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## Using the TRANSLATE Framework to Support Practice Transformation: Perspectives of a Practice Facilitator

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### Abstract

**Background:** In 2008, the Minnesota Department of Health (MDH) awarded Statewide Health Improvement Partnership (SHIP) funding to community health boards (CHBs), directing them to partner with schools, worksites, communities, and health care to address obesity and tobacco use/exposure.

**Methods:** Each CHB selected one of two health care strategies: implement obesity and healthy lifestyle guidelines or connect clinics to community resources. The CHB in rural west-central Minnesota chose to champion clinical guideline implementation, assigning one of its own county-level public health nurses the role of practice facilitator (PF). This decision set the stage for a novel community partnership between public health, clinical guideline developers, and local providers of relevant clinical services.

**Lessons Learned:** This community perspective describes how the PF organized support for clinical guideline implementation using the TRANSLATE framework, and explores the capacity of the TRANSLATE framework to accommodate particularities of clinical partners that is necessary in working to transform evidence-based knowledge into real-world practice.

### Keywords

Nursing, community health partnerships, health promotion, Midwestern United States, guideline adherence, outcome and process assessment (health care), rural health, public health, practice facilitation

In 2008, the Minnesota Department of Health (MDH) awarded Statewide Health Improvement Partnership (SHIP) funding to community health boards (CHBs), the legal governing authority for local public health in Minnesota. Each CHB represents a minimum of 30,000 residents and in some rural areas spans multiple counties. CHBs partner with MDH to address areas of public health responsibility, including but not limited to the promotion of healthy behaviors and healthy communities. Herein we report on the SHIP initiative in which the MDH directed CHBs to partner with schools, worksites, communities, and health care organizations to address obesity and tobacco use/exposure via policy, system, and environmental changes. With regard to the health care component, the MDH asked each CHB to select one of

two strategies: implement the Institute of Clinical Systems Improvement (ICSI) obesity and healthy lifestyle guidelines or connect clinics to community resources. The CHB in rural west-central Minnesota chose to champion clinical guideline implementation, assigning one of its own county-level public health nurses the role of PF. This decision set the stage for a novel community partnership between public health, clinical guideline developers, and local providers of relevant clinical services. In this scenario, public health was tasked with partnering directly with clinics to implement clinical guidelines. This stands in stark contrast with the more traditional and complementary partnership, where public health augments primary care via the creation of healthy, supportive environments. This community perspective describes how the

PF organized support for clinical guideline implementation using the TRANSLATE framework, originally developed by researchers to assess implementation of evidence-based guidelines within a primary care focused research project.<sup>1,2</sup> In particular, we explore the capacity of the TRANSLATE framework to accommodate particularities of clinical partners that is necessary in working to transform evidence-based knowledge into real-world practice.

## BACKGROUND

To facilitate the MDH-sanctioned guideline implementation strategy, MDH contracted with ICSI to offer a 12-month collaborative process related to clinical guideline implementation. The PF (the CHB county-level public health nurse) recruited the collaborative partners via email, phone, and in-person invitation, and worked in tandem with ICSI to facilitate the collaborative meetings. Recruited partners included five primary care clinics and one independent physical and occupational therapy clinic; in consultation with ICSI the CHB broadened the definition of “clinic” in the clinical guideline to include four local public health departments desiring to systematically integrate a tobacco screening and referral process and/or a body mass index (BMI) screening and management component into client visits. Of these 10 partners, 70% were rural and 60% received public funding, representing two major health care systems, a migrant health service, and a federally qualified health care center. Each partner designated an inter-professional team to participate in the collaborative process, which included face-to-face sessions, interactive phone calls, and webinars. The teams learned quality improvement basics, crafted partner-specific action plans with aims and measures that addressed barriers, and established measures to evaluate short-term and long-term goals. The collaborative also provided opportunities for celebrating planning and implementation successes. After the 12-month collaborative, the PF made quarterly on-site visits with each partner for 3 additional years to continue working on guideline implementation.

To explore and document the challenges of implementing evidence-based clinical guidelines into practice, the PF appropriated the TRANSLATE CKD framework. This framework provides a structure to organize practice facilitation in support of practice transformation by assessing progress according to nine distinct components: targets, reminder systems,

administrative buy-in, network information systems, site coordination, local physician champion, audit and feedback, team approach, and education.<sup>2</sup>

## COMMUNITY PERSPECTIVE

The TRANSLATE framework begins with setting targets. This task was accomplished during the initial collaborative and subsequent on-site team meetings as the PF worked with site staff to negotiate aims and measures tailored to each partner practice. After target-setting meetings, the PF updated and emailed an action plan to each partner along with encouragement to adapt the measures to represent their specific capacity and intentions. Subsequent meetings reviewed action plan progress and/or barriers; several partners had not met or even addressed proposed targets. Self-reflection by the PF revealed that when partners were asked to approve a measure, rather than feeling empowered to craft their own measure, progress was limited or even stalled. For example, several partners initially agreed to become registered sites for the Minnesota Fax Referral Program for Tobacco Cessation to facilitate cessation referrals to the Quit Line. Partners registered and received a site-specific fax referral identification number and program information and began to fax referrals to the quit line. However, referrals soon ceased. When asked, most partners stated they preferred to give clients the brochure and toll-free number, rather than use a multistep fax referral process that was not integrated into their electronic medical record (EMR). Partners also mentioned that the quit line concept did not work well for clients with limited phone minutes and/or who do not answer calls from unknown numbers. The PF, acknowledging expertise within the local clinical partners, responded by switching to a more partner-centered approach and began collaborating with each partner to craft site-specific targets.

The second TRANSLATE element, reminder systems, fleshed itself out externally and internally. Initially, partner team leaders did not request or receive reminders to address action plan targets. After various partners “confessed” they had not looked at the targets since the previous quarterly meeting, a reminder system was put in place. Emails sent before subsequent visits reminded partners that the updated action plan would guide the site visit conversation. Second, internal reminders proved invaluable for triggering evidenced-based practice. One partner communicated to their administration

and IT department that specific EMR changes could trigger provider action, such as highlighting a BMI in red if it was equal to or greater than 30 kg/m<sup>2</sup>. After several months, the change was implemented. However, a year after implementation, the EMR vendor changed; the PF prompted the clinic manager to ask for and receive assurance that these BMI-related reminders would remain in the system. The new EMR went live and the calculation of BMI was poorly integrated into the record; it now required an additional step in regard to patient height, was no longer highlighted, and only displayed to providers if they searched for it. Realizing that ready access to information impacted the rate at which clinicians addressed patient obesity, the clinic manager requested restoration of the BMI trigger. After several months the BMI highlighting was restored. This example illustrates one of the challenges practices confront in their efforts to transform and improve. It also demonstrates one reason for the receptivity to outside practice facilitation.

Administrative buy-in, the third TRANSLATE element, varied between settings and generated mixed results. One partner setting had strong buy-in, as revealed by the allocation of resources and time. However, only the pilot project staff seemed to make practice changes to systematically address BMI and tobacco use/exposure. In a second setting, a supportive administration selected the supervisor champion and team members from a department other than primary care. This team created and facilitated adoption of a BMI policy, but implementation was slow and restricted to BMI calculation. A third partner had significant administrative buy-in from the clinical manager who had the resources, personnel, quality improvement expertise, and status to make suggested changes. This team made great strides in documenting BMI, building motivational interviewing capacity, capturing data related to numbers of patients with a BMI of greater than 30, and sharing the data with providers and nurses. Three years into the project, the PF shared information regarding intensive behavioral therapy for obesity, a Medicare benefit offered by another local health care system. This partner's strong administrative support enabled them to embed intensive behavioral therapy for obesity into their EMR, implement it, and offer it system-wide within a period of weeks. Progress was tracked and the program tweaked as necessary, all with minimal practice facilitation support. Another partner with

limited administrative buy-in who simultaneously received the information regarding intensive behavioral therapy for obesity made minimal progress in systematically offering patients access to this beneficial wellness program.

Addressing the fourth TRANSLATE element, network information systems or registries, required ingenuity by the PF to best support the continuum of information systems found among partner settings. When the collaborative launched, partner information systems ranged from paper to electronic and few could successfully create BMI and/or tobacco-related registries. One partner with paper records did not have staff time allocated to create registries. Other partners were either converting to an electronic system or upgrading to a new electronic system and able to capture some patient information, but BMI and tobacco-related registries were not among them. Initial practice facilitation work consisted of assessing current registry capacity and encouraging partners to make their registry wishes known to those with power to inform the future system. The smaller, independent partners connected easily with their Internet technology personnel with proposed changes often implemented quickly. Partners from larger systems generally waited several weeks or months for a response only to be told that their input was forwarded to a best practice committee for consideration of a system-wide response.

Site coordination, the fifth TRANSLATE element, was generally the responsibility of the manager, supervisor, or director. Unfortunately, even though the mission of reducing rates of obesity and tobacco use/exposure was clear, coordinators at the partner sites had limited time for quarterly site visits and related quality improvement activities. Staff turnover among partner site coordinators also created delays, because new coordinators generally lacked familiarity with project goals, requiring a significant portion of time allocated and reallocated to project orientation. Some partner settings experienced turnover multiple times over the course of the project, impeding progress.

The local physician champion, the sixth TRANSLATE element, proved the most difficult to secure and maintain. In one partner setting, administration selected the local physician champion; the physician initially attended collaborative meetings and participated in creating the action plan. However, the physician soon stopped attending project meetings and began actively campaigning internally against the adoption

of a BMI, nutrition, and physical activity screening and intervention. When the other team members became discouraged and considered dropping out of the collaborative, the PF encouraged them to maintain the partnership and focus on environmental and system changes that could set the stage for future guideline implementation. Another partner site coordinator recruited several nurses and registered dietitians to join the collaborative team, but no physician champion. However, because the site coordinator was highly respected by the physicians and the organization experienced minimal administrative, provider, and staff turnover, guideline implementation work moved forward.

Regarding the eighth TRANSLATE element, a team approach, each partner setting recruited an interprofessional team to participate in the practice transformation work. Some partners maintained team participation during the quarterly on-site visits, and others opted to have the site coordinator alone or site coordinator along with one or two additional team members communicate specific input/feedback and/or technical assistance request on behalf of the team. Sometimes a void was identified, and specific content experts were recruited to join the team. For example, one partner team lacked a quality improvement champion, and after several months into the project, intentionally recruited a quality improvement expert. This new addition to the team was instrumental in facilitating the addition of clinical BMI measures and outcomes to provider dashboards, strengthening the seventh TRANSLATE element, audit, and feedback loop, while also engaging additional clinicians into the interprofessional team. In another partner setting, the site coordinator had difficulty engaging clinic staff in addressing BMI. The PF encouraged the coordinator to audit the clinic with regard to the number and percentage of adult patients with a BMI equal to or greater than 30 kg/m<sup>2</sup>, and then share the results back to clinic administrators and medical providers. The audit results astounded the site coordinator and the medical providers, and inspired them to set and meet numerous BMI-related clinical guideline goals.

The ninth and final element, education/staff training, was systematically embedded into and sustained throughout this initiative. The educational component offered during collaborative meetings introduced organizational readiness to change, obesity and tobacco-related evidence-based clinical guidelines, adaptive versus technical challenges and solu-

tions, and quality improvement techniques. Staff training needs fleshed themselves out as the teams adapted an action plan for local implementation and discovered that the lack of clinical expertise in motivational interviewing—a patient-centered manner of interacting with patients that empowers the patient to consider and set small measurable change goals—was a huge void. Partners readily took advantage of grant-funded trainings organized or referred to by the PF such as motivational interviewing (MI) trainings, Certified Tobacco Treatment Specialist (CTTS) training, and the National Diabetes Prevention Program (NDPP) lifestyle coach training. Partners built significant internal capacity in regards to trained staff; one partner added MI training to its employee orientation requirements. Those who attended MI training returned better equipped for patient conversations; some also made personal wellness goals. Follow-up on the completed training opportunities offered mixed results because not every partner took the next step to supervise MI skills and/or adopt a referral system to refer patients to the newly available patient resources. In one case, even after training of staff as NDPP lifestyle coaches, and 3 years of scheduling and recruiting program participants, including partnership with a local worksite in recruiting participants, the eight patients needed to offer the program had yet to be recruited.

## CONCLUSION

Clinical settings are constantly challenged by the need to adapt practices, workflows, and processes to incorporate new guidelines and new evidence about effective ways to improve patient health outcomes. The foundational collaborative experience plus the on-site and predictable presence of the local public health PF empowered health care settings to continue to move forward in the midst of these challenges. One partner observed, “it’s easy to think you’re going to do something, but then work happens, and you kind of forget this stuff, but then because we’ve had [county-level public health nurse PF] coming, checking in with us, and reminding us of things, and reviewing previously set goals, and assisting us in setting future goals . . . it’s helped us stay on track, and it’s helped us continue to be mindful of the process.”<sup>3</sup> Partners viewed the PF as a valuable asset and strategic colleague whose quality improvement expertise complemented the clinical expertise of the health care partners and served as a valuable catalyst

for translation of clinical guidelines into practice.

This manuscript chronicles the complexities of organizational and practice change encountered by one PF in light of the TRANSLATE framework. Although introduced as a framework for monitoring implementation of guidelines within a research protocol, this experience suggests that the TRANSLATE framework sensitizes PFs to variability among sites and provides insights into how partners bring different expertise, resources, and experience to the table. Framework utilization empowers both PF and clinical partners to remain focused on their respective goals, leading to implementation success and strengthening of the partnership. In responding to the challenge of creating public health and clinical care partnerships, use of the TRANSLATE framework for shaping shared expectations and managing how organizations and individuals approach and orchestrate changes in quality improvement deserves further study.

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