

# Dissemination of a Care Collaboration Project

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A core project team was able to identify essential implementation components for a successful dual-care program aimed at improving communication and collaboration with non-VA health care providers.

“ I always pray that my patient won't need supplies, like oxygen, because that means dealing with the VA. It's impossible.”

Similar sentiments are shared by community health care providers (HCPs) when addressing the needs of their dual-care patients; those veterans who receive care from both the VHA and non-VHA providers and health care organizations.<sup>1,2</sup> Many Medicare-eligible VHA primary care patients access primary and specialty care outside of VHA.<sup>3-6</sup>

The consequences of dual care for veteran patients have been well described in the literature. Dual-care patients are at risk for several sub-optimal health outcomes (higher A<sub>1c</sub> values, dying of colon cancer, rehospitalization for recurrent stroke or for any other cause),<sup>7-11</sup> which may result from receiving fragmented or duplicative care.<sup>3,12</sup>

Much less attention has been paid to the interactions and care processes that occur between VHA providers and their community counterparts. Many community HCPs experience confusion and frustration when trying to coordinate patient care with VHA and are,

not surprisingly, unfamiliar with VHA goals, policies, and procedures.

A study that explored perceptions of nonfederal physicians regarding barriers to effective dual care for veterans showed that coordinating care with VHA is often considered difficult.<sup>13</sup> Most study respondents indicated that they were rarely or never informed about the visits that the patient makes to the VHA. There was the perception that information sharing is more common from non-VHA to VHA than vice versa. Most respondents indicated that they were unable to access the VHA formulary, making prescribing medications for their veteran patients problematic. More than half noted that the patient transfer to a VHA facility was problematic.

Similar difficulties were experienced at the White River Junction VAMC (WRJVAMC) in Vermont. In hopes of alleviating the problems, a pilot project was conducted. The project provided information sharing and discussion meetings for community organizations often involved in dual care. As the project progressed, the VHA case managers observed that community nurses were more

likely to have relevant data needed to transfer patients to a VA hospital. Meeting attendees expressed a desire to have greater communication and collaboration with VA. The WRJVAMC leadership recognized the positive impact of this pilot project on community engagement. An expanded trial was proposed and funded by the VHA Office of Rural Health (ORH).

The current project began in 2009 and is conducted throughout VISN 1, which encompasses all the New England states and includes 8 VAMCs and 47 additional access points, including community-based outpatient clinics (CBOCs) and outreach clinics. It is hoped that the project can create an organizational culture change in which VHA facilities move from a dual care to a comanaged care perspective. Presentations are made to community HCPs and staff who may provide care to veterans also served by VHA. The presentations explain the processes for delivery of VHA care; the history and mission of the VHA; eligibility for VHA health care; obtaining VHA prescriptions, medical supplies, and medical records; and transferring a patient to a VHA hospital. Presentations also include adequate time for conversation and questions.

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**Table 1. Deconstructing the Project**

| Project Component      | As Originally Implemented  | Issues Encountered  | Suggested Traffic Light |
|------------------------|--|---|-------------------------|
| Leader-champion        | VISN 1 Primary Care Service Line director  | Dedicated time to commit to active, visible project leadership  | Red                     |
| Local champions        | Physicians, nurses, case managers from each of 8 medical centers across VISN 1   | Time available to the project varied across project sites   | Red                     |
| Project manager        | VRHRC-ER staff person provided project management  |   | Red                     |
| Administrative support | Assistant to VISN 1 Primary Care director and VRHRC-ER administrative officer  | Need to address unanticipated concerns and act effectively across medical centers   | Red                     |
| Project evaluation     | VRHRC-ER staff members developed forms, tracked responses, performed analyses  | Evaluation tool revised as needed; self-selection of respondents limits depth of analysis                                 | Yellow                  |
| Communication          | Weekly conference calls via telephone with capacity to share documents as needed; annual in-person full team meeting; regular updates to VISN leadership; quarterly updates to ORH                               |   | Red                     |
| Community attendees    | Targeted community physicians/providers for 30- to 60-minute presentation  | Many physicians/providers did not have time to attend but sent nurses or other office staff                               | Red                     |
| Presentation content   | Presentation template developed by local champions; content and formatting approvals obtained  | Slide templates to capture “local” information (addresses, contact numbers) must be completed by local team members       | Red                     |
| Presentation materials | Hard copy of presentation slides, informational flip books, form letters, brochures  | Handouts can be used as long as they are VA approved  | Yellow                  |
| Presentation tone      | “Good neighbor,” humble, knowledgeable, conveyed that the community is a needed partner for good veteran care  |   | Yellow                  |
| Event scheduling       | Local teams identified and contacted participants and arranged presentation  | Localized struggles to identify audiences; a list of facilities to target was provided using GIS                          | Green                   |
| Logistics              | Funds for projectors and salary support for overtime sent to each participating VAMC; printing of presentation booklets handled centrally; facility-specific information booklets were obtained through the VISN | Challenge identifying the appropriate person at each VAMC to contact regarding purchasing and obligating the salary funds | Green                   |

Abbreviations: GIS, geographic information system; ORH, Office of Rural Health; VRHRC-ER, Veterans Rural Health Resource Center-Eastern Region.

The project lead is the director of primary care for VISN 1, and teams of local champions were assembled at each of the 8 medical centers. To facilitate recruitment of project staff, interested individuals attended a kick-off meeting held at a central location. Attendees heard a presentation about the consequences of dual

care and spent time in a facilitated brainstorming session regarding the difficulties of comanaging care with community hospitals, providers, and health care organizations. The immediate overarching goal to “be good neighbors” to community partners was discussed. Finally, the expectations of project participation

were considered, and questions were answered.

Following the in-person meeting, telephone calls were arranged with each site team to answer any remaining questions and secure participation. The majority of teams were composed of 1 primary care physician and 1 nurse/nurse case manager.

The VISN 1 team was aided by staff from the ORH Veterans Rural Health Resource Center-Eastern Region (VRHRC-ER) to support project planning, implementation, and evaluation.

The presentations were developed by the core project team members and the local VAMC project champions. The initial presentations targeted community physicians and primary care providers (PCPs). These short 30- to 60-minute presentations were designed to fit within lunch breaks and staff meetings. Along with the short presentations, longer (up to 3-4 hours), in-depth presentations targeted to medical staff (nurse case managers, social workers, financial/billing personnel) were scheduled through fiscal years (FYs) 2014-2015. These in-depth presentations will continue in FY16.

A 4-step protocol, outlined by Tomioka and colleagues, was chosen to guide dissemination activities and allow for evaluation of the degree of fidelity to the project model on replication.<sup>14</sup> The steps begin with identifying the components of the program and advance through determining implementation and evaluating the degree of fidelity at the new site. Described here is the application of step 1 of the protocol. The second component is under way, and all remaining steps will be reported in a future article.

### METHODS

Through a series of focused discussions, the core project team delineated the specific project components. Each team member independently assigned an Adaptation Traffic Light designation to each component. *Red light* changes were those elements that cannot be altered without negatively impacting fidelity to the project model. *Yellow light* changes can be undertaken with cau-

tion, as they could potentially result in substantial deviations from the original project model. Finally, *green light* changes can be made without negative impact on the program.<sup>14</sup> The team reconvened, discussed rationales for the assignments, re-evaluated the values assigned, and reached an agreement about the light designation for each component. In cases where an agreement could not be reached through discussion, the team reexamined the component and made changes to the definition where warranted. For example, a concept that had been defined too broadly was broken down further until an agreement was reached regarding categorization of the resultant parts.

### RESULTS AND DISCUSSION

The project components, how they were implemented, and the Adaptation Traffic Light designations are presented in Table 1. This exercise brought clarity and focus to how the core project team viewed the implementation activities.

#### Red Lights

Several staff roles and project components were identified that were considered essential to success. First on this list was the role of the leader-champion. To have full impact, the leader-champion must be in a position of authority. For this project, the role of leader-champion was filled by the VISN 1 Primary Care Service Line director. The leader-champion actively facilitated weekly meetings, acted as a project ambassador to VA leadership, and expressed an even-tempered, supportive, problem-solving perspective with the various medical center project leads.

Because this project is implemented across a wide geographic area, local champions at each VAMC were deemed a red-light component.

Having motivated people “on the ground” who are invested in the project’s goals is essential for success. For optimal outcomes, local champion involvement must be a choice and not an additional assigned responsibility. Maintaining a stable project team is ideal. In the instances where VAMC teams lost members, the core project team would actively assist in finding new members and orienting new members to the project.

An experienced project manager was also thought to be a red-light element for successful implementation. The project manager must maintain project focus, momentum, and trajectory while identifying opportunities for improvement and expansion.

This project could not be successfully implemented without dedicated administrative support and therefore could not be replicated without administrative assistance. Administrative support for this project was provided by 2 individuals. One individual maintained the weekly meeting schedule, arranged in-person team meetings, produced and circulated meeting minutes, and maintained a calendar of presentations. The second individual provided logistic support to ensure that project funds, equipment, and materials were accessible to each local medical center team as needed.

Community attendees were also a red-light component. On project initiation, the study team intended physicians and midlevel PCPs to be the target audience. However, many physicians were unable to attend due to time constraints. Instead, nurses and other office staff attended—only 13% of the attendees identified themselves as physicians or midlevel providers. As a result, the large project team decided to shift the initial focus from targeting providers to a the broader complement of HCPs. Work began

to develop a more in-depth presentation, which would be of interest to nurses, case managers, social workers, administrators, and other medical office personnel.

Presentation content must be consistent across the sites and was, therefore, a red-light element. It is vitally important that the core message being delivered is unified. A small number of slides in the presentation were edited locally to include information specific to the individual medical center (clinic locations, addresses, telephone numbers, and local processes), but the majority of slides had identical content and formatting. The slide set is available on request.

### Yellow Lights

Three project components were thought to have yellow-light flexibility and could, when changed with caution, allow for dissemination with fidelity to the project model. The printed materials distributed at presentations included booklets, tri-fold brochures, information sheets, and other resources seen as useful by each medical center team. Any printed materials could be distributed as long as they were VHA vetted and approved.

Although the evaluation is an essential component to tracking project impact and should be carried out in some form, it is recognized that not all facilities will need or want to conduct such a structured and time-intensive evaluation. In this case, evaluation included before-and-after presentation feedback forms and a telephone call 3 to 6 months after attendance.

Immediately following the presentation, participants were asked to rerate their VA-specific knowledge and identify the presentation elements they found most impor-

**Table 2. Self-Reported Knowledge: Percentage of Respondents Who Rated Their Knowledge as Adequate or Better**

| Topic Area                               | No. of Respondents Before (%) (N = 598)<br>Response Rate = 35% <sup>a</sup> | No. of Respondents After (%) (N = 585 <sup>b</sup> )<br>Response Rate = 34% <sup>a</sup> |
|--|---|--|
| Mission of VHA                           | 131 (22)  | 521 (89)   |
| Local VHA hospital and clinics           | 227 (38)  | 532 (91)   |
| Eligibility for VHA care                 | 96 (16)   | 462 (79)   |
| Obtaining VHA records                    | 78 (13)   | 456 (78)   |
| Obtaining prescriptions                  | 78 (13)   | 462 (79)   |
| Obtaining medical supplies               | 54 (9)  | 415 (71)   |
| Transferring a patient to a VHA hospital | 84 (14)   | 439 (75)   |

<sup>a</sup>Response rates were calculated with 1,700 as the denominators.

<sup>b</sup>Thirteen individuals did not return the feedback after form.

tant. At the 3-month follow-up call, attendees were asked to give feedback about any situations in which they had comanaged care with VA, explain how any interactions had gone, and discuss whether they used any of the printed handouts. As of February 28, 2015, 101 presentations were made to more than 1,700 individuals. A total of 1,183 feedback forms (598 before and 585 after) were returned. The results showed a dramatic increase in self-rated knowledge of VA-specific topics and procedures (Table 2). Open-ended comments articulated appreciation for the VA teams' willingness to openly share information, respectfully hear concerns from the community, and proactively work to improve care for veteran patients.

Presentation demeanor is very important but has some flexibility. The presenter does not have to be a seasoned public speaker. However, the presenter should adopt an unassuming, genuine, open stance and be willing to hear comments and criticisms in a gracious way. In those cases where a participant shares a bad experience in dealing

with VA, the presenter must assure the speaker that the intention is to improve collaboration.

### Green Lights

Event scheduling and identification of potential presentation sites was largely left up to the local VAMC and CBOC teams. Methods included contacting nearby health care facilities, leveraging existing professional and personal relationships, and targeting community facilities that were known to treat veterans. The status of presentations was reviewed at each team meeting. Finding the time to schedule and arrange presentations was difficult for many of the teams. The core project team enlisted the help of the Geospatial Outcomes Division at the Malcom Randall VAMC in Gainesville, Florida, to use geographic information system technology to create a list of facilities in the area of each VAMC. This allowed the teams to further target potential attendees.

Various other tasks were still noteworthy in their significance to the project's success in VISN 1. The VISN 1 Care Collaboration project required portable projectors

for each team. Funds for the projectors were sent to each participating facility to procure the projector locally. Salary support funding was sent to each participating VAMC to allow overtime as needed for presentations. Funding was also sent to each medical center to cover travel expenses related to project activities. Printing of presentation booklets was handled centrally, using the GPOExpress program, which allows printing at any FedEx office location and provides deep discounts for printed products. The ability to print on demand to a remote location with very short turnaround times was crucial in many instances.

## CONCLUSIONS

This project began as a pilot implemented at a single medical center in 2009 and grew into a VISN-wide initiative. After expansion, all 8 VISN 1 sites, the core project team was able to have substantive discussions about the project's components, their relative importance in the dissemination process, and suggestions for alternatives to identified barriers.<sup>14</sup>

In FY15, the VISN 1 core project team has helped expand the project in VISN 19. The new project team, located at the Salt Lake City VAMC in Utah, has long been interested in improving communication and collaboration with the non-VA health care community. However, interest and enthusiasm alone are not suf-

ficient for successful uptake. Many sites likely will not have special funding to implement this program.

As a tool to support successful implementation, essential implementation components were identified, based on experience. Local facilities can use the information included in Table 1 to consider and assess their assets, identify enthusiastic staff in their facility, consider creative local partnerships that would support implementation, and reach out to local rural health resources for assistance. Efforts to build collegial relationships with community providers will enhance communication and improve the quality of care received by all veterans. ●

### Author disclosures

*The authors report no actual or potential conflicts of interest with regard to this article.*

### Disclaimer

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