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Recruiting Practices for Change Initiatives is Hard: Findings from EvidenceNOW

Shannon M. Sweeney¹, Jennifer D. Hall², Sarah S. Ono^{2,3}, Leah Gordon², David Cameron², Jennifer Hemler¹, Leif Solberg⁴, Benjamin F. Crabtree¹, and Deborah J. Cohen²

¹Robert Wood Johnson Medical School, Department of Family Medicine and Community Health, Research Division, Rutgers University, New Brunswick, NJ

²Department of Family Medicine, Oregon Health & Science University, Portland, OR

³Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System, Portland, OR

⁴HealthPartners Institute for Education and Research, Minneapolis, MN

Abstract

Engaging primary care practices in initiatives designed to enhance quality, reduce costs and promote safety is challenging as practices are already participating in numerous projects and mandated programs designed to improve care delivery and quality. Recruiters must expand their recruitment tools to engage today's practices in quality improvement. Using grant proposals, online diaries, observational site visits, and interviews with key stakeholders we identify successful practice recruitment strategies in the EvidenceNOW initiative, which aimed to recruit approximately 1500 small-to-medium-sized primary care practices. Recruiters learned they needed to articulate how participation in EvidenceNOW aligned with other initiatives and could help practices succeed with federal and state initiatives, recognition programs, and existing or future payment requirements. Recruiters, initiative leaders and funders must now consider how their efforts align with ongoing initiatives to successfully recruit and engage practices, ease practice burden, and encourage participation in efforts that support practice transformation.

Keywords

Research Practice Recruitment; Health Services Research; Primary Health Care; Qualitative Research; Quality Improvement

Corresponding author: Shannon M. Sweeney, MPH, PhD, smsween@rwjms.rutgers.edu, Telephone: 848-932-0207, Fax: 732-932-1451.

Conflict of Interest Notification

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Introduction

The quest for safe, effective, patient-centered, timely, efficient and equitable health care has been growing since the Institute of Medicine's 2001 report, *Crossing the Quality Chasm* sought to bring attention to the fundamental change needed in health care.¹ In response to these concerns over the past decade, initiatives such as the Safety Net Medical Home,² the National Demonstration Project,³ the Beacon Community Program,⁴ and the Agency for Healthcare Research and Quality's (AHRQ) Infrastructure for Maintaining Primary Care Transformation (IMPACT)⁵ were launched to improve quality of care. In addition, over the past decade programs such as Meaningful Use (MU), Physician Quality Reporting System (PQRS), and the Primary Care Medical Home (PCMH) are among the many competing initiatives practices must navigate.

Engaging practices so they see the potential contribution that a new study or quality improvement (QI) project makes to their practice and, most importantly, patients they serve is one of the first steps for a new initiative. In the past, strategies for enrolling practices into initiatives and grant projects have involved physicians recruiting physicians;^{6–12} leveraging personal contacts and networks;^{13–16} conducting face-to-face meetings;^{7,13,17} emphasizing monetary and non-monetary incentivizes such as Continuing Medical Education credits (CMEs);^{7,12,18} keeping data collection to a minimum;⁶ obtaining endorsements from physician leaders;¹¹ and persistently following up with non-responsive practices.^{8,11,12,16,19–21} These strategies, among others, have been summarized as the seven R's of recruitment: relationships, reputation, requirements, rewards, reciprocity, resolution and respect²⁰ and have been demonstrated to be effective at recruiting and enrolling practices for participation. However, these strategies focus on the mechanics of how to recruit and not the nuances of how to craft recruitment messages, which is critical to the work of enrolling practices.

Those implementing practice improvement initiatives or practice redesign must understand not only which approaches help to successfully recruit and engage practices, but the importance of messaging when communicating with practices. We address this literature gap by focusing on the nuances of recruitment and describe the most successful messaging strategies for recruiting and engaging 1500 small-to-medium (fewer than 10 clinicians) primary care practices as part of the EvidenceNOW.

Methods

Setting

EvidenceNOW is an AHRQ-funded initiative that aims to help primary care practices improve patient heart health through the adoption of the evidence-based ABCS of cardiovascular disease prevention: aspirin in high-risk individuals, blood pressure control, cholesterol management, and smoking cessation.² AHRQ funded seven Cooperatives that cover geographically dispersed regions (single state or contiguous states) involving 12 states^{22–24} and an independent National Evaluation called **E**valuating **S**ystem **C**hange to **A**dvance **L**earning **A**nd **T**ake **E**vidence to **S**cale (ESCALATES) to inform large-scale dissemination and implementation of evidence.^{3,25}

Each Cooperative designed its own intervention focused on helping primary care practices implement evidence-based guidelines for cardiovascular preventive care targeted to patients at risk for cardiovascular disease. All Cooperatives' leadership teams included practicing physicians who helped develop their intervention, and several Cooperatives also had clinicians in advisory roles from whom they sought feedback. All Cooperatives incorporated similar implementation strategies, particularly practice facilitation and feedback and benchmarking, while employing a range of models for transformation and practice change. All interventions were also designed to be flexible enough to have enrolled practices provide some input into the focus of the intervention content they received. Each Cooperative had a common aim, to recruit and engage approximately 250 small-to-medium-sized practices in their region that did not have a consistent, internal source of QI support. Although each Cooperative created its own study design, varying the amount of time allocated to recruitment, no Cooperative planned for more than 12–18 months for all start-up related activities to occur. Identified start-up activities included: developing local partnerships, intervention refinement, hiring, materials preparation, Institutional Review Board (IRB) approvals, and recruitment and enrollment.

Data Collection

The data informing this study include documents (e.g., grant applications, recruitment materials); fieldnotes from observational site visits; semi-structured interviews with recruiters, practice facilitators and study leadership; and online diaries. Online diaries are web-based platforms that allow team members from each Cooperative to record their recruitment and implementation experiences in real-time, with data access limited to the ESCALATES team and individuals from each Cooperative.²⁶ Grant applications contained descriptions of the methods Cooperatives planned to use to recruit practices. This information was compared with information shared on the diaries and in interviews to assess changes in recruitment strategies and approaches. Between August 2015 and April 2016, ESCALATES researchers conducted informational and observational site visits and interviews with Cooperative team members, stakeholders, and partners. ESCALATES researchers recorded detailed observations and asked questions about Cooperative team development, history of partnerships, study design, practice recruitment/engagement strategies, progress to date, and barriers and facilitators to execution of start-up activities identified in the research plan. Interviews were audio-recorded, professionally transcribed, and reviewed for accuracy. Following each site visit, researchers completed detailed fieldnotes which were then circulated to team members not attending site visits for review and incorporation of details to clarify as needed. See Figure 1.

Data Management and Analysis

Qualitative interview and fieldnote data, entries made on the online diaries, recruitment materials provided by Cooperatives, and when possible, screenshots of online information used in recruiting were entered into Atlas.ti (Version 7.0, Atlas.ti Scientific Software Development GmbH, Berlin, Germany) for data management, coding, and data analysis. Our multi-disciplinary team comprised of experts in communication, primary care, public health, and anthropology used a combination of coding text followed by an immersion crystallization approach to analyze the data.²⁷ We began by using a single code to broadly

tag all text relevant to practice recruitment across the seven Cooperatives. Then we discussed the tagged data as a group and identified emerging recruitment themes and created and coded with a codebook updated iteratively using a consensus process. When our team was consistent in how we coded text, we divided the remaining recruitment data, and team members coded the data individually. We met weekly to review how we analyzed data to ensure reliability, discuss findings, and resolve any questions about appropriate codes for specific data. Next, we immersed ourselves in the coded data to understand the recruitment and engagement strategies Cooperatives used, paying special attention to strategies described by many or all of the Cooperatives, and identify what was needed for practices to agree to participate. The study team compared the reported successful recruitment strategies across the Cooperatives and found similarities in approaches.

Results

Recruiters and Cooperative team members from each of the seven Cooperatives described the established strategies of leveraging relationships and “touching” or contacting practices many times through different modes as necessary but insufficient. Recruiting practices for EvidenceNOW became more than enrolling them in the initiative; it involved continuous engagement and relationship building before practices would enroll. Recruiters from all seven Cooperatives also found that the key communication strategy to recruit and engage practices was to demonstrate alignment with other initiatives. After pre-existing relationships with practices, practices regularly reported alignment as playing the strongest part in practice rationale for participating, as practice staff felt they were constantly juggling many requirements and projects and thus, saw value in EvidenceNOW’s ability to accomplish several complementary tasks. Specific and customized persuasive messaging was also critical. These three findings are further described in detail below.

Alignment

Cooperatives consciously framed the EvidenceNOW initiative as aligned with other initiatives in which practices were already participating. This required understanding competing demands in the region and eligibility requirements for participating in other projects. Recruiters explained that practices could simultaneously work on PCMH recognition and receive Maintenance of Certification (MOC) Part Four for quality and performance improvement in practice of patient care²⁸ and CME credits for various aspects of EvidenceNOW, which gave clinicians concrete and significant credit for working on the initiative. Highlighting how EvidenceNOW was aligned with existing requirements (e.g. PQRS and MU) helped to demonstrate the value and benefit of participation:

So when the physician stands up and asks the question “What’s in it for me?” I am not surprised nor caught off guard. I commend her for her honesty and her authenticity. As part of the continued recruitment process, recruiters must be quick and ready to answer this question with confidence. The focus has to be not on forms and definitions, but on the benefits including alignment with current work. (Diaries, Cooperative 1)

One Cooperative framed EvidenceNOW as a stepping stone to future QI initiatives that would further aid the practice in its path for continuous QI:

There is a cohort of practices not accepted into the State Innovation Model (SIM) cohort that were given feedback to participate in EvidenceNOW to get ready for second wave of SIM... They can get prepared to do SIM through EvidenceNOW. (Fieldnotes, Cooperative 6)

By framing EvidenceNOW as a way to get involved in SIM, (which had garnered a lot of attention in the state), the Cooperative aligned the initiatives, providing practices with a clear path for building QI capacity.

Cooperatives also framed the initiative as a means to prepare practices for upcoming payment reform (e.g. Medicare Access and CHIP Reauthorization Act (MACRA), part of the Merit Based Incentive Payment System (MIPS)) in which practices were motivated to participate. One Cooperative received a letter from a large insurer in the region explaining that EvidenceNOW would help prepare the practice for future QI needs; this encouraged practices, even those that had already declined, to participate:

The value proposition includes data alignment with existing initiatives... and to be ready for value-based payments. We are making the case that participation in [EvidenceNOW] is the antidote to what is reported as limited bandwidth. (Diaries, Cooperative 4)

These messages aided recruitment by focusing on the ways in which EvidenceNOW aligned with other QI initiatives, helped practices receive incentives and credit for work they were already doing, and positioned practices to better prepare for future national requirements and initiatives.

Specificity

While alignment was key in attracting practices to participate in EvidenceNOW, it was often just the beginning of a series of conversations with the practice. Cooperatives found practices wanted specific information about the initiative and asked for details about the cost-benefit ratio, such as the requirements, benefits, and time commitment. Practices had questions about participation expectations: how much time it would take; what was required to receive incentives; what metrics, surveys, and data reporting was necessary; what electronic health record (EHR) capabilities were required; what training the practice facilitators and other staff had received; and what strategies for QI were going to be used. Although Cooperative team members anticipated answering some questions, they were surprised by the number of questions and the level of detail practices requested and required before agreeing to participate. Team members were not always fully prepared to respond during the initial recruitment period:

While the project sounds interesting to practices, they want details—what exactly are the measures, what format do you need the measures, how will you support our MOC, how much time will this project require, etc. Also, practices are under a lot of pressure to meet ongoing demands. We've had some practices tell us that they

are overwhelmed and can't take on another project, especially one that requires that staff complete multiple surveys. (Diaries, Cooperative 4)

Cooperatives often reported that practice staff and clinicians felt overwhelmed and burnt out with the work already required of them and asked questions regarding specific details about how this initiative would not add to their stress and schedules. Once recruiters were able to identify the emergent commonly asked questions, they revised recruitment materials. Having readily available answers to practices' questions saved valuable recruitment time, helped recruiters capitalize on each contact with a practice and was a step towards building a relationship with the practice.

Customization

After gaining experience aligning EvidenceNOW with other initiatives and answering practices' questions, recruiters soon learned to deliver nuanced messages to the practices based on their particular needs:

[Recruiters] have been working on the value proposition with [Cooperative's] physician advisory board to better understand what small practices will really want out of this project. They are using this information to tailor messages around the value added. (Fieldnotes, Cooperative 2)

Recruiters had a deep understanding of sub-communities of practices (e.g. FQHCs, health systems, tribal practices), and tailored their recruitment messaging and materials to these communities and their decision makers. In some cases, tailoring was less targeted at practice sub-communities and more to individual practices by leveraging known needs and goals from previously existing relationships. In other cases, customization was an iterative process and messages were tailored through ongoing discussions, with recruiters asking questions and listening to practice responses to determine practice interests and priorities throughout the recruitment and engagement period:

[Recruitment] was customized not by type of practice but actually, practice by practice... You really had to listen to them and pay attention to what their pain was and figure out how to answer it... my whole thing was: we just got to get them. So people would ask sometimes some kind of crazy things and I'd have to bring it back to the team and be like, 'Well, how do we accomplish this? Can we do this? Can we make this happen for them?' (Interview, Cooperative 5)

Recruiters customized their messages through conversation, which helped the practices understand how participating would fit their needs or goals, encouraging them to join. This was, in part, made possible by the flexibility Cooperatives designed in intervention delivery, knowing not all practices would need or want the same assistance. While recruiters had to be careful to ensure they did not promise anything that could not be accommodated, they modified their talking points and highlighted specific support elements of the intervention that were applicable to the practice:

We have continuously spoken of the project as an opportunity for sites to undergo a broader, systems-wide transformation through intensive practice facilitation and coaching, while "meeting the site" where it is. In other words, tailoring an

individualized agenda of activities predicated on the [chronic care model] to assist sites. (Diaries, Cooperative 3)

By customizing the recruitment messaging and description of the intervention, practices seemed more willing to join. When recruiting and enrolling practices, Cooperatives reported the importance of customizing their conversations to practices' goals and needs, often by mentioning EvidenceNOW's alignment with specific local, state or federal initiatives; as one recruiter noted, "Recruitment is not cookie cutter. That's important." (Fieldnotes, Cooperative 5)

Discussion

In the past, researchers believed that practice recruitment could be accomplished through a combination of physicians recruiting physicians,^{6–12} conducting face-to-face meetings,^{7,13,17} obtaining endorsements from physician leaders,¹¹ emphasizing incentives,^{7,12,18} leveraging existing relationships,^{13–16} and following up with practices.^{8,11,12,16,19–21} The findings from the EvidenceNOW initiative show that these strategies when used alone are insufficient; and more nuanced messaging strategies such as aligning with existing initiatives and requirements, explicitly specifying project details, and customizing recruitment messages to the needs of the practice are also necessary.

To increase practices' chance of success and their ability to gain skills and build sustained QI capacity from participating in initiatives such as these, those recruiting and engaging practices must listen to them, determine what is important to them, and think through the initiative's broader implications and how it benefits the practice and its patients. These efforts support relationship development, which recruiters need, especially when working to build the infrastructure that is necessary to support primary care practices and accelerate the dissemination and implementation of evidence based practices in health care.

One of the reasons that additional efforts are necessary for successful practice recruitment is that primary care physicians today feel overworked and underappreciated compared to previous times.^{29,30} Many changes to the nature of their work have contributed to this, including increasing pressure to participate in a wide variety of initiatives, increasing numbers of performance measures and associated penalties/incentives to improve them, escalating demands for additional services and documentation, and added time needed to complete forms and personally enter data in the electronic medical record instead of dictating notes.^{31,32} One result of these pressures is the growing problem of physician burnout which has led the American College of Physicians to identify the reduction of administrative tasks as an urgent need.³³ Thus when approached by a recruiter for yet another initiative, practice leaders often will not even consider participating unless the project has minimal burden and either offers the potential to reduce other pressures or fills a particular need for that practice.

In a piece for the New Yorker, Dr. Atul Gawande observes that success is often incremental and that primary care is the field that has the greatest overall impact, including lower mortality and better health, not to mention lower medical costs.³⁴ We, as researchers, may be coming to a point where it is essential to think about our work as a similar kind of

incrementalism. A single study is not conducted in isolation; it is part of a larger effort much like a thread being woven into the fabric of our knowledge. Large, multi-state initiatives are a coordinated effort to build on the existing evidence base and then disseminate this knowledge to primary care practices with the improvement of patient health as the driving motivation. Part of what EvidenceNOW has identified is the difference between an effort to change ABCS outcomes and the potential to develop a set of skills, honed around the task of improving ABCS outcomes, that can support QI and practice change based on evidence across a range of chronic conditions. The subtle shift in thinking about recruitment as bi-directional relationship-building with practices, and about QI efforts as incremental, may also inform how policy-driven funding agencies develop and coordinate large-scale efforts in the future. This shift may become even more important as burnout rises,³⁰ and with it comes the need for more continuous support.

Limitations

Although ESCALATES collected data from all seven Cooperatives through several modes and every Cooperative shared recruitment experiences with the ESCALATES team, there may have been state, regional and local external factors that influenced recruitment in ways we were not able to capture in these data. In addition, EvidenceNOW recruitment took place at a particular moment in a dynamic and quickly changing national health care environment. Challenges encountered by Cooperatives may be specific to this moment; however, if small practice consolidation continues at the current pace, the challenges identified may intensify.

Conclusion

Researchers and those embarking on QI initiatives need to be prepared to have conversations with practices about their needs and wants. They must understand and appreciate practices' motivations and concerns, and articulate how their study aligns with those considerations. When used in conjunction with the seven R's of recruitment, recruiters are better equipped to support and encourage receptivity and engagement in efforts that build practices' capacity to improve care quality and patient-centered outcomes.

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Figure 1.
Methods Overview