	6	17.7	9	26.5	1	2.9	1	2.9	17	50.0

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3a (N=36, 30.77% of those who answered question 1 and 59.02% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3B. **Your solution for delays in getting an:** Evaluation by the PTSD clinical team . Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction? Now, **in your solution, how important are each of the following elements**?

Table I-30. Post-Traumatic Stress Disorder: Question 3B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	35	13	37.1	11	31.4	8	22.9	2	5.7	1	2.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	35	21	60.0	10	28.6	4	11.4	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	35	11	31.4	10	28.6	9	25.7	5	14.3	0	0.0
d. Acquire and/or improve availability of equipment.	35	2	5.7	4	11.4	12	34.3	10	28.6	7	20.0
e. Implement or increase the availability of telehealth services.	35	3	8.6	14	40.0	13	37.1	4	11.4	1	2.9
f. Improve information technology (e.g., scheduling system, electronic health record).	35	7	20.0	16	45.7	6	17.1	4	11.4	2	5.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	35	6	17.1	13	37.1	7	20.0	7	20.0	2	5.7
h. Improve personnel supervision, management, or incentives.	35	6	17.1	9	25.7	16	45.7	3	8.6	1	2.9
i. Increase weekend and evening availability of services.	35	2	5.7	9	25.7	14	40.0	7	20.0	3	8.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	35	3	8.6	6	17.1	16	45.7	9	25.7	1	2.9
k. Some other solution(s).	35	8	22.9	6	17.1	3	8.6	1	2.9	17	48.6

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3b (N=35, 29.91% of those who answered question 1 and 68.63% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3C. **Your solution for delays in getting an:** Evaluation using telehealth in CBOCs (all sizes). Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction? Now, **in your solution, how important are each of the following elements**?

Table I-31. Post-Traumatic Stress Disorder: Question 3C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	29	11	37.9	10	34.5	7	24.1	0	0.0	1	3.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	29	9	31.0	11	37.9	7	24.1	0	0.0	2	6.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	29	6	20.7	10	34.5	11	37.9	2	6.9	0	0.0
d. Acquire and/or improve availability of equipment.	29	6	20.7	8	27.6	8	27.6	3	10.3	4	13.8
e. Implement or increase the availability of telehealth services.	29	8	27.6	12	41.4	6	20.7	2	6.9	1	3.5
f. Improve information technology (e.g., scheduling system, electronic health record).	29	10	34.5	11	37.9	5	17.2	2	6.9	1	3.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	29	4	13.8	7	24.1	5	17.2	8	27.6	5	17.2
h. Improve personnel supervision, management, or incentives.	29	5	17.2	6	20.7	8	27.6	6	20.7	4	13.8
i. Increase weekend and evening availability of services.	29	1	3.5	6	20.7	15	51.7	6	20.7	1	3.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	29	1	3.5	4	13.8	11	37.9	11	37.9	2	6.9
k. Some other solution(s).	28	2	7.1	3	10.7	4	14.3	0	0.0	19	67.9

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3c (N=29, 24.79% of those who answered question 1 and 54.72% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3D. **Your solution for delays in getting an: e**valuation for mental health services in CBOCs (all sizes). Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction? Now, **in your solution, how important are each of the following elements**?

Table I-32. Post-Traumatic Stress Disorder: Question 3D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	61	31	50.8	19	31.2	9	14.8	2	3.3	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	61	37	60.7	20	32.8	4	6.6	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	61	16	26.2	18	29.5	18	29.5	8	13.1	1	1.6
d. Acquire and/or improve availability of equipment.	61	5	8.2	6	9.8	22	36.1	20	32.8	8	13.1
e. Implement or increase the availability of telehealth services.	61	10	16.4	19	31.2	24	39.3	7	11.5	1	1.6
f. Improve information technology (e.g., scheduling system, electronic health record). .	61	18	29.5	16	26.2	11	18.0	13	21.3	3	4.9
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	60	7	11.7	13	21.7	17	28.3	16	26.7	7	11.7
h. Improve personnel supervision, management, or incentives.	61	8	13.1	24	39.3	14	23.0	12	19.7	3	4.9
i. Increase weekend and evening availability of services.	60	1	1.7	12	20.0	30	50.0	15	25.0	2	3.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	61	5	8.2	11	18.0	20	32.8	21	34.4	4	6.6
k. Some other solution(s).	60	6	10.0	10	16.7	3	5.0	4	6.7	37	61.7

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3d (N=61, 52.14% of those who answered question 1 and 81.33% of those who reported any delay) if they indicated they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3E. **Your solution for delays in getting:** appointments when patients are self-referred for an evaluation in general mental health. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction? Now, **in your solution, how important are each of the following elements**?

Table I-33. Post-Traumatic Stress Disorder: Question 3E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	24	7	29.2	6	25.0	7	29.2	4	16.7	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	24	13	54.2	6	25.0	4	16.7	1	4.2	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	24	6	25.0	6	25.0	9	37.5	2	8.3	1	4.2
d. Acquire and/or improve availability of equipment.	24	0	0.0	2	8.3	7	29.2	10	41.7	5	20.8
e. Implement or increase the availability of telehealth services.	24	1	4.2	8	33.3	7	29.2	7	29.2	1	4.2
f. Improve information technology (e.g., scheduling system, electronic health record).	24	7	29.2	7	29.2	7	29.2	2	8.3	1	4.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided	24	3	12.5	7	29.2	6	25.0	7	29.2	1	4.2
h. Improve personnel supervision, management, or incentives.	24	3	12.5	7	29.2	8	33.3	5	20.8	1	4.2
i. Increase weekend and evening availability of services.	24	0	0.0	6	25.0	11	45.8	7	29.2	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	24	1	4.2	6	25.0	9	37.5	7	29.2	1	4.2
k. Some other solution(s).	24	5	20.8	5	20.8	2	8.3	1	4.2	11	45.8

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3e (N=25, 21.37% of those who answered question 1 and 45.45% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

PTSD Treatment

3. Now please think about patients who have a PTSD diagnosis. IN THE PAST 90 DAYS, how often were there *clinically meaningful delays* scheduling these patients for **PTSD treatment**? Indicate the percent of patients who experienced delays for whom the service was indicated.

Table I-34. Post-Traumatic Stress Disorder: Question 4

		No Delay		1-10% of patients experience delay		11-25% of patients experience d		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Pharmacotherapy in general mental health	116	47	40.5	43	37.1	13	11.2	5	4.3	4	3.5	4	3.5
b. Pharmacotherapy in CBOCs (all sizes)	116	32	27.6	42	36.2	18	15.5	6	5.2	6	5.2	12	10.3
c. Pharmacotherapy using tele-mental health in CBOCs (all sizes)	116	47	40.5	33	28.5	15	12.9	6	5.2	1	0.9	14	12.1
d. Group or individual psychotherapy in general mental health	114	41	356.0	42	36.8	17	14.9	5	4.4	4	3.5	5	4.4
e. Group or individual psychotherapy in CBOCs (all sizes)	116	27	23.3	40	34.5	25	21.6	12	10.3	5	4.3	7	6.0
f. Group or individual psychotherapy using tele-mental health in CBOCs (all sizes)	116	41	35.3	34	29.3	14	12.1	7	6.0	3	2.6	17	14.7
g. Group or individual psychotherapy with a provider trained in evidence-based psychotherapy for PTSD	116	40	34.5	48	41.4	17	14.7	5	4.3	5	4.3	1	0.9
h. Group or individual psychotherapy with a provider trained in evidence-based psychotherapy for PTSD in CBOCs (all sizes)	116	26	22.4	41	35.3	18	15.5	12	10.3	11	9.5	8	6.9
i. Group or individual psychotherapy provided by tele-mental health with a provider trained in evidence-based psychotherapy for PTSD in CBOCs (all sizes)	116	40	34.5	36	31.0	14	12.1	6	5.2	4	3.5	16	13.8
j. A PTSD specialty bed in MH Residential Rehabilitative Treatment Programs (MH-RRTP)	116	22	19.0	25	21.6	7	6.0	6	5.2	12	10.3	44	37.9
k. Intake with the Substance Use Disorder/PTSD treatment program	116	62	53.5	27	23.3	8	6.9	3	2.6	4	3.5	12	10.3

5. Think about those PTSD patients who experienced *clinically meaningful delays* in obtaining **treatment. IN THE PAST 90 DAYS**, which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q4 in order to identify their top three delays for Q6.

Reducing Delays in Obtaining PTSD Treatment

6A. **Your solution for delays in:** Pharmacotherapy in general mental health. Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-35. Post-Traumatic Stress Disorder: Question 6A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	37	8	21.6	9	24.3	11	29.7	7	18.9	2	5.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	37	22	59.6	12	32.4	3	8.1	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff). below.	37	9	24.3	14	37.8	10	27.0	3	8.1	1	2.7
d. Acquire and/or improve availability of equipment.	37	2	5.4	5	13.5	12	32.4	9	24.3	9	24.3
e. Implement or increase the availability of telehealth services.	37	3	8.1	10	27.0	14	37.8	8	21.6	2	5.4
f. Improve information technology (e.g., scheduling system, electronic health record).	37	9	24.3	10	27.0	5	13.5	10	27.0	3	8.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	37	4	10.8	11	29.7	11	29.7	8	21.6	3	8.1
h. Improve personnel supervision, management, or incentives.	37	6	16.2	14	37.8	12	32.4	4	10.8	1	2.7
i. Increase weekend and evening availability of services.	37	2	5.4	5	13.5	21	56.8	7	18.9	2	5.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	37	2	5.4	6	16.2	13	35.1	13	35.1	3	8.1
k. Some other solution(s).	36	3	8.3	3	8.3	5	13.9	3	8.3	22	61.1

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6a (N=37, 31.9% of those who answered question 4 and 56.92% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6B. **Your solution for delays in:** Pharmacotherapy in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-36. Post-Traumatic Stress Disorder: Question 6B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	37	15	40.5	10	27.0	7	18.9	3	8.1	2	5.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	37	24	64.9	11	29.7	1	2.7	1	2.7	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	37	10	27.0	14	37.8	9	24.3	3	8.1	1	2.7
d. Acquire and/or improve availability of equipment.	37	3	8.1	7	18.9	10	27.0	14	37.8	3	8.1
e. Implement or increase the availability of telehealth services.	37	4	10.8	10	27.0	18	48.7	5	13.5	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	37	10	27.0	9	24.3	7	18.9	9	24.3	2	5.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	37	4	10.8	9	24.3	7	18.9	12	32.4	5	13.5
h. Improve personnel supervision, management, or incentives.	37	5	13.5	12	32.4	11	29.7	7	18.9	2	5.4
i. Increase weekend and evening availability of services.	37	2	5.4	5	13.5	18	48.7	10	27.0	2	5.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	36	6	16.7	5	13.9	9	25.0	13	36.1	3	8.3
k. Some other solution(s).	36	3	8.3	1	2.8	2	5.6	3	8.3	27	75.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6b (N=37, 31.9% of those who answered question 4 and 51.39% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6C. **Your solution for delays in:** Pharmacotherapy using tele-mental health in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-37. Post-Traumatic Stress Disorder: Question 6C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	2	18.2	2	18.2	6	54.6	1	9.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	8	72.7	1	9.1	2	18.2	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	2	18.2	5	45.5	4	36.4	0	0.0	0	0.0
d. Acquire and/or improve availability of equipment.	11	1	9.1	3	27.3	4	36.4	3	27.3	0	0.0
e. Implement or increase the availability of telehealth services.	11	4	36.4	4	36.4	3	27.3	0	0.0	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	11	3	27.3	4	36.4	3	27.3	1	9.1	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	0	0.0	4	36.4	3	27.3	3	27.3	1	9.1
h. Improve personnel supervision, management, or incentives.	11	0	0.0	3	27.3	6	54.6	2	18.2	0	0.0
i. Increase weekend and evening availability of services.	11	0	0.0	0	0.0	6	54.6	4	36.4	1	9.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	0	0.0	2	18.2	3	27.3	5	45.5	1	9.1
k. Some other solution(s).	11	0	0.0	0	0.0	0	0.0	2	18.2	9	81.8

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6c (N=11, 9.48% of those who answered question 4 and 20% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6D. **Your solution for delays in:** Group or individual psychotherapy in general mental health. Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-38. Post-Traumatic Stress Disorder: Question 6D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	35	13	37.1	11	31.4	4	11.4	5	14.3	2	5.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	35	20	57.1	9	25.7	6	17.1	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	35	8	22.9	11	31.4	11	31.4	4	11.4	1	2.9
d. Acquire and/or improve availability of equipment.	35	1	2.9	4	11.4	9	25.7	9	25.7	12	34.3
e. Implement or increase the availability of telehealth services.	35	2	5.7	6	17.1	14	40.0	7	20.0	6	17.1
f. Improve information technology (e.g., scheduling system, electronic health record).	34	8	23.5	9	26.5	8	23.5	7	20.6	2	5.9
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	35	7	20.0	4	11.4	13	37.1	6	17.1	5	14.3
h. Improve personnel supervision, management, or incentives.	35	5	14.3	12	34.3	10	28.6	3	8.6	5	14.3
i. Increase weekend and evening availability of services.	35	0	0.0	4	11.4	15	42.9	15	42.9	1	2.9
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	35	1	2.9	6	17.1	11	31.4	12	34.3	5	14.3
k. Some other solution(s).	35	9	25.7	5	14.3	2	5.7	1	2.9	18	51.4

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6d (N=35, 30.7% of those who answered question 4 and 51.47% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6E. **Your solution for delays in:** Group or individual psychotherapy in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-39. Post-Traumatic Stress Disorder: Question 6E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	42	20	47.6	13	31.0	6	14.3	3	7.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	42	24	57.1	11	26.2	5	11.9	2	4.8	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	42	8	19.1	11	26.2	13	31.0	9	21.4	1	2.4
d. Acquire and/or improve availability of equipment.	42	0	0.0	6	14.3	11	26.2	16	38.1	9	21.4
e. Implement or increase the availability of telehealth services.	42	2	4.8	13	31.0	17	40.5	5	11.9	5	11.9
f. Improve information technology (e.g., scheduling system, electronic health record).	42	9	21.4	12	28.6	7	16.7	11	26.2	3	7.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	42	5	11.9	11	26.2	11	26.2	11	26.2	4	9.5
h. Improve personnel supervision, management, or incentives. .	42	6	14.3	13	31.0	16	38.1	5	11.9	2	4.8
i. Increase weekend and evening availability of services.	42	0	0.0	7	16.7	19	45.2	16	38.1	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	42	2	4.8	4	9.5	14	33.3	19	45.2	3	7.1
k. Some other solution(s).	42	4	9.5	6	14.3	2	4.8	6	14.3	24	57.1
This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6e (N=42, 36.21% of those who answered question 4 and 51.22% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

6F. **Your solution for delays in:** Group or individual psychotherapy using tele-mental health in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in accessing group or individual psychotherapy using tele-mental health in CBOCs (N = 9).

6G. **Your solution for delays in:** Group or individual psychotherapy with a provider trained in evidence-based psychotherapy for PTSD. Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-40. Post-Traumatic Stress Disorder: Question 6G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	25	10	40.0	9	36.0	2	8.0	3	12.0	1	4.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	18	72.0	6	24.0	0	0.0	0	0.0	1	4.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	25	4	16.0	8	32.0	10	40.0	1	4.0	2	8.0
d. Acquire and/or improve availability of equipment.	25	1	4.0	5	20.0	4	16.0	8	32.0	7	28.0
e. Implement or increase the availability of telehealth services.	25	2	8.0	5	20.0	13	52.0	3	12.0	2	8.0
f. Improve information technology (e.g., scheduling system, electronic health record).	25	6	24.0	5	20.0	8	32.0	3	12.0	3	12.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	25	6	24.0	5	20.0	9	36.0	3	12.0	2	8.0
h. Improve personnel supervision, management, or incentives. .	25	3	12.0	6	24.0	9	36.0	3	12.0	4	16.0
i. Increase weekend and evening availability of services.	25	0	0.0	4	16.0	12	48.0	7	28.0	2	8.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	25	1	4.0	2	8.0	11	44.0	5	20.0	6	24.0
k. Some other solution(s).	25	8	32.0	1	4.0	1	4.0	1	4.0	14	56.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6g (N=25, 21.55% of those who answered question 4 and 33.33% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6H. **Your solution for delays in:** Group or individual psychotherapy with a provider trained in evidence-based psychotherapy for PTSD in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-41. Post-Traumatic Stress Disorder: Question 6H

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	31	18	58.1	5	16.1	5	16.1	1	3.2	2	6.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	31	25	80.7	4	12.9	2	6.5	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	31	6	19.4	5	16.1	13	41.9	6	19.4	1	3.2
d. Acquire and/or improve availability of equipment.	31	2	6.5	7	22.6	5	16.1	11	35.5	6	19.4
e. Implement or increase the availability of telehealth services.	31	3	9.7	8	25.8	15	48.4	3	9.7	2	6.5
f. Improve information technology (e.g., scheduling system, electronic health record).	31	7	22.6	9	29.0	5	16.1	9	29.0	1	3.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	31	4	12.9	7	22.6	8	25.8	8	25.8	4	12.9
h. Improve personnel supervision, management, or incentives.	31	5	16.1	6	19.4	11	35.5	7	22.6	2	6.5
i. Increase weekend and evening availability of services.	31	1	3.2	9	29.0	14	45.2	7	22.6	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	31	3	9.7	3	9.7	10	32.3	12	38.7	3	9.7
k. Some other solution(s).	31	3	9.7	3	9.7	2	6.5	0	0.0	23	74.2

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6h (N=31, 26.72% of those who answered question 4 and 37.8% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6I. **Your solution for delays in:** Group or individual psychotherapy provided by tele-mental health with a provider trained in evidence-based psychotherapy for PTSD in CBOCs (all sizes). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-42. Post-Traumatic Stress Disorder: Question 6I

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	3	27.3	3	27.3	3	27.3	2	18.2	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	5	45.5	3	27.3	2	18.2	1	9.1	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	1	9.1	2	18.2	4	36.4	4	36.4	0	0.0
d. Acquire and/or improve availability of equipment.	11	2	18.2	4	36.4	2	18.2	3	27.3	0	0.0
e. Implement or increase the availability of telehealth services.	11	2	18.2	6	54.6	2	18.2	0	0.0	1	9.1
f. Improve information technology (e.g., scheduling system, electronic health record).	11	1	9.1	4	36.4	4	36.4	2	18.2	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	2	18.2	3	27.3	2	18.2	3	27.3	1	9.1
h. Improve personnel supervision, management, or incentives.	11	1	9.1	2	18.2	3	27.3	4	36.4	1	9.1
i. Increase weekend and evening availability of services.	11	0	0.0	2	18.2	4	36.4	5	45.5	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	0	0.0	1	9.1	6	54.6	4	36.4	0	0.0
k. Some other solution(s).	11	2	18.2	2	18.2	0	0.0	0	0.0	7	63.6

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining PTSD treatment (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6i (N=11, 9.48% of those who answered question 4 and 18.33% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6J. **Your solution for delays in:** A PTSD specialty bed in MH Residential Rehabilitative Treatment Programs (MH-RRTP). Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Table I-43. Post-Traumatic Stress Disorder: Question 6J

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	8	47.1	6	35.3	1	5.9	1	5.9	1	5.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	3	17.7	8	47.1	3	17.7	2	11.8	1	5.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	2	11.8	8	47.1	4	23.5	2	11.8	1	5.9
d. Acquire and/or improve availability of equipment.	17	0	0.0	0	0.0	4	23.5	5	29.4	8	47.1
e. Implement or increase the availability of telehealth services.	17	0	0.0	2	11.8	3	17.7	4	23.5	8	47.1
f. Improve information technology (e.g., scheduling system, electronic health record).	17	1	5.9	2	11.8	4	23.5	4	23.5	6	35.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	17	1	5.9	2	11.8	3	17.7	5	29.4	6	35.3
h. Improve personnel supervision, management, or incentives.	17	0	0.0	4	23.5	6	35.3	3	17.7	4	23.5
i. Increase weekend and evening availability of services.	17	0	0.0	3	17.7	3	17.7	5	29.4	6	35.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	17	0	0.0	4	23.5	3	17.7	3	17.7	7	41.2
k. Some other solution(s).	17	5	29.4	2	11.8	1	5.9	0	0.0	9	52.9

This question (question 6) is based on respondents who indicated that patients experienced delays (n= in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6j (N=17, 14.66% of those who answered question 4 and 34% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6K. **Your solution for delays in:** Intake with the Substance Use Disorder/PTSD treatment program. Think of the most effective way to reduce treatment delays for PTSD patients. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in intake with substance use disorder/PTSD treatment program (N = 8).

Issues that Affect Provider and System Efficiency

7. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency in the provision of care for PTSD patients?

Table I-44. Post-Traumatic Stress Disorder: Question 7

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	115	20	17.4	39	33.9	27	23.5	25	21.7	4	3.5
b. Providers performing administrative activities that could be performed by others	115	7	6.1	25	21.7	37	32.2	46	40.0	0	0.0
c. Residency training/teaching requirements	115	51	44.3	36	31.3	11	9.6	6	5.2	11	9.6
d. Insufficient clinical/administrative support staff	115	9	7.8	23	20.0	33	28.7	50	43.5	0	0.0
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	115	13	11.3	17	14.8	27	23.5	58	50.4	0	0.0
f. Unnecessary documentation requirements or inefficient CPRS interface	115	9	7.8	33	28.7	40	34.8	31	27.0	2	1.7
g. Patient no-show rates	115	3	2.6	48	41.7	47	40.9	17	14.8	0	0.0
h. Poor patient flow management (room/bed turnover, appointments)	115	29	25.2	44	38.3	27	23.5	8	7.0	7	6.1
i. Too many administrative requirements (Initiatives/Policies/Programs)	115	9	7.8	29	25.2	32	27.8	40	34.8	5	4.3

Workforce

8A. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-45. Post-Traumatic Stress Disorder: Question 8A

	N	Yes		No		Not Applicable	
Staff Positions		n	%	n	%	n	%
a. Psychiatrists	115	95	82.6	18	15.7	2	1.7
b. Psychiatric Nurse Practitioners	115	69	60.0	27	23.5	19	16.5
c. Psychiatric Physician Assistants	115	27	23.5	23	20.0	65	56.5
d. Pharm D psychopharmacologists	115	17	14.8	44	38.3	54	47.0
e. Mental Health Social Workers	115	35	30.4	79	68.7	1	0.9
f. Psychologists	115	68	59.1	46	40.0	1	0.9
g. Marriage/Family Counselors	115	19	16.5	25	21.7	71	61.7
h. Advanced Practice Nurses specializing in mental health	114	60	52.6	27	23.7	27	23.7

Reasons for Staff Recruitment/Hiring Problems

9. Please enter **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types in the past year.

Table I-46. Post-Traumatic Stress Disorder: Question 9

Staff Positions		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Psychiatrists	95	4	4.2	57	60.0	11	11.6	3	3.2	2	2.1	0	0.0	4	4.2	7	7.4	2	2.1	35	36.8	32	33.7	30	31.6
b. Psychiatric Nurse Practitioners	69	6	8.7	39	56.5	4	5.8	1	1.4	2	2.9	0	0.0	1	1.4	2	2.9	0	0.0	22	31.9	32	46.4	27	39.1
c. Psychiatric Physician Assistants	27	3	11.1	14	51.9	2	7.4	0	0.0	0	0.0	0	0.0	0	0.0	1	3.7	0	0.0	9	33.3	11	40.7	13	48.1
d. Pharm D psychopharmacologists	17	3	17.6	5	29.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	5.9	8	47.1	7	41.2	9	52.9
e. Mental Health Social Workers	35	8	22.9	11	31.4	3	8.6	1	2.9	2	5.7	0	0.0	0	0.0	2	5.7	1	2.9	9	25.7	22	62.9	9	25.7
f. Psychologists	68	12	17.6	22	32.4	3	4.4	3	4.4	6	8.8	2	2.9	0	0.0	4	5.9	3	4.4	23	33.8	35	51.5	21	30.9
g. Marriage/Family Counselors	19	6	31.6	3	15.8	0	0.0	0	0.0	1	5.3	1	5.3	1	5.3	0	0.0	0	0.0	4	21.1	12	63.2	9	47.4
h. Advanced Practice Nurses specializing in mental health	60	8	13.3	26	43.3	4	6.7	3	5.0	2	3.3	0	0.0	1	1.7	1	1.7	0	0.0	19	31.7	31	51.7	23	38.3

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring.

This question (question 9) is based on respondents who indicated that their local health care system had problems recruiting or hiring certain personnel categories (question 8A). Question 9 was asked for each personnel type marked "yes" in question 8A.

Reasons for Staff Retention Problems

8B. IN THE PAST YEAR, did your local health care system have problems **RETAINING** the following personnel categories?

Table I-47. Post-Traumatic Stress Disorder: Question 8B

	N	Yes		No		Not Applicable	
Staff Positions		**n**	**%**	**n**	**%**	**n**	**%**
a. Psychiatrists	115	63	54.8	50	43.5	2	1.7
b. Psychiatric Nurse Practitioners	115	26	22.6	67	58.3	22	19.1
c. Psychiatric Physician Assistants	115	9	7.8	44	38.3	62	53.9
d. Pharm D psychopharmacologists	115	7	6.1	55	47.8	53	46.1
e. Mental Health Social Workers	115	36	31.3	78	67.8	1	0.9
f. Psychologists	115	47	40.9	66	57.4	2	1.7
g. Marriage/Family Counselors	115	5	4.3	35	30.4	75	65.2
h. Advanced Practice Nurses specializing in mental health	114	22	19.3	56	49.1	36	31.6

10. Please enter **top two reasons** why there were problems **RETAINING** these personnel types in the past year.

Table I-48. Post-Traumatic Stress Disorder: Question 10

		Lack of opportunity for professional growth/promotion		Dissatisfaction with supervision/management support		Dissatisfaction with support staff		Dissatisfaction with physical demands of the job		Dissatisfaction with workload		Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		Organizational culture that does not prioritize/ encourage productivity		Administrative/ Program Demands		Lack of professional autonomy		Dissatisfaction with pay		Work schedule		Inadequate equipment/ resources/office space		Burnout	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Psychiatrists	63	3	4.8	9	14.3	6	9.5	1	1.6	27	42.9	1	1.6	2	3.2	15	23.8	7	11.1	24	38.1	8	12.7	1	1.6	21	33.3
b. Psychiatric Nurse Practitioners	26	5	19.2	4	15.4	0	0.0	1	3.8	7	26.9	0	0.0	0	0.0	4	15.4	2	7.7	13	50.0	3	11.5	2	7.7	6	23.1
c. Psychiatric Physician Assistants	9	0	0.0	2	22.2	0	0.0	0	0.0	2	22.2	0	0.0	0	0.0	3	33.3	0	0.0	5	55.6	1	11.1	0	0.0	2	22.2
d. Pharm D psychopharmacologists	7	1	14.3	3	42.9	0	0.0	0	0.0	1	14.3	1	14.3	0	0.0	2	28.6	0	0.0	1	14.3	1	14.3	0	0.0	3	42.9
e. Mental Health Social Workers	36	16	44.4	5	13.9	2	5.6	1	2.8	8	22.2	3	8.3	0	0.0	9	25.0	2	5.6	11	30.6	3	8.3	1	2.8	10	27.8
f. Psychologists	47	18	38.3	4	8.5	0	0.0	1	2.1	12	25.5	2	4.3	1	2.1	13	27.7	2	4.3	15	31.9	3	6.4	2	4.3	19	40.4
g. Marriage/Family Counselors	5	0	0.0	1	20.0	0	0.0	0	0.0	0	0.0	1	20.0	0	0.0	1	20.0	0	0.0	0	0.0	1	20.0	1	20.0	1	20.0
h. Advanced Practice Nurses specializing in mental health	22	8	36.4	3	13.6	0	0.0	1	4.5	4	18.2	1	4.5	0	0.0	2	9.1	0	0.0	12	54.5	2	9.1	2	9.1	4	18.2

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention
This question (question 10) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 8B). Question 10 was asked for each personnel type marked "yes" in question 8B.

Appendix I.1.3 SUD

Section 3: Substance Use Disorders (SUD)

Comprehensive Evaluation for SUD

1. Please think about patients who are in need of an **initial evaluation** for a SUD. **IN THE PAST 90 DAYS**, how often were there *clinically meaningful delays* in getting these patients an **initial evaluation** leading up to either a diagnosis or initial treatment plan? Indicate the percent of SUD patients that experienced delays for whom the service was indicated.

Table I-49. Substance Use Disorders: Question 1

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Referral to general mental health	112	65	58.	33	29.5	6	5.4	1	0.9	0	0.0	7	6.3
b. Referral to SUD specialty care	112	76	67.9	24	21.4	8	7.1	1	0.9	0	0.0	3	2.7
c. Referral to tele-mental health	108	42	38.9	22	20.4	6	5.6	0	0.0	2	1.9	36	33.3
d. Referral to SUD services located in CBOCs (all sizes)	111	47	42.3	29	26.1	10	9.0	3	2.7	2	1.8	20	18.0
e. Referral to methadone clinic	112	28	25.0	12	10.7	5	4.5	1	0.9	4	3.6	62	55.4
f. Patients who are self-referred for a SUD evaluation in general mental health	112	73	65.2	23	20.5	3	2.7	1	0.9	1	0.9	11	9.8
g. Referral to SUD services from the Administrative Parent to fee-basis or contracted care	112	23	20.5	11	9.8	6	5.4	2	1.8	6	5.4	64	57.1
h. Referral to residential treatment at another Administrative Parent	112	19	17.0	29	25.9	11	9.8	7	6.3	20	17.9	26	23.2

2. Think about those SUD patients who experienced *clinically meaningful delays* in getting an **initial evaluation. I**n the **PAST 90 DAYS**, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q1 in order to identify their top three delays for Q3.

Reducing Delays in Initial Evaluation for SUD

3A. **Your solution for delays in:** Referral to general mental health. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-50. Substance Use Disorders: Question 3A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	20	6	30.0	7	35.0	5	25.0	1	5.0	1	5.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	20	9	45.0	8	40.0	3	15.0	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	20	4	20.0	6	30.0	7	35.0	2	10.0	1	5.0
d. Acquire and/or improve availability of equipment.	20	0	0.0	3	15.0	3	15.0	9	45.0	5	25.0
e. Implement or increase the availability of telehealth services.	20	0	0.0	4	20.0	11	55.0	4	20.0	1	5.0
f. Improve information technology (e.g., scheduling system, electronic health record).	20	6	30.0	6	30.0	1	5.0	7	35.0	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	20	5	25.0	3	15.0	5	25.0	7	35.0	0	0.0
h. Improve personnel supervision, management, or incentives.	20	4	20.0	7	35.0	7	35.0	2	10.0	0	0.0
i. Increase weekend and evening availability of services.	20	1	5.0	2	10.0	7	35.0	10	50.0	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	20	1	5.0	5	25.0	2	10.0	8	40.0	4	20
k. Some other solution(s).	19	4	21.1	0	0.0	2	10.5	1	5.3	12	63.2

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3a (N=20, 17.86% of those who answered question 1 and 50% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3B. **Your solution for delays in:** Referral to SUD specialty care. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-51. Substance Use Disorders: Question 3B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	22	10	45.5	6	27.3	3	13.6	2	9.1	1	4.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	22	16	72.7	5	22.7	1	4.6	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	21	5	23.8	10	47.6	6	28.6	0	0.0	0	0.0
d. Acquire and/or improve availability of equipment.	21	1	4.8	4	19.1	3	14.3	10	47.6	3	14.3
e. Implement or increase the availability of telehealth services.	22	2	9.1	8	36.4	11	50.0	1	4.6	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	22	7	31.8	2	9.1	3	13.6	8	36.4	2	9.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	22	3	13.6	3	13.6	5	22.7	7	31.8	4	18.2
h. Improve personnel supervision, management, or incentives.	22	4	18.2	9	40.9	4	18.2	4	18.2	1	4.6
i. Increase weekend and evening availability of services.	22	1	4.6	4	18.2	8	36.4	9	40.9	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	22	3	13.6	5	22.7	5	22.7	6	27.3	3	13.6
k. Some other solution(s).	22	4	18.2	0	0.0	1	4.6	1	4.6	16	72.7

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3b (N=22, 19.64% of those who answered question 1 and 66.67% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3C. **Your solution for delays in:** Referral to tele-mental health. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-52. Substance Use Disorders: Question 3C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	16	5	31.3	7	43.8	1	6.25	2	12.5	1	6.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	16	4	25.0	7	43.8	4	25.0	0	0.0	1	6.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	16	2	12.5	4	25.0	8	50.0	2	12.5	0	0.0
d. Acquire and/or improve availability of equipment.	16	2	12.5	2	12.5	5	31.3	5	31.3	2	12.5
e. Implement or increase the availability of telehealth services.	16	2	12.5	3	18.8	6	37.5	5	31.3	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record). .	16	3	18.8	1	6.3	5	31.3	5	31.3	2	12.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	16	2	12.5	1	6.3	1	6.3	8	50.0	4	25.0
h. Improve personnel supervision, management, or incentives.	16	2	12.5	3	18.8	4	25.0	4	25.0	3	18.8
i. Increase weekend and evening availability of services.	16	0	0.0	7	43.8	6	37.5	3	18.8	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	16	1	6.3	2	12.5	4	25.0	7	43.8	2	12.5
k. Some other solution(s).	16	2	12.5	1	6.3	2	12.5	3	18.8	8	50.0

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3c (N=16, 14.81% of those who answered question 1 and 53.33% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3D. **Your solution for delays in:** Referral to SUD services located in CBOCs (all sizes). Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-53. Substance Use Disorders: Question 3D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	35	11	31.4	12	34.3	6	17.1	2	5.7	4	11.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	35	14	40.0	9	25.7	8	22.9	1	2.9	3	8.6
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	35	6	17.1	11	31.4	12	34.3	3	8.6	3	8.6
d. Acquire and/or improve availability of equipment.	35	1	2.9	4	11.4	10	28.6	10	28.6	10	28.6
e. Implement or increase the availability of telehealth services.	35	3	8.6	12	34.3	13	37.1	4	11.4	3	8.6
f. Improve information technology (e.g., scheduling system, electronic health record). Describe the technology improvements needed in the comments box below.	35	8	22.9	7	20.0	7	20.0	8	22.9	5	14.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	35	5	14.3	7	20.0	8	22.9	10	28.6	5	14.3
h. Improve personnel supervision, management, or incentives.	35	7	20.0	11	31.4	11	31.4	2	5.7	4	11.4
i. Increase weekend and evening availability of services.	35	1	2.9	8	22.9	13	37.1	10	28.6	3	8.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	35	2	5.7	8	22.9	6	17.1	12	34.3	7	20.0
k. Some other solution(s).	35	3	8.6	6	17.1	3	8.6	2	5.7	21	60.0

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3d (N=35, 31.53% of those who answered question 1 and 79.55% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3E. **Your solution for delays in:** Referral to methadone clinic. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-54. Substance Use Disorders: Question 3E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	15	1	6.7	2	13.3	3	20.0	3	20.0	6	40.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	15	3	20.0	3	20.0	3	20.0	1	6.7	5	33.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	15	2	13.3	1	6.7	7	46.7	2	13.3	3	20.0
d. Acquire and/or improve availability of equipment.	15	1	6.7	1	6.7	2	13.3	5	33.3	6	40.0
e. Implement or increase the availability of telehealth services.	15	0	0.0	2	13.3	2	13.3	5	33.3	6	40.0
f. Improve information technology (e.g., scheduling system, electronic health record).	15	0	0.0	2	13.3	2	13.3	5	33.3	6	40.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	15	0	0.0	2	13.3	0	0.0	7	46.7	6	40.0
h. Improve personnel supervision, management, or incentives.	15	0	0.0	2	13.3	2	13.3	5	33.3	6	40.0
i. Increase weekend and evening availability of services.	15	1	6.7	3	20.0	2	13.3	3	20.0	6	40.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	15	6	40.0	6	40.0	2	13.3	1	6.7	0	0.0
k. Some other solution(s).	15	4	26.7	3	20.0	1	6.7	0	0.0	7	46.7

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3e (N=15, 13.39% of those who answered question 1 and 68.18% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3F. **Your solution for delays in:** Patients who are self-referred for a SUD evaluation in general mental health. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-55. Substance Use Disorders: Question 3F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	12	5	41.7	2	16.7	4	33.3	0	0.0	1	8.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	12	4	33.3	5	41.7	3	25.0	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	12	3	25.0	4	33.3	4	33.3	1	8.3	0	0.0
d. Acquire and/or improve availability of equipment.	12	0	0.0	2	16.7	4	33.3	5	41.7	1	8.3
e. Implement or increase the availability of telehealth services.	12	2	16.7	4	33.3	5	41.7	1	8.3	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	12	4	33.3	2	16.7	4	33.3	2	16.7	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	12	1	8.3	2	16.7	3	25.0	6	50.0	0	0.0
h. Improve personnel supervision, management, or incentives.	12	0	0.0	7	58.3	5	41.7	0	0.0	0	0.0
i. Increase weekend and evening availability of services.	12	1	8.3	3	25.0	6	50.0	2	16.7	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	12	1	8.3	1	8.3	4	33.3	3	25.0	3	25.0
k. Some other solution(s).	12	1	8.3	0	0.0	2	16.7	1	8.3	8	66.7

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3f (N=12, 10.71% of those who answered question 1 and 42.86% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3G. **Your solution for delays in:** Referral to SUD services from the Administrative Parent to fee-basis or contracted care. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-56. Substance Use Disorders: Question 3G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	24	2	8.3	5	20.8	4	16.7	4	16.7	9	37.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	24	1	4.2	9	37.5	2	8.3	5	20.8	7	29.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	24	2	8.3	6	25.0	7	29.2	4	16.7	5	20.8
d. Acquire and/or improve availability of equipment.	24	0	0.0	6	25.0	3	12.5	6	25.0	9	37.5
e. Implement or increase the availability of telehealth services.	24	1	4.2	5	20.8	5	20.8	7	29.2	6	25.0
f. Improve information technology (e.g., scheduling system, electronic health record). Describe the technology improvements needed in the comments box below.	24	2	8.3	5	20.8	4	16.7	8	33.3	5	20.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	24	5	20.8	3	12.5	3	12.5	8	33.3	5	20.8
h. Improve personnel supervision, management, or incentives.	24	3	12.5	4	16.7	4	16.7	8	33.3	5	20.8
i. Increase weekend and evening availability of services.	24	0	0.0	4	16.7	4	16.7	10	41.7	6	25.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	24	7	29.2	10	41.7	2	8.3	3	12.5	2	8.3
k. Some other solution(s).	24	3	12.5	3	12.5	2	8.3	1	4.2	15	62.5

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3g (N=24, 21.43% of those who answered question 1 and 96% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3H. **Your solution for delays in:** Referral to residential treatment at another Administrative Parent. Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements in your solution**?

Table I-57. Substance Use Disorders: Question 3H

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	58	18	31.0	19	32.8	6	10.3	6	10.3	9	15.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	58	18	31.0	12	20.7	11	19.0	8	13.8	9	15.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	58	15	25.9	13	22.4	13	22.4	7	12.1	10	17.2
d. Acquire and/or improve availability of equipment.	58	2	3.5	3	5.2	10	17.2	18	31.0	25	43.1
e. Implement or increase the availability of telehealth services.	58	0	0.0	10	17.2	15	25.9	13	22.4	20	34.5
f. Improve information technology (e.g., scheduling system, electronic health record). Describe the technology improvements needed in the comments box below.	58	6	10.3	7	12.1	11	19.0	15	25.9	19	32.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	58	7	12.1	12	20.7	11	19.0	14	24.1	14	24.1
h. Improve personnel supervision, management, or incentives.	58	5	8.6	17	29.3	8	13.8	8	13.8	20	34.5
i. Increase weekend and evening availability of services.	58	2	3.5	2	3.5	20	34.5	16	27.6	18	31.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	58	5	8.6	13	22.4	15	25.9	13	22.4	12	20.7
k. Some other solution(s).	57	9	15.8	3	5.3	9	15.8	2	3.5	34	59.7

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3h (N=58, 51.79% of those who answered question 1 and 86.57% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

SUD Treatment

4. Now please think about patients who have a SUD diagnosis. **IN THE PAST 90 DAYS,** how often were there *clinically meaningful delays* scheduling these patients for **SUD treatment or follow-up care** in the following areas? Indicate the percent of SUD patients that experienced delays for whom the service was indicated.

Table I-58. Substance Use Disorders: Question 4

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Medication-assisted Withdrawal Management for Alcoholism provided as an inpatient within your local health care system	113	71	62.8	15	13.3	5	4.4	1	0.9	1	0.9	20	17.7
b. Medication-assisted Withdrawal Management for Alcoholism provided as an inpatient through fee-basis or contracted care	113	37	32.7	11	9.7	5	4.4	1	0.9	2	1.8	57	50.4
c. Medication-assisted Withdrawal Management for Alcoholism provided as an outpatient within your local health care system	113	61	54.0	13	11.5	7	6.2	1	0.9	1	0.9	30	26.6
d. Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient within your local health care system	113	61	54.0	14	12.4	4	3.5	0	0.0	0	0.0	34	30.1
e. Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient through fee-basis or contracted care	113	29	25.7	14	12.4	4	3.5	4	3.5	1	0.9	61	54.0
f. Medication-assisted Withdrawal Management for Opiate Dependence provided as an outpatient within your local health care system	113	56	49.6	22	19.5	11	9.7	1	0.9	2	1.8	21	18.6
g. Outpatient SUD Psychosocial Treatment (either group or individual) within your local health care system	113	73	64.6	28	24.8	5	4.4	1	0.9	3	2.7	3	2.7
h. Psychosocial Treatment (either group or individual) within Residential SUD care	113	39	34.5	24	21.2	6	5.3	2	1.8	19	16.8	23	20.4
i. SUD Psychosocial Treatment in CBOCs (all sizes)	111	43	38.7	30	27.0	6	5.4	5	4.5	6	5.4	21	18.9
j. SUD Psychosocial Treatment (either group or individual) using tele-mental health in CBOCs (all sizes)	111	43	38.7	15	13.5	6	5.4	1	0.9	5	4.5	41	36.9
k. Pharmacotherapy for Alcoholism provided in specialty mental health clinics within your local health care system	112	55	49.1	24	21.4	5	4.5	4	3.6	1	0.9	23	20.5
l. Pharmacotherapy for Alcoholism provided in specialty SUD clinics within your local health care system	113	68	60.2	24	21.2	3	2.7	3	2.7	0	0.0	15	13.3
m. Pharmacotherapy for Alcoholism provided in CBOCs (all sizes)	111	38	34.2	32	28.8	10	9.0	6	5.4	1	0.9	24	21.6
n. Maintenance Pharmacotherapy for Opiate Dependence: Buprenorphine within your local health care system	113	53	46.9	30	26.6	8	7.1	2	1.8	5	4.4	15	13.27
o. Maintenance Pharmacotherapy for Opiate Dependence: Buprenorphine provided through fee-basis or contracted care	113	17	15.0	18	15.9	4	3.5	5	4.4	8	7.1	61	54.0
p. Methadone Maintenance within your local health care system	113	15	13.3	7	6.2	2	1.8	2	1.8	3	2.7	84	74.3
q. Methadone Maintenance provided through fee-basis or contracted care	113	35	31.0	7	6.2	9	8.0	2	1.8	8	7.1	52	46.0

5. Think about those SUD patients who experienced *clinically meaningful delays* in obtaining treatment and follow-up care. In the **PAST 90 DAYS,** which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q4 in order to identify their top three delays for Q6.

Reducing Delays in Accessing SUD Treatment

6A. **Your solution for delays in:** Medication-assisted Withdrawal Management for Alcoholism provided as an inpatient within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-59. Substance Use Disorders: Question 6A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	2	18.2	6	54.6	2	18.2	1	9.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	12	5	41.7	6	50.0	1	8.3	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	12	5	41.7	6	50.0	1	8.3	0	0.0	0	0.0
d. Acquire and/or improve availability of equipment.	12	1	8.3	4	33.3	5	41.7	1	8.3	1	8.3
e. Implement or increase the availability of telehealth services.	11	0	0.0	3	27.3	2	18.2	2	18.2	4	36.4
f. Improve information technology (e.g., scheduling system, electronic health record).	12	0	0.0	5	41.7	1	8.3	1	8.3	5	41.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	12	0	0.0	3	25.0	3	25.0	3	25.0	3	25.0
h. Improve personnel supervision, management, or incentives.	12	0	0.0	7	58.3	2	16.7	0	0.0	3	25.0
i. Increase weekend and evening availability of services.	11	0	0.0	1	9.1	4	36.4	2	18.2	4	36.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	12	0	0.0	5	41.7	4	33.3	0	0.0	3	25.0
k. Some other solution(s).	10	2	20	3	30.0	0	0.0	0	0.0	5	50.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6a (N=12, 10.62% of those who answered question 4 and 54.55% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6B. **Your solution for delays in:** Medication-assisted Withdrawal Management for Alcoholism provided as an inpatient through fee-basis or contracted care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing medication-assisted withdrawal management for alcoholism provided as an impatient through fee-basis or contracted care and answered question 6b with solutions to this delay (N = 5).

6C. **Your solution for delays in:** Medication-assisted Withdrawal Management for Alcoholism provided as an outpatient within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-60. Substance Use Disorders: Question 6C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	3	30.0	5	50.0	2	20.0	0	0.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	5	50.0	5	50.0	0	0.0	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	2	20.0	6	60.0	1	10.0	1	10.0	0	0.0
d. Acquire and/or improve availability of equipment.	10	0	0.0	3	30.0	2	20.0	3	30.0	2	20.0
e. Implement or increase the availability of telehealth services.	10	0	0.0	3	30.0	2	20.0	4	40.0	1	10.0
f. Improve information technology (e.g., scheduling system, electronic health record).	9	0	0.0	3	33.3	2	22.2	3	33.3	1	11.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	0	0.0	3	30.0	0	0.0	6	60.0	1	10.0
h. Improve personnel supervision, management, or incentives.	10	1	10.0	6	60.0	1	10.0	2	20.0	0	0.0
i. Increase weekend and evening availability of services.	10	1	10.0	2	20.0	1	10.0	5	50.0	1	10.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	2	20.0	4	40.0	2	20.0	2	20.0
k. Some other solution(s).	9	3	33.3	2	22.2	0	0.0	0	0.0	4	44.4

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6c (N=10, 8.85% of those who answered question 4 and 45.45% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6D. **Your solution for delays in:** Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient within your local health care system and answered question 6d with solutions to this delay (N = 7).

6E. **Your solution for delays in:** Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient through fee-basis or contracted care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Medication-assisted Withdrawal Management for Opiate Dependence provided as an inpatient through fee-basis or contracted care and answered question 6d with solutions to this delay (N = 4).

6F. **Your solution for delays in:** Medication-assisted Withdrawal Management for Opiate Dependence provided as an outpatient within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-61. Substance Use Disorders: Question 6F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	2	20.0	4	40.0	2	20.0	1	10.0	1	10.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	5	50.0	4	40.0	1	10.0	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	2	20.0	2	20.0	3	30.0	2	20.0	1	10.0
d. Acquire and/or improve availability of equipment.	10	0	0.0	0	0.0	5	50.0	3	30.0	2	20.0
e. Implement or increase the availability of telehealth services.	10	0	0.0	1	10.0	1	10.0	5	50.0	3	30.0
f. Improve information technology (e.g., scheduling system, electronic health record).	10	1	10.0	0	0.0	3	30.0	4	40.0	2	20.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	9	0	0.0	0	0.0	3	33.3	4	44.4	2	22.2
h. Improve personnel supervision, management, or incentives.	10	0	0.0	1	10.0	3	30.0	4	40.0	2	20.0
i. Increase weekend and evening availability of services.	10	0	0.0	1	10.0	4	40.0	3	30.0	2	20.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	2	20.0	1	10.0	5	50.0	2	20.0
k. Some other solution(s).	10	2	20.0	1	10.0	1	10.0	1	10.0	5	50.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6f (N=10, 8.85% of those who answered question 4 and 27.78% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6G. **Your solution for delays in:** Outpatient SUD Psychosocial Treatment (either group or individual) within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-62. Substance Use Disorders: Question 6G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	14	2	14.3	3	21.4	6	42.9	3	21.4	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	14	7	50.0	5	35.7	2	14.3	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	14	3	21.4	2	14.3	6	42.9	3	21.4	0	0.0
d. Acquire and/or improve availability of equipment.	14	0	0.0	1	7.1	1	7.1	10	71.4	2	14.3
e. Implement or increase the availability of telehealth services.	14	1	7.1	4	28.6	3	21.4	6	42.9	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	14	1	7.1	0	0.0	3	21.4	8	57.1	2	14.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	14	1	7.1	3	21.4	0	0.0	8	57.1	2	14.3
h. Improve personnel supervision, management, or incentives.	14	2	14.3	4	28.6	3	21.4	2	14.3	3	21.4
i. Increase weekend and evening availability of services.	13	0	0.0	2	15.4	4	30.8	7	53.9	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	0	0.0	3	21.4	3	21.4	5	35.7	3	21.4
k. Some other solution(s).	13	0	0.0	0	0.0	1	7.7	1	7.7	11	84.6

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6g (N=14, 12.39% of those who answered question 4 and 37.84% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6H. **Your solution for delays in:** Psychosocial Treatment (either group or individual) within Residential SUD care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-63. Substance Use Disorders: Question 6H

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	32	18	56.3	8	25.0	3	9.4	1	3.1	2	6.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	32	12	37.5	9	28.1	4	12.5	4	12.5	3	9.4
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	32	9	28.1	10	31.3	6	18.8	3	9.4	4	12.5
d. Acquire and/or improve availability of equipment.	32	1	3.1	6	18.8	3	9.4	11	34.4	11	34.4
e. Implement or increase the availability of telehealth services.	32	2	6.3	5	15.6	7	21.9	9	28.1	9	28.1
f. Improve information technology (e.g., scheduling system, electronic health record).	32	3	9.4	6	18.8	7	21.9	10	31.3	6	18.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	32	4	12.5	6	18.8	6	18.8	9	28.1	7	21.9
h. Improve personnel supervision, management, or incentives.	32	4	12.5	9	28.1	7	21.9	4	12.5	8	25.0
i. Increase weekend and evening availability of services.	32	3	9.4	5	15.6	7	21.9	9	28.1	8	25.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	32	5	15.6	10	31.3	7	21.9	4	12.5	6	18.8
k. Some other solution(s).	28	5	17.9	5	17.9	1	3.6	0	0.0	17	60.7

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6h (N=33, 29.2% of those who answered question 4 and 64.71% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6I. **Your solution for delays in:** SUD Psychosocial Treatment in CBOCs (all sizes)**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-64. Substance Use Disorders: Question 6I

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	25	11	44.0	8	32.0	4	16.0	2	8.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	14	56.0	8	32.0	2	8.0	1	4.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	24	5	20.8	11	45.8	6	25.0	2	8.3	0	0.0
d. Acquire and/or improve availability of equipment.	25	1	4.0	6	24.0	7	28.0	9	36.0	2	8.0
e. Implement or increase the availability of telehealth services.	24	3	12.5	9	37.5	10	41.7	1	4.2	1	4.2
f. Improve information technology (e.g., scheduling system, electronic health record).	25	8	32.0	5	20.0	3	12.0	9	36.0	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	25	6	24.0	5	20.0	3	12.0	10	40.0	1	4.0
h. Improve personnel supervision, management, or incentives.	25	7	28.0	7	28.0	6	24.0	4	16.0	1	4.0
i. Increase weekend and evening availability of services.	25	2	8.0	6	24.0	7	28.0	9	36.0	1	4.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	25	3	12.0	4	16.0	10	40.0	7	28.0	1	4.0
k. Some other solution(s).	23	2	8.7	1	4.4	3	13.0	1	4.4	16	69.6

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6i (N=25, 22.52% of those who answered question 4 and 53.19% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6J. **Your solution for delays in:** SUD Psychosocial Treatment (either group or individual) using tele-mental health in CBOCs (all sizes)**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-65. Substance Use Disorders: Question 6J

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	12	9	75.0	0	0.0	2	16.7	0	0.0	1	8.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	12	6	50.0	1	8.3	2	16.7	2	16.7	1	8.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	12	4	33.3	4	33.3	3	25.0	1	8.3	0	0.0
d. Acquire and/or improve availability of equipment.	12	5	41.7	4	33.3	2	16.7	0	0.0	1	8.3
e. Implement or increase the availability of telehealth services.	12	4	33.3	5	41.7	2	16.7	1	8.3	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	12	2	16.7	5	41.7	3	25.0	1	8.3	1	8.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	12	1	8.3	5	41.7	1	8.3	2	16.7	3	25.0
h. Improve personnel supervision, management, or incentives.	12	1	8.3	5	41.7	3	25.0	0	0.0	3	25.0
i. Increase weekend and evening availability of services.	12	0	0.0	2	16.7	4	33.3	3	25.0	3	25.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	12	1	8.3	2	16.7	5	41.7	2	16.7	2	16.7
k. Some other solution(s).	11	0	0.0	1	9.1	3	27.3	0	0.0	7	63.6

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6j (N=12, 10.81% of those who answered question 4 and 44.44% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6K. **Your solution for delays in:** Pharmacotherapy for Alcoholism provided in specialty mental health clinics within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Pharmacotherapy for Alcoholism provided in specialty mental health clinics within your local health care system and answered question 6k with solutions to this delay (N = 8).

6L. **Your solution for delays in:** Pharmacotherapy for Alcoholism provided in specialty SUD clinics within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Pharmacotherapy for Alcoholism provided in specialty SUD clinics within your local health care system and answered question 6l with solutions to this delay (N = 5).

6M. **Your solution for delays in:** Pharmacotherapy for Alcoholism provided in CBOCs (all sizes)**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-66. Substance Use Disorders: Question 6M

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	3	17.7	5	29.4	4	23.53	1	5.9	4	23.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists). below.	17	7	41.2	4	23.5	4	23.53	0	0.0	2	11.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	5	29.4	5	29.4	2	11.76	2	11.8	3	17.7
d. Acquire and/or improve availability of equipment.	17	1	5.9	3	17.7	6	35.29	2	11.8	5	29.4
e. Implement or increase the availability of telehealth services.	17	0	0.0	5	29.4	5	29.41	2	11.8	5	29.4
f. Improve information technology (e.g., scheduling system, electronic health record).	17	3	17.7	3	17.7	3	17.65	3	17.7	5	29.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	15	2	13.3	3	20.0	0	0.0	5	33.3	5	33.3
h. Improve personnel supervision, management, or incentives.	17	1	5.9	7	41.2	3	17.65	3	17.7	3	17.7
i. Increase weekend and evening availability of services.	16	0	0.0	4	25.0	5	31.25	3	18.8	4	25.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	17	2	11.8	2	11.8	4	23.53	3	17.7	6	35.3
k. Some other solution(s).	14	0	0.0	3	21.4	2	14.29	0	0.0	9	64.3

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6m (N=17, 15.32% of those who answered question 4 and 34.69% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6N. **Your solution for delays in:** Maintenance Pharmacotherapy for Opiate Dependence: Buprenorphine within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-67. Substance Use Disorders: Question 6N

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	20	1	5.0	6	30.0	7	35.0	6	30.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	21	10	47.6	7	33.3	3	14.3	1	4.8	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	21	3	14.3	7	33.3	6	28.6	4	19.1	1	4.8
d. Acquire and/or improve availability of equipment.	21	0	0.0	1	4.8	3	14.3	13	61.9	4	19.1
e. Implement or increase the availability of telehealth services.	21	0	0.0	2	9.5	4	19.1	12	57.1	3	14.3
f. Improve information technology (e.g., scheduling system, electronic health record).	21	1	4.8	1	4.8	4	19.1	13	61.9	2	9.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	21	0	0.0	0	0.0	3	14.3	14	66.7	4	19.1
h. Improve personnel supervision, management, or incentives.	21	0	0.0	3	14.3	5	23.8	10	47.6	3	14.3
i. Increase weekend and evening availability of services.	21	0	0.0	1	4.8	6	28.6	11	52.4	3	14.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	21	1	4.8	4	19.1	3	14.3	9	42.9	4	19.1
k. Some other solution(s).	19	1	5.3	1	5.3	3	15.8	3	15.8	11	57.9

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6n (N=21, 18.58% of those who answered question 4 and 46.67% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6O. **Your solution for delays in:** Maintenance Pharmacotherapy for Opiate Dependence: Buprenorphine provided through fee-basis or contracted care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-68. Substance Use Disorders: Question 6O

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	1	5.9	4	23.5	0	0.0	5	29.4	7	41.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	9	52.9	2	11.8	0	0.0	1	5.9	5	29.4
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	2	11.8	6	35.3	2	11.8	1	5.9	6	35.3
d. Acquire and/or improve availability of equipment.	16	1	6.3	0	0.0	2	12.5	6	37.5	7	43.8
e. Implement or increase the availability of telehealth services.	17	0	0.0	2	11.8	3	17.7	6	35.3	6	35.3
f. Improve information technology (e.g., scheduling system, electronic health record).	17	1	5.9	2	11.8	2	11.8	6	35.3	6	35.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	17	3	17.7	1	5.9	3	17.7	3	17.7	7	41.2
h. Improve personnel supervision, management, or incentives.	16	4	25.0	1	6.3	2	12.5	4	25.0	5	31.3
i. Increase weekend and evening availability of services.	16	2	12.5	1	6.3	2	12.5	5	31.3	6	37.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	17	7	41.2	1	5.9	2	11.8	4	23.5	3	17.7
k. Some other solution(s).	17	5	29.4	5	29.4	0	0.0	1	5.9	6	35.29

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining treatment and follow-up care (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6o (N=17, 15.04% of those who answered question 4 and 48.57% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6P. **Your solution for delays in:** Methadone Maintenance within your local health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Methadone Maintenance within your local health care system and answered question 6p with solutions to this delay (N = 5).

6Q. **Your solution for delays in:** Methadone Maintenance provided through fee-basis or contracted care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for SUD patients at this junction. Now, **in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Methadone Maintenance provided through fee-basis or contracted care and answered question 6q with solutions to this delay (N = 9).

SUD Care Transitions

7. Please think about patients with a SUD diagnosis who need to **be transitioned to another level of care**. **IN THE PAST 90 DAYS**, how often were there *clinically meaningful delays* in transitioning a patient to another level of care when needed? Indicate the percent of patients that experienced delays for whom the service was indicated.

Table I-69. Substance Use Disorders: Question 7

		No Delay		1-10% of patients experience		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. From primary care (excluding CBOCs) to outpatient specialty SUD care	112	82	73.2	24	21.4	2	1.8	2	1.8	0	0.0	2	1.8
b. From general mental health to residential SUD care	112	39	34.8	29	25.9	7	6.3	7	6.3	17	15.2	13	11.6
c. From Emergency Department to outpatient specialty SUD care	112	71	63.4	25	22.3	1	0.9	1	0.9	1	0.9	13	11.6
d. From Emergency Department to inpatient detox	112	70	62.5	20	17.9	4	3.6	0	0.0	1	0.9	17	15.2
e. From ambulatory detox to residential SUD treatment	112	29	25.9	23	20.5	8	7.1	5	4.5	18	16.1	29	25.9
f. From CBOCs (all sizes) to specialty residential SUD care at your local health care system	112	27	24.1	35	31.3	8	7.1	6	5.4	14	12.5	22	19.6

8. Think about those SUD patients who experienced **transition delays.** In the **PAST 90 DAYS**, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q7 in order to identify their top three delays for Q9.

Reducing Delays in SUD Care Transitions

9A**. Your solution for delays in transitioning:** From primary care (excluding CBOCs) to outpatient specialty. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-70. Substance Use Disorders: Question 9A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	18	5	27.8	6	33.3	5	27.8	1	5.6	1	5.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	18	10	55.6	6	33.3	1	5.6	1	5.6	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	18	5	27.8	8	44.4	4	22.2	1	5.6	0	0.0
d. Acquire and/or improve availability of equipment.	18	0	0.0	3	16.7	4	22.2	8	44.4	3	16.7
e. Implement or increase the availability of telehealth services.	18	0	0.0	4	22.2	4	22.2	7	38.9	3	16.7
f. Improve information technology (e.g., scheduling system, electronic health record).	18	0	0.0	3	16.7	6	33.3	7	38.9	2	11.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	18	0	0.0	3	16.7	5	27.8	8	44.4	2	11.1
h. Improve personnel supervision, management, or incentives.	18	0	0.0	6	33.3	5	27.8	4	22.2	3	16.7
i. Increase weekend and evening availability of services.	18	1	5.6	2	11.1	9	50.0	5	27.8	1	5.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	18	0	0.0	1	5.6	9	50.0	4	22.2	4	22.2
k. Some other solution(s).	17	3	17.7	0	0.0	1	5.9	2	11.8	11	64.7

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9a (N=18, 16.07% of those who answered question 7 and 64.29% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9B**. Your solution for delays in transitioning:** From general mental health to residential SUD. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-71. Substance Use Disorders: Question 9B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	52	18	34.6	17	32.7	9	17.3	4	7.7	4	7.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	52	18	34.6	15	28.9	6	11.5	6	11.5	7	13.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	52	13	25.0	16	30.8	9	17.3	6	11.5	8	15.4
d. Acquire and/or improve availability of equipment.	52	0	0.0	6	11.5	13	25.0	16	30.8	17	32.7
e. Implement or increase the availability of telehealth services.	52	1	1.9	9	17.3	11	21.2	15	28.9	16	30.8
f. Improve information technology (e.g., scheduling system, electronic health record).	52	5	9.6	6	11.5	9	17.3	18	34.6	14	26.9
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	52	5	9.6	6	11.5	12	23.1	15	28.9	14	26.9
h. Improve personnel supervision, management, or incentives.	52	5	9.6	11	21.2	11	21.2	12	23.1	13	25.0
i. Increase weekend and evening availability of services.	52	2	3.9	8	15.4	14	26.9	14	26.9	14	26.9
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	52	7	13.5	13	25.0	13	25.0	7	13.5	12	23.1
k. Some other solution(s).	51	8	15.7	6	11.8	4	7.8	0	0.0	33	64.7

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9b (N=52, 46.43% of those who answered question 7 and 86.67% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9C**. Your solution for delays in transitioning:** From Emergency Department to outpatient specialty SUD care. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-72. Substance Use Disorders: Question 9C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	3	27.3	5	45.5	2	18.2	1	9.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	6	54.6	2	18.2	1	9.1	2	18.2	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	4	36.4	3	27.3	2	18.2	2	18.2	0	0.0
d. Acquire and/or improve availability of equipment.	11	0	0.0	2	18.2	1	9.1	6	54.6	2	18.2
e. Implement or increase the availability of telehealth services.	11	1	9.1	2	18.2	1	9.1	5	45.5	2	18.2
f. Improve information technology (e.g., scheduling system, electronic health record).	11	1	9.1	2	18.2	1	9.1	5	45.5	2	18.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	1	9.1	2	18.2	2	18.2	6	54.6	0	0.0
h. Improve personnel supervision, management, or incentives.	11	1	9.1	1	9.1	2	18.2	4	36.4	3	27.3
i. Increase weekend and evening availability of services.	11	0	0.0	2	18.2	4	36.4	4	36.4	1	9.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	0	0.0	2	18.2	3	27.3	3	27.3	3	27.3
k. Some other solution(s).	11	1	9.1	1	9.1	0	0.0	1	9.1	8	72.7

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9c (N=11, 9.82% of those who answered question 7 and 39.29% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9D**. Your solution for delays in transitioning:** From Emergency Department to inpatient detox. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-73. Substance Use Disorders: Question 9D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	18	5	27.8	5	27.8	1	5.6	5	27.8	2	11.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	18	3	16.7	5	27.8	3	16.7	4	22.2	3	16.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	18	4	22.2	4	22.2	3	16.7	5	27.8	2	11.1
d. Acquire and/or improve availability of equipment.	18	2	11.1	1	5.6	0	0.0	10	55.6	5	27.8
e. Implement or increase the availability of telehealth services.	18	0	0.0	3	16.7	0	0.0	10	55.6	5	27.8
f. Improve information technology (e.g., scheduling system, electronic health record).	18	1	5.6	2	11.1	0	0.0	10	55.6	5	27.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	18	0	0.0	3	16.7	2	11.1	9	50.0	4	22.2
h. Improve personnel supervision, management, or incentives.	18	0	0.0	7	38.9	1	5.6	8	44.4	2	11.1
i. Increase weekend and evening availability of services.	18	2	11.1	1	5.6	1	5.6	9	50.0	5	27.8
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	18	2	11.1	4	22.2	5	27.8	3	16.7	4	22.2
k. Some other solution(s).	17	5	29.4	4	23.5	2	11.78	1	5.9	5	29.4

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9d (N=18, 16.07% of those who answered question 7 and 72% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9E**. Your solution for delays in transitioning:** From ambulatory detox to residential SUD treatment. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-74. Substance Use Disorders: Question 9E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	48	21	43.8	13	27.1	7	14.6	4	8.3	3	6.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	48	14	29.2	14	29.2	7	14.6	5	10.4	8	16.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	48	9	18.8	20	41.7	6	12.5	5	10.4	8	16.7
d. Acquire and/or improve availability of equipment.	48	1	2.1	5	10.4	9	18.8	18	37.5	15	31.3
e. Implement or increase the availability of telehealth services.	48	1	2.1	5	10.4	12	25.0	18	37.5	12	25.0
f. Improve information technology (e.g., scheduling system, electronic health record).	48	2	4.2	6	12.5	6	12.5	20	41.7	14	29.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	48	1	2.1	7	14.6	9	18.8	17	35.4	14	29.2
h. Improve personnel supervision, management, or incentives. P	48	6	12.5	8	16.7	11	22.9	12	25.0	11	22.9
i. Increase weekend and evening availability of services.	48	3	6.3	6	12.5	14	29.2	13	27.1	12	25.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	48	5	10.4	12	25.0	12	25.0	8	16.7	11	22.9
k. Some other solution(s).	48	6	12.5	7	14.6	6	12.5	3	6.3	26	54.2

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9e (N=48, 42.86% of those who answered question 7 and 88.89% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9F**. Your solution for delays in transitioning:** From CBOCs (all sizes) to specialty residential SUD care at your local health care system. Think about the most effective way to reduce the *number of clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-75. Substance Use Disorders: Question 9F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	49	20	40.8	10	20.4	11	22.5	3	6.1	5	10.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	49	21	42.9	10	20.4	5	10.2	5	10.2	8	16.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	49	17	34.7	11	22.5	7	14.3	5	10.2	9	18.4
d. Acquire and/or improve availability of equipment.	49	3	6.1	5	10.2	12	24.5	13	26.5	16	32.7
e. Implement or increase the availability of telehealth services.	49	2	4.1	8	16.3	12	24.5	13	26.5	14	28.6
f. Improve information technology (e.g., scheduling system, electronic health record).	49	3	6.1	4	8.2	10	20.4	18	36.7	14	28.6
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	49	4	8.2	7	14.3	8	16.3	17	34.7	13	26.5
h. Improve personnel supervision, management, or incentives.	49	6	12.2	8	16.3	9	18.4	12	24.5	14	28.6
i. Increase weekend and evening availability of services.	49	3	6.1	4	8.2	13	26.5	14	28.6	15	30.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	49	6	12.2	8	16.3	8	16.3	11	22.5	16	32.7
k. Some other solution(s).	49	5	10.2	6	12.2	2	4.1	3	6.1	33	67.4

This question (question 9) is based on respondents who indicated that patients experienced transition delays (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9f (N=49, 43.75% of those who answered question 7 and 77.78% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

Issues that Affect Provider and System Efficiency

10. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of care for SUD patients?

Table I-76. Substance Use Disorders: Question 10

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	112	30	26.8	38	33.9	25	22.3	15	13.4	4	3.6
b. Providers performing administrative activities that could be performed by others	113	17	15.0	23	20.4	32	28.3	41	36.3	0.0	0.0
c. Residency training/teaching requirements	113	51	45.1	33	29.2	9	8.0	4	3.5	16	14.2
d. Insufficient clinical/administrative support staff	113	15	13.3	23	20.4	26	23.0	48	42.5	1	0.9
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	113	24	21.2	29	25.7	27	23.9	31	27.4	2	1.8
f. Unnecessary documentation requirements or inefficient CPRS interface	113	25	22.1	30	26.5	30	26.5	26	23.0	2	1.8
g. Patient no-show rates	113	9	8.0	29	25.7	52	46.0	23	20.4	0.0	0.0
h. Poor patient flow management (room/bed turnover, appointments)	113	34	30.1	42	37.2	21	18.6	8	7.1	8	7.1
i. Too many administrative requirements (Initiatives/Policies/Programs)	113	14	12.4	31	27.4	26	23.0	38	33.6	4	3.5

Workforce

11A. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-77. Substance Use Disorders: Question 11A

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Prescribing mental health providers	113	86	76.1	21	18.6	6	5.3
b. Prescribing providers with X-waiver for office-based Buprenorphine	113	66	58.4	34	30.1	13	11.5
c. Mental health social workers	113	36	31.9	73	64.6	4	3.5
d. Psychologists	113	53	46.9	51	45.1	9	8.0
e. Clinical nurse specialists or psychiatric physician assistants	113	55	48.7	35	31.0	23	20.4
f. Clerical staff/appointment schedulers (other administrative staff in mental health clinics)	113	41	36.3	61	54.0	11	9.7
g. Other substance use clinicians	113	29	25.7	64	56.6	20	17.7

Reasons for Staff Recruitment/Hiring Problems

12. Please enter the **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types in the PAST YEAR.

Table I-78. Substance Use Disorders: Question 12

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Prescribing mental health providers	86	7	8.1	49	57.0	11	12.8	5	5.8	4	4.7	1	1.2	3	3.5	6	7.0	1	1.2	26	30.2	27	31.4	30	34.9
b. Prescribing providers with X-waiver for office-based Buprenorphine	66	5	7.6	36	54.5	8	12.1	3	4.5	2	3.0	0	0.0	6	9.1	5	7.6	1	1.5	20	30.3	16	24.2	29	43.9
c. Mental health social workers	36	8	22.2	7	19.4	1	2.8	0	0.0	5	13.9	0	0.0	1	2.8	1	2.8	0	0.0	10	27.8	22	61.1	13	36.1
d. Psychologists	53	6	11.3	11	20.8	1	1.9	4	7.5	5	9.4	0	0.0	0	0.0	3	5.7	3	5.7	18	34	30	56.6	22	41.5
e. Clinical nurse specialists or psychiatric physician assistants	55	8	14.5	26	47.3	2	3.6	1	1.8	3	5.5	0	0.0	1	1.8	3	5.5	1	1.8	16	29.1	22	40.0	24	43.6
f. Clerical staff/appointment schedulers (other administrative staff in mental health clinics)	41	13	31.7	12	29.3	3	7.3	1	2.4	6	14.6	0	0.0	0	0.0	2	4.9	0	0.0	4	9.8	23	56.1	16	39.0
g. Other substance use clinicians	29	9	31.0	6	20.7	1	3.4	1	3.4	6	20.7	0	0.0	1	3.4	2	6.9	1	3.4	7	24.1	13	44.8	9	31.0

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring. This question (question 12) is based on respondents who indicated that their local health care system had problems recruiting or hiring certain personnel categories (question 11A). Question 12 was asked for each personnel type marked "yes" in question 11A.

Reasons for Staff Retention Problems

11B. IN THE PAST YEAR, did your local health care system have problems **RETAINING** the following personnel categories?

Table I-79. Substance Use Disorders: Question 11B

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Prescribing mental health providers	113	59	52.2	49	43.4	5	4.4
b. Prescribing providers with X-waiver for office-based Buprenorphine	112	39	34.8	57	50.9	16	14.3
c. Mental health social workers	113	36	31.9	72	63.7	5	4.4
d. Psychologists	112	35	31.3	69	61.6	8	7.1
e. Clinical nurse specialists or psychiatric physician assistants	113	21	18.6	68	60.2	24	21.2
f. Clerical staff/appointment schedulers (other administrative staff in mental health clinics)	113	37	32.7	66	58.4	10	8.8
g. Other substance use clinicians	113	19	16.8	78	69.0	16	14.2

13. Please enter the **top two reasons** why there were problems **RETAINING** these personnel types in the PAST YEAR.

Table I-80. Substance Use Disorders: Question 13

		Lack of opportunity for professional growth/promotion		Dissatisfaction with supervision/management support		Dissatisfaction with support staff		Dissatisfaction with physical demands of the job		Dissatisfaction with workload		Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		Organizational culture that does not prioritize/encourage productivity		Administrative/ Program Demands		Lack of professional autonomy		Dissatisfaction with pay		1Work schedule		Inadequate equipment/ resources/office space		Burnout	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Prescribing mental health providers	59	8	13.6	7	11.9	2	3.4	1	1.7	17	28.8	1	1.7	1	1.7	12	20.3	8	13.6	30	50.8	9	15.3	2	3.4	13	22.0
b. Prescribing providers with X-waiver for office-based Buprenorphine	39	5	12.8	8	20.5	3	7.7	0	0.0	10	25.6	0	0.0	0	0.0	11	28.2	6	15.4	18	46.2	5	12.8	4	10.3	6	15.4
c. Mental health social workers	36	13	36.1	8	22.2	2	5.6	2	5.6	8	22.2	3	8.3	0	0.0	6	16.7	3	8.3	8	22.2	3	8.3	1	2.8	11	30.6
d. Psychologists	35	15	42.9	7	20.0	2	5.7	2	5.7	7	20.0	1	2.9	1	2.9	11	31.4	5	14.3	4	11.4	2	5.7	4	11.4	8	22.9
e. Clinical nurse specialists or psychiatric physician assistants	21	7	33.3	1	4.8	0	0.0	0	0.0	9	42.9	1	4.8	1	4.8	5	23.8	1	4.8	6	28.6	2	9.5	3	14.3	5	23.8
f. Clerical staff/appointment schedulers (other administrative staff in mental health clinics)	37	17	45.9	3	8.1	1	2.7	0	0.0	10	27.0	0	0.0	0	0.0	10	27.0	0	0.0	18	48.6	2	5.4	2	5.4	9	24.3
g. Other substance use clinicians	19	7	36.8	3	15.8	2	10.5	0	0.0	2	10.5	1	5.3	0	0.0	2	10.5	1	5.3	6	31.6	3	15.8	1	5.3	8	42.1

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention
This question (question 13) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 11B). Question 13 was asked for each personnel type marked "yes" in question 11B.

Appendix I.1.4 5.4 TBI

Section 4: Traumatic Brain Injury (TBI)

TBI Assessment After Screening (Comprehensive TBI Evaluation)

1. Consider patients who "screen positive" for possible TBI symptoms during a primary care or mental health clinic visit. IN THE PAST YEAR, where would these patients typically be sent to receive a **comprehensive TBI evaluation (CTBIE**)?

Table I-81. Traumatic Brain Injury: Question 1

	N	n	%
Neurology clinic	107	20	18.7
Mental health clinic	107	11	10.3
Primary care clinic	107	9	8.4
Physical medicine & rehabilitation clinic	107	47	43.9
Interdisciplinary TBI clinic within your local health care system	107	56	52.3
Interdisciplinary TBI clinic at a different local health care system	107	6	5.6
Interdisciplinary TBI clinic at a non-VA facility (fee-basis or contracted care)	107	1	0.9
Depends upon where the primary care & mental health clinics are located (VAMC vs. CBOC, and if CBOC, its size and location).	107	2	1.9
Other	107	5	4.7

2. Think about patients who "screen positive" for possible TBI and across all settings. IN THE **PAST YEAR,** how often were there delays in obtaining a **comprehensive TBI evaluation** (CTBIE)? Indicate the percent of patients that experienced this delay for whom the service was indicated.

Table I-82.Traumatic Brain Injury: Question 2

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
CTBIE	107	47	43.9	32	29.9	11	10.3	10	9.3	3	2.8	4	3.7

Reducing Delays in Completing Comprehensive TBI Evaluation

3. Think of the most effective way to reduce the number of delays that TBI patients experience obtaining a **comprehensive TBI evaluation** (CTBIE). Now, **in your solution, how important are each of the following elements in your solution?**

Table I-83. Traumatic Brain Injury: Question 3

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	56	4	7.1	10	17.9	22	39.3	14	25.0	6	10.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	56	17	30.4	12	21.4	18	32.1	5	8.9	4	7.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	56	7	12.5	15	26.8	17	30.4	12	21.4	5	8.9
d. Acquire and/or improve availability of equipment.	56	0	0.0	6	10.7	15	26.8	26	46.4	9	16.1
e. Implement or increase the availability of telehealth services	56	1	1.8	18	32.1	17	30.4	15	26.8	5	8.9
f. Improve information technology (e.g., scheduling system, electronic health record).	56	10	17.9	17	30.4	15	26.8	9	16.1	5	8.9
g. Change “central office policies” that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	56	10	17.9	11	19.6	19	33.9	11	19.6	5	8.9
h. Improve personnel supervision, management, or incentives.	56	4	7.1	11	19.6	17	30.4	15	26.8	9	16.1
i. Increase weekend and evening availability of services	55	2	3.6	5	9.1	21	38.2	19	34.5	8	14.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	56	2	3.6	4	7.1	15	26.8	27	48.2	8	14.3
k. Some other solution(s).	34	2	5.9	8	23.5	4	11.8	5	14.7	15	44.1
This question (question 3) is based on respondents who indicated that patients experienced delays (n=56) in obtaining a comprehensive TBI evaluation (question 2).											

Additional Assessments After Comprehensive TBI Evaluation

4. Please think about TBI patients for whom the following assessments are ordered. IN THE **PAST YEAR,** how often were there delays in obtaining the following assessments? Indicate the percent of patients that experienced delays for whom the service was ordered.

Table I-84. Traumatic Brain Injury: Question 4

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. MRI	107	50	46.7	31	29.0	7	6.5	7	6.5	6	5.6	6	5.6
b. Comprehensive sleep evaluation	106	29	27.4	31	29.3	15	14.2	9	8.5	9	8.5	13	12.3
c. Neuropsych evaluation	107	41	38.3	34	31.8	14	13.1	5	4.7	9	8.4	4	3.7
d. Case management services	105	80	76.2	12	11.4	5	4.8	0	0.0	3	2.9	5	4.8
e. Mental health evaluation	106	68	64.2	19	17.9	8	7.6	6	5.7	3	2.8	2	1.9
f. Neuro-optometry/ ophthalmology testing	106	49	46.2	26	24.5	8	7.6	3	2.8	5	4.7	15	14.2
g. Hearing assessment	107	67	62.6	22	20.6	9	8.4	3	2.8	2	1.9	4	3.7
h. Balance and vestibular testing	105	56	53.3	29	27.6	5	4.8	2	1.9	3	2.9	10	9.5
i. Physical therapy evaluation	106	64	60.4	26	24.5	9	8.5	0	0.0	4	3.8	3	2.8
j. Occupational therapy evaluation	107	77	72.0	14	13.1	6	5.6	2	1.9	1	0.9	7	6.5

5. Think about TBI patients who experienced delays in their additional assessments. IN THE **PAST YEAR**, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q4 in order to identify their top three delays for Q6.

Reducing Delays for Assessment After Comprehensive TBI evaluation

6A. **Your solution to delays in** obtaining an MRI**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-85. Traumatic Brain Injury: Question 6A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	24	5	20.8	10	41.7	3	12.5	2	8.3	4	16.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	24	5	20.8	8	33.3	5	20.8	1	4.2	5	20.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	24	5	20.8	8	33.3	5	20.8	2	8.3	4	16.7
d. Acquire and/or improve availability of equipment.	24	7	29.2	10	41.67	3	12.5	1	4.2	3	12.5
e. Implement or increase the availability of telehealth services.	23	0	0.0	6	26.1	3	13.0	4	17.4	10	43.5
f. Improve information technology (e.g., scheduling system, electronic health record).	23	1	4.4	9	39.1	7	30.4	2	8.7	4	17.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided). Describe the policy changes needed in the comments box below.	24	2	8.3	8	33.3	1	4.2	5	20.8	8	33.3
h. Improve personnel supervision, management, or incentives.	24	2	8.3	6	25.0	5	20.8	2	8.3	9	37.5
i. Increase weekend and evening availability of services.	24	2	8.3	8	33.3	8	33.3	3	12.5	3	12.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	24	0	0.0	12	50.0	5	20.8	3	12.5	4	16.7
k. Some other solution(s).	17	2	11.8	3	17.7	0	0.0	0	0.0	12	70.6

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6a (N=24, 22.43% of those who answered question 4 and 47.06% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6B. **Your solution to delays in obtaining** Comprehensive sleep evaluation**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-86. Traumatic Brain Injury: Question 6B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	40	5	12.5	13	32.5	13	32.5	3	7.5	6	15
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	41	10	24.4	14	34.2	10	24.4	2	4.9	5	12.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	41	7	17.1	11	26.8	16	39.0	2	4.9	5	12.2
d. Acquire and/or improve availability of equipment.	41	3	7.3	13	31.7	14	34.2	6	14.63	5	12.2
e. Implement or increase the availability of telehealth services.	41	0	0.0	6	14.6	10	24.4	7	17.07	18	43.9
f. Improve information technology (e.g., scheduling system, electronic health record).	41	1	2.4	5	12.2	12	29.3	9	21.95	14	34.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	41	0	0.0	4	9.8	16	39.0	6	14.63	15	36.6
h. Improve personnel supervision, management, or incentives.	41	0	0.0	4	9.8	13	31.7	13	31.71	11	26.8
i. Increase weekend and evening availability of services.	39	1	2.6	6	15.4	16	41.0	5	12.82	11	28.2
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	41	3	7.3	9	22.0	19	46.3	7	17.07	3	7.3
k. Some other solution(s).	29	0	0.0	8	27.6	5	17.2	2	6.9	14	48.3
This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6b (N=42, 39.62% of those who answered question 4 and 65.63% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

6C. **Your solution to delays in** obtaining Neuropsych evaluation**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-87. Traumatic Brain Injury: Question 6C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	42	7	16.7	11	26.2	12	28.6	4	9.5	8	19.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	42	23	54.8	12	28.6	6	14.3	0	0.0	1	2.4
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	42	7	16.7	15	35.7	9	21.4	6	14.3	5	11.9
d. Acquire and/or improve availability of equipment.	41	3	7.3	7	17.1	8	19.5	9	22.0	14	34.2
e. Implement or increase the availability of telehealth services.	41	3	7.3	2	4.9	17	41.5	9	22.0	10	24.4
f. Improve information technology (e.g., scheduling system, electronic health record).	41	3	7.3	6	14.6	13	31.7	9	22.0	10	24.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	42	5	11.9	1	2.4	13	31.0	10	23.8	13	31.0
h. Improve personnel supervision, management, or incentives.	42	2	4.8	5	11.9	13	31.0	11	26.2	11	26.2
i. Increase weekend and evening availability of services.	42	2	4.8	4	9.5	18	42.9	10	23.8	8	19.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	42	3	7.1	7	16.7	21	50.0	8	19.1	3	7.1
k. Some other solution(s).	30	2	6.7	5	16.7	4	13.3	2	6.7	17	56.7

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6c (N=42, 39.25% of those who answered question 4 and 67.74% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6D. **Your solution to delays in** obtaining Case management services**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-88. Traumatic Brain Injury: Question 6D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	1	10.0	1	10.0	3	30.0	5	50.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	9	3	33.3	2	22.2	4	44.4	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	3	30.0	3	30.0	3	30.0	1	10.0	0	0.0
d. Acquire and/or improve availability of equipment.	10	1	10.0	0	0.0	2	20.0	6	60.0	1	10.0
e. Implement or increase the availability of telehealth services.	10	1	10.0	2	20.0	5	50.0	2	20.0	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	9	1	11.1	4	44.4	2	22.2	2	22.2	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	2	20.0	1	10.0	4	40.0	3	30.0	0	0.0
h. Improve personnel supervision, management, or incentives.	10	1	10.0	1	10.0	4	40.0	3	30.0	1	10.0
i. Increase weekend and evening availability of services.	10	1	10.0	1	10.0	3	30.0	4	40.0	1	10.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	0	0.0.0	4	40.0	4	40.0	2	20.0
k. Some other solution(s).	8	1	12.5	0	0.0	1	12.5	0	0.0	6	75.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6d (N=10, 9.52% of those who answered question 4 and 50% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6E. **Your solution to delays in** obtaining Mental health evaluation**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-89. Traumatic Brain Injury: Question 6E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	25	4	16.0	11	44.0	7	28.0	2	8.0	1	4.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	15	60.0	5	20.0	3	12.0	1	4.0	1	4.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	25	4	16.0	8	32.0	10	40.0	2	8.0	1	4.0
d. Acquire and/or improve availability of equipment.	25	0	0.0	2	8.0	6	24.0	9	36.0	8	32.0
e. Implement or increase the availability of telehealth services.	25	4	16.0	7	28.0	12	48.0	1	4.0	1	4.0
f. Improve information technology (e.g., scheduling system, electronic health record).	24	5	20.8	3	12.5	4	16.7	8	33.3	4	16.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	24	6	25.0	4	16.7	3	12.5	7	29.2	4	16.7
h. Improve personnel supervision, management, or incentives.	24	3	12.5	5	20.8	9	37.5	4	16.7	3	12.5
i. Increase weekend and evening availability of services.	24	5	20.8	4	16.7	8	33.3	4	16.7	3	12.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	24	2	8.3	5	20.8	8	33.3	7	29.2	2	8.3
k. Some other solution(s).	14	2	14.3	2	14.3	2	14.3	0	0.0	8	57.1

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6e (N=25, 23.58% of those who answered question 4 and 69.44% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6F. **Your solution to delays in** obtaining Neuro-optometry/ ophthalmology testing**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-90. Traumatic Brain Injury: Question 6F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	13	0	0.0	3	23.1	5	38.5	3	23.8	2	15.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists)..	14	4	28.6	7	50.0	1	7.1	0	0.0	2	14.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	14	2	14.3	2	14.3	6	42.9	1	7.1	3	21.4
d. Acquire and/or improve availability of equipment.	14	0	0.0	3	21.4	5	35.7	2	14.3	4	28.6
e. Implement or increase the availability of telehealth services.	14	0	0.0	1	7.1	4	28.6	4	28.6	5	35.7
f. Improve information technology (e.g., scheduling system, electronic health record).	13	0	0.0	4	30.8	1	7.7	4	30.8	4	30.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	14	0	0.0	3	21.4	3	21.4	2	14.3	6	42.9
h. Improve personnel supervision, management, or incentives. .	14	0	0.0	5	35.7	4	28.6	2	14.3	3	21.4
i. Increase weekend and evening availability of services.	14	0	0.0	2	14.3	6	42.9	2	14.3	4	28.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	1	7.1	3	21.4	8	57.1	0	0.0	2	14.3
k. Some other solution(s).	12	1	8.3	3	25.0	2	16.7	0	0.0	6	50.0
This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6f (N=14, 13.21% of those who answered question 4 and 33.33% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

6G. **Your solution to delays in** obtaining Hearing assessment**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-91. Traumatic Brain Injury: Question 6G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	2	20.0	5	50.0	2	20.0	0	0.0	1	10.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	2	20.0	5	50.0	2	20.0	0	0.0	1	10.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	0	0.0	5	50.0	4	40.0	1	10.0	0	0.0
d. Acquire and/or improve availability of equipment.	10	2	20.0	3	30.0	4	40.0	0	0.0	1	10.0
e. Implement or increase the availability of telehealth services.	10	1	10.0	0	0.0	2	20.0	4	40.0	3	30.0
f. Improve information technology (e.g., scheduling system, electronic health record). Describe the technology improvements needed in the comments box below.	10	2	20.0	2	20.0	2	20.0	3	30.0	1	10.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	1	10.0	2	20.0	2	20.0	2	20.0	3	30.0
h. Improve personnel supervision, management, or incentives.	10	0	0.0	2	20.0	2	20.0	4	40.0	2	20.0
i. Increase weekend and evening availability of services.	10	3	30.0	3	30.0	2	20.0	1	10.0	1	10.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	1	10.0	3	30.0	2	20.0	4	40.0	0	0.0
k. Some other solution(s).	9	1	11.1	3	33.3	1	11.1	0	0.0	4	44.4
This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6g (N=10, 9.35% of those who answered question 4 and 27.78% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

6H. **Your solution to delays in** Balance and vestibular testing**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-92. Traumatic Brain Injury: Question 6H

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	2	20.0	3	30.0	3	30.0	1	10.0	1	10.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	2	20.0	4	40.0	4	40.0	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff). .	10	1	10.0	3	30.0	4	40.0	1	10.0	1	10.0
d. Acquire and/or improve availability of equipment.	10	1	10.0	5	50.0	2	20.0	1	10.0	1	10.0
e. Implement or increase the availability of telehealth services.	10	1	10.0	1	10.0	3	30.0	5	50.0	0	0.0
f. Improve information technology (e.g., scheduling system, electronic health record).	9	1	11.1	1	11.1	2	22.2	4	44.4	1	11.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	0	0.0	4	40.0	2	20.0	3	30.0	1	10.0
h. Improve personnel supervision, management, or incentives.	9	0	0.0	3	33.3	2	22.2	3	33.3	1	11.1
i. Increase weekend and evening availability of services.	10	0	0.0	1	10.0	3	30.0	6	60.0	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	2	20.0	3	30.0	5	50.0	0	0.0
k. Some other solution(s).	7	0	0.0	3	42.9	1	14.3	2	28.6	1	14.3
This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6h (N=10, 9.52% of those who answered question 4 and 25.64% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

6I. **Your solution to delays in** obtaining Physical therapy evaluation**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-93. Traumatic Brain Injury: Question 6I

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	13	0	0.0	9	69.2	2	15.4	2	15.4	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	14	1	7.1	8	57.1	4	28.6	0	0.0	1	7.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	14	1	7.1	5	35.7	5	35.7	2	14.3	1	7.1
d. Acquire and/or improve availability of equipment.	14	0	0.0	6	42.9	4	28.6	3	21.4	1	7.1
e. Implement or increase the availability of telehealth services.	14	0	0.0	3	21.4	4	28.6	5	35.7	2	14.3
f. Improve information technology (e.g., scheduling system, electronic health record).	14	1	7.1	4	28.6	4	28.6	4	28.6	1	7.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	14	0	0.0	6	42.9	1	7.1	5	35.7	2	14.3
h. Improve personnel supervision, management, or incentives.	14	1	7.1	4	28.6	6	42.9	2	14.3	1	7.1
i. Increase weekend and evening availability of services.	14	0	0.0	2	14.3	9	64.3	3	21.4	0	0.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	1	7.1	3	21.4	3	21.4	6	42.9	1	7.1
k. Some other solution(s).	8	0	0.0	1	12.5	1	12.5	0	0.0	6	75.0

This question (question 6) is based on respondents who indicated that patients experienced delays in obtaining assessments (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6i (N=14, 13.21% of those who answered question 4 and 35.9% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6J. **Your solution to delays in** obtaining Occupational therapy evaluation**.** Think of the most effective way to reduce the delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in accessing Occupational therapy evaluation and answered 6j (N = 7).

TBI Care Transition

7. Please think about patients who have previously been assessed for TBI in the DoD system. IN THE **PAST YEAR,** how often were there delays receiving **necessary medical records from the DoD assessment**? Indicate the percent of patients that experienced delays in having their records transferred to the VA.

Table I-94. Traumatic Brain Injury: Question 7

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
DoD records	106	32	30.2	24	22.6	13	12.3	7	6.6	21	19.8	9	8.5

TBI Ongoing Care

8/9. Is your local VA health care system a Polytrauma Network Site? How would you best characterize provision of care to patients with ongoing TBI symptoms at your local health care system?

Table I-95. Traumatic Brain Injury: Question 8/9

		N	n	%
Q8: Is your local VA health care system a Polytrauma Network Site?				
Yes		107	34	31.8
No	107	73	68.2	
Q9: How would you best characterize provision of care to patients with ongoing TBI symptoms at your local health care system?				
Most ongoing TBI care occurs at my local health care system rather than the regional polytrauma network site	73	64	87.7	
Most patients who need ongoing TBI care are referred out to the regional polytrauma network site	73	9	12.3	
This question (question 9) is based on respondents who indicated that their local VA health care system is not a Polytrauma Network Site.				

10. Please think about patients who require ongoing TBI care. IN THE **PAST YEAR**, how often were there delays in accessing the following services? Indicate the percent of patients that experienced delays for whom the service was required.

Table I-96. Traumatic Brain Injury: Question 10

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Ongoing care by a TBI specialist at your facility	107	65	60.8	23	21.5	7	6.5	3	2.8	4	3.7	5	4.7
b. Ongoing care at a regional polytrauma network site	107	53	49.5	13	12.2	4	3.7	2	1.9	2	1.9	33	30.8
c. Neuropsych therapy	107	48	44.9	27	25.2	11	10.3	3	2.8	5	4.7	13	12.2
d. Other mental health therapy	105	67	63.8	19	18.1	8	7.6	6	5.7	2	1.9	3	2.9
e. Pain clinic for refractory symptoms	106	33	31.1	30	28.3	13	12.3	8	7.6	12	11.3	10	9.4
f. Sleep clinic follow-up for refractory symptoms	106	31	29.3	28	26.4	16	15.1	6	5.7	9	8.5	16	15.1
g. Physical therapy	106	65	61.3	25	23.6	9	8.5	2	1.9	1	0.9	4	3.8
h. Occupational therapy	106	78	73.6	14	13.2	3	2.8	3	2.8	1	0.9	7	6.6
i. Speech therapy	107	75	70.1	16	145.0	8	7.5	0	0.0	3	2.8	5	4.7
j. Vocational rehabilitation	105	59	56.2	14	13.3	8	7.6	1	1.0	4	3.8	19	18.1

11. Think about delays among patients who need ongoing TBI care. IN THE **PAST YEAR**, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q10 in order to identify their top three delays for Q11.

Reducing Delays in TBI Treatment

12A. **Your solution to delays in: accessing** Ongoing care by a TBI specialist at your facility. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-97. Traumatic Brain Injury: Question 12A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	4	23.5	3	17.7	5	29.4	4	23.5	1	5.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	7	41.2	7	41.2	2	11.8	0	0.0	1	5.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	3	17.7	6	35.3	7	41.2	1	5.9	0	0.0
d. Acquire and/or improve availability of equipment.	17	1	5.9	3	17.7	5	29.4	5	29.4	3	17.7
e. Implement or increase the availability of telehealth services.	17	1	5.9	4	23.5	4	23.5	4	23.5	4	23.5
f. Improve information technology (e.g., scheduling system, electronic health record).	17	1	5.9	5	29.4	4	23.5	4	23.5	3	17.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	16	2	12.5	3	18.8	2	12.5	5	31.3	4	25.0
h. Improve personnel supervision, management, or incentives.	16	2	12.5	2	12.5	0	0.0	7	43.8	5	31.3
i. Increase weekend and evening availability of services.	17	2	11.8	3	17.7	6	35.3	4	23.5	2	11.8
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	17	1	5.9	2	11.8	4	23.5	6	35.3	4	23.5
k. Some other solution(s).	13	1	7.7	4	30.8	1	7.7	0	0.0	7	53.9

This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12a (N=17, 15.89% of those who answered question 10 and 45.95% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12B. **Your solution to delays in: accessing** Ongoing care at a regional polytrauma network site. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-98. Traumatic Brain Injury: Question 12B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	0	0.0	4	40.0	2	20.0	2	20.0	2	20.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	3	30.0	5	50.0	1	10.0	0	0.0	1	10.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	0	0.0	5	50.0	4	40.0	0	0.0	1	10.0
d. Acquire and/or improve availability of equipment.	10	0	0.0	3	30.0	2	20.0	3	30.0	2	20.0
e. Implement or increase the availability of telehealth services.	9	0	0.0	3	33.3	4	44.4	1	11.1	1	11.1
f. Improve information technology (e.g., scheduling system, electronic health record).	10	1	10.0	4	40.0	4	40.0	1	10.0	0	0.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	2	20.0	5	50.0	3	30.0	0	0.0	0	0.0
h. Improve personnel supervision, management, or incentives.	9	0	0.0	4	44.4	0	0.0	3	33.3	2	22.2
i. Increase weekend and evening availability of services.	10	0	0.0	1	10.0	7	70.0	0	0.0	2	20.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	2	20.0	4	40.0	4	40.0	0	0.0
k. Some other solution(s).	8	0	0.0	2	25.0	0	0.0	1	12.5	5	62.5

This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12b (N=10, 9.35% of those who answered question 10 and 47.62% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12C. **Your solution to delays in: accessing** Neuropsych therapy. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-99. Traumatic Brain Injury: Question 12C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	33	7	21.2	8	24.2	7	21.2	6	18.2	5	15.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	34	14	41.2	14	41.2	3	8.8	1	2.9	2	5.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	34	5	14.7	13	38.2	6	17.7	6	17.7	4	11.8
d. Acquire and/or improve availability of equipment.	32	2	6.3	3	9.4	10	31.3	11	34.4	6	18.8
e. Implement or increase the availability of telehealth services.	34	0	0.0	5	14.7	16	47.1	6	17.7	7	20.6
f. Improve information technology (e.g., scheduling system, electronic health record).	34	3	8.8	6	17.7	7	20.6	10	29.4	8	23.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	33	3	9.1	4	12.1	10	30.3	6	18.2	10	30.3
h. Improve personnel supervision, management, or incentives.	33	3	9.1	6	18.2	5	15.2	11	33.3	8	24.2
i. Increase weekend and evening availability of services.	32	3	9.4	5	15.6	9	28.1	11	34.4	4	12.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	33	2	6.1	9	27.3	13	39.4	7	21.2	2	6.1
k. Some other solution(s).	24	2	8.3	3	12.5	1	4.2	1	4.2	17	70.8

This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12c (N=34, 31.78% of those who answered question 10 and 73.91% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12D. **Your solution to delays in: accessing** Other mental health therapy. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-100. Traumatic Brain Injury: Question 12D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	25	2	8.0	8	32.0	8	32.0	5	20.0	2	8.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	12	48.0	8	32.0	3	12.0	1	4.0	1	4.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	24	2	8.3	6	25.0	9	37.5	6	25.0	1	4.2
d. Acquire and/or improve availability of equipment.	24	0	0.0	2	8.3	3	12.5	9	37.5	10	41.7
e. Implement or increase the availability of telehealth services.	25	2	8.0	8	32.0	12	48.0	2	8.0	1	4.0
f. Improve information technology (e.g., scheduling system, electronic health record).	23	1	4.4	2	8.7	6	26.1	8	34.8	6	26.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	24	0	0.0	3	12.5	8	33.3	6	25.0	7	29.2
h. Improve personnel supervision, management, or incentives.	24	0	0.0	7	29.2	6	25.0	6	25.0	5	20.8
i. Increase weekend and evening availability of services.	23	4	17.4	3	13.0	10	43.5	5	21.7	1	4.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	24	0	0.0	2	8.3	13	54.2	6	25.0	3	12.5
k. Some other solution(s).	11	0	0.0	2	18.2	1	9.1	1	9.2	7	63.6
This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12d (N=25, 23.81% of those who answered question 10 and 71.43% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

12E. **Your solution to delays in: accessing** Treatment from a pain clinic for refractory symptoms. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-101. Traumatic Brain Injury: Question 12E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	50	15	30.0	16	32.0	14	28.0	2	4.0	3	6.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	49	21	42.9	20	40.8	4	8.2	1	2.0	3	6.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	50	9	18.0	19	38.0	16	32.0	3	6.0	3	6.0
d. Acquire and/or improve availability of equipment.	50	6	12.0	8	16.0	18	36.0	11	22.0	7	14.0
e. Implement or increase the availability of telehealth services.	46	2	4.4	6	13.0	19	41.3	9	19.6	10	21.7
f. Improve information technology (e.g., scheduling system, electronic health record).	47	5	10.6	13	27.7	7	14.9	10	21.3	12	25.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	47	4	8.5	8	17.0	11	23.4	11	23.4	13	27.7
h. Improve personnel supervision, management, or incentives.	48	3	6.3	11	22.9	13	27.1	11	22.9	10	20.8
i. Increase weekend and evening availability of services.	47	5	10.6	6	12.8	15	31.9	13	27.7	8	17.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	48	4	8.3	8	16.7	23	47.9	8	16.7	5	10.4
k. Some other solution(s).	33	2	6.1	4	12.1	2	6.1	1	3.0	24	72.7
This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12e (N=52, 49.06% of those who answered question 10 and 82.54% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

12F. **Your solution to delays in**: **accessing** Treatment from a sleep clinic for follow-up for refractory symptoms. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-102. Traumatic Brain Injury: Question 12F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	34	5	14.7	12	35.3	9	26.5	3	8.8	5	14.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	34	8	23.5	15	44.1	7	20.6	0	0.0	4	11.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	33	5	15.2	13	39.4	9	27.3	2	6.1	4	12.1
d. Acquire and/or improve availability of equipment.	33	1	3.0	13	39.4	11	33.3	3	9.1	5	15.2
e. Implement or increase the availability of telehealth services.	34	1	2.9	2	5.9	12	35.3	4	11.8	15	44.1
f. Improve information technology (e.g., scheduling system, electronic health record).	34	2	5.9	6	17.7	7	20.6	8	23.5	11	32.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	34	2	5.9	6	17.7	5	14.7	10	29.4	11	32.4
h. Improve personnel supervision, management, or incentives.	32	1	3.1	6	18.8	8	25.0	8	25.0	9	28.1
i. Increase weekend and evening availability of services.	34	2	5.9	5	14.7	15	44.1	6	17.7	6	17.7
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	33	3	9.1	7	21.2	15	45.5	5	15.2	3	9.1
k. Some other solution(s).	22	0	0.0	3	13.6	3	13.6	1	4.6	15	68.2
This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12f (N=36, 33.96% of those who answered question 10 and 61.02% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

12G. **Your solution to delays in: accessing** Physical therapy. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-103. Traumatic Brain Injury: Question 12G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	2	18.2	4	36.4	4	36.4	1	9.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	2	18.2	4	36.4	4	36.4	0	0.0	1	9.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	0	0.0	6	54.6	4	36.4	1	9.1	0	0.0
d. Acquire and/or improve availability of equipment.	11	0	0.0	2	18.2	4	36.4	5	45.5	0	0.0
e. Implement or increase the availability of telehealth services.	11	0	0.0	2	18.2	5	45.5	2	18.2	2	18.2
f. Improve information technology (e.g., scheduling system, electronic health record).	11	2	18.2	1	9.1	4	36.4	3	27.3	1	9.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	0	0.0	0	0.0	5	45.5	5	45.5	1	9.1
h. Improve personnel supervision, management, or incentives. .	10	0	0.0	2	20	4	40.0	3	30.0	1	10.0
i. Increase weekend and evening availability of services.	11	0	0.0	3	27.3	3	27.3	3	27.3	2	18.2
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	1	9.1	3	27.3	2	18.2	3	27.3	2	18.2
k. Some other solution(s).	7	0	0.0	0	0.0	1	14.3	0.0	0.0	6	85.7
This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12g (N=12, 11.32% of those who answered question 10 and 32.43% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

12H. **Your solution to delays in: accessing** Occupational therapy. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in accessing Occupational therapy and answered 12h (N = 4).

12I. **Your solution to delays in: accessing** Speech therapy . Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in accessing Speech therapy and answered 12i (N = 9).

12J. **Your solution to delays in: accessing** Vocational rehabilitation. Think of the most effective way to reduce the number of delays that TBI patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-104. Traumatic Brain Injury: Question 12J

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	2	20.0	1	10.0	3	30.0	1	10.0	3	30.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	2	20.0	3	30.0	2	20.0	1	10.0	2	20.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	9	1	11.1	1	11.1	5	55.6	0	0.0	2	22.2
d. Acquire and/or improve availability of equipment.	10	0	0.0	1	10.0	0	0.0	2	20.0	7	70.0
e. Implement or increase the availability of telehealth services.	10	0	0.0	1	10.0	3	30.0	1	10.0	5	50.0
f. Improve information technology (e.g., scheduling system, electronic health record).	10	1	10.0	1	10.0	3	30.0	2	20.0	3	30.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	3	30.0	0	0.0	3	30.0	2	20.0	2	20.0
h. Improve personnel supervision, management, or incentives.	10	1	10.0	0	0.0	3	30.0	2	20.0	4	40.0
i. Increase weekend and evening availability of services.	10	0	0.0	1	10.0	3	30.0	2	20.0	4	40.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	1	10.0	4	40.0	1	10.0	4	40.0
k. Some other solution(s).	8	2	25.0	0	0.0	1	12.5	0	0.0	5	62.5
This question (question 12) is based on respondents who indicated that patients experienced delays in accessing ongoing TBI care (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12j (N=10, 9.52% of those who answered question 10 and 37.04% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.											

Issues that Affect Provider and System Efficiency

13. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of TBI care?

Table I-105. Traumatic Brain Injury: Question 13

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	106	44	41.5	26	24.5	13	12.3	18	17.0	5	4.7
b. Providers performing administrative activities that could be performed by others	104	17	16.3	23	22.1	25	24.0	34	32.7	5	4.8
c. Residency training/teaching requirements	105	43	41.0	26	24.8	2	1.9	3	2.9	31	29.5
d. Insufficient clinical/administrative support staff	106	15	14.2	24	22.6	25	23.6	38	35.8	4	3.8
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	106	20	18.9	14	13.2	25	23.6	42	39.6	5	4.7
f. Unnecessary documentation requirements or inefficient CPRS interface	106	10	9.4	29	27.4	25	23.6	37	34.9	5	4.7
g. Patient no-show rates	104	0	0.0	29	27.9	30	28.8	44	42.3	1	1.0
h. Poor patient flow management (room/bed turnover, appointments)	105	36	34.3	30	28.6	13	12.4	10	9.5	16	15.2
i. Too many administrative requirements (Initiatives/Policies/Programs)	104	14	13.5	25	24.0	25	24.0	33	31.7	7	6.7
j. Inadequate physical space (e.g., exam rooms) or equipment (e.g., MRI scanner)	105	26	24.8	31	29.5	22	21.0	18	17.1	8	7.6

TBI Workforce

14A. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-106. Traumatic Brain Injury: Question 14A

		Yes		No		Not Applicable	
Staff Positions	N	n	%	n	%	n	%
a. Neurologists	103	38	36.9	34	33.0	31	30.1
b. Neuro-radiologists	101	19	18.8	20	19.8	62	61.4
c. Neurological Surgeons	101	21	20.8	15	14.9	65	64.4
d. Psychiatrists	105	45	43.3	41	39.4	18	17.3
e. Physical Medicine & Rehabilitation Physicians	104	56	53.8	30	28.8	18	17.3
f. Pain Management Physicians	104	47	44.8	35	33.3	23	21.9
g. Physicians with specific training or expertise in TBI (any primary specialty)	106	35	33.0	37	34.9	34	32.1
h. Neuropsychologists	102	34	33.3	43	42.2	25	24.5
i. Other behavior health personnel	103	41	39.8	41	39.8	21	20.4
j. Physical Therapists	105	40	38.1	52	49.5	13	12.4
k. Occupational Therapists	104	28	26.9	58	55.8	18	17.3
l. Speech Therapists	103	23	22.3	51	49.5	29	28.2
m. Vocational Therapists	102	17	16.7	43	42.2	42	41.2
n. Case Managers (RN or Social Worker)	104	27	26.0	59	56.7	18	17.3

Reasons for Staff Recruitment/Hiring Problems

15. Please enter the **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types.

Table I-107. Traumatic Brain Injury: Question 15

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Neurologists	38	3	7.9	20	52.6	3	7.9	0	0.0	1	2.6	0	0.0	0	0.0	5	13.2	3	7.9	9	23.7	9	23.7	11	28.9
b. Neuro-radiologists	19	3	15.8	9	47.4	0	0.0	0	0.0	2	10.5	0	0.0	0	0.0	1	5.3	2	10.5	4	21.1	4	21.1	3	15.8
c. Neurological Surgeons	21	2	9.5	15	71.4	0	0.0	0	0.0	6	28.6	1	4.8	0	0.0	2	9.5	1	4.8	4	19.0	2	9.5	3	14.3
d. Psychiatrists	45	2	4.3	26	55.3	2	4.3	0	0.0	1	2.1	1	2.1	1	2.1	6	12.8	1	2.1	15	31.9	15	31.9	8	17.0
e. Physical Medicine & Rehabilitation Physicians	56	7	15.6	25	55.6	0	0.0	1	2.2	0	0.0	2	4.4	1	2.2	2	4.4	1	2.2	11	24.4	17	37.8	13	28.9
f. Pain Management Physicians	47	5	8.9	37	66.1	2	3.6	1	1.8	4	7.1	0	0.0	2	3.6	5	8.9	1	1.8	12	21.4	14	25.0	13	23.2
g. Physicians with specific training or expertise in TBI (any primary specialty)	35	4	11.4	22	62.9	0	0.0	1	2.9	1	2.9	0	0.0	1	2.9	2	5.7	1	2.9	11	31.4	10	28.6	7	20.0
h. Neuropsychologists	34	8	23.5	10	29.4	1	2.9	0	0.0	1	2.9	1	2.9	0	0.0	2	5.9	0	0.0	7	20.6	14	41.2	11	32.4
i. Other behavior health personnel	41	6	14.6	17	41.5	2	4.9	0	0.0	0	0.0	1	2.4	2	4.9	1	2.4	0	0.0	9	22.0	16	39.0	10	24.4
j. Physical Therapists	40	5	12.5	20	50.0	0	0.0	2	5.0	1	2.5	0	0.0	1	2.5	3	7.5	0	0.0	7	17.5	23	57.5	6	15.0
k. Occupational Therapists	28	4	14.3	15	53.6	0	0.0	1	3.6	1	3.6	1	3.6	2	7.1	2	7.1	0	0.0	3	10.7	15	53.6	4	14.3
l. Speech Therapists	23	4	17.4	11	47.8	0	0.0	0	0.0	2	8.7	0	0.0	2	8.7	1	4.3	2	8.7	4	17.4	11	47.8	4	17.4
m. Vocational Therapists	17	4	23.5	3	17.6	0	0.0	0	0.0	1	5.9	1	5.9	1	5.9	0	0.0	0	0.0	0	0.0	8	47.1	4	23.5
n. Case Managers (RN or Social Worker)	27	9	33.3	7	25.9	1	3.7	0	0.0	0	0.0	0	0.0	3	11.1	3	11.1	0	0.0	3	11.1	15	55.6	5	18.5

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring.

This question (question 15) is based on respondents who indicated that their local health care system had problems recruiting or hiring certain personnel categories (question 14A). Question 15 was asked for each personnel type marked "yes" in question 14A.

Reasons for Staff Retention Problems

14B. IN THE PAST YEAR, did your local health care system have problems **RETAINING** the following personnel categories?

Table I-108. Traumatic Brain Injury: Question 14B

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Neurologists	102	22	21.6	50	49.0	30	29.4
b. Neuro-radiologists	101	5	5.0	28	27.7	68	67.3
c. Neurological Surgeons	102	7	6.9	22	21.6	73	71.6
d. Psychiatrists	102	28	27.5	46	45.1	28	27.5
e. Physical Medicine & Rehabilitation Physicians	104	26	25.0	62	59.6	16	15.4
f. Pain Management Physicians	101	22	21.8	48	47.5	31	30.7
g. Physicians with specific training or expertise in TBI (any primary specialty)	104	19	18.3	53	51.0	32	30.8
h. Neuropsychologists	102	13	12.7	63	61.8	26	25.5
i. Other behavior health personnel	102	27	26.5	49	48.0	26	25.5
j. Physical Therapists	103	19	18.4	69	67.0	15	14.6
k. Occupational Therapists	105	12	11.4	78	74.3	15	14.3
l. Speech Therapists	100	9	9.0	75	75.0	16	16.0
m. Vocational Therapists	103	7	6.8	62	60.2	34	33.0
n. Case Managers (RN or Social Worker)	103	15	14.6	72	69.9	16	15.5

16. Please enter the **top two** reasons why there were problems **retaining** these personnel types.

Table I-109. Traumatic Brain Injury: Question 16

		Lack of opportunity for professional growth/promotion		Dissatisfaction with supervision/management support		Dissatisfaction with support staff		Dissatisfaction with physical demands of the job		Dissatisfaction with workload		Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		Organizational culture that does not prioritize/ encourage productivity		Administrative/ Program Demands		Lack of professional autonomy		Dissatisfaction with pay		Work schedule		Inadequate equipment/ resources/office space		Burnout	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Neurologists	22	4	18.2	6	27.3	1	4.5	0	0.0	8	36.4	0	0.0	1	4.5	4	18.2	1	4.5	7	31.8	2	9.1	3	13.6	5	22.7
b. Neuro-radiologists	5	1	20.0	1	20.0	0	0.0	0	0.0	2	40.0	0	0.0	0	0.0	0	0.0	0	0.0	3	60.0	1	20.0	0	0.0	0	0.0
c. Neurological Surgeons	7	0	0.0	1	14.3	0	0.0	0	0.0	2	28.6	0	0.0	0	0.0	0	0.0	1	14.3	3	42.9	0	0.0	0	0.0	0	0.0
d. Psychiatrists	28	2	7.1	5	17.9	0	0.0	0	0.0	9	32.1	2	7.1	0	0.0	3	10.7	5	17.9	12	42.9	5	17.9	0	0.0	7	25.0
e. Physical Medicine & Rehabilitation Physicians	26	4	15.4	3	11.5	0	0.0	0	0.0	6	23.1	0	0.0	1	3.8	4	15.4	1	3.8	9	34.6	6	23.1	3	11.5	9	34.6
f. Pain Management Physicians	22	0	0.0	2	9.1	1	4.5	0	0.0	7	31.8	0	0.0	0	0.0	3	13.6	2	9.1	8	36.4	3	13.6	4	18.2	5	22.7
g. Physicians with specific training or expertise in TBI (any primary specialty)	19	2	10.5	3	15.8	1	5.3	0	0.0	2	10.5	1	5.3	3	15.8	3	15.8	0	0.0	7	36.8	5	26.3	2	10.5	3	15.8
h. Neuropsychologists	13	2	15.4	2	15.4	2	15.4	0	0.0	3	23.1	0	0.0	0	0.0	1	7.7	0	0.0	4	30.8	4	30.8	0	0.0	3	23.1
i. Other behavior health personnel	27	4	14.8	2	7.4	1	3.7	1	3.7	5	18.5	0	0.0	1	3.7	5	18.5	0	0.0	6	22.2	4	14.8	0	0.0	6	22.2
j. Physical Therapists	19	5	26.3	2	10.5	1	5.3	1	5.3	3	15.8	3	15.8	0	0.0	2	10.5	1	5.3	11	57.9	2	10.5	1	5.3	4	21.1
k. Occupational Therapists	12	3	25.0	2	16.7	1	8.3	0	0.0	1	8.3	1	8.3	0	0.0	2	16.7	1	8.3	6	50.0	2	16.7	1	8.3	2	16.7
l. Speech Therapists	9	1	11.1	1	11.1	0	0.0	1	11.1	2	22.2	1	11.1	0	0.0	2	22.2	0	0.0	4	44.4	1	11.1	1	11.1	1	11.1
m. Vocational Therapists	7	2	28.6	1	14.3	0	0.0	0	0.0	0	0.0	0	0.0	2	28.6	0	0.0	0	0.0	2	28.6	0	0.0	0	0.0	1	14.3
n. Case Managers (RN or Social Worker)	15	1	6.7	4	26.7	1	6.7	1	6.7	4	26.7	1	6.7	0	0.0	5	33.3	1	6.7	1	6.7	2	13.3	1	6.7	7	46.7

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention. This question (question 16) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 14B). Question 16 was asked for each personnel type marked "yes" in question 14B.

Appendix I.1.5 5.5 ACS

Section 5: Acute Coronary Syndrome (ACS)

ACS Diagnosis and Assessment

1. Please think about patients presenting to your Emergency Department with symptoms suggestive of Acute Coronary Syndrome (ACS). **IN THE PAST 90 DAYS,** how often did patients experience delays receiving the following services? Indicate the percent of patients that experienced delays for whom the services were required.

Table I-110. Acute Coronary Syndrome: Question 1

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Completing the Emergency Department (ED) evaluation	98	48	49.0	36	36.7	5	5.1	0	0.0	0	0.0	9	9.2
b. Transfer from the ED to a short-stay observation unit (i.e., 'chest pain unit')	98	22	22.5	16	16.3	4	4.1	0	0.0	0	0.0	56	57.1
c. Transfer from the ED to a telemetry bed	98	30	30.6	36	36.7	14	14.3	2	2.0	3	3.06	13	13.3
d. Transfer from the ED to a CCU or ICU bed	98	34	34.7	38	38.8	7	7.1	0	0.0	3	3.06	16	16.3

2. Think about those ACS patients who experienced delays getting an **evaluation.** IN THE PAST 90 DAYS, which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q1 in order to identify their top three delays for Q3.

3A. **Your solution to delays in**: Completing the Emergency Department (ED) evaluation. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-111. Acute Coronary Syndrome: Question 3A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	36	13	36.1	14	38.9	6	16.7	2	5.6	1	2.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	36	4	11.1	12	33.3	16	44.4	2	5.6	2	5.6
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	35	7	20.0	15	42.9	9	25.7	2	5.7	2	5.7
d. Acquire and/or improve availability of equipment.	36	3	8.3	5	13.89	17	47.2	9	25.0	2	5.6
e. Implement or increase the availability of telehealth services.	34	0	0.0	6	17.7	11	32.4	12	35.3	5	14.7
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	36	6	16.7	7	19.4	13	36.1	8	22.2	2	5.6
g. Improve personnel supervision, management, or incentives.	36	9	25.0	7	19.4	9	25.0	10	27.8	1	2.8
h. Increase weekend and evening availability of services.	35	7	20.0	7	20.0	13	37.1	7	20.0	1	2.89
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	34	5	14.7	6	17.7	15	44.1	5	14.7	3	8.8
j. Some other solution(s).	36	8	22.2	9	25.0	9	25.0	9	25.0	1	2.8

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3a (N=36, 36.73% of those who answered question 1 and 87.8% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3B. **Your solution to delays in**: Transferring from the ED to a short –stay observation unit (i.e., "chest pain unit").Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-112. Acute Coronary Syndrome: Question 3B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	12	6	50.0	6	50.0	0	0.0	0	0.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	12	4	33.3	2	16.7	4	33.3	1	8.3	1	8.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	12	3	25.0	6	50.0	3	25.0	0	0.0	0	0.0
d. Acquire and/or improve availability of equipment.	12	2	16.7	0	0.0	6	50.0	4	33.3	0	0.0
e. Implement or increase the availability of telehealth services.	12	0	0.0	0	0.0	4	33.3	6	50.0	2	16.7
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	0	0.0	2	18.2	6	54.6	1	9.1	2	18.1
g. Improve personnel supervision, management, or incentives.	12	0	0.0	6	50.0	2	16.7	4	33.3	0	0.0
h. Increase weekend and evening availability of services.	12	2	16.7	3	25.0	4	33.3	3	25.0	0	0.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	12	0	0.0	4	33.3	6	50.0	2	16.7	0	0.0
j. Some other solution(s).	12	0	0.0	1	8.3	7	58.3	3	25.0	1	8.3

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3b (N=12, 12.24% of those who answered question 1 and 60% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3C. **Your solution to delays in**: Transferring from the ED to a telemetry bed. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-113. Acute Coronary Syndrome: Question 3C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	50	17	34.0	26	52.0	6	12.0	1	2.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	49	8	16.3	13	26.5	17	34.7	9	18.4	2	4.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	49	15	30.6	13	26.5	17	34.7	4	8.2	0	0.0
d. Acquire and/or improve availability of equipment.	50	6	12.0	6	12.0	16	32.0	19	38.0	3	6.0
e. Implement or increase the availability of telehealth services.	50	0	0.0	3	6.0	11	22.0	23	46.0	13	26.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	50	5	10.0	8	16.0	15	30.0	19	38.0	3	6.0
g. Improve personnel supervision, management, or incentives.	49	5	10.2	10	20.4	13	26.5	16	32.7	5	10.2
h. Increase weekend and evening availability of services.	50	5	10.0	14	28.0	13	26.0	14	28.0	4	8.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	48	5	10.4	13	27.1	11	22.9	14	29.2	5	10.4
j. Some other solution(s).	49	4	8.2	8	16.3	13	26.5	20	40.8	4	8.1

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3c (N=50, 51.02% of those who answered question 1 and 90.91% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3E. **Your solution to delays in**: Transferring from the ED to a CCU or ICU bed. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-114. Acute Coronary Syndrome: Question 3E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	39	19	48.7	12	30.8	6	15.4	2	5.1	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	39	11	28.2	9	23.1	11	28.2	7	18.0	1	2.6
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	39	15	38.5	12	30.8	9	23.1	3	7.7	0	0.0
d. Acquire and/or improve availability of equipment.	38	6	15.8	4	10.5	12	31.6	15	39.5	1	2.6
e. Implement or increase the availability of telehealth services.	38	1	2.6	4	10.5	4	10.5	19	50.0	10	26.3
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	39	3	7.7	8	20.5	6	15.4	18	46.2	4	10.3
g. Improve personnel supervision, management, or incentives.	39	3	7.7	8	20.5	10	25.6	15	38.5	3	7.7
h. Increase weekend and evening availability of services.	38	6	15.8	5	13.2	12	31.6	11	29.0	4	10.5
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	39	3	7.7	9	23.1	12	30.8	12	30.8	3	7.7
j. Some other solution(s).	39	4	10.3	8	20.5	6	15.4	19	48.7	2	5.1

This question (question 3) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3d (N=41, 41.84% of those who answered question 1 and 85.42% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

4. Please think about “pain-free” inpatients or observation unit patients in whom a definitive ACS diagnosis has not yet been made, or whose coronary anatomy is not yet defined. **IN THE PAST 90 DAYS,** how often were there delays in obtaining the following services? Indicate the percent of patients that experience delays for whom the service was required.

Table I-115. Acute Coronary Syndrome: Question 4

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Cardiology consultation	99	69	69.7	15	15.2	2	2.0	2	2.0	1	1.0	10	10.1
b. Echocardiography	99	46	46.5	32	32.3	9	9.1	2	2.0	1	1.0	9	9.1
c. Non-invasive coronary evaluation (e.g., nuclear stress testing)	99	35	35.4	34	34.3	10	10.1	3	3.0	3	3.0	14	14.1
d. On-site coronary angiography	99	48	48.5	11	11.1	3	3.0	0	0.0	0	0.0	37	37.4
e. Transfer to another VA health care system for coronary angiography	99	21	21.2	9	9.1	8	8.1	2	2.0	7	7.1	52	52.5
f. Transfer to non-VA facility for coronary angiography (fee-basis or contracted care)	99	40	40.4	20	20.2	6	6.1	1	1.0	0	0.0	32	32.3

5. Think about those ACS patients who experienced delays getting an **evaluation.** IN THE PAST 90 DAYS, which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q4 in order to identify their top three delays for Q6.

6A. **Your solution to delays in**: Cardiology consultation. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-116. Acute Coronary Syndrome: Question 6A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	12	3	25.0	2	16.7	2	16.7	3	25.0	2	16.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	12	4	33.3	4	33.3	2	16.7	0	0.0	2	16.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	2	18.2	5	45.5	2	18.2	1	9.1	1	9.1
d. Acquire and/or improve availability of equipment.	11	1	9.1	3	27.3	3	27.3	3	27.3	1	9.1
e. Implement or increase the availability of telehealth services.	11	0	0.0	3	27.3	2	18.2	3	27.3	3	27.3
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	12	2	16.7	3	25.0	3	25.0	2	16.7	2	16.7
g. Improve personnel supervision, management, or incentives.	12	3	25.0	2	16.7	4	33.3	2	16.7	1	8.3
h. Increase weekend and evening availability of services.	11	0	0.0	1	9.1	6	54.6	2	18.2	2	18.2
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	12	2	16.7	5	41.7	2	16.7	2	16.7	1	8.3
j. Some other solution(s).	12	2	16.7	3	25.0	3	25.0	2	16.7	2	16.7

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6a (N=13, 13.13% of those who answered question 4 and 65% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6B. **Your solution to delays in**: Echocardiography. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-117. Acute Coronary Syndrome: Question 6B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	35	6	17.1	9	25.7	9	25.7	8	22.9	3	8.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	35	6	17.1	7	20.0	11	31.4	9	25.7	2	5.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	33	12	36.4	11	33.3	7	21.2	3	9.1	0	0.0
d. Acquire and/or improve availability of equipment.	35	7	20.0	9	25.7	10	28.6	8	22.9	1	2.9
e. Implement or increase the availability of telehealth services.	35	1	2.9	2	5.7	5	14.3	14	40.0	13	37.1
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	34	5	14.7	9	26.5	6	17.7	6	17.7	8	23.5
g. Improve personnel supervision, management, or incentives.	35	2	5.7	6	17.1	10	28.6	11	31.4	6	17.1
h. Increase weekend and evening availability of services.	35	2	5.7	8	22.9	7	20.0	12	34.3	6	17.1
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	35	4	11.4	9	25.7	16	45.7	5	14.3	1	2.9
j. Some other solution(s).	34	5	14.7	4	11.8	8	23.5	12	35.3	5	14.7

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6b (N=36, 36.36% of those who answered question 4 and 81.82% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.`

6C. **Your solution to delays in**: Non-invasive coronary evaluation (e.g., nuclear stress testing). Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-118. Acute Coronary Syndrome: Question 6C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	39	5	12.8	8	20.5	10	25.6	12	30.8	4	10.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	38	4	10.5	13	34.2	10	26.3	7	18.4	4	10.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	40	8	20.0	12	30.0	10	25.0	8	20.0	2	5.0
d. Acquire and/or improve availability of equipment.	40	8	20.0	10	25.0	7	17.5	12	30.0	3	7.5
e. Implement or increase the availability of telehealth services.	40	1	2.5	3	7.5	5	12.5	19	47.5	12	30.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	39	4	10.3	3	7.7	7	18.0	17	43.6	8	20.5
g. Improve personnel supervision, management, or incentives.	40	5	12.5	3	7.5	8	20.0	17	42.5	7	17.5
h. Increase weekend and evening availability of services.	40	3	7.5	7	17.5	10	25.0	14	35.0	6	15.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	40	6	15.0	9	22.5	9	22.5	9	22.5	7	17.5
j. Some other solution(s).	38	5	13.2	6	15.8	9	23.7	11	29 .0	7	18.4

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6c (N=41, 41.41% of those who answered question 4 and 82% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6D. **Your solution to delays in**: On-site coronary angiography. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-119. Acute Coronary Syndrome: Question 6D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	5	50.0	1	10.0	2	20.0	2	20.0	0	0.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	3	30.0	2	20.0	3	30.0	2	20.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	3	30.0	5	50.0	1	10.0	1	10.0	0	0.0
d. Acquire and/or improve availability of equipment.	10	4	40.0	2	20.0	1	10.0	3	30.0	0	0.0
e. Implement or increase the availability of telehealth services.	10	0	0.0	2	20.0	0	0.0	7	70.0	1	10.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	0	0.0	3	30.0	1	10.0	6	60.0	0	0.0
g. Improve personnel supervision, management, or incentives.	10	1	10.0	1	10.0	1	10.0	6	60.0	1	10.0
h. Increase weekend and evening availability of services.	9	0	0.0	1	11.1	2	22.2	6	66.7	0	0.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	4	40.0	3	30.0	3	30.0	0	0.0	0	0.0
j. Some other solution(s).	10	2	20.0	2	20.0	2	20.0	4	40.0	0	0.0

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6d (N=10, 10.1% of those who answered question 4 and 71.43% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6E. **Your solution to delays in**: Transfer to another VA health care system for coronary angiography. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-120. Acute Coronary Syndrome: Question 6E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	22	6	27.3	4	18.2	4	18.2	4	18.2	4	18.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	22	4	18.2	6	27.3	2	9.1	8	36.4	2	9.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	22	3	13.6	2	9.1	7	31.8	8	36.4	2	9.1
d. Acquire and/or improve availability of equipment.	22	1	4.6	2	9.1	5	22.7	10	45.5	4	18.2
e. Implement or increase the availability of telehealth services.	22	0	0.0	0	0.0	4	18.2	10	45.5	8	36.4
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	22	1	4.6	1	4.6	5	22.7	11	50.0	4	18.2
g. Improve personnel supervision, management, or incentives.	21	3	14.3	7	33.3	3	14.3	6	28.6	2	9.5
h. Increase weekend and evening availability of services.	19	3	15.8	4	21.1	4	21.1	6	31.6	2	10.5
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	20	3	15.0	4	20.0	6	30.0	3	15.0	4	20.0
j. Some other solution(s).	22	8	36.4	3	13.6	4	18.2	5	22.7	2	9.1

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6e (N=22, 22.22% of those who answered question 4 and 84.62% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6F. **Your solution to delays in**: Transfer to non-VA facility for coronary angiography (fee-basis or contracted care). Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-121. Acute Coronary Syndrome: Question 6F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	20	4	20.0	1	5.0	2	10.0	6	30.0	7	35.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	20	4	20.0	4	20.0	1	5.0	7	35.0	4	20.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	20	6	30.0	0	0.0	3	15.0	6	30.0	5	25.0
d. Acquire and/or improve availability of equipment.	20	4	20.0	0	0.0	3	15.0	7	35.0	6	30.0
e. Implement or increase the availability of telehealth services.	20	1	5.0	2	10.0	1	5.0	8	40.0	8	40.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	20	3	15.0	1	5.0	3	15.0	7	35.0	6	30.0
g. Improve personnel supervision, management, or incentives. .	20	7	35.0	2	10.0	1	5.0	7	35.0	3	15.0
h. Increase weekend and evening availability of services.	20	2	10.0	4	20.0	3	15.0	8	40.0	3	15.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	19	6	31.6	3	15.8	4	21.2	1	5.3	5	26.3
j. Some other solution(s).	20	8	40.0	3	15.0	5	25.0	3	15.0	1	5.0

This question (question 6) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6f (N=20, 20.2% of those who answered question 4 and 74.07% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

ACS Treatment

7. Think about patients who present to your **local VA health care system** with STEMI. **IN THE PAST YEAR**, how often were there delays in the following services?

Table I-122. Acute Coronary Syndrome: Question 7

		No Delay (%)		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Emergency department activation of STEMI protocol	97	48	49.5	27	27.8	8	8.3	2	2.1	0	0	12	12.4
b. Primary PCI at an on-site catheterization laboratory	99	36	36.4	8	8.1	4	4	2	2	0	0	49	49.5
c. Primary PCI at a different VA facility (via transfer)	98	11	11.2	6	6.1	2	2	2	2	0	0	77	78.6
d. Primary PCI at a non-VA facility (via transfer)	99	33	33.3	25	25.3	6	6.1	3	3	0	0	32	32.3
e. Thrombolytic therapy	99	25	25.3	8	8.1	0	0	0	0	0	0	66	66.7

8. Think about those ACS patients who experienced delays getting an **evaluation.** IN THE PAST 90 DAYS, which of these delays had the **most negative impact on patients**?
Results not presented. Respondents were only asked this question if they identified more than three delays in Q7 in order to identify their top three delays for Q9.

9A. **Your solution to delays in:** Emergency department activation of STEMI protocol**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-123. Acute Coronary Syndrome: Question 9A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	34	3	8.8	10	29.4	7	20.6	12	35.3	2	5.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	34	7	20.6	8	23.5	7	20.6	12	35.3	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	33	7	21.2	9	27.3	6	18.2	11	33.3	0	0.0
d. Acquire and/or improve availability of equipment.	34	4	11.8	2	5.9	8	23.5	19	55.9	1	2.9
e. Implement or increase the availability of telehealth services.	34	1	2.9	1	2.9	11	32.4	15	44.1	6	17.7
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	34	3	8.8	6	17.7	8	23.5	14	41.2	3	8.8
g. Improve personnel supervision, management, or incentives.	33	7	21.2	4	12.1	5	15.2	14	42.4	3	9.1
h. Increase weekend and evening availability of services.	34	5	14.7	6	17.7	10	29.4	12	35.3	1	2.9
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	34	5	14.7	4	11.8	8	23.5	11	32.4	6	17.7
j. Some other solution(s).	34	6	17.7	6	17.7	8	23.5	11	32.4	3	8.8

This question (question 9) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9a (N=34, 35.05% of those who answered question 7 and 91.89% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9B. **Your solution to delays in:** Primary PCI at an on-site catheterization laboratory**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-124. Acute Coronary Syndrome: Question 9B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	14	5	35.7	0	0.0	3	21.4	4	28.6	2	14.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	14	5	35.7	4	28.6	1	7.1	2	14.3	2	14.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	14	5	35.7	4	28.6	1	7.1	2	14.3	2	14.3
d. Acquire and/or improve availability of equipment.	14	3	21.4	3	21.4	1	7.1	5	35.7	2	14.3
e. Implement or increase the availability of telehealth services.	14	1	7.1	1	7.1	2	14.3	5	35.7	5	35.7
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	14	2	14.3	3	21.4	1	7.1	4	28.6	4	28.6
g. Improve personnel supervision, management, or incentives.	14	2	14.3	3	21.4	1	7.1	5	35.7	3	21.4
h. Increase weekend and evening availability of services.	14	3	21.4	3	21.4	1	7.1	4	28.6	3	21.4
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	6	42.9	2	14.3	3	21.4	0	0.0	3	21.4
j. Some other solution(s).	14	3	21.4	1	7.1	3	21.4	3	21.4	4	28.6

This question (question 9) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9b (N=14, 14.14% of those who answered question 7 and 100% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9C. **Your solution to delays in:** Primary PCI at a different VA facility (via transfer)**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-125. Acute Coronary Syndrome: Question 9C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	10	5	50.0	2	20.0	1	10.0	1	10.0	1	10.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	10	3	30.0	3	30.0	2	20.0	1	10.0	1	10.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	10	2	20.0	3	30.0	2	20.0	2	20.0	1	10.0
d. Acquire and/or improve availability of equipment.	10	1	10.0	1	10.0	3	30.0	3	30.0	2	20.0
e. Implement or increase the availability of telehealth services.	9	1	11.1	1	11.1	2	22.2	4	44.4	1	11.1
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	10	1	10.0	1	10.0	1	10.0	6	60.0	1	10.0
g. Improve personnel supervision, management, or incentives.	9	2	22.2	1	11.1	2	22.2	3	33.3	1	11.1
h. Increase weekend and evening availability of services.	10	1	10.0	1	10.0	1	10.0	5	50.0	2	20.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	2	20.0	1	10.0	2	20.0	3	30.0	2	20.0
j. Some other solution(s).	10	1	10.0	0	0.0	3	30.0	4	40.0	2	20.0

This question (question 9) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9c (N=10, 10.2% of those who answered question 7 and 100% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9D. **Your solution to delays in:** Primary PCI at a non-VA facility (via transfer)**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-126. Acute Coronary Syndrome: Question 9D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	33	4	12.1	6	18.2	1	3.0	12	36.4	10	30.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	33	5	15.2	3	9.1	4	12.1	12	36.4	9	27.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	33	5	15.2	5	15.2	5	15.2	9	27.3	9	27.3
d. Acquire and/or improve availability of equipment.	33	6	18.2	3	9.1	2	6.1	11	33.3	11	33.3
e. Implement or increase the availability of telehealth services.	32	2	6.3	2	6.3	5	15.6	8	25.0	15	46.9
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	32	3	9.4	3	9.4	5	15.6	10	31.3	11	34.4
g. Improve personnel supervision, management, or incentives.	33	5	15.2	2	6.1	6	18.2	10	30.3	10	30.3
h. Increase weekend and evening availability of services.	33	4	12.1	8	24.2	4	12.1	8	24.2	9	27.3
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	33	4	12.1	7	21.2	6	18.2	4	12.1	12	36.4
j. Some other solution(s).	32	9	28.1	3	9.4	11	34.4	4	12.5	5	15.6

This question (question 9) is based on respondents who indicated that patients experienced delays in getting an evaluation (question 7). If 1-3 delays were mentioned in question 7, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 7, this question was repeated for the top three delays mentioned in question 8. Respondents were eligible to answer question 9d (N=33, 33.33% of those who answered question 7 and 97.06% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

9E. **Your solution to delays in:** Thrombolytic therapy**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in accessing Thrombolytic therapy and answered 9e (N = 4).

10. Please think about inpatients who have already undergone diagnostic catheterization, are currently pain-free, but who have one or more unstable coronary lesions. **IN THE PAST 90 DAYS**, how often were there delays in getting the following services?

Table I-127. Acute Coronary Syndrome: Question 10

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. On-site Percutaneous Coronary Intervention (PCI)	99	38	38.4	13	13.1	3	3	0	0	0	0	45	45.5
b. Transfer to another VA facility for PCI	98	16	16.3	10	10.2	6	6.1	1	1	2	2	63	64.3
c. Transfer to a non-VA facility for PCI	98	38	38.8	23	23.5	2	2	0	0	0	0	35	35.7
d. On-site CABG	98	11	11.2	5	5.1	12	12.2	1	1	2	2	67	68.4
e. Transfer to another VA facility for CABG	99	15	15.2	11	11.1	10	10.1	6	6.1	6	6.1	51	51.5
f. Transfer to a non-VA facility for CABG	99	39	39.4	20	20.2	3	3	1	1	2	2	34	34.3

11. Think about those ACS patients who experienced delays getting the following services. **IN THE PAST 90 DAYS,** which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q10 in order to identify their top three delays for Q12.

12A. **Your solution to delays in:** On-site Percutaneous Coronary Intervention (PCI)**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-128. Acute Coronary Syndrome: Question 12A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	13	7	53.9	1	7.7	1	7.7	2	15.4	2	15.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	13	6	46.2	1	7.7	1	7.7	3	23.1	2	15.4
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	13	5	38.5	5	38.5	1	7.7	1	7.7	1	7.7
d. Acquire and/or improve availability of equipment.	13	6	46.2	1	7.7	1	7.7	3	23.1	2	15.4
e. Implement or increase the availability of telehealth services.	13	2	15.4	1	7.7	0	0.0	7	53.9	3	23.1
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	13	2	15.4	1	7.7	3	23.1	5	38.5	2	15.4
g. Improve personnel supervision, management, or incentives.	13	2	15.4	0	0.0	4	30.8	5	38.5	2	15.4
h. Increase weekend and evening availability of services.	13	2	15.4	2	15.4	3	23.1	4	30.8	2	15.4
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	13	3	23.1	2	15.4	3	23.1	2	15.4	3	23.1
j. Some other solution(s).	13	4	30.8	1	7.7	3	23.1	1	7.7	4	30.8

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12a (N=14, 14.14% of those who answered question 10 and 87.5% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12B. **Your solution to delays in:** Transfer to another VA facility for PCI**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-129. Acute Coronary Syndrome: Question 12B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	16	6	37.5	3	18.8	2	12.5	2	12.5	3	18.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	16	4	25.0	2	12.5	3	18.8	3	18.8	4	25.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	16	5	31.3	1	6.3	3	18.8	3	18.8	4	25.0
d. Acquire and/or improve availability of equipment.	16	2	12.5	2	12.5	4	25.0	3	18.8	5	31.3
e. Implement or increase the availability of telehealth services.	16	0	0.0	1	6.3	3	18.8	6	37.5	6	37.5
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	15	0	0.0	3	20.0	2	13.3	8	53.3	2	13.3
g. Improve personnel supervision, management, or incentives.	15	2	13.3	4	26.7	3	20.0	5	33.3	1	6.7
h. Increase weekend and evening availability of services.	14	2	14.3	2	14.3	4	28.6	6	42.9	0	0.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	2	14.3	1	7.1	5	35.7	4	28.6	2	14.3
j. Some other solution(s).	15	3	20	4	26.7	3	20.0	4	26.6	1	6.7

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12b (N=16, 16.33% of those who answered question 10 and 84.21% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12C. **Your solution to delays in:** Transfer to a non-VA facility for PCI**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-130. Acute Coronary Syndrome: Question 12C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	2	11.8	1	5.9	2	11.8	8	47.1	4	23.5
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	2	11.8	3	17.7	2	11.8	6	35.3	4	23.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	2	11.8	3	17.7	2	11.8	7	41.2	3	17.7
d. Acquire and/or improve availability of equipment.	17	2	11.8	1	5.9	1	5.9	7	41.2	6	35.3
e. Implement or increase the availability of telehealth services.	16	0	0.0	2	12.5	3	18.8	7	43.8	4	25.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	16	1	6.3	1	6.3	5	31.3	5	31.3	4	25.0
g. Improve personnel supervision, management, or incentives.	17	2	11.8	1	5.9	3	17.7	6	35.3	5	29.4
h. Increase weekend and evening availability of services.	16	0	0.0	3	18.8	2	12.5	6	37.5	5	31.3
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	15	0	0.0	3	20	4	26.7	5	33.3	3	20.0
j. Some other solution(s).	17	3	17.7	2	11.8	8	47.1	3	17.7	1	5.9

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12c (N=21, 21.43% of those who answered question 10 and 84% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12D. **Your solution to delays in:** On-site CABG**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-131. Acute Coronary Syndrome: Question 12D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	21	5	23.8	4	19.1	6	28.6	5	23.8	1	4.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	21	9	42.9	8	38.1	3	14.3	1	4.8	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	21	6	28.6	9	42.9	4	19.1	1	4.8	1	4.8
d. Acquire and/or improve availability of equipment.	21	4	19.1	2	9.5	4	19.1	9	42.9	2	9.5
e. Implement or increase the availability of telehealth services.	21	1	4.8	3	14.3	0	0.0	14	66.7	3	14.3
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	21	3	14.3	1	4.8	2	9.5	11	52.4	4	19.1
g. Improve personnel supervision, management, or incentives.	21	4	19.1	1	4.8	3	14.3	10	47.6	3	14.3
h. Increase weekend and evening availability of services.	21	3	14.3	4	19.1	3	14.3	8	38.1	3	14.3
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	21	4	19.1	3	14.3	8	38.1	3	14.3	3	14.3
j. Some other solution(s). .	21	5	23.8	1	4.8	4	19.1	8	38.1	3	14.3

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12d (N=21, 21.43% of those who answered question 10 and 105% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12E. **Your solution to delays in:** Transfer to another VA facility for CABG**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-132. Acute Coronary Syndrome: Question 12E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	28	9	32.1	2	7.1	4	14.3	6	21.4	7	25.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	28	8	28.6	5	17.9	3	10.7	9	32.1	3	10.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff). .	28	6	21.4	3	10.7	5	17.9	9	32.1	5	17.9
d. Acquire and/or improve availability of equipment.	28	4	14.3	2	7.1	3	10.7	10	35.7	9	32.1
e. Implement or increase the availability of telehealth services.	28	1	3.6	3	10.7	3	10.7	12	42.9	9	32.1
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	28	2	7.1	5	17.9	4	14.3	12	42.9	5	17.9
g. Improve personnel supervision, management, or incentives.	28	3	10.7	6	21.4	6	21.4	8	28.6	5	17.9
h. Increase weekend and evening availability of services.	28	7	25.0	2	7.1	6	21.4	8	28.6	5	17.9
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	28	7	25.0	3	10.7	7	25.0	6	21.4	5	17.9
j. Some other solution(s).	28	8	28.6	8	28.6	5	17.9	4	14.3	3	10.7

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12e (N=31, 31.31% of those who answered question 10 and 93.94% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

12F. **Your solution to delays in:** Transfer to a non-VA facility for CABG**.** Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-133. Acute Coronary Syndrome: Question 12F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	23	4	17.4	1	4.4	6	26.1	5	21.7	7	30.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	23	5	21.7	3	13.0	2	8.7	6	26.1	7	30.4
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	21	3	14.3	1	4.8	4	19.1	7	33.3	6	28.6
d. Acquire and/or improve availability of equipment.	22	4	18.2	1	4.6	3	13.6	6	27.3	8	36.36
e. Implement or increase the availability of telehealth services.	23	1	4.4	2	8.7	1	4.4	9	39.1	10	43.5
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	23	2	8.7	3	13.0	3	13.0	7	30.4	8	34.8
g. Improve personnel supervision, management, or incentives.	22	7	31.8	0	0.0	3	13.6	9	40.9	3	13.6
h. Increase weekend and evening availability of services.	22	3	13.6	2	9.1	3	13.6	9	40.9	5	22.7
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	23	4	17.4	2	8.7	5	21.7	4	17.4	8	34.8
j. Some other solution(s).	23	6	26.1	3	13.0	8	34.8	3	13.0	3	13.0

This question (question 12) is based on respondents who indicated that patients experienced delays in getting services (question 10). If 1-3 delays were mentioned in question 10, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 10, this question was repeated for the top three delays mentioned in question 11. Respondents were eligible to answer question 12f (N=24, 24.24% of those who answered question 10 and 92.31% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

13. Please think about times when you are called about a stable ACS patient who is at another facility (VA or non-VA, ER or inpatient). IN THE PAST 90 DAYS, how often were there delays **transferring patients from an outside hospital to your hospital for further evaluation?**

Table I-134. Acute Coronary Syndrome: Question 13

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Transferring patients from an outside hospital to your hospital for further evaluation.	98	24	24.5	16	16.3	3	3.1	4	4.1	25	25.5	26	26.5

14. Think of the most effective way to reduce the number of delays that **ACS patients experience when transferring from an outside hospital to your hospital for further evaluation.** Now, **in your solution, how important are each of the following elements**?

Table I-135. Acute Coronary Syndrome: Question 14

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	47	26	55.3	14	29.8	5	10.6	1	2.1	1	2.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	47	8	17.0	13	27.7	9	19.1	13	27.7	4	8.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	47	11	23.4	13	27.7	13	27.7	6	12.8	4	8.5
d. Acquire and/or improve availability of equipment.	47	7	14.9	4	8.5	6	12.8	20	42.6	10	21.3
e. Implement or increase the availability of telehealth services	46	2	4.3	2	4.3	7	15.2	14	30.4	21	45.7
f. Improve information technology (e.g., scheduling system, electronic health record).	46	4	8.7	4	8.7	8	17.4	17	37.0	13	28.3
g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	46	4	8.7	4	8.7	13	28.3	12	26.1	13	28.3
h. Improve personnel supervision, management, or incentives.	46	4	8.7	9	19.6	9	19.6	13	28.3	11	23.9
i. Increase weekend and evening availability of services	47	6	12.8	7	14.9	12	25.5	12	25.5	10	21.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	46	5	10.9	5	10.9	7	15.2	12	26.1	17	37.0
k. Some other solution(s).	41	7	17.1	2	4.9	4	9.8	4	9.8	24	58.5
This question (question 14) is based on respondents who indicated that patients experienced delays (n=48) in transferring from an outside hospital to the respondent's hospital for further evaluation (question 13).											

15. Please think about ACS patients who have been discharged from the hospital. **IN THE PAST 90 DAYS**, how often were there delays in obtaining the following services?

Table I-136. Acute Coronary Syndrome: Question 15

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Follow-up cardiology clinic appointments (PCI)	98	51	52.0	25	25.5	11	11.2	3	3.1	1	1.0	7	7.1
b. Non-invasive coronary evaluation (e.g., nuclear stress testing) as outpatients	96	49	51.0	22	22.9	9	9.4	2	2.1	4	4.2	10	10.4
c. Initial CT surgery appointment for patients referred for possible elective CABG	97	31	32.0	21	21.7	7	7.2	6	6.2	3	3.1	29	29.9
d. Pre-operative testing (e.g., carotid ultrasound) for patients under consideration for elective CABG	97	55	56.7	18	18.6	5	5.2	1	1.0	1	1.0	17	17.5
e. Elective CABG surgery	97	34	35.1	17	17.5	13	13.4	5	5.2	6	6.2	22	22.7
f. Elective (or otherwise non-emergent) angiography or PCI	97	57	58.8	16	16.5	4	4.1	0	0.0	0	0.0	20	20.6

16. Think about those ACS patients who experienced delays getting services after being discharged from the hospital. IN THE PAST 90 DAYS, which of these delays had the **most negative impact on patients**?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q15 in order to identify their top three delays for Q17.

17A. **Your solution for delays in:** Follow-up cardiology clinic appointments (PCI). Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-137. Acute Coronary Syndrome: Question 17A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	32	17	53.1	6	18.8	5	15.6	3	9.4	1	3.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	32	18	56.3	8	25.0	3	9.4	1	3.1	2	6.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	32	12	37.5	9	28.1	8	25.0	2	6.3	1	3.1
d. Acquire and/or improve availability of equipment.	31	4	12.9	3	9.7	5	16.1	13	41.9	6	19.4
e. Implement or increase the availability of telehealth services.	32	1	3.1	8	25.0	6	18.8	11	34.4	6	18.8
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	31	7	22.6	5	16.1	5	16.1	8	25.8	6	19.4
g. Improve personnel supervision, management, or incentives.	30	4	13.3	5	16.7	12	40.0	4	13.3	5	16.7
h. Increase weekend and evening availability of services.	32	4	12.5	4	12.5	8	25.0	8	25.0	8	25.0
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	32	1	3.1	3	9.4	11	34.4	12	37.5	5	15.6
j. Some other solution(s). .	32	1	3.1	6	18.8	9	28.1	10	31.3	6	18.8

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17a (N=33, 33.67% of those who answered question 15 and 82.5% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

17B. **Your solution for delays in:** Non-invasive coronary evaluation (e.g., nuclear stress testing) as outpatients. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-138. Acute Coronary Syndrome: Question 17B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	28	6	21.4	9	32.1	4	14.3	8	28.6	1	3.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	28	5	17.9	12	42.9	7	25.0	2	7.1	2	7.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	28	5	17.9	12	42.9	10	35.7	0	0.0	1	3.6
d. Acquire and/or improve availability of equipment.	28	5	17.9	8	28.6	5	17.9	7	25.0	3	10.7
e. Implement or increase the availability of telehealth services.	28	0	0.0	2	7.1	1	3.6	17	60.7	8	28.6
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	27	4	14.8	2	7.4	5	18.5	10	37.0	6	22.2
g. Improve personnel supervision, management, or incentives.	28	1	3.6	5	17.9	6	21.4	10	35.7	6	21.4
h. Increase weekend and evening availability of services.	28	1	3.6	4	14.3	7	25.0	10	35.7	6	21.4
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	28	0	0.0	7	25.0	7	25.0	9	32.1	5	17.9
j. Some other solution(s).	27	4	14.8	3	11.1	6	22.2	11	40.7	3	11.1

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17b (N=28, 29.17% of those who answered question 15 and 75.68% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

17C. **Your solution for delays in:** Initial CT surgery appointment for patients referred for possible elective CABG. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-139. Acute Coronary Syndrome: Question 17C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	29	4	13.8	5	17.2	3	10.3	10	34.5	7	24.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	30	10	33.3	8	26.7	4	13.3	7	23.3	1	3.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	28	5	17.9	5	17.9	7	25.0	8	28.6	3	10.7
d. Acquire and/or improve availability of equipment.	29	2	6.9	6	20.7	2	6.9	12	41.4	7	24.1
e. Implement or increase the availability of telehealth services.	29	1	3.5	2	6.9	9	31.0	10	34.5	7	24.1
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	28	3	10.7	4	14.3	7	25.0	9	32.1	5	17.9
g. Improve personnel supervision, management, or incentives.	30	5	16.7	4	13.3	6	20.0	10	33.3	5	16.7
h. Increase weekend and evening availability of services.	29	5	17.2	4	13.8	9	31.0	8	27.6	3	10.3
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	29	3	10.3	5	17.2	4	13.8	10	34.5	7	24.1
j. Some other solution(s).	30	7	23.3	5	16.7	5	16.7	5	16.7	8	26.7

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17c (N=31, 31.96% of those who answered question 15 and 83.78% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

17D. **Your solution for delays in:** Pre-operative testing (e.g., carotid ultrasound) for patients under consideration for elective CABG. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-140. Acute Coronary Syndrome: Question 17D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	2	11.8	5	29.4	7	41.2	0	0.0	3	17.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	1	5.9	4	23.5	5	29.4	1	5.9	6	35.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	15	0	0.0	7	46.7	7	46.7	0	0.0	1	6.7
d. Acquire and/or improve availability of equipment.	17	2	11.8	3	17.7	7	41.2	2	11.8	3	17.7
e. Implement or increase the availability of telehealth services.	16	0	0.0	2	12.5	4	25.0	2	12.5	8	50.0
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	16	1	6.3	1	6.3	8	50.0	0	0.0	6	37.5
g. Improve personnel supervision, management, or incentives.	16	0	0.0	3	18.8	5	31.3	2	12.5	6	37.5
h. Increase weekend and evening availability of services.	17	2	11.8	0	0.0	7	41.2	3	17.7	5	29.4
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	16	2	12.5	1	6.3	10	62.5	2	12.5	1	6.3
j. Some other solution(s).	17	1	5.9	3	17.7	7	41.2	2	11.8	4	23.5

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17d (N=17, 17.53% of those who answered question 15 and 68% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

17E. **Your solution for delays in:** Elective CABG surgery. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-141. Acute Coronary Syndrome: Question 17E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	34	11	32.4	3	8.8	5	14.7	11	32.4	4	11.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	34	13	38.2	6	17.7	6	17.7	6	17.7	3	8.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	34	7	20.6	7	20.6	7	20.6	9	26.5	4	11.8
d. Acquire and/or improve availability of equipment.	34	5	14.7	2	5.9	6	17.7	13	38.2	8	23.5
e. Implement or increase the availability of telehealth services.	34	2	5.9	2	5.9	6	17.7	13	38.2	11	32.4
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	33	3	9.1	4	12.1	7	21.2	11	33.3	8	24.2
g. Improve personnel supervision, management, or incentives.	32	4	12.5	7	21.9	5	15.6	9	28.1	7	21.9
h. Increase weekend and evening availability of services.	34	4	11.8	8	23.5	6	17.7	11	32.4	5	14.7
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	33	5	15.2	5	15.2	6	18.2	12	36.4	5	15.2
j. Some other solution(s).	34	8	23.5	4	11.8	9	26.5	5	14.7	8	23.5

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17e (N=34, 35.05% of those who answered question 15 and 82.93% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

17F. **Your solution for delays in:** Elective (or otherwise non-emergent) angiography or PCI. Think of the most effective way to reduce the number of delays that ACS patients experience at this junction. Now, **in your solution, how important are each of the following elements?**

Table I-142. Acute Coronary Syndrome: Question 17F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	1	9.1	3	27.3	1	9.1	4	36.4	2	18.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	1	9.1	1	9.1	5	45.5	2	18.2	2	18.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	1	9.1	2	18.2	2	18.2	4	36.4	2	18.2
d. Acquire and/or improve availability of equipment.	11	2	18.2	1	9.1	0	0.0	6	54.6	2	18.2
e. Implement or increase the availability of telehealth services.	11	0	0.0	0	0.0	2	18.2	7	63.6	2	18.2
f. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	1	9.1	0	0.0	3	27.3	5	45.5	2	18.2
g. Improve personnel supervision, management, or incentives.	11	0	0.0	1	9.1	2	18.2	7	63.6	1	9.1
h. Increase weekend and evening availability of services.	11	1	9.1	0	0.0	3	27.3	6	54.6	1	9.1
i. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	1	9.1	0	0.0	3	27.3	6	54.6	1	9.1
j. Some other solution(s).	11	2	18.2	2	18.2	1	9.1	5	45.5	1	9.1

This question (question 17) is based on respondents who indicated that patients experienced delays in getting services after being discharged from the hospital (question 15). If 1-3 delays were mentioned in question 15, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 15, this question was repeated for the top three delays mentioned in question 16. Respondents were eligible to answer question 17f (N=12, 12.37% of those who answered question 15 and 60% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

Issues that Affect Provider and System Efficiency

18. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of care for ACS patients?

Table I-143. Acute Coronary Syndrome: Question 18

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	98	30	30.6	30	30.6	19	19.4	13	13.3	6	6.1
b. Providers performing administrative activities that could be performed by others	98	13	13.3	20	20.4	32	32.7	28	28.6	5	5.1
c. Residency training/teaching requirements	98	39	39.8	20	20.4	15	15.3	6	6.1	18	18.4
d. Insufficient clinical/administrative support staff	98	12	12.2	16	16.3	22	22.4	43	43.9	5	5.1
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	98	12	12.2	27	27.6	20	20.4	32	32.7	7	7.1
f. Unnecessary documentation requirements or inefficient CPRS interface	97	19	19.6	27	27.8	19	19.6	27	27.8	5	5.2
g. Patient no-show rates	98	13	13.3	48	49	28	28.6	1	1.0	8	8.2
h. Poor patient flow management (room/bed turnover, appointments)	98	18	18.4	38	38.8	19	19.4	14	14.3	9	9.2
i. Too many administrative requirements (Initiatives/Policies/Programs)	98	15	15.3	19	19.4	21	21.4	36	36.7	7	7.1
j. Inadequate number of staffed inpatient beds	98	19	19.4	21	21.4	16	16.3	31	31.6	11	11.2
k. Inefficient processes related to outmoded or suboptimal physical infrastructure (e.g., catheterization laboratory) or equipment	98	25	25.5	22	22.4	18	18.4	13	13.3	20	20.4
l. Delays in obtaining specialized supplies or devices (e.g., catheters or defibrillators)	98	35	35.7	21	21.4	12	12.2	9	9.2	21	21.4

ACS Workforce

19A. IN THE PAST YEAR, did your facility have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-144. Acute Coronary Syndrome: Question 19A

	N	Yes		No		Not Applicable	
Staff Positions	N	n	%	n	%	n	%
a. Cardiologists (interventional)	97	17	17.5	32	33.0	48	49.5
b. Cardiologists (echocardiography)	97	26	26.8	34	35.1	37	38.1
c. Cardiologists (electrophysiology)	97	22	22.7	21	21.6	54	55.7
d. Cardiologists (general)	98	35	35.7	37	37.8	26	26.5
e. Cardiothoracic Surgeons	98	15	15.3	17	17.3	66	67.3
f. Physician Assistants or Nurse Practitioners with expertise in cardiology	98	30	30.6	36	36.7	32	32.7
g. RN Cardiovascular Specialists	96	25	26.0	22	22.9	49	51.0
h. Echocardiography Technicians	98	39	39.8	35	35.7	24	24.5
i. Catheterization Lab Technicians	98	25	25.5	26	26.5	47	48.0
j. Perfusionists	96	7	7.3	15	15.6	74	77.1
k. Emergency physicians	96	37	38.5	27	28.1	32	33.3

Reasons for Staff Recruitment/Hiring Problems

20. Please enter **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types in the PAST YEAR. Use the drop-down menu to select the top two reasons per personnel type.

Table I-145. Acute Coronary Syndrome: Question 20

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Position	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Cardiologists (interventional)	17	1	5.9	14	82.4	1	5.9	0	0.0	3	17.6	0	0.0	1	5.9	2	11.8	2	11.8	1	5.9	6	35.3	3	17.6
b. Cardiologists (echocardiography)	26	2	7.7	22	84.6	2	7.7	0	0.0	2	7.7	1	3.8	2	7.7	3	11.5	2	7.7	1	3.8	13	50.0	1	3.8
c. Cardiologists (electrophysiology)	22	3	13.6	14	63.6	2	9.1	0	0.0	3	13.6	1	4.5	2	9.1	4	18.2	2	9.1	1	4.5	3	13.6	7	31.8
d. Cardiologists (general)	35	4	11.4	27	77.1	0	0.0	0	0.0	0	0.0	0	0.0	1	2.9	5	14.3	2	5.7	5	14.3	14	40.0	7	20.0
e. Cardiothoracic Surgeons	15	1	6.7	11	73.3	1	6.7	0	0.0	1	6.7	0	0.0	0	0.0	2	13.3	2	13.3	0	0.0	5	33.3	2	13.3
f. Physician Assistants or Nurse Practitioners with expertise in cardiology	30	5	16.7	20	66.7	1	3.3	0	0.0	1	3.3	2	6.7	1	3.3	2	6.7	0	0.0	2	6.7	16	53.3	4	13.3
g. RN Cardiovascular Specialists	25	7	28.0	17	68.0	2	8.0	0	0.0	0	0.0	0	0.0	0	0.0	1	4.0	0	0.0	2	8.0	13	52.0	6	24.0
h. Echocardiography Technicians	39	9	23.1	28	71.8	1	2.6	0	0.0	1	2.6	1	2.6	0	0.0	0	0.0	0	0.0	3	7.7	25	64.1	6	15.4
i. Catheterization Lab Technicians	25	5	20.0	22	88.0	3	12.0	1	4.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	15	60.0	3	12.0
j. Perfusionists	7	1	14.3	4	57.1	0	0.0	0	0.0	0	0.0	1	14.3	1	14.3	1	14.3	0	0.0	0	0.0	4	57.1	0	0.0
k. Emergency physicians	37	0	0.0	29	78.4	3	8.1	0	0.0	1	2.7	1	2.7	0	0.0	7	18.9	0	0.0	8	21.6	11	29.7	9	24.3

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring.
This question (question 20) is based on respondents who indicated that their facility had problems recruiting or hiring certain personnel categories (question 19A). Question 20 was asked for each personnel type marked "yes" in question 19A.

Reasons for Staff Retention Problems

19B. IN THE PAST YEAR, did your facility have problems **RETAINING** the following personnel categories?

Table I-146. Acute Coronary Syndrome: Question 19B

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Cardiologists (interventional)	98	11	11.2	50	51.0	37	37.8
b. Cardiologists (echocardiography)	98	9	9.2	58	59.2	31	31.6
c. Cardiologists (electrophysiology)	97	8	8.2	40	41.2	49	50.5
d. Cardiologists (general)	95	11	11.6	63	66.3	21	22.1
e. Cardiothoracic Surgeons	97	6	6.2	29	29.9	62	63.9
f. Physician Assistants or Nurse Practitioners with expertise in cardiology	98	18	18.4	46	46.9	34	34.7
g. RN Cardiovascular Specialists	98	15	15.3	37	37.8	46	46.9
h. Echocardiography Technicians	95	25	26.3	54	56.8	16	16.8
i. Catheterization Lab Technicians	98	19	19.4	37	37.8	42	42.9
j. Perfusionists	97	3	3.1	26	26.8	68	70.1
k. Emergency physicians	97	26	26.8	36	37.1	35	36.1

21. Please enter **top two reasons** why there were problems **RETAINING** these personnel types in the PAST YEAR. Use the drop-down menu to select the top two reasons per personnel type.

Table I-147. Acute Coronary Syndrome: Question 21

		01 Lack of opportunity for professional growth/promotion		02 Dissatisfaction with supervision/management support		03 Dissatisfaction with support staff		04 Dissatisfaction with physical demands of the job		05 Dissatisfaction with workload		06 Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		07 Organizational culture that does not prioritize/ encourage productivity		08 Administrative/ Program Demands		09 Lack of professional autonomy		10 Dissatisfaction with pay		11 Work schedule		12 Inadequate equipment/ resources/office space		13 Burnout	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Cardiologists (interventional)	11	2	18.2	1	9.1	0	0.0	0	0.0	0	0.0	2	18.2	1	9.1	1	9.1	0	0.0	7	63.6	1	9.1	4	36.4	0	0.0
b. Cardiologists (echocardiography)	9	3	33.3	1	11.1	2	22.2	0	0.0	0	0.0	0	0.0	1	11.1	0	0.0	0	0.0	6	66.7	0	0.0	3	33.3	1	11.1
c. Cardiologists (electrophysiology)	8	1	12.5	1	12.5	0	0.0	0	0.0	1	12.5	0	0.0	1	12.5	0	0.0	0	0.0	5	62.5	0	0.0	2	25.0	1	12.5
d. Cardiologists (general)	11	4	36.4	2	18.2	3	27.3	0	0.0	0	0.0	0	0.0	1	9.1	0	0.0	0	0.0	8	72.7	0	0.0	1	9.1	0	0.0
e. Cardiothoracic Surgeons	6	1	16.7	1	16.7	1	16.7	0	0.0	0	0.0	2	33.3	0	0.0	1	16.7	0	0.0	4	66.7	0	0.0	2	33.3	0	0.0
f. Physician Assistants or Nurse Practitioners with expertise in cardiology	18	3	16.7	2	11.1	3	16.7	3	16.7	2	11.1	0	0.0	2	11.1	2	11.1	1	5.6	12	66.7	1	5.6	1	5.6	2	11.1
g. RN Cardiovascular Specialists	15	4	26.7	4	26.7	3	20.0	1	6.7	1	6.7	0	0.0	3	20.0	0	0.0	2	13.3	8	53.3	2	13.3	0	0.0	1	6.7
h. Echocardiography Technicians	25	5	20.0	2	8.0	1	4.0	2	8.0	2	8.0	1	4.0	0	0.0	0	0.0	1	4.0	12	48.0	1	4.0	0	0.0	3	12.0
i. Catheterization Lab Technicians	19	5	26.3	3	15.8	3	15.8	0	0.0	4	21.1	1	5.3	1	5.3	1	5.3	0	0.0	13	68.4	2	10.5	0	0.0	4	21.1
j. Perfusionists	3	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	33.3	2	66.7	0	0.0	1	33.3
k. Emergency physicians	26	7	26.9	4	15.4	3	11.5	2	7.7	3	11.5	1	3.8	1	3.8	1	3.8	0	0.0	15	57.7	4	15.4	1	3.8	2	7.7

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention
This question (question 21) is based on respondents who indicated that their facility had problems retaining certain personnel categories (question 19B). Question 21 was asked for each personnel type marked "yes" in question 19B.

Appendix I.1.6 Colon Cancer

Section 6: Colon Cancer

Screening

1. Which of the following are commonly-used methods of **Colon Cancer screening** for average-risk patients over age 50 in your local health care system? **Consider patients screened within the PAST 90 DAYS.**

Table I-148. Colon Cancer: Question 1

	N	n	%
Fecal occult blood test (standard guaiac)	109	39	35.8
Fecal immunochemical test	109	76	69.7
Flexible sigmoidoscopy every 5 years	109	18	16.5
Colonoscopy every 10 years	109	100	91.7
Double contrast barium enema every 5 years	109	4	3.7

2. Which of the following would best characterize the availability of the **fecal immunochemical test** at your local health care system?

Table I-149. Colon Cancer: Question 2

	N	n	%
Available at **all** facilities associated with this local health care system (i.e., VAMC and all CBOCs)	109	80	73.4
Available at **some locations** within this local health care system but not others	109	11	10.1
Not available at any facilities within this local health care system	109	18	16.5

3. Which of the following would best characterize the CPRS implementation of automated clinical reminders to perform Colon Cancer screening at your facilities?

Table I-150. Colon Cancer: Question 3

	N	n	%
Reminders for Colon Cancer screening are implemented	107	107	100.0
Reminders for Colon Cancer screening are **not** implemented	107	0	0.0

4. It is our understanding that providers can change their CPRS settings to turn off some types of laboratory alerts and not others, and that sometimes alerts are easy to miss. Which of the following would best characterize implementation of CPRS "view alerts" for positive Fecal Occult Blood Test (FOBT) results for patients in your local health care system?

Table I-151. Colon Cancer: Question 4

	N	n	%
An abnormal FOBT generates an alert that can be suppressed based upon a clinician's CPRS settings	109	16	14.7
An abnormal FOBT generates an alert which may easily be overlooked (e.g., if a clinician becomes distracted while viewing a patient's chart)	109	35	32.1
An abnormal FOBT generates an alert which requires some sort of acknowledgement by the clinician	109	49	45.0
An abnormal FOBT is automatically routed to gastroenterology for follow-up	109	24	22.0
FOBT alerts are **not** implemented	109	5	4.6
Other	109	20	18.3

Colonoscopy

5. Consider the use of **colonoscopy** for patients with the following indications. In the 12 MONTHS, what do you estimate to have been the **average wait time** (elapsed days from consult request to scheduled procedure date) for the procedures listed below?

Table I-152. Colon Cancer: Question 5

		Days				Not applicable	
Procedure	N	Mean	Median	Standard Deviation	Range	n	%
a. Colonoscopy screening for average-risk patients (if used)	105	56.1	55	35.3	1 – 200 days	20	19.0
b. Colonoscopy screening for high-risk patients (e.g., strong family of Colon Cancer or personal history of inflammatory bowel disease)	106	42.0	30	25.9	7 - 150	17	16.0
c. Colonoscopy for patients with positive FOBT test	106	33.4	30	17.1	5 - 90	15	14.2
d. Colonoscopy for patients with iron deficiency anemia	106	34.4	30	18.3	5 - 90	19	17.9
e. Colonoscopy for patients with other symptoms or indications	106	35.1	30	21.4	5 - 90	25	23.6
This question (question 5) allowed respondents to either mark a numerical entry or mark N/A or can't assess with an explanation.							

6. Please think about patients who need a **colonoscopy. IN THE PAST 12 MONTHS,** how often did patients experience *clinically meaningful* delays in getting a **colonoscopy** for the following indications? Indicate the percent of patients that experienced delays for whom the service was indicated.

Table I-153. Colon Cancer: Question 6

		No Delay		1-10% of patients experience a delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not Applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Colonoscopy screening for average-risk patients	107	57	53.3	24	22.4	11	10.3	6	5.6	4	3.7	5	4.7
b. Colonoscopy screening for high-risk patients (e.g., strong family of Colon Cancer or personal history of inflammatory bowel disease)	107	66	61.7	25	23.4	6	5.6	7	6.5	1	0.9	2	1.9
c. Colonoscopy for patients with positive FOBT test	107	64	59.8	33	30.8	3	2.8	5	4.7	0	0.0	2	1.9
d. Colonoscopy for patients with iron deficiency anemia	107	67	62.6	26	24.3	8	7.5	4	3.7	0	0.0	2	1.9
e. Colonoscopy for patients with other symptoms or indications	107	60	56.1	31	29.0	9	8.4	4	3.7	0	0.0	3	2.8

7. *The colon cancer module did not include a question 7.*

8. Think of the most effective way to reduce the number of *clinically meaningful delays* in patients receiving a colonoscopy. Now**, in your solution, how important are each of the following elements**?

Table I-154. Colon Cancer: Question 8

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	64	17	26.6	16	25.0	15	23.4	8	12.5	8	12.5
increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	64	32	50.0	18	28.1	8	12.5	2	3.1	4	6.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	64	26	40.6	17	26.6	14	21.9	2	3.1	5	7.8
d. Acquire and/or improve availability of equipment.	64	10	15.6	11	17.2	18	28.1	19	29.7	6	9.4
e. Implement or increase the availability of telehealth services	63	1	1.6	1	1.6	16	25.4	31	49.2	14	22.2
f. Improve information technology (e.g., scheduling system, electronic health record).	64	12	18.8	20	31.3	13	20.3	14	21.9	5	7.8
g. Change “central office policies” that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	63	12	19.0	18	28.6	19	30.2	9	14.3	5	7.9
h. Improve personnel supervision, management, or incentives.	64	8	12.5	13	20.3	26	40.6	13	20.3	4	6.3
i. Increase weekend and evening availability of services	64	0	0.0	6	9.4	22	34.4	29	45.3	7	10.9
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	64	3	4.7	13	20.3	30	46.9	16	25.0	2	3.1
k. Some other solution(s).	62	15	24.2	13	21.0	8	12.9	3	4.8	23	37.1
This question (question 8) is based on respondents who indicated that patients experienced any delay in getting a colonoscopy (question 6) (N=64)											

Management of Biopsy-Proven Colon Cancer

9. Please think about patients who have already had a colonoscopy and have biopsy-proven Colon Cancer. **IN THE PAST 12 MONTHS,** how often were there *clinically meaningful* delays in the following assessment and treatment steps (among patients for whom the step is indicated)? Indicate the percent of colon cancer patients that experienced delays for whom the service was indicated.

Table I-155. Colon Cancer: Question 9

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Initial evaluation by a surgeon	107	81	75.7	16	15.0	4	3.7	2	1.9	0	0.0	4	3.7
b. CT scan for staging	107	91	85.1	12	11.2	1	0.9	0	0.0	1	0.9	2	1.9
c. Elective surgery (i.e., partial colectomy) at your local VA health care system	107	62	57.9	14	13.1	4	3.7	3	2.8	0	0.0	24	22.4
d. Elective surgery (i.e., partial colectomy) at another VA health care system	106	27	25.5	15	14.2	5	4.7	3	2.8	1	0.9	55	51.9
e. Elective surgery (i.e., partial colectomy) at a non-VA facility (fee-basis or contracted care)	107	35	32.7	15	14.0	6	5.6	1	0.9	1	0.9	49	45.8
f. Starting chemotherapy at your local VA health care system	107	71	66.4	13	12.2	3	2.8	0	0.0	0	0.0	20	18.7
g. Starting chemotherapy at another VA health care system	106	27	25.5	6	5.7	4	3.8	2	1.9	0	0.0	67	63.2
h. Starting chemotherapy a non-VA facility (fee-basis or contracted care)	107	35	32.7	11	10.3	1	0.9	0	0.0	1	0.9	59	55.1
i. Starting radiation therapy (any location)	107	73	68.2	15	14.0	5	4.7	1	0.9	0	0.0	13	12.2

10. Think about those Colon Cancer patients who experienced *clinically meaningful delays*. In the PAST 12 MONTHS, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q9 in order to identify their top three delays for Q11.

11A**. Your solution for delays in:** Initial evaluation by a surgeon. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I-156. Colon Cancer: Question 11A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	14	3	21.4	1	7.1	5	35.7	0	0.0	5	35.7
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	14	9	64.3	3	21.4	2	14.3	0	0.0	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	14	2	14.3	6	42.9	1	7.1	1	7.1	4	28.6
d. Acquire and/or improve availability of equipment.	14	2	14.3	2	14.3	3	21.4	1	7.1	6	42.9
e. Implement or increase the availability of telehealth services.	14	1	7.1	0	0.0	0	0.0	9	64.3	4	28.6
f. Improve information technology (e.g., scheduling system, electronic health record). .	14	1	7.1	2	14.3	5	35.7	3	21.4	3	21.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	14	1	7.1	2	14.3	6	42.9	2	14.3	3	21.4
h. Improve personnel supervision, management, or incentives.	14	1	7.1	2	14.3	6	42.9	3	21.4	2	14.3
i. Increase weekend and evening availability of services.	14	0	0.0	2	14.3	3	21.4	6	42.9	3	21.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	14	4	28.6	1	7.1	3	21.4	5	35.7	1	7.1
k. Some other solution(s).	13	5	38.5	0	0.0	2	15.4	0	0.0	6	46.2

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11a (N=14, 13.08% of those who answered question 9 and 63.64% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

11B**. Your solution for delays in:** CT scan for staging. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing CT scan for staging and answered 11b (N = 8).

11C**. Your solution for delays in:** Elective surgery (i.e., partial colectomy) at your local VA health care system. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I-157. Colon Cancer: Question 11C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	17	6	35.3	2	11.8	4	23.5	4	23.5	1	5.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	17	8	47.1	6	35.3	1	5.9	1	5.9	1	5.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	17	4	23.5	3	17.7	6	35.3	2	11.8	2	11.8
d. Acquire and/or improve availability of equipment.	17	2	11.8	2	11.8	6	35.3	5	29.4	2	11.8
e. Implement or increase the availability of telehealth services.	17	1	5.9	0	0.0	4	23.5	7	41.2	5	29.4
f. Improve information technology (e.g., scheduling system, electronic health record).	17	3	17.7	1	5.9	4	23.5	6	35.3	3	17.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	17	4	23.5	2	11.8	5	29.4	3	17.7	3	17.7
h. Improve personnel supervision, management, or incentives.	17	1	5.9	3	17.7	7	41.2	4	23.5	2	11.8
i. Increase weekend and evening availability of services.	17	1	5.9	1	5.9	4	23.5	8	47.1	3	17.7
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	17	2	11.8	6	35.3	4	23.5	3	17.7	2	11.8
k. Some other solution(s).	17	5	29.4	2	11.8	2	11.8	1	5.9	7	41.2

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11c (N=17, 15.89% of those who answered question 9 and 80.95% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

11D**. Your solution for delays in:** Elective surgery (i.e., partial colectomy) at another VA health care system. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I-158. Colon Cancer: Question 11D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	18	1	5.6	1	5.6	2	11.1	1	5.6	13	72.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	18	4	22.2	4	22.2	0	0.0	1	5.6	9	50.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	18	2	11.1	3	16.7	2	11.1	1	5.6	10	55.6
d. Acquire and/or improve availability of equipment.	18	1	5.6	3	16.7	1	5.6	3	16.7	10	55.6
e. Implement or increase the availability of telehealth services.	18	0	0.0	3	16.7	3	16.7	5	27.8	7	38.9
f. Improve information technology (e.g., scheduling system, electronic health record).	18	0	0.0	4	22.2	3	16.7	1	5.6	10	55.6
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	18	3	16.7	1	5.6	4	22.2	1	5.6	9	50.0
h. Improve personnel supervision, management, or incentives.	18	1	5.6	2	11.1	2	11.1	4	22.2	9	50.0
i. Increase weekend and evening availability of services.	18	0	0.0	1	5.6	0	0.0	6	33.3	11	61.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	18	2	11.1	5	27.8	2	11.1	0	0.0	9	50.0
k. Some other solution(s).	18	2	11.1	1	5.6	0	0.0	0	0.0	15	83.3

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11d (N=19, 17.92% of those who answered question 9 and 79.17% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

11E**. Your solution for delays in:** Elective surgery (i.e., partial colectomy) at a non-VA facility (fee-basis or contracted care). Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I-159. Colon Cancer: Question 11E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	16	1	6.3	2	12.5	1	6.3	3	18.8	9	56.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	16	2	12.5	5	31.3	1	6.3	2	12.5	6	37.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	16	2	12.5	5	31.3	1	6.3	2	12.5	6	37.5
d. Acquire and/or improve availability of equipment.	16	1	6.3	2	12.5	3	18.8	3	18.8	7	43.8
e. Implement or increase the availability of telehealth services.	16	0	0.0	1	6.3	3	18.8	5	31.3	7	43.8
f. Improve information technology (e.g., scheduling system, electronic health record).	16	0	0.0	6	37.5	4	25.0	4	25.0	2	12.5
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	16	1	6.3	2	12.5	6	37.5	3	18.8	4	25.0
h. Improve personnel supervision, management, or incentives. .	16	1	6.3	1	6.3	5	31.3	5	31.3	4	25.0
i. Increase weekend and evening availability of services.	16	0	0.0	1	6.3	1	6.3	7	43.8	7	43.8
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	16	2	12.5	5	31.3	4	25.0	2	12.5	3	18.8
k. Some other solution(s).	16	0	0.0	2	12.5	2	12.5	0	0.0	12	75.0

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11e (N=16, 14.95% of those who answered question 9 and 69.57% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

11F**. Your solution for delays in:** Starting chemotherapy at your local VA health care system. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I-160. Colon Cancer: Question 11F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	2	18.2	2	18.2	5	45.5	1	9.1	1	9.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	4	36.4	1	9.1	3	27.3	1	9.1	2	18.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	3	27.3	1	9.1	4	36.4	1	9.1	2	18.2
d. Acquire and/or improve availability of equipment.	11	0	0.0	0	0.0	6	54.6	3	27.3	2	18.2
e. Implement or increase the availability of telehealth services.	11	0	0.0	0	0.0	2	18.2	6	54.6	3	27.3
f. Improve information technology (e.g., scheduling system, electronic health record).	11	1	9.1	0	0.0	2	18.2	5	45.5	3	27.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	0	0.0	2	18.2	5	45.5	1	9.1	3	27.3
h. Improve personnel supervision, management, or incentives.	11	2	18.2	1	9.1	3	27.3	2	18.2	3	27.3
i. Increase weekend and evening availability of services.	11	0	0.0	2	18.2	3	27.3	4	36.4	2	18.2
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	1	9.1	1	9.1	3	27.3	2	18.2	4	36.4
k. Some other solution(s).	11	1	9.1	1	9.1	2	18.2	2	18.2	5	45.5

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11f (N=11, 10.28% of those who answered question 9 and 68.75% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

11G**. Your solution for delays in:** Starting chemotherapy at another VA health care system. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Starting chemotherapy at another VA health care system and answered 11g (N = 8).

11H**. Your solution for delays in:** Starting chemotherapy a non-VA facility (fee-basis or contracted care). Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Responses to this question are not presented due to small number of respondents who identified delays in accessing Starting chemotherapy a non-VA facility (fee-basis or contracted care)and answered 11h (N = 8).

11I**. Your solution for delays in:** Starting radiation therapy (any location). Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now**, in your solution, how important are each of the following elements?**

Table I 161. Colon Cancer: Question 11I

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	13	2	15.4	3	23.1	1	7.7	3	23.1	4	30.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	13	2	15.4	3	23.1	2	15.4	2	15.4	4	30.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	13	1	7.7	5	38.5	2	15.4	2	15.4	3	23.1
d. Acquire and/or improve availability of equipment.	13	3	23.1	3	23.1	1	7.7	2	15.4	4	30.8
e. Implement or increase the availability of telehealth services.	13	0	0.0	1	7.7	0	0.0	7	53.9	5	38.5
f. Improve information technology (e.g., scheduling system, electronic health record).	13	0	0.0	1	7.7	4	30.8	4	30.8	4	30.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	13	2	15.4	1	7.7	3	23.1	2	15.4	5	38.5
h. Improve personnel supervision, management, or incentives.	13	0	0.0	2	15.4	4	30.8	3	23.1	4	30.8
i. Increase weekend and evening availability of services.	13	0	0.0	2	15.4	2	15.4	4	30.8	5	38.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	13	3	23.1	4	30.8	0	0.0	3	23.1	3	23.1
k. Some other	13	1	7.7	2	15.4	2	15.4	1	7.7	7	53.9

This question (question 11) is based on respondents who indicated that patients experienced delays in the management of biopsy-proven Colon Cancer (question 9). If 1-3 delays were mentioned in question 9, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 9, this question was repeated for the top three delays mentioned in question 10. Respondents were eligible to answer question 11i (N=13, 12.15% of those who answered question 9 and 61.9% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

Issues that Affect Provider and System Efficiency

12. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of Colon Cancer screening, diagnosis, and treatment?

Table I-162. Colon Cancer: Question 12

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	107	29	27.1	20	18.7	27	25.2	26	24.3	5	4.7
b. Providers performing administrative activities that could be performed by others	107	12	11.2	16	15.0	39	36.4	37	34.6	3	2.8
c. Residency training/teaching requirements	107	39	36.4	30	28.0	9	8.4	5	4.7	24	22.4
d. Insufficient clinical/administrative support staff	107	8	7.5	19	17.8	35	32.7	42	39.3	3	2.8
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	107	14	13.1	21	19.6	39	36.4	31	29.0	2	1.9
f. Unnecessary documentation requirements or inefficient CPRS interface	107	22	20.6	21	19.6	30	28.0	32	29.9	2	1.9
g. Patient no-show rates	107	5	4.7	32	29.9	48	44.9	21	19.6	1	0.9
h. Poor patient flow management (room/bed turnover, appointments)	107	26	24.3	34	31.8	28	26.2	14	13.1	5	4.7
i. Too many administrative requirements (Initiatives/Policies/Programs)	107	15	14.0	27	25.2	25	23.4	35	32.7	5	4.7

Workforce

13. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-163. Colon Cancer: Question 13

		Yes		No		Not Applicable	
Staff Positions	N	n	%	n	%	n	%
a. Gastroenterologists	107	72	67.3	19	17.8	16	15.0
b. General Surgeons	107	39	36.4	35	32.7	33	30.8
c. Surgical Oncologists	106	25	23.6	15	14.2	66	62.3
d. Medical Oncologists	107	39	36.4	28	26.2	40	37.4
e. Other physicians/surgeons trained in colonoscopy	107	29	27.1	27	25.2	51	47.7
f. Physician Assistants or Nurse Practitioner Gastroenterology Specialists	107	28	26.2	46	43.0	33	30.8
g. Nurse Specialists with oncologic expertise	107	17	15.9	31	29	59	55.1

Reasons for Staff Recruitment/Hiring Problems

14. Please enter **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types in the PAST YEAR.

Table I-164. Colon Cancer: Question 14

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Gastroenterologists	72	6	8.3	67	93.1	2	2.8	0	0.0	3	4.2	2	2.8	1	1.4	6	8.3	3	4.2	18	25.0	19	26.4	15	20.8
b. General Surgeons	39	0	0.0	35	89.7	2	5.1	0	0.0	4	10.3	1	2.6	4	10.3	3	7.7	1	2.6	11	28.2	7	17.9	8	20.5
c. Surgical Oncologists	25	1	4.0	22	88.0	0	0.0	1	4.0	2	8.0	0	0.0	2	8.0	3	12	2	8.0	1	4.0	7	28.0	7	28.0
d. Medical Oncologists	39	4	10.3	30	76.9	2	5.1	1	2.6	2	5.1	1	2.6	3	7.7	2	5.1	3	7.7	8	20.5	13	33.3	7	17.9
e. Other physicians/surgeons trained in colonoscopy	29	3	10.3	21	72.4	2	6.9	1	3.4	3	10.3	0	0.0	0	0.0	3	10.3	0	0.0	7	24.1	5	17.2	9	31.0
f. Physician Assistants or Nurse Practitioner Gastroenterology Specialists	28	7	25.0	13	46.4	4	14.3	0	0.0	1	3.6	0	0.0	2	7.1	3	10.7	0	0.0	2	7.1	15	53.6	5	17.9
g. Nurse Specialists with oncologic expertise	17	5	29.4	8	47.1	0	0.0	0	0.0	3	17.6	0	0.0	1	5.9	2	11.8	0	0.0	1	5.9	9	52.9	3	17.6

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring.

This question (question 14) is based on respondents who indicated that their local health care system had problems recruiting or hiring certain personnel categories (question 13). Question 14 was asked for each personnel type marked "yes" in question 13.

15. IN THE PAST YEAR, did your local health care system have problems **RETAINING** the following personnel categories?

Table I-165. Colon Cancer: Question 15

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Gastroenterologists	106	40	37.7	47	44.3	19	17.9
b. General Surgeons	105	20	19.0	50	47.6	35	33.3
c. Surgical Oncologists	105	9	8.6	24	22.9	72	68.6
d. Medical Oncologists	104	19	18.3	48	46.2	37	35.6
e. Other physicians/surgeons trained in colonoscopy	105	10	9.5	34	32.4	61	58.1
f. Physician Assistants or Nurse Practitioner Gastroenterology Specialists	105	18	17.1	48	45.7	39	37.1
g. Nurse Specialists with oncologic expertise	105	10	9.5	28	26.7	67	63.8

Reasons for Staff Retention Problems

16. Please enter **top two reasons** why there were problems **RETAINING** these personnel types in the PAST YEAR.

Table I-166. Colon Cancer: Question 16

		Lack of opportunity for professional growth/promotion		Dissatisfaction with supervision/management support		Dissatisfaction with support staff		Dissatisfaction with physical demands of the job		Dissatisfaction with workload		Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		Organizational culture that does not prioritize/ encourage productivity		Administrative/ Program Demands		Lack of professional autonomy		Dissatisfaction with pay		Work schedule		Inadequate equipment/ resources/office space		Burnout	
Staff Positions	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Gastroenterologists	40	3	7.5	12	30.0	6	15.0	2	5.0	3	7.5	2	5.0	1	2.5	9	22.5	1	2.5	25	62.5	4	10.0	6	15.0	4	10.0
b. General Surgeons	20	6	30.0	8	40.0	4	20.0	0	0.0	4	20.0	0	0.0	2	10.0	3	15.0	2	10.0	5	25.0	1	5.0	1	5.0	4	20.0
c. Surgical Oncologists	9	4	44.4	2	22.2	1	11.1	0	0.0	0	0.0	0	0.0	1	11.1	1	11.1	0	0.0	6	66.7	0	0.0	2	22.2	1	11.1
d. Medical Oncologists	19	0	0.0	4	21.1	0	0.0	2	10.5	2	10.5	1	5.3	1	5.3	6	31.6	2	10.5	9	47.4	3	15.8	4	21.1	4	21.1
e. Other physicians/surgeons trained in colonoscopy	10	1	10.0	2	20.0	2	20.0	2	20.0	2	20.0	0	0.0	0	0.0	2	20.0	1	10.0	4	40.0	2	20.0	1	10.0	1	10.0
f. Physician Assistants or Nurse Practitioner Gastroenterology Specialists	18	2	11.1	9	50.0	5	27.8	2	11.1	4	22.2	0	0.0	1	5.6	2	11.1	0	0.0	6	33.3	0	0.0	1	5.6	4	22.2
g. Nurse Specialists with oncologic expertise	10	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

This question (question 16) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 15). Question 16 was asked for each personnel type marked "yes" in question 15. Due to a programming error, respondents who indicated problems with retaining Nurse Specialists with oncologic expertise were not asked to provide the top two reasons for retention problems for this specialty. Therefore this data should be considered missing.

Appendix I.1.7 Diabetes Mellitus (type 2)

Section 7: Type 2 Diabetes

Delays in Management After Diagnosis

1. Please think about patients who are in need of the following Type 2 Diabetes management services. **IN THE PAST 90 DAYS**, how often were there *clinically meaningful delays* in patients' access to the following diabetes management services? Indicate the percent of Type 2 Diabetes patients that experienced delays for whom the service was indicated.

Table I-167. Type 2 Diabetes: Question 1

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Primary care clinic appointment for issues related to glycemic control (e.g., symptoms or glucometer reading)	110	44	40.0	37	33.6	11	10.0	3	2.7	6	5.5	9	8.2
b. Consult with endocrinologist/diabetes specialist (e.g., or poor glycemic control, or for patients at high risk for complications)	110	44	40.0	32	29.1	19	17.3	5	4.6	4	3.6	6	5.5
c. In-person care at endocrinology, for poor glycemic control, or for patients at high risk for complications	110	44	40.0	36	32.7	12	10.9	6	5.5	3	2.7	9	8.2
d. Nutritionist	110	75	68.2	20	18.2	11	10.0	1	0.9	2	1.8	1	0.9
e. Podiatry clinic for preventative care	110	44	40.0	33	30.0	16	14.6	8	7.3	4	3.6	5	4.6
f. Retinopathy screening services	110	73	66.4	20	18.2	7	6.4	3	2.7	3	2.7	4	3.6
g. Retinopathy treatment services	110	48	43.6	41	37.3	5	4.6	6	5.5	0	0.0	10	9.1
h. Bariatric surgery (in patients deemed to be good candidates)	110	18	16.4	12	10.9	5	4.6	7	6.4	18	16.4	50	45.5
i. Dispensing diabetes-related personal equipment such as glucometers or special footwear	110	84	76.4	18	16.4	6	5.5	1	0.9	0	0.0	1	0.9

2. Think about those Type 2 Diabetes patients who experienced *clinically meaningful delays.* In the PAST 90 DAYS which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q1 in order to identify their top three delays for Q3.

3A**. Your solution for delays in:** Primary care clinic appointment for issues related to glycemic control (e.g., symptoms or glucometer reading)**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-168. Type 2 Diabetes: Question 3A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	44	15	34.1	12	27.3	10	22.7	6	13.6	1	2.3
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	44	20	45.5	10	22.7	10	22.7	2	4.6	2	4.6
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	44	13	29.6	19	43.2	9	20.5	3	6.8	0	0.0
d. Acquire and/or improve availability of equipment.	44	1	2.3	8	18.2	14	31.8	13	29.6	8	18.2
e. Implement or increase the availability of telehealth services.	44	5	11.4	9	20.5	21	47.7	8	18.2	1	2.3
f. Improve information technology (e.g., scheduling system, electronic health record).	44	17	38.6	8	18.2	7	15.9	11	25.0	1	2.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	44	10	22.7	12	27.3	14	31.8	8	18.2	0	0.0
h. Improve personnel supervision, management, or incentives.	44	9	20.5	9	20.5	13	29.6	9	20.5	4	9.1
i. Increase weekend and evening availability of services.	44	3	6.8	6	13.6	16	36.6	15	34.1	4	9.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	44	1	2.3	4	9.1	17	38.6	17	38.6	5	11.4
k. Some other solution(s).	44	11	25.0	7	15.9	4	9.1	2	4.6	20	45.5

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3a (N=44, 40.0% of those who answered question 1 and 77.2% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3B**. Your solution for delays in:** Consult with endocrinologist/diabetes specialist (e.g., or poor glycemic control, or for patients at high risk for complications)**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-169. Type 2 Diabetes: Question 3B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	44	12	27.3	9	20.5	11	25.0	6	13.6	6	13.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	44	16	36.4	10	22.7	12	27.3	2	4.6	4	9.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	44	9	20.5	16	36.4	15	34.1	1	2.3	3	6.8
d. Acquire and/or improve availability of equipment.	44	2	4.6	2	4.6	15	34.1	14	31.8	11	25.0
e. Implement or increase the availability of telehealth services.	44	3	6.8	7	15.9	24	54.6	8	18.2	2	4.6
f. Improve information technology (e.g., scheduling system, electronic health record).	44	7	15.9	12	27.3	13	29.6	10	22.7	2	4.6
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	44	7	15.9	13	29.6	13	29.6	8	18.2	3	6.8
h. Improve personnel supervision, management, or incentives.	44	6	13.6	11	25.0	13	29.6	8	18.2	6	13.6
i. Increase weekend and evening availability of services.	44	0	0.0	6	13.6	14	31.8	19	43.2	5	11.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	44	2	4.6	7	15.9	16	36.4	16	36.4	3	6.8
k. Some other solution(s).	43	6	14.0	6	14.0	3	7.0	2	4.7	26	60.5

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3b (N=45, 40.9% of those who answered question 1 and 75.0% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3C**. Your solution for delays in:** In-person care at endocrinology, for poor glycemic control, or for patients at high risk for complications**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-170. Type 2 Diabetes: Question 3C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	41	11	26.8	8	19.5	13	31.7	5	12.2	4	9.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	41	15	36.6	14	34.2	7	17.1	2	4.9	3	7.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	40	9	22.5	12	30.0	16	40.0	0	0.0	3	7.5
d. Acquire and/or improve availability of equipment.	41	0	0.0	6	14.6	13	31.7	13	31.7	9	22.0
e. Implement or increase the availability of telehealth services.	41	2	4.9	10	24.4	20	48.8	6	14.6	3	7.3
f. Improve information technology (e.g., scheduling system, electronic health record).	41	7	17.1	9	22.0	13	31.7	9	22.0	3	7.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	39	5	12.8	9	23.1	16	41.0	5	12.8	4	10.3
h. Improve personnel supervision, management, or incentives.	41	2	4.9	13	31.7	10	24.4	8	19.5	8	19.5
i. Increase weekend and evening availability of services.	40	1	2.5	3	7.5	12	30.0	16	40.0	8	20.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	41	1	2.4	7	17.1	16	39.0	14	34.2	3	7.3
k. Some other solution(s).	41	4	9.8	5	12.2	5	12.2	1	2.4	26	63.4

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3c (N=41, 37.3% of those who answered question 1 and 71.9% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3D**. Your solution for delays in:** Nutritionist**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-171. Type 2 Diabetes: Question 3D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	2	18.2	3	27.3	4	36.4	0	0.0	2	18.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	4	36.4	3	27.3	1	9.1	1	9.1	2	18.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	2	18.2	4	36.4	4	36.4	1	9.1	0	0.0
d. Acquire and/or improve availability of equipment.	11	0	0.0	1	9.1	2	18.2	5	45.5	3	27.3
e. Implement or increase the availability of telehealth services.	11	0	0.0	0	0.0	9	81.8	1	9.1	1	9.1
f. Improve information technology (e.g., scheduling system, electronic health record).	11	1	9.1	4	36.4	3	27.3	0	0.0	3	27.3
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	0	0.0	1	9.1	5	45.5	2	18.2	3	27.3
h. Improve personnel supervision, management, or incentives.	11	0	0.0	3	27.3	2	18.2	3	27.3	3	27.3
i. Increase weekend and evening availability of services.	11	0	0.0	1	9.1	5	45.5	3	27.3	2	18.2
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	11	0	0.0	1	9.1	3	27.3	3	27.3	4	36.4
k. Some other solution(s).	11	1	9.1	1	9.1	3	27.3	0	0.0	6	54.6

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3d (N=11, 10.0% of those who answered question 1 and 32.4% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3E**. Your solution for delays in:** Podiatry clinic for preventative care**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-172. Type 2 Diabetes: Question 3E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	34	9	26.5	12	35.3	7	20.6	4	11.8	2	5.9
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	34	17	50.0	8	23.5	7	20.6	1	2.9	1	2.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	34	9	26.5	13	38.2	8	23.5	3	8.8	1	2.9
d. Acquire and/or improve availability of equipment.	34	1	2.9	10	29.4	8	23.5	10	29.4	5	14.7
e. Implement or increase the availability of telehealth services.	34	0	0.0	6	17.7	7	20.6	15	44.1	6	17.7
f. Improve information technology (e.g., scheduling system, electronic health record).	34	5	14.7	4	11.8	10	29.4	10	29.4	5	14.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	34	8	23.5	2	5.9	13	38.2	8	23.5	3	8.8
h. Improve personnel supervision, management, or incentives.	34	5	14.7	5	14.7	10	29.4	11	32.4	3	8.8
i. Increase weekend and evening availability of services.	34	0	0.0	6	17.7	14	41.2	12	35.3	2	5.9
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	34	1	2.9	11	32.4	16	47.1	5	14.7	1	2.9
k. Some other solution(s).	34	3	8.8	6	17.7	6	17.7	3	8.8	16	47.1

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3e (N=34, 30.9% of those who answered question 1 and 55.7% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3F**. Your solution for delays in:** Retinopathy screening services**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-173. Type 2 Diabetes: Question 3F

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	11	3	27.3	2	18.2	3	27.3	1	9.1	2	18.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	11	4	36.4	4	36.4	1	9.1	1	9.1	1	9.1
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	11	5	45.5	3	27.3	1	9.1	1	9.1	1	9.1
d. Acquire and/or improve availability of equipment.	11	4	36.4	3	27.3	2	18.2	1	9.1	1	9.1
e. Implement or increase the availability of telehealth services.	11	1	9.1	8	72.7	0	0.0	1	9.1	1	9.1
f. Improve information technology (e.g., scheduling system, electronic health record).	11	2	18.2	2	18.2	3	27.3	3	27.3	1	9.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	11	3	27.3	2	18.2	1	9.1	3	27.3	2	18.2
h. Improve personnel supervision, management, or incentives.	11	4	36.4	2	18.2	1	9.1	3	27.3	1	9.1
i. Increase weekend and evening availability of services.	11	2	18.2	3	27.3	2	18.2	3	27.3	1	9.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	10	0	0.0	4	40.0	2	20.0	3	30.0	1	10.0
k. Some other solution(s).	11	5	45.5	1	9.1	0	0.0	2	18.2	3	27.3

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3f (N=11, 10.0% of those who answered question 1 and 33.3% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3G**. Your solution for delays in:** Retinopathy treatment services**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-174. Type 2 Diabetes: Question 3G

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	21	5	23.8	8	38.1	3	14.3	4	19.1	1	4.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	21	9	42.9	6	28.6	4	19.1	1	4.8	1	4.8
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	21	9	42.89	4	19.1	6	28.6	1	4.8	1	4.8
d. Acquire and/or improve availability of equipment.	21	3	14.3	6	28.6	7	33.3	4	19.1	1	4.8
e. Implement or increase the availability of telehealth services.	21	2	9.5	8	38.1	5	23.8	5	23.8	1	4.8
f. Improve information technology (e.g., scheduling system, electronic health record).	21	5	23.8	6	28.6	5	23.8	4	19.1	1	4.8
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	21	5	23.8	5	23.8	4	19.1	6	28.6	1	4.8
h. Improve personnel supervision, management, or incentives.	21	4	19.1	4	19.1	9	42.9	3	14.3	1	4.8
i. Increase weekend and evening availability of services.	21	1	4.8	3	14.3	6	28.6	8	38.1	3	14.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	21	1	4.8	5	23.8	10	47.6	5	23.8	0	0.0
k. Some other solution(s).	21	1	4.8	3	14.3	2	9.5	0	0.0	15	71.4

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3g (N=21, 19.1% of those who answered question 1 and 40.4% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3H**. Your solution for delays in:** Bariatric surgery (in patients deemed to be good candidates)**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-175. Type 2 Diabetes: Question 3H

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	25	4	16.0	3	12.0	10	40.0	1	4.0	7	28.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	5	20.0	8	32.0	5	20.0	1	4.0	6	24.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	25	4	16.0	5	20.0	6	24.0	1	4.0	9	36.0
d. Acquire and/or improve availability of equipment.	24	3	12.5	2	8.3	6	25.0	6	25.0	7	29.2
e. Implement or increase the availability of telehealth services.	25	1	4.0	2	8.0	6	24.0	9	36.0	7	28.0
f. Improve information technology (e.g., scheduling system, electronic health record).	25	2	8.0	1	4.0	8	32.0	7	28.0	7	28.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	24	7	29.2	4	16.7	6	25.0	3	12.5	4	16.7
h. Improve personnel supervision, management, or incentives.	24	3	12.5	2	8.3	9	37.5	2	8.3	8	33.3
i. Increase weekend and evening availability of services.	25	0	0.0	1	4.0	4	16.0	10	40.0	10	40.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	25	7	28.0	8	32.0	5	20.0	3	12.0	2	8.0
k. Some other solution(s).	25	6	24.0	2	8.0	3	12.0	2	8.0	12	48.0

This question (question 3) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 1). If 1-3 delays were mentioned in question 1, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 1, this question was repeated for the top three delays mentioned in question 2. Respondents were eligible to answer question 3h (N=25, 22.7% of those who answered question 1 and 59.5% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

3I**. Your solution for delays in:** Dispensing diabetes-related personal equipment such as glucometers or special footwear**.** Think of the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Responses to this question are not presented due to small number of respondents who identified delays in Dispensing diabetes-related personal equipment such as glucometers or special footwear *and answering question 3i (N = 2).*

Complications of Type 2 Diabetes

4. Please think about patients who had the following **complications** from Type 2 Diabetes. **IN THE PAST 90 DAYS**, how often were there *clinically meaningful delays* in patients' access to treatment for these **complications of diabetes**? Indicate the percent of Type 2 Diabetes patients that experienced delays for whom the service was indicated.

Table I-176. Type 2 Diabetes: Question 4

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
Service	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Evaluation and treatment by vascular surgery for non-acute limb ischemia	110	51	46.4	28	25.5	14	12.7	3	2.7	2	1.8	12	10.9
b. Evaluation and treatment by ophthalmology for declining vision	110	60	54.6	32	29.1	7	6.4	4	3.6	1	0.9	6	5.5
c. Evaluation and treatment by nephrology for worsening renal function	110	62	56.4	22	20.0	13	11.8	2	1.8	3	2.7	8	7.3
d. Evaluation and treatment by cardiology for new symptoms or refractory hyperlipidemia	110	62	56.4	24	21.8	11	10.0	3	2.7	0	0.0	10	9.1
e. Evaluation and treatment by podiatry for new foot lesions	110	56	50.9	32	29.1	12	10.9	4	3.6	2	1.8	4	3.6

5. Think about those Type 2 Diabetes patients who experienced *clinically meaningful delays*. In the **PAST 90 DAYS**, which of these delays had the **most negative impact** on patients?

Results not presented. Respondents were only asked this question if they identified more than three delays in Q4 in order to identify their top three delays for Q6.

Reducing Delays in Care for Complications of Diabetes

6A. **Your solution for delays in:** Evaluation and treatment by vascular surgery for non-acute limb ischemia. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-177. Type 2 Diabetes: Question 6A

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	36	7	19.4	8	22.2	10	27.8	9	25.0	2	5.6
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	36	14	38.9	13	36.1	6	16.7	1	2.8	2	5.6
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	36	7	19.4	14	38.9	7	19.4	6	16.7	2	5.6
d. Acquire and/or improve availability of equipment. .	36	4	11.1	10	27.8	5	13.9	12	33.3	5	13.9
e. Implement or increase the availability of telehealth services.	36	1	2.8	5	13.9	14	38.9	7	19.4	9	25.0
f. Improve information technology (e.g., scheduling system, electronic health record).	35	3	8.6	9	25.7	3	8.6	13	37.1	7	20.0
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	35	7	20.0	4	11.4	9	25.7	8	22.9	7	20.0
h. Improve personnel supervision, management, or incentives.	36	6	16.7	6	16.7	9	25.0	10	27.8	5	13.9
i. Increase weekend and evening availability of services.	36	3	8.3	2	5.6	10	27.8	14	38.9	7	19.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	35	2	5.7	7	20.0	16	45.7	7	20.0	3	8.6
k. Some other solution(s). .	35	4	11.4	7	20.0	0	0.0	0	0.0	24	68.6

This question (question 6) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6a (N=36, 32.7% of those who answered question 4 and 76.6% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6B. **Your solution for delays in:** Evaluation and treatment by ophthalmology for declining vision. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-178. Type 2 Diabetes: Question 6B

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	31	7	22.6	7	22.6	9	29.0	2	6.5	6	19.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	31	12	38.7	13	41.9	4	12.9	0	0.0	2	6.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	31	7	22.6	9	29.0	9	29.0	3	9.7	3	9.7
d. Acquire and/or improve availability of equipment.	31	4	12.9	13	41.9	5	16.1	4	12.9	5	16.1
e. Implement or increase the availability of telehealth services.	30	1	3.3	9	30.0	11	36.7	4	13.3	5	16.7
f. Improve information technology (e.g., scheduling system, electronic health record).	31	3	9.7	7	22.6	14	45.2	4	12.9	3	9.7
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	31	8	25.8	3	9.7	12	38.7	5	16.1	3	9.7
h. Improve personnel supervision, management, or incentives.	31	4	12.9	6	19.4	11	35.5	7	22.6	3	9.7
i. Increase weekend and evening availability of services.	31	3	9.7	4	12.9	9	29.0	9	29.0	6	19.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	31	3	9.7	9	29.0	12	38.7	2	6.5	5	16.1
k. Some other solution(s).	31	8	25.8	4	12.9	2	6.5	1	3.2	16	51.6

This question (question 6) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6b (N=31, 28.2% of those who answered question 4 and 70.5% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6C. **Your solution for delays in:** Evaluation and treatment by nephrology for worsening renal function. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-179. Type 2 Diabetes: Question 6C

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	29	4	13.8	8	27.6	8	27.6	4	13.8	5	17.2
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	29	8	27.6	13	44.8	5	17.2	1	3.5	2	6.9
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	29	3	10.3	10	34.5	9	31.0	5	17.2	2	6.9
d. Acquire and/or improve availability of equipment.	29	3	10.3	3	10.3	7	24.1	9	31.0	7	24.1
e. Implement or increase the availability of telehealth services.	29	1	3.5	6	20.7	12	41.4	5	17.2	5	17.2
f. Improve information technology (e.g., scheduling system, electronic health record).	29	2	6.9	6	20.7	5	17.2	11	37.9	5	17.2
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	28	4	14.3	5	17.9	4	14.3	10	35.7	5	17.9
h. Improve personnel supervision, management, or incentives.	29	3	10.3	7	24.1	5	17.2	11	37.9	3	10.3
i. Increase weekend and evening availability of services.	29	1	3.5	3	10.3	8	27.6	11	37.9	6	20.7
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	29	0	0.0	8	27.6	14	48.3	6	20.7	1	3.5
k. Some other solution(s).	28	1	3.6	4	14.3	3	10.7	2	7.1	18	64.3

This question (question 6) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6c (N=29, 26.4% of those who answered question 4 and 72.5% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6D. **Your solution for delays in:** Evaluation and treatment by cardiology for new symptoms or refractory hyperlipidemia. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-180. Type 2 Diabetes: Question 6D

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	23	6	26.1	8	34.8	5	21.7	1	4.4	3	13.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	23	8	34.8	7	30.4	6	26.1	0	0.0	2	8.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	23	4	17.4	6	26.1	8	34.8	2	8.7	3	13.0
d. Acquire and/or improve availability of equipment.	23	1	4.4	8	34.8	6	26.1	4	17.4	4	17.4
e. Implement or increase the availability of telehealth services.	23	3	13.0	5	21.7	7	30.4	7	30.4	1	4.4
f. Improve information technology (e.g., scheduling system, electronic health record).	23	3	13.0	4	17.4	7	30.4	5	21.7	4	17.4
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	23	2	8.7	5	21.7	7	30.4	4	17.4	5	21.7
h. Improve personnel supervision, management, or incentives.	23	1	4.4	3	13.0	6	26.1	8	34.8	5	21.7
i. Increase weekend and evening availability of services.	23	1	4.4	4	17.4	7	30.4	7	30.4	4	17.4
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	23	1	4.4	4	17.4	9	39.1	7	30.4	2	8.7
k. Some other solution(s). .	23	3	13.0	3	13.0	3	13.0	1	4.4	13	56.5

This question (question 6) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6d (N=24, 21.8% of those who answered question 4 and 63.2% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

6E. **Your solution for delays in:** Evaluation and treatment by podiatry for new foot lesions. Think about the most effective way to reduce the number of *clinically meaningful delays* at this junction. Now, **in your solution, how important are each of the following elements**?

Table I-181. Type 2 Diabetes: Question 6E

		Critically important		Very important		Somewhat important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds).	36	8	22.2	13	36.1	9	25.0	5	13.9	1	2.8
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	36	14	38.9	13	36.1	8	22.2	1	2.8	0	0.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	36	8	22.2	15	41.7	10	27.8	2	5.6	1	2.8
d. Acquire and/or improve availability of equipment.	36	2	5.6	11	30.6	10	27.8	9	25.0	4	11.1
e. Implement or increase the availability of telehealth services.	36	1	2.8	6	16.7	11	30.6	14	38.9	4	11.1
f. Improve information technology (e.g., scheduling system, electronic health record).	36	3	8.3	4	11.1	13	36.1	12	33.3	4	11.1
g. Change 'central office policies' that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided).	36	7	19.4	3	8.3	12	33.3	10	27.8	4	11.1
h. Improve personnel supervision, management, or incentives.	36	4	11.1	4	11.1	16	44.4	10	27.8	2	5.6
i. Increase weekend and evening availability of services.	36	3	8.3	4	11.1	12	33.3	14	38.9	3	8.3
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community.	36	0	0.0	9	25.0	18	50.0	7	19.4	2	5.6
k. Some other solution(s).	36	3	8.3	6	16.7	1	2.8	3	8.3	23	63.9

This question (question 6) is based on respondents who indicated that patients experienced delays in accessing diabetes management services (question 4). If 1-3 delays were mentioned in question 4, this question was repeated for each delay mentioned. If 4 or more delays were mentioned in question 4, this question was repeated for the top three delays mentioned in question 5. Respondents were eligible to answer question 6e (N=36, 32.7% of those who answered question 4 and 72.0% of those who reported any delay) if they identified delays in four or more services and indicated that this was one of the three delays that had the most negative impact on patients or if this service was one of the three or fewer services for which a delay was indicated.

Issues that Affect Provider and System Efficiency

7. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of care for Type 2 Diabetes patients?

Table I-182. Type 2 Diabetes: Question 7

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	110	9	8.2	31	28.2	38	34.5	30	27.3	2	1.8
b. Providers performing administrative activities that could be performed by others	110	2	1.8	16	14.5	41	37.3	47	42.7	4	3.6
c. Residency training/teaching requirements	110	35	31.8	27	24.5	8	7.3	7	6.4	33	30.0
d. Insufficient clinical/administrative support staff	110	8	7.3	24	21.8	35	31.8	42	38.2	1	0.9
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	110	9	8.2	21	19.1	30	27.3	50	45.5	0.0	0.0
f. Unnecessary documentation requirements or inefficient CPRS interface	110	8	7.3	30	27.3	25	22.7	46	41.8	1	0.9
g. Patient no-show rates	109	4	3.7	56	51.4	33	30.3	16	14.7	0.0	0.0
h. Poor patient flow management (room/bed turnover, appointments)	110	13	11.8	46	41.8	29	26.4	18	16.4	4	3.6
i. Too many administrative requirements (Initiatives/Policies/Programs)	110	5	4.5	20	18.2	37	33.6	47	42.7	1	0.9

Workforce

8A. IN THE PAST YEAR, did your local health care system have problems **RECRUITING OR HIRING** the following personnel categories?

Table I-183. Type 2 Diabetes: Question 8A

		Yes		No		Not Applicable	
Staff Positions	N	n	%	n	%	n	%
a. Primary Care Physicians	110	79	71.8	20	18.2	11	10.0
b. Non-Physician Primary Care Providers (Physician Assistants/Nurse Practitioners)	110	47	42.7	48	43.6	15	13.6
c. Endocrinologists	110	36	32.7	36	32.7	38	34.5
d. Podiatrists	110	28	25.5	48	43.6	34	30.9
e. Nutritionists	110	20	18.2	69	62.7	21	19.1
f. Nurse Specialists with diabetes expertise	110	32	29.1	47	42.7	31	28.2
g. Physician Assistants/Nurse Practitioners with diabetes expertise	110	32	29.1	33	30.0	45	40.9
h. Ophthalmologists	110	35	31.8	38	34.5	37	33.6

Reasons for Staff Recruitment/Hiring Problems

9. Please enter **top two reasons** why there were problems **RECRUITING AND HIRING** these personnel types in the PAST YEAR.

Table I-184. Type 2 Diabetes: Question 9

		Senior management does not agree to post new position		Non-competitive wages		Work schedule (e.g., call requirements)		Benefits (e.g., health insurance, leave, continuing education, travel)		Equipment/resources/office space		Facility condition		Case types/complexity		VA reputation		No academic affiliation/lack of protected time for early career investigator		Geographic location of facility		HR process (e.g., time to advertise; length of time from job offer to start date)		Lack of qualified applicants	
Staff Positions	N (Yes to Q8)	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Primary Care Physicians	79	7	8.9	47	59.5	8	10.1	2	2.5	3	3.8	2	2.5	0	0.0	10	12.7	0	0.0	19	24.1	34	43.0	26	32.9
b. Non-Physician Primary Care Providers (Physician Assistants/Nurse Practitioners)	47	5	10.6	33	70.2	1	2.1	1	2.1	4	8.5	2	4.3	0	0.0	3	6.4	0	0.0	10	21.3	22	46.8	13	27.7
c. Endocrinologists	36	4	11.1	25	69.4	1	2.8	1	2.8	4	11.1	1	2.8	1	2.8	3	8.3	0	0.0	4	11.1	18	50.0	10	27.8
d. Podiatrists	28	1	3.6	19	67.9	1	3.6	1	3.6	2	7.1	1	3.6	0	0.0	1	3.6	0	0.0	7	25.0	14	50.0	9	32.1
e. Nutritionists	20	4	20.0	10	50.0	2	10.0	0	0.0	2	10.0	0	0.0	0	0.0	2	10.0	0	0.0	4	20.0	10	50.0	4	20.0
f. Nurse Specialists with diabetes expertise	32	9	28.1	19	59.4	2	6.3	0	0.0	1	3.1	1	3.1	1	3.1	2	6.3	0	0.0	6	18.8	10	31.3	11	34.4
g. Physician Assistants/Nurse Practitioners with diabetes expertise	32	8	25.0	18	56.3	0	0.0	0	0.0	2	6.3	1	3.1	1	3.1	1	3.1	0	0.0	7	21.9	11	34.4	13	40.6
h. Ophthalmologists	35	3	8.6	29	82.9	1	2.9	2	5.7	2	5.7	1	2.9	1	2.9	2	5.7	0	0.0	8	22.9	11	31.4	10	28.6

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting recruitment and hiring
This question (question 9) is based on respondents who indicated that their local health care system had problems recruiting certain personnel categories (question 8A). Question 9 was asked for each personnel type marked "yes" in question 8A.

8B. IN THE PAST YEAR, did your local health care system have problems **RETAINING** the following personnel categories?

Table I-185. Type 2 Diabetes: Question 8B

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
a. Primary Care Physicians	110	69	62.7	28	25.5	13	11.8
b. Non-Physician Primary Care Providers (Physician Assistants/Nurse Practitioners)	110	34	30.9	63	57.3	13	11.8
c. Endocrinologists	110	19	17.3	57	51.8	34	30.9
d. Podiatrists	110	11	10.0	64	58.2	35	31.8
e. Nutritionists	110	7	6.4	77	70.0	26	23.6
f. Nurse Specialists with diabetes expertise	110	11	10.0	59	53.6	40	36.4
g. Physician Assistants/Nurse Practitioners with diabetes expertise	110	12	10.9	48	43.6	50	45.5
h. Ophthalmologists	110	15	13.6	49	44.5	46	41.8

Reasons for Staff Retention Problems

10. Please enter **top two reasons** why there were problems **RETAINING** these personnel types in the PAST YEAR.

Table I-186. Type 2 Diabetes: Question 10

		Lack of opportunity for professional growth/promotion		Dissatisfaction with supervision/management support		Dissatisfaction with support staff		Dissatisfaction with physical demands of the job		Dissatisfaction with workload		Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)		Organizational culture that does not prioritize/ encourage productivity		Administrative/ Program Demands		Lack of professional autonomy		Dissatisfaction with pay		Work schedule		Inadequate equipment/ resources/office space		Burnout	
Staff Positions	N	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
a. Primary Care Physicians	69	9	13.0	2	2.9	8	11.6	7	10.1	31	44.9	3	4.3	2	2.9	15	21.7	6	8.7	15	21.7	1	1.4	5	7.2	34	49.3
b. Non-Physician Primary Care Providers (Physician Assistants/Nurse Practitioners)	34	5	14.7	2	5.9	5	14.7	6	17.6	14	41.2	0	0.0	0	0.0	6	17.6	2	5.9	10	29.4	2	5.9	3	8.8	13	38.2
c. Endocrinologists	19	2	10.5	4	21.1	2	10.5	3	15.8	4	21.1	0	0.0	0	0.0	5	26.3	3	15.8	9	47.4	2	10.5	1	5.3	3	15.8
d. Podiatrists	11	1	9.1	0	0.0	1	9.1	1	9.1	4	36.4	0	0.0	0	0.0	4	36.4	0	0.0	5	45.5	0	0.0	1	9.1	5	45.5
e. Nutritionists	7	1	14.3	2	28.6	0	0.0	1	14.3	2	28.6	0	0.0	1	14.3	1	14.3	1	14.3	2	28.6	1	14.3	0	0.0	2	28.6
f. Nurse Specialists with diabetes expertise	11	3	27.3	4	36.4	2	18.2	0	0.0	2	18.2	1	9.1	2	18.2	0	0.0	2	18.2	4	36.4	0	0.0	1	9.1	1	9.1
g. Physician Assistants/Nurse Practitioners with diabetes expertise	12	3	25.0	1	8.3	1	8.3	2	16.7	4	33.3	0	0.0	1	8.3	0	0.0	2	16.7	5	41.7	0	0.0	2	16.7	3	25.0
h. Ophthalmologists	15	2	13.3	1	6.7	3	20.0	0	0.0	2	13.3	1	6.7	0	0.0	4	26.7	1	6.7	10	66.7	1	6.7	3	20.0	2	13.3

N refers to the proportion of respondents who listed each "reason" as one of the two most important affecting retention
This question (question 10) is based on respondents who indicated that their local health care system had problems retaining certain personnel categories (question 8B). Question 10 was asked for each personnel type marked "yes" in question 8B.

Appendix I.1.8 Gynecologic Surgery

Section 8: Gynecologic Surgery

Gynecologic Surgery

1. Please think about patients who need gynecologic surgery either as an in-patient or an outpatient, for conditions, which include, but are not limited to, endometriosis, cervical, uterine or ovarian cancer, fibroids, or a miscarriage. **IN THE PAST 12 MONTHS**, how often were there *clinically meaningful delays* scheduling these patients for an initial surgical evaluation with the following providers?

Table I-187. Gynecologic Surgery: Question 1

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%	n	%
a. VA Gynecologist located at **this Administrative Parent** (local health care system)	107	58	54.2	15	14.0	7	6.5	0	0.0	0	0.0	27	25.2
b.VA Gynecologist located at **another VA health care system**	107	29	27.1	7	6.5	5	4.7	2	1.9	2	1.9	62	57.9
c. Community Gynecologist (fee-basis or contracted care)	107	52	48.6	21	19.6	9	8.4	5	4.7	1	0.9	19	17.8

Reducing Delays in Evaluations for Gynecologic Surgery

2A. **Your solution for delays in getting an initial surgical evaluation with a: VA Gynecologist located at this Administrative Parent (local health care system)**. Think of the most effective way to reduce the number of *clinically meaningful delays* in patients receiving an **initial surgical evaluation.** Now, **in your solution, how important are each of the following elements**?

Table I-188. Gynecologic Surgery: Question 2A

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	22	5	22.7	8	36.4	4	18.2	3	13.6	2	9.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	22	7	31.8	9	40.9	4	18.2	1	4.5	1	4.5
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	22	7	31.8	9	40.9	4	18.2	1	4.5	1	4.5
d. Acquire and/or improve availability of equipment.	22	3	13.6	9	40.9	3	13.6	4	18.2	3	13.6
e. Implement or increase the availability of telehealth services	22	0	0.0	6	27.3	9	40.9	3	13.6	4	18.2
f. Improve information technology (e.g., scheduling system, electronic health record).	22	5	22.7	4	18.2	8	36.4	2	9.1	3	13.6
g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	22	2	9.1	8	36.4	4	18.2	5	22.7	3	13.6
h. Improve personnel supervision, management, or incentives.	22	7	31.8	4	18.2	4	18.2	5	22.7	2	9.1
i. Increase weekend and evening availability of services	22	1	4.5	0	0.0	14	63.6	5	22.7	2	9.1
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	22	2	9.1	4	18.2	7	31.8	8	36.4	1	4.5
k. Some other solution(s).	22	3	13.6	6	27.3	2	9.1	0	0.0	11	50.0
This question (question 2a) is based on respondents who indicated that patients experienced delays (n=22) in getting an initial surgical evaluation with a VA Gynecologist located at this Administrative Parent (question 1a)											

2B. **Your solution for delays in getting an initial surgical evaluation with a: VA Gynecologist located at another VA health care system**. Think of the most effective way to reduce the number of *clinically meaningful delays* in patients receiving an **initial surgical evaluation.** Now, **in your solution,**

Table I-189. Gynecologic Surgery: Question 2B

		Critically Important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	16	1	6.3	3	18.8	4	25.0	0	0.0	8	50.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	16	2	12.5	9	56.3	0	0.0	0	0.0	5	31.3
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	16	3	18.8	3	18.8	3	18.8	0	0.0	7	43.8
d. Acquire and/or improve availability of equipment.	16	2	12.5	2	12.5	3	18.8	2	12.5	7	43.8
e. Implement or increase the availability of telehealth services	15	0	0.0	2	13.3	7	46.7	1	6.7	5	33.3
f. Improve information technology (e.g., scheduling system, electronic health record).	15	0	0.0	1	6.7	6	40.0	2	13.3	6	40.0
g. Change “central office policies” that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	15	0	0.0	2	13.3	4	26.7	2	13.3	7	46.7
h. Improve personnel supervision, management, or incentives.	16	1	6.3	3	18.8	6	37.5	0	0.0	6	37.5
i. Increase weekend and evening availability of services	16	0	0.0	1	6.3	7	43.8	2	12.5	6	37.5
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	16	3	18.8	3	18.8	4	25.0	1	6.3	5	31.3
k. Some other solution(s).	16	0	0.0	6	37.5	1	6.3	1	6.3	8	50.0
This question (question 2b) is based on respondents who indicated that patients experienced delays (n=16) in getting an initial surgical evaluation with a VA Gynecologist located at another VA health care system (question 1b).											

2C. **Your solution for delays in getting an initial surgical evaluation with a: Community Gynecologist (fee-basis or contracted care)**. Think of the most effective way to reduce the number of *clinically meaningful delays* in patients receiving an **initial surgical evaluation.** Now, **in your solution,**

Table I-190. Gynecologic Surgery: Question 2C

		Critically important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	36	4	11.1	5	13.9	6	16.7	8	22.2	13	36.1
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	36	8	22.2	9	25.0	4	11.1	6	16.7	9	25.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	35	10	28.6	6	17.1	8	22.9	3	8.6	8	22.9
d. Acquire and/or improve availability of equipment.	36	4	11.1	10	27.8	3	8.3	6	16.7	13	36.1
e. Implement or increase the availability of telehealth services	35	0	0.0	7	20.0	9	25.7	9	25.7	10	28.6
f. Improve information technology (e.g., scheduling system, electronic health record).	35	5	14.3	9	25.7	11	31.4	4	11.4	6	17.1
g. Change “central office policies” that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	35	3	8.6	5	14.3	14	40.0	5	14.3	8	22.9
h. Improve personnel supervision, management, or incentives.	35	5	14.3	5	14.3	9	25.7	9	25.7	7	20.0
i. Increase weekend and evening availability of services	35	0	0.0	4	11.4	12	34.3	9	25.7	10	28.6
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	36	4	11.1	16	44.4	10	27.8	3	8.3	3	8.3
k. Some other solution(s).	36	3	8.3	9	25.0	5	13.9	4	11.1	15	41.7
This question (question 2c) is based on respondents who indicated that patients experienced delays (n=36) in getting an initial surgical evaluation with a Community Gynecologist (fee-basis or contracted care) (question 1c).											

3. Now please think about patients who have an indication for gynecologic surgery. IN THE PAST 12 MONTHS, how often were there *clinically meaningful delays* in the patient **receiving the surgical procedure at the following locations**?

Table I-191. Gynecologic Surgery: Question 3

		No Delay		1-10% of patients experience delay		11-25% of patients experience delay		26-50% of patients experience delay		51% or more of patients experience delay		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%	n	%
a. At this local VA health care system	107	50	46.7	16	15.0	6	5.6	2	1.9	1	0.9	32	29.9
b. At another local VA health care system	107	28	26.2	5	4.7	6	5.6	3	2.8	1	0.9	64	59.8
c. In the community using fee-basis or contracted care	107	58	54.2	19	17.8	10	9.3	2	1.9	2	1.9	16	15.0

Reducing Delays in Gynecologic Surgery

4A. **Your solution to delays in patients receiving gynecologic surgery:** at this local VA health care system. Think about the most effective way to reduce the number of *clinically meaningful delays* for **patients receiving gynecologic surgery**. Now, **in your solution, how important are each of the following elements**?

Table I-192. Gynecologic Surgery: Question 4A

		Critically important		Very Important		Somewhat Important		Unimportant		Not applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	25	4	16.0	11	44.0	4	16.0	4	16.0	2	8.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	25	7	28.0	7	28.0	6	24.0	3	12.0	2	8.0
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	25	7	28.0	10	40.0	6	24.0	1	4.0	1	4.0
d. Acquire and/or improve availability of equipment.	25	6	24.0	5	20.0	8	32.0	3	12.0	3	12.0
e. Implement or increase the availability of telehealth services	25	0	0.0	2	8.0	10	40.0	6	24.0	7	28.0
f. Improve information technology (e.g., scheduling system, electronic health record).	25	5	20.0	6	24.0	9	36.0	3	12.0	2	8.0
g. Change “central office policies” that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided)	25	3	12.0	5	20.0	6	24.0	4	16.0	7	28.0
h. Improve personnel supervision, management, or incentives.	25	5	20.0	3	12.0	8	32.0	5	20.0	4	16.0
i. Increase weekend and evening availability of services	25	1	4.0	2	8.0	8	32.0	7	28.0	7	28.0
j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community	24	3	12.5	3	12.5	11	45.8	3	12.5	4	16.7
k. Some other solution(s).	25	3	12.0	4	16.0	5	20.0	3	12.0	10	40.0
This question (question 4a) is based on respondents who indicated that patients experienced delays (n=25) in receiving surgery at this local VA health care system (question 2a).											

4B. **Your solution to delays in patients receiving gynecologic surgery:** at another local VA health care system**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for **patients receiving gynecologic surgery**. Now, **in your solution, how important are each of the following elements**?

Table I-193. Gynecologic Surgery: Question 4B

		Critically important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	**N**	**n**	**%**	**n**	**%**	**n**	%	n	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	15	2	13.3	2	13.3	4	26.7	1	6.7	6	40.0
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	15	3	20.0	5	33.3	2	13.3	1	6.7	4	26.7
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	15	5	33.3	2	13.3	2	13.3	1	6.7	5	33.3
d. Acquire and/or improve availability of equipment.	15	3	20.0	4	26.7	1	6.7	1	6.7	6	40.0
e. Implement or increase the availability of telehealth services	15	1	6.7	1	6.7	3	20.0	4	26.7	6	40.0
f. Improve information technology (e.g., scheduling system, electronic health record).	15	2	13.3	2	13.3	3	20.0	3	20.0	5	33.3
This question (question 4b) is based on respondents who indicated that patients experienced delays (n=15) in receiving surgery at another local VA health care system (question 2b). Due to a technical problem in the survey software, we do not have data about the importance of the following solutions for resolving delays at another local VA health care system: g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided); h. Improve personnel supervision, management, or incentives. Please describe in the comments box below; i. Increase weekend and evening availability of services; j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community; k. Some other solution(s). Please describe your recommendations in the comments box below.											

4C. **Your solution to delays in patients receiving gynecologic surgery:** in the community using fee-basis or contracted care**.** Think about the most effective way to reduce the number of *clinically meaningful delays* for **patients receiving gynecologic surgery**. Now, **in your solution, how important are each of the following elements**?

Table I-194. Gynecologic Surgery: Question 4C

		Critically important		Very Important		Somewhat Important		Unimportant		Not applicable	
Solution	N	**n**	**%**	**n**	**%**	**n**	%	n	**%**	**n**	**%**
a. Create additional space for patient care (e.g., more exam rooms, procedure rooms, inpatient beds)	33	5	15.2	4	12.1	4	12.1	8	24.2	12	36.4
b. Increase the number of licensed independent practitioners (e.g., physicians, nurse practitioners, psychologists).	33	7	21.2	11	33.3	5	15.2	5	15.2	5	15.2
c. Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff).	33	8	24.2	8	24.2	5	15.2	5	15.2	7	21.2
d. Acquire and/or improve availability of equipment.	33	7	21.2	5	15.2	4	12.1	6	18.2	11	33.3
e. Implement or increase the availability of telehealth services	33	1	3.0	6	18.2	8	24.2	7	21.2	11	33.3
f. Improve information technology (e.g., scheduling system, electronic health record).	33	6	18.2	4	12.1	9	27.3	5	15.2	9	27.3

This question (question 4c) is based on respondents who indicated that patients experienced delays (n=33) in receiving surgery in the community using fee-basis or contracted care (question 2c). Due to a technical problem with the survey software, we do not have data about the importance of the following solutions for resolving delays in the community using fee-basis or contracted care: g. Change "central office policies" that affect workflow and efficiency (e.g., rules governing documentation or how quickly certain services must be provided); h. Improve personnel supervision, management, or incentives. Please describe in the comments box below; i. Increase weekend and evening availability of services; j. Increase use of fee-basis or contracted care and/or simplify administrative processes for approval and transfer to care in the community; k. Some other solution(s). Please describe your recommendations in the comments box below.

Issues that Affect Provider and System Efficiency

5. IN THE PAST YEAR, how much did the following issues negatively impact provider and system efficiency related to the provision of gynecologic surgery?

Table I-195. Gynecologic Surgery: Question 5

		None		A little		A fair amount		A lot		Not Applicable	
	N	n	%	n	%	n	%	n	%	n	%
a. Providers performing clinical activities that could be performed by individuals with less training	106	33	31.1	21	19.8	20	18.9	11	10.4	21	19.8
b. Providers performing administrative activities that could be performed by others	106	17	16.0	23	21.7	18	17.0	28	26.4	20	18.9
c. Residency training/teaching requirements	106	37	34.9	13	12.3	11	10.4	2	1.9	43	40.6
d. Insufficient clinical/administrative support staff	106	14	13.2	26	24.5	20	18.9	28	26.4	18	17.0
e. Inadequate scheduling system and policies (e.g., hard to cancel or reschedule, coordinate)	106	27	25.5	20	18.9	24	22.6	18	17.0	17	16.0
f. Unnecessary documentation requirements or inefficient CPRS interface	106	24	22.6	24	22.6	21	19.8	20	18.9	17	16.0
g. Patient no-show rates	106	10	9.4	35	33.0	30	28.3	16	15.1	15	14.2
h. Poor patient flow management (room/bed turnover, appointments)	106	32	30.2	27	25.5	15	14.2	6	5.7	26	24.5
i. Too many administrative requirements (Initiatives/Policies/Programs)	106	27	25.5	20	18.9	24	22.6	17	16.0	18	17.0

Workforce

6. IN THE PAST YEAR, did your local health care system have problems **RECRUITING AND HIRING** gynecologists?

Table I-196. Gynecologic Surgery: Question 6

		Yes		No		Not Applicable	
Staff Positions	**N**	**n**	**%**	**n**	**%**	**n**	**%**
Gynecologist	106	30	28.3	76	71.7	0	0.0

7. Please enter up to **FIVE** reasons why there were problems **RECRUITING AND HIRING** gynecologists.

Table I-197. Gynecologic Surgery: Question 7

	N	n	%
Senior management does not agree to post new position –	30	7	23.3
Non-competitive wages	30	25	83.3
Work schedule (e.g., call requirements)	30	10	33.3
Benefits (e.g., health insurance, leave, continuing education, travel)	30	3	10.0
Equipment/resources/office space	30	15	50.0
Facility condition	30	5	16.7
Case types/complexity	30	10	33.3
VA reputation	30	12	40.0
No academic affiliation/lack of protected time for early career investigator	30	6	20.0
Geographic location of facility	30	13	43.3
HR process (e.g., time to advertise; length of time from job offer to start date)	30	25	83.3
Lack of qualified applicants	30	11	36.7
This question (question 7) is based on respondents who indicated that their local health care system had problems recruiting or hiring gynecologists (question 6). N refers to the proportion of respondents who listed each "reason" as one of the five most important affecting recruitment and hiring. This question (question 7) is based on respondents who indicated that their local health care system had problems recruiting or hiring gynecologists (question 6).			

8. IN THE PAST YEAR, did your local health care system have problems **RETAINING** gynecologists?

Table I-198. Gynecologic Surgery: Question 8

Staff Positions	N	n	%
Yes	106	13	12.3
No	106	93	87.7

9. Please enter up to **FIVE** reasons why there were problems **RETAINING** gynecologists.

Table I-199. Gynecologic Surgery: Question 9

	N	n	%
01 Lack of opportunity for professional growth/promotion	13	7	53.8
02 Dissatisfaction with supervision/management support	13	4	30.8
03 Dissatisfaction with support staff	13	4	30.8
04 Dissatisfaction with physical demands of the job	13	1	7.7
05 Lack of frozen pathology or gynecology backup	13	2	15.4
06 Lack of trained operating room support or lack of post-operating room nursing support	13	5	38.5
07 Dissatisfaction with workload	13	5	38.5
08 Lack of incentives or "management levers" to encourage productivity (i.e., no accountability)	13	3	23.1
09 Organizational culture that does not prioritize/encourage productivity–	13	4	30.8
10 Administrative/Program Demands–	13	5	38.5
11 Lack of professional autonomy–	13	4	30.8
12 Dissatisfaction with pay–	13	8	61.5
13 Work schedule–	13	2	15.4
14 Inadequate equipment/resources/office space–	13	8	61.5
15 Burnout–	13	3	23.1
N refers to the proportion of respondents who listed each "reason" as one of the five most important affecting retention This question (question 9) is based on respondents who indicated that their local health care system had problems retaining gynecologists (question 8).			

Appendix I.2 Survey Participant Comments

The comments from each survey respondent are grouped together, separated by a blank line between respondents. Comments are provided verbatim, except that: (1) Potentially identifiable comments have been redacted and redactions are noted as such (2) Some typographic errors have been corrected, and (3) duplicate comments from a given respondent have been deleted.

- **Chief of Staff**

Walk in visits to PC are acceptable and the Urgent Care Clinic is available for emergent/urgent care needs between 8am and 8pm
"Streamline documentation processes (utilize scribes, dictation software), decrease amount of clinically insignificant alerts, staff in PACT team work to highest level of scope. The physician should not be a "secretary"
Medical issues that are not clinically meaningful/urgent can be delayed.
Need to focus on basics; special initiatives and programs are mandated without thought of impact on the field or the needs of Veterans. There is a disconnect between Central Office and the facilities providing the care
"As applicable for primary care
If for all services, up to 10%"
"Closure of intensive care unit, ED and decrease of surgical services available on site"
At the main campus

Not able to assess whether and to what extent such occurs
Unable to determine
Some authorizations are for care of a specified duration
Some authorizations include a sufficient timespan so that f/u encounters for that problem are included
Educational sessions

"Unable to determine with any level of confidence. 88% of patients are getting in within 30 days. Some of the remaining 12% may have experienced a clinically meaningful delay. On the chance that some small number may have experienced a clinically meaningful delay, we answered 1 - 10%."
"Need to expand one of our rural CBOCs to provide space for an additional PACT provider and staff.
Need to hire growth teams at the parent site and one CBOC
Additional resources for FEE basis staff will help fill gaps."
No show rates impact some clinics more than others.
"Section on hiring issues did not give the opportunity to address our real problem areas. Urology is a critical shortage and non-competitive salaries are the major driving factor. Psychiatrists are in very short supply. Salaries are currently competitive, but may get to the point where they are not if supply and demand continue to be out of balance in both public and private sectors."
VLER penetration rate is low but increasing. We expect to do much more sharing of records electronically in the future. When the two large local healthcare systems are part of VLER sharing will increase dramatically.
The consult is valid for 12 months

We use hot spots in a few locations
Patients from other VA facilities and/or home to Providers in [location redacted].
Also within the Primary Care at [location redacted] VA

Decrease amount of hours required of LIPs to complete mandatory training.
Access to care
Cable not run through entire facility due to the presence of asbestos

"We have the capacity and systems in place to assure new patient access to primary care. Although some sites are at capacity, alternate sites are available within a modest distance <15 miles."

We have added provider extenders (NPs and PAs) specifically to assure same day/next day access for needed care.
The lack of sufficient exam rooms makes it very difficult to have efficient speciallty clinic flow or to expand capacity even when we have providers. Inpatient bed flow is similarly impaired by the lack of single patient rooms. The difficulties in trying to assure coordination of care through NVCC and the Choice program is creating substantial additional workload on clinicians that diminishes efficiency.
"Varies depending on the scenario. If we know in advance that the care will span a period longer than 60D, we can authorize a longer period. However, we would not authorize an indefinite time frame."
"CBOC Wifi is needed. ALthough delayed, we finally had our facility wifi upgrade completed in 12/14. We did out own internal guest wifi for the main facility encompassing selected inpatient wards and waiting areas."
We use the VA teleradiology program as well as internal resources (e.g radiologists with access from home).
"As noted on earlier response, we also use our providers reading from home as well as VHA teleradiology. We are collaborating with other VISN facilitiese to create an internal VISN teleradiology program housed at our VA"
This is a high end estimate and it is only certain urgent ED and off tour inpatient studies (e.g. stroke code) that might require this.
A large portion of our Telehealth program (including the Regional telemental health program) is housed offsite co-located with a PTSD/TBI-focused RRTP.
Direct to home CVT
Off-site facility telehealth center

Veterans sometimes choose not to get their care at the VA and demand we pay for them. They also demand second opinions which puts us in an awkward situation
"NVCC authorizations are good for 90 days. So after 90 days, they need a new authorization."

cooperation of other major VA to provide consultation service in a timely manner
n/a
parent va

"Need competive hiring processes such as direct funding for interviews, use of Public Health Service, home buy out, higher salaries"
"Need ability to work with community providers and not necessarily go thru 3rd party admin for local fee, DoD, and native sharing agreements"
Clinical reminders and alerts are overwhelming staff
We purchase some primary care and we purchase a high amount of specialty care that we do not offer in house.
We offer care closer to home which results in purchased care and we do not offer many specialty services so we purchase them.
There are barriers to sharing records with non VA providers electronically for over a year tied to info security and back ground checks.
We authorize a period of care of 90 days with a number of visits within the period of care under one referral
"If patient needs additional visits beyond hte initial period of care, we amend the original to the end of the fiscal year for reconcilation."
VAMC has WIFI for med equipment only.

We have a full time radiologist for our outpatient facility. We send exams for remote reads when he is on leave for coverage.
We send to another VA in VISN and VA National Tele Radiology program.
We provide teleMH with services from Dom to CBOC; CBOC to CBOC; VAMC to CBOC; VAMC to [location redacted] site.

temporary loses of staff
Depends on the service and provider
National VA Tele-radiology services

We specify the number of visits allowed within a 90-day window. We use the same referral to add more visits if necessary.
"After 90 days, we request a second referral for additional care."

Specify number/duration of follow up in NVCC consult request
telegenomics is in[location redacted]
VAMC

"I would estimate that very few patients, if any, experienced a clinically meaningful delay. Veterans are given the option of receiving primary care in the community, if we cannot provide access within 30 days."
"Information technology revolves around security ONLY and not the needs of those caring for Veterans. We use slow, outdated, and underpowered equipment that is geared to care in the late 20th century and not the needs of caregivers in 2015 and beyond. There is no flexibility of use.
Central Office policies, although possibly well-intentioned, often fly in direct contrast to the needs of our Veterans or with requirements made for those at the facility level. The shear amount of documentation often dwarfs the actual time caring for the Veteran."
"The VA has been overrun with beaurocratic policies and oversight that often lays in direct contrast to access and quality of care needs of our Veterans. The idea that “if a little is good, much more must be better“ is the standard operating procedure of the VA."
"Lack of inpatient beds
Ugent/Emergent Care"

home

particularly women Veterans with mammography based on VHA Directive
one referral will cover all EXPECTED visits for a given condition during a specified (EXPECTED) timeframe. these are not open ended and may require additional approval for UNEXPECTED number of visits/conditions

support the facility staff; leadership is leaving with substantial gaps

Space and lack of exam rooms is the primary barrier.
"While eligibility category is considered, the major focus is on clinical needs and acuity."
Difficult to get good data about non-VA wait times.

"One referral is used for an episode of care which may include multiple visits depending on the nature of the referral. As much as possible, additional services of visits are identified and approved in the intial referral."
"If the length of a course of therapy is known, we try and approve it as a whole. Where needed, separate 60 day authorizations may be used, but to the extent possible, one referral is used."
"Guest Wifi is available and installed in designated inpatient areas, waiting rooms, and cafeterias."
Only certain studies. Most are interpreted by on-call radiology staff
VA TeleRadiology Program as needed
We have a large telehealth center that is stationed at an offsite location that also houses a VA residential treatment program. It is not a CBOC.
Telehealth services to home
Off-site telehealth center co-located with a VA RRTP

increased space less fee for care...not veteran centric
space

dependent on services requested
primarily the primary VA medical center

"Prescriptive directives regarding required language to be documented, clinical reminders, informed consent documentation and discipline requirements."
Tertiary Care VA referral site has no access
"f/u appointments do not need a separate referral, but do require a second authorization review."
Methods are in place to bring the patient back in to the VA system if clinically appropriate.
home CVT
local VA

"Central office policies pertain to use of create date vs. desired date for new patients. A new patient may not want an appointment right away, particularly if they have previously been under the care of an outside provider.
Improved management relates to standardizing approaches for demand management across clinics."
"Improved IT relates to the scheduling system - there have been ongoing problems with selecting the correct desired date.
Changing central office policies refers to the many yearly clinical reminders that physicians need to clear even if a yearly appt is not otherwise necessary for the patient."
We focus on providing appointments to all Veterans who need care
"Prefer to bundle, but will question appropriateness for period longer than 60 days out"
Colon cancer and Diabetes clinics use telehealth for patient education
We have a speech language pathologist who provides care from [location redacted]
we provide clinical video telehealth to the home

depends on how consult is entered by physician and how it is approved.
based on review by the clinical chief

Unanticipated loss of providers at 2 CBOCS
"1. Need to be able to hire Physiciand- primary care and mental health -non competetive salaries, lack of efficient HR and contracting support are major impediments

2. Having adequate support staff- to answer phone calls and make scheduling changes
3. Easy to use scheduling software including options that allow Veterans to select and manage their own schedules- see commercial app“ZocDoc“; as an example
4. the process for using purchased care and the veterans choice options is deeply flawed and the contractor incapable of handling the needs"
"1. Reduce the lag time in hiring processes
2. Allow rentives etcapid implementation of locum contracts for temporary staffing
3. Improve the incentive process - repayment of educational debt, sign up incentives
4. Allow efficient staffing of front desk clerks and telephone call centers.
5. Multiple clinic rooms for effient throughput
6. VA policies to allow nurses etc to be more independent
7. Efficient scheduling software to allow for scrubbing and managing schedules
8. Higher graded clerical staff who can be trained to better interact with Veterans"
Loss of providers at 3 sites has required the remaing providers to take on their panels and limited the available capacity in the remaing providers
The PACT team has to function like a doctors office- where all but the essentila medical work is handled by other staff. Here the support staff have no incentive to support the doctor- just do the minimum work as listed in their PD or functional statements thansk to VA policies and labor agreements
Lack of capacity at the more complex sister Vas
Clical Urgency takes precedence
Sharing records is very difficult
Depends on the clinical situation- Usually for one visit unless its obvious that a follow up wil be needed
Depends on the situation

Fixed number of visits - depending on the need - specific time frame
Several of our PT providers located out of state and provide tele PT
We provide CVT to home and other NON VA locations

Where we have not had timely access we have utilized Non-VA care to provide
Need MDs and NPs to provide the care; Need PACT team support staff for team to function; Need equipment to make clinic rooms functional; Scheduling package wholly out dated and meets our needs poorly and is far from user friendly needs replacement critically; central office seems solely politically driven is not using best medical evidence to drive decisions on access and focuses on process not outcome measures; HR systems outdated and OPM rules cumbersome and limiting
"We have become a system driven by process measures which have cause and effect relationship to quality outcomes, there is little to no interest in getting input from those in the field; the bureaucracy from VISN upward needs “constant feeding“ and adds next to no value and has grown 15-20 fold in 15 years; the last 6 years the VA seems to be solely guided by politics; The functional business unit is the facilities"

"LIP: Having more physicians and mid-levels are needed to see new patients in a more timely manner.
Support personnel: Need PACT specific support personnel and other non-PACT hospital/clinical support such as pharmacists, techs, phlebotomists, clerks.
IT: A new scheduling package is important to help ensure appropriate scheduling and the EHR would be improved by having modern abilities for automation.
Central Office Policies: Policies get pushed down from Central Office that are often more mandates than guidelines and recommendations without field input or sufficient consideration for clinical repercussions."

"LIP: Having more physicians and mid-levels are needed to see new patients in a more timely manner.
Support personnel: Need PACT specific support personnel and other non-PACT hospital/clinical support such as pharmacists, techs, phlebotomists, clerks.
IT: A new scheduling package is important to help ensure appropriate scheduling and the EHR would be improved by having modern abilities for automation.
Central Office Policies: Policies get pushed down from Central Office that are often more mandates than guidelines and recommendations without field input or sufficient consideration for clinical repercussions."
"No, our local guidelines are that the NVCC request state a timeframe for all necessary follow-up care. e.g. referral for broken leg with 5 visits and necessary associated care for the next 2 months."
"No, our local guidelines are that the NVCC request state a timeframe for all necessary follow-up care. e.g. referral for broken leg with 5 visits and necessary associated care for the next 2 months."
"Tele-radiology services will start for weekend coverage in our facility as of July 1st, 2015."
Not sure this question makes sense to us. Each CBOC has different providers who provide tele-health services.

"We offer all patients who enroll, same day PC appointments. Patient scheduled only if they decline same day"
"Depends, some reerrals are eval and some are eval and treat"
"Again, depends on the condition and referring providers concerns, documentation and nature of request"

Too many alerts
Complex care
Patient satisfaction data from SAIL
Re-consult for ongoing care past 6 months
Telework

AGILE HR SERVICES AND PROCESSES!
THE PROLIFERATION OF COMPETING/SUPERFLUOUS/OVERLAPPING POLICIES BROUGHT FORTH BY CO AND PGM OFFICES NEGATIVELY IMPACTS TIMELINESS AND QUALITY OF PATIENT CARE
"One referral will cover all related visits to this specialist WITHIN THE LENGTH OF TIME ALLOWABLE FOR THE AUTHORIZATION, typically 60 days, and providing that the number of related visits requested is evidence based."
a separate referral will be needed after 60 days for further visits

"Better access to gap providers when urgent need arises, i.e., VA locums or related. It is taking way too long to get new hires for backfilled positions on board."
"Provider education re use of other VA facilities not uniformly good at this time; also, regional VA partners will occasionally indicate their inability to see patients even though they have the services"

"Increased access by expanding space, practitioners and support staff including clerks and nursing. Telehealth here is doing well although primary Tele-health is just starting. A reliable system of note dictation is crucial since enormous time is spent typing. Supervision of timely scheduling is very important. I believe that “fee“ care for primary care services is to be avoided if possible since the model of delivery that is a hallmark of VHA quality cannot be assured under these circumstances."
Issues for new appointments less critical although the time saved by good record creation would also be an issue here. Current weekend and night hours are poorly attended by Veterans.

Follow-up care is rarely delayed.
Scheduling rules do not always allow clerks to meet Veteran needs. Excessive educational requirements subtract from time with Vets.
VCL offered to Vets based upon distance or access. For access rarely accepted. Otherwise it is for services we do not do.
The local health care system cannot make those judgments.
We are looking at the average time. Data should be collected but it is not.
"Referral includes the number of visits necessary, procedures and post procedure visits for up to six months."
will need another referral if is past 6 months. Facility is capable of follow-up.
"Wireless internet access available in one CBOC. However, access meant for Vets and families and not staff."
Nighttime coverage outside this Admin. Parent.

STAT readings
Data sent to Veteran's outpatient PCP

Clinical space for efficient flow is an issue. Providers are not assigned multiple rooms for efficient patient flow
Maternity Care isnot done at VA medical centers. Space needs at the medical center prevent expansion of services locally
If a service connected veteran cannot be scheduled in a timely manner then this is brought to the attention of MAS and clincal supervisors in the area and resolved.
One referral will cover related visits for a period of 60 days
Authorization will be extended for the required time frame.
less than 5% but all are re-read by our radiologist
We are now starting CVT in the home. largest CVT is in MH
and Main VA hospital

VA interpretation of OPM rules constrain our ability to hire staff at salaries that are competitive with our private sector competition. We cannot hire health techs since they were downgraded to GS5. HR has been decimated by downgrades and cannot hire the VACAA positions we were designated to receive.
We have 650 positions stuck in the hiring queue
"Scheduling package: see Jon Stewart
We have 1985 tools to manage our systems of care. VACO imposes reporting criteria that make it difficult to schedule, but facilitate their reporting of our scheduling."
We prioritize almost exclusively based on medical need.
All of our teleradiology reads are overread the following morning. THe only official reads are VA reads.
We use teleradiology for emergencies at night

"Ability to recruit and retain physicians is a huge problem. VA pay for providers has not kept track with what has been available in our area. Additionally, once we get good providers in place, in unending bureaucracy, difficulty dealing with non-productive clerical staff, and burdensome clinical reminders leads them to consider other jobs. Too many of our provider hires consider the VA at “temporary“; job until something better comes along or they can move to another area. For the most part, we have the appropriate number of support personnel, but maintaining those with a good work ethic is difficult and getting rid of those who are unproductive is even more difficult. Equipment procurement and contracting are extremely difficult to navigate, making new purchases a challenge. Central Office's

requirements, while noble, fail to take in to account the current status of non-VA health care systems across the country. Mandating 30 day evaluations for the VA when most clinicians in our area can't accommodate similar requests is unreasonable. Patients that we send out via Choice are rarely seen any sooner than we could see them in our facility."
Issues are similar to those expressed in previous section. I would add that the VA scheduling program is extremely outdated and very user unfriendly.
Approval will typically cover initial visit and necessary follow-up visits.

question makes no sense; what is the denominator?
not sure about last question
home or on college campus as part of VITAL program

"Information management - need updated EMR
h. change pay to incentivize productions, also change Title 38 leave to be used hourly.
j. administrative burden"
Generally panel specific--as a composite we do not have delays.
Overall administrative burden is out of control.
limited local specialty care
"Limited specialty care.
Serve large population."
Will structure based on episode of care
Home/telework
home/telework
"Currently Home Telehealth and Home TeleMOVE combined have over 500 patients. 1 Lead RN, 4 RNs and 2.2 RDs."
"RDs are stationed out of Medical Center,(telework from home). 3 RNs are at CBOCs (telwork from home). 2 RNS stated at Medical Center (telework from home). The RNs are assigned to specific PACT teams with geographical location kept in mind when assigning."

"1. In [location redacted], space is one of our most critical needs. It has been very difficult to obtain space in a timely manner due to the incredibly cumbersome contracting process.
2. VHA contracting policies/practices must be redesigned to be more user friendly, efficient and timely. This is one of our biggest barriers to providing timely care.
3. The rules/regulations around Non-VA care must be simplified and the process must be streamlined if we are to ever be successful in obtaining care in the community.
4. [Location redacted] is in the process of reorganizing our services into product lines to have higher accountability from mid-level supervisors."
"See comments on prior section - many relate to established pts as well. In addition:
1. We have hired many new providers. We just need to get their panels up to capacity which takes some time.
2. We must continue to aggressively hire the support staff that helps compose the rest of the primary care team.
3. We will never be successful if we continue to expect some of our lowest graded (entry level) employees to use an antiquated, overly complex scheduling system. We need a new system asap or we are setting ourselves up for failure."
"1. The current volume of suspenses, reports, etc. coming from VHA is untenable. Many of our leaders spend great amounts of time completing these and then never receive feedback. For example, we just

completed the bi-annual Uniformed Mental Health Services survey - nearly 600 questions that we will never see the results of and that will not help us improve.
2. We burden our providers with administrative tasks that are either not-value-added OR that could be done by someone else."
1. [Location redacted] is reportedly the largest user of Non-VA care in the U.S.
"We have allowed for longer timeframes, but not unlimited."
only VA issued equipment are allowed on the wifi. patients do not have access to the system.
I'm not 100% certain about this.
"we use telehealth/teleconsultation with other VAs. For example, Tele-genomics with Salt Lake City."

Under this last question would include significant TMS requirements especially a flood of new requirements recently that are taking providers out of patient care to complete
Lack of appointment availability in [location redacted]
Veteran priority/SC are considered sometimes when scheduling surgery appointments. These issues do not affect clinic appointments
Usually all visits will be covered within a specified global period.
"Visits outside the global period are reviewed and normally authorized on the same consult. Sometimes another consult is required depending upon the situation, time since last appointment, how far outside the global period the requested appointment is"
Also weekends and holidays
Home telehealth (other than monitoring) or telehealth for Alaska

"For surgical cases, as described above, the pt would be covered under global period for 90 days for all visits and would not require an additional referral. For physical therapy, a certain number of visits are authorized on a single request. For follow-up visits not within the scope of the initial referral, an additional consult would be required. Short answer, it depends on the service and whether or not multiple visits are required to provide the service"
See previous response
At a referring facility or at home

More flexibility at Medical Center level to solve problems.
Provider turnover - note the difference between services we normally would provide to those that we would not.
One referral to provide all clinically indicated services.

one referral will cover all related visits within the designated timeframe.
they would need a subsequent referral for the extended time frame

systems redesign
systems redesign
one referral with time limit on approval
one referral with approval for increased timeframe

Veteran gaming the system

PC has a 1-2 day wait time.
Need to work on cultural transformation in some clinics.
Compassionate care when distance is involved or end of life are.

We share images from radiology with outside providers when appropriate. We routine use data on wait times.

Change VA primary care model staffing similar to Kaiser.
Fully staff PACT and get people work at top of license.
Excessive clinical reminders. Too much typing.

"If Veteran is frail and condition requires frequent visits to medical center may refer to fee basis to avoid undue stress to vet, at times a second opinion is sometimes requested and is not readily available at another VA"
"1% of the CVT encounters by provider are conducted by Geneticist out of network located in Salt-Lake City, UT.
1% of the CVT encounters by provider are also conducted by SCI providers outside our network."
"1% of TH patients outside our network are seen by Spinal Cord Injury providers in EOVAMC.
3% of TH patients are seen via ?Video to Home(CVT)? which precludes the patient from presenting at a CBOC or VAMC and instead present in the comfort of their homes."

Home

We allow walk-in appointments and we have an ED for patients to use.
"We only have one exam room per PCC MD. This makes patient flow inefficient. We have a shortage of Primary Care MD/DOs. Our scheduling system is poor and makes us spend too much time trying to justify mistakes. Telehealth is something we have begun to use, but it requires more space. The number of clinical reminders is too large, thus making it difficult to address all issues in the allotted appointment time.We have not found weekend clinics to be used by Veterans. The difficulty in receiving information from outside venders is an ongoing problem."
We unexpectedly lost providers and have been detailing providers from other sections to help cover.
We do not have a neurosurgeon and we just recently hired our second ortho doc.
One provider works from home.

"Delays have resulted only when a miscommunication has occurred and a pattern is that the patient themself has contributed. At this facility, there has been a minimum of clinically meaningful delays."
"1. Create additional space for patient care:
Primary care providers at [location redacted] are limited as they must perform all activities and a single examination room. Flow of busy clinics is enhanced by increasing the number of available clinic once per provider. 2 exam rooms per provider would greatly facilitate workload. Note as well that mandatory assignment of full large rooms for supportive staff seems wasteful. Smaller cubical type environments would likely suffice for nursing intakes and nursing clinic visits.
The strengths of this largely rural facility are in its outpatient venues with the exception of some areas where strengths should be maximized (orthopedic surgery program). Maximization of outpatient capabilities will be more effectively and efficiently utilize the resources available. His facilities greatest vulnerability as its inpatient acute care service and it is quite difficult to higher skilled hospitalist and intensivist and emergency department physicians. Additional inpatient beds are therefore not currently warranted.
2. Increase the number of licensed independent practitioners:
[Location redacted] Health Care System resides primarily in the [location redacted]. The geographic isolation of this area influences the availability of care. Hiring young professionals into our city and county is difficult. Private sector resources are also limited. Many specialties are served by monopolies.

Inpatient hospitalist coverage and outpatient primary care provider coverage are limited and additional providers in these venues would be greatly valued. Specialty care in urology is a huge challenge. Other specialties such as general surgery are currently meeting demand. Both physician assistant and nurse practitioner resources would be evaluated as well. Mental health support/psychologists and psychiatrists is a huge needed.
3. Increase the number of other personnel:
Pharmacist support is lacking. The sophistication of medications and especially psychotropic medications is often beyond the vernacular of primary care providers and the expertise of pharmacist availability would be greatly valued. Current requirements for medication reconciliation, oversight of psychotropic medications, use of hepatitis C therapies and other venues require on the spot expertise that has become outside the usual fund of knowledge for physicians. The quality of care can only increase by optimizing pharmacist support. Clerical support is very lacking. The entry nature of the position of a clerk, particularly a clerk assigned to scheduling, results in rapid transitions. The expertise of an individual in a clerical roll is therefore quickly lost. Additionally the scheduling software, ancillary tasks assigned by auditing agencies and the need for data extraction frequently overwhelmed these personnel. Centralizing clerical services appears to be a favorable influence however functional interactions between clerical services and clinical services is not occurring as is standard.
4. Acquire and/or improve availability of equipment:
This is a more difficult question to answer. Budgetary constraints often truncate the wish was to this facility however I respect the organizations prioritization of equipment that contributes to patient care. Acquisitions are encumbered by contracting and processes are quite challenging.
5. Implement or increase the availability until a health services:
Telemedicine and tele-health are exceptional attributes of the VA. Growth of this modality is in the organization?s best interest. Telemedicine can provide backup for absent providers and reach Veteran patients in remote locations. Specialty care not available locally is accessed and distant resources.
6. Improve information technology:
This cannot be answered quickly. Scheduling software is defective antiquated inefficient non-intuitive. The methodology by which electron a size data is extracted requires a substrate of clinic in location definitions that is also overwhelmingly confusing and, because of its complexity, often misused. It appears that the priority is the VERA capitation model. The entire system is built on a Foundation that collecting capitation data is optimized. Clinical data is de-prioritized to the top of the pyramid. Rather than starting out with the clinical report and extracting encounter data and other data from the clinical information, the current system asks that the encounter location and definition either platform upon which the clinical information is built. This inversion of priorities as a basic programming assumption results in a lack of understanding throughout the system. CPRS, the actual EMR, is user-friendly in many ways that normal gallop is are not. It allows speech to text input. It is moldable. It is not however standardized and in position of some standardization would help. Short staffing of IT and helpfullness of IT are extraordinarily poor. There is poor attitude in the IT staff there is a lack of willingness to facilitate the organization omission and there is a sense of self abuse and punishment imposed from outside. It is difficult to describe the frustration of day-to-day computer and software dysfunction. It is even more difficult to realize that they help available from information technology is essentially absent most of the time.
7. Change central office policies that affect work flow and efficiency:
Central office policies are often a “one size fits all“ mandate that does not match the needs of any specific facility but represents a lowest common denominator of expectation. Mandated programs such as the women"
See answers already submitted in earlier question.

"Followup has been more challenging than an initial appointment. Particularly in CBOCs, support personnel are limited. Providers themselves have demonstrated lack of flexibility to facilitating scheduling. Clerical behavior has also been in obstruction. Clinically meaningful delay does occur more often with followup visits then with an initial appointment."
Requirements imposed by off as an inspector general are many times opaque to the providers that must comply. For example documentation that the patient understands the instructions regarding flouroquinolone administration is a requirement that has been emphasized to the point of ridiculousness. The history of many requirements he is obscure and the rationalization has been lost
Limited resources available on station. Geographic isolation of our location. These factors for small business out to the private sector.
A multitude of reasons exist. Travel difficulties for veterans who are not qualified for travel reimbursement is an issue.
Data regarding her patient's electronically with private sector providers is a huge handicap to the care of patient's. The over-prioritization of privacy restrictions hamstrings our ability to share vital information with outside hospitals and providers.
"Generally speaking, non-VA coordinated care is managed our facility by optimizing the likelihood that additional referrals will not be needed."
"Generally speaking
Episodes of care require additional referrals. Cases that span extraordinarily long times are discussed on a daily basis for decision-making purposes."
Wireless has been handicapped by privacy issues. General availability of wireless is not present. It is difficult to access the Internet in this facility.
Use of NTP has been extremely common in this facility.
Some of this utilization has been the discretion of the radiology service and less autonomy in this decision-making is anticipated.
Tele-health services are also provided by specialists are station to patient's at the facility/administrative parent.
At the main facility/administrator parent

"Need locum tenems capability or gap/surge providers when providers are out or leave. Also, increase retention incentives to minimize turnover"
Loss of providers often leads to delay in follow-up appointments that rely on a patient's interpretation of clinically meaningful as they have walkin availability but often don't utilize it.
one referral but authorization will be updated based on clinical review of request from non va provider.
new but related followup managed for up to 1 year on same referral.
Provider at home.
patient at home

Eliminate the arbitrarily set expectation that patients must receive an appointment within 30 days of the clinically indicated date. It has no clinical relevance.
eliminate unnecessary clinical reminders that have no clinical relevance.
"A specific clinical service is not available, or vacancies exist that contribute to delays.l"
We have access to some non-VA provider's electronic record portals
For Veterans Choice One referral covers all related visits up to 60 days. A reevaluation is then completed to determine the need for further care.

probably 11-20% of the time

ED diversion due to full inpatient beds
one referral covers all related visits within a specific timeframe

Use of Contract Providers and Locums Tenems; expand affiliation with local PA Schools
Too many View Alerts with limited clinical value added
"one referral will cover all related visits within a stipulated timeframe, eg 3 visits in 6months"
additional referrals are required for services to be rendered that will involves other diagnostic and therapeutic interventions
at the Parent facility with satellite offices in the CBOC

"The system is perfectly designed to get the results it achieves.
Serious IT interface issues, network speed, built space layout issues, training and competency issues for non-physician and physician staff, ineffective staffing on PACT's (why LPN, RN and clerk....was the old physician with 3 MA's and an RN case manager, Pharm D and APN to cover 1100-1500 in a panel so bad?) Also....illness and complexity of patients in panels not considered in staffing. No consideration for standardized work and real competency on the teams. A 85K a year RN answering phones is a waste of personnel. And if a physician does not have three exam rooms and a mobile computer, how do you ever expect them to see more than 8 -9 a day. I would invite anyone who thinks they can do it, rather than pontificating on the merits of PACT or PCMH within the VA to come down and try it out for themselves. PACT can work, but it is a fignewton of the imagination in it's current structure. Almost no VA's have the full elements that were found in the Commonwealth Fund article to be needed to make PACT really work. You can get mad at Dr. Stark, bit no one is listening to the 49% of providers that are burnt out or the front lines. The plan forward is to make the VA physician led on PACT's. Providers are paid a capitated amount based on quality, panel size and disease severity, access and patient satisfaction and total costs of care. Providers can earn more by practicing better medicine and getting larger panels. Pay issues are self correcting. Providers select their team members who are also incentivized to share in the success of the team. Team members who do not perform can be replaced if they cannot produce to the level of care that is needed. Providers, must however, work with HR to help replenish team members that are lost. The Union should be the fiduciary owner of worker quality. The new bargaining agreement should include FTE hiring and incentive pay plans based on achieving certain value based metrics for outcomes in quality, cost of care, patient satisfaction, access and overall health of the population."
"Political pressure by local politicians to do so, especially in [location redacted]. DAV is telling veterans they can go wherever they want due to the new ACT. We try to explain the ACT politely and accurately but there is little willingness to listen as this is not reinforced in political offices which have even turned us over to the press when the answer has not pleased the veteran."
"This would be considered unethical from a medical perspective. In reality, it creates a caste system in the VA and breeds disrespect on both sides, high ranking and low ranking. Either give everyone the same benefits or don't give benefits at all. On no planet is this even remotely ethical."
We do this with the new VCL program and they are waiting in general significantly more than within the VA. Forget trying to find a new PCP in the community.
There is usually a limit but we try to cover the entire episode of care or one year whichever is most appropriate.
"They might, but usually this does not happen. Globals cover the surgery and global period. Outside of the global period, the surgeon usually just calls and requests and we approve. It was being gamed a bit in the past so this is why the re-referral."

establish a pool of primary care provider to cover new or existing positions

it depends

"For patients that cannot be scheduled quickly, we make telephone contact with each one to ensure that no urgent need exists (i.e., a delay would be clinically meaningful). If one exists, they are seen immediately. Otherwise they are given a true choice - wait for PCP or use Choice for the community options. Almost all choose to wait."
"At 90 days we can see all returning patients. 30-day timeframe is a little tighter with their own provider. However, if there is an urgent need, they will be seen by someone, but perhaps not their own PCP."
"There are many activities that to a clinician are considered clerical, but somehow are defined as clinical by others (arranging travel, facilitating procurement of OTC prosthetic items like socks). There is a fair amount of required training with no medical value that negatively impacts access. We manage our no-show rates by appropriate overbooking once we hit the lowest rate we can, so that is not actually a problem. CPRS inefficiencies, including documentation requirements for regulatory and not medical reasons, definitely lowers productivity (I have a list of these if anyone asks)."
"[Location redacted] is unique in that we have > 100,000 enrolled veterans [informationr edacted] but no inpatient facilities, so ALL tertiary care must be bought in the community. This will change very shortly (2015) with the activation of our new/first hospital. Even so, over the last 5 years we have been steadily increasnig the complexity and capacity of the care we can provide as an outpatient facility (e.g. 450 surgeries per month, advanced endoscopy)"
"As stated before, [name redacted] is huge [redacted]). Geographically, we live in a veteran-dense area, so < 1% of our veterans live more than 40 miles from any facility. It is solely a question of having a limited portfolio, and as we activate our hospital in the next 6 months, we will be able to bring much more care into the system; we expect our community reliance to drop by at least half."
"We triage by medical necessity. Having said that, we have never had the situation where we would need to “bump“; one veteran at the expense of another; all receive the care they need in a timely fashion, either internally or through one of the purchased care mechanisms."
"For electronic sharing, we have a va-employed hospitalist team at a local hospital for up to 30 admitted patients and can see their electronic record, but no one else's (and we fee out $140M per year, so this is the minority). We do track wait times through NVCC-managed care, and the community is in many ways worse than we are. Choice-ACT/VCL care is much harder to track, and we review that as well; again, the VA does at least as well as the community in the things we do offer. Many patients have asked to cancel their VCL-appointments when the realize the VA may actually see them sooner. We have much better overall control of care through NVCC, though, and will make sure patients are seen when they medically need to be."
"Depends on the indication. For some things we know in advance will require comprehensive care (multidisciplinary cancer treatment, e.g.), we attempt to authorize the entire episode up front. For specific surgeries, e.g., we authorize the post-op visits and rehab, but additional care will need additional review."
"As before. We try to anticipate the length of the episode of care needed to address a problem completely and preauthorize it. Sometimes we guess wrong and the veterans do need additional authorizations for a single issue, but this is rare in our system."
"This is an evolving topic. In two of our OPC's and our hospital, WiFi is available. It is not yet available in 4 of our CBOCs, but there is a firm plan to implement it."
"We are an outpatient-only facility at this time, but we do use remote reading when appropriate, either among our own sites and through the national VA telerads contract (who does much of their work overnight)."
As previously described in question 15.

"We use the national telerads program to cover unanticipated absences and manage variability in radiology supply. [redacted] Our goal is to have the majority of our studies read by our own physicians, even if at different sites, and use teleradiology for a small amount to smooth out demand / supply."
"We use telemedicine extensively in a provider-patient modality (including with patients who are abroad), and for selected clinics with provider-provider modality for access to specialists as listed above."
We have no hospital; but we have three very large OPC
"We have no hospital in our system.
Our 3 very large OPC's support each other, but the majority of that support is directed at CBOC's which have fewer specialists or even primary providers. A small amount of our patients receive telecare directly outside of a VA facility."
"Keep in mind that we have > 100,000 patients enrolled, so even with the same % of adoption, we will also have one of the largest absolute number of enrollees."
We maintain a high absolute number of patients enrolled because of our innately large patient base.

"The number of clinical reminders, performance measures have ballooned since Kyser's initial items to where there are over 300+ measures. Also requirements for encounter completion, adds workload to providers which from the patient's prospective would not be value added. Also direct enter of progress notes with out facilitated technologies greatly limit our primary care and specialty care providers to numbers of patients that can be seen in comparison to private practice providers."
"Authorizations are specific to type of care that is requested, some consults cover a whole episode of care with associated procedures (e.g. Hemodialysis 3 times a week; Nephrologist office visits 2-3 times a month; Temporary catheter if indicated, monthly labs, AV fistula or graft if indicated, to include venous mapping, revision of fistula/graft, post imaging, shunt replacements/revisions certification period 10/01/14-09/30/15). Other authorizations specify evaluations with requirement for present recommendations pre-authorized care (e.g. Veteran is approved to be outsourced to neurosurgeon for evaluation and treatment recommendations for lumbar disc prolapse with radiculopaty. All labs, radiology exams, physical therapy and durable medical equipment are to be requested through the additional COS consult for pre-authorization. Review of administrative eligibility has been completed.)"
"Care is outlined in authorization, with when to re-contact facility for additional authorization, (e.g. Veteran is approved to be outsourced to community urologist for cystscopy for evaluation of hematuria, also approved is one UA with cytology, follow-up office visit to discuss findings. All pathology slides positive for malignancy must be sent to Veterans Healthcare System [location redacted]. Review of administrative eligibility has been completed.)"
"There is Wi-Fi at main facility for medical instruments, VA lap tops, but there is no access available currently for private use of staff or Veterans and visitors."
VISN with contract radiology providers.
Just a guess
Tele retinal reading for store and forward
Tele-Health program is supervised by ACOS of primary care. Most of the Tele-Health staff are located at the Medical Center a few in larger CBOC

I am not aware of any untoward events in this arena.
Vista appointment sytem should be replaced with off the shelf product. very old and complex. CPRS needs to be either refurbished on the user interface or be repalced.
"This varies based on volume, inpatient capability, overall lack of supportive resources throughout the enterprise."

Lack of resources.
This is performed by PC-3 they provide dashboard data.
Defined number of vists and scope of care are given. We can always add or subtract additional visits based on the Veterans needs.
Some may go during the normal work hours based on demand.

New PC appointments scheduled between 91 and 120 Days = 13.38 % and PC appointments scheduled > 120 Days =10.51% based on the Veterans Preferred Date
Established PC appointments > 90 Days = 15.58% and Established PC appointments > 120 Days = 5.23% based on the Veterans Preferred Date
"[Location redacted] VAMC utilizes a high percentage of NVCC, Choice, and PC3, as a level 3 facility much of our specialty services are fee-basis or contracted care"

"The items marked “a lot“ are common themes in provider feedback provided to the facility, and are a significant hindrance to providers attempting to deliver care"
Patients feel entitled to non-VA care and demand we fund it.
"We consider priority in new patient evaluations (in primary care), otherwise not"
Word of mouth is that veterans wait significantly longer for care in the private sector.
"We authorize an “episode of care“. This is typically one visit, but sometimes more depending on the service required (eg. surgery will authorize a follow-up visit along with the surgery itself)"
"I believe our timeframe is 90 days. If it requires more than 90 days to complete the episode of care, we require a separate consult/auth"
Nights and weekends
NTP program
"Surgical post-ops and some pre-ops can be done via CVT technology.
TBI requires face-to-face evaluation."
"We primarily use telehealth from the parent. Occasionally, one CBOC helps another. We are investigating the possibility of some care from remote areas (interstate)"
"The only patients at the main facility (for CVT) are ones receiving services from another main facility (spoke and hub, where hub reaches out to us)"

One referral will cover related visits to this specialist regardless of timeframe unless it crosses fiscal years and then a new consult is required.

nothing to add
one referral will cover all related visits within a given timeframe
for VA devices

No cases have been identified indicating that patients experienced a clinically meaningful delay but it is plausible that that may have occurred.
"Though no adverse outcome has been identified, delay and lack of continuity of care has occurred due to vacancies and Provider turnover."
Referral sites may not be able to provide timely access to specialty care (depending on the specialty).
"It depends on the reason for referral. Evaluation and recommendations only or evaluation and treatment or evaluation treatment and follow up. If recommendation is made for further follow up, then it is approved by adding an addendum (separate referral is not needed)"
This also depends on the reason for referral. We try to get patients back to the VA system. If needed we authorize for further nonva care.

"For MRI and Nuclear medicine tests, as well as for STAT requests when staff radiologist is not available."
Utilize CVT into the Veterans home

Requests for fee care are reviewed on an occasional basis to accommodate special circumstances. We also get pressured to approve fee care by our Congressional folks in area
Dependent on the condition being requested on the referral. Some will automatically include other visits for the management of the care
Most likely one referral will cover the related condition and the approval will be added to the consult

We need to be able to shift funds between the 3 major appropirations.

depending on the clinical necessity
depending on clinical necessity and travel distance
NTP MOU
at parent facility also

"Our facility needs more space for primary care, better incentives and pay to recruit and retain high quality providers (loss of retention pay 2 years ago is difficult), and authority to increase the number of primary care teamlets to make our growth in uniques (there is a horrible lag in this regard, meaning that we only add teamlets when we've gone beyond capacity)."
Referrals are authorized for specific care delineated within the authorization for NVC. Timelines are rarely given to providers that state how much time they have to complete that care.
We would love to have this but it is simply not affordable based on our current local budget.
We use the another facility in our network on occasion and use NTP every day for after hours work that needs a STAT reading.
Other locations is medical genetic consults at SLC.

[Location redacted] is trending in the right direction
"Under primary care provider retention, View Alerts are the biggest reason for provider burn-out. A primary care provider will receive approximately 100+ View Alerts per day. A large part of the view alerts involve either esoteric clinically irrelevant information or alerts sent to multiple individuals leaving the primary care physician with the burden of determining who may have already taken action on a certain alert. [Location redacted] VAMC has done
all it can within the current flexibilities of CPRS to decrease the view alert burden. Facilities must acquire additional authorities to locally modify CPRS such that primary care providers can focus their efforts on those alerts that they must take action on. Under “other solutions“, primary care providers must provide pain management to medically complex patients with significant psycho-social issues. Under the Opioid Safety Initiative (OSI), primary care physicians must offer alternatives to narcotics, which does not easily lend itself to a 30-minute appointment. TMS pain management education modules give interesting but operationally impractical information. I propose that VHA fund one pain management specialist for each Patient Aligned Care Team (PACT).
Under “central office policies“, Facilities must obtain the authority to hire, fire, and promote on the spot with minimal interference from federal statutes or VHA policy."
"See comments under “new patients”“
[Location redacted] is trending in the right direction.

"[Location redacted] VAMC is working to change the culture towards improving the above. However, VACO can assist with the following:
1. Eliminate administrative burdens such as the verbal consent requirement for HIV testing. The private sector does not do this.
2. Increase authorities for facilities to modify CPRS.
3. Enable facilities to hire, fire, and promote personnel on the spot with minimal interference from federal statutes or VHA policy. This will go far in changing the culture and increasing morale."
Varies among specialties
Veteran eligibility for NVCC is determined prior to appointment being made. COS approves all exceptions to eligibility.
[Location redacted] VAMC must scan in records from the private sector into Vista.
"Generally, non-VA care will authorize a limited number of visits with a specific provider. However, if the conditions require other services such as diagnostic studies or treatment modalities (eg: physical therapy, prosthetics, etc), then VA must submit an additional referral."
"If beyond 60 days, VA requires a referral to cover the additional 60 days."
"Remote by an outside vendor takes place every night, weekend, and holiday."
"For diabetes, [location redacted] VAMC will implement “downloadable“; glucometers so primary care providers can improve diabetic control."

"equipment-just BP cuffs, ekg machines, etc
EHR: information needed is not at point of care. I would like to have information on which patients had recent med changes, specialty recommendations.
Policies/procedures. The return to clinic mandatory electronicordering as per VISN [location redacted] has created difficulty in workflow. the provider gets the order in sometimes after the patient leaves, so the scheduling is not face to face.
Med recon is hard to implement. It is 1 more task on the providers. There should be a way for the patient to enter his meds and flag any questions or concerns for review with the provider.
A standard intake form electronically that would populate the provider note would really help. The veteran could enter his fall data, med changes, med questions and it would pull into doc note. The specialist recommendations would pull in. Then patient education material could be automatically printed (on fall recuction, medication side effects) for the provider to review with the veteran."
"see previous question response.
Also, realign clerical and nsg staff under PACT to decrease silos."
"The COS and nursing office often has to make up for inefficiencies and poor performance in the business office and HR, leading to loss of focus on access. Our AA to the COS spends most of her time on HR. Which is ironic, since we have only hired 10 VACAA positions so far, of which 5 were internal hires, and only 1 is a provider. There is a lot of time spent with little seen for the effort."
lack of inpatient mental health and medicine/ICU beds
"we are moving toward 1 referral (example: orthopedic surgery will have a preop visit, surgery and PT)"
If over 90 days per the NVCC staff
VA contract
Home
At parent facility

"Need more nurses and clerical staff.
Our scheduling software is archaic and is not flexible enough to accommodate the types and complexities of appointments.
The access standards are inflexible and “one size fits all“. Expectations are often unrealistic.

Physician/provider compensation is not aligned with access and productivity. Incentives do not adequately reward high performers."
"Documentation requirements are excessive and sometimes comical.
Other comments same as in previous section"
"We used a contract, but transitioned to a VA contract in past year or thereabouts"

"Depends on the referral; for example, surgical oncology would be approved for a pre-op visit, the surgery, and a specified number of post-op visits over a year"
"Depends on the specialty, but generally would be approved for a certain number of visits over a certain period of time"
CVT to home

Provider works from home

At another VA providing telehealth consultation not at our location
Patients to receive these services at home

Provider and Nursing vacanies
Hard to get data from [name redacted] vendor
Parent facility

Adhere to the 60 day time frame
"Under other locations, a few providers are providing service from home."
On-site at VAMC

"We estsblish timeframes, frequency and duration for all referrals"
we have many providers working all diffent schedules at facility and CBOCS

Number of visits authorized at time of initial referral
Up to 12 months
Remote reading instituted within past few months
Patient home

Number of approved visits is specified
It is decided case by case
[Location redacted] is a HCC not a VAMC
All are located at the HCC

urgency not able to be accomodated
only in EWL are these things considered per policy
"it depends on what is approved. sometimes follow up is approved on initial authorization, sometimes not"
it depends on the authorization
the NTP system has been a game-changer
NTP
at the main site

"We have significant space issues. We have turned providers away because of lack of space. It takes far to long to obtain space.
Everyone thinks to hire the doc, but truly the doc can be far more efficient with support staff. We need more nurses and techs.
Every year we have equipment needs that get placed to the bottom of the list. I need new OR lights, all defibrillators are at end of life. I could use 5 million more surgical instruments.
surgical complexity requirements are too restrictive on smaller, rural facilities.
The NVCC process is difficult at best. Far to many requirements and steps. It just creates barriers to care."
see other responses
"Providers approving eye glasses and all sorts of prosthetic items, Nurses can play a larger role, the electronic records makes things more difficult especially with scanning etc.
Consult process is cumbersome. Would be great to have support staff assist in process.
The alert process is difficult for providers.
Providers required to do the coding pieces.
Too many clinics-- required do to copays, billable, non billable, Inpt clinics now.
CPRS has become admin record and not a clinical record."
lack of space to hire specialists Too many restrictions to keep a provider competent
"This is not usually needed, our wait times are not clinically excessive."
another VA facility
Indian Health reservation

"Administrative burden including inordinate amount of clinical reminders, view alerts, suspenses, metrics requires large amount of administrative time that could be better used to see patients"
We try to approve all visits with one referral but does not happen consistently
One telehealth psychiatrist works in Minnesota but is on staff here.
Main facility

Can authorize several visits and then extend if needed
not really sure on this one. Some of the patients are at one of our CBOCs while others are at the main facility
currently in [location redacted]

VACO policies are contributing to the problem. Please let us do our job.
Veterans requiring obstetric care are covered by a single referral
We've not had an issue takinig care of these patients in-house
"If you's stop asking mind-numbingly stupid questions, we could get on with real work"

May require separate approval if a procedure is recommended after consultation.
Done on case by case basis as clinically indicated.
There is wireless internet but it can only be accessed via VA devices.
Tele-retinal cameras are in CBOCs where images are acquired and then forwarded to another facility in the VISN for interpretation.

"most troublesome admin barriers are leasing delays, no space's poor flow
hiring barriers"
uncertain the projected impact of the CARE program.
home

Too many non clinical requirements take away time from meaningful and value added Veteran care expereience and timely acces for Veterans
Lack of availability of timely care from neighboring tertiary care VA facilities - esp. since the close tracking of timely acces to care
Is based on clinical needs.
"All outpatient visists can be on one referral
Inpatient care requests need another referral and authorization accoding to CBO
In the example above, if the Veteran needs an inaptient stay following operative fixation, then he needs another authorization - significantly adds to admin workload and at times scrambing to avoid delays in care for Veterans"
Home

Lack of space to expand services. Lack of support staff to schedule.

Expect that emergent/urgent care needs would be prioritized by clinical staff without delay.
Same as prior answer
"Fee basis is growing rapidly as system and expectations change. However, the vast majority of care is still being delivered in VA."
Usually for specialized services that VA does not provide
within reason. Additional referral and approval may be needed if the care plan changes.

We do follow national guidelines for Dental eligibility
We do share paper copies when clinically indicated at the patients request.
We use a combination of one referrals and multiple referrals based on the individual patient's clinical need.
One referral will cover all related visits to this specialist within a specific timeframe.
But we also have onsite staff as well.
We have Radiologists that telework readings from home.
Some on-call and telework reading
Also at our parent facility

Remote location (designated rural health hospital); Tertiary care facilities in VISN [location redacted] do not accept patients readily: preserve their own numbers (performance measures)
"Other VISN [location redacted] facilities have those that approve the transfers in low clinical levels, which allows for inconsistent decisions secondary to work load requirements on transfer."
"To reduce potential cost issues, f/u visits are required to be approved by chief of staff before scheduling."
Older buildings with blackage of wireless access by degree of obstructive materials used in older constructions.
CVT is located where specialty services are available at VA facilities.
"At the parent facility (VAMC). The facility is a rural access hospital, and all home telehealth is supported by in house providers."

One referral with specific time frames and services.
Extension of time frame is authorized.

Ease from restrictive Civil Service (H R) Rules would facilitate hiring

care is covered for up to 60 days
individual decision: will be reviewed for need of further care
at the Parent Facility

One referral if requests states the number of visits and the time frame
Several visits may be requested over an extended period of time
Wireless internet access is being installed at a CBOC at this time
One provider delivers care from home work site
"We have consistently had over 1,000 enrollees. The number fluctuates slightly over time."
The last time we were under 500 enrollees was before 2010.
We also have a NP assigned to the Home Telehealth Program who assists with health care needs of those Veterans enrolled in the Program.

Same day access for all established patients is available in all Primary Care locations.
"Lack of sufficient beds to admit patients, causing diversion (due to lack of nursing staff)"
Based on clincial needs and only under 1 year.
"If original authorization is exceeded, then a new authorization will be needed for the extended visits, based on clinical need."
HBPC CVT to the home.

Patient request - PTSD or prior bad experience at VA

One referral covers all related visits for a period of 90 days.

"Need new scheduling package, need competitive salaries, need better contracting and IT, need streamlined HR"
"Space, improved HR, Improved scheduling package"
At the VAMC

"Increase in psychiatrists, medical officer of the day coverage, PACT providers and Medical Support Assistants. Very difficult to recruit to this rural area. No equipment needed. New scheduling package is essential.Central Office policies of 1 size fits all does not work in all arenas of healthcare especially in rural/frontier areas."
Refer to previous comments
"Due to difficult to recruit area, we have providers participating in roles that could be more efficient with use of other disciplines."
limited access capacity at tertiary facilities in our VISN
As long as the original referral is authorized as such after the initial clinical review
See previous comment

Handled on a case by case basis depending on nature of the treatment.
At the local VAMC.

"IT equipment needed and scheduling package is inadequate. Requirement for times of appointment indicated by consult, fails to recognize later veteran preference for time of care."
as for 2
Time specified in approval
specified at approval up to 60 days

For some scans. In house for most by day
home

"The degree of management by numbers rather than actual clinical outcomes causes delays in access and decreases in Veteran satisfaction, specifically relying on numbers to measure care impedes the clinical process. The non-VA option for care was working for access, now CHOICE will worsen it yet again based on non-clinical people determining how clinical care should be driven. Simply put, stop having non-clinical people determine how care is delivered"
"They will be approved for a certain amount of visits, applicable to the clinical condition"
as in 13 a

biggest issue with patient flow is lack of space and the time frame for acquisition of new space which can take as long as 5 years for our most recent CBOC.
"specialized services that we cannot provide such as radiation therapy, nursing home care, home health aids"
we manage our access to take care of ALL our veterans within a clinically appropriate timeframe
Our info security program office does not allow sharing of electronic medical records. We do receive electronic records from outside providers.
"referral covers entire episode of care but is time limited based on what type of care is required. For example, 2nd opinion is a single visit; if we know the veteran needs surgery the referral covers pre-op and post op visits as well as surgical procedure."
see 13 A comments
VA Office of Information Technology has been unable to support this.
Colon cancer: tech is available but not in use for colon cancer
Have some offsite office space for telemental health so doesn't use much needed clinical space in med center.
using home CVT telehealth
telework from home to free up scarce and much needed clinical space

- **PTSD**

modify from 14 days to 30 days for new pts
modify 14 day to 30 day requirement for new pts
increase availability tele-health equipment
clerical staff; need additional computers and telehealth equipment; hiring and retention initiatives

"*outgrowing all opt clinical space
All LIP needed
*Pharm D, clerical staff, nursing
*Improve organizational structure with admin support
*Scheduling System improve user friendly. *Decrease number of opt clinics to manageable size
*Must continue to build BHIP Teams"
"* Psychologist, LCSW or equiv, nursing, Psychiatrist, pharmd and admin
* build teams with supervision internally"
"*Space for CBOCs to include exam space and additional inpt beds due to growing demands
*Telehealth-space,equipment and staff needed to include prescribers, therapists, technicians admin, nursing
*User friendly scheduling pkg
*create teams supervised by member of the team"
"*Space to build more treatment teams to include prescribers, therapists, nursing and admin equipment to include bp machines
*pbm also exists in scheduling return appts. this is critical once initial visit/diagnosis made"
"*need space, staff to include prescribers, therapists, nursing, admin, pharm d.
*Teams function as a unit supervised by team member
*Major pbm is scheduling timely return appts after initial eval/diagnosis"
"*space for staff, additional staff to include therapists, admin, technicians who can perform testing
*build teams with leads and supervision in teams
*Pbms rescheduling timely follow up appts once initially seen"
"*physicians tend to carry the burden of care
*improve flow with additional staff and space
*too many clinical reminders"

"b. Reassign [location redacted]telehealth responsibility away fron [location redacted]. Have CHOICE telemental health provider
c. Someday more newly hired-MHI social workerinto offices in [location redacted] CBOC and [location redacted] CBOC.
g. Reduce SPRS reminders and required TMS training."

"More LIP therapists, particularly psychologists and LCSWs.
Mental health Suite consumes more time than is neccessary and is redundant information. Such information should be in the providers note.
Nurse Case managers could be extremely helpful particularly with managing individuals with multiple conditions (i.e. Polytrauma (PTSD, TBI, and Chronic Pain))
Desperately need admin person or persons dedicated exclusively to our Psychology and LCSW Training Programs."
"Need for more general mental health therapists (psychologists, LCSWs).
Redundancy of Mental Health Suite; information in the MHS should be included in the clinicians evaluation report, usually in a more efficient, concise and readable fashion.
Nurse Case Managers could help facilitate and ensure continuity of care for patient''s with comorbidities and complex conditions (i.e. Polytrauma (PTSD, Ortho, TBI, Chronic Pain)"
Mental health Suite is redundant and does not provide useful information.

"Need tele-screening capability--working on this at present.
Weekend and evening coverage will require a ""culture shift for both patients and clinicians."
scheduling system is too old/cumbersome

"We are lucky to be hiring more staff, but HR policies and not enough HR staff are slowing down the hiring process. Without MH new staff, mainly psychologists, GMH and PCT cannot keep up with psychotherapy demands. Metrics do not help us, but rather slow us down and often use data that does not accurately reflect our work and patient care. Admin support is inadequate due to low staff and poor training. Administrative processes for non-va care are slow and have gaps in the process. Solution: stop asking current staff to take on the work of these deficiencies and give more staff who are trained and most importantly, give us space. Contracting issues have slowed our leased emergency space to 2 yrs!!! It is taking years to build new buildings. Solution: cut the red tape especially in contracting."
"Need more staff to meet psychotherapy demands with the space to go with that. It is taking 2 yrs for our emergency lease space and years to build any new buildings. Solution: cut red tape in contracting. Admin staff need more training. Veterans are telling us that vcl is taking longer than being seen at the VA. Hire staff to manage vcl and ewls for psychotherapy. Needs for psychotherapy are different than PC or even psychiatry since psychotherapists see the same vets weekly for 3-6 months. That leaves no room to take on new cases until the others are done. Productivity measures for psychologists need to be different than one size fits all disciplines since psychologists have many roles which are not always direct patient care. Need more staff for infrastructure to support our work such as clinic profiles staff, HR staff, clerical staff. Archaic processess like vista scheduling and multiple forms needing multiple signatures delay work. It took me almost 3 mos to get the paperwork for teleworking through and we got it done when I mentioned we"
"The same 3 things are critical for every section in this survey 1) More staff 2) More space 3) More admin support. Not able to retain staff due to overloading them with clerical tasks, not providing adequate training (MSAs), Same gaps in the process for vcl as mentioned before."
"Staff are coming, but until then (months) we are understaffed for psychotherapy. We are almost doubling our staff size, but have no space for when they get here. Our waiting room holds 8 seats. Emergency lease space is taking 2 yrs!! Our new building is taking yrs to build. Vista scheduling is archaic. The paperwork to start to telework staff creates delays. There is no wait for telehealth because the demand is low. The wait for our cbocs for psychotherapy was clinically significant until recently because we hired more staff."

Our SUD/PTSD services are in the same PCT clinic. The same comments for the other sections apply here.
"As providers, we have to do many clerical tasks since our admin support is overwhelmed with patient demand. Our infrastructure is a house of cards....we have to double check the work of support staff because there are either errors or things are not done because support staff are a skeleton crew. Constantly having to remind support staff (this is not just clerks) to get things done or fix mistakes is frustrating and doubles the provider''s work. The scheduling system is inflexible and so, does not reflect how we work to meet the veteran''s needs. Veterans no-show because there is no consequence for not showing (being charged or losing sessions authorized). They know they can show when they want. However, this often means another veteran could have been seen. The no-show veteran for intakes goes to the back of the line which makes the consult open for months. There are so many policies regarding cancelling clinics, tours,taking leave, working hours, etc., that are rigid and do not provide flexibility for employees."

"We currently have a 1.0 FTEE SW providing 100% of EBPs for PTDS at Rockford. There are occasional delays for Veterans to commence psychotherapy for PTSD in [location redacted]when referral rates are higher. This waxes and wanes over the course of a year. If new FTEE were requested for [location redacted], it would be for a psychologist or social worker."

"1. We literally hae no space for the additional providers that we need to serve our Veterans. We have money for new staff, but cannot use it because of lack of office space.
2. Because of the emphasis upon hiring staff for the Homeless Veterans program, HRMS is forced to delay many hiring actions for other staff.
3. We need additional clinicians in all disciplines. Workload data indicates that average clinician productivity in this station exceeds Directive 1161 RVU targets by about 50%, and we still have difficulty meeting the clinical needs of our Veterans.
4. Additional clerical staff (schedulers) and at least one additional administrative staff member are needed in MH.
5. The scheduling system is archaic, cumbersome, and does not meet the needs of modern healthcare systems. It needs not a set of ”fixes““, but replacement.
6. ACRP is extremely limited in its capabilty to provide meaningful reports on provider productivity. The interfaces that have been developed to pull data from VISTA cnstitute improvements, but they too are very limited, and I have found mathematical errors in the one being promulgated nationally.
7. As a manager, I am extremely limited in the incentives I can offer my staff. Given how hard most of them are working, this means I cannot adequately reward the degree to which some of them truly go ““above and beyond““. This leads to poor morale.
8. This station has for years had the lowest salaries for most disciplines in the VISN, and indeed, is among the lowest int he country, despite having one of the highest costs of living. With our budgetary restraints, we have staff in various disciplines leaving here to go elsewhere within the VA system, for similar positions, and getting ~10% more pay in lower cost of living areas.
””[comment redacted because potentially identifiable]
11. Weekend and evening hours have been extremely underutilized despite extensive marketing."
Already addressed previously in survey
"Greatest needs are:
1. Support staff for telehealth
2. Greater bandwidth
3. More space for equipment, though ideally this would be accommodated by desktop telehealth units in provider offices(but too few offices)

4. Providers..."
"1. Personnel needed:
a. Providers: psychologists, LCSWs
b. Support staff: clerks & admin
2. IT: scheduling package. Also, I should have mentioned earlier, that CPRS needs a significant ”overhaul”“ or replacement:
a. Notes and Discharge Summaries modules should function like a word processor, not like a typewriter.
b. Notes Module should permit direct insertion of images.
c. Template system should be both more capable and user-friendly.
3. VACO polices - as previously addressed.
4. Incentives, as previously addressed."
"1. Psychiatrists spending hours per week literally doing social work care coordination, similar examples in all disciplines.
2. Providers and managers spending MANY hours each week doing scheduling, running administrative reports, etc., that could be effectively done by personnel at the GS9-11 level, but are being done by personnel at the GS13-GS15 level due to lack of such support staff.
3. Terrible scheduing software, as mentioned previously.
4. Outdated CPRS interface, as discussed.
5. Poor bed management system for residential care.
6. Providers spend substantial time meeting ”clinical” performance measures that are actually of very limited value."

Other solution: decrease administrative burden on clinicians which would allow more time for patient care
Decrease administrative burden on clinicians
Our residential program has been reduced to 6 beds (from 12 beds) due to space constraints. Additional space is of essence for this program to be fully functional.

"We are currently operating at 60% mental health staffing which has impacted clinicians ability to schedule additional appointments for veterans. Initial Access to care has not been impacted, but has adversely impacted morale of staff as staff work through lunches, essentially triaging scheduling of returning veterans, and working late or coming in early. Given that PTSD is the 3rd most common diagnosis for this facility, it would be helpful to have a defined PTSD program. Having a defined PTSD program would help flow over veterans from specialty care to less intensive mental health services delivered through PCMHI. Difficult to do telemental health groups as there are usually problems with the equipment either at the main clinic or at the CBOC. On average it would take 20 minutes to start a group using telemental health equipment which negatively impacted veteran care. IT support staff available would be helpful. Central policies are well intentioned and useful; however, we need to have an active role at the local level in implementation and development in writing for how these policies will work in outpatient. I hear this frequently “we need more things written down.” The strongest concern from local staff is that the policies are not reviewed and discussed in a timely manner. It would be helpful to have additional support staff with clear expectations of roles in scheduling and coordinating communication between veterans and clinicians. For example, some days MSAs use outlook to check clinicians schedules and on other days just Vista. When veterans are rescheduled or request to have an appointment change, it would be helpful for the MSA to make the appointment change instead of asking the clinician make the call. Given the decrease in clincians, it would be helpful to not have to make additional administrative calls. Management could be better supported in assisting staff with barriers to

doing their job or holding staff accountable to do their assigned job. Improve role definition between different displines (i.e., psychologist, social worker, RN) would likely improve morale as clinicians would be working towards the top of their license. Increase incentives/recognition for clinicians working towards making positive changes in the department. We already have extened hours in outpatient mental health. We are already utilizing fee-based care with positive results."
Recommend increased incentives for hiring and retaining psychiatrist or nurse practioners for CBOCs. Additional support staff and clinicians may help improve retention of psychiatrist or nurse practioners. Increase availability to use and improve system for telemental health so psychiatrist or nurse practioners at the Anchorage clinic can readily deliver these services to CBOC's. Have a SOP in place for this process and how to manage staffing issues in the CBOC. Increase availability of rooms for telehealth. Fee-based care is highly utilized in the CBOCs.
"Increase support for psychiatrist and nurse practioners to do telemental health. For example, have IT available to answer questions quickly. Support in scheduling appointments. Make space available for veteran to be seen by a psychiatrist or nurse practioner from the main clinic to a CBOC."

"Psychology and LCSW staff needed.
Scheduling system should be made more user-friendly to improve efficiencies.
In order to increase evening/weekend clinical hours there need to be increased support staff hours as well.
Discharge planning needs are made difficult in an entitlement-based system."
"See previous comments, as they apply here as well."

clerical support

"Vista is so old, would be nice to have a new system."
"CBOCs have limited space and are understaffed in BH services. Social workers are wearing 3 hats: PACT social work, PCMHI, and BH. Some CBOCs might have only a BH prescriber and a social worker or have these services only available via tele-health during very limited hours. Policies that are predicated on attendance, which VA staff have no control over, should be recinded.
We need a scheduling system that allows schedulers to see clinic availability in multiple clinics at one time."
Space and personnel are primary issues. Reference the literature or VA studies regarding evening and weekend hours. No-shows during these times are problematic.
"Policy can dictate; but without staff to support, will be impossible to implement. In addition, policy can dictate by xxx time, xx% of all visits will be non-F2F. What if the Veterans prefer F2F. Which is more important, Veteran centered-care or policy?"
"During the recent allocation of Choice positions, our facility ”received”“ 4.1 additional BH slots. Need is much greater. Only 1 of those 4.1 positions went to a CBOC."
"When staff is limited (7 psychologists in our entire system) and programs/initiatives require o.3 to 0.5 or more time allotment for implementation AND staff are assigned more than one program, staff availability for treatment is significantly impacted.
We have attempted to assign these program duties to other staff, with the result that implementation was negatively impacted."

"Additional Psychiatry, Social Work (LCSW) and/or Psychoolgy staff at some of our CBOC’’s is needed."

"More staff (LCSW;LPMHC;PhD) would improve access. Limited telepsych is staff related, not equipment related; lack of administrative support (e.g. clerks) leaves clinical staff doing admin. work that takes from clinical time; multiple ”coordinator”“ positions and collateral duties also reduce clinical availability; Strong emphasis on specific credentials (e.g. jobs rolled out by VACO for only psychologists) can also limit availability. Strong emphasis on hiring Veterans sometimes makes recruitment of the best possible clinicians difficult."
"As stated in previous section - more staff are most important, office space will be a problem if more staff are hired, lack of admin support that is program specific is a problem; limitations of supervision (e.g. GS 12 team lead can"
As noted previously - pay incentives for clinicians to travel to remote CBOCS would be helpful in recruiting.
Incentives to work at remote CBOCS. More streamlined supervision process. More ability to recruit external providers who are not Veterans or internal candidates when jobs are posted
"As noted before - we are understaffed. CBOCs are more understaffed, but everywhere is. More staff will need more office space, which is also a problem, especially at the CBOCs"
"Providers must do consult management, schedule appointments, handle all administrative tasks. Training programs pull psychologists’ time a good deal, so do the multiple coordinator positions; as

team lead, I have spent hours reviewing charts related to measures and writing business case plans to beg for more staff when, as an EBP trained trauma therapist, I could have been seeing clients."

"Scheduling software needs a lot of improvement, not flexible and we are trying to do too much with it that it was not designed to do."
Need more providers in certain CBOCs and is hard to recruit particularly with non-compete clauses that the community has them sign. Community will also often pay them a stipend while in residency in exchange for a certain number of years of work. We cannot compete with that.
Space and staffing are important factors in most of our CBOCs. Groups do not work well with tele-health so we need on-site staff for this.
Scheduling software needs to be modernized

More demand than beds available; no community residential PTSD programs

"need to cease using ancient scheduling system, including use of “clinical profiles” in this system which are so restrictive and arduous to update when providers’’ availability changes. Our #1 problem with access for PTSD patients is in regards to the way scheduling is done!"
"MH supervisors need dedicated time to provide meaningful clinical supervision to assure PTSD services are done in accordance to Best Practice Guidelines and to assure clinical CPRS templates are updated and being used appropriately. Also, MH supervisors need dedicated time to establish and maintain telehealth arrangements with Hub sites."
see previous comments as they all apply for this section as well
we don’’t have enough dedicated PTSD providers nor do we have the space for additional offices or group treatment rooms
please see previous comments
wait time for residential treatment is terrible

"b. Psychologists, Social Workers, Family Therapists
c. LMFTs, Nurses, Clerks, Pharmacy support for CBOCs
f. Scheduling system does not accomodate groups well
g. NEPEC reporting takes too much time away from clinical care; EBP is not for everyone; EBP training programs are rigid, cumbersome, and at times traumatic to therapists; Performance measure ““force”“ patients into therapy whether they need it or not.
h. Clinicians need more autonomy and increasaed flexibility in the workplace."
same as previous

"We need general mental health support for stable, long term PTSD patients outside of the PTSD Clinical team. PTSD
Team needs a single, “dedicated” Administrative Staff person to coordinate all scheduling and monitoring of all required paperwork."
We need more clinical staff who can see patients for medication. Delays are critically difficult when a patient misses an appt. and cannot get a new one for weeks.

"Additional Clinical VA Staff vice locums or fee-based.
Additonal Administrative Staff would also be beneficial."
"Incentives would be nice.
Policies could be more flexible to recognize differences in facilities

Reports/Ratios are not the same for rural and urban medical centers, yet we are all held to and judged by, the same standards.
An IT system, or Enterprise Resource System, that is web based and can ”talk”“ to all facets of treatment - unlike the hodge podge of systems of wildly vintages that the VA uses now.
Just interoperability of what we have now would be an improvement."
"IT infrastructure is critical to CBOC care.
Incentives would be nice.
Additional clinical staff would be nice as well."
More clinical personnel would allow for a slight increase in the number of cohorts being conducted at any one time.
"Increasing the # of Admin Staff, Scheduling software, and CPRS upgrades would all be desirable."

the scheduling package that we currently use is antiquated and not practical for use in Mental health services where you have both individual and group therapy
"the schedulilng package makes it very difficult with so many grids, due to liminitation of the package and multiple stop codes"

"We are in dire need of more space and more providers. If both were increased, the access issue would be resolved. We have well trained and dedicated staff. The situation is worsening, and CHOICE is making it worse for a variety of reasons. VACO needs to set and disseminate feasible standards for mental health care in terms of expected productivity of providers. The mandates on our providers are MUCH more extensive than they were even 5 years ago, yet know additional time has been allocated for those ”non-direct care”“ tasks. CPRS is okay, but the scheduling software is very outdated and causes huge inefficiencies. The fact that we have over 20 distinct passwords that change every 90 days is also inefficient - why not one password connected to our PIV cards?"
"The environment in VHA currently is punitive in many cases rather than offering rewards for excellent ideas, policies, and procedures."
"The demand for mental health services has skyrocketed in recent years, and the number of truly new, independent providers has not kept pace. We need space to put new providers in."
It is difficult for us to recruit and retain psychiatrists - many have left the VA or reduced hours due to salary and burnout (they report feeling overwhelmed by the workload).
"We have some of the best trained staff in the nation - including trainers in EBPs. However, there are insufficient therapy slots because of the multiple cometing demands on our providers."
"EPBs work very well, but they require a bit more prep time and sometimes more time during and after appointments. Without incentives, therapists find it difficult to add this additional workload when productivity doesn’’t change."
"No shows are seen as a system cost, but to individual providers no shows are seen as an oppotunity to catch up on the many other required duties. It is critical to understand this when solutions are proposed. ”Missed Opportunities”“ often means “Opportunity for something else that helps Veterans.”

"Licensed independent practitioners: are in great need of additional therapists (psychologists and LCSW), as well as mid-levels to support medication management services.
Technology: MHS is very cumbersome and time-consuming
Central Office policies: having to call all no-show patients 3x regardless of risk status (particularly time-consuming for groups)
Personnel incentives: for some disciplines, the compensation at VA is not competitive with private sector, and make it difficult to recruit and retain high quality professionals

Other solutions: need to create ways to have some variety in duties/responsibilities as well as some ”down time”“ in order to reduce provider burn out; would be good to partner more with VSOs and other organizations regarding some of the ”myths”“ that many veterans buy into regarding types of services/frequency, etc that is needed to obtain/increase/keep their level of service connection"
"For areas that are same for initial evaluation in previous question, would have the same comments. For this section, would recommend need for additional tele-health equipment with adequate time for training of staff"
"Would give same comments as in previous sections. Would also add that for our facility the majority of MH is provided via tele-health, with little face-to-face contact- often this is a complaint of veterans. Additionally, except for MH staff most of the providers in our CBOCs are contracted, and veterans often complain about this- the quality of care they receive, and the high turn over rate. This impacts their medical care for physical health concerns, but also impacts their MH care as well (ex: veterans become frustrated and either don’’t come back or request to have their care transferred back to the main VA, which limits their ability to come for appts due to the distance travelled; often the contracted staff are not as aware of the MH services available to the veterans so may not refer as needed/appropriately"
"Critically important to have more clinical psychologsits and LCSW to provide group and indvidual therapy; also, office space for these providers is essential.
Technology: use of MHS is cumbersome and time consuming, especially so for documenting group interventions; scheduling technology is slow and not very user friendly, especially when trying to schedule multiple appts (ie, for a group or an EBT protocol)
Other solutions: better educate non-EBT providers regarding the EBTs- what they are, what makes a good referral for this type of treatment, educating veterans of what to expect"
Would offer same comments as in previous section.
Would offer same comments as in previous section.

"Need more clerical staff who are competent to do their job and who are well/appropriately supervised
Need additional group rooms. We are very constrained space-wise"
There are too many reporting requirements and metrics that are not meaningful from a care perspective. These duties take away from valuable patient care time and do not add to the well-being of the Veterans.

need more space in CBOC’’s and more TCT’’s to room the pts and monitor.
need more space to provide services
continue to offer EBT training and we are trying to make sure we have enough in the CBOC
Need more PTSD MHRRTP programs. maybe if we had more space and it was easier to start them up?

"Better Tele-equipment would be helpful, as well as more available units. Begin using iPad’’s for ERANGE and HBPC. Working in two time zones there are occasional double books and other scheduling problems."
Increase prescribers (Psychiatrists and NP/PA or PharmD). Improved computers/tele-equipment. Incentives are important in rural settings. Better scheduling packages would help with double booking and other errors.
"Psychiatrists are badly needed (along with NP/PA or PharmD with mental health training), nurses or LVNs as support to the prescribers, nurse case managers would also be very helpful regarding follow-up care and follow-thru on care planning. Good tele-equipment is very important especially in rural settings. Better scheduling systems would potentially decrease scheduling errors especially when dealing with multiple sites and two time zones. In rural settings incentives and other enticements are important given what the provider will give up leaving more urban environments."

"Psychiatrist, and other prescribers are crticial with support needed from nursing, and administration/health techs. Improved tele-mental health equipment is needed especially in rural areas. In a rural setting, incentives and other enticements are important."
"Physicians within the CBOCs are critically important. Support for the physicians in the form of nursing/health tech would support a higher quality of care, along with space to work. Better scheduling system would be helpful along with incentives that would support the move to a rural setting."
"Psychiatrists are critical with nurses/LVNs and other support staff being very important. Better tele-equipment with improved scheduling programs would also be important. Finally, being in a rural region incentives and better access would improve care but there are few providers in some of these rural communities that would allow Veterans to use fee-basis or other forms of care."

"In our clinic, our scheduling options are limited for PTSD services because of stop code requirements. Guidance about setting up clinic profiles to allow for more flexibility would improve access. Now, clinicians are bound to evaluating certain patients within certain stop codes.
Our current assignments include overburdened supervisors, who have to attend to administrative duties rather than being available for clinical supervision - this reduces efficiency in providing care to Veterans suffering from PTSD. Recruiting talented and experienced clinicians (Psychologists for example) with the current benefits structure of only 2 weeks of AL is extremely difficult although other benefits are inviting."
"Once again, we are located in a rural hard to recruit area - improving recruitment incentives such as benefits (specifically AL) would be very helpful to our recruitment efforts. The scheduling system and requirements need to be improved. We work hard to get Veterans timely services, but getting a Veteran seen in consult quickly does not guarantee that follow up is adequate. I personally don''t see contracted care as the solution, as our community does not have staff who are as well-trained and knowledgeable about Veteran care. (Ex: the state of WV does not require doctoral level for psychology licensure, the VA does and we believe this is the best level of educational background to treat Veterans)."
"We have CBOC that are too small to accommodate staff, and more space is needed. Telework options are limited in some rural areas where Veterans do not have access to broadband services (VA equipment availability is actually quite good - but not helpful if you can''t reach a Veteran). Once again, better recruitment incentives are crucial."
"1 of our CBOC''s has NO group room, one has a small and limited space for groups that is shared space with telehealth equipment limiting services and requires extraordinary coordination. More space is needed. Veterans have not, in our experience, enjoyed attempts to participate in groups via telehealth with a group of Veterans at our parent facility (even our staff who use telehealth equipment to be involved in team discussions feel removed and thus it is more difficult to engage). Efforts to recruit staff for weekend services has been extremely challenging and our current availability of weekend services is thus limited - evening services are better but only in the parent hospital."
"Our hospital doe not have a PTSD residential option, thus we refer to other VA''s with delays in admission. Community options are not available."
"We have a plan to build and open a SA residential rehabilitation program that will include programming for dually diagnosed SA/PTSD Veterans. If approved, this will be of benefit. Also, we are attempting to recruit experience personnel to expand our SA/PTSD services. In this area, addiction rates are quite high. We have the required SA/PTSD psychologist but need at the very least one more experienced staff member - Luckily we have an interested candidate."
"A sensitive issue: Staff here are required to continue running support groups that are not effective in promoting recovery, this limits availability to focus on EBT''s. We are attempting to utilize Peer Support Specialists to address this, which is helpful, but previous directives “not to discontinue” these types of

groups is an issue here and I believe, across the VA. Turnover rates in personnel have impacted the balance between providing supervision to trainees and providing clinical services. The impact of productivity standards often limits what some of our professional staff is willing to do to support our training programs. We view training as essential to building a strong, experienced workforce to treat out Veterans - clinicians should not be penalized for providing this type of supervision more intensely with low productivity reports. It would be very helpful to have national guidance on how to address no-show''s more effectively - we need to utilize technology to remind patients of appointments including email and text reminders."

"Need to have staffing which allows for loss of provider without impacting patient care; Currently staffed at bare minimums; need to have a scheduling system which is geared toward mental health and appropriate; need additional, well trained scheduling staff;"
Current staff are insufficient for the demand; Cannot get patients back for weekly psychotherapy when necessary; scheduling system is grossly inappropriate for mental health; Staffing is at bare minimums and loss of a provider would result in compromise of patient care.
"Need to staff for growth. As stated before, our MH system is working but we are seeing increases in demands; pushback from administration about staffing levels; CBOCs are viewed as "primary care" with "mental health as a side show""
Need to have an appropriate scheduling system for mental health; need to have staff with availability in schedule to see patients appropriately; need better clerical support in the CBOCs.
Need better scheduling package for MH needs; Need better clerical-admin support for clinicians; need less reminders and more therapy services;

"Some of our CBOCs have no MH staff available to even partner with, to combine in person and vtel services. Managing MH needs completely by vtel is a huge challenge."
"Our scheduling system is extremely cumbersome. We need a way to be able to assign into appropriate clinics (and stop-codes) after the appointment has been completed, so that we are not limited by having to use certain clinics for certain appointments."
"I would consider implementation of CBOC BHIP teams, including providers from a number of CBOCs and vtel providers from the parent VA."
"This one is tough.....as technology advances, it may be appropriate to do more structured group therapy via vtel, but right now it is a bit iffy..."

"- More clerical staff
- Would help if CO streamlined documentation policies and reduced number of changes per year. Staff spend significant amount of time learning new ways of documenting which change often.
-"
"We have the equipment but the training is very time consuming.
-Personnel - we need a full team of Telemental Health administrative staff."

Increasing space in the CBOCs to use telemental health would increase access. Also streamlining the administrative scheduling process telemental health.
Access to initial evaluations and treatment are negatively impacted by space and staff limitations.
Nurse care managers to assist in contacting and screening self referred patients for the most appropriate services.
Trained staff is very important. Additional support staff is needed along with extended hours. However space is often the limiting factor.

Support staff are necessary to contact patients to schedule for groups. Providers are needed to be trained in evidenced based psychotherapies to provided treatments to reduce symptoms and encourage recovery. Current issues include ineffective treatments or groups designed to hold patients while waiting for an EBP.
"Similar to previous comment increase in trained clinicians and support staff to contact, screen and schedule patients are needed."

"The CBOC''s we work with primarily need more licensed independent providers. However, even more, the staff in the contract CBOC''s need much greater instruction on VA policies especially regarding patient confidentiality and rules around privacy."
"general mental health services providing PTSD care need larger group rooms, more licensed personnel, more scheduling clerks."
CBOC''s need more licensed clinical staff and improved weekend hours.
"In order to provide services via telemental health more effectively, the CBOC''s need more equipment, more licensed clinical staff and expanded weekend hours."
Primarily lack of adequate staffing has made for an unnecessary stress on providers working well under their license ceiling.

We need more office space that will allow for TMH to other CBOCS. We need more administrative support for therapist. Currently there is not a delay in care because staff see patients in their administrative time. The coordinator of PCT uses all of her administrative time for patient care. We do not have the space to add more clinicians
We only have access to 16 hours of Substance Use/PTSD available each week; this is not enough time to take care of all of the Veterans that are presenting for care in PCT. Other clinical staff and the Coordinator are using their administrative time to take care of the request for care. Currently we do not have the space to add more clinicians.
"PCT Clinicians provide all administrative support for themselves. We have 8 hours of administrative support dedicated to PCT. These hours are sometimes used for other departments, attending staff meeting, tracking some data."

"Tele-health clerical staff at one CBOC and LIP''s at multiple CBOC''s - e.g. psychologists, social workers. Organization is already in process of bringing on more LIP clinical staff - e.g. MH staff, especially psychologists, which should help."
Facility in process of bringing additional LIP''s to CBOC''s which should improve this area. Need more available physical space for therapy in CBOC's.

New scheduling system is needed. But our few delay typically stem from administrative processes that we''re working to refine. (Fix already underway.)
Hard-to-fill vacancies for psychiatrists are the challenge; we''re actively recruiting
See previous question.
"Challenge is transfer to other VISN facilities, as we have no RRTP at our site. However, these other sites are short-staffed for providers as well. Administrative processes for intra-facility transfers continue to be challenging"
We''re working to transform ”legacy groups” into peer-led (rather than clinician-led) functions.
Scheduling system needs upgrade

staffing resources (LIPs) would be critical (VACO has estimated that we are 10FTEE ‘‘down’’. Support staff would also help in streamlining some processes (alllowing to work at top of license

same as comments on prior page

"General outpatient psychiatry medication prescribers or PC MDs are needed to follow PTSD patients on stable treatment regimens. PTSD MDs are overloaded with such cases, making it difficult to meet with more complex cases (e.g., OEF/OIF/OND veterans with acute PTSD, suicidality, aggression related to trauma exposures. Nursing staff could also follow stable patients, freeing up MD, and therapist time for acute needs.
Clerical staff needed to track patient caseloads and manage complex scheduling- the MHTC program has created a level of administrative work for clinicians that does not appear to yield benefits for patient care.
Clinicians are burned out, but must spend large amounts of time on administrative matters. Good administrative support is needed."
Comments for preceeding question apply here
"Space is unavailable for FT providers in MH and in PCMH. There is a general lack of interest in telemental health in the patient population who can travel easily to the medical center. Need for MH support personnel - NP, nurses, admin to manage MD and therapist case load. Evidence-based treatment is available. Older veterans prefer supportive counseling and some state they are entitled to frequent appointments; younger veterans often requuire crisis-management and case management (e.g., housing, safety planning, legal services, employement and educational services) before evidence based treatment can be initiated."
"Evidence-based treatment for PTSD treatment is always available. Older veterans with PTSD prefer supportive counseling and some state they are entitled to frequent appointments; younger veterans often requuire crisis-management and case management (e.g., housing, safety planning, legal services, employement and educational services) before evidence based treatment for PTSD can be initiated."
"No shows are a frequent occurrence and the clinic utilization system is outdated and does not adequately capture a clinician''s workload. The scheduling system is inflexible. The multiple required outreaches for people who consistently no show for appointments could be conducted by admin or bachelor''s level clinical staff, but there is no staffing available for this. Space is unavailable. Training is time consuming, but this is something that providers enjoy doing."

Va needs to provide streamlined access to off-the-shelf psychological testing products and these need to be integrated with CPRS. Right now the security and privacy concerns VA has with computerized testing systems are preventing the utilization of products widely in use in the private sector. This grossly attenuates the utility of testing in the clinical environment of care. This is especially important as we are trying to be accountable for providing evidence based therapies and measurement based care for Veterans.
"It is critically important to provide support staff for clinical care. This goes beyond scheduling to include key supports like care management, communication with patients, follow-up care, etc. we also need to promote an embedded leader in every team...too often in VA teams are accountable to a leader who is completely absent from the environment of care."
Need more MH specific leadership embedded in the teams
"Need a new and functional scheduling package that interacts with other key,critical data such as provider leave,
And that is adaptable to the complexity of mental health"
"There is no space for groups, even individual offices appear to be impossible to get. Uncertainty and variability in the care environment creates problems in Veteran treTment. Unavailability of group spaces leads us to be less productive and offer far less access than we could otherwise. Also, insufficient numbers of support staff are a challenge"

Need a streamlined and simplified scheduling system

psychologists specifically trained in evidence based trauma-related treatments and psychiatrists

"Extend funding period for access to care positiong for mental health programs. One year funding limited local facilities from fully implementing new positions.
Dedicated funding for medical providers to support RRTP screening requirements."
"Equalizing locality pay between the [location redacted] and [location redacted] campus, clinical staff workinig on the [location redacted] campus are paid a lower locality rate despite a high percentage comuting from the [location redacted]area. This causes a higher turnoever rate and difficulty in recruitment."
"Extend access to care fudning for mental health positions, one year funding period limited local facilites from implementing all new positions.
Increase locality pay for [location redacted] based clinicians as lower locality rate negatively impacts retention and recruitment of specialty PTSD providers (PCT located in [location redacted])."
"A large volume of administartive demands coming in the form of site visits, action items, auditing tools and other tasks that are a duplication and not directly linked to patient care take critical time away from providers."

Antiquated scheduling system; high turnover of administrative staff and delays in filling vacancies.

"The scheduling s ystem is often down, is not controlled by clinicians directly, and is difficult to manage. Administrative support (e.g., clerical) is lacking due to understaffing."
"Need more personnel (e.g., staff to triage emergent patients, prescribers, therapists, support staff). The new SAIL metric measuring patients who have had a diagnosis of PTSD and requires two sessions in the specialty clinic will reduce access to EBT for patients who are interested and motivated."
"The current scheduling system creates errors in displaying availability, double bookings, and timely scheduling (as it often crashes) which restricts access. The SAIL metric, which focuses on providing treatment rather than offering treatment, may block access to full, EBT participation in the absence of more staff."
Please see prior comments; all still apply.

The area impacting this issue the most is the limited number of prescribing providers.
"Limited providers in the outpatient clinic has resulted in large panel sizes for providers that limits frequency of sessions. Further, new ideas for groups are often not able to be developed given limited group room space."
"While there are several providers who are certified to offer EBPs for PTSD, large panel sizes due to limited providers has resulted in difficulty offering sessions on a weekly or bi-weekly basis. For many, they are simply unable to offer these treatments with any regularity given lack of staff in the clinic."
"Policy states there must be three attempts to contact veterans following a no-show. This often takes place via phone or mailed letter and can be time consuming. Further, there is no clear policy regarding procedures/guidelines in situations in which a veteran has a pattern of not showing to appointments or canceling without sufficient notice."

Patient flow from PTSD programs needs to be encouraged; tele health technology is a viable way to improve access in underserved areas.

need psychiatrists and therapists

therapists
"changes in scheduling had a big impact negatively both for veterans and staff .
not enough clerical staff to facilitate program management data collection"

"less barriers in making changes overall (e.g., hiring process, clinic profiles, scheduling). Each barrier lends to increased time to make effective change, thus decreasing clinic time available"

"Our delays are relatively modest in terms of % of Vets effected. However, they are tied to staffing in outpatient mental health services, particularly LIP''s."
"As we noted earlier, our delays are relatively modest (2-3% face delays of 30+ days). However, they are tied to staffing in outpatient mental health services, particularly LIP's"
"We have a flow work group that has been addressing these issues for several years, but there is always room to improve."

Space is the number one issue. Second issue staffing timely by Human Resources. Third is less mandates from central office and need more autonomy at service level.
"Space, autonomy service level, Timely and efficient help from human resources for recruitment, less mandates from central office"
"Space, Human Resources support for timely recruitment, autonomy at service level and less mandates from central office"
"Initiative, policies are quite cumbersome and time consuming"

Dedicated BHS clerical staff needed. More therapists and psychiatrists needed. Updated scheduling system needed to facilitate ease of scheduling multiple appointments in a row as required by EBPs.
Increase BHS dedicated clerical staff as well as update scheduling system so that scheduling is not so burdensome in terms of time. Allow providers to schedule their own appointments.
Increase number of therapists and psychiatrists as well as BHS dedicated clerical staff. Update scheduling system so that scheduling is not so burdensome in terms of time. Allow providers to schedule their own appointments.

TRANSPORTATION AT TIMES CAN BE DIFFICULT
Increase PCMHI in OPC with a certain volumn
Ability to recruite non-citizens
"Evening and weekend directive is too prescriptive, the medical centers need to be able to have flexability to meet the needs of the Veterans they treat."

recruitment and retention bonuses and flexible tours/telework etc for greater staff satisfaction
flexible tours/telework. Recruitment and relocation incentives
recruitment/relocation incentives. Flexible tours and telework options

Increase space for providers and increase psychologists and psychiatrists. Also allow these providers to schedule their Veterans to ensure they are put in the system and on correct day and time.
Increase number of psychologists which will require an increase in space. Allow them the option to schedule their own Veterans to ensure correct day and time.
Ensure telehealth equipment is available and there is enough support staff to arrange the sessions and manage paperwork.
Increase psychiatry and nursing staff which will lead to an increase in office space.
Increase all staff in residential programs to increase bed space. At times the wait is 4 to 6 months.

There are a large number of reminders to complete and need to go into more than one system MH Suite and CPRS.

Ability to hire additional staff efficiently is critical. Current HR processes for onboarding and offering incentives are inefficient and untimely. Space for additional staff is critical. Ability to recruit to rural and remote locations (where the community is also lacking resources) needs to be incentivized in VHA. Space and staffing are critical. In smaller health care systems the loss of 1-2 providers in a team results in delays due to lack of ability to cover their caseloads and slowness in the recruitment/hiring process. The current scheduling package is also arcaic and makes it difficult to overlay multiple clinics and schedule correctly.
There is significant need for a user friendly scheduling package.

More technicians on the patient side for telehealth.
"1) Will likely need more clinical social workers and psychologists to keep up with the psychotherapy demand.
2) As clinical staff increase, a proportional increase in support staff is needed.
3) SAIL measures create unnecessary burden by prescribing the number of psychotherapy sessions within artificial time frames.
4) Implementation of DRAGON dictation software would help with documentation of care."
"1) Will likely need more clinical social workers and psychologists to keep up with the psychotherapy demand.
2) As clinical staff increase, a proportional increase in support staff is needed.
3) SAIL measures create unnecessary burden by prescribing the number of psychotherapy sessions within artificial time frames.
4) Implementation of DRAGON dictation software would help with documentation of care."
Staff are slowed down by excessive clinical reminders and inefficient Treatment Plan Suite software.

"LIPs - need competitive salaries for LIPs. Need to be able to hire them in a timely fashion. Need an up to date EHR, not one that is an antique. Need streamlined policies that are collaborative vertically and horizontally."
"Need better more competitive salaries for providers.
Need an EHR that is modern, integrated, and has better scheduling functionality. The ”AR”“ unsigned notes, and several other problems would simply go away.
Policies really need to be made with better vertical as well as horizontal transmission for optimal understanding of local impact.
Regarding personnel supervision and management: We need to be able to FIRE people who cannot or do not do their jobs. Right now that is nearly impossible."
"See previous reply - same here, with the addition that we do need more after hours capability in the cbocs."
same as previous
same as previous

"Need additional therapists/clinicians (current openings in program); improvements in information technology to assist in looking at openings across a team (not just an individual) and to better gauge openings for EBPs for PTSD (i.e., weekly therapy slots for a provider); personnel/management: clinicians and staff are supervised by individuals not on team at this time, and this at times results in inefficiencies and complications in the process, and there are minimal incentives for the staff how are demonstrating efficiency"

"telemental health is widely used for PTSD assessment, however, the scheduling of providers to match room availability in the CBOC can be challenging; TMH to home could be suggested after the evaluation, but clinically we prefer to assess first within a clinic; there are numerous people involved in the process; the TMH lead is readily available and helpful but remains a more time-involved activity to arrange these assessments and coordinate with the local supports on the patient's end"
"telehealth has been an option to increase service delivery for those clinics with gaps; however, room is needed in both locations; telehealth coordinator has been very available and helpful, but a centralized scheduling strategy to streamline these efforts would be helpful"
"CBOCs are offering evening and weekend hours, but need additional staffing that can work weekly in evenings to permit delivery of EBPs in evenings); CBOC providers also need to cover numerous functions, like PC-MHI in CBOCs based upon central policies; they seem to be divided into too many essesntial and mandatory roles that little time can be left for EBPs"
long waits within the VISN for PTSD beds at several locations; it would be beneficial for more TMH to be utilized for assessments and intakes for programs

"most important issues (order of importance) are
1, HR to increase efficiency of hiring process
2. need to recruit more LIP
3. VA to provide better IT support to build clinics and manage work load"
"1. improve efficiency of HR hiring
2. increase LIPs
3. better techinical and administarative support"
"1. increase speed of HR hiring
2. increase number of LIPs
3. increase administarative and technical support"
"1, increase speed of HR hiring
2. increae number of LIP
3. increase admin and tech support
4. increase salary for physician so VA can be more competitive"
"1. increase speed of HR hiring
2. increase salary for physician
3. increase number of LIPs
increse admin and tech support from VACO"
"1. increase speed of HR hiring
2. increase number of LIPs trained in EBP
3. VACO to help in tracking EBP outcomes"
VACO should be more cooperative and direct in assisting each medical center and write clear policies. Most policies are vague and cause confusion between MCDs and Chiefs

Working to increase the availability of services
Working to increase the availability of services
Working to increase the availability of services
Working to increase the availability of services

"--We need to be able to hire and retain talented clinicians, such as psychiatrists, psychologists, social workers, and nurse case managers with a background in psychiatric care.
--We need the support staff to be able to do less administrative tasks as c"

"--We need to be able to hire and retain talented and trained clinicians. With the disparity in pay between professions (i.e., social work and psychology) that are providing the same trained services (i.e., evidence-based treatments for PTSD), we are seein"
"--Our CBOCs need additional staff in the form of psychiatrists, nurse case managers, psychologists and social workers. However, with space being an issue, the amount of additional staff provided would need to come along with the addition of space.
--Tel"
"with the volumes of Veterans needing services, outpatient mental health needs to be able to hire and retain psychiatrists and/or nurse practitioners to meet the demands for medication management. additional clinical pharmacists would be helpful in reviewing medications for interactions and educating Our Veterans about how to take their medications. nurse case managers would be helpful in assisting to follow up with Veterans in between appointments."
"Adding personnel to the CBOCs is critically important, but space is an issue in that additional space is needed to house any new staff. Increasing the use of telemental health services in critical both for pharmacological interventions as well as therapeutic interventions. However, there needs to be adequate space and technology available to make this happen."

"Space has been a constant worry over the last 15 years. Our facility was built as a hospital and much of the space has been jury rigged to work as outpatient offices. The speed at which space is fully remodeled and repurposed does not keep up with the hiring of staff and expansion of services. We have new “”watched staff”“ coming on board with no offices for them to land in, no furniture as of yet as well as other resources. I truly believe the problems don"
"The biggest single challenge for our PTSD care providers has been that the volume of patients seeking care has increased over time and we have needed to grow our clinic which we did with recent access staffing hiring initiative.
The evidenced based psychotherapies are a tough sell with the veterans as whole. It is not easy to get them engaged in a therapy process that requires more active participation - but this is true in the civilian sector as well. I think the national expectations for the adoption of these therapies and their clinical penetration was unrealistically hopeful."
"CBOC’s are contracted space and over time our clinics have become landlocked with no space to grow into.
Hiring in some of the rural areas has been difficult. The recent pay band changes for Psychiatry have helped and without this we would have even more openings. We may not pay more than the community but at least we are closer to being competitive. Students loan repayment has also been effective in recruiting for some positions. These are welcome additions."
"The hiring of prescribers in more rural areas has benefited from recent pay band changes but there is a nationwide shortage of Psychiatrists. I think advertising loan repayment options in a more obvious way would help - right now they are there but a bit of secret.
Space and office equipment are challenges that vary over time."
Again staffing in rural areas can be difficult. We seem to be able to find qualified PHD and MSW therapists. Hiring practices are clunky and we could use some support and flexibility with regards to the behind the scenes work that must occur to hire someone.
"All mental health staff have to work together at improving scheduling and access. MH is not staffed nor is it’’s space ready to adopt a PACT like model and so more of the day to day task fall onto the clinicians to perform or manage. In tour MH clinic the prescribers do the bulk of the reminders but for our primary care teams the MA’s and RN’’s do the bulk of the clinical reminders.
The mental health treatment planning software has added little in the way of value added. Why must we use this if we are the only MH provider seeing a given veteran? Does a team of one need to write

themselves a treatment plan to follow - this is a time waster and feedback on national calls seems overwhelming negative and yet we persist with it."

"Need more beds space (funding) to increase patient flow. Also, will need additional nursing and clerk staff. Also, retaining qualified employees is VERY challenging. Need incentives that are attainable and renewable."

Increase clinical staffing in CBOCs to meet workload demand
Increase CBOC clinical and support staff and office space to suppor them
Increase clinical and support staff in CBOCS and provide the space necessary for increased staffing

"The incredible length of time it takes to hire psychology staff is absolutely an impediment to having services available. Also, staff who are ”maxed” out on the GS scale often lack the incentive to be anything other than ordinary in their work performance---needs to change!!"
make the hiring process quicker!!
mandate that providers must be trained in EBT’s
"our time is constantly bombarded with e-mails, trainings, surveys,meetings etc."

"PTSD IS a PRIMARY reason MH services in VA exist---yet we are funding more and more general care. Soldiers from OEF-OIF are becoming Veterans, with PTSD as one of their signature injuries, but PTSD programs not gaining staff. The idea apparently is that patients will do BRIEF work in PTSD, then transfer to general care---but most traumatized vets have great difficulty trusting, and transfers of care are problematic.
scheduling system is a dinosaur (VISTA)
We are CONSTANTLY being pulled away to deal with mandates and measures. The paperwork requirements are overwhelming.
More performance incentives for THERAPISTS (GS 11-13 Psychologists and GS11 SW), not just for Psychiatrists. More ability to promote, and based on merit, not longevity
Fee basis care is expensive and a logistical nightmare, as is the CHOICE act.
Stop throwing quick solutions at the VA without talking to clinicians rather than adminstrators at a high level only."
We need more psychiatrists AND we need HR to make hiring easier and take off restrictions on who we can hire.
"We need more therapists/clinicians in PTSD--primarily either psychologists with real training in EBP’s, or experienced social workers"

"Need more providers, particularly psychologists. Need additional space in the CBOCs for tele-mental health. Need more bandwidth."
"As before, space, tele-MH providers, particularly psychologists, more bandwidth."
"Need more space in CBOCs, more providers, more bandwidth. Many community providers don’t have the skills needed to treat military related PTSD."
"Same answer, more space in CBOCs, more providers doing tele-MH, more bandwidth."
"Same answer, more space in CBOCs, more providers, more bandwidth."
Mental Health Suite Treatment Planning is cumbersome and doesn’t integrate with CPRS well.

"The community lacks the quality of care that the VA demands of us and using FEE or community to service our Vets also makes it difficult to coordinate care. It requires a whole new level of managers to make sure the patients don’’t get lost and the quality they are receiving in the community are up to

standards. VA Handbook 1160 is very proscriptive in must do'' for our providers/patients with unreasonable demands given staffing. It requires that Psychiatrists become Case Managers for their patients using Behavioral Health guides (stronger than normal JC guides for mental health). This requires teams with case manager in the team to actually do a "recovery based"" treatment plan. The documentation requirements and paternalistic rules for managing patients are so overwhelming that it over tasks the providers and causes huge morale issues. In addition we have been begging for space for the past 5 years and are yet to see any movement on this. The biggest reason I am told is the Contracting and in this Town where there is a big military presence we have to compete with all the other federal agencies when we need any thing done that involves a contract. We lost a mental health building because it took two years for contracting to offer the owner a bid and then the property had appreciated so much in that time that the owner laughed and turned it down. We find that patients generally do not want late appointments, some will use Saturday but many of the young who have families do not want either. So these clinics are not well utilized. I do not have enough providers to cover both weekends, evenings and day time clinics, as this requires extra support staff and give I also have to cover call this is another morale downer for providers. Central Office now realizes that MH teams need to be exactly that , teams, so we can do all the things the Handbook requires but this also requires hiring more administrative staff and nursing. We have a long way to go to get staffed up to the recommended BHIP size and in addition pair down the recommended panel size per BHIP. This would enable us to better" "Case Manage"; our patients but we cannot do it if I don''t have space in which to place the teams. Finally HR rules are onerous and outdated and interfere with getting well qualified applicants hired timely. The process requires to much level of oversight by the head of HR because of common mistakes made by the HR representatives. In all my years of trying to understand the inefficiencies of HR the only thing I can surmise is that you must have to have a PhD in human resources at the very basic level of helping a service get providers on board because despite all the training they have had the rules keep changing like a moving target so paper work keeps getting returned and in the mean time the provider we are trying to hire takes a job elsewhere and we have to start all over again."
Please see my previous comments they apply here as well.
"My comments remain true for every aspect of care. I do want to add that for substance abuse services I need a more beds to be available and a large facility so we can do a better job of offering Intensive Outpatient Services. Currently we are managing but we had to build extra office space on the porches of the existing building. [potentially identifiable comment redacted]
I want to emphasize that the community cannot even take care of the community at large so to use the community to manage our patients is not an option. Also most of the community lacks the skills of evidenced based therapies and hence cannot help our veterans with the same quality that we have trained up to do.
In order to case manage our patients I need more administrative and nursing support."
Please see previous comments.
"Please see previous comments. I would like to add that additional personnel needed are substance abuse counselors and Addictions Psychiatry, especially if Extended Hours, I am currently not adequately manned for extended hours as I do not have enough personnel to offer this service and keep operational during normal duty hours too Immediate (same day) appointments are expected and difficult to accomplish also secondary to manning, but I need space if I am to grow in manning. I do believe that same day appointments are essential in this population because you have to catch them when they are ready. Secondary to the lack of space (see previous comments about our Domiciliary, our outpatient program shares the building) we are at critical mass for being able to expand and offer good coverage of services to this population."
"The mandated use of Mental Health Suite for treatment plans has only added a layer of unnecessary, inefficient, not patient centered and useless paperwork for both the patient and the provider. It

consumes time and does not lend itself to producing a plan that is recovery based or easy to read and understand when printed. It needs to be scratched and un-mandated. We are now starting to use the ”standardized““ templates for EBTs, but I have heard they are in need of ““tweaking““ but this is a welcome over the MHS. Again because of the expectation of case management I need more nurses and lower level (SW or LPCs) to help with coordination of care issues."

"Mental health staffing and space is the biggest issue. The VACO office of mental health operations has outlined staffing models but our facility cannot meet demand and we are not staffed properly. In addition, we are unable to compete for certain disciplines - nurse practitioners in particular-with the local metro market and even the VISN. We have had recruits decline due to pay. Our psychiatrists are at least 20K under the metro. My last three hires -including two from other VAs [location redacted] are taking a paycut to come here -coming for other reasons (spouse job, etc). Equipment needs for MH are related to telehealth infrastructure. VISN [location redacted] is huge geographically - our ability to provide high qulaity care to our rural vets depends on improved infraastructure including expanding innovative modalities - CVT into the home. The inability to lease space, the time it takes for new buildings to get approved for construction,etc are untenable in a 1a facility with a 8% growth rate for the past few years. We have already outgrown some of our blueprints that have yet to be built. Recently VACO OMHO did change access measure for MH to 30 days which is better. Would revisit critically all metrics and compare to what other MH care systems (non-VA) are doing. Staffing models seem to neglect the importance of administrative staff, -MSAs/PSAs, data analysts, etc. The regular occurence of downgrading positions and not classifying positions for folks based on their own expertise and experience also negatively impacts recruitment and retention. the process for fee-basis and contracted care is very cumbersome and not easy to navigate. HR and MPS services are understaffed and take too long to onboard staff -we have lost recruits as a result."
previous comments secction addresses most concerns. VACO OMHO expectations for evidence based psychotherapies (EBP) - metrics are too idealistic and difficult to achieve in a high growth 1a facility. In order to have robust programming of EBPs you need to have adequate staffing models of psychologists and SWs (we do not meet the BHIP staffing model requirements) - our focus is on access -again with the disproportionate growth in unique Veterans vs growth in staffing - making the frequency requirements of these EBPS (X #of sessions in Y #of weeks) difficult. One comment on telehealth capacity within the Portland CBOCs - there is no space-multiple tele services competing for in most places a single tele room. Services that have telehealth as a core mission must have dedicated space in CBOCs. Clinicians are doing admin work -not at top of their license due to shortage of admin staff
evening and weekend clinics would be wonderful but we cannot realistically contemplate here in Portland without staffing increases.
same as previous comments.
with not being able to provide market pay - the education mission is often what appeals to our applicants and why we are able to get high quality staff. THe requirements for three contacts post no-show for all Veterans is burdensome and is in direct conflict with the conceptual model of recovery and ownership of one’s own care. Would like to actually see evidence based support for that required policy. This is also not the community standard. Does make sense for oflks with a high risk suicide flag.

Re-designing MH services delivery in alignment with current provider scarcity realities and evidence based medical interventions.

Staff all RRTP beds in the VISN. Make admission process more transparent and efficient. Consider using TeleHealth to screen Veterans

"The number of Veterans seeking services have outgrown the clinical admin infrastructure. No issues with clinical staffing, but most service lines are thin in terms of AO, MSA support. Too many requests coming from VACO for data that require considerable time to collect."

"We are in critical need of additional staff to provide services. Particularly, med providers including psychiatry services. We also need improvement in our electronic medical record. It is difficult to use." Increase the number of providers available to improve veteran care. We do not have enough psychiatrists or other med providers. We also need increased levels of therapist and admin staff.

Some VACO policies make things worse. The MHTC policy has created a tremendous amount of work for clinicians with little to no gain in patient care.
We do not have enough PTSD staff to meet the needs. We need additional clerical support. Some VACO policies (i.e. MHTC) take time away from critical patient care.
CBOC staffing is inadequate for the patient needs.
General mental health does not have enough clinicians to provide psychotherapy; they essentially function as case managers.
"CBOCs do not have enough staff to meet the needs, and also have space issues."
"We do not have enough staff, nor do we have enough space."
"Clinicians spend far too much time on nonclinical duties. We have a ridiculous amount of irrelevant TMS trainings, for instance."

Allow managers to hold employees more accountable and terminate employees who are repeatedly performing poorly. The union interferes with this and perpetuates the problem.

"We need:
- Pharmacists, technicians, psychologists, clerks, SW and supervisors.
-Infrastructure to track Non VA cases at the clinical level."
"We need more technical support and adequate staff to assist the clinician in the scheduling, care management, evaluation of the Veterans in need of the service."
CBOCs lack the staff and supervision to implement our mandates and provide same level of care.

"We are having to pull clinicians away from clinical care to keep up with the growing amount of time devoted to complete administrative requirements, training, completion of reports,etc. The effeciency of providing care is being greatly reduced."

"licensed independent practitioners: psychology, psychiatry, and social work; need more administrative support staff especially at clerk level; IT: scheduling package should allow us to view a single provider's availability at a given time regardless of stop code/ clinic number - an Outlook-type schedule would be helpful; we need to improve the way we deploy all of the staff with an emphasis on providing same day access for new patients, not just patients already enrolled - requires cooperation across all disciplines; some other solutions: creating greater availability of same day access particularly for new patients by making more efficient use of resources, including same-day weekend and evening access"
Need additional psychologists/social workers in PTSD Clinic.
increase number of psychologists and social workers in PTSD Clinic; assign psychiatrists to PTSD Clinic

general mental health is in need of additional LIPs in order to be able to offer weekly or every other week therapy (in order to prepare for or augment PTSD specific treatment) for veterans on a consistent basis. This would also require additional space as our system currently has some MH providers without

a full time dedicated space. We are also in need of additional program support assistants to support the number of clinicians and programs in our system.
All LIPs sharing case management duties rather than consideration of dedicated case managers in system.

"Need new scheduling package
Need to be able to pay and otherwise provide incentives to providers with less restrictions"

"Some CBOC''s are short staffed on both psychiatrists and therapists. This impacts access to care, especially therapists trained in evidence based practices for PTSD. More evening hours for telehealth and couples based treatments are needed at several locations"
See question 2 comments
See answer to queston 2

"We are having difficulty recruiting clinical staff in CBOC''s in rural areas. MD''s, psychologists and LCSW."
Difficulty recruiting med providers
retention-recruitment incentives would help with this.
Increase space for CBOC for groups and for access to Vtel for each provider.

"VISTA scheduling package was designed more than 30 years ago. Creates numerous problems with convenience, access, efficiency, and Veteran satisfaction.
We lead the nation in the use of telemental health and need to expand it further. Is a great thing--rarely done well in the private sector.
Would be helpful for efficiency to have additional TCTs for our clinicians doing telemental health"
Marked N/A for ""fee-basis" question as we only very rarely need to do utilize fee-basis for clinical care
Are hiring new staff and anticipate resolution of minor delays in pharmacotherapy appts for established patients within the next few months.
"See response for previous comments section,
Would also be helpful to have additional CBOC TCTs"

need additional subspeciality licensed independent providers.

"3 psychologists, one nurse practitioner, one nurse supervisor, one clerk"
"two RN, three psychologists, one MD, one NP, one LVN"
"two RN, three psychologists, one MD, one NP, one LVN"
"5 psychologists, one social worker, 1 clerk"
"3 psychologists, one clerk"
"3 psychologists, one clerk"

Limited space beds for inpatient or residential PTSD. Some veterans choose to wait for Northport PTSB bed rather than going to another facility for the program. They are followed by MH.
Could always use more therapists to conduct individual psychotherapy. Have evening and weekend hours currwntly.

Increase efficiency of the consult process

Increase EDRP money available to stations. We cannot offer without money. Need more telehealth equipment and space for providers.

"Provider space, EMS equipment, CPRS training, local PRRTP program"
"Need more provider space; focus on clinical care not political care; eliminate government roadblocks and bureaucracy, eliminate irrelevant and unsuccessful measures unrelated to providing good clinical care, revamp phone and scheduling programs"
See previous comments
"Provide MH-RRTPs locally for each medical center, sending Veterans long distances does not support reintegration and recovery into their local environment, family, friends and/or community"

"More IT support and updated PC''s and printers
Too much time away from clinical work with too many traininjg requirements and burden of the amount of clinical reminders.
Higher grade and pay for secretaries for more effecient and more capable suppoirt staff."
"More IT support and updated PC''s and printers

"Ineffecient secretarial staff.
Burden of surveys, reviews, reminders, training."
‘
Changing performace based measures to assess patient outcomes. Majority of focus is on access to care but not quality or evaluating effectivness of interventions. Policies to support the delivery of evidence based treatments over supportive care/case management. Providing incentives to providers who routinely implement and provide evidence based treatments.

"Most of the delays in Veterans receiving services are in general mental health, not in the specialty clinics (like, PCT, MST, PRRC, etc.). Access to speciality clinics is great. I think that Salisbury has been slow to implement BHIP teams, and this is just starting now, which will help access in general mental health. Also, our leadership in mental health is not very supportive or respectful of its staff, so staff morale can be low, which inevitably affects patient care, timeliness, etc."

We are out of space and we need to add additional providers to meet the need. We have a large volume of referrals to contracted providers (about 20%) but many Vets insist on being seen at the VA.

Improve amount of TMH and greater case management and administrative support.
Adding personnel at CBOCs is critical.
Use of consults has added significantly to the administrative burden.

[Location redacted] has submitted expansion plan to VACO for additional Residential Rehabilitation Treatment Program beds (2015)

"addition of case manager/nursing personnel to help coordinate care, complete clinical reminders and administer symptom rating scales would be beneficial, have adequate number of LIP positions but several vacancies and filing vacant positions is a lengthy process. addition of TMH services would help access and requires equipment, staff and space"
"Not enough TMH access at busiest CBOC-adding service requires space, staff and equipment"
"Program has adequate positions approved but several open vacancies and lengthy process to fill, having case management/nursing staff to help with care coordination and paperwork would be helpful,

expanding TMH would require new equipment as well as staff at the remote site and program being fully staffed with providers trained in EBTs"
"increased availability of TMH services at CBOC would decrease delays in service, increasing TMH requires equipment, space and staff at both locations- fully staffed with providers trained in EBTs in order to provide services"
"increased availability of TMH services at busiest CBOCs requires space, equipment and support staff to make service run smoothly at remote location and requires PTSD program being fully staffed, being able to refer those out who can not be served in a timely manner is essential"
"increased access through greater availability of TMH especially at heavily utilized CBOCs, offering extended wkends and evening hours, fully staff and addition of staff to support LIPs, ability to refer to community providers when necessary"
"LIPs spend time making no show phone calls, entering symptom rating scales that could be done by staff with less training, we have good administrative support but when that person is out often have no coverage, patients call central scheduling to cancel but clinic is not notified, computer often is slow impacting workflow"

"- need for additional psychologists and prescribers (psychiatrists and/or NPs), as well as nursing support - antiquated VISTA scheduling system and clinic grids do not allow for sufficient flexibility in scheduling to better meet veteran needs"
"A major impediment to utilizing more telehealth for provision of psychopharmacology is difficulty accessing telehealth clinic slots at the CBOCs. To some extent this is due to limited space (only a single telehealth room to be used for all specialties across the Atlanta VAMC system and limited coverage with TCTs if on leave). Bigger issue is related to scheduling. It would be very helpful to have an active calendar that demonstrates all clinic slots available for telehealth so that any available slot can be booked if it matches the psychiatrist and patient schedule. Currently, different programs typically have specifically assigned slots (i.e. Thursday from 2-3 pm) that may not match pt scheduling needs and therefore may be going unutilized but could be used to provide clinical care for other services who might be able to utilize that slot. In addition, telehealth requires separate clinics in CPRS, which does not allow for psychiatrists to flexibly utilize any clinic slot they have available to see a telehealth patient, but again locks them into more‘’rigid’’ slots that may not meet patient needs or CBOC telehealth availability."
"Very similar issues to previous question. One of the main issues impeding provision of these services by telehealth is availability of accessing telehealth clinic slots at the CBOC. To some extent, this is related to limited space (one single room utilized for all telehealth services provided by the Atlanta VA system) or limited personnel (providing backup for TCTs when on leave or pending hiring/backfill). Bigger issues relate to lack of flexibility in scheduling. Rather than having a ‘’real time’’ calendar that demonstrates all clinic slots available for booking, in general there are specific slots assigned to a given program (i.e. Thursdays from 2-3 pm). If that slot does not work for the patient(s) then it may go un-utilized, whereas other services may be able to utilize that slot. Similarly, the requirement for separate telehealth clinics locks therapists into specific clinic slots for provision of telehealth (which may or may not meet patient needs) rather than allowing them to flexibly utilize any of their clinic slots to see patients via telehealth."
"There is not a PTSD RRTP associated with the [location redacted] VAMC despite a very large population of veterans diagnosed with PTSD and a large Trauma Recovery Program with clinicians with significant expertise in the treatment of PTSD. The primary barriers are physical and staffing - building space and residence space are needed to create a PTSD RRTP associated with the [location redacted] VAMC and staff are needed to provide care (psychiatry, psychology, social work, nursing, peer support, residence

staff) during days, evenings and weekends. Currently, veterans often need to wait for extended periods of time to be accepted into and enrolled in PTSD RRTPs outside the VISN."
"1) No show rates are at approximately 15%. As no show reminder calls are not made in a sufficiently reliable manner, we are beginning a pilot of ‘‘robo calls’’ to provide reminders
2) due to limited administrative support, much clinician time is devoted to consult management, data tracking (i.e. treatment plan completion, medical record review, etc.), and scheduling outreach."

- **SUD**

"Space needs include additional access to group spaces at main campus, and space for individual and group sessions at all CBOC"
Space is a critical need at all CBOC
"Similar responses to previous questions. Group space is important for ability to do additional group therapies, as are additional substance abuse counselors (more than one dedicated outpatient counselor for facility and CBOC''s). Adding additional supervisors and/or management ""bandwidth" would be helpful, as would fee basis. Evening hours helpful only if additional staff."
Simply need additional psychiatrists; numbers are critically low with two suboxone-qualified outpatient psychiatrists on deployment or indefinite leave.
Need more psychiatric providers. Additional education and support for prescribing in this area from general psychiatric providers could be useful as well.
"Need more psychiatrists. In addition to vacancies, currently two outpatient suboxone-qualified psychiatrists are away on leave or mobilization."
Same answers for section 1 detailing challenges with outpatient SUD services.
Same comments as section 1 detailing SUD services
"At many CBOC sites, CPRS bandwidth is severely limited and very slow computer responsiveness. If all required activities were actually completed (reminders, treatment plan in MHS by all disciplines, note, encounter, med reconciliation, safety plans and risk assessments), outpatient time on charting per encounter is significant, with most of this done by provider rather than medical assistant. A primary care provider will appropriately have three support staff, a cardiologist or specialist will have a nurse. A psychiatrist is expected to work with a fraction of a nurse and a fraction of a scheduler."

Support SuD Business Plan to have veterans seen on more odd tours of duty and SUD focuse teams for weekend clinics duty.Expand MAT TX in CBOC s.
Community Fee-Base programs feels that VAs are not paying enough vs medicaid rates.
Veterans wanting the improvement to occur in VA and not contracted to some programs that have poor enviorment for recovery.
Continue to improve SUD Quality of care.

"1. Technology: telehealth from home would improve pt access and outcomes but VA would need to supply ipad and needed equipment. Standardized biofeedback equipment such as apps and finder monitors which are used on personal cell phones be funded and made available to veterans for mood regulation.
2. CO policies: maintain centralized SUD services for uniformity; establish earmarked funds for SUD rather than fund through general mental health dollars; continue trend to monitor by effective, outcome-based bench-marking.
3. Personnel: recommend all BHIP teams have designated SUD specialist for identifying SUD issues, provide Brief Intervention, case management. Recommend the acute phase of treatment each SUD sub-speciality have MD specializing in addictions, a nurse practitioner, social worker or psychologist, addiction therapist, and peer support, Specify staffing models for different levels of care based on ASAM criteria to include designated staffing for ancillary/support services such as gym, recreation therapy, occupational therapy, vocational rehab. Ancillary services are critical to reconditional the limbic system/ leisure time activity and reduce relapse risks. Such changes provide uniformity and consistency among all VHA.
4. Recommend all sites have ability to use dip sticks for immeidate/ on-site urine drug screens"

"VHA standardized bed board and intrafacility consult process for referrals outlining best practice for points of contacts and referral authoriztion to reduce bottle neck when sending to another facility. Also, travel pay guidleines needed so monies are available to transport veterann to and from out of catchment area facility"
"1. Technology: telehealth from home would improve pt access and outcomes but VA would need to supply ipad and needed equipment. Standardized biofeedback equipment such as apps and finder monitors which are used on personal cell phones be funded and made available to veterans for mood regulation.
2. CO policies: maintain centralized SUD services for uniformity; establish earmarked funds for SUD rather than fund through general mental health dollars; continue trend to monitor by effective, outcome-based bench-marking.
3. Personnel: recommend all BHIP teams have designated SUD specialist for identifying SUD issues, provide Brief Intervention, case management. Recommend the acute phase of treatment each SUD sub-speciality have MD specializing in addictions, a nurse practitioner, social worker or psychologist, addiction therapist, and peer support, Specify staffing models for different levels of care based on ASAM criteria to include designated staffing for ancillary/support services such as gym, recreation therapy, occupational therapy, vocational rehab. Ancillary services are critical to reconditional the limbic system/ leisure time activity and reduce relapse risks. Such changes provide uniformity and consistency among all VHA.
4. Recommend all sites have ability to use dip sticks for immeidate/ on-site urine drug screens
5. More clinicians with certifications in SUD. Currently, SUD certifications are not reimbursed and pay scales to not reflect if paid out-of-pocket by provider. Addiction therapsists need to be Level I and Level II independent providers within the VHA system to practice their full capability and reduce clinical supervision requirements."
"1. Technology: telehealth from home would improve pt access and outcomes but VA would need to supply ipad and needed equipment. Standardized biofeedback equipment such as apps and finder monitors which are used on personal cell phones be funded and made available to veterans for mood regulation.
2. CO policies: maintain centralized SUD services for uniformity; establish earmarked funds for SUD rather than fund through general mental health dollars; continue trend to monitor by effective, outcome-based bench-marking."
"Frontline clinical prescribers needed with specialty in SUD with devoted labor-mapping to SUD clients solely so emphasis, time/ attention is provided.to this difficult, complex, veteran population"
"See question 3 for suggestions.
1. Personnel: increase SUD specialization/ knowledge through incentivizing SUD certification as associated costs of obtaining SUD certification is not currently reimbursed by VA and does not increase staff pay if such costs are paid out-of-pocket.
2. Also, revised personnel standards/ qualifications to allow for addiction therapists to be AT 1 for entry level and AT 2 for advanced level providing a licensed independent provider status to those with a master''s degree."

Limited physician time limits how many admissions we can schedule. WOuld help if we broadened the time period for completion of admission process for them and allowed for more activities to be done by other providers.
incentives needed to take referrals at other sites when we send them

Preparing copies for group sessions could be done by admin staff.

Would require an added addiction psychiatrist and another nurse practitioner who could do the physical screening so that the person cold be staffed and inducted.
"1. Rules about how quickly veteran services need to be scheduled in the community are not dependent on VA referral agents. Rather, it is dependent on the outside agencies. This puts heavy pressure on VA staff who cannot control the speed in which the No-VA Care agency gets the veteran in for services.
2. VA needs to market and recruit more Non-VA Care agencies in some areas (e.g. Methadone/Suboxone) as there is far more need and not enough services available."
"1. Increase in number of residential beds, especially “dedicated residential beds”, would reduce need for Non-VA Care referrals.
2. Increase in residential staff, along with unit nursing staff, to accompany the increase in number of beds, would also reduce need for Non-VA Care referrals.
3. Increase in marketing and recruitment of Non-VA Care agencies that provide residential services in areas that are geographically far from Cleveland, yet fall in our VISN."
"1. Need added office space for new staff (see below).
2. New addiction psychiatrist to see added Suboxone patients.
3. New nurse practitioner to complete necessary physical exams and screen new patients for Suboxone induction."
Work on marketing and recruiting added Non-VA Care agencies that are accredited and can provide Suboxone services to veterans in more geographically remote areas.
"1. Need added office space for new staff (see below).
2. New addiction psychiatrist to see added Methadone patients.
3. New nurse practitioner to complete necessary physical exams and screen new patients for Methadone induction."
"1. Increase number of residential beds.
2. Increase number of Dedicated SUD Beds
3. Increase number of Providers and Clinical Staff
4. Increase number of nursing staff on the unit"
"1. Add more residential beds
2. Add more dedicated beds for addiction (e.g. SUD) treatment
3. Hire more Providers and Clinical Staff
4. Hire more nursing staff to run the new/expanded unit"
"1. Add more residential beds
2. Add more dedicated beds for addiction (e.g. SUD) treatment
3. Hire more Providers and Clinical Staff
4. Hire more nursing staff to run the new/expanded unit"
"1. Clinical staff do perform a lot of administrative duties - CPRS documentation and other paperwork is cumbersome
2. CPRS problems result in Open Encounters - glitches in system are known but local says national CPRS will not (cannot?) fix them
3. Program did not have enough administrative support for number of months, recently rectified
4. Problems with scheduling, do not preschedule residential appointments due to vets having other appointments - avoid missed opportunities
5. MHTC Coordinator assignments do not make sense for a Specialty MH service"

"Methadone Maintenance not available in the ECHCS aside from fee-basis to community providers. There are 2 vendors in the [location redacted], both with wait times. Individuals who live in more remote areas often cannot travel to clinics daily for dosing, as is required in the early stages of

treatment. Fee-basis approval can be a slow process as there is limited staff to process consults and limited programs in the community that offer this service"
"There are not currently fee-basis relationships with any treatment providers in the community. Would suggest increasing access to community SUD treatment providers, to include detox services. Currently there are no options to refer veterans to services in the community. Transportation makes it difficult for veterans to attend the level of treatment needed for SUD services. Would like to see Choice Act and/or fee-basis include community providers to allow patients better access to services in their community."
"There is no available VA residential care for SUD in [location redacted]. We must refer to [location redacted] for services. Often there are lengthy application processes and complicated travel arrangements for treatment. There is also not a centralized way to know about waittimes. It would be beneficial to have residential services available in Colorado, be able to reimburse for payment in the community and/or streamline the process for referral/admission for residential programs in other states."
"Alcohol withdrawal is managed by inpatient medicine. There are not currently options for outpatient detox, nor preventative medical detox. Services are only available for individuals who are in acute medical crisis due to withdrawal. Would recommend increasing services for this population, to include reimbursement for community detox facilities."
Opioid Withdrawal Management is not a service provided by ECHCS unless there are complicating medical factors. This is a high request area with little resource to address it. Would recommend increasing availability for this service and/or providing reimbursement for these services to be provided in the community.
"SUD services are not offered in all CBOCs, despite identified needs. Would recommend ensuring all CBOCs offer sufficient services for SUD, or providing reimbursement for community providers in areas where services are not available."
"increasing staffing and room availability would allow for shorter wait times. In addition, more resources in the community would likely increase access to services, esp for people living outside the Denver metro area."
no residential services offered in [location redacted]. Must coordinate with surrounding states.
"increasing staffing and space would allow for expedited access, as would more available community services."
"High rate of no-shows, not enough support staff to make reminder calls. Need additional staffing for urinalysis, breathalyzers, etc. No peer support available."

Limited number of SUD beds for rehab (five beds) leads to gap in time between inpatient care (detox often) and beginning rehabilitation. Need space and funding to increase SUD rehab beds. Need nurses and rehab techs to accomodat patient load.
"Again, bottleneck is seen with small number of SUD beds in rehabilitation program."

need more physician assistant support for assessments
Need SUD residential care which does not require homelessness as part of eligibility.
"decrease ratio of supervisory staff to clinicians in general mental health clinic. Consider adding psychiatrists and allied health staff to SUD program for direct admission capability and team based care within SUD. Increase support for mental health from human resources, particularly in terms of managing employee accountability and hiring."

"1. increase HR speed of hiring
2. increase number of LIPs

3. increase admin and tech support from CO"
"1. increase speed of HR hiring
2. increase # of LIPs
3. increase salaries
4. inform MCD of importance of MH staff and not to hold off hiring in MH becasue of percieved low producitivity"
improve communication to residential facilities.
"train more providers in suboxone
pay suboxone providers more"
improve communication between medical centers and residential facilities
lack of suboxone providers in the community who can take on more patients
increase residential beds and improve communication to residential facilities
lack of beds in residential facilities
lack of beds in residential treatment facilities
"too much admin requirements from VACO, OMHO, VISN and others"

"WE DON''T HAVE A METHADONE CLINIC OR ANY OPIOID SUBSTITUTION CLINIC HERE, NEED TO DEVELOP ONE."
"GIVEN WAIT-TIMES AT ANY AND ALL MHRRTPs, I''D SUGGEST CREATING MORE MHRRTP BEDS NATION WIDE"
ANY QUESTIONS PERTAINING TO DELAYS IN RESIDENTIAL CARE AT THIS FACILITY REVOLVE AROUND HAVING AN INSUFFICIENT NUMBER OF RESIDENTIAL BEDS
"ALOS IN OUR RRTP IS, IN MY ESTIMATION, ENTIRELY TOO LONG"

"Increase psychiatrists, psychologists and SW with SUD training. May need to employ incentives to entice trained and experienced professionals to a rural area. Nurses with specialty training could be very helpful."
"Could use incentives, bring in specialists to CBOCs (psychiatrists, psychologists, social workers, trained in SUD work), there are few fee-based providers in rural areas."
"Hard to get qualified and experienced SUD providers within rural regions, let alone para-professionals able to provide support. Incentives would be helpful but there are few local/fee based providers in rural regions."
Would help to hire professionals by offering incentives and providing support.
Its difficult to comment on local resources in a rural community where there isn''t enough of many resources let alone specialized care for substance withdrawal. Incentives would likely help but they would likely be more than the VA is willing to consider.
"Psychiatrists and support staff would be helpful but also lab equipment that would allow for testing/screening, etc..."
"Psychiatrist/psychologists, social workers, with incentives for moving to a rural area."
"Would cost way too much to build, hire (provide incentive) and support the specialty providers needed for SUD Residential Treatment Program in this rural setting."

"Need new scheduling package
Need to be able to pay and otherwise provide incentives to providers with less restrictions"

"Space, Human Resources support for timely recruitment, autonomy at service level and less mandates from central office"

"Space, Human Resources support for timely recruitment, autonomy at service level and less mandates from central office. Make a policy for MH providers to work from home (telework) if space is issue."
"Space, Human Resources support for timely recruitment, autonomy at service level and less mandates from central office. Approve telework (working from home) for MH providers."

"Hire additional Personnel - psychiatrists, social workers, psychologists, nurses
Improve access within the system rather than improving access to non-VA fee basis or contracted care
Allow trainees to be certified to do telehealth
Patients who decline appointment must have one scheduled when discharged from inpatient which leads to high no show rates and missed opportunities to fill appointments for veterans interested in care"
"Rather than improving referral to non-VA care the best solution to this problem is to improve access within the VA by increasing staff, space, and other support to accomplish this"

Limited suboxone providers in community and on staff at this time.
Provider availability is limited in the community and delays are longer than any delays we have in house.
"We are hiring more MDs who can provide this service, This is the only solution I can see to help improve access to opiate replacement tx."
"Some patients complete detox but they choose to delay entry into residential or opt SUD for variious personal reasons. This may appear like a delay, but it is patient driven."

RRTP requirements change often and take time to implement and track new requirements.

"1. The shortage of office space to see patients at [location redacted] Clinic and [location redacted] is a rate-limiting step in increasing access. There are additional well-qualified clinical trainees who could expand our clinical capacity whom we cannot accept for lack of space. Further, we have no space for any growth in permanent staffing.
2. The parent site and CBOCs will each need an additional MD with buprenorphine waiver to accommodate the expanding demand for office-based buprenorphine treatment.
3. We need additional RN staffing. Currently there is no nursing coverage when our sole outpatient SUD is on SL, AL, or attending meetings or training. Such coverage is essential for providing high quality SUD/MH medical management.
3. Our main use of fee-basis or contracted care is for methadone treatment for opioid dependence. We have tremendous difficulty with these referrals because local providers find the VA payment systems overly cumbersome and slow, such that most will not accept our referrals.
4. There is an acute need for increased physical space and staffing to provide appropriately supervised specimen collection for urine drug testing. The current, inadequately supervised process allows tremendous room for invalid test results.
5. IT: The current ”clinic profile”“ and scheduling software is overly rigid and restricts flexibility in meeting patient needs. As an attending psychiatrist, it is appropriate for me to see, within the same clinic half-day, both patients enrolled in SUD treatment and those receiving MH care but not active SUD treatment. It should be possible to have a single clinic profile and to designate the stop code (SUD vs. MH) when completing the encounter form rather than limiting any given scheduled clinic to one or the other. This may seem trivial, but it really restricts flexibility in meeting patient needs. It is an example of the over-segmented structure of MH care.
6. We need higher-paid, better-trained and more thoroughly supervised administrative support staff to provide excellent service in as complicated system as ours.

7. The current ”matrix management” system is highly problematic. As an SUD program director, I lead a team composed of clinicians from multiple clinical services (psychology, social work, nursing, psychiatry, chaplains). The ability to define staff roles and responsibilities and provide meaningful supervision is grossly impaired by the cumbersome ”matrix”“ in which these clinicians’ supervisors tend to have limited interest in my input our program’’s needs and their employees’’ performance in the actual care setting.
8. Given our heavy reliance on CPRS, we need much faster and more reliable computer performance. Significant time is lost every day to computer hang-ups, freezes, etc.
9. The process of referring to SUD residential care at other facilities remains problematic. Each of the RRTP’’s has an entirely different referral mechanism and documentation requirements, which makes the process extremely cumbersome and inefficient. The basic referral/application process should be standardized across RRTP’’s. Admission criteria need to be explicit and consistently applied.
10. I need increased administrative support as an SUD program leader, to be able to access, search and organize existing computer data about our patients and services. I know that a tremendous amount of potentially useful data is being stored, but it feels like a black box in terms of useful access.
11. In all honesty, there are too many top-down external mandates and measures. The effect is to stifle local initiative and creativity when the overwhelming emphasis in on meeting externally defined criteria. I recognize that some of these measures are valid and meaningful, but a more appropriate balance is needed, respecting the intelligence, initiative and professionalism of ”the field”“"
We need more inpatient beds.
There is a need for more residential treatment beds in VISN [location redacted].
Need more residential beds.

"Pschologist, Psychiatrists, SW, Clerical, Nurses"
"Psychologists, SW, Psychiatrists, Nurses, Clerical staff.
Use of the MH Ste.
Central office policies are sometimes difficult to meet given many factors including local veteran culture, rurality, etc."
"Need for additional MH Prescribers, space and a process which to streamline access"
"Need for additional MH Prescribers,
Need for additional Nursing support, space, Need for streamlined access to clinical care"
"MH Prescribers, Support staff, space for providers"
Multiple and sometimes conflicting requirments and clinical staff required to complete administrative tasks.

[Location redacted] has a dely in residential treatment due to Supply vs. demand. We have 20 beds with a wait list that flucuates between 2 to 3 months. We need to increase beds and staff in order to eliminate this wait.
We need an increase in beds and staff for SATP Residential and or contracts in the community to provide residential SATP in order to eliminate the wait for SATP residential treatment.
Increase beds and staff to make this service available or create community contracts with providers in the local community for this service.
Either increase beds and staff at the main [location redacted] facility to decrease wait and or create contracts in local communities around the CBOC tro provide this service.
Training opportunities within the VHA system has been down to almost zero. We need continuous training to opportunities to keep providers thinking about the most up to date treatment practices.

Availability of contract methadone clinics in [location redacted]

Ease of getting contracts and maintaining with supervision of contracts - staff availability to monitor.
Ability to do telehealth with contracted services.
Ease flow with simplified and expedited administrative and transfer request forms(electronic).
Ease of ability of admit for detox of opiates in medicine and psychiatry service
Availability of local fee basis for methadone.
"Availability of LIPs to help refer and ease of referring to community methadone clinics, e.g. contract and simplified fee basis."
"Additional fee basis care available for residential treatment. Additional staff(counseling, social work, nursing, therapy assistant) for monitoring and documentation."
"Additional homeless housing for SUD patients associated with IOP, additional counseling and social work staff for treatment. Additional contract/fee basis for referral for residential."
"Additional homeless housing for SUD patients associated with IOP, additional counseling and social work staff for treatment. Additional contract/fee basis for referral for residential. Weekend or evening services not avail at CBOCs."
"Lack of clerical support staff for patient visits, groups, meeting minutes. Social worker and doctor/NP calling patients for missed appts. Mult new requirements and standards. Need to cancel missed group therapy appointments. Admin done by MDs, counselors, etc."

"b. Buprenorphine providers, LIPs specializing in addiction
c. Addiction treatment presence in CBOCs
d. SmartBoard, TV, DVD, Projector, education materials, reliable stat lab testing
f. computers need to be able to play DVDs remotely; telehealth scheduling is cumbersome; IT separation from VHA is problematic; national helpline is not effective; telehealth training process changes too frequently and communication is poor.
g. Too many inspections, surveys, and suspenses, for example, this survey took 6 hours of staff time (12 patients could have been seen in this time!)
h. Staff are tired of ”over-measurement”“; more flexibility with small time off awards."

"1. Renumeration for care by community based providers, who provide Medication Assisted Treatment-Methadone, Buprenorphine, Naltrexone injectable should be competitive to encourage them to sign up and provider services when travel and distance makes it difficult for SARP to deliver the care. Most community base providers shierk from medicare reimbursement rate.
2. DEA to increase the number of pts community based providers can treat in Office Based Buprenorphine. Currently there is a ceiling of 100 pt. per provider. This severely restrict access to treatment."
"1. Increase the pt ceiling (presently 100) that community based, office based Buprenorphine providers can treatment."
"1. [Location redacted] VAMC need a Domicilary program that will provide residential SUD care for pt who need a higher level of care. Our Domicilary program has been in gestation nearly 10 years.
2. Contract with community based residential SUD programs to meet this need."
please response for mental health to residential SUD care
"1. Program could benefit from a Health Technician on team who will assist in collecting urine toxicology screen and sent to Core Lab for processing.
2. Program support specialist to help in gathering data, tracking and trending to help improve quality of care."

Our data suggest 2-3% of Vets are delayed 30+ days. Staffing and staff management seem to be the most critical factors.

"again, staffing and enhanced flow strategies seem to be the most likely areas to furhter improve delays. We have been working at this for several years, but still have room to improve."
Telehealth is popular and so flow through these services can create occasional delays. This is related to staffing and to management of flow.
"We have modest delays in this, which are mostly related to capacity and flow. We are actively managing this but have further room to improve."
"We have excellant services in this area, but still have modest delays in this, which are mostly related to capacity and flow. We are actively managing this but have further room to improve."
"This effects relatively few Vets, but is most closely tied to resources and management of flow. We have been working on this for several years, but still have room to improve."

"Beds are full on a consistent basis, requiring a wait time of 2 weeks for patients vulnerable to relapse."
"Delay in telemed based on high demand within the CBOC's. Need for telemed machines, rooms, etc."
"Increase CBOC provider''s willingness to work with SUD Specialty and pharmacy to offer alcohol dependence medication. Typically is ""turfed"" to SATP to handle, when the primary care provider should work with SATP. Providers appear scared or uncomfortable with addiction and treatment."
"Need more inpatient beds in [location redacted], or create inpatient level of care in [location redacted]."
No healthy environment during 2-week wait time to residential.

"Simplifying adminstrative processes would be a benefit to the Veterans.
More space and more qualified clinical personnel would allow for a slight increase the in the number of Cohort groups in simultaneous operation."
Many of these stem from having a system for capturing workload which allows for some required entries to remain blank - allowing for loss of workload unless fixed within 7 days.

"We are told there "isn''t enough bandwith" to increase telehealth services. I do not understand what this means, but we are often not able to provide the amount of SUD services needed because of this reason."
"I do not have enough SUD specialty staff to keep up with the number of Veterans who are recommended to outpatient treatment. I need at least one additional clinician, but I am told this is not an option."
There are significant waiting lists for other residential programs in the VISN. It is difficult to refer people for care as a result.
"We are in need of at least one additional staff member due to a waiting list for outpatient services. We have enough evening hours and telehealth equipment, but not enough providers to take an individual caseload and facilitate groups"
See previous comments. We are in need of additional staff and telehealth availability to increase services that are needed
See previous comments. We are in need of at least one additional staff member and more telehealth bandwith to provide more services
We are in need of additional SUD speciality staff to meet the demands of the services requested.
We are in need of additional SUD specialty staff and offices to meet the demands for SUD services
We use fee basis detox. We are in need of more services for this and more beds.

More expedient referral process to Parent Facilities with residential programs
"Better incentives for Psychiatrist, more clinical staff in parent residential facilities and/or increase funding for more local contracted residential programs"

More expedient process to referr to parent larger VISN facilities residential programs
better pay for Psychiatrist
Very poor patient motivation to enter rehabilitation program

There are not any inpatient detox services within this healthcare system. We are dependent on the providers at the joint venture. They are sometimes reluctant to provide detox to repeat patients. We would need 24/7 detox capabilities within this HS in order to provide consistent services.

It takes an extraordinary amount of time to get administrative tasks done to make improvements to the system. This needs to be streamlined or simplified. It takes months to hire a new staff leaving services shorthanded. It takes months to hold ineffective staff accountable. We have to weigh whether we should get rid of incompetent staff against how long we will go without staff at all. This impacts patient care on many levels. Maybe we need to outsource HR with incentives to get things done in a timely manner.
It just takes a long time for approval for fee-based services and then to set them up. Also it is difficult to find providers due to them not being reimbursed in a timely manner. Many providers simply refuse to serve VA patients.
Often patients are denied entry to inpatient treatment at other VA locations due to their need to serve their patient population first. We also struggle with timing for patients to come from out of town to detox at our hospital then to be able to go directly to out of town inpatient care. Our facility refuses to lodge them for a day or two and it puts them at risk to have to go home and wait for a bed. The other VAs often refuse to set a date for them unless they detox first. It makes the timing difficult and puts the patients at risk of relapse.
We do not have adequate program support. Our PSA has been moved away from the clinic and is working in another building. Clinical staff are now having to do many tasks that are administrative and not clinical at all in nature. This is a waste of highly qualified and paid clinical employees. This occurs in multiple programs in behavioral health. The administrative supervisor has complete control of this situation and moved all PSAs close to her and away from their clinic staff and patients.

"Understaffing is the biggest problem, particularly in CBOCs. Difficulty recruiting when positions are open is also a problem. Office space becomes a factor if more staff are hired."
Recruiting to CBOCs is particularly challenging. Syracuse is understaffed to offer enough telehealth to CBOCs. Non VA Care works and we use it a lot.
"Our experience in referring to residential care is that they all have policies that Veterans must try outpatient first, before being admitted to residential. This is rigid and does not allow for the outpatient provider''s assessment of a Veterans needs related to severity of substance use, available resources, living conditions, ability to travel for appointments etc."
"I cannot speak to staffing at residential facilities, but the policy of insisting on outpatient first is a problem."
"Again, staffing at CBOCS is particularly problematic and understaffing at the main facility makes increasing telehealth services impossible. Space needs are also a big issue in CBOCs"
"Again, cannot speak to why there are problems in residential sud care. My impression is Central Office policies re mandating outpatient first is an issue that leads to delays"
Allow outpatient SUD providers to determine need for residential treatment rather than mandating outpatient first.
"Not enough admin staff, nobody focused on SUD Clinic, SUD Clinician handles scheduling. team lead is split with .5 SUD, .5 PTSD and the team lead also trying to do PTSD clinical work. Staffing money saved, but reduces functioning of the STS Clinic."

Currently all physicians in the program are exceeding expectations for RVUs. In order to expand services will need more prescribers. We have very poor support for appointment creation and our HAS clerks are consistently short staffed. We need both licensed providers and administrative support staff increases to improve performance of our clinic.
"Long waits for transfer for veterans who would like care at another facility exist throughout our area. Our program is not residential and when we try to assist our patients to get into residential care, we have long waits and sometimes are told that our veterans can''t access the desired program because they have too long of a waiting time for their own residents."
We have not had a substance abuse counselor in the primary care clinic for several months due to slow hiring at our facility. We have just hired one and expect to have this issue resolved. Slow hiring is a problem at our facility.
We do not have a residential program. Referrals out can take months for admission.
"While we are meeting our performance measure for bringing a patient in to the program, we would like better case management from the ER to facilitate patient''s transition to care in the interim."
We have poor administrative support in my clinic and we have not been assigned a permanent program support individual. It is extremely difficult to have appointments scheduled due to very poor HAS support.

"We have a facility in which the majority of SUD services are given. This facility is a rented building that has been maxed out in terms of space. We have created offices on what used to be porch space just to make room for more providers. We are in dire need of a new building so we can offer more beds for Residential treatment of substance abuse. We need more space so we can adequately perform outpatient detox, we also need more technicians and clinical staff so we can provide extended hours clinics. We were on the Skip plan for 2017 to get a new building but I am expecting a delay in this because we also have competing space needs for General Outpatient Clinic for Primary Care and Mental Health and this will take precedence over any new plans for space for substance abuse because Government Contracting is notoriously slow and must prioritize all the projects they have. So far we have not offered substance abuse services as FEE base or contractual secondary to the basic needs of this population along with multiple psychosocial issues that only the VA is geared to manage. This include homelessness, getting engaged in primary care, helping with getting the veteran back to work once they obtain sobriety. WE do have Grant Programs in the community as well as HUDVASH vouchers which help transition for our patients. We offer Buprenorphine but do not as yet offer Methadone. This will be costly once the new handbook is published which apparently has the requirement to offer both forms of treatment. When this happens Methadone will have to be FEE to the community as we do not have the resources to provide this. I understand of all the Methadone clinics in this area there is one that meets SAMSHA requirements. Our substance abuse patients are the most difficult to treat. We have had several process improvement and currently I have an ongoing project to try to find ways of managing this population so that the revolving door stops. This is project is ongoing and we are trying to tackle several issues to include making the services quickly available and also using motivational techniques and case management, finding ways to communicate with these veterans (they usually don't have phones or addresses), and making sure their transportation needs are met. This all takes manpower and hence space. The desire is to engage these veterans in this health care system to minimize the morbidity and mortality that this difficult population succumbs to. Feeing them out will only cause more of the revolving door and will increase the likely hood that they will get lost to follow-up."
Please see previous comments. More beds for Substance abuse will improve access to treatment for residential. This would require an increase in Substance abuse counselors. Enhancement of our

outpatient and extended hours services also would be benefited by increase of substance abuse counselors as currently I do not have enough providers to offer this service without fatiguing my existing providers. This again requires more space for providers as well as patients. Using Fee-basis is not an option per previous comments. As you add providers there is need for more computers. With more providers we can offer more vtel to more distant CBOCs but they too must have space available for the patient to be received.
"Delay comes when CBOC provider places a consult for patient to receive substance abuse services and the patient is not yet ready and refuses or no shows the consult or does not respond to efforts to schedule an appointment. There is an ongoing initiative to start anti-craving medications in the Primary Care through the SUD Queri initiative and this is a current research project ongoing at this time. In addition Behavior Health Psychology, which is embedded in Primary Care works with the patient to get them motivated for change. Both these programs need to be enhanced and when growing Primary Care Clinics special attention needs to be emphasized to not forget space for PCMHI is also needed to support primary care CBOCs. Finally Contract CBOCS which are generally Large CBOCS or Less in size do not have PCMHI so either the contracts need to be changed to have MH embedded in Primary CAre in the contract CBOCs or space considerations need to be taken into account when the Mental health needs/Behavioral Health needs of a primary care patient in the Contract CBOC needs attention. because the PCMHI provider is providing services to those contract clinics as well but when adding contract clinics there is no additional space provided for PCMHI. A perfect example is [location redacted] that only has space for 2 full time mental health people but the need is great for more. We have utilized every square inch providing Vtel in space that is not utilized when not seeing patients and also sending MH providers to [location redacted] to see patients in office space that is Vacant because primary care provider is on leave that day. This takes a great deal of coordination of schedules and choreography to make sure we are utilizing space to the maximum but also making sure our providers are also being fully utilized."
"Please see previous comments. Delays from outpatient to SUD treatment are usually secondary to the patient not responding to efforts to schedule the consult or No showing to the scheduled appointment. Anti-craving medications can be started and ongoing conversations are necessary to motivate patients for treatment. Patients that engage with their MH provider have an increased likely hood of following up with this treatment over time. This is another reason that Fee Basis does not work as we do not have time or personnel to manage the care of patients that are sent to the community for services.
I have sent many FEE services out and have been disappointed with the quality of care in the community yet I am responsible for the quality and have to ensure the patient is continued for care if they need treatment. By doing a FEE contract I believe I have delayed the necessary care for the patients. At issue is that I, the Chief of Mental Health, am the one person that has to review these FEE contracts for quality and necessity for continued care as I do not have the clinical staff to do this as they are all trying hard to see the patients that come into the system. This is bad for my morale and is taxing when especially we strive hard to give good quality care and are expected to manage our patients above and beyond personal responsibility of the patient. For instance if a patient misses his mental health appointment the provider has to make three attempts to contact the patient and get them rescheduled. If a patient is High Risk for suicide they must have weekly appointments, have meds controlled (cant be done if sent to the community) and be monitored closely for risk assessments and suicide safety plans. ALL MH patients are required to have a RECOVERY BASED treatment plan using MH SUITE. This software does not lend itself to recovery based treatment plans and is not standardizable and only serves as one more documentation requirement that wastes the providers'' time and the patients'' time. We created template based treatment plans that were felt to be outstanding by JC and CARF and The VACO SITE visitors told us in no uncertain terms we had to use MH SUITE for our treatment plans. TOO much money was spent on this software as it does not help the provider and produces a document that is

miles long and not understandable from the perspective of the patient. The mandated use of MH suite is another paper pushing exercise that makes the provider glue to the computer and spend actual less time face to face with the patient. Also its mandated use requires additional admin time for documentation which the provider has to take out of hide because we have to have them seeing patients. It is not patient centric and destroys morale of the providers.
I would challenge the community to be able to meet all the mandated requirements of the MH Handbook/ I do believe the handbook to be full of wonderful quality initiatives but I also feel the people who created it had no idea of the resources required to meet the mandates in the handbook and are still lacking the basic understanding of what more we need to meet the true intent of the handbook and the costs associated with that. In addition because of the lack of resources for case management (the part that currently my most expensive providers are expected to do) this causes a huge moral issues among these providers and causes them to burn out and leave."
Please see previous responses
"I have already discussed the MH handbook and how it is a wonderful Quality Initiative. However it takes much more administrative resources and support services than we currently have in place to be able to have true quality and intent of the handbook. Mental Health Treatment coordinators are exactly that. Treatment coordinators and currently 90 % of my MHTCs are psychiatrists, who do not have time to coordinate care for their patients. The New BHIP model is designed as a solution for this but it will take me years to reorganize my clinics to get the BHIP model fully staffed and incorporated. And without space I cannot do it at all."

Providers frequently are not willing to prescribe pharmacotherapy for alcohol use disorder. More incentives and education are needed.
More providers need certification for buprenorphine. Very few exist in the local community.
There is only 1 community methadone site in the state. we need more community resources.
Need more residential beds and staffing to have shorter wait times. Contracts with community are used extensively.
Need more staff and residential beds
Need more beds and staff

A barrier to obtaining timely access to care for fee-basis community providers is the difficulty with the VA paying community providers for their services in a timely manner.
VA needs to pay community fee-basis buprenorphine providers in a timely manner so that they will continue to accept Veterans for treatment.

We are desperately in need of more mental health/SUD clinicians (CBOC''s in particular are understaffed).
"We have no SUD specialists at the CBOC''s and limited specialty telehealth. We need support staff to reduce wait times for some services (e.g. more nursing staff in CBOCs would allow them to do Suboxone inductions, thus relieving the wait time for that service, currently only offered at the main hospital."
Create expedited process to get medical clearance for people in need of rehab. The rest of the delays occur at the residential facility and we cannot control that.
We need more therapists and support staff in the CBOCs!!
We need more nursing staff at CBOC''s in order to make it possible for them to do buprenorphine inductions. We may need more psychiatrists to manage increased workload of new patients with weekly appointments.

Veterans need to be sent promptly to local hospitals when they need detox. We have had times in the past where we had to wait for beds or services to be declined from another VAMC and the patient walked out of the ER.
Mental Health Suite is cumbersome.

need a psychiatric/medical provider with SUD experience with time dedicated to outpatient MH SUD services. Management needs to assure those with time intended to be dedicated to SUD services are providing those services in an efficient and effective manner (psychiatry/medical). improved communication and processes between the emergency department and inpatient withdrawal management to understand services and criterion for admission (hospital - non MH).
assign a prescribing provider with SUD experience time dedicated to SUD outpatient services.
management to assure that psychiatry providers engage effectively with SUD outpatient service clinical providers.

we do not have residential treatment at our facility and the demand for this type of service is so high in our VISN that we are unable to get veterans into the treatment facility within our VISN. we are not having to refer outside of our VISN for this type of care
"we need additional resourses for residential treatment. i think there needs to be additional beds and programs opened up and that all 1a, 1b and 1c facilities should have these on campus"
we do not have residential beds and the ones within our VISN are always full and there is a long delay
"we do not have residential beds, there are non in the community and the VISN residential program is always full. recommend that all 1a, 1b and 1c level facilities have residnetial beds"

Need more support staff for scheduling and administrative support for practitioners
"There are not enough residential treatment resources in our area. We have too few beds to support our number of veterans. We cannot rely on other proximal systems, they are also full. We end up utilizing private care, but often this care is below va standards and does not provide the care a veteran prefers."
Need more SUD detox beds
"We need more treatment space, especially space to do private, individual care"
Need to find ways to support outpatient detox in CBOCs
Need more beds...
We need more inpatient beds for detox...veterans prefer treatment in VA...also need streamlined approach to de-escalate inpatient detox to outpatient detox and community beds to support this
"We have delays in our availability of residential treat,net beds mainly for lack of space"

Referrals across parents to other institutions are case-by-case.
Make referral conductable electronically
"Not enough health tech time. No health techs for evening hours.
CPRS has flaws."

"We need more psychologists. We also need more administrative support in the clinics. Scheduling is extremely difficult - we need a centralized, user-friendly scheduling system that tracks both appointments and room availability, because telehealth is shared by multiple providers. We could use more telehealth rooms to increase scheduling flexibility and we could also use more evening and Saturday hours."
"See the previous question, most apply here. We need more psychologists and masters level clinicians - the psychologists to provider oversight and program development for SUD in the outpatient clinics."

"Please see previous 2 questions. In addition, our SUD program at the main campus is sorely understaffed. We need more psychologists and masters level clinicians to meet the need. The scheduling system needs updating, but is not as critical as it is for telemental health. And they literally have NO administrative support, which impacts care as well."
Additional staff devoted to screenings would reduce time from referral to admission.

"Space is at a premium , so having more office space would afford privacy of care to veterans. Increase number of psychiatrists to manage this complex group of patients , to continue to provide ambulatory detox safely . also need nursing support as well as addiction therapists to be able to provide MI and support , to engage patients in treatment even as they are undergoing detox."

"Our contracted residential facilities have very restrictive criteria. Services in the community do not seem to exist with the same emphasis as VA services (e.g., evidence supported use of suboxone and methadone)."
This facility has approved key personnel to improve in this area. We are not yet able to fully make the improvement due to HR related delays in start dates and posting necessary positions.
"A residential sud program for this facility has been approved and positions are being filled. this inhouse capacity will likely address only 1/3 of the demand. approval for more dom sa/sarrtp beds for this facility would be ideal. we''d also need the space and staff, etc for this expansion."
"this facility has already approved staff changes to improve this problem, but in the past year since approved we have not yet been able to have new ftee EOD. this will improve once staff are on board and new structure implemented."

More efficient and timely processes to enroll veterans in RRTPs.
Open and staff all RRTP beds in the VISN. Make standardized screening processes.
Open and staff all RRTP beds. Transparent and efficient screening processes.
Open and staff all RRTP beds. Transparent and efficient screening processes. Could screen by TeleHealth
"As the number of Veterans/Services have increased, we have outgrown the clinical administrative structure. Too much admin burden and “due todays” are coming from CO."

"We could use more Psychiatrists, social workers, and admin support staff. Better incentives and salaries for MDs will help"
Would need additional case managers.

"More addicition trained staff - all levels but especially addiction physicians
Improve drugs of abuse testing capabilities to allow for adequate chain of custody and confirmatory toxicology at each main facility.
Modernize the archaic VISTA scheduling
system.
”Horinzontal”“ alignment and integration at the top (Centraol Office) to be maintained as policies work their way down for Front Line implementation.
The biggest supervisory challenge is not allowing CLINICAL staff sufficient time to perform supervisory responsibilites."
Increasing non-VA care without corresponding CLEAR processes for COORDINATED and INTEGRATED care carries the risk of Veterans suffering from lack of coordinated care.
"Insufficient number of beds for a region. Matter is critical in parent facilities that are mostly rural. Thus, non-VA facilities with required service also likely NOT to be available or existing. Veterans and families

are not well supported (and are often unable) to travel sometimes litreally across the country to where services may be available."
"We are sending out Veterans for care that could (and should) be provided inhouse. It is cumbersome to obtain necessary administrative changes: for example, change designated beds thatwould reduce delay and keep care in VHA."
"We are sending out Veterans for care that could (and should) be provided in house. It is cumbersome to obtain necessary administrative changes: for example, change designated beds that would reduce delay and keep care in VHA."
There is just not enough staff or space for example to properly and safely perform ambulatory detox.
The facility needs to do better in facilitating the use of EB pharmacotherapies that do not require SUD specialty level of expertise.
Residential care is extended length care. Thus there is likely to be delays whether within VHA or outside VHA.
Limited number of facilities providing this care in the community coupled with the limits within VHA make delays inevitable.
Help clinicians be involved in administrative and management by providing adequate non-clinical support.

"Answers to questions about another administrative parent''s programs are estimates. Difficult to say what staffing or equipment needs another site may have.
Typically what we hear is delays are due to lack of space and/or ability to accept referral sooner (possibly related to staffing).
IT system is cumbersome; this likely could improve efficiencies in transferring Veterans to another site for care.
At times arranging transportation is a factor in delays experienced."
Referral system is cumbersome; approval system also. Access to community resources could be improved.
In order to facilitate residential SUD care additional options for referral when facility''s program is full would be helpful.

".Have concerns about standard of care at local methadone clinics. Some ambiguity about how responsible VA staff are for care at outsourced private clinic. The VA system responds fairly quickly to consults.
We just lost an excellent social work SUD counselor to Homeless program because she was able to get GS 12 promotion. Specialized staff should have same opportunity for promotion.
Need build out for a more private space to conduct observed urine toxicology screens."
"We need our own residential treatment program. Our patients have to wait 2-5 weeks to get into residential facility at another site.
Difficult to detox severely alcoholic patients in outpatient setting as this is a rural community and many live too far to come to daily outpatient treatment. Need our own residential program and more support for inpatient detoxification."
There are delays in private residential programs as well do to over flow. Again we cannot guaranty quality care.
Patients with significantly elevated BAL are admitted to medicine overnight and kept if they have co-morbid acute medical conditions. CIWA is instituted while inpatient but often they are immediately discharged often with benzodiazepine prescription. We are a rural community and so many patients live too far to attend IOP. If they live close enough and can be safely detoxed we can do that on outpatient

basis. If we had a residential program we could slow down the revolving door and offer more outpatient detox to those who live too far to come to clinic daily.
WE do not have staff with substance abuse expertise in CBOCS and so CBOCs send them to main hospital. CBOCS are over crowded with no additional space to house new mental health staff.
We do not have inpatient detox capability unless medicine will admit for co-morbid acute medical.
We do not have residential on -site and there is a wait list for other facilities.
We need a build out for residential. Proposal is has already been submitted.

"e. There have been significant problems in establishing telehealth SUD services in [location redacted] CBOC due to space, bandwith, equipment, staff support problems. Not so much the other CBOC"
Same comments as questions number 3.

We are in pro cess of hiring additional Medical staff which will eliminate delays.
Increase available beds for inpatient and residential placement for patients who are not benefitting from outpatient treatment.
Increase supply to meet demand.
Currently hiring so we should be eliminiting any delays in the coming months.
Currently hiring additional staff (Addiction Psychiatrist) which should resolve any delays.
More beds are necessary in the network to allow for timely referral.
Clarify admission criteria and coordinate continuuim of care so that there is no delay between detox/stabilization and start of inpatient rehab or other inpatient care.

"Front line admin. staff are needed to process consultation referrals after triage. There are providers with open slots in their schedules and a backlog of patient who have been accepted for the service but are waiting to be scheduled.
Space and equipment is needed in order to provide our Vets with all ASAM levels of alcohol detox. care.
The appropriate compliment of staff e.g. prescribers, RN, health techs, clerks.
In order for policies to be useful, staff need the required resources to do what is indicated in the policy."
Need to be able to more easily fee-base services immediately un-available at this facility
Need an alcohol detox. program that can treat all ASAM levels of detox.
Need a free-standing SUD treatment center that can provide in-pt. treatment for substance detox.
otherwise allow for fee-base treatrment
see previous comment
Need to either provide services within the VA system or allow for fee-based care
need a formal detox. center with immediate transition to residential care
Need to be able to access fee-based care especially in remote areas.

Need more psychologists for assessment of SUD; need more psychiatrists or APRNs for medication management; need more testing materials to properly assess SUD; overworked staff lack any incentives to improve productivity or morale.
"The [location redacted]VA does not have it’s own residential SUD unit. The [location redacted] VA is contracted with one agency [location redacted], and beds are frequently difficult to obtain, as the agency serves the [location redacted], etc. The SATP team at the [location redacted] has been ;largely unsuccessful in sending veterans to other VAs for residential SUD care. The ““denial”“ of our veterans by other VAs is perceived to be a lack of space/providers, as the reason given is that the VA is already full with patients from their own catchment area."
The [location redacted]VA currently does not have a clinic to address acute alcohol withdrawal. Veterans in withdrawal are sent to the TAMC ER.

The [location redacted]VAs delays in opioid withdrawal has been impacted by staffing issues. This is expected to be resolved within the next 2-3 months by recruitment and hiring of appropriate personnel.
The [location redacted]VAs delays in buprenorphine management maintenance has been impacted by staffing issues. This is expected to be resolved within the next 2-3 months by recruitment and hiring of appropriate personnel.
"The [location redacted]VAs CBOCs are [location redacted], varying from [locations redacted]. Delays are typically due to travel and housing arrangements, and are not due to appointment availability in the outpatient treatment facility. Delays in residential treatment are also impacted for the CBOS by travel and housing arrangements, and by available space at the contracted agency. An increased number of contracted residential providers would be helpful in decreasing wait times."

need a functioning fax machine in our building
"once pts are assessed and seen as appropriate for referral to non-VA methadone care, the primary delay in care is getting MH Administration approval for the fee-basis referral."

"Also need second dosing window and dosing nurse for that window, as well as confidential space for dosing line."
"We have no clearly defined admin person in the CVAMC trained, time alotted, and clearly advertised as the ““go-to”“ person to send our fee-basis referrals to. As well, our payment rate is low to these fee basis providers such that they are not eager for our business."
"We need to hire 6-7 more therapists, who need offices too. We also need to streamline the fee basis process."
"We need to hire more therapists, give them offices, move our dosing area to a confidential location near our addiction specialty providers, add another doing window. We also need to streamline the fee basis process."
"Our residential unit in small in capacity, relatively speaking. We need to be able to increase our census as we have a typical wait time of 10 days - wherein patients relapse, have complications, or worse. We may consider fee basing some of this volume out."

"We need a more automated system to reduce no shows. We also need tech support staff to collect urine specimens, administer breathalyzers, etc."

We have availability at our facility without delays so we to not need to use contract or fee for service outside providers. We also have more qualified providers at our facility than the providers in the community
We have the above listed treatment options at our facility and there is no need to use outside services
we have no delays in providing SUD treatment at our facility so we have no need to use outside services
Using clinicians to address administrative requirements and reports which removes them from clinical activities - ineffecient care

We need more community detox programs in our rural areas/areas far from medical center.

Space constraints at CBOC can limit access. Adding LIPs would improve access. VistA scheduling package is outdated and does not meet organizational needs. Administrative burdens affect clinical efficiency.
Addiction psychiatry vacancies has affected operations.

"More clinicians who have training or direct experience in dual diagnosis treatment to work in all settings -- inpatient, outpatient, residential. More staff to call pts to remind them of appts or when they are expected to attend groups."
Group space and office space is at a premium at our facility. Groups frequently cannot be conducted at the times we would like to have them because group space is already reserved. We also need more office space for trainees to see patients. Our float office space is not adequate.
The psychiatrists need staff who can take care of simple refill orders rather than the MD/Psychiatric NP having to take care of every request. We also need more staff who can take a phone call to an MD/asking when their next appt is. No shows leave clinicians with unscheduled hours for pts on one day and overbooked hours on other days to accomodate the rescheduled no shows.

"We do have some rural patients who participate in buprenorphine, but there is the expense of time and travel to get to the main medical center. They must travel to the medical center because there are not enough of them to offer psychosocial group treatment via telehealth. If there were more rural community providers of buprenorphine, we could refer rural patients to them and these patients would be able to obtain services more conveniently."
"The problem here is that our VA does not offer methadone therefore if a patient wants that they have to be referred to the community where there are significant delays getting into an approved program. We do not have high numbers of patients requesting or appropriate for methadone at this time, however when we do, it is a long and difficult process. My perception is that there are not enough methadone programs in the community and they have long waiting lists. The other alternative would be to apply through VA channels to have a methadone program here at our VA. However, there are not enough patients requesting the service to support a methadone program."

"We are in critical need of Psychiatrists/NP, RN and LVN in outpatient SUD. In the last year we have lost/will be losing in next 30 days approximately 1.7FTEE MD time, .4 FTEE is TMH SUD, .5 CBOC. It is critically important we are able to fill these positions. We are also in need of RN/LVN assistance in ADTP-OP to fill the need to assist with SUD-OP medical treatment needs (detox/pharmacotherapy). A FT pharmacists in SUD-OP and our SARRTP. A fee basis need is community based detox. Equipment-bed bug oven, breathalyzers, wheel chairs, and vital sign machines with pulse ox. A treatment planning tab in CPRS."
The main needs are to fill recently departed MDs and to hire RN/LVN to support op alcohol withdrawal.
The main needs are to fill recently departed MDs and to hire RN/LVN to support op opioid withdrawal.
The main needs are to fill recently departed MDs and to hire RN/LVN to support pharmacotherapy for opioid use disorder.
There is brief number of delays in detox bed availability.

need more SUD providers and space at CBOC''s.
could use more trained SUD staff
most residential programs have some of the same issues with demand and we probbaly need more of these programs throughout the country
need more incentives to recruit Suboxone certified providers.
if we had more beds i''m sure we could fill them.
we could use suoxone certified providers and it's difficult to recruit them.
screening process and sometimes pts do not want to come in immediately to a residential program
screening process and residential requires committment from pt

"We provide SUD care in our CBOC''s but finding staff with specific SUD experience in large metro area is a challenge and even more so in more rural areas. Psychiatrists with a sub-specialization in addiction medicine are rare, their salaries are rising and many of them have an academic bent which are factors against hiring them in CBOC''s. Then there are space and support challenges that we exp. in general that add to the mix."
We have a very good carf accredited methadone clinic near our main facility that we are lucky enough to contract with. They do an excellent job and I believe they can provide methadone treatment more efficiently than we would be able to. At our CBOC''s the contracting out for methadone is more hit and miss. Suboxone is a wonderful treatment but takes a lot of appointment slots to manage and we don''t have much at all in terms of nursing support in the CBOC''s to help case manage the patients. So if we only have so much in the way of prescriber time do we spend it doing pharmacotherapy for 3 patients with PTSD and Depression whom we see every 3 months or do we see 1 patient on suboxone for the 12 monthly appointments? In this case it has made sense to look to the community to help provide suboxone treatment.
Providers who want to work with veterans who have SUD''s are harder to find than a generalist OP Psychiatrist. We aren'' built to run a SUD clinic at the CBOC''s as we are at the main facility and aren''t staffed with RN''s to case manage the patients.
We had 2.6 FTEE Psychiatrists sub specialty boarded in addiction medicine. One moved to another VA. Our .6 is retiring and we cannot staff our fellowship. Ads have been out for over a year and we have tried co- recruiting with our affiliated medical school and have no applicants as of this writing. Pay does matter but the VA might want to think of sponsoring Psychiatrists who enter this field or be more open and generous with tuition reimbursement. There is a difference between having staff who can treat a problem if they have too and staff who chose to specialize in treating a given problem.
"A PACT model would work great for our SUD clinics. We have tried to emulate this but a national effort to boost staffing of RN''s, MA''s and MSA''s would help. We were fortunate to have a skip plan approved to remodel space which will be primarily for SUD care and purpose built for that population. This is the result of a decades worth of planning and work to get to this point. We hope to have the project start early next FY."

Increasing access to SUD care in CBOCs is critical.
Having personnel in the CBOCs is critical.
More programs are needed.
More staff are needed to offer these services.
More staff are needed in the CBOCs due to increasing demand for these services.
More providers needed to deliver TMH.
More clinicians are needed.
The administrative burden has been steadily increasing. The number of tasks have been increasing and take up significant time to manage.

Working to improve access to care

Working to increase the availability of services

"We need more space and prescribers and psychologists in the CBOCs. It would likely be good to offer financial incentives to support staff for efficiency, and to have more scheduling staff."
The most important factor is bed availability. Interfacility consults could be more user-friendly. Increased scheduling staff and increased pharmacy involvement would be helpful. At times more beds would be helpful and at other times there is no delay in getting into our residential program

Having more sud prescribing providers in the CBOCs and offering POC drug screening would be helpful. At times the SARRTP is full and there is a short wait.

scheduling software is not helpful and outdated.

Need to have better scheduling package; need clerical support; need to recognize issues of rural level 3 care facilities when it comes to providing any service; staff need more praise and gratitude from upper management
Need better scheduling tools for MH; need clerical staff for SUD; Need to recognize challenges of level 3 care facilities; Need less staff in VISN and VACO and more in facilities... especially clinicians.
Need to have easier fee out processes for some of the medication management related to SUD; Need specific addictions psychiatrist position within MH if these demands are expected to be met
"Need to have specialized programs at different facilities. For instance, a small rural site should be able to refer to a larger facility for specialty SUD care in some instances. Small sites cannot afford a full time, dedicated SUD psychiatrist when our outpatient clinic in general MH is barely staffed appropriately"
"Need to review the literature to have a system with requirements which are logical, empirically based, and supported by administration; need more admin staff to support clinical functions; need nursing cooperation"

"Space and personnel seem to be the two biggest issues in access. We also need to find ways of decreasing waits for inpatient SUD services, particulalry because we don''t offer them at our Ambulatory Care Center."
Increase in the number of inpatient beds along with sufficient staff to manage the workload would go a long way in improving access to inpatient SUD treatment.

"Space for provision of care is critical as is allowing for overhires in order to maintain access when providers are lost. An improved, user friendly scheduling package is needed. Opportunities for career progression are important to retention."
Same comments as in prior section.
Our Veterans recieve residential treatment in other health care systems due to lack of residential services in our own. The addition of fee based residential care could assist as would adding resources to residential programs in our sister systems.
All our residential care is provided in other VA systems.
Need an improved scheduling package.

"Efficient and timely referrals, acceptance, and transfer to SARRTPs"
SUD intake and evaluation is fast but methadone clinics have delays to their own assessment and lose patients during this interval
"Referral, evaluation, acceptance and transfer takes too long"
Provide local SARRTP
Provide more CBOC personnel to provide more timely SUD treatment
"Delay from ADTP intake to initial referral assessment with fee basis provider, non-VA vendor does initial intakes on one day per week during a limited and specific time, lose Veterans in the meantime"
"Transfer to other VA SARRTPs takes too long, transfer to a local fee-basis vendor is denied many times"
"Not enough inpatient beds are available, refer these to fee-basis when inpatient full"
"Open up local SARRTP, Veterans have to travel far, time to referral, acceptance and transfer takes longer than neccessary"

"Difficult to estimate physical limitations at other facilities.
Autonomy in triaging in selecting appropriate candidates is questionable."
Increasing # of beds.

"ancient and arduous scheduling system creates too many errors, to include process of adjusting clinical profiles to improve access"
none additional
"moving patients from acute detox to inpatient or residential care is the weak link in the treatment chain. Currently, patients are receiving inpatient acute detox, discharged with ”regular”“ outpatient care wherein they’’re very likely to ”use”“ again and by the time their name comes up for inpatient care, they’’re not willing/able to make the decision to engage in care. Its a terrible cycle."
"our hospitalists express lack of competency around inpatient detox services for opiate withdrawal. So much so that some patients are turned away from this care, depending on which physician is working that shift."
DEA restrictions require no more than 100 patients of suboxone patients per provider. which presents a real limitation.

more recently we tried to refer Veterans requiring Methadone treatment into community which is very complex. Hiring should be easier and should be able to hire staff with skill set for a particular job.
[Location redacted]needs residential SUD facilty
[Location redacted]needs a residential SUD program .
we do not have SUD Residential facility.
we do not have personnel to implement SUD Telehealth services but plan to start when vacant positions are filled.
plan to implement Telehealth services in CBOC once vacant positions filled.
we need SUD Residential facility or easier process to refer pts out to the community.
we need Residential SUD facility
needs SUD Residential facility

There is a need for increased clerical staffing through MH Service. We would like to increase psychiatrists for Telepsychiatry but it is difficult to get new psychiatrists as they do not appear to pursue work in this area.
We need more psychiatrists to increase our Telepsychiatrist program. We also need more clerical staff.
"We need more psychiatrists, especially an addictionologist but they are difficult to recruit in this area. We need more clerical staff."
We would like to hire more psychiatrists to increase our Telepsychiatry services. We also need more clerical staff.
We need more psychiatrist to increase Telepsychiatry services. We need more clerical staff.
There are too many MH Initiatives that somewhat overlap making it difficult to give your full attention to the core group of initiatives.

Only reason for delay was transfer of our one-of-one addiction therapist to another positions. Personnel policies and resource limitations lead to delays (can’’t backfill before incumbent leaves; can’’t recruit without lengthy resource approval process)
"Transfers between facilities for residential SUD care has been a long-standing challenge in our VISN. Not sure what the problem is, or the solution"
"Fix transfer challenges between VISN facilities. Not sure what the obstacles are on their end, but I believe the VISN leadership is working on this"

There’’s no community program to which to refer
Fix problems with transfer to VISN partner for RRTP. Not sure what the obstacle is on their end
Same as previously comments

Approving officials increase efficiency in providing approval/disapproval.

"There need to be more beds at he VISN level for residential treatment. VISN beds are always full, and run over capacity. As there is not an RRTP at our facility, I can only estimate what needs there would be at another facility if they were to add beds. Contract beds may be part of a solution to this concern."
See previous comments regarding access to residential care.
See previous comments

We have no Residential Program in [location redacted].
No PRRC in the [location redacted].
No Residential Program in the [location redacted].
We have no Residential SUD care.
We have no Residential SUD care in [location redacted].

need more bandwidth
"most veterans are started on medication assisted therapies for ETOH within SUD services, this could be done in outpt mh as well"
same as answer to previous question
"CPRS and AMS (methadone software) don’’t communicate, clinical reminders are repetitive when veterans are seen daily"

VISTA scheduling package hopelessly antiquated.

- **TBI**

"Appt. booking times do not always work for patients. Often they are involved in school, work or inpatient program activities and cannot make an 8:30am appt or 3pm appt."
We do not offer MRIs on site and have to send pt. to another facility to have this done. This can create a delay in services.
"Currently, the Provider performing the TBI is not allowed to submit a consult for Optometry and must request that this be submitted by patient''s PCP, which lead to a delay in care. The TBI providers need to be able to submit the consult for this service which will decrease wait times and booking for this evaluation."
Audiology services are not currently available on site so patient''s have to be referred out to another VA facility. This contributes to a delay in scheduling and evaluations.
To have more access for TBI evaluations through the development of a full time TBI clinic where patients can be seen and evaluated quickly.
Currently we do not have an active pain management department and staffing. Need to send patients out to another VA for these services.
The completion of the secondary level evaluation and the resulting consults submission is time consuming for the practitioners. More help in this regard would help to streamline the appt. scheduling.

"If there is delay in providing the Second Level Evaluation it is often not because of the scheduling practices of our fcility. It is often times the Veteran''s schedule or other psycho-social barriers that create delays. Veterans frequently cancel or no-show and when the appointments are are re-scheduled per the Veterans request it often gives the appearance of delay on the part of the facility. The facility makes every attempt to schedule within the required time frames, however, we have to take into account when the Veteran is available for that appointment.
In rare instances a technical glitch in the CPRS system may prevent a TBI consult from being generated to notify the appropriate clinicians, however, that too is unique."
The lack of medical records from DoD does not delay or providing the Second Level TBI Evaluation. We always provide the evaluation regardless of records from DoD.
The questions relative to Pain and Sleep Clinics are out of our scope of practice.
Veteran no-shows and missed opportunities are a major issue. The facility is often pernalized for the Veterans missed opportunity. The system could have an improved communication system for centralized scheduling. There are far too many templates in CPRS that ask the same questions in a different way.

"most of the resources were allocated to mental health, however they are not the best ones to evaluate patients for TBI"
"I do not know the delay in this institution, later on they send me consultation requests to evaluate patients for TBI, eventhough this may had happened many years back"
"Here they need more people that are competent enough to evaluate these patients, this does not happens here they limits themselves to fill up templates or just click a filled template already, Quality of the ancillary service is poor, quality of the MRI is terrible and they sent patient have this done outside they do not do the appropriate sequences on MRI, they need here is a 3-5 tesla MRI to obtain better quality images. This service should be and must be available here 24/7. So far as far as have seen this is just virtual reality medicine"
"both do not apply here. The whole place is not equipe and have the qualified personal to do this task.,"

Recently added additional neuropsychologist and technician for test administration. May need to add additional staff if back log not resolved. Fee basis for this testing is difficult in local community as not many skilled providers available in the community.
"Have had difficulty replacing open position, finding psychologist interested in this role at our VA. Currently have candidate who has been offered position, plan to start in august."
"TBI clinic provides numerous processes for reminders to vets regarding appointments, but still clinic has large no show rate. appointments are offered per vet''s preference, letters are sent, reminder calls x 2 are provided. Vet still no show. Vet's offer that they no show for clinic due to forgot, car wouldn''t start, bad weather, have headache, too anxious to leave house on appointment date, etc., despite a phone conversation of day before that they plan to attend."

"For Comprehensive TBI Evaluations, many private sector providers are not as knowledgeable in military expsores to provide a thorough and understanding evaluation."
"My local health care system has a Polytrauma Support Clinic Team. Majority of patients we see are able to be managed as an outpatient. When necessary, referrals are made to our Polytrauma Network Site."
Delays often caused by Veterans having multiple evaluations scheduled after no-showing. Limited slots are available due to staffing in CBOCs as CBOC visit is done by primary care specialist.
"For Veterans with TBI who do not want to seek primary care within VA, they are unable to see metnal health. In some CBOC''s mental health appointments are booked out. If >30 days Veteran may be able to use choice but it is not typically clinically appropriate to switch counselors or mental health providers. Continuity is very important in ongoing mental health counseling."
Very limited options for pain management outside of primary care are available.

Implement team supervision vs. having each team member reporting to different service lines/supervisor.

"[Location redacted] is has limited access to both VA and non-VA comprehensive sleep evaluations, especially as the local private market is already saturated."
Unsure
"Increased access to VA and non-VA resources for comprehensive sleep studies. However, current VA and non-VA markets are saturated."

Need physical and occupational therapists. Need space to conduct therapies and need to streamline ability to provide care for patients. Also need to breakdown barriers and allow people to just get work done rather than constantly responding to NATs
"we have a shortage of space, therapists, equipment and schedulers. With issues at the VA being so compartmentalized when there is a problem at any point along the deliver chain we are unable to properly care for patients."
"Again, not enough therapists, problems with space, scheduling, human resources in terms of bring people on board, lack of computers and equipment."

rehab clinic but evaluations completed by primary care and mental health staff
"Facility is without Neuropsychiatry.
Remote CBOC''s depend on Telemedicine and fee basis to serve Veterans"
"Facilty is without Neuropsych provider, fee basis providers utilized."
Facilty had only very limited case management services. Facilty has since hired 2 case managers and administrative support. Space for these providers is limited. Case Managers and other staff do work evenings to accomodate Veterans.

Typical delay is in obtaining mental health records.

We need to proceed with our space project that has not begun yet to separate TBI to it''s own clinical space. We need to backfill vacancies in OT.
We only have neuro psychologist as part of team. We send referrals to mental health for all other services.
We need approval to backfill the vacant 0.5 FTE Occupational Therapist vacant since beginning FY2015. Approval on hold.

"Demand for sleep studies is such that NVCC & Choice must be used, but administrative policies & practices for use of both NVCC and Choice are challenging."
"See previous response re: NVCC, Choice for sleep studies."
"See previous response re: NVCC, Choice for sleep studies."

Our facility receives approximately 100 consults a months with only 1.5 FTE provider(s) to see those requiring a CTBIE.
"The requirement of how many time to reach a patient to schedule them for an appointment is time consuming and wasteful. We still have a 25% no-show despite these efforts. With the outreach being greater in the outlying areas it is difficult to meat the mandate of completing the CTBIE with no change in staffing for the last 10 years. It makes telehealth efforts harder because one provider is being as decrease in person clinic availability to tele-health. Why do we have to contact the veteran for the an appointment? The veteran should have some empowerment to call and make their own appointments. I know consult have to be tracked, but maybe have veteran know that they have 10 business days to make the appointment or the consult is voided. The veteran often get irritated with us chasing them down for an appointment in order to meet a mandate and at the same fighting a loosing battle in missed opportunity rates. I have found in other clinic where the patient makes there own appointment, they are more likely to show up and most of the time call in a timely manner to cancel if unable to make it. If the process doesn''t change then more FTE is needed to complete the CTBIE in the 30 day mandate. Additionally, what I find problematic is when the veteran transfers to another VA the TBI screen comes up again when patient already had one at a previous VA. Isn't there a way for the screen to auto-populate with last time one was done and ask if there has been new deployment since there last screen?"
Performance CTBIE is heavily dependent on scheduling and re-scheduling particularly no-shows as they are clogging up available slots for new consults and not necessarily delivering quality care.

improve access to sleep speciality assessment
increase clinical staffing and provide the space for them to provide services
increase clinical staffing and provide the necessary space for services
increase clinical staffing and space
Increase clinical staff and space

"In addition to evaluation neuropsychology, treatment psychology services would be advantageous"
"Audiology services are delayed. If C&P audiology could be outsourced, this would help."
Do not recall requesting DoD records
Delays in neuropsych assessment sometimes as long as 4 months.
"the intake packet, paper questionaires, is often lost by patients, Without a completed packet the patient cannot get to their first appointment. Couldn''t this be electronic?"
Newly hired Pain Management specialist having trouble getting started due to lack of clinic space.

"the pain management, audiology, and neuropsych issues."

"These cases are triaged so I am reasonably confident that there are no adverse outcomes, only failure to meet guidelines"
"1. Central Office loves to increase administration and all positions which do not provide direct care, and never adds providers, or people who word directly under the supervision of providers. ”Clip board nurses” who provide no patient care are the plague!
2. A national electronic record so that all information is readily available is essential to efficiency and good care."
"The VA is run, to quote a director, so as“ “to control the doctors” You cannot run a health care system against the doctors. All the problems mentioned above derive fundamentally from the desire to by CO to control the system not let professionals do their job."
“”“”"
DOD is uncooperative and condescending.
“”“”“”“”
"we just need more staff in the therapy sections for the outpatient services. Vision for tBI, vestibular and OT staff for the mTBI"
need another OT vision therapists and a full time OT
we have s system in place but one record system would be best
we have some gaps in personnel because of our large inpatient workload
vision rehab done by OT for TBI
make the physicians the highest costs FTE in the VA the most efficient FTE...give them the tools and staff to make them efficient and not to administrators who are not involved in patient care

Timely submission of consults. Providers available at remote sites. Reminder phone calls. Improved NVCC services.
Support clerical staff needed. NVCC services.

Other mental health therapy
"Web-based templates for CTBIE, Mayo Portland and IRCK has been inoperable intermittently and not user-friendly"

Need to decrease clerical staff turn over in dealing with the TBI CTBIE’’s. Many rules to be adhered to and takes a long time to train new staff members. This creates the possibility of delays and missed scheduling of veterans.

"Interdisciplinary Team Evaluation, patient not physically present."
This is due to provider shortage and rescheduling. Travel distance is a significant impediment to obtaining timely evaluations. This is a rural/frontier state.
"We are dealing with a shortage of providers, both physicians and mid level providers. There is a shortage of nursing personnel, both RN and LPN. We have a critical shortage of physical space, not enough exam rooms to the point of inhibiting productivity. Telemedicine has increased our ability to reach rural areas, and this should be expanded. Providers other than neurologists and physiatrists are capable of performing the CTBIE. We are currently doing this, otherwise we would not be capable of keeping up with the demand."
"We have a significant shortage of licensed neuropsychologists. Each neuropsychologist needs to have trained technician support. We do not have a Physiatrist, no neuro-ophthalmology capability, no vestibular specialist. Audiology access is limited."

"We have a significant shortage of independent licensed professionals, especially psychiatrists, to provide the care. This impacts available timely appointments, both face to face as well as telehealth."
"VA providers need ready access to DoD health records via electronic medical record systems. There is significant delay in accessing the hard copy records. Additionally, the DoD EMR is cumbersome and not easy to read."
"The PNS is overwhelmed and as a PSCT, we have developed alternative capabilities.."
"As noted previously, most issues are due to shortages of professional staff. Once staff is acquired, the necessary support personnel needs to be hired. We do not have specialists in Physical Medicine or a Pain Management specialist."
"Again, the issue is a shortage of trained personnel."
"We do not have a pain specialist on staff. Availability in the local communities is limited. Again, it is a shortage of personnel."
The problem with scheduling relates to decreased availability of appointment slots due to lack of specialty trained personnel. Space is also limited.

"This is awkward in that I am answering proposed solutions about another department, yet I am not privy to what their specific challenges. I am guessing at my answers here."
"Again, I am not privy to the challenges of another department, so I cannot legitimately propose their unique solutions. However, we have a system wherein Mental Health allows walk-ins only rather than allows for physician to physician referrals to psychiatry. I believe strongly that a TBI Physiatrist should be able to make a referral to a Psychiatrist colleague."
"We can do this here in SPRS, however we need the appropriate personnel. I am not sure whether or not this has been identified as a priority by the supervision in SPRS."
This is my favorite question so far and directly speaks to our inefficiencies. We have a doctor and nurse doing a great deal of clerical work and much of the documentation requirements do not feel meaningful to the actual care of the patient.

Weekend clinics and extended hours have been developed in the MRI section
Extended hours on the weekend

[potentially identifiable comments redacted]
"The time between the consult and the expectation of when the patient will be seen is unrealistic for Veterans many of whom were injured years before being screened. The TBI clinics are designed to be one deep, and that puts an unrealistic demand upon staff to treat as an emergency a condition that is not a recent injury when that one deep provider is expected to perform other duties. The EPRP pulls continue to drive and are used to measure the TBI clinic, and might be the best measure, but all of the other focus has shifted to using SAIL as the most important metric for evaluating clinic efficiency. It seems as if all the resources and hires are primarily based on SAIL data, yet most of the criticism and pressure on clinic performance continues to come through EPRP. It feels like metric mismatch. One hears about SAIL constantly, but all the heat comes from the EPRP pulls. It would be nice to only have to worry about a single metric."
"This is a trick question. Remote data allows you to access DoD records from CPRS. However, those records are rarely relevant to the evaluation. They are often VA records that have been transferred into the DoD database, and almost never contain information about injures that happened in theatre or that involved medical care while on Active Duty that is associated with the reported TBI."
"We are exploring starting a Pain Clinic. Fellowship trained pain specialists need to be hired. You have to determine what expertise they are brining to the facility to determine if additional equipment, like a C-arm, is necessary. But many providers won't come to a place that is not set up to allow them to practice.

We at present have some of the components to manage pain patients, but without the Pain clinic leadership we are still working through issues. We are going to be recruiting a Pain Doctor this year, we hope."
"We lost a provider, lost our social worker and our clinic nurse over the last year. We are just now beginning to fill those positions, but we are still struggling to recruit another TBI physician."

"headed by trained NP,OT, as available neuro/forensic psych"
we meet goal of < 30 days
"planning on second LIP to cover PRN
Vaco actions- MUST have easy way to correct record if pt screens + in error and or end s up on tracking application in error"
"Access to BHS critical, we have lost our dedictaed psych on team with littlehopeof replacement in near future.Our neuro psych was murdered in VA clinic."
for us to be fully functioning team need access to bhs same day as TBI eval done as has been case almost always in past 7 years
I have been granted full access to DoD EMR
I have access to virtually any aspect of TBI care needed in house or fee based to ELP
"I provide on going care if needed, PCP manage vast majority of care"
I need a neuro psych or a trained psych on embedded team
"I do not have a SLP, I have to refer all to community this is vital to have on my team"

radiology

the facility has a poly trauma consult used for referral.
"1 Optomologist in recruitment
2 Opthopic tehnicians currently in recruitment
Program currently triages level of urgency for patient access."
Extend funding for acces to care mental health positions.

Polytrauma Network Site
"1. Delay in PCP or OEF/OIF provider placing consult.
2. Reduced FTE in PNS clinic.
3. Patient''s no showing or cancelling appts."
"1. Increase FTE for PM&R physicians with TBI specialization, potential increase FTE in nurse practitioners with TBI training, increase FTE with nurse case managers and clerks.
2. Improved access/speed of the CTBIE web application.
3. Dueling policies for CTBIE completion and EPRP. If a patient doesn''t qualify for CTBIE, they may qualify for EPRP reporting and this is a waste of resources. Also, CTBIE countdown starts from the moment the primary screen is completed as positive, but TBI clinic has no ability to affect when a provider places a consult or if the Vet chooses to return the call/make an appointment.
4. It would be inappropriate to use contracted care for this patient population as it take as long time to create a rapport with patients with TBI such that they will be forthcoming with information, also, VA providers know the DoD system much better than civilian providers, so can empathize with Vets."
We use at times Janus Joint Legacy Viewer and DoD data is difficult to come by.
"Currently, Vocational Services are provided by Vocational Specialists through the Compensated Work Therapy program. This program severely limits the distance a patient can live (25 miles) from the facility. Anyone further is not allowed to enroll. Also, the program will not allow ”underemployed” Veterans to enroll as they currently have a job. One other issue is that the program does not support Vets returning

to school. Vocational Rehabilitation Counselor using a supported employment model with distance restrictions or underemployment restrictions will be ideal."

problems with providers for the service being addressed
lack needed providers and techs

"best guess, veterans no show or cancel appt's"

"This clinic is always staffed by a NP, a psychologist, and a case manager (nurse and social work CM alternate)"
"We get veterans scheduled within the 30 day period, unless requested to do otherwise by veterans."
"As for MRI here in Memphis, we have generally one person who reads them and the facility joke is that one must have a 5 cm or greater hole in the head for it to be read as anything beyond normal for stated age. Personnel is vital, but really here an MRI is only meant to r/o organic change other than TBI, as anyone who has read the literature knows that MRI is not close to sensitive enough for TBI. DTI, SPECT, etc. are better techniques for imaging with better relations with treatment, diagnosis, etc."
"First of all, when related to PT, driving 2-3 hours to go to a PT appointment (especially for back or LE) is a farce. One does more damage driving here than can be repaired while here. Home telehealth could be a strong option if equipment is mobile. Additionally, it should be known that providers understand that central office requirements are often ignored so that a facility can "rob Peter to pay Paul." Finally, providers have some good incentives, depending on how well written evaluations are within a particular service or facility. However, our greatest problem are the clerical staff. They have no incentives to do anything. I would never request them to schedule, as they care far less than I do about our veterans as whole. As such, when one does not have intrinsic motivation, then extrinsic motivation can be of assistance."
"Delay is less important at this level of care than the idea that there was little care within DoD, and the plan was to separate the servicemember to receive care in the VA. Sometimes that delay is more dfficult for the veteran and decreases investment and trust."
"At this juncture, this level 1A hospital has two 0.5 psychologists who treat PTSD. This is far less than prior to 911. This is beyond unacceptable. Consults are resolved through a one-time group setting, the wait for evaluation can be several months, and then most people who are given a dx of PTSD are shuffled to a group, with a trauma-focused treatment that may not be best for them. Anyone with subclinical PTSD is sent back to the mental health clinic, where their needs are not really met. A true trauma-focused clinic where subclinical PTSD is treated would be best. It is important to state that this clinic actually does a very good job with the few providers it has. However, we are losing one provider and will be down to one 1/2 time psychologist. Backfills do not seem to happen in Mental Health, but because of the immense strain on providers, people are leaving in droves."
"Sleep medicine has made great strides and are very receptive and the nurse practitioner in charge is a wonderful addition. However, there are problems with providers and clerical staff. Veteran miss appointments, and often the appointments are made without the agreement of the veteran, which would never be acceptable for any of us were we to be the patients. As such, people are not properly informed of their appointments or they are not scheduled at great times. Again, the clinic is doing a very good job communicating with the TBI team and working with our veterans. We also are piloting a CPAP adherence group which assists with that relationship."
"Again, with such a wide catchment area, fee basis seems to be a far more intelligent idea that asking veterans to drive four hours for physical therapy. For those who can do home exercises, telehealth to home may be a great option to keep veterans on track and to examine their efficacy at home."

"Our greatest problem is provider staffing, specifically with mental health. Next,relationship with neurology is not strong. As such, we are creating an Interdisciplinary Headache Clinic within Polytrauma to better meet the needs of our veterans. No show rates, clerical staff, and the ridiculous CPRS/VISTA interface are interconnected problems. Our veterans are younger, do not listen to messages, and only receive texts. Recent research has demonstrated that no show rates decrease with text reminders (Schnur, P. et al. 2015). MHV can be an excellent way to get in touch with veterans as well, which I use personally in my clinics.
Finally, according to OIG from 2010 visit, Polytrauma was doing quite well and received recommendations on care. However, we did not have a physiatrist associated with our team. At this point, the physiatrist at the medical center does sign off on notes, but does not assist with needs. For example, he has yet to countersign our sole medical provider (NP) on her ability to prescribe narcotics (which she rarely does but should have the ability to do). We will also need the physiatrist's or someone''s support in the continued development of our headache clinic."
Study ID fagUsw
Often a neurology consult is generated as well as a mental health consult as TBI and PTSD often occur together. Usually an EYE consult and possibly an Audiology consult as well.
"Delays can come from logistical challenges, e.g. patients can not make designated appointment dates due to problems getting gas money to come to [location redacted] or cannot get off from work. Other challenges are ensuring that the right address and phone # are correct and that the patient''s cell phone and voice mail are working."
"1) scheduling so that a patient can be seen at multiple clinics in one day is quite labor intensive and it''s challenging to make work. Usually this requires assigning an administrative person to coordinate the scheduling.
2) More telehealth availability is helpful/important for f/u for patients
3) fee basis consults are still quite delayed for some specialties, although this is improving. Fee basis consults can be lost or delayed for months in some circumstances. The critical consults for TBI are sleep and eye."
"MRI availability is a problem, although capacity expansion is starting to catch up. In the mean time, we have a patchwork of fee basis consults that result in a report. Fee basis takes the report and considers the consult closed. However the referring physician (often me) has to call the MRI center doing the study and get the CD and then have it loaded into the iSite system. Not very efficient and with all these handoffs, things fall through the cracks. A better solution would be for fee-basis to take ownership of the entire process. Another option would be some sort of electronic transfer of the DICOM files to the VA and supervised upload of the files to the iSite system for visualization."
"We currently use a mixture of in-house and fee basis sleep studies. The combination of ”sleep study in a box” where the instrumentation is mailed to the patient, the patient hooks up the instrumentation and then mails it back is helpful for a crude first pass, ideally we would have this as an internal capability for integrated scheduling and flexibility. We are also capacity constrained for full in-house sleep studies and have to rely on external labs also. Part of this is due to the distances involved, but we have been short of capacity for about 3-4 years. **Our internal measurements of performance seem to have not resulted in change until about the last year, even though sleep disturbances are highly correlated with TBI (there are a number of studies now showing this, which is consistent with my clinical experience)."
"I''m not sure what I would do differently. We cannot put physical therapy in all facilities, but the driving distances are such that any benefit from the physical therapy can be offset by the driving"
"I can''t even answer this question as I never see medical records from DoD assessments for TBI unless I go looking for them in the CPRS Remote system or in the new JLV system (not rolled out nationally yet, but I have access). I never see the inpatient records from Walter Reed, Landstuhl or Iraq or Afghanistan. I sometimes see the outpatient records from remote facilities in Iraq or Afghanistan, but they are few

and far between. I *never* have access to things like sleep studies or the images from studies such as CT or MRI and usually have to re-image anything that I want to look at. I do not have access to MEB''s or PEB''s. Patients routinely arrive in my clinic room saying "I gave the VA all my records" and I have no idea who has them or where I could look for them. Occasionally I find records in IMaging. I have treated a Coast Guard patient and none of her records are in the system as the Coast Guard seems to have their own EHR, not accessible to me."
"Most of the severe TBI goes to [location redacted] and maybe then comes back to the [location redacted] system. 8-90% of TBI is mild TBI, which we handle in GNV as well as stable moderate to severe TBI."
"We are capacity constrained in mental health due to the number of providers we have and the demands for services. We can see patients quickly, but then they may have a long wait to be seen again. We are might be able to be more effective if we see the same patient more often, but that results in delays in seeing others, As delay is what is being measured, not effectiveness (a tough measure), we end up with many patients being seen, but not very effectively."
"The interventional pain management service''s requirement of the area have an MRI before they will do an intervention is reasonable, but this then pushes the patient into the currently quite long MRI queue. So more MRI scanners might help reduce the delay in being seen by pain management."
"Noted previously, availability of sleep study lab slots and f/u on CPAP fittings or re-fittings and SD card downloads is limited. People, space and hardware are needed. I can''t fix PTSD or even sometimes have clear diagnoses of seizure before I get the sleep understood, if not straightened out."
"My administrative support is limited to someone doing my scheduling for me and taking messages. I end up chasing down MRI CD''s to review as well as returning routine phone calls.
Not having MRI scanner capacity directly impacts ability to sent people for interventional pain consults as well as slows down my workup."

some occur at CBOCs via Telemedicine led by Interdisciplinary TBI team
"we are able to offer visits in timely fashion, patients often opt for later times or no show which impacts care"
improved communication of DoD or civilian sleep study results into the VA record would help to expedite this process

Working on increasing the availability of services

"Access is not the issue, many times Veterans prefer a date outside the 30 day requirement, and that negatively impacts the data. Also high rate of no shows in this population causes the same problem."

Change Central office policies: When we have our EPRP the denomintor is very low and this does not represent our TBI services.
Neuropsych is very important Needed for treatment.
"delays also involve contacting the Veteran.
No-shows are very high with this population.
Should maybe not see until the SC is determined."

". There are absolutely no delays stemming from our PM&R TBI providers or staff. Any delays are the result of a veteran who cancels or no shows his appointment, or cannot be reached despite multiple phone calls and certified letters."
"1.)The process of cajoling the reticent or unwilling veterans who have a positive primary TBI screen into making and keeping an appointment for a secondary screen is inefficient and disproportionate to the

number of veterans served by this endeavor. It ties up staff who could be doing other productive things. Some of our veterans have alluded to the process as approaching harassment in a lighthearted way.
2.) ‘‘No-show’ rates contribute to delays in many areas of veteran care, to include those related to TBI.As long as ‘‘no-show’’ rates remain high--usually 20-30%--there will be unnecessary delays. Patients who do not really want to come in, despite our best efforts to reach and educate them as to the reason, will tend to ‘‘no-show’’.
3.) Eliminate the requirement that the TBI provider fill out a registry tool. It is redundant and adds zero value to the clinical encounter (although I would assume it has statistic, research value for someone.)"
"1.)We have workload analyses demonstrating with near mathematical certainty that our number of PT staff is insufficient to handle the number of referrals in timely fashion. We simply need more PT FTEEs.
2.) The hiring process is fraught with delays and inefficiency. Some is bureaucratic and some is related to poorly performing HR staff.
3.) We are not allowed to use wireless technology that would allow PT (and other) staff to use tablets to document bedside or at the point of care as is becoming common in the private sector. This creates inefficiency and space problems as all of the PTs converge on one area to document on desktops."
Sometimes it is available on ‘‘remote data/Vista’ and sometimes it is not.
This is a redundant section. These questions were already answered in a prior section.

"primarily d/t failed attempts at contacting pt; they do not call back or respond to certified letter. Also, once the appt is made, there is a high no-show rate (traditionally almost 50%, improved to 33% d/t overbooks, not because patients are showing up more frequently!!)"
current central office directives are put too much onus on the healthcare system rather than the individual patient.
"cannot comment, as I have no knowledge of TBI assessements in DoD"

PM& R in the Post Deployment Integrated Clinic

The Interdisciplinary TBI clinic is within the PM&R department.
Need more providers and have a reasonable expectation of the length of time it takes to accomplish visits for the VA staff and the community. A better scheduling system is needed with schedulers who work with the clinic to keep it filled not just follow protocols.

"The scheduling system is very antiquated and does not allow for the flexibility that is required in the clinic setting. It is also hard to accommodate individual needs because the performance measures group people. This causes people with low medical priority but high connectability, i.e. OEF/OIF/OND to receive priority care. Triaging of care should be based on medical necessity. Needs to be less layers of supervision and more clinical or patient direct care providers hired."
"The supply versus demand for physical therapy has traditionally been inadequate. The current space has been maximized for treatment. Access is very important but many variables confound the situation, i.e. having a seperate service schedule consults, performance measures that make patients priority which competes needlessly for medical needs. Fee Basis is difficult as it is hard to oversee care and determine necessity without notes and notification. It would better serve our veterans to receive services here for continuity of care"
Our availability of providers and treatment area is adequate. Our difficulty arises in scheduling services. This is a seperate service in our facility which makes it hard to oversee. Would like to see scheduling come back under the services for outpatient to have more oversight. New scheduling program for flexibility and efficiency would be appreciated

WE make DOD patients a high priority for TBI and all related treatment options. Have been highly successful in the past
Part of the delay in care was that we were down a 0.6 FTE in NP. Now that we have the 1.0 FTE we have been able to meet the Veteran''s need in a more timely manner. We have tried pilots of scheduling on weekends which have not been successful with high missed opportunities.
Mental health has the best staffing and office space in the facility. The barrier becomes that competing performance measures that makes triaging/access more diffficult. Improving communication with services is helping facilitate scheduling based on medical necessity.
Some questions have already been answered. The high demand of this service makes it difficult to schedule patients with competing priorities. All of the same suggestions made earlier apply
We''ve had difficulty with the second level evaluation template which has not been functioning this year. this requires extra work in the provider filling out a hard copy and scanning into CPRS.

Barriers can results from layers of bureaucracy at times that distract from true patient care.
Loss of staff created delay in referral. Space and other issues as noted unchanged.
short time without trained staff resulting in patients being referred and delay. Now hired staff and no delays.

Designated ”TBI/SCI Clinic”“
"If neuropsych is requested as part of comprehensive work up, NP clinic is significantly delayed in scheduling evals."
"Staff need time to refine/update specialty skills, coordinate with TBI/polytrauma staff at VISN level, coordinate with other PCP providers. Need clerical/SW/NP staff to keep program definition sharp vs “any PCP”“ can address TBI/SCI issues mentality. Even mTBI pts create a more intensive case load."
Wait list is into NOVEMBER (6mos) due to only on NP on staff. Speech therapy staff pressured to perform outside scope of practice due to shortage which puts pts at risk. Field is moving towards remote administration but we''re not there yet; NPs are hard to come by so fee basing service is unrealistic. Late in day/early evening appts already in place.
"No NP therapy allowed/possible given only one provider on site to meet entire assessment needs of hospital (TBI AND all other consult requests). Again, difficult to fee base due to scarcity of providers. Evening feedback sessions now offered."
"Pain, depression are crucial aspects of many polytrauma veterans. With current Opiate Initiative, adequate staff to treat pain in other ways is crucial (BH chronic pain mgmt./Biofeedback/SCS and other pain strategies)."
High volume demand service and not available in house. Should be considered vs fee basis. Ongoing need for TBI pts with increased comorbid OSA but also need for BH and PC pts.

"Primarily related to delay in scheduling per HAS, not due to clinic availiability"
"There are available providers/appointments however there is delay in getting those appointments scheduled. Additional issue is when primary care, MHC providers or others incorrectly fill out initial screening, when second level is not indicated. This may be a central office issue to figure out how to correct these reports, thus not have that information “counted” as pending appointments when second level screening is not indicated."
"We have only one MRI scanner and I do not know staffing or hours of operation of this service. Additional scanner may be useful, but would require more space, staff and support staff. Currently fee basis is utilized. Also, process of scheuduling not always clear and if order cancelled for any reason,

there is no record of it ever having been ordered in CPRS. (Unlike a consult that still lists as discontinued)."
"The VA of southern nevada has had a lot of turn over in neuropsych. Perhaps looking at compensation or staffing (support staffing/scheduling) may be issue. Currently, new providers coming on board, and flow may improve. Fee basis referrals have been done on occasion."
"Currently there is no ""consult"" that can be placed for MHC services, even when Veteran requests it. The ability to request a consult could improve, because this population of patients not always great about follow through (some memory issues common). Also, in near future, a psychologist will work part time with TBI team, to hopefully provide some MHC support at time of initial TBI appointment as needed."
"There is often difficulty obtaining the DoD data from Vista Web. I have inconsistently had benefit of using Joint Legacy Viewer, and recently have stopped trying to utilze it during clinic, because it is not easily accessible (like VIsta WEb is from CPRS) and if ever the PIV card is not inserted prior to starting to see a patient, then program will not even load."
There can be delay in follow up appoitnments due to scheduling issues.
The main delay with pain management clinic is the scheduling of the initial consult.
"Appropriate staff should be hired and retained (recently no one in pulmonary sleep clinic, as provider left VA.)"

"There have been delays in the past for sleep studies and for neuropsychological testing. I have not seen adverse outcomes for veterans and there is always high quality care when delivered. In fact, I highly prefer our internal consultants over outside providers. These are just two services that seem to take longer to complete relative to others. Perhaps more neuropsychologists or techs are needed. That said, if I ever call and request more clinically urgent services, I am always accommodated especially for neuropsychology as they are active members of our TBI interdisciplinary team."
please see detailed response on previous question
Many DOD records available in Vista Web. I am also a participant in a pilot for the new JLV (Joint Legacy Viewer) EMR that pulls records from DoD and VA health systems into a user friendly interface.
Have never referred to regional PNS. Have referred severe TBI/ABI patients to PRC sites.
see previous comments regarding neuropsychological services.
"I am not familiar with the needs and staffing of the sleep clinic. This service has improved in the last 1-2 years, but anecdotally, does tend to take longer to complete relative to other utilized services. That said, if I feel services are urgently needed, I will call directly for accommodation or pursue non-va referral for which I am always supported."
"The required time to open and fully complete the extensive CTBIE template is inefficient. It is a good system but utilization adds several minutes to the encounter, multiplied by ever encounter and it adds up. Also prone to technical failure but VACO remedies quickly and with good communication. Scheduling/rescheduling requirements add to recurrent no-show rates and take slots that first time appointments could have."

"I think there is much consensus that screening for a condition (mtbi) that is expected to recover in days or weeks for the vast majority is a waste of resources. If this must be done, then requiring 3 no shows before a consult can be closed restricts access. There should be a VA uniform no-show policy for all Veterans. Regarding staffing, we were without a dedicated physiatrist position for over a year which delayed timeliness of CTBIE evaluation."
More neuropsychologists would make for better access.
"I am currently split (SW) 50/50 with SCI, a very needy population of which I have 230 patients to case manage. This leaves little to no time for Polytrauma case management."

"PT has been understaffed, as has administrative support."
I know have access to JLV which is great.
"Again, requiring 3 no shows before completing is excessive and restricts access. More support staff might allow designation of scheduling/tracking functions and free up clinical time for case management."

"Sometimes requesting providers do not enter the consult request, in spite of prompts. Some enter the wrong clinic consult."
"Having a dedicated scheduler to monitor positive 1st-level TBI screens would help tremendously or having that info readily available in real-time; educating PCP's to enter Polytrauma consult has been tried, but should have helped; having faculty who are available on weekends could help;"
I have no idea. Not familiar enough with their administrative policies.
Essentially all sleep studies have to be performed through NVCC -- and these have to be approved by a cascade of people -- incredible delays.
"In all cases, DoD records are unavailable."

nearly half of patients requiring speech therapy services live a long distance from VA and many also have jobs/school which impact ability to schedule. With limited speech staff it becomes difficult to arrange appointments that meet the needs of the Veteran in a timely manner. Having easy access to care in the local community would alleviate these issues.
"The TBI second level screening tool in CPRS is difficult to use, frequently does not work and is very slow. While it may allow VACO to collect data, it adds nothing to clinical care for the Veteran."

previously worked in PM&R clinic in [location redacted] VA
pending filling of several positions: 1) MSA 2) PSA 3) SW and 4) Psychologist. pending new telehealth program.
not fully aware of all of the challenges. service has new space and staff.
center of excellence is being developed. support staff is needed.
need more providers for vets
"flow of info has improved with JLV, but it is not always accessible. would love improved access to records"
difficulty with getting testing completed in a timely fashion.
stringent requirements for scheduling tbi pts (central office mandates). just moved to new clinic space and have added new providers this year.

"VHA needs to move forward with non traditional hours, clinics open until 7PM and on Saturdays. Tele-heath capabilities expanded for secondary evaluations at all sites."
This is a service best delivered by the VHA and is central to the core mission of the VHA

Week end & evening availability of services have been implemented lately. Fee base NVCC consult has to be simplified especially for reporting back MRI results.
Increase sleep eval. through Neurology service other than the Pulmonary service providing the testing. This will enhance collaborative management of sleep dysfunction throughout the healthcare system. .
"There's a need for dedicated optometrist/ neuro opthalmologist for TBI patients due to the specific visual problems. Currently, there''s a short staff in Eye clinic at [location redacted] VAHCS."
The mental health eval. & documents are not readily available through the DoD portal.
Improve patient flow in existing pain clinic. This is already being addressed. New pain clinic areas will soon be activated within the next 4 weeks.

Very tedious scheduling & EPRP process. Patient No show rate remains at about 20-22% due to patient NOT engaging.

Veterans received from DoDO facility usually include medical records in the referral packet.

Polytrauma Clinic
"Clinic access to contract clinics and CBOCs for all mental health services including STS, increase availability of walk-in assessment and medication evaluation, access to acute detox programs, access to Anger Management programs."
"telehealth assessment for medication management in outlining clinic areas, more access to interventional pain management services. Improved communication with DoD regarding pain services received in military."
CO requirement for certified letters for scheduling purposes?

"In order to improve services to Veteran and remain compliant with the timeliness of the CTBIE''s, the Wilmington VAMC needs a dedicated provider who is flexible and able to see patients at their convenience. Veterans are often inconvenienced by having to return to the WVAMC to complete their CTBIE. This provider should be under the PM&R service line."
"For the [location redacted] VAMC, the [location redacted]VAMc was initially doing their Neuropsychological evaluations. This process stopped in December 2014. Now that our providers are responsible for completing them, we do not have enough staff to administer them in a timely manner. Two of our Psychologists are trying to incorporate the NeuroPsych evals into their schedules. It is very difficult to accommodate Veterans who require a Neuropsych eval due to the already overwhelming caseload that the providers have. It is vital that the [location redacted]VAMC have the ability to hire one or two professionals who are capable of providing Neuropsych evaluations in a timely manner."
"This writer, who is responsible for all of the case management services for the Polytrauma/TBI Veterans, has been detailed to other clinics within this hospital over the past year. It has been difficult to maintain timely access and case management services for Veteran when more immediate concerns are present. This writer has begun the discussion of Telehealth implementation with the necessary personnel at this facility."
The majority of Veteran that are seen in the Polytrauma/TBI clinic are already affiliated with BHS. Some of them are already being seen by providers and other are being referred to the intake evaluation after completing the CTBIE. The [location redacted] VAMC could always use additional MH providers to provide specific treatments for our Veterans.
The [location redacted] VAMC no longer has a Speech and Language Pathologist. We have been down to one SLP for the past year. She recently resigned and we are now sending our SLP patients to Perry Point VAMC for evaluation. [Location redacted]only has a few openings for our patients that they are trying to fit in.
"There is no dedicated MSA for the Polytrauma/TBI program. Most of the Administrative paperwork, scheduling and telephone calls are completed by the Polytrauma/TBI Coordinator."

This is not due to access to the TBI clinic however due to Veteran forgetting/re-scheduling clinic multiple times therefore prolonging time from positive screen till TBI eval or the Veterans'' preference on being seen in a certain location. Also at sites where we use telemedicine there has been technical difficulties with the equipment. At [location redacted] we are able to see the patient typically with in 5-10 days.
"It would be helpful to offer one Saturday a month for therapy and CTBIE time slots, and perhaps two evenings a month."
Upgrade their current facility.

C.O. needs to formalize what they define as Pain management. This system would be more holistic and involve not only medical management but also inclusive of C.A.M.

Reduce time from consult for sleep study to actual getting the appointment scheduled in the community

"We need more providers to be able to complete the 2nd level evals in the 30 days. Also need more streamlined scheduling, currently only billing office can do and they do not understand our schedule needs. Working on getting texting available to veterans."
The city only has 1 neurooptometrist. The VA does not have one. Not sure how enthused the Opthamology staff is to send patients out for testing.
A lot of our veterans live over an hour from the hospital. They don''t qualify for fee services but can''t travel for therapy that far. We do have some CBOC services but could use more locations for PT.
"Same as PT. Need to fee more out, too far for a lot of the patients to drive for services. We do not have OT services out in the CBOCs."
We currently do not have a pain provider. It takes a long time to get the services feed out to the community.
"The providers have to put in our own orders, make phone calls, run state drug screens, etc. No nurse to do that for us. The Case Managers do not have time to do it either."

Use of technology to improve or circumvent no show rates such as texting patients or using telehealth. Very limited reception of VA cell phones in our facility makes it difficult to use this mode.

"1) IT - CPRS scheduling is inflexible and is hard to allow admitting patients off regular hours.
2) Change ”central office policies”” (a) the filling out of the template is very time consuming; in addition it prevents optimal eye contact with the patient, hence effective communication; (b) the rush to admit patients on time (even when the injuries occured years ago) adversely effects the quality of the time spent seeing new patients
3) ““Increase weekend and evening availability of services” - if the numbers of critical staff can''t be increased, then increasing the hours of the clinic is needed, but difficult yo implement due to staffing inssues
4) ”Some other solution(s)““ - Allowing for time of the MD to review new patinets with the LCSW and RN (since the see the vet 1st) would help improve initial insight - but this is not possible since there is a ruch to get patients in and seen"

"which includes PM&R TBI specialist physician, PT, OT SLP, Psychology and Nursing"
"central office policies”“ 30 day policy - the community does not have 30 day routine access. CHOICE does not have anything close to 30 day routine access, nor does pc3. PERSONNEL: need more sleep techs who are paid well. VHA pay lags the community significantly. VHA HR PROCESSES ARE ANTITHETICAL TO THE PROVISION OF TIMELY QUALITY CARE."
”“““
personnel actions remain constipated in HR processes that are outdated, too narrowly interpreted and with multiple layers of narrow interpretation (local HR ass't, local HR specialist, local asst chief of HR, local HRO, VISN CCU, VISN HRO, CO HRO). Perfectly designed to avoid onboarding quality personnel in a timely fashion."

"It would be helpful to be able to better utilize technology (text messages, email, etc) to help with scheduling of these young veterans."
currently feeing out some neuropsych evals

currently feeing out large number of ophthalmology services all all neuro-opthal.
DOD and VA do not have nation-wide systems to share medical recors. This hascontributed to delays in ontaining old medical records.
TBI interface crashes often.

"Delay due to staffing, this has since been corrected."
"Increase LIPs, nursing, and SW. It would be beneficial to have text messaging of reminders for upcoming appointments. Tele-health - provides prefer face-to-face for initial appointment."
Have medical records ”talk”“ to one another. Our Audiology group expanded weekend hours to accommodate Veterans. Continued efforts to reduce waits for Sleep studies using nonVA care or Choice.
"Audiology noted delays, other services report no problems."

Difficult to recruit area due to rural frontier arena
Non-VA care has limited access capacity in the State.
See previous comment

"NP’s or physicians as well as LPN/MSA, improvement in speed/processing of required templates would improve efficiency, scheduling software (VISTA) is incredibly inefficient and cumbersome, our Vets have been surveyed and do not desire evening/weekend appointments"
"Difficult to assess services provided by different departments.
Scheduling package makes scheduling and monitoring difficult across services"
Unable to speak directly to the needs for the service providing MH
Difficult to speak for another service/discipline
Difficult to speak to the needs of another service

cumbersome templates

Our process that led to delay involved lack of speicalty trained provider onsite to complete the CTBIE. We are in process of modifying this to have a PCP trained onsite to complete.

PSCT (Polytrauma Support Clinic Team)
"no delays resulted in adverse effects - however, with only one provider performing CTBIE(and all other assessments regarding TBI) there are inevitable delays and the metric does not reflect the true number of referrals."
"more space is always needed
back up to solo provider for CTBIE
allow use of up to date technology such as text to remind Veterans of appointments
Use Fee basis back up for CTBIE"
We are a Polytrauma Support Clinic Team (part of the Polytrauma System of Care)
see previous comments
I am not conversant with the reasons for any delays in Mental Health
"across the board increase in funding, space and clinical and support personnel needed"
there is too much redundancy in the reporting required by VACO for TBI the CTBIE report is of little clinical value and the use of the Mayo Portland is not appropriate for many settings.

"1) We need for more staff trained in diagnosis and management of TBI.

2) However, there are a number of patients that repeatedly miss appointments, and thus extend the wait time for everybody."
we need more openings in neuropsychology
there are no fee-basis services that are really applicable to these patients

"Timely receipt of referral for Comprehensive TBI Evaluation to PM&R from Primary Care or Mental Health, following TBI Screening, has caused delays in CTBIE"
Providing Medical Supports Assistants(Clerks) to scheduled patients in the required CTBIE time frames is very important
"Increased Sleep Lab Rooms, Technicians would greatly improve Sleep Assessments"
"Increased Mental Health Professionals, and Telehealth would greatly improve Mental Health services to Veterans."
Increased Neuro-Ophthalmologist would greatly improve eye care.
Patients are often received from distant DOD medical facilities with limited medical records.
Increased Pain Specialist would improve care.

Post Deployment Polytrauma clinic

Lots of funding for Polytrauma site- those funds need shared with Polytrauma Support Clinic Sites as that is where the bulk of follow up and long term care resides.

"MRI's main challenge is space. [Location redacted] VAMC needs an additional MRI for a rapidly growing veteran population, but we must build additional space to house the MRI."
[location redacted]VAMC is critically short on exam room space.
"Audiology''s main challenge is a shortage of hearing booths for a rapidly growing veteran population. We can acquire the booths, but need space to place them. We also experience a large Comp & Pen demand for audiology booth time. Perhaps we can relax the VA policies on hearing test requirements in comp & pen."
We must have seamless bi-directional interface between DoD and VA electronic medical records.
Space in PM& R for TBI counseling is our main challenge.
Neuropsychologists are extremely difficult to recruit.
"Pain Management clinic must meet the space requirement for CARF accreditation, which is extremely challenging given our growing veteran population. Psychologists and OIPP Directors are extremely difficult to recruit."
Same comments as in primary care. CPRS inflexibility is a huge issue.

"currently no delays, did have space restraints. Also, training provided to schedulers."
"Expanded hours in optometry. Recently hired additional Ophthalmolist. Currentlyno wait time issues. We have a Center of Balance, with designated team that is able to adress many clincal assessments in one visit."
We have a designated Polytrauma Team working out of the PM& R section that follows patients closely and offer a wide range of services and adaptive devices.

Currently meeting need No show is biggest problem
Vist is 4 hrs and no show biggest problem
Vision therapy not eval feed out
almost impossible to get
more staff

TCM Team

Additional neuropsychology services have been added during the past year. There is no longer a delay.
Problem of delays was addressed during the past year
The TBI screening program is flawed and has resulted in too many veterans being diagnosed with TBI based on limited info. The need to complete Mayo-Portland evaluations for mild TBI patients is not helpful.

Need more MAS for scheduling. Need to improve phone system for faster and more efficient communication for patients. Reminders by text.
see initial comments

Availability of MRI is limited at facility. Fee Basis care is often utilized but the process often gets in the way of timeliness. Our facility needs more equipment to perform MRIs or the process for Fee Basis care should be simplified to provide access to these services more quickly.
"There are no sleep lab services available at present at facility, however, a sleep lab is in development which will improve access to this service. Fee Basis is the current way to access sleep studies and the process gets in the way of timely studies. Fee Basis process should be streamlined."
Facility needs a full time Neurologist to evaluate and treat Veterans. Fee Basis process is utilized but takes time to get approval and an appointment scheduled in the community.
"Sleep studies are not available at facility but are arranged per Fee Basis in community, however, the process takes too long. Sleep study lab is being implemented now which will open access to care once completed. Fee Basis process needs to be streamlined."
CTBIE template is not user-friendly and is periodically updated resulting in errors that lead to inefficient use of provider time as the provider must enter clinical information several times before server will save data. Policy Documentation requirements overlap and result in redundancy in documentation for example: TBI Second Level Evaluation has a plan of care and yet a Rehabilitation and Reintegration Plan of Care is required which has same information noted.

"There is a need for Vestibular Rehab -- combination of MDs, PT and Audiology. Collaborative efforts among these specialists will help in the well-being of our Veterans. Resources are available within the VISN."
"More space need to be allocated for the Audiology section. In 1 campus, the space allocated need to be reassessed for increased efficiency. Additionally, staff coaching can also be instrumental in increasing the efficiency of this section."
Staff training/coaching on gaining balance and vestibular rehab.
Individuals trained in the cognitive and physical aspects of TBI with regard to schooling and employment.
"Reasons for Patients No Show include transportation, clerical and constant reminders."

Greater clarity in national recommendations

"Patients are sent to Physical Medicine and Rehab clinic; however, there is no dedicated provider in this clinic to timely respond to completion of 2nd level TBI evaluation."
Delay due to staffing issue and lack of leadership support to address this issue in hiring appropriate personnel.
"1. Dedicated physician to complete evaluation.

2. Training of primary provider and other disciplines in completion of the initial TBI screen.
3. Backfill TBI Coordinator''s (Social Work) position to manage the process, respond to consults, complete treatment plan, and coordinate appropriate clinical interventions."
Dedicated Neuropsych provider for OEF/OIF/OND Veterans to assist with evaluation and clinical interventions.
"1. Backfilling TBI Coordinator (Social Worker) position to provide adequate case management services.
2. Dedicated schedule to contact patients.
3. Training"
Hire dedicated trained mental health provider in providing care to TBI patients.
"1. Hiring dedicated TBI Coordinator and physician.
2. Hire Nurse to support team and managing care.
3. Hire admin support staff to support scheduling of the clinic."

"PM&R TBI/Polytrauma Clinic includes physiatrists, neuropsychologist, and RN case manager."
"Delays only occur when the person performing the TBI clinical reminder screen fails to send the consult for a CTBIE, which is automatically opened by a positive screen."
"Space and clinical staffing are adequate. Telehealth equipment is available but remote site staffing is not. Current clinic scheduling package is woefully inadequate. Efficient scheduling is difficult when physicians see patients in multiple clinics having different stop codes (e.g., TBI, amputee, EMG, physiatry, and pain), with each stop code requiring a separate clinic profile. Technical definitions for compliance monitors need to change to remove patients who screen positive in error from analysis(e.g., LVN enters positive screen then PACT MD deletes CTBIE consult after determining patient did not understand screening questions and had no exposure). Adding resources should only be considered after the extremely poor selectivity of the TBI clinical reminder screening tool has been addressed. The false positive rate is unacceptable. Section 4 should be reworded to clarify any current symptoms must have started and continued from the time of the exposure, not have developed de novo."
Need another MRI scanner.
One of 3 pain physician slots and a pain PA slot have been vacant > 1yr. New pain physician scheduled to start next month. PA candidate declined due to salary. See previous comment regarding scheduling software.
"Mandatory training, often on material covered multiple times in the past, cuts into clinical time and reduces workload credit. Staff physicians have little administrative/secretarial support. Medical record entries must be typed by the providers. Lack of dictation services (a few providers have Dragon software)."

Need addition of ILP (physiatrist and psychologist) to increase capacity. Central office policies need to be adjusted to allow for repeated no-shows/cancellations with these referrals. Number of Veterans disengage from the process after referral and cannot be contacted for scheduling.
DoD records were not requested on any referrals in the past year.

We generally don''t see acute or subacute TBI

Change the timeframe metric/requirement for Veterans who no-show/repeatedly no-show

Information technology - a better way to track who has received a positive TBI reminder but that a consult may not have been placed.
In the past we have not received any records from DoD assessments. With the roll out of JLV we now have some access to these.

TBI Clinic is held in the PM& R Department with an interdisciplinary team.
Evaluations are generally available in remote data.
Regional polytrauma referrals are made with initial moderate to severe injury and are made on an as needed basis for chronic symptoms less frequently.

"New psychologist was selected and currently ungoing HR processing.
No adverse events occured as pateints were offered appropiate MH treament."
"To prevent delays, if DoD information is not readily available we contact DoD Practioners"

Focus should be on symptoms management and not ‘‘TBI’; mild concussion. I think we do more ‘‘damage control’; with that label . Also manage symptoms in context of psychosocial issues. cannot use a traditional medical model to treat these Veterans with Combat Stress issues. Eliminate Level II TBI evals - essentially useless - uses up valuable time away from symptoms and psychosocial management. Focue on rehab and job school success rather than treat ‘‘TBI symptoms’; Very unproductive and improvements not long lasting until overall psychosocial issues addressee with at least equal importance
"The whole Level II TBi evaluation process with perfomrance measures are too cumbersome. Penalized in performance measures if you are ‘‘tenacious’’ and able to schedule patients beyond the required three phone calls, certified later. - Median days to level Ii TBi eval is longer despite following ‘‘leave no vet behind’’/"

Add addtional in-house MRI capability.
add in-house capacity for main hospital and CBOCS for MH services.
Recruit neuro-opthalmology resource to add to neuro-ophthalmology/Neurology resource already available.
"make the DOD and VA electronic record sharing more robust and comprehensive,this will take the burden away from case managers who have to get paper records.Also,DOD should improve scanning the outside care documents into their electronic records."
Add more in-house MH capacity

Provider covering TBI clinic changed so there was a time when no one was covering TBI clinic.

Speech therapist are vital in the role of moderate and severe outpatient TBI treatment. The use of NVCC is vital for those that live a great distance. Many CO directives do not address the real need of having the ability to schedule and contact Veterans more efficiently. Wait times are arbitrary and rarely reflect clinical need or community standards.
Many Veterans that are screened for TBI are many years past the initial incident. It is important to address their clinical needs but the required templates are not necessary for many of the evaluations. The scheduling system is often down and does not provide an easy scheduling process. The documentation often requires providers to complete encounter information that is purely administrative and adds to documentation time.

- **ACS**

"Because of affiliations with teaching institutions, we need to have more house-staff in ED, Internal Medicine, Cardiology, CT surgery, etc. in addition to professional staff (physicians, mid-level providers, nurses, techs, PSAs, etc.) in well-equipped chest pain units with user-friendly ACS pathways and protocols."
To have ambulances at site 24/7 for possible transfer to non-VA facilities where there is no cath lab available on evenings and weekends.
"To provide funding to make current cath labs 24/7 operations with space, including separate CCU and step-down units, and adequate staffing."
We need 24/7 on-site CT surgery with adequate staffing of a SICU geared towards cardiovascular diseases and postoperative care.
"We were on diversion and no beds were available in the ICUs, telemetry or general wards."
"We need to make our current observation unit to a well-equipped and adequately staffed cardiovascular observation unit with 24/7 operations. Most importantly, we need our own CCU as a separate space with adequate equipment and staffing at all levels."

"Last minute requests (like this survey) detract from patient care time. So do long training modules, and associated interruptions in provider computer access."
"Retention allowances were delayed or eliminated, and consequently sonographers lost."
Need more beds.
Survey is becoming duplicative and tedious. Information from this point on is of dubious reliability.

education that PCI and thorombolytics are equally effective in some patients.

Often we hear ”no beds available” for admission of ACS patients -- not so much because of inadequate physical beds -- but because of delays in discharges or transfers out and inadequate nursing staff to open all potential beds.
See preceding comments about inadequate nursing staff to open all potential beds to accept transfers in.

"We have enough medical provider staff- we could use a LMSW to help us move people more quickly out of the UCC so we can can for our ACS and other urgent patients more quicly. We areflexing scedules to better serve during peak hours. We have antiquated space/layout that is in the plan for renovation. We will be working on a method to simplify transfers and may need additinal support assistance after duty hours.Beacuse we are an UCC with an inhouse telemetry unit, admissions or transfers are a hot priority here. We get immediate approval for transfers, delay is on the receiving end.or transportation. Overuse of UCC for primary care continues to plague us as well as the rest of the nation.We need pharmacy support afterhours to improve our flow and service but that generally does not impact ACS. We have routine orders , as soon as they are ruled in or out, they are transferred. If unstable chestpain-immediate transfer. Cut and dried."
Straemline CPRS.
Cardiology services here available M-F 8-1630
"Our hospital is a level 3 facility no invasive cardiology services. We are too far from the nearest VA hospital to offer VA emergent cardiac invasive procedures- all are done locally. Usually the next facility does not have bed availability for emergent cardiac services, if it can wait ."
"Cardiologist is alotted a fair amount of time to review echoes, stress testing. Fee based provider on boarding to increase volume.

UCC poroviders have a fair amount of administrative work- cardiologist 95 &+ clinical."

[Location redacted]does NOT have inpatient medical beds
[Location redacted]does not have cardiac specialty or inpatient medical beds.

"Having more exam rooms, so patients are not waiting and ability to independantly manage patients will help expedite the entire process."
This is not a significant problem for our va.
"documentation, cart notes and imed consent is cumersome. efforts to do urgent cases locally are already in place so we can avoid delay in care."
This is not a significant problem for our va. Delays are rare.
More beds necessary at the accepting VA transfer site ([location redacted]) reason for delay for the most part is no available beds.
"This is not a significant problem for our va, transferring patients to local hospital for urgent care. Delays are quite rare. If a procedure is emergent, every effort is made by both parties to transfer pt for prompt care to non va facility."
"Busy schedules at the accepting VA facility I think cause the delay in care. Lack of spots for surgery, cause delays."
Ability to do echo''s and nuclear stress tests during the weekend can expedite the process.
"Not enough clinic slots, limited providers,
inability for primary care to take care of patients independantly"
"This is a rare problem, our accepting VA makes every effort to accomodate"
lack of beds to accept transfer is the main issue

We would benefit from more Interventional Cardiology FTE and from increasing Cardiology salaries to be competitive with local non-VA salaries.
Increase Interventional Cardiology FTE and salaries
"Our VA referral site for CABG is 4-5 hours away. This is too far for patients to travel and makes appropriate follow care difficult. In addition, the VA we refer to has a very large catchment area for referrals and cannot reliably handle the load."
It would be in the veterans' best interest to be able to undego CABG locally.
"Our facility has too few inpatient beds for busy months of the year, e.g., flu season"
It would improve referral times if we could use local non-VA surgery practices.

Follow-up appointment as outpatient after ACS is too long due to lack of clinic availability.
Access post ACS in timely fashion to outpatient clinic is main bottle neck.
Post ACS access to clinics after hospital Discharge is the key SHORTAGE in ACS.

More provider (physician/NP/PA) coverage may be helpful. Additional tele beds and nursing would be helpful. Reducing paperwork for transferring STEMI and Imed delays would be helpful.
Admitting mid-level support for the teams may be useful on Saturday/sunday and additional provisions for admitting patients during busy times. More nursing for more inpatient beds would also help.
Redirect patients with STEMI and likely higher risk NSTEMI when w/in system cath is not available.
Echo on weekends would be helpful at times. That would require echo techs/cross trained radiology techs and either remote reading or in house reading.
"More nuclear stress testing capacity, both on weekends and perhaps even after hours would be very helpful in risk stratification."

"We find that it is very difficult to transfer patients to other VA facilities for coronary angiography. Building and staffing a cath lab in Boise would help, as would more use of fee-basis service and medically re-directing when in-system resources are not available."
"We usually get our STEMIs out in time and there are no issues with local acceptance. Rarely ED crowding issues might delay STEMI care, but this would be quite rare. When we have had delays, it is purely systems issues like using non-emergent ambulance."
More capacity to do coronary interventions within the VA is essential. We frequently have trouble transferring patients for coronary interventions and wind up using local non-VA care.
"We can usually get non-VA CABG done, but within the VA system getting CABG done can be delayed by bed availability in our tertiary centers."
"On occasion we cannot accept a patient in transfer because of bed availability, but in general we can accept patients if they are appropriate (however we do not have a cath lab)."
"Getting a cath lab here would help a lot, as would additional inpatient telemetry/icu beds."
"More capacity (fee-basis, after hours, etc) for nuclear stress testing would be nice."
More capacity for CABG in our tertiary referral centers and more CCU/telemetry beds would expedite elective CABG.
"Increased cath lab availability and the attendant staffing would improve our access to PCI, either at our facility (none now) or our referral centers."

"We have resolved our situation with the delays in echocardiography scheduling now, but about 3-4 months ago, there were significant issues. This is related to some of the regulatory rules about when we can advertise for new personnel. Specifically, we knew several months ago about the retirement of one of our echo sonographers. However, we were not allowed to post for their position until the person actually left. This left us in an impossible situation where we did not have enough sonographers to cover the entire number of people referred. It took several months before we could hire and bring in a new person. All this could potentially have been avoided if we could post for positions sooner, especially when we have advanced notice about an employees' departure.
The vast majority of Veterans do not want to take advanatage of fee-basis opportunities or the Veterans Choice Act. If the services can be offered at the VA, they seem committed to staying within the VA. So, it would be helpful to provide the infrastructure to help them do so."
"Some ER physicians rotate through the ER on a fee-basis and so they are not as aware of the protocols in place to evaluate ACS patients, particularly the STEMI patients who require rapid evaluation.
Easier and more efficient methods to transimt ECGs to cardiologists to evaluate would be helpful especially during "off-hours." When there are ECGs that raise concern amongst ER physicians, they often would like a cardiologist to quickly read, and facilitating this could improve Veteran care."
"The transfer of patients within the VA happens quite well. However, we do notice that at some VA facilities, there are Veterans who could have been transferred to our VA in [location redacted], but the patients somehow end up going to a local non-VA facility. If this was patient-driven, it may be okay, but our perception is that often times, it is a decision driven by a fee-basis physician working at the outside VA facility."
"The scheduling of preoperative testing does results in some delay in the scheduling of procedures, such as CABG."
"One of our cath labs requires an upgrade, and the time for upgrading it seems quite long due to lack of funds and the number of approvals required. This particular lab does repeatedly break down requiring additional servicing. Fortunately, it has not led to a significant patient-care issue or delay in therapy as yet.
There is occasionally issues with bed availability restricting our ability to quickly turnover patients, though this rare.

The no-show rate is somewhat problematic in the outpatient setting and prevents us from seeing the maximum number of patients possible."

We have physical beds but not enough nurses to take care of patients; hence the wait time for inpatient beds. We cannot transfer ACS patients (to our VA for cardiac cath) easily from outside hospitals or other VAs because of the ‘‘bed situation’’
Lack of nursing staff despite adequate physical beds and space. There are plenty of doctors and cardiologists who are happy to care for these ACS patients who are turned down due to low bed availability
No delay for any urgent or emergent cardiac cath or echo services. Occasionally stable patient Echo may be done the next day if schedule is too full.
"Need more OR space and time for CT surgery
Need an additional CT surgeon for CABG"
"CT surgeons may need another day of OR time and space on Sat to manage the workload.
Also easier fee basis transfer to affiliated Univ hospital could be expedited to help manage the workload"
"No physical beds
Poor communication between bed control and AOD
Too much of paperwork/computer work"
"Need better functioning over weekend to enable transfers
Better communication with Bed control and AOD
More weekend personnel to facilitate transfer and care
NEED MOR BED CAPACITY"
"Need more CT surgeons
Need more OR space and time for CABG
Need additional Nurse Practitioner / PA to help manage the CT surgery work load
Better fee basis to Univ for elective cases which could be delayed"
Not a big issue or delay with this aspect
"Need more CT surgeons
Need more OR time and space"
If we have more staffed physical beds and some more personnel we can easily take care of 50% more volume happily

Remains critical to foster community relationships as we rely on community resources to rapidly accept our referrals
Again continuing to foster/nurture relationships with community resources as we fee out all acute coronary care
Currently our only available risk stratification is ETT with or without sestamibi. This is reasonably available (same or next day) M-F. Other modalities (dobutamine echo or stress echo) are done by fee. Improving timeliness of these approvals/referrals would be helpful.
Beds on the receiving end (in a tertiary center) always seem to limit availability to refer within the VA.
Our access (via phone or tele ICU) with tertiary facilities is good.
again fostering good community relationships is key to access local care quickly as these are all referred locally within the community.
Still all about local facilities willingness to accept our referrals.
Beds in referral facilities is the key rate limiting aspect of these referrals.
”Stable ACS patient” is an oxymoron. As we don’’t cath patients at this facility we don’’t generally accept chest pain referrals.

"Don''t think it is reasonable to anticipate the workload for more than a M-F service. In our small facility there is 1 ekg tech and 1 nuc med tech, and their absence (for sickness, leave) derails our ability to obtain ETT with sestamibi, our only modality. Dobutamine echo as an option would require substantial investment in personnel and space, and so long as these are available timely by fee I don''t think it is worthwhile for us to do these."
"Again, as we don''t cath patients most of our process is assessment and referral by fee for care locally either as an inpatient or electively."

"Patient load in ED has increased tremendouslywithout corresponding increase in room, support staff, facilities, medical staff, administrative staff. We've noted the ED has a crisis limit where even a few patients over that limit causes major slowdown in patient care. All services (Hospitalists, Psychiatry, Surgery) affect the flow of ED and are out of control of the ED. Further, a non-urgent acute care department needs to be associated with every ED in order to better serve the patients with serious illness."
"The ED needs to be at least twice as large as it is currently to serve the Veterans. Needs to be staffed with more full time ED docs, nurses, NP/PA, admins, phlebotimists, transport, pharmacists. VA needs a functional schedule system and health record that is based on modern technology-a commercial software used by other hospitals should be fine. Radiology should be available 24/7. Full time psychiatry support in ED is critical as SI/HI patients often require tremendous personnel support and rooms, slowing down ED care."

"Currently remodeling 4th floor which should increase number of tele beds assuming more units will be used once the extra beds are open. Sometimes have to put patients in ICU when tele/SDU beds are full. I think the delays are usually attributable in small parts to several services which add up. Busy MDs need time to eval in ER and write admission orders, busy nurses need time to take report and admit new patient, bed turnover from the last patient takes time."
Our Medical ICU has 6 beds and usually has to use SICU beds for spillover. Being at 2 different ends of the hospital it is inefficient but works for the most part. If MICU expanded nursing staff would have to be increased. Keeping up with monthly data about timeliness would keep it in the forefront of the minds of LIP/nursing/ancillary staff.
"We currently need more echo techs because their schedule is full. If one tech is out the other has a double load. Also, inpatients wait until afternoon behind outpatients to get their echo which can delay discharge. No echo available on weekends so some requiring holding until Monday afternoon to be evaluated."
We would like to hire another cardiologist which would give more flexibility to our current staff. Patient''s with intermediate risk factors admitted over a weekend have to stay until Monday to get their stress test. Don''t think our institution is big enough to justify 7days/week availability.
Currently our cath lab is only used for scheduled cases and emergencies during regular work hours. We are trying to increase cardiology staffing which might allow for more availability in some situations.
"If we have an STEMI after hours it will require transfer from VA to university which will take a minimum of one hour, usually more, to work out. We cannot staff a cath lab 24h, 7d a week."
"Having 24h, 7d/week cath availability here is not feasible. It is a long tedious process to send an inpatient to another facility after hours. Not sure what parts could be simplified or eliminated."
Transferring a Veteran to a larger VA offering CABG services is slow and usually requires keeping the patient on our inpatient service for days until (1) Cardiothoracic surgeon reviews films and agrees to do it (2) picks a day they want him to arrive and (3) travel can be arranged. The answer is to stop requiring us to send people so far from their home and family to get life-altering surgery.

"Transferring someone anywhere from inpatient service requires so much administrative work, however, I''m not sure any of it can be eliminated. Per my last patient transfer--there just weren't any obvious short cuts."

"VA should conduct a yearly market salary analysis for all providers to maintain competitiveness with community standards. We should also be flexible in allowing for incentive pay for physicians based on RVUs or productivity. Regarding recruitment and hiring processes--HR should be able to have a provider start date of 30 days or less. Current practice is 4-6 months before EOD date is given to selected employee. Regarding Contracting issues in relations to equipment purchases, simplify process to allow acquisition of equipment in a timely manner (60 days or less)."

Optimal availability of resources
The cardiac cath lab must be optimally equipped.

"Facility volume in general and the ED''s in particular has greatly increased and without a corresponding increase in resources. We need additional ED exam rooms and the staff to service them including Physicians, Nurses, LPN''s, and techs.
There are an insufficient number of Tele and ICU beds for our population. These areas are often filled to capacity requiring our patients to be transferred out. Additional rooms and appropriate staff, eg; ICU RN''s and so forth are needed.
Everything needs an increase on the order of 50%, and this is simply to catch up to present demand. This does not allow for future growth in our population base, which is clearly going to occur.
We need an X-ray suite within the ED,
Radiology needs additional personnel for staffing on nights and weekends when there is often only one X-ray tech for the entire building and services the ED, ICU and OR simultaneously.
All departments involved in the care of the cardiac patient need improved and increased administrative support at all levels.
Central office rules on Physician scheduling are too restrictive and need to allow for working more than 80 hours in one pay period either with compensation for overtime pay or additional leave days, or by allowing fewer hours to be worked in other pay periods.
An in-house transport service to move patients to and from X-ray and to inpatient beds from the ED would speed flow. This is at present a volunteer staff and at that is inadequate in number for present needs."
"Facility volume in general and the ED''s in particular has greatly increased and without a corresponding increase in resources. We need additional ED exam rooms and the staff to service them including Physicians, Nurses, LPN''s, and techs.
There are an insufficient number of Tele and ICU beds for our population. These areas are often filled to capacity requiring our patients to be transferred out. Additional rooms and appropriate staff, eg; ICU RN''s and so forth are needed.
Everything needs an increase on the order of 50%, and this is simply to catch up to present demand. This does not allow for future growth in our population base, which is clearly going to occur.
We need an X-ray suite within the ED,
Radiology needs additional personnel for staffing on nights and weekends when there is often only one X-ray tech for the entire building and services the ED, ICU and OR simultaneously.
All departments involved in the care of the cardiac patient need improved and increased administrative support at all levels.

Central office rules on Physician scheduling are too restrictive and need to allow for working more than 80 hours in one pay period either with compensation for overtime pay or additional leave days, or by allowing fewer hours to be worked in other pay periods.
An in-house transport service to move patients to and from X-ray and to inpatient beds from the ED would speed flow. This is at present a volunteer staff and at that is inadequate in number for present needs."
"Facility volume in general and the ED''s in particular has greatly increased and without a corresponding increase in resources. We need additional ED exam rooms and the staff to service them including Physicians, Nurses, LPN''s, and techs.
There are an insufficient number of Tele and ICU beds for our population. These areas are often filled to capacity requiring our patients to be transferred out. Additional rooms and appropriate staff, eg; ICU RN''s and so forth are needed.
Everything needs an increase on the order of 50%, and this is simply to catch up to present demand. This does not allow for future growth in our population base, which is clearly going to occur.
We need an X-ray suite within the ED,
Radiology needs additional personnel for staffing on nights and weekends when there is often only one X-ray tech for the entire building and services the ED, ICU and OR simultaneously.
All departments involved in the care of the cardiac patient need improved and increased administrative support at all levels.
Central office rules on Physician scheduling are too restrictive and need to allow for working more than 80 hours in one pay period either with compensation for overtime pay or additional leave days, or by allowing fewer hours to be worked in other pay periods.
An in-house transport service to move patients to and from X-ray and to inpatient beds from the ED would speed flow. This is at present a volunteer staff and at that is inadequate in number for present needs."
"Ratings apply to patient care in general, as it is difficult to isolate care of ACS patients from the general population in these aspects."

"Employ well trained ED phyusicians. Not newly graduates. Provide ongoing training, feedback, case discussion and follow-up for ED physicians."
I recommend immediate cardioogy consult in the ED for every patient being considered for ACS admission. As done in the private sector.
"Delays may be improved by pre-procedure screening and adhering to ACC/AHA appropriated use criteria. By reducing unnecessary tests, delay would be reduced."
"Staff training, mock drills, in-service for new health care provider, physician feedback"
"Having the PCI team memebers living wihthin 30 min to the hospital makes it easier to achieve 90 min D2B time. Otherwise, the team have to make up time in other process areas."
"dealy due to
1. lack of beds
2. lack of nursing staff
3. inefficient discharge process that ties up beds"
"Blocking patient transfer UNTIL a bed is physically empty. Bed control is unwilling to ”anticpate” upcoming discharges and patietn transfer time. i.e. if one knows a bed will be available in two hours, then one should accept pt for transfer that has a transfer time > 2hrs."
The surgical service admits patient 3-4 days for pre-CABG evaluation. An inefficient use to time and beds.

Too MANY nurse administrators (chiefs)monitoring and not doing actual patient care work. Too many repetative documentations set up by administrators to meet JACHO requirement. Too many hospital wide balnket policies that should be taylored to departmental needs.

"All delays have to do with transportation, not the personnel at either facility; and certainly not due to delay of care. I would recommend improving the contracts with services that transport our patients, OR to have our own transport immediately available (although I am aware that this is a very costly service to maintain).
I recall cases (not so much names unfortunately) where there was a 2-3 hour wait for STEMI or NSTEMI - because the ambulance couldn't get there in a timely manner, for a 10 minute drive to the nearest hospital that could perform PCI. Fortunately in all cases the patient had already begun to stabilize clinically, but I wouldn't prefer to rely on luck alone."
"All delays are related to transportation time and availability. I would recommend improving the contracts with services that transport our patients, OR to have our own transport immediately available."

Establish better memoranda of agreement.
Increased bed availability of beds at the receiving hospital.
Bed availability is the primary issue

[Location redacted] VA does not have a cath lab. and it doesn''t make a true business case to have one.
Transfer of patients to other VA is delayed by distances not used in cases of ACS
Delay is lack of bed in different hospital.
Primary PCI in STEMI not usually done at another VA due to distance traveled.
Stable ACS transfer for possible PCI would like to have further testing over the weekend prior to transfer accepting provider from outside hospital doesn''t want to take a patient earlier.

"VA is not competitive (salary) in hiring echo technicians. This results in delays in getting inpatient echocardiograms. Also numan resources process is extremely slow, hiring process takes 6 months or more. An alternate short term solution was suggested at this VA (hire contract echo techs on an as needed basis; it turns out that drawing up a contract for this is also very slow). VA has become increasingly bureaucratic and inefficient in terms of hiring, this is affecting patient safety and care, and is also very expensive as increasing numbers of patients are sent out to community."
"Generally inpatient response is reasonable, problem mostly on outpatient side. Weekend coverage would clearly shorten hospital length of stay for patients arriving on Friday or Saturday. ."
Currently ED is staffed nights and weekends by moonlighting University fellows many of whom are not expert in rapid diagnosis of STEMI. Hiring ER trained and certified staff 24/7 is only way to fix the problem.
The delays in primary PCI are related to delays in diagnosis in the ED (see question 8). There have not been problems with timely arrival of cath lab staff once the STEMI team is activated.
"Our VA needs to recruit and hire additional cardiovascular surgeons, it is currently routine for non-urgent surgeries to be delayed a week or more, and for urgent surgeries to be sent out. Patients with unstable angina are typically sent home to come back for surgery later. Most of this is related currently to shortage of surgeons, in past when more surgeons were available a problem was availability of the OR only 3 days/week (due to lack of CV anesthesia support and OR staff and space). Anesthesia staff resistant to doing more than 1 case/day, need incentives to improve efficiency or hire contract staff to allow a second CV case. Finally night and weekend coverage is non-existent, those cases are routinely

sent out to non-VA facilities. Need night and weekend coverage by qualified CV anesthesia staff (either VA call-back system, or contract call from non VA facility)."
"Delays are common. Mostly this results in extra expense to the VA as patient is treated at a non-VA facility. Reason for delay is shortage of inpatient beds, and no ability of CCU to restrict CCU beds to cardiology patients."
"Main problem is insufficient inpatient beds. At times in past nursing shortages have also been an issue, resulting in not all beds being open; this hasn';t been an issue in past 90 days. There is no consistent effort to prioritize transfers based on acuity of their illness.
Supervision and incentives: Unlike the private sector there is not a "service mentality" in the transfer office. The transfer process is "unfriendly"" to referring hospitals, typically they have to leave a message and get a call back, rather than having a transfer clerk consistently available to answer the phone directly. This is a problem both for referring physicians and in-house physicians trying to get a patient admitted."
"Recently hired CRNPs should help with delays in clinic appointments, especially hospital discharge patients. However, currently no morning clinic space (despite long backlog in patients). We could see more patients if we had more space, would also require some additional physician FTE. Also there are many issues in the clinic that make it inefficient, slowing patient flow:
1) Lack of adequate support staff (certified techs) to do things like medicine reconciliation. Latter currently not happening in any real sense unless the physician does it, which is VERY inefficient use of resources
2) The subspecialty clinics have no control over the support staff to enforce things like med reconciliation (the staff report to nursing service, which is not very responsive to request for change).
3) The electronic medical record is no longer state of the art, and is not well connected to scheduling system, which contributes to inefficiencies in both scheduling and patient thru-put."
More nuclear techs and equipment. Weekend coverage would less hospital length of stay.
"Need more CV surgeons.
Anesthesia is inefficient, difficulty staffing more than 1 CV case per day. Lack of qualified CV anesthesia coverage at night and on weekends. Need fee basis coverage from non-VA facilities for night and weekend anesthesia coverage, and also for second cases during the day. Need additional trained CV nursing staff, need to increase caseload to make job attractive (or hire fee basis contract CV nurses from non-VA facility as needed)"
"Administrative and lack of support staff mostly in outpatient area. Rare delay in inpatient studies due to one of the two cath labs suboptimal for complex procedures, competition for time with EP procedures in same space; replacement lab for older cath lab scheduled to be on-line in next 6 months to address this."

Recedntly opened new cath lab.

"Our single biggest deficiency is in availability of inpatient beds. Most often, but not always, the actual shortfall is in bed staffing (i.e. nursing) and not in physical beds. This results in delays in transfer of patients from the ED to the floor, and creates further bottlenecks for the procedure areas. For example, in the Cardiac Cath lab patients often must be held in the Recovery area for additional hours due to lack of available telemetry beds, which pulls cath lab staff from other duties and affects procedure throughput.
In Cardiology we have a shortfall in technologist positions -- primarily cath lab techs and echo techs. Technologist pay scales fall far below market in high cost of living areas, and we have continual problems attracting and retaining these critical personnel."
"Similar to last question.

Our single biggest deficiency is in availability of inpatient beds. Most often, but not always, the actual shortfall is in bed staffing (i.e. nursing) and not in physical beds. This results in delays in transfer of patients from the ED to the floor, and creates further bottlenecks for the procedure areas. For example, in the Cardiac Cath lab patients often must be held in the Recovery area for additional hours due to lack of available telemetry beds, which pulls cath lab staff from other duties and affects procedure throughput.
In Cardiology we have a shortfall in technologist positions -- primarily cath lab techs and echo techs. Technologist pay scales fall far below market in high cost of living areas, and we have continual problems attracting and retaining these critical personnel."
"The echo lab relies heavily on contractors to fill sonographer positions, due to the large gap between VA and community payscales for the technologists who perform echo procedures. This leads to inefficiencies and to some degree of uncertainty with regard to echo lab staffing. Physician staffing is not the issue.
Overall, equipment is very good. However, the VISN recently imposed a change in PACS systems that was un-asked for at the local level. The new system has been inadequately supported at the IT level, such that technical problems in transferring clinical reports from the reading system to CPRS/Vista have led to delays in having these reports available for patient care for hundreds of patients."
"I am told that it is sometimes difficult to add on inpatient nuclear stress tests in an expedient manner - e.g., can''t get a slot for stress testing for a patient who comes in through the ED the afternoon or evening prior."
"Our VA medical center does not have a true page operator who can facilitate simultaneous and efficient contacting of the STEMI team to ensure that everyone is notified in a timely manner for this time-sensitive function. We rely on the nursing supervisor to play the role of page operator, which is an imperfect solution."
"CT surgery at SFVA has difficulty ramping up for urgent inpatient procedures. In general they perform a single operation most weekdays with the exception of Thursdays, when they have clinic. The CT surgery chief has pushed very hard to be able to perform two procedures per day when there are urgent inpatients, so that these patients may be accomodated without necessarily moving or cancelling the scheduled outpatients. Gaining support for this from OR and anesthesia staff has been challenging."
"The issue with accepting transfers generally involves bed availability, and at SFVA the issue limiting beds is more often than not RN availability for staffing those beds. In general, patients with ACS should not wait very long, so when we do not have bed availability, those patients are transferred to other cardiac centers so as not to impact care. The cath lab nearly always has capacity to add on urgent inpatient transfers."
"CT surgery can generally get patients in to clinic within a reasonable amount of time. Like many clinics at SFVAMC, they suffer from a shortage of clinic space, which impacts efficiency and numbers of patients seen. Tele-health can be applicable for some patients. The case manager role is essential for organizing these complex patients."
"Carotid ultrasound can generally be acquired quickly.
Full PFTs (CT surgery generally requests full PFTs, as opposed to bedside spirometry) generally take quite some time (on the order of 2 months, according to the TAVR coordinator) to obtain."
"Insufficient administrative support is a chronic issue.
The number of staffed inpatient beds has long been an issue, which impacts our ability to get patients out of the ED, to bring in urgent transfers for advanced care, and to move patients from the procedure areas to the floor.
Cath lab equipment is overall excellent. The physical space is inadequate for all needs, however -- sterile storage is in several rooms that are physically separate from the cath lab area. This suboptimal situation

was created when the hybrid cath lab/OR was built (which took some space that was previously used for storage), and has not been remedied."

"Need licensed emergency medicine physicians instead of mid-level providers in the ER, more technicians, pharmacists and nursing staff."
"We need more echotechnicians, weekend echo availability, more licensed physicians instead of NP''s in the ER, more bed availability in other VA facilities to which patients are transfered to for coronary angiography, provide an in-house coronary intervention capability so patients don't have their care delayed due to waiting for transfers to other VA or non-VA facilities."
"Our patients are transfered to VAAA for angioplasty and there is invariably a delay secondary to lack of beds at the accepting facility, lack of physicians available to perform procedures on weekends."
We need to have our own ambulance service available at our disposal. We need better clerical staff that can expedite transfer. We need user friendly steps that IT can help us with. We need central office to recognize that we have had approval to increase the complexity of care here in our facility to do high risk coronary angiography and interventions and help us gain support form our local VISN.
"We need to have licensed emergency physicians instead of NP''s and/or moonlighters of other medical fields in the ER to help better recognize ST elevation on EKG. We need the central office to support us in having the ability to have an on-site interventional lab so we depend less on transfers outside the hospital for acute care, where time is money."
"We need the central office to support us in having the ability to have an on-site interventional lab so we depend less on transfers outside the hospital for acute care, where time is money."
"Most of our delays to another VA facility for PCI is lack of beds. In addition there are no physicians available outside work hours and weekends which delays things significantly. Wait for CABG is significantly long in the accepting VA facility. We need central office to support us in having the ability to have an on-site interventional lab so we depend less on transfers outside the hospital for acute care, where time is money."
"Most of our delays to another VA facility for PCI is lack of beds. In addition there are no physicians available outside work hours and weekends which delays things significantly. Wait for CABG is significantly long in the accepting VA facility. We need central office to support us in having the ability to have an on-site interventional lab so we depend less on transfers outside the hospital for acute care, where time is money."
We need support to increase complexity of surgical procedures done in our own institution so there is less dependency on outside VA or non-VA facilities so we can better serve our veterans with ACS in a timely fashion.
The delays are usually because of lack of beds. If beds are available there is no other key step that is a limiting factor.
More providers should be hired to improve access. Weekend availability of services including tests would also help. More OR''s and OR equipments would also help improve access.
Availability of tests over the weekend and more equipments and tech availability to help improve access.
"All our inpatient CABG delays are due to lack of beds in the accepting VA facility (VA [location redacted]). Outpatient CABG delays are related to restricted OR time for CABG, eithe rdue to limited availability of CT surgery in the respective VA."
We need more licensed physicians in the emergency room instead of nurse practitioners. We need to have the ability to do on-site coronary interventions. We have been approved for it by central office but not by our local VISN due to local politics which is not acceptable.

"Severe space limitations in ED; delays also due to limited ICU, ward beds

Variable, but ED Clinical staff not infrequently overwhelmed by large patient volume
Need simplified/expedited processes for transfer of care for STEMI patients (we do not have staff to offer PCI 24/7). Collaboating with community to establish better direct routine of STEMI patients to PCI centers without adminitrative delays"
Limited telemetry bed availability impacts delays both directly and indirectly (slows bed transfers from ICU and therefore bed availability there).
Limited number of ICU beds (shared med-surg-cardiac) in consistenly very high demand. Secondary impact from limited ward and telemetry beds to which ICU patients can be transferred.
"Weekend/night coverage only by physician/Fellow performance as emergency. technician staffing currently satisfactory, but chronic problem in recruitment due to grossly noncompetitive salary structure"
"Staffed only with one part-time physician; when on leave, no nuclear cardiology capability and must fee-base out. If services expanded may need more technical personnel support"
This facility provides primary PCI only during business hours if (single) cath lab is available. Delays in intrahospital transfer night/weekends related to recognition and facile activation of STEMI system for transfer or throbolytics+ transfer. Need to work with community to permit transmission of first-contact ECGs and administrative authority to directly route patient to closest PCI center for optimal STEMI care without cost to patient
"Limited bed availability at receiving hospitals can delay care. Referral to other centers would be greattly facilitated by establishing transfer coordinators and centers at each site to coordinate practical aspects of arrangements. High bandwidth data access between sites (including across VISN lines) to facilitate image transmission and discussion (cath films, echo studies, etc)."
Limitation is timely transfer of patients to non-va facilities when needed--ambulance transfer even short distance often delayed. Would be desirable to establish authorization to direct acute STEMI patients to outside PCI facility without having to come to ER when apprpriate
See previous comments. Need more expeditious transfer capabilites as transport is most common source for delay
"Biggest limitations are bed availability and limited surgical staffing at recieving facilities, long distance to referral sites. Limited capabilities to take high risk patients (surgical depth, LVAD access, etc)."
Administrative authorization and cost sensitivities are most common reasons for delays
Ability to transfer here from other facilities limited primarily to access due to limited number of ICU and other beds
"Outpatient clinical facilities, staffing already beyond capacity. Difficult to meet various time metrics given these limitations. Very limited clerical/administrative support for specialty care. More fee-basis access to specialty care for patients at long distances from central facility would be better for patients"
"Need more depth in nuclar medicine staffing, particularly physician staffing."
Limited CT surigical staffing/capacity at referral centers. Arcane and inappropriate travel restrictions for outpatient transfers for appointmens

"1]Install state of the art computer system. CPRS is outdated and full of ”patches” which slow it tremendously.. Look at the systems currently used by private sector.
2]Our CPRS is run by 11 years old processors !!! Get new processors.
3] the ER should be staffed by ER trained physicians -not by Primary care and internists physicians."
"1]This facility cardiac nuclear services are run by an employee of the Radiology department who is not capable of doing the job and creates major obstacles .
2] Cardiac nuclear studies should be offered along the weekend."
"1] retire cardiac surgeons who are no longer able to provide state of the art operations and real oncall coverage

2] create maximal cooperation/integration with the private secotr's cardiac surgery program and surgeons[[location redacted]Hospital]"
"1]Cardiac nuclear studies must be done expeditiously
2] CT surgery must employ fully competent,eager to work and energetic surgeons."
"The department of CT surgery requires a substential overall. Employ energetic,eager to work and most importantly-competent cardiac surgerons."
see previous comments concerning the functionality of CT surgery

"Personnel management - when hiring new staff for technical positions, such as echocardiography technician, it is important to test the technical skills of the people applying. With current HR rules, it is difficult to do (if there are no local veterans applying, then you have to consider veteran applicants from across the country but nobody pays them to fly out for an in-person interview)."
"Transfer from ER when patients present with STEMI, is not a problem. The only delay that happens in our hospital when patients have STEMI, is when the patient is already hospitalized (so transfer now has to be inpatient-to-inpatient), especially when STEMI is diagnosed in "off-hours" (nights or weekends) . The issues are following: 1) no available beds in the surrounding community hospitals who accept STEMI, 2) our transfer center is closed on nights and weekends and the Administrative Officer on Duty has trouble coordinating the transfer, 3) STEMI from inpatient requires ACLS transport, and in our locality this may take up to 40 minutes to arrive. RECOMMENDATIONS: 1) local transfer center with ACLS transport on-call 24/7, or contract with ambulance services to provide ACLS transport in a timely manner, 2) better supervision of various AOD and NODs who are on call at night/weekends"
"Significant amount of patients who are stable enough to be transferred to another VA facility for CABG, experience delays due to 1) lack of beds in the referral VA - [location redacted], 2) delay in accepting the patients by the surgeons due to busy OR schedule or the surgeon simply not being available (there have been significant staffing changes and turnover in CT surgery in VISN[location redacted]). For us, it would be better to use contract surgery in the affiliated University hospital where the surgeon (who has an intermittent appointment at the VA) could come over and see the patient for a consult, and the patient can then get the surgery in the affiliated University hospital by contract. This happens now with patients who are not stable for transfer to another VA, with very good outcomes. Using similar process for patients with ACS who require inpatient CABG but are still stable to transfer, would improve quality of care (surgeon would consult the patient before the transfer), timeliness of care, and patient satisfaction."
"In few patients, there can be a short delay in transferring to the non-VA university referral hospital for urgent CABG due to lack of bed in the accepting hospital, or due to their busy OR schedule. This delay has been minor compared to the delays we experience transferring patients to another VA."
lack of ICU/telemetry beds in our hospital
Most of the delay in transferring patients from outside hospital to our VA occurs due to lack of beds. Some of it has to do with lack of nursing personnel though it has been addressed now.
"Patients who are discharged from the hospital after ACS and are referred for outpatient CABG, should get their CT surgery appointment in 2 weeks. [location redacted]VA accommodates this, [location redacted]does not - however, they do see patients in 30 days. I do not know what solutions should be in place for them to see patient quicker."
"Delays in getting outpatient CABG for patients after ACS happen often, partially because the referral center surgeons insist on multiple consults by other services before seeing the patients. Also, I assume because of lack of OR. Often patients wait for months to get outpatient CABG in the referral VA. Better communication between cardiologists at our VA and surgeons in referral VAs may help, and we can work on this on our own. VISN level cardiovascular meetings where the Chiefs of Cardiology or even all cardiologists/CT surgeons get together to discuss pressing issues, would help A LOT."

"There is no ”cardiovascular conference” where we could discuss patients with the referring cardiologist (at our VA), the referral cardiologist (at referral VA where they do complex PCI), and the referral CT surgeon could all get together and discuss what to do with the patient. A great solution would be weekly teleconference between 2 VAs where both sides would have access to patient record and medical images, and management decisions for complex patients could be made with all parties participating. Currently the referring cardiologist talks to the referral interventional cardiologist and then has to talk to the CT surgeon separately."

"Our ED is being expanded this summer.
Our hospital is being expanded within the next two years. This should help."
"We need more beds. This is a process, which is ongoing.
We are interviewing for two Cardiology provider positions.
Equipment is sufficient."
"Once we have more beds available, patients will not need to be transfered out anymore, except the few who might need urgent/immediate cardiac catheterization."
On-call Cardiologist must be available by phone within 5 minutes and can direct care even when off-site.
There is good communication with the ED physicians.
"The approval of our PCI business plan is overdue. Once approved, we can do PCI here at our facility."
Transfer process works OK for us
We have had a very good relationship with [location redacted]hospital in [location redacted]and all of our urgent open heart surgery patients have gone their quickly and efficiently.
Patients have to travel out of state for cardiac surgery at other VAs. Would be nice to routinely have this done in Las Vegas at a contract hospital.
Would be nice to have CABG surgery done locally rather than traveling to another state to get to a VA offering this service
We need more beds in the [location redacted] hospital to accomodate the increasing number of patients. This is in the planning stage. Any “increase in speed” regarding this process would be beneficial to patient care.
"VA purchasing system is very cumbersome.
Whenever something is being requested, this should start with ”Email 1” and be dated and followed at close intervals, with someone being responsible for progress."

"We don’’t do ACS evals, since we do not have a cath lab"

Increase awareness of ”time is myocardium” for after-hours and weekends to the ED medical staff.
Same as before. Increase awareness of “time is myocardium”.
Timely call for STEMI is needed. I am referring to one case in particular.
We need more surgeons and telemetry beds along with Mid-level providers for both CT surgery and Cardiology.
No beds available.
We need more telemetry beds cared by an Attending with mid-level providers. These are stable patients and residents get a max patients they can cover.
We need to increase availability for XR/US studies
We are short on CT surgeons.
Physicians are now asked to be “administrative personnel” and perform multiple tasks for which we have not being trained nor studied for.

"if inpatient beds increased, would likely need more inpatient attendings/hospitalists to staff these patients"
"Our options for ACS are to transfer patients locally (we have a local contract with a community medical center) or to send ~200 miles to [location redacted]or [location redacted]. The patients have to wait on average 2-3 days or longer for beds at those outside facilities. The VA ‘‘preference’; is that we send within the VA rather than the community for financial reasons. however, it is inappropriate for ACS patients (even stable patients, cp free, with mild or no troponins) to wait > 48 hrs. So, either bed capacity, cath lab capacity with staff at those facilities need to increase, or we need to make a permanent contract locally to avoid these delays. We are also working on starting our own catheterization lab as well"
"we don’’t currently have a cath lab, so we don’’t run into this situation"
"People can typically be seen within a 1 week of hospitalization or certainly within 30 days. However, delay occurs when patient needs a week follow up from an outside community hospital, and that consult request isn’’t forwarded to us in good time. Better communication needs to happen between the outside facility and the VA schedulers"
"Typically, if patient getting a CABG for ACS at an outside VA ([location redacted]), they might do it the same admission. If the patient is more stable, they would set that up as an outpatient. At both outlying facilities, it usually is more than a 30 day wait for elective visits with CT surgeon or the surgery itself. I don’’t know why the delay is, but assuming they are fully scheduled, they may need more CT surgeons. Again, these facilities are 200 miles away, we need local contracts to take care of this in Fresno. Local surgeons would see these patients within 7 days and get the surgeries scheduled soon thereafter"
"due to old systems, doctors are retranscribing echo reports and holter reports and stress test reports from one electronic system into cprs. secretaries were doing this in the past but there was too much delay and/or errors made, so now physicians do directly but it wastes their time. This applies to all cardiology patients as well as ACS. we are working for upgrades to our systems as well as obtaining the clinical procedures cprs module which is suppposed to help avoid this"

"Hospital needs more beds/space. Often it is difficult to find appropriate type of bed for ACS patients. The number of independent licensed practitioner’’s is too small to take care of current patient volume. There is no weekend availability of tests like in house echocardiogram caths
cath lab supplies/ disposables needs to available in timely fashion"

Important that there are adequate personnel that can do the procedures and that are available to communicate easily with physicians and ancillary staff from the referring center. The line of communication must be wide open throughout the entire process so that the referring center is always aware as to the status of their patients.
"In general, there has to be easy access to communicate with the personnel at the VA that is performing the procedure. There have to be an adequate number of surgeons to perform these procedures at this center or additional VAs must be added to the system so that these procedures are done in a timely manner."
"As mentioned before, there have to be an adequate number of surgeons at the VA to perform CABGs. There also has to be an adequate line of communication so that the personnel at referring VA know at all times exactly what the status of their patient is and the rationale behind decisions made."

Improve contracting process at the VACO to make cardiac catheterization laboratory supplies be available in a timely manner
"1)Ability to transmit EKG images immediately to STEMI providers via cell phone /wife fax is not feasible due to privacy concerns

2)Ability to upload the EKG in VISTA immediately is not feasible due to EKG machines not having wifi capacity
3) There is no incentive or on-call pay for physicians on STEMI call - which can be every other day or every third day
4) Process for hiring of staff is too prolonged due to VA regulations
5) Pay for interventional or other cardiologists are much lower than market pay ranges"
"Our cardiologists and CT surgeons are excellence and available 24/7, but nursing staff shortage , availability of operating rooms and perfusionists coverage can be a limiting factor."
"This is a critical issue. Due to central office contracting magnates, we cannot receive cath lab supplies in a timely manner.
Similarly, we cannot get cath labs remodeled or upgraded in a timely manner, having to compete at the VISN level for equipment purchases for CT , PET scan etc."

Need space for a well-staffed chest pain unit with fixed equipment .
Critical need for additional patient''s rooms including telemetry beds. Nursing staff
Need for additional well staffed CCU beds
"Additional well-staffed operation rooms dedicated to CT surgery.
More operating time for CT surgery under current space conditions."
Non VA facilities have limited capacity
"We need more patient beds, telemetry, intermediate and intensive care."
Need more inpatient beds and a more efficient transfer center
More patient beds and more operating rooms.
Procurement issues are serious and affect patient care

Need to expand technology to allow more telemetry beds available at facility and increase number of nursing staff so sufficient should there be a call off due to illness. Some of CO policies do not effectively translate to facility needs or cause unintended consequences such as delays related to obtaining services/personal i.e. contracting procedures.
See previous comments.
Transport to non-VA PCI facility has inherent risks of delays due to traffic patterns and area emergencies. Continue working with local ambulance and EMS systems to assure transport accomplished in a timely manner.

"We need more cardiologists on-site, and more nurse practitioners"
"We need better accountability from our cardiac surgeons, expanded OR time and better scheduling in order to improve through-put, and accountability of the OR team when things don't go as planned."
We need MORE BEDS to accept transfer patients!
"More inpatient beds, nurses to staff those beds, and nurse executives who are invested in success rather than in preserving the (inefficient) status quo."
"We critically need more cardiologists, cardiology nurse practitioners, and bigger outpatient clinic facilities."
Need more CT surgeons!
The OR needs to expand its hours so that more than 1 case per day can be done.

Far too much TMS activity. Too many superfluous E-mails. Leadership sometimes out of sync with clinical realities. Too much top down direction. Not enough input into clinical direction of programs. Residency time requirements have reach levels of intolerance.

Need of an additional CT surgeon
Need of additional CT surgeon
Need for more Internal Medicine Beds

"Maintaining EMS and support staff very difficulty due to low pay, low staffing, difficulty getting staff hired due to HR processes/limitations.
Equipment: very difficult getting new and replacement equipment needed for room turnover and patient care due to obstacles in contracting."
"Cath lab does not have adequate recovery space, especially after hours/weekends.
Inadequate turnover/transport/support staff also concern."
Bed lock.

Improve local ambulance response time to transfer patients in a timely manner
Ensure that local ambulance arrives in a timely manner for transfer
Timely transfer via ambulance
Timely transfer via local ambulance
timely transfer via ambulance

"b. Physicians
c. Nurses
g. resources to reward staff"
More funding for providers and support staff and for imaging equipment.
c. x-ray technician
c. x-ray tech

We do not have a nuclear medicine service hence need to transfer patients fo area facilities causing a delay in this urgent but not emergent testing
Our affiliated referral VA's for cardiac care are sometimes short of beds leading to delays in transfers for higher level care
Increased bed availability at our referal VA's
Planned CABG procedures are done within the VA system if possilbe. NonVA surgeries are often outgrowth of earlier transfer to NonVA care settings with ACS
good relationship with private area hospital
Additional on-site Cardiology FTEE
CT surgery not available at facility. Use either referral VAs or community partners and when elective can be delayed (somewhat)
overall the ACS patient group care model works fairly well

Need access to more tele-beds/obs and same day stress tests if appicable.
need more tele-obs beds and same day stress tests
need to save a few slots each day in nuclear stress test schedule for quick rule -outs
"13. No beds were available to transfer
Valve replacements patients have 10% delay because CABG gets priority."

"- Cardiology clinic needs more suport staff. There is one receptionist who is the "secretary" for all the providers.
-Consider additional session for fellows or support staff, NP RN for fellows. Fellows are only in clinic one day per week, so "

"Stress lab needs more supervision. Scheduling is very disorganized, disjointed.
Flow throughout the nuclear department could be improved and made more efficient, by using a “flow coordinator”."

NEED TO STREAMLINE PROVIDER PROCESSING THROUGH HR AND REDUCE TIME SPENY ON NON CLINICAL ACTIVITIES. TMS IS A WASTE OF TIME
NEED TO MAKE TRANBSFER A PRIORITY
USUALLY A STAFFING ISSUE
NEED ADDITIONAL PROVIDERS
CURENT AREA CLOSED DUE TO CONSTRUCTION
NOT AN ISSUE
ALL PATIENTS ARE TRANSFERRED
PATIENTS ARETRANSFERRED
TRANSFER PROCESS IS IN PLACE
NEED MORE STAFF
NEED COMPLETION OF CONSTRUCTION

Without means to take pt to cath lab at our facility we would not accept ACS; ‘‘stable’’ and ‘‘acute’’ are not compatable terms.
"need to add an additional nucleay camera with all the support personnel that involves, at a new HCC. Need addition of 2 onsite cath labs. at medical center."

"1- Chest pain unit with protocols based on new high sensitive troponin I; patients could be triaged in 2 hours. (Send home or admitted to CP unit to complete rule out or further testing in house vs out-patients).
2-Increase hospital bed capabilities, including unit beds or better step down units uniquely to cardiology (4 beds for one RN ratio with Tele).
3-A dedicated transport person to Cardiology (Cath lab, Non invasive lab and PM examining Rm)
4-Increase Echo lab personnel 3.5 positions, with increasing VA patient population for Echo cardiograms, Stress test.
5-Ciritcally important now is to increase the Cath lab tech and RN. We are the busiest VA cath lab in the nation for interventions with a skeleton of personnel al least 3 more people to avoid burn out fatigue and mistakes. Currently overtime pay estimates we could hire two extra people, but that’’s not enough for our current conditions.
6-New cath lab with EP/Pacemaker implant capabilities with assigned personnel.
7-Hospice beds for terminal heart failure patients (is not available in our institution) and or in outpatient based palliative care.
8-Allow patient who have critical conditions, potentially could be treated with procedure not offered in our intuition, but are offered in local community. (i.e. LVAD’’s, cardiothoracic in high risk pts)
9- Extra corporal counterpulsation therapy for angina patients not amenable to coronary interventions or CABG."
"1- Chest pain unit with protocols based on new high sensitive troponin I; patients could be triaged in 2 hours. (Send home or admitted to CP unit to complete rule out or further testing in house vs out-patients).
2-Increase hospital bed capabilities, including unit beds or better step down units uniquely to cardiology (4 beds for one RN ratio with Tele).
3-A dedicated transport person to Cardiology (Cath lab, Non invasive lab and PM examining Rm)

4-Increase Echo lab personnel 3.5 positions, with increasing VA patient population for Echo cardiograms, Stress test.
5-Ciritcally important now is to increase the Cath lab tech and RN. We are the busiest VA cath lab in the nation for interventions with a skeleton of personnel al least 3 more people to avoid burn out fatigue and mistakes. Currently overtime pay estimates we could hire two extra people, but that''s not enough for our current conditions.
6-New cath lab with EP/Pacemaker implant capabilities with assigned personnel.
7-Hospice beds for terminal heart failure patients (is not available in our institution) and or in outpatient based palliative care.
8-Allow patient who have critical conditions, potentially could be treated with procedure not offered in our intuition, but are offered in local community. (i.e. LVAD''s, cardiothoracic in high risk pts)
9- Extra corporal counterpulsation therapy for angina patients not amenable to coronary interventions or CABG."
"We could do all the work locally with the appropriate support (personnel equipment and space, currently lacking)"
"Hire more cardiothoracic surgeons to help out with the number of complex cases at least two...and ancillary staff, a surgical SICU person while they are operating to cover 24hrs/7d)"
"the process is done in cumbersome way, cost saving is the goal, not providing the best care possible, in services we cannot provide here but available in local hospitals.
Other VA are in the same circumstances and cannot absorb our volume for complex pts since Nov last year.
Expert in the decision making is lacking."
due to proper bed allocation when small VA health care faciliites
Not enough surgeons for the volume complexity of the cases with support for in house SICU team post CABG while surgeons is operating. 24hrs/7 d coverage
"Too many administrative personnel related to non patient care and too many regulators not dedicated to patient care, too many rules and unnecessary documentation double documentation making the system very inefficient.
Mandates for ”Lean projects”“ and other charter projects lined to salary incentives which take time away for patient care.
i.e. Lean project take extra times hours per week, making some teams in cardiology stay overtime that had to be paid, and delaying the procedures for pts and discharge.
Is well know in the literature that Pay-Performance doe snot work for improving care, but still embedded in the culture of administration.
Lean projects then have to presented like in ” high school” diverting MD from patient care. and not enough people to support them."

"unable to get rid of unproductive or problematic employees
HR is rarely helpful"

"[Location redacted]uses the CCU ICU beds as a holding area for all general ward admissions when the wards are full. These patients, who do not need internsive care stay in the CCU for days and fill up the beds and delaying care for paitnet who need CCU ICU"
the number of STEMIs are small in the VA since ambulance will take these patients to nearest ER. contract withcommunity hospitals more efficient than developing a STEMI program in the VA
VA refuses to allow physicians to reivew echo images from home during nights and weekends due to ”information secutiry reasons” One option is t have ”night hawk” readuers similar to Radiology

In most VAs number of STEMI is smal ldue to ambulances taking the patients to nearest ER and not to the VA. A quick transfer to the nearest tertiary center is likely more cost effective
To transfer a STEMI to a non-VA facility three different forms need to be filled out by the physician and records copied ....there may or may not be a clerk in the ER
usual reason for delay is lackk of monitored beds
We have a single cardiac surgery team with limited OR time - resulting in delyas during busey times
"Cardiology has no secretary and the physicians do clerical work and MAS work (e.g., cancelling no-show consults). this is waste of physician time"

"Biggest delay incurred is when wanting to transfer semi urgent cases to tertiary center such as [location redacted], either directly from ED or inpatient. Delays are incurred in requesting interfacility transfer and often require Non Va care due to lack of ”bed availability” at tertiary centers."
"Inpatient volume unpredictable, have to balance protected time for inpateients with maximizing outpatient scheduling"
nuclear stress testing requires appropriate nuclear medicine tech staffing
Tertiary referral centers should be adequately staffed/supported with beds to reasonably accomomdate stable Veterans for transfer to avoid Non VA/fee basis transfer.
As before need adequate beds/supp[ort at other facilities ([location redacted])
bed availability/support
"Stress tests are treated as consults and tracked that way, as opposed to a diagnostic test like radiology. For someone who the primary provider wants to have there CAD followed up with an otherwise ”routine stress test” should not be given the same priority as a more concerning indication. Once a consult is received, it is scheduled in next available slot. Cancellation slots are used to fill unpredicatable urgent consults, or known urgent consults. Limited overbook abilty on short notice due to need for adequate time to schedule on nuclear camera and obtain nuclear isotope"

Need more nurses who can take care of critical patients and CARDIAC CARE beds
Critical care nurse staffing as well as space and proper financial incentive for the doctors.
Nuclear cardiology should be part of Cardiology and not radiology
Need on call nursing/ Tech. team and need to simplify the regulation from pharmacy.
Need ICU/CCU bed managed by efficient cardiac nurses.
Increase nurses and incentive for the physician.
"Need Left ventricular assist device, CSI atherectomy and critical care beds."
Need contract with accepting Hospital.
The other VA is 120 miles away and they do not take any Veteran who Is not a good candidate. Need local CV surgery program.
Need to let Cardiology MD to decide transfer and VA need to pay its bill on timely basis and not delay due to poor office staff.
Bed shortage .
Need bed staffed by critical care nurses and flexible staff to accommodate pt. needs.
Need local CT surgery program and need accountability from existing CT surgery program.
Need technician and need for radiology to interpret locally.
Pt. should be able to go to local hospital or VA should have its own program.
Need to have nursing and tech. support to help in documentation/ clerical work.

Working to increase the avialability of services

"Many VA employees are not hindered by a lack of supervision or incentives. Their satisfaction comes from helping Vet's. If their ability to help Vet''s is blocked at any level for any reason it creates an environment of consternation. Among the greatest road-blocks are access, double-standard care system(on-tour/off-tour), professional collegiality."
If this VA has available beds and the patient is stable there is no delay in transferring the patient.

Simplify HR and Contracting Process
"Reliability of Pager system notification
Maintaining IT support for notification system
Maintaining ER staff knowledge
Enhancing acute ECG evaluation skills"
"OR time
Midlevel support for CT surgery
Recovery/SICU space"
Very limited bed availability for ACS
"HR process delays
Nursing staffing model problems, VA different from all other hospitals"
"Exam room scheduling flexability needed
Midlevel support for Cardiology
Nursing, tech, Clerical support for clinic
Data entry support for documentation"
"OR Time
Midlevel support for CT surgery
SICU postop care space and staff"
"Contracting limitations (supplies)
Number of inpatient beds"

.[potentially identifiable comment redacted] Acute coronary syndrome patients either present to our urgent care unit or are transferred there from other departments in the facility. Once the decision is made that the patient has an acute coronary syndrome, they need to be transferred by ambulance to an inpatient facility. Depending on the urgency of the situation as determined by the Urgent Care physician, the patient is transferred to a local non VA facility or (if very stable) to a VA hospital which is 90 to 120 miles away. Because the VA must pay Medicare rates if admitted to a non VA facility, there is emphasis on trying to admit to a VA facility if deemed safe. If our clinic could work out a financial arrangement with a local inpatient facility, it would alleviate the need to transport long distances patients with potential unstable cardiac conditions."
"All of our STEMI patients are sent by squadto local non VA facilities. We generally notify the receiving emergency room that a STEMI is coming, so they can start preparing"

"ours is urgent care , we do not have ER
we should reduce the time taken to transfer to local Hospital. we should try to reduce the forms we have to fill"
"simplify administrative processes for approval and transfer, we need good echo machine"

The other VA [location redacted]is 2 hrs away hence not applicable. we have to transfer to Local hospitals. the processes takes long time . we have to simply and physicians and nurses need practice .
"we have to increase physicians and nurses in UC or ER or CBOC
administrative processes have to be simplified"
as above simplify the administrative processes
"telehealth for CBOC is imp.
increase qualified physicians and nurses"
"this is same as ACS, simplify administrative processes, telehealth for CBOC"
"increase physicians and nurses , Nurses should help getting local non- va cardiologist and NVCC nurses and other concerned persons on line to physicians who is transferring the veteran"
same more physicians and nurses. good administration

"We need to have more providers at the front lines. Adding adminstrative processes tends to slow the process of taking care of patients. The addition of physician extenders has shown in the private sector to be useful, freeing up the physcians to concentrate on more urgent or complicated patients and issues"

increase in the number of CT Surgeons at our Institution
increase in number of tech''s for non invasive procedures
Our delays for c. cath is due to no weekend coverage
improve night and weekend services
improve weekend and night sevices
improve access to services on Weekends and nights
increase personell and more procedure rooms
increase personel

Need to expedite infrastructure renovations and space
Need to expedite completion of current renovations and acquire additional space for personnel and patients
Need to improve prompt transfer of coronary angiograms from referring site

Nursing shortages/understaffing at VA facilities often result in inability to transfer within VA. Lack of operating room time/surgeons at heart surgery centers result in ability to refer within VA from this facility for heart procedures.
Delays can be result of availability of ambulance service for transfer to PCI capable facility within the community; there is rarely a circumstance for delays due to accepting facility capacity.
Bed availability based on understaffing is the main reason for delays to VA facilities for PCI. As a result almost all ACS patients are referred to the community with little if any delay of transfer.
"rarely, there are delays to community, often related to transfer issues with ambulance service; rarely due to bed availability at the receiving facility."
"Referral to VA facilities from this site is almost nonexistent due to lack of availability for heart surgery procedures within a timely manner. [location redacted], the VISN hub NEVER accepts our patients due to availability or operating times and I cannot recall in my 8+ years at this facility ever having a [location redacted] patient have heart surgery at that center. The other center which has taken [location redacted] patients ([location redacted]VA) now also states no operating times within an acceptable time."
delays may be due to lack of records from referring facility to determine appropriateness of transfer.
True ACS patients who need PCI are not transferred to this hospital as not PCI onsite in [location redacted].

Rarely is a transfer delayed due to bed availability at [location redacted]. Most often these patients require transfer to a PCI capable facility which is often in the community and not VA.
[Location redacted]has been understaffed in Cardiology for 9 years. We are on the cusp of having enough physicians with the recent hiring of a 4th FTEE cardiologist; our other critical limiting factor is physical space in the clinic (exam rooms) to see patients; this is at crisis proportion and creates havoc when multiple specialists are competing for very limited exam room space; often I have cardiology staff to see patient and no rooms to actually see patients.
"Inadequate support staff - providers have to request records;
Inadequate primary care providers - cardiology providers required to complete primary care clinical reminders/teaching/etc during appointments.
Lack of adherence by primary care to existing service agreements for referral to cardilogy that if followed would help facilitate and not hinder delivery of cardiology care.
Chronically overbooked clinics often as much as 200% imposing restrictions for limited time per patient for cardiology evaluation
I cannot emphasize enough the negative impact that these local policies, procedures and deficiencies have on the provision of cardiology care at this facility."

"1. Cath lab RN, (supervisor), cath and EP lab RN as cath lab RN have to cover EP lab, Cath lab Tech
2. 1 Cardiology attending and 2 mid-level (PA/NP) to provide dedicated ER consults and ER advised stress testing for rapid triage of ER patients"
Define time to consult for in- and out-patients clearly in policy documents
"We have been waiting for requested echo tech. echo lab RN, dedicated clerk and MD position for the echo lab. We desperately need more space for the main campus echo lab."
We have been waiting over 4 years to replace frequently damaged cath lab equipment that breaks down along with cath lab RN and tech positions. We have 2 interventionalists taking q24 hours call for over 10 years and need additional FTE.
Multiple Cardiology request for on-site VA based primary CVTS CABG services have been made. Our facility will significantly benefit from VA based dedicated cardiac surgery service.
Need VA based dedicated CVTS surgeons or fee-basis during the transition period working together with university affiliated cardiac surgery team

VISN wide connectivity with interconnected Cardiology PACS is critical in eliminating wait times between VA facilities. Also more specialized fee-basis physicians should be approved and allowed for services that can be provided within existing facilities but are not available just for lack of a specific specialist.
No open beds at our facility to receive patients.
Need more space and providers for timeliness of care. Bed control should be open and available for all to see.
Current clinics are full to capacity without any reserves. More clinic space and mid-level providers are needed. Administrative support is also essential. Need assessments should not be done based on FTEs only but also on what kinds of FTEs are needed and where.
"VAs that we refer to should be electronically linked via intranet so that PACS are accessible to physicians at accepting facilities. This is the number one hold-up and delay causing issue.
Need more availability of fee-basis physicians until VAs are linked and they can see patients referred to them by tele health."
None. Just link the VAs
Contracting and Prosthetics should be on-board

"We are land locked with patient beds. Most delays would be corrected with bed availablity.

We often need to switch patients to make room for another patient from the ED. Many of these patients are identified early in the ED and sent to the community for cardiac catherizations."
We have many ED providers that are not employees. Supervising and setting benchmarks for them is difficult. Hiring a full staff would be what is needed.
"TEchnology has been difficult in getting the interpretations returned. Equipment ”matching”“ with older versions Windows, XP cause delays in the ”handshake” between programs. Very difficult to work with."
It is critical that we have a tiertiary hospital that is responsive to us as a level 1 recently 2 system. When we need to send a critically ill patient we are often waiting 4-6-8 hours for responses. It is critical to have a referral system that works. Incentivize or evaluate the services these hospitals give to us. It is often ”near”“ less than standard conditions that hold us hostage.
Our ER physicians complete evaluations and assements but often battle with who will accept the patients from our facility.
"If central office could incentivize our teirtiary hospitals to take our patients, incorporate customer service reviews perhaps this could change. Our community hospitals are more accepting and easier to deal with. We have many frustrating calls to make with unorganized responses."
Timeliness is key. We are able to give thrombolytics. When we recognize that a patient needs to go out for higher level of care we often are not able to send to VA facilities.
We do not perform these.
We send out these patients with ease and effeciency.
If these delays occur it is usually a room availablity or nurse staffing issue
Room or space is an issue.
We currently have practitioners without essential support staff. They are performing clerical duties. Maximizing their patient time and adding another provider are necessary.
"Limits exist in sharing a nuclear room in radiology. This is a ”growing Pains” situation.
Access would be improved with more scheduled time in radiology."
We run with little to no support for our cardiologists and specialists. The facility is behind the times in structure and function.

"Bed availability is often an issue. The ED services are currently contracted out. While some providers are good, many do not have the basic ability to identify serious cases, or to identify patients in whome a strict time bound protocol needs to be followed. Telehealth need not be a priority, and I am not sure why resources are being diverted to this modality at the expense of the needs of real, tangible ER and workspaces."
"We need more secreterial staff. There is one secretary in all of cardiology. The supervision of services is haphazard. Echo is supervised under respiratory therapy. We would expand clinics, but there are no clinic rooms available. Most patients want to see their provider and are willing to drive long distances. Resources need to be diverted to clinical and support staff rather than to telehealth or multitude of administrators doing little productive work."
Reports do not get transferred to CPRS. We still need to cut and paste it. Unions have undue say in workflow. This should be a clinical decision. Equipment requests are not transparent.
"Cardiology physicians are board certified and willing and eager to read nuclear stress tests, but are not allowed. Need more mid level providers, so that they have defined roles rather than being shunt to areas of greatest need."
There should be ability to read off site EKGs from mobile platforms. Cath lab nurses are nearing retirement. Recruitment and retention is a problem due to poor pay compared to community.
The service chiefs should be involved with personnel decisions. There have been changes in support staff that were not communicated to service chief. This is not an isolated incident.

Bed should be available. All other systems work well.

"Need more inpatient beds, more staffing of nurses. Incentives of management and staff need to be focused on improving throughput. Decreased protections for underperforming employees/dead weight on system."
"We need more night/weekend availability of services, or to make easier the transfer of patients out as needed. Staffing is again a major issue. Management incentives are not sufficiently aligned to provide more services, rather they appear to be to just do as little as the budget allows."
"For coronary angiography, we have minimal delays, but do not have 24/7 hours, and only one shift of two nurses. This is inadequate for the need, and we have to transfer patients out frequently. Need to have several shifts of teams and possibly a second cath lab."
"Need to allow for easier contracting with outside facilities, and easier transfer out for patient care needs."
"Transfers again need to be made easier, contracting process simplified. We need to make 4 calls to transfer someone at this time, and it takes an inordinate amount of time for an acute patient."
"Incentives for VA surgeons are misaligned, to be overly conservative compared with private practice physicians. They should be incentivized to not delay care by asking for more testing. Having alternatives like Fee-Basis has been the only option for some of our patients."
"Need to facilitate payments to outside providers, and expedite transfers."
"Our receiving site cannot see our films or patient records even though they are part of our system. Getting them access to our films/records can be a large source of delay, as the administrative structures/people for this are only there Mon-Fri, and don't respond quickly to requests."
"We have plenty of surgeons on staff at our receiving facility - they are just not incentivized to do more surgeries, and are punished for poor outcomes, so they are very very conservative and this slows patient care."

It would be reasonable to have a MOU of certain cardiology groups in the locality where our clinic is located.
"The voucher process for outpatient care needs to be improved; this is critical, there should be no delays in scheduling patients for cardiac studies/consultations"
We need to be able to offer nuclear stress imaging at our facility; and improve feeing out for studies. Scheduling outpatient cardiac stress tests and consultations needs to be streamlined and much more timely and efficient

"1. Fully implement matrix organization
2. Have a more responsive HR system as the delay in hiring new employees severely hampers our ability to meet the health care needs of our veterans"
1. The critical problem in the ED is the lack of qualified physicians/nurses so that cardiology is notified when an ACS presents
1. The main reason for a delay in the activation of STEMI is the lack of appropriate expertise in the ED physician/nursing staff such that ECGs are often misinterpreted and/or cardiology is not notified in a timely manner.
1. Unfortunately and unacceptably large number of our veterans who need CABG experience delays due to the lack of responsiveness of Columbia where we are obligated to send many of our patients during the ramp-up phase of our cardiac surgery program in St. Louis. We are now sending more patients to non-VA facilities to lower the latency from consult to surgery in these critically-ill patients.
The major source of delay is the availability of beds at [location redacted]VAMC.

The delays in providing care for ACS patients needing to be transferred to JC VAMC from non-VA facilities would be significantly reduced with (1) more available beds; and a better strategy for ”turning-over” our existing beds including stream lining discharge policies/procedures.

"Personnel needs; There should be no delay in hiring echocardiographers
Equipment needs: 1) Echo machines, 2) treadmill machines, 3) echo reading stations
Information technology: Biomed and IT are constantly blaming each other when equipment fails, there should be a clearcut policy and physicians should be not asked to figure out their issues
Central office policies: 1) Tests such as echos, treadmills etc should be ordered as tests and not as consults"
Need for second cardiac cathlab and need to develop overtime options for nurses and techs and hire enough staffing
Communication between non VA facility and VA is sometimes the cause of delay
"Physicians should be given incentives for starting new programs.
Development of a second cardiac cath lab and more lab time for cardiology section is paramount in developing the program and preventing delay in PCI"
Cathlab equipment maintenance should be done after hours. Here the cathlab is routinely requested to stop functioning to do maintenance work or to fix something on regular days rather than weekend or after hours as in private sector

EDIS is still glitch. Improvement there would help flow management. Would be helpful to have more discretion and funds to reward and retain high performers.
"Improve EDIS board functioning, reliability, ease of use."
"Need more funds to recruit, reward, retain key personnel - techs and MDs."
"We need another cath lab and more dollars to recruit, reward, and retain cardiologists, cath lab nurses, X-ray techs"

Only reason for delay is no available bed at our facility.

follow recommendations of specialists for referral
same as prior question
robust transfer process and agreements
case management and coordination of care processes.

Decrease dependency on fee-basis ED physicians and move toward ED certified physicians
Need additional sonographer and upgrade equipment
Need more ED certified physicians (less dependence on fee basis
Having dedicated cardiology beds (CCU or cardiac unit)
Need dedicated CCU beds with appropriate staffing
Would like on-site CT surgery program
More assistance from health tech on hospital wards

better scheduling

"Independent practioners-Physicians
Other personneol-Nursing
Information technology- Allow CPRS to implement changs recommended by clinicians that improve pt care

Improve personnel supervison in ER- need better RN, MD supervison of triage staff. This can be an important point of delay when pts symptoms , especially chest pain,
are under-appreciated."
"More physicians in ER to identify the ACS pt with atypical symptoms that a triage RN might miss
More RN staff to focus on the CAS pt
The problem with CPRS is that there are so many mandatory templates that the critical H&P information seems to be under-appreciated
Central office policies need to focus on the promt recognition and triage of ACS pts in the ER. It sometimes seems like once the troponin level is drawn less attention is paid until the troponin comes back elevated.
Need better supervison of triage RN"
"More ER physicians
More ER RN''s
Better supervison of ER traige personnel"
"More echo exam rooms
More echo techs
Scheduling system for oupt Echos is cumbersome this indirectly slows down the accessibility for inpt Echos
Need adequate support personnel for scheduling Echos
Administrative processes for fee basis and contracted care desperately need simplification. There seems to be no coherent central VA policy on regionalizing
acute ACS care"
"Adequate salary competitive with private practice interventionalists and on-call compensation
Need more cath lab RN''s
Simplify administrative processes
Need funding to allow for acth lab RN and technicians to be on call for emergency cases on nights and weekends"
Cardiology APRN''s play a critical role in in expediting pts urgently./emergently needing transfer to non-VA facility for PCI
On-site availability of cath lab on nights and weekends is most imporatant factor id reducing delys in primary PCI for STEMI
"Need appropriate incentives for VA funded interventional cardiologists to be vaailable for emergency PCI on nights and weekends
Initiate on-site cardiac surgery at our VA
Have to have RNs and cath lab technicians availble on nights and weekends"
Need faster contracted amulance resonse
Adequate cath lab RN and technician staffing
Have had problems at times with copying coronary angiography cine done on-site to non-VA interventional cardiologists
Need to havd availability for immediate copying th coronary angiography done on-sit to receiving non-VA CV surgeons
"Need more outpt clinic space for cardiology outpts post ACS to be seen
Need mor cardiologists and carddiac APRN''s
 Having the business office responsible for scheduling outpt cardiology clinic appointments rather than employees of the department of medicine is unacceptable as it is currently organized
" Central office should abandon the use of the business office employees for scheduling cardiology clinic appointments"

"Pt transportation to another VA for elective CABG is currently a major problem. There is currenlty no regularly scheduled transportation transportation for our elective CAG pts to VA hospitals in our VISN who accept our pts for surgery
There should be uniformity among all VA hospitals on which elective CABG pt can be fee based to a local non-va facility (including university hospitals connected by a walk-way) versus having to travel many hours and miles. Also there seems to be no incentive for a VA to accept elective CABG pts from another VA. Our experience is that the cardiologists and surgeons are happy to take our pts but medical center administraors say no. There needs to be a cntral VA policy."

a modest increase (5-10%) in the number of telemetry beds and additional staff to observe patients in a step down unit may alleviate the ocasional shortage of telemetry beds
Timely PCI for STEMI during WHEN hours for thrombolytic ineligible patients would require a plan for transfer from ED to a 24/7 STEMI center
Lack of CCU beds and reluctance to transfer patients on weekends due to concern over LOS leads to some delay
Opening up step down beds and making cath/PCI available on weekends for stable ACS patients would decrease these delays
"minor inefficiencies in the system have little impact on ACS care, but patient difficulties woth travel to our facility lead to a significant no sahow rate for clinic appointments and procedures (10-15%)"

"More nursing staff needed. Increase the number of technicians to support after-hours/weekend non-invasive imaging, with increase in specialty staff needed to handle higher volume. Support upgrading of existing digital imaging infrastructure. MORE BIOMED AND INFO-TECH(IT) STAFF NEEDED FOR ASSISTANCE WITH COMPUTERIZED MED. DEVICES & INFRASTRUCTURE (more incentive pay to retain staff). Increase the number of beds that can be opened in the facility; policy change."
"More nursing staff needed. Increase the number of technicians to support after-hours/weekend non-invasive imaging, with increase in specialty staff needed to handle higher volume. Support upgrading of existing digital imaging infrastructure. MORE BIOMED AND INFO-TECH(IT) STAFF NEEDED FOR ASSISTANCE WITH COMPUTERIZED MED. DEVICES & INFRASTRUCTURE (more incentive pay to retain staff). Increase the number of beds that can be opened in the facility; policy change."
"Increase the number of echo technicians, and Echo Lab Attending''s needed to handle higher volume. MUST have more space available for performing exams, currently no additional rooms availability in the facility. Support upgrading of existing digital imaging infrastructure. MORE BIOMED AND INFO-TECH(IT) STAFF NEEDED FOR ASSISTANCE WITH COMPUTERIZED MED. DEVICES & INFRASTRUCTURE (more incentive pay to retain staff)."
"Comments are only applicable for after-hours/weekend coverage. Cath Lab Attending, Nursing and tech staffing locations/housing do not allow for efficient after hour/weekend coverage of ACS/acute MI interventions. In general the close proximity of a non-VA facility with in-house call of cath lab personnel, allows for <=90min door to cath/balloon time for ACS/MI patients. The limiting factor is transportation service."
Improvement in efficiency and staffing of outside transfer service used.
"Delays can occur due to co-morbidities of patients, often requiring an optimization of medical management before surgery. Medical support services are available to address these issues. Increase in Anesthesia staffing and supporting service is needed."
"Increased social worker or AOD coverage for negotiating the transfer process. On weekends and after-hours an AOD covers for the social worker, in addition their standard duties."

"Lack of available beds lead to placement of facility on temporary bypass status, at times delaying transfers. Opening more beds for use (policy issue), would be important, as is increasing number of nurses, specialty staff and ancillary staff. Resolution of some staffing issues are in progress."
"The progressive increase in patient volumes has not been previously matched with the need for an increase in specialty staff, clerical staff, nursing staff and exam room availability. The Cardiology Service Line Agreement needs to be followed by practitioners, to reduce the number of inappropriate consults and to increase the efficiency of handling clinic requests. The current clinic model in undergoing a Systems Re-design. However the concerns of specialty staff, clerical staff and nursing staff needs a better way of being address by administrative personnel."

"1. Need more space in the ED - always cramped/ on internal diversion
2. Need more hospital beds to transfer patients out of the ED"
need more beds in the hospital to decompress the ER. We are always on internal diversion.
Never happens - we are ALWAYS full

The two main factors that contribute to delays in Veterans obtaining echos as our facility are personnel and equipment. We need to hire a cardiology tech and we need another standard echo machine.
"We need to hire a cardiology tech. If we have this person in place, we could begin nuclear stress testing at one of our CBOCs."
We do not manage ACS patients here at this facility. We have an agreement with the local Air Force Hospital that accepts all of our ACS patients that present to the ED or that need transferring from the inpatient units. To my knowledge there have been no delays in getting these Veterans transferred from our facility to the Air Force Hospital for ACS management.
We need additional nursing support in our Cardiology clinics. Providers spent many hours taking vitals and calling patients with lab and diagnostic test results.

Surge staffing for nursing when inpatients are being held in the ED. Develop alternative temporary bed location for inpatient admission holds. Could agency nursing staff be utilized during periods of high bed occupance. Specific discharge directive specifying early discharges and rules to expidite discharge planning. Increase nuclear med ECHO and stress testing on weekends and holidays.

Need more RNs on telemetry-capable units to fully staff all available beds. Lack of nursing staff delays throughput of patients.
Lack of appropriately skilled nursing staff limits the number of truly available beds on telemetry floors - this is vital. Also needed - more beds in progressive care unit for ACS patients.
Need incentives for leadership that are based on number of veterans being sent to outside hospitals due to unavailable beds due to lack of skilled RNs. Need more RNs to fully staff beds.
Need LIPs to conduct nuclear stress testing
"Need 1) Early recognition of STEMI by ED clinicians and 2) consistent, effective activation of Cath Lab by administrative staff without delay"
Need administrative staff to be adequately incentivized (and supervised) to activate Cath Lab in a timely manner when STEMI patient presents to ED
Need additional cardiologists and nurses to staff additional clinic sessions
Need additional LIP and technician staff to increase availability of nuclear stress testing
Too much administrative burden on physicians including mandatory training that reduces availability for patient care.

"Patients with chest pain should be evaluated in local ER and service should be provided (paid for) by the VA. If patient requires admission, cath, etc stabilize and transfer to the VA. Currently services outside the VA are not paid for unless patient is service connected. This means many patients attempted to drive long distances (hours) to a VAMC for ACS. The result is substantial delay in treatment of ACS"
Out of date equipment (nuclear camera) unnecessary danger in some areas
Need new nuclear cameras to facilitate evaluation of patients. New cameras use less radiation for each test and require less acquisition time.

- **Colon Cancer**

national clinical reminder
our nurses double check the labs

"Electronic Reminders-Pop Ups
However if patient is not seen it may go unrecognized."
We are not offering screening colonoscopies for Average risk patients.
"b-More Endo-Teams needed
c-more schedulers needed
d- more scopes needed
g-consent and starting iv's
k-talk to people involved in these procedures"

clinic reminders to all PCC''s for pt's 50 and older for screening colonoscopy

clinical reminders in primary care
less than 30 days
less than 30 days
as early as indicated
more providers with support staff and better workflow solutions

A GI case manager is in charge of this process
A FOBT positive is picked up by the case mannager
"Better salaries for GI physicians, to recruit to VA."

"In the past 6 months , a process of electronic referral and call back for repeat colonoscopy (?surveillance colonoscopy?)after colonoscopy, done at this VA, is + for colon adenoma or colorectal cancer, has been reestablished here by the Chief of Medicine in conjunction with his GI providers and support staff ."
"All + FOBT areidentified /captured by the lab and routed to the GI providers by secure e-mail weekly, in addition to the automatic alert which is generated and sent to the ordering provider (usually PCM) though CPRS."
Wait time for routine screening or surveillance colonosocpy is 42 days (6 weeks).
up to 42 days for asymptomatic patients
FOBT + wait time is 30 days or less.
Depends upon acuity of labs results and associated signs and /or symptoms. Can be as little as 1 day and as long and 42 days.
1-42 days. Patients are triaged according to clincal assessment of severity of disease. Can be as quickly as 1 day (inpatient) or as great as 42 days.

yearly fobt
lab contacts provider for every positive fobt

Clinical Reminders section of Med Record

"Need more nursing support, technician support, anesthesia services. Additional physician positions in addition to the nursing and technician support would enable a greater number of procedures to be

done. We would also need a manager that reports to the physician endoscopy unit manager to facilitate patient flow and to oversee patient scheduling and coordination of services with patient transportation or housing in order to recover those patients that receive sedation."

Reminders are implemented in the Clinical reminder pane. They are initiated by age (automatically at age 50) or by procedure as clinically appropriate.
Dependent on the symptoms/ indications. Urgent cases may be completed in less than 2 days.
"Increasing personnel: physicians/LIP, nurses & techs. Availability of equipment: colonscopes, vital sign monitors. Ensure guidelines/timeframes from Central Office are supported by best available medical evidence."

"I only see pt. w/ Dx colon cancer , I do not screen them ."
We see both IDA and Colon Ca

"When patient turn 50, at the primary care visit."
Hospital encourage FOBT testing over screening colonoscopy.
"VA need to come up with competitive, less complicated ways to hire gastroenterologist. Our VA is struggling to hire a gastroenterologist replacement for last 2 yrs. Hiring process is very much dependent upon local administration perception of market. There is more top down approach, when it comes to implementing work process in individual department, which leaves staff with a feeling that they do not have much say in the process thus no buy in from stake holder, passive behavior and eventually loss of personal."
Close coordination and follow up of patients who are send out on fee basis

clinical reminders via CPRS to primary care PACT teams
"Desperately needed - GI physicians and endoscopy nursing personnel;
Badly needed - more endoscopy rooms"
"GI physicians doing administrative work, including mandatory training that interferes with clinical availability"

Colon cancer screening reminder triggered at age of 50 and every 10 years. There is also a Repeat Colonoscopy reminder to trigger for interval colonoscopy procedure

Clinical reminders appear in the clinical reminder section of the CPRS coversheet. Templated charting in CPRS drives the reminders.
We currently send average risk patients to the community via NVCC process. I do not have access to those wait times.
Currently use NVCC process.
"At Dorn we are limited by nursing staffing, tech staffing, and number and configuration of procedure rooms. I am TOLD that the NVCC process results in long delays of care. Our equipment is up-to-date. The implementation of the electronic consent probably costs 4 procedures a day. However, administration is actively trying to improve in these areas."

Yearly
All +FOBTs are detected by GI nurse who follows up with PCC providers.
Available on request
Available on request
Nurse hiring and retention problematic due to noncompetetive grades/salaries and long HR delays.

Most fee basis delays are due to inefficiency and incompetence in Business Office.
Administrative delays are common due to poor functioning of Business Office.
Understaffing of VA administration and support personnel is a pervasive and longstanding VA problem.
A particular need is cancer care coordinators/navigators which is cost effective.

"uncertain, this is usually done by primary care. most that I see are done by colonscoopy"
this is usually not triggered via oncology but rather through primary care
"uncertain, this is via gi"
via gi
via primary care
via primary care
via gi
This is not a physician centric institution. the physicians are viewed as the problem and the solution is ancillary personal. this is backwards. The focus needs to be on physicians and patients.
Again we need qualified physicians. Not folks who can write notes that say to see physician. The bottle neck is that the va seems to feel NPs and PAs are equivalent to physicians
"Qualified colo rectal surgeons, not PAs or refer to Huntsman Cancer institute as many of us have dual priveledges"
We have in SLC the resources to dual with most things either at the VA or HCI. referrals out really not the issue
Administrative stuff is unmanageable and out of control. Secretaries are unable to order labs. Everything is delegated to physicians. as a half time physician I have a 20hr/wk tour but 60 hours of annual training

THe physician puts in forthe reminder but I am not sure what happens next.

Reminders in CPRS
"Limited number of endo rooms, lack of nursing support and delays in replacing equipment are major causes for delays."
Very limited number of surgical oncologists with very restricted operating time due to lack of OR rooms

Triggered based upon age and no code for FIT in the last year or colonoscopy in last 10 yrs
Secondary clinical reminder also in place for positive FIT
Screening for Colon Cancer in average risk patients is typically completed via FIT.

usually see the GI attending first for consult and then the colonoscopy scheduled from there.

Recall reminders that pop up when patients are seen in the primary care clinic. Colon cancer screening reminders pop up yearly.
In the surgery clinic we have a mid level provider who gets all FOBT/FIT + results and reminds PCP''s and other providers if no action is taken. This serves as a back up.

"Automatic physician reminder
OncWatch"

The clinical reminder is activated for all patients over age 50. The nurse will distribute the FIT tests to the patients and assist in compliance. There is also a clinician in each PACT who reviews outstanding tests and contacts those patients. If a FIT test is positive there is a nurse practitioner assigned to this

project to make sure the PCP has entered a request for colonoscopy within a 30 day period of receiving the positive FIT.
An abnormal FIT test alerts the PCP. In addition the lab sends the results of all abnormal FIT tests to a GI Nurse Practitioner who job is to monitor these results and alert any PCP who has not placed the approrpiate GI colonoscopy request within the designated time period.
"It is critically important to hire additional physicians (Gastroenterologists) and nurses - cannot perform procedures without either. We also need additional mid-level providers to assess patients prior to scheduling, monitor FIT testing and screen and triage consults.
Gastroenterologists must receive salaries on par with the community in order to recruit and retain endoscopists. Salaries are too low and there are never significant increases or incentives.
The Central Office policies need to be revised because obviously non-clinicians are making decisions as to how quickly patients need to undergo procedures. The doubling time in the colon is ~5 years therefore the average patient does not need to have a procedure performed within 30 days or even 60 days. In the community patients are getting screened and procedures performed on an elective basis and often the wait times are >30 days. If a cancer is found it didn''t ''develop'' within the 30-60 days waiting period - it was there most likely year(s) prior.
If Veterans are to receive the appropriate care and screening for colorectal cancer they need to have the same resources (up to date equipment, ancillary personnel staffing must be adequate, and skilled nurses and physicians be must available)"
Need to increase the number of GI sureons at our facility. Three of four are leaving at the end of this academic year (June 2015) and certainly because of higher salaries elsewhere or the chance to enter into a productive private practice. This is crucial! There is also the need for more spaces in the surgical schedule and more anesthesiologists and nursing personnnel.
"The oncology section needs to expand - again! They have outgrown a space designed for them ~10 years ago. There is no space for additional patient treatment rooms, physician offices and nursing stations. They also need to consider weekend infusions."
"Radiation Department needs additional skilled providers physicians and nures that will allow them to provide services on weekends, evening times. In addition need to review their equipemt to assure that it meets current standards, etc."

reminders are for primary care they are turned on for all patients 50-75 years of age they are turned off after a colonoscopy for 10 years. They are not adjusted based on path that is up to the PCP or GI to follow. If FOBT is done it will be turned off for a year
a positive FOBT of any kind generated appropriately or inapropriately generates an automatic consult to Gi
Longest wait times are for those patients that need the procedure with the assiatnace of anesthesia-need MAC not just conscious sedation.
"The problem is the patients desired scheduling date is often out further than the available time slots. If a patient needs to be seen we will get them in.
Longest wait times are for those patients that need the procedure with the assiatnace of anesthesia-need MAC not just conscious sedation.-"
"The problem is the patients desired scheduling date is often out further than the available time slots. If "provide updated technollogy
increase space increases endo rooms, need preprocedure area.
our patients do not do well when sent on to the outside need to improve our abilities. This requires, increased admin staff and clnical nurse supprt not just in the nedoscopy room but all physicians especially procedureal physicians need nurses to follow up with patietn labs, etc and to remind and

educate patients regarding their upcoming proceudre appointments otherwise we have an increase in no show and cancellation rates.
Increase avaialbeility of out of OR anesthesia"
"improve OR room and nursing, anesthesia availability
Improve contracting out for specialty surgeries"
"We need more OR space, more nurses, more ICU nurses for the beds that we have and often our neighboring hospitals don''t want to take our patients so we need to improve our resources."
Residents take time but they also do a lot of work that would otherwise have to be done by the attending staff and that would hae a great impact on flow. Additonally most good providers would not work for this system without trainees.

We have an RN assigned to also receive the positive FOBT view alerts to assist.
"We do not perform colonoscopys on station, and they have to be sent either to tertiary site or community. The time can vary from 15 days to 45 days."
"We do not perform colonoscopys on station, and they have to be sent either to tertiary site or community. The time can vary from 15 days to 45 days."
"We do not perform colonoscopys on station, and they have to be sent either to tertiary site or community. The positive FOBT are a priotrity and can occur quickly."
"We do not perform colonoscopys on station, and they have to be sent either to tertiary site or community. Patients with iron deficiency anemia are sent to a higher level of care immediately without delay."
"We do not perform colonoscopys on station, and they have to be sent either to tertiary site or community. Patients with symptoms are sent to a higher level of care immediately without delay."

Unaware of CPRS alerts to remind providers of screening and/or surveillance(follow-up) colonoscopy.
This question would be best answered by a primary care provider.
"<30 days, based on best judgement"

Most of the delays in our institute is for patients that need an anesthesiologist for MAC (monitored anesthesia care) since we have only one day a week that MAC procedures are done. Our wait time for these procedures is over 90 days. We are in critical need of an anethesiologist who is dedicated to GI procedures. These patients cannot be outsourced because they are considered high risk by community gastroenterologists and they don''t accept them for outpatient procedures. Lot of our time is also spent in documentation at VA. My choice program for Veterans essentially does not work because it puts the burden on the patient to make the phone call. Triaging our consults also takes a lot of time for PA and physicians -we do need additional Gi rpoviders in our hospital.
Increase the number of surgeons
"A lot of time is spent by providers in administartive work, triaging consults etc. No training is given to provders to capture work load properly, coding etc. Every few days there is some ”suspense”‘ to be answered within few days or some such VA document to be completed. We have to drop everyhting and answer that."

all pts 50 and above have reminder on for fecal testing turned off for 7 years if have colonoscopy
several checks in place to assure all pos occult tests are tracked
biggest problem is no shows and cancelled by patient too late to move someone in

By PCP; on computer

Available at VA Togus
BY the PCP and GI team

A GI staff member reviews all positive fobt results to ensure speedy referral to GI
"Elective screening exams are scheduled per patient preference sometime during the year after turning age 50. There is wide variability when these exams are scheduled- I would estimate most are completed within 3 months, but is entirely based on patient preference."
"Elective screening exams, including those for asymptomatic high risk patients, are scheduled per patient preference sometime during the year after turning age 50. The clinician seeing the patient does encourage the patient to undergo prompt testing and appointment slots within 30 days are offered. There is wide variability when these exams are scheduled- I would estimate most are completed within 3 months, but is entirely based on patient preference."
All positive FIT patients are offered an endoscopy slot within 14 days. However scheduling is based on patient preference
"Like positive FIT tests, patients with red flag symptoms are offered appointment slots within 14 days. Patients with other less urgent symptoms, like bloating, are offered slots within 30-45 days. Scheduling is per patient preference for the exam"

"Colorectal cancer screening reminders are implmented and also serve as surveillance reminders. Age 50-75, no colonoscopy within last 10 years or colonoscopy is said to be due again for follow up, no FIT/FOBT in past year, no flex sig/CT colonography/ACBE in past 5 years."
We are no longer using FOBT. It has been replaced with FIT.
change in prep for colonoscopy.We still use Go lytely

Triggered annually in health summary. Last colonoscopy performed and date done is present on Veteran''s problem list.
"Our facility needs additional endoscopists. We also have a delay in pre-procedure processing. We also are challenged with standardizing provider output, i.e. benchmarking productivity through all positions."
"Facility was not performing colon surgery until March of 2015. After returning to Intermediate surgical complexity status, we have been able to meet our clinical load in surgery."
We do not provide Radiation therapy locally and use fee-basis providers. The NVCC unit seems to be challenged by the load of all types of consults that they must address. I do not see clinically significant delays because of this.

"There is a standard alert system to the PCP''s for routine 10 year screens. they order these.
Those with polyps or other conditions discovered on colonoscopy have f/u exams ordered by the endoscopist and these are entered into an approved recall system."
"If we cannot see them in our [location redacted] office within 30 days or due to distance they are either fee based out or if appropriate given ”choice”“, predicated on the patient accepting our offer for appointment. Once they are fee based or use choice we have no knowledge if they are seen within 30 days, 50,60,90 etc. This is not tracked as far as I know."

The extensive documentations and requirement for physicians to write all orders regarding return to clinic slows down the procedures. The scheduling and administrative support personnel and their supervisors need to be significantly strengthened.

clinical reminders seem to be based on review of labs and charts for prior screening. Much/most of past CRC screening was out-sourced and this information is often not available so accuracy of the clinical reminders is often flawed
"Need more endoscopists to perform the work with trained, experienced motivated support staff. Primary Care needs education for indications for colonoscopy. Non-VA information needs to be obtained for accuracy in the medical record. IT/CAC support would be great to develop order sets to streamline patient throughput in the endoscopy unit. VA regulations should be reviewed/re-interpreted to assess their usefulness in timely patient care. If the VA is held to the volume of the community, then the same resources and standards need to be considered. There are often too much regulatory pre- and post-procedure processes that delay efficient patient through put in the endoscopy unit."
Additional surgeons will be starting in the next few months. This facility has suffered from the scarcity of trained colorectal surgeons. There are also not enough surgical providers in the local community so some patients need to be sent to other geographic locations; their wait times are based on the resources at those facilities.
More TRAINED surgeons are critical to proper and timely care of our patients. The support personnel (RNs and techs) need to be trained and committed to efficient competent patient care.
Additional experienced physicians/providers would significantly improve patient care with decreased wait times.
"There are too many mandatory regulatory and administrative processes both local and national. Often redundant and cumbersome, sometimes unnecessary documentation. Support staff should be educated, experienced and engaged in performing high-quality efficient patient care"

"After a colonoscopy is completed, the GI provider re-sets the clinical reminder to indicate when colonoscopy is due, i.e. 10yr repeat colonoscopy for repeat screening after a negative colonoscopy in an average risk patient."
"diagnostic colonoscopy for GI bleeding or sudden change in bowel habits, involuntary wt loss or alarm symptoms"
"Currently we need more clerical staff (MSAs), more nurses, techs, and MDs to be able to have all 6 Endscopy procedure rooms at JP VAMC up and running. The Sat colonoscopy clinic worked well in the past. Scheduling package could be modernized and simplified to make it easier for all who use it."

CPRS produces a view alert when the patient turns 50. This is automatically reset if a FIT result is seen for 1 yr. and automatically reset to 10 years if a colonoscopy cpt code is seen. This is modified by the GI section if the colonoscopy found polyps or if the prep was poor.
Every month the lab runs a list of the FIT positive patients and an administrator notifies all primary care providers of any patients that are FIT positive that have not been acted upon.
Urgency is dependent on the findings. Abnormal CT within 2 weeks for example
"We have been blessed with adequate space, close to adequate nursing and technical support, new equipment should be on contract in the next fiscal year. We are short on independent practitioners. Some policies make for less effeciency and consume patient care providers time."
"We have been blessed with a new endoscopy area, endoscopy program, and we will be getting new rental endoscopes in the next fiscal year. We are very short on independent practitioners and to some extent nursing administrative and technical support specifically to our area. Endoscopist can still get significantly more money outside the VA system."
Many of the scheduling and telephone calls to patients that is currently performed by a physician could be performed by a clinical case manager nurse. We have cross trained a number of people in the area to function outside their core responsibilities which has been a great assistence.

Automatic reminders pop up in record when patient comes to PCP
all of the estimates are until the first scheduled date. patients frequently reschedule or request dates farther in the future
varies 14- 45 days ie decreasing hgb and IDA are done sooner whereas IDA and minimal stable anemia may wait upto 45 days
"wait time depends on clinical urgency ie brb with dropping hgb are done w/in 15- days, brb with stable hgb w.in 30-45 days"
"increased MD,RN, LPN and clerical support are crucial, increased Anesthesia support it is needed, At present space and equipment are adequate, the addition of a clinically indicated date has been a help"

"Under cliinical reminders, triggered by age for screening between age 50-75"
FOBT list is printed and addressed with daily pending consult list by GI NPs
Estimate based on clinical observations
30-60 days depending on the severity and urgency of the individual veteran's situation
It would be helpful to streamline the amount of computer clicks that are needed to process a consult for colonoscoy surveillance/screening. Pharmacist in the GI setting would be helpful. An additional NP to provide increased clinic availability.
A big issue is patient no-shows.

Reminder protocols are based on recorded chart findings using age and past screening results.
Abnormal FOBTs are also built into reminder logic.
<;30 days
"<30 days.
Can be triaged to lower number based on medical need."
"<30 days.

Occult blood testing clinical reminders on CPRS cover sheet
It is easy to overlook abnl lab results if they are mixed in with literally hundreds of other abnormal lab results.
If patient has more than one indicator of colon cancer risk patients can sometimes be overbooked if efforts are made.
Need more endoscopy techs to allow more endoscopies per day. Working on a reduced schedule.

Please contact [name redacted] if you have quesitons about reminders in VISN [location redacted].
"However, a staff member actively follows up on all positve tests to be sure they are acted on"
"It takes longer to do the paper work than perform the procedure and MOST of the paper work is not value added. GI procedures are treated like SURGERIES (e.g. special purpose wrist bands, time outs, "gurney consent" etc) Now we are required to put estimated blood loss in our reports. Leadership should realize that GI procedures should not be considered OPERATIVE procedures and the rules/regs should be reaxed"

"FOBT every year, Colonoscopy every 10 years, flexible sigmoidoscopy avery 5 years. Triggered when no longer applicable."
"Triaged by GI, screening intervals of 10 years"
"Triaged by GI, screening intervals 2- 5 years."
"Triaged by GI, sooner if other symptoms."
Triaged by GI for urgency
Urgency determined by GI provider

"VA target of 85% for CRC screening is much higher than achieved the community. Some FOBT are not indicated for patients with co-morbidities and resources not available for such ambitious program. CPRS and inflexibility of interphase between EMR and non-VA endoscopy report system leads to many inefficiencies such as recall and scheduling."
Cancer coordinator/ navigator will help thorough follow-up.
Cancer coordinator will be of help for follow-up. VA processes are cumbersome.
"VA rules /regulation are cumbersome barriers (e.g. fee service paperwork, consent process, CPRS interphase) that further compound insufficient staff."

Lab completes positive obt provider notice note and adds PCP as additional signer to the note
Vast majority of our diagnostic colonoscopies are referred to Buffalo or Syracuse VA as we do not provide the service on site. [Location redacted]monitor the 30 day mark for completion of the study.
Vast majority of our diagnostic colonoscopies are referred to [location redacted]VA as we do not provide the service on site. [Location redacted] monitor the 30 day mark for completion of the study.
Vast majority of our diagnostic colonoscopies are referred to [location redacted] VA as we do not provide the service on site. [Location redacted] monitor the 30 day mark for completion of the study.
chemo and radiation usually require a regular cycle of treatment - for various reasons it is difficult for patients to attend a treatment center that is far from home.

implemented on all patients yearly as part of the standard clinical reminders process
we currently have an efficient system to route patients through colon cancer screening processes

"In Primary care clinic the reminder is automatically turned on at age 50 to start screening. Once a patient undergoes colonscopy, depending on findings and path a recommendation for surveillance colonoscopy is generated. The remined for f/u colonoscopy is activated in CPRS by the nurse navigator who writes the endoscopy follow up report to the patient. The pateitn is also informed about the recommended f/u."
colonoscopy completed within 60 days of request
within 59 days from the date FOBT was found to be positive
these are reviewed by the physician to see if they have had any w/u in past and if so what would be the next best w/u. If no endscopies have been done in past usual wait time can vary from 2 weeks to one month.
these are reviewed by the physician to see if and what w/u has been done and what would be the next best w/u. If no endscopies have been done in past usual wait time can vary from same week (for eg Hematochezia) to one month (vague abd pain).

This is managed by the primary care providers and not the GI-endoscopy providers
"Again, this would be best answered by PCP, but my answer is my best impression."
consent process could be improved with greater flexibility

Reminder is triggered to the Primary Care Provider for average risk patients with the appropriate age characteristics
"8b:physicians and nurse practitioners
8c: registered nurses and clerical staff
8H: improve pay and incentive"
Unclear what their needs are at other VA health care system

Test handed out at CBOCs - sent to parent for lab there

Reminder used that asks for dates/ results and recommended interval for screening
"We do not have GI onsite
All abnormal labs are a mandatory alert
Clinicians receive many alerts - making it easier to miss something"
Clinicians here can speak with surgeons - only discipline doing scopes - if need to expedite something
"Space is adequate for demand. Have no GI - rural site - surgeons do all scopes.
HR support for prompt hiring would be helpful - fee basis/ hard to find providers -remote location and VA reimbursement is low and often paid late"
I cannot assess why the larger VA we refer to cannot accommodate referrals
This is a small rural/remote community - limited services
"Chronic issues with outdated VISTA scheduling
CPRS - has resulted in excessive reminder use"

"Reminders are implemented, however, all providers are not consistently utilizing them"
"Timeframe depends on the reason for the visit. If we cannot see patients within guideline timeframes (ex. BRBPR in 30 days), they are sent via Non VA Care"
"Timeframe is dependent upon whether we can see the patient within timeframe guidelines, or if we send them to Non VA Care"
"Currently, FOBT positive patients are not automatically referred to GI, unsure of wait time"
"Many of our patients are outsourced due to inability to see patients within prescribed timeframes, timeframes vary between providers"
"Many of our patients are outsourced due to inability to see patients within prescribed timeframes, timeframes vary between providers"
"The majority of our patients are sent through Non VA Care, due to low number of providers available, and not enough nursing staff. Increasing physicians and staff would also generate the need for more space. Increasing providers, staff and patient load would require an increase in equipment (scopes, towers, procedure rooms, etc.) Since the majority of our GI patients are sent through Non VA Care, many have wait times for procedures, which we have no control over. The BIGGEST problem with Non VA Care is that the facilities that do the procedures typically do not send the patient records back to the facility as they are supposed to do according to the authorization letter. This is one of the biggest reasons that we have so many consults that are not complete, even if the procedure has been done. There is a significant lack of timely document return in the community. Lots of time is spent requesting and re-requesting patient records. For the patients that are seen at the facility, their appointments are made promptly and consult processing is very timely."
Increasing the hours that a wide range of radiologic services are provided could be helpful.
"Elective/outpatient surgery is very high volume at this facility. Inpatient beds are limited, esp. ICU beds. Weekend outpatient surgery might be a viable option."
"Unfortunately, we don't have control over what the Non VA providers do. As long as consults are submitted and processed by Non VA Care in a timely manner, authorized for payment and scheduled, that is all we can "control"

CRC screening reminders are managed (turned on and off) through the primary care clinics an appropriate screening exam has been completed
"MAJOR issue is the volume of consults directed to the GI service by primary care. A large portion of these consults are incomplete (not enough provided information to triage the consult well), duplicates (consults for established patients; 2 or more consults entered around the same time for the same issue) or inaccurate/inappropriate (e.g. colonoscopy requested for a patient who just had a normal colonoscopy). It still takes man power to review all of these consults and focus our efforts to address

the relevant consults, but need to wade through all of the entered requests to do this. Also, consult to GI for colonoscopy for a positive FIT is often not entered in a timely manner, so time to colonoscopy is delayed."
More reliable scheduling system with reminders and follow up calls to patients would be important.

Clinical reminder triggered yearly
We have had gastroenterology positions posted for 5 years; unable to fill due to inability to match community pay

patient reaches age 50
MORE PROVIDERS

Based on patient demographics or prior endoscopy results.
Rules governing moderate sedation require such extensive documentation and chart auditing that we lose capacity to care for patients.
VA pay tables for oncologists are not competitive with community rates. This makes recruiting staff oncologists a challenge.
We generally send these patients to a tertiary VA or into the community.

"Clinical reminder in place when diagnosis code of colon cancer, colon polyps, or family history of colon cancer are entered into problem list for every five years. Otherwise, a reminder of every ten years."
less than 90 days
30-60 days
30 days or less
30-90 days
less than 60 days
Worling to increase the availability of services

"1) Reminder Cohort: Meets age 50 to 75 without Risk Factors with patients over age 75 being assessed if screening is applicable. If applicable, providers are able to turn the reminders off completely Screening, Diagnostic, and Surveillance “not applicable.” Resolution: FOBT (every year), Flexsig (every 5 years), FOBT (every year) and Flexsig (every 5 years), DCBE (every 5 years, prior to 10/1/10), CT Colonography (every 5 years), Colonoscopy (every 10 years)
2) Reminder Cohort: Meets age 40 and older with Risk factors (must meet one of the following): Family history of colon cancer, Family history of familial polyposis coli, History of Ovarian or Uterine Cancer. Diagnostic and Surveillance reminders “not applicable;” Resolution: Colonoscopy (every 5 years)"

"Clinical Reminder, Set Age 50-75, turned off when FIT negative x 1 year, colonoscopy x 3-10 years based on results, flex sig x 5 years, BE x 5 years"
GI follows up any +FIT or FOBT that has not been acted on by the ordering provider w/in 2 weeks of test result
High risk patients are usually scoped w/in 30 days
Patients w/ Iron Defic. Anemia are usually scoped w/in 30 day
"Important to understand the clinical meaningful timing for specific indications and not lump all indications together. National standards should be upheld for high risk patients, recognizing that screening for average low risk patients can safely be delayed many many days."
Ability to start and deliver chemotherapy to outpatients over the weekend. Increase provider FTE when needed both at main facility and referring facilities.

"Colon cancer screening reminder pops up for Veterans age 50 and over per USPSTF guidelines/recommendations for colorectal cancer screening when Veterans see their PACT team. When Veterans complete endoscopic procedures, GI results notes link with future reminders so CPRS users including PACT teamlet are aware when procedure is recommended to be performed again."
40 days average wait time for low or average risk colorectal screening. Sometimes patients have a specific preference for day of week or beginning/end of month when they have driver or can clear their work schedule. When this preference is accommodated sometimes that makes the wait time shorter (i.e. we have had a cancellation that we can schedule them into) or it makes the wait time longer because we are honoring their request.
25 days average wait time for higher risk risk colorectal screening or for patients with IBD. Sometimes patients have a specific preference for day of week or beginning/end of month when they have driver or can clear their work schedule. When this preference is accommodated sometimes that makes the wait time shorter (i.e. we have had a cancellation that we can schedule them into) or it makes the wait time longer because we are honoring their request.
25 days average wait time for +FIT. Per our policy these should have procedure performed within 60 days and we work to schedule them this way. Sometimes patients have a specific preference for day of week or beginning/end of month when they have driver or can clear their work schedule. When this preference is accommodated sometimes that makes the wait time shorter (i.e. we have had a cancellation that we can schedule them into) or it makes the wait time longer because we are honoring their request.
30 days average wait time for patients with IDA as traditionally this requires a double procedure i.e. EGD and colonoscopy. Sometimes patients have a specific preference for day of week or beginning/end of month when they have driver or can clear their work schedule. When this preference is accommodated sometimes that makes the wait time shorter (i.e. we have had a cancellation that we can schedule them into) or it makes the wait time longer because we are honoring their request.
"Scheduling urgency (or not) depends on the patient's symptoms or clinical indication. Some symptoms are more of a red flag which triggers providers to request a procedure in 1 week, 2 weeks, 3 weeks or perhaps routinely with notation that patient can safely wait up to 3 months to complete study."
"More clerical staff are needed now that we have moved to live scheduling or negotiated appts for all consults. This is very time intensive. We also need more nursing staff to answer patient questions pre-procedure since our patients come in on day of study. We need expansion of physical exam to interview patients pre-procedure. We need a 3:1 bed ratio between procedure suites and pre and post-procedure recovery space. This requires more patient monitoring equipment and stretchers, stretchers bays or spaces."
"Solid service-level consult review and management DAILY by either MD''s, PA''s or ARNPs so that urgent consults coming in are seen and triaged immediately. This reviewer would have a good working relationship with clerical or RN navigator staff who could contact pt right away to negotiate appt. This handoff and communication should all be documented in CPRS. More CT scan machines and use of after hours and weekends would reduce wait times for these important staging scans which then assist the specialty care provider on best plan of action. if patient cannot travel here for care, simplified referral process for community based care would be appreciated and have this process be as transparent as possible so all providers know when and where this Veteran was seen and what the plan is."
"Increased CT scanners required more radiology staff to read studies, requires more clerical support to call and schedule patients for studies. Would require more Xray staff to walk patients through the scanning appt. Timely electronic notification to ordering provider requiring electronic signature not just a VA viewer alert would be the best way to communicate results."

The clinic nurses often place the order when alert comes up that patient needs screening. More education needs to take place with the nurses re: when screening is and is not indicated per the standards. This would improve patient's quality of care by not putting them at increased risk such as FIT testing a patient 75-80 or older(not recommended due to increased risk of perforation.
Clinical reminders are used. When they show up PCP and PACT teams give out the FIT test kit with instructions
FOBT results inputted into tracking tool and I call the patient if PCP has not already to initiate the consult to endoscopy clinic. Sometimes the PCP will beat me to it and place the consult at which time the consult is answered by a provider and MAS contacts the patient for earliest possible appt.
We do have a problem with managing medically complicated patients here but non-VA resources are financially limiting and IFC is denied due to work load. Is appropriation of funds directly proportionate to the geographical population of veterans ? Might consider.
More practitioners and support staff as well as resources will improve our ability deliver more efficient services. Right now we are SO low on PCP''s that consults for specialty services are down. Active recruiting/ incentives for good quality staff important. Look at the workload and day to day tasks placed on PCP''s. Limited 30 minute time slot for H&P''s is inadequate for providers to access and manage complicated patients but we have been forced to work at that level to increase access to veterans. More NP are not being hired due to the inability to manage pain with narcotics.
We are not provided any time to do mandatory educational training required by the hospital/VA system.

Provider receives a reminder and responds.
We get in any high risk patient.
We are in critical need of GI physicians. We are in a rural community and salary has been a concern.
"CPRS is difficult, often redundant in tasks.
One or two no show in procedures out 40 cases. Not enough support staff, walking patients takes half of the scheduled appointment time."

CRC clinical reminder is triggered for age >50 once a year if FIT testing only. If colonoscopy is completed it triggers every 10 years.
"To avoid any patients slipping through the cracks, we established an interdisciplinary team GI and Primary care running positive FIT testing report regularly and monitor scheduling proactively of the colonoscopy within 60 days of the positive FIT test result. This team reports quarterly to the ECMS."
Within 60 days of the positive FIT
"We have been successful in decreasing wait times significantly by hiring additional GI physician and APNs, nurse coordinator, as well as more RNs and techs.
The vista scheduling package overall need a major overhaul due to inflexibility and being very cumbersome for the clerks. This also applies to the consult package especially since we use Endoworks for colonoscopy reports which does not automatically close the consult as it creates a report in vista imaging instead.
We have a minor project approved to remodel the GI lab and increase number and size of operational exam rooms and efficient recovery room flow."

"Colorectal Cancer Screening
Cohort: Target Group: All veterans 51 to 75 years of age.
Exclusions""
Life expectancy <6 months
Diagnosis of Colorectal cancer
Total colectomy

”Veterans who only receive Behavioral Health Care in the VHA with explicit documentation of refusal of VHA Primary Care and that primary care is received in a non-VHA setting*
*This exclusion is an identified variance from HEDIS.”
Indicator Statement: Percentage of patients who have received appropriate colorectal cancer screening

Numerator: Patients receiving appropriate colorectal cancer screening

Denominator: Patients 51-75 years old at the time of the qualifying visit
Technical Description:
This reminder is triggered annually for all veterans aged 51 to 80 years of age.

The reminder is satisfied for one year by the Lab Test Occult Blood X3, which indicates that three FOBT cards have been screened. If less than three cards are submitted, if one is positive, it is accepted as adequate for the screen.

The reminder is satisfied for five years by entry of one of the codes contained in the Taxonomy SIGMOIDOSCOPY; or for ten years by the entry of one of the codes contained in the Taxonomy COLONOSCOPY; or for one year by indicating FOBT was done elsewhere; or five years by indicating sigmoidoscopy was done elsewhere; or for 10 years by indicating colonoscopy was done elsewhere. Progress note must contain date and results of tests done at another facility."
We have a PA who tracks with lab all +iFOBTs in the system to ensure completed in 60 days.
Using our MR dashboard for all of the 321 stop code wait time. Unable to drill down past 321 stop code into procedure types.
"Less than 30 days.

"primary care is very aggressive in obtaining FIT for all veterans, often overly aggressive"
Nurse leader who reviews all positive FIT testing and insures that alerts are followed up for scheduling
"not routinely used, some patients will specifically request screening by colonoscopy and we attempt to accommodate as soon as openings available"
within that time unless the patient requests another date
variable based on when consult is received and if true iron deficiency is present
"individualized, but usually within 60 days, sometimes slower if special needs exist such as a requirement for anesthesia to deliver sedation or admission for concurrent medical problems"
"we are in the process of hiring adequate GI MD, endoscopy RNs are very important as are well trained GI Techs- it could be helpful in retention if they could be recognized for expertise by becoming certified endoscopy nurses (supported by VA). We are frequently short on schedulers to get patients on the books. CPRS is slow and it is not efficient to use in endoscopy. The time out procedure is not suitable for endoscopy- you must enter why you did not SIGN THE OPERATIVE SITE!"
critically short on General and abdominal surgeons and we are losing our best surgeon to another VA
same as prior question- losing our best general surgeon we will be critically short
"Oncology service is good, there are plans for a new oncology infusion suite within the next 3-6 months"
if we could anticipate no shows we could attempt to fill the slots with other patients

These automated reminders are answered by primary care providers.
"Depends on indication. If urgent, a colonoscopy can be performed within days - This is based on the clinical judgement of a physician and not generally limited by resources. If not urgent, then it may be longer."
"Space and personnel are key, but we could do many more procedures with existing structural resources of our processes were more efficient/streamlined. There are major organizational and regulatory (VA-specific) impediments to efficient care. Examples: 1) misaligned incentives between nurses/techs and physicians; 2) High nurse turnover; 3) High regulatory burden (i.e. excessive time out requirements, lack of ability for nonphysician consents, etc) 4) antiquated scheduling system; 5) lack of operational data to guide process improvement. This being said, the patients in the VA are MUCH more complicated then your normal community screening patient, and so non-VA benchmarks don''t apply
Re: equipment - the VA needs a national Endoscopy Report Writer that is standardized across the VA and interfaces seamlessley with CPRS. There is such TREMENDOUS effort spent managing software that it has become a serious burden on our staff and impedes effective care."
"You read my mind; all of these items are critical obstacles to improving access to CRC screening. I would love to see a pilot program within the VA to waive some of these administrative requirements, while assuring patient safety, to improve throughput. Much more could also be done to improve flow of information from primary care to gastroenterology. Some of this is limited by consult system in CPRS."

"Case managers follow on results , once returned to lab"
A GI case manager is in charge of this process
"Increase salaries of GI doctors , so they will come to the VA. They make to much money in the civilian world to work at the VA."
"Again very few radiologist want to work@VA. The radiology dept in my opinion is very inefficient!!!!!"
"More OR space , more good and aggressive
surgeons need it"
"We do not have a RT dept. A facility this size
should consider building one. W/ the money
we pay contract radiation oncologist through the year we could have built one"

"Clinical reminders are implemented by a robust system that alerts primary care that a screening procedure is due. Patients are assigned to be informed of the options by the primary care team or are consulted to the GI department. There, the options are discussed. Appropriate notes are required to be entered documenting these elements. The reminders are turned on or off for varying lengths of time depending on the initial path choosen, IE colonoscopy vs FIT testing. Other options including flexible sigmoidoscopy or CT colonography are rarely choosen but are available."
"As part of the C4 initiative, it was noted that at times positive FOBT tests were not enacted upon in a timely mannor by PCP''s for a variety of reasons. We have for several years now routed all FOBT+ results directly to the GI department, reported on a weekly basis to us. We also directly schedule the patients in the GI department and simultaneously in the endoscopy suite, hopefully within 30 days of the date of positive test. This allows there to be rescheduling still within the 60 day time frame should there be a missed appointment. With this system and very close oversight, we have achieved well over 90% of patients getting colonoscopy within 60 days, including those patients that refuse to have it done in that time frame or refuse completely, taking out the studies that are not done appropriately for screening or if there is a contraindication to the procedure at the time."

"During the past 12 months there has been a large decrease in the wait time. It probably started around 90-120 days to now being 30-45 days. A prior backlog of cases was addressed lasst summer by the access to care initiative, with 900 or so procedures referred out to non-VA care. This, in concert with continued efforts to bolster clinical staff as well as nursing support staff in the endoscopy unit has resulted in the much shorter overall time. In addition, we are seeing patients within the required 30 day interval from time of consult more often. At the present time, we are seeing mocheduling presures as the large access to care has ended. We currently have a policy to treat all patients as FIT + patients and have their procedure within 60 days regardless of the indication. As this is a VA wide standard, it seems to make sense that the 60 day time frame would be appropriate and certainly expedient enough for all patients except those with more sever urgent needs, which would be seen much more emergently (within a day or 2 if needed. This was not present in the years past and we did not have the opportunity to send out patients that we could not see in a timely mannor. In late 2013 I noted on a chart review that patients seen in the clinic in Nov were being scheduled the following April or so. tghis was delt wit hin part as I have describved previously with access to care. In addition, we offered only FIT testing to patients with average risk for a time (as had been discussed with National colorectal program director who approved this based on available rescources), but are now back to offering colonoscopy to everyone that wants it"
"These patients would not be offered fit testing, only colonscopy. Again, the time frame for these patients has improved due to availability. On an individual basis they would be stratified as to the need and required time froam for the procedures. For an example, unless they were a new IBD patient, they would have been actively followed in the clinic and would have been seen well prior to their due date for their procedure, thus insuring that they could be easily scjheduled at the appropriate time."
"While this has probably improved somewhat, these patients for a number of years were always given priority and not placed on access to care as that was actually much slower than having their procedure performed in house"
"This is too diverse a group to give a number as it includes some patients with highly urgent required procedures and others with trivial symtoms that most likley were of benign etiology. The range would be from 1-2days to app 90 days. some of these patients would have been sent to acdess to care and again attempt was made to stratify them as to urgency. However, the fee department was overwhelmed and there was a fair amount of time to get these patients in. Despite attempting to manage and follow these patients, many did not get procedures done on the outside for a variety of reasons and were ultimately brought back to [location redacted] to have them performed . I have not included these patients in my estimate of the scheduling her of 2-60 days. Clearly many of these patients were much longer."
"Many of the items in this area have been addressed in Salisbury over the past several years, and thus the answers reflect where we stand in 2015. For example, renovations have generally been completed to allow for increased space for patient care bot in the clinic and the endoscopy units. There will be 2 CBOCS opening in the next year or so with more than enough capacity space wise to perform endocopies far into the future. The availability of increased staff to perform procedures is, however critical and is an ongoing challange. Since coming to [location redacted] almost 8 years ago, there has been a plan to increase the number of GI physicians to 5. They have been hard to recruit and we have just reached that 5 number within the past 6 months. It is likley that we will lose at least one within the next 3 months. While there are many issues here, the physican that is leaving to go to the private sector notes a general lack of respect for physicians in the VA system, certainly at [location redacted], that she had not noted in the private sector, and I agree with her. In addition, the salary range for GI physicians is still far lower than in the private sector. In addition, despite the increase recently in the salery caps, these increases will only be given to new hires which creates striff within the organization, particularly as I have recently learned that at the 2 year review, it is unlikley that existing staff will be paid at even

the same rate as new staff coming on board. This will mean that the seasoned staff including the department chiefs will be paid less than the ‘‘freshman’’ One additional staff member of mine is thinking of leaving if his salary does not get at least raised to the level of the new hires at his 2 years review. Due to all thes factors, I think it is unlikley that the excellent new facilities will be abe to be adequately staffed for some time. There will need to be additional support staff to man the clinics, IE NP/PA. These have traditionally not been as difficult to hire. The scheduling for procedures at Salisbury has long been hampered by a lack of MSA’’s dedicated to the GI department. There has been an extreme shortage of all MSA’’s here. The ones that have done the GI scheduling have not been assigned exclusively to us, and the result has been that the scheduling had been done very poorly in the past. The current administration has been extremely responsive to the needs of the GI department, the busiest in our VA wit h marked growth, and one of the highest volume endoscopy units in the country. As part of their commitment, a system redesign group was formed. the result was marked increased nursing staff, and the assignment of several dedicated MSA’’s to GI. The results have been stageringly sucessful. However, the MSA’’s are not assigned to clinc, only to procedures. The providers again all feel that these should be more dedicated functions to specific assigned employees. I believe it would also be helpful if the supervision for these employees came from the medicine department. The consenting of patients for procedures is extremely inefficient due to several factors. First, while there are a number of VA’’s that still employ this practice, PA/NP are forbidden from consenting patients here for procedures. This is extremely common practice outside the VA in private sector and as stated in many VA’’s This is a result of VA regulations enacted some years ago that stated the practitioner who consented for the procedure needed to be able to perform the procedure. The authors of this policy were queried, and agreed that if the PA’’s NP’’s assisted with the procedure in some capacity that they would be able to consent for the procedure. Despite the approval for this from the authors of the policy, the General Counsel in this Vison felt that the interpretation did not allow them to consent. The second part of this that has hampered work flow is the requirement that the patient remain in street clothes prior to the consenting process by the clinician. This destroys flow as the patients are not able to be gotten ready for their procedure until the clinician is free from the prior procedure. This policy has been streamlined in various VA’s by the sending out of brochures and other educational materilal, and these VA’’s have been felt to be abiding by the poicy. However, the interpretation has varied from one region to another and this is not allowed here. This entire clothes on consent requirement has had outcries from multiple GI section chiefs including the national VA GI chairman, who points out that this policy was enacted without representation of GI or any surgical groups that are affected. This policy is supposed to be revamped, but that has been markedly delayed. The curent endoworks system employed for documentation has had a good bit of difficulty interfacing with CPRS. There have been a series of breakdowns, and has largely attributed to server malfunction. Periodically reports would not be available for review in the chart, and clinicians would have to go through a very time consumng process of receiving a list of not crossed over cases, and having the procedures copied and scanned into CPRS. Thes images are far from ideal. The current servers are out of date and is a major reason for this. The buying of new ones has been delayed for some time."

"I have no knowledge of other systems to be able to answer this question, and the prior answer was just a guess."

"The non va care department is overwhelmed by the demand created by the new various programs, As in all cases, every effort should be made to streamline paperwork."

"Coordinating patienet care outside the VA can be difficult particularly for veterans that live a great distance, and may not have easy means to get to facilities. The can be difficult for our facility, but even more so when trying to get a Veteran the care needed at various outside places. We have continued to increase oncology resources here, and this will be the best long term solution"

"I have addressed many of these previously. Having more staff to help with administration woul be beneficial. right now a PA is occupying much of her time doing the complex scheduling for all the providers as there is no one else available. The documentation requirements before procedures are of course necessary as required by JCAH. However, there are multiple nursing notes that depend on doctor notes to complete here. We are working on integrating these better for effficiency. Once IT issues arrise, the time required to fix small issues is often excessive. Again, better support here would be beneficial"

>30
Need more personal/clinics in referral sites
Increase providers at referral sites

"While they are available to all currently, we may not be able to cope because of impending departure of one MD in next few weeks. The vacancy is still open without good chances for filling in near future"
Above won''t apply after July 1st due to impending departure of physician and no hiring or locum tenem is on horizon
"The salaries of gastroenterologists are less than half of those in local community. Even our academic affiliate medical school faculty make more. As such, recruitment and retention is a problem. One person has left and another might be retiring in a year. No new recruits are on horizon since we are not competitive financially."
"Unless the VA is competitive financially in a realistic fashion for hiring, things won''t work. National income surveys may not apply to local areas as in our case. In such cases, veterans in those areas may feel the brunt."
"Too many administrative mandatory trainings, meetings, time bound action items on top of limited staff makes people do more than one thing or one patient at a time creating potential for patient safety."

best determined by Primary Care section
handled through Primary Care section
<30 days

all results reviewed by a Nurse practitioner

Reminder becomes active at age 51 until the patient reaches 75 years old. The reminder is managed by primary care providers. The reminder remains active until a screening test is performed and results are available.
Colorectal cancer case manager tracks abnormal tests and coordinates with PCC for timely GI consults and also coordinates appointments for colonoscopies.
If patients does not want to wait for a screening colonoscopy in house are referred to Non-VA care. Access is the community is limited as well
If patients does not want to wait for a screening colonoscopy in house are referred to Non-VA care. Access is the community is limited as well
"Currently we have 3 procedure rooms partly staffed. Even though we have expanded the operation hours from 7 am through 5:30 PM we are unable to cope with the demand. Turnaround time of the procedure rooms is not efficient enough. Besides expediting the down time of the procedure rooms which is currently < 15-20 minutes, we need to increase the number of procedure rooms in order to be able to increase the number of procedures. Furthermore, by changing the concept from GI physician

directed moderate sedation to an anesthesia administered sedation; we would further increase the number of procedures by just decreasing the amount of time spent by the endoscopist in documentation moderate sedation pre, intra and post anesthesia care. It takes >45 minutes documenting all the required notes (i-Med Consent, H & P, pre anesthesia assessment, airway assessment, ASA, post procedure anesthesia assessment, PACU I, PACUII, Medication reconciliation, procedure note, patient instructions, etc.) while the procedure lasts <30 minutes or less. If the sedation is documented by anesthesia then the endoscopist would dedicate this precious time in doing the procedure and writing just the pertinent documentation associated to it. In summary my recommendation is to standardize how we do GI procedures throughout the nation. My recommendations are to perform these procedures in an ambulatory center where anesthesia is responsible for the sedation. Based on our demands for services we would need twice the procedure rooms (6) in order to have the endoscopist move from one procedure rooms to another and have the appropriate number of recovery beds. Each room would need to be staffed by at least 1 GI technician and an anesthetist to monitor the patient while doing the procedure. At least 2 additional gastroenterologists would be required as well. Clerks and support personnel to help decrease the no-show by routine phone calls reminding appointments would be great.
In terms of information technology, IMed is very slow and prone to down time, intra-procedure recording is also somewhat time consuming as are the thousand and one required notes. Furthermore, procedure documentation software should be developed in order or facilitate documentation, abstraction of quality reports and imaging. Current commercial software (EndoWorks by Olympus) will no longer available which will create additional burden in terms of acquiring quality measures data.
As important to mention is that even though there is a national contract for endoscopes, here at [location redacted] we have been unable to lease scopes due to the fact that we live in [location redacted]. It has taken us 3 years to get included in the lease and now we are in the process of updating all our scopes. We will have to wait to determine if we would finally have the new technology on board.
In terms of incentives, GI physicians remain underpaid and underestimated. It is very difficult to recruit GI physicians using VA pay scales. Private sector is by far more attractive to young graduates.
In terms of Non-VA care; to me this is the worst of all possible solutions. Our experience has been that we end up repeating studies due to poor quality of procedures performed resulting in waste of resources and what is worst delay in diagnosis and treatment. Furthermore, community resources are limited and waiting times are even longer that at the VA. While we devote to high quality procedures; we end up offering substandard care in the community due to lack of capacity to cope with the demand."
"Although there are no major delays in surgery, oncology evaluation and chemotherapy there are severe space and staffing constraints in Oncology. Clinic office spaces, chemotherapy unit and staffing are absent, minimal or insufficient to cope with the demand for services. Furthermore, cancer patients lack social worker, nutritionist, PharmD and psychology support which is extremely important when providing patient centric cancer care. Oncology should be treated as a Specialty PACT team. This population is in extreme need for proper multidisciplinary approach. I understand that VACO should enforce and mandate this multidisciplinary patient-centric approach for cancer care through all VA hospitals. Cancer care is not all about chemotherapy and radiotherapy. We must also care for the mind and soul of those that are in need. Oncologists become the primary providers of cancer patients and should be considered as such when distributing resources. In our station we are in need of additional Oncologist also. Those available are extremely productive and dedicated, but they are not enough."
"Additional space and staffing are required to meet Radiation therapy space and staffing gap. Additional radiation Oncologist and dosimetrist would be required. These positions are very difficult to recruit.

Furthermore additional equipment is required. Penidng purchase of new VarianTrueBeam. Non-VA referral fails to provide timely care. Coordination with few Radiation specialists in the community takes time and there are few providers available."

clinical reminders
we provide procedures on weekends and community providers when available

"How - computer generated
When - no colonoscopy or 10 years or previously determined by provider or FOBT in 12 month and age 50"
Need to be award of provider time/opportunity cost in the mandatory TMS training

This portion (clinical reminders) are managed by Primary Care. The reminders are triggered when a patient visits their PCP.

Study ID rYEL75
I am not aware if PCP office has a reminder system in place for colonoscopy

The reminder is triggered if there is not an iFOBT within the past year or a colonscopy listed within the past 10 years
increase pesonnel at the hub facilities for these specialties

Alerts section of the cover sheet if over the age of 50
Depends on actual diagnosis/reason for requesting colonoscopy

Reminder activates when patient is due for screening.
Generally within 60 days.
Generally within 30 days upon receipt of consult.
"Physicians are increasingly being asked to do paper work, answering numerous supsension with short turnaround time is one such example. Get rid of some of these hassles and let providers see patients and take care of them. Stop trying to micromanage the providers and tell them what to do. The more you do that, the less enpowered and engaged they will feel. You need to give physicians a chance to do what you hire them to do. Not in front of the computer keep doing“ “paper work”, filling out documents, attending meetings, developing and revising policy that have no impact on patient care and outcome. I see we are spending time inputing data that are ”required” by policy but have absolute no releverance or impact on patient care and outcome. It often left providers wondering who came up with these metrics. Are they evidence based?"

"The reminder is turned on by primary care provider. The reminder is divided in average risk, all patients above 50 years whom there is no contraindication or high risk for example family history or familial cancer syndromes. The positive occult is flagged to ordering providers through view alert H* which means it cannot be turned off by individual providers."
"The occult blood alert goes back to the ordering clinician to order the colonoscopy.
It is H* therefore cannot be turned off."
Some of those were completed by non-VA contract screening colonoscopies (these data was actually collected data from review of 96 reported records.
"Can’’t access.
To avoid delays they have been sent out on fee - mostly Atlanta Gastroenterology"

To avoid delays they have been sent out on fee - mostly completed by [location redacted] Gastroenterology"
"Increase number of clinic exam rooms, number of procedure room, incentive pay for full time physicians who agree to work overtime and weekends, improve timeliness of process to classify new employees, post position, obtain certificates and time of hiring for Nurse Practitioners, Physician Assistants. Allow those providers to be trained for procedures and match their salaries with community salaries. Incentive pay to match the salary of gastroenterologist who are procedure oriented to match salary with community (if you wait until they have a formal offer letter for retention bonus, it is too late, they accept the outside job). Fee basis is not ideal. The VA patients are not the private sector highest priority and the results are not available timely on the medical record.
The regular referral pattern change and lend to not ideal continuation of care."
"The system is transferring responsibilities previously performed by MSAs to physicians, ex. enter labs before signature order. The insufficient number of exam rooms and procedure rooms slows down the process of clinic appointments. The entering of time by part time physicians is time consuming, screening and management for minor side effects could be done by trained providers, not necessarily the physicians performing the procedures.
Phone call could be returned by qualified RNs so that the physicians can evaluate more patients in clinics.
MSAs or PSAs can call the patient after they leave messages so that the physicians do not call the patients just to find out that they want to reschedule appointments.
Insufficient staff to call patients. A personal call works much better than any automated system."

Primary care alert
less than 60 days.
less than 30 days.

There is a clinical reminders section which states when a colonoscopy or screening for CRCS is due
Need to have more Gastroenterologists to do the screening colonoscopies for average risk and high risk patients. Also need to have the capacity for more beds to prebed and recover patients thereby avoiding slowing down of entire process due to lack of space
Need to have more OR capacity at our facility and need to have more surgeons to do the required surgeries as they appear to be overwhelmed sometimes as there are not enough surgeons .
We do not have a Oncologist at present and there is need for 2 or more oncologists to handle the chemotherapies needed for the patients.
"We do not have Radiation oncology department at our facility at present. They are sent out. Therefore, it may be critical to get the radiation oncology department at our facility along with the required personnel"

I think. It is in our facility as standard of care. I don''t know about other hospitals in the system.
I believe as part of the Primary Care Physician''s electronic reminder ''package'
Patients who have iron deficiency from a cause other than GI blood loss would not necessarily need a GI workup.
"Our GI group is very attentive and has increased their capacity by holding ''scope sessions' on weekends. Because our hospital is running a budget deficit, these extended services are threatened. The patient load is increasing much more rapidly than the increase in resources - both personnel (physicians and nurses) and instruments."
"The evaluation and initial care of patients with any kind of cancer depends on the availability of physicians/nurse practitioners and clinic space. We in Oncology are hampered by both. We have had

no increase in qualified oncologists in the past 6 years (in fact, we';ve lost 'eighths) while, at the same time, the clinical load increases by 5-10% per year. This is not sustainable. We need more qualified practitioners and more clinic time to see patients with newly diagnosed cancer of any kind, including colon cancer, in a timely fashion."
The patient scheduling system is very inefficient. We also have a heavy teaching load in the clinics. The short answer is that we need more trained (qualified care-givers) to be able to see patients in a timely fashion given the restrictions on clinic sizes (room availability).

Colonoscopy in available at the VAMC. FIT tests can be given at the VAMC and CBOCs.
We do not have a wait time for endoscopy.
"We have expanded our operation to provide more endoscopy to eliminate the number of paitents referred to non VA care, but this has not occured with the necessary increase in space, increase in the necessary clinical staff or reduction clinical duties, such as rounding on inpatient medical service."

Any FIT pos results gets processed by the CRC nurse and tracked to completion
days between GI confirming that request is indeed for average risk screening and colonosocpy
"this category excludes any other high risk, such as listed below."
"includes rectal bleeding, wt loss"

The Clinical reminder is in CPRS. It is reset every time a patient does the FIT test or has a colonoscopy.
The primary care receives a phone call as well from the lab as a critical value.
Our goal is 60 days. Depending of local staffing we have mad this goal 40-50% time.
These are made a priority as well But we do not have the staff or the rooms needed to see patients rapidly in the clinic.
"Need more clinic rooms and gastroenterologists. More rooms for the nurses to do patient teaching and schedule.
We can''t attract GI MD''s at this salary"

'

Need better contracting processes. 24 hour staffing and the amount of providers and clinical staff is important to increase services and decrease wait times. Low staffing is affecting the number of rooms that we can run.
Need more oncologists and oncology nursing staff
Need the ability to provide radiation locally. Currently all of the Veterans need to travel to Philadelphia 1 1/2 hours away

'

by primary care in CPRS template note
"Need more GI physicians who can perform endoscopy, outsource fewer in the community (those are the ones with delays, community is slower), add capacity for high risk patients that need MAC (more anesthesia/critical support available), increase flexibility of nursing staff to be able to assist with multiple patient care tasks & coordination"
"Need surgeons, particularly colorectal trained surgeons.
Shorten/streamline process for pre-op clearance by primary care.
Need OR facilities/inpatient facilities available.
Nursing/clerical support to cut down on clerical work done by providers.
Fee basis in community is often slower than in-house services & there is less communication."
"Need more surgeons, particularly specialty.

Need nursing & clerical staff to be able to assist providers so providers are not spending time on clerical work. Rigid service lines prevent nursing from providing care at their full potential.
Decrease the time from equipment request to obtainment/use."
Create policy to decrease time frame from referral to procedure & require reports be sent back within 14 days instead of 30 or more
There are sometimes adequate numbers of clerical staff but they are not working in a useful capacity. Too much rigidity in service lines & perceived institutional policies & not enough teamwork. Very little support staff that works as team members with providers. Centralized scheduling with very little communication with providers. Large/anonymous system atmosphere. Patient population that tends to have transportation & psychosocial issues.

The CPRS reminders are completed at the PCP appointments.
I'm unsure if the FOBT alert is a "mandatory" alert such as a critical value which can''t be turned off.
We complete the procedure within 60 days of the positive result.
"Variable, each consult is screened by the MD and then the timing is determined by the urgency of the symptoms or findings."
"There is a large disparity between the ratio of the consults received per day to the number of procedures that can be done per day. We have adequate space at this point but we lack the staff to run the rooms--- an additional provider, nursing, and administrative. Consults sent to Fee Basis actually created more work in our area and was extremely disorganized. At this point it is unclear that the results were adequately followed up on as well. In addition many Veterans preferred to stay in the VA system for their procedure and were unhappy about being sent to the private sector. Our scheduling system could also be improved, VISTA as a scheduling system is not user friendly."
I do not work in the area and I''m unclear on the issues present that cause the delay
I am not present in the area and I''m unclear on the issues.
Again I''m not present in the area and I''m unclear on the issues.

"Every PACT visit for all patients 50-75 years of age. It the patient has had positive fecal occult blood testing, colorectal cancer clinical reminder will be turned off for one year. If the patient has had colonoscopy done, CRC reminder will turn off for the length of time as specified by the gastronenterology attending taking into account the procedure findings. This later step is relatively new and representsa very significant improvement to the process that allows the primary provider to fine tune the interval for surveillance or follow up screening colonoscopy."
"FOBT positive tests are considered of high importance and actually generate a call fro the laboratory to the requesting provider with the results, in addition to a CPRS alert. The policy in the ambulatory care area is that no laboratory results should be suppressed by clinicians."
"B- Additional gastroenterology physician (one); Physician extender (one) to take responsibility for non-urgent clinical tasks of division
C- Nursing shortages due to insufficient staffing leads to inefficiency in endoscopy unit functioning and decreased patient volume per day
H- Significant barriers to effective scheduling due to insufficient and unreliable clerical staff"
"1-
Additional surgical and anesthesia staff are necessary. Surgical staff optimally would have expertise in colorectal surgical techniques
2-
Streamine interfacility consult management"
"1- Streamline interfacility consult management.

2- Outreach to community physicians and implementation of policies to allow for fast payment for service without obstructive requirements."
"Unreliable and unmotivated clerical staff lead to difficulties in reliable scheduling. Issues with staff persist despite multiple attempts at reeducation.
Inability to reassign staff or hire reliable staff hinders scheduling."

"reminder shows up on cover sheet as ‘‘due’’ when needed. annually for occult acrds, 10 yrs for colonoscopy etc"

"Ability to hire doctors that are not US citizens.
Adequate number of adequately trained Clerical staff."
Typcially no delay in being evaluated by surgeon. Issues with contacting vet and scheduling can occur
Understaffed in Oncology svc
NA to VAPHS
self explanatory

Triggered annual or based on clinical indication after screening.
"Delay in provider availability when general surgeon is performing procedures other than colon cancer screening.
Limited by basic complexity/CRNA service-patients requiring higher levels of care for services, oncology or anesthesia require review and consultation to alternate fee services.
Recruitment for Chief, Surgical services=difficult recruitment."
Consider improving flow administratively for radiation oncology to non-VA care.
Scheduling - difficult to customize scheduling for complex cases or variable appointment lengths.

Yearly reminders in CPRS
"this is after all the factors we have no control of, ie : inability of pt to get a ride, cancelations due to illness, road conditions"
"There are simply not enough people to do the endoscopic exams in [location redacted], both in the private sector and VA, salaries make it difficult for the VA to compete for providers."
There simply are not enough providers and the system is cumbersome in getting things done. Physicians spend to much time doing clerical work
patient guides ie nurse coordination would help patients navigate the system
We need more providers!
system is cumbersome and not enough providers and providers spend a lot on time doing clerical work

"via alerts on the patients electronicmedical records
A GI coordinator oversee the alerts so no patients are missed."
"Our GI Coordinator is alerted, likewise the PMD"
pay physicians especially in the rural settings at the 70-90th percentile range(salary.com).Current Surgeon salary ceiling is below 50th percentile.This is the single most important reason why quality staff recruitment and retention is a chronic VA problem.

These are triggered via automatic alerts in CPRS. They are also being triggered as part of the CONFIRM trial.
Unable to assess - do not have local data
"I can perform colonoscopies every 45 min in my academic practice, and stay on time. If the VA had more efficient pre-procedural policies it would allow for more procedures. The documentation process

takes at a minium 20-30 min prior to each case. In addition, the documentation process after each case is also slow Endoscopy reporting systems should be uniform across the VA. Endoscopists should also be tracked for meeting colonoscopy quality benchmarks."

clinical reminder
an appropriate scheduling system and CONSISTENT guidance from VACO.

Reminders have been in use consistently for 6-7 years. They are mandatory to complete as a part of every screening colonoscopy report and are entered by primary or ordering providers when FIT testing is done. The reminders are triggered to alert 3 months prior to the ”due date”“ to allow time for renewal of screening tests.
FOBT/FIT positive results are tracked by the lab and routed to endoscopy directly for scheduling.
Standard alerts are sent to primaries as noted above.
"We have long struggled with constraints of space and personnel. Currently we have 3 full-time endoscopists. This is inadequate to meet current clinical needs. Hiring a fourth endoscopist (gastroenterologist) is an important step but we need additional clinical space (a third fully developed endoscopy room plumbed for anesthesia services), additional nursing staff to support the room (2 nurses) and additional prep/recovery beds to support the extra room (3 prep/recovery beds for every room). In our current location we SHARE 10 prep/recovery beds with our 3 endo rooms (2 of which we can reliably staff with nurses), cardiac cath, ophthalmology, VIR and our 5 room OR. This is GROSSLY inadequate and huge bottleneck in our process. It might be helpful to offer weekend/evening hours but this would require FLEX TIME or COMPRESSED schedules which administration has resisted. Also helpful might be asking existing providers to work Saturday morning to do endoscopies when on call but absent additional pay for working 6 days a week or FLEX TIME/COMPRESSED schedule arrangements this is unhelpful. Many staff are also resistant to longer hours. Most fruitful then, would be adjusting our physical plant and hiring additional full time staff. We may, in fact, need 5 FTE of endoscopists to fully meet our demand. I made the assumption that VA would like to see procedures done within 30 days in most cases."
Having adequate administrative support for our unit has been absolutely CRITICAL to our achieving the level of success we have managed to date. If we don’’t have effective admin support personnel then our nurses take up the slack which hamstrings our clinical activities. We have 1 admin support person to do all our scheduling and could easily use 1-2 more in endo/OR/IR.

Age appropriate but not for followup
Would best be answered by VAPHS Chief of GI
Create a Cancer Service Line for screening through survivorship
"Increase compensation for medical oncology providers to match market pay. This would improve the caliber and intellectual pursuits of applicants and retention of VA oncologists.
Also focus on rebuillding a VA Central Cancer Tumor Registar Team."

triggered annually after age 50 in CPRS via clinical reminder system. provider action closes out if colonoscopy or FIT has been completed
this retrospective average includes many patients who no-show or cancel and reschedule their initially scheduled procedure which was initially targeted to occur within 60 days
Increase efficiency of clinical operations through system redesign and/or fix flow initiatives. Improve VA allowable incentives for tying productivity to market incentives in private sector
Addition of Colon and Rectal trained MD Providers to our facility to avoid need to outsource. Improve numbers and efficiency/productivity of CBO Case Manager staff for non-VA care.

Improve communication and coordination between facilities
based on previously noted need for increased admin support staff

A clinical reminder is set up to remind primary care providers to order FIT testing yearly on patients for colon cancer screening.
"Our full time GI provider does not have a designated office or exam room. We have recruited for a full time GI physician for 8+ years & recently obtained one, but he is currently off on medical leave. If he does not return, it is imperative we recruit & obtain a full-time GI physician. We need a dedicated GI scheduling clerk. Currently we share 3 clerks that schedule for multiple other specialty clinics also. If we are unable to maintain a full time GI physician it would be imperative we have a tele-health GI physican that the two midlevels that work in GI could have available to discuss complex cases and help manage the IBD & cirrhotic patients. We only have 2 part time fee for service GI providers and access to schedule GI procedures timely is very poor. If this pattern continues we need clear guidelines on triaging which patients for GI procedures. We often times lack GI coverage on the weekends if our one local GI fee for service provider is unavailable. Inpatient consults often do not get answered in a timely manner due to this providers limited availability at our facility. We live in a very rural area and in past experience the fee basis referrals are not getting seen any quicker in the community then they are at our facility & communcation is lacking (we often do not get medical records back in a timely fashion if at all). We are limited in how many procedures we can schedule due to issues with anesthesia coverage and the sharing of OR staff between the GI doc and other surgeons that may be doing procedures on the same day. The turn around time between GI patient procedures is very lengthy. There is lots of room for improving the efficiency of our SDS and OR work flow. In the past we have been told to cancel GI procedures if another surgeon was working and anesthesia coverage was inadequate. Our facility has a policy that patients have to be seen within 30 days of their GI procedure date. When access to procedures is so poor, it impacts our clinic access tremendously as we are seeing each of these patients twice and this is taking up access that new consults could be seen in. On the other hand when we continue to see new consults but have no access to schedule them within 30 days for their procedure we need to establish some sort of policy on who refers these for fee basis services (do we cancel the consult and recommend PCP do it, do we see them 1st and the GI provider submits the consult but this does create delays in patients care when they wait to see us on consult first)."
"We need more colorectal surgeons at our tertiary VA centers in order for clinic access to improve. I think establishing tele-health services with the colorectal surgeons at our tertiary VA centers would help. They would be able to review the cases with us and establish what type of pre-surgical work up they need before seeing the patients that we could possibly complete at our facility. This would limit travel and number of patient visits at their facility which in turn would help improve their access. Our current policy is to submit dual consults to two tertiary facilities at the same time and wait and see which facility can see the patient the earliest. However, having a second lingering consult out there creates unecessary work load on the other facility. Often times patients get schedule appointments at both facilities and the patient ends up being a no show at one of the facilities due to keeping the early appointment at the other facility. We do not perform colorectal surgery at our facily so it is imperative we have fee basis options to refer these patients to. But again, we live in a rural community and often times their access in getting the patient in is not timely either. Communication is poor and some of these patients gets lost to follow up. The fee basis department sends fax inquiries to request medical documentation but often times it is not receive timely or at all."
See my comments on prior section.
Please see my comments on prior section.

"Clinical Reminder is turned on for all Vets >50yo. Clinical Reminder logic is turned off for 1 year by a negative FOBT results. For colonoscopy, a letter is generated for all patients post-procedure which triggers the Clinical Reminder to alert the PCP based on guidelines related to the procedure, patient history, and tissue histology."
All screening procedures are Fee Based due to lack of capacity at our facility.
"Our facility currently runs a deficit of 100 procedures every month. We are understaffed with respect to GI providers and nurse/techs to run the rooms. We do not have sufficient Facilitators to schedule procedures, and we do not have enough Nurse Care Coordinators to manage the complex patients we do see."
"The amount of time spent by clinicians to document the pre-procedure and post procedure assessments is 5 times more onerous, tedious, and wasteful than any other endoscopy program in the country."

"Reminders come to PCP in CPRS as pop up. Provider can clear by ordering tests, verifying it was done elsewhere, or stating pt is too sick to merit CRC screening."
We discourage use of FOBT in our system. Colonoscopy is the preferred mode of screening.
We have no wait for colonosocopy. Pts can easily be accommodated w/in 30 days.
as above
"Again, we don''t like FOBT. It''s a poor screening test. We discourage use. BUT, if done and positive, we'll do colonoscopy w/in 30 days"
It will be scheduled w/in 30 days in all cases unless pt desires otherwise.
The key is a charge nurse and physician director who are thoroughly invested - and empowered - to run the unit efficiently.
"Within our local radius, we provide all services at our site w/o delay. For pts living remotely, there simply aren''t sufficient services available to provide high quality chemotherapy or XRT."
"We perform XRT at our University affiliate and get great service. We have no delays in access. For patients who live remotely, we have had problems with VA contracted services with groups/facilities with which we do not feel comfortable, i.e., quality of service is not what we expect. This is an onoging problem for the VA: the quality of care is BETTER at the VA than contracted sites, especially in more rural locations."
"We are suffocating in checklists, tedious consent processes, and documentation requirements. The requirment for a provider to send f/up letters after procedures is incredibly burdensome. It could be automated (as Kaiser does) - but the IT group hasn't deemed that of sufficient importance to move forward. SO, we spend many hours each month sending out individual letters."

activated automatically based on age of patient
Additional space for procedure duties is necessary. Improved scheduling personnel/practices and staff for monitoring of CRC obligations are necessary. Prefer not to fee-base our care as this creates complexities in acquiring results and is unnecessarily costly.
More surgeons needed at our facility.

Available at [location redacted] only
Reminders are used
I do not know about the FOBT triggers or responses
less than 90
"Need additional physicians to perform endoscopy. Need to STOP primary care from performing FOBT tests a year after normal colonoscopy and re-referring the patient for endoscopy. Need to APPLY the guidelines that stop screening at age 75, so that 82 year-olds stop being referred for routine endoscopy

and clogging the system. Need to stop the absurdity of timeline constraints on ”open consults”“--a patient referred for routine screening colonoscopy because it has been 10 years since his last one should have ONE YEAR--365 days--to get his procedure done sometime in that calendar year.
Need to improve the quality of endoscopy equipment, and make a system where the scope report can be easily moved into CPRS; the electronic health record."
"RESTORE all VA inpatient facilities the RIGHT to perform surgery!!!!!!!!! This, without a doubt, is the biggest stumbling block in the ability to provide care to veterans. The unilateral decision by the NationalSurgeryOffice (NSO) to restrict surgeons from being able to actually perform surgery has crippled the services offered locally to all veterans. In addition, it has made recruitment of physicians very difficult. Why would a surgeon come to my facility only to be told he cannot perform colon resections or other bowel surgery here, and that all these cases must be referred to outside facilities because we do not have a cardiologist or intensivist?? There is not a single medical study which supports this rationale impoised by the NSO. Quite the contrary, studies show that rural surgeons perform just as well as ‘‘centers’’. It is not about quantity of work. Plus, the overall hypocrisy of this NSO edict is exposed by the fact that orthopedic surgery IS allowed to continue at these very same facilities which are unable to offer cancer surgeries to our patients. It is pure economics."
"At this facility, to get a colonoscopy:
1.Consult placed for colonoscopy
2.Patient must have 3 appointments:
**endoscopy nurse
**anesthesia
** surgeon (endoscopist)
3. Await a date from the Endoscopy scheduler
4.Colonoscopy done.
Surgeon must write:
Brief op note in CPRS
OPERATIVE note
Orders
Endoworks report with pictures for patient--this is done on a completely separate computer, as CPRS does not talk to endoworks, AND at this institution, they are not even allowed to be on the same computer network.
GI follow up letter
Clinical Reminder
Notification of Pathology note.
That’’s a lot of steps for a colonoscopy."

"age > 50 annually, FOBT"
"Ex. had pt. identified in CBOC with rectal bleeding and other symptoms last week. That day did telehealth colonoscopy screening with PA at hospital, sched. colonoscopy for this week."

- **Diabetes**

One podiatrist on staff; one APN for foot care/limb preservation. They are available for acute needs but scheduling outpatient tends to be prolonged
All consultants are available for same day consultation in case of urgent intervention. Follow up is good with most. Cardiology does not manage refractory HLD but will offer suggestions to the PCP. Staffing is key in most of the issues related to tx. delays
"Some reminders could be done by staff other than provider. Clinic panels are not well managed eg. providers retired or gone for other reasons with pending follow up needed in panel...and no designated surrogate to follow up. The call back for scheduling system does not work...they are sent a reminder letter to call 30 days in advance to make a call, they call and are told ”too early”, they call back in 2 weeks and now providers are booked out beyond the 30 days and by that time, patient is out of meds. Even making appointments for 30 days later is a stretch for most of the providers. Patients frequently complain that they want to have an appointment scheduled before they leave the facility”. Lots of provider turnover. Long way to go in continuity of care. Long way to go in employee satisfaction. Clerical staff not supportive and numerous complaints re “poor attitudes” and ”rudeness” from front desk personnel. Many of these individuals feel protected because they are Veterans. Providers are not given sufficient time to perform exam and ”check the boxes” of all the clinical reminders required of them."

"The Medical Center outpatient primary care clinic layout/design does not allow for coordinated, patient-centered care and services. Nursing staff provide basic diabetes self-management education in both the inpatient and outpatient setting but this is ineffective and often leads to delays in follow up communication and care. Multiply factors including space, time constraints, ineffective or poor communication, etc. also contribute to the ineffective delivery of diabetes self-management education and services. Additionally, information technology issues such as, the lack of interface capabilities between diabetes equipment/software and CPRS make the exchange or sharing of information such as blood glucose data cumbersome and inefficient. Use of a diabetes registry would help to improve diabetes care coordination but registries are not available to all facilities. The use of a diabetes registry is frequently limited to very large medical centers or sites who have participated in a pilot study. Incentives should be disbursed among all members of the healthcare team and should be based on the performance rating of the overall team and each individual. Individual and group diabetes education is not offered in the evening or on the weekend. Offering education and classes during non-administrative times is patient-centered and beneficial to those patients who work or have family members or caregivers who work. Telehealth diabetes classes are available from a larger VA facility within the VISN but the class schedule is inflexible. There are 4 classes, one each week, on Tuesday afternoon from at 1 - 2 pm and classes must be completed in consecutive order. Patients must attend all 4 classes and class attendance cannot be tailored to meet specific patient education needs. Additionally, patients are required to wait until the next class series starts before beginning Telehealth diabetes education classes. Within the SVAHCS catchment area, availability of non-VA diabetes education programs and services is limited, thus it is often challenging to provide fee-basis or contracted care services to non-VA diabetes education programs."
"Additional access to tele-endocrinology services could be made possible with the addition of 1-2 tele-endocrinologists, additional Telehealth primary care rooms and Telehealth Clinical Technicians would be needed at each location to facilitate additional appointments. Appointment availability during non-administrative hours would be patient-centered and beneficial to patients who work or those patients who have family members or caregivers who work. The availability of non-VA endocrinology services is limited within the SVAHCS catchment area. Use of fee-basis or contracted care services to non-VA endocrinology providers would be challenging."

"Additional access to dietitians could be made possible with an increase of 1-2 additional dietitians. Specialized nutrition counseling and education related to diabetes self-management is very important because healthy, consistent nutrition is a key aspect of good diabetes self-management and the prevention of long-term complications. Increase use of Telehealth would improve Veteran access to nutrition counseling and education to Veterans who receive care in the CBOCs."
Additional access to optometry and ophthalmology services utilizing Tele-Retinal Exam and fee-basis care would be the best solutions to decrease delays. Additional training Telehealth clinical Technicians (TCTs) and training for TCTs would facilitate increased access to care.
"Additional access to nephrology services utilizing Tele-Primary care and fee-basis care would be a good solution to decrease delayed care. Additional space for Telehealth appointments, additional TCTs, as well as access to nephrology specialists would facilitate improved access to care."
"Additional access to cardiology services utilizing Tele-Primary care would be a good solution to decrease delays in care. Additional space for Telehealth appointments, additional TCTs, as well as increased access to cardiology specialists would facilitate improved access to care."

"We have been challenged with hiring podiatry support personnel, such as nursing. With a growing veteran population, space has become constrained. Central Office must allow for leasing of temporary mobile space to relieve the constraint."
"We can recruit general ophthalmologists, but are challenged with recruiting the ophthalmology subspecialists such as retinal, glaucoma, and oculoplastic sub-specialists. Central office must allow for temporary leasing of mobile space to relieve space constraints."
"We have an under-staffed prosthetics sections because this service line falls under the VISN and not the facility. Prosthetics must come back under the facility. Prosthetics also has an under-performing contractor that has generated a fair amount of patient complaints. Central office must also change the business rules for prosthetics and move towards order sets instead of consults. With a growing veteran population, we have become constrained for space. Central Office must allow for temporary leasing of mobile exam room space."
[Location redacted] VAMC currently has no vascular surgeon. We have been trying over a year to recruit one and have had several declinations in spite of very attractive recruitment / relocation incentives. We are currently pursuing a locums contract.
See previous comments on podiatry. Central Office must allow for leasing of temporary mobile office exam room space.
"Podiatry has been challenged with recruiting adequate support staff, such as nursing. Central Office must allow for temporary leasing of mobile office space for exam rooms."
"Same comments as in ”new patients”“ in the General Facility Questionnaire [name redacted]. Inflexible CPRS, lack of support personnel, View Alert burden. Space is a constraint and Central Office must allow for leasing of temporary mobile office space for administrative personnel."

Need more nephrologist given increasing demand for these services. Need nephrology nurse specialist. Need more dialysis equipment and space. CPRS needs to be compatible with community standard (Electronic medical record). There is difficulty in coordination of care with NVCC to VA providers.
"Need more nephrologist, nephrology nurses, dialysis equipment and space. CPRS needs to be more compatible with community electronic medical record. Diffculity getting information from NVCC providers on VA patients they treat."
The electronic medical record needs to upgrade and hinders provider’’s ability to provide patient care. Providers are given too many clerical dutieis that dedicated personnel could do

"Decisions regarding how soon patients need to be seen by specialists should be made by the specialty clinicians, not administrative non-clinical data analysts."
"This VA had 1 endocrinologist & 2 diabetes nurse specialists 25 years ago. Today, 25 years later, with the incidence of diabetes in veterans now at 25%, we increased to 2 endocrinologists (1 month ago) & 3 diabetes nurse specialists (6 years ago). The [location redacted] VA has 25 certified diabetes educators. There is a critical lack of resources/personnel for the volume of veterans with diabetes at every VA in VISN 15."
Podiatry dept. is grossly understaffed for needs of this facility and throughout VISN [location redacted].
"There are seriously inappropriate behaviors occuring between the nephrologists in the nephrology department. Upper level management needs to step in and take actions to ensure professional communications between these physicians, as it highly impacts patient care."
Administrative changes that dictate how patients must be rescheduled greatly impact efficiency of clinician and patient f/u requirements.

pt. do not keep nutrition appts.

Patient has to be in Move program for 6 months and has to lose certain amount of weight before eligible for surgery. Some patients are not able to lose weight. The policy needs to be changed.

down load of the insulin pump
I tiwould be nice to have a team working together to help manage diabetes which includes dietitian CDE and endocrinologist and NP

"Currently and RN CDE runs our diebetes program. Program includes two dieticians, two part time Pharm Ds. Nutrition appt are back logged."
Limited nephrologist in community. No nephrologist on staff.

"Blanket mandates for timing between consultation request placement and delivery of care cause inefficient utilization of limited resources.
Expanding clinics to non-standard hours is possible but entails simultaneous expansion of ancillary services and clinical personnel expansion.
Patients tend to prefer to be seen at the VAMC rather than the private sector. The private sector does not attend to the combined needs of our veterans as efficiently as a VAMC.
Central Office mandates to manipulate specialty care flow are overly simple and do not acknowledge the complexities of specialty care."
"Expanding podiatry clinics to non-standard hours is possible but entails simultaneous expansion of ancillary services and clinical personnel expansion. Similarly, telehealth podiatry clinics are possible, but require adequate staffing and infrastructure support, which are currently lacking.
The scheduling package available to schedulers is antiquated and inflexible, and produces inefficiencies in access. The facility desperately requires a modernized telephone system that permits monitoring of call volumes, call timing and durations, direction through automated answering trees, lost-call rates, etc.
Patients tend to prefer to be seen at the VAMC rather than the private sector. The private sector does not attend to the combined needs of our veterans as efficiently as a VAMC."
"Screening for diabetic retinopathy is a dual function of primary care access and efficiency. Primary care at this facility is under resourced with respect to both staff and space, leading to excessively large panels, and lack of space within CBOCs for screening equipment and technicians to run them."

"Access to vascular surgery is impaired at many steps, including limited space and personnel to assess peripheral vascular disease, number of vascular surgery providers, space for vascular surgery providers to evaluate and treat patients, and surgical OR time.
Policies that dictate time until evaluation, without consideration of clinical need, exacerbate system inefficiencies."
"Access to nephrology is impaired at many steps, including limited space and personnel to assess renal disease.
Policies that dictate time until evaluation, without consideration of clinical need, exacerbate system inefficiencies.
Expanding weekend services is feasible, only if additional staff were available, and required ancillary services were also available. Outsourcing care to the private sector is possible but undermines attempts to coordinate care across medical disciplines for veterans."
"Delivery of podiatric care is limited primarily by space and staff considerations. Trained technicians, as well as podiatrists are needed, as well as appropriate work spaces. Delivery of care by telehealth would facilitate care, but requires sufficient space, and technician assistance at CBOCs. In addition, telehealth screening modalities typically lead to increased discovery of disease that requires interventions only available at the medical center. Podiatry care is further hampered by limited access to operating room (OR) time by podiatrists. OR efficiency is limited by an antiquated and dysfunctional telephone system that does not permit timely communication with patients with respect to procedure scheduling."

need additional nutritionists
Improve speed with which prosthetic requests are processed and delivered.

we need more endocrinologist or the ability to get people into community clinics faster
we spend too much time on the computer answering clinical reminders that all competent physicians should handle routinely w/o the reminder and most have shown no benefit to the veteran. they are also redundant as these are mostly addredded in the progress note.
we need a cardiac lab and interventionist to use it
we need to find a way to decrease view alerts and just plain make 90% of clinical reminders go away.
clinic cancellation policy is draconian.

Stop code issues with the scheduling system make appropriate appointment making incredibly difficult. Lack of training and high turnover of MSAs makes this problem worse.

"In the pt care are, more full time staff instead of more part time for better continuity of care and coverage"

There is a problem with the culture in Nephrology. They are more invested in the opportunities for education than aligning their resources with care for the entire population of Veterans with renal disease.
The members of PACT beisdes the PCP do not engage in a population management approach to DM nor do they work at the top of their license.

Lack of adequate clinical and clerical support staff limits the efficiency of our services. We have no dedicated nursing staff for the diabetic clinic and physicians must do tasks normally done by nursing support staff. Physicians have even been asked to call patients and schedule their appointments to remedy inefficiencies in the patient appointment scheduling system. Added administrative requirement for the physician to call back or notify patient by personal letter of every lab result ordered by the

physician increases administrative physician time that could be better utilized directly seeing patients. But we do the best we can with our limited clinical support.

"The NVCC process is entirely cumbersome for no reason, simplify the process so care can be delivered more timely"
"the NVCC process is to cumbersome, please simplify so that care can be timely."

"I can truly only comment on what I see in the endocrine division and our associated subspecialty clinics. I cannot comment on the other clinics (primary care, vascular, ophtho, etc) that provide service to our patients."

Planned 6 month appointments with the primary care provider is not adequate for good control of diabetes mellitus. BUT the staffing for specialty care of all diabetics can never be adequate---not enough endocrinologists to do that in the USA or elsewhere. We must have generalists care for many of those patients.
Fee basis podiatry services for nail/foot care for persons with diabetes over age 60 would be VERY helpful
Wound care close to home is important because most are elderly and/or impaired. Increased fee-basis wound care would greatly improve foot care.
"Retinal surgeons are in short supply, so fee-basis services are essential."
Fee-basis services are likely to be needed to get prompt attention to these patients.
Policies are “one size fits all” and patients simply don’’t follow those ”rules”

"increase the number of support personelle ie clerical, nursing (MA, RN, LPN) as well as assign each group a coordinator whether APN, PharmD, PA etc that works with the providers in the area. Design to be collaborative and to work at top of their training.
Central office policy is understandably changed with new needs. This can at times result in difficulties implementing the mandates without sufficient time to give feed back about the local results - both good and bad.

The VA is easy to have bad PR both from outside as well as inside the VA at times - patients and staff. This helps us do even better but would be nice to have regular focus also on how great the care and services are most of the time."
see question two comments section. Also forgot to answer about improve management etc. Most of us are here because we are proud to serve our Veterans and help with their healthcare needs. Process and meeting the goals of processes has become too large a focus and believe that helping everyone feel the satisfaction of caring for Veterans is very important.
see prior answers also. For retinopathy treatment would also need more providers and technical staff as well as other support people.
"see prior answers also
for these questions, would almost always be taken care of in clinic (theirs or referring) or seen in ER. Those who are missed would relate mostly to process issues that more support staff would be expected to help."
see prior comments. Cardiology needs more space and technical staff. All answers are for new symptoms not refractory hyperlipidemia which is also or primarily done by endocrinology and preventative general medicine.
see prior comments

"Over the past year there were many changes to the scheduling policies that resulted in decreased system efficiency. However, currenlty his is fixed. With less staff, patient flow can decrease efficiency. With better flow, more staffing there would be a likely need for more space. TMS requirments being the same every year and without much if any grace period and similar for all people decreases provider and system efficiency."

More operating room time for surgeons. Additional surgeons experienced in bariatric surgery.
No show or cancelling close to clinic date is significant problem.

Need more primary care providers
Need more nephrology availability with more subspecialists
Need more cardiologists and nurses for improved clinic availability
"Poor patient show rate for DM clinics historically; also - too many administrative duties, including mandatory training interferes with physician availability to patiients"

"Improved and effective Coordination of clinical and administrative services (ie scheduling by business office vs by clinic staff)
May need a designated advanced MSA who can understand the process and the options available for open spots
Also syncing patients preference and clinical priority.
patient accountability for multiple no shows (over 3) .
Having more rooms for multidisciplinary clinics
Telehealth services will certainly improve no show rates and is excellent for diabetes follow up appointments
Availability of sensors for type 1 diabetics(equipment /device)
Diabetes Section providers
We have set up clinics for high risk diabetes patients (ie frequent admissions and ER visits and complications) staffed by our diabetes NP .
we alos have insulin pump clinicstwice a month.
Fee basis may not be a great choice for chronic diseases such as diabetes.
VA has great national guidelines, policies and resources for diabetic patients and we just need to streamline the care from prevention to managing complications."
"RTC notes take time
Can we make it an order instead?
Also it takes time to explain locations of labs, radiology,pharmacy ,prosthetics etc to pt
To improve flow and time ,can we have nursing staff or trained MSA explain disposition details so provider can move on to clinical duties.
Also having a CDE available at all clinics is quite helpful to explain about insulins, review injections and meal plans."
"In my experience veterans who use the VA access VA system prefer to get all their specialty care at the VA for reasons of communication and continuity.Fee basis does not help, since care is fragmented."
as mentioned previously midlevel provider trained in diabetes will be helpful

Have CDE certified nutritionists
Concurrent clinic activity
Enhanced interface of clinical activities

Study ID EkfhJJ

"These opinions are entirely my own, based only on my perceptions and experience.
RE:Reducing delays in PACTs.
I did a quick survey of random PACT clinics in [location redacted]. Out of 15 clinics seven had an open appointment in 1-4 weeks and in eight clinics the next available appointment was > 1 month away which I consider a ""clinically meaningful delay"" in the treatment of poorly controlled diabetes. Since 50% of the clinics I sampled can't see any patient for > 1month some people would say that''s an indication we need more providers but I disagree and I make my point below.
ADDITIONAL SPACE: Space is a peripheral problem. I worked in our primary care clinics >10 years, during that same time I was also working part-time in a primary care private practice night clinic. The 2 physical and functional models were totally different and definitely had an impact on efficiency. In the private practice I saw 20 patients in 4 hours. In the VA, then and now, I can''t see more than 12 patients in 8 hours. From a quick survey of the PACTs it seems PCPs have from 10-18 slots per day. The model the VA follows does not support the PCP. The PCP is burdened with too many non-medical ancillary tasks that in private practice are done by clerks, MAs and nurses. The PCP spends an inordinate amount of time on non-patient care tasks, as a result the number of patients we see is limited. We don''t need more PCPs. We just need to give the PCPs we have more support. Ordering of tests, looking up results, entering consults, etc should be done before and after the appointment by the ancillary staff. At one time CPRS was helpful but that system is now antiquated, inefficient and simply burdensome.
LIP: As I said above compared to a private practice we have plenty of LIP but they are burdened with too many non-patient care duties DURING CLINIC time that decreases their efficiciency
OTHER PERSONNEL: PharmDs and TMC clinics are a very efficient means of getting pts quick evaluation and tx of diabetes.
YES we need more ancillary staff, MAs, LPNs, and RNs trained to support the
PCP by taking over more of the pre-appointment and post-appointment duties and free the PCPs time to see more patients. The VA needs to more closely follow the private practice model.
EQUIPMENT: Diabetes research has firmly established that good diabetes control depends on frequent home monitoring of blood sugars and patients being knowledgeable in diabetes self-managment. The VA policy that restricts patients not on insulin to 150 strips/year is a direct barrier to helping a patient get faster control of their diabetes and necessitates MORE clinic visits. Since my patients can't test as much as I need them to I have to depend on the A1C which necessitates the patient make more trips for lab and more f/u time in clinic. Medicare-B covers 1 strip/day for pts not on insulin and any number of strips as Rxd for pts on insulin. Many of our patients have Medicare-B and can get strips outside the VA if the provider will write a RX. However the general understanding among PCPs and other providers is that NO outside RXs can be written. This prevents patients from benefitting from their Medicare-B coverage and increases the VA cost because it means ALL strips must be provided by VA. In addition to test strips pts need education on how/when to test and how to use that information. Our pts are not under any obligation to participate in diabetes education and the majority choose NOT to participate in education which results in inefficient use of test strips, poorly controlled diabetes, more diabetes complications, more use of primary care clinic time and all VA resources/equipment. ALL OF THIS RESULTS IN MORE CLINIC VISITS REDUCING THE OVERALL EFFICIENCY OF OUR PRIMARY CARE CLINICS.
TELE-HEALTH SERVICES: We have several diabetes/metabolic telehealth clinics. Yes, tele-health can take the place of some primary care clinic appointments if the patient is comfortable with the technology.
INFORMATION TECHNOLOGY: CPRS is antiquated, slow and inefficient and greatly decreases the efficiency of all providers. It''s also unusual in this day and time that providers can''t access a patients record from home. It''s common practice in private practice to be able to review records from home.
CENTRAL OFFICE POLICIES: If this refers to Performance Measures then YES changes need to be made. Current research supports that PMs do not improve patient care and PMs should be limited in their use.

If you look at the typical PCP note it's full of redundant information and PMs with little pertinent personal information about the patient.
PERSONNEL MANAGEMENT: Business Office personnel and practices are the weakest links in the efficiency of our PCCs.The system needs a new model and new leadership. BO personnel do not preceive themselves as part of the care team. They seem to function as independent entities and do not think of themselves as ”support”“ staff. In fact some BO clerks resent the title ”support staff” because they don''t believe they are here to support anyone but just to do the job they are assigned. I''ve observed some very, very poor customer service from BO staff but even a tactful suggestion on what might be a better approach is resented. Basically BO staff have never been encouraged to be part of the PACT team. BO supervisors and staff do not attend staff meetings so are not part of the conversations on customer service and clinic efficiency. The BO clerks are the face and voice of our clinics. They set the tone for the entire clinic visit but they are often the least polite, least professional and least efficient members of the PCCs.
INCENTIVES: Yes, they work if they are based on significant and objective measures and if they have real value to the employee. Our own surveys have shown that employees place most value on cash awards and PTO. I also personally believe the awards must be given frequently enough for employees to feel they may actually have a chance to be recognized. The reasons an employee is recognized must also be widely and publicly announced so others will know what is necessary to earn an award. I''ve received substantial cash awards for “achievement” that I only knew about because I looked at my LES. The public recogniton and appreciation would have made me feel even better than the cash and would give other's incentive to work towards an award. [location redacted]'s Clinic has been voted ”Best Place to Work”“ and I''ve recently been a patient for multiple visits at 2 of their locations. The employee spirit and camaradie was noticeable from the minute I walked in the door. The staff was friendly, smiling, polite, professional from the beginning to the end of every one of my visits. Talk to their HR I''m sure they can give you some ideas.
WEEKEND AND EVENING CLINICS; YES!! Providers and patients have been asking for evening clinics for the entire 30 years I''ve been here! Years ago we had semi-annual Diabetes Health Fairs on Saturday mornings. Over 200 patients attended each health fair. One of the survey questions asked if pts preferred Saturday or a weekday for the health fairs. Over 90% responded they preferred Saturdays. We have many vets in blue-collar, labor and part-time jobs that do not offer the luxury of PDO. Vets should not have to sacrifice pay to come to the VA for their health care or be forced to come to the ED. We are doing ourselves and our vets a disservice by not providing evening clinics.
INCREASE FEE-BASIS OR CONTRACT CARE AND SIMPLIFY ADMIN PROCESS: The answer to this question just seems too obvious to answer."
I am familiar with only one patient who has had bariatric surgery and it seemed to me it took her a very long time to go thru the evaluation process.

"The bariatric surgery process is something that could clearly be streamlined. it''s hard to say the delays are clinically significant because the procedure is ultimately elective, but there is a huge burden on referring providers trying to make bariatric surgery referrals
Re: fee basis care, my opinion is that this is a poor solution because of the care discontinuity it creates - e.g., when my patient sees a non-VA eye care provider, I seldom receive the results"
No-shows - I deliberately overbook my endocrinology clinic to 9-10 patients in a half-day expecting that 1-2 will no-show. This takes appts away from other patients - having admin support to improve apt confirmations with pts would be helpful.

‘

contract out recruitment process; increase the number of credentialing personnel to facilitate the entry on duty
considering expanding a nurse run foot clinic for nail care; implement point of care scheduling established patients

"Only a small percentage of patients medically eligible for bariatric surgery end up with the procedure. This is true not just at our VA (where bariatric surgery is not performed), but is also true in the private practice setting. This is a bottle neck in our health care system; locally, nationally, private, and government."
"There seems to be an issue with scheduling. Often, when I''m in clinic my panels aren''t full; yet, I keep getting reports about backlogs. Scheduling is moving from a centralized model to a clinic-based model in the next few weeks. Perhaps this will help."

"Staff and Space are always an issue and the lack thereof leads to specialty care of the most complex diabetics being refused or deferred back to PACT where there is less expertise. Specialty care providers lack adequate admin support and nursing support to traffic feedback from patients on glycemic control and to redirect treatment plans and so providers are relying on mailing letters that are often not received or the patients lack sophistication to interpret them or translate them into functional self care plans. Patients have had the most success with high quality RN level care coordination (which is uncommon), especially in groups and 1 on 1 and we have too few nurses to manage the population and they are not well skilled at diabetes management and delegating the varied elements of care to other memebers of the team, so diverting too much of the work of chronic diease management back into the providier visits. They would benefit from more treatment protocols and/or NP/PA extenders to support their efforts. Clerical staff perform poorly in general on all domains and elements of their jobs. This is an opportunity for developing ''specialty'' PACTs for diabetes, coalescing the most complex patients in fewer numbers with more richly staffed and trained teams."
Not sure how this question is any different from the one prior?
"Specialty care such as Podiatry is not held to the same standard for access, efficiency, care coordination, access, etc as Primary Care. Clinics could use total review and redesign for efficiency and ideally Podiatry should have a presence in the PC clinic and not be so remote and inaccessible to the teams. Since so many podiatric needs are acute, with poorly controlled diabetics finding their way to PC clinic with infections and injuries, there needs to be a clinic flow with more carved out urgent drop in capacity"
"Nephrology as a service is poorly reponsive to PACT and veterans, generally declining or deferring care and participating minimally in it. Care coordination is poor at the nursing level especially in dialysis patients and there is much that could be done with virtual care modalities and a more comprehensive and welcoming approach by the specialty especially regarding management of blood pressure, dialysis related medication &nutritional needs, and timely intervention in stage 4 CKD to plan for future dialysis. Ideally Nephrology should have a clinical pharmacist and an NP supporting their efforts."
Podiatry has moved to another building and is very difficult to reach and communicate with. Patients who present with acute foot needs are often delayed while too many staff spin heels trying to get help and often have to defer to ER. Ideally there should be a podiatrist rotating thru primary care and ample capacity set aside in podiatry clinic for acute diiabetic foot disease
"Culturally PACT is failing locally as non-provider staff and services have failed to increase their performance towards top-of-the license care, still walking away from or poorly performing too much work that then ends up on the provider''s plate. Scheduling accuracy is poor and clinic staff have to spend additional time working around scrubbing of bookings to protect access. Nursing often pushes back against patients seeking care and defers them to provider visits, ER, etc. Clinics are too small with

too few rooms, buildings are poorly designed and delapidated and Primary Care areas have received the least and most delayed attention in remodels compared to all specialties. The growing burden of clinical reminders and performance measures that tasks to providers to document for the sake of QM and other admin staff has so strangulated the office visit that it has negatively impacted the care experience and patient satisfaction"

hiring of RNs certified as diabetes educators; the use of diabetes planned visits as a way to efficiently bring togethe the diabetes care team around the patient during one clinic visit; create nurse protocols around insulin titration to ensure appropriate dosing and adminstration of insulin especially for poorly controlled; partner with community based organization to develop relevant self-management educational strategies that involve the patient and family; decrease barriers such as criteria for referral to those specialtly services who address dm complications; increase access to opthalmologic services either by expanding VA staff or partnering with high quality community providers; use telehealth to expand home access to education and acute care services - RN Call Center with Telehealth capabilities; Create templates in CPRS with decision support capabilities and registry access; create policies around care coordination to make transitions of care seamless
"Additional ophthalmology services needed; mechanism by which to easily capture opthalmology services received in community; a look at workflow and use of PACT to optimize patient wait times, communication between providers and creation of multidisciplinary plans of care"
similar to previous question; to prevent treatment delays processes around care coordination that are interdeparmental not just limited to primary care
"Given the prevalence of macrovascular complications is patients with diabetes, access to vascular consultation and on going care is critical. a dedicated wound care center staffed with physician, nurse and physcian extenders would create a team approach to preventing and treating vascular complications."
"Yearly retinopathy screening drives high demand for ophthalmologic services. Therefore, appropriate staffing is required in order for screening practices to be appropriate. Expanding these services with the addition of space and personnel is recommended"
"Expand interventional cardiology services and diagnostic cardiology, to ensure timely access."
"Creating processes that optimize patient flow, work roles and clinic processes so that team members work efficiently and at the top of their licenses. Automate process so that they are less provider driven and more driven by the TEAM and or the clinical guidelines of the patients diagnosis. Example, flow sheets to ensure that recommended testing and DM goals are met"

"For patients with uncontrolled Diabetes, a more focused approach with emphasis on self-management education and support are critical. We are very good at providing medical care and high risk psychiatric care (suicide, PTSD, etc...) But when a moderately depressed patient has no motivation to change behaviors that directly impact his/her chronic conditions (watch TV all day, poor sleep, erratic eating patterns, poor dietary habits, sedentarism), we have very little to offer them. This may be one of the most important interventions and are very limited in most places."
"In our case, we”require”“ that patients coming to the diabetes clinic, have previously received “basic diabetes education” in primary care. (We standarized such a process). When consults without such documented education process are received, scheduling of appointments suffer delays."
We have a referral process to the [location redacted] VA which patients are not very keen of.

"Improving and increasing space for Primary Care clinic will allow for additional providers and nursing staff and improve access to care, health behavior teaching and support. This will help improve diabetes management."

"The lack of endocrinologists available for diabetes care of high risk patients has hurt our care of patients with uncontrolled diabetes. There are several additional or newer medications available that could help with diabetes management, but without the endocrinologist eval and approval, Primary Care is unable to prescribe these."
We have a lack of podiatrists available for routine foot care of diabetics including nail care. Part of the criteria to be seen by the Podiatrist is to have an insensate foot however many patients would benefit from more routine evaluation than waiting until advanced diabetic foot care.
We have a backlog of cases that need evaluation and follow up by ophthalmology and many NVCC referrals to the community because of this back up. This is the service most in need of growth at [location redacted].
"We have way too many alerts that are not needed to be reviewed by providers. This leads to rushing and missing important alerts. Many clinical reminders can and should be done by ancillary staff, yet are left to providers to complete and this takes time away from patient care responsibilities."

"Space is very tight here. If we were to grow in-house services, we would need more space to support those programs.
Biggest difficulty is getting Endocrinology/Diabetologist expertise. VA salary ranges are generally below what''s being offered in the community.
Currently most PCP''s just try to manage diabetic control on their own because there isn't endocrine capacity to assist them.
Pharmacist support for poorly controlled diabetics needing insulin titration has been helpful, but is far from comprehensive.
Central office policies and procedures just make care overall more inefficient, decreasing capacity further.
Fee basis and Choice program are too complicated and have too many ”rules” that only serve as barriers to care."
"Currently our facility does not offer this service. This service is only available outside our VISN (in another VISN) and they accept very few veterans and have numerous requirements before even considering a referral.
The community has LOTS of resources, but we do not refer patients for this service under Fee or Choice that I know of.
The easiest and most cost effective strategy might be to refer these folks into the local community unless an in-house surgeon with skill/experience could be recruited. In that case, compensation becomes a major issue."
"We only have limited Vascular Surgery support from the community. Most vets who need surgical intervention (e.g. bypass), are referred to VISN tertiary facilities where there are delays. Community providers exist, but in general Fee does not support those referrals unless it''s acute limb threatening ischemia. Again, salary ranges for the VA fall below community compensation, so getting surgeons to join the staff is nearly impossible."
"For many years we were unable to recruit enough opthalmology staff need to meet our demands. Fee basis referrals into the community still occur for people with retinal issues, which can lead to delays and fragmented care. The Eye Clinic as plans to expand. That said, the demand is huge. There needs to more shaping of this demand, since PC staff and patients choose opt for eye care even when there''s no clear need for it. In clinic screening (e.g. visual acuity and glaucoma testing) might be a better way to provide eye care while decreasing demands on Eye Clinic specialty services and providers. Fee basis care in to the community has been good for patients but again only leads to fragmented care."
"Currently we have only limited Nephrology support in the outpatient arena (PA one day a week, MD one half day a week). Inpatient support is available and provided by outside nephrologists who consult

as needed. The clinic often doesn''t have enough space when it runs. Fee basis outpatient consultation is generally not available, so patients wait for in-house consultative support/appointments. Ideally the facility needs at least a half time MD and a full-time NP/PA to allow for more frequent and earlier interventions (hopefully to prevent ESRD events). Dialysis support when it is needed is generally good and provided entirely out in the community which is appropriate."

"One of the biggest barriers to diabetes care in our VA is resources. The primary care providers are overwhelmed with large patient loads and can''t attend education sessions to help them improve their DM care. There is a lack of certified diabetes educators to help with the massive education load. Our patient population is very complex and requires extraordinary amounts of education re: diet, exercise and management of complex medical regimens. If PCP';s could have more time with diabetics (60" vs. 30") or if they had qualified diabetes educators to help it would make a significant difference."
The biggest issue is that we spend a lot of money sending people to the private sector because they can From the minute the patient is checked in the delays begin. Our LPN''s recheck out of range BP''s multiple times because they are trying to meet a performance measure of BP''s <140/80. This delays patients getting back to a room in time. The provider is given 30"; patient slots so if the vitals are delayed the provider is delayed and forced to provide quick care. This extra documentation is often not necessary because the pt is just hypertensive. We don't have enough staff to do this and it delays pt care.

"Need more providers: endocrinologist, NPs or PAs. Currently only one endocrinologist at [location redacted] VAMC. Need better reminder system for Veteran to keep consultation appointments, because ""No-show"" wastes precious consultation time. It is not necessary to split Diabetes from Endocrine consultation."
"Need more ophthalmologist, and nurses to work at eye clinic.There is only 2 opthamologist in our facility."
"Need more podiatrist. In our facility, currently all podiatry consuiltation was sent out to non-VA provider, since we only have on part-time podiatrist. Cannot give any care if no provider!"
"Need more endocrinologist and NPs or PAs. Frequently we do not have a nurse (RN or LPN) in the diabetes/endocrine clinic; high turn-over rate, no continuity. Paper works (CPRS) took 1/3-1/2 of our clinical time. Need better reminder system to decrease no-shows."

The number of overall clinical reminders are excessive.

"Policies should allow triaging of patients - some don''t need to be seen urgently, others do"
pharmacist would be good

"The main problem is lack of adequate professional personnel to see the patients, and also the need for increased numbers of treatment rooms."
The two biggest problems or lack of adequate professional help from MDs and there'' practitioners and lack of space if and when we can get these practitioners.
"Again, the main problem is lack of adequate Eye doctors to see the patients."

To allow nurse care managers to be nurse care managers. Streamline clinical reminders and consults. Stop providers from being clerks and allow them to be providers. Active recruitment of healthcare professionals instead of passive recruitment.

Some times it is hard to communicate with a veteran before scheduling an appointment. This has cause delay in scheduling even though an appointment is open & available.
At this point we have to call a veteran before scheduling. This policy has cause delay as some times it is not possible to reach a veteran
Schedule a veteran for appointment in case he cannot be reached by 2 telephone call within a week
More ophthalmology staff will be helpful.
You get the job done from Monday to Friday if you have enough staff based on demand
More patients can be seen if progress notes are dictated than typed.

"No case manager for division; only clerk and MDs are available to assist patients. Questions from patients sometimes lost since providers not sure whom to contact. Also, other clerks allowed to schedule into clinic, making clinics sometimes difficult to manage. Would be helpful to have case manager assist with streamlining services."
Same as previous comments.
See previous comments

decrease involvement by CO and distractions related to requirements that do nothing to improve care

"We have 1 endocrinoloigist and several pharm d in DM clinics. PC access is better, still improving. fee base access to community needs improvemnt, elp is a health shortage area and spec are in short supply"
"1 endocrinoligist on staff meaningful changes require more 1deepMD. have several Pharm d but need support staff, rooms,space."
need to be more than 1 deep in MD position.
"we do not have vascular in house all cases go to army/fee base, a smooth process is critical but a shortage of providers exist on outside"
"we have access to limited nephrology care in house, most are fee based to community in an area where there are staff shortages. Pts get care with limited delay"

Increase personnel in spec clinics at ref centers

METER AVAILABILITY

"Currently at the [location redacted] VA there is a critical shortage of available space in the primary care clinic for current staff and thus new staff become a bigger issue for space.
The current consult system is totally ineffecient often requiring 2-3 consult rewrites to obtain timely care. This is further compounded that there are 4 different pathways for our patients and often all 4 are tried causing delays in care. Those are internal, NVCC, IFC, and choice counsults. Patients often spend months in the consult system trying to obtain care. The consult system should have only on consult for all four pathways."
Simply the consult system in “broken” causes significant delays in care.
Again consult system is responsible for almost all delays

"CPRS is an antiquated EHR. It is nearly impossible to identify high risk diabetic patients within CPRS. High risk population mangement only becomes possible by exiting CPRS and creating ”work around”“ data extration programs i.e. patient registries, that having various level of reliability and validity. We need real time testing, outcomes and consult management programs.

The VA';s scheduling program is archaic and should have been updated years ago. We spend too much time implementing strategies specifically designed to work around the systems limitations in order to become compliant with CO requests.
Gluccometer download software incompatibility and malfunctions is rampant esp at CBOCs"
"High risk diabetic podiatric patients need rapid, multidisciplinary access and intervention in order to optimize outcomes. Care remains disjointed and uncordinated more often than not secondary to limited leadership, antiquated EHR and staffing.
Easy access for patient initiated contact needs improvement"
We have no Bariatric surgeon nor support staff or OR space. The closest facility is greater than 300 miles away. There currently is no fee basis model locally
CPRS does not provide real time updates or scheduling info (i.e. missed appointments) of high risk nephrology patients
Cardiology while providing excellent care in face to face situations is understaffed and thus unorganized and like diabetes is faced with an epedemic of high risk patients
View alerts and Clinical Reminders are without rationale and burdensome

"Primary Care need to take more ownership of the patient. They cannot be a traffic police sending patient to sub-specialties.
Software to download and create useful report from the glucose meters used by patient is critical for appointment at Primary Care and Metabolic Clinic.
Continous Glucose Monitoring equipment is very important to facilitate an efficient evaluation and management of patients."
"Dietitians trained to teach carbohydrate counting is very limited at PACT.
Food model are in great need.
The policy has been that the patient see the dietitian when they come to see the primary care but if the dietitian is busy or not available that date then the patient does not see the dietitian. Schedule appointment are needed for some patients. Open acess does not work for everybody. The patient may be re-evaluated by the PCP in 4-6 months and that is too much time for re-evaluaton with the dietitian if the patient is not in adequate glycemic control."
"We do not do Bariatric Surgery at our Station. There is very limited availability in the community, frequently having to wait 6-8 months. The system requires pre-approval by Chief of Surgery, who requires patient going thru MOVE program. The MOVE program has several months delays. Therefore, is a roadblock after anothter one taking at least 1-2 years before finally getting a patient to realy close to be schedule for bariatric surgery."

"IT: The ability to write to CPRS from the Primary care Almanac to quickly flag patients for rapid follow-up and order needed labs would be of great assistance. Clinical Reminders developed locally are currently used for DM management. They are poorly designed and hinder care.
Policies: Recall policy makes regular follow-up scheduling in Primary care unreliable.
Supervision: Direct supervisors for the PSAs are needed to better train and supervise clerks in scheduling processes."
"Information Technology: New scheduling package
Policies: Providing diabetic foot wear is delayed due to the requirement that patients be evaluated by a podiatrist first.
Personnel: Scheduling clerks"
see my prior comments

"Need more clinical space.

Need another Endocrinologist or dedicated practitioner.
Need a CDE and dedicated nurses.
Need a more facile EHR for diabetes care.
Need a case manager -especially for PC
PCP need to take diabetes more seriously and learn tools to treat"
"It is very difficult to get bariatric surgery approved - it is almost an obstacle course for the patient
There should be a patient navigator
Our program asks that the patient lose 10% weight before consideration - which essentially excludes almost all patients"
Vascular Surgery is very Hands-Off - the surgeon rarely sees the patient - usually it is resident or licensed physician extender
"Need an ophthalmologist - almost all work is contracted out
There are delays in care"
Nephrology is over-burdened
"Endocrinology clinic has been promised more Nursing support through a PACT system - which has not happened due to staffing and space
There is no single number that patients can call for help
Our medical center abandoned ADA recognition many years ago
A diabetes educator is a critical need"

"Allow staff podiatrists in system to be able to provide podiatric care at CBOCs, where podiatrists are contracted."

more LIPs and support staff
need to recruit additional qualified certified diabetic nurse educators and registered dietitians as well as support staff to allow them to function efficiently
"more podiatrists, more administrative and clinical support staff more space"

"CBOC&'s have struggled more with deficits in administrative and support staff; No show rates are moderate, but higher than desired. We have identified issues with patient cancellations."

Primary Care panel sizes are to large. operating at 100% of capacity increases risk of burnout and leads to lapses in care. Therefore more pact teams are needed. Additional resources are also needed to expand clinical pharmacy specialists to support PACT. There needs to be stronger link between what program offices require and the funding to the field. Currently the requirements of program offices are often unfunded mandates. Program offices need to understand that incremental change ultimately requires re-thinking staffing models or the field dies a death of a thousand cuts.In our location night and weekend hours are not desired by our patients and requiring continuing these activities is wasteful. Some of the changes coming in the IT and EHR world like active notes could be game changer. Tele health has been oversold as a potential solution. Smaller panel sizes and more PACT teams imply more space. the current space planning process is so lengthy that space is often too small by the time it is opened.
see responses to the primary care section above.
Bariatric surgery is difficult to obtain within the VA system (limited number sites performing the service and a lot of barriers to utilize it). Need more bariatric surgeons and locations.
more access to cardiology testing and technology. this means both more cardiologists and associated support staff and all that this implies include space.
Need more and better foot care support which is finally on the way here. same issues as related before.

Providers are saddled with to many things to do for each patient and are drowning. mandatory education detracts from patient care and needs to be required more thoughtfully. Need to find ways to augment providers with more support for basic activities.

Need adequate number of rooms for specialty services. Guidelines suggest one room for each provider which is very inefficient.
See previous comments

"Need more providers to see patients more quickly. In our specialty (Endocrinology/Diabetes), long waits for appointments are not uncommon since there are many people with endocrine problems especially diabetes, the kind of advanced diabetes patients we see are those who cannot be discharged from our clinics, and there are not enough endocrinologists. This is not just a problem in VA; it is a problem in private sector as well. Obviously, more providers require more space. As the number of patients is increased, more clerical staff is required not only to help schedule patients, for instance, but also to provide triage for providers. Scheduling is a problem. The recall letter system implemented several years ago has not improved things, simple made them worse, in my opinion. Centralized call in centers tend to be impersonal and might be better replaced by local systems where people answering the phones know the providers. In any case, such clerical personal need better supervision. Central Office has to be more realistic on access times. I now understand that all new consults (non-emergent) must be seen within 30 days of request. That sounds great, but probably is unrealistic. Private sector does not do that, as assessed in my non-scientific survey of many endocrinologists outside VA :). There should be incentives especially for clerical people who are critical to smooth flow of the system. Weekend and evening availability is not critical since many patients are retired and coming during the day is not a problem. If late or weekend services are offered, they need only be limited and all involved should get incentive pay. Fee basis, in my opinion, should be limited to people who are very, very far from VA facilities. There are unanswered questions about fee basis -- how long does it last, who writes the scripts, will VA pay for meds acquired outside VA, how will VA oversee the outcomes?"
"Often, though not always, time spent in calling patients or writing letters about lab results could be done by others. Obviously, there are some sensitive, serious situations in which the provider can/should call. The scheduling system needs to be simplified and upgraded. The patient should have a appointment date for the next clinic given at the clinic visit. The recall letter system wastes time and is inefficient. Unnecessary documentation refers to answering clinical reminders. The reminders are usually helpful and some (but not all) need to be answered. No-show is a chronic problem both here and at our university affiliate. I was on a committee to solve the problem but we could not! Patient flow in clinic needs to be faster. There are too many things that have to be done at each visit. This is where more clinical support is necessary"

"Safe and quality diabetes care CANNOT be delivered to all veterans who need it in the current care delivery paradigm. We have strong data that system based diabetes case management models work well but facilities must provide sufficient qualified personnel (diabetes case managers) AND support medical directors (e.g.MD, DO) to oversee these programs. The type of effort involved in effective/safe diabetes care that is well established to be time-intensive MUST be able to be captured and recognized as effort (beyond current RVU based methods) . the number of Primary care MD''s are also currently insufficient to provide diabetes care to patients who are not high-risk (that diabetes case management and endocrinologist see)."
We have strong bariatric surgery programs regionally.
schduling grid archaic. we need more space to see patients on days with many rotaters

Personnell are doing the best they can w/ their resources. Having more PharmDs to help manage diabetics aggressively would help.
we only have one endocrinologist in a state with huge numbers of patients with diabetes. Having additional specialists and pharmDs to aggressively manage patients would help.
same as previous comments.
delays occur due to staffing shortages. fee basis is used but there is delay there too. we do not get reports back from fee basis providers.
cardiologists at our facility do not see patients for lipid issues..this is a primary care providers job. They see acute cardiac issues promptly.
"Providers are taskes with doing everything. Despite PACT, this stil occurs. View alerts keep providers doing admin work. They are not focused on face to face patient care."

"often times directives/madates/policies from central office bring challenges from a clinical standpoint, this makes it difficult to provide care"

we do not have ophthalmology on site so cannot answer for their issues. for retinal attention
would be helpful to have access to contract providers for extended leave issues; and local podiatry access to community is strained
"staff shortages, delay in hiring, Many dm 2 treatments can be nurse protocol which are being developed now"

"We need more endocrinologists at [location redacted] Section of Endocrinologist. Candidates were interviewed however annual salary was not attractive for them to accept the position.
Nursing staff- At this time, we have 3 nurses with 2 full time endocrinologists but when we have a third endocrinologist in the future, nursing support staff is needed. It does not have to be an RN that will be helping the section. A health tech or LPN is enough for nursing support staff."
"We are in need of more endocrinologists.
There were a number of candidates who interviewed however annual salary was not attractive for them to join the VA [location redacted]Section of Endocrinology.
Re:Nursing staff. At this time, nursing service provided a 3rd support staff for 2 full time endo mds but when the third endo md will come in- Nursing support staff will be needed. It does not have to be an RN. LNP or Health tech is good for us."
We need more podiatrists at [location redacted] VA. There were at least 2 podiatrists left and have not been replaced. More technicians are need for toenail trimming. Choice care is being offered as the section can’t cope up with the demand
"Section of Nephrology: Inpatient and Dialysis unit were added to the services offered by the section however the number of Nephrologists were even lower. One nephrologist left for almost a year and no new nephrologist came on board. One is leaving in 6 weeks. We are down to 2 nephrologists. Waiting time for a new consult to see them is around 3 mos.
Same holds true with podiatry staff as previously stated."
Having more Foot and Ankle surgeons would decrease the delay of patient care. More Technicians for toenail trimming would decrease the back log .
"Certain Nursing staff unwilling to help out medical provider eg: faxing outside prescriptions or going thru Prior authorization for a certain drug to be approved. Front desk staff takes care of the flow of the patients coming in and checking in and receiving phone messages thus medication related issues should be done by nursing staff.

From 3 full time endocrinologists down to 2 full time providers and absorbing the patient pop'n on top of our patient population, the no-show rate is low. It''s difficult to reschedule because there are no slots available ."

"Additional clerical support needed for scheduling and consult management.
Scheduling software is one of the biggest impediments to patient care. VISTA based package is bulky, not user friendly, and unqueriable in a meaningful fasion.
IT support for glucometer downloads is lacking in terms of manpower and capabilities."
Please refer to clerical support and scheduling software comments from previous section.
Clerical and scheduling issues are same as previously. Additional vascular surgery MD FTEEs required to manage the volume of vascular burden that this facility sees. Unable to recruit fulltime vascular surgery MD staff due to marked discrepancy with community salaries.
"MDs spend inordinate amount of time managing alerts, 50% of which could be handled by lower trained staff. Scheduling package is immensely cumbersome and impedes patient care. Difficult to cancel and reschedule without getting penalized due to performance measure standards relate dto canceled by clinic standards. Space is major impediment to care impacting pt flow on a daily basis. Insufficient exam room space and cumbersome clinic layout not conducive to robust patient flow. Insufficient clerical staff to support the volume of patinets being seen in clinic. CPRS requirements have rendered chart documentation almost useless unless there is free text somewhere within the note. Administartive burden is heavy with documentation requirements, TMS requirements, etc.... that have no bearing on direct patient care."

"The endocrine section at the [location redacted] VAMC lack administrative support staff for diabetes related patient care activities. More administrative support in this area would be greatly appreciated on behalf of the Veterans.
A large amount of administrative requirements such as clinical reminders and view alerts which focus on directives and policies take away the ability to concentrate more on the Veteran''s overall health care."

Hiring additional staff to do nail care for veterans with Diabetes which fortunately is being done now.
"Numerous requirements for bariatric surgery, not all of which are consistently clinically relevant"

working to increase the availability of services

"Scheduling is often not appropriate and there are few dedicated, capable individuals to accomplish this. I have gotten certified to perform scheduling simply because I cannot rely on our system to provide appropriate, adequate scheduling assistance, clearly beneath the scope of my practice as an APRN, CDE specializing in the treatment management of patients with diabetes. We need dedicated clerks and provide incentives to keep them in their positions so they won''t always be seeking more money elsewhere in the system."
"Fee basis is not an option I would consider. I think veterans should be seen within their facility. I think more trained clinicians should be available to see these patients and more support staff to ensure adequate use of the clinician''s time/expertise.
All persons from the top down to the bottom up should be held accountable by ensuring their time is not spent surfing the web, watching movies on their phone, making personal phone calls, or yucking it up."
"This is not available for patients and should be. They must jump through hoops designed by ”Dietary?!”“ Why not Endocrine of APRN specialists? Absolutely they need to show accountability prior

to surgery, but nutritionists decide whether or not they should be given the go ahead. I think Endocrine of APRN specialists should have this responsibility"
"veterans need to be seen immediately when limb threatening lesions present; they are often sent to ER where trained staff are not available. They will often call for vascular surgery to evaluate, but not always."
"Must merely monitor and manage lipids more rigorously, either by more personnel to see and counsel and treat the patient, or specialty clinics for this."
"Need more podiatrists or foot nurse specialists to see, treat and manage LE wounds, DM problems immediately."

"More nursing would facilitate calls regarding bg management advice
Dopplers at all clinics where I perform telemedicine visits
I just went from 70% to 100% endocrine practice. Not sure yet how good my access will now be. Previously poor
I am also increasing my telemedicine (CVT)availability. Good resources are available.
telehealth (CCHT) is readily available and very helpful.
Out-sourcing endocrine care tends to fragment care, since communication is less good.
Group medical education and group medical visits. We have implemented a multidisciplinary comprehensive diabetes education course. Group medical visits for patients with diabetes are likely to be helpful."
group medical visits
We have urgent care such that urgent issues can be treated. The delays when patients call before they can speak to the call center is a real barrier to their calling when having difficulties. The CCHT nurse will often pick up on problems and notify me.
"Delays in being seen in boston. Challenges in reaching service due to need for more clerical personnel make facilitation difficult. For vascular procedures, due to the cost of eval, outside referral is likely not cost effective"
"We just increased cardiology, which should help
more use of econsults."

"WE need a certified diabetes educator for hospitalized patients. We need at least a second diabetes educator for clinic patients.
We need a behavior health person to help us while we are in clinic
We need a dietician present when we are in clinic.
We need a full time nurse case manager who is a diabetes educator to help manage our patients.
We need our own nurse to room our patients- often the nurses rooming our patients are inadequate.
WE need more SPACE- we need an area designated for classes for our patients,
THe diabetes educators space is abysmal- she is working in a closet.
THe exam rooms are not well stocked- we stock them ourselves.THe exam tables are facing the wrong way.
THe scale and height measuring is inadequate.
WE need to be able to do a point of care a1c.,
WE need new dragon systems in all the exam rooms.
We need a secretary who will have time to help the patients more - who they can call and will be assured the doctors receive their messages.
We need to have bariatric surgery done locally - bariatric surgery cures diabetes, it needs to be an easy process without a lot of hurdles to jump through before the patients can speak with a program."
Patients need to be able to have bariatric procedures easily and locally.

"Patients must be able to call and speak with someone and schedule an appointment to see a primary care physicain within 14 days. From that point the patient can start treatment and be referred to the proper specialist, if needed. Communication between the patient, HAS staff, and primary care must be improved. The number of no show appointments need to be reduced by proper scheduling. They also should have a separate walk in clinic for veterans with urgent needs (not part of primary care) that can triage patients appropriately."
Patients should have access and in some cases same day access to a dietitian which would require an increase in number of staff. Also need to improve scheduling procedures to reduce the number of no show appointments which impact all veterans.
Patients should be scheduled efficiently and expeditiously. The number of no show appointments needs to be reduced. There should be podiatry designated to see scheduled appointments but should also have podiatrists available for same day access.
"Currently, at this VA center we do not have immediate access to surgery on site because there is no inpatient services. All surgery is fee based out to the community. Between the time the consult is placed and the patient is scheduled with outside surgery should be within 14 days, but that does not always happen within that time."
"Our clinics have a 10-15% no show rate which impacts negatively on patient accessibility. We have some nurses who are RNs who do not practice at the level of their training and only check patients BP and weight. We have multiple issues with scheduling with not utilizing all of our clinic availability, not rescheduling patients within a reasonable amount of time."

"There is not adequate space for the increased capacity of patients we should be seeing. It would be ideal to have a check in space, then 2 exams rooms for the providers. This would allow for increased flow and increase the amount of patients we could see. At this time, we only have one endocrinologist and one full time CDE working in the diabetes clinic. This is grossly understaffed for the needs of the facility. At this time the PACT teams have inadequate follow-up for their patients with uncontrolled DM. Better staffing could improve this. Would also like to see closer monitoring to make sure providers are acting within guidelines. Well trained clinical pharmacists to help with patient management would also be useful"
"Need more endocrinologist, psychologist to support the diabetes service, midlevel providers to extend endocrinologist, RN to assist providers, clinical pharmacist, additional health technician for patient check in and support with scheduling. Also need to increase space."
"need increased eye providers to do exams and treat growing population; need techs to support providers and schedule patients. Need full eye lanes to be able to evaluate patients. Clarification regarding the retinal exam policy would be important. If teleretinal imaging could be done as screening every year, it might free up time of the eye providers to see those that truly need an exam"
We do not have our own vascular surgery department. We utilize fee basis to receive care. Delays typically occur when providers don''t refer early enough to vascular surgery
"Space is a significant issue. Lack of space prevents growth of the service. We currently have only one full time cardiologist for the main facility and surrounding CBOC''s. Much care is sent to fee. With additional physicians, additional support staff would be needed."
Staffing and space shortages limit the ability to see more patients. Increased use of telehealth would help to support the CBOCs

Physician and nursing staff shortages have increased patient wait times; hence the above answers
These questions better answered by Medicine service Chief
none

"dedicated diabetes clinic
support staff (RN/LPN, CDE, Foot Care) for chronic disease management"

"Most services for diabetes care are provided in a timely and effective manner. The one area where delay continues is in opthamology where issues exist due to lack of providers, clinic space, and clinic flor. More assistance is needed to help them organize their current system and expand given the huge patient need."
"Current process to refer to bariatric surgery is cumbersome. Patient must complete a 5 step MOVE! program and often “drop out” of hte program before moving onto steps in pharmacologic treatment, meal replacement, and surgery. Because of this, the number of bariatric surgeries done are incredibly low compared to outside hospitals. Further, no meal replacement program exists- a key step in the process."
Please comments for retinopathy. Same comments exist for opthamology referrals. Too few providers and space given the need. Further organization within clinic is lacking per patient report.
Our endocrine section is small requiring clinicians (MDs and NPs) to take on more administrative responsibility than elsewhere. However; recent changes to admin help in past 6 mos (MSA supervisors and 100% MSA coverage to endocrine) has helped this immensely.

"increase number of pact members-pcp, rn, lpn and msa in some clinics. patient compliance is a primary issue in glycemic control success."
increase endocrinology f2f appts. patient compliance is a primary issue w/glycemic control.
no available routine appts >90 days. need more staff-podiatrist and support staff. not familiar w/space in podiatry but suspect increased staffing needs more space and equipment. patients are being fee based to private sector but many patients are choosing to stay w/the VA-will take next aa.
"need adequate staff including LIP’s to do the exams, functional equipment and physicians to read the reports."
need adequate staff and providers to schedule and evaluate the patients
scheduling staff need to be efficient. all trained professionals need to function at their highest level. RN’’s could monitor the problematic uncontrolled patients under the guidance of the pcp.

We do not have endocrine onsite - I cannot assess why the larger VA we refer to has delay
Cannot assess why the larger VA we refer to has delays
We are trying to recruit a podiatrist - federal pay scale (podiatry/optometry and chiropractor are on one scale) is ridiculously low. Remote/rural area - fewer options for fee care here. We are also recruiting a nail tech
I cannot assess why the larger VA we refer to has delays on consults from us
"Cannot assess why the larger VA we refer to has delays
Limited care in rural location on fee service"
"We have a 0.2 cardiologist - not adequate for 17k pts
Refer to larger VA- cannot comment on their issues"

Too many measure put in place by CO just distract the frontline provider from actually getting time to see patients.
Too many administrators creating tasks for front line providers that distract from patient care.
More clinical space needed!

Retinal specialists are a highly paid specialty - huge wage disparities significantly hinder ability to hire

Increasing salary and CME training opportunities and reimbursement

"Regarding licensed independent practitioners though not critically important, adding mid-level provider with diabetes management to primary care could improve the patient care and the level of care provided by existing providers
Is even more important than other personnel such individuals greatly increase the tailored individualized pa is even more important than other personnel such individuals greatly increase tailored individualized patient car and increase the knowledge of the PC providers.
A huge concern is the EHR. Our system is not good for efficiently allowing providers to input info and to have point of care decision support. It is too soloed. The customized regional data warehouse reports that have developed across the Enterprise are a testament to how good the integration of info can get but a good EHR would allow that with greater ease and at the point of care. (From what I have seen, the new eHMP does this. PUT ALL POSSIBLE RESOURCES INTO COMPLETING AND RELEASING IT)
Regarding central office policy, let''s use our nationwide innovative resources to recognize our best practices, the facilitate their dissemination. E.g. In 2008 after seeing it demonstrated hands on at a veHu conference, I came back to my site with a proposal to create a process whereby incoming faxes would not be printed, circulated as paper then scanned back in to the EHR. Keeping the documents in electronic format and ""capturing"" them into Vista has so many benefits. Despite receiving a cash award for the idea we have made no change (in 7 years). The stated concerns related to information security and stumbling blocks included purchasing fax/copy machines that were incompatible. It''s being done elsewhere in VA but we languish with an archaic process, a champion who has spent his enthusiasm, and resources wasted on equipment that did not facilitate progress.
I am taking this survey at 6AM on a Sunday. We don''t need more supervision and incentives. Sure I want more money for what I do, a asked for it and got little, but one cannot develop the perfect set of incentives to drive the progress. Just remove some barriers to efficiency, provide the type of support mentioned (space for one on one teaching and for groups, excellent diabetes educators, and a facile EHR) FYI it take roughly 30% of the time allotted for office visit to document,place orders etc. there''s room for improvement when our highest paid personnel are doing this...."

Also, since fm specialty care is not strongly reliant on the physical exam, telehealth is certainly appropriate"
Teleretinal even in clinics co located with an Opthamology service
"Comments regarding CPRS were already made. The scheduling system was developed shortly after the Rosetta Stone was created. Need I say more? Having the space and team let functional support to allow the provider to do, in their time directly with the patient, what only a provider can do is the goal to be sought."

"space is critical to accomodate needed eye techs, pharm D''s and clerks, Endocrinology is a very difficult to recruit specialist in our area, t few local FEE providers accepting veterans due tothe cumbersome process to get authorizations approved and paid, The CPRS system needs a complete revision, the amount of time Providers use on clerical duties and clearing view alerts could be better utilized in direct patient care."
"Additional space needed for more LIP''s and group appointments,use of tablets for nursing will increase the availability of clinical space ,the fee process requires incredible amount of time on the PCP''s for entering information, consult requests create multiple unnecessary alerts and create a bottleneck in providing timely response to the veterans needs/
Nursing needs training on how improve triage skills. and need more diabetic educators."

"We have the resources but have not improve the workload, have room for improvement on supervision and employee training and education"
"Need space for Ophtalmology, need at least 2 ophtalmologist not able to recruit, support personnel is available but retention is poor, perhaps incentives to stay will increase VA committment"
"Providers are tasked with menial clerical duties ,(i.e. manually entering all lab orders because MAS now is not ”authorized”“ to transcribe orders from a progress note to the orders tab in CPRS) . In our HCS Unscheduled visits are allowed all day long, creating disruption of the PCP’’s schedules flow, the fact that we do not have a Hospital or Emergency Room gives the patients the impression that they can come in at anytime for anything urgert or not, perhaps the creation of an Urgent clinic in each of the 3 largest clinic will work , but again we are in a geographical area difficult to recruit and retain Providers. The non va care consult system has created an extraordinary amount of clerical/administrative time consuming duties that PCP’s devotes less and less time with face to face or direct patient care. decrease job satisfaction and burn out is also more frequesnt now than before non va care was initiated, we need administrative coordinators of these visits."

decreased training requirements and increase provider clinic time
increased provider access in CBOCs
this service is not available at all locations but is a referral
to much mandatory training

"We need more endocrinologists at the VA to take care of our veterans’’ needs. More support staff such as nurses, dedicated diabetes educators and pump specialists are needed to help support physicians take care of veterans."
"To help with patient wait times and improve diabetes care, more endocrinologists and support staff such as diabetes educators and nurses are needed."
"As mentioned earlier, with more staff, more veterans can get better quality care."
More nephrologists are needed to take care of more veterans
More staff will help patients be seen sooner.
"With more opthalmologists dedicated to treating diabetic retinopathy, that will help veterans to be seen sooner."

Organization and reporting structure is not aligned ideally to facilitate team function
Availability of vascular surgery providers within facility would aid process
Having additional providers either by telehealth or comunity referals is important to providing timely care
We need access to additional providers to meet targets for timely evaluation
Providers report that 20-40% of time is spent on tasks that can be done

Our local VA is acutely short of specialist Local. Non VA endocrinologist are already overworked
need more endocrinologist in the VA. Local non VA endocrinologists have long wait time

"Question licensed independent practitioners: this refers to physicians, MD
Question personnel supervision, management, or incentives: I think that it should be given emphasis to the fact that VA is a premiere medical institution and the culture should not be ”well this is the government” but “this is the best medical provider of the country”. In the context of creating a culture of excellence there should be rewards and incentives when established performance measures are reached

Question Increase weekend and evening availability of services: by not restricting our activities strictly Mon Fri 8-4 we will be able to amplify the number of encounters/activities/procedures. Specialists should travel from tertiary centers to community clinic and have weekly clinic.
Generally speaking I do not believe I increasing fee base services. If the mission of serving the veterans is presented in an attractive fashion, VA labor force will develop a loyalty toward the veterans, and services will be of higher level when given in-house rather than by a fee-based facility"
Comments here are the same as in the section of the previous page
[I work at a large VA hospital], and yet it does not have a bariatric program. This is a serious lack, because ~ 40% of our patients are obese and prospective studies have shown that bariatric surgery decreases CV morbidity and overall mortality, and cures diabetes. We refer our patients to a dysfunctional bariatric program in our VISN, which from what I understand (unofficial information) handles 10-20 patients per year. The threshold to send our patients to this center is very high, many are refused after they complete a very large number of tests -some of which invasive-. It is a loosing enterprise and the consequence is suboptimal or no patient care. In my opinion every tertiary VA hospital should be given funds to generate an internal bariatric programs. I do not think fee base initiatives are the answer to this problem."
Patient with acute vascular problems are usually seen right away. Patient with sub-acute problems may experience delays. I have not been able to determine if the changes in personnel promoted by VACAA have implemented changes in this area. No need to increase fee base services in this area if the philosophy of the agency is to generate a culture of loyalty to customers (i.e. veterans).
"A problem is that nephrologist are very well paid in the private sector, and it is difficult to recruit and retain nephrologists at VA hospitals."
Like for nephrologists there are not too many podiatrist working at the VA.
"One of the most frequent comments I hear is that we are spending a lot of time being our own secretaries. Mid levels (PA''s and NP''s) and administrative personnel (PSA''s) are usually doing excellent work. The agency does not do enough to attract PA''s, there should be a well outlined career path for PA''s. The agency has been at the forefront for the use of technology, but has an incredible fear that there will be a leak of private information, and so use of technology some times is delayed. For instance, we do not have wifi."

executives need to be more proactive in access problems solved

we have made efforts to improve flow but space per provider remains rate limiting. Each provider has only one exam room and this limits ability to increase number of patients seen
Actively recruiting for ophthalmologist. New chief has been recruited and will start in 3 weeks. Delays in getting equipment and software. Getting trained Eye tech support challenging from a HR standpoint.

- **Gynecological Surgery**

We are currently trying to hire a part time gynecologist.

OB/GYN services did not participate in teaching training requirement as there was not enough clinical space for the students.

[Location redacted] does not refer any Gynecology patients to other VA facilities. I cannot comment on any Gyn clinic scheduling/access issues another facility may be experiencing
"[Location redacted] refers gynecologic cancer patients to the community, typically to our academic affiliate. Care delays occasionally occur. Typically these originate out of the Fee office e.g. due to delay in authorization, non-receipt of authorization via fax by outside vendor, or delays in scanning outside records in for VA provider review. Solutions include increasing Fee office FTE, streamlining fee processes, and adding RN care manager FTE to ‘‘ride herd’’ on critical patients being referred out into the community"
"[Location redacted]has 1.5 FTE Gynecology, which is more than many VA facilities. Gynecology is present at 4 sites including our VAMC, and hopes to expand to 6 sites in FY16. Owing to our geographic reach, occasionally clinically signficiant delays in care occur. The main determinant in delays is Gynecology FTE - a Gynecologist can only be at one site at a time. Additional determinants include lack of a RN care manager for Gynecology, OR access constraints, antequated scheduling software, and burdensome documentation requirements that take time away from direct patient care activities."
"VISN[location redacted] has two robust Gyn surgical programs: [locations redacted]. [Location redacted] closed its Gyn surgical program in 2014 due to a single adverse outcome. [Location redacted] has a non-operating Gyn. [Location redacted] is highly selective in what they do and refer harder cases to [location redacted]. Solutions for delays at other facilities include restoring [location redacted] Gyn surgical program, and increasing Gyn pay to attract high quality surgical Gynecologists that can perform surgeries locally. The number of Gyn FTE in VISN [location redacted] is an issue, but also the quality and capabilities of existing FTE"
"Same comments as for fee appointment access - need to improve Fee office processes, can hire RN care manager FTE to ‘‘ride herd’’ on Gyn surgical patients referred out into community"
"Occasionally, [location redacted] women Vets experience clinically significant delays in getting surgery. Any emergent cases are done on a same-day basis. Main determinants of delays include Gyn FTE and OR access. [Location redacted] has a small main OR (4 rooms) and runs at >80% capacity utilization. To improve OR access, would need to add more OR personnel, which would allow us to open up more rooms on Fridays and perhaps do weekend cases"
"Main determinants that adversely impact Gyn clinic and surgical care include Gyn providing care that could/should be provided by others (this clogs up our clinics with routine care items), slow IT systems, documentation requirements, and lack of adequate support staff. In my opinion VA should take the PACT model and apply it to all specialties in a modified format i.e. relax the 1:1 provider to care manager ratio. Administratively, too often we are assigned duties without adequate data reports, and without staff well versed in how to generate that data. So we spend gobs of time figuring out how to get the data we need. IMO every administrative duty assigned should be accompanied by a list of the data reports that will be needed, and a plan to generate any new reports that are needed but do not already exist."

"The reason for delay at our local VA is that I am not approved to do laparoscopy or laparotomy at [location redacted]. I have to take these cases to [locations redacted]. I have to cancel a day of clinic to

go to those locations, so I often will schedule the surgery for 6 wks or more from the time of the consultation. This is to avoid having to reschedule already booked patients in my clinics."
"The biggest improvement could be made by allowing gynecologic laparoscopic procedures (for ovarian cysts, endometriosis, adhesions, etc) and laparotomies (hysterectomies, myomectomies, etc) and vaginal surgery (vaginal hysterectomies, cystocele, rectocele repairs) to be done in the [location redacted] ORs. I could block a 1/2 day/ week for such cases. It would be SO much easier for the patients than driving 1-2 hours further for their procedures, with an additional day to get anesthesia beforehand at [location redacted]. I would not have to cancel as much clinic time. Patient care would be more stream-lined, efficient, and more accessible to the patient.
In response to the first question above, we could use another gynecologic procedure room, so that when both gynecologists are in the clinic at the same time, we can both see patients. Right now there is only one room.
If allowed to perform procedures here, we have most all the equipment initially needed already. Exception is suction D&C equipment, which would need to be acquired.
I need a new exam table. There is no height adjustment, and it needs to be wider to accommodate our bigger patients."
"I start appointments at 740am. If my RN calls in, there is no one in the clinic in the morning to assist me or chaperone.
If iMed consent link with CPRS is not working, it significantly impacts my clinic as many of my appointments involve procedures - all of which require an iMed consent. There have been at 3 occasions that this has occurred in the past year. One of them lasted several days, despite many work order requests. I had to do written consent forms, and this delayed the clinic and increased work burden.
There are many TMS requirements that do not seem effective or useful. They require a great deal of time to complete each year."

"We need another physician, nurse, and medical support personnel"
simplify administrative processes for approval and transfer to care in the community.
Too many administrative requirements

"Typing takes a lot of time that culd be spent with teh patietn, a dictatoin or transcriptoin systme would allow more patients to be seen per hour."
"we need two providers, one a gynecologist wiht each ahving a RN assistant-chaperone
At our facility equipment is not a problem"
The private sector can not see refferals in < 30 so why does the VA system think it can see patients < 30d for appointments
This is a very poor survery. Questions are not specific enough or easy to understand. I feel this is another wate of VA funds that will not benefit the veteran.
"I think this is a very poor survery. The questions are not specific, and many are redundent. Another waste of VA funds that wont change anything to help the veterans"

We are in process of selecting an additional Gynecologist and will add surgical care as a new service line with this provider
Streamlining fee basis care will lessen delay

"A support person is needed. Currently, the coordinator does pre-opt teaching, pre- and post-op calls, triage patients, triage consults, schedule, coordinating with ancillary services, etc. It can sometimes be overwhelming"

"A support person is needed. Currently, the coordinator does pre-opt teaching, pre- and post-op calls, triage patients, triage consults, schedule, coordinating with ancillary services, etc. It can sometimes be overwhelming."
No Gyn on staff.
Additional staff is needed to facilitate the initial approval of fee-based referrals.

"This Facility has a tremendous shortfall in surgical space, resources, & management of such. Consequently, GYN is only afforded ONE DAY PER MONTH of block time in the OR. This allottment is not close to sufficient for the volume needed. Additionally, given the oft requirement for timing surgery with menstrual cycles or simply offering Veteran centric availability for working women & families, this is obviously inadequate. Resultingly, 50-60% of our GYN surgery is done on days other than ""block time"", using other surgical services time who are on leave or are underutilizing there time. This practice is inefficient & demoralizing.
Despite the above circumstances, the GYN service manages to avoid most clinically meaningful delays in surgery by using the strategies outlined above or alternatively, if it is determined that our surgical schedule or lack of resources will not allow care at the local VA Facility, prompt referral of Pts to Fee Basis is done on their initial GYN surgical consult."
"The scheduling packages for both clinic appointments as well as surgery scheduling are in a word, abhorrent. They are inefficient, user unfriendly, & realistically, a decade or more outdated.
Data management is woefully inadequate. We have reams of data but no section or service administrative managers to present meaningful summaries to Section Heads or Service Chiefs that can be used to show what's working & what''s not.
Contracting for purchasing specialty operative equipment is terribly difficult. Often this equipment is ""one of a kind"" & requires sole source justification. That process and methodology appears to be materially flawed. For instance, we purchased a proprietary electrosurgical unit generator (ESU) to do a certain type of endometrial ablations. Sole source justification was performed and approved including full transparency regarding anticipated volume for ongoing use of the proprietary single use disposable handpieces that are used with the ESU. Purchasing these handpieces continues to be an ongoing saga of duplicative futility with contracting requiring repetitive sole source justifcation. I have had to make extraordinary arrangements to get equipment to do timely procedures at the VA that if I were in the Private sector, would never even be an issue.
Support staffing for GYN clinics is way below what''s used in the private sector. We are often operating at a ratio of Nurses/Providers of < 1/1. Considering the following issues: 1. EVERY EXAM requires a chaperone, 2. EVERY PROCEDURE requires a chaperone plus pre & post procedural teaching/monitoring, etc., 3. Checking in Pts, 4. Phone calls, walk ins, and triage.....we do not have required support staff to allow Providers to be efficient."
"The scheduling packages for both clinic appointments as well as surgery scheduling are in a word, abhorrent. They are inefficient, user unfriendly, & realistically, a decade or more outdated.
"Most telephone triage, f/up, call backs, and lab result calls fall on the physicians.
In the private sector, the vast majority would be done by support staff."

"I answered this question based on delays due to gynecology, not delays due to patient's not getting a medical clearance through their PCP"

"I have not seen a significant delay in patient care in our community. The referral process can be approved by not canceling consults that are placed, but instead communicating with the referring provider to correct any problems with the consults. This would decrease delays in care."

It is sometimes difficult to find providers that will accept VA patients in the community because of low reimbursements and delays in reimbursements.
"The VA''s fee basis staff need better training. Some staff workers lack the knowledge to make referrals to appropriate specialties. We have had patients that were sent out for maternity care but instead of being referred to a obstetrical provider they were sent to a perinatologist, who usually don''t provide general obstetrical services. There is also a significant delay from approval to scheduling with community providers. We have had some patient''s with significant menorrhagia that have had long delays to be scheduled to see the community provider in their area. A consult should never be cancelled, but instead the referring provider should be contacted and asked to correct any deficiencies in the referral. In other words instead of canceling the consult it should be ”worked” by the feed basis personnel to completion. This process would keep physicians from overlooking canceled referrals."
The process would be greatly improved if we could get someone in the Fee service department to answer the phone or return phone calls promptly.

"Definitely could use a Gyne NP to help the gynecologist and also could use a full time gynecologist, only having gyne 1.5 days a week can be somewhat limited, especially if one of those days is a surgery day or a holiday. Also, would be better if the gynecologist was an employee of the VA and not contracted"
Need to have competent employees to help simplify the scheduling system

Our business office can not process our non-VA care requests fast enough and do a miserable job at bill paying. Female vets need to fend off collection agencies and fight damaged credit due to non-payment of maternity care bills.
NON-VA care in our area is saturated. Doing more in-house is the solution
"1)OR time/space, a more welcoming attitude from the established surgical services will be key to getting started.
2)updating the tier pay panel salary max with delay/impede recruiting GYN docs. 250K for a MIGS fellowship trained GYN is insulting and gender biased.
3)Women's health at CO has been very focused and successful at outpatient PC MD/RN training. We need to get our OR nurses and inpatient nurses the same level of nationally uniformed training."
Scheduling for all services is moving to a central location. it''s hard enough for our own clerks to know which provider can place an IUD and which can do a PAP...mischeduled patients is a chore

We do not offer GYN surgery at this facility

We utilize surgical providers at WNY and [location redacted] VAMC sites or refer locally to fee basis providers.

"We do not have a gynocologic surgeon, so all patients are sent out via NVCC/fee-basis."

be able to schedule apptmts with vendors directly by relatively independently functioning PACT teams
This is due to vendor associated lead times for scheduling
Be able to schedule vendor apptmts directly by PACT teams

[potentially identifiable comment redacted] space is already too small to accommodate all of our current providers. In addition, the location which was originally intended for gynecology services is going to be utilized for a different service. Unfortunately, there does not appear to be an alternate area for gynecology services which has the appropriate number of procedure rooms and examination rooms along with appropriately located restrooms.

Number of licensed practitioners: Our greatest impediment to providing prompt gynecologic services is that we do not have an adequate number of well-trained primary care providers"
"If a patient needs gynecologic surgery but has other complicating medical conditions, it is frequently difficult to have those conditions addressed in a timely fashion. For example, preoperative medical clearance for surgery, optimization of management of hypertension, diabetes, hypothyroidism, etc."
"Our biggest problem in providing gynecologic surgery in a timely fashion is having an adequate amount of well trained primary care women''s health providers to identify patients with gynecologic problems and refer them to the gynecology service for further evaluation and treatment. It appears that many women are not being asked if their menses are regular, if they are having pain, if they are having incontinence, etc. In addition, many of our non-women's health primary care providers are ordering mammograms but not performing or referring the patient to a women''s health provider for breast and pelvic exams."
"Our department of surgery has not had a permanent AO (administrative officer) for 2 years. This makes it nearly impossible to get needed equipment, staffing, and resolution of problems.
Our scheduling system is getting worse with numbers of ""no shows" or last minute reschedules. The patients need to be contacted by phone several days in advance so that if a patient cancels her appointment, we still have time to schedule a new patient in that time slot."

Problems with getting another surgeon to assist in major cases. Very limited support from mid levels as well.
Fee basis is the best option for gynecological emergencies. It is important to make it easy and seamless.
"Our biggest problem has been having surgical assistants and OR time for one of the newer providers.
Need MD surgical assist for major cases.
Mid level surgical assistant for both surgeons; adequate block time for both providers in the operating room.
Telehealth hopefully will be utilized in future for consent signing for patients that live far away.
Need provider friendly scheduling system.
Need significant assistance from Department of Surgery and incentives for getting procedures done in a timely fashion (pay for performance measure maybe!).
Need ability to do hysteroscopy and LEEP procedures in the clinic. We have the space but we need more LPN support and ACLS certified RN support to do so.
Need another MSA in clinic to support gynecological services. PACT MSA is supporting gynecological services at present.
It is very difficult to handle gynecological surgery cases in an emergency. Both our gynecologists are part time and do not take call. We need to have a contract with a gynecology group for all these services ideally. That could be our academic affiliate or a private practice group.
Getting equipment is a very tedious process and left up to the gynecologists who do not know the process or do not have the time to do so. We have a Innovations project at present and hopefully learn the process and put it on SharePoint.
We need more training for OR technicians and nursing in post operative period for gynecological cases.
VA should pay the bills in time so that private contracted service providers do not opt out of providing service to our veterans. It is a major problem with our OB patients."
"The process of getting surgery done is long and tedious. We have a 0.2 gynecological surgery coordinator but still there are many barriers to getting surgery done.
Poor support from affiliate for gynecology.

There is a lot of paperwork in the VA that physicians are expected to do as compared to private sector. It is a major barrier for recruitment of quality providers. New providers need a lot of administrative training to function optimally."

Increase communication in electronic consults.
"Improve coordination of fee basis care, getting appointments made, communicating results."
Improve communication.

fee based process is too slow
fee based process takes too long

"increase number of gyns on staff
provide orientation of MODs on womens issues and for new providers as well"
"Having additional gyn md availability.
Being able to schedule an appt after hours
streamline credentialing process
address womens issues at part of MD /provider new orientation process as well as MODs"
"increase number of gyns
provide training on womens issues to MODs and new providers"
"MD finds paperwork burdensome esp with biopsy and specimen questions that don''t appy to gyn but are required to fill out.
Understaffed due to budget"

"We need more primary care providers, nurses and some specialty care. Once our women get in our system there is no delay in patient care. Getting into the system initially takes too long."

We desparately need more space and more providers. We are being blamed by our congressman for appt delays and they are his fault for not appropriating money to make it possible for us to see more veterans without delay.
[name of contracter] seems to be a borrle neck in approving veterans for non VA care!
[name of contracter] is the bottleneck in getting Veteran care at non VA locations

"Increasing work space would allow the hiring or an additional provider which would decrease patient wait times for an appointment.
Hiring of a part-time Gynecologist would decrease wait time for surgical initial evaluations and wait time for surgical procedures to be performed.
A nurse tech as a chaperone would increase productivity because the nurse would be able to screen the next patients in line for an appointment.
An a electronic tracking system for preventative screening would increase productivity of current staff. Women"
Creation of additional space would allow the hiring of a nurse practioner or gynecologist to be hired to assist with the clinic. The hiring of a nurse tech to chaperone patients during exam instead of nurse so that the next patient may be triaged and checked in. Currently the process through [name of contractor redacted] in Fee-basis and contracted care is causing delays. In addition when [contractor] calls facilities to schedule appointments they have no medical knowledge or ability to look up the answers. This leaves the facility in the dark on exactly what is needed for the appt and whether the appt is considered more urgent than the consult was written for.
Delays due to [contractor]

All Gynecological surgeries are fee-based

"When we do a fee basis consult, we do not get direct immediate feedback as it is being processed because GYN here only 0.15 FTE. The two times there were delays, the patient had to check in with the LPN in the WCCC to assure that the fee basis consult was moving along. It would be helpful to have a nurse care manager assisting with this process."

we have 2 part time GYN Providers and they have been able to manage the workload without delay Women''s Health clinic has a higher no show rate and or patient clinic cancellation rate than any of the primary care clinics. MSA Staff work with patients on appointment dates and a reminder letter is sent to the patient about the appointment date and time about a week ahead of the appointment. We are working with the PACT Teams to establish other ways to decrease the no show or clinic cancellation rate.
"To streamline the Non VA Care for Reproductive Endocrinology, Infertility, Gynecological Oncology and Maternal Fetal Medicine, the Veterans needing these services have been underserved in the past and their care has been delayed. Moving forward, these Veterans should be evaluated with 7 days by VA Point of contact to identify appropriate referral, education of the Vetran and get all the necessary pre-workup in house."
Simplify administrative process by educting providers.

"[Location redacted] VA only has limited GYN resources and have only recenlty reinstated GYN surgeries at the site Wait times for appts are long and not realistic for someone with an urgent need , these veterans are referred to community thru fee basis though now being told should be VA Choice , providers must enroll and this is not a timely process"
[comment redacted because potentially identifiable]

"b: increase # of GYN providers at [location redacted] (Facility that we refer to)
f: need more efficient scheduling system that includes texting capabilities"
scheduling is not efficient for VA nor Non-VA appointment
obtaining records/documents can cause a delay at times
obtaining records and/or documents can cause delays

"We have no in house GYN, getting records back in a meaningful way into our system does not exist."
Need more providers in rural areas lack of providers is worst problem

"We will be required to hire and support FTE in Gynecology. In the interim we need to increase the efficiency and productivity, which may include increasing numbers, of Case Managers while we are exclusively outsourcing. Streamlining records management will certainly help."
W lost our only Gynecologist in 12/14 and we are primarily outsourcing care. We need to continue recruitment efforts and will hire ASAP; and have the equipment and support staff to run the section efficiently if more than one provider is obtained.
"The best way to improve this is to not have to rely on it, in other words to hire and retain our own FTE in Gynecology and support those FTE. In the interim we need to improve the efficiency of the fee process and the efficiency and productivity of case managers involved in that care."
Hire and retain FTE in Gynecology

Create incentives for providers performing more than expected RVUs.
Improved transportation to sister facility VAs for patients traveling for surgery.

Improve electronic communication between non-VA care providers and VA providers to facilitate timely transfer of patient information.
Create incentives for providers who perform more than expected RVUs.

Improve primary care pract. referral process so appropriate cases referred and other abdom pain worked up before assumed to be GYN
acquire more instrument sets for the OR

Having specified NVCC consult services. For example Gen Gyn vs Gyn-Onc or REI. Patient''s often have to go through another generalist on outside to get to specialist they need.
"More streamlined and helpful consult templates.
Holding primary care providers to completing paps so consult spots not clogged."
Limited OR services and days do not allow for many surgical cases. Also OR process inefficient and time consuming for doc and patient.
"Again, more specified fee consult tabs."
"- Less paperwork to schedule.
- Less convoluted scheduling process.
- Better trained OR staff.
- Higher level of OR services to reduce number of fee-based patients"
- Hard to get a return appt for preop planning b/c no return spots left in schedule. Schedule overfilled with new consults. Mays f/u and planning difficult.

‘
"Increase the number of other personnel - Fee needs to have more nurse care navigators to coordinate care and ensure resolution.
Improve information technology by allowing the record systems to communicate with one another. If this is not possible then the nurse navigator would be most useful here.
Change ""central office policies"" that affect workflow and efficiency - VA Choice was not rolled out very well. It is not standardize and it is still quite vague."
"Increase the number of other personnel - We need the auxiliary staff to support the providers. We need LPN, RN and a MSA or a chaperone that is separate from the LPN/RN, particularly for this patient population. We are currently functioning with one or the other but not all 3.
Improve information technology - Dhcp is outdated and does not merge well with CPRS.
Change ""central office policies"" that affect workflow and efficiency - The current system for measurement of success does not correspond with Direction or mission of the agency. One example, If we are to fully implementing PACT then the clinic utilization should be low. We continue to stuff successful PACT clinics with more patients to meet access numbers. We implement PACT or missions without the infrastructure to be successful.
Improve personnel supervision, management, or incentives - Our salaries are not competitive to the private sector. Our nurses cannot bonuses or pay for performance which is positive incentive.
Improve access to care by increasing the number of designated women's health providers and ensuring all the clinics are properly supplied. We also need to have access and time to attend regular training. Lastly they need POC pregnancy testing."
"Increase the number of other personnel (e.g., nursing, technicians, pharmacists, clerical staff). -
Increase the number of nurse navigators and MSAs for NVCC.
Central office polices as per previous discussion."

"nursing, technicians, pharmacists, clerical staff and a gynecologist"

there is limited resources in the community that accept VA vouchers
"physicians, nurse practitioners, nursing and support staff"

"we have a university and excellent private community however hard to refer because of cumbersome mass fee and one unit refers to private drs through their primary care system
we consult for the current need 2 days per week and prn as needed so servie may change with increased numbers"
"we need uro gynecology services
less hassle with referring infertility patients or referring patients with complex gyn urology needs a limiting factors is rooms, privacy, chaperones and if we get urogyn we need more clinic time ultrasound vaginal series should be available on the clinic we need urogyn equipment for diagnosis in the office we need a microscope for teaching and diagnostic purposes we also need diagnostic hystersocopic equipment and training and we need to be able to perform sonohysterograms for diagnosis rather than needlessly putting all people to sleep"
it snafus are always very common and overburden our efficiency
we do the best we can for the load alwys looking for better ways to offer more on sight services and to avoid delays biggest issue we always need more nursing staff and other support for exams and organizing care
overburden with enormous administrative bureaucratic t time taking away from patient care

It is difficult to say what another VA facility needs to provide more services but the biggest problem to accessing gyn surgical care at another facility from the view of this referring facility is inadequate number of gynecologists that have surgical privileges. One or none at a facility is inadequate.
Recruitment would be significantly easier if salary was more in line with the private sector - about 50% more than currently offered.
"Same as previous recommendations, hire more gynecologists at a salary that is competitive with the private sector. If that is not possible use fee basis for care in the private sector. I have no knowledge to comment on what other needs another facility has."
"Other than no-show rate, no problems here. Patients receive appointment letters and automated call and still high no-show/last minute cancellation rate."

"-personnel responsibilty and accountability for specific work loads only.
-avoiding cross coverage of staff for a long period of time, where short term is acceptable.
-pharmacy and drug availability
-supplies availability"

"Access is available within 2 weeks even though our current consultant provider only works 3 days per payperiod. However, some appointments are scheduled greater than 30 days.
We are looking to provide better access by hiring a part-time provider (0.6FTEE) rather than continue with a part-time (0.3FTEE) consultant."
All surgeries are scheduled as needed and always within 30 days unless the patient chooses otherwise.
"Patient no show rates have always been about 50% higher than other surgical specialty clinics despite multiple automated and direct calls to the Veterans.
The consultant is paid as a ”fee for services” provider and we often have to cancel clinics to complete mandatory and other TMS training."

We have one part time GYN physician on staff who does not perform surgery at this facility. We lost one part time Family physician in Women's clinic. We are awaiting one full time GYN physician to come on board in the fall. All GYN surgical procedures (other than minor procedures) are sent out by contract.

"Availability of in-house female provider for women requesting a female physician.
Classification of reports by clinical priority would assist in triage of and timely review of reports by providers"
Availability on in-house female provider for patients requesting a female provider
Additional operating rooms to keep up with surgical demand; additional nursing staff

"The No-show rate, scheduling and administrative questions are regarding gynecology clinic. We do not perform gynecologic surgery at our VA."

"Space is not so much an issue, but increasing funding, staffing and supervision for the fee basis office is of the essence. They are severely understaffed and quite overwhelmed with the increased volume of fee basis appointments. There is also a need to streamline the system and make it less bureaucratic. The latter is a serious flaw and problem in our system. Expectations of many middle managers are completely unrealistic and not aligned with clinical realities."
Delays in surgical scheduling were primarily related to our limited OR time. We have one major surgery day and one minor day. Juggling patients'' and surgeons' schedules around 2 OR days/month can be difficult. Because GYN is a small clinical service competing for OR time with much larger and more politically powerful services this is not always seen as important (though I must add that immediate supervisors and Surgery admin staff are very responsive and try their best).
"In general, scheduling patients for GYN surgery goes smoothly especially since we have excellent support in Anesthesia''s preop testing area. The [location redacted] VA really needs more space (inpatient beds, ORs) and while this is said to be in the works the challenges are significant.
I would like to say that fee basis care is not the solution. Many of our patients use the VA for their health care because it''s their safety net and because of their social and psychiatric problems. Our experience is that many have not done well being seen outside the VA. Also, the fact of the matter is that delays for appointments in the private sector are usually much longer for routine care (the exception is for GYN oncology surgery) than in VA."
"Space is a problem. We are very very limited insofar as rooms, especially procedure rooms."

patients are sent out only for GYN Oncology surgery

Cannot comment on why the larger VA we refer to has delays on consults we send
Remote/ rural area - limited amt of are in community available
limited availability in community - cannot assess the larger VA we also refer to
Cannot assess the larger VA we refer to
cannot assess community issues - remote/rural area with limited amt of providers in community
No gyn surgery at this facility

"We very rarely use outside GYN services. They might include GYN oncology, obstetrics, mammogrma and Ultasound imaging"
"IF a patient is snet out to the community, I personally am uanware of how long it takes as I am not involved in that process"
?
GYN surgeries are limited by lack of adequate equipment and personel avaliable

"Improve OR scheduling package
Improve fee-basis referral system and options and eliminate HealthNet!
Offer in-vitro fertilization when appropriate
Increase funding for gyn surgical equipment"
too much mandatory training

Additional OR space and support staff to run additional rooms. Streamline HR hiring process and incentives to hiring WH designated providers. Over hire when know staff leaving to avoid access issues when staff turnover. Incentive need to be in place for sterile supply staff and surgical techs as with out them can not run. Need to look at the pay scale for the staff including program assistants who schedule our appts. We currently cover 24/7 for GYN via call and Womens clinic offers weekend primary care appts at our main facility. Streamline process for equipment purchasing for clinics and OR. Even the few patients we have placed on Veterans Choice list had appts with GYN sooner than outside providers.
"We have been able to get appts very quickly with outside providers when specialty care- ONC, REI, ob. Sometimes wait time for non specialist is the same as here and patient wants appointment sooner but it is not clinically indicated. Travel to specialist is issue but there are limited GYN ONC specialists and we have a large physical area in our system"
"More OR time allocated to GYN is needed at main facility for major procedures. Or space/allotment is related to support staff- Nurses, anesthesiology and sterile supply staff.
Turn over in staff in CBOC''s and Women''s Clinics and lack of designated WH providers primary care can delay patients getting to GYN or referred appropriately out of system for services not provided in house(GYN ONC and Reproductive endocrine) We do currently have a good referral process to non va care for Onc, OB and REI. Delays in ability to order equipment and that new equipment requests go through long approval process and are done centrally delays getting new technology in OR as well as getting outpatient or sites up and running. Need additional support staff. No clinical coordinator. Delays in HR in hiring when staff turnover whether MD or Midlevels. Phone system and accessing care for veteran can be difficult."
Delays have been for elective surgery but has never put patient at risk If suspect malignancy sent out side VA for care via non VA care. Only delay I am aware of is a delay in diagnosis that was not recognized as soon as came to attention to GYN provider addressed and appropriate care.
"GYN's do not need to be doing routine annual exams they can be done by Designated WH provider. To much time spent on admin tasks as very little clerical and admin support. RN do not order tests and consults so lots of ordering. Redundant documentation also on admission and preop paper work. High no show rate and if occurs at last minute difficult to fill slot.
Hard to reach patients by phone. Providers spent lots of time with patient result letters, coordinating care and redundant documentation. Also have to order equipment and deal with deadlines placed by administration for items. (survey's, action items etc) These take away from patient direct care."

Nights and weekend coverage for ob/gyn in the ED is currently being addressed. We plan to contract to [outside institution redacted] Gynecology for this service.

we try to avoid sending pts outside our institution as it is not necessary in the vast majority of cases
"Again we try to avoid sending patients out as we have the capacity from provider standpoint to take care of nearly all gyn issues. The problems are the few patients we want to send out, for example for pelvic physical therapy, the fee basis process is so onerous and time consuming they often do not get the therapy at all or not in conjunction with appropriate additional therapy"

"having policies such as if a surgical date is more than 30 days out that they HAVE to be put on a list is ridiculous, especially for elective procedures. Prioritizing patients is important, so making policies that ALL pts have to be seen within a certain time period precludes thoughtful triaging. Admin staff and scheduling staff can help with no shows, we need to be able to provide incentive to the staff, the physicians should not be held accountable for things outside their control when it comes to their incentive (eg no shows).
We should consider instituting a no show fee to improve utilization. We need more space, an outpt surgerical center would be best"
"our no show rate is a significant impediment to good clinic utilization. Additionally, there needs to be a centralized process for alerting patients to normal lab or pathology results as we have significant amount of these. Additionally, fact that there is only one person that can create appointments is ludicrous. Each section should designate a person that can help with scheduling so that full utilization of the provider and clinic time and space is possible."

"We need adequate trained nursing support staff, enough exam rooms for providers, proper equipment for in-office procedures."
"We need enough trained support staff, enough exam rooms for providers, enough equipment for in-office procedures."
Fee-based care would take care of waiting/backlog
"C& P could be fee-based out, thus freeing up the only gynecologist in the [location redacted] region."

"At our facility, there were plans when our Women''s Clinic was being designed to include a treatment room for procedures such as LEEP. However, a female administrator at the time changed the plan to a conference room without notifying the medical staff. We have been unable to do these planned procedures since that time 7 years ago."

[potentially identifiable comment redacted] There is no delay, if Veteran needs a service not available in [location redacted], they are sent to another VA, usually [location redacted]or through Non-VA Care. There is no delay in sending patients where they need to go to receive care."
"[Location redacted]has a space issue due to adding more staff in anticpation of the hopsital which is necessary. This cause some problems on all medical services, but staff worked together. [Location redacted] Medical Director handled most administrative tasks for the Gyneologist so they were not tied up in these things."

"As we rebuild our program it will be important to have some general gynecology on staff and then add fee basis or NVCC/contracts for specialized care in the community. As volume, predicted to grow increases, will be able to justify expanding in house services. As in house services expand will likely need additional clinic and OR equipment and support personnel."
We have a low number of female Veterans accessing GYN services. Over the past year had only office based GYN and utilized NVCC for operations. Working with affiliate now to establish more robust GYN program. Difficult secondary to volume. If we build it correctly (space/clinics/staffing) I suspect the program will grow.

Our facility is not currently performing GYN surgery on site. Fee basis GYN services are utilized and provided in a timely manner.
"There are occasional challenges with nonva providers who do not have access to CPRS and exchange of information. This includes timeliness of lab results, ability to contact staff by phone.

We do not have a Gynecologist on staff. We are a smaller facility with a broad geographical catchment area."

Increasing the number of providers and exam space will correct our issues with access. Extending hours has not been beneficial in this speciality
We would prefer to keep our patient's in-house.
"VAGINAL ULTRA SOUND EQUIPEMNT(PROBES) - NEED MORE.
Increase accuracy of coding of surgical procedures so that work load can be better measured."
Mandated TMS is 290+ hrs for a gynecologist - that plus vacation takes up 2 months a year.