EvidenceNOW
AN AHRQ INITIATIVE

Developing and Sustaining State-Based Infrastructure To Support Primary Care Quality Improvement – A How-To Guide

August 2024

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

AHRQ
Agency for Healthcare Research and Quality

Abt Global, LLC developed this guide under a contract with the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (Contract No. HHSP233201500013I, Task Order No. 75P00120F37007).

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Acknowledgments: The Abt team included Jessie Gerteis, Ellen Childs, Colette Tano, Daniella Chambers, Nam Ha, Elizabeth Leftwich, Nataly Johanson Tello, Sarah Shoemaker-Hunt, Alyssa Brocker, Molly Vaughan, and Ann Loeffler. We would like to thank the four EvidenceNOW Building State Capacity cooperatives: Alabama Cardiovascular Cooperative, Healthy Hearts for Michigan, Heart Healthy Ohio, and Tennessee Heart Health Network. This guide draws upon content from their grant applications and progress reports, as well as on information they shared directly with the Abt team. We would also like to thank our AHRQ colleagues who provided valuable direction and feedback throughout the development of this guide, including Cindy Brach, Jesse Crosson, Daniel Miller, and Nora Mueller. We would also like to thank Julie Schilz from the Primary Care Development Corporation for her review and insights.

Suggested Citation: Abt Global. Developing and sustaining state-based infrastructure to support primary care quality improvement: A how-to guide. AHRQ Publication No. 24-0073. Rockville, MD: Agency for Healthcare Research and Quality. August 2024.

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PURPOSE AND FOCUS

The purpose of this guide is to share guidance about developing and sustaining state-based cooperatives that aim to strengthen the capacity of healthcare systems, other healthcare organizations, and clinicians to deliver evidence-based whole-person care.

The guide includes effective approaches, lessons learned, and example materials from the Agency for Healthcare Research and Quality (AHRQ) initiatives designed to provide external quality improvement (QI) support for primary care practices. This guide draws mainly from the experiences of AHRQ's EvidenceNOW: Building State Capacity initiative,[a] but also reflects other AHRQ and primary care/healthcare extension efforts. This guide will be useful to groups planning or developing similar infrastructure, including healthcare extension programs with a focus broader than primary care.

TERMINOLOGY AND NAMING CONVENTIONS

Primary care extension programs provide external support to primary care practices to help them implement new evidence in care delivery and increase their capacity for engaging in quality improvement (see the section on Primary Care Extension Programs and EvidenceNOW for more information). **Healthcare extension programs** also provide external support for the implementation of evidence-based care, but with a focus across the whole healthcare system. AHRQ refers to the multiorganization programs that provide primary care/healthcare extension services as "**cooperatives**."

In addition to establishing primary care extension cooperatives, AHRQ's EvidenceNOW: Building State Capacity grantees (located in Alabama, Michigan, Ohio, and Tennessee) were each charged with building and maintaining a statewide network of primary care practices that would benefit from cardiovascular and QI support resources. The grantees also recruited a smaller number of primary care practices to actively participate in a QI project to improve patients' cardiovascular health through implementing evidence-based findings to improve care. The names of the EvidenceNOW: Building State Capacity cooperatives, their statewide networks of practices, and their QI projects appear in Table 1 and are referred to throughout this guide.

[a] Though this guide includes information about how AHRQ grantees developed the primary care/healthcare extension program (i.e., cooperatives) in their state, it does not go into detail about how they provided QI support or practice facilitation to practices. Those topics are already covered in other sources (see AHRQ's The EvidenceNOW Model: Providing External Support for Primary Care and Practice Facilitation resources).

Table 1. Names of Cooperatives, Practice Networks, and QI Projects, by State

State	Cooperative	Statewide Network of Practices	Project
Alabama	Alabama Cardiovascular Cooperative	Cardiovascular Risk Reduction Network	Heart Health Improvement Program
Michigan	Healthy Hearts for Michigan	Healthy Hearts for Michigan	Healthy Hearts for Michigan
Ohio	Heart Healthy Ohio Initiative	Heart Healthy Ohio Initiative	Heart Healthy Ohio Quality Improvement Project
Tennessee	Tennessee Heart Health Network	Tennessee Heart Health Network—Tiers 2 and 3	Tennessee Heart Health Network—Tier 1

It should be noted that the Tennessee Heart Health Network was part of the broader Tennessee Population Health Consortium, which is similarly working to improve primary care by focusing on diabetes, cancer, and health system improvement. In addition, the Heart Healthy Ohio Initiative was closely aligned with the Ohio Cardiovascular and Diabetes Health Collaborative (CardiOH), a statewide initiative to improve health outcomes of Medicaid patients and reduce health disparities.

OVERVIEW OF CHAPTERS

The guide includes the following chapters:

1. **Background and Introduction.** This chapter provides background information about primary care extension programs and AHRQ's EvidenceNOW initiative. The chapter also discusses the value of establishing programs that include partners from across multiple organizations and disciplines.

2. **Developing and Running a State-Based Extension Program To Support QI in Primary Care.** This chapter describes key steps for effectively establishing a multiorganization entity to support statewide QI in primary care. These include:
    - Conducting a landscape review to identify relevant partners, leverage past experience, and coordinate current efforts
    - Developing a mission statement
    - Inviting partners
    - Developing an organizational and governance structure
    - Forming the program's regular activities, charter, and bylaws
    - Assessing partner engagement regularly

3. **Building and Maintaining a Network of Primary Care Practices.** This chapter describes approaches for recruiting primary care practices to participate in both a statewide network and specific QI projects, as well as strategies for practice engagement and retention.

4. **Selecting and Delivering Services To Support Quality Improvement.** This chapter provides information and examples for understanding the needs and interests of primary care practices, selecting a range of QI support services to provide, and training staff to provide that support.

5. **Moving Toward Sustainability.** This chapter describes how to ensure sustainability and strategies to secure sustained funding.

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1. Background and Introduction

SUPPORTING PRIMARY CARE IMPROVEMENT

Implementing high-quality primary care nationwide requires getting the latest evidence from patient-centered outcomes research out to practices (i.e., dissemination). It also requires that practices have the capacity and skills to engage in quality improvement (QI) activities based on that evidence (i.e., implementation). However, engaging in QI is new for many practices, and it requires significant training and support.[1] Implementing QI in care delivery settings requires dedicated time and resources for primary care practices that are already facing challenges, such as declining financial margins, an aging population with increasingly complex medical needs, workforce shortages, and high clinician and staff burnout rates. Fortunately, research shows that external supports can help a wide variety of primary care practices effectively engage in QI.[1,2]

> **"High-quality primary care is the foundation of a robust health care system, and… is the essential element for improving the health of the U.S. population."**
>
> – National Academies of Sciences, Engineering, and Medicine, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021)

In recent years, federal and state initiatives have provided QI support to help improve primary care quality in the United States and align these supports with payment and incentives. These initiatives have included efforts led by the Centers for Medicare & Medicaid Services (CMS) (e.g., Primary Care First and Making Care Primary); the Health Resources and Services Administration (e.g., National Training and Technical Assistance Partners and the Small Health Care Provider Quality Improvement Program for rural health); the Centers for Disease Control and Prevention (e.g., Community Transformation Grants program); and the Agency for Healthcare Research and Quality (AHRQ) (e.g., EvidenceNOW). The large number of these initiatives points to an opportunity to develop sustainable state-based multiorganizational extension programs that can help to support, coordinate, and align primary care QI efforts.

PRIMARY CARE EXTENSION PROGRAMS AND EVIDENCENOW

To improve primary care quality, the Affordable Care Act of 2010 authorized AHRQ to establish a federal Primary Care Extension Program.[3] It was modeled on the U.S. Department of Agriculture's extension program, which was started in the early 1900s to disseminate innovations and best practices from land-grant universities to communities and farmers.[4,5] The Affordable Care Act laid out the purpose of the Primary Care Extension Program:

> "[P]rovide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice."[6]

Although Congress has not yet provided funding for this authorization, AHRQ has developed a series of projects to identify and test methods and approaches for primary care extension programs. Starting in 2011, AHRQ developed the Infrastructure for Maintaining Primary Care Transformation (IMPaCT) initiative,[1,3] which was followed in 2015 by the EvidenceNOW initiative.

The IMPaCT grants (in New Mexico, North Carolina, Oklahoma, and Pennsylvania) focused on studying and spreading the use of **state-level primary care extension programs** to support QI efforts in small and medium-sized independent practices.[1] These programs also provided technical assistance to partners in other states to assist them in developing their own extension programs. The IMPaCT initiative ultimately led to the establishment of primary care extension services in 17 states.[3,7]

AHRQ recommends that healthcare extension programs be organized within the boundaries of a single state. The EvidenceNOW: Advancing Heart Health grantees found that primary care extension programs spanning multiple states faced challenges in adapting and responding to local needs. Depending on the needs and resources available, extension programs could be organized at a regional level within a state. This guide focuses on statewide efforts, but the information presented here can also be applied to regional or local efforts within a state.

The first EvidenceNOW initiative—EvidenceNOW: Advancing Heart Health—funded seven grantees to use primary care extension programs to disseminate and implement evidence-based guidelines to improve heart health.[8] Based on lessons from this initiative, AHRQ developed the EvidenceNOW Model of primary care extension services. The model includes five core services:[9]

1. **Practice facilitation.** Practice facilitators (also known as coaches) work closely with primary care practices to build their capacity to implement the best clinical evidence and connect with community resources.
2. **Health information technology support.** Many practices need support to use their electronic health records (EHRs) for QI purposes. Practice facilitators who specialize in health information technology can help practices minimize the burdens of data entry and build staff's ability to generate reports with the information necessary to engage in QI improvement and population health efforts.
3. **Data feedback and benchmarking.** Data feedback is when data on key indicators of interest are tracked over time to assess whether there has been any improvement. The data for this can come from internal practice sources, such as the EHR or registries, or from external sources, such as health information exchanges, payer claims data, or hospital utilization data. Benchmarking is when a practice's performance on selected measures is compared with accepted standards or the performance of other practices or providers.
4. **Expert consultation (also known as academic detailing).** Short-term education from experts to provide specialized, in-depth information or technical assistance on a targeted topic to help a practice achieve its QI goals. Experts can include physicians, pharmacists, nurses, or others. Typically, expert consultation pairs experts with practice team members from the same professional background.

The EvidenceNOW Model

5. **Shared learning collaboratives.** Bringing together a group of practices, in person or virtually, to facilitate joint learning and focused improvement in an identified area of need. Learning collaboratives generate and sustain gains in quality by giving primary care practice teams the opportunity to learn from one another and share their experiences and solutions.

Following these initial investments in primary care extension, AHRQ funded three additional initiatives using the EvidenceNOW Model. Two of these initiatives focused on using the model to disseminate and implement patient-centered evidence in new clinical topic areas: EvidenceNOW: Managing Unhealthy Alcohol Use and EvidenceNOW: Managing Urinary Incontinence. The third initiative, EvidenceNOW: Building State Capacity – Advancing Equity in Heart Health, focused on building and sustaining a state-based infrastructure to provide primary care QI support.

THE VALUE OF MULTIORGANIZATIONAL EXTENSION PROGRAMS TO SUPPORT PRIMARY CARE QI

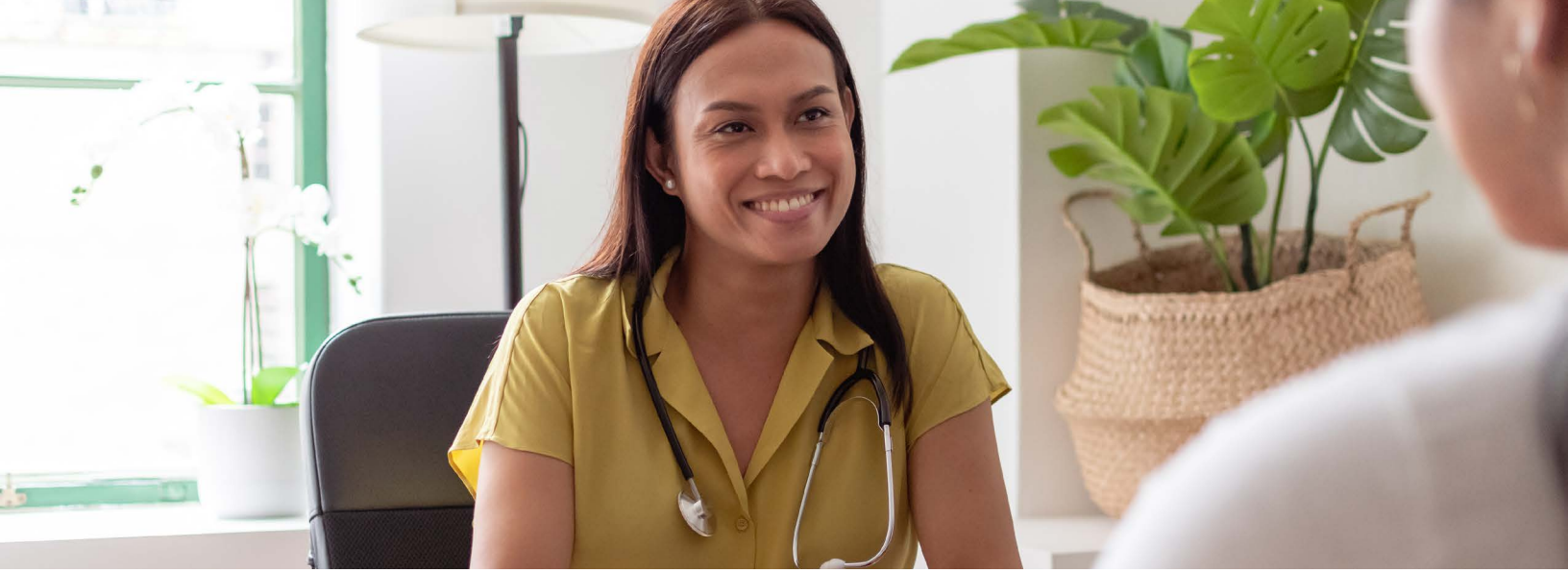
To be most effective, healthcare extension programs convene an array of public and private partners that are drivers of healthcare improvement in their state. For primary care–focused efforts, these partners typically include:

- Research universities where patient-centered outcomes research (PCOR) evidence is developed
- Primary care organizations and associations
- Quality improvement organizations or practice transformation organizations
- Practice facilitation providers
- Public and private payers
- Public health agencies
- Community-based organizations
- Consumer or patient advisory groups

Organizations participating in extension programs bring expertise in areas such as clinical QI, practice engagement, practice facilitation, evidence-based and patient-centered care, clinical-community linkages, program evaluation, data feedback and benchmarking, and techniques for using EHR and other health information technologies to monitor and support QI.

Bringing together **the collective efforts of multiple organizations** in a primary care extension program has the following potential benefits:

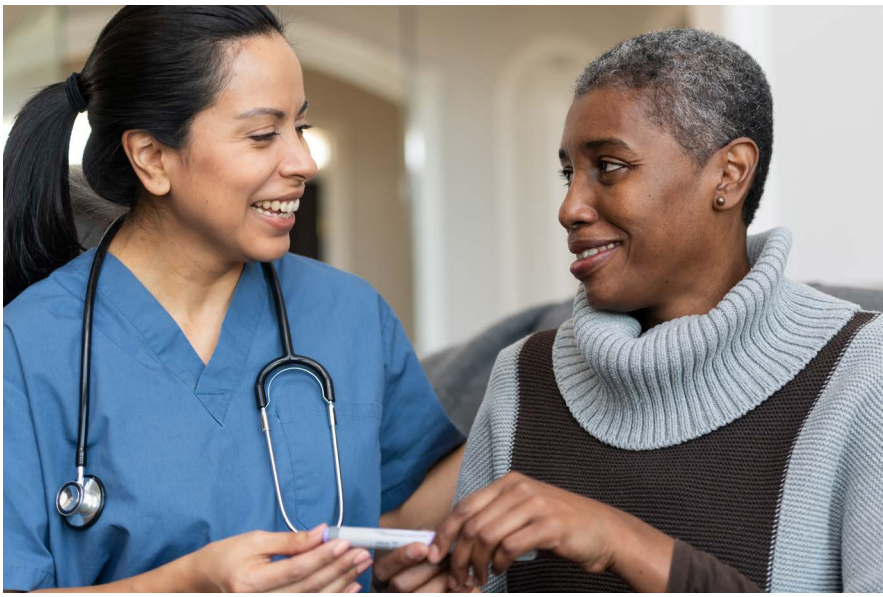
- **Coordinate efforts.** By involving a wide range of partners from across multiple disciplines, an extension program can help coordinate across primary care QI efforts throughout the state. Without such coordination, QI initiatives can end up duplicating efforts and limiting their impact. The cooperative also helps to simplify practice engagement in QI initiatives. Instead of practices being approached by multiple organizations about various initiatives, the cooperative can centralize practice engagement. This may also make it possible for practices to work with the same facilitator across efforts.
    - For example, a heart health improvement initiative pursued independently by the state Medicaid agency and a private payer might end up requiring practices to focus on different quality metrics for different patients within the same practice. Instead, a multiorganizational extension program could engage both payers during project development and work to align quality outcome measures, making practice-level participation simpler.



- **Increase impact.** By aligning primary care QI efforts across a state, an extension program can maximize the potential impact. Aligning efforts increases the resources available for practice-level QI support, thereby making those resources available for more practices.
  - » For example, multiple organizations might provide practice facilitation services to practices. Instead, coordinating the provision of these services through the extension program helps prevent overlap and ensures that the largest number of practices can benefit from these services.

- **Promote broad and equitable inclusion of practices.** By engaging large healthcare systems, networks of practices, and independent practices, extension programs can ensure that QI efforts reach primary care practices serving the widest variety of communities and patients within a state.
  - » For example, by working across health systems, federally qualified health centers (FQHCs), and independent practices, the extension program can target areas with the most pressing health disparities or highest need, such as urban and rural areas.

- **Increase sustainability.** Building an extension program that includes payers (including Medicaid and insurance companies) aligns policy and payment with QI goals, thereby increasing the sustainability of these efforts. Including state agencies (such as departments of public health and mental health and state Medicaid agencies) ensures that extension programs focus on the state's needs as state policymakers have identified them while coordinating across services that state agencies have provided outside of the primary care setting.
  - » For example, payment changes could support primary care provision of behavioral or mental health services. Engagement with state policymakers would ensure that those services are coordinated with existing community-based services and are targeted to the areas of greatest need within the state (such as treatment for substance use disorders).



2. Developing and Running a State-Based Extension Program To Support QI in Primary Care

Bringing together a wide range of partners to support primary care quality improvement (QI) can help increase capacity and expertise, reduce duplicative efforts, reach a broader and more diverse set of practices, and help sustain QI efforts over time. Additionally, the inclusion of trusted organizations increases the credibility of the effort—for the practices you are aiming to recruit, for potential funders, and for outside observers.
This chapter describes key steps for effectively establishing a state-based healthcare extension program to support QI in primary care, drawing on the experiences of AHRQ initiatives and lessons learned from them.

CONDUCT LANDSCAPE REVIEW AND NEEDS ASSESSMENT

Before developing a healthcare extension program, it is useful to conduct a thorough landscape review and needs assessment to understand existing capacity and needs in the state. A landscape review will help you to assess the state's current QI activities, identify related ongoing QI efforts and opportunities to coordinate with these efforts, and identify potential partners for your work. A needs assessment will help ensure the program fills an existing gap and that its services and offerings address the specific needs of primary care practices in your state (or sub-state region of focus). An effective landscape review and needs assessment will include web-based searches and review of relevant publications, as well as meetings with interested parties within your state (e.g., state Medicaid agency, the state department of health, primary care clinicians, and primary care professional organizations) for on-the-ground insights.

Understand Your State's QI Experience and Existing Capacity

A good first step for your landscape review is to collect information about past and current state and regional QI projects and other health-specific initiatives and the groups responsible for those efforts. It is helpful to identify successful programs, existing barriers to implementation, any clear gaps that need to be addressed, and any already developed infrastructure (e.g., trained practice facilitators) or primary care QI capacity, before determining what you need to develop.

For example, consider the extent to which practices in your state have participated in the following (see Table 7 in chapter 5, for additional examples):

- Alternative payment models and value-based care models that support QI:
  - » The Centers for Medicare & Medicaid Services' Shared Savings Program Accountable Care Organizations (ACOs) and its Innovation Center's innovation models, such as the Transforming Clinical Practice Initiative, Comprehensive Primary Care initiative(CPC), Comprehensive Primary Care Plus (CPC+), and Primary Care First
  - » State Medicaid programs and Medicaid managed care plan value-based care models

- Federal QI grant initiatives:
  - » AHRQ's IMPaCT and EvidenceNOW
  - » The Health Resources and Services Administration's National Training and Technical Assistance Partners and Small Health Care Provider Quality Improvement Program for rural health
- Health topic–specific QI initiatives such as Million Hearts®, Cancer Moonshot℠, Ending the HIV Epidemic, National Hypertension Control Initiative, and National Diabetes Prevention Program
- QI initiatives through the state department of health, the state Medicaid agency, and Medicaid managed care plans
- QI initiatives led by private health plans, health systems, primary care associations, and primary care professional associations
- Quality Innovation Network–Quality Improvement Organizations (QIN-QIOs) improvement interventions
- Health information technology efforts that support QI through Regional Extension Centers and Health Center Control Networks

To help states evaluate their alignment with federal primary care initiatives, the Virginia Center for Health Innovation and Milbank Memorial Fund have developed a Primary Care State-Federal Alignment Tool, which can be found here.

Once you have the full picture of the current QI- and primary care–focused efforts in your state, you can determine the areas of greatest need for new or more coordinated efforts. It might also be helpful at this stage to consider whether it makes more sense to start a new program or expand an existing program.

Understand the Needs and Interests of Primary Care Practices

A needs assessment can be helpful to understand the QI capacity of practices in your state and to understand the needs, interests, and priorities of practices to help determine the focus of your QI projects. Such an assessment could result in focusing your efforts, at least initially, on a particular disease or other content area (e.g., improving heart health or equity), on certain types of practices (e.g., rural, or small independent practices), or on specific areas of practice improvement (e.g., using electronic health records for QI).

To gather these types of insights at the outset, it can be helpful to consult with leaders from the state primary care association and state and local chapters of primary care professional associations (e.g., the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Physician Associates, and the American Association of Nurse Practitioners). In addition, practice-based research networks (PBRNs) work directly with primary care practices and likely have a good sense of their needs and priorities. It can be helpful to reach out to the PBRN(s) in your state or sub-state region to gather its perspective. Attending conferences or other meetings where primary care clinicians in your state gather is also a good way to learn about current concerns from the clinician perspective. You might also want to review other resources such as the primary care score card for your state developed by the Robert Graham Center, to review trends in key primary care indicators to identify areas of strength and those in need of improvement.

Once practices have been recruited to participate in your extension program, you can conduct needs assessment surveys to better understand how to tailor your QI services to best meet their interests and needs. Read more about needs assessment surveys in Select and Tailor QI Services in chapter 4.

DEVELOP A MISSION STATEMENT

Drafting a mission statement/statement of purpose and a vision statement is a key step in strategic development. The program's mission statement is likely to evolve over time and with the inclusion of the various perspectives of partners. The revised version can become part of your project charter or bylaws (see the Project Charter and Bylaws section below). However, drafting an initial mission statement at the outset can help clarify and communicate your program's key goals and objectives. As an example, the Tennessee Population Health Consortium (a broad group of statewide QI initiatives of which Tennessee Heart Health Network is a part) developed the tagline, mission statement, and vision statement shown in the box below.[11]

Tennessee Population Health Consortium

Tagline: Reimagining Primary and Preventive Care for a Healthier Tennessee
Mission Statement: To encourage adoption of evidence-based practices, transform primary and preventive care, and measurably improve health outcomes, quality of life, and health equity for the people of Tennessee
Vision Statement: An effective health system that invests strategically in primary and preventive care to measurably improve population health and health equity in Tennessee

INVITE PARTNERS TO PARTICIPATE

Including a diverse set of organizations in your extension program helps to bring in the varied expertise, skills, and perspectives—as well as the credibility, capacity, and connections—necessary to carry out an effective statewide QI support effort. For the success of the program, it is also important to identify and invite partners with values that align with your mission/purpose for the extension program. It can also be useful to consider whether there are any organizations or people in the state who might be opposed to your program's goals or (perhaps more likely) might see your program as competition for limited resources and the attention of primary care practices. Inviting these groups to partner with your extension program can be an effective strategy to reduce opposition, as long as you are able to align the mission and objectives of the two organizations.[10]

Identify Needed Expertise

Depending on the expertise and skills of the lead organization and initial partners, you might need to identify additional organizations and people to help meet the specific goals of your extension program. Relying on organizations based within your state to fill these roles is ideal, but it could be necessary to seek out regional (or even national) partners to fully cover one or more of these needs—at least while you work to build expertise and capacity inside your state.

The EvidenceNOW cooperatives included partners with the necessary knowledge, expertise, or skills in the following areas:[b]

- **Clinical evidence.** EvidenceNOW: Building State Capacity cooperatives included organizations with knowledge and resources on the latest clinical evidence related to heart health in primary care. For example, the cooperatives included the following types of organizations:
  - » Universities and university systems including schools of medicine, Clinical and Translation Science Awards recipients, academic health systems (e.g., MetroHealth), and a college of pharmacy (Auburn University School of Pharmacy in Alabama Cardiovascular Cooperative)
  - » Professional associations including state-based associations for physicians such as family physicians and internists; professional associations of nurses, nurse practitioners, physician assistants, pharmacists, and dieticians; and primary care associations
  - » Disease-specific associations such as the American Heart Association

[b] The EvidenceNOW: Building State Capacity cooperatives also considered the primary care practices involved in their QI projects and networks to be cooperative partners. However, because practices had a unique role in this work, as well as a unique set of needs for recruitment and retention in the cooperative, we discuss engaging practices in the next chapter (3. Building and Maintaining a Network of Primary Care Practices) rather than here.

- **QI support.** The EvidenceNOW: Advancing Heart Health cooperatives found that partnering with multiple organizations to supply practice facilitators in their region of focus provided access to a workforce that was larger and better distributed than what they would have gotten by hiring their own practice facilitators or partnering with one organization.[12] In addition, relying on more than one organization for practice facilitators protects your program if one of those organizations closes. Organizations that might employ practice facilitators include QIN-QIOs, PBRNs, Regional Extension Centers, university-based clinical and translational science centers, Area Health Education Centers (AHECs), and state offices of rural health.

- **Practice recruitment.** It can be helpful to partner with organizations that have credibility and established relationships with the types of practices you want to recruit to participate in your program. The partners that helped the EvidenceNOW cooperatives with recruitment included organizations with expertise in QI, healthcare organizations (including health systems), PBRNs, professional associations, and universities.

- **Geographic reach.** Partnerships are critical to reaching and providing support to practices across an entire state. Land-grant universities have agricultural extension programs that are already engaged in health-related activities and can help with geographic reach across a state. The EvidenceNOW: Building State Capacity cooperatives engaged a wide variety of partners to ensure broad geographic reach. For example:

  - The University of Alabama at Birmingham developed a new partnership with the Auburn University School of Pharmacy to expand the reach of its cooperative.
  - The Heart Healthy Ohio Initiative worked with three regional health improvement collaboratives to ensure broad practice recruitment.
  - The University of Tennessee Health Science Center, which led the Tennessee Heart Health Network, has four campuses spanning the state and is part of a larger land-grant university system that has a robust regional extension service. By partnering with the extension service, the Tennessee Heart Health Network expanded support for primary care delivery of population health services to every rural county in Tennessee.

> **The Heart Healthy Ohio Initiative partnered with CVS Pharmacy as a nontraditional provider of primary care that has a significant reach and impact on health throughout the state.**

- **Equity.** To be more equitable, the EvidenceNOW: Building State Capacity cooperatives partnered with organizations serving traditionally excluded and underserved groups, such as people who are uninsured or underinsured, people who live in rural areas, and people from racial or ethnic minorities such as African American and Native American populations. For example:

  - Alabama Cardiovascular Cooperative partnered with the Alabama Primary Health Care Association to recruit federally qualified health centers throughout the state. Community health centers provide low-cost care to people who are underserved.

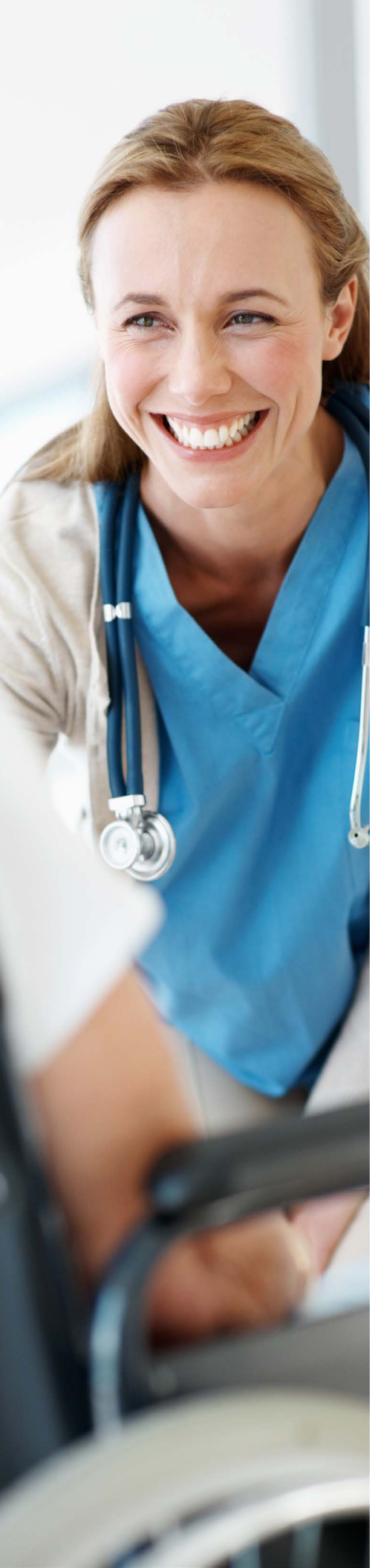
  - » Healthy Hearts for Michigan focused on reaching rural practices and brought in the Michigan Center for Rural Health to help adapt the QI project and services for a rural setting. Michigan also targeted recruitment activities to practices that serve Native American communities.
  - » The Tennessee Heart Health Network focused on practices serving African American communities in the western region and rural Appalachian communities in the eastern region of the state.

- **Patient perspective.** When patients and other people with lived experience are included in the planning and growth of an extension program, their experiences and needs can best be reflected in the program's approach and activities. For example:
  - » The Tennessee Heart Health Network created patient advisory councils to help inform its work. Members of these councils served as patient experts, adding the patient's voice and perspective at every stage of the practice improvement process.

- **Data collection and reporting.** EvidenceNOW: Building State Capacity cooperatives engaged partners such as state health information exchanges to help collect practice data and create data dashboards to inform practices' QI activities. For example:
  - » Alabama Cardiovascular Cooperative worked with the state health information exchange and a vendor that collected data and provided dashboards for practices.
  - » Healthy Hearts for Michigan partnered with the Health Information Technology Regional Extension Center for Michigan.
  - » The Tennessee Heart Health Network was closely aligned with the Tennessee Population Health Data Network in its collection and reporting of QI data.

- **Program evaluation and research capacity.** Academic partners provide expertise in both qualitative and quantitative methods to assess the implementation and impact of the QI projects. For example:
  - » Healthy Hearts for Michigan relied on its academic partners, Northwestern University and the University of Michigan, to share knowledge with community-based partners (e.g., Quality Improvement Organizations, professional associations) on topics such as human subjects research, institutional review boards, obtaining informed consent, research fidelity, and dissemination.

- **Coordination and sustainability.** State government (including state departments of health, social services, aging, and mental health) and payers (e.g., Medicaid, commercial health plans) can help establish statewide QI goals, eliminate duplicative efforts, and align QI efforts with payment and policy (e.g., harmonizing formulary access for QI projects with a focus on blood pressure medications). These partners can help sustain efforts after initial grant funding ends by maintaining the network of practices and providing ongoing funding for external QI support.



Engage Partners

Once you have identified which partners you want to include, you can begin reaching out to pitch your extension program. These meetings can be used to share your vision, why you believe the organization or person would be a good partner, and what participation might entail (roles, time commitments, etc.). In addition to sharing your mission statement, consider also developing a value proposition to make your case to potential partners about how involvement in your healthcare extension program could benefit them (see more in Develop a Value Proposition in chapter 3).

Through discussion, you will be able to gain a more complete understanding of the specific skills and assets the partner would bring to your program and assess their interest level and their willingness to participate. Fully understanding the interests and strengths of each partner will help you assign roles within the program that will best capitalize on the varied skills, knowledge, credibility, energy, and dedication that each partner brings. For example, the Heart Healthy Ohio Initiative team developed a survey for potential payer partners to assess their willingness to participate in program activities and collect additional information about the heart health–related coverage the payers provided their members.
In addition to figuring out which organizations to invite to participate to fill the needs of your extension program, you will also want to consider what type of role each partner organization will play. For example:

- Some key organizations will have a role in leadership and decision making (e.g., sitting on an executive council).
- Some will be involved in the day-to-day activities of running the extension program and carrying out the QI work, even sharing staff or funding.
- Other organizations will play a more advisory, ad hoc, or peripheral role. Your extension program might want to designate terms, such as “member” or “key partner,” to differentiate the organizations with a more significant or integral role from the other organizations playing a less central or more informal role. The EvidenceNOW: Building State Capacity cooperatives each included a large group of partners that came together to support and advise the overall effort, as well as a smaller core group that participated in the regular activities of the cooperative (such as in working groups).

Your extension program might want to designate terms, such as “member” or “key partner,” to differentiate the organizations with a more significant or integral role from the other organizations playing a less central or more informal role. The EvidenceNOW: Building State Capacity cooperatives each included a large group of partners that came together to support and advise the overall effort, as well as a smaller core group that participated in the regular activities of the cooperative (such as in working groups).

Once a partner has agreed to participate in your program, it can be helpful to develop and have both parties sign a Scope of Work, Letter of Agreement, or Memorandum of Understanding. Having such an agreement in place can help prevent misunderstandings related to roles and levels of involvement and ensure continuity even if there is staff turnover and the original members leave the organization. For partners that share funding, Subcontracting Agreements might be required.

DEVELOP AN ORGANIZATIONAL AND GOVERNANCE STRUCTURE

Organizing Framework

Using a framework to guide the development of your extension program can provide an organizing principle to help achieve your goals. As an example, Teresa Hogue's Community Based Collaboration: *Community Wellness Multiplied*[13] (Table 2) provides a framework for community-based initiatives showing the range of linkages, from loosely organized networks to collaborations with a shared vision.

EvidenceNOW: Building State Capacity grantees used frameworks to guide the development of their cooperatives.

- Alabama Cardiovascular Cooperative used the **Community-Academic Partnerships framework**,[14] which aims to promote and advance equal partnership between academic researchers and interested community organizations in creating and executing implementation research. This framework offers guidance on "(a) building a coalition, (b) conducting local consensus discussions, (c) identifying barriers and facilitators to implementation, (d) facilitating interactive problem solving, (e) using an advisory board or workgroup, (f) tailoring strategies, (g) promoting adaptability, and (h) auditing and providing feedback."[14]
- Healthy Hearts for Michigan used the **EPIS framework** to assess the facilitators of and barriers at each of four stages of cooperative development (Exploration, Preparation, Implementation, and Sustainment).[15]
- Heart Healthy Ohio Initiative used the **Collective Impact Model**. The model posits that "complex problems require collaborative and synchronized approaches involving leaders from community partners representing diverse backgrounds and perspectives."[16] The Initiative applied this model in a co-design process to engage a diverse set of partners in collaborative development of an external QI infrastructure (see more about the Collective Impact Forum's model on its website and in this article).

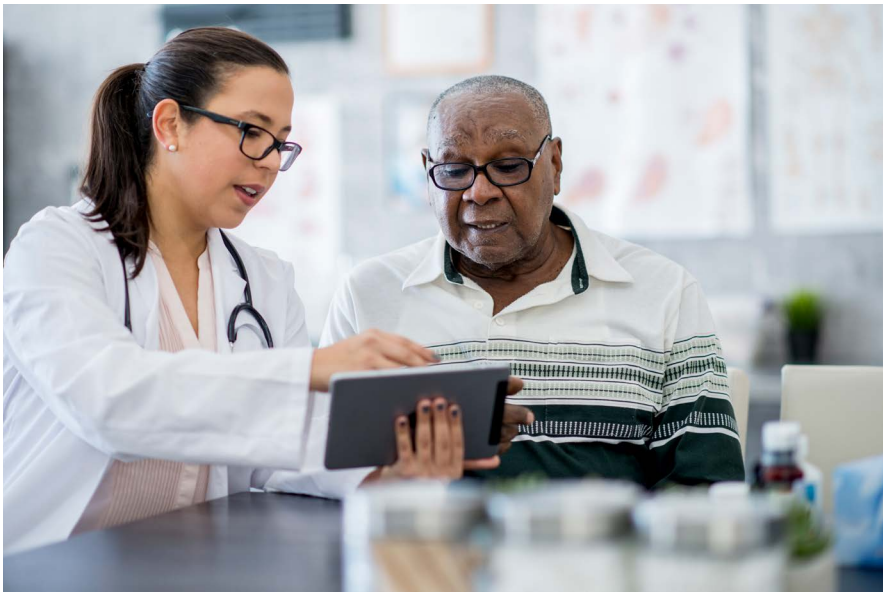


Table 2. The Range of Linkages for Community-Based Initiatives

Level	Purpose	Structure	Process
Networking	• Dialogue and common understanding • Clearinghouse for information • Create base of support	• Nonhierarchical • Loose/flexible links • Roles loosely defined • Communication is primary link among members	• Low-key leadership • Minimal decision making • Little conflict • Informal communication
Cooperation or Alliance	• Match needs and provide coordination • Limit duplication of services • Ensure tasks are done	• Central body of people as communication hub • Semiformal links • Roles somewhat defined • Links are advisory • Little or no new financial resources	• Facilitative leaders • Complex decision making • Some conflict • Formal communication within central group
Coordination or Partnership	• Share resources to address common issues • Merge resource base to create something new	• Central body of people consists of decisionmakers • Roles defined • Links formalized • Group leverages/raises money	• Autonomous leadership but focus is on issue • Group decision making in central and subgroups • Communication is frequent and clear
Coalition	• Share ideas and be willing to pull resources from existing systems • Develop commitment for a minimum of 3 years	• All members involved in decision making • Roles and time defined • Links formal, with written agreement • Group develops new resources and joint budget	• Shared leadership • Decision making is formal with all members • Communication is common and prioritized
Collaboration	• Accomplish shared vision and impact benchmarks • Build interdependent system to address issues and opportunities	• Consensus used in shared decision making • Roles, times, and evaluation formalized • Links are formal and written in work assignments • Resources and joint budgets are developed	• Leaderships is high, trust level is high, productivity is high • Ideas and decisions are equally shared • Highly developed communication systems

Lead Organization

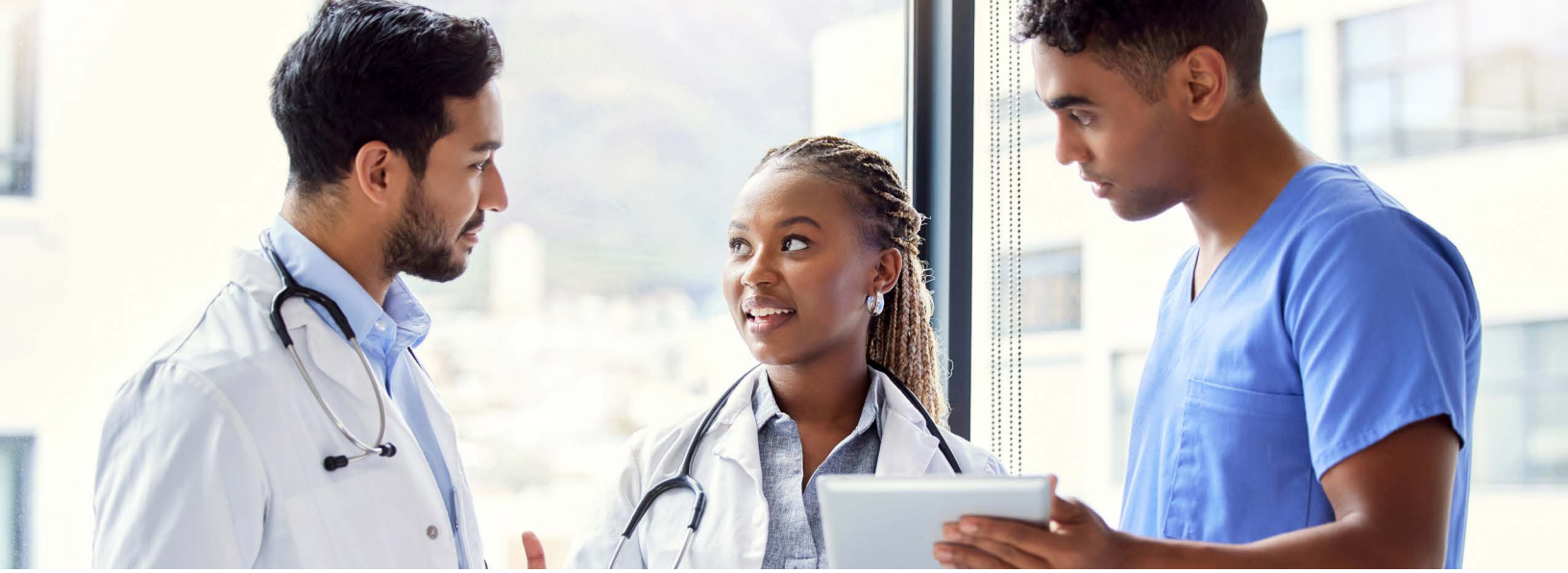
The organization that leads an extension program generally assumes significant responsibility for the administrative operations of the group, including securing funding and overseeing finances, convening meetings, and organizing communications across partners. However, depending on the organizational and governance structures that are set up, the lead organization might or might not share decision-making authority with other partners (see the section on Leadership and Governance Structure below for additional discussion of decision-making authority in an extension program).

Different types of organizations can effectively lead a healthcare extension program. For example, a healthcare extension program could be led by a QI organization, a payer (including Medicaid), a university, or even a state government agency. What organization is best suited to lead the extension program depends on historical leadership roles in the state and trust in the convening organization across partners.[7] Academic institutions have commonly served as the lead organization for AHRQ-funded cooperatives in large part because they were funded as research grants or cooperative agreements, and academic institutions have the infrastructure to apply for and manage large federal research grants. For example, universities led three of the four EvidenceNOW: Building State Capacity cooperatives. Universities also have expertise on clinical health topics and on the latest evidence for clinical practice. However, other types of lead organizations have different potential benefits. For example, an effort led by state government might be able to mandate support from payers in the state or provide dedicated funding over time.

Leadership and Governance Structure

As described in Building a Collaborative Governance Framework: A Five Step Process, the complexity and formality that are required for a group's governance framework increase in proportion to the size of the group and the nature of the relationships in the group. "For example, large groups with unfamiliar participants, significant conflict, or great differences in participants' power may require a more structured governance framework. By contrast, groups with strong prior relationships, low conflict, and group members with balanced power may have less need for structure."[17]

Primary care extension programs typically have a governing group or committee with responsibility for guiding overall activities and direction. Among the EvidenceNOW: Building State Capacity cooperatives, this group was variously known as a Steering Committee, Executive Committee, or Executive Council and typically included a chair, who might or might not have come from the lead organization. In some cases, this group was large and included representatives from across partner organizations; in other cases, the group was very small and included only representatives from the lead organization and members from one or two other primary partner organizations.Primary care extension programs typically have a governing group or committee with responsibility for guiding overall activities and direction. Among the EvidenceNOW: Building State Capacity cooperatives, this group was variously known as a Steering Committee, Executive Committee, or Executive Council and typically included a chair, who might or might not have come from the lead organization. In some cases, this group was large and included representatives from across partner organizations; in other cases, the group was very small and included only representatives from the lead organization and members from one or two other primary partner organizations.



The EvidenceNOW: Building State Capacity cooperatives each employed a "hub-and-spoke" model, with a central group or committee (e.g., an Executive Committee) that provided leadership (the "hub") and working groups dedicated to implementing the various components of the project (the "spokes").

- **Alabama Cardiovascular Cooperative** was governed by an Executive Committee that included representatives from the lead organization and three core partners. The Executive Committee had decision-making authority and used consensus to ensure members retained equal influence over group direction and activities. An advisory board, with representatives from diverse sectors throughout the state, provided guidance and recommendations to the Executive Committee.
- **Healthy Hearts for Michigan** had a Steering Committee that met twice a year and was responsible for broad oversight of the cooperative's activities. The Steering Committee included the two project principal investigators (PIs), representatives from member partners, and the leads from each working group. The PI from the lead organization headed the Steering Committee and maintained decision-making authority. A Physician Advisory Committee included physicians from across partner organizations and provided clinical guidance. A project management team made up of a small group from the two lead organizations managed day-to-day operations.
- **Heart Healthy Ohio Initiative** had an Executive Team with 10 members representing the lead organization and five other key partner organizations. An informal voting and feedback structure was in place to share input from partners to help inform the Executive Team's decisions.
- **Tennessee Heart Health Network** had an Executive Council with representatives from all key partners. The Executive Council had an elected chair and 12 members that the partners selected. Other representatives of member organizations attended and participated in an ex-officio role. The Council met three or four times per year; provided strategic oversight, guidance, and support to the cooperative; and had ultimate decision-making authority. An Operations Team oversaw daily activities and made most day-to-day programmatic decisions.

Working Groups

Extension programs typically form working groups to carry out specific activities. Because the working groups often meet independently to accomplish their key activities, it can be helpful to also hold regular meetings of the working group leads to promote cross-team engagement and alignment.

Partners are likely to commit to differing levels of effort on the working groups, based on their role in the program and their other commitments. Generally, partner representatives will be expected to spend only limited time on program activities, unless they receive funding for their involvement or the program's efforts closely align with the partner organization's mission. The Collective Impact Forum has an online toolkit to help working groups get started, including an Action Planning Template.

Though the specific names, activities, and staffing of the working groups varied across the EvidenceNOW: Building State Capacity cooperatives, each included groups focused on QI implementation and evaluation. Some of the cooperatives also used working groups to cover administrative activities, partner engagement, practice recruitment and retention, dissemination, marketing and communications, and sustainability. Table 3 describes selected working groups from across the EvidenceNOW: Building State Capacity cooperatives.

Table 3. Selected Working Group Names and Functions Across Cooperatives

Alabama Cardiovascular Cooperative	
Engagement Core	Oversaw recruitment and engagement of primary care practices.
Implementation Core	Oversaw practice facilitation and QI support. This core was co-led by representatives from the partner organizations that employed the practice facilitators working with practices.
Healthy Hearts for Michigan	
Intervention Design and Implementation Workgroup	Responsible for designing the implementation model and evidence-based cardiovascular care activities for the QI project. It included subject matter experts on hypertension and tobacco cessation from partner organizations.
Practice Facilitation Community	Oversaw the development of the practice facilitator training and materials.
Heart Healthy Ohio Initiative	
Stakeholder Engagement Team	Served in an advisory capacity to engage key partners including payers, professional organizations, state governmental agencies, and patient and family representatives.
Co-Design Team	Responsible for engaging in co-design of the active QI project with practices in a way that was both practical and feasible for later implementation.
Marketing and Communications Team	Led the implementation of the project website, podcast, and social media activities.
Dissemination, Engagement, and Sustainability Team	Developed, implemented, and tracked dissemination activities.
External Support Infrastructure Team	Leveraged support from the seven medical schools in Ohio and the three regional health improvement collaboratives to sustain the cooperative.
Tennessee Heart Health Network	
Practice Facilitation Team	Supported practice facilitation by working with practices to examine data, move quality measures forward, and develop learning collaboratives.
Tracking, Reporting, and Evaluation Team	Supported QI data reporting and qualitative data collection and analysis; obtained and maintained Institutional Review Board requirements.

QI = quality improvement

Staffing

Staffing structures vary across extension programs, but generally include one or more project leaders, a project coordinator or program manager to oversee administrative and other project activities, several staff to lead the working groups (as described above), and practice facilitators to support QI in the field. Sometimes the program manager position is full-time.

Different possible staffing models exist for practice facilitators, as described in chapter 5 of AHRQ's Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide. Models include hiring facilitators as program employees, contracting with other organizations to provide facilitators, or relying on volunteers or practice staff to serve as facilitators. Primary Care Extension programs have often used a mixed approach for staffing, and then adjusted over time as the program matures and staffing needs change.[18] Among the EvidenceNOW: Building State Capacity cooperatives, the number of practice facilitators ranged from 4 full-time facilitators working with Alabama Cardiovascular Cooperative to 10 part-time practice facilitators engaged by Healthy Hearts for Michigan. Two of the cooperatives appointed lead practice facilitators to coordinate and oversee the work of the practice facilitators.

Career advancements and funding changes often mean that staff cannot continue to contribute to the project at the same level for multiple years—particularly staff working for academic partners. To minimize the loss of project knowledge and momentum when staff change, the program can develop staffing plans and conduct regular succession planning and cross-training.

FORM THE EXTENSION PROGRAM

A systematic review found that facilitative factors for establishing multiorganization partnerships include trust and respect between partners; a shared vision, goals, and/or mission; effective communication; and well-structured meetings. Challenges include excessive time commitments; funding pressures or control struggles; and unclear roles or functions of partners.[19] In their progress reports, annual reports, and other interactions with AHRQ, the EvidenceNOW: Building State Capacity cooperatives agreed that developing a cohesive group of partners working toward shared goals from a common understanding typically took more than 12 months.

In this section we describe steps you can take to bring together your partners and help establish and maintain a cohesive and well-aligned extension program.

Meetings and Other Activities

Engaging in early (and ongoing) relationship building and communication efforts can help build trust and collaboration among partners. Meetings, both in-person and virtual, are a primary way to bring partners together, develop relationships, and build common understanding and group identity.

Initial Launch Meeting(s)

The initial launch meeting (also known as a kickoff meeting) is an opportunity for representatives from partner organizations to meet one another, discuss and clarify roles, coalesce on the goals of the program, and strategize about future activities and next steps. During the initial launch meeting the lead organization reviews the primary purpose and goals of the extension program, describes any structures that are already in place or are nonnegotiable, and has a plan or clear proposal for how any remaining big decisions will be made (e.g., by majority or consensus).

Having a successful and productive first meeting can help set the tone for the rest of the work and generate excitement and forward momentum. Aiming to have a productive first meeting, Alabama Cardiovascular Cooperative planned to start its project with a day-long kickoff retreat, conducted by a facilitator experienced in coalition building. Because of COVID-19 precautions, the in-person retreat was replaced with a series of virtual meetings with the same goals; it resulted in the development of program procedures and governing documents.

Co-creating an agenda with the meeting participants, or at least sharing it in advance and asking for input, is a good way to build team investment in a successful meeting. It is important to plan for adequate time during the meeting for in-depth discussions and to allow participants to get to know one another. Often, the most valuable results of these meetings are the relationships and ideas generated from discussion among the participants. It is also useful to have a notetaker who can share key takeaways and action items after the meeting with all participants.

In addition to an initial program-wide launch meeting, each working group can hold a launch meeting to build rapport, establish specific goals, clarify participants' roles and responsibilities, and determine action items.

Standing Meetings

After the initial launch meeting, the extension program can collectively decide how frequently to come together for program-wide meetings (e.g., quarterly or biannually) and who will participate (e.g., some meetings include all partners and others include only key partners). For example, Alabama Cardiovascular Cooperative maintained two monthly all-member meetings for program-wide status updates and decision making and hosted an annual all-member, in-person retreat. Healthy Hearts for Michigan held all-hands meetings twice a year for partners to share updates.

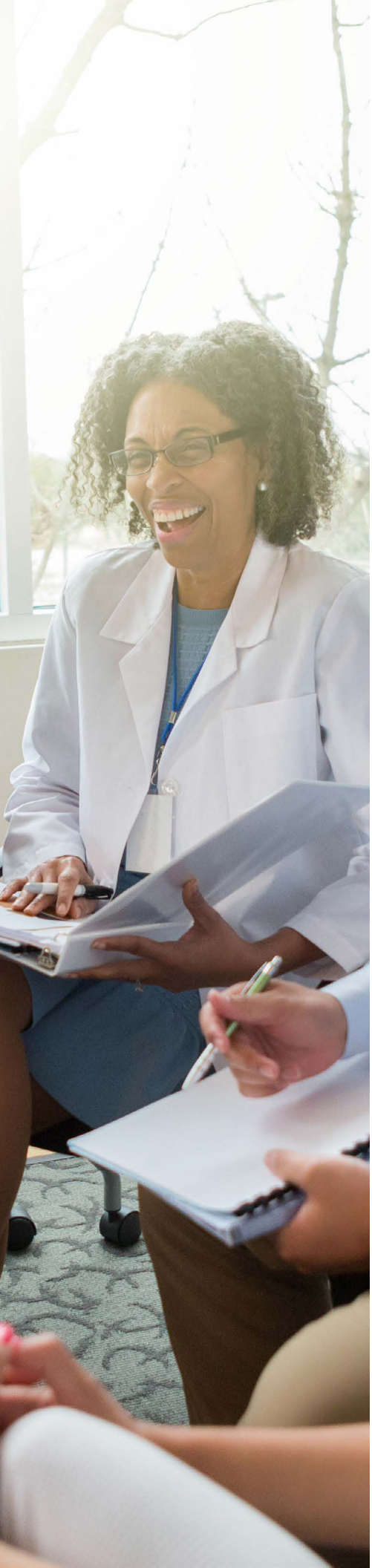
Tips for Program Meetings

The tips below summarize feedback Alabama Cardiovascular Cooperative and Heart Healthy Ohio Initiative received from partners about how program meetings could be improved:

- Invite only participants who have a role that is relevant to the meeting's purpose or will benefit from hearing the discussion.
- Develop agendas with goals that clearly align with the cooperative's aims.
- Share the agenda with participants a few days in advance of meeting; in the agenda, clearly identify expected participant contributions.
- Encourage active participation and discussion during meetings.
- Assign tasks to be worked on between meetings.
- When possible, make clear and final decisions during meetings, and recap decisions at the end of the meeting.
    - » When a decision cannot be reached during a meeting, plan to collect information and hold additional conversations between meetings, and then bring proposed solutions to the following meeting.
- Send out meeting summaries and action items to participants after each meeting.
- Ask for partner feedback after every few meetings, and revise the approach as needed.

Other Communication Activities

In addition to holding regular program-wide and working group meetings, it can be useful to develop newsletters, listservs, websites (particularly with member-only sections), and dedicated social media groups to support information sharing. For example, Healthy Hearts for Michigan developed a monthly e-newsletter for partners (see an example here), held regular Lunch & Learn meetings to share information with partners on relevant topics of interest (see a recorded example here), and emailed a weekly update to a core group of partners to relay noteworthy items (such as practice recruitment progress) and list upcoming meetings and events.



Develop a Project Charter and Bylaws

Once key partners have been engaged and the organizational and governance structures for the program established, it can be useful to develop a project charter and bylaws.

A **charter** sets a common understanding of the program, what it intends to do, who is involved, and how it intends to work. For the charter to be effective, partners will review and agree on the initial charter, and then revise it periodically. As an example, the Heart Healthy Ohio Initiative leadership developed its charter by building on the charter of the Ohio Cardiovascular and Diabetes Health Collaborative (another QI initiative in the state with some of the same leadership and a similar mission), and then sharing it with partners for review, feedback, and approval.

Extension programs might want to develop charters both for the overall group and for working groups, to help achieve explicit alignment and agreement across members. For example, each of the working groups in Healthy Hearts for Michigan established a charter, to be updated as needed throughout the project. (See the charter for its Outreach and Engagement Workgroup, as well as a template the cooperative developed to help create workgroup charters.)

Bylaws are akin to a detailed operating manual for your program:

> "Bylaws are the written rules that control the internal affairs of an organization. Bylaws generally define things like the group's official name, purpose, requirements for membership, officers' titles and responsibilities, how offices are to be assigned, how meetings will be conducted, and how often meetings will be held. Bylaws also govern the way the group agrees to function, as well as the roles and responsibilities of its officers. They are essential in helping an organization map out its purpose and the practical day-to-day details of how it will go about its business."[20]

See the bylaws of the Tennessee Population Health Consortium for an example.)

ASSESS PARTNER ENGAGEMENT

Developing strong partnerships is key to an effective extension program, so it is a good idea to regularly ask partners for feedback and solicit suggestions for improvement. Each of the EvidenceNOW: Building State Capacity cooperatives conducted regular surveys with its members (as an example, see Alabama Cardiovascular Cooperative's Heart Health Improvement Project survey).

In addition to conducting a partner survey, Healthy Hearts for Michigan conducted interviews with a subset of partners as part of its first assessment (see the interview protocol). Alabama Cardiovascular Cooperative gained insights from a survey it conducted with partners in the first year that provided valuable direction for future improvements. For example, these initial insights included that partners did "not feel [their] roles are fully articulated or understood; that power is shared equally among members; nor that Cooperative meetings are as productive as they could be."[21] (See Alabama Cardiovascular Cooperative's Members' Survey report for more details.)

3. Building and Maintaining a Network of Primary Care Practices

In addition to developing a multiorganizational cooperative, the EvidenceNOW: Building State Capacity grantees were each tasked with building a statewide network of primary care practices interested in receiving resources for ongoing quality improvement (QI) support. The goals for developing the statewide networks of practices included building QI capacity for primary care practices across the state; sustaining QI support beyond any one initiative; and maintaining a group of engaged practices that could be recruited to participate in specific QI projects over time—depending on practice capacity, needs, and interests. In this chapter of the guide, we discuss developing a statewide network of practices and describe strategies for practice recruitment, engagement, and retention.

PLAN A STATEWIDE NETWORK OF PRACTICES

As was the case for the EvidenceNOW: Building State Capacity cooperatives, timeline and funding requirements can lead primary care extension programs to first recruit practices for a specific QI project and then develop a network of practices for ongoing QI work, rather than the other way around as was intended. However, it is important to have a plan for how to develop and maintain a broad and ongoing network of practices from the outset.

The first step in planning a statewide network of practices for QI includes deciding which kinds of practices will be included. For example, depending on the goals for your extension program and the identified QI needs in your state, you might choose to target specific types of practices (e.g., small and medium-sized practices, independent practices, or health system–affiliated practices), practices that serve a particular population (e.g., medically underserved or rural populations), or practices without much previous QI experience. For example, Alabama Cardiovascular Cooperative focused primarily on engaging federally qualified health centers (FQHCs). Alternatively, you might want to recruit a large and diverse group of primary care practices to build a broad coalition throughout the state focused on QI in primary care. For example, the Tennessee Heart Health Network recruited a mix of independent and health system practices, academic health centers, and FQHCs.

Another consideration is whether to start the network of practices in a particular part of the state and then expand it over time, or else develop and maintain multiple hubs throughout the state from the outset. These decisions will likely depend on the size of your state and the existing QI infrastructure. For example, if primary care practices and practice facilitators are primarily located in one key city, it could make the most sense to start in that city and then expand to other regions over time. Alternatively, if there is existing infrastructure throughout the state, a more distributed model could work well from the outset. For example, Healthy Hearts for Michigan partnered with three regionally based QI organizations to focus on reaching rural practices. Practice facilitators were assigned to work with practices near their homes to minimize the distance they would need to travel for their regular in-person visits.

RECRUIT PRACTICES

Recruiting primary care practices to participate in a broad network or QI project can be a challenge. Clinicians and practice staff report being hesitant to sign on to new things because of heavy workloads, staffing shortages, and competing priorities including participation in other initiatives—both voluntary and mandatory. One review of the experience of recruiting practices for the EvidenceNOW: Advancing Heart Health initiative found that recruiting practices to participate in a healthcare extension program can be time-consuming and labor-intensive, and cooperatives would be well advised to plan their budget and timeline accordingly.[22] Another analysis by one of the EvidenceNOW: Advancing Heart Health cooperatives found that practice recruitment was facilitated by an alignment with practice priorities, using incentives, and building on prior relationships and that retention requires ongoing and close communication.[23] Recruitment strategies that focus on entities with multiple practices, such as health systems and health center networks, can also be an effective way to optimize recruitment efforts.

Many of the recruitment strategies described in this section can be used both for active QI projects and for building a larger network of practices interested in QI—although the focus and intensity of the recruitment activities can vary depending on your specific goals. In the sections below, we draw on the practice recruitment experiences and lessons learned from across the EvidenceNOW initiatives, sharing examples of materials they have developed and used when relevant. In addition to the information and materials shared here, the Agency for Healthcare Research and Quality (AHRQ) has a toolkit for Recruitment and Retention of Primary Care Practices in Quality Improvement Initiatives, which includes specific tips and templates. Another AHRQ guide, for practice facilitators, also includes helpful information for Engaging Primary Care Practices in Quality Improvement.

Align With Practice Priorities

To effectively recruit practices to participate in your network of practices or QI project, it is helpful to identify their current priorities and what motivates them, and then develop messages to address these motivations. The EvidenceNOW: Advancing Heart Health cooperatives found that to effectively persuade practice leaders to participate, the burden of participation should be minimal or offer "the potential to reduce other pressures or [fill] a particular need for that practice."[24]

The Tennessee Heart Health Network held a listening tour with practices from across the state to help inform its recruitment efforts. Through these efforts, it learned that practices were looking to support health coaches, internal QI efforts, and health information technology personnel. In response to what they learned through this process, the cooperative budgeted to include an annual monetary incentive for practices participating in its QI project that could be used toward these expenses (see additional discussion in Provide Incentives later in this chapter).

> **"If I had approached those practices individually and asked, 'Wouldn't you like to do some quality improvement in your practice?' or 'Wouldn't you like to transform your practice?' they would have hung up the phone on me. But because it was a countywide project, addressing a real need that the county had identified, and they wanted to be part of something bigger than themselves, they all joined the project."**
>
> **— Jim Mold, Oklahoma IMPaCT grant Principal Investigator**

The Tennessee Heart Health Network also learned that though practices saw the value of participation, many reported they could not commit to the required time and resources to participate. To help address this barrier, the cooperative created three tiers of engagement:

- **Tier 1 (QI project participants).** Practices in this tier participated in the active QI project and received practice facilitation, access to training, and certification for staff in motivational interviewing and health coaching. Practices submitted quality data to the Tennessee Population Health Data Network (TN-POPnet) and received quarterly practice improvement reports to track progress on heart health quality measures. These practices also participated in virtual learning collaboratives to share best practices.
- **Tier 2 (active network participants).** Practices in this tier submitted data to the TN-POPnet and received quarterly practice improvement reports to track their progress on heart health quality measures. They had access to toolkits, implementation guides, and webinars, and they received regular communications about cooperative activities.
- **Tier 3 (general network participants).** Practices in this tier had access to toolkits, implementation guides, and webinars, and they received regular communications about cooperative activities. They did not receive reports or other direct support and were not required to submit any data or commit any time to participation.

In a study across quality initiatives (including EvidenceNOW), researchers looked at the most common barriers to participation and suggested ways to make QI studies more feasible and attractive for practices. Key suggestions included the following: [(25)]

- Reducing participation requirements for already overburdened physicians, and instead focusing on what other clinicians and practice staff can do
- Compensating practices for time spent away from patient care
- Reaching out to practices beyond email alone, as clinicians and practice staff are already inundated by email

In an analysis of their recruitment efforts for EvidenceNOW: Advancing Heart Health, a research team found that recruiting practices to participate in a QI project was more challenging when no prior relationship existed. They found that among practices where a relationship already existed, or there was a warm handoff from someone with a personal connection, almost 1 in 3 practices agreed to participate. This rate fell to only 1 in 20 for practices with no connection to a person or organization already in the cooperative. In addition, they found that the cost of recruiting practices without an existing connection was seven times greater than that for recruiting practices with a connection.[(22)]

Develop a Value Proposition

A value proposition is a statement that explains how involvement in your program can benefit the target audience (i.e., primary care practices) and makes the case for why they should participate. An effective value proposition reflects your target audience's needs and motivations and communicates what is unique about what you are offering. Once you have developed your value proposition you can use it to develop recruitment materials. For more information about how to develop an effective value proposition, examples, and sample language, see AHRQ's Recruitment and Retention of Primary Care Practices in Quality Improvement Initiatives: A Toolkit. When recruiting primary care practices to participate in a statewide QI network, a value proposition could highlight the following potential benefits as relevant:

- Belonging to a statewide effort to improve the quality of primary care for communities served
- Access to QI resources to support efficient and effective care delivery practices, including implementation toolkits
- Opportunities to participate with peers in shared learning activities, including webinars and podcasts
- Access to future opportunities to participate in specific QI projects to support care delivery
- Opportunities to participate in a community of practice with other primary care practices
- Access to data feedback to support focused QI activities

In addition, it can be helpful to keep requirements for participation in the broad QI network of practices at a minimum, and highlight this low barrier for entry to help motivate practices to participate.

The value proposition for practices participating in specific QI projects can be more focused. In their value propositions, the EvidenceNOW: Building State Capacity grantees outlined the following benefits to practices from participation in their QI projects:

- Improving the health and healthcare of patients
  - » As heart health was the focus of both EvidenceNOW: Advancing Heart Health and EvidenceNOW: Building State Capacity, the cooperatives highlighted the high burden of cardiovascular disease in their state or region, and developed messages to harness the strong motivations of clinicians to improve patient outcomes.
- Assistance to increase value-based payments and alignment with national quality initiatives
  - » Connecting value-based payments to participation can be a particularly effective way to get buy-in from practice leadership. The EvidenceNOW cooperatives highlighted how practice facilitators taught participating practices to increase value-based payments through the implementation of chronic care management, telehealth, and health coaching to improve quality outcomes.

  - » Some cooperatives promoted their alignment with federal quality reporting requirements. For example, Healthy Hearts for Michigan highlighted that practice facilitation support could help practices improve their Merit-based Incentive Payment System (MIPS) and Healthcare Effectiveness Data and Information Set (HEDIS) quality reporting scores.
- Improved staff skills, practice workflow, and capacity for QI
  - » Skills development can lead to professional growth and contribute to higher satisfaction, engagement, and retention. Cooperatives promoted access to no-cost training to improve staff skills in shared decisionmaking, health coaching, motivational interviewing, patient engagement, patient navigation, and QI techniques. Tennessee Heart Health Network offered evidence-based health coach training to participating practices.
  - » Cooperatives called attention to how participation could improve overall practice functioning. Healthy Hearts for Michigan shared that participation could help improve practice workflows, team-based care, and provider-to-provider referrals.

Examples of value propositions are included in the recruitment materials of Tennessee Heart Health Network and Alabama Cardiovascular Cooperative. Healthy Hearts for Michigan shared that participation could help improve practice workflows, team-based care, and provider-to-provider referrals.

Provide Incentives

Offering incentives to practices for their participation helps signal appreciation for their time and energy and often makes practices more receptive to your pitch. Though participation in a QI project ultimately might help practices share in cost savings through value-based payment programs, there are likely costs associated with their participation before those benefits can be realized. For example, participation might require staff to take time away from billable activities. Although unlikely to cover all costs to practices, financial incentives (within the limitations and guidelines of your funding agency) can be used to help offset some of the upfront costs for practices participating in a QI project.

The limitations of participation-specific financial incentives are something that partnerships with payers could potentially address. For example, if a QI project aims to reduce rates of uncontrolled blood pressure and the practice needs to improve on this measure to optimize value-based payment, linking the QI project to this payer priority can demonstrate other financial benefits of participation beyond a symbolic incentive recognizing participation.

Build on Existing Relationships

The EvidenceNOW: Advancing Heart Health cooperatives and others found that building on existing relationships is one of the most successful strategies for recruiting practices. Given this, programs might want to start recruitment efforts by reaching out to their own contacts, along with those of their partners. As described previously in Identify Needed Expertise in chapter 2, the program can select some partners from the outset specifically for their credibility among and ability to reach primary care practices. As also described in chapter 2, specific partners can help with recruitment both broadly and within select groups (e.g., those in rural or remote areas, those that provide care to underserved populations).

The EvidenceNOW: Building State Capacity cooperatives used existing relationships to recruit practices:

- Alabama Cardiovascular Cooperative relied on connections between its two principal investigators and three existing networks of practices and other related entities within the state (the Alabama Practice-Based Research Network, the Deep South Continuing Medical Education Network, and the Rural Research Alliance of Community Pharmacies) to reach clinicians serving high-risk and underserved communities.
- Heart Healthy Ohio Initiative relied on its partnerships with professional organizations (including those for physicians, nurse practitioners, nurses, pharmacists, physician assistants, and dieticians), three regional health improvement collaboratives, and seven academic medical schools across the state.
- In addition to using its professional association partners and the Quality Innovation Network-Quality Improvement Organization in its region to help with practice recruitment, Tennessee Heart Health Network drew on the deep connections of its physician partners, who are health leaders who have helped train many of the primary care physicians working throughout the state.

When a direct relationship with a practice does not already exist, it can be helpful to get a warm handoff or a referral. Ask participating practices to introduce you to other practices or clinicians or share testimonials about their reasons for joining your initiative.[(26)]

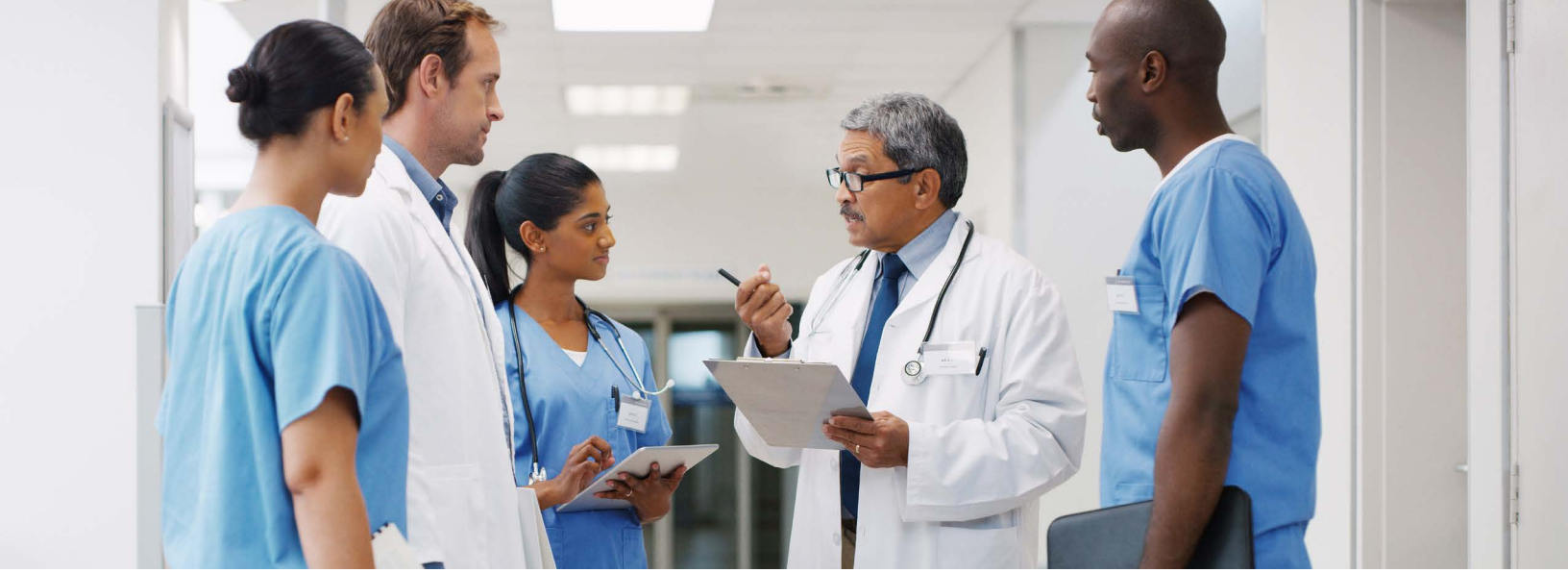
Though relying on existing relationships is an effective approach for recruitment, it can have the unintended consequence of limiting the types of practices you are reaching, preventing you from reaching the practices that could most benefit from your support. To avoid this pitfall, be sure to partner with organizations that specifically focus on practices that could be hard to reach, such as rural practices or those that focus on traditionally underserved populations.

Design Effective Outreach Strategies

Effective practice recruitment requires a multifaceted approach. EvidenceNOW cooperatives found it necessary to use multiple modes of outreach and a layered approach to effectively reach practices and get the word out about the opportunity to participate in the statewide QI network and QI projects.

The following strategies can help recruit practices:

- **Promoting the project widely**, including through partner social media accounts (i.e., LinkedIn, Facebook, Twitter); primary care listservs, newsletters, and blogs; presentations at state conferences and events focused on primary care; press releases to local media; and project and partner websites.



- **Sending an initial outreach letter** from a source that practices know and trust.
  - » See an example outreach email from Healthy Hearts for Michigan.
- **Emailing, mailing, or faxing a fact sheet or flyer** that describes participation benefits as well as any obligations or requirements. (Note that faxing can be an effective way to reach practice staff.)
  - » Healthy Hearts for Michigan found it effective to purchase a list of primary care physicians in its state and send recruitment letters via U.S. Mail addressed directly to them.
  - » See examples of recruitment flyers for Healthy Hearts for Michigan.
- Holding informational webinars and developing recruitment videos, which can be recorded and shared on a project website.
  - » See example recruitment YouTube videos that Heart Healthy Ohio Initiative developed: Heart Healthy Ohio Quality Improvement Project–Join Today! and Join the Heart Healthy Ohio Initiative!

In addition to the outreach approaches described above, it can be helpful to **follow up with phone calls and in-person visits** to reach the practice leaders responsible for decisionmaking, answer practices' questions, and clarify project requirements. For practices that expressed an interest in participation, the EvidenceNOW: Building State Capacity cooperatives held **in-person or virtual meetings with practice leaders** to clarify project requirements (e.g., any required electronic health record capabilities), discuss the expectations for participating practices, and describe the different levels of engagement available.

Finally, primary care extension programs should regularly revise their practice recruitment strategies, messages, and outreach materials to focus on the approaches that have been the most effective.

Additional Recruitment Strategies for Recruiting Practices for a QI Project

Additional strategies that can be helpful for recruiting practices to participate in a QI project include targeting practice leaders, tailoring your pitch, and sharing the requirements of participation in detail up front.

- **Target practice leaders.** When recruiting practices to participate in your QI project, it is helpful to identify and reach the leaders within a practice who are responsible for decisionmaking. Practice leaders vary across practices and might be a physician in one practice and a practice manager in another. Leadership can variously reside with a person or a group. For example, Healthy Hearts for Michigan found that when it was not able to reach enough practices through mail, email, and phone outreach alone, it was useful to show up in person at practices and ask to speak directly with the practice manager or a head clinician.
- **Tailor your pitch.** Think through what will likely be the most successful messages for recruiting different types of practices (e.g., FQHCs, independent practices, health systems) as well as different types of leaders within a practice (e.g., clinician, office manager), and then develop tailored recruitment messages. Each of these unique audiences can have different motivations for and barriers to participation.

- **Share program details up front.** The EvidenceNOW: Advancing Heart Health cooperatives were surprised by the amount of information that practices wanted about the program before signing up. For example, practices asked for specific information about requirements and expectations, expected time commitments, what exactly was required to receive incentives, what level of data reporting was necessary, what EHR capabilities were required, what training the practice facilitators had received, and what strategies for QI were planned.[24] Recruitment flyers and other materials should clearly include information about the requirements and expectations of participation in addition to the benefits. In addition, to help recruiters provide consistent and detailed information to answer these types of questions, it can be helpful to develop an FAQs document in addition to recruitment scripts.
    - » A template for developing an FAQs document for recruitment purposes is included in AHRQ's Recruitment and Retention of Primary Care Practices in Quality Improvement Initiatives: A Toolkit.

ENGAGE AND RETAIN PRACTICE PARTICIPATION

After practices are recruited, effective onboarding and regular contact can help ensure practices stay engaged over time.

Onboard Practices

Some EvidenceNOW cooperatives required practices to complete a **readiness assessment** prior to engaging in the QI project. Readiness assessments commonly measure the following elements: willingness to change, organizational function, practice resources, and leadership engagement.[27] For example:

- Alabama Cardiovascular Cooperative administered two questionnaires to assess practice readiness for participation: the Change Process Capability Questionnaire for organization leaders (i.e., lead provider, quality manager, or chief executive officer); and the Organizational Readiness for Implementing Heart Health Improvement Project, which was meant to be completed by as many practice staff and administrators as possible. Cooperative leadership reviewed practices' readiness scores before official enrollment.

During onboarding, practices joining an active QI project should be asked to **identify a practice champion**, and practices joining either an active QI project or a larger QI network should **identify a primary point of contact**. Practice champions are essential for successful QI implementation efforts because they can help overcome organizational resistance, address day-to-day issues that arise, and maintain staff enthusiasm. EvidenceNOW cooperatives found it useful to ask practices to also name an alternative point of contact at each practice, to reduce disruptions if the champion or primary contact left the practice, became too busy, or was otherwise unavailable (e.g., the champion went out on maternity leave for several months).[26] Heart Healthy Ohio Initiative asked practices to identify a clinician and staff champion duo, to help promote a team-based approach.

Practices that want to participate in an active QI project should **sign a letter of agreement** (also known as a letter of intent or letter of participation) outlining the agreed-upon program expectations. For example, it is essential to be clear up front with practices about the amount and type of data required and to assess their internal capacity to pull data as needed. The letter of agreement should also indicate what practices can expect from participation in the cooperative. An example is Tennessee Heart Health Network's letter of intent. Similarly, extension programs could need to enter into a **business associate agreement (BAA)** or a **data use agreement** with practices that will be sharing data. These agreements outline contractual and legal permissions for using and sharing data, include safeguards to prevent unauthorized use, and require notification of any breach.[28,29] The U.S. Department of Health and Human Services provides sample BAA language.

Maintain Practice Engagement

Once practices are onboarded, the focus shifts to keeping them engaged. EvidenceNOW cooperatives used multiple strategies to disseminate program information and create a sense of community to keep practices engaged. For practices in the network or the QI project, this included the following strategies:

- **Program websites** to help participating practices access programmatic information.
- **E-newsletters or listservs** to share relevant information such as new evidence-based guidelines; share program updates, deadlines, and information about upcoming events; and share practice success stories or celebrate milestones and accomplishments. For example, see a PDF version of Tennessee Heart Health Network's e newsletter.
- **Webinars, videos, and podcasts** to share information more conveniently; for example:
  - » Lunch & Learn webinars from Healthy Hearts for Michigan
  - » A series of podcasts developed by Heart Healthy Ohio Initiative
  - » Video stories from patients, clinicians, and others developed by Tennessee Heart Health Network
- **Ongoing tailoring of learning collaborative curriculum** around expressed needs of the practices to ensure continued value from the QI activities.

For practices involved in a QI project, some EvidenceNOW cooperatives chose to hold a **kickoff meeting** prior to engaging in any QI activities. These meetings served to introduce program staff and partners to one another, share a timeline, provide an overview of upcoming activities, and build collaboration and collegiality between cooperative staff and the practices. It can also be helpful to provide practices with recognition of their participation and celebrate their successes over time. For example, extension programs can consider the following:

- **Acknowledge participating practices publicly** on project websites, in social media, in state medical association journals, and via other modes including local media, as relevant.
- **Provide practices with a poster or plaque to display** on their wall; a virtual "badge" to post on websites, newsletters, and social media; or lapel pins for clinicians and practice staff to wear. For example:
  - » Alabama Cardiovascular Cooperative created a digital badge that participating practices could post online (see graphic).
  - » Healthy Hearts for Michigan and Heart Healthy Ohio Initiative gave participating clinics lapel pins for staff to wear to promote the program.
- **Recognize individual practice successes** when a practice meets early and intermediate goals for QI implementation.
- **Share practice-related publications and results**.

4. Selecting and Delivering Services To Support Quality Improvement

Extension programs provide a range of services to support quality improvement (QI) in primary care practices, including programs designed specifically to support the practices engaged for specific QI projects and the broader network of practices. In this chapter, we offer information and examples that extension programs can use to understand the needs and interests of primary care practices, select a range of QI support services to provide, and train staff to provide this support.

SELECT AND TAILOR QI SERVICES

To determine which QI support services your program will provide, it will be essential to have a good understanding of the existing QI capacity and needs of the primary practices in your state.

You can start to build this understanding from discussions with healthcare leaders, clinicians, and patient organizations in the state, as described in Understand the Needs and Interests of Primary Care Practices in chapter 2. In addition, many of your partners, such as QI organizations, state Medicaid agencies, and the state department of health, could have deep knowledge about the QI needs throughout the state and be able to advise you.

Once you have recruited practices to participate in your extension program, you can collect information from them that you can use to tailor your QI services and materials to best meet their specific interests and needs. Past Agency for Healthcare Research and Quality (AHRQ) grantees have found that using this type of "demand-driven," rather than "supply-driven," approach is critical for engaging practices.[30]

Needs assessment surveys are an effective method to collect information across a broad network of practices as well as with a smaller set of practices participating in a QI project. The Heart Healthy Ohio cooperative conducted two such surveys:

- A survey with team leaders at the primary care practices participating in its QI project, to collect clinic-level characteristics including current strategies to improve cardiovascular preventive care, staffing, ownership, participation in other programs, and patient demographics
- A survey with team members at the participating clinics, to identify practice concerns and assess team member burnout at the participating clinics

You can use more direct and more in-depth strategies in addition to surveys to collect information from a smaller group of practices. This can include individual **practice engagement and feedback sessions** and **co-designing activities** to involve practices in the tailoring of QI services. For example:

- **Practice engagement.** Alabama Cardiovascular Cooperative compiled a list of evidence-based QI services from various sources including AHRQ's Primary Care Practice Facilitation Curriculum and the Centers for Disease Control and Prevention's Million Hearts® Change Packages. A practice facilitator then worked with each practice to identify opportunities for improvement and recommended QI services based on the practice's interests, motivations, current strengths and weaknesses, and existing capacity. Tennessee Heart Health Network had participating practices select which of three QI projects to implement after the practice had worked closely with a practice facilitator for about a month.
- **Co-design.** Heart Healthy Ohio engaged in an in-depth co-design process with four practices before rolling out QI services to a larger set of practices. First, practice facilitators conducted baseline needs assessments (with practice observations and interviews) to identify issues with implementation of evidence-based recommendations and team functioning. Then a working group was formed, including staff and patient representatives from each of the co-design practices, practice facilitators, and cooperative leadership. Next the working group discussed the identified problems, brainstormed changes they could make, and selected QI services to develop into a prototype. Finally, the co-design practices piloted the prototype using Plan-Do-Study-Act (PDSA) methodology to evaluate and refine the QI project until it was ready to be rolled out across other participating practices.

DEVELOP QI SUPPORT SERVICES AND MECHANISMS FOR DELIVERY

Each extension program might select a somewhat different set of QI support services and activities to offer. The tables below provide an overview of these services, both for broad statewide networks of practices (Table 4) and for practices engaged in active QI projects (Table 5). The tables include illustrative examples from the EvidenceNOW: Building State Capacity cooperatives. In addition, AHRQ has developed a suite of practice facilitation materials to support primary care QI activities, which are available on its website. This includes the following:

- A searchable repository of curated QI tools and resources (EvidenceNOW Tools for Change)
- A practice facilitation curriculum and training modules
- A handbook for health information technology advisors and practice facilitators for obtaining and using data for practice improvement

Support for Practices in a Broad Network

As described in Table 4 below, extension programs can offer shared learning opportunities and virtual communities of practice to practices throughout a state or region.

Table 4. Quality Improvement Support for Practices in a Broad Network

Type of Support	Description	Examples
QI Information and Materials	Materials designed to share information about QI strategies or relevant clinical topics. This includes standalone materials as well as full toolkits that can be used for implementation. Materials are often distributed through the following channels: • Public-facing websites • Curated e-libraries of tools and resources • E-newsletters	Healthy Hearts for Michigan curated a library of tools, educational resources, and materials reviewed or created by partners including the American Medical Association, the American Heart Association, the American College of Cardiology, and the Million Hearts® campaign and shared through a public website. Heart Healthy Ohio Initiative developed an online toolkit focused on its heart health QI project. Tennessee Heart Health Network developed toolkits focused on health coaching, pharmacist-physician collaboration, and heart health messaging.
Education and Training	QI content developed and presented to educate and train practice staff. This content can include Continuing Medical Education credits and is often delivered through: • Webinars • Podcasts • Interactive e-learning modules	Heart Healthy Ohio Initiative hosted monthly podcasts for its QI network, available through its website. Tennessee Heart Health Network held regularly scheduled **webinars** open to all practice partners in its broad QI network.
Shared Learning	Opportunities for participating practices to come together (in person or virtually) to learn from one another; build peer support and community; and share strategies, challenges, and lessons learned for QI implementation. Formats include: • Learning collaboratives • Virtual communities of practice	Alabama Cardiovascular Cooperative developed a virtual community of practice to offer opportunities for participating clinicians to learn best practices focused on heart health evidence-based practices. Among other sharing opportunities, participants can read success stories submitted by peer providers and identify local resources for their patients.

QI=quality improvement

Supportive Services for Practices in a QI Project

Typically, practices engaged in QI projects will have access to all the activities and materials shared with the broader network of practices (as described in Table 4) as well as additional, more intensive QI supportive services. The services described for active QI projects in Table 5 below include both activities that AHRQ believes to be central to QI support activities—described in the EvidenceNOW Model (and labeled in the table as "Core QI Support Activities")—and activities that are sometimes included but are less typical (labeled "Additional QI Support Activities"). The extension program can select a different set of services to offer for each QI project it engages in over time, depending on specific goals and needs.

Table 5. QI Supportive Services for Practices in a QI Project

Type of Support	Description	Examples
Core QI Support Activities		
Practice Facilitation	Practice facilitators work closely with primary care practices to help build practice capacity to implement the best clinical evidence. Activities include: • Assessment and redesign of practice workflows • Tailored training for practice staff on QI methods and evidence-based care • Providing, or connecting practices with, QI supports	Alabama Cardiovascular Cooperative provided practice facilitators with a protocol that outlined suggested meeting schedules with goals for the number of contacts with practices and data collection each week. The recommended minimum number of contacts was one in-person visit and two phone/video/email contacts per month, although practice facilitators could use their discretion to schedule more meetings based on practice needs. Practice facilitators met weekly with the group leader to summarize activities, report successes, troubleshoot challenges, and strategize next steps. Practice facilitators met biweekly for ongoing training and peer learning opportunities.
Expert Consultation (also known as academic detailing)	Short-term and intensive education from experts (often clinicians) to provide knowledge on a defined topic to aid with the uptake of evidence-based practices	For the EvidenceNOW: Advancing Heart Health initiative, the Heart of Virginia Healthcare cooperative had several family medicine physicians serve as expert consultants who provided peer-to-peer learning support for the practices engaged in QI activities.[31]
Optimization of Health IT and Health IT Support	Data experts or practice facilitators with health IT expertise support practices in using their EHRs to support QI. Includes helping practices minimize the burdens of data entry and maximize their ability to generate reports they can use for QI and population health–related activities	Heart Healthy Ohio Initiative provided training in using population health tools for data visualization. One-on-one assistance was also provided to practices needing support for EHR data reporting. Healthy Hearts for Michigan worked with participating clinics to implement a Hiding in Plain Sight protocol, which used existing EHR data to identify patients with potential hypertension but no documented diagnosis.

Table 5. QI Supportive Services for Practices in a QI Project (Continued)

Type of Support	Description	Examples
Core QI Support Activities		
Data Feedback and Benchmarking	Data feedback includes tracking practice performance and improvement on key process and outcome indicators over time through reports or dashboards Benchmarking consists of comparing a practice's performance on selected outcome measures with accepted standards or with the performance of other practices The data for feedback and benchmarking can come from within the practice (e.g., the EHR, chart audits, registry data) or from external sources (e.g., health information exchanges, claims data, hospital utilization data)	Heart Healthy Ohio Initiative developed an interactive dashboard that allows practices to review summary data on measures and create customizable charts based on selected inclusion criteria (such as race/ethnicity, primary insurance class, and medication intensity). The dashboard compares data across practice sites, using unique ID numbers so practices can identify only their own data. Practice facilitators review these data with the practice team during coaching sessions. Participating practices submit monthly EHR data through a portal using a secure transfer. Healthy Hearts for Michigan developed practice dashboards to report key metrics to participating clinics. Dashboards show trends in clinical quality measure data, comparing results with those of other participating clinics as well as with state and national benchmarks of patients identified via the Hiding in Plain Sight protocol and the number of patients referred to tobacco cessation services.
Additional QI Support Activities		
Financial Management Guidance	Guidance for practices to help them achieve sustainable financing for ongoing QI activities	Heart Healthy Ohio Initiative developed resources for practices about how to establish a business case for their QI projects, including this podcast. Tennessee Heart Health Network developed an overview and guidance for using CPT codes for payment for the health coaching sessions that the practices provided.
Workforce Development	Opportunities for practice staff to receive training and credentialing related to QI activities	Tennessee Heart Health Network offered free and reduced tuition for staff from participating practices to enable them to participate in online training programs on motivational interviewing, health coaching, and patient navigation.
Community Connections and Resources	Assistance connecting practices to community resources to help address the social determinants of health for patients (e.g., assistance with housing, food, utilities, transportation, education)	Heart Healthy Ohio Initiative helped connect practices to community resources within their regions by working with rural health innovation collaboratives to pair patients with community health workers. It also shared information about community resources from local public health departments.
Patient Engagement	Support or guidance for practices to help bring the patient perspective into improvement activities	Tennessee Heart Health Network convened regional patient advisory councils where members contributed the patient voice and perspective at every stage of the practice improvement process. Members reviewed resources and toolkits the cooperative developed to provide feedback and insights from the patient perspective.

CPT®=Current Procedural Terminology. EHR=electronic health record. IT=information technology. QI=quality improvement.

PRACTICE FACILITATION

Across the range of services provided for a QI project, practice facilitation is a key approach for helping primary care practices implement evidence-based approaches to improve patient outcomes. The EvidenceNOW: Advancing Heart Health initiative found that practice facilitation can:[32]

- Increase practices' capacity to implement the best clinical evidence
- Connect practices to information, resources, and strategies to improve care
- Help practices overcome electronic health record (EHR) challenges and optimize their EHR for meeting QI goals
- Help practices harness patient and practice data to identify gaps in care and monitor effects of improvement activities
- Help mitigate the impact of major disruptions (staff turnover, changing EHRs, clinician loss, etc.) on the practice
- Link practices to community resources that patients and clinicians can use to support care plans

The AHRQ website includes valuable resources for practice facilitators along with lessons learned about practice facilitation from the EvidenceNOW: Advancing Heart Health initiative. Among these lessons, evaluators found that effective practice facilitators use a combination of the following strategies:[33]

- **Cultivating practice motivation** by using a flexible, tailored, and open approach
- **Guiding practices through the change process** by sharing best practices while empowering practice staff to do the work themselves
- **Addressing resistance to change**
- **Providing accountability** by assigning tasks, establishing target deadline, and tracking progress

Practice Facilitation Approach, Training, and Oversight

For each QI project, the extension program will determine its approach for providing practice facilitation. This approach includes who will provide the practice facilitation services, how these services could vary by type of practice (e.g., independent versus system affiliated), how frequently practice facilitators will engage each practice, how many visits will be virtual versus in-person, and how much choice practices will have in selecting the QI activities they want to engage in. For details about how to select a practice facilitation approach, see Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide (chapter 4). Primary care extension programs also decide how to train and provide oversight for their practice facilitators. Practice facilitators come with a wide range of experience, training, and styles—regardless of whether the program directly hires them or it partners with an organization that provides their services (see Staffing in chapter 2 for more on this topic). The EvidenceNOW cooperatives generally required practice facilitators to have completed a certified training program, have significant work experience, or both. Still, most programs held their own training sessions to ensure that the support provided to practices was consistent.

Across the EvidenceNOW: Advancing Heart Health cooperatives, practice facilitator trainings included a review of general practice facilitation principles, skills, and approaches, as well as training in project-specific content including protocols, tools, and subject matter (e.g., evidence-based practices to improve cardiovascular preventive care).[(12)] These facilitator trainings were typically multiday, in-person events conducted with a mix of didactic modules and role-playing activities. In addition, the EvidenceNOW: Advancing Heart Health cooperatives approached facilitator training as an ongoing process. The initial training event was complemented with regular "booster" trainings, including follow-up meetings (both in-person and virtual) and webinars. Some cooperatives incorporated having less-experienced facilitators observe firsthand how a more-experienced facilitator worked with a practice.

As an example from the EvidenceNOW: Building State Capacity grantees, Healthy Hearts for Michigan held a robust practice facilitator training over 7 weeks, with 2 hour sessions each week. For the first 5 weeks, the team reviewed the AHRQ Primary Care Practice Facilitator Curriculum. The last 2 weeks went over the project-specific QI services and resources, including discussions with clinical subject matter experts. In addition to this training program, Healthy Hearts for Michigan also provided the following ongoing support:

- A practice facilitator community of practice, which included discussion-based meetings and a listserv to debrief on their experiences working with the participating practices, identify and discuss challenges, and share best practices for implementation
- Weekly "office hours" with clinician leaders to provide opportunities to get advice and input on clinical topics and concerns that arose during implementation

It is also good practice for the lead facilitator to conduct one-on-one "ride-alongs" with each practice facilitator to observe how the facilitator interacts with practice staff and to provide real-time feedback. The lead facilitator should also conduct regular quality checks on practice facilitator reporting to ensure consistency of the services delivered.

5. Moving Toward Sustainability

Though it can be difficult to contemplate sustainability planning during the early stages of designing and developing a healthcare extension program, it is important to consider your ultimate goals and plan for sustainability from the outset. This involves identifying both short- and long-term goals for building an extension program and inviting partners that can help develop and realize your vision—including potential future funders. It is useful to review and update your sustainability planning as the program matures, and as the vision and goals evolve over time. In this chapter of the guide, we describe several domains related to sustainability planning for extension programs to consider, and then focus on strategies to secure sustainable funding to ensure program longevity. (Some of the content included in this chapter can also be found in Finding Sustainable Funding for Primary Care Programs).

PLAN FOR SUSTAINABILITY

Planning for program sustainability requires attention to multiple interconnected areas. Table 6 describes seven domains related to sustainability that teams should consider at the design and development phase of their extension program, and then periodically over time.[34-37]

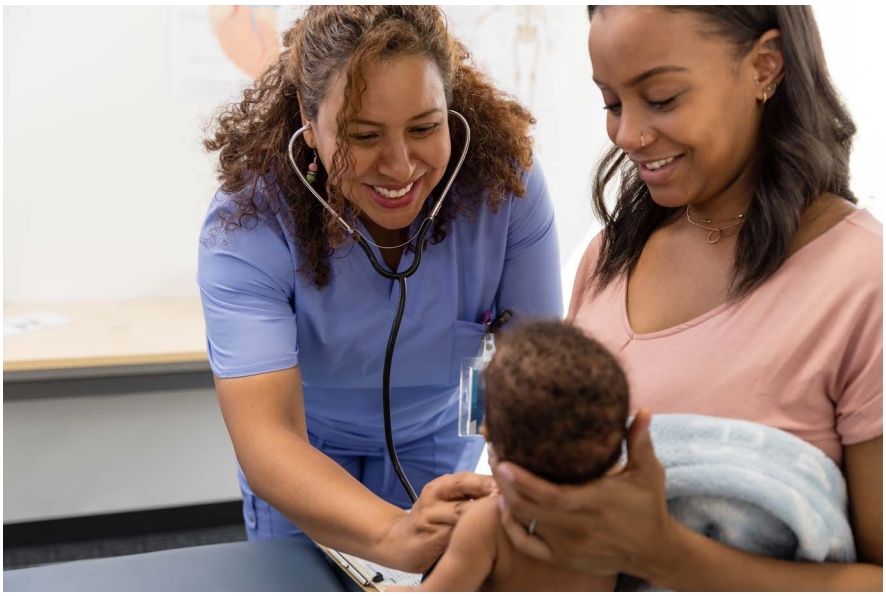


Table 6. Sustainability Domains With Descriptions and Considerations

Domain Name	Domain Description	Considerations
Core QI Support Activities		
Strategy and Strategic Planning	Using processes that guide the directions, goals, and strategies of your extension program	What is your vision for the program 3-5 years from now? (For example, do you plan to expand statewide or focus on a specific population or region within the state; do you want to expand across multiple health conditions or even become topic neutral and let practices focus on the areas of greatest concern to them?) Once the program is mature, consider what parts of the work are most important to maintain. Which key organizations would be most important to engage to ensure that these parts are maintained?
Leadership, Collaboration, and Environmental Support	Having a supportive internal and external cultural, political, and economic climate and effective leadership to drive success Cultivating connections with interested parties and developing strategic partnerships	Who are the organizations in your state that can help leverage support and resources for your program after it is established? (Consider academic institutions, agricultural extension programs, healthcare organizations, private and public payers, and the state department of health.) • What are their most pressing concerns and needs? • How can you convince them to support your vision (e.g., evaluation data, advocacy of medical professional associations or other key influencers, program adjustments to increase sustainable impact, proven return on investment)? • What opportunities can enable you to share more about how your work helps to address their concerns? Building and sustaining relationships across a broad group of partners can help you to respond quickly when new funding opportunities arise.
Financial Stability	Establishing consistent funding sources and a financial base to support the program over time	Consider developing a business plan with short- and long-term financial milestones. A business plan can help add to the program's credibility with funders.[b]
Organizational Capacity	Having the support and resources needed to effectively manage and implement the program	To maintain momentum, build and maintain your workforce and subject matter expertise over time and across projects. Consider how to maintain practice improvement staff necessary for delivering key services, such as practice facilitators, health information technology experts, and implementation scientists. Deliberate succession planning and cross-training can help to reduce "brain drain" when staff or leadership changes. Consider how to best document current policies and procedures for future reference.
Program Evaluation	Conducting regular assessments to inform planning and program improvement and to document results	Document program successes, including clinical quality improvements and returns on investment to share with potential funders. Identify best practices to share with others.

Table 6. Sustainability Domains With Descriptions and Considerations (Continued)

Program Adaptation	Taking actions that adapt program structure and programming to ensure effectiveness, efficiency, and value	Use what you have learned from evaluation efforts and feedback from practices, funders, and other partners to adapt your program to best meet the needs in your state.
Communications	Developing strategic communications for funders, interested parties in your state, and the public about the program	Tell the story of how the program adds value to efforts to improve population health in your state.

[b] Funding strategies are discussed, in the section Find Sustainable Funding for Your Primary Care Extension Program.

FIND SUSTAINABLE FUNDING FOR YOUR PRIMARY CARE EXTENSION PROGRAM

Healthcare extension programs are often funded, at least initially, through federal or state grants.[7] Grant funding can be essential for establishing the coalition of partners throughout a state needed to carry out the work and develop needed statewide infrastructure. However, without ongoing funding for core infrastructure costs, inevitable gaps between grant funding periods occur. These gaps can lead to loss of trained and specialized staff—and with them the collective knowledge, skills, and relationships that allow healthcare extension programs to be efficient and effective.[7,12] Most extension programs have found they need funding from multiple sources to sustain their work. This often includes a mix of both project-based grant funding and ongoing non-project-based funding.

Some extension programs have been successful at securing **sequential funding**, where previous grant experience is leveraged for new (and often larger) grants across agencies. Other approaches are **braiding or layering funding**, where multiple funding streams support a program:[c]

- In braided funding, the full costs of the program are shared across multiple funding sources, with each funding stream remaining separate so it can be individually tracked. In this strategy, cost-allocation methods are used to make sure program and administrative costs are appropriately shared between funding sources and to prevent any duplication in funding.[38-40]
- In layered funding, existing funding for the program's core services is supplemented with new funding (from the same source or other sources), allowing the provision of broader or more- comprehensive services.[41] An advantage of this approach is that core services are not disrupted if supplemental funding ends.[39]

Sequential, braided, and layered funding approaches can all be used to help sustain healthcare extension services over time.

Potential Funding Sources

In this section we discuss sources of potential funding that can be used to support the work of healthcare extension programs. Below, we provide an overview of various sources of support available for QI efforts in primary care, by the geographic reach of that support (Table 7).

[c] Another funding strategy is **blending**, referring to mixing together funds from multiple sources such that individual funding sources lose their program-specific identity and cannot be tracked separately. We did not find any examples of blended funding to support primary care extension programs.

Table 7. Support for Primary Care Quality Improvement, by Type and Geographic Reach

Support/Initiative Type	Geographical Reach		
	National	State	Local
QI-Specific Initiatives			
Health system led QI initiatives, which include their primary care practices	✓	✓	✓
Primary care professional association led QI initiatives (e.g., American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists)	✓	✓	
Primary care associations and the National Association of Community Health Centers (for federally qualified health centers and look-alikes) led QI initiatives, as well as those run by state rural health associations and the National Rural Health Association (for rural health centers)		✓	✓
Federal grants supporting QI, often with a topic-specific focus (such as HRSA's Small Health Care Provider Quality Improvement Program for rural health, and National Training and Technical Assistance Partners for HRSA grantees)	✓		
State departments of health led QI initiatives, including their offices (e.g., office of chronic disease, maternal health, behavioral health, rural health, etc.)		✓	
Health IT Efforts That Support QI			
Health information exchanges/regional extension centers and social health information exchanges, as well as federal connectivity initiatives supporting information system connectivity and collaboratives and data networks	✓	✓	✓
Federal and state funding for health information exchange and clinical infrastructure supporting disaster response, climate change resiliency, and public health emergencies (rural broadband, vaccine storage)	✓	✓	✓
Health Center Control Networks (for federally qualified health centers) and other state/region-specific entities seeded by federal funds (e.g., supporting a range of efforts such as business intelligence, quality improvement data monitoring and reporting, linkages to specialty care networks, and other technical assistance supporting existing state/region-specific entities that were seeded by federal funds)		✓	
Health-Related Efforts That Support QI			
National and local nonprofit patient advocacy and experience organizations and consumer health initiatives offering grant funding or technical assistance and materials (e.g., Institute for Patient- and Family-Centered Care)	✓	✓	✓
Foundations and private donors investing in improving health/health-related services and infrastructure	✓	✓	✓
Health topic-specific nonprofits providing grants, technical assistance, and resources supporting quality patient care (e.g., American Cancer Society, American Heart Association, Komen Foundation)	✓	✓	
Payment Models That Support QI			
Private/commercial health plan value-based care models paying for reporting and improvement on quality metrics	✓	✓	
Centers for Medicare and Medicaid Services care and payment transformation efforts with practices and accountable care entities (such as ACO REACH, Primary Care First, and Making Care Primary)	✓		
State Medicaid programs and Medicaid managed care plan value-based care models paying incentives for quality outcomes as well as for services that support quality care (e.g., care coordination, case management, and other services)		✓	

ACO = Accountable Care Organization. HRSA = Health Resources and Services Administration. QI = quality improvement.

However, healthcare extension programs require financial support beyond QI funding. Below we discuss different types of funding to support healthcare extension programs more broadly. The content shared here draws heavily from interviews we conducted with representatives from programs that provide healthcare extension services: the Oregon Rural Practice-Based Research Network (ORPRN),[42] the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC),[43] and the University of New Mexico's Office for Community Health's Health Extension Regional Offices (HEROs) program.[44]

Legislative Appropriation in the State Budget

State legislatures can authorize funding for programs focused on primary care improvement. For example:

- OPHIC receives a small amount of annual funding from the state to cover some infrastructure expenses (office space, administrative staff, etc.) and to develop and support interagency community coalitions, called County Health Improvement Organizations.

University Funding and Nonfinancial Support

Often, healthcare extension programs are coordinated through one or more universities—often the clinical and translational science center at a state university. This relationship with the university can benefit the program through financial investment and infrastructure support, as well as through staff- and faculty-sharing arrangements. For example:

- ORPRN, which exists as a standalone unit within the School of Medicine at Oregon Health & Science University, gives all indirect funding from its grants to the university. In return, ORPRN does not pay for any overhead costs (such as for office space, central finance, human resources staff, etc.). This arrangement provides stability for the program when it experiences gaps in funding between large grants.
- OPHIC is organizationally situated within the University of Oklahoma's federally funded Clinical and Translational Science Institute, which serves as its dissemination and implementation arm.
- The University of New Mexico's Health Sciences Center provides continuous, sustainable funding for administration of the HEROs program and for partial funding of program positions.

Federal Grants

Though it is not recommended that healthcare extension programs rely solely on federal grants, these grants often make up a sizeable portion of overall funding. Several federal agencies provided funding to support healthcare extension services, including the agencies presented in Table 7 above. You can view all available grants at Grants.gov and set up to receive notifications for current and projected funding opportunities (Tip: A successful application for a federal grant requires staff with grant-writing skills and experience. Programs that are not run through a university might want to partner with one for this type of support or hire professional grant writers for their team.)

State Contracts and Funding

State departments of health (including public health or mental health) and Medicaid agencies often contract with healthcare extension programs to support QI. For example:

- The Public Health Division of the Oregon Health Authority has supported several ORPRN initiatives, generally related to working with primary care clinics to improve prevention activities, such as screening for heart disease or diabetes and referral to self-management programs. In addition, ORPRN had several contracts with the State of Oregon (state Medicaid and the vaccine program) to support primary care practices with COVID vaccine storage and handling.
- OPHIC has had several subcontracts with Oklahoma's Departments of Health and Mental Health to gather data to support chronic disease management and to design and implement systems to screen for alcohol and substance use disorders.

Some states have funds designated for health promotion, such as cigarette tax revenues or tobacco settlement money (and eventually opioid settlement money), that are a possible source of funding for QI efforts. For example:

- Oregon provided ORPRN with start-up funding from tobacco settlement funds.

Contracts With Payers and Other Entities for Technical Assistance, Training, or Other Services

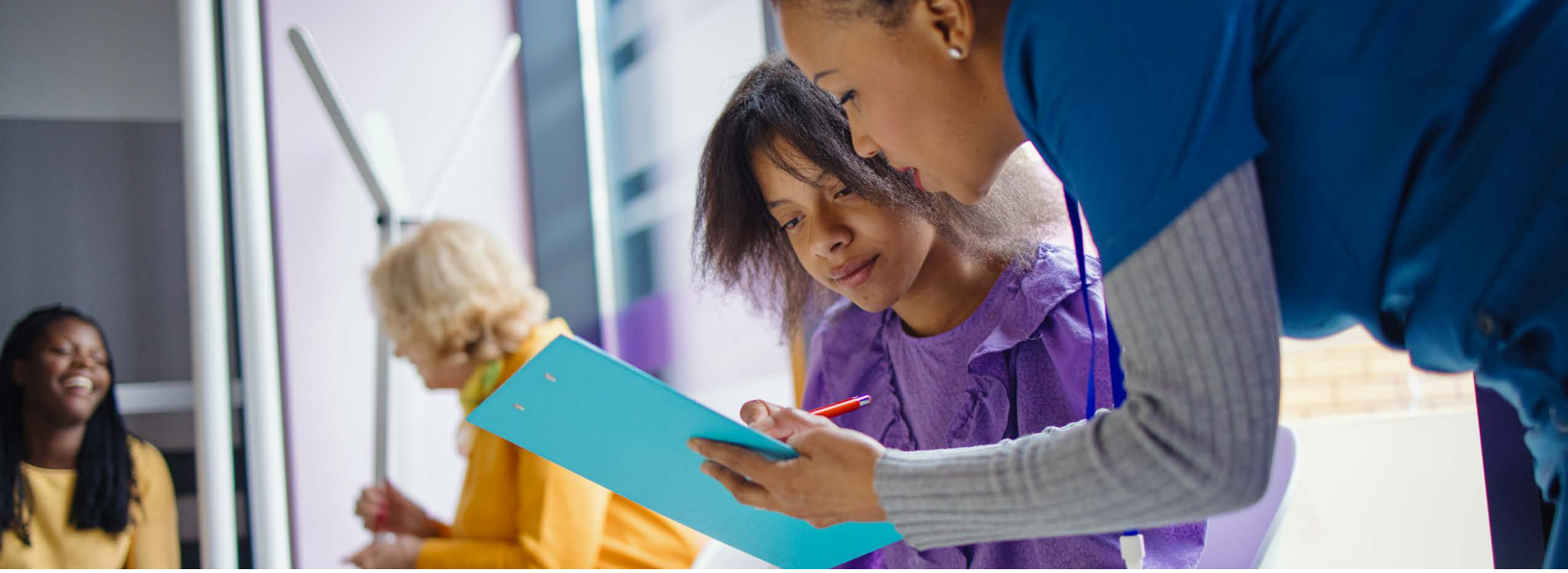
Payers (including private health insurance plans and Medicaid or Medicare managed care plans), provider associations, health systems, primary care practices, or other entities will sometimes contract with healthcare extension programs. Contracted services include technical assistance or staff training for QI activities, practice facilitation, information technology support, and multidisciplinary case management infrastructure. For example:

- Medicaid Coordinated Care Organizations (CCOs) in Oregon contracted with ORPRN to provide technical assistance and education to primary care practices and other health system partners on improving quality measures such as depression screening. Technical assistance included training practice staff in QI methods to build practices' QI capacity. ORPRN also helped CCOs in Oregon develop and implement tools and strategies to analyze community needs, to inform community health improvement plans.
- New Mexico's Medicaid funding of its managed care organizations has been a significant, long-term funding source for the University of New Mexico's community health worker programs, including funding the role of some HEROs.

Fees or Membership Dues

Payers, health systems, primary care practices, or other entities sometimes pay healthcare extension program fees or membership dues for services. For example:

- ORPRN runs its Extension for Community Healthcare Outcomes (ECHO) program using a membership model. ECHO provides remote education from clinical specialty experts to help primary care providers manage patients with health conditions that would otherwise have to be referred to specialty care. Currently, most payers in Oregon, including the state Medicaid program, pay to be members and then can invite a certain number of providers to participate based on their share of the cost of the program.
- Some primary care extension programs receive fees for providing technical assistance to consult with other states on establishing statewide QI infrastructure.



Funding From Foundations, Private Trusts, or Individual Donors

Some healthcare extension programs have had success getting supplemental funding from foundations or individual donors. For example:

- New Mexico's health extension program receives substantial funding from local foundations and private donors. W.K. Kellogg Foundation of New Mexico and the local JF Maddox Foundation fund the health extension work in rural and urban underserved areas.
- OPHIC receives modest funding for its primary care extension program though individual donors.

Endowments can offer long-term, stable funding for primary care extension. For example:

- In New Mexico, a substantial amount of support for extension work in research and with community-based organizations comes from private donors. The University of New Mexico identifies private donors through its Development Office.

Healthcare conversion foundations (also known as health legacy foundations) could potentially provide funding for healthcare extension programs. These foundations, which are formed when a hospital, health system, or health plan is converted from nonprofit status to for-profit status, are intended to fund efforts that improve the health of the community that the original institution serves.[45,46]

Other Funding Strategies and Tips

In addition to seeking broad funding, other strategies can help healthcare extension programs sustain their work.

- **Consider different funding sources for different components of the work.** It could be more effective to pitch parts of your program to certain funders, rather than pitching the full program. As one researcher described, "Outcomes meaningful to Medicaid-managed care insurers may differ from outcomes of interest to the local, nonprofit community."[44] For example:
  - » Some funders (e.g., local foundations) might be more interested in funding practice facilitators than in funding the healthcare extension program more broadly.
  - » The Agency for Healthcare Research and Quality's guide Developing and Running a Primary Care Practice Facilitation Program includes ideas for finding funding to support such positions.
- **Community health workers** (CHWs) are sometimes included in a healthcare extension program. Because CHWs provide a direct service to patients, it might be easier to show a short-term return on investment from their work (e.g., a reduction in hospitalizations) than from practice facilitators, whose impacts are more indirect and long term. Because of this, a hospital or health system might be more willing to help cover the salaries of CHWs.

- **Pitch relationships with practices to funders.** Healthcare extension programs can pitch their strong and trusting relationships with primary care practices, and knowledge of community needs and organizations throughout the state or region, to potential funders. For example:
  - » According to ORPRN's Anne King, "It helped that we had staff embedded in communities because Oregon is a really huge state, and we had staff in communities where there wasn't anybody else." ORPRN was able to bring on funders, including payers, by showing them "we have relationships with primary care practices, that we understand how they operate, we know how to get in and help facilitate change."[42]
  - » OPHIC maintains the most complete and accurate database of primary care practices within Oklahoma, which it then markets as a valuable resource to various state agencies and offices.

- **Invite potential funders to serve on your Advisory Board or Board of Directors.** One way to build relationships with potential funders is to invite them to participate in your program early on. For example:
  - » OPHIC founder Jim Mold described how it did this during an earlier iteration of the program in Oklahoma: "We established a Board of Directors that included representatives from many of these groups, including Medicaid and the health department—anybody we thought might be interested and have some money. [By doing this] we got to know the folks and how their funding systems work."[43]

- **Make use of intragovernmental transfers.** State-based public entities can often share funding with other state entities without a contract, using an intragovernmental transfer. For example, a state-based hospital, the state Medicaid program, or a state's department of health could fund a primary care extension program housed in a state university for services that benefit patients in the state, without entering into a contract or grant. This type of arrangement is appealing to the state because it is easier and more flexible than a contract. For primary care extension programs run by state entities, the arrangement can mean easier access to significant amounts of funding. For example:
  - » The University of New Mexico's Office for Community Health and University of New Mexico Hospital negotiated an intergovernmental transfer of funding with the state's Human Services Department, which runs state Medicaid. This funding was used to support work of the Office's HERO and CHW programs in the service of Medicaid patients.

Another strategy some organizations use is to **house a healthcare extension program in an organization that has a broader overall mission**, which allows the program to use funds that might not be available otherwise. For example:

- » The health extension program in New Mexico is not limited to primary care or even clinical settings, but rather provides broad services to improve the health of people throughout the state.
- » Other groups provide extension services as part of a practice-based research network that conducts research on quality improvement, pragmatic clinical trials, and patient-centered outcomes research in primary care.

OTHER RESOURCES FOR FINANCIAL SUSTAINABILITY

- ReThink Health has developed A Typology of Potential Financing Structures for Population Health, which is part of a larger Financing Workbook for multisectoral partnerships. These materials could be useful to primary care extension programs to identify additional funding sources and approaches.
- New Mexico developed an online Health Extension Toolkit so other states can learn more about the model it has developed, including different ways its health extension work is funded.[47]

Conclusion

Developing a state-based healthcare extension program to support quality improvement in primary care practices is challenging work. It requires establishing and maintaining broad partnerships, developing a governing and workgroup structure to carry out the work, building and maintaining a network of practices, designing and delivering quality improvement supports, and finding ongoing funding sources to sustain the effort over time. This guide aims to help by sharing what has been learned across the Agency for Healthcare Research and Quality's EvidenceNOW initiative. We recognize that future healthcare extension efforts will likely have a different focus and will identify new approaches and best practices to continue to build the knowledge base. However, we hope that readers can find information they find useful, adapt it as needed, apply it in their work, and then in turn share their own insights about what they have learned.

References

1. Taylor E, Peikes D, Geonnotti K, McNellis R, Genevro J, Meyers D. Quality Improvement in Primary Care: External Supports for Practices. Rockville, MD: Agency for Healthcare Research and Quality; 2014.
2. Balasubramanian BA, Marino M, Cohen DJ, Ward RL, Preston A, Springer RJ, et al. Use of quality improvement strategies among small to medium-size US primary care practices. Ann Fam Med. 2018 Apr;16(Suppl 1):S35-S43. doi: 10.1370/afm.2172. PubMed Central PMCID: PMC5891312.
3. Phillips RL, Kaufman A, Mold JW, Grumbach K, Vetter-Smith M, Berry A, et al. The primary care extension program: a catalyst for change. Ann Fam Med. 2013 Mar;11(2):173-8. doi: 10.1370/afm.1495.
4. Ono SS, Crabtree BF, Hemler JR, Balasubramanian BA, Edwards ST, Green LA, et al. Taking innovation to scale in primary care practices: the functions of health care extension. Health Aff (Millwood). 2018;37(2):222-30. doi: 10.1377/hlthaff.2017.1100. PubMed Central PMCID: PMC5805471.
5. The National Primary Care Extension Program: Next Steps. National Primary Care Extension Program Meeting February 21; Washington DC2014.
6. Patient Protection and Affordable Care Act, House of Representatives, 111th Congress Sess. (2009-2010).
7. Kaufman A, Dickinson WP, Fagnan LJ, Duffy FD, Parchman ML, Rhyne RL. The role of health extension in practice transformation and community health improvement: lessons from 5 case studies. Ann Fam Med. 2019;12(17 (Suppl 1)):S67-S72. doi: 10.1370/afm.2409. PubMed Central PMCID: PMC6827669.
8. Meyers D, Miller T, Genevro J, Zhan C, Mare JDL, Fournier A, et al. EvidenceNOW: balancing primary care implementation and implementation research. Ann Fam Med. 2018;16(Suppl 1):S5-S11. doi: 10.1370/afm.2196.
9. The EvidenceNOW Model: Providing External Support for Primary Care Rockville: Agency for Healthcare Research and Quality; 2021 [updated May 2021; cited 2022 September 28]. Available from: https://www.ahrq.gov/evidencenow/model/index.html.
10. Cohen L, Baer N, Satterwhite P. Developing Effective Coalitions: An Eight Step Guide. Gaithersburg, MD: Prevention Institute; 2002.
11. Tennessee Population Health Consortium: The University of Tennessee Health Science Center; 2024 [cited 2024 May 13]. Available from: https://www.uthsc.edu/research/populationhealth/.
12. Sweeney SM, Hemler JR, Baron A, Woodson TT, Ono SS, Gordon L, et al. Dedicated workforce required to support large-scale practice improvement. J Am Board Fam Med. 2020 Mar-Apr; 33(2):230-9. doi: 10.3122/jabfm.2020.02.190261. PubMed Central PMCID: PMC7175633.
13. Bergstrom A, Clark R, Hogue T, Iyechad T, Miller J, Mullen S, et al. Collaboration framework: addressing community capacity. Columbus, OH: The National Network for Collaboration. [cited May 13 2024]. Available from https://www.thenationalcouncil.org/resources/collaboration-framework-addressing-community-capacity/
14. Pellecchia M, Mandell DS, Nuske HJ, Azad G, Benjamin Wolk C, Maddox BB, et al. Community–academic partnerships in implementation research. Journal of Community Psychology. 2018;46(7):941-52. doi: 10.1002/jcop.21981.
15. Moullin JC, Dickson KS, Stadnick NA, Rabin B, Aarons GA. Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) Framework. Implementation Science. 2019;14(1):1-16. doi: 10.1186/s13012-018-0842-6.
16. Sagrestano LM, Clay J, Finerman R. Collective impact model implementation: promise and reality. Journal of Health and Human Services Administration. 2018;41(1):87-123.
17. Johnson J, Willis W, McGinnis C. Building a collaborative governance framework: a five step process. Portland, OR: National Policy Consensus Center, 2020 May. Report No.: 18.
18. Knox L, Taylor E, Geonnotti K, Machta R, Kim J, Nysenbaum J, et al. Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide. Rockville, MD: Agency for Healthcare Research and Quality; 2011.

References

19. Drahota A, Meza RD, Brikho B, Naaf M, Estabillo JA, Gomez ED, et al. Community-academic partnerships: a systematic review of the state of the literature and recommendations for future research. The Milbank Quarterly. 2016;94(1):163-214.
20. Hampton C. Section 7. Writing Bylaws: The University of Kansas; 2024 [cited 2024 May 9]. Available from: https://ctb.ku.edu/en/table-of-contents/structure/organizational-structure/write-bylaws/main.
21. Creger T, McCollum G. Alabama Cardiovascular Cooperative: Findings From a Members' Survey. Birmingham, AL: The University of Alabama at Birmingham; 2021.
22. Fagnan LJ, Walunas TL, Parchman ML, Dickinson C, Murphy K, Howell R, et al. Engaging primary care practices in studies of improvement: did you budget enough for practice recruitment? Ann Fam Med. 2018;16:S72-S9. doi: 10.1370/afm.2199.
23. Cuthel A, Rogers E, Daniel F, Carroll E, Pham-Singer H, Shelley D. Barriers and facilitators in the recruitment and retention of more than 250 small independent primary care practices for EvidenceNOW. American Journal of Medical Quality: The Official Journal of the American College of Medical Quality. 2020;35(5):388-96. doi: 10.1177/1062860619893422.
24. Sweeney SM, Hall J, Ono SS, Gordon L, Cameron D, Hemler JR, et al. Recruiting practices for change initiatives is hard: findings from EvidenceNOW. American Journal of Medical Quality: The Official Journal of the American College of Medical Quality. 2018;33(3):246-52. doi: 10.1177/1062860617728791.
25. McHugh M, Heinrich J, Philbin S, Bishop D, Smith J, Knapke J, et al. Declining participation in primary care quality improvement research: a qualitative study. Ann Fam Med. 2023;21(5):288-394. doi: 10.1370/afm.3007. PubMed Central PMCID: PMC10519762.
26. Recruitment and Retention of Primary Care Practices in Quality Improvement Initiatives: A Toolkit. Rockville, MD: Agency for Healthcare Research and Quality; 2021.
27. Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, et al. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. Rockville, MD: Agency for Healthcare Research and Quality; 2015.
28. Business Associate Contracts Washington, D.C.: U.S. Department of Health and Human Services; 2013 [cited 2022 November 28, 2022]. Available from: https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html.
29. Disclosures for Emergency Preparedness - A Decision Tool: Data Use Agreement: Office for Civil Rights; 2022 [cited 2023 January 12]. Available from: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/data-use-agreement/index.html.
30. Johnson K, Penfold R, Schaefer J, Reardon J, Gerteis J. AHRQ Infrastructure for Maintaining Primary Care Transformation (IMPaCT) Grants: A Synthesis Report. Contract No.: HHSA-290-2010-0000-4-I. Rockville, MD: Agency for Healthcare Research and Quality; 2015. 15-0066-2-EF
31. Goetz Goldberg D, Haghighat S, Kavalloor S, Nichols LM. A Qualitative Analysis of Implementing EvidenceNOW to Improve Cardiovascular Care. J Am Board Fam Med. 2019 Sep-Oct;32(5):705-714. doi: 10.3122/jabfm.2019.05.190084.
32. Practice Facilitation. Rockville, MD: Agency for Healthcare Research and Quality; 2021 [updated 2023; cited 2023 February 22]. Available from: https://www.ahrq.gov/evidencenow/practice-facilitation/index.html.
33. Sweeney SM, Baron AN, Hall JD, Ezekial-Herrera D, Springer RJ, Ward RL, et al. Effective facilitator strategies for supporting primary care practice change: a mixed methods study. Ann Fam Med. 2022;20(5):414-22. doi: 10.1370/afm.2847. PubMed Central PMCID: PMC9512557.
34. Sustainability Planning Worksheet for Children's Bureau Discretionary Grantees. In: AHRQ, editor. 2021.
35. Program Sustainability Assessment Tool: Washington University in St. Louis; 2023 [cited 2023 April 28]. Available from: https://sustaintool.org/psat/understand/.
36. Sustainability Planning Tools: Rural Health Information Hub; 2023 [cited 2023 April 28]. Available from: https://www.ruralhealthinfo.org/sustainability.

References

37. Sustainability Action Plan: AHRQ; 2023 [cited 2023 April 28]. Available from: https://www.ahrq.gov/hai/quality/tools/cauti-ltc/modules/sustainability/assessment-tool.html.
38. Butler S, Higashi T, Cabello M. Budgeting to promote social objectives - a primer on braiding and blending. Washington, DC: The Brookings Institution; 2020.
39. Gonzalez K, Caronongan P. Braiding federal funding to expand access to quality early care and education and early childhood supports and services: a tool for states and local communities. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation; 2021.
40. Child Care Technical Assistance Network. Layering or Blending and Braiding Multiple Funding Streams Washington, DC: Administration for Children and Families. [cited 2022 October 26]. Available from: https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending.
41. Matacotta J. Blended... Braided... Layered? Tracking the Complexity of Funding Streams. Vertical Change; [cited 2022 October]. Available from: https://medium.com/verticalchangehq/blended-braided-layered-tracking-the-complexity-of-funding-streams-20bb239a573.
42. King A. Interview with Anne King from the Oregon Rural Practice-Based Research Network. 2022.
43. Mold J. Interview with James Mold from Oklahoma Primary Healthcare Improvement Cooperative. 2022.
44. Kaufman A, Pacheco M. Interview with Art Kaufman and Mario Pacheco from University of New Mexico Health Sciences Center's Office for Community Health. 2022.
45. Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, Maynes C, Skipper B, Powell W, Kaufman A. Community health workers and Medicaid Managed Care in New Mexico. J Community Health. 2012 Jun;37(3):563-71. doi: 10.1007/s10900-011-9484-1.
46. Easterling D, Smart A, McDuffee L. Hospital & Health Conversion Foundation [cited 2022 October 26]. Available from: https://stakeholderhealth.org/conversion-foundation/.
47. Health Extension Toolkit: Agency for Healthcare Research and Quality. [cited 2024 May 9].. Available from: http://healthextensiontoolkit.org/.