Change Agents in Action: Lessons Learned from Leading Primary Care Practice Facilitation Programs

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Goals
Outline

- Overview of practice facilitation programs
  - Highlight AHRQ’s *Guide to Developing and Running a Primary Care Practice Facilitation Program*

- Lessons learned from leading programs
  - Highlight new *Case Studies* series

- Insights from leaders
  - North Carolina
  - Vermont

- Questions and dialogue
Revitalizing the nation’s primary care system is foundational to achieving AHRQ’s mission of improving the quality, safety, efficiency, and effectiveness of health care for all Americans.
The PCMH is a model for renewed primary care

- Built on the fundamentals of primary care
- Supported by structures and processes for delivering the fundamentals
- Recognizing the need for sustainable resources
A primary care medical home is not simply a place but a model of primary care that delivers the care that is:

- Patient-Centered
- Comprehensive
- Coordinated
- Accessible, and
- Continuously improved through a systems-based approach to quality and safety

AHRQ believes that Health IT, workforce development, and payment reform are critical to achieving the potential of the medical home.
Supporting Primary Care Transformation

- Creating Capacity for Improvement in Primary Care: The Case for Developing Quality Improvement Infrastructure
- Building Quality Improvement Capacity in Primary Care
Four Key Tools

- Data, feedback, and benchmarking
- Practice facilitation (or coaching)
- Academic detailing / Expert consultation
- Shared learning and learning collaboratives
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Practice Facilitation programs utilize all four
What is Practice Facilitation?

- PF is one way to support medical practices in their ongoing efforts to redesign and transform primary care.
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- PF services are provided by trained individuals or teams, using a range of QI and practice improvement approaches.
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- PF is one way to support medical practices in their ongoing efforts to redesign and transform primary care.
- PF services are provided by trained individuals or teams, using a range of QI and practice improvement approaches.
- These services are designed to build the internal capacity of a practice so it can achieve both practice transformation and ongoing QI goals.
In 2012, AHRQ brought together folks who were using practice facilitators and running practice facilitation programs to share their experiences.

Distilled wisdom captured in a How to Guide aimed at organizations, a series of webinars, and a national newsletter and users group.

PCMH.AHRQ.Gov -- Practice Facilitation
Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide
## Chapters and Key Topics

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In 2013, AHRQ published the series, *Case Studies of Leading Primary Care Practice Facilitation Programs*, to complement the How to Guide.

- 10-12 page detailed descriptions each of four programs:
  - NC AHEC Practice Support Program
  - Oklahoma Physicians Resource/Research Network
  - The Safety Net Medical Home Initiative
  - Vermont Blueprint’s Expansion and QI Program (EQuIP)
Lessons Learned

- Effective facilitations hinges on strong relationships.
- Facilitation alone is not sufficient for practice change, it should be combined with feedback, academic detailing, and peer learning opportunities.
- Learning communities are valuable not only to practices, but also to facilitators.
Lessons Captured

- Lessons Learned from Leading Models of Practice Facilitation
  - Lessons on Administrative Infrastructure
  - Lessons on Designing PF Interventions
  - Lessons on Training Facilitators
  - Lessons on Assessing Effectiveness
Hearing from the Experts

- Ann Lefebvre MSW, CPHQ
  Associate Director
  NC AHEC

- Jenney Samuelson, MS, MCHES
  Assistant Director
  Vermont Blueprint for Health, Department of Vermont Health Access
The NC AHEC Program

- Employs over 1500 people across NC
- NC AHEC residencies (over 3000 MDs)
- Student housing (over 10,000 a year)
- Continuing education activities (over 200,000 health professionals a year)
- Health Careers and Workforce Diversity
- Practice Support Services (Regional Extension Center and IPIP)
Practice Support Services Provided

Paper Charts
- Learn how to:
  - Assess the needs of your practice in an EHR system.
  - Redesign your paper practice to ready for an EHR.

Electronic Health Records
- Learn how to:
  - Select a certified EHR that meets your needs.
  - Implement an EHR for optimal use in your practice.

Meaningful use of HIT
- Learn how to:
  - Use your EHR to meet the federal requirements for the HITECH Act Meaningful Use Incentive Payments from Medicare or Medicaid.

Improved Clinical Outcomes
- Learn how to:
  - Produce population-based reporting to test the efficacy of your care.
  - Use proven methods and techniques to improve the outcomes of your patients.

Patient Centered Medical Home
- Learn how to:
  - Meet the requirements of the NCQA Recognition program for PCMH.
  - Approach the PCMH application process with improvement techniques.
Nine Teams of Experts

QI Consultants
Systems Specialists
TA Specialists

North Carolina AHEC
creating a better state of health
Chart is placed at vitals station

Patient is called to vitals station

H,W,BP Taken & recorded

Patient is taken to exam room

Chart is placed in sleeve on exam door

How many vitals stations?

How often do we room without vitals?

Are cuffs and scales available in rooms?

How many BPs do we miss?

Where are the data?
Key Driver Diagram for NC AHEC Practice Support Program

Improved clinical outcomes

Measures of success:
- Diabetes:
  - \( \geq 70\% \) BP < 130/80
  - \( \geq 70\% \) LDL < 100 mg/dl
  - \(< 5\%\) A1c greater than 9.0%
  - \( \geq 80\%\) received dilated eye exam
  - \( \geq 90\% \) tested (or treated) for nephropathy
  - \( \geq 90\% \) counseled to stop tobacco use
- Asthma:
  - \( \geq 90\% \) control assessed
  - \( \geq 90\% \) with persistent asthma on anti-inflammatory medication
  - \( \geq 90\% \) with influenza vaccination
  - \( \geq 75\% \) with assessment of control + anti-inflammatory + influenza vaccination
- Hypertension:
  - \( \geq 90\% \) BP < 140/90

Ischemic Vascular Disease
- \( \geq 70\% \) LDL < 100 mg/dl

Smoking and Tobacco Cessation
- \( \geq 90\% \) assessed
- \( \geq 90\% \) counseled

Clinical Information System
- Identify each affected patient at every visit
- Identify needed services for each patient
- Recall patients for follow-up

Planned Care
- Care Team is aware of patient needs and work together to ensure all needed services are completed

Standardized Care Processes
- Practice-wide guidelines implemented per condition (asthma, diabetes)

Self-Management Support
- Realized patient and care team partnership

Implement Electronic Database
- Determine staff workflow to support
- Populate EHR with patient data
- Use EHR for routine documentation
- Use EHR to manage patient care & support population management

Use Templates for Planned Care
- Select template tool from EHR or build customized template
- Determine staff workflow to support template
- Use template with all indicated patients
- Ensure template contains clinical decision support
- Monitor use of template

Employ Protocols
- Select & customize evidence-based protocols for disease state
- Determine staff workflow to support protocol, including standing orders
- Assign team-based care wherever possible
- Use protocols with all patients
- Monitor use of protocols

Provide Self-Management Support
- Obtain patient education materials
- Determine staff workflow to support SMS
- Provide training to staff in SMS
- Set patient goals collaboratively
- Document & monitor patient progress toward goals
- Link with community resources and care management
Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act, Plan, Study, Do

Percent of Asthma Patients with Flu Vaccine

- Reminders to patients
- Flu vaccine clinics
- New flow sheet
-Reviewed documentation guidelines/flowsheet
Additional Incentives

- Blue Quality Provider Program (BQPP)
- Maintenance of Certification Part IV
- PI CME (20 hours of cat 1 CME per year)
- Peer Networking
- Access to Practice Based Research and national leaders
- Digital Library Services
Future Practice Needs

- MU Stage 2
- PCMH Initiatives
- Payer Initiatives
- Gov. Payment Programs
- ACOs
- Payer Profiling
- ICD 10

Year 2012
Year 2013
Year 2014
Year 2015

System Implementation
System Improvements
Vermont Blueprint for Health: Expansion and Quality Improvement Program

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Major Components of Blueprint

• Advanced Primary Care Practices (PCMHs)
• Community Health Teams
• Community Based Self-management Programs
• Multi-insurer payment reforms
• Health Information Infrastructure
• Evaluation & Reporting Systems
• Learning Health System Activities
Blueprint Advanced Primary Care Practices

- Multi-disciplinary quality improvement team
  (Continuous QI & NCQA PCMH recognition)

- Seamless coordination of care
  (CHT development)

- Information technology
  (DocSite/VITL interface)
Patient Centered Medical Homes and Community Health Team Staffing in Vermont

*Since joining the Blueprint, three practices have combined to form a new practice, one practice has joined an existing practice, and one practice has closed.*
Community Health Teams

- Multi-disciplinary support for PCMHs & their patients
- Work locally in communities and directly with practices
- Functionally integrated into the practice setting
- Team is scaled based on the # patients in the PCMHs they support
- Core resource that is readily available to patients based on need
- The ‘glue’ in a community system of health for the general population
Continuum of Health Services

Higher Acuity & Complexity

Level of Need

Lower Acuity & Complexity

Advanced Primary Care Practice

- Health Maintenance
- Prevention
- Access
- Communication
- Self Management Support
- Guideline Based Care
- Coordinate Referrals
- Coordinate Assessments
- Panel Management

Community Health Teams

- Support Patients & Families
- Support Practices
- Coordinate Care
- Coordinate Services
- Referrals & Transitions
- Case Management
  - Medicaid Care Coordinators
  - Senior Services Coordinators
- Self Management Support
- Counseling
- Population Management

Specialized & Targeted Services

- Specialty Care
- Advanced Assessments
- Advanced Treatments
- Advanced Case Management
- Social Services
- Economic Services
- Community Programs
- Self Management Support
- Public Health Programs

Locus of Service & Support 34
Blueprint Integrated Pilots
Health Information Infrastructure

Central Registry
- Visit planners
- Care coordination
- Reporting

Core data elements

Medical Home

Hospital (hosted EMR)

data warehouse

Core data elements

FQHC (hosted EMR)

Medical Home

Core data elements

Medical Home EMR

Core data elements

Medical Home EMR

Medical Home EMR

Medical Home No EMR

Core data elements

VITL HIE

Core data elements

Central Clinical Registry (DocSite)

Community Health Team

Web Access

ADT
Financing

Medicaid
Medicare
BlueCross
MVP
Cigna
Self Insured

Payment Reform

Fee for Service (Volume)

$ PPPM - NCQA Score

“Phase 1”

Shared Costs

“Phase 2”

Delivery System Reform

Advanced Primary Care

NCQA Standards
Patient Centered Care
Access
Communication
Guideline Based Care
Use of Health IT

Community Support

Community Health Teams
MCAID CCs
SASH Teams

Specialized Services

Hospitals
Specialty Care
Mental Health Services
Substance Use Services
Family Services
Social Services
Economic Services
Long Term Care
Nursing Homes
Dynamics & Infrastructure for a Learning Health System

Integrated health services model, ongoing improvement & refinement

Supportive Core Data Dictionaries & Measure Sets

Data Capture, EMR Templates, Interfaces & HIE, Blueprint Registry, Chart Review, MPCD, other

Process Measures, Outcomes Measures, Models, Actionable Knowledge

Evaluation, Reporting Systems, Analytics, Simulations

Collaborative Learning, Site Level Facilitation & Coaching

Patient Centered Health Services

Guiding Legislation & Policy

Finance & Payment Reforms

Established Guideline & Measures

6/6/13
Practice Facilitation

- 13 Practice facilitators
- Diverse backgrounds
- Long term relationship with practices
- Focused on the interests of the practices
- Quality improvement support
- Assist with NCQA Patient Centered Medical Home recognition
Types of Support

- Consultation
- In practice facilitation
- Group learning activities
  - Collaboratives Current
    - NCQA Recognition
    - Asthma
    - Cancer
    - Medication Assisted Treatment for Opioid Addiction Training
Data is Critical for QI

- Electronic Health Record
- Central Clinical Registry
- Multi-payer Claims Database
- NCQA Scoring
- Patient Provider Qualitative Assessment
- Patient Experience
Where are we going next?
Questions and Dialogue
Thanks

- For more information on the resources discussed today, please visit:

PCMH.AHRQ.Gov