

Case Studies

of EXEMPLARY PRIMARY CARE
PRACTICE FACILITATION
TRAINING PROGRAMS



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov



Prevention & Chronic Care Program
IMPROVING PRIMARY CARE

CASE STUDIES OF EXEMPLARY PRIMARY CARE PRACTICE FACILITATION TRAINING PROGRAMS

As part of its ongoing commitment to practice improvement, the Agency for Healthcare Research and Quality has developed resources and products to support the use of practice facilitation in primary care settings (www.pcmh.ahrq.gov/page/practice-facilitation). A growing body of evidence indicates that practice facilitation, which is based on the creation of an ongoing, trusting relationship between an external facilitator and a primary care practice, is an effective strategy to improve primary health care processes and outcomes. Practice facilitation activities may focus in particular on helping primary care practices become patient-centered medical homes, but they can also help practices in more general quality improvement and redesign efforts.

As part of its work in this area, AHRQ commissioned Mathematica Policy Research to conduct case studies of three exemplary practice facilitation training programs in the United States and describe their formation, operation, and curricula. The three programs, which vary in location, administrative homes, and organizational and training models, were selected based on results of an environmental scan of existing practice facilitation training programs and nominations from the field.

We hope that these case studies will be useful to groups and individuals who are developing or improving primary care practice facilitation programs; trainers and students in existing programs; and other members of the primary care community, including clinicians and policymakers.

We are deeply grateful to the case study participants from the three exemplary programs for their time and significant contributions to this work:

Health TeamWorks Coach University

Marjie Harbrecht, M.D., Chief Executive Officer, HealthTeamWorks

Jennifer Snyder, R.N., M.S.H.S., NEA-BC, Regional Director - East Coast, HealthTeamWorks

Kelly Bowland, M.S.M., Education and Training Manager/Quality Improvement Coach, HealthTeamWorks

Ballard Pritchett, M.B.A., Sales and Marketing Consultant and Strategist, HealthTeamWorks

Millard Fillmore College Practice Facilitator Certificate Program

Larry Gingrich, Associate Dean, The State University of New York at Buffalo, Millard Fillmore College

Lyndee Knox, President, L.A. Net Community Health Resource Network

June Levine, Instructor - Practice Facilitator Certificate Program, The State University of New York at Buffalo, Millard Fillmore College

Diana Anderson, Practice Enhancement Assistant at The State University of New York at Buffalo, Department of Family Medicine



Deborah Kane, Program Manager, The State University of New York at Buffalo, Millard Fillmore College

Jeremiah Grabowski, Online Programs Coordinator, The State University of New York at Buffalo, School of Public Health and Health Professions

Chester Fox, Professor of Family Medicine, The State University of New York at Buffalo, Department of Family Medicine

Practice Coach Training for the North Carolina AHEC Practice Support Program

Ann Lefebvre, M.S.W., CPHQ, Associate Director, Statewide Quality Improvement, NC AHEC Program, University of North Carolina at Chapel Hill

CASE STUDIES OF EXEMPLARY PRIMARY CARE PRACTICE FACILITATION TRAINING PROGRAMS: OVERVIEW

The purpose of these case studies is to describe in detail the formation, operation, and curriculum of three exemplary Primary Care Practice Facilitation (PCPF) training programs. The case studies were selected based on results of an environmental scan of existing PCPF training programs and nominations from leaders in the field. As a group, the programs reflect varying geographies, administrative homes, and elements of PCPF organizational and training models. We profile the following training programs:

- ▲ HealthTeamWorks' Coach University
- ▲ Millard Fillmore College Practice Facilitator Certificate Program
- ▲ North Carolina Area Health Education Center (AHEC) Practice Support Program training

Characteristics of PCPF training programs selected for case study

	HealthTeamWorks' Coach University	Millard Fillmore College Practice Facilitator Certificate Program	North Carolina AHEC Practice Support Program Training
Host organization name	HealthTeamWorks	State University of New York at Buffalo—Millard Fillmore College	North Carolina Area Health Education Center
Organization type	Nonprofit quality improvement organization	Continuing education college	State workforce program
Year started	2010	2013	2006
How curriculum content is determined	Adapted to clients enrolled in training	Standardized curriculum, updated and refined over time	Adapted to internal staff needs
Sample areas of training	Quality improvement methods, care coordination, population management, using evidence-based guidelines, meeting facilitation, problem solving, and health information technology systems	Quality improvement methods; collection, analysis, and use of data to improve performance; meaningful use of electronic health records; meeting facilitation and team building; and practice assessment	Clinical improvement consulting, practice system redesign and innovation, National Center for Quality Assurance patient-centered medical home recognition, electronic health record incentive program consulting, and practice management consulting
Delivery mode(s)	In-person training	Online	Video conferencing Webinars and in-person trainings
Duration and intensity	One-week boot camp plus yearlong followup period	13 weekly sessions at 90 minutes per session plus 40 hours of fieldwork preceptorship	One-day orientation plus tandem site visits, monthly Webinars, and ongoing training
Average class size	6 to 15	14	NA
Faculty	Faculty are HealthTeamWorks coaches	Course instructor and 2 or 3 guest speakers per session	3 regular course instructors and 6 or 7 outside experts
Availability of training	External, but only for organizations that contract with HealthTeamWorks	External (bachelor degree and relevant experience required)	Internal, coaches hired by the North Carolina AHEC program

	HealthTeamWorks' Coach University	Millard Fillmore College Practice Facilitator Certificate Program	North Carolina AHEC Practice Support Program Training
Tuition	Incorporated into organization's quality improvement contract with HealthTeamWorks	\$4,000	NA
Number of trainees to date	Nearly 100	28	70

NA = not applicable.

Training Program Summary: HealthTeamWorks' Coach University

Strong training is key to developing effective practice facilitators or coaches to support improvements in primary care practices. This case study profiles Coach University, a training program offered by HealthTeamWorks, a nonprofit organization located in Lakewood, Colorado. Coach University has trained almost 100 coaches since it began in 2010 and is considered one of the leading medical-practice coach training programs in the country.

The program offers several lessons for others interested in developing and delivering training for practice facilitators, such as:

- ▲ Effective practice facilitator training relies not only on knowledge of practice transformation topics and techniques but also on skills related to relationship building, complex adaptive change (adapting to multiple changes occurring at the same time), and culture change.
- ▲ A practice facilitator training program requires full-time leadership and committed faculty, all of whom have real-world experience working with practices.
- ▲ Keeping a practice facilitator training curriculum current and reflective of policy shifts and industry changes is crucial.
- ▲ Practice facilitator training that includes both direct instruction and experiential learning methods has significant benefits.
- ▲ Using a variety of practice facilitators as faculty is important in order to expose the trainees to different perspectives and teaching styles.
- ▲ Delivering practice facilitator training at the right level for trainees of varying backgrounds often requires on-the-fly faculty adjustments to the content and delivery of the curriculum.
- ▲ Trainees have a wealth of knowledge and experience that provides opportunities for peer-to-peer learning.
- ▲ Offering ongoing support and networking opportunities to new coaches after training benefits their long-term development.
- ▲ Helping coaches work effectively within their specific contexts is an important part of helping trainees succeed.

I. Background and history of Coach University

Coach University is a coach training program created and run by HealthTeamWorks. Various organizations, including health plans, health care delivery systems, and practices send staff to the program to be trained as coaches. Staff trained through Coach University then return to their sponsoring organizations prepared to function as a practice facilitator or coach, with ongoing support from the HealthTeamWorks network of experienced coaches.

Since 2006, HealthTeamWorks has offered coaching services. Initially, the organization worked with the national boards and societies of primary care providers through a program called Improving Performance in Practice (IPIP), under the leadership of the American Board of Medical Specialties. Through grants from the Robert Wood Johnson Foundation, the Colorado Department of Public

Health and Environment, and others, primary care practices in Colorado were able to work with trained facilitators from HealthTeamWorks who provided onsite help with quality improvement strategies. As HealthTeamWorks scaled up this program to offer coaching services to practices outside Colorado, the organization began to consider how to support sustained practice transformation after HealthTeamWorks staff left a particular practice. As a result, HealthTeamWorks developed a collaborative coaching model in which organizations send their own staff members to be trained as coaches in addition to receiving direct coaching from HealthTeamWorks coaches. As local coaches gained more experience and confidence under the guidance of HealthTeamWorks coaching, they would take on more responsibility until, eventually, they became the primary practice coach with less direct guidance needed.

In 2010, HealthTeamWorks developed Coach University to bring together groups of trainees for a weeklong educational program (referred to as *boot camp*) that focused on the knowledge and skills needed to be a successful practice facilitator. The development of Coach University allowed HealthTeamWorks to work with several trainees at once, which made it possible for trainees to benefit from the knowledge and experiences of the entire group. After boot camp, each trainee has access to 1 year of individualized support from HealthTeamWorks coaches, staff, and resources. This support is tailored to each trainee and can include mentoring by a HealthTeamWorks coach, participating in Webinars, and having access to the learning network of HealthTeamWorks coaches and other former students.

II. High-level design of Coach University

The mission of Coach University is to achieve sustainable practice transformation by teaching key people within health care organizations to facilitate continuous quality improvement. This educational process includes two main components:

1. Teaching the technical information necessary to facilitate transformation, including the principles of the patient-centered medical home (PCMH).
2. Developing the change management and relationship-building skills needed to successfully facilitate transformation to a culture of continuous quality improvement.

HealthTeamWorks leaders describe these two components as “the information side” and “the human side,” respectively, and consider Coach University to be successful if those who complete it not only are well informed about practice transformation and can convey information to others but also are skilled at working with people at every level of a practice. They note that knowledge alone won’t bring about practice transformation; rather, “transformation happens with people.”

“Education [of practice coaches] has both ‘the information side’ and ‘the human side.’ The human side involves the skills needed to build relationships, [as well as] facilitation skills. Coach University tries to further both the information and the human sides. And if we’re successful, the people that do this program for a year are informed . . . but are also skilled at working with people, because transformation happens with people.”

—HealthTeamWorks sales and marketing consultant and strategist

Coach University trainees are trained in two stages. First, trainees attend a weeklong boot camp at HealthTeamWorks headquarters in Colorado. This stage includes classroom learning as well as visits to practices engaged in quality improvement initiatives. After boot camp concludes, trainees receive a year of followup support from HealthTeamWorks coaches while they are beginning the process of facilitating practice transformation within their organizations. This support can range from Webinars on new subjects in the field (such as updated clinical practice guidelines or details on new health information technologies [IT]) to more individualized support tailored to the needs of the trainee.

III. Training program description

A. Program content

HealthTeamWorks leaders consider the joint principles of the PCMH, along with other quality improvement methods, to be foundational subjects taught during Coach University. Within this broad subject area, key topics include care coordination, care management, population management, and use of evidenced-based guidelines. Other areas of focus vary by client needs. For instance, HealthTeamWorks incorporated information on behavioral health integration when it began working with trainees from a large behavioral health plan. In addition to deepening their knowledge in these foundational subjects, Coach University participants also undergo training in technical and interpersonal skills necessary for their work, such as effective meeting facilitation, problem solving, extracting data from health IT systems, using these data for quality improvement, conducting practice assessments, and engaging in process improvement.

Consistent with the idea that transformation happens with people, Coach University emphasizes the development of interpersonal and relationship-building skills. These skills include the ability to communicate and work with a wide range of people—everyone from the CEO of a hospital system to a front-desk staffer in a practice—to help engage the entire organization in the transformation process.

Coach University objectives for trainees:

- Understand how the Model for Improvement is used with primary care practices and be able to apply concepts such as AIM statements, plan-do-study-act (PDSA) cycles and process mapping.
- Be able to identify how the Chronic Care Model relates to their own program's goals and understand how to use it to help their practices achieve program and/or program-level goals.
- Have a basic understanding of the main principles and functions of patient registries.
- Be familiar with the types of data and terminology for population management.
- Understand how information is captured and analyzed, which data analysis techniques are best for various situations, and how to use data to improve performance.
- Have the ability to use leadership concepts to facilitate team change, manage conflict and resistance, and run effective meetings.

<http://www.healthteamworks.org/coach-training/trainingobjectives.html>

Trainees must learn how to help both leadership and staff understand what practice transformation is, convey why and how a practice should transform, and provide them with the tools needed to undergo the transformation process and sustain the changes made. Interactive classroom exercises, as well as visits to practices engaged in quality improvement efforts, help trainees learn strategies to build multiple levels of relationships, including relationships with the wider organization or system (for example, a large hospital system), the practices within that organization or system, and individuals on the quality improvement team.

HealthTeamWorks primarily measures trainees' learning through pre-training and post-training assessments of key competency areas at the start and end of boot camp. In addition, HealthTeamWorks staff members observe trainees in the field during their 1 year of followup support and make recommendations for professional development during this time.

B. Program delivery

Coach University begins with a 1-week boot camp, offered three to four times a year, in which 6 to 15 trainees (ideally, 8 to 12) gather for intensive, in-person training. HealthTeamWorks leaders value the professional and life experiences each trainee brings to the training and aim to gather trainees from a range of backgrounds with a variety of skill sets so that trainees actively learn from each other within the classroom. To facilitate learning, HealthTeamWorks leaders encourage storytelling and interactive learning among the participants. Group size is a key ingredient in facilitating peer-to-peer learning. Large groups make it challenging for staff to engage in interactive classroom exercises while giving each trainee the individual attention he or she needs, and very small groups limit shared experiences. All Coach University faculty members are experienced coaches and bring a variety of perspectives to the classroom. HealthTeamWorks leaders note that the opportunity to interact with professional coaches with differing styles and perspectives allows trainees to see that there are many good approaches to coaching and that no one approach is the ideal.

HealthTeamWorks leaders believe the ideal size for its intensive in-person coaching class is 8 to 12 students, which allows for a variety of perspectives and experiences among students but maintains the ability for peer-to-peer learning and interaction.

Coach University's boot camp includes classroom instruction along with visits to practices to illustrate real-world applications of lessons. Within the classroom, faculty members use a mix of direct instruction and experiential approaches designed for participants to apply newly acquired knowledge and build coaching skills. For example, role playing is used to help trainees apply new knowledge and develop relationship-building skills. Trainees simulate a quality improvement meeting with Coach University faculty, playing the roles of quality improvement team members to practice using meeting facilitation skills, such as bringing a disengaged person into the conversation and managing an individual who dominates a conversation. The boot camp also includes opportunities to shadow a HealthTeamWorks coach as he or she works within a practice. During these visits to practices, trainees are given a tour of the facility and observe and assess various quality improvement processes being used within the practice. While on site, trainees either observe a quality improvement team meeting facilitated by the HealthTeamWorks coach or have the opportunity to talk with various members of the practice staff (such as physicians, practice managers, nurses, and front-line staff) to hear their perspectives on practice transformation work.

After boot camp concludes, all Coach University trainees continue to receive some level of support throughout the year through the collaborative coaching model. HealthTeamWorks notes that the level of followup varies by trainee, with some speaking with HealthTeamWorks staff once a month and others wanting more intensive support. This support can include mentoring by a HealthTeamWorks coach as well as access to the broader HealthTeamWorks learning network of coaches and trainees. Through this learning network, trainees can pose questions by email or phone to the HealthTeamWorks coaching staff, who then reach out to others to locate answers if needed. In some cases, HealthTeamWorks coaches might put trainees in contact with other coaches who have experience working in similar practices and facing similar challenges. In this way, HealthTeamWorks coaches help trainees build their professional support networks. Recent trainees often tap into the learning network for specific needs—for example, advice before they go into a difficult meeting or more extensive information on a topic or skill covered during boot camp. Another form of ongoing support of recent trainees is HealthTeamWorks’ Webinars on specific skills or knowledge.

IV. Trainees

Trainees typically come to Coach University because their employer has a contract with HealthTeamWorks to provide assistance with practice transformation activities. These organizations select the staff members that attend Coach University.

Trainees arrive at boot camp with a diversity of backgrounds and varied levels of experience with practice transformation concepts and facilitation skills. About one-quarter of trainees are nurses; another quarter have masters-level training; and the remainder have a mix of bachelor degrees, medical degrees, or doctorates. Approximately three-quarters of trainees are currently employed as coaches; others are part of a management or leadership team. Some trainees have coached practices for several years, though many are new to practice facilitation and the field of quality improvement and are unfamiliar with the elements of the PCMH and related concepts. While many participants have past experience in health care in some capacity, and some have worked for their employers for many years, many trainees are taking on coaching as a new role or as an additional responsibility.

V. Faculty

All Coach University faculty members are coaches themselves, working directly with practices as employees of HealthTeamWorks. Some are managers or regional directors within HealthTeamWorks but continue to work with practices to keep their practice facilitation skills and knowledge current. While all HealthTeamWorks coaches have significant field experience, they have a wide variety of clinical and nonclinical backgrounds, including business administration, nursing, mental health, and group practice management.

HealthTeamWorks leaders believe this diversity of skills and knowledge among the coaching faculty—or “depth on the bench,” as one coach called it—is a crucial element of Coach University’s success. This diversity benefits trainees, who are able to tap into the network during and after training as questions or challenges arise in the course of practice transformation work. Thus, while one coach may work in a specific practice, that person has 12 to 15 other coaches at HealthTeamWorks with wide-ranging backgrounds to assist with challenges that may arise.

HealthTeamWorks coaches all share a common set of knowledge and skills. Specifically, coaches must do the following:

- **Be strong presenters and storytellers** to convey information to practice staff and facilitate change.
- **Be well versed in adult learning theory** to effectively communicate with and train others in ways appropriate for adults.
- **Have excellent conflict resolution and interpersonal skills** to facilitate getting others to recognize areas for improvement and make change.
- **Understand practice transformation tools and techniques** to use them and teach to practice staff with whom they work.
- **Be efficient managers** to coordinate work with several practices simultaneously (the typical panel size for a HealthTeamWorks coach is 10 to 25 practices).

Although Coach University faculty are experienced in practice facilitation when they become HealthTeamWorks employees, Coach University uses what one program leader described as “a robust orientation” to ensure new faculty have the knowledge base necessary to perform well. Many of the topic areas covered in this orientation mirror those covered in the training provided to trainees.

In addition, new coaches have the opportunity to shadow more experienced HealthTeamWorks coaches before teaching a Coach University session for the first time.

Coach University faculty benefit from several types of ongoing training and support provided by HealthTeamWorks, including funds provided for coaches to attend continuing education classes. HealthTeamWorks also runs a monthly staff training meeting to discuss current and emerging topics in practice transformation and to share challenges and best practices. In addition, ad hoc training sessions address specific topics of interest to coaches using Webinars or in-person events that range from 1 hour to a full day in length.

HealthTeamWorks monitors coach effectiveness through a periodic review of performance. A yearly survey asks coaches to rank themselves on knowledge of different topics and requests feedback on what topics they feel they need to learn more about. Coaches also undertake a 360-degree annual review, during which they discuss feedback on their performance from supervisors, peers, and clients (those practices for which they have served as coaches).

“[Coaching] is not something [that just] anyone can do. You have to be able to facilitate and not tell people what to do.”

— HealthTeamWorks CEO

VI. Program administration

Many HealthTeamWorks staff members work on Coach University in addition to other organizational activities. Given the broad involvement in Coach University among HealthTeamWorks employees, we will first describe the organizational structure of HealthTeamWorks and then detail the program administration of Coach University.

HealthTeamWorks organizational structure. HealthTeamWorks staff members are loosely divided by their roles as either administrators or those more directly involved in the delivery of program services, such as boot camp or coaching. However, these distinctions are not absolute; for example, HealthTeamWorks' chief executive officer teaches a boot camp session in addition to her leadership responsibilities. The administrative staff of HealthTeamWorks includes:

- ▲ A chief executive officer
- ▲ A chief financial officer and two staff members involved in finance
- ▲ A sales and marketing team consisting of a vice president, a regional sales representative, and a marketing and Web specialist
- ▲ A data and guidelines department, which develops and updates evidence-based guidelines
- ▲ A human resources representative
- ▲ A health IT representative
- ▲ Four support specialists who help with the administrative tasks associated with practice support
- ▲ Two administrative assistants who support the executive team

The HealthTeamWorks program staff is led by three regional directors who oversee activities for a particular region of the United States: Colorado/Mountain, East and Southern Central time zone, and Pacific and Northern Central time zone. Under each regional director, there are three program managers, who manage projects with clients and supervise and assist three to five coaches each. There are also three project managers, who manage projects and supervise coaches in addition to being responsible for a particular HealthTeamWorks project area, such as education and training. Employees in all of these roles wear many hats, and all serve as coaches for Coach University.

Coach University administration. HealthTeamWorks' manager of education and training oversees Coach University and is responsible for:

- ▲ Boot camp planning and logistics, with the help of administrative assistants.
- ▲ Curriculum development, with direction from a work group of HealthTeamWorks coaches, program managers, and regional directors.
- ▲ Program assessment and evaluation, with input from HealthTeamWorks coaches and leadership. This includes "after-action meetings" with all HealthTeamWorks staff involved with a particular Coach University course. The staff discusses how the course went, reviews participant feedback, and considers whether and how to make improvements for future courses.

Every coach, program manager, and regional director employed by HealthTeamWorks is expected to be able to present topics at Coach University, and all staff members currently in these roles have done so. HealthTeamWorks has a core team of coaches who typically serve as Coach University faculty, but any coach, program manager, or regional director can serve as faculty if needed.

Tuition. Tuition for Coach University varies according to the level of engagement and contract parameters the trainee's organization has with HealthTeamWorks for practice transformation activities. If a contracted organization wishes to send more than one employee to Coach University, HealthTeamWorks adjusts unit costs downward to account for economies of scale.

VII. Evaluation and internal quality improvement of the training program

As a quality-focused organization, HealthTeamWorks pays close attention to its own monitoring and evaluation processes and uses feedback from Coach University coaches and trainees to inform development of new topic and skill areas to be added to the program curriculum. Prior to each session of Coach University, HealthTeamWorks sends trainees a survey of the topic areas the program aims to cover and asks them to rank their understanding of a range of topics related to practice facilitation. For example, a participant might be asked to rank her understanding of “the importance of primary care as part of the health care system” on a scale of no understanding, basic understanding, intermediate understanding, or advanced understanding. HealthTeamWorks incorporates survey results into the upcoming boot camp session by adapting discussions, examples, and classroom exercises to the participants’ levels of knowledge.

Over time, the Coach University curriculum has evolved to reflect trainees’ growing familiarity with basic PCMH tenets and to account for changes in the health care system and in health care policy. While there continue to be many trainees who are unfamiliar with the PCMH upon entering Coach University—which was common when the program first started in 2010—trainees now often come with basic knowledge of these concepts and seek a more in-depth understanding. In addition, recent trainees and their employers have expressed interest in pursuing more specialized topic areas such as behavioral health integration in primary care, cost reduction strategies, provider and staff satisfaction, and patient engagement or activation—all topics Coach University has incorporated or is considering how to incorporate in its training. Currently, Coach University is also focusing on helping trainees understand the ways in which the landscape of payment models is shifting. HealthTeamWorks leaders are also interested in developing an addition to the Coach University curriculum that addresses the need to move patient-centered health care beyond the medical home and into the entire health care system.

VIII. Outcomes and placements

Since August 2010, when HealthTeamWorks launched Coach University in its current form, more than 100 trainees have completed the boot camp. Almost all of these trainees have also completed the yearlong follow-up period. After completing the program, trainees return to their organizations and work to develop and implement practice transformation goals. HealthTeamWorks estimates that approximately half of its trainees work as coaches in large health systems, with smaller numbers employed in Federally Qualified Health Centers, Accountable Care Organizations, various grant-funded practice facilitation programs within Colorado, medical societies, educational institutions, or in medical residency programs. HealthTeamWorks leaders noted that most trainees take on coaching activities in addition to their other responsibilities, and HealthTeamWorks coaches often help trainees and their employers determine how to integrate these new activities with existing duties.

IX. Next steps

With very few exceptions, training at Coach University currently is offered only to staff from organizations that contract with HealthTeamWorks for other services. Moving forward, HealthTeamWorks plans to increase its capacity to train anyone willing or interested in receiving practice facilitator training. In addition, HealthTeamWorks is considering ways to provide education on PCMH principles to clinical or office staff who do not aim to become practice facilitators but would benefit from developing a familiarity with this information as their organization or system moves towards transformation.

Coach University is also planning to expand its curriculum to include information on securing buy-in at all levels of a health care system. HealthTeamWorks staff note that while many practices are interested in transformation work, they often have trouble convincing system-level leadership that the process is worth the investment. Alternately, the leadership of a large health system may want to engage in transformation work but has trouble convincing individuals within practices of the value of that work. Addressing the both sides of this issue is expected to be important future work for HealthTeamWorks.

X. Lessons learned

HealthTeamWorks leaders identified a number of key lessons learned in the process of developing and implementing Coach University:

- ▲ **Effective practice facilitator training relies not only on knowledge of practice transformation topics and techniques, but also on skills related to relationship building, complex adaptive change (adapting to multiple changes occurring at the same time), and culture change.** Knowledge of PCMH components, quality improvement techniques, and related core competencies is crucial to practice facilitation. Skills such as meeting facilitation, encouraging buy-in to an idea or process, and motivating people to achieve practice transformation goals are just as important. In addition, learning how to help practices adapt to multiple, simultaneous, complex changes, which can be overwhelming, is an important component of practice facilitator training.
- ▲ **A practice facilitator training program requires full-time leadership and committed faculty, all of whom have real-world experience working with practices.** This on-the-ground experience, when shared by faculty within the classroom setting, helps trainees absorb the content and process it in a way that makes it easier to apply later on.
- ▲ **Keeping a practice facilitator training curriculum current and reflective of policy shifts and industry changes is crucial.** HealthTeamWorks continuously gathers suggestions from trainees and clients, and the HealthTeamWorks sales and marketing team gathers input about new client needs.
- ▲ **Practice facilitator training that includes both direct instruction and experiential learning methods has significant benefits.** HealthTeamWorks leaders note that Coach University trainees appreciate the ability to engage in activities and exercises that help them apply their knowledge and develop the relationship-building and change management skills necessary to do their work well.

- ▲ **Using a variety of practice facilitators as faculty is important in order to expose the trainees to different perspectives and teaching styles.** There is no single, ideal type of faculty member. Trainees benefit from interactions with faculty who have different types of skills, knowledge, experience, and teaching styles.
- ▲ **Delivering practice facilitator training at the right level for trainees of varying backgrounds often requires on-the-fly faculty adjustments to the content and delivery of the curriculum.** A single group of trainees might include one person who has never heard of the PCMH and another who has several years of coaching experience. Coach University faculty assess each group of trainees to determine their level of knowledge and skill, and adjust lessons in real time to provide information at the right level.
- ▲ **Trainees have a wealth of knowledge and experience that provides opportunities for peer-to-peer learning.** HealthTeamWorks leaders note that when trainees have a variety of skills and experience levels, they benefit from teaching one another. Moreover, trainees often teach the faculty some new lessons, too.
- ▲ **Offering ongoing support and networking opportunities to new coaches after training benefits their longer-term development.** Since only a limited amount of material can be covered during boot camp, many Coach University trainees find they need additional support and information on specific topics. They may also require advice from a more seasoned coach when faced with difficult situations. For these new coaches, the ability to draw on a source of ongoing support can be instrumental to their success.
- ▲ **Helping coaches work effectively within their specific contexts is an important part of helping trainees succeed.** In some cases, practices or organizations may send a staff member to be trained in practice facilitation but do not alter the staff member's existing job description or set aside time or resources for him or her to take on additional responsibilities. In such cases, HealthTeamWorks has helped coaches develop job descriptions and has worked with their employers to help them understand what new skills and benefits the coach can bring to the organization.

This case study was developed as part of a contract funded by the Agency for Healthcare Research and Quality and was authored by:

Tricia Collins Higgins, Ph.D., M.P.H., Researcher, Mathematica Policy Research

Lisa Schottenfeld, M.P.H., M.S.W., Analyst, Mathematica Policy Research

Jesse Crosson, Ph.D., Senior Researcher, Mathematica Policy Research

Erin Taylor, Ph.D., M.P.P., Associate Director of Health Research and Senior Researcher, Mathematica Policy Research

Deborah Peikes, Ph.D., M.P.A., Senior Fellow, Mathematica Policy Research

Training Program Summary: Millard Fillmore College Practice Facilitator Certificate Program

Strong training is essential to developing effective practice facilitators (PFs) or coaches to support improvements in primary care practices. This case study profiles the Practice Facilitator Certificate Program at Millard Fillmore College of the University at Buffalo (UB) of The State University of New York. Available to the public, this program is an online distance-learning course that seeks to develop the knowledge and skills needed to build organizational capacity for change and support meaningful quality improvement (QI) in diverse medical practices. The course was designed and developed by national experts who drew heavily upon the training modules in the Agency for Healthcare Research and Quality (AHRQ) Practice Facilitation Handbook.¹

The program offers several lessons for others interested in developing and delivering training for practice facilitators:

- ▲ Building on existing partnerships and leveraging existing resources can help form a robust training program.
- ▲ Having a well-formulated structure aids in developing an online course.
- ▲ Involving experienced online instructional design support during course development is crucial.
- ▲ Combining classroom and field experiences is an effective teaching approach.
- ▲ Incorporating elements of adult learning theory supports student engagement and learning.
- ▲ Planning ahead can reduce technical challenges in an online learning environment.
- ▲ Using an instructor who has both content expertise and online teaching experience is critical.
- ▲ Investing in ongoing QI efforts helps ensure program quality.
- ▲ Marketing is important and can be challenging.

I. Background and motivation for developing the PF training program

The Millard Fillmore College Practice Facilitator Certificate Program began as a project of the Coalition of Coordinated Networks (CoCoNet2), a group of six primary care practice-based research networks (PBRNs) funded in 2012 by AHRQ² to stimulate innovation in the delivery and organization of primary care and to accelerate QI in primary care practices.³ In the past, members of CoCoNet2 routinely worked with practice facilitators, each training their own staff for this work. As a result, they saw a potential benefit to developing a standardized and centralized training program that would allow them to leverage each other's expertise and take advantage of economies of scale.

¹ <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html>

² <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-12-002.html>

³ <http://coconet2.org/>

In addition, the consortium expected that such a training program would be important for meeting the growing demand for well-trained PF staff to support ongoing reform of the Nation's health care delivery system. Three goals of this collaborative effort were (1) developing a standardized program for training individuals with little or no PF experience to effectively support practices in implementing organizational change, (2) offering certification to experienced PFs already working in the field, and (3) building a nationwide community of PFs to share ideas and learn from each other.

Two factors converged within CoCoNet2 to support the project. First, staff at one of the CoCoNet2 member organizations, L.A. Net Community Health Resource Network (L.A. Net), in partnership with AHRQ, had recently completed a guide to assist in the training of new PFs—The Practice Facilitation Handbook—and suggested that the Handbook could be used as the foundational content of a standardized training program. Second, a researcher with another CoCoNet2 member organization, Upstate New York Network (UNYNet), who is on the faculty at the UB Department of Family Medicine, suggested that housing the training program at a university would bring credibility to the program. Consequently, he approached the associate dean of Millard Fillmore College—the university's college for continuing education and professional studies—as a potential partner and offered to support the development, launch, and pilot of the first session using CoCoNet2 member resources and grant funds. The associate dean agreed to partner with the UB Department of Family Medicine and CoCoNet2, as the intent of the course matched the mission of the college to help professionals start or build a career and update their credentials. The college was also interested in being the first to offer a university-based PF training and certificate program in a job market sector they perceived as expanding.

The pilot course was offered in summer 2013, followed by a second course in fall 2013 and a third course in spring 2014. The goals and focus of the training program have remained the same over time.

II. High-level design of the PF training program

The Practice Facilitator Certificate Program is an online distance-learning course available to interested students nationwide. The program consists of 13 weekly online seminars that include lectures and virtual group discussions led by an experienced instructor, guest presentations by national experts, and weekly reading and other assignments. The program also includes a fieldwork preceptorship, which provides practical training in the field overseen by an experienced PF. Millard Fillmore College is the academic home to the program within UB and supports and facilitates the delivery of the course; the UB Department of Family Medicine and others from CoCoNet2 are responsible for recommending faculty and ensuring that the course design and content are of high quality. The Millard Fillmore College associate dean who initially agreed to the college's participation described the course as innovative in that it effectively brings

“We captured a lot of the major leaders in the field to guide and direct and contribute to the materials in this course, so we have national expertise from all over the country working together. And it's all open source. It's the idea that you have access to what we think is the best thinking on PF training thus far, and it's been pulled from a national group—not just one group doing it their way.”

—Member of the UB Department of Family Medicine faculty and CoCoNet2, February 2014

together internal resources and resources from other organizations to build a program that helps adults who are seeking career opportunities.

The course was developed by national experts who are members of CoCoNet2 and draws heavily on the training modules in the AHRQ Practice Facilitation Handbook. Because the Handbook was designed as a downloadable print resource to be used by trainers when teaching new PFs, Millard Fillmore College course developers had to transform and add to the content so that it could be used in an online learning environment. In doing so, they combined some topics covered in the Handbook as separate modules into a single classroom session, reorganized the overall sequence of modules, and created a set of presentation slides. Course sessions use, adapt, and add to the Handbook's original learning objectives and suggested readings and activities.

The course uses online instruction and a supervised preceptorship to provide PFs with the knowledge and skills needed to support meaningful QI in diverse medical practices. Priority topics include QI and measurement skills, organizational assessment, and team building. As is fitting for an online program aimed at adult and continuing education students, the course takes a practical and shared approach to learning in which both instructors and students learn from one another. Likewise, the course follows adult learning principles by making content relevant to students' professional and personal experiences and by inviting students to reflect upon and share their knowledge and experiences with the class.

III. Training program description

The goal of the course is to teach core competencies of PF work, as well as specialized skills facilitators will need when working with a medical practice. Course learning objectives include understanding the scope of PF services, using assessment tools to identify practice needs and drive QI, collecting and applying performance data for QI, and applying QI methodologies to improve patient care and organizational systems.

Program content. At the beginning of the course, students are asked to complete a professional development plan, in which they assess their previous experience working in health care settings, supporting quality improvement, and collecting and analyzing data. This information is used by the instructor to focus the course content on the needs of students enrolled in each particular session.

Core competencies. Core competencies are skills that are valuable for PFs regardless of the substantive focus of their work, such as QI methodologies and measurement skills.

Students learn about the history of various QI approaches, as well as the evidence and context for using each approach. QI topics and skills covered during the course include workflow mapping and

Course learning objectives

- Synthesize a PF's contributions to practice site improvements.
- Use assessment tools to facilitate development of strategies to improve organizational systems.
- Implement strategies to conduct more effective performance data reviews.
- Apply quality improvement methodologies to improve patient care and organizational systems.

redesign, Plan-Do-Study-Act (PDSA) cycles, root-cause analysis, academic detailing, developing QI plans, and supporting practices in implementing change.

Measurement skills addressed during the course include selecting and developing measures, conducting readiness and organizational assessments, measuring and benchmarking clinical and organizational performance, conducting chart audits, and preparing and presenting data to practices in a way that helps them identify areas for improvement and that stimulates a desire to change.

Specialized skills and topics. The course also develops students' ability to conduct specific tasks with diverse medical practices as part of the facilitation process. Specialized skills and topics include: understanding practice facilitation as a resource for practice improvement, team building, implementing the chronic care model⁴ and patient-centered medical home (PCMH), understanding electronic health records (EHRs) and their meaningful use, and tracking progress and outcomes of PF services.

The course begins with developing students' understanding of the role of the PF and the contributions that PFs can make to a medical practice. Students learn the common elements of the facilitation process, basic premises for working with medical practices, and tactics for introducing and preparing practices to work with a PF.

Students develop the ability to build strong relationships and teams within practices so that facilitation can be effective. Specialized skills include strategies for running successful meetings, identifying staff members who are appropriate for specific projects, and creating QI teams to facilitate projects and organizational change.

The course builds students' knowledge in care model implementation and PCMH transformation through understanding of self-management support, population management, registries, and team-based care. There are also sessions on understanding EHRs, helping practices attain meaningful use of health information technology, and using clinical and administrative data for QI purposes. The course concludes with a session on documenting the content and outcomes of facilitation services to track practice priorities and monitor progress.

Assessment of student learning. The course is graded on a pass-fail basis. To pass the course, students must attend or make up each of the weekly sessions (a maximum of two make-up sessions are allowed), complete all required readings, complete the two required assignments satisfactorily and on time, submit weekly reflection journals, contribute productively during online sessions and via

Overview: Millard Fillmore core competencies

- Overview of practice facilitation
- Practice assessment
- Implementing the chronic care model and improving self-management support
- QI approaches
- Measuring and benchmarking clinical performance
- Understanding EHRs
- Meaningful use mapping and redesigning workflow

⁴ http://www.improvingchroniccare.org/index.php?p=The_%20Chronic_Care_Model&s=2

discussion boards, and satisfactorily complete a 40-hour preceptorship. Although there are no specific exams for the course, students complete a self-assessment both before and after the course. This self-assessment measures students' knowledge and confidence levels regarding several topics related to working with practices including using assessment tools, facilitating meetings, leading teams, conducting PDSA cycles, working with clinical data, and developing QI plans. Fieldwork preceptors assess students' professionalism, motivation, critical thinking skills, and ability to complete common facilitator tasks (conducting PDSA cycles; workflow mapping and redesigning; collecting, managing, and interpreting data; and facilitating team meetings).

Program delivery. Educational content is delivered to students via weekly online sessions, materials, assignments, discussion boards, journals, and the fieldwork preceptorship.

Weekly online sessions. The course includes 13 weekly sessions hosted on the UB online learning platform. Students link to the platform from their own computers to view course materials, participate in class sessions, and interact with the instructor and other students in real time. Each session lasts 90 minutes and includes a formal presentation delivered by the course instructor. Students with prior experience related to course content are occasionally asked to give presentations. National experts also are invited to present guest lectures occasionally.

Pre-session reading and materials. Each online session has requirements for pre-session preparation. Most sessions require completion of readings prior to class. Readings are often chapters from the AHRQ Practice Facilitation Handbook, case studies, or journal articles. Other pre-session materials include examples of practice assessments or other QI tools and links to YouTube videos showcasing specific PF strategies. All pre-session materials are posted on the online learning platform along with questions that students prepare to answer during the session.

Assignments. Students complete two assignments during the course. In the first, students develop and describe each of the steps in a hypothetical PDSA cycle that could be used to measure the effects of a change implemented by a practice. In the second, students map a workflow and describe the steps involved in the work process, explain the usefulness of mapping the process, identify the staff involved in carrying out the process, and explain how the student would help a team use the workflow map to make and sustain change.

Online discussion boards. At three points during the course, students participate in an online discussion board viewed by the entire class to reinforce concepts from the readings and to encourage critical thinking and discourse. In each of the three discussion boards, students are required to post one substantive comment in response to the topic posed by the instructor and another in response to a classmate's comment.

Journals. Students submit weekly journal entries to the instructor in which they reflect on what they learned during the seminar and fieldwork and discuss how they will apply what they learned.

Preceptorship. The course requires completion of a 40-hour preceptorship to provide students with hands-on experience, enable them to apply course materials, and further build students' knowledge and skills. The preceptorship experience can be spread throughout the 13-week course or completed during a 1-week intensive period concurrent with the course or soon after its completion.

Knowledge Network. Students are provided an opportunity to participate in an online learning community (the Knowledge Network) of PFs who are participating in or who have graduated from the program where members can post questions, answer questions, and share resources and ideas.

Methods of instruction. The course includes didactic instruction paired with self-reflection and experiential learning. Didactic teaching methods including instructor-led lectures and student pre-session reading are used to help students build a knowledge base. Experiential learning methods including assignments and supervised practice and application during the preceptorship are used to build skills. Students also complete journals reflecting on knowledge gained during lectures and on their experiences applying knowledge and skills during the preceptorship.

The course strives to be interactive. During the first weekly session, the instructor emphasizes expectations for student participation in online discussions and discussion boards. She makes clear that students are expected to come to each session prepared to answer questions posted on the learning platform, calls on students during class time, and occasionally asks students to make a formal presentation during a future session. She also uses online collaboration tools, including online polling and a chat room feature that enables students to type questions and comments readable by the rest of the class to see to invigorate discussion.

“There are opportunities to interact and to speak on each issue—it’s live, so we’re listening to people speak on their different frames of references or experiences. There is a lot of content, so you really have to be present. Students need to be attentive and ready to answer questions that will create dynamic conversation in the group.”

— Graduate, Summer 2013 session

Duration and intensity. The course requires a commitment of approximately 92 hours, including 19.5 hours of class time (13 weeks at 90 minutes per session), 32.5 hours of reflective learning (including pre-session reading and materials, assignments, discussion boards, and journals), and 40 hours of fieldwork.

IV. Trainees

Millard Fillmore College allows for a maximum of 20 students in each session, with an ideal class size of 12 to 15 students to cover costs. However, according to the course instructor, approximately 7 to 8 students per class is optimal from a teaching perspective. This is due to the difficulty of maintaining a high level of interaction and participation with larger class sizes in an online platform. On average, the number of students in each class has been 14 students.

Students must meet certain eligibility requirements in order to take the course, including having both a bachelor’s degree and relevant occupational experience. The majority of students that have enrolled in the course thus far have experience working in health care settings and have included physicians, health care administration staff, and nurses as well as PFs who want more training or certification. Many students have come from university- or community-based PBRNs and some from individual or group medical practices, including community clinics. Host organizations or practices commonly pay tuition on behalf of the student as a professional development investment.

Given that practice facilitation is an emerging field, marketing the Practice Facilitator Certificate Program has been a challenge. In addition to a general lack of awareness of the PF role in the marketplace, there is also limited understanding of the variety of work PFs do. Millard Fillmore College has found word-of-mouth to be most effective in spreading news of the program; as students gain certification and apply the techniques they have acquired in their home organizations and practices, other individuals and practices are learning about the program and expressing interest. The college plans to increase marketing efforts with a focus on expanding the national reach of the program. Additionally, the college plans to capitalize on existing relationships with PBRNs affiliated with CoCoNet2 and is evaluating the possibility of reaching out to national professional organizations such as the Patient-Centered Primary Care Collaborative. Millard Fillmore College is also reaching out to regional workforce development initiatives and medical practices as well as on-campus academic departments.

V. Faculty

The course instructor is an adjunct faculty member hired by Millard Fillmore College on a course-by-course contract basis. She was identified and recommended by several members of CoCoNet2 due to her depth of experience in PF, involvement in the development of the AHRQ Practice Facilitation Handbook, and experience using the Handbook. Millard Fillmore College instructional design staff members assist with development and implementation of online course content and provide ongoing technical support throughout the duration of the course. In addition, there are two to three guest speakers per course who give presentations on specific topics in their area of expertise, such as the meaningful use of EHRs. At the end of the course, students evaluate the effectiveness of the instructor and provide course feedback. The associate dean also consults with the instructor routinely to review progress toward achieving course objectives.

According to Millard Fillmore College staff, CoCoNet2 members, and others involved with the training program, instructors should have several key qualities to effectively teach the PF course. As basic qualifications, the instructor must have significant experience in facilitating practice transformation, be actively involved in the field, and have previous experience supervising or training practice facilitators. PF students come from varying professional backgrounds and have different levels of expertise in the subject. Because of this diversity, the course instructor noted the importance of being able to adapt to the flow and content of the course as needed. As with any traditional course, instructors must be effective teachers with a strong understanding of pedagogy and an ability to lead group discussions.

Those involved in the development and delivery of the training program also pointed out that there are a number of unique qualities required of the instructor due to the online format of the course. It is helpful for the instructor to have previous online teaching experience and a high degree of comfort with technology. The instructor must be a dynamic, organized, and adaptable facilitator of learning to maintain a high level of student interaction in a virtual environment.

VI. Program administration

The administrative structure for the Practice Facilitator Certificate Program includes several organizational entities. Millard Fillmore College is responsible for academic and administrative oversight of the program. The UB Department of Family Medicine is responsible for curriculum development and instruction. CoCoNet2 members serve as expert consultants to both the college and the department on program content and delivery.

As the academic and administrative home to the program, Millard Fillmore College provides general support to ensure that the program conforms to university standards, facilitates registration and communication with interested students, and provides marketing support. The college funds instructional design and development, information technology support, and the instructor's salary and benefits. Additionally, the college coordinates access to the online distance-learning platform used by the program.

The UB Department of Family Medicine is a critical partner in offering the program. Not only did a member of the department's faculty initiate the development of the program, but as a part of CoCoNet2, he continues to provide expert consultation and program oversight. The department also funds an educational administrative assistant, who supports course administration and program development, creates course evaluation materials, and oversees the application and certification of preceptor sites.

CoCoNet2 members were heavily involved in and funded the development of the program, including the transformation of the AHRQ Practice Facilitation Handbook into an interactive online learning course. Members met with the instructional design staff while the program was in development and met regularly with the course instructor and other Millard Fillmore College and UB Department of Family Medicine staff during the pilot session to provide ongoing feedback and support. CoCoNet2 members continue to serve in an advisory role supporting ongoing course development and delivery.

Funding. The initial development of the course was sponsored as a CoCoNet2 project with grant funding from AHRQ. The instructor, a staff member of one of the CoCoNet2 member sites, donated her time during the pilot. Additionally, students who participated in the pilot session did not pay tuition since all were affiliated with CoCoNet2 PBRN sites or were staff at Millard Fillmore College. During the pilot, the college paid costs for the instructional design and technology support staff.

Program staff

Millard Fillmore College

- Administrative oversight by the associate dean (approximately 0.05 FTE)
- Marketing and development director (approximately 0.5 FTE)
- Instructional design and technology support staff (approximately 0.25 FTE)
- Faculty (approximately 0.25 FTE)

UB Department of Family Medicine

- Academic partner by professor of family medicine (approximately 0.05 FTE)
- Course educational/administrative assistant (0.5 FTE)

CoCoNet2

- Core members provide expert consultation (approximately 0.02 FTE)

After completion of the pilot, the program transitioned to a self-supporting model. Funding for the program includes student tuition (\$4,000) and in-kind donations of time from UB Family Medicine staff and CoCoNet2 members. If a student completes the preceptorship at a certified site, the site receives a \$1,000 incentive. The associate dean described the program thus far as a

break-even course in that tuition generated enough revenue to cover all direct costs. Future course offerings are expected to cover both direct and indirect costs.

“Programs such as this require considerable investment of personnel resources to get started. It’s a lot of work. But we expect to recover costs and be successful with a self-supporting financial model for this program.”

— Millard Fillmore College associate dean, February 2014

VII. Monitoring the quality of the PF training program

Millard Fillmore College and UB Department of Family Medicine have established mechanisms to monitor the quality of the content and delivery of the training program and have demonstrated a commitment to ongoing quality improvement. The first session of the course was considered a pilot, and all staff and students associated with the course participated actively in providing or responding to feedback. Methods used to monitor and improve the program during the pilot included:

- ▲ **Student feedback.** Students were asked to complete two mid-course and one end-of-course evaluation. Each evaluation included four general questions asking students to assess how helpful the content had been in providing them with knowledge they could apply, identify information they considered most and least helpful, and share recommendations for improving the content or delivery of the course. Additionally, the Millard Fillmore College marketing and development director enrolled as a student in the course and was able to provide feedback both as a student and university representative.
- ▲ **Biweekly QI team meetings.** A QI team including the course instructor, the college’s associate dean and marketing and development director, the UB Department of Family Medicine faculty liaison, the administrative assistant, and the instructional design staff person met biweekly to discuss how the course was proceeding and any modifications that could be implemented immediately. The team discussed curriculum development, course and session learning objectives, student performance and feedback, and strategies for reaching out to the market.
- ▲ **Ongoing consultation.** In addition to the biweekly meetings, the course instructor and instructional design staff person met at least weekly to discuss recommendations and changes that needed to be made to the format and content of the online curriculum.

A number of changes were made to the course in response to feedback gathered during the pilot session. Overall, students were pleased with the course content and no major changes were made. Students and the instructor alike, however, reported that the course was too long and that the required preceptor hours were too extensive. In response, the course was modified from its original 16-week format to the current 13 weeks. The only topic dropped from the course was panel management (because it was considered by the instructor to be more technical than most students required), but

other topics were combined into single sessions. Preceptor hours were reduced significantly, from 104 to 40 hours. With regard to course delivery, students reported that the course was not as interactive as they had expected. In response, the instructor began to more fully utilize the chat room and online polling collaboration tools of the online platform to draw students into dynamic group discussions. Some of the challenges faced during the pilot were related to the learning management system or to students' ability to effectively apply technologies to participate in the course.

Now that the course is out of the pilot phase, the College and the Department of Family Medicine continue to monitor the quality of the program. The university administers course evaluations, and the QI team meets once a month to discuss, evaluate, and identify any modifications needed. Because he is ultimately responsible for ensuring that the program meets university standards for quality, the associate dean also asks the instructor to report on her experience.

The college and the UB Department of Family Medicine were approached by a researcher interested in conducting a formal evaluation of the program; planning is currently underway.

Student outcomes and placements. To date, 28 students have successfully completed the course and received PF certificates. Two students were unable to complete the course due to difficulty making the required time commitment. Since most students who have taken the course have done so under the auspices of their employers, host organizations, or medical practices rather than independently, they have continued to work for those entities after completing the program. In many cases, this is expected by the employer who either subsidized or fully paid for the student's time and tuition. Thus far, the majority of students have been affiliated with PBRNs; a few were staff members of a medical group practice.

"UB's Millard Fillmore College is proud of the collaborative work with our partners to achieve the shared goal of developing an online Practice Facilitation Certificate Program. We are committed to this professional development program to prepare those who are seeking career opportunities as practice facilitators."

—Millard Fillmore College
associate dean,
February 2014

VIII. Next steps

Millard Fillmore College plans to continue to refine and expand offerings of the Practice Facilitator Certificate Program. Depending on demand, the college plans to offer two to three sessions per year. Program leadership, staff and the instructor will continue to review the course and make adjustments to content and format based on student feedback. The course is also continually updated to reflect new developments in the field in order to ensure that the material remains current and relevant.

The long-term vision of Millard Fillmore College is to have a nationally known and recognized standardized training program for practice facilitation. In addition, they hope to build a learning community of PFs, starting with a listserv that includes current students and past graduates of the certificate program. The eventual goal is to extend this community to include PFs nationwide and not just those affiliated with the program.

The college also plans to launch an intensive marketing campaign to spread the word about the course and recruit students. Program leadership and staff are currently identifying a number of strategies

targeted at both the national and local level. Based on the current success of the program and established relationships with PBRNs nationwide and medical practices locally, the college is expecting a continued increase in demand for the course and other programs like it.

IX. Lessons learned

A number of lessons emerge from the experiences of the Millard Fillmore College, the UB Department of Family Medicine, and the CoCoNet2 partnership that could be useful to others interested in developing a PF training program:

Building on existing partnerships and leveraging existing resources can help form a robust training program. The Practice Facilitator Certificate Program grew out of a partnership between university partners (Millard Fillmore College and the UB Department of Family Medicine) and external organizations (CoCoNet2's affiliated members), each of which contributed expertise and resources. The course benefited from existing resources including AHRQ's Practice Facilitation Handbook and grant funding to CoCoNet2, the content expertise and PF training experience of CoCoNet2 members, the course administration and marketing skills of the college and the Department of Family Medicine staff, and a UB faculty champion who was a driving force for the program's development.

“Developing partnerships and working in collaboration with those partners is essential to the success of this program. We rely on their expertise for curriculum development, teaching, marketing, and recruitment.”

—Millard Fillmore College
associate dean,
February 2014

Having a well-formulated structure aids in developing an online course. The AHRQ Practice Facilitation Handbook was essential as a foundational document. The structure of the Handbook, including its clear learning objectives, reading assignments, and activities for each module, simplified the process of translating the content into an online format. Each module included a table that plainly laid out student expectations for assignments and the amount of time anticipated to complete them.

Involving experienced online instructional design support during course development is crucial. Developing a course for an online platform creates many unique challenges and considerations. Because of this, instructional design staff with expertise and skills in this area should be involved from an early stage. Instructional designers can assist with organizing course content, defining learning objectives, ensuring the effectiveness of instructional material, and identifying how best to engage students in an online environment. These individuals generally have a strong understanding of adult student learning needs, which allows them to identify the most effective teaching strategies and instructional media to facilitate the online learning process based on the instructor's teaching style. In the case of the Practice Facilitation Certificate Program, the instructional designer provided invaluable expertise not only in the technological aspects of implementing the course but also in educational theory and practice.

Combining classroom and field experiences is an effective teaching approach. A program that includes both didactic and experiential learning is an effective means for building the knowledge and skills PFs will find necessary in their jobs. Requiring students to complete a fieldwork component under the supervision of a more experienced PF enables them to apply the course material and further builds the student's knowledge and skills.

Planning ahead can reduce technical challenges in an online learning environment. Including material that requires students to download and test software programs before the first class along with tutorials welcoming students and explaining how to use the online platform dramatically lowers the number of technical obstacles encountered.

Incorporating elements of adult learning theory supports student engagement and learning. Part of offering a successful continuing education and certificate program involves understanding how adults and professionals learn best. The Practice Facilitator Certificate Program incorporates adult learning principles by using approaches to learning that are interactive, collaborative, reflective, and applied rather than simply didactic. The course also emphasizes that both the instructor and the students have life experience and knowledge to offer.

Using an instructor who has both PF content expertise and online teaching experience is critical. In order to be successful, courses require an effective instructor. To succeed in an online distance learning course, instructors must not only have significant subject matter expertise and general teaching experience but also be experienced in online pedagogy. Also important is being skilled at encouraging dialogue and maintaining a high level of student interaction in an online setting. Finally, they must be comfortable working with technology.

Investing in ongoing QI efforts helps ensure program quality. Millard Fillmore College and UB Department of Family Medicine staff and CoCoNet2 members invested heavily in conducting a pilot session of the course, developed a variety of mechanisms to monitor the quality of the content and delivery of the program, and are committed to making ongoing improvements and changes in response to feedback. The course is continually updated to reflect new developments in the field in order to ensure that the material remains current and relevant.

Marketing is important and can be challenging. The status of PF as an emerging field presents both opportunities and challenges for marketing a PF course. Millard Fillmore College has noted that relationship marketing is crucial to the success of programs like this. Some promising approaches identified include taking advantage of existing relationships and networks, reaching out to professional organizations in the field, and working with local workforce programs and local practices. Properly defining the target market and developing an equivalent business plan are also essential to tailoring an effective marketing campaign.

The Millard Fillmore College Practice Facilitation Certificate Program uses a combination of online instruction and a supervised preceptorship to deliver content and instruction. Students enrolled in the program receive training in a variety of core competencies and specialized skills needed to support meaningful QI in diverse medical practices. The experience of the program provides an illustrative model and practical lessons for those interested in building a training program for PFs.

This case study was developed as part of a contract funded by the Agency for Healthcare Research and Quality and was authored by:

Dana Petersen, Ph.D., M.P.H., Researcher, Mathematica Policy Research

Liz Babalola, M.P.H., Analyst, Mathematica Policy Research

Jesse Crosson, Ph.D., Senior Researcher, Mathematica Policy Research

Erin Taylor, Ph.D., M.P.P., Associate Director of Health Research and Senior Researcher, Mathematica Policy Research

Deborah Peikes, Ph.D., M.P.A., Senior Fellow, Mathematica Policy Research

References

Agency for Healthcare Research and Quality. Practice Facilitation Handbook. <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/index.html>

Coalition of Coordinated Networks (CoCoNet2). <http://www.coconet2.org>

Millard Fillmore Practice Facilitator Certificate Program. <http://www.millardfillmorecollege.com/practice-facilitator>

Training Program Summary: Practice Coach Training for the North Carolina AHEC Practice Support Program

Strong training is essential for developing effective practice facilitators (PFs) to support improvements in primary care practices. This case study profiles the practice facilitator (called practice coach) training of the North Carolina Area Health Education Center (AHEC) Practice Support Program (PSP). Available only to staff of the North Carolina AHEC PSP, the training program prepares practice coaches to serve on regional practice facilitation teams that work with primary care practices to improve quality of care, transform to patient-centered medical homes (PCMHs), implement electronic health records (EHRs), and attain meaningful use certification.⁵

Practice coaches specialize in one of three areas—quality improvement (QI), data acquisition and reporting, or EHR implementation—and work together on facilitation teams in one of nine AHEC regions in the State. The North Carolina AHEC PSP has trained a total of 70 practice coaches since 2006. Training forms the heart of the State’s AHEC PSP and is intensive and continuous. Coaches participate in weekly to biweekly virtual training, on-site training, tandem field experiences, and peer-to-peer learning. In addition, they have access to an online resource library and a secure listserv. Coaches are trained in 49 coaching competencies, and training content is continually updated to keep coaches well prepared to help practices respond to emergent needs in the field.

The North Carolina AHEC PSP has trained a total of 70 coaches since 2006. Training is intensive and continuous. It includes weekly to biweekly virtual trainings, on-site trainings, field experiences, peer-to-peer learning, an online resource library and a secure listserv.

The North Carolina AHEC PSP training strategy offers several lessons for others interested in developing and delivering PF training:

- ▲ Training should be continuous and intensive and should have a means for identifying emergent issues in the field and preparing practice coaches to address them.
- ▲ As coaches come from a variety of backgrounds, training should be tailored to meet each learner’s needs.
- ▲ Coaches should be trained first in the topics that are of the highest urgency and the most important to their practices to ensure that they can be immediately useful to their practices.
- ▲ Training should include a robust apprenticeship with an experienced practice coach. Ideally the apprenticeship should take place in the practices that the trainee will eventually support.

⁵ A 2013 AHRQ case study describes the North Carolina AHEC PSP program in depth and can be accessed at: http://pcmh.ahrq.gov/sites/default/files/attachments/NorthCarolina_020413comp_0.pdf

I. Background and motivation

The North Carolina AHEC Practice Support Program has provided support to 1,100 primary care practices in North Carolina. Its focus is on helping primary care practices to improve quality and transform to PCMHs. The North Carolina AHEC PSP also houses the North Carolina Health Information Technology Regional Extension Center (HITREC), which aids practices in selecting and implementing EHRs and attaining meaningful use certification.

The North Carolina AHEC PSP program began in 2006 as a pilot program as part of the Improving Performance in Practice initiative. Program staff consisted of two practice coaches who supported a total of 16 practices. The results of the pilot were so encouraging that the State of North Carolina funded an expansion of the program to all nine AHEC regions of the State. This necessitated a scale-up plan that included practice recruitment and preparation of new facilitation teams for each region. At this point, program staff consisted of only one practice coach; that individual is now director of the statewide program. To accomplish the scale-up, the director began with a single region and then moved sequentially to each of the remaining regions, until a core of approximately 10 primary care practices had been recruited and a facilitator had been deployed in each region.

To recruit the start-up practices, the director reached out to practices and stakeholder groups, like Community Care of North Carolina, in each AHEC region. Once practices had been identified, the director began active facilitation work in these practices. Concurrent with this, she also began recruiting and training members of the facilitation team for the region. Teams included an expert in QI and an expert in data. When the PSP was expanded to include the State's HITREC, experts in EHR implementation were added to each team.

To prepare these staff to work with practices and as facilitators, the director had the individuals serve as apprentices with her as she worked with the start-up practices. Once she thought the team members were sufficiently trained and that facilitation intervention was solidly underway in a practice, she turned over leadership of the intervention to the newly trained personnel. The director then moved to the next AHEC region, beginning the process over again until she reached all nine regions.

In explaining the intensity of effort required for this initial scale-up, the director half-jokingly explained that she measured her progress by how many oil changes she had to make to her car each month.

II. High-level design

Currently, the North Carolina AHEC PSP training is only for program staff and is designed to prepare individuals as practice coaches to serve on the program's PF teams located in each of the State's AHEC regions. Facilitation teams include experts on QI, data acquisition and reporting, and EHR implementation. Training prepares individuals with these differing areas of expertise to work with their fellow facilitators and practices. The training helps each trainee develop his or her particular area of expertise while acquiring a basic understanding of change management and QI methods.

Training is continuous throughout a facilitator's tenure with the North Carolina AHEC PSP and combines didactic, peer-to-peer, and experiential learning. Instruction is tailored to the specific

learning needs of each staff member, and new content is continually being added in response to requests from team members to address emergent needs of the practices. The majority of the training takes place virtually to allow facilitation teams from across the State to participate, but there are at least two and sometimes more in-person training sessions each year. Training also includes access to a learning community of facilitators and a very active internal listserv that team members use to share ideas and best practices.

III. Program description

Program elements. The North Carolina AHEC PSP training consists of eight elements: (1) orientation for new hires, (2) tandem site visits, (3) biweekly training on general coaching skills, (4) as-needed training on new or priority topics, (5) in-person training conferences, (6) daily use of a secure listserv for coaches to exchange ideas and best practices and share emergent issues in the field, (7) a Web-based library of coaching resources, and (8) access to the program director and her staff for individualized assistance and problem solving as needed.

The program combines didactic, peer-to-peer, and experiential learning and is grounded in adult learning theory.

Coaches are expected to develop competencies appropriate to their specific area of expertise on their facilitation team. All coaches, regardless of their area of expertise, are expected to learn basic change management and project management processes.

Orientation. Orientation lasts 1 day and takes place at the North Carolina AHEC PSP offices. New hires learn about the PSP’s mission, coaching approach, and improvement packages (a structured series of activities that coaches are expected to facilitate at their practices to attain improvements in particular areas). Orientation is offered twice yearly, or more frequently if needed. One to 20 students participate, based on the number of new hires at the time of the training.

Tandem site visits. New hires complete site visits to the practices they will eventually support in tandem with a facilitator who is already working with the practices. During these visits, the new coach meets people at the practices, learns about the improvement work currently being conducted, and also meets individuals from the larger medical community.

Twice-monthly training Webinars. All practice coaches participate in biweekly training calls led by the program director or the QI manager. These 1- to 2-hour-long meetings focus on skill building in the 49 core coaching competencies and on peer-to-peer learning. They also provide an opportunity for the coaches to alert the director and her staff to new developments in the field or training needs that they would like addressed during future training sessions. Facilitation teams from each region are expected to host at least one Webinar a year. During these sessions, the teams share approaches and resources that are working well in their practices as a method of sharing best practices.

Emergent issues training Webinars. In addition to standard biweekly training calls, practice coaches may also participate in virtual training sessions on emergent issues. These training sessions, called “office hours,” are focused on emergent issues in the field such as new State or Federal regulations or payer initiatives. The training director is also currently holding biweekly calls on meaningful use Stage 2 standards to prepare the coaches to support their practices in this area. During these calls, coaches can

also register questions they or their practices have about the given topic, and the director and her staff will provide training on these topics on future calls.

Training conferences. In-person 2-day training conferences take place twice a year and are mandatory for all practice coaches. The conferences focus on filling gaps in knowledge and skills identified through an annual coach self-assessment. Coaches share best practices with each other during these sessions and problem solve areas that are not working. The director and staff use information shared in this peer-to-peer learning to inform development of future training sessions and to improve the services provided to practices by the PSP.

Listserv and secure Web site. The secure coach listserv is an important part of the North Carolina AHEC PSP training. The listserv, which is open only to practice coaches and support staff in the program, provides a forum for coaches to ask questions of their colleagues, report problems in the field, and share information about resources and effective methods. It also provides a place for coaches to share frustrations and request support from each other. Because practice coaches often work in isolation from each other for substantial periods of time, the listserv functions as a virtual community for them or, as the director describes it, as a “virtual water cooler.” The listerv is very active, with 20 or more posts a day. A librarian tags and uploads key information from the posts to a secure searchable Web site, thus creating a knowledge resource that coaches can access and use as needed.

Professional development. PSP coaches are also encouraged to attend a QI 101 workshop offered through the NC AHEC program, to use the Institute for Healthcare Improvement’s (IHI’s) Open School, and to access other professional development offerings through national conferences and training programs.

Program content. The North Carolina AHEC PSP training instructs practice coaches on 49 core coaching competencies, as well as on emergent issues identified from the field. The core competencies fall into six categories:

- ▲ **Program mission and methods.** Orients the student to the North Carolina AHEC’s mission and model, the PSP mission and model, and elements of the PSP training and knowledge management systems.
- ▲ **Clinical improvement consulting.** Focuses on the structure and processes of primary care and on basic skills in QI coaching.
- ▲ **Practice system redesign and innovation.** Focuses on the chronic care model and on training practice coaches to use the different change methods (structured intervention processes) for improving patient care.
- ▲ **PCMH recognition.** Trains coaches in assisting practices applying for recognition.
- ▲ **EHR incentive program consulting.** Includes knowledge and skills for helping practices implement and optimize EHR systems and attain meaningful use certification.
- ▲ **Practice management consulting.** Trains practice coaches on issues such as payment reform, improved coding, and business models focused on improved quality.

New content is continually being added in response to requests from practice coaches and to address emergent needs of the practices.

For each competency, four levels of proficiency are possible: (1) the ability to describe the topic to a practice, (2) the ability to explain the program or topic to the practice and refer the practice to additional resources, (3) the ability to demonstrate the target skill or knowledge and use it with the practice, and (4) the ability to teach a practice the target skill or knowledge and facilitate use by practice staff.

Staff are expected to attain the level of proficiency established by the program for each competency. In some instances, practice coaches need only attain the first degree of proficiency. In other instances, they are expected to attain the fourth level. A list of competencies, with the target proficiency level noted, is provided in the Appendixes.

Coach assessment. Practice coaches complete a self-assessment of their skills and knowledge of the 49 core coaching competencies when they enter the training and annually thereafter. The program director and her staff use these assessments to plan tailored training and to identify coaches with sufficient expertise to serve as faculty.

Training delivery. Training is delivered using video conferencing Webinars, in-person meetings, and a listserv. Video conferencing makes it possible for all practice coaches to participate in training regardless of their location. It also makes the training more cost-effective. Sessions are recorded and made available online to coaches who are unable to attend the live sessions. In-person training occurs twice a year and takes place at the program's central offices at the University of North Carolina at Chapel Hill. Although it is more expensive, in-person training is seen as vital to the cohesiveness of the program. These sessions give coaches an opportunity to connect with each other, and give coaches and trainers time to explore best practices in greater depth than is possible using virtual meetings. The program's listserv gives coaches a way to communicate and exchange ideas on a daily basis. This is an important part of coach training as well as support. The listerv is maintained through the program's administrative office. It and the Web-based resource library are part of the comprehensive information management and data reporting systems designed for the program by faculty from the University of North Carolina at Chapel Hill.

Methods of instruction. Training includes didactic instruction, self-study using online resources, peer-to-peer learning, and field experience. Didactic instruction makes up a large portion of the virtual and in-person training sessions. All practice coaches are asked to complete self-study modules on basic quality improvement through IHI's Open University. Peer-to-peer learning takes place during didactic sessions, since each regional team leads at least one session each year and shares lessons learned; through interactive discussions during Webinars; and through daily use of the listserv. Field instruction is conducted in sites where the learner will be working and occurs most frequently as an apprenticeship with a more experienced coach.

In a team approach to facilitation, coaches need to be proficient in their particular area of expertise but do not need to be proficient in every competency.

Duration and intensity. Each coach participates in an estimated 108 hours of virtual training and 32 hours of in-person training each year. New hires complete an additional 8 hours of in-person training. In addition, coaches participate in daily peer-to-peer learning and support through the program's listserv.

IV. Trainees

The number of staff participating in training ranges from 9 to 50, depending on the number of coaches employed by the program at the time. Practice coaches come from a variety of backgrounds, including public health, health administration, social work, nursing, and psychology. To be hired by the program, an individual must have worked in health care, preferably in ambulatory care. Most coaches hold a master's degree, and many come to coaching as a second career.

V. Faculty and trainers

The program director and QI manager serve as primary faculty for training practice coaches. In addition, the program is in the process of adding a health information technology (IT) manager to further support and develop training in meaningful use of health IT. In addition, outside experts (typically physicians selected for their expertise in QI and transforming health care processes and systems) provide training on a variety of topics. Most of these experts come from a university in North Carolina. The Carolinas Center for Medical Excellence provides EHR adoption training for new staff. The program also relies on its partnerships with the State health information exchange, Community Care of North Carolina, payer organizations, public health agencies, and other entities to identify experts to provide support and training. The use of outside faculty members is seen as building credibility for the program in the guest faculties' communities and increases the visibility of the program across the State.

Outside faculty are important resources for a PSP. Not only do they provide training to coaches, but they can also serve an important public relations function for the PSP.

VI. Program administration

Staffing. The North Carolina AHEC PSP director serves as the training director. She spends 20 percent of her time working with the training program and is responsible for administering the training as well as serving as faculty. A QI manager spends 60 percent of her or his time on teaching QI methods, producing curriculum, and disseminating specific QI resources. A health IT manager will spend 60 percent of his or her time training practice coaches on meaningful use and EHR use. He or she will produce training materials and dissemination packages for coaches on successful health IT improvement efforts. A full-time librarian supports both the overall PSP program and coach training by monitoring and tagging listserv content, maintaining an online resource center of training and improvement tools for the coaches, scanning key publications for pertinent information to include in training, and preparing curricula. All staff members continuously monitor and respond to questions from coaches on the listserv and field phone calls from coaches needing information and resources.

Funding. No tuition is collected from staff. Costs of training are covered by incorporating them into contract and grant budgets when possible, through philanthropic gifts, and through contracts with payers.

VII. Evaluation and internal QI of the training

The North Carolina AHEC PSP does not formally evaluate training efforts. They acknowledge they would like to do this in the future.

VIII. Outcomes and placements

The North Carolina AHEC PSP has trained 70 practice coaches. Training takes place concurrently with the coaches' work for the program. The loss of coaching staff to other organizations that can offer higher salaries has been a challenge, especially given the high investment made in training and supporting these staff. However, program administrators regard the fact that their staff are highly sought-after as a mark of the quality of the program and the highly skilled individuals that they employ.

IX. Next steps for training

The North Carolina AHEC PSP hopes to implement a formal evaluation of its training program in the future. Staff members continue to update curriculum content to keep pace with changes in local, State, and Federal health care regulations and requirements.

X. Lessons learned

Training has grown in diversity and scope along with the program. The training strategy grew from a small-scale, predominately apprenticeship program at start-up to one that now has multiple training methods and components.

Coaches are as effective as the training and support they receive. Coaches are the means for pushing out new content and interventions to practices, and as such are the primary means of intervention for a PSP. Investments early and often in training and support of coaches are important to developing an effective coaching workforce and PSP.

It is easy to underestimate the costs of effective coach training. The process of coach training can be costly, and it is easy to underestimate the funding required to make that training effective. To be effective, coach training needs to be intensive and continuous. It also requires development of new training content on a regular basis, all of which requires funding and time.

Training content should be tailored to meet the learning needs of different students. Many individuals come to coaching as a second career. As a result, they bring a diversity of knowledge, skills, and experience. Coaches' existing knowledge and skills should be assessed before training starts, and training content should be adjusted to accommodate previous experience and to address gaps.

Apprenticeship in the practices that staff will eventually support is ideal. This allows the staff to build relationships with the practice and with his or her team members at the same time he or she is building skills.

In a team approach to coaching, practice coaches need to be proficient in their particular area of expertise but do not need to be proficient in every competency. Coaches should focus on building their skills in their area of expertise, be familiar with the areas of mastery of their fellow coaches, and be adept at engaging them on a facilitation team when that particular skill is needed. A training program's curriculum should allow for this type of differentiated learning and instruction.

Training programs should help coaches become proficient first in areas that are highly valued and immediately useful to practices and build skills in less urgent areas later. This helps coaches build self-confidence by giving them a way to be immediately useful and increases practice members' trust and interest in working with the coaches. This in turn supports future work to build quality improvement capacity.

The training curriculum cannot be static. New materials need to be developed regularly to keep practice coaches up to date with new regulations and programs. Training programs need a mechanism for tracking new developments and for training coaches in these areas in a timely manner.

Outside faculty are important resources for a PSP. Not only do they provide training to practice coaches, but they can also serve an important public relations function for the PSP. Engaging outside experts as faculty can bring desirable expertise and help build local credibility for the PSP.

This case study was developed as part of a contract funded by the Agency for Healthcare Research and Quality and was authored by:

Lyndee Knox, Ph.D., Director, LANet

Jesse Crosson, Ph.D., Senior Researcher, Mathematica Policy Research

Erin Taylor, Ph.D., M.P.P., Associate Director of Health Research and Senior Researcher,
Mathematica Policy Research

Appendix A: North Carolina AHEC PSP Training Program Partial Competency List and Target Proficiency Level

Describe: I know what this is and can describe it to others.

Explain/refer: I can explain this to others and refer them to reliable sources of more in-depth information than I can provide.

Demonstrate/apply: I apply this in my daily work; someone can observe me doing this.

Teach/facilitate: I teach this and facilitate others in its use.

Content area/topic/skill	Level
NC AHEC mission	1
Practice support program mission	1
Organizational structure	1
Funding	1
Criteria and standards by which program is evaluated	1
Partner organizations	1
Program work groups (e.g., data reporting, QI training, etc.)	1
Other QI approaches (LEAN, six sigma, etc.)	2
Motivational interviewing	2
Group medical visits	2
Access scheduling	2
NCQA application process	2
PCMH resources (CCNC Webinars, NCQA Webinars, PBWorks, Google)	2
NCQA 2011 standards and criteria	3
PCMH/MU core and menu measure crosswalk	3
Applying QI/EHR/REC/CMS/MU knowledge to PCMH consulting	3
Role of AHEC practice support consultant	3
Co-consulting (with other AHEC consultants, CCNC staff, etc.)	3
Practice recruitment and engagement (explaining program, executing agreements, etc.)	3
Practice assessment (readiness to change, key driver implementation scale [KDIS], etc.)	3
Planning and facilitating effective practice visits	3
Custom report writing, extracting clinical improvement measures data from EHR	3
Core resources (e.g., Dartmouth Green Book, IHI, Safety Net Medical Home Resources, etc.)	3
Practice coaching (e.g., water line model, change management, leadership, etc.)	3
Regional collaboration (e.g., sharing data, peer learning, collaborative meetings, etc.)	3
Setting post go-live goals and facilitating optimization process to achieve goals	3
EHR customization/optimization/reporting—MU and QI	3
MU gap analysis	3
REC practice milestones	3

Content area/topic/skill	Level
QI data (e.g., run charts, control charts, etc.)	4
Practice Support Program change package—general approach to improving clinical care promoted by NC AHEC Practice Support Program	4
Diabetes change package—clinical guidelines, improvement strategies, and measures specific to diabetes improvement	4
Asthma change package—clinical guidelines, improvement strategies, and measures specific to asthma improvement	4
Hypertension change package—clinical guidelines, improvement strategies, and measures specific to hypertension improvement	4
IVD lipid control change package—clinical guidelines, improvement strategies, and measures specific to IVD lipid control improvement	4
Tobacco dependence change package—clinical guidelines, improvement strategies, and measures specific to tobacco dependence improvement	4
Population management	4
Practice protocols	4
Planned care	4
Self-management support	4
Community resources	4
Team-based care	4
Model for improvement	4
Clinical improvement measures	4
QI tools (e.g., flow charts, check sheets, cycle time chart, balanced scorecard, etc.)	4
Basic project management	4
Meeting management	4
Clinical quality measures (CQM)	4

Appendix B: North Carolina AHEC PSP Core Competencies

Area 1. Program mission and methods

General overview

- ▲ North Carolina AHEC mission
- ▲ Practice Support Program mission
- ▲ Organizational structure
- ▲ Funding
- ▲ Criteria and standards by which program is evaluated
- ▲ Partner organizations
- ▲ Program work groups (e.g., data reporting, QI training, etc.)

Program systems, processes, and tools

- ▲ Clinical improvement data capture and reporting (www.ncipip.org) --> MyAHEC practice support
- ▲ PBWorks (northcarolinaahecdigital.pbworks.com/n/home)
- ▲ AHEC quality source (www.ahecqualitysource.com)
- ▲ REC data system (www.ncahecrec.net)
- ▲ REC Monday training calls
- ▲ Practice Support Program listserv
- ▲ MU office hours call
- ▲ AHEC consultant self-assessment tool
- ▲ CCME training modules
- ▲ Tutorial on REC Web site
- ▲ MOC Part IV credit process

Area 2. Clinical improvement consulting

Primary care systems

- ▲ Primary care office systems
- ▲ Payment, incentive, and recognition programs
- ▲ Practice types

Facilitative/empowerment consulting/coaching

- ▲ Co-consulting (with other AHEC consultants, CCNC staff, etc.)
- ▲ Planning and facilitating effective practice visits
- ▲ Basic project management
- ▲ Meeting planning and facilitation
- ▲ Practice recruitment and engagement (explaining clinical improvement program, executing agreements, etc.)
- ▲ Practice assessment (ACIC, key driver implementation scale [KDIS], etc.)
- ▲ Model for improvement (IHI Open School)
- ▲ Other QI approaches (LEAN, six sigma, CQM etc.)
- ▲ Custom report writing, extracting clinical improvement measures data from EHR
- ▲ QI data (e.g., run charts, control charts, etc.)
- ▲ QI tools (e.g., flow charts, check sheets, cycle time chart, balanced scorecard, etc.)
- ▲ Core resources (e.g., Dartmouth Green Book, IHI, Safety Net Medical Home Resources, etc.)
- ▲ Practice coaching (e.g., water line model, change management, leadership, etc.)
- ▲ Regional collaboration (e.g., sharing data, peer learning, collaborative meetings, etc.)
- ▲ Generic consulting
 - Facilitative/empowerment consulting/coaching
 - Co-consulting (with other AHEC consultants, CCNC staff, etc.)
 - Planning and facilitating effective practice visits
 - Basic project management
 - Meeting planning and facilitation

Area 3. Practice system redesign and innovation

- ▲ Chronic care model
- ▲ Practice Support Program change package—general approach to improving clinical care promoted by North Carolina AHEC Practice Support Program
- ▲ Diabetes change package—clinical guidelines, improvement strategies, and measures specific to diabetes improvement
- ▲ Asthma change package—clinical guidelines, improvement strategies, and measures specific to asthma improvement
- ▲ Hypertension change package—clinical guidelines, improvement strategies, and measures specific to hypertension improvement

- ▲ IVD lipid control change package—clinical guidelines, improvement strategies, and measures specific to IVD lipid control improvement
- ▲ Tobacco dependence change package—clinical guidelines, improvement strategies, and measures specific to tobacco dependence improvement
- ▲ Population management
- ▲ Practice protocols
- ▲ Planned care
- ▲ Self-management support
- ▲ Community resources
- ▲ Team-based care
- ▲ Motivational interviewing
- ▲ Group medical visits
- ▲ Access scheduling

Area 4. NCQA PCMH recognition

- ▲ NCQA 2011 standards and criteria
- ▲ PCMH/MU core and menu measure crosswalk
- ▲ NCQA application process
- ▲ Applying QI/EHR/REC/CMS/MU knowledge to PCMH consulting
- ▲ PCMH resources (CCNC Webinars, NCQA Webinars, PBWorks, Safetynet Medical Home)

Area 5. EHR incentive program consulting

- ▲ CCME training modules
- ▲ Tutorial on REC Web site
- ▲ Stage 1 MU
- ▲ Stage 2 MU
- ▲ Clinical quality measures (CQM)
- ▲ Setting post go-live goals and facilitating optimization process to achieve goals
- ▲ EHR customization/optimization/reporting—MU and QI
- ▲ MU gap analysis
- ▲ ONC milestones

Area 6. Practice management consulting

- ▲ Payment reform (e.g., value-based modifiers, bundled payments, ACO, physician compare—financial capacity and skills required, etc.)
- ▲ RVU analysis
- ▲ Benchmarking
- ▲ Coding/billing 101
- ▲ Business models for quality (e.g., CMS wellness exam, transitional care management, nurse visits)



AHRQ Publication No. 14-0054-EF
August 2014