

An Overview of Practice Facilitation Programs in Canada: Current Perspectives and Future Directions

Aperçu des programmes de facilitation de la pratique au Canada : panorama actuel et orientations à venir



CLARE LIDDY, MD, MSC

*Assistant Professor, Department of Family Medicine, University of Ottawa
Clinical Investigator, Bruyère Research Institute and C.T. Lamont Primary Health Care Research Centre
Ottawa, ON*

DIANNE LAFERRIERE, RN, BSCN

*Outreach Facilitator, Improved Delivery of Cardiovascular Disease through Outreach Facilitation (IDOCC)
C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute
Ottawa, ON*

BRUCE BASKERVILLE, PHD

*Senior Scientist, Propel Centre for Population Health Impact, University of Waterloo
Waterloo, ON*

SIMONE DAHROUGE, PHD

*Director, C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute
Ottawa, ON*

LYNDEE KNOX, PHD

*Chief Executive Officer, LA Net Community Health Resource Network
Los Angeles, CA*

WILLIAM HOGG, MSC, MD

*Professor, Department of Family Medicine, University of Ottawa
Clinical Scientist & Senior Research Advisor, C.T. Lamont Primary Health Care Research Centre,
Bruyère Research Institute
Ottawa, ON*

Abstract

Practice facilitation has proven to be effective in improving the quality of primary care. A practice facilitator is a health professional, usually external to the practice, who regularly visits the practice to provide support in change management that targets improvements in the delivery of care. Our environmental scan shows that several initiatives across Canada utilize practice facilitation as a quality improvement method; however, many are conducted in isolation as there is a lack of coordinated effort, knowledge translation and dissemination in this field across the country. We recommend that investments be made in capacity building, knowledge exchange and facilitator training, and that partnership building be considered a priority in this field.

Résumé

Il est démontré que la facilitation de la pratique est un moyen efficace d'améliorer la qualité des soins de santé primaires. Le facilitateur de la pratique est un professionnel de la santé, habituellement externe, qui visite régulièrement l'établissement pour apporter un soutien à la gestion de changements visant l'amélioration de la prestation des soins. Notre analyse du contexte montre que plusieurs initiatives au Canada font appel à la facilitation comme méthode d'amélioration de la qualité; cependant, plusieurs de ces initiatives demeurent isolées puisqu'il y a un manque d'efforts coordonnés, de diffusion et de transposition des connaissances dans ce domaine au pays. Nous recommandons la mise en place d'investissements pour le renforcement des capacités, pour l'échange de connaissances et pour la formation de facilitateurs; nous recommandons également que l'établissement de partenariats soit considéré comme une priorité dans ce domaine.

IN CANADA TODAY, THE PREVALENCE OF CHRONIC DISEASES IS RISING, RESULTING in increased healthcare costs together with higher rates of disability and death (Health Council of Canada 2007; WHO 2005). Primary care practices are well positioned to address these needs, improving health outcomes and reducing healthcare costs (CIHI 2009; Greene et al. 2001; OMHLTC 2007). The challenge to improving primary care often lies in the inability of practices to implement adaptive changes that can enhance their ability to deliver evidence-based guidelines and best practices (Cabana et al. 1999; Grimshaw et al. 2005; Hulscher et al. 1997; McKenna et al. 2004; Stange 1996). Often-cited barriers include lack of time, resources, tools and incentives to make these necessary changes (Epping-Jordan et al. 2004; Hensrud 2000; Majumdar et al. 2004; Tremblay et al. 2004). The support of an individual with expertise in change management, such as a practice facilitator, has been shown to help practices make and maintain the required practice changes (Baskerville et al. 2012 ; Nagykaladi et al. 2005).

The purpose of this paper is to provide a general background on practice facilitation, describe current practice facilitation programs and studies in Canada, identify the gaps in research and implementation, and suggest future directions to address these gaps. By raising awareness of current initiatives and knowledge gaps, we aim to inform and increase dialogue between policy makers and program implementers from across Canada in order to enhance national coordination and to guide future initiatives to support the effective implementation of this approach across the country.

Practice Facilitation

In its most general sense, practice facilitation in healthcare is a quality improvement (QI) process that involves bringing an individual with expertise in change management and a solid understanding of healthcare (commonly nursing) into a practice to assist the group in adapting their clinical practices to optimize patient care delivery through increased adherence to evidence-based guidelines (Knox et al. 2011). A recent meta-analysis of 23 studies involving 1,398 primary care practices found that primary care physicians are nearly three times as likely to implement evidence-based guidelines into care when supported by a practice facilitator (Baskerville et al. 2012).

Practice facilitators (also known as outreach facilitators, practice enhancement assistants and practice coaches) engage and build a partnership with providers over time. They work with practices to identify areas for improvement (often through audit and feedback), set goals for care improvement, provide tools and approaches to reach these goals and follow up regularly with the practices to support change. The approach is grounded in key elements of the Chronic Care Model such as adopting evidence-based care, implementing planned care and recall, using a team approach, and supporting patient self-management and integration with the community (ICIC n.d.).

Unlike a knowledge broker, whose role is to communicate research findings to end users, practice facilitators actively work with providers over time to help them change their clinical practices by adopting evidence-based approaches more readily and effectively. The focus is on re-organization of the practice for sustained delivery of high-quality care rather than increasing specific content knowledge.

The origins of the practice facilitation model can be traced back to the Oxford Prevention of Heart Attack and Stroke project in England (1982–1984). Practice facilitators were described by Fullard and colleagues (1984) and Cook (1994) as healthcare professionals who could help assess current processes and plan implementation measures to enhance prevention strategies and be cross-pollinators of ideas and resource providers. The literature suggests that a practice facilitator can help build relationships within the practice and between the practice and health networks, who can share resources (Nagykaldi et al. 2005; Thomson et al. 2000).

Since that time, the practice facilitation concept has been implemented across the globe in countries such as Australia, the Netherlands, the United States and the United Kingdom. In Canada, the first community-based primary care facilitation study was conducted in 1997

in Ontario. The performance of practices randomly allocated to the practice facilitation arm gained substantial improvements (12% absolute increase over an 18-month period) in the delivery of preventive services (i.e., blood glucose monitoring, smoking cessation counselling, hypertension management and more). This effect was estimated to translate into a net long-term savings to the healthcare system at a rate of return of 40% after one year of intervention (Hogg et al. 2005; Lemelin et al. 2001).

In contrast to other QI approaches in primary care such as didactic education, passive dissemination strategies, and audit and feedback, which have shown little or no effect (<5% improvement), multifaceted approaches such as practice facilitation have been shown to be more effective in improving uptake of preventive care guidelines (>10%) and thus hold promise for the implementation of chronic disease prevention and management.

Three facilitation research studies are ongoing in Canada. The BETTER project (Building on Existing Tools to Improve Chronic Disease Prevention in Family Practice) targets primary care practices in Toronto and Edmonton with the aim of improving prevention and screening for cancer and other chronic diseases, such as diabetes and heart disease. The newly initiated TRANSIT project in Quebec has engaged nine primary care practices and aims to improve cardiovascular disease prevention and management. Finally, the Improved Delivery of Cardiovascular Care (IDOCC) program in Ontario also aims to improve the quality of care delivered to patients with or at high risk of developing cardiovascular disease through practice facilitation. The project was initiated in 2008 and involves 83 practices (Liddy et al. 2011). The facilitation strategies used in the projects commonly involves performing a chart audit and feedback to provide a perspective on current practices and processes, assisting with goal setting and achieving consensus on strategies for reaching the goals. Tools used include Plan, Do, Study, Act (PDSA) cycles, process mapping (ImpactBC 2012; IHI 2012) and project evaluation plans, and these are tailored to the requirements of the practice.

The Need for Knowledge Exchange

Despite the increasing adoption of practice facilitation in Canada, there has been little knowledge exchange – defined as collaborative problem solving between researchers and decision-makers through linkage and exchange, resulting in mutual learning – within this approach until recently. In January 2011, we conducted a two-day workshop, “The Art and Science of Outreach Facilitation,” in Ottawa, Ontario. This event provided a forum for various stakeholders from across Canada and the United States, including researchers interested in the approach and primary care providers considering implementing such an approach in their practice, to share knowledge on the efficacy and implementation strategies of practice facilitation. Our panel of facilitation experts shared their expertise in this QI intervention and conducted interactive training sessions. We offered concepts and training strategies for practice facilitation, concepts for change management and practical methods to engage primary care practices in QI initiatives.

Primary Care Quality Improvement Programs in Canada

We have since continued to build the network of facilitation users, and have compiled an inventory of practice facilitation programs across Canada to assist with knowledge dissemination (see Figure 1 and Table 1 [see Table 1 online at: <http://www.longwoods.com/content/23177>]). Through Internet searches and telephone interviews as well as informal discussions with experts in the field, we have established that several provinces are already engaged in QI initiatives founded on facilitation, some of which rely on a facilitator internal to the practice. It is not clear whether the competing obligations and interests that might be placed on internal facilitators affects their work.

FIGURE 1. Facilitation projects across Canada



- British Columbia uses a general strategy to target primary healthcare with practice facilitation (ImpactBC 2012); online resources and tools are available for those practices wanting to participate.
- Alberta has a large provincial partnership of organizations (Alberta AIM: Access Improvement Measures) and brings together groups of practices (collaboratives) to redesign practice systems and manage chronic diseases better within primary care. The lead AIM facilitator is developing an orientation, training and resources package for facilitators

to ensure a consistent standard of skills among their facilitators and to increase capacity. Towards Optimized Practice (TOP) offers assistance to physicians and teams to support practice redesign to increase the uptake of evidence-based care. For example, the Health Screen in ACTION project, initiated by TOP, provided over 500 physicians with a prevention/screening checklist tool that resulted in a 14% improvement over 10 evidence-based manoeuvres. A separate program in southern Alberta, in the Chinook Primary Care Network, uses internal facilitators as part of its ongoing quality improvement efforts to increase efficiencies, access and chronic disease management. Through its work with 25 clinics, the Chinook PCN has demonstrated significant improvements in reducing access delays and process indicators such as cancer screening, immunizations and blood sugar screening.

- Saskatchewan's Health Quality Council has several facilitation-based initiatives underway to redesign practice systems that address issues of access, efficiencies, communication between primary and specialty care and disease management.
- Through the programs Pursuing Excellence and Manitoba Patient Access Network (MPAN), Manitoba is expanding facilitator capacity at all levels of healthcare and, by means of targeted funding, is increasing patients' access, identifying and reducing inefficiencies, and improving patients' overall healthcare experience.
- Multiple jurisdictions are using external facilitators within collaboratives as a way to disseminate QI methods to many providers simultaneously. In Ontario, Health Quality Ontario is offering QI opportunities to practices across Ontario to enhance access, practice efficiency and chronic disease management. HQO uses facilitators to assist with audit and feedback, goal setting and reaching consensus on how to achieve goals. As well, there are recent programs within Ontario that use external facilitators to address issues of practice redesign and improving access for specific targeted areas, such as smoking cessation and diabetes management.
- Quebec has research and implementation projects to identify priorities of care and increase knowledge transfer in primary and mental healthcare using facilitation.
- The Maritime provinces also have facilitation programs in place. New Brunswick is developing training programs and professional development in QI initiatives, using a collaborative approach and a published manual on facilitation. Nova Scotia has a QI program to increase practice facilitation capacity and improve diabetes management by focusing on several target processes and outcomes.

We have not been able to determine whether there are facilitation programs in the remaining provinces and territories of Canada.

There are multiple facilitation projects across the United States; they are too numerous to list here. Federal agencies such as the Agency for Healthcare Research and Quality (AHRQ) are helping to create infrastructure to support local programs and in anticipation of a potential national primary care extension program that would make facilitation support available to small and medium practices across the country. In addition, primary care practice-based

research networks, state health departments, health insurance plans and others are using facilitation as a quality improvement method within primary care, and to support timely translation of new medical and health service discoveries into the community. In addition, groups such as the Institute for Healthcare Improvement (IHI), Clinical Microsystems and others are investing in facilitator training (Knox 2010).

Research and Implementation Gaps

While there is enough evidence to conclude that practice facilitation, as it is broadly defined, is effective as a QI intervention to improve delivery of care, and although multiple practice facilitation programs have already been implemented across Canada, there remain gaps to address, in terms of both research and implementation.

How a facilitation program is best structured remains uncertain. Studies addressing the optimal intensity and duration of a practice facilitation intervention are not conclusive. Greater intensity has been associated with larger effects (Baskerville et al. 2012); however, longer and more intense interventions are associated with increased costs and are likely to attract fewer participants because they require longer commitments on behalf of the practices. Other important questions that need to be addressed include the extent to which the changes are sustained after the end of facilitation intervention. Many factors (practice-related, disease-related, healthcare-related) can affect the success of the change and its sustainability.

What are the essential qualities of a practice that make it more likely to be successful at implementing change when using facilitation as an intervention? Facilitation is often multi-pronged. What are the components of practice facilitation that are necessary to achieve change? Does tailoring to practice requirements matter? Receiving feedback on the practice performance and setting goals are effective tools in moving a practice towards improved care (Thomson et al. 2000), but are there other elements of facilitation, or aspects of a facilitator, that make this intervention more likely to succeed? Are the elements of practice facilitation documented, and the necessary skills compiled and disseminated, so that there is a consistency in this QI intervention?

Most facilitation programs in Canada have been developed in isolation, and without much consultation from similar programs in neighbouring jurisdictions. While there have been some initial attempts to begin the process of disseminating knowledge and expertise in facilitation, there remain significant gaps in that area.

In Canada, policy documents addressing the role of practice facilitation in primary care are scarce. In 2006, the province of Newfoundland and Labrador published the result of a multi-jurisdictional collaboration to increase awareness of facilitation and how it could be used (Department of Health and Community Services 2006). Within our IDOCC project, we built on this original work and developed our own training manual adapted to the needs of our project. Further to this project-specific manual, we have applied for funding to develop and pilot a facilitation training program and general manual that is applicable across facilitation programs, and to offer a learning session to facilitators at the start of their programs. In this way, consistency and capacity can be built into the healthcare system, and facilitation can be used by health

authorities when starting their QI initiatives. This approach has been adopted in the United States with a recently released “how-to” guide on developing and running a practice facilitation program that is an integral part of the resources related to primary care renewal based on the Patient Centered Medical Home Model (Knox et al. 2011).

As we discovered through the process of compiling the inventory, there are many variations of facilitation among the provinces, from internal to external facilitator, various QI targets, varying amounts and models of intervention and participation. How should a facilitation effort deal with the flow of interest in practice redesign when a practice has to cope with multiple priorities? Is success more likely if time and incentives are awarded? If so, should a primary care practice receive protected time and incentives to participate in these programs? Should facilitation be time-defined, or should facilitators maintain contact with the practice to support sustainability? Collaboratives have been extensively used in multiple jurisdictions, but do we know if they are the most effective way to introduce change concepts and assist with goal setting and reaching consensus? Or is a one-on-one method more successful?

Recommendations for Future Directions

Looking to the future, we suggest that the following recommendations would help leverage the progress of our current understanding of facilitation interventions. Ongoing partnerships within the different levels of government health agencies and authorities are vital to transfer knowledge among health researchers, providers and policy makers, as well as to ensure that facilitation efforts align with the direction of policy in the jurisdiction. We have begun to develop a network of experts through our workshops, inventory and position paper in an effort to disseminate knowledge of facilitation. Those involved in practice facilitation in different jurisdictions should consider sharing their experiences through publications, presentation, workshops and other means.

A formal network within Canada would be useful, and could be linked with others internationally. A training manual on facilitation is a useful tool when setting up programs; and the creation and piloting of a universally relevant training manual and program within Canada is important. Of late, increased emphasis has been placed on improving care for individual chronic diseases, such as diabetes and cancer. While each disease has a significant impact on health outcomes and the facilitative method is effective in such initiatives, we suggest that the method be applied generally to practice systems as a whole, rather than to a specific disease. If an initiative is disease-specific, there may be a tendency to duplicate efforts and the initiative may not be cost-effective. Perhaps office management and practice delivery design using the Chronic Care Model should be introduced at medical schools to develop a consideration for the elements of excellent care delivery. While a federal and provincial objective may be to involve all primary practices in care improvements, it may prove more feasible to work with smaller groups within regions as practices voluntarily choose to participate. Incentives, training and protected time should be considered to curtail barriers to implementation and enhance practice involvement.

There have been numerous projects of practice facilitation both in Canada and the United States, and many of these have employed rigorous methods to assess the effectiveness of practice facilitation. The synthesis of this work demonstrates that practice facilitation works in translating evidence into practice and improving the quality of primary care. Additional short-term, pilot projects are not required; rather, policy research is needed on ways to scale up practice facilitation to extend its impact and to determine sustained funding and training initiatives for the long-term implementation of practice facilitation in primary care.

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Correspondence may be directed to: Dr. Clare Liddy, C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute, 43 Bruyère St., Ottawa, ON K1N 5C8; tel.: 613-562-6262, ext. 1326; fax: 613-562-6099; e-mail: cliddy@bruyere.org.

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