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A Comparison of Rural and Urban Veterans Health Administration's Home Based Primary Care

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Introduction/Objective: In the over 40 years since VA Home Base Primary Care Programs (HBPC) were created, the program has expanded to nearly 400 sites serving both urban and rural populations. Our objectives are to compare the current state characteristics, structure, practice and team functioning of VA HBPC in rural and urban settings, including primary care provider models, team attributes, services delivered, work environment and perceived team effectiveness.
Design/Methodology: As part of a multiphase national study of VA HBPC, we first designed a Background/Structure Portfolio survey. The survey included Program Director characteristics, HBPC site characteristics, HBPC Veterans populations characteristics, primary care provider model and physician roles, HBPC team characteristics, acute coverage provided to Veterans, and programs and services available to Veterans. The survey was sent to all VA HBPC program directors using REDCap, with a response rate of 60% (n=236). In the second phase, HBPC team members from the programs that responded to the BSP survey were recruited to complete an online organizational assessment questionnaire (HBPC-OAQ) survey to measure HBPC work environment and perceived work effectiveness. A survey was mailed to 2,852 HBPC team members in 249 HBPC sites (of the total 395). Survey responses were received from 1606 individuals (56.3% return) representing 245 teams (98%).
Results: Of the HBPC sites that indicated their location (n=233), more were based in rural areas (58%, n=136) than in urban areas (42%, n=97). Rural programs were newer (8.9±8.6 years, median 7 vs. 18.0±12.2 years, median 12; $p<0.001$) and served a smaller average daily census of Veterans (84.3±62.4 vs. 138.9±83.5). Rural and urban sites enrolled similar populations of Veterans and had no significant differences in the characteristics of their Program Directors. While there were no significant differences in Primary Care Models employed, rural sites reported less participation by HBPC physicians and psychologists in interdisciplinary care planning meetings than urban sites (74.6% vs. 87.5% ($p=0.0163$) and 65.4% vs. 84.5% ($p=0.001$), respectively. Overall, rural and urban sites had similar programs and services available to Veterans and offered similar coverage for urgent care needs during both regular operating and after hours. Rural and Urban HBPC teams reported similar average team effectiveness and average communication/care coordination.
Conclusion/Discussion: Overall, rural and urban HBPC sites have similar reported structures and similar perceived team effectiveness. Some variability in process was noted, particularly with respect to interdisciplinary team care planning participation. It remains unclear whether this reflects adaptation to the rural environment of care or differences in provider availability and/or practice. Greater understanding of how variations in care processes in rural and urban located HBPC programs impact Veteran outcomes.
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A Study of Remote Medication Management Using Veterans Affairs Clinical Video Telehealth Services

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Introduction/Objective: Community Based Outpatient Clinics (CBOCs) are centers that allow primary care to be delivered to veterans that are a long distance from a main Veterans Affairs (VA) campus. However, these CBOCs often do not have physicians who are trained in geriatric principles. In Pittsburgh, a clinical video telehealth (CVT) dementia consult service based in the Pittsburgh VA allows for remote care of dementia patients, particularly in the optimization of medications.
Design/Methodology: We analyzed CVT patient data for a 6 month period from January 1, 2016 to June 30, 2016. We compared each of kind of medication adjustment (additions, discontinuations, and dosage modifications per encounter) between those seen in the initial CVT consults and those seen in the follow up visits. In addition, we further broke down each kind of adjustment by medication type to see which medications were more likely to be affected by the initial CVT consults or the follow up visits. Comparisons between the two groups were done via t-test.
Results: We were able to analyze 105 separate encounters in the 6 month period, with 68 being initial CVT consults and 37 being follow-up visits. We found that the initial CVT consults, compared to follow up visits, had a greater number of added medications per encounter (0.750 vs. 0.351, $p=0.0115$), a greater number of medication discontinuations per encounter (0.838 vs. 0.135, $p=0.0007$), and a greater number of total overall medications changes per encounter (1.956 vs 0.758, $p=0.0002$). Both had similar dosage modifications per encounter (0.368 vs 0.270, $p=0.4161$). In looking at the types of medications that were added, discontinued, or had dosage modifications, we found that only the number of additions per encounter of nutritional supplements (e.g. vitamin B12, vitamin D3) between initial CVT consults and follow up visits reached statistical significance (0.235 vs. 0.054, $p=0.0271$), whereas all other medication types did not.
Conclusion/Discussion: The difference in medications changes in the initial CVT consults compared to the follow up visits show the effect of CVT on patients without regular geriatric primary care. For those patients that are unable to see a geriatrician in person, our CVT service is able to optimize medications lists. The significantly fewer additions and discontinuations at follow up visits is strong evidence that our patients' medications tend to stay optimized between visits. We found it interesting that the addition of nutritional supplements was the only type of medication change that reached statistical significance and that a larger sample may help tease out