

Heart Health Now!

The North Carolina Cooperative for AHRQ's

EvidenceNOW

Advancing Heart Health in Primary Care

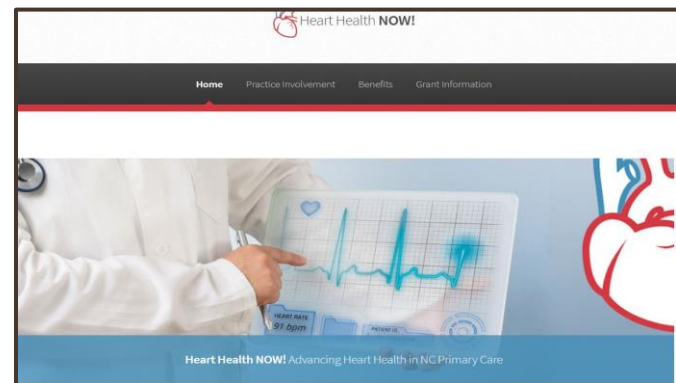


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Title: Practice & Practice facilitator level factors associated with enhanced team engagement; findings from the Heart Health Now study

- Halladay JR, Weiner BJ, Kim J, DeWalt DA, Pierson S, Fine J, Lefebvre A, Mackey M, Bergmire D, Cene C, Henderson KH, Cykert S



Agenda

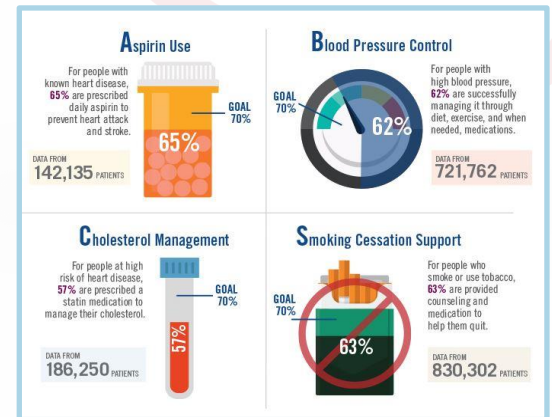
- Heart Health Now
- Analysis of Interest

HHN – CVD Primary Prevention

- 245 practices in NC
- ≤ 10 providers
- Practice Facilitation (PF) model

Assist with implementing evidenced based processes -
the “ABCS” of CVD

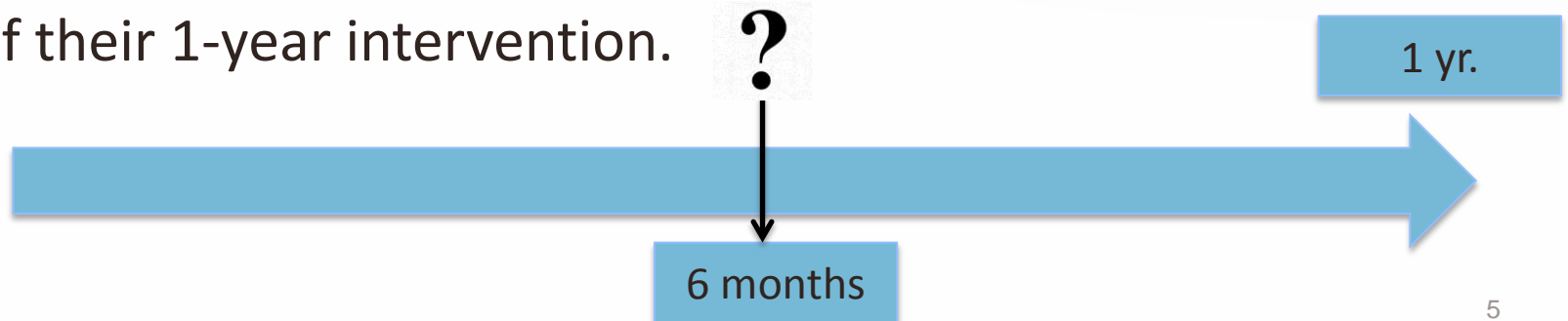
- ✓ ASA use by high-risk individuals
- ✓ BP control
- ✓ Cholesterol management
- ✓ Smoking cessation



Today's discussion

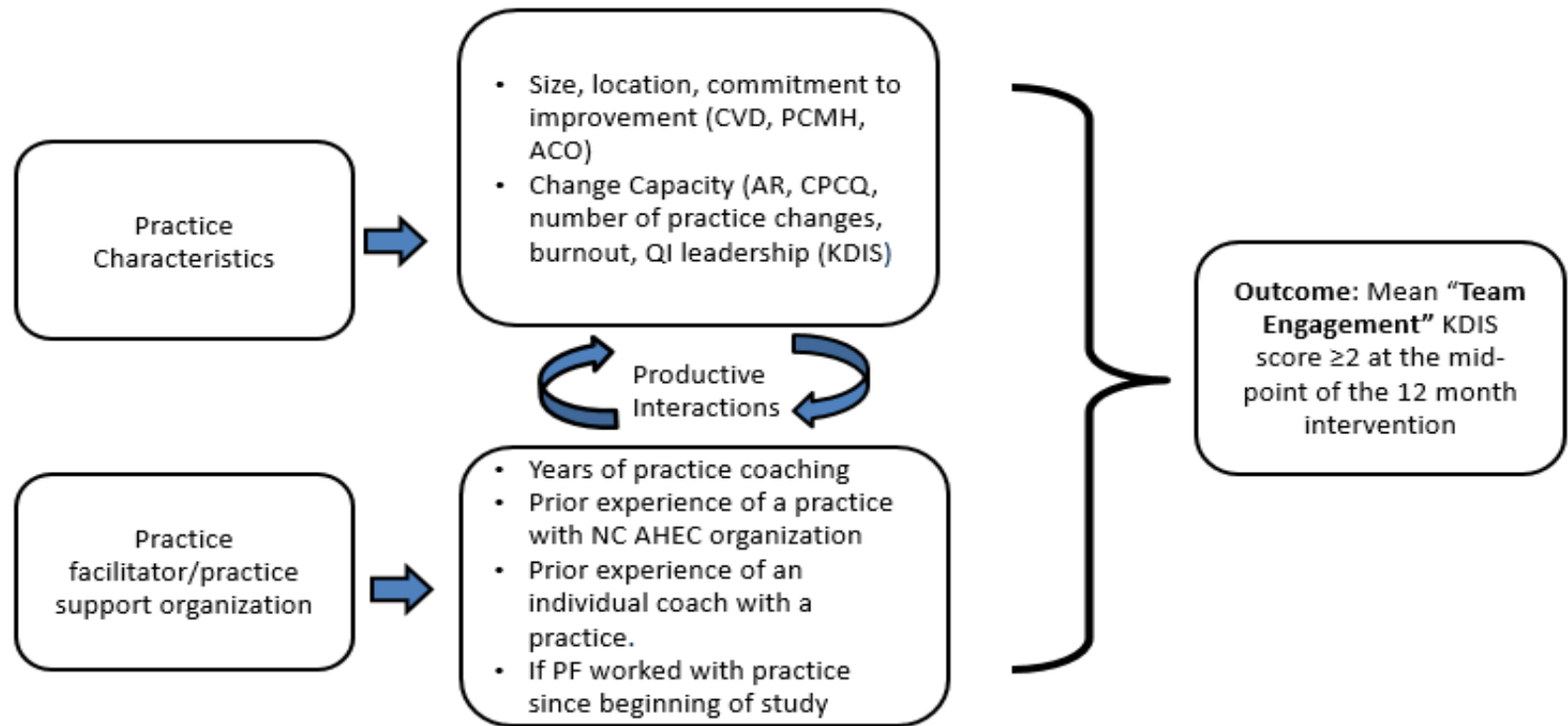


- **Engagement** with PF's requires that practices are open to partnering with facilitators.
- Little is known about **practice or facilitator level factors associated with greater engagement** with practice facilitators.
- Our objective : explore **the factors associated with higher levels of engagement of facilitators with practice teams** at mid-point of their 1-year intervention.



Conceptual Model

Figure 1. Conceptual Model : HHN Primary Care Practice Engagement with Practice Facilitators as Team Members



Instruments:

- organizational readiness (*PMS) (use Ready or readiness1, not both)
- Adaptive Reserve (AR) (*PMS)
- Burnout (B) (*PMS)
- Change Process Capability Questionnaire (CPCQ) (^PCS)
- CVD Priority (CVD) (^PCS)
- Degree of Disruptions (DD) (^PCS)
- PCMH recognition/ACO participation (PCMH)(^PCS)
- Key Driver Implementation Scale (KDIS) (team engagement and QI leadership)

*PMS = practice member survey thus ≥ 1 response/practice

^PCS = practice characteristic survey/CPCQ thus where there is 1 leadership response/practice

Outcome measure

- No QI activities related to hypertension currently
- Occasional meetings or discussions regarding QI for hypertension but no practice-wide understanding of QI
- A QI team communicates regularly (through meetings, huddles, emails, memos, etc.) to plan tests and discuss results of hypertension QI. QI team can describe project focus and measures.
- A QI team is planning and discussing multiple tests simultaneously to improve HTN control, and communicates findings to each other. QI progress is communicated to entire office staff. Most staff can describe QI focus and measures.

Team Engagement scores are submitted **MONTHLY** by practice facilitators

- PF's document practice progress with implementing key activities that drive change (KDIS measures).

Analysis outcome measure: “adequate” Team Engagement (TE ; 0-3 scale) = mean TE score of 2 or greater at six months

- Mean score using score at months 4,5, and/or 6 months, where ≥ 2 scores available.

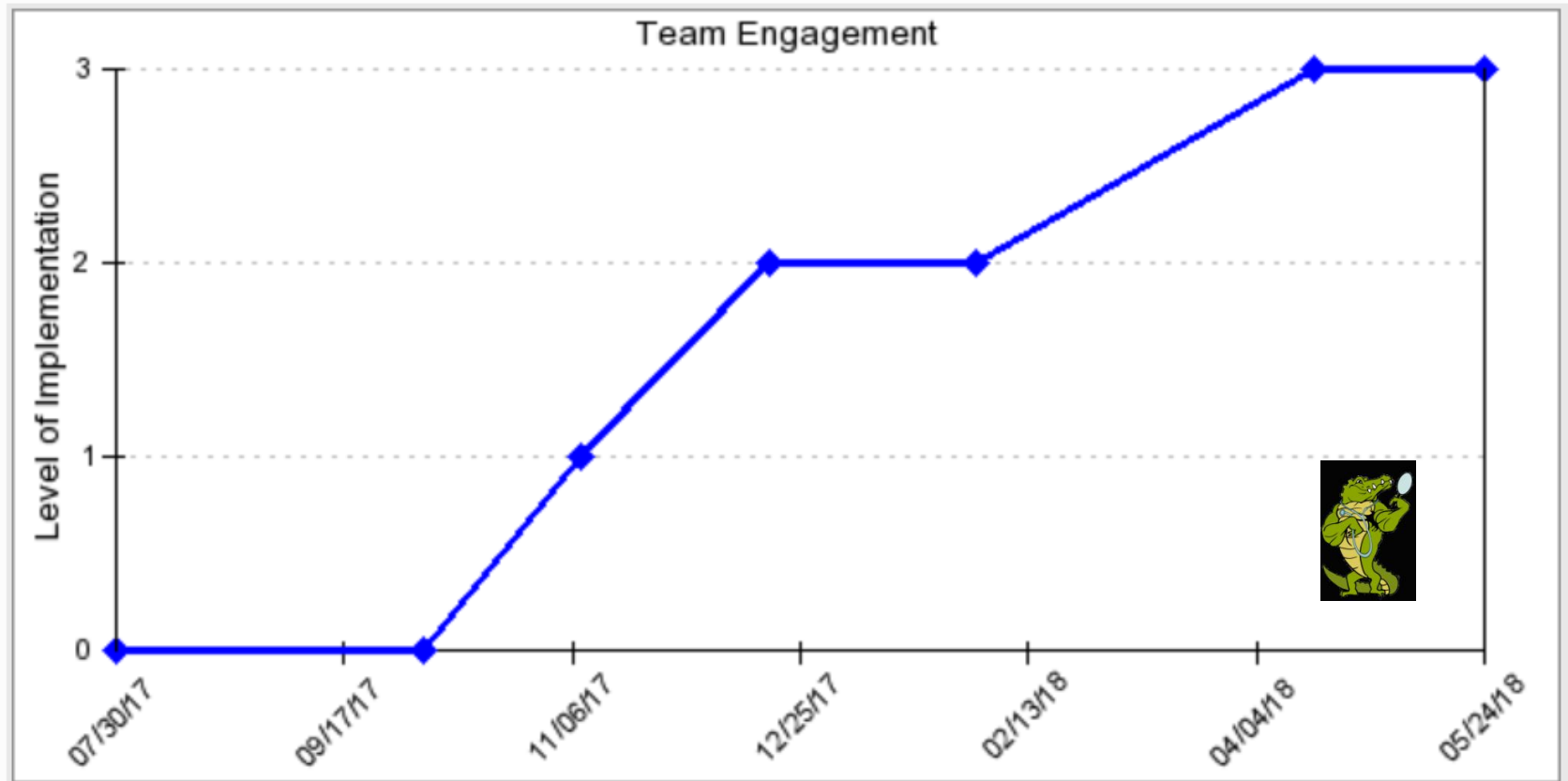
KDIS score – ordinal scale

- No QI activities related to hypertension currently
- Occasional meetings or discussions regarding QI for hypertension but no practice-wide understanding of QI
- A QI team communicates regularly (through meetings, huddles, emails, memos, etc.) to plan tests and discuss results of hypertension QI. QI team can describe project focus and measures.
- A QI team is planning and discussing multiple tests simultaneously to improve HTN control, and communicates findings to each other. QI progress is communicated to entire office staff. Most staff can describe QI focus and measures.

Team Engagement	
0 - No activity	No engagement
1 - Occasional meetings	Team meets infrequently to discuss improvement; no practice-wide understanding of improvement work exists
2 - Regular meetings	Improvement team communicates regularly (through meetings, huddles, email, memos, etc.)
3 - Active engagement	Improvement team plans multiple tests simultaneously and communicates findings

Graph of enhanced TE over time

2. TEAM ENGAGEMENT



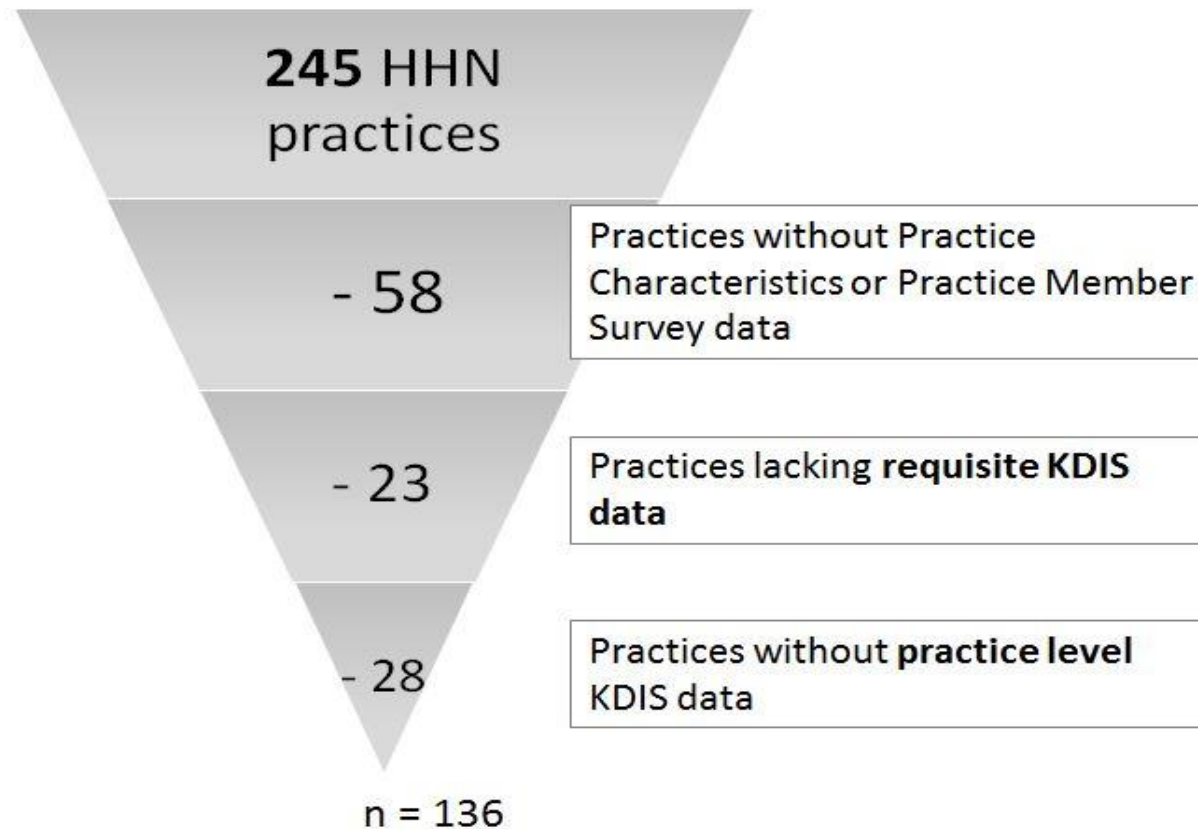
Data Sources

Practice Surveys

- Practice Characteristics
 - **1 respondent** / practice (leadership role)
 - Demographics, involvement in Accountable Care Organizations, cardiovascular disease care priority, # practice disruptions, others
- Practice Member
 - **Multiple responders** with different roles
 - Burnout, Adaptive Reserve, Readiness

Determining Practice Eligibility:

Figure 4 : Selection of Analytical Cohort



Among 245 HHN practices, 58 were missing either the practice characteristics or practice member survey data. From this group of 187, 23 were eliminated for having incomplete KDIS data. Among this group, 28 were ineligible due to having KDIS data that represented groups of networked practices instead of individual practice sites. This occurred in cases where network administrators representing 3 practice organizations centralized the QI work, thus we do not have individual level practice data on these practices.

Table 1. Practice Characteristics- N=136 HHN Practices	N or mean (%, SD) , [range]
Practice Characteristics Survey items, [# missing]	
Practice Size (number of providers MD, DO, NP PA),[2]	4.9 (4.2)
Practice Ownership Type, [0]	
Clinician-owned Solo or Group Practice	70 (52 %)
FQHC or Look-alike/Rural Health Clinic	37 (27%)
Academic Health Center/Faculty Practice	9 (7%)
Hospital/Health System	20 (15%)
Payer Mix [13], %, (range)	
Medicare	30.6% , [5-82%]
Medicaid	15.4% , [0-50%]
Dual (Medicare/Medicaid)	9.1% , [0-70%]
Commercial	32.5% , [0-79%]
No insurance	11.8% , [0-60]
Practice Location in a Medically Underserved Area (MUA), [0], YES	54 (40 %)
Number of Major Practice Changes (0-7), [0]	1.1 , [0-4]
Practice Leadership Score , scored 0-3,[0]	2.0 (0.7)
Involvement in an Accountable Care Organization (ACO), YES	61 (45%)
Mean Team Engagement Score of Months 4-6,[0]	1.6 (0.7)

^aData provided as absolute numbers or means and standard deviations (SD) for continuous variables and proportions with chi squared test for categorical variables as appropriate. Ranges included for payer mix and number of patients seen per day by a full-time clinician.

Table 1. Practice Characteristics - n = 136 HHN Practices**N or mean
(%, SD)****Practice Member Survey Items**

Adaptive Reserve Score (18 items, aggregate score 0-1),[0]

0.7 (0.1)

Practice Level of Burnout (single item, 0-4)

1.9 (0.6)

Practice Readiness (readiness1) single item

4.0 (0.5)

Practice Facilitation Experience Survey Items

Years of Experience as a Practice Facilitator, [1]

4.2 (3.7)

Practice facilitator worked with practice since the beginning of the project [1]

102 (75%)

Practice Experience with NC AHEC Practice Support Program, [1], Yes

38 (27.9%)

Practice-PFacilitator Experience Together Prior to HHN, [1],Yes

9 (6.7%)

Demographic summary

Among the 245 HHN practices:

- 136 met our inclusion criteria
 - 73 with a 6-month TE score of ≥ 2
 - 63 scored <2
- 70% were clinician owned, 27% were FQHC's, 15% hospital or health system owned.
- 40 % percent located in a Medically Underserved Area (MUA)
- ~ 28% of practices had previously worked with the NC AHEC practice support program.

Methods

- Univariable logistic regression to identify variables associated with the odds of having team engagement scores ≥ 2 vs. < 2 .
- Variables with a $p \leq .07$ were included in multivariable logistic modeling.

Results – Univariate logistic modeling

- > # Practice changes (new EHR, new ownership, new leadership, etc.)
- > Practice KDIS leadership scores
- Location in a medically underserved area (MUA)
- If part of a hospital or health system vs. being privately owned (solo or group practice)
- If a PF worked with a practice since the beginning of the HHN project
- More uninsured, fewer dually eligible patients.



NOT associated

- Levels of burnout, adaptive reserve and readiness were not associated with TE scores.

Multivariable Logistic Regression – Best fit model

Statistically significant adjusted odds ratios of greater TE with:

- Higher practice QI leadership
- MUA location
- Being hospital or health system owned compared to being in solo/group practice

No facilitator characteristics that were measured were independently associated with greater TE

Univariate and Multivariable Logistic Models, Odds Ratios for achieving a mean TE score of ≥ 2 at the study mid-point (~ 6 months)

	Univariate Logistic Model OR (95% CI), [p value]	Multivariable Logistic Model* OR (95% CI), [p value]
For every one-point increase in leadership	9.42 (4.37-20.30), [0.000]	7.66 (3.72-18.42), [0.00]
For practices located in a Medically Underserved Area (MUA) vs. not in an MUA	2.43 (1.19-4.97), [0.06]	3.11 (0.94 – 11.33), [0.06]
For practice's that are hospital or health system owned, compared to solo/private owned.	7.20 (2.17-23.9), [0.001]	6.80 (2.06 – 26.76), [0.001]

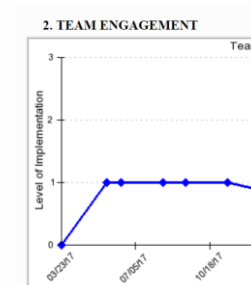
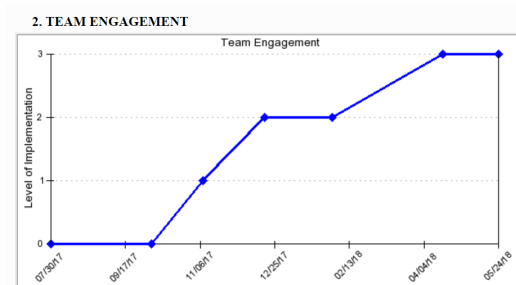
*Model adjust for leadership, number of disruptive changes and practice location.
Data presented as Odd ratios (OR) (95% CI) of TE ≥ 2 , [p value]

Conclusions??

With limited human resources, does it make sense to consider this data when deploying a PF work force?

And/or is it something to consider analyzing during studies to trouble shoot/alter strategy and even type of engagement depending on progress?

Others?



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Thank You!