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Commentary

Listening to the Voice of the Veteran

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As a combat Veteran and CEO of a non-profit organization that supports Veterans, I often hear people comment on ways our nation can improve VA care for America's heroes. When I think of the awesome responsibility we have to nurture Veterans, I know there are some common sense solutions to streamline efforts that offer guidance and support to our former servicemen and women. One suggestion is for VA to incorporate military and Veteran cultural competency trainings for all staff, especially those who do not come from a military background. Another idea is to encourage organizations and individuals who support the Veteran community to finally work together to solve important issues. Cooperation can help us overcome any conflict.

In this article you will not hear cries of contention or assertions that restricting VA's budget will bring about positive change. I will not quibble over how dollars are expended towards VA programs and initiatives. Additionally, there will be no tough talk about the need for an evaluation of the strategic planning at this federal agency that is responsible for millions of Veteran lives. This article is not about pointing fingers, but inspiring hope. Though I will not provide statistics to validate my claims, many Americans agree that change is undoubtedly needed in VA.

Now, more than ever before, VA patients, staff, and leaders need inspiration and hope. The hope that I see lies in a new branding campaign! Across this nation VA has no synergy and no consensus about who it is and what it represents. At present, when it

comes to VA's brand or image, perceptions too often depend on what day you call, which location you visit, and how the day has been for the employee answering the phone. We need to change that.

We need to demand that there be a national branding campaign that conveys a message of compassion, concern, and caring for Veterans, from the receptionist to the division directors to the Secretary of VA. As so many people scrutinize VA to uncover what it does wrong, a comprehensive campaign will help inform and excite Americans about what it does right, such as VA staff's focus on improved patient engagement

"As so many people scrutinize VA to uncover what it does wrong, a comprehensive campaign will help inform and excite Americans about what it does right, such as VA staff's focus on improved patient engagement and patient-centered care."

and patient-centered care. Such a campaign can play a dual role in exciting VA staff about their part in Veterans' care. No good branding campaign happens without some internal planning, training, and staff development. Let staff become excited not about being the voice of the Veteran but listening to the voice of the Veteran and his or her family. VA staff can ensure that a certain level of the "respect the rank, or respect the service" philosophy is shown through Veteran care, not to belittle staff, but to encourage them to have pride about their role in serving our nation's heroes.

Due to recent wars, many in our nation have embraced efforts to support and serve our brave men and women who pledged



Director's Letter

The current enthusiasm for “patient-centered care” (a recent Google search returns 6 million entries) can be confusing and off-putting to many clinicians. Confusing because it has been applied to a disparate set of care innovations, off-putting because it seems to imply that clinicians need to be reminded to care about their individual patients. VHA’s new operational guide for moving towards focused Veteran-centric care, the “Blueprint for Excellence,” describes “healthcare that is personalized, proactive, and patient-driven.” I find this definition helpful because it identifies distinct actions that together put patients closer to the center of their care. First, patients need to determine what they want from their care and, then, work with their care team to devise a treatment plan matched to their specific desires, conditions, and abilities. As patients live longer and accumulate more chronic conditions (and often more providers), what is most important to them—which is often remaining independent and comfortable—may get lost or be in conflict with the disease-specific clinical goals of their clinicians.

One of the transformational actions envisioned by the Blueprint is for the Office of Patient Centered Care and Cultural Transformation to implement personalized health plans that clarify each Veteran’s personal life priorities and goals for their health. These plans can then be used to coordinate care across different providers. The second element is to make our care more proactive, focusing upstream on how we can keep patients healthier rather than focusing all our attention after they become sick. This shift in focus will require engaging resources in the community, such as Veterans’ service organizations as described in Jeff Whittle’s article in this issue. The final element is transforming into a “patient-driven” model of care rather than one that revolves around the workflow of clinicians. This shift can entail everything from making the hospital environment more welcoming for patients and families; using mobile health to facilitate communication and scheduling; and most important, engaging patients in their own care, as described in several of the articles in this issue.

Engagement is not just about making patients feel better about their care—decades of research have shown that levels of patient activation or engagement are strong predictors of better health outcomes as well. The need for more engagement extends to research. In HSR&D, we have recently formed a patient-engagement workgroup which is charged with making recommendations to HSR&D leadership about how to increase the engagement of our Veterans in the research priorities we pursue. By increasing the “voice of the Veteran” in our research, we hope to increase the chances that providers will adopt the findings of that research more quickly, resulting in improvements that Veterans care about.

*David Atkins, M.D., M.P.H.
Director, HSR&D*

their lives to defend freedom. This renewed sense of collaboration and civic responsibility can aid efforts to care for Veterans and their families. We must capitalize on this goodwill. Every employee needs to be inspired by the fact that he or she repre-

sents a federal agency that has responsibility for taking care of our heroes. There is no greater joy than to meet personnel who recognize why they should care. One way to improve the system is to start an awards competition that celebrates VA facilities that

are meeting their goals for serving Veterans. The task is simple. We must make sure that when service members fight for us, we take care of them.

We must remember that even though every VA facility is unique, each facility represents the same body. *E pluribus unum: “out of many, one.”* The Department of Defense has mastered this motto, because it doesn’t matter if you are in the Navy, Marines, Air Force, Army, or Coast Guard—you always recognize that the cause you represent is bigger than yourself. You have a creed, a mission, and a model, and there isn’t anyone in this world who could attempt to compromise that image. So it seems only right that the same be reflected in the federal agency that cares for those heroes who have completed their duties.

Over the years, I have learned that when people believe in a mission, they put personal feelings aside and focus on common goals; they learn it, they know it, they understand it, and they pursue it. I wonder how many VA employees know about VA’s mission? How many VA employees know what image VA represents? I think now is the time to start asking these questions. We must all join in the fight to improve programs and services and lead our Veterans on a journey of hope.

ARVets grew out of the research and work of the Arkansas Yellow Ribbon Taskforce, which conducted an in-depth analysis of the needs of Arkansas Veterans and how efficiently those needs were being met. The Taskforce determined the need for an organization that would connect Veteran-specific resources to Veterans and their families. ARVets provides and coordinates resources for members of the military, Veterans, and their families through a variety of programs and services, including a job readiness program that improves the ability of Veterans to successfully acquire and sustain gainful employment. More information may be found at www.arvets.org.

Response to Commentary

Patient-Centered Communication—An Important Dimension of Patient-Centered Care

Howard S. Gordon, M.D., Jesse Brown VAMC, HSR&D Center of Innovation for Complex Chronic Healthcare, Chicago and Hines, Illinois

VA is making substantial efforts to communicate the VA mission and goals throughout its workforce. A recent effort to communicate this mission across VA is embodied in our commitment to the core values represented in the acronym ICARE (Integrity, Commitment, Advocacy, Respect, and Excellence). A reflection of VA's mission is also found in the four themes and 10 strategies that constitute the VA Blueprint for Excellence, which details a vision for the future of VA. Both ICARE and the Blueprint are national brand campaigns that highlight the importance of patient-centered care. The Blueprint identifies patient-centered care as one of the six aims for high-quality health care identified by the Institute of Medicine.

Patient-Centered Communication

The focus of this response will be on patient-centered communication, which is one aspect, but also a main ingredient in delivering patient-centered care. Provider-patient communication can be patient-centered or provider-centered. Patient-centered communication achieves several functions including: fostering healing relationships, exchanging information, responding to emotions, making decisions, managing uncertainty, and enabling patient self-management.

Efforts to improve patient-centered communication that focus on physicians' communication have not harnessed the full potential of patient-centered communication because they focus on half of the conversation. Attention to patients' communication is equally important. Patients' active participatory communication behaviors (e.g., asking questions, giving opinions) are important because these types of active behaviors are influential in medical encounters. Because of social norms of communica-

cation, when patients are active (e.g., ask a question) they can expect to get a reciprocal response from their provider (e.g., an answer to their question). That is, provider-patient communication is a two-way street. Patients' active participatory communication is powerful because patients who ask questions, make assertions or requests, and communicate concerns and opinions can influence providers' communication, behavior, and recommendations.

Several studies have shown that interventions aimed at teaching patients better communication behaviors lead to improved process and outcomes of care. Yet, efforts to coach patients on how to improve communication behaviors rarely occur because coaching interventions require time, labor, and resources. Paper-based methods of delivering coaching interventions have had modest or no effect on patients' communication behaviors. Intervention options that bridge the gap between resource intensive person-to-person coaching interventions and paper-based interventions need to be investigated. Alternative ways to coach patients might involve patient navigators, peer support, video, and electronic methods. A video intervention may overcome prior barriers to implementation because video-based approaches offer several advantages over other approaches. Video-based direct-to-consumer programs are used effectively by the pharmaceutical industry on television. These advertisements influence patient behavior and activate patients to make specific requests. Few studies have explored video as a medium for delivery of interventions to encourage patients' active communication behavior. I have worked to understand the full potential of video, which has the advantage of being significantly less expensive than interventions requiring coaching personnel, and may be more easily disseminated than coaching interventions that rely on trained personnel.

Patient-centered care depends on clinicians to use patient-centered communication and patients (and their companions) to be prepared to use active participatory communication. Patients who have difficulty using active participatory communication behaviors are less involved in consultations with their providers, receive less information and support, and are less satisfied with their care. In turn, these patients may not understand their treatment options. Furthermore, even when a treatment is chosen, patients may have less knowledge about that treatment, fewer positive beliefs about it, and less trust in the providers administering it. Consequently, patients may have poorer adherence to treatment and self-care recommendations and may experience poorer health outcomes.

Positive Role Modeling: “Speak Up”

As part of my research program, I developed “Speak Up,” an educational video to encourage patients to use active participatory communication behaviors in visits with their provider. Based on focus group data, literature reviews, and input from our expert panel, the video presents positive role modeling of communication in medical encounters. Role modeling is an effective method of preparing patients for visits and for encouraging appropriate behaviors; in fact, such modeling is a standard approach in medical education.

In our evaluation, we have found the video to be acceptable to VA patients and feasible for use in a busy VA primary care clinic. We have used the video as part of new patient orientation at a VA community-based outpatient clinic. We are currently testing whether watching the video influences patients' communication in a project funded by HSR&D. Another HSR&D project will evaluate pre-visit video as a means to promote improved communication in the setting of clinical video telehealth visits. Our research projects include provider training in agenda setting, so that providers are prepared for activated patients.

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Research Highlight

Using the *My Story: Personal Health Inventory* for Engaging Patients in Care

Barbara G. Bokhour, Ph.D., HSR&D Center for Healthcare Organization and Implementation Research and Center for Evaluating Patient-Centered Care in VA, both at the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts

The VA Blueprint for Excellence focuses on developing strategies for providing personalized, proactive, patient-driven care. This approach is not a new idea: VA has been moving in this direction for many years, having established the Office of Patient-Centered Care and Cultural Transformation in 2010 to move VA health care away from being disease-centered (i.e., “What is the matter with this patient?”) to a patient-centered model of care (i.e., “What matters to this person?”). To be truly *patient-centered*, providers need to invite patients to engage in setting and attaining personal health goals. To that end, the Blueprint for Excellence calls for the implementation of personal health planning; such planning requires patients and providers to work collaboratively to create a plan of care that starts with the patient’s goals, priorities, and preferences.

What is the *My Story: Personal Health Inventory*?

A personal health planning tool, the *My Story: Personal Health Inventory* (PHI), is being piloted in many VA medical centers throughout the country.¹ The PHI was designed by the VA Office of Patient Centered Care and Cultural Transformation (OPCC&CT), based on the work of Dr. Tracy Gaudet, to assist in creating a partnership between Veterans and their health care providers. Using the PHI, Veterans choose health goals based on their own values and work with providers to implement goal-oriented lifestyle changes.

The tool consists of a series of questions that encourage Veterans to reflect on multiple facets of health, referred to as the Components of Proactive Health and Well-Being. These components include: working the body; recharge; food and drink; personal development; family, friends, and co-workers; spirit and soul; surroundings;

and power of the mind. The tool then asks the Veteran to:

1. Answer several overarching open-ended questions: “What really matters to you?” “What brings you joy and happiness?”
2. Rate his/her current physical well-being, emotional/mental well-being, and how it is to live his/her day-to-day life.
3. Think about each of the components of health and well-being, and state where he/she is now, where he/she would like to be, and how he/she thinks he/she might achieve their goal.
4. Comment briefly about the preventive and clinical care they receive, and reflect on their vision of their best possible health, identifying any areas they would like to work on.

The purpose is for the patient and practitioner together to use this information to identify a personal health goal and steps to reach that goal.

The Center for Evaluating Patient-Centered Care

In partnership with OPCC&CT, the Center for Evaluating Patient-Centered Care in VA (EPCC-VA) investigators are evaluating the implementation and effects of PHI use. In our first study, we conducted qualitative analyses of Veterans’ PHIs to develop a tool for coding patients’ open-ended responses; this tool was then used to examine how Veterans respond to the questions.² The distribution of codes found in 100 PHIs indicates that the tool is achieving its intended goal. Notably, Veterans’ responses were coded most frequently as ‘being with family,’ ‘sleep,’ ‘eating proper foods,’ ‘being healthy,’ and ‘social engagement,’ whereas more medico-centric concerns such as adherence, medical issues, and even death were among the least coded responses.

In a second study, we examined perceptions and reactions to completing a PHI from data collected by OPCC&CT in listening sessions with both patients and providers at six pilot sites. We found that both groups viewed the PHI as helpful, allowing patients to self-reflect, providers to understand the patient’s perspective, and bringing all providers onto the same page. The groups also noted that the tool is best used in conjunction with a health coach or provider who can build upon the responses.

We have also conducted surveys with Veterans who had documentation of completing a PHI. Preliminary analyses reveal that 1/3 of patients surveyed reported they had completed a PHI. Those who also set one or more personal health goals and reported engaging in activities to address those goals, reported better communication with their providers and better outcomes on several dimensions.

Many questions remain. We are conducting a mixed-methods national study of sites that have initiated personal health planning with Veterans. This study will identify differences in implementation, and examine patient-reported experiences with care and patient-reported outcomes. Initial data from one site which had done many PHIs with Veterans, indicates that successful use of the tool requires engagement of clinicians in changing the conversation.

How can we foster a truly Veteran-driven health care encounter, and ultimately a health care system that is responsive to what matters most to patients rather than one driven by a focus on disease? Personal health planning using the *My Story: Personal Health Inventory* tool encourages shared goal setting and improved self-management by engaging Veterans in their own care. Through our evaluation, the EPCC-VA team hopes to identify the strengths of this tool and better understand its implementation to ensure its success at sites throughout VA.

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Research Highlight

Exploring OEF/OIF Veterans' Perceptions of Patient-Centered Care through PhotoVoice

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In 2001, the Institute of Medicine identified patient centeredness as a priority area for improving the quality and equity of health care. Defined as “providing care that is respectful of and representative to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions,” this emphasis on the agency and autonomy of patients signaled a sea change in medicine.¹ Within VHA, the formation of the Office of Patient Centered Care and Cultural Transformation, the national roll-out of Patient Aligned Care Teams, and more recently, VA’s Blueprint for Excellence have all brought a focus on patient centeredness. These efforts recognize the importance not only of the *quality* of care Veterans receive, but also Veterans’ *experiences and perceptions* of that care and the environment in which it is delivered. Gaining a deep and productive understanding of Veterans’ perspectives on patient-centered care requires innovative approaches that highlight collaboration, dialogue, and prioritization of Veterans’ voices.

PhotoVoice: A Place for Participatory Action Research in VA

PhotoVoice is a community-engaged research approach that entails giving cameras to individuals to document and convey the conditions, resources, and unmet needs around a specific problem facing their community, as well as identify potential solutions.² This approach repositions ‘research participants’ as collaborators and co-owners of research data who are key partners in the development and dissemination of findings. This approach also incorporates elements of advocacy and social action, and creates opportunities for dialogue between research partners, policymakers, and other key stakeholders. PhotoVoice encompasses key principles of participatory action and patient-oriented research, and aligns with

VHA’s goal of increasing Veteran engagement in developing processes and policies to enhance patient-centered care and patient experiences at VA facilities.

With VA HSR&D funding, my research team and I undertook a PhotoVoice collaboration with OEF/OIF Veterans to explore and convey their experiences of deployment, homecoming, and engaging in VA health care. The collaboration places an emphasis on identifying barriers to care and ways to ameliorate those barriers. Through outreach via community-based organizations and student Veteran groups, we ensured participation of Veterans who avoid or abandon VA health care as well as those who rely on VA for health care services. Twenty-nine Veterans from all four major branches of service contributed over 300 photos to the project and described the meaning behind each photo. Through analysis of photos and interview transcripts, we identified common themes around how OEF/OIF Veterans define patient-centered care, the impact of negative health care encounters on a Veteran’s decision to seek or continue treatment, and suggestions for how VA health care providers and staff can build trusting relationships with Veteran patients. We also developed an exhibit of Veterans’ photo-narratives, entitled *From War to Home*, which has been traveling for the past three years, including installations at five VA Medical Centers so far.

OEF/OIF Veterans’ Visions for Patient-Centered Care at VA

Veterans’ photo-narratives highlighted the role of military cultural identity—including norms of stoicism and self-reliance—in shaping how they think about health, illness, and help-seeking. Veterans’ stories revealed the challenges they faced in initiating treatment, getting to an appointment, and mak-

ing themselves vulnerable to care providers. Their stories emphasized the importance of encountering healing environments, respectful staff, and providers who asked questions about their experiences, needs, and goals—and listened to their responses.

Veterans’ stories conveyed how essential it is that VA staff and providers avoid making assumptions about an individual Veteran’s military service or current circumstances, but rather, get to know each Veteran as an individual. In particular, Veterans want to feel that they are “more than just a number” or a collection of symptoms; as one Veteran noted, “I need my provider to treat me as a person, instead of just thinking ‘this medication goes with this symptom.’” Study findings on barriers to mental health care, including Veterans’ photo-narratives, were published in a recent issue of the journal *Qualitative Health Research*.³

Next Steps: PhotoVoice as Dialogue

Our PhotoVoice collaboration produced compelling, personal, and rich photo-narratives that engage Veterans and their families, health care providers and staff, and the general civilian public on a deep and visceral level. As the exhibit travels, we are developing new venues for featuring Veterans’ stories and perspectives through a website (www.va.gov/FromWarToHome), photo book, and multi-media presentations with Veterans as expert speakers. Audiences for these events value the opportunity to hear directly from Veterans, while the Veterans who share their stories through *From War to Home* exhibits and events find the experience cathartic. The conversations about how VA can meet Veterans’ visions for patient-centered care are just getting started.

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Research Highlight

Engaging Patients and Partners in a Stakeholder Council to Improve Patient Care

Monica M. Matthieu, Ph.D., L.C.S.W., Nicole Hart, B.A., Bridgette Larkin-Perkins, M.B.A., Jeffery A. Pitcock, M.P.H., Kathy L. Henderson, M.D., Angela B. Swensen, M.S.W., JoAnn E. Kirchner, M.D., all part of Mental Health QUERI Stakeholder Council, Central Arkansas VA Healthcare System, North Little Rock, Arkansas

The Mental Health Quality Enhancement Research Initiative (MH-QUERI) is a national quality improvement and research program within VA's Health Services Research & Development (HSR&D) Service that focuses on the intersection of mental health services research and implementation science. As a leader in the application of evidence-based mental health practices into routine VA care settings, MH-QUERI developed a unique mechanism for partnering with Veteran patients: the MH-QUERI Stakeholder Council. The Council provides a conduit for Veteran inclusion in the design, delivery, and optimization of VA's mental health services.

The Council's purpose is to serve as a critical resource to MH-QUERI investigators. Comprised of Veteran patients, family members, clinical providers, community advocates, and administrators, the Council provides expert opinion to our researchers at multiple points across the research continuum, from project conceptualization, to data interpretation, and finally, to dissemination. In essence, the Council is a highly regarded consultation activity that offers research review and targeted feedback from patients and other stakeholders so that investigators may improve the impact of their research.

Engaging Patients and Partners

The Council was developed in four phases over the past three years. In Phase I, we partnered with Veteran patients of all eras, advocates, and other community stakeholders with the goal of including their voices early in the research process. We also engaged various stakeholders from inside VA—clinical providers, clinic managers, and administrators from local to national lev-

els—to provide a robust view of the myriad layers of VA's mental health service delivery system. We selected stakeholders for the Council based not only on their own experience as Veterans or status as VA employees, but also for their ability to advocate within the characteristic or role for the group they represent. Additionally, we sought members with an active interest in improving VA patient-centered care, with a Veteran-centric mindset, and who possessed a macro and tactical view of population-based mental health improvements. Finally, the heart of a volunteer is also required for our Council as we can only offer volunteers the promise that their time, expertise, and contributions will make a difference for other Veterans seeking VA mental health services.

In Phase II, we collaboratively developed and pilot tested the operational procedures that would guide the Council. After identifying a chairperson, we collaboratively designed processes and procedures that would maintain the Council's Veteran-centric value, and its bi-directional knowledge exchange. The processes focused on how the MH-QUERI staff would administratively support the Council so as to reduce burden on our volunteers, as well as how to share criticism effectively with investigators during the research review process.

As part of this effort, MH-QUERI staff prioritized the list of affiliated investigators selected to present to the Council. Investigators then submitted specific research materials, including an abstract, a grant proposal, a brief slide presentation, and discussion questions. Prior to sharing these materials with the Council, MH-QUERI staff reviewed the materials and encouraged investigators to present in lay language, avoid acronyms, and define the impact of

their research for a *typical* Veteran seeking mental health services in VA.

Improving Patient-Centered Care

In Phase III, we developed an evaluation plan that would assess the nature of the bi-directional partnership, co-production of research, and knowledge exchange between our stakeholders and investigators. Our evaluation plan outlined the data collection processes and evaluation activities that would assess qualitative data on satisfaction, perceived value, diversity, and use of the Council consultation from MH-QUERI investigators. The plan also called for collection of quantitative data on submission and funding success rates from MH-QUERI administrative data. The final phase, currently in progress, focuses on assessing our outcomes.

Initial evaluation results suggest that our Council is a bi-directional mechanism for our Veteran patients and partners to share their perspectives early in the research process. Overall, the stakeholders provide powerful and valuable expert opinion, as one MH-QUERI investigator stated: "...*the input from both the primary care physician and the Veteran was extremely helpful because this intervention was to target the attitudes amongst primary care providers and they heard the intervention, and were able to tell me how it would be received and how their emotional reaction or how much of a buy in I would get from the recipient group. And the Veteran's perspective helped me kind of understand the issues that the Veterans face when they are working with their primary care provider.*"

The MH-QUERI Stakeholder Council is designed to improve patient care, not just on behalf of Veterans, but *with* Veterans and partners working together. This inclusive approach has the potential to accelerate the implementation of effective interventions into routine clinical practice, and ultimately, to improve the quality of mental health services for our nation's Veterans. Yet, perhaps even more compelling, as one Veteran Council member stated: "*In general, it's great to know that this Council exists! [laughs] ... as a Vet receiving services, I'm really glad that there's this much thought, and this much care going into, you know, the research that will eventually affect people like me.*"

Research Highlight

Conducting Research in Partnership with Veterans Service Organizations: One Center's Experience

Jeff Whittle, M.D., M.P.H., Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

As health care systems increasingly recognize the need to engage more deeply with the individuals they serve, the Veterans Healthcare Administration (VHA) has the advantage of a defined target population. One appealing approach for VHA clinicians and researchers is to work with Veterans groups, particularly Veterans Service Organizations (VSOs) such as the American Legion.

History of Collaboration with VSOs

Researchers at Milwaukee's Clement J. Zablocki VA Medical Center (ZVAMC) have engaged VSOs in research activities since 2005. Because this collaboration has been in place longer than many others, its history may be of interest to others in the field. Following the precepts of community-engaged research, we first visited the leadership of various VSOs to gain support for our efforts to work with their membership. While three VSOs had substantial presence in the Milwaukee area (American Legion, Veterans of Foreign Wars (VFW), and Vietnam Veterans of America (VVA)), the VFW became our first partner when the organization's leadership signaled its interest following introductions by a key contact at the ZVAMC.

While many VSOs have sophisticated state and national organizations with full-time professional administrators, the primary organization unit is a local one, most often referred to as a post. These units meet regularly, typically monthly, to conduct business; for example, a post might distribute funds to Veterans in need, organize care packages to deployed active duty forces, and sustain long term programs like an honor guard, Boy Scout Troop, or youth sports team. We wrote to post leaders and asked to visit the posts to talk about how members could take an active role in research regarding the care of chronic disease.

Most posts welcomed the opportunity to have a VA physician attend a meeting. The resulting discussions generally led to positive interest in health promotion and an expressed interest in participating in research in this area. Despite encouraging post members to view the choice of topics as a collaborative process, they tended to defer to researchers regarding the focus of health promotion research efforts. These initial discussions then led to VA HSR&D-funded research efforts that employed the post infrastructure to provide peer support for improved hypertension self-management.

Lessons from Working with VSOs

In addition to contributing to research findings, these projects also provide valuable lessons about working with VSO posts. First, we learned that we needed more time to develop a relationship where VSO members felt empowered to provide direction to physicians. This finding may reflect an older population trained to obey doctors' orders, and further screened by membership in VSOs, which have military style command structure. Second, we learned how powerful peer pressure could be—a substantial majority of all post members with hypertension consented to participate in the randomized trial we designed. Since post members served both as interventionists and recruiters for the research project, we considered there might be ethical issues regarding coercion. Post members believed that once the post had decided to participate in a project, typically by majority vote, individual members should participate, though they acknowledged members should not be directly coerced. They expressed no ethical concerns that peer pressure might influence free choice. We discuss these findings in more detail in published work.¹ Third, we witnessed spread of the intervention from post to post, and across organizations, as many VFW members are

also members of the Legion, the VVA, or the DAV. Fourth, we found that posts vary widely in their ability to engage effectively in complex research activity. In general, posts with more resources were both more willing and also more able to participate.² This finding raises concern that our efforts to target Veterans in their community settings is of disproportionate benefit to the communities with the greatest existing resources.

In 2008, word of mouth brought us into contact with the leadership of Dryhootch of America (DH), an organization of Vietnam Veterans formed in 2005 with the mission of "helping Veterans who survived the war, survive the peace." The organization's mental health focus was a clear departure from our prior experience, but the shared interest in self-management and peer support encouraged us to work together. A small initial grant led to participation by Zeno Franco, Ph.D., a psychologist with VA experience and a trauma psychology research interest. In contrast to the initial experience with older VSOs, the DH partnership was driven by the participating Veterans from the outset. Perhaps because of this less traditional relationship, or because DH is a small and dynamic organization, interactions have sometimes been more complex. Dr. Franco and DH member Mark Flower recently described some of the challenges this collaboration has encountered.³ Dr. Franco leads a \$750,000 foundation-funded grant and has helped DH leaders reach out to the Substance Abuse and Mental Health Services Administration (SAMHSA) and other grantors—efforts that have led to over a million dollars in additional funding.

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FORUM

Translating research into quality health care for Veterans

Center for Information Dissemination and Education Resources
VA Boston Healthcare System (152C)
150 South Huntington Avenue, Boston, MA 02130-4893

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Our video intervention provides specific communication strategies and behaviors for patients to model in preparation for their visit. A timely video intervention that specifically addresses patients' self-efficacy in a culturally sensitive manner

and prepares patients for the medical visit may increase patients' active participatory communication in medical consultations. A program that prepares providers and activates patients to use patient-centered communication has the potential to improve communication in medical encounters and to improve both visit and health outcomes.

A Fond Farewell to FORUM Editor-in-Chief, Gerry McGlynn

We would like to offer a heartfelt thank you and farewell to Gerry McGlynn, who served as FORUM's Editor-in-Chief since 2004. With Gerry at the helm, FORUM maintained its dedication to bringing information derived from health services research to the attention of both VA clinicians and managers. Her energy, enthusiasm, and leadership will be sorely missed. Gerry stepped down as Director of the Center for Information and Dissemination and Education Resources (CIDER) in early 2015. We wish her all the best.

FORUM

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