

Using multiple qualitative methods to study changes in care delivery, in-home vaccination, & social isolation of home-based Veterans and caregivers during the COVID-19 pandemic

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Veterans Emergency Management Evaluation Center (VEMEC)



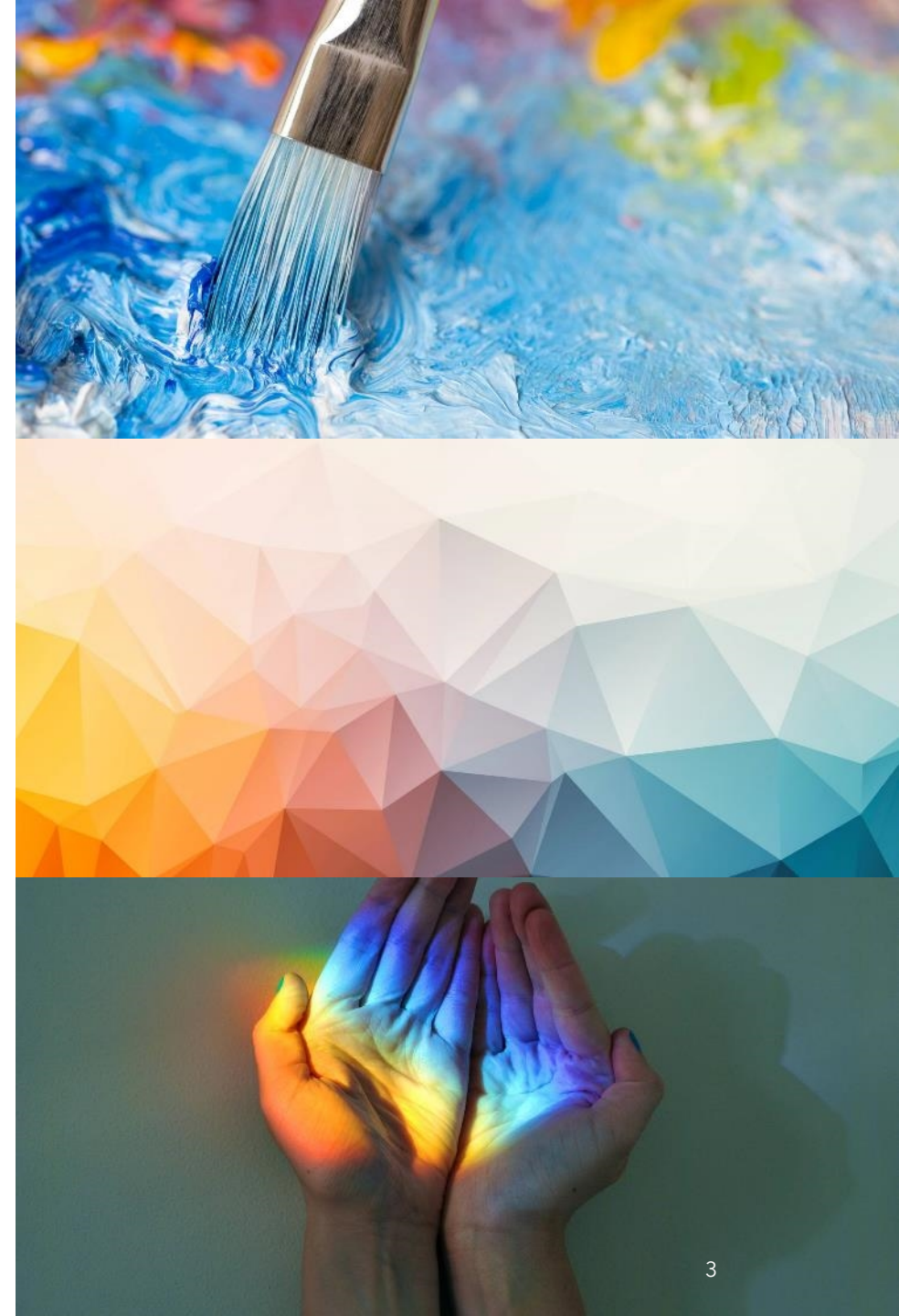
Overview

- Describe our research project studying adaptations in VA home-based care delivery for Veterans during the COVID-19 pandemic & how using multiple qualitative methods allowed us to best answer our research questions
- Explain how we analyzed a large volume of open-ended qualitative data from the national survey we fielded to VA Home Based Primary Care (HBPC) staff
- Explain the qualitative interview study we conducted to gather perspectives from Veterans and caregivers on both changes in care delivery and social isolation

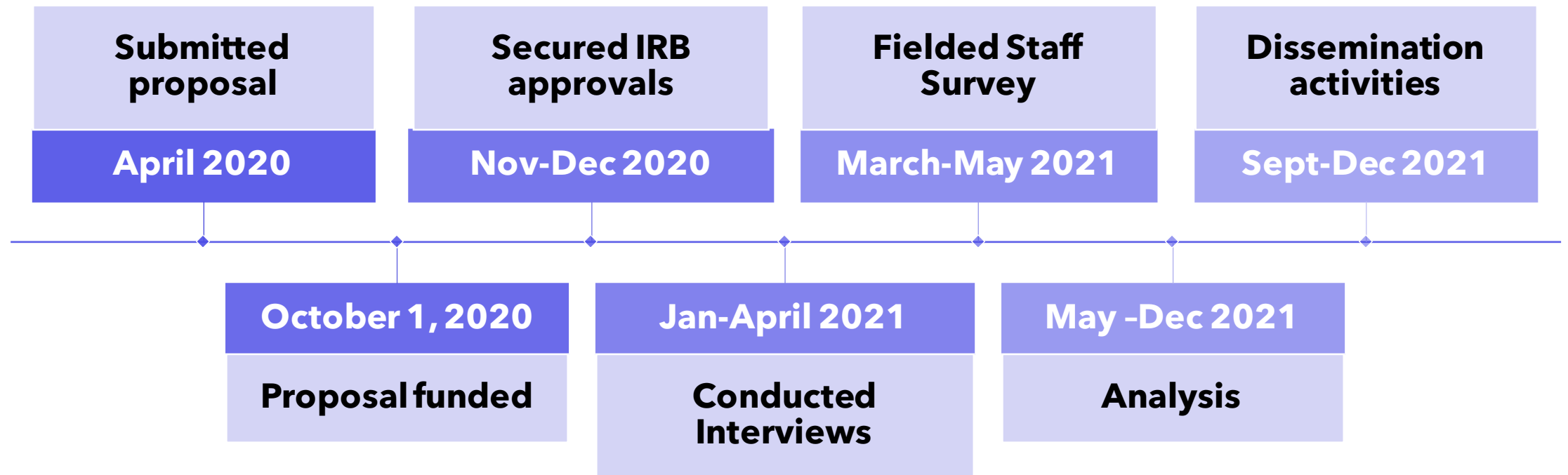


HBPC Background

- The Department of Veterans Affairs (VA) Home Based Primary Care (HBPC) Program provides care to Veterans with complex, chronic, and disabling conditions in Veterans' homes
- Care is provided by interdisciplinary HBPC team members
- VA's HBPC program includes teams based out of 145 VA Medical Centers and cares for about 50,000 Veterans across the United States



Research Study Timeline



**HBPC Staff
Experiences**

**HBPC
care
during
COVID**

**HBPC
Veterans'
& Caregivers'
Experiences**

Research Objectives & Targeted Methods

1. Describe changes in HBPC care delivery during the pandemic as experienced by HBPC staff

- Wanted to invite all HBPC programs from all VA Medical Centers to respond (~145 nationally), so one-on-one interviews not feasible
- In fall 2020, began designing a **national survey** including both **open** and **closed-ended questions**
- Allowed for collection of open-ended qual data & descriptive quant stats

2. Describe how Veterans & their caregivers adapted to changes in care delivery and explain how they managed increased social isolation due to the pandemic

- Targeted scope for study sample, recruiting from 8 HBPC programs we had previously studied
- Designed interview guides to conduct **semi-structured phone interviews** with Veterans & caregivers

The Survey

Survey Data Collection

- Designed survey in RedCap
- Pilot tested survey at two HBPC sites, with a total four HBPC team members
- Fielded survey from March-May 2021 via HBPC program directors and directly sending to staff lists provided by program directors
- **N=573** completed from **over 72 HBPC programs** and respondents from over **13 different roles**



What to do with all this survey data?

Describe experiences discussing the COVID-19 vaccine with HBPC Veterans & their caregivers & providing it to Veterans

Describe demographic data of VA staff survey respondents & telemedicine utilization patterns

Describe telemedicine use, changes in care delivery, & VA staff's experiences providing care during the pandemic

Analytic Approach to Survey Data

Thematic analysis of vaccine data

- Three survey questions focused on vaccines
- Five study team members analyzed these data line-by-line using Atlas.ti
- Mostly inductive approach
- Developed themes from this analysis

Descriptive Frequencies

- Demographic data
- Telemedicine utilization patterns
- One quant analyst led these analyses w/ one Co-I, interpreted findings with five team members

Thematic analysis of telemedicine and care provision data

- 13 Telemedicine open-ended questions
- 11 care provision open-ended questions
- Five team members analyzed these data using Atlas.ti
- Mostly inductive approach
- Six team members developed themes from analysis

Learning Curve: Preparing qual survey data to be analyzed in Atlas.ti

Began with Vaccine Data

- Exported data from RedCap into MS Excel
- Must assign appropriate syntax in Excel column heading *as a prefix* to communicate correctly with Atlas.ti
 - For example, using a colon before the label in the column header like this **:Site Name** tells Atlas that data in that column indicates the name of the site that respondent was from
- Spreadsheet must be all prepped prior to importing data into Atlas.ti
 - From the RedCap output, prepare spreadsheet to include only the questions you want imported for the Atlas analysis
- Each row in Excel becomes a unique document in Atlas

Learning Curve: Preparing qual survey data to be analyzed in Atlas.ti

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- Using the syntax `::` allows for deductive codes to be assigned automatically to data in that column
 - For example, the text before `::` in the column header becomes the code name, and the text after the `::` becomes the code definition or in our case, survey question
 - Example:**
overall experience discussing vaccine::Please share your overall experience discussing the Covid-19 vaccine with your Veterans and/or their caregivers.
- Once syntax is assigned to appropriate column headers, we imported data from excel into Atlas.ti

!Rec_id	<RecdCap Project:Site	overall experience discussing vaccine::Please share your overall experience discussing the Covid-19 vaccine with your Veterans and/or their caregivers.	facilitators & barriers providing & accessing vaccine::Please describe any facilitators and/or barriers to providing or accessing the Covid-19 vaccine for your Veterans.	Role::What is your role on the HBPC Team?
101	Hollywood	It was very hard at first	transportation challenges	Producer

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Code Definition

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	<R				
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_id	ct	:Site	caregivers.		
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Syntax: turns cell value into a group in Atlas.ti

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Syntax `<` column is ignored in Atlas.ti import

Learning Curve: Preparing qual survey data to be analyzed in Atlas.ti

Began with Vaccine Data

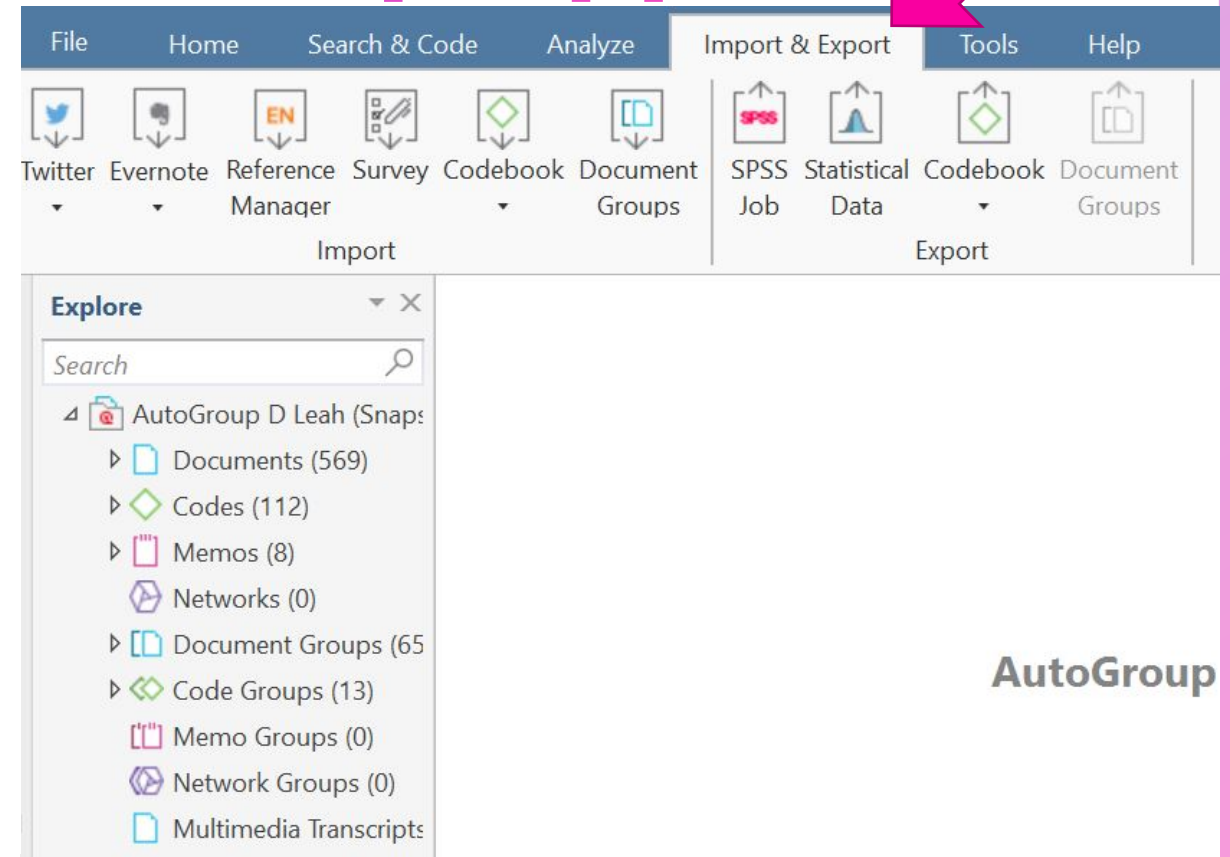
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Syntax ! Data in cells is used as document name in Atlas.ti

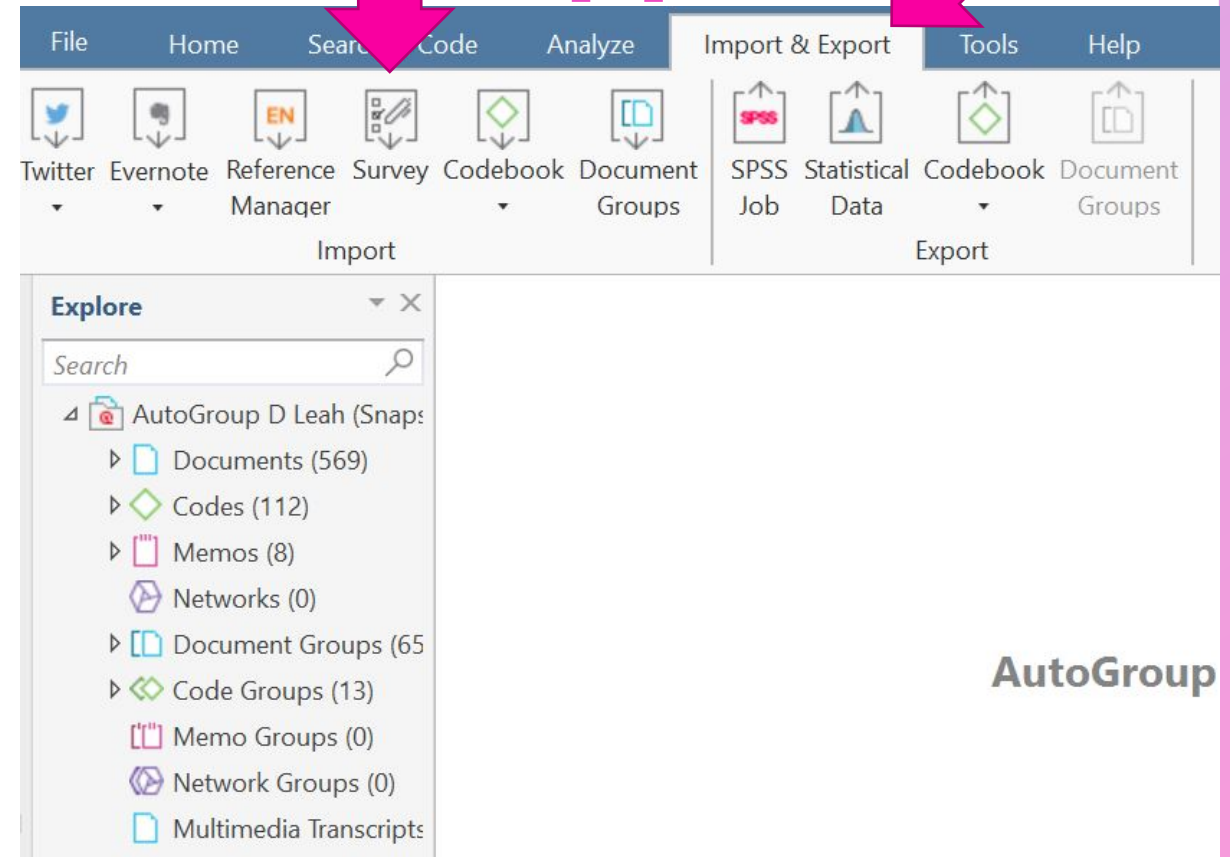
Steps for Importing Survey Data into Atlas once spreadsheet is prepped

1. Create a new project in atlas
2. Select the **Import & Export** tab and then the **Survey** button
3. Select the Excel file to be imported and click **Open**; **the Excel file must be closed in order to import it**
4. The import procedure starts
5. You see a progress report and ATLAS.ti informs you when the import is finished
6. Check the Document Manager to see how Atlas sorted Document Groups, document names
7. Check the code manager to check codes from Survey import



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Atlas lessons learned

Atlas Challenges

- Even though survey data is much less voluminous than long interview transcripts, the more records the harder time Atlas has; ended up grouping data in batches of <100

Prepare Excel Spreadsheet in advance & Check on your imported data

- Do some trial runs first to ensure the data is prepared correctly and imported correctly

One data manager to handle merging data

- The analyst who first imports the Excel document should be assigned to be the data master

Inductive Coding Process: wrangling the vaccine data

- **Methodologist selected data from two HBPC sites for five team members to code independently**
- **Met over a series of five meetings to reach consensus on coding and code definitions**
- **Three team members divided the remaining survey responses and coded them independently**
- **Met regularly with full team from May-July 2021 to discuss codes and code definitions and develop themes with the other two team members**
- **Potential data queries and theme development born out of team discussions and insights from methodologist who queried data for team members to closely review**

Three themes emerged around discussing & delivering the COVID-19 vaccine

- Vaccine communication & education
- Advocating for prioritizing HBPC Veterans' Vaccinations
- Logistics of delivering & administering the vaccine





OK great, but what about all that other data?

*Don't worry we have more to
share!*

What to do with all this survey data?

Telemedicine Use & Care Delivery Data

Many possible approaches to organize data to make sense of it and answer our RQs;

We divided respondents into telemedicine use groups based on their responses

- **Grouped respondents based on types of visits they reported using telemedicine: Admission/Intake, Follow-Up Care, Wellness Checks**
- **High utilizers** (n=86):
 - **TELEPHONE**: checked yes for **all** three types of care
 - **VIDEO**: checked yes for **all** three types of care
- **Low utilizers** (n=61):
 - **TELEPHONE**: checked **one, two, or three** types of care
 - **VIDEO**: checked NO
- **“No” utilizers** (n=62)
 - **TELEPHONE**: checked NO
 - **VIDEO**: checked NO
 - Respondents in the “no utilizer” group presented with irregularities in their responses and were therefore not included in the final utilizer group quantitative analyses

Inductive Coding Process: wrangling the telemedicine & care delivery data

- Separate Excel spreadsheets were prepared for Atlas import for the high, low, and no groups
- One data manager/master created separate Atlas projects for the High, Low, and No groups and imported the Excel data
- Three analysts coded 15 records independently across three different HBPC staff roles and then met over a series of three meetings to reach consensus on inductive coding and code definitions
- Divided the remaining survey responses and three analysts coded them independently
- Met regularly with remaining team to discuss codes and code definitions and develop themes with the other two team members
- Potential data queries and theme development born out of team discussions and insights from methodologist & analysts who queried data for team members to closely review

What about the rest of the survey data? Telemedicine Use & Care Delivery Data

Middle Utilization Group (n=364)

- We still had 364 respondents in the middle group
- Because of the high volume of data, decided to randomly sample for analysis
- Co-I randomly selected every other record & quant analyst created a spreadsheet of randomly selected respondents (n= 153)
- Qual analysts prepared spreadsheet for ATLAS.ti import as earlier explained
 - Same process was used to prepare spreadsheets for the high, low, and no use groups (removing unnecessary columns, checking syntax)
 - Yes, this means that we had several different Atlas projects—organization is KEY! As is the Atlas data master/manager
- Middle group broken into two Atlas projects of (n=77 and n=76) to prevent Atlas.ti from crashing
- Spreadsheets were imported into ATLAS.ti and created project bundles for team
- **Imported the inductive code list from the high/low user groups**

Inductive Coding Process: wrangling the telemedicine use & care delivery data

- Since the team had already reached consensus on coding the high, low, and no groups, there was no need for more consensus on the middle group data
- Three analysts coded the N=153 middle group responses
- Potential data queries and theme development born out of team discussions and insights from methodologist who queried data for team members to closely review
- Began querying data to answer question on describing care delivery changes during pandemic
- Early themes emerging:
 - Explain how teams adapted to deliver safe care in home; including role of leadership
 - Examples of Teamwork and Communication
 - Perspectives on ability of Vets & Caregivers to use TH for visits
 - Positive and sustained changes to care delivery influenced by pandemic
 - Value of HBPC
 - Finalizing themes to begin writing manuscript currently



I thought you also mentioned Descriptive Frequencies

*Oh yes, we have lots for you on
that!*

Managing the quantitative data

- **Quantitative analyst downloaded .csv file from RedCap in three groups**
 - **Data from the individual links**
 - **Data from the surveys sent out directly by the Program Directors to their staff**
 - **Data from remaining stragglers**
- **Data was combined into a single .csv file, imported into Stata, and cleaned**
- **Simple descriptive statistics including percentages were calculated**
- **Bivariate analyses (i.e., McNemar tests) were conducted to test differences among groups.**

Demographics

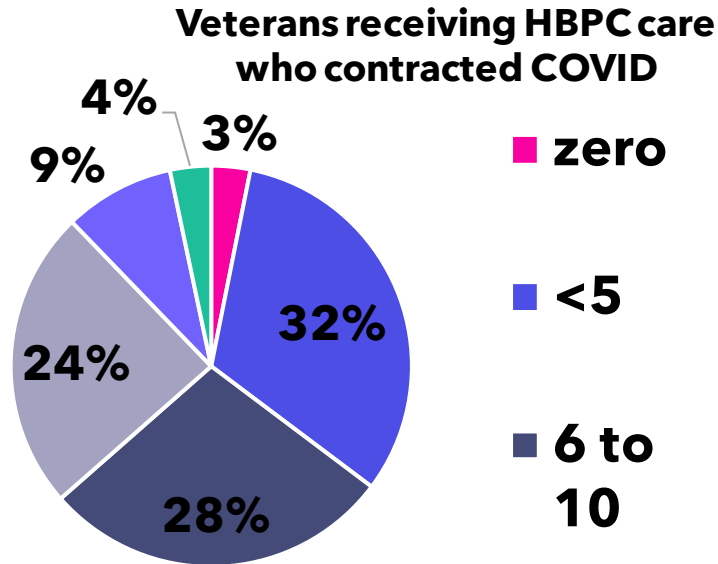
# of participating sites	
# of respondents	# of sites
≥ 20	2
15 to 19	6
10 to 14	16
5 to 9	15
2 to 4	13
1	20
Mental Health (MH) survey*	36*

***Of the 51 MH surveys, for all but 36 we were able to identify site**

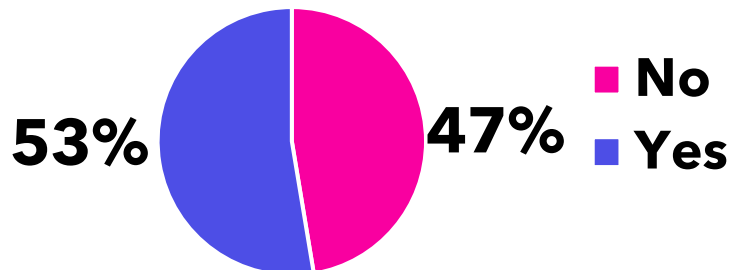
Participating Team Member Roles

Role	n	% of Respondents
Nurse	176	31%
Primary Care Provider	82	14%
Psychologist	77	13%
Social Worker	61	11%
Rehab	47	8%
Dietician	40	7%
Program Director	21	4%
Pharmacist	19	3%
Medical Director	12	2%
Other	12	2%
Unidentified	26	5%

Veteran Care and COVID-19



HBPC team members who personally cared for HBPC Veterans who contracted COVID



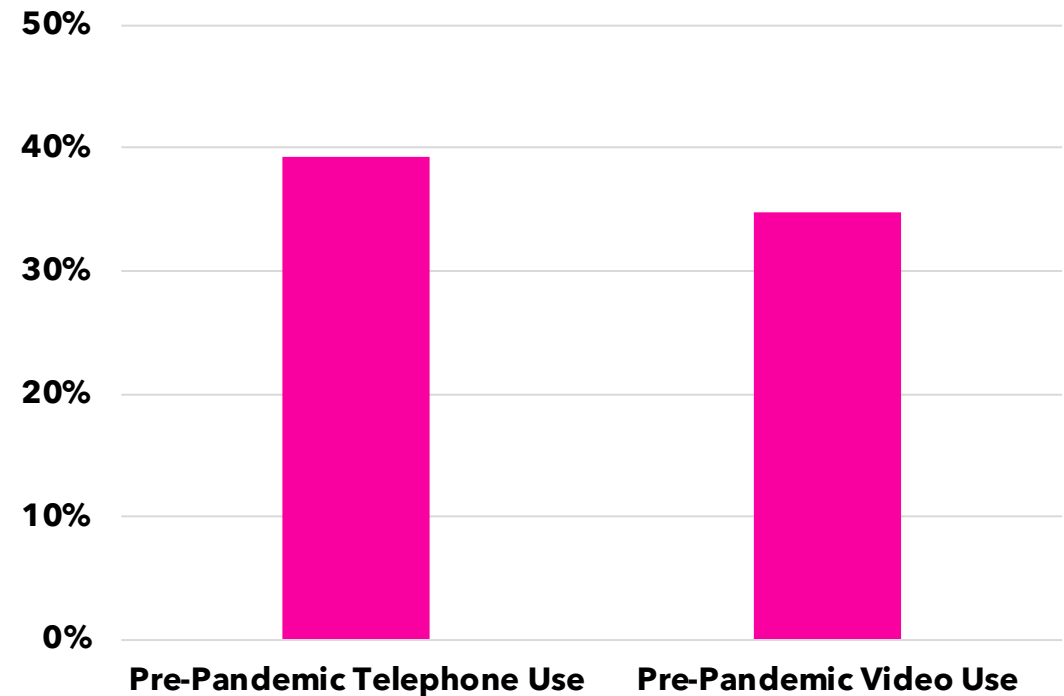
	TM Use - NO	TM Use - YES	Total
Care for Vet with COVID NO	n = 34 (13%)	n = 237 (87%)	n = 271 (47%)
Care for Vet with COVID YES	n = 12 (4%)	n = 288* (96%)	n = 301 (53%)
Total	n = 46 (8%)	n = 526 (92%)	

*p<0.001

➤ HBPC team members who cared for Veterans w/COVID-19 had a higher % of telemedicine (TM) use during pandemic

Pre-Pandemic Telemedicine Use

- **46% indicated telemedicine use in HBPC work, *pre-pandemic***



Pandemic Telemedicine Use

n = 526 (92%) indicated telemedicine use in HBPC work *during* the pandemic

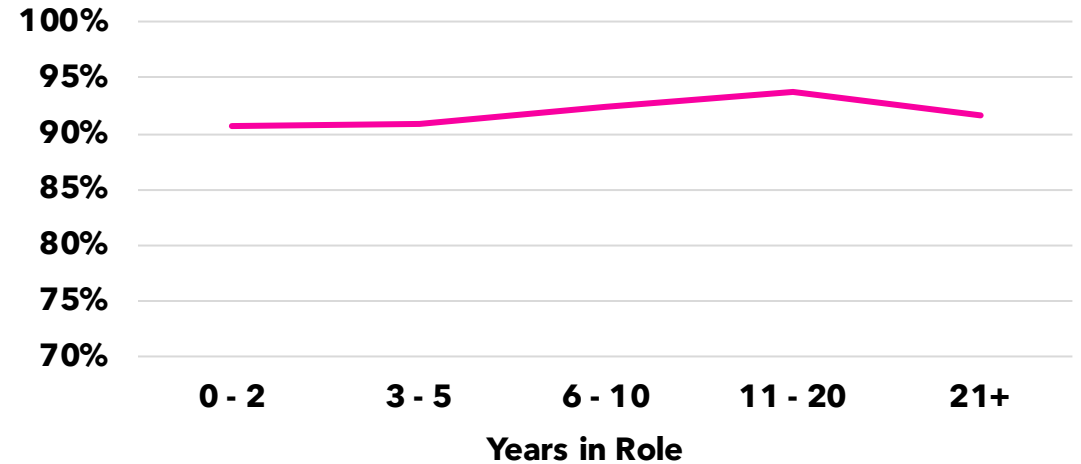
- **7 of 9 roles > 90% adoption of TM use**
- **< 65% adoption in the Program Director category**
 - **expected due to administrative role**

Role	n	% within in Role
Nurse	155	88%
Primary Care Provider	78	95%
Psychologist	77	100%
Social Worker	57	93%
Rehab	46	98%
Dietician	40	100%
Pharmacist	18	95%
Program Director	13	62%
Medical Director	11	92%

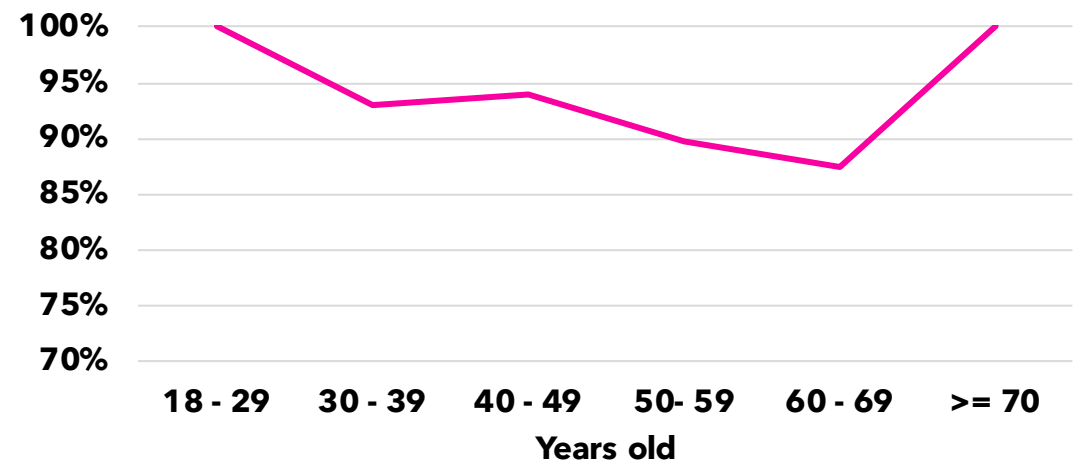
Pandemic Telemedicine Use

***“Use of telehealth is wonderful and, as I am retiring soon, I thought I would NEVER provide that type of format to my Clients”
- Psychologist***

% within Length in Role



% within Age



Pandemic Telemedicine Modality

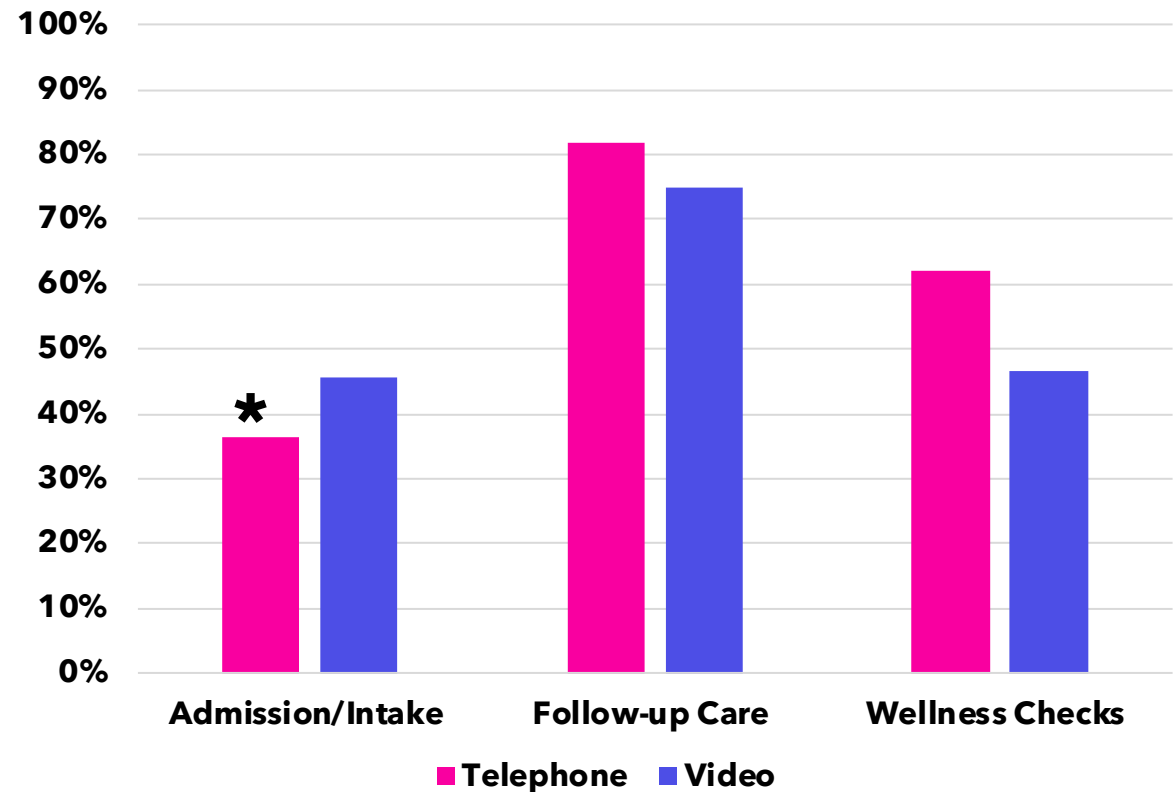
- Within the clinical team, primary care providers and nurses had lower adoption of telephone
- There was more variability among roles in adoption of video

Role	TELEPHONE % within in Role	VIDEO % within in Role
Psychologist	100%	96%
Dietician	100%	100%
Rehab	96%	85%
Pharmacist	95%	68%
Social Worker	93%	82%
Primary Care Provider	87%	89%
Medical Director	83%	67%
Nurse	83%	72%
Program Director	57%	52%

Pandemic Telemedicine Modality by Activity

"For the Veterans who can manage the tech...using this approach can increase accessibility for repeat visits. I still prefer initial assessments/testing to be done in person to capture the environment and use measures in a valid manner."

- Psychologist



* $p < 0.001$

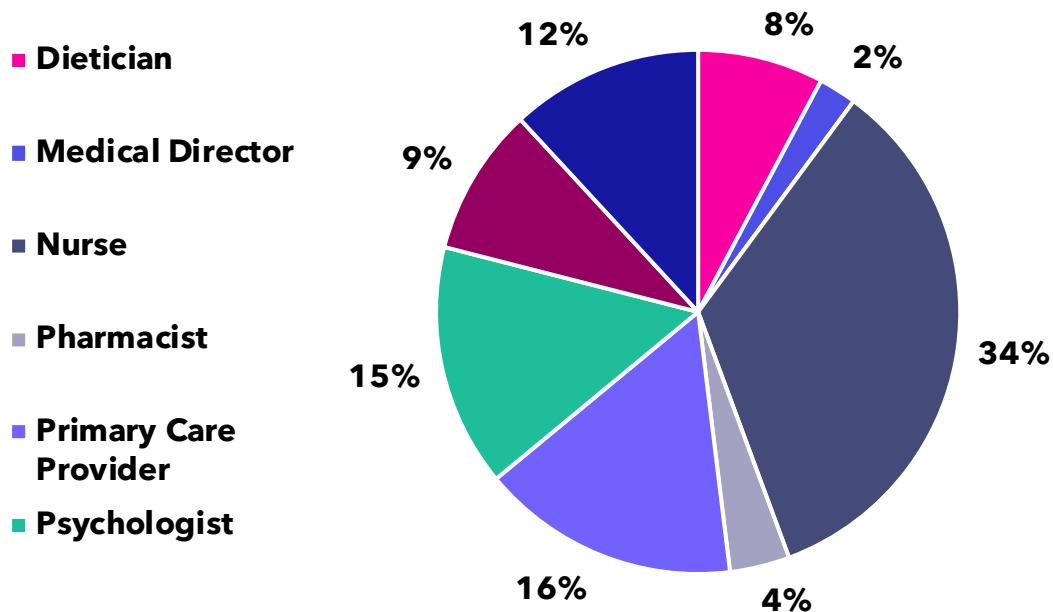
Pandemic Telemedicine High Utilizer Group (n=86)

DEFINITION OF TYPE OF USE

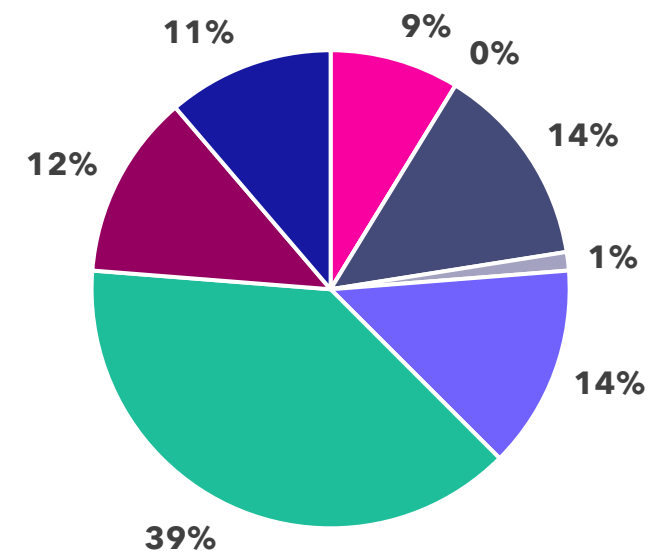
(Admission/Intake, Follow-Up Care, Wellness Checks)

- TELEPHONE: checked **all** three types
- VIDEO: checked **all** three types

Clinical Team (Full Sample)



Clinical Team (High Utilizer)



Benefits of HBPC Telemedicine

only make home face to face visits if deemed essential going forward - RN

VVC, CVT [clinical video telehealth] has been beneficial, and I would like to see utilized to supplement in-person visits. Patients have adjusted to it and PCP can get quite a bit of information quickly, to make treatment decisions. - NP

I didn't think the VOD [video on demand] would work. I now believe it will. I know it won't work for everyone but today I have to drive 2 hours to enroll new clients (4 hours - 2 there and 2 back) once I get them hooked into VOD life will be easier. - Psychologist

VVC [VA Video Connect] is great for the patients! especially our lonely ones and just in general to confirm correct med admin technique and confirm education - Pharmacist

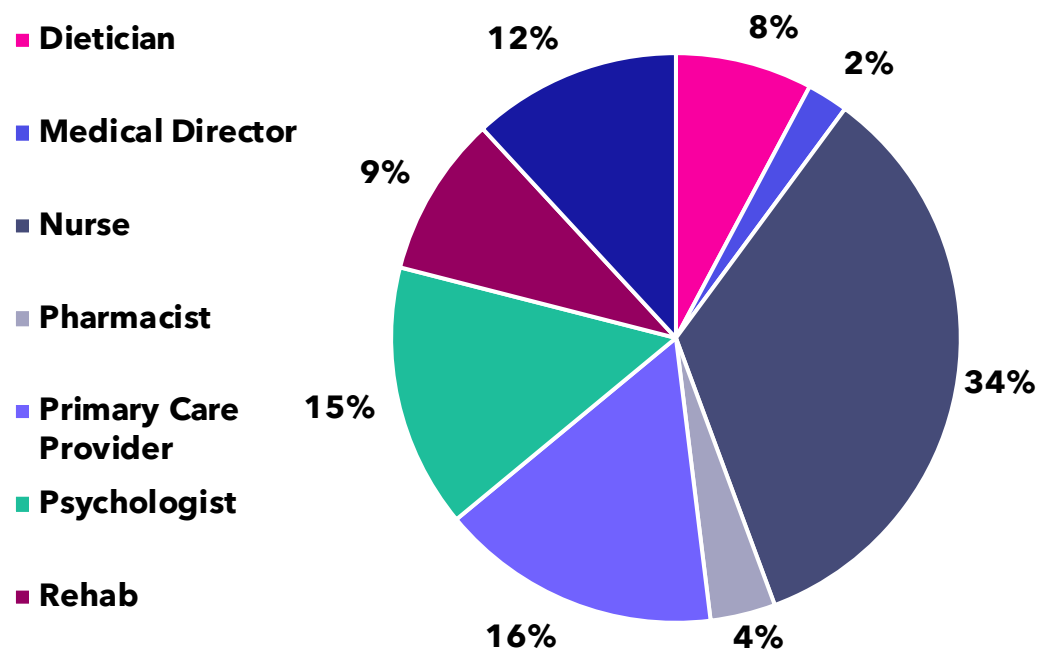
Pandemic Telemedicine Low Utilizer Group (n=61)

DEFINITION OF TYPE OF USE

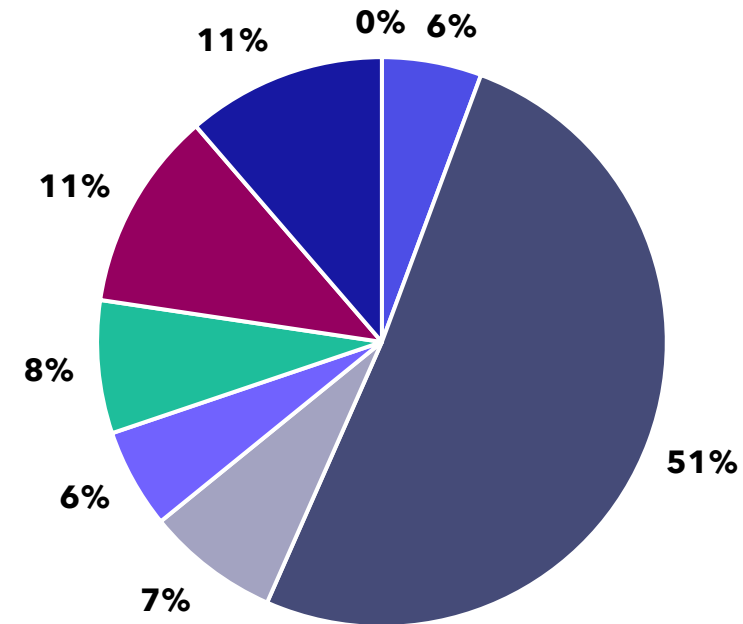
(Admission/Intake, Follow-Up Care, Wellness Checks)

- TELEPHONE: checked **one, two, or three** types
- VIDEO: checked **NO**

Clinical Team (Full Sample)




Clinical Team (Low Utilizer)



Barriers to HBPC Telemedicine Adoption

My feelings have not changed since pandemic and feel like the Veterans enjoy having staff in home vs. telephone or computer. I also would rather see my Veterans in person. HBPC is geared to have a in person relationship and Veterans deserve to feel comfortable to communicate to their team and have in home visit if they wish. If a Veteran does not want staff in home during the pandemic they should get that option but should be dc'd to PACT [Patient Aligned Care] team if they continue to decline home visits after pandemic is over. - RN

**"[The pandemic] has just reminded me how much value there is in HBPC and in providing care in Veteran's homes. Building a relationship with our patients and being able to fully assess needs and potential needs is greatly enhanced by home visits."
- Social Worker**



**Didn't you say
you also did a
qualitative
interview
based study?**

Oh yes, let's get to that!

Study Design & Data Collection

- **Qualitative study conducting phone interviews with Veterans and/or their Caregivers**
- **Interviews conducted between December 2020 & April 2021 by three researchers**
- **Recruited from 8 HBPC teams across the U.S.**
- **Selected these teams as we had studied these teams previously**
- **Conducted N=35 interviews w/ N=43 participants**
- **N=8 were dyads (22.8%)**



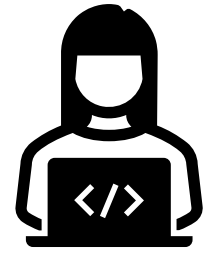
Participant Breakdown by Site

Veterans average age 78; 88% male

Caregivers average age 62

	#	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
Total	43	7	9	8	6	3	1	7	2
Veterans	27	5	4	5	3	1	1	6	2
Caregivers	16	2	5	3	3	2	0	1	0
Dyads	8	0	3	2	1	1	0	1	0

Analytic Approach



- **Deductive and inductive content analysis leading to theme development**
- **Weekly team meetings January 2021-May 2021 to discuss interviews, emergent codes, edit interview guide**
- **Recorded & transcribed interviews, uploaded to Atlas.ti, four researchers coded data line-by-line**
- **Weekly team meetings May – August 2021 to discuss analytic process and develop themes to answer research questions**

Findings

- **5 themes emerged addressing how VA HBPC Veterans & caregivers managed increased social isolation during the COVID-19 pandemic**



Findings

- Normalizing challenges brought on by the pandemic & looking forward to it passing

“...accepting that it [social isolation] is a normal part of dealing with a pandemic... and just knowing that eventually this will pass” –Caregiver

“...it's the same for everybody else. They can't do it [be more sociable] either. So, I just go with it. I don't complain.” –Veteran

Findings

- Caregivers had a harder time managing isolation than Veterans. Veterans used to being primarily homebound; Caregivers worried about exposing Veterans to COVID, also caregivers relied on HBPC team members for support

**“I have a system in the garage, I have boxes and I have the kids put the food in the boxes, and I wipe them--I don't know if it works or not, but I just want to try to make sure that we take every precaution that we can”
–Caregiver**

**“...I have felt extremely alone. I felt more depressed. I had to see my psychologist for, well, psychiatrist for more antidepressants. I feel like the house is falling in on me. It's so constrictive of a world. But I don't think [Veteran-spouse] has those feelings.”
–Caregiver**

Findings

- Veterans & caregivers relied heavily on social support of family as well as neighbors/friends for social support

P1: “We see her [their daughter] or talk to her every day.”

I: Great. But have you seen her face-to-face during COVID?

P1: “Oh, yeah. Most of the time, she goes to the grocery store for us and does all the errands that she can for us to keep us away from different people because of [Veteran’s] health.”–Caregiver

“What’s happened now [the pandemic], is going to continue in various fashions, in different times, in the future. So, I guess I would say the biggest lesson I’ve learned is how important family is, at a time like this... I love my kids. I love my grandchildren. They’re the greatest things in the world. And I’ve always had that feeling within myself. I mean, they’re the closest things in my heart. Now, more important than they had been, previously.”

–Veteran

Findings

- **Care setting mattered:** Those living in their own homes managed isolation better than those living in assisted living facilities (ALFs), who had more pronounced isolation & day to day changes. Those at home also had more visits from HBPC staff and some home health aides.


**“Don't forget we're on restriction here as far as people being able to visit now...I mean...We've got serious COVID-19 problems here... In this residence facility, there have been a lot of people that have passed on, that have died.”—
Veteran in ALF**

**“I've got four walls, and I get to walk to and from my bathroom and to and from my bed. And most of the day, I sit here in front of a 50-inch television in my recliner...You can't believe going through this isolation.”
—Veteran in ALF**

Findings

- Veterans and caregivers were very creative with activities they did during increased periods of pandemic-influenced isolation

- Play cards on the computer
- Learned to play online Video games with family
- Instant Messenger
- Marco Polo video apps
- Facebook
- Virtual Zoom Bingo
- Long car rides
- Family visits, masked, with pets



“One of the things that we are doing differently, because they all used to go in the room and visit with [Veteran] at times, but one of the things that we do different now is I have this app on my phone that's called Marco Polo. Everybody in my family has it. So, we send each other messages so he's able to hear their voices.” –Caregiver

Implications

- **Older homebound Veterans & their caregivers with stronger social networks & previously curated social capital drew upon that to manage isolation & by normalizing COVID, while those with less familial social support & those who lived in ALFs had a harder time managing isolation**
- **Lessons learned can inform community programs, health care systems, and policy makers to create supportive programs and policies for older adults and caregivers especially those with smaller social support networks and those living in ALFs**

Project Team

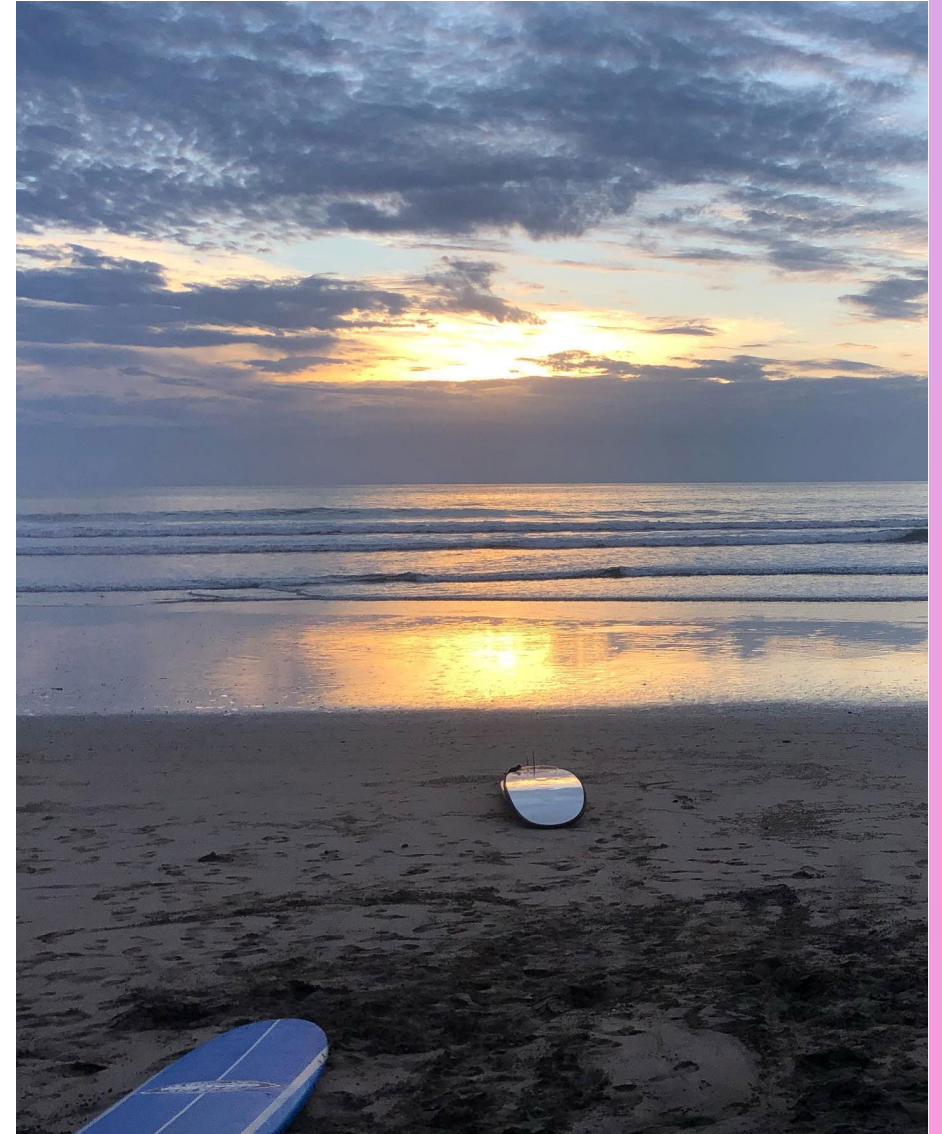
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Thank you! Questions?

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