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# Designing (and Improving) Your Practice Facilitation Intervention

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May 30, 2012

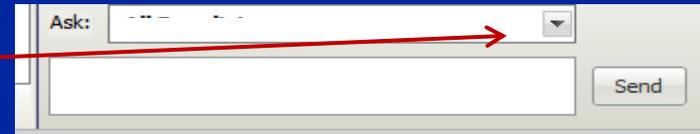
David Myers, AHRQ

Lyndee Knox, LA Net

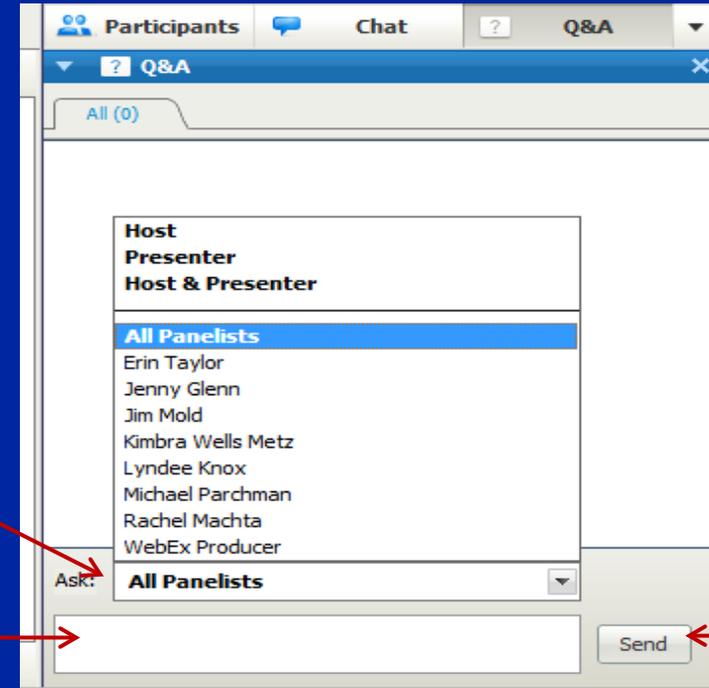
Erin Fries Taylor, Mathematica Policy Research

## Submitting a Question to Q&A

- In the Q&A panel , please click on the dropdown menu arrow
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- Then type in your question in the field below the dropdown menu.
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- The question will then be sent to all panelists.



Type in question

Hit “Send”

# Introduction

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**David Meyers, AHRQ**

For more information please visit:

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# Acknowledgments

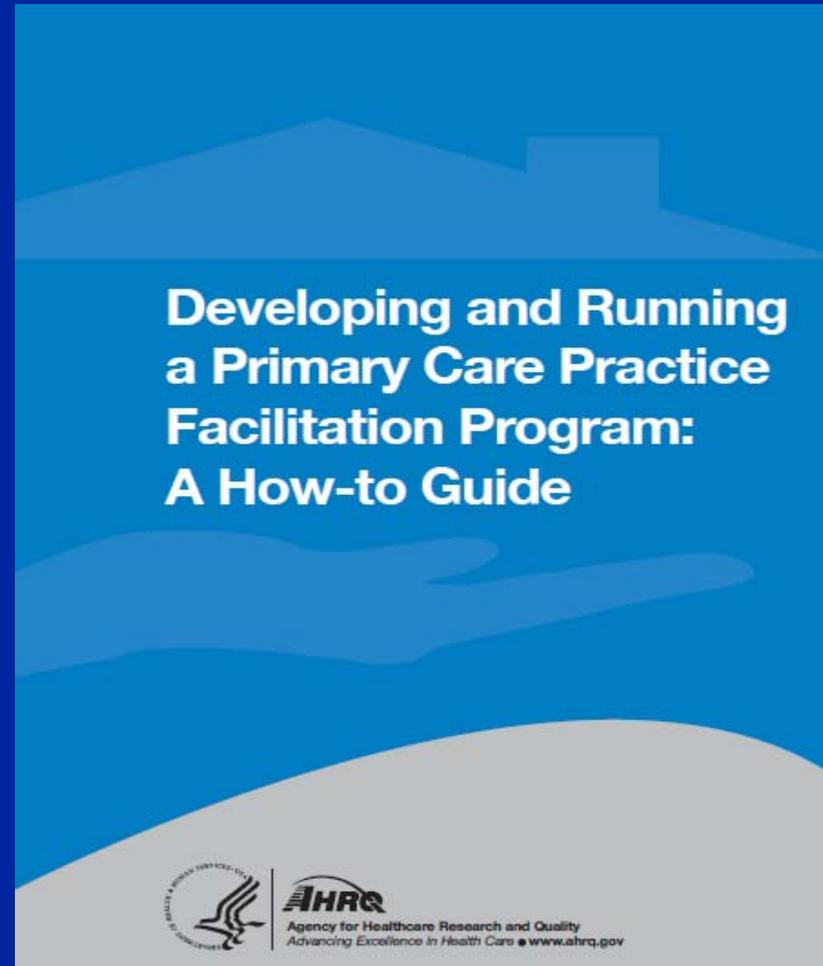
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# Designing a practice facilitation intervention: What the experts said



Lyndee Knox, PhD

Chief Executive Officer

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## Clarifying vocabulary

**A FACILITATION PROGRAM is a collection of facilitation resources and services that support improved patient care and outcomes.**

**They may be LOCATED IN A VARIETY OF DIFFERENT settings**

- **Quality Improvement Organizations (QIOs)**
- **HITECH Regional Extension Centers (RECs)**
- **State health departments**
- **Others**

**They often DELIVER a variety of different FACILITATION INTERVENTIONS. For example:**

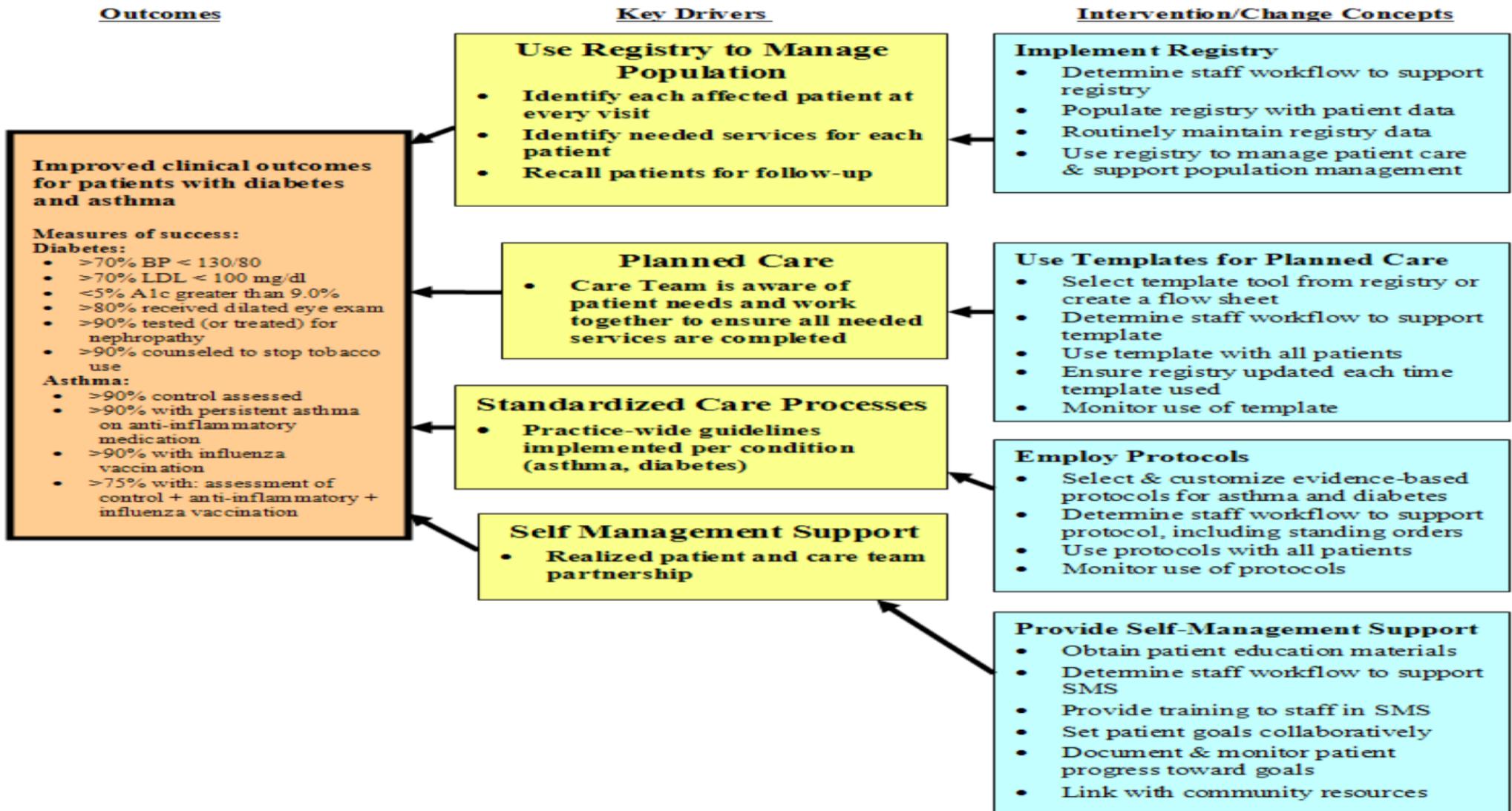
- **to implement Chronic Kidney Disease guidelines**
- **to support Patient Centered Medical Home recognition**
- **to implement care coordination**
- **to improve diabetes care**

# What the experts said about designing a practice facilitation intervention

**Start by developing a “Key Driver” model and use it to guide design of your intervention**

# Example of a Key-driver model

## IVER DIAGRAM



# Incorporate multiple improvement approaches

- **Facilitation alone is not enough.**
- **To be maximally effective, it needs to be part of a multi-modal intervention that includes:**
  - Local learning collaboratives
  - Audit and feedback
  - Benchmarking
  - Academic detailing
  - Executive coaching
- **Facilitation can be the “hub” or “coordinator” for the other approaches.**

# Examples

- **Blueprint Vermont**
  - Practice facilitation supports PCMH recognition and implementing Community Health Teams
  - Community Health Teams (Care coordination, other resources based on local need)
  - Payment reform
  - Learning collaboratives
  
- **Oklahoma (OKPRN)**
  - Practice facilitator that coordinates:
    - Academic detailing
    - Local learning collaboratives
    - Audit and feedback
    - Benchmarking

# Decide on a team or individual approach

- **Individual facilitation**
  - Non-complex interventions
  - Interventions that facilitator has deep expertise in
  - Interventions that practice has deep expertise in
  
- **Team approach**
  - Complex interventions that require outside expertise
  - Some suggestions by the experts:
    - Generalist facilitator should **STILL** be the **PRIMARY POINT OF CONTACT** with the practice
    - Generalist facilitator should **FORM RELATIONSHIP** with practice **BEFORE** “experts” from team are introduced
    - Generalist facilitator **COORDINATES AND LEADS** the team

# Include time in the intervention process for relationship building & for maintenance

## Primary Activities

Relationship building



Capacity building,  
process facilitation,  
hands--on support,  
assessment of progress



Monitoring and  
maintenance planning

## Typical Stages of Intervention

Stage 1: Practice recruitment  
and readiness assessment

Stage 2: Kickoff meeting:  
academic detailing, and start-  
-up activities

Stage 3: Practice assessment  
and goal setting

Stage 4: Active improvement  
efforts

Stage 5: Holding the gains

Stage 6: Completion and  
maintenance

# Dose and schedule should fit needs of practice and goals of intervention

- **Dose is determined by:**
  - The GOALS of the intervention
  - READINESS of the practice to engage in improvement
  - SIZE and complexity of the practice/organization
  - Already EXISTING RESOURCES & CAPACITY for improvement
  - RELATIONSHIP of facilitator with the practice
- **Schedule is determined by:**
  - Ability of practice to “metabolize” the change (intensive is not always best...)
  - Predictability in order to build relationships & accountability
  - Existing capacity of practice to drive work forward
  - Complexity of the change (guidelines vs. practice transformation)
  - Funding and project timeline

# Examples of dose/schedule

- **Oklahoma Physicians Resource/Research Network**
  - ½ day a week (ACTIVE)
  - ½ day every three months (MAINTENANCE)
  - 6-10 months
  
- **Oklahoma Department of Health**
  - Daily for 4 weeks (ACTIVE)
  - Booster 2 weeks at 8 months post-intervention (MAINTENANCE)
  - 1 year

# Location of Support

- **On-site**
  - Essential for relationship building
  - Many things learned from water cooler discussions & observation
  - When there is need for hands-on support to get over hump
  - Relationship issues
- **Virtual**
  - Check-ins/accountability
  - Training
  - Some individual coaching
- **Combination**
  - To lower costs
  - Increase feasibility
  - To overcome long distances

# Ratio of facilitator to practice should be tailored to the goals and practice need

- **Ratio of facilitators to practices:**
  - Systematic review by Baskerville, Liddy, and Hogg (2012) suggests that effects of a facilitation intervention decline as the number of practices the facilitator supports increases.
- **Factors to consider**
  - Pre-existing relationship of facilitator with practices
  - Modality (virtual vs. on-site)
  - Complexity of the changes being pursued
  - Practices' capacity to self-facilitate
  - Travel time/distance to practices
  - Ability to leverage “lessons learned” from other practices (using local learning collaboratives, etc.)
- **Range:**
  - 4 to 20 (active)
  - 30 (maintenance)

# Practice Facilitator Role & Activities

- Build relationship
- Build priority for change in leadership (using data)
- Gather and report data
- Develop data systems for QI and new clinical processes (panel management)
- Train on QI methods
- Facilitate meetings
- Manage projects
- Train practice on content areas (e.g., panel management, team-based care)
- Manage external facilitation team and form team with expertise needed by practice
- Procure knowledge and other resources (academic detailer, expert consultant)
- Provide executive coaching to leadership
- Identify and spread good ideas from other practices
- Facilitate local learning collaboratives

# Perspectives From a Physician Receiving Facilitation



Jehni Robinson, MD  
Chief Medical Officer  
Saban Free Clinic  
Los Angeles, CA

## Perspectives from the Field



Marly McMillen, MBA  
Health Consultant

Focus: National Demonstration Project  
using facilitators for PCMH  
transformation

# Designing a PCMH Initiative – Step 1

- **Step One: Baseline**
  - How many practices will be involved
  - How many practices per facilitator
  - What are desired outcomes
    - ◆ For the practices
    - ◆ For the initiative
    - ◆ For patients
  - Incentives for change
  - How will data be retrieved, measured, and reported
  - What performance measures will you expect from practices, such as NCQA recognition
  - Baseline Assessment

# Designing a PCMH Initiative – Step 2

- **Step Two: Implementation**
  - **Review assessment results**
    - Determine if everyone is on the same page and ready to move together in unison, or if a “scramble” format is best
  - **Kick-off Meeting**
    - Invite champion physician and lead staff person per practice (or more)
    - Discuss results of assessment
    - Discuss next steps – what practices can expect
    - Discuss incentives, goals
  - **Facilitator/Practice meetings**
    - Regular group practice managers (bi-weekly or monthly)
    - Regular 1:1 meetings with practice managers (weekly)

# Designing a PCMH Initiative – Step 2 (continued)

- **Step Two: Implementation**
  - Track and Measure Progress
  - Be sure to include easy achievements along the way (low-hanging fruit)
  - Share
    - Successes across practices
    - Data across practices
  - Conduct regular Learning Collaborative meetings to discuss results, get practice leaders together, share lessons learned, maintain motivation

# Designing a PCMH Initiative – Step 3

- **Step Three: Follow-up**
  - **What happened? Provide a follow-up report sharing what each practice changed/added as part of the initiative**
  - **PCMH is not a destination – develop a system to be sure practices sustain and build on PCMH efforts**
  - **Promotion – make sure that practices & the initiative receive credit in the community for hard work done as part of the PCMH Initiative (press release)**
  - **Publish – What are lessons learned and outcomes from the initiative that can be shared either via informal and/or peer-reviewed publications or PCMH-focused presentations**

# Tailoring Your Practice Facilitation Approach



Perry Dickinson, MD

Professor

University of Colorado School of  
Medicine

Department of Family Medicine

Focus: Internal and external facilitation  
intervention models.

# Context

- Eighteen practice facilitation projects involving over 600 primary care practices
- Funding from NIDDK, NIMH, AHRQ, local and national foundations, EPA, IPAs, health systems
- Focus largely on implementation of Chronic Care Model or PCMH

# Range of Projects

- **Implementation of practice facilitation for quality improvement – with evaluation**
- **Evaluation of other folks' practice facilitation projects**
- **Training coaches within an organization, practice system, or practice**
- **Randomized clinical trial of practice facilitation approaches**

# Modality

- Usually on-site facilitation by external facilitator, sometime complemented by presence over the phone
- Occasional training and deployment of internal facilitator in a practice system with ongoing mentoring and support
- Team leader training – identifying and training staff and/or clinician leaders who can take over from the facilitator over time

## Other Components

- **Academic detailing often used to promote shared goals, leadership alignment**
- **Assessment of practice culture, current status of whatever is targeted for change, with feedback to the practice**
- **Formation of improvement teams**
- **Modified collaboratives (focused primarily on sharing among the practices)**

# Focus

- Blend of implementation of QI process, training on the topic area, and improving change culture
- Prescribed vs. practice led?
- Probably takes a bit of both – practices need some framework and focus to guide changes, but specific changes need to be practice determined
- Individual practice tailoring is crucial

# Length of Facilitation

- Depends on what you are trying to accomplish and baseline state of practices
- Implementation of PCMH in practices with little to no QI experience or quality metrics – can take many months
- Focused improvement of chronic disease quality measures in practices that have good quality metrics available – less time

# Dosing of Facilitation

- **Number of practices per facilitator – according to what outcome is targeted**
  - Asthma guidelines implementation and use of spirometry – 1.5 coaches per 53 practices, 3 to 5 visits to practice; about 12 hours per site
  - Residency PCMH project – initially 1.5 coaches for 10 practices, now 1.0 – many visits, many hours
  - Depends on intensity of change, level of transformation of work flow and roles

## Practice Facilitation and IPIP



Darren A. DeWalt, MD, MPH  
Associate Professor of Medicine  
Division of General Internal Medicine  
University of North Carolina at Chapel Hill

Focus: Designing interventions for statewide  
roll-out

# Improving Performance in Practice

- **7 states developed programs**
- **Variation in design**
  - some more collaborative oriented
  - others more coaching oriented
  - all had elements of coaching and collaborative learning
- **All worked on measures related to diabetes or asthma**
- **All worked on chronic care model type practice changes**

# Useful Models

- **Model for Improvement**
- **Promoting Action on Research Implementation in Health Services (PARiHS)**
  - Evidence, context, facilitation
- **Diffusion of innovations**
- **Complexity theory**
  - Implementing changes can be nonlinear and unpredictable

# Organize Plans at Practice and Program Levels

try to simplify, if possible

# Driver Diagrams

- Communicates great deal with one picture
- Allows productive discussion of what we are trying to accomplish and what changes we think will result in improvement
- Leads to a measurement system
- Helped us to keep efforts aligned

## IPIP System Diagram

### Outcomes

#### Improved clinical outcomes for patients with diabetes and asthma

##### Measures of success:

##### Diabetes:

- >70% BP < 130/80
- >70% LDL < 100 mg/dl
- <5% A1c greater than 9.0%
- >80% received dilated eye exam
- >90% tested (or treated) for nephropathy
- >90% counseled to stop tobacco use

##### Asthma:

- >90% control assessed
- >90% with persistent asthma on anti-inflammatory medication
- >90% with influenza vaccination
- >75% with: assessment of control + anti-inflammatory + influenza vaccination

### Key Drivers

#### Use Registry to Manage Population

- Identify each affected patient at every visit
- Identify needed services for each patient
- Recall patients for follow-up

#### Planned Care

Care Team is aware of patient needs and work together to ensure all needed services are completed

#### Standardized Care Processes

Practice-wide guidelines implemented per condition (asthma, diabetes)

#### Self Management Support

Realized patient and care team partnership

### Intervention/Change Concepts

#### Implement Registry

- Determine staff workflow to support registry
- Populate registry with patient data
- Routinely maintain registry data
- Use registry to manage patient care & support population management

#### Use Templates for Planned Care

- Select template tool from registry or create a flow sheet
- Determine staff workflow to support template
- Use template with all patients
- Ensure registry updated each time template used
- Monitor use of template

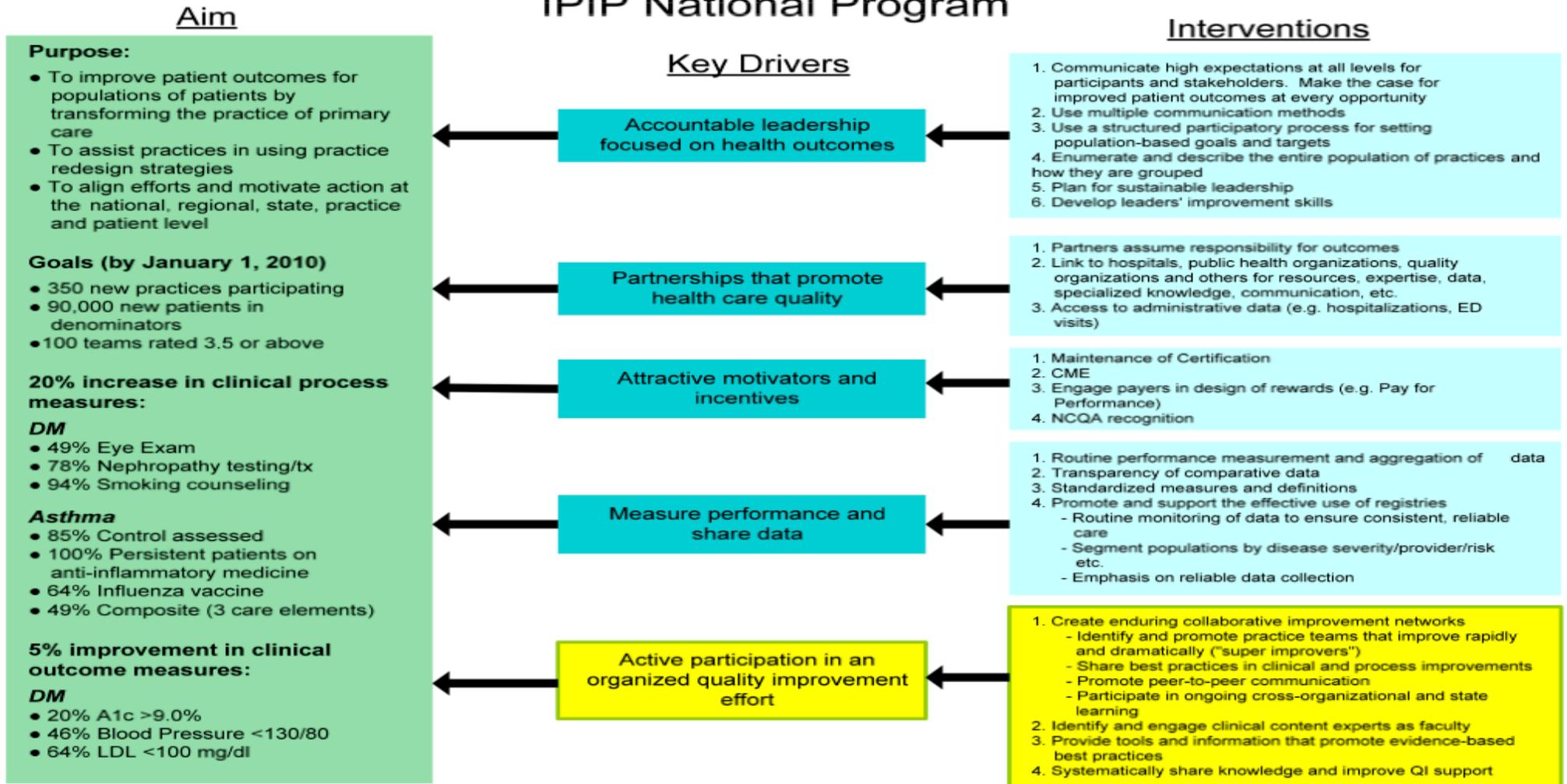
#### Employ Protocols

- Select & customize evidence-based protocols for asthma and diabetes
- Determine staff workflow to support protocol, including standing orders
- Use protocols with all patients
- Monitor use of protocols

#### Provide Self-Management Support

- Obtain patient education materials
- Determine staff workflow to support SMS
- Provide training to staff in SMS
- Set patient goals collaboratively
- Document & monitor patient progress toward goals
- Link with community resources

# IPIP National Program



**FIGURE 2.2:** IPIP national program key driver model. The highlighted boxes are the areas of focus for practice coaches.

# Facilitators Can't Do Everything

Other factors must be leveraged

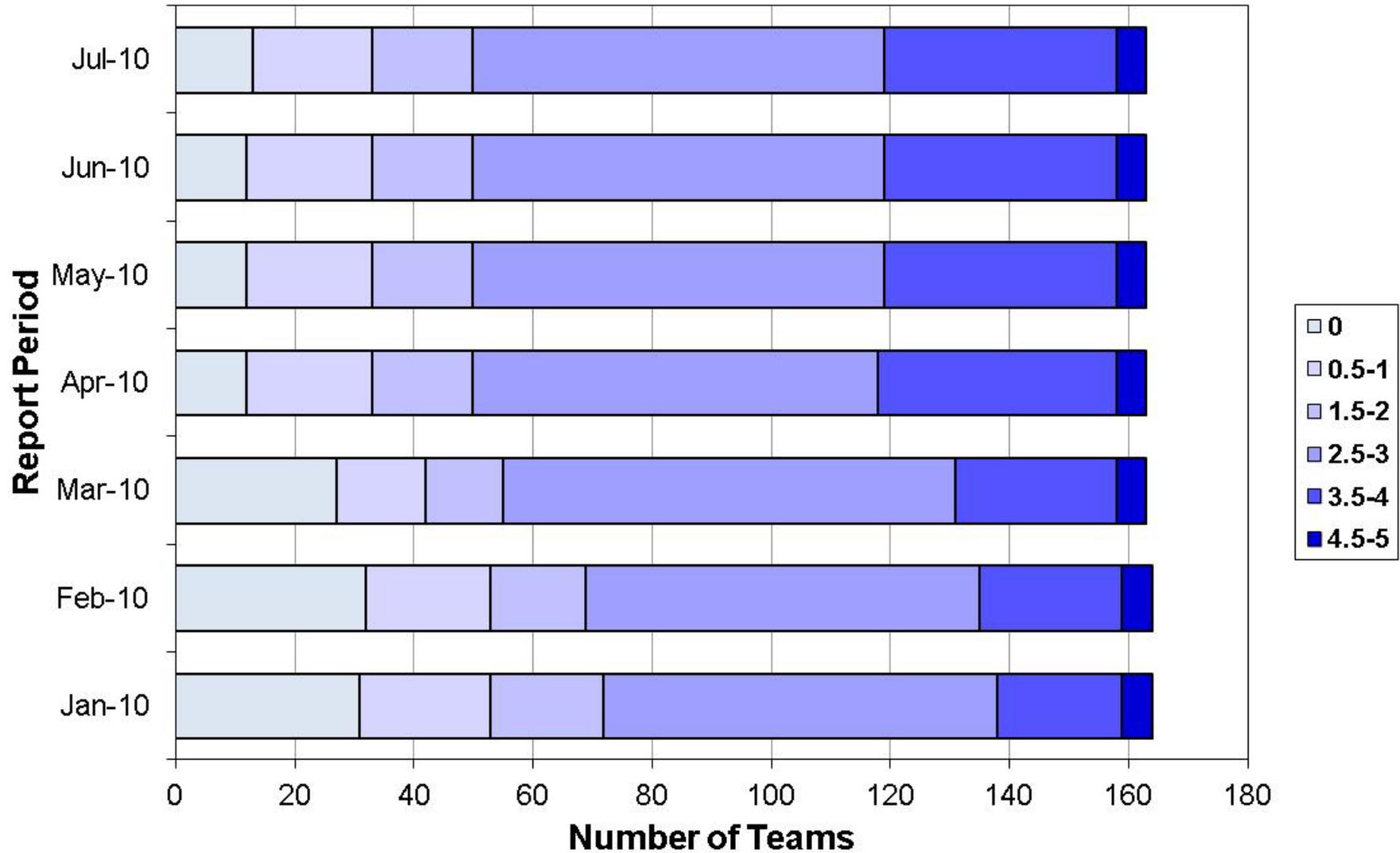
# Facilitators Can't Do Everything

- Important to know the limitations of using facilitators only
- In IPIP, most facilitators were nurses or had public health background
  - Needed some physician back up at times
- Aligning motivators and incentives, role of senior leadership (often not addressed by the facilitator)
- Facilitators need to address mid-level managers and staff to empower action

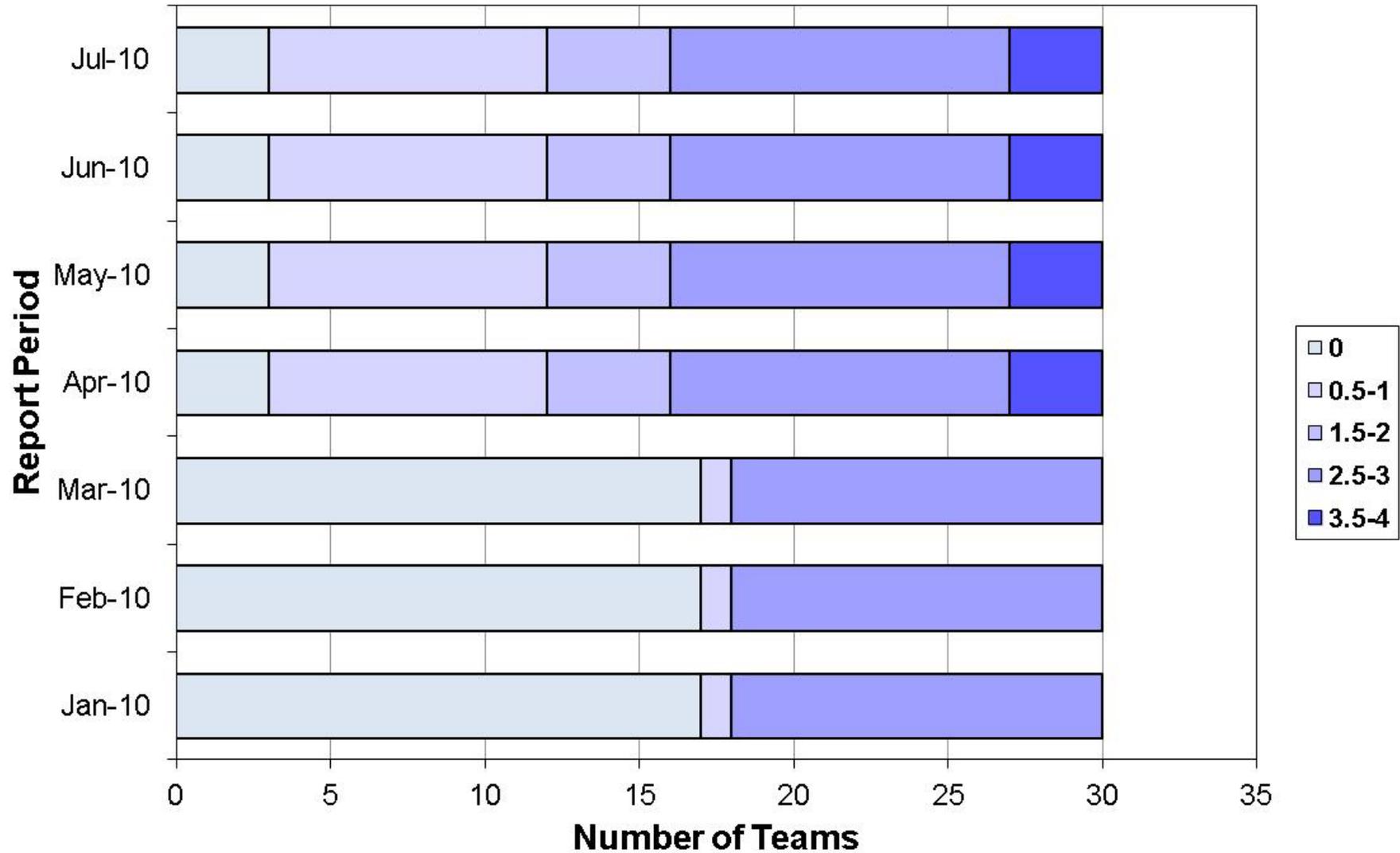
# Run the Program with Improvement Science

- **Measure aspects of the program that are required for success**
  - Participation
  - Engagement
  - Implementation progress
  - Improvement progress
- **Want to generate focused discussion in how the practices are achieving the aims and how facilitators are supporting changes**

## Self Mgmt Support Ratings by Report Period



## QIC 1 Self Mgmt Support Ratings by Report Period



# Choose Practices Wisely

# Summary

- Organize plans
- Facilitators can't do everything
- Run the program with improvement science
- Choose practices wisely

# Questions & Answers

Please submit your questions through the Q&A panel on the right hand side of your screen

## Thank You & Next Steps

- Please respond to the survey *immediately* following this webinar
- Next Webinar: Funding Your Facilitation Program
  - Date: To be announced (expected in late July or August)
- Please join AHRQ's PF listserv by emailing [PCPF-request@LIST.AHRQ.GOV](mailto:PCPF-request@LIST.AHRQ.GOV)
- Visit <http://www.pcmh.ahrq.gov>
  - Note the Practice Facilitation webpage