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Funding and Evaluating Primary Care Facilitation Programs

September 28, 2012

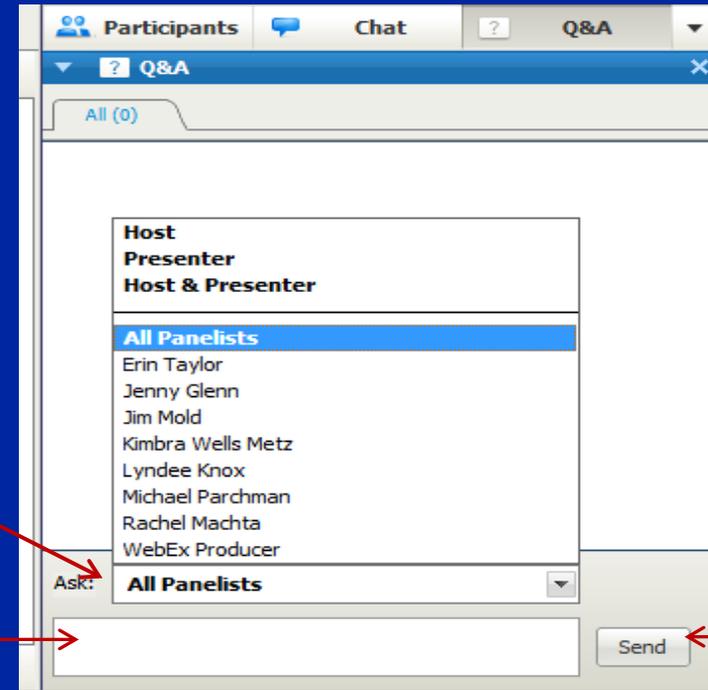
**Janice Genevro, AHRQ
Lyndee Knox, LA Net**

Submitting a Question to Q&A

- In the Q&A panel , please click on the dropdown menu arrow
- A dropdown list of the panelists and an All Panelists selection will appear



- **Select “All Panelists”**
- Then type in your question in the field below the dropdown menu.
- Hit “Send.”
- The question will then be sent to all panelists.



Type in question

Hit “Send”

Introduction

Janice Genevro, AHRQ

For more information please visit:
<http://www.pcmh.ahrq.gov>

Acknowledgments

- This work is supported by the Agency for Healthcare Research and Quality (Contract No. HHS A290200900019I)
- Project team included:
 - AHRQ – David Meyers, Janice Geneviro
 - LA Net – Lyndee Knox, Nadia Ramos
 - Mathematica – Erin Taylor, Kristin Geonnotti, Rachel Machta, Eugene Rich, Jung Kim, Jessica Nysenbaum, Debbie Peikes



Lyndee Knox, PhD
Chief Executive Officer
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Network

Today's Topics

- **Voices from the Field**
 - A health plan-based facilitation program
 - Facilitation in pediatric settings
- **Budgets and Funding Sources**
- **Evaluating Facilitation Programs**
- **Future Directions**

Voice from the Field



Hunter Gatewood, MSW
Director of Health Improvement
San Francisco Health Plan

Why San Francisco Health Plan Invests Our Resources in Practice Coaching

Hunter Gatewood,
Director of Health Improvement
San Francisco Health Plan

Who We Are, Who We Serve

- Medicaid managed care plan, in 15th year
- 73,000+ insured
 - Medi-Cal, Healthy Families, Healthy Kids, Healthy Workers
- 50,000+ Healthy San Francisco
 - <http://www.healthysanfrancisco.org>

Our goals

- Universal Coverage
- Quality Care and Access
- Exemplary Service
- Financial Viability for safety net

SFHP Provider Network

- 450 primary care providers
 - 28 clinics plus small practices
- 7 medical groups
- 2,000 specialists
- 100 mid-levels
- 6 hospitals, 9 campuses
- 200 pharmacies
- 200 vision providers



How We Influence Clinical Quality and Care Experience

- Pay for Performance
- Quality improvement (QI) learning and action projects
- Leadership development in clinics
- Care incentives for patients (plan members)
- Ongoing measurement and monitoring

http://www.sfhp.org/providers/quality_improvement/

Practice Coaching Across Programs

2010 Part of year-long collaborative

2011 Main support on a QI project,
part of a clinics leadership course

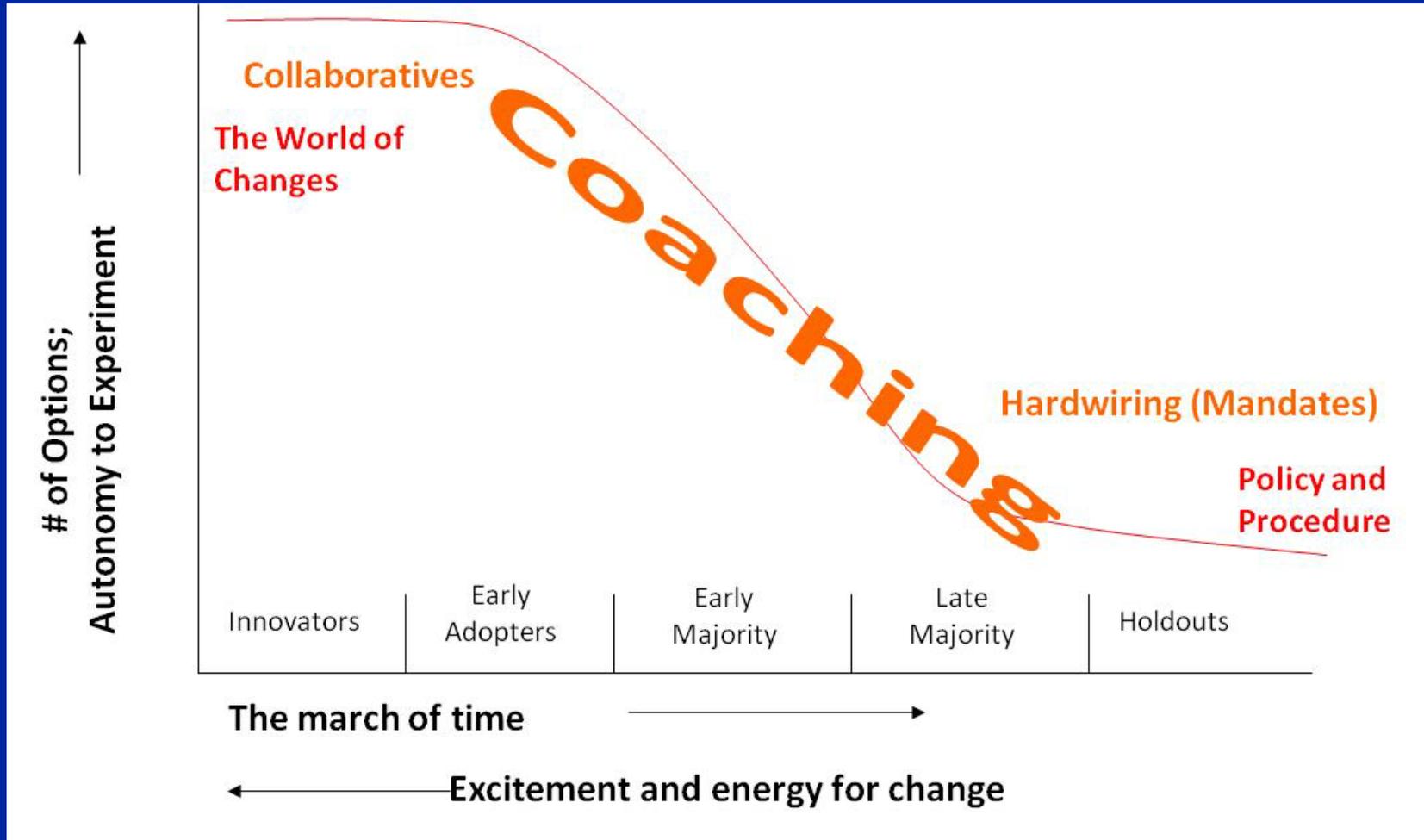
2011 – 2012 Tailored to site's request

2013 – 2015 Coaching program
for 28 clinics

Why Practice Coaching?



Coaching Helps Spread of Key Changes





Beware: Lonely Ringing Pay Phone Phenomenon

**Change mechanics of
improvement to
standardize, avoid
project chaos.**



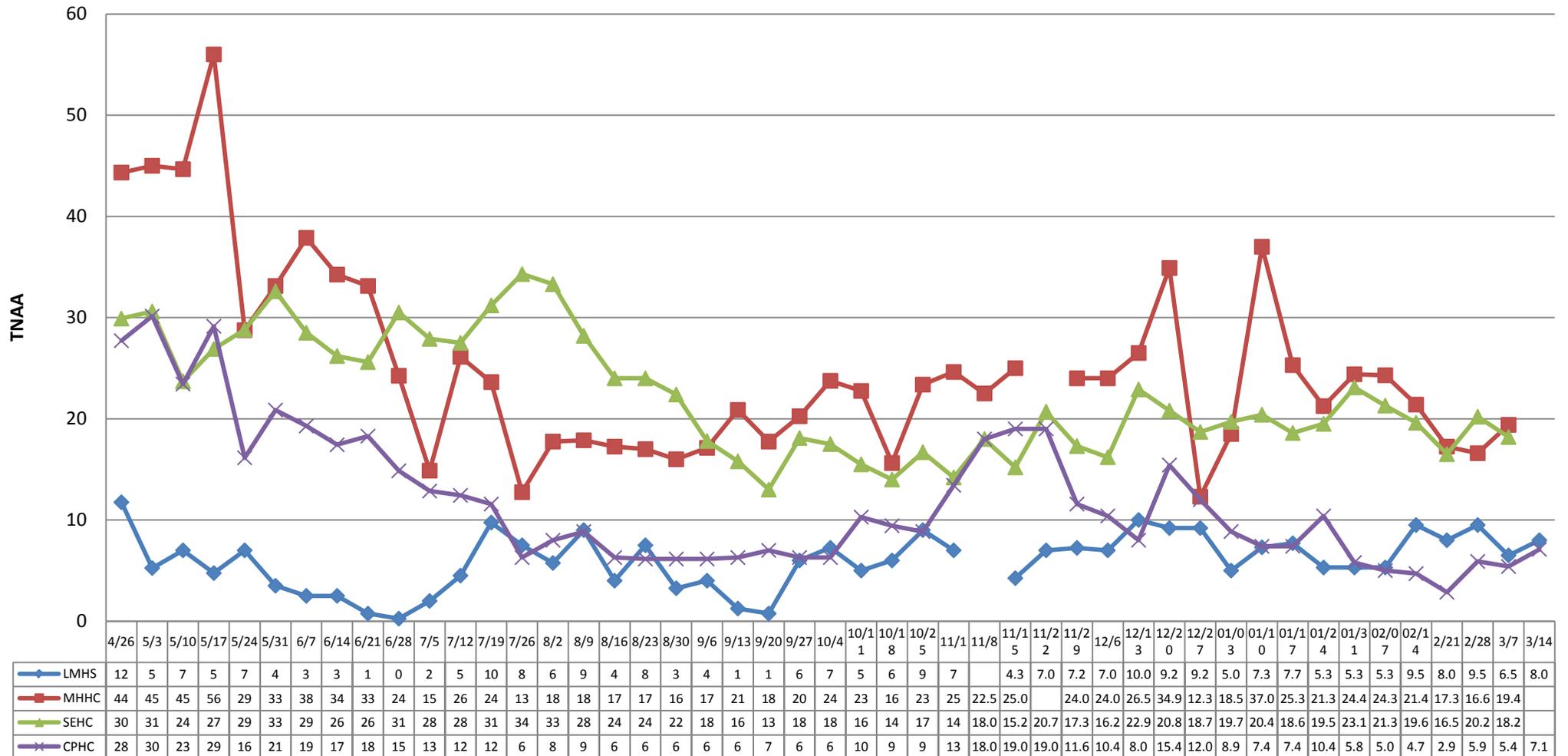
2010

Coaching as Part of Learning Collaborative

- **4 clinics: Appointment Access, with Mark Murray**
- **5 clinics: Improved Patient Communications, with Institute for Healthcare Communications**

Results: Delay Reduction

TNAA Average by Clinic



Clinics Cut Appointment Wait Time **WHILE** Taking More Patients

| Clinic | Panel Size, April 2010 | Panel Size, Dec 2010 |
|--------------------------------|---------------------------|-------------------------|
| Chinatown | 3,706 | 4,021 |
| Lyon-Martin Health Services | 2,081 | 2,535 |
| Maxine Hall | 2,975 | 3,211 |
| Southeast | 3,001 | 3,100 |

Communication Improvement Results, CAHPS visit survey

| Measure | Baseline | At 10 months | Absolute Change |
|--|--------------|--------------|-----------------|
| Doctor knows important medical history | 90.3% | 91.9% | 1.5% |
| Doctor explanations easy to understand | 94.8% | 95.0% | 0.2% |
| Doctor shows respect | 96.6% | 96.9% | 0.3% |
| Office Staff (composite) | 94.1% | 95.9% | 1.8% |
| Rating of provider | 86.1% | 89.0% | 2.9% |
| Patient recommends clinic | 89.7% | 92.7% | 3.0% |
| Clerks and receptionists respectful | 96.0% | 96.9% | 0.9% |
| Clerks and receptionists helpful | 92.3% | 94.8% | 2.5% |

2011 Coaching for QI project as part of leadership development course

- 19 clinics, 2 clinic-network leadership teams
- 8 didactic sessions on leadership and management team development
- QI project, with a practice coach
 - EHR readiness
 - Appointment access Or Visit flow efficiency
 - Patient-centered communication
 - Behavioral health integration

Table 3: Results of Coach Evaluation

| Our QCS coach... | Strongly Disagree (1) | Disagree (2) | Neither (3) | Agree (4) | Strongly Agree (5) | Mean |
|---|-----------------------|--------------|-------------|-----------|--------------------|------|
| ...helped our team apply the content provided at the 8 SFQCS learning sessions. | 0 | 1 | 3 | 10 | 7 | 4.10 |
| ...encouraged our team to test changes that we may not have done on our own. | 0 | 1 | 3 | 10 | 7 | 4.10 |
| ...helped extend the perspective of our team by providing outside experiences and sharing information from other clinic settings. | 1 | 0 | 2 | 7 | 11 | 4.29 |
| ...helped us build a better and more effective team. | 1 | 2 | 4 | 8 | 6 | 3.76 |
| ...was committed to our team's success. | 0 | 0 | 3 | 6 | 12 | 4.43 |
| ...bonded with our team through his/her motivation and encouragement. | 0 | 3 | 2 | 4 | 11 | 4.15 |
| ...empowered our team by setting the stage and then giving us permission to do things on our own. | 0 | 1 | 2 | 9 | 8 | 4.20 |
| ...was a valuable resource because of his/her knowledge and expertise in the specific strategy we chose to work on. | 1 | 0 | 3 | 6 | 11 | 4.24 |
| ...helped hold our team accountable to SFQCS deliverables. | 0 | 0 | 1 | 10 | 10 | 4.43 |
| ...was integral to the successful execution of our SFQCS QI project. | 1 | 2 | 2 | 5 | 11 | 4.10 |



One Clinic's Experience

“Prior to QCS, we were not collecting or monitoring data in a standardized way. Our project and the training we received, and **our QCS coach**, dramatically enhanced our organization's capacity to collect, analyze, monitor and respond to our data.”

2011 – 2012: Coaching by invitation, part of pay for performance



The Coaches

- **SFHP staff coaches (in-kind)**
 - Two IHI Improvement Advisor graduates
 - One IHI Practice Coaching Program student
 - One Project Management Professional
- **Contract coaches (grant-funded)**
 - One second-career PCP
 - One EHR implementation consultant
 - One (more) IHI Improvement Advisor
- **Educations (across all coaches)**
 - OT, MSW, MPH, MBA, RN/MD

Funding: Work with What You Have, and Build

- **Grants**
- **Coverage program funds**
 - SF Health Plan (Medicaid managed care)
 - Healthy San Francisco (access program)
- **In-kind salary support**
 - If you can commit to training and resources, QI staff will do this in addition to regular workload: fun, challenging, rewarding

2013 – 2015

Coaching program to reach 28 clinics

- **Coaches: SFHP and UCSF Center for Excellence in Primary Care**
- **Goal: 10 Building Blocks of High-Performing Primary Care**
 - Bodenheimer et al.’s step-wise model, includes: data-driven improvement, team-based care, population management, access to care, care coordination
- **Opportunity**
 - Align PCMH-related content, delivery
 - Serve clinics at different starting points
 - Help clinics integrate lessons from past efforts

Lessons Learned by SFHP

- Yes, you can start small and build up
- **Roles! Expectations!** Scope coach role
 - QI process?
 - Project management?
 - Subject matter expertise?
 - NOT a staff resource to lead project for clinic
- Train coaches on role, they train sites
- Works with/without a collaborative
- Without a collaborative, need time and structure for didactic topic content



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Facilitation in Pediatric Practices

Voice from the Field



Jeanne W. McAllister, BSN, MS, MHA
Director
Center for Medical Home Improvement
Crotched Mountain Foundation

Facilitation in the Pediatric, Family-Centered Medical Home

Jeanne W. McAllister, BSN,MS, MHA

Director, Center for Medical Home Improvement

<http://www.medicalhomeimprovement.org>

Co-Director, National Center for Health Care Transition

<http://www.gottransition.org>

Adjunct Assistant Professor Psychiatry & Pediatrics

Geisel School of Medicine at Dartmouth

1997 CMHI - Began Facilitation in Pediatrics – At that time clarification was needed with every aspect including how to have a team meeting...

- **What is a medical home?**
 - What do we do? How do we measure it?
- **A team of clinician, care coordinator and parent?**
 - What is a parent partner? How do we choose/engage and use them?
 - What is a care coordinator? How do I find one? How do we pay for them?
- **What do you mean by Children/Youth with Special Health Care Needs (CSHCN)?**
 - What conditions are "included"
 - How do you rank a child's needs using complexity
 - What is a registry?
 - What is a care plan?

Pediatric Context/History/Today: MCHB Priorities/National Centers/\$ Support

<http://www.communitybasedservices.org/mchb-national-centers>

1. Families as Partners -Family Voices (national and state)
 - Center for Cultural Effectiveness - Georgetown
2. Medical Home –
 - AAP National Center for Medical Home Implementation
 - MH Learning Collaboratives
 - State implementation grants
3. Insurance - Catalyst Center
4. Screening (Early and Continuously for SHCNs)
5. Ease of Access to Community-based services
6. Health Care Transition – **GotTransition?** All aspects of adult life, including adult health care, work, and independence.

Pediatrics – Unique? Most Proud of?

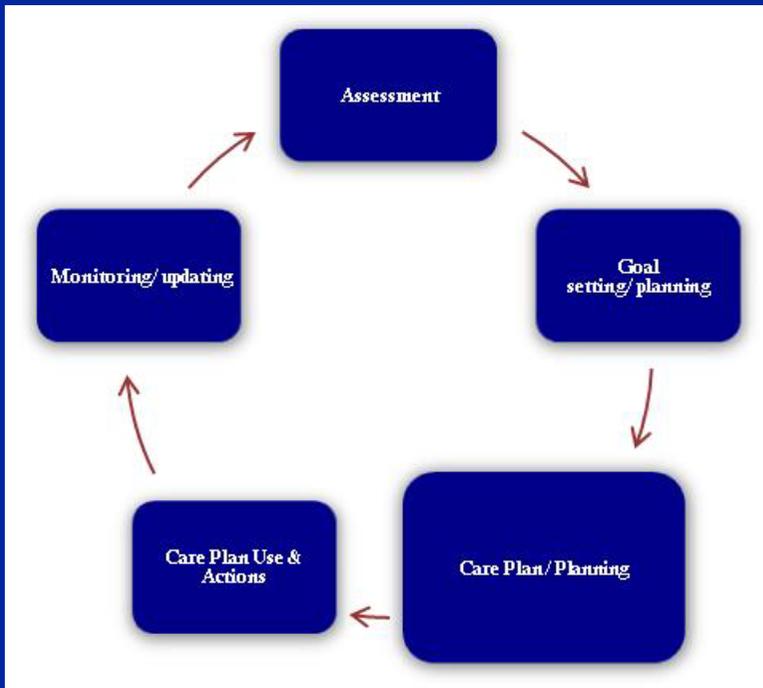


COMMUNITY/FAMILY & FAMILY SUCCESS

Build & Learn from Previous Work

■ TAPPP

- Teamwork (leadership; families)
- Access options/communication)
- Population (CSHCN/All children)
- Planned coordinated care
- Patient and Family-Centered Care



<http://www.commonwealthfund.org/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-System.aspx>



Mindset – Mission orientation/culture practice team best people in world



- Help families succeed in their community; Help parent partners outside of team meetings; be a boundary spanner for team

Emphasis on partnerships

“Nothing for us, without us”



Continuum of ways to engage patients & families, as:



Providers of Feedback

- Suggestion box
- Q&A Poker Chips
- Surveys



Experience of Care/ Tutors

- Diaries
- Focus Groups
- Practice walk thru



Teachers/Story

- About their family
- Topical/review panel experts
- Workshop speakers



Partners for Improvement

- Practice team/ redesign partners
- Advisory/Boards

Facilitation in pediatrics 2012

Keep growing, deepening the work

- Engaged in ongoing, continuous effort to make things better (AKA QI vs. Transformation)
- Engage families/youth 10 ways > 10 times
- Coordinated care; care plans; with mutual goal setting; linkages to community professionals and their “care plans”
 - Engage community neighborhood/connections
- Health Care Transitions (with an across the lifespan attitude)
 - Providers/settings
 - Process of a) preparation b) planning and c) implementation
Six Core Elements of Health Care Transition www.gottransition.org
 - Expectations/communications Pediatric and Adult Practices
- Funding for Facilitation in Pediatric settings
 - USMCHB/Title V/Chapters; Hospital networks (Rainbow Babies); CHIPRA

Blended Principles to Remember

| Three Maxims - | Meaning |
|---|---|
| (1) “The needs of the patient (<i>family</i>) come first.” | The idea that designs of (practice) habit or convenience are subordinate to designs that serve the patient (child, youth, family) |
| (2) “Nothing about me without me.” <i>(Nothing for us without us)</i> | Levels of transparency and participation uncharacteristic of most health care systems. (partnership) |
| (3) “Every patient is the only patient.” | We are “guest” in the patient’s (families) life; expresses confidence in the feasibility and desirability of customization of care to the level of the individual (memory). |



Funding Your Practice Facilitation Program

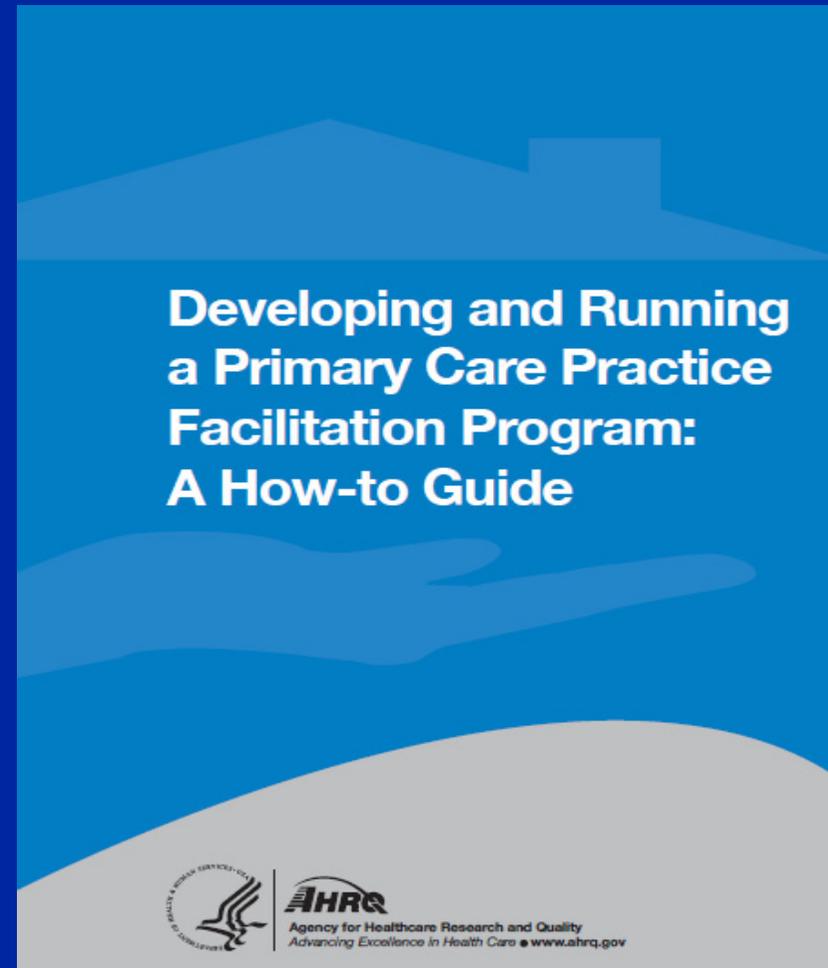
Resources in the How-To Manual

How-To Manual

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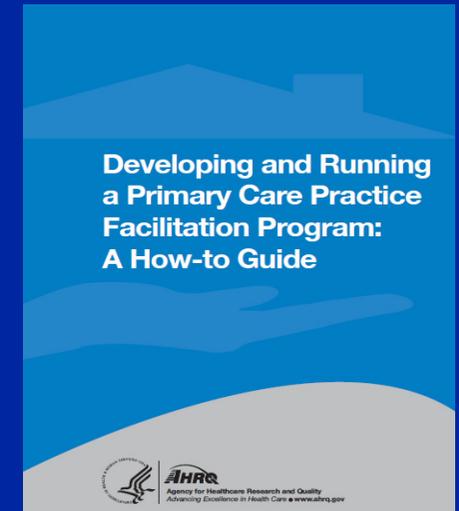
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How-To Manual's Content on Funding a Facilitation Program

Chapter 3. Funding Your Practice Facilitation Program (Pages 23-32)

- Creating a Business Plan for your program
- Develop a plan for funding your program
- Potential funders for PF programs
- Typical program costs and budgets
- Market your program to funders
- Practical resources



Funding Sources & Strategies

| Source | Type(s) | Examples |
|---|--|---|
| Federal | Longer-term; programmatic; Project-focused | <ul style="list-style-type: none"> •AHRQ grants and task orders (research focus only) •AHRQ's Primary Care Extension program (if funded) •HRSA, Bureau of Primary Care Services •CMS, Center for Medicare and Medicaid Innovation |
| State/county health departments | Programmatic; Project-focused | <ul style="list-style-type: none"> •Vermont Health Department's Blueprint for Health |
| Single payers and multipayer groups | Programmatic; Project-focused | <ul style="list-style-type: none"> •L.A. Care NCQA PCMH Coaching Initiative •Pennsylvania's multipayer collaborative |
| Philanthropic | Project-focused | <ul style="list-style-type: none"> •Commonwealth Fund's Safety Net Initiative •RWJF's Improving Performance in Practice (IPIP) •California HealthCare Foundation |
| Provider organizations and associations | Programmatic; Project-focused | <ul style="list-style-type: none"> •Primary care associations •IPA in Northern California •Brookings ACO Learning Network |
| Business community | Programmatic; Project-focused | <ul style="list-style-type: none"> •Large employers such as IBM •Patient-Centered Primary Care Collaborative •Business coalitions |
| Advocacy organizations | Project-focused | <ul style="list-style-type: none"> •Community Health Councils of L.A. partnership w/ LA Net's PF program to improve diabetes care |

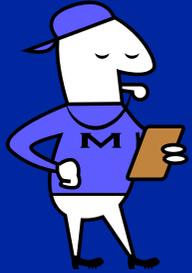
Funding Practice Facilitation Programs



Michael Parchman, MD, MPH

Director

MacColl Center for Health Care Innovation
at the Group Health Research Institute



Cost of Practice Facilitation and Some Ideas for Funding

Michael Parchman
Director, MacColl Center
Group Health



Background: ABC Study

- Randomize 40 small independent primary care offices/clinics
- Use Practice Facilitation to improve ABCs for diabetes by implementing the Chronic Care Model
 - A1c
 - Blood Pressure
 - Cholesterol



Practice Facilitation Role in ABC Study

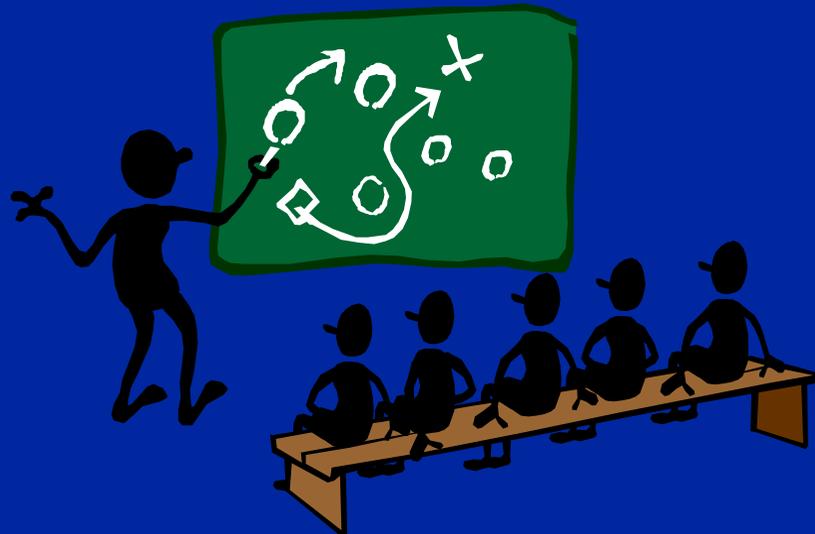
- **Welcome Visit**
- **Baselines Assessment**
 - Staff survey
 - Patient Survey
 - Chart Audit
- **Practice Report: start the conversation**
- **“Toolbox” of ideas for improvement**
- **At least 6 “improvement team meetings” with PF over 12 months**

Cost of Practice Facilitation Analysis

- **Calculated direct variable costs of facilitation: Facilitator time, travel and food**
- **Cost estimates do not include the cost of facilitator training, or the fixed costs of office rent, utilities, information technology etc. which are likely to vary by geographic location**
- **Assumptions about Facilitator Salary: hourly wage of \$30 (~\$60,000 per year in wages and benefits)**

Practice Facilitation Activities

- Orientation and Planning
- Practice Evaluation
- Active Facilitation
- Monitoring, Assessment, Feedback



Cost of Practice Facilitation in ABC Study

- Total annual average facilitation cost per clinic was \$10,250 (range \$8,047 to \$15,682).
- Approximately 50% of total cost is attributable to practice assessment and start-up activities, with another 31% attributable to active facilitation visits.
- Sensitivity analysis suggests that the total average costs of a 24-visit protocol would only increase cost per clinic to \$16,284.

| PF Activity | Mean | Median | Range |
|--|-------------|---------------|--------------------|
| Facilitation Orientation | \$409 | \$374 | \$291 to \$627 |
| Practice Evaluation | \$2,995 | \$2,992 | \$2,602 to \$3,577 |
| Creating and Providing Baseline Report | \$1,220 | \$1,133 | \$968 to \$2,099 |
| Active Facilitation | \$1,414 | \$1,315 | \$1,225 to \$1,962 |
| Monitor/Assess/Feedback | \$452 | \$447 | \$318 to \$614 |
| Travel Costs/Food | \$924 | \$765 | \$418 to \$2,447 |

Caveats

- Only variable costs, not fixed costs
- Does not include facilitator training
- Only the first year of a new program so practice evaluation costs will go down in future years

What would a Practice Facilitation Program look like in an Accountable Care Organization (ACO)?

- Assume organization with 60 primary care practices, Practice Facilitation cost at \$10,000 to \$13,000 per practice per year, 1 Practice Facilitation per 10 practices.
- Total direct variable costs over the first year would be approximately \$600,000 to \$780,000.
- Assume overhead/indirect cost rate of 40%, the total costs would be \$1,000,000 to \$1,300,000 in the first year of the program.
- Much of cost of Practice Facilitation is devoted to start-up and practice assessment. As a result, the costs of facilitation activities for an ACO in subsequent years are likely to decrease.

The ROI for Practice Facilitation

- Medicare ProPAC reported in 2009 (during the study period) that acute care hospital cost per discharge on average ranged from \$5,800 to \$6,400.
- Using the lower of these estimates, the breakeven case for returning direct variable cost of Practice Facilitation activities from a delivery system perspective is that Practice Facilitation activities would pay for itself if a practice could reduce the number of future hospitalization or readmissions by 2 per year.

How Develop Sustainable Funding for a Practice Facilitation Program

- Be creative
- Entrepreneur
- Think “market” “message” “networking”
- Identify needs of clients and meet those needs



Develop Your “Elevator Speech”

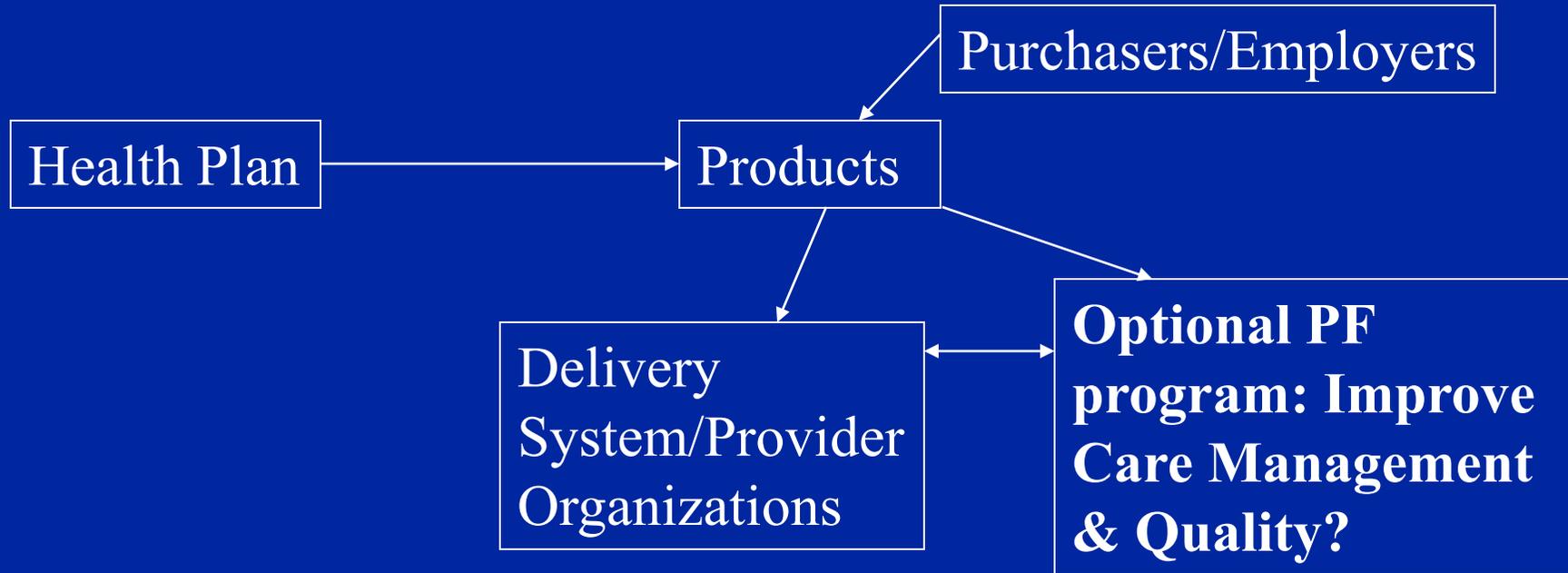
- Delivery of primary care is a team sport
- Every team Needs a coach



Identify Potential Customers

- Health Plans
- Professional Organizations
- Newly formed ACOs
- Hospitals (e.g. think reducing 30 day readmissions)
- State Medicaid Programs
- Health Care Control Networks (comprised of Federally Qualified Health Centers)

Health Plans: Competitive Advantage?



Practice Facilitation as a Component of a Larger Program: Control Costs/Improve Quality

- **Lessons from Medicare’s Demonstration Projects on Disease Management & Care Coordination**
- **34 programs “...had little or no effect...”**
- **Of the 18 programs with fees at risk:**
 - 2 of 18 programs reduced total Medicare spending
 - 1 program increased spending
 - 15 “had no discernable effect”

Congressional Budget Office
Issue Brief, January 2012

Disease Manage/Care Management

- Health plans think they know how
- The gap is huge
- Employers and purchasers are demanding changes



Questions at end...

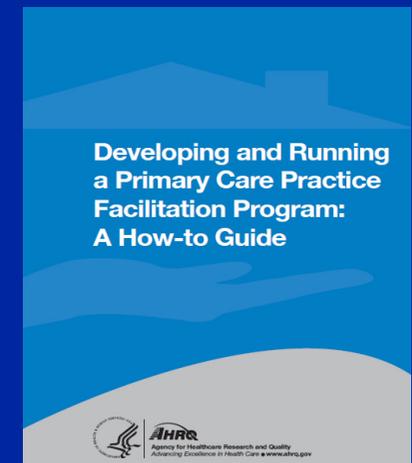


Evaluating Your Practice Facilitation Program

Content from the How-To Manual on Evaluation & Research

Chapter 8. Evaluating the Quality and Outcomes of Your Facilitation Program (Pages 87-96)

- *Evaluation*
 - Why evaluate?
 - What is the “sweet spot?” – feasibility/rigor balance
 - Selecting a study design
 - Outcomes to consider
 - Sources of data
- *Research – Generating Generalizable Knowledge*
 - What to consider
 - When to participate



Findings from the 2012 Systematic Review of Practice Facilitation

Perspectives on Evaluating Practice Facilitation Programs



Bruce Baskerville, PhD
Senior Scientist & Associate Research
Professor
Propel Center for Population Health
Impact
University of Waterloo

A Systematic Review and Meta-analysis of Practice Facilitation Within Primary Care Settings

N. Bruce Baskerville, B.A.(Hons.),M.H.A.,Ph.D.¹

¹Propel Centre for Population Health Impact, University of Waterloo

September 28, 2012

Practice Facilitation Webinar, Agency for Healthcare Research and Quality

NB Baskerville, C Liddy, W Hogg. A Systematic Review and Meta-analysis of Practice Facilitation within Primary Care Settings. *Annals of Family Medicine*. 2012;10(1):63-74.

Introduction

- **The evidence-practice gap**
- **Barriers to professional behavior change:**
 - Professional context
 - Organizational context
 - Environmental context
- **Systematic reviews have excluded practice facilitation**
- **Practice facilitation is multifaceted and narrative reviews (Nagykaldi et al. 2005) indicate impact**

Research Questions

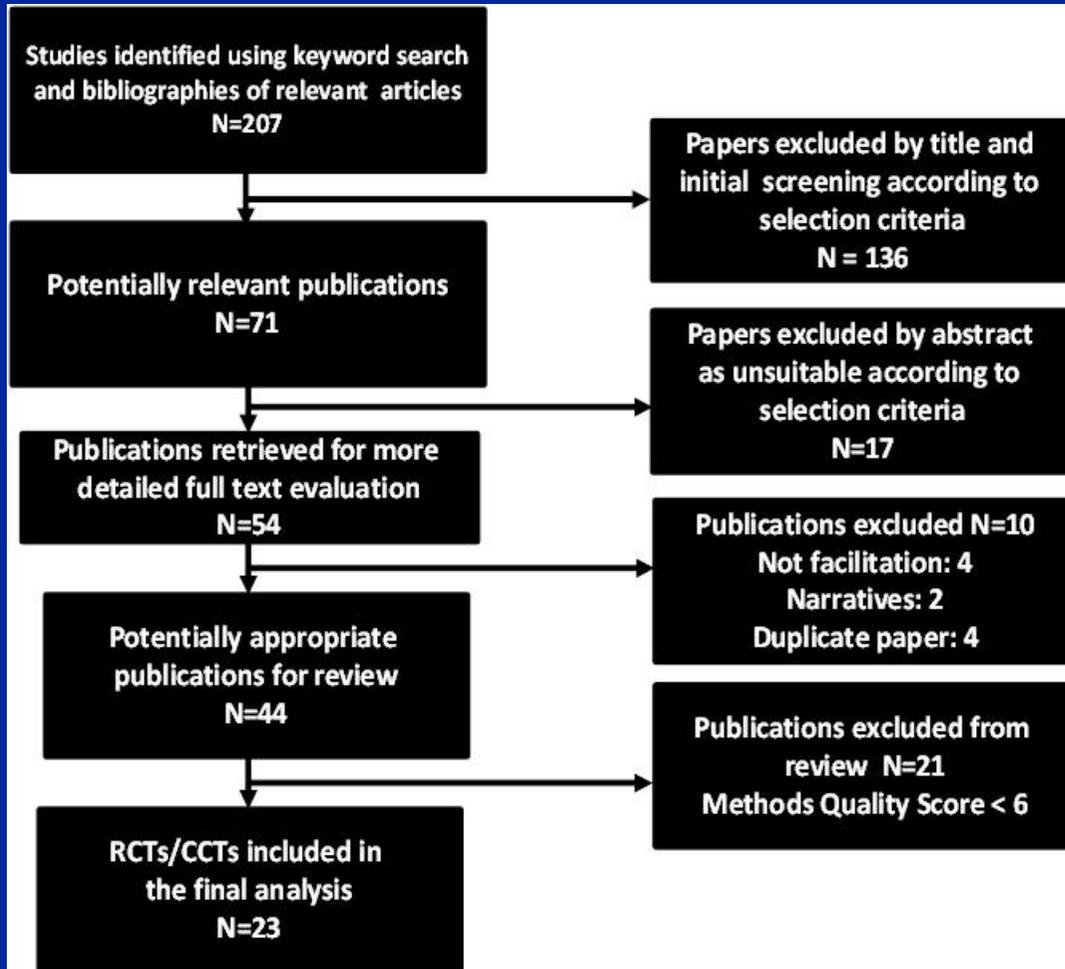
- What is the overall effect size of practice facilitation for the implementation of guidelines?
- What factors moderate that impact?

Methods – Data Collection

- **Inclusion criteria** - Controlled trials or evaluations of practice facilitation in primary care settings published from 1966 to December 2010 in English language journals.
- **Primary outcome** - change in evidence-based practice behavior calculated as a standardized mean difference (SMD).
- **Quality assessment** - Modified 12 point version of the PEDro scale¹, quality score range 0 to 12.
- **Studies independently rated by three reviewers** - inter-rater reliability very good $K = .78$ (95% CI 0.73-0.84).

¹ Bhogal, S. et al. The PEDro scale provides a more comprehensive measure of methodological quality than the Jadad scale in stroke rehabilitation literature. Journal of Clinical Epidemiology 2005; 58: 668-673.

Flowchart of Identification of Relevant Studies



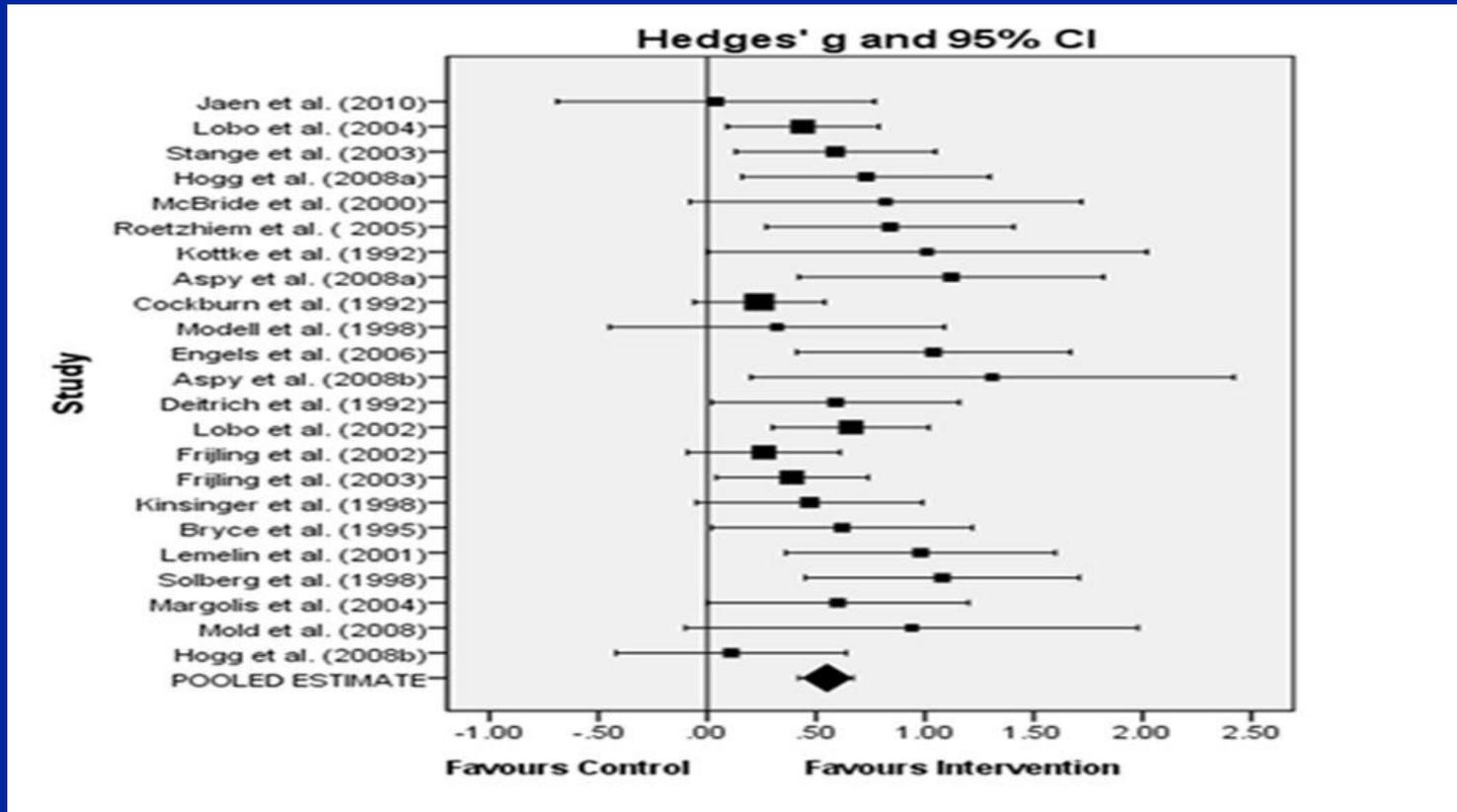
Reasons for exclusion:

- 76% were non-randomized trials
- 95% did not blind outcome assessments
- 100% did not report allocation concealment
- 7 of 9 randomized trials were excluded due to unmatched groups at baseline

Results - Study and Intervention Characteristics (n=23)

- 20 studies were randomized controlled trials.
- 52% US-based studies.
- 83% of studies reported a form of preventive service as the primary outcome measure.
- 44% of studies described qualifications of facilitator as registered nurse or masters educated.
- Audit and feedback was a component of 97% of studies, 91% employed consensus building, and 39% used a reminder system.
- 74% reported that the practice facilitator tailored the intervention to the needs of the practice.

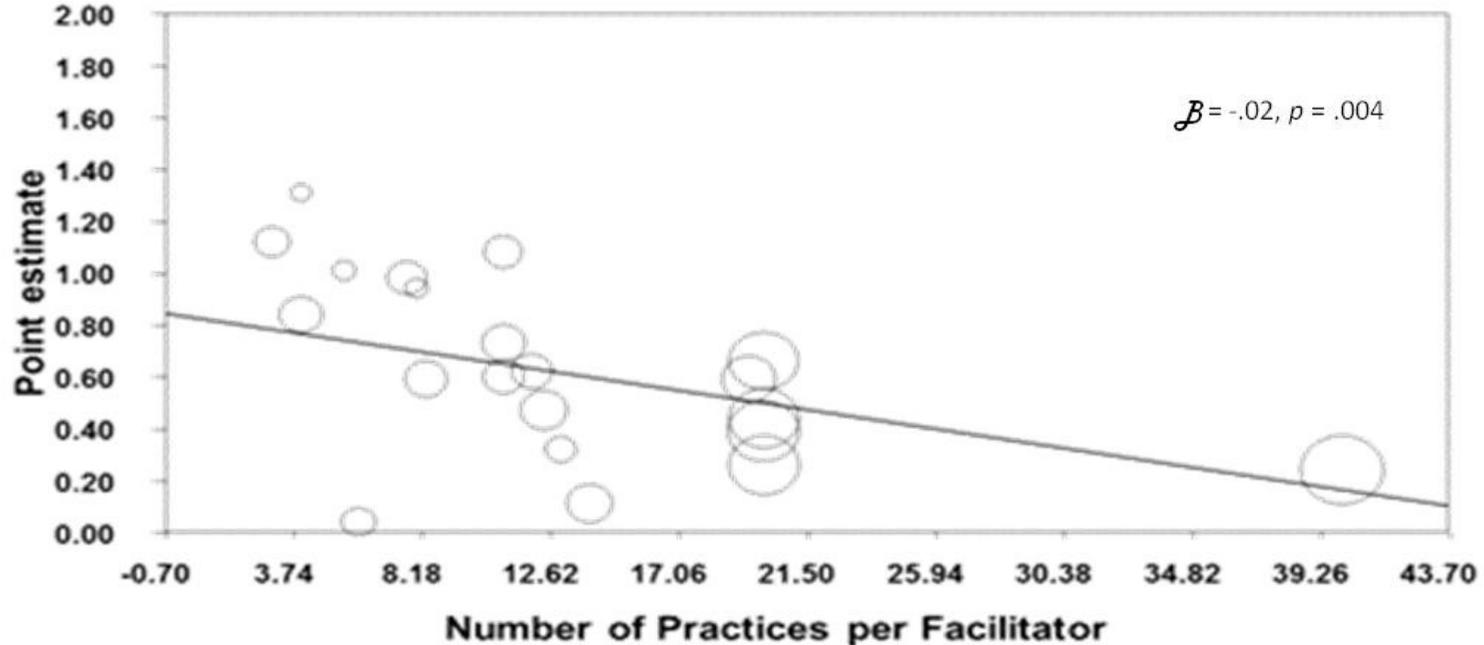
Results – Practice Facilitation Impact



- 1,398 participating practices - 701 allocated to control and 697 to practice facilitation
- Standardized Mean Difference (SMD) = 0.56 (95% CI 0.43-0.68), $z=8.76$, $p < .00001$
- Heterogeneity non-significant, $\chi^2(1,N=22)=27.55$, $p=.19$, $I^2 = .20$

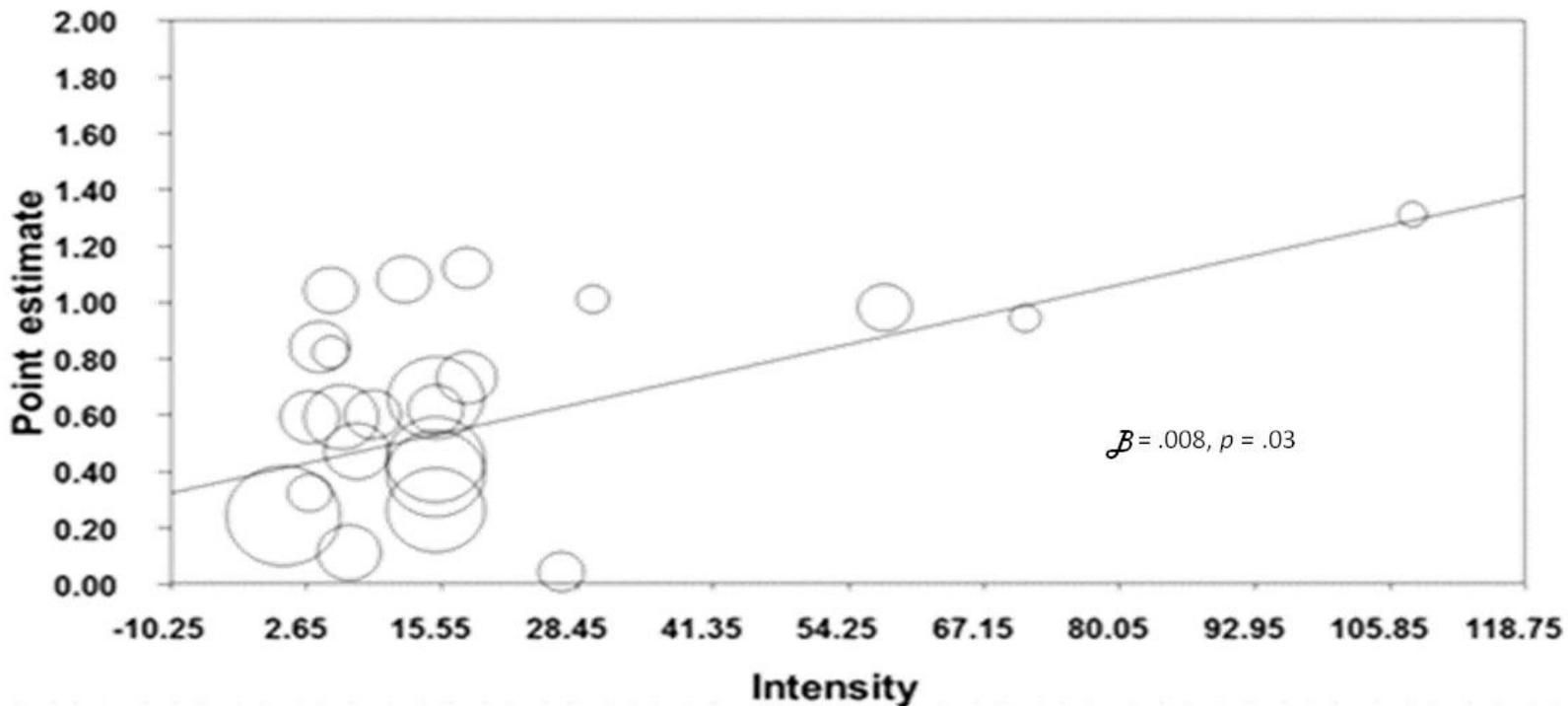
Results – Number of Practices per Facilitator

Ratio of Practices per Facilitator and Effect Size (n=21)



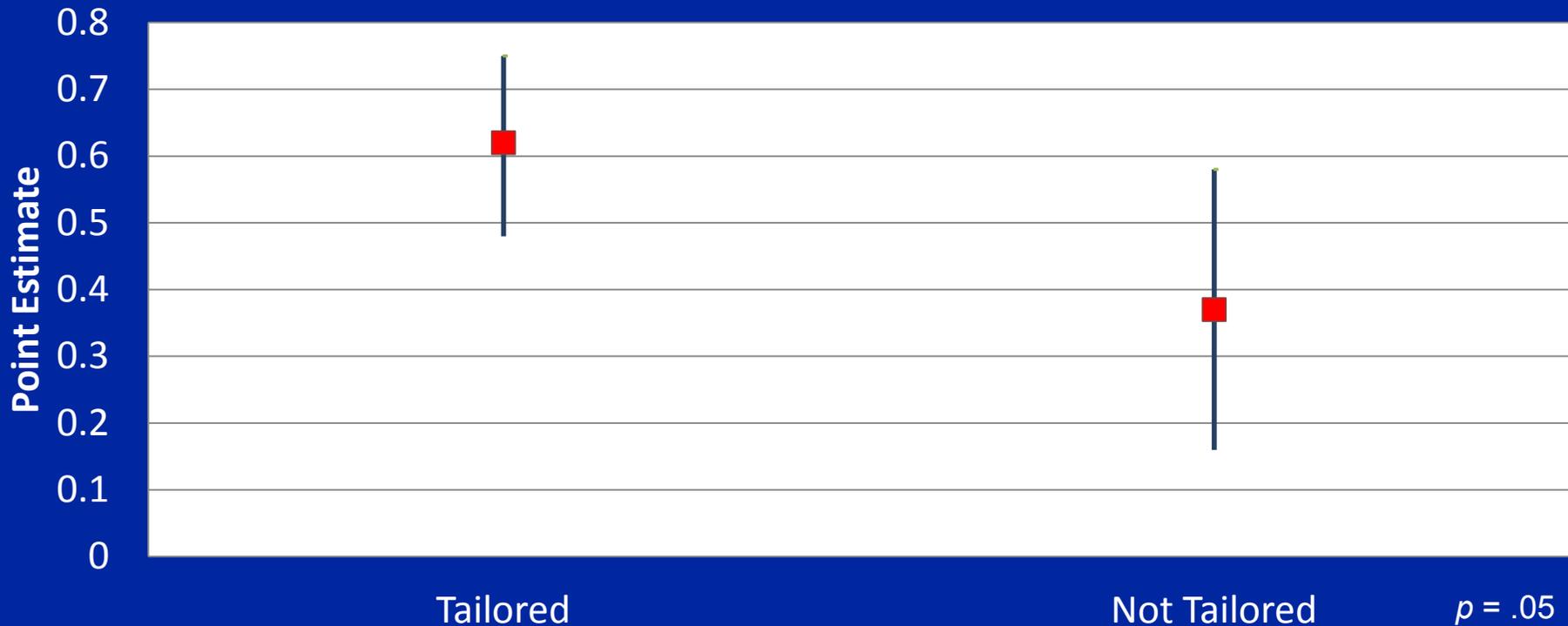
Results – Intensity of Facilitation

Intensity of Intervention and Effect Size (n=23)



Results – Tailoring to Practice Context

Tailoring to Practice Context and Effect Size (n=23)



Key Take Away Messages

- **Primary care practices are 2.76 (95% CI 2.18 - 3.43) times more likely to adopt evidence-based guidelines through practice facilitation**
 - Practice facilitation works - despite the professional, organizational and broader environmental challenges of getting evidence into practice.
- **Variation in the process of implementation significantly influenced effects:**
 - Number of primary care practices assigned to each facilitator;
 - The intensity of the intervention in terms of contacts and hours per contact; and
 - Tailoring to the needs of the practice.
- **Majority of studies focused on adoption of preventive care guidelines**
 - Can practice facilitation work for chronic illness care management?
- **Larger scale, collaborative, practice-based evaluation research is needed**
 - Sustainability and costs-benefit to the health system.

Questions at end...

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Practical Considerations for Evaluating a Practice Facilitation Program

Perspectives on Evaluating Your Practice Facilitation Program



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Director of Oklahoma Physicians
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University of Oklahoma

Disclaimer

- **My training, interest, and expertise are not in the area of program evaluation, so take my suggestions with the appropriate amount of salt.**
- **We have never considered our series of implementation projects as a “facilitation program,” so it is difficult for me to think about “program evaluation,” but since I have been asked to reflect on this, I guess there are at least 3 levels of evaluation involved:**
 - **Ongoing evaluation of the effectiveness of individual facilitators**
 - **Evaluation of the process and outcomes of specific initiatives**
 - **Ongoing evaluation of the effectiveness/cost effectiveness across a series of initiatives**

Evaluation of Individual Facilitators

Most of the time the facilitators are acting independently, so it is more difficult to evaluate their activities. We use 5 different sources of information:

- **Weekly individual and group meetings to review progress and challenges**
- **Visit notes, which include required quantitative process information in addition to qualitative information**
- **Feedback from the practices, both informal and formal**
- **Direct observation (limited)**
- **Performance data from the practices**
- **Annual evaluation**

Typical Facilitator Schedule

- 8 practices per facilitator per 6 month project cycle
- 1/2 day per practice per week so 4 days per week in practices
- 1 day per week in the Department
 - 30 minute individual debriefing session with supervisor to discuss progress in each practice and specific challenges
 - 1 hour group meeting to review each ongoing project (typically 5-6), with an emphasis on logistics (enrollment, milestones, challenges, opportunities, etc.)
 - 1 hour training
 - 6 hours to catch up on paperwork, research for the practices, scheduling, etc.

Visit Notes

Process measures

- Time preparing for the visit
- Time in practice - (We believe that it is important for the facilitators to spend a full half-day in each practice every week, even if they have nothing specific to do.)
 - Broken down into specific types of activities
- Perception of progress made toward meeting objectives

Feedback from Practices

- Encouraged to contact supervisor at any time
- One-page evaluation form to be completed periodically
 - Rating scales
 - Qualitative assessment of facilitator performance
- Sporadic queries by supervisors when visiting practices or with clinicians for other reasons

Evaluation of Individual Initiatives

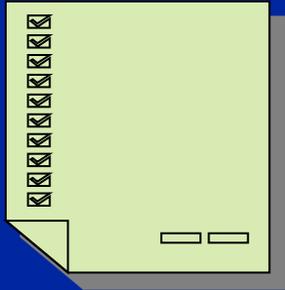
- **Performance improvement across all practices**
 - Typically see between 30% and 400% improvement in proportions of patients/visits meeting expectations
- **Performance improvement between practices within facilitators**
- **Improvement in practice change capacity (the component of Solberg's QI for which facilitation is our major intervention)**
 - **Priority for change: Performance evaluation/feedback, academic detailing, facilitation, learning collaboratives**
 - **Change capacity: Facilitation**
 - **Care process content: Academic detailing, facilitation, learning collaboratives**

Evaluation of a Series of Initiatives

- **Based upon goals and objectives of the organization**
- **Process**
 - Multiple domains possible
 - Facilitator job satisfaction
- **Outcomes**
 - Requires some sort of comparison group so cRCT, step-wedge design, time lag, etc.
- **Cost – Our cost is \$5,000 - \$7,500 per practice per year, but this could be reduced with less travel and existing relationships between facilitators and practices.**

Ideas on Future Directions for Practice Facilitation

Effective Implementation of Innovations in Primary Care



**Performance
Feedback**

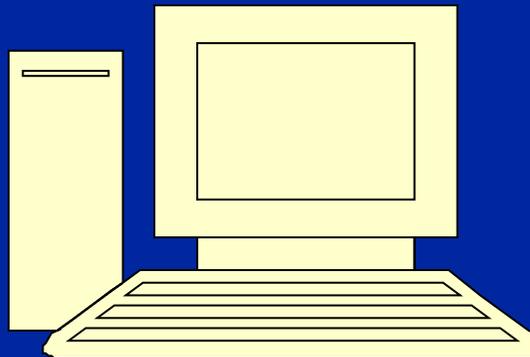


**Academic
Detailing**

Facilitation



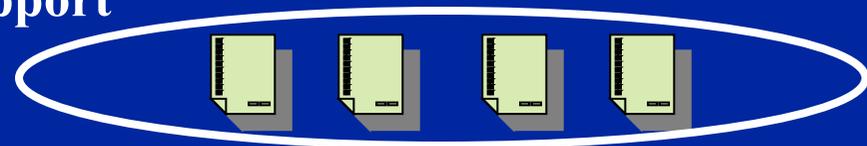
Local Learning Collaboratives



IT Support



**Practice Enhancement
Assistant**



Challenges and Revelations

- **Success depends heavily upon the strength of relationships between practice and facilitator**
- **Cost can be reduced by embedding facilitators within communities of practices**
 - Longitudinal relationships
 - Less travel time/cost
- **That's Cooperative Extension!**

An Extension System for Primary Care

- **Message reached the right people (law of the few)**
 - Kevin Grumbach, Art Kaufman, David Meyers, Bob Phillips
- **Concept of PC extension caught on (sticky idea)**
 - HIT Regional *Extension* Centers
- **Affordable Care Act (context was right)**
 - Section 5405: Primary Care Extension Program
 - Authorized but funding not appropriated
 - Assigned to AHRQ
- **AHRQ RFA: IMPaCT**
 - 4 awards (9/11 – 8/13): NC, PA, NM, and OK
 - Dissemination to 12 additional states (3 each) so 16 states
 - National IMPaCT meeting in OKC Feb 2013

Primary Care Extension in Oklahoma

- **A state hub: The Public Health Institute of OK**
 - 501c3 organization established to improve the health of Oklahomans
- **AHECs as Regional Coordinating Centers connecting CHIOs to academic resources**
 - Will hire, deploy, and supervise facilitators who live and work within their own counties
 - Will arrange for academic detailing when appropriate/requested
- **Certified non-profits developed from existing coalitions in each county or county cluster called County Health Improvement Organizations (CHIOs) with primary care involvement (BOD and Advisory Committee)**
 - Mission: Improve the health of citizens of county

Funding and Programs

- **Sustainable funding**
 - Health insurance companies through Minimum Risk Ratio
 - Tobacco Settlement Endowment Trust
 - Practice membership fees
- **Project-specific funding**
 - CDC, HRSA, CMS, AHRQ, NIH, TSET, foundations, etc. etc.
- **Programs**
 - QI in primary care practices (e.g. HIT, HIE, PCMH)
 - Shared resources for practices (e.g. care managers, community health workers, mental health clinicians)
 - Community-based health improvement projects

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
 - Please give us your ideas for shaping the future of Practice Facilitation
- Please join AHRQ's PF listserv by emailing PCPF-request@LIST.AHRQ.GOV
- Visit <http://www.pcmh.ahrq.gov>
 - Note the Practice Facilitation webpage