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Session: The Influence of Facilitation on Care Coordination in VA Primary Care: Evaluation of the CTAC Quality Improvement Project

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Dr. David Ganz: So, greetings everyone. We are going to be speaking today on The Influence of Facilitation on Care Coordination in VA Primary Care: Evaluation of the CTAC Quality Improvement Project. You’ll be hearing from me as well as from Dr. Lauren Penney and Dr. Polly Noel. And then in addition during the question and answer period we will have Tanya Olmos-Ochoa and Neetu Chawla available. They are our two facilitators who were key in this project.

I also want to acknowledge all of our collaborators and in particular today I want to acknowledge Jenny Barnard who will be fielding your questions behind the scenes and teeing them up for us at the end, during the question and answer period. I also want to acknowledge our funder the VA Quality Enhancement Research Initiative.

So in terms of our agenda, we will be starting with a brief project background to orient you to what we’ve been working on. And then we will talk about our coaching or facilitation intervention. During this talk we are going to be using the words coaching and facilitation interchangeably to refer to the implementation strategy of implementation facilitation. It’s just a little bit easier to roll off the tongue if we say coaching sometimes. So you’ll see that, but we mean the same thing, we mean implementation facilitation when we use the word coaching. We’re going to be providing our preliminary results both qualitative and quantitative. We really welcome your feedback on these preliminary findings because we are still analyzing the information. So feedback that you give us may inform our analyses going forward. We should have plenty of time for discussion and questions.

So I’m going to start with the project background.

First, just a definition of care coordination. We use a very broad definition provided by the Agency for Healthcare Research and Quality. And that is the deliberate organization of patient-care activities between two or more participants including the patient, involved in a patient’s care to facilitate the appropriate delivery of health care services. And this is broad because the two participants could be two providers that are communicating about a patient. It could be a primary care provider and a nurse in a clinic. It could be a nurse handing a brochure to a patient. There are many ways that care coordination can occur. And this has become a major priority area for the VA. Particularly with the increased use of care in the community. The number of handoffs and the type of handoffs have dramatically increased.

And then I also wanted to talk a little bit about quality improvement. Quality improvement in a large complex organization like the VA requires both extensive technical and interpersonal skills. People have to be able to work effectively in teams to identify root causes for quality gaps and be able to establish specific goals for improvement. Test and analyze effects of potential changes and be able to institutionalize and spread improvements. These are not things that necessarily were, things that people were trained in when they took their job. And we know from experience that local quality improvement projects with a passionate champion are quite common throughout the VA. But these are rarely sustained and spread without external support.

So with that as background we asked the question, with the goal of improving care coordination how can we provide efficient quality improvement support to primary care practices in a national integrated delivery system?

And these are our specific aims. We started by first developing a care coordination toolkit and distance coaching manual to improve care for high-risk Veterans. We then piloted the care coordination toolkit and distance coaching manual at one site and engaged participating networks, medical centers, and clinics. And then lastly what we’re going to be talking about today, we compared the effectiveness of the care coordination toolkit alone to the combination of the toolkit plus the distance coaching over a 12-month project period. We used a cluster-randomized design with randomization at the primary care clinic level.

And I wanted to briefly talk about our care coordination toolkit. First a toolkit can be defined as an action-oriented compilation of related information, resources, or tools. These typically support implementation of an evidence-based practice or a promise in practice. We actually reviewed 300 tools to arrive at 18 that were relevant to care coordination in VA primary care. And we winnowed down the tools both through an explicit set of inclusion and exclusion criteria, as well as expert review by clinicians who work in primary care and end-user input including from patients. This toolkit is available on the VA intranet and the link is available towards the end of this presentation.

I also wanted to define facilitation. It’s been defined as a multifaceted approach that involves skilled individuals who enable others through a range of intervention components and approaches to address the challenges in implementing evidence-based care guidelines within the primary care setting. And I think what you can see from this definition is that this is a very broad strategy. It’s a very broad and flexible approach that allows tailoring specifically to address challenges that are encountered while trying to implement a particular evidence-based practice.

So now I wanted to turn it over to CIDER for our poll question.

Rob: Thank you, Dr. Ganz. We will launch that poll. And the poll is up. This is a check all that apply question. Question being, what types of experiences have you had with coaching or facilitation? Answer options are; I have facilitated a project, I have evaluated a facilitation project, I have been a recipient of facilitation, I have participated in a facilitation project in other ways, and none of the above. I need to let you know Dr. Ganz and others that the nature of a check all that apply question in GoToWebinar’s polls will result in more than 100% when I read the answers off. But we have almost 80% of your viewing audience, over 80% now having made their choices. So I think I’ve blathered on long enough and I’m going to go ahead and close the poll and share out the results. And once again this will be more than 100% but 41% say that they’ve facilitated a project, 34% have evaluated a facilitation project, 17% have been a recipient of facilitation, 55% the largest number have participated in a facilitation project in other ways, and 24% say none of the above. So once again in terms of numbers; 41, 31, 17, 55, and 24. And now I’ll close, and we’ll be back on your slides.

Dr. David Ganz: Thank you, Rob. So we have a wonderful turnout today. It sounds like many of you have been involved in a facilitation which hopefully will make these findings particularly relevant to you. And for those of you who haven’t hopefully this will pique your interest in the topic.

So in the CTAC project we used distance facilitation, and this is basically the practice facilitation concept but extended to virtual modalities including phone and webinar technology. Much of the evidence-base actually focuses on in-person facilitation but distance facilitation is becoming more common and it’s particularly timely as we’re now going through the COVID pandemic. The advantage of distance facilitation is that it addresses the limited travel budget and scalability issues that exist in the setting of a national organization. However it is unclear whether weekly distance facilitation is sufficient to improve the quality of primary care. And that sort of sets us up for this particular project.

So in terms of our implementation strategies we have one group of clinics that received the, access to the online toolkit only. But it also included a priority setting meeting with the leadership at the facility to choose tools and a project focus. And then with the toolkit plus the distance coaching group they got all of the toolkit only items plus one in-person site visit at the start and then weekly coaching by phone and webinar. We added the in-person site visit after consultation with experts because a purely virtual approach seemed like it would not allow for a sufficient rapport to be established.

In terms of our primary care clinics we had five different sites. The first site had a total of four clinics and the remaining sites had two each. They were recruited on a rolling basis from August 2017 through October of 2018. And then on the right-hand side of the table you can see the topics that each coached clinic covered. Many of them were interested in handling walk-in patients and you’ll see there were other topics including medication renewal workflow and increasing referral to a prediabetes class. At each site the pairs of clinics were matched and then one clinic from each pair received coaching. We have two coaches and each coached three clinics.

Here is a quick overview of some of our major data sources. In terms of pre-project information we did clinic readiness interviews with a representative from each clinic. We had a patient survey which took place prior to any intervention. And we did the site visit as mentioned. During the project we conducted stakeholder interviews at the 6-month mark. And then we have copious coaching call notes and coaches’ written reflections about their coaching experience. During the post-project period we have stakeholder interviews at the 12-month mark. We have a follow-up patient survey that started after the clinics’ projects were completed. And then we have 18-month stakeholder interviews focused on looking at sustainability and spread.

So now I’m going to segue way into a brief description of what our coaching and facilitation intervention consisted of in practice.

So coaches conducted a number of activities with clinic teams. Their first task was to identify a QI project that would improve care coordination in primary care working together with the clinic team. They then assisted clinic teams with completing an action plan with relevant SMART goals and timeframe. And they had to prepare for and conduct weekly coaching phone calls with the clinic teams at each site for the 12-month project duration.

There was also a lot of communication with clinic team members as needed between scheduled coaching calls to maintain accountability and momentum. And they, coaches provided clinic teams with support in project management, evaluation methods, data collection and management, and implementation strategies such as usability testing of patient-facing materials and also Plan-Do-Study-Act cycles.

And then finally coaches did a lot of, placed a lot of emphasis on facilitating teamwork and communication between clinic team members to accomplish project goals. And they facilitated monthly collaborative calls with all active clinic teams, that is teams that were in the middle of and working on their projects, to encourage cross-site learning.

So now I’m going to turn it over to Dr. Lauren Penney who will guide us through our preliminary findings from the qualitative evaluation.

Dr. Laura Penney: Thank you, David. Next slide please.

So the qualitative arm of our CTAC evaluation has two main objectives. The first is to understand whether and how distance coaching plus online toolkit versus toolkit only strategy could be effective in supporting the implementation of care coordination improvement projects at our sites. And to explore at the clinic-level the association between contextual factors, coaching strategies, and project success. Next slide please.

As mentioned our main source of data across our sites is our semi-structured interviews with system leaders, site champions, and frontline staff at 6-month, 12 months, and 18 months and there it is. For our coached sites we additionally drew on baseline site visit notes, post-project debriefs that we conducted with the coaches about each of the coached sites. The copious coaching notes that David mentioned, as well as each site, each coached site completed a final project report with lots of information. So we pulled all that information together. And next slide please.

We coded our data using domains from the consolidated framework for implementation research. As well as some [unintelligible 14:15] domains related to facilitation as well as implementation patient, staff, and service outcomes. We further analyzed our data using matrix analysis where we started to triangulate all the different data sources we have. And matrix analysis, if you’re not familiar, involves creating a grid in which we’re able to compare all the sites across each of our domains of interest. And this starts to, allows us to start to identify themes within the domains and make comparisons across sites which helps us start to understand potential interactions between domains. Next slide please.

Today we’re going to focus on our preliminary analysis for aim one which was to identify broad similarities and differences between our coached and non-coached sites. We found that coached sites had detailed project SMART goals as David mentioned. Whereas the non-coached sites usually had less formal and less well-articulated aims. Across the sites their goals were usually pretty well aligned with current clinic concerns and/or ongoing projects. We found that projects at coached sites tended to have multiple components and multiple targets. So for example, they might have developed and implemented a tailored patient brochure to inform patients of alternatives to walking in the clinic for help. While also revising and standardizing nurse and clerk workflows around walk-in patients. By contrast non-coached sites usually had a single component project that involved doing one thing like implementing a generic save a trip form. While coached sites often had more complex projects in terms of the components and different types of people and behavior they were targeting. Both the coached and non-coached interventions required fairly simple skills to deliver the intervention such as handing a patient a brochure or doing things a little bit differently in terms of workflow. Sites used fewer CTAC toolkit materials then we expected but coached sites were less likely to be able to identify if and how they’d use materials because a lot of their use was mediated by their coach. Next slide please.

When looking at implementation processes we found that coached sites consistently engaged in more of these processes than non-coached sites. In terms of planning coached sites had those weekly moderated meetings with their coaches. The non-coached site meetings tended to be few and often were irregular. Usually if they were regular they only lasted a short period of time. Coached sites similarly did more and had formal engagement work with their clinic staff. So they might have prepared formal presentations to educate their staff about new workflows. Whereas it tended to be less formal in non-coached sites. So a champion might just talk to a clerk about what they wanted to do. Coached sites similarly, sorry, across sites champions were often nurses and most of them described engaging in champion-type activities such as doing the work to drive their projects forward and having a commitment to change. So we didn’t, so far we haven’t seen very many broad differences between champions at the two types of sites. The coached site teams were usually much larger and more diverse than the non-coached sites. But there was also more turnover among their team members. Coached sites did more data collection and evaluation and used multiple points of data to help tailor and evaluate their work. Whereas non-coached sites sometimes would use administrative data, usually didn’t collect their own data and it was usually fairly limited in terms of what they were looking at. Next slide please.

The barriers and facilitators across sites were you know fairly unsurprising. However we found several factors which could either support or hinder their implementation based on the context and sort of how these factors interacted with it. Click please. So these are highlighted in that yellow box. Leadership engagement was often helpful. Leaders could help bring insight about larger organizational priorities and they could also help frame projects in a bigger picture which seemed helpful in terms of bringing meaning and purpose to the projects. They could also provide resources, but they often had variable engagement. So they wouldn’t attend every weekly meeting. So they might miss a few and then show up and that presence could be disruptive when it could, that they could detract or derail weeks’ worth of progress that had been done in the previous meetings. And the lack of presence could also mean missed opportunities for their input at important decision points. QI experience was variable across champions and teams. It was often helpful to have members who had relevant knowledge and skills but when this sort of brand of QI experience they had differed from the CTAC approach it could be challenging for coaches to gain buy-ins. Especially, this came up especially around data collection when those sites were experiencing resource shortages. It could be really tough for the coaches to convince them that they needed to do more data collection. Team turnover could likewise have variable impacts. Losing staff members could result in a loss of momentum. However for teams that were struggling new members could bring new energy and ideas as well as shift team dynamics in positive ways that helped to move projects forward. Next slide please.

And our data show that the CTAC coaches provided a number of things that participants found particularly helpful. So participants talked about the importance of the tailored encouragement and social support coaches provided, the structured but flexible planning and organizational support, accountability, ideas, and insights, as well as mediation. Next slide please.

We’re currently analyzing a variety of different implementation, service, patient, and staff outcomes. So I’m just going to focus on two today. While the coached sites often had multiple component projects which varied in terms of their spread in general coached site projects were more likely than non-coached sites to be implemented across their whole clinic. Non-coached sites were more variable in terms of their penetration ranging from not implementing anything, to small one-provider pilots that were not sustained to projects that were made actually available outside the clinic. Two of the three sites that were highly successful among the non-coached group had implemented a save a trip form from the toolkit and the other one didn’t use this toolkit. So it was interesting to see that those that were more successful were actually using the toolkit. Coached site participants were much more likely than the non-coached participants to describe more holistic and general positive skill and relationship gains from participating in CTAC. Whereas non-coached site staff if they discussed personal benefits were more likely to mention gaining knowledge or skills that were directly related to their project’s focus. For example, one site did a project around hypertension and some of the involved members talked about learning a lot more about hypertension. Next slide please.

Projects across coached and non-coached sites didn’t require specialized skill or complex behavior change but coached sites undertook more complex projects that had multiple components and engaged a wider range of people. Coached sites were much more likely to describe engaging in implementation processes like planning and reflecting and evaluating. And that commitment to weekly coaching calls created this base and resources for doing those processes. They also were more likely to spread their projects across their clinics. And staff who were interviewed often described how they gained skills and developed relationships which could potentially have long-term impacts on their clinic’s functioning. Although we didn’t have much time to discuss it here when we were looking at the non-coached sites those that were more successful and had some degree of penetration at least across the clinic addressed issues that had previously been worked on in their clinics. And so were issues that had resonance and familiarity and in some cases had a base on which they could build upon. They also tended to give their PACT teams and staff a lot of flexibility in terms of how they took up and used their project. Next slide please.

Some broader lessons that we’ve so far learned and have talked quite a bit about as a team was the rare use of the toolkit. Despite our efforts to ensure that the toolkit would be relevant and usable for sites people talked about really not having time or interest and kind of wading through the toolkit. Although that was highly variable. Some people were really excited about the toolkit and talked about having already gone back to it to look at it. Coaching provided organization and structure as well as tailored support that the non-coached sites really described as finding challenging to create in their own projects. Coaches had to modulate their approaches and activities with sites to meet the clinics where they were, regardless of the type of project they undertook. So David mentioned that many worked on walk-in related projects however the actual activities and approaches the coaches took to each of those clinics varied quite a bit. And they had to tailor that based on local barriers and team dynamics. And many sites had challenges in their readiness to engage in QI work. Even with the coaching support. We found that while leaders may have enthusiastically agreed to participate, that buy-in didn’t always translate to the clinic level which made sometimes for you know month line, long efforts on the coaches’ part to try to gain buy-in by those staff members. And that’s what I have for the evaluation, the qualitative evaluation part. I’m going to turn it over to Polly.

Dr. Polly Noel: Thank you, Lauren. Next slide.

So our main objective for the quantitative evaluation was to determine whether patient’s experience improved more at the clinic level in the coached clinics than non-coached clinics over the 12-month period from baseline to follow-up. Next slide.

Our data source was a patient survey that included a patient experience questionnaire, a single item to distinguish Veteran’s use of the VA health care only versus VA and non-VA health care. Two items to assess self-rated physical and mental health. As well as items to assess demographic characteristics. We administered the survey to serial cross-sections of patients at baseline and 12 months follow-up. Next slide.

Using the Corporate Data Warehouse we identified patients with four or more visits to their assigned clinic in the prior 12 months. We randomly selected 480 patients from each of the larger clinics and selected all patients at the two smaller clinics which were women’s clinic, for a total sampling frame of about 5,100 Veterans. The baseline surveys were collected prior to the start of clinic intervention activities. We used a mixed mode of administration which included a mailed survey with an option to complete it online. As well as phone calls to non-responders of, after two mailouts. Next slide.

The primary CTAC outcome was assessed with the health care systems hassles scale. This 16-item patient experience questionnaire is recognized as the measure of care coordination and it was developed and validated in the VA. The hassles scale assesses problems with general health care such as poor communication between different health care providers. Respondents are instructed to rate each of the listed 16 items with a five-point scale ranging from zero: not a problem at all to four: a very big problem. For ease of interpretation we dichotomized the ratings to simply zero equaling no problem at all versus one for any level of problem indicated which yielded a total hassles count that ranged from zero to 16. And we imputed missing values if any person or more of the hassles’ items were completed. Next slide.

For the baseline survey 80, 48% of Veterans returned eligible surveys. Respondents were predominately male, 65 years of age or older, and non-Hispanic white, 79% of the Veterans reported one or more hassles. And the hassles ranged from zero to 16 with a median of four. Unfortunately, there was an imbalance in reported hassles at baseline between the non-coached and coached clinics. With Veterans from the non-coached clinics reporting an average of 5.2 hassles compared to 4.6 hassles from Veterans from the coached clinics. Next slide.

The top five hassles reported were having to wait a long time to get specialty appointments, poor communication between different providers, lack of information about which treatment options are best for your medical conditions, lack of information about your medical conditions, and difficulty getting questions answered or getting medical advice between scheduled appointments. Next slide.

For the follow-up patient survey we achieved a similar response rate with 48% of Veterans returning eligible surveys. There was a 10% overlap between the baseline and follow-up samples. The baseline and follow-up respondents were largely similar. The only significant differences were in marital status with 63% at baseline reporting being married or partnered versus 66% at follow-up. And also a difference in self-rated mental health rated as excellent, very good, or good with 69% at baseline reporting this and only 65% at follow-up. Next slide.

Given the excess zeros in our hassles count data we used zero-inflated negative binomial regression for our difference-in-difference impact estimates. Difference-in-difference analysis is often used in quasi-experimental designs and we thought it would be useful given the imbalances in our baseline hassles. And so we used this analysis to determine again the difference between the coached and non-coached clinics in a change from baseline to follow-up in patient-reported hassles. Next slide.

So we used a two-part model. The base model which is not displayed here adjusted for clinic fixed effects and clustering of survey responses. The full model included both, well included the base model and also adjusted for patient characteristics. Although the confidence intervals for the pre/post differences which are displayed in the fourth column indicate that both the non-coached and coached clinics achieved statistically significant improvements in self-reported hassles. The difference-in-difference which is reported in the fifth column is not statistically significant. Next slide.

So there’s several limitations to our quantitative analysis that may have contributed to our null findings. Because we recruited matched clinics in pairs the participating clinics were not representative of all clinics that were approached. The limited number of clusters that participated most likely contributed to baseline imbalances in our primary outcome and insufficient power. Also a hassles scale may not have been sensitive to the improvements that did result from the diverse projects that were carried out at the coached sites. In our future analyses will examine the top three hassles that coached sites thought would be most impacted by their main projects. Next slide.

So to summarize, the key findings from our primary quantitative analysis coaching did not improve patient experience beyond favorable secular trends. But it’s important to note that the hassles scale measures improvements in overall patient experience at the health system level and the items are not restricted or focused specifically on primary care. An alternative interpretation is that the non-coached sites projects were as effective as the coached sites projects resulting in equal improvement, but this seems unlikely given the qualitative data that Lauren just presented. Next slide.

But we recently completed a post-hoc analysis that provides a more nuanced look at possible coaching effects. In the follow-up survey we included supplemental process questions tailored to the project undertaken by coached clinics within each pair. So as an example, for the Veterans at the coached and non-coached sites, coached and non-coached clinics at site one we asked whether or not they had received a brochure about how to refill or renew their medications in the follow-up survey. And for this particular site there were no significant differences in the percent who said they had received such a brochure. Of note, the only two coached clinics that were significantly different from the non-coached clinics, that’s for site two and site six, the coached clinics received the highest ratings of engagement from the coaches who were blinded to the quantitative outcomes. So now I’m going to turn it back to David so he can wrap it all up for us.

Dr. David Ganz: Thank you, Polly.

So to summarize what we found were that, was that clinics randomly assigned to an online toolkit plus facilitation, distance-based facilitation, undertook projects of greater reach and complexity than clinics assigned to the toolkit only. Also we found that staff at clinics receiving facilitation developed their quality improvement skills and internal team relationships. We found that patients noted receiving brochures more commonly at two of the five coached clinics that distributed a brochure. And those two clinics as Polly mentioned were the two highest rated in terms of level of engagement by the coaches. However patients’ experience of care improved similarly in clinics that did and did not receive the distance-based facilitation.

So I just wanted to walk through some of the implications of our findings starting with implications for future implementation. One item is that although CTAC sought leadership buy-in in the end projects were essentially driven by frontline staff. With clinic staff choosing projects that were feasible to complete on their own. And specifically the more challenging care coordination problems, for example, across settings like between primary care and specialty care for example, were not tackled. And to tackle those problems would have required higher-level leadership buy-in to engage more stakeholders. Even the chosen projects though needed substantial internal leadership engagement in order to be successful. We also found that sites’ interest in managing walk-in patients was an emerging theme that cut across very different local contexts. And this was a topic that we were actually not planning to coach, that we adapted to the interest that we found among the sites.

In terms of implications for future evaluations we envisioned a friendlier recruitment environment than the one we encountered. And we were actually prepared to have difficulty recruiting and we had even more difficulty than we thought. In terms of reasons that prospective sites decided not to participate in the project for some prospective sites the idea of cluster randomization to coaching was a drawback because not all sites would be coached. So from a political perspective it was different to agree to, it was difficult to agree to participate knowing that not all sites would get the quote/unquote good treatment. On the other hand for other prospective sites having weekly coaching calls was too high in intensity to contemplate given competing demands. And so some sites just stopped at that point thinking this is too much to take on. And in reality though the weekly coaching didn’t end up being a problem for the sites that did participate. Because we were having difficulty in recruitment we responded by allowing sites more flexibility in choosing their projects. This was a common question that came up during recruitment calls where we discussed CTAC.

Given the increased project flexibility we also increased resources for the qualitative component of the evaluation to capture details of projects as they unfolded. We specifically interviewed more stakeholders than we originally planned to. And coaches had dedicated time for written reflections after each call noting successes and challenges. And from this we learned that future evaluations could be more naturalistic to allow for a better fit between implementation and evaluation efforts.

So I want to just stop here and just give you our contact information which will be in the slides for you.

And also to point out some of our publications that you can look up online.

And a few of the references that were noted in our presentation today.

So we’ll now stop and take some questions.

Jenny Barnard: Okay. Hi, this is Jenny Barnard. Can you hear me?

Dr. David Ganz: Mm-hmm.

Jenny Barnard: Okay. Great. We have a few questions. The first one, probably directed to David and Polly. And the question is, it sounded like both coached and non-coached sites implemented projects. So why was both groups having a patient effect, the hassles scale, unlikely due to qualitative data?

Dr. David Ganz: I’ll take, I’ll take a shot at answering that. So we know from the qualitative data that, for example, there, and actually yeah, from the stakeholder data that one clinic on the non-coached side didn’t even get up and running at all. So that was one thing. The second thing I think is that the, as was noted by Lauren in her presentation, the extent of the projects undertaken by the non-coached sites was much less, there was much less penetration of the clinic. So for example, we have this tool called the save a trip form and you can hand it out to patients. And at one of the sites that used it, it started out just in one pod of the clinic. And eventually it spread to a second pod but if memory serves me right it didn’t make it to the third pod. And so this is an example that some of the non-coached sites didn’t actually get as far in terms of covering the entire patient population that might be served in the clinic. I don’t know if Lauren you have anything to add to that.

Dr. Lauren Penney: Yeah, exactly. I think too for the sites where, I had mentioned that on the non-coached sites they were much more flexible in terms of how, allowing providers and staff in their clinics to uptake the intervention. So for example, the save a trip form. And the example that David gave in that clinic, some of the providers decided to use it. Sometimes in the pods the clerks were using it. Other pods the nurse might be handing it out. So it really was very variable and uneven in terms of how things were implemented across the clinics.

Jenny Barnard: Okay. Thank you. Another question, given the challenges primary care clinics face to engaging in and sustaining QI efforts such as this, what do you think you could have done differently to prepare the sites? Does this require addressing systems issues or can it just be addressed at the clinic level?

Dr. David Ganz: I think I’ll start with, start that one off. So this is clearly written by somebody who has lived through this experience. You’ve almost answered the question. I mean I think the, the systems issues are pronounced. We experienced a lot of issues with turnover in staff. And staffing shortages that caused people not to be able to attend all calls. And those issues are systemic. They’re not, a facilitator can’t solve that problem if the clinic can’t maintain some of these basic metrics like having adequate staffing and being able to retain staff. So I think in the long run that was kind of a meta finding, was that you have to address the systems issues. And particularly an external facilitator is not positioned to do that. That has to be handled internally by management at the site. And then you have to ask yourself why is staffing, you know why are people understaffed, why is there turnover. I mean we know anecdotally from at least one of our sites that for example salaries for licensed practical nurses were not competitive with the local marketplace. So sometimes there are structural factors that make it difficult to hold onto people. So I hope that helps answer the question. But yes, there are, there’s only so much we can do given the context that we find ourselves in.

Jenny Barnard: Great. Thank you. And we, I just have a comment on here too from actually one of the champions at one of our sites, Shelley Rae [phonetic], she said the save a trip gained a lot of leadership support and use has now spread cooperate-wide.

Dr. David Ganz: That’s great to hear!

Jenny Barnard: Yeah. Thank you, Shelley for leaving that comment. We have another question, can you please talk more about the facilitators and barriers identified as part of the qualitative evaluation?

Dr. Lauren Penney: This is Lauren, I can start but would invite Tonya and Neetu to also comment if you would like to. So I had mentioned that I think the barriers and facilitators on the slide I shared are not very, are not unsurprising. I’m sorry, did somebody say something? Okay. So the barriers across sites that really rose to, or were very pronounced were, had to do with resource issues as well as relationship issues. So in some sites there were people, as you won’t be surprised to hear, you know worked in practice style that was maybe didn’t have a lot of interactions with other disciplines or services within their clinic which created tensions that sometimes had to be worked through by the coaches. We found that at, really strong facilitators across sites were having to adapt champions as well as that interdisciplinary collaboration and the coaches really helped facilitate that collaboration. And then I had mentioned this, the factors which seemed to really vary in terms of context, having interacted with the context. And I know that the coaches had a lot of, have a lot of experience with these factors and wonder if they have any additional thoughts on them.

Rob: That was to Tanya and Neetu, right?

Dr. Lauren Penney: Right.

Dr. Neetu Chawla: I think one of the surprising ones, oh go ahead.

Dr. Tanya Olmos-Ochoa: This is Tanya. I think in terms of the challenges with facilitation, I think one of the things that we encountered the most was sort of, most challenging was buy-in in terms of additional data collection which I think was touched upon in the presentation. But just for some sites getting sites to you know do usability texting on patient-facing products that they were creating. To check in with staff on workflows they were developing that would change you know the way, for example, the walk-in patients were handled. So getting quality improvement teams at the clinics to do that, to conduct that extra step was often challenging. And then also there were at times issues within, the clinics that were separate from CTAC that would sometimes come into play when the quality improvement teams were trying to complete their CTAC projects and so as the facilitators we helped them a lot with lot with team dynamic issues and ensuring there was appropriate communication between team members around the CTAC teams but that sometimes bled out into other clinics processes as we tried to really get them to work together. Neetu I don’t know if you have [inaudible 47:04]\_

Dr. Neetu Chawla: Yeah. This is Neetu. I would just, I think Tanya touched upon most of the things I was going to raise. I think the main thing I would just add is really the issue around team dynamics which for some sites was, you know some more challenging than others. And just being, you know we had a number of different workflows that we did sometimes you know having a buy-in from the MSA staff as well as the clinical staff was really important. So just ensuring that we had the right people at the table when we were trying to make changes to workflow processes and things like that was very important. So I would just sort of raise that and just mention the team dynamics piece was a very important aspect that we had to manage as well.

Jenny Barnard: Okay. Great. We have one more question, tell us more about the toolkit and how you hoped it would help improve care coordination? I think that would be directed at Dr. Ganz.

Dr. David Ganz: Thank you. Yes. So we, when we first proposed this project we knew that the toolkit would be a kind of a passive approach to improving quality of care. However toolkits are widely used within the VA. And for, whether or not they really work and by themselves is kind of the question, part of the question we were trying to answer with this project. But we saw them as a, sort of like a steppingstone. So we went to quite a bit of trouble to make the tools [inaudible 48:48] and also to have a range of difficulty. Some of the easier tools like the patient brochures, save a trip form, were things that could be easily customized for a particular site. And then didn’t require too much in the way of like internal coordination with a lot of other stakeholders in order to get approved. We also had more complicated tools like tools to support good handoffs between primary care and specialty care when primary care providers were placing consults. These tools were considered to be advanced because they required a connection between primary care and specialty care and potentially information technology support as well to develop the appropriate Electronic Health Record template. So we tried to cover a range of difficulty. But we saw the toolkit as a steppingstone where it could be used by a motivated site that had sufficient leadership buy-in. But we understood that it was going to be the weaker, potentially the weaker of the two strategies but also much less resource intensive. Meaning that you can create the toolkit, you can post it, and make it available to everybody and the marginal cost is pretty much zero after you’ve created it. Eventually you have to update it and keep it current but still costs are low for creating such a thing. So the effect might be weak, but the costs are also low. So that was kind of the cost-benefit analysis and why we thought, like at a global level, it could potentially improve care coordination. What we found though was that there was relatively limited uptake as you heard. And that really the easier tools were the ones that were primarily used. And so, so that was a big lesson for us is that we kind of scoped the project expecting more of the tools to be used at a higher level and we kind of overshot in terms of what the readiness of the clinics actually was for taking on these types of projects.

Jenny Barnard: Great. Thank you. Thank you, everyone who submitted questions. Rob those are all the questions that we have.

Rob: Wonderful. Well there is still some time left. Sometimes questions come in a little bit late. But this is a good opportunity for anybody to make any comments that, you know about parts of the research that didn’t get hit on in the slides or anything that they thought was notable. I think just this is a good opportunity for anybody to jump in with any comments they want to make or even just closing comments at this time while we wait to see if any more questions come in. Okay well if nobody wants to volunteer I’ll just ask, I’ll go in the order I have here of people who joined. Dr. Ganz do you have any closing comments you’d like to make?

Dr. David Ganz: Well I just want to encourage people to reach out to us if you have an interest in this area. And particularly to provide us with your observations. You know maybe it’s, you don’t want to share it in a group, but we would welcome your observations about sort of the benefits and drawbacks of facilitation or toolkits as strategies. What you’ve learned from your own experience and how you think we could do better in terms of developing these strategies to work within the VA.

Rob: Thank you. To that end, David can you bring up your slide that has everybody’s email on it.

Dr. David Ganz: Sure.

Rob: And I’ll give Dr. Penney an opportunity to make closing comments if you’d like to, Lauren.

Dr. Lauren Penney: Sure yeah. I’m just sitting here pondering some of the discussion that’s come out of this, in thinking about how, if readiness is so variable and as to toolkits are you know pretty low cost but passive approach that probably will only be taken at maybe the most simple forms by sites that have, you know good readiness. How do we help those sites that are lagging, like what kind of facilitation is really necessary to help them, get them ready for not just doing one project but multiple projects and then sustaining them? That’s an area that I would like to think more about and work on. And would be interested if anybody else, would be happy to take emails or communication with anyone also thinking about that.

Rob: Thank you. I have next, Dr. Noel, Polly.

Dr. Polly Noel: Yes. Thank you. I just want to I guess emphasize just what a great project this has been that we’ve been working on for almost five years now. And how helpful the qualitative evaluation and findings are for helping us understand the results of, the quantitative results. And that’s all.

Rob: Thank you. And next up in my list I have Neetu, Dr. Chawla.

Dr. Neetu Chawla: Yes, I would just say that it has been a really interesting project to be part of. It’s been a great team and you know there’s, one of the things I found as part of the qualitative data and as part of the coaching that was really unique was the coaching reflections. And you know the use of those. And that I thought was a very distinctive type of data collection that ended up you know being very valuable in retrospect. So I would just say that if others are doing facilitation or working as part of facilitation projects to consider having reflections. And you know we added things around what we thought was a success and what was a challenge from each of the calls. And I think that was a really valuable piece of information that was added as part of the data collection. So I would just say that. And then if people are interested in facilitation and want to share their experiences, you know feel free to email or to have any follow-up questions.

Rob: Thank you. And last but not least, Dr. Olmos-Ochoa, Tanya.

Dr. Tanya Olmos-Ochoa: Thank you, Rob. Yeah I think I agree with Neetu that the time to reflect after each coaching call was incredibly helpful. It allowed us to really think through our coaching process and figure out how to be more effective on follow-up calls, I thought that was time well spent. And I think what I’ll say to conclude is just to, you know this project wouldn’t be possible without the clinic sites that we did coach and I’m just very thankful the quality improvement teams that we worked with, that they, you know that they were motivated to participate, they were on almost every single call on a weekly basis for a year. So I just wanted to say thank you to them for their participation and you know I’m glad that it was helpful to them.

Rob: Wonderful. Well thank you all for your work and for VA in general and specifically for preparing and presenting for today’s presentation. And a very special thanks to Jenny Barnard for helping to get this webinar happening and successful. And with that, I’ll just ask that when I close the webinar momentarily attendees you’ll be presented with a short survey. If you could take a few moments and provide answers to those questions we do appreciate it and we use those answers to continue to bring you high-quality Cyberseminars such as this one by reviewing them and sending them to our presenters. So with that, I’ll just wish everyone a good day. [ END OF AUDIO ]