Case Studies of LEADING PRIMARY CARE PRACTICE FACILITATION PROGRAMS

Program Snapshot: The Safety Net Medical Home Initiative

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Prevention & Chronic Care Program
IMPROVING PRIMARY CARE

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 (www.safetynetmedicalhome.org), 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.

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).[4] 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.

[4] With the exception of the Pittsburgh region, which has a citywide focus, the other regions are statewide

Table 2. 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[5]	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

[5] 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. These materials[6] 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[7], 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.

[6] 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.

[7] 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

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 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.

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

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 anticipa ted 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[8] 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.

[8] Available at www.ihi.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIs CollaborativeModelforAchievingBreakthroughImprovement.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,[9] 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

[9] Available at: 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

RESOURCES

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

General Background on the Initiative: 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
- 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

Change Concepts and Implementation Guides: 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-Supplement-Engaged-Leadership.pdf
  - 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
  - www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-2.pdf
- Empanelment
  - www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment-1.pdf
  - 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
  - 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

- Patient-Centered Interactions
  - 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
  - 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
- Care Coordination
  - www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf
  - 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
  - Patient-Centered Medical Home Assessment (PCMH-A): www.safetynetmedicalhome.org/sites/default/files/PCMH-A.pdf

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www.safetynetmedicalhome.org/about-initiative/newsroom

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