



The Case for Practice Facilitation Within Primary Care

A primer and advocacy guide

July 2020

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About the Guide

This guide frames the College of Family Physicians of Canada (CFPC)'s position as a national advocate for practice facilitation support. It is intended to be a resource to support provincial CFPC Chapters, medical associations, organized primary care groups, national/provincial/territorial policy-makers, and health system decision-makers in advocating for and deploying practice facilitators to support primary care quality improvement (QI) initiatives.

The impetus for developing this guide was the launch of the CFPC's Practice Improvement Initiative in 2017 to promote and advance QI, practice facilitation, and research in family medicine and primary care. The in-depth needs assessment conducted between February and May 2017 across Canadian provinces, territories, and family medicine residency programs identified considerable variability in terms of needs, gaps, and resources. Furthermore, stakeholders highlighted the need for practice facilitation to assist practices in improving their quality of care.

The overarching goal of this guide is to support advocacy efforts under way provincially and nationally to advance the uptake of practice facilitation. More specifically, the guide aims to:

- Summarize the evidence for and benefits of practice facilitation in family medicine and primary care
- Demonstrate the return on investment (ROI) on practice facilitation and practice facilitators
- Highlight the importance of establishing a sophisticated set of structures and processes to support practice facilitation efforts
- Highlight why QI and practice facilitation are important strategic components of ensuring the delivery of high-quality care for patients
- Provide a guide for CFPC Chapters, departments of family medicine, health care organizations, and provincial and territorial ministries of health to advocate for and help implement practice facilitation support for family physicians and their primary care teams and colleagues

This guide was developed in collaboration with partners and stakeholders from across Canada and representatives from the United States. The CFPC also met with its provincial Chapters to discuss the opportunities and challenges they had. To support this work a special advisory and editorial group was established.

Given the emerging nature of this work, the CFPC has developed a web page to house current resources to support the development of practice facilitation and to connect key players with one another. It is available at: www.cfpc.ca/pii.

Executive Summary

This guide—*The Case for Practice Facilitation Within Primary Care*—provides an overview of how practice facilitation has been adopted and applied in primary care in Canada with the goal of supporting provincial and national advocacy efforts in this field. It is intended as a resource to emphasize why practice facilitation is important and what evidence there is to support it. It provides information on practice facilitation programs, models, and examples in Canada.

A sustainable, high-quality health care system depends on primary care as a foundation with family physicians and their teams committed to providing the best possible care for their patients and communities. They do so by engaging in continuous QI, which has made QI a cornerstone of primary care practices, as is reflected in the Patient's Medical Home (PMH) vision that is being advanced by the CFPC and its provincial Chapters across Canada. Practice facilitation enhances the ability of family physicians and their teams to undertake QI.

What is practice facilitation?

Practice facilitation is the process of engaging and coaching primary care teams to test and implement changes to optimize clinical and non-clinical processes. Practice facilitators typically come from health care, community development, or educational backgrounds and are trained to support primary care teams in these endeavours using a range of organizational and project management skills. Depending on the needs of each team, practice facilitation may include activities such as leadership training, the use of practice data to direct change, needs assessment, the identification of best practices, and technical assistance; on a provider level, these projects can encourage better teamwork, effectiveness, and communication.

Why do we need practice facilitation?

Clinician workload is a key consideration related to building capacity for continuous improvement. In 2017 a survey the CFPC conducted as part of the Practice Improvement Initiative demonstrated that in almost all provinces the workload, when coupled with increasing system demands, has created conditions conducive to burnout among family physicians.¹ Improving the work life of providers is a core component of the Quadruple Aim, and the CFPC's survey of members highlighted the need to improve the team experience to support a balanced work life.^{1,2} To achieve this, the respondents acknowledged the need to build capacity for continuous improvement.

Practice facilitation builds the system's capacity for continuous improvement, including working across sectors and supporting population health goals. It accelerates change for practices working on processes that require team behavioural modifications, and it enables the translation of learnings from early adopters to accelerate the spread to the early and late majority.

Research suggests that practice facilitation, when applied judiciously, nearly triples the uptake of evidence-based guidelines in primary care practices, and it builds systemic capacity for continuous improvement.³ It offers a 40 per cent ROI for the primary care team and organization involved as well as for the system funders.⁴ However, it is important to note that practice facilitation is least impactful among practices that are already exemplary in their performance or that do not meet basic readiness criteria.⁵

Practice facilitator profiles

A practice facilitation program can be integrated into a practice or group of practices either through project-specific funding or through funding for a generalist role. For the former, the practice facilitator is engaged to support a specific study; in the latter, the role of the practice facilitator is to support practice improvement as a long-term organizational strategy. Ultimately, practice facilitation is employed to advance research and clinical or process-oriented goals and approaches.

There are four overarching profiles or roles of practice facilitators, each with a different focus: 1. QI facilitators; 2. research practice facilitators; 3. electronic medical record (EMR) data practice facilitators; and 4. practice facilitators with mixed responsibilities. Each requires skill sets that are context-specific, but there are attributes, knowledge areas, and core competencies for practice facilitators that are not necessarily context-specific, such as interpersonal, communication, and project management skills.

Examples of practice facilitation

Some provinces, such as Alberta and Quebec, have realized the need for and the benefits of investing in practice facilitation resources. Other provinces are encouraged to adopt such an approach, leveraging their own strengths and opportunities and developing partnerships with organizations with similar goals, including the Chapters of the CFPC and the Canadian Medical Association. Examples from across Canada are highlighted in the guide to provide others with exemplars and sustainable models of practice facilitation programs.

Training for practice facilitators

There are numerous resources available, including courses, programs, and open-source materials that can be leveraged to train practice facilitators and develop practice facilitation programs, including different practice facilitation approaches.

Practice facilitator role as enabler of transformation

Primary care organizations focused on evidence-based QI, increased value, and health care sustainability have been investing in practice facilitation. Infrastructure and an increase in reliable provincial funding are needed to embed this role appropriately within primary care to build capacity for continuous change and improvement. Practice facilitation enables primary care renewal and broader health system transformation for better patient care and population health.

Implementing practice facilitator programs

Current practice facilitator initiatives in Canadian jurisdictions such as Alberta, British Columbia, and Quebec provide examples of effective funding and partnership opportunities used to deploy practice facilitators.

Conclusion

Practice facilitation requires a network of facilitators, leaders, and decision-makers to share resources and learn from each other. The CFPC has developed a web page to house current resources to support the development of practice facilitation and to connect key players with one another. It is available at www.cfpc.ca/pii.

The CFPC is an advocate of primary care innovation, and it is therefore calling on provincial ministries of health and other funding bodies to increase their investment in practice facilitation and in the resources offered to support practice facilitators.

The Canadian health system depends on the evidence of best practices to make decisions that allow for and support system renewal. Practice facilitators enable primary care physicians and other team members to make changes to reach provincial goals and practice goals and to better serve patients, families, and populations.

1. What are Practice Facilitation and Practice Facilitators?

Practice facilitation is increasingly recognized as an integral part of QI and is being integrated into QI initiatives across Canada and internationally. QI is a key activity in the CFPC's Family Medicine Professional Profile and has been introduced in CanMEDS–Family Medicine as a competency for the Leader, Scholar, and Health Advocate Roles.^{6,7} As part of its Practice Improvement Initiative and advocacy for practice facilitation, the CFPC co-hosted the Canadian Invitational Quality Improvement Symposium in September 2018, which included discussions about the various profiles and roles of practice facilitators as well as the body of evidence supporting practice facilitation. There is a growing body of evidence to show that practice facilitation, in the right circumstances and with adequate support, can apply the theoretical evidence to support change, accelerate and enhance improvements, and sustain those improvements. This evidence is summarized in chapter 3.

Practice facilitators are health care professionals who assist primary care teams in undertaking practice improvement through QI efforts, often using research or EMR data to support the work.⁸ The concept of practice facilitation can be traced back to a component of a large heart disease prevention program in the United Kingdom in the 1980s.⁹ Thereafter, practice facilitators were used to support practice improvement in Europe and Australia and primary care practice-based research networks (PBRNs) in the United States.⁸ Practice facilitation is now applied in many jurisdictions around the world.

Practice facilitators can work in many ways, which may vary by country, province/state, region, and practice. As this guide illustrates, practice facilitation has also evolved over time, making it challenging to find a universal definition that captures all its dimensions. For the primary care setting, practice facilitation has been described as a multi-faceted approach that involves skilled individuals who support and enable team members, through various types of interventions and approaches, to address the challenges in implementing evidence-based guidelines.³ These individuals use a range of organizational development, project management, QI, and practice improvement methods to build the capacity of a practice to engage in improvement activities over time and to reach incremental and transformative improvement goals. This support may be provided on-site, virtually (through teleconferences and webinars), or through a combination of on-site and virtual visits.

Practice facilitators work to develop the knowledge, skills, and capacity of a practice or its individual staff members, often using a blend of several approaches.

Practice facilitators work to develop the knowledge, skills, and capacity of a practice or its individual staff members, often using a blend of several approaches. The Agency for Healthcare Research and Quality (AHRQ) has identified a wide range of activities for practice facilitation in support of improvement, change, and redesign that depend on the needs and goals of the practice or jurisdiction.¹⁰ These activities are summarized in Table 1.

Table 1. Practice facilitation activities


- Assessment of and feedback to practices on organizational, clinical, and business functions driving change
- Use of practice-level data to drive change
- Training of staff in QI methods and specific transformation processes, such as team-based care
- Formation and facilitation of practice QI teams
- Executive coaching and leadership training
- Best practices in QI structures and methods
- Support, encouragement, reinforcement, and recognition of successes
- Project and change management
- Resource identification and procurement
- Capacity building in the use of health information technology to support improved clinical care and office efficiency
- Cross-pollination of good ideas and best practices between primary care practices
- Capacity building for improved linkages to outside resources
- Technical assistance in implementing models of care, such as the chronic care model¹¹

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Building on a 2012 systematic review and on the AHRQ's definition of practice facilitation,^{3,10} for the purposes of this guide we define it as the work undertaken by practice facilitators who are specially trained to engage health care providers and teams in building organizational capacity for continuous improvement and meaningful changes related to patient experience, population health, cost, provider work life (the Quadruple Aim) and the PMH transformation goals.^{2,12} In their various roles, practice facilitators usually build relationships over a period of time with teams and individuals and support them through the change process, differentiating them from short, time-limited, and episodic interventions. They therefore become a resource that supports ongoing QI and evidence translation adapted to the local context.¹⁰ This guide focuses on their roles in supporting practice improvement, particularly by way of QI. Their roles are elaborated upon further in chapter 5.

The model of practice facilitation used is highly dependent on the environment in which the work is occurring, and it is important that the approach aligns with the goals of the governing organization. If practice facilitation is viewed as the process of engaging and coaching primary care teams to test and implement changes to optimize clinical and non-clinical processes, then practice facilitators serve as critical catalysts and coaches in helping practices improve.

Understanding where to start an improvement journey can be daunting. Practice facilitators help a team assess its current performance, choose an area of focus, map current processes, and test small changes and new processes to achieve greater patient satisfaction, access, continuity, efficiency, and quality outcomes. This process entails coaching a team to plan, test, learn, implement, monitor, and sustain small (and then larger) change efforts. The initial approaches and activities are important for building the confidence and skills of teams in support of their improvement journey.



While the practice facilitator may use specific tools and approaches, it is through altering the mindset of teams that they aim to make change stick. As teams become more comfortable with change, they may take on more innovations and practice changes.

Ideally, practice facilitators would work across several practices for an extended time period because they grow with the teams they support, facilitate the creation of a culture of continuous improvement, share learning across practices, engage and align leadership with change efforts, optimize data, and help form communities of practice for QI.

Since the optimal ratio of practice facilitators to practices and teams depends on the practice/team size, the composition of the clinical staff, the maturity of QI in the practice, and the supporting infrastructure, a general guideline is to have one practice facilitator for every five to seven clinics (assuming four physicians per clinic).¹³

2. Why Do We Need Practice Facilitation?

Background

Primary health care is recognized universally as the foundation of the health care system. The Global Conference on Primary Health Care in 2018—which marked the 40th anniversary of the Declaration of Alma-Ata—reaffirmed “that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system.”¹⁴ Health systems with strong primary care have better health outcomes, greater health equity and, often, lower health care costs.¹⁵ A 2018 Canadian study concluded that “investment in effective primary care services may help reduce burden on the acute care sector and associated expenditures.”¹⁶ For most Canadians, a regular primary care provider—usually a family physician, nurse practitioner, or primary care team—is their point of entry into the health care system who provides most of their health care, maintains a continuing relationship with them, and facilitates/coordinates the health care they receive from other providers and places.¹⁷

The health system, including primary care, should celebrate its successes, spread these successes, and always strive to improve.

Frameworks for improvement

Continuous QI is increasingly viewed as a core activity and responsibility of the health care system and of family physicians, their primary care colleagues, and their teams. The design and implementation of improvement efforts in primary care are supported by several existing theories, models, and frameworks, and practice facilitation has an important role to play in supporting them. As one expert explained it at the North American Primary Care Research Group International Conference on Practice Facilitation in 2018: “A theory is why it happens; a model is how it happens; a framework describes what elements are involved.”¹⁸

Quadruple Aim

The approach of practice facilitators in supporting practices in their efforts to improve the quality of care is typically informed and guided by the Quadruple Aim framework (Figure 1) and the Six Dimensions of Quality: 1. timeliness; 2. efficiency; 3. equity; 4. safety; 5. effectiveness; and 6. patient-centredness.^{2,19}

Figure 1. Quadruple Aim Framework²



Patient's Medical Home (PMH)

QI is also a key component of the PMH. This vision of care advocates for comprehensive, continuous, and high-quality care. According to the CFPC, “the PMH is a family practice defined by its patients as the place they feel most comfortable presenting and discussing their personal and family health and medical concerns.”¹² The CFPC’s vision for the PMH provides a framework for the evolution toward improved patient care. It advocates “practising quality improvement (QI) principles to achieve the results necessary to meet the needs of their patients, their communities, and the broader health care community, now and in the future.”¹² Figure 2 presents the CFPC’s framework for the PMH.¹²

Figure 2. The CFPC Patient’s Medical Home



At the heart of the PMH are team-based care and strong physician leadership, along with an increased level of expertise and capacity for improvement and a willingness to improve continuously. Practice facilitation could provide a key strategy for advancing these components as well as implementing and sustaining change successfully; ultimately, achieving these transformation goals makes a practice PMH aligned. Although not all types of QI themes and approaches are named explicitly in the PMH vision, the elements of the PMH serve as guideposts for the delivery of high-quality primary care. Patient safety is a constant focus for PMH changes in practice. Practice facilitators guide teams in the continuous QI performance measures that improve individual patient experience and outcomes.

The PMH also promotes capacity building at the practice level to initiate and sustain change throughout the community. This means providing services that reflect the needs of the community at large and connecting care across the medical neighbourhood—including hospitals, long-term care facilities, and home care; public health units; laboratory and diagnostic imaging services; physiotherapy and rehabilitation; mental health and addiction; and other health and social services.

Practice facilitators aid primary care teams in adapting the PMH elements in response to the inherent social accountability contract that providers and practices have with their communities. This facilitation of better transition processes is an important QI activity in ensuring that the PMH vision is meaningful and relevant and increases safety at the patient panel and population levels. Understanding and addressing the population health needs of the community and planning for panel-based care are important aspects of primary care accountability, and there are numerous opportunities for facilitators to support practices in this regard, including having patients and the community involved in improvement activities.

Theories to guide improvement

Improvement requires change. Sustaining a successful change or improvement does not occur spontaneously; it needs to be nurtured and supported. There is much written about best practices in change management in support of continuous QI in health care, as well as about the barriers and facilitators of change, that should be used to guide change efforts. Research suggests that applying evidence to guide practice improvement is possible, but there is no single approach that suits all situations. Instead, the practice facilitation strategy used must be tailored to the setting and participants, and it must account for potential barriers and opportunities that could influence success.²⁰

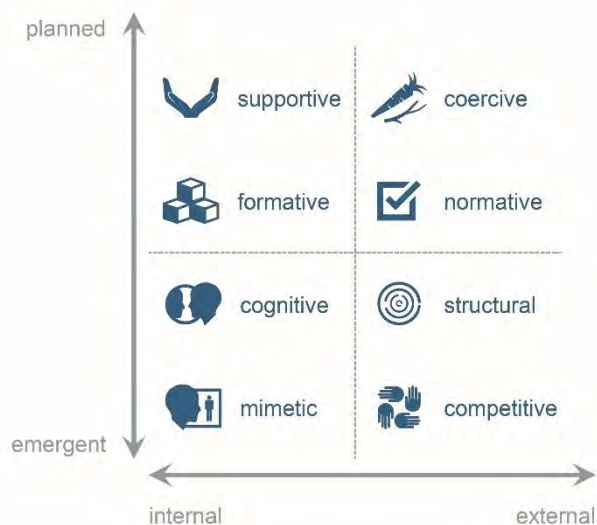
A 2017 synthesis of published frameworks for levers of change outlines eight key levers of change: 1. cognitive levers providing awareness and understanding; 2. mimetic levers informing about others' performance to encourage emulation; 3. supportive levers providing facilitation, implementation tools, or models of care to support change; 4. formative levers developing capabilities and skills through teaching, mentoring, and feedback; 5. normative levers setting performance against guidelines, standards, certification, and accreditation processes; 6. coercive levers using policies, regulatory incentives, and disincentives to force change; 7. structural levers modifying the physical environment or professional cultures and routines; and 8. competitive levers attracting patients or funders.²¹

As shown in Figure 3, there are two dimensions to the framework's matrix of four quadrants that explain the different ways in which change occurs: 1. motivation, or why change occurs (internal versus external); and 2. the origin of change (planned versus emergent).²¹

The levers of change are a reminder that at the system (or external) level, several contextual factors need to be considered, including the environment (e.g., government pressures and incentives; community motivation; the system manager's expertise and leadership; and the alignment of improvement work with strategic goals).²² Barriers at the system level can include a lack of common improvement priorities, targets, and language; limited coordination, integration and alignment of efforts; and insufficient practice or sector engagement.

Figure 3. Levers for change²¹

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Additional factors that influence QI at the practice level include the extent of resources and technological infrastructure; expertise and training; leadership; and motivation.²² Achieving change is not simply about disseminating knowledge and providing education. Didactic education and passive dissemination strategies tend to be ineffective, whereas interactive education, reminder systems, and multi-faceted interventions have a greater effect.^{23,24}

Several methods have been shown in the literature to support a culture of change in clinical practice, many of which blend organizational systems and processes with reforming front-line professional practice. Factors that contribute to a supportive context for delivering high-quality care are listed in Table 2.²⁵

Table 2. Enablers of a culture of change

<ul style="list-style-type: none"> • Having a shared purpose • Anchoring change in a supportive organizational culture • Organizational capacity to support change • Clinician accountability for performance • Quality having a “shared, collective meaning, value and significance within the organization” • Applying clinical standards and guidelines and performance benchmarks • Monitoring change and performance over time • Valuing innovative thinking • Promoting a learning culture and learning from others • Rewarding initiative and problem-solving • Challenging “it won’t work here” attitudes, silo thinking, and unwillingness to take risks • Having a willingness to try again after initial failure • Strong working relationships between management and clinicians and joint planning • New working relationships with various professional groups • Co-location of different professionals 	<ul style="list-style-type: none"> • Staff engagement • Addressing subculture diversity and “tribalism” • Recognizing and celebrating team and individual efforts • Regular clinician peer review • Valuing bottom-up change • A culture focused more on support and autonomy than command and control • A positive safety environment with constructive ways to address errors • Incentives that support long-term goals (versus short-term fixes) • Reducing conflicting incentives in the health care system • Understanding and acknowledgement, especially by central authorities, of the complexities, time, and resources required to achieve sustainable change (and thus realistic demands and timelines for those on the front line) • Investment in infrastructure, such as information technology systems, data analytics, and decision support tools
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The enablers of change provide important considerations for change and improvement at the practice level. Practice facilitation can support the engagement of family physicians and their professional team members who, despite the demands of their multiple roles and responsibilities, wish to improve. Change requires helping health care providers and teams identify and understand the various opportunities available to them, test proposed changes in practice through their own lenses and contexts, see the impact for themselves, and become part of the change.

Importantly, family physicians and their team members need to take ownership of, participate in, and often lead QI. Practice and QI are not the responsibility of a practice facilitator. Rather, the role of the practice facilitator is that of a coach and guide. The coaching is focused on increasing the resilience and resourcefulness of the team to continue to improve and evolve over time. Primary care practices that have built this “muscle for change” tend to be open to ongoing improvements, but they still benefit from the assistance of a facilitator in maintaining this strength.^{26,27}

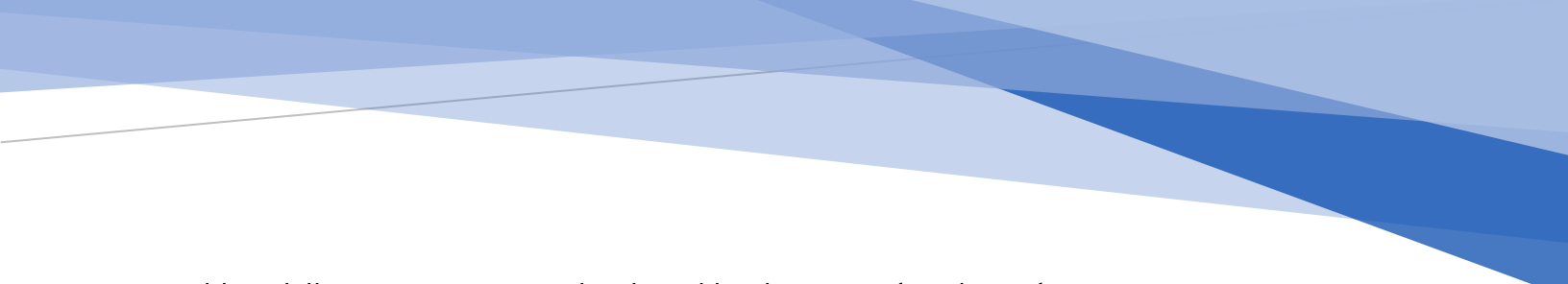
Opportunities for practice facilitation in the Canadian context

The 2018 Canadian Invitational Quality Improvement Symposium included a dedicated practice facilitation stream to profile the spectrum of facilitation approaches across the country. It profiled leading practices in several Canadian jurisdictions and internationally, including factors for success and lessons learned. (These programs are summarized in Appendix A.)

Every province and territory has undertaken primary care renewal and transformation to varying degrees. Models of primary care practice, structure, funding, and payment vary greatly across and within the provinces and territories, and each Canadian jurisdiction has implemented QI and practice facilitation in different ways. In recognition of this important activity, many jurisdictions have established health quality councils (or equivalents) to report on the status of health care services and outcomes, identify areas for improvement and successes, and promote and spread learning. In addition, ministries, regional authorities, primary care delivery models (e.g., primary care networks [PCNs], family health teams, community health centres, and family practice networks), universities, and professional associations and colleges have undertaken various QI activities within their respective jurisdictions. Additionally, national organizations, such as Choosing Wisely Canada and the Canadian Foundation for Healthcare Improvement, support practice improvement. Some efforts are based on general, practice-driven improvement work; others focus on a project or disease, or on EMR and data improvement.

Some jurisdictions have implemented practice facilitation more successfully than others and serve as role models. While the approaches taken need to reflect the context in the jurisdiction, organization size, practice characteristics, system goals, funding/funder expectations, and the mandate of the QI organizations, there are some common elements that support success. Case examples are provided in Chapter 7.

The context of the Canadian health care system provides an opportunity to leverage partnerships and regional strengths in QI to support a networked approach to developing national capacity for primary care practice change and system transformation, including support for practice facilitator training and development. Different terms are used across Canada to refer to practice facilitators, including improvement professionals, improvement facilitators, practice coaches, QI coaches, EMR coaches, EMR facilitators, and QI consultants. Despite the different naming conventions and approaches, the core skills, competencies, and training to support the growth and development of these roles have been similar across the country. They are described in more detail in chapter 5. Most of the skills fall within one of the four skill domains identified by the AHRQ: 1. Interpersonal skills to build support for and facilitate change; 2. Methods for accessing and using data to drive change; 3. QI and change management strategies; and 4. Health IT optimization.

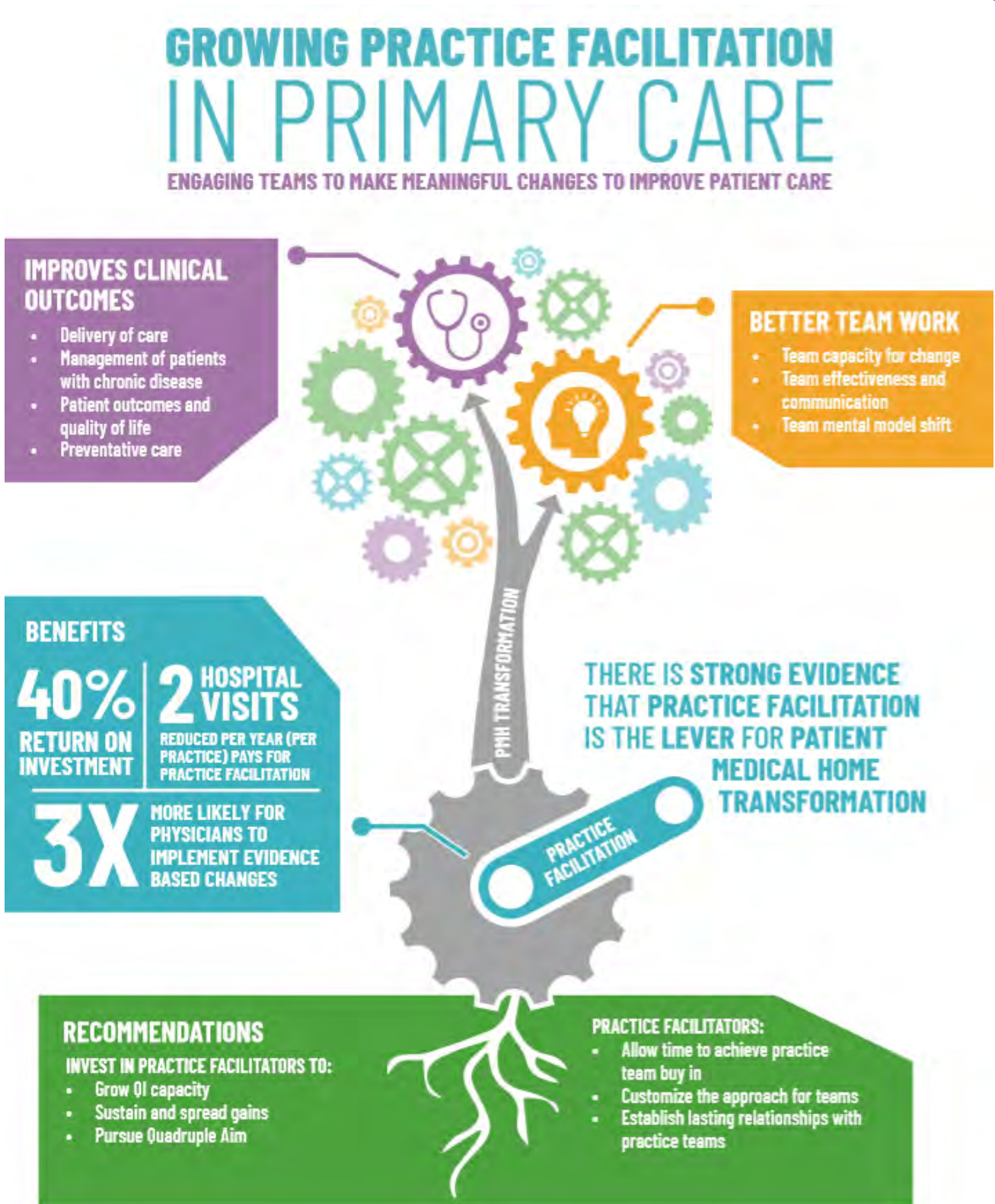


Building skills in improvement at the clinical level creates a foundation for primary care to partner across the health care sector. Improved care access and coordination within primary care support better transitions of care within the medical neighbourhood and community programs. Practice facilitators work with practices and can support integrated care and community engagement to improve patient care and address the social determinants of health. For Canadian health care decision makers, there is value in having a national vision and approach for practice facilitation in primary care as a key element of the workforce needed to support its transformation.

3. The Evidence Supporting Practice Facilitation

While integrating practice facilitation into routine QI programs is not necessarily simple or straightforward, there is a growing body of evidence that demonstrates its impact and effectiveness in supporting practice change and improvement. A summary of the evidence for the benefits of practice facilitation in primary care and system transformation is outlined in Figure 4.

Figure 4. The evidence for practice facilitation in primary care[†]



[†] This infographic was created by the CFPC in collaboration with the Accelerating Change Transformation Team.

One of the first systematic reviews on practice facilitation was published in 2005.⁸ The review included studies on the impact of facilitators and described their roles, methodologies, and funding. Of the 47 articles reviewed, 25 measured the effect of interventions involving facilitators on patient outcomes. Eight were randomized controlled trials (seven of which investigated multi-component interventions in which practice facilitators were a part), two were case-control studies, and 14 were before/after studies. In the area of prevention, the studies demonstrated increased eye and foot examination rates among patients with diabetes, increased cancer screening rates, and increased preventive interventions for cardiovascular disease, among others. One study noted that facilitators enhanced the understanding and use of smoking cessation tool kits, but not cost-effectively. Facilitators were found to be cost-effective in the support of retinal screening in patients with diabetes and in the improved diagnosis and treatment of childhood asthma. Numerous system-level improvements were noted across the studies. Practice facilitators accelerated improvements by educating clinic staff on the need for and benefits of improvement, as well as providing necessary materials and feedback. The extent of practice team members' understanding and implementation of QI methods was significantly higher in practices with facilitators, and their attitudes toward QI helped sustain improvements over the long term. Better chart documentation of some health conditions and patient recall systems were also documented.

A 2012 systematic review and meta-analysis looked at practice facilitation in primary care settings.³ It included 23 randomized and non-randomized controlled trials and prospective cohort studies in an analysis that included 697 practices randomized or allocated to the practice facilitation intervention and 701 to a control group. An overall effect size of 0.56 favouring practice facilitation was found. Primary care practices were found to be 2.8 times more likely to adopt evidence-based guidelines through practice facilitation. All the studies in the 2012 review included audit with feedback, the practice of consensus building and goal setting as key components, and the basing of the change approach on common QI tools, such as the plan-do-study-act approach. Many incorporated collaborative meetings, which the authors noted add costs to the initiatives, but it is unknown whether these resource-intensive meetings increased effectiveness. There was variation in implementation processes among the studies, including facilitator qualifications, training, the number of practices, and intensity and duration of the intervention. The review found that as the number of practices per facilitator increased, the overall effect of the facilitation diminished, indicating that the number of practices supported by a single facilitator is an important consideration in implementing practice facilitation. Moreover, the intensity of the intervention was associated with larger effects, as was tailoring interventions to the practice (i.e., considering the practice's context, realities, and resources). Importantly, the authors concluded that facilitation needs to be tailored to a practice's context, with a focus on processes and the organization of care.³

Practice facilitators have also been found to help practices transform in ways that align with the PMH vision. The effect of facilitation on practice outcomes was assessed in the patient-centered medical home (PCMH) National Demonstration Project in the United States, as practices implemented different components of the model.²⁸ Thirty-six family practices were randomized to intervention groups that either had practice facilitators or required self-direction. Practice facilitators were found to be important in articulating to practice teams how to implement PCMH components. They helped teams create road maps for change, select priorities, and use the right tools to support the shift. They also trained the teams in change management and project management skills. Controlling for baseline differences and practice size, facilitated practices had greater increases in adaptive reserve and the number of the PCMH model components implemented.

More complex changes in practice, such as virtual visits, team-based care, and population management, were reported to be most amenable to practice facilitation. Interestingly, very motivated practices—those identified as innovators—were better able to self-manage and implement the elements of PMH independently, but with less of an improvement in patient experience of care.^{13,28}

Another study of the National Demonstration Project explored facilitation strategies for enhancing practice transformation.²⁹ This secondary analysis described a sequence of strategies used to produce change in primary care practices attempting to adopt the new model of care. The authors analyzed qualitative data generated by a facilitator working across six practices. The findings indicated that coaching encouraged the following sequence of events: 1. Physician leaders switching from a hierarchical, top-down communication style to a more expansive, multi-directional, attentive style of communication; 2. collaborative planning and problem-solving among practice members in the clinical setting, including daily huddles; 3. physicians modelling facilitative leadership and addressing administrative and human resource concerns; and 4. physicians developing an expanded vision of their role within the practice and in overall patient care. The results of the study highlighted that consistent coaching leads to practice members being able to implement the model components and identify new ways of working.²⁹

The evidence suggests that practice facilitation can help both high- and low-functioning practices. However, it may be less effective if practices are struggling with deep challenges (e.g., the least functional practices) or if they are very highly functional (e.g., exemplar practices).⁵ Nonetheless, starting with or establishing a strong foundation and a capacity for improvement allows for more complex improvement initiatives to be undertaken and for the introduction of processes that entrench improvement and make it a strategic part of operations and culture.³⁰ In terms of longevity, studies have observed the effects of practice facilitation, once ceased, for up to 12 months.³¹⁻³⁴

There is also a growing evidence base in Canada. Several participants at the 2018 Canadian Invitational Quality Improvement Symposium gave presentations on practice facilitation interventions that have improved practice processes and patient care outcomes. One study, the Improved Delivery of Cardiovascular Care program, looked at how practice facilitators affected family physicians' reactions to a QI program in Eastern Ontario from 2007 to 2011.³⁵ It highlighted that while the benefits and impact of the program varied, overall, the interventions were viewed positively and physicians appreciated having access to a practice facilitator. Three key roles were filled by facilitators: 1. acting as a resource centre; 2. being a motivator; and 3. providing an outside perspective. Supported by their practice facilitators, the physicians implemented changes that included the adoption of clinical information systems, decision support tools, and delivery system redesign.³⁵ An earlier Canadian study found that compared with practices without facilitation, those with facilitated support applied more relevant and impactful measures and saved \$1.87 per patient or \$3,321 per physician, which resulted in an ROI of 40 per cent.³⁶

The need for investment in external support to help primary care practices undertake change and adopt innovations was highlighted in a 2018 study.³⁷ It describes the use of health care extension in the EvidenceNOW project in the United States that was launched for the rapid dissemination and implementation of evidence-based guidelines for cardiovascular preventive care in the primary care setting. Seven regional grantee cooperatives provided the foundational elements of health care extension—technological and QI support, capacity-building practice, and links with community resources—to more than 200 primary care practices in each region.

The study indicated that health care extension is a feasible and potentially useful approach for providing QI support to primary care practices.

A 2019 supplement of the *Annals of Family Medicine* brought together examples and key learning related to practice transformation, including insights into practice facilitation. An editorial in this issue stated:

*Most practices lack time, energy, and resources to make these changes on their own, and most lack means of learning about the policies pushing them to change or examples from which they can learn. ... Practice facilitation, health extension, and other forms of support for practice transformation and community health improvement are important systems-level interventions to improve health care and accomplish the quadruple aim.*³⁸

One article in the supplement reported on a randomized controlled trial in smaller practices (10 physicians or fewer) across three US states.³⁹ The trial explored the impact on practices of various types of implementation support for practice facilitation QI to improve cardiovascular risk; 209 practices participated and received up to 15 months of support. The study compared the effectiveness of four scenarios: 1. practice facilitation as a stand-alone intervention; 2. a combination of shared learning and practice facilitation; 3. a combination of educational outreach visits and practice facilitation; and 4. a combination of shared learning, educational visits coupled with practice facilitation. Overall, the findings suggested that there were no significant differences in the clinical quality measures used for the interventions. However, smaller practices with external support were able to improve their performance on cardiovascular disease risk factors and reach their target performance level across all four arms of the study. To enhance the performance for these practices further, the study suggested that additional, continued opportunities such as educational outreach visits, shared learning opportunities, and practice facilitation could be used.

In that same *Annals of Family Medicine* supplement, another study described how remote facilitation was successfully used to coach optometry practices across all 50 US states in a QI initiative that promoted urgent eye care to reduce emergency department use. The practice facilitators in that project conducted practice assessments remotely, established goals with each practice, and assisted in implementing iterative plan-do-study-act cycles.⁴⁰

A group of researchers in New York, NY, having observed that small, independent primary care practices often lack the resources to implement system change, studied the effectiveness of practice facilitation in improving cardiovascular disease in 257 small practices.⁴¹ Clinicians perceived practice facilitation to be an important resource for connecting their practices to the external health care environment and resources and for helping their practices build QI capacity through teaching, hands-on support, and solutions that use electronic health records. The role of practice facilitation in creating awareness of quality gaps and in connecting practices to information, resources, and strategies was also highlighted.

4. Practice Facilitator Profile

Practice facilitators implement strategies individually or in combination to achieve and sustain change. Single strategies can include group education, facilitated team planning, individual instruction, feedback, and reminders. Combined strategies can include educational materials and feedback; group education combined with other strategies; individual instruction with other strategies, feedback, and reminders; and feedback combined with peer reviews or academic detailing. Support is provided to groups of clinicians in one or more professions, or to solo practices, although the latter is less common as solo practices often do not have the resources to bring in practice facilitators.

Practice facilitators understand processes and contexts. Many practice facilitators have a health care background and may have practised in an allied profession, while others come from community development or education fields with strong change management experience.

Figure 5. The four profiles of practice facilitators



Quality improvement

Practice facilitators take on a broad range of roles related to QI. A practice facilitator works with practice staff to plan interventions, determine and assign tasks, study the effects of the interventions, and refine the interventions based on staff feedback and pilot results. In this role, practice facilitators can either be “generalists” who are able to facilitate many kinds of QI initiatives or “specialists” specific to only one type of QI initiative.

Various roles include engaging teams in the use of QI tools and methods, such as process mapping, the Model for Improvement, LEAN process improvements, the development of run charts, and the use of data for improvement and decision-making. Facilitation also enables a focus on the important aspects of sustaining and spreading impactful change, as described in the National Health Service Sustainability Model and the IHI Framework for Spread.^{42,43} More advanced roles may include teaching and supporting the team with value stream mapping, control charts, surveys, and qualitative reviews. A common method practice facilitators use involves conducting chart audits. Based on these audits, practice facilitators prepare reports, provide feedback to clinical staff, and assist in planning to bring about the desired improvement. Advanced roles also include helping to spread and scale up initiatives across practices and even across the health care system, including applying the diffusion of innovation skills.

Practice-based research

Research practice facilitators tend to work either in the context of a PBRN (where they are funded by the network) or on a specific study with funding that includes research facilitation. In this role, practice facilitators can be either generalists or specialists.

The research support role involves helping practices become both research ready and active. Being research ready includes practices being able to collect, store, and manage data (including data sharing and transfer) according to best ethical practices (including privacy, ethical principles, and standards) and understanding different types of studies. Enhancing practices’ understanding of research processes, approaches, and methods is critical in this regard. Being research active includes helping a practice identify and recruit potential study participants and ensuring research reporting processes and safety monitoring are in place and being followed. Support may also include helping prepare regular research reports. Other supported research competency development may include reviewing literature, preparing research protocols, applying to research ethics boards, recruiting participants, collecting data, and assisting in qualitative interviews if these are required. More advanced skills development support may include managing a research database and conducting statistical analyses (although this is usually the responsibility of the statisticians in studies).

EMR data use

In this role the practice facilitator’s main function is to help the practice harness the full potential of its EMR data, often to inform and support practice improvement activities such as audits or QI projects. This requires practice facilitators to be acquainted with different EMRs and their components and functions, to know how data are captured and entered into EMRs by clinicians, and to be able to assess the quality of the data. The role involves helping clinicians and practices improve the entry of data into EMRs to ensure that they have high-quality, reliable data repositories for auditing and tracking performance, can generate practice reports and analyze their

data to find areas of strength and areas for improvement. Practice facilitators also assist practices in using data decision supports to frame the key questions that need to be addressed in a practice.

The data and information can inform strategic practice decision-making, as well as the monitoring and assessing of the impact of practice improvement initiatives. This role often overlaps, to different degrees, with the QI facilitation role.

Combination of roles

Some practice facilitation roles require a combination of two or more of the above roles (e.g., QI and EMR data use roles). However, the more roles that are added, the higher the burden on the practice facilitators and the more difficult it is to find individuals with the expertise and training to address the different roles adequately.

As PBRNs move toward becoming learning systems, where QI and research co-exist in support of practice improvements, the demand for facilitators with competencies in both areas will likely increase. A couple reviews have described how PBRNs in the United States have used practice facilitators, including for the coordination of research projects, the development and implementation of system-level interventions (such as immunization and preventive services, chronic disease management, chart audits, and QI feedback), patient education, and, increasingly, patient engagement in QI and research.^{8,44} In one example, the Oklahoma Physicians Resource/Research Network used five full-time equivalent facilitators (called practice enhancement assistants in this case). They helped member practices participate in individual and network-wide research and QI projects.⁸

Practice facilitators can enhance communication and spread useful ideas among practice sites (cross-pollination), and they can help establish new connections between members of the same practice or different practices within a network of providers.³ Primary care providers often work in isolation, even in the same practice group, and generally do not share methods, ideas, or discovered practical solutions with one another. Practice facilitators can connect providers effectively and facilitate the sharing of experience and resources so a network of clinicians functions as a learning community. These connections are particularly important for rural practices that are isolated from the resources available in a metropolitan area (such as tertiary medical centres).

Appendix A offers summaries of practice facilitation programs in some Canadian provinces and how they have funded and deployed practice facilitators.

5. Practice Facilitator Competencies, Roles, and Approaches

Practice facilitators can apply different roles and approaches, and the competencies required can vary. However, practice facilitator roles build on a foundation of core skills and attributes that include:

- Interpersonal skills
- Facilitation and teaching skills
- Communication
- Coordination and organization
- QI and change management strategies
- Leadership behaviours
- Emotional intelligence
- Knowledge of health information technology optimization
- Ability to use data (EMR and administrative) to drive change
- Curiosity and openness
- Understanding of primary care operations and frameworks
- High valuation of continuous improvement

As described earlier in Chapter 1, the AHRQ has grouped the competencies that primary care practice facilitators need into four domains:

1. Foundational knowledge
2. General skills
3. Specialized skills
4. Professional skills, knowledge, and commitment

See Table 3 for a description of these roles and the associated competencies.⁴⁵

Table 3. AHRQ primary care practice facilitator competencies

Domain	Description	Examples of competencies
Foundational knowledge	Familiarity with key topics important for improving and redesigning primary care	<ul style="list-style-type: none"> • Organizational change processes • Goals of QI for improving patient care • Principles of the PCMH[‡] and the logic through which it intends to affect health care outcomes • Strategies for the diffusion of innovations and organizational learning • Familiarity with the changing primary care practice environment, including regulatory and policy changes • Knowledge of health systems and the local primary care market • Understanding of payment models and their relationship to care delivery • Knowledge of culturally and linguistically competent care delivery
General skills	Competence in applying foundational knowledge to various transformation tasks	<ul style="list-style-type: none"> • QI methods (e.g., understanding of plan-do-study-act cycles) • Organizational assessment (e.g., assessing practice readiness for change) • Education of teams in QI methods • Change management • People, project, and meeting management
Specialized skills	Competence in the use of specific techniques to support change	<ul style="list-style-type: none"> • Data collection and analysis to inform QI • Use of information technology systems • Work process engineering methods
Professional skills, knowledge, and commitment	Effective communication and stakeholder engagement	<ul style="list-style-type: none"> • Competence in the use of effective communication techniques • Interpersonal and facilitative skills • Skills in establishing trust with practice staff members • Knowledge of practice facilitation as a profession and as a national community of practice • Commitment to self-evaluation, lifelong learning, and transparency

Reproduced with the permission of the Agency for Healthcare Research and Quality. Crosson J et al. *Primary Care Practice Facilitation Curriculum* [introduction]. Agency for Healthcare Research and Quality; 2015.

[‡] PCMH = Patient-Centered Medical Home (equivalent to the Patient’s Medical Home of the CFPC)

An understanding of primary care, its operations, and its frameworks is imperative for effective practice facilitation. For example, if the change work involves implementing aspects of the PMH, then a practical and theoretical understanding of the PMH's framework, components, and change concepts are required. Moreover, an understanding of practice, organizational, and system factors is important to aligning efforts with innovations and public policy over time.

Facilitation is a key skill that includes a range of abilities. It requires knowledge of when to use various supportive functions to move a group toward an identified outcome—when to be a “collaborator” and gather ideas, when to be a “consultant” to share knowledge, when to be a “coach” to enhance someone else’s skills, and when to be an “evaluator” to assess progress and targets. In addition, the role of the practice facilitator is that of a mentor and guide, with the aim being to enable and empower, rather than to assume all the responsibility for practice improvement, and to increase the resilience and resourcefulness of the practice team so it can continuously improve. A practice facilitator may also have a leadership role in influencing and guiding work, helping to form teams, managing conflict, and engaging internal and external stakeholders, including patients. The ability to navigate political influences and tensions that may exist within teams diplomatically is invaluable.

Valuing improvement as a continuous journey, not simply a destination, is foundational in the success of a practice facilitator. Practice facilitators require high emotional intelligence and the ability to listen and communicate in a way that resonates with others’ experience and thinking. Being a curious and open thinker and fostering that ability in others are essential to creating an environment for change and innovation that supports the learning of each member of the practice team.

6. Practice Facilitator Training

Several courses and programs exist across Canada and internationally to support the acquisition and maintenance of practice facilitator competencies. Some require self-learning while others are group-based. Training is delivered using traditional classroom-based learning, online-only interactions, or a hybrid of both.

Training programs (such as courses and certificate programs) are generally geared to a level of competency or expertise (e.g., foundational, intermediate, and advanced levels). As with any role, most people start their training at a foundational level, and then over the course of their careers advance to intermediate and advanced levels. Advances in the level of expertise usually occur with a combination of professional development (i.e., attending additional training or workshops) followed by relevant experience and the application of learning. The competencies described in chapter 5 are generally acquired at the foundational and intermediate levels of training, but these levels can also involve advanced competencies.

Practice facilitator programs must invest in continuing professional development opportunities and the creation of resources to support facilitators in their roles. This is needed not only to advance their competency, effectiveness, and abilities to contribute to practice improvement or practice-based research, but also, in many cases, to address any gaps in their competencies. Given the broad scope of competencies and roles required, it is not expected that programs can recruit individuals with all the required skill sets.

Though it can be difficult to find a single training program that addresses all the practice facilitator competencies required, some provincial health organizations are starting to build comprehensive programs geared to this goal, such as the *Blueprint for Change Agents Supporting Patient's Medical Home and Integration of the Health Neighbourhood in Alberta*.⁴⁶ There are programs—including the CFPC's Practice Improvement Essentials workshops and the HealthCareCAN programs—that offer relevant content such as methods of communication and collaboration; standard setting with practice teams; principles of data collection and analysis; managing change and encouraging teamwork. The standards for provincial programs are aligned with US national programs from the IHI (Improvement Advisory Training), the AHRQ (Practice Facilitator Curriculum), and the University at Buffalo Practice Facilitator Training Certificate Program, which is more advanced. Appendix A has more information on these programs.

There are different ways in which local jurisdictions can identify, train, and support practice facilitators. However, a national approach has the potential to enable change in three important ways: 1. finding and sharing current best and promising practices; 2. supporting the knowledge, education, and skill acquisition needed to foster capacity building; and 3. creating networks and relationships that accelerate the spread of improvements.

Examples

All provinces are exploring or investing in sustainable ways to support primary care, such as practice facilitation. Each is at a different level of maturity/capability in this regard, with a few examples included below.

Canada

Alberta: Practice facilitators are hired and assigned to practices by the PCNs and offered training, mentorship, and support from the Alberta Medical Association (AMA)'s Accelerating Change Transformation Team (ACTT). The ACTT's practice facilitator blueprint outlines the organizational commitment through practice facilitator recruitment, development, deployment, and progression.⁴⁶ A three-day training program, supported by the IHI Open School and virtual learning, advances a comprehensive competency framework designed to prepare practice facilitators to support PCN-level priorities. These priorities are aligned with provincial strategies to advance the PMH. Practice facilitators are seen to play a key role in transformation, as are physician champions and EMR facilitators. EMR facilitators are provided with vendor-specific training, tools, and resources to leverage the EMR data reports to support practice-level planning and implementation.⁴⁷ Alberta physician leaders have set a target of having one practice facilitator per five clinics (20 physicians) and is halfway to reaching that target.

Currently, the AMA's ACTT is training practice facilitators for the uptake of and change management needed for a Central Patient Attachment Registry and the Community Information Integration initiative to advance relational, informational, and management continuity for better patient care.

British Columbia: BC Patient Safety & Quality Council is collaborating with the General Practice Services Committee (GPSC)—a partnership between the Ministry of Health and Doctors of BC—and the University of British Columbia's Innovation Support Unit (ISU) to develop and refine new and existing ways of supporting primary care teams. The ISU has developed the team mapping method to help budding team-based care initiatives (e.g., PCNs and patient medical homes) explore and describe how teams could be structured. Funded by the GPSC, this train-the-trainer approach will include a focus on team mapping preparation, the facilitation of team mapping sessions, and the analysis and reporting processes that allow communities to take the findings from team mapping processes and translate them into learning and action.

Newfoundland and Labrador: Practice facilitators have focused on EMR uptake and the optimization of EMRs for patient care through eDOCSNL. Family Practice Renewal Program is launching a new initiative to bring support for practice facilitators to a quality-improvement, practice-management, and enhanced-access initiative for physicians across the province.

Ontario: The University of Toronto Practice-Based Research Network (UTOPIAN) recruits practice facilitators with strong skills in surveying, statistical analysis, communication, and project management. They are provided ongoing skills development and mentorship, and they collaborate with QI organizations to bring in complementary skills.

OntarioMD has built a roster of practice facilitators (called practice advisors) and peer leaders to help advance the use of EMRs for practice management, information management, and diagnosis and treatment support. OntarioMD's Peer Leader Program is a provincewide network of more than 60 physicians, nurses, and clinic managers who are expert users of OntarioMD-certified EMRs and who are available to help medical practices get more clinical value from their EMRs. Peer leaders have several years of EMR experience that practices can leverage to enhance the quality of patient data in their EMRs to deliver better patient care. They can assist practices in developing EMR enhancement plans that lead to real and measurable improvements.

Quebec: Continuous QI agents have been integrated into academic family medicine groups. Their primary roles are to consolidate a culture of continuous QI and coordinate local priority projects, often guided by committees. These agents are supported through basic training, a virtual community of practice, and an onboarding support program. They are assigned to practices based on a weighted panel size framework.⁴⁷ Quebec also integrates Patient-Oriented Research Facilitators through Réseau-1 and PBRNs. They are developing an onboarding POR facilitation program that includes conferences, networking, access to shared templates, mentorship, applied learning, and a community of learning.

United States

The **AHRQ's Primary Care Practice Facilitator (PCPF) Curriculum** is the organization's latest and most extensive effort to support the education and training of practice facilitators. PCPFs need to develop several core competencies to work effectively with primary care practices and help them engage in continuous QI, become PCMHs, and fundamentally transform the way they provide care. The PCPF Curriculum offers a series of modules for developing the competencies across each of the four distinct domains of knowledge and skills that are needed for supporting primary care practice transformation: 1. foundational knowledge; 2. general knowledge; 3. specialized skills; and 4. professional skills, knowledge, and commitment.⁴⁵

In the **Oklahoma Physicians Resource/Research Network**, the practice enhancement assistants help member practices participate in individual and network-wide research and QI projects. Initial training for practice enhancement assistants includes a comprehensive introduction program followed by project-specific training.⁸

7. Establishing a Practice Facilitation Program

Project-specific versus all-purpose roles

Practice facilitation, be it to support QI, research, or EMR optimization, is generally integrated in a practice or groups of practices by way of one of two routes: through project-specific funding or through funding to support an all-purpose or generalist role within the practice or group of practices.

In the project-specific role, the practice facilitator is hired to support a specific project or study, usually with funding from a research agency. For example, this may be a QI initiative to improve cancer screening or to help implement a specific component of the PMH model, such as panel and continuity.

In the all-purpose or generalist role, the practice facilitator's work is not limited to a specific QI initiative or research study, but rather supports practice improvement, research, or the optimization of EMR data in general. Their mandate is to support the practice in undertaking various initiatives identified by that practice as priority areas. The PMH is sometimes used as the guiding vision to transform a practice through a series of interdependent QI initiatives.

Project- or study-specific roles are often time-limited and of relatively short duration (months or a year or two); they last only for as long as there is funding available for the project or study. While the facilitator often aims to create opportunities to advance these projects beyond their term, the end of the project also often represents a loss of expertise, Relationships, momentum, and a precious resource for the practices. This guide encourages proactive planning at the outset of the project to reduce the impact of the project termination. The following steps could be considered:

- Start planning for longer-term engagement of the project facilitator with alternative funding sources; perhaps several practices can team together to collaborate on supporting a shared practice facilitator
- Build mechanisms and processes for the facilitators into the project, in collaboration with the practices, to nurture a QI culture and learn about QI or research readiness in general so that this mindset and the change skills extend beyond the end of the project and have a long-lasting impact (that is, they become hard-wired into the practices' everyday operations)
- Calculate the qualitative and quantitative ROI of the practice facilitator roles in order to promote ongoing inclusion of this role in future initiatives
- Consider supporting a practice facilitator network to promote shared learning, including knowledge of upcoming project opportunities within primary care
- Design primary care initiatives that adjust to scale and can demonstrate system level value

Ideally, practice facilitation should be considered a long-term investment, where practice facilitators work closely with a practice over an extended period, and funding should be sought and provided accordingly. Building practice facilitation, including bringing on board practice facilitators, represents a large and important investment in terms of know-how, capacity, expertise, and relationship building. Although benefits can be realized in the short term (e.g., a successful QI project or successful completion of a short study), the ROI is maximized over the long term.

Long-term support by a practice facilitator can help build the team's experience and buy-in in undertaking practice improvements and/or participating in research or EMR data optimization, and it can nurture a culture of continuous improvement and scholarship. To date, the successful long-term implementation of practice facilitation in Canada and abroad (e.g., the United States, United Kingdom, and Australia) has come about through government funding or funding from government partnerships with medical organizations and, in Canada, Chapters of the CFPC.

Case examples

Across the country and internationally, several approaches to building a workforce to support change in primary care have been used, all based on the premise that practice facilitation increases the speed and effectiveness of change. Recognizing the differences between these approaches and the funding and mandates of the governing bodies they are associated with, three approaches have been identified:

- A specific project or initiative has been used to build internal capability for improvement
- PBRNs are leveraged as facilitators for change across the practices in the networks
- The primary care organization focuses on building the capacity of a team for a greater strategic goal, such as PMH-level performance

Large-scale, all-purpose practice facilitation

In Alberta practice facilitators are hired by PCNs and serve as key figures in advancing organizational shared goals. Such large-scale practice facilitation initiatives are facilitated through partnerships and provincial collaborations. In 2014 in Alberta, a consortium of governmental, university, and health care organizations agreed on a common focus, resources, and tools.[‡] The consortium identified relational continuity as a priority, as there is strong evidence linking this concept to improved patient outcomes and system performance.⁴⁸ Physician leaders set a target that 80 per cent of family physicians would be engaged in panel identification and maintenance.^{47,48} Practice facilitators within PCNs received training through the AMA's TOP program and were provided with the resources and tools to help practices make these changes, for instance through Access Improvement Measures Alberta, the Health Quality Council of Alberta (HQCA), and other organizations. According to HQCA, the proportion of family physicians actively maintaining their panel populations rose to 71 per cent in 2018 from 54 per cent in 2015 and continuity of care has been increasing at the provincial system level (HQCA, unpublished data, 2018 and 2017).

[‡] The consortium was composed of Alberta Health Services, Access Improvement Measures Alberta, the Alberta College of Family Physicians, Physician Learning Program, the University of Alberta Department of Family Medicine, the HQCA, Toward Optimized Practice (TOP), the Primary Care Networks Program Management Office, and the Alberta Medical Association.

Project-provided practice facilitation

While specifics may differ between projects, the basic premise is that the project will recruit participating clinics, provide them with a tool kit for change, and link them to a practice facilitator who will guide their improvement process. These facilitators may be independent contractors, linked to an organization such as a medical association, or associated with a health authority. These initiatives are designed not only to achieve the outcomes of the specific project, but also to strengthen the skills of the practice team and leave behind the infrastructure that will allow practices to continue their improvement journeys toward excellence.

Christina Southey is a practice facilitator in Ontario. She is contracted to specific projects and typically works with between eight and 12 practices over a one-year period. By introducing the approach and providing space for team members to work together to explore the ideas most relevant for them, Christina sets the stage for improvement. She focuses on building the practice team's capacity for a chosen project topic and offers a reusable QI framework. Christina has found that clinicians are comfortable setting aims and identifying measures, and they benefit most from guidance on moving thoughts to action and testing change ideas. Working with a variety of practices (solo practices, family health teams, teaching clinics, etc.), Christina says she has learned it is best to "always assess practices for their strengths and resources first to make sure to build on what they have" (oral communication, April 2019).

Research network practice facilitation

PBRNs have been facilitators of change in various areas of Canada and the United States. Members of PBRNs connect to examine best practices and develop relevant research questions to drive a continuous cycle of knowledge translation and improvement in primary care.⁴⁹ Practice facilitation in this context has a strong focus on identifying gaps between current and best practices, understanding EMR data, and improving quality of care outcomes.

Zsolt Nagykaldi started working as a practice facilitator 20 years ago with the University of Oklahoma in the Department of Family and Preventive Medicine (oral communication, May 2019). He was assigned between eight and 10 practices and supported them with implementing academic projects, but he also understood the real-world needs of practices could inform research opportunities in the department. This two-way flow of ideas—where practice informed research and research informed practice—worked well, and the program grew. As the number of facilitators reached about 12 and the department was working with practices across the entire state, they found they required greater infrastructure and support. They developed a networked model with multiple practice facilitators that covered specific regions, with "super facilitators" to provide mentorship and guidance. The network allows for the cross-pollination of ideas and skills and holds true to its academic roots, embedding research and learning into all areas of practice.

This is a highly relationship-focused model that is designed not by a project or research need, but rather by the development of long-term relationships and a deep understanding of the culture of two worlds and linking them: the research/academic context and real-world practice.

Primary care organizational practice facilitation

Process-based internal practice facilitation within a primary care organization is geared to team-based service redesign, often aligned with larger performance and strategic goals such as aligning with the PMH. Models that align with this vision are already operational in various jurisdictions in Canada and seem to work well where there is a pre-existing networked approach to primary care delivery and governance.

As of 2018 there were more than 100 practice facilitators, hired by PCNs, working with individual practices in Alberta.⁴⁷ PCNs choose to divide their provincial resources between administrative, clinical, and practice facilitation supports. Some family health teams in Ontario choose to use their government funding to employ practice facilitators to support their clinics' ongoing improvement efforts. In Quebec academic family medicine groups hire practice facilitators to serve 46 sites using a hybrid model supported by a partnership between the government and the universities. The practice-to-facilitator ratio varies across sites. Some have one facilitator allocated to between five and seven practices, while others use total patient numbers on a panel to determine the allocation of support (e.g., one full-time facilitator for every 12,000 patients).¹³

Embedding the role within the primary care organization builds capacity to address a mix of provincial and local priorities and helps teams establish a culture of continuous QI. Jurisdictions have struggled with the implementation of practice facilitation within existing primary care funding models that were not designed to support this long-term continuous improvement approach. The CFPC strongly encourages governments to invest in this important infrastructure, which provides a demonstrated ROI and other benefits.

Dr. Brad Bahler is a family physician in an eight-doctor practice in rural Alberta (oral communication, May 2019). Brad was working hard to build QI into the practice by introducing team members to leading evidence, measures, and strategies, but the changes just weren't sticking. Then Sandee Foss, a practice facilitator from the AMA, was linked to the PCN and used practice facilitation methods with the clinic to focus on advancing the PMH vision, starting with screening improvement and then adding other topics of their choice. Sandee engaged the team in discussions. They explored and tested changes and built a sense of ownership of the new ways of doing things. The practice has now trained internal practice facilitators that have embedded QI in their routines.

Funding and partnerships

Funding

Where provinces are investing in practice facilitation, the health ministry provides funding to a host organization tasked with implementing primary care innovations either through projects or new operational infrastructure. These host organizations include provincial medical associations or health authorities and sometimes regional primary care organizations such as PCNs. These host organizations typically hire practice facilitators to work directly with practices for improved EMR use, quality outcomes, and uptake of evidence-based practices. This funding is often grant-based or based on annual renewals, and only Alberta, Ontario, and Quebec currently have sustainable funding.

This paper advocates for reliable and expanded funding for practice facilitation through investment in the role of practice facilitators within primary care. If Canada is to realize the whole-system benefits of primary care transformation, practice facilitators must be embedded into provincial primary care systems. They pave the way for busy practices to optimize their processes to be more efficient, allowing them to take on more patients and to coordinate more effectively transitions of care with hospitals, other specialists, and community services.

Partnerships

Practice facilitators are being recognized as a key component of health system renewal. As such, health organizations are partnering to bring this new role into the system. Within each province that is focused on primary care transformation, partnerships are required between health organizations such as medical associations, provincial Chapters of the CFPC, health regions, university departments of family medicine, and the primary care organizational structures.

In Alberta, Newfoundland and Labrador, and Ontario, health ministries are funding and working with medical associations, CFPC Chapters, and departments of family medicine to put in place and fund practice facilitation. In Quebec, the health ministry is funding practice facilitators groups and collaborating with university family medicine groups to engage practice facilitators to support primary care teams in making evidence-based changes in their practices.

One example of the power of partnerships is the large-scale, all-purpose collaboration in Alberta that was elaborated on in the preceding section. This partnership advanced the patient panel process by using a common message to better support interventions through practice facilitation. This collaboration was one of a series of coordinated investments in practice facilitators as enablers of the PMH vision in Alberta.

Interprovincial collaborations are occurring to strengthen programs and to share learning and resources. Provinces that do not have practice facilitation in place can, and are, approaching entities in other provinces that have resources to share and leaders who can offer advice and training. At the 2018 Canadian Invitational Quality Improvement Symposium, examples of collaboration between the provinces of Alberta and British Columbia; British Columbia and Ontario; and Alberta and Newfoundland were shared.⁴⁷ It is hoped that further interprovincial collaborations can be established by sharing progress through papers such as this, through the CFPC website, and through new relationships and networking via national events such as the 2018 Canadian Invitational Quality Improvement Symposium.

Support for infrastructure and process development

Support for infrastructure and process development is needed when implementing practice facilitation across a primary health care system, whether it be QI-, research-, or EMR facilitation-focused. The level of support required varies depending on factors such as provincial funding, enabling policies, available training programs, local communities of practice, and ratios of practice facilitators to physician practices. Various approaches have been taken across the country to develop the infrastructure needed to support the training, employment, and evaluation of improvement facilitators.

At the 2018 Canadian Invitational Quality Improvement Symposium, participants identified key conditions that tend to be in place or considered when building a practice facilitation program:

Having enabling policies/funding: Funding and policy decisions are linked to strong primary care performance.⁵⁰ The recognition of practice facilitators as key members of multidisciplinary primary care teams is required within policy and funding frameworks designed to drive primary care transformation.

Leveraging existing opportunities: Building the role of practice facilitation within primary care is an evolution, not a revolution. Practice facilitators represent a relatively new role, so organizations can expect to invest in training to meet the broad competency requirements of this role.⁵¹ Linking the work of practice facilitators to the mandate of your organization is important. Some options are:

- Using the current mandate of your organization to promote the use of practice facilitation
- Leveraging funding opportunities for projects and key priorities that will enhance the skills of your change management personnel; rotate your staff through different opportunities to build their experience
- Looking for training opportunities in the skill areas identified to support your staff
- Using field trips to tour clinics that have greater experience with practice facilitation to understand the context and learn from others' mistakes and successes¹³

Understand what is unique to primary care: Ensure that the practice facilitation program and practice facilitators understand primary care well. The role of primary care, its frameworks, models, and history, as well as the political environment, culture, and hard skills (such as working with EMRs), are all considerations to build into any orientation program.

Alignment or cross-training of EMR experts and practice facilitators to intensify the effectiveness of both roles can be advantageous.⁵¹

Adapting to your audience: Building support for change into primary care may be a relatively new idea for many practices. Additionally, different kinds of challenges require different kinds of support. Practice facilitation can significantly help primary care teams advance their goals; however, as outlined in chapter 3, it may be less effective with practices at either end of the performance spectrum.⁵

Focusing on the overarching goal: The role of practice facilitator is optimized where there is a clear practice transformation goal that is addressed through a series of activities over the long term (such as transforming into a PMH-aligned practice, or undertaking practice improvement in general) rather than through discrete, short-term projects.⁵¹

Building from within—but knowing when you need dedicated infrastructure: Hiring practice facilitators to serve several clinics has advantages for primary care organizations over training someone from within each practice or engaging individual practice facilitators for each clinic.^{37,51} Anecdotally, Zsolt Nagykaldi—who provided the case example from Oklahoma earlier in this chapter—noted that to cover statewide needs in urban and rural centres, there was a tipping point of about 12 facilitators before an overarching administrative function was needed to ensure that networks and relationships were fostered and balanced with the skill needs and development of the practice facilitators across the state. Creating a learning environment where a body of knowledge is developed and shared for the benefit of all is a key success factor—and challenge—of a practice facilitation network.

Building time into practice for improvement: Time and effort invested in participation in continuous QI activities should be recognized as having value and not be disincentivized through inappropriate remuneration models. Dedicated time and capacity to perform these activities should be built into the practice's operational principles.¹²


Taking advantage of multiple methods: There are QI delivery approaches such as LEAN events and the IHI's Breakthrough Series learning collaboratives that may be leveraged in whole or in part. Some provinces leverage practice facilitators to support these interventional approaches to delivery. Researchers are currently exploring the QI approaches that work best at different stages of practice maturity and initiative maturity.^{27,37}

In 2018 the CFPC launched its Practice Improvement Essentials workshops, which provide participants with a practical introduction to basic QI techniques and tools that participants can implement in their practices with their teams.^{5,52} These include a practical, step-by-step planning and implementation model that takes participants through the steps of establishing a team, identifying an area for improvement, setting practice-relevant goals, developing a plan, and going through small iterative cycles of plan-do-study-act to achieve change. This program builds readiness in physicians to take advantage of, and collaborate with, practice facilitators to improve the quality of care they provide.

In 2011 the AHRQ engaged a panel of 30 experts in building practice facilitation in a variety of settings. They also looked at the similarities and results across all the different models and approaches. It led to the online guide [Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide](#).⁵³ It highlights the evidence supporting practice facilitation, its administrative and human resources needs, funding requirements, and strategic and tactical approaches, and it outlines how to train and supervise staff and how to evaluate the impact of interventions.

The AHRQ model for supporting PBRNs is an interesting one to study. The AHRQ has been funding PBRNs with millions of dollars over many years through specific grants and infrastructure support.⁴⁷ The agency has also been sharing knowledge through different approaches; maintaining

⁵ Visit the website at www.cfpc.ca/pij.



a repository of evidence as well as practice and training opportunities across the country; linking best practices; and fostering learning through conferences, webinars, and ongoing research.^{47,54} These functions help build capacity on the ground and the evidence needed for funding and the advancement of knowledge.

In Canada, a few provinces (Alberta and Quebec, with some examples from Ontario and British Columbia) have invested in practice facilitation support for family medicine practices. Funding for practice facilitation has come from various sources. Operational dollars in team-based primary care organizations have been used in provinces with organized team-based care models such as PCNs (Alberta) and family health teams (Ontario). Some PBRNs and academic organizations have invested in practice facilitation as an implementation strategy. Pilot projects and grant funding are also being used to support short-term projects that are leveraging the value of a practice facilitator to achieve successful outcomes.

As Canada looks to highlight and scale strengths across all provinces, an organization is needed to serve as the broker of information, the central hub of key contacts, and an advocate for the changes that have been found to support family physicians in integrating better processes into their practices. The CFPC is well-equipped to take on this role.

8. Conclusion

Primary care transformation is needed for overall health system renewal and sustainability. Models of primary care need to be adaptive to change, and practice facilitation has been shown to be a key enabler of improvements. The inclusion of practice facilitators in primary care offers provinces a significant ROI in advancing their goals of obtaining greater value from health care services.

Despite the practice facilitator being a relatively new role, robust support is available to recruit and train these professionals to be embedded in primary care teams and to be part of the enabling infrastructure for the optimized use of EMRs, greater uptake of evidence-based care, improved team processes, and better patient and provider experiences.

This new role requires a network of facilitators, leaders, and decision-makers to share resources and learn from each other. Given the emerging nature of this work, the CFPC has developed a web page to house current resources to support the development of practice facilitation and to connect key players with one another. It is available at: www.cfpc.ca/pii.

The CFPC is an advocate of primary care innovation, and it is therefore calling on provincial ministries of health and other funding bodies to increase their investment in practice facilitation and in the resources offered to support practice facilitators. The Canadian health system depends on the evidence of best practices to make decisions that allow for and support system renewal. Practice facilitators enable primary care physicians and other team members to make changes to reach provincial goals and practice goals and to better serve patients, families, and populations.

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10. Appendices

Appendix A: Organizational Resources for Practice Facilitation

The information in this section has been reproduced with the permission of the appropriate sources. Last updated: December 2019.

Practice Facilitation Programs	
QI agents deployed in academic family medicine clinics (available in French only) Quebec Ministry of Health and Social Services	
Agency for Healthcare Research and Quality Primary Care Practice Facilitation <ul style="list-style-type: none"> • Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide • EvidenceNOW • Webinars Case studies and lessons learned, QI practice facilitators (white paper , quick-start guide , tip sheet)	
Alberta Medical Association: Accelerating Change Transformation Team	
INESSS/CoMPAS+	Workshop duration: up to one full day
Primary Care Quality Practice Facilitation Program Pinecrest-Queensway Community Health Centre	Duration: 6 to 24 months
Patient Safety Education Program – Canada Canadian Patient Safety Institute	
TeamSTEPPS Canada Canadian Patient Safety Institute	Delivered in Alberta in collaboration with the Health Quality Council of Alberta

Agency for Healthcare Research and Quality (AHRQ) practice facilitation website

pcmh.ahrq.gov/page/practice-facilitation

The AHRQ in the United States of America has a large practice facilitation and practice facilitator program with a website full of very useful resources. These resources include modules on learning more about practice facilitation and practice facilitators, and a whole curriculum for practice facilitators. The resources include the AHRQ Primary Care Practice Facilitator (PCPF) Competencies and a whole Primary Care Practice Facilitator Curriculum with over 20 excellent modules to help train practice facilitators. For information on AHRQ's Primary Care Practice Facilitation Curriculum (Sept 2015), see pcmh.ahrq.gov/sites/default/files/attachments/pcpf-complete-curriculum.pdf as well as [How-to Guide on developing and running a primary care practice facilitation program](#).

Alberta Medical Association (AMA) Accelerating Change Transformation Team (ACTT) Program (formerly Toward Optimized Practice)

top.albertadoctors.org/PMH/capacity-for-improvement/practicefacilitationresources/Pages/PF-Resources.aspx

The AMA ACTT is the largest primary care transformation team in Canada. The website features content to advance all elements of the PMH within the health neighbourhood and offers capacity-building training and networking opportunities.

British Columbia General Practice Services Committee Practice Support Program

gpscbc.ca/what-we-do/professional-development/psp

The Practice Support Program (PSP) helps doctors and teams build capacity in their practices, enabling them to practise more efficiently, focus more on clinical care and patient relationships, and adopt attributes of the patient medical home in BC. Supporting full-service family practices, the PSP's tailored practice facilitation services are available to doctors and their teams directly in practices. The PSP provides evidence-based tools and services to bolster practice improvement (sometimes referred to as quality improvement) activities. These include:

- [Data-based Supports](#) to enable data-informed QI activities
- [Learning Opportunities](#) to provide customized learning opportunities
- [Practice Facilitation](#) to support through coaching and mentoring

For general inquiries, email psp@doctorsofbc.ca.

HealthCareCAN CHA Learning Programs

HealthCareCAN offers online courses for health care professionals, which include courses on leadership, quality and safety. The Leadership program is inspired by the LEADS learning series and explores each of the LEADS domains. The Quality and Safety program covers a range of programs and courses from becoming a Canadian Patient Safety Officer to Integrated Quality Management and Measuring and Monitoring Quality and Resource Utilization. The full courses can be viewed at chalearning.ca/programs-and-courses.

Institute for Healthcare Improvement (IHI)

ihi.org

The IHI is a world leader in QI at micro, meso, and macro levels in a health care system and health care organizations. In addition to many resources on QI approaches and methods, it offers courses and programs on the topic. Many of these are very applicable to practice facilitators. Some of them are free online programs and modules (such as the IHI Open School), but they also offer in-house courses, such as the IHI Improvement Coach Program.

Want more information?

Current programs and contacts are available at cfpc.ca/pii.

Appendix B: Recommended Resources in Key Areas

Primary care practice facilitation is supported by key research articles demonstrating the evidence for practice facilitation; the approaches to training and capacity building; expected costs and savings; and implementation strategies. To further enhance the knowledge base, other resources from international jurisdictions are also included.

Practice facilitation in Canada in general

Liddy C, Laferriere D, Baskerville B, Dahrouge S, Knox L, Hogg W. An overview of practice facilitation programs in Canada: current perspectives and future directions. *Healthc Policy*. 2013;8(3):58-67a.

Kotecha J, Han H, Green M, Russell G, Martin MI, Birtwhistle R. The role of the practice facilitators in Ontario primary healthcare quality improvement. *BMC Fam Pract*. 2015;16:93. doi: 10.1186/s12875-015-0298-6. Available from: [ncbi.nlm.nih.gov/pmc/articles/PMC4520205](https://pubmed.ncbi.nlm.nih.gov/pmc/articles/PMC4520205). Accessed March 25, 2020.

Evidence for practice facilitation

Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. *Ann Fam Med*. 2012;10(1):63-74. doi:10.1370/afm.1312.

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