Adventures in Program Implementation and Expansion: Improving Transitions of Care for Veterans

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Today's Webinar

- Why did we go on this adventure?
- How did we plan?
  - Pre-implementation assessment
- What did we do?
  - Community Hospital Transitions Program
  - Implementation
- Taking a road trip: Program expansion
  - Pre-implementation assessment
  - Early implementation

Poll Question #1

- What is your primary role in VA?
  - Student, trainee, or fellow
  - Clinician
  - Researcher
  - Administrator, manager or policy-maker
  - Other

Poll Question #2

- Which best describes your experience with implementing quality improvement projects?
  - have no experience
  - have collaborated with others
  - have conducted one myself
  - have applied for funding
  - have led a funded grant

Why Did We Go On This Journey?

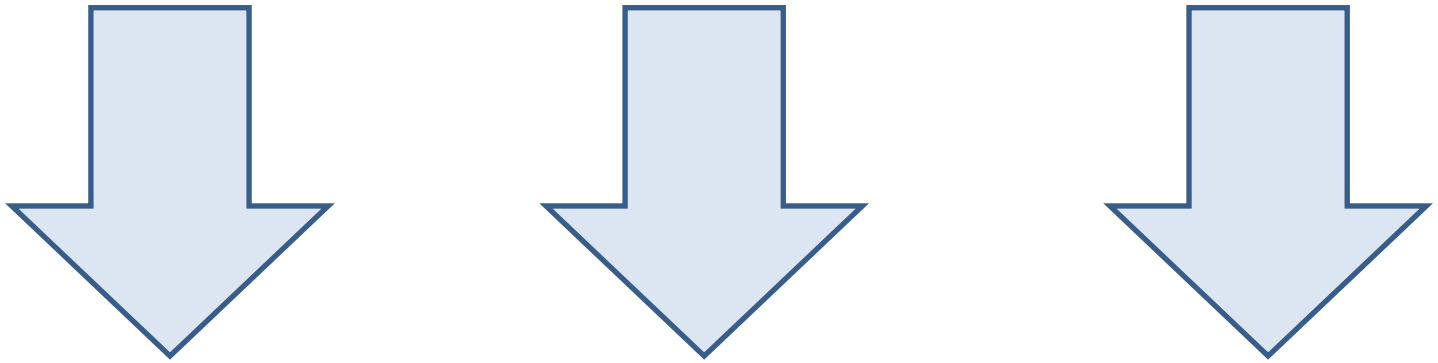
- VA has increasingly partnered with community hospitals to provide needed healthcare services to Veterans[1,2]

- Veterans who receive healthcare services at both VA and community hospitals (dual users) are at high risk of:
  - increased hospitalization and 30-day readmissions
  - fragmented care resulting in duplication of tests and treatments
  - difficulties with medication management [3-10]

- The VA faces challenges in coordinating care for patients who are dual users[11]

Goals we Wanted to Accomplish

- To describe the processes and identify VA and community hospital clinicians' and staff as well as Veterans' perspectives of the barriers and facilitators to providing high-quality transitional care.



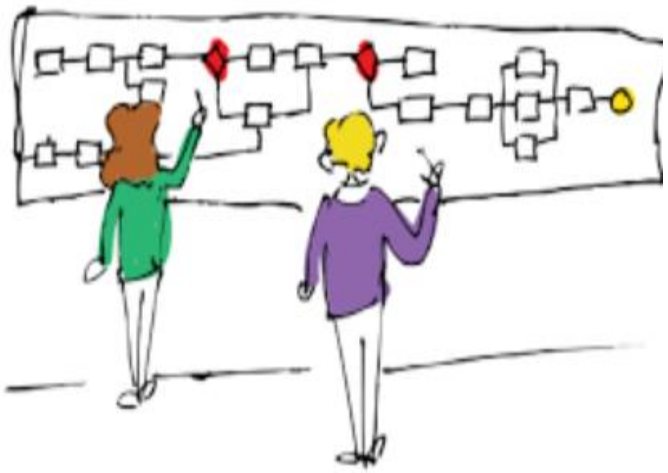
- To inform the design of a more efficient intervention that improves care coordination for dual-use Veterans who transition from community hospitalizations to VA primary care.

The Path to Pre-implementation Assessment

- Conducted a qualitative assessment:
  - in-depth, semi-structured, role-specific key informant interviews
  - interview guides were developed for Veterans, clinicians and staff
    - Informed by PRISM model, Lean approach and the ideal Transitions of Care bridge
  - used purposive sampling
  - permission to recruit was obtained from hospital leadership
- Veterans were approached for sampling if they were discharged from a community hospital in the last quarter of fiscal year 2015

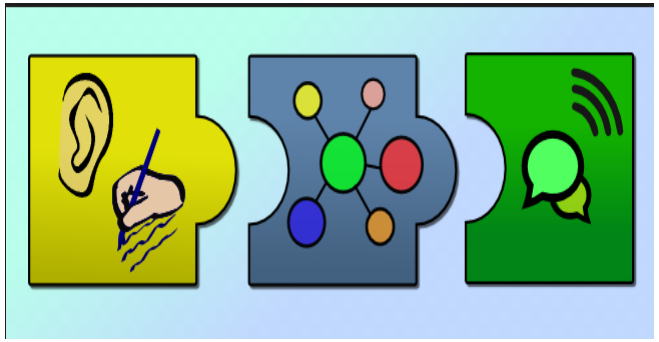
Pre-Implementation Assessment

- Lean Assessment
  - Process Map
    - Created a process map based on the qualitative data
    - Validated the process map with the front-line providers and staff
  - Value Stream Map
  - Root-Cause Analysis
    - Identified and prioritized areas to intervene



Undertaking Our Analysis

- Guided by Conventional Content analysis
  - using a deductive and inductive coding approach



- Initial code book was developed independently using the first three interview transcripts

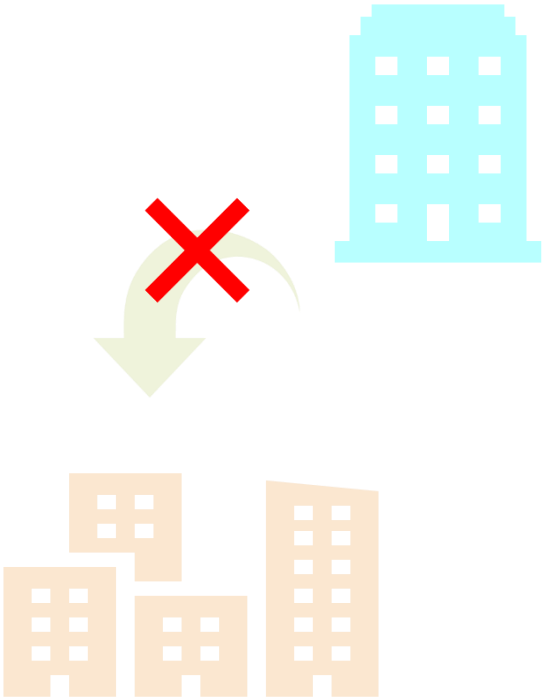
- Consensus building was achieved

First Accomplishments!

- Completed 70 key informant interviews
  - 23 VA and 29 community hospital clinicians and staff
  - 18 Veterans
- We identified
  - Barriers
  - Facilitators
  - Suggestions for improvement of the current process
- Created transitions of care process maps

Speed Bumps in the Current Process

- Transitions were often perceived as inefficient when community hospitals could not:
  - Identify patients as Veterans and notify VA primary care of discharge
  - Transfer the community hospital's medical record to VA primary care
  - Obtain follow-up care appointments with VA primary care
  - Write VA formulary medications for Veterans to fill at VA pharmacies



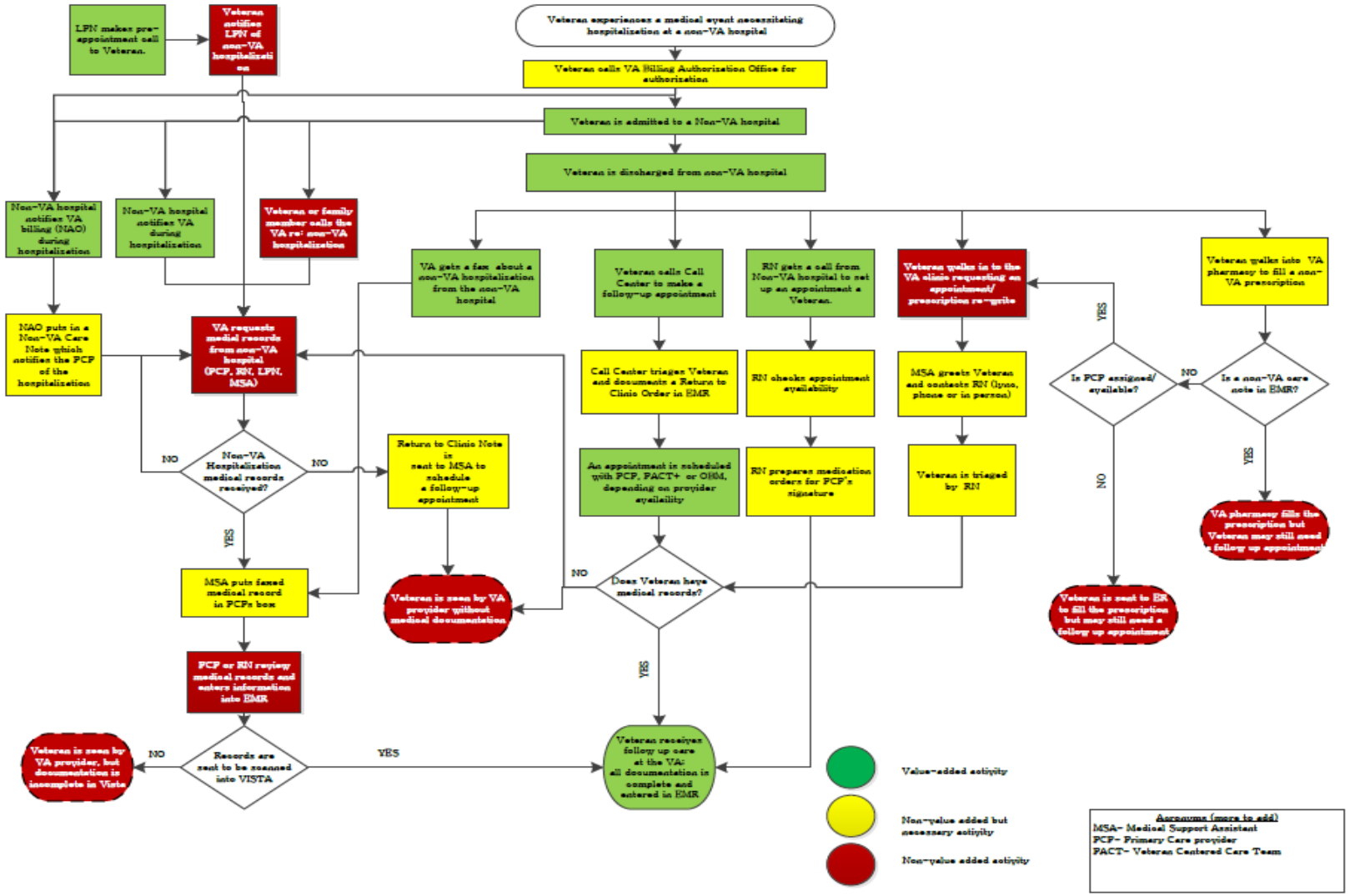
Smooth Sailing

- VA increased amount of appointment spots and walk-in appointment slots
- Community hospital staff noted an increasingly availability of follow up appointment slots
- VA CBOC participated in Community Transitions Consortium
  - Improving transparency and communication with community

Suggestions for Improving the Transitional Care Process

- VA and Community participants wanted:
  - Care coordinator with clinical background
  - Educate Veterans about what to do when hospitalized in a community hospital
- Veterans wanted:
  - an efficient system for obtaining medications
  - the ability to schedule timely follow-up appointments
  - education about the VA transition of care process

Current Transitions Process Map

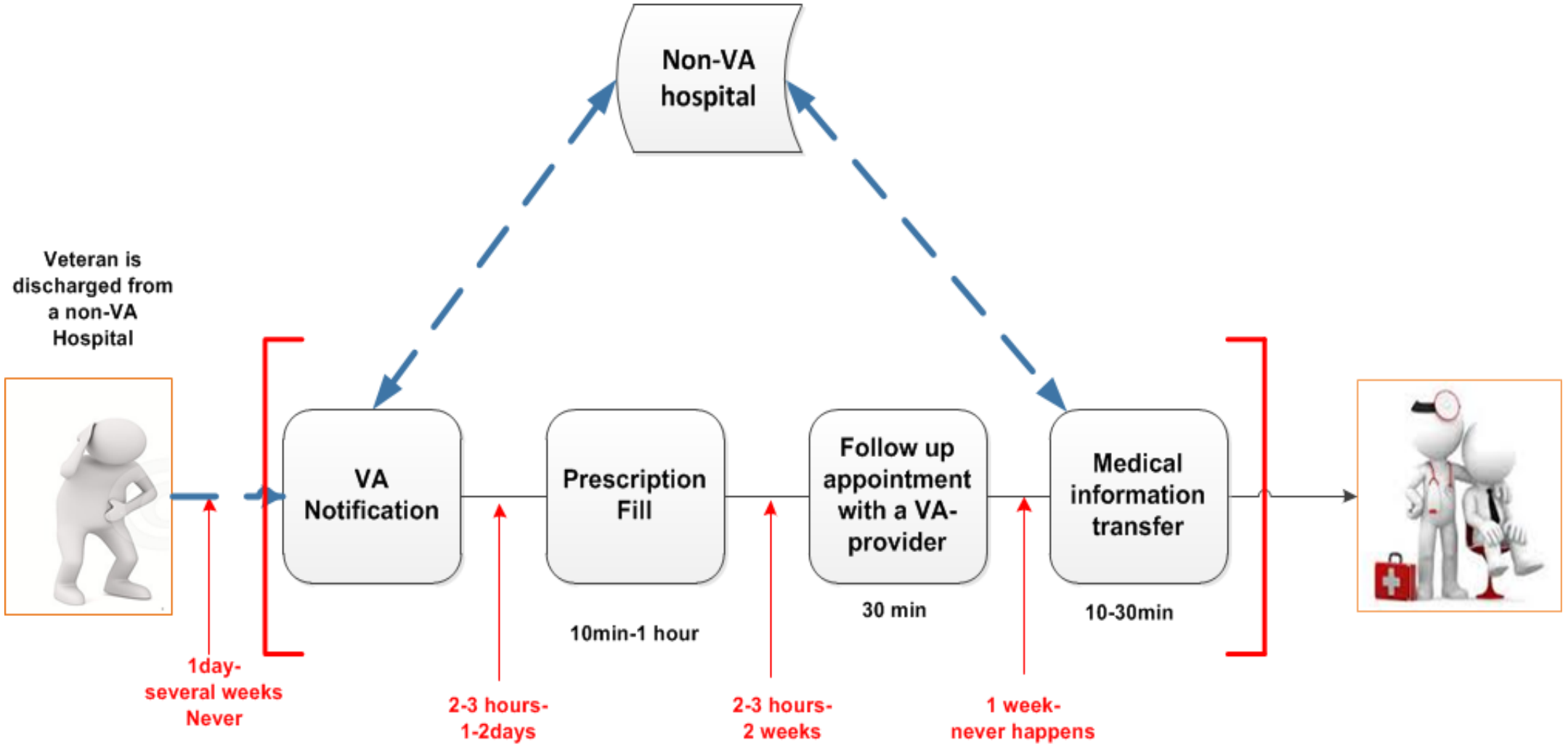


Value added activity

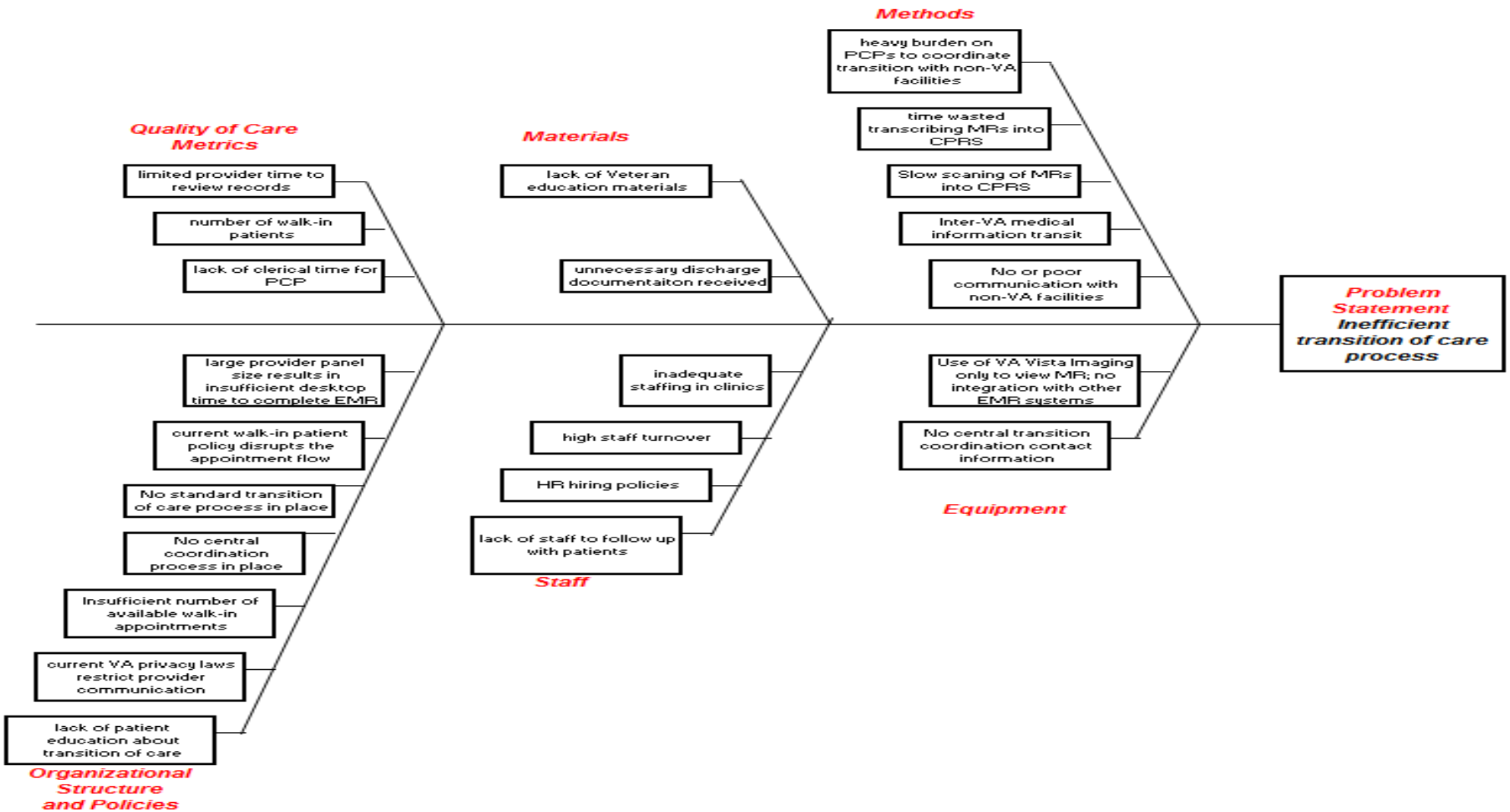
Non-value added but necessary activity

Non-value added activity

Value Stream Map

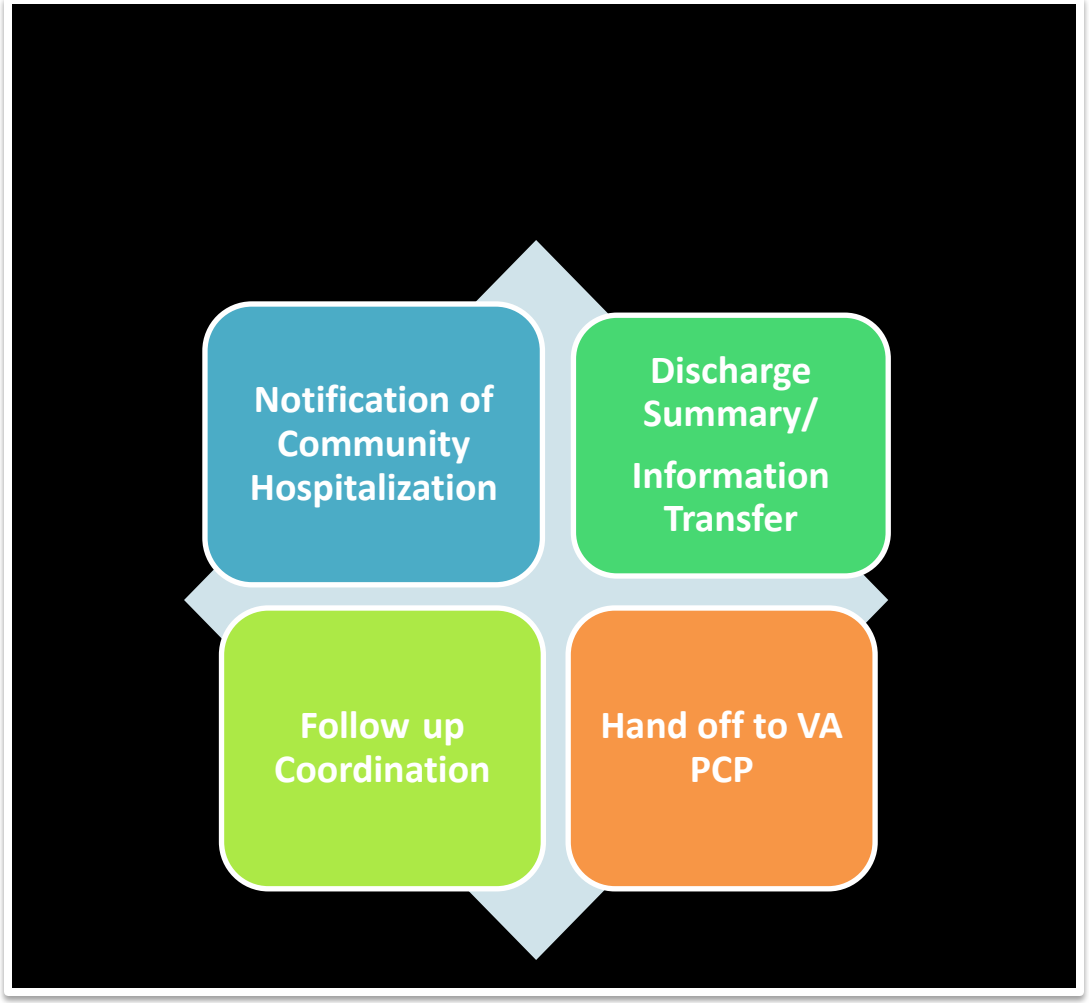


Fishbone Diagram



Community Hospital Transitions Program

- Short-term, episodic care coordination program
- Pillars of the program:
  - Community Hospital transitions Program Nurse
  - System changes to facilitate better communication
  - Veteran education using Veteran care card



Come Along for the Ride

- Initial Development of:
  - Letter explaining our program
  - Role of the Community Hospital Transitions Nurse
  - Description of what we are sending to our Veterans/the care card
  - Quick reference guide containing phone numbers and links to resources
- Initial In-services to communicate program goals and asks
  - Staff meetings
  - Leadership meetings

Implementation Strategies

- Audit and Feedback
- Facilitation
- Modified Rapid Process Improvement Workshop

Evaluation Framework: RE-AIM

	Measures
Reach	• Number, proportion, and representativeness of Veterans reached
Effectiveness	• ED utilization rate after community hospital discharge [**of those Veterans who interacted with our program] • 30-day (60 and 90-day) re-admission rates post community hospital discharge [**of those Veterans who interacted with our program] • Veteran satisfaction with transitional care using IVR • Number, proportion, and representativeness of Veterans who had VA PCP assignment after d/c from community hospitals if no current PCP
Adoption	• Number, proportion, and representativeness of community hospitals who inform us of Veteran admission

Implementation	• Implementation of core components: number of times all or part of the core components are met for each patient
	  ○ Number of medical records received and discharge summaries uploaded
	  ○ Number of follow up appointments made
	  ○ Number of patients who had the full intervention completed
	• Barriers and facilitators to implementation
	• Return on investment/cost

Maintenance	• Documentation of rapid prototyping • Documentation of local adaptability

Let’s hit the Road!

- Soft roll-out
  - June 1, 2017
  - Began with two community hospitals
- Lessons Learned
  - Solidify intervention core components
  - Checking in with the VA and community stakeholders
  - Follow up with the implementation team

Tracking our Progress

- Theoretical Domains Framework

- Adaptations:
  - Modified Stirman framework

Methods to Assess Adaptations

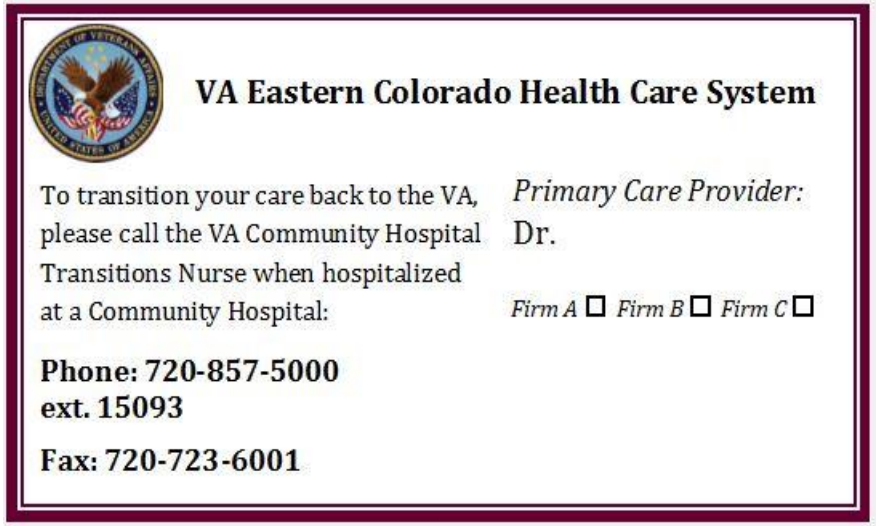
- Observational techniques
- Focused interviews
- Questionnaires, checklists, and logs
- Content analysis of key documents and curricula
- Study databases and clinical databases
- Weekly team check-ins

Examples of Adaptations

- Changed from physical fax machine to dedicated electronic fax line
- Clarified the four core components of the intervention
- Revisions to program database

Shout from the Rooftop!

- Modified resource guides and public relation materials for VA and community hospitals



VA Eastern Colorado Health Care System

To transition your care back to the VA, please call the VA Community Hospital Transitions Nurse when hospitalized at a Community Hospital:

Primary Care Provider: Dr.

Firm A ☐ *Firm B* ☐ *Firm C* ☐

Phone: 720-857-5000 ext. 15093

Fax: 720-723-6001

- Ongoing In-services to communicate program goals and asks
  - Staff meetings
  - Leadership meetings

Requests for Payment and Authorization

It is your responsibility to call...

Emergency Services

When admitted or discharged from a community hospital or emergency room, please contact Network Authorization Office (NAO) within **72 hours:**

1-888-795-0773 ext. 1

Non-Emergent Services

Non-emergent services require a referral and authorization from a VA provider to receive care at community hospitals. Please contact CHOICE and Non-VA Care Coordination offices **before** receiving non-emergent care at non-VA hospitals:

720-857-5988; ext. 1 for CHOICE, ext. 2 for Non-VA care

Taking a Road Trip to Expansion

- Expansion Site – Omaha, Nebraska
    - Leadership buy in
    - Site characteristics
    - Memorandum of Understanding
    - Nurse Hiring
    - Site Champion

Pre-implementation Site Visit

Before our visit:

- Planning
- Data collection pre visit

During our visit:

- On site agenda
- On site data collection methods

Nurse Training

- Onsite, hands on training
- Wikipage development
- Education waves
- Weekly phone calls

The Adventure Continues

- Rollout in Omaha
- Database tracking
- Audit and feedback, facilitation
- Continuous engagement
- Mid year evaluation
- Outcome evaluation

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❑ QUERI

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Questions/Comments?

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