

**TITLE OF SUBMISSION:** PF level 1 competencies in high value care coordination (Medical Neighborhood) when working with small practices to big systems.

**PRESENTATION TOPIC AREA:** Practice Facilitator Training and Ongoing Development

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

Studies indicate that 60-70% of referrals contain inadequate information. This leads to frustration for both the patient and the care team (i.e., disagreements about the need for referrals, wasted time on the part of the clinician and the patient, etc.); it can also increase the cost of care due to unnecessary duplicative testing. One study's results showed that primary care physicians reported a 19% repeat referral rate due to issues that had not been addressed during the first visit, leading to costly physician time being used for multiple visits.

This is partially due to an underdeveloped medical neighborhood in medical settings that have primary and specialty care. The medical neighborhood contains all of the practices, referring clinicians, community resources, and patients. Studies have shown that a highly coordinated medical neighborhood is key for provider satisfaction and reduced burnout; if this neighborhood is not well developed, referral quality suffers as well as patient care and satisfaction for both patients and staff. In one example of a well-developed medical neighborhood that included a strong referral system, the "number of encounters in which specialists were unsure of the reason for consultation declined by almost 50 percent in medical specialty clinics, and by almost 75 percent in surgical specialty clinics."

<https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/acp-san-high-value-care-coordination-training-materials>

**SETTING/METHODS:**

The High-Value Care Coordination (HVCC) program was developed by the American College of Physicians (ACP) in collaboration with specialty and primary care practices, TCPI national faculty, and patient advocates. This program will assist in implementing changes that improve processes and effectiveness of the medical neighborhood: the referring primary care clinicians, specialist clinicians receiving referrals, and the patients at the center of the referrals.

In this venue, we would be going through Action Step #1. There are 4 action steps in all but this gives PF's a foundation of working on the medical neighborhood with practices/systems.

**RESULTS AVAILABLE OR PLANNED:**

- Close the loop metric (MIPS)
- Access to specialty care
- Collaborative guideline creation and sustainability
- Duplicative lab tests (cost/utilization)
- ED avoidance

**CONCLUSION/NEXT STEPS:**

This is the American College of Physicians content that they want practice facilitators to have as they work with practices across the country. They would complete Action step 1 and if interested in the other 3 action steps, we would bring them on to the full ACP program. We have demonstrated this program across the country with various PTNs and QIN/QIOs involved in Transforming Clinical Practices Initiative (TCPI).

**AUTHORS:**

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**TITLE OF SUBMISSION:** Practice Facilitation + Academic Detailing for Behavior and Clinic System Change in Opioid Prescribing Practices

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Academic detailing (AD) and practice facilitation (PF) complement each other by providing a synergistic approach to provider education and clinical systems change. The classic AD model targets provider knowledge and informs evidence-based (EB) behavior but does not address quality improvement (QI) or practice transformation in clinical systems. PF focuses on team-based practice improvement approaches and methods to build the internal capacity of practice systems to help them engage in quality improvement activities over time. Each intervention method on its own is beneficial to improving patient care but the innovative approach of combining the two produces a synergistic approach whereby EB knowledge informs QI, and vice versa, for sustainable clinical change.

**SETTING/METHODS:**

When implementing AD training to rural practices, the clinicians asked about systems change they could make to incorporate the new knowledge into their practices. When implementing PF-QI processes in practice, the participants asked about the evidence informing clinical practice guidelines. From this combined demand, we designed an overlapping system where, during AD encounters we included all pertinent practice staff in order to assure that everyone had the same foundational knowledge as a QI starting point. And during PF visits we provided EB information that met the clinician's individual learning needs, which also informed the clinic systems changes needed for QI. Practices that want to make systems changes based on evidence opted for team AD visits so that PF could also be included. Combining AD and PF creates interactive group learning where clinical administrators can then develop system goals. This creates lasting sustainable change and stimulates AD follow up visits to deliver current and new educational topics.

We performed a comparative mixed-methods effectiveness study using AD as the intervention, and interviews, surveys, and prescribing data to investigate clinician behavior changes in opioid prescribing for chronic non-cancer pain (CNCP). We used an adaptive pragmatic design that allowed us to combine PF and AD in the intervention. As we learn more about linking AD and PF, we are postulating that incorporating both around targeted health topics important to the clinic can have a longer sustainability effect than just utilizing AD or PF alone.

**RESULTS AVAILABLE OR PLANNED:**

Preliminary results indicate PF + AD improved self-reported opioid prescribing practices compared to controls. Participants felt more comfortable managing and safely prescribing opioids for CNCP as a result of the full intervention. The overlap between individual provider behavior change and clinical system change has created partnerships between Ads and PFs.

**CONCLUSION/NEXT STEPS:**

Implementation of this combined approach has demonstrated the benefit of combining PF with AD to improve healthcare systems and sustain EB clinical behavioral change. Practices are selecting group-training sessions containing PF+AD to improve EB knowledge and shape clinical systems. After initial practice-group sessions, individual clinicians benefited from AD-type visits that included PF follow-up, to their practices. This created sustainable changes and established combined AD+PF services as a resource for the clinic administration as well as the providers. Currently, we have extended this approach to several additional projects targeting multiple health topics.

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**TITLE OF SUBMISSION:** Applying coaching / facilitation concepts from quality improvement to inform the design of effective continuing education

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Quality improvement (QI) coaching or facilitation and health professional continuing education are characterized by the mutual goals of improving and learning. QI coaching is an approach used to support practices or practitioners through a focus on building capacity for improvement in healthcare. Similarly, in continuing educational activities, the goal is to improve knowledge, skills, and performance for clinical practice. We proposed that QI coaching concepts could inform effective continuing education design to synergistically facilitate improvement in knowledge, skills, behaviours, and patient and system outcomes.

**SETTING/METHODS:**

A literature review was completed on QI coaching and facilitation concepts and frameworks with an emphasis on the primary care context. Literature on best-practice in continuing education in the health professions was also reviewed. Common themes were compared for the purpose of identifying key coaching and facilitation concepts that demonstrate relevance to and potential alignment with effective program design. The utility of these concepts was then explored through application to a hypothetical education scenario.

**RESULTS AVAILABLE OR PLANNED:**

Six QI coaching and facilitation concepts were found to demonstrate relevance to effective education design including: adaptation to practice culture; attending to adaptive reserve; goal-setting/gap identification; readiness assessment; role tailoring; and competence in improvement approaches. The potential for practice impact could be described from the lens of the learner, team, patient, organization or system.

**CONCLUSION/NEXT STEPS:**

The successful mapping of QI coaching and facilitation concepts to educational program design presents an opportunity for developers of continuing education activities to focus on impact that is beyond the usual attempt to simply influence attainment of knowledge, skill and attitude. This impact, described through the application of learning following an educational event, has the potential to improve care simultaneously while improving competence, confidence and quality.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Building Capacity through Facilitator Training: Development, Evaluation, Outcomes, and Lessons Learned

**PRESENTATION TOPIC AREA:** Practice Facilitator Training and Ongoing Development

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Facilitation, an evidence based implementation strategy, has been applied in multiple contexts to implement innovations with varying complexity. However, little is known about how to train new facilitators in the complex skills needed to conduct implementation facilitation (IF) across health care settings. Further, once IF skills are initially obtained, even less is known about sustaining these competencies over time. This panel presentation, will describe an IF training program within the Department of Veterans Affairs, including the rationale, need, and process for content development. Speakers will also describe the components of the training itself, program evaluation data, and finally, lessons learned from an ongoing formative evaluation process.

**SETTING/METHODS:**

In response to a request from a clinical partner within the Department of Veterans Affairs, in 2011, a two-day training program and companion manual to support IF scale-up and spread was created. The IF training program and manual were recently revised based on current research and emerging tools to support its application. Training components include IF knowledge, skills and core competencies; facilitator roles and activities across the implementation phases; products and processes that support facilitation; practical tips to ensure success; role-playing challenging situations; group problem-solving and discussion of IF application to trainee projects. Training participants include clinical leaders, researchers who plan to apply IF in their own projects, and clinical facilitators. An independent evaluation team administered quantitative surveys and conducted qualitative interviews with the first four cohorts of our revised IF training. Quantitative surveys were administered prior to, immediately following, and 6 months post-training to assess perceived and experienced IF knowledge and skills. Over 51 participants have completed the quantitative survey associated with our revised training program. The most recent training cohort from May 2018, completed baseline and post-training surveys and will complete the 6-month survey prior to December 2018. To evaluate knowledge transfer and skill use over time, post training semi-structured qualitative interviews were conducted at 6-months to document trainees' experiences with using facilitation skills. To date, 19 individuals (2 cohorts) have completed the 6-month follow-up interview and the two most recent cohorts will have completed the 6-month follow-up interview prior to December 2018.

**RESULTS AVAILABLE OR PLANNED:**

Both quantitative and qualitative data will be presented. Quantitative findings indicate significant change in participants' perceived IF knowledge and skills before and after the training. Preliminary 6-month post training qualitative findings indicate that participants describe the training as engaging and worthwhile, providing a solid conceptualization of the facilitator role. Trainees report they have utilized skills to prepare for IF site visits, and leadership engagement. There was some uncertainty among trainees about putting these skills into practice, and participants described how the role still felt "so new" to them. Trainees recommended ongoing mentorship by IF training faculty, development of an IF refresher course, and development of a SharePoint site for sharing IF resources.

**CONCLUSION/NEXT STEPS:**

Preliminary findings indicate significant improvement in perceived IF knowledge and confidence after the training. While trainees confidently applied these skills post-training, findings highlight the need to integrate ongoing mentorship and skill booster sessions to ensure sustainability over time. Based on these findings, the training is being revised using a continuous quality improvement process, to further address trainees needs. The final speaker will describe this process, as well as our work with a learning consultant, and our planned next steps to expand IF training capacity and reach.

**AUTHORS:**

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**TITLE OF SUBMISSION:** The Potential Role of Motivational Interviewing in Practice Facilitation

**PRESENTATION TOPIC AREA:** Practice Facilitator Training and Ongoing Development

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

The New York City health department's Primary Care Information Project (PCIP) deploys Practice Facilitators (PFs) to assist primary care practices in quality improvement (QI) activities. PCIP's PFs have helped grow practices' capacity for QI through programs such as Medicare and Medicaid's Meaningful Use, EvidenceNOW's HealthyHearts NYC (HHNYC), and the Centers for Disease Control and Prevention's Join the BEAT. Motivational interviewing (MI) is an evidence-based intervention technique designed to help individuals address ambivalence to change. MI has previously been tested for counseling patients on substance abuse, smoking cessation, HIV-risk reduction, and diet and exercise. However, little is known about the use of MI by PFs as a strategy to engage practices in QI activities.

**SETTING/METHODS:**

Three PFs worked with a psychologist expert in MI to develop a train-the-trainer MI curriculum for 18 PFs who support small practices (SPs) and community health centers (CHCs). The curriculum includes a six-session core program on four key MI elements: increasing collaboration between the PF and the practice, drawing out the practice's ideas about change, emphasizing the autonomy of the practice, and cultivating empathy. During nine maintenance sessions, PFs were asked to report instances they used MI with practices and their perceptions of MI's usefulness. PFs individually recorded written responses to questions then verbalized their responses during a group discussion. Tracking of practice involvement in QI activities (e.g., site visits, webinars) was recorded in a customer relationship management platform. Information recorded included date, number and type of activity. We analyzed both written and oral responses to better understand whether PFs were receptive to using MI as a method to engage practices in QI, and if so, which elements of MI were perceived as the most versus least useful. We also analyzed the number and type of QI activities to assess level of practice engagement.

**RESULTS AVAILABLE OR PLANNED:**

From January 1, 2016, to December 31, 2017, 18 PFs used MI to engage 257 SPs and 80 CHCs in QI. PFs engaged with practices in a total of 3,742 QI activities. Among practices participating in HHNYC, almost all (94.1%, n = 240) received at least 13 visits, with 49.0% (125) receiving exactly 13 visits and 45.1% (115) receiving 14 to 18 visits during the yearlong project. Only 5.8% (15) received fewer than 13 visits, with no site receiving fewer than 10 visits. PFs used open-ended questions, affirmations, and reflective listening to understand and overcome resistance and reported that MI helped them to reinforce collaboration and address practice barriers (e.g., fear of new technology, lack of staff buy-in, uncertainty about reimbursement, and competing priorities).

**CONCLUSION/NEXT STEPS:**

As evidenced by PFs' feedback and their ongoing engagement with practices on QI, we concluded that PFs accepted MI as a helpful tool and demonstrated its potential for future application in QI activities. We plan to conduct more in-depth evaluation of MI to better understand how it impacts practice facilitation and how trainings could be expanded for delivery to practice staff to support patient engagement.

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# OP506

**TITLE OF SUBMISSION:** Using Practice Facilitation to Build Quality Improvement Capacity using Electronic Health Record Systems

**PRESENTATION TOPIC AREA:** Leveraging Technology in Practice Facilitation

**FORMAT:** Workshop

**SESSION DESCRIPTION:**

Primary care is facing a new world of electronic health record (EHR) systems and increasing demand to improve patient care. Qualis Health developed a model that utilizes the EHR to build quality improvement capacity. This effort was part of Healthy Hearts Northwest (H2N), in the EvidenceNOW initiative. This will be an interactive session designed for leveraging the EHR when working with clinics, by targeting patient populations, using clinical quality metrics, and applying team based care.

**BACKGROUND/RATIONAL:**

Primary care is facing a new world of electronic health record (EHR) systems and increasing demand to improve patient care. Qualis Health developed and implemented a practice facilitation model that utilizes the EHR system to build quality improvement capacity to measure and reduce cardiovascular risk for use in small-to-medium sized primary care settings. This improvement intervention is designed to help clinicians achieve clinical improvement goals for cardiovascular risk factors. It combined technical assistance for optimal use of EHR data to produce population health reports and workflow modification techniques to improve the quality of care patients receive.

**SESSION FORMAT:**

Session will be interactive, hands on session using a practice facilitation model to lead teams to strengthen and build quality improvement skills focusing on process improvement using an electronic health record system

**LEARNING OBJECTIVES:**

- Describe a practice facilitation model that utilizes the electronic health record system when working with primary care teams
- Participate in activities that support practices in technology based improvement interventions
- Describe opportunities of Health IT in practice facilitation

**CONCLUSION/NEXT STEPS:**

Practice Facilitators have opportunities to leverage the electronic health record system when working with primary care clinics to advance quality improvement interventions. By supporting practices in targeting specific patient populations, leveraging clinical quality metrics, and applying team based care workflows, practice facilitation can help transform primary care practices with sustainable systems to deliver high quality care.

**AUTHORs:**

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**TITLE OF SUBMISSION:** "ClinvestiGator": A True Data Animal

**PRESENTATION TOPIC AREA:** Leveraging Technology in Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

ClinvestiGator was developed based upon over 30 years of experience in clinical research and medical informatics. The ClinvestiGator team of informatics system experts includes computer scientists, programmers, methodological, statistical and research experts and an exceptional user support team.

ClinvestiGator is a web-based system for data collection where the researcher defines the data fields and the forms that need to be included. The ClinvestiGator team creates web-based versions of the forms as part of the database. Data from other sources can be imported into the system and data may be entered by a diverse group of users including research staff and study participants. ClinvestiGator facilitates study coordination since Principle Investigators (PIs) can very easily manage the flow of the study protocol, follow participants over time, determine participation status at any point in time, and track workload and productivity of study team members. Also, time sensitive "To Do" lists can be maintained by the system and information can easily be communicated among various study team members. Reports, which can be run in real time, can be generated to identify populations or outcomes of interest. The reports can also analyze variables of interest, determine overall study status and to export data.

There are many levels of security that can be incorporated including user access control, role level security, task level security, multi-site security and all data entry can be fully auditable. ClinvestiGator is HIPPA compliant, uses strong encryption and password rules and has a data recovery mechanism.

**SETTING/METHODS:**

Three academic institutions are conducting a research project comparing two strategies designed to improve blood pressure control in primary care practices serving rural southeastern African Americans with low socioeconomic status living in the "Black Belt". The "Black Belt" is in the heart of the Stroke Belt, a geographical area recognized to have the highest cardiovascular disease mortality in the US. The University of Alabama is leading this study with the University of North Carolina and Eastern Carolina University as co-investigators.

80 practices have been identified and will enroll 25 patients (n=2000). Of those 80 practices 20 will randomize to practice facilitation, 20 will randomize to peer coaching, 20 will randomize to practice facilitation and peer coaching and 20 will randomize to enhanced usual care with no intervention. The hypothesis is that both interventions will improve BP more than the enhanced usual care, and that both interventions delivered together will result in greater improvements in BP than either intervention alone.

In order to manage data captured in the study, the data system chosen needed to be accessible to study personnel from each of the three institutions mentioned above. In particular, the practice facilitators needed to be able to document their practice engagement, PDSA progress and to track time related to work at each practice.

**RESULTS AVAILABLE OR PLANNED:**

Thus far, practice facilitators are able to utilize the data entered into ClinvestiGator to export specific data or generate reports or graphs for providers, practice staff and current funders. The ability of the practice facilitators to share their data with each other has been monumental in the success of writing PDSA's that are measurable, understandable and can be accomplished. The ability to review data entered by other study staff has also made it easier to understand the demographics of the practice when planning visits and various approaches to each individual practice. The use of ClinvestiGator has also made it easier for the PIs to stay abreast of the progress of each practice facilitator and provide support when needed.

**CONCLUSION/NEXT STEPS:**

This is an ongoing study, however, several changes have been implemented since the initiation of the study but with minimal effort due to the system's flexibility, the expertise of the site administrators and the remote access function. This customizable system allows the monitoring of practice facilitation productivity and workload, practice recruitment efforts and has provided a great advantage for a multi-site trial that engages 2000 patients and 80 practices in predominately rural areas across two states.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Supporting Practice Facilitators to Ensure Success

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

Practice facilitation can be a very rewarding profession although without support and resources it can be a very daunting and frustrating process that potentially leads to high turnover. Developing a base and network of support can provide a satisfying career for practice facilitators.

**SETTING/METHODS:**

This session will demonstrate how to best support practice facilitators by effectively developing and maintaining a practice facilitation team, using technical resources to track practice coaching and building a resource library to enhance facilitator coaching. Discussion regarding: effective practice facilitation teams will include information such as: recruitment, learning within the team and how to keep facilitators engaged. The technical resources will touch on how document and monitor practice transformation. Finally, learn how to develop a repository of tools and coaching strategies to support practice facilitators in the practice transformation work. After a presentation with discussion participants will break into small groups to share their successes and challenges with each other. The session will close with a brief report out from each of the small groups.

**RESULTS AVAILABLE OR PLANNED:**

1. Learn how to build a strong practice facilitator team
2. Develop strategies for practice facilitators to document and monitor practice results
3. Identify 1 or more coaching strategies that participants will utilize within their organization

**CONCLUSION/NEXT STEPS:**

To provide effective facilitation to practices, practice facilitators need a strong network of support and a multitude of resource to provide practices with effective opportunities in practice transformation.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Practice level factors associated with enhanced engagement with practice facilitators; findings from the Heart Health Now study.

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

The Evidence NOW project is an AHRQ funded cardiovascular disease (CVD) prevention project that spans across seven regional cooperatives throughout the US. The NC cooperative's study is called Heart Health Now (HHN). An objective of the HHN study is to understand if providing primary care practices with on-site practice facilitation for 1 year can help small to medium sized practices build capacity to identify at risk patients and implement practice changes to optimize patient outcomes. Engagement with practice facilitators requires that practices are open to partnering with facilitators who can guide them to understand and implement quality improvement (QI) methods. Little is known about practice or facilitator level factors that are associated with greater engagement with practice facilitators. Our objective is to explore the factors associated with higher levels of engagement of facilitators with practice teams at mid-point of their 1-year intervention.

**SETTING/METHODS:**

HHN includes 245 small to medium sized primary care practices in NC. For this analysis, we used practice characteristic and demographics data obtained via baseline surveys completed by practice staff and leadership. Variables include levels of practice burnout, adaptive reserve, involvement in accountable care organizations, previous involvement in CVD QI efforts, recent experience with disruptive practice changes, along with number of clinicians, practice location, practice ownership type and others. To capture measurements of practice QI leadership and engagement with facilitators, we used data included in monthly Key Driver Implementation Scale reports generated by practice facilitators. This is an ordinal 0-3 item scale where higher numbers indicate greater leadership or engagement. We define our outcome measure of adequate team engagement (TE) as a mean TE score of 2 or greater at six months, calculated as an average in the four to six-month time interval if at least 2 scores were available. Practice leadership scores were generated similarly. Practice facilitator characteristics were provided by the NC AHEC organization that leads the training of support for the practice facilitators. We used univariable logistic regression to identify variables associated with the odds of having team engagement scores  $\geq 2$  vs.  $< 2$ . These variables with a  $p \leq .05$  were included in multivariable logistic regression.

**RESULTS AVAILABLE OR PLANNED:**

136 practices met eligibility criteria of having the requisite KDIS and practice survey data. Among these, half are clinician owned solo or group practices, 21% are federally qualified health centers, and just over 12 percent are hospital or health system owned. The mean and median number of clinicians per practice is 6.3 (SD 8.2) and 4.0 respectively. Patient payer mix varied widely among the practices. The top three patient payers are Medicare (mean 31% [SD 17%], range 5 - 82%), Commercial Insurance (33% [SD 18%], range 0-79%), and Medicaid (15% [SD 15%], 0- 50%). 31% of practices are located in a Medically Underserved Area. In our univariate logistic modeling, greater number of practice changes, greater leadership scores, and location in a medically underserved area were associated with a statistically significant increase in the odds of engagement with practice facilitation at six months of the 1-year facilitation intervention. The multivariable logistic regression analysis demonstrated statistically significant adjusted odds ratios for greater engagement with practice facilitation, with independent effects for greater practice leadership, location of a practice in a medically underserved area, and greater number of practice changes. No practice facilitator-level characteristics were independently associated with the outcome.

**CONCLUSION/NEXT STEPS:**

In our analysis, practice engagement with practice facilitators appears to be enhanced in practices located in medically underserved areas, in practices that have undergone greater number of disruptive practice changes, and in those with greater involvement of leadership in quality improvement efforts. Facilitator specific characteristics appear to be less influential in engagement at the six-month mark of our one-year intervention.

It is important for study teams and organizations that train and support practice facilitators to understand the practice characteristics that are associated with greater engagement with facilitation so that facilitators are prepared to seek out and mitigate barriers to the facilitation process. As well it may help practice facilitation organizations understand what types of practices may be best positioned to accept and benefit from practice facilitation resources.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Facilitating Improved Cardiovascular Health in Health System Operated Primary Care Practices

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Heart Health Now (HHN) was the North Carolina Cooperative funded by the Agency for Healthcare Research and Quality as part of the national effort that AHRQ dubbed Evidence Now. This was North Carolina's effort to enhance cardiovascular risk reduction through supporting primary care practices across the state. The intent was to prove the value of supporting primary care through practice facilitation to disseminate valuable information and to implement processes to improve their patients' cardiovascular risk. North Carolina is the 32nd worst state in cardiovascular risks and deaths. The annual cost to North Carolina is almost \$5 billion a year for in-patient care alone. In terms of risk factors, 32% of the adult population is hypertensive, 10% diabetic, 20% smokers, 40% have high cholesterol, 65% are obese/overweight, and 54% lack physical activity. Primary care has a huge opportunity to impact these numbers and improve the health of the population. The impact of specific interventions can be fast. If a patient improves only 1 or 2 of these risks, their chance of a heart attack, a stroke, or death can be reduced by as much as 25% within 2 years. If all risk factors are controlled the lifetime risk of cardiovascular mortality is reduced by 75%.

**SETTING/METHODS:**

Heart Health Now was introduced into primary care practices across the state of North Carolina. In some instances there was a group of practices within the same health system that participated. One such system is located in Western North Carolina and had 7 primary care practices. The facilitation approach specific to this group of practices was to combine individualized practice facilitation with collaborative education and sharing between providers and practices.

Individualized Practice Facilitation - Each practice created a QI Team to work on this project. Each team chose at least 1 quality measure to improve in addition to the common system-wide measure of Controlling BP in Hypertensive patients. The systematic process with each individual QI Team included:

1. Initiation of monthly QI Team meetings dedicated to Heart Health Now - These were set up on a recurring basis to maintain consistency and to block provider schedules as necessary
2. Monthly meetings consisted of:
  - a. Review action items and changes from previous month
  - b. Review measure data by provider compared to baseline
  - c. Discuss staff and provider education needs
  - d. Development of improvement ideas
  - e. Create action items and plan for implementation of process change

Collaborative Group Education and Sharing - The HHN project in this health system created the opportunity to leverage knowledge and ideas across the varied providers and practices. This sharing was facilitated through quarterly all-practice collaborative meetings. The format of the meetings consisted of the following:

1. Review charts of measure data by provider and practice
2. Discuss and share ideas and best practices for driving improvement; high performers shared their processes
3. Clinical education -Topics included: Ambulatory BP Monitoring, The Utility of Risk Scores, Population Health and Using Dashboards, Discussing ASCVD Risk Scores with Patients, E-Cigarette Updates, 2017 ACC-AHA Hypertension Guidelines, Heart Healthy Nutrition, and Heart Healthy Exercise (Providers earned 1 CME for attendance each meeting)

**RESULTS AVAILABLE OR PLANNED:**

The HHN practice facilitation occurred from November 2016 through April 2018. The improvement results for the group of primary practices included:

1. 989 patients with high BP that was not controlled now have it under control.
2. The practices increased the percentage of patients receiving smoking cessation counseling from 37% (baseline) to 53%.
3. Among patients with an ASCVD risk score greater than 10% who were not taking a statin, 432 started taking a statin
4. Among patients with an ASCVD risk score greater than 10% who were not taking aspirin, 589 starting taking low-dose aspirin

**CONCLUSION/NEXT STEPS:**

Practice Facilitation within a health system should be customized to the practice setting and organizational structure through a combination of individualized practice plans and group collaborative activities. The value of collaborative activities is gained through sharing data, knowledge, and best practices across all sites and providers. Practice facilitation can spread important information, improve workflows, and positively impact health outcomes.

**OPTIONAL UPLOAD:**

[https://s3.amazonaws.com/files.formstack.com/uploads/2995173/61994995/424930327/61994995\\_pardee\\_heart\\_health\\_now\\_infographic.pdf](https://s3.amazonaws.com/files.formstack.com/uploads/2995173/61994995/424930327/61994995_pardee_heart_health_now_infographic.pdf)

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# OP511

**TITLE OF SUBMISSION:** Assessing the Experience of Practice Facilitators in Their Role to Improve Heart Health in Oklahoma Primary Care Settings

**PRESENTATION TOPIC AREA:** Practice Facilitator Training and Ongoing Development

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Practice facilitators (PF) are "change agents" who can be effective in facilitating individualized solutions through rapid plan-do-study-act quality improvement (QI) cycles in medical practices. Although the work itself engenders much satisfaction and sense of goal achievement among PFs, few systematic evaluation has been designed to assess the overall experience, from training to project completion, of PFs. Objectives of this study are to present results from a comprehensive evaluation of PT experience and PF reports and input on their role in a QI project aimed to promote heart health.

**SETTING/METHODS:**

The PFs assisted 263 primary care practices, delivering a QI intervention bundle (e.g., goal setting, change management, streamlined work flow, information technology assistance, and connections to health information exchange) to improve cardiovascular disease prevention as a part of the Healthy Hearts for Oklahoma (H2O) Study. PFs received didactic training through the national certification program and additional onsite project-specific training. Monthly meetings are conducted where debriefing and information/lessons learned were shared. At the completion of practice facilitation with H2O practices, PFs had a final briefing to complete the evaluation process, which included a structured survey, a semi-structured questionnaire, and focus group discussions. Descriptive statistics were compiled to summarize response distribution for questionnaire items and thematic analyses were applied to qualitative data.

**RESULTS AVAILABLE OR PLANNED:**

All 19 PFs completed the survey and participated in focus groups, reporting on two aspects of their work: satisfaction and support, training and supervision received. Ninety to 100% of PFs reported satisfaction or high satisfaction with the workload, support provided by program manager and leadership, teamwork with fellow facilitators, and overall satisfaction. However, only 79% of facilitators were satisfied with the amount of feedback they received. Regarding support and training, over 90% agreed or strongly agreed with items on fair and accurate performance ratings and confidence in getting help when uncertain about executing tasks. Between 80-89% of PFs agreed or strongly agreed that leadership cared about their work satisfaction; cooperation and teamwork exist; materials, services, and processes have been designed to meet the needs of enrolled practices; the team problem-solved to prevent recurring errors, and training was appropriate. Qualitative synthesis showed that PFs advocated for better tracking of changes, where one suggested, "...the information would often change after the training. I would recommend future trainings after there is one clear, concise message, and the kinks have mostly been worked out." Various electronic tools (e.g., web meetings, Sharepoint) helped to facilitate communication. PF noted, "Information was communicated well considering that everyone worked all over the state and had different schedules with their clinics."

**CONCLUSION/NEXT STEPS:**

PFs have proven to be effective in helping primary care practices implement new processes of care and quality improvement efforts. To ensure their success, H2O employed a comprehensive evaluation that assessed all aspects of the role and work of facilitation. PFs' satisfaction and perspectives on support and training helped to identify job components that were effective and those that required improvement to strengthen the program overall. The evaluation approach can be generalizable to other programs with minimal adaptation.

**AUTHORS:**

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**TITLE OF SUBMISSION:** The EvidenceNOW Model for Supporting Primary Care Practice Improvement: Concepts, Key Drivers, and Resources for Practice Facilitators

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

The Agency for Healthcare Research and Quality (AHRQ) has implemented an innovative model for supporting primary care practice improvement with the overarching aim of helping practices implement the best clinical evidence. Practice facilitation is a core component of the model.

The model was implemented in EvidenceNOW (EN), a multiyear AHRQ grant initiative designed to advance the adoption of clinical evidence in primary care practices. EN's two primary goals are to: 1) help practices across the country use the latest evidence to improve the heart health of millions of Americans; and 2) to understand what type of external supports best help primary care practices implement evidence and improve quality of care. The EN Model directly addresses the aim of how best to organize and provide external support to practices for quality improvement.

This work was conducted to understand how best to organize and provide external support to practices for quality improvement. The presentation is designed to share this understanding with the practice facilitation community.

**SETTING/METHODS:**

As part of EN, seven regional implementation grantees (cooperatives) deployed practice facilitators to work with over 1500 small- and medium-size primary care practices across the U.S. to improve their capacity to implement evidence.

The innovative elements of the EN Model for supporting primary care practice improvement were developed through an iterative process involving all EN grantees, the AHRQ EN team, and the EN Technical Assistance Center (TAC). As part of the foundational information supporting the EN Model, the AHRQ EN team organized and synthesized previously developed AHRQ insights and guidance for organizations interested in providing external quality improvement support services, such as practice facilitation, for primary care practices. In addition, the AHRQ EN team and the EN TAC led a process to identify a set of key drivers and change strategies that can be used by practice facilitators with primary care practices to build their capacity to implement evidence. There were multiple steps in this process, including: 1) synthesizing the quality improvement frameworks used by the regional EN cooperatives into a key driver diagram (KDD), which included key drivers and change strategies; 2) obtaining feedback from grantees and revising the KDD; 3) soliciting input from EN practice facilitators during a series of conference calls and further refining the KDD; 4) incorporating outside expert review; and 5) finalizing the KDD. In a separate and extensive process involving the EN community, the AHRQ EN team and the EN TAC also collected and curated tools and resources that were developed or used by the cooperatives as part of their EN activities.

**RESULTS AVAILABLE OR PLANNED:**

The EvidenceNOW Model for supporting primary care practice improvement includes a key driver diagram with six key drivers and associated change strategies. The key drivers are:

- 1) Seek, select, and customize the best evidence for use by the practice;
- 2) Implement a data-driven quality improvement process to integrate evidence into practice procedures;
- 3) Optimize information systems to extract data and support use of evidence in practice;
- 4) Create and support high functioning teams to deliver high-quality evidence-based care;
- 5) Engage patients and families in evidence-based care and quality improvement; and
- 6) Nurture leadership and create a culture of continuous learning and evidence-based practice.

A total of 31 change strategies and hundreds of tools and resources were identified from recommendations by practice facilitators who worked with primary care practices from around the country as part of EvidenceNOW. A curated subset of these resources and tools, including assessments, QI resources, EHR optimization guidance, team building, and practice and patient facing tools, will be available on the AHRQ EvidenceNOW Web site in the fall of 2018. A related section of the Web site will provide resources for the development of practice facilitation skills.

**CONCLUSION/NEXT STEPS:**

Practice facilitators can use the comprehensive EN Model to guide their engagement with practices. Facilitators will find the resources hosted on the AHRQ EN Web site helpful in assisting practices with each key driver and change strategy. By encouraging the use of materials that have already been used and found to be helpful, EN is helping to spread techniques and tools that aid in the implementation of clinical evidence.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Evaluation of Practice Facilitation from the Perspectives of Oklahoma Primary Care Practices

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Practice facilitation (PF) can help primary care practices that face resource constraints to achieve strategies to meet environmental challenges and implement quality improvement (QI) initiatives. The relationships established by the PF team with members of the practice are critical to the team's effectiveness and achievement of clinical goals and organizational outcomes for the practice. Often times, PF occurs in practices but the extent to which the team is successful is not fully recognized or assessed. The objective of this study is to evaluate the effectiveness of the PF teams who worked with a cohort of primary care practices in Oklahoma to improve heart health among their patients.

**SETTING/METHODS:**

The PF team assisted primary care practices, delivering a QI intervention to improve metrics related to aspirin therapy, blood pressure control, cholesterol management, and smoking cessation (ABCS) as a part of the Healthy Hearts for Oklahoma (H2O) Study. The H2O PF team included a primary care physician academic detailer, certified practice facilitator, and an electronic health records (EHR) technical advisor. The QI intervention components included: (1) practice coaching/academic detailing, (2) systematic performance feedback, (3) practice facilitation to enhance workflow and goal setting, (4) health information exchange (HIE) and information technology support, and (5) a listserv to share best practices. At the completion of PF, each practice was asked to complete an assessment of their PF team. The assessment includes a structured survey and open-ended questions. Descriptive statistics were compiled to summarize response distribution for questionnaire items.

**RESULTS AVAILABLE OR PLANNED:**

Responses were received from 123 practices (response rate=56%) among those enrolled in H2O. The final sample was 113 after removing practices nested within a common health care system that provided identical answers. Forty-two-percent of the respondents were clinicians, 40% were office managers, and 4% were office staff. Overall, 87% of the respondents agreed/strongly agreed that academic detailers helped the practice understand ABCS guidelines, identify opportunities, and set QI goals. Eighty-four-percent and 83% agreed/strongly agreed that academic detailers developed a supportive relationship with their practices and provided useful written guideline summaries, respectively. Evaluating their facilitators, over 80% agreed/strongly agreed that they helped improve documentation, care processes to increase performance on ABCS measures and other QI metrics, QI information and tools, as well as developed good interpersonal relationships and fit well into the practice. Over three-quarters of respondents indicated that the facilitator helped their practice analyze performance measures from EHR and HIE, develop and implement practice policies to sustain QI, increase internal QI capacity, and patient engagement. Two-thirds of respondents agreed/strongly agreed that their EHR technical advisor helped their practice generate ABCS reports, maximize EHR functionality, and connect to HIE.

**CONCLUSION/NEXT STEPS:**

PF teams proved useful for helping primary care practices with implementation of new processes of care to improve the management of patients at risk for cardiovascular events. Deploying a PF team and focusing on specific QI targets were approaches that were well suited for working with smaller practices with limited resources. Furthermore, effects of PF can be long-lasting as the practices increased their QI capacity and technical know-how through the PF process.

**AUTHORS:**

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**TITLE OF SUBMISSION:** How practice facilitators adapt practice context to optimize implementation of evidence-based practices

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Practice facilitation is a strategy that provides external expertise to help primary care practices develop the capacity to implement innovative care processes tailored to their local context. HealthyHearts NYC (HHNYC), funded through AHRQ's EvidenceNOW initiative, is studying the effectiveness of practice facilitation to increase capacity among small independent practices (SIPs) and Federally Qualified Health Centers (FQHCs) aimed at improving cardiovascular disease (CVD) related care and outcomes. HHNYC is a partnership between NYU School of Medicine (NYUSOM), the New York City Department of Health and Mental Hygiene, Primary Care Information Project (PCIP) and the Community Healthcare Association of New York State (CHCANYS). The scope of HHNYC provides a unique opportunity to fill gaps in identifying qualitatively: 1) contextual challenges that influence the practice facilitation process and 2) strategies practice facilitators (PFs) employ in addressing variations in practice context.

**SETTING/METHODS:**

The study enrolled 257 SIPs and 19 FQHC sites located in NYC. Fifteen PFs from two partner organizations, PCIP (n=13), and CHCANYS (n=2), were responsible for the delivery of the one-year CVD intervention, which included monthly on-site visits. NYUSOM researchers developed a semi-structured interview guide based on the Consolidated Framework for Implementation Science. Interview questions assessed the PFs' perceived role, challenges in implementing the HHNYC intervention, PFs perceptions of practice and provider characteristics that created challenges and/or facilitated the PFs role in promoting prescribed system changes to meet clinical outcomes and effective strategies used to adapt their approach to optimize the intervention in the specific practice context. Interviews were transcribed verbatim from audio recordings. Deductive (theory-driven), and inductive (open) approaches were used to code the interviews and identify themes. Analysis was completed in Atlas.ti 8.1.

**RESULTS AVAILABLE OR PLANNED:**

Three primary themes were identified that influenced the PF process and delivery of the HHNYC intervention: (1) External regulations (adapting to new payment models) and participation in other local and statewide quality improvement (QI) initiatives, (2) Practice characteristics (provider and staff related challenges such as staff turnover, time constraints related to competing demands, lack of follow through on proposed system/workflow changes between visit, lack of leadership buy-in, and provider's resistance to change), and (3) Patient characteristics (diverse immigrant and vulnerable patient populations (e.g. homeless)). PFs retained core components of the intervention but adapted to the practice through alignment of the HHNYC intervention with the site's priorities and goals, remaining flexible (e.g., addressing other practice needs outside HHNYC when necessary to demonstrate value) and persistent, applying electronic health record (EHR) expertise and training staff to optimize use of EHR when needed, using motivational interviewing techniques to foster change, and facilitating community linkages to meet patient specific needs (e.g., language concordant resources).

**CONCLUSION/NEXT STEPS:**

This study fills gaps in our understanding of the complexity of the PF role and process, and demonstrates the wide range of skills and knowledge PFs need to support primary care transformation while adapting their approach to the practice's local context. Findings also emphasize the need for a baseline assessment of practices' goals, resources and expertise to inform the process of tailoring facilitation to the practice, provider and patient needs and the need for continuous assessment of both adaptation and fidelity to ensure that core components of the intervention are implemented.

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**TITLE OF SUBMISSION:** Practice Facilitation in Rural Primary Care Practices to Improve BP Control for African Americans: Implementation Requirements in the Rural South

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Poster Only

**BACKGROUND/SIGNIFICANCE:**

Practice facilitation (PF) can be a useful tool to help guide rural primary care practices develop strategies for improving hypertension related outcomes that address their unique populations and needs. Rural areas, especially in the southeastern United States, bear a disproportionate burden of hypertension (HTN) morbidity and mortality, but have limited resources to address these issues. Understanding the resources needed to provide practice facilitation in rural areas can help providers, healthcare administrators and public health officials when considering PF in ongoing quality improvement efforts. This abstract provides an overview of the infrastructure, training, and time resources used by the Southeastern Consortium for BP Control Study (SEC-BPC) to provide PF.

**SETTING/METHODS:**

The SEC-BPC is a cluster-randomized, pragmatic, comparative effectiveness trial that compares 3 interventions with enhanced usual care, to improve BP control among rural African Americans with uncontrolled BP. Ultimately 80 primary care practices (50 practices in AL and 30 practices in NC) will be randomized into 1 of four arms: 1) enhanced usual care (control group), 2) practice facilitation, 3) peer coaching, or 4) practice facilitation plus peer coaching. Twenty-five (n=25) African American patients with uncontrolled HTN at each practice (total n=2000) will participate.

The PF intervention (50% of practices) includes an initial meeting with a core group of clinic providers and/or staff that agree to be involved in quality improvement efforts. Practice facilitators communicate at least monthly with a practice champion via onsite visits or phone meetings and supplemental emails in between visits, over a total of 12 months. Practice facilitators follow the Model for Improvement to build internal practice capacity for QI and engaging in data driven quality improvement. Additionally they embed their activities in Key Drivers of Implementation such that they can rate not only if practices are engaging in new activities, but also having them become part of the fabric of every day operations. The SEC-BPC leverages the existing PF infrastructure of the NC Area Health Education Center (AHEC) to provide field experience and ongoing training. Practice facilitators in AL are hired through their regional AHEC, with the hope of establishing their own practice support program over time. Each practice facilitator is trained and certified through the University of Buffalo Practice Facilitation program and participate in twice monthly webconferences to share best practices, and to problem solve on how to move practices forward.

Practice facilitators use an electronic data collection tool, to track progress being made for each practice, the amount of time they spent in supporting practices in completing PDSAs, and the type of interaction they had (e.g. onsite, email, phone, remote access, driving).

**RESULTS AVAILABLE OR PLANNED:**

To date there are data for 24 practices receiving the PF intervention. Regarding payer mix, the average percentage of patients covered by either Medicaid, are dually eligible (Medicare plus Medicaid), or are uninsured is 26.7% (SD 13.1), 8% (SD 8.4) and 23.4% (SD 22.5) respectively. Of practices in the arms receiving PF, 36 % are certified by the National Committee for Quality Assurance (NCQA) as Primary Care Medical Homes (PCMH). Further, 40%, 60%, and 32% of these practices respectively report that they 1) already had a registry of hypertensive patients, 2) implement an evidence-based protocol to address hypertension, or 3) have established support systems to help patients with hypertension self-management.

Per practice, per month, practice facilitators reported spending an average of 301 minutes on all activities (SD = 98), 93 minutes physically onsite (SD = 31), 50 minutes communicating via email (SD=20), 18 minutes on phone calls (SD=21), 2 minutes via remote access (SD = 5), and 138 minutes driving to and from a participating practice (SD = 75).

**CONCLUSION/NEXT STEPS:**

Preliminary data suggests that providing PF to rural practices using centralized staff requires substantial investment of time and resources. More information is needed to gain a better understanding of the time and resources used by providers and clinic staff to interact with practice facilitators and to complete PDSA cycles. At the end of the intervention, providers and clinic staff that work with practice facilitators will be given a satisfaction survey that will provide more insight into their experience with the practice facilitator. Collecting this detailed process information throughout implementation of the study provides important information needed to document the fidelity of the intervention and to help with future strategic planning and allocation of resources.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Increasing Adoption of Self-Measured Blood Pressure Monitoring Through Practice Facilitation

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Poster Only

**BACKGROUND/SIGNIFICANCE:**

Current clinical guidelines recommend self-measured blood pressure monitoring (SMBP) paired with clinical support as a strategy to identify white coat hypertension (HTN), confirm diagnosis of HTN, and improve blood pressure (BP) control. Successful integration of SMBP into clinical care requires health care providers and care team members to adopt a protocol that incorporates both patient education and patient monitoring.

The New York City Department of Health and Mental Hygiene (DOHMH), through the Primary Care Information Project (PCIP), uses practice facilitation to assist primary care providers on improving population health. As part of a strategy to help practices improve HTN control rates (percentage of adults with BP  $\leq$ 140/90), practice facilitators (PFs) engaged small independent practices and community health centers to integrate SMBP into routine clinical care. We aim to describe the practice facilitation implementation and practices' willingness to support SMBP for their patients.

**SETTING/METHODS:**

From June 2015 to June 2018, 18 PFs worked with 269 practices to implement workflow changes and customized protocols to facilitate or expand the adoption of SMBP. A cohort of practices (n=100) located in neighborhoods characterized by high poverty and higher prevalence of HTN than the city average and/or whose EHR data showed below-average HTN control rates (i.e., lowest quartile) as compared to other practices were offered free BP monitors to implement a BP monitor loaner program. PFs surveyed the practices to assess willingness to support SMBP and responses were recorded in a customer relationship management (CRM) platform, Salesforce. PFs also recorded practice engagement activities (e.g., site visits, webinars, emails, phone calls) and barriers/facilitators to SMBP implementation. After an introduction to available educational materials, practices were asked to order materials through a toll-free number. We assessed the CRM to describe how practice facilitation influenced practices' willingness to engage in strategies to support SMBP and identified barriers/facilitators. Further, we tracked which practices ordered SMBP-related materials.

**RESULTS AVAILABLE OR PLANNED:**

PFs engaged with both clinician and non-clinician team members to use the electronic health record (EHR) to identify patients who would benefit, leverage available patient and practice education developed by the DOHMH, promote team-based care, improve workflows to support adoption, and refer to community pharmacies for supplementary support. A majority of the 269 practices (n=221, 82 %) stated that they were willing to support SMBP. All 100 practices offered free BP monitors agreed to implement a loaner program. 76% (n=205) of practices requested patient and provider materials related to HTN and SMBP. PFs reported that practices found workflow mapping and redesign useful for the implementation of SMBP and cost and/or lack of insurance coverage was a barrier.

**CONCLUSION/NEXT STEPS:**

Initial findings suggest that practice facilitation is a promising approach to increasing practices' willingness to support SMBP. Further evaluation will investigate which PF strategies were most readily adopted and successfully integrated to facilitate or expand SMBP and whether the integration of SMBP led to improved BP control.

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**TITLE OF SUBMISSION:** A Coaching/Facilitating Two for One: Engaging Physicians and Teams in Quality Improvement through MOC Part IV Achievement

**PRESENTATION TOPIC AREA:** Practice Facilitator Training and Ongoing Development

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

The majority of specialty boards require physicians to complete a Practice Improvement (PI) Activity or Maintenance of Certification (MOC) Part IV activity every three years. Physicians often find it burdensome and time consuming to complete these activities, and they rarely result in any meaningful quality improvement changes within their practices. The goal of this pilot project is to develop e-Learning modules for PI Activity/MOC Part IV credits focused on TCPi milestones; and train practice facilitators to engage physicians and practice teams on utilizing the e-Learning modules to complete the PI Activity/MOC Part IV, meet their TCPi milestones, and sustain this work as part of their quality improvement work.

**SETTING/METHODS:**

Five diverse specialty practices and one family medicine residency practice in Colorado participated in this project for approximately four months. Three practice facilitators (PFs) participated in two training sessions about the goals and objectives of the project and review the e-Learning modules. PFs also participated in pre-and-post qualitative interviews and ongoing support conference calls. PFs met monthly with their practice physicians and teams to complete one of the e-Learning modules and integrate this work into their TCPi milestone deliverables and ongoing quality improvement work. Physicians participated in post-project qualitative interviews to determine their experiences with this pilot.

**RESULTS AVAILABLE OR PLANNED:**

Results are ongoing as this pilot will be completed in September 2018. Results presented at this session will include: 1) quantitative and qualitative data gathered from surveys and interviews that will describe number of physicians, specialties, team approach, and PF skill development; 2) best practices of how to utilize a PI Activity/MOC part IV to assist physicians with meeting this requirement and integrate this work into sustainable team quality improvement; and 3) challenges encountered and possible solutions.

**CONCLUSION/NEXT STEPS:**

Training PFs to engage physicians and practice team members in completing a PI Activity/MOC Part IV can be an effective method for meeting this requirement, meeting milestones for initiatives such as TCPi, and integrating this work into sustainable quality improvement work. Blending QI and MOC requirements along with support from PFs and a team approach is a win-win strategy.

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**TITLE OF SUBMISSION:** Collaboration between Primary Care and Public Health Practice Facilitators to Improve Population Health

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

Primary care and public health have critical roles in providing for the health and well-being of communities across the nation. Although they each share a common goal, historically they have operated independently of each other. However, there are opportunities that bring the two sectors together in ways that can yield substantial and lasting improvements in the health of individuals, communities, and populations.

**SETTING/METHODS:**

In 2014, Minnesota Department of Health (MDH) was awarded the CDC's State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke grant. MDH implemented population-wide and focused (priority populations) evidence-based approaches to address hypertension control, undiagnosed hypertension and prediabetes and to reduce disparities in these conditions among adults. Through this grant, state and local public health staff received a Practice Facilitation Certificate through Normandale Community College. Normandale is part of the Minnesota Consortium of Practice Facilitation which was developed by experts in health care, quality improvement, public health and education. Two MDH staff and 4 local public health staff serving different geographic areas completed the practice facilitation training. Twelve primary care clinics and two behavioral health clinics were offered practice facilitation support services. Support services included data collection and analysis, process improvement strategies, patient engagement techniques, and community-clinical linkages.

**RESULTS AVAILABLE OR PLANNED:**

This presentation will describe an example of effective primary care and public health collaboration by using public health practice facilitators and examine practical approaches a state public health agency employed to include: organizational agreements, data collection and analysis, action planning, clinical tools and community resources, and additional technical assistance through experts in health information technology and learning collaboratives. Results from clinic pre and post assessments and clinical quality measure outcomes will be shared.

**CONCLUSION/NEXT STEPS:**

Public health and health care collaboration helps foster a better understanding of the health needs of a population among public health practitioners and providers of clinical services and the ways in which each of these disciplines can improve health status. MDH will continue to promote practice facilitation as an approach for public health to collaborate with health care and help to facilitate the two sectors to establish a set of population health priorities and target their resources to achieve agreed-upon objectives.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Improving Patient Safety in Primary Care Across Academic Sites: Reflecting on the Quality Improvement(QI)Coach/Facilitator Role

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

In February 2017, the Quality and Innovation Program of the Department of Family and Community Medicine (DFCM), University of Toronto recommended the Institute for Healthcare Improvement (IHI) Breakthrough Series - a Learning Collaborative, as the organizing framework for a primary care, patient safety community of practice.

In support of the patient safety-focused community of practice across the DFCM's academic sites, two QI coaches were engaged to support and enable education initiatives to build capacity for carrying out primary care patient safety initiatives and to explore and leverage collaborations between teams. Participating primary care teams selected the focus of their improvement work which ranged from medication reconciliation to a focus on learning from significant event analysis to designing organizational structures and processes to support patient safety improvement.

**SETTING/METHODS:**

Two QI coaches provided virtual and in-person support for eleven academic primary care teams located in and around Toronto, Canada. The coaches helped determine the scope and scale of the patient safety focus; alignment of the patient safety focus with ongoing QI work; identification of relevant team members; support for initiation and maintenance of a workplan; and completion of a team assessment. The latter was intended to support teams in discussion about the knowledge, skills, and resources required to effectively engage in the improvement work.

We used qualitative methods to understand the impact of the learning collaborative. Specifically, the evaluation examined the impact of the learning collaborative on faculty & learner experience and improvement outcomes, and the enablers and barriers to building QI capacity in the realm of patient safety from both the team and QI coach perspective.

**RESULTS AVAILABLE OR PLANNED:**

Engagement with the QI coaches was varied across the participating primary care teams. The qualitative evaluation results highlighted that in situations where the QI coach was engaged by a team, the role was effective in leveraging collaborations between teams and in providing application support of the improvement methodology. Teams that were less inclined to access QI coach support reported confidence with the QI process and/or projects that were targeted toward structural or procedural aspects of patient safety improvement such as the development of a committee to review and provide leadership oversight. The QI coaches reported that learning collaborative design supported the concept of 'readiness to participate' in that teams were encouraged to focus on what mattered to them in relation to patient safety. They also shared the notion that the diversity of project foci made it more challenging to support teams and negatively affected the potential for networking and sharing.

**CONCLUSION/NEXT STEPS:**

The experience of the DFCM patient safety learning collaborative demonstrated that the coaching role was effective with teams who accessed the support and subsequently applied the learning. The experience also highlighted the merit of careful learning collaborative design as a foundation for coaching/facilitation for improvement.

The consideration was offered that a standardized aim and change package for all teams may have encouraged more networking and collaboration and in turn, increased the impetus for accessing coach support to support improvement in patient safety.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Implementation of Measurement-Based Care: Creation of an Implementation Planning Guide

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Measurement Based Care (MBC) is the systematic process of collecting patient self-report data throughout the course of care from initial screening to termination, and using that information to monitor treatment progress, assess outcomes, and inform shared decision-making clinical treatment decisions over time. The Department of Veterans Affairs started a national initiative to implement MBC in 2016. Subsequently, beginning January 1, 2018, The Joint Commission (TJC) revised their standards to require MBC implementation. There are multiple, well-documented benefits of implementation and utilization of MBC in mental health (MH) services, including improved outcomes, increased communication, enhanced involvement in and understanding of care, improved treatment fidelity, and facilitation of quality improvement efforts. Despite these benefits, significant gaps remain in implementation of MBC within MH service delivery. To address these gaps, an Implementation Planning Guide was developed to support implementation of MBC in diverse clinical contexts.

**SETTING/METHODS:**

Qualitative interviews were conducted with eight MBC leaders at six VHA facilities, identified by analysis of administrative data indicating high utilization of standardized measures at the site prior to the initiation of the MBC in MH Initiative.

Interviews were conducted with a semi-structured qualitative interview guide developed to capture barriers, facilitators, and steps for successful MBC implementation. After conducting these key informant interviews with high performing sites, researchers identified recurring themes across interviews and implementation steps. These findings were translated into actionable items and informed the development of the implementation planning guide.

**RESULTS AVAILABLE OR PLANNED:**

Qualitative themes include the need for a collaborative process that ensures active participation from front line clinicians and leadership, the importance of communicating a vision and a rationale to all stakeholders, need for thoughtful measure selection that ensures use of targeted (clinically actionable) measures, provision of sufficient training and mentoring, the importance of local champions, and the value of protected time for those learning and implementing MBC. Concerns also emerged about the potential for an over-emphasis on mandated outcome data from leadership and the potential misuse of data. These themes and action steps were then used to inform the development of the planning guide, which will assist programs in thinking about key decisions for successful MBC implementation.

**CONCLUSION/NEXT STEPS:**

The MBC implementation planning guide provides a step-by-step sequence of key decisions for consideration to support successful implementation of MBC within the context of on-going local qualitative improvement process. This MBC implementation planning guide has applicability across settings to support implementation of MBC consistent with TJC policy requirements

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**TITLE OF SUBMISSION:** Effective strategies for survey data collection in practice facilitation research studies

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

HealthyHearts NYC (HHNYC), a cooperative in the EvidenceNOW initiative, tested the effectiveness of practice facilitation (PF) on the adoption of cardiovascular disease evidence-based guidelines in small independent practices (SIPs) and Federally Qualified Health Centers (FQHCs). When studying the effectiveness of PF interventions and factors associated with their success, researchers often seek to describe practice and staff characteristics (practice size, staffing infrastructure, etc.) of the intervention's setting. Surveys are a common method to collect this critical data from multiple personnel. However, in health services research, survey completion poses a challenge, as physicians and staff have limited time and, understandably, prioritize patient care. Given its scope, HHNYC provides an opportunity to describe effective strategies for survey collection in a large sample of physicians and clinic staff.

**SETTING/METHODS:**

HHNYC administered three separate surveys to 260 SIPs and 19 FQHCs in New York City. Two of the three surveys were distributed at three time points - baseline, end of the intervention (12-months), and 6-month post intervention. The third survey was distributed to each site until it was completed once. All surveys were self-administered and delivered to study sites through multiple methods including, in-person visits by research staff, mailings, and emails with a link to complete the survey online. HHNYC researchers documented the outcomes of survey distribution attempts, allowing for adjustments to their outreach and distribution methods in response to experiences in the field.

**RESULTS AVAILABLE OR PLANNED:**

Based on these experiences in the field, HHNYC found that in-person visits to study sites were the most effective distribution method and identified five specific strategies for optimal survey collection. First, set a date to pick up completed surveys, instead of relying on participants to mail surveys. Second, establish and maintain a relationship with an office manager or other staff member at the practice, instead of relying on inconsistent interactions with various site members. Third, set specific deadlines and follow-up plans, instead of allowing overly flexible deadlines and vague expectations. Fourth, make clear the surveys' relevance to the PF work, instead of distributing surveys without explaining why the PF project requires them. Fifth, create an individualized approach for each practice accounting for their office culture, instead of using a one-size-fits-all approach. Underlying these five strategies was open communication between research staff and practice facilitators, which enabled the two groups to communicate and set priorities cohesively with study sites.

**CONCLUSION/NEXT STEPS:**

In facilitating data collection by researchers who do not themselves deliver the PF intervention or have established relationships with study sites, these suggested strategies shift a data collection burden off practice facilitators. By dispersing this responsibility while promoting effective data collection, these strategies suggest the value of partnerships between practice facilitators and academic institutions able to support evaluation efforts. Importantly, these effective data collection strategies can help direct and refine future PF projects, by ensuring the systematic assessment of practice characteristics and factors that contribute to PF's effectiveness or illuminate areas for further attention.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Lagniappes Facilitation ICPF Abstract 71718

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Implementation Facilitation (IF) is an effective implementation strategy for complex clinical interventions like those in behavioral health. Successful IF is grounded in partnerships with leadership and clinical stakeholders. Previous researchers have documented unintended negative consequences of implementation-time, financial, and opportunity cost. There is no report of unintended positive consequences of IF. Positive consequences of facilitation may enhance site likelihood to participate in implementation projects and add benefits to the facilitation effort.

**SETTING/METHODS:**

We are employing IF in an ongoing stepped-wedge, Hybrid Type 2, pragmatic trial to implement Primary Care Mental Health Integration via televideo in six small rural VA clinics. Two facilitators are conducting six months of pre-implementation facilitation with each site and for six months during the implementation phase. We are performing an implementation-focused formative evaluation of IF activities, including experiences of the facilitators, through weekly debriefing interviews with facilitators. Positive unintended consequences emerged as an important theme in debriefings on the first two study sites. We extracted all data on this theme from detailed debriefing notes and conducted a rapid content analysis to identify positive consequences.

**RESULTS AVAILABLE OR PLANNED:**

We will present examples of unintended positive consequences of IF in our first two sites, including: 1) Identifying a lack of mental health emergency plans at Clinic A and ensuring the clinic developed formal policies; 2) Helping to resolve a long-standing scheduling issue that prevented capture of on-site workload at Clinic B; 3) Assisting Clinic A in obtaining scheduling permissions for clerks to provide backup for telehealth appointments; and 4) Identifying and facilitating resolution of several tele-health process and systems issues at Clinic B that had not been anticipated and will benefit the parent VAMC's impending rollout of a larger telehealth program. We will discuss other positive consequences and how they benefit the sites, strengthen our ongoing partnerships, and improve implementation efforts.

**CONCLUSION/NEXT STEPS:**

Knowing possible unintended positive consequences of IF may secure engagement of leadership and clinical partners. When using IF for complex interventions in behavioral health, facilitators should be aware of and consider leveraging unintended positive consequences as boons for the site that add efficiency to the IF strategy.

CITATION: Woodward, E. N., Drummond, K. L., Oliver, K. A., Meit, S., Deen, T., Owen, R. R., & Kirchner, J. E. "Lagniappes" (A Little Something Extra): Unintended Positive Consequences of an Implementation Facilitation Strategy.

**AUTHORS:**

Eva Woodward, PhD  
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**TITLE OF SUBMISSION:** Using Standardized Data Visualization Tools to Engage Practices in Quality Improvement Efforts Through the Healthy Hearts Northwest Study

**PRESENTATION TOPIC AREA:** Leveraging Technology in Practice Facilitation

**FORMAT:** Poster Only

**BACKGROUND/SIGNIFICANCE:**

Data visualization instruments can be effective tools for practice facilitators supporting clinics in quality improvement (QI) efforts. Healthy Hearts Northwest (H2N), one of seven regional collaboratives funded by AHRQ's EvidenceNOW initiative, developed a data visualization tool called The Pulse that was available to all participating practices. H2N practice facilitators used The Pulse as a facilitation tool, providing uniform data visualization to support QI efforts in practices with varying levels of EHR functionality and QI readiness. This standardized tool helped clinics monitor the quality of their data and had a positive impact on their ability to report data to external partners and payers.

**SETTING/METHODS:**

H2N engaged 209 small- to medium-sized primary care practices across Washington, Idaho, and Oregon for a pragmatic clinical trial comparing the impact of different evidence-based methods for disseminating cardiac risk reduction interventions. The practices received 15 months of dedicated practice coaching, access to clinical experts, and high-value tools for QI and measure reporting. Practice facilitation meetings happened either in-person or virtually, with the mode, structure, and duration of meetings being tailored to fit practices' preferences. Quarterly Clinical Quality Measure (CQM) data on Aspirin, Blood Pressure, Cholesterol, and Smoking Cessation (ABCS) were collected from all practices and displayed in The Pulse. We collected descriptions from facilitators on their use of The Pulse in practice facilitation in order to understand the various ways it was implemented in practice.

**RESULTS AVAILABLE OR PLANNED:**

The Pulse provided a broad spectrum of functions that were used by practice facilitators to provide tailored support to practices across a number of different domains. Many clinics did not understand the specifications of the CQMs or where the data should be entered in the EHR in order to satisfy the metrics. Facilitators were able to present these measure specifications and associated data in The Pulse in order to generate discussion and solidify understanding of measure logic among staff. Once the measures were understood, data visualization was instrumental in QI efforts. For many clinics, this was their first time regularly monitoring data in a meaningful way. By displaying data trends from the state, regional, and national levels, clinics were able to compare their performance to their peers. This benchmarking helped drive motivation and set realistic goals for improvement. The Pulse also provided potential error flags and the ability to view numerators and denominators changing over time. This enabled clinics and practice facilitators to better monitor data quality, understand fluctuations in performance, and reduce erroneous reporting to external partners and payers tied to reimbursement. All of these uses of The Pulse helped increase practice confidence in QI, staff engagement in the QI process, and an understanding of population health management.

**CONCLUSION/NEXT STEPS:**

The Pulse proved to be an extremely effective tool for practice facilitators on the H2N project. The versatility of functionality allowed facilitators to tailor their intervention to meet the specific needs of each practice, allowing practices to expand their internal QI capabilities. Data visualization tools like The Pulse could be an effective addition to any data driven QI project using practice facilitation.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Practice Facilitation in Primary Care

**PRESENTATION TOPIC AREA:** Sustaining and Managing Practice Facilitation Programs

**FORMAT:** Poster Only

**BACKGROUND/SIGNIFICANCE:**

Practice Facilitators (PFs) enable researchers, primary care clinicians and practices to answer important healthcare questions and translate findings into practice. University of Toronto Practice Based Research Network (UTOPIAN) currently has three Practice Facilitators available to engage in research initiatives in primary care research projects.

**SETTING/METHODS:**

Many primary care practices do not have adequate resources, skills or knowledge to undertake essential research activity in their practice. PFs provide a wide range of supportive services in order to improve the quality of care delivered, patients' experience with care, and patient outcomes (support includes assistance with REB applications, recruitment and EMR searches).

**RESULTS AVAILABLE OR PLANNED:**

Since 2012, UTOPIAN has been involved in approximately 25 primary care research projects spread over 14 family medicine teaching sites and around 1400 faculty members. Providing research support to family practices by a process of facilitation, increases number of research projects within the network, research project success and willingness of practices to take part in primary care research.

**CONCLUSION/NEXT STEPS:**

Practice facilitation has allowed busy clinicians and researchers to actively engage in research projects, recruit sites, clinics and patients and establish realistic, workable processes ensuring project success.

**AUTHORS:**

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**TITLE OF SUBMISSION:** The NCQA process as a path to practice transformation

**PRESENTATION TOPIC AREA:** Developing Best Practices and Resources for Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

The National Committee for Quality Assurance (NCQA) has developed a rigorous program for primary care practices to receive recognition as patient centered medical homes (PCMH). The Care Transformation Collaborative of RI (CTC), a multi-payer initiative supporting primary care transformation, requires its participating practices to achieve NCQA's PCMH recognition. CTC practice facilitators work with the practices on their NCQA applications, offering training, support and education.

This presentation addresses the following objectives.

1. Participants will learn how practice facilitators can use the NCQA framework to initiate and scale practice transformation efforts so that they are successful and sustainable.
2. Participants will learn how to adapt their approach to practice transformation based on the size of the participating practices, their resources and transformation efforts to date and their decision to pursue NCQA recognition.
3. Participants will be able to identify barriers to practice transformation and recognize solutions for engaging staff and providers in adopting PCMH change concepts.

**SETTING/METHODS:**

Practice facilitators in Rhode Island work with community health centers, private practices and ACOs to help them achieve the PCMH designation and transform their practices into patient centered medical homes. Following the guidelines set out by NCQA, the practices direct their efforts towards improving access to care, coordination of services, patient satisfaction and patient care.

**RESULTS AVAILABLE OR PLANNED:**

While some practices benefit greatly from participation in the NCQA process, others find it to be primarily a low-value administrative burden. The size of the practices, the resources they are able to dedicate to the project and the degree to which they have already made changes all contribute to their perception of the value of the project. The role of the practice facilitator also varies widely, depending on the level of understanding of the process on the part of the practice, their commitment to change and the skills of the practice personnel. Practice facilitators may use the NCQA framework for helping practices improve, regardless of their intention to seek PCMH recognition.

**CONCLUSION/NEXT STEPS:**

Using the NCQA program as a framework can be a valuable tool for practices and facilitators to implement change. However, the framework may not be beneficial to all practices. Facilitators should become familiar with the NCQA program in order to discern which areas of change will be most useful to their practices. The program may also offer benefits to practices that want to improve, whether or not they choose to seek PCMH recognition.

**AUTHORS:**

Suzanne Herzberg, PhD  
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**TITLE OF SUBMISSION:** Scaling Practice Transformation Statewide

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral Presentation Only

**BACKGROUND/SIGNIFICANCE:**

Discovering models that achieve real quality improvement across geographies and settings remains a challenge for practice transformation nationwide. As a Practice Transformation Network, Pacific Business Group on Health worked with 16 provider organizations, 1,900 practices and 4,800 clinicians to understand key ingredients for effectively scaling transformation in small primary care practices across California. This session highlights learnings from its train-the-trainer collaborative, which utilized improvement coaches to improve outcomes for 55,000 patients and save \$101million in just two years.

**SETTING/METHODS:**

In our practice transformation model, the provider organizations hire practice facilitators who our PTN trains to engage directly with practices on quality improvement. Our technical assistance is also designed to help the provider organizations leverage their centralized resources to contribute to changes in the practices. We coach at multiple levels (provider organization leaders and practices facilitators), have infrastructure to collect data at clinician, practice and organization levels, and hold quarterly in-person convenings of the entire network plus monthly virtual meetings. The goal of our model is to deeply engage at the provider organization level so that infrastructure and improvements last beyond TCPI, leading to sustainability within the organizations and practices.

A unique characteristic of our PTN's network is that 90% of practices are very small (1 or 2 providers), reflective of the fact that the majority of provider organizations participating in our program are IPAs. We intentionally recruited these organizations as they and their affiliated small practices are generally not well-resourced. Our PTN aims to fill a gap in knowledge about how practice transformation happens and which change elements are most impactful for the small independent practices in our state.

Our PTN's data partner, Integrated Healthcare Association (IHA), developed a linear regression model to determine what facets, if any, evaluated in the CMS Practice Assessment Tool (PAT) were related to performance across our measure set. Practice level measures and PAT results were linked using a unique practice identifier (Tax Identification Number or Level 2 National Provider Identifier). The analysis included all data reported through 6/30/2017. A diagnosis of fit test (DFIT) was performed to remove any influential observations within each regression model. Any practices who had not completed a PAT or had a measure denominator count less than 11 were removed from the model. The analysis was conducted in Stata (Release 15).

**RESULTS AVAILABLE OR PLANNED:**

The Pacific Business Group on Health will share results of a statistically significant analysis of intervention and outcomes data from over 1,000 practices in our Practice Transformation Network. Relationships highlight five characteristics to scale transformation of value-based care delivery among small practices. Implementation case studies will detail how practices, practice facilitators, and provider organizations can effectively collaborate for improvement.

**CONCLUSION/NEXT STEPS:**

With all that practice transformation entails, small practices are often overwhelmed in undertaking changes towards value-based payment. Scarce resources of money, time, expertise, and staff in small practices make even the most impactful process changes challenging to undertake on their own. High-performing practices carry out these processes by leveraging support and resources from provider organizations and their practice facilitators. This analysis equips us to distill the transformation to 5 key process changes that make transformation an easier sell and change to small practices. Prioritizing improvement interventions and focusing on a few to start enables a practice to see results quickly and build motivation and momentum for continued efforts, as well as training practice facilitators and deploying them to practices more quickly and effectively.

**AUTHORS:**

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**TITLE OF SUBMISSION:** The QI Coach/Facilitator Role in a Primary Care Research/QI Collaboration to Improve Care for Elderly Patients with Complex Care Needs

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Collaborations between primary care quality improvement (QI) and practice-based research can promote the translation of evidence into clinical practice. Simply stated, the QI lens offers attention to a contextually-sensitive, methodological approach to change and the research lens offers the scientific evidence for implementation.

Focused on the collaboration opportunity between research and QI - the 'translating of evidence to practice' - we designed and initiated SPIDER: A research and QI collaboration supporting practices improving care for complex elderly patients living with polypharmacy. The intent of this study is to support primary care teams to deprescribe, as per clinical evidence, where polypharmacy exists in elderly patients. The Teams will participate in a Learning Collaborative and will be supported by a QI coach/facilitator in understanding QI methods and implementing QI tools for the process of deprescribing. It is important to support practices in this complex work, recognizing that 'how' evidence is translated to practice is not always intuitive and is often not sustainable.

**SETTING/METHODS:**

To encourage a contextually-sensitive, patient-centred, and sustainable approach to the study intent an experienced primary care QI coach/facilitator has been engaged to support eleven family physician-led teams from the Department of Family and Community Medicine (DFCM) at University of Toronto who will participate in SPIDER. The focus of the QI coaching/facilitation will be to enable:

- " Contextual goal-setting and gap identification using system diagnostic tools and measurement
- " Reflection on teaming effectiveness and strategy development for improvement
- " Inclusion of patient-experience improvement

**RESULTS AVAILABLE OR PLANNED:**

The learning collaborative will launch on September 14, 2018. We will have initial information on the experiences of the participating teams and the perspective of the QI coach/facilitator by the date of the conference. It is anticipated that the progress of teams from an incremental improvement and engagement perspective will also be able to be shared with reflections on what is working well, hypothesizing on why, and what next.

**CONCLUSION/NEXT STEPS:**

As a project, SPIDER offers primary care teams the opportunity to experience the challenging task of translating evidence into practice on a quality improvement platform, with external support (the QI coach/facilitator), and in a learning collaborative designed to support networking and sharing. We anticipate that our observations and experiences relating to the role of the QI coach/facilitator will be invaluable when reflecting on change in work and the relevance of research, patient engagement, measurement and sustainability.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Coaching Style Defined: Analysis of Literature Supports Six Domains of Coaching Styles in Primary Care Redesign

**PRESENTATION TOPIC AREA:** Practice Facilitator Skill Building

**FORMAT:** Oral or Poster

**BACKGROUND/SIGNIFICANCE:**

Primary care practice redesign benefits from facilitation. External facilitation (i.e. coaching) of internal practice facilitators may assist practices by providing expert, impartial guidance on navigating a complex redesign process. However, little is known about coaching styles - or individual approaches to communicating with facilitators - used by external coaches. This study reports the results of a literature review on coaching of primary care practice redesign. It also reports a coaching team's outcomes in using these results to confirm styles used to support internal facilitators guiding practice redesign.

**SETTING/METHODS:**

This study is part of a large, pragmatic, comparative effectiveness trial of a protocolized quality improvement initiative to integrate behavioral health in primary care practices (n = 43) across the U.S. Within practices randomized to the intervention arm (n=20), an internal facilitator was selected to guide a small group of practice members (staff and providers) through the intervention and engage with an external coaching dyad that included one expert in practice facilitation. All coaches (n=6) were instructed to use the same coaching model to frame their interactions with practices, while operating within a randomized trial. Coaches held weekly meetings to discuss coaching style and coaching issues. During team coaching and peer meetings, the coaching team identified differences in approach among the team members. A literature search yielded multiple domains to describe coaching styles within the field of primary care practice redesign. Coaches self-reported their use of coaching style by domain and collected data on facilitators' acceptance of coaching.

**RESULTS AVAILABLE OR PLANNED:**

The literature review identified six domains related to coaching style: (1) Establish the coaching relationship; (2) Assess coachee's developmental stage for change; (3) Develop situational awareness and be flexible in response to coachee's needs; (4) Engage leadership; (5) Support change sustainability; and (6) Support internal facilitator sustainability. Coaches matched their experiences with these coaching style domains. Despite differences in coaching style, based on these domains, all practices that started the intervention (n = 21) accepted an external coach as a contributor to their redesign process, demonstrated by the facilitator's (or their designee's) attendance at one or more coaching meetings. Additionally, practice team facilitators engaged in the coaching process by sharing challenges, asking questions, responding to feedback, and creating plans for follow-up.

**CONCLUSION/NEXT STEPS:**

Coaching styles identified in the literature were confirmed by coaches in the context of a randomized trial, but variation existed in self-report of the different domains. Coaching styles can look different but can achieve similar results. External coaching appears to be helpful in moving practices through the practice redesign process and in supporting acceptance of change.

**AUTHORS:**

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**TITLE OF SUBMISSION:** Scaling Behavior Change in Primary Care

**PRESENTATION TOPIC AREA:** Advancing the Science of Practice Facilitation

**FORMAT:** Workshop

**SESSION DESCRIPTION:**

Growing evidence suggests that practice facilitators, trained to integrate technical changes with the core motivators of physicians, staff, and leadership, can drive practice transformation. This session will focus on ways health systems and practice teams can benefit from practice facilitation, and will review early insights from the North Carolina Area Health Education Center program to scale practice transformation by extending facilitators' reach through measurement, tools, and technology.

**BACKGROUND/RATIONAL:**

**SESSION FORMAT:**

**LEARNING OBJECTIVES:**

- Participants will understand the value of practice facilitation and how it can help scale transformation within a health system.
- Participants will learn how leaders like NC AHEC have used facilitators and technology to engage leadership and align their teams, and how they can take into action those lessons learned.
- Participants will learn how the integration of service components (content, facilitators, measurement, software, network) can help scale practice transformation.

**CONCLUSION/NEXT STEPS:**

Practice facilitation can help practices build the infrastructure and "know-how" to implement care delivery improvements that can be replicated in many environments; engage the workforce in their own care delivery redesign; and result in consistent improvement in outcomes, patient experience, joy in work, and total cost of care.

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