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Early Lessons Learned in Implementing a Women's Health Educational and Virtual Consultation Program in VA

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Abstract

Background—Many Veterans Health Administration primary care providers (PCPs) have small female patient caseloads, making it challenging for them to build and maintain their women's health (WH) knowledge and skills. To address this issue, we implemented a longitudinal WH-focused educational and virtual consultation program using televideo conferencing.

Objective—To perform a formative evaluation of the program's development and implementation.

Research Design—We used mixed methods including participant surveys, semi-structured interviews, stakeholder meeting field notes, and participation logs. We conducted qualitative content analysis for interviews and field notes, and quantitative tabulation for surveys and logs.

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Subjects—Veterans Health Administration WH PCPs.

Results—In 53 postsession surveys received, 47(89%) agreed with the statement, “The information provided in the session would influence my patient care.” Among 18 interviewees, all reported finding the program useful for building and maintaining WH knowledge. All interviewees also reported that sessions being conducted during their lunch hour limited consistent participation. Logs showed that PCPs participated more consistently in the 1 health care system that provided time specifically allocated for this program. Key stakeholder discussions revealed that rotating specialists and topics across the breadth of WH limited submission of cases.

Conclusions—Our WH education and virtual consultation program is a promising modality for building and maintaining PCP knowledge of WH, and influencing patient care. However, allocated time for PCPs to participate is essential for robust and consistent participation. Narrowing the modality's focus to gynecology, rather than covering the breadth WH topics, may facilitate PCPs having active case-based questions for sessions.

Keywords

Veterans; women's health; Continuing Medical Education; qualitative methods

BACKGROUND

Women Veterans are a rapidly growing minority among Veterans Health Administration (VA) patients. Although ethically and judicially entitled to receive care equivalent to their male counterparts, achievement of this goal is an organizational challenge.¹⁻³

As a vertically and horizontally integrated health care system, VA is organized into health care systems with specialty, hospital, and emergency care being generally located at medical centers, and primary care services being located both at medical centers and free-standing, geographically dispersed clinics called community-based out-patient clinics (CBOCs). CBOCs were developed to improve access to primary care by reducing distances Veterans need to travel to receive basic services.⁴ However, the majority of CBOCs do not have comprehensive women's health (WH) multispecialty clinics; in order to access in-person WH specialty expertise, CBOC patients often must travel significant distances to VA medical centers, or use health care settings outside of VA.⁵⁻⁹ Further, many CBOC primary care providers (PCPs) have relatively small caseloads of women Veterans, and have limited ongoing exposure to a depth and breadth of WH issues. Therefore, it is often difficult for them to maintain their WH knowledge and skills.¹⁰ Recent data demonstrate that women Veterans give lower ratings for the WH skills of PCPs at CBOCs with fewer women Veteran patients, compared to PCPs at large VA sites with WH centers.⁸

VA has invested in a number of initiatives to address this issue. Among these initiatives is a PCP education and virtual consultation program called WH Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). SCAN-ECHO is VA's implementation of University of New Mexico's Project ECHO, which uses televideo conferencing and case-based learning to train and support PCPs in developing knowledge and self-efficacy on a variety of topics.^{11,12} SCAN-ECHO provides VA PCPs with virtual specialist consultation on patient cases and serial patient-based advanced education by

exposing PCPs to a depth and breadth of cases and issues within a defined clinical area. Before each session, PCPs submit consultation requests on patients for whom they want diagnostic and/or therapeutic management advice. During sessions, a specialist at a “hub” facility and PCPs at multiple “spoke” sites engage in videoconference group discussions about the cases. In addition to giving recommendations, the specialist discusses the underlying evidence or rationale. Content also includes patient communication strategies. The PCP who submitted the consultation request, as well as other PCPs participating in the session, interact with the specialist and with each other, asking clarifying questions. The specialist also provides a brief didactic relevant to the cases. Continuing Medical Education (CME) credit is provided. To date, most of VA's SCAN-ECHO programs have focused on specific medical conditions (eg, hepatitis C, diabetes, chronic obstructive pulmonary disease). We adapted the SCAN-ECHO model to develop and pilot the first WH SCAN-ECHO program, which, instead of focusing on a single medical condition, addressed the spectrum of care for women Veterans as a special population.

This WH SCAN-ECHO program was coordinated through the VA Greater Los Angeles Healthcare System; PCP participants were from Greater Los Angeles, San Diego, and Oklahoma City VA health care systems. VA mandates that every primary care clinic have 1 designated PCP who is interested in and proficient in WH and to whom women Veterans are preferentially assigned (WH PCPs).¹³ All WH PCPs in these 3 systems received electronic mail (e-mail) invitations to sessions and the program was additionally promoted through presentations at meetings with WH PCPs in these systems. The program consisted of 14 one-hour monthly sessions from October 2012 through December 2013. PCPs in one of the systems were provided allocated time to participate. In the other 2 systems, the sessions were held during PCPs' lunch hour. Approximately 15 minutes of each session consisted of a “mini-didactic” on a selected topic (eg, abnormal uterine bleeding, menopause management, diagnosing/managing cardiac disease in women, genetic testing and counseling, mental health, fibromyalgia), with the remaining 45 minutes being used to discuss submitted patient consultations and other illustrative cases. Topics were selected based on the cases that were submitted for consultation, results from an internal survey-based needs assessment, and conversations with field-based WH medical directors. Rotating subspecialists (eg, gynecologists, cardiologists, geneticists, psychiatrists, pain medicine specialists) presented didactics and discussed cases in order to cover the breadth of WH topics. Subspecialists, rather than expert WH PCPs, led the sessions, so that they could comment on diagnostic studies or therapeutic interventions that PCPs could potentially initiate in advance of in-person subspecialty consultations, if needed, as well as issues relevant to PCP-specialist comanagement of conditions.

In order to inform its development, as well as the development of other population-focused SCAN-ECHOs and similar programs within non-VA integrated health care systems, we performed a mixed-methods formative evaluation of our program's development and implementation.

METHODS

Design

We used semi-structured telephone interviews with program participants and potential participants as our main method of assessment. Interviews were conducted for the combined purpose of assessing educational needs of WH PCPs and experiences with, and perceptions of, virtual education and consultation modalities, including WH SCAN-ECHO. For this analysis, we utilized the portion of the interviews focusing on WH SCAN-ECHO. We augmented our interview data with findings from postsession participant surveys, participation logs, and stakeholder meeting field notes to assess program development and implementation. Our study was approved by the Institutional Review Board of the VA Greater Los Angeles Healthcare System.

Setting, Participants, and Recruitment

Interview and survey participants were PCPs designated as WH PCPs in the Greater Los Angeles, San Diego, and Oklahoma City VA health care systems. For the interviews, we obtained lists of all WH PCPs from the WH medical directors in these systems. We sent all identified WH PCPs e-mail invitations to participate in a 30-minute telephone interview. For the survey, after each WH SCAN-ECHO session, all participants in that session were sent an e-mail invitation to complete a postsession internet-based survey, with survey submission being required in order to claim CME credit. We requested PCPs complete a survey each time they participated in a session. Stakeholder meeting field notes were generated from meetings with clinical and administrative WH leaders in the same 3 VA health care systems and in 2 other VA health care systems being considered for program expansion.

Data Collection

PCPs who responded favorably to our interview requests were interviewed by one of 2 experts in qualitative data collection (A.B.H. or J.L.Z.), neither of whom was involved in program implementation or had any prior relationship with the interviewees. Interviewees were asked about their participation in WH SCAN-ECHO, facilitators and barriers to participation, and perceptions of the usefulness of the sessions. One SCAN-ECHO implementation leader (K.M.C. or D.L.W.) observed interviews and was available for answering questions that arose regarding the content or structure of the program.

Survey participants were asked to indicate, on a 5-point Likert scale, to what extent they agreed or disagreed with 10 statements assessing the session speaker, quality of content, and extent to which the respondents expected the content to affect their patient care. See Table 1 for exact statements. They were also asked the following optional open-ended questions: "Was the teaching method for this activity appropriate and effective?" and "What other CME topics would you recommend be included in this activity?." Finally, they were asked to indicate their professional designation (MD, DO, NP, PA) and if the presentation was free of commercial bias and the speaker's conflict of interest disclosed.

Field notes were compiled from telephone and in-person meetings between the WH SCAN-ECHO implementation leaders and WH leaders in the participating and potential VA health care systems. Participation logs were populated during each WH SCAN-ECHO session.

Analyses

All interviews were audio-recorded and transcribed verbatim. A qualitative expert not involved in program implementation (J.L.Z.) summarized content by topic, identified salient themes, and then rereviewed interview transcripts for exemplary quotations. Program implementation leads (K.M.C. and D.L.W.) reviewed their field notes to identify salient themes. Interview responses were tabulated. Participation logs were used to count the number of PCPs participating in each session and measure distribution by health care system.

RESULTS

Fifty-three PCPs received monthly invitations to participate and 43 (81%) participated in 1 sessions, with an average of 10 participants per session. Ten PCPs participated in a single session; 18 participated in 3 sessions. Providers in the 1 health care system that had time protected from direct patient care participated in 78% of the sessions to which they were invited, compared to providers in the other 2 systems without this protected time participating in 14% of the sessions to which they were invited.

We conducted interviews with 18 PCPs (40% of those invited) beginning in the month of program initiation, October 2012, and extending through April 2014, 4 months after the last WH SCAN-ECHO session. All interviewees reported SCAN-ECHO to be useful for building and maintaining their knowledge on WH topics. Combining didactic with case discussions was reported as being especially useful, with 1 participant stating, “I definitely think it was useful. I think it was nice to have the format of the short didactic followed by specific cases that were real world cases.” Another participant specified that the cases were the most useful element: “It’s a great experience, especially when they’re discussing case scenarios. That actually helped us a lot—especially [in] getting more knowledge....[The specialists] discuss some of the cases...similar [to the] kind[s] of patients we are dealing with. So we know how they manage and what will be the best thing to do [for our patients].” Another PCP said, “You get the expert opinion and decisions and how they process the decision-making on a lot of conditions that we don’t see often enough.”

All interviewees in the 2 health care systems without time allocated for participation reported this lack of protected time to be a major barrier to participation, reporting that clinical responsibilities often run into the noon hour. “You try and finish early but you’re usually late for the SCAN-ECHO so you don’t catch everything that has been said.” Another relayed, “We try to get to education when we can, and when we can’t, we can’t. We’ll work through lunch. If administration would give us the time to block our schedules for the education, that would be greatly appreciated.”

We received 53 postsession surveys (38% response rate) from at least 18 unique PCPs (10 surveys were returned without the respondent’s name filled in). Table 1 details survey

responses. All, or nearly all participants, agreed or strongly agreed with statements indicating that the learning objectives were met, that the speaker was knowledgeable and effective, and that they understood the information. Nearly 90% agreed or strongly agreed with the statements, “The information was useful to me,” and “The information will influence my patient care.” When specifying how the information provided would influence their care, 64% indicated that the information would change their ordering of diagnostic studies; 74% their treatment plans; and 53% their prescription of medications. Thirty-five of the surveys had a response to the question, “Was the teaching method for this activity appropriate and effective?” Of these, 32 responded with a positive comment (eg, “yes”), 2 commented on problems with technology (static on the videoconference equipment), and 1 commented that the information provided was too basic.

Discussions with key stakeholders echoed the themes that were found in the interviews and surveys: the sessions were valuable and had a high likelihood of impacting patient care, but providers found it difficult to participate without allocated time. In addition, stakeholder discussions revealed that, although appealing in their comprehensiveness, the rotating specialists and topics across the breadth of WH (ie, both sex-specific topics, such as gynecology, and sex-related topics, such as cardiovascular disease in women) limited submission of cases. The timing of PCPs’ case-based questions often did not align with the monthly specialist’s area of expertise. For example, a PCP would have a gynecology-related question in a month that a cardiologist was discussing cardiovascular disease in women. Therefore, for the sake of expediency, the PCP would seek alternative modalities for obtaining the needed information (eg, send the patient for an in-person gynecology consultation).

DISCUSSION

We found that VA’s SCAN-ECHO program is a promising modality for building and maintaining PCP knowledge on WH topics. Interviewees perceived that participating in WH SCAN-ECHO would likely result in them building and maintaining their WH knowledge and improving the care they provide to women Veterans. Attendees indicated, through survey responses, that it would influence their patient care. However, we also found, in both interviews and stakeholder discussions, with supporting evidence from participation logs, that providing PCPs with time protected from clinical responsibilities is essential for robust and consistent participation. This finding is consistent with internal SCAN-ECHO program evaluations (S. Kirsh, personal written communication, 2014). Further, we found that attempting to cover the breadth of WH topics in this 1 program impeded PCPs from having active case-based questions for the sessions.

These are important learning points, relevant not only to future WH SCAN-ECHO programs, but to VA’s overall SCAN-ECHO program and other educational efforts to build and maintain capacity among VA’s workforce. Our findings have particular relevance for other population-based (eg, geriatrics) SCAN-ECHO programs.

VA is committed to the goal of delivering equitable, high-quality, and comprehensive health care to women Veterans.¹⁴ Concordantly, VA has invested in numerous initiatives to improve

sex-specific and sex-related care provided in primary care settings.¹⁵ Our findings demonstrate that, when provider education is employed as part of a plan to enhance care, making it available is not sufficient; allocated time to engage in this education is also necessary

VA's investment in SCAN-ECHO has potential for improving quality of care provided to women Veterans, while decreasing costs. In preliminary evaluations of SCAN-ECHO, across conditions, program implementation appears to be improving quality, access, care coordination, and primary—specialty care relationships.¹¹ Furthermore, inconvenient and potentially costly patient travel is avoided when a Veteran is able to receive specialist input through her PCP. More data are needed regarding these potential effects as well as specific investigation into the effects of WH SCAN-ECHO, and its potential effects on women Veterans' perceptions of the care they are receiving.

Education theory posits that “just-in-time” learning, where information is provided to the adult learner at the time of needing it, is extremely valuable, suggesting that the timely, case-based learning that is a key feature of SCAN-ECHO is crucial.¹⁶ Our interviewees substantiated this hypothesis. However, we found that having a breadth of clinical topics within our program actually hindered case submission, as there was a mismatch between when the specialist was available and when the participants had case-based questions. Therefore, future population-focused programs should consider narrowing in on a consistent subject area, such as gynecology, rather than the full spectrum of topics in WH. Although this sacrifices the program's comprehensiveness by not covering the breadth of WH, it may facilitate PCPs having active case-based questions for sessions and thereby benefitting from “just-in-time” learning. Incorporating a discussion of sex-related issues into SCAN-ECHO programs in other areas (eg, addressing cardiovascular disease in women in a Cardiology SCAN-ECHO program) may be 1 strategy to continue to addressing these areas.

This work has several limitations. Most notably, this implementation of WH SCAN-ECHO was limited to 3 VA health care systems; providers in other locations may have different perceptions and experiences. As WH SCAN-ECHO has since been started in other VA locations, experiences of these participants should be assessed. Second, although the interviews were performed as part of a research project, with assurance of confidentiality of responses, there was an overlap in the personnel between the research team and the implementation team, which may have led to social desirability in the responses. Finally, there were low interview and survey response rates among participants, which affect the generalizability of our results.

In conclusion, our findings suggest that SCAN-ECHO is a useful modality for VA to build proficiency in WH care among PCPs practicing in community-based clinics, if they are provided with time allocated to participate and the clinical topic is narrowed, such as a focus on gynecology. Future work should assess the effect of SCAN-ECHO on VA PCPs' knowledge, women Veterans' perceptions of care, and the quality and efficiency of VA's primary care for women.

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TABLE 1

Postsession Survey Responses

| | Indicated “Strongly Agree” or “Agree” (n = 53) n (%) |
|---|--|
| The learning objectives were met | 52 (98) |
| The speaker was knowledgeable | 53 (100) |
| The speaker was effective in his/her presentation | 52 (98) |
| I understand the information | 52 (98) |
| The information was useful to me | 46 (87) |
| The information will influence my patient care | 47 (89) |
| Information from this session will change my overall interactions with patients | 29 (55) |
| Information from this session will change my ordering of diagnostic tests/studies | 34 (64) |
| Information from this session will change my treatment plans | 39 (74) |
| Information from this session will change my prescription of medication(s) | 28 (53) |