Ci2i
CENTER FOR INNOVATION TO IMPLEMENTATION

Principal Investigator: Dr. Karleen Giannitrapani, PhD
VA HSR&D Project #: C19 20-207
September 30, 2020

VA OCCUPATIONAL HEALTH NEEDS ASSESSMENT

Problem Statement

In the United States, medical personnel carry a heavy burden regarding COVID-19 – in some states representing up to 20% of known coronavirus cases. Within the Veterans Health Administration (VHA), early involvement of Occupational Health (OH) may have protected employees, Veterans, and their families from even worse transmission rates. The roles and responsibilities of OH providers have greatly expanded and continue to evolve as the pandemic progresses.

Background

With the emergence of COVID-19, on March 15th, 2020, the Deputy Under Secretary of Health for Operations and Management sent out a memo to Department of Veterans Affairs Network Directors putting Occupational Health in the center of the organizational response. As OH providers and teams across the VHA mobilized for management of COVID-19 spread and employee health, investigators at the Center for Innovation to Implementation (Ci2i) undertook a rapid national needs assessment. The goal of this research was to identify best practices and gaps in order to support the expanding role of OH providers by documenting early learnings and needs in advance of additional COVID-19 waves and future infectious pandemics.

Executive Summary

1. VHA Occupational Health (OH) providers want standing policies for viral pandemics that include: standard chain-of-command; supply control; identified experts; protocols for delegating responsibilities; uniformity across sites
2. Gaps need to be addressed at the level of 1) structure (adequate staffing); 2) tools (EHR/community exposure communication); and 3) national-level leadership/communication
3. Opportunities exist to: leverage information-sharing via an existing national OH listserv; standardize and spread response through alignment with CDC and other federal protocols/agencies; develop an employee-focused electronic record to facilitate population management strategies

Approach

This Lightning Report approach (Brown-Johnson et al., 2019) leverages rapid qualitative analysis to present main ideas from key informant interviews in a maximal variation sample. Insights are drawn from the input of n=11 OH providers (MD=5, NP=4, RN=2) interviewed for 30-60 minutes between July 7TH and September 30th 2020. This sample is geographically diverse, representing 8 VHA facilities from diverse regions of the country (large, medium, and small facilities in the Mid-Atlantic; medium sites in South; large facilities in the West and Pacific Northwest). Key summary points are organized at the national and local level.

Results

National Insights	**Facilitators to the ability of Occupational Health to adapt and expand roles and responsibilities in the context of COVID-19** *Peer-to-peer* support • Occupational Health Forum listserv facilitated connection among OH providers across the country • Collegial spirit – sites willingly shared database tracking templates in Excel, Standard Operating Procedures (SOPs, i.e., policies), and information • Highly trained experts were available and accessible through the listserv. Ideally, funding would have been available to support expert time spent answering queries from across the VHA in this venue *CDC* seen as central information and source for policies

For more information please contact study PI – Dr. Karleen Giannitrapani karleen.giannitrapani@va.gov

Challenges/Gaps

Lack of centralized resources and policy, resulting in:

- OH providers' desire for regular communication from national OH leadership
- Lack of protocols leading to individual sites creating protocols and policies (SOP) out of urgency as opposed to well thought out strategy
- Provider overwhelm, an example of which was related to how frequently the CDC updated/changed policies and recommendations
- Recognition of the need to build a "deeper bench" for OH – more expertise or experience from OH-adjacent specialties (e.g. infectious disease, public health, etc.)

Tools needed

- Electronic health record (EHR) and tracking during outbreaks to look across care populations (employees, patients, veterans)
- Employee management: Population health infrastructure exists for patients, allowing for large-scale problem-solving during disasters. In an infectious disease outbreak, employees become a population that also needs management

Ideas from the field

- As a policy-making position, national OH leadership needs full-time resources and highly-networked leadership with expertise and interdisciplinary leadership support, eg. from occupational health, mass testing, policy, infectious disease. Leadership would benefit from being "several people deep" with policy experience
- Emphasize communication: a) Reinstate previous OH 1.0FTE divided among five national subject matter experts to answer Forum listserv questions ("incredibly valuable") to provide direction and clinical guidance; b) more frequent and bi-directional communication between national OH leadership and front-line OH providers and staff
- Ideal: SOPs delivered from National leadership to all VHAs
- TB policy has been useful (ie., blood-born pathogen policy), and especially experience with a live TB incident in the last few years, which included contact tracing. Suggestion for viral pandemic drills considering how valuable lived experience has been

Local Issues and Insights

Facilitators to the ability of OH to adapt and expand roles and responsibilities in the context of COVID-19

Staffing

- Successful strategies for local staffing included: shifting ("detailing") staff from other services or temporarily-closed clinics, accessing transient labor pool, engaging travel nurses

Local leadership and networks

- When OH local leadership was well-networked across specialties within the local site, there was success in raising OH-related employee concerns to incident command
- Local leadership involvement in OH (e.g. site level executive leadership volunteering to detail with OH during surges) directly resulted in additional resources and leadership understanding of OH problems and needs
- OH demonstrated their value through involvement with local COVID-specific incident command; some sites leveraged that perceived value to secure more permanent staffing

For more information please contact study PI – Dr. Karleen Giannitrapani karleen.giannitrapani@va.gov

Ci2i
CENTER FOR INNOVATION TO IMPLEMENTATION

VA OCCUPATIONAL HEALTH NEEDS ASSESSMENT

Principal Investigator: Dr. Karleen Giannitrapani, PhD
VA HSR&D Project #: C19 20-207
September 30, 2020

Challenges/Gaps

Staffing

- Inexperienced/temporary staff resulted in lack of continuity, skills, and OH "know-how"
- Temporary staff were removed too quickly from OH (after having been detailed during surges)
- OH departments were chronically understaffed prior to COVID, putting them at an initial deficit
- Providers articulated burnout risk: No one took a break- "Local OH worked every day from the start of COVID through July"
- Site OH leaders emphasized they need a way to quantify/ justify the need for higher staffing (e.g., FTE per employee population)

Electronic Health Record (EHR)

- OH needed proper tools for tracking, charting, reporting, calculating. Without tools (eg. EHR), OH unable to leverage modern and efficient standing infrastructure (eg. QR codes for vaccines)
- Limited ability to use population management strategies
- Some VAs lacked current databases of who their employees were or where they worked (need better integration with updates from human resources)

Ideas from the field

- For large sites (4000+), procure coordinators for major OH health tasks (call center, testing, tracking/reporting, etc.) to distribute responsibilities within OH
- Institute programs for cross-training to OH, which will be vital to recruit new talent to OH and prepare for future crises
- Set expectations for potential staff flexing with cross-training through OH; prepare to pool staff resources across specialties (primary care, hospital, OH, etc.)
- Standardize across sites to leverage the work individual sites have done, for example template Excel & Access databases for calls, testing, contact tracing, and testing scheduling
- Develop a whole-person health record that respects and prioritizes employee privacy
- Possible funding source: move funding from new employee physical exams to EHR – even without physical exams since March there were low to no instances of new-hires being unfit for work

Next steps

We will conduct additional interviews moving towards capturing the experience of OH providers that are located in smaller facilities and sites serving various regions of the country. We will also explicitly target sites serving rural populations.

Acknowlegements

This work is supported by a VA Health Services Research and Development (HSR&D) rapid pilot (C19 20-207) to improve the VHA's rapid response to COVID-19. Team members include Karleen Giannitrapani PhD, Karl Lorenz MD, Sara Singer PhD, Cati Brown-Johnson PhD, Matthew McCaa MTOT, and Cheyenne Deshields BS of VA HSR&D Ci2i; Elizabeth Yano PhD from VA HSR&D CSHIIP; VA Occupational Health provider advisors.

Lightning Report Method

For more information about this method, see: Brown-Johnson, C, Safaeinili, N, Zionts, D, et al. The Stanford Lightning Report Method: A comparison of rapid qualitative synthesis results across four implementation evaluations. Learn Health Sys. 2020; 4:e10210. https://doi.org/10.1002/lrh2.10210

For more information please contact study PI – Dr. Karleen Giannitrapani karleen.giannitrapani@va.gov

Ci2i
CENTER FOR INNOVATION
TO IMPLEMENTATION

VA OCCUPATIONAL HEALTH NEEDS ASSESSMENT

Principal Investigator: Dr. Karleen Giannitrapani, PhD
VA HSR&D Project #: C19 20-207
September 30, 2020

For more information please contact study PI – Dr. Karleen Giannitrapani karleen.giannitrapani@va.gov