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Short Communication

A Framework to Guide Practice Facilitators in Building Capacity

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Abstract

The evidence base for the use of practice facilitators to assist ambulatory care practices in transforming care delivery is growing. While the role of the practice facilitator is still developing; it is showing promise as a beneficial delivery model to help primary care practices transform to meet the higher functioning demands of the US healthcare system. However, if applied poorly, the practice facilitator role may inadvertently add a layer of staffing to a practice as opposed to building the capacity of existing staff to learn new roles and skills. In this article, we describe a new diagnostic framework to assist practice facilitators in applying the most appropriate delivery mechanism for information needed to build a practice's capacity. The ultimate aim is for practices to create and sustain improvement in their care delivery.

ABBREVIATIONS

PCMH: Patient Centered Medical Home; AHEC: Area Health Education Centers

INTRODUCTION

The transformation of the primary care delivery model to target the triple aim of lower cost, higher quality and a beneficial patient experience is the cornerstone of the future of the US healthcare system. Yet, transforming busy practices in the midst of caring for patients in the current climate is very challenging. This is why "practice facilitation" has become an important strategy for spreading innovation, improvement, and redesign in ambulatory care settings.

Practice facilitation is a supportive service provided to a practice by a trained individual or team of individuals. In such facilitation, a range of methods is used to build the internal capacity of a practice to engage in improvement activities over time to reach both incremental and transformative goals [1]. Multiple studies have demonstrated the effectiveness of practice facilitation, especially in improving the implementation of evidence-based guidelines for prevention and chronic illness care [2-6].

Practice facilitators must continually work to move practices toward independence in using new roles and changes sustainably in their work. We refer to this move from dependence on the practice facilitator to independence "building capacity." A clear objective of building capacity in the practice must include plans for a gradual "weaning" of practices away from higher levels of support from the practice facilitator so that the practice, over time, will implement new concepts, models and techniques on their own [2-6].

In our experience, decision-making about the level of support needed in the practice can be quite complicated and is certainly nonlinear. Practices are strained by the demands of change in the healthcare environment. It is very hard for them to incorporate new roles and tasks. This may lead to considerable pressure on practice facilitators to perform basic tasks for a practice rather than developing a way for the practice to learn to perform the task for themselves. When this happens, the facilitator inadvertently adds a new layer of staffing to the practice as opposed to building the capacity of existing practice staff through the more thoughtful delivery of information.

To our knowledge, the extent of this problem in practice facilitation has not been studied. However, we observed these tendencies to "do for" frequently enough in our own practice facilitation programs to generate concern. In this article, we describe the framework we developed to address this concern and our experience with its application. Our goal is to promote discussions about a more unified model in practice facilitation to assure building capacity.

The challenges to building capacity

We observed challenges to building capacity at the practice level in multiple and diverse venues. One author (AL) is the director of the North Carolina Area Health Education Centers' (AHEC) Practice Support Program, one of the largest practice facilitation programs in the United States with more than 50 practice facilitators. These facilitators have worked with more than 1300 primary care practices from diverse settings, ranging

from small independent practices with 1 – 2 physicians to larger practices with as many as 92 physicians, which were part of integrated health systems. The remaining authors (NB, CS) have worked with the Institute for Healthcare Improvement (IHI) on initiatives for ambulatory practice transformation. Over the course of three years (2010 – 2013), we served together as faculty for the Institute for Healthcare Improvement's professional development program for facilitators of primary care practices.

Our consultation on many case situations brought by practice facilitators as well as a review of the literature identified at least three major factors that contribute to the complexity of the choices a practice facilitator must make when building the capacity for change in a practice setting. The three factors are: (1) the unique way the journey of transformation unfolds within each practice; (2) dynamics inherent within the process of helping or facilitating change; and (3) tendencies of consultants and coaches to favor certain interventions regardless of suitability at any given time for building capacity.

The first factor is based in growing evidence that the journey of transforming a practice to address all three aspects of the triple aim (lower cost, higher quality and a beneficial patient experience) is not linear. It is a long, multi-year journey with many challenges and the emergence of unexpected barriers. Trajectories of change vary widely across practices [3,6-15]. Even practices with a strong will for change and high readiness can go through difficult times. Relationship, leadership, staffing and structural issues can emerge which impede progress [7].

These challenges of transformation make for a demanding "on-the-ground" reality for practice facilitators. At any given moment, the practice facilitator has to make quick assessments within complicated interpersonal situations to find the best strategies to use to assist the practice. For example, in a distressed practice, we found that it is deceptively easy for even very experienced practice facilitators to fall into "doing tasks for" a primary care team. If performed routinely by the practice facilitator, this behavior could be detrimental to the goal of building capacity in the practice for this work. Yet, in certain situations, practices may temporarily benefit from the facilitator performing a particular task as a form of modeling or "jump starting" in order to get a new task off the ground or to gain respect or build rapport.

A second factor which complicates the choices of interventions by practice facilitators has to do with the inherent dynamics of being a helping professional. Researchers and experts who focus on the role of helping others have noted a strong, innate tendency for helping professions to get into the role of "fixing" (another form of "doing for"). This behavior can undermine sustainable change within a practice since the practice staff will not have built in the understanding or internal capacity to support the change or to improve it further once the practice facilitator has moved to a new practice setting. Fixing the problem for the practice does not promote the kind of self-motivation which drives shifts in habits and patterns of behavior that are necessary for the changes to be sustained over time [16-24].

Finally, the professional literature of organizational development and consulting has recognized that most consultants tend to favor certain interventions with which they feel most skilled, satisfied, or comfortable. (16 – 19, 24) Under stress and pressure, any facilitator could feel a pull toward such favored interventions and miss the implications for building capacity in a practice team.

The framework

The framework we developed to help practice facilitators manage the above complexities is comprised of five delivery methods. These methods provide guidance for practice facilitators in choosing how they can best deliver necessary information (concepts, models, techniques) during any visit to practices and at any time throughout their relationship with practices.

We elected to define and rank facilitator interventions based on the degree to which the practice is using their own process expertise (e.g. running a meeting) and/or content expertise (e.g. providing technical information or direction) (Figure 1). In general, in interventions ranked more to the left side of the continuum, the practice has less responsibility and the facilitator more responsibility for tasks—at the far left, the facilitator is "doing tasks for" the practice.

The ordering of interventions does not represent a set sequence for building capacity but is intended to raise the practice facilitator's awareness about their plan for interventions over time. The situation and resources at any given moment may necessitate moving farther to the left or right. But, in general, while interventions more to the left side of the continuum may be necessary at a given moment, staying with such interventions consistently over time raises the risk for undermining the building of capacity for the practice. This would limit the practice ability to create and sustain change on their own after the practice facilitator leaves. Likewise, in general, assuring more interventions towards the right of the framework over time makes it more likely the practice facilitator is building the capacity within the practice to sustain the work.

Definitions used in the framework come from existing literature and are as follows: [2–6,16–24].

Doing tasks for the team: Doing a specific technical task for a team and could include such actions as data entry, report generation, designing and implementing a PDSA cycle, creating tools, etc.

Facilitation: Offering expertise in managing a process for a practice team and could include planning, leading, and/or facilitating a meeting.

Consultation: Offering expertise about content and providing direct answers and/or guidance to the practice based on the facilitator's knowledge or experience.

Training: Offering content and/or process expertise via an educational model and in a structured way, which enables the practice team to apply the knowledge or tasks themselves and to learn as they go.

Coaching: Facilitating a team or individual to use their own content and process expertise to solve problems and make progress.

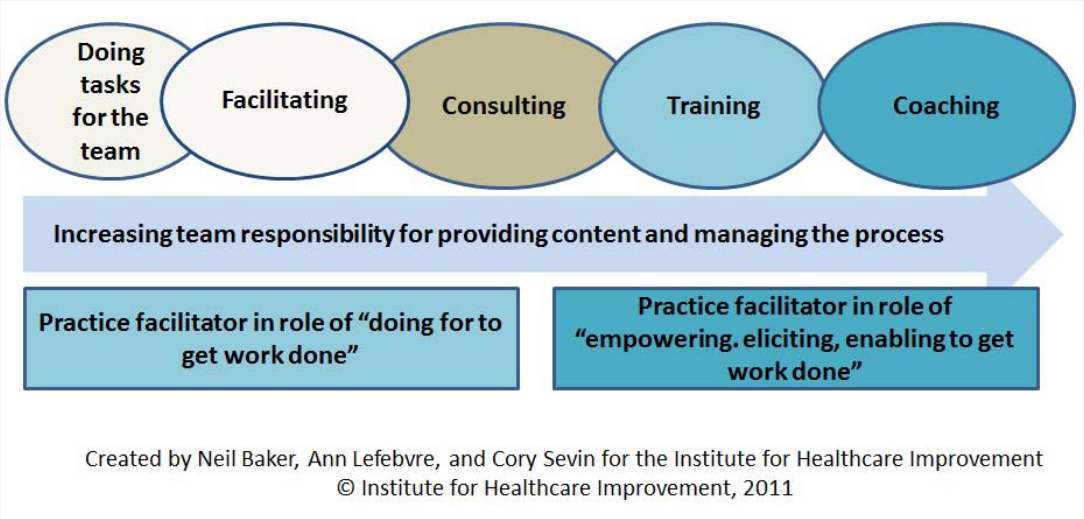

Figure 1 Framework for practice facilitator interventions.

Application of the framework

The framework was presented first in the North Carolina AHEC program in individual and group meetings with facilitators. In these discussions, the facilitators found the framework useful in validating ongoing pressures they felt from the practices for them to move to the left end of the spectrum of interventions. This may be due to practices' inability to take on this work or the practice facilitator's feeling of pressure to demonstrate his/her own knowledge and expertise by performing tasks for the practice.

Case example: The following case example illustrates how the application of the framework can help practice facilitators ensure that they are actively choosing, at any given time, the best delivery model for their interventions with practices.

Case: A small rural primary care practice with two providers and three staff wished to improve their patient health outcomes and transform to become recognized as a patient centered medical home (PCMH). The practice facilitator was contracted to visit the practice at least twice per month to help the practice team generate data about clinical outcomes and other related issues from the electronic health record. Based on this data, the practice would then test and implement changes to make improvements to their delivery systems. Also, the data would help practices apply for recognition as a PCMH. This particular practice facilitator was managing a caseload of 22 practices at that time.

For three months, the practice facilitator routinely worked with the electronic health record vendor to develop reports for the practice to use in their quality improvement meetings. She discovered that the practice often cancelled their quality improvement meetings because they did not have computer-generated data and often did not progress with testing changes to their care delivery system. She felt a lot of pressure to get the reports for the practice to use in order for them to engage fully with her services.

The practice facilitator perceived that persistent understaffing by the practice as well as a lack of knowledge on the part of the practice regarding their own electronic health record system had likely been a major driver of her taking on the tasks of generating the data reports for the practice. By referring to the framework for building capacity, the facilitator realized that her willingness to do the work for the practice might actually have become a barrier to the practice itself integrating change in a sustainable way.

The practice facilitator then developed a strategy for the practice to engage more in the work. In subsequent weeks, the practice facilitator trained the practice manager on pulling the data reports, facilitated calls between the vendor and practice manager, and conducted training with the entire practice to get their quality improvement meeting back on track.

Today, the practice no longer relies on the practice facilitator to do their work. Instead, they rely on the practice facilitator primarily as a consultant on specific questions about their implementation strategies or as a coach to help them integrate higher-level improvement techniques. The practice has seen an improvement in their clinical data and is very close to submitting the application to be recognized as a patient centered medical home.

DISCUSSION

In the case example, the practice facilitator initially chose helping actions toward the left end of the intervention framework. This "doing for" the practice seemed very productive and necessary and was appreciated by the practice at the time. However, by referring to the framework, the practice facilitator was able to identify that continued use of this intervention was quite likely undermining or slowing the process by not building the practice's internal capacity for transformation.

The framework has been a helpful guide in our work with practice facilitators in identifying and addressing problematic situations concerning the building of capacity within practices. However, use of the framework is still at an early stage. The data we have about its impact is anecdotal and experiential. More

experience and research is needed to substantiate its usefulness. In the interim, we strongly recommend that practice facilitators continually re-evaluate their choices of interventions in order to assure that the practices are fully supported in developing their capacity and processes to take on this work.

Our experience also suggests that more study is needed to ensure that the field of practice facilitation is continually geared towards supporting practices in building the capacity for creating and sustaining positive change rather than building yet another permanent and costly position within the practice setting.

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