

AACP: Embracing the PBRN Model to Improve the Medication Use Process
Friday, February 23, 2007

Research to Meet the Needs of Academia and Practice

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Earlene Lipowski: Thank you for taking your seats and we're about ready to get started. We have one more speaker before we do what I threatened earlier, to roll up our sleeves and to get to work ourselves and to let all of our questions and thoughts start pouring out. In anticipating what it is that people might want to know, the planning group scientific program committee for this venture we talked about, well, maybe we should set a research agenda. And what was nice is Lyle Bootman and his committee did it for us. They really did a great job of laying out things that should be prioritized and where we could begin. So we really wanted to dive right in at this conference with let's operationalize it. Let's not just talk about what we'd like to do; let's talk about how to do it. Let's truly get started.

One of the impediments in addition to just where do I begin and how do I begin to eat the elephant is the fact that this is the American Association of Colleges and Pharmacy and a lot of us are affiliated with universities. There's a lot of college faculty now who are on non-tenure track clinical appointments. They're expected to do scholarship but we give them precious little time and training to do that. So the question occurs is this real research? Is this scholarly activity? Can you engage in practice-based research and fulfill that charge and that part of your job description? And I think I alluded to it, at least in my mind, earlier that some of the things I have looked into, questions I've tried to answer didn't seem to me to be publishable material because it wasn't research. And our last speaker, Lucy Savitz, is somebody I've heard address this question. Lucy has a lot of background experience, but one thing I've noticed, I told her when I called to invite her to participate - there are two credentials I've seen her put on her slides, PhD, MBA. She wears both hats very well. She's a very well-qualified and knowledgeable researcher, and she's a businessperson. She understands that there's real work and a real world that has to be paid attention to.

Right now she is a Senior Associate with Abt Associates. She's had about 20 years of experience in health services research and in the healthcare industry. She's had a hands-on role in managing and coordinating activities, particularly activities related to practice research, but she's qualified to talk about anything from study design and data collection to statistics, integrated delivery systems, and dissemination research. Just listen to a couple of the positions she's held. She was an economist for the Colorado Legislative Council, a financial planner for UNC Healthcare, a faculty member at UNC at Chapel Hill, and a senior health services researcher at RTI. She's been in a lot of different environments. And so it's with a great deal of pleasure that I turn the microphone over to Lucy to help us sort out are we doing research or quality improvement here

Lucy Savitz: Thank you all very much. Let me tell you first what an honor it is for me to be here. I've been doing applied research for over 12 years now and the kind of research I do would

not be possible were I not able to work with people like yourselves. And I think we share a commonality in that we're all dedicated to quality and safety and healthcare delivery. So I think it's sort of that unification that brings us to the table. I heard from Earlene that we have a multi-generation representation here in the room, so we have those people who've really dedicated their lives and careers to reducing medication errors and promoting safety and quality in healthcare delivery. We have those people who are sort of teetering here. And I think I'm one of those people. You know, you've been working and working so hard and sometimes it's really hard to see the progress that you're making, but I would contend we have made progress. And then we have young zealous people who are ready to sort of pick up the gauntlet and I think energize a lot of us. So it's again a real privilege and honor.

What you have here is my email address, which is the best way to reach me. So if you want to followup on anything I talk about today, please do not hesitate to email me. I'd be happy to be respond. I'm not so good with telephone I'll warn you right now, unless you're my children and you have my cell phone. Also, let me explain my background a little bit. I have so many careers that are under my belt because I'm a trailing spouse. So for those women in the room primarily who've been trailing spouses that explains why I've done so many different things. But I think the strength that that brings is it gives me a lot of different perspectives to bring to some of these problems. And to let you know a little bit more about some of the things that I have done and am doing that are relevant to this, I was the director of the integrated delivery system research network when I was at RTI for five years. That is another AHRQ program that was funded primarily to support applied research that brings together clinical and health services research partners to do research. And I've done about a half a dozen studies that are specific to pharmaceuticals and therapeutics. And I'd be happy to talk some more about those at another time if you're interested.

We then were awarded the, what's now called the ACTION network which is the next generation of the IDSRN. So as AHRQ has promoted PBRNs, let's see how many alphabet soups I can get up here, they've also promoted health services research through these other partnership activities. There's also the DECIDE networks that AHRQ sponsors that many of you may be aware of. And I've sat on a couple of expert panels in the past four years where almost every federal agency is looking at the notion of partnership. So I think it's really important that you are including that on your agenda and thinking proactively about how we come to the table in a meaningful way. And that's what I'll try and discuss just based on those kinds of experiences.

I also currently serve as a senior scientist for Intermountain Healthcare in Salt Lake City, Utah. And my job there is really to promote the scientific stature of clinical investigators and I teach a series of courses, one on proposal writing, one on doing systematic literature review, one on writing for publication, and one on qualitative research methods. And the idea is to give the skills to the clinicians so that they can be more active, driving partners in the research process. And I'll tie that in a little bit.

So first I'd like to talk about seeking good alignment and then seeking balance in doing applied research. So let's check in for a minute on competing priorities with respect to you as a clinician and you as a researcher. We'll put all the family obligations and social obligations on the side for the moment. How many people would consider themselves primarily a clinician, a practicing

clinician? This is your exercise for the morning. How many people consider yourselves primarily a health services researcher or clinical researcher? And how many people sort of wear both hats? So these are our schizophrenic friends in the room. So I think everybody in the room can attest to the fact that there's this incredible pull on you as you think about what your responsibilities are as a clinician and what your responsibilities are as a researcher. And it's almost in that recognition that's really driven me to focus a lot of my attention on research translation because I think that's sort of the binding force. And I'll explain why I believe that in a minute.

But we're also trying to balance. We all need that paycheck at the end of day in addition to our altruistic goals and commitment to our jobs. So we need to seek a balance between our obligations and the expectations that our employers have. And there are different obligations and expectations associated with research than there are for clinical practice. Can anybody think of any examples? How many people are going for tenure? What are your obligations as a researcher and in that tenure track process? Funding, money, and publications. And, you know, for all of us trying to get research funding right now we know how difficult it is. There's not a lot of investigator-initiated money and so there are different mechanisms we look to find funding and partnerships become even more important when we think about trying to meet those obligations.

Now what about clinical practice, what are the obligations and expectations there? Production. And not just production at any quality level or any safety level, but high quality production. You want to be as efficient as possible but you want to be as effective as possible. And I don't think anybody shows up to work as a clinician saying, "Well, I can do just this sort of a mediocre job today and that will be okay." Nobody's really comfortable when things don't go as expected. So when you're seeking this sort of goal alignment, you need to think about things related to your individual career ambitions and your job expectations. Is it important that you're a published author? You know, I know people who by the time they were 40 they had 200 peer-reviewed obligations. One of them I was married to and he had a wife, so. Some people have things that help them move along that trajectory. But when you think about what your career ambitions are, you really need to think about that as you engage in the research process. How important is it for you to be the principal investigator? How important is it for you to be the lead author on a publication? Where are you in your career and can you transition more to a mentor role so that you can give opportunities to other people who are sort of more junior and need those research credentials so they can submit proposals, so they can assume leadership positions.

The contribution to safe and high quality patient care is clearly something that I think those people doing research in the kinds of areas that we're thinking about researchers and clinicians come together here. The organizational mission and strategic priorities, how important is it to your employing organization that you engage in this? And this is particularly an issue for clinicians. An individual clinician, I know this, I was a financial planner at UNC Healthcare and it drove me absolutely insane that we did everything by crisis management. When it was an issue we'd look for the data and we'd try to address the problem. And this was in the sort of mid to late '80s before there was a diagnosis for AIDS. And a coworker and I did a study where we tried to identify the AIDS syndrome working with clinicians to estimate what was going to be the impact on the healthcare system in the next 5, 10 years so that we could prepare for that. That was initially frowned upon by the senior administrators in the organizations. But it was doing those kinds of studies that really led me to go to get my PhD because I wanted to look at the

problems while there was still an opportunity to address them, not to wait until it was crisis and you had many more limited options to be able to address the issues in terms of how would you humanely provide services to people, where were you going space those services, how were you going to pay for those services? So think about your organization mission and strategic priorities.

One of the reasons that Intermountain Healthcare asks me to come out to teach these classes is because they've decided as a high quality safe healthcare provider and in order to contribute to the evidence base they want their clinicians to be involved in health services research. And when I say clinicians, I use the term very broadly. It's not just doctors... It's nurses...It's pharmacists...It's social workers. It runs the gamut of clinicians. So it's not segregating out physicians, for instance, which some organizations do. We're starting to see many health systems around the country start having a vice president for nursing research. So there are things that are happening that are really engaging clinicians in a very different kind of way. But you need to be sure that the work that you're engaging in is something that has organizational fit. And if it does not, you'll be doing this work in the evenings and on the weekends and in your spare time. And irrespective of the organizational fit, you'll probably do some of that anyhow in reality.

You also need to have real commitments among the research partners. And I'll give you a model that I've developed over time. And to think about the extent to which you are engaging in community service by doing this kind of work. So I'm going to ask you to just pull out a piece of paper right now and think about yourself and a current research opportunity or think about something that you foresee happening in the next couple of months coming to you as an opportunity. And ask yourself, do a pro/con analysis and say, "Why should I engage in the research or why should I not engage in the research?" And I'll just give you a minute to do that.

Okay, I see people starting to look up. Tell me some reasons why it's important for you to engage in research. Great, one.(response from audience) Great. Others? (response from audience) Great. We always hope we're doing that. Anybody else? Opportunity to collaborate. Improve patient care. Career. Let's not forget the pragmatic folks amongst the group. And that's not a bad thing. That's nothing to be ashamed of because once you establish yourself in your career you then have power to do different kinds of things and enable other people in the same pathway.

Okay, what are some reasons why you would choose not to engage in research?

Time: Our most precious resource. What other reasons? Opportunity costs. Not the mission of the organization. Well, I hope if you leave here with one piece of information it will be that that is false. Yes, and I do too. Great minds think alike. But I think you're right. I think people are intimidated by the process. Others? Let's take one or two more other negative reasons, why would you not? Lack of funding. That's a big one. Others? No other reasons why you would not? Skills and ability.

So these are a couple that I came up with. But I think that you're right on track. So why would you engage on research? To address a clinical priority or identified need. In your clinical practice you observe issues all the time. And I think one of the most refreshing things I've ever done is to collaborate with people who are outside of my discipline because if everybody has been trained

in the same way you all come to the problem with the same blinders on. And the best question you can ask is why do we do it this way? Healthcare, you know, I can't tell you how many times—we've just finished a project on quality and waste in healthcare, and one of the biggest problems in healthcare delivery is when we fix something instead of liberating those freed resources and applying them elsewhere we just layer things on top of each other. And then people forget. There's no historical legacy about why have we always done it this way. So coming together with other people helps you to think differently about the work you do and how you can challenge and improve the work you do.

The opportunity to have a voice in evidence-based or national regional efforts. You know, as people start pushing these efforts on quality improvement measurement and they keep pushing the efforts on performance reimbursements, you have to think about: do I want to just be the lemming that follows along and takes what comes down the pike? Or do I want to have a seat at that table and a voice at that table to help influence it? And that alone in some cases brings organizations to the table. You can argue with senior leadership that if we don't participate now we're going to have to take what comes to us. Otherwise we're part of the process. We understand the process. We can prepare for the process. Have visibility. Let's not forget some people have egos. It's really nice to get up. I was talking to my boss yesterday and she said, "Why are you running down to Charlotte to give that talk?" I said, "Because it makes me feel good. It really makes me feel good." And to have visibility with clinicians like you. You know, one day we may meet on a telephone call or at a meeting and you may be potential partners of mine. So it's great that you'll know who I am when I call you up and say, "Hey, you want to work on this project together?"

To meet your job expectations: In some places you are required to do research. And so you have to think about how you're going to meet those obligations. One of my mentors is Arnie Kaluzny, who was a long-time faculty in the department of health policy and administration at UNC Chapel Hill. And one of the most important lessons he taught me is that early in his career he partnered with another faculty member which was very different than another faculty member's mentality. For those of you in academia, you'll understand this. Most academicians work in their little silo and they're doing their work and they're very protective, you know, here is my work, this is my space, and I'm going to be the first author on my publications, and I'm going to be the PI, etc., etc. Well, what Arnie and Jim did is they flipped it. You be the PI this time, I'll be the PI next time. You be the first author this time, I'll be the first author next time. And that increased their productivity exponentially that they were able to do that because it wasn't one person working alone, it was two people coming together.

Another reason it's important is because it holds your feet to the fire. You're obligated to somebody else. You know, doing research is like getting a postgraduate degree. The only one who's going to incentivize you to move forward is you. You know if you're stuck writing that dissertation or writing that master's thesis I think most universities give you 10 years to finish but there are clear opportunity costs to spending 10 years finishing that. So if you have somebody else who's setting deadlines for you and sort of pushing you forward, that can be a very positive thing.

And then having available technical assistance. I did a leadership program for the American College of Obstetricians and Gynecologists for seven years when I was on the faculty at UNC. And one of the things that would always happen inevitably at the end of these intensive week-long sessions is that clinicians would come up and say, "God, I feel I need to go get an MBA and a JD after leaving this program." And I said, "That's not the point." The point is you can't specialize in everything. But if you can find people that you trust to be partners to work with you, you bring all of that expertise together. We're all human. We don't have, you know, there are very few of us who have room in our brains to constantly be balancing all those different disciplines. So thinking about the team is a real opportunity to bring in areas that you're weak in.

There's a great book on breakthrough thinking. And one of the main points to that book is that most of us spend 80% of our time compensating for the things that we don't do well, and 20% of our time doing the things that we do well. And what the authors advocate is that you should reverse that. You should spend 80% of your time doing the things that you do really, really well, and 20% of the time compensating for those things. And you make up that difference by working with other people who make up for it. So it encourages you to surround yourself with people who bring different skills to the table. I always tell people if I die and go to hell there are four things that I would do. Can you guess what they are? I bet not. I would iron for eternity. I would Xerox for eternity. I would be an accountant. And I would be a computer programmer. Now that doesn't mean that I have any disrespect for any of those things. In fact, I have the utmost respect for them. I can program, but it probably takes me 10 hours to do something that a trained programmer could do in one or less, probably. I'm of the days when we had punch cards and then later when you were looking for the missing semicolon in the program with these cryptic error messages, and I can't tell you how many times I've been at 3:00 in the morning looking for those things. So, you know, thinking about how you can bring that technical expertise on board to help extend you and make the work that you do more pleasant because you will be donating some of your time when you do this kind of work.

So the cons. It detracts from patient care. I have done probably 30 some studies with clinical investigators and it's really hard for them. If there's a deadline or there's a meeting but you've got a pressing clinical situation, there has to be understanding amongst the researchers that there's a patient life at stake or there are patients who won't get their medications on time. And for some patients that can be life threatening. You know, so having this sort of mutual understanding that in some cases you want to prepare yourself for backup plans when patient care is at stake because patient care needs to take priority over submitting the manuscript today. Okay?

Ethical issues: In some cases there are ethical issues. Can anybody think of any ethical issues that might, I'm sorry? I can't hear you. Stem cell research. So are there some research investigations that may be problematic given the organization that you're partnering with. One of my main research partners is the Catholic Healthcare System and they've been an incredible research partner, but there are certain problems that we don't investigate in that environment and I'm sure you can guess what those are.

Insufficient time and competing priorities. Now this is where it goes beyond just the time issues associated with your job and your interest in research. We all have families. And there are sick

children, there are sick parents that people, you know, we're looking at a generation of people who now have responsibilities taking care of their elder parents. So people have issues and problems that go beyond the job sphere that we need to be accounting for.

One of the other lessons that Arnie taught me, Arnie's a very senior person, he says he's retired but he still works probably 40 hours a week, so you can guess how many hours a week he worked before he was retired. You know, he looks back now that he has grandchildren and sees the joy that he has with his grandchildren and reflects on how much he missed with his own children. And so there are certain personal decisions you have to make about how you're going to allocate your time in the research arena or the clinical arena or making decisions about should I be more fully in the research arena or more fully in the clinical arena. And really having truthful conversations with yourself about that because that makes you a better partner. If you 'fess up to where I'm putting my priorities and how I'm allocating my time and you can be honest about that.

I have a colleague who called me up and said, "I need you to work on this paper with me and it's reporting on a re-analysis of a project that we completed three years ago." And I said, "You know, these are all the things I have to do this week. If you need it by Saturday, all I can do is write one paragraph for you." So being really honest and not taking on more than you think you can do.

Insufficient resources. Not having the space, not having the computer hardware or software that you need to do the work, not having the right people to help you do the work. And the biggest problem as a researcher is not having the right data. Questionable role or value to the organization. If your organization doesn't value it, then it's a con.

And I'll tell you at the end of this talk some strategies that I have for converting some of these cons into pros within the organization. Barriers to research participation, we've talked about limited time and adequate resources.

No formal administrative infrastructure. This is a big one. One of the problems that we've had working with clinical partners is they are not research organizations. Abt Associates, like RTI, like Mathematica, like Rand, and many universities are research organizations. They know how to do research. They know how to submit a proposal. They know how to do the budgets. They know how to submit the progress reports. And that's one reason why a research organization can be a valued partner, if they're willing to take on that responsibility for you because they have a contracts office; they have a legal department that can process this. They understand all of those things. And now with the electronic submission of NIH grants they understand the electronic submission process which, believe me, after spending two days trying to submit a proposal last week I value that I can next time hand that off to somebody else who can go through the multiple error messages that you get. Remember my love of computers and programming.

So I'll give you an example. We're working with Coastal Family Health centers. It's a network of 18 community health centers that are based in Biloxi, Mississippi. Six of their facilities were severely damaged after Hurricane Katrina hit. And we were actually putting in this grant application with them. They're not a research organization. They have no researchers working

there. They have one finance person who does all of their billing for them. And so basically what Abt was able to do, and I'm not here marketing Abt, but I'm marketing partnering with a research organization, we were able to put their budget on the right form. We were able to draft up a budget justification for them. We were able to actually sit down with them through the submission process because they were the primes on the grant application. So we actually brought those resources to the table. So just because you work in a clinical organization and you think, "I don't have the administrative support to do this," you can reach out and acquire that.

Limited incentive to do research: You know, in your organizations if you're not on a tenure track what will it get you if you publish something in the peer-reviewed literature? It may stroke your ego a little bit, you know, that you find something in print and you can send it to your mother. I'm waiting to get my son's first peer-reviewed publication. But it doesn't give you a whole lot. And if I had to tell you in the area of research that I do, I really study the implementation of clinical process innovations that are associated with improved quality and safety in healthcare, which is a mouthful, but if I—when I look at that literature, the literature is biased. And it's biased because for the most part, probably 95% of the studies that are published publish positive results. Do you think in quality improvement that 95% of the attempts to improve quality are positive outcomes? Probably not. So what that means is there are a lot of people doing quality improvement and not reporting it in the literature. And in many cases we learn more from the failures than we do from the successes.

The other bias that I've seen when I've looked at the literature is that even when somebody reports a positive finding it's very difficult to read that article and say, "Okay, we're going to do it here. They had a really good result at Brigham & Women's, or they had a really good result at Vanderbilt, and we know those are good places, so we're going to try and model that here." You can't necessarily expect to achieve the same success by modeling that if the investigators haven't evaluated it in a way or collected the data in a way that lets you say of the seven things that we did that comprised this quality improvement intervention, three of them are essential. You've really got to implement them intact. And four of them can be adapted to your clinical setting or the environment, you know, maybe you're in a rural environment instead of an urban environment. And so the real sort of challenge for us as health services researchers as we partner is to think about when we do the studies, even if it's quality improvement, to try and collect the data in a way so that we understand what is essential and what can be adapted. And then we can begin to build an evidence base that allows people to build on the evidence base and allows people to model the successes that we identify so that we can sort of share them more broadly so we can spread and have impact. And I can tell you, working for AHRQ, whether you're working in a PBRN, an IDSRN, an ACTION, or a DECIDE, impact is a big deal. They want to understand how can you sort of move across that impact pyramid.

Poor team communications are a big problem. And they're a big problem because depending on who represents your organization or who's on the team a single form of communication does not always keep people in the loop. So if the only way you communicate is at meetings there are some people who just can't attend the meetings for one reason or another. And there are certain people who feel like telephone calls don't really work for them. You know, we all process information differently. Some of us can sort of shoot from the hip, you know, and I can tell you what I think right now. And other people are ponderers. They like to have something presented

to them. They go away and they think, “Ah,” you know, I have an ‘aha’ moment and that I’d like to share with the group. So without having mechanisms to communicate and allow everybody on the team to participate, it can create some problems. And I’ll show you a sort of model that I developed related to that.

Unequal partnerships. How many clinical researchers here have been in an unequal partnership where you felt like you were sort of the second class citizen on the team? Has anybody had that experience? I’m sure. Some people are intimidated to raise their hand, but I bet you there are people in the room who’ve had that experience. And sometimes it’s self-imposed. Sometimes you think, “Well, gee, that person has a PhD or that person has some string of letters after their name and I don’t understand the statistics or I couldn’t do the programming.” And so you feel like you’re sort of the stepchild of the process. Or another big problem, and I think it’s sort of a cultural issue, is that many academicians will come to clinicians and all they want is your data. They take your data, they go away, they’ve published their results, and you may or may not ever see those published results. And that has caused sort of these suspicions to sort of be manifested in research organizations. And so we need to think about when you come to a research partnership setting a set of rules and expectations.

So if you expect, if your organization is participating in the research maybe your leadership requires that you review any publication before it goes out. Not that you’re going to inhibit the publication process, but that you want to look at how your organization is going to be painted in the peer-reviewed literature. Or maybe you require if people do research they have to produce a one-page fact sheet that synthesizes the research findings and suggests what’s recommended to improve clinical practice. What has high operational utility to your healthcare organization? And that’s one of the things that we’ve tried to do. So your responsibility is not just to contribute to the peer-reviewed literature, but it’s also to improve practice. And if you’re going to effectively do that, you need to be able to communicate in very different kinds of ways, use different dissemination channels, make presentations at multiple meetings, not just national meetings, but meetings within the clinical organization that are targeted to those clinicians who are impacted by the research.

You know, if it’s research about how nurses use a Pyxis system, if the only people that you present those results to are people who read, what’s the main journal in your field? Huh? *JAMA*? Okay. So how many nurses who use Pyxis do you think regularly read *JAMA*? You know, not many. So you have to think about how do I get that information? Do I do a partner paper that goes into the *American Journal of Nursing* that then would take those results and give that information to nurses as well as give that information to other researchers or to other clinicians who would then regularly read that? One of the projects that I’ve been working on looks at using electronic medical record data so that we can develop a set of triggers, if you will, for adverse drug events, for nosocomial infection, and for pressure injuries in the hospital. And we have determined in doing that study that in some cases it’s important to merge different kinds of data from different kinds of systems because there’s so much variability and information technology across hospitals and health systems.

And one of the things that we saw is that health administrators, CEOs, COOs, CIOs, in hospitals, are making really important decisions that affect the kind of data that’s available to you

electronically to develop such tools. So whether people decide to template the information or to allow it to be free text is a big difference. If you have templated information you can use it for research purposes and you can use it for developing trigger tools. When it's free text we don't yet have the software available that can go through that free text and cull out the information that's required. Now when people put an EMR in place or an EHR, whichever you want to call it, they're not thinking about how this be used for research or triggers. They're thinking about let's put an IT tool in place that can be used to improve clinical practice. So from their perspective they're making really good decisions. And they don't necessarily understand this. So our primary target audience is hospital administrators. And we're publishing this in the peer-reviewed literature, but we're also putting in an article in *Modern Healthcare*. And we're also doing presentations at the American Healthcare Executives conference because we need those people to understand that it's not just about providing clinical care at the point of service, but it's also bringing together the population-based data that can allow us to make the improvements in quality and safety that could be achieved by having that electronic data readily available. So helping them understand as they're making those decision making processes what some of the implications are.

Burned bridges. How many people have had bad experiences doing research? Probably more hands come up here. You know, so that's a barrier. If you have one bad experience you're going to think a couple of times before you engage, even if it's a completely different team. And I hope at the end of this presentation you'll walk away in the spirit that you will revisit some of those decisions and think more clearly about who the research partners are, what your expectations of that research process are, and try to find positive opportunities.

And past losses. One of the first lessons I learned in doing health services research was that persistence pays. I worked at the Shep Center for Health Services Research as a graduate student in Chapel Hill and there was a grant that had been submitted, this was before the three times and you're out rule of NIH, it had been submitted four times before. And it didn't get funded until the fifth time. And it led to the publication of a book, "Geographic Methods for Health Services Research. You can get it at amazon.com. But the point is is those people believed so much in the idea they didn't stop. You know, I've sat on study section; many of you have sat on study section. You know, in some cases especially now they're funding at such a high level but there are many good quality proposals that go unfunded right now. When you don't get funded it doesn't necessarily mean that you didn't have a good idea or you didn't have a good team, it may mean that there were insufficient resources available or it may mean that your proposal didn't go to the right agency or foundation that was a good fit for the research idea. So persistence pays. Keep trying. Keep applying yourself. Look for unrestricted funds from pharmaceutical companies. Look for, you know, un-sponsored research opportunities that your own organization might provide. Some organizations have seed money to do pilot work.

Enabling factors. Pre-established working relationships. If you have good working relationships. Partnership trust and credibility. And I would say of anything this is probably the number one or number two attribute. If you want to be in a research partnership, having trust and credibility of your research partners is essential. This is one thing that you really cannot do without. Perceived value. That there's not just value to the researchers, there's value to the clinicians. And the clinicians can clearly see how the research that's being done will have operational utility and it

will be communicated in a way that that operational utility can be realized. And the ability to leverage resources. Like I talked to you about Coastal, the proposal that we put in.. When we are funded, I'm thinking positively here, when we are funded it's going to be a really important infrastructure to Coastal Family Health centers. And so it will be an ability for them to leverage resources. For me working in a research organization it would be impossible for me to do research without their clinical setting. The kind of research I'm proposing to do I simply could not do without that clinical setting. So you bring a resource whether it's money or not.

Clear goal alignment, that's articulated for people. The opportunity to grow and improve is another important opportunity.

This is a framework that I developed. I've been the lead on the partnership subcommittee for the AHRQ council of partners for the past four years. And in my partnership grant I tried to say what does it mean to have a successful partnership? And this is an adapted model from some work by Lasker and Rice. And so when you think about a research partnership you really need to think about the elements that hold it together and can make it successful. One is the leadership and management, who's going to assume responsibility for that? What are the critical characteristics of the process? And then in terms of this perceived value, is there individual empowerment? Do I empower you to go back to your organization and share information that's useful that makes you look good in your organization? The social capital, how we relate to each other and team with each other. And then the synergy, the extent to which we're studying ideas that are important to contribute to the evidence base from a research perspective but also are very meaningful in the clinical operations. That you're coming together to collaboratively solve problems. And in some cases the clinicians are the ones who actually generate the ideas and identify the problems that are really worthy of study. And then figuring out how to learn successfully and then transport those interventions to other places. So keep that in the back of your mind.

We actually developed - we pooled information from a variety of validated surveys. And we created a partnership strength tool that we actually use on a quarterly basis with our research partners. And we use that to check in and monitor the quality and value of the partnership. If you'd like a copy, I'd be happy to email it to you. Just email me because I know I'm short on time here.

So what makes a good research partner? Fulfilling your obligations on time, both research and administrative, and not creating backlogs. I've worked with a very senior researcher in the past that was notorious for this. And you literally had to say to him finally, "You have until this date at this time to respond and if you do not we're going to go ahead and submit the paper." You've got to figure out who is your backlog in that process. Attending meetings and staying abreast. And it's okay to ask for tools that help you do that. If you know that you travel a lot, asking people for meeting summary notes, that's an okay thing, or having follow-up calls with people to say, "You know, I'm sorry I missed the meeting, but could you tell me, you know, basically what happened?" And understanding that many times you get volunteered for things when you don't show up for the meetings.

Providing constructive feedback. Don't like get frustrated and hold it in. It's like any kind of relationship in your life; you need to be sort of up front about what it is. We always teach

people when they're starting on writing a paper or working on a grant project, one of the first things that you have to do is to establish who's going to be the lead author. Don't wait and don't let people expect it. You know, because it causes hurt feelings. It causes sort of bad juju. Looking beyond what's in it for me and contributing as a team member. And I think that's a really important issue. And especially for senior people, to think about is it so important that I get one more notch on my CV belt? Is that really the most important thing or is it more important for me to sort of help lift some other people up, give some other people some visibility? And then giving visibility to the work within your own organization. One of the things that makes a good clinical partner in a research process is they become committed to the research process because the organization itself sees values. So when there are opportunities to generate measures from your work that can be used by a quality subcommittee of the board of directors or to have presentations to such committees, or to find ways to highlight the work that you're doing to senior leadership, if there are executive management meetings that you could present before and say, "Okay, we did this research. This is why it's important. This is why it contributed to the process."

And let me just talk to you a minute. There's some colleagues of ours, Dennis and Lomas, who've really thought a lot. They're Canadian researchers. Has anybody read their work or seen them at meetings? They've done some really wonderful things and if you're interested in their web site I'd be happy to supply it to you. But they really talk about the need for ongoing interaction between clinicians and researchers in order to enable these kinds of partnerships. And so they talk about that exchange as being a deliberate set of interactions and processes designed to specifically bring together those who study social problems and issues, which are the researchers, with those who act on or within those social problems and issues. Those are the decision makers, the practitioners, the citizens.

And it's really important to think about, you don't pull your team together at the last minute and reviewers will look for this. They want to know that you have pre-established working relationships with people, that we didn't come together just for this proposal, that we've been thinking about how do we work together for some time and that's what a PBRN is about. It's about bringing together people or any of these research networks, whether it's formally sanctioned and funded by a federal agency or it's something that you pull together as a collaborative in your own community. These are a set of relationships where people perceive value, there's trust, and there's credibility. And ways to create demand for useful high operational utility research include creating forums for the exchange. Are there ways in which you can have meetings or you can invite researchers into the clinical experience whereas clinical researchers attend meetings and get to know folks.

Having an organizational structure and value and visibility for research within the organization. I described to you at Intermountain Healthcare how they've really revised their mission to include research as an organizational priority and then have done things like commissioned people like me to come in and give individual skills which are the next thing.

Give individual skills on how to participate. If you're trained as a clinical pharmacist you may have never been exposed to learning how to write a research paper. Most of the people who've got PhDs are never taught how to write a research paper. So giving people those experiences to

learn. And then just sort of developing sort of a knowledgebase that you can build upon so that if you can share with your colleagues or give exposure to your colleagues on how this has worked it's a word of mouth way that we can increase this. When you're in a PhD program learning research, you don't learn about research practice. And you don't learn about how to be a good research partner. And you really don't learn about how to translate research into practice at all. That's not—people, you know, the currency in academia are peer-reviewed publications. It's not preparing a fact sheet. It's not preparing a little blurb that goes into one of these e-newsletter kinds of things. So think about sort of pulling yourself out of the box. And I'm sorry, I think I'm out of time now. But, again, you have my email address. I'm happy to communicate with you further, and thank you very much for your time. Good luck.

Earlene Lipowski: Thanks, Lucy, I needed that. Originally when we planned the program I had Lucy penned in on the second day and the planning committee looked at what we thought she would bring to the program, they said, “No, you've got to move her to the first day.” And so I'm so glad we did.

At this time we're going to get ready to go to lunch. But before I let you go I'm going to turn the program back to, or turn it over. I'm actually through the part of this meeting I've been dreading which was being a moderator or introducer. I want to get back down there and be a participant and get to work now. So I'm going to turn this over—everybody's—us over to Jann and Patti and let them do their thing, lead us through some creative, and they're going to give us an overview before we go to lunch so we have some sense of where we're going from here.