Primary Care Practice Facilitation Curriculum

Module 6: An Overview of the Facilitation Process

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Primary Care Practice Facilitation Curriculum

Module 6. An Overview of the Facilitation Process

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Contents

Module 6. An Overview of the Facilitation Process

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge of facilitation process and purpose

Time

- Pre-session preparation for learners: 15 minutes
- Session: 60 minutes

Objectives

After completing this module, learners will be able to:

1. List the stages in a typical facilitation process and describe their purpose and content.
2. Name and describe three characteristics of effective facilitation.
3. Identify at least three frequently encountered challenges to improvement.

Exercises and Activities To Complete Before and During the Session

Pre-session preparation: Ask the learners to review information in item 1 (15 minutes)

1. The content of this module.

During the Session: Presentation (30 minutes)

1. Present key concepts from the module.
2. Hindmarsh M. Using self-management support in your coaching approach. QIIP Practice Facilitator Training; 2008 May 12-13; Toronto, ON. See Appendix 6.

Discussion: Ask questions and explore answers with learners (30 minutes)

1. What are the different stages of a facilitation intervention?
2. What challenges might you experience during the different stages of the facilitation process? Which stage do you expect will be easiest for you? The most difficult?
3. Discuss the Hindmarsh slide deck. Ask learners the following questions:

    a. In what ways are the 5 A's for self-management support applicable to practice facilitation?
    b. How does this change (or not change) your understanding of facilitation and the work you will be doing with practices?

Module 6.

Facilitators support change in practices by focusing a practice's attention on the process of change and by empowering members of the practice to engage in the change process together. They work to create an environment that supports continuous improvement and introduces values such as respect, inclusion, and neutrality, and where people feel they are involved in the decisionmaking process. Facilitators help demystify improvement methods, evaluation, and research and support data-driven and evidence-based decisionmaking and actions. They create opportunities for practices to learn from each other and help create communities of practice that bring together peers to share best practices and lessons learned. They use participatory methods and have expertise as adult educators and facilitators of change (Department of Health and Community Services, 2006).

Most facilitation interventions pass through a series of predictable stages. Figure 6.1 shows the six stages of most practice facilitation interventions.

Figure 6.1. Common stages in a practice facilitation intervention (Adapted from Knox, 2010)

Stage 1: Recruitment and Assessing Readiness

The first stage involves recruiting practices to participate in improvement and evaluating their readiness to engage in this work. This phase takes place before active facilitation starts and will typically involve you and other members of your program. It includes several activities:

- Inviting practices to participate in improvement work.
- Orienting practices to the concept of practice facilitation and what facilitators do.
- Conducting an assessment of the practice's readiness and ability to undertake the proposed improvement effort. Completing preliminary paperwork such as business associate agreements that will allow you to access clinical data for measuring and monitoring practice performance.
- Setting goals with the practice early.
- Identifying the champion for the improvement effort at the practice and beginning to build a working relationship with him or her.
- Identifying other practice members who will be key participants in the improvement work.
- Beginning the process of identifying an individual who might eventually be developed as an "internal facilitator" that you will work to train in core competencies of practice facilitation. Identifying this individual typically will take some time, but you should begin evaluating individuals in the practice for this role from day one.

Stage 2: Kickoff Meeting

Stage 2 is the launch of the formal intervention. Typically, it involves an initial meeting with the project champion, you, and other individuals from the practice whom the champion and practice leaders have identified as important to the improvement effort. In this phase, you will work with the project champion to identify his or her quality improvement (QI) team and help ensure that the team includes representatives of staff in operational areas that will help implement the desired improvements.

You will help convene and facilitate a kickoff meeting for the improvement effort and will work with the QI team to further define and refine the improvement goals identified during stage 1. In this meeting you will also work with the QI team to understand your role and goals as the facilitator or the roles and goals of your team if you use a team approach to facilitation. If the improvement project involves implementation of new treatments or care processes, you may also include a physician academic detailer (a peer from another practice who shares experiences and effective strategies) in the meeting.

Effective facilitation is based on effective relationships. You will need the trust and respect of the practice to succeed. Many of the strategies that salespeople use to develop and maintain customers can be useful as you get to know a new practice.

Keeping a card deck with information about each clinician and staff person in the practice can help you remember the preferences, concerns, and interests of the individuals with whom you will work. Creating a map of the practice and key locations within it can also help. As one expert says, "You'll know when you've established an effective relationship with a practice when they give you the combination to the back door."

Stage 3: Assessment and Goal Setting

During stage 3, you will work with the QI team to conduct an initial assessment of the practice in areas related to the improvement effort. You will help the team review and use these data to finalize their goals and performance indicators for the effort.

One of your roles will be to help the practice identify a few easy goals to begin with that can allow you and them to build skills in using the Model for Improvement (MFI) and Plan Do Study Act (PDSA) cycles to test and spread change. It also will help them use tools such as a key driver model (see Module 20) to focus on and select from among the thousands of changes possible those that are most likely to be "high yield" and lead to the greatest improvements for the practice and its patients.

During this stage, you will also continue to identify an individual or individuals in the practice who can be developed as "internal facilitators" to support the practice when the intensive work you are doing with the practice for this improvement effort is over. Throughout this and the following stages, you will work with this/these individual/s and the improvement champion and team to develop their knowledge, skills, and capacity for adopting new evidence and continually improving quality at the practice.

Stage 4: Active Facilitation

Stage 4 is the heart of the facilitation intervention. One of your earliest and most important jobs in this phase is to help practices build their capacity to generate performance data on the metrics that matter to them and their patients. For many, this step is uncomfortable at first. Clinicians and staff often resist performance reporting; afraid they or their practice will be singled out as underperformers. Most have legitimate concerns about the accuracy of the data that are used in performance reports.

During this stage, you will assist the practice in monitoring its progress toward its improvement goals by conducting monthly chart audits and other assessments and providing feedback to the QI team on the results. To do this, you will need to know how to access data from registries and different electronic health record (EHR) systems, as well as how to conduct paper chart audits. You will need to know how to manage and conduct simple analyses of data, and you will need to have a solid understanding of the role of denominators and numerators in performance reporting.

Another important activity you will engage in during this stage is workflow mapping. You will map existing workflows and assist the QI team and practice to redesign various workflows to support desired improvements. You will train the team in the MFI and assist them in designing

and carrying-out PDSA cycles to test changes. (See Module 8.) You will train staff and clinicians on key change concepts, provide support and training to staff to build skills and knowledge for assuming new roles or activities, and engage expert consultants and academic detailers to provide additional support, training, and mentoring when needed.

You will work with the EHR and registry managers to create reporting systems designed to monitor performance in the targeted areas. In addition, you will work with them to introduce modifications to the practice's EHR and related workflows to support care innovations such as panel management and use of care teams. When you and the practice's IT staff cannot produce the desired modifications, you will help the practice engage their vendor or will add facilitators with expertise in EHR optimization to your team. The additional facilitators can provide technical assistance to the practice in this area.

You will work with the QI team and your "internal facilitator" to build knowledge, skills, and practice systems to support improvement work, and help keep them and the practice on track with the improvement work and ensure that it does not get lost in the crush of busy workweeks. You will help convene meetings and ensure that they are well facilitated, help the practice create systems for holding team members accountable for deliverables, and help manage and mediate conflicts and disagreements that often arise during change.

Finally, you will work with members of the practice to incorporate a new language of change into their day-to-day vocabulary that reinforces their commitment to continuous improvement and the changes and gains that have been made. For example, when a practice successfully makes a change, you can encourage the use of statements such as "This is the way we do business in our practice" that reinforces that change. You will also want to work with the practice to implement a language of possibility for future changes. For example, encouraging them to say, "we haven't made that improvement 'yet'" rather than "we haven't improved." The language a practice uses helps shape its culture and actions. Helping practices adopt a language of change is an important part of creating organizations with a culture of continuous quality improvement.

Stage 5: Holding the Gains

Once a practice has achieved its desired changes, attention will drift to other issues. Your job in stage 5 will be to assist the QI team and practice leadership to maintain their gains by creating the conditions needed to sustain the changes long term. You will help them continue performance monitoring and determine how the performance data will be used to ensure that the changes are sustained. You will work with them to incorporate the changes into the practice's or organization's policies and procedures, job descriptions and evaluations, and staff orientation and training.

Stage 6: Completion and Transition to Maintenance

While most active facilitation interventions last for less than a year, a priority of your work should be to establish a long-term relationship with your practices. Your ability to achieve this

relationship will be determined by your program and by available funding. But the promise and power of practice facilitation lies in the relationships facilitators establish with their practices and the fact that these relationships remain in place over time. Long-term relationships enable a facilitator to rapidly and efficiently re-engage with a practice as needed to support implementation of newly developed treatments, guidelines, and models of care.

In the final stage of an active intervention with a practice, you will focus on closing out the existing improvement intervention and ensuring that:

- the practice has access to all the resources and tools engaged to support the improvement work,
- the practice develops a clear and empowering narrative or "story" about the improvement effort that it can incorporate into its history and organizational memory, and
- the QI team and practice at large have an opportunity to reflect on and react to this story.

Finally, you will work with the practice to transition from active facilitation to maintenance where you will no longer work with the practice on a regular basis, but instead will check in once every 3 to 4 months. To do this, you will work with the individual/s you have been training to serve as internal facilitators and the QI team to identify the next set of goals that they may want to work on, which should include continued monitoring of the improvements recently put in place. In an ideal scenario, you will have had a chance to provide sufficient training to the "internal facilitators" so that you can step back and allow them to facilitate these discussions and decisionmaking processes for the QI team with support from you only as needed.

Finally, you should create a means of maintaining a relationship with the practice while they are not part of an active facilitation effort. This might involve sending periodic emails to the QI team, or if appropriate, engaging them to participate as academic detailers or "exemplars" to another practice that is in active facilitation. You also could drop by every few months to check in.

Note: this module is based on Module 3 of the Practice Facilitation Handbook. Available at https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html

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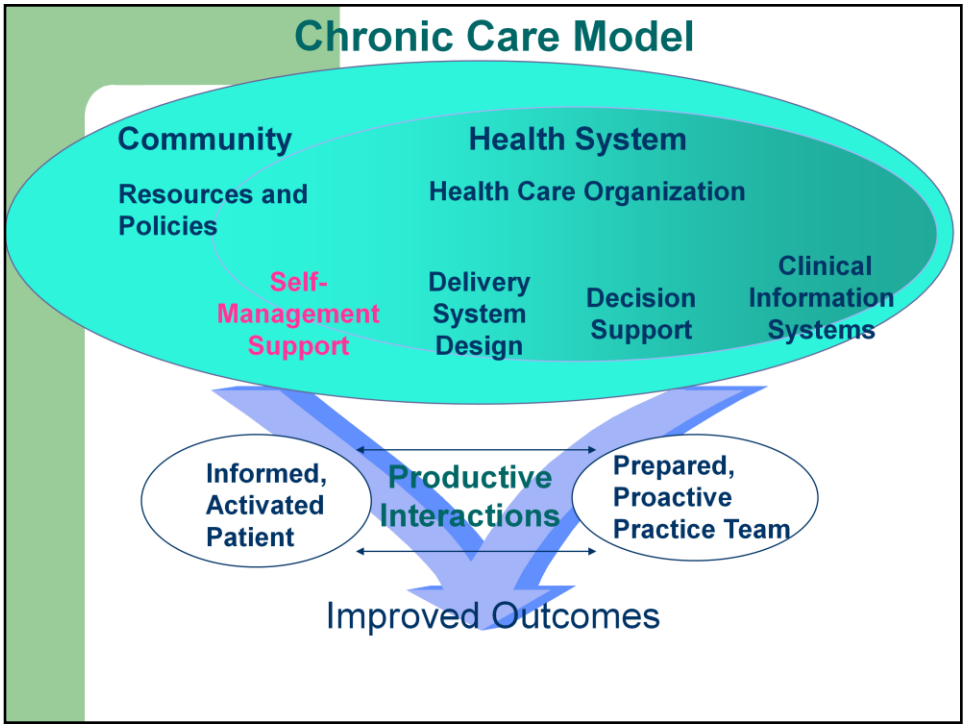
Department of Health and Community Services, Government of Newfoundland and Labrador. Guiding facilitation in the Canadian context: enhancing primary health care. St. John's, Newfoundland: Department of Health and Community Services; 2006.

Knox L, ed. Report on the AHRQ 2010 consensus meeting on practice facilitation for primary care improvement. (Prepared by LA Net under Contract No. HHSA2902007100110.) Rockville, MD: Agency for Healthcare Research and Quality; 2010.

Appendix 6


Using Self-Management Support In Your Coaching Approach
Mike Hindmarsh
Hindsight Healthcare Strategies
QIIP Practice Facilitator Training
May 12-13, 2008
Toronto, ON

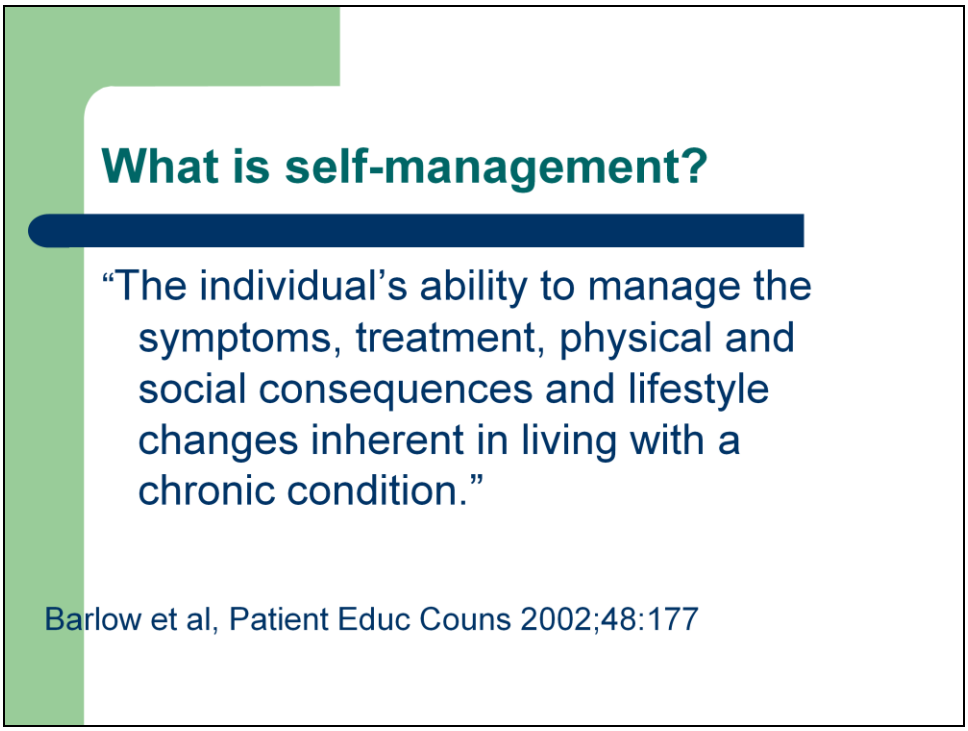


Wagner EH, Davis C, Schaefer J, Von Korff M, Austin B. A survey of leading chronic disease management programs: Are they consistent with the literature? *Managed Care Quarterly.* 1999;7(3):56-66.
Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA* 2002 Oct 16; 288(15):1909-14.
Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A., Improving chronic illness care: translating evidence into action. *Health Aff* (Millwood). 2001 Nov-Dec;20(6):64-78.

Bodenheimer, Lorig, Holman, and Grumbach Patient self-management of chronic disease in primary care. JAMA 2002;288:2469-2475

Glasgow, Davis, Funnel and Beck, in submission

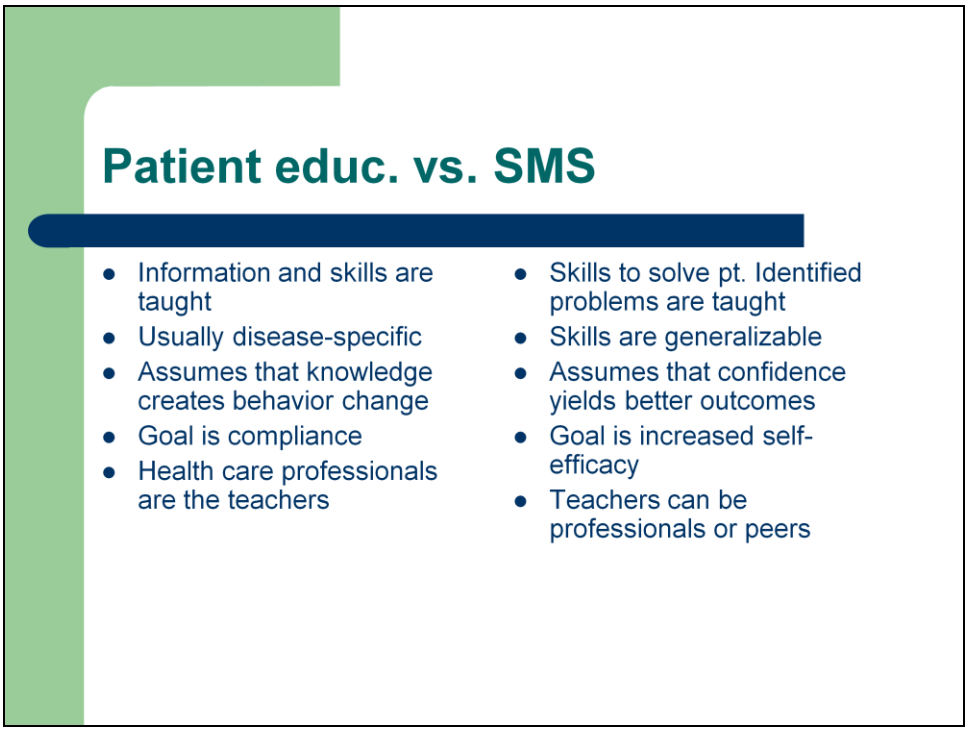
Whitlock et al. Evaluating Primary Care Behavioral Counseling Interventions: an Evidence-based Approach



Barlow goes on to say:

Efficacious self-management encompasses ability to monitor the condition and to effect cogitive, behavioral and emotional responses necessary to maintain a satisfactory quality of life.

It is a dynamic, continuous process of self-regulation.



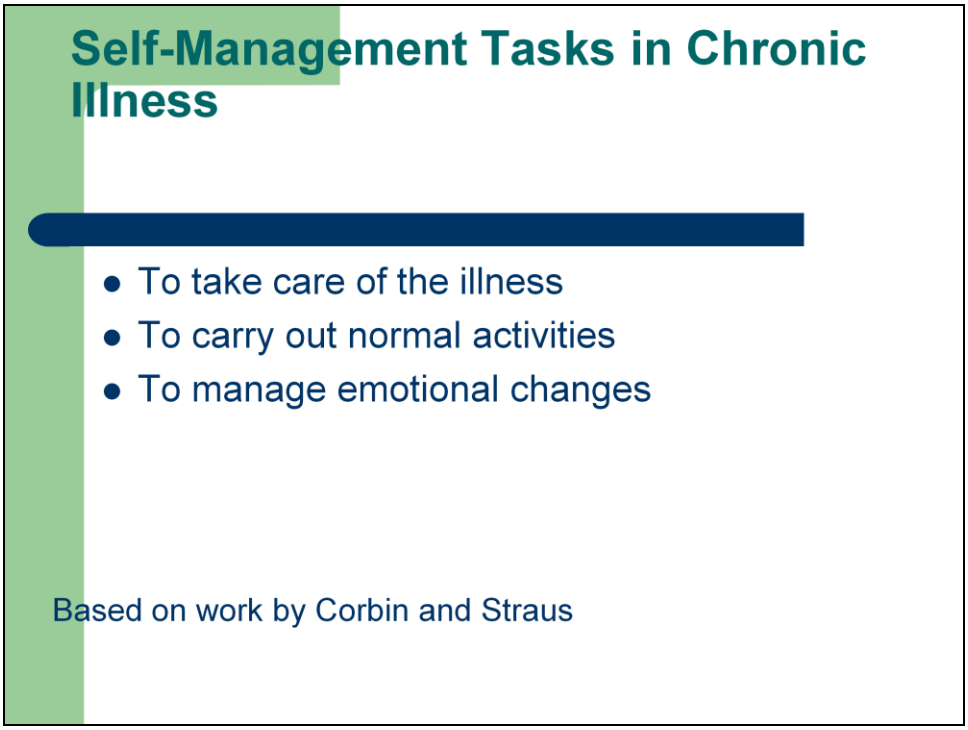
Both patient education and SMS are necessary.

Some aspects of patient education work well, some do not. Information is necessary and skills must be taught.

Knowledge does not create behavior change, and compliance is not a useful goal.

Adapted from Bodenheimer, JAMA 2002;288:2469

Norris et al. Effectiveness of self-management training in type 2 diabetes, Diabetes Care 2001;24:561-587.



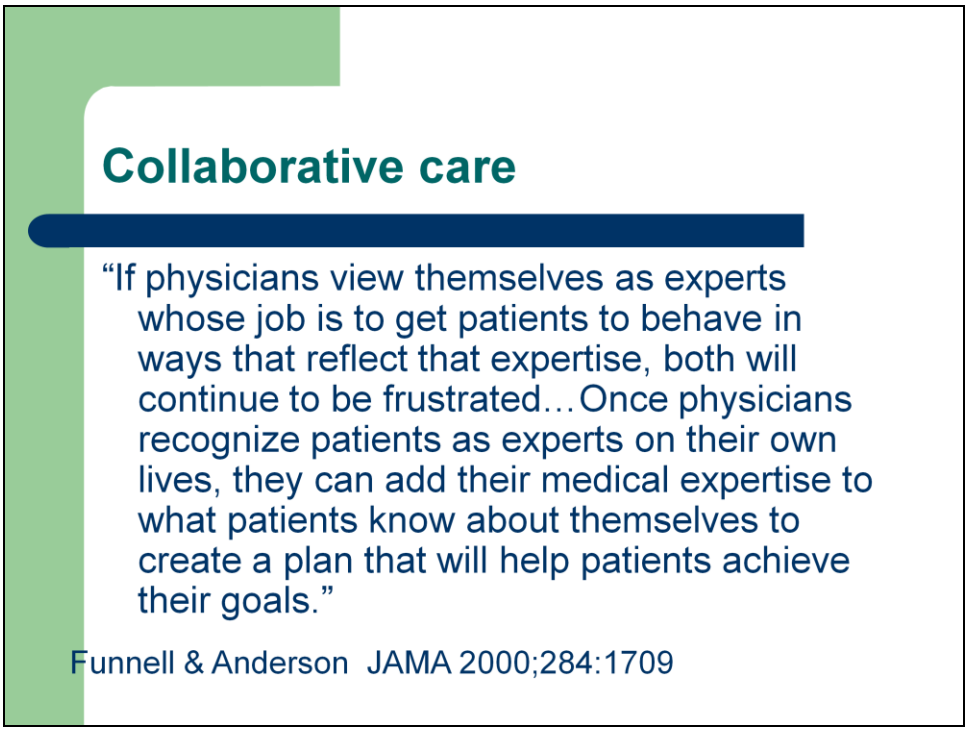
Take care of illness means handling medical management such as taking medication, changing diet, or self-monitoring.

Carrying out normal activities means creating and maintaining life roles, such as job, family, friends (how do I manage working night shift with diabetes? How do I play soccer and keep my asthma in control?)

Emotional changes are most frequently anger, fear and frustration, often depression. Changes view of future and relationships with others.

When you are interacting with a patient, or designing a system to support self-management, consider if you have touched on every task.

Corbin J, Strauss A. Unending work and care: managing chronic illness at home. San Francisco, Jossey Bass, 1988

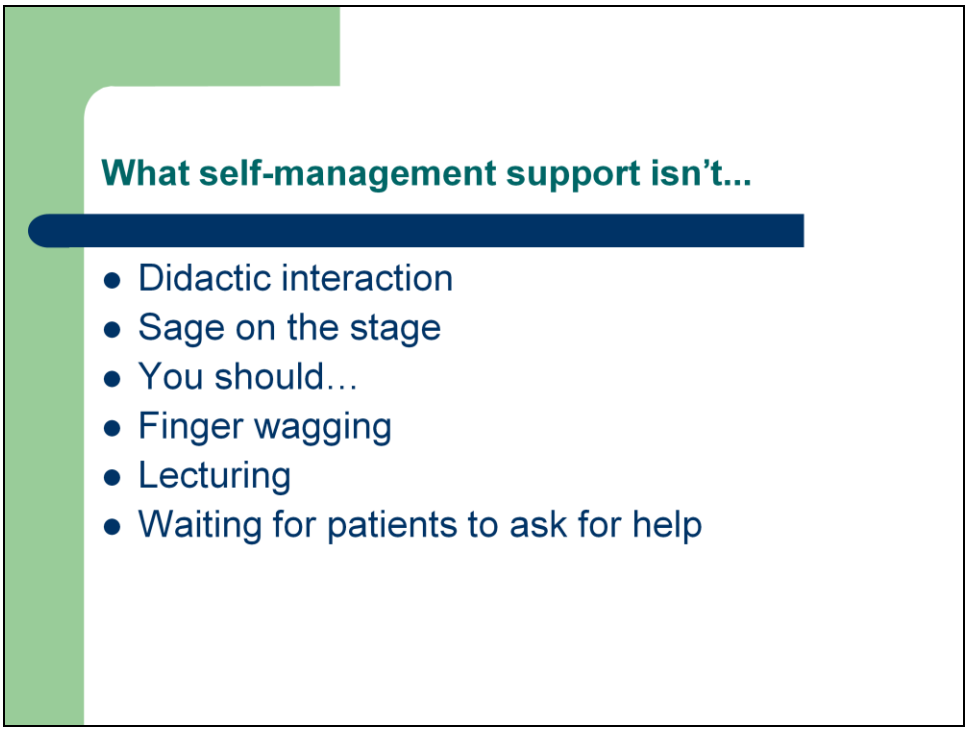


This describes the patient empowerment philosophy.

Need interaction of clinician's ideas and patient's ideas.

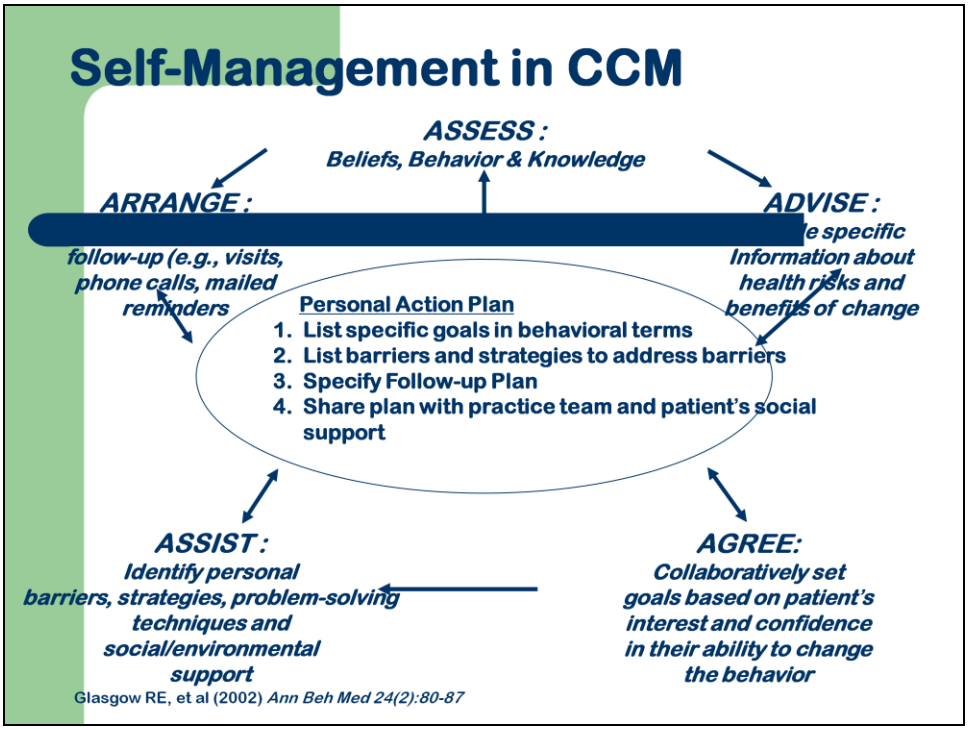
Professionals may blame pts for poor outcomes, attribute it to noncompliance, denial.

If we accept that pts define their problems, compliance and adherence aren't relevant concepts.



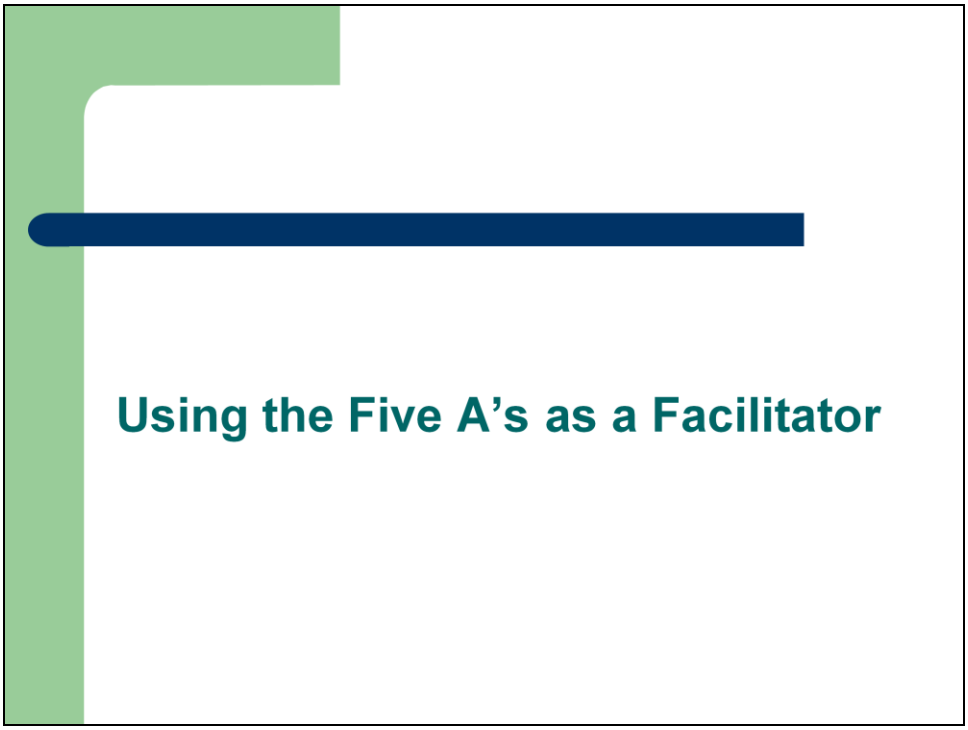
Not sage on the stage, but the guide on the side (Karen Artz)

Source: ICIC

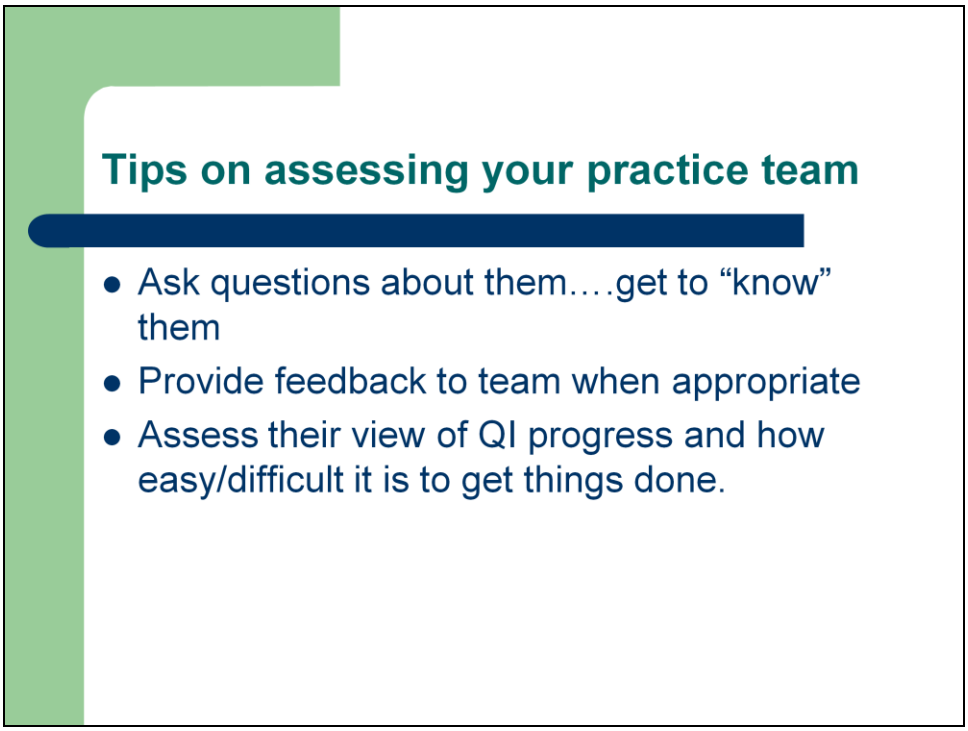


One way to make sure that you are using effective strategies is to incorporate the 5 A's into care.
Assess, Advise, Agree, Assist, Arrange.
This diagram draws on the 5 A's that some of you may be familiar with from smoking cessation brief counseling.
(Start at the top and go around the figure, reviewing each A.)
The central activity is the creation of a Personal Action Plan.

Glasgow RE, et al (2002) *Ann Beh Med 24(2):80-87*


Using the Five A's as a Facilitator

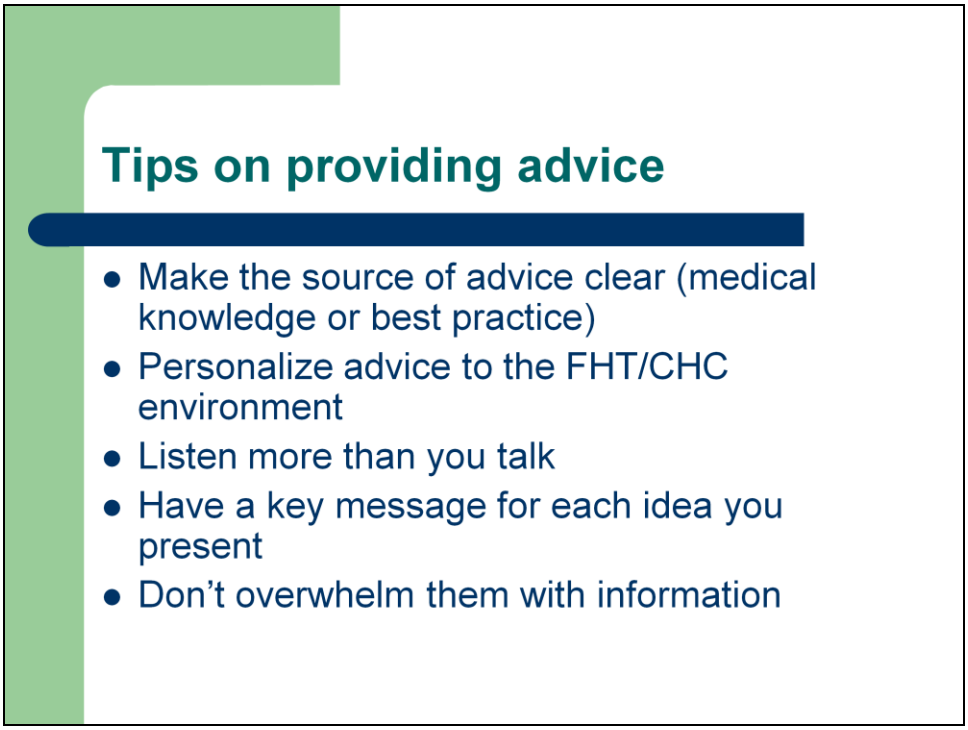
Now we will look at each of the A's in succession. They will help us organize our efforts in self-management support.



Here are some tips to consider during assessment.

Many of the patient choices are behaviors, but some are also attitudes about their illness.

The second A is Advise.

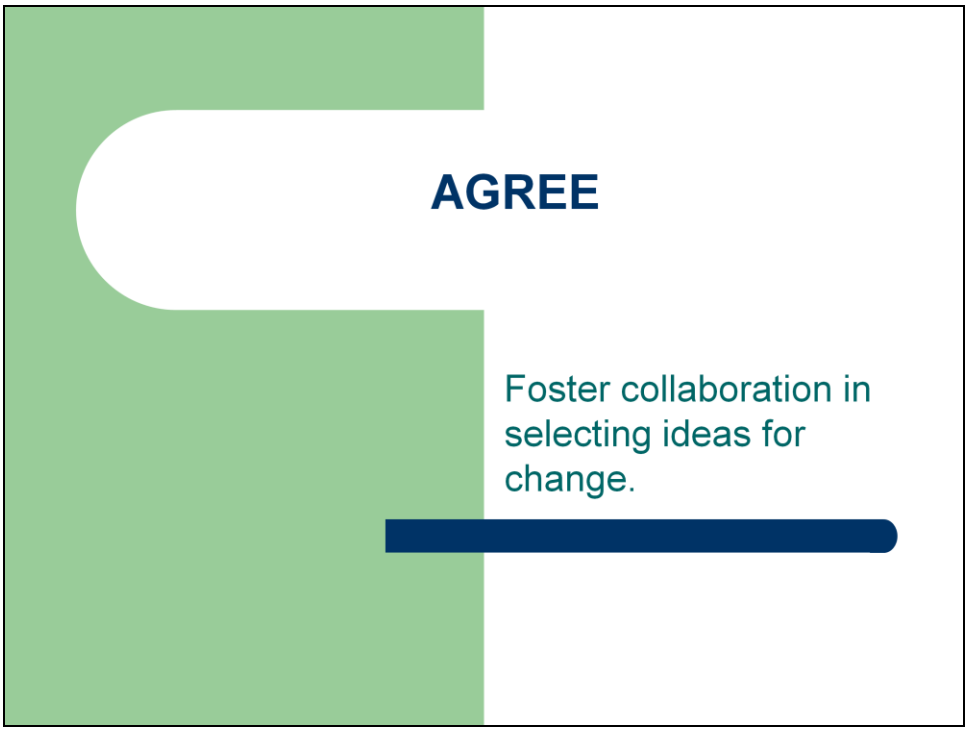


It is important to clarify what kind of information you are providing. Regarding clinical care, remember techniques from shared decision making. If it is in relation to some lifestyle decision, patients like to hear information from patients like them.

There is much evidence that supports the power of physician advice. (see Whitlock for refs)

One example of personalizing lab values is to graph them. For people with diabetes, draw a body with areas to put in their HbA1c, BP, microalbumin, eye exam, etc. Help patients understand how their choices influence their health status, for example how regular exercise contributes to better function for people with arthritis, or how trying new things contributes to a sense of confidence.

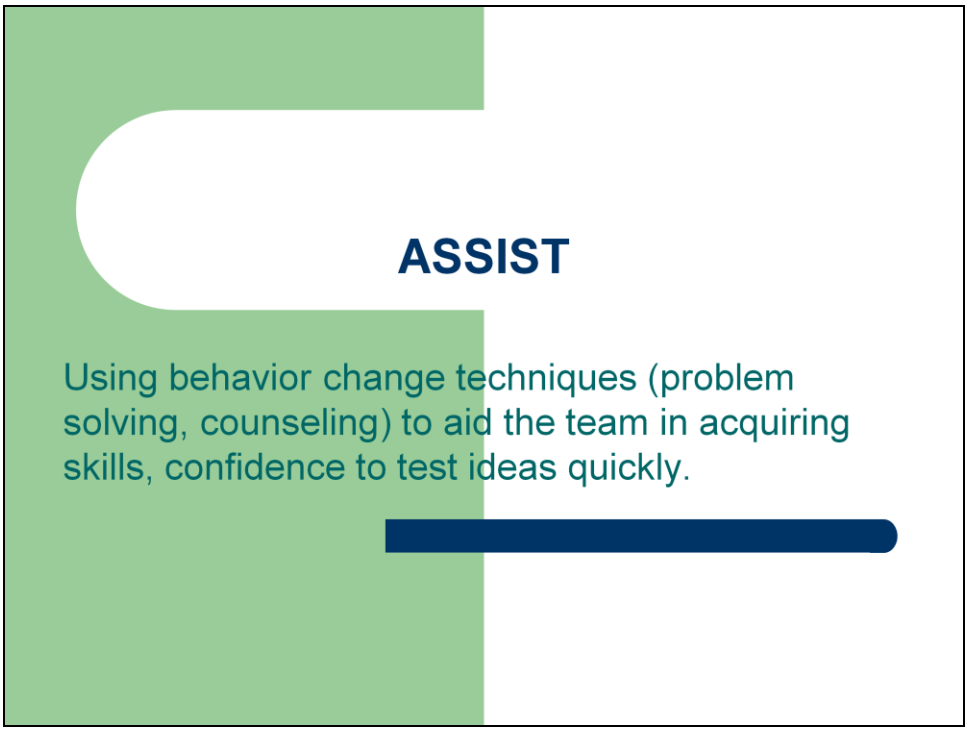
Source, Glasgow et al in submission



The third A is Agree.

Remember the goal is the patient's and we want them to be successful. Often the goal or plan does not seem related to the chronic illness from our point of view, but to the patient they make sense. Sometimes patients choose something small or apparently peripheral to do, but with success, they will take on more challenging and specific things to try.

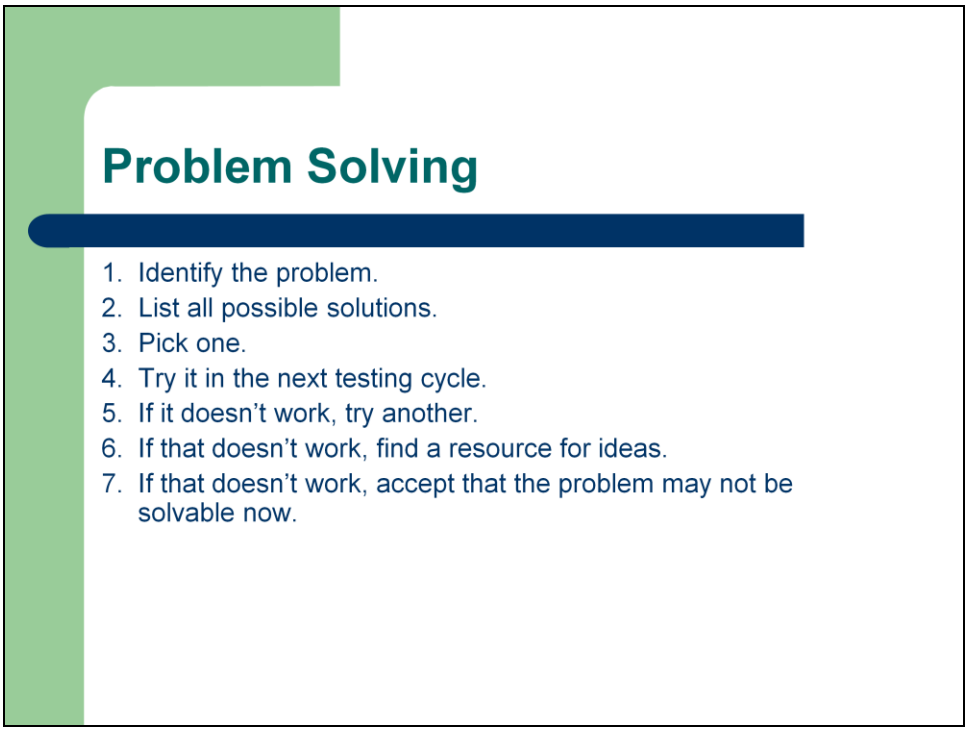
Source, Glasgow et al in submission



Agree and assist are the steps that lead to the creation of a personal action plan.

Tips on assisting patients

- Use other teams as examples
- Address helplessness
- Learn and use a problem-solving approach
- Link to the assessment of barriers and environment
- Avoid telling them what to do
- Avoid speeches
- Avoid cheerleading

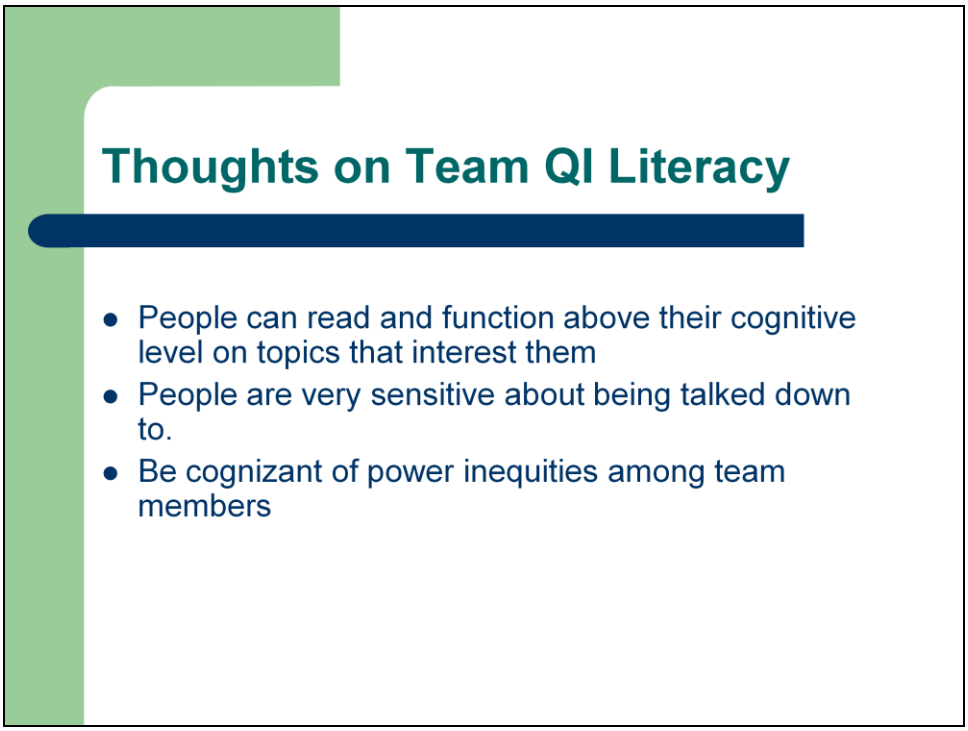


This is a very straightforward problem solving approach, which is used in many successful self-management programs. It can be done individually or as a group.

The first step may be tricky. If the patient can't think of ideas for the second step, ask them if they would like ideas from other patients like them. Check up on their progress.

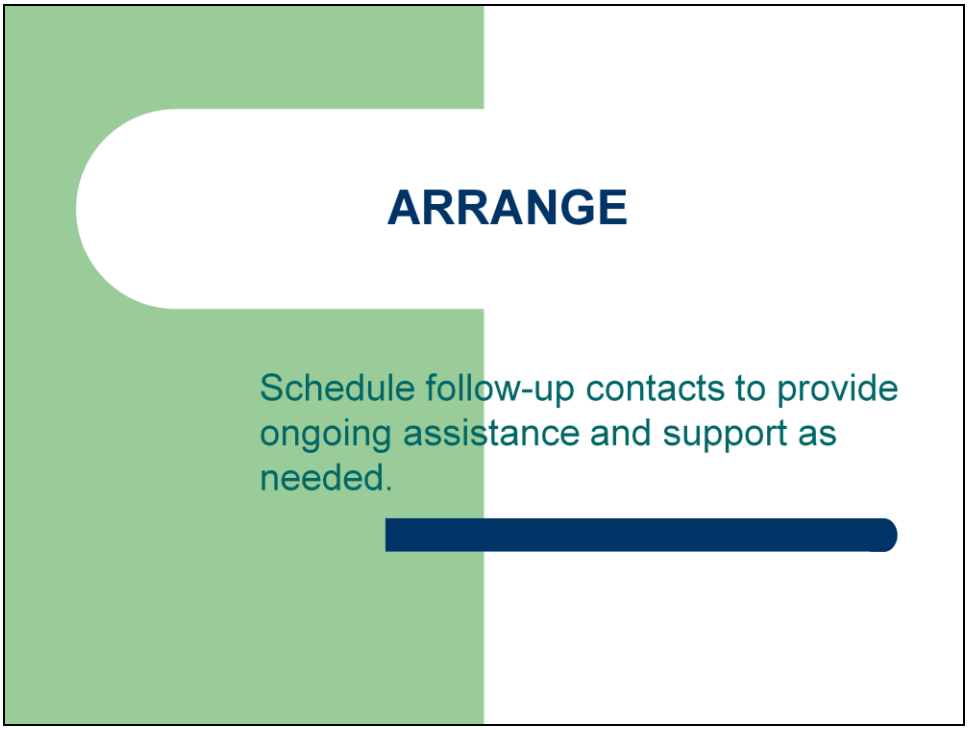
From Kate Lorig, Chronic Disease Self-management program

Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001



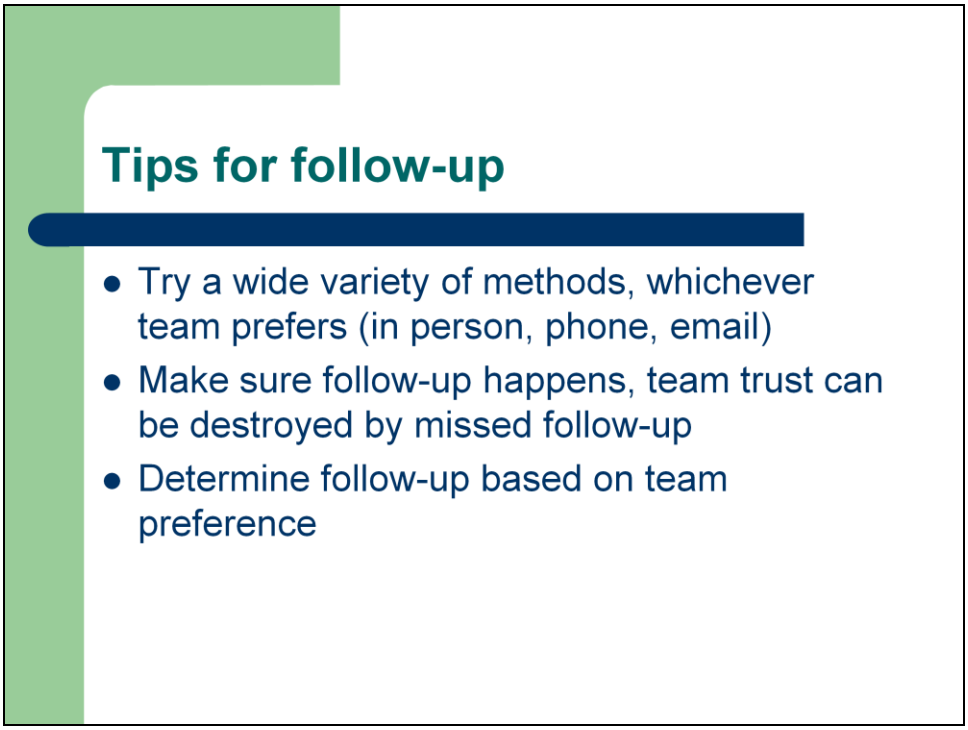
Key point is to give patients a choice on whether or not they want written material and to have options

From an email response of Kate Lorig to leaders of the CDSMP program, Sep 2002



The final A

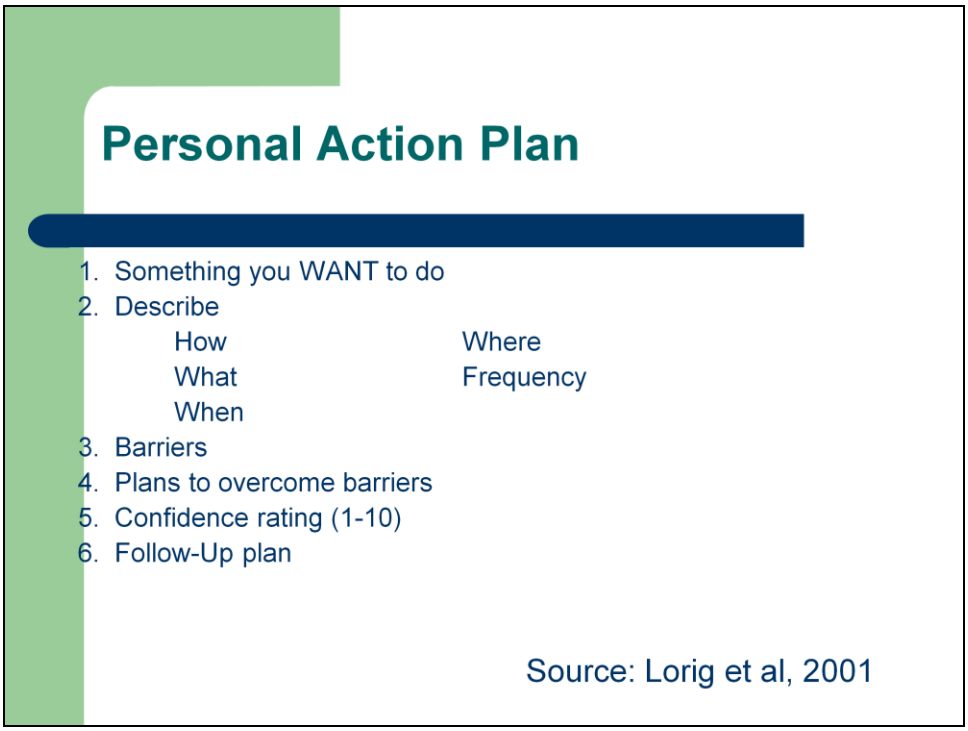
Whitlock et al



Glasgow et al in press.

Efficacy of other methods Whitlock et al Evaluating primary care behavioral counseling interventions: an evidence-based approach

http://www.ahrq.gov/clinic/3rduspstf/behavior/behsum1.htm



This is the center of the diagram.

Goals are too big to work on all at once, and need to be broken down into steps. Action plans should be made for 1-2 week periods of time.

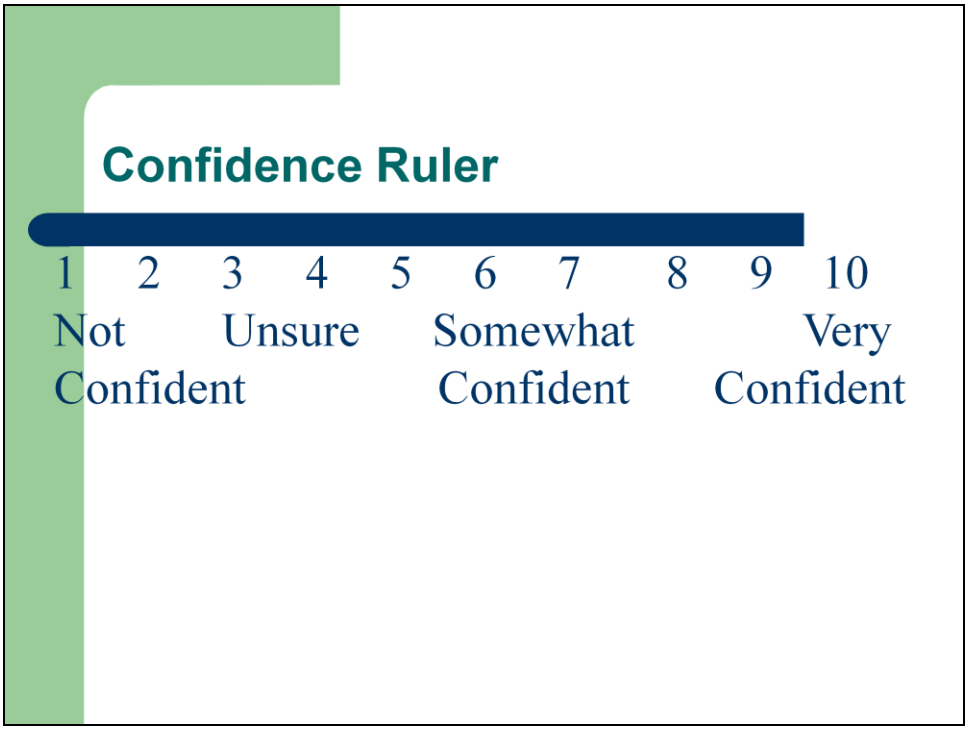
Need to be behavior-specific (someone could observe them doing it).

Confidence see next slide. Confidence is behavior specific. Can be very confident can take meds, but not confident can avoid salt at the church pot-luck if have CHF.

Follow up may be in person, on phone, email. Important to follow-up!!!

(From Kate Lorig, Chronic Disease Self-management program

Lorig K, Holman, H, Sobel D et al Living a Healthy Life with Chronic Conditions 2 ed, Palo Alto, Bull publishing, 2001



People can quickly learn to gauge their confidence.

You can ask, how confident are you that you can complete the entire plan we just set?

If their confidence is less than 7, look at the plan more closely. It is more important for patients to succeed than to have an ambitious plan. Review all the steps. Sometimes the confidence is low because the plan is not something that the patient wants to do. Sometimes they have been overly ambitious with the plan and chosen too much or too often. Remind the patient that they can always do more.

For More Information on Self-management Support

www.improvingchroniccare.org

thanks