Organizing for Quality Improvement in Health Care: An Example From Childhood Obesity Prevention

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Children in rural areas face higher rates of obesity than children in urban areas, and their clinicians face challenges with preventing and managing obesity and translation of evidence into practice. We evaluated how the quality improvement (QI) intervention, Healthy Eating Active Living TeleHealth Community of Practice (HEALTH COP), at 7 rural California clinics addressed these challenges. Focus group interviews with QI team members assessed their experiences and factors related to adoption of key changes. Key challenges were clinician and staff buy-in, changing ingrained clinical practices, and motivating patient and families. Facilitators were top-down organizational requirements for QI, linkages to local QI resources, involvement of clinical champions, alignment with existing practices, incorporating a learning system connecting similar clinics, and clear and consistent communication channels. Evaluations of QI interventions should include not only measurement of effectiveness but also identification of factors associated with change and interactions with organizational processes and contexts.

**Key words:** childhood obesity, education, qualitative methods, quality, rural health

**BACKGROUND**

Childhood obesity and overweight affect approximately 30% of children in the United States.\(^1\) Children in rural areas have higher rates of obesity, lower levels of physical activity, less healthy diets, more screen time, and poorer access to healthcare than children in urban areas.\(^2\) Clinicians in rural areas face challenges related to childhood obesity, including inadequate patient education resources, lower access to subspecialists and support services, and difficulties in obtaining continuing education on clinical recommendations.\(^5\) Although national recommendations advise that children be assessed and receive counseling for obesity prevention at well-child visits, there is significant variation in clinicians’ adherence to these guidelines.\(^6\)

Quality improvement communities of practice facilitate organizational development in quality and provide a framework for clinical teams to share learning and effective practice strategies.\(^12\) Despite their widespread use, knowledge of factors that accelerate their success is still developing.\(^13,14\) Organizational context is critical in evaluating QI interventions. Bate et al.\(^15\) describe a framework for organizing for quality on the basis of contextual factors that interact in introducing, managing, and sustaining change: structural, political, cultural, educational, emotional, and physical/technological. Successful health care organizations tend to deal with these factors concurrently and possess the ability to adapt solutions to organizational contexts.\(^16\)

We developed The Healthy Eating Active Living TeleHealth Community of Practice (HEALTH COP), a virtual QI learning network involving 7 rural clinics in California.\(^17\) Our goal was to increase assessment and counseling for childhood obesity prevention. Through shared learning within a community of peers and ongoing clinical system redesign, teams developed goals for improvement, identified and implemented change strategies, assessed their performance, and worked toward continuous improvement.\(^12\)

Significant variation in care for childhood obesity in rural clinics existed prior to participation in HEALTH COP\(^15\). Following participation, there was significant improvement in weight assessment and obesity
prevention counseling. Children in participating clinics significantly improved their nutrition and physical activity. To better understand how HEALTH COP might be generalized to other rural clinics, we assessed clinics’ motivations for participation, barriers, and facilitators to participation, resources gained, and lessons learned.

METHODS

Human subject research approval was obtained from the University of California Davis Institutional Review Board. Eligibility criteria included clinics in California with telehealth services provided by UC Davis and no access to specialty pediatric weight management services. We purposefully sampled 7 clinics—3 where most well-child care was provided by pediatricians, 2 where most well-child care was provided by family physicians, and 2 where most care was provided by nurse practitioners or physician assistants. Although all clinics provided care to underserved patients, clinic populations were substantially diverse and clinics were geographically dispersed (Figure 1 and Table 1).

Participants in focus groups included preexisting members of clinic QI teams who participated in the HEALTH COP intervention, which has been described in detail in a previously published report. Team members, who included clinician champions, nurses, office staff, and volunteer parent advisors, were invited to participate in a 1-hour focus group interview conducted by video-conferencing 1 month after participation in HEALTH COP between May and August 2011. Clinic-level performance data on outcome measures benchmarking individual clinics’ performance against the other 6 clinics were sent to clinics prior to the focus group.

The interview guide included guiding questions and prompts based on published literature and probes relevant to clinic performance data (Table 2). Interviewees were prompted to offer examples of barriers and facilitators related to QI and to discuss the influence of organizational, clinic team, and patient-level factors. Focus group recordings were transcribed and de-identified prior to analysis. Analysis of transcripts involved initial coding and identification of domains important to QI initiatives as explored by guiding questions, secondary coding for recurrent themes, subtopics related to Bate et al’s 6 universal challenges to organizing for quality, and deviant/extreme case analysis to assess heterogeneity between clinics.

Figure 1. Location of rural clinics participating in HEALTH COP.
Table 1. Characteristics of Rural Clinics Participating in Health Cop

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Population Characteristics</th>
<th>Local Economy</th>
<th>Clinic Characteristics</th>
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<tbody>
<tr>
<td>1</td>
<td>Mexican American</td>
<td>Mountain and lake resort community, tourism. Most families hold jobs in local service industry</td>
<td>2 family physicians, 1 pediatrician, 1 nurse practitioner</td>
</tr>
<tr>
<td>2</td>
<td>White, European American</td>
<td>Tourism, lumber, fisheries</td>
<td>3 family physicians, 1 nurse practitioner</td>
</tr>
<tr>
<td>3</td>
<td>Native American</td>
<td>Outdoor recreation, tourism</td>
<td>Indian Health Service clinic serving 7 tribes. 2 pediatricians, 1 nurse practitioner</td>
</tr>
<tr>
<td>4</td>
<td>Hispanic/Latino, less than half the adult population graduated high school</td>
<td>Agriculture</td>
<td>1 pediatrician, 1 nurse practitioner</td>
</tr>
<tr>
<td>5</td>
<td>Mexican American</td>
<td>Outdoor recreation, skiing. Most families hold jobs in local service industry</td>
<td>1 pediatrician, 1 nurse practitioner, 2 physician assistants</td>
</tr>
<tr>
<td>6</td>
<td>Hispanic/Latino, Approximately half the adults are high school graduates</td>
<td>Agriculture, cattle feed production, beef-packing</td>
<td>1 pediatrician, 1 nurse practitioner, 1 physician assistant</td>
</tr>
<tr>
<td>7</td>
<td>Native American</td>
<td>Agriculture, vineyards</td>
<td>Indian Health Service clinic serving 9 tribes. 1 pediatrician, 1 physician assistant</td>
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Table 2. Open-Ended Questions Used to Guide Focus Group Interviews

- Clinic culture and organization
- How does this clinic work?
- How was HEALTH COP implemented at this clinic?
- Potential adaptability to novel ideas and changes
- How does staff at this clinic feel about HEALTH COP?
- How do parents at this clinic feel about HEALTH COP components?
- How would you describe staff’s ability to adapt to and integrate novel ideas regarding interventions that might change the nature of their work?
- HEALTH COP Evaluation
  - What was the key motive for participation?
  - What did you find to be the major barriers and facilitators to participation? (Let’s start with barriers . . .)
  - What did you get out of participating in HEALTH COP? (Ask first as open-ended question; then provide feedback on clinic’s rates of assessment of weight status, counseling, and patient outcomes)
  - How did clinical practice change as a result of involvement in the HEALTH COP?
  - Organizational contributions to HEALTH COP
  - What role do you believe your clinic played in contributing to HEALTH COP?
  - Is there anything else about this clinic or about implementing HEALTH COP here that you think is important for me to know, but I haven’t asked?

with the greatest and smallest improvements in performance.22

Two authors individually reviewed each transcript for recurrent themes related to each domain and then met to discuss recurring themes. A list of barriers and facilitators was generated through review and extraction of processes that limited or enhanced the impact of HEALTH COP. Specific examples and quotations that exemplified coded categories and themes were flagged. The 2 authors iteratively reviewed and compared all transcripts, and until they arrived at consensus on key elements of organizational culture and the role of HEALTH COP.23

RESULTS

Settings and participants
Thirty-one team members participated in 1 of 7 focus group interviews. Interviewees included 7 physician champions, 9 nurses, 11 office staff persons, and 4 parents. Interviews lasted 65 to 80 minutes each.

Motivations for participation in HEALTH COP
Most clinics cited mandates or directives from organizational leadership as motivation for participation. The remaining clinics cited motivations of clinical champions within the organization with specialty training or who currently managed other nutrition-related initiatives. Participation in HEALTH COP, whether motivated by organizational directives or clinician champions, derived from the need to address obesity in clinic populations.

Few clinic teams reported strong resistance to organizational mandates for QI. Factors that enhanced uptake of mandates included leveraging interests and training of clinicians, building on existing and related QI initiatives, using HEALTH COP to boost pride in care provided by the unit within the larger

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organization, and connecting the unit and larger organization to external resources. The biggest barriers to implementation were modifying perspectives of overburdened and resource-deprived staff, and reorienting perspectives of patients and families. Nearly all teams reported participating in HEALTH COP as facilitating access to clinician-, staff-, or patient-oriented resources.

**Existing resources and acceptability of HEALTH COP**

Clinicians and staff reported that most existing resources for childhood obesity in their clinic were outdated, not utilized, not readily accessible to clinicians, not sufficiently engaging to their patients and families, or did not adequately fit the needs of their patient population.

We developed a hand-out and the parent of every child over the age of 2 took a hand-out home that had the child’s BMI plotted on the BMI [body mass index] chart, and on the reverse side a list of local resources for exercise programs, etc. Some people said, “oh, this is really interesting,” and a lot of people said, thanks. Then we found the hand-out on the floor of the waiting room after the visit. [Physician]

Few clinics reported having consistent access to specialized professionals such as nutritionists. In the few cases where specialized professionals were available, clinicians admitted to referring patients to them, rather than counselling patients themselves.

I sense that there is reluctance for some clinicians that have been here a while, and they are so used to just writing a referral and saying here, I’m going to send you to the dietician. [Physician]

Even clinic teams who were highly motivated reported patient engagement being a significant barrier to QI initiatives for obesity. Clinicians with connections to resources struggled to get patients to return for appointments with nutritionists and competed with other units in obtaining access to these limited resources.

We have a nutritionist through the clinic. We can do referrals but it would still be something that parents are maybe going to have to pay for. Some children are on programs that wouldn’t necessarily pay for that kind of thing. We’re a big clinic but aren’t always able to deal with scheduling. We’re not offering nutrition services now because of budget cuts. [Clinic Administrator]

**Challenges and barriers to adopting HEALTH COP**

The biggest barrier to implementing HEALTH COP was staffing and resources, which forced reliance on specific individuals to take the initiative in implementing changes. Clinicians and staff reported inadequate time to address competing demands, scheduling timely follow-up appointments for patients, and obtaining broader organizational support, even when the team demonstrated success. Those championing HEALTH COP believed that they needed to work harder to gain commitment from clinicians and staff working with stretched resources.

I think that the biggest thing in our organization is the amount of work load on the physician and staff. These conferences are at lunchtime and so I provided them lunch, which is usually something they have to pay for. But people are reluctant to give up their lunch hour. They don’t want to, especially in the winter months when we’re so busy. [Physician]

When the organization was engaged in other QI activities, competition for scarce resources strained staff and provider loyalties to new initiatives. One clinician champion admitted, “I don’t ever recall asking about the whole QI program and what I needed to do as part of it. I think if I had known, I wouldn’t have done it because I was already too over-extended. It’s a big amount of work for a small clinic.” [Physician]

The 2 clinics that reported having staff and support to send out patient reminders or schedule timely patient follow-up visits described inadequate time during patient visits for obesity-related discussions.

We’ve always had appointments available. The only thing is time—the amount of time that we actually have for clinicians to spend time talking about obesity, because it’s a very busy clinic with lots of children. The fact is we don’t have openings to fit people in for a long discussion about nutrition. [Front office staff]

In addition to inadequate time during patient visits, clinician champions described challenges to consistent patient follow-up, lack of educational tools for staff and patients, and varying approaches to using resources. Several teams described clinicians’ apprehension in discussing BMI with parents and children and concerns regarding the cultural fit of BMI to their patient populations.

I didn’t talk about BMI specifically. The other providers didn’t either. I’ve always thought BMI was a research tool—I didn’t think that it was applicable to discussion with patients. I’ve actually found that the majority of parents know what BMI is and want to talk about it, and often comment on the fact that their child fell outside the 85th percentile. You could tell them the overweight range, but they didn’t really think that their child was overweight and weren’t terribly worried about it. [Nurse Practitioner]
Clinicians willing to consistently use BMI explained that there were inadequate resources to convey educational messages and insufficient follow-up appointments to enhance the impact of obesity-related initiatives. Teams expressed the need for further training in using BMI, strategies for engaging patients, as well as concerns about additional work. In most settings, finding standard ways to incorporate clinical guidelines into everyday routines challenged even the most innovative and motivated teams.

I was contacting patients on a weekly basis, but our financial situation here at the clinic caused a few employees to be laid off and we went on furloughs. So my role ended up becoming a medical assistant due to the fact that I was short-staffed by two medical assistants. And following up with patients when I had multiple other responsibilities . . . it’s been extremely hard. [Nurse]

All teams identified challenges with parental understanding and perception of childhood obesity, poor follow-up with clinical care, and social determinants of health. Teams described the complexity of dealing with emotional and cultural issues related to obesity along with other demands during clinic visits, and difficulties in bridging the information gap between what clinicians know about obesity and how families and patients understand it.

One thing I didn’t realize because I come from a different culture— I didn’t realize the food habits of this population. After working here and staff telling me what happens, what the patients’ diet is . . . that made me understand the kinds of foods they eat and what they actually add to cook it, so I could understand how to make it healthier. I was telling them “don’t eat this” and “don’t eat that,” but I don’t think that it was the best way to do it. I had to understand what a Mexican diet contains before telling them, “make changes.” And then I had to know what a tortilla is made of to tell them to go for corn tortillas rather than wheat tortillas. [Physician]

Teams acknowledged that strategies to address obesity commonly focused on children rather than engaging the family. They identified that success required overcoming clinicians’ concerns with and resistance to mediating parent-child conflict.

There’s really no getting away from it. There is psychological stuff that comes with it . . . how parents think about themselves . . . and they teach the next generations that. It goes pretty deep. There’s got to be a way to get through without igniting resistance. Because if you come at people with a lecture, they’re going to resist. [Nurse]

Further complicating successful engagement were poor patient follow-up and the complexity of social problems in rural communities.

Physician: When I have kids who are obese we talk about strategies for changing their plot on the BMI curve besides different diets. And then I’d say well I’d like to see you back in a month or six weeks to see how you’re doing.

Staff member: And some people on the spot say they can’t come back in . . . or they’d say, “fine I’ll be back,” and then not make an appointment . . . or make the appointment and then cancel it. I think it might be a ripple effect, if they can’t afford another visit or pay for the visit or transportation or are missing work. [Physician and Staff Member]

Recognizing that obesity is part of a complex set of challenges for people living in rural communities prompted all teams to consider approaches to enhance family engagement.

Facilitators to HEALTH COP interventions
Having a recently trained clinician champion with knowledge of guidelines related to childhood obesity facilitated the formation of clinical teams and the uptake of HEALTH COP interventions. Clinical champions who attempted to align interventions with existing practices and clinic needs reported less resistance to implementing change. Structured implementation plans with clear and consistent communication channels increased staff commitment. Efforts yielded greater success if they were aligned with local resources such as schools, food markets, or sports programs. Clinical champions and teams with stronger linkages to local communities reported greater ability to engage families as well as to tailor interventions to families’ needs.

Key Changes as a result of participation in HEALTH COP
Despite organizational and local barriers, teams reported several changes as a result of participation. At the organizational level, HEALTH COP created consistent channels for communicating patient outcomes and promoted sharing of resources and ideas for improvement between clinics. Participation prompted conversations locally on how to deliver information related to new initiatives to clinicians and staff, and how to engage families and patients. When issues related to clinician, staff, and family engagement were addressed, all teams reported change in clinical practices related to pediatric obesity, including consistent measurement of weight, calculation of BMI, and clinicians’ counseling on diet and nutrition. Parents reported increased awareness related to pediatric nutrition, exercise, and weight that spread to the entire family.
She [daughter] did go through the program and she has done really well. We have made some lifestyle changes. I’m finding a challenge in living 15 miles out of town and it’s not easy for me to drive home, cook dinner, and get my kids back in time for soccer or appointments. My mom lives in town, so I tell her, I’m in the store buying groceries and bringing them to your house and I’m going to be making dinner. So I made a pot roast last night with lots of celery and carrots in it and my daughter went to her practice. It helps everyone eat healthy... it helps our family. I think one of the breakthroughs that she had was learning that she could say “no” to how much she got on her plate. And that’s actually translated over into a lot of things in her life. [Parent]

Teams obtained tools and strategies for enhancing obesity prevention that were used as is or adapted to other QI initiatives. Examples included patient education materials, tools for BMI calculation, color-coded growth charts to communicate unhealthy BMI to families, and developing networks with other clinics through HEALTH COP videoconferences.

We got materials from your program and then from that point on we tried to get more. So if we had a nutrition brochure in the exam room, patients would be waiting for me and they’d be looking through this brochure and then I’d say, “Oh, you can take that home.” People liked that. I would say we became more aware of having things in the exam rooms for patients to take home. [Nurse Practitioner]

Teams reported that participating in HEALTH COP changed their approach to addressing weight. Changes included beginning well-child visits with discussions of growth and BMI, incorporating counseling on nutrition and exercise into all visits, tailoring strategies to patient and family contexts, encouraging follow-up visits for high-risk patients, and periodically revisiting strategies to adjust to evolving family needs. Assessment of outliers through deviant/extreme case analysis allowed us to analyze variations in characteristics and patterns between clinics with the greatest and smallest quantitative improvement (Table 3).

DISCUSSION

This study applied organizational theory to identify factors promoting the adoption of interventions in a virtual QI community of practice in a diverse range of rural practices. A key motivator for participation in HEALTH COP was top-down requests or mandates by organizational leadership. Factors that promoted the adoption of interventions included alignment between the initiative and other organizational efforts, strong involvement of clinical champions, selecting champions who had specific interest in the focus area of the initiative, standardizing clinician practices, enhancing clinicians’ connections to local community-based resources, focusing interventions on families rather than on children, and increasing availability of relevant and accessible family-centered education materials. Challenges to adopting interventions included maintaining clinician and staff commitment, changing engrained clinical practices, and addressing nonadherent patients and families.

We assessed core challenges for organizing for quality in health care. Challenges in organizing for quality in the 9 large hospitals in the United States and Europe studied by Bate et al also applied to the small underserved rural clinics in HEALTH COP. Our study reinforces the need to attend to multiple challenges simultaneously and to adapt changes to organizational contexts. Structural challenges relate to the organization, planning, and coordination of QI initiatives. Political challenges refer to the politics of change affecting QI efforts. Both structural and political challenges were more likely to be overcome when there was a top-down approach to implementation and when the intervention was aligned with organizational priorities. Assessment of a community of practice of Dutch hospitals noted that organizational and external change agent support was related to the success of interventions, but that there was significant variation in the level of organizational support between hospitals.

Cultural challenges refer to the shared meaning and value of QI within an organization. Emotional challenges address engagement and motivation and connect QI efforts to individual and collective beliefs. The level of engagement of clinician champions and their belief in the value of HEALTH COP were key determinants of its success. The value of clinical champions or “Special People” has been widely described in the context of implementing computerized physician order entry and electronic health records. Given the critical role of clinical champions in the success or failure of QI interventions, priority must be given to their recognition and development, especially in underserved clinics facing urgent QI needs.

Educational challenges refer to developing learning systems that aid QI. The virtual community of practice enhanced clinicians’ knowledge of recommendations for pediatric obesity and contributed to organizational learning by educating frontline staff on QI skills such as the application of rapid cycle QI to system redesign efforts. Physical and technological challenges address infrastructure and technological systems that support QI. The HEALTH COP intervention utilized existing technology (telemedicine) that was available and familiar to clinics for a novel purpose (building a virtual community of practice).

Although a limitation of this study is the relatively small number of clinics included, our sampling procedures increased the likelihood of selected clinics being representative of rural health clinics across California in size, geography, and patient population. Although status differences between participants in a
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<tr>
<th></th>
<th>Clinic With Greatest Improvement</th>
<th>Clinic With Smallest Improvement</th>
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<tbody>
<tr>
<td>Motivations for participation</td>
<td>Decision of clinician champion, a pediatrician. High rates of childhood obesity locally. Medical assistant’s commitment to providing patient education during visits, even prior to HEALTH COP</td>
<td>Clinician champion’s prior experience with using telemedicine and interest in applying it for another purpose. Clinician champion was a pediatrician concerned about childhood obesity as a major societal problem.</td>
</tr>
<tr>
<td>Existing resources and acceptability</td>
<td>Availability of nutritionist 20 min away from clinic for referral of children who required further support</td>
<td>Availability of nutritionist 2-3 d a week in the clinic.</td>
</tr>
<tr>
<td>Challenges and barriers</td>
<td>Inadequate time and number of clinicians. Three-month wait time for appointment with nutritionist. Nutritionist located in neighboring city with families having to use public transportation. Language barriers with predominantly Spanish-speaking population and non-Spanish-speaking clinicians. Low socioeconomic status of patient population affecting ability to purchase healthier foods. Long parental work hours, increasing likelihood of family eating fast food, instead of home-cooked meals. Hot climate reduced likelihood of outdoor physical activity. Cultural foods of local population have high carbohydrate content.</td>
<td>Clinical champion’s belief that BMI is a research tool with limited clinical utility, especially in overweight (nonobese) children. Inadequate time for in-depth discussions on lifestyle, due to high clinic patient volume. One clinician (pediatrician) assigned to implementing HEALTH COP interventions. When this clinician was out of the clinic, team did not participate in HEALTH COP video-conferences. Office manager’s belief that phone calls to patients will not contribute to behavior change. Clinic had access to nutritionist, but services were not be covered by some health insurance plans. Low success with getting families to keep appointments to follow-up BMI and lifestyle. Low parental belief that their child is overweight, even if BMI fell within the overweight range. Individualized patient education sheet developed by clinic and distributed to families at every well child visit was frequently found left behind in clinic.</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Prior efforts of clinical champion in obesity prevention. Close follow-up of high-risk children by clinical champion and medical assistant. Incorporating attention to cultural dietary practices and emphasizing moderation in intake of specific foods, vs complete change in eating habits. Tailoring messages to family needs and socioeconomic status. Highly engaged medical assistant who provided families with educational materials at visits and verbally reinforced diet and activity messages until families were able to see the nutritionist. High adherence by families to well child visits and follow-up visits. High family motivation and openness to obtaining obesity prevention services offered by clinic staff. Increased ability of families to obtain fruits and vegetables through Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Testing lipid levels in high-risk children and sharing results with parents. Relating family history of diabetes and heart disease to child’s overweight/obesity and future health risks.</td>
<td>Office manager appointed to contact families by telephone to support lifestyle changes. Clinic was used to perform weight and height measurements at all well child visits.</td>
</tr>
<tr>
<td>Key changes as a result of participation</td>
<td>Standardized assessment of BMI and counseling on key obesity prevention messages at every well child visit by modifying visit templates. Closer monitoring for high-risk patients: Medical assistant maintained a list of patients to contact weekly by telephone. Monthly 10-minute patient appointments with medical assistant for BMI follow-up. Using patient educational material and waiting and examination room posters with key messages. Targeting family-level changes in diet and activity. Consequently, parents were more likely to make appointments with their own clinicians for laboratory investigations and weight checks. Praising families for improvements in lifestyle.</td>
<td>Developed new patient education sheet provided to families at every well child visit. Sheet included patients’ BMI plotted on growth chart, key HEALTH COP nutrition and physical activity messages, and a list of local physical activity resources. Sheet used during well-child visits as a reminder/prompt to clinicians and as a visual educational aid for patients.</td>
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Abbreviation: BMI, body mass index.
clinic-specific interview design could potentially limit discussion, it was logistically easier and economically more feasible than stratifying and conducting groups based on participant roles across clinics. We anticipate that status differences were overcome because interviews were conducted by a facilitator skilled in prompting participants reticent to speak and within contexts familiar to participants. Although focus groups lend themselves to “group think,” utilizing a skilled facilitator and interviewing each clinic team separately minimized this limitation. Focus group interviews were conducted shortly after implementation of HEALTH COP and therefore focused on organizational factors that enhanced or impeded its acceptability and implementation, but not its long-term sustainability. Future studies that address organizational and environmental factors affecting sustainability of interventions can advance this understanding.13

In conclusion, our study identified that key organizational factors affecting QI initiatives in underserved clinics include the commitment and beliefs of clinical champions, incorporating a learning system that connects similar clinics, utilizing a top-down approach to introduce change, and incorporating family-centered approaches. Our results indicate that evaluations of QI communities of practice need to focus not just on measuring their effectiveness, but also on understanding factors associated with change and their interactions with organizational processes and contexts. This holistic approach to organizing for quality provides a well-rounded picture of challenges in change management that can increase the impact and success of current and future QI initiatives.

REFERENCES