



Practice Facilitation for PCMH Implementation in Residency Practices

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BACKGROUND AND OBJECTIVES: Primary care residency programs continue to adapt and change to become high-performing training sites for advanced primary care. Practice facilitation is a key method to assist practices in implementing organizational changes. This evaluation described the unique nature and essential roles and qualities of practice facilitation for residency program patient-centered medical home (PCMH) transformation.

METHODS: Evaluation of the Colorado Residency PCMH Project from 2009 through 2014 included template and immersion-crystallization approaches to qualitative analysis of field notes, key informant interviews, and meeting documentation to identify themes related to external facilitation for practice transformation in 11 Colorado primary care residency practices.

RESULTS: Important practice facilitator roles in residency practice transformation included supporter of quality improvement and NCQA implementation, connector of practices, and leadership and engagement coach. Key qualities included the relationship development between practice members and facilitators over time, flexibility, consistent presence and communication, and an external nature that provided a valuable outside perspective.

CONCLUSIONS: Residency programs provide a unique environment that is particularly well-suited for transformation, though it also presents challenges. External practice facilitators that demonstrate key roles and qualities can support residency practices through this complex transformation process.

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Primary care practices have become increasingly engaged in efforts to implement the patient-centered medical home (PCMH) and other advanced primary care models. To transform, practices must shift from care of those individuals who present for office visits to population management, a markedly different method

of patient care.^{1,2} Residency practices hold a particularly important role in this ongoing transition to new models of practice and payment in the United States. Although complex,^{2,3} residency practices offer an environment ripe to support and adopt new models of practice. Improvements in health outcomes and care provided to patients and achieving cost

control can be addressed through the redesign of residency curriculum and shape the future practice of graduates.³⁻⁵

Residency practices pose both challenges and opportunities for practice transformation. The majority of providers see patients on a part-time basis and otherwise have chaotic schedules, which presents complications related to scheduling meetings and providing the intense focus on the practice that transformation requires. Residency practices also have difficulty with empanelment, producing problems in optimizing continuity, team-based care, and population management. Difficulties in aligning with sponsoring hospitals' rules and approaches to quality improvement (QI) can cause a lack of control over staffing formulas, an inability to flexibly define staff roles, restrictions on standing orders, and other limitations to practice transformation. Alternatively, residency practices boast some characteristics advantageous for practice transformation. They are often more open to new innovations due to the educational nature of the practices, and they are often

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rich with team resources, including behavioral health clinicians, pharmacists, nutritionists, diabetes educators, and care managers.

Colorado residency programs have collaborated to develop the competent and skilled workforce needed for delivering high-quality, patient-centered care. The Colorado Residency PCMH Project had a goal to transform nine Colorado family medicine residency programs (10 practices) and one internal medicine residency practice through external practice facilitation and a variety of supports for curriculum redesign. Practice facilitators guide faculty, residents, and staff in practice improvement approaches that address the quality of patient care and patient experience and drive improvements in health outcomes.

Practice facilitation has emerged as a key method for assisting practices in implementing organizational changes. It has proven to be a successful method for improving preventive care and implementing the Chronic Care Model and the PCMH.⁶⁻²² Facilitators assist practices in implementing evidence-based programs, tailoring programs to individual practice situations, improving incorporation of programs into practice operations, and increasing sustainability. External practice facilitators can effectively assess practice environments and focus practice redesign efforts specifically to the context of the individual practice.²³ With practice facilitators supporting practices, they adopt more PCMH elements than their self-directed counterparts.⁴ The ability of practice facilitators to tailor QI to the practice's abilities, priorities, and circumstances increases the capacity for transformation efforts to be adopted and sustained.^{21,24} Some key characteristics of successful practice facilitators have been studied and elucidated. These include practice facilitation skills and knowledge,^{24,25} personality and continuity with the practice over time,⁵ and the ability to adapt to practice culture.⁷ The

literature does not describe, however, the essential characteristics of practice facilitation for residency programs, including whether the process differs from other types of practices. This manuscript describes a qualitative evaluation of practice facilitation in the Colorado Residency PCMH project.

Methods

Setting

The Colorado Residency PCMH Project took place between 2009 and 2014 in 11 Colorado primary care residency practices. Each practice was paired with a trained practice facilitator (known in this project as a Quality Improvement Coach [QIC]) from a nonprofit organization, HealthTeamWorks.[®] The practice facilitator attended monthly practice QI meetings, providing training, guidance, support, and resources for practice transformation and helped practices work to achieve National Committee for Quality Assurance (NCQA) PCMH Recognition. Practices were also invited to attend twice-yearly Learning Collaboratives (LC), where residents, faculty, and staff convened to learn from national and local speakers and, most importantly, share lessons learned across programs.

Evaluation

This report utilized field notes kept by the practice facilitators and other project personnel, key informant interviews, and meeting notes. This initiative was evaluated by a team at the University of Colorado, Department of Family Medicine and was funded by The Colorado Health Foundation. This project was reviewed by the Colorado Multiple Institutional Review Board and approved as exempt from further human subjects review.

Data Sources

Practice facilitators completed field notes on each practice interaction, documenting meeting content, reflections on the process and practice

progress, milestone accomplishments, and barriers. Key informant interviews conducted with faculty, residents, and staff members at baseline, upon residents' completion of the residency, and near the end of the initiative; field notes and evaluations from collaborative sessions; and notes from the project team's regular "lessons learned" discussions were also included in the analysis. More than 650 field notes and documents from 6 years of the project were analyzed.

Data Analysis

Two qualitative analysts on the evaluation team reviewed all documents as they were received or upon program completion to become familiar with the material. All qualitative documents were loaded into ATLAS.ti [Version 7.5; Scientific Software Development, GmbH, Berlin, Germany, 2014] for analysis. One analyst utilized a template coding style¹⁹ to efficiently organize the qualitative data according to *a priori* codes aligning with key evaluation questions, including one about practice facilitator activities and impact, while also allowing other themes to emerge in an immersion-crystallization process. The segmented data related to practice facilitators were then organized into a set of conceptual categories, which were reviewed, discussed, and refined by the authors and are presented in this article.

Results

Evaluation results are described below in two categories: practice facilitator roles and practice facilitator qualities. Illustrative quotes pulled from evaluation data are presented throughout the results where relevant.

Practice Facilitator Roles. *Supporter of Quality Improvement and PCMH Implementation*

Practice facilitators' primary role was providing training and support in QI concepts and the PCMH model. Foundational QI support was

critically needed in residencies, as few faculty members in leadership roles had prior training in this area, and resident rotation and graduation turnover created an ongoing knowledge gap. “Resident rotation creates a need for ongoing coaching, and there is also more staff turnover...more competing demands.” Education on the nuts and bolts of process improvement models including QI teams, meeting structure, and QI tools such as process mapping, AIM statements, strategic planning, and the PDSA cycle were critical to jumpstarting practice transformation: “For teambuilding, forms, action planning, resources from other practices, clinic flow, process mapping... very helpful.” Another person noted, “How far you get depends on the resources and tools.” The implementation of QI teams and care teams with regular meetings were identified by several practices as among their top accomplishments in this project, and many expressed the value of QI and teambuilding skills brought by facilitators.

Practice facilitator roles evolved throughout the project: “It’s about providing the right resources at the right time.” NCQA PCMH recognition was chosen as a key outcome, as the most widely recognized operationalization of the PCMH framework. Practice facilitators received formal training from NCQA, and one became a PCMH Certified Content Expert. Practices described the need for an initial practice-wide introduction to PCMH principles and a focus on team building and development of a practice transformation structure, eventually giving way to heavier focus on the NCQA PCMH application: “At the beginning it was a lot of teambuilding. Now, functions as a reviewer of the NCQA elements: interpreting, helping us stay on the timeline.” At times practices required a stronger push; one described how their facilitator spurred progress by “respectfully but professionally” communicating the importance of meeting application deadlines and

at other times by providing ongoing gentle reminders of the need to continue so as to not lose momentum.

Practices strongly voiced the importance and value of the practice facilitator in the NCQA PCMH application process. One practice called their facilitator “invaluable with NCQA process, especially answering specific questions.” Practices highlighted facilitators’ contributions to project management, translating recognition requirements, and compiling documentation: “Helps translate [NCQA requirements]... didn’t just translate; also taught us to speak it.” Facilitator involvement eased faculty, resident, and staff workload: “I think we couldn’t do it without the coaching. Keeps us on track... Will need the same coaching in 2 years again [for renewal].” Practices’ interest in NCQA PCMH recognition increased over time, and all received Level 3 recognition by project completion.

Connector of Practices

Facilitator-led connections between residencies, direct and indirect, were important for transformation. Practices connected directly at LCs, obtaining new strategies for transformation by brainstorming common barriers and keys to success, such as best practices for EHR navigation, workflow development, and data reporting. They placed high value on this information sharing and the reassurance it provided: “Realizing that others are struggling with the same problems; that they are universal. It’s not just us.” Residencies especially valued the opportunity to learn from other residencies, with the perception that other types of practices did not share many of the issues faced in residency programs. It was important for practices to be able to decide for themselves what information and resources from other practices were relevant to them, highlighting the importance of connecting directly at the LCs: “We felt that collaboratives were helpful because we could learn from others directly and also make the call on

whether or not they were similar and if it could work in our practice.”

Facilitators refined LC content over time in response to practice needs and feedback, tailoring material to engage providers and staff, identifying trends in practice challenges, and asking specific clinicians and staff members to share related successes in targeted interactive presentations. As a result, LCs were more relevant and engaging for attendees, helping to spread QI concepts throughout the practices: “People who attended took more ownership in practice transformation.” LCs helped faculty, residents, and staff to understand PCMH concepts, associated benefits, and their role in transformation: “[Attendees are] energized and ready, see the bigger picture. Helped them to see their role in QI and see the value of their work.”

Leadership and Engagement

Coach. Previous evaluations indicated that skepticism and resistance to PCMH transformation were barriers to change in residency practices.²⁵ Initial resistance was most frequently expressed through opposition to changing and expanding roles. Practice facilitators also encountered resistance among providers with more traditional mindsets or cynicism about transformation, as many had experienced past failed iterations of health care reform. In addition, faculty members who were not trained or experienced in PCMH concepts were often resistant to implementing or teaching these concepts.

This resistance was also present at the leadership level; facilitators experienced difficulty making and sustaining change in practices where hospital leadership did not prioritize PCMH concepts: “If we did not get approval [from hospital system]... we would not have been able to move forward [with PCMH].” Some hospitals’ top-down leadership approach and tight control of staffing hindered

QI team formation and team-based care.

This leadership hierarchy necessitated that facilitators align transformation efforts with the hospital system's strategic direction, balancing focus areas with larger programmatic goals. At the practice level, facilitators paid particular attention to leadership attitudes toward and support for transformation, addressing resistance through engagement strategies including leadership development, communication, and priority alignment. Faculty, residents, and staff received leadership training, and facilitators identified the need for individualized leadership intervention and facilitated meetings with PCMH experts. Facilitators promoted communication to spread project information throughout the practice, providing explanation for changes and advocating for dedicated QI time.

As a result, attitudes toward transformation improved over time, with practice members becoming more invested in PCMH efforts: "Overall, there is an interest in practice improvement, more than when we started." Multiple practices identified improved staff engagement among their top project accomplishments, with increased staff empowerment, input on process development, and involvement in care teams. "There was not a lot of emphasis [on PCMH] before. We've had big cultural shifts, which was positive for us." Practices reported broadened concepts of leadership, sharing duties with residents and staff: "After leadership training, we noticed differences in leaders showing up or sending others and coming up with agendas and action items." Residency PCMH activities became a selling point, as some incoming residents sought out programs specifically because of their engagement in PCMH transformation, a major contrast from somewhat negative initial resident reactions. Despite improvements, facilitators paid continued attention to engagement levels

throughout the initiative, as low resident, staff, or provider engagement recurred in some practices.

Practice Facilitator Qualities

Certain characteristics emerged as helpful or necessary to carrying out the facilitator role. Developing relationships between practice members and facilitators proved important, similar to the concept of continuity of care. "[Important coach qualities are] time, relationship-building, [and] presence." Ongoing relationship building was critical to understanding practice circumstances, characteristics, history, and team composition that changed over time. Some practices reported frustration when circumstances required transition between facilitators, stating that "Historical knowledge is important." Successfully implementing QI tools and processes required consistent, ongoing participation in QI team efforts: "She gets our clinic—how we operate here with what we have." Practices valued facilitators' regular presence, with monthly practice visits supplemented by interim telephone and email contacts: "The biggest factor is that they be here regularly."

Response to External Facilitation by Different Practice Cultures

Practices and facilitators reported positive and negative aspects of having facilitators who were external to the practice, and this partly depended on the culture of the practice. Benefits in most practices included providing an outside perspective and best practices from other practices, as well as providing a consistent external reminder of the importance of the work. "External coaches can be the bad guy in the practice," or function as "a third party to be a culture coach." However, some practices were more amenable than others to receiving feedback and suggestions from someone outside the practice, with some appearing to have a culture that was somewhat closed to external perspectives. Practices exhibited

varying levels of openness to outsiders from the outset of the initiative, requiring greater attention and time for relationship building and understanding practice history before facilitators could be fully accepted. In some cases facilitators worked strategically through identified internal change agents, providing them with education and resources to essentially become internal facilitators.

Discussion

A variety of roles can be played by practice facilitators during practice transformation, and this analysis suggests that the most critical ones involved training in QI methods, providing support for NCQA PCMH recognition, connecting practices to learn from each other, assisting in leadership training, and acting as an external "nudge" to keep the change process moving.

The results identified that practice facilitators needed to show flexibility in the content provided to practices and how PCMH concepts were addressed. As practice facilitators became familiar with practice challenges related to PCMH transformation over time, they became integral members of the practice team. Facilitators were key contributors in planning learning collaborative content due to their ability to identify best practices across sites. The knowledge shared among practices allowed for the development and dissemination of best practices regarding effective QI and PCMH processes and led to discussions of solutions to common barriers. Long-term facilitator continuity with practices helped diversify content and develop practice sharing opportunities that were fresh and innovative.

Successful practice facilitators were able to manage resistance, change fatigue, and conflict in individuals and groups without taking ownership for the group's success. In order to meet the needs of practices, facilitators had to manage the intensity and type of approach provided at different times, providing evolving,

flexible, and responsive facilitation. The need for flexibility applied to the approach toward an individual practice at any given time (with changing needs over time), the understanding that different practices require different approaches and resources and changes in the facilitator role over time.

Differences seen in residency practices compared to other types of practices revolved especially around the part-time presence in the practices by residents and faculty, the regular turnover of residents, the degree of turnover of staff, and the relative lack of control over staffing models, roles, and hours. Practice facilitators had to repeat trainings in quality improvement, change leadership principles and methods to accommodate to the turnover of personnel. Practice leadership was often complex and confusing, which greatly increased the time spent in leadership engagement and coaching. Conceptual PCMH principles were difficult to implement in residency programs when faculty did not feel well prepared to teach or lead the PCMH transformation, and substantial time was needed for faculty development. The lack of control of practices over staff required the facilitators to be flexible and inventive in designing complicated workarounds in scheduling of meetings, engagement of staff members, and development of work flows and roles that could accommodate to the often rigid and inflexible rules of practices' health care systems. Finally, the educational context required that the practice facilitators contribute to and coordinate with the residency curriculum, with transformation needing to align across the practice and the curriculum. All of these factors resulted in practice facilitation in residency practices being more complex and a longer term process than in other practice types.

Limitations

This paper reports on structured observations within a small set of

residency practices that were not selected to represent residency practices generally. This is not a report on the effectiveness of this particular intervention, and the validity of the observations reported is not assessed. There may be other essential aspects of practice facilitation in residencies that we did not observe in the data; however, the longitudinal data over multiple years offered many opportunities to document key aspects of facilitation and were easily observed across a range of practice settings. We also acknowledge that the practice facilitators' field notes tended to capture problems or concerns that needed attention, which may have unintentionally produced a dataset weighted toward more negative aspects of practice transformation. Our limited sample suggests that practice facilitators with a learning community and knowledge of a collection of practices may benefit practices more than an internal or isolated practice facilitator. However, this evaluation did not allow us to fully explore these differences.

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