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.

Stacy Fischer, MD:

I'm Stacy Fischer, I am a professor at University of Colorado, and I am here with Doctors Laura Hanson, Hillary Lum, and Liliana Ramirez-Gomez. I'm so thrilled to be here with you all and to discuss the grand rounds for the IMPACT Collaborative that we were all part of last week, describing the adaptation of, Dr. Hanson, your randomized controlled trial of palliative care for hospitalized dementia patients, and Liliana and Hillary, your work with community-based research methodology to adapt that to the Latino population. Please watch the webinar, watch the video of this incredible body of work and all the efforts. I'm just wondering, at this point, just starting off, what was the most challenging piece of that adaptation process for you all? Dr. Hanson.

Laura Hanson, MD, MPH:

One of the things that was challenging going into this was to recognize that this was a fundamental flaw in research design in general. I've done a number of clinical trials with the population of people living with dementia, and I've always had an English-speaking exclusion because so many of our measures and the way that we just implement research is dependent on communication in, at least the United States, in English, and recognizing what an incredible barrier that is. It's so incorrect relative to the needs of the larger population, and not only was it a hurdle because I didn't know how to begin, thank goodness I found colleagues who did know how to begin, but also because I realized that it would require additional resources to be inclusive, that it wasn't going to be something that could be done based on the original plans for the trial.

Liliana Ramirez-Gomez, MD:

Once you do this kind of work, the work is already in progress and therefore one of the challenges is to be able to make changes, make the adaptations and sometimes tweak the intervention if it's possible and feasible to make it culturally relevant and all of that. That's one of the challenges. Ideally for our audience, I would encourage you all to think about these type of projects from the beginning, like, if you're going to have an arm that is from a different culture, background, language, that you consider those things from the beginning so you don't need to change the procedures or other things that may come across as you develop this work.

Hillary Lum, MD, PhD:

One of the challenges that stands out to me as we were seeking to listen well to our Latino advisors is how diverse culture is, how multifaceted someone's background is. On one hand, this research study could seem quite specific. Individuals with advanced dementia and their care partners who are hospitalized, actually quite specific in the bigness of the world, and yet as we were really thinking about how are aspects of the study heard and understood by individuals who are being approached to consider the study, we realized that the words palliative care or hospice or care partner or caregiver or dementia or concepts of hospital-based care really had different understandings and reactions. And that also varied by region, by country of origin or immigrant status, and more recent experiences are larger,

so I don't know if we want to use the metaphor of an onion. Metaphors are also hard because they are culturally based, so just quite complex.

Stacy Fischer, MD:

Great. I just really appreciate this discussion and this kind of tension between when is the right time to make these cultural adaptions and how different in a randomized controlled trial, whether these adaptions are put into place at the very beginning or midway through the trial? How do you balance and think about thinking through the distinction between flexibility, between maybe arms or adaptations or by culture and how that might affect fundamental hospice or hypotheses or how the, integral pieces of the intervention? Laura.

Laura Hanson, MD, MPH:

I would say it would have been better, and I would have liked to have thought this through from the very beginning. I recognize that more and more that's a priority because of the diversity of the population of the United States, if that's where research is taking place. Thinking about it from the beginning, it seems to me ought to be the priority. There is a concept in behavioral research and in more pragmatic research called adaptive trial design, and I think that is really perhaps the direction that we should be going, is to start the research, recognizing that for different populations, different settings, perhaps, it will be important to be flexible, to be able to adapt. That, it seems to me, is that sweet spot where you're not necessarily going in saying, I'm comparing one cultural group to a different cultural group, but instead I'm trying to create an inclusive clinical trial, and I might not know everything about my population before I start, but I'm going to set up an adaptive trial design as part of my plan.

Hillary Lum, MD, PhD:

I want to jump in and add just a practical aspect of how I saw us trying to honor the desire to be flexible while absolutely being true to fidelity so that we could analyze based on our primary hypotheses. I think it was a commitment to a diverse and well-trained team who met frequently over time.

I'm specifically thinking about how our clinical research coordinators were involved from the very beginning of when we started this cultural adaptation, so they really understood the purpose, had great rapport with the Latino caregiving advisors, and therefore were seeking themselves to think about how they could flexibly enact the values that they were hearing. Even if they couldn't put into place the specific recommendation, because that would've been very different, perhaps, they sought to do it in their practice of outreach to patients, and then that commitment to meeting together to circle back and debrief and say, what was your experience, and to be able to calibrate together, like, this is an okay way that we can be flexible, or actually this is now beyond where we can be flexible, because I think as they had a greater diversity of experiences, that coming back and meeting together and saying, "Is this still okay?," was really important.

Liliana Ramirez-Gomez, MD:

I want to commend the team here because I think something that was really well done is that we went farther from having a bicultural, bilingual competent team into the community participatory research and really including the people who have the lived experiences. And we talked about this during our grand rounds, but I want to emphasize here that we now need to go beyond the team, which is extremely important, and also to include the people who are experiencing this, how they lived through it, and include them not only as recipients or spectators, but as active and integral part of the research team.

Stacy Fischer, MD:

I really appreciate that perspective and how important that is. Thinking about ongoing engagement with these advisory groups, how and at what point do you think it makes sense to go back to the advisors, to our partners, community research partners to say, "Have we done this right? Have we optimized this fit in terms of tailoring and adaptations?" At what point, or points, does that make sense?

Liliana Ramirez-Gomez, MD:

As we have described through the adaptation process, it's very important to have them be part of each step. Right away, including our team, are discussing that we are ready to present to them the results of what we have done because they not only helped us adapt the materials and revise and give us input about language and other processes, but also how this went, what we found, what are conclusions, because we always have to put into practice here and then give back to the community and to what they know and ask again, is this right? Is this what you were trying to say, the suggestions you were giving us? Or what other changes do we need to make?

In addition to that, the advisors also have a learning process because as you mentioned, they learned that palliative care implies support as well as all the things that you do in palliative care, so they learned that and now they have a different perspective, they also replicate that with their peers in the groups they have. So also hear back from their learning experiences on additional suggestions because what we are learning is they are giving us ideas of future research projects.

Laura Hanson, MD, MPH:

I just want to follow on that, that we've already heard from our community advisors some of the recommendations that we couldn't put into place because it would go too far from fidelity and the fundamental structure of the study, but as Liliana just said, it's giving us really good ideas for the next research application because they're advising us in a modification of this approach, and that's exciting.

Stacy Fischer, MD:

As you think about the cultural adaptations and tailoring and we think about also cultural universals, things that are so important, I think, across cultures, are you getting any sense, and I think at this point obviously it would be much more of a qualitative sense, of differences amongst the preference between the groups of Latino participants versus the non-Latino participants in terms of how caregivers are coping with dementia or how they're thinking about preferences for care moving forward?

Liliana Ramirez-Gomez, MD:

I would like to mention a few. Of course there are many, because here is where the importance of culture and beliefs and partnership comes across. For example, we have learned the values of families more, respect in how they receive this intervention and they put it into practice and how some people may reject on the basis of believing that that is not important for their family, that it wouldn't add anything or wouldn't be helpful. That, for me, was an important learning from this study, how even a single choice of wording or how we deliver an explanation makes a difference in their understanding, because actually, when they know what this is about, they were so grateful, they were happy, appreciative of what this has to offer to them.

Another important thing that is different is that they were not exposed or they haven't heard of this before in the outpatient setting or in different settings outside of the emergency room or the hospitalization, so that was another highlight of the importance of culture and how to also make it

available, because of course here we encountered all the systems, the difficulties that we have in access to care and all that.

Hillary Lum, MD, PhD:

Yeah, I wanted to add on related to that aspect of resources being available, it was really good as a team to think through every aspect of this complex intervention and to try to get input from the advisors on every aspect of it. Specific to the Dementia Resource Guide, at Colorado it was very interesting to specifically work with some different Latino care partners that we knew through clinic, specific to the resource guide. We didn't really even introduce the larger study and thinking about approaches in the hospital, but instead just asked for feedback on the presentation of a paper handout of resource guides, and in that case, actually, because we weren't talking about palliative care or hospice, there was overwhelming desire, please more resources.

This is perhaps the first time someone has offered or asked our opinion about what resources would be helpful. Even though the guide was actually quite big and they had very helpful points including cost, including whether there was capacity at various agencies and organizations for bilingual or Spanish only support, we sort of thought that it was overwhelming, too much and they said, no, please include all of it, even if we don't look at all of it, it's helpful to know it's here. Which was a little counterintuitive.

Stacy Fischer, MD:

Shifting gears a little bit, I want to go back to something Laura, you had mentioned in the grand rounds, which was, you've got, on the one hand, NIH wanting to ensure that we have diverse populations that are reflective of larger populations and that are representative. Yet, what we know is that enrollment in these kinds of clinical trials rarely achieve that. You mentioned that it really wouldn't have been possible without the supplemental funding to do this complicated work. How do we as palliative care, geriatric, clinician scientists advocate for ensuring that the funding is sufficient to do this work in the way that it's supposed to be? How can we get involved and what are your thoughts about how you advocate?

Laura Hanson, MD, MPH:

I have been thinking a good bit about that, because I feel as an investigator, I've done collaborative community-based participatory research, but it's not my forte, it's not the thing that I lead with. Recognizing that the supplemental funding was absolutely essential for this trial, because we really took this adaptation very seriously and viewed it as an exemplar methodology, learning from the method itself, a method that others could generalize for future dementia clinical trials or even other clinical trials in serious illness. I think moving forward, and the IMPACT Collaboratory has been very visionary in this way, the whole world of pragmatic behavioral clinical interventions needs to start with this concept. How can you call a trial pragmatic if you're not thinking about inclusion of the diverse population that's out there wrestling with this condition? Alzheimer's disease and related dementias is a really powerful example because we know that Black Americans, Hispanic Americans get this condition more than people who describe themselves as White.

And yet clinical trials, both pharmaceutical and non-pharmaceutical have not enrolled those populations. I don't want to dismiss the supplement, I'm very grateful for supplemental funding, but I really think moving forward, we need this as the model for at least later stage clinical trials. Clinical trials that say we're moving into pragmatism, into real world efficacy or implementation stages of research. I would argue, if I were sitting at the NIH, we're going to invest in that, but we're also going to put it out there as the model for pragmatic trial design. That a pragmatic trial, if you're running it in a context where there's a large Mandarin Chinese-speaking population, then that trial needs to be adapted to

accommodate and enroll participants who both speak that language and are part of a cultural set of norms that they represent. I would love to see collaborative conversations between investigators who are doing this work, and obviously we're not the only ones in the NIH to come up with a model approach that is the recommendation that we use moving forward.

Stacy Fischer, MD:

And appreciating your comment about investment, because it is more resource intensive and should be to ensure that you can accommodate and address all the barriers. And knowing that socioeconomic and social determinants of health often tracks sometimes with some of our underrepresented populations. Another question is, thinking about how do we also hold researchers accountable when projects aren't inclusive? Is that something that is kind of the other side of that coin, in addition to encouraging that? How do we approach that? What are your thoughts about that, coming on the other end of this work?

Hillary Lum, MD, PhD:

I guess I'll jump in, and I'll speak from an efficacy trial that I'm running separate from this, and I think it's probably not binary, inclusive or not. And instead it's a frame where I'm being asked to give an account for how I'm under-enrolling even equivalent to my county demographics. And there are a lot of factors there, and it's really important that I be asked and held accountable to thinking through all of the different factors of my enrollment. That's just, I think, one space to realize that we don't just start a trial and then it finishes five years later, but actually there's a lot of continuing to iterate, being in a posture of learning. We mentioned earlier actually, when is it appropriate to go back to our community advisors? I think that it's not when we have everything packaged and we have great news, instead it's a discipline of going back consistently to share how things are going, to continually be in a learning posture saying, what can we do better? How close are we? How can we get closer?

Laura Hanson, MD, MPH:

I agree with everything you just said, Hillary, and I want to add that I think one of the interesting learning opportunities, and I agree with the idea, we need to be in a learning posture, not a mandating posture. One of the learning opportunities that we have had in this clinical trial is the screening process that we're using to identify potentially eligible individuals who have late-stage Alzheimer's disease or other dementias. And what we can easily see is, for example, where I am in North Carolina, even though we have a significant Hispanic Latino population demographically, that population is youthful and has not aged into the target population for this clinical trial, and yet in the screening process in Boston or in Denver, there is a population that has achieved eligibility for the target population that is also Hispanic Latino.

I think that screening data out of clinical trials is actually a potentially rich resource to understand this better, to understand that in different geographies, different communities, we're going to see different types of diversity. It's not right or wrong, but that accountability of, I need to look at the diversity in my screened pool and the diversity in my participant pool and have some congruence between those two populations.

Stacy Fischer, MD:

I want to shift gears again. Going back to your patient caregiver research partners. We talked a lot about the group being part of the intervention through the planning, feeding back to them, and I'm wondering, it's very clear how the research has benefited from their participation, and I'm wondering what are your perceptions of how they've benefited? What are they getting out of this? As best you can tell.

Liliana Ramirez-Gomez, MD:

I want to start by saying that actually this goes both ways, it's reciprocal. Because they help us, but we are helping them in a more meaningful way. That's what we all want to do with research. We really want to bring solutions, resources to our community, and when we really hear what they need and we realize that that's what we are doing or what we are not doing yet, that's where we find opportunities to improve. Also, because they really know, we say this, but they are the ones who know what they need, and as Hillary said, they wanted more resources and something that was counterintuitive, we thought maybe this is too much to navigate, but no, they are saying, please give me more. This happens not only in this trial but in others. I also work with other resources that we provide for care partners and caregivers of people living with dementia, and then they always ask for more. I think that's what we are offering them, the hope that we are really working with them towards making things better and specifically developing interventions, addressing issues that they need help with.

Hillary Lum, MD, PhD:

I think I'll also jump in here, Stacy, we haven't yet specifically asked. And I know we mentioned that we have a fourth meeting planned, and I think that it's important to incorporate an informal discussion of what has this experience been like, ask for feedback, and then from the community engaged research literature, there are also emerging tools. Those tools are not necessarily also culturally adapted or accessible in the same way to all different populations. A lot for us to continue to learn to do this well, to also hold ourselves accountable to what you're alluding to, that it really is a reciprocal relationship.

Stacy Fischer, MD:

Great. I think I want to end with a final point here, and I'd love to hear from each of you. If you had to distill it down to one takeaway, impression, or reflection from doing this work, I'm hoping that you could share that.

Laura Hanson, MD, MPH:

I'll just say that my takeaway is that I am never going to design a clinical trial again without this in mind. I have learned so much and think this is so important to the research work that we're doing. It will change how I design studies, and I hope it'll change how my colleagues design studies.

Stacy Fischer, MD:

Laura, as a leader in our field, I think your impact is really important as a mentor, as a leader, and I think you setting the tone and setting these expectations is really important.

Liliana Ramirez-Gomez, MD:

The importance of collaboration and the team. Like, really making the team diverse not only in terms of culture, language, all of that, but also disciplines, like this interdisciplinary research, it's very important. Diversity has so many meanings and includes a lot of things, and that applies to our team, our disciplines, what we study, and that only makes us better because we are all working together towards the same goal.

Stacy Fischer, MD:

I completely, it changes the conversation in the room. The conversations in the room when you have representation is just different, so I really appreciate that.

Hillary Lum, MD, PhD:

My takeaway is similar. As I have had the privilege to be part of this study, and then also seeing opportunities to integrate cultural adaptation intentionally into other work that we're doing, seeing how important it is to my team members where this work is so close to their own personal background and lived experience. From a mentorship perspective, seeing the opportunities then to be a support to allow more of a focus on things that are very passionate to individuals from historically underrepresented populations, sort of orienting the resources we have in the university to be more equitably distributed. I think just the takeaway of how consistent this work needs to be, and the intentionality required is important.

Stacy Fischer, MD:

Great, thank you so much for being here and letting me kind of sit down with you all and talk through some of this really important work. It's been a privilege.

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.