VAIL
Veterans Assessment and Improvement Laboratory
VISN 22

PACT
PATIENT ALIGNED CARE TEAM

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

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This Session…

- Review and define EBQI (Rubenstein)
  - Rationale
  - Key prior studies
  - Core features
- Stakeholder perspectives (Stockdale)
- Next generation: Reflections on EBQI for women's health (Yano)

Poll Question: Why are you interested in Evidence-Based Quality Improvement (EBQI)?

Have you ever or would you could consider participating in EBQI as a

- **Research team** leader or member
- **Manager, clinician leader, or QI leader**
- **Front line clinician or clinical team member**
- **Other**, or I'm just curious

What is EBQI?

- Systematic quality improvement method for engaging frontline primary care practices in improvement that
  - Introduces “best science” and evidence *in the service of operational goals* at all relevant points during improvement
  - Is supported by a partnership between multi-level, interdisciplinary operations stakeholders and a research team

Rationale: What Does EBQI Add to Other QI Methods?

- Aimed at developing learning organizations through multi-level, across discipline engagement with science and data
- Provides explicit QI support by science teams to enable
  - Context-tailored but evidence-based innovations
  - Social science theory on provider/team behavior
  - Improved use of implementation and QI methods

Rationale: Why Engage Frontline Primary Care?

- Primary care teams are smart and committed
- Alternatives are:
  - Non-managed primary care improvement
    - Difficult to deliver needed resources
    - Expensive, often not evidence-based
    - Outcomes inconsistent or not measured
  - Top down policy
    - Important as guideposts, but ineffective or worse when used as micro-management
- And—shouldn't "best science" be used closest to patients?

What Do We Mean By Best Science?

- "Best science" is tailored to the task at hand
  - Evidence to inform intervention design
  - Methods for meaningful multi-level, interdisciplinary stakeholder engagement
  - Methods/measures/data retrieval to support frontline PDSA cycles or formative evaluation
  - Summative evaluation by a research team
- In the partnership, researchers continuously adapt scientific methods for improvers to use

What settings has EBQI been studied in?

- VA—depression care in primary care, serious mental illness, smoking cessation, women's health, implementation of the patient centered medical home model (PACT)
- Kaiser Permanente—depression care in primary care
- Six managed care organizations—depression care in primary care

EBQI Rules of Thumb

- Where evidence provides clear guidance, operations partners abide by the guidance
  - Where there is no evidence, operations partners use best judgement, and evaluate results
- Most funding, and decision-making, for QI is in the hands of operations partners
  - EBQI requires separate funding for an existing scientific team with access to any needed skills
  - Partnership begins before funding with development of a specific project proposal & budget

Settings Appropriate for EBQI

- Groups of primary care practices linked through some kind of administrative superstructure
  - Managed care organizations and medical centers
  - VHA regions and medical centers
- Demonstration primary care practices chosen by operations leaders based on criteria (e.g., size); comparison practices
- Comparison practices are spread sites

Key Participants

- Multi-level, interdisciplinary clinical operations partners including
  - regional leaders
  - local practice site leaders
- Scientific team
- Patient representatives
- Any other critical stakeholder representatives
  - E.g., subject matter experts, specialists

Needed Prior to Starting

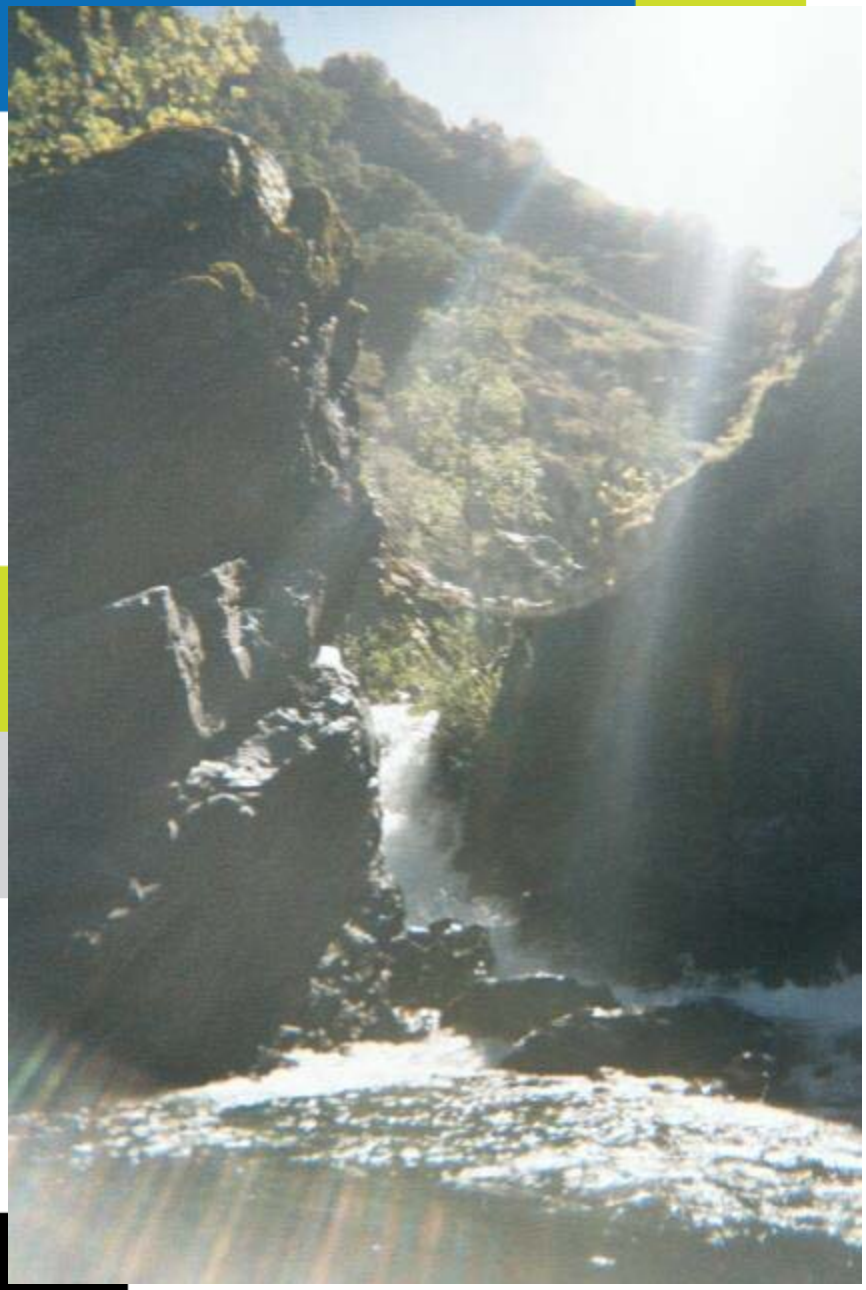
- A statement of the problem or goal
- Proposed project configuration and key elements
- Memorandum of Understanding between researchers and operations leaders indicating support for each key element, including payment
- A logic model connecting intervention & evaluation
- And underlying—a willingness to improve

Key Activities in the EBQI Tool Box

- Regional priority setting based on expert panel methods
- Face to face learning and sharing sessions
- Ongoing across-site teleconferences
  - Working groups
  - Community of practice calls
  - Learning & consultation sessions
- Project management and data support
- Tool creation, implementation, revision (spread)

At the end of an EBQI project, the setting should be changed…

- Structures for improvement
  - E.g., committees, policies, communication networks, training opportunities
- A stronger QI culture toward & in primary care
  - Frontline skills development
  - Stronger appreciation of and communication and familiarity with primary care by upper leadership/other relevant disciplines



One step at a time, and that well-placed, we reach the grandest height

--Author Unknown

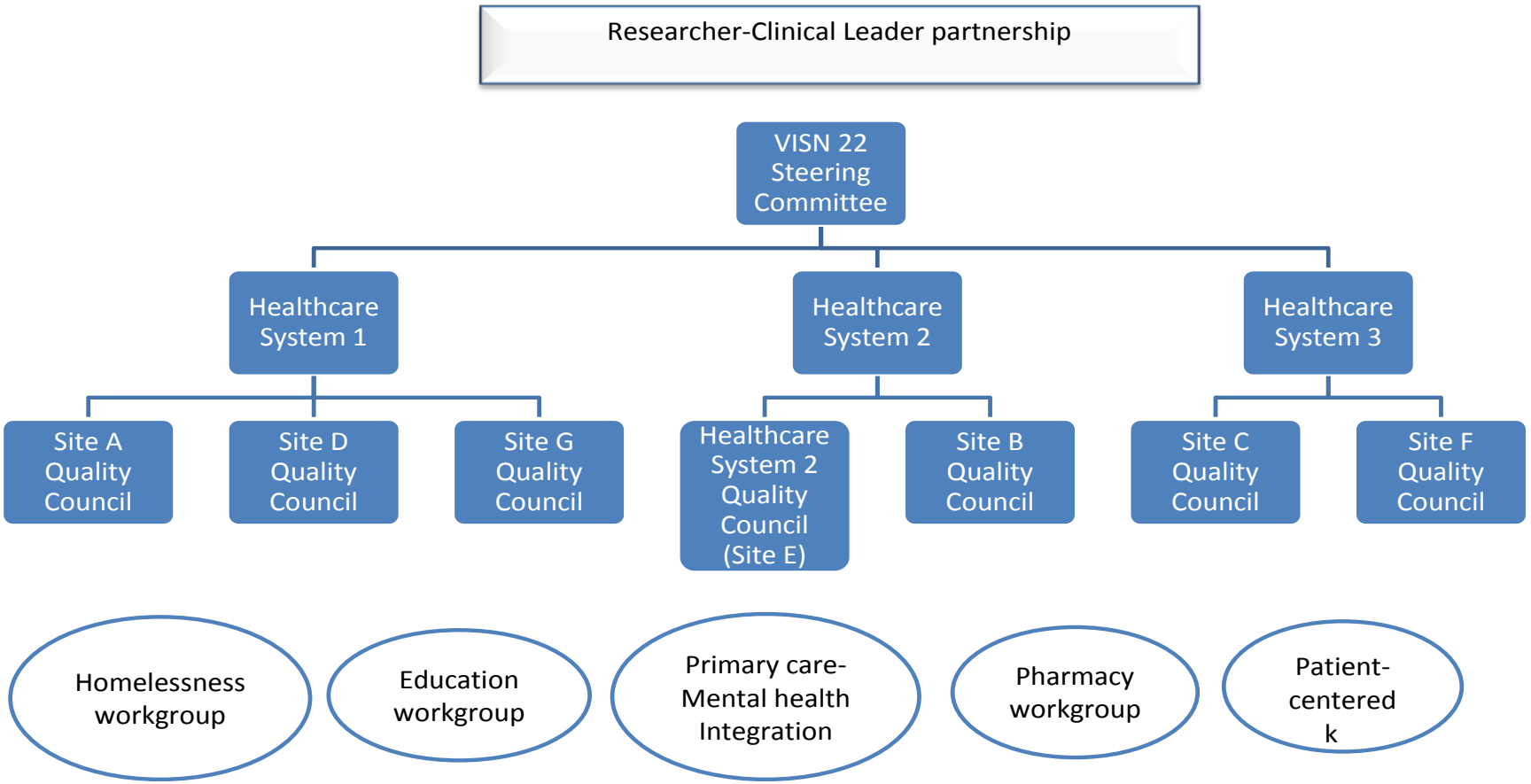
EBQI-PACT

- Veterans Assessment and Improvement Laboratory (VAIL) – VISN 22 PACT Demonstration Lab
- Use EBQI approach to implement PACT
- Clinical-research partnership
  - Started with 3 VISN 22 healthcare systems, rolled out in 3 phases to 7 sites

Focus of this talk:

- Describe 2 components of the EBQI PACT Intervention
  - Developed multi-level **organizational infrastructure** for implementing EBQI for PACT
  - **Facilitated Quality Improvement** with external and internal facilitators
- Present results of implementation evaluation and summative evaluation

EBQI-PACT Infrastructure



Infrastructure – Quality Councils

- Were designed to
  - Foster interdisciplinary leadership for PACT QI
  - Establish a structured, local QI process for primary care with oversight and accountability mechanisms
  - Facilitate frontline QI innovation within the demonstration practices
- Successfully fostered interdisciplinary leadership, structured QI process
  - Facilitating frontline QI was difficult, though 4/6 sites succeeded
- Ref: Stockdale, et al 2016

VAIL Intervention: Facilitated EBQI for PACT Implementation

- External facilitators – Health services researchers
  - Engaged regional, HCS leaders
  - Organized, implemented priority-setting process
  - Learning collaborative - Biweekly training/mentoring calls, bi-annual conferences
  - SharePoint site for tool development & sharing
- VAIL-supported Quality Council Coordinators
  - Master's level support for admin, QI projects
  - Helped obtain real-time data for QI projects

Results – outcomes for EBQI-PACT facilitation process

- QCs and workgroups submitted total of 71 project proposals (2011-2014)
- 21 projects approved across 4 rounds of Steering Committee review
- Resulted in 12 toolkits posted on VAIL SharePoint site for spread across VA

VAIL SharePoint:

http://vaww.portal.gla.med.va.gov/sites/Research/HSRD/VAILPCC/vtkits/Pages/vtk_home.aspx

Key Ingredients for Success

- Engagement of interdisciplinary leaders in roles appropriate to leadership level

*"Our [practice] leaders are pretty innovative in seeking out solutions, and **they oftentimes fix and solve problems without help, maybe even better than I know how to go about it**. But I have had some interactions with them about challenges they've been facing . . . and **have intervened in some ways and supportively to help resolve some issues related to the implementation** of the two different program efforts. . . ."*
[Service line leader, Healthcare System 3]

Key Ingredients, cont.

- Data support from VAIL, Quality Council coordinators

*"That role has been . . . almost like a godsend to ambulatory care . . . as far as **data gathering and data manipulation and presentation**, she has been simply been outstanding. Anything that we've asked, from compiling it to **putting it in a format that's understandable, readable**, I don't think our meetings would be what they were . . . had it not been for that role. We rely on them immensely." [Practice lead, Site D]*

Key Ingredients, cont.

- Leadership-frontlines priority setting process

*"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 was a lot of really neat things that were going on but, then, my goal is always how do I get that information when it's working disseminated to the sites." [VISN leader, VAIL Steering Committee member]*

Summative Findings

- Accelerated decreases in ambulatory care visits, increases in non-F2F visits (Yoon, 2016)
- Accelerated reduction in primary care provider burnout (Meredith, submitted)
- Improved communication with patients (SHEP) (Huynh, in preparation)
- Some successful individual innovations & spread using QI statistics with comparison (Huynh, in preparation)
- Continued use of 12 VAIL tools

Post script on sustainability

- 4-5 of the 7 original VAIL sites participate in “community of practice”
  - Continue with active QI projects, twice-monthly calls
  - Coordinates with V22 Primary Care committee
  - Identifies QI issues affecting PACT, promising practices

Using EBQI for tailoring PACT

- Women Veterans fastest growing segment of new VA users but are numerical minority (<10%)
- Logistical challenges in delivering gender-sensitive comprehensive primary care
  - Limited #s affect provider WH proficiency/experience
    - High rates of military sexual trauma, PTSD, depression, anxiety
    - Gaps in provider/staff gender sensitivity and comfort handling trauma histories, problems with chaperone access, room privacy
  - Persistent gender disparities in quality, ratings of care
  - Efforts to establish gender-focused primary care models
    - Designated women's health providers, women's health clinics

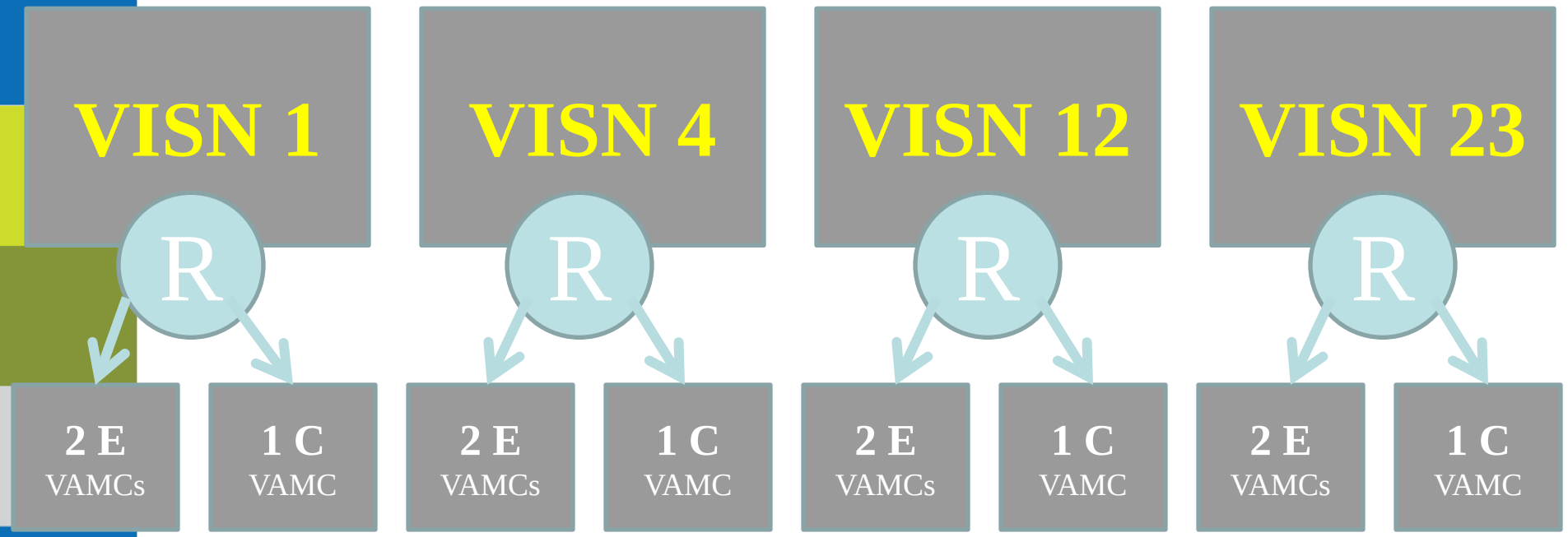
Why tailor PACT?

- Challenges remain under VA PACT model
  - Many parttime MDs (upends staffing model)
  - 20% ↓ in panel size frequently forgetten locally
  - PACT staffing did not recognize chaperone need
  - PACT metrics not reported by gender
  - High care coordination demands (e.g., non-VA)
  - Co-located GYN piggybacking off of PACT staff
  - Variable comprehensiveness and sometimes unclear accountability between PACT and WHCs

Why tailor PACT?

- Had national guidance on VA PACT and on health care services for women (1330.01)
- Convened VA national expert panel to define *gender-sensitive* comprehensive care
- Had evidence in hand on general primary care and WH clinic features related to quality
- Decided on EBQI as strategy to test
  - Adapted VAIL EBQI effort to women's health

Used VA Women's Health Practice Based Research Network (PBRN)



PBRN gave "boots on the ground" entré and insights

How did we apply EBQI?

- VA network-level stakeholder panel meetings
  - Multilevel (VISN, VAMC, Department, Clinic)
  - Interdisciplinary (PC, WH, MH, IT, QI, WVPM…)
  - Expert panel methods, came to consensus on QI priorities
- EBQI training for local QI teams
  - Jumpstarted local QI project proposals, EBQI expert input from VAIL, national PC & WH leadership called in
- Local QI teams picked project from QI "roadmap"
  - Research team provided external practice facilitation, formative feedback, ongoing across-site calls
- Progress/results briefings back up the chain

How did we apply EBQI?

- No Quality Councils
  - Worked with local WH Medical Directors, WVPMs and/or PBRN Site Leads (varied by site)
  - Local QI teams engaged key stakeholders in projects (e.g., HAS for improving assignment of new patients to DWHPs)
  - Involved QI/system redesign when available (varied)
  - WVPMs report to Chief of Staff (quad link)
- VISN level oversight varied
  - One VISN created WH PACT steering committee
  - Other VISNs relied on existing councils
- VHA engagement for policy clarification

What did EBQI sites accomplish?

- ↑ **new patient appointment access, 1st appt content**
  - 100% assignment to DWHP, >80% get labs before 1st appt
- ↑ **follow-up abnormal breast cancer screening results**
  - 27% ↑ in follow-up documentation, ↓ avg 6 days faster
- ↑ **follow-up abnormal cervical cancer screening**
  - <50% abnormals managed per upd'd guidelines, now >85%
- ↑ **coupled reporting of cervical cytology results**
  - Pap smear and HPV screening results now 96% compliant
- ↑ **PACT team functioning, climate, performance**
  - Virtual team meetings, huddle checklists, team training

What did EBQI sites accomplish?

- **Identified emergent MH needs before 1st appt**
  - Developed high-risk MH list, process to contact → 30% need MH intervention → counseling, warm handoffs, appt sched
- **↑ teratogen prescribing thru e-consults, education**
  - Almost half filled 1+ categ D/X med, only 37% counseled
- **↑ residents' trauma-sensitive communication**
  - Health psychologist in exam room, post-visit feedback
- **↑ environment of care (welcoming, ↓ harassment)**
  - Response to formative feedback that 1 in 4 harassed at VA
  - Leadership video, shared medical appts, volunteer education
  - Social marketing, volunteer escorts, physical layout changes

What about EBQI worked?

- **Regional interdisciplinary stakeholder planning**
  - Critical for leadership awareness/buy-in, data “powerful”
- **Training of local QI team members**
  - Variable access to QI personnel + most focused on JCAHO
- **Practice facilitation, expert review and feedback**
  - Evidence for internal and external facilitation effectiveness
  - Regular calls support accountability, progress, momentum
- **Formative data feedback**
  - VA performance data not routinely reported by gender
  - Included new measures (stranger harassment, AUDIT-C)
  - Analyses helped drill down to factors driving WVs’ ratings

What about EBQI worked?

- **Early evidence of EBQI impacts promoted spread**
  - Team function projects yielded noticeable burnout ↓
    - VISN-wide “Grand Rounds” to spread EBQI & team function work
  - ↑ follow-up of abnormal cervical CA screening
    - VISN-wide spread of EMR reminder and template
  - ↑ test reporting of cervical cytology results
    - VISN-wide spread of methods and policy
- **Next steps**
  - Developing EBQI toolkits for spreading innovations
  - Developing strategies for sustaining EBQI processes *without the research team*

What did these partnerships take?

- **Trust-building – learn partner priorities, add value**
  - Sent easy-to-use research briefs, “cheat sheet” summaries
  - Briefings linked to their priorities/needs (“name that tune…”)
  - Not a “one off,” cannot collect data and just walk away
  - Walk-through formative data collaboratively, answer Qs
- **Engagement and time investment varies**
  - Partnerships evolve, as does policy climate/environment
    - Explicitly manage/address turnover (new partners, their links)
    - Avoid “hitching wagon” to a single person, things change
  - Some relationships run deep, others broad, both important
  - Reliability highly valued, keep promises, don’t fall off radar

What were the benefits?

- **Some more obvious than others…**
  - Access to clinics, local and network resources
  - Senior VA leader engagement got attention of other levels
  - Multilevel stakeholder engagement began to "churn"
    - Capitalizes on, leverages existing infrastructure, systems, people
- **Direct engagement of partners in research**
  - ↑ focus and relevance of research ("out of comfort zone")
  - ↑ uptake, adoption, implementation and spread of EBQI
    - WHS has adopted EBQI to improve care in low-performing VAs
  - Unexpected spinoffs (e.g., national culture campaign)
  - ↑ research team's satisfaction, success and impacts

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