

AHRQ's Primary Care Practice Facilitation Forum

This email newsletter is the first step in our plan to create a learning network for individuals with an interest in practice facilitation. We will use this listserve to share perspectives on questions and answers submitted by learning forum members, as well as resources, research articles, and events of interest.

Perspectives from the Field

Last week, we asked: How should developing programs think about the nature and intensity of facilitators' work with practices?

Below is some information from AHRQ's how-to guide for PF programs, along with a response we received from one practice facilitation program, which is housed within a QIO and focuses heavily on population management and health IT.

Other programs are likely to have different perspectives, depending on their focus, context, and other factors. How does your experience compare?

Chapters 4, 5, and 6 of "[Developing and Running a Practice Facilitation Program for Primary Care Transformation: A How-To Guide](#)" provide information on defining your facilitators' roles with practices and staffing your program. Experts who contributed to the guide suggested that a single facilitator can support between 8 (onsite, more intensive) and 20 (distance, less intensive) practices during an active intervention. The ratio of facilitators to practices depends on the intervention intensity and complexity, geography, the experience of the facilitator and practice, whether the intervention is provided on site or using distance technology, and other factors. Regardless, a facilitator's work with a practice needs to include enough regular interaction that a facilitator can build a strong working relationship with the practice.

Perspectives from Mike Speight, Senior Director, Telligen:

What is the ideal number of practices per facilitator?

MS: Our experience indicates the "ideal" duration of practice facilitation is for the facilitator to spend 6-8 weeks onsite in each practice. That would mean each practice facilitator could support approx. 7 practices per year.

How often and how many visits should a facilitator make to a practice?

MS: Periodic visits to the practice are not as effective as an embedded facilitator who spends every day in the practice for an extended period of time (6-8 weeks).

Should facilitation be tailored to the practice and the nature of the intervention?

MS: Yes and no.....the core components of practice facilitation (such as population management, process redesign, performance measurement) are standard and should be included in any practice facilitation initiative. Other aspects of the initiative (such as the clinical gaps in care targeted for improvement or the work flows selected for redesign) can be selected based on the unique situation in each practice.

How should one go about this 'tailoring' process?

MS: Ideally, any tailoring should be based on actual data from the practice. What gaps in care exist between the care provided compared to the care expected based on evidence based guidelines? Where are the greatest opportunities for improvement? What are the improvement priorities for members of the practice team? What competing priorities are present in the practice and how will they impact the practice facilitation initiative? Answers to these questions will help the facilitator and the practice team develop a "customized" facilitation initiative designed for meet the needs of the practice.

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What do you think?

If you'd like to join the discussion, please send your thoughts. Please also let us know what other questions you have by sending an email to PracticeFacilitation@mathematica-mpr.com. Your responses will be compiled and shared in weekly newsletters.

Upcoming Event

Practice Facilitation Webinar- Part II

Wednesday, April 11th, 12:15-1:30 EDT **Save the Date!**

Title: Hiring, Training, and Supervising Practice Facilitators

Description: What should you look for when you are hiring a facilitator? What type of training and supervision do facilitators need to be effective? This webinar will discuss the core competencies needed by facilitators and various staffing models used by existing facilitation programs; approaches and strategies for training your facilitators; and best practices in supervising your facilitation staff.

Webinar registration link to be included in future newsletters. Stay tuned!

Articles of Interest

- Peikes D, Zutshi A, Genevro J, Smith K, Parchman M, Meyers D. **Early Evidence on the Patient-Centered Medical Home.** AHRQ Publication No. 12-0020-EF. Rockville, MD: Agency for Healthcare Research and Quality. February 2012.

Description:

The patient-centered medical home (PCMH, or medical home) aims to reinvigorate primary care and achieve the triple aim of better quality, lower costs, and improved experience of care. This study systematically reviews the early evidence on effectiveness of the PCMH.

Access the full text at:

http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_evidence_evaluation_v2

- Peikes, D., Zutshi, A., Genevro, J., Parchman, M., Meyers, D. **Early Evaluations of the Medical Home: Building on a Promising Start.** *The American Journal of Managed Care*, February 2012; 18(2): 105-116.

Published Abstract:

Objectives: To systematically review the current evidence on the patient-centered medical home (PCMH, or medical home), which aims to reinvigorate primary care and achieve the triple aim of better quality, improved experience, and lower costs.

Study Design: Systematic review of quantitative evidence on the PCMH.

Methods: Out of 498 studies published or disseminated from January 2000 to September 2010 on US-based interventions, 14 evaluations of 12 interventions met our inclusion criteria: (1) tested a practice-level intervention with 3 or more of 5 key PCMH components and (2) conducted a quantitative study of one of the triple aim outcomes or of healthcare professional experience. We synthesized findings on interventions that were evaluated using rigorous methods. We also provide guidance to structure future evaluations to maximize learning.

Results: The interventions most often cited to support the medical home can be viewed as precursors to the medical home. Evaluations of 6 of these interventions provided rigorous evidence on 1 or more outcomes. This evidence indicates some favorable effects on all 3 triple aim outcomes, a few unfavorable effects on costs, and many inconclusive results.

Conclusions: Although the PCMH is a promising innovation, rigorous quantitative evaluations and comprehensive implementation analyses are needed to assess effectiveness and refine the model to meet stakeholders' needs. Findings from future evaluations will help guide the substantial efforts practices and payers invest to adopt the PCMH with the goal of achieving the triple aim outcomes.

Access the full text at <http://www.ajmc.com/publications/issue/2012/2012-2-vol18-n2/Early-Evaluations-of-the-Medical-Home-Building-on-a-Promising-Start>.

Resources

Please visit the PCMH Resource Center at www.pcmh.ahrq.gov to explore white papers, briefs, a searchable citations database, and other resources related to the Patient-Centered Medical Home and primary care improvement.

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