



# Ready or Not?

## Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans

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## Preface

Veterans represent a special population of men and women who have served their country, many facing extraordinary health risks during deployment. Because many veterans have served on overseas missions, including in combat, veterans with service-connected health issues are a clinically complex and potentially vulnerable population. The mission of the U.S. Department of Veterans Affairs (VA) health care system is to meet the health care needs of this population. Over the past decade, the demand for health care services among veterans has increased. In response, VA has increased both the number of health professionals working within its facilities and its purchases of care from private-sector providers to accommodate veterans whose needs cannot be met in-house. Thus, providers working in the civilian sector are an increasingly important part of the overall health workforce addressing veterans' needs. However, we know very little about whether private-sector health care providers are equipped to offer timely access to high-quality care that addresses the unique needs of veterans. As a result, many of the current training programs to sensitize private health care providers to these unique circumstances might not be targeting the areas or topics of greatest need.

This study was designed to assess the capacity and readiness of health care professionals to address the service-connected health-related needs among veterans in New York State. This report describes the findings with respect to the training, experience, practices, and attitudes toward veterans and the VA health care system among licensed health care professionals across the state. The report should be of interest to policymakers and others interested in addressing concerns about veterans' access to high-quality care. The findings are also relevant to those who design training efforts aimed at increasing provider capabilities to attend to the special needs of this population.

This study was sponsored by the New York State Health Foundation and conducted within the Health Services Delivery Systems program of RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at [www.rand.org/health](http://www.rand.org/health). Questions about this research can be directed to [Terri\\_Tanielian@rand.org](mailto:Terri_Tanielian@rand.org) or [Carrie\\_Farmer@rand.org](mailto:Carrie_Farmer@rand.org)

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## Abbreviations

DO	doctor of osteopathic medicine
MD	doctor of medicine
MTF	military treatment facility
NP	nurse practitioner
NYSHF	New York State Health Foundation
OT	occupational therapist
PA	physician assistant
PC3	Patient-Centered Community Care
PT	physical therapist
PTSD	posttraumatic stress disorder
VA	U.S. Department of Veterans Affairs



# Background on Veterans' Health Care in New York State

**V**eterans are a unique population of men and women who have served their country, many facing extraordinary health risks during their deployments. Because many veterans have served on overseas missions, including in combat, veterans with health issues related to their military service are a clinically complex and potentially vulnerable population.

Service-connected health issues include mental and physical health problems caused by disease, events, or injuries incurred or aggravated during active military service. While many of these conditions might be the basis for veterans' disability compensation, they are also the focus of health care services provided to veterans by the U.S. Department of Veterans Affairs (VA).<sup>1</sup>

The mission of the VA health care system is to meet the health care needs of this population. Over the past decade, the demand for health care services among veterans has increased (Eibner et al., 2015). To meet this demand, VA has hired more health professionals to work in its facilities and has expanded its purchases of care from private-sector providers to accommodate veterans whose needs cannot be met within the VA setting. At present, the Veterans Health Administration's Office of Community Care manages and funds a number of non-VA programs to provide veterans with care in the community; these programs are hereafter referred to as VA Community Care. The Veterans Choice Program, implemented in 2014, facilitates access to care in the private sector for veterans who face long wait times for an appointment in the VA health care system or who live far from a VA health care facility. VA also manages legacy programs through which VA purchases care through local contracted providers on an as-needed basis, including the Patient-Centered Community Care (PC3) program. A recent extension of funding to the Veterans Choice Program has also increased the local flexibility for referral from VA to community providers (VA, 2017a).



Many veterans receive care from outside the VA health system. This includes care purchased by VA in the community for eligible veterans, as well as care that veterans choose to purchase on their own.



Veterans represent a clinically complex population, experiencing higher rates of suicide, posttraumatic stress disorder, diabetes, hearing loss, and cancer.

While VA is a critical source of veterans' health care, many veterans receive care from outside the VA health system. Most veterans enrolled in VA health care have another source of health coverage, such as Medicare or employer-sponsored insurance. Studies of veterans' overall use of health care find that veterans enrolled in VA health care receive only 30 percent of their care on average from VA (Farmer et al., 2016). In part, this might be because of veteran preference. For example, in our prior work in New York, we found that approximately one-third of veterans prefer to seek care for mental health problems outside VA (Schell et al., 2011). Some veterans might also hesitate to seek care at VA because they are concerned that documentation of treatment might limit opportunities while serving in the reserves or upon re-entering military service, thus using other sources of coverage to secure services. Finally, many veterans are not eligible for VA care because of the nature of their service or discharge (Eibner et al., 2015).

Providers working in the private sector are an increasingly important part of the overall health workforce in addressing veterans' health care needs. Studies consistently demonstrate that veterans represent a clinically complex population, experiencing higher rates of suicide, posttraumatic stress disorder (PTSD), diabetes, hearing loss, and cancer than similar nonveteran populations. As a result, community-based health care providers that serve veterans should be prepared for higher rates of comorbid conditions (Eibner et al., 2015) in this population. In addition, as VA strives to reduce the rate of suicide among veterans, particularly those not engaged in VA care, community-based providers will be an important part of a public health response to identifying those at risk. However, we know very little about whether private health care providers are equipped to offer timely access to high-quality care that addresses the unique needs of veterans (Farmer et al., 2016).

In the past several years, VA has launched toolkits for community providers to serve veterans more effectively; there has also been a proliferation of nongovernmental programs designed to raise awareness and offer training to community-based health professionals. But without an understanding of private-sector providers' capacity to treat veterans, many of these training programs might not be targeted to the areas or topics of greatest need. Understanding the current experience of community-based providers in addressing veterans' health-related issues can inform educational and training strategies to ensure providers are prepared for and capable of addressing veterans' health care needs.

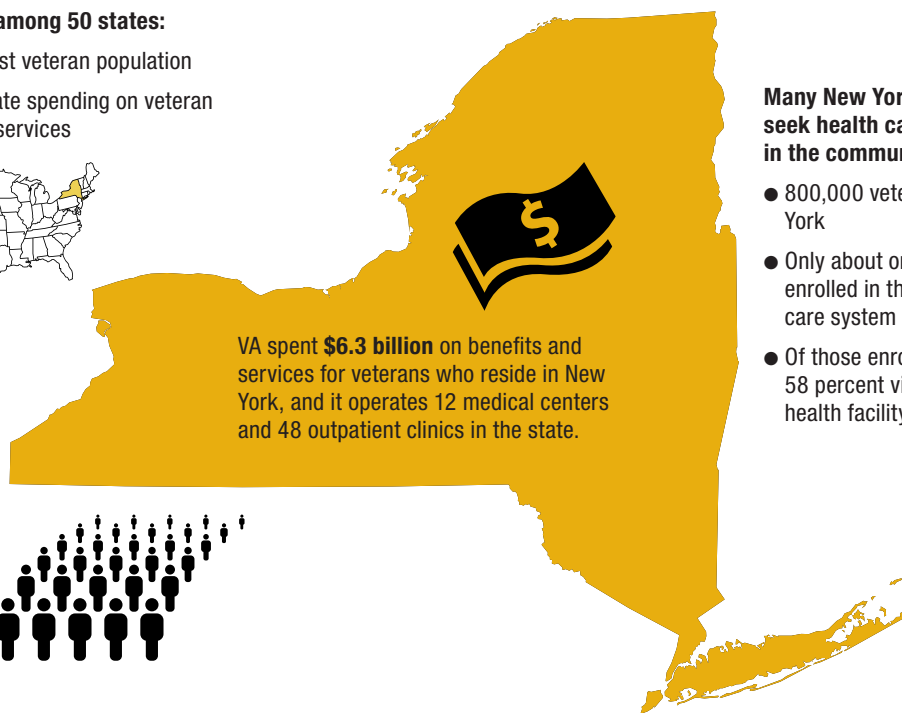


## VA Spending and VA Usage Among Veterans in New York State

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### Rankings among 50 states:

- 5th largest veteran population
- 4th in state spending on veteran medical services



### Many New York veterans seek health care services in the community sector:

- 800,000 veterans in New York
- Only about one-half enrolled in the VA health care system
- Of those enrolled, only 58 percent visited a VA health facility in 2015



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## Understanding the Capacity and Readiness of Health Care Professionals in New York State to Meet Veterans' Health Care Needs

New York State is home to more than 800,000 veterans, one-half of whom are younger than 65 years old (New York State Health Foundation [NYSHF], 2017). New York has the fifth-largest veteran population among the 50 states (National Center for Veterans Analysis and Statistics, 2017b) and ranks fourth in state spending on veteran medical services (National Center for Veterans Analysis and Statistics, 2017a). VA spends approximately \$6.3 billion on benefits and services for veterans residing within New York, with nearly one-half of that amount going toward medical care services. While VA operates 12 medical centers and 48 outpatient clinics across the state, only about one-half of the New York veteran population is enrolled in the VA health care system. Of those enrolled, only 58 percent visited a VA health facility in 2015 (NYSHF, 2017). Thus, many New York veterans are likely seeking health care services in the community sector. This, coupled with VA's increasing reliance on community-based care,



**To assess New York State capacity, we surveyed licensed health care providers, including:**

- physicians
- physician assistants and nurse practitioners
- mental health care providers (psychologists, mental health counselors, or social workers)
- physical and occupational therapists.

raises a concern about the capacity of the community sector to meet veterans' health care needs and absorb demand.

To understand the capacity and readiness of health care professionals to address the service-connected health-related needs among veterans in New York, we conducted a survey of licensed health care professionals to assess their training, experience, practices, and attitudes toward veterans and the VA health care system. In this report, we outline our methods, summarize our results, and discuss the implications and recommendations for improving the capacity of community-based health care professionals to address the health care needs of veterans within New York State.

## Survey of Licensed Health Care Professionals

To assess the capacity of New York State health care professionals, we designed and implemented a web-based survey to gather information about provider characteristics, knowledge of military veteran culture, practice behaviors, and attitudes toward VA. The next section outlines our sampling and recruitment methods, the domains assessed, and our analytic approach. Our study was reviewed and determined to be exempt from further review by the RAND Human Subjects Protection Committee. More details can be found in Appendix A, available online (Tanielian et al., 2018).

### Sampling

To generate a representative sample of health care professionals in the state, we requested data on licensed health care providers from the New York State Board of Regents. We received a list of 244,438 licensed health care providers: physicians ( $n = 94,708$ ); physician assistants and nurse practitioners ( $n = 35,496$ ); mental health care providers (psychologists, mental health counselors, or social workers;  $n = 76,162$ ); and physical and occupational therapists ( $n = 35,646$ ).<sup>2</sup> The list contained full contact information for the provider (name and mailing address as well as phone number and email address where available). For purposes of our study, we limited the survey sampling frame to only those providers who had an email address listed in the file ( $n = 21,635$ ).<sup>3</sup> We used provider zip code data to categorize providers by region: metropolitan, central/capital, or western New York.

Separately, we also obtained a list of health care providers registered as part of VA's purchased care contracts (PC3 and the Veterans Choice Program).<sup>4</sup> The contractor file contained only provider names and addresses (no email addresses). We cross-referenced the provider lists to create an indicator for VA-contracted providers in the sample file. For purposes of our sampling, we oversampled contracted providers across our provider types in an effort to increase the likelihood that providers had prior experience working with veterans in their clinical setting.

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Participants were asked whether they agreed that the VA health care system meets the needs of veterans.

We used a two-stage stratified sampling design. We stratified the population of providers by provider type, geographic region, and VA contractor status and then drew a random sample of participants within each strata in two phases. In the first phase, we drew a sample of 583 providers across strata to participate. We used data from the first phase on the rate of email bounce backs, the proportion ineligible for the survey, and response rate by provider type to inform our sampling strategy for the second phase. Since the response rate was lower than we anticipated, we increased our sample size in the second phase and drew two additional samples of providers across strata to attain our goal of 800 completed surveys. In each sampling phase, we drew a stratified random sample of providers using the SAS SURVEYSELECT procedure.

We contracted with the Davis Research Group to host the online survey and recruit providers. Sampled providers were sent an email inviting them to participate in a 20-minute, web-based survey. Respondents were eligible for a token of appreciation for completing the survey.<sup>5</sup> Overall, we contacted 12,886 providers (59 percent of the total population of providers in our original sampling frame; i.e., providers with email addresses).

### **Respondent Characteristics and Sample Weights**

Our final analytic sample consisted of 746 providers, yielding an overall response rate of 6.4 percent. Response rates differed by type of health care professional (with the highest participation rate among physician assistants and nurse practitioners, and the lowest among physicians) and geographic region (with the lowest participation rate in the metropolitan region and highest in the western region) but did not differ by VA contractor status. More information about the sampling weights are included in Appendix A (Tanielian et al., 2018).

We constructed survey sampling weights so that our analytic sample would reflect the distribution of the population of providers in the state of New York by type of provider (physicians, mental health care providers, nurse practitioners or physicians' assistants, and physical or occupational therapists), geographic region (central/capital, metropolitan, and western), and VA contractor status.

### **Survey Instrument/Measures**

The web-based survey was designed to collect information from providers across several different domains. These domains were chosen to assess the readiness and capacity of the New York civilian health workforce to deliver high-quality care for veterans. Survey items were drawn from prior studies of health care professionals across a number of domains: provider characteristics, practice setting, provider caseload characteristics, provider knowledge and experience with the military health or veteran health

systems, practice behaviors, use of practice guidelines, and experience with VA Community Care. Table A.2 in Appendix A (Tanielian et al., 2018) provides an overview of the survey domains, a description of the specific constructs, and information about how the items were used in analysis. We selected these items with a goal of using them to examine the readiness of these providers to deliver high-quality care to veterans with service-connected conditions. Thus, we wanted to understand their usual practice patterns, familiarity with the population and with specific conditions that veterans experience, and respondents' attitudes and perceptions about VA. Recognizing that respondents might practice across multiple settings (e.g., hospital campus and ambulatory clinic), we asked a series of questions to identify the practice setting where they treat the most patients each week and instructed respondents to answer subsequent questions with respect to that practice setting. Additional information about specific items can be found in Appendix A (Tanielian et al., 2018).

### Survey Analysis

Simple univariate measures (frequencies and percentages) and assessments of bivariate relationships (chi-square tests) were applied to examine differences in readiness (defined in a later section) by provider and practice characteristics, geographic region, proximity to a VA medical center, and overall opinion of VA care. We constructed logistic regression models to better understand the influence of these characteristics on provider readiness. Survey weights and strata were applied to all analyses. All survey analyses were conducted using SAS version 9.4.

#### *Proximity to VA*

Using the zip code that respondents indicated as the primary location of their practice, we calculated the geographic distance to the closest VA Medical Center or clinical facility,<sup>6</sup> which we recoded into a four-level categorical variable (less than 10 miles away, 10–25 miles away, 26–40 miles away, 41 or more miles away). These results are described in Chapter Two, and the proximity variable is included in the multivariate models examining predictors for readiness.

#### *Opinion of VA Health Care*

We constructed a variable to measure providers' opinions of the VA health care system. Participants were asked whether they agreed that the VA health care system meets the needs of veterans and returning reservists; provides high-quality health care; provides adequate customer service for nonurgent issues; and provides care to veterans in a timely fashion. Providers were also asked whether they had any hesitation in referring patients to VA for health care based on quality. We developed a scale from these items with scores ranging from 0 (negative or no opinion of the VA

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Providers were also asked whether they had any hesitation in referring patients to VA for health care based on quality.

# Provider Readiness Definition

## Based on Seven Components

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- 1. Currently accepting new patients.** Provider reports that his or her practice is accepting new patients, which is essential to being able to offer timely care.
- 2. Prepared to deal with conditions common among veterans.** Provider is somewhat or well prepared to manage care for patients with more than one-half of the listed common concerns (see items in Appendix A).
- 3. Provides high-quality care to their patients.** Assessing quality among such a diverse group of providers based on a self-report measure was challenging; we chose to define quality by whether providers reported using clinical practice guidelines (which are typically based on the best available evidence with respect to safety, efficacy, and effectiveness) to inform treatment decisionmaking.
- 4. Screens for other conditions common among veterans.** Provider occasionally, often, or always screens patients for more than one-half of the listed common conditions.
- 5. Accommodates patients with disabilities.** Veterans are more likely to have disabilities or special health care needs that require accommodations. Provider's practice makes three or more accommodations for patients with disabilities (for mental health professionals, accommodation criterion is met if provider makes two or more accommodations) (see items in Appendix A).
- 6. Familiar with military culture.** Provider is familiar with more than one-half of items pertaining to knowledge of military culture (see items in Appendix A).
- 7. Screens patients to determine whether they are current or former members of the armed forces or family members of such a person.**



health care system) to 5 (positive opinion of the VA health care system). This variable was included as a predictor in our multivariate models examining predictors of readiness.

### Main Outcome of Interest: Provider Readiness

Improving the outcomes of veterans with service-connected conditions is predicated on their access to and receipt of *high-quality care*, which has been defined as meeting several criteria—timely, patient-centered, effective, safe, efficient, and equitable (Institute of Medicine, 2001). Using our self-reported provider data, we constructed a profile of provider readiness to deliver high-quality care. We focused on specific dimensions of the Institute of Medicine definition in developing our measure of readiness: timeliness, patient-centeredness, effectiveness, and equity.

We developed a definition of readiness composed of seven individual components. We consider each of these components to be an integral part of being ready and capable of delivering culturally competent, high-quality care to veterans in the community. We defined providers as “ready” if they met the criteria for all seven components.





# Characteristics and Capacity of New York State Health Care Providers

**N**ew York's physicians, nurse practitioners, physician assistants, mental health care providers, and occupational and physical therapists are a diverse population whose characteristics vary by provider type. Our sample consisted of 746 respondents, and data were weighted to reflect the population from which they were drawn.<sup>8</sup> Among survey respondents, 46.5 percent were physicians, 30.9 percent were mental health providers, 10.4 percent were physical or occupational therapists, and 12.2 percent were physician assistants or nurse practitioners. Most (65.2 percent) of New York's health care providers reported practicing in the metropolitan region of the state, with the remainder split between the central/capital region (17.6 percent) and the western region (17.1 percent). The majority of physician respondents were male; across all other provider types, most respondents were female. Physicians were more likely than other provider types to have completed their training at least 20 years ago. Nearly one-half (49.3 percent) of all physicians reported some training experience in a VA setting, compared with only 4.4 percent of mental health providers. Few providers had personal experience with the military; fewer than 10 percent of them had served in the military (physicians were slightly more likely to have served than other provider types) and one-quarter (26.1 percent) had a family member who had served. (For more on all these data, see Tanielian et al., 2018, Appendix A.)

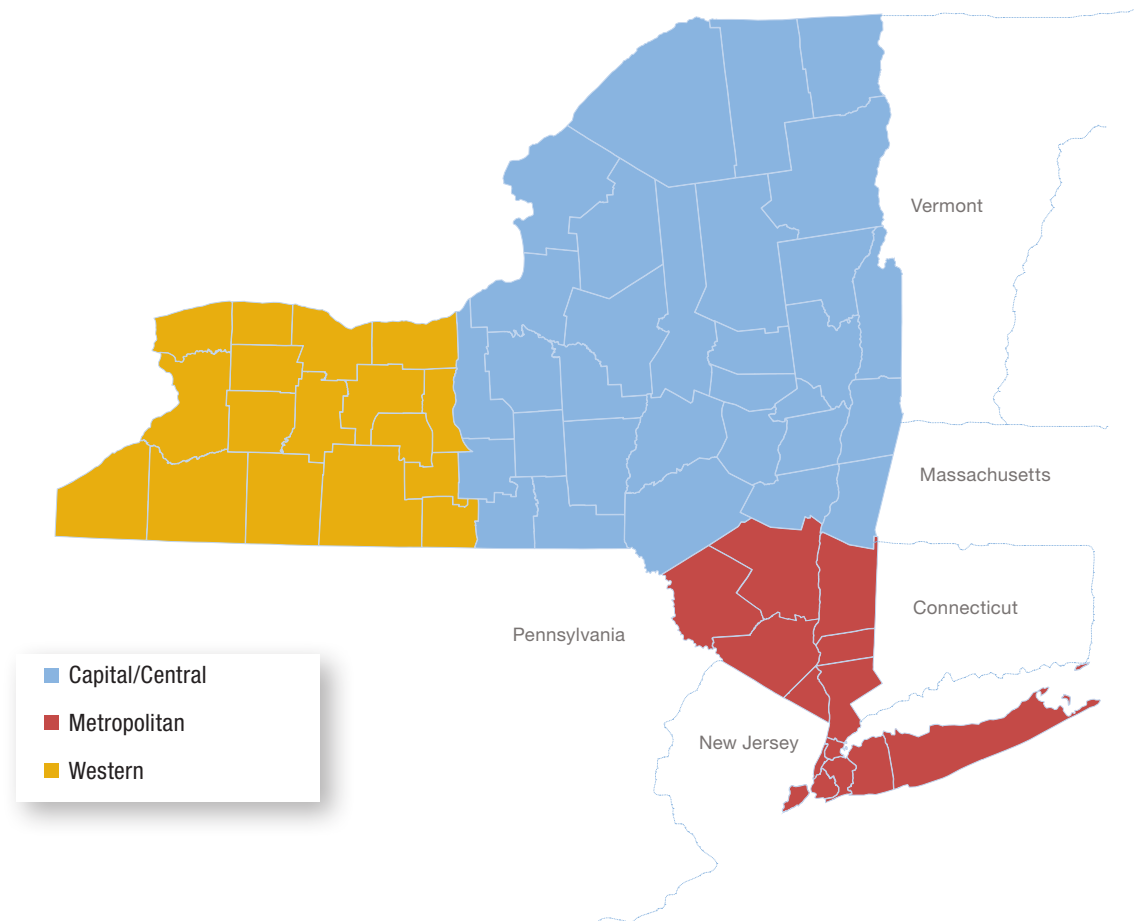
The practice characteristics of health care providers in the state also varied by provider type. Three-quarters of health care providers reported spending more than 20 hours per week in patient care. One-half reported spending time teaching, one-third reported spending time on research, and physicians were more likely than other providers to report these characteristics. Approximately 48 percent of providers overall reported seeing patients during evenings or weekends; this was most common among mental health providers (73 percent). Having a fixed salary was the most

commonly reported compensation method across all health care providers. Mental health providers were most likely to report that a home or private office was their main practice setting; other providers primarily reported working in ambulatory clinics or centers. Physicians were more likely than other providers to report working more than 51 hours per week.

Overall, most providers (71.3 percent) practiced at a location that was less than ten miles from a VA clinical facility.<sup>9</sup> No providers practiced at a location that was more than 40 miles from a VA facility, the distance criterion used for determining veterans' eligibility for the Veterans Choice Program. Providers in the central/capital region were more likely to be located far (more than 40 miles) from one of New York's 12 VA Medical Centers (27.4 percent) than those in the western region (4.9 percent) or the metropolitan region (less than 1 percent). Distance between practice location and the nearest VA Medical Center did not differ by provider type.

## New York State Regions

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## Demographics and Training History of New York State Providers

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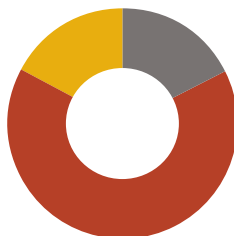
What is their race/ethnicity?



**74.1%**  
Non-Hispanic white  
**18.5%**  
Other/declined  
**5.0%**  
Hispanic  
**2.5%**  
Non-Hispanic black



In what region do they practice?



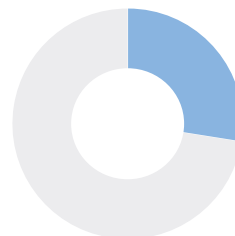
**17.6%**  
Central/capital  
**65.2%**  
Metropolitan  
**17.1%**  
Western

Any military service?



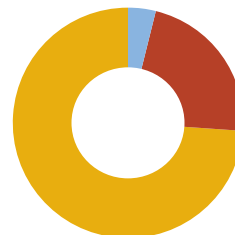
**5.4%**  
Yes

Trained in VA hospital?



**27.7%**  
Yes

Ever worked in a military treatment facility (MTF) or VA?



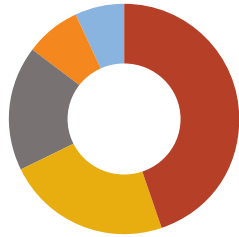
**3.9%**  
Worked in MTF only or MTF plus VA  
**22.2%**  
Worked in VA only  
**73.8%**  
Never worked in either MTF or VA

NOTE: Numbers may not sum to 100 because of rounding.

## Characteristics of Providers' Practices

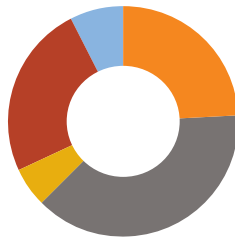
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What is their compensation method?



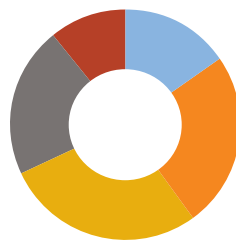
**44.9%**  
Fixed salary  
**22.9%**  
Salary adjusted for performance  
**17.4%**  
Shift, hourly, or other time-based payment  
**7.8%**  
Share of practice billings or workload  
**6.9%**  
Other method

What is the provider's main practice setting?



**24.3%**  
Hospital campus  
**38.2%**  
Ambulatory clinic or surgery center  
**5.8%**  
Rehab/long-term care  
**24.3%**  
Home or private office  
**7.4%**  
Patient home/other

What is the average number of patients at their primary practice?



**15.4%**  
10 or fewer  
**24.6%**  
11-25  
**28.0%**  
26-50  
**21.2%**  
51-100  
**10.6%**  
More than 100

Do they see patients during off-hours?



**47.9%**  
See patients during evenings or on weekends

NOTE: Numbers may not sum to 100 because of rounding.

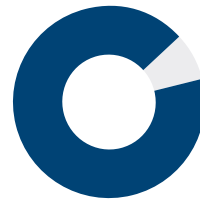
## Access to Timely Care

More than 90 percent of health care providers across all types indicated that they were accepting new patients, and most indicated that the wait time for a new patient to get an appointment was two weeks or less. New patients might have better access to timely care in the metropolitan region, where almost 70 percent of providers reported that new patients could get an appointment within two weeks, compared with one-half of providers in other regions of the state. Nearly one-third of all providers indicated that most of their patients who requested a same-day appointment can receive one.

## New York State Providers' Structural Capacity: Wait Times for Appointments and Ability to Accept New Patients

### Nearly all providers accept new patients

Currently accepting new patients **92.1%**  
Yes



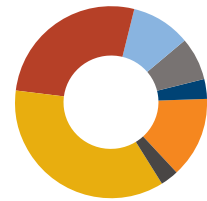
### More than one-half of providers have appointments available for new patients within two weeks

Time for a new patient to get an appointment

<b>35.8%</b>	Within 1 week
<b>26.8%</b>	1–2 weeks
<b>9.9%</b>	3–4 weeks

<b>7.3%</b>	1–2 months
<b>3.3%</b>	3 or more months

<b>13.5%</b>	Do not provide routine visits
<b>3.3%</b>	Do not know



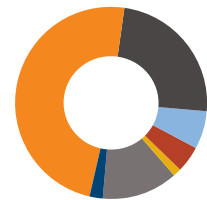
### Nearly one-half of existing patients are able to get an appointment within one week

Time for an existing patient to get an appointment for a routine visit

<b>48.7%</b>	Within 1 week
<b>24.0%</b>	1–2 weeks
<b>6.5%</b>	3–4 weeks

<b>4.5%</b>	1–2 months
<b>1.2%</b>	3 or more months

<b>12.7%</b>	Do not provide routine visits
<b>2.4%</b>	Do not know



### Nearly one-third of practices report that almost all patients who request one are able to receive a same-day appointment

Percentage of patients who receive a requested same-day appointment

<b>31.6%</b>	Almost all (more than 80%)
<b>14.9%</b>	Most (60–80%)

<b>7.5%</b>	About one-half (41–59%)
<b>20.4%</b>	Few (less than 20%)

<b>14.9%</b>	Some (20–40%)
<b>10.7%</b>	Do not know



NOTE: Numbers may not sum to 100 because of rounding.



# Familiarity of New York Providers with the Population of Veterans, Service Members, and Their Families

**W**e asked several questions to assess providers' prior experience working with military service members and/or veterans. This included prior work experience in a VA or military treatment facility, as well as questions about whether the provider was currently treating any service members, veterans, or their family members. Overall, 25 percent of New York health care providers had worked or trained in either a VA or military treatment facility, with physicians more likely to have worked in these settings than other provider types. For purposes of comparison, in a prior survey of primary care providers and mental health clinicians within the Mid-Atlantic Health Care Network (VA's Veteran Integrated Service Network), Kilpatrick et al. (2011) reported that approximately 31 percent of respondents had reported prior training in VA.

Nearly four out of five health care providers indicated that they had current military, veteran, or military family patients in their caseload (see top of next page). There was some variation by provider type and by region with respect to the proportion of providers who reported currently treating TRICARE patients and VA Community Care patients. A higher proportion of physicians reported seeing TRICARE patients than other provider types, and mental health providers were least likely to report seeing VA Community Care patients. With respect to regional differences, providers in the metropolitan region were least likely to report treating TRICARE and VA Community Care patients (see bottom of next page).

## How Common Is It for Providers to Treat Veterans, Service Members, or Military Families?

	Overall		Medicine (MD, DO)				PT, OT		PA, NP		Mental Health	
	N	%	N	%	N	%	N	%	N	%		
Military/veteran/military family patients	598	79.8	219	83.1	88	77.8	121	74.7	170	77.5		
Veteran patients	515	65.8	191	70.7	82	73.9	114	69.8	128	53.8		
Military/veteran family members	507	68.5	192	72.9	68	61.2	101	62.2	146	66.9		
Current service member patients	244	31.1	107	38.6	28	22.7	63	38.1	46	20.8		
Reserve/Guard patients	311	39.9	139	50.1	32	26.8	73	44.7	67	28.3		
Any TRICARE patients	293	36.3	125	45.2	45	37.6	61	38.0	62	21.8		
Any VA Community Care patients	213	24.0	73	24.2	44	37.2	61	38.6	35	13.7		

NOTE: MD = doctor of medicine; DO = doctor of osteopathic medicine; OT = occupational therapist; PA = physician assistant; PT = physical therapist; NP = nurse practitioner.

## Are Providers in Certain Regions of New York More Likely to Have Veteran Patients?

	Overall		Central/Capital		Metropolitan		Western	
	N	%	N	%	N	%	N	%
Military/veteran/military family patients	598	79.8	168	83.5	242	77.6	188	84.7
Veteran patients <sup>a</sup>	515	65.8	145	73.3	202	61.2	168	75.4
Military/veteran family members	507	68.5	152	75.4	202	66.4	153	69.6
Current service member patients <sup>a</sup>	244	31.1	85	45.3	83	26.0	76	36.0
Reserve/guard patients <sup>a</sup>	311	39.9	109	57.9	108	33.8	94	44.8
Any TRICARE patients <sup>a</sup>	293	36.3	106	55.3	89	28.4	98	46.5
Any VA Community Care patients <sup>a</sup>	213	24.0	66	33.1	69	18.1	78	36.9

<sup>a</sup> Statistically significant difference by practice region and provider type,  $p < 0.01$ .



## Knowledge of Military and Veteran Culture

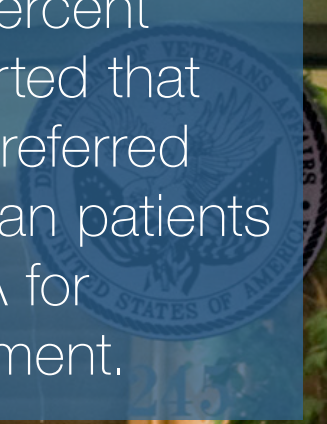
In a 2011 article, Hoge argued that it is essential for treatment providers to understand aspects of military and combat culture to help those who have served feel understood by those who are attempting to care for them. Therefore, we asked providers to rate their level of familiarity with various aspects of military and veteran culture. The table below displays the distribution of providers who reported being at least moderately familiar with each of the specific items; less than one-third (30 percent) reported familiarity with more than one-half of these items. Roughly 13 percent of providers indicated that they had participated in formal training regarding military and veteran culture. Across provider types, participating in formal training was highest among mental health providers (22 percent). Among those who had not received such formal training, less than one-half of all providers, across all types, indicated interest in receiving training in the future.

## The Numbers Show That New York State Health Care Providers Have Room for Improvement in Understanding Military Culture

	Percentage of providers familiar with the topic
Military rank structure	<b>30</b>
Different cultures of different military branches	<b>25</b>
Differences and similarities between active and reserve components of the military	<b>35</b>
General and deployment-related military slang and terms	<b>19</b>
General and deployment-related stressors for service members and veterans	<b>37</b>
General and deployment-related stressors for military affiliated families	<b>38</b>
Programs and services available to support healthy adjustment for military-affiliated patients	<b>21</b>
How behaviors learned in war can be maladaptive at home	<b>45</b>
Specific health care needs for women veterans	<b>22</b>
At least moderately familiar with more than one-half of above items	<b>30</b>

# DEPARTMENT OF VETERANS AFFAIRS

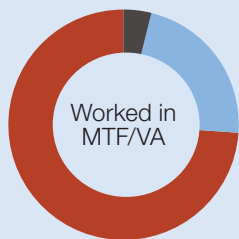
Many providers had some direct experience with VA: Nearly 37 percent reported that they referred veteran patients to VA for treatment.



# Experience with VA and VA Community Care

**W**e asked providers about their familiarity with and perceptions of VA health care, including their interactions with VA providers and participation in VA Community Care. Overall, only 16.8 percent of providers reported being a registered provider with one of the programs within VA Community Care, with physicians being more likely to report this status. However, many providers had some direct experience with VA: 36.6 percent reported that they referred veteran patients to VA for treatment, although this varied by provider type and region. Mental health providers were more likely than other provider types to refer veteran patients to VA. Nearly one-half (45.7 percent) of providers in the central/capital region reported referring veteran patients to VA, compared with 38.0 percent of western region providers and 33.7 percent of metropolitan region providers. While one-half of respondents reported having attempted to contact a VA provider or clinic in the past two years, most (72 percent) had few or no current patients who were also treated by VA (25 percent did not know whether they had any patients treated by VA). Less than one-third reported knowing how to refer a patient to VA. (For more, see Tanielian et al., 2018, Appendix A.)

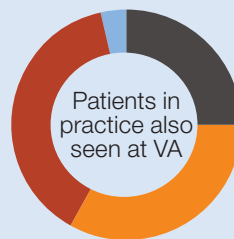
## What Experience Have Providers Had with the VA Health Care System?



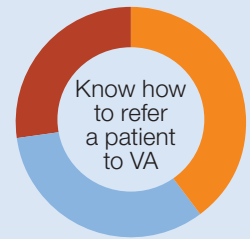
**3.9%**  
MTF and/or VA  
**22.2%**  
VA only  
**73.8%**  
Neither



**36.6%**  
Yes



**25.0%**  
Do not know  
**33.1%**  
None  
**38.5%**  
1%–10%  
**3.4%**  
More than 10%



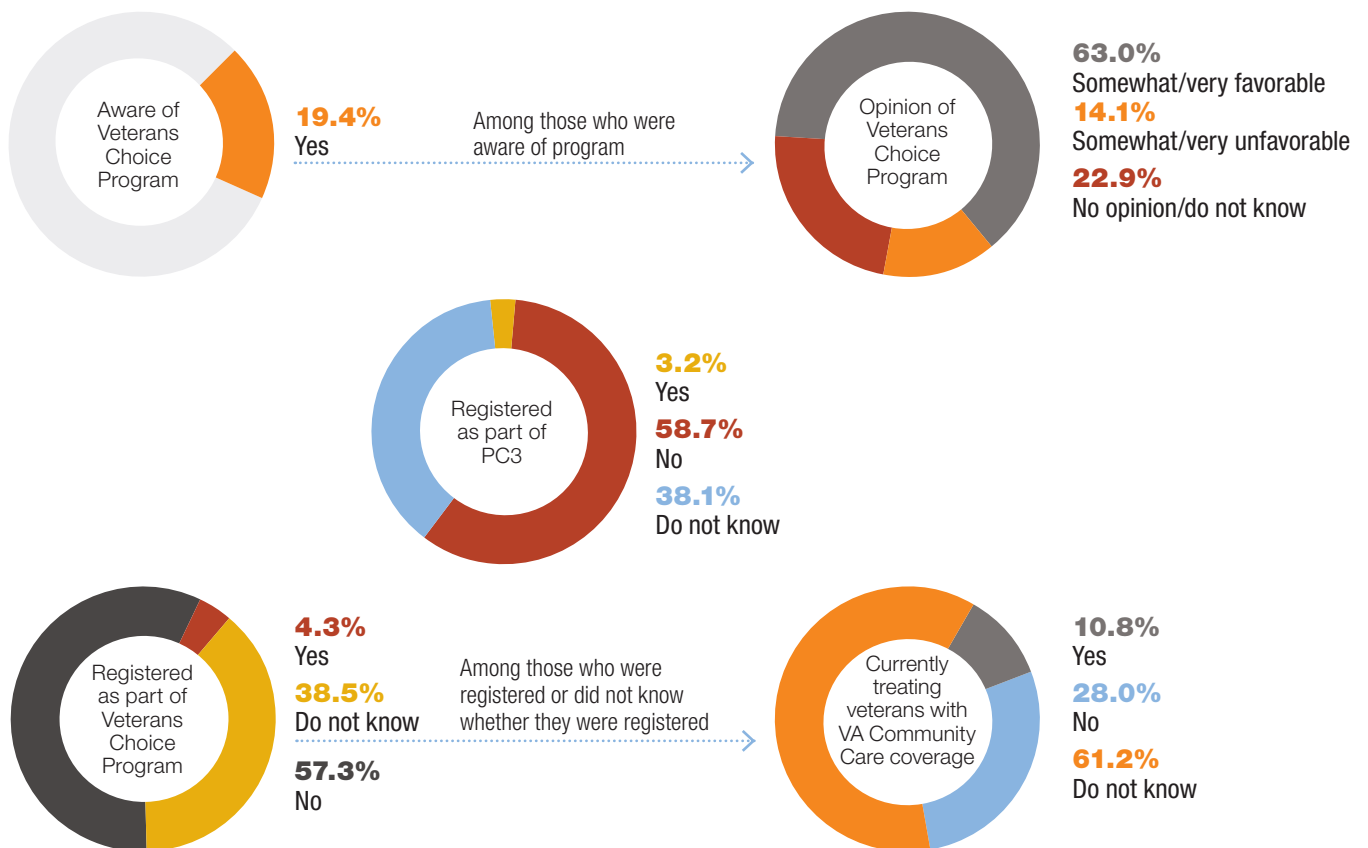
**39.8%**  
Strongly disagree/disagree  
**33.0%**  
Do not know/neither  
**27.2%**  
Strongly agree/agree

NOTE: Numbers may not sum to 100 because of rounding.

Few providers (less than 5 percent) reported participation in VA Community Care, including both the legacy PC3 program and the Veterans Choice Program. One reason for low participation might be confusion about the names of these programs; 11 percent reported treating patients with VA Community Care coverage, more than twice as many as reported being registered with these programs. Another reason could be awareness; for example, only 19 percent of providers reported being aware of the Veterans Choice Program, with wide variation by region. Approximately one-third of providers in the central/capital and western regions were familiar with the program, whereas only about 15 percent of metropolitan region providers reported being aware of the program. Among those who were registered with VA Community Care, only 10 percent reported currently treating veterans through these mechanisms. (See Tanielian et al., 2018).

In a study of community-based primary care and mental health providers, Finley et al. (2017) found that less than 10 percent of surveyed providers in Texas and Vermont were receiving reimbursement from VA through one of the programs within VA Community Care. In that study, awareness of the program was much higher, ranging from 22.9 percent to 42.9 percent across the surveyed groups.

## What Experience Do Providers Have with VA Community Care?



NOTE: Numbers may not sum to 100 because of rounding.

We asked specific questions about providers' opinions of the Veterans Choice Program because it is the largest and most visible (albeit newest) component of VA Community Care. Among those who were aware of the Veterans Choice Program, two-thirds had a somewhat or very favorable opinion of it. Providers who reported that they were not participating in the Veterans Choice Program were asked why they were not participating. Across provider types and regions, being unaware of the program was the most common reason for not participating, followed by concerns about reimbursement rates, complex paperwork, and administrative requirements to join the program (see p. 25). Other responses included close proximity to a VA hospital, not accepting insurance of any kind or only private payment, focus on a different target population, or lack of authority to decide whether to participate in the Veterans Choice Program.



We queried providers about their perception of the quality and timeliness of VA care. In general, only about 15 percent of providers felt that VA provided both high-quality and timely care for veterans (see below). Physicians and mental health care providers tended to view VA health care more favorably than other provider types; still, less than one-third had a positive perception of VA for each of the items. There were no differences by region in providers' perceptions of VA health care.

### Provider Perceptions of VA Health Care, by Provider Type

	Overall	Percentage Strongly Agree/Agree			
		Medicine (MD, DO)	PT, OT	PA, NP	Mental Health
The VA health care system does an adequate job of meeting the health care needs of veterans and reservists. <sup>a</sup>	24.6	29.1	17.0	14.3	23.9
The VA health care system provides high-quality health care services.	28.0	30.9	21.4	22.7	27.9
VA provides an adequate customer service experience for nonurgent issues. <sup>b</sup>	26.5	32.3	14.0	26.2	22.7
VA provides care to veterans in a timely fashion. <sup>b</sup>	16.9	21.4	6.3	14.3	15.2
I am hesitant to refer patients to VA because of quality concerns.	18.2	18.7	22.1	16.5	16.4

<sup>a</sup> Statistically significant difference between medicine (MD, DO) and PA, NP,  $p < 0.01$ .

<sup>b</sup> Statistically significant difference between medicine (MD, DO) and PT, OT,  $p < 0.01$ .

As a point of comparison, in a study of community-based primary and mental health providers in Texas and Vermont, between 31.6 percent and 69.4 percent of respondents agreed that VA provides high-quality health care services, compared with 21.4–30.9 percent in our study of New York providers.

We tabulated a composite score for providers' opinions about VA health care (see Chapter One for more detail on the construction of this variable). Physicians had higher overall opinions about VA health care than other

provider types; however, the difference between physician and mental health provider scores was not statistically significant.

We also asked providers why they believe veterans might seek care from a community provider rather than VA. The most common reason reported was that veterans have established relationships with community providers. Many providers also responded that they believe that veterans perceive community providers as providing better care and having greater expertise than VA providers. Approximately one-third of health care providers perceived that veterans chose community providers because of proximity and limited access to specialty care at VA facilities. A 2014 qualitative study of non-VA primary care providers' perspectives on care for rural veterans asked similar questions and found a slightly different pattern of results (Gaglioti et al., 2014). In that study, the top five reasons interviewed providers gave for rural veterans choosing community care were: having an established relationship (81.8 percent), receiving Medicare or Medicaid (43.3 percent), believing that veterans perceive "we give better care" (38.8 percent), and having private insurance (29.0 percent). While these results are included for comparison, it should be noted that the study was qualitative in nature and was focused on primary care physicians enrolled in a practice research network.

**The most commonly stated reason that providers do not participate in the Veterans Choice Program is that they are unaware of the program.** Other top reasons include concerns over complex paperwork and reimbursements.

**66.3%** are unaware of the program

**12.6%** have concerns about the reimbursement rates

**11.8%** cite complex paperwork and/or administrative requirements to join

**9.2%** cite complex paperwork and/or administrative requirements to comply

**4.2%** have difficulty receiving payment for services rendered

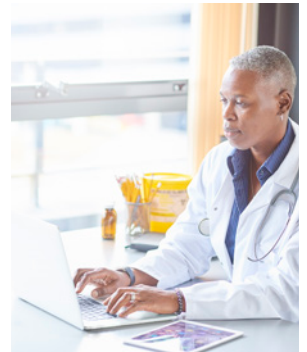
**3.9%** are not accepting new patients

**3.6%** have inadequate staffing, are not able to meet access demand at this time

**1.2%** say that patients tend to not keep appointments

**0.4%** accept only a certain number of VA Community Care patients

**25.3%** cite other reasons



**39.1%** They have established relationships with us

**35.6%** They say we give better care

**33.4%** They say we have greater expertise

**31.7%** Limited access to specialty care at VA

**31.1%** Our office is closer to them or the VA is too far away

**27.0%** They have Medicare or Medicaid or some other federal or state medical coverage

**17.9%** They have private insurance or TRICARE

**11.4%** Lack of emergency or urgent access at the VA

**Why do veterans seek care from community providers rather than VA facilities?**

Providers offer these reasons.







# Capacity to Provide High-Quality, Timely, Veteran-Centered Health Care for Veterans

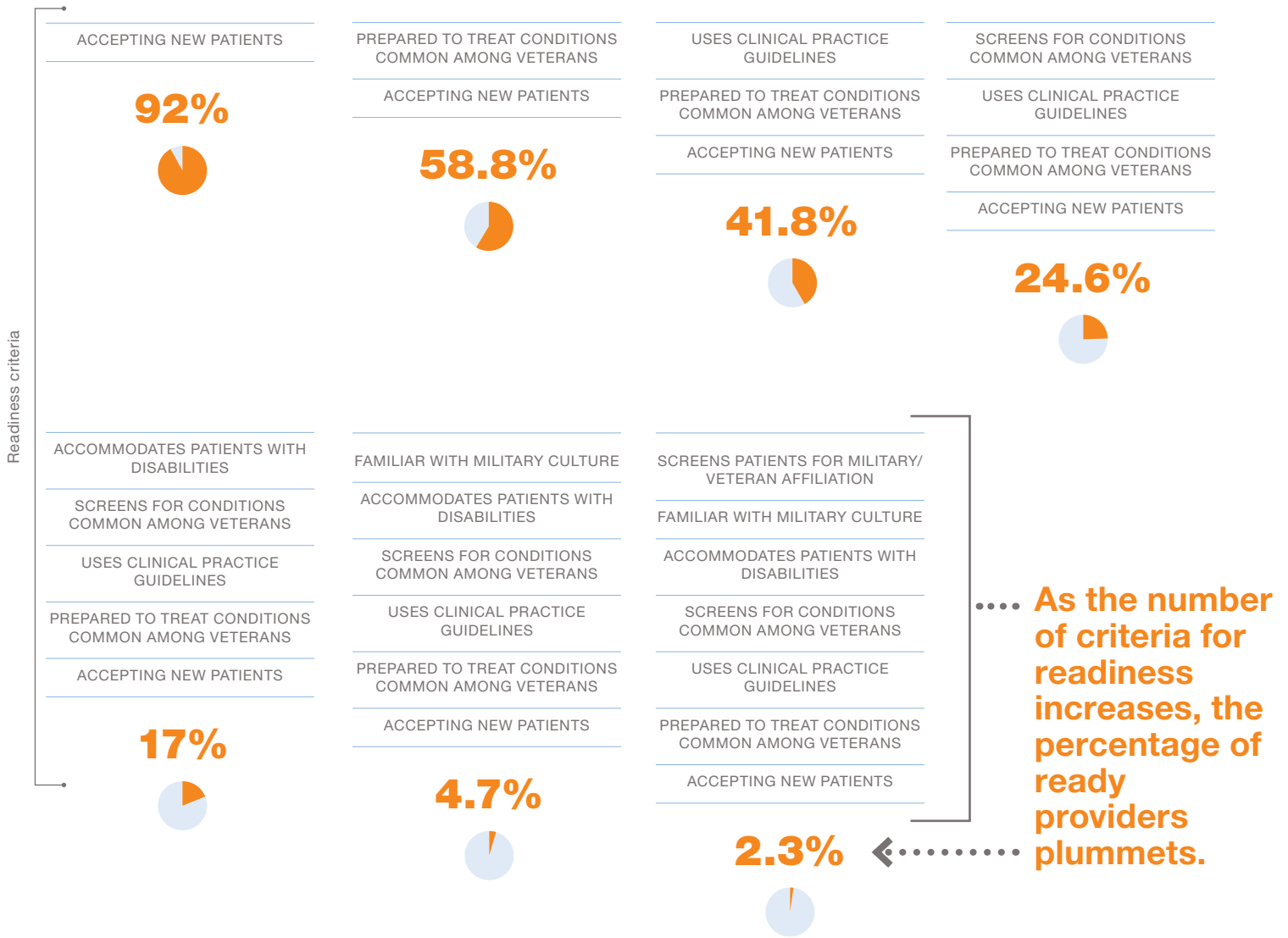
In this chapter, we examine the extent to which providers meet the seven components of readiness and the characteristics of providers that are most likely to do so.

As discussed in previous chapters, the vast majority of providers are accepting new patients, and this does not differ by provider type. Nearly two-thirds of providers met the criteria for being prepared to handle patients with common veteran conditions, and this varied widely by provider type. For example, only 45 percent of mental health professionals met this criterion, while 73 percent of physical and occupational therapists met the criterion. Seventy percent of providers indicated that they often or always used clinical practice guidelines to inform treatment decision-making, which was consistent across provider types. Less than one-half of providers screened for common conditions among veterans. Nearly 60 percent of providers provided some accommodations; despite having a lower threshold to meet the criteria for accommodations, mental health providers were still less likely to provide accommodations than the other type of providers. However, mental health professionals were most likely to be familiar with military culture and much more likely to screen patients to determine whether they are veterans, service members, or family members of veterans/service members. (For a breakdown of the proportion of providers who meet each of the readiness component criteria by provider type, see Tanielian et al., 2018, Appendix B.)

In the figure on page 29, we demonstrate how increasing the number of criteria for readiness results in fewer providers meeting our definition of readiness. Nearly all of the providers meet the most basic criterion, which is accepting new patients. When we add the requirement that providers must also be prepared to handle patients with common veteran conditions, roughly 60 percent of providers are still considered “ready” (readiness at this point varies by provider type, with nearly three-quarters of PT/OTs and fewer than one-half of mental health professionals meeting both of these criteria). Requiring that providers often or always use clinical practice guidelines to inform treatment decisionmaking further reduces the number of providers considered ready to treat veterans to 42 percent, and requiring regular screening of common problems reduces the percentage to 25 percent. Adding the requirement that providers must offer accommodations for patients with disabilities and special needs results in a decrease in readiness to 17 percent. After removing providers who do not have sufficient knowledge of military culture, only 5 percent of providers meet the readiness definition. When we apply the last criterion and remove providers who do not screen to determine whether patients are veterans, only 2 percent of providers meet our final definition as ready to provide timely and quality care to veterans in the community.



# Cumulative Results of Provider Readiness



## What Are the Provider Characteristics That Are Associated with Readiness?

We examined the bivariate relationships between the seven individual components of readiness (see below) and the step-wise levels of readiness with key provider characteristics (provider type, primary practice setting, prior training at VA or MTF, region, proximity to VA, etc.). Logistic regression model results are presented in Appendix B, available online (Tanielian et al., 2018). We discuss each outcome.

### Components of Readiness by Provider Characteristics (Individual Components)

		Accepting New Patients	Practice Prepared to Handle Patients with Common Veteran Conditions	Provider Often or Always Uses Clinical Practice Guidelines to Inform Treatment Decisionmaking	Provider Screens for Common Conditions Among Veterans	Provider Makes Accommodations	Provider Is Familiar with Military Culture	Provider Screens for Current/ Previous Military Service/ Family
		%	%	%	%	%	%	%
Provider type	Medicine (MD, DO)	91.5	<b>69.0</b>	67.3	47.7	64.1	25.9	<b>11.9</b>
	Mental health	91.7	<b>45.9</b>	69.5	35.8	47.5	34.1	<b>36.6</b>
	PA, NP (non-mental health)	92.9	<b>73.7</b>	78.9	46.7	59.1	18.1	<b>11.1</b>
	PT, OT	94.4	<b>77.4</b>	74.6	40.5	72.5	20.7	<b>9.9</b>
Practice setting	Hospital campus	94.6	<b>77.7</b>	79.2	39.0	65.3	24.1	<b>11.0</b>
	Ambulatory clinic or surgery center	90.1	<b>63.8</b>	67.8	49.0	64.5	25.8	<b>21.0</b>
	Rehab/ long-term care	89.0	<b>89.2</b>	78.7	44.4	85.7	22.9	<b>19.4</b>
	Home or private office	96.1	<b>44.9</b>	61.7	38.9	40.5	31.1	<b>19.5</b>
	Other	82.8	<b>55.7</b>	73.4	38.7	58.0	31.9	<b>35.8</b>
Registered as TRICARE/ Veterans Choice Program provider	No	91.4	62.7	70.0	41.8	<b>54.7</b>	<b>22.3</b>	18.5
	Yes	94.1	65.0	70.2	47.0	<b>74.7</b>	<b>42.0</b>	20.9
Completed training on military culture	No	91.5	63.9	69.2	42.1	60.5	<b>20.8</b>	<b>14.9</b>
	Yes	95.0	58.4	75.8	49.6	51.9	<b>67.6</b>	<b>47.9</b>
Worked or Trained in VA/MTF	No	92.4	<b>58.6</b>	69.6	41.3	55.1	<b>22.4</b>	20.5
	Yes	91.4	<b>72.3</b>	70.8	46.5	67.7	<b>35.8</b>	16.7
Opinion of VA	0	91.7	58.9	68.2	37.0	59.3	<b>21.9</b>	16.1
	1	90.0	65.8	69.5	53.1	57.0	<b>23.8</b>	18.5
	2	93.7	69.9	73.2	40.4	57.9	<b>30.3</b>	15.3
	3	90.8	63.7	71.9	43.5	54.9	<b>29.4</b>	21.0
	4	94.8	67.2	76.6	49.5	63.4	<b>30.7</b>	34.9
	5	94.7	67.2	68.6	48.6	71.7	<b>58.0</b>	25.1

NOTE: Bold text indicates a statistically significant difference (chi-square;  $p < 0.05$ ).

### **Provider Is Accepting New Patients**

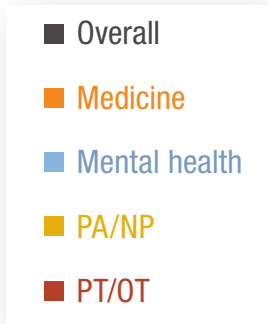
As discussed earlier in this chapter and in prior chapters, most providers that we surveyed reported that they were accepting new patients, and this did not differ by provider type or any of the other provider characteristics that we examined.

### **Provider's Practice Is Prepared to Handle Patients with Conditions Common Among Veterans**

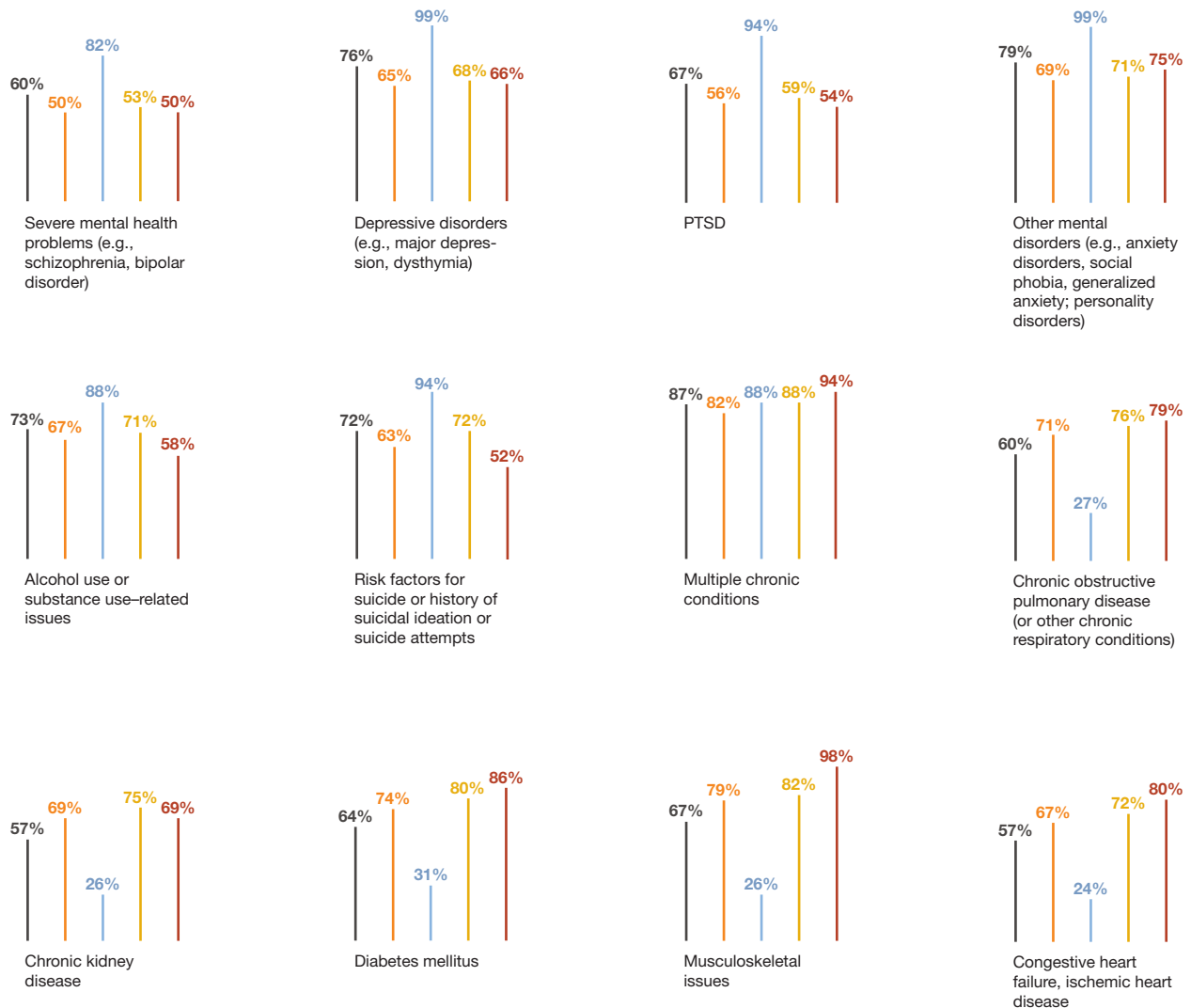
Providers might be more prepared to care for veterans with service-connected conditions if they have prior experience addressing those conditions among their other patient populations. Thus, we queried providers to assess their perceived practice preparedness to handle patients with health care conditions common among veterans. We identified conditions that are common among veterans by reviewing several surveillance reports (Eibner et al., 2015; U.S. Department of Veterans Affairs, 2015; United Health Foundation and Military Officers Association of America, 2016). We asked providers “How prepared is your practice to manage care for the following patients?” and listed 25 conditions common among veterans and older civilians. In the phrasing of this question, we intended for providers to consider their ability to provide care for the patient who has this comorbidity, rather than their preparedness to treat the condition itself. For example, a physical therapist could be well prepared to treat patients with schizophrenia for their physical conditions. Likewise, a mental health provider could be well prepared to treat a patient with significant physical disability for a mental health condition. However, we recognize that some respondents might have interpreted the question differently and responded based on their perceived preparedness to treat each specific condition. We therefore applied a generous threshold for defining provider readiness to manage care for patients with these common veteran conditions. Providers who self-reported being somewhat or well prepared to serve patients with these conditions were considered to have met this readiness criteria.

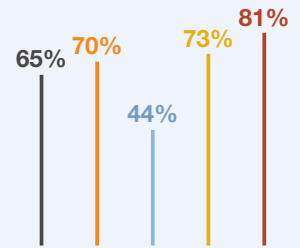
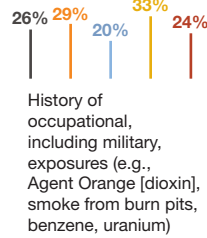
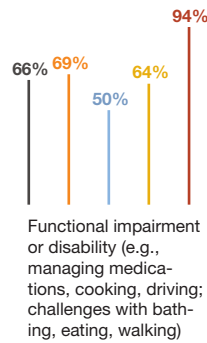
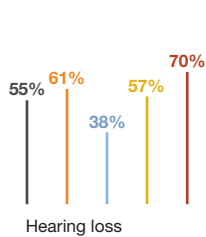
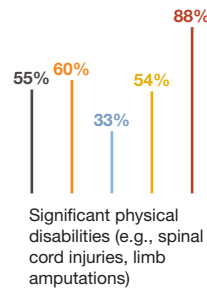
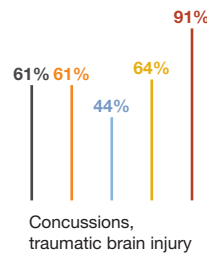
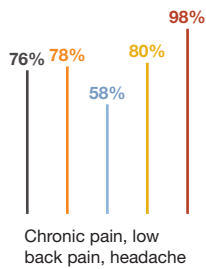
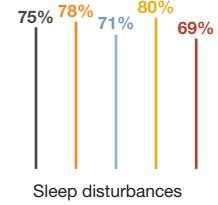
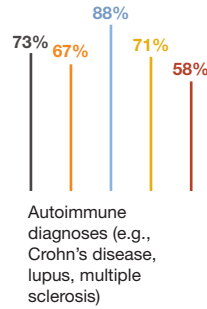
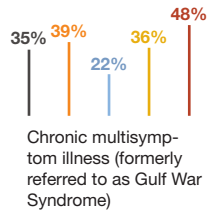
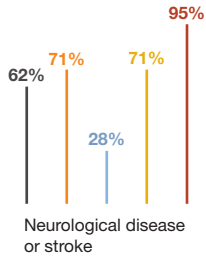
Providers with a prior history of working or training in an MTF or VA hospital were more likely to report being prepared to handle patients with common veteran conditions than those without prior experience (see pp. 32–33); however, this effect was not statistically significant in the logistic regression model after controlling for other factors. Similarly, we found that physical and occupational therapists were most likely to report that their practices were somewhat or well prepared to manage care for more than one-half of the conditions we assessed (see pp. 32–33), while mental health providers were the least likely—44 percent reported being prepared to manage at least one-half of these conditions. However, when we controlled for other factors in the logistic regression model, mental health providers were as likely to report being prepared to handle patients with common veteran conditions as physicians. Providers working in a private or home office were less likely to report being prepared to handle patients with these conditions than those who worked in a hospital setting or rehabilitation/long-term care facility. (For more detail, see Tanielian et al., 2018, Appendix B.)

# Providers Were Asked How Prepared They Think They Are to Manage Patients with Conditions Common Among Veterans

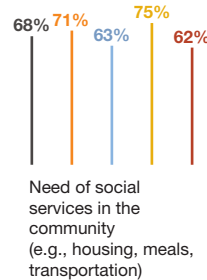
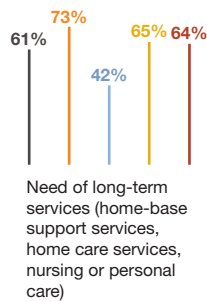
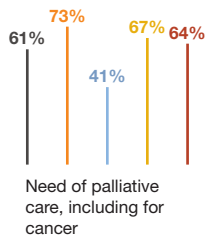


Percentage of providers who answered that they were “somewhat” or “well prepared” to provide care for patients with these conditions





**Percentage of providers who feel that they are “somewhat” or “well prepared” to manage care for at least one-half of conditions**



### **Provider Often or Always Uses Clinical Practice Guidelines to Inform Treatment Decisionmaking**

The use of practice guidelines is a proxy for whether providers rely on the best available evidence about the safety and effectiveness of different treatment options in advising their patients. VA has mandated the use of clinical practice guidelines since the mid-1990s (Hysong, Best, and Pugh, 2007). Studies on the implementation of these clinical practice guidelines have found variability in adherence to guidelines across VA facilities (Hysong, Best, and Pugh, 2007; Doebbling et al., 2002). However, a systematic review has demonstrated that VA outperforms non-VA settings on adherence to accepted processes of care (Trivedi et al., 2011). Given this finding, there is concern that community-based providers might not adequately adhere to clinical practice guidelines. To meet this readiness criteria, we required that providers self-report often or always adhering to clinical practice guidelines.

Overall, we found that 70 percent of providers reported often or always using clinical practice guidelines. We found that length of time since medical training was associated with use of clinical practice guidelines among New York health care providers. Providers who completed their training more recently (five to ten years prior to taking the survey) were the most likely to indicate often or always adhering to clinical practice guidelines. This finding was also consistent in the logistic regression model. Providers working in ambulatory clinics, surgery centers, or private or home offices were less likely to adhere to clinical practice guidelines than providers who primarily worked at a hospital campus.

### **Provider Screens for Common Conditions Among Veterans**

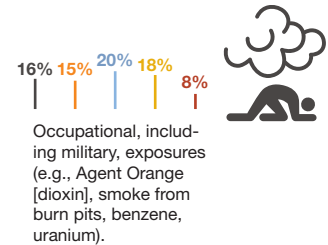
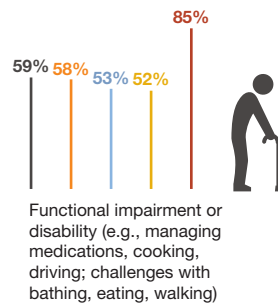
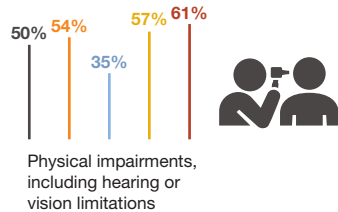
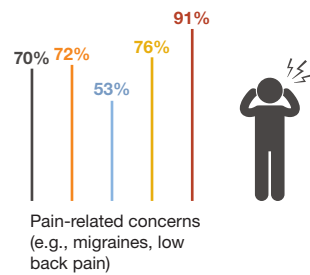
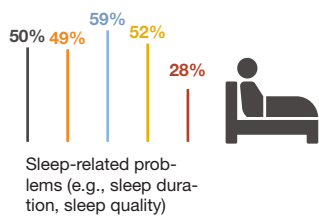
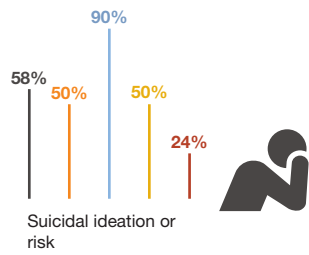
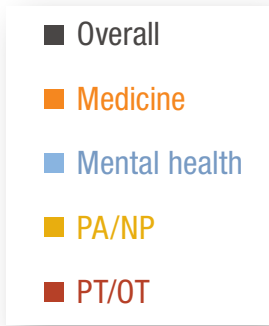
Screening veteran patients to detect various health problems is a common and mandated practice in VA health care settings. For example, VA primary care providers are mandated to screen for depression (Yano et al., 2012) and alcohol use (Grant et al., 2016) once per year for all patients. More than 90 percent of veterans treated in VA settings receive annual screening for unhealthy alcohol use (Bradley et al., 2006), and a prior RAND study found that 81.8 percent of veterans had documentation of screening for suicide in their medical record during the study period (Watkins et al., 2011). These screening practices allow providers to identify individuals at risk of undiagnosed problems and facilitate appropriate referrals. Thus, as one element of provider readiness, we wanted to understand the extent to which providers in the community were routinely assessing their patients for the types of issues that are common among the veteran population.

We found that most providers regularly screened patients for pain-related concerns, but fewer regularly screened for suicide risk, sleep-related problems, and other issues (see next page). Providers in the metropolitan region



# Providers Were Asked How Often They Screened or Assessed Patients for These Conditions

Percentages given from those who answered “occasionally,” “often,” or “always”



were less likely than providers in the western region to screen for common conditions among veterans. There were no significant differences by provider type overall, and we found that very few providers reported screening for occupational risk exposures among their patients. Given what we also understand about the relative risk of suicide among the veteran population compared with nonveterans, our finding that slightly more than one-half of providers routinely screen for suicide risk is concerning.

### **Provider Makes Accommodations for Patients with Special Health Care Needs or Disabilities**

Understanding the potential accommodations made for individuals with disabilities is one aspect of understanding the accessibility and equity of care for veterans with special needs. We asked providers a series of questions about whether their practice provides specific accommodations (extended appointment times, assistance with using facilities, assistance with intake forms, etc.). We then imposed a threshold for providers to make a minimum of either two (for mental health providers) or three of the ten specific accommodations (see Tanielian et al., 2018, for a distribution by accommodation and by provider).

As discussed earlier in the chapter, we found that PTs and OTs were most likely to make accommodations for patients, while mental health care providers were least likely to make accommodations; however, there was no significant difference between mental health providers and physicians after controlling for other factors. This is perhaps not surprising, given the nature of physical and occupational therapists' scope of practice—they are often working in a rehabilitative capacity with individuals who experience functional physical limitations. Unsurprisingly, we found that providers working out of private or home offices were much less likely to provide accommodations than those primarily working in a hospital campus setting.

We found that providers who participated in TRICARE or VA Community Care networks were more likely to make accommodations than those who did not participate in these networks, even after controlling for other factors.

### **Provider Is Familiar with Military Culture**

Familiarity with military culture is an important component of being able to provide culturally competent care for veterans (Hoge, 2011). We found that mental health providers were much more likely to report familiarity with military culture than other provider types (see p. 30), and this difference remained statistically significant after controlling for other factors in the logistic regression model.

Those with work or training experience in a VA or MTF, those who participated in TRICARE or VA Community Care networks, and those who completed formal training on military culture were more likely to be familiar with military culture, according to our assessment. Notably, only 68 percent of those who reported receiving formal training on military culture reported being familiar with military culture, suggesting that training participation alone might not be sufficient for achieving high military cultural competency. The relationships discussed in this chapter were also significant in the logistic regression model.

### **Provider Screens for Current/Previous Military Service/Family**

Only 19.2 percent of providers reported that they regularly screen their patients for military or veteran affiliation. This number is significantly different from the finding in a previous survey of non-VA community-based providers in the Mid-Atlantic Health Care Network (Kilpatrick et al., 2011), in which 44 percent of primary and mental health care providers reported regularly screening their patients for such an affiliation. It is also lower than screening rates reported in a study of mental health professionals in Maryland and New England, where 50 percent and 75 percent of respondents, respectively, reported routinely screening their patients for military history (Koblinsky, Leslie, and Cook, 2014; Richards et al., 2015). Within our sample, mental health providers were not only most familiar with military culture, they were also most likely to screen to determine whether patients previously served or currently serve in the military or whether they are family members of such a person. Those who completed formal training on military culture were also more likely to screen than those who did not. These relationships remained significant after controlling for other factors in the logistic regression model.





# Discussion and Conclusions

Improving the outcomes of veterans with service-connected health issues is predicated on their access to and receipt of *high-quality care*, which has been defined as meeting several criteria—care that is timely, patient-centered, effective, safe, efficient, and equitable (Institute of Medicine, 2001). With only one-half of the 800,000 veterans residing in New York State enrolled in the VA health care system, community-based providers play an essential role in meeting the health care needs of the population. This role might expand as VA continues to increase its reliance on community sources of care. Thus, understanding the readiness of health care providers in New York is critical if we are to ensure access to timely, high-quality care for all veterans regardless of the site of care. This study is the first to assess the characteristics of non-VA providers and to examine the potential for veterans to access high-quality health care in their communities in the state of New York.<sup>10</sup> While the data are based on provider self-report, they do provide an interesting glimpse of the current capacity of community-based care across the state. Here, we summarize the major findings of this study and outline a series of recommendations aimed at increasing the readiness of New York health care providers to address the needs of veterans.

### Summary of Findings

We specifically aimed to assess the capacity of New York health care providers to deliver high-quality care to veterans with service-connected health problems. While it was not feasible to conduct an in-depth assessment of specific health care encounters for veterans, we used a survey to examine various parameters of New York providers' typical practice behaviors that might yield insight into the quality of care they would provide to veterans. In the following sections, we summarize our findings across three major elements of high-quality care.

### Access to Timely Care

Much of the recent concerns about VA's ability to deliver care to veterans have been about the timeliness of that care, specifically about the time it takes for a veteran to get an appointment. As we look at the availability of timely appointments in the community, we found that almost all of the

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Understanding the readiness of health care providers in New York is critical if we are to ensure access to timely, high-quality care for all veterans regardless of the site of care.

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If VA-enrolled veterans are to receive care from a health care provider registered with VA Community Care, access might be a concern because of the relatively low proportion of network providers across the state.

New York providers reported accepting new patients and most (61 percent) reported that new patients would be able to get a visit within two weeks, with almost one-half (45 percent) indicating that most patients could get a same-day appointment. If these reports hold true in practice, then access to timely health care in the community should not be a major concern for New York veterans. However, if VA-enrolled veterans are to receive care from a health care provider registered with VA Community Care, access might be a concern because of the relatively low proportion of network providers across the state. We found that less than 5 percent of health care providers in the state reported being part of the VA Community Care network, with significantly fewer mental health care providers than other provider types. Thus, efforts might be needed to expand the number of providers who participate in these contracts. Increasing awareness of the programs within VA Community Care will be an important first step, as less than 10 percent of providers indicated they were aware of the program. Potential barriers to increased participation included concerns about the reimbursement rate and perceptions about the complexity of administrative requirements associated with joining the program. Participation in and awareness of VA Community Care also varied across the region, with those living in the metropolitan region reporting the lowest rates. While the total number of available providers might be higher in the metropolitan region, a significantly lower proportion of them are participating in VA Community Care, which might create an even bigger access challenge for VA-enrolled veterans living in the area.

### **Access to Culturally Competent Care**

Providers must have a minimum level of familiarity with the unique circumstances and experiences of a particular population to be able to provide culturally competent care to that population. Gaining this understanding often begins by first asking appropriate questions about patients' history and background. Unfortunately, only 20 percent of New York-licensed health care professionals reported routinely screening their patients for a military or veteran affiliation. This was significantly lower than a similar study of providers in South Carolina in 2011. There were also significant differences across provider types and by region. As a result, many providers are missing an opportunity to begin a conversation about how having a military history and background might have contributed to their veteran patients' current medical condition. Providers are also missing an opportunity to understand how military culture could shape veterans' preferences and attitudes about treatment (Weiss, Coll, and Metal, 2011).

Over the past several years, there have been significant efforts aimed at trying to increase providers' awareness of and familiarity with the unique issues facing the military community. Despite these efforts, we found in this current study that only one in three providers met a minimum threshold for familiarity with military culture. We observed significant

differences across provider types in the level of familiarity with specific aspects of military and veteran culture. Across all items assessed, a significantly smaller proportion of physician assistants and nurse practitioners reported familiarity with military culture compared with other types of providers. Mental health care providers were the most likely to be familiar with various aspects of military and veteran culture. This is likely a result of the preponderance of cultural trainings aimed at this provider group—there are fewer programs for other health care professionals.

In our 2014 study of mental health providers, we suggested that cultural competence was important for achieving therapeutic alliance with the veteran (Tanielian et al., 2014). Other studies have also reported that this lack of understanding and awareness might contribute to veterans' unwillingness to seek and remain in care (Weiss, Coll, and Metal, 2011). These findings raise concerns about whether providers in the community will have had sufficient experience and training to truly understand the circumstances affecting veterans who seek health care.

We also found significant differences by provider type with respect to perceptions of VA health care, which could affect willingness to make referrals to VA for certain types of care for veteran patients. Physicians held VA in higher regard in terms of quality and timely access than other provider types, but even among this group, only about one-third reported that they at least moderately agreed that VA provided high-quality care and adequate customer service. A lower proportion of providers overall reported that VA provided timely care. Given the low rates of experience referring to VA among those we surveyed, it is likely that these perceptions have been largely informed by the media accounts of access concerns in recent years.

### Access to Quality Care

Ensuring that veterans get the right care at the right time assumes that they have been assessed appropriately and that safe and effective treatments are delivered when and where needed. To understand whether veterans would be assessed to detect service-connected conditions in non-VA settings, we examined how often community-based providers screen for specific health concerns that are common among veterans (e.g., sleep-related problems, pain-related concerns, physical impairments). We set a relatively low threshold of screening for at least one-half of these common conditions and found that only 43 percent of providers routinely conducted such screenings. Once a condition is identified, providers select and advise on a course of treatment. Clinical practice guidelines are often used to help guide treatment decisions for particular conditions by providing evidence-based recommendations for safe, efficacious, and effective approaches. Seventy percent of community-based providers in New York reported that they often or always used clinical practice guidelines to inform their treatment decisionmaking.





Providing assistance and accommodations to patients with special medical needs is another dimension of providing high-quality care, particularly as it relates to ensuring equity for those with disabilities. While the specific types of accommodations offered varied by providers, roughly 60 percent of New York health care providers reported making at least two accommodations (e.g., providing extended appointment times for patients with complex medical needs, providing assistance with undressing when needed) for individuals with disabilities in their setting. It is unclear whether two is a sufficient number of accommodations to meet the needs of the veteran population, but even with this low threshold, this finding suggests that veterans with significant disabilities might not always receive appropriate accommodations in the community-based health care setting.

### Overall Provider Readiness

When we considered these dimensions of high-quality care and imposed our step-wise definition for overall provider readiness to deliver timely, culturally competent, high-quality care, we found that very few providers meet our readiness criteria. While 92 percent of New York health care providers were accepting new patients, only 2.3 percent met all of our criteria. We observed some associations between certain provider characteristics and our readiness criteria. For example, providers who had trained or worked in a VA or military health care facility were more likely to report that their practice was prepared to handle patients with conditions common among veterans and to be familiar with military culture.

### Recommendations

Ensuring that the health care needs of our nation's veterans are met in a timely fashion remains a national priority. Recent efforts to improve and expand VA Community Care are predicated on the need to ensure that veterans have access to timely services in close proximity to their home. However, our study reveals significant gaps and variations in the readiness of community-based health care providers to provide high-quality care for veterans. To address these gaps, significant efforts are needed to increase the readiness of community-based providers to deliver culturally competent, high-quality care. This includes efforts to increase health care professionals' understanding and use of information about the military and veteran culture, the unique health care risks and issues that affect this population, and the preferences and expectations for treatment. At the same time, efforts are needed to encourage health care professionals to screen their patients specifically for relevant health care concerns—without such information, providers might miss an opportunity to render a more accurate diagnosis and facilitate the appropriate treatment approach.



## Increase Familiarity with and Preparedness Related to Military Culture and Service-Connected Health Conditions

While 63 percent of New York health care providers met our criteria for being prepared to address conditions that are common among the veteran population, only one-quarter met our definition of having military cultural competence. Many campaigns and specific training programs have been aimed at increasing awareness among health care professionals of military culture and the conditions that affect veterans.<sup>11</sup> We found low participation in such prior training (roughly 12 percent of all health care professionals). Of those who had not participated, one-half expressed interest in doing so. However, our analyses also showed that participation in training did not predict competency. Only two-thirds of those who reported receiving training reached our criteria for military cultural competence. It is unclear whether this suggests that the training they received was ineffective in changing their knowledge level or whether it was so long ago that they need refresher training, but it seems clear that while exposing more providers to training opportunities would increase the proportion who receive the training, it might not increase the overall level of readiness. If this is the case, more-targeted approaches might be required to ensure that existing cultural competency training is effective in improving knowledge. One means of doing this would be to impose post-training testing to demonstrate cultural competency. To this end, some organizations that are focused on increasing competency have discussed how to incorporate appropriate questions into either medical board or state licensing and certification exams as a means of incentivizing providers to learn the material. Given the detailed nature of military culture training, there also might be value in having more-accessible resources for providers to review during the course of clinical practice. For example, an online military screening instrument for health care providers could be developed that integrates relevant military culture information into a personalized document for each patient. A potential follow-up step would be to pilot test how these approaches might improve provider competency and capacity to address the unique health issues facing veterans.

## Improve Provider Screening Practices

Providers must ask the right questions to understand patients' backgrounds, current clinical concerns, and any relevant occupational or environmental exposures. These types of screening practices are common in VA, enabling providers to facilitate appropriate referrals and follow-up exams. We found that too few New York health care providers were routinely screening their patients for current or prior military or veteran affiliation. In addition, less than one-half of providers often or always screened for various exposures and/or clinical and functional issues that are common among veterans. Thus, if veterans are going to receive the appropriate care in the community, non-VA health care providers will need to increase

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Significant efforts are needed to increase the readiness of community-based providers to deliver culturally competent, high-quality care.

the frequency with which they assess patients' military and clinical backgrounds. As Boyce (2014) indicated, had these questions been asked, it might have given him an opportunity to get help. While there have been some efforts to encourage health care providers to ask about veteran status,<sup>12</sup> more will be needed to expand this practice to include questions not just about current or prior military affiliation but also follow-up screening questions to identify any potential service-connected health issues that need attention. Thus, as new educational campaigns are considered for improving screening in the community sectors, these campaigns should expand the set of questions to be included.

### **Improve Understanding About and Engagement with VA and Available Resources for Veterans**

Among veterans enrolled in VA health care, most actually receive much of their health care outside VA. VA-enrolled veterans often have multiple sources of health coverage, including employer-sponsored insurance, TRICARE, and Medicare, and receive about 30 percent of their overall health care from VA (Farmer et al., 2016). Still, VA remains an important source of care for these veterans. While the focus of the programs within VA Community Care has largely been to facilitate referrals from VA out to the community, community-based providers might also need to refer eligible patients back to VA for follow-up care for the same clinical condition, specialty procedures, or treatments for other types of conditions. In our survey, most (72 percent) New York health care providers did not know how to refer a patient to VA. Similarly, very few (one in five) were aware of the programs within VA Community Care or were engaged in treating VA patients through the programs; this varied by region.

The VA website lists wait times for a primary care appointment in VA clinical facilities in New York that range from zero to eight days, with the majority of facilities reporting the ability to see a patient within four days. Still, VA has requested increased funding to support VA Community Care, citing higher-than-anticipated demand for referrals into the community sector. For example, in 2016, VA reported issuing more than 2 million authorizations for veterans to receive care through the Veterans Choice Program specifically. This represented a fivefold increase in just one year, and VA plans to spend a total of \$13.2 billion to support community care for veterans in 2018 (Shulkin, 2017). Thus, community-based providers are an ever-increasing component of our nation's system of care for veterans. To ensure continuity and coordination across sectors, efforts will be needed to increase awareness and comfort among community-based providers as well as among VA providers about how best to share information and refer patients.

As VA proposes changes to how patients might be referred to community-based providers (see, for example, the Veteran Coordinated Access and

Rewarding Experience [CARE] Act proposed to Congress in October 2017 [VA, 2017b]), initiatives will be needed to educate and inform health care professionals about the Community Care Programs as a way to increase the number of providers available to receive such referrals. In our survey, most (66 percent) health care providers reported that they did not participate in VA Community Care because they did not know about it. Strategies to increase awareness of the program should include specific information about the type and quality of the services delivered by VA. This type of information could be incorporated into the VA Community Provider Toolkit. Third-party administrators responsible for VA Community Care contracts (e.g., Federal HealthNet Services) could play a bigger role in pushing this toolkit out to their network providers. It will be particularly important to assist community providers in recognizing when a patient might benefit from referral to VA or another care provider in the community with specific capacities. Our survey results showed that only 28 percent of New York health care providers believed that the VA health care system provides high-quality health care (and one-half were unsure whether this was true).

Undertaking and pursuing such efforts as those suggested here would present an opportunity to target specific providers, such as those currently registered as VA Community Care–contracted providers through the PC3 or Veterans Choice Program contracts. This focus will be critically important if there is to be a focus on seamless quality of care from VA into the community. Just as VA has taken steps to focus on training its workforce and requiring use of routine screenings and clinical practice guidelines, third-party administrators responsible for VA Community Care contracts might need to implement similar requirements for network community-based providers. We observed that metropolitan region health care providers were least likely to report that they treat veterans, refer them to VA, or know about VA Community Care. With the density of veterans in the metropolitan region, it is likely that many of these providers might be seeing veterans unknowingly. Thus, efforts to increase their awareness of the needs of this population will be critical.

### **Implement a Quality Monitoring and Management System for VA Community Care**

A quality monitoring and management system for community providers caring for veterans could be implemented to assess provider capacity and readiness on an ongoing basis. This system would identify areas of strength and opportunities for improvement and could inform decisions to include or exclude providers from VA Community Care. Currently, there is no such monitoring and management system in place. As VA continues its relationship with third-party administrators to coordinate networks of private providers, it might wish to extend their internal systems of quality management to their purchased care networks as well by imposing reporting requirements into their contracts.

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With the density of veterans in the metropolitan region, it is likely that many of these providers might be seeing veterans unknowingly.

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While our analysis found that most health care providers in New York report being able to provide timely care and follow clinical practice guidelines, we discovered that most also know little about the military or veterans.

## Conclusion

This study is the first of its kind to assess the readiness of non-VA health care providers to provide high-quality, timely, culturally competent care for veterans across a spectrum of physical and mental health conditions. While our analysis found that most health care providers in New York report being able to provide timely care and follow clinical practice guidelines, we discovered that most also know little about the military or veterans, are not routinely screening for conditions common among veterans, and are unfamiliar with VA and initiatives to expand access to community-based care for VA-enrolled veterans. Training programs to increase providers' military cultural competence and knowledge of VA, as well as efforts to incentivize providers to appropriately screen veteran patients for common service-connected conditions, could improve the readiness of health care providers across the state as increasing numbers of veterans seek care from non-VA providers. While motivating providers to comply with new standards or expectations for training, screening, or reporting can be challenging, VA may have unique leverage to impose these requirements as part of its Community Care contracts that purchase services from private providers. These options could be incorporated into their plans to pay for performance and improve value.

## Limitations

The study, like others that rely upon self-reported data, is not without limitations. There are two main sources of potential bias that should be acknowledged. First, we restricted our sampling frame to those who had an email address in the New York Board of Regents file. While we did not observe any differences among the characteristics we could examine between those with emails and those without, it is possible that other differences exist and could influence our responses. Second, we rely on self-reported and individual items that could be subject to social desirability in the level of endorsement for some items (e.g., on timeliness of first appointment). We must also recognize that our study had a low response rate and small sample size, although we did apply appropriate weighting methods to enhance the representativeness of our findings. Despite multiple emails and the use of tokens of appreciation, surveying busy health care providers can be challenging. We did not have the resources to implement follow-up mail or telephone surveys as a means to increase the response rate, so, despite our efforts to apply weighting techniques, our results might still be subject to bias from the low response rate or unmeasured confounders.

The survey items and criteria for assessing capacity were drawn from prior studies of health care professionals and common standards of quality and preparedness in the field of health services. However, there is no evidence that these criteria are reflective of veterans' preferred health care provider characteristics. We recognize this as a limitation to the study. We applied

standard survey domains, validated items, and common readiness criteria in the absence of data on what factors veterans perceive to be important in community-based health care.

The measure of provider readiness is sensitive to the thresholds applied to each of the criteria. While we did strive to apply reasonable and defensible thresholds, we recognize that they are subjective. That said, we did our best to apply reasonable thresholds based on expectations for providers to be sensitive to the complex needs of their patients and conduct thorough assessments.

Like the other studies of community-based professionals we cited throughout the report, an additional limitation of our study is the absence of a VA provider comparison group. We did not survey VA providers, so we are unable to directly compare the self-reported readiness of providers in VA and non-VA settings. We cite VA-mandated processes and evidence from the peer-reviewed literature, but we could not conduct a comparison of readiness in VA and non-VA settings within the limited scope of our study. This prevents us from making conclusive claims about the relative readiness of providers practicing in the community versus those in VA.

Readers should also take caution in generalizing these findings to providers in other states. While New York is home to a large population of veterans, the demographic characteristics of the veteran and provider populations might differ from those in other states.

While these limitations are important to document, this study is the first to gather information about the capacity of community-based providers across a wide array of profession types to address the specific health issues facing veterans. A follow-up study could be pursued that surveys VA-based and community-based providers to enable a comparison of readiness to serve veterans between practice settings. In doing so, more-robust data would be available to compare the readiness of individual providers across settings, states, and other characteristics.

## Notes

- <sup>1</sup> VA provides disability compensation to veterans who have a documented service-connected health problem. For more information about the types and amount of disability compensation, see the VA website on compensation (VA, 2013).
- <sup>2</sup> We selected those provider types that were more likely to be among those providing primary or specialty care directly to patients.
- <sup>3</sup> We found no statistical difference across provider types and region with respect to whether the provider had an email address on file.
- <sup>4</sup> During the time window for this study, VA contracted with Federal HealthNet Services to administer private-sector care for eligible VA-enrolled veterans under both the PC3 and Veterans Choice Program.
- <sup>5</sup> We offered respondents a choice among incentives—either an electronic gift card to Starbucks or Amazon or a donation on their behalf to the American Red Cross. Incentive values varied by provider type: physicians and mental health therapists were offered \$75; other providers were offered \$50.
- <sup>6</sup> VA locations were identified from the VA Open Data Portal (VA, undated). Distance was calculated as driving distance from the zip code center to the closest VA facility.
- <sup>7</sup> Because many of the items referred to accommodations for physical examinations, we had less-stringent criteria for mental health care providers providing accommodations.
- <sup>8</sup> A comparison of unweighted and weighted population characteristics with the full state sample frame is included in Appendix A (Tanielian et al., 2018).
- <sup>9</sup> VA locations were identified from the VA Open Data Portal (VA, undated). Clinical facilities include medical centers, community-based outpatient clinics, or other clinics.
- <sup>10</sup> There have been studies to assess similar constructs among providers within other regions, including studies of mental health professionals in Maryland (Koblinsky, Leslie, and Cook, 2014) and in New England (Richards et al., 2015). A study of primary care providers and mental health professionals was also conducted in 2011 in the Mid-Atlantic Healthcare Network (VA-VISN 6) (Kilpatrick et al., 2011).
- <sup>11</sup> Campaigns include Have You Ever Served; programs include, for example, PsychArmor, Star Behavioral Health Program, National Center for PTSD resources (including the War to Home series), and Center for Deployment Psychology online courses.
- <sup>12</sup> See, for example, the New Hampshire–based campaign Ask the Question (undated).

## References

- Ask the Question, homepage, undated. As of December 28, 2017:  
<http://askthequestionnh.com/>
- Boyce, Ross, “The Forever War,” *Annals of Internal Medicine*, Vol. 161, No. 9, 2014, pp. 676–677.
- Bradley, K. A., E. C. Williams, C. E. Achtmeyer, B. Volpp, B. J. Collins, and D. R. Kivlahan, “Implementation of Evidence-Based Alcohol Screening in the Veterans Health Administration,” *American Journal of Managed Care*, Vol. 12, 2006, pp. 597–606.
- Doebbeling, B. N., T. E. Vaughn, R. F. Woolson, P. M. Peloso, M. M. Ward, B. J. BootsMiller, T. Tripp-Reimer, and L. G. Branch, “Benchmarking Veterans Affairs Medical Centers in the Delivery of Preventive Health Services: Comparison of Methods,” *Medical Care*, Vol. 40, No. 6, June 2002, pp. 540–554.
- Eibner, C., H. Krull, K. Brown, M. Cefalu, A. W. Mulcahy, M. Pollard, K. Shetty, D. M. Adamson, E. F. L. Amaral, P. Armour, T. Beleche, O. Bogdan, J. L. Hastings, K. A. Kapinos, A. M. Kress, J. Mendelsohn, R. Ross, C. M. Rutter, R. M. Weinick, D. Woods, S. D. Hosek, and C. M. Farmer, *Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs*, Santa Monica, Calif.: RAND Corporation, RR-1165/1-VA, 2015. As of November 21, 2017:  
[https://www.rand.org/pubs/research\\_reports/RR1165z1.html](https://www.rand.org/pubs/research_reports/RR1165z1.html)
- Farmer, C. M., S. D. Hosek, and D. M. Adamson, *Balancing Demand and Supply for Veterans’ Health Care: A Summary of Three RAND Assessments Conducted Under the Veterans Choice Act*, Santa Monica, Calif.: RAND Corporation, RR-1165/4-RC, 2016. As of October 8, 2017:  
[https://www.rand.org/pubs/research\\_reports/RR1165z4.html](https://www.rand.org/pubs/research_reports/RR1165z4.html)
- Finley, E. P., P. H. Noel, M. Mader, E. Haro, N. Bernardy, C. S. Rosen, M. Bollinger, H. Garcia, K. Sherrieb, and M. Pugh, “Community Clinicians and the Veterans Choice Program for PTSD Care: Understanding Provider Interest During Early Implementation,” *Medical Care*, Vol. 55, Supp. 7, 2017, pp. S-61–S-70.
- Gaglioti, A., A. Cozad, S. Wittrock, K. Steward, M. Lampman, S. Ono, H. S. Reisinger, and M. E. Charlton, “Non-VA Primary Care Providers’ Perspectives on Comanagement for Rural Veterans,” *Military Medicine*, Vol. 179, No. 11, November 2014, pp. 1236–1243.
- Grant, S., K. E. Watkins, A. Bogart, S. M. Paddock, and K. A. Hepner, “Patient-Reported Offers of Alcohol Treatment for Primary Care Patients at High-Risk for an Alcohol Use Disorder,” *Journal of the American Board of Family Medicine*, Vol. 29, No. 6, November–December 2016, pp. 682–687.
- Hoge, C., “Interventions for War-Related Post Traumatic Stress Disorder: Meeting Veterans Where They Are,” *JAMA*, Vol. 306, No. 5, 2011, pp. 549–551.
- Hysong, S. J., R. G. Best, and J. A. Pugh, “Clinical Practice Guideline Implementation Strategy Patterns in Veterans Affairs Primary Care Clinics,” *Health Services Research*, Vol. 42, No. 1, Part 1, February 2007, pp. 84–103.
- Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academies Press, 2001.
- Kilpatrick, D. G., C. L. Best, D. W. Smith, H. Kudler, and V. Cornelison-Grant, *Serving Those Who Have Served: Educational Needs of Health Care Providers Working with Military Members, Veterans, and Their Families*, Charleston, S.C.: Medical University of South Carolina Department of Psychiatry, National Crime Victims Research and Treatment Center, 2011.
- Koblinsky, S. A., L. Leslie, and E. T. Cook, “Treating Behavioral Health Conditions of OEF/OIF Veterans and Their Families: A State Needs Assessment of Civilian Providers,” *Military Behavioral Health*, Vol. 2, No. 2, 2014, pp. 162–172.
- National Center for Veterans Analysis and Statistics, “Expenditures,” webpage, U.S. Department of Veterans Affairs, May 18, 2017a. As of December 22, 2017:  
<https://www.va.gov/vetdata/Expenditures.asp>
- , “Veteran Population,” webpage, U.S. Department of Veterans Affairs, August 31, 2017b. As of December 22, 2017:  
[https://www.va.gov/vetdata/Veteran\\_Population.asp](https://www.va.gov/vetdata/Veteran_Population.asp)

New York State Health Foundation, *Veterans and Health in New York State*, New York, July 13, 2017. As of December 22, 2017:  
<https://nyshealthfoundation.org/resources-and-reports/resource/veterans-and-health-in-new-york-state>

NYSHF—See New York State Health Foundation.

Richards, L. K., E. Bui, M. Charney, K. C. Hayes, A. L. Baier, P. K. Rauch, M. Allard, and N. M. Simon, “Treating Veterans and Military Families: Evidence Based Practice Practices and Training Needs Among Community Clinicians,” *Community Mental Health*, Vol. 53, No. 2, 2017, pp. 215–223.

Schell, T., T. Tanielian, C. M. Farmer, L. H. Jaycox, G. N. Marshall, C. A. Vaughan, and G. Wrenn, *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation*, Santa Monica, Calif.: RAND Corporation, TR-920-NYSHF, 2011. As of October 8, 2017:  
[https://www.rand.org/pubs/technical\\_reports/TR920.html](https://www.rand.org/pubs/technical_reports/TR920.html)

Shulkin, D. J., Secretary of Veterans Affairs, statement for the U.S. Senate Committee on Veterans Affairs on the budget request for fiscal 2018, June 14, 2017. As of December 28, 2017:  
<https://www.veterans.senate.gov/imo/media/doc/VA%20Shulkin%20Testimony%2006.14.2017v2.pdf>

Tanielian, T., C. Farmer, R. Burns, E. Duffy, and C. Messan Setodji, *Ready or Not? Assessing the Capacity of New York State Health Providers to Meet the Needs of Veterans*, online appendixes, Santa Monica, Calif.: RAND Corporation, RR-2298-NYSHF, 2018. As of February 1, 2018:  
[https://www.rand.org/pubs/research\\_reports/RR2298.html](https://www.rand.org/pubs/research_reports/RR2298.html)

Tanielian, T., C. Farris, C. Batka, C. M. Farmer, E. Robinson, C. C. Engel, M. Robbins, and L. H. Jaycox, *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*, Santa Monica, Calif.: RAND Corporation, RR-806-UNHF, 2014. As of October 8, 2017:  
[https://www.rand.org/pubs/research\\_reports/RR806.html](https://www.rand.org/pubs/research_reports/RR806.html)

Trivedi A. N., S. Matula, I. Miake-Lye, P. A. Glassman, P. Shekelle, and S. Asch, “Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings,” *Medical Care*, Vol. 49, No. 1, January 2011, pp. 76–88.

U.S. Department of Veterans Affairs, Open Data Portal, undated. As of December 22, 2017:  
<https://www.data.va.gov/sites/default/files/VAFacilityLocation.json>

———, “Compensation,” webpage, October 22, 2013. As of December 22, 2017:  
<https://www.benefits.va.gov/COMPENSATION/types-compensation.asp>

———, *Post-Deployment Surveillance Report*, Vol. 1, No. 1, Washington, D.C., 2015.

———, “Fact Sheet: Extension of Veterans Choice Program Funding,” Washington, D.C., 2017a.

———, “VA Announces Veterans Coordinated Access and Rewarding Experiences (CARE) Act,” October 16, 2017b. As of January 3, 2018:  
<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2963>

United Health Foundation and Military Officers Association of America, *Health of Those Who Have Served*, Minnetonka, Minn., 2016.

VA—See U.S. Department of Veterans Affairs.

Watkins, K. E., H. A. Pincus, B. Smith, S. M. Paddock, T. E. Mannle, Jr., A. Woodroffe, J. Solomon, M. E. Sorbero, C. M. Farmer, K. A. Hepner, D. M. Adamson, L. Forrest, and C. Call, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report*, Santa Monica, Calif.: RAND Corporation, TR-956-VHA, 2011. As of January 12, 2017:  
[https://www.rand.org/pubs/technical\\_reports/TR956.html](https://www.rand.org/pubs/technical_reports/TR956.html)

Weiss, E., J. E. Coll, and M. Metal, “The Influence of Military Culture and Veteran Worldviews on Mental Health Treatment: Practice Implications for Combat Veteran Help-Seeking and Wellness,” *International Journal of Health, Wellness and Society*, Vol. 1, No. 2, 2011.

Yano, E. M., E. F. Chaney, D. G. Campbell, R. Klap, B. F. Simon, L. M. Bonner, A. B. Lanto, and L. V. Rubenstein, “Yield of Practice-Based Depression Screening in VA Primary Care Settings,” *Journal of General Internal Medicine*, Vol. 27, No. 3, 2012, pp. 331–338.



Providers working in the private sector are an increasingly important part of the overall health workforce addressing veterans' health needs. However, very little is known about whether private health care providers are equipped to offer timely access to high-quality care that addresses the unique needs of veterans. Without an understanding of private-sector providers' capacity to treat veterans, training programs to help community providers serve veterans more efficiently might not be targeted to the areas or topics of greatest need.



This report addressed several specific research areas: assessing the demographics, training, and practice characteristics of health care providers in New York; how familiar those providers are with aspects of military and veteran culture; and provider experience with veterans as patients and with the Veterans Health Administration. A six-point definition was used to determine provider readiness: Providers must be accepting new patients, they must be prepared to treat and manage conditions common among the veteran population, they should be using clinical practice guidelines for high-quality care, they should be screening for problems that are common among veterans, they should provide accommodations for those with disabilities or mental health care needs, they should have a basic understanding of military and veteran culture, and they should routinely ask if patients are veterans, service members, or military family members.

The authors determined that while timeliness was not a problem, the number of prepared providers dropped precipitously when factoring in such qualities as familiarity with military culture and screenings for military affiliation or for conditions common among veterans.



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