Practice Facilitation in Integrated Behavioral Health and Primary Care Settings: a Scoping Review

Elizabeth Siantz, PhD, MSW
Brian Redline, BA
Benjamin Henwood, PhD, MSW

Abstract

Little is known about the contributions of practice facilitators in settings aiming to deliver integrated behavioral health and primary care. This scoping review identifies peer-reviewed articles that describe efforts to deliver integrated behavioral health care with the support of practice facilitators. Five databases were systematically searched to identify empirical and conceptual papers. Fourteen articles met the following inclusion criteria: (1) empirical studies evaluating the effectiveness of practice facilitation (n = 4), (2) study protocols that will test the effectiveness of practice facilitation (n = 2), (3) studies that included practice facilitators as part of a larger intervention without evaluating their effectiveness (n = 5), and (4) conceptual manuscripts endorsing practice facilitation for integrated care (n = 3). Practice facilitators can potentially support health systems in delivering integrated behavioral health care, but future research is needed to understand their necessary qualifications, the effectiveness of practice facilitation these efforts, and what study outcomes are appropriate for evaluating whether practice facilitation has been effective.

Introduction

Persons living with mental illness receive less and lower-quality medical care[1,2] and continue to be at elevated risk for early mortality from chronic diseases.[3] Persons with chronic disease are at elevated risk for depression and other mental health conditions[4] and experience high rates of

Address correspondence to Elizabeth Siantz, PhD, MSW, Department of Family Medicine and Public Health, University of California, San Diego, 9500 Gilman Drive #0622, La Jolla, CA 92093-0901, USA.

Elizabeth Siantz, PhD, MSW, College of Social Work, University of Utah, Salt Lake City, UT, USA.

Brian Redline, BA, Suzanne Dworak-Peck School of Social Work, University of Southern California, Los Angeles, CA, USA.

Benjamin Henwood, PhD, MSW, Suzanne Dworak-Peck School of Social Work, University of Southern California, Los Angeles, CA, USA.

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behavioral health comorbidities.[5] Meeting the health care needs of these populations by delivering integrated behavioral, mental, and primary health care has become a national priority.[6] However, implementation of integrated behavioral care requires collaboration between mental, physical, and behavioral health practitioners, along with leadership from health departments and health plans.[6] Communication difficulties between fragmented systems of care, a lack of experience needed to identify and initiate quality improvement activities, and other challenges also continue to undermine the process of sustaining such efforts.[7]

To facilitate quality improvement, the primary care workforce has deployed practice facilitators,[8,9] who are skilled individuals who work with clinical practices and service delivery systems to make changes designed to improve patient outcomes. These individuals support service providers and quality improvement teams to develop the skills needed to adapt clinical evidence to the contexts of their health care delivery environments.[9] Practice facilitators have served as "coaches" who help practices achieve their quality improvement goals and as "change agents" who promote the adoption of practice transformations.[9] Systematic reviews have reported that practice facilitation can support implementation of system-level improvements[8] and support medical practices in adopting evidence-based guidelines.[10]

Recently, the reach of the practice facilitation model has expanded to assist health systems to develop the capacities needed to deliver integrated behavioral health care.[11] However, whether practice coaches are routinely used in this way, the types of integrated behavioral health initiatives they support, and the definition and roles of "practice facilitators" in integrating systems is unclear. This topic is important to explore given the specific challenges health systems face in making the practice transformations needed to deliver integrated care.

A scoping review is an ideal approach to gain further insight on the roles of practice facilitators in integrated settings.[12] Questions answered by scoping reviews are broader in nature than systematic reviews and emphasize identifying gaps in a body of literature rather than focusing on study quality or outcomes.[12] Scoping reviews also allow researchers to clarify definitions and map the conceptual boundaries of a nascent research topic. The aims of this scoping review are to (1) identify articles describing efforts to deliver integrated care programs with the support of practice facilitators, (2) understand the roles of practice facilitation in these initiatives, and (3) describe the current evidence base for practice facilitation in the creation of integrated behavioral health care settings.

Methods

Search strategy

In January 2018, five electronic databases were searched—MEDLINE, Embase, PsycINFO, CINAHL, and Web of Science—for peer-reviewed articles and dissertations examining initiatives to deliver integrated care using practice facilitators for support that were published and indexed in library databases between 2006 and January 2018. Information about this study's search strategy is detailed in Table 1.

The start date of 2006 was chosen because it followed the publication of "Morbidity and Mortality of People with Serious Mental Illness,"[2] which increased attention to the public health crisis among people living with mental illness who experience 25 years of life lost compared with the general population largely due to preventable and treatable medical conditions and thus attention to the need for integrated care among behavioral health professionals.

The definition of "practice facilitator" used in this study is derived from the Agency for Healthcare Research and Quality (AHRQ).[13] In the present study, a practice facilitator is defined as an external consultant who works with providers toward the goal of delivering integrated care. The definition of "integrated care" used in this study encompasses settings that deliver (or endeavor to

Table 1
Search parameters

Source	Practice facilitation search terms	Integrated care search terms	Other parameters	Results
PsycINFO	practice coach*	integrated care		364
	"practice coaching" (exact phrase)	subject ("Integrated Services ")	PsychINFO subject	
	practice facilitation	integrated healthcare		
	practice facilitator	care coordination		
	practice enhancement			
		subject ("interdisciplinary treatment approach")	PsychINFO subject	
		integrated behavioral health		
		Integrated mental health		
		integrated care		
		subject ("Integrated Services ")	PsychINFO subject	
Ovid Medline	practice coach*	integrated care		8
	practice facilitation	integrated services		
	external facilitation	interdisciplinary treatment approach		
	practice enhancement	integrated mental health		
	practice transformation	integrated behavioral health		
		Exp "Delivery of Health Care, Integrated		
Embase	practice coach*	"integrated care"/exp		255
	practice facilitation	"integrated health care system"/exp		
	practice facilitator	"care coordination"/exp		
	practice enhancement	integrated mental health		
	practice transformation			
	"practice coach"	"primary health care"/exp		
	external facilitation	"mental health service"/exp		
		"behavioral health"/exp		
Web of Science	practice coach*	integrated care		625
	practice facilitation	integrated health		

Table 1
(continued)

Source	Practice facilitation search terms	Integrated care search terms	Other parameters	Results
	external facilitation	care coordination		
	practice enhancement	interdisciplinary treatment approach		
	practice transformation	"integrated care"		
	"practice coaching"	integrated mental health		
	"practice facilitation"	integrated behavioral health		
CINAHL	practice coach*	integrated care		
	practice facilitator	(MH "Health Care Delivery, Integrated")	Searches the exact CINAHL subject heading; searches both major and minor headings under the subject "Health Care Delivery, Integrated"	10
	practice facilitation	integrated services		
	external facilitation	interdisciplinary treatment approach		
	practice transformation	interprofessional collaboration		
	practice enhancement	Care Coordination		

" "were used to search the exact phrase practice coaching rather than the keywords in random order
Subject is the part of the controlled vocabulary of PsycINFO found in the thesaurus. Used to help increase the retrieval of relevant material under integrated services
Exp means "exploded" the subject heading so it includes all the subheadings in that hierarchy in the search
*Searching for all forms of the word (e.g., "coaching, coaches, coached")

deliver) primary care, mental health, and behavioral health services; primary care and mental health services; or primary care and behavioral health services through co-location or care coordination. While primary care clinics are a leading source of mental and behavioral health services, efforts to deliver integrated care have been based out of both primary care practices[11] and mental and behavioral health settings.[14,15] Therefore, this study aimed to locate information pertaining to all efforts to deliver integrated care that were based out of either type of setting.

Inclusion criteria were the following: (a) the manuscript must describe a study or initiative that occurs in a setting that delivers integrated care (defined above) or is undergoing or considering undergoing a system transformation to deliver or improve delivery of integrated care and (b) includes an external consultant (i.e., a practice facilitator) who works with providers to improve delivery of integrated care. Studies and manuscripts that were written in a language other than English were excluded. Multiple published reports from a single study that met inclusion criteria were treated as a single data point. In situations where more than one paper published from a single initiative or integration effort met inclusion criteria, all papers that describe the initiative and its results were reviewed. This was in an effort to gain as much information as possible about the practice facilitation role. Given the nature of scoping reviews, all types of research studies, study protocols, and conceptual manuscripts that provided evidence, information, or ideas related to practice facilitation in the context of delivering integrated health care were included.

Data extraction and analysis

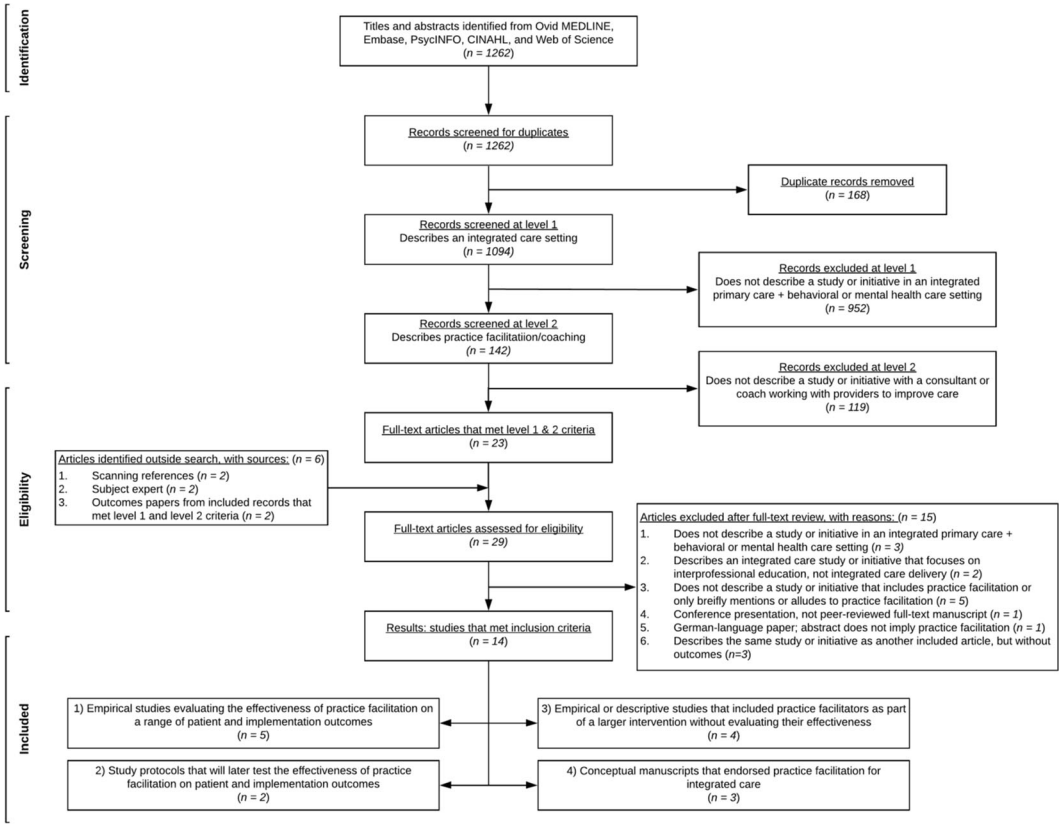
The following information was extracted and documented from studies that met inclusion criteria: study sample, service delivery setting (e.g., Federally Qualified Health Center, Patient Centered Medical Home, US Veterans Administration), study objective and design, whether outcomes pertaining to practice facilitation were reported, the practice facilitation model, the training background of the practice facilitators, and study results (where applicable).

Results

This scoping review includes 15 manuscripts that describe contributions and potential contributions of practice facilitators in settings that deliver (or aim to deliver) integrated care. Figure 1 details the study selection process. This study's search yielded a total of 1262 citations, of which 168 duplicates were removed. Upon screening titles and abstracts of the remaining 1094 records, 952 were excluded because the article did not pertain to integrated care, and 119 additional studies were excluded because they did not involve practice facilitation. Upon initial review of the remaining 23 records, six articles that did not appear in the original search were added through reference scanning ($n = 2$), referrals from a subject expert ($n = 2$),

Figure 1

PRISMA flow diagram. Details the flow of information through the different phases of the scoping review; maps out the number of records identified, included, and excluded, as well as the reasons for their exclusion or inclusion



and identifying the main outcomes paper of already-included studies ($n = 2$). These 29 full-text articles were thoroughly reviewed for inclusion. Nine were excluded because they did not fit this study's definition of integrated care ($n = 5$) or did not focus on practice facilitation ($n = 5$). Two more were excluded because they were not full-text, English-language manuscripts, and three were excluded because they described the same study or initiative as another included article, but without reporting outcomes.

The 14 articles that met inclusion criteria were organized into four subtypes: (1) empirical studies evaluating the effectiveness of practice facilitation on a range of patient and implementation outcomes ($n = 4$), (2) study protocols that will later test the effectiveness of practice facilitation on patient and implementation outcomes in health systems undergoing redesign ($n = 2$), (3) empirical or descriptive studies that included practice facilitators as part of a larger intervention without evaluating their effectiveness ($n = 5$), and (4) conceptual manuscripts that endorsed practice facilitation for integrated care ($n = 3$). These studies occurred in practices of varying sizes across a range of geographic regions.

Empirical studies that evaluated effectiveness of practice facilitation

All four empirical studies that evaluated the effectiveness of practice facilitation occurred in primary care settings. Two studies occurred in Patient Centered Medical Homes (PCMH)[16,17]: one occurred in a primary care practice aiming to achieve PCMH status,[18] and one occurred in Veterans Health Administration (VA) clinics.[19] Health systems featured in these studies had goals to become a PCMH,[18] support a new PCMH to achieve implementation goals,[17] increase behavioral health integration in a PCMH,[16] and improve mental health integration in a VA setting.[19]

Facilitators supported system transformation by assisting primary care practices in applying for and achieving PCMH status,[18] expanding practices' use of health information technology,[16,17] facilitating evaluation of efforts to deliver integrated care,[16,19] and supporting organizations in overcoming implementation challenges. Facilitators in these studies were undergraduate students majoring in health care management,[18] doctorate level psychologists,[17] and implementation researchers.[16,19,20] Other facilitators had specific training in implementation of integrated care[19] and finance.[17]

Facilitator effectiveness was evaluated with a range of study designs and outcomes (Table 2). One case study[18] assessed facilitator competencies from the perspectives of office managers using 5-point Likert scales that assessed their professionalism, interpersonal skills, and technical knowledge and reported that the facilitators were highly competent (3.87–4.83/5.0). Two quasi-experimental pre/post studies were also identified.[16,19] One of these studies evaluated clinics' progress with implementing BH services into a PCMH using organization-level self-assessments,[16] reporting that a higher dose of practice facilitation was associated with an increase in achievement of organizational goals. The other quasi-experimental study[19] followed the Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) framework to understand whether the facilitated group improved service use outcomes and reported that primary care patients at facilitated clinics were more likely to be seen for mental health needs compared with non-facilitated clinics. The remaining study was a randomized controlled trial[17] which compared facilitated and non-facilitated sites with respect to the proportion of PCMH national demonstration project criteria implemented and reported that at 2 years, intense facilitation increased the number of PCMH components.

Protocols

Two protocols for studies in progress that will test the effectiveness of practice facilitation in Patient Aligned Care Teams (PACT) within VA primary care clinics were identified.[21,22] One study will assess the impact of practice facilitation on the implementation of mental health peer specialists compared with standard implementation,[21] while the other will use facilitation as part of an evidence-based quality improvement (EBQI) strategy to develop integrated women's health

Table 2

Studies that evaluated the effectiveness of practice facilitation

Study authors, year, and title	Sample/setting	Study objective	Study design	Facilitator backgrounds
Lane & Watkins[18] Using a Facilitation Model to Achieve Patient-Centered Medical Home Recognition	$N = 12$ primary care settings in rural North Carolina participated in the "Multi-Payer Advanced Primary Care Demonstration Project." Practice sizes ranged from 1.5–5 fulltime clinicians.	To evaluate the contributions of practice facilitators who assisted rural primary care practices to achieve National Committee for Quality Assurance Patient-Centered Medical Home status.	This is a one-shot case study evaluation of practice facilitator behavioral and technical competencies, from the perspectives of office managers. Facilitators were assessed after 2 years of implementation. Facilitator time on the project ranged from 2 months to 2 semesters.	Facilitators were juniors and seniors from the health care management and pre-professional sciences programs who had completed 2 health care management introductory prerequisites.
Roderick et al.[16] Integrated Behavioral Health Practice Facilitation in Patient Centered Medical Homes: A Promising Application	$N = 12$ PCMHs in Rhode Island ($n = 4$ private practices; $n = 8$ FQHCs; 5 urban, 6 suburban, 1 rural) with varying behavioral health services. Sites self-selected to be in the pilot. The initiative is called "Care Transformation Collaborative Rhode Island" (CTC-RI).	This multi-payer initiative focused on creating PCMHs. Its goal was to assess the degree of BH integration change in PCMHs when using a practice facilitator trained in implementing integrated care.	In this pre-test/post-test quasi-experimental study, measures were taken at baseline and at 10 months post implementation. Data were analyzed using Student's t test.	Facilitators were psychologists with a doctorate in clinical health psychology with expertise in behavioral health implementation plus 12 years of clinical leadership in integrated settings, plus a fellowship in primary care psychology.
Nutting et al.[17] Effect of Facilitation on Practice Outcomes in the National Demonstration Project Model of the	$N = 36$ primary care practices ($n = 17$ facilitated, $n = 18$ self-directed). Practices were located in 25 states, with 11 in rural	To study the effect of facilitation on practice outcomes in the 2-year patient-centered medical home (PCMH) National	In this randomized controlled trial, $N = 36$ family practices were randomized to a facilitated intervention group or a self-directed	Facilitators had backgrounds in finance, practice management, and organizational psychology.

Table 2
(continued)

Study authors, year, and title	Sample/setting	Study objective	Study design	Facilitator backgrounds
Patient-Centered Medical Home	communities, 16 in suburban areas, and 9 in urban areas. Ten practices were solo physicians 8 were small (2–3 physicians), 10 were medium sized (4–6 physicians), and 8 practices were large (≥ 7 physicians).	Demonstration Project (NDP) intervention.	intervention group. Authors used a repeated-measures analysis of variance to test effects of practice facilitation.	
Kirchner et al.[19] Outcomes of a Partnered Facilitation Strategy to Implement Primary Care-Mental Health	*N* = 7 VA primary care clinics received an Implementation Facilitation intervention plus national support, while *N* = 7 matched comparison clinics received national support only. All practices were in urban locations with practice sizes ranging from 4025 to 35,000.	The Primary Care Mental Health Integration (PC-MHI) initiative evaluated the effectiveness of an internal/external implementation facilitation strategy within efforts to integrate mental health services in VA primary care clinics.	This was a quasi-experimental, Hybrid Type III study with a matched comparison group. Generalized estimating equations assessed differences across sites. Data were analyzed at baseline, at a late-phase evaluation period, and at a maintenance phase. Exact evaluation periods varied by site.	The national external expert facilitator (NEEF) was an implementation researcher with clinical leadership experience. Internal regional facilitators (IRF) had clinical training and experience in PC-MHI. *Note: sites were tasked with finding their own IRF.

Study authors, year, and title	Practice facilitation role or model	Outcome measures	Study results
Lane & Watkins[18] Using a Facilitation Model to Achieve Patient-Centered Medi-	Facilitators assisted primary care practices in transforming their processes and to apply for and	Practice facilitators were evaluated using a 5-point= Likert scale (1 = limited competency to	Mean competency scores ranged from 3.87 to 4.83. Respondents generally agreed that most of the

Table 2
(continued)

Study authors, year, and title	Practice facilitation role or model	Outcome measures	Study results
cal Home Recognition	achieve patient-centered medical home recognition. Undergraduate student facilitators (who received academic credit) were assigned to 1 of 14 practices to help practices.	5 = very competent) to understand domains related to their professionalism, interpersonal skills, and technical knowledge.	students demonstrated all the competencies. Qualitative data revealed that coaches provided the person power for PCMH application.
Roderick et al.[16] Integrated Behavioral Health Practice Facilitation in Patient Centered Medical Homes: A Promising Application	Facilitation goal was to assist primary care practices in research and QI activities and use practice enhancement methods to facilitate system-level changes. Facilitators served as program evaluators and met monthly with each site for an hour.	(1) Behavioral Health Integrated assessment (from Main Health Access Foundation Site Self-Assessment) (2) The Goal Attainment Scale (3) "Dose" of practice facilitation (aka intensity of intervention) = the number of meetings between the sites and the facilitator over 10 months.	At 10 months, sites reported increase in behavioral health integration and 10/12 sites achieved successful implementation of unique goals. The higher the percent dose of practice facilitation, the higher the maximum goal attainment was achieved (goal was 10 meetings over 10 months).
Nutting et al.[17] Effect of Facilitation on Practice Outcomes in the National Demonstration Project Model of the Patient-Centered Medical Home	Facilitated practices received ongoing assistance from a "change facilitator" who used multiple practice change strategies including site visits, frequent communication, conference calls, metrics, and learning sessions. The intervention occurred over 2 years.	(1) Proportion of 39 components of the NDP model (such as behavioral health care) that practices implemented (2) Aggregate patient rating of the practices' PCMH attributes (3) Practices' ability to make and sustain change.	At 2 years, Intense facilitation increased the number of PCMH components implemented and improved practices' ability to make and sustain changes (group difference by time, $p = .005$) and the proportion of NDP model components implemented (group difference by time $p = .02$)
Kirchner et al.[19] Outcomes of a Partnered Facilitation Strategy to Implement Primary Care-Mental	The NEEF partnered with providers, plus regional, facility, and clinic managers to implement PC-MHI. IRFs conducted site visits to help	Guided by RE-AIM: Reach: Percentage of patients seen in primary care with a mental health encounter	At 6 months, primary care patients at facilitated clinics were more likely to be seen for mental health (OR = 8.93, $p < 0.001$); primary

Table 2
(continued)

Study authors, year, and title	Practice facilitation role or model	Outcome measures	Study results
Health	sites implement and refine their implementation plans, assess and address barriers, and monitor progress. They also gave "audit and feedback" by documenting completion of activities identified in sites' implementation plans and monitoring program fidelity.	Effectiveness: Percentage of primary care patients with an initial visit to mental health care Adoption: Percentage of PCPs referring PC-MHI; proportion of patients referred to PC-MHI Implementation: % of patients referred to PC-MHI that were seen on the same day Maintenance: A re-assessment of each measure defined above during the maintenance phase.	care providers from facilitated clinics were more likely to refer patients for PC-MHI (OR = 7.12, $p = 0.029$).

services within PACT teams.[22] Practice facilitators in both protocols will support teams through implementation phone calls, learning collaborative meetings, sharing of current evidence, general problem solving, and feedback. The facilitators in both protocols had clinical or research doctorates and were members of the evaluation team in one protocol (Table 3).[22] Both studies are cluster randomized controlled trials: one cluster-randomized hybrid type II trial and one parallel two-arm cluster trial. Both studies will evaluate the effectiveness of facilitation by assessing change in organizational-level factors such as readiness for change,[21] accessibility, care coordination, and team-based care.[22] Chinman[21] followed the RE-AIM framework and will also test for patient level outcomes.

Studies that included practice facilitation without evaluating their effectiveness

Three studies were situated in primary care clinics[23–25] and two in VA settings.[26,27] Study objectives are related to addressing tobacco and alcohol use in primary care,[23,26] improving care for depression among persons with diabetes[24] and other primary care needs,[27] and becoming a level-3 PCMH.[25] Facilitators supported their sites through Plan-Do-Study-Act (PDSA) cycles, general problem-solving, frequent phone calls, and regularly occurring onsite visits. Facilitators engaged with their sites on a monthly or every-other-monthly basis, either in person or by phone call, and usually a combination of the two, for 1–3 h. Practice facilitators from one study[27] followed an EBQI framework. In terms of background, facilitators were national experts in implementation and alcohol use disorder treatments,[26] and members of the study team,[27] and not described in some cases (Table 4).

Narrative manuscripts that described practice facilitation for integrated care

Three narrative manuscripts that described practice facilitation to support the implementation integrated care were identified (Table 5). Two were directed at primary care providers[28,29]: one recommended using facilitation for integrated care[28] and the other characterized practice facilitation as critical to becoming a PCMH.[29] The third narrative manuscript emphasized practice facilitation as a potential role for psychologists working in integrated settings.[30] All three manuscripts described facilitators as capable of assisting with such practice transformations as the establishment of group medical visits or chronic disease support groups, flow charts and reminder systems,[29] and can provide opportunities to connect with colleagues at other practices for peer support.[26,27] These articles noted that practices are more successful in transformation with outside assistance[28] and that psychologists are essential to this work, and noted that primary care providers should welcome their contributions.[30] However, the most effective facilitation models, the most critical skills for practice facilitators, and how they should be trained were not described.

Discussion

This scoping review described efforts to deliver integrated care programs with the support of practice facilitators. This study also aimed to understand the roles of practice facilitation in the context of health care systems delivering integrated care or undergoing transformations to become integrated and to describe the evidence base for this approach to implementation. Fourteen peer-reviewed manuscripts were analyzed, which yield four main points of discussion.

The first discussion point relates to the types of initiatives and study settings that were identified in this review. While these initiatives occurred in various regions of the USA and in practice settings of varying sizes, all studies that met inclusion criteria occurred in primary care settings that were community health clinics, PCMHs, or VA primary care clinics. Likewise, three narrative manuscripts that described the utility of practice facilitation for primary care settings that wish to deliver behavioral health services were also identified. This is not surprising, given that practice

Table 3

Study protocols

Study authors and year	Sample/setting	Study objective	Study design	Facilitator backgrounds	Practice facilitation role or model	Outcome measures
Chinman et al.[21] Provision of peer specialist services in VA patient aligned care teams: protocol for testing a cluster randomized implementation trial	Veterans Health Affairs Patient Aligned Care Teams (PACT) that serve as "medical homes" and include mental health peer specialists. Study included a convenience sample of $N = 25$ PACT sites.	To assess the impact of facilitation implementation support on mental health peer specialist services in PACT vs standard implementation.	Cluster-randomized hybrid type II trial PACT sites are randomly assigned to a standard implementation vs facilitated implementation provided for 1 year. Qualitative interviews to assess key barriers and facilitating factors to integrated peer specialists into PACT, questions based on i-PARIHS.	Three doctorate-level psychologists trained in the facilitation model Integrated Promoting Action Research on Implementation in Health Services (i--PARIHS).	Pre-implementation: Assess and engage facility stakeholders, education PACT on implementation strategies, and/or evidence related to peer support; assist PACT in developing implementation goal. Post-Implementation: Bi-weekly calls to discuss status of implementation and problem solving as needed; monthly learning collaborative calls with all facilitation sites; monitor and provide feedback on implementation progress; help problem solve; monitor use of suggested solutions.	Context measures: Organizational Readiness for Change (ORC) scale and the Team Development Scale (TDC). Service delivery measures: peer workload and the peer fidelity measure. Veteran outcome measures: patient satisfaction, health status, patient activation measure (PAM), and VR-12, which is the Veteran's version of the SF-36.
Yano et al.[22] Cluster RCT of a multilevel evidence-based quality improvement approach to tailoring VA Patient Aligned Care Teams to the needs of women Veterans	$N = 12$ US Veterans Health Administration Veterans Integrated Service Networks from 9 different states from Midwest, east coast, and Appalachia.	To use evidence-based quality improvement (EBQI) in the context of the Chronic Care Model to develop and test achievement of women's health Patient aligned care teams (PACT).	Parallel two-arm, cluster randomized controlled trial $N = 8$ intervention sites assigned to EBQI $N = 4$ control sites have standard support.	Project evaluators were the Practice Facilitators.	Practice coaches were part of EBQI implementation strategy. Specific coaching responsibilities included Regular EBQI team contacts with local QI teams by telephone and e-mail, troubleshooting of local problems using Veterans Integrated Service Networks oversight/communication plans, and a team-moderated monthly call	Primary outcome measures will focus on achievement of the PACT model, including changes in achievement of the following: access, continuity, care coordination, team-based care, patient-centeredness, and gender sensitivity. Secondary outcome measures will focus on PACT outcomes such as improvements in health status, service utilization, and costs.

Table 4

Studies that include practice facilitators but do not evaluate their effectiveness

Author and title	Study setting	Study objective	Study overview	Facilitator background	Facilitation role
Aspy et al.[23] Integrating Screening and Interventions for Unhealthy Behaviors into Primary Care Practices	*N* = 9 clinicians from three clusters of Oklahoma, primary care Physicians Resource/Research Network Practices were located in west-central Oklahoma, central Oklahoma, and north-east Oklahoma.	To address tobacco use, unhealthy diet, physical inactivity, and risky alcohol use in a primary care setting by testing an implementation strategy that included audit, training, practice facilitation, and quality circle meetings.	Each cluster received a multicomponent training intervention addressing diet & physical activity, tobacco use, and risky alcohol use in three 6-month cycles. The Intervention included baseline and monthly audits with feedback; bimonthly quality-circle meetings. Nurses, medical assistants, or both were taught to do screening and very brief interventions such as referrals and handouts. Clinicians were taught to do brief interventions.	Backgrounds of "Practice enhancement assistants" were not specified.	Facilitator was assigned to each cluster of clinicians to implement new screening and intervention methods using PDSA quality improvement cycles. Facilitators performed monthly chart audits to provide feedback to the clinicians on their progress. Facilitators worked with clinicians to modify office routines, forms, and computer templates, identify community resources and helped teams find or develop patient education materials. They kept diaries and field notes on every facilitation session. At 2, 4, and 6 months, the facilitator, cluster, and

Table 4
(continued)

Author and title	Study setting	Study objective	Study overview	Facilitator background	Facilitation role
					PI met to review progress.
Rossom et al.[24] Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease	*N* = 18 medical groups and 172 clinics in Washington, Colorado, Southern California, Minnesota, Florida, Michigan, Massachusetts, Pennsylvania, and Minnesota. Participating systems included integrated health systems, federally qualified health centers, multisite physician practices and individual practice associations.	The "Care of Mental, Physical and Substance-use Syndromes" (COMPASS) initiative was a quality improvement collaborative to implement integrated care for patients with depression and uncontrolled diabetes and/or cardiovascular disease.	COMPASS was based on the chronic care management model, and included intensive case management using rigorous treat-to-target guidelines for depression, diabetes and cardiovascular disease delivered by a care management team. COMPASS teams had a care manager and met weekly for systematic case reviews.	Coaches were affiliates of the Institute for Clinical Improvement Systems, the organization that was overseeing the program.	Facilitators helped medical groups and clinics organize, provide, and customize the local trainings for the COMPASS care teams. Organizations had regular monthly calls with their coach and two site visits in years 2 and 3 of the project. Coaching activities focused on advancing progress toward implementation milestones, understanding barriers, helping with problem solving, reviewing process and outcomes reports for progress toward goals, holding teams

Table 4
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Author and title	Study setting	Study objective	Study overview	Facilitator background	Facilitation role
					accountable for fidelity to program requirements, and sharing best practices. Coaches were also responsible for identifying needs across the medical groups and clinics on an ongoing basis
Halladay et al.[25] The Cost to Successfully Apply for Level 3 Medical Home Recognition	*N* = 4 primary care practices in North Carolina working toward a level 3 Patient Centered Medical Home status. Practice sizes ranged from 2.5 to 10.5 FTE providers; patient visits per year ranged from 4477 to 39,172.	To identify the costs incurred by primary care practices in applying for and being recognized by the NCQA as a level 3 PCMH.	The study calculated the cost estimates of becoming a level 3 PCMH. A survey collected the costs of completing activities listed in PCMH survey tool application.	Facilitators were from the North Carolina Area Health Education Center's Practice Support Program.	One group of practice facilitators identified primary care practices to participate in the study. External consultants in the study provided 2–3 hours of on-site support monthly to help practices identify training materials and to guide the PCMH application processes.
Hagedorn et al.[26] (protocol) Harris (2017) (outcomes) Enhancing access to	Three large VA primary care clinics.	To enhance access to alcohol use disorder treatment in primary care settings.	Primary care providers receive consultation from local clinical champions and	External facilitators were national experts in implementation	Teams had monthly teleconference meetings with external facilitators

Table 4
(continued)

Author and title	Study setting	Study objective	Study overview	Facilitator background	Facilitation role
Alcohol use disorder pharmacotherapy and treatment in primary care settings			external facilitators, educational materials, and a dashboard of patients with alcohol use disorders (AUD) on their caseloads for case identification. Veterans with AUD diagnoses receive educational information in the mail just prior to a scheduled PC visit.	and AUD pharmacological treatments.	for 9 months to review outreach plans, monitor progress, and identify implementation barriers and strategies to overcome them. Access to an external expert consultant upon request was also available. External facilitators helped address the feedback reports and helped clinics interpret and apply the information learned from the reports.
Rubenstein et al.[27] Using Evidence-Based Quality Improvement Methods for Translating Depression Collaborative Care Research Into Practice	*N* = 7 VA primary care practices that are part of 3 different regional health systems under an initiative called Translating Initiatives in Depression into Effective Solutions (TIDES). Four clinics	To adapt and implement the Chronic Care Model for depression to VA primary care clinics using the Evidence Based Quality Improvement framework, and to evaluate model	Clinics followed the EBQI framework. Facilitators supported primary care practices in adapting the CCM using PDSA cycles while trained nurse depression care managers collected	Members of the study team worked in the practice facilitation role.	Researcher facilitators provided organizational change tools, assisted workgroups with implementation using PDSAs, assisted workgroups with education,

Table 4
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Author and title	Study setting	Study objective	Study overview	Facilitator background	Facilitation role
	were in rural or semi-rural locations, while three were small cities. Practice sizes ranged from 4634 to 14,005 patients.	fidelity and impact on patient outcomes.	data on model fidelity and patient adherence and outcomes, which were evaluated at baseline and 6 months.		"facilitation," and technical support.

Table 5
Narrative manuscripts

Study authors and year	Focus of manuscript	Description/definition/model of practice facilitation	Key recommendations related to practice facilitation in integrated settings	Audience
Dickenson[28] Strategies to Support the Integration of Behavioral Health and Primary Care: What Have we Learned Thus Far?	To review empirical studies of coaching in medical settings to create recommendations for using coaching in settings that deliver integrated behavioral health care.	Facilitators assist practices in implementing quality improvement and change management programs, improving incorporation of innovations into operations and increasing sustainability.	Practices are more successful in transforming care in learning collaboratives and with outside assistance. Practice facilitators can facilitate collaborations between professionals from different backgrounds, can foster trust and rapport, help teams learn each other's strengths and weaknesses, and develop effective work flows and care processes.	Family medicine physicians and other primary care providers
Fisher and Dickenson et al.[30] New Collaborations for Providing Effective Care for adults with Chronic Health Conditions	To review models of collaboration, barriers to effective integration and potential contributions of psychologists in integrated settings.	Practice coaching is an emerging role for psychologists in primary care settings. They can establish group medical visits or chronic disease support groups, design a time study to help streamline patient flow, help a practice develop the internal resources and skills to adopt and sustain use of new programs, or develop integrated programs to bring in non-adherent patients with diabetes to provide more intense	Practice facilitation is a potential role for psychologists. In addition to normal coaching roles, psychologists can develop and supervise programs for nurses and care managers, and facilitate team collaboration and assist with changes to traditional clinical roles. Primary care practices should accept psychologists as trusted partners in practice transformation.	Psychologists

Table 5
(continued)

Study authors and year	Focus of manuscript	Description/definition/model of practice facilitation	Key recommendations related to practice facilitation in integrated settings	Audience
		monitoring and care.		
Homer and Baron[29] How to Scale Up Primary Care Transformation: What We Know and What We Need to Know?	To characterize factors that are critical to becoming a patient centered medical home.	Expert and facilitated assistance can include in-office consultants who coach teams using specific approaches to change management, combined with specific tools such as flow charts and reminder systems. External support can provide new ideas, approaches, change frameworks, and can connect to opportunities for peer support.	Expert and facilitated assistance are both critical to primary care practice transformation. Future work should study what form of facilitation is most effective, the most effective coaching models, which core skills are most critical, and how should facilitators be trained.	Primary care physicians (and other providers)

facilitation has been used to support primary care quality improvement efforts for several years.[8] It is important to note that some quality improvement initiatives designed to deliver integrated care have followed a "reverse integration" approach, in which primary care services are delivered in mental and behavioral health settings.[14] These initiatives target persons with serious mental and behavioral health needs who frequently enter the service system through the mental and behavioral health systems of care.[31] "Reverse integration" approaches have been moderately successful in improving medical outcomes for this population in both research and "real-life" settings.[14,15] To increase the capacity to deliver physical health care for those with severe mental and behavioral health needs, public mental and behavioral health systems should consider enlisting the support of practice facilitation resources, including learning collaboratives.[15]

Second, this study indicates that practice facilitators' roles in integrated settings were similar to those described in the primary care quality improvement literature.[8] Their roles included frequent communication with clinical sites, giving feedback on implementation progress, supporting practices in identifying and resolving implementation barriers using the PDSA framework, and facilitating learning sessions. In a few cases, facilitators served as program evaluators,[16,22] and in other cases,[20,22,27] the facilitation role was guided by the EBQI framework. Unique to integrated settings, some facilitators assisted clinics with PCMH applications.[18,25] However, it is worth noting that most studies included here provided a brief description of their facilitation model and little in-depth information on the facilitation process. One exception to this was a qualitative[32] companion piece to the Nutting (2011) study,[17] which highlighted practice facilitator's role as including "confidential assistance" and "disclosure of personal matters" to assist in the personal transformation of professionals engaging in integrated care. An additional conceptual paper[33] that reflected on the National Demonstration Project described building relationships between providers and team members as a cornerstone of practice facilitation. The relational elements of practice facilitation might be especially important within the context of an integrated system since facilitators could potentially be facilitating collaboration across different health care specialties and also helping negotiate disciplinary differences. Therefore, when planning to incorporate practice facilitators to support systems change, health systems should give equal weight to these and other "unofficial" responsibilities.

Related to their roles (both official and unofficial), this study found that practice facilitators had a variety of training backgrounds, but few studies reported having formally trained their practice facilitation team for work on their integration efforts. Facilitators featured in the included studies were senior experts in the field of behavioral health integration, held clinical and research doctorates, and possessed several years of clinical leadership, with the exception of one case.[18] In this case, facilitators were undergraduate students who assisted with a PCMH application as part of a practicum for course credit. One narrative manuscript described PhD-trained psychologists as ideal for filling the facilitation role, since they have historically been engaged in teaching primary care residents about the emotional aspects of managing of chronic conditions, including psychopathology, depression, and addictions and also have the qualifications to lead quality improvement initiatives.[30] This variation suggests that coaching can occur in various forms but raises questions surrounding what skill level and competencies are needed to facilitate system transformation related to integrated care and how to otherwise train professionals for this work. While there are no set standards, AHRQ recommends minimum standards for facilitation, such as a master's degree and professional health care experience. This might be especially critical when supporting systems planning to deliver integrated care, since facilitators will need to effectively communicate with providers from various backgrounds and have working knowledge of the political and administrative aspects of care systems that have historically been separated.

The final discussion point pertains to the emergent evidence base of practice coaching in integrated settings. This study identified five studies that evaluated the effectiveness of practice

facilitation and reported positive outcomes. However, whether studies with null or unfavorable results have been excluded or rejected from the literature due to publication bias remains unclear.

The studies included in this scoping review utilized a range of study designs including quasi-experimental,[16,19] case study,[18] and RCT,[17,20] with two additional RCTs currently in progress.[21,22] Across these studies, facilitation was generally evaluated using organizational outcomes, such as degree of change, ability to make change (also known as adaptive reserve), referrals to mental/behavioral health, and number of patients seen by mental and behavioral health providers. However, one study[20] and one protocol[21] included the evaluation of patient response to health care after receiving integrated services. The heterogeneity in study designs and program goals precludes us from making definitive statements on the effectiveness of practice facilitation in integrated settings. An important next step is to address the question of what exactly the field hopes to accomplish with the support of practice facilitators and which outcomes are appropriate for evaluating whether they have been effective. This should be accomplished in ways that account for changes in provider experience, challenges that clinic staff might experience receiving instruction from an outside facilitator, and challenges that could be experienced by facilitators, such as organizations being resistant to change.

Limitations

These findings should be taken in light of some limitations. Although the search methods used in this scoping review were exhaustive, some studies may have been missed. It is possible that this scoping review did not capture all studies on practice facilitation in integrated settings or that articles that did not characterize practice facilitation as such were inadvertently excluded. Further, publication bias of studies with favorable outcomes could overstate what appears to be emergent evidence for practice facilitation in integrated settings.

Implications for Behavioral Health

Given current health policy emphasis on delivery of integrated care for persons with complex care conditions and behavioral health needs, it is a critical moment to facilitate practice transformation using the support of these professionals. The results of this study highlight the potential contributions of practice facilitators to health systems that are developing the capacity to deliver integrated care. Practice facilitators have a promising role in the development and delivery of integrated programs, but further research is needed to understand their essential qualifications, responsibilities, and evidence of their effectiveness.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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