OP101: Training Practice Facilitators to Deliver a Team-Based Curriculum in Medication Assisted Treatment for Opioid Use Disorder for Primary Care Practice Teams: the Implementing Technology, Medication Assisted Treatment, Team Training, and Resources (IT MATTTRs™) Train the Trainer Program

Kristen Curcija, MPH; Linda Zittleman, MSPH; Christin Sutter

BACKGROUND/SIGNIFICANCE:

Opioid use disorder (OUD) has seen an epidemic rise in the United States over the past decade and was identified as a primary concern by practices and community members in rural Colorado. To address this issue, the IT MATTTRs™ Program supports not only provider waiver training in MAT but also training for full practice teams. Primary care clinicians, Practice Facilitators, and researchers from the High Plains Research Network and Colorado Research Network, in collaboration with OUD experts with the American Society of Addiction Medicine, created a four-module Practice Team Training curricula for primary care and behavioral health practice teams to treat OUD. The curriculum can be used in practices with or without a waivered buprenorphine prescriber. The team training is designed to be delivered by Practice Facilitators or health educators with facilitation experience. The IT MATTTRs™ Train the Trainer Program was developed to train Practice Facilitators and other education professionals to deliver the congruent, evidence-based content to practice teams.

SETTING/METHODS:

The IT MATTTRs Train the Trainer Training consists of a 12hours training that covers: the epidemiology of the OUD epidemic; a 2-hour comprehensive, foundational education in opioids and MAT for OUD session taught by an clinician experienced in MAT; thorough review of the four primary care team training modules by a master trainer; and a cross-walk of the primary care and behavioral health curriculum. The training uses a mix of experiential learning and didactic sessions. Trainees are asked to complete an online evaluation within a month of their training.

RESULTS AVAILABLE OR PLANNED:

Four IT MATTTRs™ Train the Trainer events have been held in Colorado (three) and Montana (one) with a total of 91 individuals. Two additional trainings were held in California and North Carolina, and evaluations are underway. A total of 56 responses have been received evaluating Train the Trainer. Of those respondents, 48% reported their primary role to be a practice facilitator, and 13% reported their role to be a behavioral health care worker. Overall, trainees had a positive experience attending Train the Trainer. 89% agreed or strongly agreed that training provided the skills and techniques needed to train practice teams in MAT for OUD. Additionally, 88% of respondents agreed or strongly agreed that they have a better overall understanding of OUD (epidemiology, pharmacology, neurobiology, etc.) than before the training, and 91% agreed or strongly agreed that they had a better understanding of MAT than before. Additional data about training will include confidence scores, reflection of knowledge gained by participants, and reactions to logistics.

CONCLUSION/NEXT STEPS:

IT MATTTRs™ Train the Trainer equips practice facilitators and other educators to confidently and effectively deliver training in MAT for OUD to primary care and behavioral health practice teams, expanding access to local treatment for people suffering from OUD.

OP102: From novice to expert: methods for transferring implementation facilitation skills to improve healthcare delivery

Mona J. Ritchie, PhD, LCSW; Louise E. Parker, PhD; JoAnn E. Kirchner, MD

BACKGROUND/SIGNIFICANCE:
Facilitation is an effective strategy for helping healthcare settings implement evidence-based innovations. However, facilitators need a range of complex skills that have both explicit and tacit dimensions. Although they need training and support to develop these skills, it is likely that didactic methods alone are not sufficient and there is some agreement that the learning process should be experiential. Understanding how such skills can be transferred is critical for ensuring fidelity to facilitation interventions and maximizing potential for successful outcomes. Yet, no studies have investigated the transfer process.

SETTING/METHODS:
This qualitative study examined methods and techniques an external expert facilitator used to transfer implementation facilitation skills to two initially novice internal regional facilitators (IRF), who, over a 30-month period, became experts. The study was part of a larger VA-funded project testing the effectiveness of a blend of external and internal facilitation for helping eight primary care clinics in two VA regions implement evidence-based primary care-mental health integration models mandated by a VA policy initiative. For this study, researchers conducted content analysis of near verbatim notes from monthly debriefing interviews and transcripts of semi-structured qualitative interviews with each of the facilitators at two time points. The analysis was informed by a review of mentoring, coaching and cognitive apprenticeship literature to identify techniques other experts use to transfer complex skills. The study also explored how the expert facilitator tailored her efforts.

RESULTS AVAILABLE OR PLANNED:
The research team identified twenty techniques and processes that the expert used to help initially novice facilitators learn facilitation skills. The methods included both active (providing information, modeling and coaching) and participatory ones. She also used techniques to support learning, i.e., cognitive supports (making thinking visible, using heuristics, sharing experiences); psychosocial supports; strategies to promote self-learning; and structural opportunities for learning. In addition, she used a dynamic process of interacting with internal facilitators and site stakeholders so that over time, they assumed responsibility for facilitating innovation implementation. Finally, the expert varied her level of focus on particular skills across skills and, at times, by IRF, tailoring her efforts to IRF and site characteristics and needs.

CONCLUSION/NEXT STEPS:
Study investigators identified a variety of techniques and processes and created a novel model of the types of methods that can foster the transfer of skills needed for facilitating implementation of evidence-based programs and policy initiatives. The study also supports the need for tailoring the transfer process to individual learners and the organizational context. Study findings can inform processes of planning, implementing and evaluating efforts to transfer facilitation skills, as well as skills needed for other complex implementation strategies, to improve implementation and sustainment of innovations. Finally, by transferring facilitation skills to internal change agents, experts can build capacity for implementing change and improving healthcare delivery.

OP103: Using ethnography to advance (inter)organizational practice, knowledge and skills of family medicine trainees

Peter Nugus, MAHons. MEd, PhD; Maud Mazaniello-Chezol, MA, MSc; Valerie Dory

BACKGROUND/SIGNIFICANCE:

Researchers and policy-makers have increasingly noted that medical students and residents need "humanistic", or so-called "soft" skills, in addition to, and to make the most effective use of, substantive bio-medical knowledge and skills. However, education in such topics as communication, professionalism and advocacy tends to focus on the cognitive processes and moral imperatives of individuals, playing less attention to the interaction of cognitive and social processes in the "real" practice-world. This is despite the fact that 60-80% of clinical adverse events had been found to stem from system, coordination or communication issues, rather than from individual cognition and motivation alone. The aim of this study was to understand the impact of, and barriers to and facilitators of, an immersed, practice-based educational intervention on understanding by medical students of the role of context on medical decision-making.

SETTING/METHODS:

The researchers undertook a mixed-method study, with data collected between 2015-2017. The setting was the intervention of a mandatory ethnography project in the Family Medicine component of second-year undergraduate medical course in a major urban centre in Canada. Instructions in two lectures, three workshops and the project guide directed students to analyze the interaction of contextual factors (e.g. interprofessional relations, technology, organizational cultures across different practice communities, and policies, etc.) with decisions about diagnosis, treatment and transfer, and report their findings in a written assignment and oral presentation. The intention was to enable students to document the "live" contextualized interplay of context and decision-making, collaboratively reflect upon it and produce an analysis of it. Methods included: likert-scale and free-text pre and post-test surveys. Factor analysis yielded two robust factors, on which were compared pre and post responses through repeated measures ANOVA. Qualitative data were derived from free-text survey responses and student assignments, which were content-analyzed.

RESULTS AVAILABLE OR PLANNED:

Results showed a statistically significant increase in understanding the impact of contextual factors on medical decision-making, a slight (non-significant) increase in attitude about organizational skills and knowledge in medical training, and a slight (non-significant) decrease in perception of their skill-level at working collaboratively with those in other occupations. Content analysis showed a pattern of increase in conceptual depth of responses from pre to post phases.

CONCLUSION/NEXT STEPS:

As a post-script to the study itself, many students complained about the perceived irrelevance of the exercise. Nevertheless, the findings of this study showed that an educational intervention, grounded in demonstrating an understanding of the contextualized, practice-world can be effective in imparting organizational, institutional, or contextual understanding about medical work and medical decision-making. This shows the importance of a practice-as-learning (rather than a cognitivist or moralistic) approach to teaching "soft skills". The study raises broader questions about: the balance of "liking versus learning"; and the balance of the legitimacy of various voices who have stakes in medical education, including students, health professionals, social scientists and the patient and citizen communities that medical education is intended to serve.

OP104: Assembling a Set of Practice Facilitation Strategies Through the Lens of Promoting Action on Research Implementation in Health Services Framework

Ann F. Chou, PhD, MPH; Christi Madden, MPA; Margaret Walsh, MPA

BACKGROUND/SIGNIFICANCE:
There is increasing evidence supporting the effectiveness of practice facilitation in helping to build organizational capacity for continuous quality improvement (QI) among primary care practices. Practice facilitators (PF) act as "change agents," who identify and implement individualized solutions through rapid plan-do-study-act QI cycles in these practices. However, factors enhancing PF effectiveness have rarely been collected and assessed in a comprehensively manner. Objectives of this study are to present PF feedback on factors that contributed to their effectiveness in working with practices on a QI project aimed to promote heart health.

SETTING/METHODS:
PFs provided facilitation in 263 practices delivering a QI intervention bundle, including streamlined workflow, information technology assistance, health information exchange connection, and change management, as part of the Healthy Hearts for Oklahoma (H2O) Study. At study completion, a focus group collected feedback, focusing on lessons learned, aspects of the study covering training, recruitment/enrollment, intervention, and maintenance/sustainability from 19 PFs. Thematic analysis was conducted, guided by the Promoting Action on Research Implementation in Health Services (PARIHS) framework, to identify factors within the 3 PARIHS domains describing evidence (codified and non-codified sources of knowledge, including research evidence, clinical experience, patient preferences and experiences, and local information), context (organizational characteristics fostering a conducive environment to translate research into practices), and facilitation (process of enabling implementation of evidence into practice).

RESULTS AVAILABLE OR PLANNED:
PFs indicated disseminating evidence was achieved via step-by-step protocols and academic detailing by clinician champions. Addressing context, PF identified resources (training, database, sufficient tools/materials) and leadership support as contextual characteristics critical to success. Facilitation is supported by creating manuals, using electronic practice records to document progress, and providing feedback to practices. Moreover, PFs noted that flexibility, incentives, and positive attitudes enhanced facilitation efforts.

CONCLUSION/NEXT STEPS:
PFs have proven to be effective in helping primary care practices implement new care processes and QI efforts. Compiling a set of lessons learned contributed to knowledge sharing among PFs and evidence base for facilitation. PFs' feedback on factors related to evidence, context, and facilitation informs the development of strategies to effectively work with primary care practices and facilitate the uptake of QI goals and overall improvement.

OP105: From Coaching Style to Coaching Quality Improvement: Case Study Example
Constance van Eeghen, DrPH, MHSA, MBA; Lee Bryan, MS; Jessica Clifton, PhD

BACKGROUND/SIGNIFICANCE:
Primary care practice redesign benefits from facilitation. External facilitation (i.e. coaching) of internal practice facilitators assists practices by providing expert, nonjudgmental support and guidance on navigating a complex redesign process. In practice, coaches exhibit varied styles to support facilitators but a tool for evaluating coaching style does not exist. We do not know if different styles are associated with different coaching outcomes or the degree to which coaching style is part of a reciprocal system of coaching, in which the person being coached plays a role.

Previous work has described coaching style in terms of both the function of a coach and the approach a coach can choose in supporting an internal practice Quality Improvement (QI) facilitator. A group of coaches, actively engaged in supporting practice QI facilitators, evaluated their coaching styles individually and in paired teams. They found differences in approach among group members and opportunities for improvement, both for personal development and for mutual support as coaching partners. A literature search yielded multiple domains to describe coaching styles within the field of primary care practice redesign. Before embarking on a QI project for performance improvement, they sought to collect feedback from facilitators to collect data about coaching style.

This report provides a work-in-process view of the translation of the definition of coaching style into a coaching QI activity, with the goal of increasing our understanding of what coaching style means and how we can act on it to improve our work. This QI effort includes the development of a feedback assessment of coaching style, collection of data from internal practice facilitators (n=25) about the coaches, analysis of those results, and development of the first cycle of plans for individual coaches in improving coaching style. This report is a continuation of a presentation in December 2018 at ICPF.

SETTING/METHODS:
This project is part of a large, pragmatic, comparative effectiveness trial of a protocolized quality improvement initiative to integrate behavioral health in primary care practices (n = 43) across the U.S. Practices randomized to the intervention arm (n=21) selected an internal facilitator to guide a small group of practice staff and providers through the intervention and engage with an external coaching dyad. Dyads included an expert in practice facilitation and a psychologist with knowledge of health services research. All coaches (n=5) were instructed to use the same coaching model to frame their interactions with practices, while operating within a randomized trial. Coaches held weekly meetings to discuss coaching style and the progress of their internal QI facilitators. Coaches used information from the literature search to create a framework of coaching values and a coaching assessment survey that will be distributed to 25 internal practice facilitators in April/May 2019. Data will be analyzed using descriptive statistics.

RESULTS AVAILABLE OR PLANNED:
Responses to the assessment will be summarized by coach, dyad, and coaching team as a whole about the following improvement opportunities: 1) coaches' application of their values, 2) performance of coaching function, and 3) delivery of coaching approach. Results will support the start of Plan/Do/Study/Act cycles for quality improvement of external coaching. This presentation will share plans for coaching style improvement and invite audience discussion about relevance, generalizability, and innovations seen in coaching quality improvement.

CONCLUSION/NEXT STEPS:
Coaching style is an important characteristic in the effective delivery of coaching services to support internal practice facilitators. Further work in this area will identify how to refine our measurement of coaching style and how to study its effect on QI facilitators.

OP106: TransformLA: A Health Plan Supported Transformation Effort for Directly Contracted Practices
Whitney K. Franz, MPH; Lyndee Knox, PhD;

BACKGROUND/SIGNIFICANCE:
L.A Care Health Plan is developing a network of directly contracted practices and offering practice transformation support through a tailored coaching model, TransformLA. L.A. Care's participation and successes in CMS's Transforming Clinical Practice Initiative (TCPI) as the Los Angeles Practice Transformation Network (LAPTN) has allowed for lessons learned and best-practices to be incorporated in the implementation TransformLA. The concurrent offering of transformation support to small directly contracted practices within the context of a nascent direct network delivery model still in flux is revealing unique challenges that require adaptations to the program's practice facilitation approach to enhance effectiveness and sustainability.

SETTING/METHODS:
L.A Care Health Plan is the largest public health plan in the nation with over 2.2 million members. Serving the Los Angeles County community and safety net, L.A. Care is building a network of directly contracted providers/practices as an alternative to the current Plan Partner and Independent Physician Association (IPA) healthcare delivery structures. Given the shortage of providers who accept Medi-Cal (Medicaid), L.A. Care cannot limit its direct network and TransformLA's focus to only those who are "ready for transformation". The type, size and functional levels of directly contracted practices are variable, but all are expected to deliver high quality care to members and will be measured on their performance. To-date TransformLA has been offered to 25 of the Direct Network's primary care practices with nine practices (caring for approximately 2000 assigned members (0.1% of total membership)) agreeing to engage with a coach and set aims, including identification of at least two priority metrics of focus. L.A. Care uses practice facilitation vendors, like L.A. Net, to source coaches for transformation work. The majority of the program's practice facilitation occurs face-to-face at the practice, focuses on practice-level improvements (ie benefiting all patients (payer-agnostic) that may walk into the practice), and uses a similar practice assessment tool (PAT) and "phased" approach to coaching as the TPCI model.

RESULTS AVAILABLE OR PLANNED:
Viewing a practice on a five level scale with qualifying criteria: (1) survival, (2) emerging functional, (3) basic functional, (4) solid functional, (5) exemplar, most of the TransformLA practices are level 1 or 2 practices. Assumptions of the current TransformLA model are that participating practices have at least basic functional/structural foundations to be ready for improvement work (levels 3-5). Ability to match coaching to practice functional level has been identified as a primary driver of program success and an area that must be enhanced. The TCPI Practice Assessment Tool (PAT) does not have sensitivity to identify the broader range of improvement areas a practice may need who hasn't already achieved basic functionalities. Practice facilitation foundational priority areas include administrative practices, business development, financial management, hiring and human resources, coding/billing, policies and procedures, and basic workflows which are often out of scope for the current "generalist" coaching support. Specific to EHR optimization support, the majority of coaching is related to basic training on EHR workflows, reporting, and decreasing reliance on paper. The TransformLA program is working to adapt and match its coaching approach and content to these lower level practices despite limited resources available for coaching a "survival" level practice.

CONCLUSION/NEXT STEPS:
With plans to expand the reach of TransformLA program as the Direct network (DN) develops and grows, L.A. Care Health Plan is working with stakeholders on refinement of the program design and coaching support to ensure participating practices' (and patients') needs are met and that their coaching support experience is positive and effective. Recommendations for improvement include:
- Adding a "readiness for improvement work" assessment (adapt the current TCPI based PAT) to more accurately identify and stratify level 1-5 type practices and then better tailor practice support and resources
- Providing more coaching resources to support level 1-2 practice needs
  - Additional training for "generalist" coaches (above basic skill set that includes workflow redesign, exemplar practice on QI metrics, executive coaching, resource brokering)
  - Development of a coaching "team" composed of both "generalist" coaches and coaches with specialized expertise that can support "survival" practices in foundational needs (admin/back office, coding/billing, business development, EHR implementation/ enhancement, data extraction/analytics)
- Adding an "ombudsman" function that would liaison from the field-based TransformLA coaching team back to L.A. Care Health Plan to elevate issues for resolution in an efficient way and allow for a feedback loop for facilitating ongoing program improvement as well as provider relations

OP107: Mi-PARIHS: The process to develop practical tools to make framework-informed implementation and facilitation easier
Sarah Hunter, PhD; Bo Kim, MD, PhD; Alison Kitson, RN, PhD

BACKGROUND/SIGNIFICANCE:
Practice facilitation is a nuanced and complex approach to implementing innovations into health care settings. One way in which the profession of practice facilitation can be supported and improved is through drawing on insights from implementation science. Implementation science is an academic field which seeks to develop and refine various approaches and frameworks to inform systematic implementation of innovations into healthcare systems. These frameworks support implementation efforts by providing information on how to plan, guide and evaluate successful implementation of clinical evidence into practice.
One such framework is the integrated - Promoting Action on Research Implementation in
Health Services (i-PARIHS) which conceptualises how innovations can be successfully implemented into health practices using the process of facilitation. This framework aligns with practice facilitation in that it is philosophically multidimensional, acknowledging complexity and the contingent impact of context.
Unfortunately, the existence of implementation frameworks alone does not provide explicit guidance or practical support for facilitators and therefore tools and resources are required in order to assist facilitators in operationalising the framework in practice.

SETTING/METHODS:
The studies reported on in this presentation are part of a program of research titled "Mi-PARIHS: Mobilising Implementation of i-PARIHS". This program of work focuses on adapting the i-PARIHS framework into a suite of tools (called the Mi-PARIHS toolkit) that can be utilised by researchers, practitioners/clinicians and facilitators to assist in planning, guiding and evaluating the successful implementation of evidence-based innovations into practice. The overall purpose of this set of tools is to help make implementation easier, more consistent, and successful, cost efficient, sustainable and scalable.
Specifically, this presentation will draw on two studies 1) a collaborative case study on how various complex, multi-site implementation projects within Australia and the US have operationalised the i-PARIHS framework and 2) a small-scale pragmatic study conducted around an interactive workshop at the 2018 International Conference on Practice Facilitation focusing on how helpful and useful an adapted version of the i-PARIHS facilitation checklist is to practice facilitators and those working in primary care settings.

RESULTS AVAILABLE OR PLANNED:
The case study analysis sheds light on several key similarities and differences in how the project teams operationalised and used the framework. Specifically, this study illustrates the ways the framework can be used when implementing different types of innovations, in different contexts and with various recipients. Not only is this illustration useful for future users of the framework, but also provides us as the framework developers, useful insight into the standardised and flexible approaches to using the framework. Therefore, this study provides insight on what tools and resources might be useful in an i-PARIHS toolkit.
The results from the small-scale study conducted at the previous International Conference on Practice Facilitation indicate that practice facilitators are highly engaged and enthusiastic about the i-PARIHS framework and the development of practical tools. The participants identified the adapted version of the i-PARIHS facilitation checklist as a useful tool to work through planning, monitoring and evaluating implementation and facilitation efforts, and also suggested specific ways in which the tool can be made more useful. Thus, this study provided tangible direction on what we need to develop and refine and how we best go about it. The results from this study will be particularly interesting to this year's conference attendees who participated in the 2018 workshop as it will provide them with the opportunity to see how their involvement in the research has contributed to the Mi-PARIHS program of work.

CONCLUSION/NEXT STEPS:
Taken together, these two studies provide important background and motivation on the need for i-PARIHS tools and resources to be developed. The insight gained from this work will inform the next stages of development. Both studies identified the importance of pre-facilitation assessment and so the initial tool to be developed will focus largely on this. Further, the feedback on the adapted i-PARIHS facilitation checklist has identified it as a useful assessment tool, however further work is required around identifying the key questions and translating the checklist from academic language into more practical language. Therefore, this piece of work will serve as the next step in the Mi-PARIHS toolkit development.

OP108: From novice to expert: a qualitative study of implementation facilitation skills
Mona J. Ritchie, PhD, LCSW; Louise E. Parker, PhD; JoAnn E. Kirchner, MD

BACKGROUND/SIGNIFICANCE:
Implementation Facilitation, a multi-faceted strategy that incorporates other implementation interventions, is widely utilized to support evidence-based program and practice implementation. This strategy is particularly useful for healthcare systems that lack quality improvement knowledge and resources. Scholars agree that facilitators need a wide variety of skills to help clinical settings implement and adapt innovations. Although a number of studies have identified activities facilitators perform, only a few studies have attempted to retrospectively identify the skills facilitators need.

SETTING/METHODS:
This qualitative study was part of a larger VA-funded project in which an expert external facilitator (EF) and two internal regional facilitators (IRFs) successfully supported implementation of evidence-based primary care-mental health integration models mandated by a VA policy initiative. The larger project examined the effectiveness of the facilitation strategy applied at 8 primary care clinics in 2 VA regions. This study examined the facilitation skills the EF transferred to the initially novice IRFs over a 30-month period during which the novices became experts. Researchers for this study conducted content analysis of near verbatim notes from monthly debriefing interviews and transcripts of semi-structured qualitative interviews with each of the facilitators at two time points. The study used inductive and deductive methods to identify and operationalize skills the EF transferred to IRFs and examine the complexity of those skills.

RESULTS AVAILABLE OR PLANNED:
Concordant with previous research, the research team found that implementation facilitators need a wide variety of skills. Specifically, they identified twenty-two skills, including communication skills and five overarching skillsets: (a) building relationships and creating a supportive environment, (b) changing the system of care and the structure and processes that support it, (c) transferring knowledge and skills and creating infrastructure support for ongoing learning, (d) planning and leading change efforts, and (e) assessing people, processes and outcomes and creating infrastructure for program monitoring. They also found that implementation facilitation skills were very complex. Each skill included multiple tasks and behaviors and many of these tasks and behaviors were not unique or distinct to a specific skill but rather were components of multiple skills.

CONCLUSION/NEXT STEPS:
This study extends knowledge of implementation facilitation by identifying skills an expert facilitator transferred, describing their complexity, and providing descriptions of how these skills were operationalized. Because there is a broad range of potential facilitator roles based on the purpose of facilitation and the organizational context, skills facilitators need likely vary. It may be that there are core components of facilitation that would improve implementation of many innovations in most settings. Understanding what these are and the related core set of skills facilitators need to apply those components could allow us to more efficiently train facilitators and plan for implementation efforts. Additionally, it is unlikely that experts can transfer highly complex skills to novices using only didactic methods. Understanding how novices learn such skills is critical for ensuring fidelity to facilitation interventions and maximizing potential for successful outcomes. Understanding the complex nature of facilitation skills can inform both efforts to transfer skills and healthcare system leaders' efforts to build implementation facilitation capacity.

OP109: Collecting Quality Measures: Substance Use, Opioid Use, and Alcohol Use. How are practices tracking this data?

Kyle Knierim, MD; Andrew BIenstok, MHA; Emma Anderson, MA

BACKGROUND/SIGNIFICANCE:
Inappropriate use of opioids, alcohol and other substances is a major public health concern. Practice facilitators (PFs) are increasingly being asked to help practices implement new workflows to improve care for patients with, or at risk for, a substance use disorder. As with all other quality improvement efforts, access to reliable data is essential to track progress and evaluate results of these initiatives. The pilot effort seeks to 1) better understand the availability and use of key clinical data sources related to opioids, alcohol, and other substances in primary care practices, and 2) identify areas that practice facilitators (PFs) and Clinical Health Information Technology Advisers (CHITAs) can support practices in addressing these important clinical topics.

SETTING/METHODS:
Setting: Up to 45 primary care practices in Colorado participating in the Implementing Technology and Medication Assisted Team Training and Treatment in Rural Colorado (IT MATTTRs2). Instrument: Locally developed Health Information Technology (HIT) Assessment survey administered by IT MATTTRs2 team members. Survey items explore a practice's capture of discrete data elements, use of the prescription drug monitoring program, use of registries for population management, and ability to produce and trust clinical quality measures related to opioids, alcohol, and other substances.

RESULTS AVAILABLE OR PLANNED:
Aggregate results of the HIT assessment will be shared for each individual measure with descriptive statistics showing frequencies and distributions. Qualitative themes from interview prompts will be summarized to highlight common barriers and any best practices.

CONCLUSION/NEXT STEPS:
We anticipate survey results providing a clearer understanding of how Colorado practices access and use data for their QI efforts around use of opioids, alcohol, and other substances. Themes of common barriers and potential solutions will be shared to improve support offered by future PF and CHITA programs.

OP110: Development of UTOPIAN: Practice-Based Research at DFCM
Ivanka Pribramska, PhD, CPMA, (IPMA); Ivanka Pribramska, PhD, CPMA, (IPMA); Aashka Bhatt, BSc, MSc Candidate

BACKGROUND/SIGNIFICANCE:
Practice-Based Research Networks (PBRN) engage clinicians in research, quality improvement and an evidence-based culture to improve health.
UTOPIAN is the University of Toronto Practice-Based Research Network that brings together:
Department of Family and Community Medicine (DFCM) faculty members, statisticians, and scientists
Researchers (including industry)
Primary care clinicians and practices
PBRNs from across the globe
Industry leaders
We answer important healthcare questions and translate findings into practice.
The mission of UTOPIAN is "to improve the health of our patients and communities by collaboratively addressing primary healthcare questions and translating research findings into practice."

SETTING/METHODS:
The transition to Electronic Medical Records (EMRs) has led to the realization that electronic health data collected as part of routine primary care practice could be used for disease surveillance, research and quality improvement activities. If collated, EMR data across many practices has the potential to be the single largest, richest and most consistently recorded source of clinical data at the individual patient level anywhere. The UTOPIAN Data Safe Haven (DSH) aims to achieve just that. The DSH extracts de-identified EMR data to create an aggregated health data repository.

RESULTS AVAILABLE OR PLANNED:
Many family physicians are keen to participate in research but find it difficult to make time to undertake research activities, meet study targets and keep their practice staff engaged. UTOPIAN currently has two Practice Coordinators (PC) available to enable busy clinicians to successfully incorporate research into their practices. The UTOPIAN team, including the PCs, engage academic and community practices in this project. There are currently over 400 family physicians (DFCM and others) contributing their data - this amount to over 500,000 de-identified patient records.UTOPIAN contributes to additional datasets for longitudinal disease surveillance and to further increase research capacity across Canada. These datasets include the Canadian Primary Care Sentinel Surveillance Network (CPCSSN), Institute for Clinical and Evaluative Sciences (ICES), and Diabetes Action Canada (DAC).

CONCLUSION/NEXT STEPS:
Since 2014, UTOPIAN has supported more than 40 research projects lead by DFCM faculty and taking place across all teaching sites. Targeted project support together with other capacity building activities enable DFCM faculty to actively engage in primary care research.

OP111: Practice Transformation Analytics Dashboard for Clinician Engagement
Niharika Khanna, MD, MBBS, DGO; Michael Dark, MPH, MA; Elena Klyushnenkova, PhD, MSPH

BACKGROUND/SIGNIFICANCE:
The Transforming Clinical Practice Initiative (TCPI) at the Centers for Medicare and Medicaid Services (CMS) funded the Garden Practice Transformation Network in Maryland (GPTN-MD) to engage practitioners in practice transformation. Practice transformation is a movement towards data driven care redesign, patient-centered care delivery and practitioner activation. To achieve practice transformation, there is a critical need for practice engagement tools as clinicians and their staff are inundated with data about quality and cost of care for their patients.

SETTING/METHODS:
48 practices with 109 practice sites participating in the GPTN-MD. This included 21 primary care practices with a total of 30 sites, 23 specialty practices with 54 sites and 4 Federally Qualified Health Centers with 25 practice sites. These practices employed 839 primary and specialty care practitioners and their staff. Data on dashboards represented 12,100 Medicare fee-for-service beneficiaries. Data on cost were derived from the Quality and Resource Use Reports provided by the CMS. Key performance indicators (KPI) and other TCPI measures collected by practices themselves or by practice transformation coaches were provided by the GPTN-MD. Based on these data, the GPTN-Maryland team created a Practice Transformation Analytics Dashboard as a tool to present data in a simple and concise manner. The dashboards were provided to practices for review at one of their monthly site visits.

RESULTS AVAILABLE OR PLANNED:
Practices were often seeing cost data on their patients for the first time when they reviewed CMS-provided data. Quarterly changes in the KPIs and other TCPI metrics helped the practices to better understand their performance during each transformation phase compared to the baseline. 72% of practices found the dashboard engaging and 48% found the data actionable. More primary care practices found their data actionable than specialty care practices. Practice transformation coaches reported finding it easier to relay the data at hand when using the dashboard tool.

CONCLUSION/NEXT STEPS:
The Practice Transformation Analytics Dashboard serves to intrigue practices to move forward in practice transformation and improvement of patient care delivery. This tool engaged practices in discussions about data, care redesign, costs of care and how to develop sustainable change within their practices. Future research is needed to study the impact on patient care delivery, costs, quality and experience of such practice tools.

https://s3.amazonaws.com/files.formstack.com/uploads/3311007/72832169/489748081/72832169_example_of_practice_transformation_analytics_dashboard.jpg

OP112: The "Drivers" of Change: Tracking practice facilitation in rural Alabama and North Carolina
Shannon Peaden, MBA, CPF; Jennifer Rees, RN CRN CPF; Alyssa Adams, MPH

BACKGROUND/SIGNIFICANCE:
In an effort to better understand the time invested in QI activities and their implementation into practice work flows, four practice facilitators (PFs) who coach primary care practices in the Southeastern Collaboration (SEC) to Improve Blood Pressure study document the time they spend working with their assigned practices in 5 distinct time categories and capture this data on a monthly basis. These 5 quality improvement (QI) activities, documented in minutes spent per month, include time spent 1) working face to face or onsite work with practice staff, 2) emailing, 3) talking on the phone, 4) driving to practices, and 5) communicating via video conferencing. The PF's focus their time with practices on understanding and implementing key QI activities deemed most important to building practice level capacity to implement/sustain QI activities and enhance outcomes. The key activities fit within an implementation framework of Key Driver domains that include the use of data to drive change, optimizing teamwork processes, using of standard care processes/protocols, and engaging patients in self management support. Understanding the workforce needs to support practice facilitation is a critical aspect of building and maintaining practice facilitation services in Rural primary care. In this analysis we share the time in minutes spent by 4 facilitators tasked with guiding practices in AL and NC to implement key driver activities in the context of at enhancing care for Adult African American patients with uncontrolled HTN.

SETTING/METHODS:
Each month facilitators document the total time in minutes spent with each practice by time category into the study's data management system (Clinvestigator). In this analysis we will share descriptive statistics of the time spent in the 5 time categories for 8 practices that have completed the full 12 month facilitation intervention as of Jan 31, 2019. We detail means, standard deviations, and ranges for total time spent on all 5 categories and time spent on individual activities.

RESULTS AVAILABLE OR PLANNED:
Among the 8 practices that have completed the intervention with the assistance of 3 of our facilitators by 1/31/19, the mean total time spent per month per practice doing on site QI work with staff was 1.6 hours (SD 0.7) while the mean drive time per month per practice was 2.2 hours (SD 0.8). Forty-three - 45% of the PF time was spent traveling to and from practices, while 28-36% of the time was spent on site with practices. For the June 2019 ICPF meeting, we anticipate having complete data on 19 of our 40 practices, thus will share descriptive statistics of time spent on each time tracker category per month and over the duration of the facilitation intervention. We will be able to compare this data by state, university site, and practice facilitator as well as other interesting findings that emerge from our data. (see graph below)

CONCLUSION/NEXT STEPS:
Our data suggests that the vast majority of time invested by facilitators when assisting primary care practices in QI is in drive time, followed by face-to-face time in practices. Wide ranges in drive time likely reflect the variation in distances required to drive to individual sites. This information can be helpful for project planning. Additionally, it calls for further research on the efficacy of coaching assistance that is provided virtually. The use of virtual conferencing platforms would allow a coach to assist more practices while reducing associated travel costs.

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OP113: "A Tale of Two Settings - Improving Health Outcomes in Rural and Urban Areas"
Virginia Brooks, MHA, CPHQ

BACKGROUND/SIGNIFICANCE:
Overcoming chronic health issues to improve outcomes in any setting is challenging. Health Quality Innovators (HQI) helped providers work with existing resources within their communities to better the health of patients, thrive as a business, and improve on CMS clinical measures. HQI will discuss the success of two providers (one rural, one urban) in Virginia. Both established partnerships in their communities that improved the health of their patients and kept their businesses viable while improving CMS clinical measures.

SETTING/METHODS:
Rural setting: HQI helped a practice in southern Virginia improve its chronic care rates by combining the resources of the practice with a local pharmacy. Emporia Medical Associates and A&B Pharmacy worked together to serve a community disproportionately affected by chronic disease. Their roles included:

Practice Role:
1.   Recruits eligible patients
2.   Collaborates with pharmacists to create a plan
3.   Submits Medicare claims
4.   Reimburses pharmacy for CCM services
5.   Follows up with pharmacist
Pharmacy Role:
1.   Meets monthly with patients
2.   Implements care plan
3.   Coaches patients and reviews medicine
4.   Coordinates with practice

Urban setting: Primary Care Specialists in Norfolk, along with its co-located, affiliated non-profit Healthy Living Center, helped its culturally diverse community prevent and manage chronic health issues like diabetes and obesity. Primary Care Specialists' clinicians use patient engagement and progressive cultural competency to improve patient health. Medical care, education and coaching teach sustainable healthy lifestyle management. Tactics include:
1.   On-location community garden, which shows how healthy living can be affordable, sustainable and enjoyable.
2.   Hosting health fairs on location, which include free health screenings and cooking demonstrations.
3.   Participating in HQI's "My Weight, My Way" project to implement intensive behavioral therapy for reducing obesity.
4.   Hosting a "Silver Sneakers" chair exercise training for patients 65 and older.

RESULTS AVAILABLE OR PLANNED:
Rural setting: Prior to HQI engagement in 2017, Emporia ranked last in Virginia for health outcomes. After implementing the CCM program, the practice improved these related quality measures: increased clinical medication reconciliation by 8%; implemented CCM; and increased tobacco cessation by 11%.

Urban setting: Primary Care Specialists became one of only four "Fully Recognized" diabetes prevention programs in Virginia by the CDC. The provider increased patient and family engagement in the community, and improved patient management of diabetes and obesity. Run charts detailing results are in supplemental documentation.

CONCLUSION/NEXT STEPS:
Rural setting: Emporia Medical Associates and A&B Pharmacy improved medication adherence, patient self-monitoring skills, gained new customers and filled an unmet need in the community. All clinicians will be able to refer patients for participation. Urban setting: Primary Care Specialists will continue engaging with its culturally diverse patient base to keep reducing the rate of diabetes and obesity.

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OP114: Designing for Improvement: Enabling Primary Care Teams to Improve Care for Elderly Patients Living with Polypharmacy

Patricia O'Brien RN, MScCH; Christina Southey MSc;

BACKGROUND/SIGNIFICANCE:

Designing a large-scale quality improvement (QI) initiative requires attention to the development of practices and resources that are capable of supporting diverse community-based primary care teams to collaborate toward achieving 'better'. Focused on a research and quality improvement collaboration to improve care for elderly patients living with polypharmacy, the initiative design for SPIDER (a research and QI collaboration supporting practices improving care for complex elderly patients), was influenced by patient advisors, primary care teams, and QI specialists. Acknowledging the national scale of the QI initiative, the variation in context, readiness, and improvement capacity of each participating team was also considered in the design. The varied roles of the QI coach served as an enabler for the initiative, both in the application of QI methods but also importantly as a networking and sharing link between participating teams.

SETTING/METHODS:

Enabling community-based primary care teams to improve healthcare outcomes for elderly patients living with polypharmacy requires attention to patient engagement, team composition, availability of patient-level data related to prescribing patterns, and exposure to improvement science. Designed as a learning collaborative, SPIDER incorporates project elements shown to increase success of local improvement and support diverse teams such as group leaning, consistent communication and feedback loops. The development of a common QI pathway based on the Model for Improvement enables teams to focus on a sequence of work with QI coach support that is contextually appropriate to them. The QI pathway also serves as a key mechanism for building capacity for improvement for teams new to QI. By pre-populating common system diagnostic tools such as process map and cause and effect diagram, and by linking those tools to the plethora of evidence-based patient and professional resources for deprescribing, teams are able to efficiently use their prescribing data to engage patients and effect improvement.

RESULTS AVAILABLE OR PLANNED:

SPIDER launched in September 2018 at the Department of Family and Community Medicine, University of Toronto as a feasibility site ahead of a broader, staged national research project. The engagement of the participating teams has been encouraging to date. Accessing the QI coach has been consistent and varied in intensity across the 12 teams; application of QI methods, including system diagnostic tools that describe the nuance of respective practices and communities has been observed; the collaboration between teams, encouraged by the coach and enabled by the learning collaborative design, has resulted in cross-community learning.

The nature of these teams being first in a series of cohorts has necessitated some flexibility in design and support to respond, in real time, to needs of participating teams. The lessons learned from this first cohort will be used to assist future cohorts to move forward more quickly and anticipate the realities of this type of improvement work.

CONCLUSION/NEXT STEPS:

The challenge in any QI initiative design is engaging diverse primary care teams across a community and country who come together to improve. The design of SPIDER as a QI initiative has demonstrated that despite variation in team composition, experience with improvement, and comfort level with data, the availability of coaching and provision of resources is impactful in achieving 'better' and that the initiative design matters.

OP115: "Coach Be Nimble, Coach Be Quick": Improving, Sustaining, and Spreading a Facilitated QI Program for Medication Reconciliation

Emily Bullard, MPH; Dane Hansen, MHA; Lyndee M. Knox, PhD

BACKGROUND/SIGNIFICANCE:
Permanent practice facilitation infrastructure increases the ability of large (and small organizations) to rapidly respond to QI challenges. Medication Reconciliation is a pillar of patient safety and waste elimination in care delivery and an important quality metric for public health systems. However some clinicians object to performing this task due to concerns about addressing medications prescribed by other clinicians, or due to lack of time, so EHR alerts and traditional methods of education are often not enough to change practitioner behavior. More is needed. Practice facilitation can provide critical additional support needed to change this behavior through identifying barriers to process and behavior change, crafting "key messages" to address provider objections and delivering performance feedback and training via academic detailing sessions and traditional presentations.

SETTING/METHODS:
Thirteen LA Net PBRN Practice Coaches working with Los Angeles County DHS Health Centers and Hospitals as part of the CMS funded TCPI initiative, conducted fall-out analyses, identified facilitators and barriers to conducting medication reconciliation, helped craft key messaging, and delivered group training and academic detailing with audit and feedback to aid in care team adoption of enhanced medication reconciliation processes. Based on the initial success of the coaching intervention in improving Med Rec rates in Primary Care, at the request of a specialty care director, DHS then expanded the coaching intervention to select specialty care settings. Because specialty care clinicians and leadership had less recent experience with formal QI processes and no experience working with practice facilitators, additional methods were added for these settings including QI readiness assessments, leadership development and support, and development of practice capacity to work with a practice facilitator/coach.

RESULTS AVAILABLE OR PLANNED:
Medication Reconciliation rates in Primary Care practices increased from 39%, to 69% in the first two months of intervention, which have been maintained at 76% for 10 months. Medication reconciliation rates in select specialty care clinics have improved from 59% to 66% over the first 6 weeks of intervention. Coaching work with specialty care will continue into the Spring and methods and outcomes are expected to mirror the work with Primary Care.

CONCLUSION/NEXT STEPS:
With a coaching program in place that is capable of evolving to meet the needs of new clinical areas, gains continue to be made across Primary and Specialty Care. With the expansion of the program to Specialty Care at the DHS Medical Centers, we expect to see similar improvements to medication reconciliation documentation that were seen in primary care clinics and over time ultimately reach the goal of medication reconciliation with every patient at every visit.

OP116: Expanding the reach of practice facilitation: Lessons learned from inter-organizational collaboration

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BACKGROUND/SIGNIFICANCE:
In 2018, The Rhode Island Department of Health's (RIDOH) Diabetes, Heart Disease and Stroke Prevention Program (RIDHDSP) received two federal grants to help prevent and manage diabetes and cardiovascular disease (CVD) in communities disproportionately affected by high blood pressure, high cholesterol, diabetes, or prediabetes due to socioeconomic factors and inadequate access to high quality care.

Through the Care+Community+Equity (CCE) initiative, RIDHDSP contracts with Federally Qualified Health Centers (FQHCs) and free clinics over a 5-year period to improve health outcomes and quality of care for people with or at risk for diabetes and/or CVD.

To support the implementation of CCE, RIDHDSP has contracted with the Care Transformation Collaborative of Rhode Island (CTC-RI), which includes a sub-contract with the Brown Primary Care Transformation Initiative (BPCTI), to provide facilitation services to all practices enrolled in CCE. CTC-RI will also provide technical assistance with a portal for data entry, storage and visual representations of the information.

This presentation will discuss the collaboration between the three organizations (RIDOH, CTC and BPCTI), the advantages of the collaboration to the organizations and to the participating practices, and the roles each group plays in practice facilitation. This presentation addresses the following objectives:

1) Participants will learn the benefits of collaboration between a state health department, a multi-payer transformation organization, and a hospital and university-sponsored practice facilitation program.
2) Participants will understand the role each organization plays in helping practices carry out the work involved in prevention and management of chronic disease.
3) Participants will be able to identify barriers and benefits to initiating a large scale, health center-based facilitation project and recognize solutions for engaging primary care sites in quality improvement and a shared data management platform.

SETTING/METHODS:
The planning process for CCE took place over a nine-month period. Meetings were organized by the RIDOH, with input from all three contributing organizations. When CCE is implemented, practice facilitators will meet regularly with all participating sites to assess their current status, help them develop and monitor quality improvement projects that relate to the grants' goals and insure the on-time meeting of required elements of the program.

RESULTS AVAILABLE OR PLANNED:
It is anticipated that the innovative collaboration between RIDOH, CTC-RI, and BPCTI will provide a meaningful, value-added experience for the CCE practices and their patients. The collaboration will enhance health outcomes and decrease some of the challenges that have existed in previous funding cycles, including little alignment of processes and a lack of clearly defined measures, objectives, and timelines for completion. This collaboration will also provide greater efficiencies and a more robust, cost effective data management system to capture and display performance improvement results.

CONCLUSION/NEXT STEPS:
The model presented here includes a unique collaboration between community organizations in Rhode Island to facilitate the implementation of chronic disease management and prevention within the setting of community health.