Cyberseminar Transcript

Date: July 23, 2020

Series: QUERI Implementation Research Group

Session: Effect of Frontline Clinical Team Participation in a Virtual Quality Improvement Learning Program on Weight Management Program Outcomes: Results from the LEAP stepped-wedge randomized controlled trial

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Heidi: And we’re just past the top of the hour here, so we’re going to go ahead and get things started. Christine, can I turn things over to you?

Christine Kowalski: Yes, thank you Heidi. My name is Christine Kowalski, and I am an implementation scientist for the Center for Evaluation and Implementation Research, and I would like to thank all of you for joining our Implementation Research Group Cyberseminar today. The IRG is a learning collaborative, we’re set up to share best practices and lessons learned in implementation science. And as a group we’re always working towards advancing the field in implementation science. We now have over 500 members, and this session today is part of our monthly catalogue of events. Our seminars usually take place on the first Thursday of the month at noon, Eastern time, this one’s slightly off cycle. But if you have any feedback about the session today please do stay on for the survey at the end. And now I’d like to thank our presenters for their work in preparing for this session today. Our first presenter is Laura Damschroder, she is a research scientist at the VA Ann Arbor Center for Clinical Management Research. She is also an investigator for the PROVE QUERI, and is the developer of the CFIR, or the Consolidated Framework for Implementation Research. And Michelle Freitag is also presenting today. She is a LEAP Improvement Coach for the PROVE QUERI at the VA Ann Arbor Center for Clinical Management Research. So, we hope that you all enjoy this seminar today, and now I will turn things over to Laura and Michele.

Laura Damschroder: Thank you so much Christine, and Heid. And I want to just reiterate Heidi’s invitation to please do not hesitate to add questions or reflections as we progress through this presentation today, into the chat box or the question box through the control panel on the right side of your screen, it should be. So this title is a mouthful, but basically this is where we are presenting results from our stepped-wedge randomized controlled trial. Looking at the impact or the effectiveness of the LEAP program. And I will explain, we will, Michele and I both explain what LEAP is, why we created it, what we have learned so far, in terms of outcomes, and process and participation. And then leave you with some lingering thoughts.

So, first of all, this is me, this is Michele, you can see our photos here, we’re not on video today. If you want to reach out to us afterwards, don’t hesitate to email us directly. Or we also have an overall kind of LEAP mailbox that is monitored by several of us on the team that will be on the last slide.

So, our usual disclaimer that our views are our own, we are not representing the VA or the U.S. government. And our team, we definitely, this work is the result of really the better part of five years of our PROVE QUERI program. And just really tremendous efforts by everyone on the team, and also to our partners who we have a wonderful productive working relationship with leaders at the National Center for Health Promotion and Disease Prevention, who include Dr. Jane Kim, Dr. Michael Goldstein, and Dr. Sue Raffa. And thank you all, if you’re on the call today especially, just to say personally thank you for all of your support through this time.

So, we are focused on the MOVE! program, which is an obesity treatment, or it’s a comprehensive lifestyle intervention that is targeted for patients who are overweight or obese within the VA. Most medical centers within the VA have a group-based MOVE! program, as well as many CBOCs. Sometimes the program is delivered virtually through various video methods to clinical community clinics. And there is also an app, you know, there are many other ways of delivering MOVE!, within the VA. But today we’re going to focus on teams who have worked with a group-based MOVE! program. And this is an onsite, in person, which you know, haven’t done that in a while, in the current COVID period that we’re in. But definitely leading up to this time, this group-based program is really the heart of treatment. But I know that the program has been really quite agile in delivering remotely or virtually, in various ways. So, there is much to celebrate about this program within the VA. And there is a lot of literature on this that actually has been published. There was a time at least that obesity screening and brief counseling was nearly universal, over 90%, at one point. And again and again we have many published studies that show modest and clinically meaningful weight loss. So, I just have some statistics here. And this is especially laudable in the context that many Veterans are on a weight gain trajectory before they come into MOVE!. And what we see is that that curve is basically changed, coming out of MOVE!.

We have high variation, just as with many outcomes, we have high variation in delivery of MOVE!. This is a measure of reach, back in 2013, which is when we were first thinking about and developing this intervention. We have an overall goal within the system and for the program to engage patients in completing 12 visits within 12 months as kind of a minimum intensity of treatment. And as you can see, there is a lot of room for improvement. And the sites with the highest amount of reach really had nearly about five times as much reach or more reach basically as a ratio. The highest site versus the lowest sites within the system. And probably you could take any indicator of clinical care and see that there is a lot of variation. It’s kind of the nature of the beast.

But we, our team and in various members of collaborators within and outside of our own center have collaborated and done many implementation evaluations of lifestyle behavior change programming within the VA, and these are just a few of the papers that have published outcomes, from implementation efforts.

And what we find is that there are recurring barriers to implementation. And here what we have done is using a highly used, Christine mentioned the Consolidated Framework for Implementation Research. And all of these published studies used the CFIR to systematically assess and articulate and report determinants within, across domains that influence implementation efforts. And we find several constructs, especially within the inner settings. So this is like within the clinics, what if the nature and quality of professional relationships, networks and communications, compatibility of programming with existing programming or processes, leadership engagement, available resources. We also find determinants or important influences within the process domain. So these are things like you know, who are people, the appropriate people engaged within the implementation process. Do we have teams that work together and reflect and evaluate and kind of refine their process as they proceed? And then what we’ve done here is linked implementation strategies to address each of these potential barriers that are all too common. So, for example, at the very top here, organizing clinician implementation team meetings to help improve relationships between professionals who are working with the program, is one example strategy.

And what we have done, and I’m just kind of beginning to introduce what the LEAP program is, but what we did was develop a program, that Michele will describe, that includes team building. That includes doing, and I’ve got highlighted here in red for teams to complete Plan-Do-Study-Act. And these are incremental cycles of change that are really at the heart of quality improvement. But what we find is that building skills in frontline teams for how to engage, and to assemble a team, and to be productive, and being able to do these cycles of tests, or of learning, or of change, whether or not you're successful in implementing a change. There’s always something to be learned and that can help to inform the next cycle of change. And so our goal was to engage frontline teams in this work and package an intervention or a program in a way that would be feasible for frontline teams to participate in. So I think at this point I turn it over to Michele.

Michele Freitag: Sorry, I found my mute button. Sorry about that. This is Michele Freitag, a LEAP improvement coach. So what is LEAP? The acronym itself, since we love those in the VA, is stands for Learn Engage Act and Process. And the LEAP program was developed with this motto in mind; everyone has the power to make Veterans’ healthcare better, even in the face of limited time and resources.

So, talking about the structure of the LEAP program, it is a 26-week program, and it’s structure and has the goals of having participants learn quality improvement skills, based on the Institute for Healthcare Improvement’s approach. While simultaneously working through and developing an improvement project with their local team. So building a local team and also a larger network or quality improvement community is also an important objective of the LEAP program. The program consists entirely of accessible content. It provides hands-on learning within a busy clinical environment. And LEAP offers coaching support to enhance learning and accountability. For that coaching component of LEAP, the teams have individual coaching calls with their coach throughout the program, and they also take part in virtual collaboratives. In which teams working in a similar space come together to talk about their improvement projects and what they’re learning along the way. So in this instance they were, as Laura mentioned, working in a similar space and working to improve their group MOVE! programming. Another virtual piece to mention is the new and written video guidance that we would upload as coaches to their SharePoint online group on a weekly basis. And this is paced to be manageable within their daily work. And then LEAP, we encourage data driven changes and support teams as they identify sources for both outcome and process level data.

So we like this visual. It shows the geographical spread of the LEAP teams that participated in this trial, and the large network that they built across the country. Almost every VISN is represented on this map. It’s not only important to mention this larger network, but also the local quality improvement communities that were built as a part of this process. So each LEAP team had an average of about five to six local team members working together, and they were encouraged to spread the guidance more widely within their facilities as well.

So the LEAP curriculum begins with weekly coaching calls to talk through forming a local improvement team, identifying data sources, gathering and prioritizing ideas for improvement, and setting an initial team developed aim. The teams are working towards building a project charter, and then testing specific changes following that Plan-Do-Study-Act cycle there in the middle that Laura was mentioning earlier. And these are, PDSA cycles are a critical component of the Institute for Healthcare Improvement’s approach, as well as LEAP’s. In LEAP, teams work toward building a suite or a portfolio of changes to serve their project aim. And they’re also working to sustain and spread successful changes. They may learn from non-successful changes as well. You can see here too our many partners that have been involved in developing LEAP. We have VA QUERI, HarvardX, IHI, as I’ve mentioned a couple times, and then the Center for Clinical Management Research here in Ann Arbor, Michigan. We’ve also worked with the Diffusion of Excellence and are listed on their marketplace. Along with many other innovative practices throughout the VA.

So, this pathway of change we’ll really build on over the course of the next few slides. And it represents our theory behind LEAP. So our first goal was to engage frontline providers and see an increase or improvement in their quality improvement scales. We asked LEAP teams to complete surveys at baseline and at the end of LEAP. These surveys ask participants to rate themselves on key skills, and we saw significant improvement in the self-ratings from baseline to the end of LEAP. Since this was a pragmatic trial, and we had evidence of the increase in skill acquisition from year one, in year two we altered the measure to assess for the use of or application of quality improvement methods before, and then six months after LEAP participation. We wanted to know whether the LEAP participants were continuing to use those quality improvement skills they learned in LEAP. Know they learned, but were they doing the quality improvement afterwards? So in year two we asked teams about their use of quality improvement methods and we saw increases six months after completing LEAP.

So, let’s break that down a little bit. You can see the breakdown here for year one, there were significant increases from baseline to post-LEAP, in developing changes, supporting them with data, testing, implementing, and spreading changes, as well as the human side of change.

And then in Year two, we saw that significant increase between baseline and six months after LEAP and the use of QI skills around developing testing and spreading changes, as well as supporting the changes with data. The human side of change didn’t significantly increase, but as you can see, the individuals participating in LEAP reported using this skill pretty frequently prior to the, joining the LEAP program.

So next on our theory, or pathway of change, we wanted to examine employee experience, and hopefully see improvements for our LEAP participants. We were interested in how empowered team members felt, and their resiliency while trying to make changes.

So, for our final cohorts of LEAP teams we asked questions about engagement, job satisfaction, and burnout in our pre and post LEAP surveys. And we saw significant change in workplace climate, and staffing, and satisfaction after LEAP. We were happy to see that staffing and satisfaction increased, or got better, though staffing seems somewhat paradoxical given the time challenges that we heard about from our LEAP teams. But Laura will speak to that more in, at another point in the presentation. So I won’t get too far ahead of myself here.

And then looking at workplace climate a little closer, initially we saw that significant dip immediately after the completion of LEAP, but to our surprise, the measure rebounded six months after LEAP. We also saw a dip in job satisfaction six months after LEAP, but that’s just another interesting finding that we have here.

We also administered LEAP program satisfaction measures at the end of LEAP. So this survey included about 20 items. However, these two items were quite representative of those data. Almost all the respondents agreed or strongly agreed that LEAP was relevant to the needs of their MOVE! program. Overall, most participants were satisfied or very satisfied with the coaching support provided to them, with the quality of the written and video guidance, the number of exercises, and the technology that was used for the program. We do distinguish here between team members and team leaders. You can see in all cases the LEAP team leaders rated each item higher than nonteam leaders, and this is a really important finding for us. The team leaders were often most engaged with the LEAP coaches and they really took ownership of the experience.

We also conducted interviews with team leaders six months after participation in LEAP. And the first team leader, you can see here, speaks to the value of the structure of the program. So, saying that it really helped get back to making changes in an incremental, or she said step-wise fashion. I heard something similar on a coaching call recently that the way that we’ve broken down the LEAP curriculum into what Laura likes to call bite sized chunks, is particularly valued. Especially as these LEAP team leaders and members are attempting to make changes in addition to their clinical and administrative responsibilities.

So back to our pathway of change, I’m going to had it back to Laura to discuss the clinical outcomes piece. Thank you very much.

Laura Damschroder: Okay, so, as we continue down our pathway of change, this is the part where we get into the results of our stepped-wedge trial where we wanted to look at okay, so we see kind of that increase in skill and actual application, or reported application anyway, of quality improvement methods to implement change. We also, Michele summarized what the employee experience measures, many of those measures come from the all employee survey. So now we want to see what the impact of participation is, and a measure of clinical outcomes.

So, we conducted a clustered randomized control trial over a two year period, and really the trial can, well, you’ll see in some subsequent slides here that this is very much a pragmatic trial. And we made changes in some of the way that we administered the trial in the first year versus the second. So for example, Michele mentioned one change, and this doesn’t have to do with the trial per se, but rather than just asking people at the end of a training program, or a coaching program, rating their kind of competence or their own assessment of their skills. We wanted to kind of raise the bar in the second year by changing the measure to asking for people to report their use of the methods six months after training. So, I will get into a couple of those details, and I’m also happy to answer questions at the end too, about the particulars of conducting this step-wedge trial. So our purpose here, basically the analytic approach was to conduct an interrupted time series analysis to determine the effect of LEAP on group MOVE! reach. And we computed reach as the number of returning and new, or new Veterans who had not participated in group MOVE! in the past, or at least six months prior. As a proportion, or as a ratio of the total number of eligible or candidate Veterans. And candidate Veterans include Veterans who are obese, or if they’re overweight and they already have a diagnosis, an obesity related diagnosis of some sort, including, for example, diabetes.

So, again, our primary outcome is reach. Our unit of analysis are 137 medical centers that had group MOVE!. And there were, there was a whole process that identified those 137, partly one of the eligibility requirements that we needed was to have an identified MOVE! coordinator. So some of the programs did not, they may have had a program vacancy at the time. So that’s why this number may be a little bit lower than what you're used to seeing. We randomized alternately over the two years. We randomized 55 sites to participate in LEAP. Or gave that opportunity to participate in LEAP. And then 82, the remaining 82 sites were randomly selected as control sites. We conducted an intention to treat analysis, and just to say that just over 71% completed LEAP with 55 as the denominator. So some of these 55 teams, actually a handful of them never started LEAP. Because they were assigned a starting date well ahead, and it’s really kind of hard to predict, and there were cases, for example, where the lead program coordinator ended up being on extended leave by the time their turn came to actually participate in LEAP. So that’s just one example of when a program was randomized to participate but they were not able to participate. And then there were a handful of teams who started LEAP but were not able to finish.

Okay, so our, this diagram shows the design and how we kind of stepped participation over the two-year period. There were eight cohorts of sites, and here it says 55 sites, so it’s just listing the total control sites, or I’m sorry LEAP sites. And then you can see the number of controls, and they vary because we randomly assigned the remaining sites to the 82 sites as controls, and we randomly assigned them to cohorts. So, in the first year, for the LEAP participants, our basic approach for engaging teams in LEAP was to first go out with an invitation, asking if they would be interested in participating in this trial. And in the first year we did that before the beginning of a fiscal year. And then we identified 24 teams, I believe it was, 24 teams, and then assigned them a starting date. So for one of four different starting dates that started each quarter of the fiscal year. And we had six teams per cohort who were assigned to those four cohorts. And like I said, by the time, you know, especially the later quarters actually came around, some of the teams were not actually able to participate. And as that year progressed we did a lot of reflection and thinking about kind of sources of bias, and you know, they’re kind of competing considerations, and we decided that in the second year we would change our invitation process to putting out a call for participation every quarter of the second year. So, all of the sites or all of the programs that said, yes, we’d like to participate this quarter. We took that list and then randomized, again, generally speaking, six teams, and per cohort. And although I see here that there are some teams that the number is higher. I’m not sure what happened there actually. So we did that randomization process every quarter, rather than just one time. Because then this would give teams the opportunity to better plan and prepare for participation.

The other thing that we did, so again, we did a interrupted time-series analysis. And the way that we organized the dataset for analysis is that for each cohort, which started at a different calendar point and calendar time, we collected data 12 months before the beginning of LEAP, and then start at the end of LEAP for another 12 months. So there’s a 12-month period pre-LEAP, there’s the period of months during LEAP, which is like the interruption in the interrupted time-series here, and then there is a post-LEAP period also of 12 months, just like the pre. So this is our general analytic structure. And one of the things that Michele just kind of quickly mentioned is that in the first year LEAP was a 21-week program. And through request and based on feedback from the teams in the first year, we extended the program to 26 weeks. We did not add any new content, but the reason that we extended the time is that teams wanted more time to be able to actually execute their change while they still had this coaching support within LEAP. So we gave basically instead of just one week to accomplish kind of the core tasks, they had two weeks to finish core tasks. A series of two-week periods, rather than just one week.

This slide shows a series of diagrams. And so the key here is to see first of all, I’ve got a red box around all of the cohorts in the pre-LEAP period. So leading into LEAP, what’s the reach trajectories of the trends were looking like coming into LEAP. Prior to participation in LEAP. And for all of the cohorts, the trend of reach was increasing. But then during the course of participation in LEAP a lot of system level things happened. For example, the introduction of direct scheduling, which completely changed the kind of referral process to get patients into the MOVE! program, and there were other considerations as well. And so by and large many of the teams or the programs after, in their post-LEAP 12-month period, saw decreases in reach. Not all of them, but many of them. And you can see this kind of general trend. And I wanted to show these graphs just to show that this was pretty much a system wide phenomenon. If you were to look at point estimates of like average reach before and after, there actually were no differences, because they kind of averaged out. But it’s really important to see that the trends were actually quite different.

Okay, so here are results of the LEAP program. And what we can see is, as I showed on the previous graph, that coming into LEAP, so on the left side, the dark black line is showing the trend of the LEAP sites for reach, and the pale blue line is showing the trend for controlled sites. I think I read that right. Yeah, for the lead sites and then the control sites. And then post, and then we had this kind of break while the teams were participating in LEAP. Coming out of LEAP, what we found were that the sites who did not participate in LEAP had a larger decrease in, kind of a more dramatic increase in reach, or decrease in reach, compared to the LEAP team. So, it appears that what the LEAP teams were able to do is to basically dampen kind of the downward pressure that a lot of the programs were feeling with respect to engaging patients in the program.

So now moving forward into challenges and opportunities. Time really continues to be a challenge. So, you can see here that in the first year, this first set of bars, shows our responses to our survey for the first-year participants. And that over half of them were either neutral or disagreed. So they gave a fairly low score for having the time, their perception of having enough time to do the work required. That number improved so that we had over half who agreed or strongly agreed that they did have time, after we lengthened the duration of the program. So, it did seem to help, but as you can see here, time really continues to be an issue. I mean the people I worked with are just like any of the clinics and programs within and outside the VA, this is not unique, even to the U.S.. Is that there’s a lot of pressure for clinical work, doing when there are vacancies you have to cover for other people, you know, many other competing demands that kind of work against people’s ability to do quality improvement work.

We found a high intention to continue, especially with the team leaders, that the teams would, they intended to continue working together after they completed LEAP to participate in the follow-up coaching that we offer, the monthly sessions, and then monitoring their data over time. So, there really was a strong intention to continue this work.

However, we also saw that in our six-month post-LEAP interviews that patient care, you know, it really should take priority. Definitely agree with that. But, a lot of clinicians are just feeling like, you know, for example, here is a quote. “She’s seeing so many patients that we have little time to plan, and little time to do a PDSA cycle because she’s doing so much patient care.” And this really is a tension that clinicians are working within in busy demanding clinical settings like this.

And I highlight this study that was published in The Lancet last year. I love this, this was a opinion piece actually, or like a commentary on a published article that has negative results after a very large-scale quality improvement collaborative in England, or in Great Britain, that included over 90 hospitals. And the title of this commentary was “QI falters after trial fails to reduce mortality.” And one of the quotes I thought was just really emblematic, and in a way it’s kind of obvious, and yet, we come up against this again and again. So they said, “we now understand the problem better. Clinicians were too busy delivering patient care and had no spare time to improve it.” So, this is a real, you know, again, this is a real tension that of course is important to take care of patients, and especially with the added emphasis in the VA over the last, especially in the period when we were conducting our trials. To improve access to care, which means more patients. So, even though we had a high rate of completion, so if we look at completion, as a proportion of the teams who started LEAP, over 80% completed the program.

Okay, so in summary, when we go back to our pathway of change, we found evidence that we can engage frontline teams in LEAP. And we found both quantitatively and qualitatively that people are really motivated to participate in improvement efforts. We found evidence of increase and use of QI methods. There’s questions about the, our ability to improve employee experience. We found some evidence, like work satisfaction did improve, but workplace climate actually got worse immediately after participation in LEAP. Even though it rebounded later. And no impact on burnout. But these effects may take longer to really kind of take hold over time. And it also requires just a whole new way of working. It really is a behavior change. And until, I think, that there’s a critical mass within clinics that are engaged in kind of incremental improvement work as a part of every day work, it’s going to continue to be a struggle to do this in a way that just isn’t adding to frustrations on top of clinical demands. We did find evidence through our trial that we can improve clinical outcomes. So even with these kind of small incremental changes over time, we do see that this has the ability to manifest in measurable impact.

So now I just want to kind of reflect about the need, the recognition, more and more in all kinds of fields and in many kind of organizational transformation initiatives. When we look at the HRO, for example, High Reliability Organization, which is the first lane high priority within the VA right now, and one of the pillars of being an HRO organization is continuous process improvement. And so, again, being a mature HRO organization, which is the goal of the VA, requires that frontline teams engage continuously in quality improvement.

When we look at learning health systems’ concepts and frameworks, that again, there is learning, there is cycles of learning that are kind of underlying, and this is behavioral, to engage teams in, at multiple levels and cycles of learning.

When we look at deep ethnography data about what does it take to implement change within clinic settings. This is an article by Reed and colleagues, and I just kind of highlighted inside that red box this, first of all, this whole diagram is very circular in nature, and that it’s very iterative that teams need to continue to engage in optimization of programs in order to more deeply and sustainably embed new interventions into clinical care.

And then the dynamic sustainability framework also has literally Plan-Do-Study-Act incremental cycles of change at the heart of their framework. And this framework insists that teams need to engage in ongoing optimization, i.e. improvement when implementing, especially when implementing something new. That this is not something that can happen in a single burst of effort if we want it to be sustained and optimized over the long-term.

So, when we put all this together, I’ve just kind of quickly identified six different streams of work, including our own empirical work that really point to the need for engaging frontline teams in cyclical small tests or cycles of change. And again, the key goal with these cycles is learning. So that even if you don’t achieve what your planned goal, that you would learn from your efforts and use that to design another cycle of change.

But we have a huge kapowee [sic] using quality improvement language. As I said earlier, lack of dedicated time and competing priorities. And I have a reference here to an article by Reed and Card, where they really highlight the need and for organizations, for leaders, to invest in allowing the space, and really time, it comes down to time, for teams, for clinicians, for clerks, for any, all key stakeholders to participate in quality improvement. And that’s all I have. Thank you.

Heidi: Great thank you, Laura.

Laura Damschroder: So we can open it to, yeah, questions now. I don’t know if anyone has posted anything?

Heidi: We do have one question in for the audience, we do have some time here for questions, please use that question pane and GoToWebinar to submit your questions in to us. That’s on the dashboard on the righthand side of your screen. Just click on that orange arrow in the upper righthand corner of your screen, if that has collapsed against the side of your monitor. And the first question that we have here. Is the LEAP program, training videos, et cetera, available outside of the VA?

Laura Damschroder: Oh, that’s a good question. It is not at this point in time. And we know that we need to think about that and figure out how to make it available. So, if you’re interested in exploring that, I guess, here is an email address and you can just email us directly and we can explore some possibilities.

Heidi: Great. Thank you. We still do not have any other questions in here, you guys must have done a great job at, with today’s session to not have any questions coming in. We can give it another minute or two if either of you have any final remarks you’d like to make? Here we go, here we go. Did you identify specific team characteristics that were associated with positive implementation outcomes?

Laura Damschroder: You know, that’s an interesting question. We did not formally measure team characteristics. Michele, as a coach who has worked with many of these teams directly, you may be able to add some insight to this. I will say that we are in the process of writing up one experience of a team, of one team, this is just one, and in fact, they were a pilot team. And I would say that their characteristics are, there’s a high level of enthusiasm and commitment for the program and wanting to continue to improve it. This is also a team that has, they have very open channels of communication with their director on down. So they’ve got leadership engagement and commitment and support for the work that they’re doing. Which seems to make a tremendous difference. I think that, the other is that they’re good at coercion building, in other words, they are good at really kind of making the work that they’re doing, making it visible and communicating it at multiple levels within their medical center. Michele, do you have insights?

Michele Freitag: Sure. I think thinking about the teams that I’ve coached and that we’ve worked with, as lead coaches in the MOVE! program, the team leaders themselves are primarily MOVE! program coordinators. And those, I think I said this earlier in the presentation, those individuals really, I mean, made this experience their own. And so the enthusiasm that Laura was just speaking to with the one particular team I think was pretty well spread across the folks that we worked with. And they were all volunteers. I don’t know if many without dedicated time for this type of work, though it was written into their position descriptions often to do quality improvement initiatives. So, I think the fact that they made the time, and volunteered, and then really took ownership of the experience, I mean that’s a resounding characteristic that stands out. But I do think it would be interesting to dig a little bit deeper. And one other thing I’ll say is that the teams were generally multidisciplinary, even though we were working with it, within the MOVE! program, we encouraged the team leaders and active team members to look outside of their current program and their current staff, and to pull people in from across the facility. And again, I think I said this earlier too, but share the guidance widely. So even if those people didn’t join the LEAP improvement team, they were still able to kind of benefit from being an ad hoc team member, you know, to join exercises here and there and learn from the LEAP guidance too.

Laura Damschroder: Right. And while you're talking about team membership, we also encourage the inclusion of patients. And there were a few teams who did include Veterans in their team as well. We also had teams that were virtually connected, so they worked at different sites, and I think, what do you think Michele? It seems that sometimes they were challenges with that, but not always, so maybe it comes down to kind of their working relationships or the degree to which they already knew each other and were working together in advance.

Michele Freitag: Yeah, I think many of the teams had team members who were in, at CBOCs, the Community Based Outpatient Clinics, and not necessarily onsite at the main medical center. And we learned some tips and tricks from having those teams working remotely or virtually with one another for these sorts of times when we’re all, many of us are working virtually, or having to find creative ways to connect with one another. Yeah, so it prepared us in a way.

Laura Damschroder: Yeah. Yeah, that’s so true. And another feature of LEAP too that we put in place was offering continuing education units. So, people could get up to, and it was usually the leaders who were the most involved and participated in all of the coaching and the collaborative sessions, but I think it was up to 32 credits. Do I have that right Michele? So I think\_

Michele Freitag: Yeah.

Laura Damschroder: \_ ranging from like 6 or 8, up to 32 CEUs that people could accrue. There are so many devil in the details, both about LEAP itself and also about the conduct of the step-wedge trial. I don’t know if others have executed step-wedge trials, but you know, when the world changes and can, taking pragmatic considerations into account, it was a very, let’s say, fun adventure for us. In many ways. I will say that one of\_

Heidi: All right, thank you.

Laura Damschroder: \_ the advantages that we were able to leverage is that working in the VA we were able to design an outcome that is available through CDW data. Which allows us to include control sites without having to formally reach out and engage those sites. Because we didn’t have to do any extra data collection for the control sites. Which is a real value added for those of us in the VA.

Heidi: Great, thank you. We have received a couple other questions in here, if we can move on to the next question?

Laura Damschroder: Sure.

Heidi: Is this something that could be utilized by other than Veterans?

Laura Damschroder: By other, say that last word?

Heidi: Other than Veterans.

Laura Damschroder: Oh, other than Veterans?

Heidi: Yep.

Laura Damschroder: Absolutely. I mean our, the LEAP program itself is actually not intervening directly with patients. Or Veterans. It’s aimed at the frontline teams or clinicians who deliver care. So, it’s really focused on improving clinical care, and not on treatment for patients. Directly. So for example, moving forward we’re going to be using LEAP with clinical teams to improve and optimize use of certain medications. So we’re going to be applying this to a very different clinical area. We have already actually engaged teams on other topics outside of the MOVE! program, so it has brought application beyond just MOVE! for sure. And whoever your patient population, I see in the list that there are people listening today from outside of the VA, whoever your patients are they can, and you know, we’ve got more and more kind of interest and emphasis on the importance, or at least the value of including patients, whoever your patients, key patient populations are. But including representatives on these teams that are designing or redesigning clinical processes.

Heidi: Great. Thank you. The next question here. Levels of burnout did not seem to change much pre- and post-LEAP; do you have any thoughts on this?

Laura Damschroder: Yes. You know, it’s actually kind of one of my favorite strands of thinking and puzzling. First of all, we really have to acknowledge that during the course of this trial there was a lot going on in the VA that may contribute to burnout generally. So, maybe the fact that it was at least flat is a good thing. It’s just hard to tell. I can say that, for many teams there were staffing issues, kind of feeling understaffed, that there was just enormous pressure to improve access. In the case of the MOVE! team specifically it was having to respond to that direct scheduling, which was enormous because they had well established referral pathways, or processes, but then all of a sudden patients, you know, that the positive thing about direct scheduling is the patient has the latitude and the freedom to decide, hey, I want to do MOVE!, and they can do it, they don’t have to get a referral from their primary care physician or anyone else. But the downside is that patients have to find the MOVE! Program on their own. Without some major kind of proactive retooling of that process. So, there were a lot of stressors, I think, within the system that were just kind of, you know, I’ll just call them secular. The other things is that there is in the literature there are theories that engaging clinicians in quality improvement, in this kind of work, can help to bolster or regain a sense of autonomy that they may feel like they’re not, you know, they may be feeling like they don’t have, and this is in the literature, but it’s going to take time. First of all, when you're learning a new skill it’s stressful. You know, when you're learning how to do a cycle of change. Learning how to write a charter. Learning how to brainstorm, with colleagues that you’ve never really worked with like this before. It’s hard work. But it’s also very gratifying. But I think that coming out and doing it just one time, versus for the teams who did continue doing this over time, we’re hoping that it will in the long run have a positive effect. But it is very difficult to measure just because there’s so many variables that impact that particular measure.

Heidi: Great. Thank you. The next question here. Are there plans to use LEAP to support QI in other processes or programs?

Laura Damschroder: Yes, there are. We are partnering actually with the national systems redesign and improvement office, and we are going to do kind of a developmental evaluation approach with doing compare, kind of compare and contrast and refine the LEAP approach to learning, QI, and engaging teams in QI, and then the about training for lean, and really kind of learn from each other’s efforts in that area. And we’re not sure what the topic is going to be exactly because like I said before, we’re really topic agnostic. This process can be used anywhere, from housekeeping to neurosurgery, to administrative functions, primary care to inpatient infection control. So, it really is, I think the key is that we look for is that there’s some, a really a key skill that we’re looking for people to come out from LEAP with is use of data and having additional increased comfort with clinical indicators and working with clinical data. To help inform where the kind of the low hanging fruit is. You know, where you’re going to get the most bang for the time that you’ve put in for your improvement numbers.

Heidi: Great. Thank you. And one last question before we close things out here. Would it make sense to have an implementation intervention to change the behaviors of health system leaders to provide more time for PDSA cycles?

Laura Damschroder: I would love to collaborate with someone who has such an intervention. I think that that would be tremendous. We are, you know, that reminds me, we had kind of a philosophy coming into this that frontline teams, oh, you know, you don’t, to do kind of small incremental changes in an everyday way that maybe there’s a way that they can kind of manage upward, where they can kind of excite people and bring people along as they go, and that they didn’t necessarily need upfront leadership approval. And many of the teams did not speak, or elicit that commitment from even their supervisors. In some cases. But for those who did, and for those who did have leadership commitment, it did really make a difference. And so I think we learned kind of firsthand the importance of that role of at least at some level just finding where those key people are in the organization to support your work and to give you the space to do that. But definitely, I mean it’s a cultural transformation. And I think that with the VA’s emphasis on HRO maturity that an intervention like that would be really, you know, really a priority. So, great idea.

Heidi: Great. Thank you. And we are at the top of the hour here. Laura, Michele, do either of you have any closing remarks you’d like to make before we close things out?

Laura Damschroder: How about you, Michele?

Michele Freitag: Just to thank, thank you to everyone who joined us today.

Laura Damschroder: Yes, and likewise. If you have any questions, don’t hesitate to reach out, and thank you for your time.

Heidi: Great. Thank you both. Christine, just wanted to check and see if you had anything you’d like to say quick before we close it out?

Christine Kowalski: Thanks Heidi, I just wanted to thank you and those at CIDER and Laura and Michele for their work today, and if people have ideas for future topics that they’d like to see for these seminars please send me a direct email. It’s christine.kowalski@va.gov .

Heidi: Fantastic. Thank you, Christine. Just a reminder to the audience that we do take the month of August off of our sessions, but you should start seeing registration information later on in the month of August. Thank you everyone for joining us today, and we look forward to seeing you at a future HSR&D Cyberseminar. Thank you everyone.

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