Mini Plenary 1: Practice Facilitation in Academic PBRN Settings

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Disclosure

- No conflicts of interest to disclose for this presentation
Overview of the Mini-Plenary

- **Introduction to the Development of Practice Facilitation in the US**
  - Emerging needs that brought facilitation to the U.S.
  - The first programs in academic settings

- **The Oklahoma PF Experience**
  - The structure of the early PF program in the Oklahoma PBRN (OKPRN)
  - The evolution of the PF program (infrastructure and scope)
  - Project examples that implemented practice facilitation

- **Barriers to Growing and Sustaining an Academic PF Program**
  - Opportunities and limitations of linking practice facilitation to research
  - The problem of sustainability

- **Models of Managing PF Programs in Academic Settings**
  - Individual organization-based or shared (centralized) PF programs?
  - CTSAs and the practice facilitation infrastructure
  - Where do PBRNs fit in?

- **Future Trends in Practice Facilitation**
  - Organic linkage to PBRNs – where is PBRN research going (and with it facilitation)?
  - Potential evolution of the PF role in the “new era” of practice-based research and quality improvement programs
Goals of Practice Facilitation

The same as the Quadruple Aim for improving primary healthcare:

- Improve the **quality** of primary care
- Improve the **health impact** of primary care
- Improve the **financial viability** of primary care
- Improve the **experience** of primary care (pt & practice)

- PFs help **build capacity** in practices to achieve the above goals (over time)

- The ultimate goal is to improve the health of the population within practices and in the community where they are
Goals of Practice Facilitation (Analogy)

• The PF is like an “enzyme”, she lowers the energy barrier for change and catalyzes transformation.

• However, they are enablers, not substitute workers: they build capacity for sustainable change via more permanent skill transfer and organizational transformation (“teaching how to fish”).
Critical Practice Facilitator Skills (Top 10)

- Excellent **interpersonal skills** (likes people)
- Effective **communication** skills
- Highly organized and systematic (follow-through)
- Attention to detail (e.g., protocols, evidence)
- An **insider-outsider** (“honorary” team member)
- Team worker and **team builder**
- Quick learner (constant learning)
- Effective user of information technology
- Understanding and **love of primary healthcare**
- Flexibility and mobility (adaptive, inventive)
The Need for PFs in the U.S. PBRN Research Trajectory (1969 – 2017)*

Family medicine training programs (1969)

John Fry’s “minimum dataset” (1991)

NAPCRG initiates ASPN (1979-81)

ASPN is reborn as NRN (1999)

PROS - Mort & WREN – Hahn (1986-87)

PBRN “card studies” (1980s)

NAPCRG founded - first president: Maurice Wood (1972)

“Classic” PBRN era ends (~2010)

EHR era starts

“Explosion” of PBRNs

ASPN grows led by Paul Nutting (1990s)

Federation of PBRNs (1997)

Jim Mold - OKPRN (1994)

ASPN is reborn as NRN (1999)

AHRQ Funding (2000)

Handful of active PBRNs in 1980s

186 active PBRNs in 2017

111 active PBRNs in 2003

28 active PBRNs in 1994

111 active PBRNs in 2003

Handful of active PBRNs in 1980s

Practice Facilitation in OKPRN: Practice Enhancement Assistants (PEAs)
OKPRN Network Governance

OKPRN – 501(c)3
Board of Directors

Committees:
PDAC
Programs
Nominations

Network Coordinator

Bylaws

President

Research Director

PEA

OUHSC Dept of Fam Med & OSCTR (part of “CTSA”)

“Pods” of OKPRN Practices

Academic Partners
State & Professional Orgs
Other PBRNs and P30s
Community Partners

Bylaws

PEA

PEA

PEA

PEA
PEAs in a POD – Facilitator Management

*Oversight by faculty & practice facilitator coordinators (H2O/EvidenceNOW)
OKPRN’s Definition of Practice Facilitation  
(Mold, Aspy, Nagykaldi 2000-2008)

- PFs/PEAs are trained healthcare professionals, who:
  - Develop personal relationships with a group of practices over an extended period of time and across projects
  - Help practices participate in research projects
  - Help practices improve the quality of care using evidence-based QI methods
  - Help create and sustain a participatory learning community through effective dissemination of ideas and best practices
<table>
<thead>
<tr>
<th>Administrative and Department Procedures</th>
<th>Clin-IQ Process (answering community-based clinical questions)</th>
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<tr>
<td>Human Subjects Protection Training</td>
<td>Past and Ongoing OKPRN Studies</td>
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<td>HIPAA Training</td>
<td><strong>Best Practices Research Methods</strong></td>
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<td>Research Skills (recruitment, data collection, aggregation and reporting)</td>
<td><strong>Guideline Implementation: Prevention and the (Chronic) Care Model</strong></td>
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<td>Chart Reviews (paper and electronic)</td>
<td>E&amp;M Coding and <strong>Value-based Care</strong></td>
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<td>Rapid Cycle QI Process (PDSA cycles, benchmarking and feedback)</td>
<td>Electronic Practice Record of OKPRN clinics (documentation of the facilitator’s work)</td>
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<td>Group Facilitation (QI and care teams)</td>
<td>Handouts, Education Materials (resource)</td>
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<td>Practice Visits (shadowing PEAs)</td>
<td><strong>Project Specific Training</strong> (e.g., Asthma care)</td>
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<td>Health Information Technology</td>
<td>PEA Resources (databases, listserv, web)</td>
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<td>Complex Adaptive Systems (CAS) Theory Applications</td>
<td><strong>Facilitating Patient &amp; Community-Engaged Research</strong></td>
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**Program-specific or background training**

**“Historic” facilitator training topics**

**New/innovative facilitator trailing topics**
“I’m making a list of everything I have to do so I can freak out in some kind of order.”

Practice Facilitator

Office Manager
The Pipeline of Research Translation*

PEAs On Earth:
Focus of Facilitator Activities

• Improvement of relationships in / between practices
• Linking rural practices to academic resources
• Preventive services & guideline implementation
• Chronic disease management support
• Practice improvement (QI) projects
• Professional education (CME) and maintenance of certification (MOC) Part IV
• Health IT implementation and optimal utilization
• Facilitating translational research
• Synergy with population health improvement
PEAs On Earth: Project Examples

- Management of patients with hyperlipidemia
- Management of no-shows and Rx refills
- Diabetes care quality improvement (registry)
- Rate/quality of preventive services delivery
- Patient and practice satisfaction surveys
- Assistance with first EHR or switching EHRs
- Training staff to use mHealth technology
- Asthma and chronic kidney disease care
- Linking practices to regional nutrition services
- Cardiovascular health (EvidenceNOW/H2O)
Practice Facilitation: an Integral Component of Practice Improvement Frameworks

Example: Implementing CKD Care Guidelines in Community Practices (2010-2013)

- Multi-PBRN R18 to disseminate and implement CKD clinical guidelines in primary care practices (multi-component intervention)
- Academic detailing on CKD management best practices
- Regular performance feedback on reaching practice goals
- Facilitation of CKD guideline implementation (workflow redesign, tailoring, sharing solutions, empowering staff)
- Technical support for new features in EHR (e.g., eGFR)
- First wave (32) of practices accelerates diffusion to other practices (64) using LLCs
“Healthier Together” Project
County Collaboration and Information Flow

PCP: Primary Care Physician/Provider
WCs: Wellness Coordinators
HD: Health Department
HIE: Health Information Exchange

CHIO: County Health Improvement Organization
PEA: Practice Enhancement Assistant
PSRS: Preventive Services Reminder System
Pts: Patients

Regional HIE
Community Registry (PSRS)
County Hospital
Other Hospitals
Other HIE
Labs, imaging
Barriers to Growing Academic PF Programs

• Reliance on (academic) research funding
  o Limited / diminishing funding for practice-based research, and facilitation infrastructure building
  o Separation of research and QI/D&I funding streams

• Competing academic priorities
  o Faculty time and availability (balancing other priorities)
  o Intramural support shifting to maintain Department fxs

• Administrative and logistical barriers
  o Burgeoning bureaucracy and community-unfriendly organizational processes
  o Slow development in adopting financial and programmatic innovations (e.g., shared/core service-based support)
Models of Managing PFs in Academic Settings

• Individual Organization (Classic) Programs
  o 1-5 PFs working for a few PIs on a changing mix of research and QI projects
  o Limited reach and bandwidth
  o Highly dependent on academic research funding
  o Logistically straightforward to maintain

• Shared or Centralized PF Programs
  o PF FTEs are shared between departments and programs
  o More diversified work portfolio
  o Wider reach (e.g., state-wide) and higher impact
  o Logistically challenging to maintain (full FTE employment while effort boundaries are difficult to keep)
Models of Managing PFs in Academic Settings

• Facilitation Infrastructure: is CTSA the answer?
  o Are we at the table or are we on the menu? - Wide variations in the roles and weight of primary healthcare in NIH-sponsored research programs (e.g., CTSA/IDeA)
  o “Community-centeredness” – is it a token or there is true commitment, which may position PFs as valued assets

• Alternative Sources for Facilitation Infrastructure
  o Large healthcare organizations (esp. health systems), payers, and some QI organizations have resources, but are they using them effectively?
  o Could they collaborate with academic centers strategically to fund a facilitation infrastructure (synergy between academic expertise and resources)
Emerging & Future Trends in Practice Facilitation

• Remote Facilitation, In-Person or Both?
  o Is it at least as effective as the traditional approach?
  o Is it more cost-effective (travel/capacity)?
  o Can interpersonal relationships be maintained?
  o What are the best (combination of) technologies?

• Can We Better Understand Complex Adaptive Systems?
  o Can we improve practice improvement predictions?
  o How can we leverage large datasets (e.g. those from EvidenceNOW) to improve the science of practice facilitation?
Emerging & Future Trends in Practice Facilitation

• Where is PBRN Research Going?
  o Where is primary care going? And healthcare?
  o Who are the main constituents of PBRNs: practices or patients/communities (what is the PBRN “community”)?
  o How much QI (e.g., contracts) vs. PBRN research?

• The Role of PFs in a Health Extension System
  o Are PFs also healthcare extension agents?
  o Are PFs collaborators of health extension agents?
  o If collaborators, how would they work together?
  o What is the role of PBRNs in an extension framework?
Acknowledgements & Contacts

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QUESTIONS?