

# Primary Care Practice Facilitation Curriculum

Module 18: Assessing Practice Readiness for Change



Agency for Healthcare Research and Quality

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# **Primary Care Practice Facilitation Curriculum**

## **Module 18. Assessing Practice Readiness for Change**

### **Prepared for:**

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# Module 18. Assessing Practice Readiness for Change

## Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Assessing practice readiness for change
- Basic skills in quality improvement and coaching

### Time

- Pre-session preparation for learners: 40 minutes
- Session: 50 minutes

### Objectives

After completing this module, learners will be able to:

1. Identify four factors experts believe are associated with practice readiness to engage in facilitated improvement.
2. Use a formal or informal readiness assessment with a practice.

### Exercises and Activities To Complete Before and During the Session

**Pre-session preparation.** Ask the learners to review the following. (40 minutes)

1. The content of this module.
2. The Practice Improvement Capacity Rating Scale, available at <http://www.rwjf.org/en/library/research/2014/01/practice-improvement-capacity-rating-scale.html>
3. Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, Genevro J. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. AHRQ Publication No. 15-0015-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at <http://www.pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators>

**During the session.** Presentation (15 minutes)

1. Present key concepts from the module.

**Read.** (15 minutes)

1. Have learners read the fictional case example in [Module 12 Appendix C](#) and use the practice assessment in the [appendix to this module](#) to answer the discussion questions.

**Discussion.** Ask questions and explore answers with learners. (20 minutes)

1. Is this practice ready for facilitation? Why or why not?
2. What additional information might you want on this practice to determine readiness for facilitation?
3. What strengths or assets could you leverage in your work with this practice? What factors might be challenges? What should you look out for when you reassess readiness at the 3-month mark?

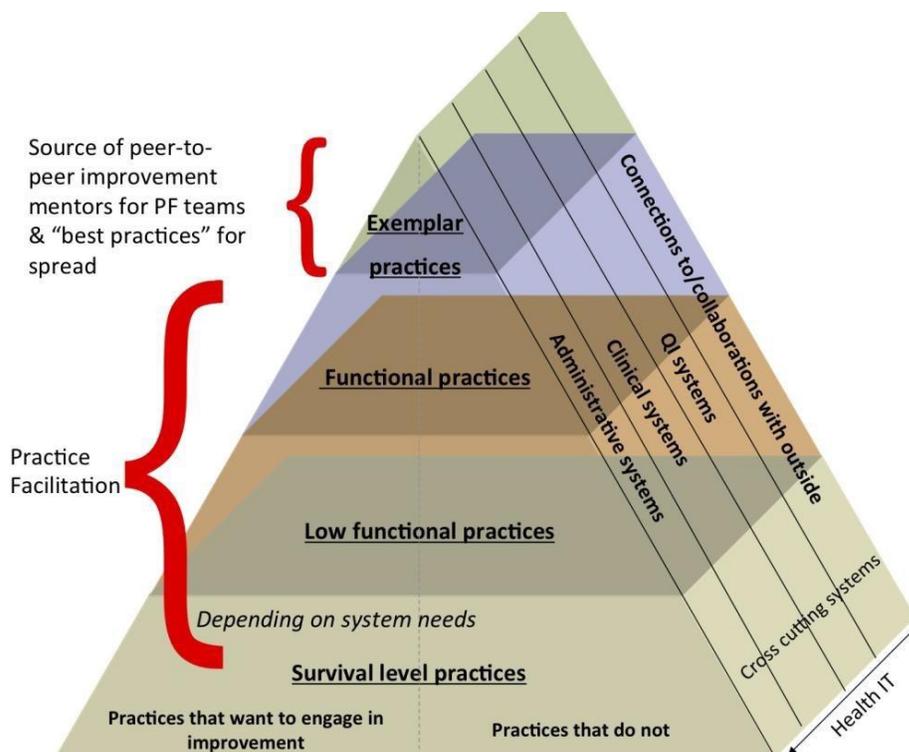
## Module 18.

Practice facilitation is a scarce resource and it is important to make careful and informed decisions about where to direct it. It is important to avoid spending valuable facilitation time attempting to facilitate change in a practice that is not ready or able to benefit from the support. This is not only a waste of a valuable resource, but also frustrating to both the practice facilitator and the practice (Knox, 2010; Knox, et al., 2011).

Focus on practices that are most likely to benefit from facilitation.

Figure 18.1 presents a model that can be used to triage facilitation resources. It reflects the view of some PF experts that resources should focus on practices most likely to benefit from facilitation.

Two categories of practices might receive little benefit from practice facilitation: those operating in “survival mode” that cannot effectively implement any of the strategies the practice facilitator suggests and those already functioning very effectively that have fewer opportunities for improvement. The latter group, however, is a valuable resource as a supply of role models and professional mentors to practices undertaking improvement work and as a source of “best practices” to spread. The two remaining levels, functioning practices and low-functioning practices, are most likely to benefit from practice improvement facilitation and are the likely audience for your work.



**Figure 18.1. Model for triaging allocation of practice facilitation resources**

Source: Knox L, 2010

You might not want to follow the triage model in some cases. For example, in a rural community with few primary care providers, it may be critically important to shore up and support whatever practices are in the area, even if they are so preoccupied with daily operations that it is difficult to engage them in improvement activities. Because they lack the basic administrative and clinical systems needed to function effectively, the form and expectations of facilitation efforts will have to be different with these practices.

Conducting an assessment of a practice's readiness for facilitated improvement work is an important first step when enrolling practices in an intervention. Readiness assessment is an inexact process, and at this point, somewhat informal. It is helpful to talk to other practice facilitators and to your program supervisor as you begin to assess practice readiness, especially if you have limited experience working with practices at this time.

## Initial Readiness Assessment

Determining a practice's readiness to implement an intervention is a critical first step to beginning facilitation. Several assessment tools are available to help you in assessing practice readiness. The Practice Improvement Capacity Rating Scale—developed as part of the Robert Wood Johnson Foundation's Aligning Forces for Quality Initiative—is a useful resource for this purpose. It is available at <http://www.rwjf.org/en/library/research/2014/01/practice-improvement-capacity-rating-scale.html>.

In addition, Figure 18.2 contains an informal list of criteria that participants in the 2010 AHRQ Practice Facilitation Consensus Meeting found useful for assessing a practice's readiness to undertake improvement work with a practice facilitator (Knox, 2010).

**Figure 18.2. Checklist for assessing practice readiness**

- Practice or organizational leadership is interested in specific or general improvement as evidenced by request for assistance or receptivity to receiving facilitation to support improvement.
- Practice or organizational leadership is willing to participate in ongoing communication with the practice facilitator and participate on the quality improvement team.
- Practice or organization is willing and able to identify an improvement champion who will be the practice facilitator's point person.
- Leadership is willing to provide protected time for key staff to engage in improvement work.
- Team members are willing to meet regularly as a quality improvement team, and members follow through.
- Team members are willing to gather and report data on practice performance on key metrics.
- Practice has sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns.
- Practice is not engaged in other large-scale improvement projects and does not have other demanding competing priorities.

The last item on the checklist evaluates practices for “improvement fatigue.” Due to the many parallel improvement and transformation activities taking place in health care today, practices can be overwhelmed by change and reluctant to engage in additional improvement work. In these cases, it may be possible for the practice facilitator to integrate the other improvement projects and leverage this activity or it may be more appropriate to delay this intervention.

Practices that meet most of these basic readiness criteria are thought to show evidence of readiness for working with a facilitator on practice improvement. This does not mean that every practice meeting these criteria will be successful in a facilitated improvement intervention, nor does it mean that practices that do not meet these criteria will fail. These criteria simply provide a starting point for thinking about the readiness of practices interested in engaging in improvement work with a facilitator. For more information on a readiness assessment tool, refer to the [Module 24 Instructor’s Guide](#).

### **Three-Month “Real-Time” Readiness Assessment**

Practices that appear “ready” and are enrolled in the intervention should be reassessed at 3 months to confirm readiness. In addition to items on the Checklist for Assessing Practice Readiness, this assessment should consider the following:

- Attendance at project meetings, including leadership presence at kickoff and initial meetings
- Progress in developing quality improvement plans
- Follow-through on action items

As a practice facilitator, you have several possible courses of action for practices that do not meet readiness criteria at 3 months:

- Continue the intervention. As the practice builds its relationship with you and as you create priority for improvement in practice leadership and build the practice’s capacity for improvement, their engagement in the improvement process will increase.
- Consider stepping back from active intervention with the practice until a time when they are better prepared to engage.
- Ramp up the intensity of the intervention. This is often done by bringing in an academic detailer (i.e., peer support) to help problem solve and create buy-in among practice leaders.

You will need to discuss these options with your supervisor or fellow practice facilitators before making a decision.

Note: this module is based on Module 12 of the Practice Facilitation Handbook. Available at <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/>

## References

Geonnotti K, Taylor EF, Peikes D, Schottenfeld L, Burak H, McNellis R, Genevro J. Engaging Primary Care Practices in Quality Improvement: Strategies for Practice Facilitators. AHRQ Publication No. 15-0015-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2015. Available at <http://www.pcmh.ahrq.gov/page/engaging-primary-care-practices-quality-improvement-strategies-practice-facilitators>

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## *Module 18: Assessing Practice Readiness for Change*

### **Appendix 18. Informal Practice Readiness Assessment**

#### **Informal Assessment of Practice Readiness for Improvement**

- Practice or organizational leadership is interested in specific or general improvement as evidenced by request for assistance or receptivity to receiving facilitation to support improvement.
- Practice or organizational leadership is willing to participate in ongoing communication with the practice facilitator and the improvement team.
- Practice or organization is willing and able to identify an “improvement” champion who will be the practice facilitator’s point person.
- Leadership is willing to provide protected time for key staff to engage in improvement work.
- Team members are willing to meet regularly as an improvement team, and members follow through with this.
- Team members are willing to gather and report data on practice performance with key metrics.
- Practice has sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns.
- Practice is not engaged in other large-scale improvement projects and does not have other demanding competing priorities.

#### **3-Month Followup**

- Practice members respond to emails and calls.
- Practice members attend meetings.
- Practice members follow through on most assignments.
- At least one meaningful PDSA cycle is complete.

Appendix 12B. Sample data inventory form

<b>Department:</b>	
<b>Date:</b>	

<b>Information being collected</b> (Summary – Optional: attach copy of variables collected to this form)	<b>Source for data</b>	<b>For what patients or activities?</b>	<b>For what purpose?</b> (Fed govt., payer, practice internal QI, other) provide details	<b>Data source/ Method?</b> (Electronic registry (name), paper survey, etc.) Provide name and details	<b>When?</b> (Daily, monthly, quarterly)	<b>Being used in QI or clinical care at practice?</b> Y/N	<b>Location of data and person in charge of data collection?</b>	<b>What information on race/ ethnicity is being collected?</b> (Be specific – list variables)	<b>HOW is race/ ethnicity info being collected?</b> (Patient completes form, verbal question by receptionist, etc.)
EXAMPLE: Diabetes lab data, PHQ 9 data, visit data	Manual entry from PHQ 9 forms; auto input from billing system; auto input from lab feed	All diabetic patients at practice	Report to County PPP program; BPC disparities collaborative	I2I registry, Excel Spreadsheet	Daily as able	Partial: Patients with elevated PHQ 9s are flagged on a monthly basis and names are given to director of behavioral health	Computer in main office; Mary Gonzales	Ethnicity: Hispanic/ non-Hispanic Race: White African American Asian American Indian	Entered from information provided by patient on “first visit form”