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The Facilitators Tailoring Menu: Pilot Study from EvidenceNOW on Managing Urinary Incontinence

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REID PARKS
Hi y'all. My name is Reid. I'm an engineering PhD student, bit of a different crowd and I don't have a clinical background but some of the folks on my team, I want to highlight that couldn't be here today: Doctor Heidi Brown is our urogynecologist, Dr Joan Neuner, general medicine, family medicine doc at MCW, Milwaukee. Yeah, Milwaukee Medical College of Wisconsin. That's what it is in Milwaukee. And then Mona Matthews and Laura Manteufel are practice facilitation experts on the team along with Doctor Flynn and Doctor Ramly, advisor and mentors on the the research side. Let me grab [inaudible]. Last things first. I'm not gonna joke. So I just give you the punchline right away. First, we all have heard tailoring a lot at this conference. I wanna hit home that it's critical. It's really, really important and it can be simplified. It's a complex process. It's hard for us to kind of do it the right way sometimes how close we have to stick to what's in the book, how much can we adapt to what's needed here. But, but it can be simplified. We can work on that. And then with it, practice facilitation can also be streamlined, simplified. We can, we can find ways to focus our approach and do things that, that work better, better for the practice, better for us, better for the experts on our teams and, and everybody involved. And then finally, this one's a little bit different from things that I've heard in other presentations, but we can compare interventions across practices and they kind of give us some insight into how that practice runs rather than just comparing practice to practice. Looking at the interventions helps us with other projects too. So diving in, all these other great projects that are going on, we've heard a lot about, about this one. And I'm involved in this one, but the toughest one made it a little bit bigger, but they're all tied together with this, this question of how external support, how facilitation can help busy practices, adhere to guidelines, guidelines say this they're doing this. How do we make those two things match? And our specific focus is urinary incontinence among adult women. And what we found in Wisconsin specifically, that's where these numbers are from is that UI affects more than 60% of adult women in recent survey and they, they want doctors to talk to them about it, right? It's kind of, it can be embarrassing to bring up. It can be embarrassing to talk about it and doctors, it's embarrassing for them to, to bring up to talk about it. Maybe they don't have the language or the questions built into their workflows and they also just a lot of things to screen. We, we've heard screening in almost every presentation at this conference. So it's just a lot of stuff to keep on their plate. And then our approach that we're bringing surprise, surprise, practice facilitation. But again, we're, we're streamlining it. We're focusing on that tailoring piece that I'll get into. And we want to balance that with how much time we're spending

with practices. We there's those studies that say, oh, there's only 15 minutes a month that they can spend with facilitators, all those those classic things, we want to find a way to maximize our time with them and get what we need out of it. So our approach based on the fact you, you've heard these in the, the keynote today, you heard them all over the place, right? Clinics have limited time, but more facilitation is better. Thats right. Hey, we want local project ownership, we want them to take the, take the lead on this. But hey, they only have so much capacity to actually focus on improvement projects. How do we balance those, those conflicting approaches? So again, we want to look at tailoring and implementing evidence based intervention. So sticking to the evidence, but still having that customization involved. A reminder, implementation, science 101 class for folks who haven't been doing as much reading as I have to during my dissertation: tailoring is the process of adapting interventions to meet local needs around the evidence. So evidence says we gotta do this. Tailoring is adjusting the things that can be adjusted while keeping that evidence at the core. Now, tailored interventions are good! Lead to success. But the best ways to tailor are are not clear, but there's lots of different approaches that people can use. And it's not like one approach is better than the other approach. So we need some understanding of the best methods. I gave a little example here, I apologize for the small font in the back. So the intervention says, and this one urinary incontinence, another surprise, but all women should be screened and treated for UI. Awesome. Government says that primary care is good and how are they gonna do it? Right? We that doesn't actually mean anything to an individual practice. So the tailoring part is saying, OK, clinic does this this way this this way and we find that puzzle piece that they need and we adapt the intervention to say, OK, at this clinic, we're going to add your incontinence screen, this question or these questions to the well women exam questionnaire that they get in the lobby or we're gonna put it on the, on the, the EHR so they get it messaged them beforehand or however it has to look what they're used to what works for them and their patients. That still meets the base intervention, everyone's getting screened and treated ideally, but then also meets the needs of the clinic and what they can actually do feasibly. So, looking at this process, I'm an engineer. So there's gonna be lots of charts, get ready for it. So we started the intervention and then ideally many meetings with the facilitator, we can get it to the point where it fits all the needs. that, that the local clinic has, right? There's we, we meet with practice members, we meet with the docs, we go in and we observe, we see what they need and then over time, maybe we can get it to a point where it's adapted and then we can get it to a point where we can roll it out. And then months later, we can see if it worked and if it didn't work, shoot that, that stinks, right? That's, that's not fun. Now, what our project is doing is saying, hey, we need to simplify that. So let's take some of the engineers on the team myself, Doctor Ramly and, and what can we learn from engineering? One thing is menus. Now, this is not engineering but a configurable menu is when I think about manufacturing, how they put different things together in different configurations. We made a menu with the experts on our team that says, OK, here's the intervention, here's all the different ways that it might be adapted to a clinic. They might do it this way or this way this way or this way. And we built that into a checklist to try and simplify this interaction. We wanted to get it to one needs assessment. They have everything they need to tailor the intervention, get an adapted intervention to local clinic needs, address all the needs that

are relevant to the intervention, but do that in one conversation. So that's the goal we see if we get there. This is just a pilot study. Early report on the other practices that are outside the pilot study. Before I get into the methods here, it's going pretty well. They're, they, they're looking good. But again, this is just a pilot study. We have 10 practices involved here that I'll talk about today. But from all different areas of Wisconsin, we have this index that, that went through a few years ago and rated each area: rural urban, is it underserved for health care needs and access? It is advantaged to healthcare needs and access? And we, we included a lot of these different practices because we wanted to understand, hey, how did different practices to respond to this intervention? How did they adapt it to their needs? So they fill out a survey, they have to do a survey, right? It's a research project and then they use that menu with a facilitator, one meeting. and out of that meeting they get a tailored intervention. That's the goal. That's how this should look for everybody. Now, we started with this, this menu and it's really, really tiny font. So I blew it up for y'all, but it's structured based on the five As. So if you haven't heard of it: ask advise, assess, assist, arrange. This, there's an EvidenceNOW thing. It's, ideally, it'll help primary care practices, low burden, improve their screening and treatment processes for different things. We're using it for urinary incontience, but it can be combined other, other processes as well. And we broke down each of the elements here. So for ask, it's, when are they gonna get asked, who's gonna give them the form? Who are they gonna hand the form to who's gonna put it in the EHR? How is the patient going get it? Are they gonna do it on their phone? On the ipad, on the clipboard? How's it gonna look? All those details that we can predict ahead of time. There's only so many answers, right? We have a couple of places where we might have to say, oh "other," because there's kind of an edge case, but most of the answers we can predict ahead of time and then when the facilitator comes across the conversation where they say, oh Yeah. So we get the survey from the patient. We put it into the EHR we can ask, well, how did the patient get the survey? Who else do we need to involve here? Do, does the front desk need to print more or are, are you getting it off the ipad? Do they have a dry erase board? How is this working? We can ask those questions that are directly related and focused on the intervention? But aren't getting into the details that we don't need to get into on oh, well, well, they're, they're doing this other form too and they're talking about this and doing that. We can really focus on what we need for this intervention. So we took that menu. It was kind of a rough cut and we worked through these 10 pilot practices to improve it because we said, hey, experts know a lot. They don't know about the real world, right? We wanted to see how this works for facilitators in vivo. How does it work with a practice? They take the menu, use it with a practice and then they come back and they'd say, hey, it works really well this way, it was kind of tough this way, the process of it, the things that were involved and we revised the content and, and how they used it and we tried it again with another practice and through all 10 practices, we continue to improve this tool so that would, it would work well for facilitators. Now, I won't show you all the middle versions, but the final version is really, really cool. We use this in real time. Facilitators can go through and fill this out and they put in the, the practice and the, the meeting that they're doing with this practice, just the name of it and the date and then they go in and they say, ok, they're gonna do it before and then they put a little note in there. They're gonna do it all before in the lobby on the ipad and, and then they fill those other details here. Hey, yep, it's in the

lobby. They actually get it from the front desk person but they may have to go and get the pen over here so they can add all those details that are great for that thick description later on. But really at the high level, we just need to know, ok, we're doing it before the visit in the lobby. Great during the visit in the exam room. Great. We can, we can really simplify the details that we focus on with this intervention and we did that for all five of ask, advice, assess, assist, arrange again. So here it's looking at the our patients getting patient resources, what resources are doctors actually taking out of the drawer to look at during the visit and use to to, to lead this intervention? And, and then assess/assist/arrange-- we all, we kind of combine together successfully. One big thing of OK, patients said, yes, experiencing urinary incontinence. What comes next? Are we referring them out, giving them meds? Are they coming back for a follow up visit? What does it look like? What are, what are next steps? And then the cool thing about this being in Excel we can actually track that interaction over time and see how it's changing in the practice. I'll come back to that later, but I just wanna wanna highlight it. Now, by refining this menu and all the ways that we use it. What a facilitator can do it during discussion. Hey, I need it this way. This way we reduce the time it takes to complete the menu by half, which was great for facilitators, it saved them time. And documentation is, is personally worst thing to focus my time on. So I, I want to limit that. But it also reduce burden on the clinical team. We didn't have to call and ask Doctor Reuner, your gynecologist after every clinic. Hey, we're doing it this way. What do you think about this adaptation that they're making? Is this OK with the evidence? We kind of bake that in at the front with these pilot practices so that if something strange pops up, we still have them to ask. But it doesn't need to be in every clinic we know. Ok. Yeah, this is in the, the realm of outcomes that are ok for the intervention we've adapted to. It's still evidence based and we're, we're on, we're on target here. And then last, it, it helps us focus what we're talking about and the needs assessments and they shortened quite a bit too. Right. We said we're gonna schedule an hour, a couple, we're getting done minutes early by the end of this thing and practice is beyond the pilot. It's it shortened even more. Because we know, ok, we need to talk about this or are you doing it this way? But we, we have the questions kind of baked into the facilitators idea of how this intervention works now. So we can really target that meeting. Now, getting into the content because those menus had a lot of data and I'm a researcher, so we had to dive into all the data and clinics that we had. We went through rapid qualitative analysis. We have a multidisciplinary teams, we all reviewed these different menus. We wanted to compare the sites and see what commonalities exist, right? Are all rural sites doing things the same way is, is a site that serves X population, doing things one way and Y patient population another? And we found themes that were common across these. So some clinics might use a paper or electronic screener. Some might do it verbally, some might use both. That's just one example, but the themes that we identify first one that I thought was really interesting and kind of not a surprise for folks that have been in, in clinics, depression screening people know how to do it. This is every day, every patient, not a problem. PHQ, here you go, collect, it goes in the EHR. That workflow is really well set and it's the strength of all these clinics that we can build on for other screening that should be consistent. Like this UI screening, we're saying, hey, screen everybody for it. You already screen everybody for this. Let's just let's staple something out of the bottom of that form or whatever it needs to be. They also

all used-- this is the human factors engineering in me. I apologize for the non applied psych nerds in the audience. Folks are using written or electronic tool tools to prompt screening to remind people hey, screen for this: they hand patients a paper, they fill up the whole thing. There's a pop up on the EHR, hey MA remember to ask about this, fill it out. It goes in the note template. Great. That's a really, really sustainable thing. And we were really happy to see practices we're using that rather than relying on individual memory to, to get these things done for the phone. Then across clinics, most patients are self administering in the lobby on the clipboard on the ipad. That's pretty common. But some clinics, especially ones with, mostly non-english speaking populations, they were kind of using their bilingual abilities as, clinicians to ask these questions. They didn't have the forms and other languages they needed. So they were doing verbal screening there. And then the last point that is probably not a surprise to you all, but for me it was: preventive visits are not a, a cookie cutter thing, right? Physicals are not physicals. They're physical personal problem visits, plus a problem visit. Annual wellness visits, you have to get through the whole checklist. But hey, six things popped up that we need to work on today or in a follow up there, there's not just a preventive visit almost ever and there's a lot of variability in the clinics and how they handle that issue of: Okay Are we gonna do it in a follow up visit or does it happen a day and we build separately? What does it look like? That was a big topic of discussion that we had to consider because we're, we're screening and preventive visits. But sometimes a problem visit is the only preventive visit patients could get. So we had to navigate them with folks. Now, a status update. I did jump ahead a little bit. August 2023, that's now. We have 37 clinics enrolled in the study, it's ongoing. No final results yet. I can say it's looking really good. We're getting cool data from these clinics. I met with five clinics at one time on Monday this week and it went very smoothly. Surprisingly. Right? Usually that stuff gets messed up over Zoom, but it worked out. So that's 185 meetings that I'm helping facilitate. We have a couple other facilitators. They're doing great. It's going really, really smoothly, but each practice is gonna do five of those meetings. So they have the assessment meeting and then there's others over the course of I wanna say 18 or 21 months that they're, they're involved in the study for. So it's really just once in a while we check in, how's it going? Good? No, OK, let's fix it and move forward. And those menus that were, I mentioned we can screen, we can track over time interventions are changing. We've met with practices and they kind of started one way, they twisted it a little bit different way. So we'll be able to see what types of practices adapt things in what ways over the life of the project and how maybe we could build in adaptations for the beginning of the next project and say, all the rural practice kind of dis things this way, so next time we meet with the rural practice, let's bake that in. Here you go, you can adapt less. There's less work to be done there hopefully is the idea. So future work course evaluation. How sustainable is this is the implementation successful that's to come? We also like other folks have talked about want to measure the cost of facilitation both for us, right? Sometimes driving to sites, spending time on Zoom, on email and that good stuff. But also on the practice side, how much time there are we taking? Are are we meeting that that 15 minute a month figure? And then our team wants to develop a tool kit for streamlining facilitation and how we can make it a little bit simpler. And different ways we can improve those skills for folks that might be built into the certificate program that we talked about as a group. Right? Again, revisit the the

punchlines: tailoring is important and we can make it more simple for folks with tools like like menus, right? It's a checklist. It's nothing too fancy even though it has an engineering makeup. Practice facilitation can be streamlined by design. We can take all those meetings and assessments and site visits and, and condense them just on the things that we need to focus on. And then comparing interventions can actually highlight the strengths that clinics have and the areas that they need support for and can help us identify some commonalities for future work. All right, big thank you to our funders at AHRQ like a lot of you all. And then last chain was plug slide. I'm graduating soon. So connect with me and if you could use an engineer and implementation scientist, let me know.

KATHY CEBUHAR
About 4, minutes, any questions?

AUDIENCE MEMBER
So I think this sounds like a really exciting new tool. I'm wondering what your perspective on like how relationship building with clinics like still fits in when you're streamlining, like effective approaches.

CHRYSTAL BARNES
You know?

REID PARKS
That is a great question. Did you read our, our clinical trials.gov page? Ok. Right. So what we're actually testing to say, hey, you all get streamlined practice facilitation, they all get streamlined practice facilitation plus partnership buildings. We're kind of evaluating the, the difference in effect when we add that in and the ways we're adding it in. We're still trying to streamline that make it easier for folks, but they're, they're meeting with clinicians to get training on how to [inaudbile], right. They're, they're connecting with local resources that we kind of do a warm hand off for. They're doing extra activities there that don't necessarily come just through the facilitator, we kind of spread it out and we engaged community partners to help us with that. So, so it is involved and it's not necessarily baked into the base intervention, but for those, those other clinics in the other arm, it is a significant part of their participation. That answer your question? Go ahead.

AUDIENCE MEMBER
Oh, thank you for your presentation. As you were presenting, I kept on thinking through of the different interventions that I'm helping with. Which ones can be check listed out. I keep thinking about it. So what is it about this particular intervention, the UI interventions or you know, the implementation approach that you're taking that makes this kind of a checklist or the streamlined approach possible. So for what types of efforts would this be more appropriate than others?

REID PARKS

That's a great question. It's definitely not one size fits all. You can't just take this and apply to every other intervention. And I think it's important to bring in folks like my adviser, Edmund Ramly. Very big shout out to all the work that he's been doing on this project because he's the one that kind of made it work. He took the Five A's with our other DNI experts on our team. And he said, OK, these are the elements of "ask" that we need to consider. These are the elements of "advice" that we need to consider because those those high level categories really work for any screening and treatment thing in primary care, which is a lot of primary care. So it could be broadly applicable, but it's really about getting these elements right? That, that makes it relevant to a project. So if you can codify, hey, here's the different elements of "ask." Here are the different elements of "advise." Here are the different elements of, of these that then it's possible but it really takes some art and expertise to be getting on the project. That answer your question? More? OK.

KATHY CEBUHAR
Right.