

IMPROVING IMPROVEMENT

TRAINING TO SUPPORT PRIMARY CARE TRANSFORMATION

A PILOT STUDY

BACKGROUND

Our earlier work,^{1,2} looking at Alberta's challenge of widespread adoption of the Patient's Medical Home (PMH), recognized the need for clinic teams to shift how they think about and do their work, addressing the distinct needs of the early majority, applying a mass customization approach, and investing in a practice facilitation (PF) workforce equipped to support these actions³. Building on these findings we wanted to explore whether we could train Practice Facilitators (PFs) in an adapted form of Cognitive Task Analysis⁴ (CTA) and Diffusion of Innovations⁵ (DOI) to support clinic teams with their PMH transformational journeys. These skillsets would complement PFs' existing quality improvement (QI) and facilitation skills, but also:

- allow them to consider mental models and team functioning, providing insights into how to help teams improve their functioning and think differently about the way they think about and do their work - CTA
- enable them to use evidence along with their own experience to tailor how they engage and support clinics - DOI

Hence, the Improving Improvement Pilot Study was formed. This summary highlights our co-design approach, key findings, lessons learned and where we plan to go next.

OBJECTIVE



To determine how best to transfer skills and knowledge from the DOI framework and an adapted form of CTA to PFs for practical application with clinic teams.

PARTICIPANTS



PRIMARY
CARE
NETWORKS
(PCNS)

i22
PARTICIPANTS

Practice Facilitators | Clinic Directors | Managers (Evaluation, Primary Care) |
Consultants (Communication, Education, EMR)

STUDY DESIGN

Initial planning meetings were held with each PCN to gain insight into how they organized themselves to support member clinics, what they wanted to learn, logistics, and who would participate. A modified co-design approach was used – i.e., the training delivery team brought the concepts and source material to the participants and then worked with them to co-create the learning experience. Evaluation results and feedback were included in ongoing co-design conversations in order to adapt training delivery to the needs of each PCN and its participants. During the conversations the training delivery team also learned from the participants about how the concepts and materials could be applied within their organizations.

METHODS

We used mixed methods to collect and analyse our data, working with the PFs and PCNs to assess how best to transfer the DOI and adapted CTA skills. Informal data journals, semi-structured interviews, and pre and post evaluations were used to assess participants' confidence in applying the skills and knowledge. Participant feedback was also collected after each training session to inform design and delivery aspects of future sessions.



KEY FINDINGS



UNDERSTANDING MENTAL MODELS OF QI IS KEY

How the PCN (i.e. Leadership) organizes QI and how it perceives and uses the PF role played a significant role in the effective delivery of the training. While initial exploratory work was done to understand a PCN's context, e.g. organizational structures and people's roles, it was evident we needed a deeper understanding which included:

- The PCN's vision and goals and how it considers its role in the primary care context
- Its approach to QI and the PF role
- How the PCN support their members (e.g. equal support or a tailored approach for each to meet needs and where they are at in their PMH journeys)

Further, we needed to explore a PCN's approach to QI and the PF role from the PF's perspective:

- Who PFs work with (e.g. PCN team members, clinic team members)
- What those interactions looked like (e.g. typical workflow, main point person for clinics or brought in for specific QI related work)
- How they distinguished their role from their team members and where they saw overlap
- What knowledge and skills they used to support clinic teams

TRAINING MUST BE PRACTICAL AND FLEXIBLE

All participants asked for practical application in the training. They suggested activities applicable to their everyday workflow (e.g. time limited interactions with clinic teams) and stepwise tools to guide application of the concepts and skills once learned. Interestingly, participants varied in how and the degree to which they wanted to work with materials and concepts.

This variability was a function of:

- **Role within their organization:** How participants were organized as a team to support clinics with QI (i.e., roles and workflow) impacted how they saw themselves applying the skillsets, hence how much they wanted to delve in.
- **Lived work experience:** Participants' interactions and experience supporting clinic teams greatly influenced their openness and ability to adopt a new way of thinking about or applying the new skillsets to challenges they had previously experienced.
- **Learning style:** Participants' desire to interact with and process the content varied along a continuum. While some of the participants absorbed the abstract concepts of mental models and team functioning (e.g., theories and terminology), others preferred that the concepts be presented in more "ready to use" terms (e.g., tools they could rely on to apply the concepts in their own contexts).

THE SAME WORK, DONE DIFFERENTLY

Insights gained into differing organizational structures, QI approaches, and roles within PCNs led us to realize the potential broader application of our program in the future. An opportunity may exist to encourage PCNs to think differently about their approaches to QI (i.e., to shift their mental models). For instance, some participants recognized that identifying where different providers/clinics fit on the diffusion curve could be used by their PCN to stratify their QI support efforts based on likelihood of uptake of a new way of working. We also saw some indications of how the concepts learned led to re-thinking about how various team roles were utilized and how team members interacted with clinic teams.

SO WHAT?

This pilot study informs us that transferring knowledge and skills from the DOI framework and CTA demonstrates potential and requires further refinement and study. We have discovered that:

- A practical and flexible approach is required
- Training needs to be offered in a way that engages participants on their terms
- A PCN's mental model influences the translation and execution of new knowledge and skill
- Time must be invested upfront to understand each PCN's mental model of QI and the utilization of the PF role
- An understanding of the PF role from the PF perspective is required
- Training may equally be a PCN team or a clinic team intervention
- PCNs may use training as an opportunity to reflect on their own approaches and perceptions of QI, while creating effective supports to apply with clinic teams

NEXT STEPS

Further co-development and testing of the training will occur with other PCNs until we believe we have a sustainable model that can be used moving forward. We will incorporate the following learnings:

- Invest time up front to understand the PCN Leadership's mental model of QI and the PF role
- Take time to understand a day in the life from the PF's perspective
- Continue to use a co-design approach
- Be flexible to participants' needs and learning styles
- Make the content practical
- Look for opportunities to demonstrate to PCNs how they can apply the concepts as an organization

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DEFINITIONS

PATIENT'S MEDICAL HOME

Alberta's vision for Primary Health Care. A proven means to improve patient access and outcomes, and to slow the rise of health care expenditures.

MASS CUSTOMIZATION

Referred to as "built to order." Enables manufacturers to meet customers' exact needs from a set pool of components.

COGNITIVE TASK ANALYSIS

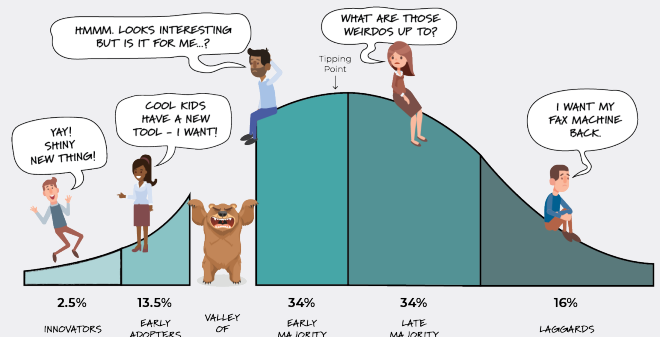
Set of qualitative tools used to elicit mental models; valuable to represent how people think when working in cognitively complex environments.

MENTAL MODELS

The lens through which we make sense of what's happening around us. More than our beliefs and values and dynamic in nature. Determines what we pay attention to, options and possibilities we consider, how we solve problems, make decisions, and act.

DIFFUSION OF INNOVATIONS

Long-standing body of literature across many industries including healthcare that explains how, why and at what rate an innovation spreads.



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EARLY MAJORITY

34% of the population for a given innovation. The key to widespread adoption. Think about and approach the work of change differently than Innovators and Early Adopters.

CO-DESIGN

The act of creating with stakeholders, specifically within the design development process, to ensure the results meet their needs and are usable. The benefits of a co-design approach include improved knowledge of stakeholder needs, higher quality and validation of ideas, increased satisfaction and support for the innovation, and better relationships between all involved.⁶

REFERENCES

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