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Session: Creating a Patient Engagement Toolkit

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Unidentified Female: At this time, I would like to introduce our speaker. Today, we are very lucky to have joining us, Shimrit Keddem, she’s the Associate Director of Operations at the Center for Evaluation of PACT, known as CEPACT, and that’s located at the VISN 4 PACT demonstration lab located in Philadelphia VA Medical Center. And at this time, I would like to turn it over to Shimrit.

Shimrit Keddem: Okay. Thanks, Molly. Hello, everyone. Can you hear me okay?

Molly: We can. Thank you.

Shimrit Keddem: Great. So today, I’m going to walk you through a process we use to develop a patient engagement toolkit for VA PACT teams and clinics. And I want to emphasis that the toolkit we created, which I’m going to show you, is still sort of in beta version, so we are currently in the process of testing it out. And just to go through my agenda for this talk, first, I’m going to give you an overview of our project, including our goals and specific aims. I’ll describe our qualitative data collection and analysis process, talk about the modified Delphi calls that we conducted, and then I’ll show you the patient engagement toolkit in its current form. Then lastly, I’ll walk you through our next steps and our anticipated barriers.

Molly: Thank you. So for our audience members, we are going to do our first poll question here. And we’d like to get an idea of what is your primary role in VA. We know that many of you wear many different hats within the organization, but we’d like to get an idea of what your primary role is. And those answer options are: student, trainee, or fellow; clinician; researcher; administrator, manager, or policymaker; or other. Please note, if you are selecting other, I will put up a more extensive list of job titles in the feedback survey at the end of the presentation and you might find yours there to select. Okay. It looks like we’ve got a nice, responsive audience. About just over 70% have responded, so I’m going to go ahead and close out the poll and share those results. We have: 0 reporting being student, trainee, or fellow; 10% responded clinician; 30% researchers; 26% of respondents said administrator, manager, or policymaker; and just over one third, 34% of respondents said other. So thank you to those respondents, and Shimrit, did you want to make any comments before I move on to the next one?

Shimrit Keddem: No. Thank you.

Molly: Okay. Yeah, no problem. And this is our second poll question for our attendees, just click the response right there on our screen. We’d like to get an idea of how familiar you are with CEPACT and the demo labs, and the answer options are: completely familiar with it; somewhat familiar with it; not sure; somewhat unfamiliar; and completely unfamiliar. So this will help give an idea of how much background detail to go in for CEPACT and the demo labs. Okay. And it looks like and we’ve had just over 70% response rate and I see a very clear trend, so I’m going to close this out and share those results. 7% feel completely familiar; 11% somewhat familiar; 4% not sure; 11% somewhat unfamiliar; and a resounding two thirds of respondents are completely unfamiliar with it. So that’s very helpful. Thank you. And I will turn it back to you now.

Shimrit Keddem: Okay. Thanks, Molly. So for those of you who are unfamiliar, the Center for Evaluation of PACT, or CEPACT, is one of four demonstration laboratories nationally that tracks the progress of PACT implementation and works to improve the PACT model. And our goals at our specific facility are to make primary care more patient-centered, to create partnerships between veterans and their team, and ultimately, we are hoping that our work can help improve patient satisfaction. And to guide some of our sampling for this project, we use a modified version of the PACT implementation index, which is also referred to as the PI². This was a metric that was created by the demo lab initiative to track PACT implementation, and we looked at four specific domains of the PI², or what we call the modified PI².

 So those four are: comprehensiveness; patient-center care and communication; shared decision making; and self-management support. And these domains are based on SHEP questions. So comprehensiveness is really using holistic care and including mental health, so a SHEP question that’s associated with that is, did anyone in the provider’s office ask you if there was a period of time when you felt sad and if you were depressed? And then, patient-centered care and communication is really about tailoring communication to the preferences of the patient. So an example SHEP question would be, how often did the provider explain things in a way that was easy to understand? And then, shared decision making, that domain was mostly questions about prescription medications. So for example, when you talk about starting or stopping a prescription medication, how much did this provider talk about the reason you might want to take a medicine? And then lastly, self-management support is really about goal setting in the context of patient preferences and barriers, so did anyone in the provider’s office talk with you about specific goals for your health? So that’s really what -- those are the areas of the SHEP and the PI² that we’re interested in.

 And so, because we are interested in patient-center care and creating partnerships between veterans and their team, we focused our evaluation around the concept of patient engagement. So our main objectives are: to identify the best practices to improve patient engagement; and then disseminate these best practices in VISN 4 and ultimately, nationally. And we are also interested in improving veteran engagement and care, and reducing racial disparities in patient engagement.

And we know that there are a number of benefits to improving patient engagement. The literature suggests that patients who are more engaged tend to make better use of resources and have a better understanding of their conditions and their health outcomes.

And so, the first thing we did was to come up with a working definition of patient engagement, and there are many out there, but this is the one that we used. So any practice, policies or procedures that A. involve and support patients and their families and representatives as active members of the healthcare team, and B. encourage collaborative partnerships between patients, healthcare providers and the organization as a whole.

So our project had a number of steps. The first step was to collect qualitative interviews with providers to find out what types of patient engagement activities and techniques are being used across sites, and that has been completed. The second step was to develop a prioritized list of best practices using a modified Delphi technique which we did using conference calls, and that has also been completed. And then the last step, disseminating these best practices through VISN 4 and then tracking that implementation, is in progress now.

And so, this is a diagram giving you an overview of the different steps we went through to arrive at our toolkit, or what we’re calling our final toolkit right now. First, we collected qualitative data and we did that through site visits and telephone interviews. This gave us our first pre-Delphi list. And then the Delphi process, which consisted of three meetings over the course of about a month, the goal of that was to get our final list, or toolkit. And I’m going to go into more detail on each of these steps.

So to start out, we did a series of qualitative interviews, where we basically asked staff to describe patient engagement efforts and any barriers and facilitators to engaging patients. We did 66 in-depth qualitative telephone interviews. Those were interviews with nurse managers, patient advocates, and primary care leads. And we also did six site visits. So during the site visit, we interviewed PACT teams and ancillary staff, and we also conducted observations of patient encounters. So we ended up, through all of this work, with over 200 data points which we analyzed to create two lists, consisting of 222 items. And those were 128 patient engagement practices, and then 94 patient engagement resources.

So what are patient engagement practice and resources? Patient engagement practices are things that staff members do directly to involve and empower the veteran in their own care, and then patient engagement resources are facilitators that help to improve and support patient engagement efforts at a facility. And I will have a lot more examples of these things, so they’ll hopefully become clearer as well.

And so, our next step was to conduct the qualitative data analysis of our 200 data points in order to assemble our first Delphi list. Our interviews were all audio recorded and transcribed. The data was entered into a software package called NVivo, and the goal of that was to just to code and really organize our data to make sense of it to come up with our lists. So there were five qualitative coders. The data was initially organized into 14 broad themes in multiple sum codes. And each coder read all of the data and coded line by line of text, and used these definitions when considering practices and resources. So patient engagement practices were defined as actionable efforts being made by staff for their patients, and then patient engagement resources were defined as actionable efforts being made at the facility level.

And so, we divided the patient engagement practices into five categories. So things that happened pre-visit, during the visit, post-visit, between visits, and classes. And so, here are some examples of the patient engagement practices from our first list. In the pre-visit, we saw eliciting patient priorities during check-in, during the visit, eliciting patient opinions, post-visit, anticipate upcoming needs, between visits, things like home logs and secure messaging, and then, the classes we saw were peer support groups and community garden.

And so, here are some examples of our patient engagement resources. And the resources list is really a list of key ingredients that enable patient engagement to occur. So we initially divided the list that you see here into three categories. One section was resources for patients only, one section was resources for staff only, and the third section was for patients and staff. And again, here are some examples. So for patients, we saw veteran learning centers, comment cards, committees. For staff, we saw training and a health behavior coordinator on staff. And for patients and staff, we saw QI projects and having a patient advocate liaison. Now these three categories were actually not our final resource categories, those ended up being slightly different and I’ll show you those when we look at the final list. But the general idea so far, as you can see, is that we took all of our qualitative data and really just organized it into items within categories.

So then, we held a series of Delphi calls to narrow down the list. So for those who are not familiar with Delphi, it’s a method that involves consensus building. So basically, what you do is, you bring together a panel of experts for some rounds of discussion and/or surveys. The goal is to move towards agreement. So in our case, the goal was to reduce the number of practices and arrive at a list by expert consensus. So our analysis, as I said earlier, produced 222 practices and resources, but in order to identify the sort of the best practices, we conducted a series of calls. So our panel consisted of 12 participants, and those included 2 veterans and 10 VA healthcare professionals. So including primary care leads, nurse managers, patient advocates, a health behavior coordinator, and a health promotion disease prevention coordinator. And our primary goal with all these calls was really to shorten and prioritize the list by determining which practices and resources were the most important and most feasible in advancing patient engagement. And to do that, we held three sessions where participants rated items and had discussions.

So week one of the Delphi. The goal of our first call with our panel was really to familiarize the Delphi panel with a list of resources and practices and to start to whittle down the list. So we asked participants to complete two surveys where each item on the survey was either a practice or a resource. On one survey, they had to rate the items on importance, and on the other survey, they had to rate them all again on feasibility. So for importance, we asked on the whole, how important is this practice to help patients to be more engaged in their healthcare, and for feasibility we asked, how easy or convenient is the practice to implement, and is the practice difficult or nearly impossible to implement?

And when we got our results back, we basically divided them into four categories. We had items that were either high importance, high feasibility, low importance, low feasibility, medium importance, medium feasibility, and then items that were polarized, so maybe they were high on importance and low on feasibility, or vice versa. And items that were rated as high on both, we kept. So you see here, we kept 74 items. Items that were rated as low on both, we removed. So that here, 32 items were removed. But we still had a lot of items remaining because remember, we started out with 222. So we had about 116 items still remaining.

And this is what the survey looked like. So here you see, here’s an item that happens in the pre-visit. So have clerks ask patients about the primary goals of their visit. And on a Likert scale, we asked them, how important is this practice for patient engagement? And then similarly, the same item, we asked, how feasible would it be to implement this practice? Same Likert scale. So items that were extremely high on both, were kept. Those that were extremely low on both, were tossed. And what was left were situations where one was low and one was high, or where they were really down the middle of the road. And those items were kept for the next round.

So week two of the Delphi. So in our second Delphi conference call, we shared the results with participants. We then revisited items that were either polarized or rated as medium. We facilitated a brief discussion to help them kind of figure out for themselves the thought process behind what makes something important, or what makes something feasible. So for items that were polarized, we asked participants to complete a survey, to rerate them on the same Likert scale. And the goal was, since they initially did not agree, we wanted to see if they could come to a consensus.

In items that were rated as medium, which are items where there was consensus of the practice or resource that was moderately important or feasible, we asked participants to complete a survey to either keep or remove those items. And so, the goal was really to push people to decide whether or not those middle of the road items, whether they were sort of good enough to include in our toolkit. So at week two, we kept an additional 57 items and these were things that were either polarized and reclassified as high importance, high feasibility, or medium rated items that were selected as keep by at least half of our panel. And we also removed 59 items at this point.

And this is what the survey looked like in week two. So polarized items were discussed and rerated. And again, you see an item here, how important is this practice for patient engagement, and it’s the same Likert scale, so we asked them to rate them again after a discussion. And then for the medium items, again, you see an item here, provide patients with a summary of information from their most recent visit so that they can review the information, such as test results, and ask pertinent questions of their PACT. And those items, we asked them, do you want to keep or remove? That’s a medium item.

So at week three, we still had 131 items, which was still too many for our toolkit. So our goal in week three was really to prioritize. Of the practices and resources they thought were important and feasible, now, which are the most essential ones to include in the toolkit? So week three, we shared the results with participants again, had some group discussion, and discussed the final survey. So in this final survey, we took our lists and we randomly separated them into groups of ten practice or resources, and then we asked participants to choose the top three practices or resources of each group. And so we ended up with 76 items, and that was based on the people removed. So a practice was removed if less than five people selected it, and a resource was removed if less than four people selected it. So the other thing that happened is that we kept 55 items. And so, that was the last week and that was really the final list. And so, that consisted of actually 36 practices and 19 resources.

And then, the final step for us is, we looked at this list, and the team reviewed it together, so a team of clinicians and researchers looked at the list. We first looked for items that were similar, so those items could be maybe merged together, so we did some cleaning like that. Then we examined to ensure that the items were really actionable things, actionable patient engaging recommendations that people could actually do. And then, we also checked that items were related to those performance metric domains, those four domains of the modified PI². And the reason for that is because that’s how we were going to measure during our evaluation.

So this is what the final survey looked like. So for each group of ten, so here, just to fit on the slide, you’re only seeing five items and in our actual survey there was a list of ten. And then, we asked participants to choose the top three for each list. And again, these were sort of randomly assembled into groups.

So this is an overview of our results. So we started out, as I said, with 222 items, 128 practice and 94 resources. And we eliminated 32 at our first meeting, 59 at our second meeting, and 76 at our last meeting. And the final toolkit, which is what I’m about to describe to you in more detail, had 36 practices and 19 resources.

So when you look at the final list of practices, you see it’s still broken down based on that original categories. So pre-visit, visit, post-visit, between visits, classes and clinics. Most of the practices, 17 of them, you see are in the visit category, so they’re happening during the visit. And then, another way we used to categorize our list was using the PI² domains I mentioned earlier. So those were comprehensiveness, patient-centered care and communication, shared decision making, and self-management support. And it’s important to note that these categories are actually not mutually exclusive, so it’s possible that our items landed in more than one category, but you see that the biggest group here is self-management support, followed by patient-centered care and communication.

 So these are some examples of those final list of practices. So under the pre-visit category, we had activate patients for the visit, prepare providers for the visit. Under the visit category, build rapport with patients, elicit patient priorities, give patients agency, also set goals, educate patients. In the post-visit category, summarize visit and next steps. Between visits, follow up with extended PACT members, follow up with calls to patients, provide patient support material. And then in the classes and clinics, use classes and clinics to support patients. So things like, new patient orientation, or having a wellness group to support patient engagement.

So here, you see a breakdown of the resources list. So you see it’s a little bit of a different organizational scheme, so these are categories based on themes. So the four categories are: encourage a supportive environment for patient engagement; patient engagement training; resources for communication; and quality improvement and feedback. And you see that our top category, the one with the most items, is encourage a supportive environment for patient engagement.

So here are some examples of what landed in our final list. So under the environment category: improved phone access; create protected time; encourage teamwork. Under the training category: require and support trainings and refresher training on communication; motivational interviewing. Under communication: create customized programming on TVs and electronic bulletin boards; create program guides for patient and staff. Under the feedback category we have: audio or video require clinical encounters; establish primary care advisory committees; appoint patient advocate liaisons to manage concerns.

And so, as I mentioned earlier, our goal is really to disseminate these practices first within our VISN and then nationally. And to that end, we’ve started by packaging our practices and resources into an online toolkit. So this here is a link to that online toolkit. I have it open so I’m going to bring it in here and show it to you. And you can get here by going to our homepage, you can Google CEPACT and then clicking on the PACT Tools button. And you see under Tools we have a little bit about our patient engagement project, we have our definition of patient engagement, what our practice and resources, what’s the difference between those, and then we have a little bit of information for our participants in VISN 4, our facilities who are going to be hopefully implementing some of these things.

And then we have two buttons, the practice and resources. I’m going to go in here and show you our toolkit. So I’m going to click on practices. So here you see that the toolkit is really organized, like I said, into these visit categories, so pre-visit, visit, post-visit, between visits, and then classes and clinics. And each of these items you can click down and get more information about. And we designed it to try to make it less overwhelming. It’s a lot of information. And so we are working on maybe making it more searchable and sort of indexing some of these things, maybe categorizing them by which team mem, so pre-visit, visit, post-visit, between visits, and then classes and clinics. And each of these items you can click down and get more information about. And we designed it to try to make it less overwhelming. It’s a lot of information. And so we are working on maybe making it more searchable and sort of indexing some of these things, maybe categorizing them by which team member they apply to, those kinds of things.

But you can see here under pre-visit, I clicked on activate patients for visit, and then underneath that, I clicked on provide patients with a summary of information from their most recent visit. Here, you see, if I click down, I get these two more options. If I click here, at check-in, provide patients with copies of their most recent labs and active medications, give them time to review these documents, and then engage them in conversation about it. And these real-life examples are all quotes from our actual interviews with staff. And we do have a collaborator who also interviewed patients, and so we have some patient quotes in here as well. So you see this is sort of a real-life example, “Whenever they’re checking in at the front desk, they’ll give them a copy of their last lab. It gives them something to do while they’re sitting there. They’ll also give them a copy of their med sheet so they can check it out.” And that came from a nurse manager who we interviewed.

If I click on post-visit here, again, I have an item here, I can click on it and it will have examples below it. And so, I have under post-visit, summarize visit and next steps. If I click here, on this item, anticipate patient’s needs by educating them about the programs or services available to them. So here I have, one example is, have staff offer services or interventions to assist the patient before their next visit. And a real-life example, “The PCP asked if he wanted a cortisone shot in the meantime, before the surgery, to relieve some of the pain, and the patient accepted. He was really happy when she suggested that, saying, ‘Anything that will give me some relief will be great.’” And that came from one of our patient observations, from our observation notes.

And then under classes and clinics we can look at that. And so there are four items here, options, ideas for classes and clinics to engage patients. So if I click on those, offer a new patient orientation that educates patients about available resources at VA, the new patient orientation may be organized and facilitated by the patient advocate, education department, or PACT teamlet in collaboration with representatives from other departments. Where down here, make the new enrollee orientations to family and caregivers, too. So I have a quote here from a patient advocate, “We do a new enrollee orientation. We say family members can come in and listen to the orientation, so they can be updated on what we do here.” So those are some examples of our practices.

If I go back to my Tools button, I can then switch over to patient engagement resources. So if I click on that, I now have these four categories, which again, are the themes of our patient engagement resources. Again, the key ingredients necessary for patient engagement to occur. So you see under environment, we have protected time, for example. And if I click on that, I have a couple of ideas, create protected time for telephone and secure messaging follow up. And here’s an idea, designate a daily or weekly time period to schedule telephone appointments. And you see we have a quote from one of our primary care physicians. And then under communication, another couple options. Having a program guide and what that might look like. Create a veteran healthcare guide that describes the different programs and keep it updated. And here, we actually have a lot of quotes and several quotes from patients, “For example, when I first came into the system, no one told me about travel pay. I learned that from other patients. To me, that is something that should be presented when you begin. You should be aware of what benefits you receive.” So something from a patient. But those are our tools that we’ve put online.

And so, I also just want to say that, this toolkit is not yet a how-to guide, but really, as you saw, a list of ideas of what is being done to engage patients. And we’re hoping that over the next couple of years, we’ll have more information on how these things can really get implemented on the ground and be able to add and augment the current toolkit. So also to emphasize again, that we’re considering this toolkit to be a working document, we’ll continue to add and improve on it over the next couple years as our evaluation sort of progresses and we learn more about how we can be useful to people.

So in addition to our website, we’ve also created some flyers as well to introduce our project and our toolkit to facilities in our VISN. We’ve also participated in two VISN 4 primary care committee calls. And we’re really reaching out to facility leadership to discuss buy-in and strategies for implementing practices.

So what’s next? Our goals for the next phase of the project are to continue with dissemination of practices and VISN 4. This is going to involve recurring meetings to support implementations. And we anticipate that those’ll be both individualized phone calls directly with facilities, maybe walking through some of their challenges and troubleshooting with them, as well as group calls where different facilities can really coach each other if they’re doing really well in one area, maybe they have some tips for someone who’s not doing as well. And we are going to be tracking the progress of implementation over the next couple of years, and really doing a lot of sort of process documentation like, what does it take to get up and running for some of these things, what’s really the effort involved? And we’re also going to be doing a quantitative evaluation of the effect of the dissemination, and the spread of the best practices. And for that, we’ll be looking at facilities’ SHEP scores, especially in relation to those four domains I mentioned, so again, comprehensiveness, patient-centered care and communication, shared decision making, and self-management support. And then, we’re hoping to continue to tweak the toolkit, as I said, and assemble a prototype that really, we’re hoping to disseminate nationally.

And this is a flyer that we created for facilities within our VISN to advertise the project and provide information on how to access our website. And you see, we also provided folks with our working definition of patient engagement.

And so, I think our biggest challenge so far is, there’s definitely a lack of understanding around what patient engagement is, as I said, even in the literature there are sort of conflicting and not clear definitions. And especially with the current push for access, I definitely think that this is viewed as secondary. So we have been working a lot over the last six months or so building buy-in, we’ve been talking to our advisory board, we’ve participated in VISN calls, we’ve reached out to leadership, and I think we’ve made a lot of headway in reaching out to sites. And certainly, as everyone knows, the time commitment is another major factor in this. PACT teams already have so much on their plate, they’re constantly being bombarded with new initiatives, and this is just another one, and they have constant conflicting priorities. So we have -- we are competing with those things.

And so, these are some of the components that are still in development for our team. We’re establishing buy-in, which we’ve made a lot of headway in, but I think it’s something that’s going to be an ongoing effort for us. And we’re identifying points of contact, we’ve mostly done that, but again, we’re anticipating that, there’ll be some turnover and we’ll have to be reaching out again to folks and finding the right people to talk to. We’re determining the criteria for tracking progress. And we’re still hammering out sort of our expectations at monthly check-in meetings and trying to differentiate our intervention from our evaluation of our intervention. So working through all of that. And we’re also developing survey and tracking tools.

And this slide gives you all some resources about patient engagement. Most of the items on this list are really certain academic journal articles that can be useful, and then the last couple items here are white papers, this second to last AHRQ, is where our definition of patient engagement came from. And so, that’s all I have. Thanks, everybody.

Molly: Thank you very much. We did get several questions that have come in, and for attendees, if you are looking to submit a question or comment, you can do so using the Question section of the Go To Webinar control panel. Shimrit, can you go ahead and leave it on your contact slide while we do Q&A? Thank you. And, yeah, we’ll get to the Q&A, so just submit it to the Question section. Just click the plus sign next to the word, Questions, and then that will expand the dialogue box. And the first one that came in, how did you achieve inter-rater reliability with five coders? That sounds like a lot of data for five people to wrangle.

Shimrit Keddem: Yeah, so we do a lot of inter-rater reliability and we especially do it early on when we’re developing our code book. And there was a lot of data, and it probably took us a good four to six months to code it, but inter-rater reliability we would do, we would match up pair of coders. Initially, we do a lot of comparison. So we might do one transcript, compare, another transcript, compare, until we all sort of come to an agreement, and then we go off and split the data. And then periodically, every nth [?] transcript we do some more double coding just to make sure there’s no drift. But we have a pretty seasoned team of qualitative researchers who are doing that coding.

Molly: Thank you. The next question that came in -- oh, I’m sorry, it’s a comment, I just want to let participants know about the patient and family engagement page at the AHRQ website. A quick Google will probably get you there, or you can do [www.ahrq.gov/professionalqualitypatientandsafety](http://www.ahrq.gov/professionalqualitypatientandsafety). So thank you to that attendee who wrote that in.

Shimrit Keddem: Yeah. And that white paper that I put up is -- AHRQ has a nice environmental scan of everything out there related to patient engagement, so that’s one of the resources.

Molly: Thank you. And, it is my understanding that PACT has been ruled out across VA. Will CEPACT continue to exist, monitor, and evaluate throughout its tenure?

Shimrit Keddem: So CEPACT is funded until the end of the fiscal year, 2019. And beyond that, we don’t know.

Molly: Beyond that, a lot of us don’t know. All right. Well, that is the final pending question, but I’d like to give you an opportunity to make any concluding comments you’d like. Nope, I’m sorry. I’m going to cut you off before that. One last question, it’s not the end. Do you think the results might have been different if there were more veterans involved?

Shimrit Keddem: Yeah. And I think we -- this is a point of frustration for us because we are QI initiative and not doing research, it’s harder for us to talk directly to veterans. We got the veteran perspective from a collaborator who, actually Susan Vickman [PH], who does a lot of work with veterans, but that’s a perspective that we often feel is missing from some of our work. So, yeah.

Molly: Thank you. Did all 12 participants participate in each of the 2 meetings? How were the patients able to rate feasibility?

Shimrit Keddem: So that’s a good question. And we knew that that was going to be challenging for the veterans because obviously, they’re not on the ground doing this stuff, and so we kind of gave them a pass on that. And we did get, for the most part, all 12 participate. I think we had a little bit of attrition, maybe we had 11 for a couple of the calls, and we had a few less surveys, if people just didn’t get the surveys done. And I think when it comes to feasibility, definitely the veterans either skipped those surveys or skipped some of the questions if they felt they couldn’t answer them.

Molly: Thank you. How much were nurses involved in this project?

Shimrit Keddem: A lot. So we interviewed -- probably, I don’t know what the number is, I’d have to check with my team, but I’d say we probably interviewed close to 60 to 80 nurses and at all different levels, LPN, nursing leadership. And it’s funny because a lot of times when we’ve gone to our primary care physicians and our primary care leadership, they often say, you need to talk to nurses for sure about this stuff, especially to understand what’s really going on, on the ground. And right now, as we’re entering our evaluation, we’re also hearing that from our physicians as well, definitely talk to nurses because they sometimes know better what’s actually being done.

Molly: Thank you. And how willing are the nurses to promote the project?

Shimrit Keddem: I don’t know if I can answer that question yet because we really just started reaching out to facilities, but I think that that’s something that we’ll learn more about over the next year or so, as we really start to talk to our points of contact. Many of our points of contact are nurses. So those are going to be the folks who are spearheading some of this at their local facilities, so I think we’ll learn more about that as we go forward.

Molly: Thank you. Okay. At the risk of being interrupted again, I think that might be the last question. So if you have any concluding comments or takeaway messages, now would be a good time. Thank you.

Shimrit Keddem: So just, thanks, everybody. I think we’re excited to have come to this point, there’s been a lot of work that went into this, and we want to see, again, as you asked, how this is going to be received within our VISN and hoping to see the final toolkit and what it evolves into.

Molly: Excellent. Well, we thank you so much for coming on and lending your expertise and people love to see the live demos and sites, so thank you for that. And thank you to our attendees for joining us. I am going to close out the session now. Please wait just a moment while the feedback survey populates on your screen, it’s just a few questions but we do appreciate your responses. It helps us to improve previously given talks, as well as help improve our program as a whole, and give us new ideas for new topics to support. So thank you once again, Shimrit, and thank you to our attendees, and to the PACT team for setting up this webinar, which happens every month, second Wednesday of the moth at noon eastern, so keep an eye on your emails for the next one.