

BRIEF REPORT

Improving Engagement and Retention to Treatment Within VHA PTSD Specialty Care: Evolution of an Outpatient Program Design

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The Veteran's Health Administration (VA) and Department of Defense (DoD) posttraumatic stress disorder (PTSD) clinical practice guidelines (2017) recommend individual, trauma-focused therapy as the gold standard of treatment for PTSD (i.e., evidence-based practices [EBP]). Moreover, these guidelines encourage the use of individual shared decision-making (SDM) to increase engagement and completion of EBPs for PTSD in line with current literature. This study retrospectively evaluated three models of program design of a VA PTSD specialty clinic over the past 8 years. In line with previous literature, the study hypothesized that leveraging individualized SDM in the clinic design would lead to increased completion of EBPs for PTSD. Analyses indicated an impact as the models shifted from a group-based model to an individualized model. Specifically, as compared to veterans who completed a group-based design, a greater proportion of those enrolled in the clinic were more likely to complete an EBP. These results may suggest that individualized, patient-centered treatment planning may be related to patient engagement in EBPs for PTSD in contrast with group-based models. Other programmatic changes, such as changes in treatment options presented to patients, a movement to focus on EBPs for PTSD, and expanded clinic hours and telehealth options, possibly impacted veteran engagement and completion in EBPs. The study highlights the potential impacts of a changing patient population within the clinic over a relatively short period. The observations are discussed, and limitations are highlighted. The study shares the hope for additional randomized prospective studies of program designs.

Impact Statement

This study examines the evolution of an outpatient VA PTSD clinical team as practices moved from group-based model to a more individualized, veteran-centric model. This study underscores the positive impact of a programmatic shift toward individualized care that occurred in concurrence with additional demographic shifts in the veteran clinical population, and availability of remote care options delivered via telehealth. Further clinical research is needed.

Keywords: program evaluation, posttraumatic stress disorder, shared decision-making, VA health care

Within Veterans Health Administration (VA), there has been a consistent effort to improve the treatment of posttraumatic stress disorder (PTSD) over time. As part of this effort, increasing emphasis has been placed on utilizing evidence-based practices

(EBPs) that have shown the greatest evidence for efficacy, including prolonged exposure (PE) and cognitive-processing therapy (CPT; U.S. Department of Veterans Affairs & U.S. Department of Defense [VA/DoD], 2017; VA, 2012). Historically, PTSD treatment was

This article was published Online First September 5, 2022.

The authors have no conflicts of interest to disclose, financial or otherwise.

The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs or the

United States government.

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often delivered in a group format, but recent iterations of VA/Department of Defense (DoD) PTSD clinical practice guidelines have highlighted individual, trauma-focused therapy as the front-line treatment option (VA/DoD, 2017). A consistent focus in VA's treatment improvement efforts has been on increasing access to treatment, as well as bolstering veteran engagement in treatment, which has remained low despite significant investment in treatment availability and provider training across the VA PTSD system of care (Sayer et al., 2017). Although a number of studies have examined predictors of EBP engagement and retention (see Johnson & Possemato, 2019, for a review), most have focused on demographic, symptom and belief-related variables as opposed to aspects of clinic structure (e.g., timing of intake treatment planning sessions).

One potential factor that may impact veteran engagement in PTSD treatment is the initial pathway to treatment—that is, which clinic treatment planning design has the best chance of increasing veteran access to and engagement in EBPs. Group-based sessions have historically been popular due to efficiency (i.e., ability of clinicians to provide orientation to multiple veterans simultaneously). Indeed, at one time, the group-based format for orientation and introduction to treatment was utilized by 90% of VA PTSD clinics (Hamblen et al., 2015). At least, one study has found that group-based treatment planning focused on EBPs could enhance EBP uptake (though not necessarily EBP completion; DeViva et al., 2017). However, other studies have found that focusing on individual treatment planning may have some advantages in terms of EBP access and completion (Mott et al., 2014). For instance, a previous clinic-based study found that shifting from group-based treatment planning to more individualized treatment planning increased the likelihood for veterans to choose to participate in an EBP and to initiate an EBP sooner (though subsequent therapy session attendance and completion did not differ; Hessinger et al., 2018). Another study found that groups designed to prepare veterans for individual EBPs did not effectively increase EBP utilization (Wiedeman et al., 2020). Taken together, this evidence suggests that individual treatment planning potentially confers benefits, namely, the ability to tailor treatment planning discussions to the individual veteran. As such, although individual sessions may increase clinician work up front, this potential baseline increase in effort may be offset by increasing the likelihood that veterans ultimately choose an EBP. The literature so far is not clear on whether group or individual treatment planning would affect EBP completion. The present study is unique as the treatment planning models included comprised three distinct designs: (a) a group model, (b) a mixed model wherein a group session was followed by an individual session, and (c) an individual-session only model. These models will be discussed throughout the method of this study.

This shift toward individual versus group PTSD clinic design also fits with another, broader trend toward the use of person-centered practices in the context of PTSD care. Shared decision-making (SDM) is a person-centered approach in which collaborative discussions allow for patients to articulate values and preferences, and for clinicians to provide information based on patient wishes (Elwyn et al., 2012). This highly individualized approach to health care has been used in the context of care for a range of medical and mental health conditions or concerns including specialty areas of medicine (e.g., Beaver et al., 2005; Cheng et al., 2020), depression

(Raue et al., 2010), and serious mental illness (Mahone, 2008; Zisman-Ilani et al., 2021). Research on SDM indicates that it is a model that may enhance engagement with treatment across a number of conditions, providing benefit to both patients and providers (Chen et al., 2021; Etingen et al., 2022; Trusty et al., 2019). Use of SDM has shown specific benefit in the outpatient treatment of PTSD, where research indicates that early collaboration with patients in treatment choice may increase selection and reception of EBPs (Mott et al., 2014; Watts et al., 2015). A qualitative study of veterans who declined treatment in a VA PTSD clinic (Hundt et al., 2018) likewise encouraged the use of a person-centered clinic model and continuity of care to increase treatment engagement. Taken together, literature indicates that the method of implementing evaluations and inclusion of SDM appears to have an impact on treatment engagement.

A previous analysis, completed by our team and conducted within a VA PTSD clinic, compared veteran selection of individual trauma-focused therapy among veterans following their participation in two clinic models—one of which followed a group-based sessions and another of which included a group-based session followed by an individual session that included SDM as a central element (refer to Hessinger et al., 2018). The results of this analysis suggested that veterans referred to outpatient PTSD treatment who engaged in individual SDM after attending an initial psychoeducation group were more likely to select and engage in an EBP for PTSD; however, no differences were found in the rate of completion of EBPs (Hessinger et al., 2018). The purpose of this present study was to explore differences in treatment initiation and completion of EBPs for PTSD across three PTSD specialty clinic models to build off of this previous study and the larger published literature. The most current model in this PTSD clinic, as described below, moved to only have individual sessions focused specifically on engaging veterans and clinical team members in SDM. In the present analysis, we leverage these data to examine whether prioritizing individual SDM as the first step in the process creates additional benefit to facilitating selection of and engagement in EBPs for PTSD among veterans. Additional historical or design changes between the clinic models are also discussed in the Methods section below and as findings are reported.

Objective

This study examines 8 years of programmatic changes in an outpatient PTSD specialty clinic housed within a large midwestern VA hospital. This retrospective analysis of clinical data explores how the clinical programmatic design shifts affected veteran treatment initiation and EBP completion. In line with the previous literature, this study hypothesized that individualized focus would significantly correlate with increased treatment engagement and completion of EBPs for PTSD.

Method

Design

This project comprises a retrospective analysis of longitudinal patient-level data collected within a large midwestern outpatient VA PTSD specialty clinic.

Participants/Setting

The current evaluation included data from 4,133 veterans who were referred to the clinic between 2012 and 2020.

Clinic Models

The organizational structure of clinic treatment planning underwent three distinct phases of redesign. The first clinic model was in practice from 2012 to 2014, the second from 2014 to 2018, and the third from 2018 to 2020.

Model 1: Group Sessions

In the first model, veterans attended two introductory group sessions which provided psychoeducation and brief overview of treatment options. Each group session was 2 hr each. The psychoeducation covered PTSD symptomology and treatment options available throughout the clinic. Treatment options included EBPs for PTSD (most frequently CPT or PE) as well as coping skill groups and other non-EBPs. These groups were led by a doctoral level trainee, social worker, or staff psychologist. Although veterans did complete self-report measures during the introductory group, these assessments were not used for treatment decision-making. The treatment options presented to veterans in this model included: referrals to other clinics, trauma preparation groups (nontrauma focused skill programs, i.e., anger management, mindfulness, and general stress coping), or individual EBPs for PTSD. After self-selecting a treatment, veterans were scheduled for their preferred group treatment choice or assigned a provider to begin an EBP for PTSD. Of note, Model 1 did not incorporate formal SDM.

Model 2: Group Session/Individual Evaluation and Treatment Planning Session

In the second model, veterans attended a psychoeducation group as they did in Model 1 and were then scheduled for individualized evaluation and treatment planning (ET) with a doctoral level trainee, social worker, or staff psychologist. During the 2-hr individual appointment, the clinician and veteran completed the Clinician Administered PTSD Scale (Weathers et al., 2018), gathered additional relevant background information, defined the veteran's treatment goals, and engaged in a treatment planning discussion with the veteran. The components of this discussion included the following: defining the recovery model (i.e., treatment can improve symptoms), discussing clinic structure and focus, and reviewing treatment options previously presented in the psychoeducation group. Veterans were encouraged to ask questions throughout the discussion and collaboratively decide on their next step in treatment based on the treatment goals they had discussed with the clinician (i.e., engaged in SDM with the clinician to establish a treatment plan). The ET concluded with the development of a treatment plan and each veteran was then referred to the appropriate program, group, or individual provider to begin treatment. The treatment options presented to veterans in this model included the following: individual EBPs for PTSD, trauma preparatory coping group or a referral to other VA nontrauma focused clinics. This clinical model refers to the first individual treatment plan that utilized SDM. This inclusion of SDM principles consistent with Elwyn et al. (2012) was presented as a way of engaging individuals with treatment planning but did not include formal fidelity measures.

Model 3: Treatment Information Consultation

The clinic underwent a redesign in 2018 following an evaluation of the first two model designs (see Hessinger et al., 2018). In the treatment information consultation (TIC) model, all sessions were shifted to one-on-one visits with a veteran and provider. This first 1-hr session involved psychoeducation, completion of self-report measures related to symptom severity, treatment planning following the principles of SDM, and then, if the veteran chose to enroll in treatment, additional appointments were scheduled for further assessment and treatment planning for individual EBP for PTSD. The treatment options presented to veterans during the first session included the following: referrals to other clinics for nontrauma focused treatment or individual EBPs for PTSD; trauma preparation groups were no longer presented as a treatment option. Staff and students were supplied with a guide for SDM for every TIC and had refresher trainings yearly and ongoing case consultation.

Treatment Initiation and Completion Status. Initiation and completion statuses represented two different clinic measures of engagement at different points. Initiation represented whether a veteran elected to engage with the PTSD clinic following initial sessions (regardless of selecting EBP vs. nontrauma groups). Completion represented whether the veteran specifically completed an individual EBP for PTSD.

Data Collection

Veterans included in the current analysis attended an initial session in the PTSD clinic between May of 2012 and March of 2020. As part of routine clinic procedures, data were routinely collected to facilitate quality assurance and quality improvement efforts. Although the primary purpose of these data is clinical and administrative use, the data may also be retrospectively analyzed for research purposes. Specific data were requested and provided to the authors from the larger clinical data repository described above following review and approval by the local VA institutional review board through expedited review. All veterans were asked to complete a series of forms prior to this session; some of the measures included on these forms changed over time, but uniformly assessed demographics including gender, age, race/ethnicity, service era, educational attainment, and employment status. The clinic staff recorded the treatment initiation decision made by each patient (whether the patient selected any treatment offered in the clinic or declined to receive treatment within the clinic). Veterans who may have previously received services in the clinic, were included in the study. In addition, the clinic staff recorded each patient's treatment completion status for individual trauma-focused psychotherapy (i.e., EBP), specifically, whether the veteran did not respond when offered individual EBP psychotherapy, declined to participate in an EBP, began participation but did not complete EBP treatment, or completed EBP treatment; this information was documented by each patient's provider (rather than assessed by proxy, i.e., the patient completing a set number of treatment sessions).

Data Analysis

We examined the sample using descriptive statistics. We then assessed differences in veteran enrollment in PTSD treatment, and completion of EBPs for PTSD, across the three clinic models using

bivariate comparisons (i.e., chi-square analyses). Data analyses were conducted using SPSS (Version 26; IBM). Prior to analyses, cases which represented obvious data entry errors or missing data were reviewed and removed from individual analyses. All available data outside of these cases were included.

Results

Overall, the sample was predominantly male (90.0%) and most commonly married (46.8%). The sample included people of white race and non-Hispanic ethnicity (52.6%), black non-Hispanic (27.9%), Hispanic white (13%), Hispanic black (1.8%), American Indian (0.7%), Asian (1.2%), Pacific Island (0.4%), and unknown/other (2.3%). Most were veterans of Vietnam (31.3%) or Post-9/11 (44.3%) and were not employed (58.4%) at the time of treatment. The majority (79.4%) enrolled for some form of treatment within the clinic visit(s). Among enrolled veterans, over one-third (39.2%) ultimately completed an EBP psychotherapy. Additional information describing the sample can be found in [Table 1](#).

Comparisons of our sample demographics across models are shown in [Table 2](#). Across clinic models, a greater proportion of veterans who were seen within Model 3 were women (13.2%) as compared to Model 1 (8.1%) and Model 2, 9.3%; $\chi^2(2, n = 4,133) = 16.1, p < .001$. In addition, a greater proportion of those who were seen within Model 3 were Post-9/11 veterans (48.0%) as compared to Model 1 (38.3%) and Model 2, 44.9%; $\chi^2(8, n = 3,866) = 93.4, p < .001$. Finally, a greater proportion of veterans who were seen within Model 3 were employed (48.9%) than those who were seen within Model 1 (31.7%) and Model 2, 42.0%; $\chi^2(4, n = 3,578) = 56.1, p < .001$. There were no significant differences in marital status or race/ethnicity among the veterans who participated in the three models.

Comparisons of treatment initiation within the clinic and EBP treatment completion (i.e., completion of trauma-focused therapy) across models are shown in [Table 3](#). Across models, a lesser proportion of veterans who were seen within Model 3 enrolled for treatment in the clinic (67.8%) as compared to those who were seen within Model 1 (90.4%) and Model 2, 81.2%; $\chi^2(2, n = 3,529) = 147.9, p < .001$. Of veterans enrolled, 63.5% of veterans seen within Model 1, 71.5% of veterans seen within Model 2, and 93.9% of veterans seen within Model 3 attended at least one session of a trauma-focused psychotherapy (i.e., EBP). A greater proportion of veterans who were seen within Model 3 ultimately completed an EBP (48.9%) as compared to those who were seen within Model 1 (36.5%) and Model 2, 36.3%; $\chi^2(6, n = 2,175) = 133.9, p < .001$. In addition, a lesser proportion of veterans who were seen within Model 3 did not respond (2.2%) or declined to participate (3.9%) when offered trauma-focused psychotherapy than those veterans who were seen within Model 1 (18.0% did not respond; 18.5% declined) and Model 2, 12.5% did not respond; 15.9% declined; $\chi^2(6, n = 2,175) = 133.9, p < .001$.

Discussion

The purpose of this study was to explore differences in treatment initiation and completion of EBPs for PTSD across three clinic models in a VA PTSD specialty clinic. Our findings provide additional evidence that utilization of the individual visit-based

Table 1

Overall Sample Demographics and PTSD Treatment Utilization

Variable	% (n)
Gender (<i>n</i> = 4,133)	
Male	90.0 (3,719)
Female	10.0 (414)
Marital status (<i>n</i> = 3,615)	
Married	46.8 (1,693)
Remarried	3.9 (142)
Widowed	3.3 (120)
Separated	5.7 (205)
Divorced	22.7 (821)
Never married	17.5 (633)
Unknown	0.0 (1)
Race/ethnicity (<i>n</i> = 4,129)	
Non-Hispanic White	52.6 (2,172)
Non-Hispanic Black	27.9 (1,154)
Hispanic White	13.0 (538)
Hispanic Black	1.8 (75)
American Indian	0.7 (28)
Asian	1.2 (49)
Pacific Island	0.4 (16)
Unknown/other	2.3 (97)
Employment status (<i>n</i> = 3,576)	
Not employed	58.4 (2,088)
Employed	41.6 (1,488)
Service era (<i>n</i> = 3,866)	
Pre-Vietnam	0.9 (35)
Vietnam	31.3 (1,210)
Post-Vietnam	10.0 (387)
Persian gulf	13.5 (520)
Post-9/11	44.3 (1,714)
Clinic models (<i>n</i> = 4,133)	
Model 1: group sessions	19.6 (810)
Model 2: group session/individual ET	55.4 (2,291)
Model 3: TIC	25.0 (1,032)
Initiation of any PCT treatment (<i>n</i> = 3,529)	
Enrolled	79.4 (2,801)
Declined	20.6 (728)
Individual EBP treatment completion status (<i>n</i> = 2,175)	
No response	11.2 (244)
Pretreatment decline	13.7 (297)
Discontinued	36.0 (782)
Completed	39.2 (852)

Note. PTSD = posttraumatic stress disorder; ET = evaluation and treatment planning; TIC = treatment information consultation; PCT = PTSD Clinical Team; EBP = evidence-based practices.

format increases chances of starting EBPs for PTSD, although this format may also increase the likelihood that veterans decline participating in treatment altogether when it is offered to them. Our results also suggest that participating in an individual session may lead to decreases in the percentage of veterans that do not respond to EBP treatment outreach or decline to engage in at least one EBP session as compared to other models. These data, collected over the course of program transition from group format (Model 1) to a hybrid model (Model 2) and finally to a fully individual model (Model 3), support research highlighting the benefits of incorporating SDM and patient-centered care into PTSD treatment ([Chen et al., 2021](#); [Etingen et al., 2022](#); [Trusty et al., 2019](#)). Beyond treatment planning models, several other clinic and demographic changes may have influenced our findings. For instance, there was a greater proportion of Post-9/11 and female-identifying veterans engaging

Table 2
Comparison of Veteran Demographics Across Clinic Models

Variable	Clinic model (%)			<i>p</i> value
	Model 1: group	Model 2: group/IND. ET	Model 3: TIC	
Gender (<i>n</i> = 4,133)				.000*
Male	91.9%	90.7%	86.8%	
Female	8.1%	9.3%	13.2%	
Marital status (<i>n</i> = 3,615)				.800
Married	49.3%	45.9%	46.6%	
Remarried	2.7%	4.1%	4.6%	
Widowed	3.1%	3.6%	3.0%	
Separated	6.0%	5.6%	5.6%	
Divorced	22.0%	23.1%	22.5%	
Never married	16.9%	17.6%	17.8%	
Unknown	0.0%	0.1%	0.0%	
Race/ethnicity (<i>n</i> = 4,129)				.071
Non-Hispanic White	55.6%	53.5%	48.3%	
Non-Hispanic Black	27.3%	27.0%	30.5%	
Hispanic White	12.2%	12.9%	13.9%	
Hispanic Black	1.4%	1.7%	2.4%	
American Indian	0.4%	0.6%	1.1%	
Asian	1.2%	1.0%	1.5%	
Pacific Island	0.1%	0.5%	0.1%	
Unknown/other	1.7%	2.7%	2.0%	
Employment status (<i>n</i> = 3,576)				.000*
Not employed	68.3%	58.0%	51.1%	
Employed	31.7%	42.0%	48.9%	
Service era (<i>n</i> = 3,866)				.000*
Pre-Vietnam	1.2%	1.0%	0.4%	
Vietnam	42.3%	31.2%	22.9%	
Post-Vietnam	9.0%	9.6%	11.6%	
Persian Gulf	9.1%	13.3%	17.1%	
Post-9/11	38.3%	44.9%	48.0%	

Note. IND = Individual; ET = evaluation and treatment planning; TIC = treatment information consultation.

* *p* < .001.

in PTSD sessions over time. Additionally, veterans reported being employed at gradually higher rates over the course of the 8-year study time frame.

Interestingly, the percentage of veterans selecting to engage in PTSD treatment significantly decreased in Model 3, demonstrating more than a threefold decline in treatment initiation as compared to Model 1. The models evolved to have greater one-on-one, veteran-centric emphasis, with psychoeducation, assessment, and

treatment planning components all occurring between the individual patient and provider in Model 3. We observed lower engagement in Model 3, which may be an example of the impact of an individualized clinic design. Self-selection in a group setting (Model 1) may have a higher treatment initiation rate but may indicate interest in general treatment versus a specific treatment plan (Lamp et al., 2014). We suspect that this decline (in line with previous research) may be a result of the individualized treatment planning approach

Table 3
Comparison of Veteran PTSD Treatment Initiation and EBP Treatment Trajectory Across Clinic Models

Variable	Clinic model (%)			<i>p</i> value
	Model 1: group	Model 2: group/IND. ET	Model 3: TIC	
Treatment initiation (<i>n</i> = 3,529)				.000*
Declined	9.6% (<i>n</i> = 78)	18.8% (<i>n</i> = 318)	32.2% (<i>n</i> = 332)	
Enrolled	90.4% (<i>n</i> = 732)	81.2% (<i>n</i> = 1,371)	67.8% (<i>n</i> = 1,030)	
EBP treatment completion status (<i>n</i> = 2,175)				.000*
No response	18.0% (<i>n</i> = 71)	12.5% (<i>n</i> = 162)	2.2% (<i>n</i> = 11)	
Pretreatment decline	18.5% (<i>n</i> = 73)	15.9% (<i>n</i> = 205)	3.9% (<i>n</i> = 19)	
Discontinued	27.1% (<i>n</i> = 107)	35.2% (<i>n</i> = 455)	45.0% (<i>n</i> = 220)	
Completed	36.5% (<i>n</i> = 144)	36.3% (<i>n</i> = 469)	48.9% (<i>n</i> = 239)	

Note. PTSD = posttraumatic stress disorder; EBP = evidence-based practices; IND = Individual; ET = evaluation and treatment planning; TIC = treatment information consultation.

* *p* < .001.

leading to better informed decision-making, which also aligns with our observed increase in EBP across models. Alternatively, some of these findings may be related to shifts in clinic design, wherein by Model 3 only individual EBPs for PTSD were offered to veterans as opposed to non-EBP options also being included in Models 1 and 2.

The degree of EBP treatment engagement differed by model. After deciding to move forward with a EBP for PTSD in Model 3, only 6.1% of veterans either did not respond to attempts to schedule an individual EBP or declined following up, whereas this was observed in Model 1 and Model 2 for approximately 18% of veterans. Given the significant differences between Models 1 and 2 versus Model 3 EBP treatment status, it is plausible that this finding could be related to the shifting of a clinic design that only offers EBP for PTSD (vs. previous inclusion of non-EBP treatments). Regardless, Model 3 saw an increased percentage of veterans who attended at least one session of an EBP for PTSD (whether veteran discontinued or completed an EBP). This is viewed by these writers as a positive finding. Although in general, EBP for PTSD attrition rates remain high (Varker et al., 2021), starting and completing treatment increased with each subsequent clinic model (48.9% completion in Model 3).

The number of veterans who reported being female, and/or employed also significantly increased from Model 1 to Model 3, which is in line with the increased number of Post-9/11 veterans who presented to the clinic. The service era changes are consistent with national data as more Post-9/11 veterans continue to seek VA care and those within this demographic are more likely to be of working age (compared to their Vietnam era counterparts, e.g., who are approaching retirement or have retired). While postulating this is a natural finding, the impacts of the clinical shift to individualized care may also be attributed in part to changing patient panel demographics. Clinic scheduling and modality changes over time were more likely able to meet the needs of working veterans, with the addition/increase of staff providing evening clinics and the expansion of telehealth services (i.e., videoconferencing). These additions/improvements are supportive of the various needs of veterans, including employment, allowing them to engage in care and respond to work needs as well as other obligations (e.g., caring for young children). These varied changes could have also contributed to the study's findings over and above the clinic model changes.

While the clinic made several changes to program design over the 8 years, there were also a number of changes that were made to promote veteran-centric, individualized care, which may impact the finding presented here. The clinic implemented tele-mental health to improve veteran access to care in 2012. Within a few years and particularly coinciding with Model 2, this care expanded to include telehealth to veterans at nonclinic locations such as their homes. From its initial implementation in 2012 through 2019, telehealth grew in scope from <1% of overall visits to more than 20% of overall visits, respectively. This additional option for care delivery format may have impacted overall engagement in treatment (Slightam et al., 2020). Given the uptick in employed veterans seen in the clinic over time, telehealth may have helped in particular by offering a more convenient way to access care. In light of recent COVID-19 pandemic, the current clinic provides telehealth services to over approximately 75% of veterans at the time of this writing. Future investigation of clinic designs must account for designs that evaluates impact of increased utilization of telehealth technology.

Limitations and Future Directions

Several limitations are noted in this study. Data were analyzed as part of a retrospective study data from a single VA clinic in the Midwest region of the United States. Retrospective studies risk nonrepresentative patient sampling, misclassification bias, and non-blinded abstractors of the data (Kaji et al., 2014). Causality should not be inferred from the results of the unadjusted analyses we present. Given the naturalistic retrospective nature of the study, the data provoke questions that can guide future studies. Thus, prospective studies are needed to further assess the impact of person-centric, individualized approaches that utilizes SDM as well as general clinic designs. These future studies should explore differences between in-person and telehealth settings. Additionally, though findings are encouraging of SDM and patient-centered care models, patient satisfaction data were only collected during Model 2. Future studies should include specific studies focused on marginalized populations.

Implications/Conclusion

This study examines the evolution of an outpatient VA PTSD clinical team (PCT) as practices moved from group-based model to a more individualized, veteran-centric model. The findings of this study suggests that individualized modifications may impact veteran engagement and treatment completion. The changes across these models, specifically the shift toward individualized model, noted an increased completion of EBPs for PTSD. This study presents one clinic's findings while moving toward individualized care that occurred in concurrence with additional demographic shifts in the veteran clinical population, and availability of remote care options delivered via telehealth. Expansion of systemic evaluations of PTSD outpatient clinics offers an opportunity to provide optimal veteran care.

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Received February 15, 2022

Revision received July 11, 2022

Accepted July 28, 2022 ■