

Treating Dual-Use Patients Across Two Health Care Systems: A Qualitative Study

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Improved communication and increased education may enhance the experience and outcomes for veterans using multiple health care systems, according to this qualitative assessment of health care provider views.

The VHA assigns all enrolled veterans to a primary care provider (PCP). However, almost 80% of veterans enrolled in VHA have another form of health care coverage, including Medicare, Medicaid, private insurance, and TRICARE for Life program.¹ Consequently, veterans may choose to use more than 1 health care system to manage their health care needs.

Studies based on merged VHA and Medicare claims data have demonstrated substantial dual use by VHA enrollees with Medicare. Petersen and colleagues reported that about 80% of VHA enrollees with Medicare chose to use services in both systems and that greater distance to VHA facilities and lower

priority level for VHA care predicted lower VHA reliance.² Among those aged < 65 years who had Medicare due to disability, 58% were dual users. These dual users relied more on private sector care for many health conditions, with the notable exception of substance abuse and mental health disorders, for which reliance on VHA care was greater.² Another study found that over half of VHA enrollees assigned to a PCP at a community-based outpatient clinic (CBOC) received some or all of their care outside VHA and that reliance on VHA outpatient care declined over the 4-year study period.³

This use of multiple health care providers (HCPs), facilities, and modalities is often described as

dual use or comanagement. *Dual use* in the case of veterans refers to use of both VHA and non-VHA health care, whereas *comanagement* implies an expectation of shared decision making and open communication between VHA and non-VHA providers. In addition to VHA PCPs, rural veterans frequently receive care from local, non-VHA HCPs in the community where they live. As health care in the U.S. evolves and patients have increasing choices through the Affordable Care Act (ACA), the challenge of comanagement for patients receiving care in multiple systems is likely to increase both within and outside VHA.

This study was part of a qualitative rural health needs assessment designed to ascertain the issues facing rural veterans and their providers in the upper Midwest.⁴ The objective was to examine VHA primary care clinic staff perspectives on dual users, perceived barriers that inhibit comanagement, and factors that contribute to the need for dual use in rural areas.

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METHODS

A qualitative study design with in-person interviews was used to elicit the perspective of VHA clinic staff on the current and ideal states of comanagement. Clinics were selected using a stratified purposeful sample of 15 urban and rural primary care clinics at VHA CBOCs and VAMCs in 8 Midwestern states (Illinois, Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Wisconsin, and Wyoming). The stratification criteria included (1) urban and rural; (2) geographic coverage of VISN 23; and (3) VHA-managed and contract clinics, resulting in a purposeful sample of 2 urban VAMC clinics, 3 urban CBOCs, 7 rural VHA-managed CBOCs, and 3 rural contract CBOCs. The distance from the CBOC to the closest VAMC ranged from 32 to 242 miles.

Interview guides were developed and tested by the research team for comprehension, length, and timing prior to data collection and iteratively revised as analysis evolved and new topics emerged. Clinic staff were asked about their perceptions of rural veteran use of VHA care; barriers and facilitators to accessing care; and their personal experience working within VHA. Several questions focused on dual use and why rural veterans use multiple health care systems, their perspectives of dual use, their expectations of patients' role(s) in health care coordination, and the perceived barriers that inhibit comanagement. Interviewers used comanagement and dual use interchangeably to discuss patients with multiple care providers, allowing interviewees to use their preferred terminology; assigned meanings were probed for clarification but not corrected by interviewers.

Between June and October 2009, teams of 2 to 3 researchers visited 15 clinics for 1 to 2 business days each. Researchers conducted interviews with a convenience sample of clinical staff. Consent forms and an explanation of the study were distributed, and those electing to participate voluntarily came to a designated room to complete an interview. All interviews were audio recorded for accuracy.

Interview recordings were transcribed verbatim and reviewed for accuracy. Prior to coding, transcripts were imported into a qualitative data management software program. A codebook, including a priori research hypotheses and de novo themes, was developed based on a systematic review of a randomly selected subset of interview transcripts.⁵ Four coders were responsible for coding all transcripts and validating coding through tests of agreement at predetermined intervals.

Regular meetings were conducted with coders and the lead qualitative investigator to discuss disagreements, clarify code definitions, or add new codes as needed. As codes were added, previous transcripts were coded/recoded for content related to the new codes. An audit trail was maintained, and iterative mediation of codes continued throughout the process. The final codebook contained 42 thematic codes, which reached saturation or data redundancy.⁶ Detailed analysis of the codes *dual use*, *distance*, and *care coordination* were used to inform this study.

RESULTS

Among the 15 sites, 64 in-depth individual interviews were conducted, ranging from 5 to 53 minutes (average 26 minutes). Clinic staff demographic characteristics are depicted in

Table. Descriptive Statistics for Clinic Staff Surveyed (N = 54)^a

Demographics	Respondents
Mean age, y (SD)	48.8 (9.7)
Sex, No. (%)	
Female	42.0 (77.8)
Race/ethnicity, No. (%) ^b	
White/Caucasian	48.0 (88.9)
Asian	4.0 (7.4)
Native American/ American Indian	3.0 (5.6)
Latino	1.0 (1.1)
Years at the VHA, mean (SD, range)	7.0 (7.0, 0.25-34.0)
Occupation, No. (%)	
Physician, PA, NP	20.0 (36.4)
Nursing staff (RN, LPN)	18.0 (32.7)
Administrative and other clinic staff	17.0 (30.9)

Abbreviations: LPN, licensed practical nurse; NP, nurse practitioner; PA, physician assistant; RN, registered nurse.

^aTen clinic staff who participated in an in-depth interview did not complete a survey but are not represented in this table.

^bRespondents may be listed in multiple categories; the response choices of African American/black and Hawaiian/Pacific Islander were not selected.

the Table. Analysis of data captured in the codes *dual use*, *distance*, and *care coordination* resulted in notable concentration in 4 thematic areas: (1) clinic staff perceptions of the influence of access, convenience, and distance on dual use for rural patients; (2) communication and patient's role in comanagement; (3) rules and regulations related to comanagement from the VHA perspective; and (4) barriers to comanagement and recommendations for education.

Influence of Access, Convenience, and Distance

Access to health care was central to the discussion of dual use and co-management by clinic staff. Convenience was identified as the primary reason for rural patients' use of non-VHA services, as many rural patients must travel outside their local community to access VHA care. Thus, dual use was most often noted for services typically available in patients' local communities, especially management of chronic conditions.

The CBOCs provide important services for primary care and management of chronic conditions but are not available in all communities and may have limited hours/days that do not fit with patients' schedules. The CBOCs are often unable to provide needed services, including but not limited to emergency care, diagnostic tests, physical and occupational therapy, and other specialty care services. As one VHA provider put it, "The biggest factor for [dual use] is availability, access, convenience.... It's a lot more convenient to go to the hospital down the street than it is to go 120 miles to [the VAMC], or for some guys who live 30, 40 minutes the other side of here it becomes 150, 160-mile one-way trip."

Related to access, distance and transportation barriers were identified by clinic staff as obstacles to care for rural patients. Despite efforts to offset the expense of travel through reimbursement to qualified veterans and coordinated van transport with Veterans Service Organizations, travel costs—both time and money—were seen as significant barriers to accessing VHA care, as was an inability to travel for those who are ill or frail and elderly. "We send people ... in the van and for the most part that works, but eventually it gets expensive, or you've got somebody with chronic

pain that can't tolerate the van ride for 2 hours," one interviewee reported.

According to clinic staff, dual-use patients also rely on non-VHA providers in particular for urgent or emergency care, while relying on VHA primary care for reduced-cost medications, diagnostic testing, chronic disease management, or annual exams. When asked why rural patients may choose to see more than 1 provider, VHA providers responded. "[It's] more convenient to have a local doctor just in case something went wrong and they need to see a doctor right away. So distance to this clinic would be the number one reason." Another reported, "If it's once or twice a year routine appointments they'll come here, but... they'd rather go to a walk-in clinic nearby than spend so much [money] on gas."

Communication and Patients' Role

Communication between VHA and non-VHA providers is a necessary element of comanagement. Although phone calls or faxing patient medical records are available options, clinic staff reported it was more common to encounter patients hand carrying their records between providers. For dual-use patients, clinic staff indicated it was often unclear who was responsible for relaying information between providers. There is often ambiguity about who will (and should) fulfill this role and not enough time to adequately address or clarify how this is done. Some clinic staff believed that acting as the main conduits of information placed an undue burden on the patients, particularly asking them to be able to accurately relay medical information about tests or prescriptions that they may not fully understand. Others said that it was primarily the

patients' responsibility to give relevant information about their care to all their providers, because of VHA regulations and patient privacy laws. "[The] patient should tell the primary doctor to send them [medical records] because we can't get the medical records without the patient's permission," said one provider.

Another provider utilized the nursing staff to call patients after their appointments to remind them to give their medical records to their non-VHA provider. The data suggest that responsibility for maintaining communication between providers ultimately falls on the patient. From the perspective of a nurse practitioner, "We just keep trying to educate the community.... I've been told that if the patient wants that privilege of using the VA for a pharmacy for an outside provider that we're glad to do that. But it is their responsibility to communicate with their [non-VHA] physician. I think we just need to keep educating the patients."

Rules and Regulations

VHA policies governing prescriptions, hospitalizations at outside facilities, and release of patient information regulate, and in some cases hinder, information flow between VHA and non-VHA providers. Many patients use VHA to obtain medications for lower out-of-pocket costs. This contributes to the number of dual-use patients in VHA and results in several challenges for VHA providers trying to manage patients' prescriptions. For example, patients will ask to fill a prescription at a VHA pharmacy from their non-VHA providers; however, VHA pharmacies can only fill prescriptions from VHA providers.

Many VHA providers are willing to rewrite these prescriptions, but they may need to see the patient

before adding or changing the prescription and require documentation to address contraindications, adverse reactions and/or therapeutic failure, and associated risks before making the authorization. VHA providers noted that because the VHA formulary does not contain all medications, non-VHA providers are often unfamiliar with the VHA National Formulary specifics and will write prescriptions for nonformulary medications, which require a nonformulary request from a VHA provider.

Clinic staff also mentioned difficulty in obtaining records from non-VHA providers. This can be particularly problematic if the patient lives a distance away from a VHA facility and does not have the necessary authorization to share records on file.

Barriers and Education Recommendations

Clinic staff identified coordination of care for dual-use patients as a barrier to providing care. Specifically, providers identified coordination as complicated by communication difficulties, inefficient medical record exchange, short staffing in VHA clinics, duplication of diagnostic services, and non-VHA providers' lack of understanding regarding the services that VHA provides. Specific to rural clinics, comanagement was reportedly hindered by limitations in technology (eg, consistent Internet access), access to routine diagnostic services, and lack of relationships with non-VHA providers. Providers most frequently reported that the critical piece missing in comanagement is a relationship—and implied communication—between VHA clinics and non-VHA community clinics. The concept of a relationship between providers is evoked as a critical element to comanaging dual-use patients; however, clinic staff had a

difficult time articulating what that relationship would actually look like if put into practice.

In spite of the numerous barriers identified by clinic staff, the recommendation for education to improve comanagement was consistent across study sites and clinic staff roles. Education was proposed for patients and non-VHA providers as the best intervention. In response to a question about ideas and recommendations to improve comanagement, clinic staff drew on varied experiences. To illustrate this theme, a provider gave this example of dual-use patients seeking prescription medication from VHA and its impact on comanagement: "I would [recommend] an outreach program to community resources and [non-VHA] providers. To let them know more about how the VA works and the resources that are available, and how specifically to coordinate care through the VA, would be a significant benefit.... If the [non-VHA] providers knew how to—who to—talk to, what information the VA needs, for example, for medication changes, it would help the patients make it work...without having to overburden the patients with having to physically hand carry their blood test results, or their notes, discharge summaries, procedure notes."

Along with providing outreach and education on working with the VHA, clinic staff addressed the need to educate patients more effectively, because they are seen as central to the information exchange. There is motivation on the part of patients to learn the system. "Just making sure that the patients realize that they need to tell their local providers to send us the records and make sure that there is an exchange going on consistently," explained a case manager. "If the patient wants to get

those medications that are costly, then they figure out pretty quick what they have to have, what they need to send to us." The need for education is an ongoing process; who is responsible for this continues to be a point of debate.

DISCUSSION

In order to better understand comanagement of dual-use patients, this study focused on the experiences and perceptions of staff at VHA primary care clinics in the upper Midwest. The data indicated that:

- VHA clinical staff perceive the primary reason patients choose to seek non-VHA care is because of access, convenience, and distance
- In order for comanagement to occur, communication and information exchange—currently facilitated largely by patients—needs to improve
- Education of patients and their non-VHA providers is recommended, to increase understanding of rules and regulations tied to exchange of patient information across health care systems
- Education may facilitate communication, develop relationships, and overcome barriers to information exchange

Distance to health care and perceived convenience were clearly seen by clinic staff as the driving factors behind their patients' dual use. In the authors' prior work, interviews with veterans and their VA providers supported this assertion as well; however, it was also found that distance must not be understood in isolation of other contingencies, such as urgency of need.⁴

Clinic staff identified institutional and individual barriers that lead to miscommunication and confusion on the part of patients and reported

misunderstandings with non-VHA providers, including 3 potential barriers to comanagement. These included (1) inconsistent communication and flow of information between VHA and non-VHA providers; (2) uncertainty about who will (and should) be responsible for information flow between providers; and (3) VHA and federal regulations over patient privacy. Throughout the interviews, access to less expensive prescription medications in VHA was considered an additional driver of dual use. According to clinic staff interviewed, education of patients and non-VHA providers could facilitate efficient and safe comanagement for dual-use patients.⁷

This study suggests both advantages and disadvantages for patients choosing to use multiple health care systems from the perspective of the clinic staff. The primary advantage is better overall health care access, especially for rural patients and those with longer travel times to VHA facilities. The primary disadvantage of dual use is discontinuity of care between multiple care sites. Specifically, this study identified concerns regarding poor communication between providers and transfer of patient medical records. An underlying theme was a concern for quality of care and patient safety, which are recognized by others in the literature as potential consequences of inadequate comanagement.⁸⁻¹²

If there is one aspect of comanagement for dual-use patients to target, this study's findings point to developing strategies to improve communication between providers caring for dual-use patients and, more specifically, cultivating relationships that are currently underdeveloped. This will necessitate a clearer articulation of what constitutes a relationship between comanaging

providers and is a direction for further research that would have applicability beyond VHA to any comanagement of patients using multiple health care systems.

There are 3 simultaneous, yet unrelated, factors that may contribute to increasing dual use. First is the rise in VHA eligible veterans from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.^{13,14} All returning veterans who meet minimal requirements are eligible for 5 years of VHA health care. A large proportion of these individuals are in the Reserve and National Guard, most of whom have nonmilitary jobs that may provide employer-based health insurance. Thus, these veterans have a greater opportunity for dual use. Second, with the aging cohort of Vietnam-era veterans, a greater proportion is becoming Medicare eligible. Third, with the recent passing of the ACA, more patients, including veterans, may choose to purchase insurance through ACA health exchanges. Taken individually or collectively, these factors will likely have effects reaching beyond VHA, especially when veterans receiving care in non-VHA health care systems engage in dual use.^{3,13,15,16}

Limitations

This study has a number of limitations. First, it was limited to VHA facilities located in the upper Midwest, which may limit generalizability to other parts of the country. The convenience sample of clinic staff at VHA clinics may not represent the full range of perspectives among HCPs generally. This study did not interview clinic staff in non-VHA clinics, although this has been the focus of other studies.^{17,18} Although dual use also applies to specialty care and related access issues in rural

areas, this was not a focus of this study. Last, the data were collected in 2009, prior to the implementation of the patient-aligned care team (PACT) model and prior to the recently revealed issues regarding patient wait times for VHA care. Thus, perceptions may have changed, and additional study is needed.

CONCLUSIONS

The results of this study support prior assumptions of barriers to care, but also introduce previously unreported challenges. Dual use is perceived to have both positive and negative impacts, but for the positives to outweigh the negatives, thoughtful comanagement is critical. This may be particularly so in rural areas where dual use is encouraged as a way to overcome distance and increase convenience in accessing care.

As demonstrated by recent events, there are still VHA health care access issues for veterans. Recently, VA leadership and the U.S. Congress proposed that veterans have greater access to community providers as well as VHA in order to overcome delays in care.¹⁹ As this option is explored and put into practice, it is more important than ever to consider the need for care coordination and management of dual-use patients, to ensure good communication and care that is timely, safe, and high quality.

Few models exist in which 2 PCPs coordinate across health care systems, and greater understanding of this dual use is needed. This information is important in designing interventions to improve care coordination across systems to ensure continuity of care, patient safety, and patient satisfaction. Although some work has been done to examine the perspectives of non-VA PCPs, little is known about VHA provider perspectives on

rural veteran dual use.^{17,18} This study explores VHA provider perspectives and identifies areas where interventions to improve care coordination across systems might be targeted.

Next steps for intervention studies would be to improve communication and develop educational tools to aid in the coordination of care between VHA and non-VHA providers. A recent example of this is the *Co-Management Toolkit* developed by the Veterans Rural Health Resource Center-Central Region, which provides information on VHA policies and targets non-VHA providers.²⁰ Although VHA perceptions of comanaging dual-use patients were the target, a similar study of non-VHA providers is important to understand this complex and multifaceted dynamic. Additional work is needed to measure the impact of dual use on clinical outcomes, patient safety and quality, and efficient use of resources, as these are understudied. As dual use continues and potentially increases with the ACA and changing health care in the U.S., it is important to understand the management of patients using multiple health care systems. This is salient as primary care adopts the PACT model and to inform interventions to improve quality and safety while eliminating duplicative health care and costs. ●

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