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Session: Dancin with the Devil You Know  
Presenter: Steve Asch  
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Molly: We have Dr. Steve Ash presenting for us. He is the chief of health services research and the director for the Center of Innovation to Implementation, VA Palo Alto Healthcare System and a professor of medicine and co-chief in the division of general medicine disciplines at Stanford University Medical School. And Steve, if you are ready I would like to turn it over to you now.

Dr. Steve Ash: I am so ready.

Molly: Excellent.

Dr. Steve Ash: And do I need to click on the show my screen thing like you said?

Molly: Go ahead and do screen two clean.

Dr. Steve Ash: And then can you see it OK?

Molly: Perfect, thank you.

Dr. Steve Ash: Hello everybody, good morning for those of you on the west coast. Good afternoon for those of you on the east coast. I am going to talk for I hope about 45 or 50 minutes so as to leave enough time for questions at the end. And what I would like to do is tell you about a dance that I have been doing for several years now. Dancing with the devil you know, partnering with delivery systems in implementation science. And it is a bit of a different talk. It is actually more of a personal story than really didactic lecture. What I hope it will do is motivate you to use your skills not just to study but to improve the institutions, particularly the VA, that you are associated with. I am both a practicing physician and a health services researcher. My master’s degree is in epidemiology. I have done a fair amount of work in the past in infectious disease. Spent most of my career in big institutions, VA especially but also universities, public hospitals.

What I have noticed myself is that almost all the good ideas that I have had personally as a researcher have come at the bedside looking at a patient and asking what generalizable story does that patient represent? How can we uncover some truths that will help people like him or her? And working in the big institutions that we all work in I often find that my gaze wanders past the bedside to the walls and asks what about the delivery system. What about me? What about the doctors, the other providers, the structure? What about that is keeping the patient from getting what he needs? How can we change it for the better? And if we did, how much of it is this place and how much of it is generalizable and usable to others? That is kind of the core motivation that I have for partnering with delivery systems.

I also think that sometimes familiarity breeds content. Our institutions are very familiar to us. On the other hand the very familiarity that we know about our own institutions, what we know best, helps us think about how to change it. So maybe we cannot change income inequality and all of this consequent effect from health which we all know about, but we should be able to figure out how to get pneumonia patients their antibiotics in a timely way by building a better mousetrap organizationally speaking, that is. Excuse me. So what I will argue today is that we should embrace that motivation which all of us feel at some time or another being associated with the delivery system as we are and as researchers engage a little bit of institutional home improvement. And as researchers that process the subject to the same scientific methods and challenges that any kind of research or health services research is. And that insight I think is at the core of implementation science and the idea of a learning healthcare system.

Uh-oh. There we go. Got it. Got it, sorry. To do that this talk has 3 parts. First I will put the flesh and bones on that little motivational speech that I just gave you. Lots of high minded theories and such coming up. The next part is kind of an advertisement for partnered research in the VA. And finally in the last part we get to all the graphs and P values that we researcher are so fond of and I am going to give you a case history of one successful partnership that I was involved in. Also time, as I mentioned, for questions at the end. Many of you might have seen this slide, I have used it before, but I am going to tell the story again.

After a long meeting in which we health services researchers had presented the results to a high level hospital manager he pulled me aside at dinner and he asked me if I had 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 that cat seem really proud of it when he gives it to you?” I said, “Yes.” He said, “You guys, you researchers, are the cats and your research is the dead mouse.” Needless to say this was a bit of a transformative moment to me and I resolved that I would endeavor to produce no more dead mouse researchers. A banner we can all get behind. So where is the disconnect between that guy, that administrator, and researchers like us? One disconnect is around how fast the results of a study will be available. Operational partners want the results fast so they can make the decisions they need to and they mean months, not years.

Second dimension is rigor or certainty. Partners have to make decisions and they just want to get pointed in the right direction. They do not care about P=0.05, they just want better than a hunch and we researchers of course want our research to be perfect and robust, all the validity \_\_\_\_\_ [00:05:52] that we know about. The third dimension is generalizability. The operational partners want to target their inquiries to a very specific operational concern and to the devil they know, their own situation. They usually do not care too much about the implications for other similar organizations. Even in the VA they do not necessarily care about other VAs. And the problem, of course, is that researchers are not consultants. We researchers want to control our own lines of inquiry rather than just do whatever the operational leaders want us to do.

If I had time to actually make a poll this would have been a poll. The question that I think we all have to say says John Overbight posed at some lecture a while ago, is our audience other scientists and academics, practitioners or policy makers, or can we serve two masters? And what I am going to try and convince you of is that the correct answer is C. Because I believe that it is more of a dance or a dialectic than a disconnect or a dichotomy as this, well, sort of pretentious Yin Yang fish scroll is meant to symbolize. A dance that balances service on one hand, objectivity on the other, timeliness on one hand, rigor on the other, relevance on one hand, and generalizability on the other. And each of these dichotomous elements are really contained in the other. So what are the theories that can accommodate this? This guy is one of my personal heroes, Paolo Freire. And a lot of philosophers way back when have contemplated this problem of the gap between the researcher and the researched, the teacher and the student. And this guy who is a Brazilian teacher and activist turned politician and philosopher in the 60s and the 70s was one of the first people to figure out how to bridge that gap from a philosophical standpoint.

He deplored the idea that the student or the object of the research was somehow an empty vessel to be filled by the newly created knowledge that researchers were going to create. He actually thought more that the relationship should be viewed as a two-way street, that learning should be reciprocal. And he talked a lot about the dialectic of the different needs and different knowledge that the researcher and the researched have. And this idea is the philosophic basis of community based participatory research as contained in its slogan here on the slide: reflection and action. So this is the cartoon that many of you will have seen of the modern version, in my opinion, of Paolo Freire’s ideas promulgated by Wallerstein and Minkler and known as the community based participatory research model. I think it was really the CDC that first promulgated in a public health context. You can see that the partnership that it envisions are in the second bubble there, group dynamics and equitable partnerships. And the multiple sub bubbles depict the need for a variety of partners and various different kinds of situations to change different things. What you will note is that none of those partners is really the delivery system yet I have been arguing that that is where we can make the most difference, the devil we know. I think to get there we have to move to the theoretical development of implementation research.

Implementation research, even though it has gotten a lot of currency recently, implementation science is relatively new and it arises from the very well established fact that medical practice, much of it we know, is not applied. Various studies have found that innovations take maybe 12 years to disseminate. I myself led a national study in quality care that found that patients were only getting half of recommended processes. So how do we change that? The traditional NIH view is depicted on this slide and this is often called translational research. Studies must be translated into practical applications, it says. First we find something—the way this works is first we find something in the laboratory then the clinical trial is you take the laboratory information and turn it into a clinical trial. And then trial, translate that into a language that practitioners can apply. I personally think that Paolo Freire would hate this, even the very word translation and application implies that new knowledge is produced and then translated or applied to those who will use it rather than involving those who will use it from the get-go despite the two-headed arrows that you see in this diagram.

I think the term implementation research is better than translation because it is less hierarchical and does not assume a one-way transfer of knowledge. This is one of the more widely accepted definitions. I will let you read it for a second rather than me read it to you. And I think the last sentence is important because you see it gets to the part that I said we should care the most about: organizational and professional behavior. Implementation science has come a long way in the last few years and actually, the NIH, CDC, and VA are all favoring research applications with this goal more than ever. This is a model of implementation science, PARIHS; many people will have seen it before. It is not named for the city; everybody thinks it is, no. \_\_\_\_\_ [00:12:11] on research and implementation health services. There are plenty of other ones. In the VA we usually do \_\_\_\_\_ [00:12:16] for implementation research. This is just easier to present quickly, that is the only reason I am using it now. And the idea here is that successful implementation is a function of the evidence that supports and that evidence is not just research but also experience and local information. Facilitating factors like is it appropriate to the purpose that the adopters want to put it to? Is it something that they have skills for? Is it consistent with their role and context? Which has always been perhaps the most important thing in implementation science, culture leadership and et cetera.

Here is how the VA tried to meld implementation science with partner based research into a pipeline and for this I am indebted to Ryan Minman. The idea is that the operational partner, I got it all there. The idea is that the operational partner is involved in all stages from identifying the research area, identifying best practice, assessing current practice. The partner and the researchers engage in a dialogue and implementing an intervention to improve current practice. It also incorporates the idea that you need to start small with pilot projects and move to small scale demonstrations and reasonable demonstrations and national rollouts. In the last part of the talk I am going to give you an example of a research stream that I think made it through most of this pipeline. That was a little bit of a late click there but there is the phase 1, phase 2, and phase 3 pilot to national rollout streams I meant to talk about a minute ago.

So far this has all been very high content, very theoretical. Before I dive into the example I want to point out that a lot of progress has already been made in this area. Not just in the VA, here are 3 relatively well known examples: Peter Pronovost checklist work reducing nosocomial infections, order sets that reduce ICU mortality, specialist/generalist teleconferences as project echo on \_\_\_\_\_ [00:14:41] Arora and outpatient HCV treatment in rural New Mexico. All of these trials had epidemiologic methods at the core of their evaluation that were very much implementation science.

Now I may be a little biased here but I think these examples pale in scale before the commitment that the VA has made to partner based research and implementation science. For the next few slides, for those of you that do not know, I am going to describe some of the structures the VA has put into place for that purpose hopefully serving as an example. First I do not have to tell you guys that the VA has all of these advantages but I would like to point out that the VA is not alone but certainly still in the lead for intramural health services research funding programs that encourage partner based research. All the COINs are required to do it. The QUERI program, even though it has undergone a reformulation, kind of a reboot this year, still trying to do that. And the CREATEs which are components of the COIN are trying to do it. We will jut skip this. I am going to tell you a little bit about the HIV HCV QUERI which has just kind of wrapped up operations and transformed itself into the bridge QUERI which still focused on those 2 diseases but is more about equity now.

But I would like to give you a bit of a history; it shows you how it made it through that pipeline that I just talked. This was the mission that we came up with 10 years ago. The mission was to partner with clinical public health and the VA to present identification and care of veterans infected with the HIV and HCV virus. And you will see that our partner’s mission was similar but not identical. So he partner, CPH, you can kind of think of as the public health department of the VA. And one of the first lessons of partner based research is to listen to where your partner is coming from and try and adapt to their needs. For example, our QUERI started out solely interested in HIV and that is what I am going to talk about for those series of projects in just a minute. But clinical public health had a lot of other diseases on their plate including and especially HCV. So we changed our mission to include HCV for the express purpose of building the relationship with them. There was heavy involvement of these partners in our queries of strategic planning.

You also have to understand where your partner is within the organization to know how best to work with them. This is kind of crazy but this is a big org chart for the VA and I think President Obama is on there somewhere, right above the top of the slide. But the point is, as many of you know, the VA organizational structure is complicated and changing and changing even more in this next year than it has in the past. And you have to keep on top of it to understand how to work. So our partners, public health, are probably moving in the next year. It is not 100% clear in this organization but this is where they were in March of 2011 when this project I am about to tell you about was culminating. Which brings me to the next lesson for partner based research as a Minkler model, the community based participatory research model, suggested it is rare that a single partner is going to be enough. So we do not have to have a monogamous relationship with public health but let us put it this way, they are kind of our main squeeze in the HIV hepatitis QUERI. But you need to reach out to a lot of other entities within the VA and you can see a list of the ones we actually did reach out to, regional management, provider groups, information technology, et cetera, in order to be true to the spirit of implementation science.

This was the structure of the QUERI and you can see that clinical public health was very much at the tope and was involved as much as we could get them to be in the construction of our research agenda. In fact, we even had shared staff that was paid for, still do, by both organizations. We have several goals and we have shifted much more to goal 3 in the current iteration of our bridge QUERI. But back then goal 1 was perhaps the most important to both us and our partners and that was better disease identification. I am going to move on to showing you how a series of projects kind of followed that implementation science partnership and that pipeline that I had showed you earlier.

So here it is again. The first thing we did was work with public health to identify our research area, ask what the best practice should be. Hoping you guys can see my mouse, I have heard you could. And assess existing practices against that standard. These are the areas in yellow here. This is traditional health services research in a way. And this is how clinical public health and we saw it when we began our series of partnered investigations. And now this is almost a decade in the past. With improved treatments HIV infection had become a chronic illness for which the benefits of early diagnosis firmly established. So we thought early identification reduced both mortality and the cost of treatment by keeping patients out of the hospital and there is good evidence for that and it encourages the reduction of risk behaviors so that would prevent transmission, too. Unfortunately, back then, despite national guidelines that recommended offering HIV tests to everybody, particularly those with known risk, about 20% back then of HIV patients did not know their status. And in the VA there was no testing in 1/2 or more of those with known risk factors. And 1/2 of the people that were diagnosed were getting diagnosed at a late stage. So that is kind of the yellow part of the pipeline. This is a little bit more the yellow part of the pipeline, the modeling work that Doug Owens actually here at the Palo VA did that demonstrates that it is cost effective. Even down to a tiny, tiny prevalence, less than 0.05% positive HIV.

And this was very important for our partners in clinical public health making the case for trying to increase the rates of HIV testing even in areas where the likely prevalence rate was low. We actually did a \_\_\_\_\_ [00:22:31] survey of VA patients to see if they were above this cost effectiveness threshold and every place we looked in fact it was. So the question was how to change it. How do we get more people screened? For that we went back to the PARIHS model. We felt we had already kind of figured out the evidence to some extent but we needed to look at the facilitators and barriers and the organizational context. So we surveyed primary care providers and asked them what they thought was keeping them from doing more testing. This is what we found: we found there were organizational barriers. At the time people may remember there was a requirement for written informed consent and pre-test counseling. This was just very time consuming and providers did not like it. There was a limited opportunity to tell people after the test what their results were and that was a barrier because they did not want to have patients come back to hear their results. And providers were worried that if they found somebody that was positive they would not know what to do. Those were organizational barriers. There were also provider barriers.

There was kind of the sex and drug and rock and roll problem which is that people do not like to talk about, discomfort, with HIV counseling. A lot of people did not understand, which I was surprised at at the time, all of the HIV risk factors out there. And instead they were relying on these specially trained counselors. And then of course with any kind of preventive care it is hard to get it to the top of the priority list. At this point we are ready to get in the next stage in the pipeline and design a test, an intervention, and pilot test it and roll it out to a few places. So here in phase 1. This was the design and the intervention. We made some organizational changes in response to the survey of the facilitators and barriers. At first we digitized the written consent when it was still required. Eventually we got it eliminated. We streamlined it. We also allowed in our pilot site for remote notification of negative test results which of course is 95%, 99% of them, and we got the clinics to reach out to the primary care clinics and say if you find a positive one we will deal with it. We will reach out to them and get them appointed in our clinic, et cetera. We did a version of academic detailing kind of like the drug companies do for drugs except for ideas and social marketing to activate the providers. And we also did some audit feedback, clinic level feedback, of HIV testing rates so that the clinics knew how they were doing. And finally because of the VA of course we had to have an electronic clinical reminder and we had one.

These were very much based on the barriers that we thought we had found in the provider survey and on the PARIHS theory. Here is the reminder; you can see it prompts for the HIV, \_\_\_\_\_ [00:25:53] reminder itself identified risk factors. Eventually now that risk factors are no longer needed for testing then meaning there is a cohort based testing, then we have a new reminder where not a longer required. We engaged with the clinical partners. We made presentations to the leadership that was done by us. And we talked about to the national leadership as well. That was mostly done by public health. We identified local champions. We helped them out with all the stuff that had to do with analyzing the data. The public health people usually were in charge of removing the organizational barriers. It was very much a partnership. Here is part of the handout materials that were involved with the social marketing and academic detailing, just as an example so you can see. Here is an example of the quarterly feedback that we provided to each of the clinics so the clinics would know that they were site K but they would not know the identity of all the other sites.

And for each site we had an implementation plan and a launch meeting. We met with the leadership, even the chief of staff, often the nursing and laboratory leadership as well, and this was trying to honor the principle of partner based research that Minkler and Freire tell us about which is they are going to have to be part of the research project that they need to be involved form the very beginning and you should be as wide as possible in involving them and that is what we were trying to do. We promoted the program at primary care team meetings. We provided those educational materials that I just showed you. And we emphasized the use of site wide rather than provider specific feedback to try and get them to think as a group. And that was a result of talking to the providers themselves saying that is what they wanted. So did it work?

Healthcare system A was the pilot site. I actually do not like this slide; I should replace it. But negative 1 means the year before the intervention. 1 means the year after and 2 means the year after that so the second sustainability year. This arrow means intervention and this is the rate at which the reminder was resolving which is how we knew whether something was happening although we did validate it to make sure that they were not just filling out the reminder not doing the work. So site A was the first place we tried and you see a big jump, twofold increase in the rate of HIV testing or at least offering the test. And then we rolled it out to site B and then C and then E and site D was control site. So you can see the \_\_\_\_\_ [00:29:06] that it worked in getting people to test. It worked across various different patient groups so you can see the pre and post odds ratio of HIV testing based on the various things that might otherwise predict HIV testing: age, income, ethnicity, all above the odds ratio 1, statistically significant.

And we also checked to see which of the components to our ability to do so, \_\_\_\_\_ [00:29:40] was not a design element. Turns out we had an accidental opportunity to test this and I have to say this is a very common thing in implementation science. You have to be very careful about looking for these opportunities when the world presents you with something that you did not expect. So what happened was that E, this site, the program was not implemented, the provider activation program was not implemented until 4 months after the institution of all the other components. This was a staffing problem that we did not expect. And so as shown in figure 2 we tried to determine how much did the provider activation program really matter. And what we found was that from baseline value of 1.4% to 7.1% in the first month after the implementation of the intervention the HIV test and offer rate actually did go up. This was actually just as much as in the other sites which have the benefit of having the full implementation of the provider activation campaign. So we came to the conclusion the provider activation campaign maybe was not such a crucial component.

So that was phase 1 and 2 in that pipeline and here is the summary of our results at that point. Implementation of this multimodal intervention more than doubled HIV testing rates in 4 facilities. The increases in testing were accompanied by increases in HIV case identification. I did not show you that data but they were. At the 2 original sites the increase in HIV testing rates were sustained in that third column over a period of time. So even after we withdrew support they continued. And the costs were not so ridiculous. They were about $40,000, $70,000 per quarter per site. And then we also came to the conclusion that the provider activation campaign which is a big part of the cost may be not so important. So here we are back at the pipeline and we were now ready for this: phase 3, regional demonstrations, or so we thought. The idea of the phase 3 regional demonstration was to assess the generalizability of this intervention which was all in 1 region to other regions with differing structural characterization. And then we also, because we were confused by that little clue, wanted to figure out if provider activation was doing anything. So what we did was we generated 2 models, central activation where national project staff were providing extensive support, that is the model that we had before, and then local activation where the local staff was encouraged to conduct their own provider activation and education activities. And we matched facilities in 3 regions.

This all seemed like a great plan to us until the real world intervened as it always will in implementation science. And again, I urge us all to understand this and plan for it. So here is what happened: in October 2008 that project that I just mentioned was funded. In 2009 we launched the 3 sites. And then the next month the VA HIV testing policy changed. We got rid of the written informed consent that I was talking about and so were the pre-imposed test counseling requirements removed. And the target audience was broadened to what it is today: routine once per lifetime testing for all patients, not just those at risk. So what do you do when things change? Well, we went back to the impediment that we had previously looked at and thought several of those were not here anymore. We do not really have to worry about informed consent and pre-test counseling as an organizational barrier anymore and we really do not have to worry about incomplete recognition of risk factors. So we revised our analysis plan to look at both at risk and routine testing and here is what we found for risk based testing. We found comparing local implementation and central implementation that local implementation worked better but that central implementation overall was doing a better job than local implementation.

And this was really important to our public health partners who had told them what they needed to do to increase HIV testing. This is just another way of saying the same thing. So this slide was risk based and this slide was routine based and in both cases the message was the same. So the summary of this phase 3 result is that risk based testing increased, so did routine testing increase by even more, and that central support performed better. And this actually was the largest widespread analysis of a structured program to promote routine HIV testing in primary care. Not one that we had planned for but one that we adapted to. I still do not know, even though it is years later, to what extent the sustainability of this program is going to last. I can tell you that the public health people have been monitoring this and it looks like HIV testing is continuing at relatively high rates but we have not been able to do it with the same degree of rigor that we did during the test. And the economic analysis, which we are still working on, remains to be complete but we think it is probably cost effective based on the Doug Owens model and we have done some work in that regard. And in routine testing Matt Goetz is still working on the rate of new case finding which would likely be lower in routine testing than it is in risk based testing. So where are we? We are here. And it turns out that the clinical public health people have done a national rollout of some versions of the work that we did. And that is something that I am very proud of as a researcher and just as a citizen in the VA.

This is my last slide. What I wanted to do is end up with the lessons that I have drawn from this kind of work of dancing with the devil you know. It is a very satisfying kind of research even though there is a lot more complicated maneuvers you have to do to make sure that everybody is happy: the partners, the researchers, and the institutions. But that kind of work is very much eased by relationship planning, programmatic funding like QUERI, so that it is not just about the project. It is about making sure that the group of researchers and the partner are working together towards a common goal. I think it makes the dead mouse kind of research that I started out telling you about less likely. And I really do believe that researchers can serve 2 masters. This project produced generalizable conclusions about implementation in addition to serving the institutional needs. With that I would like to acknowledge these people, the many people, the cast of thousands that made this work possible and turn it over to Molly for questions.

Molly: Excellent, thank you so much. For attendees that joined us after the top of the hour, if you would like to submit a question or comment you can do so by using the question section of the Go-To webinar dashboard that is on the right hand side of your screen, just click the plus sign next to the word questions. That will expand the dialogue box. And then you can—we will get to those in the order that it is received. The first question we have, “Can the HIV model you showed be used for other key health issues? For example, suicide prevention.”

Dr. Steve Ash: Yes, before I answer the question just a process issue, do I see the question somewhere? And if so, where?

Molly: No, you do not, but I can give you that ability if you would like to.

Dr. Steve Ash: That is OK. I think I can remember them when you ask them. I just thought I might look at it. The model—HIV here is just an example. I was trying to present a very generalizable model of partner based research. And I think it is applicable to just about anything if you think about it as development of a relationship with operational portion of the VA and reaching out to them in a way that is going to serve those 2 masters, both the master of identifying generalizable truth and the master of serving institutional need. Now the question might have been what about the intervention itself, what about the very specific things that we did as versus building the relationships. Which was provider activation, electronic clinical reminders, and the various other elements that I described to you. You have to match those elements to your assessment and your partner’s assessment of the barriers and organizational context and facilitators that are preventing our system from accomplishing what it needs to, in this case doing the best that we can to avert the terrible problem of veteran suicide. So may answer to the questioner is yes, I think the partner based model very much applies but not necessarily the very specific interventions that I described.

Molly: Thank you for that reply. The next question: “Great talk and thank you. As researchers we are dependent on academic products and grants as part of promotions. Can you please describe the academic products that emerged?”

Dr. Steve Ash: Yes. So sympathetic to this, especially these days when I am the co-chief of the division of general medical discipline and I encourage my faculty to do this sort of partner based research and yet they all need to publish or perish and that is a real and important thing. So first, from the very beginning, if it is going to be a two-way street you have to tell the partners it is a two-way street and what you need, you the researchers, need to get out of it is publications and generalizable knowledge in addition to helping the institution. And you would be surprised. You would think that they would just know that but that is not true; most of them do not and they do not think that way. And it is really important to identify that in the very beginning. Now the question remains \_\_\_\_\_ [00:41:55] the question from the other side, from the university side, which is to what extent is this kind of thing going to produce the sort of data that you can write big splash papers on and make an academic reputation for yourself because you have to in academics. So it is a lot easier now is all I can say but it is still not as easy as if you are doing things that have been more traditionally accepted. Maybe 10 years ago I think you would have had a hard time finding any implementation science in the leading medical journals, JAMA, *New England Journal*, et cetera. Now you see it quite regularly in the big journals. And there are many more venues, lower tier venues, than those very high prestige journals that are predominantly devoted to this kind of work. And so you certainly can publish it. Moreover, I think that in most universities now the committees on academic promotion have softened their stance on implementation science which they would maybe 10 years ago have thought of as not something that would necessarily count towards the national reputation, et cetera, that they are supposed to evaluate.

I look at this progression as the same thing that happened to health services research when I started out in health services research in the 90s. I benefitted from trailblazers in the 80s who made health services research as acceptable in general medical, in divisions of general medicine, and now even in specialty circumstances and institutions as any other kind of research. I was right at the very tail end of that revolution as a young faculty member. And I think young faculty members now, like many will be listening to me, should expect that this sort of very applied research is going to be increasingly acceptable in academic medical centers, especially as academic medical centers realize that it is going to benefit them in the marketplace, the academic medical centers themselves.

Molly: Thank you. That person has a second portion to their question. How do you personally balance the time taken for operations partnerships with academic needs?

Dr. Steve Ash: I do not know that anybody should model their ability to balance their lives on my ability to balance my life. But I will answer the question anyway. You have to do what you think is going to make you happy in your professional life. And truthfully maybe 10 or 12 years ago I remember having to prepare my CD for some sort of promotion thing and looking at all these papers that I had written. I had written, I do not know, maybe a hundred or something at the time. And realizing that almost all of these papers could be translated by 2 or 3 words: things could be better. Things are a problem. And I realized that I just did not want to keep for the rest of my life writing papers that said things could be better. I would like to show how things could be better, not just tell people that things could be better. And I just decided that that is what I wanted to do and I ended up taking a little bit of a hit in academic productivity but later in my career than many of you are, by developing these partner based relationships. And they mostly serve me well. Sometimes I feel kind of swept up in the political currents of VA central office when things change in ways that you do not understand or you get criticisms that do not seem too based in science but rather in people’s egos. But frankly the same thing happens when you are doing health services research that is not partner based. It just happens inside the walls of academia. So I try these days to lean relatively heavily in the direction of implementation science and partner based research but it is not exclusively what I do. I still do some quality measurements that especially methods work that I find enjoyable.

My answer to the questioner, wherever he or she is, is I do not think my example really helps you. It is a tough internal debate that you have to have with yourself.

Molly: Thank you. The next person writes: “Wonderful presentation, thank you. So now how do we walk that line in our grant writing, especially for those of us who are proposing very practical projects in response to partners’ priorities, proposals that would have been query projects but now must go to HSR&D?”

Dr. Steve Ash: Yes, that is a tough one and it is very specific, of course, to the recent change in the QUERI program which does not now allow for individual projects but rather is funding all projects as part of the infrastructure of QUERI. I have had conversations with David Atkins about this and what he says is that the review committees are encouraged in the HSR&D scientific review board to be more open to implementation science but I do worry about a few things. One, that timing issue that was the first row in the dichotomy slide from way back when, the fifth slide or something in my talk. It takes a long time to get things through the \_\_\_\_\_ [00:48:04]. It takes about 18 months if you are lucky from conception to funding. And then it takes you a year or something or 2 years to do the project. And you have this problem where your partners kind of forgot they asked they question. If you tell them now we have the answer and it is 3 years later. So the most important thing you can do with the partners is try and make them aware that the questions that you think you can help them with are the eternal questions, the ones that are going to be important even 3 years from now. The access problem in the VA is not going to go away in the next 3 years. The make or buy issue in the VA, which many of the partners are struggling with, should we do it inside the VA or should we refer out? That is not going to go away. I think it will still be an issue 3 years from now.

And my opinions on what are still going to be an issue 3 years from now are not anywhere near as important as the partner’s opinions. One of the things that I have found very gratifying is when you bring this stuff up to the operational partners they are kind of grateful. Because they are so buffeted by the latest congressional inquiry or the current fad in quality improvement, whatever it may be that they relish the opportunity to think strategically even if it is just for an hour or 2 during a meeting. The fine line that the questioner asks is one that acknowledges the strengths and weaknesses of both sides of the partnership equation.

Molly: Thank you. The next question: “Sometimes the individual person in an operational leadership role changes partway through a project. Can you comment on how you address this in a partnered project?”

Dr. Steve Ash: Yes, that is a tough one. It actually did happen to us several times. First we had shared staff. So if it is at all possible to do that that is great. That means that there is a slot, if you will, in the organization \_\_\_\_\_ [00:50:23] at the VA that belongs to you both and that person serves as a bridge. And in our QUERI we have had that for a long time and I think that can make a big difference. Another thing is to be as broad as you can, not just in all the different partners that might have an interest but also within the partnership group. So within clinical public health there are various people and they are not all going to change at once usually. And so making sure that you are not identified with just one of them even though that one might be the most supportive insulates you from that sort of change. And then I will go back to my answer to the last question. If the often central office \_\_\_\_\_ [00:51:11] or could be a VIZN there, could be a facility, has a true and enduring interest then having people change chairs should not make that much difference. And being able to evaluate the extent to which this is really just this guy’s pet project or this woman’s pet project is a skill that is required on our side of the operational partnership.

Molly: Thank you for that reply. The next question: “Are there any parallels to be drawn with research being promoted by QUERI in which patients, as opposed to operations or organizational leaders, are partners?”

Dr. Steve Ash: Yes, absolutely. So in a sense it is a generalizable model and in fact the original community based participatory research model did not envision, as I pointed out, institutions as partners. It envisioned patient groups as partners. Inside the VA it is not always that easy but I strongly recommend having patient representatives at the very least on steering committees. That is something, an easy step, that is still not done very often and I think should be done, in my opinion, should be a review criteria at the \_\_\_\_\_ [00:52:37]. It is not, I am sorry, I am not suggesting that that is the way it is being evaluated now; that is just my opinion. And there is a little touchiness in the VA about the VSOs because of their strong political power but I noticed that the barriers to working them have gotten a little less over the last couple of years. People have been more encouraging about so doing.

Still, it is really important to make sure that your institutional partners know that you are doing that. Often they will know of landmines that you do not know about in reaching out to patients as partners. I have often thought also that there are a lot of projects out there where we could involve groups of veterans in trying to help construct the intervention in ways that we have not done as much in the past. We did have a patient representative on that HIV work I was describing. But I wish that there was a way for the central office people who are trying to figure out what program implementation strategies they should take. I wish they had a way of talking directly to veterans. And I think maybe they often do not and maybe we can help provide that as researchers.

Molly: Thank you for that reply. I am going to go ahead and put up our last slide real quick. And Dr. Ash, I want to give you the opportunity to make any concluding comments that you would like to.

Dr. Steve Ash: Just my pleasure and of course you will see my contact information here, very happy to hear from any of you. And as a shameless plug, we are recruiting at our center and in my division of general medical discipline. So if anybody knows of any researchers who are looking for a change I am very happy to talk to them as well.

Molly: Excellent. Thank you so much, Dr. Ash, for lending your expertise to the field and of course thank you to our attendees for joining us. If you take a quick look at this slide I also have a shameless plug. There is a new site going on, VA Pulse. We have an HSR&D cyber seminar, VA Pulse, site and we encourage you to come to this site and continue this discussion as well as any other research topics you would like to address. And it will also be a location where you can access our archive catalog, I mean, our archive videos, our archived handouts, things of that nature. You do need a VA email address to sign up but once you are in you are in and you can search freely around there. Please do join us and we will be shooting out an invite to you as well. Thank you once again, Dr. Ash, thank you to \_\_\_\_\_ [00:55:29] and the CDA EI team for helping to coordinate the session and to our attendees for joining us. And this does conclude today’s session. I am going to close it out momentarily and you will be directed to a feedback survey. Please take just a moment to respond to those few questions. We do look closely at your responses and it helps us to improve the sessions we have provided as well as new sessions to support. Thanks again, everybody, and this does conclude today’s HSR&D cyber seminar. Thank you, Steve.

[End of audio]