Moderator: We'll actually just get started. First, I'd to introduce our first presenter, Dr. Yano. And she's the director at the VA, Los Angeles HSR&D Center for the study of healthcare innovation, and implementation, and policy, and also the director of the Women's Veterans Healthcare CREATE and director of the VA's Women's Health Research Network Consortium. Please welcome Elizabeth Yano.

[Applause]

Elizabeth Yano: Thank you very much. It's a real pleasure today to talk to you about some of the early findings from our Women's Health CREATE trial, doing a little more technology here as we go. Alright, do I have to point it to you gentlemen? Livestreaming technical difficulties. That works? Thank you. So as many of you know, the VA policy guidance for VA's Patient Centered Medical Home or patient-aligned Care Team implementation was not originally adapted for special populations, and that includes for women Veterans. And that's been particularly important because women Veterans are the fastest growing segment of new users in the VA, but represent a numerical minority. They have co-morbid physical and mental health burdens that are quite substantial. On the physical health side, even though they are on average younger than male Veterans, they actually have high chronic physical burdens. And for mental health burdens, they have higher mental health burdens as well, often as a result of high rates of military sexual trauma, PTSD, depression, and anxiety. And also, all of these are complicated by the overlay of the need for gender-specific services. So the combination of these health care needs complicates their primary care delivery. Next Slide.

The logistical challenges that the numerical minority raises in delivery gender sensitive comprehensive care come from a variety of factors. These include a smaller patient volume that affects the proficiency of providers and their experience in having such a small volume of patients. It's unfortunate to say that there are demonstrated gaps in provider and staff gender sensitivity and also demonstrated discomfort among general care providers in addressing the needs of women with military sexual trauma histories. PACT-staffing, as it was originally laid out, also did not accommodate chaperone needs. We also have data that demonstrates that prior primary care teams where they would share chaperone needs, no longer work in a traditional PACT-staffing model, because people are concerned about it affecting their metrics. And also, many women's health clinics have co-located gynecologists who basically piggyback on the back of the additional clerk and staff as it is, stretching these teams even tighter. Many of the women's health pack teams also have part-time positions, which can undo some of the staffing metrics, and complicate some of the management as well. The VAs worked very hard in their efforts to establish gender-focused primary care models, including women's health clinics, either in parts and separated off from general primary care clinics, and also the use of designated or women's health primary care providers. Next slide. Alright back in control, although that's always an elusive concept, isn't it? [Laughter]

So the objectives for this work were to test an evidence-based quality improvement approach to tailoring packs to meet the needs of women Veterans. Focused today on our findings around local innovations and improvements that were accomplished by the local QI teams. We also sought to better understand the features of EBQI associated with local innovation success. Success, I like that success as well. This is evidence-based QI, I want to just walk through with you. It's a systematic approach to developing a multilevel research clinical partnership approach to quality improvement. It includes top-down-bottom features to engage local organizational senior leaders, and local QI teams. We use national policies and strategic directives as guides, we have regional expert panels that set innovation design priorities, local QI teams that design and implement local projects, and then we as researchers are really technical experts, educators, and guides. As I often when to these sites, "I'm in Los Angeles, what do you care? I have no authority over anything. But I'm going to try and help you improve care in a systematic way." The other important key part of EBQI is that it emphasizes the application of prior evidence, measurement, formative feedback, with an eye to organizational and provider behavioral change, and adaptation to local context, and in our case, external practice facilitation.

So how did we apply EBQI? We worked with each of four VISNs to create multilevel VISN stakeholder panel meetings, that were halved in length. By "multilevel", we mean network and medical center, department and clinical leadership, interdisciplinary through primary care, women's health, mental health, information technology, anyone we could find with quality improvement and system redesign training and backgrounds, as well as the women Veteran program managers. And we used expert panel methods to come to a consensus on VISN level quality improvement priorities, with an eye to the participating VA medical centers. We then provided EBQI training for the local QI teams, jump-started their local QI project proposals, provided some EBQI testimony from prior experience of folks who had already worked in this space, and also had national primary care and women's care leadership call in to these training sessions. They recognized that this was part of a broader initiative. The local QI teams that then picked one project from the VISN QI road map and the research team provided external practice facilitation, formative data feedback from our patient provider staff surveys, key stakeholder and team interviews, as well as ongoing across-site calls to share best practices. And then an important part of this was also the progress and results in briefings back up the chain.

So this was in the context of a 12-site cluster randomized trial with an unbalanced 2 to 1 allocation because we anticipated variations in EBQI implementation. We also did this in the context of women's health practice based research network, which provided us eyes on the ground, a notion of where the landmines were before we stepped on them, and the like. For this particular talk today, the methods focused on qualitative findings. The EBQI teams collected their own QI project data, the research team tracked their progress on facilitation calls, and then we conducted a series of key stakeholder interviews with the local QI teams. In summarizing the interviews using a template informed by the interview guide topics, summaries were then organized into matrices to compare and contrast findings across sites and levels, and matrices were supported by generation of a preliminary codebook for more in-depth analysis using ATLAS TI. And we used a constant comparison and analytic approach to elaborate the code book based on the measured themes, and adjusted as each round of interviews was completed.

So I'm going to start just providing you a notion of what EBQI accomplished with these sites, or really what the sites accomplished with EBQI support, and go through this fairly swiftly. First off, these are eight EBQI sites, and so they've completed about 15 QI projects in a 24-month time period. One of the sites focused on new patient access, and basically had significant difficulties in terms of getting patients to designated women's health providers, and achieved 100 percent assignment rate. They previously had had no one showing up for their first appointments with any kind of labs, and they managed to get over 80 percent of their patients to do so. Another site focused on improving follow-up of abnormal breast cancer screening results and improved that by 27 percent in terms of follow-up documentation, and improved notification by at least an average of a week. Another side focused on follow-up of abnormal cervical cancer screening, demonstrating initially that fewer than half of women who were abnormal were being managed by the updated guidelines, and by the end of their QI project it was over 85 percent. Another site improved coupled reporting of cervical cytology results, where women Veterans were originally mismatched on pap smear and HPV screening results, which is now 96 percent compliant.

Two other sites focused on PACT team functioning. Despite our best efforts, this suggests that was not exactly low-hanging fruit, and yet both improved team function claim and performance scores dramatically over the course of the project. Another site focused on proactive identification of women Veterans in mental health distress or crisis before their first primary care appointments, developing a high-risk mental health list, process and contacted them, found 30 percent were in need of mental health intervention before their first primary care appointment, and created a process of warm handoff and appointment scheduling with mental health, that increased patient and provider satisfaction. Another project focused on improving \_\_\_\_\_\_\_\_ [00:09:29] medication risk counseling, finding that only 30 percent had been counseled previously, and that project has now gotten to well over 50 percent. Another focused on improving residents trauma-sensitive communication by bringing a health psychologist into the exam room, and providing them with post visit feedback, and found significant improvement in communication skills, and greater comfort addressing trauma. Several sites focused on improving the environment of care for women, and this was in response to formative feedback that one in four women Veterans had been harassed on their way to see their VA provider. These included everything from a leadership video, shared medical appointments in the women's clinics, volunteer escorts, and education as well.

So in terms of the results of the key stakeholder interviews, what about EBQI worked for these sites? Basically, they said the importance of the regional interdisciplinary stakeholder planning sessions were critical for leadership awareness and buy-in, and that the data that we presented to them, which started with VISN level gender differences and patient ratings of care, were very powerful in getting that buy-in. We also learned that training of local QI team members was rated very important because there is variable access to QI personal on VA campuses--if you're not focused on access, you're not on the radar very often. And most of those were focused on joint commission. They also valued the practice facilitation, the expert review on feedback with our regular calls, and support the accountability, progress, and momentum they provided, and then formative feedback in terms of VA data, not having routinely been reported by gender, and the inclusion of new methods, and stranger harassment, agenda tailored audits that identified four times the number of patients who are at risk for alcohol use disorder. The evidence of EBQI impact also promoted their spread. The team function products resulted in noticeable burnout reductions among primary care providers and resulted in a VISN-wide invite to do virtual runarounds to do spread EBQI in project activities and improve team function. The improvement of abnormal cervical cancer screening has been spread VISN-wide, and the improvement of coupled cervical cytology results was spread VISN-wide as well.

So in conclusion, VA MCs participating in EBQI made substantial progress and gains in a wide range of QI targets that were aligned with VISN priorities and adapted to local contexts. And these innovations were supported by research-delivered technical support and formative feedback, which fostered employee engagement and design, and implementation and spread of promising practices. Otherwise, this was without any other additional direct funding, other than for the evaluation itself. The implications here are, I wanted to spread beyond, and I know I've got 30 seconds probably. But the importance of this experience for us and our takeaways further for evidence-based QI implementation and partnered research, is the importance of the trust building, to learn the partner priorities, and to add value. We set easy-to-use research briefs and cheat sheet summaries, rather than the usual research summaries. We provided many briefings like, I can dare say, 36 briefings over those 24 months to different levels of leadership, to meet their priorities, kind of what I called "Name that tune" and however many notes you give me on your agenda. These are not one-off relationships, you can't collect data and just walk away. And the walkthrough of the formative data collection collaboratively becomes important because there are numeracy challenges no matter high, or perhaps, the higher you go, those numeracy challenges may be even greater. Engagement and time investment vary, as do the partnerships and the policy climate environment. We had to explicitly manage and address partner turnover, there are relationships that run deep, and others broad, but both are important. And again, reliability is highly valued. We need to keep our promises, and not fall off their radar. Am I out? Okay.

So lastly, the benefits for us of partner research here is the access to clinics, local and network resources, senior level engagement that got the attention of other levels, and multilevel stakeholder engagement produced synergies we couldn't have anticipated at the outset of the project. And direct engagement of our partners improved the focus and relevance of our research. Several of us have mentioned that we live outside the comfort zone, somebody would give us the keys back into something that's comfortable, but such is life. We've improved the uptake adoption and implementation of EBQI such that women's health services now adopted it to improve care in low-performing facilities, and I have to say that our team is much more satisfied and successful, and has had other impacts in the meanwhile. So I'll stop there, and apologies for going a little bit over.

[Applause]

Moderator: We actually have time for one or two clarifying questions. Does anybody have any questions to ask? I think we have a question in the back.

Janet Fara: It's really concerning research. My name is Janet Fara [?]. I'm just curious, is there any indication from the teams that you trained that they may continue to do this type of work? I have interests in research capacity and building research capacity, and it seems like you spend a lot of time teaching these local teams how to perform this wonderful evidence-based QI, so I was just kind of curious about that.

Elizabeth Yano: At least for some of the follow-up calls, they actually ask the practice facilitation to continue regardless of funding in the projects. So we've continued some other calls thereafter, but we've actually submitted CREATE supplements to evaluate spread and sustainability at this juncture.

Janet Fara: That is great.

Moderator: Okay. If there are no further questions, we'll move on to our next--