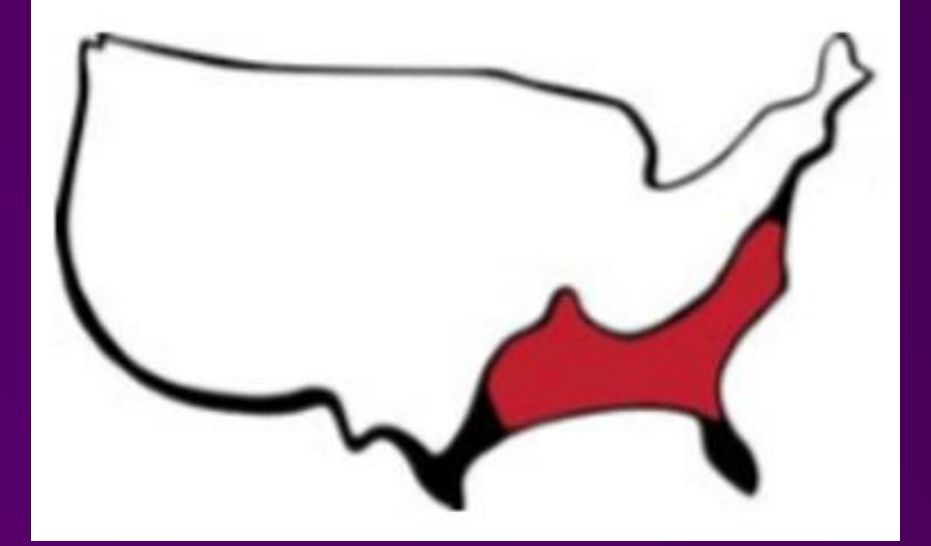


Practice Facilitation Implementation Requirement in Rural Primary Care Practices to Improve Blood Pressure Control for African Americans



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Introduction

- Practice facilitation (PF) can be a useful tool to help guide rural primary care practices develop strategies for improving hypertension (HTN) related outcomes in a way that address their unique populations and needs.
- Rural areas, especially in the southeastern United States, bear a disproportionate burden of hypertension (HTN) morbidity and mortality, but have limited resources to address these issues.
- Understanding the resources needed to provide practice facilitation in rural areas can help providers, healthcare administrators and public health officials when considering PF in ongoing quality improvement efforts.
- This abstract provides an overview of the infrastructure, training, and time resources used by the Southeastern Consortium for BP Control Study (SEC-BPC) to provide PF.

Methods

- A cluster-randomized, controlled, pragmatic implementation trial that will compare 4 distinct interventions, to achieve BP control among African American patients in rural primary care practices in AL and NC (see Figure 1).

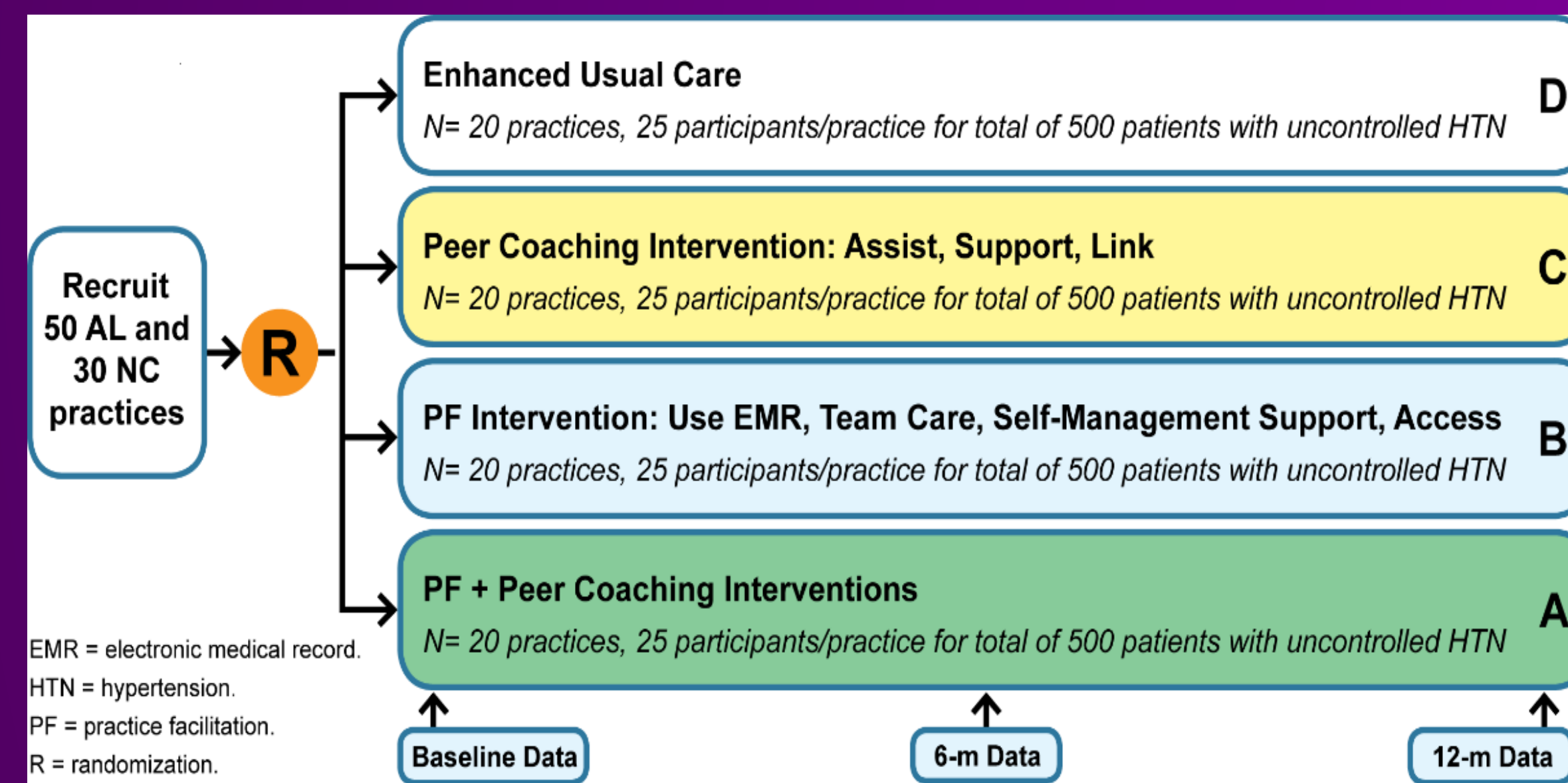


Figure 2. Design of the Cluster-Randomized, Controlled, Pragmatic Trial.

What is Practice Facilitation?

- Also known as practice coaching or quality improvement coaching
- Carried out by a trained practice facilitator also known as practice coaches, QI coaches, and practice enhancement assistants

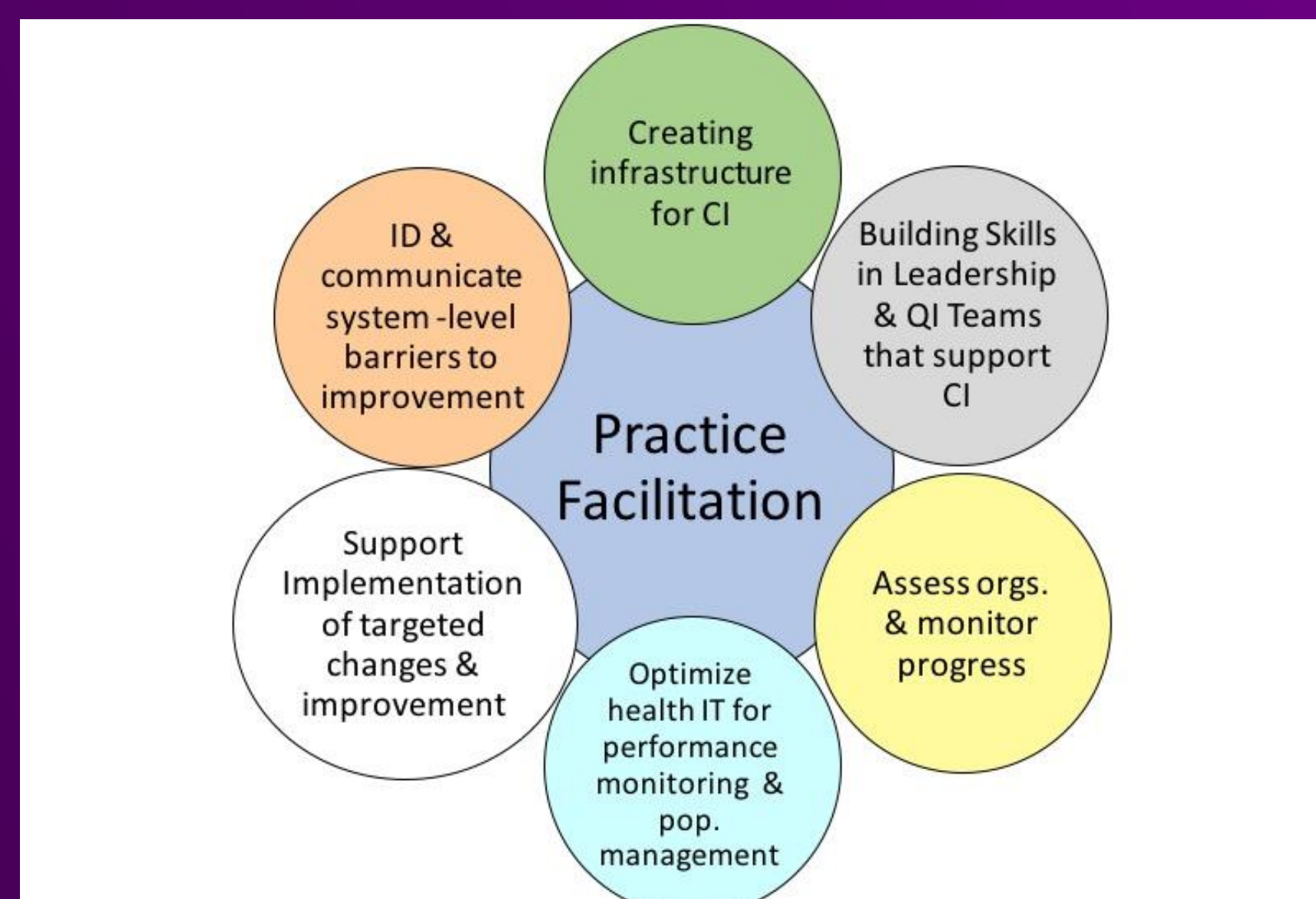


Figure 3. Practice Facilitator Activities

Methods Cont'd.

Summary of Practice Facilitation Intervention

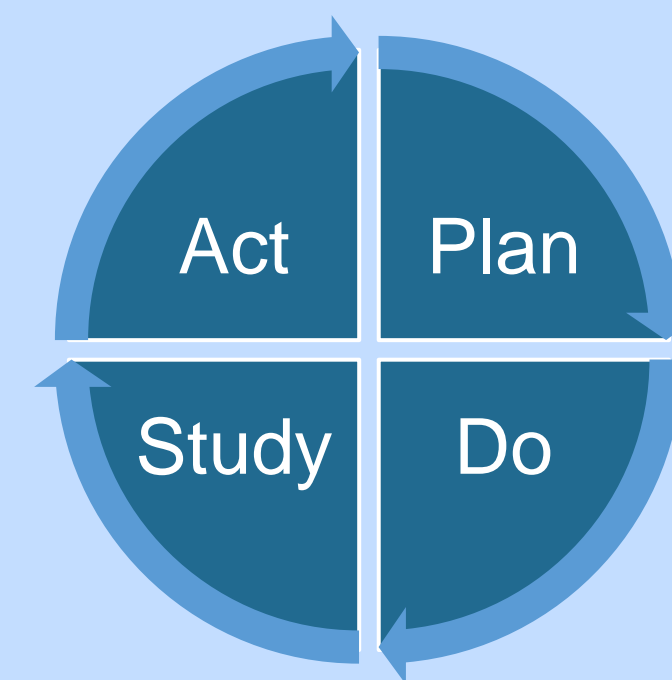
Establish and Maintain Working Relationships



PF meets practice champion and other key staff in person at least once per month for 12 months

Phone, email, or remote access as needed

Build Capacity



- PF follow the Model for Improvement to build internal practice capacity for QI
- PF help engage practices in data driven QI
- PF support practices in completing QI activities that align with change concepts of the Key Drivers of Implementation (see below)

Measure Progress

Key Drivers for Improving Blood Pressure Control

Clinical Information System	<ul style="list-style-type: none"> Registry or EHR used to manage patient care and support population management 	<ul style="list-style-type: none"> Monthly PF assess the implementation of the 4 Key Drivers using the Key Driver Implementation Scale (KDIS) Mean systolic blood pressure calculated Frequency, type and duration of PF contact recorded in electronic data collection tool
Team Engagement/Optimized team care	<ul style="list-style-type: none"> Staff teams share in identifying gaps in patient care and works in teams to optimize patient care 	
Standardized Care Process	<ul style="list-style-type: none"> Practice-wide guidelines and processes implemented for patients with high blood pressure 	
Self-Management Support	<ul style="list-style-type: none"> Patient and care team work as partners to help patient achieve blood pressure control 	

Practice Facilitation Infrastructure, Training and Support North Carolina AHEC

- SEC-BPC leverages existing PF infrastructure of the NC AHEC
- Provides field experience and ongoing training for entire study
- Practice Facilitators hired by regional NC AHEC or UNC

Alabama AHEC

- Practice Facilitators are hired through regional AL AHEC
- Aiming to establish own statewide Practice Facilitator program

Each Practice Facilitator

- Trained and certified by University of Buffalo practice facilitator program
- Participate in twice monthly web conferences to share best practices and to problem solve how to move practices forward

Results

- All practices located in either NC or AL and serve a predominately rural population, high proportion of indigent patients, and a high proportion of African Americans patients.
- As of July, 2018 there are data for 24 practices receiving the PF intervention.

Table 1. Practice Characteristics (N=24)	Mean	Standard Deviation
Percent of Medicaid patients	26.7	13.1
Percent of Dual Eligible (Medicaid + Medicare)	8	8.4
Percent of uninsured patients	23.4	22.5
NCQA certified PCMH (%)	36	
Practices that reported to have a registry of hypertensive patients prior to study (%)	40	
Practices that reported to have implemented an evidence-based protocol to address hypertension prior to study (%)	60	
Practices that reported to have had established support systems to help patients with hypertension self-management prior to study (%)	32	

Table 2. Time Spent by Practice Facilitators

Activity	Average Minutes Per Practice, Per Month	Standard Deviation
All Activities	301	98
Onsite Meetings	93	31
Email Communication	50	20
Phone Communications	18	21
Remote Access	2	5
Travel	138	75

Conclusion and Next Steps

- Preliminary data suggests that providing PF to rural practices using centralized staff requires substantial investment of time and resources.
- Especially when working in rural areas, maximizing technology can provide opportunities to save time and resources.
- More information is needed to gain a better understanding of the time and resources used by providers and clinic staff to interact with practice facilitators and to complete PDSA cycles.
- At the end of the intervention, providers and clinic staff that work with practice facilitators will be given a satisfaction survey that will provide more insight into their experience with the practice facilitator.
- Collecting this detailed process information throughout implementation of the study provides important information needed to document the fidelity of the intervention and to help with future strategic planning and allocation of resources.