Case Studies

of LEADING PRIMARY CARE PRACTICE FACILITATION PROGRAMS

Lessons Learned From Leading Models of Practice Facilitation

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care ● **www.ahrq.gov**

Prevention & Chronic Care Program
IMPROVING PRIMARY CARE

LESSONS LEARNED FROM LEADING MODELS OF PRACTICE FACALITATION

Practice facilitation (PF) is one way to support medical practices in their ongoing efforts toward primary care redesign and transformation. PF services can be a national, regional, State, or locally organized resource. Health plans, Quality Improvement Organizations (QIOs), State health departments, Practice-Based Research Networks (PBRNs), Area Health Education Centers (AHECs), independent practice associations, and accountable care organizations are all potential providers of PF services to primary care practices. PF services, which are provided by trained individuals or teams, use a range of quality improvement (QI) approaches designed to build the internal capacity of a practice to attain both incremental and transformative QI goals. As practices are encouraged by purchasers to focus on quality and to pursue efforts such as patient-centered medical home (PCMH) transformation and electronic medical record (EMR) implementation, the use of PF services has grown rapidly, and numerous PF programs have emerged within the past few years.

As potential host organizations consider developing PF programs, what can they learn from existing programs? In this brief, we describe cross-cutting lessons that emerged from an analysis of four exemplary PF programs.[1] These lessons are based on the programs' diverse experiences with a range of practices, and can offer guidance to others interested in starting or enhancing PF programs. The profiled programs were the following:

▲ **North Carolina's Area Health Education Centers (AHEC) Practice Support program**, which offers PF services focused on primary care QI and adoption and meaningful use of electronic health records through statewide regional centers.

▲ **The Oklahoma Physicians Resource/Research Network (OKPRN)**, which incorporated PF services into an existing PBRN.

▲ **The Safety Net Medical Home Initiative**, which provide PF services, training, and technical assistance to safety net practices through a national hub and five Regional Coordinating Centers.

▲ **Vermont Blueprint's Expansion and Quality Improvement Program (EQuIP)**, which provides PF services as part of State health care delivery reform efforts.

These programs were selected to reflect varying geographies, administrative homes, practice settings, and QI topics. Below we describe cross-cutting lessons from the PF programs studied, focusing first on general lessons, followed by lessons about designing PF interventions, training facilitators, and monitoring program effectiveness.

General Lessons about Providing PF Services

Effective facilitation hinges on strong relationships. Staff from the four PF programs profiled uniformly agreed that strong, positive relationships among facilitators, clinicians, and other practice staff are crucial for effective facilitation. Facilitators must establish a good rapport and, over time, develop a strong and trusting relationship with practice staff. Developing strong relationships can take

---

[1] Detailed case studies for each of these PF programs are available here.

several months, but the investment of time and resources, say these innovators, pays off later. Practice staff ultimately will be more receptive to and trusting of the facilitator, and the facilitator can be more effective in helping the practice implement new QI activities and maintain improvements over time.

Facilitation alone is not sufficient for practice change. Leading PF programs recognize that facilitation is an extremely useful means of promoting practice change, but usually insufficient on its own. Many PF programs use facilitation in combination with other QI approaches, such as performance feedback, academic detailing, learning communities or collaboratives, and health IT support.[2] For example, OKPRN staff believe that all of these supports are important, but a facilitator has an especially important role to play in arranging and coordinating the various QI activities and approaches. A facilitator also helps a practice to access additional resources as necessary—so a practice gets what it needs when it needs it.

The concept of the learning community is applicable to both practices and facilitators. Learning communities bring people with common goals together to share information, lessons, and best practices, thereby enhancing their capacity to make meaningful change. For example, learning communities of primary care practices—often called learning collaboratives—typically focus on training, evaluating performance, and sharing lessons learned or best practices across diverse practice settings. These collaboratives may exist locally or through a larger network, such as a statewide network of practices. Bringing practice staff together—either in person or virtually—allows for peer-to-peer learning that also instills a sense of positive peer pressure toward practice change. In addition, learning communities of practice facilitators can be an effective way of sharing ideas and strategies among facilitation team members, quickly building the facilitation skills of new facilitators, and allowing for brainstorming about how to tackle new challenges. Such learning sessions can also help to build rapport and establish trust among team members—which encourages further sharing outside of learning sessions. All four of the profiled programs have established learning communities of practices and of facilitators.

Lessons on Administrative Infrastructure

There is no one "best way" to establish an administrative home for a PF program. These four profiled programs illustrate four different administrative arrangements, each with potential benefits and challenges to the program in terms of funding, program flexibility, and resources that can be leveraged. The programs profiled include a nonprofit quality improvement consulting firm, a State Medicaid agency, a PBRN, and a statewide AHEC housed within a State university. New PF programs are often developed administratively within whatever arrangement is available when the program is started, and many different arrangements can be successful.

New programs should leverage existing resources whenever possible. Housing new PF programs within existing organizations (such as a QIO or PBRN) often provides programs with access to many resources—including staff, physical space, financial resources, and connections to a network of practices and/or thought leaders in the community. For example, OKPRN was able to leverage extensive resources from the University of Oklahoma to grow considerably and expand its reach. While OKPRN started very small, with just one facilitator, it's now taking steps toward building a statewide QI infrastructure. The North Carolina Practice Support program evolved out of a QI program run through a nonprofit alliance of

---

[2] See Chapter 4 of the AHRQ manual, *Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide*, for more information on these approaches. pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2

State health care leaders. The State AHEC became involved by leveraging its internal capacity to support two initial QI coaches through a Robert Wood Johnson Foundation grant. Based on these initial efforts and experience, the program then secured additional funds from many sources, including the State budget; the Division of Public Health and Medicaid Office; the Federal Office of the National Coordinator for Health Information Technology; and the Duke Endowment to provide a robust PF program of 49 facilitators and support personnel serving 1,000 practices statewide.

For PF programs with relatively large catchment areas, it is important to balance a centralized infrastructure with flexibility at the local level. Each of the programs profiled operates across multiple sites and covers a relatively large geographic area (statewide or larger). To do so efficiently, these programs provide centralized resources, tools, and technical assistance to their facilitators and facilitation teams, which can help to ensure program consistency and quality across regions. At the same time, programs are also flexible enough to allow facilitators to tailor their work to each practice's specific QI goals and needs. In the case of the Safety Net Medical Home Initiative, Qualis and MacColl developed a centralized infrastructure of general trainings, tools, and resources that can stimulate specific, actionable steps toward change. Facilitators in each regional coordinating center use the tools and resources most appropriate for the practices with which they work. Moreover, while practices are encouraged to follow the Initiative's sequence of practice transformation stages, facilitators adapt these "change concepts" to best meet individual practice needs.

Lessons on Designing PF Interventions

PF interventions are most effective when tailored to the interests and needs of each practice. PF programs consistently report that their work with practices is most effective when tailored to practice needs. While an overarching framework (such as the Chronic Care Model)[3] and a "key-driver model" (which identifies the most important factors and activities needed to reach a desired outcome) clearly guide a PF intervention's activities, the goals for improvement and the schedule for accomplishing those goals should be practice driven. Facilitators need to arrange their schedules to accommodate the different intensity levels of intervention work at different practices, as well as different practice needs. In addition, facilitators need to conduct work that closely reflects practice interests and priorities at the start-up of a project—this is a useful method for building practice buy-in for later, more difficult practice improvement work. Facilitators also should assess practice readiness for change, given that those practices more skeptical about the potential benefits of QI work are often less engaged and less successful. In these instances, more grassroots engagement approaches and education about QI benefits may be required. In short, PF work must be useful and meaningful to a practice to generate buy-in.

---

[3] For more information, see Wagner (1998) and Improving Chronic Illness Care (2012).

Closely integrating EMR implementation and PF services can make both more successful. EMRs are an integral part of high-functioning primary care practices, yet EMR implementation efforts often are siloed from QI work. To increase their effectiveness, PF programs should incorporate EMR efforts into their work. Including EMR consultants from the Health Information Technology Economic and Clinical Health (HITECH) Regional Extension Centers (RECs) on facilitation teams can intensify the effectiveness of both the facilitator and EMR consultant and helps both of them work in a coordinated fashion to support practices' QI work and redesign efforts. Along these lines, EQuIP's practice facilitators work closely with the state REC in improving care in State practices and have found this to be highly effective. The NC Practice Support program is built upon a foundation of comprehensive QI work, and all of its EMR implementation work is framed as a QI effort and integrated into the overall QI framework. This unique approach enables the NC AHEC to integrate multiple funding sources and deliverables into a comprehensive and sustainable PF program.

Lessons on Training Facilitators

It is critical that facilitators possess core coaching skills and QI technical expertise before working with practices. As one PF program director said, "If an organization is building a new PF program, they should have a number of things in place before working with sites, including a staffing and training model that ensures coaches have a basic set of core skills and content knowledge." Many organizations likely to house PF programs may be better equipped to train on technical content than on core facilitation skills. If this is the case, an organization could either develop needed resources and build to support facilitation skill development over time or contract with other organizations that specialize in core coach training. Another possibility is to rely on a learning community of facilitators to support the development of core facilitation skills (especially among newer facilitators), which allows them to capitalize on the interchange of information and learning among peers. Whichever model is chosen, it's critical to establish formal processes for educating new staff, both initially and over time.

Most facilitators require extensive training, and this training often takes longer than anticipated. While most PF programs look to hire facilitators with knowledge of QI methods, background in using data to drive improvement, some experience in a clinical setting, and strong interpersonal and other core coaching skills, finding people who meet all of these criteria is often challenging. In Vermont, the EQuIP program initially had problems in finding people with the necessary background. As a result, EQuIP invested heavily in training programs and built its own workforce from the ground up. This type of training can be very time consuming. Because there are costs to practices in working with facilitators (for example, unbillable hours, extra work), programs should build in adequate time for training before facilitators begin working directly with practices to ensure that the initial interactions are positive and productive. As one PF program director said, "You don't want a site to have low confidence in the coach. You want to make sure that sites see their interaction with the coach as a benefit. If that means enrolling sites a month, or 2, or 6 months later, it might be worth it." Another way to address gaps in the skills of a single facilitator is to use a team approach to facilitation. For example, the NC Practice Support program organizes its facilitation efforts via teams of staff with complementary skills, so that team members can draw on the expertise of their colleagues when needed.

Direct hiring and management of facilitators makes it easier to stay true to the intervention

model. Subcontracting with external organizations to provide PF services can produce challenges to fidelity. While direct hiring of facilitators is not always possible, particularly for new PF programs, program directors need to recognize the challenges associated with subcontracting for PF services and similar arrangements. For example, EQuIP originally staffed its program by subcontracting with external health care organizations to use a percentage of a staff person's time to serve as facilitator. This made it hard for the EQuIP director to supervise or train those people and oversee their work. Moreover, that staff person's ability to provide the contracted services often was compromised by competing demands from the external organization. As a result, EQuIP shifted to direct hiring of facilitation staff, which has been much more successful. With this approach, staff loyalties lie with the EQuIP program, not another organization; EQuIP is able to supervise and monitor the progress of these staff effectively; and staff are not at risk of being pulled from their work as QI facilitators to address other needs in the health care organizations they support.

Lessons on Assessing a PF Program's Quality and Effectiveness

Monitoring helps maintain program quality. PF programs and their staff, like practices, should be assessed and reassessed for their capacity and effectiveness in supporting practices in the transformation process. The Safety Net Medical Home Initiative, for example, includes mechanisms that monitor practices' transformation progress—and also indirectly monitor facilitators' work at regional centers. These include a useful combination of subjective facilitator-completed tools and objective practice indicator tracking. Facilitators also submit reports to Qualis Health that detail their own accomplishments with each practice, strategies that did or did not work well, and future intervention plans, including the types of assistance they need from the national hub. Qualis Health uses information from these sources to identify common challenges, which then inform the development of future training and support.

In another example, EQuIP staff members monitor facilitators' work and fidelity to the intervention by using a database that captures information on time spent with practices, activities completed during encounters with practices, who participated in meetings with the facilitator, and the expected versus actual content and outcomes of the meetings. This information is used to identify areas for program improvement and guide training and supervision.

Conclusion

As PF continues to attract attention as a useful strategy for supporting practices in their ongoing QI efforts, more organizations are creating PF programs. Developing a successful program requires the integration of numerous components, including an appropriate administrative home, a well-defined PF intervention flexible enough to meet individual practice needs, effective hiring and training of facilitators, and ongoing monitoring of the program's quality and effectiveness. While the field of PF is quickly evolving, the cross-cutting lessons that emerged from our analysis of four leading PF programs highlight some approaches that have been successful to date. Developing a successful PF program can be challenging work, but the potential payoff may be considerable: improving quality of care and patient outcomes, and possibly increasing practice efficiency and reducing overall costs.

Resources

Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/ pcmh_home_v2.

Program Snapshot: North Carolina's Practice Support Efforts. http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_12547_958915_0_0_18/NorthCarolina_020413comp.pdf

Program Snapshot: Oklahoma's Practice Enhancement Assistants. http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_12547_958916_0_0_18/Oklahoma_020413comp.pdf

Program Snapshot: The Safety Net Medical Home Initiative. http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_12547_958917_0_0_18/Qualis_020413comp.pdf

Program Snapshot: Vermont Blueprint's EQuIP Program. http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_12547_958918_0_0_18/Vermont_020413comp.pdf

References

Improving Chronic Illness Care. Chronic Care Model Primer. Available in Integrating Chronic Care and Business Strategies in the Safety Net. http://www.improvingchroniccare.org/downloads/ICIC_Toolkit_Full_FINAL.pdf.

Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Eff Clin Pract 1998;l(1): 2–4.