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Session: Dancing with the Devil You Know: Partnered Implementation Science Research

Presenters: Steven Asch, MD, MPH

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Molly: We are at the top of the hour, so I do want to introduce everyone. Speaking first we do have Dr. Deykin here. He is director emeritus, the former director of HSR&D and professor emeritus at Boston University School of Medicine and Public Health. And he will go ahead and make a few comments for us and kind of set the stage for how this award came about. So Dr. Deykin, I’ll turn it over to you now.

Dr. Daniel Deykin: Well, good afternoon everyone. I can't tell you how pleased and honored I am to be part of this award ceremony. It's now 25 years almost to the day when we decided that we wanted to initiate a program that recognized excellence in rising stars in HSR&D. Our motto was not really the career development award that was a medical career development award, something I had had in another world when I was doing biomedical investigation, but rather it was more modeled on the William T. Grant Career Development Award, which recognized excellence in that field of research that we would now call HSR&D.

And so from the beginning it was a program that recognized excellence in rising stars, but we also added something else, and that something else was another criterion that seemed very important to me. And that was not launching these young great rising stars without pairing them with mentors. It seemed to me that that's the best thing we could do for a rising star was to establish a liaison with someone who has already demonstrated his or her excellence and a passion for mentoring.   
  
So that was the start, and we had a very distinguished group of our first award. There were five. And I can't tell you how thrilling it has been to watch the evolution of this program into the kind of master program that it has turned into. And when I look at the accomplishments of those who have received this award, which is among the most wonderful things that has happened to me over my academic life, what can I only say? I'm swelling with gratitude over how this thing has happened.

And I want to congratulate Dr. Asch, and I can't wait to hear what Dancing With The Devil You Know has to say. So I’ll just say once again, congratulations. You've done everything that I had ever hoped for and so much more.

Molly: That's wonderful. Thank you, Dr. Deykin. Now I'd like to turn it over to Dr. Amy Kilbourne, the acting director for HSR&D and the director of QUERI. She will be providing Dr. Steve Asch’s introduction.

Dr. Amy Kilbourne: Great! Thanks so much. And thank you, Dr. Deykin. That was a wonderful introduction and context by which we do this award. And I'm really honored to also have the opportunity to introduce Dr. Asch, Steve, as the recipient of the Daniel Deykin Award for Outstanding Mentor. Steve is professor at Stanford in the general medical disciplines and vice chief for research and also directs the VA Palo Alto’s Center for Innovation to Implementation, Ci2i.

I just had to say he is internationally known for his work in quality measurement and has time to still be a practicing internist and a palliative care physician, and most importantly has mentored countless people in VA and beyond in the past, including yours truly, which I'm truly honored to be one of his mentees. So I’ll, without further ado, turn it over to you, Steve. And please tell us what it’s like to be Dancing With the Devil You Know. And we look forward to hearing your presentation.

Dr. Steven Asch: Well, thank you very much, Amy. Thank you. I, myself, am also honored to have been your mentor but especially honored to have received this award, Dr. Deykin. This is truly, truly a deep honor to get the award that bears your name.

So I have spent, as Amy mentioned, my career mostly in the VA but also in other big institutions, like universities and public hospitals. And I have mostly been a clinician. Almost all the good ideas I've had as a researcher have come there at the bedside, looking at a patient, asking what's that generalizable story that he or she represents? And how can we uncover some truth that will help patients like him or her?

And like a lot of you who are listening to me now, I've often found my gaze wandering past the bedside, past the institutional walls, and asking what about the delivery system, the doctors, the providers? The structure of the delivery system keeps that patient from getting what he needs. How can we change it for the better? And if we did, how much is particular to this place, the institution I know so well? And how much of it is generalizable or useful to other people?

So our own institutions are very familiar with us, and I think the cliché that familiarity sometimes breeds contempt does apply here. But I've often thought maybe better the devil you know than the devil you don't because our own institutions are what we know best, and that is why we should know how to change them. Maybe we can't change income inequality. Maybe we can't change the effects that income and inequality has on health. But we should be able to figure out how to get patients with pneumonia the antibiotics that they need.

We should be able to build a better mousetrap, organizationally speaking that is. And so what I'm going to argue today, in the next 45 minutes or so, is that we should embrace this motivation, which all of us feel as researchers, if we’re clinicians, as trainees to engage in a little institutional home improvement. And as researchers, that process is subject to the same scientific methods and challenges that any other kind of health services research is. And really that's what we mean by implementation science. So this is an award speech for mentoring. And so I hope you'll indulge me that on the way to that goal I would like to honor my own mentors and tell you just a little bit about my journey to dancing with the devil that I know.

So my journey, if you could go the next slide. There you go. My journey, of course, starts when I was a kid. This is my dad. He was a surgeon. He told me I could be anything I wanted to be when I grow up as long as it was a surgeon. And I cannot confirm or deny that he took me to the operating room one day and that I had to leave because I was a little too busy to keep watching. But I can say that he did inspire me and probably was my first mentor because he worked at a county hospital, and he was very devoted to making sure that people there got the care that they needed. And I've only done one project in my whole life with my dad. And it was a photo essay about that hospital, called Harbor Hospital in Los Angeles. And you'll see a few pictures, like this one that he took, in the photo essay I wrote the words for. Next slide.

Other than my dad, my first mentor is one who I never met. As an undergraduate I was very interested in philosophy and the social sciences and this guy was one of my intellectual heroes. He wrote, Thomas Kuhn, he wrote The Structure of Scientific Revolutions. He’s the guy who made the word paradigm shift famous. And at the core of his ideas is that all scientific inquiry is socially constructed.

What does that mean? It means that why there might be such a thing as objective truth, the right answer, or in the case of quality measurement, the right way to provide medical care, say. Our approach is inevitably and inescapably conditioned by the social and the intellectual currents that we swim in. Importantly, he presents this essentially in a value neutral way. Not that it’s a failure to think objectively but rather that it's just inevitable.

This interest in social conditions and medical care blossomed in residency and fellowship. And I really had these two people to thank for that, my mentors then. Both of them were committed to eliminating access barriers for our most vulnerable patients. So it kind of echoed my first experiences with my dad at the county hospital. Howard Waitzkin taught me that you can combine advocacy and research, and Lillian Gelberg taught me how.

Access to care is the big policy focus these days in the VA. That's where I started my career. And my hope then was that highlighting poor access should motivate governmental policies to improve access. I'm afraid a lot of times I'm still hoping.

This is one study from back then. I thought how better to motivate people to see that the health of all of us depends on the access to care of the most vulnerable of us than to study an infectious disease? TB bugs don't know your insurance status when somebody coughs next to you. So we surveyed all the TB patients in Los Angeles one year and asked those who delayed seeking care long enough to spread the disease, what was access problems that they faced? And one thing that really jumped out at us was that immigrants, who are afraid that the federal government might deport them, were four times more likely to delay that long, long enough to spread the disease.

I’ll tell you, I am reminded of the study more and more when I read the newspapers these days. And that’s not only because of the current rise in anti-immigrant sentiment, but because that was my first encounter with seeing work that I was involved with reported in the lay press. Though the data had been collected a long time before, the study actually came out just a few weeks before California voter Proposition 187 that would have required doctors to report immigrants to authorities. And Andy Warhol says everybody gets 15 minutes of fame, so I guess that was my first 15 minutes. Suddenly everybody wanted to talk to me. There's an L.A. Times headline on the slide. And the Republican governor then, who supported the proposition, said the study was politically motivated. And ironically, so did the ACLU, said that it overemphasized the risk of TB in immigrants. And the proposition passed. Even though honestly I thought that data should have supported the other way.

And I began to wonder then if studies of access were really going to change things. Maybe the target of societal policy was too broad, and it was better to focus on what my competitive advantage as a clinician and a physician researcher would be, not how best to deliver care or quality. So I began to shift from measuring access to measuring quality. Once patients got in the door of the medical system, did they get the right care?

And these two mentors really helped me out there. Bob Brook and Beth McGlynn were and still are very much in the forefront of how best to measure quality. And with Beth and Eve Kerr and a lot of other people, we built a really broad measure of quality of care. We called it QA Tools. QA Tools covered 30 conditions and a large proportion of the reasons that people seek care, more than half that, a lot of very clinically detailed indicators, just bread and butter stuff, like do you get a beta blocker after a heart attack?

We had 45 experts, five expert panels, [xxxx 12:45] indicators. We did a nation wide data collection with interviews and medical record abstraction, nationally representative sample. And it was very widely reported at the time.

And we found widespread problems. Overall, people were only getting half of recommended care. So I thought, here's my chance, my chance to do the definitive study of disparities, the same vulnerable groups that led me to health services research. So I couldn't wait to see how quality varied by income. So it was great to find out that poor people were getting worse care overall, of course not so great for the poor people who are so affected. But when I looked at these data closely, I began to realize that the real message was something different. The differences between groups were statistically significant, but they’re pretty small.

Here’s a slide where I just changed the Y axis to make the differences look better, make me feel better. But really it’s like it was on previous slide. Next slide.

So I think I was just fooling my myself. To paraphrase Obi-Wan Kenobi, these are not the disparities I was looking for. In this broad measure of quality, disparities between race and income groups pale before the disparities between the current state and what we would all hope everybody would get. This isn't to say that other studies that looked at specific conditions or procedures were wrong when they found disparities. It's just when you look at the really, really big picture, the differences were smaller. In particular, the differences seemed to be concentrated in high-cost procedures mostly.

Similarly, it’s not to say that there weren't access problems, that the previous studies had got the access problems wrong. It's just that once you’re in the system, once you're in the door, basic medical care didn't seem to depend that much on race or income. So this study also got a lot of press. And I was actually kind of bummed out by the press. For instance, a right wing think tank used data that we have published to justify restricting public insurance subsidies to the poor, which is of course not how I would have interpreted it.

So again, I began to think maybe the focus was wrong. Rather than trying to influence policy to promote quality, maybe I should think closer to home and focus instead on the delivery system itself, the devil you know. That’s the dance I mentioned in the first slide. I started working with operational leaders in the VA, the national, the VISNs, the facility levels to see if we could get this health services research being used.

So I apologize to people who are cat fans or have heard this slide before, and some people might have. But around this time I do want to tell a story that happened regarding the cat. After a long meeting in which we health services researchers, including myself, had presented our results to this VA policy maker, who I guess will remain nameless. He pulled me aside and he said, do you have a cat? I said, yes. He said does your cat ever bring you dead mice as presents and leave them at the front door? I said, unfortunately, yes. He asked, doesn’t the cat seem really proud when he gives it to you? I said, yes, getting increasingly concerned, honestly. But you really don’t want that mouse, do you? No. No I don’t. Well, listen, he said, and the little bit tipsy, you researchers are like the cat and the research you do is like the mouse. You seem really proud of it. But I have no idea what to do with it.

Needless to say, this bit of honesty was transformative to me. And I resolved then, and I still stand by this, that I would endeavor to produce no more dead mouse research. And two people who helped me think about how not to produce dead mouse research are here on this slide. A lot of philosophers have thought about what is this gap between the people who use research and the people who produce it? Lisa Rubenstein is definitely a philosopher and a mentor of mine. So was Paolo Freire, the guy who’s in the picture on the right, who was a politician and an educator in Brazil in the '70s. And both of them, both Lisa and Paolo, deplored the idea that the student or the object of the research was somehow an empty vessel to be filled by this newly created knowledge. And he urged instead that the relationship be viewed much more as a two-way street. He talked a lot about the dialectic of contending needs and how that dialectic would produce a higher and more relevant truth, one that would result in social change, Paolo Freire did.

So where is this disconnect between my dinner party partner, the health services skeptic who was an operational leader and health services researchers like all of us? I think one disconnect is around how fast the results of the study will be available. Our partners want the results soon so they can make the decisions they need and by which they mean usually months, not years. And we researchers want our own conclusions to be robust. And we want longer.

The second dimension is rigor or certainty. The partners have to make decision right away. And they just want to make sure they're going in the right direction. While we, ourselves, want to make sure, the researchers, that anything that we say is definitely right, even if that means that we can't say anything for a little while.

The third dimension is generalizability. The partners tend to target their inquiries to very specific operational concerns, to the devil they know, their own situation. They usually don't care too much about implications for other similar organizations. But, of course, we researchers aren't consultants. We want to produce generalizable knowledge. And we want to control our own lines of inquiry.

So to resolve these differences, I think you have to think about the problem differently. So instead of a disconnect, I think of it more like a dance. That’s the title of the talk and where the fiscal might suggest, a dance that balances service and our objectivity, timeliness and rigor, and relevance and generalizability. And each of these dichotomous elements are really contained in the other.

So what are the theories that might accommodate those? A lot of people who will recognize this cartoon of one theory that Minkler and Wallerstein came up with. This is community based participatory research. They were the first to apply it to health. And they promoted it at the CBC. If you scrutinize the contents of these bubbles, though, what you won't find is the delivery system or at least not the delivery system in the way that we think of it. And yet for us health services researchers, I've been arguing that that's the place where we can make the most difference, the devil we know. So we have to view the healthcare system as a community itself. And that is I think where implementation science can help.

So here’s how the VA tried to meld implementation of, there you go. Here's how the VA tried to meld implementation science with partner-based research into a sort of a pipeline. And this is an old cartoon, but I think it'll work for this talk. The idea is that the operational partner is involved in all the stages from identifying the research area to identifying best practice and assessing current practice. The partner and the researchers engage in a dialogue for implementing an intervention to improve the current practice. It also incorporates the idea that you need to start small with pilot projects and move to small scale demonstrations and then to regional demonstrations and national rollouts finally.

And in this last part of the talk I'm going to try and follow one research stream through this pipeline as an example. But before I do so, I just want to make sure that we don’t stay too high in concept and theory and just say that there has been lots of work. And some of the people who are on the phone I'm sure have participated in some of this work that are examples of projects that really had made it all the way through the pipeline.

These are just a few non-VA examples. The work that Peter Pronovost has famously done in checklists to reduce nosocomial infections started out on the left-hand part of that pipeline and is now widely applied throughout the country. Atul Gawande even wrote a book describing it, The Checklist Manifesto. There’s been a lot of work in order sets to reduce ICU mortality. The SCAN-ECHO program in the VA was based on the ECHO program described in the New England Journal by Sanjeev Arora in 2011, another project that is now literally being internationally disseminated. So things can make it from the beginning to the end and be very delivery system specific. And all of them, the examples I gave you, have been translated into the VA in one way or another.

But the VA project that I want to tell you about is one of the foundational projects of the QUERI, formally know as HIV/HEP. As almost everybody on this call is going to know, especially Amy, the QUERI has taken this partner-based research idea and implementation in science idea in the VA to the next level. Our QUERI was focused, this QUERI which has since changed its name, was focused on improving HIV care.

So here’s another dancing lesson. As the Minkler model suggested, it’s rare that a single partner is going to be enough in getting a project through the entire pipeline of dissemination and implementation. So we did not have a monogamous relationship with public health, the part of the VA that was most concerned with HIV. Well, I guess you’d call them our main squeeze or something like that. We also needed to reach out to lots of other entities. And here's just a short list of them within the VA to improve HIV care. You can see groups like the VISNs or provider groups or information technology and lots of others.

Here’s another dancing lesson. You have to understand where your partner is if you're going to, within the organization if you’re going to be able to best work with them to develop this implementation science research agenda. This is the then-current big org chart. You can see it was signed by Petzel. And you can see in yellow where our main partner, public health, was. So there was then and still is, although it’s eroding, a big divide between policy and operations. And our partner was very much on the policy side and so had little direct control over operations. And any work we had to do was going to have to inform policy if it was going to help them. And we couldn’t depend on them for entrée to any actual clinical care but had to cultivate other boxes in this big diagram.

So the first thing we did together with public health and other partners was to identify our research area, to ask what the best practice should be and assess existing practices against that standard. That’s straight up traditional health services research.

And this is what we knew then. This is how clinical public health and we thought. We saw the HIV treatment had changed. It had become a chronic illness rather than a death sentence. And the benefits of early diagnosis were very firmly established. Early identification was reducing mortality, keeping people out of the hospital, encourage the reduction of risk behavior and thus prevented further transmissions.

And despite that, then, and despite national guidelines that recommended offering HIV testing to everybody, a lot of people just didn't know what their risk factors were, sorry, what their risk status was. Over 20% of the 1.2 million people then were unaware of their status. And it seemed the same in the VA when we did studies. And even though screening and testing was a high priority for the VA, those studies that public health and we did showed there was a lot of lack of compliance and a lot of late stage diagnosis.

We did a study to show that it was also cost effective by those traditional measures of cost effectiveness. So why? Again, thinking of ourselves in the early part of that pipeline, we did a provider survey asking what the impediments to HIV testing in the VA were and we found some barriers. Most of these barriers in implementation science terms would be called intercontext [inaudible 27:51] categorization. Organizational barriers, like then you needed written informed consent, pretest counseling. The providers felt like this was taking up too much time, that they weren’t sure what to do if they actually diagnosed somebody with HIV. They were afraid that they would not have the ability to refer them for further care. Or provider behaviors, like not being willing to talk about the stigmatized HIV risk factors, the sex, drugs, and rock and roll problem. Or relying instead on a completely separate cadre of trained counselors to order the HIV test rather than just have your primary care doctor do it. Or feeling like their patients didn’t need it, that it was a low priority.

So at this point we were ready to begin the next stage in the pipeline in design and intervention and pilot test it and then roll it out to a few sites. And this is, again, another dancing lesson. Each of these interventions...

Molly: Steve? I’m sorry to interrupt. We actually have a clarification question, so I did want to ask you before we move on. A lot of noncompliance and early testing of veterans. Can you please clarify the meaning of noncompliance on the last slide?

Dr. Steven Asch: Could you go back one? One more. So I’m not 100% sure I understand the question. What was happening is that people weren’t getting HIV tested.

Molly: So I think it was just one more before this is when the question came in.

Dr. Steven Asch: Okay.

Molly: So they were looking for what does noncompliance mean on this?

Dr. Steven Asch: [Inaudible 29:48]. Well, I’m just going to do my best to answer the question. What I was trying to make the point of is that people were, when I was talking about provider's actions is that they were not offering the test and patients weren’t receiving the tests when they needed the test. And that was despite the fact that it was pretty clear that it was both cost effective and effective. That’s my best answer. Let’s keep going.

Molly: Thank you.

Dr. Steven Asch: So another dancing lesson, if you will, is that if you’re going to work with the delivery system, you’re going to have to make sure that the interventions that you have are directed at the organizational barriers that you’ve identified. And sometimes that means it’s going to be a big suite of them. And that’s what we did.

So we tried to address the organizational barriers through digitizing written consent. Eventually it was eliminated. Streamlining the counseling. We tried to address the provider prioritization problem by activating providers through academic detailing and social marketing. And we tried to give some feedback to them as to how they’re doing by feeding back clinic level HIV testing rate. And we used the information technology to support that decision with clinical reminders for at-risk patients, patients who the reminder had identified as having a risk factor for HIV.

This is just an example of that clinical reminder. So we’ve taken back because it doesn’t really look like that anymore. Next slide.

And again, I want to point out that it wasn’t like QUERI-HIV did all of this. We had to do it as part of the delivery system itself. And we had to, for instance, split up the tasks and this was just some of the tasks that we split up. So when we had to present to regional or local leadership to try and get the program that I was just describing implemented, mostly we did it, because I told you that the public health people actually had very little direct contact with the delivery system itself.

When we tried to promote the installation of the reminder, we couldn’t really do it ourselves. But it turns out that the policy people did have an entrée. And two of them we worked with, a combination of the National IT and public health people and so on. So the very researchy stuff, like IRB submission, we did. The provider activation, we developed the tools, but then those local partners themselves had to actually do it. And so it’s very important, I believe, in developing this kind of research to clarify the role that you and your partner are going to have in getting the program pushed out there.

Here’s another part of the intervention. There are pocket cards and overview sheets and posters and pamphlets that we developed and were handed out at the sites. It’s actually very similar in some ways, the top card anyway, to the checklist stuff that Pronovost was working on at the same time.

Here’s an example of the quarterly feedback that the clinics got on their rate of HIV testing and their rate of clinical reminders. We didn’t tell any individual site how the other sites were doing. So they didn't, they knew they were Site B, but they didn’t know who Site A and K, etc., were. But it gave them a sense as to what was possible.

Did it work? Yes! It worked! In this diagram, healthcare System A was the pilot site and it was rolled out to other sites, B and C and E, in different years. And you can see that there was a two-fold increase in aggregate HIV testing rate. And then the control Site D, not much change at all. So we’re very pleased with this initial regional rollout.

Now we were ready for a larger regional rollout, what you would call a Phase III trial, where we were going to take it from just our local region to multiple other regions as well. And this is what we thought the Phase III trials should look like. We thought we should attest the generalizability of intervention with, to the VA, to other VA facilities that had very different structural characteristics. And we were wondering to what extent provider activation, the academic detailing and social marketing campaign was really necessary because that was pretty labor intensive. And so we randomized the facilities to either receive extensive central support versus modest support for this provider activation campaign. And we built the whole thing around the idea that first we’d have to figure out who’s at risk for HIV. And then if they were at risk, we would test them. This all seemed great to us until life took a little detour, like it often does.

Right after the project was funded and launched, the VA HIV testing policy changed. And that’s because the world changed. Instead of written informed consent, verbal agreement was thought to be enough. And you didn’t have to do pre- and post test counseling anymore. And instead of risk-based testing, everybody should be offered testing. So a lot of the barriers that the intervention was aimed at just disappeared. And even the target population disappeared. If this were a clinical trial, we would have had to just stop it. But it wasn’t a clinical trial. This was partner-based research. So instead, we adjusted.

We decided to focus on the remaining barriers and to look at at-risk patients, to look at all patients, sorry, in addition to at-risk patients. And it worked. You can see that we found that, again, testing was increased. And we also found that this implementation process of keeping things central and having that intensive academic detailing approach, which we called central implementation, worked better. The increase in testing was around 158% versus 78%. And that was the argument that we made to the public health people. We doing on time? Pretty good? Alright.

So at this point we were ready. We were ready for policy and national rollout. And I’m not going to talk about that too much because it happened, actually, after the handoff to the policy and operations part of the VA. But I will say that I’m very gratified because what happened was a relatively widespread increase in HIV testing throughout the VA so that the numbers that we saw in our intervention group are now fairly typical for the VA overall.

This idea of a dance that isn’t necessarily going to go very smoothly for partnered research with the delivery system I’ve encountered over and over again. And a lot of times I’ve encountered it with the mentees that I’ve spent so much time working with and been honored to help out. I just thought I’d very briefly talk about three other ones.

So, for instance, with Donna Zulman, we were working on a VA project to try and improve care for multimorbid patients. And in the middle of the trial that we had designed, it became very clear that the participants wanted to be able to refer patients rather than simply randomize them to either get this program to help these so-called high-need, high-cost patients. And again, if this were traditional research, that would be a big no-no. But we actually thought that it would be a good idea to accommodate. And so what we did is we put a cap on the number of referred patients and built an analytic structure that would accommodate it.

Similarly with Anita Vashi, we were, we’d been evaluating the VA Lean program, and right in the middle of it the leadership changed and the national rollout strategy changed. But we were able to adapt the evaluation program to learn lessons that would still be useful to the Lean project and probably to other projects that are trying to improve access to the VA. Another project I was working on with the Cancer Center, they shifted the intervention from nurse coordinators to patient navigators in the middle. And that’s pretty difficult to accommodate, but we were able to do so by using the same outcome structure and just noting with a lot of precision when the changes occurred so that we transformed it into an interrupted time period.

So the lesson here I hope that you’re seeing, not just from the longer story that I told you but these very mini stories, is that you have to adjust to your partner's moves if you really want to learn in partnered research.

And speaking of mentees, I would just like to end my talk by expressing deep, deep gratitude to the many, many people that I have been privileged to help out along their career. And I imagine that I’ve left one or two of them out on this list and it’s not because I wanted to. And I feel like the thing that I enjoy the most, personally in my career, is being able to work with mentees to help them figure out what they want to study, what they are interested in, whether that be partner-based implementation science or anything else.

Next slide. Wow. That was an animation I didn’t know was there. But I’m glad that we’re spinning because you can see some of the pictures of the people that I just feel the most deep gratitude to have been able to work with over the many years. And I look at each one of their faces and think about the great discussions that we’ve had along the lines that I’ve been describing.

So what are the lessons from dancing with the devil you know? Perhaps most importantly, pick your research topic to where you can make the most difference. I quickly came to the conclusion that the kind of policy-oriented access work I was doing was just not affecting the changes that I’d hoped. And that shifted something that I feel very, very comfortable with and glad that I did over the many years since.

Second, if you’re going to do partner-based research, you have to have a structure for doing so. You have to build the research enterprise so the partners by relationship planning and programmatic funding, like QUERI. That made an enormous difference to the work that I’ve done. And that that kind of research is how we’re going to avoid dead mouse research. And finally, and perhaps most importantly, don’t think you’re making a choice between truth and relevance, between doing research and doing quality improvement or something applied. I think we can serve both masters. Next slide.

So I’ll probably end with this quote from Louis Pasteur, who of course not only helped us establish the germ theory of disease but applied that germ theory of disease to the process of pasteurization that has saved so many lives. And he said, “To that person who devotes his life to science, nothing can give more happiness than increasing the number of discoveries. But his cup of joy is full when the results of his studies immediately find practical applications.” That’s where I think the future of health services research lies. Thank you very much. I’m happy to take questions.

Molly: Thank you very much. So we do have some pending questions. And for any of you who joined us after the top of the hour and are looking for a way to submit your questions or comments, just use the control panel on the right-hand side of your screen. Click the orange arrow if you need to expand it. And then down at the bottom you’ll see a question section. If you just click the arrow next to the word questions, that’ll open up the dialogue box and you can submit your questions or comments there. And we’ll get right into it.

The first person writes most of us believe that patients are full members of the care team. Have you partnered with and/or mentored any patient leaders?

Dr. Steven Asch: So I think almost all implementation scientists these days would say that you need patient input. And our own center, the Center for Innovation to Implementation, has a patient advisory committee. And we vet every single one of our projects with this panel of patients. So I don’t think it’s a choice between partnering with the delivery system and partnering with patients but rather a community. And I would encourage everybody to find this patient input. The hazard, of course, is that patients can tell you why you do the research, can even tell you how the research might be useful, but they have a lot of trouble advising you on how to construct the research or how to measure the outcomes. So it’s important to make sure that everybody is playing to their competitive strength there.

Molly: Thank you. Where do you suggest publishing implementation research as journal often do no see this as “real research”?

Dr. Steven Asch: I think that the world has changed greatly in that regard. I’ve seen implementation science research in the most prestigious journals. The New England Journal of Medicine published Peter Pronovost’s work. They published Sanjeev Arora’s work, which is clearly implementation science. That being said, I’m not saying that there aren’t reviewers that are still worried about the “squishiness” of implementation science. Of course there are venues that are deliberately focused on implementation science that’s not exclusively the journal which has the name of the field itself in its title, implementation science.

I’m the incoming editor for the Journal of General Internal Medicine. And one of our goals is to increase the number of implementation science articles that we’re going to publish. So I think that fear, while not completely unjustified, has been fading away. And even the funders have recognized that. The proportion of NIH funding going to implementation science has increased. Amy oversees, when she’s wearing her QUERI hat, one of the largest implementation science funding efforts in the country. So I’m actually optimistic in answering that question.

Molly: Thank you. Can you comment on the challenges you might have faced with getting IRB approval for some of this work at the VA?

Dr. Steven Asch: Yeah. It’s an interesting problem. And actually this one I don’t think has been completely resolved, although there has been a lot of progress in recent years. So first of all, the first problem is when is it quality improvement and when is it research and should you apply the same research protections that you would apply to a randomized controlled trial of some dangerous drug? And there have been, I’m forgetting the name of the first author, but there have guidelines published on how to decide whether something is quality improvement or research. And it doesn’t mean that if it’s determined to be quality improvement that you can’t publish it. It just means that it’s not subject to research regulations.

And often our IRB here locally will give projects that are clearly focused on improving the work at our own institution what’s called an NRD or non-research determination. That doesn’t excuse you from using rigorous methods, which is one of the things that I always emphasize to mentees. Just because the IRB has said that it’s not subject to research regulation doesn’t mean you can’t borrow research methods to make sure you understand what the right thing to do is.

For instance, we’ve had projects that had a random selection of patients to first get an intervention because there weren’t enough resources for everyone to get the intervention right away. And once the delivery system made that choice, then we were able to analyze it as if it were a randomized control trial and still have it be called quality improvement as long as the choice was clearly and firmly in the hands of the people who were doing the intervention rather than for us as evaluators. So again, the world is changing. The world is changing in the direction that I think it should so that it becomes easier and easier for IRBs to accommodate these sorts of investigations. .

Molly: Thank you. The next question, which phase of the implementation research can be written as fundable grant proposal?

Dr. Steven Asch: [Inaudible 48:28] know. So can people still see the screen?

Molly: We can.

Dr. Steven Asch: Ok, in the, yes, could you go back [inaudible 48:38]. So just going back to this [inaudible 48:41]. There we go. Just going back to this pipeline. First of all, I have to say that even though I used this for the ease of exposition, I actually don’t view it as a pipeline because the arrows really aren’t in one direction here. I think the research actually can curl back on itself so that implementation work can inform best practices, etc. But the question is what is the easiest place in this pipeline to get funding inside the VA. The traditional HSR stuff, which you see in the white boxes here, I think has a good funding stream from the HSR&D office. But they’ve also become increasingly interested in the implementation research blue box stuff. I find that the pilot projects are a little bit harder to get funded from HSR&D and that it’s better to wait until you’re able to do a small scale demonstration or even a regional demonstration if you’re looking for IR funding from HSR&D. And of course, the QUERI programs themselves are funding quite a lot of evaluations of these Phase III and even Phase IV efforts.

Outside of the VA, which I think is one of the friendliest funders for implementation science, the NIH has become increasingly friendly to doing so. I always point out NIMH as one of the leaders, also NINR, the nursing research people. And of course HRQ, in the past and hopefully still in the future, was a great funder of implementation science. So my own take is the very small pilot projects, it’s best to get your institution to get you over that hump. And that once you get to Phase II and Phase III, you can go out there in the wide world of federal funding and get it funded.

Molly: Thank you. The next question, I am on the operations side of the equation. I found your presentation enormously enlightening. How do implementation scientists socialize their operational partners to the existence of the inevitable tensions as a normative experience or process?

Dr. Steven Asch: I really love that question. I’m not sure it needs to be socialized. That’s for the operational partners. I think, as I was trying to point out, I think it’s actually a partnership and a dance and that’s how you do it. You have to pay a lot of attention to relationship building in the beginning. So my own experience, and then perhaps the questioner will agree, is that operational partners frequently are distracted by emergencies that the policy apparatus imposes upon the federal bureaucracy.

And then one of the ways in which we can prove our worth is to, sort of as sounding boards, or sometimes even produce very quick and dirty answers and then that builds the trust. But then the trust has to go both ways. And the way that you can build that trust is to have honest conversations about what is still going to be interesting 18 months or two years from now? What is the big problem that we need a real study to try and figure out? And that no matter what the political currents we’re swimming in, how they will buffet us, that this is still something that we care about.

So access to care, we’re going to care about it for the foreseeable future. How to manage or coordinate care outside the VA? We’re going to care about it for the foreseeable future. What is the right way to take care of high-need, high-cost patients? That’s a problem that’s facing the VA and every other delivery system. So one of the ways in which, and I hesitate to use the word socialization, but one of the ways in which that relationship can be built is to be explicit about what is the things that are really kind of deep and long term. And yet understand that we’re still going to have to respond to short-term stuff, too.

Molly: Thank you. That is the final pending question at this time. Many people did write in to thank you for the great presentation. I do want to give you the final say, Dr. Asch. But first I’d like to check in with Drs. Kilbourne and Deykin and see if either of you have anything you’d like to wrap up with, the final words on implementation.

Dr. Daniel Deykin: Sure. This is Dan Deykin speaking. Way back when in 1995, I had the opportunity to serve as an advisor to the newly formed Health Services Research Department and the National Health Service in Britain. And it became immediately apparent that the interaction between the funders, i.e., the National Health Service, and the clinical world was one that was very similar to the bag of stovepipes that you showed. And it became very clear to us that we had to pay a great deal of attention to the influences that the political world and the funding world are under.

It’s important to understand the press input, the political input, and the interaction then with the research department. Because what you want to avoid is an office somewhere with large volumes of research results that have been presented to people who are no longer there and questions no longer relevant. And I think your emphasis on a dynamism, if that's the word, and the interaction with the funders is crucial. And being able to shift quickly while retaining relevance and rigor is a real problem. It’s more a tango than a two step. And that relationship is one that requires trust from the funders to HSR&D.

Give an example. One day, this was when we first started the technology improvement question, a paper was presented that one of the teaching hospitals, one of the teaching VA hospitals had worse outcomes in certain areas than at other hospitals. And there was a congressional hearing. I think Waxman was the person involved. And it was clear that the results had not been stratified. So in the middle of a Christmas vacation I got a call from the top floors. Do something. And so we had to scramble to create a system that could rapidly respond with rigor to the kinds of things that happen in Washington, particularly the deadliest thing, which is a congressional letter, which distracts you from everything.

I think you’re onto something, which is this ability to shift quickly while maintaining the overview of your question that you’re trying to solve. It’s very important to maintain relevance. And I just congratulate you on the success that you’ve done. I think it’s terrific.

Dr. Steven Asch: Thank you so much.

Molly: Thank you. Dr. Kilbourne, did you want to wrap up with any final thoughts?

Dr. Kilbourne: No. I just want to thank Steve for a great presentation. And it’s great to hear from Dan Deykin as well and your perspectives over the years. So just fabulous work and keep it up.

Dr. Daniel Deykin: My pleasure.

Molly: Steve, what would you like to wrap up with?

Dr. Steven Asch: I think I already have in the sense that I would just like to, again, express my deep gratitude to the VA, to my mentors, but especially the many mentees that I’ve had the honor of working with and even the ones that we’ve been helping here with the CDA enhancement program around the country. That’s the thing that makes me want to come to work every day. And I hope to continue it for the foreseeable future. And I’m grateful for the award.

Molly: Excellent. Well, thank you so much for coming on and sharing your expertise with the field and congratulations again. And a huge thanks to Drs. Kilbourne and Deykin for joining us on the call. It really adds a lot and gives us some grand perspective.

So thank you, once again, everybody. This is the final moments of our HSR&D Cyberseminar for today. This has been recorded. You will receive a follow-up email with a link leading to the recording, so feel free to pass it on to your colleagues. Thanks once again, everybody. Have a great rest of the day!

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