Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide

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Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Authors:
Lyndee Knox, LA Net
Erin Fries Taylor, Mathematica Policy Research
Kristin Geonnotti, Mathematica Policy Research
Rachel Machta, Mathematica Policy Research
Jung Kim, Mathematica Policy Research
Jessica Nysenbaum, Mathematica Policy Research
Michael Parchman, Agency for Healthcare Research & Quality

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Contributors

Carolyn Allshouse, Family Voices of Minnesota
Cheryl Aspy, Ph.D., University of Oklahoma Health Sciences Center
Thomas Bodenheimer, M.D., M.P.H., San Francisco General Hospital
Bonni Brownlee, M.H.A., Qualis Health
Caroline Carter, M.S., L.S.W., Center for Health Care Research & Policy, MetroHealth Medical Center
Katie Coleman, M.S.P.H., Group Health Cooperative
Allen Dietrich, M.D., Dartmouth Medical School
Darren A. DeWalt, M.D., M.P.H, University of North Carolina School of Medicine
Perry Dickinson, M.D., University of Colorado
Elizabeth Foley, M.B.A., Medical Care Development
Brenda Fraser, M.Sc., Quality Improvement and Innovation Partnership
Allyson Gottsman, Health TeamWorks
Joanne Gutowsky, Michigan Primary Care Consortium (MPCC)
William Hogg, M.D., Department of Family Medicine, University of Ottawa
Craig Jones, M.D., Vermont Blueprint for Health
Ann Lefebvre, M.S.W., CPHQ, NC AHEC Program at University of North Carolina at Chapel Hill
Clare Liddy, M.D., Department of Family Medicine, University of Ottawa
Jeanne McAllister, B.S.N., M.S., M.H.A., Center for Medical Home Improvement
Marly McMillen, M.B.A., The Dochterman Group
Gail McNutt, M.D., Department of Veterans Affairs
James Mold, M.D., University of Oklahoma College of Medicine
Regina Neal, Primary Care Development Corporation
Amanda Parsons, M.D., M.B.A., New York City Department of Health & Mental Hygiene
Joan Pernice, R.N.C., M.S., Massachusetts League of Community Health Centers
Diane Powers, M.A., University of Washington
Mary Ruhe, R.N., M.P.H., Case Western Reserve University
Constance S. Sixta, Ph.D., R.N., M.B.A., Sixta Consulting Inc.
Jenney Samuelson, Vermont Blueprint for Health
Lisa Watkins, Vermont Blueprint for Health

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Preface

"If we truly believe that primary care is too important to fail, how will we ensure its success?" This is the question that motivated the development of this how-to guide. The delivery of primary care is complex, to say the least. Changing a complex system like a primary care practice is fraught with difficulties and challenges, leading to the common analogy of redesigning an airplane while it's flying. One of the most promising methods to support primary care transformation is a practice facilitation model that supports an ongoing, trusting relationship between an external facilitator and a primary care practice. This is not the traditional "parachute in" model of facilitation often seen in the corporate world. Although some of the basic facilitation skills may be similar, this model is much more aligned with the Federal Government's agricultural cooperative extension system developed in the early 20th century. The intent of this manual is not to describe how to facilitate change in a primary care practice; rather, its focus is on how to establish and run an effective practice facilitation program. Its intended audience is organizations or individuals who will develop and run such a program.

This manual draws on the collective experience and knowledge of a remarkable group of people who have been involved in practice facilitation for many years. As a participant on many of the calls conducted in preparing this work, I found their commitment to the writing of this manual inspirational. We here at AHRQ express our heartfelt appreciation for their invaluable contributions. Our thanks to this team for taking on and completing this extremely challenging task. It is our hope that this manual will be a starting point for many successful practice facilitation programs, and that the delivery of primary care in the United States truly will be transformed as a result.

Michael L. Parchman, M.D., M.P.H.
PBRN Initiative Director & Senior Advisor for Primary Care
Center for Primary Care, Prevention, and Clinical Partnerships
Agency for Healthcare Research and Quality

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About This Guide

The contents of this guide were developed from the suggestions and experiences of a panel of more than 30 individuals recognized by their peers as possessing expertise in the design and management of practice facilitation programs for primary care transformation. Unless otherwise noted, the "experts" referred to throughout the guide are the contributors listed on the title page who served as members of the working group. While the contributors included many prominent experts representing a wide range of organizations, we recognize that other practice facilitation experts and organizations exist whose views are not necessarily reflected here.

This guide reflects current practical knowledge and hard-won lessons from the area of practice facilitation. Its aim is to provide information for others to draw on, but should not be taken as a final statement on how to develop facilitation programs. This work is intended to assist others so they do not have to reinvent the wheel, while recognizing that other, more refined approaches and techniques may evolve over time—particularly as facilitation programs focus increasingly on transformational efforts in primary care practice.

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Overview

Why Was This Guide Developed?

This how-to guide was developed by the Agency for Healthcare Research and Quality to support organizations interested in starting a practice facilitation (PF) program for primary care transformation. The focus on primary care transformation reflects the growing consensus that the U.S. primary care system must be redesigned in fundamental ways so that, in the end, we improve health and patient experience and lower costs.

In this guide, we define PF as a supportive service provided to a primary care practice by a trained individual or team, using a range of quality improvement (QI) and practice improvement approaches to build the internal capacity of a practice to improve over time. Another aim of PF is to support attainment of both incremental and transformative QI goals, with the ultimate goal of improving patient outcomes.

What Are the Goals of This Guide?

This guide was developed based on information and resources shared by more than 30 experts in the field of PF. The guide focuses on designing and administering facilitation programs, not the content of an actual facilitation intervention. It is designed for use by directors of facilitation programs, not the facilitators themselves. Its goal is to make the knowledge and experience of these experts available as a resource for you and your organization as you design and administer your own facilitation program. This manual can also be a resource to directors of existing programs who want to enhance their program and intervention models.

Who Is This Guide For?

This guide is for future and existing directors of facilitation programs to use as they make important decisions about the start-up and administration of their own programs. It can be useful to any organization interested in developing a facilitation workforce to improve or transform primary care services. This includes groups such as:

- State or local departments of health
- Quality improvement organizations (QIOs)
- Area health education centers (AHECs)
- HITECH regional extension centers (RECs)
- Practice-based research networks (PBRNs)
- Primary care associations (PCAs)
- Accountable care organizations (ACOs)
- Chartered value exchanges (CVE)
- Large health care systems
- Insurance companies
- Anyone else interested in improving the quality of U.S. primary care

How to Use This Guide

As a resource to directors of facilitation programs, this guide can be read cover to cover as an introductory text on creating a facilitation program, or to dip into for specialized content in a specific area. Through the tools and links provided in the document, the guide also can serve as a jumping-off point for accessing other resources on facilitation. The following table lists some of the topics covered in the guide's eight chapters.

Chapter		Selected Key Topics
1	Background and existing evidence for practice facilitation	• History and current state of PF • Evidence supporting PF's effectiveness • PF in the context of the current policy environment and existing QI activities
2	Creating the administrative foundation for your practice facilitation program	• Selecting an organizational home for your PF program • Forming an advisory board • Defining your mission and primary goals • Staffing
3	Funding your practice facilitation program	• Creating a business plan for your program • Identifying potential sources of funding • Typical PF program budgets • Marketing your program to funders
4	Developing your practice facilitation approach	• Creating a key driver model • Identifying your PF team • Stages and key activities • Defining facilitator roles and core activities
5	Hiring your practice facilitators	• Core competencies needed by facilitators • Deciding who to hire • Staffing models
6	Training your practice facilitators	• Assessing and leveraging existing training resources • Creating a curriculum • Selecting your educational approach and strategies • Selecting your trainer and training team
7	Supervising and supporting your practice facilitators	• Selecting a supervisor for your facilitators • Deciding on individual versus group supervision • Providing supervision in-person or by distance technology • Suggestions for creating a learning community
8	Evaluating the quality and outcomes of your practice facilitation program	• Creating an internal QI program • Identifying metrics for use in your QI process • Evaluating the outcomes • Identifying data sources
9	Conclusions and next steps	• Share relevant resources and tools with others • Learn more at www.pcmh.ahrq.gov

At the end of the guide, you'll find an appendix of helpful tools and resources (Appendix B). It includes a wide variety of aids, such as:

- Frameworks for improving primary care/chronic care
- Theoretical models of change
- Links to other facilitation manuals and related tools
- Tools for assessing a practice's readiness to change
- Tools for involving patients and families
- Practice facilitator job descriptions
- Curricula and coaching resources
- Measurement tools
- Selected articles and presentations

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Contents

Chapter 8 *(continued)*

Figures

Tables

Appendixes

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Chapter 1. Practice Facilitation for Primary Care Transformation: Background and Existing Evidence

The purpose of this chapter is to introduce you to basic information about practice facilitation (PF) and provide background information and the evidence behind it that can help you as you develop your program and seek funding.

This chapter will introduce you to the following:

- History and current state of PF as a resource for transforming primary care
- Evidence supporting PF's effectiveness
- The role of PF in practice improvement and transformation to patient-centered medical homes
- How PF fits in the national health care context

What Practice Facilitation Is and Does

What is practice facilitation? PF is a supportive service provided to a primary care practice by a trained individual or team of individuals. These individuals use a range of organizational development, project management, QI, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals. This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits. In the research literature, PF sometimes is called quality improvement coaching or practice enhancement assistance.[1]

Practice facilitators are specially trained individuals who work with primary care practices "to make meaningful changes designed to improve patients' outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment" (DeWalt, Powell, Mainwaring, et al., 2010). Facilitators also may help clinicians carry out research about their practices (Nagykaldi, Mold, and Aspy, 2005). Facilitation is different from many other types of consulting because the practice facilitator and the practice usually have a longer-term relationship and a closer connection, and the facilitation supports a broad range of improvement activities (Knox, 2010).

> *"Practice facilitators… help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment."*
>
> *(DeWalt, Powell, Mainwaring, et al., 2010)*

Practice facilitators are generalists trained in primary care improvement and have competencies in many areas, including QI methods, project management, and team facilitation. Many also have technical expertise in specific areas, such as the meaningful use of heath information technology (health IT) to support improved patient care. As described in Table 1.1, a facilitator may be internal to a practice or health system (that is, employed by the practice or its host organization) or external (for example, someone deployed to support a practice with no affiliation to that practice or health system).

Table 1.1. Advantages and disadvantages of different types of facilitators

Type of Facilitator	Advantages	Disadvantages
Internal to the practice or health system	• Understands the culture, current processes, and personalities • More likely to take ownership of QI more quickly	• Often subject to a top-down approach • More directly affected by internal politics, organizational pressures, and interpersonal dynamics • Prone to being pulled into clinical care or other practice priorities (clinical demands outweigh QI)
External to the practice and health system	• More likely to empower the practice and facilitate, rather than "do for" the practice • Clearer boundaries of roles • Less likely to be affected by health system pressures	• Can take longer to establish rapport and trust with practice and set expectations and goals • Prone to becoming a crutch for the practice; might require tapering off of activities by facilitator

External facilitation is the primary focus of this manual—many experts believe that external facilitators are more effective because they support multiple practices and don't face the same competing demands as internal facilitators, who sometimes are reassigned to meet other daily or acute needs. Facilitators provide interventions that vary in intensity, scope, and duration but, broadly speaking, PF recognizes change as an ongoing process.

Facilitators focus on assessing initial practice conditions and creating a tailored approach to working with a practice based on its specific needs (Goodwin, Zyzanski, Zronek, et al., 2001). This type of individualized approach may be better in dealing with the distinct goals of a particular practice or using opportunities that arise, and could result in more sustainable change (Stange, Goodwin, Zyzanski, et al., 2003). Practice facilitators have been characterized as "catalysts for change," supporting transformation at the individual, team, organization, and systems levels (Guiding facilitation in the Canadian context, 2006). That is, facilitators help promote a culture of learning and QI within practices and so they set the stage for meaningful, sustainable practice redesign.

What activities do practice facilitation programs support? PF may involve a wide range of activities, depending on the needs and goals of the practice. Taken together, these form a coherent set of activities for practice change and redesign. They include, but aren't limited to, the following:

- Assessment of and feedback to practices regarding organizational, clinical, and business functions to drive change
- Use of practice-level data to drive change
- Training of staff in QI methods and specific transformation processes, such as team-based care
- Formation and facilitation of practice QI teams
- Executive coaching and leadership training
- Best practices in QI structures and methods

- Support, encouragement, reinforcement, and recognition of successes
- Project and change management
- Resource identification and procurement
- Capacity building in the use of health IT to support improved clinical care and office efficiency
- Cross-pollination of good ideas and best practices between primary care practices
- Capacity building for improved linkages to outside resources
- Technical assistance (TA) in implementing particular models of care, such as the chronic care model (CCM)

In addition to supporting general QI work and these specific activities, practice facilitators also can support activities more directly related to patient centered medical home (PCMH) transformation goals. An example of this is the initiative by the Community Health Care Association of New York State (CHCANYS) and the Primary Care Development Corporation (PCDC). In this case, facilitators are helping practices to navigate the PCMH recognition process, which also includes such functions as managing the associated work flows and operations (PCDC, 2011). While this is not a QI initiative per se, the functions of these practice facilitators are very similar and, in their role as coordinators, interpreters, and guides, they work with the practice mainly to help it accomplish complex tasks and achieve its specific goals for practice transformation.

A Brief History of Practice Facilitation

The origins of PF can be traced back to its use in 1982–1984 as a part of the Oxford Prevention of Heart Attack and Stroke Project in England (also known as the Oxford Project). In this project, investigators used primary care facilitators to support clinicians with practical assistance for improving screening for cardiovascular disease (Fullard, Fowler, and Gray, 1984; Guiding facilitation in the Canadian context, 2006). Reports published from this study showed the success of the facilitator model and that facilitation supported the process of change and resulted in improved identification and followup of factors for these diseases. England was an early adopter of PF and used it as part of a comprehensive approach to support primary care. In the 1990s, the concept spread to other countries, including Australia, the Netherlands, and the United States (Nagykaldi, Mold, and Aspy, 2005). Several provinces in Canada have implemented province-wide PF efforts, and a research program on the effects of facilitation on the processes of care and patient outcomes is being directed out of the University of Ottawa.

During the past decade, the use of PF has continued to grow in the United States. Organizations such as practice-based research networks (PBRNs), State health departments, professional associations, and health plans all have implemented PF programs, using many different models. These programs have focused on a variety of areas, including translating evidence-based guidelines and practice models into care, supporting dissemination of best practices, and supporting transformation of primary care practices into PCMHs.

Most recently in the U.S., Federal agencies and policymakers have been looking at the potential value of PF both as a resource for helping to improve primary care and as a way to

speed the adoption of new treatments, guidelines, or models of care from research into practice. The Affordable Care Act (ACA) calls for the creation of a primary care extension program in the United States to support improved quality in primary care practices across the country, to be modeled after the successful U.S. Department of Agriculture cooperative extension system. The legislation states that this will be "to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services…and evidence-based and evidence-informed therapies and techniques" (Section 5405). Quality Improvement Organizations (QIOs), Health Information Regional Extension Centers (RECs), and PBRNs are some of the groups that could form the core of the proposed extension program, and practice facilitators are a likely workforce for the program. In the proposed model, practice facilitators would provide a way to spread new information—just as extension agents do in the agricultural system. Facilitators would be used to close the information gap between research and practice.

Evidence Supporting PF as a Resource for Practice Improvement

There is a growing body of evidence that supports the effectiveness of PF interventions. It is helpful to be familiar with this literature as you develop your program as it can help guide decisions about program and intervention design, and also assist you in building a case for support with funders and practices alike.

A recent meta-analysis of studies of PF within primary care settings concluded that **primary care practices are almost three times as likely to adopt evidence-based guidelines through PF** compared with no-intervention control group practices (Baskerville, Hogg, and Liddy, 2011). The study found that, as the number of practices supported by a facilitator increased, the effect size of facilitation decreased, while the intensity of the intervention—the number and length of facilitation sessions—was associated with larger effects.

Two systematic literature reviews have been conducted on PF. In the first review, Nagykaldi and colleagues (2005) searched publications from 1966 to 2004 and found 25 studies that measured the effect of interventions involving practice facilitators on patient care outcomes in primary care. Of the eight with rigorous study designs, the authors found that, while there was evidence supporting the effectiveness of practice facilitators, they often were a part of an intervention with many other components, making it difficult to distinguish effects due solely to practice facilitators.[1] Nevertheless, Nagykaldi and colleagues concluded that practice facilitators increased the delivery rates of preventive services and also improved relationships and communication between providers, assisted clinicians with chronic disease management, provided professional education, and facilitated system-level improvements.

In his review of the PF literature, Baskerville (2009) found solid evidence for the effectiveness of PF as a means of improving quality of primary care services and concluded that these improvements were most likely to occur when:

[1] Eight studies used a randomized, controlled trial (RCT) design, while the majority (14) used a pre-/post-design.

- Multicomponent interventions are used, such as PF that employs a number of activities[2]
- Interventions focus on organizational and systemic aspects of a practice
- The systems and tools used reflect the reality of a practice setting

Other studies have looked at whether the effects of PF are sustained over time. One early study found that the effects were not sustained past the intervention period (McCowan, Neville, Crombie, et al., 1997). However, multiple studies conducted since then have found the effects of PF were sustained for as many as 12 months postintervention (Dietrich, Sox, Tosteson, et al., 1994; Hogg, Baskerville, Nykiforuk, et al., 2002; Stange, Goodwin, Zyzanski, et al., 2003; and Hogg, Lemelin, Moroz, et al., 2008).

To date, one study—the National Demonstration Project (NDP)—has looked at the impact of PF on practice redesign (Nutting, Crabtree, Stewart, et al., 2010). This study compared two implementation approaches of a PCMH: facilitated and self-directed. Thirty-six family practices were selected for the study based on their readiness to adopt the NDP model and diversity of practice characteristics, such as location, size, structure, and scope of practice. The authors assessed the adoption of 39 components of the NDP model, patient ratings of the practice as a PCMH, and the capability of practices to make and sustain change. They found that facilitation increased the practices' capability to make and sustain change and increased the adaptive reserve in the practices (their organizational capacity to engage in ongoing QI). The NDP also found that complex structural changes required a higher level of effort—those that had an impact on multiple roles and processes or required coordination across units or adoption of a different model of primary care.

Practice Facilitation as a Resource for Primary Care Redesign and Transformation

PF also can be a vital resource in supporting national, State, and local efforts to redesign and transform primary care. The 2001 Institute of Medicine (IOM) report, "Crossing the Quality Chasm," as well as several major pieces of recent health reform legislation—including the American Recovery and Reinvestment Act of 2009 (ARRA) and the ACA—have called for transformation of the way primary care is delivered in the U.S.

The concept of PCMH has gained momentum as a means of transforming care in the United States and has emerged as a priority for organizations across the country.[3] The components of the PCMH include patient-centered care, with an orientation toward the whole person, comprehensive care, care coordinated across all the elements of the health system, superb access

[2] For example, Dietrich and colleagues (1992) found that a system intervention (assistance from a facilitator plus physician education) was associated with improvements in six preventive procedures, while education alone was associated with an increase in only one preventive procedure.

[3] Throughout this manual, references to the PCMH relate to the concept broadly speaking—which others may refer to as a medical home, health home, or advanced primary care. Unless specifically noted, we are not referring to PCMH recognition or certification programs.

to care, and a systems-based approach to quality and safety. (See www.pcmh.ahrq.gov for more information.)

Currently, most primary care practices—operating within the existing health care delivery and payment environments—are not designed to function as medical homes. PF can be a resource for practices, local health plans, accountable care organizations (ACOs), county and State health departments and the Federal Government in providing the education and support to practices necessary to support their redesign and transformation.

PF offers a potentially effective and efficient way to deliver the training and support needed for different types of primary care practices across the country to transform into medical homes and other forms of primary care redesign. Facilitators are able to tailor their support to address the unique needs of a particular practice, based on its size, organizational structure, patient population, geography, and health care context. In the midst of the many reforms and practice improvements now taking place, facilitators can help practices coordinate and prioritize these activities. Facilitators build permanent capacity within practices for continuous quality improvement and establish sustained relationships with practices that can be activated efficiently and rapidly to speed adoption of new treatments and models of care as they are discovered in the future. (See Figure 1.1 at the end of this chapter for a logic model of PF as a means of primary care transformation.)

Practice Facilitation in the National Health Care Context

While the majority of PF work takes place at the practice level, it also occurs within the broader context of the health care system in the region and even as part of national efforts to transform primary care. As the director of a PF program, it is important that you understand how your program fits within the larger health care context. Considering how your PF program aligns with other efforts to transform care will help you identify potential partners, funding sources, and unmet needs in your area that your program and facilitators can help to address.

Payment reform. Payment reform is an important strategy for stimulating QI and practice transformation in health care. Without major changes in payment approach, transformation isn't likely to take hold, at least among most primary care practices. Many experts consider payment reform a necessary precursor to real and sustained practice redesign. Such reform often provides the impetus and incentive for a practice to change, which in turn initiates the use of other QI strategies or changes to workflow and other processes.

Several models of payment reform recently have received attention. Each is designed to improve quality while containing costs, which has been difficult under traditional fee-for-service (FFS) models. Through well-designed payment reform initiatives, QI is driven by financial incentives to providers for using clinically appropriate services (Schneider, Hussey, and Schnyer, 2011).

It is important to consider how your facilitators can help their practices gain the maximum benefit from any payment reform efforts in your region, and also how your program aligns with these broader efforts. Partners in multipayer reform efforts are potential stakeholders and partners for your program, and your facilitators should be able to provide technical assistance (TA) to practices so that they can benefit from payment reform initiatives. For example, primary care practices may need TA to navigate the necessary administrative reporting requirements and

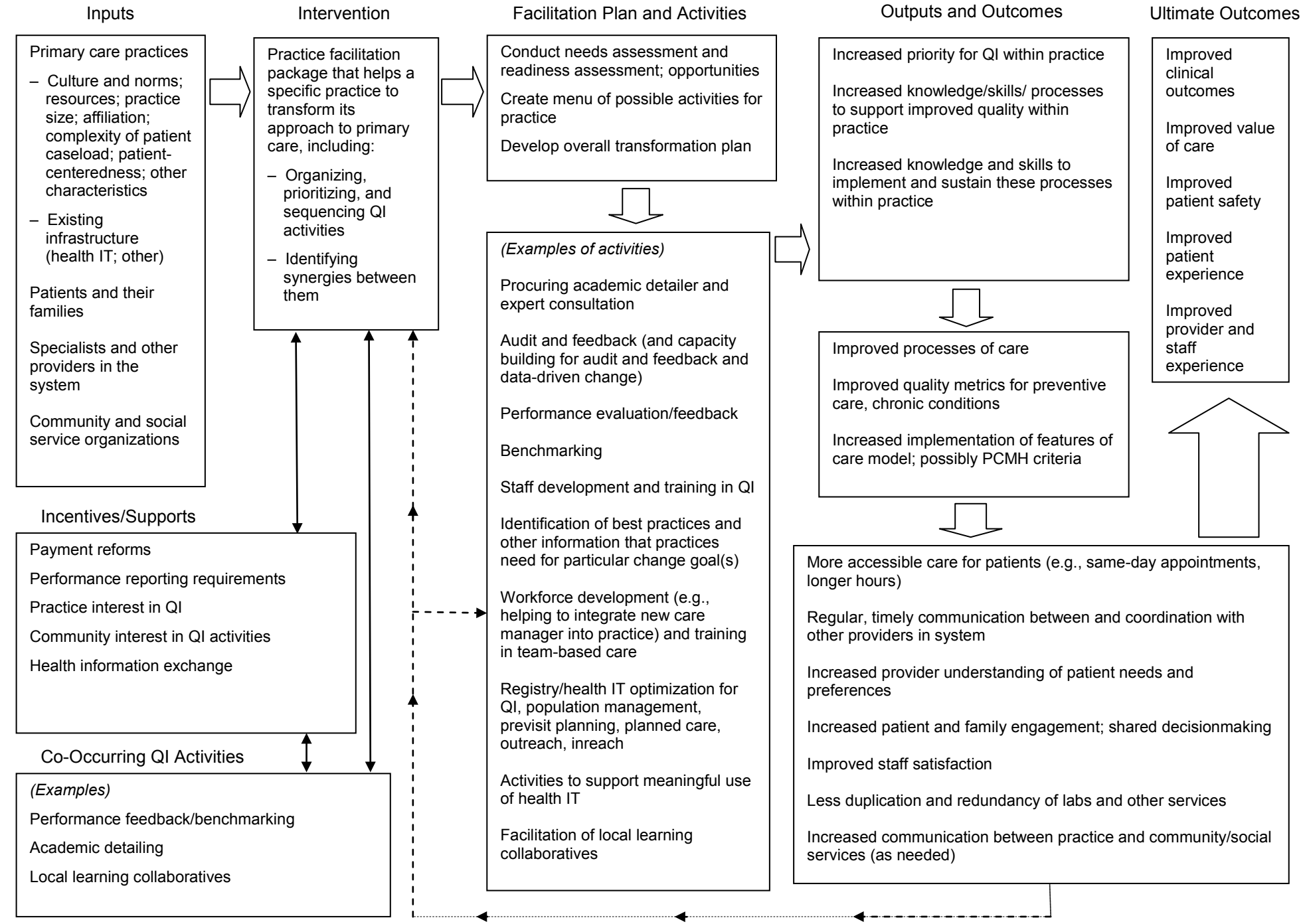
other operating issues to participate in a multipayer demonstration project (many of which currently are underway, with others likely to follow). Given their process-oriented skills, practice facilitators are well positioned to help practices participate in and benefit from payment reform initiatives, and this often requires activities that facilitators are already engaged in as part of their facilitation work with the practice, such as audit and feedback, benchmarking, and supporting attainment of specific indicators of care quality.

The primary care extension program. As mentioned earlier, the primary care extension program was authorized by the ACA (but currently is not funded). To carry out this model, health extension agents would operate at the local level to provide assistance to primary care practices via QI or system redesign activities. While many of the details of this program still must be developed, practice facilitators—and PF programs more broadly—are highly relevant and likely to play a key role in the primary care extension concept at the local level. The extension program thus may provide some resources for practice support.

Regional extension centers. Authorized by the HITECH Act, RECs support health care providers in becoming meaningful users of health IT, including electronic health records (EHRs). (RECs, along with the national Health Information Technology Research Center (HITRC), form the Health Information Technology Extension Program.) The Office of the National Coordinator for Health Information Technology currently funds 62 regional extension centers across the United States, which provide on-the-ground assistance to local practices (ONC HIT Web site, 2011). RECs rely on health IT consultants to support selection and implementation of EHRs in primary care. The work of preparing for and implementing an EHR is an outstanding opportunity to simultaneously transform care in the practice. Too often, EHR implementation takes place without a concurrent focus on transforming care, so the EHR implementation simply duplicates existing processes of care at the practice and—even more problematic—fossilizes them, making it very difficult to change them once they've been replicated and reinforced by the new EHR system. Developing a PF workforce housed within the RECs, or that closely coordinates with the RECs, would allow them and the Nation to use this important opportunity to introduce both health IT and real transformation to the processes of delivering primary care.

Accountable care organizations. The emergence of accountable care organizations (ACOs) is another development PF programs should be aware of. ACOs have received considerable attention recently as a potential means of encouraging high-quality health care and controlling costs by holding groups of providers jointly responsible for the costs and outcomes of care for a defined population of patients. Details of ACOs still are emerging, and specific decisions on financial incentives and how the risks will be divided among participating providers are likely to be made by a particular ACO's governing body; however, potential payment models for ACOs include shared savings, global payments, or other approaches. Also, the degree to which the PCMH—or patient-centered care more broadly—plays a central role in ACOs remains to be seen but is likely to be important. PF programs could be hired by (or even developed by) ACOs as they explore ways to improve health outcomes for patients and control costs by improving the overall quality of health care services, the delivery of preventive and chronic care services in primary care, transitions between hospitals and primary care settings, referral processes to specialists, and health outcomes for patients. It will be important to consider if and how your program aligns with ACOs in your area and if any potential for collaboration exists.

Figure 1.1. Practice facilitation as a means of primary care transformation



Chapter 2. Creating the Administrative Foundation for Your Practice Facilitation Program

Practice facilitation (PF) programs require a strong administrative foundation, so you will need to make some decisions related to administration. These include where your program will be housed, its mission, and its fit in the local community. Because PF interventions are based in large part on relationships that develop between the facilitators and the practices they support, PF programs must have an intimate understanding of their health care community and its needs. Designing a program to be as "local" as possible allows facilitators to develop and maintain relationships with practice staff more easily (perhaps establishing trusted relationships more quickly), understand contextual factors better, and possibly reduce the overall costs of quality improvement support. Even for programs that serve large geographic areas, "going local" can be achieved by staffing your program with facilitators who live and work in your local area and using resources such as Web conferencing and other distance technologies to support centralized activities like training and supervision.

This chapter will introduce you to several topics, including:

- Selecting an organizational home for your program
- Forming an advisory board
- Defining your program's mission and primary goals, and available frameworks for doing so
- Staffing your program
- Considering information technology (IT) needs
- Determining physical space needs

Select an Organizational Home for Your Program

In many cases, the choice of an organizational home for your PF program will be predetermined. Although PF programs can be for-profit or not-for-profit standalone entities, often they need to find a host organization. Facilitation programs that develop within practice-based research networks (PBRNs), for example, are likely to be located in a university. Those started by a quality improvement organization (QIO) probably will be housed within that setting. In some cases however, you may need to decide where to locate your program. Multistakeholder groups that want to start a PF program, for example, will need to decide which, if any, of the organizational collaborators would make the most effective home. The North Carolina Statewide Quality Improvement Program was developed through the collaboration of multiple stakeholders. Originally, the different components of the program were housed in different stakeholder organizations. Once the program was up and running, the decision was made to locate the program and its facilitators within the area health education center (AHEC) because it was a statewide organization and the program was being developed as a statewide resource.

Regardless of whether the organizational home for your program is already set or remains to be identified, it is important to evaluate the benefits and challenges of its administrative setting.

What are the goals and methods of your PF program and how do they align with those of the host organization?

Table 2.1 provides a list of potential homes for PF programs and the possible benefits and challenges of each. Programs can be located in many different settings, but the most typical are State health departments, QIOs, university and community-based PBRNs, AHECs, and multistakeholder groups. Other potential settings include health plans, HITECH regional extension centers (RECs), primary care associations (PCAs), independent practice associations (IPAs), integrated health systems, and advocacy groups.

Locating a PF program within an existing organization has some clear advantages. It can build on the organization's infrastructure and leverage its resources. For example, the organization's staff and physical resources can be useful and its reputation in the community can help legitimize and build interest in the PF program and its services within the primary care community.

There are also disadvantages to this approach. The host organization may have competing demands that can pull the PF program away from its core mission. For example, programs located within organizations that serve an oversight role with health care providers may find it challenging to develop the types of trusting relationships with providers needed for PF to be effective, and also may have to resist being used by their host organization as a resource for monitoring rather than transforming performance. For example, some programs are located in State health departments that maintain PF services to improve care in practices that serve a high proportion of State-funded patients. These programs may face special challenges in collaborating with these practices because they're likely to see the facilitators as auditors rather than as resources for change.

It helps when the primary mission of your host organization is similar to that of your program—but that might not always be the case. Health plans, State health departments, and other groups that help fund health care can be ideal organizational homes, but you need to be aware of where their priorities might be different from those of your program. That's also true for programs located in PBRNs and universities, whose primary emphasis is often on research, which sometimes aligns with the goals and work of practice transformation—but not always. It's important that practices view the PF program as focused primarily on their needs and QI goals. If practices instead believe that the program is focused primarily on the interests of the host organization, their staff may question your program's motivation and intent.

Form an Advisory Board for Your Program

At the start of a program, it can be very useful to establish an advisory board of key stakeholders to assist in defining your mission and ensure that it is in synch with the local community. Over time, this group can continue to advise your program on a wide variety of issues, from facilitator recruitment to program funding.

Specific functions of an advisory board. An advisory board is not a governance board. It should provide guidance to the program director and his or her staff on the design and development of the program and ensure that your program and its services remain responsive to the needs of the target community.

Table 2.1. Possible administrative homes for practice facilitation programs

Category	Organization	Potential Benefits	Potential Challenges
Governmental	State Departments of Health or Public Health; County Departments of Health or Public Health	Congruent with PF's focus on population health; tend to focus on practices caring for uninsured, "frequent flyers," and individuals without a medical home	Given this group's focus on supporting direct patient care, QI is often the first item cut when budgets are tight; sometimes have difficulty thinking long term and supporting long-term PF presence in practice; tendency to be project rather than mission driven
Regional infrastructure	QIOs; AHECs; HITECH RECs	May benefit from existing infrastructure and relationships with practices; synergies between PF and the QIOs, RECs, and AHECs; AHECs focus on capacity building	QIOs seen as compliance and audit entities and sometimes viewed with distrust; RECs focus on technical assistance and do not necessarily see transformation as part of their scope of work; funding for RECs is short term
Academic health centers	PBRNs; Clinical and Translational Science Institutes (CTSIs)	May benefit from existing academic resources and infrastructure; PBRNs focus both on QI and translation of research evidence; CTSIs have mandate to translate evidence and engage community	CTSIs tend to focus most heavily on research and investment in community; translation often receives little funding or attention; CTSIs mainly interested in subject recruitment, so little interest in practice transformation without stimulus from funders; PBRNs are struggling for funding, and mainly are located in universities, which can create administrative barriers to effective and nimble QI
Provider organizations and associations	PCAs; IPAs; integrated health systems; accountable care organizations (ACOs)	Strong connections to practices and medical community; interested in providing support and adding value to their practices so facilitators can help them meet this goal	No immediate source of funding to support PF, so likely to fall victim to budget issues and may be difficult to sustain in the long term

Table 2.1. Possible administrative homes for practice facilitation programs *(continued)*

Category	Organization	Potential Benefits	Potential Challenges
Payers	Health plans	Invested in lowering costs by improving care, such as implementing care coordination to reduce ED visits, etc.; Clear alignment of PF and health plans in these areas	Plans may be reluctant to fund PF if much of the benefit accrues to patients of other payers; also project driven, so may be hard to sustain PF in the long term; often focused on targeted changes, such as care coordination, and can be very top down in their approach to practice improvement
Multistakeholder groups and organizations	Multiple private and public payers working together toward common goals	If structured properly, can provide external motivation for transformation that PF can leverage and help support rapid improvements in practices	May be challenging to start and/or maintain funding for PF; can fall victim to competing agendas across stakeholders; requires buy-in from many organizations, not just the practice
Community-based organizations	Not-for-profit and for-profit organizations serving the local community, region, or broader area	Strong ties to local community; flexibility to pursue different sources of funding, including self-pay by practices; ability to work across organizations and focus on supporting practices	Funding can be a challenge; do not have the financial reserves of larger organizations; advocacy groups may have too narrow a focus

The advisory board also can help your PF program find funding. Ideally, the board will include people who are well known and respected in health care, QI, and primary care, as well as those who can offer alternative perspectives, which helps to prompt productive discussion and analysis about mission and methods.

In addition, the advisory group can be useful in helping to prioritize the work of the program and the larger QI community. Practices easily can become overburdened by having a number of improvement efforts and activities. The advisory board can help set priorities for improvement work and assist in deciding what to do next, especially through its representatives from the front-line practice community. Once recruited, it is important to keep an advisory board engaged in your program's work and provide its members with opportunities to see how it's making a difference for practices and their patients.

Selecting individuals to serve on board. Advisory boards typically consist of a range of stakeholders—including primary care providers and patient representatives—who can help to identify program goals and provide ongoing feedback about the real needs in the provider and patient communities. This kind of board should include members from the practice community the program will serve. For example, if your program is designed to transform care for vulnerable patients in safety net settings, the board should include providers and administrators from federally qualified health centers and small private practices in low-income urban areas, all

of whom can speak to the needs of your PF services' end users, the overall program's mission and goals, and the potential effectiveness of your proposed intervention model.

An advisory group also often includes representatives from the larger health care and QI communities, such as representatives from local health plans, State and county health departments, and professional and practice associations, depending on the program's overarching purpose and goals. Representatives from groups with unique sources of funding, such as local foundations, advocacy groups, and representatives from the business community also can often play a useful role on an advisory board. See the list of practical resources at the end of this chapter for additional information on creating successful advisory boards.

Define Your Program's Mission and Goals

A PF program can pursue many goals. Clearly defining the central mission and goals is an important first step for any new PF program. Without these clear definitions, your program's work easily can become too diffuse or unfocused and spread your facilitators too thin by trying to tackle a scope of work that's too broad.

The most effective PF programs are those developed with the idea that they will become sustained and integral parts of the local health care and civic infrastructure. Defining a broad mission for your program provides room for it to grow over time and respond to the evolving needs of the surrounding health care community. For example, the North Carolina Statewide Quality Improvement Program began as a small collaborative project across health care organizations, with only two practice facilitators and 16 practices, but has evolved over time to become a statewide infrastructure and resource. Started as a diabetes QI effort, the program eventually extended its mission to that of one "supporting primary care practices." This broader mission gave it flexibility, supported its growth in addressing other needs in the primary care community, and allowed it to bring its mission into line with the larger health care and QI communities in North Carolina. Depending on your QI approach and orientation, you also may want to *consider program goals that extend beyond the physical boundaries of a practice,* such as connecting primary care practices to community resources or the broader medical neighborhood, including State and local public health agencies and others.

Consider how your program aligns with other efforts in your area. When defining your program's mission and goals, give careful consideration to how your program fits with health care priorities in your region and other QI and transformation efforts underway in your area. Understanding the local environment, and looking for ways to align your facilitators' work can help you identify the possible connections between your program and others in your region; in turn, this can support coordination and collaboration among these efforts and help maximize their effects while not putting practices under too much of a burden. It also can help you identify "gaps" in the QI landscape that your program can help to fill, creating a niche for your program and increasing its value to the health care community at large.

Involve key stakeholders, including patients, in helping to determine the mission and goals of your program. It is important to *involve primary care practice providers and staff and other key stakeholders* (such as community-based organizations and advocacy groups that work closely with providers) in this process. You can do this through their participation in an advisory board or in other ways. Regardless, their involvement will help you be sure that your program's goals are aligned with the needs of the larger QI community in the area, aid in identifying

synergies, and ensure that your program's services and methods are a good fit for the practices you aim to serve.

You also should *make every effort to include representatives from the patient community* in defining the goals and mission of your program. This can be uncomfortable for some providers and other stakeholders, but ultimately it can help produce a significantly more relevant and powerful program than when patients are not included. Family Voices of Minnesota, which focuses on improving the quality of pediatric health care, includes parents of special-needs children in defining the goals of its facilitation program and delivery of services to practices. Later in this manual, we'll provide ideas about how to get patients involved as members of PF teams.

Create a program charter. Charters serve to remind you, your staff, and your advisory board of your program's purpose and main focus. Program charters, usually written by a small group of stakeholders, should reflect decisions made before your program is launched, including the roles and responsibilities of individuals, as well as its vision and goals and the resources needed to meet them. In addition, the charter should clearly lay out the organizational structure of the overall program, the amount of time a facilitator will work with each practice, and the number of practices for each facilitator to handle (DeWalt, Powell, Mainwaring, et al., 2010).[4] A charter can help keep your program's leaders and facilitators focused on key goals and outcomes, and keep it internally consistent while its administrators develop and implement program components, hire facilitators, and recruit practices. It's a particularly important tool to help keep your team focused when the program involves collaboration among various stakeholders in the community. A sample outline for a PF program charter is provided in the practical resources section at the end of this chapter.

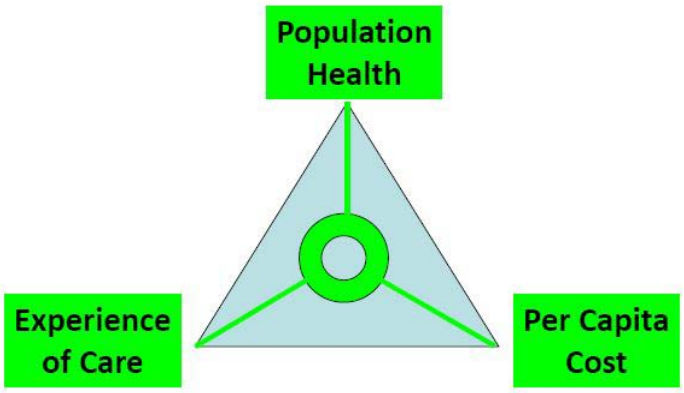
Frameworks to Guide You in Identifying Program Goals

Current models of care can be useful when you're starting discussions about your program's mission and goals. These models can help you think through what your program wants to achieve in the practices it serves and also serve as a resource and guide as you develop your intervention and key-driver model. Three of the more popular frameworks are the **Triple Aim**, the **Chronic Care Model**, and **Patient-Centered Medical Home**.

The **Triple Aim**—as conceived by Berwick and colleagues—represents a vision for health care that includes improved patient experience, improved population health, and reduced per capita costs (Berwick, Nolan, and Whittington, 2008). (See Figure 2.1.) Achieving a balance among the three aims is important because improving one dimension may affect the other two negatively. For example, some approaches to improving care for individuals can raise costs either in the short or long run. The three goals also can influence one another positively, such as by eliminating overuse, which can both improve population health and decrease costs. To

[4] The final report on "Team Development and Implementation in Saskatchewan's Primary Health Care Sector" contains an example of a program charter, in this case focused on interdisciplinary primary health care teams. In addition to the elements described above, it also includes measures of success and processes for communication, decisionmaking, and conflict resolution. Available at www.health.gov.sk.ca/primary-health-care-team-development. Accessed April 29, 2011.

Figure 2.1. The triple aim in health care

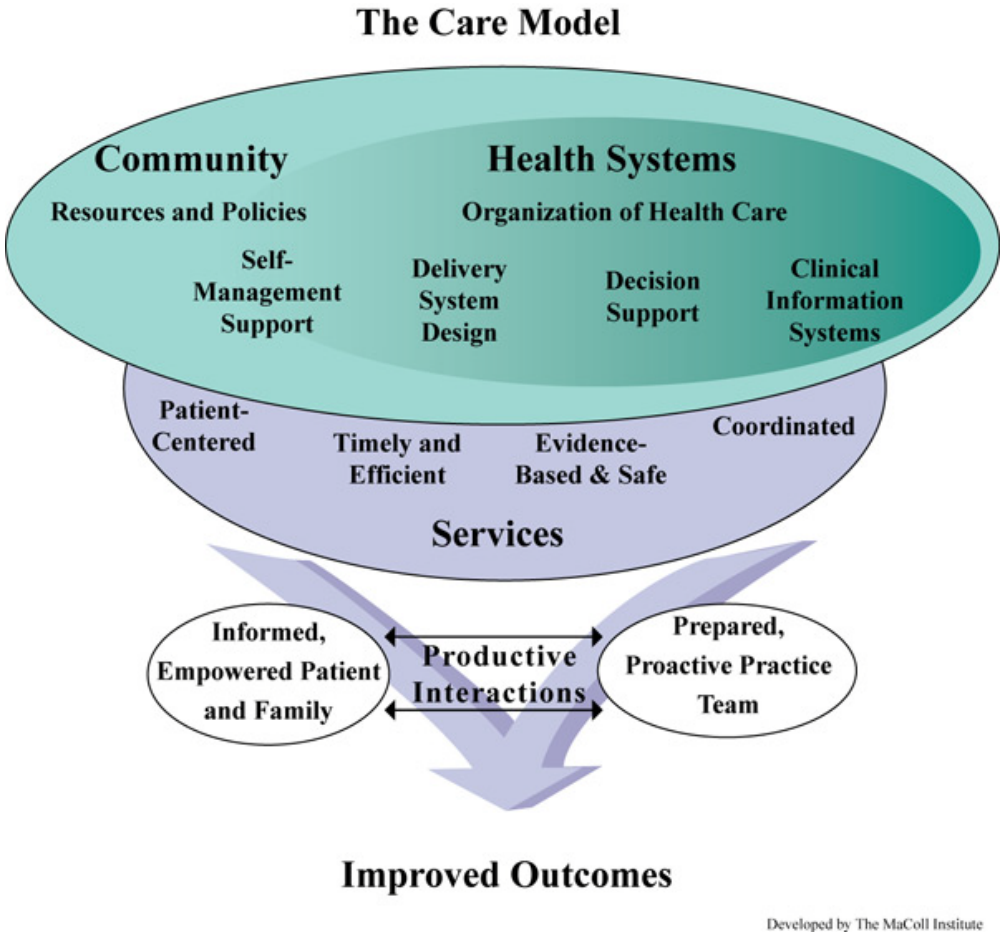


Source: Institute for Healthcare Improvement (IHI) Triple Aim initiative. www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx.

accomplish the triple aim effectively, these experts suggest the use of an "integrator" who accepts responsibility for all three goals for a certain population and thus plays a role in coordinating services and organizations (Berwick, Nolan, and Whittington, 2008). The National Quality Strategy, which was established by the Secretary of Health and Human Services in response to requirements in the Affordable Care Act, is closely related to the concept of the triple aim and sets priorities for reaching the goals of better care, healthy people/healthy communities, and affordable care. (More information is available at www.ahrq.gov/workingforquality/nqs/.)

The **Chronic Care Model (CCM)** is "an organizational approach to caring for people with chronic disease in a primary care setting." Developed by Wagner and his colleagues at Group Health (1998), the model has formed the basis of many of the recent efforts to transform primary care in the United States from a reactive, acute care-based delivery model to one providing continuous (chronic) care over the lifespan. The CCM identifies essential elements of a health care system that encourage high-quality chronic disease care: the community, the health system, self-management support, delivery system design, decision support, and clinical information systems (Improving Chronic Illness Care, 2011). Some experts now refer to the CCM as the "care model" or "expanded care model," given its more recent application to the delivery of preventive services and health promotion (Hung, Rundall, Tallia, et al., 2007; Barr, Robinson, Marin-Link, et al., 2003).

Figure 2.2. The expanded care model



Source: Copyright 1996-2011 The MacColl Institute. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Group Health's MacColl Institute for Healthcare Innovation.

The **Patient-Centered Medical Home** (PCMH) is a concept that originated in Community-Oriented Primary Care and the American Academy of Pediatrics' Family-Centered Medical Home. The PCMH involves transformation of the underlying processes of care, such as shifting from physician-centric care processes to those incorporating all members of the health care team practicing at the level of their licenses; this model also places the patient at the center of care. In addition, it involves designing care systems to improve the patient experience, increase the cultural and linguistic appropriateness of care, and increase the availability and accessibility of health care teams to the patient.

A number of organizations have developed or are developing tools for recognizing practices' patient-centered care, including the National Committee for Quality Assurance, and the Joint Commission. While such tools can be useful, experts caution about the potential danger of focusing only on the formalized recognition processes for becoming a PCMH; these can lead practices (and facilitators) to focus too heavily on meeting the demands of the "test" while not necessarily creating deep and lasting changes in the way they are delivering care.

More information and related tools are available at AHRQ's PCMH Web site: www.pcmh.ahrq.gov

Too often, certification processes promote a practice becoming good at the paper chase rather than engaging in the real work of transformation. So, while formal accreditation processes can be useful or even essential when they are linked to payment, it is unwise to select them as the only or even primary goals of a PF intervention.

Each of these models is complementary and interrelated, with considerable overlap between the CCM and the PCMH. The Triple Aim—which represents a vision more than a framework or model—is a likely outcome for both the PCMH and chronic care models.

Staff Your PF Program

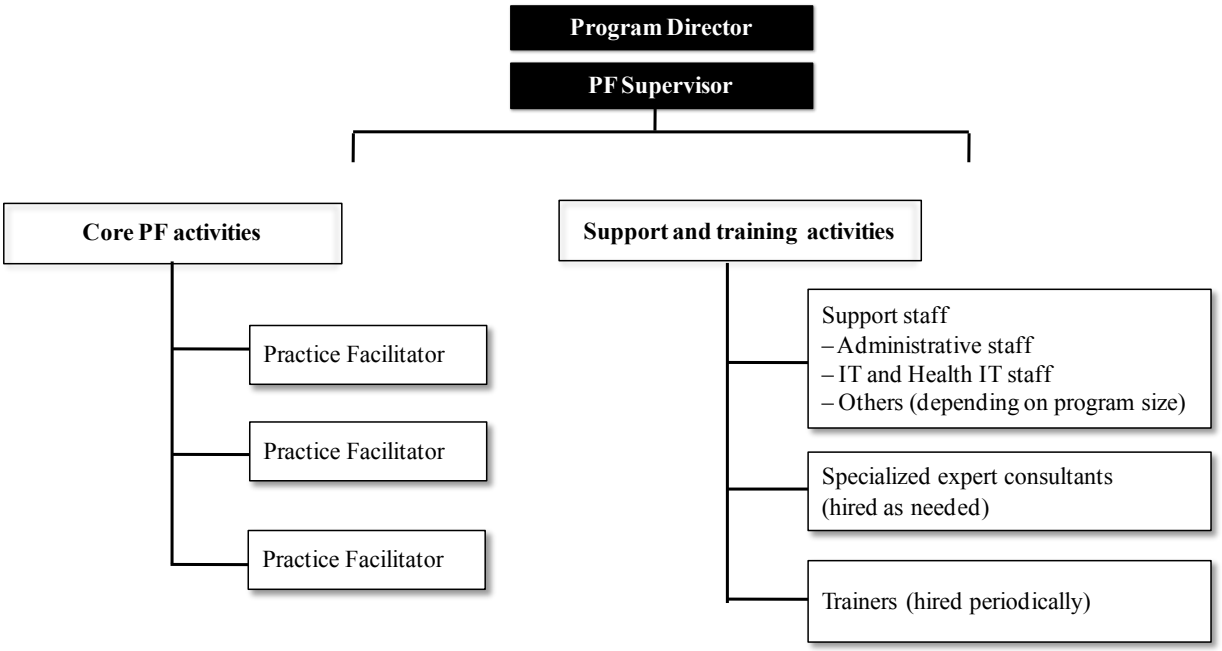
Practice facilitators. Practice facilitators are the heart of any PF program and, more than any other element of the program, will make or break it. Administrators should put considerable care into hiring them. They are the program staff responsible for operating in the field, so they're often seen as the catalysts for change and the "face" of the PF program. Experts agree that there are some basic competencies critical to effective facilitation. (See Chapter 5 for detailed information on selecting and hiring facilitators for your program.)

Other key staff. It takes more than facilitators to create a well-functioning PF program. In an ideal scenario, your program also should include staff for supervision as well as administrative, IT, and data support (see Figure 2.3). However, the need for such positions varies, based on program size and approach; also, the program's ability to fund these positions will depend on the resources that are available. While these services ideally would be provided in-house or through contracted organizations, a number of PF programs with limited funds have developed creative approaches to providing these additional supports, such as volunteer faculty and Web-based solutions, especially for training and supervision.

Program director. As the head of a facilitation program, the program director makes a program work and keeps all of its components moving. The director provides leadership and vision, overseeing the program as a whole; leading business operations; and usually playing a large role in its development, financing, marketing, and sustainability over time. This person generally is responsible for marketing a program to funders and new practices. The director also is likely to play a key role in writing proposals and grants for future funding. This individual must have a thorough understanding of organizational change and the program's intervention model, as well as a focus on capacity building, rather than just "doing for" the practice. The program director also needs to make sure that the facilitation program is in line with broader QI efforts in the community.

Trainer. The trainer provides facilitators with the skills they need to work effectively in the field and efficiently as a team. Depending on the program's size and model, you may have multiple trainers, either culled from your host organization or brought in as experts from the community. On the other hand, larger programs may hire someone specifically for the purpose of training. Hiring an expert from another PF program to provide initial training for a startup program can be an effective strategy. (See Chapter 6 on training and supervision to learn more about different design options for training.)

Figure 2.3. Sample organizational chart for a practice facilitation program



Practice facilitation supervisor. The PF supervisor provides individualized training and support to the facilitators and monitors the progress of each toward specified goals in the practice and fidelity to the intervention model. Supervisors are likely to be engaged in evaluating the impact of the PF services. They serve as a source of expertise when issues come up and also are available to help facilitators identify needed resources (for example, tapping expert consultants). In addition, they facilitate and encourage interaction, support, and idea sharing. Many programs provide weekly to monthly supervisory support, and experts suggest no more than a one-to-eight ratio of supervisor to facilitators.

Ideally, a supervisor will have prior experience as a facilitator and extensive knowledge of the realities of the practice environments in which the facilitators will be working. In addition, they should be skilled not only in interpersonal and group facilitation, but also in the acquisition and use of data to drive QI work. The supervisor needs to thoroughly understand the program's intervention model and broad goals, and have an excellent knowledge of external resources that facilitators could possibly use. They also should be knowledgeable about the local health care and QI community and understand how the practice facilitator's work lines up with other ongoing efforts in the region.

Administrative support staff. Robust PF programs require a strong administrative staff to assist in their work, and experts warn that you "can't skimp on this." These staff may include a project manager and administrative support staff who provide day-to-day word processing and a range of logistical support. Clearly, the number of administrative staff required depends on the size of the program, but even at the start, you will need administrative support.

Information technology personnel. IT is playing an increasingly important role as a core element of almost any QI process. In addition to working with IT systems in the practice environment, facilitation programs are using an increasingly wide array of IT tools as part of their work with practices, ranging from collaborative software to Webinars that support local learning collaboratives and information exchange. Given the current stage of development for

health IT, much of this work is difficult, is not intuitive, and requires expertise in working across many different health IT and IT platforms. Thus, it is important that your program have sufficient access to IT support and resources.

Data management and support staff. Information is a critical element of any QI or transformation effort. Data build motivation for change in a practice, help the facilitator and practice determine what goals they should pursue, and aid a practice in tracking progress over time. While, in general, facilitators should have strong skills in the acquisition, analysis, and reporting of data to drive change, it may be useful to have people on staff who can assist them in these activities—depending on the number of practices they are supporting. This person should be skilled in accessing data through practice registries, electronic health records (EHRs), practice management systems, and lab and other data systems, as well as analyzing and displaying these data in a form meaningful to practice staff.

Determine IT Resource Needs of Your Program

As discussed previously, most PF programs use some form of technology to support the work of their facilitators. Key considerations for selecting an appropriate technology should include cost, versatility, and usability. Social network platforms are freely available for possible use by your program. You can use various technologies in both training and supervision to support a learning community—thereby facilitating collaboration and providing virtual support for facilitators in the field.

Many of your IT needs will be determined by the specific intervention approach used by your program but most require some basic resources. Hardware, such as laptops or netbooks and smart phones, is essential. For facilitators who travel extensively, global positioning system (GPS) devices also may be crucial. Facilitators must have the ability to access the Internet to look for resources and communicate with supervisors, other facilitators, and other practices while out in the field. Collaborative software programs that help facilitators organize their work across multiple practices can be very valuable and also can support practices in their own QI work. For example, a technology may allow a facilitator to post a question to the entire PF team while at a practice site and then receive an immediate answer. Ideally, this platform also could be used for storing reference materials, templates, and other documents to make them readily available to the facilitator. A technology might provide a virtual location where facilitators can share their work with their supervisors via message centers or formal submission of progress reports. Ideally, technology also will support the evaluation and reporting of your practices, allowing you to track progress and goals.

Existing programs use many types of IT software and tools for various purposes. For example, the Quality Improvement and Innovation Partnership (QIIP) program in Ontario, Canada, uses a collaborative software package to support both its practices and facilitators. The software provides a repository for information, a means of communication (through online chat, email, and other technologies), and project management capabilities. LA Net uses an online project collaboration tool to support practices' QI work and an interorganizational Twitter-like technology called Yammer to support facilitator-to-facilitator communication while out in the field. The Oklahoma Physicians Resources/Research Network makes frequent use of email lists to communicate and stimulate idea sharing across its practices. Participating practices use them to bounce problems off each other, discuss financial issues, and collaborate on equipment

purchases. Practice facilitators post a "question of the week" based on their work in the field as a means of stimulating discussion and building community across the practices. TransforMed, at the American Academy of Family Physicians, uses a members-only online sharing resource, Delta Exchange, as a way of disseminating resources and supporting cross-practice discussions.

Case Example: The Primary Care Development Corporation's Use of Information Technology

The Primary Care Development Corporation (PCDC), which uses a mix of employed staff and contracted coaches, relies heavily on virtual workspace for organization, motivation, training, and QI activities. A WebEx site functions as the PCDC's virtual office. It is used for a range of activities, from scheduling and simple calendar functions to database and tracking activities. The platform's database function is used to track the progress of work and collect specific data on measureable outcomes from practice sites—including both process and outcome goals. The WebEx site also has a library function. With this, the PCDC stores materials to help staff in their day-to-day work with individual practice site; it also serves as a reference location to store documents for staff reading and professional development.

Coaches fill out report forms on a weekly basis, providing notes on each of their teams. These report templates, as well as final reports, are stored on the WebEx site. Reports are tactically focused; that is, they include specific progress or problems the team is having and specifics on what the coach plans to do to help the team stay on course or overcome barriers. Reports are designed in this way so that coaches don't get wrapped up in the details of the story and fail to synthesize the key points.

The PCDC has expanded the functions and uses of its WebEx site over time. Initially, only the project team used the site, but more recently, they have expanded use of the site to teams at the practice sites. Now, practices are responsible for inputting their own data into the registry and use the site to ask questions and provide feedback via discussion forums. The landing page for the site was redesigned to remind people where they are in their journey and highlight results, share quotations, and motivate staff.

Determine the Physical Space Needs of Your Program

Another important need of PF programs is physical space, a need that varies from program to program. If the facilitation program is serving geographically diverse areas, it may need only a small office for administrative staff, and facilitators may work from offices in their homes or small satellite offices located in their communities. However, larger program with greater administrative needs may require a larger physical space. Locating facilitators as close as possible to practices is both important and useful. Given that facilitators spend a lot of time traveling between practices, making sure that they are close to these practices means less travel time and fewer travel expenses—and also may make for a happier workforce.

Physical space needs also will vary, depending on whether the program is running in-person or virtual activities. If space is constrained or facilitators are dispersed geographically, consider innovative approaches to many of the activities traditionally done in a centralized manner. For example, facilitator training and supervision can be done via Webinars, Internet conferencing, and other types of virtual media that enable facilitators to participate from their local communities, thereby reducing physical space needs. That said, existing programs cite the benefits of in-person meetings; when possible, programs should allow for space for in-person trainings, face-to-face supervision, and physical space for administrative work. This can help build a sense of community and camaraderie among your program staff. Programs with more

physical space can also consider hosting events such as learning collaboratives (depending on the intervention model).

Checklist for Developing a PF Program's Administrative Infrastructure

- ☐ Select an organizational home for your program that aligns with your program's overall mission and goals
- ☐ Identify resources from the organizational home that can support development of your PF program
    - May include funds, existing staff, content expertise, reputation, connections to the community
- ☐ Form an advisory group that includes providers, patient representatives, and other key stakeholders
- ☐ Clearly define program mission and goals
- ☐ Align program mission and goals with other efforts in the region and the needs of the health care community
- ☐ Create a program charter
- ☐ Begin to develop a staffing plan based on program size, approach, and resources
- ☐ Define an IT plan
- ☐ Determine your physical space needs

Practical Resources

- Sample rules for an advisory group
- Sample program charter
- Sample job description for a practice facilitator

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Chapter 3. Funding Your Practice Facilitation Program

Funding is a fundamental and ever-present concern for every practice facilitation program. Who will pay for the program's services? How can a program market itself to potential funders? This chapter provides information on:

- Creating a business plan for your program
- Identifying potential sources of funding
- An overview of typical PF program costs
- Marketing your program to funders

Create a Business Plan for Your Program

Developing a sustainable business model for your PF program is critical. Many such programs are subject to short-term, project-driven funding. Without a formal business plan and vision for how the program will grow and sustain itself over time, it may fail to develop a solid foundation. Ultimately, this may result in a program having substantially less impact on the health care community than it could have if only administrators had developed the structures and mindset that would establish the program as a permanent rather than short-term resource for the surrounding health care community.

Business plans also can help build a culture of long-term, mission-driven programming, rather than work based on project-driven serial funding. PF programs often are housed in academic departments and practice-based research networks, which may not regard PF and similar efforts as having a sustainable infrastructure. Business plans can help to create a long-term vision for your program and help to get program staff, partners/collaborators, and others in the community thinking more about growth and sustainability.

The business plan for your PF program should cover everything from start-up costs and sources of start-up funding to marketing the value of the services it will deliver. What does it actually cost for you to provide support to a practice, and what is the value of your services to potential funders? What will your deliverables be to the practices? To the funders? Some believe that for a PF program to function well and be sustained over time, it must be run like a business, with a tight grasp on overhead and other costs. This can be a significant shift, especially for those used to more academic or research-oriented work. Depending on your background and orientation, you may want to consider hiring a consultant to help you develop a formal business plan.

A typical business plan often includes the following:

- **Executive summary.** What are the mission and goals of your PF program? What is the overall business approach to providing facilitation services?
- **Description of your program and services.** What services are you providing? Why are they useful? How will they improve primary care? What intervention model will you use to help practices reach their goals?

- **Market analysis.** What is the state of your industry and field? What is your target market? What are this market's critical needs? How will you reach your market?
- **Organization and management.** How is your program organized and managed? Include an example of your organizational chart. What is the legal structure of your business? Include brief bios of the key leaders.
- **Marketing and sales strategy.** Who are your customers/clients? How will you reach them with your services? What is your "sales" strategy? How will you price and promote your services?
- **Financial plan.** What are your estimated start-up costs? What will be your projected income statement, balance sheet, and cash flow statement 12 months out? What are the potential sources of funding? How could you diversify your funding sources over time? What are the target levels for short-term and longer-term funding, and how might these change and evolve? What costs do you expect to incur, both fixed and variable? How do revenues and costs compare, and what are the expected profits (or losses) in years 1, 2, and 3?
- **Long-term strategy and implementation plan.** What are your business goals for the program over time and your strategy for meeting them? (For example, when will you start to break even, and how will you achieve this?) What are your proposed timelines for reaching your goals? Which members of the PF team are responsible for meeting which goals? How will you assess your progress?

Develop a Plan for Funding Your Program

You will want to develop a funding plan as you develop your program. Finding start-up funds can be particularly challenging. At this point, most PF programs rely on a mix of Federal, State, and local funds. Most funding available to support PF programs at present is project specific. Typically, this funding is short term, ranging from 1 to 5 years in duration, and focuses on delivery of a specific intervention aimed at producing a prescribed set of outcomes. Sources of project-specific funding include grants and contracts for applied research from Federal agencies, such as the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration, and the Centers for Disease Control and Prevention, as well as foundations. AHRQ, the Robert Wood Johnson Foundation, and the Commonwealth Fund provided some of the early seed funding for development and evaluation of facilitation interventions and programs.

Much more desirable—but harder to find—is long-term funding aimed at supporting the core operations of PF programs. Traditionally, State health departments and the Centers for Medicare & Medicaid Services have been sources for these types of funds. More recently, health plans and large, self-insured employers—which have a lot to gain from improving the way primary health care services are delivered—have begun discussing alternative payment mechanisms as another way to establish permanent quality improvement infrastructure, including PF programs. Such entities thus may emerge as another important funding source. It's also worth noting that a larger number of foundations are beginning to provide core operational support to organizations that have proven themselves effective and responsive to the needs of their communities.

For example, North Carolina and Oklahoma both have facilitation programs that receive funding from their States—Community Care of North Carolina and Health Access Networks of Oklahoma. Similarly, in Michigan, Blue Cross Blue Shield funds a facilitated QI program through its Provider Group Incentive Program. The State of Vermont is developing a robust PF program as one component of a larger effort to transform care—the Vermont Blueprint for Health.

Assessing the advantages and risks of each type of funding. Whether funding is project specific or supports core program operations, it's important to think about who is paying and continually assess the alignment of the funding with a program's goals. You'll need to look at both the specific projects funded and the broader objectives and motivation of the funder—these can have implications for how your program evolves over time and how it may be perceived by the practice community.

Longer-term funding that focuses on program operations clearly is desirable. It enhances sustainability and allows facilitators to realize their full potential as a resource to the health care community, as it allows them to develop and maintain long-term relationships with practices. These relationships can be activated whenever the need arises, eliminating the cost and time involved in developing a new relationship with a practice every time new short-term funding becomes available. This type of funding can be difficult to obtain, however, and often is subject to reductions, such as State budget cuts. For these and other reasons, many programs will need to look elsewhere for funding or complement long-term programmatic support with shorter-term funding tied to specific projects.

> *"There are many possible funding streams, and each may introduce different requirements. This can lead to multiple tails wagging the dog, so you need to be aware of the pros and cons of each."*
>
> *—Ann Lefebvre, North Carolina AHEC Program at UNC-Chapel Hill*

Short-term, project-specific funding may be easier to find than long-term support and can be very useful in helping programs get up and running. It is often the only practical option for new PF programs, and in many cases can be used later to attract additional funding. A number of PF programs have sustained themselves for many years primarily on this type of funding. Short-term, project-focused funding comes with a number of risks, however. One of the biggest risks is that a program will drift away from its core mission because it is pushed in different directions by the interests and priorities of its various funders. For this reason, a program should ensure that short-term projects align with its mission and goals as well as its intervention design. It can be difficult for programs to develop a solid identity and build robust partnerships with other QI stakeholders in the community if they are continually looking for their next source of funding. Programs that rely exclusively on short-term funding may also have difficulty in creating a sense of permanence.

Potential Funders for PF Programs

A number of potential funders of facilitation programs exist, as discussed below. Table 3.1 provides a list of these funders and the types of funding they might provide.

Table 3.1. Potential funding sources for PF programs

Source	Type(s)	Examples
Federal	Longer-term; programmatic; Project-focused	• 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	• Vermont Health Department's Blueprint for Health
Single payers and multipayer groups	Programmatic; Project-focused	• L.A. Care NCQA PCMH Coaching Initiative • Pennsylvania's multipayer collaborative
Philanthropic	Project-focused	• Commonwealth Fund's Safety Net Initiative • RWJF's Improving Performance in Practice (IPIP) • California HealthCare Foundation
Provider organizations and associations	Programmatic; Project-focused	• Primary care associations • IPA in Northern California • Brookings ACO Learning Network
Business community	Programmatic; Project-focused	• Large employers such as IBM • Patient-Centered Primary Care Collaborative • Business coalitions
Advocacy organizations	Project-focused	• Community Health Councils of L.A. partnership w/ LA Net's PF program to improve diabetes care

Federal sources. Federal entities are likely sources for both programmatic and project-focused funding. The Affordable Care Act and its proposed primary care extension program is one potential source of programmatic funding. (See Chapter 1 for more information on this program.) Incorporating facilitation programs into existing HITECH Regional Extension Centers (RECs) and Area Health Education Centers (AHECs) may be another funding source. For example, the North Carolina AHEC program houses a large facilitation program and the State appropriated funds to the NC AHEC that cover approximately 60 percent of the costs of the facilitators. The National Institutes of Health's Clinical and Translational Science Institutes, with their mandate to engage the community, are another potential source of funds—although they mainly focus on evidence translation. Per-member per-month fees through CMS or multipayer initiatives also may be a source of programmatic funds.

Federal agencies are sources for shorter-term, project-specific funds, which have been the bread and butter for many early facilitation programs—including research funding from AHRQ, and research and project funding from HRSA, NIH, and others. For example, the Oklahoma Physicians Resource/Research Network (OKPRN) has maintained its program for more than 15

years through successive project-focused funding from Federal research grants and contracts, State contracts, and foundation funding. More than 90 percent of this funding has come from Federal sources.

State and county health departments. Funding provided by State and county health departments is mainly programmatic and generally has been targeted to the safety net and practices serving high-risk groups. The motivation for channeling State and local funding in this direction is to reduce costs for these populations via reductions in emergency department visits, readmissions, and avoidable hospitalizations through improved self-management, care coordination, case management, and preventive services.

Insurers and health plans. Insurers and health plans also may be interested in funding PF work, especially as the focus on value-based purchasing continues to grow. While some experts originally believed that these sources would be the primary source of funding, single payers are focused mainly on their own enrollees, which conflicts with the notion of the practice-wide interventions typically led by facilitators. To date, funding from single payers has focused mostly on specific projects and initiatives—such as patient-centered medical home (PCMH) recognition through the National Committee for Quality Assurance and implementation of evidence-based practice guidelines—and has targeted their enrollees only.

Multipayer initiatives. Multipayer initiatives—which combine financial incentives for QI across multiple payers to strengthen their effect and get more traction in the provider community—also are emerging as potentially solid sources of both programmatic and project-focused funding for facilitation programs.

Foundations. Foundation funding generally supports project-focused facilitation work. Robert Wood Johnson Foundation, the Commonwealth Fund, and the California HealthCare Foundation were early supporters of facilitation efforts. A number of funders have begun incorporating "venture philanthropy" approaches to funding, in which they invest in strengthening and sustaining the core operations of effective organizations, and allow the organizations and the communities they serve to determine the actual content and focus of their work. This may provide opportunities for longer-term funding for PF programs as well.

Provider organizations. A variety of provider organizations and associations could serve as potential funders of facilitation work. In general, the larger and more established provider organizations may be in a better position to offer financing but also may be more interested in staffing the facilitation work internally. For example, primary care associations might fund facilitation as a resource for their members. Integrated health systems and independent practice associations might be willing to finance facilitation work for their providers and practices, although they may be more inclined to pursue internal facilitation services.

Accountable care organizations (ACOs) also could be a source of funding, but it's still not clear to what extent QI will enter into the discussion and eventual culture and priorities of ACOs. At the moment, this discussion seems to be focused on transitions of care across organizations and creating entities that can provide wraparound services such as care coordination, with relatively little discussion of QI per se. If QI is thought of as part of these wraparound services, ACOs may become a source of programmatic and project-focused funding for PF.

Primary care practices themselves might evolve into a potential funding source. While some experts feel that funding is unlikely to come from practices, others believe this is a real possibility. The likelihood of this will be driven by the "value" the facilitation can provide to the practice and, in particular, its ability to impact the practice's financial viability. It is often not difficult to get specialty practices to adopt new procedures when the procedures come with increased revenue. If payment incentives eventually are aligned to reward improvements in quality through enhanced reimbursement and other financial incentives, individual practices may become possible sources of funding for facilitation services. Moreover, given the requirement by the American Board of Medical Specialties for all primary care disciplines to conduct a QI project in their practices at least every 10 years, clinicians may be interested in using facilitation interventions to meet these requirements (and indeed this has been a major inducement for the practices to *participate* in PF interventions to date). For example, facilitators can assist clinicians with their continuing medical education Part 4 maintenance and certification requirements through developing and working together on a QI project.

Business community. The business community as a whole potentially has the most to gain from improvements in care, and business organizations were key players in recent efforts to promote primary care redesign and the PCMH. Members of the business community are possible sources of funding for facilitation programs and should be included on advisory boards but so far have not played a direct role in funding facilitation programs.

Advocacy groups. Advocacy groups seeking to improve care for vulnerable groups, such as pediatric patients or low-income and minority communities, also are potential funders for facilitation programs. Practice facilitators can be useful partners for these organizations when their goals are to transform care for a particular population or condition. While advocacy groups do not have funding to support PF programs, programs may partner with these groups in joint applications for funding that can support both.

Typical Program Costs and Budgets

PF programs face a variety of fixed and variable costs in developing and implementing their activities. Fixed costs reflect the support a program needs regardless of the number of practices it serves, although the ability to offset these costs may depend on the program's scale. Variable costs represent per-unit costs that vary with the number of facilitators and practices served. Many program directors think in terms of the per-unit metric of facilitation costs per practice, since per-unit pricing is often what funders want to know. Below, we briefly discuss costs per practice and then turn to a general discussion of budget line items, which include both fixed and variable expenses.

Costs per practice. Costs per practice are highly dependent on a number of factors, including the goals of the particular project, the intervention design, the facilitator staffing model (discussed in Chapter 5), and the geography and types of practices being served. The costs of facilitation interventions can range from $7,500 per practice for a 6-month, evidence-based,

practice-focused intervention using a one-to-eight facilitator-to-practice ratio in a rural setting,[5] to $60,000 or more for complex changes focused on total practice redesign.

Costs are higher during the start-up of an intervention—it is during this time that facilitators develop relationships with their practices and get to know their systems, needs, and available resources. Costs decline steeply for future projects with these practices because each facilitator's ongoing relationship with the practice affords efficiency in entering and working with it on successive projects.

Budgets for PF programs. Program budgets are driven primarily by the intervention model and the funding source, although program geography and administrative context also matter considerably. A general principle when developing budgets for facilitation programs is to avoid becoming too top heavy in terms of staffing. Experts suggest that more effective facilitation programs use the majority of their funding in supporting direct service delivery by facilitators.

In addition to costs for core program staff and administrative infrastructure, you should consider other costs when budgeting. The following provides some guidance:

Practice facilitator expense. A practice facilitator's salary is dependent on educational background, amount of experience, and region of the country. Average salaries range from $35,000 to more than $100,000 (plus fringe benefits).

Travel. Travel costs also are dependent on the intervention model and geography. For interventions that take place predominately via distance technologies, such as Web conferencing, travel costs will be less. For programs that use onsite visits and are geographically far apart, requiring facilitators to travel long distances, costs can be substantial. Having facilitators located in the communities they serve is one way to reduce these costs and another reason for emphasizing the use of local facilitation programs. Even in dense urban communities, facilitators can easily travel up to 500 or more miles a week for their work. Some larger programs provide cars for their facilitators, while others reimburse them by the mile. For some, the direct payment of travel is seen as a form of additional income and a perquisite, even though technically it covers the costs of gasoline and wear on their cars.

Funds for physical space. Unless a program uses a virtual approach, it needs to include in its budget the costs for leasing or otherwise obtaining physical space for its staff. In some cases, a PF program's host organization may provide office space for free or at reduced cost.

Funds to support home offices of facilitators. Programs that opt to have their facilitators work out of home offices and commute to practices need to include funds to provide project-based resources for working remotely. These can cover such items as laptops, printers, and basic Internet connectivity.

IT equipment and online resources. Most PF programs use a variety of technologies as part of their core program operations and interventions; such technology helps to reduce costs by

[5] This model assumes that, in the course of 1 year, each facilitator works with eight practices for 6 months and a second set of eight practices for 6 months.

increasing the efficiency of interventions, reducing the amount of travel needed, and lowering the cost of engaging high dollar consultants by eliminating the need for them to travel to a site and making more efficient use of their time. It also can increase the reach, efficiency, and effectiveness of the interventions. As with every other aspect of PF program budgets, this line item will be determined by the discrete factors of each program, ranging from the intervention model to program size.

A program should include funding for either the purchase or leasing of such equipment as laptops, projectors for in-practice trainings, printers, and smart phones. Other needs for your program could include broadband connectivity for facilitators in the field; collaborative software platforms that support work between the facilitator and the practices; data management software; Web-conferencing platforms for delivering facilitation and practice training; and learning communities, listserv capabilities, and Web-based survey programs. Programs also need to make funding available for basic administrative needs, such as off-site back-up of program documents and Web site design and management.

IT support. You also should allocate funds to support the various distance technologies that will be used as part of the PF intervention and to support difficulties facilitators may encounter when accessing data via practice registries, electronic health records (EHRs), and other technologies used in the practices. If the intervention includes the actual installation of these technologies in practices, you will need to fund this, either by providing funds for hiring an employee within the program or supporting a subcontract with an outside organization.

Professional development of the facilitators and project team. Professional development of the staff is an important line item that often is left out of program budgets inadvertently. Facilitators need an opportunity to share their expertise within the program, as well as expand their own skills, knowledge, and awareness of what is taking place in other areas or regions. When possible, you should set aside funds to allow facilitators to travel to one or two conferences a year or conduct site visits to other programs across the country. Sometimes facilitators will be interested in pursuing training in specialized areas, such as self-management support. The pool of funding, however, should be designated for professional development related specifically to developing higher-level skills in QI and should be matched to each facilitator's competencies and professional development plan.

Practice recruitment. You will have a constant need to recruit practices that want to engage in facilitated QI work, especially when reimbursement policies are not yet aligned to encourage direct investment in QI. Recruitment has to be tailored to each practice, depending on its needs, as well as to different members within a practice. For example, clinicians are likely to be interested primarily in the potential impact of facilitation on clinical processes and outcomes. Administrators will be interested in how facilitation support can help them firm up workflows and introduce efficiencies. Accordingly, the costs associated with practice recruitment can be substantial—especially when starting a new program; during startup, this might require up to 50 percent of a staff person's time.

Other program costs. PF programs may have other costs, depending on their intervention design, size, and other considerations.

Expert consultants. Funds should be included for purchasing time from consultants who will provide support to the program's generalist facilitators in areas that require a high degree of

specific expertise. The particular makeup of the expert consultant pool can be anticipated and planned based on the facilitation program and practice community's goals for the intervention, as well as the expected needs of the practices.

Academic "detailer" for QI. It can be helpful to begin your PF interventions with a peer-to-peer/M.D.-to-M.D. visit to build buy-in for the work about to be undertaken, and as an opportunity for the visiting physician to share lessons learned. The PF program also could structure these initial visits so that members of the practice beginning the intervention go on a site visit to an exemplar site. If your intervention model will use this method, make sure to include funding for the physician conducting the detailing visit or the costs for members of the practice to visit the exemplar site.

Funds for practices to conduct site visits. Many agree that seeing the work of an exemplar practice in action is invaluable, as it provides a level of understanding and knowledge not possible just from hearing about another practice's experience. Program administrators should consider setting aside funds to allow staff from various practices to conduct site visits.

Local learning collaboratives. If your intervention model includes the use of local learning collaboratives (a smaller version of more traditional learning collaboratives), you should allocate funds for facilitators to develop and facilitate these sessions. This funding should include a budget for meeting space, food, audiotaping, and—when appropriate based on the model—faculty.

Program communications. Some larger facilitation programs include funding for communications staff who do program writeups and develop program and promotional materials and the program's Web site, among other things. In some cases, these positions are pivotal to the program and provide "back-office" support to the facilitators when they need to prepare program documents and presentations. Experience in working in virtual environments can be a plus for these positions.

Market Your Program to Funders

If you build it, they will not necessarily come. You will need to conduct marketing and outreach to potential funders and purchasers of your services. As part of the business plan you develop as you start up your program, you will need to conduct a market analysis and develop a detailed marketing plan. It will be important to identify those organizations in your community most likely to fund your program and its services, and to understand how the services you provide line up with the mission and goals of these organizations, as well as those of other QI programs in the area.

It is important to develop strong promotional materials about your program and its services. These materials can be used not only to increase funder awareness of your program, but as outreach materials to the practices you will support. These materials provide an excellent opportunity to share the results of any assessment or evaluation you have done of your program's impact, as well as well-crafted summaries of existing evidence supporting the effectiveness and value of PF for primary care transformation. Case examples and statements from primary care providers and administrators who have worked with your facilitators can also go a long way in helping funders understand the value your program brings to the community.

Your Web site will be another important marketing tool, and more progressive programs are exploring the value of social networking sites as a way of making others aware of their program and its services. Health plans, State and county departments of health, community advocacy groups, integrated health systems, ACOs, local foundations, RECs, CTSIs, universities, and the practices themselves are all potential purchasers of PF services. Materials should be developed with these audiences in mind. Many of the groups you will seek to reach may not be familiar with PF as a resource for QI. There are significant differences and advantages that PF holds over more traditional approaches (such as consulting) by merit of the relationship-driven and long-term structure of PF; these may not be immediately obvious to funders and you will need to spell them out.

As you develop your marketing and outreach plan, the ability to leverage the good reputation of the PF program's host organization can be invaluable. A well-recruited advisory board can also be quite useful.

Checklist for Funding and Marketing Your PF Program

☐ Create a business plan for your PF program

☐ Create a sample budget for your program that incorporates key line items related to your program model

- Consider how line items may change over time

☐ Identify likely funders and create a funding plan

☐ Develop marketing and outreach materials that illustrate the unique advantages of PF as a resource for practice transformation

Practical Resources

- Business plan generator and template
- Sample marketing brochure

Chapter 4. Developing Your Practice Facilitation Approach

One of the most important steps in creating your practice facilitation (PF) program is developing your approach or strategy for how you will engage and work with practices. There are many factors to consider. For example, some facilitators provide support onsite at the practice, while others deliver support using video conferencing and other distance learning technologies. Some programs use a very intense but short schedule, in which facilitators are onsite all day every day for a month. Others who work with smaller practices believe that such an intense schedule can overwhelm a small practice and so opt for one that is less intense, involving weekly encounters but lasting as long as 12 months. In some PF programs, a facilitator works independently. In others, the facilitator heads a multidisciplinary facilitation team. You will need to consider these and many other dimensions when developing your PF approach or strategy. Ideally, your decisions will be based on best practices in the field of facilitation. To some extent, they also will depend on a number of other issues—including your overall program goals, your theory of practice change, the priorities of your funders, the amount of funding available to support your program, the goals of the practices you're serving, and alignment with efforts already underway in your area's health care and quality improvement (QI) community.

This chapter provides information that can help you make important decisions about developing your PF approach or strategy, including:

- Creating a key-driver model
- Incorporating a variety of QI approaches and strategies
- Deciding whether to use a team or individual PF approach
- Outlining the stages of your strategy and key activities for each
- Deciding on the dose and schedule
- Deciding on the location of the services (onsite or remote)
- Determining the ratio of facilitators to practices
- Defining the role and core activities of your facilitators
- Determining criteria for selecting practices to participate

For those interested in theories of practice change, we briefly review three theories frequently used in QI and PF in Appendix A.

Create a Key-Driver Model for Your PF Intervention

Facilitators can engage in hundreds of useful activities in a practice. Many of these may be useful but do not necessarily "move the needle" in improving quality of care or transforming practices into patient-centered medical homes (PCMHs). A key-driver model can help to keep your facilitators and their practices focused on "high-yield" activities likely to produce the desired outcomes. A key-driver analysis (sometimes called importance-performance analysis) is frequently used in business to define relationships among factors that contribute to a desired outcome, in order to identify the most important ones.

Key-driver models, which are similar to logic models, define the pathway to the desired transformation. Key-driver diagrams graphically display the strategies and activities needed to achieve goals and aims of the practice improvement effort (see DeWalt, Powell, Mainwaring, et al., 2010). The diagrams include the specific outcomes you want to accomplish with the intervention, such as increased annual foot and eye exams and improved patient hemoglobin A1c; the key organizational and care processes believed to drive these improvements and that result in the desired outcomes (key drivers); and specific steps toward creating these changes (change concepts). Together, these elements form a key-driver model that will focus your facilitators and their practices on the five to eight high-yield changes likely to result in the desired outcomes. They can be developed at both the practice and program levels.

A good key-driver model and diagram can help to keep you and your facilitators focused on those activities likely to result in significant improvement in a practice. It also can help guide decisions about the content of your PF training, which should prepare your facilitators to implement the key-driver model, provide a roadmap for evaluating the progress your practices make over the course of an intervention, and introduce a shared vocabulary and set of change concepts for your facilitators and their practices, thus supporting clear communication between them.

Developing a key-driver model is a useful first step in designing your PF intervention. The models developed by IPIP and the SNI can serve as points of departure in developing one for your own program, as can similar models from other QI interventions.

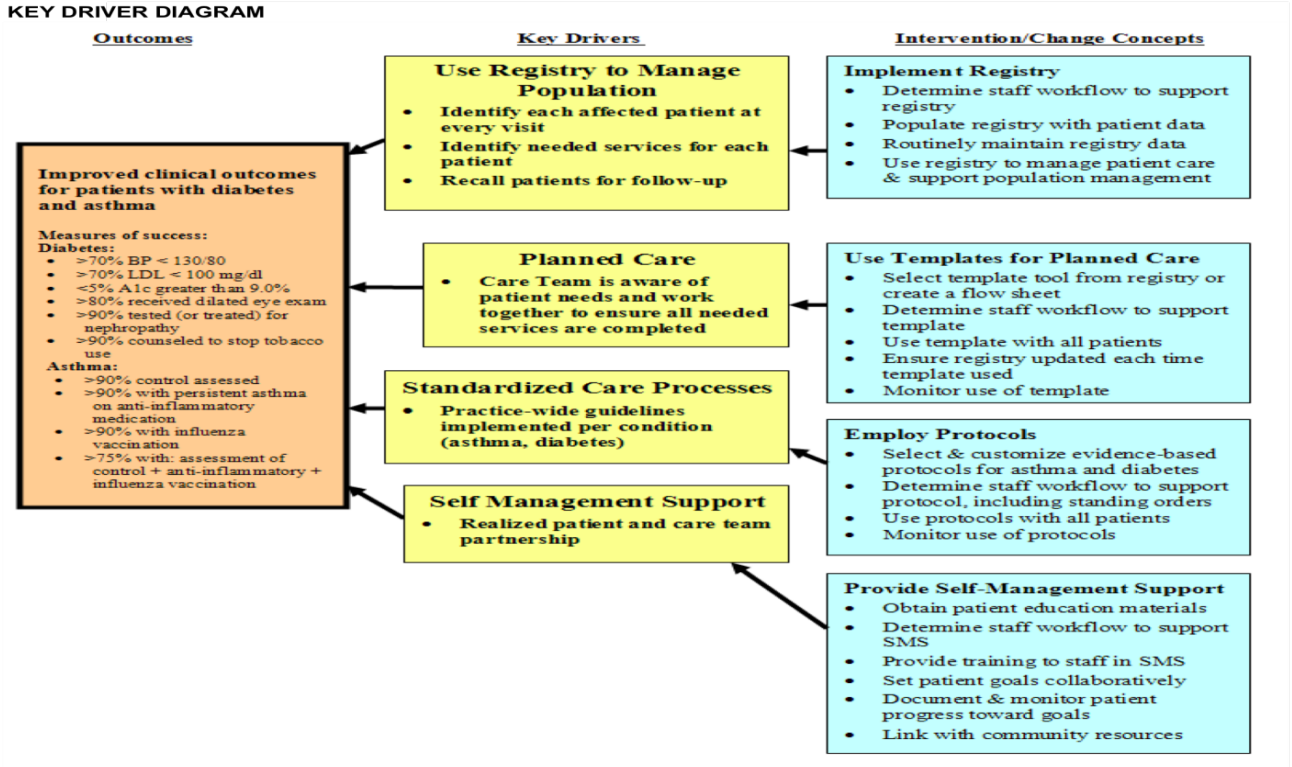
As you develop your key-driver model, one aspect to consider is how prescriptive vs. self-directive your intervention will be. Most program directors and facilitators agree that practices benefit most from interventions that have clearly prescribed outcomes, key drivers, and change concepts, but that allow them some flexibility in how they go about implementing the change concepts. Practices vary in the degree to which they want to own and develop their own methods and strategies for implementing these and to what extent they prefer the implementation process itself to be prescribed by the PF intervention. In large part, it will be up to the facilitator to fit the degree of prescriptiveness versus self-direction to the culture and needs of each practice. Practice facilitators need to know how to manage both types, and your intervention design should be able to accommodate and provide paths for both.

Two Examples of Key-Driver Models

Improving Performance in Practice (IPIP) created a key-driver model to guide the work of QI coaches and practices. The IPIP model consists of four key drivers of improvement—use of registries to manage populations, planned care, use of practice guidelines, and self-management support—that, once achieved, are expected to produce the desired improvements in quality of care for diabetes and asthma, and improved patient outcomes. Each key driver then is broken down into the "intervention or change concepts" needed to attain a particular key driver. The facilitators focus their work with the practices on implementing the change concepts and attainment of the key drivers (DeWalt, Powell, Mainwaring et al., 2010). Figure 4.1 provides an outline of the IPIP key-driver model.

Another example of a key-driver model is one used in the Safety Net Medical Home Initiative (SNI). The SNI identifies eight key drivers of improved outcomes and related change concepts. Figure 4.2 provides an overview of this model.

Figure 4.1. Key-driver model from Improving Performance in Practice



Source: Improving Performance in Practice change package. See www.ipipprogram.org.

Figure 4.2. Key-driver model from the Safety Net Medical Home Initiative

1. Empanelment	2. Continuous and Team-Based Healing Relationships	3. Patient-Centered Interactions	4. Engaged Leadership
PCMH practices: • Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental, or additional services. • Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need. • Understand practice supply and demand and balance patient load accordingly.	• Establish and support care delivery teams. • Link patients to a provider and care team so both patients and team recognize each other as partners in care. • Ensure that patients are able to see their provider or care team whenever possible. • Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members. • Cross-train care team members to maximize flexibility and ensure that patients' needs are met.	• Respect patient and family values and expressed needs. • Encourage patients to expand their role in decisionmaking, health-related behaviors, and self-management. • Communicate with their patients in a culturally appropriate manner in a language and at a level the patient understands. • Provide self-management support at every visit through goal setting and action planning.	• Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change. • Establish and support a QI team that meets regularly and guides the effort. • Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care, consistent with the medical home model. • Build into staff hiring and training processes the practice's values for creating a medical home for patients.

Figure 4.2. Key-driver model from the Safety Net Medical Home Initiative *(continued)*

5. QI Strategy	6. Enhanced Access	7. Care Coordination	8. Organized, Evidence-Based Care
PCMH practices: • Choose and use a formal model for quality improvement. • Establish and monitor metrics to evaluate improvement efforts and outcomes; ensure that all staff members understand the metrics for success. • Obtain feedback from patients/family about their health care experience and use this information for quality improvement. • Ensure that patients, families, providers, and care team members are involved in QI activities. • Optimize use of health information technology.[a]	• Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits. • Provide scheduling options that are patient- and family-centered and accessible to all patients. • Help patients attain and understand health insurance coverage.	• Link patients with community resources to facilitate referrals and respond to social service needs. • Provide care management services for high-risk patients. • Integrate behavioral health and specialty care into care delivery through co-location or referral protocols. • Track and support patients when they obtain services outside of the practice. • Follow up with patients within a few days of an emergency room visit or hospital discharge. • Communicate test results and care plans to patients/families.	• Use planned care according to patient need. • Use point-of-care reminders based on clinical guidelines. • Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

Source: Developed as a reporting tool for practices in the MA PCMH-I and SNMHI. More information about the SNMHI is available at: www.qhmedicalhome.org/safety-net.

Incorporate a Variety of QI Approaches in Your PF Intervention

As you design your PF approach, you should consider what additional improvement strategies you will use in concert with PF. In general, experts suggest that PF interventions that use a variety of strategies are likely to be the most effective.[6] The use of multiple strategies may be particularly important for improvement work focused on practice transformation, as opposed to more narrow or targeted changes, such as implementation of practice guidelines.

> *"It's important to realize that practice facilitation alone is not enough in many cases to produce the changes we are after. Practice facilitation should occur in the context of other efforts and strategies such as payment reform, benchmarking, and academic detailing, among others."*
>
> *—Dr. James Mold, OKPRN*

[6] Recent work suggests that a multicomponent intervention strategy consisting of performance feedback, academic detailing, a practice facilitator, and health IT support was more effective than interventions that using fewer components in implementing evidence-based preventive services delivery processes for adults and children (Mold, Aspy, and Nagykaldi, 2008).

Some strategies that are often included as part of PF interventions and are either delivered or coordinated by the facilitator are described below.

Academic detailing. This approach involves peer-to-peer education and is one of the more common approaches to QI. It has been shown to change certain behaviors successfully (O'Brien, Oxman, Davis, et al., 2000). While academic detailing originally was developed for pharmaceutical marketing and used to improve inappropriate prescribing patterns in physicians (Soumerai and Avorn, 1990), it has been adapted for improving other aspects of care. This method is used mostly to share information about what seems to work for others in similar types of practices. Broadly speaking, academic detailing includes (1) using market research/focus groups to discern provider motivations for behavior; (2) using a physician educator to establish credibility; (3) targeting high-potential physicians (in the case of prescribing, based on utilization data); (4) involving local opinion leaders or early adopters to influence their peers; (5) presenting both sides of the issue, so that the counterargument can be disproven proactively; (6) repeating a few key points; and (7) using graphic materials.

Facilitators can help identify providers with the right experience who can deliver the academic detailing and then arrange these visits for practices at the start of a PF intervention. This can be an effective way to increase practice buy-in to the PF intervention and identify a practice's first goals. The facilitator may arrange academic detailing visits throughout the course of the PF intervention when the visits are needed to provide information to a practice on a particular topic. Academic detailing can occur in person at the practice, through video-conferencing, or through providers and staff participating in site visits to exemplar practices.

Facilitators may help to set up peer-to-peer learning sessions. While they could not provide academic detailing, they may be the liaison to such sources that the practice does not know about. In this way, the facilitator does indeed facilitate on behalf of the practice to ensure that it is receiving the tools it needs to reach its improvement or transformation goals.

Audit and feedback. Audit and feedback involves providing health care professionals with data about their performance that can help them improve. In audit and feedback, a practice is compared with itself over time. Data are collected on key process and patient outcome indicators are collected on the practice and then tracked over time to assess improvement. (For more information, see Jamtvedt, Young, Kristoffersen, et al., 2006.)

Facilitators can use audit and feedback as part of an initial assessment of a practice at the start of a PF intervention. They can use the data to help the practice set goals for the intervention and track improvement over time. Facilitators may see the capacity to carry out regular audits as a critical part of ongoing QI and so identify it as a key capacity for the practice to develop.

Benchmarking. Benchmarking provides clinicians with specific feedback on their performance in comparison to national standards and other practices and providers. It is based on the premise that primary care clinicians tend to overestimate how well they deliver services and thus need solid feedback (Mold, Aspy, Nagykaldi, et al., 2008). Some studies have found that benchmarking can have a greater effect than traditional audit and feedback approaches (Hysong, 2009). It uses mathematical calculations to compare performance across practices and also provides improvement goals for them (for example, achieving the 90^{th} percentile). Benchmarking uses data collected from a practice—often from either a patient registry or chart audits—to make these calculations. This could include measuring processes of care (for example, whether foot

checks or routine tests of HbA1c are performed among patients with diabetes) or outcomes (such as actual values for those HbA1c tests).

Facilitators can support and use benchmarking in ways similar to audit and feedback. They can help a practice gather and benchmark practice data as part of an assessment of the practice at the start of a PF intervention, help the practice use the data to set improvement goals, and use the data to track progress over time.

Collaborative learning groups. Collaborative learning groups, also called learning collaboratives, take place when a relatively large number of practices come together in a central location to receive training, periodically evaluate performance, and work individually and collaboratively to implement changes over time. Bringing the practices together creates positive peer pressure for change and also provides a forum for sharing lessons learned across groups.

Local learning collaboratives are similar to collaborative learning groups but involve fewer practices and take place in the local community. They can be more feasible for smaller practices because they do not require extensive travel and their meetings usually are shorter but more frequent, often occurring at lunch time (Aspy, Mold, Thompson, et al., 2008). Both traditional collaborative learning groups and local learning collaboratives have been effective in supporting QI and practice transformation in primary care practices.

Facilitators can interact with collaborative learning groups and local learning collaboratives in two ways. They can provide supplemental and between-session support for a collaborative learning group initiative and can support implementation of learning by helping practices to synthesize and integrate messages to the specific needs of their practice. Facilitators also can initiate and facilitate a learning collaborative as part of a PF intervention they are leading in multiple practices.

Examples of Learning Collaboratives

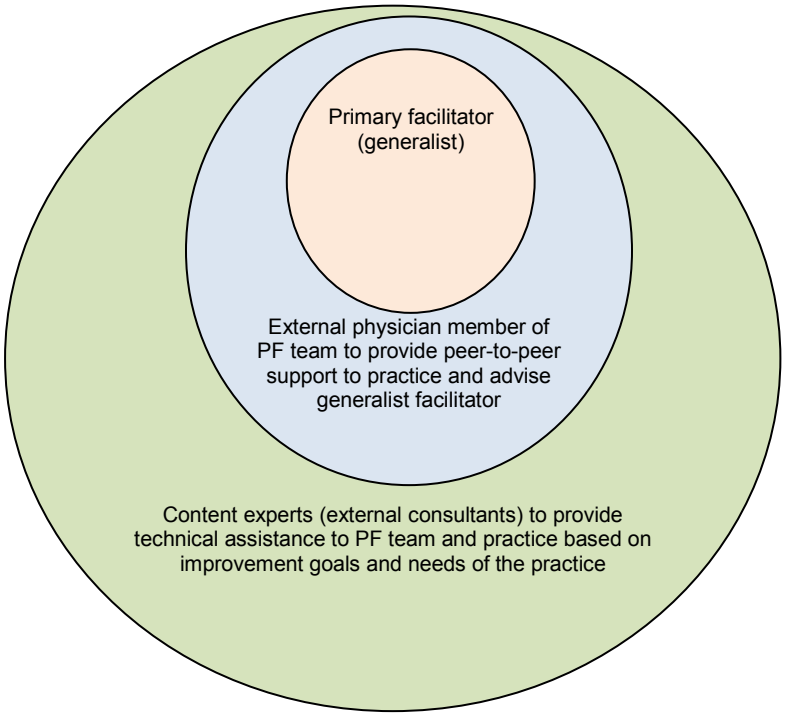
The **Community Health Care Association of New York State** (CHCANYS) and the **Primary Care Development Corporation** (PCDC) have developed a learning collaborative that brings together 12 safety net primary care practices serving more than 125,000 patients. The collaborative's goals are to help these practices achieve meaningful use of Electronic Health Record certification and PCMH recognition. This transition can be challenging for practices, which often need to shift operations, workflows, and patient communication processes (PCDC, 2011). The learning collaborative and the associated practice facilitation activities are resources that can give practices the knowledge and tools they need to achieve these recognitions/certifications.

Quality Counts! is a PCMH pilot program sponsored by the Maine Quality Forum and the Maine Health Management Coalition. Starting in 2009, 26 primary care practices began implementing the PCMH model, with the ultimate goal of having every practice in the State adopt this model of care. As a part of this initiative, the program offers practice support, both in the form of learning collaboratives and a network of "quality improvement coaches," or practice facilitators. Learning sessions bring together representatives from each of the participating practices, as well as consumers and community partners. Each session focuses on a different relevant topic, and materials from the sessions are made publicly available on the program's Web site (Maine Quality Counts! Web site, 2011).

Decide Whether You Will Use a Team or Individual Approach to PF and Form Your PF Team

You may opt either to use a team approach to PF or an individual facilitator to deliver your intervention. In the team approach, the generalist facilitator and a PF physician typically make up the core of the PF team. In some cases, the PF team consists of the generalist facilitator and the PF physician only. Other team members can be added based on the goals of your intervention and its key drivers. For example, depending on your program's goals, you may want to use an expert on electronic health record implementation or advanced access or one on the management of a particular clinical condition and its recommended guidelines. The generalist facilitator should assemble and coordinate the team based on each practice's unique needs. The PF physician also should be central to the team, be available for the first meetings with the practice, and assist the facilitator in troubleshooting when he or she encounters barriers to improvement at the site. Figure 4.3 shows the typical makeup of a PF team.

Figure 4.3. Generalist facilitator coordinates members of a PF team



In the individual PF approach, the generalist facilitator mainly works independently of other professionals, and the focus is on the types of support the facilitator is able to deliver independently on his or her own. An individual facilitator may be more effective with small tightly knit, family-like practices that have few interactions with outsiders or practices that value established relationships. In these practices, developing a one-to-one trusted relationship with the facilitator may be more effective in engaging the entire practice "family," such as in small rural practices. This relationship also may be useful when practice change is in response to outside requirements rather than internal values—changes that may be necessary but nonetheless feel forced upon the practice—and the practice may be prone to view a team as "outsiders." Another instance is when the practice change involves help with standard practice functioning, for which

most facilitators have a solid base of knowledge and experience (for example, many of the structure and processes of delivering primary care).

Individual approaches are particularly useful in practices for which a team approach might be intimidating. Logistically, individual facilitation models are easier to implement and manage, and may be less expensive to operate. Also, an individual facilitator can develop a relationship with reluctant staff and leadership in practices that might not be as ready for transformation and then wait until the practice is ready to engage in more extensive work.

The drawback to individual PF models is that the range of support and expertise the facilitator can provide to the practice is limited. It is unrealistic to expect that any single facilitator will have all of the content knowledge and expertise a practice needs to engage in substantive transformation. A lone facilitator also may be more prone to burnout and become more easily embroiled in the dynamics of the practice he or she is helping, possibly resulting in a loss of objectivity and effectiveness.

In the team PF approach, a similar set of advantages and disadvantages exist. This may be most effective for larger practices or in situations in which the changes are more complex or require a wide range of expertise and deep technical assistance. Team coaching may be more effective in these instances because a group of facilitators is more likely than an individual to possess all of the knowledge and skills necessary to support the range of changes a practice might need. Establishing a team model is more than using a team of facilitators to work with a practice; it also involves setting up the infrastructure behind the facilitators and supporting their knowledge base. Team approaches to coaching create a reservoir of knowledge from which a facilitator can draw over the course of his or her work with a practice.

There are several benefits of a team approach to PF. First, it builds internal capacity for your organization. As practice facilitators work with content experts on high-complexity changes, they will build their own knowledge and skills in these areas and may acquire sufficient knowledge and skills over time to be able to dispense with expert consultants. Second, acquiring new knowledge can be rewarding to facilitators and provide a means for them to enjoy ongoing professional development. Finally, a team approach can reduce feelings of isolation and burnout for an individual facilitator and, when well designed, can give an enhanced range of support at a cost similar to that of an individual facilitator model.

Potential drawbacks to team approaches are the greater logistical challenges they present in forming and managing them, the potential for higher costs, and the possibility that the relationship of the practice with the lead facilitator could be compromised if the timing and interaction with the team is not well managed.

Role of the generalist facilitator on the PF team. The generalist facilitator should assemble and lead the PF team and serve as the practice's primary contact with the team. The generalist facilitator provides the majority of support to the practice in collaboration with the PF physician and brings in expert consultants on an as-needed basis for a limited period of time to provide highly specialized knowledge and skills.

> *"A generalist [facilitator]…is the primary point of contact, or the orchestra leader.… And then we have other resources that we call on when they need something deeper and more intense…a toolkit of resources for when…more evolved practices know enough to know what other depth they want."*
>
> *—Allyson Gottsman, Health TeamWorks*

Role of the physician on the PF team (PF physician). A physician is an essential member of a PF team, who helps ensure that the work of the PF team keeps the needs of clinicians and the realities of clinical care at the center of the PF intervention. The PF physician is an employee of or consultant to your PF program and is typically not a member of a practice with whom you are working. Rather, he or she works as a member of your PF team for all of the practices your PF team is supporting. His or her role is to assist in the start-up of a PF intervention at a site with a peer-to-peer exchange with practice leadership about the PF support process and its goals, serve as a resource to the generalist facilitator as he or she goes about working with the practice, and when he or she encounters problems with follow-through by physicians at a practice over the course of an intervention.

Finding the right PF physician(s) for your program and intervention team is important. The PF physician may be someone you recruited to serve on your advisory board and so has a deep knowledge of your program and its mission, methods and goals, and also would be able to provide feedback to you and the advisory board as a result of his or her participation on your PF intervention team. Another source for PF physicians comes from practices that you have supported in the past. Physicians who emerge as QI leaders as their own practices participate in a PF intervention can be an excellent source for PF physicians for your larger program.

It is important to provide training and support to your PF physicians and ensure that they have an inclusive approach to practice improvement that supports participation of all types of clinicians and staff from a practice in the improvement efforts, and has a commitment to capacity building and empowerment of personnel in these areas. You should budget funds for the PF physician's training as a member of the PF team, his or her time and travel for peer-to-peer exchanges at the first sessions with practices, time to advise and brainstorm with the facilitator about the needs of a particular practice site, and for additional support for practices where the generalist facilitator encounters difficulty obtaining or maintaining the engagement of physicians at the practice.

Case Example: QIIP's Champions (PF Physicians)

QI Champions in the Quality Improvement and Innovation Partnership (QIIP) are people from Ontario primary care practices—usually family physicians—recruited to play an ambassadorial or faculty consultant role with their peers. QIIP developed a cadre of QI Champions as part of a strategy designed to help increase the interest and uptake of QIIP initiatives by other primary care practices. This approach also aligned with the overall goal of increasing capability and capacity for QI in primary care in Ontario

(that is, a "made in Ontario" approach that reflected the health care delivery system in the province and the experiences of local practitioners while decreasing reliance on external experts).

QI Champions were individuals on primary care teams who had participated in a QI initiative (that is, a learning collaborative) and had direct experience in applying the methodology and seeing sustained clinical process or outcome improvements in their own settings. These people often were identified by QI Coaches based on their experience in working directly with them. Important traits considered essential for QI Champions include an understanding and application of QI methodology; the ability to link their direct experiences to QI principles and broader change concepts; demonstrated performance improvement, including regular measurement in their own practice settings; regard/respect from their peers; and excellent presentation skills. Champions were used as guest speakers at subsequent learning sessions, linked for one-to-one phone consultation or presentations to interested peers, or videotaped, to provide compelling and concrete examples to new teams. An example of a QIIP QI Champion can be seen on this clip of Dr. Cathy Faulds, available at the Learning Community Web site: actiongroup.qiipvideo.ca/flv/office_redesign.html.

In addition to their role as ambassadors for QI's potential to transform primary care, QI Champions also were used to answer questions and deal with some of the natural skepticism often present when primary care practitioners first are exposed to such QI concepts as advanced access and moving to same-day appointments. A QI Champion perceived as a peer can relate to the potential hesitancy of a colleague ("I was there, too"), provide specific examples based on his or her own experience, and deal with some of the details related to the clinical and business case beyond the scope of a QI Coach.

Role of the content expert(s) on the PF team. A content expert possesses deep knowledge of and skills in highly technical or complex changes that are beyond the scope of the generalist practice facilitator and the PF physician to support. For example, such experts provide support for the activities involved in implementing EHR systems or advanced access. The generalist facilitator is responsible for identifying and enlisting the help of expert consultants as needed and for structuring encounters with them to maximize benefits while reducing costs.

The content expert is usually hired as a consultant to your program and a particular PF team and participates for a short time—sometimes only a few, carefully curated hours—to provide the required expertise to the practice and facilitator. For example, the facilitator might coordinate a meeting between the practice and the expert using Skype and then facilitate the session to ensure that it addresses the practice's needs. This can lower the cost of the consultation dramatically by eliminating travel time and associated costs and ensuring a consultation focused on practice needs.

The facilitator can do much if not all of the preliminary leg work that might otherwise be done by the expensive expert, again reducing costs. An added benefit is that, over time, the facilitator's own knowledge of the specialized area will grow as he or she works with the consultant. Thus, the need for the consultant will diminish as the facilitator's expertise increases—another potential source of savings.

While content experts can be an essential part of a PF team, their use presents some special challenges and must be managed carefully to prevent disruption of the primary facilitator/practice relationship. First, whenever possible, you should not bring in content experts until after the generalist facilitator has developed a solid relationship with the practice. Introducing additional people too quickly can confuse or overwhelm the practice and disrupt its primary relationship with the generalist facilitator. Second, the facilitator should take care not to

overuse content experts—this can result in the expert becoming the central figure in the practice transformation, supplanting the work of the facilitator. When this occurs, it can affect the facilitator's ability in the future to engage with the practice and result in an intervention that is more consultative than facilitative.

The Oklahoma Physicians Resource/Research Network (OKPRN) PF program for example, encourages its facilitators to limit their use of content experts in a practice to 10 percent or less of the total intervention time. OKPRN does this to ensure that the facilitator—not the expert consultant—retains primary responsibility for the intervention and serves as the main resource for the practice.

Table 4.1 lists types and examples of content experts that might be needed.

Table 4.1. Types of content experts that might be needed to support a facilitation team

Category	Examples	Type of expert team member
Clinical	Disease-specific, evidence-based practices (such as diabetes, asthma, and depression) New treatments	Specialists in disease-specific areas and primary care experts who understand issues related to managing complex chronic disease and comorbidity (vs. a disease specialist who might not understand the unique aspects of management in primary care practice settings and some of the issues related to social determinants)
Structure and processes of delivering care	Advanced access Team-based care Group visits Panel management Integrated mental health services Integrated systems Meaningful use Patient safety	Consultants with expertise in key areas
Finances	Billing Contracting Pay for performance Grant writing	Billing and practice finance experts
Health IT	Registry implementation and optimization EHR implementation and optimization	Experts in health IT and meaningful use
Accreditation processes	PCMH certification (National Committee for Quality Assurance [NCQA], Joint Commission, others)	Experts in certification/ accreditation

Patients and families as members of the facilitation team. Consumers bring vitality to a practice's QI team. A practice interested in becoming recognized as a medical home will need to address patient and family engagement and, in some cases, establish a family council or similar means of eliciting input. For these reasons, facilitators should help practices think about how to engage families and patients. The goal is to identify and engage consumers—either parents of

patients, adult patients, or family caregivers—to become team members and work on improvements, thereby constantly adding a consumer perspective.

Some innovative PF programs include members of the patient community on the facilitation or QI teams, either at the practice or by training them to serve as facilitators themselves. This can be particularly effective when the issues are highly compelling to patients and a natural and motivated constituency exists. Pediatrics is a good example. Parents of children with serious illnesses or disabilities are natural advocates and highly motivated, and can become potent and highly effective practice facilitators. Other groups with motivated patient communities include those who care for low-income families. In these instances, community-based organizations and advocacy groups might be sources of effective practice facilitators and advisors for the PF team. These individuals have intimate knowledge of the community and its needs, and may be able to assist in identifying community members willing to participate on a PF team. Similar to community health workers or *promotores* (people from the community trained to deliver public health interventions), members of the patient community and the practice—with appropriate support and training—can become effective partners in practice transformation. This kind of help can be particularly compelling and useful because the community resident comes with knowledge of and a perspective on the needs of the community not always available either to the practice or the professionally trained facilitator.

Practices often resist the idea of involving patient representatives on a QI team to help with the change process, as opposed to using them later, when the practice is operating well. Facilitators will need special training and skills to help practices engage patients representatives. Several PF programs across the country have been successful and can be a source of lessons learned for your program. One program director related a story that illustrates the value of including patient representatives on a QI team early in the process. In this case, the parents of children attending a pediatric practice were participating on the QI team.

> A discussion came up about improving the waiting room. The practice staff were focused on how they might beautify the space and improve the play area for the children, but the parents insisted that the first thing they needed to do was improve the accessibility of the waiting room for their patients with physical disabilities. Practice staff were surprised at these statements and insisted that the building was very accessible. The parents proceeded to share that while the building itself had ramps and automatic doors, the entry into the waiting room did not, and that it was very difficult for them to navigate the entry way into the waiting room with their children's wheelchairs. Upon hearing this, the staff and providers at the meeting were stunned. They had never realized this was a problem. They always entered the practice by the back door.

Facilitators must be skilled in creating a vision for patient involvement on the team, building the case, and addressing resistance to the idea. Facilitators also should understand that some consumers are more easily engaged than others. For example, as discussed above, parents of young patients often are very motivated, but adult patients with multiple comorbidities are likely to have more constraints on their time and must manage their health needs. In the latter case, the facilitator must be more flexible or persistent in soliciting these patients' ongoing engagement.

Once consumers agree to take on this participatory role, they also need support. Based on the experience of program leaders, practices may benefit greatly from consumer participation—

especially by patients and families within the practice—but it can be an intimidating for many consumers. Training a group of consumers to participate and providing specialized support to the members can help. A number of resources are available to assist programs that want to do this. (For example, see Scholle, Torda, Peikes, et al., 2010.) Additional resources can be found in Appendix B of this document.

Case Example: Facilitators can become "junior experts" in specific areas over time

In Pennsylvania and Massachusetts, Sixta Consulting uses a generalist facilitator. She is the primary assigned facilitator for her own teams; she pulls in content experts, who provide support in areas such as electronic medical records (EMR) and patient registries. The generalist facilitator knows what her teams are doing and prioritizes and schedules appropriately. While generalist facilitators have a broad set of skills, many may develop an interest in specific areas, such as NCQA recognition programs, patient-centered care, or motivational interviewing. The program director reports that facilitators really want to grow in their role and are encouraged to take on such specific areas in a way that does not compromise their role on the team or overwhelm them. Encouraging and supporting facilitators in their professional development is important to their job longevity and satisfaction; they enjoy this learning and feel good about their own growth.

Outline the Specific Stages of Your PF Intervention and Key Activities That Will Take Place During Each Stage

PF interventions pass through distinct phases. You should define the stages of your particular PF intervention and the key activities at each stage. Most interventions move through six basic stages: recruiting practices; startup of the intervention; assessment and goals setting; active facilitation; holding the gain; and completion and maintenance.

Stage 1. Practice Recruitment and Initial Practice Readiness Assessment

This stage involves the first contact with a practice to discuss participating in a PF intervention and an initial assessment of its readiness for change.

During this stage, the PF program director, facilitator, or funder may contact the practice and invite it to participate in the intervention. They may provide the practice with a flyer describing the intervention and its aims, and also conduct a preliminary assessment of its readiness to participate and how well the intervention fits the practice. Several tools are available for assessing a practice's readiness to improve, but most are designed mainly for use in research rather than for practical applications. You should determine what criteria you will use to select practices for inclusion in a PF intervention and what constitute "readiness." Examples of commonly used criteria for assessing practice readiness include:

- Investment of practice leaders in improving the practice
- Willingness of practice leadership to set aside time of staff and providers to participate in the intervention
- Presence of a practice physician who will be a champion for the PF intervention
- Presence of effective leadership

- Absence of a disruptive level of organizational stress or disruption

This initial or early contact can take place by phone or video conference or in person. In some instances, it may happen predominately through written announcements.

For this stage, you might want to have a basic brochure available that describes the PF intervention and outlines expectations for the practice and your facilitators, a basic timeline, anticipated benefits to the practice, and the intervention's alignment with other priority activities in the health care community. This stage may last from 1 day to several weeks.

Examples of common activities during Stage 1 include:

- Invitation to participate in the PF intervention
- Provision of a written description of the PF process and general expectations and roles
- Preliminary and often informal assessment of practice readiness to improve

Stage 2. Orientation to the Project, Completion of Paperwork, and Practice Team Formation/Engagement

During this stage, the facilitator and PF physician meet with the practice leadership and initial practice improvement team. It is important that this meeting take place in person, if possible. A typical length for the meeting is 60 minutes. It should include academic detailing by the PF physician. This can help build the practice leadership's ownership of the project and provide an opportunity for the physician to share a success story of implementing similar changes in his or her practice. Treating this first meeting as a type of academic detailing session can go a long way toward eliminating any concerns by the practice regarding the intervention's relevance or the competence of the facilitator.

Other agenda items for this kickoff meeting should include identifying preliminary improvement goals for the practice, identifying potential members of the practice improvement team, and completing paperwork. This can encompass memoranda of understanding, business agreements, and Federalwide Assurance forms and consents if the intervention will include a substantial evaluation component or is part of a research effort. Another very important activity during this stage is orienting the practice on how to use a facilitator, clarifying expectations of what can and cannot be accomplished through facilitation, and outlining the practice's responsibilities and roles in the process. A sample agenda for the orientation meeting is provided in Table 4.2.

Participants from the practice should include the medical director and other practice leadership as well as the practice staff and providers who will participate on the team. This might include the clinic manager, a key provider, IT staff, or a medical assistant or registered nurse. The makeup of the practice improvement team should be determined by the aims of the intervention and include diverse representation from the practice. Formation of this team is a critical point in implementing the PF intervention.

In some instances, medical directors may indicate that they will handle the project on their own, or that only physicians will be invited to serve on the team if it is clinically focused. This is

a first opportunity to intervene with the practice and help them to think more broadly about the improvement effort and include representatives from all areas of the practice that might play a role in the targeted transformation.

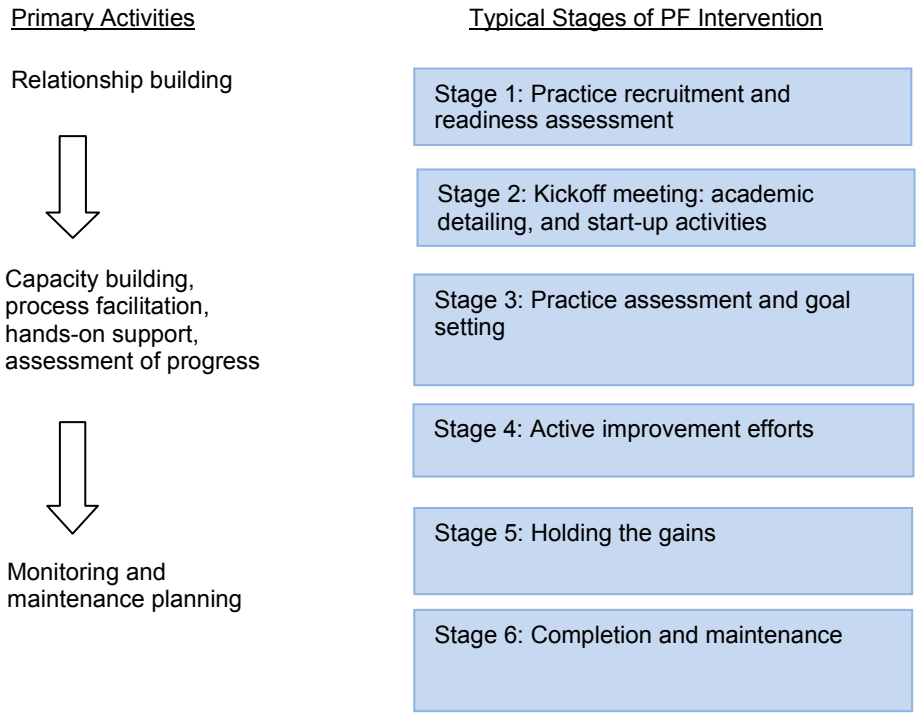
Examples of common activities in stage 2:

- Kickoff meeting
- Academic detailing session
- Preliminary goal setting
- Completion of paperwork
- Scheduling first PF session for data collection/assessment

Table 4.2. Sample agenda for a PF intervention orientation/kick-off meeting

12:00-12:05	Welcome and introductions—practice facilitator
12:05-12:15	Review of existing guidelines and improvement—PF Physician
12:15-12:30	Discussion and initial goal setting
12:25-12:35	Review of PF process and roles and expectations of facilitator and practice—PF physician and facilitator
12:35-12:45	Discussion
12:45-1:00	Paperwork and scheduling first facilitator visit for assessment/data collection

Figure 4.4. Common stages of a practice facilitation intervention



Source: Adapted from Knox, 2010 (Report on the AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement).

Stage 3. Practice Assessment and Goal Setting

During this stage, the facilitator conducts an assessment of the practice that is specific to the outcome goals of the improvement effort. A number of useful tools for assessing practice systems and performance are available. For example, the MacColl Institute for Healthcare Innovation and Clinical Microsystems each have a variety of tools that be used by a facilitator at this stage to guide an assessment of a practice.[7] However, in many cases, the facilitator will need to design an assessment tailored to the needs of the practice and the intervention model.

This aspect of the PF intervention process is critically important, as it lays the foundation for data-driven change. While the facilitator is collecting the data, he or she also should be conducting an assessment of the practice's capacity to continue these assessments, the validity of the data, and the data infrastructure resources and gaps at the practice. This information will guide the facilitator's future work in developing the practice's capacity for data-driven change.

Once the data are collected, the facilitator presents findings to the practice and facilitates a second round of discussions about improvement goals based on the assessments. Often, facilitators first will need to work with practices to address concerns about the reliability and validity of data it currently maintains and help practice members develop collection processes that produce reliable and valid data for use in improvement work. Providers and staff often overestimate their performance, so external benchmarks and comparisons can help the practice to develop a more realistic and nuanced understanding of its current effectiveness.

Examples of common activities in Stage 3:

- Assessment of practice
- Feedback of data to the practice
- Finalization of practice goals for PF intervention
- Capacity building for data-driven change through training, introduction of dashboards, and other resources

Stage 4. Active Improvement

During this stage, the facilitator assists the practice in developing its internal capacity for improvement and implementing specific improvements specific to the intervention's key-driver model and the goals set during Stage 3. Depending on the needs of the practice and the particular improvement project, the facilitator may:

- Provide training to the practice staff and providers on QI methods and strategies
- Help manage improvement projects

[7] For example, see clinicalmicrosystem.org/assets/materials/worksheets/microsystem_assessment.pdf and www.qhmedicalhome.org/safety-net/upload/PCMH-A_public.pdf for an assessment tool on the PCMH.

- Provide executive coaching for practice leadership
- Train staff members in new skills
- Provide technical assistance in specific areas, such as registry development for implementing team-based care
- Identify and set up meetings with content experts as needed
- Form and facilitate local learning collaboratives and arrange for additional academic detailing sessions with the PF physician, as needed
- Engage members of the patient community in the change process, as appropriate

The facilitator also may introduce the practice to exemplar practices in the region as well as overall best practices. Sharing best practices sometimes may be as simple as telling stories about what changes other local practices have made and how they did it. In some cases, the facilitator will provide monthly data reports to the practice improvement team to help track progress toward stated goals and key drivers, and plan for maintenance of any gains.

> *During Stage 4, "It is important for the facilitator to make sure that the changes that have been tested and found to be effective…are cemented into the fabric of the practice in every way that they can be."*
>
> *—Dr. James Mold, OKPRN*

Examples of common activities in Stage 4:

- Facilitation of active improvement efforts, such as Plan-Do-Study-Act (PDSA) cycles and pilots
- Technical assistance specific to key drivers and underlying change concepts
- Training for staff and providers
- Project management
- Executive coaching
- Procurement of content experts as needed
- Procurement of academic detailing as needed
- Monthly data-driven reporting on progress
- Early planning for holding the gain

Stage 5. Holding the Gains

During Stage 5, the facilitator works with the practice to develop systems that will monitor the improvements achieved and also maintain them. The facilitator may work with staff to institutionalize the use of dashboards, assessments, and other monitoring procedures put in place during the PF intervention to track and monitor performance and progress.

Examples of common activities in Stage 5:

- Institutionalize maintenance and use of dashboards and other data-driven approaches to monitoring gains and progress
- Develop infrastructure and procedures that support effective use of this monitoring

Stage 6. Completion and Maintenance

During Stage 6, the facilitator begins a phased withdrawal from the practice and increasingly transfers more of the coordinating functions to practice staff. This stage often includes an assessment of the practice's progress and what work remains to be done. The facilitator continues to be available to provide support on an as-needed basis, conduct booster sessions, and re-engage to facilitate new improvement initiatives. Instead of exiting a practice and ending involvement at the site, some PF programs shift practices from an intensive active facilitation schedule to less intensive maintenance. This can help to support maintenance of improvements achieved during Stages 4 and 5, and make it easy for the facilitator to re-enter the practice later to support new improvement or dissemination efforts. An additional advantage of ongoing maintenance visits is that the facilitator can stay current on new challenges faced by practices and report them back to your program to guide future interventions.

> *"Our goal is to leave a practice as more competent at implementing, and changing, and growing on their own.… So we balance, on a regular basis, being the expert [with] encouraging the practice to believe in its own internal expertise and ability to learn and develop and carry on…."*
>
> *—Mary Ruhe, Case Western Reserve University*

The OKPRN PF program provides two tracks for practices: active facilitation, which involves weekly or biweekly visits by a facilitator; and maintenance, in which a practice receives a PF visit every other month. OKPRN facilitators maintain a panel of 8 practices in active facilitation and an additional 22 in maintenance. OKPRN offers low-intensity maintenance support to its "graduate" practices for as long as they wish to continue it.

Examples of common activities in Stage 6:

- Reduce frequency and length of PF visits
- Institutionalize changes achieved during PF intervention
- Empower staff to continue QI work
- Develop plan for ongoing QI
- Transition the practice to a maintenance schedule

Case Example: Stages of the Chronic Kidney Disease PF Intervention

The Chronic Kidney Disease (CKD) PF intervention currently being carried out by OKPRN, LA Net, the Wisconsin Research and Education Network, and the Minnesota Academy of Family Physicians Research Network offers a good example of the stages of an intervention. The CKD intervention begins with an initial kickoff meeting between the facilitator, a peer educator, and the members of the practice who will be involved in the PF intervention. During this session, the peer introduces the practice facilitator and creates buy-in for the intervention. The group reviews specifics of the PF intervention and finalizes the project team and a plan for conducting an audit and feedback on relevant indicators. Next, the facilitator gathers the data and presents them to the practice. During the feedback session, the facilitator works with the practice to identify strategies for improving performance in areas below the desired level and works with staff in the ensuing months to make and build the capacity to sustain the changes needed to improve performance in these areas. This process works well, as it also allows the practice facilitator to identify exemplars across multiple practices, study those practices to determine what they do that works, and finally translate these successful efforts for other practices in their panel.

Case Example: Holding the Gains in the QIIP PF model

QIIP incorporates a holding-the-gains phase into its PF process. It is built in at the end of an active learning cycle for those primary care practices that have engaged in a QI initiative. Prior to this phase, teams participate in a *pre-designed program* that includes a recruitment, application, and pre-work phase, learning sessions and action periods, and meeting/celebration at a predetermined time (usually at the 8- to 12-month mark) modeled on the Breakthrough Series Model. During the *active learning cycle phase*, the practices are supported by a QI Coach, participate in face-to-face and virtual learning sessions, test change ideas and measure progress, and participate in a Web-based virtual community to share information. At the end of the formal learning cycle, the practice teams move into a less intense phase; during this time, they're still connected to a QI Coach and the other practice teams (via the Web site application for exchange of information, document posting, etc.). This phase is intended to focus on sustaining the improvements made during the more active participation in a QI initiative, including the ability to continue measuring and reporting data used to monitor progress and detect opportunities for improvement. Practices often do not successfully hardwire changes or redesigned processes to maintain them over time, especially when faced with staff and scheduling changes, the demands of a busy clinical practice, or unanticipated disruptions. A structured link to a QI Coach and other practices that support the implementation of a plan for sustainability and spread during the holding-the-gains phase can lessen the tendency toward slippage and loss of previously achieved improvements. The *holding-the-gains* phase also can assist in building a culture of quality across the practice. This phase varies in length, depending on the practice's area of focus (i.e., clinical improvement versus office practice redesign) but typically lasts 3–6 months. During the holding-the-gains phase, practices may identify new areas they wish to work on and can use their continued relationship with a QI Coach to explore them.

Decide on the Dose and Delivery Schedule

Another important decision to make about your intervention design is its dose and schedule. The dose or total number of hours of support a PF program delivers ranges from as little as 40 hours to more than 300 per practice. Currently there is not much research to guide decisions about the overall dosage a practice will need to make different types of changes. The complexity of the changes you pursue will be a key determinant of intensity, as will the capacity of the practices with which you are working. Focusing your work on implementing evidence-based best

practices will require less time than interventions aiming to restructure an entire practice. Practices that already have sufficient capacity and resources for improvement and simply need someone to help with information gathering and basic support will need less assistance.

Some general rules of thumb for making decisions about the total hours and intensity of your PF intervention include:

1. The type and complexity of the change the PF intervention is attempting to effect in the practices should be considered when determining the total number of hours your facilitator will support a practice. Structural changes to the way a practice functions or delivers care such as implementing team-based approaches to care or transforming to a PCMH will typically require substantially more hours of PF support to effect change compared with those focused on implementing a practice guideline for a specific condition or a new treatment.
2. The readiness of a practice to engage in improvement work and practice transformation with a PF will also affect the number of hours of support your PF will need to provide to a practice. Practices that are highly motivated to implement the improvements, already have a functional QI process, and whose leadership have prioritized improvement work and committed time and other resources to implementing change likely will require fewer hours of support from a facilitator compared with practices with fewer resources available to bring about improvements. For practices at lower levels of readiness, facilitators will need to dedicate a certain amount of time to increasing practice readiness and developing the foundational resources the practice needs to implement and sustain the desired improvements.
3. The size and complexity of the practice and its organizational home also will affect the total number of PF support hours needed. Large practices with multiple divisions and departments typically will need more hours of support than smaller, less complex practices. In larger practices, the facilitator will need to work with multiple levels of leadership—the practice leadership as well as the leaders of the various divisions or departments in the practice—to build capacity for, plan for, and implement improvements. This understandably takes more time than practices that have a single layer of leadership. Similarly, facilitators working with a practice that is part of a large organization with several locations, such as a Federally Qualified Health Center with multiple practice sites, will need additional time to ensure that the work taking place at the practice level is supported by and coordinated with work going on at the organizational level. All of this must be taken into consideration when determining intervention dosage.
4. One of the most important elements of PF is the relationship your facilitators develop with their practices. As discussed earlier, this relationship is one of the primary active ingredients of a PF intervention and what sets it apart from traditional approaches like consulting and other QI support models. It is also what creates the efficiency of the PF approach to practice improvement: once a relationship is created between a PF program and a practice, the program's facilitators are able to enter a practice and support improvement or disseminate new treatments and service models more rapidly than would be possible using a consultant or intervention approach that involved no prior relationship to the practice. Because the relationship between the PF and the practice is so central to the facilitator's ability to work effectively with a practice, it is

essential that you allocate sufficient time for the facilitator to develop a relationship with a practice during his or her initial exposure to a practice, and then to maintain that relationship long-term through maintenance contacts with the practice between active interventions.

An issue related to dosage is the schedule for delivering support to your practices. Some PF programs have their facilitators work with their practices very intensively (such as every day for 30 days) and then return for a maintenance session in 6 months. Other programs have their facilitators work with their practices a half-day per week for 10 months. Still others may start off with an intensive work week and then drop to once-a-month check-in calls.

As with dosage, very little research is available to guide your decisions on scheduling, but here are some general rules of thumb for making these decisions:

1. The intervention schedule should build in enough time for the practice facilitator to develop a working relationship with the practice based on trust and mutual respect. This can take as little as a few weeks to as much as 4 months in larger, more complex practices in which the facilitator must get to know many different departments and division heads. In fact, facilitators are always building and maintaining relationships with their practices. These relationships distinguish facilitators from traditional consultants and other QI resources, and help them to work more efficiently with a practice over the long term. (Note that it takes a facilitator much less time to reconnect with a practice and ramp up an intervention when he or she has already established a relationship with the practice on another project and maintained it over time through intermittent check-ins.)
2. While concentrated schedules (for example, one in which a practice facilitator is present daily for a period of time) may sound appealing, this easily can overwhelm practices, especially smaller ones. You should consider carefully the capacity of a practice to "metabolize" information and changes introduced through PF and then build in sufficient time for this to happen. Otherwise, changes may occur immediately because of the intensity of the effort but fail to take hold over the long term.
3. Schedule and duration also should be based on the complexity of the changes your program undertakes. Interventions focused on complex changes, such as restructuring processes of care, will require more intensive support from the facilitator and PF team.
4. Schedule and dose also will vary by which stage the practice has reached in its overall involvement with your PF program. Practices working with a practice facilitator for the first time or participating in an active PF intervention will require a more frequent and higher dose of support. Those operating in a maintenance phase rather than engaged in active PF work will require less frequent visits and support.

The OKPRN uses a schedule of a half-day per week or a full day every other week for 6 months for PF interventions, focused mainly on implementing practice guidelines. For practices not involved in an active PF intervention, monthly check-ins to maintain the relationship and keep abreast of practice needs—conducted in person or by phone—work well. The facilitation program of the C.T. Lamont Primary Health Care Research Centre in Ontario, which also is focused on guideline implementation, has its facilitators interact with practices once every 2 months for an hour, mainly by phone. Results of randomized controlled trials of

both of these intervention models have shown positive effects, which are sustained for more than 18 months (Aspy, Mold, Thompson, et al., 2008; Hogg, Lemelin, Moroz, et al., 2008).

Decide Whether You Will Provide Services Onsite or From a Distance

PF support can be provided to a practice onsite or at a distance through mechanisms like teleconferencing, video conferencing, and email. You'll need to decide whether your facilitators support their practices primarily through onsite visits, distance technologies, or a combination of both. You should make your decision based on the amount of money available for the intervention, your intervention's goals, and the territory your program is trying to cover.

Onsite facilitation. Onsite support usually is preferable for delivering PF services to a practice. This is particularly true in the early stages of an intervention, when the facilitator is developing a relationship with a practice and conducting an assessment of its resources and capabilities. It is very difficult to establish relationships when the facilitator interacts with the practice only on the phone or via the Web. In addition, much of the "incidental" assessment and observations that practice facilitators make while onsite are essential in helping them to identify barriers and resources for change and developing interventions likely to be successful. Even when the facilitator conducts an extensive formal evaluation of a practice, there are many things practice staff are unable to communicate easily or of which they are not even aware. The onsite presence of the practice facilitator makes "water cooler" observations possible; these often are critical to the success of the overall intervention.

Onsite support also works for situations in which the practice needs additional capacity and adaptive reserves (that is, the ability of a practice to use its time, resources, infrastructure, and culture to make and sustain change) to engage in improvement work. Direct support from a practice facilitator can make it possible for a practice to "get over the hump" and develop enough reserves to engage directly in improvement activities; sometimes a practice may not be able to do this without the facilitator's support. Similarly, in situations that require complex changes and communication across a number of departments or units within a practice, onsite interventions often are the most effective, as they make it easier for the facilitator to bridge the gaps between multiple individuals.

In addition, the physical presence of the facilitator at the practice site serves as a reminder to staff about the improvement work and can promote greater engagement in the transformation as they anticipate the regular visits from the facilitator and prepare for them. At the same time, onsite delivery of services typically is more expensive and often involves travel costs and more of the facilitator's time, so these factors must be weighed against the benefits of an onsite presence. However, it is important to keep in mind that, in the long run, a cheap but ineffective intervention is always more expensive than a more costly but effective one.

Distance facilitation. Providing PF support using distance learning technologies is generally less expensive. It saves on travel costs and lets a facilitator support a greater number of practices at any one time. Some have suggested that the use of such technology also can help reduce practice dependence on the facilitator and promote greater independence and capacity building. However, this is likely to be true only for practices that already have considerable capacity for improvement work and sufficient adaptive reserves to take on that work without outside support.

On the down side, the use of distance learning technology can make it difficult to establish a strong relationship with a practice and, in cases where the change being pursued is complex or the practice does not have sufficient adaptive reserves without some direct support, the reliance on this technology may result in an ineffective intervention.

Practice facilitators at the C.T. Lamont Primary Health Care Research Center at the University of Ottawa provide support to practices throughout Ontario. To make this feasible, they provide the majority of their support to practices via teleconferencing. Similarly, the PF program at the Primary Care Development Corporation supports interventions throughout New York State, covering extensive distances. Practice facilitators are located in areas close to the practices they serve.

Combination of onsite and distance facilitation. Many PF programs use a mix of modalities to deliver support to their practices. In interventions that rely mainly on distance facilitation, the kickoff meeting might be done on site, followed by distance facilitation and periodic in-person check-ins. For those programs that rely mainly on onsite facilitation, the facilitator can provide additional support between encounters through email or video conferencing, or the intervention might involve a virtual learning collaborative. A lead facilitator also might engage educators or content experts and peer educators to participate onsite, or use distance learning technologies. Table 4.3 presents recommendations when using these technologies.

Determine the Ratio of Facilitators to Practices

Determining the number of practices each of your facilitators will support at any one time is another important decision you must make. On average, a single PF can support between 8 (onsite, more intensive) and 20 (distance, less intensive) practices during an active intervention. A facilitator can support as many as 30 practices in a maintenance phase (monthly to quarterly check-in visits). For example, the QIIP in Ontario maintains a 1-to-13 practice facilitator-to-practice ratio. The OKPRN program uses a 1-to-8 ratio for active PF and a 1-to-30 ratio for practices in the maintenance stages.

When determining the appropriate ratio of facilitators to practices for your PF intervention, you should consider several factors:

Intensity of the intervention design is important. More intensive schedules will require lower practice facilitator-to-practice ratios.

Geography and modality also factor into this decision. A facilitator who must travel long distances to reach practices can support fewer practices. A facilitator who provides the majority of his or her support via distance technology can support more practices at one time than one who provides most support onsite.

The experience of both the practice facilitator and the practice also are important factors. In general, less experienced facilitators should support fewer practices until they have developed sufficient skills and knowledge. Such experience is related to the intervention goals and the complexity of the changes. Practices new to the PF intervention, and QI processes in general, will require more time from the facilitator in the early stages and during active intervention.

Table 4.3. Recommendations for using distance-learning technologies

Mode	When to Use	When Not to Use	Key Considerations
Web conferencing	To encourage participation at meetings or presentations, when used strategically; To present case studies or PDSAs, or to develop aim statements	Overuse will lead to a drop off in in-person participation when attendees are given a choice; To teach theory	• Create an atmosphere that suggests participants are in the same room. • Be well prepared; when possible, collect data ahead of time to display and discuss. • Have a strategy to make the meeting interactive. In advance, identify practices implementing an improvement activity that fits the focus of the meeting and ask for short experiential sharing. Ask participants about their thoughts and experiences. • Be selective about the topics presented via Web conferencing. • Keep presentations short and use lots of pictures. • Recording the meeting offers the ability to play it back for those who missed the presentation and is a good tool for facilitators, giving them the opportunity to focus on the discussion and not take as many detailed notes. Ask participants' permission to record the discussion.
Email	To communicate decisions or dates	Most of the time (avoid use of email as much as possible) To send resources, since this can easily overwhelm a practice To have a discussion or conversation	• Limit email communication to the key contact at the practice. • Keep the content of emails short; use bullets, numbered lists, or summaries of key information, such as a weekly digest of key topics. • Keep attachments to a minimum. • Provide an alternate source, such as a password-protected Web site, to obtain the same information provided in the email.

The availability of community resources to promote QI may affect the ideal facilitator-to-practice ratio (DeWalt, Powell, Mainwaring, et al., 2010). For example, the presence of a strong local learning collaborative may allow for a higher ratio.

Prior work with the practices. A facilitator usually does the hard work of establishing a relationship with a practice and laying the groundwork for ongoing improvement during the first intervention. Later work with the practice can build on these already existing relationships and infrastructure and thus require significantly less time from the PF and, as a result, less money. In fact, the real efficiencies and value of PF over other approaches, such as collaboratives and consultative models, are realized when practice facilitators can establish and maintain a long-term relationship with a practice and engage it in successive improvement interventions.

The full potential of PF as a resource for practices—and for the Nation—can be realized mainly within the context of ongoing involvement with practices and the creation of PF as a permanent resource for a practice community. This does not mean that any particular practice

will be involved in continuous, active PF work, but rather that the practice and the facilitator will cycle in and out of active and maintenance phases over time, depending on the needs of the practice and local and national priorities and improvement agendas.

Case Example: OKPRN's Approach to Staffing Facilitators Across the State

In OKPRN's PF program, each of its four facilitators is assigned practices in a quadrant of the State, for a total of about 35 practices each. A facilitator is in active facilitation with 8–10 practices in his or her quadrant at any one time but conducts regular (bimonthly or quarterly) check-ins with the remaining practices to keep track of their progress and priorities and maintain the relationship with them. This in turn makes it possible for the facilitator to move a practice to active status quickly when the need arises. Focusing facilitators on particular areas of the State creates a "local" presence and also helps them become very familiar with the resources and needs of their area. This approach produces greater efficiency and effectiveness in their facilitation, and also makes it easier for facilitators to identify and "cross-pollinate" best practices, both in their own quadrant and to facilitators supporting other sections of the State.

Define the Facilitator's Role and Core Activities

While many practices are likely to be very familiar with compliance auditors or expert consultants, they may be unfamiliar with PF and uncertain as to how to use or work with a practice facilitator at the beginning of the process. Experienced program directors suggest that many practices need help in building "receptor sites" for working with facilitators. Common feedback from practices when they participate in a PF intervention for the first time is "I wish I had understood what a practice facilitator could do for us, I would have engaged him/her much more...or differently."

You should be careful to define the facilitator's relationship to the practice clearly. The primary roles and activities of the practice facilitator should be reviewed with the medical director and his or her team, and be based on the goals and design of the PF intervention. It can be tempting for practices to engage practice facilitators as an extra set of hands, but it should be clear that the primary role of the facilitator is to build capacity within the organization and provide facilitative support for improvement—not to "do for" the practice. When thinking about a facilitator's relationship with a practice, the adage "give a man a fish, and he eats for a day; teach him to fish, and he eats for life" captures this concept.

There are times when it can be appropriate for a practice facilitator to help directly with the work of a practice. These include activities being done for the first time, as a way to help the practice learn; one-time occurrences, such as helping to draft a policy and procedure on access to facilitate NCQA recognition; at the very beginning of building a relationship with the practice; populating a registry for the first time; and collecting data for performance feedback to focus early intervention work. Actual performance of this work for the practice should decrease quickly once the facilitator settles into his or her role, and the practice staff begin to build their own knowledge and capacity.

Both the practice and the practice facilitator need to be clear that the latter is not an employee of the practice, but an outside resource. This gives the facilitator the objectivity and distance he or she will need to guide the practice through various changes. On the other hand, the facilitator and practice also should be clear that a primary goal for the facilitator is to build a trusted

relationship with practice personnel—one that could support multiple waves of improvement work over time, as determined by the needs of the practice.

It also should be made clear to the practice that the facilitator is there to support organizational change, not to deliver direct clinical services. While not usually an issue when the practice facilitator comes from a nonclinical background, it can become problematic when the facilitator has a clinical degree, such as an R.N., M.S.W., or Ph.D. in psychology.

Common Activities of Facilitators in a Practice

The principal activities of your practice facilitators will depend on the goals of your intervention, your key-driver model and intervention approach, and the needs of the practice. Common activities of practice facilitators during most interventions include:

Developing a trusting relationship with the practice. A central activity of a facilitator is to build and maintain a close relationship with his or her practice. This means developing relationships with key members of the practice leadership, providers, and staff. In the OKPRN Practice Enhancement Assistance program, facilitators maintain "card decks" with each staff person's name, work location, and important information about that individual, ranging from his or her role in the organization to personal likes and dislikes. It is the relationship that the facilitators develop with a practice that distinguishes them from consultants and other types of support individuals. It is also what makes PF so potent. Once a relationship is established, the facilitator is able to enter a practice again and again to deliver a range of technical assistance and support without having to learn how the practice operates and gain the trust of the providers and staff each time. The facilitator does challenging and important work the first time and then maintains it over time.

Assessing the practice and providing performance feedback. Data-driven change is the central feature of effective QI. Data create buy-in, motivate reluctant providers and staff to change, and provide information on how much progress is being made and how well changes are being maintained. Data also point out the practice's areas of need and strengths, and can help facilitators identify practices that are exemplary in particular processes or areas to serve as models for others. Some of the most important activities of the facilitator are gathering and presenting data to the practice on its performance and progress. This activity is ongoing throughout the intervention period.

Building the internal capacity of a practice to engage in data-driven change. Facilitators must be able to clearly articulate the differences between data for improvement versus data for research or accountability. In addition to providing performance feedback, facilitators should build the capacity of practices to become more data driven. This could include helping them to set up reports from their registries, developing Excel spreadsheets that can generate graphic displays of the practice's performance over time automatically, and helping to develop "dashboards" showing the same information. In some instances, the facilitator might reach outside of the practice to an area health plan or County agency to support improved use of data. For example, a PF program in Canada has been working with the provincial organization that receives health care utilization data from its provincial health system to provide feedback to practices.

Providing training for the practice on QI methods and skills. A central function of the practice facilitator is to provide training to practice staff and providers aimed at building their capacity for QI.

Providing training and technical assistance to the practice in key content areas. Another activity of the facilitator is to provide training and technical assistance for the practice in content areas related to the key-driver model for the PF intervention. Practice facilitators may provide this training directly, engage a peer educator, or bring in a content expert. In some cases, the facilitator may engage a member of the practice in doing this work if he or she possesses the knowledge but has not been called upon to provide it by their practice.

Facilitating meetings. An important activity of most practice facilitators is helping to convene and facilitate meetings. Practices often lack the time or capacity to do this well. The facilitator can provide this type of direct support by training and modeling the methods for running an effective meeting. A key element is introducing methods that support timely followup on action items and participation and meaningful input from a diverse group of staff and providers.

Managing projects. Another important activity of the facilitator is to assist in project management. Again, the facilitator might offer direct support to the practice, but the long-term goal is to help the practice develop its own resources and skills to manage improvement work effectively. This can include introduction of collaborative software that can support more effective project management.

Providing executive coaching for practice leadership. Effective leadership is essential for PF. A core function of the practice facilitator is first to engage and then build the knowledge and capacity of the practice leadership. In some cases, this may resemble traditional executive coaching. In others, it may involve targeted training and development around QI methods or activities specific to the intervention goals and key drivers.

Building the practice's belief in its ability to change and motivation to do so. A vital activity of a facilitator is to build a practice's belief in its capacity to change. In many practices, staff and providers have attempted changes in the past and failed, and so may lack confidence or belief in the ability to change. Often a major role of a facilitator is to build staff and provider confidence in their ability to change through serving as a sounding board, helping practice staff identify areas where they have succeeded, reframing past failures, and orchestrating opportunities for the practice to experience "small wins" to build both skills and confidence in improvement work. Being mindful of the human component of change management is perhaps one of the most important functions of your facilitator over the course of his or her involvement with a practice.

A facilitator's routine will vary from clinic to clinic since each clinic is likely to be at a different stage of intervention and project focus. Nevertheless, the following schedule outlines what a "day in the life of a facilitator" might look like.

A Day in the Life of a Practice Facilitator

Arrive at Clinic A (8:00 am – 8:30 am): Briefly say hello to staff upon entry to inform them of my presence, station self in designated area to review agenda and timeline and respond to clinic emails

Prepare for Quality Improvement Committee meeting (8:30 am – 10:00 am): Review and update agenda, review timeline, send reminders of meeting, print resource materials for meeting, take call on Practice Registry helpdesk to resolve data entry problem specific to Hepatitis B population

Facilitate QI committee meeting (10:00 am – 11:00 am): Address each item on the agenda for developing a QI work plan, while addressing concerns and followup, keep time, and review each member's expected deliverable for the next meeting, schedule next meeting to include content expert in the patient centered medical home

Complete weekly encounter form (11:00 am – 11:30 am): provide a weekly update on the events that occurred at the site, including barriers and progress made, with anecdotes

Travel to Clinic B (11:30 pm – 12:00 pm)

Lunch Break (12:00 pm – 12:30 pm): Use this opportunity to take a lunch break with clinic staff and make them aware of my presence. Make reminder call to Clinic C's Chronic Disease Coordinator on an action item needed by the end of the week per her request

Prepare for Panel Committee meeting (12:30 pm – 2:30 pm): Review agenda and timeline, research Mark Murray's Method for calculating panels, obtain reports from IT support needed for providers' patient counts, plug numbers from report into the template for panel calculations, send and respond to clinic emails, send meeting reminders

Setup for Panel Committee meeting (2:30 pm – 3:00 pm): Rearrange tables for team, setup projector, plug in laptop, upload relevant documents on panel updates, and print any necessary handouts

Facilitate Panel Committee meeting (3:00 pm – 5:00 pm): Review timeline, outline agenda for the day, keep time on each agenda item, encourage discussion on each subject, inquire about a Webinar resource and team interest, schedule next meeting, announce progress made and next steps based on the timeline previously developed by team

Complete weekly encounter form (5:00 pm – 5:15 pm): Provide a weekly update on the events that occurred at the site, including barriers and progress, with anecdotes.

Source: Vanessa Nguyen, LA Net practice facilitator

Determine the Criteria You Will Use for Selecting Practices for Your Intervention

You should give careful thought to which practices you will recruit and select to participate in an intervention. Practices need to have a certain level of readiness before they truly can benefit from PF, but assessing this can be difficult. Several assessment tools exist for evaluating readiness for change; we provide a list of such tools in Appendix B. However, these tools currently do not have a strong evidence base supporting their use and often are more useful in a research context than as practical tools for selecting practices for PF. Experienced PF program

directors suggest the following characteristics as common to practices they view as ready to participate in a PF improvement effort:

- Buy-in of practice leadership
- Perspective that change is one of the practice's top priorities
- Willingness and resources to form and meet as a project team on a regular basis
- Willingness and resources to engage in the performance feedback process
- Sufficient organizational and financial stability to avoid becoming too distracted or overwhelmed by competing demands or financial concerns

While such lists can be useful, program directors acknowledge that some of their most effective interventions have taken place with practices that do not meet these criteria. In some cases, a PF program may engage a practice only to realize quickly that the practice is not ready for or benefiting from the intervention. At such times, some program directors believe an effective strategy is to pull the facilitator back and use a less intensive approach. During this time, facilitators can continue to provide some type of outreach (for example, checking in periodically until the practice shows signs of being ready to re-engage in a more substantive manner). Meanwhile, the practice facilitator can direct his or her efforts toward those practices mostly likely to benefit while remaining alert to opportunities to re-engage with less ready practices at a later point. All practices go through periods when they are ready to change and periods when they are not. It is important for a facilitator to be ready and available when the practice is.

Checklist for Developing Your PF Approach

☐ Define goals for the PF intervention

☐ Develop a key-driver model for your program

☐ Define the different stages of the intervention

☐ Decide if the program will be more prescriptive/structured or flexible

☐ Select an individual or team-based PF model

☐ Select onsite or distance PF delivery

☐ Determine the schedule and duration of the intervention

☐ Clearly define the role of the facilitator in the practice

☐ Develop materials to help practices know how to use a facilitator effectively

☐ Determine the appropriate ratio of facilitators to practices for the active phase of your intervention

☐ Determine the appropriate ratio of facilitators to practices for the maintenance phase of your intervention (if applicable)

☐ Develop a strategy for assessing the readiness of practices to participate in the intervention

Practical Resources

- Example MOU
- Example handout of expectations of practice and facilitator in a PF encounter

Chapter 5. Hiring Your Practice Facilitators

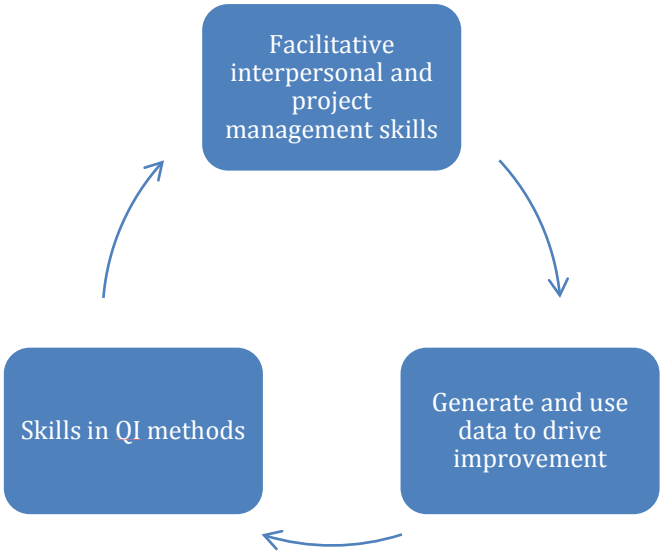
Practice facilitators are the heart of any practice facilitation program. They are the catalysts for change and the "face" of the program. One of the most important decisions you will make as you develop your PF program is to decide who to hire as your facilitators, and how you will train and support them. These critical decisions often can make or break your program. This chapter provides information on:

- Core competencies needed by facilitators
- Deciding who to hire as facilitators
- Selecting a staffing model to use when you hire them

Core Competencies Needed by Practice Facilitators

All practice facilitators need to possess or acquire skills in three core areas: facilitative interpersonal skills, ability to generate and use data to drive improvement, and skills in quality improvement (QI) approaches and methods. The latter two categories are developed more readily through training, but interpersonal skills—which some experts refer to as the "sparkle factor"—may be qualities not easily taught; they may be skills people simply must have when they walk in the door. Figure 5.1 depicts the basic skills needed by a practice facilitator.

Figure 5.1. Core competencies needed by all practice facilitators



Facilitative interpersonal and project management skills. Excellent interpersonal skills that can facilitate movement toward a goal while empowering and building capacity within a practice are essential to being an effective practice facilitator. Facilitators must be excellent communicators as well as project managers. They must garner the trust of practices and be viewed as empathetic individuals to whom the practices can relate easily. At the same time, they must encourage members of the practice to improve and provide constructive feedback that inspires and drives change and builds the practice's internal capacity. Facilitators should be well versed in adult education strategies, conflict resolution, and personal coaching strategies, such as executive coaching. They also must be skilled in setting and maintaining professional boundaries that allow them to provide support while not becoming so involved that they lose their objectivity or are unable to keep a practice focused on high-yield improvement work.

> *"For facilitators, there's a balance between developing good relationships and getting too personally involved. A facilitator can't be so empathetic that it's hard to push for change. Similar to a physician agreeing to focus on concerns of a patient, but reserving the right to address issues like smoking and obesity as the relationship develops, facilitators must be able to do the same with their practices. Otherwise the work they do together with their practices may look good to both parties, but fail to engage in the sometimes difficult and uncomfortable work often needed to produce meaningful change."*
>
> *—Lyndee Knox, LA Net*

Competencies in acquiring and using data to drive improvement and transformation. Facilitators need extensive technical skills in the use of data to drive improvement. Data-driven change is a central element of effective QI. Practice facilitators must be highly skilled at acquiring these data from paper and electronic media (registries, electronic health records). They also must be comfortable working with, analyzing, and reporting data. Facilitators must think strategically about how to build capacity to conduct ongoing QI data tracking and reporting in a practice as a regular function.

Competencies in QI methods. Facilitators need thorough knowledge and skills in QI theories, approaches, and methods. They should be familiar with a range of popular models, such as the Model for Improvement, LEAN, and Six Sigma.[8] Having broad exposure to these theories may be more effective than being highly skilled in any single approach.

Two reports on core or basic practice facilitator competencies—one developed by the Quality Improvement & Innovation Partnership (QIIP) and the other by the 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement convened by the Agency for Healthcare Research and Quality (AHRQ)—can be a good starting place for you as you being to define the core competencies for your own facilitators. The competencies identified in these reports are listed in Table 5.1. Both are also available online, and links are provided in Appendix B of this manual.

[8] Good places to look for resources in these areas include www.impactbc.ca/, http://www.qhmedicalhome.org/safety-net/, www.clinicalmicrosystem.org/, www.ihi.org/Pages/default.aspx, www.improvingchroniccare.org/index.php?p=The_MacColl_Institute&s=93, and www.qiip.ca/.

Table 5.1. Examples of core competencies for practice facilitators

Core competencies identified by QIIP

- QI expert
- Communicator
- Systems thinker
- Manager
- Educator
- Scholar
- Leader

Core competencies identified by AHRQ Consensus Meeting Participants

- Knowledge of primary care practice environments
- Knowledge of theories of practice and organizational change
- Skills in QI methods
- Skills in project management
- Skills in use of health information technology to support population management
- Skills in implementing practice guidelines
- Skills in implementing team-based care and self-management support programs
- Skills in using data to drive change
- Communication and conflict resolution skills
- Professionalism

Competencies specific to your key-driver model and intervention. In addition to these basic competencies, your facilitators must possess or acquire additional skills in areas specific to your intervention model, key-driver model, and target practice environments. For example, the Improving Performance in Practice (IPIP) intervention focuses on change in four key areas: use of registries to manage populations, planned care, standardized care processes, and self-management support. Practice facilitators working within the IPIP intervention needed to develop competencies to support these specific changes in their practices.

As you develop your ideal list of facilitator competencies, you should consider which competencies can be acquired through training and which are "inherent" skills that are difficult to acquire. The "sparkle factor" falls into the second category—in fact, many PF program directors say this is an essential competency for facilitators. Because much of the work of facilitators involves motivating practices to change and, in many instances, managing the conflict inherent in transforming an organization, effective interpersonal skills generally are considered an essential competency not easily acquired through training. For this reason, you should screen for these skills when you're hiring. Other skills often can be acquired through effective training or can be supplied by adding consultants to your PF team who are expert in team facilitation models.

For LA Net's Care Model and Business Strategies facilitation program, based on AHRQ's Integrating the Care Model and Business Strategies in the Safety Net Toolkit, facilitators were selected based on their interpersonal skills (their "sparkle"), resourcefulness, and ability to problem solve and think on their feet. LA Net then provided training on other competencies needed to deliver the specific intervention. These included knowledge of Federally Qualified Health Center environments; executive coaching skills with the chief executive officer, chief medical officer, and other practice leaders; forming a QI team; creating a QI or Practice Charter; training practices to use and manage Plan Do Study Act cycles to drive improvement work; conducting in-depth practice assessments using new and already existing practice data; and

working with registries and optimizing their use for population management, empanelment, and planning for and assisting practices in implementing team-based models of care.

Decide Who You Will Hire as Facilitators

Given the competencies needed for strong facilitation, you may consider hiring from various clinical disciplines, such as allied health (social work), nursing, counseling, psychology or health management, financing, and organization (such as people with a master's in public health). Facilitators with a background in counseling or psychology may be particularly well suited because of their knowledge and understanding of one-on-one and group interactions (Knox, 2010).

People with backgrounds in business (such as a master's in business administration) also have been used successfully by PF programs, although this approach is less common. Other programs have used QI experts from other industries, such as the automotive industry, as facilitators (for example, the IPIP program in Michigan), while still others have used representatives from the patient community (Family Voices of Minnesota).

In addition, some programs have been successful in hiring laypeople to serve as facilitators. These might be people who have had many interactions with the health system, either because of their own health conditions or those of family members, and also a strong commitment to advocacy. As frequent users of the system, these individuals have unique perspectives regarding the health system and so can serve in a patient advocate capacity. For example, Family Voices of Minnesota has trained the parents of special needs children to serve as facilitators for pediatric practices in the State.

Some experts feel that it is important for facilitators to have prior experience working in clinical environments (such as a physician's office). Others believe that this is not necessary and can even be a barrier, as such people may be prone to seeing the clinical setting through their own disciplinary frame and past experiences, thus limiting their openness to new or different models and ideas.

Facilitators who excel at facilitation and are happy in their jobs often have several important personality traits:

- Able to work autonomously and stay focused on the real needs of the practice (not focused solely on developing and maintaining relationships with staff members)
- Satisfied with long-term goals, given that facilitators are not likely to experience immediate, day-to-day signs of improvement
- Resilient and flexible (for example, facilitators often travel long distances only to find that a meeting has been cancelled due to a clinical emergency)
- Able to build confidence and capacity within the practice rather than keep the dependence focused on themselves
- Good teachers who understand QI and the importance of valid data and can explain data to others

Select a Staffing Model for Your Facilitators

Existing PF programs use a variety of staffing models for their facilitators. The model that calls for a core staff of facilitators as program employees is a preferred one, according to some experts. Other approaches for PF, such as hiring consultants and using volunteer facilitators, also exist. New programs sometimes begin with a mixed approach—for example, hiring two facilitators and using one or more consultants as needed—and then adjust the staffing model over time as the program matures.

Facilitators as program employees. A common staffing approach is to hire practice facilitators as employees. This approach gives you the greatest control over the facilitator in terms of training and requiring adherence to a particular intervention model. It also supports the development of a permanent facilitator workforce for your program. That said, sometimes it is difficult to find individuals who have the type of experience needed to work effectively with practices. Maintaining these positions over time also can be a challenge, given the episodic nature of funding for many facilitation programs. This clearly can present a challenge for the people you hire and may affect their long-term commitment to your program, as most probably are seeking more permanent positions.

In many cases, the ideal staffing model is to gradually hire a permanent workforce of facilitators that can provide ongoing support to your practices and community over time. Some experts find that the longer facilitators work with the same practices, the more effective they become—their longevity allows facilitators to establish trusting relationships with practices and offer them continuity. Some experts see the facilitator role as that of a continuous QI coordinator for a practice over time.

Facilitators as internal employees of the practice. Another staffing model is for primary care practices (or the larger entities with which they are affiliated) to hire in-house facilitators. While this model is explicitly not a focus of this guide, we note that it might be useful in building internal capacity in the longer term, especially for certain types of activities, such as the development and use of disease registries and other data sources. However, most experts generally find this approach ineffective as a primary strategy for staffing a facilitation intervention, except for very large organizations in which the facilitator is internal to the organization but external to the practice—thus having some independence from the latter. Because the clinical demands of practices are almost always more compelling or a higher priority than QI work, internal facilitators usually are pulled away from such work to address the never-ending stream of urgent clinical needs.

Contracting with consultants to serve as your facilitators. Contracting with individuals to provide PF services for your program and its target practices is an alternative to hiring facilitators as employees of your program. This approach can make it easier to staff-up quickly as it allows for a more flexible relationship with your program, and allows you to hire folks on a less than part-time basis. This can widen the pool of individuals available to staff your program—for example, an individual with the background and skills you are seeking may be available quarter time and able to support two or three practices, but would not be available full time. This approach also can help you build a cadre of individuals over time who are trained and available to deliver services for your program, and make it easier to provide PF services across a large geographic area, such as an entire State or region. (You can contract with individuals from

different regions of the State to support practices in their respective areas, and provide centralized training and supervision to ensure each is delivering the intervention as designed.) Contracting with skilled individuals in your area instead of hiring part- or full-time staff can help to get a program off the ground quickly. It also can be a win-win: just as the contractors who are usually consulting with a variety of different organizations bring their experience and skills to your program, they also benefit from being associated with your program, allowing them to build their relationships with practices in the community.

There are also downsides to contracting with consultants to serve as your facilitators, rather than using an employee/staff model. First, you likely will have less control over consultants you hire to deliver your PF services than you do over your employees, and less ability to ensure that they deliver your intervention as designed. Centralized training and supervision can help mitigate this, but does not eliminate the issue. In addition, many of the individuals you might contract with are often already working as consultants with practices. In many cases, they will be using a traditional consultative model for working with their practices, which is fundamentally different than the PF approach. One expert put it this way: in traditional consultation models, a consultant typically will "parachute in, work with a practice, then parachute out again" and offer a "rescue model" for an intervention, seeing their role as saving the practice. In contrast, facilitation focuses on creating a long-term relationship in a practice and developing the practice's internal capacity and skills. It can be difficult for consultants to make the transition. In addition, the relationship between the facilitator and the practice ideally should be long term, and this may be more difficult for contracted individuals to provide. Their level of commitment to the program is likely to be less than that of an employee/program staff person. In addition, they may use the PF encounter to build their own consulting business, which sometimes can run counter to the goals of the PF program. To mitigate some of these issues when using consultants, a program needs to clearly delineate consultants' responsibilities, remain aware of their competing demands, and make sure that their approach and perspectives are aligned with those of the program.

Using volunteers as facilitators. Some programs use volunteers as facilitators. This model typically requires many more individuals to support a group of practices than does a paid model—given that each individual volunteers only a small portion of his or her time. Moreover, all volunteers require training, so the program incurs training costs for a larger number of individuals than if it pursued another staffing model. Nonetheless, the model may allow programs to tap experts in QI (and perhaps other areas) at relatively low staff costs, given that facilitators are volunteers. For example, the IPIP program in Michigan uses volunteer QI experts from the auto industry to serve as facilitators in helping primary care practices improve care processes and outcomes and become patient-centered medical homes (PCMH) (Automotive Industry Action Group, 2011).

Subcontracting for PF services. Some organizations, such as primary care associations, health plans, or State Departments of Health, may be interested in providing PF services but prefer not to staff these programs internally. They may choose instead to subcontract for these services from an existing PF program. In this case, the organization outsourcing the PF services will want to assess the quality of the PF program with which they are contracting, as well as the program's fit with their mission and goals of the PF services. While this guide was not developed for this specific purpose, you can use this manual to identify the types of questions you may want to ask PF programs with which you are considering contracting. For example, you will want to ask questions about a program's PF intervention design, whether it uses a team or individual PF approach to facilitation, how it train and support their facilitators, and how it monitor the

progress of the PF intervention and evaluate the effectiveness of the work. In addition, you will want to work with the PF program to review its key-driver model and its fit with the mission and goals of your organization, and make sure the program tailors the intervention to your needs. For example, tailoring might require additional training for their facilitators, modifications to the methods they use to track progress through the intervention process, and modification of the intervention design itself.

Checklist for Developing Your Facilitator Workforce

☐ Determine what qualifications you want your facilitators to have—including educational background, prior experience, and skills

- What are the basic competencies you would like all of your facilitators to possess?
- Are there other qualifications that you would like at least one or two of your facilitators to have?

☐ Consider the skills needed by your facilitator workforce as a whole, recognizing that each facilitator may not need to possess every skill or qualification

☐ Decide on a staffing model for your facilitator workforce

Practical Resources

- Job descriptions for practice facilitators
- Core competencies for practice facilitators
- Sample protocol for interviewing applicants for facilitator positions

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Chapter 6. Training Your Practice Facilitators

Once you have selected your facilitators, they will need robust training and support to work with your practices and deliver your practice facilitation intervention model effectively. To varying degrees, and depending on their background, they will need training to help them acquire both the core and specialized competencies they need to do their job and grow professionally over time.

This chapter provides information to help you and your team design a training program for your facilitators that prepares them to work with practices and implement your intervention model effectively. It addresses these topics:

- Assessing and leveraging existing training resources in your organization
- Deciding if you will train in house or outsource your training
- Selecting the location of the training
- Creating a curriculum for your facilitators
- Examples of educational approaches and strategies
- Selecting your trainer and training team
- Setting the training schedule
- Training for other PF staff

Assess Resources in Your Organization That Can Be Used to Support Training for Your Facilitators

When designing a training and support program, you should use the resources available from the host organization to the extent possible. Thus, the first step in building a training program is to conduct a scan of available resources. This should include tangible resources, such as physical space, computer systems, and finances, as well as intangible resources, such as relationships, skills, and experiences. After identifying the resources that the host organization and community can offer your practice facilitators, you also should look at areas in which these organizations might have gaps in essential knowledge. For example, facilitation programs housed in university-based practice-based research networks (PBRNs) may have access to excellent resources for training facilitators in data collection, management, and reporting but not know as much about the real-world circumstances of practices or the realities of gathering and using data to guide change in busy practice environments. In the same way, quality improvement (QI) or other organizations may have excellent knowledge of compliance work in real-world settings through their access to data, but much more limited knowledge of empowerment approaches to improvement or the value of establishing long-term relationships with practices.

Decide Whether You Will Provide Training In-House or by Outsourcing

Training for your facilitators can be provided in-house using the expertise of your program staff, guest lecturers, or expert consultants brought in for the purpose, or outsourced to groups that already provide training for facilitators, such as the Institute for Healthcare Improvement (IHI) or Clinical Microsystems. The decision about whether to develop training services internally or contract them out will depend on a number of different factors: your training budget, the feasibility and efficiency of providing training in house versus externally, and the types of resources you can access for training support. It also will depend on the number of facilitators you expect to train through your program over time, how specialized the training content is, and whether you expect your program to be ongoing or short term.

Both approaches have strengths and weaknesses. Internal training builds internal capacity for continuous support of your facilitators and the resources to train new facilitators continually. It also can be tailored specifically to the content of your PF intervention model and practice environments. On the other hand, developing a high-quality training program from scratch is a difficult if not daunting task and doing so can be costly. Outsourcing the training of your facilitators to organizations that routinely provide this type of education can be efficient and help ensure the rigor and high quality of the training. However, this option also can be costly and it is not always possible to match the training content to the specific content of your intervention model.

The remainder of this chapter is focused on issues related to training facilitators in-house. This content also can help you evaluate the quality of PF training if you plan to contract it out.

Select the Location of the Training: In Person or Online

You can use in-person/onsite training, distance learning technology, or a combination of the two. In-person training is preferable in most cases because it supports more interaction between the students and the trainer(s); makes it easier to use interactive training approaches, such as role plays and "bug-in-the-ear" coaching methods; and makes it easier for the trainees to participate in site visits and "mini internships" in which they shadow an experienced PF in the practice for a day or two. In-person training provides more opportunities to engage in team-building among your facilitators. However, this type of training can require that the facilitators travel more often to the central training site, and can be more difficult logistically, requiring planning for travel time and even overnight stays for sessions lasting more than a day.

Training through distance learning technology often is more efficient and less costly. It eliminates travel time and costs for both the trainer and the facilitators, since they do not need to go to another site for training. It also is easier logistically, since facilitators can join the training from any location. Programs with a large geographic spread or limited budget, and/or where travel to an onsite location is logistically difficult or too expensive, often provide training for their facilitators through online Webinars and training sessions. The downsides of distance training are that it tends to be more impersonal, it can be difficult to incorporate experiential learning into the sessions, and it is generally less effective for developing collaboration and teamwork among your facilitators.

A combination of both approaches can bring the best of both worlds to your training program. Some programs, for example, provide short weekly trainings (1-2 hours) onsite for their facilitators and also include quarterly sessions with content experts via Skype.

Create the Curriculum

The content of the PF training curriculum should be aimed at helping your facilitators acquire the core and specialized competencies outlined in the previous chapter and based on your intervention design and key-driver model. Table 6.1 provides a sample curriculum from an existing PF program.

Table 6.1. Sample curriculum for facilitator training

- Introduction to the values, mission, and culture of the PF program and its host organization
- Working as a team with your PF program staff and other facilitators
- Preparation of all program staff to work together effectively as a team, including supervisors and support staff
- Introduction to PF and your PF intervention and its design, goals, and methods
- Introduction to the practice environment in which the facilitator will be working
- Stages of a PF intervention and particular skills needed for startup, setting expectations for the practice and the PF encounter, tracking readiness and progress, engaging in active facilitation, and concluding an intervention
- Accessing, analyzing, and using data to support practice improvement and transformation
- Essential skills in QI processes and methods of practice improvement and transformation
- Concepts and strategies for empowering staff and building organizational capacity
- Project management
- Forming and managing a facilitation team
- Specialized content specific to your key-driver and intervention model (for example, using registries for population management, implementing team-based care, and/or panel management)
- Common problems in PF interventions
- Professionalism for the facilitator (for example, maintaining appropriate boundaries with the practice)
- Administrative responsibilities and expectations of the facilitator (for example, documenting encounters, participating in support sessions)

Because facilitators come from a wide variety of backgrounds, it is important that you develop a training program that is flexible and able to be tailored to the individual learning needs of your facilitators within a clearly defined set of competencies drawn from the mission and goals of the PF program. For example, a facilitator with a background as a registered nurse who has worked for many years in primary care may not need extensive training in clinical processes or the practice environment but may instead need assistance in "thinking outside the box" of prior experience so that he or she can bring new solutions to old problems. On the other hand, a facilitator with a background in public health may need in-depth practical experience in a clinical environment to acquire the cultural competency he or she needs to work well in these different environments.

HealthTeamWorks, a PF program in Colorado, creates professional development plans for each facilitator as soon as he or she is hired. The plan, which identifies existing and needed competencies, then is used to develop a tailored training program for the facilitator. Similarly, the Oklahoma Physician Resource/Research Network (OKPRN) conducts an informal assessment of their facilitators prior to beginning training by having the facilitators review the table of contents of the training materials and discuss the areas in which they believe they require more training as well as those for which they already possess the needed competencies. This information then is used to determine the training sessions for that particular facilitator.

Examples of Educational Approaches and Strategies

First and foremost, your training should mirror the culture, approach, and methods you want your facilitators to use with their practices. This takes a skilled trainer and training content mindful of these connections.

Whenever possible, your PF training program should use experiential and applied training approaches. While didactic instruction and training in a theory can be helpful, the work of the facilitator is very much grounded in the real world, so in practice, to the extent possible, your training methods should mirror this reality.

Case-based learning, often used in medical education, is a useful strategy for training facilitators. This approach emphasizes the practical and applied nature of the work of the facilitator and caters to it. Role plays and similar strategies are other helpful approaches. Still other programs have modified the concept of the "standardized patient," used to train medical students, for use with the facilitator. Still others use observation rooms and bug-in-the-ear technologies, commonly used to train psychotherapists, to provide intensive, experiential training to facilitators in such skills as group facilitation, conflict resolution, and executive coaching.

Ideally, the curriculum should include field experiences, in which your facilitators can follow an experienced facilitator in the field for a day or more and then return to the training room to debrief on what they observed and learned. Shadowing can be a way for trainees to view multiple facilitation styles as well as a range of practices along the change continuum.

Selected examples of training approaches. At OKPRN, new facilitators complete 2 days of training in the classroom and then spend 2 days in the field with an experienced facilitator. The trainees are asked to keep "diaries" of their experiences in the field as a way of supporting the debriefing and reflection process.

As part of ongoing training at the South Texas Ambulatory Research Network, facilitators audio-record a facilitation session with a staff person in one of their practices shortly after starting work there. Their facilitator colleagues and supervisor listen to the recorded sessions as a group and provide feedback to the facilitators on their performance.

The State of Vermont takes an innovative approach to training its facilitators by co-training them with the practices with which they will be working. In this way, both the facilitator and the practice are on the same page at the start of the PF intervention and share the same vocabulary in the effort, and the practice is primed early in the intervention to move into high-impact work with the facilitator.

HealthTeamWorks has its facilitators audio-record their encounters with the practices as part of their training program; the facilitators then bring the recording back to review it. The training team also reviews it and provides additional training and feedback based on the content of the tapes. The organization also has developed a "standardized practice" exercise analogous to the "standardized patient" experience used to help train medical students. In the standardized practice approach, facilitators run a practice encounter while the training and PF team observe and provide suggestions and feedback using bug-in-the-ear communication technology.

While some of these methods can be relatively costly, low-cost methods also exist that can increase the experiential nature of your training. These include problem- and case-based learning models, role plays, and the opportunity to shadow a more experienced PF for a day or two out in the field.

Select Your Trainer and Training Team

The person you select for training may be someone from your PF program or your program's host organization, or someone with whom you contract to provide the training. Ideally, this individual has worked as a facilitator and has a deep knowledge of its challenges and rewards and the types of practices your facilitators will be supporting. In addition, a trainer should be well versed in and able to teach empowerment concepts and strategies and model for the facilitators the methods you want them to use with their practices. Whenever possible, experienced facilitators from your program should be included on the training team to provide real-world examples to your trainees and help ensure that the training they provide is applied and practical.

Set the Training Schedule

You will need to decide the schedule for your training program. How frequently will you provide training, and for how long? Most programs have their facilitators participate in an orientation training designed to teach basic concepts and skills related to the PF intervention, followed by ongoing training that builds on these initial sessions and addresses new topics raised by facilitators during supervision.

For example, OKPRN provides a 2-day intensive workshop for new facilitators at startup, followed by weekly 2-hour training sessions for all facilitators; these sessions are ongoing throughout the year. LA Net begins with a 5-day intensive training for its new facilitators that includes 2 days of orientation and QI methods training, 1 day of academic detailing sessions with their practices, 1 day shadowing a PF in the field, and then 1 day of debriefing about the field observation and initial intervention planning for their practice/s. Facilitators then participate in weekly 2-hour group training and individual training sessions onsite at the LA Net offices or through video conferencing.

Here is an example of what startup and continuous training might entail:

Startup training. Most facilitation programs have their facilitators complete an introductory training, which can range from 2-day intensives to several weeks of regular 2-hour sessions. Typically, these early trainings introduce new practice facilitators to:

- The PF model they will be using
- The fundamental and program-specific competencies they will need to implement the program's intervention model
- The practice environments in which they will work

In addition to these fundamentals, the introductory or kickoff training should prepare all members of your PF program, including supervisors and support staff, to work together effectively as a team. Training should introduce facilitators to the values, mission, and culture of the PF program and its host organization. For example, the training should address such questions as "What does it mean to be a member of your organization?" Training should establish norms and procedures around communication and introduce protocols for regular feedback about what is working well and areas needing improvement.

Continuous training. Your PF program should emphasize continuous learning**.** The continued learning cycle should be driven by issues brought up during supervision and facilitator learning community interactions. Training should reinforce the idea that learning and improvement is ongoing. These trainings can be accomplished through onsite training, Web conferences, site visits to other PF programs, sending your facilitators to conferences focused on QI, and even self-study programs. An email list and similar resources also can be useful in providing ongoing training by allowing facilitators and their trainers to hold continuing discussions about particular PF topics.

Training for Other Members of the PF Team

Training for PF physicians. If you are using a team approach to facilitation (discussed in Chapter 4), you also will want to provide training for the other PF team members. Even in nonteam models, you most likely will include a PF physician as a resource for your generalist facilitator to provide academic detailing visits at the start of an intervention and as a resource to troubleshoot practice engagement issues later in the intervention, or to provide training and support on a range of topics. Your PF physician will need a solid orientation to the mission and goals of your PF intervention and to your facilitators as a resource for practice transformation. He or she will need a clear understanding of his or her role on the PF team and in supporting the facilitator, as well as detailed information on the process, purpose, and goals of the initial academic detailing visit. In addition, the PF physician will need to be oriented on the importance of engaging diverse staff and clinicians from a practice in transformation efforts, and on the concepts of capacity building and empowerment. This training can be accomplished in a fairly short period of time and is important to assure the effectiveness of your PF intervention and teams.

Training for content experts. Content experts who are brought in as members of the PF team should also receive a brief orientation to the PF process, their role on the team, and of course the specific goals of the practice they have been brought in to assist. It should be clear that the goal does not involve ongoing consultation with the practice, but rather is to provide concentrated and time-limited support to the practice and the generalist facilitator and his or her team in an area where the facilitator and practice do not have sufficient knowledge or skills to undertake on their own. It should also be clear that their "client" in these instances is your PF program in collaboration with the particular practice, not the practice themselves, and that the

purpose of their engagement is to develop the knowledge and skill of both your facilitators or PF team and the practice.

Training for other staff. You also should provide training for other program staff who will be supporting the work of your facilitators. These include your administrative support staff, members of your IT team who will support your facilitators, and of course their trainer and supervisor. This training should be aimed at creating a shared sense of mission and goals for all members of your program, emphasizing a commitment to quality improvement both in the practices and within your own program, and promoting effective team work.

Checklist for Training Practice Facilitators

- ☐ Develop a list of specific competencies your facilitators will need to be able to implement your intervention effectively
- ☐ Develop a curriculum, or adapt an existing curriculum, aimed at building these competencies in your facilitators
- ☐ Create a tool for assessing the learning needs of the facilitator prior to the start of training and a mechanism for tailoring the training to the needs of the individual facilitator (depending on his/her background and experience)
- ☐ Incorporate adult education principles and experiential teaching methods into the training program
- ☐ Select someone to provide facilitator training
- ☐ Consider ongoing training and professional development plans for your facilitators
- ☐ Develop training for other PF staff

Practical Resources

- Sample training schedule and curriculum
- Resources for PF training

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Chapter 7. Supervising, Supporting, and Monitoring the Progress of Your Practice Facilitators

A strong supervision model provides essential guidance and support for facilitators and gives them a mechanism for continuous learning. Supervision helps facilitators monitor their progress with each practice, stay focused on high-yield activities, and solve problems at individual practice sites.

As with other aspects of the program, the supervision model should be consistent with the goals of the practice facilitation program and its intervention. PF supervisors should model the approach and strategies that the facilitators themselves are expected to use in the practices. For example, if an intervention model emphasizes empowerment and capacity building in the practices, the supervisor should model these in his or her own work with the facilitators. If the facilitators are expected to develop and implement quality dashboards within their practices, the supervisor should model the use of these with his or her own supervision work.

In addition to supervision, facilitators also need a mechanism to connect with their PF teammates and the larger community. Creating a community of facilitators provides a source of ongoing support for the often challenging work of PF and gives facilitators an avenue to share good ideas and lessons with each other.

This chapter provides information to help you design a supervision program for your facilitators and create a community that supports facilitators' work and allows for the spread of good ideas. Specifically, it provides information on:

- Selecting a supervisor for your facilitators
- Orienting and training your supervisor
- Deciding on individual versus group supervision
- Providing supervision in person or by distance technology
- Deciding on the schedule for supervision
- Determining the focus and content of supervision
- Monitoring the progress of your facilitators and their practices
- Creating a peer support group and learning community for your facilitators

Select a PF Supervisor

Selecting the person who will supervise your facilitators is extremely important. An effective supervisor can increase the effectiveness of your facilitators tremendously, and an ineffective one can bring your program to a grinding halt. You should take great care when selecting and orienting this person to your program. Ideally, she or he should be a master facilitator and an expert in the environments in which your facilitators will be working. The supervisor's own personal competencies should be the same as those you have defined for your facilitators. To be effective, your supervisor must have a deep understanding of your program and its change concepts and key-driver model(s). He or she must be very comfortable with the acquisition and

use of data for improvement, and committed to using both processes with the practices and in supervising facilitators. The person must be deeply skilled in quality improvement and possess the same facilitative interpersonal skills as your facilitators. A supervisor also must understand and be able to model empowerment approaches to working both with practices and facilitators, and have a clear commitment to building the capacity of the practices and facilitators. Finally, she or he must have a deep understanding of the difficulty of this type of work and the interpersonal demands it creates.

An effective supervisor also must be skilled in helping facilitators maintain objectivity and not become so much a part of the practice system that they are no longer able to assist. The supervisor also should be effective at helping to reduce burnout. Supervisors can come from a variety of backgrounds. It can be helpful for them to have a clinical degree but, in some cases, this may limit the possibilities they perceive in a practice because of their own past experiences.

Orient and Train Your Supervisor

Because of the PF supervisor's oversight role and the assumption they are already experts in the subject, it can be easy to forget the importance of training your PF supervisor. But providing in-depth training to your supervisor is essential. PF supervisors need an in-depth orientation to your program, its mission and goals, your key-driver model and intervention approach and the health care environment and practice settings in which their facilitators will be working. In addition, depending on their background and existing competencies, they may need training on adult education strategies, and approaches to supervision that emphasize empowerment and capacity building. As part of this training, they should be encouraged to adopt supervision methods that mirror the work they will be helping the facilitators carry out at the practice level, including incorporation of feedback from front-line workers (in this case, the facilitators) into program and intervention design and methods. As with your facilitators, you should provide opportunities for ongoing professional development for your supervisor through participation in conferences and professional development training related to primary care transformation and quality improvement.

Determine Whether You Will Use Individual or Group Supervision

Supervision of your facilitators can occur one on one, through a group, or through a combination of each of these approaches. Each has its own strengths and weaknesses.

In individual models of supervision, the supervisor meets with the facilitator on a regular basis, ranging from weekly to monthly. The facilitator and the supervisor review progress, discuss difficulties the facilitator may be experiencing in the practices, and develop intervention plans. The supervisor acts partially as instructor, partially as a sounding board, and partially as a resource broker for the facilitator. Because PF often is relationship- and conflict-intensive, an important role for the supervisor is assisting facilitators in maintaining objectivity in their work with their practices.

Individual supervision models can help to foster strong and trusting supervisor-facilitator relationships and give facilitators the private space to share those concerns they might be reticent to share in a larger group. Disadvantages to individual supervision approaches are their higher

cost and the absence of input from PF teammates that often can be as or more useful than feedback from the supervisor.

In group approaches to supervision, the supervisor meets with two or more facilitators at a time and provides the same types of feedback and support as in individual supervision sessions. In addition, group members may also offer insights and ideas to each other, providing an additional source of input for the participating facilitators and a mechanism for spreading "good ideas" identified at the practice or PF level.

Group supervision can be less costly, in that a single supervisor can support multiple facilitators at a time, and allows for team building, mutual problem solving, and the spread of good ideas among facilitators. The weaknesses of the model are that it can inhibit sharing of sensitive information, and facilitators may not feel comfortable discussing certain problems in a group setting.

Mixed approaches that combine individual and group supervision are likely to be the most effective. For example, a supervisor may start with group supervision and then provide one-on-one meetings for facilitators who need more intensive support or are dealing with particularly sensitive issues.

In addition to individual and group supervision, some programs allot time on a regular basis for experts external to the program to interact with the facilitators and provide additional support. Facilitators may be asked to come up with questions in advance and then use the time with the expert to explore answers and brainstorm together.

Decide Whether Supervision Will Be Provided In Person or Using Distance Technology

As with training, supervision can be provided in person or by using distance learning technology. In-person supervision allows for more personal relationships but is more costly. Supervision via Web or teleconferencing also is used by some PF programs, especially those with facilitators spread across large geographic areas. The use of distance learning technology can lower costs of travel as well as the use of facilitator and supervisor time and also make the sessions more accessible. In addition, they offer the possibility of video recording the sessions for later viewing, depending on HIPAA and other privacy concerns.

The Primary Care Development Corporation (PCDC), with the assistance of Coleman Associates, developed a process for supervising its facilitators using video conferencing. Because its facilitators were so geographically dispersed, PCDC provided supervision virtually using video conferencing technology. Facilitators and their supervisor met weekly and reviewed each practice's progress through the interventions' key change concepts and developed plans for the coming week. As part of its supervision process, PCDC would pair facilitators who were experiencing problems with a practice with a "virtual mentor" facilitator who may have special expertise in the types of changes the practice was attempting, or who had encountered and solved similar problems in the past with other practices. Onsite supervision and training meetings were conducted occasionally as budget and timeframe allowed, but the majority of support was delivered virtually.

Decide on the Schedule for Supervision

Facilitators need regular supervision. Depending on the complexity of the changes they are supporting, as well as the practices, a facilitator may need supervision weekly or more often. In general, supervision should take place at least once a month. In difficult settings, or when facilitators are supporting very complex changes, the facilitator may need to check in with the supervisor several times a week. Thus, providing the option of consultation through Web or teleconferencing is important.

The Oklahoma Physicians Resource/Research Network (OKPRN) brings its facilitators to the office for one half day a week for individual and group supervision sessions, followed by a "facilitator support group" in which only facilitators participate and where they share challenges as well as lessons learned in the field. Because of its size and wide geographic spread, the PCDC provides supervision to its statewide network of facilitators through monthly Web conferences. Facilitators working in various parts of the State join the Web conference once a month for training and supervision. These meetings are supplemented by less frequent and periodic training sessions that are in person.

Determine the Focus and Content of the Supervision

PF supervisors can focus on many areas in their supervision of facilitators. Some important areas include:

- Assisting facilitators with developing and maintaining facilitative relationships with their practices (for example, positive relationships that advance the intervention and practice transformation process)
- Assisting facilitators in maintaining effective boundaries with their practices; this allows the facilitator to focus on capacity building rather than "doing for" the practice, but also permits hands-on support when appropriate
- Providing the content knowledge needed for the particular PF intervention
- Assisting facilitators in forming and managing their PF team for a practice
- Assisting facilitators in monitoring their panel of practices' progress through the stages of the intervention model and implementation of change concepts and key drivers, and problem solving as barriers are encountered
- Providing professional development for facilitators

Design Reporting Mechanisms to Monitor Progress of Facilitators and their Practices

Data are an essential element of both QI work in a practice and PF supervision. You, your PF supervisor, and your facilitators will need an efficient and effective way of tracking the facilitator's progress with each practice. Analogous to a provider managing a panel of patients, facilitators manage a panel of practices and need a way to track progress through key milestones of the intervention to identify any practices not responding well and those that are exemplars.

Ideally, facilitators should keep regular progress notes on their practices. These notes will allow the facilitator and supervisor to assess progress, and will help the supervisor to identify areas where the facilitator is more or less effective and provide training and support to remediate any areas of weakness. Some programs use structured progress report forms. Others use a more informal means, such as "diaries." These reports enable supervisors to stay involved and provide feedback to facilitators. When shared with a group of facilitators, these tools can support mutual brainstorming and problem solving.

In addition, your program should provide a "registry" of practices that allows facilitators to track their progress. Several PF programs have developed "PF registries" that enable facilitators to track progress across all of the practices they are supporting and allow supervisors to look across all practices supported by a program. The registries also let the facilitator and the supervisor identify potential exemplars from among the practices—these practices might be able to share lessons learned—as well as practices not progressing as expected that need further assessment and remediation.

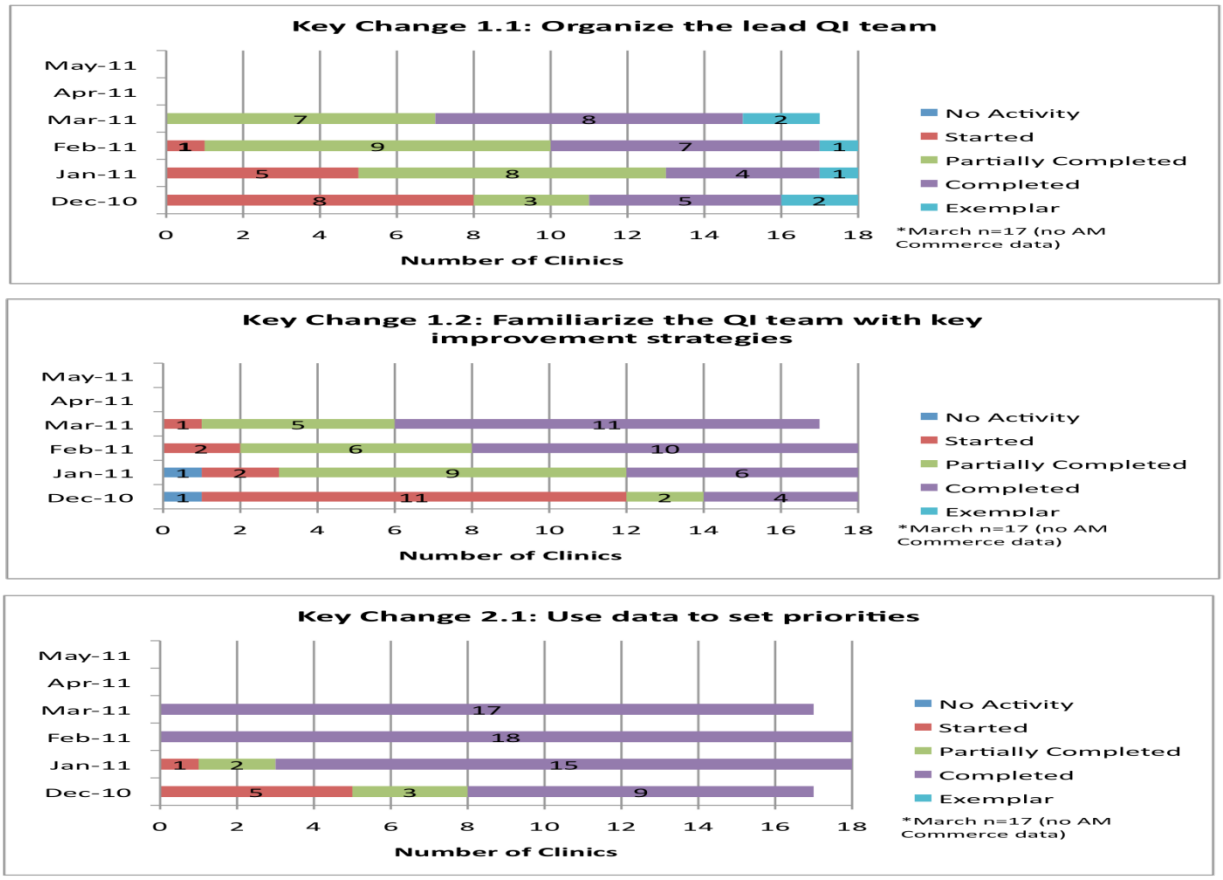
Improving Performance in Practice (IPIP) developed a Web-based database and practice registry that allowed program directors and facilitators to track progress across several hundred practices in that initiative. A screen shot of this report is shown in Figure 7.1. Figure 7.2 provides another example of a tracking tool LA Net developed for its Care Model intervention that builds on the IPIP registry model. Ideally, the fields that populate the registry should be consistent with and track to key phases in your PF intervention and the change concepts and key drivers in your intervention model.

Figure 7.1. Screen shot of a report from the IPIP registry

	Practice:	Sample Practice
	Topic:	Asthma
	Practice ID:	194836768173
	Contact:	#N/A
	QIC:	Sample
	Report Period:	Aug-10
	Last Practice Contact:	1/1/10
	Date of Final Report:	
AIM		
Enter the team aim statement:		
PRACTICE ASSESSMENTS for August 2010		**Notes**
Overall Team Assessment	0.5 - Intent to Participate	
Team Engagement	0 - No Activity	
Leadership	0 - No Support	
CHANGE ASSESSMENTS for August 2010		**Notes**
Implement Electronic Database (Registry)	0 - No Activity	
• Select, install registry or EHR to identify patients	0 - No activity	
• Develop registry workflow & assign team roles	0 - No activity	
• Populate registry with patient demographic data	0 - No activity	
• Enter patient clinical data	0 - No activity	
• Produce reports on measures	0 - No activity	
• Use Registry to manage patients, population	0 - No activity	
Develop a template for planned care	0 - No Activity	
• Select template or create flowsheet	0 - No activity	
• Determine staff workflow to support use of template	0 - No activity	
• Use template with all patients	0 - No activity	
• Make sure registry populated each time template used	0 - No activity	
• Monitor use of template	0 - No activity	
Self-Management Support	0 - No Activity	
• Obtain patient education materials	0 - No activity	
• Determine staff workflow to support SMS	0 - No activity	
• Provide training to staff in SMS techniques	0 - No activity	
• Set patient goals collaboratively	0 - No activity	
• Document & monitor patient progress toward goals	0 - No activity	
• Link with community resources	0 - No activity	
Use Asthma Protocol	0 - No Activity	
• Assess and document asthma severity and control	0 - No activity	
• Prescribe appropriate asthma medications & monitor overuse of beta agonists	0 - No activity	
• Use Asthma Management plans	0 - No activity	
• Establish visit frequency protocol	0 - No activity	
• Assess and treat co-morbidities	0 - No activity	
• Assess, counsel, and prevent exposure to environmental triggers	0 - No activity	

Source: IPIP registry.

Figure 7.2. Example of a visual progress tracker based on a PF program's key-driver model (partial)



Source: LA Net Progress Tracker.

The PF supervisor and facilitators from the PCDC assigned a color code to each practice every week based on their progress through the intervention model. Practice teams that were on track were coded green, those that were experiencing some difficulties were coded yellow, and those that were demonstrating a lack of engagement or follow-through were coded as red. The majority of supervision time was spent developing plans for yellow and green practices since this is where PCDC believed its facilitators could have the greatest effect. Red practices were discussed and plans were developed, but not as much time was devoted to this group. This process of color coding was done informally but could easily be formalized and used with other PF programs.

Obtain Regular Feedback from Practices on Facilitator Progress

Facilitators spend most of their time out in the field, working independently with practices. As a program director, it is easy for you to lose touch with the practices and for problems with facilitator/practice interactions to go unnoticed. Thus it is important that you create ways to obtain regular feedback from the practices participating in the PF intervention. This feedback should be requested at least every 3 months, and more frequently if a facilitator is

experiencing difficulty with a practice. This can be done via email, telephone, or even through an online survey. You should ask practice leadership for their input on progress towards the goals of the improvement interventions, their perceptions of the overall effectiveness and value of the PF intervention in moving them toward these goals, and recommendations for improvement. Practice leadership also should indicate if they feel a meeting with the program director might be useful. Facilitators should be knowledgeable about this feedback process with the practices, and be involved in developing the feedback process and questions/forms. The feedback should be shared with the facilitator as part of his/her regular supervision sessions, and used to guide tactical planning for interventions at the various practices as well as ongoing training and supervision of the facilitator.

Provide a Peer Learning Community for Your Facilitators

In addition to regular supervision, your facilitators will benefit greatly from the opportunity to share ideas and brainstorm with a community of their peers. In fact, creating such a community could be considered an essential component of a PF intervention, as it enables the spread of good ideas from one facilitator to another and from the practices of one facilitator to those of another.

> *"There has to be this return and re-group and shared learning between the facilitators….a shared ecology. …That environment may help facilitators mature quickly."*
>
> *—Dr. Craig Jones, Vermont Blueprint for Health*

A Peer Learning Community brings together the facilitators on your team on a regular basis, either virtually or in person, for social support and to share ideas and strategies for working with practices. These groups are led by the facilitators themselves and typically do not include the supervisor or administrators, so that the facilitators don't feel inhibited in their discussions with each other. These learning community meetings can occur in conjunction with supervision, and facilitators can report on topics that came up during the meetings, either to feed into the training and supervision materials or stand alone. Some programs schedule regular sessions, while others allow them to take place spontaneously at the initiative of the facilitators. These encounters, while likely more effective in person, can also take place virtually, through email lists, Yammer, or other methods, such as instant messaging.

Several programs report that these sessions are quite useful for spreading good ideas among facilitators. For example, one program reported that in one meeting, a facilitator shared a simple strategy that one practice had used to increase its foot exam rate by 40 percent in less than a month: the chief medical officer of this practice had placed monofilament in exam rooms to remind providers to conduct the foot exam. It was a low-cost and simple idea and produced a solid effect in a short time. During the learning community meetings, the facilitator for this practice shared this experience as possibly useful to facilitators working in other practices.

Checklist for Supervision

- ☐ Select a supervisor for your facilitators who can provide supervision that models empowerment strategies and your intervention model

- ☐ Select individual or group supervision approaches, or a combination of both

- ☐ Decide whether you will provide supervision in person or using distance learning technology
- ☐ Develop tools to assist the supervisor in tracking the performance of facilitators and their practices
- ☐ Create a learning community for facilitators in which they can share experiences and lessons learned and support the spread of good ideas

Practical Resources

- Sample encounter form
- Sample job description for supervisor

Chapter 8. Evaluating the Quality and Outcomes of Your Facilitation Program

Quality improvement is relevant not only to the practices your facilitators support, but also to your own program. As with the practices they serve, practice facilitation programs need their own internal QI infrastructure to support ongoing improvement of the PF intervention and the program housing it. Similar to the practices with which you work, the internal QI infrastructure for your program should include a QI team, a formal QI plan, and well-defined methods for identifying and implementing essential improvements and supporting a culture of ongoing quality improvement in your organization.

An essential part of any robust QI program is evaluating the organization's outcomes and overall effectiveness. As the director of a PF program, you should ensure that some resources are set aside to support at least a basic evaluation of your program's outcomes and effectiveness that can support improvement of PF intervention and build a case for your program to practices and funders alike.

> *"PF programs should have some sort of built-in evaluation that helps them improve. Each program will have a theory of how they help practices improve or transform, and they should have some metric of whether they are achieving that."*
>
> *—Dr. Darren DeWalt, University of North Carolina School of Medicine*

The purpose of this chapter is to provide information about QI and evaluation specific to PF programs, not a comprehensive text on how to carry out either activity. There are many excellent resources for both QI and evaluation already available, many of which you may already know about through the work you do with practices. A few of these are listed in the practical resources provided at the end of this chapter.

This chapter provides information that can assist you in developing the infrastructure within your program to support its ongoing QI and the important task of evaluating the outcomes and effectiveness of your program, including:

- Forming an internal QI team and creating an internal QI plan
- Identifying metrics for use in your QI process
- Assessing the fidelity of implementation of your PF intervention
- Evaluating the outcomes and effectiveness of your PF program
- Selecting a study design
- Determining which outcomes to evaluate
- Identifying data sources to use in the evaluation
- Determining the uses and limitations of the evaluation
- Deciding to participate in large-scale evaluations of PF

Form an Internal QI Team

The membership of your internal QI team should be diverse and include representatives from all areas of your organization. For example, your team might include the program director, practice facilitators, a representative from the administrative staff, a provider from the practice community you're serving, the provider champion working with your facilitators to do academic detailing visits, your IT staff person, a patient representative, and a representative from another key stakeholder group, such as the local health plan.

Create an Internal QI Plan for Your Program

Conducting internal QI is an essential part of developing your program. In a process similar to that which your facilitators use with their practices, you should create a QI team and plan for your program that specifies its purpose, aims, membership, and methods.

At the same time your internal QI program helps to ensure that your program and PF interventions are optimally effective, it can also serve to model for your facilitators and other staff the same activities they may use to assist their practices. For this reason, it is useful to incorporate in your program's internal QI plan those QI processes and methods similar to those your facilitators will be introducing to their practices. For example, if your facilitators are charged with supporting QI teams, they may already be working with data walls or dashboards of key quality metrics selected by the practices. They also may be conducting Plan-Do-Study-Act (PDSA) cycles to test and implement improvements quickly.

Your internal QI process should define how often your team will meet, who will be responsible for the core activities in the process, how the team will communicate both internally and with the larger program staff, and how it will implement and sustain changes. Also essential are creation of mechanisms for you to solicit and continually incorporate feedback from your frontline facilitators and providers into your program and intervention design.

Identify Quality Metrics to Use in Your Internal QI Process

Your internal QI process should emphasize data-driven change, consistent with the kind of change your facilitators seek to implement in the practices they support. You and your team will need to identify program metrics to track as part of internal QI. Unlike the primary care practice itself, metrics to assess the quality of PF programs are not yet well established. That said, the observations and suggestions of experienced directors, facilitators, and practices can be used as a starting point. Some suggested metrics are provided in Table 8.1.

Assess Fidelity of Implementation of Your PF Intervention at the Practice Level

It is important to assess the degree to which facilitators deliver the intervention to the practices as planned. This will help you and your QI team identify where facilitators may be having difficulty in implementing certain aspects of the intervention, where they may need additional training or support, and where the intervention or key-driver model may need adjustment. These data also will help you interpret the results of your outcome evaluation. They

Table 8.1. Some suggested quality metrics for PF programs

Program mission, goals, and methods are aligned with those of the surrounding health care system
Program is in an organizational home that aligns with its mission and goals
Program has a detailed business plan, including a funding approach that incorporates efforts to obtain long-term operational funds and considers the impact of funding on program mission and methods
Intervention has a well-defined key-driver model used to guide facilitator work with practices, facilitator training, and evaluation of the outcomes
Program and intervention are informed by an advisory group of key stakeholders, and program and intervention are provider-centered
Intervention design aligns with its key-driver model, utilizes best practices in PF, and is provider centered
Core and specialized competencies that facilitators need to implement the intervention are defined clearly and based on the intervention's key-driver model
Core competencies guide hiring decisions regarding facilitators
Program provides robust training and supervision for its facilitators, aligned with its key driver model and best practices in the field
Program provides regular opportunities for peer support for its facilitators
Program has an internal QI infrastructure that is data driven and mirrors (when possible) the processes that facilitators use with their practices
Program regularly evaluates the outcomes of its interventions at the practice, provider/staff, and patient levels
Program routinely tracks the fidelity with which the intervention is implemented in its practices
Program regularly assesses satisfaction of key stakeholders with its intervention/s and incorporates this feedback into the program design
Program participates in multisite evaluations to assist in building the knowledge base on PF when possible and appropriate

can help you determine if a lack of effect is the result of an ineffective intervention or due to a failure to implement the intervention as designed. In more complex evaluations, the data can help you examine outcomes relative to intervention dosage and fidelity, among other factors.

A simple checklist can be a low-cost and relatively easy way to document intervention fidelity. The checklist is completed by your facilitators on a monthly or other appropriate schedule and documents progress with implementing change concepts and improvement drivers. In addition to providing data for the evaluation, these checklists can be used by the facilitators' supervisor to track their progress with individual practices and identify areas where a facilitator may be experiencing difficulty.

Another resource for assessing both fidelity and PF progress through the intervention model is the practice progress tracker. This tool is used by the PF supervisor to keep track of facilitators' progress in their practices. It is discussed in greater depth in Chapter 7, which provides an example of a progress tracker.

Evaluate the Outcomes and Effectiveness of the PF Program

PF interventions are expected to produce changes at practice and patient levels. At the practice level, depending on its goals and design, an intervention may be expected to produce changes in a practice's administrative processes and systems, clinical processes and systems, QI processes and systems, health information technology processes and systems, and the practice's connections with the surrounding community. Interventions also aim to increase or improve the knowledge, skills, behaviors, and attitudes of providers and staff working in the practice.

At the patient level, PF interventions are expected to produce improvements in patient outcomes and experience. Such improvements, as well as reductions in the costs of care, are the ultimate aims of PF, which pursues them through interventions that improve the functioning of the practice and its employees.

Before you begin to use data from a practice for your own program's evaluation purposes, you must become familiar with the basic concepts of research involving personal health information and human subjects. Online courses on these issues are available such Collaborative Institutional Training Initiative's training for human subjects research. These will familiarize you with the different issues you must consider. In addition, before beginning evaluation, you should execute a business associate agreement (BAA) and a data use agreement (DUA) with each practice. Usually, you already will have executed a BAA with the practices prior to beginning the PF intervention to allow your facilitator to access practice data for purposes of supporting practice transformation. The BAA also should be crafted to cover the use of data for evaluating the outcomes of the PF intervention. In some cases, you also may want to include a DUA that specifies who has access to the data and how the data can be used and reported. If you think you may want to publish or disseminate your findings, you may also want put agreements in place with the practices as well. An example DUA is provided in the practical resources at the end of this chapter.

Select a Study Design for Your Evaluation

When selecting the design, you should pay careful attention to the issues of cost, feasibility, and intended use of the evaluation results.

Rigorous study designs that use a randomized controlled approach or strong comparison groups, and/or extensive qualitative interviewing, can be costly and create significant additional burden on your practices. Evaluations using these designs typically are intended to produce knowledge that can be generalized to other programs beyond the ones being studied. PF programs usually do not have the money or technical expertise needed to engage this level of evaluation; typically, programs are seeking to generate information that is useful for improving their own program.[9]

[9] Several resources on designing strong evaluations of efforts to redesign or transform practices into medical homes are available at www.pcmh.ahrq.gov.

More basic designs, such as a simple pre-post study, are more feasible for PF programs to undertake on their own without external funding. Such designs, however, are less rigorous because they lack a control group and impacts cannot be attributed directly to the PF program. This said, they are often sufficient for a PF program seeking information to support improved quality of its own services and, in some instances, requests for support from local funders. Pre-post study designs need to be used with care, however, even if the results are only being used to support quality improvement in the program. For example, combining data from multiple practices in an evaluation of PF program warrants careful consideration and a thoughtful approach to dealing with differences in these practices at baseline is important. An understanding of the limitations of pre-post study designs—namely the fact that their results can only be *suggestive* of possible impacts—also is key. Such studies may be strengthened with a followup assessment several months after the intervention is completed to ascertain sustainability of changes and additional later outcomes. There are many excellent evaluation research texts that can help guide your evaluative work. Classic texts such as *Evaluation: A Systematic Approach* (Rossi, Lipsey, and Freeman, 2004) can provide valuable guidance as you develop your evaluation. In addition, the Improving Performance in Practice manual has an excellent section on evaluating PF programs that you may also find useful (DeWalt, Powell, Mainwaring, et al., 2010).

A basic evaluation of the outcomes of your PF intervention often should be conducted using data your facilitators already are collecting as part of the initial assessment they conduct with each practice at the beginning of the intervention to aid in goals setting, as well as the continuing assessments that take place as part of the data-driven change process they support at the practice. This can lower the costs of the evaluation considerably, and greatly reduce or even eliminate additional burden on the practices and facilitators as a result of the evaluation.

A mixed methods approach that includes both quantitative data, such as HEDIS indicators and provider surveys, and qualitative data from observations and key-informant interviews will provide a deeper and potentially more useful understanding of your program than either type of data alone. Interviews with individuals carefully selected for their ability to reflect on an aspect of your program for which you would like to acquire a more in-depth understanding are almost always both feasible and affordable. In these instances, it can be most useful to interview individuals with different experiences and opinions of your program. For example, speak with both individuals who report a positive experience with PF and those who report a negative one. This ensures that you will get the most comprehensive picture of your program possible, which can help you to continue improving your program.

Determine What Outcomes You Will Track

The outcomes that you will assess through your evaluation should align with the key-driver model for your program. You may also want to incorporate additional outcomes that reflect particular goals the practices identify for the PF intervention.

As you design your evaluation, you should consider the degree to which particular interventions reasonably can be expected to produce a particular outcome, given the goals, methods, and dosage of the PF intervention and the timeline for your evaluation.

For example, interventions focused on structural transformations may take many years to translate into measurable changes in patient outcomes. They may even show a short-term decline

for certain measures, such as patient experience, during the transformation period, while patients are disrupted by the changes being made in the practice. In contrast, a PF intervention focused on implementation of discrete changes, such as adherence to practice guidelines for chronic kidney disease, are likely to translate more rapidly into changes in patient outcomes tightly focused around the target condition, but show little effect on the outcomes of other patients or the overall capacity and functionality of the practice.

Creating a map of the expected sequence of outcomes from the PF, again drawing from your key-driver model, can assist you in selecting outcome measures appropriate for the design of your PF intervention and your evaluation's timeframe. See Figure 8.1 for an example. (Detailed logic models may provide similar information, allowing you to drill down to several levels of intended outcomes.)

Identify Data Sources for the Evaluation

Whenever possible, you should seek to make "double use" of data. The data you use to evaluate your program should come from information already being collected in the practices as part of the PF intervention—for example, chart audit data for assessing progress toward quality-of-care goals. This will reduce both the costs associated with evaluation and the burden on your practices and facilitators.

Practice registry. Practice (not patient) registries can be useful sources of data for continuous quality improvement (CQI) and more formal program evaluation. These registries enable facilitators and their supervisors to track the progress of their multiple practices as they move through key elements of the intervention. These data can be useful for evaluating both implementation fidelity and practice progress.

PF encounter forms. Clinicians make progress notes regarding their patients. In a parallel process, facilitators can make progress notes on their practices, which can include their progress, CQI/transformative goals, and other important aspects of facilitation work. There are several reasons for using this type of system: (1) using it as a communication tool; (2) tracking how practices are doing over time—where they are making advances and what may be holding them back; and (3) using this information qualitatively to inform program evaluation. See Appendix B for examples.

Performance data from practice data walls and dashboards. A key element of most PF interventions is the use of data to drive change. As part of the intervention, facilitators may collect and aggregate performance data through chart audits, electronic health records, or registries, and use them for initial performance feedback. These data might focus on care for a particular condition, the administrative functioning of the practice, or other salient metrics; these should be chosen based on the goals of the intervention. The data being collected to increase buy-in and support data-driven goal setting and improvement at the practice level also can be used for internal CQI and evaluation purposes.

Interviews and direct observation. It also can be useful to conduct key informant interviews with practice leads or observe facilitators while they work in the practice. This type of qualitative data can be an excellent source of information on intervention fidelity and overall processes of care.

Figure 8.1. Example of part of an outcome map for a PF program for use planning an evaluation

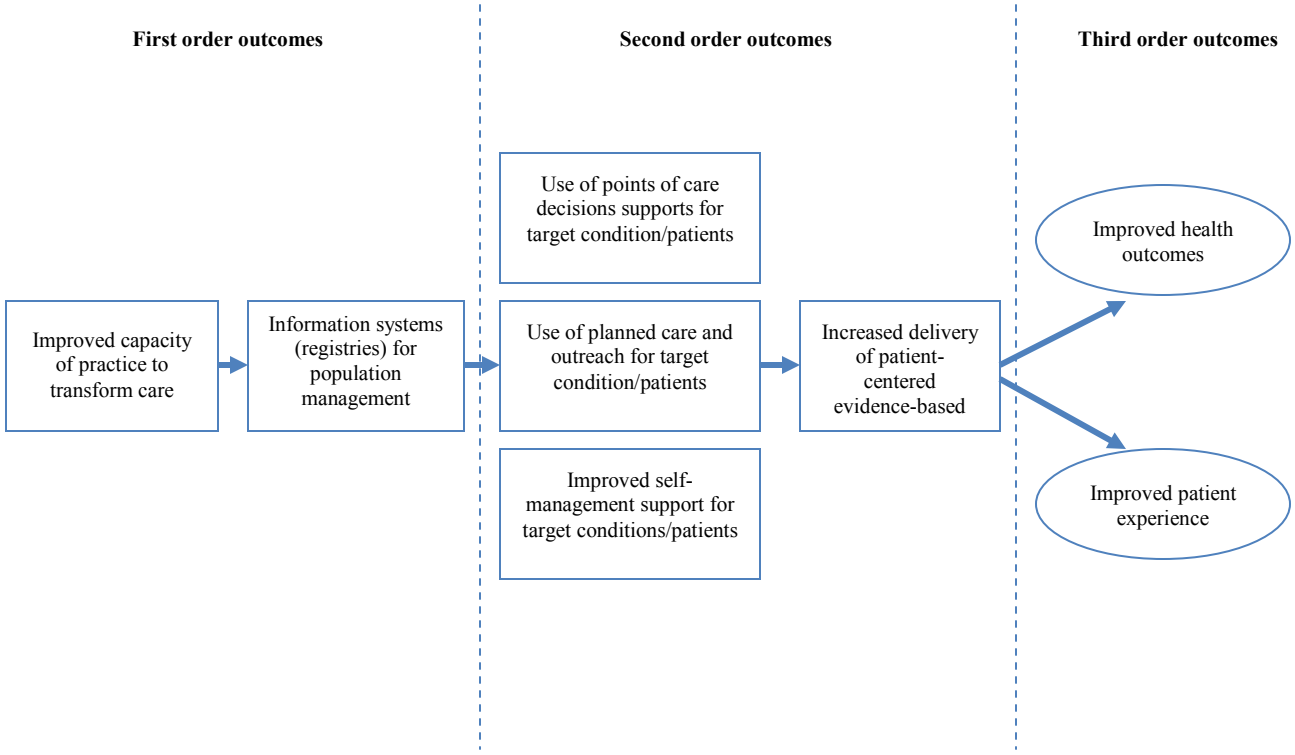


Table 8.2. Example of outcomes that could be assessed in an evaluation of a PF intervention

Practice-level outcomes
Improvements in a practice's overall capacity to engage in transformation
Improvements in administrative, QI, IT, and community systems and processes
Changes in targeted clinical processes
Changes in targeted care quality
Provider/staff outcomes
Changes in provider and staff knowledge, skills, behavior, satisfaction
Patient-level outcomes
Health status and outcomes for patients (Examples: A1c, smoking cessation, blood pressure, depression level)
Patient experiences with care
Patient quality-of-life outcomes
Outcomes specific to additional goals for the intervention as defined by the practice
Example: Implement panel management
Example: Improve cultural competence of patient care

Surveys. As part of the initial assessment and ongoing performance feedback, facilitators may collect surveys on provider/staff and patient satisfaction and experience of care. These data also can provide information on the outcomes for the PF program. See Appendix B for examples.

Determine Appropriate Use for and Limitations of Evaluation Results

The information you generate from a basic evaluation of outcomes can be used in your internal QI process, help inform development of your services, and aid in attracting funding—all of which can be quite useful. It is important to recognize the limitations of evaluation, however. Without a control or comparison group, it is not possible to attribute any changes detected in your evaluation to the effects of your PF intervention. Moreover, even with a strong study design, the many different transformation activities underway at any one practice can make it very difficult to determine which changes specifically flowed from the PF work.

Consider Participating in Evaluation Aimed at Creating Generalizable Knowledge

While most programs do not have the financial resources to conduct large-scale studies of PF or studies using experimental designs, there are an increasing number of opportunities to participate in them. This level of evaluation research seeks to produce knowledge that can be generalized to the larger field of PF and practice transformation and typically requires outside funding.

Federal agencies like the Agency for Healthcare Research and Quality (AHRQ) or large foundations such as the Robert Wood Johnson Foundation or the Commonwealth Fund may provide funding for studies aimed at understanding the effects of PF on primary care practice, patient outcomes, and health care costs. As the knowledge base supporting the effectiveness of PF for improving practice has grown, attention has begun to shift to identifying best practices in PF and examining its comparative effectiveness to other transformation approaches such as learning collaboratives.

There are different ways to learn about opportunities to participate in these types of studies. Posting on research and other email lists, such as the practice coaching list, can be a good way to identify study opportunities. AHRQ supports research in this area and its Web site is another resource (www.ahrq.gov). AHRQ's Practice-Based Research Network Resource Center is another place to look for information on studies on PF and practice improvement (pbrn.ahrq.gov/portal/server.pt?open=512&objID=969&mode=2).

Consider the Potential Positive and Negative Effects of the Evaluation Process

Evaluation efforts have the potential to affect program integrity in both positive and negative ways. On the positive side, the results of formative evaluation studies can be used by participating programs to make adjustments to their program and intervention model, and improve the overall quality and impact of their services. They are also useful in building the case

with funders for future support, and for creating buy-in and positive expectations for the PF intervention in practice leadership.

On the negative side, evaluation efforts, especially those that require rigorous study protocols, have the potential to have unintended effects on the PF intervention model and your program that you will need to manage.

First, the impact of collecting data for use in evaluation studies is something that you will need to consider whether it is for a basic evaluation you undertake of your own program, or as a participant in a larger, multisite study. For example, facilitators may find that the data collection required by a multisite study conflicts with the data collection processes central to the intervention itself. Collecting data as a QI tool and for an external evaluation sometimes can confuse both the practice and the facilitators and cause them to see data collection as a part of "the research"—not as a tool for QI. This can result in both the facilitator and the practice failing to "own" data collection and utilize for their internal use, instead seeing it as something being done for the researchers for purposes other than QI.

It is important to address such issues directly with the practice and the facilitators, and provide training and intermittent booster sessions on the different purpose and uses of data related to the PF intervention and study; this can reduce the likelihood of confusion.

Second, it will be important to monitor and make thoughtful decisions about modifications to your intervention model that may be required in order to participate in larger, more rigorous studies of PF. For example, your program may include use of local learning collaboratives in addition to your PF intervention, but in order to participate in a funded study, you could be asked to eliminate use of the local collaborative from your model. In another example, a study may call for randomization of practices to an intervention condition, and as a result, some practices may not meet the "readiness" criteria set for your particular PF intervention. A large study also might specify the dose of the intervention (say 50 hours) in order to standardize how it is delivered across multiple sites, but your program dose may average 100 hours per active intervention.

If your program participates in these larger studies, it will be important for you and your staff to remain aware of such unanticipated iatrogenic effects of research on your intervention design, and communicate these to the study team. It would be ideal if someone from your program can serve on the study team. Teams that combine researchers and frontline service providers (in this case PF program staff) are able to identify and address these issues much more effectively than those that include only researchers, and result in a better study and more research that is ultimately more relevant to the field.

Typically, the advantages of participation far outweigh the potential disadvantages. The first and most obvious benefit is that evaluation efforts can provide evidence on the positive value of your work, which can help in obtaining financial support for your PF intervention. Participation also can give you and your program staff access to leaders in PF and primary care transformation, and provide access to cutting-edge information and technology related to PF that can help advance your own program's intervention design. Finally, participation serves an important civic function, in that you are contributing to the knowledge base for PF, thus informing future program improvements and policy.

Checklist for Creating an Internal QI Program and Evaluating the Outcomes of Your PF Program

- ☐ Execute business associate, data use, and publishing agreements with practices for the use of practice data for PF program QI and evaluation purposes
- ☐ Form a QI team with diverse representation
- ☐ Create an internal QI plan for your program that clearly defines its purpose and aims
- ☐ Assess the degree to which the PF intervention is implemented in each practice as designed (fidelity)
- ☐ Evaluate the outcomes of the PF intervention
- ☐ Select an affordable and feasible study design
- ☐ Identify the outcomes you will evaluate
- ☐ Identify data sources using already existing data, whenever possible
- ☐ Determine appropriate use of evaluation results as well as their limitations
- ☐ Ensure that facilitators and practices are oriented to the purpose of the evaluation, and carefully monitor so that evaluation does not affect intervention fidelity
- ☐ Identify opportunities and participate in large-scale studies to develop generalizable knowledge, when feasible and appropriate to do so

Practical Resources

- Sample data use agreement
- Link to sample QI plan
- General resources for evaluation design

Chapter 9. Conclusions and Next Steps

Developing a successful practice facilitation (PF) program requires the integration of numerous components, including administration and finance, approach and strategy, hiring and personnel management, and development and implementation of training, as well as ongoing program assessment. This guide is just the first step in an effort to gather practical knowledge and experiences of those involved in PF programs. While developing a successful PF program can be challenging work, the payoff can be considerable: improving the quality of care and patient outcomes, and possibly increasing practice efficiency and reducing overall costs. We hope this guide is a useful starting point in your journey to helping primary care practices reach these goals.

The PF field is constantly evolving—particularly as it focuses increasingly on primary care redesign and transformation. Since best practices are just now beginning to emerge, it is important that those in the field work together to capitalize on quality improvement and practice transformation occurring across the country. More refined approaches and techniques for PF are likely to develop over time as the field continues to grow and mature.

In recognition of the evolving state of PF, AHRQ invites you to learn more about PF and primary care improvement. Links to this PF guide and future related initiatives from AHRQ can be found at the following Web site: www.pcmh.ahrq.gov.

AHRQ encourages you to share your ideas, stay connected to others in the field, and invite your colleagues to do the same. AHRQ hopes that through this work an active and vibrant PF learning community will emerge—one where members can grow, share lessons learned and best practices, advance the field of PF, and ultimately, help to transform primary care in the U.S. to achieve better care, affordable care, and improved experiences for both patients and health care providers.

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Appendix A. Theories of Organizational Change

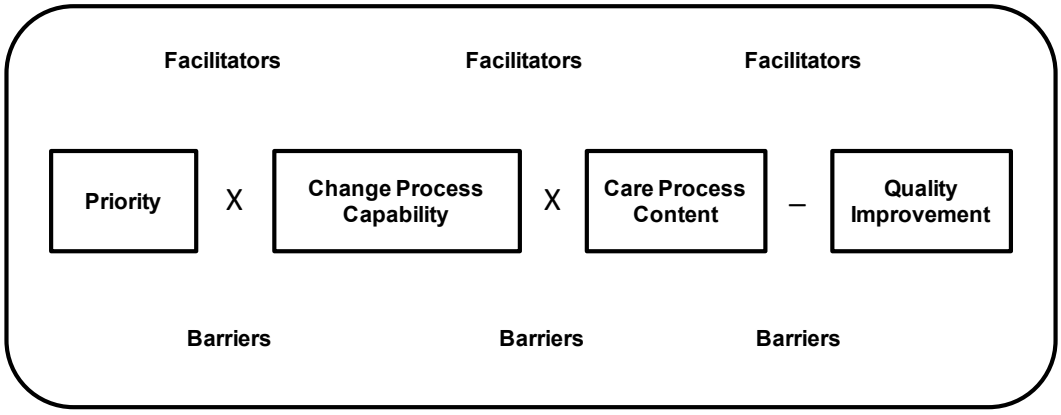
Change is at the heart of PF. A facilitator works with a practice to change its processes of care and, ultimately, improve clinical outcomes and patient experience. Given that PF is all about change, becoming familiar with theories of practice change can help guide your decisions about your program's design. These theories describe how organizations undergo change, what motivates change, and how change occurs.

Below we briefly review three theories of practice change frequently used in QI and PF, but there are many more from which you can choose. There are rich sources of information on practice change and the broader topic of organizational change in the health services literature, business literature, and popular press that are constantly evolving and will give you new ideas about how you can continually enhance your PF intervention model and its effectiveness.

Framework for practice improvement. Drawing on three decades of experience with QI research and practice redesign, as well as a review of the organizational change and QI literature in the medical care and other fields, Leif Solberg (2007) created a framework of the core capacities a practice needs for improvement (Figure A.1). It is based on three elements:

- **Priority.** QI is a high priority shared among top leaders and personnel at all levels, "reinforced by focused actions and commitment of resources" (Solberg, 2007).
- **Change process capability**. The practice possesses internal capacity to support improvement, including strong, effective leadership, a high degree of trust and teamwork, and a mature and capable clinical information system.
- **Care process content.** The practice has the knowledge and capacity to implement the particular changes in care processes being pursued. In particular, these include "systems level changes in the practice environment rather than simply asking individuals to simply do better" (Solberg, 2007).

Figure A.1. Conceptual framework for practice improvement



Source: Solberg (2007).

Complexity theory holds that complex adaptive systems are composed of individuals who learn, interrelate, self-organize, and evolve together in response to changes in their internal and external environments. Interactions are nonlinear and unpredictable; change in one area has the potential to affect the context of other elements and is not necessarily immediate (Miller, Crabtree, Nutting et al., 2010; Kernick, 2006). Miller and colleagues (2010) describe complexity theory as a way to understand the relationship-centered practice development approach used in the American Academy of Family Physicians' National Demonstration Project. The natural tendency of individuals to form patterns of relationships, learn, organize, and evolve suggests that interventions enhancing these activities will lead to better outcomes than those suppressing them. PF using a complex adaptive system framework often focuses on enhancing these elements in a practice around specific QI tasks (Lanham, McDaniel, Crabtree et al., 2009). According to Miller and colleagues (2010), "successful, sustained practice development requires strengthening of both internal relationships within the practice and external relationships with the local community and patients. A relationship-centered practice development approach helps make sense of why some practices improve, respond to external and internal changes, and even transform, while others doggedly resist change." Figure A.2 shows one representation of a practice change model based on complexity theory.

Figure A.2. Example of a practice change model based on complexity theory

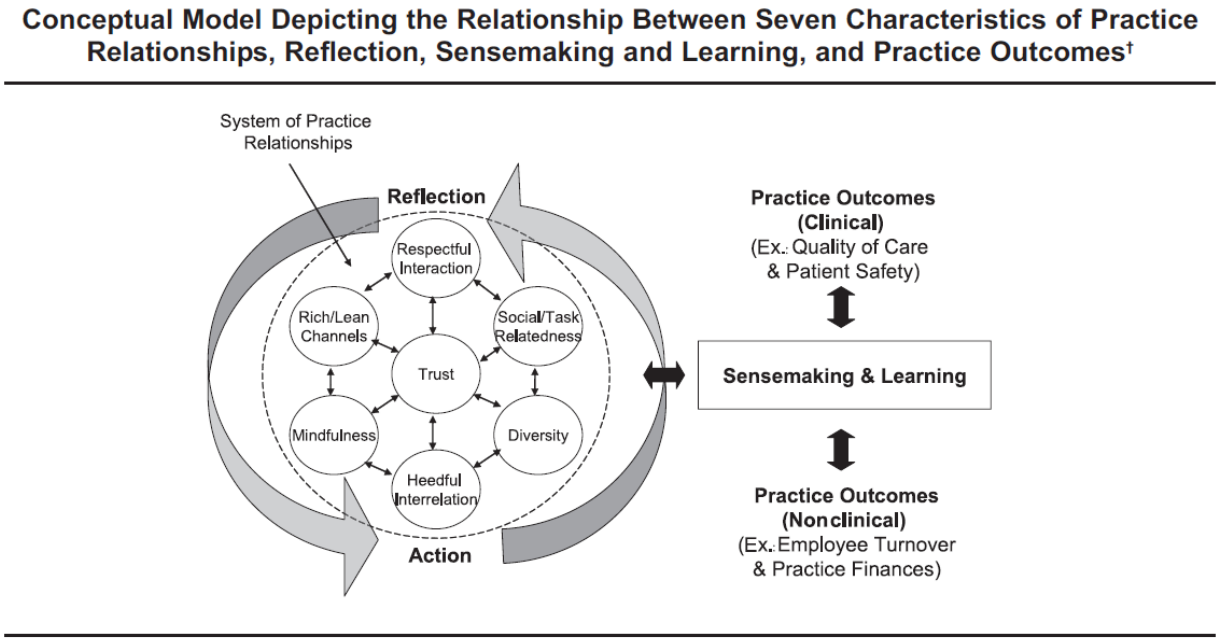


Figure 2. *This figure represents work underlying Figure 2 published in Safran D.G., Miller W., Beckman H.: Organizational dimensions of relationship-centered care: Theory, evidence, and practice.* J Gen Intern Med *21(suppl. 1):S9–S15, Jan. 2006. The original work is acknowledged there. Model building occurred iteratively through the identification of relationship characteristics. Although secondary analysis of P&CD and STEP-UP data was performed before primary analysis of ULTRA data, both primary and secondary data analyses informed model building.Ex, example.*

Source: Lanham, McDaniel, Crabtree, et al., 2009.

Complexity theory also helps to illustrate how particular contexts place limits on generalizability and reinforces the importance of tailoring an intervention design to those contexts. In the words of Litaker and colleagues, "because opportunities for change vary at each practice, complexity theory predicts that interventions successfully addressing problems or barriers in one setting may have limited utility elsewhere. To bring value, therefore, the design of these interventions must take existing conditions, practice configuration, and dynamics into consideration" (Litaker, Tomolo, Liberatore et al., 2006).

Waterline model. The Waterline model, which was developed about 40 years ago, has been credited to Harrison, Short, and Scherer (1970). This model posits that, in any group, different levels of activities and processes occur at different levels. Thus, maintaining a high-functioning group requires different interventions to produce change at different levels. Four levels of activities—structural, group, interpersonal, and intrapersonal—often are not visible; they are "below the waterline." Activities "above the waterline" are the actual tasks completed over time. At each level, processes become more focused on individual behavior. "As depth of intervention increases, so also do a number of concomitants of depth: dependence on the special competence of the change agent, centrality of the individual as the target of the change attempt, costs of intervention, and the risk of unintended consequences for individuals" (Harrison, Short, and Scherer, 1970).

Regardless of whether you select any of these theories to guide your program design, or just familiarize yourself with them and use them to advance your thinking on the overall challenge of supporting sustainable change in such a dynamic setting as a primary care practice, possessing a solid understanding of the literature in this area will facilitate your thinking and that of your team.

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Appendix B. Tools and Resources

Key Literature and Research on Practice Facilitation	
Existing Evidence on Practice Facilitation	**Practice facilitators: A review of the literature** http://www.ncbi.nlm.nih.gov/pubmed/16145629 **Systematic review of practice facilitation and evaluation of a chronic illness care management tailored outreach facilitation intervention for rural primary care physicians** http://uwspace.uwaterloo.ca/handle/10012/4298 **The effect of facilitation in fostering practice change** http://www.graham-center.org/online/graham/home/publications/onepagers/2009/op60-effect-facilitation.html **Effect of facilitation on practice outcomes in the National Demonstration Project model of the patient-centered medical home** http://www.ncbi.nlm.nih.gov/pubmed/20530393 **Improved preventive care in family practices with outreach facilitation: Understanding success and failure** http://www.ncbi.nlm.nih.gov/pubmed/12425778 **Improving prevention in primary care: Evaluating the sustainability of outreach facilitation** http://www.ncbi.nlm.nih.gov/pubmed/18474705 **Practice facilitators and practice-based research networks** http://www.ncbi.nlm.nih.gov/pubmed/16951300
The Role of Practice Facilitation in Primary Care Transformation	**A health care cooperative extension service: Transforming primary care and community health.** http://www.ncbi.nlm.nih.gov/pubmed/19549977 **Report on the AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement** http://www.lanetpbrn.net/report-on-the-ahrq-2010-consensus-meeting-on-practice-facilitation-for-primary-care-improvement
Primary Care Transformation	**Health Affairs 2010 issue on reinventing primary care (vol. 29, issue 5)** http://content.healthaffairs.org/content/29/5.toc?etoc **How can primary care cross the quality chasm?** http://www.ncbi.nlm.nih.gov/pubmed/19273872
Key Literature and Research on the PCMH Model as a Means of Primary Care Transformation	
General PCMH Resources and Information	**AHRQ PCMH Web site** http://www.pcmh.ahrq.gov **Joint principles of the patient-centered medical home** http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home **How can we remodel practices into medical homes without a blueprint or a bank account?** http://www.ncbi.nlm.nih.gov/pubmed/21160347

General PCMH Resources and Information *(continued)*	**Patient Centered Primary Care Collaborative** http://www.pcpcc.net/ **PCMH Resources and Publications Library—Qualis Health** http://www.qhmedicalhome.org/publications.cfm **Patient Aligned Care Team (PACT)** http://www.va.gov/PRIMARYCARE/PACT/index.asp **Putting Theory into Practice: A Practical Guide to PCMH Transformation Resources (PCPCC)** http://www.pcpcc.net/guide/transformation_guide
PCMH Recognition and Assessment Tools	**Patient-centered medical home recognition tools: A comparison of ten surveys' content and operational details** http://www.cms.gov/reports/downloads/Burton_PCMH_Recognition_Tools_May_2011.pdf **Standards and guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2011** www.ncqa.org/tabid/631/default.aspx **Joint Commission's PCMH Designation** http://www.jointcommission.org/accreditation/pchi.aspx **Comparison of requirements for Joint Commission and NCQA for PCMH** http://www.jointcommission.org/assets/1/18/PCMH-NCQA_crosswalk-final_June_2011.pdf **Patient Centered Health Care Home Toolkit (URAC)** https://www.urac.org/healthcare/pchch/toolkit.aspx **Baseline PCMH Self Assessment Tool (PCDC)** http://www.pcdc.org/resources/patient-centered-medical-home/pcdc-pcmh/ncqa-2011-medical-home.html **PCMH Assessment Tool (MacColl Institute for Healthcare Innovation, Group Health Cooperative)** http://www.qhmedicalhome.org/safety-net/upload/PCMH-A_public.pdf **PCMH Clinician Assessment (developed by Perry Dickinson)** http://www.lanetpbrn.net/wp-content/uploads/PCMH-Clinician-Assessment-survey.pdf **PCMH Clinical Assessment Subscales (developed by Perry Dickinson)** http://www.lanetpbrn.net/wp-content/uploads/PCMH-Clinical-Assessment-Subscales-survey.pdf **The Medical Home Index. Measuring the organization and delivery of primary care for children with special health care needs** http://www.medicalhomeimprovement.org/pdf/PediatricMedicalHomeFamilyIndexandSurvey_2005.pdf **PCMH Practice Monitor** http://www.lanetpbrn.net/wp-content/uploads/PCMH-Practice-Monitor-survey.pdf
Conceptual Frameworks and Models for Primary Care Improvement	
Conceptual Frameworks	**Improving medical practice: A conceptual framework** http://www.ncbi.nlm.nih.gov/pubmed/17548853

Conceptual Frameworks *(continued)*	**The Triple Aim: Care, health, and cost** http://www.ncbi.nlm.nih.gov/pubmed/18474969 **The Chronic Care Model** http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 **Evaluating the public health impact of health promotion interventions: The RE-AIM framework** http://www.ncbi.nlm.nih.gov/pubmed/10474547 **Primary care practice development: A relationship-centered approach** http://www.ncbi.nlm.nih.gov/pubmed/20530396 **Improving medical practice: A conceptual framework** http://www.ncbi.nlm.nih.gov/pubmed/17548853
Key Driver Models	**IPIP change package** http://www.lanetpbrn.net/wp-content/uploads/Change-Packagev1DeWalt1-2.doc **Change concepts overview—Safety Net Medical Home Initiative** http://www.qhmedicalhome.org/safety-net/change-concepts.cfm **Key driver presentation—Collaboration for Leadership in Applied Health Research and Care** http://www.lanetpbrn.net/wp-content/uploads/Key-Driver-Presentation-Collaboration-for-Leadership-in-Applied-Health-Research-and-Care-presentation.pdf **Key driver presentation—Center for Healthcare Quality Improvement** http://www.lanetpbrn.net/wp-content/uploads/Key-Driver-Presentation-%E2%80%93-Center-for-Healthcare-Quality-Improvement-presentation.pdf **Sample QI plan/strategy (Safety Net Initiative)** http://www.qhmedicalhome.org/safety-net/qistrategy.cfm
Practical Toolkits and Manuals for use by Facilitators and Program Directors	
	Integrating chronic care and business strategies in the safety net: A practice coaching manual http://www.ahrq.gov/populations/businessstrategies/coachmanl.htm **Practice coaching program manual (IPIP)** http://www.qiteamspace.org/ipip/af4q **Guiding facilitation in the Canadian context: Enhancing primary health care** http://www.gnb.ca/0053/phc/pdf/Facilitation%20Guide%20-%20English.pdf **Tools and toolkits from Maine Quality Counts** http://www.mainequalitycounts.org/resources-for-providers.html **Implementing the patient-centered medical home model. A practice facilitator's guide to visiting clinical teams** http://www.qhmedicalhome.org/upload/Site-Visit-Guide_0411.pdf **ACP medical home builder** http://www.acponline.org/running_practice/pcmh/help.htm **Small practice edesign** http://www.chcf.org/projects/2009/small-practice-edesign

Practical Resources To Aid Program Directors in Developing a PF Program	
Program Administration	**Sample rules for an advisory group/board/council—see page 27 of link** http://www.pcpcc.net/files/ConsumerGuidelines.pdf **Outline of a practice facilitation charter** http://www.lanetpbrn.net/wp-content/uploads/Outline-of-a-Practice-Facilitation-Charter-example.pdf
Financing and Marketing a PF Program	**Business plan generator and template** http://web.sba.gov/busplantemplate/BizPlanStart.cfm **Cost savings associated with improving appropriate and reducing inappropriate preventative care: Cost-consequences analysis** http://www.ncbi.nlm.nih.gov/pubmed/15755330 **The patient-centered medical home: A purchaser guide** http://www.pcpcc.net/content/purchaser-guide **Return on investment health homes forecasting calculator** http://www.chcsroihealthhomes.org/Welcome.aspx **Sample marketing brochure** http://www.lanetpbrn.net/wp-content/uploads/Marketing-brochure-for-PF-services-example.pdf
Designing a PF Approach or Strategy	**Driving value in Medicaid primary care: The role of shared support networks for physician practices** http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Mar/1484_Highsmith_driving_value_Medicaid_primary_care.pdf **Riding the wave of primary care research: Development of a primary health care research centre** http://www.ncbi.nlm.nih.gov/pubmed/19826140
Case Examples of PF Program Implementation	**A nurse coach quality improvement intervention: Feasibility and treatment fidelity** http://www.ncbi.nlm.nih.gov/pubmed/18263844 **Implementation research: Lessons learned in OKPRN** www.okprn.org/Presentations/Impelementation_Research_2.ppt **Practice facilitators and practice-based research networks: Four examples of a PF model** http://www.ncbi.nlm.nih.gov/pubmed/16951300 **Quality improvement implementation and disparities. The case of the health disparities collaboratives** http://www.ncbi.nlm.nih.gov/pubmed/20613665

Job Descriptions	**Practice enhancement assistant job description (OKPRN)** http://www.lanetpbrn.net/wp-content/uploads/Practice-Enhancement-Assistant-Job-Description-example.pdf **Quality improvement coach job description (QIIP)** http://www.qiip.ca/user_files/QIIP%20-%20QI%20CoachJob%20Description%20Launch%20Jan-10.pdf **Sample job description for PF supervisor (QIIP)** http://www.qiip.ca/user_files/qimanagerjobposting.pdf **Sample protocol for interviewing applicants for facilitator positions** http://www.lanetpbrn.net/wp-content/uploads/Protocol-for-interviewing-applicants-for-facilitator-positions-example.pdf
Core Competencies	**Quality improvement coach competencies** http://www.qiip.ca/user_files/QIIP%20-%20QI%20Coach%20Competencies%20Launch%20Jan-10.pdf **Report on the AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement** http://www.lanetpbrn.net/report-on-the-ahrq-2010-consensus-meeting-on-practice-facilitation-for-primary-care-improvement
Training and Support for Facilitators	**Primary care practice coach development program** http://www.ihi.org/offerings/VirtualPrograms/Webinars/PrimaryCare/Pages/default.aspx **Quality improvement coaches tools and resources** http://www.qiip.ca/coach.php **Microsystem Academy curriculum and coaching resources** http://www.clinicalmicrosystem.org/coaching **Facilitator training topics** http://www.okprn.org/Topics%20Covered%20in%20PEA%20Training.doc **5 stages of group development** http://med.fsu.edu/uploads/files/FacultyDevelopment_GroupDevelopment.pdf **Using self-management support in your coaching approach** http://www.lanetpbrn.net/wp-content/uploads/Using-Self-Management-Support-in-Your-Coaching-Approach-presentation.pdf **Practice enhancement assistant question of the week** http://www.okprn.org/peaquestion.html **Improving healthcare by coaching-the-coaching** http://www.lj.se/info_files/infosida35103/coachingthecoaching_godfrey.pdf
General Resources for Program Evaluation	**Measuring an organization's ability to manage change: The Change Process Capability Questionnaire and its use for improving depression care** http://www.ncbi.nlm.nih.gov/pubmed/18539980 **A systematic approach to practice assessment and quality improvement intervention tailoring** http://www.ncbi.nlm.nih.gov/pubmed/19851234

General Resources for Program Evaluation *(continued)*	**Improved preventative care in family practices with outreach facilitation: understanding success and failure** http://www.ncbi.nlm.nih.gov/pubmed/12425778 **Improving prevention in primary care: Evaluating the sustainability of outreach facilitation** http://www.ncbi.nlm.nih.gov/pubmed/18474705 **Evaluation handbook (W.K. Kellogg Foundation)** http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx **Logic model development guide (W.K. Kellogg Foundation)** http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx **The program manager's guide to evaluation (ACF, HHS)** http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html **Evaluation toolkit (The California Endowment)** http://www.calendow.org/article.aspx?id=1764&ItemID=1764 **Robert Wood Johnson Foundation: Tools for program evaluation** http://www.rwjf.org/pr/search.jsp?&typeid=166 **American Evaluation Association: Program evaluation standards** http://www.eval.org/evaluationdocuments/progeval.html
Example Forms and Measures for Program Evaluation	**Practice staff questionnaire** http://www.lanetpbrn.net/wp-content/uploads/Practice-Staff-Questionnaire.pdf **Practice staff questionnaire subscales** http://www.lanetpbrn.net/practice-facilitation-resources **Assessment of chronic illness care version 3.5** www.ihs.gov/ipc/documents/Foundations_ACIC_v2.pdf **CAHPS clinician & group survey version: Adult primary care questionnaire 1.0** https://www.cahps.ahrq.gov/content/products/CG/PROD_CG_CG40Products.asp **Completing and scoring the ACIC** http://www.improvingchroniccare.org/downloads/2.1_assessment_of_chronic_illness_care_scoring_guide.pdf
Sustainability	**Sustainability guide by the NHS Institute for Innovation and Improvement** http://www.institute.nhs.uk/sustainability_model/general/welcome_to_sustainability.html **Plan for sustainability and spread—QIIP** http://www.lanetpbrn.net/wp-content/uploads/Plan-for-Sustainability-and-Spread-example.pdf
Other General Resources	**LA Net: Practice facilitation resources** http://www.lanetpbrn.net/practice-facilitation-resources **Quality improvement & innovation partnership: Quality improvement coaches** http://www.qiip.ca/coach.php

Resources for Practice Facilitators	
Patient Engagement	**Strategies to put patients at the center of primary care** http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_11787_953651_0_0_18/FINAL Patient engagement decisionmaker brief.pdf **Parent partners: Creative forces on medical home improvement teams** http://www.medicalhomeimprovement.org/pdf/CMHI-Parent-Partner-Guide.pdf **Center for Consumer Engagement, PCPCC** http://www.pcpcc.net/center-consumer-engagement **Family Voices of Minnesota** http://www.familyvoicesofminnesota.org/
Assessing Practice Readiness	**Measuring practice capacity for change: A tool for guiding quality improvement in primary care settings** http://www.ncbi.nlm.nih.gov/pubmed/19851235 **Developing and testing a model to predict outcomes of organizational change** http://www.ncbi.nlm.nih.gov/pubmed/12785571 **Assessing organizational readiness for change** http://www.ncbi.nlm.nih.gov/pubmed/12072164 **Measuring organizational attributes of primary care practices: Development of a new instrument** http://www.ncbi.nlm.nih.gov/pubmed/17489913
Strategies for Working with Practices	**Barriers and facilitators to recruitment of physicians and practices for primary care health services research at one centre** http://www.ncbi.nlm.nih.gov/pubmed/21144048 **Strategies for guiding PCMH transformation from within** http://www.qhmedicalhome.org/safety-net/upload/Implementation_EnagagedLeadership_1110.pdf **5 stages of group development** http://med.fsu.edu/uploads/files/FacultyDevelopment_GroupDevelopment.pdf **Team building in primary healthcare—A resource guide** http://www.qiip.ca/tbrg.php

Sample Forms for Use with Practices	**Example practice facilitation plan** http://www.lanetpbrn.net/wp-content/uploads/Practice-Facilitation-Plan-example.pdf **Clinic site encounter form** http://www.lanetpbrn.net/wp-content/uploads/Clinic-Site-Encounter-Form-example.pdf **Cumulative monthly practice report** http://www.lanetpbrn.net/wp-content/uploads/Cumulative-Monthly-Practice-Report-example.pdf **Example memorandum of understanding (MOU)** http://www.lanetpbrn.net/pf-resource/example-memorandum-of-understanding-mou **Example data sharing agreement from the AAFP National Research Network** http://www.researchtoolkit.org/primer/docs/AAFP-NRN%20DUA.pdf **Data use agreement for DARTNet benchmarking reports** http://www.lanetpbrn.net/wp-content/uploads/Data-Use-Agreement-example.pdf **HMO Research Network DUA** http://www.researchtoolkit.org/primer/docs/HMORN_DUAToolkit.pdf **Example business associate agreement (BAA)** http://www.lanetpbrn.net/pf-resource/example-business-associate-agreement-baa **Example handout on expectations of practice and facilitator in a PF encounter** http://www.lanetpbrn.net/pf-resource/example-handout-of-expectations-of-practice-and-facilitator-in-a-pf-encounter