Overview
The goal of the Bridging the Care Continuum (BridgeQUERI) program is to improve vulnerable Veterans’ use of services across the Care Continuum, “bridging” the Continuum by improving outreach and diagnosis, as well as linkage and engagement with specialty care, which will lead to better health outcomes. BridgeQUERI will implement and test models of care to help vulnerable Veterans negotiate the Care Continuum. The Secretary’s Impact Priorities guide our work. We strive to improve access to specialty care while ensuring consistency of best practices and developing a high-performing health network. We also engage employees in improvement processes, and this contributes to restoring Veteran trust and confidence in the VA. To achieve this, several selected sets of problems will be targeted, including comorbid substance use and mental illness, hepatitis, and incarceration—not because they address all health vulnerabilities, but because they are important opportunities for improvement. The problems are serious, disproportionately prevalent in vulnerable Veterans, and require complex, specialized services.

Implementation Strategy
Veterans with social vulnerabilities face grave challenges negotiating or “bridging” the Continuum of Care that extends from diagnosis to treatment, and ultimately to improved health outcomes. Why do Veterans—who have good health coverage—still face this difficulty? The VA Blueprint for Excellence makes the case that, “Individuals with multiple health vulnerabilities—age, poverty, social isolation, physical and mental illness, substance use, and homelessness—fare poorly even with robust insurance coverage.” Poverty, justice system involvement, homelessness, and social circumstances make Veterans more vulnerable to serious health problems requiring specialized, often highly complex care.

The Care Continuum (see Figure 1) suggests where to intervene and for whom, and guides how BridgeQUERI investigators measure effectiveness. The Consolidated Framework for Implementation Research (CFIR), a conceptual model for implementation, sustainment, and spread of successful health processes and programs, provides guidance on how to intervene, accounting for context and evidence. Projects are using Blended Facilitation as an implementation strategy. Facilitation is a well-known and widely used implementation strategy, but its use in settings serving vulnerable populations has not been studied in depth. Thus, the BridgeQUERI’s findings will advance implementation science in this important area.

(over)
**Project Summaries**

- **Hepatitis C Testing, Linkage, and Treatment.** For this local quality improvement (QI) project, investigators partnered with VISN 1, the New England VA Engineering Resource Center (VERC), in addition to receiving support from the VA HIV, Hepatitis, and Related Conditions Program. This project employed QI and Lean Management to improve local practices, and expand hepatitis C (HCV) testing and linkage to care in order to prevent cirrhosis among Veterans. This project reinforced the need for strong linkage to specialty care after diagnosis in primary care. The HCV Testing, Linkage, and Treatment project spawned projects of interest to operational partners. One project examined provider and patient experiences with the Hepatitis C Choice program, through qualitative interviews. A second project is evaluating a VA text messaging system—both in terms of understanding implementation issues and assessing effectiveness at improving patient self-management for Veterans undergoing treatment for HCV.

- **Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION).** Investigators will integrate mental health and substance treatment, engaging homeless Veterans in healthcare. This project is being implemented in the Greater Los Angeles Homeless-PACT clinics to understand facilitation in implementing a complex intervention.

- **Post-Incarceration Engagement.** Investigators are conducting a contextual analysis, including qualitative and quantitative data collection, and network mapping to prepare and implement a peer support program that links and engages Veterans with VA and community healthcare and other supportive services after release from incarceration. This is a two-state comparative implementation, initiated in one state and then adapted for a second.

- **Cirrhosis Management.** This quality improvement project aims to implement an intervention known as Population-based Cirrhosis Identification and Management Strategy (P-CIMS), which is a web-based, case identification and tracking application that links to the electronic health record and allows for timely identification of all patients with cirrhosis, and facilitates their linkage, treatment, and retention in care. P-CIMS has been implemented at the Michael E. DeBakey VAMC in Houston, and also will be implemented at the VA Palo Alto Health Care System.

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**Principal Operational Partners**

- HIV, Hepatitis, and Related Conditions Pathogens Program (HHRC), Office of Specialty Care
- VA's National Center on Homelessness among Veterans
- Health Care for Re-entry Veterans Program
- Office of Health Equity

**For More Information**

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