Lessons in Advancing Evidence-Based Primary Care from the Heart of Virginia Healthcare EvidenceNOW Cooperative

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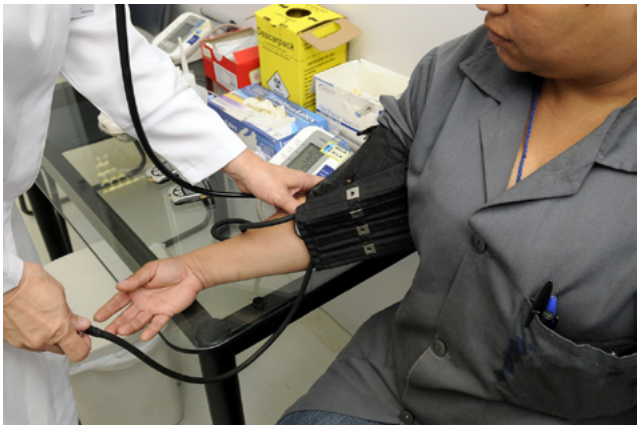

Nearly two decades ago, the National Academy of Medicine released its landmark report *To Err is Human*,[1] followed by *Crossing the Quality Chasm*.[2] These two reports documented disturbing gaps between actual and optimal clinical care, including the failure to implement appropriate, evidence-based preventive and treatment measures. *Crossing the Quality Chasm* also highlighted the extensive time lag -- a staggering average of 17 years -- between the emergence of new scientific evidence and its routine uptake in clinical practice.

As major purchasers of health care services for public programs such as Medicare and Medicaid, federal and state agencies have a compelling interest to close the gaps between research evidence and clinical practice in a timely fashion. States seeking to advance evidence-based clinical care can draw on the experiences of a major federal effort -- the Agency for Healthcare Research and Quality's (AHRQ) EvidenceNOW initiative -- to promote evidence-based prevention in primary care. EvidenceNOW is a $110 million investment in seven regional cooperatives working with more than 1,500 small- to mid-sized primary care practices in 12 states. The focus is to prevent heart disease by improving primary care provider performance on four basic measures known as that "ABCS," which includes recommending aspirin for high-risk individuals, blood pressure monitoring, cholesterol management, and smoking cessation.

The National Academy for State Health Policy (NASHP) is collaborating with the Virginia EvidenceNOW cooperative, known as the Heart of Virginia Healthcare (HVH), to promote evidence-based primary care prevention by sharing relevant insights and findings for state health policymakers.

HVH was unique among EvidenceNOW cooperatives because it recognized the need to "restore joy in practice" as essential to quality improvement.[3] This brief focuses on lessons learned from HVH's quality improvement efforts designed to close the gap between evidence and practice in primary care. It also includes several examples of state-based approaches to promote evidence-based prevention in primary care in Colorado, Idaho, Nebraska, Rhode Island, South Carolina, and Vermont.

Supporting Evidence-Based Prevention Through Practice Facilitation

The Virginia-based EvidenceNOW cooperative, called HVH, engaged 249 small- to mid-sized primary care practices to work on quality improvements around four cardiovascular prevention measures. The intervention, which consisted of three cohorts of practices, launched in February, April, and August of 2016, ended in August 2017. Each practice received three months of weekly coaching by a practice facilitator, or practice coach, followed by an additional nine months of continued active support by the facilitator as needed. Practice facilitation was augmented by expert consultation, collaborative learning events, an online support center, and data feedback reports and benchmarking.

Practice Facilitation: AHRQ defines practice facilitation as "a supportive service provided to a primary care practice by a trained individual or team of individuals. These individuals use a range of organizational development, project management, quality improvement (QI), and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals." Practice facilitation can also include using practice-level data to drive quality improvement, which was a major focus for HVH. For more information about practice facilitation, including case studies from Oklahoma, North Carolina, and Vermont, please see AHRQ's practice facilitation resources.

Lessons Learned from the Heart of Virginia Healthcare

Successful recruitment requires an understanding of the demands on primary care: Typical primary care practices participate in a variety of both voluntary and mandatory quality improvement and practice transformation initiatives. A practice might decline to participate in an additional voluntary program, not because they are uninterested or uncommitted to its goals, but simply because they are overwhelmed with competing priorities. Looking across EvidenceNOW cooperatives, a team of researchers determined that demonstrating how a quality improvement initiative like EvidenceNOW aligns with other ongoing federal and state quality improvement initiatives, recognition programs (e.g. patient-centered medical home), and/or other delivery system and payment reform efforts, is key for successful recruitment.[4]

Recruiters are also working in a climate where physicians are reporting historically high levels of burnout.[5] Successful recruitment strategies must acknowledge the reality of primary care practice today and, when possible, should seek to alleviate burdens on primary care providers rather than adding additional demands to already over-burdened practices. For example, HVH's approach to recruitment included a focus on adding value to participating practices by restoring "joy in practice" through workflow redesigns to enhance patient care and practice efficiency. (HVH's approach to restoring joy in practice and state strategies to address provider burnout are the focus of the first brief in this series.[6])

Relationships are key for both recruitment and affecting change: Relationships were essential for the initial recruitment of practices and to establish sustainable change within a practice. Personal connections between primary care practices and cooperative partners such as the Virginia Commonwealth University and the Virginia Center for Health Innovation were crucial for successfully connecting with practices. Particularly within large health systems, knowing the appropriate people within an organization is essential for effective recruitment and implementation. The time commitment involved in establishing relationships that lead to successful recruitment can be substantial and should not be underestimated. The average HVH practice took eight "touches" (or contacts) for recruitment. Once re-

cruitment is complete, a positive relationship between the practice facilitator and the practice is essential for effective practice transformation. This relationship allows the practice facilitator to understand the practice and its needs and allows practice facilitators to establish themselves as trusted sources for helping practices meet their goals. Smaller, independent practices, often located in rural areas, were particularly responsive to engaging with practice facilitators, possibly because they encounter fewer opportunities for quality improvement support than practices embedded in larger health systems. The relatively greater autonomy of independent, rural practices, compared to those within health systems, may also contribute to their responsiveness.[7]

Identifying and aligning with practice goals is key: Though EvidenceNOW cooperatives had different styles of practice facilitation, according to the national evaluation team known as ESCALATES (Evaluating System Change to Advance Learning and Take Evidence to Scale), cooperatives shared the strategy of "meeting practices where they were.[8] One HVH practice facilitator described her experience with this approach:

> *"Across the board, the most successful strategy not only in engaging the practices but keeping them motivated was to find out what they were already working on…Finding out their priorities, be it meaningful use, MIPS[9], or PCMH certification[10] … and then working the HVH initiative goals into workflows that also addressed their own practice goals worked well."[11]*

During the kick-off meeting for each cohort, practices were presented with a complete HVH toolkit and asked to identify their priority areas for improvement. For example, one practice was struggling with medication reconciliation. The practice facilitator worked with the practice to make improvements to their medication reconciliation process that included a better process for patients on aspirin, one of the ABCS measures.[12] Other practices chose a variety of goals, including things like improving workflow, optimizing their electronic health record (EHR), pre-visit labs, and team huddles, which all helped free up time and resources in order to enable a practice to more effectively and easily improve its ABCS measures.

Looking across cooperatives, ESCALATES found that financial factors exerted a strong impact on a practice's ability to utilize external supports such as practice facilitation. Examples of relevant financial factors included national payment reforms represented by the Centers for Medicare & Medicaid's (CMS) new Merit-based Incentive Payment System (MIPS) for Medicare. While some practices understood and were motivated by EvidenceNOW's ability to help them prepare to participate in MIPS, others were confused by the CMS program. ESCALATES also identified state budget pressures and the lack of Medicaid expansion in some states as factors creating "uncertainty and stress, diminishing the priority placed on engaging with EvidenceNOW for some practices."[13]

Extracting data from EHRs was an unexpected challenge. The HVH cooperative's work revolves around the ABCS, including aspirin use by high-risk individuals, blood pressure control, cholesterol management, and smoking cessation. Quality improvement goals for these measures were premised on the assumption that practices would be able to extract the necessary data from their EHRs. The reality was that many practices were not able to extract the required data. An unanticipated level of effort was required to simply establish the baseline data from which improvements could be measured. Multiple HVH practice facilitators identified data collection and management as one of their biggest challenges. According to one facilitator:

> *"I can say that one of the most eye-opening experiences with this endeavor was that initially it felt like everyone had a sense that we would be able to get at the ABCS data for these practices in a relatively similar and seamless process. Most of these practices had participated in PQRS[14] or Meaningful Use.[15] Of course we can get at their data and leverage it to help them improve their ABCS measures, right? It didn't take long to realize that one of the more frustrating issues for me was [not] being able to extract data and use their data to help them improve their ABCS measure outcomes. The various EHR vendors all had different ways to pull this data, some charged extra to be able to easily get at the data without being a SQL[16] database professional, some had poor vendor support so when you called to get assistance they wouldn't understand what you wanted."*[17]

Challenges extracting data from EHRs were not unique to HVH, but were common across the EvidenceNOW cooperatives, with the exception of the New York cooperative where the participating practices were all Federally Qualified Health Centers operating with a common EHR. For HVH, contrary to what might be expected, it was actually harder to get data from practices that were part of large health systems than it was from smaller practices. This was because smaller practices had more freedom in decision-making than did practices within health systems with system-wide health information technology (IT) policies. Smaller practices, however, often lacked a dedicated IT professional and instead relied on nurses or office managers to fill this vital, time-consuming role. At the end of the intervention in August 2017, there were still some practices that could not generate reports on all of the ABCS measures. Additionally, once collected, the data was not immediately useable and often required additional work between a practice facilitator and a practice in order to verify that the data was trustworthy and meaningful enough to be actionable.

Meeting individual practice needs and the demands of an evaluation can be a balancing act. Each practice facilitator attempted to understand and meet the needs of the individual practices related to their performance on the ABCS measures as well as other, broader quality improvement initiatives. While the resulting, tailored approaches were effective in meeting the needs of practices, they sometimes created conflicts with the uniformity required for purposes of the national EvidenceNow evaluation, ESCALATES. States designing their own practice facilitation efforts across practices may wish to explore ways to allow for flexibility across practices that is necessary for effective engagement while still maintaining methodological rigor.

State Initiatives for Evidence-Based Prevention in Primary Care

HVH and the six other EvidenceNOW cooperatives nationwide used a variety of interventions, including practice facilitation, to improve cardiovascular disease prevention measures.[18] The Oklahoma cooperative, known as Healthy Hearts for Oklahoma, also used a more targeted, on-site intervention known as academic detailing. Academic detailing is typically a one-on-one educational encounter in which a trained detailer -- often a pharmacist or an individual with a clinical background -- provides clinicians with evidence-based recommendations to improve patient care.[19] Outside of EvidenceNOW, multiple states have implemented initiatives to promote quality improvement either through practice facilitation, implementation support, and/or academic detailing. For example, states have used practice facilitation to support delivery system innovations, such as implementing patient-centered medical homes in Vermont,[20] implementing and optimizing EHRs in North Carolina,[21] and increasing practice capacity for quality improvement through Oklahoma's practice-based research network.[22] States have also conducted outreach to primary care practices for a variety of targeted, evidence-based prevention efforts, primarily with support from the Centers for Disease Control and Prevention (CDC) Health Department

Demonstration Projects or through CDC disease-specific prevention grants. Examples include:

- **Opioids**: South Carolina's Department of Health and Environmental Control and Rhode Island's Department of Health use practice facilitation and/or academic detailing to promote safe opioid prescribing and to increase the effective use of the state's Prescription Drug Monitoring Program to prevent opioid misuse and abuse.[23]
- **Cancer screening**: Idaho's Department of Health and Welfare has a Comprehensive Cancer Control Program that partners with Community Health Centers to increase colorectal cancer screening rates in primary care. The program offers clinic implementation support, initiated by a kick-off meeting where a clinic-specific work plan is developed. The first cohort to participate in the program experienced a 10 percent increase in screening rates.[24]
- **HIV infection**: Colorado's Department of Public Health & Environment employs a full-time academic detailer for HIV prevention efforts, including educating primary care providers to increase awareness and appropriate prescribing of PrEP (pre-exposure prophylaxis) in patients who would benefit.[25]
- **Diabetes**: Nebraska's Department of Health and Human Services partners with Buffalo County Community Partners to increase referrals for evidence-based diabetes prevention and treatment programs. Their approach uses academic detailing to increase provider awareness of local resources to assist patients with pre-diabetes and diabetes in order to make more effective referrals. Though EHRs were envisioned to enable more effective referrals, Nebraska has found that it takes "a human touch."[26]

Lessons learned from states: In October 2017, NASHP conducted a series of key informant interviews with state officials from Colorado, Idaho, Nebraska, Rhode Island, South Carolina, and Vermont. The experiences of their work with primary care practices to increase evidence-based care echoed some of the lessons learned by HVH. For example, multiple states highlighted the importance of relationships, especially for "getting in the door" with primary care practices. They also emphasized that building trusting relationships between facilitators/detailers and practices requires ongoing contact. States also highlighted the importance of partnerships with external organizations, such as universities, state primary care associations, or local health improvement coalitions to successfully implement their programs.

Quantitative evaluation and tracking of quality measures for state-based programs to increase evidence-based practice has been relatively limited for several reasons. Some programs are not adequately funded or large enough to allow for a rigorous, quantitative evaluation. Other programs have not existed long enough to generate concrete results, while others cited challenges in accessing data necessary for evaluations. Most state programs administer provider surveys to gain qualitative feedback about the intervention and assess its impact, including self-reported changes in provider knowledge and behavior. Overall, based on these evaluations, providers have been receptive to this kind of intervention and appreciate evidence-based resources that they can readily incorporate into their practice.

Conclusion

This brief, the second in a series, shares major qualitative findings from the HVH EvidenceNOW cooperative as well as experiences from other state approaches to evidence-based prevention. Major challenges experienced by HVH included recruiting busy practices and extracting relevant data on ABCS measures. Successful strategies included leveraging and strengthening key relationships as well as aligning quality improvement initiatives with other ongoing priorities for a practice, such as MIPS. Quantitative analyses, including examination of the intervention's impact on practices' performance on the ABCS measures, will be included in the final brief in this series.

Endnotes

1. Institute of Medicine (IOM). 2001. Crossing the Quality Chasm. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press. (The National Academy of Medicine was previously known as the Institute of Medicine.)
2. Institute of Medicine (IOM). 2000. To Err Is Human: Building a Safer Health System. L. T. Kohn, J. M. Corrigan, and M. S. Donaldson, eds. Washington, D.C: National Academy Press.
3. See "Primary Care Provider Burnout: Implications for States & Strategies for Mitigation," by Jennifer Reck, EvidenceNOW: Insights for State Health Policymakers Series (No. 1, January 2017) http://www.nashp.org/wp-content/uploads/2017/01/VCU-Burnout.pdf.
4. Shannon M. Sweeney, et al. "Recruiting Practices for Change Initiatives is Hard: Findings from EvidenceNOW," American Journal of Medical Quality (2017); 1-7.
5. Tait D. Shanafelt, et al. "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population between 2011 and 2014," Mayo Clinic Proceedings 90, no. 12 (December 2015): 1600-1613.
6. Please see: EvidenceNOW: Insights for State Health Policymakers Series (No. 1, January 2017).
7. ESCALATES, Virginia Coop Blog, "Opportunities for the Future," September 22, 2017.
8. Jennifer Hemler, ESCALATES Qualitative Team, "A Trip Win: Tailoring External Support to Practice Needs," accessed on November 21, 2017.
9. The Merit-Based Inventive Payment System (MIPS) is one of two payment models that providers can choose under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. See "EvidenceNOW MACRA/MIPS Fact Sheet," accessed online November 21, 2017.
10. Patient-Centered Medical Home (PCMH) is a care delivery model whereby a primary care practice coordinates care to delivery to ensure patients get the right care when and where they need it. For a map of states implementing PCMH through Medicaid, see: http://nashp.org/state-delivery-system-payment-reform-map/
11. ESCALATES, Virginia Coop Blog, "Learning Reflections," September 28, 2017.
12. Evaluating System Change to Advance Learning & Take Evidence to Scale (ESCALATES).
13. Cynthia Perry, ESCALATES, "Understanding the Bottom Line: How Utilization of External Support is Affected by Finances," accessed on November 22, 2017.
14. PQRS is the Physician Quality Reporting System. For more information, see "Reporting Using an Electronic Health Record (EHR) Made Simple (V1.5, 2/23/2017).
15. Meaningful use refers to using EHRs to improve quality, care coordination, patient engagement and outcomes. For more information, see: https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives
16. Structure Query Language (SQL) is used to communicate with a database.
17. ESCALATES, Virginia Coop Blog, "My Biggest Takeaway," September 21, 2017.
18. For more information on the other EvidenceNOW cooperatives please visit AHRQ's website at: https://www.ahrq.gov/evidencenow/cooperatives/index.html
19. For more information about academic detailing, please see the National Resource Center for Academic Detailing (NARCAD).
20. Agency for Healthcare Research and Quality. 2013. Vermont Blueprint's EQuIP Program: A Practice Facilitation Program Supporting Statewide Health System Reform, accessed on November 27, 2017.
21. Agency for Healthcare Research and Quality. 2013. Facilitation in the Context of an Area Health Education Center: The North Carolina AHEC Practice Support Program, accessed on November 27, 2017.
22. Agency for Healthcare Research and Quality. 2013. Facilitation in the Context of a Practice-Based Research Network: Oklahoma's Practice Enhancement Assistants, accessed on November 27, 2017.

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