Jill Harrison, PhD:

Hi, this is Jill Harrison, Executive Director of the National Institute on Aging IMPACT Collaboratory at Brown University. Welcome to the IMPACT Collaboratory Grand Rounds podcast. We're here to give you some extra time with our speakers and ask them the interesting questions that you want to hear most. If you haven't already, we hope you'll watch the full Grand Rounds webinar recording to learn more. All of the companion Grand Rounds content can be found at impactcollaboratory.org. Thanks for joining.

Vincent Mor, PhD:

Good afternoon. We're speaking today with guests on our Grand Rounds that we held yesterday as part of the IMPACT Collaboratory. And this is a really interesting discussion we had with chief medical officers from various different kinds of healthcare settings. And it's important for us as researchers to understand how they think about implementing. Because for decades, researchers have tested the impact of interventions on patients with complex chronic conditions, ranging from care management to provider education in order reduce prescriptions of inappropriate drugs. While there are exceptions, these programs, when they're managed by researchers under laboratory conditions, often result in very positive effects, and that's what gives us our New England Journal articles, et cetera. However, too often, when these are actually implemented by healthcare systems where the staff do the work, the results are often not as positive. Sometimes this failing is because the new program wasn't properly re-engineered to be compatible with existing workflow or other things, but sometimes it's the sites.

Vincent Mor, PhD:

Some sites don't really prioritize it and seem to forget about it all together, while some sites actually do it. This experience with challenges of implementing innovative programs as part of embedded pragmatic trials, raises the question, really, from our perspective, of how healthcare systems go about making purposeful changes, and how healthcare systems leaders know whether the changes are being consistently effective. And today, I have with me three lions in the field who have done this work in very different settings. So, one is the Executive Vice President and Chief Medical Officer of CVS Aetna, Troy Brennan. Next is Richard Feifer, who's just stepped down as Chief Medical Officer of Genesis Health, one of the larger nursing home companies in the country. And then finally, Saul Weingart, who is currently President of Rhode Island Hospital. Prior to that, he was Chief Medical Officer at Tufts Medical Center in Boston.

Vincent Mor, PhD:

And so, they're going to respond to some of the questions I have and also some of the questions that came in from the audience during our Grand Rounds. So, first off, I'd like to ask each of you to think of a modification of change, that you were responsible for introducing into an existing care process, an existing thing that was going on in your health system, whether it's infection control or advanced practice discussions with patients. What strategy did you use to roll out this modification to all units, stores, or facilities, and was there some kind of manager who was responsible for this? And did it work or didn't it work? So, Rich Feifer, I'll turn to you first.

Richard Feifer, MD, MPH:

Well, Vince, what we're really talking about here are the elements of a change management strategy, and change management's hard, and hard problems usually don't have simple solutions. They require complex solutions. So, I'd suggest that there are six necessary components to any effective change management strategy, whether it's a pragmatic trial where we're seeking adoption of change, or

whether it's a wholesale clinical or operational change. And there are three roles and three tactical domains within the six. Let me just summarize what they are and then I'll get into an example. The three roles that one needs to have are, first, executive buy-in and executive sponsorship. Second, local champions in the field or in the units or in the facilities where the change is sought to happen. And third is dedicated program management. Someone who is going to get their hands dirty to ensure day-to-day pull through and follow up, and be the bridge between the frontlines and the executive sponsors.

Richard Feifer, MD, MPH:

Those are three key roles. And the three tactical domains are communication, incentives and alignment with priorities, and transparent reporting of engagement and adoption. Those are the three tactical domains. So, let's talk about an example. Advanced care planning, such an important topic, especially in post-acute and long term care, a major priority for us at Genesis. And we've been working for years to try to increase advanced care planning conversations in terms of their frequency and robustness and effectiveness. Goals of care, advanced care plans, and the like. And we've all struggled across the healthcare industry and certainly in post-acute and long-term care when we've gone at it head first, trying to get providers to do more and more effective advanced care plans. As we dug into that issue further, we realized that there were not aligned priorities. In fact, some of the different stakeholder groups that were influencing this issue had conflicting priorities.

Richard Feifer, MD, MPH:

For example, our accountable care organization, had a very strong desire to reduce hospice utilization, because hospice was a big driver of cost. That was their priority. Advanced care planning, sure, it was on the radar, on the list, but not the top. Our facilities themselves, our skilled nursing facilities had a strong incentive to utilize hospice to the extent allowed for various reasons that we could talk about. And our physician group and our provider group was struggling with high hospitalization rates, especially at the end of life. And so, bringing that all together and coming at advanced care planning through the perspective of the different stakeholder groups.

Richard Feifer, MD, MPH:

Realizing that advanced care planning could be the solution rather than the objective, the solution to what they were all trying to achieve by first framing it as a means of addressing hospice utilization and hospital utilization when it was not adding value to the patient, often well before the last six months of life, where the need and the benefit was of questionable value. And also within the last six days of life, when the intervention is frankly too late to benefit the patient and their family. So, framing the solution that we're trying to go after through the lens of the stakeholders is one way of addressing the incentives and alignment with existing priorities.

Vincent Mor, PhD:

Thanks very much. That's great. Saul, how about you?

Saul N. Weingart, MD:

Thanks. I'd like to also address an issue or a project related to advanced care planning. And I'm going to go back about 10 years to when I was overseeing the quality program at Dana-Farber Cancer Institute. At that time, we were dismayed to discover that the percentage of patients who, by and large, had a cancer diagnosis or a serious so-called benign hematologic disorder, that we were running about 20% of patients having identified a healthcare proxy who could make decisions for them on their behalf if they

were unable to do so. This was a bit of an embarrassment and seemed like a call to action. So, we put together a committee with all the appropriate stakeholders. We had palliative care, and ethics, and social work, and psychiatry, and representatives for medical oncology and nursing, and so forth, and identified a very capable facilitator from the quality department who had training in industrial engineering and was quite personable.

Saul N. Weingart, MD:

The committee met for a long time, and had not a lot of traction. It turned out there were a lot of complicated things to work through. The clinicians were often reluctant to have a goals of care or advanced care planning conversation with women who came in with early stage breast cancer that was entirely curable. Did not want to upset or worry the patients. Similarly with things like thyroid malignancies or early stage prostate cancer. So, it was concerning to them about how to do that. We also did a large number of second opinion consults, where there was one interaction with a patient who was referred from elsewhere, and again, the clinicians were a bit reluctant to initiate that conversation. What also often happened is, patient came in for an initial visit, decision was made to proceed, they launched into therapy, and then it seemed like it was a little too late to have the conversation because care was already underway.

Saul N. Weingart, MD:

So, the group met regularly. Groups like this often meet on a monthly basis until the end of days. And after about two years, there was a sense of frustration, disappointment, exhaustion, that they were not really able to move the needle despite putting a number of interventions in place, doing more education, preparing promotional materials, even making changes in the electronic medical record that prompted the clinician to discuss and to record the result of their conversation. It was not moving, and folks were beginning to dread going to the meetings, because it felt like Groundhog's Day. Now this was an initiative that we rolled out across the entire enterprise, and we had a number of satellite clinics, not at the main campus, that focused on general oncology rather than on disease specific programs. And we learned that at several of the satellite facilities, they were running rates of 60, 70% of patients having identified a healthcare proxy.

Saul N. Weingart, MD:

And that was a bit of a narcissistic injury for the luminaries who worked downtown at the main campus, and was an opportunity to try to understand what they did differently than what we were trying to do. And it turned out that what they did was they identified an individual at registration whose responsibility was to ask the patient the question, "Is there somebody you'd like to identify as a healthcare proxy?" and described a little bit about what that was. I reflected on my father's experience as a salesman, and his bromide was always to be personal about impersonal things and impersonal about personal things. So, your car is the expression of your aspirations. It was a funny kind of a thing. And if there was something very serious, like making life plans or buying a funeral plot, that was a much more cut and dry, what do you like large, medium, or small?

Saul N. Weingart, MD:

So, we tried a similar kind of an approach. We decided that at registration when the registrars, either at initial registration or when patients checked in, they would ask to update insurance information, address, and phone number, and, oh by the way, would you like to identify a healthcare proxy? And it turned out that that worked extraordinarily well. There were a number of concerns raised early on by

the committee that was trying to plan this out about what would happen if someone got upset and how would you have resources and backup available? So, we put a rather elaborate plan in place with an individual carrying a 24/7 beeper who was trained to respond to some questions. We had a social work backup, and then a palliative care physician who would back up that person. And in the first several months we had one call to the backup system and it was, "Where do you keep the forms? I can't seem to find them."

Saul N. Weingart, MD:

So, in short order, we had really changed the way things work at the organization. Patients, it turned out, by and large were delighted to have the opportunity to identify a loved one who could help make decisions for them. There was some concern that our patient family advisory committee raised about being asked multiple times about people who either couldn't decide or didn't want to decide. And so we put a cutoff after several reminders and built that into the system. And in the end, there were some subtle, difficult conversations that needed to happen in the exam room, but by and large, this became a way that we do business and much less emotionally wrought for the people who planned the program and much more successful.

Saul N. Weingart, MD:

We ended up climbing to 60, 70, 80% adherence, and we were really delighted with that. And there were some lessons. Often, we might want to take out some of the emotional baggage that we assume patients have about difficult decisions. It turns out having an interdisciplinary team that's committed to the work with effective facilitation and executive leadership may not be the right approach. And in some ways, being inspired by some of your satellites and looking for success can really be an important element to pulling off a successful intervention.

Vincent Mor, PhD:

Thanks. So, that's actually very intriguing because, while it's advanced care planning that both of you spoke about, you actually ended up speaking about what is a fundamentally different thing for Rich, and Genesis. They need to deal with a decision about whether to hospitalize or not hospitalize, which is a very specific, complicated decision, rather than a much broader open-ended contingency that's got to deal with a much more heterogeneous population, like who would be a healthcare proxy? But what's really key is, if we just come and ask about advanced care planning, we could get it completely wrong. We could be asking the wrong question. And I wonder if there are examples. It may well be, Saul, like the board of Dana-Farber was asking the wrong question. They wanted the wrong check off the box. Whereas a different approach might have been much more helpful, a different question. And Rich, I would imagine the same kind of thing in the nursing home world.

Richard Feifer, MD, MPH:

That's right, Vince. It really is very important to get the question, right, and sometimes the right question for one audience or stakeholder is not the right question for another. Let me give an example. Pneumococcal vaccination is very important, especially for aging and vulnerable populations, certainly for our population. And it's rather standardized to ask patients when they're admitted to a skilled nursing facility, whether they have, or would like to receive a pneumococcal vaccine. But that's not necessarily the right time to effectively ask that question if the goal is to maximize vaccination. But if the goal is just to ask the question, well, then it's pretty straightforward. We can get a yes or a no, or an accept or decline, and get nearly a hundred percent adherence if that's the question.

Richard Feifer, MD, MPH:

And so getting the question right's really important. As we emerged as an accountable care organization, for our long-term care patients, we had to reframe the question, because then the question wasn't, "Did we ask the question each and every time we admitted someone?" The question was, "How do we maximize our vaccination rate?" The actual needle in arm rate, and that's much harder. And the admission moment, that event is not necessarily the right time to ask that question, because there are other priorities and the data aren't always available for whether someone had received the pneumococcal vaccine in the recent or somewhat distant past. And so we needed to rethink the entire workflow based upon a different question around the same exact issue.

Vincent Mor, PhD:

That's really a great example. Saul, do you want to comment on that?

Saul N. Weingart, MD:

I have another example that I think is relevant. It was about readmissions. So, there's been a lot of interest nationally, in fact, there's a penalty that Medicare imposes on 30 day readmissions. Nowadays, we know there's some question about whether that's actually a quality measure or a utilization measure, but regardless of that, there was interest when I was at Dana-Farber, and in my subsequent jobs, in managing readmission rates. It was regarded by the board as an important quality measure. But it turns out that in a condition like heart failure, many hospital readmissions are preventable if you can do the right things in the ambulatory setting. If you can measure daily weights, and titrate medications, and ensure medication adherence, and avoid salt load, that kind of thing. For oncology patients, typically what happens is the patients are followed closely if they're in therapy.

Saul N. Weingart, MD:

And often there's an escalation of care, where the patient is seen for an office visit. And if they're looking a little funky, they might get a little bit of fluid. And if they're still looking a little funky and they may come in the next day and be started on antibiotics or receive some sort of antiemetic. And if they get admitted, it's not a failure of care, it's an escalation of care that's appropriate. And, as one of the chief medical officers used to say, many of our patients don't get better and aren't expected to get better. So, the question is: what's the outcome we're trying to address? So, again, I think you're right. The question you ask is very important to the answer you get and whether it's the correct answer to the proper question.

Vincent Mor, PhD:

Right. That's something that actually is really critical also when we think about things from the regulatory perspective as well, because it's the regulators, or the payors who have certain quality quote unquote standards. And it's not necessarily one size fits all, and designing those indicators to grapple appropriately with the various exceptions is just like trying to put together an intervention or an innovation that has to be distributed across the entire system. That's a really good point.

Saul N. Weingart, MD:

One of the things we ended up doing was distinguishing between a preventable admission and a discretionary one. So, a discretionary admission might be something you do at five o'clock on a Friday because you don't have a service that's offered late. And if you actually had a more complete range of services, you might not need to do the admission. So, those are the kinds of things we tried to sort out.

Vincent Mor, PhD:

So, Troy, this is the question we started off the Grand Rounds with when we were asking about, so all of these issues around how to actually get a program or a new initiative actually implemented in your many, many stores. And if you could just give me an example of one of those times and what kinds of efforts you went through to actually get some program implemented, let's say, particularly with your nurse practitioners in your Minute Clinic stores, so, it was a new initiative. And then how you made sure that it was actually being done.

Troyen Brennan, MD:

So, I would say a good example of how we implement things, would've been our move to do testing in the stores in a more expanded fashion in the retail pharmacy. I refer to them as stores. And it really required two things. The first was, set up a program where people could come to our drive-in and get a swab test in a program that we called "swab and send", where we then captured the test and the information on the individual patient, and they deposited the test specimen in a container, which we then sent off to labs for PCR testing. And it required us to bring capabilities around the revenue cycle, as well as data capture to the drive-in window at the retail pharmacy, meaning that we had to train a bunch of people to work on what is essentially our Epic system, who hadn't previously sort of had contact with it.

Troyen Brennan, MD:

And then the second thing we did was, we set up a point-of-care testing program where we put small kiosks, we purchased nearly a thousand kiosks, so, almost like a small trailer that we put in parking lots of stores. And we opened testing there, with the idea being there were going to be a lot of people who wanted to be tested with presumptive symptoms, but again, we didn't want them necessarily sort of in the store. So, we had basically testing equipment and EMR electronics in these kiosks. So, it was a big logistical undertaking. And we hired a lot of people. We probably hired something on the order of 30 or 40,000 people to work on this program. But I would say both the Minute Clinic and the retail pharmacies, have very strong field organizations and those field organizations and the people who do the implementation developed a series of key parameters, so-called KPIs that are going to be followed through the elaboration of the program.

Troyen Brennan, MD:

And they tell us whether or not we're performing the way that we think we should be performing. It requires a good deal of oversight, but the retail pharmacy and the Minute Clinic are used to undertaking these kinds of programs in the field. This was an especially big one, an especially big effort, but it was something that paid off really well. At the heights, the various heights of the pandemic we were doing more than 130,000 tests per day. So, I think provided a real resource for the community.

Vincent Mor, PhD:

So Troy, let me just follow up on that. Is your organizational operations, is that sort of regionalized or is it all centralized in terms of the lines of authority and responsiveness?

Troyen Brennan, MD:

We're centralized. Everything occurs from the center. So, we own all of our stores and we operate them. There's no such thing as a sort of franchisee. So, the entire program was designed centrally, but then there's a strong field organization to elaborate, to going out from various different regional vice

presidents, to district leaders, to individual retail store and pharmacy leaders at the various institutions. So, it's hierarchically arranged, but definitely centrally administered.

Vincent Mor:

So, you are sufficiently familiar with, as a scientist as well, how clinical research organizations do large scale multi-site clinical trials. And they have this regionalized structure and they monitor performance and recruitment and adherence, et cetera. Is there some lesson that others could learn from a place like CVS, about the management and operations of implementation, in terms of actually trying to run, let's say, a cluster randomized trial from that process?

Troyen Brennan, MD:

I'm not sure. We have strong industrial engineering resources, and when we have a program like this, we put that through an industrial engineering prism and they come up with solutions. The interesting part about this one was flexibility, the relative flexibility and thoughtfulness with which we used the electronic medical record information. A lot of our peers didn't have as many nurse practitioners who could basically order these tests. Tests had to be ordered by an individual practitioner. And so, we had to virtually have nurses who were doing the ordering and the checking of the results. But the EMR and the flexibility of the EMR with regards to this nearly virtual approach was very helpful.

Troyen Brennan, MD:

That's the kind of thing that industrial engineers would put together, that they would understand and sort what our needs would be. We also had very strong support from our digital teams. So, we streamlined the program repeatedly for both logging into our system, as well as sort of getting results, and that obviously increased the number of people who were picking up their results and also sped our process enormously. So, there are people who are trained in Facile, a digital technique, that are basically wired on to hard drive systems like our electronic medical record, as well as industrial engineering, I think can provide insights for individuals who are trying to streamline.

Vincent Mor, PhD:

Great. And one last just follow up to that is, there must have been some stores that seemed to be performing less well than other stores. What is the repercussion? What is the action that it is taken and how does that happen? What are the lines of authority that go through that?

Troyen Brennan, MD:

There's a field team that undertakes addressing those kinds of problems. So, we'll send a group of people out, two or three people out who go out, do root cause analysis with individual stores, confer with the individual store leadership, confer with leadership of that particular district, and develop an action plan to bring people back online. And of course we see it. So we monitor the KPIs on a store basis, and when the stores fall out of line, then they get an elevated over time response that will end up, in many situations, with a visit from a team that can help them get back on track.

Vincent Mor, PhD:

Great. All right. Well, thank you very much. That was extremely helpful because it's those mechanics of how the monitoring happens and steps to redress the performance gaps is really critical, and something we probably don't do as well in the clinical trials community as you guys are apparently doing.

Vincent Mor, PhD:

Thank you very, very much. I appreciate it tremendously.

Jill Harrison, PhD:

Thank you for listening to today's IMPACT Collaboratory Grand Rounds Podcast. Please be on the lookout for our next Grand Rounds and Podcast next month.