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Dr. Susan Stockdale: Before we get started I just want to acknowledge the collaborators for our PACT Demonstration Lab and also our funder which is the VA Office Patient Care Services. Today we are going to share with you some of our results from our Evidence Based Quality Improvement Intervention and we are also going to talk a little bit about what the intervention entails.

The intervention was called “Evidence Based Quality Improvement for PACT” and it began in approximately 2010, towards the end of 2010 about the same that PACT started. First I am going to describe some of the motivation behind the intervention and what that actually entailed and then my co-presenters will present some results from our evaluation.

I am sure this audience is aware that the quality improvement is not a new concept within healthcare organizations. Systematic quality improvement is well established in hospitals and inpatient healthcare settings in terms of having committees and departments and processes in place. Also, some of the new models of care being adopted in primary care settings which is patient-centered medical homes embody the principles of QI with an emphasis on performance goals and innovation and quality improvement. But there are few if any models for how to do systematic quality improvements in primary care. This is where our intervention comes in, the EBQI PACT intervention was based on a previous EBQI interneurons that were developed and implemented by Dr. Lisa Rubenstein who is the PI of our demonstration lab around smoking cessation and depression care in primary care.

Now I would like to find out how familiar the audience about Evidence-Based Quality Improvement so I will turn it over to Molly for a poll question.

Molly: Excellent thank you so much. For our attendees, I am going to go ahead and put up the first poll question now and that question is as Susan was just saying is - How familiar are you (let me make sure that is showing properly, there we go). Okay how familiar are you with Evidence-Based Quality Improvement? Very familiar; somewhat familiar; a little familiar; or never heard of it and just go ahead and click the circle right there on your screen that corresponds to your response. It looks like we have a very responsive audience, we have already had seventy percent vote so thank you for that. Okay it looks like we have maxed out, about three-quarters of our audience so I will go ahead and share those results. You can see that we have nineteen percent saying they are very familiar with evidence-based quality improvement; forty-nine percent saying somewhat familiar; twenty-eight percent a little familiar and four percent never heard of it. Thank you to those respondents and I will turn it back to you now Susan.

Dr. Susan Stockdale: Right well I am glad that at least most people have heard of it so I will talk a little bit about it but maybe in the Q&A if people have questions they can talk about it a little bit more.

Our EBQI-PACT Intervention was developed as part of the our VISN 22 PACT Demonstration Lab which is called the Veterans Assessment and Improvement Laboratory or also known as VAIL. We used an EBQI approach to implement PACT and at the foundation of the EBQI approach with a clinical-research partnership that included leaders at all levels of the VISN we started with three VISN 22 healthcare systems and the intervention was rolled out in three phases. In the first phase each of the three healthcare systems selected on primary care practice to participate. In the second phase, each of those three healthcare systems selected a second primary care practice and then in the final and third phase we opened it up to all of the primary care practices in the VISN and so we ended up with seven participating primary care practices at three healthcare system.

One of the main goals of an EBQI approach is to align top management priorities with frontline QI and we did this by engaging VISN healthcare system leaders and the local primary care practice leaders in a priority setting process which I will describe in a little bit more detail momentarily. Our intervention included two primary components. The first was to develop a multilevel organizational infrastructure for implementing EBQI for PACT and the second was facilitated quality improvement with external and internal facilitators.

This slide here shows the organizational infrastructure of EBQI-PACT. This is the first component of the intervention and as you can see the infrastructure included a VISN Level Steering Committee whose primary role was to set improvement priorities for PACT. It included VISN leadership in medicine, PACT training, system redesign, also somebody from the Patient Advocates office as well as mental health. And the VISN Steering Committee also included the Executive Leadership of the three healthcare systems that participated in the intervention. Each of the primary care practices was required to establish a Quality Council which has led the primary care based group that was interdisciplinary and included medicine, nursing and healthcare administration as well as a patient representative and also some representatives from the PACT Neighborhood Services like Social Work and HBDP. The infrastructure also included these cross-sites workgroups which are displayed in ovals across the bottom of the figure and these were special topic workgroups that provided support and expertise for ovulations such as homelessness or special topics like PACT in academic settings.

At the heart of the infrastructure were really these Quality Councils that were at the primary care practice level and when they signed on to the intervention they signed a Charter that outlined these three goals here as being their primary focus. The first we had to develop or foster interdisciplinary leadership for PACT QI; second to establish a structured local QI process with oversight and accountability mechanisms and third to facilitate frontline QI innovation within the primary care practice demonstration sites. We recently completed some analyses of key stakeholder interviews from the first two days of the project which included the first six sites and what we found is that all six of these sites met the first two of these goals and four of the six met or personally met the third goal.

In terms of the second component of the intervention the Facilitated QI this involved a priority setting process that engaged VISN healthcare system and local primary care practice leaders. And the way it worked is with the Quality Councils and workers submitted proposals for the QI projects to the Steering Committee for review and approval. The approved projects received support from VAIL researchers and staff; VAIL also arranged for the leaders of these projects to have some release time and VAIL provided some seed funding for any extra supplies or resources or even a little bit of salary support that these projects may need above and beyond the usual. VAIL also provided support for on Quality Council Coordinator for each healthcare system and this person acted as an internal facilitator with facilitation skills and also some data collection and reporting skills and project management skills. VAIL acted as an external facilitator by providing mentoring and coaching and QI methods and also helped with collecting data and developing measures for the QI projects and VAIL also sponsored and organized two learning sessions per year between 2011 and 2014.

This Facilitated QI process resulted in the Quality Council and workgroups submitting a total of seventy-one project proposals between 2011 and 2014. Twenty-one of these projects were approved by the Steering Committee after four rounds of review and these projects resulted in twelve toolkits which are now posted on the VAIL SharePoint site for spread across the VA.

This last slide just has some references for EBQI for people in the audience who want to learn more about it. Now I will turn it over to my co-presenter, Lisa Meredith.

Dr. Lisa Meredith: Good morning everybody, thank you Susan for setting me up very nicely and I have to apologize to everybody that for technical reasons I cannot connect directly to the website so I am going to ask Susan to advance my slides for me. I am going to present results from our longitudinal evaluation of the impact of the “Medical Home Demonstration on Primary Health Care Health Professional Emotional Exhaustion and Satisfaction”. We did look at burnout in one paper that is published using cross-sectional data for the first wave looking at burnout and so now we are looking at all three ways with data. We got this paper drafted and hopefully we will be submitting this to the *Journal of General Internal Medicine* very soon and any feedback you have today will help us tie up the bows of that package.

Moving to the next slide, I will begin the story by just noting that as you are all probably aware, patient-centered medical home models are promising because they do have potential to improve primary care provider and staff morale. PCMH model like the VA’s PACT initiative also can make healthcare more efficient by reducing utilization and costs and Jean is going to be presenting her work that addresses some of this. Ultimately these primary care transformations can improve the clinical care patients. So practice transformation can be a positive experience for both providers and patients.

On the other hand change is hard so PCP’s and staff can burnout and job satisfaction can either improve or worsen especially in the early stages of transformation when it might be necessary to manage change fatigue and implementation challenges before the machine gets well oiled. As Susan explained VAIL implements the use of this EBQI strategy to engage practices and innovations and also with the goal of easing potential burnout and hopefully improve satisfaction well during this process. I believe the few references I sited here are in Susan's list. Next slide.

There are a number of determinants of satisfaction and burnout during implementation and many of these have been identified in work by our colleagues included Christian Helfrich and his team and there are some of those citations at the end of this presentation. Some of these determinants are provider autonomy, also participatory organizational decision making style, adequate and consistent staffing of care teams, we have heard a lot about that being a challenge. Also good communication and transformational leadership along with other working conditions can ease this process. Many features of the patient centered medical home model like teamwork and good quality communication, coordinated panel management for example are all features that indeed can bring joy but there can also be negative consequences. So there have not been very much work that has really looked at how interventions to improve primary care team outcomes are impacted during the transformation process. Next slide.

The design of the study and as Susan mentioned this particular provider survey is only one component of a much larger evaluation. In general it is a quasi-experimental design to compare the impacts of PACT transformation alone with the addition of the EBQI and implemented in two stages. So as Susan mentioned we have one group of three clinics that started shortly after the National PACT rollout and then another that started about nineteen months later and then for this survey we had seventeen comparison clinics that did not engage in EBQI. Next slide please.

The main purpose of the survey was to track change over time in attitudes and experiences of primary care staff and other staff who work in primary care as they relate to implementing PACT. We hope that this would aid the design of better processes to identify best practices down the line. As you know PACT was rolled out to over nine hundred practices in the VA system nationally. For this study we feel that the surveys to look at changes over time in PCPs and staff in twenty-three VISN 22 practices over a thirty-nine month period. You can see that the first survey was fielded in late 2011 and went through March. The second wave was field in August of 2013 and we just recently completed at the beginning of this year the third and last wave of the surveys. Next slide.

This is an analytic model of what the analyses I am presenting essentially looked at. We tested both the direct effects of the different forms of PACT Implementation on burnout and I should mention that we defined that as the nine items subscale of the Maslach burnout inventory that looks at the emotional exhaustion component and then we looked at job satisfaction using a single item reading of overall satisfaction with your job. So the direct analyses are represented in past seeds where we have the three different implementation types and looking at their impact on emotional exhaustion and satisfaction. Then we also looked at the mediation assessed or the indirect effect of implementation on those outcomes but as a function of some of the other experiences with PACT. We used structural equations modeling to look at three types of mediators, one of them is the efficacy of implementing PACT so it is essentially a set of items such as we implement PACT I feel I can handle it with ease. A second mediator is experience of PACT changes and this is indicated by six types of facilitators for example use of new measurement tools or teamwork huddles and understanding the extent to which people use those types of facilitators. Then the third effectiveness variable was the same six items rated in terms of how helpful they are for improving patients care. Next slide.

Now I am going to turn this back to Molly to actually do another poll just so I can get a sense of who is in the audience.

Molly: Excellent.

Dr. Lisa Meredith: I cannot see it, Molly you can summarize the results.

Molly: Excellent, thank you I will do so. As Susan was saying we want to get an idea for who is in our audience. We understand that many of you probably wear many different hats within the VA but we are trying to get an idea of your primary role so go ahead and please click one of the white circles next your response. Those answer choices are: PACT Physician; PACT Nurse; Other Primary Care Role such as dietitian, pharmacist, social worker; Investigator or Research Staff; Administrator or Other. Looks like we have had about two-thirds of our audience vote so we will give people a few more seconds to get their responses in. Great I see a pretty clear trend so I am going to go ahead and close it out and share those results. If you are selecting Other please note that we will have a more extensive list of job titles during the Feedback Survey at the end. So five percent of respondents are PACT Physicians; ten percent PACT Nurses; eighteen percent Other Primary Care role; thirty-one percent Investigator or Research Staff and thirty-seven percent Administrator or other. So thank you to those respondents and I will turn it back to you Lisa.

Dr. Lisa Meredith: Thank you Molly. Interesting we have a lot of researchers and administrators hopefully administrators are thinking about maybe some lessons for helping to ease implementation in future roll outs. I am going to turn to the next slide and give you some data finally.

This slide shows our response rates across all three waves of the data and if you are one of the five percent physicians you would have been reflected in the blue bars if you were in VISN 22 and filled out a survey. And then all of the other, excuse me I should say physicians also nurse practitioners and physician assistants are reflected in the blue bars and then all of the other types of staff are in the green bar and then the light gray bar is the overall. You can see that we did a lot better with our response rate in wave one which was really high for a providers and staff survey. We did a little not as good in wave two and three however, close to fifty percent overall is really pretty good for this kind of a survey. Alright the next slide.

These are the demographic characteristics of the analytic sample. It included three hundred and fifty-six professionals; a hundred and seven of them were primary care providers and two forty-nine staff who completed at least two of the three waves of the survey. As you might expect, no surprises, here staff are significantly more likely to be female, almost eighty percent compared to primary care providers which is about forty-two percent female. And staff also have greater representation of non-White, non-Latino staff and younger people and have worked in a study clinic for fewer years relative to PCP. Next slide.

Here is the distribution of type of provider that ended up in our analysis sample. I already mentioned there are a hundred and seven physicians; most of them are internal medicine physicians which reflects the VA nationwide. And we had a good number of RN’s ninety-seven of them, seventy-eight LPN’s or vocational nurses and then we had a smattering of mental health professionals, dietitians and about twenty-nine med techs or assistants and clerks. Next slide.

This pair of charts illustrates the unadjusted findings for the emotional exhaustion outcome over time for each of the three groups. The solid line is the comparison group that did not have exposure to EBQI, the larger dotted line is the early phase of the EBQI clinics and then the smaller dotted line is the later phase. We found relatively large intervention effects over time for the primary care physicians reflected in the left panel especially for wave three where you see a lot of separation. But we found little change over time in staff emotional exhaustion if you look at the right hand panel, the lines overlap pretty much. The emotional exhaustion scores for the comparison practices looking at the PCP again for the comparison practices burnout actually increased although it was not significant from wave one to wave two by almost two points on the scale which ranges from zero to forty-five, but it did increase significantly from wave one to wave three by almost five points. This five point increase is equivalent to almost a half of a standard deviation so that is relatively substantial. Then when we look at the later EBQI-PACT phase which again is the smaller dotted line it showed actually a decrease in burnout by wave three that was equivalent to six point/two point compared to the comparison practices. We also ran models that accounted for covariates using sort of differences in differences analysis and in those analyses the later EBQI-PACT phase decreased by wave three at almost seven points compared to the other practices. Pretty big burnout effects and if we can go to the next slide.

These are the same findings for satisfaction and what we see here is that for primary care providers we found no differences for the EBQI-PACT compared to the other or versus the comparison group over time. But in contrast for staff on the right hand side, we see a significant decrease in satisfaction. So even though going back to primary care providers there is a slight trend in the late group for increasing and even in the other although it as not significant for staff there is actually a significant decrease in satisfaction. Again this decrease is pretty substantial about .4 of a standard deviation. I will move on to the next slide.

I do not expect you to fully see the process all of this. The bottom line is that we found no mediation effects for the relationship between EBQI-PACT Interventions versus the comparison group. On either of the outcomes for all three of the mediators that we tested this is just an example of the findings for one of the mediators the experience measure. What we see is, so the arrows with multiple effect separated by a slash those indicate the effects for the early versus the late PACT group respectively relative to comparison. And you can see that none of these pass to burnout through experience were significant so again no mediation there. The intervention effect operates directly regardless of whether you have more experience with PACT over time. Next slide and then I am almost ready to wrap it up.

Just to summarize we found that EBQI intervention initiated during the National VA PCMH Implementation was associated with reduced burnout over time for PCPs but not for staff in comparing to the other prices. This effect was of moderate to large size in magnitude. We did not find an effective EBQI for job satisfaction although there was a trend towards better satisfaction for the early EBQI phase. And the addition of support for transforming practice using local EBQI innovation and interdisciplinary inter-organizational communications across practice as well as spread across sites and support for project management, all of these things our findings suggest that many of these ingredients associated with EBQI do indeed improve the process of implementing patient centered medical homes over time. And that EBQI may be helpful for reducing the substantial variations that we have observed in implementation across different practice sites.

That is pretty much the end; I have one last slide like Susan’s where I provided some references, some papers from the VAIL team including the cross-sectional paper on burnout is in there. I believe I am on time and I am now going to turn this over to Jean Yoon who is our final presenter.

Dr. Jean Yoon: Thank you Lisa. We will be looking at the impact of EBQI-PACT on utilization. In terms of background a lot of different healthcare systems have adopted the patient centered medical home and there have been several different evaluations that have tried to assess the impact of PCMH utilization. And these studies have found all different effects. For example some studies have found that PCMH has reduced hospitalizations and ED visits and then some studies have not found any effect on none of these utilization outcomes. In VA PACT’s model it emphasizes mode of care such as non-face-to-face care using telephone visits, electronic messaging with providers. It emphasizes care coordination between providers and also emphasizes mental healthcare access and primary care such as primary care and mental health integration. These modes of care have the potential to reduce unnecessary acute care in the form of ED visits and hospitalizations. Our hypothesis was the EBQI-PACT sites could be more successful in implementing PACT which would then lead to more telephone care and less face-to-face visits for things like primary care, specialty care and mental health. And that there would also be fewer hospitalizations and ED visits. Because EBQI PACT might be more successful especially in the early stages at implementing PACT we would expect change in utilization to occur earlier compared to the other sites.

The objective for our study overall were to look at changes in utilization for different types of utilization and costs for patients who received care from EBQI sites compared to regular PACT sites over a five year period.

Our study design used longitudinal study design. We looked at a cohort of patients who were using primary care in thirty-four different practices in VISN 22. So most of our utilization outcomes came from the National Patient Care Databases and then we created categories for primary care; specialty care; mental health; substance abuse care; telephone diagnostics; lab; ancillary and ED visits. We also looked at inpatient stays for all-cause stays and stays for ambulatory care sensitive conditions. Then we conducted some regression models where we adjusted for various patient and practice characteristics. So we adjusted for things like patient age, gender, service connection and then we adjusted for practice characteristics like size, type of clinic and whether it was urban or rural.

In our study design what we did was we used the timing of the initiation of EBQI methods to then estimate the impact of the EBQI on utilization. We were able to do this because we had sites that did not implement EBQI and the sites that had EBQI implemented in phases. We had phase one sites that began EBQI by early 2011; phase two sites that began EBQI by 2012 and then the comparison sites. What we did in our regression model is we created a measure of EBQI-PACT participation with an indicator variable. So it was equal to zero in the years prior to implementing EBQI and it was equal to one in the year it began and the subsequent year. Then for the comparison sites it was equal to zero for all of the study years. We also wanted to incorporate interaction terms between EBQI-PACT and year to account for any differences that would happen over time.

The next slide shows a table of the sites so basically we had three sites in phase one and they had an overall three and then as a minimum but that is up to four years of EBQI experience. There were three sites who were phase two practices and in our study period they had only two years of EBQI experience. Then most of the practices in our study were PACT only sties.

Next I am going to focus on our main outcomes for our study. The outcomes I am going to show you are all adjusted so they are all adjusted for patients and practice characteristics. We have found in terms of primary care encounters we found that all sites had reduced primary care encounters over time beginning of PACT Implementation. We see in the red dotted line that EBQI sites had a faster decrease at the beginning of PACT compared to the PACT only sites. But in the later years of PACT implementation their rate of primary care encounters sort of decreased so that by the end they actually had a slightly higher number of mean encounters per patient than the PACT only sites.

For specialty care encounters we see a very similar relationship so again we see that for all sites the number of specialty care encounters per patient decreased over time. We see that there was a much bigger decrease for the EBQI sites compared to the PACT only sites but by the end of the study period they had very similar numbers of mean number of encounters per patients.

Then again, for the outpatient mental health we see a larger effect for mental health then we did for primary care and specialty care. And we do see again all sites had decreases in face-to-face mental health encounters over time and that there was a pretty big effect of EBQI decreasing mental health encounters in addition to the decrease that was happening in the PACT only sites. But it did level off a little bit towards the later years of PACT implementation so by the end of the study period they had similar numbers of mental health encounters per patients.

I will not show our other results for the other utilization outcomes that we looked at but I can tell you that we did not find any other effects of EBQI-PACT on telephone encounters, ED visits, hospitalizations or healthcare costs.

In conclusion what we found was that there were utilization changes in all sites but they were more rapid in the EBQI sites but there was some sort of offsetting effect over time. Because we saw a decrease in face-to-face encounters, we did not find any increase in hospitalizations or ED visits. This suggests that there were not any adverse health effects of these reduction in encounters and that may ultimately represent more efficient management of patient’s primary care.

As we saw in the results by the end of the study period all the sites appeared to have a similar number of encounters per patients so it may be that because innovations were shared across the VISN like we saw earlier that sites were creating toolkits to help other sites implement similar intervention, these sorts of toolkits and other shared innovations may have helped the comparison practices catch up to the EBQI practices. Overall our results suggest that using EBQI methods may ultimately help practices engage in practice transformation using models like PACT.

What I shared with you was sort of a brief overview of our study. If you are looking for more details of the study itself and some of the measures that we created it was published recently in M*edical Care* and this is the citation here. In terms of questions and comments for us, if you have any for any of us on the presentation today, here is our contact information and we are happy to answer any questions right now.

Molly: Excellent, thank you all very much. For our attendees I know a lot of you joined after the top of the hour, to submit your questions or comments use the Question section of the Go To Webinar Control Panel that is on the right hand side of your screen, just click the plus sign (+) next to the word Questions and that will expand the dialogue box and you can then submit it there.

The first question you have – I joined late, I apologize if you went over this already. Does the VA have a plan to implement PACT across all VISN’s and if so you know when that might roll out?

Dr. Lisa Meredith: PACT has already been implemented across all VISN’s although it has been a little spotty here and there. I mean it has not been rolled out equally across all VISN’s.

Dr. Susan Stockdale: I wonder if the question was about whether EBQI PACT was going to be rolled out?

Molly: We can go ahead and assume that and go from there. If they have further clarification they can write in but yeah go ahead.

Dr. Susan Stockdale: This is Susan. EBQI PACT has not been rolled out across all VISN’s; it was rolled out only in VISN 22 so far.

Molly: Thank you. The next question – can you expand on the differences between PACT and EBQI-PACTS?

Dr. Susan Stockdale: Yeah this is Susan I can address that. We are still looking at our data but the EBQI-PACTS had more, one of the things that Lisa Meredith highlighted was this finding about shared decision making or I think it is called shared decision making, participatory decision making excuse me between the frontlines and the management and leadership of the healthcare system. This was one thing that we are seeing has really been standing out and the EBQI sites this was emphasized very much through the partnership with the researchers helping to facilitate leadership interacting with the frontlines. So that was one difference of the EBQI sites. I think one of the other things that is coming out in some of our more recent analyses is that the providers and the staff at the EBQI sites felt more empowered to make improvements and to try to adapt processes so that PACT could work better. We find so often in the VA these mandates come down from central office and you just have to do it and there is not a lot of guidance and sometimes the frontlines feel very unautonomous and unempowered and this EBQI-PACT was really a way to get them more involved in the whole process of implementing PACT and I think the change management literature shows that getting people more involved and them feeling like they have a voice in change also makes a difference.

Molly: Thank you for that response. Can you provide more detail about the work done by the EBQI infrastructure and workgroups?

Dr. Susan Stockdale: Well, I should have put this up. If you want to email me I can send you a link to the SharePoint site and you can look through the SharePoint site at the toolkits and things that the projects did. There were a number of innovation projects that dealt with things like mental health integration, with meeting some of the PACT performance measures like the post-discharge calls and getting people to sign up on My Health Event and use secure messaging, there were interventions that addressed walk-ins, continuity. So if you want to email me on the side I will be happy to share that link with you.

Molly: Thank you. There may be some overlap in your answers for these following questions. What were the differences between EBQI, I am sorry. Oh yeah, what were the differences between the EBQI and the PACT training provided to all facilities?

Dr. Susan Stockdale: That is a good question. I do not now if you can just kind of sum up the PACT training provided because I think it varied a lot across facilities. As some people may know, especially the people that were involved in PACT Implementation there were the regional collaborative which were meant to provide training for PACT for one team per facility. That team traveled to these learning collaborative I think there were six total conferences that they went to to get extra training in how to implement PACT. At those regional collaborative there was an emphasis on quality improvement and using quality improvement not that and they received training on things like population management and how to huddle efficiently and things like that. But it was only team per facility and when that one team came back the idea was they would spread but sometimes that did not happened very well. Then other facilities, most facilities I think had some PACT training in the beginning where everybody was trained but sometimes team members were not trained together, they were trained separately. And sometimes new people at joined PACT did not get an official training on PACT until after they had been at the VA for a while, they would get basically training on the job in how to do PACT. At the EBQI sites, I mean they got the same training as everybody else at the site would have gotten for the facility in terms of how to implement PACT, but in addition to that they got extra training from the VAIL researchers on quality improvement methods. Also at the learning sessions that VAIL hosted we had some sessions about extra topics like population management and that kind of thing that PACT was trying to do.

Molly: Thank you. Can you speak a little to the actual EBQI practices that were changed or implemented? I am asking because we were recently given access to a telephone triage protocol and I have been using it more to improve access and reduce unnecessary visits as well as using it for walk-ins.

Dr. Susan Stockdale: I am not quite sure what the question is, can you repeat the first part of the question Molly?

Molly: Yeah. Can you speak a little to the actual EBQI practices that were changed or implemented?

Dr. Susan Stockdale: Yeah. I am not quite sure what is being asked there. I can say that they did roll out a number of QI projects that addressed things like trying to reduce access. And because they participated in basically collaborative style where we had biweekly calls with all the sites and they shared what they were learning the sites did learn from each other. I am not sure that is what that person was trying to get at about the EBQI sites.

Molly: They are welcome to write in for further clarification. Right now, that is I believe the last question. If anybody is looking we have a few requests for the references, if you download today’s slides all the references that have been included are within the handouts, you can download those and keep them for future reference.

With that I do want to give each of you ladies to make any concluding comments if you would like, I guess we will just go in order of speakers. Susan would you like to give any concluding comments?

Dr. Susan Stockdale: No, I do not think I have anything more to say.

Molly: Okay how about you Lisa? Lisa you may still be muted.

Dr. Lisa Meredith: You are right I think I am off mute now, sorry about that. I just wanted to make a comment about how many provider and staff surveys VA folks are subjected to and it is always a challenge when we do yet another survey and worry about our response rates. I was pleased when we had an error, I was pleased that our wave two response rate was actually higher than I thought and so I just wanted to thank everybody in case any of you were a respondent.

Molly: Thank you. Jean would you like to give a wrap up with anything?

Dr. Jean Yoon: I just want to say thinks to everyone for joining us today. If you have any ideas or suggestions on what sort of things we should look at in the future in terms of effective EBQI-PACT we will be happy to hear from you.

Molly: Excellent and I would like to thank you all very much for coming on and lending your expertise to the field. We really appreciate it and of course thank you to our attendees for joining us. In just a moment I am going to close out the session for our attendees, please wait just a second while the feedback survey populates on your screen and please answer those few questions, yet another survey but we do look very closely at your responses and it helps us to improve presentations we have already given as well as ideas for future presentations. And as always, please join us monthly for our PACT Cyberseminars they are always the third Wednesday of the month at noon eastern. Once again, thank you everybody and have a great rest of the day.