Safety Net Medical Home Initiative

IMPLEMENTING THE PATIENT-CENTERED MEDICAL HOME MODEL

A Practice Facilitator's Guide to Visiting Clinical Teams

"A coach has a most powerful influence on those he or she leads, perhaps more than anyone outside of the family. Therefore, it is the obligation of that coach to treat such responsibility as a grave concern." —John Wooden, UCLA Basketball Coach

IS THIS GUIDE FOR ME?

Are you interested in helping primary care teams implement the medical home? Wondering about what role practice coaches or facilitators can play? If so, read on!

Implementing the changes associated with the Patient-centered Medical Home (PCMH) model is a lot of work for primary care practices. The PCMH model requires practices to improve access to services, proactively engage patients in high quality preventive and chronic care, and create systems to coordinate care with specialists and other community resources in new ways. To achieve these goals, the roles of medial assistants and nurses must evolve and electronic medical records and other technological infrastructures must be implemented or optimized. The way a practice conducts its daily work changes in almost every way.[1]

prac·tice fac·il·i·ta·tor

1. a specially trained individual who assists primary care teams in research and quality improvement projects;
2. distinguished from consultants by specialized training, broad scope of practice, and long-term relationships with an organization, its providers and its patients;
3. aims to improve quality, access and improve financial viability at the practice level.

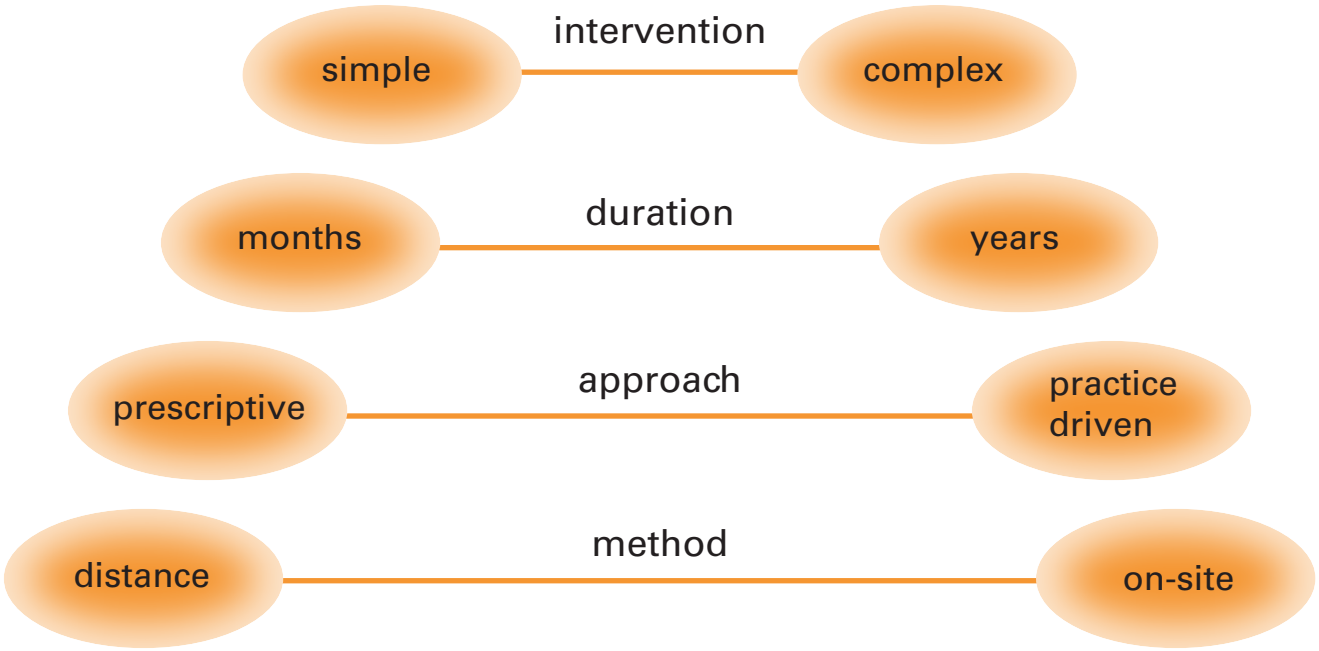
Source: Institute for Healthcare Improvement's (IHI's) Triple Aim.

Such dramatic changes may be assisted by an organized approach to learning PCMH concepts and trying out new ways of operating. Learning collaboratives, consultants, and practice facilitators or coaches (these terms are used interchangeably) can all be part of a technical assistance approach. Recent anecdotal evidence suggests that using multiple modes of engaging with practices may be the optimal combination to facilitate change.[2] Several quality improvement efforts now combine the use of learning collaboratives and practice facilitators when working with practices, including the Safety Net Medical Home Initiative.

By using a multi-method approach to practice transformation, the best parts of each technique can be harnessed. For example, learning collaboratives provide practices with access to experts, an organized schedule for meeting and discussing changes, and perhaps most importantly, an opportunity to share experiences with and learn from other practices implementing similar changes. When a practice facilitator works with individual practices between learning sessions, practices get highly tailored input and sustain a strong momentum for change by getting questions answered and issues resolved quickly. Practice facilitators are also able to provide proven resources that can help practices avoid implementation pitfalls.

Practice facilitators can work with clinical teams in a variety of ways, depending on the goals and structure of the initiative. Figure 1 shows four ways in which interventions using facilitators can vary: the level of intervention, the length of the intervention, the type of intervention, and the structure of the intervention.

Figure 1: Four Dimensions Across which Interventions Using Practice Facilitators Vary



This guide will focus on practice facilitation that is used in combination with structured learning collaboratives to help practices implement a complex intervention, like the PCMH. A working assumption is that practices have a relatively long period of time to implement the changes and have input on the sequencing and content of the changes they are trying.

Though emailing and phone conversations have their place, one of the most powerful ways a coach can engage with teams is by visiting them where they practice. When working on complex changes over a long period of time, in-person visits are even more important for relationship building and providing the coaches with a good sense of the context in which the team is working. The purpose of this guide is to provide practice facilitators a high-level overview of how to harness the power of an in-person visit and to make it as useful to the practice and the facilitator as possible. Specifically, this guide will:

☑ Identify the role and skill set of improvement coaches.
☑ Clarify the purpose and utility of initial in-person visits and the specific activities and approaches for making them successful.
☑ Note barriers that can impact a site's ability to do system transformation.

WHAT MAKES A GOOD PRACTICE FACILITATOR?

Practice facilitators can be effective in helping clinical teams improve patient quality and experience.[3] While helping a practice team implement a complex intervention like the PCMH, a practice facilitator will wear multiple hats. He or she will act as a:

- Convener
- Facilitator
- Agenda setter & task master
- Skill builder
- Knowledge broker
- Sounding board
- Problem solver
- Change agent

With so many different roles to play, what makes a great coach? Though there is some debate among experts on the importance of clinical expertise, most people agree that excellent interpersonal and facilitation skills are essential.[4] The very nature of coaching is interpersonal, and coaches must have an ability to work well with everyone in a clinical setting – from those with a high school education to highly trained clinicians. At the 2010 North American Primary Care Research Group Annual Meeting, a group of physicians was asked to indicate what skills or characteristics they thought were most important for coaches or facilitators to have. From a list that included high-level clinical degrees and detailed content knowledge, the consensus responses were having strong interpersonal skills and the ability to facilitate communication.[5]

In addition to excellent interpersonal skills, coaches must have some level of content expertise in quality improvement methods. This includes:[6]

- Familiarity with data systems, including registries.
- Ability to understand and explain data reports in different ways to different stakeholders.
- Some clinical understanding and credibility.
- Knowledge of, and experience with, the Chronic Care Model.
- Knowledge of, and experience with, the Model for Improvement.
- Understanding of performance reporting and measurement.
- General quality improvement methods.
- Group facilitation skills.
- Project management skills.
- Knowledge of practice management and/or financial aspects of the practice.
- Experience with and understanding of the outpatient clinical setting.

Some coaches act as generalists, and this level of content expertise is sufficient. Others are more specialized and can provide detailed assistance on certain program components. Clinical teams may benefit by having access to both types of coaches as they move through a complex intervention like PCMH transformation.

SETTING UP THE FIRST IN-PERSON VISIT

The first visit with a new team is an opportunity that only comes once. First impressions matter. It is a coach's chance to set the stage for future work. Though there are several potential functions of the first visit, the key ones include: building relationships and trust, establishing ground rules and expectations, identifying strengths and concerns at the site, and sharing tools and resources that can support a team in getting started with the transformation work.

> The first site visit can be intimidating for a coach. Even if you have done preparation and know one or two team members, walking through the door, you are never sure what the team dynamics will be, what has been happening in the health center that day or what the visit will be like. A very valuable trait of a coach is flexibility. – Pittsburgh Regional Health Initiative (PRHI) coaching team

Much like in sports, successful coaching is built on a foundation of trusting relationships. The first visit with a practice team is an opportunity for the coach to establish both a relationship and credibility with the team members. Therefore, thoughtful preparation is very important. Ideally, more time will be allotted for this first visit than for subsequent ones as there are several items to cover. On the following pages are some of the strategies and activities that can help facilitate a great initial site visit.

BEFORE THE VISIT

Do some research. Prior to any initial contact with the team, do some research on their site. This can be done both formally and informally. Begin with any application materials for the initiative or program. Note who the team members are and their roles. View the site's website if they have one to see what and how they are presenting to the world. Look for participation in other initiatives or projects, what kinds of resources they have available for their patients, operation times, any data, and any information on their key leaders.

Set up a call with senior leadership. Use this call to better understand their intentions for participation in the initiative and to assess their understanding of the amount of effort and time needed for completion. Discuss overall expectations and how you will work with their team. Make clear who you expect to attend the visit so it can be scheduled to accommodate all team members.

Set up a call with the improvement team members. This is an opportunity to explain expectations (and activities) and to answer any questions about prework materials prior to the visit. Topics for discussion may include: clarifying that the whole improvement team is expected for the initial visit, a discussion about their aim for the initiative, a review of the expectations for participation in the initiative on an ongoing basis, scheduling a regular team meeting time, etc.

Review prework. Typically, quality improvement initiatives require prework from participating sites that includes things such as baseline data collection on a set of required measures, a team worksheet identifying team roles and responsibilities, demographic profile of the patient population, and some personal anecdotal information on team members. Additionally, general information about why a site is participating, other initiatives they are currently participating in, barriers that may impact a site's ability to succeed such as implementation of an EMR, and particular strengths that can help a site succeed can be collected.

Identify tools and resources. Based on your conversations and research, think of what tools you can take to the visit that may be useful to the team. Consider what has been useful with similar organizations and what has been useful for similar initiatives.

Set an agenda. Make sure you know exactly how much time you will have with the leadership and with the team members. Consider the key activities you want to accomplish and information you'd like to gather and prioritize how you will use your time. Share the agenda ahead of time with attendees.

Schedule the visit. Ideally, use a regularly scheduled team meeting time if they have one or a time that all team members can be available.

DURING THE VISIT

Make introductions. Briefly introduce yourself and your background to establish credibility, but remember that this visit is about them. Have all team members introduce themselves and their particular role at the site. Take notes so you can reference the right person for the right reason later on. Ask questions to elicit more detail and to show interest in each individual. Identify the key contact person (or people) with whom you will have regular interaction throughout the initiative.

Do an overview. Though discussed on the first call with the team, review the overall initiative and expectations for the site's participation. Additionally, share what you will do for and with them throughout the initiative. Include things such as how often you intend to do site visits, types of support you can offer, and how you will provide feedback to them.

Identify barriers and resources. Ask them to identify things they do really well at their site. Ask the senior leader on the team (maybe an MD or an administrative executive), to share their vision for participation and how they intend to support the initiative. Ask each team member to share their thoughts – concerns and enthusiasms – for the initiative. During this time, note observations on team interactions and level of sharing. Remember that asking 'what' their challenges are can really mean 'who' are the challenges. Facilitate this discussion delicately. If you sense resistance to share verbally, another option is to have the team members take some time to write down concerns that they can share with you anonymously.

Do an activity. Have the team complete an activity together. This can help them identify areas for improvement that might be a good place to start in their work with the initiative. One example comes from the Clinical Microsystems program at The Dartmouth Institute at Dartmouth-Hitchcock Medical Center, called Know Your Processes. Another example of an activity is to give each team member six sticky notes on which they write three strengths and three opportunities for change in their system which are put together on flipcharts for discussion. In addition to helping the team, having them do an activity will allow you to observe how the team functions together and the team dynamic.

Share tools. Take time to share any tools you brought that you thought would be useful based on the information gathered prior to the visit.

Do a walkthrough of the site. Ask for a tour of the clinic and ask questions throughout. Make observations such as: Is there evidence of quality improvement efforts such as displays of data in the staff room or hallways? What is the physical layout of the practice and how does it seem to impact flow and efficiency? Does the site feel welcoming to patients? Are there patient educational materials out? Are they in more than one language? Do the staff members seem 'happy'? Are the staff and providers functioning in care teams? Is the waiting room full?

Record information. Take notes throughout this visit as it is easy to forget observations and details once you leave. Write down any questions that need follow-up such as clinical issues or questions for other experts.

Identify team meeting time. Ideally, the team will already have a regular meeting time established. If not, make setting one a priority. Generally, teams need to meet as a group about an hour a week for improvement efforts. They may choose to do this as a weekly meeting or may choose daily huddles with formal meetings once a month.

Ask for feedback. Do a short debrief of the visit and identify any topics that didn't get covered or need additional attention.

Establish a next meeting time and action items, as appropriate. This may be a call or another site visit. Use their already set team meeting time if possible.

AFTER THE VISIT

Summarize visit. Take a little time to write down any additional thoughts or observations that you observed during the visit.

Send a thank you note. Acknowledge the time and effort of the team members and the senior leadership. Let them know you will be following up soon with answers to any questions and next steps. Include your contact information and the best times and ways to reach you.

Contact experts. Gather answers to any questions the team had that you could not answer.

Send materials. Once you've received answers to their questions, send those along with any tools and resources identified as needed during your visit. These may include forms and templates, process improvement content, examples from other organizations, and links to other resources. Also include next steps and the date / time for next contact. You may want to create a calendar of events for them. This may include upcoming visits, conference calls, in person meetings, etc.

SUBSEQUENT SITE VISITS

As an improvement initiative moves forward, the amount of in-person coaching provided to each site will vary based on several factors including, but not limited to, the following: the financial resources available to cover coaching time, the geographic spread of the sites, the number of sites the coach is working with, and the general needs of each site. In the Safety Net Medical Home Initiative, the approach to coaching in the five regions is hugely impacted by geography. In Pittsburgh and Massachusetts, the Medical Home Facilitators go to the sites often – sometimes weekly – as the sites are all located within a fairly small geographic region. In Oregon, Colorado, and Idaho, the Medical Home Facilitators go to sites less often, especially the very rural sites.

Research on practice coaching has not clearly identified a 'right' amount of in-person time or support or the ideal type or way of coaching. However, Wageman and Hackman note that coaches use different skills—motivation, education, and consultation—at different points during the lifecycle of a project. A coach needs to be responsive by adding the right KIND of coaching at the right time.[7]

> *Motivational Coaching* addresses the amount of effort that group members collectively put into the task, especially by enhancing the conviction and confidence they bring to the work[7] through encouragement, reassurance, permission, and nudges.[8]
>
> *Educational Coaching* addresses the knowledge and skills that members bring to bear on the group's work.[7] Educational coaching can take the form of information sharing, skills training, and role feedback.[8]
>
> *Consultative Coaching* fosters use of performance strategies that are especially well-aligned with and appropriate to the task.[7] Consultative coaching may include rapid response to needs and requests, interactive problem solving,[8,9] and suggestions for change concepts or resources.

As noted earlier, successful coaching is built on the foundation of a relationship. A coach – or coaches – in an improvement initiative will need to determine the right mix of motivation, education, and consultation that is needed for each site with an understanding that the needs will shift over the course of the initiative.

A great site visit can rely on many factors, but nothing beats the feeling of working with a team that is focused, has goals and walks away with action items. This is a great sign for the future of the coaching relationship. One of my favorite moments was going to a team staff meeting and realizing that I did not need to be there. I contributed to the conversation, but the team had an agenda, focused discussion, assigned responsibility and follow up items and worked effectively on their own. This has come over time, but was a wonderful moment. – Kay Brewer, Medical Home Facilitator, PRHI

How time is used at subsequent in-person visits will depend on the amount of time a coach can spend at a site and what the specific needs are. A good place to start each visit is with a discussion of what is going well. Acknowledge achievements and efforts. Review their current data to see if the changes they are working on are leading to improvement. Then, ask about their current concerns or issues. Additional things to consider doing with practice teams while visiting include:

- Review basic quality improvement strategies, such as how to do rapid cycle testing of changes.
- Review the practice team's data with them and highlight ways to use it to determine areas for change.
- Identify steps in a work flow and areas of waste.
- Discuss and facilitate changes to roles and responsibilities of team members within the framework of the improvement initiative.
- Share tools and resources from other sites and /or initiatives.
- Do team building activities with the practice team.
- Encourage team leaders or improvement champions to conduct regular team meetings in a similar way to how they are conducted when the coach is present such as setting agendas, taking minutes, and identifying action items in order to keep the initiative moving forward in a structured way.

In addition to doing in-person visits with sites, coaches can support the improvement process in other ways:

- Conduct monthly coaching calls with all teams together to facilitate cross sharing and learning.
- Conduct regular calls with individual teams.
- Schedule calls / webinars with experts to highlight a specific change area.

UNDERSTANDING A PRACTICE'S READINESS AND ABILITY TO CHANGE

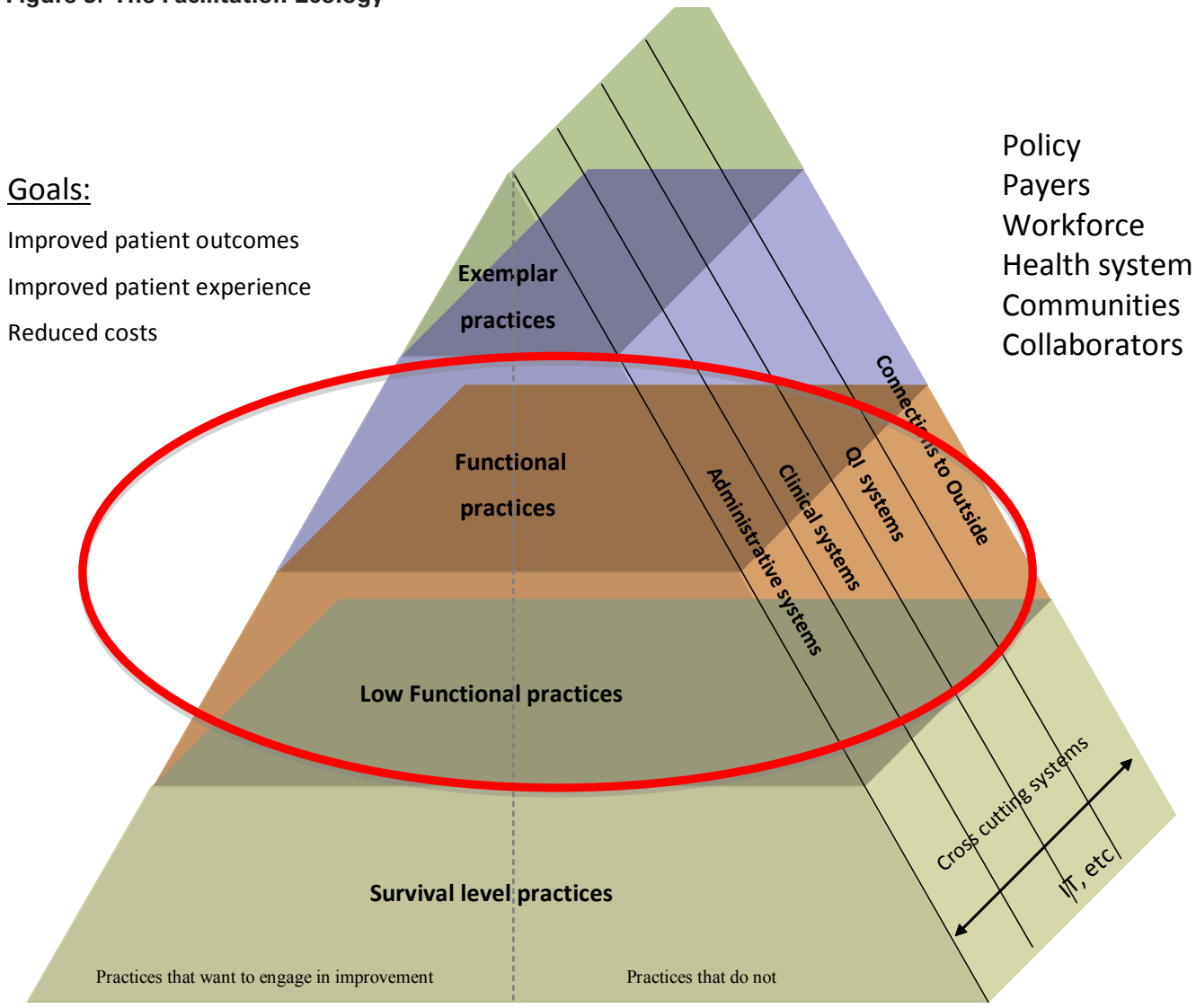
A handful of problems commonly faced while implementing a quality improvement program are noted below. Many of the 'deal compromisers' can be managed with good communication and a bit of planning between the practice facilitator and the team. There should be a person within the practice that is tasked with acting as the day-to-day leader of the transformation effort. Many times, competing priorities, communication issues and staff transitions become problematic when this day-to-day leader has not been clearly identified or given sufficient authority to enact changes. Problem solving between the coach and the on-site leader can be fruitful, and a good coach can engage leadership when necessary.

Figure 2: Examples of Common Barriers to Effective Quality Improvement

Deal Compromisers	Deal Breakers
New CEO/COO/CMO doesn't understand the effort	New CEO/COO/CMO not interested in the QI effort
Nurse/MA/QI coordinator quits/goes on maternity or sick leave	IT division unwilling to help gather data or support registry technology
Organization decides to implement electronic health record	Double data entry required to track population data
No computer expertise on team	MD/NP/clinical leader not on board with QI effort
Clinic sold/bought by new company	Team won't start effort without new monies
MD leaves practice	Cost-cutting strategies target frontline teams
Cost-cutting strategies target QI personnel	Performance measurement burden is too great on team (especially cost data)
Joint Commission or other accreditation during QI effort	
Nurse/MA/other on team not onboard with effort, or resistance to change from one or more team members	
Scope of practice issues when assigning new team roles and responsibilities	

The 'deal breakers' often emerge in teams that were not ready for the intervention in the first place. Determining practice readiness is a critical first step to any effective quality improvement effort. Some example readiness assessments are listed in the Tools and Resources Section of this guide, but all place emphasis on having the support of leadership, basic functionality and sufficient resources to support the change, and a demonstrated ability to engage in the change process. A recent Practice Facilitation Consensus Panel outlined the Facilitation Ecology in Figure 3 to identify which practices are most likely to benefit from facilitation.[4] Neither the exemplar practices nor the practices struggling to survive are ideal candidates. To benefit from resource intensive practice facilitation, teams ultimately have to want – and be able – to change.

Figure 3: The Facilitation Ecology[4]



CONCLUSION

"Individual commitment to a group effort - that is what makes a team work, a company work, a society work, a civilization work." —Vince Lombardi, Head coach, the Green Bay Packers and the Washington Redskins

The role of a practice facilitator in an improvement effort is varied and depends on the needs of each site and the scope and scale of the improvement being tried. It is important for the coach to not only be able to identify those needs but also be able to maintain the vision of success when things get really challenging. In the end, a coach isn't the one who is going to make the transformation happen in a practice site, but the coach can and often is instrumental in making sure that the team at the site is prepared, motivated, and tenacious in their effort to succeed.

TOOLS AND RESOURCES

Websites, Manuals, Training

MacColl Center for Health Care Innovation: Coaching Manual which includes a literature review, interview with 20+ facilitators, approach to coaching, tools www.improvingchroniccare.org

Institute for Healthcare Improvement (IHI): Year-long training program for people interested in becoming coaches www.ihi.org

Improving Performance in Practice: RWJF-funded coaching program in six states www.ipipprogram.org

LA Net: A Practice-Based Research Network currently leading an AHRQ-funded initiative to better understand coaching www.lanetpbrn.net

Dartmouth Clinical Microsystems: Manuals and trainings available for those interested in improving facilitation skills www.clinicalmicrosystem.org

Quality Improvement and Innovation Partnership (QIIP): Quality Improvement Coach Tools and Resources www.qiip.ca/coach.php

Assessing Practice Readiness for Facilitation

Organizational Readiness for Change (ORC)
Lehman, W.E.K, JM Greener, DD Simpson. Assessing Organizational Readiness for Change. *J Subst Abuse Treat.* 2002;22(4):197-209

Learning Teams for Reflective Adaptation (ULTRA) readiness survey
Ohman-Strickland PA, John OA, Nutting PA, et al. Measuring organizational attributes of Primary Care Practices: Development of a New Instrument. *Health Serv Res.* 2007; 42(3 Pt 1):1257–1273.

Predicting Outcomes of Org Change Survey
Gustafson DH, Sainfort F, Eichler M, et al. Developing and testing a model to predict outcomes of organizational change. *Health Serv Res.* 2003;38(2):751-776.

Suggested Citation:
Safety Net Medical Home Initiative. Van Borkulo N, Coleman K. A Practice Facilitator's Guide to Visiting Clinical Teams. 1st ed. Qualis Health and the MacColl Center for Health Care Innovation; Seattle, WA: February 2011.

References:

[1] Safety Net Medical Home Initiative. Change Concepts for Practice Transformation. Qualis Health and the MacColl Center for Health Care Innovation; Seattle, WA: April 2010. click here. Accessed March 2011.

[2] Personal communication with Darren DeWalt MD MPH. Improving Performance In Practice. April 2009.

[3] Baskerville N. *Systematic Review of Practice Facilitation and Evaluation of a Chronic Illness Management Tailored Outreach Facilitation Intervention for Rural Primary Care Physicians* [dissertation]. Ontario: University of Waterloo; 2009. http://uwspace.uwaterloo.ca/handle/10012/4298. Accessed January 2011.

[4] Knox L. LA Net: Practice Facilitation. Slides presented at: 2010 Practice Facilitation Concensus (Coaching) Meeting; Los Angeles, CA. http://www.lanetpbrn.net/practice-facilitation-resources. Accessed January 2011.

[5] McGinnis P, Davis M, Coleman K, Van Borkulo N. Slides presented at: North American Primary Care Research Group Annual Meeting Breakout session on Coaching Practices to Become Medical Homes; November 16, 2010; Seattle, Washington.

[6] Coleman K, Pearson M, Wu S. A practice coaching manual. In: *Integrating Chronic Care and Business Strategies into the Safety Net.* Rockville, MD: Agency for Healthcare Research and Quality. Publication NO. 08-0104-EF | Contract No./Assignment No: HHSA2902006000171;2009. http://www.ahrq.gov/populations/businessstrategies/businessstrategies.pdf Accessed January 2011.

[7] Hackman JR, Wageman R. A theory of team coaching. *Acad Manag Rev.* 2005;30(2):269-87.

[8] Stetler CB, Legro MW, Rycroft-Malone J, et al. Role of "external facilitation" in implementation of research findings: a qualitative evaluation of facilitation experiences in the Veterans Health Administration. *Implement Sci.* 2006;1:23.

[9] Cohen D, McDaniel RR, Crabtree BF, et al. A practice change model for quality improvement in primary care practice. *J Healthc Manag.* 2004;49(3):155-68.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

QUALIS HEALTH

THE COMMONWEALTH FUND

GroupHealth

MacColl Center for Health Care Innovation