



HHS Public Access

Author manuscript

J Nurs Care Qual. Author manuscript; available in PMC 2020 July 01.

Published in final edited form as:

J Nurs Care Qual. 2019 ; 34(3): 210–216. doi:10.1097/NCQ.0000000000000376.

Blended Facilitation as an Effective Implementation Strategy for Quality Improvement and Research in Nursing Homes

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Abstract

Background: Blended facilitation, which leverages the complementary skills and expertise of external and internal facilitators, is a powerful strategy that nursing stakeholders and researchers may use to improve implementation of quality improvement (QI) innovations and research performed in nursing homes.

Problem: Nursing homes present myriad challenges (eg, time constraints, top-down flow of communication, high staff turnover) to QI implementation and research.

Approach: This methods article describes the theory and practical application of blended facilitation and its components (external facilitation, internal facilitation, relationship building, and skill building), using examples from a mixed QI and research intervention in Veterans Health Administration nursing homes.

Conclusions: Blended facilitation invites nursing home stakeholders to be equal partners in QI and research processes. Its intentional use may overcome many existing barriers to QI and research performed in nursing homes and, by strengthening relationships between researchers and stakeholders, may accelerate implementation of innovative care practices.

Keywords

evidence-based practice; implementation science; nursing homes; quality improvement; research design

There is broad consensus on the need for improvements to nursing home quality of care.¹ There are also increased calls for enhanced implementation of evidence-based practices in long-term care settings.² Despite these recognized needs, nursing homes often fail to implement or sustain innovative practices.^{3,4} Unique challenges such as time constraints, top-down flow of communication, and high staff turnover may contribute to this lack of uptake. Limited attention has been paid to methods that nursing home stakeholders and the research community employ to improve the adoption and maintenance of practice innovations. In this article, we describe blended facilitation, a technique from implementation science that has been called the “active ingredient” in the adoption of new knowledge into clinical practice.⁵ Our experience applying blended facilitation through quality improvement (QI) projects initiated within a research study in Veterans Health Administration (VHA) nursing homes (ie, community living centers [CLCs]) serves as an example for how to operationalize blended facilitation in practice.

CHALLENGES TO QI EFFORTS AND RESEARCH IN NURSING HOMES

Quality improvement efforts often fail in nursing homes.^{6,7} Similarly, research efforts that rely on nursing home staff members to implement innovations also tend to have poor adherence to intervention and data collection protocols.⁴ In both cases, a potential cause is staff members being limited in the amount of time they can devote to implementation activities. There are time demands caused by staffing shortages, caring for residents with increasingly complex conditions, and ensuring and documenting compliance with strict regulations.^{8,9} Because of perceived lack of time, staff may appear to be resistant to change¹⁰ and wary of QI efforts.⁶ Similarly, researchers may be seen as outsiders who make burdensome requests for staff participation,⁴ may open the system to additional compliance risk, and tend to conduct research that focuses predominantly on deficits.¹¹ Some research teams have addressed these challenges by relying exclusively on researchers from outside the setting to implement the innovation, yet this strategy may overcome these hurdles only to incur significant others, particularly inattention to real-world conditions, which may preclude scale-up and spread of the innovation.⁴

Other issues may impede the success of implementation efforts in nursing homes. The typical nursing home has a vertical organizational structure in which communication takes place via a chain of command; this may inhibit the open bidirectional communication flow often necessary for efficient implementation processes. High staff turnover can also be problematic, because the individuals trained to facilitate, conduct, or document the intervention may leave¹² or transfer to other settings,⁴ thus interrupting the continuous flow of implementation processes. Staff may also lack the experience necessary to implement an innovation or collect QI research data.⁴ All of these factors also contribute to poor sustainability after study completion, despite a given study's demonstrated efficacy or benefit to nursing home residents.³

FACILITATION

Implementation science may offer some solutions to these issues. This field seeks to understand factors that influence adoption and integration of evidence-based practices into routine health care and public health practice. It is particularly concerned with identifying what, why, and how innovations are fully and effectively adopted. Implementation studies strive to develop generalizable knowledge for application beyond the context under study, and thus these concepts are also applicable to QI efforts. Indeed, implementation research studies often are conducted in conjunction with QI efforts with participation or leadership from frontline staff.¹³ Common to both implementation science and QI efforts is a technique known as facilitation.

Facilitation has been used successfully in the implementation of evidence-based practices and innovations in complex clinical programs.¹⁴ It involves interactive problem solving and provision of interpersonal support in the context of a QI process or implementation study.¹⁵ It is conceptually grounded in organizational learning theory, which posits that knowledge acquired by individuals can influence higher-order learning processes for the entire system,

¹⁶ and has overlap with participatory action research, which recognizes the essential role of research participants in the development and use of knowledge.¹⁷

BLENDING FACILITATION

Blended facilitation refers to a specific type of facilitation that employs a team-based approach to implementing a QI or research program that leverages the complementary skills and expertise of external and internal facilitators. External facilitation requires a change agent who operates *outside* a setting.¹⁵ In QI, external facilitators could be members of an interorganizational agency tasked with supporting quality (eg, a corporate office quality program) or members of a learning collaborative who work in another organization (eg, Pioneer Network National Learning Collaborative). In a research effort, external facilitators are typically research team members with expertise in the evidence base of a research program, implementation activities, or project and change management.^{18,19} Internal facilitation refers to facilitation that comes from within the setting where the innovation is being implemented.¹⁵ Internal facilitators, therefore, are individuals who are familiar with the organizational structures, procedures, culture, and clinical processes of the target health care setting.¹⁹

A third defining characteristic of blended facilitation is its 2-way process of relationship building and skill building, which creates a supportive environment that makes it possible for facilitators and nursing home stakeholders to exchange knowledge, identify barriers to implementation, and develop processes to overcome those barriers.¹⁹ Team-building efforts in non-acute health care settings have been shown to improve team functioning and, subsequently, patient care,²⁰ and blended facilitation has been used in experimental studies of pain assessment in nursing homes²¹ and of ongoing implementation of chronic care models.²²

We used these 3 critical aspects of blended facilitation (external facilitation, internal facilitation, and relationship building and skill building) in a VHA-funded, CLC-based study, Developing and Implementing Resident-centered Efforts in Cultural Transformation (DIRECT). Detailed information about DIRECT is available elsewhere.^{23–25} Briefly, DIRECT sought to improve 2 aspects of person-centered care— positive interactions with staff and resident engagement in daily life—in a sample of 6 VHA CLCs using an intervention that targeted staff behavior change. This mixed-methods study focused on improving interactions between residents and staff, thereby ultimately aiming to improve resident engagement. We implemented the intervention by (a) using a set of evidence-based practices for implementing QI²⁵ and (b) combining primarily CLC-based staff facilitation with researcher-led facilitation. Champions at each participating site were taught QI methods and were supported by researchers to choose a QI project for their CLC. Data collected in the CLC via surveys of residents and staff, researcher observations, and semistructured staff interviews showed that the intervention was feasible and influenced staff to make simple enhancements to their behaviors that improved resident-staff interactions and staff-assessed resident engagement. Because DIRECT consisted of site-level QI efforts occurring within the larger framework of a research study, this example simultaneously illustrates the QI and research applications of blended facilitation.

Real-world example of blended facilitation

The Table outlines the facilitation activities and facilitation actors involved at different stages of DIRECT implementation.

External facilitation in theory—External facilitators ideally partner with internal facilitators and other stakeholders at multiple levels of the organization to gain a good understanding of the environment in which the QI or research program is implemented. External facilitators also provide internal facilitators with structure and guidance to develop performance improvement goals and processes that will maximize their potential for success. This may involve working with internal facilitators to design projects that are feasible and tailored to the needs of the setting and that also use data sources that allow the team to monitor progress toward goals. External facilitators may also be called upon to provide various types of evidence (eg, academic research or best practices from implementation efforts in similar settings) or additional resources to support the implementation and maintenance of the QI or research program.

External facilitation in practice—For DIRECT, external facilitators were VHA researchers who had content expertise in nursing homes, methodologic expertise in implementation research, and expert knowledge of the theoretical basis for the intervention. External facilitation included a series of preimplementation phone calls to allow researchers and nursing home stakeholders to share personal experiences and identify QI goals, creating a foundation for productive relationships. These calls also reviewed important concepts relevant to the research study and trained internal facilitators and CLC leadership in specific QI skills (eg, facilitating staff buy-in) and research protocol skills (eg, recruitment techniques congruent with the study protocol). Following the calls, members of the external facilitation team conducted an initial site visit and held weekly check-in calls with the internal facilitation team. Check-in calls focused on a variety of topics relevant to the QI project implementation and team building, such as discussing challenges and successes, jointly reviewing QI data, and reviewing scripts for discussing QI data findings with other CLC staff.

Regular contact with sites helped external facilitators identify opportunities for overcoming hurdles in study implementation, clarify misconceptions and misunderstandings about study implementation, offer additional training, and make practical modifications of the study protocol. Examples of these include overcoming provider resistance to the study, helping staff prioritize both huddling and clinical assessment, providing additional training on how to use the observation tools when discrepancies in use arose, and changing observation form to highlight areas users were forgetting, respectively. This support, in turn, empowered internal facilitators to generate their own solutions to issues that arose.

Internal facilitation in theory—The internal facilitation role may be filled in various ways, depending on individuals' interests in QI or research, their role function, and local contexts. Examples include administrative or clinical leaders or staff members who are not in designated positions of leadership but who are recognized for having a demonstrated commitment to improving care. Internal facilitators contribute to the QI or research effort by

providing insider perspectives; helping the research team build relationships with other key stakeholders; teaching, training, and mentoring other staff in implementing the innovation; and devising additional implementation strategies that are likely to succeed in their specific organization. They also *drive* the project by helping the organization develop its own vision for change, creating the momentum for that change and reinforcing it.

Internal facilitation in practice—Internal facilitators for DIRECT included both points of contact designated by CLC leadership and self-selected champions, such as directors of nursing, nurse managers, nurse educators, licensed nurses, certified nurse assistants, and non-nursing providers. They were responsible for reaching consensus about a target QI goal, ensuring that other CLC staff (registered nurses, certified nurse assistants, interdisciplinary team members, and environmental management services members) were trained on use of the study data collection tools, creating enthusiasm around the project, conducting quick frontline stand-up meetings (huddles) to share QI data findings, and participating in weekly check-in calls with external facilitators. They also identified methods for generating and maintaining CLC staff engagement with the project, including ideas to recognize staff contributions and generate interest and excitement via internal publicity (eg, bulletin boards, newsletters, e-mails).

Relationship building and skill building in theory—Although specific facilitation activities vary depending on the needs of the participating organization, critical elements of a successful facilitation process are relationship building, sharing of common goals, effective communication, and collaboration.²⁶ Those seeking to implement a QI project or research program in a nursing home may want to consider forming and supporting separate but overlapping configurations of facilitation teams: (1) 1 comprised of external and internal facilitators, as described previously, and (2) 1 comprised of internal facilitators and other nursing home staff who will be involved in implementing the innovation.

The team of external and internal facilitators ideally needs to engage in purposeful, progressive, and iterative exchanges that focus on building trusting relationships and establishing and sharing common goals.²⁶ Ongoing contact through blended facilitation also enables collaborative 2-way learning. Introductory and ongoing check-in meetings help the external facilitator transfer an understanding of effective implementation activities to the internal facilitator,²⁷ equipping him or her with implementation skills and tools to sustain the innovation. External facilitators, in turn, become familiar with the perspective, priorities, needs, and research capacity of the clinical environment, as well as learning best practices for engaging with stakeholders at multiple levels.

Implementation of QI or research innovations—or any other facility-wide change—requires involvement of individuals who represent all aspects of a shared work process.²⁸ Positive work relationships between internal facilitators and nursing home staff, manifested through shared goals, shared knowledge, and mutual respect, are therefore paramount. An important first step in developing an internal facilitation team is training internal facilitators in the use of huddles and equipping them with communication scripts or discussion prompts to facilitate relevant discussion and constant, bidirectional communication.

Two-way learning occurs within this team of internal facilitators and nursing home staff through facilitated communication. By conducting frequent but brief huddles, internal facilitators receive rapid feedback about the level of engagement of staff with the project. Repeated practice allows the internal facilitator to develop skills for engaging with intra- and interdisciplinary staff. Through consistent communication, staff members receive clarification on the goals and the innovation's potential contributions to the nursing home's care processes and resident outcomes. Staff members may also receive corrective feedback and informal training on the QI or research protocol or tools, as needed, potentially boosting staff members' confidence in their ability to fully implement the innovation.

Relationship building and skill building in practice—In DIRECT, external and internal facilitators held weekly 15-minute calls that fostered trust and group cohesion, allowing internal facilitators to be more forthright about implementation challenges as the relationship developed. External facilitators were available to staff as needed via e-mail and phone and sent reminder and motivational e-mails. Throughout the study, internal facilitators underscored the need for this personal, individualized support, which helped keep the project moving in the face of many competing demands. External facilitators also capitalized on the site visits, during which they assisted internal facilitators in attaining buy-in from their stakeholders by inviting these stakeholders to meetings about the study.

Because the internal facilitators were embedded in the research setting, they were able to notice subtle indications of implementation difficulties that escaped the notice of the external facilitators. Many internal facilitators discovered through huddles that CLC staff were initially resistant to using the QI tools because they did not have time or did not understand the rationale for their use. They used the huddles or just-in-time teaching to address these issues and increase staff participation, learning, for example, that they needed to continually remind staff to focus not on deficiencies but the bright spots they observed. Internal facilitators also noticed unexpected positive effects of the QI projects, for example, how staff began to appreciate their colleague's hard work and to enjoy receiving recognition for their own work. As a result, several internal facilitators reported an unexpected outcome of improved collegiality among staff.

DISCUSSION

This article briefly introduces the reader to blended facilitation as an implementation strategy and provides examples from DIRECT to demonstrate its application in a nursing home-focused QI and research initiative. More detailed resources exist for those interested in employing blended facilitation in their settings. These include the VHA's implementation facilitation training manual,¹⁹ recent studies^{18,29} and foundational papers on facilitation,^{15,27} and a relevant implementation framework.³⁰

Strengths and limitations of blended facilitation

Intentional use of blended facilitation has the potential to overcome many existing implementation barriers to implementing and sustaining QI and evidence-based practice in nursing homes. Its use enables staff as well as researchers to implement practical and effective interventions in real-world conditions. It may also help overcome existing barriers

to implementation and sustainment by underscoring the necessity of strategically and thoughtfully supporting different types of facilitation throughout the implementation of an innovation, including by fostering internal-external facilitator partnerships.

Even the most effective interventions lack merit if they are never used. With blended facilitation, the intensity of the facilitation can be varied to local capacity and, similarly, allows the implementation to be adapted, within reason, to the needs of the target nursing home. With this in mind, it is important that external facilitators always communicate and support the use of the critical, non-modifiable pieces of an innovation.³¹ The blended facilitation team should feel empowered to make deviations from a protocol when warranted for the success of the implementation (eg, providing unplanned training, creating ways of rewarding behavior, or suggesting protocol modifications that promote more accurate data collection among staff).

The use of blended facilitation is not without difficulties. Key challenges are the identification of appropriate nursing home stakeholders to serve as internal facilitators and ongoing engagement of staff who are often excluded from QI and research (eg, certified nurse assistants³²). Depending on clinical responsibilities and positions in the organization's hierarchy, internal facilitators may be directors of nursing, nurse managers, nurse educators, licensed nurses, certified nurse assistants, or non-nursing providers. Strong leadership from management and ongoing engagement of staff allow QI processes to become embedded into routine practices to improve resident care.³ Meaningful and ongoing engagement with nursing home leaders prior to the formal implementation period, therefore, is imperative for connecting with individuals to fill the internal facilitation role and for sustaining positive impacts of the QI and research efforts.

CONCLUSIONS

Synchronous use of external facilitation, internal facilitation, and relationship building and skill building was critical to the success of our CLC-based study. Although DIRECT was based in the VHA, the largest health care system in the United States, our approach to implementation may provide valuable insights into how QI and research can be facilitated at the local level within a large system. Blended facilitation holds much promise as an effective means to advancing nursing homes' organizational learning, QI, and research capacity. This is vital to ultimately enhancing nursing home quality. Blended facilitation may be a powerful tool for improving the quality of care in nursing homes.

Acknowledgments

The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs. This work was supported by the Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development, Health Services Research and Development (I01HX000797) and Rehabilitation Research and Development (IK2RX001241 to W.L.M.), and the National Cancer Institute (R25CA172009 to C.P).

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Facilitation at Different Stages of DIRECT Implementation

Table.

DIRECT Study Phase	Facilitation Activities	Involved Facilitators
Prior to QI/research study implementation	5-wk series of teleconferences, including individual "getting to know you" sessions	External and internal facilitators
During 6-mo QI/research study	Initial in-person site visit	External facilitator
	Weekly 15-min check-in phone calls	External and internal facilitators
	As-needed brainstorming sessions by phone to discuss specific implementation concerns Reminder/motivational e-mails	External and internal facilitators External facilitator
After close of formal study	Maintenance of QI activities	Internal facilitator

Abbreviations: DIRECT, Developing and Implementing Resident-centered Efforts in Cultural Transformation. QI, quality improvement.