Primary Care to Order: Adapting the Customized Care Intervention to VA Integrated Primary Care Settings

Julie C. Gass[1,2] , Jennifer S. Funderburk[3,4,5], & Marsha N. Wittink[6]

[1]VA Center for Integrated Healthcare, Buffalo VAMC
[2]Department of Psychology, University at Buffalo, Buffalo NY
[3]VA Center for Integrated Healthcare, Syracuse VAMC
[4]Department of Psychology, Syracuse University
[5]Department of Psychiatry, University of Rochester
[6]University of Rochester Medical Center

U.S. Department of Veterans Affairs

Center for Integrated Healthcare

Background

- In primary care (PC), there is not always enough time to address all needs of patients with multimorbidity(1)
- Wittink and colleagues developed and piloted a tablet-based, PC waiting room intervention called Customized Care (CC) that allows patients to specify and prioritize which concerns (medical, mental, socio/environmental) they'd like to address at the appointment using adaptive technology (2) (see Figure 1)
- CC has been used in non-VA PC settings and has improved provider and patient satisfaction (2)
- The VA, like many other settings, has embedded behavioral health providers (BHPs) in most PC clinics, which may be beneficial for patients with multimorbidity

Study Aims

Our primary research aims were:

1. Interview providers and administrative staff at VA integrated PC clinics to determine relevant barriers and facilitators to implementing CC in VA clinics
2. Evaluate how/if CC can be used to facilitate linkage to an embedded BHP
3. Focus on providers in high-yield community based outpatient clinics (CBOCs), who have fewer available resources than providers at VA medical centers

Method

- We conducted semi-structured formative qualitative interviews with a purposive sample of 6 primary care physicians, 6 primary care nurses, and 2 primary care front desk administrative staff members of VA CBOCs in Western New York
- Interview questions, were guided by the Proctor's implementation model (3), which includes questions in the domains including local context, stakeholder experiences and evidence, and facilitative pathways as well as the Integrated Promoting Action on Research Implementation in Health Services (iPARiHS) implementation primary domains (evidence, context, and facilitation/function) (4)
- Interviews were recorded and researchers took detailed field notes as recordings were reviewed
- We used rapid qualitative analysis techniques including structured templates and a matrix display to examine qualitative data

Results

Questions

Feasibility/ Acceptability

Could you see CC **fitting into** your practice? Why/why not?

What would be some **challenges** to implementing CC in your setting?

What could we do to make CC as **feasible** as possible?

What could we do to increase how **acceptable** CC is to you?

Facilitation

In your setting, **who** do you think would be administering CC and looking at its data?

How **much time** should the CC questionnaire take?

How could the CC tool be used to **facilitate warm handoffs or referrals** to your embedded BH provider?

What do you see as potential **benefits** of CC in your practice?

Participant's Stated Potential Benefits of CC Tool

- Improve patient autonomy and patient empowerment
- Will give structure to the appointment, particularly with regards to mental/ behavioral health concerns
- May improve timing in the appointment; can help patients/providers narrow down what to discuss
- CC could be used to facilitate warm handoffs

"It will be really hard for the Veterans, a lot of the elderly, to be sitting in the waiting room doing it without any assistance"

(in regards to time concerns) ***"In the whole 30 minute appointment experience, I get the last 5 minutes with the patient."***

"We'd need to get everyone trained on how to do it first, and who's in charge of what."

Summary of Results

- 92.8% of participants thought that CC could be used, or be adapted to be used, in their clinics
- 64.2% of participants stated that technology barriers would be present, particularly with older Veterans
  - -28.5% of participants felt that a paper version/option would be beneficial
- Time was cited as a possible barrier by many participants (35.7%), but participants felt that if CC could be brief (~5 minutes was the average time desired), it would easily fit in
- Participants (64.2%) felt that the tool could be used to more easily refer/link patients

"A little more structure [in my appointments] would be good."

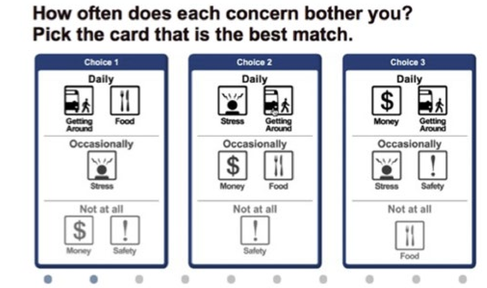
"I think it would help the Veteran too because they're initiating the [topic], it is not something we're bombarding them with which I feel like a lot of them feel like we're bombarding them with questions"

"I think it would be a wonderful tool for us to use because it will get them to say, 'Hey, I could use help with this' and open that door for us to talk about it easier."

Barriers/Facilitators Noted

- Technological barriers were cited frequently – suggested option to have a paper backup
- Would need training and clear protocol of who hands patients the iPad, who looks at their answers, who troubleshoots tech issues, etc.
- Time may be a barrier; recommend keeping CC questionnaire short

Figure 1. Example of Customized Care iPad question



Discussion

- Providers feel that CC is generally feasible in their community-based integrated PC settings at the VA
- Some modifications (such as having a paper-pencil option) may be necessary for certain clinics, such as those with no Wifi or those that serve primarily older patients
- Clear roles in the process, which can be achieved by training providers in a clinic, will be key
- VA PC providers were optimistic about using CC in their settings, and could see how it might benefit their patients with multimorbidity, especially by streamlining the session and opening up a discussion regarding referral to an embedded BHP

References

1. Stillman, D., Strumpf, N. E., & Paier, G. (2010). Meeting the needs of older adults for primary health care. *Nurse Practitioners: The Evolution and Future of Advanced Practice*, 192.
2. Wittink, M. N., Yilmaz, S., Walsh, P., Chapman, B., & Duberstein, P. (2016). Customized care: an intervention to improve communication and health outcomes in multimorbidity. *Contemporary clinical trials communications*, *4*, 214-221.
3. Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., ... & Hensley, M. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Administration and policy in mental health and mental health services research*, *38*(2), 65-76.
4. Hunter, S. C., Kim, B., Mudge, A., Hall, L., Young, A., McRae, P., & Kitson, A. L. (2020). Experiences of using the i-PARIHS framework: a co-designed case study of four multi-site implementation projects. *BMC Health Services Research*, *20*(1), 1-14.

Corresponding author: Julie Gass, email: Julie.gass@va.gov
Center for Integrated Healthcare, https://www.mirecc.va.gov/cih-visn2/index.asp

This research was supported in part by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development (HSR&D) Career Development Award-2 (grant 18-006) and from the CFHA Research & Evaluation Committee Fellowship awarded to Dr. Gass in 2019. The views expressed in this presentation are those of the authors and do not represent the position or policy of the Department of Veterans Affairs or the United States government.