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

Meeting AHRQ's Mission

- 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.

Primary Care Renewal: PCMH

- 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

AHRQ PCMH Definition

- 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?

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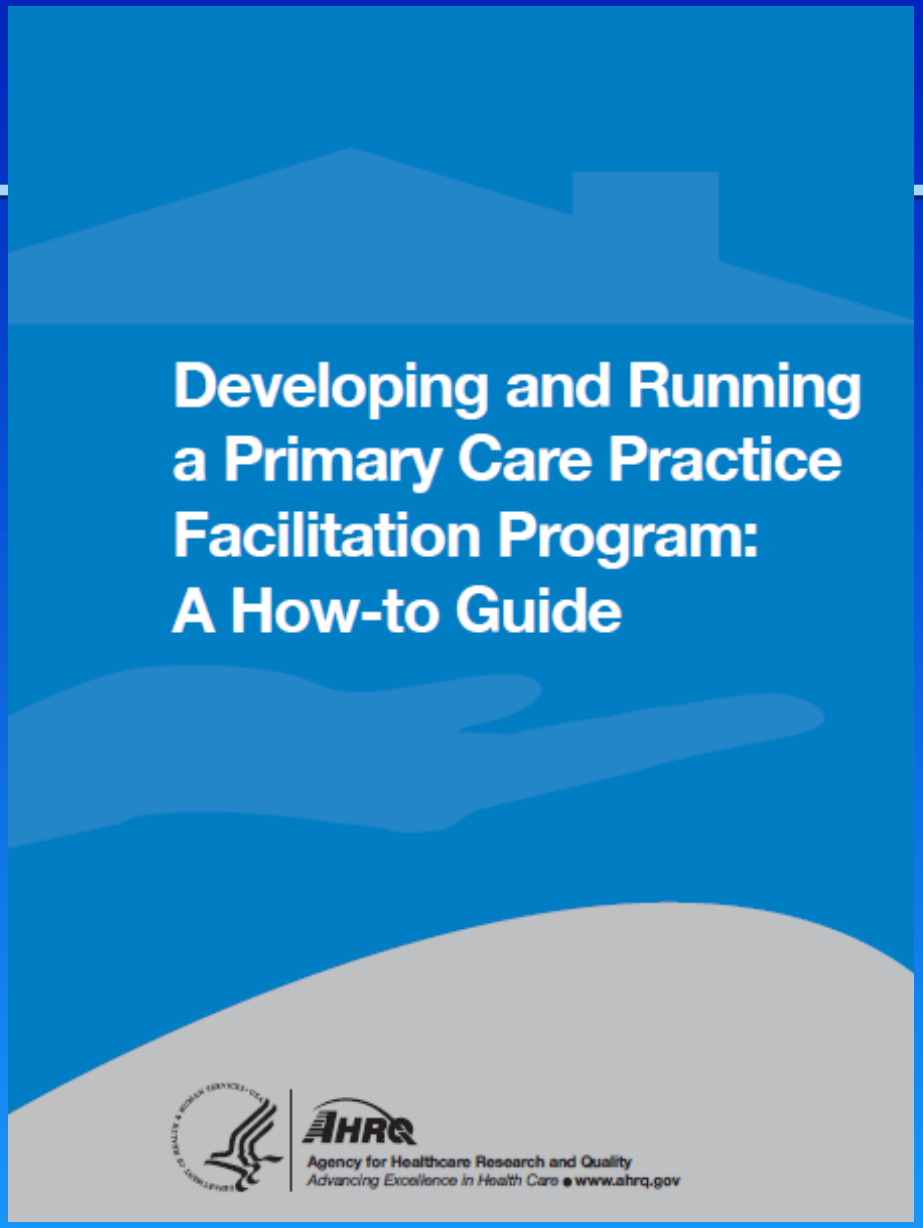
- PF is one way to support medical practices in their ongoing efforts to redesign and transform primary care.
- PF services are provided by trained individuals or teams, using a range of QI and practice improvement approaches.
- These services are designed to build the internal capacity of a practice so it can achieve both practice transformation and ongoing QI goals.

Learning from Experience

- 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
AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Chapters and Key Topics

Chapter	Selected Key Topics
1. Background and existing evidence for PF	• History of PF • Evidence for PF's effectiveness • PF in the current policy environment
2. Creating an administrative home	• Selecting an organizational home • Defining your mission and goals • Staffing
3. Funding your PF program	• Creating a business plan • Identifying potential funding sources • Marketing your program to funders
4. Developing your PF approach	• Creating a key driver model • Identifying your PF team • Stages and key activities • Defining facilitator roles and activities

Chapters and Key Topics - *continued*

Chapter	Selected Key Topics
5. Hiring your practice facilitators	• Core competencies needed • Deciding who to hire • Staffing models
6. Training your practice facilitators	• Assessing and leveraging existing training resources • Creating a curriculum • Selecting your educational approach and strategies
7. Supervising and supporting your facilitators	• Selecting a supervisor for your facilitators • Deciding on individual versus group supervision • Ways to create a learning community
8. Evaluating the quality and outcomes of your PF program	• Creating an internal QI program • Identifying metrics for your QI process • Evaluating the outcomes

From Theory to Practice

- 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

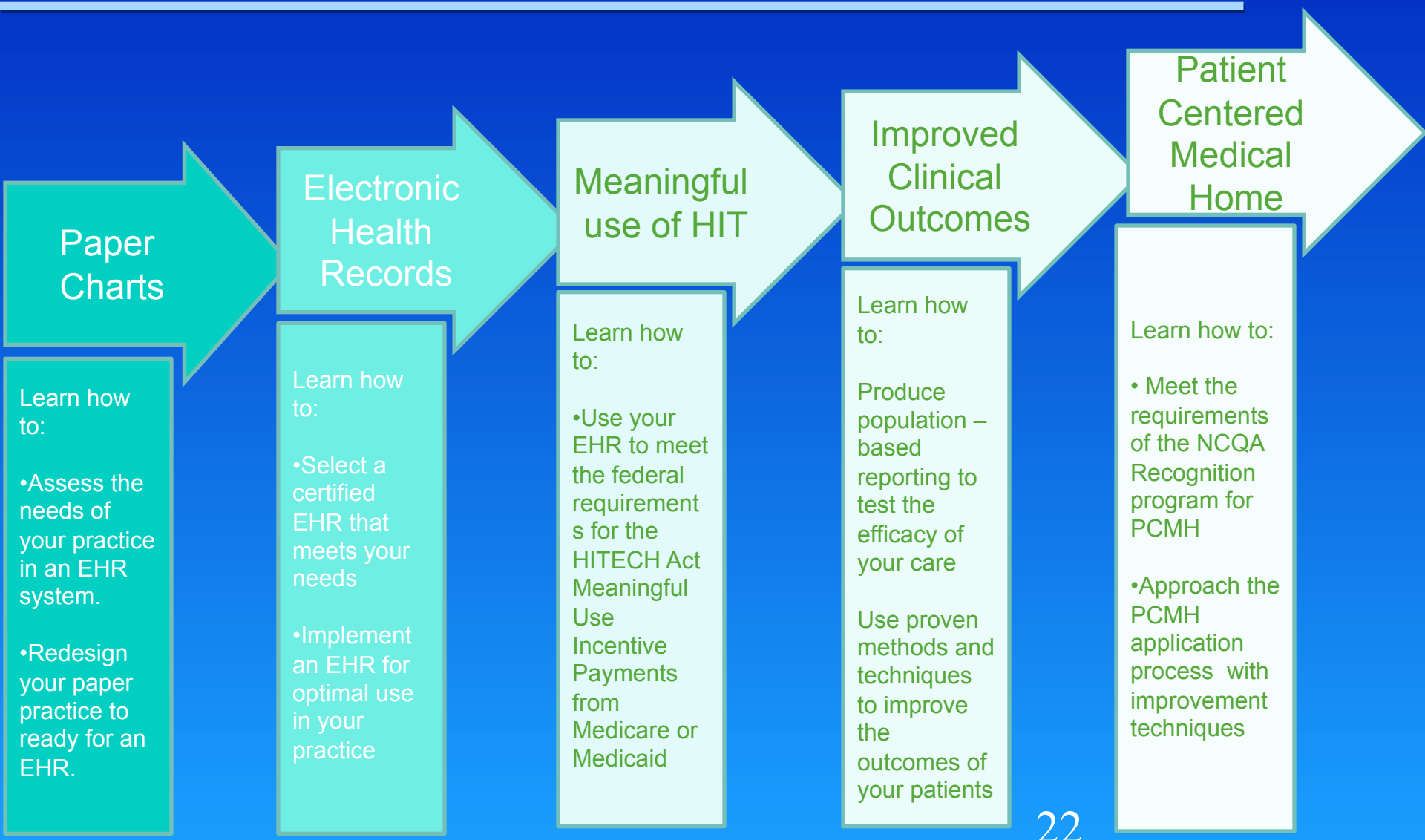
- **Ann Lefebvre MSW, CPHQ**
  Associate Director
  NC AHEC

- **Jenney Samuelson, MS, MCHES**
  Assistant Director
  Vermont Blueprint for Health,
  Department of Vermont Health Access

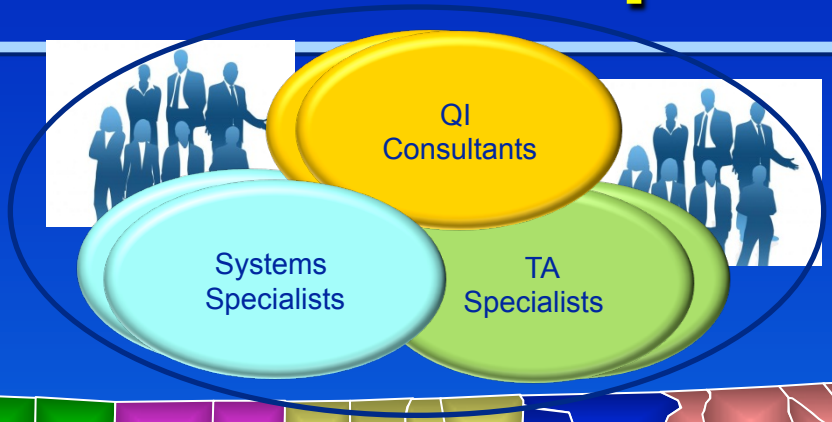
The NC AHEC Program

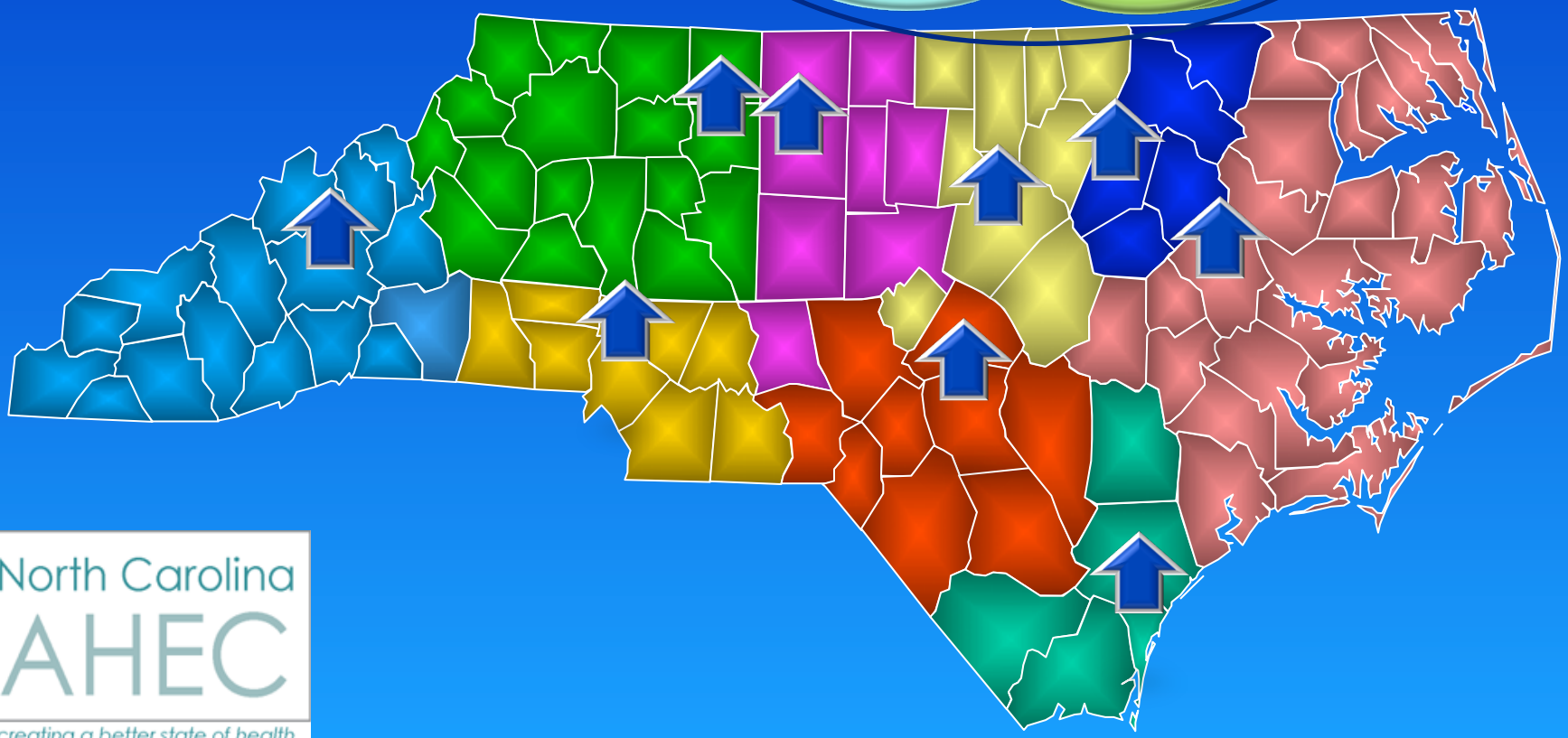
- Employs over 1500 people across NC
- NC AHEC residencies (over 3000 MDs)
- Student housing (over 10,000 a year)
- Continuing education activities (over 200,000 health professionals a year)
- Health Careers and Workforce Diversity
- Practice Support Services (Regional Extension Center and IPIP)

Practice Support Services Provided



Nine Teams of Experts





North Carolina AHEC
creating a better state of health

Chart is placed at vitals station

Paper trigger

Patient is called to vitals station

H,W,BP Taken & recorded

Template needed

Patient is taken to exam room

Chart is placed in sleeve on exam door

Paper trigger

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

Outcomes

Improved clinical outcomes

Measures of success:

Diabetes:
- >70% BP < 130/80
- >70% LDL < 100 mg/dl
- <5% A1c greater than 9.0%
- >80% received dilated eye exam
- >90% tested (or treated) for nephropathy
- >90% counseled to stop tobacco use

Asthma:
- >90% control assessed
- >90% with persistent asthma on anti-inflammatory medication
- >90% with influenza vaccination
- >75% with: assessment of control + anti-inflammatory + influenza vaccination

Hypertension:
- >90% BP <140/90

Ischemic Vascular Disease
- >70% LDL <100 mg/dl

Smoking and Tobacco Cessation
- >90% assessed
- >90% counseled

Key Drivers

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

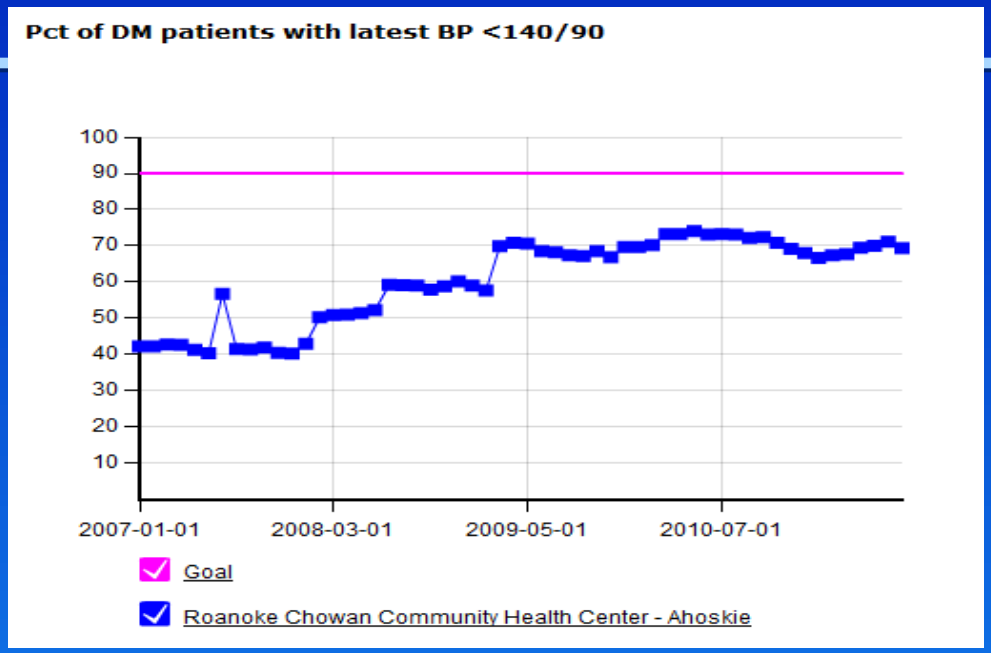
Intervention/Change Concepts

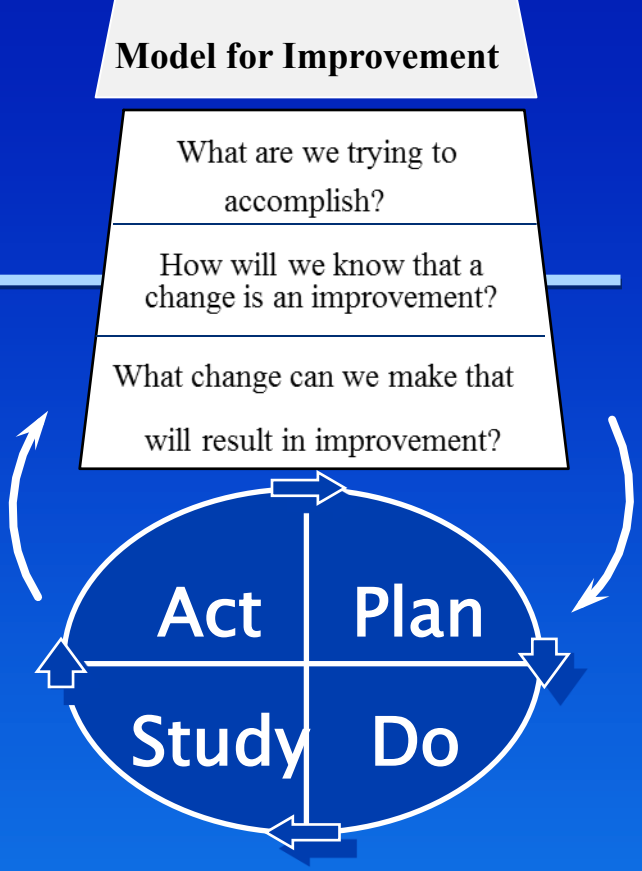
Implement Electronic Database
- Determine staff workflow to support
- Populate EHR with patient data
- Use EHR for routine documentation
- Use EHR to manage patient care & support population management

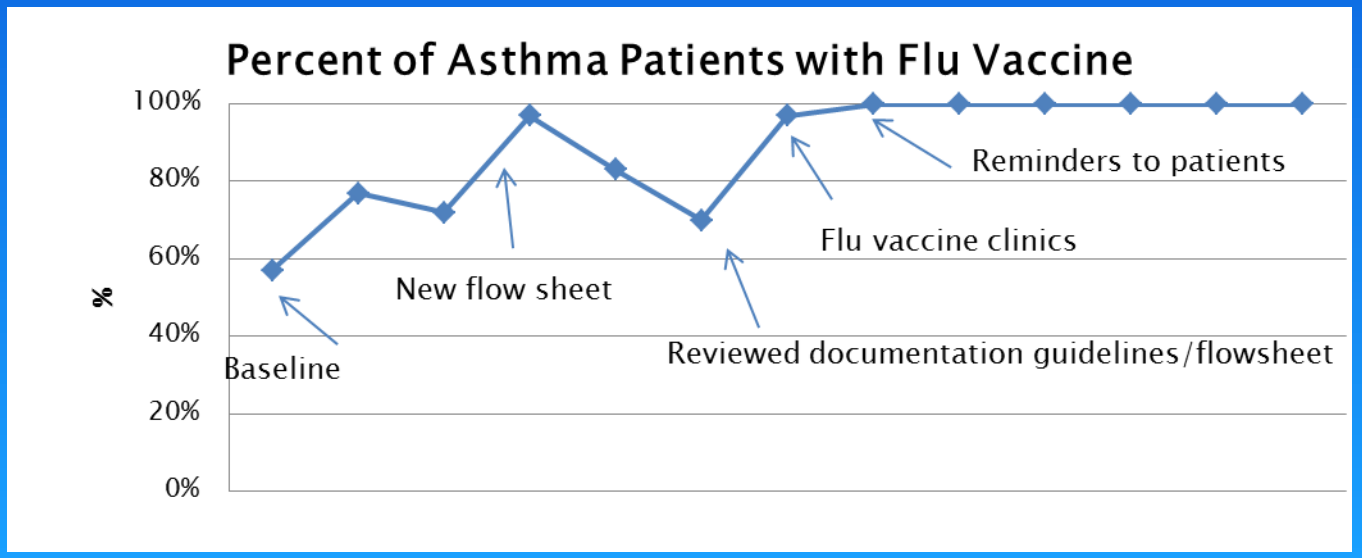
Use Templates for Planned Care
- Select template tool from EHR or build customized template
- Determine staff workflow to support template
- Use template with all indicated patients
- Ensure template contains clinical decision support
- Monitor use of template

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


Pct of DM patients with latest BP <140/90
100
90
80
70
60
50
40
30
20
10
2007-01-01
2008-03-01
2009-05-01
2010-07-01
Goal
Roanoke Chowan Community Health Center - Ahoskie

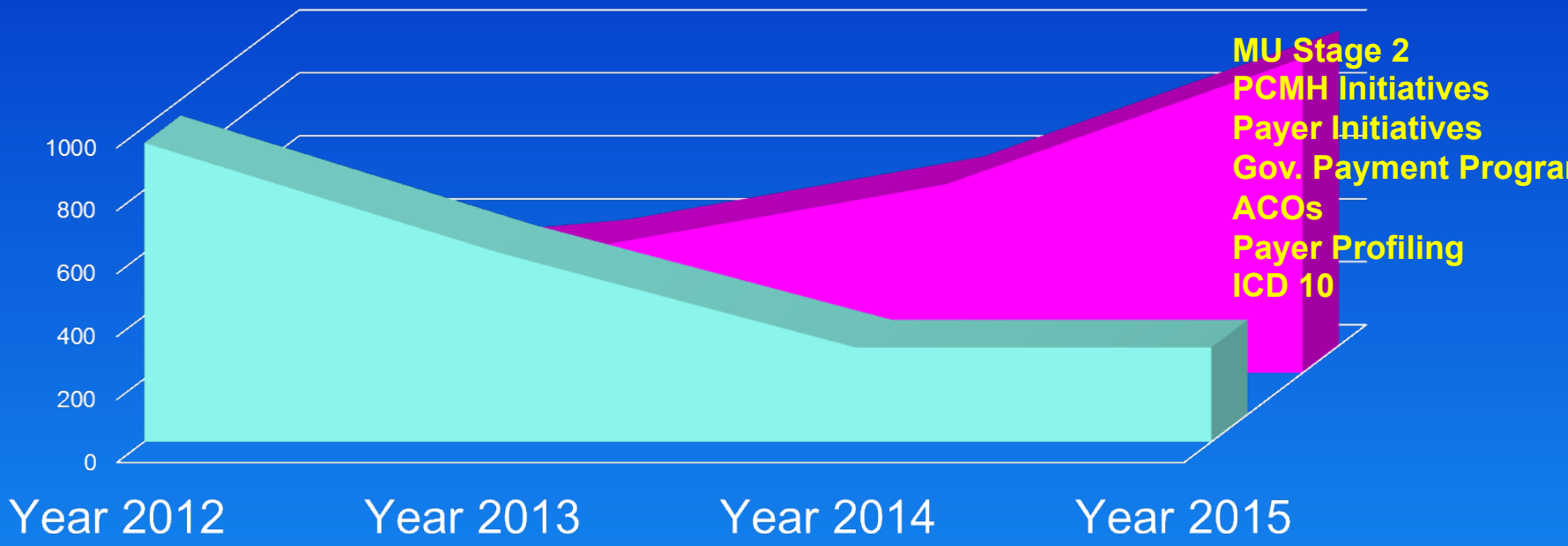

Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do


Percent of Asthma Patients with Flu Vaccine
100%
80%
60%
40%
20%
0%
%
Baseline
New flow sheet
Reviewed documentation guidelines/flowsheet
Flu vaccine clinics
Reminders to patients

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



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

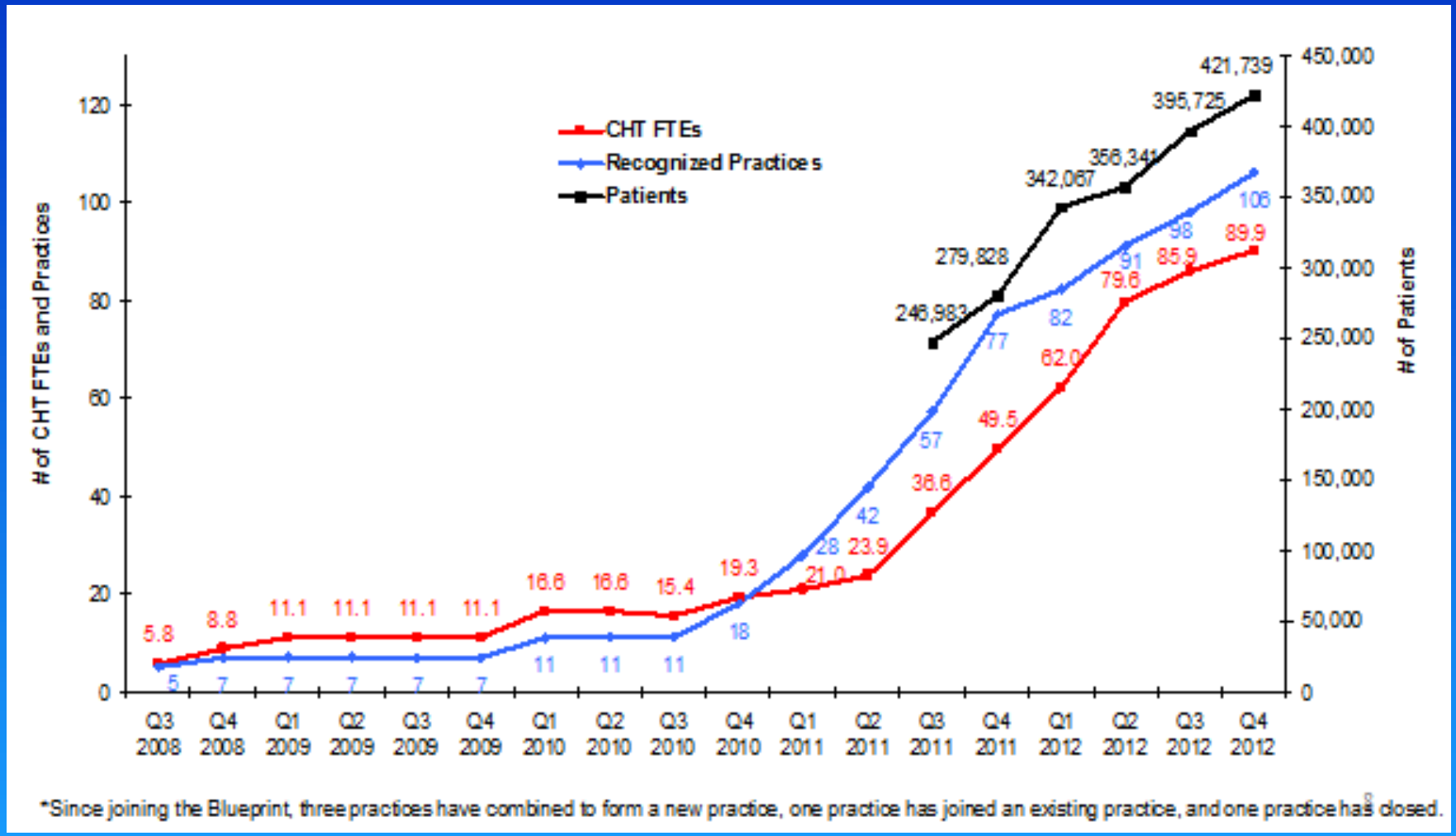
Blueprint Advanced Primary Care Practices

- 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

6/6/13

Continuum of Health Services

Level of Need

Higher Acuity & Complexity

Lower Acuity & Complexity

Advanced Primary Care Practice

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

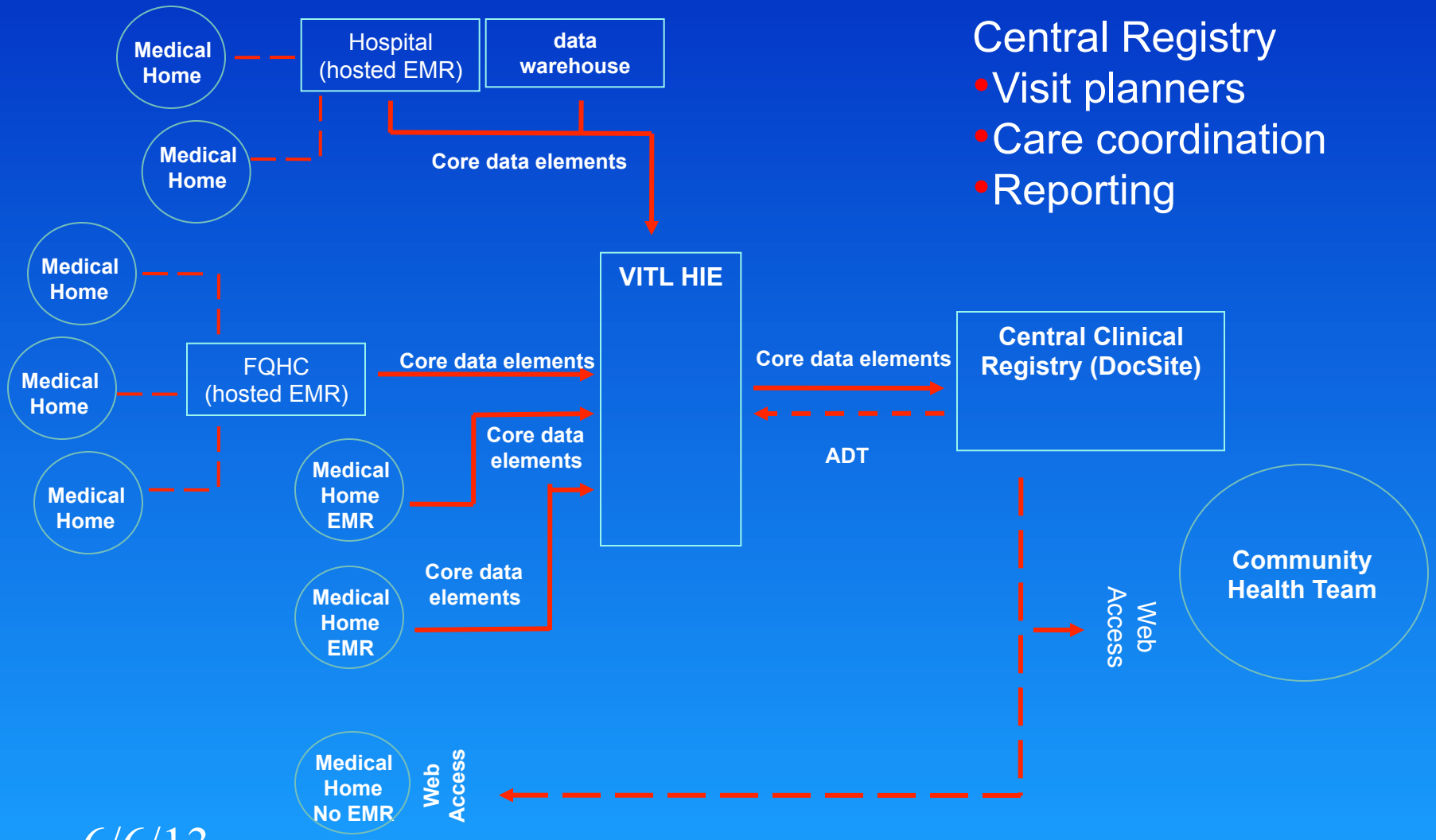
Community Health Teams

- 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

Blueprint Integrated Pilots
Health Information Infrastructure



Central Registry
- Visit planners
- Care coordination
- Reporting

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

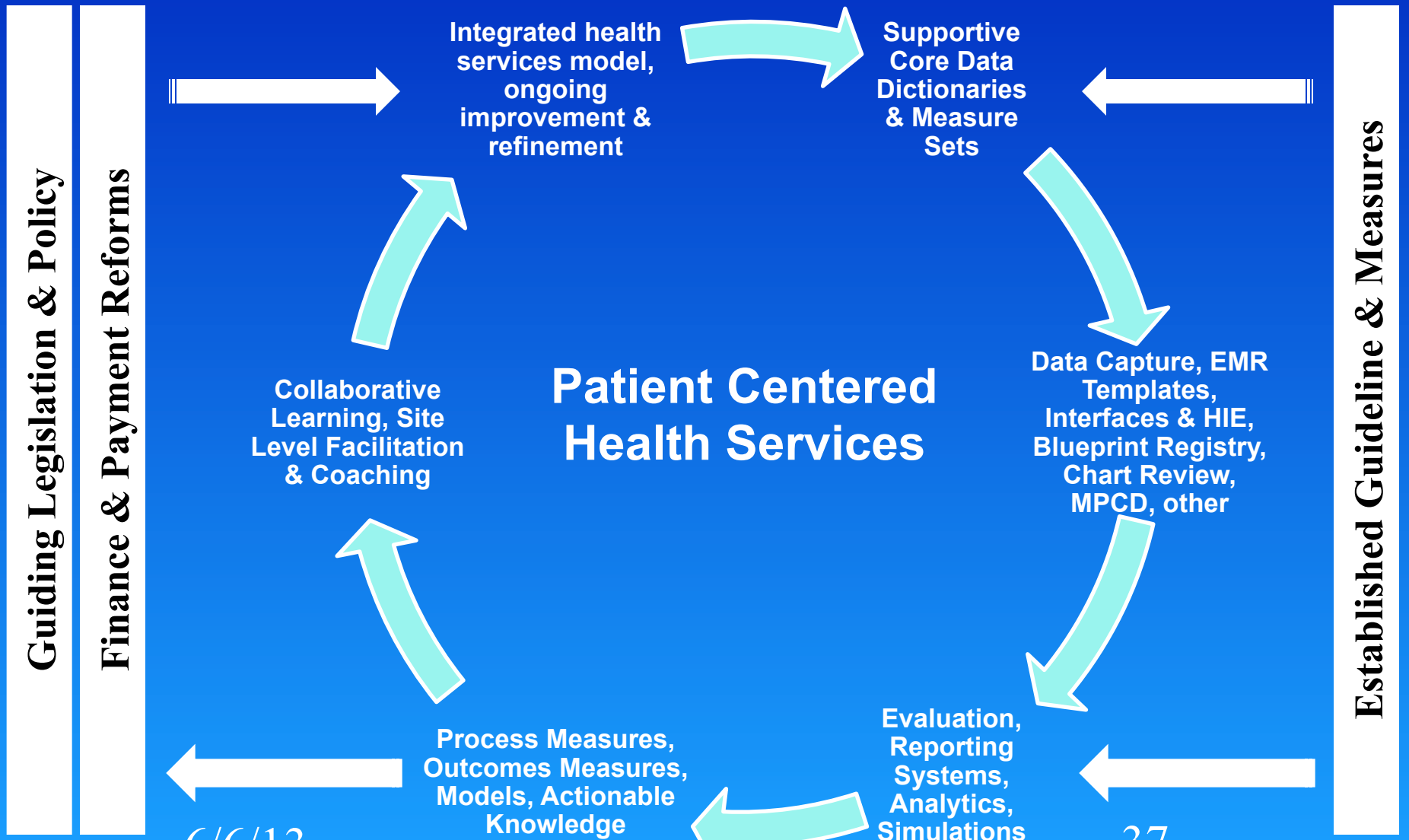
Community Support

- 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



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