Moderator: The next speaker is LeChauncy Woodard. LeChauncey is an internist and investigator at the Houston COIN and she has an interest in multi-morbidity and quality of care disparities.

LeChauncy Woodard: Thank you so much. I’m really excited to be here to share some of the work that we’ve done as a part of part of our Houston PACT CREATE project. I’m a health services researcher and also a general internist at the Michael E DeBakey VA Medical Center out of Houston COIN and Baylor College of Medicine. So this project was really exciting for me because it was an opportunity to use our research to engage clinicians and patients more fully in our care. So I’m excited to share some of this work with you today.

I’d like to start by thanking the VA for their generous support of this work. This work was funded through the VA’s CREATE mechanism and it’s one project of four as part of our Houston PACT CREATE. And so our team was pretty extensive and overall CREATE, which is all four projects together, was led by Laura Petersen. Our research team for this project is Lucy Bayer [PH]. And as important as our research team was our VISN 12 collaborators. So we had co-investigators and Dr Praveen Mehta who’s the CMO of VISN 12. And Drs Brian Hertz and Howard Gordon who are our local site investigators and really served as champions for this project. And then our clinical partners who spread across the sites that implemented this intervention.

So as background, if all of you are aware, diabetes is a highly prevalent, chronic condition affecting 25 per cent of VA users. And vascular complications from uncontrolled diabetes are a significant source of morbidity and mortality in this patient population.

Self-management skills are particularly critical for this patient population in helping to control their diabetes. And goal setting and action planning are actually recognized as best practices by the American Diabetes Association. But oftentimes in primary care it’s difficult for us to support and train patients in self-management because we’re faced with time constraints for visits. And oftentimes care providers have limited training in behavioral coaching. And so the PACT model is really uniquely situated to address some of these challenges that we find, particularly because we have the support of many clinicians from diverse backgrounds to help us with these patients and to help us with the complex care management issues that we have.

So all of you I’m sure are aware of our PACT structure in the VA. I’d like to highlight that for this project as we worked with our partners, the providers who became our clinicians to deliver the intervention were actually our providers from nutrition, pharmacy, and behavioral health. So these were great colleagues who participated in this intervention and who actually, I mean actually if you ask me, I’m a physician but I think who were actually more skilled in motivational interviewing and behavioral health coaching and so really helped to make this intervention a success.

So our goal was to adapt the EPIC intervention for implementation into routine primary care workflows within PACT and also to examine the success of implementation and the intervention’s effectiveness at improving diabetes control and reducing diabetes distress in patients who have persistently uncontrolled diabetes.

As background EPIC intervention was actually first developed and studied in Houston by the co-PI on this study Dr Aanand Naik. And the intervention at that time was a four-session intervention that was delivered pre-PACT, so 2009 was pre-PACT, by researchers. And at that time the intervention did show effectiveness in lowering hemoglobin A1C and reducing diabetes distress and improving self-efficacy among patients who had diabetes.

But at 12 months we did start to see some regression to the mean. So our goal in implementing this inter-routine PACT care was to hopefully be able to sustain those improvements that we saw.

We conducted a hybrid implementation effectiveness study and this slide just gives you an overview of the different steps that we went through really in implementing this project. And so I’ll go through each of these individually.

Our formative evaluation: We conducted a formative evaluation with 33 key stakeholders ranging from frontline clinicians all the way to facility leadership and everything in between to get an idea of how we could best implement this intervention and what modifications we needed to make in order to make this intervention be successfully implemented into routine primary care.

So you’ll see some of the things that we changed listed here, I apologize for the small font, but from our collaborators we found that a group medical appointment or shared medical appointment was the best way for us to implement the intervention to be able to have all of the staff work together, and also to be able to obtain workload credit for our providers.

We were able to offer a continuing education unit, I heard you mention that. I think that really enhanced the value to our clinicians who underwent the training in the EPIC protocol. And we ensured that we involved clinicians who had expertise with diabetes management. As I mentioned it was really our nutritionists, our pharmacists, and our HPDP specialists who worked with us.

We were able to develop a recruitment script, and we got this feedback really from our collaborators in VISN 12 who really allowed Veterans to feel like not only were they helping themselves but they were helping and supporting their fellow Veterans, which was important to them.

We expanded our EPIC intervention from four to six sessions. Part of the feedback we got from Jesse Brown was that they felt like the level of the intervention was maybe a little too high to be delivered over four sessions with the literacy of their more inner city patient population. So they asked that we expand the intervention to six sessions and we incorporated adaptations to address low health literacy.

And then really importantly was that we were able to align with some of the strategic priorities that were going on in VISN 12s. So they have a very big initiative focused on personalized goal setting and patients who have diabetes. And so this fit very well with what they were doing in addition to the work that they’re doing with the whole health initiative. So this aligned really nicely with that.

In addition, Dr Howard Gordon had developed a Speak Up video, which is aimed at improving patient provider communication. And so we were able to use that Speak Up video, which was actually funded in a prior HSR&D study as a part of our session that addressed this provider-patient communication.

So this is ultimately what the EPIC intervention ended up looking like. It was six sessions. As you’ll see, really diabetes education is a small part of this intervention so it really was complementary to diabetes education. And that’s important because when we came in, some of the people who did diabetes education really felt like we might be stepping on their toes a bit. And so it was important for us in getting buy-in to be able to explain that this was really synergistic with what they were doing.

So only session two really focused on the diabetes ABCs, the rest of the sessions were really around collaborative goal setting and action planning. And so participants of five to eight Veterans went through the intervention together over a three-month period. The sessions were about every other week. And they had the group session followed by individualized one-on-one coaching with one of the clinicians who were a part of the larger group.

At the same time that we’re doing the formative evaluation, it was really important that we also obtain local site engagement. And I will say this actually started very early on. So as part of our development of our CREATE proposal, we worked with VISN 12 from the very beginning. I will say though, with the timeline to research funding, some of that initial work that we had done, you know, when we came back it was like, what project is this? I remember that. So there was a lot of work to do also to really build up that local engagement.

So this really happened concurrently with us doing our formative evaluation. And so we worked with our local site investigators to facilitate introductions. Importantly, if we were going to engage pharmacy in our intervention, oftentimes we had to go and talk to pharmacy leadership and say, “How does this work within the work constraints that your pharmacists have?” So they helped to facilitate those introductions. They helped us to establish multi-level partnerships. So again we were working with clinicians, sort of the mid-level leadership, and also facility leadership.

And this also helped us to identify the synergy that we talked about with ongoing efforts and then to navigate local challenges. One being, like I said, sometimes there was that feeling that we might be coming in to do something because maybe there was a thought that their diabetes education wasn’t working, when it really wasn’t that at all. This was something that was there to complement what they were doing.

Then we had to identify the staff to deliver the intervention. So we had figured out sort of what the best complement of staff were but then we had to find staff that were interested. So fortunately with the help of our site investigators and champions, they helped us to reach out to different staff. We had lots of meetings, lots and lots of meetings to talk to people, explain what the intervention was, how this could potentially fit within their routine workflows, what they needed from us to help make this successful. And so that bi-directional communication I think was really helpful.

Every group had a prescriber. It was really important so that if patients had an issue with medication there was somebody who could address that. Our prescriber was typically a pharmacist but for one group it was a nurse practitioner. And then there were two to four coaches, and so the other coaches were again dietician or nurses or psychologists.

Then we had to do logistics. Just a few things of many, we got a CU accreditation from EES. We created local clinic grids. This was really important because it afforded the clinician to work on this intervention to get workload credit. That was a big deal. They had to be able to show productivity from participating in this. And then it also allowed us to retain the research standing for Veterans so that they weren’t charged co-pays for participating in this. And then finally it triggered the regular appointment reminders systems so these Veterans, because this was a part of routine primary care and there was a clinic, appointment made, they got regular appointment reminders to come in for the EPIC sessions.

We think that reserving space is a simple thing to do, it often was not. A lot of our VAs, they’re space challenged including our Houston VA, particularly in primary care. So some of our sites you saw were CBOCs. It was a lot easier in CBOCs to get space than it was at the parent facilities. And then coordinating things like phlebotomy. So we didn’t think about this but we had an introductory meeting and so patients would come in and we needed to check their baseline hemoglobin A1C. Well, we sent all the patients who came in to that meeting to the lab, the lab was like, “Whoa, this is too many people coming in.” So we had to work with them to come up with a schedule of how this could work with them. So just different things that we encountered along the way that we had to work through.

And then finally, after we conducted the intervention, we’ve now done all of our sessions, we’ve done a summative evaluation, actually we’re in the progress of doing a summative evaluation, so we successfully enrolled 280 Veterans who had a hemoglobin A1C of greater than or equal to eight over the six months prior to recruitment. We conducted 25 EPIC cohorts and they were recruited from July 2015 to April 2017. And the bottom just shows you the participants were subjects. The bottom shows you the different disciplines that our clinicians came from.

And so quickly, our summative evaluation has involved exit interviews with our patients, qualitative interviews with our clinicians, and then an analysis of cross-facility calls. So we did cross-facility calls every three months and it allowed the teams that were doing this to share best practices but also to problem solve among themselves which was actually typically more effective than with us, but also to problem solve with us.

And so quickly I’ll go through the results. The Veteran experience with EPIC was generally positive with Veterans reporting 3.7 out of 4 in overall satisfaction.

Themes that we got from our interviews thus far is that it enhanced learning and peer support, increased self-efficacy with setting self-management goals, provided individualized patient-centered care that sometimes they weren’t able to get because of the time constraints of routine visits and also the many different competing demands. And then it was synergistic with other VA diabetes management activities. So we had one patient who was doing MOVE at the same time and he felt like these worked really well together. And patients uniformly said it helped them to take more responsibility for their diabetes care.

Our clinicians were also positive. Of course, again there’s always working within their time constraints but overall clinicians who participated were very positive. They felt that the Veterans were eager to learn and be coached. They felt that EPIC facilitated satisfying collaborations with each other, which was really important. And they endorsed the culture change towards really working more in alignment with what the goals of PACT are.

So we learned that aligning our research with the priorities of VISN 12, our operational and clinical partners was very important, that clinicians thought and wanted specific opportunities to experience and develop expertise with the transformational elements of PACT, and that EPIC facilitated enhanced engagement and collaboration among clinicians, and that these sorts of interventions really can facilitate a cultural change towards PACT, improve and plan Veteran engagement and improve satisfaction.

So with that I’ll stop and I’m happy to take any questions.

[Applause.]

Unidentified male: We have time for a quick question if there is anything? You know, one thing that occurs to me in these programs is maybe an evolving role of healthcare providers as we have more and more medical decision supports and technologies that can facilitate the diagnosis and treatment of patients, is there a role for more of the interpretation and interaction with patients? And how do you see that expanding into other areas?

LeChauncy Woodard: Well, I think in particular our patients really like the opportunity to have more one-on-one time with providers from different disciplines who are able to devote that time to really sit down with them and individualize their goals for their care and to help them to track those goals and to see whether or not they were meeting them. And if they weren’t to help them problem-solve around why that wasn’t happening. And so I think that the patients really appreciate it.

And I think the important thing about this is that it has to be moderate but sustainable. And so for us the sustainability part of it was really figuring out how it could be integrated into routine workflows and how the clinicians who are doing this could get workload credit.

I think there are still some challenges to getting Veterans to this sort of intensive intervention but I will say, I want to say that 75 per cent of our Veterans came to four or more sessions so they really appreciated the opportunity to do this and to learn with and from each other.

Unidentified male: Really cool. Donna.

Donna Washington: Hi, Donna Washington from VA Greater Los Angeles. This was a really fantastic study. I have lots of questions but I’ve limited myself to one. Just thinking about some of the changes in central office and how much of the shift of decision making will be shifted to the VISNs locally, a study like this that engages the local \_\_\_\_\_ [00:15:13] leadership is really powerful and timely. So my question is what are some of the strategies that you use to engage VISN and local leadership?

LeChauncy Woodard: So I think part of it was that when VISN 12 … Because people have asked, “Well, you’re in Houston and then this is VISN 12 which is like the mid-west, so Chicago.” Part of it was that we had a relationship with them. I had done partnership work with them before and contract work with them looking at the quality of care for chronic medical conditions and specialty care. So I think having that relationship was helpful.

But ultimately what was I think the most helpful was aligning with their priorities. I think the ability for them to be able to say, “Oh, this fits really well with the whole health initiative which we’ve put into our strategic plan,” was important.

Also letting facilities self-select, so facilities that felt like they needed this sort of intervention was helpful. One of the facilities, for example, had lost their health promotion disease prevention leader who did diabetes education and diabetes programming. And so this really filled a void at that facility.

So there were different things that made it mutually beneficial. I think the biggest thing is that we weren’t coming in with a tremendous amount of asks. There certainly were some but it was mutually beneficial so we were able to really, I think, provide benefit to them. And so they are interested in continuing this and we’re actually spreading to another site within VISN 12. So we hope to be able to continue to spread this further.

Unidentified male: Great, thank you.

Donna Washington: Thanks.

[Applause]