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Session: Resilience or inter-professional team communication (part 1) and exploring the effects of membership change event characteristics (part 2)

Presenter: Cody Reeves  
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Speaker: Joining us today we have Dr. Cody Reeves, he will be presenting for us first today, he is part of the VSN 23 pact demo lab at the center and the Center for Comprehensive Access and Deliver Research and Evaluation, known as CADRE and that’s for the Iowa City VA Health Care System. He also has a new position as assistant professor in the Department of Organizational Leadership and Strategy at the Marriott School of Management at Brigham Young University.

Presenting second for us today is Dr. Cheryl Ward; she is the director for the Center of Excellent and Primary Care Education in Greater Los Angeles VA Healthcare System. We are very thankful to both of them for joining us today.

At this time, I am going to turn it over to you Dr. Reeves.

Dr. Reeves: Great, thanks Molly. Am I coming through okay?

Speaker: You are thank you.

Dr. Reeves: Okay, thanks. Yeah, thank you for attending today; we are glad to have you here. Today I will be talking a bit about a project we have worked on regarding the effects of membership change in PACT teamlets. Before I begin, I do want to just recognize the great efforts and help of my colleagues, Greg Stewart, Eean Crawford, Stacy Astrove and Samantha Solomeo who are also in the VSN 23 Demonstration Lab, for their support on this project and others that we’ve worked on as well. I would also like to offer a brief apology for my voice. I cheered a little bit loud at this weekend’s BYU football game, so I may have to stop for water a couple of times. My apologies, but hopefully my voice holds out.

That said, we would like to open today with a quick poll question, just to get a sense of who is here in attendance. So we will take a break for a second for you to answer that, just to get a sense for the audience for Carol and I. Molly

Speaker: Thank you so much, so for our attendees you can see up on your screen there is a poll question. So just click the circle that best represents your answer. The question is, what is your primary role in VA, and we do understand that many of you wear many different hats within VA. But we want you to select your primary role and if you are one of the people selecting the option Other, please note that we will have a more extensive list of roles in our feedback survey at the end of the presentation. You might find your exact title in that list.

We have a nice response of audience, about three-fourths of our audience has replied already, so we are going to give people just one more second. While we wait for the final answer to come in, Cody, would you mind explaining what a demonstration lab is real quick, for some of our people not familiar with PACT?

Dr. Reeves: A demonstration lab... so we’re working doing research regarding this new PACTS... well, the new PACT formation that they’ve set in the VA back in 2010, and so ultimately evaluating its effectiveness and also finding ways to improve how this new team based system of healthcare is working within the VA.

Speaker: Thank you very much and we do have an excellent 90 percent response rate for the poll questions. At this time, I am going to share those results and you can talk through them if you would like.

Dr. Reeves: Great, thanks Molly. It looks like we’ve got at least a few students and then pretty balanced between other roles, cost clinicians, researchers, policy makers, and a fair amount of other positions that I’ll look forward to seeing what that is as we look at the feedback comments at the end; but there’s a healthy mix of people here today.

Speaker: Great, thank you; and we will just carry on with your slides at this point.

Dr. Reeves: All right, are we up there... great... yeah as we briefly mentioned, just a quick primer, or reminder for those who are already familiar, about the PACT team and what context we work in. So in 2010, the VA health system launched an initiative in more than nine hundred clinics nationwide, in which they moved to a more team based healthcare delivery system. In this, you have as you can see, four core roles, a provider, an RN, a clinical associate, often a licensed practical nurse or a health technician, and an administrative associate. These four roles are filled by individuals who then take care of about twelve hundred patients more or less as a target. And so you end up with this patient centered care model in which this team of four is working with these patients exclusively, or ideally at least, can provide more continuous care, get to know them better and track their healthcare along the way.

Another proposed benefit as well is that it also helps the patients to get to know their care providers and their nursing staff.

Now, with this new PACT model, and working more with teams, or as they’re called teamlets in the VA, there are some... You know, turnover is pretty frequently, and so Christian Helfrich, back in June in a cyber seminar, brought up some great statistics regarding the amount of turnover being seen in some of these PACT teamlets, and found that roughly sixty percent of the respondents had at least one staffing change in the prior twelve months.

So the majority of these teams, it would seem, are facing turnover at a fairly frequent and high rate. And this is also something that has been brought up in the news. Some of the difficulties and issues that have arisen in the VA. You have seen coverage, and turnover is frequently brought up as one of the primary issues. The government accountability office has raised it. Here are just a few snippets and quotes from other researchers and journalists who have commented about the amount of turnover in the VA and some of the problems it’s causing.

Just very quickly, talk a little bit about why turnover is disruptive. You know, when a turnover occurs and an individual leaves from a team, they bring with them all of the skills that they have amassed and a new person arrives with a different set of skills.

Now, in general skills, sometimes the newcomer may be more skilled, less skilled, more experienced, less experienced. The one thing that they will not have are these team specific skills. Knowing how to coordinate with those specific team members, understanding the pacing of the team, and being familiar with other team idiosyncrasies that are just different from team to team because different individuals go about things in slightly different ways. Additionally... In addition to that change in the amount of skills held by the newcomer, there’s also... it’s difficult and it causes disruption to teams, because it requires effort from teams to integrate the newcomers helping them feel welcome in the team, become a part of the team while they’re getting up to speed, compensating for their inexperience, and then even based on their specific skillset, reconfiguring work flows, learning to do things in maybe a slightly different way that better suits the team when you have that new member, as opposed to the old member.

And so, for us, the question that we raised and wanted to look at with this project, understanding that yes the literature and empirical data show that turnover is generally disruptive, we wanted to get a sense for when turnover is the most disruptive. And a few areas we wanted to look at, one is the number of turnover events that’s occurring. So simply, teams that experience more turnover in a shorter time, are they disrupted more? Is it that sheer amount of turnover with more moving pieces? Also, what role does it play... The role that is affected by the change... is it the number of people changing, or is it also who is changing?

A couple of different routes this might go, at least what the literature would suggest, is it that those individuals who have more authority over how decisions are made on the team, when they’re changed that causes more flux in how the team operates because more changes can be implemented. Does that lead to greater disruption, or is it perhaps that greater disruption occurs when you have roles that are just more directly involved with paths. So maybe with the decision-making you look more towards the primary care provider or the RN. Or is it the individuals who are more routing the workflow, getting patients in and ready for their visit with the RN or provider, so that the licensed practical nurse, or the administrative assistant. Is it perhaps when they turn over that more disruption is caused to these PACT teams?

One other area we chose to look at is the amount of shared experience of those who remain. Recognizing again that turnover is not just who changes and their skills, but also the rest of the team has to deal with it and get that individual up to speed.

The literature would suggest that as teams work together for longer periods of time, they settle into habits and develop routines and learn to do things a certain way. And so when change occurs, they’re less responsive to it. They notice it less; they just keep going with their routine. And so we have hypothesized that these teams that have worked together for longer periods of time, they would actually be disrupted a little bit more, especially over time, as they would fail to recognize the need to integrate that newcomer and maybe make adjustments that are better suited for them.

We also want to look at the possibility that this relationship is curve-linear. Yes, as teams gain some experience, they learn to work together and can therefore to help integrate new comers in a more uniform fashion. Because they do know each other, so is it possible that this turnover, at very low levels of experience, is very disruptive. And very high levels of experience is disruptive, but maybe there’s a middle ground in there somewhere where it’s not as disruptive because teams aren’t quite settled into their habits and routines. And at the same time, they also do have some familiarity and the ability to work together and coordinate as they integrate those newcomers.

Those are some of the basic questions we are looking at and wanted to examine these areas of turnover, membership change and the method we used to do so was an archival data analysis. So we collected the team assignment reports between September 2013 and October 2014. The reason for that October cut off is because at that time several different measures in the VA were changed, and so there’s no longer that continuity of measurement that we could look at over time. So we’ve cut it there for now and perhaps we’ll look at more samples in the future once we have enough time from the new metrics.

So team assignment reports basically suggest who is working with whom. So on each of these primary care teams, these PACT teams, who is assigned to them. So we looked at that composition over time and how it changed to notice where turnover occurred.

We also looked at the PACT compass, the performance metrics for PACT, and looked at continuity, or this idea of when patients are being seen, are they being seen by their PACT team? Does the PACT team have the capability to see their patients, as opposed to them working less efficiently and somebody else needing to pick up that slack.

The sample that we looked at, we were able to get a sample of 253 of these primary care PACT teams and as we looked through the sample, we whittled it down by a few criteria. One is the team had to have existed for at least six months prior to membership change to give us baseline performance measure. Then also, following the membership change event, the focal one, they needed to exist for at least six months uninterrupted. So it’s a six month follow up period with no additional turnover events occurring within the team. The reason for that being is we looked at performance over time, we didn’t want that confounded by additional change events occurring. And so to find the select group that did have a six month follow up with no further interruptions.

We also wanted to look at teamlets that had identical structure. From a prior study that has been presented here at the cyber seminars by Eean Crawford, actually about a year ago today, we learned that there are very different structures still existing within the VA and how these teamlets are structured. Some of them have fewer members than the four that are recommended. Others have more. Some of them share members with other teams, which can cause some issues and can confound some variables there. Additionally, some of them have unfilled roles, or duplicate people in the same role. So we wanted to focus on identical team structures, so we matched that to the dataset and all these teams were structured the same way, in the ideal way, with these four members that aren’t shared with other teams.

And then also, we limited this by teamlets where departing members were replaced within a single performance period understanding that if teams exist for a long time with a shortage, or being understaffed. So a member leaves and it takes three or four months for the new person to get hired and brought in, in those cases it’s a different experience for the turnover of the team. Some different processes come into effect as the team tries to compensate for the loss of the member. So in order to avoid that confound, these 253 teams that we did focus on, also were able to replace their departing members within a single performance period. So relatively immediately.

At a quick glance, the way it broke down, about 140 of the teams had one change event, 80 of them had two, and 33 experienced three change events. So there was some space in there as far as how many events occurred. And looking across roles, they were roughly balanced, but we did get a good sample of each on at least over a hundred changes that affected each of the three focal roles. And you’ll notice that on those roles, the primary care provider is not listed there. The reason for that is because A, we could not obtain the primary care turnover data as a lot of the data is nested by a provider. And so as they leave, matching that up with the remaining team does become difficult.

We did make an effort to do so, and we found that in the vast majority of cases, when a primary care provider leaves, the rest of the staff is kind of scattered across to other staff members. Perhaps this is due to the fact that these providers take a little bit longer to replace. But the staff members often don’t work together, so the team generally dissolves. And so we did focus on these other three roles instead for the study to see how the change in those roles affected team performance.

The measures we used to do so, in looking at the number of events that occur, we looked at the number of recent changes. So within that six month lead up period, how many membership change events occurs.

We also looked at which roles were changed by dummy coding for each of those three roles that I mentioned. And shared team experience, we looked at dyadic shared experience of continuing members. So how long each of the members had worked with each other averaged out to the team level among continuing members to get a sense for on average, how long had those remaining individuals worked together.

Then for our dependent variable, we looked, as I mentioned before, continuity, which is this idea of how many of the patient encounters are with their assigned team out of all their patient encounters. So how often are they seeing their assigned team of medical staff, as opposed to just seeing anyone else who is available?

Before we get to the methods, we will leave you in suspense there for just a second. We would like to go to our second poll question and get a sense here for... so we look at these three different roles, nurse care managers, clinical associates, and administrative associates. If you had to guess, based on your understanding of how primary care is delivered and a PACT changes, which of these roles do you think would be the most disruptive. Molly, we will turn it over to you.

Speaker: Thank you so much. For out attendees, once again just go a head and click the circle next to your response. These are anonymous responses and you are not being graded, so feel free to take an educated guess. And it looks like we already have about sixty-six percent of our audience vote and answers are still streaming in, so we’ll give people some more time. We do have a nice spread across the board, so this should be interesting.

Okay, it looks like we’ve got a pretty good trend and we’ve topped out at above eighty-five percent response rate, so I’m going to go ahead and close the poll and show the results. Do you want to talk to that real quick?

Dr. Reeves: Yeah, sure thing. So it looks like most respondents are thinking nurse care manager. If this were the ask an audience out of Who Wants to be a Millionaire, I’d probably go with that based on your response; still a healthy amount thinking perhaps the clinical associate, or the administrative associate; so excellent, thank you for your responses.

Are we back up and online?

Speaker: We are.

Dr. Reeves: Great, okay we will look to see how it turns out as to whose departures affected the teams more. So the method we used to evaluate this is a technique called discontinuous growth modeling. It’s a form of longitudinal growth modeling developed by Singer and Willett, that also allows you to account for these discrete, almost shock events; events that can change the trajectory of a team and how they are performing. And so in this example, one thing that it accounts for, one form of disruption is an initial drop. So the individual... one individual leaves the team, one or more I guess, and they are replaced by one or more individuals. During that transition, as the new individuals are just arriving, how much that harm is that initial team performance?

The other form of disruption that it allows us to look at is in the change of the subsequent slope. So after the change occurs, what happens to the slope of performance? Do teams start improving more rapidly? Do they maintain that same trajectory they were on and just slowly recover over time? or do teams actually start on a negative trajectory and start becoming worse? So this method allows us to look at both types of discontinuity and the disruption that occurs, both immediate and over time.

Now looking at the number of events, so that quantity, we found overall that it is disruptive. When membership change occurs, it does harm team performance. Teams perform worse overall starting that month afterwards. But, it’s not the number of events that’s driving that. Looking at how many events occurred; there were just no significant results. So it is disruptive, but it is not necessarily how many people are changing. However, when we looked at who is changing, the different roles and how they’re affected, as you can see, looking at that first initial drop and that cut down after the yellow line, the yellow line representing that’s the time when the membership change event occurred. When that occurred, in the following month, the largest drop was actually seen among the two roles of administrative associate and the clinical associate. The RN, the drop in performance when the RN turned over was actually not significant. However, with the clinical associate and the administrative associate, actually a little bit more with the administrative associate, that initial drop was more.

Now the slopes afterward were not significant, so there was no change in trajectory based on who changed, however the amount of initial drop off was more in those... some would say lower roles, but the roles of clinical associate and administrative associate.

A couple possible explanations for why this is, when it comes especially to continuity and are teams able to bring their own patients to see them as opposed to offloading them to another team, perhaps the clinical administrative associates are simply the drivers of team workflow. They are the ones that get the patients in and processed and if they are working slower, the RN and the provider cannot do more because there is a bottleneck that is introduced.

Another couple of possible explanations, one that in those so-called lower roles, those roles that involve less formal training, perhaps there is simply a greater variety in skill level upon arrival. And so there’s almost having to get up to speed and maybe not knowing as much about the work as you would when you have an RN or a doctor who have gone through greater levels of formal training.

Or it could simply be that there’s greater expectations of variety, so regardless of whether there’s actual differences in their skills, maybe team members expect a greater variety, and therefore adjust differently when those team members arrive. A couple of guesses, but possible explanations as we thought through these results.

Now looking at shared experience, these results surprised us a bit. as you look at... As teams have more shared experience among the continuing members, not only do they drop off more initially, but performance over that six month window that we looked at, actually becomes worse. To the point of those teamlets that had high levels of shared experience among the individuals, roughly a little less than two years that those individuals had worked together, when that occurs, not only was there a larger drop off as you can see, but those teamlets consistently became worse and worse and worse over the following six months. And so this theory that perhaps these teamlets are so ingrained in habit, that they just have a difficult time recognizing a need for change and it’s difficult for these newcomers to these experienced teams to adjust and adapt. It seems to pull out in the data.

So just a brief summary of what we were able to find, overall as we expected, turnover is disruptive. Who it is who changes does appear to be more important than simply the number of changes that occur. It’s which role is being affected that is playing out on the impacts on the care of being provided to veterans, and then the high levels of shared experience, does cause a greater initial disruption, but then also it can really hinder post change adaptation. These teams have a harder time bouncing back from that initial disruption. Whereas teams with less shared experience appear to have an easier time doing so.

A couple of just brief issues that we want to look at going forward, one what happens if replacement isn’t immediate. What affect does that have when you give the team some time to adjust to maybe having a shortage of members and working in an understaffed environment? Then we introduce the new person, does this change?

Also, those teamlets that are formed in PACT structure, we evaluated those exclusively. How does it compare to teamlets structured in other ways? We have seen some facilities where there is almost a pool of common nurses that get pulled from for multiple teams. Do those teams whether turnover in a different way? Then possibly looking as well at is it voluntary or involuntary departure, how that may play out in the results.

So we have enjoyed the slides, it has been fascinating to us to see what kind of problems turnover is causing in the VA and especially how it’s affecting PACT teams and I thought we found some surprising results. So, thank you, I appreciate your time and we’ll pass this over to Carole now.

Speaker: Thank you so much Dr. Reeves, so Carole, you should have the pop up now to share your screen. Wonderful and we are good to go, thank you.

Carole Warde: Thank you all very much; and Cody, that was an excellent presentation. I would also like to take a moment just to thank Molly and Cynthia who help organize this.

So my... our project here had to do with resilience of PACT teams, so maybe as we were planning this, we were hoping that this would be a nice flow. You have patients leaving, or providers and team members leaving teams, so maybe this was a way to help prevent that from happening. This project actually is a quality improvement project to help address burnout and job satisfaction. And it was born when our nurse manager at our \_\_\_\_\_ [00:25:04] site said what can we do about this? She was truly distressed that people were not happy.

The chief of the medical service of the NFA, the chief of the providers were also part of this management team and they were all concerned about the burnout and job satisfaction and were really very supportive in getting this whole project started.

We began with the resilience steering committee and those people were hand selected by the administrators to be a part of the resilience steering committee. They were the total reason why this project was even able to go on and then we have support in the form of the facilitator and a data manager from the veteran’s assessment and improvement laboratory for VSN 21. So I would also like to thank specifically Rob and Summer for that.

Okay, so just to see what... just to kind of get you on the same page and get you to think about what the level of burnout is in your local PACT clinics.

Speaker: Excellent, so as she just mentioned, what is the level of burnout in your local clinic? Do you believe it is none, ten to twenty-five percent, twenty-six to fifty percent, or greater than fifty percent. And once again, these answers are anonymous, so feel free to respond freely. And it looks like about two-thirds of our audience has already voted and the answers are still streaming in. so we’re going to give people as much time as needed to get those. We do have a spread across the board. That is interesting. Okay, it looks like we have capped off at about seventy-five percent response rate, so I am going to go ahead and close the poll and share those results. So it looks like about a third of our audience say that the burnout rate is greater than fifty percent. Almost half of our audience reports twenty six to fifty percent. Seventeen percent of our respondents say ten to twenty-five percent and two percent of our respondents say none. So thank you very much for those answers and Carole, I will turn it back over to you now.

Carole Warde: Okay, well, I think that is a very sad response rate. I think it is really unfortunate that so many primary care team members are burnt out, and I think the national numbers for physicians show that those people on the front line of care do experience a lot of burnout, so I’m hoping that we can help provide an answer to this.

Just to get you thinking and not only identifying the problem, but do you think that we can actually improve this.

Speaker: Thank you, so this is our final poll, so you think it is possible to improve PACT burnout rates in your local clinics. Absolutely yes, probably, no, or I’m not sure, and people are quick to respond to this one, we already have sixty percent of our audience vote and the answers are still streaming in so we’ll give people some more time. Okay, we have reached three-quarters of our audience has responded and they are still coming in, so we will give people more time. All right, I think we have a pretty clear trend and an eighty percent response rate, I’m going to go ahead and close the poll and share those results. So almost half of our audience says absolutely yes, we can improve PACT burnout rates. Thirty-nine percent of our respondents said probably, five percent say no and eight percent are not sure. Thank you again to our respondents.

Carole Warde: Well, I am really encouraged by those answers. I am so sorry... maybe you do not even need this... need the rest of this cyber seminar if you really feel positive. I think it is great. You need that level of positivity to make something like this project successful.

So just as a little bit of background, transitioning to the VA traditional primary care clinics to PACTS has really been quite disruptive for some and has required many major changes in work expectations, a definition and accountability to new roles and responsibilities for front line care teams. And I also might add, I think there was a bit of cynicism of oh, this is just another VA mandate and it’s going to go away after a year. But I think after four years, or five years, this is... I think PACT is really here to stay.

So change, fatigue, decreased job satisfaction, burnout, staff turnover as Cody spoke to so eloquently, can really result and may affect the quality of care. Now, resilience is the ability to thrive during ongoing change, and I think anybody who is part of PACT and has been part of the transition, and part of the VA realizes that change is just a part of our daily lives.

We all like to get comfortable with things and get settled in our roles and responsibilities and the people we work with, but in reality, change is going to happen. And a lot of times it’s for the better. So factors that can affect disability to endure change are control of job duties, decrease time pressure, supportive team relationships, protected time for reflection, and minimize workplace chaos.

So Mark Windsor and his group from the University of Wisconsin in Minnesota have done a lot of great work to help define some of these answers that are shown on this slide. The problem that we identified is that to address PACT teamlet resilience, we wanted to initiate a yearlong quality improvement innovation with the following three goals.

Number one, we wanted to find a way to do it. How do we even approach this problem? So we implemented a model and a method to measure and improve PACT team resilience. We identified strategies that would decrease the workplace stress and burnout... or that we hoped would... and we wanted to share lessons from our efforts to promote PACT team resilience in all of your sites.

Our plan was... Our setting, first of all, we’re a large community based outpatient clinic and we have twelve primary care PACT teamlets. We also have a certain number of sub specialty clinics on selected days. Our own radiology department, our own lab, so we do not have the inpatient services, but it is a pretty all-encompassing CBOC.

Our aim was to improve PACT teamwork satisfaction, stress, and burnout and we needed a model to help frame how we categorized what was causing the problems and how we could approach the solution. Again, Mark Windsor and his long time work over the past nearly twenty years, has identified kind of a model of stress that we could frame our causes and our solutions. So on this little teeter totter model, I love it because it kind of sticks in my head and it makes total sense that work demands when they’re too high, stress goes up. And minimizing factors to help bring that teeter totter down are more control over your workplace, and more support from your administrators and support from your colleagues. And even support from your patients who provide the satisfaction for doing what we do.

So our plan was a six step improvement process and as we were doing this... have not quite identified so nicely, but I think as we reflect on it, what we did, we were really able to identify the six steps.

So the first step was really probably the most crucial and created... The administrative leads created a resilience steering committee and they selected a representative from each of the PACT disciplines to be involved in this steering committee. So they selected people who were engaged in PACT, people who... representatives who could speak, who weren’t too shy, and representatives who were not too negative and cynical. We wanted people who could really help us and who have good relationships with the other members of the teams.

So they selected a team of representatives from each discipline and a facilitator... we actually have two facilitators. We have a facilitator just to help with the media and then we engage the head of psychology to help us when we entered some of the more difficult discussions as we rolled this out.

Since that time, they’ve also added with the mental health integration, they’ve added mental health representatives, and I’d like to say that those mental health representatives on the steering committee are really just a Godsend because of their expertise in conflict management and communication and just how to deal with some of the strong emotions.

So the second, we conducted a needs assessment. Now, this was just a paper copy. It turned out that the paper was just easiest. People are just so sick of the e-mail surveys that we adapted a single page two-sided survey to get at some of the issues. And this mini Z clinician work life survey was adapted from Dr. Linzer. He gave us permission to adapt it and also, the needs assessment was a focus group. Once we got the results of the needs assessment, the focus group, which was the resilience steering committee, looked at what the major issues were. We divided them by the demand, control, and support, where they sit and we identified what may be the next steps that we could go... how we could even start this process. So that was the needs assessment, it was the survey and the focus group.

The third step was we conducted a kickoff event. This was a two-hour session where there were actually two, two-hour sessions where half of the team was attended. And the staff, all the staff were there, the administrators were there, and this is where our facilitator was really very helpful. We reviewed the results, not in any big, huge scientific way; we presented a few slides that were made so everyone could understand it. It was definitely not a research presentation; it was just here is where we are. Then we presented what we felt would be reasonable solutions to some of the problems that we identified.

After this kickoff event, this is where really everyone got to be engaged. There was lots of negative feelings, why didn’t we do this, and why didn’t we do this, and you haven’t gotten this. But the facilitator was really crucial in helping to acknowledge those really strong feelings and to move on so that we could get to okay, here we are, what is it that you really want to do? And it turned over the control of this not to the resilience steering committee, but turn over the control of this... okay, you guys, let’s pick where we want to go first. And that was, I think, a really important process that happened at that kickoff event, for both sides.

So the fourth was we initiated QI initiatives. Now, we initiated the initiatives that the whole group decided was important, but in reality it was that steering committee that really made this happen. And each quarter, we did new data to find out where we were and each quarter, at the beginning of the quarter, we initiated the new improvements that were to happen.

The fifth step was to have monthly PACT team resilience meetings and this was again to be provided with all of the teams... the five teamlets... so there would be two big meetings where this would happen monthly, for say fifteen minutes, to twenty minutes.

To support the teams we presented the results. It was great to foster communication and to share stories. One of the big contextual factors that we couldn’t control, like in any QI project, was the access crisis hit in the middle of this and our particular clinic was really hit pretty hard by that our access was pretty... It was not terrific, and so the administrators... not our site administrators that had started this, but the administrators above them from the health system, basically canceled all of the meetings where this resilience work was to happen. So it was a big blow to us on the resilience committee, but we... I think we made it through and we problem solved.

And then the sixth piece of this was to assess the improvement on quarterly and give feedback on improvements.

So this is a noisy slide, but I’m going to walk you through it. So I hope you can see my pointer. So here on the top row, we have time and this was at our baseline before anything happened. And notice the end here and how the end over the course really kind of declined. We think this was impart because we were not meeting regularly. I think that was probably a big part.

Then here is quarter one, quarter two, quarter three and quarter four. So keep these columns in mind as we go through. So here’s the intervention and I’m not going to go through the interventions for each of the four quarters, I’m going to start with the first one. And as we talk about the interventions, we’ll just look to see what happened with some of the numbers.

So the first quarter we initiated the same day team which was probably the single biggest factor across all time that helped... that was the most engaging. Every single team member engaged in this specifically the providers. And it was basically a walk in teamlet to handle those walk ins that were not related to the teamlet. So it was like an unassigned patient or a patient from an outside clinic. We also incorporated the resilience topics into the education time that was we had them once a month. We started protective clerk time so the clerks had a half a day a week where they were protected and covered by the other clerks so they could get the administrative work of their teamlets done. we started a suggestion box and then we also started a team education program. So here’s that baseline, this was not statistical but you can see there was a trend towards job satisfaction going up. the stress actually went up, but this is probably the most significant finding of the whole thing. The burnout rates really went down, they were cut in half. And think about where you were on your own burnout rate and where this... this is significantly below what the national average was.

It turned out that work interruption was really the most sensitive indicator. So the work interruptions, this is high control over their work interruptions, it really doubled the amount of control they felt they had. The teams pretty much felt like they were efficient. The other thing I want to point out here is the leadership support. This was really... it looked like between the value of the line that was the leadership, leadership creating an enjoyable work place, and leadership creating growth possibilities for the individuals was really at a pretty low level. And this did not change much the first time. Then workplace chaos; I am going to quickly go through the other quarters.

Now this quarter, this is where the access crisis hits and everything was canceled, pretty much everything. What we did do, we started the coffee cart to go around and just talk to people and create newsletters for communication. So it was really... and the administrators started joining us on these walk arounds. So the job satisfaction actually stayed up, the job stress didn’t change, but the burnout went back up almost to where it was at base line.

In Quarter three, the most things were reinstituted, the burnout rate started to go down, but not back to where it was and we felt like people were pretty cynical about what had happened, and they were still just reeling from adjusting to all this change. And by the fourth quarter, when everything was pretty much back and the coffee cart continued, the burnout rate interestingly didn’t really change that much. It never got back down to where it was, but the job satisfaction continued to get getter. The control over the interruption was back up high, so they... the control over their work interruptions was really helpful, the team support and efficiency stayed the same, but look at what happened to the relationship with the leaders. They started out with the values on line with thirty, and it was back up to sixty-one, even though this was just a trend, it looked pretty good to us. And their feeling like management created workplace enjoy ability, it was still up.

Okay, so PACT team member comments were in the beginning what is resilience. In the second quarter when… this is when we were first starting, people were commenting, people on teamlets were talking to each other. In quarter three after we’d been through the big change, I think we do a great job, but we need a little more staff and then the fourth quarter, they were grateful that they had more social workers, they wanted to have weekly updates on clinic changes, they were really getting into the changes that were going on.

I am not going to go over this because I just did. Our successes... so PACT team members became engaged in the process. The resiliency steering committee developed supportive relationships with each other and that seemed to spread out to the teamlets. And they were really the positive role models in resistance. Team members felt safe in going to this resilience committee and the resilience committee and the administrators really worked together communication improved and there was a lot of empathy for local site administrators.

Some of the challenges were just the work environment changes, the staffing, this was something we could never really get at is their resistance to a desk job accountability at all levels. From administrative down to every PACT team members, people are afraid of that. And then site leadership could not make some of the important changes that they wanted to because their hands were tied by their upper level management.

Some of the lessons learned was that we found this six step approach was a useful method to get the PACT teamlets engaged in the change process. Burnout rates and workplace control were really the most sensitive measures that we found to making changes. We found that PACT team members were really open to the dialogue and to our improvement process in this area. Venting was a really important part to acknowledge and to let happen and the psychologists are just so helpful in helping to manage this. Communication is key between staff and administration, but it is often strained. Facilitators are helpful. Administrators are often really wanting to help the process, but they’re just not appreciated. They get blamed for a lot of stuff that is not under their control and the process for dealing with accountability really needs to be addressed at all levels. And I guess with that, I’m done. so questions, comments, thank you for your time.

Speaker: Well wonderful, thanks to both of you. So far, attendees have joined us after the top of the hour can submit your questions or comments for the presenters just use the question section of that go to webinar dashboard on the right hand side of your screen. Just click the plus sign to expand the dialogue box and you can submit those now. If your question is for one or the other presenter in particular, please indicate that so we can get it asked and answered in a timely manner.

And the first question, this one if for you Cody, could you please explain who “shared experience” was defined?

Dr. Reeves: Yeah, sure thing. Definition wise we were looking at those members who did not experience membership change. So those who were continuous members of the team. And we looked at the average amount of experience they had shared with each other individual, so calculation if that helps with the definition... say you have one person turns over on the team, three others remain. You would average the amount of experience that... and say it’s the RN who leaves... the average amount of experience that the LPN has with the provider, that’s one fact that entered in. and then how much the LPN has with the administrative associate, and how much the administrative associate has with the provider. So each dyad of individuals, you look at how much experience they have working together, and then we average that at the team level to form a composite. Hopefully that helps.

Speaker: Thank you for that reply, our attendees are always welcome to write in for further clarification. I believe this may have come in during Carole’s portion, but you will both be able to tell me better. Would you mind reposting the slide with the six-step approach?

Carole Warde: Sure... Oh, I cannot, I do not have control of this Molly.

Speaker: In the lower left hand corner of your slide... well, you should be able to reverse back, or you can press escape...

Carole Warde: Oh, there you go, I have it. Is that what you want?

Speaker: Yeah, we will just leave that up for a moment while they review it. Okay, the next question, Cody, did you hear about human resource/boarding problems about slowed down hiring of new PACT staff, especially nurses?

Dr. Reeves: You know, I was not aware of any broad trends, and so... luckily in our sample we are able to see... have about an equal distribution of each position. But that would be fascinating to go back and identify where that time was and how that impacted the teams. Especially if we are getting a sample if we are looking at the effective delays on how teams adjust. It sounds like there might be a natural quasi experiment line there that we could look at, so if there is more information I would appreciate it if you e-mailed to me so I can get a sense for when those dates were. That would be great.

Speaker: Thank you for that reply. Before we move on to the other questions, many people are thanking you guys for a great presentation and want the handouts. You already have access to the handouts; they are in the reminder e-mail you received this morning. There is a hyperlink to download them.

What specifically do you mean by SB Teamlet?

Carole Warde: Oh, okay... so the same day teamlet was... It was a teamlet that was cleared of their responsibilities. So let’s say teamlet one is the same day teamlet of the day. So there were no patients scheduled and all of the walk in patients that were not assigned to other teams, or whose provider was out, came to the same day walk in teamlet. So it also... they covered if a provider called in sick, then they worked with their nurse and their care manager and their LVN to figure out how can we manage this. So that was something else. They really took up the slack for all of the things that were driving the providers with full schedules. And we have full schedules. We have fourteen patients scheduled per day because our access is so bad. So this was a true help to those in the fully scheduled PACT teamlet.

Speaker: Thank you for that reply. Next question, were there any issues with access or decrease in workload, with the process. It is a multi-part question, so we will start with just that. Were there any issues with access, or decrease in workload with the process?

Carole Warde: I guess I am assuming you mean the process... I think there is two ways I could take this. So, during the intervention, you may be talking about the protected time for all five teamlets to meet together. So, we had had a half a day a month before this started, that was four hours, where we did our... addressed our PACT measures, we made announcements, new changes, and it was also a time for the staff to get together and to foster communication and become friends with each other. So that was a significant... that was protected time, but totally worth it because once we stopped it, and I don’t think it was just the change, I think people were just hungry for that time with each other. To get things together, to share experiences and to figure out how you were going to work efficiently. So that’s one hour of protected time that was there. But the higher administration actually let us reinstitute after the access crisis was over, but not for four hours, but for two once a month. So that’s one thing.

Then for the access crisis for the same day teamlets, I think. For the full time providers, it was not such a big deal. It was actually kind of nice because it gave... If you ended up having a day... like the morning, it typically was not very busy, and at noon, it was not very busy, it gave those covering team’s time to catch up on some of their other work. So in that respect, I think it helped them and their access numbers weren’t affected quite so much. It was the part-time providers who had a problem with the access and taking the time out.

Speaker: Thank you, we will get to the other portions of that multi part question. Next, was any realistic supply and demand analysis done to see if the current demand and expectations are realistic, as it would seem this great process is set up for failure if the basic issue is the work supply-demand?

Carole Warde: This is our work environment and I think this is part of not being a scientist. That is what QI is. QI has to take place in the real world and our workload demands actually went up, and I think... we did not measure this... I mean, the numbers are there, we could certainly go back and look at it, but our workload absolutely went up because just the number of all of our telephone taken away when this access crisis hit. We had no walk in slots, so basically we had probably at least two more patients scheduled per day as a result of the access crisis. And everybody was full and we were all asked to take on new patients, so our workload actually increased, but not because of the intervention, just because of what was happening in the real world.

Speaker: Thank you for that reply. Looks like we have lots of good, pending questions. Cody, do you consider the effect of the team that was involved in the recruitment of the replacement member?

Dr. Reeves: No, with the data we had available, we were not able to track that. It is something I would love to get my hands on if it is possible, to examine the effects. But yeah, the degree to which the team was involved in the recruitment, we just didn’t have the data on that to be able to model. Good question, I would love to have that if it is out there.

Speaker: Dr. Warde, over what time frame did the overall project last. If you have mentioned it, I am sorry; I overlooked that.

Carole Warde: It was set for about a year. It actually went probably fourteen months just we could not collect all the data... we could not collect the last survey, so it actually probably went fourteen months. And I want you to know that this is continuing and expanding and we have new members on it. So many people wanted to be on the committee to help lead the effort, but it has been pretty, pretty successful.

Speaker: How do you think the inclusion of veteran peer support specialists on PACT teamlets will impact PACT burnout?

Carole Warde: Is that for... I guess we could both answer that. Did you want one of us to answer that?

Speaker: They did not indicate for whom that question was for, so...

Carole Warde: Cody, do you want to take a shot at it?

Dr. Reeves: We have not looked particularly at burnout, at least in my study. I don’t know if you want to start and then... I know Greg Stuart who is working the project with me is also on the line. If you want to take if first Carole, he may want to weigh in afterwards depending on familiarity.

Carole Warde: I should tell you that we had... At the administrative meetings, there is a patient who is on that meeting and they... there were two of them, and they were actually... they helped us form this process. They came to the kickoff event; people knew them, so they were part of it. People behaved... they selected words much more carefully, the issues come up, they just select them much more carefully, and I think that is a good thing. So I think having patients involved in this whole process is a win-win situation.

Speaker: Thank you, Dr. Stuart, would you like to talk. If you would like to go ahead and unmute your telephone line and chime in; not to put you on the spot or anything.

Dr. Reeves: Well, maybe not.

Speaker: Did you have anything you wanted to add?

Dr. Reeves: No, not in particular.

Speaker: We have got just a few questions left. Can you comment on the reliability of the PACT compass and team assignment reports?

Dr. Reeves: To a degree yeah. The compass is what the VA has been using to track... I do not know as much about the overall reliability of that other than I know that they are constantly working on it to keep it up to par and high standards. With the team assignment reports, when we first got in and we are looking at them, we heard from some people, “oh that’s not accurate,” “it is not right.” And so as part of another project, we generated these images of networks that basically show how people are related and at least in our examples we’ve shown that to people across different parts of VSN 23 to reflect their own locations. And people have been able to point out, oh yeah that this. Looking at the structure, they’ve been able to identify who the individuals are and we’ve gotten generally a positive response that yeah, what’s in those team assignment reports accurately affects how the work is being done. So the compass, to the reliability, I can’t speak as much, but to the team assignment reports, all the investigation that we’ve done shows that to those who are on the ground, it is a true reflection of their work.

Speaker: The next question we have, it sounds like same day teamlet helped to create access, but may not have satisfied the provider level access continuity performance measures.

Carole Warde: You know, I cannot really answer that. I think this is a really good question and I can’t really answer that. We had several things going on, so the schedules were changed, so there were more slots for the providers to see patients. The same day teamlets, I’m not sure those numbers got counted as walk ins, but it didn’t get... they certainly didn’t get counted as same day visits because they weren’t being seen by their teamlet. So I don’t really know how to answer that question. I would be happy to talk with you more, e-mail me more specifically what you want and I can discuss that with you, whoever asked that question.

Speaker: Thank you, in fact, can you fast forward to the final slide with your contact info on it please. Thank you. Just two pending questions. It appears your administration was supportive of surveying staff and finding creative approaches to addressing staff burnout. Was this the case from the beginning, or did it take some convincing?

Carole Warde: Oh no, they were the ones that started this. They were really concerned about the morale of people. And my gut feeling is that I think that this process and this committee and everything that went along with it, I think it really helped to mitigate and maybe keep that job satisfaction up as the access crisis hit and we were having to go through all these changes and increase in workload during that time. So no, they were truly engaged and they really felt their hands were tied by their own managers above them. That is what it looked like to me and they struggled. They would go and advocate for us with the upper level management and they would constantly come back and say sorry guys, this is the way it goes, but that empathy from the frontline staff, or the administrators, really improved and everybody was talking differently. And the fact that they walked around and talked to everybody, even though we couldn’t do anything, we could only have the coffee cart. And they bought all the treats and the coffee because we can’t buy food. So they were truly engaged and wanted this to work and the level of communication really did improve.

Speaker: Final question. Carole, what did you mean by resistance to address job accountability is high. How do people view or think about what is job accountability.

Carole Warde: I guess accountability means when someone... we have all the PACT roles are pretty much defined. And there are some teamlet members who will follow those roles, and some teamlet members who will absolutely refuse. So there is difficulty on the part of the teamlet members themselves saying hey, we expected you to do this, what happened? And then there was also a level of resistance on the part of some of the management because of... for lots of various reasons I don’t want to go into it here, but to hold some of these teamlet members who aren’t performing very well, hold them to the level where they should be. So that’s what I meant.

Speaker: Thank you for that reply. Those were some excellent questions from our audience. We really appreciate it, and of course, we appreciate you two lending your expertise to the field. I do want to give you the opportunity to make any concluding comments if you want. Cody, we can start with you if you would like to wrap up with anything.

Dr. Reeves: Not in particular, just thanks overall. Carole, fascinating presentation and it’s great to see your work as well, and hopefully we can keep this moving forward and help the VA better serve patients. That is the ultimate goal, so thank you to everyone.

Carole Warde: I would like to thank Cody, I learned a lot and I really appreciate you taking such a scientific approach to this. It is an important issue. And I would just like to encourage you all to start this process. It was really one of the most rewarding projects I have ever worked on and I think when one of the clerks came up to me and said when is our next resiliency committee meeting? It was just... it warmed my heart to see that people were so engaged and so excited about an improvement process. So thank you for your questions and your attention.

Speaker: That is great to hear. Once again, thank you both and of course thank you to our attendees for joining us today. And a special thanks to Cynthia Lutan [PH] who helps us coordinate this series. And for our attendees, I’m going to close out the session in a moment. Please wait while the feedback survey populates on your screen and take just a moment to fill out those few questions. We do look closely at your responses and it helps us decide which future sessions to support. So thank you so much for your attention today and this does conclude today’s HSRandD cyber seminar. Thanks Carole, thanks Cody.

Carole Warde: Thank you.