Published in final edited form as:

Healthcare (Amst). 2013 December ; 1(3-4): 130–135. doi:10.1016/j.hjdsi.2013.09.002.

Using FastTrack to Implement an Academic Medical Center and Community Health Center Collaborative for Cancer Care Delivery

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Background

Racial and socioeconomic disparities in cancer are well documented, but little is known about how to effectively implement interventions to address them.¹⁻³ This case study describes the process used to coordinate the implementation of a clinical outreach program based on an innovative delivery model⁴ across the three participating institutions, and the lessons learned from this approach. The process entailed a multi-disciplinary, multi-departmental and multi-institutional effort to integrate services for an innovative strategy to address cancer disparities, and execute it in an accelerated timeframe within an academic medical setting.

Organizational Context

Whittier Street Health Center (WSHC) is a Federally Qualified Health Center that has been serving residents in Roxbury and other nearby underserved communities in the Greater Boston area since 1933. WSHC provides comprehensive health services including primary care, behavioral health care, substance abuse services, dental care and eye care to over 25,000 patients. WSHC also engages in extensive outreach, health education and health promotion activities for local residents. It has a longstanding mission to deliver high quality care to vulnerable patient populations. Fifty-four percent of WSHC patients live below the poverty level and 92% of these patients live below 200% of the poverty level. Eighty-three percent live in public housing, and 35% are uninsured.⁵ To accommodate a patient population originating from approximately 25 countries, interpreter services are offered for 12 languages.⁶

An affiliate of Harvard Medical School and a Comprehensive Cancer Center designated by the National Cancer Institute, Dana-Farber Cancer Institute (DFCI), an internationally-recognized ambulatory cancer center, has approximately 480 specialists who treat cancers across all disease sites, and participates in over 700 clinical trials.^{7,8} Also an affiliate of Harvard Medical School and a partner in the Comprehensive Cancer Center, Brigham and Women's Hospital (BWH), a tertiary care academic medical center, is one of the highest ranked institutions in the United States and has approximately 3,000 physicians and 46,000 annual inpatient admissions.⁹ Through a longstanding collaboration, the two centers offer integrated services for adult patients from a multidisciplinary team of specialists across 13 disease centers, each focusing on a different type of cancer. Most outpatient services are provided at DFCI and inpatient services are provided at BWH.^{8,9}

The DFCI Community Benefits office is responsible for education and outreach to communities in local areas. WSHC has been a partner in these efforts for over a decade, hosting patient education forums and serving as a screening site for the DFCI mobile mammography van screening program. More recently, a community survivorship program was started at WSHC in conjunction with the DFCI survivorship program. The CEO of WSHC is also on the DFCI Board of Trustees.

Personal Context

The FastTrack was organized and led by the faculty director of the clinical outreach program, the DFCI Vice-President (VP) of External Affairs, and a management consultant.

The faculty director of the clinical outreach program is a medical oncologist, clinician and health services researcher with an interest in health disparities. His interest in the program stemmed from his training at a safety-net hospital, and formed the backdrop for his goal of improving access to DFCI for the urban underserved.

The VP for External Affairs is a member of the DFCI executive leadership team, and directly oversees Community Benefits and Government Relations activities. Her interest in the program evolved from more than a decade of collaboration with WSHC to improve cancer education, screening and early diagnosis for at-risk residents of the community it serves. This work aligns with the community benefits mission of DFCI.

The FastTrack consultant, a management consultant and faculty instructor, has over 20 years of experience in providing business organization expertise to global corporations, non-governmental organizations and governments. Having initially adapted FastTrack, a rapid organizational change process, from corporate to global public health settings, he was invited to expand its application to community and institutional partnerships in U.S. clinical settings as part of an initiative sponsored by the Community Health Innovation and Research Program of Harvard Catalyst, Harvard's Clinical and Translational Science Center.

Problem

DFCI has long been involved with outreach to vulnerable communities in the city of Boston. Concordant with a recent needs assessment commissioned by the DFCI Community Benefits office,⁴ several oncologists had become increasingly concerned about the low numbers of patients of racially underserved populations being seen at DFCI, and the lack of integrated care from prevention to survivorship available for patients from racially underserved and low income populations. As a result, DFCI decided to establish a comprehensive Cancer Care Equity Program with the goal of broadening access to vulnerable patient populations and to join its community partners in the quest for equitable care across the spectrum of cancer-related disease.

The inter-institutional collaboration offered the potential to be mutually beneficial. Improving cancer access allows WSHC to improve patient care and patient outcomes which can provide them with a competitive advantage over other community health centers. For DFCI, it was anticipated that this program would increase trust and build relationships in communities where its presence had been lacking, potentially laying the groundwork for treating underserved populations. It was also viewed as a good alignment with the NCI's emphasis on increasing the participation of racially underserved populations in clinical trials.

Initial discussions around the conceptualization of the model took place DFCI over the course of a year. The integrated cancer care services already offered by DFCI and BWH provided the foundation to extend this partnership for the outreach program. For the pilot clinical outreach facility, DFCI chose to partner with a community health center with which it had already worked closely to implement other outreach programs over the past decade. This decision reflected DFCI's ongoing commitment to the communities served by WSHC, while the institutional and interpersonal ties that had been developed through prior collaborations were considered to be critical to addressing the complex logistics required to implement this innovative model. During the intervention design phase, several discussions among the faculty director, other oncologists participating in the intervention, and WSHC providers were held to outline a program. Subsequently, broad support for the initiative was obtained from the DFCI and WSHC leadership, a legal agreement describing the roles and responsibilities of the two institutions was put into place, and external funding was secured. The goal was to have the clinical outreach facility become operational within the next five

months, when WSHC was to move to a new site that would include a dedicated space for the facility. To accomplish this, it was necessary to take into account the different populations served by each participating institution, integrate all of the different functions (including clinical, referral processes, insurance, financial, legal, interpreter services, social work) across three institutions, and obtain the buy-in from the relevant stakeholders at each institution.

The intellectual underpinnings of the project were strong, based on a foundation of patient navigation and a review of interventions from the disparities literature,¹⁰⁻¹² but the actual formation of the outreach model occurred in three stages. First, discussions were held with DFCI leadership, as well as WSHC leadership regarding the need for the program. Second, iterative discussions with DFCI nursing, medical oncology leadership, community benefits, and access management were imperative to the development of a formal business plan that was completed after a yearlong process. Thirdly, the business plan was vetted and adjusted via discussion with the WSHC physicians, and plans for implementation began. It is important to note that the financial support from the program came about via philanthropic donation, and as such the business plan was structured to allow for examination of sustainability after initial program metrics were collected in later years.

Solution

To implement the clinical outreach program, key stakeholders were brought together using a facilitation process titled “FastTrack” (Figure 1). Adapted from *GE’s Work-Out*¹³ for use in public health and health care settings, FastTrack enables organizations to solve problems within a short timeframe by identifying and bringing together the appropriate stakeholders to meet in structured, focused sessions guided by trained facilitators. Executed across three phases (Figure 2), stakeholders develop *and implement* practical solutions to achieve their goals, with the support of senior sponsors and organizational leadership.

During the FastTrack design phase, the FastTrack consultant worked with the faculty director and VP of External Affairs to identify and recruit the key institutional stakeholders whose participation was needed, including physicians, the program nurse, administrators, and senior-level representatives from clinical, nursing, financial, social support, interpreter, and transportation services. None of these people had met together as a team before, nor were they all acquainted with one another.

In line with FastTrack criteria, clear, measurable objectives that could be achieved within a 90-day timeframe were developed (Figure 3). The overarching goal of the FastTrack was to structure clinical and administrative processes across the three participating institutions in order to create a new clinical outreach facility. To measure whether the integration of services across the three participating institutions had been achieved, and whether patient care could be provided through the referral pathways within a clinically appropriate timeframe, the team decided to pilot test the new system with mock patients. The finalized objectives were to structure the administrative processes and clinical care to 1) enable 10 mock patients to flow through the referral pathways among the three institutions; and 2) develop a plan of care within 21 days of their initial appointment at the clinical outreach facility.

During the FastTrack meeting phase, participants were provided with an overview of the FastTrack methodology and the specific project goals, and divided into a Clinical Team and a Business Team. A preliminary strategy to integrate services across the three institutions was developed, guided by facilitators who helped participants to focus conversations and develop plans with concrete, concise action items for each team member. Decisions were

made in real time; stakeholders selected to participate in the FastTrack were either in leadership positions within their departmental areas or had been given the authority to make decisions during the meetings. At the end of each meeting the two teams reconvened in order to summarize their issues and solutions and receive feedback from each other.

During the FastTrack implementation phase, each team brainstormed to anticipate and address the broad range of issues that could arise from coordinating clinical, administrative and financial services across three institutions, and developed several mock patient scenarios to use for a practice run of the facility.

Several procedures were developed to ensure continuity of care across the three participating institutions, including: billing and referral mechanisms; communications between and among primary care and oncology practitioners; access to medical records; provision of social work and interpreter services; and coverage for patients whose insurance was not accepted by all three institutions. These procedures were then pilot-tested through a variety of scenarios with mock patients. All 10 mock patients were successfully navigated through the referral pathways across the three institutions. Due to using mock patients, it was not possible to determine whether a resolution to their cancer symptoms could be obtained within 21 days. However, through the referral processes developed for the intervention, the timeframe for processing the mock patient referrals was reduced to two days compared with the standard five day timeframe for new referrals into DFCI. Based on these results, the FastTrack participants felt confident about implementing the full program and the clinical outreach facility opened on schedule.

By incorporating clinical and administrative stakeholders from each institution into working group sessions to make decisions in real time, the clinical outreach program became operational within the targeted timeframe. The program provides integrated evaluation services at WSHC, treatment referrals to the DFCI and BWH, and patient navigation, comprised of: medical oncology in collaboration with primary care physicians; coordinated referral services; and support and education. After the clinic opened, it became clear that a mechanism was needed to track patient referrals, appointments, tests, and navigation processes. A tracking database has since been developed.

Challenges Encountered

Institutional participation—Although the WSHC leadership were committed to the intervention and shared the goal of the clinical outreach facility being ready to open by the target date, they were already overextended due to maintaining their existing clinical services while preparing to move to a new building that was still under construction. To avoid delays in implementing the intervention, DFCI and BWH decided, with the endorsement of WSHC, to proceed with the FastTrack in order to work on the portions that pertained to these two institutions. However, the WSHC CEO and CFO did attend the final FastTrack meeting phase session, and provided their input in order to finalize the action plans for the implementation phase.

Securing the “buy-in” of individual stakeholders—A number of DFCI and BWH personnel did not understand why they were being asked to participate in the FastTrack initiative. Some of the financial and administrative stakeholders were skeptical about whether each institution could accept the patients who might be referred to them. In addition, several stakeholders were hesitant about committing to a series of in-person meetings. Ultimately, the faculty director and VP of External Affairs persuaded them that the process of bringing all the stakeholders together for face-to-face meetings to make decisions in real time would save time for everyone involved.

Scheduling—In corporate settings, participants typically meet for 1-3 days and emerge with an action plan.¹³ Although the FastTrack consultant has maintained this type of schedule for other types of public health and health care initiatives, it was not possible within a clinical setting due to patient obligations. Therefore, the action plan was developed through an initial 2-hour session followed by two 5-hour sessions held over the course of a month.

While most tasks could be completed among the team members, both teams had to arrange follow up meetings with WSHC stakeholders in order to take care of remaining needs, including issues pertaining to interpreter services and social work, procuring equipment and supplies for the clinical outreach facility, and training the DFCI staff to use the WSHC medical records system and billing codes. A system for coordinating between DFCI and WSHC to schedule appointments at the clinical outreach facility was not fully developed until the facility had already become operational.

FastTrack timeline—In industry settings, the design stage is normally completed within 4 weeks, followed by a 1-3 day meeting phase and a 90 day implementation phase.¹³ In public health and health care settings, the FastTrack consultant has found it necessary to slightly extend these time frames (Figure 2). Due to the diffuse nature of the leadership within and across the participating institutions in the clinical outreach program, however, it took 4 months to assemble the FastTrack teams and a full month to complete the meeting phase. Therefore, the implementation stage had to be accelerated and completed within just 35 business days so that the clinical outreach facility could still open by the time WSHC moved to its new location.

Administrative and billing issues—The Clinical team's objective was structure the patient and process flow across WSHC, DFCI and BWH, which it accomplished by developing a patient intake form, rotation schedule for the participating oncologists, and patient brochure. While the Business team had to structure several administrative, financial and legal processes, its greatest challenge was that the institutions did not all accept the same insurance plans. Team members brainstormed solutions to several insurance scenarios, and developed an administrative process flow chart to document the procedures to be implemented within and across institutions (Figure 4).

It was determined that patients to be seen at the clinical outreach facility would first need their insurance verified by both DFCI and BWH in order to avoid delays in referrals or the prospect of having to tell patients in need of a referral that they would have to seek care elsewhere. To minimize patient burden, a process was developed for the program nurse and access management personnel from each institution to handle the insurance verification process and problem-solving on patients' behalf. Patients with high-risk insurance coverage would be provided with the opportunity to switch their insurance coverage if eligible, with the assistance of the program nurse and WSHC access management. Those unwilling or ineligible to change coverage could still be seen at the clinical outreach facility, which would operate under the WSHC license. However, for those in need of a subsequent diagnostic work-up at BWH and/or treatment at DFCI, authorization would first need to be sought from the insurance carrier. If denied, the program nurse would work with the primary care provider and a referral coordinator for services from one or both institutions to be provided by another facility.

Lessons for the Field

Despite encountering several potential obstacles, implementation of the clinical outreach program via the FastTrack process was successfully completed within the target time frame.

Several elements were key to this success. Most importantly, the appropriate stakeholders were identified and became invested in the implementation process. This was achieved by effectively communicating to them the value of the intervention, the value of each stakeholder's role in its implementation, and the value of the implementation process, i.e., that it was a worthwhile use of their time to participate in face to face meetings. This was facilitated by formal endorsements from institutional leadership as well as the funding for the clinical outreach program having already been obtained, demonstrating to stakeholders that the clinical outreach program was a high priority and that these meetings were not simply to discuss a hypothetical initiative.

Second, findings from a process evaluation undertaken to evaluate the fidelity with which the FastTrack was conducted indicate that a high degree of "implementation effectiveness" was achieved.¹⁴ Implementation effectiveness refers to the consistency and quality of participants' use of the innovative practices and strategies developed to carry out the implementation.^{15,16} Utilizing an external consultant and skilled facilitators was critical to implementing the intervention in a healthcare setting that required coordination among stakeholders across departments and institutions who do not normally work together. The external consultant was helpful for identifying the relevant stakeholders, achieving their buy in and introducing the FastTrack process to structure to the implementation process. The facilitators, in turn, helped to keep meetings focused, maintain a positive climate, and move participants through a series of stages from brainstorming ideas to generating action items and assigning responsibility for carrying them out.

Third, the FastTrack organizers recognized the need for flexibility in the implementation strategy. In particular, the timeframe and scheduling for implementing the FastTrack process had to be adapted in order to be workable in a health care setting. While the FastTrack design and meeting stages took significantly longer than anticipated, once all of the stakeholders were identified and the meetings scheduled the FastTrack process and the beneficial pressure of a fixed deadline gave everyone the discipline to make decisions and take action quickly.

Fourth, DFCI chose to partner with institutions with which it had already successfully collaborated and established strong ties. Without this foundation, implementation of this complex innovative cancer care delivery model might not have been possible, especially since the WSHC stakeholders were unavailable during the time period when the FastTrack needed to be scheduled in order for the clinical outreach facility to open on time. Certainly it would have been optimal to have stakeholders from all three institutions participate throughout the entire process, and initially this issue threatened to put the entire implementation process on an indefinite hold. The FastTrack was able to continue, however, due to the longstanding relationship that had already been established and ongoing communication with the WSHC leadership throughout the FastTrack process.

Fifth, DFCI and WSHC were able to establish a synergistic relationship by identifying mutually beneficial goals, including deliverable, patient-centered outcomes that were relevant to all institutions. For WSHC, the onsite specialist services offer the potential to improve patient care and convenience, providing a competitive advantage. The collaboration has enabled DFCI, in turn, to address local-level cancer disparities, build relationships in underserved communities, and align with the NCI's goal of increasing clinical trial accrual of patients from racially underserved populations.

Finally, multidisciplinary, multi-departmental participation and viewpoints were valuable. Although the faculty director initially had reservations about the FastTrack process, he quickly realized its utility after the initial kick-off meeting. One of the challenges of inviting

other stakeholders to participate in the FastTrack process was that it required relinquishing some control over the innovation. However, allowing others to contribute their expertise and actively engage in the implementation process led to improvements in the intervention. By bringing together a variety of stakeholders from the clinical, financial, administrative and social support services, the vast majority of potential issues that could arise in relation to referrals, insurance, billing and information transfers across institutions were anticipated and resolved by the time the first patient was seen in the clinical outreach program. As an added benefit, the timeframe for processing referrals was reduced to two days compared with the standard five day timeframe for new referrals into DFCI. Moreover, some participants noted that the FastTrack was not only successful at facilitating communications for the clinical outreach program, but had a long term impact of strengthening the broader level of communications and collaborations both within and between DFCI and BWI.

One of the benefits to using the FastTrack facilitation process was its emphasis on developing clear, measurable goals that can be achieved within a 100-day timeframe. By revising the first goal to include pilot testing the clinical outreach with mock patients, it became measurable. As noted earlier, the second goal, to achieve a resolution to patients' cancer symptoms within 21 days, could not ultimately be tested with mock patients. However, the expedited timeframe for processing the mock patient referrals gave the leadership team confidence that this goal would be achieved once the facility opened. An evaluation of this and other clinical outcomes is currently in progress. To fully evaluate the generalizability of the program metrics of effectiveness must be utilized. Plans for expansion of the model depend upon two factors: clinical effectiveness, and sustainability. Once the program has been established it is essential that clinical data be analyzed in a rigorous fashion before the program can be scaled up.

Implementation of an innovative, inter-institutional healthcare delivery model is a challenging process. The successful launch of the clinical outreach program was achieved by identifying and obtaining active participation from key stakeholders across multiple departments and institutions, providing a well-structured process, and recognizing the need to make changes to the strategy as necessary. Academic medical centers should consider reaching out beyond educational forums and didactic lectures to create clinical collaborations with free standing community health centers on specialized care. Through these collaborations, synergistic relationships can be formed, benefiting CHCs as they improve access to specialized care, and underscoring the mission of the academic medical centers to disseminate not only information, but quality health care to the communities they serve.

Acknowledgments

The Cancer Care Equity Program is funded by a grant from the Kraft Family Research Fund. The FastTrack was conducted with support from Harvard Catalyst | The Harvard Clinical and Translational Science Center (National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health Award 8UL1TR000170-05 and financial contributions from Harvard University and its affiliated academic health care centers). The content is solely the responsibility of the authors and does not necessarily represent the official views of Harvard Catalyst, Harvard University and its affiliated academic health care centers, or the National Institutes of Health.

The authors wish to thank Laura Cathro for creating the patient referral process flow chart (Figure 4), and the following individuals for their contributions to the FastTrack process: Maureen Akisik, Lori Buswell, Karen Flaherty, Laura Hallisey, Karyn Hoffman, Kerin Howard, Eileen Reid-McCusker, and Melissa Shore.

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Implementation Lessons

- Formation of a clinical outreach program between an academic medical center and a community health center is achievable with specific shared common goals, including deliverable, patient-centered outcomes that are relevant to all institutions.
- Creation of the program requires commitment from participating institutions, and must evolve out of need, as determined by local incidence and mortality data.
- The implementation of the program requires integration of both the administrative as well as clinical staff prospectively, with specific emphasis on structural impediments to patient access.

What is FastTrack?

A problem-solving methodology that enables teams to:

- Solve problems quickly
- Implement solutions within 90 days
- Improve sustainable outcomes

Requirements for a successful FastTrack:

- Clearly Defined Problem Statement and Goals
- The Right Stakeholders: Those Closest to the Problem
- Enough Information to Develop Solutions
- Skilled Facilitation throughout Process
- Immediate Decision Making by Senior Sponsors
- Solutions and Implementation by Stakeholders

Key to Success: Implementation of strategies and action plans by those who are closest to the issues.

Figure 1.
FastTrack Overview.

FastTrack Timeline and Phases

Figure 2.
Overview of the typical FastTrack facilitation process

Setting the FastTrack Goals

FastTrack Goal Criteria:

- Measurable and tangible
- Short-term, 90-100 day target
- A significant improvement
- Achievable with defined resources and authority

Best Goals Are:

- Results-Oriented
- Quantitative
- Simple and clear
- Memorable
- Inspiring

FastTrack goals for the clinical outreach program

Figure 3.
FastTrack goals for the clinical outreach program

Figure 4.
Patient Referral Process Flow