

Practice Facilitators' and Leaders' Perspectives on a Facilitated Quality Improvement Program

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ABSTRACT

PURPOSE Practice facilitation is a promising approach to helping practices implement quality improvements. Our purpose was to describe practice facilitators' and practice leaders' perspectives on implementation of a practice facilitator-supported quality improvement program and describe where their perspectives aligned and diverged.

METHODS We conducted interviews with practice leaders and practice facilitators who participated in a program that included 35 improvement strategies aimed at the ABCS of heart health (aspirin use in high-risk individuals, blood pressure control, cholesterol management, and smoking cessation). Rapid qualitative analysis was used to collect, organize, and analyze the data.

RESULTS We interviewed 17 of the 33 eligible practice leaders, and the 10 practice facilitators assigned to those practices. Practice leaders and practice facilitators both reported value in the program's ability to bring needed, high-quality resources to practices. Practice leaders appreciated being able to set the schedule for facilitation and select among the 35 interventions. According to practice facilitators, however, relying on practice leaders to set the pace of the intervention resulted in a lower level of program intensity than intended. Practice leaders preferred targeted assistance, particularly electronic health record documentation guidance and linkages to state smoking cessation programs. Practice facilitators reported that the easiest interventions were those that did not alter care practices.

CONCLUSIONS The dual perspectives of practice leaders and practice facilitators provide a more holistic picture of enablers and barriers to program implementation. There may be greater opportunities to assist small practices through simple, targeted practice facilitator-supported efforts rather than larger, comprehensive quality improvement projects.

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INTRODUCTION

There is a growing body of evidence suggesting that quality improvement programs that use practice facilitation can produce meaningful positive changes in primary care practices.¹ Practice facilitators, also known as practice coaches or quality improvement coaches, are specially trained individuals who help practices engage in quality improvement projects and develop capacity for continuous quality improvement.^{2,3} They offer practices a variety of supportive services, for example, using practice-level data to drive change, implementing best practices in quality improvement structures and methods, and building capacity in the use of health information technology to support improved clinical care and office efficiency.⁴ Practice facilitator-supported quality improvement may be particularly beneficial for small, independent practices, which are less likely than large practices to implement improvements that benefit from economies of scale (eg, health information technology, multidisciplinary teams, after-hours care) and may not have the capacity or resources to lead change themselves.⁵⁻⁷

Given its promise, an understanding of the enablers and barriers to implementation of facilitator-supported quality improvement may help to drive its adoption. Although implementation studies have been undertaken in the past, they have generally been limited to other countries,^{8,9} and none have considered the perspectives of both practice facilitators and practice leaders, who have distinct but complementary and vital roles in quality improvement.^{3,10} The purpose of this article is to describe enablers and barriers to a practice facilitator–supported quality improvement program aimed at improving preventive cardiology within small and medium-size independent primary care practices. This qualitative study is unique in its inclusion of perspectives from both practice leaders and practice facilitators, which allows for examination of where their perspectives align or diverge.

METHODS

Intervention

Healthy Hearts in the Heartland is a research program that works with small and medium-size primary care practices to implement and evaluate quality improvement strategies for cardiovascular disease prevention using practice facilitation. Healthy Hearts in the Heartland is funded by the Agency for Healthcare Research and Quality as part of the EvidenceNOW: Advancing Heart Health in Primary Care initiative, which is dedicated to improving the heart health of Americans.¹¹ Practices were eligible to participate if they had fewer than 20 primary care clinicians and were located in Indiana, Illinois, or Wisconsin. All participating practices were assigned a primary practice facilitator for 12 months who met with practices as often as requested, ideally at least once a month. Practice facilitators received structured training on clinical topics and quality improvement strategies related to the ABCS of heart health: aspirin use in high-risk individuals, blood pressure control, cholesterol management, and smoking cessation.¹² The practice facilitators' training included formal, weekly, Web-based sessions delivered by subject matter experts for 12 months, and three 2-day interactive in-person sessions over 15 months. Practice facilitator–supported discussion sessions, both virtual and in-person, were held weekly for 24 months and then became biweekly.

Practice facilitators had a broad menu of quality improvement strategies from which practices could choose related to the 4 ABCS measures that are used in national quality incentive programs, such as Meaningful Use, Physician Quality Reporting System, and accountable care organization shared savings programs.^{13,14} The quality improvement strategies included

audit and feedback, clinical decision support within the electronic health record (EHR), standing orders, workflow improvements, and patient education and outreach. The performance measures and 35 improvement strategies can be found in the Supplemental Appendix, available at http://www.annfam.org/content/16/Suppl_1/S65/suppl/DC1/. Practice facilitators primarily spent their time in offices leading staff trainings, discussing performance data with physicians and staff, providing one-on-one training on EHR documentation, and gathering performance measure data.

Study Participants and Recruitment

There were 226 practices grouped into 4 waves based on the date they were recruited for Healthy Hearts in the Heartland, and each wave began its 12-month interventions approximately 3 months apart. Wave 2 practices were the focus of this qualitative study. The wave included 40 practices, though only 33 were actively participating after 9 months, when we began recruitment for the qualitative interviews. Practice leaders from these practices received up to 6 contact attempts by telephone, e-mail, or fax asking them to complete a 1-time, 30-minute telephone interview. The interviews were conducted between March and May 2017, which corresponded to months 10 to 12 of the practices' 12-month practice facilitation period. Interviews were digitally recorded. This study was approved by the Northwestern University Institutional Review Board.

Data Collection and Analysis

We used rapid qualitative analysis to guide the collection, organization, and analysis of interview data. Rapid qualitative analysis is often used in evaluations of quality improvement projects and is characterized by several features that support timely feedback: research questions that are explanatory, targeted data collection protocols (eg, semistructured or structured protocols), and simultaneous data collection and analysis.^{15,16} Indeed, using this approach, we were able to provide practice facilitators with a summary of our findings within 5 months of the start of data collection. This information was the most comprehensive feedback provided to practice facilitators since the start of the Healthy Hearts in the Heartland program.

We used a semistructured interview protocol based on the Consolidated Framework for Implementation Research (CFIR),¹⁷ a conceptual framework developed to guide assessment of implementation contexts to identify factors that might influence intervention implementation.¹⁸ The framework considers how intervention design, the quality improvement process, the internal and external environments, and the characteristics of individuals influenced program implementa-

tion. The interview protocols can be accessed in the Supplemental Appendix.

Analysis was conducted using the following steps designed to organize and meaningfully reduce the data while maintaining the context in which the data were collected.¹⁹ First, we created a neutral question name that corresponded to each interview question (eg, a question about Healthy Hearts in the Heartland's strengths was named "H3 strengths"). There were several questions that pertained to each domain of the CFIR. Second, we created a summary template in Excel that listed all the question names in 1 column, and a second column for a summary of respondents' answers. Additional spaces were added for other observations that did not fit within the domains. Third, 2 team members, both experienced in qualitative research (M.M., T.B.), independently listened to the recordings of 3 interviews and completed the summary templates for each interview. The 2 team members discussed their summaries to assess consistency and to modify the template to ensure the domains were intuitively labeled. Often the summaries included illustrative, full quotations. Fourth, after consistency was established, 1 of the 2 team members summarized the interviews led by the other (and vice versa), using the template. All summaries were read by the interviewer (M.M. or T.B.) to assure consistency with their recollection of the interviews. Fifth, the completed templates were aggregated into a summary matrix that listed the domain names down a column and respondents across a row. The final product was a display designed to assemble organized information into an immediately accessible compact form.¹⁹ Finally, the 2 team members met twice weekly for 3 weeks to discuss the content across the domains.

RESULTS

Characteristics of Respondents

We completed interviews with practice leaders from 17 of the 33 eligible practices and all 10 practice facilitators assigned to those practices. (Five practice facilitators were assigned to multiple practices.) Most practice leaders were physicians, though several were nurses or office managers. Most were from small practices, with a median of 3 clinicians, and on average, the practices received approximately 6 quality improvement visits from their practice facilitator before our interviews (Table 1). Across all practice facilitators at the start of Healthy Hearts in the Heartland, 33% had 0 to 2 years of experience working as a practice facilitator, 42% had 3 to 5 years of experience, and 25% had 6 or more years of experience. One-half (50%) of practice facilitators had backgrounds in health information technology (eg, a valuable experience providing sup-

port for effective use of EHR), and 44% had a clinical background (eg, a nurse). Table 2 summarizes key themes from the interviews by respondent type. Below we describe areas where practice leaders' and practice facilitators' perspectives aligned and diverged, organized according to the CFIR domain.

Intervention Design

Practice leaders and practice facilitators overwhelmingly described their experience in positive terms. Practice leaders often commented on the value of working with a practice facilitator, who provided them with resources that they otherwise would not have had. One practice leader enthusiastically described his practice facilitator as "better than a magazine!" because she provided up-to-date information on changes in the industry, including the Medicare Access and CHIP Reauthorization Act of 2015 and the merit-based incentive payment system.^{13,14} Many respondents pointed to the value of practice facilitators' assistance with their EHRs.

Our practice facilitator is more skilled at pulling data out of our EHR than anyone else in our institution.... Everyone here wears 10 hats.... We do not have anyone to help with our EHR once the practice facilitator leaves the building.

Additionally, several respondents reported the value of the high-quality educational materials, for example, materials from the American Medical Association and the Million Hearts campaign. Although these resources are freely available, many practices did not know about them and did not have the time to go looking for them.

Additionally, the programs' focus on the ABCS was attractive to most practice leaders interviewed. Although many practice leaders were confident in their

Table 1. Characteristics of Participating Practices and All Wave 2 Practices (n = 33)

Characteristic	Interviewee (n = 17)	All Wave 2 Practices
Clinicians in practice		
Mean (SD), No.	2.82 (2.2)	2.3 (0.8)
Median (range), No.	3.0 (1-10)	2.0 (1-10)
Part of larger organization, No, %	5 (29)	7 (21)
State		
Indiana, No. (%)	6 (35)	12 (36)
Illinois, No. (%)	8 (47)	17 (51)
Wisconsin, No. (%)	3 (18)	4 (12)
H3 quality improvement encounters		
Mean (SD), No.	6.4 (2.9)	6.4 (3.0)
Median (range), No.	6.0 (0-13)	6.0 (0-14)

H3 = Healthy Hearts in the Heartland.

Table 2. Summary of Key Themes From Interviews, by Respondent Type and Consolidated Framework for Implementation Research Domain

CFIR Domain	Practice Leaders	Practice Facilitators
Intervention design	<p>H3 was a valuable program that provided practices with skilled practice facilitators and access to new resources. H3's educational resources were of high quality</p> <p>H3's focus on the ABCS was highly attractive, because many quality-based incentive programs include ABCS measures. A minority of respondents, however, questioned the validity of the ABCS measures</p> <p>A shortcoming of H3 was its limited support for improving patient adherence</p> <p>H3 offers little added value for very advanced practices (eg, practices that excel on the ABCS measures) and very high-need practices (eg, practices with a large number of homeless patients).</p>	<p>H3 was a valuable program that provided needed resources to offices with limited quality improvement capacity. The educational resources were of high quality</p> <p>H3's focus on the ABCS helped practice facilitators recruit practices to the program</p> <p>H3's internal structure was supportive for practice facilitators, including communication channels that permitted shared learning, and access to internal medicine physicians who provided guidance and clinical expertise regarding the ABCS measures</p> <p>Practice facilitators' dual responsibility of conducting quality improvement work and collecting ABCS data required for the H3 evaluation was burdensome and time consuming</p> <p>Despite extensive training before the launch of H3, practice facilitators reported substantial learning on the job.</p>
Quality improvement process	<p>A strength of H3 is that it is tailored to each practice, based on the practice's needs and capacity to change</p> <p>H3 was a relatively low priority for the practices</p> <p>The easiest H3 interventions to implement were EHR documentation changes, connecting patients to state-run smoking quit lines, and providing guidance to nurses and medical assistants on best practices for blood pressure measurement</p>	<p>H3's reliance on practice leaders to determine the frequency of visits and interventions to implement led to a lower dose of the H3 intervention than expected</p> <p>H3 was a relatively low priority for the practices</p> <p>The easiest H3 interventions to implement were EHR documentation support and other interventions that did not alter the way that physicians delivered care</p>
Internal environment	<p>Lack of clinician time and staff turnover were considerable barriers to H3 implementation</p> <p>A capable, easy-to-use EHR platform and well-functioning team approach to care were enablers to H3 implementation</p> <p>H3 was a good fit for most practices</p>	<p>Lack of clinician time and staff turnover were considerable barriers to H3 implementation</p> <p>Limited engagement in H3 by clinicians from many practices compromised the fit of the program for many practices</p>

ABCS = aspirin use, blood pressure control, cholesterol management, smoking cessation; CFIR = consolidated framework for implementation research; EHR = electronic health record; H3 = Healthy Hearts in the Heartland.

care delivery practices for heart disease and stroke prevention, they saw value in additional supports. Further, the ABCS measures aligned with measures included in many quality-based incentive programs, and several practice leaders reported that the study helped them to be better prepared to participate in those programs. Practice facilitators agreed that the focus on the ABCS helped them to recruit practices into the Healthy Hearts in the Heartland program.

Nevertheless, respondents also noted shortcomings of the program design. Both practice leaders and practice facilitators said that the program was focused on improving patient care and documentation, but not patient adherence to treatment, which was a more immediate and vexing problem for some practices.

Quality Improvement Process

Although the study interventions were led by the practice facilitators, both practice leaders and practice facilitators reported that the process was driven by practice leaders. Ultimately, the practice leaders determined how frequently practice facilitators would visit the practice and which interventions the practice would implement. The benefit, often reported by practice leaders, was that Healthy Hearts in the

Heartland was highly tailored for each practice, based on the practice's needs and capacity to engage. Many practice facilitators, however, reported this flexibility as a hindrance. First, there was no standardized project plan for the practice facilitators to follow. Rather, they had to create a unique plan for each practice. Second, Healthy Hearts in the Heartland was often described by practice leaders as a relatively low priority, and leaders often did not make time for the program. Practice facilitators frequently reported "having a hard time getting into the practice." One practice facilitator said,

I don't think I've ever had a single H3 [Healthy Hearts in the Heartland] practice [leader] reach out to me. They never call me. They've never brought an original idea about what they want to work on. If I wanted to get into the office, I had to chase after them. That's a point of frustration—everything they're doing is upon my request.

We asked all respondents about which interventions were easiest and most difficult to implement. Both practice leaders and practice facilitators frequently reported that EHR documentation support, for example, showing practices where to document when they prescribe aspirin or counsel patients who smoke, was a "quick win." According to 1 practice leader, "Most of the time we

were doing everything right, but not checking the right box, so that we could get credit for the things we were already doing." These relatively small interventions yielded big benefits, according to practice leaders.

Remarkably, practice leaders often said that they found all the interventions to be relatively easy to implement. Practice leaders also reported engaging in relatively few quality improvement strategies, however (typically fewer than 5 of the 35 offered). Practice facilitators reported that some practice leaders declined to pursue certain interventions, for example, referring patients to a community pharmacist for hypertension medication management or adding automated alerts within their EHRs. In other instances, the limited number of interventions implemented reflected the limited time practice facilitators had at the practice to focus on quality improvement or that the practice had already implemented other, similar quality improvement efforts. Although practice leaders spoke of the interventions in positive terms, at least 1 said, "I don't think we've really changed anything because of [H3]."

Internal Environment

When asked about the internal factors that enabled or hindered implementation of the quality improvement strategies, nearly every interviewee mentioned lack of clinician time. According to some respondents, the practice leader limited participation to 15 minutes per month. "The practice is struggling as is," according to 1 respondent, and there was limited time to focus on an outside quality improvement effort. Commonly identified factors that helped implementation were having a robust, easy-to-use EHR platform, a culture of open mindedness and willingness to engage (as opposed to "set in their ways"), a well-functioning team approach to care, and stability of physicians and staff. Several practice facilitators reported difficulty when their primary contact left the practice; it often took time for a suitable replacement to be identified, and often the replacement was not as engaged in the program as was the predecessor. Additionally, several practice leaders and practice facilitators reported that they had been working together, before, on other quality improvement projects. These long-standing relationships were viewed as helpful by both practice facilitators and practice leaders. "I had credibility to start with," according to one practice facilitator. Both practice leaders and practice facilitators said that internal practice factors were much more influential over the implementation of Healthy Hearts in the Heartland quality improvement strategies than factors external to the practice.

When asked whether Healthy Hearts in the Heartland was a "good fit" for their practice, most practice

leaders responded in the affirmative. Practice facilitators were less uniformly positive in their assessment of whether it was a good fit for the practices. Several practice facilitators said the program had recruited too many practices that were not prepared to fully participate. For example, 1 practice facilitator reported, "My main point of contact was very overwhelmed and stressed and not a real champion for [H3]." Another said, "If [the practice] could have committed more time to H3, it would have been a good fit." Practice facilitators expected greater engagement from the practices than was actually the case in some instances.

DISCUSSION

Our interviews on the enablers and barriers to implementation of Healthy Hearts in the Heartland, a practice facilitator-supported quality improvement program, found several areas of agreement between practice leaders and practice facilitators. For example, both groups held the program in high regard and saw value in providing direct assistance to practices with limited resources and implementing changes designed to improve cardiovascular preventive care. Both groups also reported that EHR documentation support and linking practices to state smoking cessation resources were relatively easy interventions to implement; patient adherence to treatment, which was minimally addressed by the study, remained a vexing problem for practices; and lack of clinician time was among the biggest barriers to implementation. There were also areas where their perspectives were divergent. Practice leaders appreciated the highly tailored nature of the Healthy Hearts in the Heartland study and the ability to determine the intensity of the intervention. Practice facilitators were less enthusiastic, however, about that aspect of the study design. Relying on practice leaders to set the pace for the interventions resulted in practices receiving a smaller measure of the program than originally envisioned. The combination of perspectives from both practice leaders and practice facilitators provides a more holistic picture of program implementation.

Our findings align with qualitative studies in the United Kingdom and Canada showing that limited practice accessibility and engagement are common barriers to quality improvement projects involving practice facilitation.^{8,20} Ultimately, the engagement of practices remains a key challenge and should be the subject of future work. Financial incentives associated with meaningful use, merit-based incentive payment system, and the Medicare Access and CHIP Reauthorization Act were effective in drawing practices to the Healthy Hearts in the Heartland, but they did not appear to be sufficient to sustain the year-long,

intensive engagement of practice leaders as currently designed. Previous studies suggest that practice facilitation is most effective when intensive and sustained,¹ which raises some doubt about the impact Healthy Hearts in the Heartland will have on the 4 performance measures. The summative evaluation is ongoing.

Prior work has shown that practice facilitation produces moderate increases in the adoption of evidence-based practices in primary care.¹ This finding has led to considerable investment in practice facilitation in both the public and private sectors, and a number of prominent stakeholders have encouraged the use of practice facilitation or made resources available to encourage adoption.²¹⁻²³ Our study and previous qualitative evaluations of practice facilitator-supported quality improvement, however, highlight the difficulties of small practices to engage long term with practice facilitators and make meaningful changes to their care practices, even if practice facilitation is provided at no cost.²⁴ The disconnect may be due to the environment—many of the quantitative studies were conducted outside the United States. More mixed methods evaluations of practice facilitator-supported quality improvement set in small US practices, such as EvidenceNOW, are needed. Further, to address the issue of clinician engagement, it may be valuable to focus more attention on the perspectives of clinicians in terms of what resources might be required for them to fully engage in a program such as Healthy Hearts in the Heartland.

An important limitation is that our analysis relied on the recollection and perceptions of only practice leaders and facilitators. Although we believe they are best positioned to report on implementation of Healthy Hearts in the Heartland, other staff within the practices may have offered different perspectives. Further, although the practices that participated in our interviews were similar to other wave 2 practices in terms of number of clinicians in the practice and number of quality improvement visits received from a practice facilitator, there may have been other meaningful differences between participating and nonparticipating practices.

In conclusion, both practice leaders and practice facilitators saw value in Healthy Hearts in the Heartland, a program for small primary care practices to implement and evaluate quality improvement strategies for cardiovascular preventive care. Practice leaders reported benefiting from targeted assistance, such as EHR documentation guidance, connections to state-run smoking cessation supports, and blood pressure measurement training. Practice facilitators, however, reported that limited engagement of practices contributed to the relatively low intensity of the study intervention. There were few reports of care practices

changing as a result. The interviews showed that there may be greater opportunities to assist small practices through simple, targeted practice facilitator-supported efforts rather than larger, comprehensive ones. More research is needed to identify best strategies for practice engagement, which may ultimately help to support the implementation of larger, comprehensive facilitator-supported quality improvement projects.

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