Author’s response to reviews

Title: Barriers and Facilitators to Implementation of VA Home-Based Primary Care on American Indian Reservations: A Qualitative Multi-case Study

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Author’s response to reviews:

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Anne Sales
Editor-in-Chief, Implementation Science

Dear Dr. Sales,

Thank you for the opportunity to revise and resubmit our article on the expansion of VA Home Based Primary Care to rural American Indian reservations.

We appreciate the thoughtful comments of the reviewers. Their comments guided our revision and we have addressed each concern in the text and in the attached table.

We would like to highlight several of the revisions. The title has been revised to more clearly indicate the methodology and the new title is, “Barriers and Facilitators to Implementation of VA Home-Based Primary Care on American Indian Reservations: A Qualitative Multi-case Study.” The opening paragraph was substantially revised to clarify the need for the study and to explicitly include study questions and purpose. The section on limitations of the study has been expanded in response to reviewer concerns. The implications of the study for planners and policy-makers have been clarified.
We respectfully declined Reviewer 1’s recommendations to augment the manuscript with a review of the international literature on Home Based Primary Care (HBPC) or to describe implementation in urban settings. We did not make these decisions lightly after considering both the existing literature and the context of our research. A recent evidence-based synthesis report on HBPC by the Agency for Health Research and Quality found that only 19 studies met criteria for evidence; of those, 16 from the United States, with 50% of the US studies in the Veterans Health Administration (VA). The existing international evidence-based literature does not lend itself to comparison. The VA HBPC program has been in place for three decades and the majority of VA medical centers offer this standard benefit; there is no current literature on urban implementation. Finally, we recognize that this study may be limited to the U.S. but we believe that it has broad relevance for the more than 560 federally recognized American Indian and Alaska Native tribes, as well as for rural communities and other ethnic enclaves or underserved communities.

All authors were employed at the VA at the time that the research was conducted and the manuscript was first written. Since then, two of the authors have left the VA. Ms. Cote is now working for Rio Hondo College in Whittier, CA and Ms. Creekmur is now working for Kaiser Permanente in Pasadena, CA.

Please feel free to call on me if you have any questions about this manuscript. I can be reached by telephone at 818 891 7711 x39311 or by email at josea.kramer@va.gov.

Sincerely,

B. Josea Kramer, PhD
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REVIEWER 1:

First, the abbreviations "VA" and "VHA" in the abstract are not spelled out and it would be worth doing that for this who are not familiar with them.

RESPONSE: To be consistent with the AHRQ evidence synthesis review, we now use the term "VA" throughout and replaced "VHA" with "VA." We also define VA as Veterans Health Administration.
Second, I was slightly confused by the description of sampling and participation. What perplexed me was the line at the start of the Results section that says "We interviewed 20 HBPC staff and clinicians, as well as 12 other knowledgeable VA staff." I was unsure where these "knowledgeable staff" came from - whether or not they were part of the "knowledgeable persons" described on the preceding page, and in any case how they were different from the HBPC staff and clinicians. It would be useful if you could amend the text to make this clearer.

We have amended the text to better describe the respondents as either 1) HBPC staff and clinicians or 2) managers that had oversight of the HBPC expansion at their respective facility or region.

RESPONSE: We replaced the confusing term "other knowledgeable VA staff" with "managers" and moved all descriptions of the sample to the methods section.

LOCATION IN TEXT: Page 6-7, lines 119-126

“Key respondents were selected from lists of knowledgeable persons that were requested of each Chief of Staff. The lists included HBPC administrative and clinical staff (e.g., program director, program coordinator, medical director, primary care provider, social worker), and management leadership with oversight of the HBPC program at the facility (e.g., Chief of Staff, GEC care line manager) or regional levels (e.g., rural health coordinator, minority Veteran coordinator). Participation was voluntary and Chiefs of Staff were not informed about the identities of volunteer respondents. The final sample of 37 respondents included 20 HBPC clinicians and 17 managers.”

REVIEWER 2

The authors define their contribution in relation to VHA/non-VHA Home Based Primary Care programs and suggest that there is little information about the implementation process and its context. Considering the international audience of Implementation Science this is a rather narrow, empirical contribution. I therefore suggest that the authors substantially rework their contribution, by putting their specific case in a broader context: What do we know about the implementation of home based primary care programmes in urban areas in the US, and how does the implementation in rural settings in the present study differ? What do we know about the implementation of similar programmes in other countries, and what does this study add? What does the present study add to the Consolidated Framework? This requires a critical review of the relevant international literature and a substantial revision of the introduction, the background section and the discussion.
RESPONSE: We appreciate this comment, which led us to realize that we failed to make a strong case for the unique contribution of this study. The unique contribution is for a healthcare organization to work closely in partnership with a community to establish access to non-institutional long term care. The literature has not previously addressed how healthcare organizations reach out beyond their own patient populations to expand access. We now add the study questions to the introduction to make clear the study focus.

LOCATION TEXT: Page 3, lines 42-52

“Recently, 14 VA medical centers (VAMC) began expansion of the evidence-based HBPC program to reach new populations of American Indian veterans living in rural reservation communities, which are served by the Indian Health Service (IHS) or Tribal Health Programs (THP)[10]. Each VAMC independently developed strategies and models to implement their rural HBPC programs and we treat each as a case study for comparative analysis. Two HBPC programs were unable to establish programs in these communities, while 12 succeeded, leading to our study question: what are the barriers and facilitators for implementation of a new clinical program on rural American Indian reservations. Secondarily we aim to describe how two healthcare organizations work together to optimize healthcare resources as a result of implementing the new program. Our goal is to inform planners and policymakers to disseminate successful programs in underserved communities.”

RESPONSE (cont): The US is unique in that American Indian communities are considered sovereign nations under the US Constitutions. Although other countries do not extend right of sovereignty to Native populations (e.g., Canadian First Nations and Australian Aborigines), the study may be applicable to expanding access and coordinating healthcare in discrete ethnic and other underserved communities. We have added these comments to the Discussion section.

LOCATION IN TEXT: Page 17, lines 367-377

"A goal of qualitative research is to document the range of variation and identify common experiences rather than a statistical description of variation and, therefore, the results may be limited to these specific case studies. The US is unique in that American Indian and Alaska Native communities are considered sovereign nations under the US Constitution. Although other countries do not extend right of sovereignty to Native populations (e.g., Canadian First Nations and Australian Aborigines), the study may be applicable to expanding access and coordinating healthcare in discrete ethnic communities. The scope of the study is also limited by its focus on developing a non-institutional long term care service for populations that may be served by other providers of record. However, the need to collaborate across healthcare organizations is also a unique contribution of this study. The literature on HBPC has not previously addressed how healthcare organizations reach out beyond their own patient populations to expand access. Finally, since there is no comparative literature on implementation of HBPC in rural areas [1], corroboration requires further research."
RESPONSE (cont): We do not compare urban and rural implementation. This VA program is a standard VA medical benefit and has been in place for 3 decades. There is no current literature on urban implementation as a new program.

RESPONSE (cont): We have now added text to place this study in relationship to the recent AHRQ evidence-based synthesis report. In that report, only 19 studies met the definition of HBPC; only 3 were non-US programs. We respectfully disagree that a thorough critical review of the relevant international literature would be helpful. We agree, however, that the issue should be addressed in the discussion of study limitations (see above limitations text).

LOCATION IN TEXT: Page 3, lines 39-42

“By this definition, the Agency for Health Research and Quality [1] found only 19 studies that report on the outcomes of these programs: one in Canada, two in Denmark and 16 in the United States of America (US), with 50% of US programs delivered by Veterans Health Affairs (VA) [2-9].”

Line 103 - It would be helpful to know more about the rationale for choosing the Consolidated Framework, also compared to the many alternative frameworks that exist. Further, this is a rather comprehensive framework, not least considering the authors relied on interviews as their only data source and included 12 case studies. How did the authors handle this challenge?

RESPONSE: We added text to describe the advantages of using CFIR over other frameworks that focus on clinical evidence, guidelines or innovative characteristics of programs. In choosing CFIR, the fit for this study was a focus on factors in both internal and external settings to describe the context and complex interactions of various factors that influence the outcome of successful or non-successful implementation of the intervention.

Semi-structured open-ended interviews were ideal for gathering data for a CFIR-based analysis. The interview guide followed the CFIR domains and prompts allowed us to explore the CFIR constructs.

LOCATION IN TEXT: Page 6, lines 107-117

“The Consolidated Framework for Implementation Research (CFIR) [38,39] uses a comprehensive multi-level determinant framework to systematically identify barriers and facilitators in five inter-related domains: Intervention characteristics, Outer setting, Inner setting, Characteristics of individuals and Process. These domains are further defined by 39 pragmatic constructs that reflect theories and hypotheses in organizational and implementation research. CFIR has advantages over frameworks that focus on clinical evidence, guidelines or innovative program characteristics and, for this study, an additional advantage to CFIR is the flexibility to address complex interactions within the internal VA settings, as well as with external settings of
Tribes, IHS/THP and Native communities. CFIR domains informed the main topical areas of our semi-structured, open- interview guide and prompts were used, as needed, to explore CFIR constructs.”

Line 114 - The authors state that they noted variation in local contexts and implementation strategies, but focused on common barriers and facilitators. What was the reason for doing this? And how does this relate to the rationale for using a multiple case design?

RESPONSE: We understand the lack of clarity in the previous version, which was a result of our poor word choice; we had no a priori notions of common barriers.

We now explicitly note that the reason to identify barriers and facilitators was to identify those that existed across multiple independent implementation efforts (page 1, line 6 and Page 3, line 43) with the goal of informing planners and policymakers.

LOCATION IN TEXT: Page 3, lines 51-52

“Our goal is to inform planners and policymakers to disseminate successful programs in underserved communities.”

RESPONSE (cont): In addition, the multiple case design is referenced in the Methods section.

LOCATION IN TEXT: Page 5-6, lines 98-107

“HBPC expansion programs serve as a natural laboratory to understand the interacting and multi-level factors that impede and facilitate implementation. We used a qualitative observational design to retrospectively document expansion and implementation of HBPC on American Indian reservations through key respondent interviews, which were conducted after the programs were fully implemented. Each HBPC program was considered as a case study for comparative analyses [37, 38] to determine if similar issues arose in multiple contexts.

"The adage, “if you’ve seen one VAMC, you’ve seen one VAMC” implies the difficulty of studying non-static implementation across multiple settings and requires an efficient analytic structure to identify and describe factors that may influence successful implementation of an intervention in different community settings.”

Line 125 - Why did the authors rely exclusively on interviews and did not use other relevant data sources? This would have allowed for data triangulation and would have made the study more robust.
RESPONSE: No other source of reliable, relevant data was available to the study. We now note this as a limitation.

LOCATION IN TEXT: Page 17, lines 359-364

“This study has a number of limitations. Respondents were selected for knowledge of the program but may have lacked overall background knowledge about the VAMC relationships with Tribes and may not have been fully aware of federal and Tribal policies. Interviews took place after the original grant-funding period and memories may have faded. Data collection was limited to interviews and no other source of information (e.g., diaries, meeting minutes) was available.”

Line 137ff - I suggest integrating the first paragraph of the results section into the methods section.

RESPONSE: Description of the sample and of the operational coding was moved to the Methods section.

LOCATION IN TEXT: Page 6-7, lines 118-134

“The study sample was structured to represent each of the 14 facilities, as well as levels of responsibility for planning and/or implementing HBPC expansion. Key respondents were selected from lists of knowledgeable persons that were requested of each Chief of Staff. The lists included HBPC administrative and clinical staff (e.g., program director, program coordinator, medical director, primary care provider, social worker), and management leadership with oversight of the HBPC program at the facility (e.g., Chief of Staff, GEC care line manager) or regional levels (e.g., rural health coordinator, minority Veteran coordinator). Participation was voluntary and Chiefs of Staff were not informed about the identities of volunteer respondents. The final sample of 37 respondents included 20 HBPC clinicians and 17 managers.

Data were collected in 1:1 telephone interviews, which were recorded with respondents’ permissions, transcribed, coded by members of the study team (JK, SC, DL) and entered into Atlas-tiTM software [41]. Coding was an iterative process. Two coders (SC, DL) initially coded narrative text, to identify and classify descriptions within the 39 CFIR constructs. Discordant coding was identified and consensus strategies were used to manage disagreements and refine code definitions as needed to be relevant to this study; if consensus was not achieved, the PI (JK) resolved the issue and provided additional training. As coding definitions were further refined, all three coders then re-coded texts using the operational definitions shown in Table 1.”

RESPONSE (cont): Other information in the paragraph was part of our process of discovery and remains in the Results section.
“Each of the VAMC in this study had well-established, mature urban HBPC programs, which continued under the direction of their respective medical directors as they adapted to delivering care at a distance from the VAMC. Few formal relationships with IHS/THP facilities were in place prior to the HBPC expansion, to the best of the knowledge of the study respondents. As indicated in Table 2, local contexts for target populations varied, by size (ranging from <5,000 to >100,000 active users), distance (ranging from <50 miles to >200 miles, one-way between health centers and possibly farther to patients’ homes) and on-reservation healthcare system (IHS or THP).

There were consistent similarities in challenges to be overcome, barriers that could not be addressed at the program level and facilitators across programs as shown in Table 3.

"While all CFIR domains were relevant, only 12 of the possible 39 CFIR constructs emerged from the rich text of these interviews; Table 4 represents the implementation experience from the VA perspective in selected quotations. Within each domain, local contexts may be essential to explain variation across cases and we note relevant differences by domain in summary descriptions of cross-case barriers and facilitators below.”

Line 332ff - The authors need to sharpen the discussion, so that the reader gets a clearer sense of specific facilitators and barriers of implementation. References to the different dimensions of the Consolidated Framework would also be helpful.

RESPONSE: We added text to the 1st paragraph of Discussion section to highlight our findings of the key domains and constructs that should inform planning for future expansions of HBPC and other medical services to American Indian reservations and other remote rural communities, as well as to coordinate care with other healthcare organizations. We made the decision to avoid using the jargon of domains and constructs because these concepts are evident in the discussion. We deleted the lengthy summary statements in the discussion section to better highlight the key findings.

LOCATION IN TEXT: Page 16, lines 329-348

“This study begins to fill gaps in the literature on implementing HBPC in rural areas, as well as developing clinical programs in coordination with IHS/THP. CFIR was a useful instrument to systematically organize data and identify shared issues across sites. Despite variation in local contexts, there was consistency in experiences that might inform planning to expand access for medical services for populations in remote rural communities and to coordinate services among healthcare providers. Although HBPC is a standard benefit with centrally authorized guidelines, implementation in rural areas added complexity to intervention’s existing program structures and
processes. Key personnel facilitated successful expansion programs through their personal interactions with Tribes, IHS and community members. These individuals were not in management leadership positions but represented the HBPC program and, consequently, the VA. In the process of implementation, champions arose in both the VA and American Indian communities, underscoring the significance for this population of developing personal relationships to establish trust and acceptance of new programs [42]. External policies promoted expansion of a well-established urban program but allowed local programs the flexibility to manage the practical aspects of coordinating care with other healthcare organizations and other government entities. Flaws in the process were noted by respondents, including the lack of a population-based needs assessment, planning in coordination with IHS/THP, as well as differing policies for medical benefits and for inter-agency communications. Those problems indicate potential conflicts between outer and inner settings in implementing programs into underserved communities.”