

# AHRQ EvidenceNOW: Building State Capacity

## INTERIM EVALUATION REPORT I

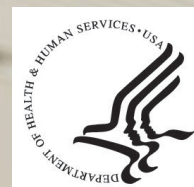
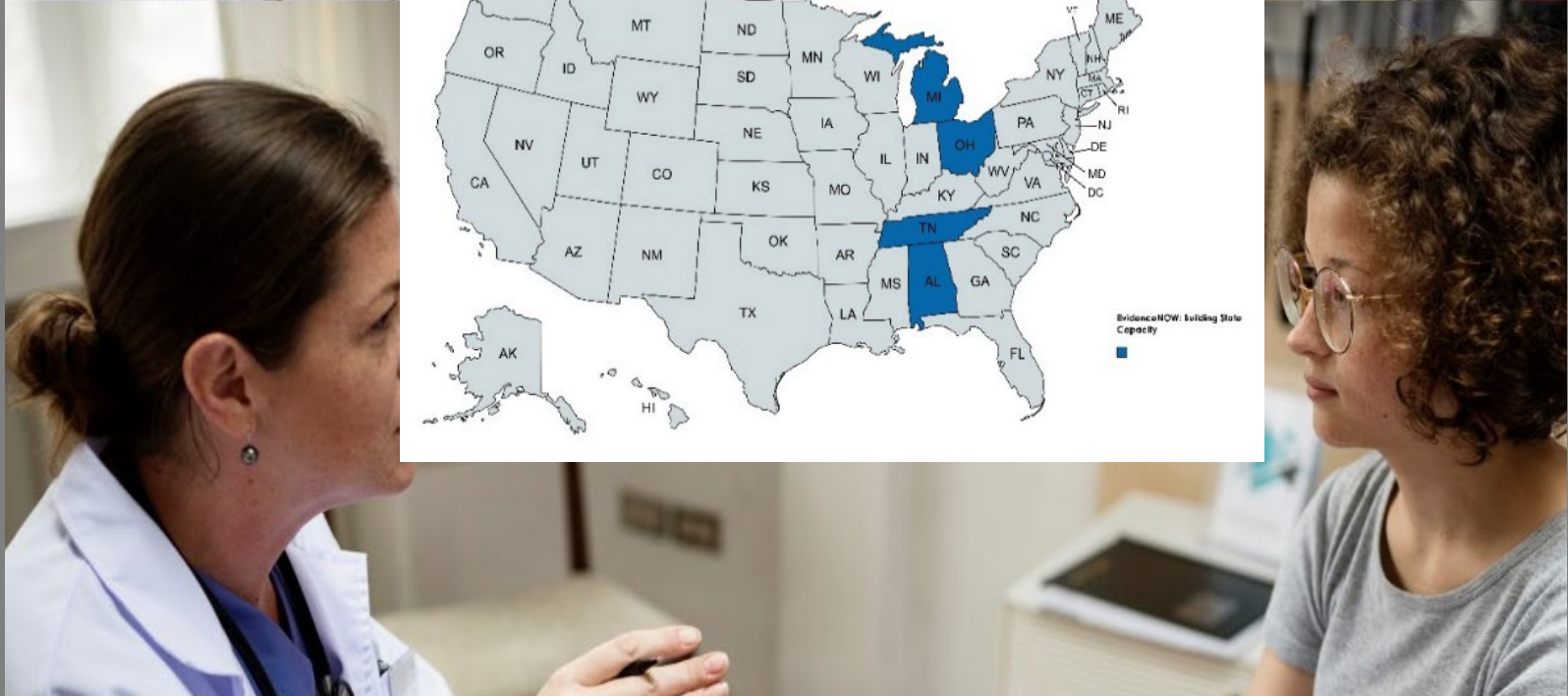
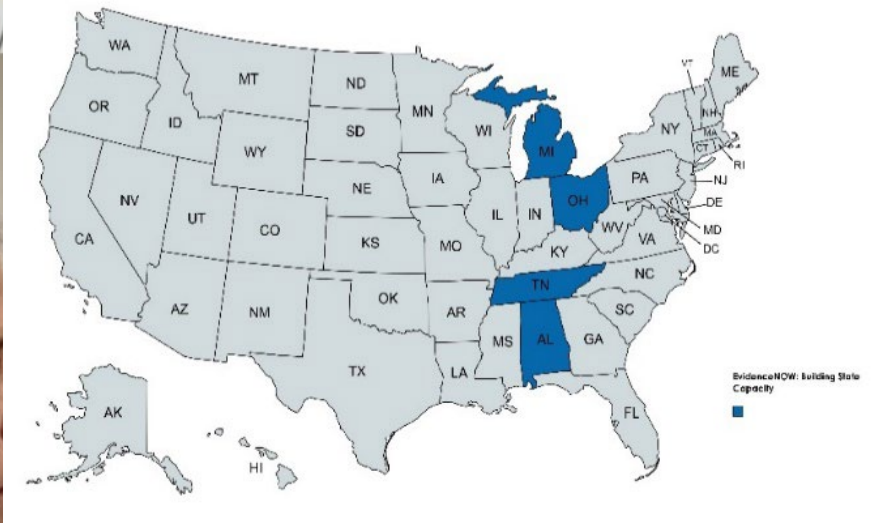
Technical Assistance to and Evaluation of Grant Initiative to Develop State-Level Capacity for Dissemination and Implementation of Patient-Centered Outcomes Research into Primary Care



# EvidenceNOW

**BUILDING STATE CAPACITY**

AN AHRQ INITIATIVE



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## Interim Report 1

# AHRQ EvidenceNOW Technical Assistance (TA) to and Evaluation of Grant Initiative to Develop State-level Capacity for Dissemination and Implementation of Patient-Centered Outcomes Research into Primary Care

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## Executive Summary

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In 2021 AHRQ funded four grantees to develop multi-organizational, state-level cooperatives and a network of primary care practices in their state, and recruit at least 50 practices to participate in the quality improvement (QI) evidence-based project to improve heart health. The grantees are from the states of Alabama, Michigan, Ohio, and Tennessee. This is the first interim report of the mixed-method evaluation of EvidenceNOW: Building State Capacity (EN: BSC), advancing equity in heart health. This report provides a profile of each cooperative and how it was built; an overview of cooperative models; key barriers and facilitators to creating the cooperative and network; and strategies used to recruit practices for the QI project.

This report, which relies largely on the primary data collected in key informant interviews, describes the first year of the EN: BSC grants, during which they launched their cooperatives and recruited practices. In November and December 2021, we interviewed 36 participants across the four grantees, including grantee and cooperative leadership, implementation leads or practice facilitators, evaluation leads, and partners. We also held a member checking session to review and discuss with grantees our emerging understanding of the cooperative models. In addition to primary data, we examined secondary data, including grantee applications, grantee progress reports, and notes from technical assistance meetings.

### ***Cooperative Building***

To build their cooperatives, grantees considered their goals of providing QI support to primary care practices in particular geographic regions and to those serving high-need populations. They first drew on existing relationships with organizations that could contribute to meeting those goals. Grantees expanded beyond existing connections to reach new partners, such as engaging with payers or forging connections to public health departments. Grantees sought to include key players in their state but were not always able to recruit specific partners (e.g., other academic institutions).

### ***Individual Cooperatives***

- **The Alabama Cardiovascular Cooperative (ACC)** is led by an academic institution in collaboration with another academic institution, a primary care association, and a QI organization from outside of Alabama. The ACC's guiding framework (Community-Academic Partnerships) calls for equal partnership between academic researchers and community stakeholders. The practices the ACC has recruited for its heart health QI project are part of federally qualified health center networks.
- **Healthy Hearts for Michigan (HH4M)** is led by a QI organization in collaboration with an academic partner leading the evaluation (with prior EvidenceNOW experience), as well as two other regionally distributed organizations to recruit practices and provide QI support. HH4M engagement and capacity building within rural primary care practices.
- **Heart Healthy Ohio Initiative (HHOI)** is led by an academic institution with support from regional QI organizations and the state department of public health. HHOI builds upon CardioOH initiative, a statewide collaborative to advance heart health. HHOI is rooted in the collective impact model and is using a co-design process to engage stakeholders.
- **Tennessee Heart Health Network (THHN)** is led by an academic institution with support from a QI organization and other academic partners. THHN draws on best practices of the Agile Implementation Playbook to understand, predict, and steer behaviors of individuals and groups in project activities. THHN is using an existing population health data network to recruit practices and provide data to practices for their QI projects. THHN is implementing a range of interventions to

improve the blood pressure and tobacco cessation of heart health in small primary care practices to reduce/eliminate disparities in cardiovascular disease outcomes.

### ***Cooperative Model Components***

The grantee’s cooperative models can be understood in terms of four central components of the cooperative structure and organizations involved, as follows:

- **Lead Organizations:** Three of four grantees (Alabama, Ohio, Tennessee) have academic institutions leading their cooperatives. Academic institutions are well suited to take on this role, given their infrastructure, experience with federal research grants, and clinical expertise. The fourth grantee (Michigan) has a QI organization leading with an academic partner with prior EvidenceNOW experience from another state to offer best practice insights and evaluation expertise.
- **Regionality Across States:** Partnerships are critical to reaching practices across a state. Grantees engaged partners from QI, healthcare or professional organizations, and academic organizations to conduct outreach and recruitment, and to provide QI support more widely across the state.
- **Cooperative Structure:** Grantee decisions to date differ in terms of the role of the principal investigator (PI) and grantee leadership, distribution of work across work teams, and engagement of patients. There are two approaches to **governance and oversight**. Ohio and Michigan use an advisory board that provides input but has no decision-making authority; the PI, with other key leaders, makes decisions. In contrast, Alabama and Tennessee’s ultimate decision-making group is a committee; the PI has a lead role in the committee. Additionally, all grantees have a core leadership team and divide tasks among work teams (a “hub-and-spoke” model). Two awardees (Ohio and Tennessee) have involved patients in the development of their cooperative plans and QI project.
- **Partner Engagement:** Grantees recruited partners strategically to meet the cooperative’s needs and support implementation of the QI project across eight domains (i.e., practice recruitment, heart health content expertise, clinical interventions, QI, practice data, evaluation, patient engagement, and sustainability). Choice of partners by the cooperatives also reflects previous relationships the leadership and recruitment teams had, the focus of the heart health intervention, and partner capacity and availability to participate.

### ***Facilitators and Barriers to Building Cooperatives***

- The common facilitators grantees reported included **existing relationships, prior experience with quality improvement projects, and partners’ enthusiasm** about participating in the cooperative.
- Grantees reported broad challenges with **project startup**, including scheduling meetings, reaching a shared understanding of roles and responsibilities, allocating staff time, and hiring new staff. The **COVID-19 pandemic** exacerbated these challenges. Grantees also encountered challenges with the **research project complexities**. For example, participants from three of the four grantees described challenges in implementing a project with a rigorous study design. While the academic institutions brought expertise in study design and conducting research, many of the QI partners were less familiar with research projects. Additionally, institutional review board (IRB) requirements and timelines posed challenges, including explaining IRB stipulations to partners less familiar with research (e.g., recruitment cannot begin until IRB approval).

### ***Strategies for Recruiting Practices***

- **Recruitment to the QI Project versus the Broader Network.** Grantees focused their recruitment efforts on enlisting practices to participate in the QI project rather than the broader network. Grantees had plans for how they would recruit to their broader network once the QI project recruitment was

complete. Some were considering the resources they would provide to practices that joined the network but were not part of the QI project.

- **Recruitment Strategies.** Grantees' approaches to recruiting practices to participate in their QI project included incorporating value propositions in their messaging, using various outreach techniques, leveraging their partners' existing networks, and offering incentives. While each grantee took its own multi-faceted approach to recruitment, a commonality across grantees was recruiting from practices with which cooperative organizations had existing relationships. Often cooperatives would recruit these practices via direct contact and conversations. Grantees aimed to recruit practices that serve diverse populations, especially underserved rural communities and communities of color. Therefore, they enlisted partners to help them reach those practices.
- **Recruitment Results.** All grantees reported challenges recruiting due to COVID-19, describing how practice leads were experiencing burnout, staff turnover, and low capacity to take on a QI project. Tennessee recruited its target number of practices most expeditiously, which may be a function of having an existing health information exchange of connected practices to pull data, which limits the burden for practices; or their offer of a sizable incentive to practices; or a combination thereof.

In the next round of data collection, we will explore the extent to which grantees were successful and the challenges they encountered in recruiting their final practices as well as achieving their goals of regional distribution or specific populations being served.

### ***What We Have Learned***

In this first Interim Evaluation Report, the Abt evaluation team provides profiles of cooperatives, describes how the grantees created their cooperatives, highlights key barriers and facilitators to creating their cooperatives and networks, and identifies the strategies used to recruit practices. The following are some reflections on what we have learned, many of which we will explore further in future data collection efforts:

- We have a preliminary understanding of the grantees' **cooperative models** and their components, as well as how they built their cooperatives. The advantages and disadvantages of different models, as well as the potential impact of key contextual factors for each state will become clearer in the remaining two years and will be explored in data collection. These forthcoming findings may provide insights for other states and regions that wish to build a cooperative to improve their state's primary care capacity.
- **Academic organizations and medical centers lead** three of the four cooperatives, which bring expertise in research and evaluation, with a local IRB to review and approve the project and protocols. They also have the infrastructure required to execute a complex grant submission, unlike most smaller organizations. Unless mechanisms for funding grants changes, the model of academic-led cooperatives is likely to continue. Whether academics, whose incentives reward research grantsmanship rather than health improvement, will be able to sustain the capacity to delivery QI support remains to be seen. We will explore the advantages and disadvantages of different types of organization leads.
- Grantees were able to **establish their cooperatives** structurally within 6 to 12 months and appear to have made some progress in achieving a cohesive, coordinated group of organizations working towards the same aims with a common understanding. They were continuing to identify other partners, particularly ones to contribute to sustainability such as payers. Grantees largely formed their cooperatives by partnering with organizations with whom they had prior relationships. Grantees reliance on **existing relationships** may have limited their engagement of other potential key partners to support sustainable, statewide capacity in their state. We will explore this further in future data collection efforts, especially when we interview organizations not involved in the cooperatives.



- In the first year, participants reported **challenges** related to reaching a shared understanding among cooperative members about the structure and organization of the cooperative, as well as individuals' roles and responsibilities. There were also different perspectives to bridge between cooperative members whose primary focus was quality improvement and those whose focus was evaluation. Improved communication might have helped. However, turnover of key roles may have contributed to this challenge.
- **External factors** disrupted cooperative development and functioning. For example, in Alabama, the cooperative had to make a major adjustment when its QI partner went out of business after losing a contract with the Centers for Medicare and Medicaid Services to be the State's Quality Improvement Organization-Quality Improvement Network. COVID-related workforce shortages not only affected primary care practices but also slowed down processes for hiring cooperative staff and obtaining IRB approval. For some grantees, there are also competing grants and priorities that may impact practice interest and capacity to participate in the QI projects.
- In the first year, cooperatives primarily focused on **recruiting practices into the QI project versus the network**. While AHRQ envisioned grantees building their cooperatives and networks first and then enlisting practices for the QI project, it may be that enlisting practices and conducting the QI project first may strengthen the cooperative's cohesion and collaboration to continue to build their state's capacity. Future data collection will explore how cooperatives are expanding their networks and supporting other future QI initiatives.
- While some **grantees may be more successful in enrolling practices** because they are more networked (i.e., part of a health system, or using practices connected to a health information exchange), these advantages for recruitment may pose downstream challenges of contamination for the evaluation. Additionally, for more networked practices it may limit the extent to which those individual practice sites are improving their capacity to improve heart health using its electronic health record data for QI. Similarly, networked practices may benefit less from the support provided or have a higher baseline capacity, which will be examined in the forthcoming evaluation activities.
- While grantees talked about their preliminary **recruitment strategies** and aims, future practice-level data collection will explore whether and to what extent grantees were able to achieve their goals for geographic distribution and specific populations.
- Despite including **partners who had relationships with networks of primary care practices**, cooperatives still had great difficulty recruiting practices. Although recruiting practices has always been a challenge, workforce shortages and the persistent COVID-19 pandemic has increased burnout and significantly reduced willingness to engage in QI or any other added effort. The inability of some electronic health records to produce clinical quality measures, observed in earlier EvidenceNOW initiatives, may be a barrier to recruitment for EN: BSC practices as well. Once grantees finish recruiting their practices, there should be clearer insight into the specific reasons practices declined to participate and other barriers to participation.
- Addressing the broader challenges that primary care providers and practices face may be a prerequisite to increasing the adoption and implementation of PCOR research evidence into practice.

Future evaluation data collection and analysis will explore many of these topics in greater detail, with the ultimate goal of describing the implementation and understanding the impact of the EN: BSC project on building statewide capacity and improving heart health.

## 1. Introduction

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The mission of the Agency for Healthcare Research and Quality is to produce evidence to make healthcare safer, of higher quality, and more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. A central focus for the Agency in the last decade has been to foster the use of evidence gained through patient-centered outcomes research (PCOR) to accelerate transformation in primary care, and to conduct research on best practices to implement this evidence.<sup>1,2</sup>

To advance its mission, AHRQ issued a Request for Applications (RFA) entitled Supporting Primary Care to Advance Cardiovascular Health in States with High Prevalence of Preventable CVD Events; AHRQ calls the resulting project EvidenceNOW: Building State Capacity (EN: BSC), advancing equity in heart health.<sup>3</sup> After reviewing the RFAs, AHRQ selected four grantees – from Alabama, Michigan, Ohio, and Tennessee – to build state-level cooperatives that included a network of primary care practices, and, from this network, recruit at least 50 practices to participate in a quality improvement (QI) project to improve heart health.

AHRQ awarded a contract to Abt Associates to conduct an independent evaluation of this new program. For the evaluation, Abt used a mixed-methods design that used both primary and secondary data, including administrative records (grant applications, grantee progress reports), key informant interviews and member checking sessions with program participants and knowledgeable non-participants, and data on grantee needs and challenges that the Abt technical assistance team had collected.<sup>4</sup>

In this first interim evaluation report, we provide a profile of cooperatives, describe how the grantees created the cooperatives and networks, highlight critical barriers and facilitators to creating the cooperative and network, and identify the strategies used to recruit practices in the network.

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<sup>1</sup> McNellis R. Facilitating Transformational Change in Primary Care. Content last reviewed August 2019. Agency for Healthcare Research and Quality, Rockville, MD.

<sup>2</sup> Ono SS, Crabtree BF, Hemler JR, et al. Taking innovation to scale in primary care practices: the functions of health care extension. *Health Aff (Millwood)*. 2018; 37(2): 222–230

<sup>3</sup> <https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-20-002.html>

<sup>4</sup> The evaluation team will use technical assistance meeting notes to shed light on grantee experiences and challenges.

## 2. Methods

### 2.1. Evaluation Design and Questions

The evaluation uses a mixed-methods design drawing on the primary data collected in key informant interviews and member checking sessions and the secondary data contained in grant applications, grantee progress reports (and practice-level data included in these), and notes from technical assistance meetings and AHRQ-grantee meetings. Guided by approaches from implementation science,<sup>5</sup> the evaluation will use comparative case study methods<sup>6</sup> and implementation science frameworks, including the Consolidated Framework for Implementation Research (CFIR) by Damschroder et al. (2009),<sup>7</sup> which comprises five domains and 41 constructs associated with effective implementation of an intervention.

In this first of two interim reports, we begin to answer the first four of ten research questions (see Exhibit 1). Specifically, this report explores the cooperative models, how grantees were building them, and the facilitators and barriers to doing so. This report also examines the strategies for recruiting and retaining practices within individual grantees, and approaches across grantees. This first report does not use the CFIR in analysis as we have not yet examined the intervention (QI support strategies and their implementation), nor does this report examine outcomes using practice-level data.

Exhibit 1 provides an overview of the analytical outputs in this interim evaluation report linked to the research questions and the data sources to help answer each question.

**Exhibit 1. Overview of Analytic Output Sections, Research Questions, and Data Sources**

Analytic Output (Sections below)	Research Questions (Questions in bold are addressed in report)	Primary Data		Secondary Data		
		Interviews	Member Checking	Grantee Applications	Progress Reports	Notes and Documents
Cooperative Models and Building Cooperatives (3.1.1 & 3.1.2)	<b>RQ1. How successful were grantees at creating cooperatives to deliver primary care QI support? What were the causes or explanations for successes and failures?</b>	✓	N/A	✓	✓	✓
	<b>RQ2. What are the organizational characteristics of the cooperatives, and how do they differ?</b> How did these differences affect outcomes?-What is the level of satisfaction with the cooperatives among the partners, other state and local organizations, network members, and QI practices?	✓	✓	✓	✓	N/A
Facilitators and Barriers (3.1.3)						
Strategies for Recruiting and Retaining Practices (3.2)	<b>RQ3. To what extent and in what ways were the cooperatives able to recruit practices into their networks?</b>	✓	N/A	N/A	✓	N/A
	<b>RQ4. To what extent and in what ways were the cooperatives successful at engaging the practices in the networks and increasing their QI capacity to implement PCOR findings?</b>	✓	N/A	N/A	✓	✓

<sup>5</sup> Damschroder LJ, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*. 2009 Dec;4(1):50.

<sup>6</sup> Yin RK. *Case study research and applications: Design and methods*. Sage Publications; 2017 Sep 27.

## 2.2. Data Sources

The primary data sources include key informant interviews and member checking sessions, which played a central role in answering the questions in this first interim report. We also relied on secondary data sources, all of which are described below.

### 2.2.1 Key Informant Interviews

From November to December 2021, we interviewed 36 participants across the four cooperatives, including grantee and cooperative leadership, project staff (e.g., implementation leads, practice facilitators, evaluation leads), and partners (see Exhibit 2). Interviews lasted approximately 45 minutes and were conducted over WebEx. Each interview included at least two members of the Abt team, an interviewer, and a note-taker; two interviewers and a note-taker attended the first two interviews to ensure a consistent approach to using the interview protocols and probes. The evaluation team met to discuss interview progress and discuss emergent challenges. The interviewers recorded all interviews with the respondents' permission.

#### Exhibit 2. Key Informant Interviews Participants by Project Role

Grantee	PI or Co-PIs	Project Managers	Project Staff	Partners	Implementation Leads	Evaluation Leads	TOTAL*
Alabama	2	1	2	1	2	1	9
Michigan	2	1	1	3	1	1	9
Ohio	4	1	1	3	1	0	10
Tennessee	1	1	1	4	1	1	9

\*36 individuals participated in interviews. In Ohio, we interviewed two participants during one interview, so we have more respondents in Ohio than for the other grantees.

### 2.2.2 Member Checking Sessions

In addition to key informant interviews, we held one of the three planned group sessions to conduct “member checking,”<sup>7,8,9</sup> or participant validation focus groups, to review and discuss emerging findings with the program participants.<sup>10,11</sup> The first session in February 2022 included grantee leadership (principal investigators, project managers, evaluation leads) and cooperative leadership (see Exhibit 3). Attendees from three grantees were able to attend the session; we conducted a makeup session for the fourth grantee in March 2022. The goal of the member checking session was to validate our characterization of grantee cooperative models and develop the taxonomy for quality improvement support strategies they plan to deliver. In this report, we focus on the results of the member checking session content related to cooperative models. The characterization and taxonomy of the quality

<sup>7</sup> Creswell, J. W., & Miller, D. L. (2000). Getting good qualitative data to improve educational practice, *Theory Into Practice*, 39(3), 124-130.

<sup>8</sup> Candela AG. Exploring the function of member checking. *The Qualitative Report*. 2019 Mar 1;24(3):619-28.

<sup>9</sup> Cohen DJ, Balasubramanian BA, Gordon L, Marino M, Ono S, Solberg LI, Crabtree BF, Stange KC, Davis M, Miller WL, Damschroder LJ. A national evaluation of a dissemination and implementation initiative to enhance primary care practice capacity and improve cardiovascular disease care: the ESCALATES study protocol. *Implementation Science*. 2015 Dec;11(1):86.

<sup>10</sup> Lincoln YS, Guba EG. But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *N Dir Eval*. 1986;1986(30):73–84.

<sup>11</sup> Cohen DJ, Crabtree BF. Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*. 2008 Jul 1;6(4):331-9.

improvement support strategies will continue to evolve as cooperatives begin to support practices and are described in future reports.

**Exhibit 3. Member Checking Attendees by Grantee**

Grantee	Attendees (#)
Michigan	3
Ohio	4
Tennessee*	3
Alabama	3
<b>TOTAL</b>	<b>13</b>

\* NOTE: MI, OH, and AL attended the formal member checking session. TN attended a makeup session with just TN.

OMB approved the package for this data collection effort on January 22, 2021 (OMB #0935-0259); approval expires on January 31, 2024. The Abt Associates institutional review board (IRB) determined that this project is exempt from IRB review.

**2.2.3 Secondary Data**

In addition to the primary data collected in key informant interviews and the member checking session, we examined secondary data available from grantee applications, grantee quarterly progress reports, and notes from technical assistance meetings.

**2.3. Qualitative Coding and Analysis**

We coded and analyzed data from key informant interviews using NVivo (v.12) qualitative analytic software. We used additional data from grant applications, progress reports, and technical assistance documents to supplement the key informant interview data to provide context about cooperative models and structure.

Codebook development was an iterative process that included deductive codes (established *a priori* from the evaluation questions and CFIR domains) and inductive codes (emerging from the data). Research team members, led by an experienced qualitative researcher, independently read selected excerpts of data sources (interview notes) to link to *a priori* codes and develop potential new codes. The research team discussed codes, definitions, and inclusion and exclusion criteria to create an initial codebook. We used the initial codebook to code three new sources (interview notes). We continued to refine the codebook until the codebook included enough detail to capture meaningful distinctions. We used that codebook to complete the coding of all materials. The codebook is in Appendix 1.

### 3. Findings

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We present the findings in two main sections: cooperative models and building the cooperatives and strategies for recruiting practices in the network.

#### 3.1. Cooperative Models and Building Cooperatives

We first describe the structure of each grantee's cooperative, and how each grantee developed their cooperative. We then provide an overview of the common and divergent cooperative model components. We end this section with facilitators and barriers to building cooperatives.

##### 3.1.1 Individual Grantees' Cooperatives and How They Built Them

###### *Alabama*

The **Alabama Cardiovascular Cooperative (ACC)** was established to expand equitable access to care by scaling up the capacity of Federally Qualified Health Centers (FQHCs) and small practices to address health disparities in cardiovascular care and treatment statewide. ACC aims to provide a forum for continuous collaboration, networking, and aligned efforts to reduce cardiovascular disparities and improve heart health outcomes in Alabama through these activities.

The ACC's approach to cooperative development is rooted in the framework for Community-Academic Partnerships (CAPs).<sup>12</sup> CAPs work to promote and advance the equal partnership between academic researchers and community stakeholders in creating and executing implementation research. Some studies of CAPs, of which there are few, have suggested the best ways to support these partnerships. Drawing on what is currently known, the ACC seeks to implement statewide cardiovascular QI projects using the following strategies to support community partnerships:

- Building a coalition
- Conducting local consensus discussions
- Identifying barriers and facilitators to implementation
- Using an advisory board or workgroup
- Tailoring strategies
- Promoting adaptability
- Auditing and providing feedback

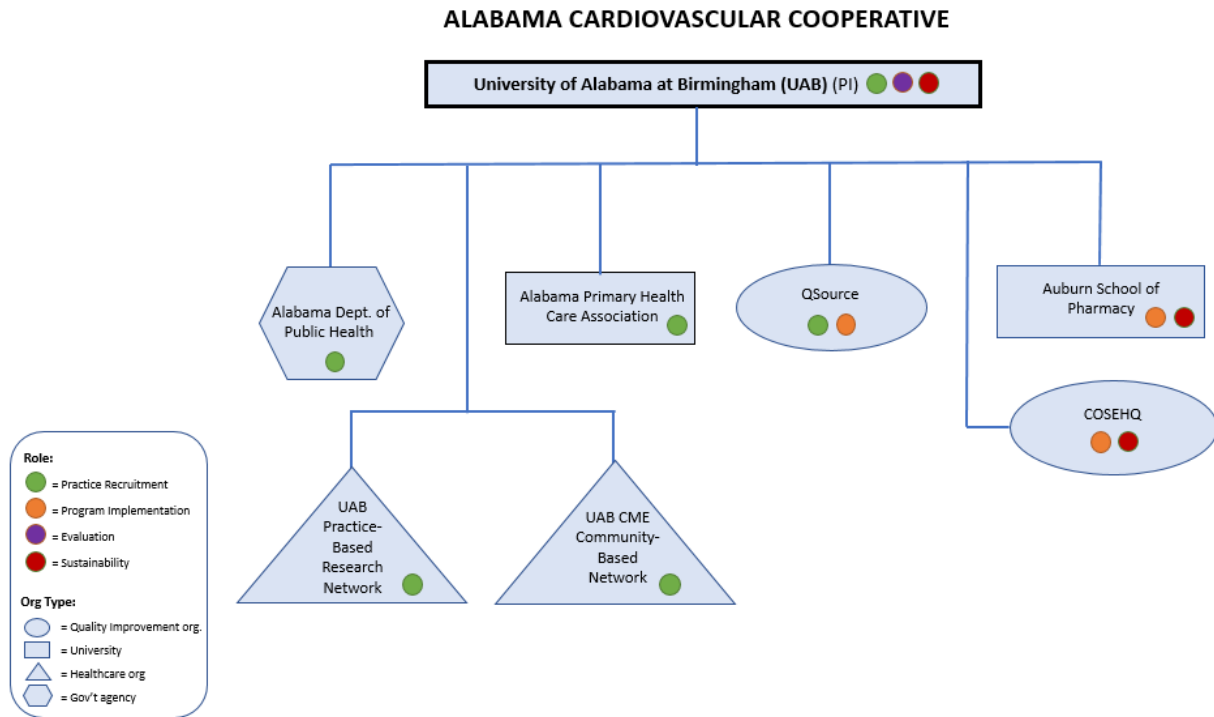
###### **Structure**

The ACC is led by Principal Investigator (PI) Andrea Cherrington, MD, MPH, of the [University of Alabama at Birmingham \(UAB\)](#), with support from partners at the [Alabama Primary Health Care Association \(APHCA\)](#), [Auburn University \(AU\)](#), and the Alabama Department of Public Health (ADPH). To provide subject-matter expertise on issues of healthcare quality and use, and practice facilitation support, the ACC engaged [Qsource](#), a non-profit healthcare QI organization and the Consortium for Southeast Healthcare Quality (COSEQH), a health information technology consulting firm. The ACC did this after the ACC's original QI partner, the [Alabama Quality Assurance Foundation \(AQAF\)](#), went out of business. See Exhibit 4.

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<sup>12</sup> Pellecchia M, Mandell DS, Nuske HJ, et al. Community-academic partnerships in implementation research. *J Community Psychol.* 2018;46(7):941-952.

Exhibit 4. Alabama Cardiovascular Cooperative



A priority of the ACC in developing their approach was to reduce the quality gap that exists in healthcare services provision statewide. In the early 2000s a nationwide push for integrated use of electronic health record (EHR) systems allowed many practices in Alabama to adapt systems through use of financial subsidies, offering access to comprehensive and comparable data. But significant maintenance and upgrade costs for these systems after the subsidies ended resulted in many practices foregoing needed system maintenance or ceasing use of EHRs entirely. As 90 percent of practices in Alabama are designated as small, underserved, or rural by the Centers for Medicare and Medicaid Services (CMS), staffing and funding constraints have historically limited small practices’ interest in QI efforts.

<b>Alabama Cardiovascular Cooperative (ACC)</b>	
<b>Leadership orgs</b>	University of Alabama at Birmingham (UAB)
<b>QI support providers</b>	Alabama Primary Health Care Association (APHCA) Qsource
<b>Cooperative focus</b>	Scaling up capacity of FQHCs and small practices to address health disparities
<b>Relationships</b>	UAB and Auburn University (AU) School of Pharmacy had previously partnered on the Center for Clinical and Translational Science; UAB, Alabama Department of Public Health (ADPH), and APHCA worked on a primary care initiative to prevent diabetes in the Deep South; UAB, ADPH, APHCA, and Blue Cross Blue Shield of Alabama (BCBS) of Alabama are engaged in a Patient-Centered Outcomes Research Institute (PCORI)-funded blood pressure control trial.
<b>Work teams</b>	<ul style="list-style-type: none"> <li>● Executive Committee</li> <li>● Advisory Board</li> <li>● Administrative core</li> <li>● Engagement core</li> <li>● Implementation core</li> <li>● Evaluation core</li> </ul>

Alabama Cardiovascular Cooperative (ACC)	
<b>Governance</b>	<ul style="list-style-type: none"> <li>The Executive Committee actively manages all ACC activities and meets biweekly via teleconference.</li> <li>The Advisory Board provides guidance and participates in meetings quarterly.</li> </ul>
<b>How does work get done?</b>	<ul style="list-style-type: none"> <li>The engagement core oversees activities and messaging related to the engagement of primary care providers (PCPs) and non-traditional providers as part of the CRRN.</li> <li>The implementation core oversees practice facilitation and QI support of the Heart Health Improvement Project (QI project).</li> <li>The evaluation core manages program evaluation across all project components.</li> </ul>
<b>Other partners</b>	<ul style="list-style-type: none"> <li>Alabama Medicaid Agency</li> <li>American Heart Association (AHA)*</li> <li>APHCA – network of FQHCs</li> <li>Blue Cross Blue Shield of Alabama (BCBS of Alabama)</li> <li>Consortium for Southeast Healthcare Quality (COSEHQ)</li> <li>State Health Information Exchange</li> <li>UAB Practice-Based Research Network</li> <li>Alabama Department of Public Health</li> </ul>

\* indicates ongoing discussions with the organization regarding interest in participation and potential role.

At the practice level, Dr. Cherrington (UAB), and partners from ADPH and APHCA, bring experience in developing a primary care network of rural providers and supporting their QI needs through their collaborative work on a National Institute of Minority Health and Health Disparities-funded clinical trial to increase diabetes screening and prevention efforts in the Deep South. Dr. Cherrington and partners from ADPH, APHCA, and BCBS of Alabama are also currently engaged in a PCORI-funded trial to improve blood pressure control among African Americans using practice facilitation and peer coaching within rural primary care practices. These ongoing efforts may impact practice interest and capacity to participate in ACC’s QI project.

At the state level, Qsource has a five-year (2017–2022) contract with CMS to provide QI technical assistance on the Merit-based Incentive Payment System to practices in Alabama and Tennessee. This funds four full-time employees to cover all clinicians working in practices with 16 or fewer providers across both states. As this represents 90 percent of practices in Alabama alone, QI support via this award is limited.

ACC partners have previously engaged in efforts to support QI initiatives. APHCA provides technical assistance and training on the topics of Meaningful Use, Patient-Centered Medical Home recognition/certification, and Uniform Data System measures. The organization also developed and operates the [Health Center Controlled Network](#), which leverages information technology to improve population health and provide cost-efficient, patient-centered care, and supports identification and prioritization of QI goals for public health programming, with a focus on improving hypertension control via access to blood pressure self-monitoring sites. Partners at UAB and AU have managed and operated the CCTS since 2008 with funding from the National Center for Advancing Translational Science to support QI-focused workforce development statewide.

At the time of application, the ACC intended to draw on the experience of the AQAF to provide QI support for ACC’s QI project. The AQAF was a seasoned provider of QI support in the state and actively developed the AHRQ proposal. Following notification of the grant, the board voted to dissolve the AQAF in response to federal funding changes impacting [CMS’s QI Organization \(QIO\) program](#). Dr. Cherrington and project partners then recruited Qsource, a QI provider that previously worked with the AQAF, to step in and provide coordinated QI support. This shift in QI support providers resulted in delays to the project. UAB now needed to add Qsource to the approved IRB before staff could actively



participate in ACC activities. Notably, this hindered practice recruitment for the QI project by Qsource practice facilitators.

Qsource is recognized as the Quality Innovation Network-QI Organization (QIN-QIO) of Indiana, but the organization has historically provided QI support across 11 states, including Alabama. Although Allegiant Health Solutions (AHS) currently serves as Alabama's QIN-QIO program, AHS was not recruited to provide QI services to the ACC. Interviews with key stakeholders suggest that ACC partners may not be familiar with AHS. During interviews, participants indicated that following the AQAF's dissolution there was no other entity in the state to take up this role. As the ACC moves forward, engaging Qsource may impact partnerships and resources available to advance QI capacity statewide. Alabama practices and stakeholders may hesitate to engage with an out-of-state QI provider if local options are available. The ACC should monitor and evaluate the impact of this staffing decision to gauge whether a change of QI provider is needed, or would be beneficial, in efforts to centralize the coordination of support for QI.

#### **Governance and Operations**

An Executive Committee governs the ACC with consultation from an Advisory Board.

- The **Executive Committee** consists of the Project PI, Dr. Andrea Cherrington (UAB), Co-PIs Elizabeth Jackson, MD, MPH, FAHA, and Larry Hearld, PhD (UAB), and Core Team Leads Sharon Parker, RN, CVRN, CHTS-CP, PCMH-CCE (APHCA), Ben Heavrin, MD (Qsource), and Richard Hansen, RPh, PhD (AU). The Executive Committee is responsible for establishing policies and operating procedures, fostering program development, participation in internal evaluation processes, and planning, execution, and evaluation. The Executive Committee makes decisions by consensus to ensure members retain equal footing and influence over the direction and activities of the group. This reflects the use of the CAPs framework, which tries to reduce the perception of hierarchy in decision-making between partners.
- The **Advisory Board** includes representatives from diverse sectors and state geography, including UAB (Departments of Family and Community Medicine, Cardiovascular Disease, and Epidemiology), [Connection Health](#), [Viva Health](#), Alabama Public Health Institute, [Alabama Medicaid Agency](#), [BCBS of Alabama](#), and the [Alabama Cooperative Extension Services](#). A member of the U.S. House of Representatives also serves on this board. The Advisory Board provides guidance and recommendations to the Executive Committee via quarterly meetings and ad hoc communications.

#### **Work Teams**

Four work teams are responsible for the ACC's operations.

- The **Administrative Core** is led by the Project PI, Dr. Cherrington (UAB), with support from the Project Director, Trudi Horton, PhD (UAB), and serves to coordinate activities and share resources across identified areas of interest, recognized as Core Teams: practice engagement, implementation, and evaluation. The Core Teams are responsible for advancing activities under their scope through collaborative work. Core Teams include:
- The **Engagement Core** is led by Project PI Dr. Andrea Cherrington (UAB), with support from the co-lead Dr. Richard Hansen (AU). The Engagement Core oversees activities and messaging related to the engagement of PCPs and non-traditional providers as part of the CRRN. Although ADPH is supportive of the project and nominally a member of the Engagement Core, its role is largely contained to responding to targeted questions.
- The **Implementation Core** is led by co-leads Ben Heavrin (Qsource) and Sharon Parker (APHCA), and oversees practice facilitation and QI support for the QI project. The ACC employs six practice facilitators between Qsource and APHCA. Qsource hired two of these individuals from the AQAF following the AQAF's dissolution; these individuals remained in Alabama for QI support purposes.

All practice facilitators have received online and intervention protocol training to support QI project practices.

- The **Evaluation Core** is led by Larry Hearld, PhD (UAB), who manages program evaluation across all project components.

**Michigan**

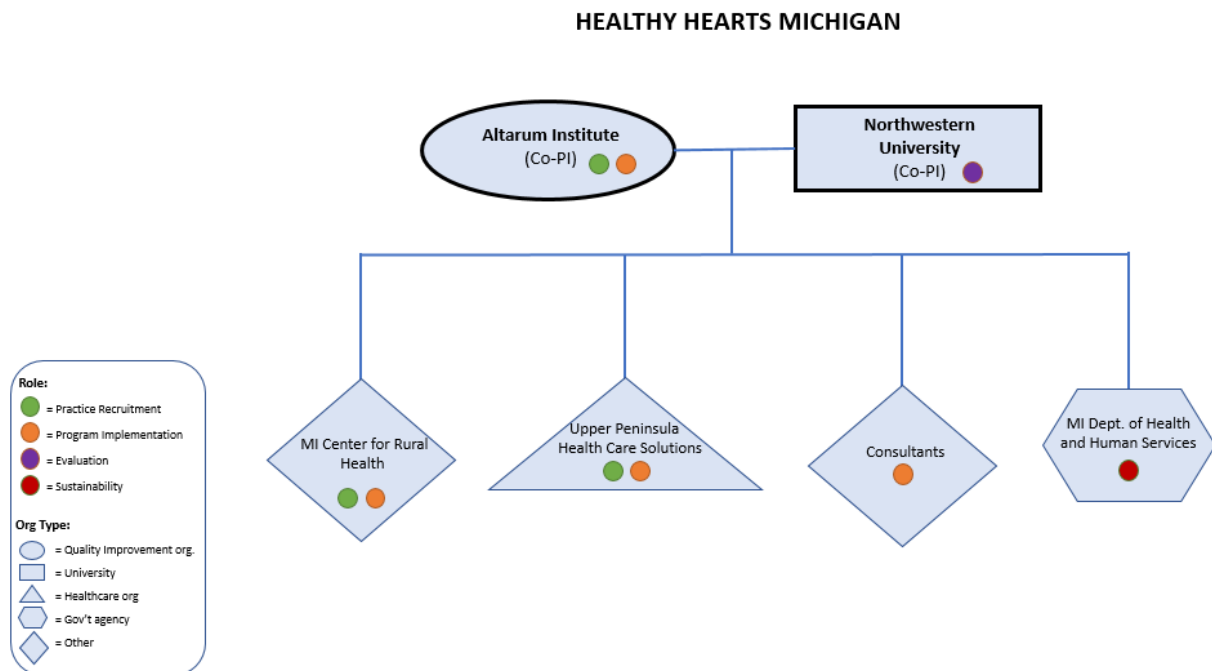
The **Healthy Hearts for Michigan (HH4M) Cooperative** seeks to draw from elements of and adapt the approach used by the [Healthy Hearts in the Heartland](#), led by Northwestern University, as one of the grantees in the original EvidenceNOW initiative.

To support rural primary care practices and build on lessons learned from AHRQ’s prior EvidenceNOW initiatives, [Northwestern University](#) (NU) joined with experienced QI providers ([Altarum Institute](#), [Michigan Center for Rural Health](#) (MCRH), and [Upper Peninsula Healthcare Solutions](#) (UPHCS) to form Healthy Hearts for Michigan (HH4M).

**Structure**

Led by Anya Day, MPH, of [Altarum Institute](#), and Theresa Walunas, MS, PhD, of NU, with support from partners at the MCRH and UPHCS, HH4M was established to improve the quality of cardiovascular disease care in rural Michigan practices by focusing on the use of clinical interventions to control hypertension and encourage people to stop using tobacco, and offering provider education on evidence-based care. Altarum, MCRH, and UPHCS are the cooperative’s QI team. These organizations bring significant experience providing practice facilitation, having worked on numerous QI, meaningful EHR use, and technical assistance projects. See Exhibit 5.

**Exhibit 5. Healthy Hearts Michigan Model**



The HH4M cooperative’s heart health QI efforts benefit from a decade of federal and state initiatives to develop foundational capacity and infrastructure to support statewide primary care capacity. Notably, the Office of the National Coordinator for Health Information Technology’s [Information Technology Regional Extension Center](#) program and the CMS [Transforming Clinical Practice Initiative](#) (TCPI) and [Comprehensive Primary Care Plus](#) model have helped Michigan practices optimize health IT and use of

EHRs, through technical assistance and peer-based learning opportunities. As TCPI efforts in the state recently concluded, the HH4M Cooperative expects to play a critical role in maintaining and expanding QI capacity among rural primary care practices.

Healthy Hearts for Michigan (HH4M)	
<b>Leadership</b>	<ul style="list-style-type: none"> <li>• Altarum Institute (Implementation)</li> <li>• Northwestern University (NU) (Evaluation)</li> </ul>
<b>QI support providers</b>	<ul style="list-style-type: none"> <li>• Altarum Institute (central MI)</li> <li>• Michigan Center for Rural Health (MCRH) (southern MI)</li> <li>• Upper Peninsula Healthcare Solutions (UPHCS) (Upper Peninsula)</li> </ul>
<b>Cooperative focus</b>	Building rural engagement and building capacity, especially across non-academic institutions; integrating community health workers into clinical care teams
<b>Relationships</b>	The NU team had experience from the first EvidenceNOW initiative; Altarum Institute and NU have worked together on previous projects. Altarum Institute had worked with UPHCS previously.
<b>Work teams</b>	<ul style="list-style-type: none"> <li>• Steering committee</li> <li>• Physician advisory committee</li> <li>• Central project management team</li> <li>• Intervention design working group</li> <li>• Study design and evaluation working group</li> <li>• Dissemination working group</li> <li>• Outreach and engagement working group</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>• The steering committee meets twice a year to provide broad oversight for HH4M activities.</li> <li>• The central project management team coordinates operational activities, teleconferencing, file sharing, and project tracking tools.</li> </ul>
<b>How does work get done?</b>	<ul style="list-style-type: none"> <li>• The intervention design working group oversees the development of the HH4M implementation model and selection of evidence-based interventions.</li> <li>• The study design and evaluation working group manages the development of the study design and evaluation methodology and oversees data collection and quantitative/qualitative analysis.</li> <li>• The dissemination working group is responsible for ongoing communications to Michigan stakeholders and dissemination of project findings.</li> <li>• The outreach and engagement working group is responsible for developing and implementing the practice recruitment strategy.</li> <li>• The practice facilitation community is responsible for the design of and instruction on practice facilitation materials.</li> </ul>
<b>Other partners</b>	<ul style="list-style-type: none"> <li>• American Medical Association (AMA)</li> <li>• Health Information Technology Regional Extension Center for Michigan</li> <li>• Michigan Community Health Worker Association**</li> <li>• Michigan Department of Health and Human Services (MDHHS)</li> <li>• Michigan Department of Public Health</li> <li>• Michigan Medicaid</li> <li>• Michigan Primary Care Association**</li> <li>• New York University (NYU)</li> <li>• Northern Pines Health Center</li> <li>• Western Michigan University (WMU)</li> </ul>

\*\* Indicates recently engaged organizations – these organizations have not yet committed to formal participation in or support of the HH4M Cooperative. Discussions are ongoing.

Altarum Institute also brings direct experience in supporting primary care practices to improve chronic care management and heart health at the practice level. From 2014 to 2018, Altarum Institute partnered with the [Michigan Department of Health and Human Services](#) on two CDC awards to prevent and control diabetes, heart disease, obesity, and associated risk factors. This work engaged primary care practices

statewide to improve cardiovascular disease and diabetes management measures. In addition, UPHCS is a three-time recipient of HRSA's [Small Health Care Provider QI Program](#) funding and has used these awards to improve access to and optimization of health information technology in primary care practices across the Upper Peninsula. The HH4M Cooperative will use this practice-level experience as foundational knowledge to support the roll-out of the practice facilitation services by a team of seven staff from Altarum, UPHCS, and MCRH.

Along with previously noted QI efforts at the state level (the Michigan Regional Extension Center or M-CEITA), Great Lakes Practice Transformation Network (GLPTN), and CMMI Innovation Award projects), MCRH also facilitates the Michigan Critical Access Hospital Quality Network, the Medicare Beneficiary QI Program, and the Michigan Rural Health Clinic Quality Network. MCRH has significant experience working on state-level QI projects implemented in rural areas from these initiatives.

HH4M partners Altarum Institute, MCRH, and UPHCS also collectively engage robust networks of practices and providers statewide due to their prior QI efforts and geographic distribution across Michigan. Altarum Institute's Primary Care Provider Network includes more than 1,000 small to medium sized primary care practices and 5,000 participating clinicians, focusing on central Michigan. MCRH's network consists of all 36 critical access hospitals and 65 rural health clinics statewide, though the organization will focus on engagement in Southwest Michigan for this project. In addition, UPHCS brings strong relationships with local clinics in the Upper Peninsula, including Upper Peninsula Tribal Health Centers.

Notably, the HH4M Cooperative engaged many critical partners throughout the state, primarily focusing on rural communities. The University of Michigan has not engaged in the cooperative, perhaps because they submitted a competing grant application.<sup>13</sup> Other key stakeholders not engaged to date include MPRO, Michigan's designated QI Organization, and the Michigan Health Information Exchange. HH4M partners elected not to pursue recruitment of MPRO because of the organization's participation in the Superior Health Quality Alliance and their current focus on nursing home care. The cooperative is considering outreach to the Michigan Health Information Exchange to support data access and transfer if needed.

#### **Governance and Operations**

The HH4M Cooperative is managed by a Central Project Management Team, with advice from a Steering Committee and a Physician Advisory Committee.

- The **Central Project Management Team**, led by HH4M project manager Bruce Maki, MA (Altarum Institute), is responsible for the coordination of cooperative operational activities, project tracking, and infrastructure development (teleconferencing, filesharing, virtual meeting tools, and protocol).
- The **Steering Committee (SC)** supports internal decision-making. Informed by participant discussion, ideas, and strategies generated by the workgroup teams, the SC collectively identifies solutions and appropriate next steps for HH4M activities. The SC consists of Ms. Day (Altarum Institute), and Dr. Walunas (NU), representatives from each cooperative member organization (MCRH, UPHCS, the MDHHS Heart Disease and Stroke Prevention Unit, MDHHS Tobacco Section), many of their partners (the AMA, [Western Michigan University \(WMU\)](#), [New York University \(NYU\)](#)), and a representative from an independent practice, and workgroup team leads. Ms. Day leads the Steering Committee. It is responsible for providing broad oversight of HH4M activities, reviewing progress against established targets, and addressing challenges or needed

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<sup>13</sup> The evaluation team will follow-up on this question if HH4M reached out to the UM or considered doing so, or not.

changes as identified to support the cooperative's growth, impact, and sustainability. As a group, the SC meets biannually.

- The **Physician Advisory Committee (PAC)** is led by Altarum Institute and provides clinical guidance to the SC on HH4M activities. The PAC consists of physicians from Altarum Institute, AMA, NU, NYU, WMU, and a rural independent practice provider, who support informed decision-making at the programmatic and clinical intervention levels.

#### Work Teams

The HH4M operates through five work teams:

- The **Study Design and Evaluation Workgroup** is led by Amy Krefman, PhD (NU)<sup>14</sup>. The workgroup manages the development of the study design and evaluation methods and will be responsible for data collection and analysis. Workgroup members include Megan McHugh, PhD (NU), and Gregory Wozniak, PhD (AMA). This workgroup meets monthly.
- The **Dissemination Workgroup** is led by Ms. Day (Altarum Institute) and oversees regular communications about HH4M efforts to Michigan stakeholders interested in advancing cardiovascular health QI efforts statewide. The workgroup will also manage the dissemination of project findings as available. Workgroup members include Dr. Walunas, (NU), Liz Jones, BA (Altarum Institute), and Mr. Maki (Altarum Institute). This workgroup meets monthly.
- The **Outreach and Engagement Workgroup**, led by Ms. Jones (Altarum Institute), is responsible for developing the practice recruitment strategy and related materials. Workgroup members include practice facilitators from Altarum Institute, MRCH, and UPHCS. This workgroup meets monthly.
- The **Intervention Design and Implementation Workgroup** consists of Ms. Day (Altarum Institute), and Dr. Walunas (NU), as well as subject matter experts on hypertension and tobacco cessation representing the AMA and NU. This workgroup is led by Ms. Day and is responsible for designing the HH4M implementation model and section of evidence-based interventions for cardiovascular care. Workgroup advisors include Michael Rakotz, MD, FAHA, FAAFP (AMA), and Brian Hitsman, PhD (NU). This workgroup meets monthly.
- The **Practice Facilitation Community** is led by Mr. Maki (Altarum Institute), with support from Jaqueline Bannon, BSN, RN, PhD (NU). This workgroup oversees the development of the practice facilitator training and materials. Workgroup members include practice facilitators from Altarum Institute, MRCH, and UPHCS. This workgroup meets monthly.

#### Ohio

The **Heart Healthy Ohio Initiative (HHOI)** builds on a current initiative funded by the Ohio Department of Medicaid with Case Western Reserve University (CWRU) to implement the Cardi-OHvascular (CardiOH) collaborative, supported by the Department of Medicaid. In the CardiOH collaborative, all seven Ohio medical schools and three regional health improvement collaboratives (RHICs) work together to expand support for high-volume Medicaid practices. The HHOI leads intended the AHRQ grant to expand their existing work beyond high-volume Medicaid practices. However, because of management and funding challenges, the AHRQ EN: BSC grant for HHOI is related to but distinct from CardiOH. The project leads see the CardiOH initiative as the statewide collaborative, whereas the HHOI is the external infrastructure to support QI projects.

The collective impact model is undergirding Ohio's approach to the HHOI. Collective impact draws from the coordinated community response (CCR) model, which posits that individual organizations or agencies

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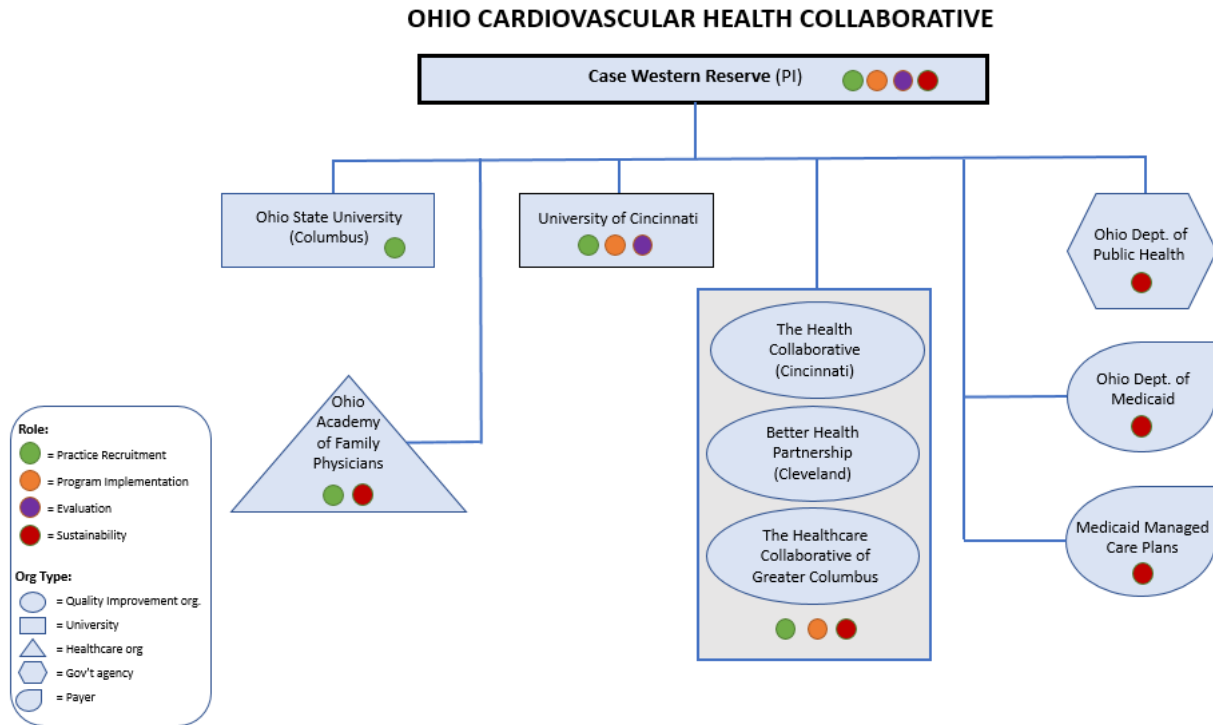
<sup>14</sup> Jody Cicolino, MS, PhD (NU) was the former evaluation lead.

cannot fully address complex community issues.<sup>15</sup> Instead, complex problems require collaborative and synchronized approaches involving leaders from community partners representing diverse backgrounds and perspectives. Collective impact expands on the CCR model to unite leaders from different groups or partners that come together to develop and implement a joint plan to solve a particular problem.<sup>16</sup> Collective impact posits that the implementation of large-scale change is improved with high levels of coordination across sectors. HHOI has applied collective impact across the project by engaging diverse partners in key organizations within the state and using a co-design process to engage stakeholders in collaborative development of an external QI infrastructure for statewide heart health improvement.

**Structure**

Led by Shari Bolen, MD, MPH and Aleece Caron, PhD, both from CWRU, and with support from academic partners at [Ohio State University](#) (OSU) and the [University of Cincinnati](#) (UC), the Heart Healthy Ohio Initiative engaged the [Health Collaborative](#), [Better Health Partnership](#), and the [Healthcare Collaborative of Greater Columbus](#) RHICs to support geographically diverse practices in Ohio and bring subject-matter expertise on topics including health technology solutions, data-informed improvement, patient-centered care delivery, and shared learning initiatives. See Exhibit 6.

**Exhibit 6. Heart Healthy Ohio Initiative Model**



While developing their application, project PIs Dr. Caron and Dr. Bolen sought to expand and position Ohio to enhance the use and effectiveness of a multi-level heart health intervention, improve cardiovascular disease care and outcomes, and reduce cardiovascular health disparities. Dr. Bolen brought

<sup>15</sup> Sagrestano, L. M., Clay, J., & Finerman, R. (2018). Collective impact model implementation. *Journal of Health and Human Services Administration*, 41(1), 87-123.

<sup>16</sup> Kania, J., & Kramer, M. (2011). "Collective impact." *Stanford Social Innovation Review*. (pp. 36-41). Beijing, China: FSG.

clinical experience and experience developing collaboratives and working with payers, whereas Dr. Caron brought experience doing QI and workforce, skills, and tool development.

Heart Healthy Ohio Initiative (Ohio)	
<b>Leadership</b>	<ul style="list-style-type: none"> <li>• Case Western Reserve University</li> <li>• Ohio State University</li> <li>• University of Cincinnati</li> </ul>
<b>QI support providers</b>	<ul style="list-style-type: none"> <li>• Better Health Partnership</li> <li>• The Health Collaborative</li> <li>• The Healthcare Collaborative of Greater Columbus</li> </ul>
<b>Cooperative focus</b>	Expansion of an external QI infrastructure to support heart health improvements across Ohio primary care practices.
<b>Preexisting or new relationships</b>	Relationships exist between many Ohio partners due to participation in initial Ohio collaborative funded by the Ohio Department of Medicaid and Medicaid managed care plans.
<b>Work teams</b>	<ul style="list-style-type: none"> <li>• Executive team</li> <li>• Stakeholder engagement team</li> <li>• Co-design team</li> <li>• Implementation team</li> <li>• External support infrastructure team</li> <li>• Data and evaluation team</li> <li>• Marketing and communications team</li> <li>• Dissemination, engagement and sustainability team</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>• The Executive Team includes 10 members, including the project PIs, leads from the three RHICs, and the project management team leads. The Executive Team coordinates activities among team leads, strategically implements the project including managing the timeline, and identifies and secures funding to support sustainability.</li> </ul>
<b>How does work get done?</b>	<p>Ohio maintains six “network teams”, which manage daily activities under their specific focus areas and report to the Executive team. The teams are:</p> <ul style="list-style-type: none"> <li>• The Stakeholder Engagement team engages stakeholders, including payers, professional organizations, state governmental agencies, and two patient/family representatives. The group serves in an advisory capacity to the HHOI Cooperative, meeting 2–4 times annually to review progress and discuss activities, analyses, and dissemination opportunities.</li> <li>• The Co-Design team engages partners across the state including primary care team members and patients, payers, practices coaches, and content experts. This team is responsible for addressing the six phases of co-design in a way that is both practical and feasible for planning for broader statewide implementation.</li> <li>• The Implementation team oversees the implementation of the HHOI intervention, including developing resources and supporting practice facilitator training.</li> <li>• The External Support Infrastructure team leverages existing support from the seven medical schools in Ohio and the three RHICs to increase the sustainability of the cooperative.</li> <li>• The Data and Evaluation team is responsible for evaluating the HHOI intervention.</li> <li>• The Marketing and Communications Team leads the implementation of the website, podcast, and social media activities.</li> <li>• The Dissemination, Engagement and Sustainability Team develops, implements, and tracks dissemination activities in partnership with other project teams.</li> </ul>
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• American Heart Association</li> <li>• CVS</li> <li>• Ohio Academy of Family Physicians (OAFP)</li> <li>• Ohio Association of Community Health Centers</li> <li>• Ohio Association of Health Plans</li> <li>• Ohio Department of Medicaid</li> <li>• Ohio Department of Public Health</li> <li>• Ohio Medicaid Managed Care Plans</li> </ul>

HROI has the benefit of building off preexisting relationships and infrastructure to support the cooperative's heart health QI efforts. Ohio contracted with three established Ohio organizations to provide staffing, services, and expertise – the [Health Collaborative](#), [Better Health Partnership](#) (BHP), and the [Healthcare Collaborative of Greater Columbus](#) (HCGC). These partners represent the state's three RHICs, which work to improve healthcare and quality, and demonstrate expertise and provide services in QI, EHR data extraction, population health, primary care transformation, quality measurement and standardization, resource identification, peer-to-peer learning, and care coordination. As part of the existing CardioH effort, the RHICs engage all seven Ohio medical schools and a network of over 800 primary care practices statewide. Other key partners, CWRU and Ohio State University, have worked together on PCORI QI initiatives to improve tobacco assessment and counseling and bring experience effectively leveraging PCOR evidence-based strategies to improve health outcomes.

HROI partners have participated in multiple practice- and state-level QI projects before launching this effort. At the practice level, partners at the BHP have engaged more than 20 safety net practices to improve blood pressure control and reduce heart health disparities by implementing hypertension best practices as part of a year-long QI program. CardioH lead CWRU has also worked to address hypertension through QI initiatives with eight high-volume Medicaid primary care practices. At the state level, partners at the Health Collaborative of Cincinnati and the HCGC have collaborated to provide QI infrastructure support to the CMS Comprehensive Primary Care Plus program practices. This project works to develop sustainable QI infrastructure by linking the state's RHICs, medical schools, and CardioH with primary care practices.

As a result of challenges in completing contractual agreements, Ohio has reduced the pilot phase from six to four months before the randomization and intervention launch. The team also scaled back the practice facilitation and coaching plan because of feedback from pilot participants.

#### **Governance and Operations**

Like the other grantees, the cooperative includes a core executive team that directs the work and “network” teams to advise or conduct the work.

- The **Executive Team** includes 10 members, including the project PIs (Dr. Bolen, Dr. Caron, CWRU), leads from the three RHICs (Carrie Baker, HCGC; Dick Shonk, MD, HC; Rita Horwitz, RN, BHP), and the project management team leads (Saundra Regan, PhD, UC; Randy Wexler, MD, MPH, OSU; Stephanie Kanuch, MEd, MetroHealth – part of CWRU; Catherine Sullivan, MS, RD, MetroHealth; Tammy Hawes, MetroHealth). The Executive Team coordinates activities among team leads, strategically implements the project, manages the timeline, and identifies and secures funding to support sustainability.

#### **Work Teams**

Ohio maintains six network teams, which manage daily activities under their specific focus areas and report to the Leadership Team.

- The **Stakeholder Engagement Team** is co-led by Kurt Stange, MD, PhD (CWRU) and Christopher Bernheisel, MD (UC), and engages key stakeholders including payers, professional organizations, state governmental agencies and two patient/family representatives. The group serves in an advisory capacity to the HROI Cooperative, meeting two to four times annually to review progress and discuss activities, analyses, and dissemination opportunities.
- The **Co-Design Team** is led by co-PI Dr. Caron (CWRU) and Richard Buchanan, PhD (CWRU), and engages partners across the state, including primary care team members and patients, payers, practices coaches, and content experts. This team is responsible for addressing the six phases of co-design in a way that is both practical and feasible for planning for broader statewide implementation.



- The **Implementation Team** is led by Dr. Caron and Dr. Bolen (CWRU). It oversees the implementation of the HHOI intervention, including developing resources and supporting practice facilitator training.
- The **External Support Infrastructure Team** is led by Dr. Caron (CRWU). This team leverages existing support from the seven medical schools in Ohio and the three RHICs to increase the sustainability of the statewide cooperative.
- The **Data and Evaluation Team** is led by Adam Perzynski, PhD (CRWU); Sandra Regan, PhD (UC); and Thomas Love, PhD (CRWU). This team is responsible for evaluating the HHOI intervention.
- The **Marketing and Communications Team** is led by Catherine Sullivan, MS, RD (MetroHealth), and leads the implementation of the website, podcast, and social media activities.
- The **Dissemination, Engagement and Sustainability Team** is led by Carrie Baker (HCGC) and Kate Mahler, CAE (OAFP). It will develop, implement, and track dissemination activities in partnership with other project teams.

Most decision-making is centralized to the Executive Team, which uses an informal voting structure to make decisions impacting the cooperative's activities and next steps. As necessary, this group will request input from the network team leads and other relevant stakeholders to inform debate and drive consensus.

### *Tennessee*

Led by the [University of Tennessee Health Science Center](#) (UTHSC) and [Qsource](#), a nonprofit healthcare QI and information technology consulting firm serving 11 states, the **Tennessee Heart Health Network (THHN)** builds on preexisting population health, QI, and data management/use initiatives across the state to disseminate and implement PCOR heart health evidence into primary care practice statewide. Tennessee's approach to the THHN is based on the Agile Implementation Playbook.<sup>17</sup> The goal of Agile Implementation is to understand, predict, and steer the behavior of individuals and groups, combining complexity science, network science, and behavioral economics. The THHN contracted with Malaz Boustani, MD from Indiana University to provide support in implementing the Agile Implementation Playbook across the project. In interviews with the Tennessee team, no team members beyond Dr. Boustani discussed how the THHN Cooperative will implement the Agile Implementation Playbook, but we will explore this future data collection efforts.

### **Structure**

[Qsource](#) leads the Tennessee Cooperative's QI support. The THHN partners with [East Tennessee State University](#) and the [University of Memphis](#) to engage and recruit practices, and in research and evaluation. See Exhibit 7.

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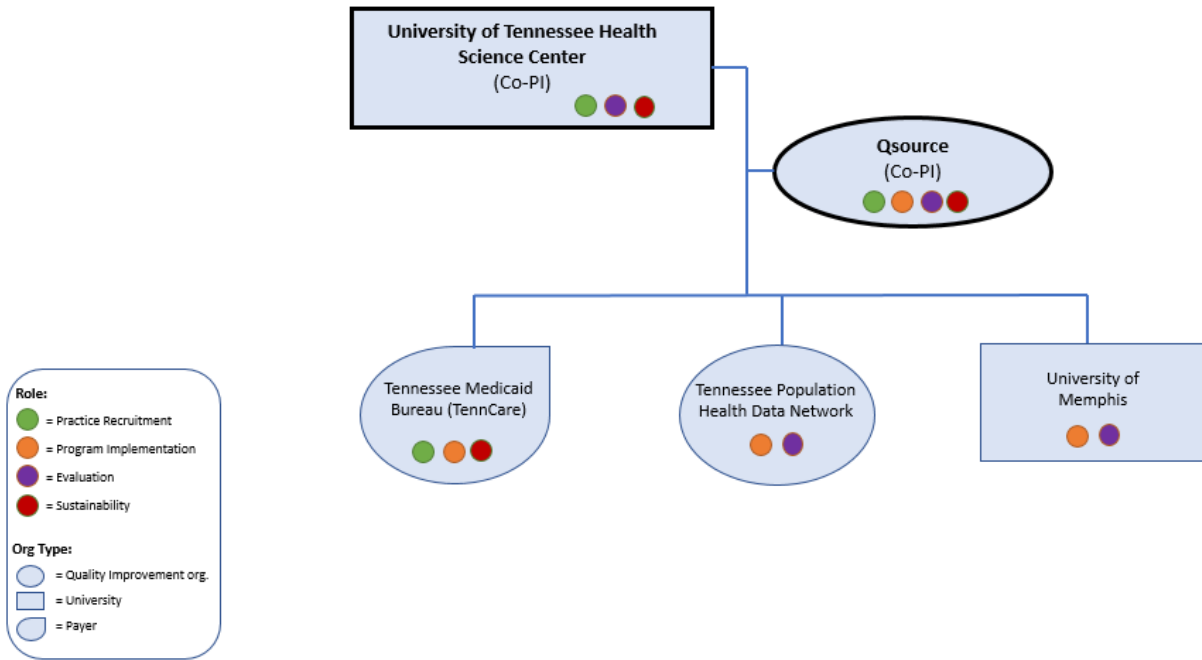
<sup>17</sup> Boustani, M. A., Van der Marck, M. A., Adams, N., Azar, J. M., Holden, R. J., Vollmar, H. C., ... & Gatmaitan, A. (2019). Developing the agile implementation playbook for integrating evidence-based health care services into clinical practice. *Academic Medicine*, 94(4), 556.

Exhibit 7. Tennessee Heart Health Network (THHN)

Tennessee Heart Health Network (THHN)	
<b>Leadership</b>	Qsource University of Tennessee Health Science Center
<b>QI support providers</b>	Qsource
<b>Cooperative focus</b>	Implementation of heart health interventions with a focus on hypertension control and smoking cessation in small primary care practices to reduce/eliminate disparities in cardiovascular disease outcomes for priority populations.
<b>Relationships</b>	Partners leverage preexisting work through PCORI projects. UTHSC had partnered with Qsource and East Tennessee State University (ETSU) for that PCORI effort. Previous work developing the Tennessee Population Health Data Network (TN-POPnet) has led to connections with health systems and already had over a million patients in the data network.
<b>Work teams</b>	<ul style="list-style-type: none"> <li>• Executive council</li> <li>• Operational team</li> <li>• Resource and education team</li> <li>• Practice facilitation team</li> <li>• Tracking, reporting and evaluation team</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>• Executive Council meets three to four times annually and provides strategic guidance.</li> <li>• The operational team (project PI/executive director, operations director, and three core team leads) oversees daily activities and makes most programmatic decisions.</li> </ul>
<b>How does work get done?</b>	<ul style="list-style-type: none"> <li>• The resource and education team develops educational materials and resources for the three interventions: health coaching, physician-pharmacist collaboration, and motivational text messaging.</li> <li>• The practice facilitation team supports the three practice facilitators in implementing the intervention.</li> <li>• The tracking, reporting and evaluation team leads the study design implementation and data collection activities (qualitative and quantitative data) and supports engagement with the TN-POPnet to link practice data.</li> </ul>
<b>Other Partners</b>	<ul style="list-style-type: none"> <li>• American Heart Association</li> <li>• East Tennessee State University</li> <li>• Indiana University</li> <li>• Tennessee Department of Health</li> </ul>

Tennessee Heart Health Network (THHN)	
	<ul style="list-style-type: none"> <li>• Tennessee Medicaid and Managed Care Plans</li> <li>• Tennessee Medicaid Bureau (TennCare)</li> <li>• Tennessee Population Health Consortium Community Advisory Council</li> <li>• Tennessee Population Health Data Network</li> <li>• Tennessee Primary Care Association</li> <li>• University of Memphis</li> </ul>

**TENNESSEE HEART HEALTH NETWORK**



At the state level, the UTHSC and QI partner Qsource have been actively involved in state initiatives to advance value-based purchasing and implementation of the primary care medical home. Qsource also has a contract with CMS to facilitate participation in Million Hearts and the Physician Quality Reporting System. At the practice level, the THHN partners at the UTHSC Tennessee Population Health Consortium have overseen the development of the Tennessee Population Health Data Network (TN-POPnet), engaging health systems for participation in a shared data registry and practice-based research network to monitor and improve chronic disease outcomes. TN-POPnet has integrated data from more than one million patients statewide. The network leverages close partnerships with many participating healthcare delivery systems in Tennessee through the UTHSC Center for Health Systems Improvement and TN-POPnet. As a result of UTHSC’s collaboration with the Tennessee Medicaid Bureau (TennCare), the network has engaged patient-centered medical home practices affiliated with the state’s managed care organizations.

The THHN is part of the broader Tennessee Population Health Consortium, which provides additional funding and infrastructure support for THHN initiatives through philanthropic funding. Project PI Dr. Bailey opted to merge the THHN Cooperative into the Tennessee Population Health Consortium to improve sustainability and connect to existing resources and built capacity. The Tennessee Population Health Consortium was built from prior PCORI-funded diabetes prevention and wellness efforts but has been expanded to include other population health projects such as this project to build state capacity. The

THHN's executive director (Dr. Bailey, also project PI) reports to the Tennessee Population Health Consortium Executive Council. As an entity, the Consortium includes a community advisory council, a learning collaborative, and a data governance board that provides broad oversight and support to the THHN.

Like the ACC, the THHN also works with [Qsource](#), a non-profit healthcare QI and information technology consulting firm serving 11 states. Qsource brings over four decades of experience addressing health quality of care and healthcare providers' utilization challenges and is a respected practice facilitation provider. The THHN has partnered with multiple statewide agencies to deliver QI support to primary care practices, including two non-profit healthcare QI organizations, state and commercial health insurance providers, the state Department of Health, healthcare delivery systems and their QI vendors, medical associations, primary care advocacy groups, the American Heart Association Million Hearts and Target Blood Pressure initiatives, and payment innovations programs.

Two key partners that the THHN has been unable to engage in the cooperative are Vanderbilt University and Meharry Medical College, which both have independent medical schools but have built strategic partnerships together. Both academic medical centers in Tennessee have been invited to participate but declined. The THHN's PI, Dr. Bailey, indicated that they had partnered with Meharry Medical College on a previous project related to COVID-19. However, Vanderbilt/Meharry Medical College have been unwilling to engage in the THHN, which THHN attributes to politics or other history between UTHSC and Vanderbilt.

#### **Governance and Operations**

The project PI plays a central role in THHN, leading the three core function teams focused on Dissemination, Facilitation, and Evaluation and serving on the operational team that oversees daily work. However, the operational team is the ultimate decision-maker.

The **Executive Council** meets three to four times per year. It includes representatives from all key network partner organizations and serves a broad advisory role. The THHN Executive Director (Bailey) reports to the Executive Council, and it can assert authority. Because the Executive Committee includes partners across the key health system partners who share their data through the TN-POPnet, the Executive Committee is built to have control over how their data are used.

The **Operational Team** manages the day-to-day decisions for the THHN. The Operational Team includes Executive Director and project PI, Dr. Bailey, project manager (Umar Kabir, DVM, MPH, PhD), and the three core team leads from the core teams of Resource and Education, Practice Facilitation, and Tracking, Reporting and Evaluation.

#### **Work Teams**

The **Resource and Education Team** is led by Susan Butterworth, PhD (UTHSC). Dr. Butterworth brings her expertise in developing motivational interviewing-based health coaching to develop resources and provide training to the practice facilitators. The Resource Education Team has developed three toolkits related to their intervention, focused on health coaching, physician-pharmacist collaboration, and motivational text messaging.

The **Practice Facilitation Team** is led by Ben Heavrin, MD (Qsource), and includes the three practice facilitators and a project manager. This team is charged with implementing practice facilitation by working with practices to examine data, move quality measures forward, and develop inter-practice support through learning collaboratives.

The **Tracking, Reporting and Evaluation Team** is led by Satya Surbhi, PhD (UTHSC). Dr. Surbhi is also the Director of Measurement and Reporting for the TN-POPnet. Cori Grant, PhD, MBA (UTHSC),

supports qualitative data collection and analysis. Fawaz Mzayek, MD (Memphis), supports the evaluation team in IRB requirements.

### 3.1.2 Overview of Cooperative Model Components

We can understand the grantees' cooperative models in terms of four central characteristics, including which organization (academic organization or QI organization) led the cooperative, how the cooperative focused on regionality across their state, how the cooperative was organized, and how partners were engaged to achieve specific goals (e.g., sustainability) or reach potential populations (e.g., professional organizations reaching out to clinical providers).

#### *Lead Organizations*

The AHRQ EN: BSC grantees have one of two types of lead organizations for their cooperatives: academic institutions leading with support from quality improvement organizations (AL, OH, TN), or quality improvement organizations leading with support from academic institutions (MI).

The leadership role of academic institutions is likely for several reasons: academic institutions have the infrastructure and track record in applying for federal research grants, and they also have expertise related to heart health topics and improving clinical care. In the case of the organizations in the EN: BSC project, the academic institutions have prior experience working with partners on similar efforts. For example, the Ohio cooperative previously worked on the CardiOH intervention. Alabama had experience managing and operating the Center for Clinical and Translational Science to support quality improvement workforce development statewide. Tennessee had other population health management projects that this grant builds upon. In this model, academic institutions partner with quality improvement organizations to provide added practical experience and trained personnel to support the implementation of interventions into practice.

Michigan has a slightly different model. In Michigan's case, the prime is a QI organization, but they opted to partner with an academic partner with previous EvidenceNOW experience that is outside of the state (Northwestern University in Illinois). Because of the focus on building state capacity and that Northwestern University was located outside of the state, they have decided while writing the grant that Altarum, with expertise in QI and located in Michigan, was a stronger prime than Northwestern to lead the cooperative.

#### *Regionality Across States*

The four statewide cooperatives participating in EN: BSC are in four large states. Cooperative leaders have incorporated three types of partners for bridging the geographic expanses: QI organizations, healthcare or professional organizations, and/or academic organizations.

- **Quality Improvement Partners:** Two grantees have partnered with organizations to provide QI support and recruit in their respective regions of each state (OH, MI). For example, Michigan engaged three organizations to provide QI support; one is located in the upper peninsula, one in southwest Michigan, and one covers the central and eastern part of the state. Ohio identified different regional healthcare improvement collaboratives in three cities to expand the work of the cooperative across the state.
- **Academic Partners:** All four grantees have engaged academic partners to expand the regional reach of the cooperative. Ohio, Tennessee, and Alabama have engaged multiple academic partners across the state. In the case of Ohio and Tennessee, these partnerships are built on existing work (CardiOH and TN-POPnet, among others). In Alabama, the University of Alabama at Birmingham developed a new partnership with Auburn University School of Pharmacy to expand their cooperative. In Michigan, Altarum reached out to Western Michigan University that they had partnered with on a prior initiative to assist in their cooperative's reach in southwestern Michigan.

- **Healthcare or Professional Organization Partners:** Three states engaged healthcare or professional organizations to support practice recruitment (OH, TN, AL). Healthcare organizations included groups like the Ohio Association of Community Health Centers, several health systems in Tennessee, and an Alabama network of federally qualified health centers (FQHCs). Professional organizations included the Ohio Academy of Family Physicians, the Tennessee Primary Care Association, and the Alabama Primary Care-Based Research Network. By connecting with these healthcare and professional organizations, the cooperatives were able to recruit practices across the state.

### *Cooperative Structure*

Within the four cooperatives in the EN: BSC project, we have identified three key components of the cooperative structure: governance, the distribution of work, and the engagement of patients.

- **Governance:** There are two models for governance and oversight. In Michigan and Ohio, they engage an advisory board that provides input but has no power to make decisions directly. Instead, both Michigan and Ohio make decisions at the project PI level, with feedback from other key leaders within the cooperative. Ohio developed this model in line with its co-design process, ensuring that participant (health system, provider, and patient) voices were integrated throughout the project in an advisory capacity. In Alabama and Tennessee, a committee is the ultimate decision-maker; in both cases, the project PI has a central role in the committee to lead discussions and make decisions through a consensus-building process. Tennessee developed a model that includes a committee check on the PI's power. Alabama hopes to institute a model where the steering committee chair rotates across committee members (and is not just the PI), but it still remains to be seen whether they will in fact rotate chairs.
- **Distribution of Work:** All four grantees have opted to use a “hub and spokes” model with a core leadership team (in AL and TN, the steering committee mentioned above) to manage the project centrally (the “hub”), with smaller groups dedicated to implementing project components (“spokes,” e.g., intervention, health information technology, evaluation). Tennessee has the fewest number of teams (five); Ohio has the most (eight). Functionally, each cooperative includes teams focused on oversight and governance, outreach and engagement, implementation, and evaluation. Ohio and Michigan also have teams explicitly focused on dissemination. In future data collection we will further explore how these groups work together, and barriers and facilitators to each model.
- **Engagement of Patients:** Two grantees (OH, TN) have intentionally engaged patients in the cooperative or intervention planning process. Ohio has included patients in their co-design process, engaging patients in understanding the intervention implementation within the four pilot sites. Tennessee engaged an existing community advisory council that is part of their steering committee.

### *Partner Engagement*

Each cooperative engaged partners with dedicated ends in mind, identifying partners who can help them achieve their aims across eight domains: practice recruitment, heart health expertise, clinical interventions, QI, practice data, evaluation, patient engagement, and sustainability. Previous relationships affected the choice of cooperative partners, as did the focus of the cooperative; for example, the focus in Michigan was on rural areas. Alabama attempted to work with the major QI organization in the state, but that organization closed at the start of the project period. We identified a few key types of partners, including:

- **Partners to support recruitment:** Grantees worked with diverse partners to identify practices and recruit them to the network. Partners used for recruitment include organizations with expertise in QI, healthcare organizations (including health systems), professional associations, and academic organizations. Grantees used these partners to disseminate information about the project and identify potential practices to provide more information.

- **Partners with clinical expertise to support heart health work:** Grantees engaged partners who could provide knowledge and resources relevant to the heart health focus of the cooperative. Each grantee identified local academic leaders with expertise in heart health-related topics. Ohio and Alabama specifically partnered with the American Heart Association. Alabama partnered with the Heart Health Improvement Project to provide added expertise about local heart health efforts. Ohio also partnered with the Ohio Academy of Family Physicians (OAFP), who agreed to regularly outreach to their members.
- **Partners to support clinical interventions:** Grantees engaged partners who have expertise and experience with clinical interventions. These partners included the partners from the CMS Transforming Clinical Practice Initiative (MI), the network of regional healthcare improvement collaboratives (Ohio), and a practice-based resource network (AL). Michigan also engaged the Community Health Worker association to include CHWs in the clinical care process. Similarly, Ohio engaged professional associations of family physicians, nurses, nurse practitioners, physicians' assistants, pharmacists, and dieticians to support clinical practice improvement interventions.
- **Partners to provide quality improvement:** Grantees engaged key partners that provided QI support. These partners were often co-investigators in the grant and central members of the team. In the case of Michigan and Ohio, the partners with expertise in QI were also regionally located to support practice improvement with practices in their region of the state. When Alabama's QI organization closed, they partnered with Qsource, which was already working to support Tennessee's cooperative.
- **Partners to collect practice data:** Grantees worked with key partners to support collecting practice data and providing dashboards to practices. Tennessee had the Tennessee Population Health Data Network to collect and report data to practices. Similarly, Alabama worked with a data vendor, COSEQH, to collect data and provide dashboards for practices.
- **Partners to evaluate:** Grantees partnered with academic institutions to support the QI project evaluation. These academic institution partners were able to provide expertise in both qualitative and quantitative methods to assess the implementation and impact of the QI projects.
- **Partners to support reach and sustainability:** Grantees partnered with groups to support broad reach sustainability, including state public health associations; funders (Medicaid, private health plans); and existing population health, heart health, and research networks.
- **Partners to provide patient experience/engage patients:** One grantee, Tennessee, included a community advisory council in the steering committee to provide patient input. Ohio engaged patients in its co-design practices, receiving feedback on its pilot implementation.

During future data collection we will explore whether types of partners were more helpful recruiting practices into the network. Given when we collected these data, the grantees were still building their network of practices, providing an incomplete picture of the relative strength of types of partners engaged.

### 3.1.3 Facilitators and Barriers to Building Cooperatives

This section describes the facilitators and barriers that all of the grantees experienced as they built their cooperatives. Facilitators that the grantees had in common included existing relationships, prior experience with quality improvement projects, and partners' enthusiasm to participate in a new QI project. The common barriers that participants discussed focused primarily on challenges with the initial startup of the project and the impact of the COVID-19 pandemic. We also heard about two grantee-specific challenges to building the cooperative that participants shared during interviews. Below we provide further detail about these facilitators and barriers to building the cooperative.

### ***Facilitators To Building Cooperatives***

In year one, participants from all four grantees pointed to three main facilitators to forming their cooperatives. These facilitators included engaging partners from established relationships, using experience from previous QI projects to inform cooperative structure and activities, and the willingness of partners to collaborate and engage.

#### **Existing Relationships**

Across the four grantees, the most common facilitator to building their cooperatives was existing relationships. In many cases, grantees leveraged their existing relationships to reach out to strategic partners who would be interested in joining their state cooperatives. Reaching out to known partners allowed them to expedite the formation of their cooperative and ensure that they had trusted partners to carry out the various components of the grant. As one participant explained:

I think one of the huge facilitators was actually having a collaborative [CardiOH] to start with and having a lot of relationships across the state. So when we reached out to folks, we had a lot of those relationships. Even though they weren't working with us in the collaborative before, they knew us, and trusted us. So it was easier to partner than if we didn't have those relationships.

While participants described how existing relationships were a facilitator, it could also be that the existing relationships caused cooperatives to rely on existing or known partners and not engage new partners. We will explore this possibility in future data collection, especially when we interview people from organizations not part of the cooperative.

#### **Prior Experience with Quality Improvement Projects**

In addition to already having existing relationships with key partners in their states, many grantees noted that the existing partner relationships had been developed while working on previous projects. In many cases, participants explained how they had used this previous QI experience to inform their approach to the EN: BSC project. One participant noted that their prior experience helped them to be more efficient in this grant because they could “tweak” certain aspects of the QI work that they had done previously:

We went with practice facilitation and the key drivers model because it is what we had just finished implementing in a previous project and it had worked well, and that was for blood pressure control. ... For this we said, “What would we need to tweak?”... Specifically, pulling more information on race and ethnicity differences and trying to work that into the monthly practice facilitation meetings and then augmenting what we had with the smoking cessation efforts.

#### **Partners' Enthusiasm About Collaborating and Engaging in the Cooperative**

Participants from all grantees described the willingness of their partners to collaborate as key to developing their cooperatives. As one participant explained:

I think we have a super engaged collaborative around this effort, which has been fantastic. Just really very engaged at the state level and at the national level. We had the [Chief Medical Officer for Prevention] at the American Heart Association come, Eduardo Sanchez, to our meeting and he (said) ... “Oh, we have to share this [QI toolkit] with everyone!”... which is great and there was a lot of enthusiasm. So I think that we've been blessed that we have a group, that really cares about the topic and has been highly engaged in the work overall.

Several participants attributed the high levels of engagement and collaboration of partners to the aims of the grant, including improving heart health and addressing populations that they are passionate about and that they have the resources to support:



Many of the organizations feel very strongly and have resources around that as well. And any resources that we've asked for they've been very good about sharing. So it's definitely a back and forth type of relationship with all of our professional organizations.

### ***Barriers to Building Cooperatives***

Participants from the four grantees noted several key barriers to creating their state cooperatives and carrying out work during the first year. These included challenges with project startup, which were exacerbated by the COVID-19 pandemic, and challenges in understanding the complex study design and completing the IRB approval process. These barriers impacted each other and created further challenges for grantees as they established their cooperatives.

### **Project Startup Challenges**

Across all four grantees, participants described challenges in launching the cooperatives, including getting the multiple partners on board, understanding diverse roles and responsibilities, aligning schedules to meet with various partners, finalizing organizational agreements, and managing workloads and competing projects. COVID-19 exacerbated some of these challenges, forcing grantees to pivot to virtual meetings at the beginning of the project, impacting relationship building. COVID-19 also impacted hiring across the grantees, causing staffing challenges.

As with any large project with multiple partners, participants reported challenges related to **reaching a shared understanding of the structure and organization of the cooperative** and individuals' roles and responsibilities in the first year of this project. In some cases, individuals or organizations proposed in the grant application were no longer available or able to assist. As one participant reported:

It's muddy getting through the setup. It's muddy figuring out who's on which team. What does the stakeholder team do versus the dissemination team? We had a shift in co-leads, so I've been here from the beginning, but we shifted the other dissemination co-lead halfway through the year. ... So I think it's working really well now. But it was kind of messy to get there.

Members of the grantee teams who were building the cooperative also reported challenges understanding the **roles and responsibilities of cooperative members**, which could have been eased by more communication, as this participant described:

I think with a lot of studies like this, the initial startup was a little bit more confusing, just in how meeting frequency, and what's communicated and what our roles are, could have been hammered out a little bit more quickly than it was.

Logistically, participants reported significant challenges **aligning schedules across partners** due to the large number of members involved. Participants also reported challenges getting **organizational agreements and memoranda of understanding** signed across partners, which caused delays. As one participant explained:

We have a whopping amount of money left here at the end of year . . . Looking at all this money we didn't spend and it's because we couldn't spend it, we weren't allowed to. We couldn't get it out to our subs. . . . There are different barriers. Like with one partner they're a subcontract so that had to go through lawyers, and we had to have a [Data Use Agreement] and that took a lot of time.

Another common challenge at the beginning of the project was **managing workloads and competing projects**. Project teams were engaged in other projects and initiatives before funding this grant and worked to manage those projects while starting up the cooperatives. When asked if they had encountered any barriers to their participation in the cooperative, one participant explained, "nothing other than my own schedule. I mean lots of demands there, so there's a lot going on."

COVID-19 exacerbated some of the challenges with project startup. COVID-19 caused significant challenges to recruiting practices into the network, but it still led to challenges in building the cooperative. Because of the public health emergency, project teams had to **quickly adapt to virtual meetings** during the early, formative time of the project. As one participant explained,

The fact that you have COVID, some of these meetings would have been easier or different face-to-face. You tend to sell ideas when you communicate emotions, most of the meetings were Zoom meetings. I have still not met a majority of people on the committee. All the relationships have been built online. Those are factors that don't make it easy. But it didn't make it so impossible to set it up because there were always ways around it.

**Participants mentioned that hiring within their organizations had paused due to the pandemic.**

Ongoing staffing delays, and competing priorities, placed more burden on the organizations.

I will say this ... it has not been for me as smooth as I would love it to be. As I've not been able to really sit down and interview as I should ... and part of that has to do with a COVID induced hiring freeze at our university and the projects that I have going on.

An inability to hire staff also directly impacted one of the state cooperatives by preventing them from hiring partners to help with the state cooperative work:

COVID was not helpful. Hiring is not easy right now. Getting the talent that you need. Sometimes there are institutional barriers, some organizations hire faster than others. Our organization is not one of those, so getting people on board to do the [QI project] work was really hard.

Two grantees reported **grantee-specific challenges**:

- In Alabama, the Alabama Quality Assurance Foundation dissolved shortly after funding. The loss of this partner was a significant disruption to Alabama's cooperative activities because they had planned to have practice facilitators from AQAF participate in the QI implementation work, and to leverage AQAF's existing relationships with practices to support recruitment to the network and the QI project work.
- Participants from Michigan described partnering with a clinical expert in the application, but they were having challenges engaging the expert after the award. When interviewed, the clinical expert explained that their lack of involvement in the project was due to the strain and demands created by COVID-19 and the impact on healthcare providers.

**Research Project Complexities**

Participants from three of the four grantees described challenges in implementing a project with a rigorous study design. While the academic institutions brought expertise in study design and conducting research, many of the QI partners were less familiar with research projects. All four grantees opted initially to implement a stepped-wedge design, which requires recruitment and randomization of all practices before beginning the intervention. As one participant explained:

It's also a bit of a, I don't want to say uphill battle, but it's a challenge trying to make sure everyone's on the same playing field, as far as the semantics of study design and research and understanding of what stepped wedge really is ... and having everyone appreciate the fact that if we want to randomize we need all this information up front. So, for those that haven't dabbled into the different types of study design, it's a learning experience for them.

Another participant explained how their inexperience with research grants required additional work to ensure they could communicate it clearly to the practices that they were recruiting for the QI project:

My personal weakness, I think on our side, is we've never done a research grant before from the PCA (Primary Care Association) side. We've done grants. Obviously, we live in the grant world, but not a research grant. So, for me, that's just a learning curve on our side. And what does that really look like and ensuring that I communicate that well with our members so that no one is distressed at the word "research" that this is a research project in the way you care for your patient. So, for me, that's the only thing that I really recognized for myself.

Conducting a research project also requires IRB approval. Participants described how the IRB process caused delays. This added extra time and complication for those unfamiliar with research studies and the IRB process. One participant explained: "We're just learning some things about just some red tape that academia has to deal with that we may not have to deal with."

In particular, recruitment could not begin until the IRB application was approved, which caused delays in cooperatives' starting recruitment. One participant noted that they could not pay one of their cooperative partners who had been contracted to do recruitment work because their IRB had not given them final approval:

[The recruitment partner lead] has been attending calls since we've been approved from AHRQ. Apparently, we still can't pay them [recruitment partner] because of the single IRB. So even though everything is signed, and everything is approved we don't have the final approval to send them money despite the fact that they've invoiced us because we still have an outstanding IRB thing. So that's been a little bit of a hindrance in terms of cooperative; they can't fully engage. ... [the recruitment partners] are attending all of the meetings so they can't really recruit practices yet, because we can't pay them.

Participants attributed the delay in the IRB approval process to staffing shortages in the IRB departments, changes in the proposed work and partners that had to be re-submitted to IRB for additional review, and lack of experience with the IRB process. Across grantees, this delay with the IRB approval process hindered their ability to recruit practices to participate in the implementation work and led to delays in their project work timeline.

### 3.2. Strategies for Recruiting Practices

Central to implementing the heart health QI projects is recruiting practices to participate and retaining them. Grantees from the original EvidenceNOW initiative identified challenges in recruiting and retaining practices in their QI initiatives. For example, Sweeney et al. (2018)<sup>18</sup> identified the importance of aligning the initiative's goals with federal and state initiatives and payment requirements to encourage participation. Fagnan et al. (2018)<sup>19</sup> noted the high cost of recruitment and found that their recruitment efforts were more effective with a warm handoff from a trusted collaborator. Cuthel et al. (2019)<sup>20</sup> identified facilitators for recruitment and retention, including established relationships with health departments, alignment of the initiative with existing practice goals and priorities, and monetary

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<sup>18</sup> Sweeney, S. M., Hall, J. D., Ono, S. S., Gordon, L., Cameron, D., Hemler, J., ... & Cohen, D. J. (2018). Recruiting practices for change initiatives is hard: findings from EvidenceNOW. *American Journal of Medical Quality*, 33(3), 246-252.

<sup>19</sup> Fagnan, L. J., Walunas, T. L., Parchman, M. L., Dickinson, C. L., Murphy, K. M., Howell, R., ... & Kho, A. N. (2018). Engaging primary care practices in studies of improvement: did you budget enough for practice recruitment?. *The Annals of Family Medicine*, 16(Suppl 1), S72-S79.

<sup>20</sup> Cuthel, A., Rogers, E., Daniel, F., Carroll, E., Pham-Singer, H., & Shelley, D. (2019). Barriers and Facilitators in the Recruitment and Retention of More Than 250 Small Independent Primary Care Practices for EvidenceNOW. *American Journal of Medical Quality*, 1062860619893422.

incentives. This section first describes the approaches and strategies for practice recruitment, including individual grantee and cross-grantees approaches. We then describe strategies for retaining practices, and end with reasons for practices’ nonparticipation.

**3.2.1 Approaches and Strategies for Practice Recruitment**

Participants reported various approaches and strategies for identifying and recruiting practices.

***Recruitment for the QI Project versus the Network***

During the first wave of data collection, participants from all four grantees described their recruitment strategies primarily related to recruiting practices to their QI interventions directly, rather than first recruiting practices to become a part of the network and then recruiting from that pool of practices into the QI project. In interviews, participants did not all acknowledge the difference between the heart health QI project and network practice recruitment.

Participants pointed to time constraints for recruitment and time frames for recruitment related to their stepped-wedge design requirements as the primary reason why they decided to focus their recruitment strategy on enrolling practices into the QI project rather than trying to build the heart health network first. As one participant from Alabama explained, “We have more [intensely] concretely been engaging practices because we don’t have that flexibility from a timing standpoint with the QI project because of the study design.”

While the focus of recruitment was on the QI project, participants across grantees explained that once they finished recruiting for the QI project, they did plan to disseminate information about their heart health projects and provide resources to various health systems, practices, and primary care organizations to raise awareness about the network and recruit additional practices to the network. Tennessee and Ohio both built public-facing websites with available resources for network practices. Ohio also developed a set of podcasts about heart health and QI topics for broad dissemination. The plans for more-general network engagement in Michigan and Alabama were less clear from the interviews.

Exhibit 8 shows recruitment goals and practices recruited to date to the QI project. Tennessee is the only grantee that has met its recruitment goals.

**Exhibit 8. Practice Recruitment Goals and Practices Recruited into QI Project**

	Alabama	Michigan	Ohio	Tennessee
Practice goal	60	50	60	75
Practices recruited	32**	30*	47**	78**

\*Michigan’s practices-recruited count from 4/21/22 project management meeting; \*\*AL,OH and TN’s practices-recruited count from email exchanges with Jean O’Connor and Dan Miller in early May 2022. Recruitment will be further examined in forthcoming data collection.

***Grantees’ Aims with Network Development and Practice Recruitment (Cross-Grantee)***

Grantees reported two fundamental aims for practice recruitment. These were reaching out to: practices across the state, to build statewide capacity; and practices that serve underserved populations, to address health disparities in their state.

**Ensure Statewide, Geographic Representation**

Participants from most of the grantees mentioned that they were targeting specific geographic regions to ensure that they enlisted practices caring for underserved populations across the state. As one participant explained, “From a strategic perspective, the majority of the practices that we’re enrolling right now are coming from the FQHCs, which have very good coverage across the state in terms of areas that are traditionally high health disparity areas.”

Three grantees specifically worked with geographically diverse organizations to draw from their networks of practices. HHOI worked with RHICs in the Northeast, Central, and Southwest parts of Ohio that could

help them recruit practices in those regions. Similarly, HH4M focused on rural areas of the state, with partners located in the Upper Peninsula, central, and southwest regions. Finally, the THHN worked with recruitment partners to focus on the existing “grand regions” of West, Central, and East Tennessee.

#### **Prioritize Efforts To Address Health Disparities**

Participants from across the grantees reported that their cooperatives had strategically included partners who could help ensure health disparities were considered and addressed throughout the EN: BSC project and the QI project. Participants from three out of the four states (AL, OH, and TN) specifically mentioned that they had partnered with organizations well connected to a network of FQHCs, which provide primary healthcare to underserved populations. Additionally, the participants across grantees described targeting practices that serve rural and underserved populations. Michigan recruited practices that serve Native American communities. Tennessee indicated that they were recruiting practices from the western region that primarily served African American communities. While the grantees focused on engaging rural and underserved populations, they may be limited in their ability to document a reduction in disparities.

#### ***Individual Grantee Recruitment Strategies***

##### **Alabama**

To enlist practices and build QI capacity statewide, the ACC formed the CRRN by drawing on three existing networks: the Alabama Practice Based-Research Network facilitated by UAB, the Deep South Continuing Education Network, also facilitated by UAB, and the Rural Research Alliance of Community Pharmacies, initially funded by AU project. Project PI Dr. Cherrington, Dr. Hansen. (AU), and Dr. Anabtawi (UAB) used their connections to these networks to reach providers serving high-risk and underserved communities for participation in the heart health QI project.

To facilitate connection and collaboration among the ACC’s CRRN, the ACC initially planned to launch the project period with a retreat focused on building trust among members, identifying shared project goals and objectives, and collaboratively designing operating procedures. This event was postponed due to COVID-19 considerations, but the cooperative did host a virtual series of meetings with the same focus to elicit member feedback. As a result of these meetings, the ACC developed its procedures and governing documents.

The ACC has also identified three strategies for supporting expanded membership of the CRRN moving forward. Strategies include:

- Serve as a statewide convener of interested stakeholders working to reduce cardiovascular disparities.
- Create interactive education modules informed by the [Chronic Care Model](#) principles on evidence-based guidelines to be shared with primary care network participants in a virtual community-of-practice setting.
- Create a website of current initiatives tackling cardiovascular health and community resources statewide.

The ACC aims to provide a forum for continuous collaboration, networking, and aligned efforts to reduce cardiovascular disparities and improve heart health outcomes in Alabama.

In the ACC, three organizations are responsible for conducting the initial outreach to practices for recruitment to the QI project: the APHCA, Qsource, and the University of Alabama.

- APHCA has been tasked with recruiting half of the 50 QI project practices, focusing on recruiting from the FQHCs. The rationale behind this is that the FQHCs prioritize healthcare for people who are low-income, under-resourced, uninsured/underinsured, and often communities of color. In addition to serving these populations, FQHCs also have good geographic distribution across the state in areas

with populations that have historically had worse health outcomes when compared to national averages.

- For the other half of the practices that need to be recruited, Qsource will split recruitment with the University of Alabama. Qsource recruited practices in the state with whom they had preexisting relationships. The University of Alabama recruited the remaining practices by leveraging their established connections with networks of providers and clinics across the state in Area Health Education Centers (AHECs).

The common theme across all three of these recruiting organizations is the pre-established and trusted relationships with practices and primary care organizations across Alabama.

Alabama participants described three strategies to engage and incentivize practices to participate in the QI project:

- **Engaging practices with whom they have prior relationships** and doing a **brief presentation** about the QI project and sharing their **value propositions** to gain buy-in. One participant noted, “Our strategy is to come in and to present to practices [about the heart health project] where we have prior relationships.”
- Disseminating a **recruitment flyer that included a provider letter** with messaging about the QI project. One participant explained “our strategy is to disseminate those [recruitment flyer and provider letter] using existing relationships that we already have. So, sending an email with those as an attachment to a provider, or an office manager that we have a relationship with.”
- Offering a **\$2,000 incentive** to participating clinics.

In future rounds of data collection, we will explore how effective these strategies ultimately were to recruiting practices.

#### ***QI Project versus Broader Network Recruitment***

In this first round of data collection, participants did not provide much detail about how they recruited into the network. As previously mentioned, Alabama’s recruitment focus was on getting practices recruited into their QI project first and then recruiting practices to the network after meeting their recruitment targets. Another reason that Alabama delayed recruiting into their network was that the website of resources that they planned to offer practices in the network had been slow to launch, and they wanted to have that established before building the network.

Once the website is launched, practices recruited into the larger network will have access to several resources that Alabama is developing including:

- Continuing medical education (CME) that they will make available through their online virtual community-of-practice website
- Virtual opportunities for practices to participate in a shared learning opportunity through peer-to-peer engagement around cardiovascular disease management with their patients

In the next round of data collection, we plan to follow up with participants about Alabama’s timeline for network recruitment and about the causes of the delay in launching their website. We will also seek to better understand how they plan to track the usage and usefulness of their website resources.

#### **Michigan**

To develop the network, the HH4M Cooperative prioritizes the recruitment of practices and providers from the preexisting Great Lakes Practice Transformation Network and a referral list of trusted Altarum

Institute, MCRH, and UPHCS practices. The HH4M Cooperative employs a **warm handoff approach** to enlist practices and providers from prior initiatives and facilitate connection to appropriate recruitment team members. In addition to these efforts, the HH4M Cooperative intends to begin using outreach strategies including **newsletter, fax, and email recruitment and clinic referral** to engage new practices and providers. To date, focus on the broader network has taken a back seat to practice enrollment in the QI project due to time constraints for recruitment and launch of the QI project.

To maintain and grow the HH4M Cooperative's primary care network during and beyond the scope of the award, HH4M partners have identified the following strategies:

- Prioritize **relationship building** between practices and Altarum Institute, MCRH, and UPHCS staff.
- **Disseminate** current information, HH4M project updates, and broad use tools via website and newsletter.
- **Align HH4M support with pay for performance program** to aid practices and providers in securing financial compensation for QI efforts.
- Offer **compensation** for time spent on HH4M data collection.

Altarum Institute, MCRH, and UPHCS implemented these strategies because they have been successful in previous recruitment efforts with their existing provider networks. The HH4M Cooperative also plans to share information beyond existing networks through coordination with the [Michigan State Medical Society](#), Michigan Primary Care Consortium, [Michigan Primary Care Association](#), and other related state organizations to raise awareness of cooperative activities and increase participation.

One key factor that participants raised often was that Michigan is a very rural state, especially in the Upper Peninsula. Many rural communities in that region experience worse health outcomes, have limited access to healthcare and suffer from high rates of cardiovascular disease and diabetes. In addition to rural communities, participants mentioned that in the more northern regions of the state, Native American communities also lacked access to healthcare, experienced significant health disparities, and encountered barriers to cardiovascular disease management. Michigan aims to address disparities by targeting practices in these communities.

Participants did acknowledge that the southeastern region of the state, which is more racially diverse and includes Detroit and other more urban areas, also has populations experiencing poor health outcomes. One participant noted that while Michigan will be recruiting some practices from this area, the primary focus is on recruiting practices that serve rural and Native American communities in the Upper Peninsula.

As with Alabama and Ohio, Michigan's value proposition to the practices focused on cardiovascular disease as an important health issue that is particularly a problem in rural and Native American communities. Michigan also focused on the fact that practitioners have to participate in quality payment programs (QPPs) and emphasized the benefit that participating in Michigan's heart health QI project offers in the form of a practice facilitator who can help them to navigate the transition from volume- to value-based care.

Three main partners in Michigan have been tasked with recruiting practices for the QI project from their existing relationships and networks:

- Altarum has been working with clinics across Michigan since 2011 in the meaningful use and QPP area.
- The MCRH has connections with critical access hospitals and rural health clinics through their GLPTN.

- UPHCS has connections to rural and Native American Practices in Michigan’s Upper Peninsula region.

Michigan participants mentioned several critical strategies they were using to engage and incentivize practices for the QI project:

- One strategy Michigan and its partners used was **reaching out to practices in their existing networks with recruitment emails** and fax sheets that provided information about the QI project and following up with phone calls and in-person visits to the practices. As one participant noted, “A lot of the outreach has started with either emailing or faxing our recruitment fax sheets, to give folks a heads up ... and then starting with phone calls ... so, it’s a function of email, fax, and knocking on doors too.”
- Michigan also **disseminated information** about their QI project through their partners’ newsletters. As one participant explained, “We’re also putting the information out through various newsletters and other channels that get out to providers. ... I think the plan in the next week or so is to start doing even broader communications, like paying for an ad in the Michigan State Medical Society (MSMS) newsletter.”
- Michigan offered **CME credits to practices** as an incentive to participate in their QI project.

In the next round of data collection, we will request additional information about which of these strategies were the most successful for recruiting practices.

#### ***QI Project versus Broader Network Recruitment***

Because most of Michigan’s focus was on recruiting for the QI project, we heard more about what Michigan *planned* to do once recruitment to the QI project was complete. One participant explained that the high-level plan for building up their network will be to take everything they can from that heart health intervention that is useful for non-practice-facilitation-led efforts. For example, Michigan has curated a library of tools, educational resources, and materials that have been reviewed or created by the AMA, the American Heart Association, the American College of Cardiology, the Million Hearts Campaign, and other reputable sources that practices can access on a public website. The plan is for these resources to be easily accessible to all practices in the network regardless of whether they are participating in the QI project. Michigan also plans to advertise and disseminate information about these resources and the opportunity to join through their partners’ existing relationships to recruit practices to the network.

#### **Ohio**

The HHOI Cooperative has relied on partners, including the state’s seven academic medical schools, three RHICs, the [Ohio Academy of Family Physicians](#), and the [Ohio chapter of the American College of Physicians](#), to conduct outreach efforts to recruit primary care practices into the network and heart health project.

- The HHOI leveraged the existing CardiOH network of practices and providers to recruit practices into their current QI project and disseminate information about their network. Engaging CardiOH practices did expand HHOI’s recruitment network. However, some CardiOH practices struggled to understand the differences between the interventions and were overburdened from CardiOH and unable to engage in HHOI.
- Additionally, the collaborative has tapped the [Ohio Association of Community Health Centers](#) to reach an additional 378 clinics that primarily serve low-income and minority populations for participation.
- As needed, Ohio leverages relationships with other professional organizations, [IPRO](#), the [State Medical Board](#), and Ohio health payers to support the identification of practices.



HHOI's recruitment strategy focused on the geographic locations of their QI organizations, including [The Health Collaborative](#) in Cincinnati, [Better Health Partnership](#) in Cleveland, and the [Healthcare Collaborative of Greater Columbus](#). The target population for Ohio's QI project focused on primary care practices that served vulnerable populations in the state who experience significantly worse healthcare and outcomes, including racial and ethnic minorities and rural populations.

HHOI's value proposition to practices and providers highlighted the high number of people with hypertension and smoking-related heart health issues in Ohio and that heart disease is the leading cause of death in the state. Ohio also focused on connecting value-based payment to the QI project to increase buy-in from practice leadership.

Ohio had exclusion criteria related to practices' data reporting capabilities. If a practice could not report data and analyze it by demographics or income, then this hindered them from being able to participate in the QI project because it prevented the cooperative from being able to focus on driving heart health improvement and reducing health disparities in the state.

Participants from HHOI identified several strategies to recruit practices:

- Partners **engaged their members** to share information. For example, the Ohio Academy of Family Physicians provided regular outreach to their members on behalf of HHOI. One participant explained, "We were able to deploy messages using ... weekly e-newsletter, we also have social media, and we also do blast emails occasionally out to our members."
- HHOI developed a **one-page flyer** with information about the QI project. One participant explained that the flyer had pretty clear messaging: "Here's what the expectations are, here's the why ... and here's the how ... . So, I think by the time we got down to the one-pager, it's pretty clear." The flyer was distributed broadly across partners in Ohio.
- HHOI **met with each practice** who expressed interest in the QI initiative to discuss the criteria, requirements and level of engagement.
- HHOI developed **informational videos and podcasts** to share information about the initiative and heart health to demonstrate the type of content and expertise available as part of the QI initiative.
- HHOI prioritized providing maintenance of certification credits as part of their initiative.

One participant identified an early challenge in the recruitment process. Initially, they had not used a "warm handoff." Partners had shared the contact information for someone from a particular practice. The HHOI team then emailed the practice without explicitly including the partner who had provided the contact. Initially, this caused practices not to respond to HHOI's outreach attempts, and the partners who had referred the practices were unsure whether HHOI was able to connect with the practices about the heart health project. Over time, HHOI changed its processes to include a "warm handoff" where possible, ensuring that partners could introduce practices to the HHOI team.

When asked which of these recruitment methods was the most successful, one participant reported that they had received feedback from the outreach team that the OAFP newsletter was probably one of the most effective tools for outreach because most of the time when they received a call from a practice interested in participating, the practice explained that they had heard about the QI project from the newsletter. Another interviewee noted that a variety of strategies led to practices agreeing to participate, including broad outreach through the OAFP newsletter and a warm handoff to the project team, provision of maintenance of certification for family practitioners, and offering evidence and assurances that key partners in their organization have already proven that they have had success in implementing QI projects that improve blood pressure control and smoking cessation.

One participant described challenges in recruiting practices from Ohio's southeastern, Appalachian region. Ohio's recruitment primarily focused on existing networks with extensive support from the RHICs. The Columbus and Cincinnati RHICs did not have extensive networks in Appalachia, and this could have contributed to challenges recruiting practices in that region. The participant felt that the practices in this region could have benefited from QI support but posited that it might be because of COVID-19 or other competing demands that practices in that region did not participate.

#### ***QI Project versus Broader Network Recruitment***

Ohio primarily focused on recruiting practices into the HHOI heart health QI project with an eye to creating valuable products and tools that could be useful for a broader audience. Ohio developed a public website with monthly podcasts for the wider network and included various tools and resources posted on the HHOI website. During interviews, participants from Ohio were primarily focused on recruiting for the heart health QI initiative but spoke to the broader resources available on their website for general use.

Interview findings showed an inconsistent understanding of the differences between the cooperative, the network, and the QI project, and a lack of consistency in terminology. This may speak to the shifts in language and roles between the CardiOH intervention and the HHOI project and a general lack of understanding of the requirements to create a network separate from the QI project (that includes a learning collaborative).

#### **Tennessee**

The THHN engaged its partners, including Qsource, the University of Memphis, ETSU, and TennCare, to engage partners across the state.

- The THHN focused practice recruitment on engaging prior PCORI research partners, their academic partners' health systems, TennCare PCMHs, and smaller rural practices affiliated with QI partner Qsource.
- In addition, they engaged the TN-POPnet, which, as previously explained in this report, is a practice-based research network that was formed to improve care for people with or at risk of chronic diseases. Tennessee leveraged this network to reach out to practices and recruit them into their QI project.

To ensure the network reflects Tennessee's diverse experiences statewide, the THHN has divided recruitment efforts by region (east, central, and west) and is committed to outreach, inviting a curated mix of independent practices, health systems practices, academic health centers, and FQHCs from both rural and urban settings to learn more about the network and QI project. Qsource primarily provided connections to small and rural practices, focusing on practices working with populations at the highest risk of experiencing health inequities and poor health outcomes.

The THHN conducted listening tours and an online survey of PCPs, healthcare delivery system leaders, and professional association leaders from across the state to inform recruitment efforts. From these activities, the THHN identified that potential participants seek funding for hiring and training health coaches and educators, internal QI, and HIT personnel support to help them participate in the TN-POPnet data registry. The THHN has budgeted \$5,000 to \$10,000 annually per practice to address these needs in response to this feedback.

With respect to recruitment strategies to recruit practices into the heart health project, we obtained limited specific information from interview participants. In the next round of data collection we will probe for additional information about their recruitment strategies and which strategies were the most effective.

Tennessee's value propositions overlap with those of the other Qsource partner, ACC, to focus on: practitioners' passion for reducing cardiovascular disease in the state, understanding value-based quality measures, and understanding and incorporating interventions that can improve patients' heart health

outcomes. They highlight that the QI project is meant to synergize with the practices' existing work rather than increase the burden of providing quality care. However, unlike the ACC, Tennessee did not have exclusion criteria related to data reporting capabilities that they used to determine practices' eligibility to participate in the QI project because they planned to obtain data directly from a health information exchange. Qsource was charged with recruiting practices into Tennessee's QI project even if they were not able to provide the needed data back to Tennessee due to insufficient EHR capabilities. Tennessee reported fewer challenges with reaching its recruitment goals for the QI project, but their laxer inclusion criteria may cause future challenges (e.g., missing or incomplete measures). We will follow up with participants in the next round of data collection to determine whether Tennessee's recruitment strategy resulted in any attrition from the QI project.

Tennessee was the first grantee to meet its recruitment goal into the heart health QI project. Participants described potential recruitment strategies that may have driven their success, including broad networks and engagement across Tennessee and not having requirements related to EHR or capacity requirements.

#### ***QI Project versus Broader Network Recruitment***

The THHN created three tiers of engagement for the practices that they recruited. Their recruitment strategies for each level were the same but allowed people who responded with interest in the initiative to opt into different groups:

- Tier 1 practices participate in the QI project. They will receive practice facilitation and other inventions (health coaching, physician-pharmacist collaboration, and motivational text messaging) and will receive monthly reports on their heart health measures.
- Tier 2 practices are in the network. They will participate TN-POPnet and receive monthly reports on their heart health measures.
- Tier 3 practices are broadly engaged in the network. They will have access to the website and other regular communications.

#### ***Strategies for Recruiting Practices into the QI Project (Cross-Grantee)***

This section describes the strategies cooperatives used to recruit practices into the QI project, including using existing relationships and warm handoffs, value propositions, and incentives to participate. Given that the first year of data collection was focused on cooperative members and partners and was during active practice recruitment, we have limited information about the relative success of each strategy. We will continue to understand the success of these strategies in future data collection efforts.

#### **Leverage Existing Relationships and Warm Handoffs**

Grantees and their partners' existing relationships with providers and health systems allowed them to approach practices as known entities with proven track records of successful QI initiatives and other projects. All four grantees indicated they met directly with office managers and providers either in person or virtually to discuss the QI project, sent dissemination and outreach materials directly to practices with which they had preexisting relationships, and asked partners to reach out through their mailing lists and networks.

#### **Provide Value Propositions**

Grantees outlined similar benefits of participating in the QI project. The two critical benefits discussed in the value propositions across all four grantees were as follows:

- The first benefit to potential practices was that improving heart health is a goal that is highly relevant and much desired by PCPs. When asked about what practices have reported as the benefits of participating in the intervention, one participant explained that improving heart health was a key driver, "lowering the cardiovascular episodes in Alabama. We rank super low at this point and there's a desire, need, and want to make it better and they want to do their part." This participant also noted

that they felt like practices wanted concrete tools and education that they could use to make a notable difference in improving heart health in their states.

- The second common benefit across the grantees' value propositions was providing information about value-based payment as part of their practice facilitation curriculum. One participant explained, "The tie-in with value-based payment makes it easier from a leadership perspective to want to participate."

#### **Offer Incentives to Participate**

Three out of the four grantees offered participants an incentive to participate in the QI project. Three of the grantees (AL, MI, OH) provided incentives in the form of CME credit, and Ohio also offers maintenance of certification (MOC) credits.

- One participant from Michigan described the CME offering: "So we sweetened the deal a little bit with a CME. So, yeah, so we added actually, it's in the recruitment materials at the end. ... I'm trying to remember if CMEs were extended to the staff. But we did add CMEs as something which would attract more practices."
- In Ohio, the cooperative offered providers the opportunity to gain MOC credits if they participated in the intervention: "The other thing that was really successful was that they're offering maintenance of certification (MOC) for family physicians for free. And we're also offering that for internal medicine as well."

Tennessee and Alabama both offered monetary incentives to practices in the QI project. Tennessee offered between \$5,000 and \$10,000; Alabama offered \$2,000. The high monetary incentive may have improved recruitment success for Tennessee, as they are the first grantee to complete recruitment, or other factors like their laxer requirement on data reporting described above. Participants from Michigan mentioned that they planned to provide money for data collection, but they did not say how much money they would offer. We will follow up with them in the next round of data collection for further clarification on this incentive.

#### **3.2.2 Strategies for Retaining Practices**

During this first wave of data collection, participants were primarily focused on recruiting practices, not retaining them. Accordingly, most participants only discussed their recruitment strategies and the barriers and facilitators they encountered when recruiting practices rather than strategies to retain the practices. Tennessee was the only cooperative where a participant explicitly mentioned future efforts to retain practices in the intervention; however, those plans were framed in terms of the importance of retention for the evaluation: "From the evaluation, I can say that it's very important to ensure high retention. Because it's a stepped-wedge trial; we just started wave 1, so practices that are in wave 2, 3, and 4, we have to try to engage with them, so we have high retention. The practice facilitators will help us to do that. Retention would be one of the challenges that I can think of, but we have a strong plan, and the practice facilitators are working hard to make sure that all the practices are engaged."

Other participants from Tennessee did not explain more about the retention plans; future data collection efforts will explore this more fully. Future data collection will also be able to explore the perceived successes and challenges with strategies for retaining practices.

#### **3.2.3 Reasons for Non-Participation**

Based on participant responses, the reasons practices most often gave for declining to participate in the grantees' networks and QI projects were:

1. Practices and clinicians felt overwhelmed trying to meet patients' needs during the public health crisis created by the COVID-19 pandemic. Thus, taking on a voluntary QI project was not an option for many practices, as the pandemic had already monopolized their resources and capacity.

2. The pandemic-related staff shortages left clinics with a limited number of staff, who often did not have the capacity or bandwidth to participate in the QI project.

Participants from all four grantees noted that the pandemic made it more challenging to recruit the desired number of practices to their networks than it would have been under normal circumstances. Participants explained that the practices they reached out to were overwhelmed in managing the public health crisis the pandemic had created. COVID-19-related work, such as vaccinating patients against COVID, managing extra work due to pandemic-related staff shortages, and addressing patients' needs through social distancing and telehealth measures, made it harder for practices to take on additional projects. When recruiting partners reached out to practices, they often were met with nonresponse or hesitation to participate in the QI project because the pandemic had left the clinicians and their staff overworked, overwhelmed, and "unable to take on one more thing." As one participant explained:

That [COVID] is a huge issue and that's part of why we're behind in this process. I sit on a couple of different committees with physicians and we're all saying, we're just absolutely overwhelmed. We're trying to take care of our patients and trying to facilitate all of these different things that we're doing and seeing acute care patients. We have set up clinics in our parking lot and outside clinics and we're doing telehealth and we're trying to, just even working short staffed. There's just never been the number of obstacles in practice that we are dealing with right now and that can feel so overwhelming that even when there's a program or a project like this that is so beneficial and is in alignment with what we want to do and has so many wonderful benefits, it's just hard to wrap your head around anything else at this point.

Despite the pandemic, participants from all the grantees said that they were able to recruit practices to their QI projects. However, there are grantees who are still in the process of meeting their recruitment quotas. In the next round of data collection, we will follow up with grantees to determine what specific factors hindered recruitment completion. The pandemic slowed down recruitment overall and was a serious challenge to building their networks. It will be essential to explore how the pandemic impacted their network development and QI projects during future data collection activities.

One state-specific factor that created a recruitment challenge was the presence of another QI initiative. In Ohio, a QI project ([Primary Care First](#)) funded through the Centers for Medicare and Medicaid Services was cited as another reason why practices declined to participate in the QI project. As one participant explained, "We keep hearing about Primary Care First, a Medicare initiative a competing initiative where people feel like they're being stretched too thin. I would say those [COVID-19 and the Primary Care First intervention] have been the biggest hurdles to recruitment but we're at 57 out of 60 practices right now, so we're pretty close."

It is likely that in the absence of a global pandemic, fewer practices would have declined to participate. All the same, EvidenceNOW classic and other initiatives have published extensively on the challenges of recruiting primary care practices. But, among the grantees, participants were optimistic that they would be able to overcome these challenges to recruit their proposed number of practices within their project timelines.

## 4. What We Have Learned

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In this first Interim Evaluation Report, the Abt evaluation team provides profiles of cooperatives, describes how the grantees created their cooperatives, highlights key barriers and facilitators to creating their cooperatives and networks, and identifies the strategies used to recruit practices. The following are some reflections on what we have learned, many of which we will explore further in future data collection efforts:

- We have a preliminary understanding of the grantees' **cooperative models** and their components, as well as how they built their cooperatives. The advantages and disadvantages of different models, as well as the potential impact of key contextual factors for each state will become clearer in the remaining two years and will be explored in data collection. These forthcoming findings may provide insights for other states and regions that wish to build a cooperative to improve their state's primary care capacity.
- **Academic organizations and medical centers lead** three of the four cooperatives, which bring expertise in research and evaluation, with a local IRB to review and approve the project and protocols. They also have the infrastructure required to execute a complex grant submission, unlike most smaller organizations. Unless mechanisms for funding grants changes, the model of academic-led cooperatives is likely to continue. Whether academics, whose incentives reward research grantsmanship rather than health improvement, will be able to sustain the capacity to delivery QI support remains to be seen. We will explore the advantages and disadvantages of different types of organization leads.
- Grantees were able to **establish their cooperatives** structurally within 6 to 12 months and appear to have made some progress in achieving a cohesive, coordinated group of organizations working towards the same aims with a common understanding. They were continuing to identify other partners, particularly ones to contribute to sustainability such as payers. Grantees largely formed their cooperatives by partnering with organizations with whom they had prior relationships. Grantees reliance on **existing relationships** may have limited their engagement of other potential key partners to support sustainable, statewide capacity in their state. We will explore this further in future data collection efforts, especially when we interview organizations not involved in the cooperatives.
- In the first year, participants reported **challenges** related to reaching a shared understanding among cooperative members about the structure and organization of the cooperative, as well as individuals' roles and responsibilities. There were also different perspectives to bridge between cooperative members whose primary focus was quality improvement and those whose focus was evaluation. Improved communication might have helped. However, turnover of key roles may have contributed to this challenge.
- **External factors** disrupted cooperative development and functioning. For example, in Alabama, the cooperative had to make a major adjustment when its QI partner went out of business after losing a contract with the Centers for Medicare and Medicaid Services to be the State's Quality Improvement Organization-Quality Improvement Network. COVID-related workforce shortages not only affected primary care practices but also slowed down processes for hiring cooperative staff and obtaining IRB approval. For some grantees, there are also competing grants and priorities that may impact practice interest and capacity to participate in the QI projects.
- In the first year, cooperatives primarily focused on **recruiting practices into the QI project versus the network**. While AHRQ envisioned grantees building their cooperatives and networks first and then enlisting practices for the QI project, it may be that enlisting practices and conducting the QI project first may strengthen the cooperative's cohesion and collaboration to continue to build their

state's capacity. Future data collection will explore how cooperatives are expanding their networks and supporting other future QI initiatives.

- While some **grantees may be more successful in enrolling practices** because they are more networked (i.e., part of a health system, or using practices connected to a health information exchange), these advantages for recruitment may pose downstream challenges of contamination for the evaluation. Additionally, for more networked practices it may limit the extent to which those individual practice sites are improving their capacity to improve heart health using its electronic health record data for QI. Similarly, networked practices may benefit less from the support provided or have a higher baseline capacity, which will be examined in the forthcoming evaluation activities.
- While grantees talked about their preliminary **recruitment strategies** and aims, future practice-level data collection will explore whether and to what extent grantees were able to achieve their goals for geographic distribution and specific populations.
- Despite including **partners who had relationships with networks of primary care practices**, cooperatives still had great difficulty recruiting practices. Although recruiting practices has always been a challenge, workforce shortages and the persistent COVID-19 pandemic has increased burnout and significantly reduced willingness to engage in QI or any other added effort. The inability of some electronic health records to produce clinical quality measures, observed in earlier EvidenceNOW initiatives, may be a barrier to recruitment for EN: BSC practices as well. Once grantees finish recruiting their practices, there should be clearer insight into the specific reasons practices declined to participate and other barriers to participation.
- Addressing the broader challenges that primary care providers and practices face may be a prerequisite to increasing the adoption and implementation of PCOR research evidence into practice.

#### 4.1. *Next Steps*

The grantees are now beginning to implement their heart health QI projects into practice. The Omicron COVID-19 variant caused recent challenges for recruiting and retaining practices. However, over the next year, the evaluation team will continue to collect data on the implementation of the QI project, as well as the work of the cooperatives and networks. The second Interim Evaluation Report (second report) will build on this report (Exhibit 9). It will include information related to the ongoing implementation, including components of Research Questions 2 through 7. The second report will expand on this report; given additional data collection and time implementing the projects, we will expand on the cooperative- and network-building process, and report on the QI support interventions and descriptive analyses.

## SECTION 4: WHAT WE HAVE LEARNED

**Exhibit 9. The Second Interim Evaluation Report: – Research Questions, Status of Data Collection, and Report Components**

Research Questions	Status of Data Collection at Submission	Report Component
2. What are the organizational characteristics of the cooperatives, and how do they differ? How did these differences affect outcomes? What is the level of satisfaction with the cooperatives among the partners, other state and local organizations, network members, and QI practices?	Data collection partially complete	<ul style="list-style-type: none"> <li>• Finalize our understanding of how the cooperatives were developed and their identified strategies for developing the network of practices. We will explore how they established their initial mission for the cooperative, identify state QI goals, and analytically develop models for how the cooperative members will work together to coordinate on QI goals. In addition, we will track the strategies cooperatives use to work together to develop QI capacity within the state.</li> <li>• Finalize the profiles of each cooperative, including the structure and governance, decision-making procedures, changes to the cooperatives over time, barriers and facilitators to building and sustaining statewide cooperatives, and the overlaps and gaps identified between the cooperatives and nonparticipating agencies.</li> </ul>
3. To what extent and in what ways were the cooperatives able to recruit practices into their networks?	Data collection complete	<ul style="list-style-type: none"> <li>• Expand on strategies cooperatives used to recruit practices into networks and retain them, identifying successful strategies and evidence of their success.</li> </ul>
4. To what extent and in what ways were the cooperatives successful at engaging the practices in the networks and increasing their QI capacity to implement PCOR findings?	Data collection partially complete	
5. To what extent and in what ways were the cooperatives successful at using new state-level capacity to launch other improvement projects/attract other funding?	Data collection partially complete	
6. What kinds of <i>strategies</i> did cooperatives use to deliver quality improvement support to practices participating in the Heart Health quality improvement project?	Data collection partially complete	<ul style="list-style-type: none"> <li>• Report the quality improvement support strategies used by cooperatives and develop a taxonomy of quality improvement support strategies used across grantees in EN: BSC.</li> </ul>
7. How did quality improvement support used contribute to increasing the quality improvement capacity of primary care practices to implement findings in general, and particularly the delivery of blood pressure control and smoking cessation?	Baseline data collected	<ul style="list-style-type: none"> <li>• Report on the preliminary descriptive analyses, including the association of baseline QI capacity and practice characteristics.</li> </ul>



## Appendices

### Appendix I. Codebook

Code	Definition
<b>Cooperative</b>	Factors at the Cooperative level
• Leadership	The impact or role of leaders in the Cooperative or in organizations within the Cooperative
• Staffing	Factors related to staffing within the cooperative.
• Recruitment	Factors related to recruiting into the cooperative (this is distinct from recruitment into the network)
• Cooperative Structure/ Organization	The structure of the Cooperative, including how meetings are run and how decisions are made and communicated.
• Cooperative Culture [links to CFIR culture]	Information related to the members of the Cooperatives, including previous and existing relationships within the Cooperative, and the norms and mores of the Cooperative.
• Communication	Modes, styles, and means of communicating within the Cooperative, and between the Cooperative and practices.
• Partners [links to CFIR Cosmopolitanism]	The degree to which an organization is networked with other external organizations
• Evolution and Change	Changes and evolution within the process or organization of the Cooperative.
• Sustainability	Factors related to the sustainability of the cooperative
• Function	Factors related to the functioning of the cooperative
• Membership	Factors related to the membership of the cooperative (who is involved; what do they do)
<b>Network of Statewide Practices</b>	Factors at the network level
• Recruitment strategies	Strategies the network uses to recruit practices; whether practices are new to the cooperative or have collaborated in the past
• Health Disparities Addressed	Strategies to address health disparities
• Communication among practices	Modes, styles, and means of communicating among practices; examples of relationships built among practices because of the network
• Network	Factors associated with the practices that are a part of the Network
• Retention strategies	Strategies the Cooperative uses to retain practices in the network.
• Non-intervention Resources	Resources for practices that are <u>not</u> part of the network.
<b>Practices</b>	Factors at the practice level
• Leadership	Factors related to leadership at the practice level, including leadership engagement or support.
• Previous QI effort	Factors related to previous experience with the practice implementing QI efforts
• IT infrastructure	Factors related to IT infrastructure and implementation of the QI initiative.
• Staffing	Factors related to staffing at the practice and the QI implementation.
• Local regulations	Local guidelines or regulations related to the QI effort or implementation.
• Sustainability	Factors related to the broader sustainability of the intervention within the practices.
<b>Implementation Strategies</b>	Methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice
• On-site practice facilitation and coaching	Provide ongoing consultation with one or more experts (“practice facilitators”) in the strategies used to support implementing the innovation
• B. Health Information Technology Support	Involve, hire, and/or consult experts to inform management on the use of health information data to support implementation efforts
• Shared Learning Collaboratives	Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation

Code	Definition
• Expert consultation	Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation
• Data feedback and benchmarking	Collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior
• Conduct educational meetings/trainings	Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation
• Other	Other implementation strategies not listed above
<b>Implementation Barriers</b>	Factors that are barriers to implementation
• COVID-19	Barriers related to COVID-19
• Organizational Agreements	Barriers related to Organizational Agreements (including MOUs, partnering)
• IRB	Barriers related to IRB
• Competing QI Projects	Barriers related to other, competing quality improvement projects
• Staff Turnover/Capacity	Barriers related to staffing, including turnover and capacity
• Data sharing	Barriers related to sharing data across the cooperative, or with practices
• Project coordination	Barriers related to project coordination
• Funding	Barriers related to funding
• Delays	Barriers related to delays
• Other	Other barriers not specified above
<b>Implementation Facilitators</b>	Factors that are facilitators to implementation
• Existing relationships	Facilitators related to existing relationships
• Expertise/experience with QI/leading large studies/projects	Facilitators related to experience with QI, or leading large studies
• Comfort with meeting electronically	Facilitators related to meeting electronically
• Learning from other grantees/EvidenceNOW meetings	Facilitators related to learning from other grantees and the EvidenceNOW meetings.
• Existing infrastructure	Facilitators related to existing infrastructure (i.e., health information)
• Collaboration/engagement	Facilitators related to collaboration and engagement
• Other	Other facilitators not specified above
<b>Grant Components</b>	Factors that are related to participating in the grant (e.g., technical assistance, evaluation leads, project officer meetings)
<b>Select CFIR Constructs</b>	
• Intervention Characteristics	Key attributes of the interventions that influence the success of the implementation
– Adaptability	The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs
– Trialability	The ability to test the intervention on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted
– Design quality and packaging	Perceived excellence in how the intervention is bundled, presented, and assembled.
– Costs	Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs.
• Outer Setting	Attributes of the context outside of the primary implementation setting (practice) that influence success of implementation

Code	Definition
– Patient needs and resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.
– Cosmopolitanism	[see partner code under cooperative]
– External Policies and Incentives	A broad construct that includes external strategies to spread interventions, including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.
• Inner Setting	Attributes of the context inside the primary implementation setting (practice) that influence success of implementation
– Implementation climate	The absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.
– Readiness for Implementation	Tangible and immediate indicators of organizational commitment to its decision to implement an intervention.
– Leadership Engagement	Commitment, involvement, and accountability of leaders and managers with the implementation.
– Available Resources	The level of resources dedicated for implementation and on-going operations, including money, training, education, physical space, and time.
• Characteristics of the individuals	Characteristics of the individuals involved in implementing the intervention
– Knowledge and beliefs about the intervention	Individuals' attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention
• Process	The process of implementing the intervention, including planning, engaging, executing, and evaluating.

## Appendix II. Protocols

### Attachment A: Grantee and Cooperative Leadership – Interview Protocol

The following are semi-structured questions to be asked in a telephone interview.

Interviewer name: \_\_\_\_\_

Respondent organization: \_\_\_\_\_

Respondent name: \_\_\_\_\_

Date: \_\_\_\_\_

Permission to record: Y/N Interviewer initials: \_\_\_\_\_

#### Consent Script

As you know, Abt is an external evaluator for the EvidenceNow project. Our goal is to understand the approaches taken by each grantee to developing cooperatives, engaging and supporting primary care practices, and ultimately identifying best practices and lessons learned. We are conducting this study for the Agency for Healthcare Research and Quality (AHRQ), which is part of the US government. If you agree to participate in this interview, we will ask you questions about the establishment of your Cooperative and network, the approach to QI and support, and any lessons learned so far.

- This interview should take at most 60 minutes to complete.
- Your participation is voluntary and you can refuse to answer any question.
- There is no cost to you for doing this interview.
- Non-participation will have no effect on your relationship with AHRQ.
- The principal risk of this interview is a small risk of loss of confidentiality. The team has many procedures in place to reduce this risk.

May we record this interview? The recording will be used as a back up to the notes and destroyed in the end of the project. Yes \_\_\_\_\_ No \_\_\_\_\_

#### Cooperative

C1. Can you describe your role and nature of involvement in this project?

C2. How did you initiate the Cooperative for EvidenceNow?

(Probes: establishment of priorities, roles of each member, governance, relationships between members, coordination, communication)

C3. How did you decide which organizations should become part of the Cooperative?

(Probes: Did you consider organizations serving diverse and/or disadvantaged populations that help to ensure that disparities are addressed? If yes, what are these? Did you collect feedback from a diverse group within state? What outreach did you do? Regional representation? Did you attempt or do you plan to coordinate with the existing state QI efforts? How did the immediate goal of reducing cardiovascular risk influence your choices? How did the longer term goal of creating an enduring, QI support system influence your choices?)

C4. How is the Cooperative organized? What are the roles of each member? How are decisions made?

(Probes: delegation, governance, relationships, coordination, communication)

C5. Does the Cooperative include organizations that help to ensure that health disparities are considered and addressed? What are these and what is their role?

C6. In what ways has this cooperative built on existing partnerships, networks, or roles, versus developing new ones?

(Probes: did the Cooperative foster the exchange of QI resources across organizations, leverage the respective provider networks of each organization and share information and services across networks, establish state-level priorities across organizations, coordinate members efforts on existing initiatives and programs within the state.)

C7. Are there organizations that you were unable to recruit into the Cooperative? What reason did they offer for non-participation?

(Probe: If public health is not a Cooperative partner: did you consider including the [state public health agency] in the partnership? Why/Why not? If community-based organizations are not Cooperative partners: did you consider including community-based organizations in the partnership? Why/Why not? Have you attempted or are you attempting to form working relationships with non-cooperative stakeholders?)

C8. Have there been other barriers or facilitators to forming the Cooperative?

C9. How well is the Cooperative working so far?

Probe: To what extent if at is your Cooperative strategies or plans deviating from what you proposed in your grant application?

### **Network**

N1. How did you identify practices to recruit to the network? Have you collaborated with these practices before and if yes, what was the nature of this collaboration?

(Probes: Are there practices in your network that you have never worked with? In what way, if at all, do they differ from practices with which you have a previous connection? Extent to which cooperative members leveraged their existing provider networks to create network?)

N2. What recruitment strategies and messages (e.g., value proposition) did you use? Which were successful and unsuccessful?

### **QI Strategies**

**The following questions are regarding practices participating in the heart health QI project**

QI1. What QI support strategies does the Cooperative plan to/is using to support practices **participating** in the heart health QI project? How and why were these strategies chosen? Were they developed from existing resources or approaches?

(Probes: Did strategies include: website and listserv providing QI resources, in-person or remote practice facilitation, educational programs, learning collaborative, QI boot camp, in-person or remote expert consultation, data feedback and benchmarking, health IT assistance, needs assessment. Was potential to specifically impact cardiovascular risk a factor in selecting QI support strategies? How so?).

QI2. Please describe the nature, type, frequency, background of practice facilitators (PFs), and other characteristics of the practice facilitation (or other key support strategies) provided to practices?

QI3. What are the outcome goals the QI strategies are intended to address and *how* are they expected to change QI capacity and reduction of cardiovascular risk (i.e., what is the theory of action/logic model)?

**The following questions are regarding practices that are in your network but are not participating in the QI project**

QI9. What QI support strategies does the Cooperative plan to/is using to support network practices that **did not participate** in the heart health QI project? How and why were these strategies chosen? Were they developed from existing resources or approaches?

(Probes: website and listserv providing QI resources, in-person or remote practice facilitation, educational programs, shared learning collaboratives, QI boot camp, in-person or remote expert consultation, data feedback and benchmarking, health IT assistance, needs assessment, strategies to address access barriers, health inequities, or disparities).

QI10. Were all the practices in the network supported in the same manner? If not, how did strategies differ and why?

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**Attachment B: Cooperative Partners – Interview Protocol**

The following are semi-structured questions to be asked in a telephone interview.

Interviewer name: \_\_\_\_\_

Respondent organization: \_\_\_\_\_

Respondent name: \_\_\_\_\_

Date: \_\_\_\_\_

Permission to record: Y/N Interviewer initials: \_\_\_\_\_

**Consent Script**

Abt Associates is an external evaluator for the EvidenceNow project. Our goal is to understand the approaches taken by each grantee to developing cooperatives, engaging and supporting primary care practices, and ultimately identifying best practices and lessons learned. We are conducting this study for the Agency for Healthcare Research and Quality (AHRQ), which is part of the US government. If you agree to participate in this interview, we will ask you questions about the establishment of your Cooperative and network, the approach to QI and support, and any lessons learned so far.

- This interview should take at most 60 minutes to complete.
- Your participation is voluntary and you can refuse to answer any question.
- There is no cost to you for doing this interview.
- Non-participation will have no effect on your relationship with AHRQ.
- The principal risk of this interview is a small risk of loss of confidentiality. The team has many procedures in place to reduce this risk.

May we record this interview? Yes \_\_\_\_\_ No \_\_\_\_\_

**Cooperative and Network**

1. Can you describe your role and nature of involvement in this project?
2. What is your and your organization's role on this effort?
3. How and why did your organization get involved?
4. Have you collaborated with any of the other partners before? What was the nature of this collaboration?
5. Does the Cooperative include organizations that help to ensure that health disparities are considered and addressed? What are these and what is their role?
6. How satisfied are you with your participation in this effort?  
(Probes: shared power and decision-making, responsibilities, return on "investment," remuneration)
7. How well is the Cooperative working so far?  
Probe: To what extent if at all are your Cooperative strategies or plans deviating from what you proposed in your grant application?
8. Have there been other barriers or facilitators to your participation in the Cooperative?

**Network**

*[Note: if the respondent's organization had a role with the network, ask the following questions.]*

N1. How did you identify practices to recruit to the network? Have you collaborated with any of these practices before and if yes, what was the nature of this collaboration?

(Probes: Are there practices in your network that you have never worked with? In what way do they differ from practices with which you have a previous connection? Extent leveraged existing provider networks to create network?)

N2. What recruitment strategies and messages (e.g., value proposition) did you use? Which were successful and unsuccessful?

### **QI Strategies**

*[Note: if the respondent's organization had a role with the QI support strategies, ask the following.]*

**The following questions are regarding practices that are in the network but are not participating in the heart health QI project**

QI1. What QI support strategies are planned for practices in the network that are not participating in the QI project? Was the QI directed toward specific topics, such as improving heart health? How and why were these strategies chosen? Were they developed from existing resources or approaches? Have these changed over time, and if yes, how and why?

(Probes: in-person or remote practice facilitation, educational programs, shared learning collaboratives, QI boot camp, in-person or remote expert consultation, data feedback and benchmarking, health IT assistance, needs assessment). Were all the practices in the network supported in the same manner? If not, how did strategies differ and why?)

QI2. Do you plan to support all the practices in the network in the same manner? If not, how will you decide which practices get which form of support? Are there changes to what you initially envisioned?

**The following questions are regarding practices participating in the heart health QI project**

QI4. What QI support strategies does the Cooperative plan to/is using to support practices **participating** in the heart health QI project? How and why were these strategies chosen? Were they developed from existing resources or approaches?

(Probes: in-person or remote practice facilitation, educational programs, shared learning collaborative, QI boot camp, in-person or remote expert consultation, data feedback and benchmarking, health IT assistance. Were all the practices in the network supported in the same manner? If not, how did strategies differed and why?)

QI5. Please describe the nature, type, frequency, background of PFs, etc of practice facilitation and other key support strategies?

QI6. How are the QI support strategies expected to change QI capacity and reduction of cardiovascular risk (i.e., what is the theory of action/logic model)?





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