

TRANSCRIPT OF WEBINAR:

What Works And Why? Lessons Learned From 6 AHRQ Grantees Implementing Comparative Effectiveness Research

NOVEMBER 17, 2014

BEGIN TRANSCRIPT:

JAN DE LA MARE: Good afternoon everyone and thank you for joining us for the AHRQ Webinar, “What Works and Why? Lessons Learned from 6 AHRQ Grantees Implementing Comparative Effectiveness Research.” My name is Jan De La Mare, and along with my colleague, Peggy McNamara, we’re delighted to welcome you on behalf of AHRQ.

I’d like to acknowledge our AHRQ grantee teams who are joining us today. A special welcome to members of the six teams funded in 2010, and also the eight teams most recently funded.

One of our goals today is to share lessons learned from earlier work to benefit the work that many of you are currently engaged in to disseminate and implement patient-centered outcomes research.

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So here you can see our agenda for today, which is divided into three segments as follows:

First, each of our grantee panelists will offer a very brief, high-level overview of their projects. And Peggy McNamara from AHRQ will moderate this portion and we’ll open up the floor briefly for some quick clarifying questions.

Next, we’ll turn to Jim Dearing from Michigan State University, and Jim will moderate a discussion among our six grantees based on three key questions. First, “What did you do that worked well?” Second, “What did you try that didn’t work as well as you’d hoped?” And finally, the third question will be, “What recommendations do you have for AHRQ and other funders related to dissemination and implementation?”

And finally we’ll hear from our grantees about tools and other resources that they’ve developed that others may wish to use or adapt for their own projects. [00:01:42]

And then we will have a brief wrap-up.

Throughout the webinar, our moderators will invite questions and comments from all of you, so when they open up the floor for questions, there are two ways that you can ask a question or make a comment. First, you can simply un-mute your phone line. They are open phone lines, so

you would just un-mute the line and ask your question. Or if you prefer, you can type your question or comment into the text box – and you should see that on the lower right-hand portion of your screen. And then our moderator will read your question to our speakers. So either option is fine.

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I'd like to go ahead now and introduce our grantee panelists. We are delighted to hear today from Dr. Keith Kanel from the Pittsburgh Regional Health Initiative; Dr. Ardis Olson from the Dartmouth CO-OP Practice-Based Research Network; Dr. Stephen Crystal from Rutgers University; Dr. Michael Dulin, who will be tag-teaming with Dr. Hazel Tapp – both from the Carolinas Health Care System; Dr. Paula Darby Lipman from Westat, representing Dr. James Mold from the University of Oklahoma Health Sciences Center; and Dr. Jill Marsteller from Johns Hopkins University. You can read more about our panelists in their impressive bios which were e-mailed to you earlier.

And with that, I will turn it over to Peggy McNamara to kick things off. Peggy?

PEGGY MCNAMARA: Thank you, Jan. We've asked our six grantees to provide an overview of their projects and accomplishments, which also will provide some context for the "Lessons Learned" discussion which will follow next. And we've given the speakers an impossible – near-impossible task – to summarize their three years of experience into three slides in three minutes.

As it turns out, three of the six seek to increase and improve – excuse me, improve mental health care and three address physical health care. And so we'll use this to create two panels and after each panel, we'll pause for some quick clarifying questions and quick clarifying responses. And so with that, next panel. Next slide, please?

This is our first panel, and Keith, you're up first. Next slide.

DR. KEITH KANEL: Well, thank you. This is Keith Kanel. I'm Chief Medical Officer at Pittsburgh Regional health Initiative. The project we did for the 2010 AHRQ grant was called "Partners in Integrated Care," which was supporting screening for depression and alcohol and drug misuse.

The affiliated network that was used in this grant was – actually a can of networks. That was the AHRQ's CVE network, and the network for Regional Health Improvement Collaborative, which is a group consortium of regional not-for-profits that are engaged in quality improvement. Significant overlap – these are essentially almost the same network. And our geographic focus were four states – that's Pennsylvania, Wisconsin, Minnesota, and Massachusetts.

I'd like to take a moment just to name the organizations that are a part of – that were the NHRI partners. And they are Pittsburgh Regional Health Initiative, the Institute for Clinical Assistance Improvement in Minnesota, the Wisconsin Collaborative for Healthcare Quality, the Wisconsin Initiative to Promote Healthy Lifestyles, and the Massachusetts Health Quality Partners.

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The thing we tried to address with PIC is how to deal with behavioral health comorbidities in primary care settings – especially depression and unhealthy substance use. It's a very strong evidence base that addressing these issues does lead to better outcomes. And the tools one would use would be screening and intervention.

Why isn't this done more often? It's because primary care physicians don't have the time. They may not have the training to implement this in a primary care practice. But more importantly, culturally, primary care practices just aren't set up for this disruptive form of work flow. And we thought we could actually come up with a way that this could happen. The evidence being disseminated are two US Preventive Services Task Force recommendations. The first is that depression screening occurs when staff assistant supports are in place. The model we used was the IMPACT model from the University of Washington, which was enormously successful in pilot trials.

Also, screening for alcohol misuse with the SBIRT model, which is Screening Brief Intervention and Referral to Treatment. Also, a USPSTF recommendation. And then there are also brief interventions for drug misuse, such as the DAST, that we imported into the model. Most of these models use a prescreening followed by a screen that can be given in a primary care practice.

The innovation was to combine these into a single office-based work flow intervention and designate a non-physician Integration Specialist who could serve as the pivot person. Our hope is to disseminate this model of the tandem IMPACT-SBIRT team-based model in 90 primary care practices in four states.

The intervention. We spent about a year developing a toolkit that would have all the necessary work flow and data recording measures in one place. We then engaged in aggressive staff recruitment, staff hiring, and protocol-based multi-state rollout. And then we spent the last two years of the grant doing live, regional site visits, meetings, on-line support to help refine these at the primary care sites.

The lead implementers in this project were the Integration Specialists, which were new roles in a primary care office. It could be a social worker, a licensed professional counselor, a medical assistant, or an RN trained in the same PIC protocol. Primary care physicians were always in control at putting these tools back into place. And there was a consulting psychiatrist that would see – that would see the patients virtually by tracking a log.

External support. Many of our sites had PCMH and ACO incentives regionally that they used to leverage on this project, and then also regional Pay for Performance targets.

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How did we do? We were able to implement the model in 57 primary care practices across the four states. We screened 60,000 patients for depression and unhealthy substance abuse. Among

those that were screened, about 3,000 received depression services and 400 received substance abuse services.

When we looked at how these people did in terms of remission and response, it pretty much matched across all the sites. Mind you there was no clear benchmark we could use, so we used internal benchmarks and we were surprised by the reproducibility of this model. The most important achievement was we defined a clear, valuable role for the Integration Specialist.

And regarding sustainability, all of our materials are available free of charge on our website. I'll give you the links in a moment. We used this to launch several other grants, including COMPASS, which is a CMS Innovation Center grant that involves 18 health systems. And several of the other partners have used this to create grants locally.

More importantly, PIC has become – is being debated as part of public policy in at least three states. Massachusetts, Minnesota, and Wisconsin are using this for their state-based public health initiatives. And in Pennsylvania, where we've got managed Medicaid, we're using – we've made these tools available to all of our managed care providers. And in Wisconsin, they're reaching out directly to employers.

That's all I have.

PEGGY MCNAMARA: Thanks so much, Keith. And now, Ardis? (pause) Ardis, you want to un-mute your phone? [00:09:43]

DR. ARDIS OLSON: Thank you. Muting is always hard. (chuckling) Thank you. I'm here on part of our Practice Research (Based) Networks at Dartmouth, the Dartmouth CO-OP, and the Clinicians Enhancing Child Health. These were like – before were overlapping organizations where the first covered predominately adult providers and the second, predominately child providers. Actually during the process of this grant, we moved their administrations closer and closer together. So they really are linked networks.

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So the evidence – this is compatible with what he just presented before, because we've taken a different turn on depression care and implemented the US Preventive Services Guidelines for Adolescents 12 to 18 years of age. And although most people noticed the screening, the guidelines are very careful to talk about only if you have systems in place to do diagnosis, therapy, and follow-up, and to make sure it happens.

So what we found is we really had to adapt from existing adult systems and the literature that was there with quite intensive office systems to one that could be done in a rural, less intensive resource setting. And we were supported identification and appropriate treatment of depression in the office with both in-person and web-based training and a customized support for each site. Many elements of quality improvement, but not a formal quality improvement model.

The lead implementers were the physicians and the – it says care managers, but kind of all players who cared in the office.

The external supports. We arranged to have MOC certification for practices who participated – and actually 7 of our 12 practices used it. They also had the option to use this to fulfill local ACO and PCMH requirements, which three practices did in Vermont. There was marginal revenue from billing for screening that did not cover billing costs for some practices, but other practices did get the support of external screening. And disseminators were engaged in payers of discussion, but there was not a local financing model found to cover the full cost of the intervention.

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So our achievements? We had started. We had approached originally 19 practices. We had 14 practices who ultimately had initial training and in 12 practices, we had full participation. In the course of a year, a little over a year – we had almost 10,000 adolescents screened. Interestingly, 7 of the 12 practices continued to screen and use the TMH registry when we went back nine months after the active intervention ended. One of the key components of this is a web-based registry that allows them to track their patient outcomes, and we can track the limited data about how they're doing.

The remaining five practices continue to screen and use educational components, but within their world of EMR, they wanted to attack follow-up differently.

Next slide. [00:13:03]

PEGGY MCNAMARA: So Ardis, I think that's it for this segment, so thank you so much. And now Stephen, the baton is to you.

DR. STEPHEN CRYSTAL: Okay. So this project is a stakeholder-driven project, and the stakeholders in this case are really large state systems. And this grew out of what's now seven years of work that we've done with states that started out with a collaborative project with the Medicaid Medical Directors Learning Network. So the premise of this is to try to move the needle on very large state systems and try to work with the decision-makers in those systems who incorporate tools that will drive the increased use of evidence-based practices, driven by concerns that both we, through the mental health CERTs, and state leaders had about data – about substantial quality and appropriateness. Issues mostly revolving around the dramatically increased and broadened use of atypical anti-psychotics, which the states had identified in our project with the MMDLN as sort of a central focus for trying to get their hands around this issue of being able to benchmark with each other, and the lack – their perceived lack of good measures that – quality measures that could be used as metrics in identifying their issues and making movement towards progress. [00:14:57]

So, we undertook to the – evidence-base includes The Teen Years guidelines that were developed through the mental health CERTs and published in Pediatrics, that dealt with appropriate management of maladaptive aggression in youth. It includes the number of evidence

– PC (Practice Center) evidence out of AHRQ including the black box warning that they have when (overlapping voices)

PEGGY MCNAMARA: Excuse me, Stephen?

DR. STEPHEN CRYSTAL: Yes.

PEGGY MCNAMARA: Stephen, this is Peggy. Should we be on slide 14 at this point?

DR. STEPHEN CRYSTAL: I'll finish with – let me go back to slide – finish slide 1 quickly.

We worked with six states, as you can see on this slide, and two additional affiliate states decided to join us on an unfunded basis.

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So as I mentioned, this is the list that I don't have time to go through, of specific clinical practices that were problematic starting with mental health targets, especially anti-psychotic poly-pharmacy, metabolic screening, and a variety of other practices. [00:16:16]

So we really disseminated evidence at two levels. Evidence about safe and effective clinical practices and the evidence about system practices and interventions that had shown success in participating states in increasing the use of clinical practices in these areas.

So we focused on working together to develop anti-psychotic quality metrics that would get buy-in from the states and be used to track improvements, identifying individuals at risk of benchmark trends.

What we did was we – we sort of were – the states were working together to identify the practices that were most effective in participating states, and share them and help transplant them into the other states. So we have state champions, particularly in New York and Missouri that had had considerable success and worked with us to help translate – but very importantly – to adapt those practices into these large state issues. So we looked for points of leverage – points of leverage meaning things like quality management processes and requirements for managed care organizations that would make these things sustainable and not dependent on future grant funding. [00:17:46]

Lead implementers included state Medicaid Mental Health and child welfare agency leadership, and other providers, stakeholders, and the members of broad state-level stakeholder collaborative work groups.

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So among the achievements was we undertook to move these metrics towards buy-in and we actually had greater success than we had anticipated because we had a subsequent opportunity to work with the stakeholders and to work with NCQA to help evolve our MEDNET metrics. Three

of them became part of the HEDIS program for 2015. So those – that I think is our real tool that can be used on a national basis and have increased buy-in. [00:18:48]

We worked with states to develop better guidelines. There are a number of processes such as feedback reports that were incorporated. We had – particularly for poly-pharmacy – some substantial measureable changes in the 40 to 50 percent range in several of the populations where we intervened working with community mental health centers and managed care and other partners. And I think we succeeded in getting the states to buy in to the measures and to incorporate them in the number of system-wide – in quality management, basically measurement-based continuous quality measurements and improvement processes – working on the idea that if you can't measure something, it's very hard to improve it. So the slide shows a few of the ways that the measurement and the strategies, such as provider feedback, such as mental health clinic-based CQI using passport-type of (overlapping voices)

PEGGY MCNAMARA: Stephen? Sorry.

DR. STEPHEN CRYSTAL: Yes.

PEGGY MCNAMARA: Maybe if you could just say a word about sustainability and then we'll – we'll have to move on. [00:20:28]

DR. STEPHEN CRYSTAL: Yeah, those were some of the things that we think [were at] sustainability.

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Is that the last slide?

PEGGY MCNAMARA: That's the last slide, so great. So before we go on to the – thank you so much, Stephen – before we go on to the next panel, let's pause here for some quick clarifying questions and quick responses – just if anyone has a burning question. And unfortunately, I cannot see any questions that were written in, Lianne, so if there were some, maybe you could read that? Otherwise, people can simply un-mute your phone and ask your question. State your name and your affiliation, and to whom your clarifying question is directed. (pause)

So Lianne, are there any written-in questions?

DR. LIANNE ESTEFAN: There aren't any that I can see. Um, Michelle, do you see any?

DR. MICHELLE PILLEN: No, I don't see any questions.

PEGGY MCNAMARA: Okay, let's just – even if you didn't write in and you have quick clarifying question, just un-mute your phone and we'll pause for a minute to see if there is one or two. (pause) And it seems like there are none, so let's move on to our next panel – our three grantees who addressed improving physical health care. And so, Michael, we'll turn to you to start it off. [00:21:49]

DR. MICHAEL DULIN: Great. Can you hear me okay?

PEGGY MCNAMARA: Super.

DR. MICHAEL DULIN: So, I'm Mike Dulin and I'm working with Hazel Tapp who's going to take the next section. I work at Carolinas Healthcare System. We're actually the second largest non-profit health system in the country. And this was a study that took place across 75 of our practices within Carolinas Healthcare System – within our integrated network, which is part of a network called the Mecklenburg Area Primary Care Research Network or MAPPR, which is located across North and South Carolina.

Our study was actually looking at three different arms and – what we called an integrated approach to care – which was basically the chronic care model applied to improve asthma outcomes across all of these practices; a shared decision-making intervention – which is what we're going to talk about today, which we implemented in six practices; and then a school-based intervention.

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So the evidence to be disseminated was two-fold. First was just bringing the evidence from the NHLBI guidelines with 400-page evidence to the point of care to our practices. And then the other component was – in particular to shared decision making – was bringing best evidence around shared decision making to the practices. And in 2009, just before we implemented this project, there was a call from AHRQ and the Institute of Medicine to look at further studies that looked at shared decision-making and asthma. And there was really, at the time, only one study that had been published – the BOAT study from Sandra Wilson's group in Palo Alto. So our aim was to take the best evidence from this one study from a very academic institution, and learn how to apply it into six primary care practices. And these primary care practices were also designated to taking care of underserved and disadvantaged populations.

In our intervention – or innovation in this approach, was to really apply lessons learned in the community-based participatory research framework and use a participatory approach to creating the shared decision-making intervention across these six practices. So (we) engaged the end-users and even patients to help design the intervention before we rolled it out. So it took us about six months to build the intervention and then we rolled it out across the six practices.

The intervention description as can be seen here was a facilitator-led approach to shared decision-making. And what we built was really a toolkit that included some components that we wanted very strict fidelity with, and some components, such as scheduling, that we allowed the practices to have some flexibility in implementing. So they could really adapt the intervention to the culture of their practice over time.

So those were the key things.

Prescribing guidelines – since we have Lindsey Kuhn on the phone, who helped us to build these – was a huge amount of work. We really had to think through all the different components of prescribing for these patients with potentially hundreds of thousands of different combinations to make sure that once we had provided the shared decision-making approach, they were actually able to follow through and provide the appropriate medications for those patients.

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So our achievements – we were very excited about the outcomes. We’ve looked at asthma overall and asthma exacerbation, as measured by patients ending up in the emergency department of the hospital, are being prescribed Prednisone in an outpatient setting. And we were able to see a 42 percent drop in emergency department use, 50 percent drop in hospitalizations, and a 46 percent drop in oral prednisone use for patients that had received a shared decision-making intervention through one of these practices. Of note, we also had significant uptake in adherence to medications. Of this, 86 percent of the patients that participated, also when they were surveyed afterwards, did claim that they had a shared role in making the decision about their asthma care.

And then finally, just a comment about sustainability. A couple of things we did first – you know the participatory approach to bringing in the users in to creating that intervention – I think that very much helped us with sustainability. We also looked at alternative methods to make sure that the providers were being reimbursed, so they got the financial incentives related to doing this. And then very carefully sent back the information to the providers that took the extra time to do the shared decision-making – also knew that it was directly impacting improving outcomes for their patients as well as providing qualitative feedback to the providers. So they would hear the stories of the patients saying that “I feel much better now that I’m using my asthma, and I really felt like I was a partner in making the decision around that.”

And we’ve now rolled it out across 278 practices across North Carolina through Dr. Tapp’s PCORI grant, which has really taken this to the next level and implemented it across the Medicaid network in North Carolina. [00:26:29]

PEGGY MCNAMARA: Thank you, Michael. That was super. And now I will pass the baton to James. Excuse me, Paula, speaking on behalf of the project that James (overlapping voices)

DR. PAULA DARBY LIPMAN: I’m representing our CKD project. The title was “Leveraging Practice Based Research Networks to Accelerate Implementation and Diffusion of Chronic Kidney Disease Guidelines in Primary Care Practice.” And the principal investigator was Jim Mold of the University of Oklahoma Health Sciences Center. Jim is recently retired and so I’m sort of the spokesperson today for our project.

So the CKD project involved four PBRNs as well as Westat as the coordinating center. For those of you who don’t know, Westat is a contract research organization. We’re located in Rockville, Maryland. And for this project, we provided some centralized project management, as well as data analysis and statistical support for the project.

So you see listed there the four PBRNs that were involved in the study, in four regions in the country: Oklahoma, L.A. (Los Angeles), Minnesota, and Wisconsin.

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So, the evidence being disseminated was – were the eight processes of care from the National Kidney Foundation Kidney Disease Outcomes Quality Initiative Guidelines. You'll see them listed there on the slide. And the primary aim of our project was to determine whether PBRNs could increase dissemination, implementation, and diffusion of these guidelines by leveraging a group of early adopter practices that were affiliated with the PBRNs, and that aim led to the development of our innovative two-wave intervention strategy.

So for Wave I, we had equivalent number of practices from each of the four PBRNs for a total of 32. And these practices received baseline and periodic performance feedback, academic detailing, and weekly practice facilitation for a total of six months. Then they transitioned to Wave II, where the Wave I clinician champions were expected to recruit two additional practices to participate in a local learning collaborative. And during that wave, those three practices received similar performance feedback and academic detailing, monthly versus weekly practice facilitation, and were expected to participate in six monthly local learning collaboratives that were led by – according to the design – were led by the Wave I clinicians, who had already gone through the prior six months of more intensive facilitation. [00:29:48]

So the lead implementers in this design were the physicians in the Wave I practices and the practice facilitators provided by the PBRNs. And external supports included maintenance of certification and CME credit.

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Okay. So in terms of achievements, in Wave I, there were 711 patients in the analysis. Thirty one of 32 expected practices were able to participate in that more intensive wave. In terms of performance outcomes, this group of patients – or clinicians, I should say – there was an increased use of ACEI or ARBs, discontinuation of NSAIDs, testing for anemia, and testing or treatment for vitamin D deficiency.

Moving to Wave II, we were able to analyze data from over a thousand patients, and 58 of the 62 expected practices did enroll in the LLC phase. Not all of them were able to actually convene the LLC meetings, but we did – this is the initial sort of enrollment phase. And in terms of performance outcomes, this group of patients also increased use of ACEI and ARBs and testing or treatment of vitamin D deficiencies. So some similar outcomes. [00:31:14]

So, we don't have any real quantitative data around sustainability, but our, you know, sort of qualitative impressions and so forth. You know, basically the interventions resulted in the development of new strategies and new processes of care. And these newly implemented processes were typically accompanied by the creation of templates, order sets, and other more permanent modifications to the electronic health records.

We also thought it was important and sustainable that the project increased awareness among clinicians and their staff of the importance of eGFR and project. Many of the practices did not necessarily—had some issues getting that – getting or calculating that eGFR, but as a result of participating in the project, many of them were able to work with their labs to be able to get that data automatically. So that’s something that’s definitely sustainable.

PEGGY MCNAMARA: Thanks so much, Paula. Appreciate that. Jill?

DR. JILL MARSTELLER: Yes, hi. Can you hear me?

PEGGY MCNAMARA: Yes.

DR. JILL MARSTELLER: Okay, great. I want to make sure I’m off mute. So this project is called the Cardiovascular Surgical Translational Study. The principal investigators were David Thompson, who’s a doctorally-prepared nurse, and Peter Pronovost, who’s a physician and also has a PhD. And then, of course, there was a cast of other characters involved, of whom I am one. We are all together at the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality. And we didn’t have a network, per se. Rather, we worked with the Society for Cardiovascular Anesthesiology to recruit individual hospitals to participate in this intervention. [00:33:00]

The geographic focus was among 11 hospitals. Ultimately that crossed over nine states, and you see the states listed there.

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So we are essentially disseminating the (inaudible at 00:33:16) that’s already out there on the prevention methods for three common infections. Now these common infections are surgical site infections, central line-associated bloodstream infections, and ventilator-associated pneumonia or other events. The definition changed in the middle of our intervention.

We were seeking to implement and evaluate the impact of the patient safety program across these ORs and the intensive care units that are associated with cardiac care, the floor units that are associated with cardiac care, and then in some of our hospitals, there were actually universal beds, which are a combination of intensive care units and inpatient unit, where a patient stays on the unit and just sort of shifts level of care.

So in particular, we’re working on healthcare associated infection rates, on improving patient safety culture across unit teamwork, and transitions of care. And then we were also comparing to passive audit and feedback that was given to these sites and to our comparison sites through the Society for Thoracic Surgeons. So that’s a side piece of the project where we developed a comparison group for our intervention group using the STS database. [00:34:46]

So the intervention is essentially these evidence-based prevention toolkits for surgical site infections and CLABSI and VAE. And those are all going to be – I will show you in a minute how you can access those toolkits. And it included the comprehensive unit-based safety program,

which is really a program intended to improve the safety culture within the specific units that we're working with. And so it does that by engaging leaders, by also sharing the philosophy of how to improve safety, how to look at the system in order to improve safety, then asking members of the unit to identify problems that they see and work on those to improve care. And finally it includes a suite of teamwork and communication tools that can also be used.

So the other piece of the intervention is essentially standardizing some technical components of the work based on these evidence summaries, and at the same time trying to kind of encourage local innovation in the adapted components. So where they are needing to implement and needing to bring about some culture change, we essentially had them think about what would fit in their own local context.

So the lead implementers were these unit-based, multi-disciplinary teams across the 11 hospitals.

And there were no specific external supports, although as I said before, many of these sites are receiving data from the Society for Thoracic Surgeons, so they may already be aware of what their various infection rates are – at least in the area of ventilator-acquired pneumonias and in surgical site infections. [00:36:39]

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So the achievements from the study were that we were able to develop and implement SSI, CLABSI, and VAP prevention bundles, and also implement the CUSP program in these 11 hospitals.

The preliminary data as of March 2014 are showing that our median CLABSI rates decreased to zero and the VAP rates have been sustained at zero, as well. The downward trend is also observed in our median SSI rates, but there is some variation across the different sites.

And the culture regarding leadership has improved as based on the Hospital Survey of Patient Safety (Culture). So it looks like leadership – their responses regarding leadership have become more positive. And their scores on open communication and feedback about errors unfortunately are still a little bit lower than they had been – or than one might hope. They are slightly lower in post-implementation compared to baseline.

In the area of sustainability, the project just ended in July 2014, so we don't really have much in terms of sustainability data at this point. But we do have a program for sustainability where we encourage the sites to embed the changes that they've made, making it, you know, policies and procedures. Making sure they're training the people. Making sure that they walk the process to the areas where it's no longer sustained. And then to expand, meaning passing it on to other units identifying and addressing the next challenges. [00:38:24]

PEGGY MCNAMARA: Super. Thanks so much, Jill. And Jill and others made reference to tools, and we will come back to those at the end of the webinar.

And now, I just want to pause to see if there are any quick clarifying questions and responses to any of these three speakers. If so, please un-mute your phones, state your name and affiliation, and to whom your question is directed. So we'll pause a minute for that.

SHEREE NEESE TODD: Hi, this is Sheree Neese Todd at Rutgers University. I sent in a question but I'm not sure if you guys have seen it. It's a question for Paula? I'm very intrigued by the examination and comparison of two interventions; one, which appears to be more intensive and with external supports versus the champion-led intervention. You note that the outcomes were sort of similar – unsurprising. But I'm wondering if you see a difference in the magnitude of change or improvement between the two different approaches?

DR. PAULA DARBY LIPMAN: Well, if you take a look at the outcomes that we mentioned, you're right. There was definitely – there were improvements on more of the outcomes for the more intensive Wave I facilitation than there were for Wave II. I hope that answers one of your questions.

But I think and I – you know, our goal was to get a better understanding of the impact of moving to this less intensive intervention. And also some issues around feasibility, which I will speak to shortly. You know, we did find that the implementation varied by PBRN or by region, if you will. So that's something to consider. But we think we were successful in terms of some evidence that this strategy was effective and less costly for diffusion of the evidence. [00:40:33]

Does that answer your question?

SHEREE NEESE TODD: Thank you very much.

DR. PAULA DARBY LIPMAN: You're welcome.

PEGGY MCNAMARA: And did others type in a question? Unfortunately, we have some technical problems and can't see them. So if you did or if you didn't, and you have one, please un-mute your phone, state your name and affiliation, and to whom your question is targeted. (pause)

PEGGY MCNAMARA: This is Peggy. Michael, I do have one for you and your shared decision-making project. Was there an explicit training for patients?

DR. MICHAEL DULIN: I'm sorry. Can you repeat that?

PEGGY MCNAMARA: Sure, Michael. Did you – you mentioned that you trained the clinical teams, but did you have any training for patients?

DR. MICHAEL DULIN: No, we did not have training specifically for patients. We got patients' feedback as part of the process through qualitative methods and focus groups. But no, we did not provide specific training for the patient. But I guess the concept was, with this new approach, that it would help the patient to be more engaged and more likely to share their voice and their overall wishes and desires and goals in terms of their asthma care.

PEGGY MCNAMARA: That's helpful— (overlapping voices)

DR. ARDIS OLSON: I have another question for Michael.

PEGGY MCNAMARA: Go ahead.

DR. ARDIS OLSON: What would the criteria that got somebody to a shared decision-making session? It wasn't everybody with asthma. [00:41:57] Can you tell what the criteria for referral— (overlapping voices)

DR. MICHAEL DULIN: There were – there were a couple – I mean a lot of them were based on referrals from other providers that were in the clinics that we were working with, so they heard about the project and would refer them in. But we also looked to find people that were high-risk based on our population reports. So people that had had prior emergency department visits or prior hospitalizations, or even poor scores on quality of life surveys that we're doing for the cohort of the asthma population that we're looking at. So we did pick a very high-risk population to go through the shared decision making process.

DR. ARDIS OLSON: [00:42:32] And your response rate in that group when you offered it to them? [00:42:34]

DR. MICHAEL DULIN: Yeah – um, I think I've got Hazel on. Hazel, can you comment on the response rate of the patients that were engaged, and how many people came and showed up at the clinics?

DR. HAZEL TAPP: Yeah, so the response rate was similar to a typical clinic. So the no-show rate was comparable with these practices that serve a very vulnerable population.

DR. ARDIS OLSON: Does that mean half? (laughing)

DR. HAZEL TAPP: It varies by practice. So it varied, I would say, between about 50 and 80 percent.

DR. ARDIS OLSON: Okay. Thank you.

PEGGY MCNAMARA: Super. Thanks everybody. And now – Jim, thank you – James Dearing, thank you for being so patient. We will pass the baton to you for an interesting discussion of lessons learned. Jim?

DR. JAMES DEARING: Thanks very much, Peggy. I'd like to thank our panelists here for these very nice overviews – the first wave of Keith, Ardis, and Stephen – and then Michael, Hazel, Paula, and Jill. We heard the objectives, activities, and then intriguing sets of results of different types across the six projects. Particularly for implementation science and dissemination science, there was a lot of reference here in this discussion to partnership, to— (loud background voice)

JAN DE LA MARE: Jim, I'm just going to step in here. We're hearing conversation on the line – if you could please mute your phone? If you could please mute your phone – we're hearing conversation. Thank you. Go ahead, Jim.

DR. JAMES DEARING: Some of the variables which come up often in the reports we've just heard are partnerships, the need for collaboration, means of achieving broad reach in the case of dissemination, and then a lot of reference here to issues of implementation quality or necessary adaptations. We're also hearing about the use or partnership with existing practice networks. And then, achievement of different types of outputs, as well as outcomes. And then impacts. [00:44:46]

I'm going to ask three questions of our speakers, and I'll go in turn through these three questions and I'll ask each of the six sets of panelists to respond to each question. And then we'll have a brief discussion period after these responses by the panelists to each of the six questions. And during these discussion periods, I'd especially like to encourage our guests who are the grantees and new teams of the eight new D and I (Dissemination and Implementation) projects funded through AHRQ Disseminating Patient-centered Outcomes Research to Improve Healthcare.

So grantees, if you would limit your responses to under two minutes apiece, that would be perfect for this first question, which is that – “What did you do that worked well in your experience with this particular project?” And let me start first with Keith Kanel.

DR. KEITH KANEL: Thanks, Jim. There's just one thing I would mention as one of our successes, and that's in how we built this field team – that is, the interface between the research group and the on-site practices. When we were – as we went out to these different states, we realized that there was an enormous cultural variability between these sites. The one thing we did is we actually created a field team that was drawn from each of our states. And we had four or five key people that became part of this team, and that same single team went out and did all the implementation, all the training, all the education. It allowed us to have a standardization of the project that was really quite nice – became very beneficial for us. But moreover, we were never foreign to any community. There was always a recognizable face. And these people obviously traveled quite a bit to make this happen. [00:46:43]

Once that trust was built up – that foundation trust – it then became very easy for us to begin running the project virtually because there were familiar faces that were now on the phone. But that allowed us to kind of keep the momentum of the project running quite nicely. So it became – apart from building the trust, it became very cost effective in the long run.

DR. JAMES DEARING: Keith, did you see the field team as a subset of your project team?

DR. KEITH KANEL: Yes. Yes, very much. For our project meetings, they were almost entirely virtual except for meetings about every four or five months when we would all get together. But the field team became a really high-functioning unit over time, and we let them grow on their own. Organically, they became excellent.

DR. JAMES DEARING: Did the field team – I’m wondering if the members of the field team, Keith, came to feel as strong an allegiance to the practice settings as they did to the study team itself?

DR. KEITH KANEL: Well, they were in both worlds. They were completely invested in the proj—in the central working group. They were part of that. They were in every meeting. So they took huge ownership in all parts of this project, which was exactly the spirit we were trying to create.

DR. JAMES DEARING: And just to clarify, Keith, it was the same four or five folks who then visited each of the states – Wisconsin, Minnesota, Pennsylvania, and Massachusetts. So they had – sounds like a great degree of accumulated knowledge then about what was going on at the sites.

DR. KEITH KANEL: Without question. [00:48:12]

DR. JAMES DEARING: Excellent. Very interesting to hear. Let’s move on to Ardis Olson. Ardis, what did you do that worked especially well?

DR. ARDIS OLSON: This was a surprise to us, in fact. We, in the course of the project, used elements of quality improvement work, but were not bound to formal learning cycles. And so it allowed us to have a flexible approach that one practice would want to put all the components in place and implement at once, and another would want to start with screening. “Okay, now let’s enhance our education. Now let’s enhance our suicide screening.” We were able to support both approaches for practices to do substantial improvements in suicide risk screening, using of self-care plan, cycle education – all components of primary care management that are seldom talked about but that are the front line of primary care.

In the process of that, I think what worked well is we went to practices really saying, “We’re talking about a new standard of care that your practice will be doing. Really that you’re going to become a mental health medical home for your patients.” And then it was an active process of engaging families in that – which was actively bought in by about 80 percent of families. And if anyone’s a clinician who’s sent someone off to a therapist and they stopped going to the therapist and they never heard about their patient again, you understand the need for coming back to a mental health medical home. [00:49:43]

So, then the other part that worked well was really an integrated site that we ran through website with our staff working with them – that had both the backup of the training materials were there, the opportunity to consult with a psychiatrist by e-mail, and be able to enter your registry data and download quality improvement you were doing, as well as a parent and teen section that was widely used there and has been disseminated and used in places all over the country and all over the world since, because of our careful parsimonious way of keeping it brief and relevant what we put on there.

So I think we’re really excited how that integrated component and the flexible approach for practices worked to have dissemination – or have implementation be successful.

DR. JAMES DEARING: Ardis, this is really intriguing to me, this flexible approach. So in the rural pediatric and family medicine practices, did you find that the clinicians already had a good grasp of quality improvement principles and methods? Did they understand PDSA cycles and things?

DR. ARDIS OLSON: We had two sets of populations – about two-thirds of ours were pediatric practices and about a third were family practice. Our family practice colleagues are much more along the path in having to do this for adult care, many of the requirements for [00:51:11] ACL. Our pediatric practices were really de novo, most of them, being able to do a quality improvement cycle in their practices, so we really had both groups represented.

DR. JAMES DEARING: I see. Okay, thank you.

Let's move on to Steve Crystal at Rutgers. Steve, in terms of MEDNET, what did you do that worked especially well?

DR. STEPHEN CRYSTAL: Alright, so this will be another little whirlwind tour here. I would say, you know, perhaps most important to be creative – finding opportunities to be creative and adaptable in finding points of leverage as they emerge and windows of opportunity as state systems changed and we were working in a system that was undergoing rapidly – rapid in evolution in many structural aspects. For example, new health homes initiatives, shifts of large populations into managed care organizations that had previously been fee-for-service, and so on. So, many of the best opportunities, I think, that we found for sustained impact were finding creative ways to take advantage of these windows of opportunity. When there's a lot of pressure at a given time, for example, from the press, the legislature, the feds, the courts – these kinds of windows of opportunity emerge to put improvement – improved systems into place or get stakeholders to commit to change. The opportunity that we've had, for example, to review and make recommendations for Texas for their statewide prescribing parameters was an example of that – incorporating these measures into oversight systems and requirements for managed care organizations as they took care of new populations was one of them. [00:53:11]

I think the things that we found most effective were finding champions that are also having depth of engagement, so when the inevitable turnovers of personnel at state agencies take place, there are additional champions ready to take on leadership roles; adapting models to each state's distinctive environment of resources, financing structure, contracting models, priorities and policy environment; not trying to rigidly stick to a pre-specified model but taking the principles of the important working ingredients – active ingredients of each state's quality initiatives and transplanting them actively into other states plans; using policy leverage that are available to states reimbursement, financial incentives, and so forth; a focus on building evidence-based models and measurement-based QI into ongoing oversight quality management and contracting processes to try to get sustained impact; flexibility in responding to stakeholders' identified needs; building as big a tent as possible; taking advantage of the desire of state policy makers to be able to talk directly to one another and to ask questions directly from peers who have implemented these kinds of things; developing personal relationships – a lot of this was really about trust building – developing personal relationships; state people that would trust us and that

we could really make ourselves useful for; be willing to let others get the credit. You can accomplish a lot as long as you're willing for others to get most of the credit. State leaders want to take credit for innovating their own programs, not necessarily for adapting the standard model for someone else. There are always multiple funding streams. Sustainability and impact involves leveraging these other funds and letting other funding sources take a lot of the credit. So that's like a very high-level summary. And, of course, working very hard on getting buy-in on common metrics. [00:55:35]

DR. JAMES DEARING: Steve, thanks so much. It really does sound like you and/or your team functioned as, you know, as policy entrepreneurs for this topic with the sets of state-level stakeholders but— (overlapping voices)

DR. STEPHEN CRYSTAL: Definitely entrepreneurial. Sheree, would you agree?

SHEREE NEESE TODD: Sounds right to me.

DR. STEPHEN CRYSTAL: Yeah, okay.

DR. JAMES DEARING: Thank you, Steve. And thanks, Sheree.

Now let's move on to Mike and Hazel in talking about ACER in terms of what worked especially well?

DR. HAZEL TAPP: Yeah, this is Hazel Tapp here and I'd like to sort of reflect a lot of the comments about flexibility, and really taking a very measured approach to planning. We spent our time really engaging with the practices and getting champions on board who were mostly physicians but could be other elements, other people in the practice. And we used the participatory approach to sort of find out what they really wanted from this structured rollout and toolkit. And we started rotating sites so that everybody could participate even if they weren't able to travel. And we had a group that met once a month from each practice to kind of work on how this would look for them, so they could tailor it individually, but they could also hear what was going on in other practices, as well. And during that time, we would busily run away and hear what they said, and then offer them a lot of different alternatives. Lindsey Kuhn, who is on the phone, was very instrumental in planning a lot of the structured rollout and a lot of different options around scheduling, how they might do it, how we could translate materials for Spanish-speaking. Just trying to adopt and adapt the processes to work for each practice. [00:57:24]

We also had the process analysis where researchers would leave the room and we'd do a focus group with the team, and just find out what was working, how the team was doing, what they would like us also to be doing. And we felt that that really engaged the practices. They didn't feel the research burnout. They wanted it to benefit their patients and it was obvious that everyone was looking to that first. So yeah, we think that was key to our success.

DR. JAMES DEARING: Thank you, Hazel. That's an excellent reminder that in a lot of the literature right now – in implementation science especially – flexibility or adaptability comes out as a primary reason why things work well when they do work well.

Let's move on to Paula Darby Lipman, who worked closely with Jim Mold in Oklahoma.
[00:58:21]

DR. PAULA DARBY LIPMAN: Hi there. So, I have a couple of points to address. The first has to do with our process of moving from Wave I to Wave II. And one of the components that worked well was to encourage the Wave I practices to recruit others who had similar characteristics. So, if you recall the Wave I clinicians needed to agree to recruit and work with two additional practices for another six months of meetings, and they were encouraged to recruit others that were – that had similar characteristics because we thought that that would help to facilitate the transfer process. So, for example, in the same health system, individuals who were known to them, familiar to them, or practices that use the same electronic health record. So we don't have again quant—we don't have numbers to certainly quantify that or say it's statistically significant, but we did find that that did facilitate the knowledge transfer.

The other point I wanted to make was regarding improvements related to chronic kidney disease care. The – one of the lessons that we learned was that putting CKD on the problem list is a critical first step in providing evidence-based care for patients with CKD. So, consequently, that was the first guideline that the practices typically worked on. And it kind of prompted us to reflect a little bit about – you know, often there is a list of guidelines and perhaps practices are overwhelmed or uncertain about where to begin. So one of the things – one of the sort of recommendations that came out of this with regard to CKD was some prioritization in terms of the guidelines and just the observation that more information about the sequencing of guidelines might be critical for quality improvement projects. [01:00:40]

DR. JAMES DEARING: Excellent. Thank you, Paula.

Let's move on to Jill Marsteller. Jill, what worked especially well in your and Peter's experience?

DR. JILL MARSTELLER: So one of the things that we think worked quite well was that we tried very hard in the structure of the project and also in the interventions that we suggested, to get the different units of the hospital to start thinking about the entire trajectory of care that the patient would experience from the time they came into the hospital until they were discharged. Rather than thinking about the patient while I have them, this is what I'm taking care of. And once they're outside of my area or my unit, then they're not really somebody I think about anymore because I have to think about all the patients who are about to come in.

And so, in having all of our educational sessions, we encouraged all of the different teams to get together and listen to the educational sessions together. We undertook some exercises with them to try to get them to think about what the other units – upstream and downstream from them – actually needed from them, and have a dialogue about that rather than just assuming that they knew what the other units required of them. And also to share what they really needed from these other units. [01:02:01]

And so there was a considerable focus on this idea of trying to get all of the different units to start relating to each other a little bit more personally and understand a little better what some of

the constraints are that the other units face, and work on common problem-solving rather than having each one of the different units working to fix something all by themselves in a vacuum from the others, which of course then may create tradeoffs or problems downstream or upstream in patient flow. That was one of the things that we really focused on that I think went quite well.

The other thing that we tried to do was to roll out the education for the prevention of each one of the infections on an over-time basis. So we focused first on central line-associated bloodstream infections and then on surgical site infections, and then finally on ventilator-acquired events. And we did that very purposefully so that they didn't have to try to think about more than one infection at a time. So after becoming facile in the prevention of one, they got to move to the second and then to the third. And I think that was helpful because any time we ask healthcare providers to think about multiple tasks that they have to undertake, it can be difficult for them to prioritize or to keep the things that they were already doing well in mind while they move on to yet a new area of additional steps or protocols for prevention of different patient safety issues. So that was again reflecting the flexibility theme that you mentioned with another strategy that we undertook. [01:03:47]

DR. JAMES DEARING: Thanks, Jill. This sounds very important to me. It wasn't just a patient safety innovation that you brought to the hospitals, but also this broadened perspective, which I'm going to guess was perceived as having unexpected value for the practitioners in terms of their understanding of hospital operations. Very important point.

Let's allow others now on the call, as well as presenters, to ask each other questions. Just a reminder, you'll need to un-mute yourselves in order to do so. And we only have two minutes for this period.

PEGGY MCNAMARA: Jim, this is Peggy. I was just wondering – we heard, certainly, arguments across the panel for the importance of adaptability. I'm just wondering if anyone has sort of counter-arguments for fidelity and any lessons learned there? [01:04:56]

DR. JAMES DEARING: Excellent question, Peggy. Panelists or new grantee teams?

DR. JILL MARSTELLER: Well, this is Jill Marsteller. One of the things that I would say there is that you – I think in these implementation projects – need to choose which things you are going to be flexible about and which things you're not. And so the main elements of your intervention – in this case, the steps to prevent the various infections – we basically can't be overly flexible about them actually using those prevention steps. Now, how they implement them locally and then, you know, which pieces of the cultural and adaptive interventions they feel they need to use, and their use of them, are areas where we can be a little bit more flexible. So, I think that we have to think about fidelity for sure, but we need to be picky or choosy about which things we can demand fidelity to and must, and then those things that – where greater flexibility will actually lead to better implementation.

DR. STEPHEN CRYSTAL: So this is Steve Crystal and I would endorse that point. It's taken us a lot of thought, really, in talking with our Steering Committee to really work together with the stakeholders to say, "What are the core things that we really expect everybody to do?" And the

more you've leveraged in the sense that you – a lot of folks have skin in the game and they're having to put in their own resources – you know, the more of a juggling act this is because those resources have to be available. [01:06:37]

But I would say, in our trajectory in the MEDNET project as it has evolved into the SMI NET project. But this has also been part of the trust-building process that we're gradually able to ask more of the partners and be clearer about what the things are that are essential. And that didn't come all at once because you had to really get the buy-in first. And in the current phase, we have taken a more focused approach – what are the core things? But still with the adaptability, what are the core things that we expect the participating states to do? But we've achieved more buy-in for it.

And the other thing is – quite similar to what Paula said – that we've gotten more explicit about the sequencing of focus so that we're not asking people to focus on so many things at once. But we've divided our current SMINET project into phases where everybody will focus on a particular practice for a period of time. You have to do preparatory work, follow-up work, but you have a period of focus on a particular thing. So I think the sequencing is important. But you just have to do a lot of continuous building of buy-in. The more that you can get, the more you can get everybody to agree to do the comparable things. [01:08:04]

DR. JAMES DEARING: Thank you. Thank you, Steve. And thanks to Jill. Let's move on now.

All of us, perhaps, might agree that when reviewing project results, we often learn as much from what didn't work as we do from what did. So let's turn the tables – go back to Keith Kanel. And Keith, what didn't work so well in the PIC project?

DR. KEITH KANEL: Oh, I will accept Peggy's invitation to talk about the dark side of flexibility.

DR. JAMES DEARING: (laughing)

DR. KEITH KANEL: One thing that we – one thing we encountered was we tried to have flexibility in our data collection scheme, and that probably was an unwise idea. We initially had planned to have a registry for our project that would span all the sites. Because of cost constraints, we ended up building our own registry which was an access data base platform registry. And as we began offering it to the sites, we began getting some push-back. Many had invested in new EHR systems. Many of those EHR systems had modules for tracking depression metrics – PHQ9s. And they said, "We'd like to use our own methodology." So, we sort of relented, but we wanted to sort of be flexible on that point. But we found out that, depending on the data platform that the site used, the completeness of the data was highly variable.

We ended up making a sort of a side research project in our study and did submit this for publication. But we found out that the sites that did use the Access data base had a data completion rate – it was somewhere around 75 percent, meaning that they would have a data element for every interaction, which was a part of this study design. Some sites that were able to work with their Legacy EHR vendor and configure the EHR specifically to support the project

had data compliance within the 80's, [which was] significantly better. And those that had invested in a specific electronic care management tracking system like the AIMS registry out of the University of Washington had some of the best numbers. [01:10:07] The sites that said we can easily put an Excel spreadsheet on a side-by-side with our EHR had far and away the worst data compliance. [01:10:16] 37 percent of data elements were completed when they had a free-standing Excel spreadsheet.

So, if we were more – if we were on the sites a little bit more aggressively, might we have prevented this variability? Perhaps. But form does follow function, and I think that we might have been a little more strict in deciding how the data would be collected.

DR. JAMES DEARING: Thanks very much, Keith. Yeah, important distinction being drawn by several of our PIs here about core components, peripheral components, what to insist on, what to give on.

Let's turn to Ardis Olson with the Teen Mental Health Project. Ardis, in brief form, what didn't work so well for you?

DR. ARDIS OLSON: I'm going to comment briefly on a similar issue and then a new issue. So we, too, had set up an external registry, but it was a dual-function registry that let them see when their patients were coming in and track what happened to their patients. We ended up revising the registry part-way through because we've gotten caught in that we would like a lot of data to follow-up the patients versus the more minimal amount that was really needed in the registry. So we backed off to make that registry more functional for practices to enter a more minimal set of data. And that we found successful – some practices even creating an EHR template.

But saying that, what was really affected is the elements of care that we said you should be delivering all the time were in fact what were in – being asked in the registries. So it has a dual function when you fill out the piece of paper that it's going to go into the registry. It is reinforcing, "This is the stuff I need to talk about." And I think that led to success. [01:12:02]

Really quick, the second one is when we wrote this grant looking at a lot of the adult literature, we put in the care manager role as an office nurse, as had been done in 3CM (Three Component Model), and what we found when we went out to practices is, that didn't work because, number one, if they had a care manager, they already had a full plate of chronic "whatever" they were trying to do. And they really saw they wanted all their nurses trained to be able to get on the phone and follow-up. And so, we really found that in rural practices, you didn't have the staff to do that lovely care manager role that in some research grants actually delivers counseling. You really had to go with what was the minimum that would let you make sure you screened and make sure you tracked – that you didn't lose track of kids. And that was a very successful way to go about it. We have all kinds of roles. The medical assistant, who works directly with the doctor, pops something in the registry and follows up versus having a higher level person.

I'll stop there so there's room for questions. They were kind of two very different issues.

DR. JAMES DEARING: Thank you, Ardis. I look forward to reading these papers, including the one that Keith mentioned – the sub-study.

Let's turn over to Steve Crystal. Steve, what didn't work so well in your experience with MEDNET project? [01:13:21]

DR. STEPHEN CRYSTAL: I think the biggest challenges that we had – in part, the answer is really the mirror image of the things that I talked about, because when you try to be overly prescriptive with these large state systems, you – they can really – you can just find yourself pushed down to the bottom of the queue because there are so many other things that are on their priority list – and such limited core resources that they have to engage in quality improvement. And so when you've thought about the areas where we had the greatest challenge, they were areas where we were doing things that were dependent on the states themselves being able to have their – some basic infrastructure elements in place in terms of their ability to work with their own data – their ability to maintain quality in their own data.

We were doing, for example, provider feedback reports in Washington to the clinic levels, working with the Medicaid agency to provide these provider feedback reports on the individual clinic's quality. And when you had a period where, due to shifts in beneficiaries from fee-for-service to managed care plans, the underlying quality of the data became problematic, and they weren't able to give them the – give them accurate feedback reports. And that created a noticeable difference in the success of our first cohort of clinics, which was more successful than the second. [01:15:11]

So you have to work – we found that we had to continue working with the states to help them really use and maintain their underlying infrastructure. The related challenge was the challenge of turnover of the champions, which always takes place. I think we were pretty creative about overcoming those kinds of challenges, but really finding that balance between adaptability and having a core set of expectations, I think. And the continuous trust-building and the continuous recruitment of new champions and helping the states themselves keep their basic core of quality measurement and quality feedback became sort of part of the crux of the matter.

Sheree, anything quick you want to add to that?

SHEREE NEESE TODD: No. Thank you.

DR. STEPHEN CRYSTAL: Okay.

DR. JAMES DEARING: Okay, thank you, Stephen. Again, thank you, Sheree.

On to Hazel and Mike concerning problems that you experienced with the implementation of ACER?

DR. HAZEL TAPP: Yeah, there's a couple of things I'd like to touch upon. We did try and do fidelity checks to try and ensure that we were really seeing the toolkit for shared decision-making getting utilized by the providers. So we had a sort of a checklist and we tried to sit in on

patient provider visits, and it didn't really go very well. It was very hard to sort of check off the box and really be sure the different elements were being done at certain times. Everyone had a different style, so we sort of backed off and realized that the proof is in the pudding. If our patients reported that they felt the decision was shared and also if our disease outcomes were improving, then this was probably the better approach than trying to nail down fidelity, which is sort of much more objective. [01:17:10]

The other thing we tried to do was template through the electronic medical record and try and come up with ways of: How are we going to record what the decision was that was made by the patient? Or what elements of the visits can we try and record? How would we do it? Where on the template would it fit? We have a unified electronic medical record, but those things were never easy to try and figure out.

We also developed an asthma action plan and had that put into the electronic medical record, which certainly was a success, but was very much, much more complex in the process than we anticipated. And I think I'll leave it at that.

DR. JAMES DEARING: Okay, thank you so much, Hazel. Paula?

DR. PAULA DARBY LIPMAN: Yes, hi there. The first point I wanted to make is very similar to what Stephen said – sort of the turnover of champions. You know, in our design we presumed that the clinician champions identified in Wave I would be available to disseminate the results to these Wave II practices. And, of course, it took a little longer to get the Wave II phase rolling and that sort of thing. And so that proved to be quite challenging. So we found we relied more on the practice facilitators to sort of retain, reapply the Wave I lessons learned. So that kind of reduced the efficiency of our approach and probably has implications for its feasibility, as well. [01:18:41]

The only other point I wanted to make was – you know it's frustrating because the practices are very, very dissimilar and they have their unique challenges. And so it's just sort of tough to really fully understand sometimes the implications of the intervention when there is such dissimilarity. We did learn that practices that were not independent – so they were part of a larger health system – were challenged in some ways because – you know, for example, if their EHR required some kind of modification, and if it wasn't the priority of a larger health system, they simply didn't get the attention of the IT folks. And it took longer to implement that process within our study time period.

DR. JAMES DEARING: Okay, thanks very much, Paula.

Jill, what didn't work so well with the cardiovascular surgical translational study?

DR. JILL MARSTELLER: Well, I think one of the things that wasn't completely successful was our individual recruitment of hospitals as opposed to using an established network. What we found was originally we started with 17 that had agreed to participate. Several of them never completed their IRB approvals, for example. Others never gave us any baseline information. And so, we ended up down to 11, despite our best efforts to actually go out and help them collect

baseline (chuckling) and help them with their IRBs, and so on. So, I'm not sure that that's necessarily related to not having them be part of an established network, but it did make their – increased the amount of follow-up that we were trying to do with the individual sites to keep them in the intervention. And so I think that that's something for us to contemplate as we go forward, moving us into additional units across different hospitals in the country. [01:20:41]

DR. JAMES DEARING: Thank you, Jill. A lot of lessons here, or things to keep in mind for the grantee teams in the new set.

Let me pause at this point and ask Jan and Peggy – just in terms of a process check, we don't have too much time left. What would you like to do at this point?

JAN DE LA MARE: Jim, I think if we could just round out with our third question there and it'll have to be a lightning round. And I would just say to the participants – I know we had marketed and advertised that we would end at about 1:30, but I think we'll probably just go probably about five to ten minutes over, because we've got a lot of good information that we've been getting here. If you need to drop off the last segment, you will see resources in the slide sets that you have.

DR. JAMES DEARING: Okay, thanks very much.

So, with our six grantees here and presenters, let's address recommendations that you may have for AHRQ or other CER funders to achieve spread or scale-up or implementation. And how about one key recommendation in brief form? Keith?

DR. KEITH KANEL: Oh, in brief, I'd say benchmark data. One thing that we really need when we talk about sustainability for these projects is data about – data from the payers – especially if there's any way that AHRQ could help smooth the transmission of Medicare and Medicaid data to investigators, it'd be very helpful.

DR. JAMES DEARING: Okay. Excellent. Thank you. Ardis? [01:22:20]

DR. ARDIS OLSON: So, I guess there's two things that I would look forward in future AHRQ announcements is that we put sufficient attention into the process. We've been talking about adaptation and development for different audiences. But too many evidence-based things are not ready to apply and translate to real-world. And as part of that, I think some more attention needs to be, "How do you produce – have some money to produce EHR variable products?" We have 40 EHRs in our region. So we really – and EHRs drive our practices now. So we need a way that we can develop cross-platform EHR products that when a project's done, multiple EHR users can use.

DR. JAMES DEARING: Thank you, Ardis.

Steve, what key recommendation would you have for AHRQ?

DR. STEPHEN CRYSTAL: I guess if I had to pick one it would be the vital role of really having funding mechanisms that support the sustained engagement. And once you build something like this, if you just do it on a sort of project by project basis, you have to create the wheel all over again when you start a new project. So it's only the ability to have the sustained data. And that includes not just things like the relationships, but – for example, building a common data model of core states was an enormously intensive effort. We've had to invest heavily in data management—highly secure data management, our secure remote access facility, and just understanding the quirks of the data. Getting data use agreements into place takes a long time and a great deal of patience. It's always resource intensive. And in the end, you can have a viable academic-public partnership at the state level, but if you're not able to keep investing in maintaining that infrastructure, then whoever comes along with the next hot topic for an RFA is going to be starting over again. And it's a continuous struggle to use these time limited mechanisms. I think Center mechanisms would be even maybe better – Centers for sort of sustained dissemination and translation with these big stakeholders. But, it takes three or four years to really get traction and to start having impact. And then you have to figure out how to do it. We had tremendous struggle just with the ARRA mechanism. The fact that it was three years without no cost extension, we were fortunate to be able to segue that into some other mechanisms. But it's a continuous mismatch between the sustained engagement that's required and the funding mechanisms that say, "Alright, here's the new thing to compete for. A new idea." [01:25:24]

DR. JAMES DEARING: This all rings true in my experience, as well, Steve. Thanks very much.

Hazel, what would you recommend to AHRQ or other CER funders?

DR. HAZEL TAPP: Yeah, I totally agree with those comments. I think that maintaining and building the trust with stakeholders is not something to take lightly. We can't go from project to project putting pressure on stakeholders without being very careful about the trust relationship we've built – and seeing that in terms of the long-term and not just a limited project time. Indeed, we ask our stakeholders what was important to them – sustainability and productivity. So we didn't have easy answers and we just made sure we discussed it frequently.

And the big problem: You throw the ball in the air and, as we've heard before, somebody leaves. A champion leaves and there's now a training that needs to happen, usually through the research group – and how do we have those processes in place to try and keep the ball in the air, you know, with what you're doing, and not have this gradual fall once the funding finishes and the teams aren't available to respond to the needs of the practices in quite the same way.

DR. JAMES DEARING: Thank you, Hazel.

Paula, what key recommendation would you make? [01:26:42]

DR. PAULA DARBY LIPMAN: I'm echoing some of the comments that I've already heard from Stephen and others. Yeah, so I agree – going back to our conversation around sort of understanding fidelity of the intervention coupled with understanding what are the core elements that we both need to implement and we also need to track fidelity around.

So I think if there was some concerted effort – and I agree it may not be one study, it might be some kind of initiative – that really seeks to identify what are those core elements. And then I think if we do that and hold a few factors still, we can maybe have a better understanding of the contextual factors so, under what circumstance are in fact those evidence-based elements effective.

DR. JAMES DEARING: Very interesting. Thanks, Paula.

Jill, what recommendation would you make?

DR. JILL MARSTELLER: I'm going to go in a slightly different direction from the rest of the panel. We had a problem where our data vendor, who was doing web-based data collection for us— You know, the first one really didn't work out very well, and we ended up with the second one, but it caused great delays in the project; it caused some level of disengagement of the sites because they couldn't put in their data; and so on. And so my thought was that perhaps AHRQ could provide a listing of vendors that have successfully worked in quality improvement studies. You know, certainly not to try to exclude any up-and-comers, but to just try to provide some ideas for those who are trying to run projects to make sure that they get a partner that can really handle the work that's involved.

DR. JAMES DEARING: Excellent advice. Thanks so much to all panelists for helping us to elucidate these issues and draw a few lessons towards the end here. And now let me turn things back over to Peggy and Jan. [01:28:35]

PEGGY MCNAMARA: Thanks so much, James. Great, great job. And thank you – the six grantee league – that was really, really intriguing and interesting; and the AHRQ recommendations, we took great notes on. So thank you for that, as well.

And now, in the interest of time, we're going to ask each of the grantees to list their top tool and maybe say a word about it, and recognizing that there are other tools there that folks will have copies of the slides – do have copies of the slides – and can explore on their own. And so with that, I think—

Next slide. Keith? You're first up to maybe pick your top tool and say a word or two about it.

DR. KEITH KANEL: Our toolkit on this slide is very basic. First off, we put everything into a comprehensive toolkit from one link – the top link – the PIC toolkit – where everything you need – our data collection tools, our marketing communication strategies, our training tools – it's all in one place. But I would really like to draw your attention to the marketing videos – which is the second tool listed there.

We created four videos, which really tell the story of our project, including the last one: The Business Case for Implementing a Collaborative Integrated Care Model in Your Community. We've had enormous interest in these models, including requests to have people acquire them. That's one reason why PRHI made them public access on our website.

I would encourage everybody to take a quick look. It takes three years of work and boils it down to three minutes.

PEGGY MCNAMARA: Thanks so much, Keith. Ardis? Next slide. [01:30:11]

DR. ARDIS OLSON: I think, in fact, we have given a comprehensive first listing under the clinician guide that really walks people through, but we've gone on and found that there were some very specific items that were high-frequency downloads from both parents and teenagers and clinicians in their daily care use. And so in addition to the first listing on the following slide, you can see that we have provided the specific links to those via the website that continues to be used both regionally and nationally. And many of these are direct downloads that our patients have chosen to use, as well.

PEGGY MCNAMARA: Thanks so much, Ardis. Steve? Next slide.

DR. STEPHEN CRYSTAL: Yeah, we've got three slides here that hopefully will serve as a resource. We're very proud of the resource guide and also the earlier resource guide that we did with the Medicaid medical directors, which is on our website – we have one addressing anti-psychotic use in youth. But I guess if I had to – also I think the guidelines have been a really influential resource to – a lot of states are using that.

But I think if I had to pick one, it's this struggle to— When you look at the, sort of the world of national quality measures, the quality of the quality measures themselves are variable, and in many cases they really have not been developing with the proper engagement with the stakeholders that will have to use them. So, trying to move towards – and they learn – you learn from our stakeholders, particularly managed care plans. You know, they want recognized, accepted metrics. And so I think that moving these metrics towards incorporation into CMS core quality measures, into the HEDIS program, and so forth. And really developing accepted measures as a tool and increasing the buy-in with them I think is one of the most important outcomes. And I think those really become very important tools for the field. [01:32:22]

PEGGY MCNAMARA: Super. Thank you. Next slide please? Michael?

DR. MICHAEL DULIN: Yes, so we put all of our tools on one page at asthma.carolinashealthcare.org. And I'll give away – this is partly dissemination, but also a secret for implementation in that when we were trying to alter the electronic medical record to implement decision support, we did it on the web first. So you can actually see our asthma action plan generator – our first generation – here on the web. And this was a tool our clinicians used first and gave feedback to before we implemented it into our EMR. The full shared decision-making toolkit is here. And you can even see videos of our shared decision-making champion, Lindsey Kuhn, providing the shared decision-making intervention, as well as all the scripts we used.

We have an implementation resources section where you can see the different tools that we used when we were engaging with practices like, “How to schedule half-day shared decision-making clinics.”

And then finally, we have a game on there, as well. There's an IOS game called "The Amazings" that we're using for – to engage children in self-governance around their asthma management.

PEGGY MCNAMARA: Thanks so much, Michael. Paula?

DR. PAULA DARBY LIPMAN: Hi there. So I have two tools listed on this slide. The first is actually a work in progress, and it's supported by AHRQ. It's based on qualitative follow-up with exemplar practices in our CKD study. So that's the Chronic Kidney Disease Clinical Practice Guidelines Implementation Toolkit, and I've listed Zsolt Nagykalai's contact information for when that toolkit is actually going to be available.

And you see the bullet points? Basically, it is a listing of lessons learned. It starts with issues and principles around each of the eight processes of care that are targeted, lessons learned, and tasks to be accomplished, including some scripts and so forth. So this is something designed to help the practitioner around improving CKD care.

The second tool I'd just like to point out to you is not really a direct result of the project, but you've heard me speak a lot about practice facilitators, and I just wanted to also indicate that there is a national practice facilitator certificate program that has been developed through Millard Fillmore College and with the University of Buffalo. So this is designed and developed by the national experts who drew upon the modules that were supported by AHRQ, and it's a web-based training, as well as a practicum.

PEGGY MCNAMARA: Thanks so much, Paula. And last but not least, Jill? [01:35:13]

DR. JILL MARSTELLER: So the first page shows – actually I guess it's all been on one page – the three infection toolkits, if you are interested in those three areas. The one I want to highlight is the Comprehensive Unit-Based Safety Program Toolkit. And the reason that I think that's worth highlighting to everyone that we found that the Comprehensive Unit-Based Safety Program can be used with a lot of different clinical foci. So you may be working on asthma, but you can still use the CUSP toolkit, for example. Now it was developed – this version – for use in a hospital, but we're also working on an ambulatory care version, as well. And we've found that it really is helpful to handle the adaptive elements that the need for changed management within either the units or the practices as they try to improve care.

PEGGY MCNAMARA: Super, Jill. Thank you, and thank you project teams again. Really, really invaluable. And now, I'll pass the baton to my colleague, Jan.

JAN DE LA MARE: Thanks, Peggy. And in closing, I'd just like to thank all of you for participating with us today. And a big thank you to our panelists from the six grantee teams. We really appreciate you sharing your experiences and valuable insights for us at AHRQ, but for all of us who are doing dissemination and implementation work.

And for any of you who have questions, maybe that you didn't get to ask or thoughts that you'd like to pass along to us or to any of today's panelists, please send an e-mail our way, to either me or to Peggy. We'd love to hear from you.

And with that, we will conclude our webinar, and have a wonderful afternoon.

PEGGY MCNAMARA: Thanks everybody!

VARIOUS VOICES: Thank you. Thank you.

END TRANSCRIPT