

# Case Studies

*of* LEADING PRIMARY  
CARE PRACTICE  
FACILITATION PROGRAMS



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## CASE STUDIES OF LEADING PRACTICE FACILITATION PROGRAMS

Practice facilitation (PF) or coaching is one way to support medical practices in their ongoing efforts to redesign and transform primary care. PF services are provided by trained individuals or teams, using a range of quality improvement (QI) and practice improvement approaches. These services are designed to build the internal capacity of a practice so it can achieve both practice transformation and ongoing QI goals.

Here, we present four case studies to complement the AHRQ manual, *Developing and Running a Primary Care Practice Facilitation Program: A How-To Guide*, which details how to develop a PF program.<sup>1</sup> These four case studies profile exemplary PF programs, highlighting each program's motivation for development, administrative structure, funding, PF approach and activities, hiring and training of staff, and monitoring of program quality. The purpose of the case studies is to provide detailed descriptions of the formation and operation of real-world PF programs. Together, the *Guide* and these case studies present a vision, framework, and practical direction for others interested in developing similar programs.

The programs profiled were chosen to reflect varying geographies, administrative homes, practice settings, and QI topics. The directors, project managers, and other key staff of these well-established programs shared their knowledge of and experiences with developing and running a PF program. Each case study highlights the specific program areas essential for effective program development, focusing on the particular context, strengths, and innovations of that program.

The following four programs were profiled:

- ▲ **North Carolina's Area Health Education Centers (AHEC) Practice Support program**, which provides PF services focused on primary care QI and adoption and meaningful use of electronic health records, offered through statewide regional centers.
- ▲ **The Oklahoma Physicians Resource/Research Network (OKPRN)**, which incorporated PF services into an existing Practice-Based Research Network.
- ▲ **The Safety Net Medical Home Initiative**, which illustrates a partnership between Qualis Health (a nonprofit QI consulting firm) and the MacColl Center for Health Care Innovation (a research organization) to provide PF services, training, and technical assistance 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.

The following table provides an overview of these four PF programs and a preview of what can be found in each of the case studies.

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<sup>1</sup> To download the manual, please visit the AHRQ Web site [www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483/pcmh\\_home\\_v2](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_home_v2).

## Facilitation Programs Selected for Case Studies

	North Carolina AHEC's Practice Support Program	Oklahoma Physicians Resource/Research Network	Safety Net Medical Home Initiative	Vermont Blueprint's Equip
Context	Statewide health care improvement effort	Statewide QI services through existing Practice-Based Research Network (PBRN) infrastructure	5-year demonstration project, sponsored by The Commonwealth Fund. National hub provides centralized support and training; 5 Regional Coordinating Centers support practices at State and local levels	Statewide health care reform initiative
Administrative Home	Statewide Area Health Education Centers (AHEC) housed at the University of North Carolina-Chapel Hill	Academic health center-affiliated PBRN	Qualis Health, a nonprofit QI consulting firm	State Medicaid agency
Objectives	<ul style="list-style-type: none"> <li>Improving health outcomes</li> <li>Improving quality of primary health care</li> <li>Lowering costs of care</li> </ul>	<ul style="list-style-type: none"> <li>Improving primary care practices' team functioning and communication</li> <li>Implementing best practices and evidence-based approaches</li> </ul>	<ul style="list-style-type: none"> <li>Transforming safety net primary care practices into patient-centered medical homes (PCMHs)</li> <li>Building regional QI capacity</li> </ul>	<ul style="list-style-type: none"> <li>Transforming primary care practices into PCMHs</li> <li>Supporting use of electronic medical records</li> <li>Building QI capacity</li> </ul>
Staffing Model	Staff hired through the regional AHECs	Staff employed by the University of Oklahoma	Facilitators are hired or contracted by each Regional Coordinating Center	Staff and consultant professionals
Location of Services	On site at practices	On site at practices	Technical assistance support from national hub is provided virtually by webinar, phone, and email; on site PF services provided to practices in each of 5 regions	On site at practices
Schedule and Duration	Driven by practice needs; typically weekly to biweekly, with durations ranging from 3 to 18 months	During the course of a project, half-day per week on site—usually for 6 months	Facilitation services offered for 4 years; intensity and form of services vary by region and practice	Twice monthly visits to practices; facilitators are permanently assigned to practices
Program Size	49 full-time equivalent (FTE) facilitators and support personnel	4 FTE facilitators	7.4 FTE facilitators (~1-2 FTE facilitator for each of 5 regions)	13 FTE facilitators
Ratio of Facilitators to Practices	~1:25 to 1:35 (varies depending on role)	1:8	~1:2 to 1:13 (varies by region)	1:8 to 1:10
Eligible Practices	Any primary care practice in the State that applies: 1,000 current participating out of ~2,000 practices in State	Any primary care practice in the network (which includes more than 240 clinicians, representing 160 practices)	Primary care safety net practices that applied to 5 regional coordinating centers	Any primary care practice in the state that applies; eligible practices estimated at 200

## PROGRAM SNAPSHOT: NORTH CAROLINA'S PRACTICE SUPPORT EFFORTS

North Carolina's Area Health Education Center (AHEC) Practice Support Program provides facilitation support to primary care practices throughout the State. It employs 49 facilitators or practice support staff to work in teams based in each of the State's nine regional AHEC centers. Each regional center houses a team of three to nine individuals with varying skills, including quality improvement (QI) coaches, electronic health record (EHR) implementation experts, and experts in optimizing EHRs for use in QI and clinical care. Each team member works with 25 to 30 practices at a time, supporting QI and EHR implementation and optimization. The program currently serves approximately 1,100 practices statewide.

The North Carolina AHEC Practice Support Program	
Context	Statewide health care improvement effort
Administrative Home	Statewide AHEC housed at the University of North Carolina-Chapel Hill, with facilitators at each of the nine regional AHEC centers
Objectives	<ul style="list-style-type: none"> <li>• Improve health outcomes for State residents</li> <li>• Improve quality of primary health care</li> <li>• Lower costs of care</li> </ul>
Funding Source	Recurrent State funding, Federal funds for the Health Information Technology for Economic and Clinical Health (HITECH) Regional Extension Center (REC), funding from the State's Division of Public Health, grant funding, private contracts from payers and integrated health systems
Staffing Model	Staff model, with the majority of staff hired through the regional AHECs and supported with resources from the State AHEC office
Location of Services	On site at practices
Model and Approach	Key drivers focus on four elements of the Chronic Care Model; approach involves team facilitation, supporting improvement, capacity building, and EHR implementation
Schedule and Duration	Driven by practice needs, weekly to biweekly, with durations ranging from 12 to 18 months (or longer as needed)
Program Size	49 full-time equivalent practice support staff
Ratio of Facilitators to Practices	Approximately one practice support staff for 25–30 practices
Eligible Practices	Any primary care practice in the State that applies to participate; approximately 1,100 currently participating
Training and Support	Internal training emphasizes QI methods, the patient-centered medical home (PCMH), and EHR implementation; QI coaches are also sent to external trainings and conferences

In this case study, we profile the NC AHEC Practice Support Program, describing its background and context; administrative structure; how it hires, trains, and supervises members of its practice support (or facilitation) teams; and how it evaluates and assesses program quality. We conclude with lessons learned from North Carolina's practice support and facilitation work for use by those interested in implementing a similar program.

## Facilitation in the Context of an Area Health Education Center: The North Carolina AHEC Practice Support Program

North Carolina's Area Health Education Centers (NC AHEC) Practice Support Program is one of the largest practice improvement or facilitation programs in the United States, with a variety of well-developed funding sources and a history of providing support to primary care practices. It employs 49 practice improvement facilitators—which the program calls practice support staff<sup>2</sup>—who work together in teams based in each of the State's nine regional AHEC centers. These individuals include QI coaches and individuals with special expertise in health IT implementation and optimization. The practice support teams support QI as well as EHR implementation and optimization, and currently serve approximately 1,100 practices in the State. Program funding comes from recurrent State funds, grants, contracts with the North Carolina Division of Public Health, and Federal funding from the Office of the National Coordinator (ONC) as the State's HITECH REC.

The NC AHEC Practice Support Program's extensive experience in facilitation offers several important lessons:

- ▲ A team facilitation approach is an effective way to make sure that practices have access to expertise in QI, EHR implementation, and the use of clinical data for improving clinical care.
- ▲ Practice support teams must reinforce the value of various types of expertise and not inadvertently emphasize particular areas because of pressure from practices. To function effectively, the team itself must recognize the value of each member's contribution as part of the comprehensive process of practice improvement.
- ▲ EHR implementation activities are most effective when included under the umbrella of QI. The impact of both the HITECH REC and facilitation work is optimized through cross training staff. HITECH REC staff are trained in and/or knowledgeable about QI principles, and QI coaches are trained in and/or knowledgeable about EHR implementation and optimization.
- ▲ Maintenance of Certification and Continuing Medical Education (CME) requirements and payer incentive programs can create interest in and readiness for facilitation work in practices. They also can galvanize support for facilitation work among local and State health care leaders.
- ▲ Practice-based improvement interventions are most effective when tailored to the interests and needs of each practice.

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<sup>2</sup> The NC AHEC Practice Support Program uses a team to provide support to the practices. In this case study, the term "practice facilitator" refers to all individuals on the practice support team, regardless of their areas of expertise. In the other case studies in this series, practice facilitator most commonly refers to the individual who is providing support on QI processes and change management.

## **I. Motivation and Development of the NC AHEC Practice Support Program**

The NC AHEC Practice Support Program began in 2007 as one of two State pilots for a QI coaching program of the Improving Performance in Practice Program, a national program funded by the Robert Wood Johnson Foundation (RWJF) with some contributing funds in North Carolina from the State Division of Public Health. While the QI coaches and day-to-day functions of the program were always located within the NC AHEC Program, the North Carolina Healthcare Quality Alliance (the Alliance), a coalition of State leaders in health care focused on improving health outcomes for the State, oversaw the startup of the project. The Alliance is a nonprofit organization funded by the Blue Cross Blue Shield of North Carolina Foundation, the NC Health and Wellness Trust Fund, and small grants from several other sources. Its board of directors includes representatives from Community Care of North Carolina, the State Department of Health and Human Services, Blue Cross and Blue Shield of North Carolina, the NC Hospital Association, the NC Academy of Family Physicians, State medical societies, academia/researchers, industry, the NC AHEC, and the governor's office.

Since its beginning, the NC AHEC Practice Support Program has focused on improving primary care practice and building practices' capacity for ongoing QI. When the NC AHEC was selected to serve as the HITECH REC for the State, the scope of the program expanded to include implementation of EHRs. The program's QI coaches had been struggling with obtaining data from individual EHR systems for years and recognized the need to develop EHR expertise to advance the use of practice data for the purpose of improvement. The NC AHEC Practice Support Program's involvement and acquired expertise in this area is part of what prepared it to house the State's HITECH REC.

Since its initial pilot, the NC AHEC Practice Support Program has grown to a program employing a staff of 49 practice support team members and supporting approximately 1,100 primary care practices statewide with a continuum of services.

## **II. Administrative Structure**

The NC AHEC Practice Support Program is administered by the State's AHEC, one of the largest and oldest in the country. The NC AHEC is a 40-year-old program started with Federal funding; it is now primarily supported by State-appropriated funds to meet the State's health and health workforce needs. The AHEC works with academic institutions, health care agencies, and other organizations to improve health care for the State.

The NC AHEC is run from a central program office at the University of North Carolina-Chapel Hill and is organized into nine regions across the State. The AHEC provides workforce training, CME, and telemedicine support for practices throughout the State; operates 11 residency programs; and provides the infrastructure for community-based training for students in all the major health disciplines.. The NC AHEC also houses the State's HITECH REC, which supports implementation of EHRs in primary care practices across the State.

With the advent of change in the Maintenance of Certification requirements from the American Board of Medical Specialties, practice-based QI is now a primary focus of maintaining board certification for physicians across the country. As such, the activities of the NC AHEC Practice Support Program are directly aligned with the AHEC's mission and scope of work; the AHEC supports this through

trainings delivered at its regional centers as well as practice-based programs that are accredited for both Maintenance of Certification Part IV and CME.

The NC AHEC Practice Support Program maintains a 5-year strategic plan focused on its long-term sustainability. The plan is updated periodically by the Practice Support Program director, the statewide AHEC director, and the regional AHEC directors. The NC AHEC Practice Support Program does not have a designated governing or advisory board, but uses the North Carolina Healthcare Quality Alliance as a sounding board when needed. The directors of the regional centers also serve as an informal advisory board.

## 1. Staff

**Centralized staff.** The NC AHEC Practice Support Program is headed by a full-time **executive director** who also functions as one of seven associate directors for the NC AHEC program. A **QI manager** oversees training and internal QI for the program, and analyzes data collected within the NC AHEC Practice Support Program to guide the regional teams in internal efforts to improve the quality of services provided to practices by the team. This occurs through quarterly milestone calls with team leaders to review data. A **grants manager** supports the director, coordinates funding sources, and tracks attainment of their deliverables across the program's different funding sources. This position works closely with the State Division of Public Health and the Federal ONC, two of the program's main funders.

Program staff also include a **business service coordinator** who manages the program's database systems and provides administrative support to the program director. This position also tracks EHR implementation data needed for reimbursement from the ONC as part of the HITECH REC program. In addition, the program has a 0.25 full-time equivalent (FTE) **medical director**. This physician is the team lead for two of the program's regional teams, and the medical director for the program's EHR- and QI-related activities. The medical director champions the efforts with provider communities and serves as a liaison between the program and physician leaders engaged with each regional center. A 0.75 FTE **intern**, typically a recent master's of public health graduate, provides data cleaning and management support.

**Regional staff.** The NC AHEC Practice Support Program provides funding through a subcontract to each regional AHEC center for its regional practice support team. Each regional center maintains its own practice support team, which includes experts in QI coaching, EHR implementation, and EHR optimization. Currently, a total of 49 FTE practice support staff are employed across the nine AHEC regions.

In addition, each regional practice support team has a designated lead who participates in regular meetings with the NC AHEC Practice Support Program's executive director and program office staff. Team leads also help to hire and manage the practice support team members in each region and are responsible for helping the regional AHEC to meet deliverables, set in cooperation with the State program office, that tie back to the requirements of the contract deliverables for the various funders.

Each regional practice support team also has a 1.0 FTE **administrative support** person to assist with the extensive amount of documentation that the teams are required to maintain for contract deliverables. The administrative support staff helps each team with gathering and entering the documentation into the State system, and scheduling practice visits and regional meetings.



## 2. Centralized Resources

The State office for the NC AHEC Practice Support Program provides **IT systems** as well as **training for practice support team members**. These systems help each regional team keep track of the number of practices it serves, the content of service encounters, and progress toward key deliverables. The State office also supplies **IT resources** to help team members track the progress of individual practices toward goals specified in the program's key-driver model and those specified as deliverables in the regional center's subcontract with the State.

The NC AHEC Practice Support Program office also supplies a **shared document storage system on a collaborative Web site**. The site, which is an internal resource for practice support team members only, contains all of the program's training materials and manuals for every vendor product with which practice support team members work in the field. The site also includes comments from team members about working with various EHR products that may be useful to other teams.

## III. Funding

**Funding sources.** The NC AHEC Practice Support Program currently offers facilitation support free of charge to qualified primary care practices in the State. The program began in 2007 with a small grant from RWJF's Improving Performance in Practice initiative. Since then, its funding sources have expanded significantly. The program receives recurrent funding through the State appropriation for the NC AHEC Program. For 3 years, the program also received support from the North Carolina Medicaid Office, but this funding was cut during the recent economic downturn. The program also currently receives funding from the ONC to serve as the State's HITECH REC.

In addition, the NC AHEC Practice Support Program receives funds from the State's Division of Public Health to deliver clinical strategies related to the community transformation program funded by the Centers for Disease Control and Prevention, and support from foundations such as The Duke Endowment for work in areas such as improving care for chronic disease and smoking cessation. Finally, the program is beginning to pursue funding from payer organizations to provide services to smaller, independent practices in the State, and recently has received its first private contract from a large integrated health care system in the State to work in the system's community-based clinics.

**Program costs.** The program budget includes funding for program staff salaries and benefits, staff training and ongoing professional development, travel to and from practice sites, and program monitoring and evaluation.

## IV. Practice Facilitation Approach

### 1. General Approach

*Enrolling in the program.* Practices interested in receiving support from a regional AHEC practice support team can complete an online application that is part of the electronic data system managed by the State office. The application is automatically routed to the appropriate regional office, where the team lead determines program eligibility based on the application and assigns eligible practices to team members for followup.

*Practice support team approach.* The NC AHEC Practice Support Program uses a team approach to facilitation. Each team consists of three to nine individuals made up of **QI coaches** who are specialists in QI in primary care settings and improvement science; **EHR implementation experts** who are EHR implementation specialists and have extensive knowledge about EHR vendors, EHR implementation, and related workflow design; and **technical assistance specialists** who are experts in accessing data from the EHR systems and help the practices to fine-tune their use of the EHR systems to support clinical and QI processes. Practice support team members work together to optimize reporting functions and pull data to drive both improvement efforts and clinical care activities.

The ratio of practice support staff to practices is approximately 1 to 25; however, team assignments vary based on the need of the practice, the funding source and its requirements, and the distances that the team members must travel to provide support to the practices. Almost all support is provided on site, with virtual support on an as-needed basis. Each regional team is a permanent resource for the practices in its region.

*Collaborative learning.* In addition to the onsite services of the regional practice support teams, the NC AHEC Practice Support Program uses collaborative learning sessions to support improvement work in practices. The program delivers these as quarterly 2-hour dinner sessions. The program developed this hybrid approach to collaborative learning in response to the costs to small practices of participating in traditional 1.5-day learning collaboratives.

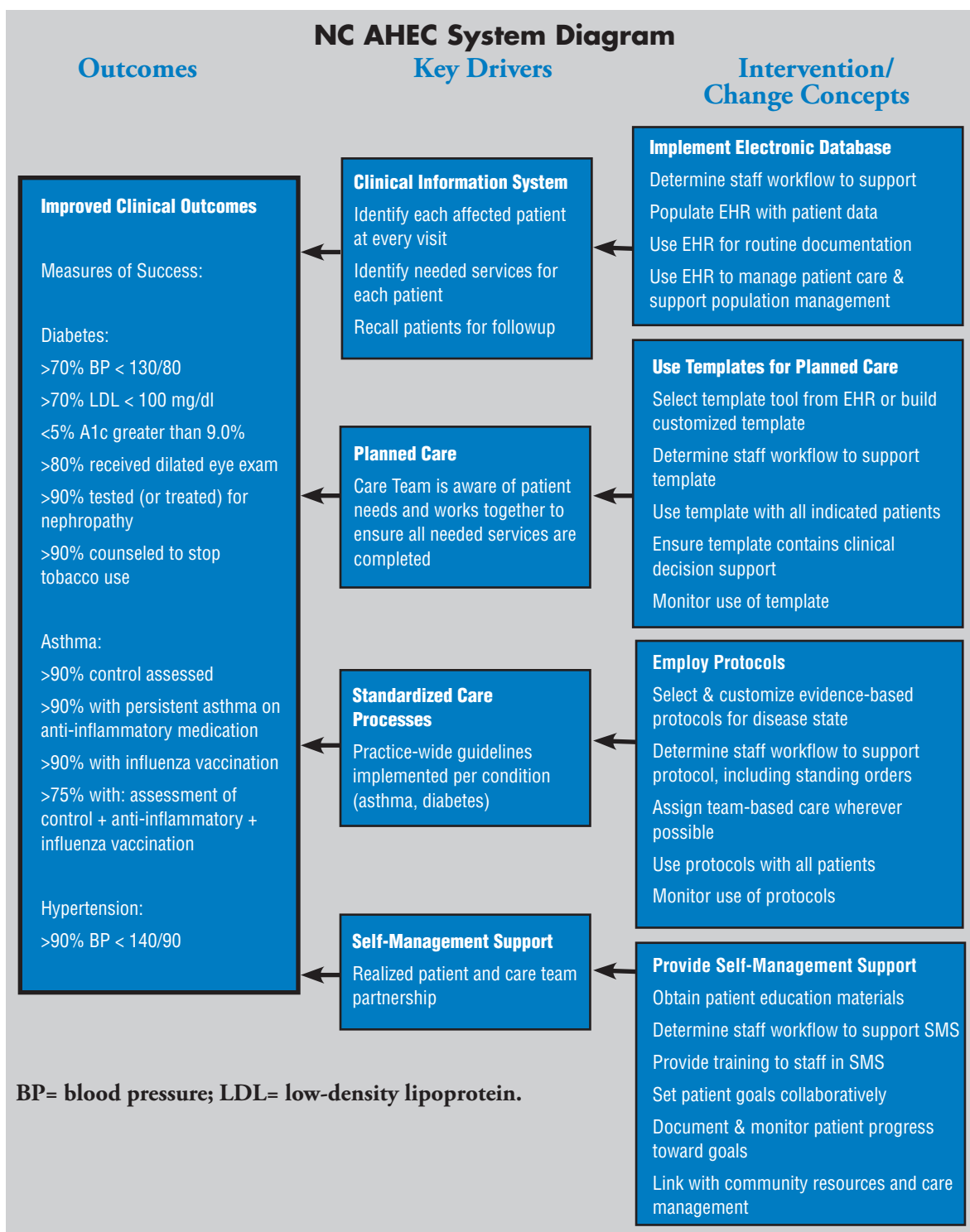
Each regional center hosts an evening collaborative meeting three to four times a year. Any practice that is participating in the program can send as many of their staff as they want from the practice to these collaborative meetings. The sessions focus on reviewing practice data, using data to improve quality, and stories from practices about the improvement work of which they are most proud, including but not limited to achievements in Federal programs such as meaningful use, PCMH, and the Physician Quality Reporting System. The attendance varies across regions; in some regions, these meetings have had as many as 150 attendees.

*Practice eligibility and goals.* All primary care practices in the State are eligible to receive support from the NC AHEC Practice Support Program and apply to the AHEC to do so. Practices can enter the program in two ways—through an interest in either QI or EHR implementation. However, all work done through the NC AHEC Practice Support Program, regardless of focus, is grounded in QI. All team members are knowledgeable in QI as well as EHR implementation skills, and are able to support practices in both areas, with additional support and expertise provided by others from their practice support team.

If a practice's initial request to the program is for QI help, a QI coach from the regional practice support team is assigned to the practice to support capacity building and work in this area. As part of this work, the coach encourages the practice to set up electronic data systems. This often includes adopting an EHR if the practice is not already using one and optimizing its use to support the QI work being done at the practice. Similarly, if a practice applies to the NC AHEC Practice Support Program for help in selecting or implementing an EHR, the EHR implementation expert from the practice support team in that region will work with the practice on these issues; at the same time, the team member will also encourage the practice to build elements into its EHR that support improvements in clinical care and QI, and offer support from the team's QI coach.

*Intervention focus.* The NC AHEC Practice Support Program developed a key-driver model to guide each team's work with practices. The model is based on the four components of the Chronic Care Model: clinical information systems, planned care, care protocols, and patient self-management support (see Figure 1). To engage practice staff, the initial focus for the intervention is determined by the practice's interests and priorities.

**Figure 1. The NC AHEC Practice Support Program's Key-Driver Model**



## 2. Focus and Schedule for Support Team Members' Work with Practices

The regional practice support teams' duration and schedule of work is determined by the needs of each individual practice. This practice-centered approach is an essential element of the NC AHEC Practice Support Program. Some practices want to move aggressively forward with QI or EHR implementation work and therefore may meet weekly with their practice support team member(s). In these instances, the practice support team members assigned to them will do their best to be available on site for these meetings. More typically, the team member will meet with the practice every other week or so. Practice needs also drive the duration of support. Some need fewer months of support, while others may require a longer duration due to the complexity of the changes being made and the progress shown. Each regional practice support team is left to manage its time and caseload in a way that enables staff to deliver support aligned with established program goals and contract deliverables, and tailored to the needs of each practice.

The program focuses on building effective relationships between the team and the practice. This is accomplished initially by having the team member determine where the practice is in the service continuum and work on the goals of the program that the practice considers a priority.

One of the overarching goals of the program is to encourage each practice to build its own internal QI program that can initiate and sustain improvements on an ongoing basis. Each regional practice support team works to provide information, education, tools, and support in the area of QI to help a practice build sufficient capacity in this area, so it is able to self-direct these activities going forward.

## 3. Typical NC AHEC Practice Support Process

At the regional level, a member of the practice support team arranges an initial meeting between the practice and the support team member. At this time, the practice signs an agreement with the program that outlines expectations and scope of work for the intervention. The team member determines how advanced the practice is in its QI work, if it has a certified EHR, and what areas the practice wants to focus on as part of its work with the team.

The regional practice support team then uses this information to identify the appropriate member of the team to lead the intervention with the practice. For QI-focused goals, the QI coach from the team is assigned as lead. For EHR-focused work, the EHR expert on the team is assigned as the lead. Each lead then brings in the other to complement and expand the work taking place at the practice.

**Assessment.** For a practice interested in QI work, a QI coach is assigned to work with it to identify its improvement goals and conduct informal assessments of the practice related to these goals. The QI coach and practice use the results of these discussions and early assessment to identify strengths and weaknesses of the practice, develop its initial improvement plan, identify early change activities that can be “easy wins” used to build confidence and capacity in the practice, and identify metrics so the practice can monitor progress toward its goals. From this point on, the QI coach works with the practice to conduct monthly assessments and rate progress toward its changes, and also prioritize improvements included in the support program's key-driver model. These defined metrics allow the QI coach and the practice's QI team to continually monitor progress even when this progress is not yet evident in the clinical quality data pulled from the practice's EHR.

**Active improvement.** The practice support teams work with a practice with the goal of building capacity as well as accomplishing the specific improvement goals set out by the practice. If the practice is focused mainly on QI, the team member assigned to the practice will focus on building internal capacity for QI and implementing improvements in areas prioritized by the practice as well as the program's key-driver model. If the practice does not have an internal QI team, the QI coach will work with the practice to form a team and develop a QI plan for it. The QI coach will also train the team in QI methods and prioritized changes based on the program's key-driver model that also support PCMH work. In doing so, the coach often focuses on one clinical category, uses this as an opportunity to build general improvement capacity, and then encourages the practice to spread improvement work to other areas on its own.

If the practice is focused mainly on EHR implementation, the EHR expert from the team is assigned to assist the practice in identifying the most appropriate EHR vendor products, mapping workflows, and implementing the system. During this process, the staff help the practice to understand some of the technology and other practice-level changes needed to support meaningful use, ongoing improvements to clinical outcomes, and the successful transformation to a PCMH. If a practice seeks assistance after its EHR implementation, a QI coach is assigned to help that practice through the improvement of clinical outcomes and the PCMH transformation. Regardless of whether a practice is initially focused on QI or EHR implementation work, the support team assists it in the attainment of meaningful use.

## **V. Hiring Practice Support Staff**

The regional AHEC offices all maintain their own human resource divisions and are responsible for interviewing and hiring staff for their regional practice support teams. Job descriptions for each position are adapted from those developed by the State-level office. The NC AHEC Practice Support Program seeks individuals who—at least in combination—possess knowledge, skills, and experience in QI, ambulatory care settings, EHR selection and implementation, and software security and use. Each region, however, determines the skills needed to round out its team to ensure that a full complement of skills and knowledge are present. Regional directors thus make hiring decisions based both on the qualifications of the individual and the skill needs of the team that person will be joining.

Preferred backgrounds of QI coaches include experience working in primary care settings and leading QI activities in these environments. These individuals often have backgrounds in practice management, nursing, and health administration, as well as experience in working on EHR implementation teams. Many of the QI coaches hired to date are mid-career professionals who bring ancillary knowledge to the job about clinical operations and financial management in practice settings, which has provided valuable additional expertise to the regional teams.

Preferred backgrounds of EHR implementation experts include prior work in the area of EHR selection, implementation, and workflow redesign. To date, several individuals hired in this capacity have had previous work experience with EHR vendors or have managed practices that have gone through the conversion to EHRs. Technical assistance specialists come from similar backgrounds, with a deeper understanding of the technical specifications of EHRs.

## VI. Training and Supervising Practice Support Teams

**Training.** All members of a regional practice support team—from QI coaches to EHR implementation specialists to experts in EHR optimization and data access and use—must be knowledgeable about QI methods and PCMH criteria. For example, QI coaches receive training in EHR implementation and meaningful use to enable them to support these activities within their practices. EHR and technical assistant personnel are trained in QI methods and processes so they are able to take these factors into consideration when implementing and optimizing EHR systems.

The State office of the NC AHEC Practice Support Program has developed an internal training program for its practice support workforce that can be individualized to fit the education, experience, and personality of each team member. The program also sends staff to external trainings and conferences. All regional practice support teams also participate in biweekly trainings and review sessions led by the State director or other invited faculty.

**Supervision.** Supervision of support teams takes place at two levels: monitoring progress of regional team members with their individual practices, and monitoring progress of regional teams and their associated centers toward key contract deliverables for their practice support programs.

At the regional level, members of each support team meet together on a regular basis to review progress toward deliverables at the practice level. During these meetings, the team discusses the progress of the practices and any barriers identified. Team members can share information and discuss any possible reassignments necessary to match the most appropriate skill sets to the needs of the practice.

The nine regional directors communicate quarterly as a group with the State-level program director and her team to discuss activities in their areas and progress toward program deliverables contained in their contracts. The teams use this call to discuss progress of their practices with the State-level team and make projections and set goals for the next quarter. These sessions also focus on grants management issues related to the program and attainment of deliverables, as well as any best practices or barriers found in the practices. They also provide an opportunity for regional teams to discuss emergent needs in their areas, and for the State-level team to share information about new resources, best practices, and the addition of new deliverables for the program. For example, if the statewide program was awarded a grant on smoking cessation, the State director would share information with the regional directors about this new program and discuss any related deliverables that might be required. Additionally, a scope of work would be written to outline the new deliverables and how they are expected to fit with the overall deliverables of the program. Each region receives a separate scope of work for each funding opportunity, and then all scopes of work are included in an overall work statement for the year, which combines all goals and deliverables for each region.

## VII. Monitoring Program Quality and Outcomes

**Internal quality monitoring.** The NC AHEC regional practice support teams' progress toward improving practice-level and regional process and quality outcomes is tracked using a central database maintained by the State AHEC office. Contract deliverables, as well as practice-level improvement data and all practice assessments, are housed in a database maintained at the program office. The practice support personnel use the database to track progress toward program goals, update visit notes, and complete QI reports for each practice. Additionally, those practices engaged in reporting their



monthly clinical data to the AHEC program have access to the database in which, after signing data use agreements, they can view their monthly data in the form of run charts as well as the run charts of other practices participating at the same level in the program. Not all practices are engaged with reporting monthly data; therefore, the privilege of viewing practice-level data is given only to those practices reporting data to the database.

The State director also holds quarterly “milestone” meetings with each regional AHEC team to track progress toward program deliverables and work in individual practices. The content of these meetings is used to tweak the program model to make it more effective by securing necessary resources and/or addressing significant barriers.

Locally, goals are set with each practice according to what its staff are currently working on with their practice support program. Some practices may be working to achieve meaningful use, while others may be working toward PCMH recognition. Still others may be working toward improvement in clinical outcomes of specific disease states. All practices are encouraged to continue their work with their AHEC consulting teams beyond meaningful use. To provide each practice with a concrete clinical improvement goal, they initially are encouraged to reduce the gap between their baseline measurement and the program goal by at least 30 percent.

**Outcomes evaluation.** The NC AHEC Practice Support Program relies on external evaluation through various grant funds. The program is currently participating in an evaluation of its practice support services through a 2011 IMPACT (Infrastructure for Maintaining Primary Care Transformation) grant from the Agency for Healthcare Research and Quality (AHRQ). This evaluation is comparing changes on HEDIS measures between practices throughout the State that receive AHEC support and those that do not. Through another grant also funded by AHRQ, the program is participating in a second evaluation that is assessing the impact of practice support on a practice’s degree of readiness for medical home transformation.

## VIII. Lessons Learned

A number of lessons have emerged from the NC AHEC Practice Support Program’s experiences:

**A team approach to facilitation is an effective way to ensure that practices have access to expertise in a variety of areas.** Generally, programs will not find a ready workforce of well-trained facilitators or coaches with expertise in the wide-ranging topics of QI, EHR implementation, and use of clinical data to drive improvement. The NC AHEC Practice Support Program’s team approach helps to address gaps in the skills that a single facilitator/coach might have by letting that person tap into the expertise of other team members. This approach also provides an opportunity to find an optimal fit for an individual facilitator’s personality and approach to a practice, and to change facilitators when the fit is not optimal.

**Regional teams need to reinforce the value of various types of expertise and not inadvertently emphasize particular areas because of pressure from their practices.** The management approach must ensure that the practice support team gives equal value to all forms of expertise on the team, and recognizes and utilizes the expertise of all members. A challenge of working in teams is making sure that everyone on the team is viewed as an equal participant and equally valuable. This is difficult, because practices often value the expertise of different team members differently. For example,

the contribution of a team member who works with a practice to obtain financial incentives for meaningful use is often valued more highly by a practice than the expertise of a team member who helps to implement enhanced self-management support or provides training on QI. While a practice may assign more value to financial outcomes than internal QI capacity development, the team must not. To function effectively, the practice support team itself must recognize the value of each contribution as part of the comprehensive process of practice improvement.

**EHR implementation is most effective when integrated with quality improvement.** QI forms the basis for all work conducted through the NC AHEC Practice Support Program, including EHR implementation. This lets the program integrate a number of funding sources and deliverables into a coherent and sustainable practice facilitation program. It also allows the program to leverage work, such as EHR implementation, that typically occurs in relative isolation to support comprehensive and sustained QI across practices in the State.

**Maintenance of Certification, CME requirements, and payer incentive programs can create interest in and readiness for facilitation programs in practices.** They can also galvanize support for facilitation programs among local and State health care leaders.

**Practice support interventions are most effective when tailored to the interests and needs of each practice.** The improvement goals and the schedule for facilitation activities should be practice driven, but also need to map to the support and facilitation intervention's key-driver model. Facilitators need to arrange their schedules to accommodate the different intensity of intervention work at different practices, as well as various practice needs. Also, facilitators should be able to conduct work that is related to practice interests and priorities at the startup of the project as a method for building practice buy-in for later, more difficult practice improvement work.

This case study was prepared by Lyndee Knox, LA Net, and Erin Fries Taylor, Mathematica Policy Research.

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## RESOURCES

General Background on NC AHEC is available at [www.ncahec.net/](http://www.ncahec.net/).

A history of NC AHEC is available at [www.med.unc.edu/ahec/about/history.htm](http://www.med.unc.edu/ahec/about/history.htm) and [aheconnect.mediasite.com/mediasite/SilverlightPlayer/Default.aspx?peid=20a3a1fb8ad14e84b275e0a94e03f5111d](http://aheconnect.mediasite.com/mediasite/SilverlightPlayer/Default.aspx?peid=20a3a1fb8ad14e84b275e0a94e03f5111d).

Information on the NC REC: North Carolina Area Health Education Centers, “North Carolina Regional Extension Center Project Narrative” is available at [www.ncdhhs.gov/healthit/regionalextension](http://www.ncdhhs.gov/healthit/regionalextension).

2012 Progress Report of the NC AHEC is available at [www.ncahec.net/pubs/2012Progress\\_Report.pdf](http://www.ncahec.net/pubs/2012Progress_Report.pdf).

### Related Literature

Newton WP, Lefebvre A, Donahue KE, et al. Infrastructure for large-scale quality-improvement projects: early lessons from North Carolina Improving Performance in Practice. *J Cont Educ Health Prof* 2010;30(2):106–13.

The North Carolina Quality Alliance: Lessons in Aligning Quality Improvement Strategies Statewide. Washington, DC: National Academy for State Health Policy, 2012. [www.nashp.org/sites/default/files/North.Carolina.Healthcare.Quality.Alliance.pdf](http://www.nashp.org/sites/default/files/North.Carolina.Healthcare.Quality.Alliance.pdf).



## PROGRAM SNAPSHOT: OKLAHOMA'S PRACTICE ENHANCEMENT ASSISTANTS

Practice enhancement assistants of the Oklahoma Physician Resource/Research Network (OKPRN) provide facilitation services to primary care practices throughout the State. Facilitation is one of several supports provided by this Practice-Based Research Network (PBRN). Practice enhancement assistants help practices implement evidence-based medicine, improve team functioning and communication, and increase practice capacity for QI.

Oklahoma's Practice Enhancement Assistants	
Context	To provide primary care physicians in Oklahoma with access to information, education, research, and technology in ways that enhance their practices and generate new knowledge through practice-based research
Administrative Home	Practice-Based Research Network
Objectives	Provide primary care practices with support for: improving team functioning and communication implementing best practices and evidence-based approaches providing cross-pollination of best practices across sites
Funding Source	Grants and contracts
Staffing Model	Staff model, with facilitators employed by the University of Oklahoma
Location of Services	On site at practices
Schedule and Duration	During the course of a project, one half day per week on site—usually for 6 months
Program Size	4 full-time facilitators; practices that have received facilitation services provide care for approximately 10 percent of the State's population
Ratio of Facilitators to Practices	1 facilitator to 8 practices
Eligible Practices	Any primary care practice in the network (more than 240 clinicians, representing 160 practices across the State)
Training and Support	New facilitators receive classroom training, followed by experiential training (shadowing experienced facilitators) All facilitators receive weekly supervision and training support designed to encourage a sense of community among facilitators
Other components and supports	Assessment and feedback, technical assistance, coordination of PDSA cycles, local learning collaborative

In this case study, we profile OKPRN's practice facilitation (PF) program, including: (1) how it started, (2) its administrative infrastructure, (3) funding, (4) program design, and (5) how the program assesses its own facilitation work. We conclude with lessons from OKPRN's facilitation work for those interested in implementing a similar program.

## Facilitation in the Context of a Practice-Based Research Network: Oklahoma’s Practice Enhancement Assistants

One of the earliest PF programs in the United States was developed by the Oklahoma Physicians Resource/Research Network (OKPRN). OKPRN, or “the network,” is a partnership between the University of Oklahoma’s Department of Family and Preventive Medicine and primary care physicians across the State. Since 1999, the university has employed facilitators—which it calls practice enhancement assistants—to help primary care practices in the network with research and QI activities. The facilitation services provided are designed to support ongoing system-level changes by improving team functioning and communication, implementing best practices and evidence-based approaches, and providing cross-pollination of good ideas across practices.

OKPRN’s facilitation program provides a good example of how a PBRN<sup>3</sup> can incorporate facilitation into its ongoing work. The program centers on four full time facilitators who service more than 160 practices across the State. OKPRN proudly contrasts its facilitation approach with the “parachute in” model of one-time consultation and feedback. Their experience offers several lessons:

- ▲ Leverage existing resources. OKPRN has tapped many resources from its university setting. It has also reached out to many other organizations about its work, which helps build networks and sometimes allows access to additional resources.
- ▲ Focus on relationships. Developing a long-term and meaningful relationship between a facilitator and a practice is critical to success.
- ▲ Develop a learning community. Facilitators can learn a great deal from each other through shadowing and weekly meetings. Practices can learn from each other, too, through local learning collaborative and through the cross pollination provided by facilitators.
- ▲ Recognize that facilitation is necessary but not sufficient for practice change. Facilitation is a valuable support for practices, but other QI approaches, such as academic detailing and performance feedback, are also important to provide in conjunction with the facilitation services.

### I. Motivation and Development of OKPRN’s Facilitation Program

In 1999, OKPRN began to use practice facilitators—which it calls “practice enhancement assistants,” or PEAs—as a resource to support the primary care practices in its network. Researchers at the university recognized that practices often lacked the time, skills, and adequate support to implement

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<sup>3</sup> A Practice-Based Research Network is defined by the Agency for Healthcare Research and Quality (AHRQ) as “a group of ambulatory practices devoted principally to the primary care of patients. Typically, PBRNs draw on the experience and insight of practicing clinicians to identify and frame research questions whose answers can improve the practice of primary care. By linking these questions with rigorous research methods, the PBRN can produce research findings that are immediately relevant to the clinician and, in theory, more easily assimilated into everyday practice.” (For more information, see <http://www.ahrq.gov/research/pbrn/pbrnfact.htm>.)

QI initiatives. Facilitation was of interest to OKPRN for several reasons: (1) it is customizable, and research shows that QI efforts are most successful when tailored to practice needs and context; (2) it allows researchers at the university to work directly with practices to improve health care in Oklahoma; and (3) it has potential to close the gap between the development of evidence-based practices and their implementation at the point of care.

OKPRN found that there were natural synergies between practice facilitation and its mission as a PBRN. PEAs logically support the dual mission of OKPRN: to provide resources to community physicians and to conduct research on the challenges faced by local practices. They can assist practices with a variety of activities, including enhancing documentation and delivery of clinical interventions, implementing best practices research, giving support through information technology (IT), and assisting with quality improvements. In addition, they can act as research assistants by supporting and training practices to be partners in research, collecting data for studies, and suggesting improvements for research protocols. OKPRN saw the role of the PEA as a marriage of research assistant and QI/practice redesign coach.

#### **How OKPRN Adapted an Existing Concept to the PBRN Context**

OKPRN's use of facilitation as a means to produce change was adapted from facilitation's long history in agriculture. In the early 1900s, facilitation was used in the United States to assist farmers in adopting modern farming techniques. County extension offices, funded by the U.S. Department of Agriculture, used extension agents to give local farmers onsite training and assistance on agricultural techniques. This Agricultural Cooperative Extension created two-way communication between farmers and the research community. The concept was applied to the health care setting in the 1980s, when practice facilitators were first used in England to help physicians with the delivery of preventive services. The concept then spread to other parts of Europe and Canada, and was disseminated in health services research journals and conferences, which drew the attention of OKPRN leadership. Intrigued by the idea, OKPRN retooled these earlier uses of "change agents" to meet its own needs as a research network interested in building connections between research and practice.

## **II. An Administrative Foundation for Practice Enhancement Assistance**

OKPRN's PEAs are housed within the Department of Family and Preventive Medicine at the University of Oklahoma. The university is the PEAs' employer. This structure provides the following benefits to the university, the practices in the network, and the PEAs:

- ▲ **The practices** in the network get support for research and QI activities at no cost.
- ▲ **The PEAs** can leverage extensive resources from the university, including staff and physical space, while enjoying the employee benefits associated with working for a large employer. PEAs also can leverage the reputation of the university, which helps to legitimize and build interest in the network and their facilitation work.
- ▲ **The university** can use the network as a laboratory to conduct research and has a unique opportunity to directly improve health care in Oklahoma.

While there are advantages to the PEAs' close connection with the university, the academic partnership presents some challenges for OKPRN's facilitation work, such as accounting issues associated with the university setting. Staff have tried to mitigate these issues by making OKPRN a separate, tax exempt nonprofit 501(c)3 organization—which gives OKPRN more independence and flexibility to govern and run itself. For example, having 501(c)3 status makes it easier for OKPRN to cover costs not allowable under the university system (for example, paying the travel costs associated with bringing in an expert to lead a learning collaborative meeting). Moreover, although OKPRN currently does not bid on grants or contracts independently from the university, its 501(c)3 status makes it possible that OKPRN could seek its own funding to support facilitation work in the future. OKPRN staff feel this status allows them to have the best of both worlds—they can benefit from the enormous resources of the university and still have the flexibility to think and work outside of the university's financial and other restrictions.

### **Role of OKPRN's Board of Directors**

While the university supplies funding and supervision for the PEAs, the network and its Board of Directors play an important role in deciding on the activities and priorities of the network. The board includes representation from the following groups:

- ▲ Physicians
- ▲ Academics
- ▲ Oklahoma State Department of Health
- ▲ Oklahoma Health Care Authority (Medicaid)
- ▲ Oklahoma's quality improvement organization (QIO)

These members represent the diverse stakeholders of the network. For this reason, they are well equipped to help ensure that the network and its services respond to the local community's needs. The board approves projects and provides strategic planning. It often has access to other resources (including financial resources) and is able to influence State policy to some extent.

### **III. Funding Facilitation Work within a Practice-Based Research Network**

OKPRN's facilitation work is funded mainly through grants and contracts won by the University of Oklahoma Department of Family and Preventive Medicine. Previous funders of OKPRN's work include the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health, the Oklahoma Foundation for Medical Quality, and the Robert Wood Johnson Foundation.

The PEAs are employees of the university and are funded directly through its grants and contracts, much like research assistants. Funding for PEAs includes base salary, benefits, and reimbursement for travel.<sup>4</sup> PEAs often drive long distances for work and OKPRN has found that it is essential to reimburse for mileage.

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<sup>4</sup> Currently the PEA salary is about \$40,000 per year, plus benefits and travel, which totals to \$53,000.

In addition to paying PEA salaries, most grants and contracts for the Department of Family and Preventive Medicine include a \$5,000–10,000 flat fee (depending on project size) that goes to the network to pay for its maintenance and administration. The University subcontracts with OKPRN to “provide the laboratory setting under which the research is conducted.” This is augmented by charitable contributions (about \$4,000–\$5,000 a year), which support the indirect costs of the facilitation program. OKPRN staff have considered other funding possibilities, such as levying membership dues on practices in its network, but to date this approach has been voted down by the board.

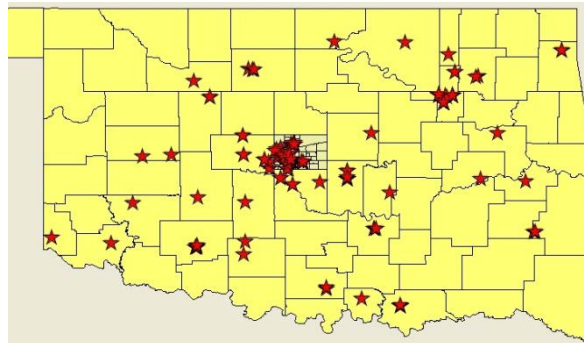
**The quest for sustainable funding.** OKPRN staff describe its current funding arrangement as an acceptable way of supporting its facilitation work, but find its dependence on grants and contracts somewhat limiting. Staff continue to look for sustainable funding that would move away from project-specific funding and instead provide a broader infrastructure for general primary care practice improvement. Over the past several years, OKPRN staff have considered how to organize an infrastructure that would offer facilitation services to primary care practices. Staff envision a model much like the cooperative extension model in agriculture, in which county Health Improvement Organizations would offer facilitation services as part of a larger, regionally coordinated network. Such an approach might be possible if Congress funded the Primary Care Extension Service provision of Section 5405 of the Affordable Care Act. In the meantime, this idea is being tested at the State level in Oklahoma through an IMPaCT (Infrastructure for Maintaining Primary Care Transformation) grant from AHRQ.

#### IV. OKPRN’S Practice Facilitation Approach

OKPRN sees one of its primary goals as helping practices to provide excellent primary care. The PEAs support a variety of specific interventions or “projects” (for example, implementation of chronic kidney disease guidelines or improvements to diabetes care) that support improved patient care and outcomes—as opposed to helping all practices implement a particular framework, such as the chronic care model or patient-centered medical home.

##### Intensity and Form of PEAs’ Work with Practices

OKPRN’s facilitation work is designed to build strong relationships between facilitators and practices over time. To support forming these kinds of relationships, OKPRN has divided the State into four quadrants and has assigned one PEA to work in each of them. Each quadrant contains roughly 40 practices in the network, but only a subset of them receive active facilitation at any given time. By working in one quadrant, PEAs are able to build long-term relationships with providers and practices and to cross-pollinate ideas among sites. Many of the PEAs have worked with OKPRN for multiple years, and many of the relationships between practices and PEAs date back almost as



long as the network itself. Despite the geographical division of PEAs and practices, Oklahoma is a big State, and PEAs still spend substantial time traveling to practice sites, which can be time consuming and expensive.

In general, OKPRN wants each facilitator to work with eight practices at a time, a half day per week, for 6 months. In practice, the duration and intensity is driven by each specific project’s needs and varies quite a bit (Table 1). Project protocols typically specify the amount of time a PEA spends in a practice. PEAs may work with more practices—or fewer—based on their experience and a project’s intensity. More experienced PEAs may be able to work with more practices, and more experienced practices may require less face time.

**Table 1. Intensity and Form of PEAs’ Work with Practices**

PEA's Caseload and Schedule	Practices in the Network That Are Participating in a QI Project	Practices in the Network That Are Not Part of a QI Project
A PEA typically provides active facilitation to ~8 practices, but this varies by project	PEAs spend half a day a week on site with a practice for a specific project, usually 6 months	Annual visits by PEA
Spends 4 days a week in the field with practices, and 1 day a week in the office for training, supervision, paperwork	PEAs spend half a day every month on site with a practice during maintenance period of a QI project, usually 6 months	Engagement with listserv, including PEA Question of the Week

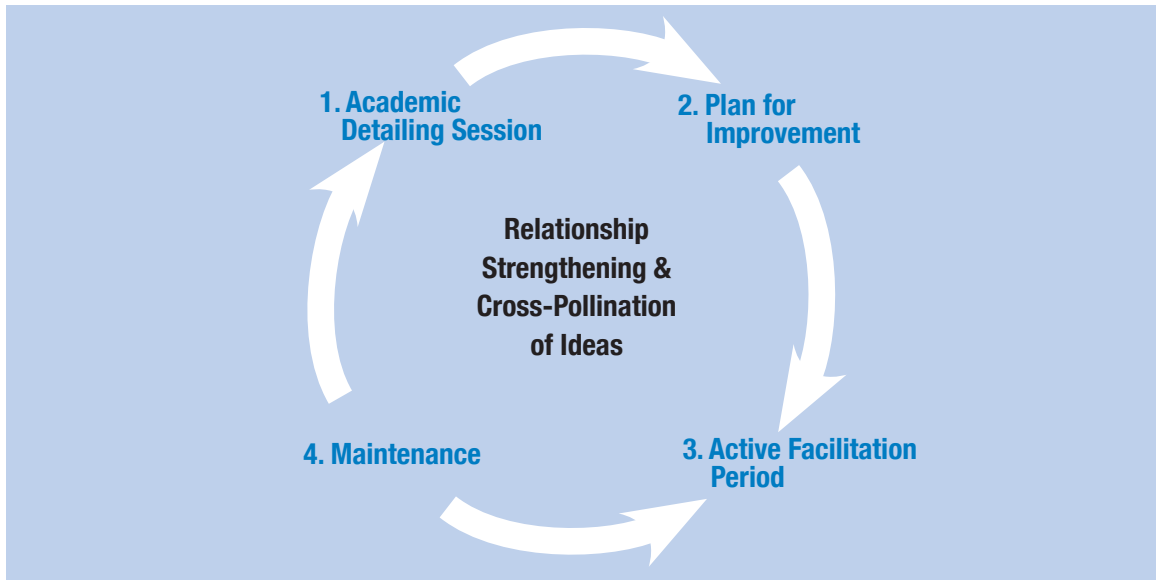
While each PEA works individually with a practice, PEAs are also supported by content or IT experts who help them with specialized functions. For example, many PEAs call on IT or billing experts to help with improvements to their electronic health records or help create registries. It is also typical for a PEA to consult faculty members with specific clinical expertise, such as pediatricians or asthma specialists. These experts might give help over the telephone, by email, or through onsite assistance. Most experts are from the university, but some are from other settings. An expert may consult directly with a practice or may go through the PEA, who then passes the information on to the practice. Either way, OKPRN emphasizes the importance of the PEA—not the expert consultant—as the primary contact with the practice, given the importance of that relationship. While facilitators can help practices with a range of activities, they can’t do everything. PEAs connect practices to different expertise and resources as needed.

### **Building a Foundation for Facilitation: A Relationship-Centered Approach**

OKPRN staff believe that the bedrock of successful facilitation is a strong relationship between PEAs and practice staff. PEAs focus on building relationships with a practice before starting a QI or research project. This relationship is built not only with the provider or clinician, but also with nurses, front desk staff, practice managers, and any other staff who “hold the access.” Successful facilitation, OKPRN believes, hinges on buy-in from practice staff and an understanding of a practice culture. Building relationships takes a long time—one staff member estimates that new PEAs should dedicate a solid 2 to 3 months to relationship building when first working with a practice.



**Figure 2. Life Cycle of a PEA intervention**



### Stages of the PEA intervention

Typically, a PEA’s work with a practice moves through distinct stages (see Figure 1). An academic detailing session with each targeted primary care practice typically serves as the kickoff to a new project.<sup>5</sup> Next comes a planning phase, followed by the period in which active facilitation occurs. The project then goes into a maintenance period. During this maintenance period, practices focus on maintaining their gains. Throughout the process, the PEA focuses on building and strengthening the relationship with the practice and sharing ideas among sites.

**Academic detailing as a starting point.** Each new project begins with an academic detailing session led by a peer physician—usually the OKPRN Director. The peer physician discusses how different principles and QI techniques might apply within that practice. The session provides an orientation to the practice regarding what a PEA can and cannot do, and encourages respectful sharing of information.

**Planning and setting goals.** The PEA plays an important role in helping a practice set goals and find the right scope for a given QI project. While PEAs’ roles are dictated mostly by the needs of a given project practice staff often have an active role in planning and carrying out QI activities. Practices are often excited to have access to a PEA and, even when focusing on a particular QI activity, often propose too many changes too quickly. As one facilitator noted, “Often practices without any QI experience suggest something that will require 10 years and \$2 million to do.” The PEA can help a practice set realistic goals and think about smaller steps needed for larger reform. These considerations go into a plan for improvement, which is developed for each practice at the start of each project. This includes things like deciding on a core QI team and setting up regular meetings to discuss project progress.

<sup>5</sup> Academic detailing involves clinician peer-to-peer education. At the kickoff of a project, a leading clinician is often brought in to share information about facilitation generally or a project specifically, providing an opportunity for the practice clinician to hear directly from a peer.

**Active facilitation.** Once a PEA creates a plan for practice improvement and develops good working relationships with key practice staff, the practice begins the active facilitation phase. PEAs have many tools for helping practices. During this time PEAs are generally spending a half day a week in the practice. Typical techniques they use with practices include assessment and feedback, coaching, team building, technical and hands-on assistance, training, and coordinating plan-do-study-act (PDSA) cycles. OKPRN interventions often use a variety of QI approaches. In addition to the initial academic detailing sessions, facilitators usually arrange for an audit and feedback session, benchmarking, and other QI approaches.

#### Top Tips for Effective Learning Collaboratives

- Find a convenient location that minimizes travel time
- Host it during lunch and provide food
- Hold meetings every 1-2 months
- Allow plenty of time for breaks to facilitate informal discussions

PEAs support and communicate with practices in many ways, but OKPRN believes there's no substitute for face-to-face contact. PEAs know that it's important to be accessible to practices by email or phone, but they find that in-person contact gives the best results, so they check in regularly in person.

OKPRN has seen positive results from local learning collaboratives, which bring together a number of practices in a central location to discuss a particular topic or project. OKPRN staff find that bringing groups of practices together not only creates a space where practices can share best practices but also creates a “sense of competition and urgency” that motivates practices. OKPRN uses 1-hour lunch meetings every few months to review performance data from all practices in a project and share successes, failures, and effective methods. Spacing of meetings is important; meetings that occur too often will suffer from low attendance, but meetings that are too infrequent will lose their sense of urgency.

**Maintaining the gains.** After the active facilitation period, practices enter a maintenance phase. At this stage, a PEA works with a practice to make sure practice staff can continue to monitor their own performance and progress. Rather than spending a half day per week in a practice, they spend a half day per month, providing practices with the equivalence of “booster shots.” The goal is to teach practices how to engage in QI projects on their own and help them to develop the internal infrastructure and capacity to support effective QI. Practices benefit greatly from continued support through followup check-ins, so OKPRN increasingly has built maintenance into project design.

OKPRN reaches out to practices even when they are not actively engaged in a facilitated project. At a minimum, PEAs do annual outreach to everyone in the network by phone or email. Many PEAs periodically return to practices to see how they're doing and say hello in person. OKPRN engages the practices in its network in all phases of the facilitation lifecycle by using a listserv. Every month, the PEAs post a question to the listserv (for example, “how do you isolate sick people from well people in the waiting room?”)<sup>6</sup> and ask practices to share their thoughts and perspectives.

“The point is you teach them how to fish—not to fish for them all the time.... You're teaching them how to manage themselves, how to implement and institutionalize ideas and things we're bringing from the outside.”

—Dr. James Mold, Program Director

<sup>6</sup> For more examples of the PEA question of the month, see <http://www.okprn.org/peaquestion.html>

## V. Hiring, Training, and Supervising Practice Facilitators

To work effectively with a primary care practice, OKPRN facilitators must possess competencies in four core areas: (1) experience in a health care setting, (2) excellent interpersonal skills, (3) good IT skills, and (4) a flexible personality. They will need other skills, such as knowledge of QI techniques and specific research methods—but they might not need these when they're hired, since they can develop them through training and ongoing supervision.

### OKPRN looks for these core competencies when hiring:

**Experience in a health care setting.** Facilitators must have sufficient medical vocabulary and some clinical background or orientation to achieve maximum effectiveness in working with practices.

**Superb interpersonal skills.** Being able to communicate and relate to the entire range of individuals in a practice—from front desk staff to physicians—is critical to collaboration. Facilitators need buy-in across the board.

**IT skills.** Facilitators need to collect and manage data, perform chart audits, and produce reports. Being comfortable with large data sets and computers is a must.

**Flexibility.** Facilitators are always on the move and often have to adjust their schedules or work plans based on the needs of a practice.

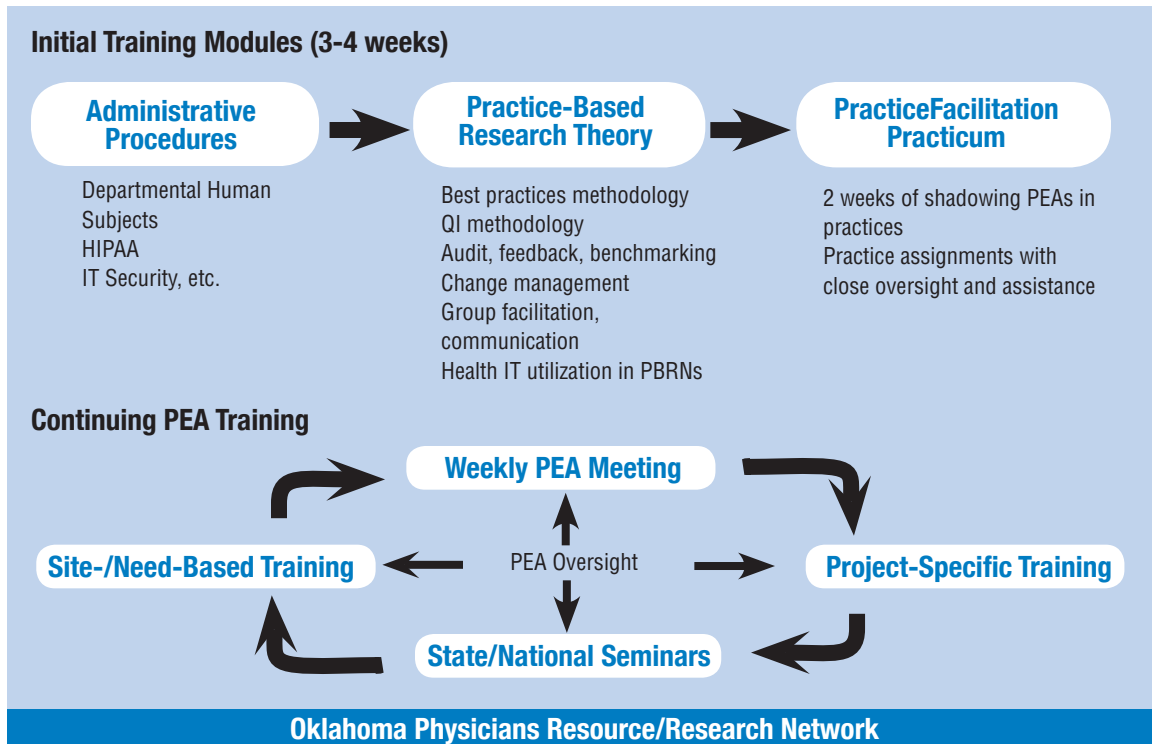
OKPRN looks to hire PEAs with master's degrees in a public health area (for example, a master's of public health in epidemiology or health promotion). In addition, OKPRN requires its PEAs to have a valid driver's license and their own car because they're required to travel to practices throughout their quadrant of the State.

OKPRN's training program covers the knowledge, skills, and approaches needed for working with primary care practices. Typically, each new PEA receives classroom instruction followed by experiential training, in which a new PEA shadows a more experienced PEA working in a practice setting. Initial training is tailored to the previous experience of the facilitator but covers certain core areas. OKPRN's training manual includes information on administrative procedures, QI methods, and research methods. The specific topics covered in the manual are listed in Table 2. Recently, OKPRN also has provided training to facilitators from other programs.<sup>7</sup> After this initial training, PEAs enter a cycle of continuing training, supervision, and ongoing support (see Figure 2).

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<sup>7</sup> The University of Oklahoma will provide its training materials via email free of charge or provide hard copies at cost. Potential PEAs can attend a 2-to 4-day training session at cost. More information is available at <http://www.okprn.org/peas.html>

**Figure 3. OKPRN Training Process**



In addition to broad training in facilitation, OKPRN also gives PEAs project-specific training at the start of each new project. These sessions cover specific research methods or clinical areas (for example, chronic kidney disease or diabetes). The PEA supervisor also actively encourages PEAs to identify specific skills that would make them more effective in their work. Training for these skills is developed and implemented as time and resources allow internally or are obtained through sending facilitators to external organizations or relevant conferences or seminars.

Following the initial training, PEAs get ongoing support and supervision. While they spend most of their time in the field, they spend 1 day in the office every week to touch base and to meet with their supervisor (they also use this day to catch up on office work and prepare for the week ahead). During the individual meetings, the PEAs and their supervisor discuss the status of ongoing projects, what’s working well, and any problems they’ve encountered. Together, they brainstorm next steps and ways to overcome obstacles. In addition to these one-on-one meetings, PEAs also use their day in the office to meet as a group to share best practices and brainstorm solutions to any issues or challenges. In this way, PEAs learn from and support each other.

When the PEAs are out in the field, their supervisor is available for questions as they arise via email, phone call, or text message. PEAs have found that text messages are a quick and easy way to communicate with other PEAs and their supervisor, and less intrusive if a PEA is at a practice. PEAs are also equipped with tablet computers so they can access resources on the go. OKPRN staff believe that this ongoing support for and timely feedback to its PEAs have been critical to its success.

**Table 2. OKPRN PEA Training Topics**

Human subjects protection training
Health Insurance Portability and Accountability Act (HIPAA)
Practice-based research skills
Medical records review (chart auditing)
Rapid-cycle quality improvement process (Plan-Do-Study-Act cycles)
Group facilitation and motivational methods (quality circles)
Practice characterization model, change management approaches
The Chronic Care Model and its implications
Practice visits and shadowing
Health information technology implementation and utilization
Best practices study methodology
Preventive services guidelines and implementation
Evaluation and management coding
Electronic Practice Record (demographics, progress notes, and plans for practices)
Handouts, patient education materials, practice resources, and project-specific training

## **VI. Monitoring the Quality of the Program**

PEAs maintain detailed records on practice progress, allowing the network to monitor and improve their facilitation work on an ongoing basis. PEAs maintain practice logs that are specific to a particular practice and contain comprehensive and longitudinal information about practice progress and what a PEA did during a given visit. These are designed to be as descriptive as possible and give a sense of specific barriers a PEA encountered or obstacle they overcame. OKPRN staff describes this log as similar to a “chart on a patient.”

PEAs are trained in what makes a good entry and how to format their entries for easy review and synthesis. Their supervisor provides them with a checklist of things to consider—this gives PEAs a good sense of which topics to cover during a practice visit. Practice logs may even include observations about physicians’ characteristics—ranging from birthdays to communication styles. That way, a new PEA spending time in that practice has a solid basis for working effectively with them.

Every week the PEA supervisor reviews all practice notes, looking carefully at changes within and across practices for a given project. The supervisor synthesizes this information to provide feedback to facilitators about what they are doing well and how they could improve. Although OKPRN doesn’t systematically evaluate its work, this process provides a form of ongoing QI of its facilitation work and gives regular and constructive feedback to the PEAs.

## **VII. Lessons Learned from OKPRN’s Practice Enhancement Assistants**

OKPRN’s experience with facilitation offers a number of lessons for others developing new facilitation programs or refining existing ones:

**Leverage existing resources.** Many people and organizations are interested in improving health care, and they may have access to additional resources. OKPRN was able to leverage extensive resources from the university for its facilitation work. This allowed it to grow considerably and expand its reach. OKPRN emphasizes that to build networks, it's important to let other organizations know what you're doing. While OKPRN started very small, with just one facilitator, it's now taking steps toward building a statewide QI infrastructure.

**Focus on relationships.** A facilitator's relationships with clinicians and other practice staff are crucial for effective facilitation. Developing strong relationships can take several months, but the investment of time and resources will pay off later. Practice staff 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.

**Develop a learning community.** At the heart of OKPRN's facilitation program is an effort to bring people together, and OKPRN has done this in a variety of ways:

- ▲ Using training and supervision activities to bring facilitators and university staff together to share best practices and learn from each other.
- ▲ Using local learning collaboratives to bring practices together and create a sense of urgency and competition. This lets practices share ideas and get support from each other, while spurring them to continue their work so they have information to report back to their peers.
- ▲ Building a board of directors with all stakeholders so groups with a shared interest and a common goal can forge relationships and move forward as a community.

**Recognize that facilitation is necessary but not sufficient for practice change.** OKPRN staff feels strongly that facilitation is a necessary support for practices, but insufficient on its own. In their facilitation work, the PEAs integrate other QI approaches, like performance feedback, academic detailing, local learning collaboratives, and health IT support. OKPRN believes that all of these supports are important, but a facilitator has an especially important role to play in arranging and coordinating all QI activities. A facilitator also should help a practice access additional resources as necessary—so a practice gets what it needs when it needs it.

This case study was prepared by Rachel M. Machta and Erin Fries Taylor, Mathematica Policy Research.

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## RESOURCES

### PEA Training and Hiring Resources

- ▲ OKPRN training manual contents: [www.okprn.org/Documents/PEA\\_Manual\\_Contents.pdf](http://www.okprn.org/Documents/PEA_Manual_Contents.pdf)
- ▲ PEA job description: [www.lanetpbrn.net/wp-content/uploads/Practice-Enhancement-Assistant-Job-Description-example.pdf](http://www.lanetpbrn.net/wp-content/uploads/Practice-Enhancement-Assistant-Job-Description-example.pdf)
- ▲ PEA Question of the Week: [www.okprn.org/peaquestion.html](http://www.okprn.org/peaquestion.html)

### Practice Facilitation Resources:

- ▲ What is a PEA? [www.okprn.org/peas.html](http://www.okprn.org/peas.html)
- ▲ AHRQ Health Care Innovations Exchange: Practice Enhancement Assistants Improve Quality of Care in Primary care Practices: [www.innovations.ahrq.gov/content.aspx?id=1768](http://www.innovations.ahrq.gov/content.aspx?id=1768)
- ▲ Practice Facilitators: A review of the literature. Fam Med. 2005; 37(8):581-8. [www.stfm.org/fmhub/fm2005/September/Zsolt581.pdf](http://www.stfm.org/fmhub/fm2005/September/Zsolt581.pdf)
- ▲ Practice facilitators and practice-based research networks. J Am Board Fam Med. 2006;19(5):506-10. [www.jabfm.org/content/19/5/506.abstract](http://www.jabfm.org/content/19/5/506.abstract)

### Practice-Based Research Network Resources:

- ▲ AHRQ PBRN Resource Center: [www.pbrn.ahrq.gov](http://www.pbrn.ahrq.gov)

### Other Useful Resources:

- ▲ OKPRN Presentation Library: [www.okprn.org/presentations.html](http://www.okprn.org/presentations.html)
- ▲ IMPaCT (Infrastructure for Maintaining Primary Care Transformation) award recipients information: [www.ahrq.gov/research/impactaw.htm](http://www.ahrq.gov/research/impactaw.htm)
- ▲ AHRQ Practice Facilitation Manual: [www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_\\_\\_home/1483/pcmh\\_implementing\\_the\\_pcmh\\_\\_\\_practice\\_facilitation\\_v2](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh___home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2)





## PROGRAM SNAPSHOT: THE SAFETY NET MEDICAL HOME INITIATIVE

Qualis Health and its partner, the MacColl Center for Health Care Innovation, plan, administer, coordinate, and monitor the Safety Net Medical Home Initiative (the Initiative). The Initiative provides training and technical assistance to staff at five Regional Coordinating Centers (RCCs) across the United States, which then support local practices through practice facilitators. Facilitators support practices in patient-centered medical home (PCMH) transformation by translating materials received from the national hub (Qualis Health and MacColl) into tangible changes in practices' processes at the local level.

Practice Facilitation in the Safety Net Medical Home Initiative	
Context	5-year demonstration project, initiated by The Commonwealth Fund
Administrative Home	Qualis Health, a nonprofit quality improvement (QI) consulting firm
Objectives	Provide safety net primary care practices with support for transforming into PCMHs (including PCMH recognition) Build regional capacity for QI and practice facilitation (PF).
Funding Source	The Commonwealth Fund and regional co-funders, including Beth Israel Deaconess Medical Center (Boston, MA); Blue Cross Blue Shield of Massachusetts Foundation; Blue Cross of Idaho Foundation for Health; The Boston Foundation; Colorado Health Foundation; Jewish Healthcare Foundation (Pittsburgh, PA); Northwest Health Foundation (Portland, OR); and Partners HealthCare (Boston, MA)
Staffing Model	Regionally hired or contracted facilitators. Some work in teams while most work individually with practices
Location of Services	On site at practices as well as virtually by Webinar, phone, and email
Schedule and Duration	Facilitation services offered for 4 years. Intensity and form of services vary by region and by practice.
Program Size	7.4 full-time equivalent (FTE) facilitators
Ratio of Facilitators to Practices	Varies by region from 1:2 to 1:13.
Eligible Practices	Primary care safety net practices that applied to RCCs.
Training and Support	Facilitators are trained and supported through Webinars, conference calls, learning sessions and community, resource library and curriculum ( <a href="http://www.safetynetmedicalhome.org">www.safetynetmedicalhome.org</a> ), social learning Web site

In this case study, we describe how Qualis Health and MacColl jointly built the Initiative's facilitation program. We discuss the Initiative's administrative structure and facilitation approach, including the processes for selecting, training, and monitoring this work. We conclude with lessons from the Initiative for others interested in developing a facilitation program.

## Practice Facilitation Activities of the Safety Net Medical Home Initiative

The Safety Net Medical Home Initiative (the Initiative) is a 5-year demonstration project to develop a replicable model to help primary care safety net practices become high-performing PCMHs. The goal of the Initiative is to help practices redesign their clinical and administrative systems to improve patient experience and health outcomes, bringing the benefits of patient-centered care to the Nation's most vulnerable populations. The Initiative, begun in 2008, provides training and technical assistance through a national hub to staff at five RCCs across the United States, which then give support to local practices through practice facilitators (or coaches). The Commonwealth Fund is the primary sponsor of the Initiative and contracts with Qualis Health and its partner, the MacColl Center for Health Care Innovation (MacColl) to plan, administer, coordinate, and monitor the Initiative. The Initiative currently includes 16 facilitators<sup>8</sup> who support the transformation of 65 safety net practices into PCMHs, and provides a model for how to build regional capacity from a national hub. The Initiative offers several lessons for others interested in developing a PF program such as:

- ▲ Building on existing partnerships between organizations with complementary expertise can help form a robust PF program.
- ▲ Combining national and local strategies can enable the spread of an intervention.
- ▲ Using a QI framework supported by resources and tools and paired with technical assistance is one effective way to guide program implementation over multiple sites.
- ▲ Following a specific sequence of stages during the PF intervention is an effective method for supporting practices' PCMH transformation.
- ▲ Ensuring that facilitators have core coaching skills and QI technical expertise is crucial.

### I. Motivation for Developing the Initiative's Facilitation Program

Qualis Health is a private nonprofit QI consulting firm whose mission is to generate, apply, and disseminate knowledge to improve the quality of health care delivery and health outcomes. In addition to providing services designed to improve health care quality and value to a broad range of public and private sector clients from its offices in six States, it has served as the Medicare QIO for Washington State and Idaho since 1984. MacColl is a research center at the Group Health Research Institute that is committed to linking research and practice by developing, evaluating, and disseminating innovations in health care delivery. MacColl is best known for its work in developing and testing the Chronic Care Model<sup>9</sup> and its RWJF-funded national program "Improving Chronic Illness Care."

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<sup>8</sup> There has been turnover in facilitator staff, so the number of facilitators has fluctuated from 15 to 20.

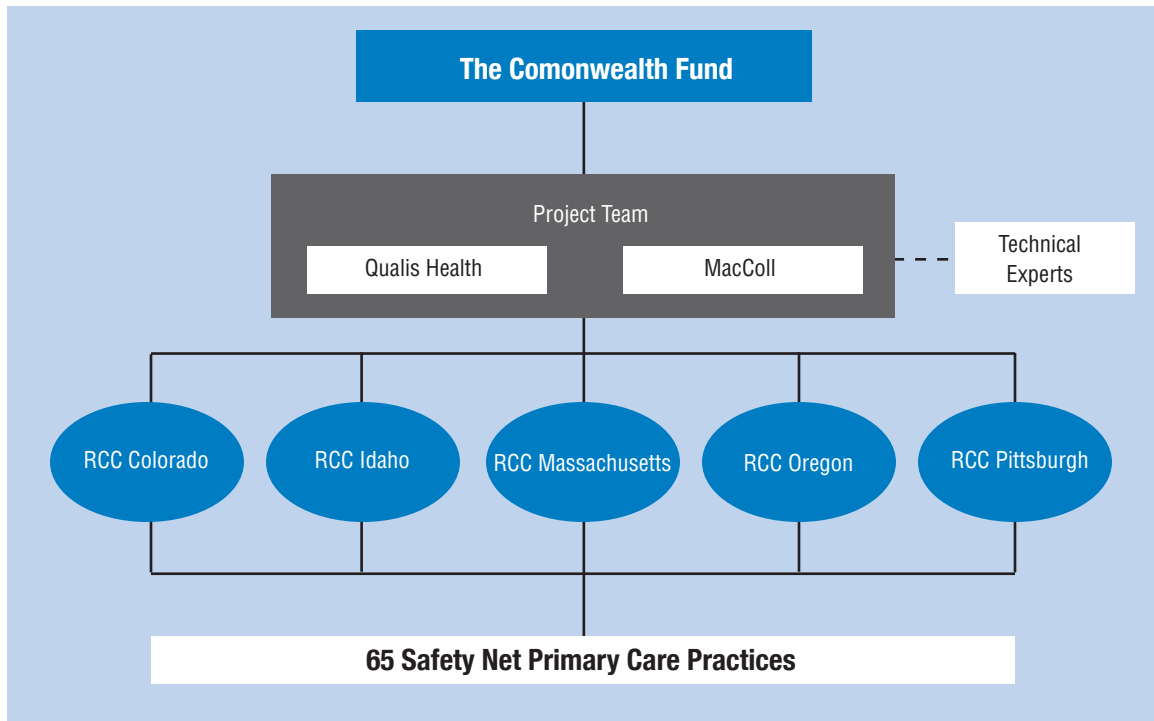
<sup>9</sup> See [www.improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

For Qualis Health, the Initiative was an opportunity for them to grow their PCMH capabilities, as a natural extension of the consultation and coaching-related QI work it already was doing in primary care, on health information technology (IT), and with learning collaboratives. Qualis Health partnered with MacColl to provide PCMH content expertise. Working with Qualis Health allowed MacColl to extend the Chronic Care Model to PCMH transformation and participate in developing a curriculum to support regional QI efforts.

## II. Administrative Structure of the Initiative

The multilayered administrative structure of the Initiative includes several organizations (see Figure 1). The Initiative operates through one central national hub, which then builds regional capacity through five RCCs. Staff from Qualis Health and MacColl serve as the national hub for these RCC organizations, which each employ facilitators to implement the Initiative through 10 to 15 safety net practices per region. This approach ensures the quality and consistency of facilitation services, while also allowing the fixed costs of content/resource development and technical assistance services to be spread across several regions.

**Figure 4. Administrative Structure of the Initiative**



As the program administrator, Qualis Health developed the Initiative’s infrastructure and is responsible for delivering funding, training, and technical assistance to support practices in achieving PCMH transformation and meeting the Commonwealth Fund’s reporting and dissemination requirements. MacColl co-developed and helps deliver Initiative materials, including the PCMH transformation curriculum and measurement tools.

RCCs were selected through a competitive process to identify organizations with the resources to recruit and support safety net practices in becoming high-performing PCMHs. The Qualis Health/MacColl team, with input from the Commonwealth Fund, evaluated potential RCCs based upon the strength of their existing connections and support from State Medicaid and local communities (including in-kind or matching resources and local co-funding), as well as the readiness of the set of practices recruited by the RCC and the facilitation

staff’s qualifications and prior QI experience. Five RCCs were selected in geographically distinct and non-overlapping regions (see text box). Four of the five RCCs are State Primary Care Associations (some working in partnership with other organization types), and the fifth is a citywide consortium of stakeholders working to improve health care quality. The RCCs were each expected to recruit 10 to 15 practices, retain at least one FTE facilitator, and provide facilitation services to practices. Table 1 describes the primary roles and responsibilities of organizations involved in the Initiative.

#### Regional Coordinating Centers

- **Colorado** Community Health Network
- Executive Office of Health and Human Services & **Massachusetts** League of Community Health Centers
- **Idaho** Primary Care Association
- **Oregon** Primary Care Association & CareOregon (facilitation support also provided by the Oregon Rural Practice-Based Research Network)
- **Pittsburgh** Regional Health Initiative

**Table 3. Roles and Responsibilities of Participants in the Safety Net Medical Home Initiative**

Organization	Primary Roles and Responsibilities
The Commonwealth Fund	Primary funder Provide guidance, strategic direction, monitoring, and oversight
Qualis Health and MacColl Center for Health Care Innovation	Develop administrative and organizational infrastructure Develop PCMH transformation framework, including resources and tools Select RCCs Provide technical assistance to RCCs and facilitators Analyze and monitor practice transformation data and progress Support external PCMH recognition Monitor/support PCMH payment and policy changes in participating States Support the sustainability and spread of PCMH transformation Publicly disseminate resources and tools created in the Initiative Report to The Commonwealth Fund
Regional Coordinating Centers	Recruit safety net practices Hire and support facilitators Provide direct facilitation services to practices, including learning sessions Participate in a national learning collaborative Convene stakeholders for PCMH policy and payment discussions Report to Qualis/MacColl

Organization	Primary Roles and Responsibilities
Safety Net Practices	Commit to the PCMH transformation process and to working with a practice facilitator Participate in national technical assistance offerings Execute Initiative requirements, including submitting data to RCCs, Qualis Health, and the external evaluator
Regional Co-Funders	Co-funders include Beth Israel Deaconess Medical Center (Boston, MA) Blue Cross Blue Shield of Massachusetts Foundation; Blue Cross of Idaho Foundation for Health; The Boston Foundation; Colorado Health Foundation; Jewish Healthcare Foundation (Pittsburgh, PA); Northwest Health Foundation (Portland, OR); and Partners HealthCare (Boston, MA)

### III. Funding

The Initiative’s funding comes from the Commonwealth Fund and eight additional partners from the participating regions. The Commonwealth Fund provides core support for the Initiative through a \$6.8 million, 5-year award to Qualis Health. This amount covers all administrative and staffing costs, as well as funding for MacColl, outside technical experts, training and technical assistance, PCMH recognition costs, partial core funding for the RCCs, and supplemental funding for RCCs and practice sites. Regional partners contributed varying amounts of core funds to the RCCs, ranging from \$10,000 to \$125,000 per year. RCCs use core funds to support facilitator salaries, local travel, and some learning activities with practices. RCCs also receive supplemental resources from the national hub to cover regional meetings and learning sessions, external training, and other activities (\$20,000 to \$70,000 a year/RCC). Participating practices are eligible to receive resources from the national hub to support special projects and field trips, and some RCCs provide practices with participation stipends.

### IV. The Initiative’s Practice Facilitation Approach

The goal of the Initiative is to help practices redesign their clinical and administrative systems to improve patient experience and health outcomes, bringing the benefits of patient-centered care to the Nation’s most vulnerable populations. Specifically, the Initiative aims to<sup>10</sup>:

- ▲ Improve the operational efficiency and quality of care in primary care safety net sites.
- ▲ Improve patients’ health care experiences.
- ▲ Reduce disparities in access to care and quality of care.
- ▲ Enhance regional capacity to support and sustain practice improvements.
- ▲ Influence health policy by involving Medicaid and other stakeholders in action toward appropriate reimbursement levels to sustain practice efforts.

**Change concepts.** To support facilitators in guiding practices through PCMH transformation, the Qualis Health/MacColl team, in consultation with a Technical Expert Panel, developed a QI framework—*Change Concepts for Practice Transformation*. “Change concepts” are general ideas used to stimulate specific, actionable steps that lead to improvement. These concepts are organized into four

<sup>10</sup> These goals were outlined in the original Commonwealth Fund request for proposals.

stages (see text box), which are each coupled with “key changes.” Key changes are the actionable steps practices must take to achieve each of the higher-order change concepts. Qualis Health/MacColl, in partnership with Initiative participants (facilitators and practices) and outside experts, developed a library of resources and tools to support this framework (<http://www.safetynetmedicalhome.org/>). [See Appendix A for a list of change concepts, key changes, and their connections to the Chronic Care Model.]

**Stages of the PF intervention.** When Qualis Health and MacColl began working with facilitators and practices, it did not prescribe a specific order for making changes, but instead allowed them to begin with the concept that interested them most. The rationale was that this would help RCCs harness the motivation of facilitators and practices. However, over time the team learned that the sequencing of changes was important, and that making some changes before others sped up the transformation process and provided a better platform for sustainability and future improvements. In the words of the project director, “it became clear that there were a few elements of the framework that were foundational—meaning practices couldn’t successfully adopt more advanced [change] concepts unless they had the foundational concepts in place.” Another benefit of following a sequence was that it facilitated peer learning across facilitators and practices, since they were sharing similar experiences in the same general time frame.

Thus, Qualis Health and MacColl’s current thinking is that the eight change concepts fall into four stages (see text box). The sequencing of these four stages is critical, but the sequencing of change concepts *within* a stage can be tailored to individual practices based on practice resources and needs. The first stage is **laying the foundation**. Change concepts in this stage—engaged leadership and QI strategy—reflect the fundamental base required to enable the practice to learn and implement changes. If these foundational changes are not addressed first, meaningful transformation cannot occur. The second stage addresses **building relationships** among teams and between patients and providers. This stage includes empanelment and continuous, team-based relationships, which both prepare the practice to deliver care efficiently and increase the likelihood of productive interactions between patients and care teams. The change concepts in the third stage focus on **changing care delivery**—patient-centered interactions and organized, evidence-based care. These changes encompass the practice system modifications associated with improvements in clinical performance. The final stage, **reducing barriers to care**, includes two change concepts—enhanced access and care coordination. These changes are no less important than the change concepts addressed earlier, but they are more difficult to implement in systems that are not already routinely providing well-organized,

#### The Initiative’s Stages of Practice Transformation and Change Concepts

1. Laying the Foundation
  - Engaged leadership
  - Quality improvement strategy
2. Building Relationships
  - Empanelment
  - Continuous, team-based relationships
3. Changing Care Delivery
  - Patient-centered interactions
  - Organized, evidence-based care
4. Reducing Barriers to Care
  - Enhanced access
  - Care coordination

patient-centered care. Although Qualis Health and MacColl believe that this is the ideal sequence for practices new to transformation, they also hope that QI eventually becomes an ongoing and continuous cycle. The deputy director at MacColl noted that “[the] trick is that at some point [the practices] have to do them all together; it means both working on the particular and seeing the whole.”

**Facilitator roles and core activities.** Facilitators work directly with practices, supporting them with PCMH transformation and implementing change concepts. Common facilitation activities include:

- ▲ Developing work plans
- ▲ Coaching on change concepts
- ▲ Establishing measurement strategies and reviewing data
- ▲ Identifying resources and tools
- ▲ Conducting workflow analysis
- ▲ Assessing and monitoring progress
- ▲ Providing overall support for change management
- ▲ Accelerating learning and shared knowledge

Facilitators, with support and guidance from the national hub, also link practices to experts and additional resources when special needs arise (for example, special topic Webinars or onsite consultation by subject matter experts). In addition to providing support to individual practices, facilitators at each RCC plan and conduct at least one full-day learning session for the group of practices in their region each year. These sessions provide a venue to reinforce core content, disseminate new content, and foster shared learning among practices.

**Intensity and form of facilitation work.** Although the PCMH content is standard across the Initiative, the amount of time facilitators spend with practices and how they fulfill their roles varies across the five regions (see Table 2).<sup>11</sup> Factors that affect variation include prior experience of the RCC with the PCMH and facilitation; historical relationships between the RCC and participating practices; historical work in the region around PCMH transformation; personalities and skills of facilitators; whether facilitators are full-time; geography of the region; and differences in expectations and capacity at the RCC-, facilitator-, and practice levels. Facilitators across the Initiative work with each practice for 4 years—a much longer time frame than typical facilitation interventions; however, the Commonwealth Fund understands that PCMH transformation is a complex and time intensive endeavor requiring robust support for optimal success.

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<sup>11</sup> With the exception of the Pittsburgh region, which has a citywide focus, the other regions are statewide.

**Table 4. Variation in Facilitation Approach Across Regions of the Initiative: 2012-13**

	Colorado	Massachusetts	Idaho	Oregon	Pittsburgh
Number of facilitation staff (people, not FTEs)	2	3	1	6	4
FTE per facilitator (range)	0.4 to 0.47	0.1 to 0.85	0.4-1.0	0.25 to 0.5	0.23 to 0.62
Total facilitation FTE per region for 2012-2013*	.87	1.45	1.40	1.95	1.70
Number of practices served in past 24 months	13	14	13	15	10
Number of practices typically served by 1 facilitator	131 <sup>12</sup>	2 to 8	13	2 to 7	1 to 4
Frequency of PF site visits	Quarterly	Monthly	Quarterly	Quarterly	Weekly or Monthly
Frequency of telephone check-ins	Monthly	Ongoing	Monthly	Monthly	Ongoing
Other PF intervention activities and schedule	Monthly NCQA standards review	Ongoing email contact	Bi-monthly roundtable calls; bi-weekly NCQA consultation calls; ongoing email contact	Monthly QI Webinars; email for on demand support and resources; bi-annual learning sessions	Regular update of Tomorrow's Healthcare site to communicate announcements and deliverables

\* Does not include FTE from non-facilitation staff members that support the Initiative within the region, including Executive Sponsors, Policy Support, Administrative Support, etc.

## V. Hiring and Supervising Practice Facilitators

The RCCs hire and supervise their facilitators without the direct involvement of Qualis Health or MacColl. The Initiative currently includes 16 facilitators, ranging from 0.1 to 1.0 FTE, some of whom are employees of the RCC home organization and others who are contracted staff. Currently, only one RCC employs a full-time facilitator and the others have multiple part-time facilitators, often with one lead facilitator or an additional staff person providing supervision and monitoring.

The RCCs directly supervise their facilitators' work and the fidelity of intervention implementation. Qualis Health and MacColl also indirectly monitor facilitators' work by observing training and technical assistance activities, and reviewing practices' transformation progress. Qualis Health and MacColl observe how facilitators and practices interact and how practices are responding to PCMH transformation activities, contacting RCCs and facilitators directly when issues arise. [See Section VII on Monitoring the Quality of the Facilitation Intervention for more information.]

## VI. Training Practice Facilitators

The Qualis Health/MacColl team provides training and technical support on PCMH transformation content to facilitators, based upon a curriculum that they developed and refined. As the deputy director at MacColl stated, "In the early days, we were developing the material as we were also asking

<sup>12</sup> Facilitators at this RCC work in a team, while at all others, they work individually with practices.



[the facilitators] to teach the practices the materials. It was an iterative process, and we polished the material into the implementation guides.” The curriculum is available on the Initiative’s Web site: [www.safetynetmedicalhome.org](http://www.safetynetmedicalhome.org). These materials<sup>13</sup> are used by Qualis Health to train facilitators, by facilitators to support practices, and as self-directed learning supports by facilitators and practices both within and outside of the Initiative.

The Initiative’s facilitator training emphasizes virtual training and centers around the Change Concepts for Practice Transformation, the barriers and challenges involved in transformation, and how to help practices move through the stages of transformation. Qualis Health and MacColl use multiple training and technical assistance methods, based on a train-the-trainer model<sup>14</sup>, to transfer knowledge to facilitators at each of the RCCs. Facilitators then train practices to apply the material to make changes in their work. In this way, the Initiative is building regional capacity for practice transformation. National training methods include:

“One of the most valuable contributions [of the Initiative] is the development of all these materials. They help us think through how to structure facilitation interventions and help practices figure out where to go next. They’re road maps for each of the different change concepts. They’re really useful—concrete and very easy to use. Practices can follow them too.”

Supervisor at the Massachusetts RCC

- ▲ Webinars for facilitators and practice staff to teach transformation content (monthly)
- ▲ Conference calls for facilitators to discuss case presentations, challenges, and successes (monthly)
- ▲ In-person learning sessions for facilitators focused on peer-to-peer learning, as well as some content and skills training (2 to 3 per year)
- ▲ A social learning Web site that includes a listserv and tool exchange functions

Support for individual or small groups of facilitators with common and emerging training needs is arranged via methods such as special topic Webinars, telephone support, and field trips. When Qualis Health and MacColl cannot support facilitators sufficiently on their own due to the specificity of the particular issues, they link facilitators to expert consultants.

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<sup>13</sup> Resources include detailed descriptions and examples of transformation strategies, Web-based core curriculum (26 Webinars), print materials (18 implementation guides), interactive tools (for example, a patient acuity calculator), and assessment resources for facilitators and sites.

<sup>14</sup> The model is based on adult learning theory, which says that people who train others remember 90 percent of the material they teach, and diffusion of innovation theory, which states that people adopt new information through their trusted social networks. See [www.healthpolicy.ucla.edu/healthdata/datademo.html](http://www.healthpolicy.ucla.edu/healthdata/datademo.html)

Through ongoing training and support, the Initiative has built a learning community where facilitators can share tools, ideas, and strategies for overcoming challenges, which accelerates the growth of facilitators and the transformation progress of their practices. Several members of the Qualis Health/MacColl team shared how they learned over time that sending information in only one direction—from the national hub to facilitators—undervalued the facilitators

#### Best Practices in Training Modes

- **Virtual learning methods**, such as Webinars and conference calls, are most helpful when teaching specific, sequential, and “how-to” content; answering basic questions and answers; or sharing case studies or tools
- **In-person group meetings** and direct support (for example, site visits, field trips, consultation) are effective when teaching complex content, or when trying to foster collaboration and team building

themselves as resources. The community capitalizes on the interchange of information and peer learning among facilitators across the RCCs. In fact, the project director at Qualis Health stated that establishing a learning community “might be the most practical approach” for supporting facilitators in programs with few resources. Similarly, the community may outlast the Initiative, allowing facilitators to continue to share learning after the Initiative ends.

The Initiative, which provided only general guidance to RCC applicants about whom to hire as facilitators, learned that some core competencies and change management skills are more easily taught than others. Although the lead facilitators originally selected and proposed by the RCCs had QI experience, most did not have specific experience with PCMH transformation. The project team anticipated this, and the Initiative was designed to provide facilitators with PCMH content training through the change concepts and associated curriculum. Early lessons learned indicate that programs should be prepared for: 1) turnover, 2) training and re-training over time, and 3) training on both QI content and core facilitation skills.

## VII. Monitoring the Quality of the Facilitation Intervention

Qualis Health and MacColl have established mechanisms that monitor practices’ transformation progress—and that also indirectly monitor facilitators’ work. To monitor practices’ progress, Qualis Health and MacColl adapted a tool from the IHI Collaborative Model for Achieving Breakthrough Improvement<sup>15</sup> that prompts facilitators to identify how each of their practices is functioning on a continuum from red (limited participation, needs close monitoring) to yellow (actively engaged, requires additional support) to green (high capacity for transformation, minimal support needs). According to the coaching lead at Qualis Health, this is a “gut level assessment based on facilitators’ knowledge of the practice team and how they think they are doing. It’s a way for [Qualis Health] to keep a tab on what’s going [on] in the sites and a flag for us to know how the practice is doing.” Facilitators also assess their practices using an additional tool that tracks practices’ overall transformation progress using criteria such as leadership/resources, data and QI strategy, congruence with PCMH content, and other distinguishing characteristics.

<sup>15</sup> Available at [www.ihl.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx](http://www.ihl.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx).

Facilitators and RCCs also submit reports to Qualis Health that detail their own accomplishments with each practice, strategies that did and did not work well, and future intervention plans, including the types of assistance that they need from the national hub. Qualis Health uses information from these sources to identify common challenges, which inform future training and support needs.

Practices submit information directly to Qualis Health every 6 months, including results from the PCMH-A,<sup>16</sup> a self-assessment tool that tracks progress toward implementation of key design features of the PCMH as described by the Change Concepts for Practice Transformation. Qualis Health analyzes PCMH-A data shares it with practices and their facilitators. These results allow Qualis Health to track each individual practice's transformation progress, as well as trends by region and for the Initiative overall. Additionally, each practice selects at least six indicators of clinical and operational PCMH improvements to submit quarterly. Qualis Health then feeds trended data back to the RCCs, which are used to guide their local work. Because the Initiative did not require standardized indicators across practices and regions, it is challenging to assess and communicate progress for the Initiative as a whole.

The external evaluation, conducted by researchers at the University of Chicago and funded by the Commonwealth Fund, will evaluate whether participating practices transform into PCMHs, how being a PCMH affects quality and efficiency, and what factors are associated with a practice's successful transformation. Qualis Health and MacColl are not involved in external evaluation data collection or analysis.

## VIII. Lessons Learned

A number of lessons emerge from the experiences of the Qualis Health/MacColl team that could be useful to others interested in developing a facilitation program. These lessons may be useful for individual organizations working with selected practices, as well as for larger organizations convening others to provide PF services through a train-the-trainer model. Lessons include:

**Building on existing partnerships between organizations with complementary expertise can help form a robust PF program.** Qualis Health and its partner MacColl have a long history of collaboration, and together, they have the content expertise and skills needed to lead the Initiative.

**Combining national and local strategies can enable the spread of your intervention.** A program that is regionally operated, but nationally supported, can build local capacity for PF. This is especially so when regional programs receive resources, knowledge, and support from a national hub and have opportunities for facilitated sharing and collaboration across regions (e.g., learning community). This is one strategy for building facilitation capacity across long distances.

**Using a framework supported by resources and tools and paired with technical assistance is one effective way to guide program intervention over multiple sites.** Having a centralized and prescribed framework that is sensitive to local needs can help maintain program consistency and quality across sites.

**Following a specific sequence of stages during the PF intervention is an effective method for supporting practices' PCMH transformation.** The Qualis/MacColl team learned that the sequencing

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<sup>16</sup> Available at: [www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf](http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf).

of PCMH work is important and that making some changes before others sped up the transformation process and provided a better platform for sustainability and future improvements. There also are advantages to practices moving through a similar sequence at the same time, in that it facilitates peer learning across facilitators and practices.

**Ensuring that facilitators have core coaching skills and QI technical expertise is crucial.** As stated by the project director, “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. These organizations could develop needed resources and build in time to support facilitation skill development or contract with other organizations that specialize in core coach training. Another possibility is to rely on a learning community among facilitators to support the development of core facilitation skills, which allows them to capitalize on the interchange of information and learning among peers. Whichever model is chosen, establishing formal processes for educating new staff over time is critical.

**Training facilitators often takes longer than anticipated.** The Initiative’s facilitators had to learn technical PCMH content at the same time that they were working with practices to apply that content. 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 initial interactions that are positive and productive. As the project 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 1 month, or 2, or 6 months later—it might be worth it.”

**Monitoring helps maintain program quality.** When working with regional or local entities, recognize that not all groups are equally ready to support practice transformation. Regional centers, like practices, should be assessed and re-assessed for readiness and capacity to support practices in the transformation process. The Initiative includes a useful combination of subjective facilitator-completed tools and objective practice indicator tracking. For those interested in aggregating results across sites, it may be important to specify the information and indicators to be reported (and the timeline for reporting), rather than letting regional centers or practices do this on their own.

**Funding infrastructure development can enhance capacity and support sustainability.** As intended by the project’s design, the RCCs have built capacity to offer facilitation support for PCMH transformation. Most sites have received additional funding from other sources and are working with practices outside the Initiative.

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## Appendix A

### The Safety Net Medical Home Initiative's Change Concepts, Key Changes, and Links to the Chronic Care Model

Change Concept	Key Change	Chronic Care Model Elements
Engaged leadership	Create visible leadership for culture change and QI Ensure time and resources for transformation Ensure protected time for QI Build PCMH values in staff hiring and training	Health care organization
Quality improvement strategy	Use formal QI model Establish metrics to evaluate improvement Involve patients, families, and staff in QI Optimize use of health IT	Health care organization Information systems
Empanelment	Assign all patients to a provider panel Balance supply and demand Use panel data to manage the practice population	Information systems Proactive care
Continuous team-based relationships	Establish support and care delivery teams Link patients to provider and care teams Ensure that patients see their provider Distribute roles and tasks among the team	Practice redesign (team care)
Organized, evidence-based care	Use planned care according to patient need Manage care for high-risk patients Use point-of-care reminders Use patient data to enable planned interactions	Practice redesign (planned care) Decision support Information systems
Patient-centered innovations	Respect patient and family values Encourage patient involvement in health and care Communicate so that patients understand Provide self-management support at every encounter Obtain patient and family feedback and use it for QI	Activate patients Self-management support
Enhanced access	Ensure that patients have 24/7 access to care team Provide appointment scheduling options Help patients obtain health insurance	
Care coordination	Link patients with community resources Integrate specialty care through collocation or agreements Track and support patients obtaining outside services Follow up after emergency room visits or hospitalizations Communicate test results and care plans to patients	Community resources Practice redesign (care management)

Source: Wagner EH, Coleman K, Reid RJ, et al. Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. 2012. [www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Feb/1582\\_Wagner\\_guiding\\_transformation\\_patientcentered\\_med\\_home\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf)

## RESOURCES

Safety Net Medical Home Initiative Web portal, including access to all resources listed below and more: [www.safetynetmedicalhome.org/](http://www.safetynetmedicalhome.org/)

General Background on the Initiative: [www.safetynetmedicalhome.org/about-initiative](http://www.safetynetmedicalhome.org/about-initiative)

### Coaching Guides

▲ Rapid Fire Sessions: Instruction Guide for Session Facilitators: [www.safetynetmedicalhome.org/sites/default/files/Facilitator-Guide-Rapid-Fire-Session.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Facilitator-Guide-Rapid-Fire-Session.pdf)

▲ Implementing the Patient-Centered Medical Home Model: A Practice Facilitator's Guide to Visiting Clinical Teams: [www.safetynetmedicalhome.org/sites/default/files/Facilitator-Guide-Rapid-Fire-Session.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Facilitator-Guide-Rapid-Fire-Session.pdf)

Change Concepts and Implementation Guides: [www.safetynetmedicalhome.org/change-concepts](http://www.safetynetmedicalhome.org/change-concepts)

### ▲ Engaged Leadership

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Engaged-Leadership.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Engaged-Leadership.pdf)
- <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Engaged-Leadership.pdf>
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Engaged-Leadership-2.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Engaged-Leadership-2.pdf)

### ▲ Quality Improvement Strategy

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-1.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-1.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-2.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-2.pdf)

### ▲ Empanelment

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-1.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-1.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-2.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-2.pdf)

### ▲ Continuous & Team-Based Relationships

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Elevating-Role-Medical-Clinical-Assistant.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Elevating-Role-Medical-Clinical-Assistant.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Team-Based-Care.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Team-Based-Care.pdf)

#### ▲ Patient-Centered Interactions

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-1.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-1.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-2.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-2.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-3.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-3.pdf)

#### ▲ Enhanced Access

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Enhanced-Access.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Enhanced-Access.pdf)

#### ▲ Care Coordination

- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf)
- [www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf](http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf)

#### ▲ Practice Transformation

- Change Concepts for Practice Transformation and NCQA PCMH Recognition Standards: A Crosswalk: [www.safetynetmedicalhome.org/sites/default/files/NCQA-Change-Concept-Crosswalk.pdf](http://www.safetynetmedicalhome.org/sites/default/files/NCQA-Change-Concept-Crosswalk.pdf)
- Patient-Centered Medical Home Assessment (PCMH-A): [www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf](http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf)

Newsroom (publications, press releases and announcements from The Commonwealth Fund):

[www.safetynetmedicalhome.org/about-initiative/newsroom](http://www.safetynetmedicalhome.org/about-initiative/newsroom)



## PROGRAM SNAPSHOT: VERMONT BLUEPRINT'S EQUiP PROGRAM

Vermont Blueprint's Expansion and Quality Improvement Program (EQuIP) provides facilitation or coaching to primary care practices throughout the State as one component of the Vermont Blueprint for Health, the State's broader health reform initiative. EQuIP's facilitators assist practices in becoming patient-centered medical homes (PCMHs) and implementing and using health information technology (IT) supports, among other activities.

Vermont Blueprint's EQuIP	
Context	Statewide health care reform initiative
Administrative Home	State Medicaid agency
Objectives	Provide primary care practices with support for: <ul style="list-style-type: none"> <li>• PCMH transformation and recognition</li> <li>• Electronic medical record (EMR) implementation</li> <li>• Building quality improvement (QI) capacity</li> <li>• Reaching other goals identified by practice</li> </ul>
Funding Source	Line item in State budget based on cost savings from a Medicaid 1115 waiver negotiated with the Centers for Medicare & Medicaid Services (CMS)
Staffing Model	Staff, consultant, and loaned professionals
Location of Services	On site at practices
Schedule and Duration	Twice monthly visits to practices; facilitators are permanently assigned to practices
Program Size	13 full-time equivalent (FTE) facilitators
Ratio of Facilitators to Practices	One facilitator to 8-10 practices
Eligible Practices	Any primary care practice in the State that applies to participate (eligible practices estimated at 200)
Training and Support	Facilitators participate in onsite, virtual, and send away training programs; also co-train with practices in selected topic areas
Other Components and Supports	Learning collaborative, care coordination and other staff support through community health teams (CHTs), health IT and data systems assistance, multipayer enhanced per-member per-month payment

In this case study, we profile EQuIP in detail, covering the following topics: background and context of the program; administrative structure; funding sources; practice facilitation activities; hiring, training, and supervision of facilitators; and evaluating and assessing program quality. We conclude with lessons from EQuIP's experiences for others interested in implementing a similar facilitation program.

## Vermont Blueprint's EQuIP Program: A Practice Facilitation Program Supporting Statewide Health System Reform

The Vermont Blueprint's EQuIP practice facilitation program began in 2008. It has several goals: to support reduced costs, improved access, and improved health outcomes for residents of the State by supporting PCMH transformation in all primary care practices in Vermont.

The EQuIP program is part of the State Department of Health Access (the State's Medicaid authority) and is one element of Vermont Blueprint for Health, the State's health delivery reform initiative. The Blueprint is a multicomponent intervention that's implemented by the Vermont legislature to address rising health care costs. In addition to the EQuIP practice facilitation program, the Blueprint also supports practices through learning collaboratives, resources for enhanced self-management support, community health teams (CHTs) that provide care coordinators and other staff to practices, and multipayer payment reform. (For general information on the Blueprint, see Appendix B.)

The EQuIP program provides practice facilitators to primary care practices that enroll in the Blueprint to help them build capacity for continuous QI, gain recognition as a PCMH by the National Committee for Quality Assurance (NCQA), and incorporate CHTs into their practices. EQuIP facilitators also work with health IT specialists from the State's Regional Extension Center (REC) to further electronic medical record (EMR) implementation in Blueprint practices and support meaningful use of EMRs and other health IT.

Important lessons learned by the EQuIP program to date include the following:

- ▲ There is no ready workforce for facilitation. In most cases, programs need to build their own by investing heavily in training.
- ▲ Direct hiring and management of facilitators makes it easier to stay true to the intervention model. Hiring facilitators through subcontracts with external organizations can present challenges to maintaining fidelity.
- ▲ Including EMR consultants from the HITECH REC on facilitation teams intensifies the effectiveness of both the facilitator and the consultant, and helps both work together to support PCMH transformation at the practices.
- ▲ Practices that are late adopters need a different facilitation approach than early adopters.
- ▲ Facilitators are most useful when they can help a practice focus on PCMH transformation activities, and assist the practice in identifying its goals. The focus is long-term commitment to improving care rather than an intermittent goal by the practice on the NCQA recognition.

### I. Background of the EQuIP Practice Facilitation Program

Practice facilitation is one part of the Vermont Blueprint for Health, designed to transform the way health care and health services are delivered in the State. The ultimate goal is to lower health care costs and improve health outcomes while providing citizens with high quality, well-coordinated health services. The Blueprint supports practices with a range of resources—including facilitation, care coordination, CHTs, enhanced self-management support, a statewide patient registry, and enhanced

payment for practices that are recognized as PCMHs. The Blueprint is designed to introduce “‘system-ness’ in a non-system” by organizing community systems of health within a context of independent providers, practices, organizations, and multiple insurers.

The facilitation program was created within the Blueprint initiative to help practices gain this recognition as PCMHs, build their capacity for continuous improvement, and integrate care coordination and the CHTs into their workflow. Vermont Blueprint offices direct the EQuIP program and assign facilitators to one of 14 health service areas.

Each facilitator supports 8 to 10 practices with visits twice a month and virtual support as needed in between visits. Facilitators are permanently attached to their practices and are intended to be a long-term QI resource for the practice. Participation in the Blueprint is voluntary, and any primary care practice in the State is eligible to participate and get support from EQuIP practice facilitators. Practices enroll in the program by applying to the Blueprint office.

As of spring 2012, the EQuIP program has 13 facilitators (approximately 9.5 FTEs) actively supporting 100 primary care practices in the State. To date, 85 practices have received PCMH recognition from NCQA. The program expects to be supporting up to 200 practices by the end of 2013; this represents 90 percent of the primary care practices in the State.

## **II. Administrative Structure of the EQuIP Program**

EQuIP is housed within Vermont Blueprint in the Department of Health Access (the State’s Medicaid authority). Being part of the larger Blueprint initiative gives facilitators access to additional human resources, such as the health service area program managers, advisory groups on integrated services and health IT, and community health teams.

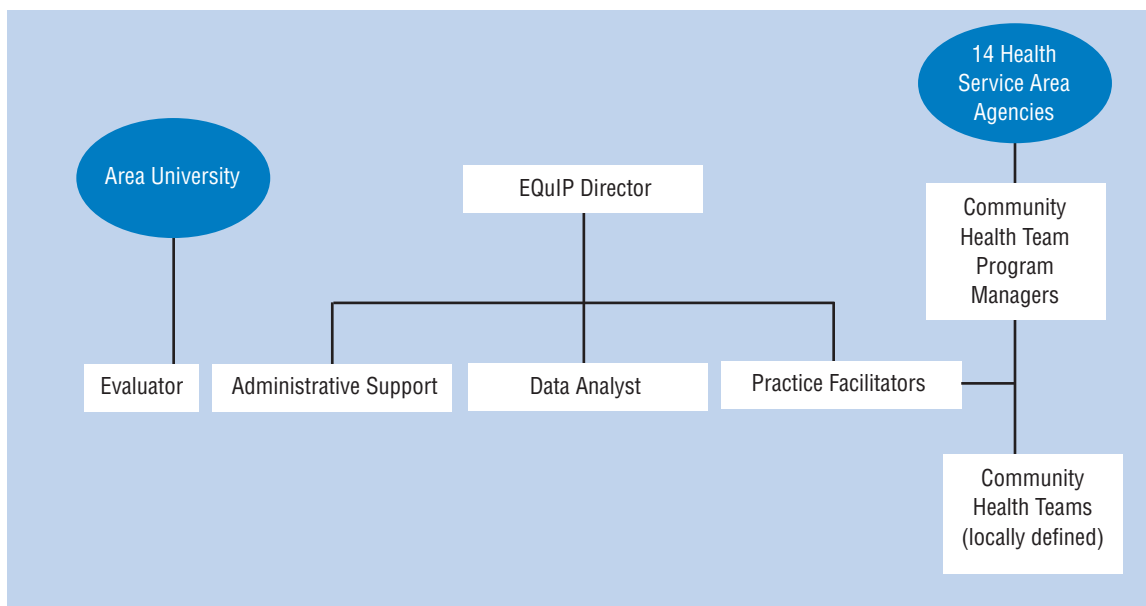
In addition to Blueprint resources, EQuIP facilitators leverage resources from other outside groups. Health IT experts from the State’s Regional Extension Center for Health Information Technology work with the facilitators during EMR implementation and also assist the facilitators in helping practices meet PCMH recognition requirements. Staff that manage Covisint DocSite, the State patient registry, provide reports on patient demographics to the facilitators and the practices. The Vermont Child Health Improvement Program at the University of Vermont (UVM-VCHIP) provides content expertise in pediatric practices and QI in these settings to the program, as well as evaluators who specialize in completing PCMH recognition applications. The Bi-State Primary Care Association provides content expertise in working with Federally Qualified Health Centers and Rural Health Centers. Facilitators also have access to resources from the Vermont Department of Health’s Division of Health Promotion, including resources for enhanced self-management support, data from its Center for Health Statistics on patient risk factors, and content expertise in chronic illnesses, such as asthma and diabetes.

The EQuIP program does not have its own advisory board, but consults with the various Blueprint advisory boards. See Appendix B for information on the Blueprint Advisory Boards.

**Staffing.** The program funds a part-time director who oversees 13 FTE practice facilitators and part-time administrative, data, and evaluation support staff (see Figure 1 for an organizational chart of

all staff; see Figure A.1 in Appendix A for a more detailed organizational chart with corresponding FTEs).<sup>17</sup> The data analyst tracks practices participating in the Blueprint. The evaluator created and now maintains a database that tracks the content of facilitator encounters with practices, as well as service hours provided, for internal QI and research purposes.

**Figure 5. Organizational Chart for Vermont Blueprint’s EQuIP**



### III. Funding the Facilitation Program

**Funding source.** The EQuIP program is funded through Blueprint Vermont, a line item in the State budget funded through its Medicaid 1115 waiver. State legislators, the State Department of Health Access, and the director of Blueprint Vermont worked closely with CMS and the State legislature to design a sustainable funding model for the larger initiative. Vermont negotiated with CMS to keep any savings from its negotiated patient capitation rate and use them to reinvest in developing the Blueprint Vermont initiative, including the practice facilitation program.

**Program costs.** The program budget includes funding for all program staff, facilitator training, guest speakers with expertise in facilitation or specific content areas supported by the facilitators, attendance at conferences for ongoing professional development, travel to and from practice sites, and analysis and evaluation research on the program.

<sup>17</sup> EQuIP is part of the larger Blueprint initiative, which includes a director, three division directors, and two assistants. These individuals also provide some ancillary support to EQuIP.

## IV. EQUiP’s Practice Facilitation Approach

All primary care practices in Vermont are eligible to participate in Vermont Blueprint and receive support from EQUiP facilitators. EQUiP’s facilitation intervention is focused on seven areas (Table 1). Facilitation is just one component of the QI infrastructure, though; practices also receive other complementary supports.

**Table 5. Areas of Focus and Additional Quality Improvement Approaches Used in EQUiP**

Seven Areas of Focus for the EQUiP Program	QI Approaches Used in Addition to Facilitation
Capacity for continuous QI	Learning collaborative
Elements of the PCMH	Health IT implementation support
Care coordination	Performance feedback from State patient registry
Community health teams	Enhanced per-member per-month payment from commercial and public insurers based on NCQA Physician Practice Connections-PCMH score
Enhanced self-management support	
EMR implementation that’s aligned with the PCMH concept	
Use of patient registries for population management	

### 1.Intensity and Form of Facilitators’ Work with Practices

As part of the Blueprint, each practice must establish an internal, multidisciplinary QI team to work on continuous QI, integration of the CHT, care coordination, and NCQA’s Physician Practice Connections-PCMH recognition. Care coordination consists of effective transitions for acute episodic care to preventive care planned visits, patient self-management support, decision support, and implementing and effectively using the health IT architecture. The teams include primary care providers, practice managers, nurses, office support staff, and a patient/consumer. One member of the team serves on the regional Integrated Health Services Workgroup. Each team is asked to provide summary information on the team, practice demographics, and PCMH application status to the Blueprint office. The teams meet at least monthly to review data and plan data-guided improvement.

Practice facilitators from EQUiP work with the practice improvement team and others weekly or biweekly, depending on practice need and preference, but at least once a month, to advance their transformation into PCMHs, build capacity for continuous QI, improve self-management support, and assist them in integrating CHTs into the practice.

Facilitators are assigned to support 8 to 10 practices engaged in active improvement at any one time, which currently allows the program to reach 125 practices. Additional facilitators will be added in the fall of 2012, increasing this reach to 225 primary care practices. The program aims to reach 200 practices, or 90 percent of the primary care practices in the State, by 2015.

Facilitators provide the majority of support on site at the practices. They use email, video conferencing, and telephone contact to provide additional support between visits. The schedule is tailored to each individual practice.

While PCMH recognition is a primary goal for the facilitation process, there is additional support for the practices in actually uploading and submitting their applications to NCQA. When practices have assembled materials and documentation for NCQA recognition process, the facilitator engages consultants from the Vermont Child Health Improvement Program who preliminarily score the practices based on the prepared materials and then scan and submit the application to NCQA. This decision was made to ensure that an objective third party that is an expert in standards completes the chart audit and verifies and reviews the materials.

Facilitators each work individually with their practices but may also use external consultants as needed, based on practice goals. In addition, they work regularly with consultants from the State REC when practices are establishing EMRs. The REC staff focus on the technology and its implementation in the practice. The facilitators make sure that the templates and workflow also support PCMH recognition and the principles of patient-centered care. They also collaborate with the manager of the State registry program, Covisint DocSite, to obtain reports on practice demographics and help practices use the registry data for QI and population management.

In an effort to formalize the collaboration between the EQuIP facilitators and both REC and State registry personnel, EQuIP is now piloting a “SWAT team” approach to facilitation related to IT integration. In this model, the practice facilitator, REC consultant, and registry manager will meet together on site with a practice when it begins with the Blueprint to assess the practice and develop a QI and EMR implementation plan. The team will continue to coordinate its work through monthly calls and onsite team meetings as needed, based on practice goals.

## 2. The EQuIP Facilitation Process

**First meeting.** During this meeting, the facilitator determines whether the practice is interested in focusing first on EMR implementation or on PCMH transformation and recognition. Based on this, the facilitator then either engages the health IT consultant from the State REC and connects that person to the practice, or initiates the PCMH transformation and recognition intervention with the practice.

**Initial goal setting and early win projects.** The facilitator works with the practice to help identify the first changes practice staff would like to make to improve patient care and outcomes. As the staff identify their improvement goals, the facilitator helps them connect these goals to PCMH principles and recognition requirements. Facilitators focus on achieving easy, early wins with their practices as an opportunity to begin building the practice’s capacity for continuous QI and understanding of the principles of the PCMH and the requirements of NCQA’s PCMH recognition process.

**Assessment.** Based on the goals the practice identifies in the first meeting, the facilitator selects the appropriate assessment. If the practice chooses implementing EMRs first, the REC consultant will work with the practice to conduct pre-health IT implementation. If the practice opts to work on PCMH transformation, the facilitator uses a comprehensive assessment tool, such as the one developed by Clinical Microsystems. The goal of this first assessment is to identify practice strengths and needs and obtain data that guide the practice’s transformation plan.

Feedback on health service gaps at the practice. As the facilitator works with the practice and learns

about the gaps in services experienced by its patients and the resources necessary to serve as a PCMH, the facilitator will give continuous feedback to the project manager in charge of forming the CHTs for the local area.

**Goal setting.** After the initial “early win” project, the facilitator continues to work with the practice to refine improvement goals and encourages staff to use a data-driven method for determining goals. The facilitator works with the practice to identify up to three high-priority conditions among its patients and three preventive health services to serve as the focus for the initial facilitation intervention. The facilitator works with the practice to use patient data and demographics to identify these conditions. These priority conditions then can serve as the priority conditions for the practice’s application for PCMH recognition.

**Build organizational capacity for QI in the practice.** The facilitator helps the practice form a QI team if it doesn’t have one. The facilitator also provides training to the team on the model for improvement and rapid-cycle change processes, and helps the team develop an improvement plan based on the results of the initial assessment conducted by the facilitator and recommendations of the team members. The facilitator helps the practice connect its improvement goals to the PCMH and its recognition process, and trains the team on both.

**Active improvement work and preparation for PCMH recognition.** Once the practice has defined its goals and developed an improvement plan, the facilitator provides a variety of supports to the QI team and practice to carry out the improvements. This support includes training on specialized content areas, workflow mapping and redesign, bringing in experts such as the health IT consultant from the State REC, gathering performance data to track progress toward improvement goals, and coordinating with a third-party vendor to conduct an initial PCMH scoring and prepare the application for submission to NCQA for PCMH recognition.

**Implementing the Community Health Team.** The facilitator works with the practice to redesign workflow and health IT systems to support implementation of the CHT within the practice. Currently the teams are placed in practices at the time of PCMH recognition, but will soon move to an approach in which they are placed in practices 6 months prior to submitting their application for recognition as a means of helping them meet NCQA’s requirements and, more importantly, to address critical gaps in care identified by the practice.

**Submission of the Patient-Centered Medical Home application.** The facilitator coordinates with the practice and an outside vendor to prepare the practice’s application to NCQA.

**Holding the gains and continuous improvement.** The facilitator continues to work on goals after the practice submits its application and remains available to the practice on a permanent basis to help with other improvement activities. Once a practice attains PCMH recognition, it must maintain this and reapply every 3 years. The facilitators remain available to support maintenance of the practice’s status and preparation for reapplication.



## V. Hiring Practice Facilitators

**Core Competencies for the Blueprint Vermont Practice Facilitators.** EQuIP adopted existing core competencies for practice facilitators from the Quality Improvement and Innovation Partnership (QIIP) for its facilitators (QIIP 2010). Based on QIIP’s work, EQuIP identified seven roles for practice facilitators and 21 core competencies needed to fulfill these roles (Table 2).

**Table 6. Roles and Core Competencies of EQuIP Facilitators**

Roles	Core Competencies
<ul style="list-style-type: none"> <li>• QI expert</li> <li>• Communicator</li> <li>• Collaborator</li> <li>• Systems thinker</li> <li>• Manager</li> <li>• Educator and scholar</li> <li>• Leader</li> </ul>	<ul style="list-style-type: none"> <li>• Function effectively as collaborative external consultants, integrating all of the facilitator roles to coach and facilitate ethical and team-centered QI integration and application</li> <li>• Establish and maintain QI knowledge, skills, and concepts appropriate to their practice</li> <li>• Perform a complete and appropriate assessment of a team, system of care, data, and outcomes</li> <li>• Use coaching and facilitation skills effectively in the application of change theory</li> <li>• Demonstrate proficient and appropriate use of QI methodology tools</li> <li>• Seek appropriate consultation from other health or QI professionals, recognizing the limits of their expertise</li> <li>• Develop rapport, trust, and ethical relationships with QI colleagues and primary health care teams</li> <li>• Elicit and synthesize relevant information and perspectives of colleagues and teams</li> <li>• Convey relevant nonjudgmental information to colleagues and teams, both oral and written</li> <li>• Develop a common understanding</li> <li>• Participate effectively and appropriately in an external consultative coaching role with primary care practices</li> <li>• Effectively work with individuals to identify, mitigate, negotiate, and resolve conflict</li> <li>• Identify the complex systems that represent the health care system</li> <li>• Demonstrate the integration and application of knowledge of complex health care systems into QI coaching</li> <li>• Demonstrate the use of coordinated self-management, information management, and resource management to provide consultative coaching effectively</li> <li>• Maintain and enhance professional activities through ongoing learning</li> <li>• Critically evaluate information and its sources, and apply this appropriately to coaching and facilitation of QI methodology content with teams</li> <li>• Facilitate the learning of teams, colleagues, and others as a mentor and educator</li> <li>• Contribute to the creation, dissemination, application, and integration of new QI knowledge, leading to its translation to practice, research, publication, and presentation</li> <li>• Demonstrate a personal, professional commitment to excellence in consultative coaching</li> <li>• Act as an ambassador for QI value to internal and external stakeholders</li> </ul>

Adapted from: Quality Improvement and Innovation Partnership. “Quality Improvement Coach Competencies.” January 2010

**Hiring criteria and approach.** The EQuIP program director aims to hire individuals with excellent interpersonal skills and a ‘sparkle’ factor—meaning facilitators who are highly skilled in engaging individuals in difficult tasks and motivating them in their completion. Most of the facilitators have master’s degrees; a bachelor’s-level degree is considered a minimum requirement. Facilitators also must have several years of prior work experience. While it is preferable that this be in health care and QI, this is not required.



**Interview process.** EQuIP uses an experiential interviewing process for identifying facilitators. In addition to standard interview questions, applicants are given “tasks” to complete. These include preparing a presentation on the PCMH and delivering it to the EQuIP leadership and facilitation team, and engaging in an unexpected problem-solving activity during the interview, in which the applicant is handed an unfamiliar piece of equipment such as a smart phone and is asked to accomplish a specified task using the item. The interview team observes their approach to solving this problem and evaluates the degree to which the applicant’s approach reflects core competencies needed for effective facilitation.

## **VI. Training and Supervising Practice Facilitators**

Training is an essential part of the program. The EQuIP Training program is called the Learning Health System, and consists of several components: onsite, virtual, send-away, and co-training. The training program leverages resources from across the Blueprint and with other facilitation programs.

The training program has evolved through several stages. Without a ready workforce of experienced facilitators, EQuIP invested heavily in training resources for its facilitators. At start-up, the program provided intensive training for its facilitators by bringing in experts from across the country and sending a portion of their facilitators to offsite programs, such as HealthTeamWorks and Clinical Microsystems.

All facilitators currently participate in a 4-week orientation training for EQuIP that provides an orientation to the Blueprint, training in the Model for Improvement and Clinical Microsystems, training in self-management support in primary care, and PCMH recognition through NCQA. This training takes place on site at the EQuIP central office.

After the initial workforce was created and new hires were added to the program, EQuIP began relying heavily on send-away programs to provide initial training. In addition, it established a mentorship program to help new hires integrate into the existing facilitation workforce. Each new hire is assigned an experienced facilitator as a mentor. They are asked to sit together at biweekly training sessions, and the new hire completes a 1-month field experience in shadowing his or her mentor in practices. New hires meet regularly with their mentors, who assist them in both skill development and building comfort with the program and the existing facilitators.

EQuIP stresses field experience in training as well as continuous training for its facilitators. All facilitators participate in weekly phone-based trainings and supervision calls, and in-person learning sessions twice a month. Facilitators also can take part in quarterly or ad-hoc learning collaboratives offered to practices as part of the Blueprint initiative. One or two facilitators are sent to conferences on special topics important to their work, such as asthma QI, self-management support, or QI methods, and then return to train the remaining staff.

In addition, EQuIP has developed an innovative co-training program, in which facilitators and practices train together in a topic area. The program co-trains facilitators and their practices on core content as a means of building skills and sharing good ideas and emerging best practices from the field with each other. This helps the facilitators and the practice build a shared vocabulary and vision of change. The practice works on the clinical content—for example, asthma guidelines—and the

facilitator attends to the process elements, such as workflow implications and health IT changes, to support the new clinical approaches.

The EQuIP program director gives supervision support to facilitators biweekly through a combination of phone conferences and onsite group sessions. During the one-on-one supervision sessions, facilitators review their progress with each of their practices based on their entries in the facilitators' practice registries.<sup>18</sup> They present case studies during group session, and the supervisor and facilitators provide feedback and perspectives from their own experiences.

## VII. Monitoring the Quality of the Program

The EQuIP program carries out both internal QI activities and external evaluations of its effectiveness.

*Internal assessment and QI processes for EQuIP.* EQuIP staff use a database developed by University of Vermont faculty specifically to gather quantitative and qualitative information on facilitator work on a weekly and monthly basis. The database captures information on time spent with practices, what the facilitators did during their encounters with practices, who participated in meetings with the facilitator, and the expected versus actual content and outcomes of the meetings. With support from the data analyst in the Blueprint Vermont office, EQuIP is also able to track the use and effectiveness of practice management and panel management databases in each practice, as well as the numbers and timelines of practices seeking and achieving PCMH recognition, and their levels. Table 3 provides the list of internal quality metrics used by EQuIP staff.

Program leadership uses these internal quality metrics to monitor progress toward the program's goal of supporting PCMH transformation in 80 percent of primary care practices in the State and fidelity to the facilitator intervention model. The leadership uses these data to identify areas of improvement for the program and guide training and supervision for the facilitators. Right now these QI activities are somewhat informal, but the program is moving toward a more structured internal QI approach that mirrors the methods its facilitators help introduce in their practices.

**Table 7. Internal Quality Metrics Monitored by EQuIP Leadership**

Number of hours of support provided by facilitators to a practice
The content and activities during these service hours
Practice progress toward PCMH recognition
Practice progress toward implementing care coordination and self-management support
Use and effectiveness of practice management databases at each site
The number of practices that have achieved recognition, and at what level

*External evaluation.* The EQuIP program partners with researchers at area universities to carry out evaluations of the facilitator program's outcomes, along with those of the larger Vermont Blueprint initiative. The researchers dedicate a minimum of 0.25 FTE to the evaluation as part of funded research by the Federal Government and are addressing questions designed to advance knowledge

<sup>18</sup> The practice registry is a Web-based tool that tracks practice progress toward program goals. The registry was developed and is maintained by a faculty member at the University of Vermont's Department of Family Medicine.

about the effectiveness of practice facilitation overall, and understand the optimal amount of facilitator support needed for practice change. Researchers also are looking at the impact of the Blueprint more broadly, on utilization, costs, and patient outcomes.

## VIII. LESSONS LEARNED

A number of lessons have emerged from the EQuIP program to date:

**A ready workforce for facilitation does not exist. In most instances, you'll need to invest heavily in training.** Initially, the EQuIP program had problems finding people with the necessary background to staff their program. To solve this problem, EQuIP invested heavily in training programs and built its own workforce from the ground up.

**Direct hiring and management of facilitators makes it easier to stay true to the intervention model. Subcontracting services out to external organizations can produce challenges to fidelity.** EQuIP originally staffed its program by subcontracting with external health care organizations for a percentage of a staff person's time to serve as facilitators. This made it hard for the EQuIP director to supervise or train the staff and oversee their work. Moreover the staff's ability to provide the contracted services often was compromised by competing demands from their home organization. As a result, EQuIP shifted to direct hiring of facilitation staff, and this 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're supporting.

**Practices that are late adopters need a different facilitation approach than early adopters.** Late-adopter practices are more skeptical about the potential benefits of QI work for their organizations and need more grassroots engagement approaches, in which the practice sets the goals and agenda for change. Early adopters, on the other hand, already have had an opportunity to see the improvement work's value.

**Using facilitators to complete NCQA PCMH applications can divert them from real improvement work into paperwork support.** When facilitators help practices complete their NCQA applications, it can easily shift the focus away from real practice improvement and transformation, in favor of filling out forms and collecting data for the PCMH application. It can be useful to have an outside person oversee submission of the application, so that the facilitator can stay focused on the improvement work needed to achieve certain levels of recognition.

**Including EMR consultants from the HI TECH RECs on facilitation teams intensifies the effectiveness of both the facilitator and EMR consultant and helps both work in a coordinated fashion to support practices' PCMH transformation.** EQuIP works closely with the State REC in improving care in State practices. Facilitators and the REC staff need to meet jointly with a practice at kick-off, and then periodically throughout the intervention, to coordinate work and realize synergies.

This case study was prepared by Lyndee Knox, LA Net, and Erin Fries Taylor, Mathematica Policy Research.

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## Resources

Blueprint Vermont Implementation Manual. [hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf](http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf)

General Information on Blueprint Vermont [hcr.vermont.gov/blueprint](http://hcr.vermont.gov/blueprint)

Quality Improvement and Innovation Partnership. “Quality Improvement Coach Competencies.” January 2010. [qiip.ca/user\\_files/QIIP%20-%20QI%20Coach%20Competencies%20Launch%20Jan-10.pdf](http://qiip.ca/user_files/QIIP%20-%20QI%20Coach%20Competencies%20Launch%20Jan-10.pdf)

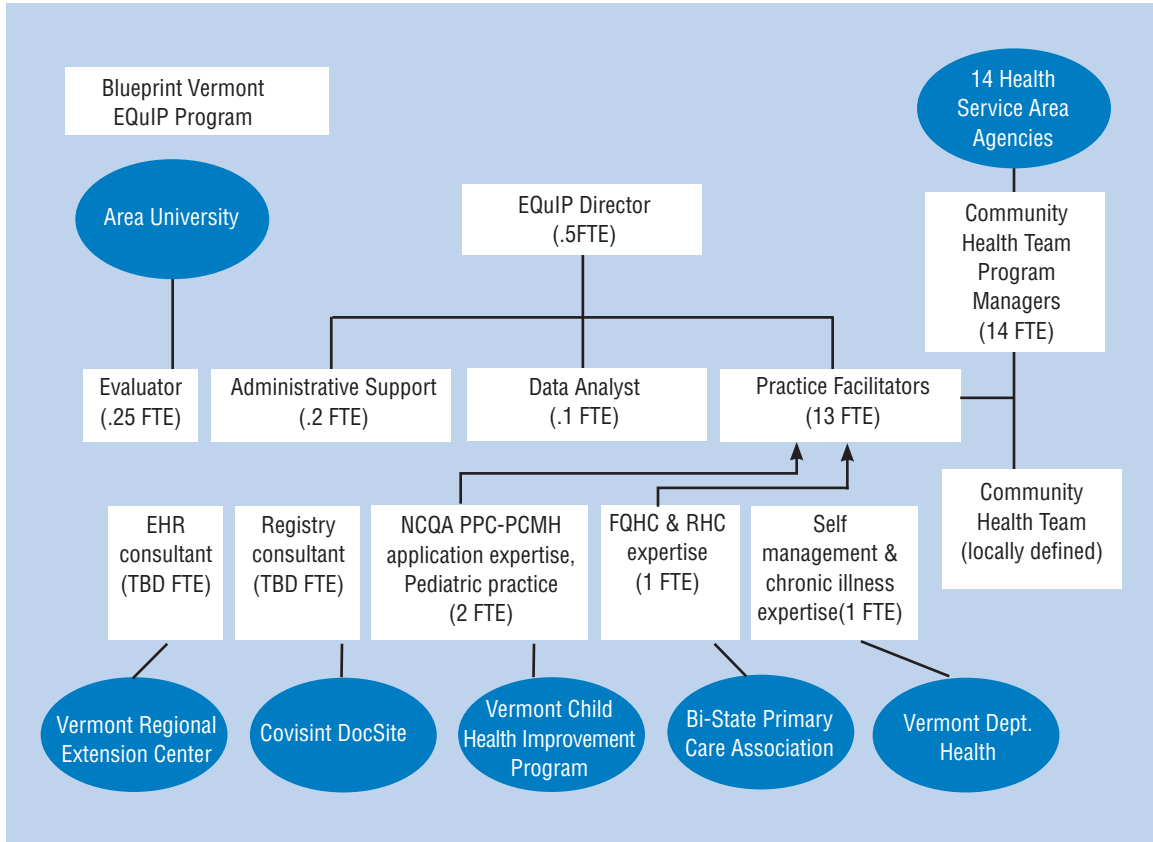
## Related Literature

Bielaszka-DuVernay C. Vermont’s Blueprint for medical homes, community health teams, and better health at lower costs. *Health Aff* 2011;30(3):383-6.

Hsaio WC, Knight AG, Kappel S, and Done N. What other States can learn from Vermont’s bold experiment: embracing a single payer health care financing system. *Health Aff* 2011;30(7):1232-41.

# Appendix B

**Figure B.1. Detailed Organizational Chart for Vermont Blueprint's EQiP**



## APPENDIX C

**The Vermont Blueprint for Health.** The Vermont Blueprint for Health is a State-led initiative designed to transform the way that health care and health services are delivered in Vermont. The overarching goal of the Blueprint model is to provide citizens with high-quality, well-coordinated health services. Its focus is to implement a health care model that organizes community systems of health within a context of independent providers, practices, organizations, and multiple insurers. It is described as “working to establish ‘system-ness’ in a non-system.” A central component of the Blueprint is changing the way in which health care is paid for, moving away from a fee-for-service model that rewards volume over quality, to one that incentivizes quality services that meet the needs of individuals and communities.

The Blueprint also provides support to practices for transformation to PCMHs, resources for enhanced self-management support, health IT, evaluation, learning health systems activities, multi-payer payment reforms and CHTs developed to provide care coordinators to practices and fill gaps in care.

The CHTs, which are funded through multipayer financing reforms, serve a group of practices across each of the 14 health service areas of the State. Rather than use a top-down approach, these teams are locally determined. The health and human services providers in each area work together to identify service gaps and form the appropriate CHT to address these gaps.

Vermont Blueprint is housed in the State’s Department of Health Access, which oversees Medicaid for the State. The Department is headed by a long-time advocate of both the Blueprint and the practice facilitation program.

The Vermont Blueprint grew out of support by executive government, legislators, and health care leaders in the State. A cost model showing the return on investment associated with improvements in quality developed by a health economist from the State has been instrumental in building support for the Blueprint.

**Advisory boards.** The Blueprint is advised by four advisory groups. The Executive Committee oversees general operations of the Blueprint. The Expansion Design and Evaluation Committee advises the Blueprint director on overall program design, evaluation, and statewide expansion. The Payment Implementation Work Group advises the program on implementation of payment reform, and the Provider Practice Advisory Group advises the director’s office on provider experience with Blueprint participation and clinical guideline adoption.

**Administrative organizations.** Each health service area in Vermont must identify, through consensus, an administrative organization that will lead implementation of the Blueprint in each service area and receive money for hiring the Community Health Teams. These organizations usually are hospitals or, in some instances, Federally Qualified Health Centers or physician hospital organizations. Each administrative organization must hire a program manager for the Blueprint for its area. This individual coordinates meetings of the local workgroups, recruitment of area practices, implementation of community based self-management, and hiring and management of the community health teams for their service area.

**Integrated Health Services Workgroup.** Each health service area also forms an Integrated Health Services (IHS) Workgroup. The IHS Workgroup is responsible for planning the community health team's composition, strategies for coordinated health services, and logistics for scoring practices on NCQA's Physician Practice Connections-PCMH standards.

**Health Information Technology Workgroup.** Each health service area also forms a health IT workgroup. This workgroup provides a forum for health care leaders from each primary care practice participating in the Blueprint to interact with the REC staff and manager of the State registry on EMR and registry implementation planning and use, and to connect to the State Health Information Exchange.

**CHTs.** Early on in the development of the Blueprint, the legislators and payer groups engaged in data-driven decisionmaking about first steps for improving care in Vermont. At the time, the majority of the payer groups in the State were mandating telephonically based chronic care programs. Data on the effectiveness of these programs were presented to the legislature and contrasted to the better outcomes achieved from person-based programs. Two payers bought into the concept of improved outcomes from person-based support, and the CHTs were born. Later, the State legislature mandated all major commercial insurers in the State share the cost of the CHTs.

The CHTs are a key component of the Blueprint. They are multidisciplinary teams hired and managed through the 14 Health Service Area agencies to provide seamless patient care throughout the community. The administrative entity for the CHTs is located in the health service area and is often a hospital. Two are Federally Qualified Health Centers, and one is a physician's association.

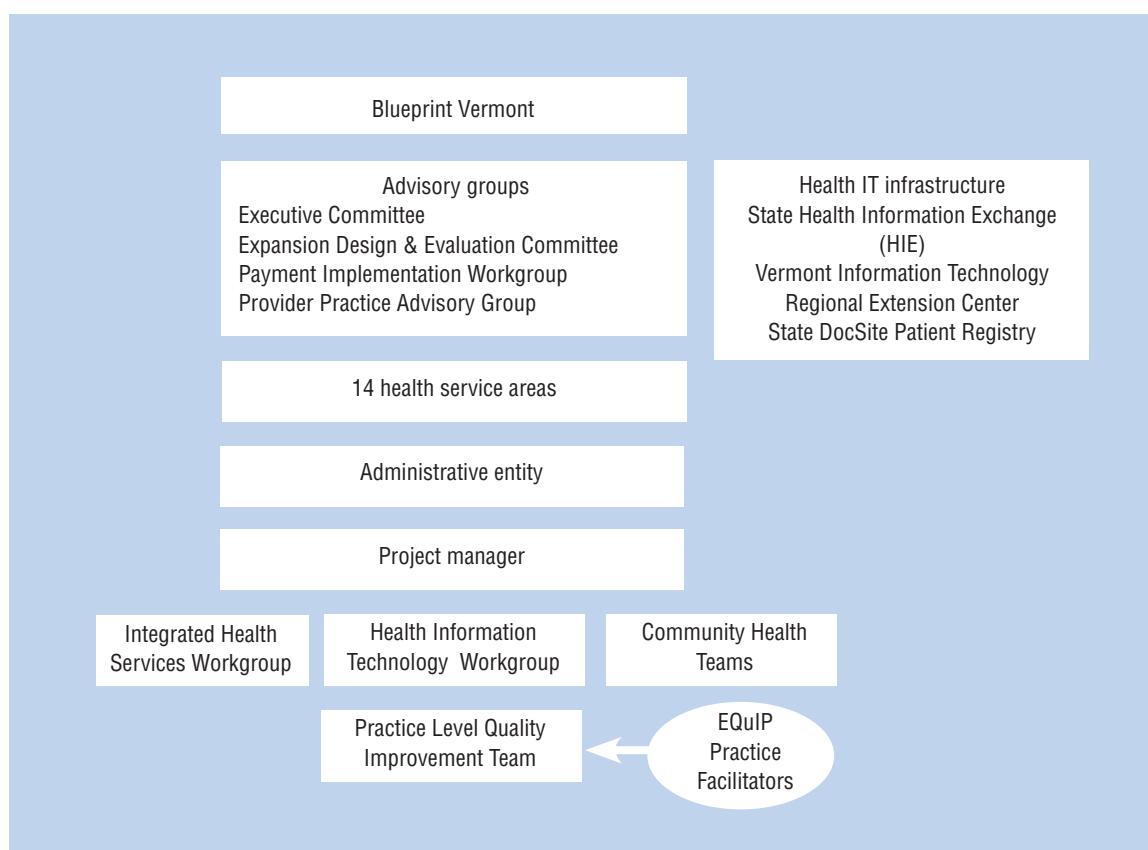
The CHTs are administratively housed in these organizations and coordinated by the Health Service Area project manager. The project manager is responsible for convening local stakeholders to identify gaps in health services that will be remedied by the health teams, incorporating feedback from local practices about service gaps into the formation of the team, coordinating work of the team within health care settings, and collaborating with the EQUiP program and its facilitators in implementing the team in individual practice sites.

The teams are funded at \$35,000 for every 2,000 patients. Each team then decides how to use these resources to fill gaps in services and reorganize services in its area so they are more effective and efficient. The team considers what services need to be embedded in area primary care practices, such as a nurse care coordinator. These resources then are embedded at the practice sites and shared across practices, depending on patient volume. The makeup of these teams is driven by local needs.

Most teams include nurse care coordinators, social work care managers, and mental health providers who deliver short-term care. The team makeup is determined by the local practices and what they determine their needs to be; for example, many CHTs also provide education on asthma and diabetes management, receive support from dietitians, dentists, or licensed alcohol and drug counselors who can serve the needs of the general population, or may focus on moving higher acuity patients over to chronic care programs. Practices receive this support at the time of NCQA recognition. With the advent of the 2011 NCQA standards, it is likely that the insurers will agree to provide the CHT 6 months prior to submission to NCQA for recognition as a PCMH.

**Practice QI Teams.** As a participant in Blueprint Vermont, each practice is required to establish an internal, multidisciplinary QI team to work on continuous QI, NCQA's Physician Practice Connections-PCMH recognition, and integration of the CHT and care coordination. The latter includes effective transitions for acute episodic care to preventive care planned visits, patient self-management support, decision support, and implementation and effective utilization of the health IT architecture. Each team is asked to provide summary information on the team, practice demographics, and their PCMH application status to the Blueprint Vermont office. The teams are asked to meet no less than monthly to review data, plan data, and implement rapid cycle QI. The teams may include primary care providers, practice managers, nurses, office support staff, and a patient/consumer. One member of the team serves on the regional IHS Workgroup.

**Figure C.1. Team Structure of Vermont Blueprint for Health**





## LESSONS LEARNED FROM LEADING MODELS OF PRACTICE FACILITATION

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.<sup>19</sup> 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

<sup>19</sup> 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.<sup>20</sup> 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

<sup>20</sup> 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](http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh__practice_facilitation_v2)

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 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)<sup>21</sup> 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.

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<sup>21</sup> 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.

This brief was prepared by Erin Fries Taylor (Mathematica Policy Research), Lyndee Knox (LANet), Dana Petersen (Mathematica), Kristin Geonnotti (Mathematica), and Rachel Machta (Mathematica).

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## 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](http://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](http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_12547_958915_0_0_18/NorthCarolina_020413comp.pdf)

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