U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality
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Introducing AHRQ's New Practice Facilitation Curriculum

August 25, 2015

3:00 – 4:00 pm ET

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Welcome and Overview of AHRQ and Practice Facilitation

Bob McNellis, MPH, PA

Senior Advisor for Primary Care

Agency for Healthcare Research and Quality

Overview

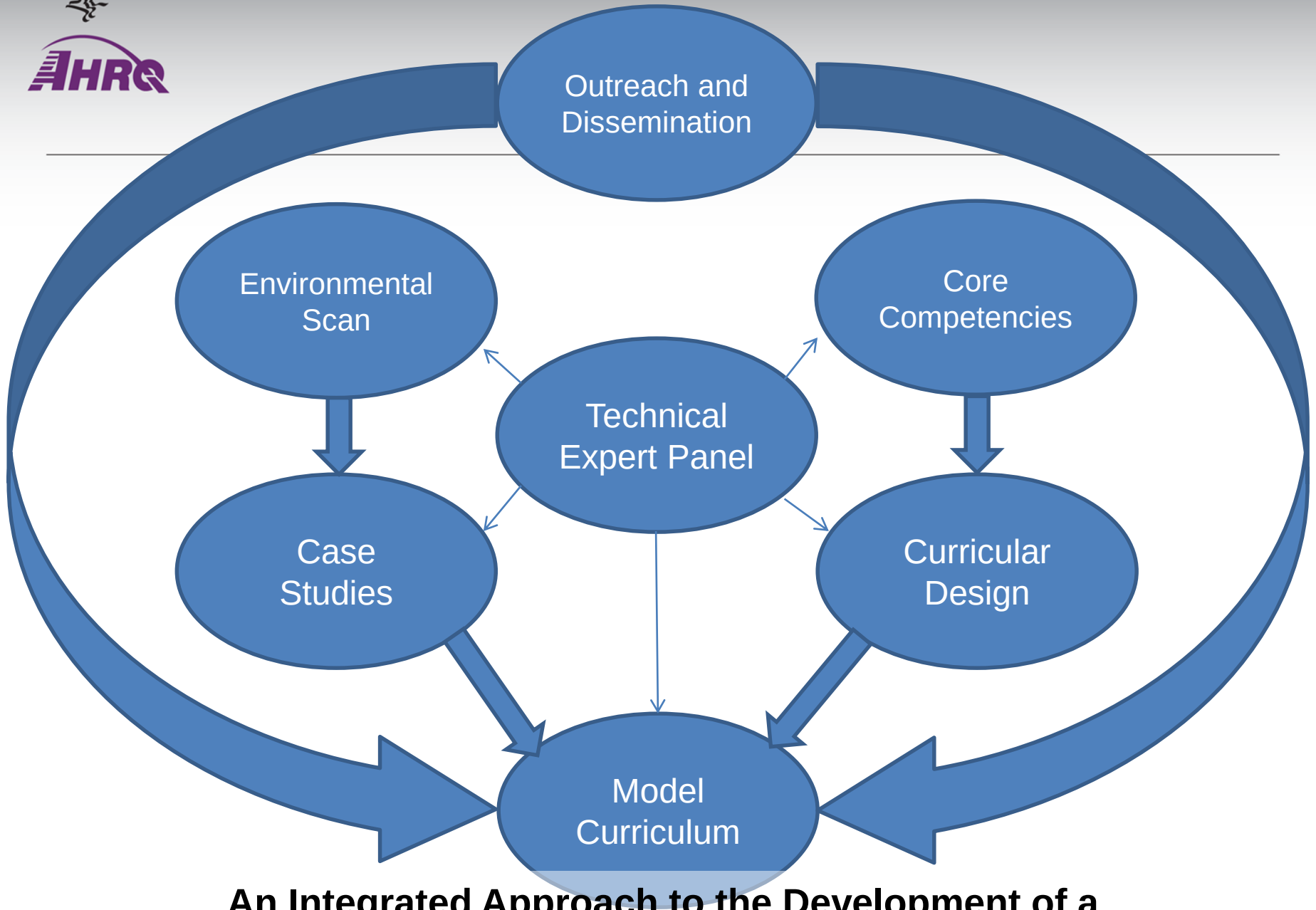
- AHRQ's mission focuses on safety, quality, accessibility, equity and affordability.
- A robust primary care system is the foundation for a health care system that delivers high-quality, affordable health care
- Primary care needs an infrastructure to support practice transformation and quality improvement
- Practice facilitation is an evidence-based strategy to assist practice change and QI

Building Quality Improvement Capacity in Practice

Taylor, Genevro, Peikes, Geonnotti, Wang and Meyers. *Building Quality Improvement Capacity in Primary Care: Supports and Resources*. AHRQ, 2013

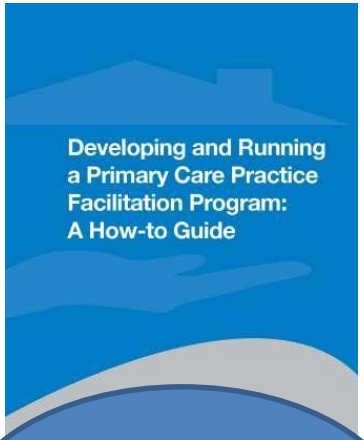
Development of an Expanded Curriculum for PF training

- Objective
  - Provide entry-level training for PFs to assist primary care practices in achieving their quality improvement and transformation goals
  - Builds upon AHRQ's Practice Facilitation Handbook
- Key Characteristics
  - Able to be delivered in-person or online
  - Links with competencies and includes specific learning objectives
  - Instructor's guide including guidance for assessment
  - Student materials and other supporting information



An Integrated Approach to the Development of a Model Curriculum for Practice Facilitators

AHRQ's Portfolio of Practice Facilitation Products

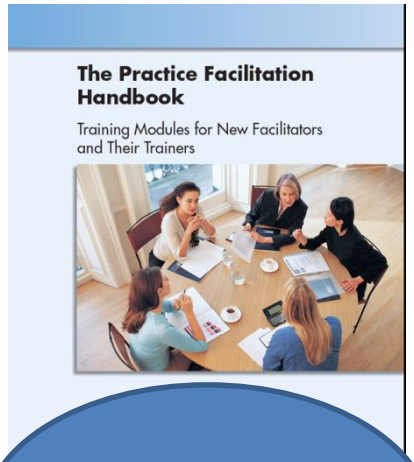


How to Guide

Support for organizations interested in starting PF programs

"Expanded," competency-based curriculum for training entry-level practice facilitators

Model Curriculum



PF Handbook

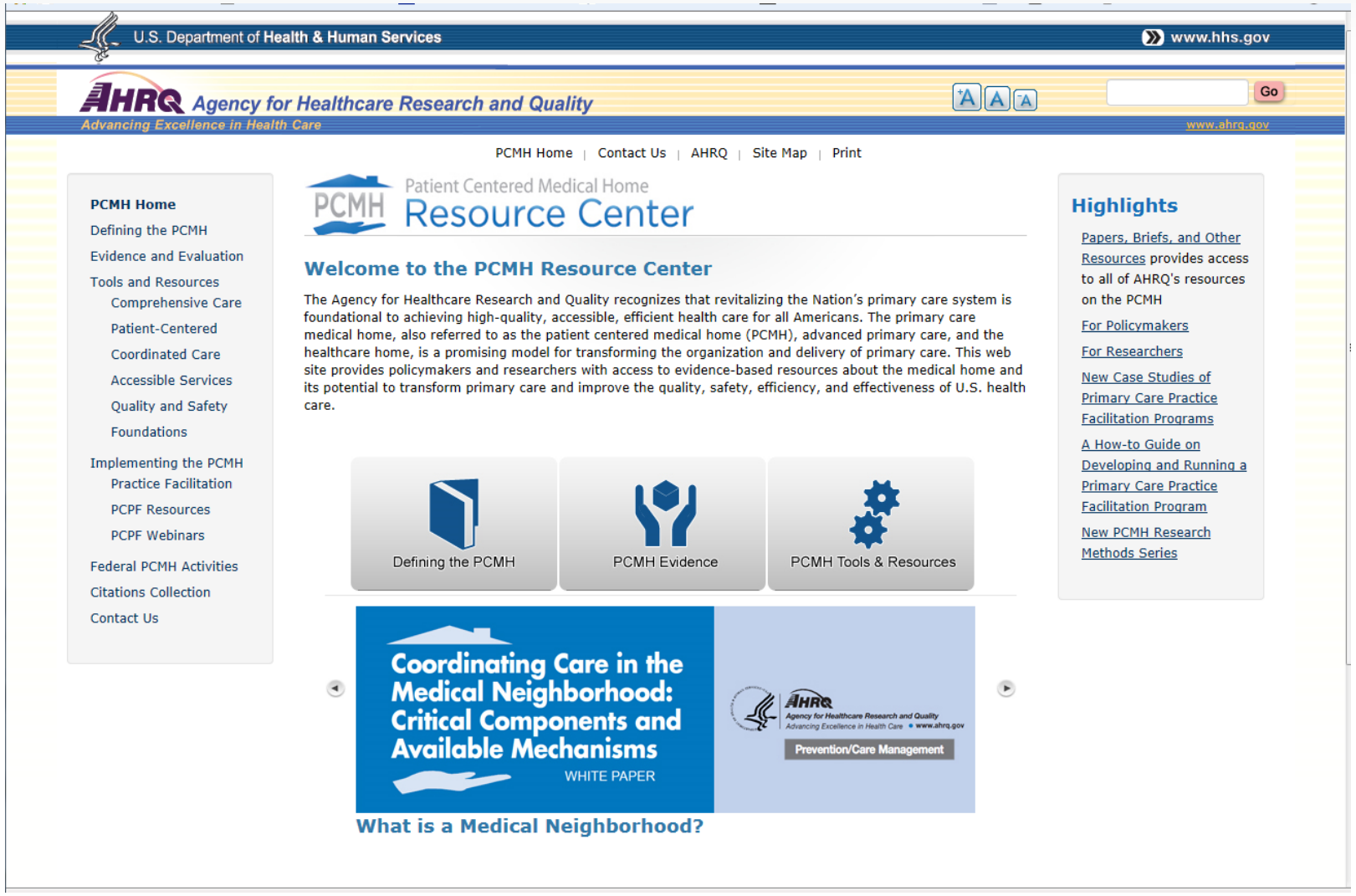
Essentials for teaching and learning the knowledge and skills for a new PF

Other New Primary Care QI Products

Creating Patient-Centered Team-Based Primary Care

Coming soon!

PCMH Resource Center



http://www.pcmh.ahrq.gov/

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Agenda for the Webinar

- Welcome and Background (10 minutes)
- Development of the expanded PF Curriculum (10 minutes)
- Module Instruction (25 minutes)
- Moderated Q & A (10 minutes)
- Wrap up (5 minutes)

Today's Speakers

- **Bob McNellis, MPH, PA**
  - Senior Advisor for Primary Care, AHRQ
- **Jay Crosson, PhD**
  - Senior Researcher, Mathematica Policy Research
- **Lyndee Knox , PhD**
  - CEO, LA Net Community Health Resource (PBRN)

Today's Speakers

Jay Crosson, PhD
Senior Researcher
Mathematica Policy Research

Overview

- **What is a Practice Facilitator?**
  - Practice facilitators are specially trained individuals who work with primary care practices “to make meaningful changes designed to improve patients’ outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment” (DeWalt, Powell, Mainwaring, et al., 2010).

Prior Work on Which This PF Curriculum is Built

- AHRQ 2010 Consensus Meeting on Practice Facilitation for Primary Care Improvement
- Developing and Running a Primary Care Practice Facilitation Program (2011)
- Practice Facilitation Handbook (2013)
- Case Studies of Exemplary Primary Care Practice Facilitation Training Programs (2014)

PF Knowledge and Skills Domains

- **Foundational knowledge**
  - Improving primary care, organizational change, PCMH principles, primary care environment
- **General skills**
  - Basic QI methods, practice assessment, meeting management
- **Specialized skills**
  - Use of health information technology, work process engineering
- **Professional skills, knowledge, and commitment**
  - Effective communication, building trust, life-long learning

Today's Speakers

Lyndee Knox, PhD

CEO

LA Net Community Health Resource Network

Audiences and Uses

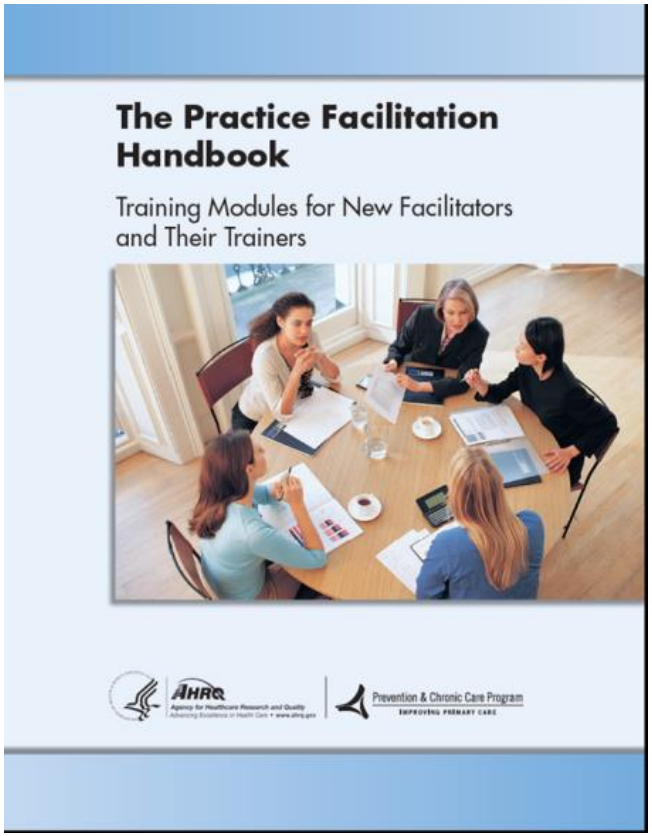
- **New practice facilitators from varied backgrounds**
  - With and without clinical backgrounds
- **Self-assessment**
  - Can be used to individualize the training program for each PF
- **Delivery methods**
  - On-line webinars, learning sessions
  - Stand-and-deliver
  - Self-study
  - Co-training of PF and practices together
- **Foundational element of a multi-component training program**
  - **Foundation: Modules**
  - Add: program-specific content (hypertension improvement, etc.)
  - Add: program specific slide decks and resources
  - Add: field experience/preceptorship
  - Add: learning community (or joining AHRQ listserv)

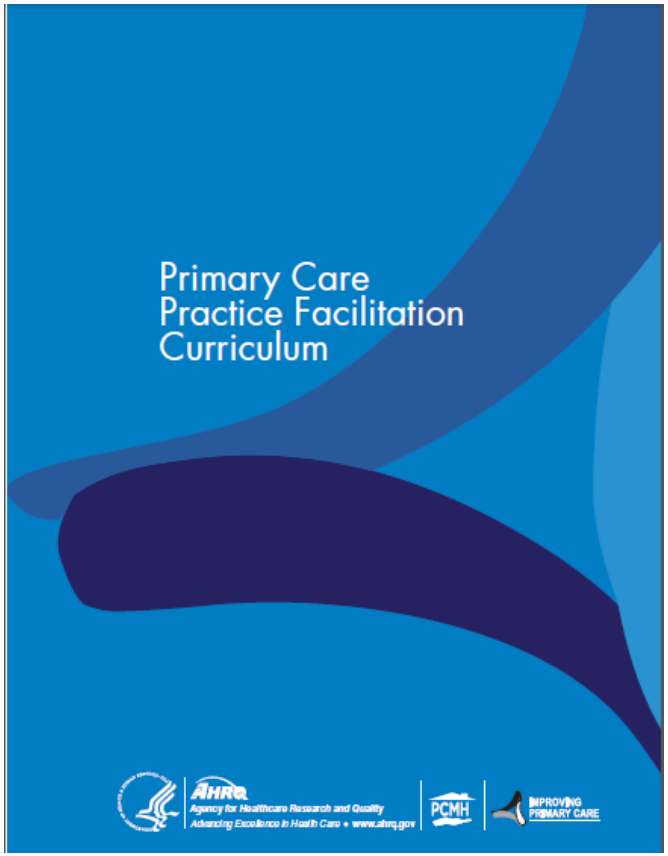
Example of Use of a Similar Resource - PF Handbook

- **Millard Fillmore College PF Certificate Program**
  - Collaboration between the PBRN community & university adult education program (SUNY Buffalo)
  - 2-hour sessions, 1x a week using “Blackboard”
  - 10-30 students at a time
  - Lead faculty member: June Levine
  - Guest speakers
  - Foundation: Modules in PF handbook
    - Added: slides
    - Added: specialized content requested by students
    - Added: assessments
    - Added: group “chat” between sessions
    - Added: 1-week field placement at a “qualified site” w/ trained PF

Millard Fillmore College PF Certificate Program

Module 30: Building Teams in PC





Module 30: Building Teams in PC

- **How identified as competency**
  - TEP
  - Experienced PFs
  - Practice leaders
  - Alignment with PCMH
- **How content developed**
  - TEP
  - PF input
  - Environmental scan of already existing resources
  - Adaptation of Tom Bodenheimer's excellent work in this area

Module 30: Building Teams in PC

Module 30.

Teams and teamwork are a vital part of every primary care practice, no matter how small or large the practice. The functioning of these teams plays a large role in the quality of care and patient experience with care, as well as the morale and job satisfaction of clinicians and other staff in the practice. Moreover, the increased focus on team-based care in the past several years means that teams are more important than ever in primary care.

One of your roles as a practice facilitator (PF) is to help these teams improve h and work together to accomplish their goals. This module will introduce the in need to help these practice teams work well together. In this module, you will

- The basics of team formation and functioning.
- The types of problems that prevent teams from accomplishing their goa
- Some basic methods for helping teams improve their effectiveness.

Moreover, this module provides additional information and resources that you practices to optimize this essential team. This module is a companion to Modu Implementing Care Teams, which you should complete before beginning this

Ways That PFs Can Help Practices Improve Their Teams Teamwork

You will find many types of teams within a primary care practice. The most ob to the patient centered medical home are *patient care teams*, which are often n

Common Challenges Faced by Primary Care Teams

As a PF, you should be familiar with the types of problems that can affect the effectiveness of care teams. Even if the practice has not engaged you specifically to address these issues, it is important for you to keep aware of them, given how central teams are to all aspects of the PCMH and practice functioning. In fact, they affect almost every aspect of the practice from who is hired, to staff training, workflow, IT, and patient experience.

Primary care teams face a number of common challenges.

The first is the **complexity of primary care itself**. The sheer scope of care and range of patient issues that care teams need to be able to address can make it challenging to define a manageable list of tasks and roles. Different workflows, processes, and teamwork can be required for different types of patients (pediatric, adult, elderly) and visits (wellness, acute, chronic).

What payers will allow practices to bill for can create another barrier to teamwork. For example, in some instances, visits with physicians, nurse practitioners, and physician assistants are billable, but visits with other types of professionals on the team may not be. This can create a disincentive to

Example of Care Team Principles from the Cambridge Health Alliance

Every patient is assigned to a care team that, at the very least, includes a primary care clinician, nurse, medical assistant, and receptionist.

The team huddles daily to care for patients in a proactive way.

The teams meet at least monthly to proactively manage the work of population health and to discuss high-risk patients. At most sites, teams meet weekly or biweekly.

The usual care team interfaces seamlessly with the complex care management team.

Module 30: Building Teams in PC

- **A. Instructor's guide**
  - Learning resources (articles, TED & other videos)
  - Objectives
  - Exercises to do in class or self-study
- **B. Module Content**
  - Overview of key concepts
- **C. Resources**
  - Links to valuable resources

Module 30: Building Teams in PC

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Meeting management
- Leadership coaching
- Basic quality improvement skills
- Change management

Time

- Pre-session preparation for learners: 1-2 hours
- Session: 1 hour

Objectives

After completing this module, learners will be able to:

1. Describe the role of the practice facilitator in optimizing teams in primary care practices.
2. Discuss how this work may differ based on the size of the practice and the type of team (clinical vs. nonclinical).
3. Discuss the five characteristics of effective teams and the relevance of each to primary care practices.
4. Use the Waterline Model to engage practice team members in self-assessment and reflection.
5. Deliver a short training on the characteristics of high-functioning care teams and common problems faced by these teams.
6. Access select online resources that are appropriate for helping a care team optimize its functioning.

Module 30: Building Teams in PC

Exercises and Activities To Complete Before and During the Session

Pre-session preparation. Ask the learners to read, review, or watch the following items. (1-2 hours)

1. The content of this module.
2. Module 29, Implementing Care Teams, which should be reviewed for the principles and processes of team-based care as a core element of the patient-centered medical home.
3. Video on the Waterline Model. Available at: https://www.youtube.com/watch?v=XTIBvQh3_zQ.
4. TED video on the marshmallow teambuilding exercise and lessons learned. Available at: http://www.ted.com/talks/tom_wujec_build_a_tower?language=en
5. Mitchell P, Wynia M, Golden R, et al. Core Principles & Values of Effective Team-based Health Care. Washington, DC: Institute of Medicine; 2012. Available at: https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-values.pdf.

During the session. Presentation (15 minutes)

1. Present key concepts from the module.

Activity for learners. (45 minutes)

1. Divide into groups of three or four. Assign roles: Practice Facilitator and Participants.
2. Have members of each group share details about a team they have been part of.
3. Have one member of each group lead a conversation about whether or not these teams were effective and why, using the "five features of effective teams" model.
4. Have Practice Facilitator report out findings to the larger group for discussion of common findings.

Excerpt: Table 30.1 - Bodenheimer's Characteristics

- **Characteristics of High-Performing Primary Care Teams**
  - High-performing care teams in primary care practices share a number of characteristics including:

    - A stable team structure
    - Co-location (i.e., team members are located in the same physical location)
    - A shift in culture to "share the care"
    - Defined roles with training and skills checks to reinforce these roles
    - Use of standing orders and protocols
    - Use of workflow mapping to clearly define workflows
    - Adequate staffing ratios for supporting new roles
    - Ground rules
    - Defined methods for communicating (e.g., regular team meetings, huddles, minute-to minute interactions)

(Bodenheimer, personal communication November 2014; Mitchell et al., 2012; Bodenheimer, 2007; Mickan & Rodger, 2000).

Excerpt: Care Team Principles and Resources to Optimize Functioning

Example of Care Team Principles from the Cambridge Health Alliance

Every patient is assigned to a care team that, at the very least, includes a primary care clinician, nurse, medical assistant, and receptionist.

The team huddles daily to care for patients in a proactive way.

The teams meet at least monthly to proactively manage the work of population health and to discuss high-risk patients. At most sites, teams meet weekly or biweekly.

The usual care team interfaces seamlessly with the complex care management team.

Resources for Helping Care Teams Optimize Functioning

Improving Primary Care: Team Guide is available at:
http://www.improvingprimarycare.org/team

TeamSTEPPS:
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/index.html

TeamSTEPPS videos

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/video/index.html

Excerpt: Table 30.2 - Resources for PFs

Table 30.2 Resources for practices to use in engaging patients

Shared decision making

AHRQ's Shared Decision Making Toolkit, available at:
http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html.

Engaging effectively with low literacy and low health literacy patients

AHRQ's Health Literacy Universal Precautions Toolkit, available at:
http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html.

Engaging patients in redesigning care delivery

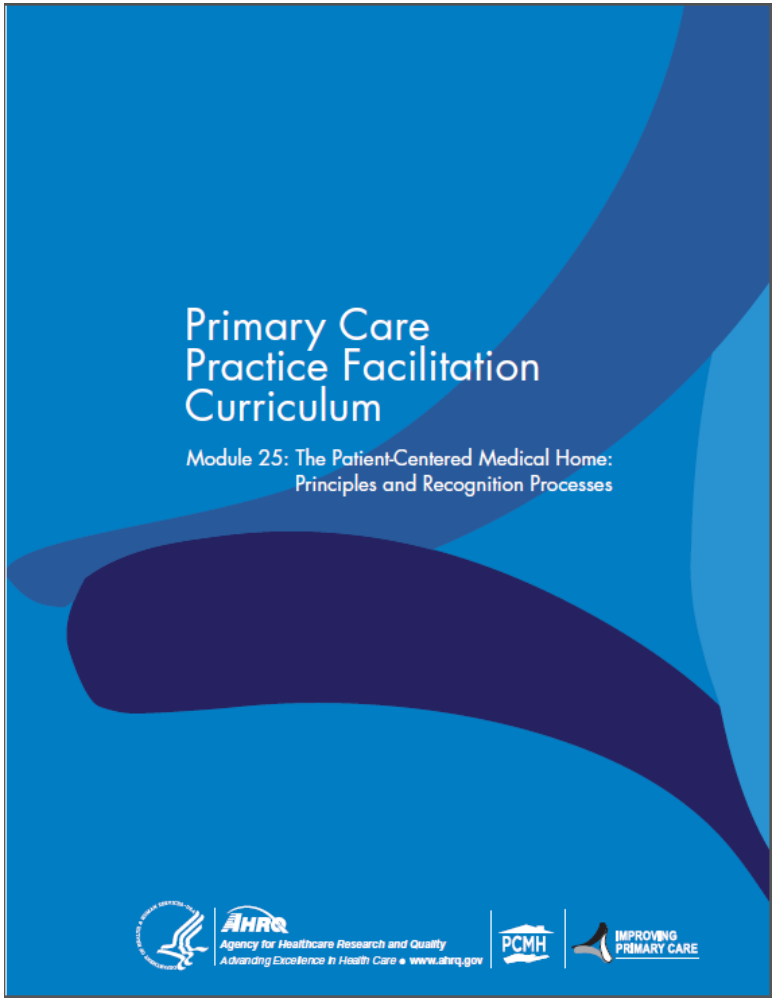
Partnering with patients to redesign care, see:
http://www.hipxchange.org/patientengagement .

Experienced-based redesign, see:
http://www.kingsfund.org.uk/projects/ebcd.

Example of Use: LA Net Network Practices and PFs

- Announced via PBRN listserv
- Sent module 1-week prior and asked to do “pre-work”
- Sent link to webinar platform – “noon” training
- Experienced PF moderated & delivered training
- Modified activity for use on-line
- Sent on-line survey to learners to “evaluate” the session & make recommendations for improvement

Module 25: The PCMH: Principles and Recognition Processes



Module 25: The PCMH: Principles and Recognition Processes

Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Foundational knowledge in the principles of the patient centered medical home (PCMH)

Time

- Pre-session preparation for learners: 60 minutes
- Session: 75 minutes

Objectives

After completing this module, learners will be able to:

1. Describe the five core principles and functions of the PCMH.
2. Describe the main PCMH recognition programs, as well as the factors that should be considered when a practice selects a recognition program.
3. Locate resources available for ongoing PCMH initiatives.
4. Describe the major PCMH payment models currently in use.
5. Locate sources to stay apprised of new developments related to the PCMH.

Module 25: The PCMH: Principles and Recognition Processes

- **Comprehensive care.** The PCMH is oriented toward the "whole person" and is responsible for addressing all the patient's physical and mental acute, chronic, and preventive health care needs. This involves the direct provision of the appropriate care when possible or arranging for other qualified professionals (such as specialists) to provide care when necessary. Care within the primary care setting is delivered by a team rather than a single clinician, so professionals with different skill sets are available to meet the patient's needs. (Module 28 has more information on team-based care and working with practice teams.)
- **Patient-centered approach.** The PCMH provides care that is relationship based and tailored to best meet each patient's needs, values, culture, and preferences. Each patient has the opportunity to build ongoing, trusting relationships with a team of health care professionals. Clinicians seek to engage patients in their health care; provide the support, education, and information they need to make informed health care decisions; and recognize them as important members of the care team. PCMH clinicians and health care professionals use their cultural competence to treat patients with dignity, respect, and compassion, and they seek to meet patients where they are so that care is delivered in the way that best suits the patient's needs.
- **Coordinated care.** All of a patient's health care is coordinated by the PCMH, including care received in hospitals, from specialists (including mental and behavioral health specialists), and through community or home-based services and supports. Coordination of care may be facilitated by patient registries, use of health information technology (such as electronic health records), and other methods. To ensure that care is properly coordinated, the PCMH strives to build strong communication with patients and among all members of a patient's care team. The goal of coordination is greater efficiency through avoidance of duplication of services, synchronization of services so that they have a maximum impact, and ensuring connection of patients to needed services.
- **Accessibility of services.** To ensure that patients are able to access care when they need it, the PCMH offers short wait times for urgent care, enhanced hours, and around-the-clock access to the care team via telephone or electronic methods (email, patient portal, etc.). Care teams also seek out and respond to patient preferences regarding access and communication (e.g., whether patients prefer to communicate via email or telephone, and what language they prefer to use when getting care).
- **Quality and safety.** To achieve optimal patient health outcomes and the highest quality of care, the PCMH is committed to quality improvement (QI), performance improvement, patient satisfaction, and population health management. Practices use evidence-based medicine and decision support tools to guide shared decisionmaking and use patient registries to track the health status of their entire patient panel. Practices use data-driven QI methodologies to continuously monitor performance in a variety of care areas. Patients are engaged in QI processes and involved in practice decisionmaking to ensure

Table 25.1. Four patient centered medical home recognition programs

Selected Patient Centered Medical Home Recognition Programs			
Accrediting Body	**Recognition Program**	**Program Elements**	**Resources**
The National Committee for Quality Assurance	Patient Centered Medical Home 2014 Standards	• Patient-centered access • Team-based care • Population health management • Care management and support • Care coordination and care transitions • Performance measurement and quality improvement	http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
URAC (formerly the Utilization Review Accreditation Commission)	Patient Centered Medical Home Accreditation Version 2.0	• Quality care management • Patient-centered operations management • Access and communications • Testing and referrals • Care management and coordination • Electronic capabilities • Quality performance reporting and improvement	https://www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/
Accreditation Association for Ambulatory Health Care	2013 Medical Home Standards	*Not publicly available.*	http://www.aaahc.org/en/accreditation/primary-care-medical-home/
The Joint Commission	Primary Care Medical Home 2014 Standards and Elements of Performance	*Not publicly available.*	http://www.jointcommission.org/accreditation/pchi.aspx

Questions?

- Please use the Q&A widget at the bottom of your webinar screen to submit your questions

Wrap Up and Next Steps

- New, expanded Primary Care Practice Facilitation Curriculum
  - http://www.pcmh.ahrq.gov/page/primary-care-practice-facilitation-curriculum
- For more information…
  - Subscribe to PF listserv
    - PracticeFacilitation@mathematica-mpr.com
    - Include “subscribe” in the subject heading
- Listen to any of our first five webinars in the series:
  - PF Case Studies,
  - Use of Health IT,
  - Supporting Patient Safety
  - Patient Engagement, or
  - Introducing the PF Curriculum
- Case studies of exemplar PF training programs available online
  - http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfcasestudies/index.html