Report on the AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement

Prepared in partial fulfillment of requirements of AHRQ Task Order 13: Implementing Practice Coaching and the Chronic Care Model into Practices Serving Vulnerable Populations

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1. BACKGROUND AND GOALS

Improving quality in primary care will be a priority issue over the next decade. Primary care is currently in a state of crisis due to a number of factors including the diminishing numbers of U.S. medical students entering primary care, patient dissatisfaction with care and access, physician dissatisfaction, insufficient funding and growing demands being placed on primary care practices (Bodenheimer, 2006).

Developing effective and efficient strategies for improving quality will be critical to the transformation of primary care in the U.S. Current approaches being used at the practice level include academic detailing, audit and feedback, benchmarking, physician education, performance-linked payment reform, organizational consulting, and collaborative learning.

Each of these approaches has supported improvements at practice and provider levels. However, none have been sufficient in achieving the type of sustained comprehensive improvement in primary care that is being pursued in the current context of health care reform.

Impact studies have shown that collaboratives can be effective in increasing motivation, knowledge and driving change in the practice setting (Goeschel & Pronovost, 2008; Institute for Healthcare Improvement, 2003; U.S. Agency for International Development, 2008). However, despite these successes their impact has been limited. Many practices cannot or do not participate in these collaboratives. Providers that do participate leave with new ideas and tools, but report difficulty implementing these in their practices due to a lack of time, human resources, and knowledge needed to tailor the strategies to fit the unique needs of their practices.

Practice facilitation[1] is a supportive service provided to a primary care practice by a trained individual or team of individuals who use a range of organizational development, project management, quality improvement and practice improvement approaches and methods to build the internal capacity of a practice to engage in improvement activities over time, and to support attainment of both incremental and transformative improvement goals.

Practice facilitators (PF) 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 et al, 2010, p 7). Facilitators may also assist clinicians in conducting research in and on their practices (Nagykaldi et al, 2006) and are distinguished from consultants through their specialized training, broad scope of practice, and longer-term, more holistic relationship with a practice and its providers and staff (Knox, 2010).

[1] Based on input from meeting participants and for the purposes of clarity, the term practice facilitation (PF) and practice facilitators (PFs) will be used in this report in lieu of practice coaching.

Practice facilitation is emerging as a promising approach for supporting practice improvement that can be used in combination with approaches such as learning collaboratives, or provided as a stand-alone resource for practices; and practice facilitators are a potential workforce for the proposed National Primary Care Extension program and Regional Extension Centers supporting implementation of Health Information Technology.

In one of the first reviews conducted of the facilitation literature, Nagykaldi, Mold and Aspy (2005) examined studies of its impact on quality of care and patient outcomes. Of the 25 studies reviewed, the authors found evidence of the effectiveness of facilitation in improving quality of care for diabetic patients, improving rate of preventive care services for children and adults, and screening for hemoglobin disorders. In some instances, facilitation also resulted in cost savings for the practice. For some practices, the effects of facilitation faded after the intervention ended; and larger practices were less likely to benefit because of the scale of operations needed for improvement.

Baskerville (2009) conducted a meta-analysis of 38 studies to evaluate the impact of facilitation on care quality and found moderate effects (0.54) for facilitation on quality. A larger effect size and likelihood of impact was associated with interventions that: a) were customized to the practice; b) involved multiple intervention components; c) took place over longer vs. shorter time periods; and d) involved greater number of service hours. Higher practice facilitator to practice ratios and the presence of clinicians described as pessimistic towards the process were associated with less favorable outcomes.

A recent study by Crabtree, Nutting, Miller, Stange, and Stewart (2010) on the use of facilitators to support transformation to Patient Centered Medical Homes (PCMHs) as part of the National Demonstration Project (NDP) compared low to moderate intensity primarily distance facilitation to self-directed practice improvement across 39 quality components that included areas such as access to care and information, care management, practice services, continuity of care, practice management, quality and safety, health information technology, and practice-based care teams. Crabtree et al found larger increases in adaptive reserve (defined as “practice’s ability to make and sustain change”) and more NDP components implemented in facilitated practices compared to self-directed practices.

At least 12 Practice-Based Research Networks (PBRNs) in the U.S. are currently using practice facilitators to support research and quality improvement in their primary care practices. These include the Oklahoma Physicians Research Network (OKPRN), the Oregon Rural Practice Based Research Network (ORPRN), the Wisconsin Research and Education Network (WREN), Advanced Practice Nurse-Ambulatory Research Consortium (ARC), Indiana University Primary Care Practice-Based Research Network (ResNet), Colorado Research Network (CaReNet), The University at Buffalo Family Medicine Research Institute and Upstate New York Practice Based Research Network (UNYNET), and L.A. Net.

States such as Vermont, Maine, Texas and Oklahoma are using facilitators to promote improvement in primary care practices serving publicly insured patients. Health plans and

foundations are also exploring the value of facilitation. Blue Cross of Michigan is engaging quality improvement experts from the automotive industry to support improvement in health care settings. Public health plans such as L.A. Care, Care Oregon and the San Francisco Health Plan are exploring practice facilitation as a resource for supporting Patient Centered Medical Home (PCMH) transformation in practices providing care to their members.

Foundations like the Robert Wood Johnson Foundation and the California Health Care Foundation have invested heavily in improvement initiatives such as Improving Performance in Practice (IPIP) initiative and the Massachusetts eHealth Collaborative that make use of practice facilitation usually as part of a multi-method improvement strategy.

Quality improvement and research organizations are also investing in facilitation. Dartmouth Clinical Microsystems and the Institute for Healthcare Improvement (IHI) offer training programs for facilitators.

Federally funded Health Information Technology Regional Extension Centers (HITECH RECs) are expected to utilize practice facilitators in their work preparing practices to implement electronic health records (EHR). Federal agencies such as the Agency for Healthcare Research and Quality (AHRQ) are supporting research and resource development in practice facilitation.

Policymakers are looking at a variety of strategies for improving the nation's primary health care system, some of which may be informed by current work in facilitation. Recently passed reform legislation (Section 5405W of the *Patient Protection and Affordability Act*) contains language calling for the creation of a National Primary Care Extension Program that might be staffed by a national network of facilitators (Grumbach & Mold, 2009).

Internationally, England was one of the first to implement a comprehensive practice facilitation program to support its primary care system. In Canada, provinces such as Ontario and British Columbia are investing in facilitation programs to support improvements in primary and specialty care.

Table 1 List of Facilitation Programs

Name	*Location*	*Website*
California Health Care Foundation, Small Practice eDesign Program	Oakland, CA	http://www.chcf.org/projects/2009/small-practice-edesign
California Health Care Foundation, Team up for Health Program	Oakland, CA	http://www.chcf.org/projects/2009/team-up-for-health-supporting-patients-for-better-chronic-care
Case Western Reserve University, Department of Family Medicine	Cleveland, OH	http://www.case.edu/med/pbrn

Name	*Location*	*Website*
PBRN		
Clinical Microsystems	New Hampshire	http://www.clinicalmicrosystem.org/
Colorado Residency Facilitation Project	Colorado	Contact: Perry Dickenson Perry.Dickinson@ucdenver.edu
Health TeamWorks	Colorado	http://www.healthteamworks.org
Impact BC	Vancouver, Canada	http://www.impactbc.ca/
Improved Delivery of Cardiovascular Care	Ottowa, Canada	http://www.idocc.ca
Improving Performance in Practice (IPIP)	Colorado, Michigan, Minnesota, North Carolina, Washington, Wisconsin, Pennsylvania	http://www.ipipprogram.org/
L.A. Net	Los Angeles, CA	http://www.lanetpbrn.net
Oklahoma Healthcare Authority, SoonerCare	Oklahoma	http://www.okhca.org/
Oklahoma Physicians Research Network (OKPRN)	Oklahoma	http://www.okprn.org
Oklahoma University Health Science Center, Department of Family and Preventative Medicine	Oklahoma	http://www.oumedicine.com
Oregon Rural Practice Based Research Network (ORPRN)	Oregon	http://www.ohsu.edu/orprn/
Pittsburgh Regional Healthcare Initiative	Pittsburgh, PA	http://www.prhi.org/
Quality Counts	Maine	http://www.mainequalitycounts.org/
Quality Improvement & Innovation Partnership (QIIP)	Ontario, Canada	http://www.qiip.ca
TransforMED	Leawood, KS	http://www.transformed.com
University of Colorado Denver, Department of Family Medicine	Colorado	http://fammed.uchsc.edu/
Vermont Blueprint for Health	Vermont	http://healthvermont.gov/blueprint.aspx
Safety Net Medical Home Initiative	Multi-state (5)	http://www.qhmedicalhome.org/safety-net/about.cfm

Name	*Location*	*Website*
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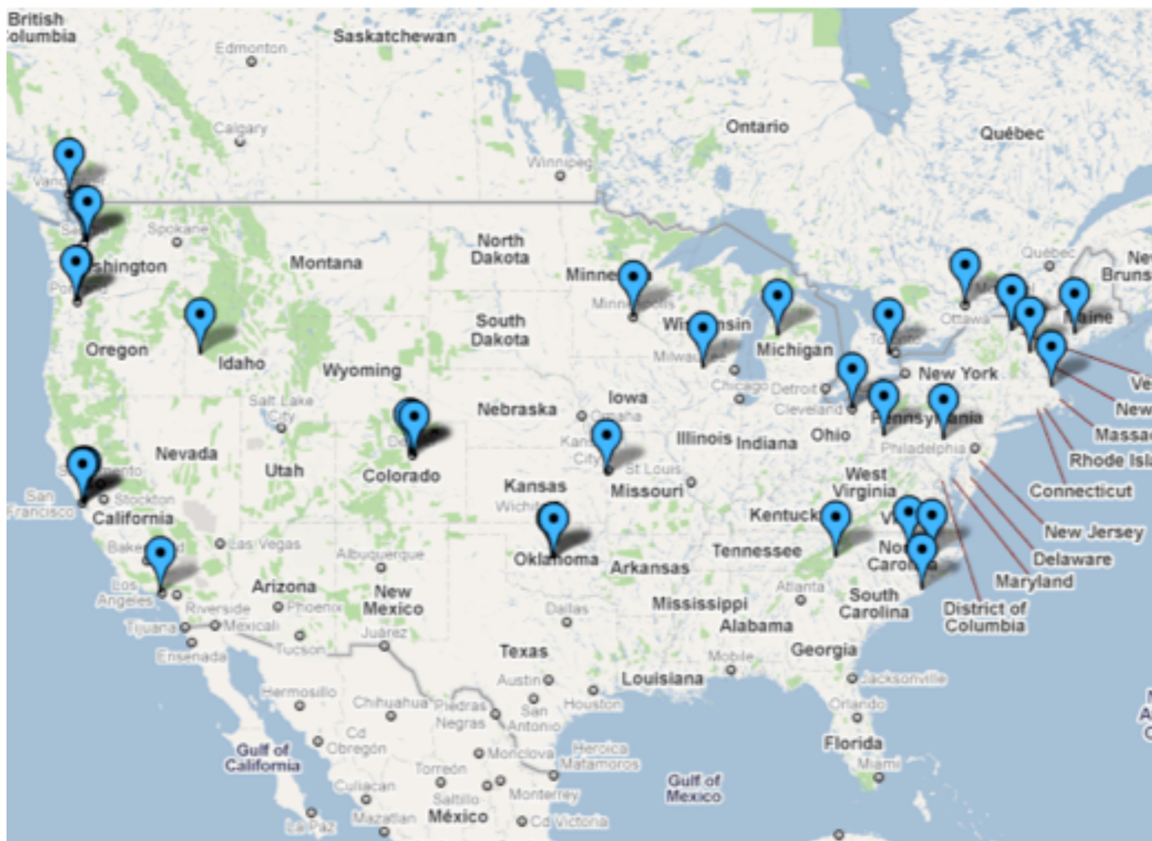
The map below displays locations of some of the major facilitation efforts currently underway in the U.S. and Canada.

Figure 1. Partial map of facilitation programs in U.S. and Canada



About This Project

In 2006 AHRQ contracted with the RAND Corporation, Group Health's MacColl Institute and the California Health Care Safety Net Institute to develop a toolkit to support implementation of the Chronic Care Model (CCM) in safety net practices. The resulting document and toolkit titled *Integrating Chronic Care and Business Strategies in the Safety Net* was published in 2009 and contains resources to guide practices through key changes to implement the CCM. It is available online at http://www.ahrq.gov/populations/businessstrategies/businessstrategies.pdf.

Originally developed for practices to use on their own, the project team and AHRQ quickly recognized most practices would require outside support in order to undertake the modifications suggested in the change package. Thus the project team developed a Practice Coaching Manual as a companion to the AHRQ Toolkit to guide practice coaches/facilitators in the best approach to using the Toolkit with practices. *Integrating Chronic Care and Business Strategies in the Safety Net: A Practice Coaching Manual* was published in 2009 (Coleman, Pearson, Wu, & Brach, 2009). The Manual provides an overview of the field of practice coaching or facilitation, suggests activities for the coach/facilitator to use in order to guide practices through the modifications recommended by the Toolkit, and provides suggestions for organizations interested in using the Toolkit to support quality improvement in their practices.

The project team conducted an evaluation of a facilitation intervention using the ARHQ Toolkit in 24 primary care practices from two safety-net organizations. There were 9 intervention practices and 15 control practices. Individuals in the intervention practices perceived facilitation as enabling them to gain skills, knowledge, and tools needed to improve their clinical care. However, they were less positive about their gains in organizational capabilities, progress improving process efficiency, and impact on revenue generation. Few statistically significant differences were found between intervention and control practices on key outcome indicators with one notable exception. A significant difference ($p < .05$) was found between intervention and control practices' diabetic patients' rates of hospitalization in favor of the intervention group. The project team attributed these differences to the use of registries to identify and intervene with high-risk patients. Facilitation was seen as bridge to the change package/toolkit and necessary for motivating and prompting people to make changes related to chronic care. Facilitators working with the practices made modifications to the Toolkit in an effort to increase buy-in to its use among the practices. However, despite this, the toolkit was not extensively used.

The team summarized their findings in five key lessons learned:

1. practice coaching is a feasible mechanism for facilitating CCM quality improvement in safety-net clinic settings
2. different models of practice coaching may work better in different settings and timing
3. the toolkit needs a bridge for its adoption
4. CCM implementation may reduce utilization in safety-net clinic settings, and
5. evaluation using randomization design presents both challenges and opportunities

L.A. Net, a primary care practice based research network comprised of Federally Qualified Health Centers and Community Health Centers in Los Angeles and a member of the Electronic Primary Care Research Network Contract consortium, was contracted to conduct the next phase of the CCM and practice coaching project. *Implementing Practice Coaching and the Chronic Care Model in Practices Serving Vulnerable Populations* is a continuation of the project described above. The current effort involves two parts: convening of a panel of experts to summarize what is currently known about the field of practice facilitation and identify what questions still need to be addressed; and to evaluate the process and impact of a facilitation

intervention based on the contents of the AHRQ CCM Toolkit. This report summarizes results of the meeting of the expert panel on practice facilitation.

Consensus meeting design

The Practice Facilitation Consensus Meeting was held in Los Angeles, California on January 28th and 29th. Its purpose was to bring together leading practitioners and researchers in practice coaching and practice improvement to share lessons learned, exchange ideas and provide pragmatic information about their experiences. The goals for the meeting were to advance knowledge about practice coaching (also referred to as practice facilitation), to identify emerging best practices in the field, and to identify areas in need of further study.

Meeting structure, goals and participants were determined collaboratively between the L.A. Net Practice Facilitation Project Steering Committee and leadership at AHRQ including Cindy Brach and David Meyers, and with input from practitioners in the field. Thirty-seven individuals participated in the meeting from both the U.S. and Canada.

Participants were invited to the meeting based on their expertise in practice facilitation. To ensure a comprehensive perspective on the practice of practice facilitation, individuals with differing types of involvement in facilitation were invited to participate including: practicing facilitators, directors of facilitation programs, researchers interested in practice improvement and facilitation, clinicians that had participated in facilitation interventions, and funders/purchasers of facilitation services. In instances where several individuals possessed knowledge of similar facilitation models or programs, only one individual was invited to allow inclusion of representatives from as broad a range of program models as possible.

Questions that were addressed during the meeting are provided in Figure 2 and were based on work started under the preceding task order that led to development of the Toolkit, a review of the facilitation literature, informal interviews with experts in the field, and input from the steering committee and AHRQ. Participants received a copy of Nagykaldi, Mold, and Aspy's 2005 review of practice facilitation to read prior to the session. The meeting took place over two days and was moderated by a professional facilitator. Large and small group discussions were audio taped, transcribed and analyzed for content and theme.

Figure 2. Questions addressed during the meeting

What should we call the discipline and its service providers?
What are some of the key lessons learned by participants from their work in practice facilitation? What improvement goals are appropriate to pursue using practice facilitation? Should facilitation be made available to all practices or only those that meet certain criteria? Do practices need to possess a degree of organizational “readiness” to engage in improvement work before they can benefit from facilitation? What functions do practice facilitators fill and which are more effective in producing desired changes? What are the different types of facilitators and is one more effective or useful than the others? Are internal or external facilitators more effective? How many hours of facilitation are needed to achieve improvement in a practice? Are long-term or short-term intervention models more effective? Is distance facilitation (provided through email, telephone, web conferences) as effective as on-site facilitation? Is there an optimal mix of distance and on-site delivery? Can practices become dependent on facilitators and how should this be managed? How many practices should a facilitator support at any one time? Can facilitation be provided as a stand-alone service or should it occur in the context of more comprehensive improvement efforts? What is the usual course for an intervention using practice facilitation? Who make the best facilitators? What core competencies and skills do facilitators need to have to be effective? What is the best way to support and train facilitators? How much does it cost per practice to provide facilitation support? Do differences in practice size, location or structure impact effectiveness of facilitation? What research questions should be answered about practice facilitation in order to increase its effectiveness?

2. SUMMARY OF DISCUSSION

2.1 What should we call the discipline and its service providers?

Naming the activity of facilitation or coaching and the individuals who deliver this service emerged as an important theme during the meeting. The area is rapidly gaining in popularity and momentum, and there is a need to thoughtfully define terms of art for describing the field and its professionals before the terminology is set by common usage regardless of its appropriateness. Establishing a common vocabulary for the field is also important for supporting continued development of a shared research and knowledge base on the topic.

At present, a variety of different terms are used to refer to activities consistent with the definition of facilitation provided in the background section of this report. These include: consulting, coaching, facilitating, quality improvement coordination, quality improvement coaching, and quality navigation (see Table 2).

Table 2. Names used to identify coaches/facilitators

Names
Practice Consultant
Practice Enhancement Coordinator
QI Coach
Practice Improvement Coach
Practice Therapist
Practice Enhancement Assistant
Practice Facilitator
Practice Redesigner
Practice Quality Navigator
Practice Enhancement and Research Coordinators
Quality improvement facilitator or consultant
Change facilitator

Participants suggested decision rules for selecting the name. The terminology should: 1) be acceptable to the individuals or groups receiving the service (e.g. the clinicians and staff); 2) clearly convey the function and role of the individual and the activity; and 3) convey sufficient gravitas to stimulate and support research and scientific publications on the activity.

Several health care practitioners and coaches/facilitators voiced support for the term facilitation suggesting that the end users of the service, clinicians, found the term coach somewhat off-putting and preferred the terms facilitator or enhancement assistant in lieu of coach. As one experienced facilitator explained: *"I do not think doctors will readily accept that term because they do not feel they need 'coaching'...whereas an enhancement assistant seems more acceptable."* However, others felt the term facilitator did not adequately capture either the level of expertise or the type of support the improvement professional provided to a practice. These differences in preferred terminology may also reflect underlying differences in opinion about the role of a facilitator/coach in a practice.

Participants did not reach agreement on a shared vocabulary for the field during the meeting however, the two terms receiving the most support were practice facilitator/tion and practice coach/ing.

2.2 What are some of the key lessons learned by participants from their work in practice facilitation?

More than 764 practices had received facilitation support from the programs represented at the meeting. Based on this extensive experience, meeting participants provided a list of 79

lessons learned from their work facilitating improvement in a variety of practice environments and across a variety of facilitation models. The lessons covered topics ranging from determining practice readiness to providers' response to facilitation and the content and process of facilitation models. They also included addressing issues such as training and supporting facilitators, managing facilitation programs, using of facilitators to implement electronic health records, and the sufficiency of coaching/facilitation for supporting practice improvement. A complete list of the lessons learned shared by participants is provided in Appendix B.

2.3 What improvement goals are appropriate to pursue using practice facilitation?

Goals for facilitation supported improvement interventions are most frequently set by the entity funding the facilitation services not the practice. However, the involvement of practices in defining goals for improvement interventions was seen as critical to practice buy-in as well as the success of the intervention. The goals and objectives for a facilitation encounter may be determined by the practice, by an external agent or a combination of both. Some participants suggest that practice buy-in to the improvement process, and as a result the success of the practice facilitation intervention, was greater when the goals to be pursued by the practice facilitation intervention were at least partly defined by the practice.

Improvement goals pursued using facilitation typically involved incremental changes rather than practice or system wide transformative changes. However, smaller changes were often seen as a pathway to transformative change over time. The goals pursued using facilitation can be transformative, meaning comprehensive changes that impact multiple systems within a practice, or incremental involving a focus on smaller, more confined changes that impact a limited number of systems within a practice. Most frequently, facilitation was described as supporting incremental changes. However, the long-term goal even for facilitation interventions pursuing incremental change was often transformative change, but achieved through repeated small-scale improvement activities rather than through comprehensive, practice-wide redesign.

Specific objectives for facilitation interventions vary widely. Participants outlined a wide variety of improvement goals and objectives that are appropriate to pursue using facilitation (see Table 3). These ranged from very concrete, defined process related goals and objectives such as empanelment or implementing group visits, to more subjective, organizationally focused outcomes such as creating hope.

Table 3. Goals and objectives for facilitation interventions

Goals and objectives that might be pursued using facilitation
Progression from reactive to purposeful, principle based care
Building capacity to do population management

Implementing components of the PCMH
Implementing the CCM
Increasing viability/capacity of the organization and its systems (clinical, administrative, financial, community linkages)
Implementing standardized care/guidelines
Instilling hope
Panel management
Keeping changes patient centered
Engaging patients as partners in change process
Translating new evidence into practice
Helping to Identify and spread “best practices”
Creating a quality improvement system for practice

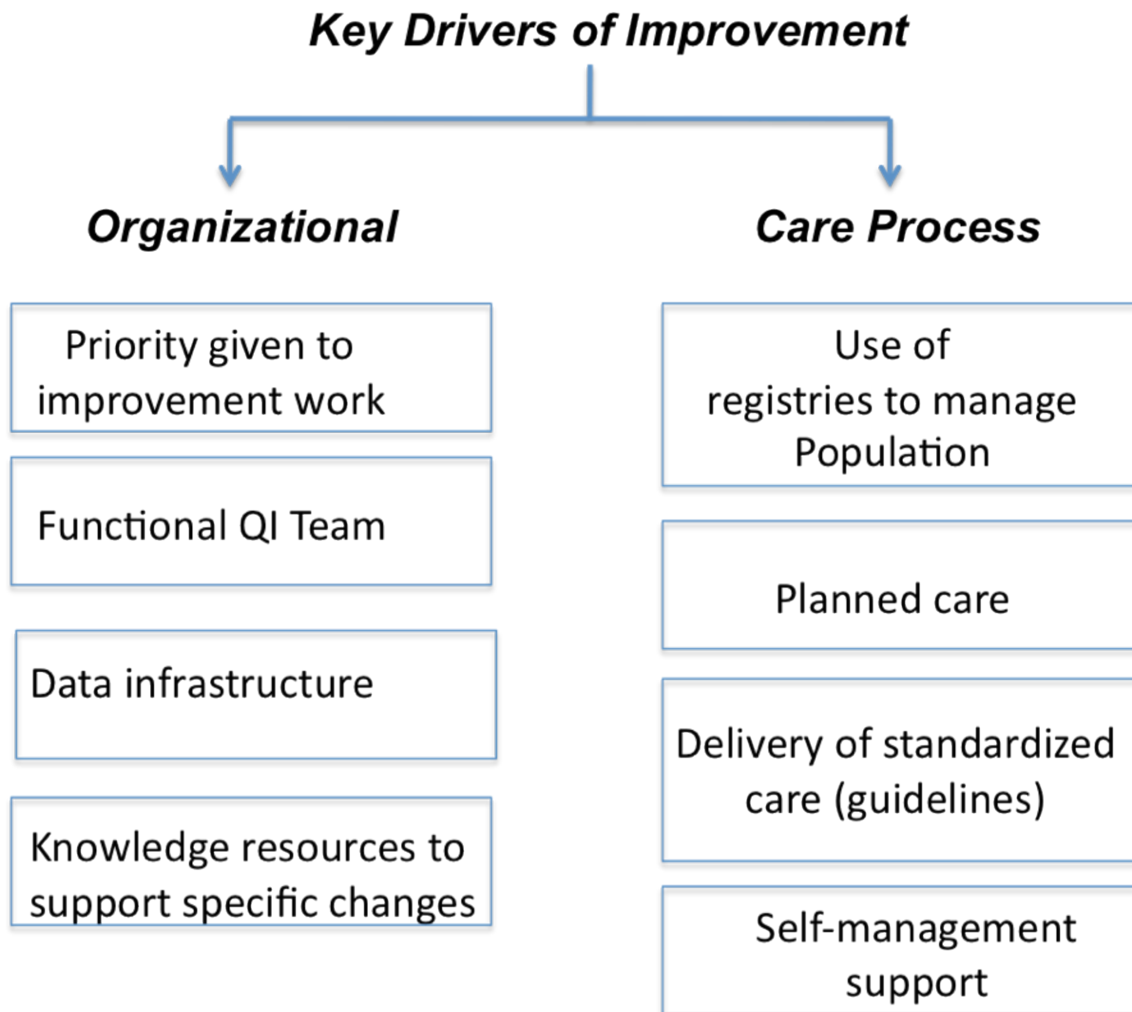
The possible goals for facilitation are potentially infinite. Because of this, some programs focus facilitation interventions on strengthening specific elements within the practice. These elements are often selected based on research evidence supporting their relationship to improved outcomes, patient experience and/or costs, or based on a particular theory of practice change or improvement. Two of the largest facilitation efforts in the U.S., the Improving Performance in Practice (IPIP) and the Safety Net Medical Home Initiative (SNI) focus facilitator support on a limited set of “key-drivers” of improvement.

In IPIP, facilitators called Quality Improvement Coaches focus their work on helping practices implement four specific processes: using registries to support population management, delivering planned care, using standardized care processes or guidelines, and providing self-management support.

Facilitators working in the Safety Net Medical Home Initiative focus their efforts on eight key drivers of improvement. These include: empanelment, continuous and team-based healing relationships, patient-centered interactions, engaged leadership, quality improvement strategy, enhanced access, care coordination, and organized evidence-based care.

Models of change used to guide facilitation work can include drivers related to building organizational capabilities to support improvement such as forming a QI team, prioritization of improvement work, creating a robust data infrastructure and acquisition of requisite knowledge and skills in quality improvement (QI) methods (Solberg, 2006); and specific changes made to clinical care processes such as the use of registries for population management, use of standardized care guidelines, and the integration of self-management support services (DeWalt, 2010).

Figure 3. An example of a change model with 8 key drivers



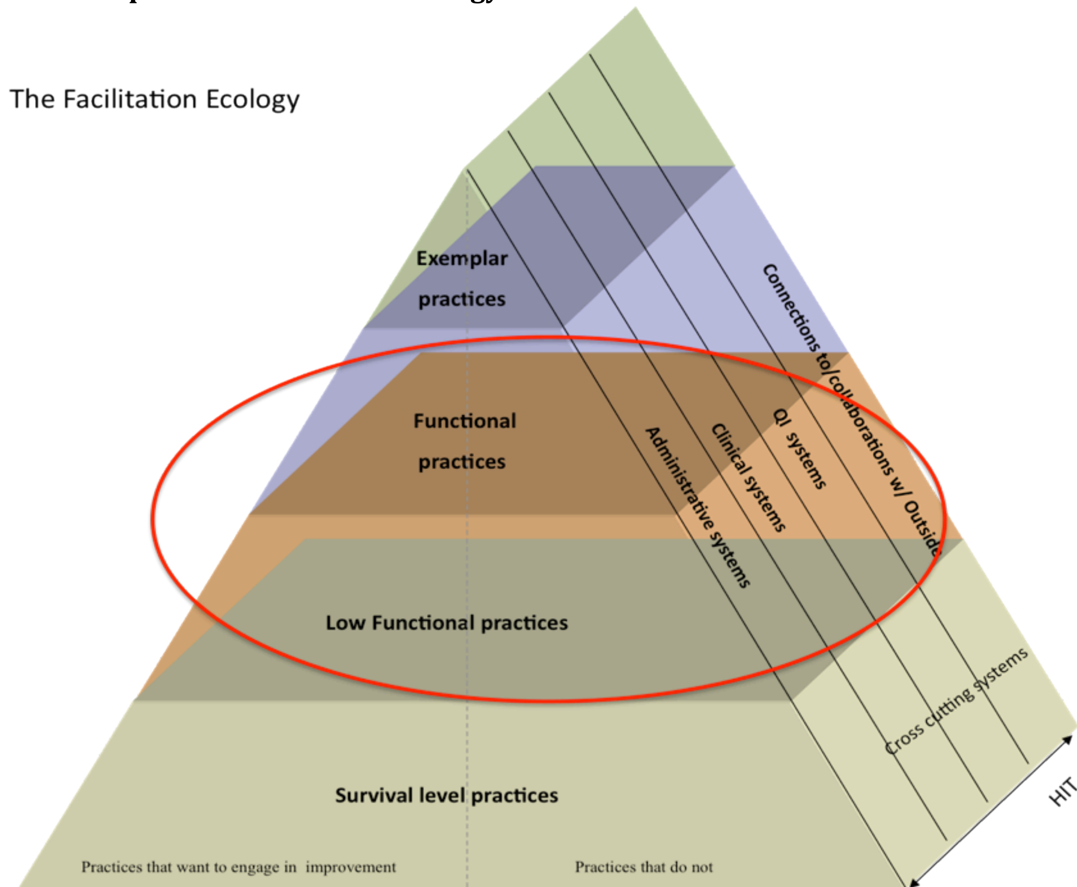
2.4 Should facilitation be made available to all practices or only those that meet certain criteria?

Participants viewed facilitation as a scarce resource and most suggested that practices will vary in the degree to which they can benefit from practice facilitation. The majority believed a strategy is needed for selecting practices that should receive facilitation services in order to ensure that the resource is directed to practices most likely to benefit.

As organizations, practices can be seen as functioning at different levels of effectiveness – exemplar, functional, low-functional, and survival. In addition, they may vary in level of effectiveness across their internal systems - administrative, clinical, quality improvement, and connections to the community. A practice may be functional in administrative and QI systems, exemplary in community connections and low-functional in clinical systems. Figure 4 defines

four levels of functioning within a practice across five internal systems that are addressed during facilitation.

Figure 4. The practice facilitation ecology



Participants suggested that practices that have already achieved high levels of quality on their own are not likely to receive significant additional benefit from facilitation and so are not likely recipients. However, these practices should be actively engaged as partners in facilitation interventions to serve as "exemplars" and a potential source for "best practices" that might be spread to practices that have not yet achieved similar levels of effectiveness in their own systems and work. At the other end of the spectrum, practices that are experiencing high levels of disorganization or organizational stress are not likely to benefit or be able to take full advantage of a facilitation intervention and so are also not likely candidates.

Different programs use different criteria for determining eligibility for facilitation services. The Oklahoma Healthcare Authority focuses its facilitation resources on practices that serve a high volume of priority or high need patients. Others target smaller practices and practices not engaged in other forms of improvement support such as collaboratives. Still others take a theory based approach, focusing facilitation resources on early adopters and opinion leaders within the clinical community as part of a deliberate strategy to support spread of innovation and maximize dissemination of the focused improvements.

2.5 Do practices need to possess a degree of organizational "readiness" to engage in improvement work before they can benefit from facilitation?

Almost all meeting participants agreed that practices should meet certain readiness criteria to ensure they are able to benefit from a practice facilitation intervention. Participants suggested the following criteria based on their experience:

- Support and engagement of the practice leadership (both clinical and non-clinical)
- Ability of the practice to devote a portion of employee time to the change enterprise
- Change/improvement is a priority for the practice
- Basic functionality across most organizational systems
- Sufficient adaptive reserve to make the changes (e.g. the time, money, people)
- Demonstration of willingness and ability to engage in a change process determined during the first 3 months of a facilitation intervention

In addition to the above, practices may also need additional competencies to benefit from interventions targeting highly specialized outcomes. For example, a short-term facilitation intervention to implement panel management may require that the practice have prior experience using registries, access to information technology (IT) support, and generally functional administrative systems in order to benefit.

Some participants noted that a phenomenon described as "change fatigue" is another factor that should be considered when determining a practice's readiness for facilitation. Because of the many parallel improvement and reform activities currently taking place in health care today, many practices are simply overwhelmed by change and reluctant to engage in additional work in this area.

Readiness assessments should be conducted prior to beginning a practice facilitation intervention. The assessments can occur informally through questions and answers with practice leadership and staff, formally through validated surveys, or through experiential assessment during a "pilot" improvement activity. Table 4 contains a list of readiness surveys that participants suggested as resources in this area.

Eight out of nine programs represented at the meeting routinely conduct readiness assessments before beginning a PF intervention. In three instances, the programs accept all practices for services, and the readiness assessment functions as a pre-assessment to guide the PF intervention.

Table 4. Resources for assessing readiness

Resources for assessing practice readiness for facilitation
Bobiak SN, et al. Measuring Practice Capacity for Change: A Tool for Guiding Quality Improvement in Primary Care Settings. *Q Manage Health Care* (2009) 18 (4): 278.284.

Resources for assessing practice readiness for facilitation
Gustafson DH, Sainfort F, Eichler M, Nutting PA, Dickinson WP, et al. Developing and testing a model to predict outcomes of organizational change. *Health Services Research* (2003) 38 (2): 751-776.
Lehman, W.E.K, JM Greener, DD Simpson. (2002). Assessing Organizational Readiness for Change. *Journal of Substance Abuse Treatment* 22: 197-209.
Ohman-Strickland, PA et al. (2006). Measuring organizational attributes of Primary Care Practices: Development of a New Instrument. *Health Research and Educational Trust* 42 (3): 1257-1273.
Ruhe, MC, Carter C, Litaker D, & Stange KC. (2009). A Systematic Approach to Practice Assessment and Quality Improvement Intervention Tailoring. *Q Manage Health Care* 18 (4): 268-277.

2.6 What functions do practice facilitators fill and which are more effective in producing desired changes?

According to participants, facilitators fill three basic functions:

- to develop the organization's internal capacity for on-going improvement
- to guide and manage improvement efforts in the practice
- to provide technical assistance in targeted areas such as implementing planned visits, optimizing registry functions to support population health, improving billing systems, and implementing health information technology with meaningful use among others

Organizational development focuses primarily on enhancing the human resources and feedback systems within a practice that are needed to support quality improvement. Facilitation focused on project management is used when a practice possesses the knowledge and skills needed to produce the desired change but needs assistance utilizing this. Technical assistance is used when a practice lacks the knowledge or skills to achieve a desired change. Depending on the nature and scope of an improvement effort, facilitation may serve one or all of these functions over the course of an improvement intervention.

No one function was perceived as more important than the others in producing outcomes. What does appear to be important, however, is the goodness of fit between the functions undertaken by the practice facilitator and the needs of the practice. For example, a practice that is focused on implementing an Electronic Health Record that is seeking technical assistance related to this may not benefit from or be satisfied with a facilitation intervention focused on developing the internal resources of the organization for QI, no matter how important this activity is to the long-term success of the practice.

2.7 What are the different types of facilitators and is one more effective or useful than the others?

Three categories of facilitators were identified by participants: generalists, specialists, and teams. A generalist facilitator possesses expertise in project management, QI methods,

resource brokering, and organizational development. A specialist facilitator also referred to as a content expert possesses deep knowledge in specialized areas such as EHR implementation and practice redesign. A facilitation team combines the knowledge and skills of the generalist facilitator with a team of content experts. Ideally the team also includes representatives from the patient community. It looks similar to the approach used in the agricultural extension program where a regional extension agent (analogous to a generalist facilitator) is able to mobilize content experts from area universities and the larger extension system as the need arises. Participants viewed team approaches to facilitation as one of the more desirable approaches to delivering improvement support to practices since it is unlikely that any one individual will possess the breadth and depth of knowledge and skills required to support all possible improvement goals that a practice might want to pursue.

Most programs represented at the meeting utilize generalist facilitators or facilitation teams in their work.

2.8 Are internal or external facilitators more effective?

A facilitator can be external to a practice, internal to a practice or embedded within the practice. An internal facilitator is someone that is employed by the practice. Often this individual has other duties in addition to supporting improvement work. An external facilitator is someone who is employed by an outside organization. Often this individual is focused only on improvement work. An embedded facilitator is someone who occupies a position in the practice over an extended period of time but is not directly employed by that practice.

External and embedded facilitators were seen as more effective than internal ones due to the lack of competing demands for their time, their ability to focus exclusively on improvement work, and their relative emotional distance. In addition, external and embedded facilitators often are able to support a number of practices at the same time, which has the added benefit of allowing them to disseminate best practices and learning across their group of practices.

In contrast, internal facilitators were seen as vulnerable to competing demands within the practice environment and so unlikely to be able to support improvement work as consistently over the long term. Staff turnover and attrition was seen as another threat to internal facilitation models. The perceived ineffectiveness of internal facilitators did not extend to the designation of internal “change champions” who work in partnership with external facilitators to support improvement. These external-internal dyads were generally seen as effective.

The one instance where internal facilitators were seen as viable was when they were situated within large organizations such as an IPA or large Federally Qualified Health Center with multiple practice sites. In this situation, although the facilitator might be internal to (e.g. employed by) the parent organization, he or she was external to the individual practice sites. However, this situation comes with its own unique challenges, and the facilitator’s connection to the corporate office may at times be in conflict with a need focus on and advocate for change at the individual practice level.

Most of the programs represented at the meeting use external or embedded facilitators. Two use an external facilitator-internal champion dyad.

2.9 How many hours of facilitation are needed to achieve improvement in a practice and how frequent are the encounters?

Among the programs represented at the meeting, the amount of time facilitators spent with their practices ranged from a low of 60 hours to a high of 200, with an average of 114 hours across the programs. The total hours spent varied by the specific improvement goals and underlying model of change.

There was no clear agreement among participants as to the minimal number of hours needed to effect improvement in a practice. Participants agreed that comprehensive changes such as PCMH transformations can require up to 5 years to achieve and a substantial number of facilitation hours. Participants suggested that as a rule of thumb, most improvement projects take up to three times longer than originally estimated and it can be useful to apply this multiplier when planning practice improvement interventions.

Most programs provided services weekly; three used a monthly schedule. All programs allowed for ad hoc support to occur between scheduled sessions. Programs provided these services through a combination of in-person visits, email, and telephone support.

2.10 Are long-term or short-term intervention models more effective?

Facilitation schedules generally fall into one of two categories: short-term and intensive or longer-term and less intensive. Short-term interventions typically take place over 30 days or less, and involve daily all-day presence of the facilitator. Longer-term interventions typically take place over 6 to 12 months, but can last as long as 24 months. These typically involve shorter visits ranging from a full day every other week to a ½ day a week.

Some participants suggested that intensive schedules can overwhelm practices, especially smaller ones that lack sufficient staff, and so can be less effective in these instances. Similarly they suggested that longer, less intensive intervention periods may also allow practices the time needed to "metabolize" changes and develop capacity and new administrative and clinical "habits" that are more likely to be sustained over the long term. Rapid intensive interventions may run a greater risk of being short lived.

Regardless of delivery schedule, booster sessions provided 8 months or more after the facilitated improvement intervention were seen as important to reinforce changes and ensure sustainability of the improvements.

Among the programs represented at the meeting, facilitation interventions ranged in length from 24 to 96 weeks, with an average length of 51 weeks. Among the programs represented, 8

out 9 provided booster sessions to practices to help cement changes implemented during the main part of the facilitation intervention.

2.11 Is distance facilitation (provided through email, telephone, web conferences) as effective as on-site facilitation? Is there an optimal mix of distance and on-site delivery?

Facilitation support can be provided at a distance using technology (telephone, email, video conferencing, webinars) or in-person at the practice site. In-person facilitation has a number of distinct advantages over distance facilitation. It can increase the ecological validity of the facilitation support, support development of trusting relationships with key individuals in the practice that are considered by many as a critical aspect of any effective facilitation effort, allow for more intensive assessment and discovery, and enable the facilitator to provide much needed hands-on assistance to the practice in strategic areas; however, it is also more costly, and can be intrusive in that it requires individuals to leave their daily tasks to meet with the facilitator.

Distance facilitation provided through telephone, email support and web-based solutions such as video conferencing and webinars is less costly, eliminates drive time which can be a critical factor in sprawling urban and rural communities, and is believed by some to reduce over-dependency by the practice. However it is also less personal, can be less motivating for practice partners and easier to push aside, and impedes delivery of hands-on support.

In reality, most programs mix distance and on-site approaches, emphasizing one more than the other. Programs that use primarily distance methods may start the program with an initial site visit. Programs that consist mainly of on-site support may provide support using distance technologies between site visits.

In-person support was by far the most frequently used modality among programs represented at the meeting. The percent of support provided in-person ranged from an estimated low of 45% to a high of 95% across the programs, with an average of 65% facilitator support provided in-person. Email support was the second most used modality, with percent of contacts conducted through email ranging from 2% to 30% across the programs with an average of 15%. Percent of support delivered telephonically ranged from 0% to 15% with an average of 12%. Internet conferencing was the least frequently used modality, ranging from 0 to 10% among the programs represented at the meeting for an average of 3%.

There is little to no rigorous research available yet to suggest a clear advantage of one modality over another; and most decisions about the use of distance vs. in-person support are based on cost and staffing considerations rather than an underlying theory of change or the findings from effectiveness research.

Among meeting participants, interventions delivered using mainly distance technologies such as the phone and web conferencing were seen as less effective than on-site programs. Distance

approaches were seen as the method of choice only with a small group of practices that were already highly motivated to change, and already possessed the adaptive reserves needed to effect the change themselves. In these instances, facilitators served to provide external accountability and to motivate the practices to keep moving forward on their improvement projects, but provided little direct intervention.

A final note on the use of technology in facilitation. Currently, distance technology is used in facilitation interventions to lower costs and increase the number of practices a facilitator can support. Limited consideration has been given to newer technologies such as social networking, sites like Facebook, or services like Skype or dissemination infrastructures such as that of Project ECHO might be harnessed to increase the actual effectiveness of facilitated improvement interventions.

2.12 Can practices become dependent on facilitators and how should this be managed?

Dependency between practices and facilitators follows a predictable developmental course. Greater levels of dependency are expected and considered normal at the start of an intervention. As the practice builds its own internal capacity to support improvement work, this dependency is expected to lessen.

One practitioner provided an excellent analogy of practice facilitation, describing it as a type of self-management support for practices. "*What practices really need is their own form of self-management support that is focused on helping us develop the knowledge and skills and habits needed to manage our own administrative and clinical functioning more effectively. The goal of self-management support is to empower a patient to be better managers of their own illness and lives. A patient still needs to see their doctor periodically to help them stay on track, but between times they do almost all of the management themselves. The same could be said of facilitation.*"

Continuing dependency past a certain point in an intervention is viewed as problematic and suggestive of a less effective intervention. Concerns about dependency influenced decisions around scheduling, intensity and duration of facilitation interventions, and were often addressed by program designs that tapered support provided to practices over time as a strategy for weaning practices from the facilitator. However it is not clear that preventing dependency actually improves outcomes. In fact, the presumed correlation between dependency and poor intervention outcomes has not been established, and the nature and impact of dependency in these contexts is not yet understood. In fact, dependency may be adaptive in some contexts and may actually support better rather than worse outcomes. Facilitation models that provide consistent support and are accessible as needed over extended periods of time may be more effective at supporting the organizational development that is required to transform care.

Another complementary and potentially more effective approach for addressing dependency is to incorporate "empowerment" approaches into the facilitation model. These emphasize

building the knowledge and skills of the participant over "doing for them." The process is nuanced and requires the ability to determine when direct intervention (doing for) a practice is needed and when the focus should be on building the practice's own adaptive reserve for improvement.

2.13 How many practices should a facilitator support at any one time?

Facilitation programs varied widely in the number of practices a facilitator supported at any one time. Programs ranged from a 1:1 to a 1:24 facilitator to practice ratio. The majority of participants at the meeting suggested a 1:6 to 1:8 ratio for early stage interventions as optimal. As an intervention progresses and practices build their internal capacity for improvement work, a facilitator can support a larger number of practices, up to as many as 30. The optimal ratio of facilitators to practices will vary based on the length of the program, the modality of service delivery, and the particular improvement goals. Short-term, intensive interventions delivered predominately on-site require low facilitator to practice ratios. Facilitators delivering longer-term, less intensive interventions or ones utilizing distance technologies as opposed to on-site delivery are able to support a larger number of practices. It's important to note however, that a recent meta-analysis of facilitation studies carried out by Bakersfield (2009) found that the effectiveness of facilitation lessened as the facilitator to practice ratio increased.

2.14 Can facilitation be provided as a stand-alone service or should it occur in the context of more comprehensive improvement efforts?

Most participants suggest that facilitation is most effective when it occurs in the context of comprehensive improvement efforts that include payment reform and other strategies such as learning collaboratives, benchmarking and academic detailing. A number of programs across the country are occurring in the context of larger improvement efforts that include all of these components. For example, the IPIP initiative in Pennsylvania and efforts such as Blueprint Vermont are combining facilitation, collaboratives and state-level payment reform with very promising results. Several participants expressed concern that facilitation not be viewed as a panacea or as sufficient to produce change alone.

A number of meeting participants felt strongly that comprehensive, scalable improvement can only be achieved in the context of payment reform. Others felt that improvement can occur without this, but that its scale and sustainability will be limited. Many of the aspirational models of primary care have a negative impact on the financial viability of individual primary care practices. To really achieve substantial improvement and change, payment must be aligned so that it supports and rewards adoption of desired treatments and care processes. Practices that view improvement activities as improving their financial viability will be much more likely to engage in desired improvement work and to sustain the changes over time than those that do not. Leif Solberg points out that adoption of new treatments and procedures in specialty care settings occur more rapidly and with little external pressure because adoption of these new treatments and procedures improve not only quality and provider reputation, but also their bottom line.

Collaboratives provide substantively different but complementary forms of support to facilitation. Where facilitation excels at delivering ecologically valid and tailored organizational and technical assistance to a practice, collaboratives provide opportunities for shared learning, idea exchange among peers, and stimulate positive competition among a community of peers that can create motivation and priority for change.

Among the programs represented at the meeting, the majority (80%) involved the use of additional QI strategies. Of these, half complemented facilitation with traditional learning collaboratives; and half added local learning collaboratives involving 3 or fewer practices. Other strategies used included payment reform, academic detailing, benchmarking, expert consultation, site visits, social networking at national meetings and provision of IT support.

2.15 What is the usual course for an intervention using practice facilitation?

Practice facilitation interventions typically progress through five stages: readiness assessment, orientation and team formation/engagement, practice assessment and goal setting, active improvement efforts, and completion. Within these, the specifics of each facilitation intervention can vary widely depending on the needs and goals of the practice and improvement initiative. While not all facilitation efforts progress through these same stages, many do.

Stage 1. Readiness Assessment. This involves the initial contact with a practice and assessment of both the practice's desire to work with a facilitator and the organizational "readiness" to engage in a facilitator supported improvement effort. This stage can last from 1 day to 3 months.

Stage 2. Team formation/engagement and orientation. This includes general administrative activities such as completing Memoranda of Understanding and executing Business Agreements. It may also involve the facilitator leading an orientation training for the practice or facilitating an academic detailing session featuring peer to peer learning. A 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 using facilitation, and outlining their responsibilities and roles in the process. Other activities include identifying de facto leaders in the practice that can help effectuate improvement efforts. Finally, during this phase the facilitation works with the practice to identify the Practice Improvement Team for the intervention.

Stage 3. Practice assessment and goal setting. During this stage, the facilitator conducts an assessment of the practice appropriate to the goals of the improvement effort. A variety of tools exist for assessing practices. The AHRQ CCM Tookit provides links to a variety of tools. Clinical Microsystems, Group Health and IHI among others also have excellent resources for conducting initial assessments. Findings from the assessment are presented as a first step towards supporting "data driven" change. Facilitators will need to work with practices to

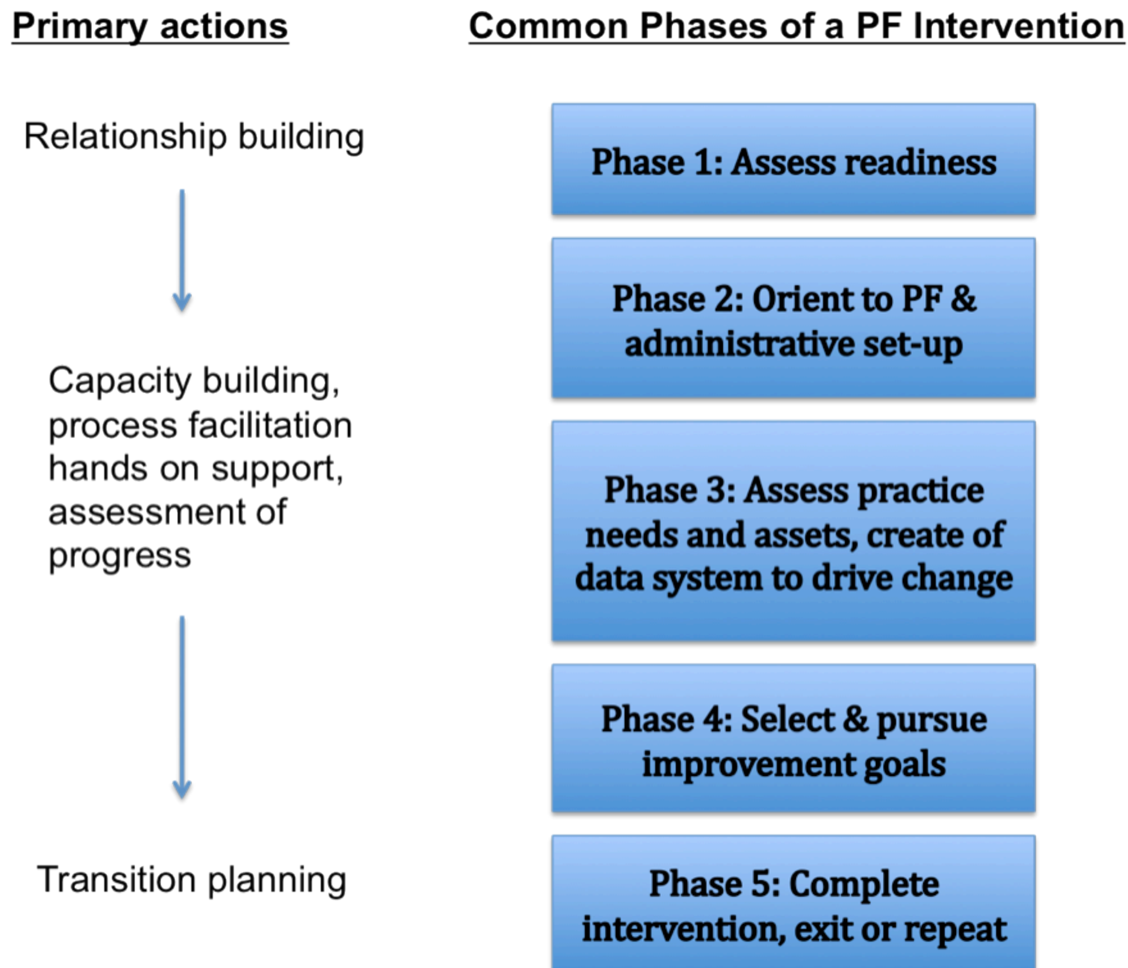
address concerns about the reliability and validity of data currently maintained by the practice, and work with practice members to develop data collection processes that produce reliable and valid data for use in improvement work. The facilitator will also need to work with practice members to test current assumptions about their functioning against the data and against external benchmarks. During this stage the facilitator may create an inventory of data the practice is currently collecting, set-up systems for regular data collection that can be used to guide change and track progress, and present findings to the improvement team in order to determine improvement goals for the intervention.

Stage 4. During stage 4, the facilitator assists the practice to build internal capacity for improvement and to pursue specific improvement projects based on findings from stage 3. During this stage, depending on the needs of the practice and the particular improvement project, the facilitator may train the practice staff and providers on QI methods and strategies, manage improvement projects and work with members to build skills in this area, provide technical assistance in specific areas, bring in content experts as needed, facilitate local learning collaboratives and academic detailing interventions, and incorporate members of the patient community in the change process as appropriate. The facilitator will provide monthly data reports tracking progress towards stated goals and work with members to build resources that are key drivers of practice improvement that can be sustained after the intervention.

Stage 5. During stage 5, the facilitator begins a phased withdrawal from the practice and transfers more and more of the coordinating functions to practice staff. The facilitator continues to be available to provide support on an as needed basis, provide booster sessions, and reengage on new improvement initiatives.

As part of this process, facilitators may draw on particular change packages such as AHRQ's CCM Toolkit, Improving Performance in Practice's change model, TransforMed's PCMH advancement materials, the California Health Care Foundation's HIT implementation process, or those available through IMACT BC to name a few. The facilitator may rely on structured improvement approaches such as the Model for Improvement, Six Sigma or LEAN; or guide their work based on a particular theory of change or prior experience in working with similar practices.

Figure 5. Typical stages of a practice facilitation intervention



2.16 What individuals make the best facilitators?

Practice facilitators need excellent interpersonal and communication skills. In addition they need the ability to approach a practice in a collaborative and humble manner without using quality improvement jargon, and should be comfortable and effective working with individuals with varying levels of education from high school level to masters and doctoral degrees. Likely they also need to understand empowerment concepts at a deep level.

Participants were split on whether a facilitator needs prior experience working in a clinical setting or a clinical degree to be effective. While some felt that this experience was essential for the facilitator to be effective, others felt that this knowledge and experience could be acquired on the job and that extensive clinical experience in some instances might impede effective facilitation.

Individuals with backgrounds in Public Health, Social Work, Nursing, Counseling and Psychology were thought to be well suited for facilitation because of their basic skills and knowledge in

human and group interactions. Individual from a business background or organizational consulting may also be well appropriate. In addition, some facilitation programs have used trained lay persons with success. Participants were split about the use of physicians as facilitators. While they possess first hand clinical experience that can make them effective facilitators, their deep involvement in the profession may also limit the ways they think about problems and their potential solution. In addition, pulling a clinician out of practice when there is a shortage of primary care physicians and nurses also warrants thought. Physicians and others with vital clinical training may best be used to provide peer-to-peer support through academic detailing and content expertise in particular areas, and as high level experts on a facilitation team.

Among the programs represented at the meeting, the majority of programs (66%) used RNs/PAs/NPs as facilitators. Fifty-five percent of programs used MPHs; 44% used MSWs as facilitators. Only 22% of programs used MBAs or doctoral degreed individuals (MDs and PhDs) as facilitators. One program used industry-based specialists (automotive) another also used OT/PTs, and a third program engaged medical students and pre-med students as facilitators.

2.17 What core competencies and skills do facilitators need to have to be effective?

Facilitators need to possess competencies in seven areas: basic knowledge of primary care practices and various theories of practice and organizational change, competencies in the use of various QI methods and project management skills, competencies in providing technical assistance to practices in key areas including the use of registries and HIT to support population management, providing standardized care for key health conditions, and self-management support, competencies in the use of data to drive change and track progress, competencies in communication and conflict management, and competencies in self-management and professionalism. Figure 6 outlines the competencies suggested by participants at the meeting:

Figure 6. Core competencies of a generalist practice facilitator

General Knowledge

- Theories of change, diffusion of innovation and complexity
- Empowerment theories and strength based approaches to assessment and intervention
- Adult learning theory
- Chronic Care Model
- Model for Improvement
- Current aspirational practice models (Ex: Patient Centered Medical Home)
- Knowledge of different practice environments, models, structures
- Knowledge of the local health care community and resource environment
- Knowledge of various change packages such as the AHRQ CCM, IPIP, etc.

Knowledge related to the design and delivery of facilitation

- Knowledge of facilitation approaches, models and evidence of best practices
- Orienting and building practice capacity to use facilitators

- Managing practice expectations of the facilitator
- Managing long-term relationships with practices
- Determining facilitation schedule
- Determining modality mix
- Problem solving and terminating ineffective facilitator-practice partnerships
- Forming and managing a practice-specific facilitation team
- Managing a budget for a facilitation intervention
- Participating in learning communities of facilitators to spread innovations and best practices

Knowledge and skills in quality improvement methods

- Forming and facilitating QI teams
- Designing charters for QI team
- Conducting workflow analyses
- Conducting chart audits and benchmarking
- Using Plan Do Study Act (PDSAs) cycles
- General understanding of LEAN, Six Sigma and other approaches
- Developing and implementing improvement workplans
- Facilitating local learning collaboratives
- Supporting implementation of standardized care (guidelines)
- Engaging peer to peer academic detailing support as needed
- Using technology as a QI tool
- Skills in building competencies in practice staff in these areas

Project and people management skills

- General project management skills
- Effective communication
- Skills in conducting effective meetings and presentations
- Managing conflict and problem solving

Knowledge and skills in obtaining and using data to drive improvement

- Developing a data inventory
- Accessing and using practice data to identify areas for improvement
- Accessing and using practice data to track progress towards improvement goals
- Identifying and remediating threats to the reliability and validity of practice data
- Skills in using qualitative data to support improvement work
- Skills in designing and administering surveys
- Skills in conducting key informant interviews
- Skills in managing data and conducting basic analysis such as frequencies, main tendencies, and creating trend lines and run charts

Knowledge and skills to provide technical assistance in critical areas

- Using registries and HIT to support population management

- Supporting standardized care
- Self-management support
- Evaluating EHRs
- Translating comparative effectiveness findings to practice
- Additional areas based on policy, payer, funder, project, practice, community

Facilitator Evaluation, Professionalism and Ethics

- Knowledge of HIPPA and human subjects and practice consistent with this
- Adherence to program requirements and policies and procedures
- Adherence to client practice policies and procedures
- Continuous self-evaluation and professional development through supervision, training and exchange with other facilitators and QI personnel in other industries
- Self-care in context of a high stress work environment
- Documenting facilitation encounters and progress
- Monitoring fidelity of the facilitation intervention
- Evaluating progress and effectiveness of the facilitation intervention against pre-defined benchmarks

Brenda Fraser one of the meeting participants has developed a set of competencies for facilitators that is available online at: http://www.qiip.ca/userfiles/QIIP%20-%20QI%20Coach%20Competencies%20Launch%20Jan-10.pdf An alternative set is outlined in *Implementing Practice Coaching and the Chronic Care Model in Practices Serving Vulnerable Populations* (Coleman et al, 2009).

2.18 What is the best way to support and train facilitators?

Meeting participants agreed that facilitators should complete specialized training designed to produce the core competencies required to be an effective facilitator. Training programs varied widely in length and scope ranging from 2-day workshops to multi-year professional development courses. Training should be delivered using adult education methods. A one to two week apprenticeship with an experienced facilitator was seen as a useful but not essential part of the training.

Training should be tailored to the facilitators' background and prior experience. Facilitators without prior clinical training or experience working in primary care settings should receive additional instruction in these areas and when possible, gain experience in these settings through an internship, or field experience that takes place concurrent with their initial work with their practices.

A number of training programs are available for facilitators. A partial listing of these programs is provided in Table 5.

Table 5. A partial list of PF training curricula and resources

Source	Title	Year	Website
Oklahoma Practice-Based Research Network	(PEA) Practice Enhancement Assistant Manual	2009-2011	www.okprn.org
Dartmouth Coach-The-Coach	Dartmouth Clinical Microsystem Improvement Curriculum	2006	www.clinicalmicrosystem.org
Healthcare Research and Quality	Integrating Chronic Care and Business Strategies in the Safety Net: A practice Coaching Manual	2009	www.AHRQ.gov
IMPACT BC	Practice Support Program Facilitator Handbook	2007	www.impactbc.ca
Institute for Healthcare Improvement	Primary Care Practice Coach	2010	www.ihi.org/IHI/Programs/ProfessionalDevelopment/PrimaryCarePracticeCoach.htm
L.A. Net	Practice Facilitator Presentation	2010	http://www.lanetpbrn.net/resources/practice-facilitation
(PCMH) Maine Patient Centered Medical Home	Quality Improvement Coach Description	2009	www.vpqhc.org
VIP Study (Rush University)	VIP Study Nurse Coach Materials	2007	**http://www.rush.edu/professionals/vip/**
Quality Improvement & Innovation Partnership (QIIP)	Quality Improvement Coach Competencies: Building Quality Improvement Capacity & Capability in Primary Healthcare	2009	www.qiip.ca
Oklahoma SoonerCare	Practice Facilitation Training Guide	2008	www.commonwealthfund.org/.../Oklahomas-SoonerCare-Health-Management-Program.aspx
L.A. Net	Safety Net Facilitator Training	2010	www.lanetpbrn.net

In addition to standard introductory training, facilitators need regular supervision and training, and meetings with other facilitators through support groups and learning collaboratives. The supervision and group sessions should serve multiple functions including provision of training, provision of emotional and social support, and collaborative learning among facilitators that supports diffusion of innovations across the community of practices served by the facilitators. Individuals who provide the supervision should be competent in empowerment strategies and use these strategies when supervising the facilitators. By doing this, the supervisor models the empowerment approaches that the facilitator in turn should be using to support his or her practices.

Most of the programs reporting trained their facilitators in-house. One program also utilized external training resources.

2.19 How much does it cost per practice to provide facilitation support?

Costs for practice facilitation vary widely and depend on the number of service hours and degree and level of training of the facilitator. Costs range from a low of $5,000 to a high of $50,000 per practice. The majority of meeting participants reported an average cost per practice ranging from under $5,000 to $15,000.

At present, facilitation programs are funded mainly through federal grants and contracts, foundation grants, funding from state Medicaid or Medicare programs, and health plans. Among programs represented at the meeting, the most frequent source of funding was federal grants or contracts (44%), followed by foundations (33%). One program received support through a state contract, and one program was supported through a county level contract. Fewer programs were supported by funding from health plans.

None were funded through direct payment by practices themselves. The later may be a reflection on the lack of financial resources of the practices or a lack of perceived value for facilitation by the practices. The recently proposed National Primary Care Extension Service and the HITECH RECs are likely to make use of facilitation services and may provide a source of longer term funding for facilitation services. Per member per month funding through health plans and CMS is another, potentially long-term source of funding for the services. Finally in the context of payment reform where improvement activities undertaken by practices are capable of producing robust financial returns on investment, at some point practices themselves may become interested in direct purchase of facilitation services.

2.20 How should facilitation programs be evaluated?

The majority of programs represented at the meeting conduct formal evaluations of their programs' outcomes. Of those reporting, the most commonly measured outcomes were quality measures (HEDIS etc)(100%), followed by assessments of degree of implementation of the CCM (77%), changes in organizational capacity (66%), changes in patient satisfaction (55%), cost (55%), impact on PCMH level (44%), and changes in provider satisfaction (44%). Only 22% of programs reporting indicate they evaluate the impact of facilitation on patient outcomes.

Participants agreed that evaluations of facilitation interventions should focus on practice-level variables such as improvements in processes of care, quality metrics, patient experience, and changes in a practice's organizational capacity to improve care quality. Other metrics might include changes in patient and staff satisfaction, and changes in the health care organization's financial viability.

Patient outcomes, although the ultimate goal of QI interventions, were not considered appropriate outcome measures since a significant amount of time is often required for changes

in care quality to manifest in improved patient outcomes. In addition, the connection between improvements on quality metrics and improved patient outcomes is still not confirmed.

Goal attainment scaling and strategies that allow for evaluation tailored to the practice's goals and needs may be appropriate to use when evaluating facilitation interventions that are based on practice-defined goals since they allows for more flexibility in defining outcomes, and allow for comparison across practices with different goals.

In order to advance the field, It may be beneficial to identify a core group of shared outcome measures that could be used to compare outcomes across different facilitation programs. This would help determine what approaches are the most effective under what conditions and with which practices.

2.21 Do differences in practice size, location or structure impact the effectiveness of facilitation?

Facilitation programs represented at the meeting support a variety of practice types. Most provide facilitation services to practices located in urban environments, more than half support suburban practices, and more than half support rural practices. The majority provide services to practices with only 1 FTE primary care provider, 85% support small practices (up to 5 FTE PCPs), 71% support medium sized practices (up to 10 FTEs), and 71% support larger practices (11 or more PCP FTEs). Eighty-seven percent of programs support residency training sites, 62% percent work with Community Health Centers and Federally Qualified Health Centers, 50% support private practices, 25% work with faculty practices, and 12% with public health centers.

Participants agreed that variations in the way a practice makes money (fee for service vs. capitated), organization (Community Health Center, other staff model, independent solo or group practice), professional mix (MD, use of mid-levels, nursing staff) and size (small, medium and large) all affect the motivation and drivers for improvement in the practice including the business case for engaging in improvement, the selection of improvement goals, the feasibility of these goals, and the resources available to support improvement activities. Participants agreed that these variations have important implications for the scope of facilitator knowledge, facilitator goals and strategies, but also believe that the core set of facilitator skills remain constant across these variations.

2.22 What research questions should be answered about facilitation in order increase its effectiveness?

Research will play an important role in guiding development of effective practice facilitation in the future. Research questions were identified from recommendations by participants and through discussion at the meeting. Questions were identified in six areas: research approaches, effectiveness, cost, organization/structure, reach, and knowledge needed to scale

up facilitation services. It will be important to determine which among these would be good to know but not essential, and which are essential to advance the field.

2.23 Suggested research questions

Research approaches

- Shared measures should be identified for use across programs. What shared measures can be used for evaluating across all facilitation interventions that can support cross program comparisons that are meaningful in answering a range of questions about the effectiveness of different intervention approaches?

Reach

- Which practices/providers are willing to/not willing to participate in a facilitation intervention and why/why not?
- Which health plans and other potential purchasers are willing to/not willing to fund facilitation services for their providers and why/why not?
- What is their relative satisfaction with facilitation vs. other approaches?

Effectiveness

- What facilitation models are most effective with what outcomes and types of practices?
    - Internal vs. external?
    - Team vs. individual?
    - Interventions with practice-defined vs. externally defined goals?
    - Short term vs. long-term?
    - Low intensity vs. high intensity?
    - Distance vs. on-site facilitation vs. combination? What is optimal mix?
    - Facilitation alone or in combination with other interventions?
    - Practice-led agenda vs. externally defined agenda?
    - Boosters or no booster sessions?

- Prescribed/scripted intervention vs. responsive?
- How do practice size, payment mix, structure, location, patient population affect the impact of facilitation?
- What is the minimal effective amount of facilitation for achieving what outcomes?
- What is the optimal facilitator to practice ratio and under what conditions?
- How long are the effects of facilitation maintained?
- Are there “sleeper effects” for a facilitation intervention?
- Which is more effective, facilitation or collaboratives or a combination and under what conditions?
- What additional value does facilitation bring to comprehensive improvement efforts?

Effectiveness in disseminating comparative effectiveness findings

- Can facilitation be used to disseminate/translate comparative effectiveness findings in primary care? If so, what models are most effective under what conditions?
- What findings are appropriate to disseminate using facilitation? What are best disseminated using other methods?
- What is the relative cost benefit compared to other strategies of dissemination?
- Is facilitation alone sufficient or does it need to occur in the context of a more comprehensive dissemination effort?

Staffing, Structure and Management

- What are the advantages and disadvantages of different organizational structures for housing facilitation programs? Are there potential best practices in this area?
- What structures/resources are needed to help facilitators disseminate learning with each other and other practices? Are there potential best practices in this area?
- What is the best way to train and supervise facilitators that is cost effective and potentially scalable? Are there potential best practices in this area?
- Are facilitators with clinical backgrounds more effective than those without?
- Should a training and career path be created for facilitators? If so, what should this look like? Are there potential best practices in this area?
- What reporting systems and structures are needed to assure the quality of facilitation services? Are there potential best practices in this area?

Cost

- What does a facilitation intervention cost?
- What cost savings or increases does it produce at the practice level? The system level?
- What are the relative costs and benefits of facilitation compared to other QI approaches?

Best practices in scaling facilitation services

- What are the lessons learned from other countries using facilitated improvement at state or regional levels that can inform development of a similar workforce in the U.S.? In funding, structure, workforce development and management, selection of practices, model of intervention, and cross program collaboration?
- What are the lessons learned from statewide efforts in the U.S. to provide facilitated improvement that can inform development of facilitation services in other states?
- What are lessons learned from other industries such as agriculture and automotives in facilitated improvement that can inform development of a facilitation infrastructure for primary health care?

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APPENDICES

Appendix A. Crosswalk between ICIC Pilot Study and Consensus Meeting
Appendix B. Lessons Learned in Practice Facilitation and Practice Improvement Shared by Participants
Appendix C. Inventory of Resources Provided by Participants
Appendix D. Table summarizing program characteristics (Under separate cover)

Appendix A
Crosswalk between ICIC Pilot Study and Consensus Meeting

Note: The two groups essentially agreed in all areas except the issue of internal vs external location of coaches. In many cases the Consensus Study Panel modified, extended or expanded upon the conclusions of the ICIC Pilot Study, as shown in the table below.

Category	Pilot study	Consensus meeting
Coaching vs. Collaboratives	Coaches, as opposed to learning collaboratives, are better able to customize the intervention to the needs of the team. More staff can participate in the practice improvement sessions with minimal impact on patient access. However, there are elements to the learning collaboratives that you lose, including a sense of normalizing the change process, brainstorming, support, camaraderie, and national physician leadership. Both types of programs provide a formal structure for teams to figure out their own issues, and this may be the most important shared characteristic of effective QI programs	Facilitating local learning collaboratives (2-3 local practices meeting over lunch to share ideas) is a core function of coaches and can provide the camaraderie, peer pressure etc. usually obtained from collaboratives
Coaching as stand alone intervention or used in combination with other improvement strategies	Not addressed	Facilitation is most effective if it occurs in the context of a more comprehensive improvement process that involves collaboratives and payment reform in particular
Relationships	Practices valued the relationship with the coach	On-site presence is important in order to create these relationships. They are difficult to create and sustain using distance technology
Preparing a practice to use a coach	Clearly defining the coaches' role and regularly checking expectations is important. Some sites perceived the coaches as consultants who were there to come in and solve a problem, while others viewed them as resources. Clearly defining the role of the external coach, how they are to partner with internal leaders, and who is expected to do what work is an arrangement that needs to be mutually and continuously agreed upon	
Proximity of services	The format of coaching might better be on-site if funding is available. The format of coaching might better be on-site if funding is available. Because people feel better and are more motivated when they see a coach in person and it is easier to communicate and discuss. While face-to-face interactions are important in coaching, email and telephone communications for question-and-answer or for problem solving could supplement face-to-face coaching Coaching should include more face-to-face interactions	

Category	Pilot study	Consensus meeting
Duration and intensity	Increasing the coaching meeting to one and a half hours instead of one hour might be a better length to allow time for more communication and idea exchanges. For the time distribution, m ore intensive coaching is needed at the beginning; then, it could become less intensive when people are self-sufficient A six-month intervention period is short, especially for teams with no QI experience and no real team orientation. Coaching intensity may need to be greater at the beginning Continue coaching for a longer period of time	There is a range of facilitation schedules currently in use ranging from intensive, daily encounters for 24 days, to weekly encounters occurring over 6 to 10 months. Most interventions average between 90 and 120 hours regardless of schedule. Little research evidence exists to suggest minimal dosage required to create effect, although a recent meta-analysis of the effects of facilitation suggests that more facilitation produces greater effects There is some suggestion that intensive (daily) short-term facilitation schedules may work in some environments, most likely larger organizations and practices that have greater numbers of staff, and be less effective and even potentially disruptive for smaller practices
Working in the context of other QI activities occurring in the same practice	Coaching can really jump-start the spread of improvement especially when someone has already participated in a QI initiative, like a collaborative, and has knowledge they would like to share but no formal time or place to do that. Harnessing their experience and knowledge as part of the coaching intervention can be powerful Frequently, there are multiple projects going one, which means being open to or seeking synergy from the diverse efforts	Practices involved in several QI efforts may experience "change fatigue" which can have negative effects on QI efforts, including efforts involving the use of facilitators
Location of coach in the organization: Internal vs. external coaches	An internal coach who knows the coached system better might be a complement to, or counterpart for, an external coach, but we do not know whether an internal coach will be a better alternative to an external coach An internal coach might be added	Internal coaches are thought to be less effective than external ones for a variety of reasons including: a) competing demands of patient care distract from QI work; and b) lack of sufficient psychological distance from practice to provide guidance/feedback Internal "champions" might be developed who can work with the facilitator and serve as a resource to the practice when the facilitator is unavailable

Category	Pilot study	Consensus meeting
		Embedded facilitators are individuals who are employed by an organization outside of the practice but that spend extended, consistent time in the practice such that they are perceived by the practice as a regular member of the practice team
Types of coaches	Coaching can also be a team activity, whereby two or more coaches bring complementary skills to interactions with the practice	Facilitators can be <u>generalists</u> (project management, basic QI skills, targeted areas of expertise such as use of data systems to support population health management) or <u>specialists</u> (targeted areas of expertise such as HIT implementation). In addition, facilitation can take place in the context of a team of content experts, patients and others organized and led by a generalist facilitator. The team approach may be the most feasible given the breadth and depth of knowledge that would be required for any one individual to be able address the needs of most practices
Readiness	Coaching needs to come at the right time in the QI process. People need to see a need for it Specific to CCM: Start where the health center is… understaffed practices overburdened with demand could not successfully implement the CCM. Practices must have clearly defined patient panels assigned to well-defined care teams before any major practice change can progress	Practices require a certain level of "readiness" in order to benefit acceptably from an improvement intervention involving a facilitator. Readiness should be assessed before accepting a practice for facilitation services. Elements of readiness include: leaders that are supportive and engaged and committed to the improvement process; the ability to provide time for staff/providers to work on improvement activities; among others; not experiencing a disruptive level of organizational/financial disorganization/distress Assignment of practice panels and creation of care teams were

Category	Pilot study	Consensus meeting
		seen by group as a potential "goal" for a facilitation intervention (e.g. facilitation may support pre-work needed to implement CCM)
Which practices should receive facilitation support?	… practices with engaged leaders and long-term quality improvement goals are more likely to embrace the changes coaches nurture…. programs using coaches may want to target practices unlikely to be able to engage in quality improvement on their own.. practices that: are not part of or supported by a larger system; cannot attend quality improvement collaboratives; require additional motivation or contain pockets of resistance or inertia that block spread of the CCM	Facilitation resources should be reserved for those most likely to benefit the most. Not all practices should receive facilitation. Exemplary practices are unlikely to receive significant addition benefit from a facilitator in areas where they are already achieving at above average levels. Highly dysfunctional practices are also unlikely to be good candidates for facilitation as the practice is focused on survival as opposed to improvement
Role of leadership	Identify a leader on-site who is accountable, creative, flexible, and empowered. It is the function of leadership, not the role that matters. It is not important if it is a nurse or administrator, physician, or executive; someone has to be authorized and responsible for the daily oversight of the program and to be able to work with leadership to remove barriers. The local leadership will function to organize meetings to facilitate teamwork, provide guidance and help to redesign care, and encourage physicians and staff to try new things The active support of all relevant leadership is important. This entails clearly assessing the hierarchy of accountability and, if multiple silos exist, trying to recruit and align all leaders	It is not enough to work just with practice leadership. Individuals throughout system and at all levels must be involved for the intervention to be effective
Core competencies	Interpersonal skills and emotional intelligence Familiarity with data systems Ability to understand and explain data reports in different ways to different stakeholders Some clinical understanding and credibility Knowledge of and experience with the CCM Knowledge of and experience with the MOI Understanding of performance reporting and measurement General quality improvement methods Group facilitation skills Project management skills Knowledge of practice management and/or financial aspects of the practice Experience with and understanding of the outpatient clinical setting	- Basic knowledge o primary care and the health care environment - theories of practice change, - General communication and facilitative skills, - general QI strategies and methods - Skills in accessing and using data for assessments and to motivate and guide change activities - Skills in managing facilitation teams and brokering knowledge and other resources for practices

Category	Pilot study	Consensus meeting
		- Deep technical skills in key drivers of improved outcomes (population management, planned and team based care, standardized care, patient partnerships) - Deep technical skills in key drivers of organizational capacity (executive and leadership coaching, team building and development, sustainable QI systems best practices) - Self-management and professionalism
Key functions of facilitators	Reach improvement goals Convene groups of staff Set agendas and serve as task masters Skills builders and trainers Knowledge brokers Sounding boards to give reality check Problem solvers Change agents who promote adoption of specific practices Benchmarking	- Keep the patient in the center of the patient-centered improvement - Provide deep technical support in targeted areas
Conclusions about coaching	Coaching is a necessary bridge to the toolkit Coaching motivates and prompts people to make changes Coaching extends the horizons of the teams Coaching has a positive effect on team building Coaching creates an emotional bond	Coaching provides direct technical assistance in core areas needed to produce improvement – use of data to support population management, panel management, benchmarking
Costs	$20,500 per site, 10 months, mainly distance coaching model	$5000-$40,000 per site depending on intensity, duration
Phases of coaching process	Relationship building, assessment Forming team Active coaching with clinical assessment, financial assessment, assessment of Chronic Care	Orientation and readiness assessment, building capacity to use facilitator Practice assessment across key systems: clinical, administrative, IT, community QI infrastructure development/engagement Active facilitation: Working w/ team on practice-led projects Active facilitation: Working with team on "indicated" projects Graduated withdrawal Termination Reengagement on new

Category	Pilot study	Consensus meeting
		issues/needs as needed. Return to #1 and repeat
Naming the field	Not addressed	Name of intervention and providers should be determined by preference of the end user (practices), and by its ability to support academic discourse/research/publications

Appendix B
Lessons Learned in Practice Facilitation and Practice Improvement Shared by Participants

Lessons learned about practice characteristics and readiness

1. Primary care practices come in an incredible variety of shapes and sizes. The capacity to innovate and to adopt externally derived innovations vary tremendously, however most primary care practices operate under conditions that near maximum capacity but leave little time for quality improvement activities.
2. Small practices do not have a thousand points of veto, so if you can get the lead physician in a group to agree to do something, it can happen. However, they do operate on a hierarchy of needs and while basic care and workload are important, financial security to a small independent practice really unfortunately sometimes trumps the patient care.
3. Business interactions are a fact of life in many small practices, many are family run small businesses and any type of intervention must take this into account.
4. We cannot risk everyone, not every practice is going to survive, and not every practice should survive.
5. The change has to be a high priority for the practice and you do have to build the business case. Because we have heard the comment back of why bother with the nurse coaches if you are not going to change the bottom line? So, I think you have to think about the big business case. I think in terms of the characteristics of the practice, they have to be ready for change, there needs to be support from senior management, and we found that change was in an environment where there was team orientation.
6. Practice "desire" to change is predictive of success. The stakeholders can agree to practice coaching, but resist change. Provider leadership is critical, they must be an active participant. Must care more about "transformation," than "transaction".
7. Federally Qualified Health Centers (FQHCs) have federally mandated quality initiatives and reporting requirements and are burdened by new changes
8. Larger practices present new challenges as they have existing QI strategies, change slower, registry implementation can be a massive undertaking, provider "buy-in" varies, and have administrative barriers.
9. For community clinics financial incentives tend to be very motivating, because they often don't have this in that scarce environment.
10. It is very difficult to predict how successful any practice might be with sustainable behavior change, they'll surprise you in either direction good or bad.
11. There are different practices and you must figure out if a practice wants a coach or needs a coach. The practices that are more successful of course are the ones that have the best leadership and the practices that are least successful are the ones with the worst leadership, but its not just leadership. We have found that if you don't deal with all the doctors in the practice and all the staff, if you have good leadership but if you have some doctors that are totally and completely resistant, it is probably not worth it working with that practice.
12. Coaching teams that do not want to be coached is not a good place to be.

Lessons learned about practice response to facilitation

13. Our experience has been is that practices need and usually want all the help that can get, the biggest concerns remain time and money.
14. It always harder than we think to engage physicians, it is even more difficult if we do it as a single pair.
15. We must address the business side of practice coaching in order to reach doctors who are busy and do not have a lot of extra reserve.
16. Do we really understand the ability or need or want of practitioners to change?
17. Practices just can't take on a practice coach if it isn't functional.

Lessons learned about what facilitation can do

18. According to Solberg for a practice to be able to implement a new process of care, change must be a high priority, the practice must have the capacity to change, and the practice must be able to implement the specific changes required. Practice facilitators or coaches seem to be able to influence all 3 components; but each component requires different coaching skills and approaches. Practice coaching is the only intervention that we've found that seems to be able to impact in practices' overall change capacity and we are still not sure how to enhance that effect.
19. For sustainable change we believe practices need to become learning organizations. In order to do that, just as the physician patient relationship needs to change, so does the relationship between the facilitator and the practice. Right from the start they should realize this is not a medical consulting model, they are not a passive recipients of your information. The facilitator going to you, fixing your problem, then leaving - we all know that doesn't work, but that's what many of them think. They need to know that the answer lies within them and you are going to help them get there.
20. Is practice improvement for the clinicians, patients or payers?

Lessons learned about the sufficiency of facilitation in supporting improvement

21. Practice facilitation by itself its probably insufficient, it probably needs to be a piece of a multi-component QI process, we think that process should include performance feedback, academic detail, HIT support, and a local grounding.
22. Practice facilitation also needs to be embedded within a system dissemination and fusing into infrastructure - much like cooperative extension that will reduce the time involved in establishing relationships. It should be ongoing and the time and costs involved in travel for the coaches will all be local, it will also make them more available when practices are ready for assistance.
23. Any individual entity, unless that entity has a significant impact on the practice, is not enough to leverage change.
24. Coaching and the desired change works best probably when it is not in isolation. So the activity of getting practitioners together and working on quality improvement PDSA cycles or Microsystems or whatever particular methods you use, can lead to change if

you have all the ingredients that you define, priority, capacity and the will to take it on. Then you will be able to see some improvement. You need the system changes to support it in order for it to be really powerful and have a lot of impact.

25. Practice coaching, we think works best in the context of other things going on. We have tried sending just the lone practice coach out to the practice without any other collaboratives going on and we've seen that it is harder to move the practice along. We've come to believe that practice coaching needs to be happening in the context of other quality improvement activities so that you build in the social connections across practices.
26. However you go about initiating practice change, ultimately, if you really want to transform practices, whether the practice has two doctors or 700, you got to have leadership that's committed to the change, and knows how to make changes that fit with the style of the organization that it leads. For any meaningful changes to be sustained beyond the beginning I think it has to have committed leaders in charge of it, instead of an outside facilitator coming in and working with a couple of committed staff members or a single physician.
27. I actually do not believe that the quality improvement is as linked to finances as I heard people say. It makes sense if you can do some pay for performance but that's not system level change at a practice level. I will challenge the assumption that you need to tackle or put too much emphasis on the financial aspect.
28. A lot of the coaching that we are talking about doing is unlearning behaviors that have been entrenched into people's styles and practices over many years. We maybe need to think about to how to teach the people to do it right the first time and therefore might need to think about going back to medical school and certainly residency. It will take a long time to change the practice that way, but otherwise we are constantly going to be chasing our tails.
29. We have to think about when it makes sense to invest in certain kinds of interventions for either a particular change or for a more system wide cultural change.
30. Nurse Case Management needs to be closely tied to Practice Coaching. Not all high risk members are cared for by a practice in Practice Coaching site, which makes this more complex. Member engagement is enhanced when a practice is recommending participation.
31. Collaboration is needed between private payers, State Health Departments, Medical Societies, Practice Research Networks, Federal (Medicare) Programs, Federal Regulators and Others.

Lessons learned about the process and content of coaching

32. Practice facilitation should not begin with any prescribed goals, must do what is important to each individual practice.
33. The aim is important and it will determine what type of practice coach needs to go out.
34. It is important to have the right HIT tools. This is actually having dashboards and things that are providing feedback to practices in real time, not an external person giving the doctor feedback and telling them what they are doing poorly and how they are going to

help them. Those are some subtle differences but I think important in terms of the approach.

35. The more I look at it the less difference there is between translational research and quality improvement. That fine line keeps getting finer and finer.
36. Physicians might not really be the people to do the population management and the care coordination. I think we often assign certain roles and expectations to the wrong people.
37. I believe it is actual behavior change that we are doing and that's why you can get the quality improvement changes. I think that behavior change is what will make change sustainable. So when we try to just focus in on one task, coach them in one item, it is not always as successful.
38. I think there are huge commonalities with practice coaching and with the self-management approach. It would be very interesting to see cross over on that.
39. Cost effectiveness on the pathway to improve quality care has to be part of the discussion. Cost effectiveness is definitely a major concern for community health centers in American and specifically in California.
40. Plan-Do-Study-Act (PDSA) rapid cycle change is very hepful.
41. It is a challenge as an external coach to really stay on the outside and to develop that culture in conjunction with the team but not really be part of it.
42. We need to think about the taxonomy of coaching; can we quantify or evaluate what they actually do?
43. Practice re-design is complex. It takes time – paradigm shifts are not instantaneous. You must develop trust and simple process improvement, the easy part.
44. Registry utilization is overwhelming for some and duplicative for some.
45. Patient compliance is a common practice concern.
46. You have to know that practice, get in there and know who they are, what they do, how they act, what's their history. To me it's a very personal thing, you really have to know them as people, not just as this the structure or that role. The role someone carries may not be the role that they function within the practice, so its really getting to know people. This also suggests longer term exposure to get that knowledge and that intimacy.
47. It's team to team, or the organization that's implementing change. It is not an isolated individual or physician. It is neither end of the spectrum, so that's a big thing.
48. We saw some effectiveness when we did work building on projects that were all ready happening. They had some momentum linking them together.
49. Seen a lot of parallels with self management support in our faculty.
50. To a certain extent it boils down to some sort of personal effectiveness, art of the coach, and understanding how to engage people's hearts and minds, and the technical piece. All those system things are important.
51. We are primarily in the business of building interpersonal relationships, over time changing habits and choices. So we are a relationship product in a service industry construct. Health care as a whole is incredibly ignorant about work force, ignores it almost entirely as a topic.

52. If you go into a practice and try to be real nice and just kind of support people on what they want to do, you are not going to get change that's worth a darn.
53. Key in quality improvement is to build a sustainable capacity for quality improvement assistance.
54. It is all about building relationships and that takes a considerate amount of time.
55. When you go into a practice they have to truly know that coaches are adaptable, and that they are not showing up with a rigid agenda that won't be modified based on their wishes and their successes
56. The whole issue of the coaches being really competent to do what they are supposed to do is very much like health coaches for patients. If you have a lousy coach for a patient, it is going to be horrible for the patient and nothing good is going to happen. It's all about having really competent coaches, because if you don't have competent coaches, it doesn't really matter how wonderful you are at building relationships and being nice to the practices, trying to help them. A coach is a job that requires a huge amount of skill.
57. Have to somehow create value and build that trust which is relationship based.
58. While it is very helpful to have coaches who have lots of tools, lots of expertise, we've found that if they say anything about the color of their belt [use QI jargon or display their credentials in QI processes], people won't listen to them. So they should bring tools for improvement but they shouldn't talk six sigma, they shouldn't talk any of this lingo because it just drives people away.
59. We are convinced that there is great potential for practice coaching to be effective.
60. If we want improve a chronic care intervention, we start with fixing our registry, we start with fixing system changes and then we go to the outliers and show them the data. That has really helped us because then all the peer pressure is on behavioral change and it's much more effective.
61. Staff turnover is problematic.
62. Salaried providers are generally less motivated to participate.
63. Providers don't read mail.

Lessons learned about HIT and facilitation

64. HIT initiatives are confusing to practices as many are uninformed and will require collaboration of stakeholders (future roles are undefined and uncertain).
65. HIT is the wolf in sheep's clothing of practice transformation. It creates an opportunity for change.

Use of data in facilitation and improvement work

66. Sharing data – sharing data between providers, sharing data between facilities, sharing data in our coalition among clinics – motivates change.
67. It is extremely important how you use measurement in data. Data management can transform how you do clinical change improvement.
68. Have to use data for improvement but you have to use that data to create intention for change and value in the practice.

Developing and supporting facilitators and facilitation programs

69. Just as physicians need support and psychologically safe environments, so do facilitators. They have an incredibly difficult job and we found, by default, that when the facilitators were able to debrief with us the evaluation team, in an environment where they weren't being judged by how successful their practices were, they were able to be creative and brain storm and think of things that they might not have thought of within a more business type environment.
70. We must develop our internal capacity and capability for this work as much as we have to assist teams to do that.
71. The challenge in evaluating effectiveness therein lies in how we train our coaches, how do we support them so that they can then do that for teams they work with.
72. Finding that right person with the right skill set is really challenging.
73. Finding the right person and defining what they will be doing from the very beginning is really important.
74. Coaches should understand the culture of the health center and the basic concepts of quality improvement.
75. I think the appropriate person to act in the role of a nurse coach, given the complexity of the role and the complexities of the practices, should have an understanding of group practice management and knowledge of evidence based guidelines. The skill set is important in the change process and having a talent for ambiguity is really important in that role.
76. Leadership and Medical Director of program's role: Needs "fulltime" attention, be a motivator, educator, good communicator, be well organized, hold staff accountable, stay well informed of numerous perspectives and initiatives, and be the Expert.
77. Funding for practice coaching will likely come from a variety of sources in at least two forms - ongoing support and project specific support.
78. We must work on the idea of who is the trusted intermediary for small practices in the community. Is it the local medical society? Is it an independent embedded practice association? Who is that entity?
79. While it is very nice to have the luxury to hire external coaches, we might have to tap into existing resources, and I think if you can provide a network, education, and skill building, then maybe you could start with existing resources.

Appendix C
Inventory of Resources Provided by Participants

Name of Participant	Resource Provided
Mike Herndon	Care Measures Guide 2.0 Training Materials
	Closing the Physician Staff Divide Article
	Health Management Program Collaborative Presentation
	Health Management Program Overview
	Health Management Program Flow Chart
	Data Use Agreement Form
	Practice Facilitation Action Plan
	Practice Facilitation Agreement
	Practice Facilitation Data Finding Presentation to Practice
	Practice Facilitation Expectations
	Practice Facilitation Initial Data Collection Templates
	Practice Facilitation Overview and Guidelines
	Practice Facilitation Practice Assessment
	Practice Facilitation Process Map
	Practice Facilitation Training Guide
	Practice Facilitation Training Skills Checklist
	Practice Facilitation Overview (PowerPoint)
	Practice Facilitation Phases Plan
	Practicing Excellence Article
	Registry audit and accountability sheet
Kelly Pheifer	Action Grant Proposal
	Pay-For–Performance Program Discussion Paper
	Strength in Numbers Overview: Supporting Chronic Care and Prevention
	Strength in Numbers Coaching Tool
	Access Quick Tip Sheet for Physicians and Office Staff
	Quick Reference Guide to Improving the Patient Experience
	Practice Site Changes Tip Sheets
	Strength in Numbers Standardization of Terms
	Dartmouth Clinical Microsystems Practice Change Satisfaction Survey
	Survey on Doctor-Patient Communication
	Short Form Survey on Experiences with your Doctor
	Experiences with Your Personal Doctor Survey
	Experiences with Your Specialist Doctor Survey
	CQC Improving Patient Experience Overall Change Package
Mary Ruhe	Ruhe et al, Practice Assessment (Article)

	Bobiak et al, Measuring Practice Capacity for Change (Article) Ruhe et al, Facilitating Practice Change (Article) Stroebel et al, How Complexity Science Can Inform a Reflective Process for Improvement in Primary Care Practices (Article) Tallia et al, Seven Characteristics of Successful Work Relationships 5 Stages of Group Development Ruhe, Facilitation Handbook EPOCHS Study: Project Facilitation Program Overview Leonard, The critical Importance of Teamwork And Communication in Providing Good Care (Article) Stetler et al, The Role of "External Facilitation" in Implementation of Research Finding (Article)
Katy Smith	Office Vital Signs Survey List of Practice Enhancement Assistant Questions of the Week
Sophia Chang	Small Practice eDesign Program: Phasing and Goals Small Practice eDesign Program: Overview
Clare Libby	Neil Baskerville Dissertation: Systematic Review of Practice Facilitation and Evaluation of a Chronic Illness Care Management Tailored Outreach Facilitation Intervention for Rural Primary Care Physicians About Impact BC (Materials from www.impactbc.ca)
Brenda Fraser and Trish O'Brien	Quality Improvement and Innovation Partnership (QIIP): Coach Competencies QIIP Coach Self-Assessment Form QIIP Coach Training and Development Outline QIIP Coach Description
Michael Barr	American College of Physicians (ACP) Forms on Practice Management Video of Small Practice in America Webinar on ACP Medical Home Builder Final Report for the Physician's Foundation for Health Systems ACP Internist (ACP Journal) Jan 08 - Staffing ACP Internist (ACP Journal) Feb 08 - Investing in EHRs ACP Internist (ACP Journal) March 08 - The Front Office Bottleneck ACP Internist (ACP Journal) April 08 - Managing Risk ACP Internist (ACP Journal) May 08 - In Office Lab Tests ACP Internist (ACP Journal) June 08 - Access
Cathy Catrambone	Catrambone et al, A Nurse Coach QI Intervention (Article) VIP Study Nurse Coach Materials

Darren DeWalt	Improving Performance In Practice (IPIP) Change Packet: Details on IPIP and its High-Leverage Changes, Measures and Scales for Practice Change DeWalt et al AHRQ Presentation Slides: IPIP - On the road to a large scale system to improve outcomes for populations of patients