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## Building quality improvement capacity in primary care: 16 key insights about practice facilitation



Healthy Hearts Northwest is a collaboration between the MacColl Center for Health Care Innovation, the Oregon Rural-based Practice Research Network, and Comagine Health.

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# Introduction

Storytelling is a human tradition that we believe can serve as a uniquely effective bridge between theory and practice. Stories help us make sense of the world around us. They can inspire, caution, and educate. We've collected stories from our own practice facilitators as well as the providers they met in this project.

The memories that our Healthy Hearts Northwest practice facilitators share illustrate what they saw and who they met in small primary care clinics across Washington, Idaho, and Oregon in 2015-2019. We also offer insights and observations from enrolled clinics and our research staff.

It is our hope that these improvement process narratives may be useful to other working practice facilitators or stakeholders interested in this field.

# 16 key insights about practice facilitation

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# Overwhelmed but motivated

*Themes emerged early on that recurred throughout the project*

By Ross Howell

One of the challenges in our Healthy Hearts Northwest work has been accessing reliable, valid data to drive quality improvement on the ABCS measures (Aspirin-Blood Pressure-Cholesterol-Smoking cessation) within our enrolled clinics. After recently talking with two of our practice facilitators about what they're seeing out in the field, I noticed themes emerging across Washington and Idaho. Let's take a deeper dive into these change patterns.

## **Practice coaching is useful for boosting health IT**

Healthy Hearts has been a great opportunity to push the boundaries of what clinics with limited functioning electronic health records EHR can do with their technology to improve patient care. One facilitator expressed that before Healthy Hearts NW, some clinics “never ran reports or could never run reports. They never had, until we started asking.” Particularly challenging for clinics are what one facilitator called “third tier vendors”—those that sell a relatively inexpensive product accessible to smaller clinics with few resources — but that lack the ability to change their user interface or see how their care helps patients at the population level.

In the end, it takes much more work and costs clinics more time in process change and fixes to report their quality measures or identify care gaps. Much of the time our facilitators spent with these clinics was dedicated to collaborative HIT (health information technology) work to improve system capacity. They also worked with clinics on making sense of the data they received. This was especially important for clinics that were reviewing data for the first time, as the numbers



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they saw often didn't match the quality of care that they knew they were delivering



When clinics run a few PDSAs (Plan-Do-Study-Act cycles) and see their quality measures move in the right direction, they get more engaged in the idea of QI. As another facilitator put it:

*"The PDSA process has been really effective for demonstrating the value of this work. It's not just random variation; you can see the improvement as you're working toward the goal."*

### **Choosing a 'good' EHR isn't the whole answer**

In several clinics that our facilitators worked with, the HIT challenges were as much as result of user knowledge gaps as system capabilities. They described several instances where reports we needed were accessible, but the clinic contact either had never received training or those reports had not been activated in the

user interface. The facilitators were able to support the clinics in accessing tech assistance or requesting the activation of reports through their vendor. Some clinics have robust, highly functional EHRs with strong reporting capabilities and easily modified templates or user interfaces, in some cases custom-built for the practice.

In other cases, EHRs are built by a third-party vendor that hosts their system remotely. In these clinics, both facilitators stressed the importance of leadership engagement:

*“Without leadership plugged into the project, it’s very difficult to make progress. Even if you have a clinic team trying to improve, they just go in circles without leadership engagement.”*

Where we can overcome institutional or analytical barriers to accessing reports and implementing short change cycles, our facilitators see improvement and positivity.

### **Size has an impact**

In smaller practices it can be easier to get the leaders to commit time and resources to Healthy Hearts NW. In large clinic groups the leadership may have many competing initiatives, of which Healthy Hearts is just one. At a certain size of organization, the administrative coordination involved in QI tends to make it difficult to innovate on the level of small clinical teams. For administrators trying to implement standard, reliable processes clinic- or organization-wide, small team-based innovation and change cycles can appear to be threatening deviations from their plan.

Despite having extensive HIT resources to support QI work, some clinics have layers of administration and bureaucracy slowing innovation and change. These tend to be large delivery systems, often associated with hospitals, with large QI departments including analysts and administrators. Our facilitators have also seen that first-tier EHRs don’t guarantee access to high quality reports, especially for the smaller QI teams. This is especially the case where the EHR is purchased through a vendor that may require additional fees to produce the



reports or connect to a third-party registry – costs that a smaller practice can't bear.

### **FQHCs have a head start**

One facilitator was careful to distinguish between private practice clinics and those that operate under federal rules and funding systems—such as federally-qualified health centers (FQHCs) or tribal clinics. Among the latter, QI methods have been in use for many years due to reporting requirements associated with their funding sources. Such clinics may have been running PDSA cycles or implementing changes for some time. Our Healthy Hearts facilitators did less basic training in QI methodology and used their visits to improve the QI processes already in place. In the words of the facilitator, these clinics “have had different approaches to QI—but when we looked at what they were doing we saw that there were refinements we could make.”

### **Clinics want to change**

It's been an uphill battle to get our clinics the data they need to change for the better, but both facilitators expressed optimism for the future:

*“With MACRA coming on, even small practices are starting to understand that this isn't sending data out to a black hole but about improving the population health of their patients”.*

Practices are increasingly “not seeing it as just about patient responsibility” but are moving toward understanding that they are part of a “synergistic relationship between healthcare and the population at large. It's a huge shift of change to understanding why QI is important and why HIT is valuable for finding the care gaps in your patients.”

The other facilitator expressed that he's seen “a lot more involvement and improvement than expected—clinics want the change.” They're overwhelmed but starting to get rolling. They see the writing on the wall—and are implementing HIT improvements to prepare.”

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*Ross Howell provided the Qualis Health Healthy Hearts NW practice facilitator team with a coordinative backbone of organizational support, meeting facilitation, and information management. Prior to joining Qualis Health he served as a teaching assistant for undergraduate courses in the University of Washington School of Public Health and a research assistant at the Northwest Center for Public Health Practice.*

**KEY INSIGHT:**

Practice facilitators have a special role to play with maximizing use of health information technology. Having a first-tier EHR doesn't mean a provider team can automatically or easily be able to extract the data needed to generate high quality reports.

# Supporting people to quit smoking can have an enormous impact

*I feel privileged to work with these providers*

By Beth Sommers and Steven Brantley

## **Portland metro area: Beth Sommers**

One of the independent, physician-owned practices I work with in the Portland-metro area has been focusing on identifying patients who use tobacco products and assessing their readiness to quit. This team developed a structured form, called the Tobacco Free Readiness Assessment (TFRA), to gather patient details around tobacco use and patient's interest in becoming tobacco-free as a means to target cessation conversations and intervention activities based on patients' self-identified stage of change readiness.

The TFRA gathers information from patients on their perceived barriers and motivations to becoming tobacco-free, gauges their awareness of resources available to help them quit, and asks whether patients are interested in receiving active support in becoming tobacco-free.

After administering the TFRA, dummy codes are used to enter these data into the clinic's electronic medical record (EMR) so that they could measure their progress. Family Medical Group Northeast created data sets to enable tracking of individual and population changes over time. They became interested in following patients who've quit using tobacco so they also assigned a dummy code to the "I have quit" stage. Additionally, they created codes to delineate non-tobacco users and to chart when the TFRA is administered. The TFRA data displays in the clinic's EMR health maintenance section.

Over six months, this practice has fully implemented a Tobacco-Free Readiness Assessment workflow across the practice, and continues with a wide

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spectrum of other smoking cessation activities. I'm so proud of the progress they made in such a short time!

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*Beth Sommers, MPH is a Practice Enhancement Research Coordinator at the Oregon Rural Practice-based Research Network (ORPRN). Her interests include social determinants of health, health policy, primary care transformation, and quality improvement. Beth received her master's degree in public health from Portland State University, and her bachelor's degree in physical anthropology from Oregon State University.*

### **Southern Oregon: Steven Brantley**

One of the primary care clinics I work with in southern Oregon has taken a slightly different approach with smoking cessation. To get started, clinical champions researched the epidemiology and impact of tobacco use in their population, city, county, and state, and presented their findings to the entire staff. They created a 10-question survey to assess staff interest in quality improvement, retention of tobacco information, and to collect ideas to improve their smoking cessation campaign.

The clinic's QI team was already screening champions: they were monitoring about 99% of their patients for tobacco use. Their opportunity was to increase their rate of counseling to patients, either via the physician or medical assistant. They worked with their IT department to develop an EMR baseline performance measure and began tracking the percentage of patients that screened positive for tobacco use and that were offered counseling. After 3 months, this counseling metric increased from 12% to 70%. After another 2

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months and a steady increase in counseling offerings, they dedicated members of the QI team to continue reporting on tobacco cessation activities.



While the team as a whole moved on to other issues as their primary focus, smoking cessation is discussed at every QI meeting. They're constantly developing new ideas to address the remainder of their care gap. Smoking cessation is just one piece in the overall structure of our initiative, but supporting people to quit smoking can have an enormous, lasting impact. It's a privilege to work with a group of providers that's doing such great work for the people in their communities.

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*Steven Brantley, MPH is also an ORPRN Practice Enhancement Research Coordinator. His interests include the spatial relationship of health determinants,*

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*primary care transformation, and improving access to healthcare. Steven received his master's degree in public health and his bachelor's degrees in biochemistry and Spanish from Oregon State University.*

**KEY INSIGHT:**

Some clinics understand population-based care and know they need to get better at doing it. They have ideas about how to get there and are extremely motivated. Facilitators are especially adept at supporting this approach to quality improvement.



# A slow-starting clinic becomes an exemplar

*Persistence pays off*

By Marion David Stipe

*The Port Smithson Family Clinic of the Martin General Hospital Family Clinics is a rural practice nestled on the banks of a large river in Washington State. When Healthy Hearts NW practice facilitator David Stipe began working with Martin General clinics, he discovered that Port Smithson, the smallest in the family, had experienced significant provider and clinic manager turnover. Although it initially seemed that this clinic could have given up, they didn't. It turned out that its slow start was just the beginning. David Stipe describes their journey.*

My work with this group of four clinics began, per usual, with scheduling a project kick-off meeting with each. The purpose of this first meeting is to complete the Quality Improvement Change Assessment (QICA), an instrument introducing team members to the high-leverage changes guiding the project's technical assistance approach as well as assesses the practice's current capabilities. Although kick-off meetings are intended for all staff, just two Port Smithson people attended. At the start of the meeting, I looked around the large room and with just the clinic manager and one provider staring back at me. I asked when the rest of the team would be joining, and was told they had too much work to do that day, and would not be attending. So, I went ahead with the meeting.

## **Is it the end of the road?**

The next month I prepared for the second of the fifteen months of technical assistance support for Port Smithson. After that uneventful and awkward first meeting and before their second H2N visit, the clinic contacted me to tell me they would be dropping out of the project altogether. The clinic gave many reasons for

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withdrawing, and with each reason, I generated a “we can do this” response. My messages didn’t work, and it seemed like the end of the road.



Soon after that conversation with Port Smithson, I met with another Martin General Hospital clinic and to my surprise, the provider champion broached the subject of Port Smithson with me. By the end of our conversation, I was told to expect a call from Port Smithson confirming that they’d re-engage with Healthy Hearts NW and all staff would attend meetings. That call came, and I scheduled a follow-up meeting. But, just prior to the meeting, the clinic manager and provider announced to me that they would be retiring. Once again it seemed like my efforts were failing and Port Smithson was going to let the H2N opportunity pass them by.

### **Or just the beginning?**

Here’s where it gets interesting: what should have been the end of the Healthy Hearts NW (and transformation) journey for Port Smithson ended up being only their beginning. I witnessed a turnaround that was truly amazing. The clinic’s two medical assistants (MAs) and front desk staff took over the project work and were

engaged from the start. They quickly started working on the tobacco measure: They created a spreadsheet of patients who reported smoking to determine how many were referred to the Washington State Tobacco Quit Line, and by doing so, designed their first Plan-Do-Study-Act (PDSA) cycle. They were eager to try out new changes in their workflow to better facilitate patient rooming and improve communications with providers. Before the first meeting was over, the staff discussed the necessary changes, drawn up the new workflow, and made a small-scale testing plan with me. Port Smithson repeated this process for all four Healthy Hearts measures.

### **Reversing initial resistance**

Additionally, as part of the project's mission to provide opportunities for shared learning between clinics, staff from Port Smithson travelled to St. Paul's Family Medicine Clinic in northern Washington for a site visit. Our site visit had its intended impact, which was to demonstrate how to translate proven quality improvement changes from one practice into another, similar clinic setting. I saw Christmas morning at our next meeting! The faces of the MAs were glowing and animated, full of curiosity, each describing and demonstrating the work and knowledge they took away from their visit to St. Paul's. The outstanding dedication of those MAs, supported by my patience and persistence, helped this clinic reverse its initial resistance.

The Port Smithson team continued to discuss and test what worked for them and what didn't. They bubbled with ideas of changes, and I felt a sense of reward working with and guiding them through the next year and a half. Despite provider changes in the clinic, their ABCS numbers still improved. They ordered ASA, statin, and smoking posters from the Centers for Disease Control. They located a state-generated blood pressure poster and developed brochures for all ABCS measures.

I soon became aware my facilitation was less and less necessary. The only support the clinic requested from me was to help locate information for them to make their own brochures. For me, Port Smithson is such a great example of success!

### **Spreading changes across multiple clinics**

While working on Healthy Hearts NW, the Port Smithson team implemented a change that was adapted by all four Martin General locations. Their electronic health record (EHR) software was not designed to readily supply necessities for patient exams, so the team added white boards to every exam room with that information. This freed up more time for the providers to spend with patients, face-to-face. If a patient's initial blood pressure was elevated, they followed the 5-minute protocol and re-took the patient's blood pressure. If it was still elevated, they marked blood pressure in red on the white board. Today, all four Martin General Hospital clinics have implemented the white boards in all patient rooms. This innovation not only improved patient-provider communications, but the white boards served to visualize this clinical quality measure information.

### **Leadership takes note of improvement**

As Port Smithson continued to progress, their work was recognized by hospital leadership and the team felt excited to know they were making a difference in their patients' lives.

Port Smithson is special to me. I am confident this group has the knowledge and skills for sustainability. They started this work with so many excuses, but a combination of new staff and engagement turned things around completely. I've shared this story with other primary care clinics whose teams believed they couldn't afford the time or resources to improve, just like Port Smithson.

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*Marion David Stipe, RRT, Practice Facilitator at Comagine Health, has worked in health care for more than 30 years. He began his career as a registered respiratory therapist and has 20 years of healthcare IT experience. He is proficient in several EHR systems including Epic, Greenway Medical and MedHost, as well as an expert with implementations and workflow. Additionally, he has deep experience in meaningful use, EHR improvements related to workflow,*

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*optimization and reporting. Mr. Stipe has previously been certified in Epic Ambulatory and MyChart modules.*

**KEY INSIGHT:**

This story shows the resilience of a small practice getting unstuck early in the improvement journey. It also describes the power of learning and collaboration across clinics. Finally, it highlights specific ways an engaged clinic team can improve upon clinical quality measures. This practice didn't drop out of Healthy Hearts: instead, it graduated with flying colors!

**I find myself saying, “You’re not alone.  
Let’s see where we can start.”**

*Life as a practice facilitator*

By Cullen Conway

I'm a Practice Enhancement Research Coordinator (practice facilitator) with the Oregon Rural Practice-based Research Network. A core component of our initiative is the dissemination of the latest evidence-based research via practice facilitators that are coaching clinical teams on improvement projects and better use of their health information technology data.

I started my work with clinics in November of 2015. I'm assigned to about 20 practices in the Willamette Valley and on the Oregon coast. I live in Portland, and from there traveled to each of my clinics for an initial in-person visit to get acquainted, go over program basics, talk about their goals, and complete a data assessment. After that first meeting, I visit each clinic monthly. Initially, I alternated between in-person trips and video conference calls, but I realized that the face-to-face meetings were more enjoyable and effective so I've begun doing all visits in-person.

Out in the field there's a wide range of capacity to do QI work. For most clinics, during the second visit we looked at their data and did early brainstorming on PDSAs (plan-do-study-act cycles.) The PDSAs usually didn't start until the third visit, but some practices are already in the swing of doing them. For instance, when I returned for the second visit to one of my clinics, they pulled out 3 or 4 PDSAs they'd run since my first visit. They learned from each experiment and



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created the next from that so this practice was involved from the start in the



iterative learning cycles that I think PDSAs are really meant to be.

“A-ha” moments with the clinics are the most gratifying. One clinic was questioning their aspirin levels and why they weren’t meeting the Healthy Hearts measure. The numbers they were generating were disappointing them. Together we dug into this, figured out what was happening, and that they were actually doing well. Taking the time to do this gave them the confidence to move towards addressing the blood pressure (BP) measure. Once we’ve been able to help pull data and define the patient population (especially the high-risk

population), I've heard pleased comments about being able to view their patient panel this way, and generating alternative ways of allocating resources.

Frustration around EHR software is common across clinics. With many EHR products, providers have great difficulty trying to pull data at a population level.

"We want the EHR to get population-level data that we can't get" I've heard this from providers and practice managers many times: "It'd be much easier for us clinically to just have paper charts". Providers have invested time and money into new technology for this type of data use, but the systems don't readily deliver this functionality.

Uncertainty around addressing data theoretically or conceptually can cause anxiety. If a clinic sees it's performing 55% on the blood pressure measure but can't see the patient denominator it can be really frustrating. Part of what I do is go into clinics' EHRs with my teams, create patient reports so they can see the patients who aren't meeting the measure, and come up with ideas on how to help reach their goal. Pulling data then shifts from a burdensome administrative requirement to information that applies to daily practice — and actually helps patients.

### **Sharing what works**

One of my most effective tools as a facilitator in this project is sharing what's been working in one practice with another. When I go into a clinic, and ask them where they want to start, they may say "We're interested in blood pressure" — and I say, "Ok these are a couple of things I've seen done" or "I've seen a lot of teams focus on outreach", etc. Sharing those stories is a good way to get the QI wheels turning in peoples' minds. If people hear that it's been working in other clinic settings it holds a lot more weight than if it was just me saying, "Let's try this." With the other coaches at ORPRN, we support each other by telling these stories to each other — what we're seeing in our clinics — and so there's a form of cross-pollination happening on many levels.

Sharing stories is not just about the positive — the things that've worked — but the struggles and frustrations that are common across the board. So I find

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myself often saying “You’re not alone. Let’s see where we can start”. It’s such a powerful message.

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**KEY INSIGHT:**

Providers are especially interested in knowing how other, similar providers have approached a problem. Facilitators share this information, serving to “cross-pollinate” innovation from clinic to clinic.

## Cultivating beginner's mind

*There are times when I feel like I've seen everything*

By Carolyn Brill

One lesson that's stuck with me from my work with Healthy Hearts NW is that there's always more to learn in the role of practice facilitator. I know this work, I know the challenges going out to do practice coaching. There are times when I feel like I've seen everything. But after ten years in this role I've learned not make assumptions about clinics based on their demographics.

When we began recruiting practices for Healthy Hearts, our emphasis was mainly on small- to mid-sized clinics. I used to have beliefs around organization size and capacity for quality improvement. For instance, I thought that organizations were likely better situated to be successful at quality improvement because they had more resources.

There are advantages to working with large organizations, certainly, including that they generally are rich in information technology (IT) resources. This is very different from working with, say, an independent practice where a provider who's seeing patients is also doing the IT work. With larger organizations, the providers don't normally run data reports. This means the providers are not as administratively burdened as someone who's running his or her own business.

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I worked with a family of clinics owned by one hospital: four clinics, all at different locations, but existing within the same hospital system. Each differed in its readiness for doing QI work, to engage their provider teams directly with their coach, and to learn skills they could take with them past the project's end.



**Lack of contact with frontline providers is a problem**

I supported some larger organizations in Healthy Hearts, and found that communications in this environment can be extremely challenging. Practice facilitation works best when it builds on a good relationship and clearly defined roles and responsibilities between the coach and the practice.

In a large system, levels of management might exist between a coach and the providers. This has the unfortunate consequence of the on-the-ground provider team really not having a good grasp of the improvement work because they're hearing it second- (or third-) hand from management, directors, or the CEO. It reminds me of that game of telephone: by the time the message gets back around to the beginning, it's completely different than what was originally said.

One of the four clinics in the hospital system was very connected to their parent organization's IT. When I met with that clinic, I met with hospital directors. Their provider champion attended, but in those meetings the agenda never strayed from high-level reporting. Their approach to Healthy Hearts was 100% about how the data were being entered into the EHR. That was the only thing they wanted to focus on.

There is a problem with this approach. Data undeniably are a big component of this work: they must be entered correctly into the system so they can be pulled for accurate reporting. However, because this clinic was solely focused on data entry, they didn't engage or include their frontline teams on clinical quality improvement. They missed opportunities to connect tasks like data pulling with the "a-ha" moments we see during the PDSA cycles that demonstrate that learning is happening. They could've done so much more.

### **Are your practices learning anything, or just pulling data?**

I've seen exceptions. Interestingly, the team and the clinic next door to the one I just described (in the same organization) continuously met with me, the provider champion, and the provider champion's nurse. We filled out PDSAs, we set an aim, we really dug in on change! They rearranged their reception area to streamline how they intake patients and answer phones. We addressed so many different areas of process improvement and QI, that I felt like they really understood as a team how they could sustain this work.

These two clinics were in the same town, on the same street, even in the same building, but the way I was able to work with them was like night and day. A few characteristics of note:



- Each clinic was caring for different populations of patients
- The clinic I was able to work with more closely had fewer providers
- The clinic I was not able to work closely with took direction from their office manager
- At the end of the project I met with the provider champion at the larger clinic, but we'd never worked together directly on QI.

Both of these clinics, in the same system, made improvements. The smaller clinic seemed to really understand from the inside out what QI could do for them. I feel confident that they're continuing to improve and grow and change. The larger clinic that focused solely on IT also saw improvements with data extraction but I'm not convinced they learned anything to take forward other than how to more efficiently use their EHR.

### **Leveraging the special skills that coaches bring**

Bringing in a practice facilitator and maximizing that opportunity is a culture change for a lot of clinics. It's about more than the coaching, really. It's one thing for a facilitator to meet with clinic staff and say "let's work together as a team on this" and dig in, versus having the office manager walk into a monthly meeting and say, "Tomorrow we're going to start doing this."

One of the talents of a facilitator is to interact with the teams they're supporting. We ask good questions. We're great listeners. We assist with evaluating what's working and what's not working. The experience and skills that the facilitator brings can sometimes get lost in organizations with many layers of management. It's unlikely that the manager or director are seeing what a facilitator sees on the front lines. Sometimes teams in larger organizations miss out!

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Carolyn Brill, Practice Facilitator at Comagine Health, has extensive practice facilitation and healthcare information technology experience. She has done builds for both Epic and Allscripts, is certified in Allscripts Enterprise, and has worked with many other EHR vendors. Previously she worked as a consultant supporting practices on meaningful use and clinical measure improvement.

**KEY INSIGHT:**

There's always more to learn! Be open to being surprised, no matter how long you work as a practice facilitator or how many different practices you've worked with.

# Deepening the practice transformation bench

*I remember feeling giddy and celebrating together*

by Angela Combe

One of the small, single-physician rural clinics I was assigned to in Healthy Hearts Northwest (H2N) stands out in my mind due to the incredible progress made during the time I worked with them. Dr. Emma Boone's Oregon clinic (a provider pseudonym) was in the process of working towards patient-centered medical home (PCMH) status when they joined H2N. They enrolled in the program with the goal of improving efficiency and processes, as well as learning to maximize their electronic health record software.

Dr. Boone's practice and its surrounding community have been experiencing steady population growth and need additional providers, but recruiting and training medical professionals has been historically difficult in this region. Dr. Boone's office was receiving 5-6 new patient calls daily to request care, but she didn't have the capacity to take on so many new patients. This was another driving reason they sought coaching assistance.

## **The office manager was extremely engaged**

In complete alignment with Dr. Boone, the clinic had a focused and driven practice manager who was invested in the health and type of care delivered in the clinic. I'd say most of the push to improve originated with the office manager, who was trying to forge a path, learn and grow, and implement best practices in the clinic. To ensure everyone was working to the top of their skills and licensure, the two medical assistants (MAs) and the office manager at Dr. Boone's practice became CMAs (certified medical assistants) during H2N so the clinic had three

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medical assistants to fill care gaps. They were extraordinarily supportive of one another, and the roles that each played in providing care to their patients.



### **No prior experience in quality improvement**

This group had never done any quality improvement work prior to H2N, and had very little infrastructure support. Though essentially starting with nothing, they were completely open to change. Of the Pacific Northwest clinics I worked with, I'd say only 25% were motivated to the extent of this clinic. Roughly speaking, 25% are completely disengaged, with the remaining 50% sort of muddling along doing their best.

A big part of facilitation in the H2N project was introducing and creating Plan-Do-Study-Act (PDSA) cycles, a classic QI activity. Although our project provided printed instructions, I planned at least one visit for an in-depth discussion about PDSAs with each of my practices. It can take months for a clinic to get the hang of PDSAs – and some never quite understand how to do them, or the value they bring.

### **Jaw-dropping progress**

I'll never forget the day I showed up at Dr. Boone's clinic, discussion agenda items in hand, for the first meeting about PDSA cycles. Nothing could have prepared me for what I encountered: the front desk staff had taken on PDSAs with the support of the entire team, and had already completed their first one. They even had results to share, such as what they learned and next action steps. They were so excited to show me what they'd done.

I think my mouth might have dropped open in shock. My plan for that visit was blown! I remember feeling giddy and happy, and celebrating that moment together. Not all days in a facilitator's life are like that one, but I hold onto that memory.

### **Meaningful and exiting to watch this unfold**

This is a perfect example of on way facilitators are uniquely qualified to support practices: by recognizing progress and celebrating success. Their success with PDSAs continued, as the whole team took responsibility for conducting them. There was no single person responsible for QI – they alternated leading each cycle. The team's enthusiasm kept them going, and it was so meaningful and exciting to watch it unfold. This was a practice that truly transformed.

Such an outcome is the reason I do this work, and seeing success happen before our very eyes is exactly what facilitators hope for. Isn't this true in so many areas of life, not just health care practice facilitation? When working to make changes, it's great to have someone who really understands to cheer us on. The positive energy just flows, and helps keep us moving towards our goals.

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*Angela Combe, MS is a Practice Enhancement Research Coordinator for the Oregon Rural Practice-based Research Network serving the Healthy Hearts NW Eastern Oregon region. She holds a Master of Science in Community Health Education and a Bachelor's of Science degree in Nutrition/Dietetics, both from the University of New Mexico. Prior to joining ORPRN, Ms. Combe worked as Faculty*

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*for the Extension Services of Oregon State University and Washington State University.*

**KEY INSIGHT:**

A critical skill for a practice facilitator is the ability to be a cheerleader. Change is hard, and sustaining change is sometimes even harder. Expressing enthusiasm and reflecting back to a provider team what's going right with their efforts helps bolster motivation to keep going.



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# Newly in the field, a practice facilitator finds her footing

*My team asked me to step into a role I knew I was qualified for, but had no real-world experience doing*

by Caitlin Dickinson

I'm a project manager with Healthy Hearts Northwest, based within Portland's Oregon Rural Practice-based Research Network. I'd like to share with you what happened when I headed out into the field as a Healthy Hearts NW coach with zero on-the-ground experience.

## **Great opportunity exists in emerging fields like ours**

Practice facilitation is still a wide-open field: no standards exist for the title of practice facilitator. Even these two nouns (coach, facilitator) are sometimes interchangeable, sometimes not. Whether coach or facilitator, working in this capacity isn't like being a registered nurse, or a licensed massage therapist, or an attorney. There's no national or state accrediting body, there is no one-size-fits-all definition of a practice coach or facilitator. If you do an internet search for employment as a health care practice coach, you'll find that many aspects of this profession vary between job postings.

I began working as a project manager at ORPRN in 2015 after earning my Master's in Public Health and working in OHSU's OB/GYN department for four years. ORPRN's mission is to improve the health of rural Oregonians by promoting knowledge transfer between communities and clinicians. Being involved in work

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that reflects community health values, priorities, and needs with like-minded colleagues is a dream come true for me.



When ORPRN embarked on Healthy Hearts NW, I supervised our team of practice facilitators. We call them Practice Enhancement Research Coordinators, or PERCs. I managed project operations, and my curriculum development perspective served me well in that role. I was intimately involved in the design of the visits and the program. I attended the PERC trainings and had in-depth knowledge of the coaching day-to-day activities.

**Staffing changes often necessitate switching roles**

Multi-year initiatives like Healthy Hearts often undergo staffing changes, and ours was no different. When we lost one of our PERCs more than halfway through,

Healthy Hearts pulled me in as a facilitator to finish out the project. Because I was thoroughly familiar with the role and the work being done by our PERCs themselves, it made sense to step in.

Here's the thing, though: I'd never actually gone out in the field. I was nervous! Changing gears and becoming a facilitator meant that I'd inherit clinics that had begun the project with someone else, and were well on their way with their project work.

H2N created a powerful tool in the Quality Improvement Change Assessment, or the QICA. It's a survey completed by staff and clinicians that assesses their current QI capabilities and describes aspirational QI capabilities. It is used by the facilitator to guide them in supporting their practice on their journey to improving patient care. In Healthy Hearts our facilitators work with their clinics to complete the QICA twice: once at the beginning, and then again approximately a year later to measure progress.

One of the practices I inherited is a great example of why I love the QICA. The practice took very good care of their patients and had an extremely hard-working team, but they lacked a unified approach for QI – the major focus of Healthy Hearts. My colleague had completed the first ten visits with this clinic. She'd already administered the QICA with the practice at her very first visit with them, and again at the tenth visit. It was at that point that I stepped in, acting as their facilitator for the last five visits.

### **Having the QICA to rely on made all the difference**

When I started working with the clinic, I had 10 months' worth of extremely detailed notes and all of this theory swirling around my head, but I needed to zero in on something. I used the QICA, and it saved me. I find this really reassuring as a new practice facilitator! Everyone on the clinic team fills out the QICA, not just the physicians. Although I appreciated having access to the first facilitator's documentation, I didn't have to sort through it all and rely on that. I had a well-rounded self-report from the team I'd be working with to guide my efforts.

I decided to focus in on a priority as determined by the QICA data, versus input from individual providers. The activities the clinic chose to work on with me arose from what they'd been learning from their data. Data began to drive the action, not self-selected provider interests.

This shift had a huge impact on team functioning! The Medical Assistants became much more involved in rolling out QI activities. They seemed happier in their jobs and started speaking up in meetings.

My successes as a practice facilitator in the end stages of our project directly result from the solid foundation built by the PERCs that came before me, and the timely administration of an effective measurement tool. This team wouldn't have gotten where they ended up without these two factors. This clinic's fabulous providers were doing well before Healthy Hearts Northwest, but they turned an important corner. They now embrace a data-driven, team-based approach to improving the way they run their practice. I feel so fortunate to have witnessed this, and to have been part of their journey.

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*Caitlin Dickinson, MPH serves as project manager for ORPRN's Healthy Hearts Northwest project. Prior to joining ORPRN, she worked for OHSU's department of OB/GYN and coordinated career development (K12) programs and research projects focused on evidence-based medicine, comparative effectiveness, patient safety, and improving teamwork and leadership among healthcare personnel. Caitlin holds a Bachelor's degree in biology and chemistry from the University of Denver and a Master of Public Health degree from Oregon State University.*

### **KEY INSIGHT:**

This story illuminates two important aspects of real life as a practice facilitator. First is the guiding structure, or curriculum, to inform the work. In our case it's the QICA tool, which measures seven change concepts and allows for input from

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everyone in the practice. These high-leverage changes expand and build quality improvement capacity in an objective manner. The QICA also provides the information that facilitators need to tailor their approaches to individual practices. On this journey, it helps to have a road map!

# Bettering the health of your community and patients

*Champions of the PDSA*

by Denise Weiss

In January 2016, I moved to the Oregon coast and joined the staff of the Rinehart Clinic in the northern Oregon seaside town of Wheeler. One of my roles as an RN is helping with Healthy Hearts Northwest, the program we've enrolled in to help provide better cardiovascular care to our patients.

Our clinic's quality improvement team meets weekly to assess where we're at with our plan-do-study-act cycles" (PDSA). You can't improve unless you know what you're currently doing, so when we got the Healthy Hearts quality measures (the ABCS), we knew we had to start with blood pressure (BP). All of the other measures are directly impacted by that.

## **We made it fun**

We did parody skits of what not to do when taking a patient's blood pressure. For example, in one skit, I wore a heavy-sleeved coat, was drinking coffee, talking rapidly and had my legs crossed. All the MAs watched and pointed out what was wrong in terms of taking blood pressure. We laughed a lot while we were learning.

With help from the Healthy Hearts' materials, we made laminated posters on taking correct BP. We put them on the walls of each exam room next to the blood pressure monitor so the patients could see. After we identified some things that were being done incorrectly, we did random skills checking with the MAs. The clinic supervisor would have each one check off what they were

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doing. Putting the laminated sheets in the exam rooms helped get the patients



involved. If an MA was busy and not doing something correctly, the patients might say something like “Oh I have my legs crossed – it says here I’m not supposed to.” So in this way we involved the patients. They are partners in improving their health outcomes.

### **Our first PDSA was just getting up to speed**

After this, our denominator decreased. Our next PDSA was on “second reading.” For those patients not having good BP control (a reading greater than 140 over 90), a second blood pressure was taken at the end of their visit. Before the MAs wrote the after-visit summary, they would take a second reading. The theory behind this is that maybe the patient was anxious during the first reading or they just had coffee or a cigarette. By doing the second reading we could see if the patient was truly hypertensive or if the blood pressure was within range.

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After the second-reading BP PDSA, we did chart audits to discover what percentage of our patients were getting that second BP reading. We saw that one team was doing really well with it, but another team was struggling. We pulled the MAs together to talk about what was and was not going well. We did another audit two weeks later and saw the same thing. We then did an incentive, a contest, where the clinic supervisor gave out lanyards. It was a small, fun motivator!

During the process of continued audits, we found an EHR glitch. Two of the MAs were entering the second reading into one field and the other MA was entering it into another field where it was replacing the first reading. In this way, we found a documentation piece that was impacting data capture.

### **Addressing blood pressure alone had a ripple effect**

After we started with Healthy Hearts, our blood pressure numbers began to improve. Then, without having made them a focus, our other numbers started to improve (aspirin therapy and tobacco counseling).

I'm really excited about doing this work. Our clinic has support from the administration and an overall vision that we are not just focused on our clinic patients, but on the health of our community. It is all related. If you improve the health of your community, you improve the health of your patients.

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*Denise Weiss, RN is a Registered Nurse at [The Rinehart Clinic in Wheeler, OR](#). The clinic's service area is a federally-designated Health Professional Shortage Area, meaning it has an acute shortage of health care providers, and also is a federally-designated Medically Underserved Area, which indicates that the area lacks resources to meet the medical needs of the resident population. The Rinehart Clinic is working to meet those needs by providing high quality, complete, personalized medical care for residents and visitors.*

### **KEY INSIGHT:**

Here's an important idea: make it fun. Involving members of a provider team in a



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silly activity can lessen potential tension or resistance to process change. And medical assistants can be wonderfully powerful transformation agents.

# When an enrolled practice disappears

*Facilitators face a dilemma when practices in a project stop communicating*

by Tara Kline and Steven Brantley

Ghosting, in case you've never experienced it, is having someone you believe cares about you (a friend or someone you're dating) disappear suddenly without explanation. It's not a new human behavior but it has become more and more common as people favor online and digital communication over face-to-face interaction.

Practices, too, can disappear suddenly in a quality improvement initiative like Healthy Hearts Northwest – sometimes resurfacing months later, sometimes dropping out entirely. During the course of our project, our facilitators followed a regular telephone and email outreach regime, but as you can imagine, for a primary care practice juggling patient, clinic, and project needs can be maddening! As a result, some practices stop responding. This can cause a facilitator to wonder, “Have I been ghosted??!”

According to one of our facilitation team, it wasn't a surprise for some enrolled practices to stop communicating altogether. In these instances, our facilitators continued a robust amount of contacts per month, shifting to lesser intensity after months of silence. Eventually we accepted that some practices

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might not want to “see” or “hear” from us. Our facilitators want what’s best for the practices they work with and in some cases, this meant letting go.



We checked in with two of our facilitators to get their take on ghosting. Here’s what they said.

**But we’re perfect for each other!**

The email came as a surprise. A practice that had been doing very well and fairly advanced in their QI structure wanted to stop participating in our initiative. We’d already met 4-5 times, and we were a perfect match: Healthy Hearts offered practice facilitation, shared collaborative learnings, and technical assistance that overlapped beautifully with their existing projects.

When they emailed to tell me they were too busy for another project, I was surprised. We had been making great progress towards the goals they outlined.

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However, I knew I needed to respond without damaging our relationship. I thanked them for the opportunity of getting to know and work with them. I told them I was sorry to see them go.

Several months passed, and I emailed them to touch base. I'm really glad I did because they were in crisis mode. Their electronic health record had dropped its analytic component, which completely removed all QI and clinical quality measures reporting capability. I explained how Healthy Hearts was helping clinics in the same predicament, which caused them to re-engage. We helped them with connecting to a registry and using a tool to evaluate their QI for improving outcomes for their cardiovascular patients.

Over time, they realized how teaming up with a collaborative effort and other resources, such as facilitators, was to their advantage in the current environment. They appreciated having experts in various areas at their fingertips.

In one of their last messages to me they said that, "Healthy Hearts Northwest wasn't such a scary project at all."

Maybe you can call me a ghostbuster!

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*Tara Kline, MS is a Comagine Health practice facilitator with expertise in meaningful use, PQRS/Value Based Payment Modifier, HIPAA security risk analysis and mitigation, and the patient-centered medical home. Ms. Kline holds a master's degree in the field of clinical laboratory science and is a Certified Professional in Health Information Technology, is a Certified HIPAA Professional, Certified Professional in Healthcare Quality, and a Certified Lean Six Sigma Black Belt.*

### **It's not you, it's me**

We recruited all our Healthy Hearts Northwest practices with the best intentions,

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yet I saw signs that some were misaligned from the start. It wasn't a surprise when such clinics dropped.

One of my practices had zero resources with little ability to act on Healthy Hearts Northwest activities. Additionally, in the middle of the project, their CEO had a massive stroke. Their leadership team fell apart, staff were in crisis, and it was a struggle just getting through each day.

We continued to meet monthly despite me doing a variation of "it's not you, it's me." I made space for them to back out, explaining that I didn't want to take up their time. They saw value in the time we spent together – even though they lacked the resources to do anything– so we kept meeting.

I connected them with another practice that had an interesting structure for staffing, one from which they could learn and take back to their practice. They weren't able to change their staffing model but they were eager for the information. I regularly shared what other practices were doing, and in some ways, I acted as their counselor.

We continued like this for 18 months, and we were almost at the end of the intervention period. At that point, they hired a new CEO who came from the federally-qualified health center world and had been doing quality improvement (QI) for most of her career. In two months, she and I wrote a charter for a QI committee and compliance credentialing. These committees convened staff members from all three sites and at the same time, added patients.

Seemingly overnight, they switched into high gear and started making big changes. We ended our time together on such a high note! They were one of my most memorable and favorite teams to work with.

Our instinct as facilitators is to be unfailingly respectful yet persistent. It's a bit of a dance, but that's part of the job. We never know which practice may end up soaring.

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*Steven Brantley, MPH is an ORPRN Practice Enhancement Research Coordinator. His interests include the spatial relationship of health determinants, primary care transformation, and improving access to healthcare. Steven received his master's degree in public health and his bachelor's degrees in biochemistry and Spanish from Oregon State University.*

**KEY INSIGHT:**

Meet practices where they are, understand their limitations, and know it's not always you. Expect the unexpected. In both stories, the practice coach was surprised by the unexpected. One practice made significant progress toward the end, and one seemingly on course both suddenly dropped out – but both practices re-engaged later. The key is maintaining a respectful relationship and cultivating large dose of patience.

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# I can't wait to find out what this clinic will do next!

*We can achieve so much through collaboration*

by Kristin Chatfield

One of the things I loved most about being a Healthy Hearts Northwest practice facilitator was working with practices as they came up with new ideas and helping them with implementation.

A perfect example was the “BP call-back card” developed by a group in one of my clinics in the relatively isolated community of Klamath Falls, Ore. This organization includes five primary care clinics varying in size, as well as specialty care clinics. The call-back card’s purpose is two-fold: to implement a standard protocol for patients who have a high BP to come in for their follow-up appointment and, more importantly, to help them begin to understand and manage their BP.

All of these primary care and specialty clinics began using the card, and the story of how the card was created highlights the great things that can happen when practices get inspired by quality improvement.

## **Forward thinking: One good idea leads to another**

There are a lot of things that made this practice special to me. For one, their patient demographic perfectly represents the community they serve—which is something we discovered thanks to a Healthy Hearts Northwest practice survey.

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Secondly, their QI work is both broad and deep. In addition to Healthy Hearts Northwest, they were involved in several other initiatives, including Quality by Design and Comprehensive Primary Care (CPC+).



And third—from managers to clinicians to IT staff—the people who work here are creative forward thinkers. The forward thinking that led to the BP call-back card began after we identified blood pressure control as an area for improvement. The first step was a system-wide training for all MAs on proper protocol for taking BP measurements. The training launched in January 2016 for primary care as well as specialty departments—like dermatology, where it is less common for staff to be familiar with the protocol if a patient has an elevated blood pressure.

By all accounts, the training was a huge success. It was clinically technical, but also funny and engaging. Instead of relying solely on tables and data, it fostered really open conversations with frontline staff sharing their challenges and what they've seen. In the process of developing the training, however, staff



immediately realized that it would not be as effective without a next step. So they started asking, “Now what?”

And then, at a regular Healthy Hearts Northwest check-in with their leadership team, someone suggested a little workflow adjustment that could help ensure patients received proper follow up after a high BP reading. The idea of the BP call-back card was born.

### **Collaboration brings the BP call-back to life**

This organization's leadership team includes people with a diverse range of expertise and rolls, including clinic managers, doctors, nurses, MAs, and people from IT. This group is egalitarian and came together in a really honest collaboration to bring the call-back card to life. The clinic operations manager first came up with the idea, but the brainstorming that followed was so open and dynamic that the concept really belongs to the entire team. The front of the card includes tips for getting accurate BP readings and important facts about risks related to high BP. On the back, patients have space to write in pulse and BP measurements they take at home or at a drugstore so they can share these with their doctor. They can also keep track of their target BP and the date of their next appointment. And thanks to a suggestion from their IT lead, the card is paired with a smartphrase in the EHR. That means, in addition to tracking overall BP numbers, they'll be able to know who is using the card and when.

### **More ideas and collaboration on the horizon**

In their overall push for good BP protocol and high-quality care, this group of clinics began thinking about developing a poster on proper BP positioning to hang in clinic exam rooms. The idea was developed in response to an important issue that came up organically during their work on high blood pressure: It's not always easy for MAs to tell patients to be quiet during a BP reading. Having a poster showing proper BP technique would give MAs a gentle way to remind patients of what they need to do to get an accurate BP measurement.

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Projects like these serve as poignant reminders of how much we can achieve through great collaboration that brings people together across primary care. I can't wait to see what these providers will achieve next.

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*Kristin Chatfield, MPP is a researcher and economist who loves using data to create social good. She believes that with a little help, rural communities have a boundless ability to innovate and create healthy, vibrant places. Kristin served as a Practice Enhancement Research Coordinator on the Healthy Hearts NW project. She received her master's degree in public policy from Oregon State University.*

**KEY INSIGHT:**

Practice facilitation can provide an opportunity for an entire care team to engage with one another, which can have a profound impact on a their ability to transform.

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# How do we keep our private rural practice open?

*A Healthy Hearts Northwest clinic describes its remarkable transformation*

by Keli Christman

I've been in health care in Wallowa County for over 26 years, and during my time at Winding Waters, we've completely transformed the care we provide.

To give you a better picture of our community, there are about 7,000 people in Wallowa County, with approximately 2.1 people per square mile. We are in the far northeastern corner of Oregon and very frontier, very remote. Many years ago, I was working in assisted living, and I used to dread taking my patients to Winding Waters Clinic! Two physicians took care of the entire patient population: They worked in the emergency room and the hospital — and saw clinic patients. You could sit in the waiting room for hours, waiting for your patient to be seen because her physician was called to the hospital to deliver a baby or see a patient in the Emergency Room.

## **Heading in a new direction**

I joined the staff at Winding Waters in 2006, a short while before we became involved in what would become the biggest influence in our transformation journey, the Safety Net Medical Home Initiative (SNMHI). At that time, we also brought a new physician on-board, Dr. Liz Powers, who would become the leader

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in our transformation journey. We look for every opportunity to continue improving, and we're always on the search for the right people to lead projects.



New leadership, combined with the SNMHI collaborative and practice coaching structure, really helped push us in a new direction. We Among many other changes, we implemented open access scheduling, a 24-hour physician advice hotline, and we started the shift to team-based care.

Our dream of true team-based care was realized in 2012 when we were invited by our local critical access hospital to design a new space within their Medical Office Building being built right next to Wallowa Memorial Hospital.

In that time of transition, Wallowa County became a Governor Designated health professional shortage area, one of only two such areas to date in Oregon, and we became an official rural health clinic. Following an intensive application process, we were awarded federally qualified health center (FQHC) status in August 2015. These designations opened so many doors for us — paving the way to partnership and networking with folks across the state struggling with the same things we were.

Whether we've compiled measurable data or not, quality has always been at the forefront of what we do. SNHMI set the framework for us to start getting good at quality improvement. It's been evolving over time, and we're getting better and better at it.

Our FQHC designation allowed us to officially become a non-profit organization. We'd been a for-profit acting like a non-profit, which I can't recommend as a business strategy. Now we do more reporting, compile more metrics, and are under more scrutiny — and all of that gives us the opportunity to continually raise the bar. We're in alignment, and it's been phenomenal.

### **Grant funding opened even more doors**

Five-plus years ago we partnered with Northeast Oregon Network and Wallowa Valley Center for Wellness (WVCW), our local community mental health agency, to apply for a Health Resources and Services Administration (HRSA) Small Practice Quality Improvement grant for the integration of behavioral health into our primary care setting. That three-year grant project provided salary support to WVCW to embed three part-time behavioral health coaches into our clinic. One had been a marriage and family counselor, the other two were LPCs. These three individuals participated in a behavioral health certification process, which was a combination of online education and face-to-face training.

The coaches immediately became an integral part of our patient-centered team. One of the coaches remained and became part of our organization after the grant ended. During that project it quickly became second-nature for our physicians to rely on coaches for help with motivational interviewing toward lifestyle changes around weight loss, diabetes, healthy eating or anxiety — with the primary goal of having a positive impact on patient health. The providers have gotten very used to our health coaches sitting next to them in our work pods to the point that when one of our health coaches is on vacation, and we only have one, I hear from them "Where's our coach, I need her!" Having behavioral health coaches in our clinic is now completely natural to how we function.

### **Let's address cost**

There's an important aspect to health coaching I want to address: costs. We have a high Medicare and Medicaid population: almost 40 percent of the county's population subsists below 200% the federally designated poverty level. Health coaching was initially offered to patients as a free service through the resources in our HRSA grant. After the grant ended, we felt compelled to collect revenue for this service so we instituted a \$5.00 fee for each 30-minute visit.

Our uptake just tanked. Our coaches told us, "I'm not very busy. I feel like I'm missing patients, they're not coming back to see me." A five-dollar \$5 charge was truly a barrier. So we re-evaluated this and went to our board of directors. Their perspective was: if our providers and clinicians really think this is a valuable service, then let us provide it without charge.

Our board's support has enabled us to go back to offering behavioral health coaching as a free service. It has been almost a year now, and we've seen the tide turn. Coaches are once again busy, and health coaching visit counts continue to grow. Patients have better controlled diabetes and hypertension, and there is a lot of engagement around healthy eating. Our health coaches can connect patients with vouchers to purchase fruits and vegetables at the farmer's market. We also have a budget for helping patients with temporary housing, transportation, dental care, and prescription drugs.

### **We look for every opportunity**

Our coaches are constantly coming up with new ideas—like let's do a cooking class, etc. Behavioral health coaching provides services that fall into the 'soft' category: We can't always attach hard data to outcomes, but they make a definite impact on our patients' lives and their engagement with health care.

In 2015, we enrolled in Healthy Hearts Northwest to help us get a better handle on cardiovascular risk factors. This project brought practice facilitators into our clinic, but this time to work with staff in helping us sharpen our capacity to compile metrics.

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Today we have 52 employees, including a full-time data analyst and a quality improvement director. We treat the entire person by integrating behavioral health, oral health, and primary care services. I am exceptionally proud of the care we offer to our community. Winding Waters is going places I would never have dreamed possible.

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*Keli Christman is the Operations Officer at Winding Waters Clinic in Wallowa County, Oregon. [Watch a short film that tells the story of how they became a non-profit, federally qualified community health center.](#)*

**KEY INSIGHT:**

Some primary care clinics can be elevated as exemplars because they're doing so many things right and so well. The practice facilitator that worked with Winding Waters Clinic alerted our project that this organization was special. Facilitators hold unique knowledge of a region's landscape and can be invaluable to researchers and stakeholders seeking to identify high-performing teams.

# Caring for our rural communities

*Rural Oregonians are disproportionately impacted by cardiovascular disease, but practice facilitation offers unique support*

By Michael Parchman

L.J. Fagnan and I have much in common: We're both licensed family physicians, we've both practiced medicine in rural areas, and we both serve as scientific investigators on Healthy Hearts Northwest, a multi-year research project to help patients reduce their risk of developing cardiovascular disease.

With support from the Agency for Healthcare Research and Quality's EvidenceNOW initiative, our Healthy Hearts Northwest project aims to increase the quality improvement capacity of primary care practices through the use of practice facilitators.

An early study goal was recruiting 250 clinics throughout Washington, Idaho, and Oregon, including many clinics located in rural areas. Enrollment for big studies like this always involves significant outreach, and these days recruitment is often accomplished via web or phone from a centralized location. Our project design included face-to-face interactions between our team and participants over a 15-month period, which hinged on us building interpersonal trust. So we began building those relationships by doing mostly in-person enrollment and logged many miles driving backroads and highways getting to the practitioners we wanted to reach.

L.J. founded the [Oregon Practice-based Research Network](#) (ORPRN) in 2002. We partnered with ORPRN because we knew that the strong relationships his organization has forged would help us reach our recruitment goal. But we were excited to collaborate with him for another reason: Rural health care practices face unique challenges. No one knows rural practice like ORPRN, and we knew



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that the Healthy Hearts Northwest approach would offer unique support. We were eager to test our approach in rural areas.

I asked L.J. questions about Healthy Hearts Northwest in the context of practicing rural medicine — and here's what he said.

**Can you describe a typical rural practice and the challenges they face?**

Those who choose to practice medicine in rural areas are special people. Rural physicians attend to clinic, take care of hospital patients, handle emergencies and trauma, deliver babies, and care for citizens in the nursing home. Rural clinicians want to be integrated into their communities in this way.

Rural, or “frontier,” is defined by less than six people per square mile, so that often means more cows than people. Frontier providers try to address the social determinants of health (housing issues, food insecurity, and transportation) along with everything else.

Generally, rural communities can be characterized as having small populations, lacking large health systems and centralized resources, and with a high degree of poverty. Because rural practices don't turn anyone away at the door, they are the safety net with over 50% of the patients insured by Medicaid

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(25%) and Medicare (25%). One in five Oregonians lives in a rural area. With our population at 4.14 million, almost 20% of Oregonians live in rural settings.



### **Why is practice-based research in rural areas important?**

The bulk of medical research studies happen in academic medical centers, but less than 2% of patients receive care at these centers. Research is about truth, but the truths found in academic medical centers might not actually be true.

Practice-based research collects data from real people in the real world, often living in underserved areas. As researchers, we have a responsibility to make life better for practitioners and the patients they serve. Casting a wider net,

using data from a variety of practices and geographies, gets us closer to a generalizable truth.

### **Why was Healthy Hearts Northwest a good fit for ORPRN?**

Central to Healthy Hearts Northwest is the use of practice facilitation, which has its roots in the agricultural extension agent movement of the 1930s. We have a great team of practice facilitators (PERCs) working directly within health systems and fifteen Coordinated Care Organizations throughout Oregon.

Our PERCs made monthly site visits to all enrolled Healthy Hearts Northwest clinics over a 15-month period (and sometimes longer.) We were excited to bring our PERC model into frontier medicine because cardiovascular disease affects rural Oregonians disproportionately. Approximately 40% of rural adults have hypertension and 15% have cardiovascular disease as opposed to 27% and 7% in urban areas. This means that there is a greater percentage of potentially excess deaths from cardiovascular disease in rural areas as opposed to metropolitan areas.

Healthy Hearts Northwest is teaching practices how to fish, as opposed to giving them fish. Rural practitioners like this because they like to be self-sufficient. We've given them tools that they can apply to other conditions, like depression and diabetes. In turn, practices teach the health services research community how to adapt the tools to the real world.

Many of the Oregon practices have told me that Healthy Hearts Northwest has made an indelible mark on them.

### **Practices that join ORPRN agree to provide data for your research studies. Like Healthy Hearts Northwest, does ORPRN offer them anything in exchange?**

The benefits go both ways. By joining the network, smaller and independent Oregon practices know that they're contributing to building an evidence base that can lead to better care for rural communities. Participating clinics are eligible for invaluable support from our PERCS navigating today's shifting health care landscape. Our technical assistance ranges from in-person practice facilitations to

helping set up a new EHR to developing innovative ways to compile reporting data to writing federal grants.

Network members tell us that ORPRN has played an important role in collegial support, practice improvement and stability for many of them in rural and remote areas of the state. They feel engaged in a network-wide dialogue about merging the varying accomplishments that we've had through the years into a coherent and sustainable vision for Oregon's future.

**You do a lot of driving! You try to visit each ORPRN practice in-person every year. Why is this important?**

It's hard to recruit busy practitioners for studies, but there's no substitute for doing it in person. Recruitment needs to be a give and take. We make practices aware of opportunities while also finding out what challenges they face. Rural practices are increasingly expected to report data and quality metrics, so I tried to find out what each was doing with that. For Healthy Hearts Northwest, I'd explain that we'd be looking to get data to reduce stroke and heart attacks, and that we think primary care is the right place to institute this. I'd tell them I thought it might work with their practice. You can't do that by email. You have to show up, make "home visits."

Also, I visit practices because I get inspired by them. I see how providers are caring for their community, and come away thinking, "Medicine's a good job, and we do really good things for people."

**What preliminary discoveries has Healthy Hearts Northwest made about rural versus urban Oregon medical practices?**

We found that rural Oregon practices were more likely to sign up for Healthy Hearts Northwest than urban practices. One in four rural practices approached for our project signed up as opposed to one in ten urban practices. Oregon rural practices were also more likely to complete the study. The urban dropout rate was 29% as compared to a rural dropout rate of 15%.

The rural practices loved in-person visits from Healthy Hearts Northwest. It was more of a sales job with urban practices.

### **What's on the horizon for rural medicine?**

We have yet to make rural practice a place that attracts medical students and other health professionals. We need a training program that trains local people to fill roles in rural medicine. New physicians leave medical school with huge debts, and they shouldn't have to sacrifice income to work in frontier areas. And we need to identify and promote a business model for a patient-centered and community-centered primary care practice — and ensure that it's sustainable.

It used to be that education was the number one employer in rural settings, but now it's health care. And if no providers want to or are able to sustain life in a rural community, there's much more at stake than losing health care; the whole community may die.

### **I think the isolation of the rural landscape has driven you to do your work. Can you talk about loneliness?**

I grew up in and am drawn to rural areas, which is typical of folks working in rural medicine. I started my own family medicine career working in Alaska with native Americans. My daughter was born in a native village. When you're in rural practice, you make do with what you have, and you learn to solve problems on your own. It's what we know and love.

And it's hard work out there. Doing what we love comes with a cost and responsibility. At any given day in a rural practice, a life might be at stake. Providers wonder, "Does someone have my back?"

That loneliness of wondering if I had any support has been a motivator for me, and what's led me to seek out other people. [Voices from Left of the Dial](#) is a paper I co-wrote about the reasons practitioners get involved in such difficult work. The conclusion we ended with is that practice-based research is the antidote to loneliness.

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*on improving chronic illness care in primary care clinics by approaching them as complex adaptive systems. A family medicine physician, Dr. Parchman previously served the Agency for Healthcare Research and Quality as the director of Practice-Based Research Network Initiative and senior advisor for primary care.*

**KEY INSIGHT:**

Rural health care practices face unique challenges in addition to the increased quality data reporting currently required of all health care providers. These include lack of resources and access to centralized support, as well as shouldering an increased burden of responsibility for all members of their communities. Networking and joining forces with fellow rural practitioners can ease the stress and loneliness that often accompany life as a frontier provider.

# Thinking outside the box

*Welcoming diverse points of view is powerful – and smart*

By Cullen Conway

One of the clinics I worked with during Healthy Hearts is a federally-qualified health center (FQHC) on the northern Oregon coast. Like other FQHCs, it mostly cares for patients who are middle-aged and/or underserved.

When I started meeting with the clinic as their practice facilitator, they already had a clinical quality manager on staff and were meeting regularly to discuss typical topics like metrics and workflows. They had been in conversation about their blood pressure metric, but were struggling to find improvement.

Things started to brighten when the clinic came up with the idea to improve BP processes by engaging the people who took BP readings: their medical assistants (MAs.) The first step in doing this was to carve out time for the MAs to gather in a room so that they could brainstorm solutions. What was interesting to me, and I think very astute, was that the administrators and providers excluded themselves from the process.

The MAs were excited to take this on! They generated fifteen ideas to address, voted to distill down the top three, and used these as the basis for their Healthy Hearts PDSAs. The MAs created great, effective workflows that were well-liked across the team.



The clinic's initial improvement approach was what we call "top-down": only high-level administrators and providers were at the discussion table. They learned that by limiting the quality improvement conversations to only those in senior leadership positions, they missed hearing directly from care team members that perform the processes they were trying to fix. Blood pressure improvement started with the higher-ups trying to figure a way to do it better, but the medical assistants ended up being the problem-solvers.

Over the course of the project, the clinic bolstered their QI committee to include multidisciplinary staff, patients, and community members. One of their big takeaways from the PDSAs was that incorporating more voices, rather than



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deferring to a single authority, often led to the most effective protocols and designs.

For example, a team member described to me how community members helped the practice think outside of their clinical box. The clinic knew it needed to improve their BMI metric. They discovered that many of their elderly patients did not want to take off their shoes to step onto the scale. As they were discussing workflow ideas for this metric in a QI committee meeting, a community member raised his hand and asked, “Well, do you have a shoehorn near the scale?” Voila! Two shoehorns were installed near their scale and the BMI metric shifted for the better. Having the community member perspective allowed them to identify basic and practical solutions that they were missing on their own.

This FQHC continued their impressive and inspiring work throughout Healthy Hearts. Most of their good work initiated from their ideas and occurred during time when I was not with them, but I was with them in spirit to support and cheer them on.

I am so happy to share these examples of what can happen when a practice makes a habit of taking an inclusive approach to thinking through problems that impact an entire clinic. More voices at the table can be effective – and smart.

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*Cullen Conway, MPH is a Practice Enhancement Research Coordinator at the Oregon Rural Practice-based Research Network. His interests include social determinants of health, social justice, and working to reduce health disparities among underserved demographics. Cullen received his master’s degree in public health from Columbia University and his bachelor’s degree in psychology from Lewis and Clark College.*

#### **KEY INSIGHT:**

A practice facilitator often creates an opportunity for others in the clinic to feel

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safe and speak up. This can change the nature of the conversation within an organization, which creates buy-in with bottom-up rather than top-down ideas.

# 5 ways to balance competing data needs

*Mixing quality improvement and research in one project can make for tricky data collection*

By Elena Kuo

I'm a senior research associate at the Center for Community Health and Evaluation (CCHE) at Kaiser Permanente WA Health Research Institute specializing in quantitative methods and program evaluation. While I work almost exclusively with my CCHE team, I jumped at the chance to join Healthy Hearts Northwest as a data scientist because I was intrigued by the project's large scope.

My main role with the project was to keep the team on track with collecting two types of data: quality improvement and research. The QI data were clinical quality performance measures for cardiovascular risk factors, for example, blood pressure control, and the research data were surveys related to practice characteristics completed by office managers and members of the primary care clinic teams. I also cleaned the first round of data before passing it on to our programmers and biostatisticians for analysis and writing.

The main reason that practices enrolled in the study was to learn how to generate QI data. Becoming facile with reporting on clinical quality measures helped practices with reimbursement and other requirements. But as often is the case in our world, back at the home office we were collecting data to address research questions. This second type of data proved to be a bit harder to get.

Looking back, I can see where our approach worked well – and the areas where we could have been more effective.

## **1. Commit to continuous engagement**

Our project kicked off with the task of recruiting practices, enrolling them into our study. But once we reached our goal of 250, we couldn't just rest easy knowing we'd met our goal. Because our project spans multiple years, a few of our facilitators left the project, over time some practices dropped out, some went dormant, etc. We were always in the position, one way or other, of engaging and retaining participants and partners in this work. With a long project, too, refinements can end up being made and then you need to get buy-in for those.

## **2. Tailor your outreach**

Different types of outreach worked for different types of practices. For instance, email worked for only half of our practices. I was surprised that many practices consider it super-high tech to be on email! Some practices were just getting their first electronic medical record when they enrolled in Healthy Hearts. I've been using email for 20 years in my work, but this was a good reminder that it's not typical across all industries.

When we needed something from a rural-based physician, such as a practice survey, faxing often worked best. From my perspective, it seems still common in rural areas. We learned that faxes are part of their workflow. They're placed in providers' inboxes and considered part of daily work. Here in Seattle we're used to Skyping and video conferencing, but I'm not convinced that's the case in a lot of outlying areas. Email tended to work for reaching urban practices, so we came to see a real distinction.

## **3. Streamline research data collection**

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Oh, this is a big one! We spent a lot of time and effort on outreach to get clinics to fill out practice surveys that we eventually concluded were much too long.



Initially our practice survey was nearly 50 questions long! When we started our project, a lot of people came up with really interesting questions for the survey and we included most of them. During the course of the project, however, we found out that just 12 of them got us the minimum amount of data we needed. In retrospect, we might've had more success collecting practice survey data if the instrument had been shorter and we could've advocated for brevity.

#### **4. Make practice facilitators your research partners**

This is key. As part of our study intervention, each practice was supported by a “coach” or facilitator. We wanted to shield our facilitators from too much nerdy science. We thought this segregation would allow them to concentrate on relationships and technical assistance, the bread and butter of facilitation. But it had the unintended result of separating them from the research part of our work.

Our facilitators worked tirelessly to create trusting relationships with their clinics. We found that it was a tough project requirement for them to ask their practices to complete long surveys, in addition to everything else.

However, we did find that involving facilitators in this data collection was absolutely essential, and in fact was not inconsistent with their work, since the insights provided by the survey results were often helpful to them.

### **5. Budget for face-to-face meetings**

Team cohesion is critical to the success of a long-term project where team members work in various organizations and live in different states. We had folks in home offices in three different institutions, and the coaches out in the field driving across Washington, Oregon, and Idaho. Still, we managed to regularly gather a couple of times per year, and these meetings really helped! After we met in person, I went from being an annoying “home office” data person bugging our practice facilitators via email for data to a real person. It takes a lot of planning and resources to support in-person project meetings, but I don’t know if we could’ve pulled off this project without having established and maintained face-time relationships with one another.

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### **KEY INSIGHT:**

Practice facilitators provide research teams with invaluable, real-world insight.

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With thoughtful planning and execution, research and quality improvement contribute and strengthen each other.

# We all want a healthy heart

*Leading with the heart led to trust*

By Kilian Kimbel

I started working on the Healthy Hearts Northwest project in 2015. In my 11 years with Kaiser Permanente Washington Health Research Institute, I had never worked on a quality improvement research project, let alone one invested in recruiting and providing practice facilitation with over 250 small- to medium-sized primary care clinics spread across the Pacific Northwest within 3 years! This work has deepened my knowledge of research, taught me about health care practice transformation, and showed me that each are profoundly human at core.

One of my first roles was tracking and managing the study's survey data collection alongside other team members. Although my heart has some sort of affiliation for wanting to input numbers and formulas into tiny boxes, I didn't realize just how close to the data I would get.

I reached out to our enrolled clinics to remind and encourage them to fill out surveys. Compared to my previous experience interviewing patients, it was much more complex to ask busy provider teams to fill out multiple, lengthy instruments they sometimes didn't have the ability or capacity to answer. Our enrolled clinics fielded big asks daily, and I learned that at the end of the day answering research questions might not be a priority for busy practitioners.

Besides ensuring practices had practical and applicable incentives for completing surveys, I also tracked response rates and held a close watch on the data itself, posing questions to our practice facilitators as needed. My favorite part of data cleaning was reading open-ended responses. These are generally at the end of a survey and provide opportunity for respondents to say what they really think. These are included in surveys so that researchers might gain better understanding of context, as well as limitations of the instrument itself. Open-



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ended responses can also shed light on external factors such as lack of resources outside of the respondent's control, which may not be reflected in the 1-10 scale.



Here are some quotes from our baseline practice and staff member surveys:

*"Some questions were impossible to answer. Staff are too busy to track down to get information. I don't know how to run reports for some of the information requested and don't have the time to research how to do it. We are an office of 5 in total."*

*"Sorry, but I do not have a report that shows me the demographic breakdown of our patients."*

*“We do not have reports available to us to accurately complete all of the requested information.”*

After I read these I wanted to say to our study’s principal investigator, “This isn’t going to work! How can we expect practices to complete a survey that requires them to access data they don’t have the ability to pull, and not because they don’t want to, but because they simply don’t have the resources or assistance to do so?”

I couldn’t know at that time that these answers would aid in the project’s understanding of practice abilities, barriers, goals and aspirations, and that they would create a direction for quality improvement. It’s important to note that survey feedback also touched on positive themes:

*“We believe we provide exceptional care, however we do not have a consistent method of tracking and reporting the care we provide. We are excited to work together with Healthy Hearts to improve the care we provide and the methods with which we gather and report that data.”*

*“Change is difficult, but we have had a lot of changes in a short time, after the negative attitudes dispel the clinic, we will get the work done and changes will happen, continued encouragement may be needed in the beginning.”*

*“Our staff do follow medical guidelines and best practices we simply don’t have all the policies and procedures for medical care we want in place, but the medical staff are all on board with establishing and helping develop these for our practice.”*

I felt encouraged by that input to continue reminding practices to complete their surveys. By remembering that continued encouragement could lead to change, I was able to connect my work to the project’s quality improvement strategy. That helped me to trust the process. I learned not to expect immediate engagement, nor to interpret engagement levels based on low (or slow) survey response rates.

In addition to supporting multiple practices on many different levels, our practice coaches took on the role of survey data collectors. They were the unspoken heroes on our project – as messengers of our research agenda, and as teachers that persevered and opened doors to contributions that spread from clinic to clinic. As we neared the end of survey data collection and I read the second set of survey responses, the coaches' magic and the value of clinic participation in Healthy Hearts Northwest became clearer to me:

*“Very helpful to have Healthy Hearts Northwest to be involved and support us with outside resources, graphs, and comparison with national averages, encourages us to improve!”*

*“Healthy Hearts Northwest has been a delight to be affiliated with. Professional and devoted staff that help with a wide array of modern clinical and technical challenges.”*

*“A slow start but overall a great program. Really helped the team focus. Facilitators were able to help the team think out of the box and also see the positives. Thanks!”*

I jumped into Healthy Hearts Northwest feet first, not knowing what would or could happen, and in the end survived! Despite the hurdles, and competing priorities and barriers, I saw that change happened, slowly but surely. I believe everyone on our team helped someone or something to change.

I witnessed our incredible practice facilitators have magical impact on clinics in Washington, Oregon, and Idaho and I'm hopeful that the knowledge they shared won't be forgotten. This project reinforced for me just how powerful simple acts of support are. And how every heart needs kindness.

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*Kilian Kimbel, BA, is a research specialist at Kaiser Permanente Washington Health Research Institute and former research interviewer in its Survey Research Program.*

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**KEY INSIGHT:**

Practice facilitators bring emotional intelligence to the workplace. Kindness and persistence are powerful and effective quality improvement strategies.

## 5 key roles of practice facilitators

*We extend gratitude to our facilitators for supporting smaller primary care practices in the region we call home*

By the Healthy Hearts Northwest research team

Throughout our project life cycle we've learned so much from our practice facilitators and the Pacific Northwest providers with whom they worked "out in the field". We're wrapping up our story series with a look back at this terrific team of change agents to summarize the roles they played in supporting their clinics.

Practice facilitators (sometimes referred to as coaches) and primary care providers everywhere share a commitment to improving patient care and making health care work well. Many of the providers we partnered with in Washington, Oregon, and Idaho were in isolated areas and coping with the challenges of limited staff and resources. We learned so much about the unique pressures faced by smaller practices in today's health care landscape. And, we came to understand that in many cases, living and working in tight-knit communities fosters innovation and the deep satisfaction of seeing the results of their dedication to high-quality patient care.

Drawing upon the experiences of the 20 Oregon Rural Practice-based Research Network and Comagine Health practice facilitators who worked on this initiative, we would like to share ways that practice facilitators can support resource-constrained health care practices and bring life-changing improvements to entire communities.



Our project had twin aims of quality improvement and research. The following is a list compiled by project staff and practice facilitators on some key quality improvement roles filled by our facilitators:

1. **Encourager:** *"Wow, looked at all you've accomplished in the last two months!"*

Our practice facilitators offered praise and encouragement when things were going well, and they pulled out all the stops to provide inspiration during tough times.

2. **Accountability agent:** *"I'll check in with you via email later this week to see how you're progressing."*

The regular visits our practice facilitators made to practices let provider teams know that they would be held accountable for the quality improvement activities they'd committed to and provided built-in time for support if things started to go awry.

3. **Knowledge broker:** *"Another practice out at the coast is facing this same situation. Here's how they're approaching it."*

We sometimes referred to our facilitators as “cross-pollinators” because they spread best practices and innovative ideas back and forth between geographical areas, somewhat like sprinkling seeds over a field. It’s an extraordinarily effective method of disseminating information, especially in rural settings.

4. **Resource provider:** *“I’ve got a worksheet that another clinic created on this very topic so you can see an example.”*

We see this as distinct from Knowledge Broker because this entails finding, curating, and keeping track of materials and resources that other clinics have created, as well as sharing other publicly available materials with clinics.

5. **Sense-maker:** *“Let’s talk about MACRA, and why this is something you need to pay attention to.”*

Our practice facilitators consistently linked the larger and sometimes confusing context of policy issues to daily clinical practice. They also continually stressed a population health perspective and its importance to becoming a high-functioning team.

Our research team relied on our practices coaches to share uniquely valuable information about what was and wasn’t working in the following ways:

**Interpreter:** *“Several of my clinics told me they didn’t complete their practice surveys because it’s so long.”*

In order to be successful, facilitators need to be extraordinarily skilled listeners. Researchers sometimes need to change course and recalibrate midway through a project in order to get closer to making real-world impact.

**Trusted ally:** *“She shows an interest in our practice. It is all about the relationship.”*

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Our facilitators cared. Not only that practices were surviving, not just that each completed their requisite surveys and did their PDSAs. Our facilitators were committed to helping clinics reach a point where they could thrive. They worked to develop an understanding of the values, preferences, and culture in each of their practices and communicated these to the research team.

We've heard from some of our enrolled practices that the intervention our practice facilitators brought made an indelible imprint and helped set them up to continue the business of delivering health care. As clinics adapt, survive, and thrive, so do individual patients, their families, and their communities.

Our entire team is grateful to the Agency for Healthcare Research & Quality for making this project possible.

**KEY INSIGHT:**

Practice facilitators do more than support resource-constrained health care practices in the business of providing better care. They can bring life-changing improvements to entire communities.



## Summary of 16 key insights about practice facilitation in Healthy Hearts Northwest

<p><b>1. Facilitators maximize use of health information technology.</b> A first-tier EHR doesn't guarantee the ability to extract data needed to generate high-quality reports.</p>	<p><b>2. Facilitators reinforce population-based care.</b> Coaches are especially adept at supporting this approach to quality improvement.</p>	<p><b>3. Facilitators carry the power of learning and collaboration.</b> Facilitators can help small practices get unstuck early in their improvement efforts.</p>
<p><b>4. Practice facilitators “cross-pollinate” innovation from clinic to clinic.</b> Facilitators spread ideas by helping providers learn how other practitioners approach similar problems.</p>	<p><b>5. Practice facilitators exemplify continuous learning.</b> Facilitators are open to being surprised no matter how long they've been coaching or how many practices they've worked with.</p>	<p><b>6. Practice facilitators are cheerleaders.</b> Expressing enthusiasm and reflecting back to a practice team what's going right with their efforts helps bolster motivation for providers to keep going.</p>
<p><b>7. Practice facilitators provide a guiding structure to inform the work.</b> Facilitators offer a road map for navigating the improvement journey.</p>	<p><b>8. Practice facilitators make it fun.</b> Involving members of a provider team in a silly activity can lessen potential tension or resistance to process change.</p>	<p><b>9. Facilitators meet practices where they are.</b> Practice facilitators cultivate relationships with provider teams based on curiosity and respect.</p>
<p><b>10. Practice facilitation can increase provider team engagement.</b> Engaging the entire care team in QI activities can have a profound impact on a practice's ability to transform.</p>	<p><b>11. Practice facilitators offer unique knowledge of regional landscapes.</b> Facilitators can be especially helpful in identifying high-performing teams.</p>	<p><b>12. Facilitators ease stress and loneliness for frontier providers.</b> Rural health care practices face unique challenges and increased data quality reporting.</p>
<p><b>13. Practice facilitators create opportunities for others in the clinic to feel safe and speak up.</b> This can create buy-in across all team members.</p>	<p><b>14. Practice facilitators ground research in the real world.</b> With the practical insights they bring to study teams, facilitators are invaluable research partners.</p>	<p><b>15. Practice facilitators bring emotional intelligence.</b> Kindness and persistence are effective quality improvement strategies, as well as powerfully supportive workplace behaviors.</p>
	<p><b>16. Practice facilitators fill many roles.</b> They do more than support resource-constrained health care practices in the business of providing better care: they can bring life-changing improvements to entire communities.</p>	

“We took away an attitude of hope that we can make a difference in the lives of our patients by being focused on a team approach we haven't had before.”

— *Healthy Hearts Northwest clinic*