Panel 2:
Health System Engagement: Partnership, Relationships and Transparency

Please submit questions for the panelists to:
PragClinTrialsWkshp@nih.gov

Health System Engagement: Partnership, Relationships and Transparency

Moderator: Eric B. Larson, MD MPH
Vice President, Research and Health Care Innovation | Kaiser Foundation Health Plan of Washington
Executive Director and Senior Investigator | Kaiser Permanente Washington Health Research Institute
May 24, 2017

Goals for today's presentation

- Provide a general understanding of health systems and their dynamic context.
- Panelists will address the need for:
  - transparency with implementation,
  - barriers, staff/leadership turnover,
  - ways to share data and progress during conduct of PCTs,
  - researchers and health systems partners working together to sustain relationships,
  - forming true partnerships between researchers and healthcare systems,
  - and learning about implementation, scaling and spread of interventions in conducting PCTs.

Panelists:

Miguel Vazquez, MD
Clinical Chief Nephrology Division
Professor, Internal Medicine
University of Texas Southwestern Medical Center

John J. Warner, MD
Chief Executive Officer, University Hospitals and Clinics
University of Texas Southwestern Medical Center

Lynn DeBar, PhD, MPH
Senior Investigator
Kaiser Permanente Center for Health Research
Kaiser Permanente Northwest

Andrew Bertagnolli, PhD
(Former) Director, Integrated Behavioral Health Care Management Institute | Kaiser Permanente
(Current) Vice President, Behavioral Health Clinical Products
Optum United Health Group

Vincent Mor, PhD
Florence Pirce Professor of Community Health
Brown University
Senior Health Scientist, Center on Innovation
Providence Veterans Administration Medical Center

NIH Collaboratory
Rethinking Clinical Trials™
Health Care Systems Research Collaboratory

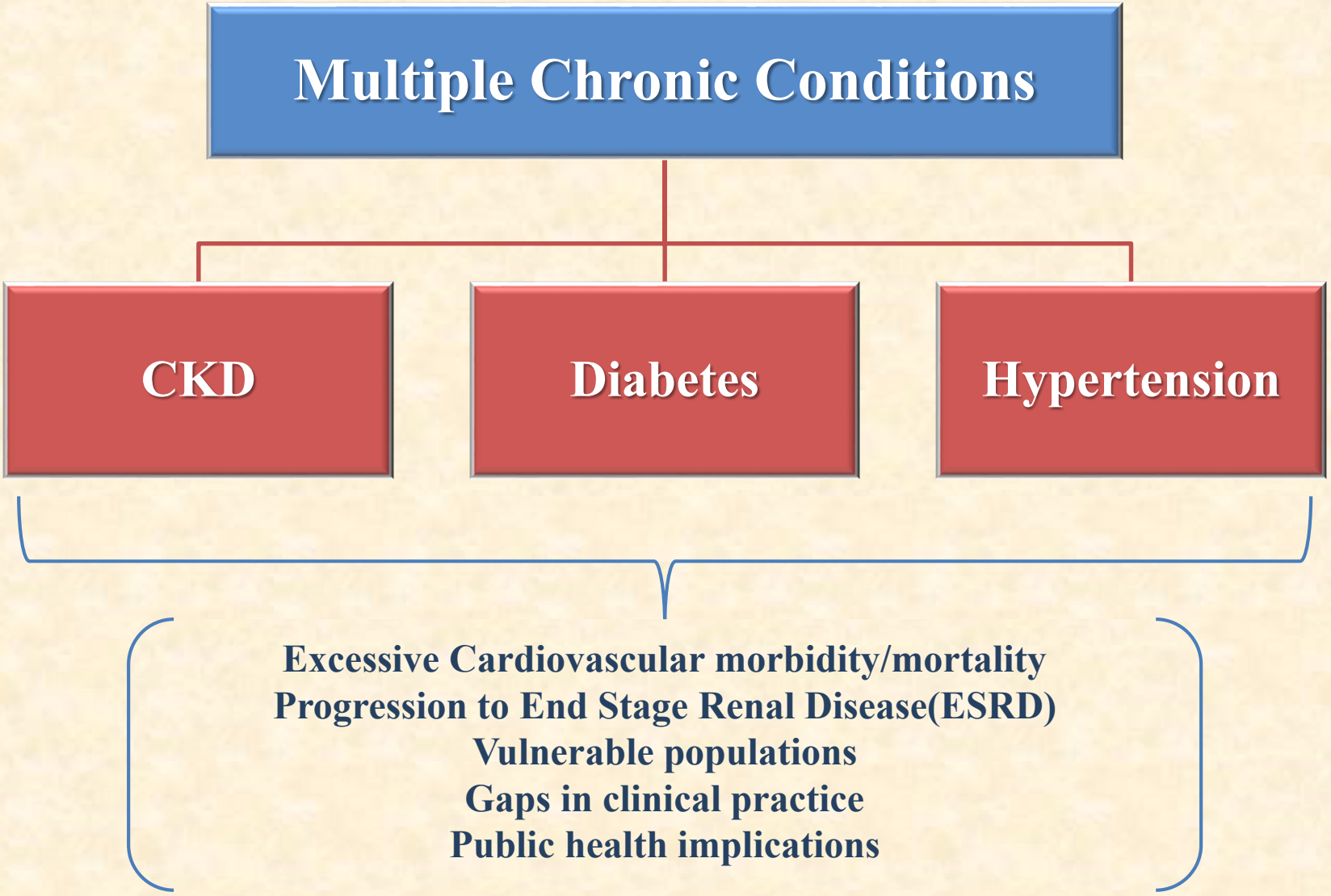
Improving Chronic Disease Management with Pieces—Health System Engagement

Miguel A. Vazquez, MD
John Warner, MD, MBA
(for ICD-Pieces Team and UT Southwestern)

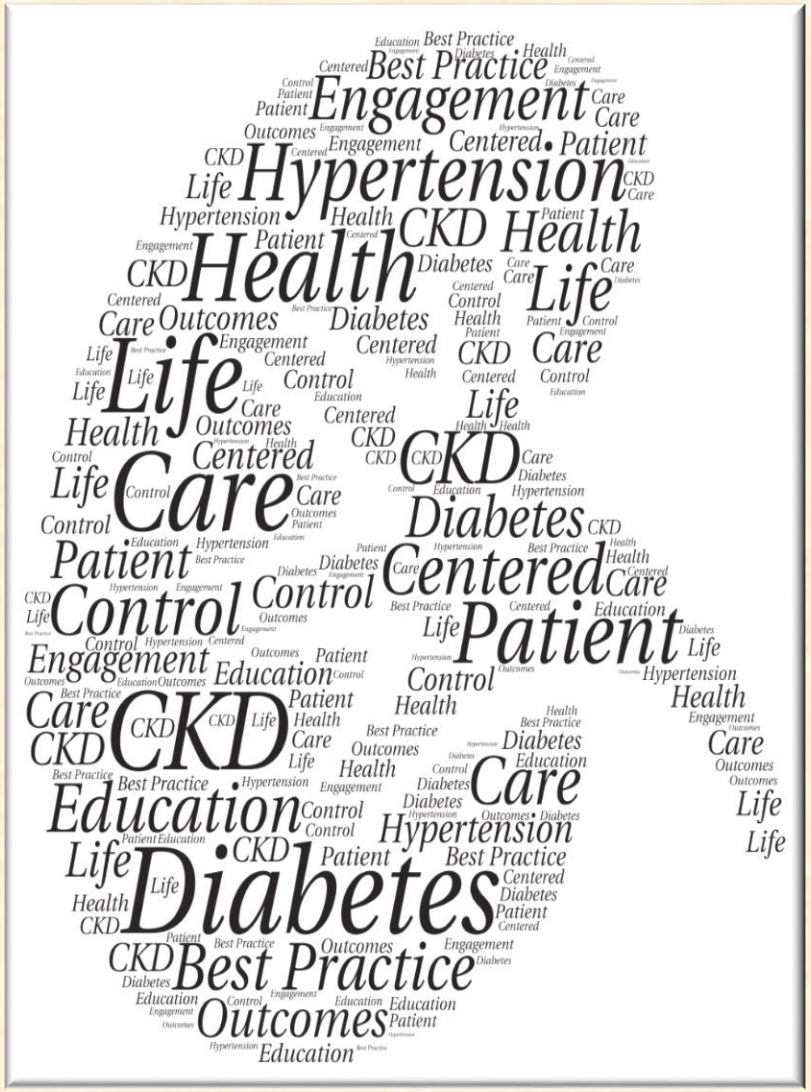
Wednesday, May 24, 2017

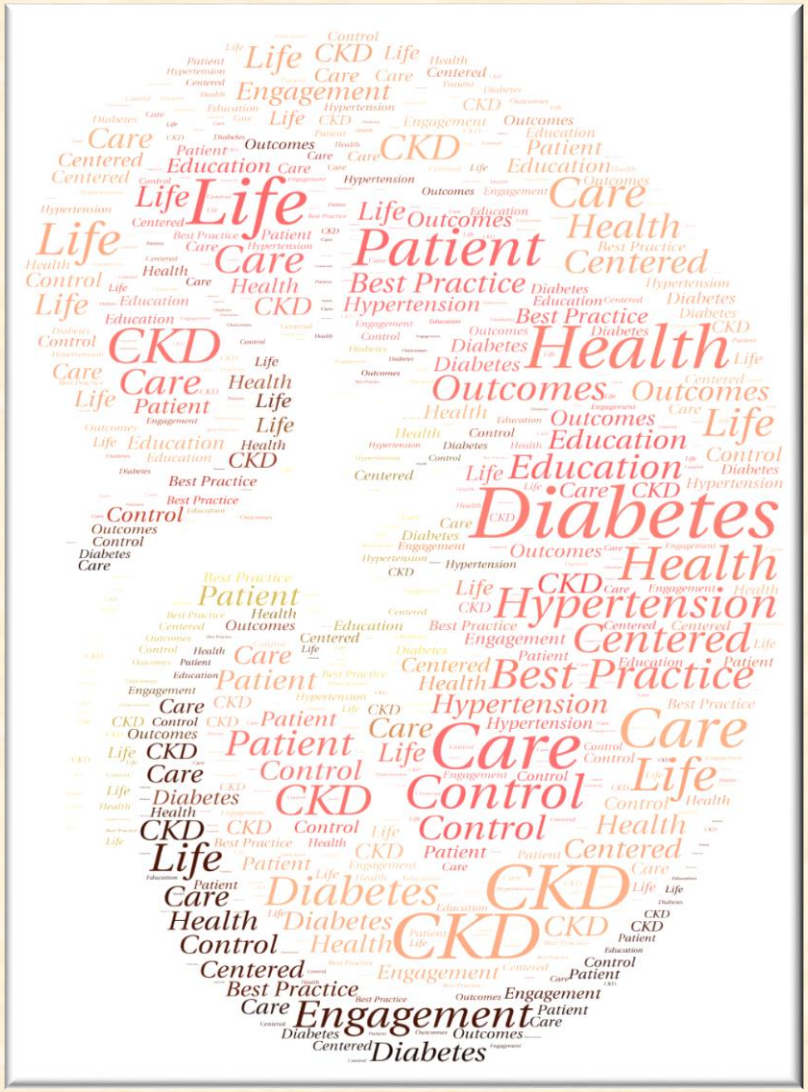
UT Southwestern Medical Center · pcci · Parkland · Texas Health Resources · ProHealth Physician · Department of Veterans Affairs · SUNY The State University of New York

Clinical Relevance



ICD -Pieces: A Pragmatic Clinical Trial in Patients with CKD, Diabetes and Hypertension





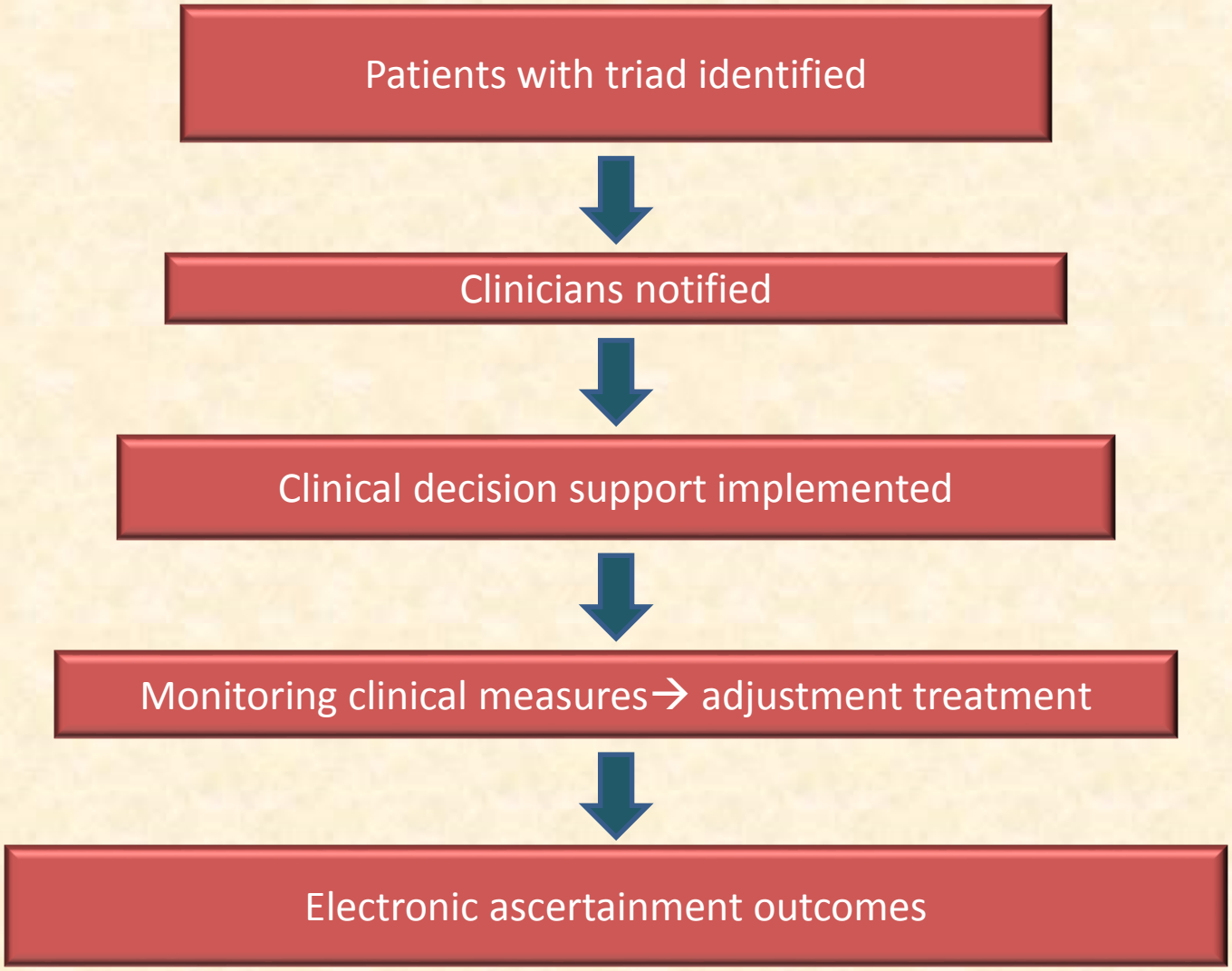
ICD-Pieces Study Hypothesis

Patients who receive care with a collaborative model of primary care-subspecialty care enhanced by novel **information technology (Pieces)** and **practice facilitators (PF)** will have fewer hospitalizations, readmissions, ER visits, CV events and deaths than patients receiving standard medical care.

Diverse Participatory Healthcare Systems and EHRs

HCS	Description	Location	EHR
Parkland	Safety-net public	Dallas County	EPIC
Texas Health Resources	Private non-profit	North Texas	EPIC/All Scripts
ProHealth	Private non-profit	Connecticut	All Scripts
VA North Texas	Federal	North Texas	CPRS

What happens in the study?



Before You Start: ICD-Pieces and PCT

- CKD, Diabetes and HTN—priorities HCS
- History of working together
- Early discussions: “needs”, “wants”, “coulds”
- Collaborative approach/ design
- Research team facilitates and HCS implements

Health Care System (HCS) Engagement and Embedded PCTs: ICD-Pieces

I. Early Planning

II. Delivery and Learning

III. Maturation and Study Completion

Early Planning

- Select the right question for the right HCS
- Align goals
- Plan together early
- Develop trust

Delivery and Learning

- Maximize use available resources
- Minimize disruptions
- Provide tools and resources to succeed
- Establish ongoing communication and updates
- Adapt to challenges

Maturation and Study Completion

- Create long-lasting value
- Sustain a dynamic system
- Promote dissemination, implementation and sustainability
- Start the process for future projects

Health System Engagement PCTs

Early Planning

- Align Goals
- Plan together
- Develop trust

Delivery

- Minimize disruption
- Provide tools
- Adapt

Completion

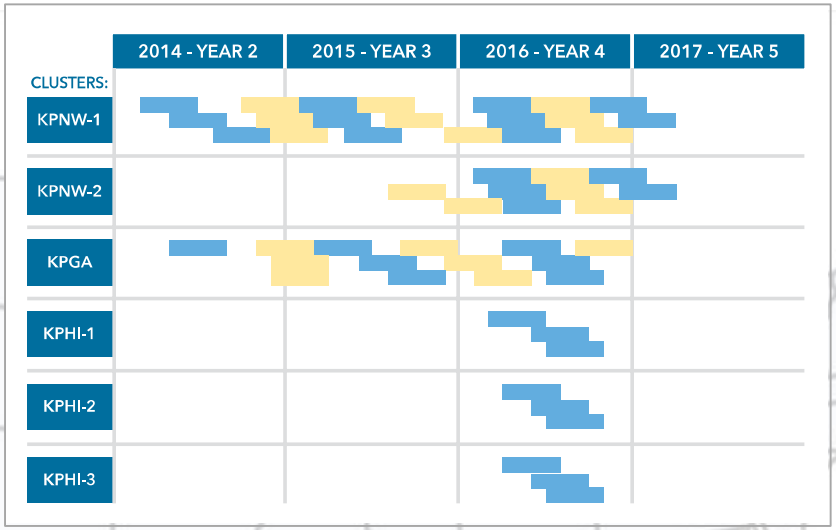
- Create value
- D / I / S
- Next project

PPACT - Collaborative Care for Chronic Pain in Primary Care: Engaging Health System Partners

Lynn DeBar, PhD, MPH
Kaiser Permanente Center for Health Research, Portland OR

Andrew Bertagnolli, PhD | Optum
Vice President, Behavioral Health Clinical Products
Formerly: **Director - Integrated Behavioral Health Care Management Institute, Kaiser Permanente**

Project support by NIH Common Fund and by NINDS through cooperative agreement (UH3NW0088731)



PPACT Overview

AIM: Coordinate and integrate services feasible/sustainable in primary care for helping patients adopt self-management skills to:

- Manage chronic pain
- Limit use of opioid medication
- Identify exacerbating factors amenable to treatment

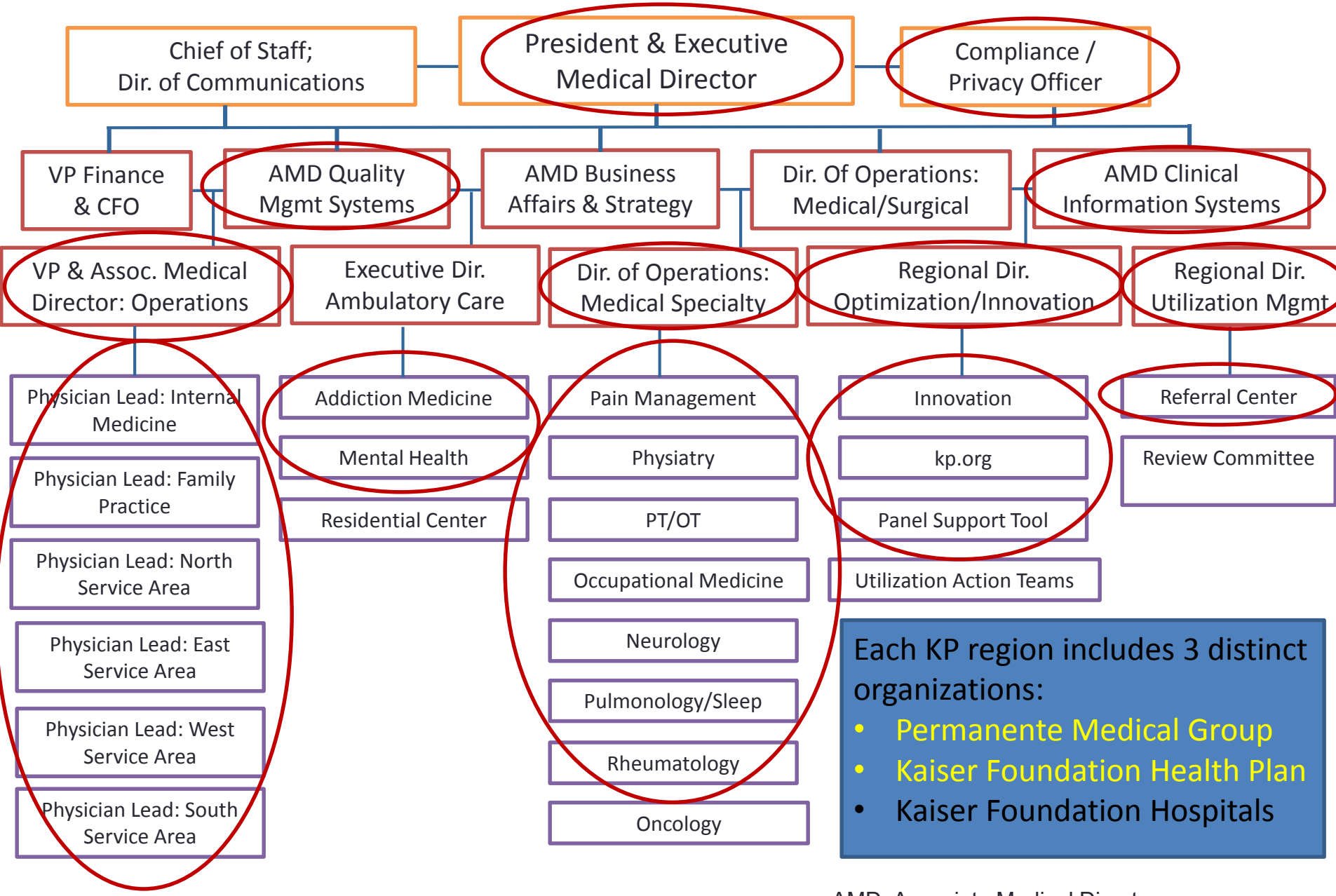
DESIGN: Cluster (PCP)-randomized PCT *(106 clusters, 273 PCPs, 851 patients)*

ELIGIBILITY: Chronic pain, long term opioid tx *(prioritizing high utilizers of primary care, ≥120 MEQ benzodiazepine use)*

INTERVENTION: Behavioral specialist, nurse case manager, PT, and pharmacist team; 12 week core CBT + adapted movement groups

OUTCOMES: Pain (3-item PEG), opioids, pain-related health services, and cost

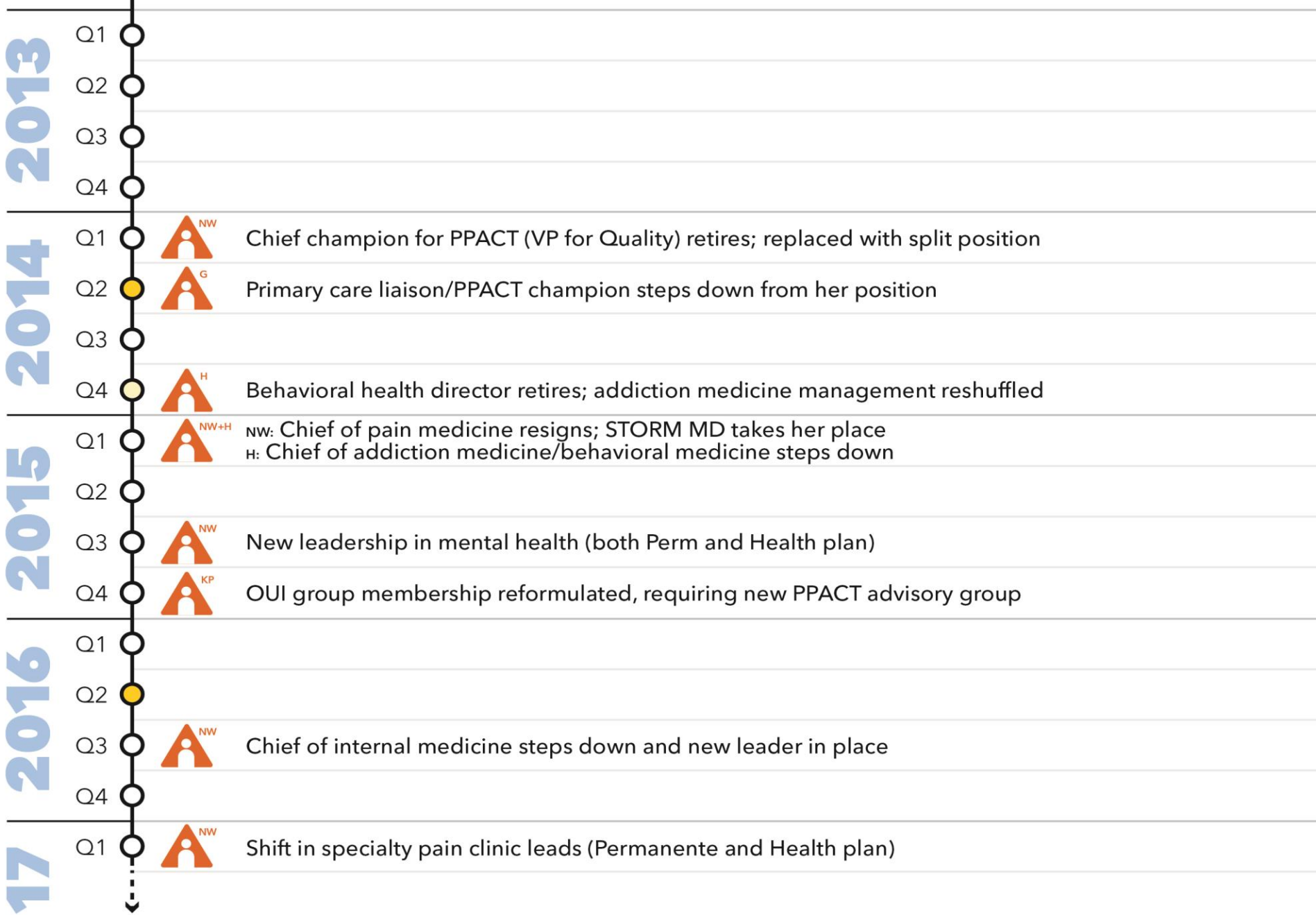
Many stakeholders no "one size fits all" engagement strategy…

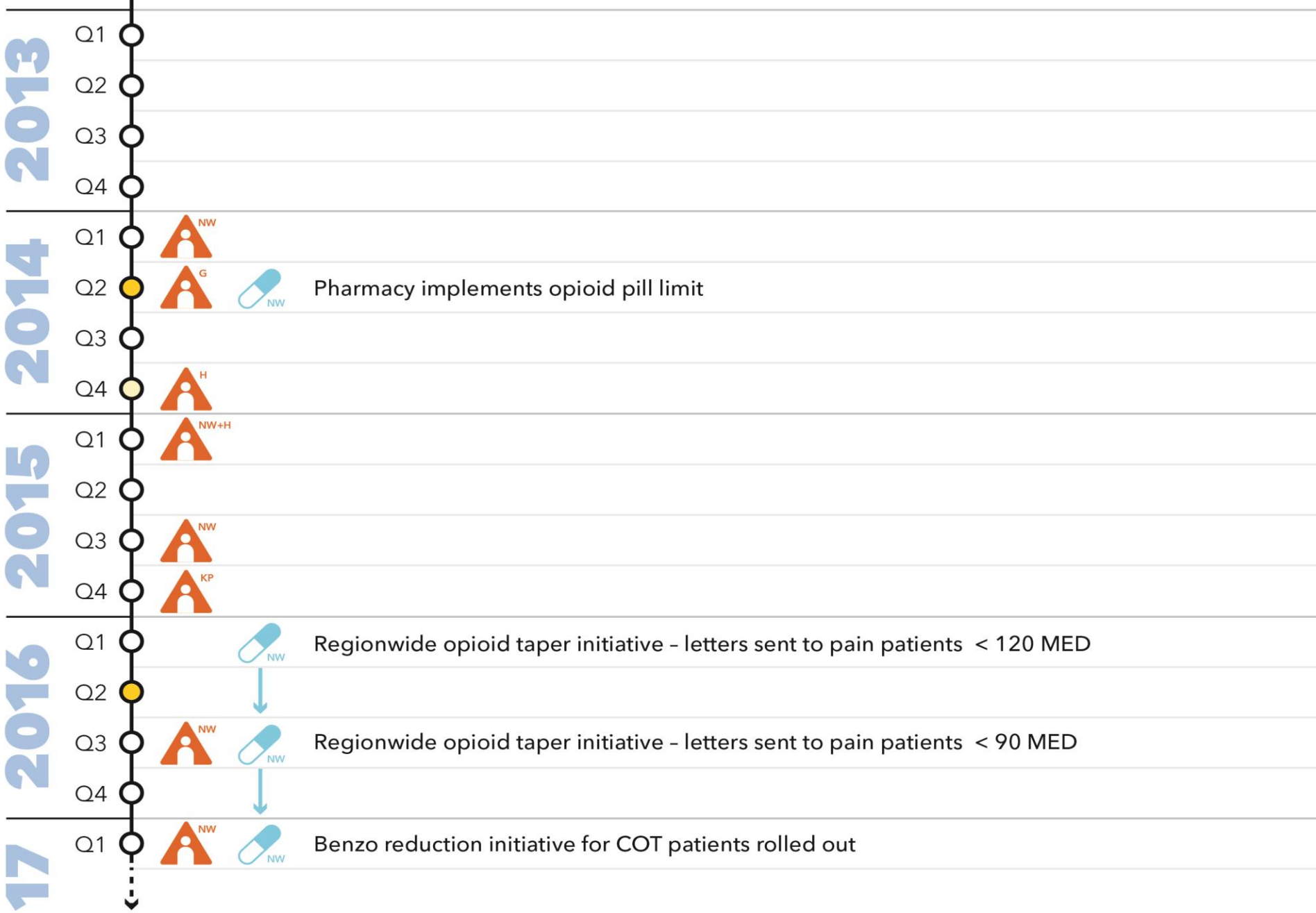


Each KP region includes 3 distinct organizations:

- Permanente Medical Group
- Kaiser Foundation Health Plan
- Kaiser Foundation Hospitals

AMD: Associate Medical Director


2013
Q1
Q2
Q3
Q4
2014
Q1
NW
Chief champion for PPACT (VP for Quality) retires; replaced with split position
Q2
G
Primary care liaison/PPACT champion steps down from her position
Q3
Q4
H
Behavioral health director retires; addiction medicine management reshuffled
2015
Q1
NW+H
NW: Chief of pain medicine resigns; STORM MD takes her place
H: Chief of addiction medicine/behavioral medicine steps down
Q2
Q3
NW
New leadership in mental health (both Perm and Health plan)
Q4
KP
OUI group membership reformulated, requiring new PPACT advisory group
2016
Q1
Q2
Q3
NW
Chief of internal medicine steps down and new leader in place
Q4
17
Q1
NW
Shift in specialty pain clinic leads (Permanente and Health plan)


2013
Q1
Q2
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2014
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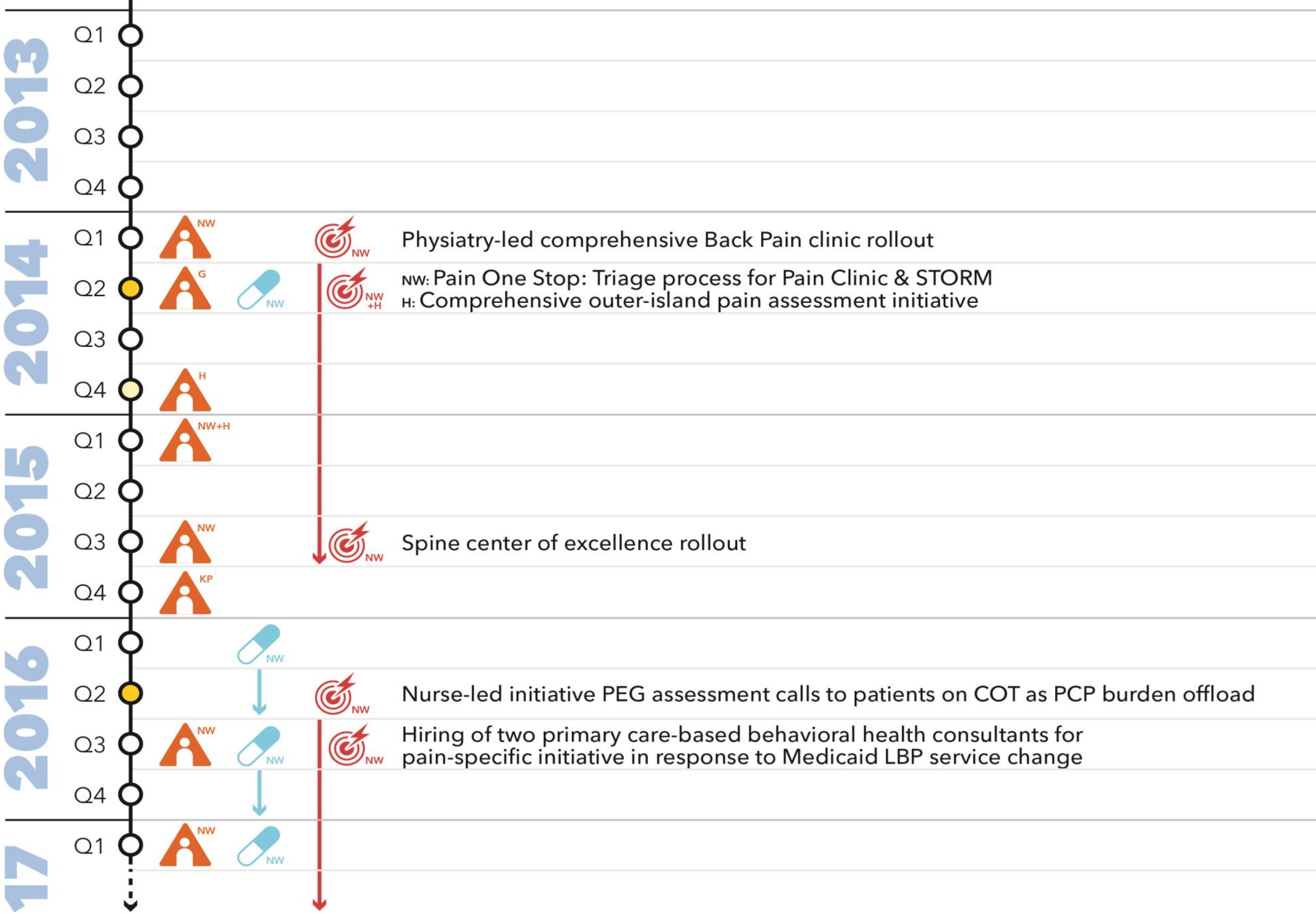
Q2
G
NW
Pharmacy implements opioid pill limit
Q3
Q4
H
2015
Q1
NW+H
Q2
Q3
NW
Q4
KP
2016
Q1
NW
Regionwide opioid taper initiative – letters sent to pain patients < 120 MED
Q2
Q3
NW
NW
Regionwide opioid taper initiative – letters sent to pain patients < 90 MED
Q4
17
Q1
NW
NW
Benzo reduction initiative for COT patients rolled out


2013
Q1
Q2
Q3
Q4
2014
Q1
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NW
Physiatry-led comprehensive Back Pain clinic rollout
Q2
G
NW
NW +H
NW: Pain One Stop: Triage process for Pain Clinic & STORM
H: Comprehensive outer-island pain assessment initiative
Q3
Q4
H
2015
Q1
NW+H
Q2
Q3
NW
NW
Spine center of excellence rollout
Q4
KP
2016
Q1
NW
Q2
NW
Nurse-led initiative PEG assessment calls to patients on COT as PCP burden offload
Q3
NW
NW
NW
Hiring of two primary care-based behavioral health consultants for pain-specific initiative in response to Medicaid LBP service change
Q4
17
Q1
NW
NW


2013
Q1
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2016
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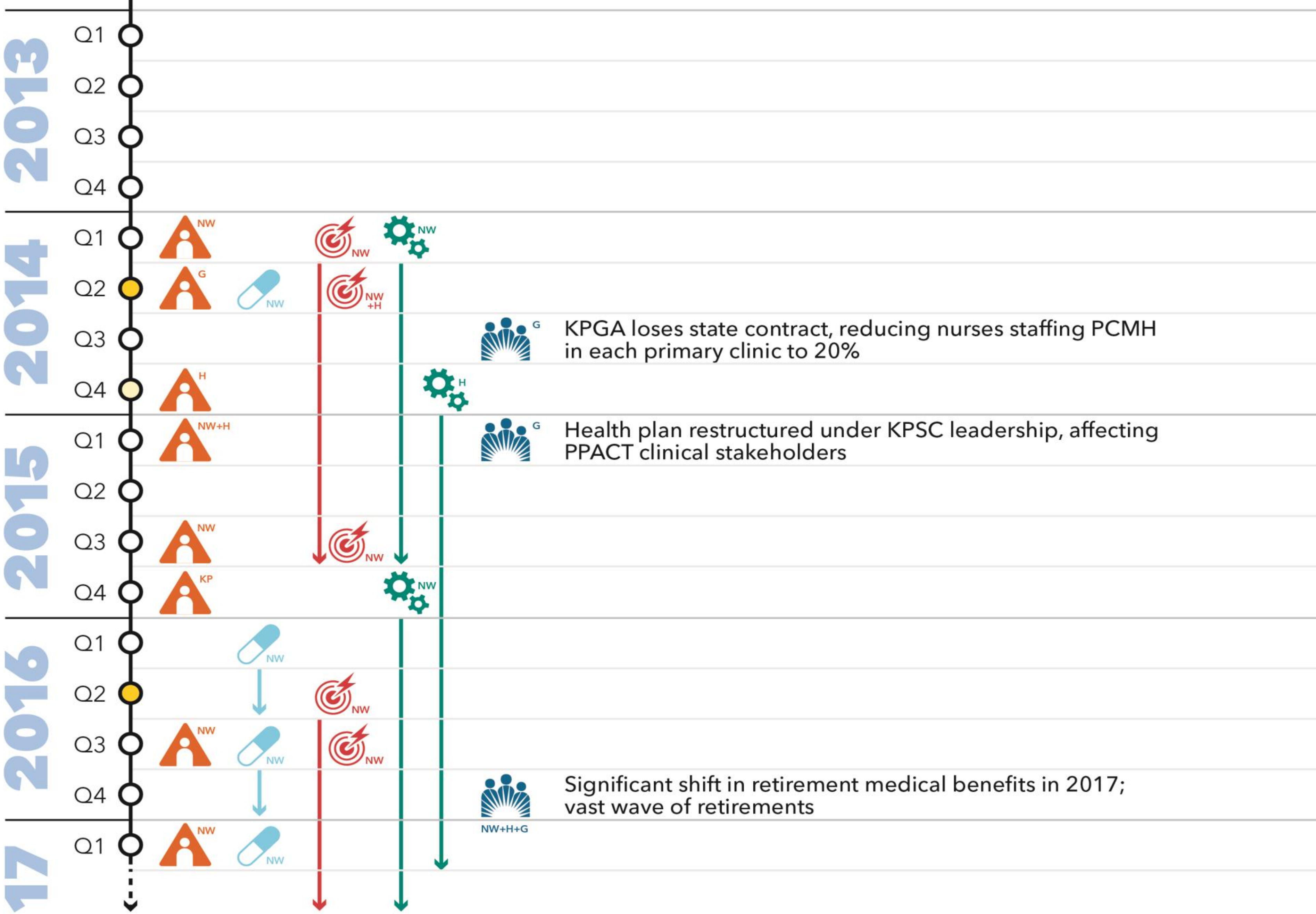
NW +H
Complex conditions primary care clinic initiative rollout
Behavioral health integration into primary care
Behavioral health integration into primary care



2013
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2014
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NW
NW
NW
Q2
G
NW
NW +H
Q3
G
KPGA loses state contract, reducing nurses staffing PCMH in each primary clinic to 20%
Q4
H
H
2015
Q1
NW+H
G
Health plan restructured under KPSC leadership, affecting PPACT clinical stakeholders
Q2
Q3
NW
NW
Q4
KP
NW
2016
Q1
NW
Q2
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Q3
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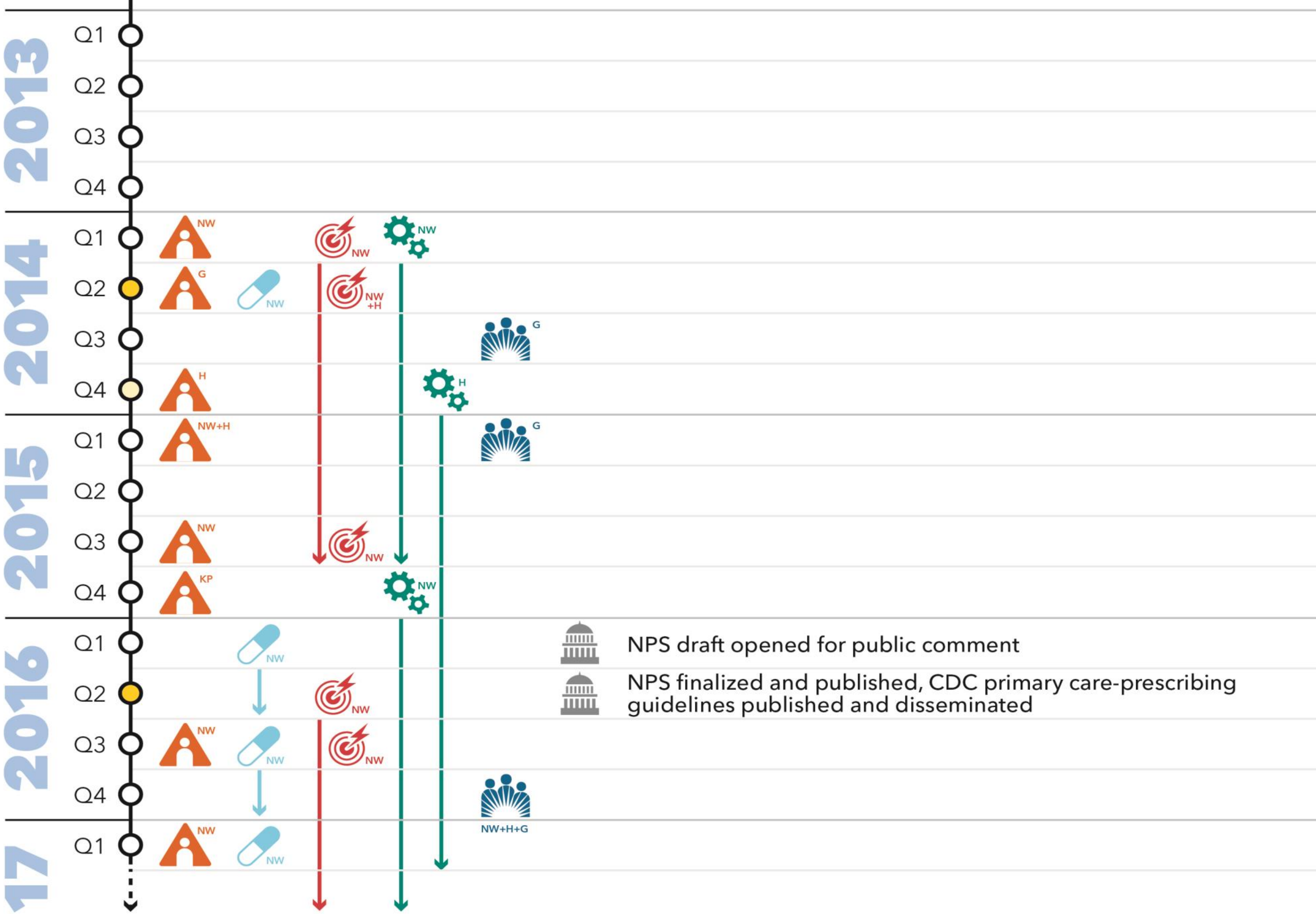
NW
NW
Q4
Significant shift in retirement medical benefits in 2017; vast wave of retirements
NW+H+G
17
Q1
NW
NW



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Q2
Q3
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NW
Q4
KP
NW
2016
Q1
NW
NPS draft opened for public comment
Q2
NW
NPS finalized and published, CDC primary care-prescribing guidelines published and disseminated
Q3
NW
NW
NW
Q4
NW+H+G
17
Q1
NW
NW

Key Learnings from PPACT and integration of broader KP Behavioral Health Initiatives re: engagement

#1 Stakeholder involvement: early, often, continuously ***and*** at multiple levels of the partnering organization (***everything is dynamic***)

#2 Compensate for the "ask": work to create early and useful products that support/ease clinical work in the delivery system

#3 Carefully consider "fit" of core intervention approach for frontline clinical staff and congruence with the organization's quality improvement approaches

PROVEN

PRagmatic Trial of Video Education in Nursing Homes

Susan L. Mitchell, MD, MPH
Vincent Mor, PhD
Angelo Volandes, MD, MPH

UH3AG049619

NIH Collaboratory Steering Committee Meeting
Panel: Health System Engagement: Partnership, Relationships and Transparency
May 24, 2017 – 10:30 am – 12:00 pm

BROWN School of Public Health

Institute for Aging Research
Hebrew SeniorLife

HARVARD MEDICAL SCHOOL

MGH 1811

PROVEN: Overview

- **Objective**: To conduct a pragmatic cluster RCT of an Advance Care Planning video intervention in NH patients with advanced comorbid conditions in two healthcare systems

- **Intervention NHs**: Suite of 5 videos to be offered facility-wide: All new admissions, care-planning meetings for long-stay and readmissions
  - Flexible: Who, how (tablet or web), which video
  - Training: corporate level, webinars, toolkit
- **Control NHs**: Usual ACP practices

- **Primary outcome**: Number of hospitalizations/person-days alive among patients >=65 years old who are in a NH >=90 days ("long-stay") and who have EITHER advanced dementia OR advanced congestive heart failure/chronic obstructive lung disease

PROVEN: Implementation

- **Sample:** 359 facilities total (across two partners)
  - 119 facilities randomized to intervention
    - Rolled out over 4 months/waves
  - 240 facilities randomized to control (2:1)

- **Compliance:**

	Partner 1		Partner 2		Total	
Admissions (MDS from partners)	3782		21665		25447	
Videos offered	2014	53.25%	16788	77.49%	18802	73.89%
Videos shown	1345	35.56%	3402	15.70%	4747	18.65%
Residents EVER* long-stay	2499		10308		12807	
Video EVER* offered	869	34.77%	4153	40.29%	5022	39.21%
Video EVER* shown	511	20.45%	872	8.46%	1383	10.80%

*Since the start of the ACP Video Program

Run with MDS and Video Status Report User Defined Assessment data through March 2017

PROVEN: Health Systems Engagement

- **Trust**
  - Partners are willing to engage with us because of our reputation
- **Shared goals**
  - Must be important to the partner and offer possible solution to a systemic problem
    - Reducing hospitalizations
    - Advance care planning needs to be done anyway
- **Joint planning**
  - Must be a “good fit” and be integrated into standard operating procedures
- **Learning from shared experiences**
  - Ongoing communication / transparent reporting about implementation and participation
  - When increased effort or changes are needed, our partners agree

Genesis Overview

Genesis HealthCare is now one of the largest providers of post-acute care services in the nation.

Publicly Traded
Ticker: GEN

~80,000
dedicated teammates

~60,000
beds

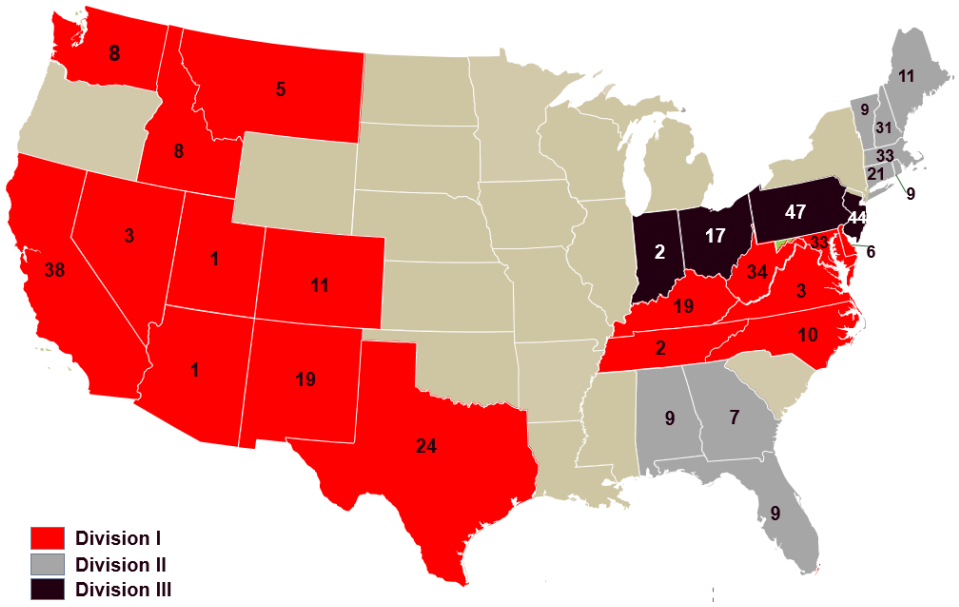
Average Occupancy
88.1% over the last 3 years

Competitive Strengths

- More than 450 facilities across 30 states
- More than 200 clinical specialty units.
- More than 425 Genesis physicians and nurse practitioners.
- Strong referral network with hospitals.
- Genesis also supplies contract rehabilitation services to approx. 1,700 locations across 45 states.

Operating With Geographic Scale and Scope

- Geographic density = operating efficiencies, strong hospital relations & coordinated sales/marketing strategies
- Geographic diversity reduces regulatory risk



- More than 450 SNF and ALF facilities across 30 states
- Top 5 states by licensed beds:
  - PA: 10.6%
  - NJ: 11.5%
  - MD: 7.6%
  - CA: 7.0%
  - MA: 7.1%

Genesis Rationale for Engagement in PROVEN:

Seeking increase in horizontal partnerships with hospitals to reduce unnecessary readmissions

Genesis' commitment to innovation in delivery of quality care.

Interest in improving advance care planning to align family and patient/resident goals with patient care plans.

Genesis physician/nurse practitioner practice designated as accountable care organization, driving need to improve care in all aspects secondary to valued based payment models/shared savings programs.

Barriers Impeding Implementation:

Staff turnover, especially in leadership positions who serve to support the study.

Time constraints and workflow challenges with chronically understaffed centers.

Lack of appreciation for advance care planning as an ongoing activity versus reliance on management of required advance care planning forms.

Partnership with researchers/primary investigators:

Consistent support, communication, and collaboration in internal data collections.

Frequent and routine conference calls allowing for free flow of discussion regarding overcoming barriers.

Flexibility in study design allowing for required changes/innovations in keeping staff involved in adhering to study components.

Helpful recognition of challneges in the long term/post acute care environment which differ in reason and scope from acute care.

Questions and Answers

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