CSHIIP
Center for the Study of Healthcare Innovation, Implementation & Policy

Implementation of Clinical Resource Hubs to Expand Access to Primary Care and Mental Health Services:

First year implementation progress, challenges, and facilitators

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VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Objectives

- Describe VA's national Clinical Resource Hub initiative
- Present findings from implementation evaluation of Year 1
  - Implementation progress measure
  - Barriers and facilitators of implementation
- Maintenance/sustainability considerations

Need for contingency staffing to address access issues

- Increasing shortage of primary care and mental health providers, VA and non-VA settings
- Staffing deficits inevitable - need for contingency staffing
  - Can result in reductions in patient access, especially for rural clinics
- Telehealth modalities provide a means for remote as-needed staffing
- VA administrative structure, prior investment in telehealth modalities provided foundation for regionally based program

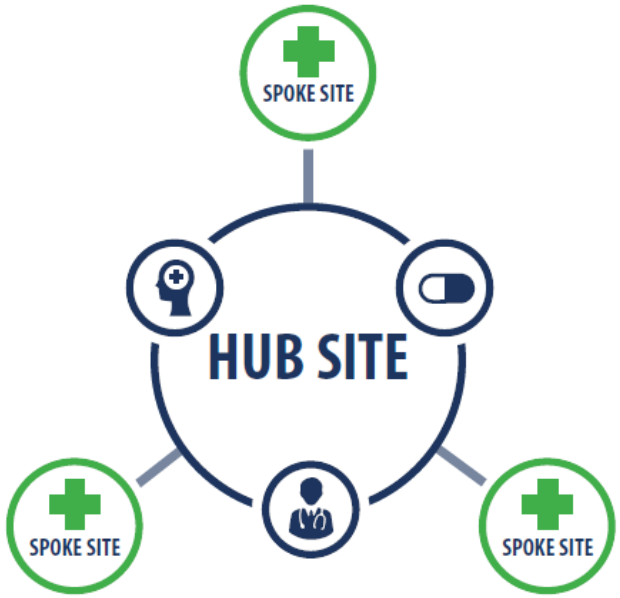
Poll Question #1

How familiar are you with the VA's national Clinical Resource Hub program?

- Very familiar
- Somewhat familiar
- A little familiar
- Never heard of it until now

Clinical Resource Hubs (CRH) launched in 2019

- 2018 MISSION Act – mandated increasing capacity, access for PC, MH in "underserved" clinics
- Leveraged existing "pilot" telehealth hubs funded by Office of Rural Health since 2010
- "Hub and spoke" model
- OPC developed implementation "roadmap" with key features and timeline, operations manual



CRH key features as specified in implementation roadmap

Year 1

- **Infrastructure** – VISN ownership, administrative governance, leadership
- **Planning** - single, standardized online request tool for CRH services; services directed to clinics with greatest need
- **Monitoring and Reporting** - metrics are submitted on a predefined schedule and upon request

Years 1- 2

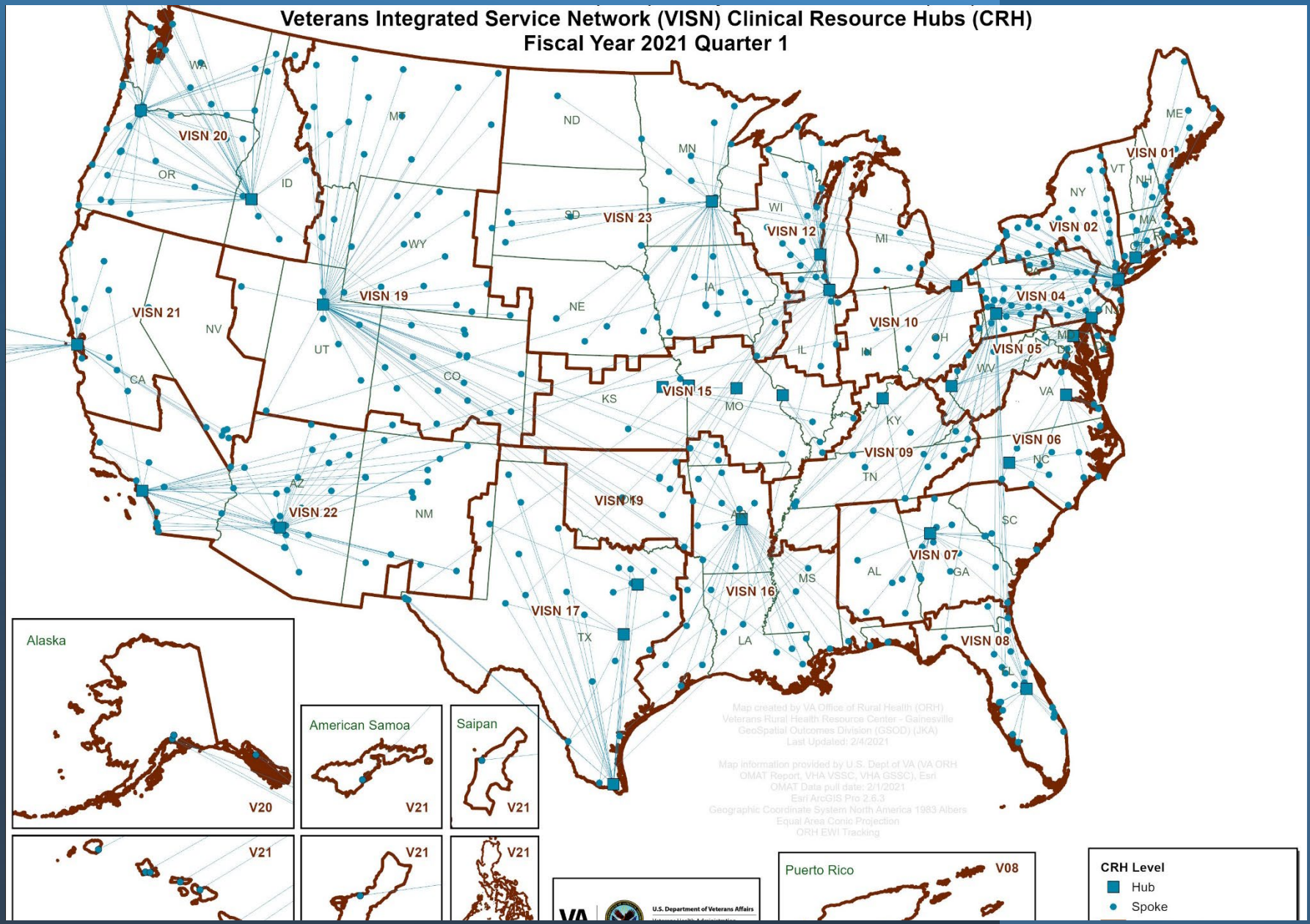
- **Support** - CRHs provide support to Telehealth Emergency Management (TEM) when activated and appropriate

Year 1-3

- **Support –** support clinical contact centers; support transition to new EMR
- **Service Delivery** - CRHs provide primary care and mental health services, at a minimum

Organization of CRH program

- National program aligned under Office of Primary care with national advisory board
- CRH program office recommended structure
  - 18 hubs, one in each VISN, with oversight by VISN governance board
  - Each hub has an overall Director in charge of operations and clinical services
  - Section chiefs for PC, nursing, MH, pharmacy, and specialty services


Veterans Integrated Service Network (VISN) Clinical Resource Hubs (CRH)
Fiscal Year 2021 Quarter 1
VISN 01
VISN 02
VISN 04
VISN 05
VISN 06
VISN 07
VISN 08
VISN 09
VISN 10
VISN 12
VISN 15
VISN 16
VISN 17
VISN 19
VISN 20
VISN 21
VISN 22
VISN 23
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
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KY
TN
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GA
FL
SC
NC
VA
WV
PA
NY
ME
VT
NH
MA
CT
RI
NJ
MD
DE
Alaska
V20
American Samoa
V21
Saipan
V21
V21
V21
V21
Puerto Rico
V08
Map created by VA Office of Rural Health (ORH)
Veterans Rural Health Resource Center - Gainesville
GeoSpatial Outcomes Division (GSOD) (JKA)
Last Updated: 2/4/2021
Map information provided by U.S. Dept of VA (VA ORH
OMAT Report, VHA VSSC, VHA GSSC), Esri
OMAT Data pull date: 2/1/2021
Esri ArcGIS Pro 2.6.3
Geographic Coordinate System North America 1983 Albers
Equal Area Conic Projection
ORH EWI Tracking
U.S. Department of Veterans Affairs
CRH Level
Hub
Spoke

"Hub and spoke" model provides PC and MH staffing gap coverage

Request for CRH services submitted	Clinic with staffing shortage requests help CRH/regional leaders identify sites with access issues
Request reviewed by CRH	Relative priority determined based on type and length of service requested, clinic staffing, availability of CRH clinicians
Spoke site set-up process	CRH works with clinic to put in place necessary service agreements, get CRH clinician access to EMR, set up telehealth equipment, train clinic staff to use equipment

Methods: first year implementation progress measure

- Goal: assess implementation progress, not fidelity
- Data sources
  - June and October 2020 CRH Directors' key informant surveys assessing progress on implementing key features
  - Approved budgets for FY20
  - VSSC CRH reports
- Measure – includes 8 components, one for each key feature specified in implementation roadmap
- Criteria for assessing achievement of key features
  - Was each key feature achieved within the expected timeframe?

Methods: Implementation progress categories

None: did not meet minimum expectations

Low: met or nearly met minimum year 1 expectations

Medium: met year 1 expectations and made progress on features expected to be in place for year 2

High: fully implemented all key features

Results – First year implementation progress

- All CRHs met or exceeded minimum expectations for year 1 progress
- Next steps: assess fidelity and adaptations (successful and unsuccessful)

Achievement level	% (n)
None	0
Low	28% (5)
Medium	61% (11)
High	11% (2)

Barriers and Facilitators to Implementing National Clinical Resource Hubs: Perspectives of Two Key Stakeholder Groups

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Methods: Semi-structured key stakeholder interviews

- Telephone interviews, June 2020 – April 2021
  - CRH national program office staff members (n=8)
  - CRH regional hub directors (n=17)
- Informed by The Consolidated Framework for Implementation Research (CFIR) conceptual framework
- Rapid analysis approach
  - Create Individual interview summaries from transcripts
  - Thematic analysis of summaries with team consensus checks
  - Special focus on barriers & facilitators to implementation

Implementation Barriers - Infrastructure

- **CRH program office limited ability to mandate standardization**
  - CRHs not implementing recommended leadership and governance structure, hiring practices
    - Program Office responsible for model fidelity, but lacking authority to enforce standards; can only give guidance and recommendations
    - Variations in leadership structure results in challenges to transparency and collaboration
- **Competing program office priorities**
  - E.g., Veterans' access to care, suicide prevention

Planning-related implementation barriers noted by program office and CRH directors

- **Lack of awareness of or misperceptions about CRH in broader VA**
  - *Program Office Leaders*: getting word out about CRHs in big healthcare system like VA is difficult in general
    - E.g., more awareness-raising & communication needed early
  - *Directors*: e.g., human resources (HR) or chiefs of services not understanding CRH or its benefits and associated costs (there are no costs), or perception that CRH will be extra workload for facility
- **Budget/funding concerns**
  - Perception that spokes sites concerned about losing workload credit (and associated future resource allocation)

Service delivery-related implementation barriers noted by program office and CRH directors

- **Technology challenges**
  - *Directors*: one of the top concerns
    - Delays getting IT equipment and connectivity for remote employees located in other regions
    - Adapting complex scheduling systems to telehealth needs
  - *Program Office Leaders*:
    - Additional money needed for equipment
    - Scheduling systems not compatible complicates service delivery to spoke sites

Service delivery-related implementation barriers

- **Hiring challenges (noted by Directors)**
  - Timing of funding for positions does not line up with candidate availability (E.g., residents/trainees available in summer but funding does not arrive until fall or later)
  - Inefficient HR processes
    - E.g., lacking single point of contact, lengthy amount of time before onboarding of new employees
- **(Early) COVID-19 environment**
  - Lack of spoke site demand due to restricted in-person visits
  - Providers passing away from COVID-19
  - Implementation delays due to uptick in cases
  - Loss of interprofessional collaboration

Infrastructure-related Implementation Facilitators

- **Directors' and program office leaders' previous experience providing telehealth services**
  - E.g., familiarity with telehealth service agreements
- **Shared online resources & coaching materials provided by CRH program office**

Planning-related Implementation Facilitator

- **Professional backgrounds and networks of Hub Directors facilitate implementation, adoption of CRH services**
  - Large professional network facilitates contact with site leadership

Key Take-Aways from program office and CRH Director Interviews

- Implementation challenges in common centered around technology, broader lack of awareness in VA about CRH, & allocation of dollars for patient workload
- Both groups had concerns for different reasons about CRH budget/funding

Barriers and Facilitators of National CRH implementation: CRH Primary Care and Mental Health Section Leader Interviews

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Methods: Semi-structured key stakeholder interviews

- Telephone/Teams/Zoom interviews with CRH primary care and mental health section leaders
  - 18 hubs represented
  - 19 PC and 22 MH lead interviews (n=41)
- Conducted 11/30/20 and 8/16/21
- Rapid analysis approach

"On a scale of 1-10, how would you rate implementation?"

Self-rated Implementation Status on 1-10 Scale		
Implementation rating	Primary Care Leads (n=19)	Mental Health Leads (n=22)*
≤4	2	2
5-7	9	8
8-10	8	11
*Note: 1 MH lead didn't provide a rating		

Reasons cited for not being a 10 (highest implementation level)

PC Leads	MH Leads
Some of the newer hubs still growing and building capacity	Not being fully staffed
Lack of awareness of CRH program among facilities	Underutilization of services
Inefficiencies in processes (e.g. hiring, LEAF requests, scheduling)	Still building relationships with spoke sites
Continued expansion of services to catchment areas	Need for increasing productivity & provision of services to different areas
Pandemic-related impacts	
Spoke site concerns	

Implementation Barriers

- **Infrastructure**
  - Need to balance CRH program requirements with local VISN/facility context and/or priorities
- **Planning/Monitoring and Reporting**
  - Perceived need for streamlining processes
  - Increased need for data/metrics
    - Challenges for hub leads to understand how well spoke sites use CRH providers (e.g., panel size) and when/how to withdraw services

Implementation Barriers (cont.)

- **Service delivery - Staffing-related challenges**
  - Recruiting, hiring, credentialing, training and privileging CRH staff
  - Staff turnover and inadequate staffing in spoke sites
  - Administrative staffing and IT support from spoke sites
  - Scheduling and MSA support on CRH and spoke site side
- **Planning - Challenges with CRH program awareness and perception**
  - Lack of awareness of CRH program among potential spoke sites
  - Spoke site concerns

Challenges with CRH program awareness and perception

- Perception that spoke sites were very appreciative of CRH help
- Lack of trust in CRH, perceived threat - need for education/better marketing
  - "Some sites need us but don't want anything to do with us."
- Financial concerns (e.g. spoke sites lose workload credit, VERA dollars)
  - "Spoke sites have been very opposed to the Hub will tell you at every turn that they are stealing from them."

Implementation Facilitators

- **Infrastructure**
  - Community of Practice calls organized by CRH national program office
  - CRH national program office support - site visits, communication, written guidance
- **Planning/Monitoring and Reporting**
  - Data/metrics to understand productivity and care gaps remaining
  - Relationship-building with spoke sites
- **Service delivery**
  - Team building activities among CRH staff
  - Ongoing communication & regular team huddles with spoke site staff
- **Planning - Importance of relationship-building with spoke sites**

Importance of relationship-building with spoke sites

- Existing networks, building new relationships with facility and spoke site leaders important
  - "We took the initiative to reach out, to introduce ourselves to MH leadership and facility leadership throughout the VISN to explain who we are, our role and purpose."
  - "We really emphasize we are there to be a good partner, not there to tell them how to do things, or assess how they are doing things, can offer ideas on what's working in other places, but really just there to be a partner and help support them - it really helps to get them to open up more, make better inroads with them."

Key take-aways from CRH PC and MH Section Leaders

- Increasing awareness of CRH program (e.g. program intention, services offered)
- Better assessment of relationship barriers between CRH hubs and spoke sites
- Streamlining processes (e.g. LEAF)
- Helping hubs adapt CRH national program guidance to local context
- Improving ways to assess data and metrics for provider productivity and provider/patient satisfaction

Summary/Conclusions from First Year Implementation Evaluation

- All hubs met minimum expectations for implementation, with a few achieving full implementation (not expected until Oct 1, 2022)
- Most implementation barriers and facilitators were related to early implementation activities
  - Infrastructure development, planning, monitoring/reporting, service delivery
- Common barriers – aligning recommended structure with VISN needs/priorities, awareness/buy-in of potential "customers"
- Common facilitators – previous telehealth experience, professional networks

Limitations

- VA-specific context may limit generalizability
  - May be applicable to other large integrated healthcare systems seeking to implement a centralized contingency staffing program
- Front-line spoke site provider & staff & patient perspectives missing
  - Future data collection will get frontline perspectives
- Data collected represents snapshot in time during CRH implementation
  - 6 year timeline, qualitative data collection is ongoing

Maintenance/sustainability considerations

- Achieving alignment between CRH program and individual VISN goals/priorities
  - May require more flexibility in program requirements, metric-reporting
- Matching supply with demand, productivity important for demonstrating value to national/VISN leaders
  - Tools/data for anticipating demand, identifying sites with need
  - Timing supply – hiring, training, matching to spoke sites, coordinating across VISNs for unmet spoke site needs

Maintenance/sustainability considerations

- Reducing barriers for spoke site adoption, address spoke site concerns
  - Marketing, educating spoke sites, streamlining process
- Addressing unresolved issues with PACT - may require CRHs to provide more support staff (RNs, MSAs, schedulers)
  - Chronic understaffing
  - Lack of standardized scheduling process

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The views expressed are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs.

Questions?

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