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Creating Value in Business:

Alliance Building at the One Intermountain Breast Care Center

By Dr. Brett Parkinson & Rich McKeown

Case Study →

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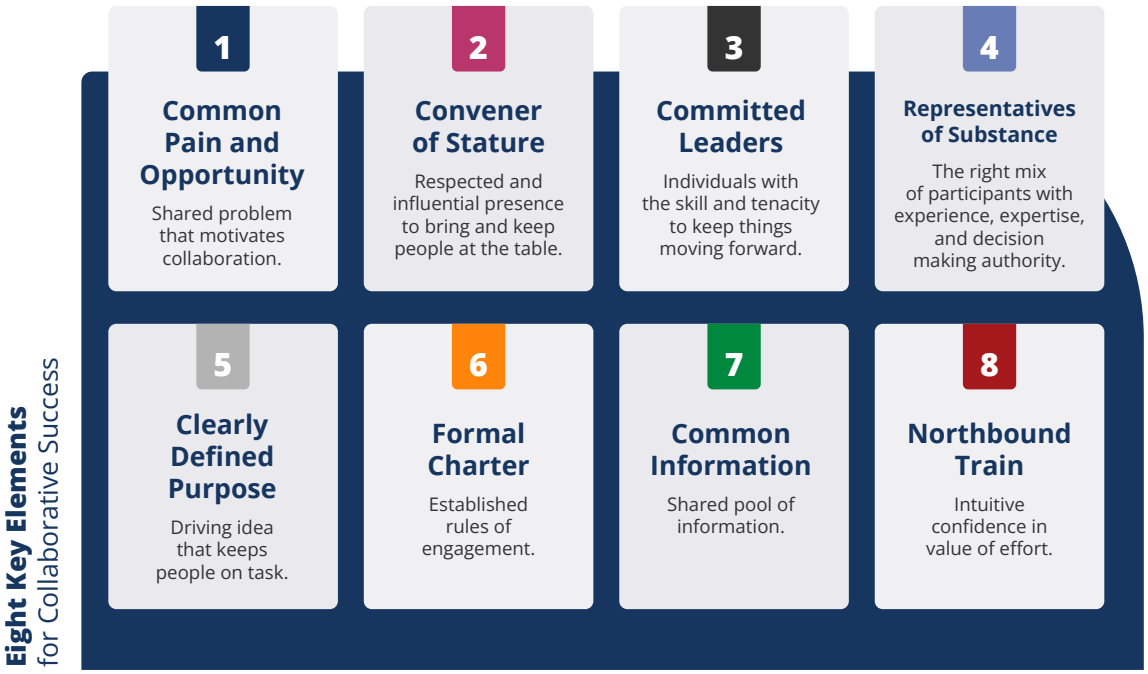
Introduction

Each alliance is unique—if you've seen one alliance, then you've only seen one alliance. There is a certain logic to this uniqueness given that each alliance's objective is distinct, and that each human member of each alliance is unique. Moreover, each alliance involves distinct alignments of "elements" and "principles" upon which rests each alliance's success. Nevertheless, each successful alliance fits within our overall framework and can be described by at least one "type," just as every person can be classified at the very least of the species of homo sapiens.

We began laying out our alliance framework in our book ***Finding Allies, Building Alliances***, and rely on that thinking in the text that follows. Our forthcoming book, ***Pathways Through Polarization by Finding Allies and Building Alliances***, elaborates on that first text, with insights drawn from almost 15 years in following the Finding Allies framework.

This case study details efforts by Dr. Brett Parkison, breast imaging medical director at Intermountain Breast Care Center, to standardize breast care protocols across multiple facilities. The initiative aimed to deliver consistent and quality care in mammography, addressing the challenges posed by varying clinic protocols and improving patient experiences. These changes led to enhanced efficiency, reduced patient discomfort, and increased cancer detection rates.



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In its February 25, 2019, edition of ***Intermountain Stories***, an internal newsletter, Intermountain Health enthusiastically reported the initial results of Dr. Brett Parkinson's efforts to organize system-wide standardized care at its multiple breast imaging facilities. As the breast imaging medical director, Dr. Parkinson was tasked with bringing major stakeholders together on how to reach consensus on standardization and implementation across the system. The long-term goal: Offer consistent, quality care at every mammography site in the enterprise. Knowing that each clinic had its own protocols for mammography, breast ultrasound, and biopsy procedures, Dr. Parkinson and his team knew they would have challenges in accomplishing their objectives. The first step: The standardization of mammography protocols in the screening and diagnosis of breast cancer at multiple clinics. Since every radiologist had their own way of working patients up with abnormal screening mammograms or symptoms, they had to come together and establish agreed-upon protocols. Later, in an effort to improve the patient experience, improve efficiency, and reduce costs, Dr. Parkinson would also tackle breast biopsy and surgical processes.

After being featured in ***Intermountain Stories***, the team realized it had to address the limitations of screening mammography. Although mammography is generally effective in detecting breast cancer, its sensitivity is markedly decreased in women with dense breast tissue, which obscures tumors on mammography, even 3D mammography. Unfortunately, dense breast tissue also increases the risk of developing breast cancer. Magnetic resonance imaging (MRI), on the other hand, is exquisitely sensitive across all breast densities. Because of this, a screening MRI program would eventually need to be implemented to ensure high-risk patients would be screened effectively.

To accomplish the first goal, the team decided it would first standardize basic breast imaging protocols, such as what special views are performed in a diagnostic mammogram, how patients are scheduled for different clinical problems, and when ultrasound should be used as an adjunct to mammography. After researching what other major institutions around the country were doing, Dr. Parkinson and his

technical co-leader, Patricia Reynolds, wrote an initial draft, which they first shared with the radiologists at the Janice Beesley Hartvigsen Breast Care Center in Salt Lake City, Intermountain's flagship facility. Once the Breast Center was on board, they shared the document with the wider group of breast radiologists across the system.

There were animated discussions about the best approach to solve a variety of clinical problems and standardize disparate clinical practices. In an effort to gain efficiency and ensure quality and consistency, compromises would have to be made. After several months of face-to-face meetings, email exchanges, and video conferences, the group reached consensus, adopting standardized protocols in December 2018. In developing the new standards, the team followed the basic guidelines recommended by their national organizations, the American College of Radiology and Society for Breast Imaging. The Intermountain scheduling team then underwent specialized training by Dr. Parkinson. They were all given a reference sheet detailing the new protocols, to ensure every patient would be scheduled for an exam tailored to her clinical problem. Since the protocols were implemented, there has been a marked improvement in scheduling efficiency, workflow processes, and patient satisfaction, as the schedulers and technologists no longer routinely interrupt their workflows to ask the radiologists how to proceed with the scheduling or performance of most routine diagnostic procedures.

Although the process of reaching consensus took months, it was easier than the next step—implementing an entirely new way to shepherd patients with suspected breast cancer through biopsy and surgery. Dr. Parkinson and his team, which included Dianne Kane, formerly the Director for Oncology Services at Intermountain, knew that the current process of diagnosis and subsequent surgical consultation was cumbersome, requiring far too many steps, patient inconvenience, and discomfort. However, before rolling out a new program across the system, they would have to pilot it at the Janice Beesley Hartvigsen Breast Care Center.

In the old paradigm, if a patient had a suspicious finding at the time of her diagnostic mammogram and/or ultrasound, she would be scheduled for a biopsy at a later date. This delay created undue anxiety and, for many women, required more time away from work, family, and other obligations. The biopsy would be performed by the radiologist at the Breast Care Center, under imaging guidance, ensuring precise sampling of the tumor. The radiologist would then place a metallic marker at the biopsy site, so that, in the event it proved to be cancer, the radiologist could later localize the suspicious lesion on the day of surgery.

Those patients with a biopsy-proven cancer would then be referred to a surgeon. After an initial consultation, the patient would schedule their surgery—either a lumpectomy or mastectomy. (Some patients with large tumors, undergo pre-surgical chemotherapy in an effort to shrink the tumor.) On the day of surgery, the patient would return to the Breast Care Center where the radiologist, using either mammographic or ultrasound guidance, would place a wire in the breast so that the tip was in the tumor. At that time, while the patient was still in the department, the radiologist would also inject a radioactive dye into the nipple, where it would then flow, following lymphatic drainage, into the armpit, allowing the surgeon to sample one or more axillary nodes to see if the cancer had spread beyond the breast. Even with local anesthetic, the radioactive dye injection was excruciatingly painful, the most uncomfortable part of the procedure. To coordinate the day's activities, the patient would have to arrive several hours before her scheduled surgery and would have to be transferred from the Surgery Center to breast radiology and back, which can take up to several hours.

After brainstorming about how to improve this process, Dr. Parkinson and Ms. Kane set out to eliminate unnecessary steps in this arduous patient journey. Their first idea: perform same-day biopsies at the time of diagnostic mammography/ultrasound. This would reduce time between abnormal imaging and diagnosis. Instead of scheduling the patient on a different day for an ultrasound-guided biopsy, they would simply perform it at the time of the diagnostic exam, right in the Breast Center. Because this same-day procedure was not built into the schedule and required flexibility on the part of the technical staff and radiologists, it was initially met with significant resistance. However, the cost and time savings were obvious: the patient was already in the department, she wouldn't have to re-register or get dressed, there would be no rescanning at a later date by a potentially different technologist and radiologist, and she would have already met the team who would do her biopsy. Although the biopsy would add about 15 minutes to the time in the ultrasound room, when taking into account patient registration, dressing, scanning, introduction to staff, and room turn-around time, a return appointment required more than an hour; a few additional minutes spent on the front end could result in an hour's time saved later.

Since the technical staff and the radiologists would be impacted by the implementation of same-day biopsy, they had to be brought to the table for an in-depth discussion on how this change might impact workflow. In addition, management would have to participate in the decision-making process, as flexibility would have to be built into the schedule. After several meetings and an open airing of the potential problems that instituting same-day biopsy would create, the major stakeholders agreed to proceed. The initial resistance on the part of the ultrasound and

mammography technologists was allayed after they understood that the change in process would free up time on the schedule in the long run. Now, the Breast Care Center performs several same-day ultrasound-guided biopsies a day, which can be easily absorbed into the schedule.

Even with a same-day biopsy, the patient would have to return to the Breast Care Center for wire placement and sentinel node injection prior to surgery. However, Dr. Parkinson and Ms. Kane had an idea. Since there was a new localization technology on the market, one that could be used instead of a wire, they explored changing that process too. This new device, called SAVI SCOUT, was a radar reflector that could be placed by the radiologist under ultrasound or mammographic guidance just prior to surgery. The reflector gives off a signal in the operating room, guiding the surgeon to the right place. Why not place this marker, which is small and easy to identify via imaging, at the time of biopsy? Even better, they could have the surgeon inject the radioactive dye necessary to assess any spread to the lymph nodes while the patient was under general anesthesia, just before making an incision, eliminating two painful procedures for the patient. These changes would reduce time spent in the Breast Care Center, as cancer patients would not have to return on the day of surgery, freeing up time that could provide additional appointment slots. Since implementation, the additional ultrasound and mammography appointments have resulted in increased revenue and decreased wait times for patients.

The decision to place biopsy site reflectors and perform sentinel node injections in the operating room required the buy in of several different groups, involving the Breast Imaging, Nuclear Medicine, and Surgery departments, and their related scheduling departments. Though there were a number of players, the overall process for the approval of SAVI SCOUT reflectors was fairly quick as the surgeons were eager to adopt the technology, and the radiologists were happy to provide the service as it resulted in decreased cost to the patient and the system. The only reticence came along with the steep learning curve for the surgeons, who had to learn how to use a special probe in the operating room to pick up the signal emanating from the marker, as opposed to just following a wire to the cancer. However, after a few months of training from the radiologists all the surgeons were enthusiastic about the new technology and were delighted that their patients didn't have to arrive early to have a localization wire placed. It helped that there was strong leadership by Dr. Teresa Reading, a breast surgeon and champion of the new technology. And, once the radiologists trained the surgeons to do the sentinel node injection, they never looked back.

However, getting approval from the nuclear medicine department and radiation safety for the injections was a fraught process. The nuclear medicine staff was reluctant to change their workflow processes, as they were afraid that the ordering of the dye and logistics of changing the injection site to the operating room would prove to be too cumbersome. In order to shift the procedure from the Breast Care Center to the operating room, Breast Care Center, nuclear medicine, and operating room personnel would all need to be trained. The procedure requires a nuclear medicine tech to be present during the injection, so they would have to be available at the time of surgery and dressed in appropriate operating room attire. This required some convincing on Dr. Parkinson's part, but he was fully supported by the surgeons, especially Dr. Reading, who agreed to be the first surgeon trained. On the day of surgery in the old paradigm, the patient was first transported to the Breast Care Center from the same-day surgery waiting area, a licensed nuclear medicine technologist would simultaneously have to carry the radioactive dye to the Breast Care Center from the nuclear medicine department, the technologist would have to wait for an available radiologist to inject the dye, and then the patient would be transported back to the surgery center waiting area. There the patient would wait to be taken into the operating room. With the new process, the patient simply checks into the surgery department and is then taken to the operating room. At that point, the nuclear medicine technologist simply takes the dye to the operating room, hands it to the surgeon, and the injection is performed after the patient is under general anesthesia. No day-of-surgery coordination is necessary with the Breast Care Center or patient transport. The surgeon simply pages the nuclear medicine technologist when they are ready to inject. And the patient has a painless procedure.

The approval process, including education and buy-in for the intraoperative injections, took more than a year. Multiple meetings were held, and at times it seemed that the process would never be approved. However, once the various parties understood that the new processes would lead to cost savings, decreased patient discomfort, and increased efficiency, they eventually agreed to pilot the program at the Janice Beesley Hartvigsen Breast Care Center.

After streamlining the biopsy and surgical experiences, the team undertook another equally important task: the implementation of an affordable, high-risk screening breast MRI program. Full-protocol breast MRI, which until recently were used for screening as well as diagnostic cases (women with symptoms of or known cancer), is very costly. However, for screening, recent studies demonstrated that an abbreviated exam is just as effective as the complete protocol. Whereas the full exam can take anywhere from 30–45 minutes, the abbreviated

scan can be performed in 10–15 minutes. The problem, however, was that insurance companies reimbursed the more expensive full protocol exam, but not the abbreviated version. So even though many academic, as well as non-academic, institutions offered the abbreviated protocol, patients were having to pay out-of-pocket.

Dr. Parkinson and his radiology colleagues believed Intermountain Health could offer a solution. Since the abbreviated scan was less expensive—and three abbreviated exams performed in the same time as one full protocol exam—it could be offered at lower cost to Intermountain patients. Additionally, as the cancer detection rate in high-risk patients, including those with dense breast tissue, is 15 per 1000 using MRI, as opposed to the five per 1000 with mammography, it would make sense for Selecthealth, Intermountain's insurance company, to cover the exam. However, before approaching Selecthealth, the team had to secure buy in from the system radiologists, as well as the other breast cancer specialists.

Once the physicians were on board, Dr. Parkinson and his colleagues met over a two-year period with high-level Intermountain administrators and leaders from Selecthealth. After the scientific data were reviewed and the efficiencies of the abbreviated protocol were demonstrated, all parties agreed to implement the program in January 2023. It was agreed that high-risk patients, those with an overall, lifetime risk greater than 20 percent, or those known to have the breast cancer gene, would be covered. Those who did not reach the 20 percent threshold would pay an out-of-pocket fee of $400—much less than the out-of-pocket cost of a full protocol study. To date, the volume of MRIs performed by Intermountain has more than tripled, and, in addition, the cancer detection rate, as predicted, is three times higher than conventional screening.

While Dr. Parkinson and his colleagues were meeting with Selecthealth, the team was also tackling the obstacle of insignificant data collection to support high-risk screening MRI; without a detailed risk assessment tool, high-risk patients could not be identified. Our then patient history-gathering and reporting tool was not up to the task. At the time, the mammography reporting system could not assess risk, nor could it accurately track outcomes. Already, routine practice audits were difficult to perform, requiring hours of corporate data analysts' time to determine mammography cancer detection rates and other metrics required by the federal government. Fortunately, the team found a company that could offer exactly what they needed: Ikonopedia.

Ikonopedia is a cloud-based data analytics and breast imaging reporting company, which was able to provide a built-in, nationally recognized risk assessment tool, standardized reporting, and accurate data collection. The risk assessment model—the Tyrer-Cuzick model—factors in density, important since dense tissue increases a patient's risk. With Ikonopedia, outcomes are now generated automatically, as are the yearly audits required by FDA. Of course, replacing the previous reporting system also required agreement among major stakeholders, including all the system radiologists, local managers, high-level administrators, and the IT department. Consensus only came about because of meticulous research, multiple meetings, emails, phone calls, and the goodwill of the stakeholders. In the end, Iknonopedia was rolled out at Intermountain just in time to implement the MRI screening program. High-risk patients are now notified of their risk by mail, informed about their eligibility for MRI, and are given a number to call to schedule an exam.

After these changes, the overall environment of the workplace has markedly improved, as doctors and other care givers realized they have improved the patient experience. Moreover, the new efficiencies increased the number of patients served. The changes also resulted in less patient pain, fewer trips to the hospital, fewer needle sticks, and better utilization of staff and resources, all of which have contributed to cost savings and efficiency. When one considers the costs associated with scheduling follow up appointments, re-gowning, the personnel to move people efficiently, and the reduction of duplicated supplies, the new processes make financial sense.

These impressive results—as well as others not addressed in this case study—came about as a consequence of what was reported as a unanimous adoption, but getting to the point of consensus among physicians and other staff took time and effort. Moreover, it required vision, inspiration, persistent leadership, and the application of specific elements and principles associated with building successful alliances. So, despite these remarkable results, the story behind these results may be more important and compelling than the actual savings and efficiency gains. It highlights the fact that improvement on this scale, and a migration to value-based health care, can be made at a local level of administration.

Such alliances do not typically form spontaneously; they require the kind of leadership exhibited by Dr. Parkinson. The concern that brought this alliance together is in some ways unique, as are the circumstances which led to Dr. Parkinson to use this theory of alliances. It was happenstance that Governor Mike Leavitt, former Secretary of Health

and Human Services and co-author of ***Finding Allies, Building Alliances***, became a personal acquaintance of Dr. Parkinson's. In discussions with Mr. Leavitt, Dr. Parkinson talked about his desire to create meaningful changes and how he was struggling to build consensus among some in the groups who were reluctant to change. Governor Leavitt referred him to the principles of alliances outlined in ***Finding Allies, Building Alliances***, and Dr. Parkinson adapted them to his needs, creating a masterpiece of collaboration and adding significant value to his department specifically and to Intermountain Health generally.

As is often the case, Dr. Parkinson started this uphill battle with a number of practitioners who did not initially see the vision and benefits that he saw. Alliances often commence as a hard sell since a common, bureaucratic response is the all-too-often-heard refrain "but we've never done it that way before."

Thus, this further examination of the story behind the results demonstrates, and hopefully inspires others to see the power and value of building alliances to solve complex problems. A significant part of this story is the fact that this effort was convened, led, and managed at the department level and not as a top-down directive from the C-suite. While Intermountain Health and the patients are the beneficiaries of the results, the pride of ownership at the department level is palpable. Operating with a set of standards that, Dr. Parkinson believes, achieve the best possible protocols for patient treatment makes a difference in the workplace environment. And in this case, according to all who have examined it, the improvement in the experience for both patients and medical personnel was nothing short of stunning.

What follows is a look at the basic elements of an alliance as deployed to advantage with the Breast Care Services Team.

Common Pain:

The first important component of building an alliance commences with a realization that there is not only common pain—the knowledge that current processes may be inefficient, and even harmful to patients—which is shared by the stakeholders, but an opportunity for improvement. Dr. Parkinson knew that the breast biopsy and surgical experience was inefficient and believed that the disparity of individually developed protocols was driving these disappointing results—increased cost, decreased efficiency and patient pain. If the team could pool their resources, they could address these problems, and so commenced their collective collaborative exploration for solutions. On that basis, Dr. Parkinson realized that it might serve as the common pain necessary to bring the group together.

Convener and Leader:

As the Breast Imaging modality team leader, Dr. Parkinson served as the convener. On a small scale, he did this with the system's radiologists to develop standardized protocols. And, on a larger scale, he did this to change the breast biopsy and surgical processes. The convener is typically a person of sufficient stature to bring people to the table. Meeting on both the small and large scale was important as, at inception, some participants dragged their feet and a few acted as saboteurs. Dr. Parkinson understood the need to start by convening smaller groups of people, an environment where people are more open hard conversations.

Representatives of Substance:

To change the day-of-surgery experience, Dr. Parkinson first met with the surgeons to discuss efficiencies. With the support of his surgical counterpart, Dr. Reading, he convened additional groups to explore the complexities of changing processes. These smaller groups were expanded to include the multi-faceted or sectored components of the team, as Dr. Parkinson and Dr. Reading came to an early understanding that it would be necessary to involve all players in the larger team—not just surgeons, but the staff, including schedulers and nuclear medicine personnel—if they were going to address a comprehensive set of solutions.

Good staffing and leadership support are critical to the effective building of alliances. Dianne Kane handled many of the behind-the-scenes issues, finding out who had to be involved and then coordinating meetings. She brought gravitas in ways that provided significant support to Dr. Parkinson and the building of the alliance. Her background as a respected person in breast care positioned her to reap the respect of the entire team. Her influence permitted her to do the behind the scenes work which got things done, helped identify barriers, and led to the resolution of many problems. It helped that she knew and understood the political backdrop, strengthening her ability to navigate efficiently. The bottom line was that Ms. Kane could identify the squeaky wheels and apply the grease as needed.

Clearly Defined Purpose:

Dr. Reading handled the parts related to the surgical interests. Dr. Parkinson felt certain they could make improvement and together they fashioned a clearly defined purpose: to improve the patient experience while saving time and money.

Common Information:

As of January 2025, the breast imaging protocols are in effect throughout the Intermountain system. Same-day biopsy, SAVI SCOUT reflector placement, and intraoperative sentinel node injection are now the standard of care across all facilities. The net result is a reduction in time from suspicious imaging findings to diagnosis and treatment, as well an improved patient experience on the day of surgery. Over the last two years, Abbreviated Screening Breast MRI has been adopted across the system, resulting in saving lives via the earlier detection of breast cancer in high-risk patients, in turn resulting in a reduction in treatment cost since, when cancers are detected at an earlier size and stage, they can be treated less aggressively, using fewer resources. For example, smaller tumors can be treated with a lumpectomy, rather than mastectomy. Moreover, earlier detection may obviate the need for radiation and chemotherapy.

Northbound Train:

Now that standardized imaging protocols, efficient biopsy and surgical procedures, data gathering, and abbreviated screening breast MRI have all been successfully implemented, the Breast Care team and other major stakeholders are focused on new ways to innovate and collaborate. The next challenge is to explore the effective use of artificial intelligence in improving efficiency, early diagnosis, treatment regimens, and the patient experience.

ABOUT THE AUTHORS

Brett T. Parkinson, MD

Dr. Brett Parkinson, a Fellowship Trained Breast Radiologist, is the Medical Director for the Breast Clinical Program at Intermountain Healthcare in Salt Lake City, Utah. He received his MD from Tulane University and completed a residency in diagnostic radiology at UCLA. He was a fellow at the Iris Cantor Breast Care Center at UCLA, completing his training in 1991.

In addition to his clinical, administrative, and research responsibilities at Intermountain Healthcare, Dr. Parkinson has been a consultant to the Utah Department of Health for mammography policy. He is the state breast cancer media spokesperson for the American Cancer Society (ACS), on whose board he served for many years. In 2007, he received the “Distinguished Sword of Hope” award from the ACS.

Dr. Parkinson served on the America College of Radiology Mammography Accreditation Committee for several years. He was the Committee Chair from 2011 to 2016, in which role he oversaw all mammography facilities in the United States and Puerto Rico. He has also served as a member of the breast exam development team for the American Board of Radiology, assisting in writing questions for the new boards. Dr. Parkinson has been an Assistant Clinical Professor for Radiology at UCLA and the University of Utah. He has been involved in philanthropic work not only in Utah, but also overseas; he and a small team of breast care specialists from Intermountain Healthcare travelled to Tanzania to assist in the establishment of a breast cancer screening program in 2008 and 2009.

Dr. Parkinson is a contributing author to breast imaging textbooks and has published articles on breast imaging and multidisciplinary breast care. He continues to lead breast outcomes projects for the Oncology Clinical Program at Intermountain Healthcare. In October 2014, he was selected as a Utah Health Care Hero by Utah Business Magazine. Dr. Parkinson and his wife, Kelly, a professional violinist, have four children and four grandchildren, and currently reside in the Avenues of Salt Lake City.

Rich McKeown

Rich McKeown co-founded Leavitt Partners and served as the firm's first CEO from 2009–2017. In 2013, Rich and Mike Leavitt co-authored the highly-acclaimed book ***Finding Allies, Building Alliances***.

Prior to Leavitt Partners, Rich served as chief of staff for Mike Leavitt at the U.S. Department of Health and Human Services (HHS). At HHS, he directed and coordinated the activities of the largest department in the federal government, serving as the Secretary's day-to-day manager for a department that employed 67,000 people and had an annual budget in excess of $840 billion. He also led the negotiations between China and FDA regarding Drug, Device and Food issues, which led to landmark agreements in 2008 and paved the way for the placement of US-FDA offices around the world. From November 2003 until January 2005, Rich served as senior counselor and chief of staff to Administrator Leavitt at the U.S. Environmental Protection Agency.

Prior to his public service in Washington, D.C., Rich served as chief of staff to Governor Mike Leavitt and as commissioner of the Utah State Tax Commission. His background is as a private practice lawyer and educator. Rich received his juris doctorate from the University of Utah and bachelor's degree from Ohio University.

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The Leavitt Center for Alliances is an initiative of Health Management Associates and Leavitt Partners, an HMA Company. The Center aims to elevate the national discourse on health care and help health care organizations solve their most complex challenges through consensus-based alliances.

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