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CLINICAL COMMENTARY

"The Voice of the Veteran": An Actionable, Focus-Group-Driven Approach to Improving Veterans' Inpatient Experience at an Urban Academic VA Medical Center

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Introduction

The Veterans Health Administration (VHA) was established in 1930, with the mission to "serve and honor the men and women who are America's Veterans."[1] A recent meta-analysis of 55 studies compared various process and outcome measures in risk-adjusted Veteran patients treated in Veterans Administration (VA) versus non-VA settings, and concluded that VA care generally compares favorably to non-VA care for this patient group.[2]

Despite evidence of quality, the VA has faced recent controversies which prompted local and national efforts to continue improving access and health care quality. Though the main focus has been on improving outpatient care and primary and specialty access, there are also opportunities to improve the quality of inpatient care. At our own, VA Greater Los Angeles (VAGLA), inpatient surveys including the nationwide Survey of Healthcare Experiences of Patient (SHEP) suggest physician communication has been a particularly low-performing area. As physicians and physician-educators we felt we could directly improve this domain.

An early intervention was conducted by our hospitalist group from 2014-15 to improve physician communication at VAGLA. Elements included teaching physicians to sit down (rather than stand) during patient interactions and creation of easier-to-understand discharge instructions using a new EMR template. The initiative's impact was measured with pre- and post-*Truthpoint Company*™ surveys of discharged patients. One behavior that achieved a small improvement was the physician introducing him/herself to the inpatient by name each encounter. However, other areas of communication did not improve, including < 80% of discharged patients felt they understood post-hospital self-care instructions and less than 70% felt well-educated on medication changes. VAGLA overall continued to perform below the national VA average in the Physician Communication and Discharge Information categories within SHEP tool.[3-5]

The quantitative approach to quality improvement, which often involves comparing Likert-scale survey response averages across sites and over time (eg SHEP and *Truthpoint* tools), provides standardization and comparability, but lacks granularity and offers little in the way of concrete suggestions for improvement. At the behest of VA's Office of Patient Experience (OPE), our group reflected on past experiences and took a *qualitative* approach to understand shortcomings in inpatient care from the *patient's* perspective. A healthy relationship has been shown to have a multitude of benefits for the patient, including improving follow-up and understanding of disease.[6,7] We sought increased understanding from the patient's perspective. We titled our project "The Voice of the Veteran."

Focus group are frequently used to gain qualitative insight into problems. Studies have examined characteristics of focus groups that influence the type and quality of discussions. One study compared online "virtual" vs. face-to-face (FTF) focus groups, describing the pros and cons of each. Though there are cost advantages to virtual groups, the study found it easier to have a more fruitful discussion when there was in-person contact.[8] We used in-person focus group consisting of recently discharged Veteran patients to better understand and potentially improve Veterans' inpatient experiences. We reviewed our discharged inpatients' open-ended insights, both to generate hypotheses for local improvement, and to demonstrate the utility and applicability of the focus group methodology to inpatient quality improvement.

Methods

Based on the available VAGLA quantitative survey data on inpatient experience, we targeted Physician Communication for qualitative assessment. The Voice of the Veteran focus group took place at the VAGLA on January 24, 2017. The project was considered exempt by our institutional review board (IRB) due to its status as quality improvement work and descriptive nature. We agreed that all patient information would be kept anonymous and there would be no named introductions between participants on the day of the focus group.

Potential participants for recruitment to The Voice of the Veteran focus group discussion included all recently-

discharged inpatients from any of our medical or surgical services. Facility constraints allowed for a maximum number of fifteen participants. The quality improvement assistant accessed a central list of patients who had been discharged from our facility in chronological order of discharge date, and worked backwards from the last day of the month prior to the scheduled focus group. Individuals who had scheduling conflicts, did not want to participate, or lacked mental capacity (i.e. patients with dementia, mental health issues, hospice status or severe delirium during their hospital stay) were excluded from the study via phone interview or chart review. All others were informed about the nature of the quality improvement project, including the date, time, and location for the focus group, and that that they would have an opportunity to respond to open-ended questions about their hospitalization in the presence of other veterans. There was no compensation other than light refreshments and bus tokens if needed. After 121 attempted contacts, a list of 15 recently discharged patients committed to attending the focus group and enrollment stopped. After reminder phone calls and cancellations, eleven participants arrived and participated in the two-hour focus group discussion.

The previous quantitative data provided the general basis for open-ended questions on the theme of Physician Communication which guided the meeting. The individual sequence of questions was generated by consensus by the physician investigators and then simplified by the focus group facilitator who had a non-medical background (Figure1). Aside from the eleven participants, the focus group was led by the facilitator and attended by two non-participating physician observers. Dialogue was encouraged by the facilitator with little difficulty in being sustained for the duration of the meeting. The physician observers maintained a deidentified written record of the group's discussion, and subsequently performed general thematic analysis of the contents. There was no audio or video recording of the focus group.

Figure 1. Voice of the Veteran Focus Group Discussion Questions

1. When your doctors talked with you, do they use big words?
2. Did you ask questions when you talked with your doctor?
1. Did they answer your questions?
2. You had to go to the hospital recently.
    a. Do you understand why?
    b. Did anyone explain it to you?
3. When you left the hospital, did anything change for you (medications, diet, clinic visits?)
4. Did anyone explain all of this to you before you left?
    a. Who?
    b. Did you get written instructions?
5. Have you been hospitalized at other hospitals?
6. If so, how does "after-care" here compare with other(s)?
7. Thinking about your hospitalization, what would you suggest to our doctors?

Results

During the Voice of the Veteran focus group discussion and ensuing analysis of discussion notes, four overarching common themes arose, including some novel insights. These themes share some common threads, but are worth identifying separately to improve future patient care.

The first theme brought up was a sense of some physicians' poor communication of the plan of care. Multiple participants felt that some physicians only spoke amongst themselves outside the patient's hospital room, rather than sharing 'real' information with patients. As one group member put it, "I could overhear everything the doctors were talking about, but didn't understand it…I just didn't know what my condition was. I still don't!" Another Veteran had been receiving care through the VA for three decades, yet only during the month prior to the focus group had felt for the first time that the physician fully explained the medical plan. Participants generally disliked when their diagnoses and prognoses were talked *around* and not directly addressed. They sometimes had to specifically request physicians to use lay terminology. As one member stated, "My doctors would only use medical words. I asked them over and over to use layman terms. I didn't understand anything." There was a consensus that the participants were not "let in" on the entirety of the conversation with the healthcare team. Overwhelmingly, Veterans expressed wanting their physicians to talk *to* them and not just *around* them, especially regarding the serious topic of their health status.

The second theme was that many patients felt uncomfortable when the entire healthcare team, often attending, resident, interns, and students, arrived into their rooms as a "herd." This term was coined by one member and then used avidly by multiple others. After many Veterans shared nods and comments about the omnipresent 'herd,' one acknowledged that the others in the group had given an appropriate name to her main qualm with care at an academic center, stating "…I agree! It really did feel like a herd of folks all coming in at the same time. It could be so intimidating." Patients did not appear to understand why there were so many health care providers involved in their case, and at the very least wished for an explanation of provider roles.

A third theme involved frustration from some patients not receiving after-care and follow-up instructions after a complex hospitalization. One participant exclaimed, "I was discharged with [a new surgical device] in place. But I was never told I had to follow-up at my doctor's office periodically to have it changed. I wasn't aware of that until the stitches were coming out and I had to come to the ER in distress!" Other patients empathized with this feeling of abandonment by the inpatient medical provider, and many shared that they did not know how to follow up after discharge. The Veterans' own service-time mantra, after all, as reflected upon by another group member, was "Leave no man behind."

The final theme was a perception of poor communication amongst different physicians and between physicians and nurses. Some participants felt that the various medical and surgical specialty teams did not talk to each other and had doubts that the teams were following a unified plan of care. They shared that different teams made contradictory statements to them, resulting in uninformative discussions. One member recalled, "My doctors don't communicate with each other. I could not get answers on what happened during surgery. They switched my surgeon at the last minute and never let me know." Some patients brought also up a sentiment that physicians at times did not exhibit common courtesy towards nurses. Some described a culture of nurses being silent and trying not to disturb the physicians, even when the patient brought up a question they wanted addressed.

Conclusion and Future Directions

The Voice of the Veteran focus group study was a hypothesis-generating qualitative exercise dedicated to improving the inpatient experience for Veterans at GLAVA. We gleaned at least four thematic areas for improvement, as detailed above. Progress can be made in these areas through promoting awareness and providing educational counseling to our physicians. To work towards better Physician Communication with inpatients, our group will conduct an educational workshop where our qualitative conclusions will be presented to the Internal Medicine residents at the training programs affiliated with our site. We would like to prepare residents to fully explain the plan of care each day to their patients. We will encourage them to practice translating medical jargon into lay terminology, which will be reinforced through role-play sessions featuring adapted versions of some of the real quotations by focus group patients. We will present the ideas of asking patient permission prior to large group encounters, as well as 'scripting' the reasons behind the 'herd' of providers often involved at academic centers. We will share methods to ensure continuity of care within our healthcare system, including ordering timely outpatient consults prior to discharge and providing written information regarding new diagnoses and follow-up care. Finally, we will emphasize the importance of communicating directly with consultants and nursing so a unified plan of care can be presented to the patient. Although the effects of such a workshop might be difficult to quantify, we feel it would be the most appropriate method of disseminating our qualitative conclusions.

Unpublished focus group data generated within individual health systems may be used to guide local quality improvement. However, most data are not published and inaccessible. While insights gained from this type of study may be institution-specific, we believe that others (such as recognition of the 'herd' effect) may have broad value. When data remains siloed within individual institutions, it is difficult to learn from the experiences of others. Hence, we have presented our qualitative, thematic conclusions. We believe the focus group methodology proved effective in gaining some valuable and previously unrecognized insights into the patient experience.

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