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Session: Improving Improvement: Evidence-based Quality Improvement as a PACT Accelerator

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Moderator: I’d like to introduce our presenters today. Susan Stockdale, PhD is a medical sociologist and health services researcher at the VA of Greater Los Angeles. Lisa Rubenstein is the founding director of the HSR&D program at VA of Greater Los Angeles, of the VISN 22 PACT Demonstration Lab, and of the National PACT Intensive Management Evaluation, is also professor emeritus of medicine and public health at UCLA, and a senior scientist at RAND. And Elizabeth Yano, director of the VA HSR&D Center for the Study of Healthcare Innovation, Implementation and Policy, professor of health policy and management at UCLA Fielding School of Public Health. And as it is at the top of the hour, I am ready to turn things over. Lisa, can I turn things over to you?

Dr. Lisa Rubenstein: Sure. And, I think as we are pulling up the slides, just welcome to everybody and thank you so much for joining. Please use the chat liberally, because we are going to be interested in talking about questions you may have at the end, and also we’ll certainly look at them after this session. This session is Improving Improvement: Evidence-based Quality Improvement as a PACT Accelerator, and we are aiming to give you an overview of both kind of the theory, and of two actual implementations of this approach. Next. So, I am going to review and define EBQI. Susan Stockdale is going to give you stakeholder perspectives on our PACT, the EBQI addressing PACT, and Becky Yano is going to give you reflections on EBQI as it was applied to women’s health.

Next. So now we have a poll question for you. Why, or have you ever, or would you consider participating in EBQI in one of these roles? As a research team leader or member, as a manager, clinician leader, or QI leader, as a frontline clinician or clinical team member, or are you just curious and you don’t belong to any of those roles, potentially. So, go ahead and vote.

Moderator: The poll is open and answers are streaming in. We are approaching 70% voted. I will give audience members a few more moments to go ahead and vote. We are just over 70%, so I will just close and share the results. And you’ll see that 49% answered research team leader or member, 29% answered manager, clinician leader, or QI leader, only 6% front line clinician or clinical team member, and 17% other or I am just curious. Back to you.

Dr. Lisa Rubenstein: Great. Thank you so much. That is really helpful for us, too, to know. I am really glad that we have both operations, research, and frontline. So, what is EBQI? Basically, it is a systematic quality improvement method for engaging frontline primary care practices in improvement, and it aims to introduce best science and evidence in the service of operational goals at all relevant points during an improvement. And it is supported by a partnership between multi-level interdisciplinary operation stakeholders and a research team.

Next. So, you might be asking, what does EBQI add to other QI methods, of which there are many? And really, it takes advantage of other QI methods, but with a specific focus. It is aimed at developing learning organizations by promoting multi-level, meaning national regional medical center, local in the VA, or similarly in other organizations, and across discipline and engagement with science and data. So it provides explicit QI support by science teams. And that is aimed at enabling a context-tailored approach to QI using evidence-based innovations, social science theory and implementation and QI methods. And you will find if you look at other QI methods, while they do use these things, they aren’t explicitly part of the method focused on in the same way.

So why engage frontline primary care? I mean, can’t you just, you know, sort of have a bunch of policies or have the medical centers order people around? Well, primary care teams are smart and committed, and we have found this over and over again, not just in the VA, but in Kaiser, in managed care companies. Primary care teams really tend to be composed of people who want to improve. And the alternatives are not so good. Non-managed primary care improvement has proven difficult to deliver because the needed resources aren’t there. It turns out to be expensive in that it uses expensive people’s time and may involve, for example, information technology. But that can end up being done in a way that is not evidence-based and the outcomes can be inconsistent, and often are not measured. Measurement is one of the big challenges for routine improvement.

Top-down policy, on the other hand, is great for guideposts, but when it is applied across multiple contexts that have different challenges and opportunities, when it is used as micro-management, it typically does not have the results it wants. And, in any case, shouldn’t best science be used closest to patients in primary care? Shouldn’t it be possible for those improvers to access what can best help them? Next.

So, what do we mean by best science? In this case, we mean best science that is tailored to the task at hand. That doesn’t mean the most reliable instrument. That doesn’t mean exactly following the recipe of the effectiveness trial that was highly controlled that provided the evidence. And that’s not to say that those things aren’t critical and important. But evidence can be used to inform, intervention, or innovation design in ways that are tailored to what a particular practice is struggling with. And we mean using methods to engage multi-level interdisciplinary stakeholder methods for measures and data retrieval. And we also include the opportunity for summative evaluation by a research team looking across multiple different innovations in different primary care practices to see what the results for the overall project or initiative are. So, researchers continuously adapt scientific methods for improvers to use within this model.

Next. EBQI has been studied in multiple different settings. These are ones that I have either touched or led, but there are about, somewhere around 35-40 publications that relate to this method. Next.

Some rules of thumb that may give you a flavor for doing this are, where evidence provides clear guidance, operations partners kind of come into it with the idea of abiding by that guidance. But where there is no evidence, operations partners use best judgement and then evaluate the results. So, really operations partners have a decision-making role in this approach. EBQI requires separate funding for an existing scientific team, but the operations partners generally provide the majority of the funding for interventions or innovations within this model. And the partnership really needs to begin before funding with the development of a specific proposal and budget for the QI, and that filters down to the frontline teams who provide two-page proposals with budgets for their innovations or QI proposals.

Next. EBQI can be done, I think, in any setting in which groups of primary care practices are linked through some kind of administrative superstructure and the approach uses demonstration primary care practices that are chosen by operations leaders. And our experience is, they choose them for a whole variety of reasons. In the Kaiser study, for example, they chose practices for a depression improvement that had never participated in any kind of depression improvement, because they thought that would be the most fair. They may pick a great practice, they may pick a practice that they think has potential but isn’t meeting that potential. So, a variety of motivations, and then the comparison practices become spread sites.

Next. The key participants, I think I have talked about these except for the patient representatives. We’ve had variable success particularly early on, before the idea of patient representatives became more broadly accepted with doing this, but whenever we have been able to do it, it has been very successful and we’ve been able to engage these people far past the time of the initial improvement process.

Next. So, prior to starting, some things to think about. You need a statement of the problem or a goal. QI starts with a problem, and then a proposed project with key elements that everyone agrees to through a memorandum of understanding, and that memorandum needs to include things like time for people on the clinical side who need to participate. They need release time, and it may include some budget elements, but the most important concept is people need to be on the same page. You need a logic model that connects what you are doing with what you are evaluating, and underlying everything, of course, a willingness to improve.

Next. Some key things that are in the EBQI toolbox, and I sometimes have presented a slide of the researcher going in with a toolbox, because I think when you are adapting to a local context, really what you’re doing is pulling from your research tools in service of the operation’s goals. Regional priority-setting based on expert panel methods that really make sure everyone is on the same page, that empower all participants to participate equally, face-to-face learning and sharing sessions such as collaborative, as are part of most collaboratives, ongoing across-site teleconferences, including those for specific working groups and some that are more community of practice calls, and other learning and consultation sessions on specific topics needed. Project management and data support is a critical piece, and the ability to help sites create tools that can then be part of spread.

Next. So, at the end of an EBQI project, the setting should be changed. It should have better structures and it should have a stronger QI culture toward an end primary care. And communication is a critical piece of what we hope we leave these sites with.

Next. So, I’ve gone through fairly quickly, I am more than happy to provide more information if anyone wants to email me, but I wanted to leave all the time for the next presenters, who have very practical application information for you. Next. And now it’s over to Susan.

Dr. Susan E. Stockdale: Alright. Thank you, Lisa. I am Susan Stockdale, and I’m going to be talking today about our intervention, which was called “evidence-based quality improvement for PACT”. This intervention was developed as part of the Veterans Assessment and Improvement Laboratory, which was and is the VISN 22 PACT demonstration lab. We used an evidence-based quality improvement approach to implement PACT, and hence, EBQI PACT. This was founded on a clinical research partnership and it was rolled out in three phases, starting in 2010 with three healthcare systems in VISN 22. Each of these healthcare systems selected one primary care practice to participate in the first phase, and then added a second practice in phase two, and then in phase three we invited all healthcare systems in the VISN to participate. We ended up with a total of seven sites by the end of the intervention period in 2014.

Next. The focus of my talk is going to be, first of all, to describe two components of the EBQI PACT intervention. These were the development of a multi-level organizational infrastructure for implementing EBQI for PACT, and a facilitated quality improvement process with external and internal facilitators. And then I am going to present the results from our implementation evaluation and just touch briefly on our ongoing results from our summative evaluation.

Next. Okay, in terms of the infrastructure, this slide illustrates the infrastructure we developed for EBQI PACT. I have already mentioned the research clinical leader partnership, which included HSR&D researchers and clinical leaders from three participating healthcare systems, who acted as co-P.I.’s for the overall project. Then you will also see a box for the VISN Steering Committee. This was a regional steering committee composed of healthcare system leaders, regional leaders including top-management in medicine, nursing, PACT training, information technology, and system redesign.

The role of the steering committee was to set priorities for PACT implementation by reviewing and approving some of the projects that were submitted by the sites for quality improvement to improve PACT. You’ll see that each of the healthcare systems was connected to the VISN 22 Steering Committee via their executive leadership who participated in the steering committee. And, as I mentioned, each healthcare system selected primary care practices to participate in EBQI PACT. Healthcare system one had three sites by the end of the intervention period. Healthcare systems two and three each had two sites. And then across the bottom of this figure, you will see two ovals which depict the topic-focused expert led workgroups which cut across sites and provided support and expertise on special topics or populations such as PACT and academic settings, or primary care mental health integration. The heart of this infrastructure, though, are really these quality councils, which you see are connected to the healthcare systems. Next slide please.

So, the quality councils, each site was required to establish a quality council, which was based in primary care and it was led by the interdisciplinary leads in primary care, including the physician lead and the nurse manager. Also, included patient representatives and frontline staff. The quality councils were designed to do three things primarily. And this was, first of all, to foster interdisciplinary leadership for PACT QI. Secondly to establish a structured local QI process for primary care with oversight and accountability mechanisms. And third, to facilitate frontline QI innovation within the demonstration site practices. In our evaluation, we found that these sites were able to successfully accomplish the first two of these design goals – fostering interdisciplinary leadership and establishing the structured local process. But achieving the third one, facilitating frontline QI innovation, proved to be a bit more difficult, and only four of the six sites that we looked at either partially or wholly met this design criteria. And if you are interested in seeing more details about this study, the reference is there on the slide.

Next. So the second component of the EBQI PACT intervention was a facilitation which included external and internal facilitators. The external facilitation was conducted by health services researchers who were part of the VAIL team, and this wasn’t the typical health services research where you sit behind the computer and crunch numbers, but it was also more than just the system redesign style facilitation of trying to figure out where to put the printer. It was more science-based. So, the external facilitators, their role was to organize and carry out the priority-setting process. And the way this worked was that the VAIL project issued an RFP to quality councils and workgroups for QI projects to improve PACT, and then the quality councils and workgroups submitted proposals which were reviewed by the VAIL Steering Committee. The VAIL Steering Committee approved a number of those projects, and for the approved projects, the QI teams participated in a learning collaborative, which was also conducted by the health services researchers, and this included bi-weekly training and mentoring calls, as well as semi-annual in-person conferences.

VAIL also developed a Share Point site and helped the QI teams to assemble their tools in the toolkits for spread, which were then posted on the Share Point. And they’re available across the VA for teams to use. The approved projects also received support from internal facilitators, which were called quality council coordinators. There was one quality council coordinator for each healthcare system. These were masters-trained individuals who provided support for administration and also the QI projects, project management, and they helped to obtain data for the QI projects from the VA’s administrative data systems. And they were supported by the health services researchers as well, who trained and mentored the quality council coordinators. Next slide please.

Okay. So, now I am going to move into talking about some of our results. The main outcome that we looked at, for the development of the infrastructure as well as the facilitation process, was the QI projects that the teams did. So, the quality councils and workgroups submitted a total of 71 project proposals for review by the Steering Committee between 2011 and 2014. Twenty-one of these projects were approved across 4 rounds of steering committee review, and from these 21 projects, there were 12 toolkits that resulted and that are now posted on the VAIL Share Point site for spread across the VA. I have put the URL on the slides of the Share Point in case anybody is interested in going and checking those out. Next slide.

Our implementation evaluation also included interviews with leadership at all levels of VISN 22, and based on those interviews we identified several key ingredients for the success of EBQI PACT. I am going to talk about just three of those today. The first one is here on this slide, and that is engagement of interdisciplinary leaders in roles appropriate to their leadership levels. This is a quote from a service line leader at healthcare system three, and what this quote does, is it shows the contrast between the roles that different leaders were playing. So, this person is commenting, first of all, on the primary care practice leaders, who this person says, “they often times fix and solve problems without help, maybe even better than I know how to go about it”. And then commenting about his or her own role, this person says, “I have intervened in some ways and supportively to help resolve some issues related to the implementation”. So, what this shows is that the primary care practice leaders, their most important role was really being on the ground, on the front lines, engaging staff, and figuring out what the problems were, and developing solutions to address those problems, whereas the service line leaders, their role was really to just provide resources and clear administrative hurdles so that the QI projects could move forward. Next slide please.

A second key ingredient was data support from the internal and external facilitators, so from the VAIL health services researchers and the quality council coordinators. This is a quote from a practice leader, commenting on the quality council coordinators, who they found to be just indispensable to the QI projects. This person said that “the quality council coordinator was almost like a godsend to ambulatory care, as far as data gathering and data manipulation. She has been simply outstanding. Anything we have asked for, putting it in a format that is understandable and readable, I don’t think our meetings would be what they were had it not been for that role”. So, the quality council coordinators were a little unique in terms of their mix of skills. They had facilitation skills as well as organizational and project management skills, but perhaps most importantly, they were able to go into the VA’s computer systems like VSSC and pull out performance data and create these reports for the QI team to track and monitor their projects. And sometimes these reports drilled down to the provider level, or even all the way down to the patient level, so the teams could really see what was going on and understand their performance.

Next. A third key ingredient was the leadership front lines priority setting process, and this was important not just for engaging the front lines and quality improvement, but it was also very informative and powerful for leaders who, you know, especially the executive leadership and the VISN leadership who aren’t there on the front lines of PACT, and don’t know what challenges the front lines are facing. So, for example, this was a quote from a VISN leader, who is also a member of the VAIL Steering Committee. This person said “what the Steering Committee does is it brings to my attention and other network leadership attention the things that are working and not working. There were a lot of really neat things going on, but then my goal is always, how do I get that information, when it is working, disseminated to the sites?” So, this person got to see what was going on, on the front lines, and the really great, promising practices that were happening on the front lines, as well as some of the issues they were facing.

Next. I am going to touch briefly on our summative findings. Our summative evaluation is ongoing. We have been comparing the sites of VISN that participated in EBQI PACT, with all the rest of the primary care practices in the VISN. What we found is that the EBQI PACT sites have experienced accelerated decreases in ambulatory care visits and increases in non-face-to-face visits, and these were two of the things the PACT especially was supposed to do. The EBQI PACT sites also have experienced accelerated reduction in primary care provider burnout, and improved communication with patients. We have been using QI statistics as well, to track the individual innovation projects, the QI projects, and their spread across sites. And we have found that some of the innovation projects have been successfully spread to other sites. And then we have been monitoring the use of the toolkits on our toolkit site and we have found that they continue to be used to this day. Next slide please.

So, before I wrap up and pass it on to Dr. Yano, I just wanted to say a word about sustainability, because these efforts can often be difficult to sustain once the funding period has ended. The funding for our first demonstration lab ended in 2014, and although we did receive a second round of funding, it was only about half of what it had been, so VAIL could no longer support the QI projects at the level that we had in the first round. The sites all lost their quality council coordinators, and the external facilitation ended also for the most part, it almost completely ended. But, in spite of that, we have about 4-5 of the original 7 sites that continue to participate in what has developed into a community of practice. And the VAIL project supports these twice-monthly calls. The sites call in and talk about their projects they are working on. They are still working on quality improvement projects, and this has also been really important for our VISN 22 primary care committee to understand what the QI issues are that are ongoing, that are affecting PACT, and also to identify promising practices that we might want to try to spread across the VISN. I am going to end right there. I am happy to answer any questions in the question and answer period, or feel free to email me. Becky, you might be on mute.

Dr. Elizabeth M. Yano: Thank you so much. So, my challenge was to build on the shoulders of VAIL and really determine how to help accelerate innovations for women Veterans who use the VA. So, when we think about using EBQI in this context, we are really talking about how to use it to tailor PACT. So, by way of background, women Veterans are the fastest growing segment of new VA users, but they remain a numerical minority, as fewer than 10% of the patients that we all see. There are obviously, as a result, some logistical challenges in delivering gender-sensitive comprehensive primary care to women. Their limited numbers effect provider of women’s health proficiency and experience, for one example. They also have very high rates of military sexual trauma, PTSD, depression and anxiety that can complicate the interaction and the coordination of services. There are, unfortunately, some demonstrated gaps in provider and staff gender sensitivity, as well as comfort handling women with trauma history. That is particularly important because in our study we found that for women who are routine primary care users, as many as 2/3 may actually have MST histories, so a discomfort in that realm can create gaps in care as well. There are also problems with chaperone access, which may have [inaudible 31:03] teamlets might not be prepared to provide chaperone time to a different teamlet, and ongoing room privacy issues, and space issues as well.

There are also unfortunately, persistent gender disparities in quality as well as ratings of care in terms of access, continuity, and coordination, and as a result there have been many efforts at both the use of designated with tools [bricks, and mortar are actually available? 31:44]. So, why tailor PACT? Well, again, challenges remain to the VA PACT model. There are many part-time physicians in the women’s health clinics that can upend the staffing model and support time. There is actually a required decrease of 20% in the panel size for women Veterans, acknowledging the complexities of physical and mental health comorbidities that are frequently forgotten locally. PACT staffing did not also recognize the chaperone need originally, and PACT metrics are not reported by gender, which makes it a lot harder for those leading women’s primary care to have a handle on how things are going for their patients.

Women Veterans also report that high care coordination demands including a higher level of non-VA care use compared to male Veterans, and often there are co-located gynecologists who are piggy-backing off of PACT staff and are not accounted for in terms of the staffing model. It is also variable comprehensiveness, and sometimes unclear accountability between PACT and women’s health clinic in terms of who’s on first, for what. So, we had national guidance on VA PACT, and on healthcare services for women in the handbook 1330.01. We convened, though, a national expert panel to define gender-sensitive comprehensive care, and we had evidence in hand from our prior health services research on general primary care and women’s health clinic features related to quality.

So, we decided on evidence-based QI as a strategy to test an adapted VAIL EBQI effort to women’s health. Now, in this context, we went beyond VISN 22, given all the VAIL work going on there, and used something that you might not know real exists, which is the VA Women’s Health Practice-Based Research Network. It is now 60 VA Medical Centers and their 300+ community-based outpatient clinics in an effort funded by VA HSR&D service to increase inclusion of women in VA research, as well as to improve our ability to conduct women Veterans-focused research. So, in this case, instead of one VISN we went to four VISN’s and worked with three different PBRN sites in each one, and what the PBRN gave us was “boots on the ground” entrée to clinics, as well as insights. I would literally ask people “where are the strengths for your site and where are the landmines”, before we go in as implementation folk.

So, how did we apply EBQI? In this case, we carried on the same kind of model as VAIL in terms of convening VA network level stakeholder panel meetings using expert panel methods. These were multi-level, with VISN, VAMC, department and clinic representatives. They were interdisciplinary, also as noted in VAIL, with primary care, women’s health, mental health, IT, QI, and women Veterans program manager staff in attendance. And what we did was use expert panel methods after we presented data about their VA Medical Centers and their women and gender differences, and what is known in terms of the evidence around women Veterans’ care, was to use that process to come to consensus on QI priorities. So, basically, a VISN QI roadmap.

We provided EBQI training for the local QI team and jump-started their local QI project proposal, provided them an expert input from VAIL quality council coordinators, kind of testimony on how it worked for them, and also had national primary care and women’s health leadership call into the training, so folks on the ground really had an understanding that this was from the highest level down to frontline folks and that everyone was on a level playing field. The local QI teams then picked a project from the local QI roadmap, or the VISN QI roadmap, and the research team provided external practice facilitation, formative data feedback, and ongoing across-site calls in order to help support innovation, sharing and spread. And then the progress and results were briefed back up the chain and that was, as Dr. Rubenstein mentioned, the importance of the communication network throughout. Now, in our case, there were no quality councils. This was not PACT proper, this was women’s health PACT, and that would be sometimes in primary care or in a women’s clinic, or both. So, instead we had worked with the local women’s health medical directors, the women Veteran program managers, and/or PBRN site leads, and that varied by site. And then the local QI teams engaged key stakeholders in each project.

So, for example, it might be health administration service, helping them improve assignment of new patients to designated women’s health providers. Or they involved QI as system redesign when available. Now that availability varied a lot, and it might be more available for PACT as a whole practice than it might be for a subset of patients in the medical center. The women Veteran program managers also by edict in handbook, report to the chief of staff, so there was a quad link automatically in these. So, again, without a quality council or a quality council, coordinator we were able to adapt those kinds of infrastructure elements to existing people in the medical centers.

VISN level oversight varied. One VISN wanted to create a Steering Committee that was akin to what VAIL had in VISN 22, but the other VISN’s relied on existing councils like quality councils or population health councils. And then VHA’s engagement helped with policy clarification along the way. So, I want to just give you a very quick notion of some of what the sites accomplished in the 24 months of EBQI. Some improved new patient appointment access and the content to first appointment, for example achieving 100% assignment to designated women’s health providers. Also ensuring that over 80% of women new to the VA have their first lab results in hand before their first appointment, which, as you can imagine, changed the comprehensiveness of what could happen at a first visit.

Another site focused on follow-up with abnormal breast cancer screening results and achieved a 27% increase in follow-up documentation, and almost shaved a week off of results reporting. Another one actually did a very complex and detailed follow-up of abnormal cervical cancer screening, re-doing and revamping the reminders and the template to a point which now is being spread across their VISN and has been plugged into initiatives in Central Office, as well. Originally, fewer than half the women that had abnormal cervical cancer screening results were managed per the updated guidelines, and now it’s over 85%, and they’re working to get it to 100%.

Another group was struggling with coupled reporting of cervical cytology results, where women were being told different things by different entities within the VA and they now have coupled reporting of 96% compliance. Two groups, we even warned them this was not going to be easy, but they said they couldn’t do any other QI without improving PACT team functioning, climate, and performance. When they did so with virtual team meetings and huddle check lists and team training, and those two have gone on to become among the highest performing PACT teamlets in their VISN. Another group identified emergent mental health needs before the first appointment for women Veterans and developed a high risk mental health list and a process to contact them and found that 30% of these new women Veterans, new to VA, needed mental health intervention, and they instituted counselling and warm handoffs and appointment scheduling before their first primary care appointment, and the women Veterans and the providers were extremely pleased with the process.

Another group improved teratogen prescribing through e-consults and education, since almost half of the women were filling one or more category D/X meds, and only 37% had been counselled, and that’ s been drastically improved now. Another group, many of these places had residents running through primary care and PACT, and they wanted to improve their trauma-sensitive communication, given how many have military sexual trauma histories. And they put a health psychologist in the exam room and gave them the post-visit feedback and the residents loved this, the women Veterans have really loved it, and the residents are actually asking for more time in women’s clinic to get this kind of feedback and training. Many are working to improve the environment of care to make it more welcoming and to reduce harassment, because we found from our baseline surveys that 1 in 4 women Veterans were being harassed on their way to see their doctors. And so the sites have been doing a lot of creative work with leadership videos, shared medical appointments, volunteer education, social marketing, and other kinds of things to help.

So, what about EBQI worked? We found from also qualitative key stakeholder interviews that these regional interdisciplinary stakeholder planning meetings were seen as critical for leadership buy-in and awareness, and that the data that we presented at the outset on gender differences was considered to be very powerful in engaging people. People also said that the training of local QI team members was really important, since they had variable access to QI personnel, and most of their on-site QI personnel were focused on Joint Commission continuous readiness, and really weren’t as engaged in this kind of innovation, development and testing.

Practice facilitation, not surprisingly, as well as the opportunity to get expert review and feedback on people’s local plans was considered important, and I think there is a lot of evidence that internal and external facilitation is effective. It depends on how you organize and structure it and the kinds of resources you have for data feedback, but they also felt that the regular calls we provided were basically, we created, you know, a no more than half-page summary of what we were supposed to do and what the sites were going to do before the next call, really supported accountability, progress and momentum. And this is another one of the things the sites haven’t wanted to stop.

In terms of formative data feedback, especially since VA performance data are not routinely reported by gender, we were able to provide some of that information back to sites. We also included new measures like the stranger harassment data and gender-tailored audit-C data that they’d never had before. And we provided information about the analyses we have been doing with the patient and provider and staff survey data that helped sites understand and drill down to factors that were driving women Veterans’ ratings of VA care. The early evidence of EBQI impacts promoted spread, so we are really pleased to say that the team function project, even though we warned them they were not exactly going after low-hanging fruit, yielded noticeable burnout reduction, and that’s been translated into a VISN-wide “grand rounds” to spread EBQI and the team function work and that is a direct result also of the VAIL work that focused on how to work with team function, and in fact, was a cross-referred support.

The improvement of follow-up of abnormal cervical cancer screening that I mentioned a moment ago is now part of a VISN-wide spread in CPRS for reminders and templates, and that has been going really well. And then the improved test reporting of cervical cytology results, where in all honesty, Central Office was pretty sure that the guidelines and the policy were quite clear, found that in fact, the VISN had not been doing this routinely and once this local innovation was reported to the VISN level with some policy clarification, they began to spread the message and the policy in the north part of the VISN and in the south part of the VISN and now the whole VISN has been doing this appropriately. The next steps for us are developing EBQI toolkits for spreading these innovations and developing strategies for sustaining EBQI process without the research team.

So, unlike VAIL, which is in another round of funding, this is part of the women’s health CREATE initiative that is funded by HSR&D, and so all of the efforts around this will conclude at the end of this fiscal year and we are trying to develop structures leveraging what exists at each location now in ways that are going to allow them to proceed without us along the way. So, I wanted to mention just what these partnerships take. It is one thing to say, “yes, have them”. I wanted to make sure people knew that what we have learned about making them actually real and three-dimensional and functional. I would say the biggest one is trust building, where we actually learn partner priorities and make sure that we are adding value.

We sent easy-to-use research briefs and kind of cheat-sheet summaries along the way to leaders to make it very clear what was being accomplished. We have done briefings linked to their priorities and needs. I often would say, “I can name that tune in however many minutes you will give me on an agenda”. These are also not one-off relationships. You can’t just collect data and walk away. That will burn it for the next person trying to come in and do innovations work and implementation work. I also found that we needed to walk through formative data collaboratively and answer questions, so it wasn’t just a matter of sending someone a formative data feedback report. Some of that is because of numeracy issues that are wide-spread internationally, and some of them are the fact that we speak research, and we needed to make sure that how we were presenting formative data was meaningful to front line providers.

Also, obviously, engagement and time investment varied. The partnerships evolve as does the policy climate and the environment, and we had to explicitly manage and address turnover with new partners and then their links, and also just a general recommendation is to avoid “hitching your wagon” to a single person because things change. We have seen an extraordinary amount of VA Medical Center and VISN leadership change even over the 24 months of EBQI and this project. Also, some relationships run deep and others broad, and both are important to manage as relationships, and it is important to remember that the reliability of the research team and the implementers is highly valued, so you need to make sure you are keeping your promises and you don’t fall off folks’ radar. I say some of the benefits were more obvious than others. We found, you know, it was tremendously important to have access to the clinics and the local and network resources. This is not about research funding innovation. It’s really about enabling frontline leaders, managers, folks up the chain to department chairs, up to facility leadership, to the VISN, in engaging them in ways they are not necessarily used to being engaged before. Senior VA leadership engagement also got the attention of other levels, and I would have to say that the multi-level stakeholder engagement that we invested in really began to churn and capitalize on and leveraged existing infrastructure systems and people.

The other part of direct engagement here about partners in research is to make sure that we are increasing the focus and relevance of our research and I’d say I got out of my comfort zone from day one, but it has been incredibly gratifying work. When we are also now, at this point, working to improve the uptake, adoption, implementation, and spread of EBQI. We found that even though we are not done with our 24-months analyses on the EBQI initiative itself, women’s health services found enough promise in what these sites have accomplished that they have adopted EBQI to improve care in lower performing VA, when it comes to comprehensive services. So, that initiative began this fiscal year. There were a lot of unexpected spinoffs, as well. The harassment data came out of anecdotes that we heard from women that are program managers, and so we collected systematic data on it and reported that through partnerships with women’s health services, as well as, now a national end-harassment group that includes secretary and under-secretary level representatives, to now develop a national culture campaign to make sure that women can get to PACT in a really sensitive and appropriate environment.

And, frankly, our research team satisfaction and success and impacts have been increased by this direct engagement of partners in research, as well. So, I think we can stop and ask, open it up for questions at this point. I wanted to just make sure folks knew that none of these happen in isolation, so this is the VAIL collaborative team. These are our EBQI collaborators. And also, obviously, our EBQI teams that, about which this work would not have happened otherwise, as well as some references at the end. So, ready for questions when you all are.

Moderator: Thank you doctors. We do have a few questions. Audience, if you would like, go ahead and submit your questions to the question pane in the Go to Webinar dashboard, and I will just jump right in. This questioner asks, “Could you further describe the comment about 1 in 4 women are harassed on their way to their first primary care appointment?”

Dr. Elizabeth M. Yano.: Sure. Basically, we asked an open-ended question about whether or not women had ever had unwanted or inappropriate behavior towards them by male Veterans specifically, and we had no idea what we would find because it was only anecdote we had before, and 25% of women basically said that they have been harassed, everything from cat calls to stalking. You know, the cat calls were the most common. There are also women Veterans with military sexual trauma histories, were also more likely to endorse that statement, meaning, you know, have that experience. We have since looked at the extent which that may also be among volunteers or employees, and it looks like about 20% of the experiences are from folks that should kind of know better. There are now efforts going on to, in fact, we have had a series of discussion groups among male Veterans and female Veterans, key stakeholder interviews, as a spinoff effort for women’s health services and other groups in Central Office, to better understand why this is going on and what can be done to reduce that behavior.

Moderator: Great. Thank you. This one is specifically directed to Dr. Stockdale. “How are you tracking the use of the 12 toolkits?”

Dr. Susan E. Stockdale: We have a Share Point site and what we can do is, we can look at the statistics on who goes to the toolkits on the Share Point sites and clicks on the pages and the toolkits. And so, what we have done is we have somebody who is able to pull the data from Share Point and look at the unique visits, excluding our team members from VAIL, and see who visits the sites. We have done some advertising on the daily bulletin here at Greater Los Angeles VA and also at some of the other VA’s in the VISN, and we have noticed that after we advertised a toolkit, we will see a spike in people going to look at the toolkits. You know, sometimes we get as many as 50 or 60 hits on average, I think over a week period, or maybe it is over a month period, on some of the toolkits, and that is how we track them.

Moderator: Thank you, Dr. Stockdale. This one is directed to Dr. Yano. “The turnover in VACO is huge. What is the best way to not hitch one’s wagon to a single partner?”

Dr. Elizabeth M. Yano: Well, I would say really understand many program offices’ priorities, that you can make sure that they are aware of the kind of work you are doing, and engage many program offices. So, you know, even in the women’s health research network that I co-lead with Susan Frein in Palo Alto and Alison Hamilton here in Los Angeles, we work with women’s health services, mental health services, the organizational excellence folks in Informatics and Analytics, I think their names changed, I can’t keep up, with also the Office of Patient Centered Care and Cultural Transformation, and that even ripples to other offices along the way. So, it is, you know, keeping on top of who is on first, for what, in Central Office is also not an easy thing, but I would say that each one of the partners’ offices that I just even mentioned, often give us insights on where they think things are transitioning, and who else they think should be aware. Primary care office was an important one because both of the senior leaders there retired or transitioned, so we have begun to work with the new leaders to make sure they are aware. I think that it is just key to make sure that you can, you know, name that tune and sing those notes to lots of different people and understand how what you are doing relates to theirs, so we just keep working with anyone who will work with us along the way. I hope that helps.

Moderator: Great. Thank you. At this time, we have one more question, so I would like to repeat to attendees, we have about 7 minutes reserved for Q&A, and I see two questions just came in. Great. So, I will just jump right into the next one. “Where did you locate the data for women Veteran performance measures, e.g., Audit-C?” Thank you.

Dr. Elizabeth M. Yano: The Audit-C was actually based on a patient survey data we collected for that project, so there are obviously some things in VSSC and, you know, one can look at the SHEP data, the patient survey data, and drill it down for gender. The problem is, is women are only over-sampled at the VISN level, so, you know, if you are in big VA Medical Centers, there may be enough women locally, but for Audit-C and some of the other measures, we were able to provide formative data feedback, because we were actually able to do a patient survey. And we now have 12 month data we have fed back to our sites and we just finished collecting 24 month data. So, even though the study will be over, we will be providing formative feedback to the VA Medical Centers and the VISN for that as well. One thing I didn’t mention, that is a whole different theme throughout all of these projects today, is that we have all worked to engage Veterans, as well, so we have a women Veteran council. I know that VAIL has a very dynamic and active Veteran engagement component to it, as well, and so now that we are at a stage where feeding back all of the data that we have collected to women Veterans is not likely to contaminate anything because we are done, we will be developing patient brochures and summaries also.

Moderator: Great. Thank you. This one is quite wordy, so stick with me. “Was one of your objectives to establish and train a team to continue the EBQI and have their position descriptions been changed to include these new responsibilities? Is there further recognition of these new capabilities and achievements by the organization? It would seem particularly important that the entire organization is made aware of this activity.”

Dr. Elizabeth M. Yano: Lisa, do you want to start with that one and I can add, at least the women’s health version. Are you muted Lisa?

Moderator: You may have been muted.

Dr. Lisa V. Rubenstein: I am muted. I am muted. I think that is a really good question, I think I would say, for all the three presentations, this is an area of future development. Within VISN 22 where the VAIL was, we’re certainly working closely with VISN primary care committee led by Tim Dresselhaus to try to institutionalize and find ways to institutionalize this kind of primary care base support. I mean, a hospital may have, I don’t know, 50 people working on improvement and primary care is usually sort of a collateral duty, and there isn’t, even though, you know, a lot of the patient safety and other issues that happen, happen in primary care. It hasn’t really been institutionalized, so I think it is a good question, and I don’t know that we have the answer. Susan or Becky, do you want to add anything there?

Dr. Elizabeth M. Yano: So, on the women’s health side of this, the training was considered valuable enough that we did end up getting asked by women’s health services to provide EBQI training in their national women’s health field leaders calls, so we have done that and people are asking for more information. We also provided an orientation and training on the practice-based research network site lead calls where they invite their full community locally and provided the same kind of training, you know, this was the one-hour version of what we did in a day-and-a-half with our PACT site, and did a poll and asked, “Did anyone want more training in this?” And it was a unanimous, “Yes, we all want more.” So, we are trying to figure out how to move forward with that. But, to your other point about recognizing folks’ abilities, you know, there is nothing in a research protocol that says, by the way go, you know, you can send a thank you email, but how do you actually acknowledge and recognize exactly what you are describing? The multi-level communication made sure that the VA Medical Center and VISN level folks knew what their folks had accomplished on a certain level, but what we realized is we wanted to give, kind of, participation certificates that acknowledged what folks had done with us for the last couple of years. So, those are getting done for all of the participants at all 12 sites.

We also have been working to identify who they report to, so that we can copy and otherwise notify folks up the chain for them, from a professional recognition and development perspective, and women’s health services has agreed to send letters of recommendation to their facilities and to the folks as well. You know, it is quote-unquote more work, but you know, there needs to be some kind of recognition, and make sure the organization, frankly, has something they can brag about, as well. I think a lot of folks that are in leadership positions get beat-up quite a bit, and their folks have done some really good work here, so, we will go through that process as well.

Moderator: Great. Thank you. I have one comment and then the final question, which is all we really have time for. I will read the comment first. “I like the way Dr. Rubenstein put it, improvement is a collateral duty”. And then, for the final question for Dr. Stockdale. “Do you think community of practice is an effective implementation strategy to boost sustainability? Has it been systematically studied for this purpose?”

Dr. Susan E. Stockdale: That is a good question. We haven’t studied the community of practice. We have been thinking about how to study the community of practice, and also how it links with the VISN 22 primary care committee because that’s really, I think, the key, is one of the keys to sustainability is linking it to a larger structure and embedding it in a larger structure so that it becomes institutionalized and kind of just becomes the way we do things here in this VISN. Another key thing, I think, for sustainability, is to make sure that there are active QI projects going on because we don’t want to just turn, degenerate into a session where everybody calls in to complain about what is happening at their site. We want people to be working productively on improving things. But, those are two things that we haven’t yet studied. It would be a good idea to do that, though.

Moderator: It is 1:00 now, so we are going to wrap up momentarily. I would like to remind audience members, if you have to leave right away, please stick around to fill out the survey. We really count on your responses to survey, but I just want to give the doctors an opportunity for final comments before we close. Anybody?

Dr. Lisa V. Rubenstein: Thank you for your participation and for your questions, and we really appreciate the opportunity to interact with people on the call anytime that you want additional information going forward.

Moderator: Thank you doctors, thank you attendees, have a good day everybody. Good bye.

Doctors: Bye.