

IMPACT Grand Rounds 15 – Update on Two IMPACT Funded Pilot Studies (Forester + Hwang)

Jill Harrison, PhD:

Hi, this is Jill Harrison, executive director of the National Institute on Aging (NIA) 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.

Vince Mor, PhD:

Good morning, everyone. Thanks very much for Ula and Brent for being involved in our grand rounds. It was really wonderful. There were a lot of great questions and responses, and I think people learned an awful lot. For our time together for this post-grand rounds event, I thought I'd ask some of the questions for you, then you could actually expand on your answers.

And Ula Hwang, Dr. Hwang, I'd like to start with you. For the people as part of your pilot who are seen in the ED and who get admitted to the hospital, how does this ED referral, does any of that information get transferred up or is there a great barrier? How does that work and how do you think about it working?

Ula Hwang, MD, MPH:

So these are all great questions about the patients that might be admitted. For now with our pilot, we are targeting those that'll be discharged with the anticipation and the hope that if patients are admitted, the team caring for them as part of their hospital admission will recognize and potentially refer these patients.

But we haven't set that up yet. We think that those that are being discharged are the more vulnerable patients because we are not necessarily sure that they're going to have follow-up and what kind of care. And so our hope is to explore that.

Vince Mor, PhD:

How does, for the outpatient referrals, do you anticipate any complications about people actually making it to the outpatient setting where you're hoping that they'll get evaluated?

Ula Hwang, MD, MPH:

Yeah, actually we do. We do anticipate several referrals. So we haven't quite launched our study yet. We started doing the referrals two weeks ago, and the plan is to follow up with them at one month, so at four to six weeks and then again at three months to see reasons why they may or may not make it to the outpatient referral. We anticipate that a large portion may not go for reasons that we can't anticipate, but we project potentially they might forget.

They may not want to go because they may feel like, "Well, I don't have any problems and at this point I..." So maybe a little bit of the stigma that sometimes can come associated with you have memory or thinking problems, and they don't want to really delve into that further. And there could also just be very basic logistical reasons that they weren't able to schedule the appointment, there were challenges with their schedule, challenges with the outpatient schedule, that might be a main one. Or just their ability to get to these appointments. So this pilot, as much as we are the implementation arm, we really

hope to explore reasons why patients may not receive the full intervention and carry through with it all so that we can augment it and make it even more effective with the actual hopefully future study.

Vince Mor, PhD:

Great. Yeah, that's the question I was going to ask you. So you can imagine this as being somewhat iterative in process?

Ula Hwang, MD, MPH:

Absolutely.

Vince Mor, PhD:

Great. Great. For Brent, Dr. Forester. So, many of the other pilots and many people doing these kinds of studies where you're in many senses relying on both the patient who's living with dementia as well as a caregiver who's on that, how in your process did you overcome the challenge of identifying and selecting who's the right caregiver? How is that working out for you?

Brent Forester, MD, MSc:

Thanks for the question, Vince, and for the opportunity to be here today. So, we have a multi-step process for identifying the caregivers. One of the challenges that we noticed immediately is that the information about who the actual caregiver is, is not always readily identifiable in the electronic medical record (EMR). And even if a caregiver is mentioned or a next of kin is mentioned, it's not really clear if that person is actually serving in the role as a caregiver or care partner for the person living with dementia.

So what we try to do at the next level is really ask the nurse care manager, who already has an established relationship with the patient living with dementia because they've been assigned to their care team within this integrated care management program sometimes for the past number of months, sometimes for years. The care manager already knows the person and they know their family situation and their caregiver situation.

So we try to help them identify who the person is who's both the healthcare proxy and has been the person that they would turn to if there was a medical crisis for substituted decision-making. And also make sure that that person is familiar with the day-to-day life of the person living with dementia so that they can accurately respond to questions around, not only the person living with dementia, their own challenges and needs, safety concerns, quality of life issues and so forth, but also can respond to questions about their own degree of caregiver stress and burden, because that's one of the outcomes that we're really interested in impacting.

Vince Mor, PhD:

Great. Thank you very much. So, I also wanted to ask you to discuss, I mean, it sounds like there are adaptations that you've actually begun thinking about in your particular environment, but more generally, tell us a bit more about other adaptations you made prior to and during the early part of implementation of the Care Eco intervention, which is well established and understood. How did you actually identify what needed to be adapted, how to adapt it, and what kind of input did you get from folks that you were participating with?

Brent Forester, MD, MSc:

So I'll start with the beginning, which was that when we decided to adapt the Care Eco model, the first thing was we decided to adapt it for a different type of sort of primary person delivering the intervention. So in the original model, the person delivering the intervention was a non-clinician healthcare navigator, and all the training modules and protocols were developed with someone without clinical training.

And what we decided to do in developing our protocol was to use an already existing nurse care manager who is part of an integrated care management program within our healthcare system at Mass General Brigham. And those nurses are deployed in multiple practices or singular practices depending on the size of the practice, and have already been assigned to care for a cohort of up to 200 individuals who are high-risk, high-need patients who are quite costly, in and out of hospitals and EDs.

So we decided that the nurse care manager would be an ideal person because a certain percent of their cohort would have individuals living with dementia, and these nurses may not have had specialized training, certainly not the kind of training that the Care Eco system model provides. So the first thing that we did was we engaged a group of nurse leaders within our system who were familiar with the nurse care manager program and obviously very familiar with what a nurse is trained or not trained to do.

And we actually had a series of three meetings via Zoom technology to speak with these nurses and get direct feedback with them about the protocols and the training tools that had already been developed by the Care Eco folks. We got their input on really having a series of these conversations, and we specifically edited the training PowerPoint slides and what we called the asynchronous lectures that we gave to them that the nurses could then view on demand.

And then we also asked them to help adapt the protocols, the assessment tools that the nurses would be using to make sure that they were specific for the level of education of somebody with healthcare training as a nurse, but not necessarily dementia-specific training. So that was the first major adaptation was the training program itself.

The second big thing that we've been doing in terms of an adaptation along the way is responding to specific feedback by the nurses once they've been trained, responding to their feedback in terms of the implementation of the actual model and the modules and the protocols that they're utilizing to collect information about persons living with dementia and the impact this is having on caregivers. And the way we're doing that is we set up a weekly, we're calling it office hours, but essentially it's like clinical supervision rounds. And there are two parts to it.

There are operational issues that come up and there are clinical issues that come up. And that's been really incredibly effective and eye-opening and illuminating. So the feedback that we've been getting from the nurses, first of all, their degree of engagement and excitement in doing this has been remarkable for us to see. We have a very engaged group. But also their insights into what's working and what's not working have been incredibly helpful and we've been modifying our intervention, our protocol as we go along and get feedback.

So the first sort of big feedback we got is, "You all gave us great information, but it was way too much and it was done over a very short period of time, and so when you train the next wave of nurses, you really need to adapt that." So that's been really helpful feedback. But for their own operational intervention right now, there were two issues that we really had to overcome. One was we didn't really give them a step-by-step, "Do this A, B, C, D, E, and follow this protocol." We basically gave them a lot of tools and said, "Have at it."

And so we have become a lot more prescriptive in terms of step one, two, three, and four, and they've been following along with that. And then the second thing is very specifically the two initial assessments that we asked them to do. One is on the person living with dementia and one is on the caregiver. One recommendation was don't do them at the same time, split them apart, it's too much. But the second one was that those assessments themselves were too long and burdensome.

They took too much time. And so we really tried to hone in and focus on the key ingredients. So we've shortened it considerably. Within four to six weeks of launching this back a couple months ago, within about a month, we had already adapted the assessment protocols. So those are now a lot more streamlined, a lot more straightforward, and the feedback that we're hearing is that it's much more user-friendly and it's less distressing for the persons living with dementia and the caregivers.

Vince Mor, PhD:

That's great, and that's actually a really interesting notion about that adaptation process, and it's going to be very valuable as you think about expanding this and launching this perhaps into a larger pragmatic trial in the quote unquote "real world." Now, for both of you, both of you have interventions that are in sort of specific locations.

Ula, in your case, it's the location of the emergency department, and Brent in your case, it's the sort of the high-risk, high-need cases that are part of a healthcare system. But they kind of both don't pay attention or don't directly relate or interrelate to the primary care physician. How do you think about the primary care physician in the context of your implementation and your intervention process? Ula, can we start with you?

Ula Hwang, MD, MPH:

Sure. So I think in terms of the primary care physician, the role here is really how do we change trajectories of care of patients that are coming through the emergency department and ultimately get that information such that the primary care physician is now aware of, "Oh, we picked something up," and this person is now, after being screened and having suspected potentially cognitive impairment and having that affirmed by an outpatient center.

In the case for our study, we're doing it at two locations. One is actually a geriatrics primary care referral, and the other one is a geriatrics comprehensive assessment center where they do sort of not just, not only will they be doing cognitive assessment, but they'll be doing functional assessments, medication review, living in home situation, that full comprehensive geriatric assessment. But that information from that comprehensive assessment would then subsequently need to go to the primary care physician.

Our hope is from the ED's perspective, if we can pick, see ourselves as the safety net and also the place where for many places, maybe it's missed in primary care. We now pick this up and can now convey this information. And that information could subsequently affect how the primary care physician may manage the patient with their medical and healthcare needs. And our hope is that this type of, I think coordination and communication of information ultimately will result in the ED playing a role in the bigger picture trajectories of a patient's overall healthcare, specifically around those with dementia.

Vince Mor, PhD:

Great. Thank you very much. So Brent, how about you? Is there a structured connection to the primary care physician in your network?

Brent Forester, MD, MSc:

Yes, very much so, Vince. This program specifically, we really wanted to do something that was integrated into and embedded within primary care. And so the beauty of the integrated care management program is that it is essentially a program that lives within primary care practices throughout our healthcare system. And the patients that are identified are patients already in risk contracts or being followed by primary care clinicians within our healthcare system. So the 200 patients that the nurse care managers are following, some of whom have dementia, some who don't, are already part of the primary care practice.

And so they're integrated both physically into the practice. During the pandemic, a lot of it's been more of a hybrid integration because of the safety concerns. But also they're integrated directly into the electronic medical record (EMR). So there's a link that very easily allows the primary care clinician and the integrated care management program team to actually communicate with one another directly in the EMR. And then in many practices, there are even rounds, case rounds on a regular basis where some of the high-risk patients are discussed on a regular basis.

Vince Mor, PhD:

So that's actually really dynamic. That's an exciting idea that it's embedded and integrated as part of that overall care system. Great. So I want to thank you both very much. It's been great responses to these questions, and I think the audience will have a much better idea of the robustness and extent to which your interventions are integrated into the broader healthcare system. So Dr. Hwang, and Dr. Forester, thank you very much for your time. I greatly appreciate it and look forward to watching the progress of both of your pilots as we move forward. Thank you.

Brent Forester, MD, MSc:

Thank you very much.

Ula Hwang, MD, MPH:

Thank you.

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.