Perceived Barriers to and Facilitators of the Implementation of Priority Clinical Preventive Services Guidelines

Cynthia G. Ayres, PhD, RN; and Hurdis M. Griffith, PhD, RN

Objective: To obtain feedback from contracted health plan (HP) clinicians responsible for implementing preventive services regarding an established set of priority guidelines identified by a coalition of medical directors and to identify barriers to and facilitators of the implementation of these priority guidelines in clinician practice.

Study Design: Qualitative design using a focus group approach.

Participants and Methods: Three focus group meetings among contracted HP clinicians were conducted in New Jersey in 3 geographic regions (northern, central, and southern New Jersey). Clinicians directly involved in delivering preventive services to pediatric, adult, and geriatric patients participated.

Results: Barriers to guideline implementation were identified by the clinicians regarding payment and cost, time, legal issues, inconsistency among HP tools, tracking, a lack of internalization, and the patient-clinician relationship. In addition, facilitators of guideline implementation, including HP support, patient materials, clinician awareness, and tool consistency, were identified.

Conclusions: Clinicians' perceived barriers to guideline implementation are in themselves a barrier to the delivery of preventive care services. If clinicians perceive barriers to implementing priority recommendations, they may be unlikely to make the conscious effort to deliver preventive care. There needs to be better dialogue between HPs and contracted clinicians to minimize the perceptions of barriers and to increase clinician awareness of and sensitivity to preventive care for priority implementation. To improve the delivery of preventive services in clinician practice, competing HPs must communicate in a single voice with contracted clinicians in the area of preventive care.

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Preventive services for the early detection of disease have been associated with substantial reductions in morbidity and mortality.[1-9] Although scientific evidence exists for emphasizing prevention in clinician practice, studies[10-12] have shown that clinicians often fail to provide recommended clinical preventive services (CPS). A reason identified in the literature is that clinicians may be uncertain of or confused about which services to provide.[6,12-16] Clinicians are confronted with various (often conflicting) sets of clinical guidelines for the provision of preventive care given the number of health plans (HPs) they contract with. In addition, CPS recommendations are issued regularly by government health agencies, expert panels, medical specialty organizations, voluntary associations, other professional and scientific organizations, and individual experts,[12] which further adds to clinicians' confusion.

BACKGROUND

In an attempt to address this problem, 8 medical directors from the largest HP in the state of New Jersey collaborated on improving the delivery of CPS among their contracted clinician base. These medical directors came to a consensus on a subset of the US Preventive Services Task Force guidelines for preventive care for priority implementation (Table 1).[17] In doing so, it was anticipated that barriers of inconsistency and confusion about conflicting CPS recommendations put forth by each HP would be minimized. Therefore, the delivery of CPS in clinician practice would be improved.

However, efforts to improve the delivery of CPS are limited by our understanding of how clinicians actually incorporate and deliver preventive services within the competing demands of their practices.[18-21] The objective of this study was to better understand the organizational features of primary care practice that may act as barriers to and facilitators of clinicians' delivery of priority guidelines in practice. Specifically, we asked the following questions: "What are the perceived barriers to the implementation of the priority CPS guidelines identified by the HP medical directors?" and "What are the perceived facilitators of the implementation of the priority CPS guidelines identified by the HP medical directors?"

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The literature suggests various barriers to and facilitators of the delivery of CPS in clinician practice.[21-23] However, studies are lacking in the area of barriers to and facilitators of guideline implementation when a collaboration of competing HPs provides a single consistent set of guidelines for preventive care. Knowledge of perceived barriers to and facilitators of the implementation of priority guidelines identified by the HP medical directors will provide HPs with a better understanding of clinicians' perceptions regarding the implementation of a consistent set of priority guidelines. It may suggest ways in which HPs may assist in the delivery of priority CPS guidelines in clinician practice. In addition, such knowledge will provide HP medical directors with an understanding of clinicians' perceptions, which could influence future collaborative activities.

METHODS

This qualitative study examined factors that affect the delivery of CPS in clinician practice. Focus groups were used to obtain clinician feedback. This design is ideal when there is a need to obtain a number of contrasting ideas or themes[24,25] (in this case, barriers to and facilitators of the delivery of HPs' priority CPS guidelines). The study protocol was reviewed and approved by Rutgers, The State University of New Jersey Institutional Review Board.

Three focus group meetings with a combined convenience sample of 26 primary care practitioners were conducted in New Jersey, 1 in each of 3 geographic regions (northern, central, and southern New Jersey). Focus groups were organized based on clinicians' geographic locations to minimize traveling distance and to facilitate participation.

The nonrepresentative sample of clinicians was recruited by the project director (CGA) on the research team. Using member directories of participating HPs, clinicians directly involved in delivering preventive services to pediatric, adult, and geriatric patients were randomly selected for potential inclusion in the study. Invitations for participation, including a brief summary of the priority CPS guidelines identified by the HP medical directors, were sent to the selected clinicians until the targeted number of clinicians (n = 10) for each focus group volunteered to participate. Letters were followed up by a telephone call by the project director to determine interest. Fifty clinicians were contacted in total before obtaining the targeted number of clinicians. Thirty clinicians (10 per group) were recruited; of these, 26 clinicians participated. Of the 26 participants, 11 were internists, 7 were family physicians, 3 were obstetricians/gynecologists, 1 was a pediatrician, and 4 were nurse practitioners.

Table 1. Clinical Preventive Services Guidelines Identified for Priority Implementation

Area
Cervical cancer
Breast cancer
Childhood immunizations
Adult immunizations
Hypertension
Depression
Tobacco use
Postmenopausal hormone prophylaxis
Chlamydial infection
High blood pressure and other lipid abnormalities
Colorectal cancer
Elevated lead levels in childhood
Neural tube defects
Physical activity/healthy diet
Motor vehicle injuries
Substance abuse
Unintended pregnancy

Focus groups were moderated by a former HP medical director with expert knowledge of CPS guidelines and clinician practice and with previous facilitation experience. Each 1-hour session was audiotaped, and the project director, serving in an observer role, kept detailed notes to supplement audiotaped proceedings.

Each focus group meeting began with an overview of the US Preventive Services Task Force guidelines[12] and of the value of using these evidence-based guidelines as the minimum level of preventive care to be delivered to the general population. Information regarding the HP medical directors' collaborative effort to identify a single consistent set of priority CPS guidelines, a description of the process used to facilitate consensus, and the list of priority guidelines were then presented.

Following this presentation, the moderator asked the following questions to stimulate discussion: (1) "What do you perceive to be the barriers to your implementation of these guidelines?" and (2) "What do you perceive to be practices that would facilitate your implementation of these guidelines?" Throughout the discussion of each topic, the moderator used additional probes to stimulate discussion and to reach saturation (ie, the point at which no new additional information was forthcoming). Following completion of each focus

Table 2. Barriers to and Facilitators of Priority Clinical Preventive Services (CPS) Guideline Implementation

Barriers
Payment and cost issues
Time factors
Legal issues
Inconsistency among health plan tools with various CPS recommendations
Tracking of CPS already delivered to patients
Lack of internalization of guidelines
Patient-clinician relationship
Facilitators
Health plan support
Patient materials
Clinician awareness and sensitivity
Tool consistency

group meeting, the audiotaped discussion was transcribed by the project director. Content analysis was performed on all 3 transcripts for the purpose of identifying and categorizing themes representative of barriers to and facilitators of CPS guideline implementation.

The project director and 2 other members of the research team analyzed the discussions based on the method described by Strauss and Corbin.[26] This process involves breaking down, examining, comparing, conceptualizing, and categorizing data. Focus group audiotapes were transcribed; every line of the transcribed text was coded for relevant themes, and as themes developed, a working definition was assigned to each code. Constant comparison of codes of new transcripts with existing codes of previous transcripts allowed researchers to develop properties of overarching categories for the identified codes. This process was ongoing until saturation was reached.

RESULTS

The following 7 themes emerged that represented barriers to implementation: (1) payment and cost issues, (2) time factors, (3) legal issues, (4) inconsistency among HP tools with various CPS recommendations, (5) tracking of CPS already delivered to patients, (6) a lack of internalization of guidelines, and (7) the patient-clinician relationship (Table 2). In terms of facilitators, the following 4 themes emerged: (1) HP support, (2) patient materials, (3) clinician awareness and sensitivity, and (4) tool consistency.

DISCUSSION

Barriers to Guideline Implementation

Payment and Cost Issues. Payment and cost barriers were the most cited obstacles to guideline implementation. Clinicians noted a lack of reimbursement for time spent providing preventive screenings such as counseling. They said that these services would take time away from seeing other patients and would result in a loss of income. They also cited an increase in office overhead associated with recommendations such as performing flexible sigmoidoscopies at their offices. A lack of reimbursement for fiber-optic equipment and the time that performing flexible sigmoidoscopies would take away from seeing other patients would result in financial loss. One clinician said: "I'm spending more money and my nurse's time. I'm not getting reimbursed a cent more. I'm losing money each time I do it. It's a problem."

Clinicians described techniques used by their practices to ensure payment for their services. Several clinicians indicated that they sometimes ask a patient to schedule a separate well-patient care visit to provide him or her with preventive services, particularly with a patient being seen for the management of a chronic condition. To ensure reimbursement, they play what they refer to as "billing code games" in scheduling a well-patient care appointment. One clinician explained: "When someone wants preventive services, I tell them to schedule a physical, and then under my physical code, I can order a bunch of things, and I know it will be covered. On the other hand, if someone just wants a separate service each time, it really takes a lot more ingenuity to make sure it's covered by the coding."

Time Factors. Time spent performing preventive services was an identified barrier to guideline implementation. A clinician pointed out that, when a patient comes into the office with multiple complaints resulting in 5 different diagnoses, there is no time nor is it a priority to discuss prevention such as wearing seatbelts. The clinician elaborated: "When you have someone telling you about their fifth problem and you're trying to deal with all 5, the last thing you want to do then is, after you're running late, flip to the front and say 'what preventive service can I give you today?'"

Time spent making referrals to specialized treatment facilities and time spent looking up billing codes to ensure reimbursement from HPs were also identified as barriers. In addition, clinicians noted that it would be time-consuming to assess the effectiveness of initiatives relative to their

practice. One clinician said: "I think, what I struggle with a lot…um…quite honestly, I never know where my practice is, and benchmarking a practice in terms of implementing these guidelines is very difficult and very time-consuming."

Legal Issues. Concerns about liability were identified as a barrier. For example, clinicians expressed concern about increased liability as a result of performing flexible sigmoidoscopies in their practice. They would rather refer their patients to see a gastroenterologist than perform these procedures in their offices. Several clinicians questioned the wording of several guidelines (such as "refer" to treatment centers and "prevent" motor vehicle injuries). They thought that the wording of these guidelines placed legal burden on them, and they expressed concern about liability if services were not implemented. One explained: "…[T]o throw in 'refer' makes an imperative to refer them. You're saying you must refer. I think a lot of us would object to that because that then becomes a medical legal issue."

Inconsistency Among Health Plan Tools With Various Clinical Preventive Services Recommendations. Inconsistency among HP tools was an identified barrier. Clinicians expressed frustration about HPs having different tools for various guidelines. Several clinicians admitted choosing a form and discarding all others. One clinician bantered: "Sometimes a good flowsheet gets buried under another good flowsheet, which gets buried under another good flowsheet."

Tracking of Clinical Preventive Services Already Delivered to Patients. Tracking patients' preventive services was also identified as a barrier to guideline implementation. Clinicians noted that patients often are unaware of what services have already been provided. This is especially true when the patient changes insurance carriers because of a move or a job change. In addition, clinicians noted that the patients who need preventive screenings the most are often individuals who do not come into the office. One clinician said: "People change practices, jobs, they move, insurance they change, they change PCPs, and never get updated. You know. You kind of lose track of who's where and when. I mean, my adult patients, you ask 'did you have your pneumococcal vaccine?' Most of them kind of know. Some of them don't."

Lack of Internalization of Guidelines. Failing to internalize guidelines into clinician practice was also identified as a barrier to guideline implementation. Clinicians may not be aware of the specific CPS that they are accountable for in delivering to their patients. Therefore, they may only deliver preventive care services for which they are audited.

Patient-Clinician Relationship. Finally, several clinicians expressed concern about the patient-clinician relationship. Clinicians thought that by discussing seatbelt use or alcohol intake with adult patients, they might be perceived as lecturing or as being offensive. A clinician complained: "A lot of patients would take offense to you lecturing about car restraints for adults, about alcohol, the use of alcohol and driving, and it creates a negative in the doctor-patient relationship."

Facilitators of Guideline Implementation

Health Plan Support. Clinicians said that HPs should provide organizational support to deliver CPS in their practices. A lack of reimbursement was a concern among clinicians. They said that HPs need to assess their policies and payment procedures to make sure they are in line with priority recommendations. Clinicians also suggested tools (such as easy-to-read charts) for rapid coding of preventive services.

In light of their concern about liability, clinicians suggested that the wording of some guidelines (such as "refer" and "prevent") be changed to "recommend." If referral is expected, clinicians suggested that HPs improve access to these services. Clinicians also noted that HPs should provide statistical tools to assess the current status of their practice and any needed improvement.

Patient Materials. In tracking their patients' preventive care services, clinicians suggested that HPs send reminders to their members. Clinicians also indicated that they should be provided with patient materials such as immunization cards to give to their patients for tracking these services.

To minimize the barrier of time factors, particularly time spent counseling, clinicians suggested the use of handouts or pamphlets. Clinicians were of the opinion that HPs should provide bilingual and age-appropriate materials to offer to their patients. They noted that this strategy would not only save time but also decrease office overhead.

Clinician Awareness and Sensitivity. Strategies to increase awareness and sensitivity of clinicians in practice were also identified as a facilitator of guideline implementation. Clinicians discussed the need to know what they will be audited for. A suggestion was made that clinicians audit other practices to familiarize themselves with this process and to internalize guidelines. In addition, they noted that incentives would facilitate implementation and internalization of these guidelines.

Tool Consistency. Finally, clinicians identified consistency among HP tools as a facilitator. They suggested that universal sheets (brightly colored and user-friendly) for all participating HPs be placed in patients' medical records.

Although focus groups were suited to the objectives of our study, the use of such groups had limitations. These were nonrepresentative groups of clinicians who participated in the

focus groups. Therefore, findings are not generalizable to the population of contracted HP clinicians providing care to the general population. Despite this limitation, data obtained from the focus groups provide valuable insights for tool development and for future research. Another limitation was that the moderator was a medical director of an HP that participated in the development of the priority CPS guideline set. Therefore, bias may have been introduced into the discussion, and clinicians may have been hesitant to share negative feedback with an individual in an administrative position within the HP with which they may have contracted.

CONCLUSIONS

As also noted in an earlier study,[27] clinicians in our focus groups identified perceived barriers to implementing a consistent set of CPS guidelines. The present study demonstrates the need to address perceived barriers among clinicians to implementing CPS guidelines to improve delivery through the use of a consistent set of priority guidelines.

Our study results have important implications for the use of a consistent set of guidelines for preventive care and for the wider dissemination effort. This study identified the need to address clinicians' perceived barriers to guideline implementation by promoting their awareness of existing support by the HPs. For example, despite the fact that all of the priority CPS services were already covered by the HPs, clinicians described techniques (referred to as "billing code games") used to ensure reimbursement for some of the services identified.

Medical directors overwhelmingly agree that preventive care services are underutilized by the general public, even among their managed care members.[28] The established set of priority CPS recommendations endorsed by that coalition of medical directors is intended to improve delivery of these services in clinician practice by minimizing barriers to implementation such as inconsistency and a lack of clinician awareness of and sensitivity to evidence-based guidelines. However, our study revealed that clinicians' perceived barriers to guideline implementation are in themselves a barrier to CPS delivery. If clinicians perceive barriers to implementing these recommendations, it may be difficult for them to deliver preventive care to their patients. Therefore, HPs must bridge the gap with contracted clinicians and demonstrate their efforts and support in facilitating guideline implementation.

Health plans should assist clinicians in putting systems into place that provide additional support to the delivery of priority CPS guidelines. For instance, incentives should be offered for clinicians who use a shared decision-making model in their practice. Priority CPS guidelines are based on scientific evidence and should be used by clinicians to facilitate discussion with their patients. Health plans should provide tools to encourage use of the shared decision-making model in clinician practice.

In addition to voluntary contribution of data for National Committee for Quality Assurance accreditation, commercial health maintenance organizations in New Jersey are required to submit Health Employer Data Information Set material for inclusion in the state's health maintenance organization report.[28] Health Plan Employer Data and Information Set measures that are collected do not reflect all CPS identified by the HP medical directors for priority implementation, nor are they practice specific. Therefore, category II *Current Procedural Terminology* codes that include all of the priority CPS guidelines should be used consistently across competing HPs as a performance measure. This would minimize administrative burdens on clinicians to assess the current status of their practice and how much improvement needs to be made regarding the delivery of these CPS. Because clinicians have enormous influence on patient adherence with CPS guidelines, improved communication with clinicians could increase the rates of preventive care services. There needs to be better dialogue between HPs and contracted clinicians to minimize the perceptions of barriers (particularly payment and cost concerns) and to increase clinician awareness of and sensitivity to preventive care for priority implementation. To improve CPS delivery in clinician practice, competing HPs need to communicate with contracted clinicians in a single voice in the area of preventive care.

Improved communication could also be beneficial at the patient member level. Future activities should include collaboration among HPs to provide consistent messages to patient members that emphasize the importance of and the coverage for priority CPS.

Take-away Points

- Studies are lacking in the area of barriers to and facilitators of guideline implementation when a collaboration of competing health plans (HPs) provides a consistent set of priority guidelines for preventive care.
- This qualitative study examined contracted HP clinicians' perceived barriers to and facilitators of the implementation of priority guidelines, providing HP medical directors with a better understanding of clinicians' perceptions and with direction for quality initiatives and future collaboration.
- Clinicians' perceived barriers to guideline implementation are in themselves a barrier. If clinicians perceive barriers to implementing priority recommendations, they may be unlikely to deliver preventive services to their patients.

Medical directors should use the data collected from these focus groups to develop consistent tools and to support systems across their competing HPs to assist their clinicians' delivery of priority CPS. Future studies should include an evaluation of clinicians' perceptions of barriers to and facilitators of implementing the tools developed by HPs. Finally, there should be an evaluation of developed tools and systems to examine whether the delivery of priority CPS guidelines was improved.

Author Affiliation: From Rutgers College of Nursing, Rutgers, The State University of New Jersey, Newark.

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Correspondence Author: Cynthia G. Ayres, PhD, RN, Rutgers College of Nursing, Rutgers, The State University of New Jersey, 180 University Ave, Newark, NJ 07102. E-mail: cgayres@rutgers.edu.

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