Center for Health Policy and Research
333 South Street, Shrewsbury, MA 01545
508.856.6222 | 800.842.9375
http://commed.umassmed.edu

Developing the Medical Home Workforce

Judith Steinberg, MD, MPH
Sai Cherala, MD, MPH
Joan Johnston, RN, MS, DNP(c)
Anita Morris, MSN, FNP-BC

AIMS

- **Objective 1:** Identify key skills and competencies for the Patient-Centered Medical Home (PCMH) workforce.
- **Objective 2:** Delineate the roles of the multidisciplinary care team members
- **Objective 3:** Understand approaches to addressing PCMH workforce challenges

BACKGROUND

The Ill Health of Our Current Health Care System

- Provider-centered, not patient-centered
- Complex, chronic disease management
- Fragmentation of health care
  - Poor communication and data/information sharing
- Lack of attention to prevention and wellness
- Shortage of primary care clinicians
- High cost/poor results
  - Process, clinical outcomes, patient satisfaction

US Overall Ranking (2013)	11
Quality of Care	**5**
Effective Care	3
Safe Care	7
Coordinated Care	6
Patient-Centered Care	4
Access	**9**
Cost Related Problem	11
Timeliness of Care	5
Efficiency	**11**
Equity	**11**
Healthy Lives	**11**
Health Expenditures/ Capita, 2011	**$8,508**

http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

PCMH Joint Principles

2007 - Original	2014 - Integrating Behavioral Health (BH)
Personal physician	Home of the team
Whole person orientation	Requires BH service as part of care
Care coordinated	Shared problem and medication lists
Quality and safety	Requires BH on team
Enhanced access	Includes BH for patient, family and provider
Appropriate payment	Funding pooled and flexible

http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf
Ann Fam Med 2014; 183-185; Joint Principles from AAFP, ABFM, STFM.
Table adapted from Sandy Blount

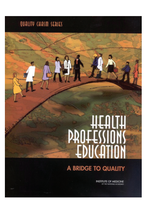
Health Care Professionals:
Health care is different from when they trained

Past and Present	Now and Future
Hospital	Community
Provider-Centered	Patient-Centered
Individual-Independent Practice	• Team-based Care • Integrated Care • Transitions
Disease and Diagnosis	Social Determinants of Health

Health Professions Education: A Bridge to Quality (IOM 2003)

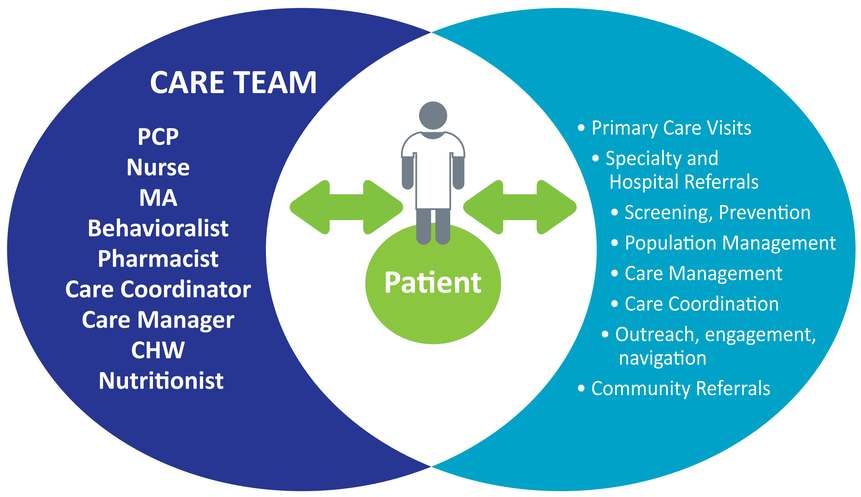
Educators and accreditation, licensing and certification organizations should ensure that students and working professionals develop and maintain proficiency in five core areas:

- Delivering patient-centered care
- Working as part of interdisciplinary team
- Practicing evidence-based medicine
- Focusing on quality improvement
- Using information technology



THE NEW MODEL

Pro-active Multidisciplinary Team-based Care



"Domains of Competency" from PCMH Principles

- Patient- and family-centered/ whole person care
- Multidisciplinary team-based care/teamwork
- Wellness and prevention
- Chronic disease management
- Population management
- Care coordination and transitions
- Integration of care
- Quality, performance, and practice improvement
- Information technology
- BH care

Adapted from Workforce Training for PCMH from Primary Care Collaborative 2010

Skills and Competencies

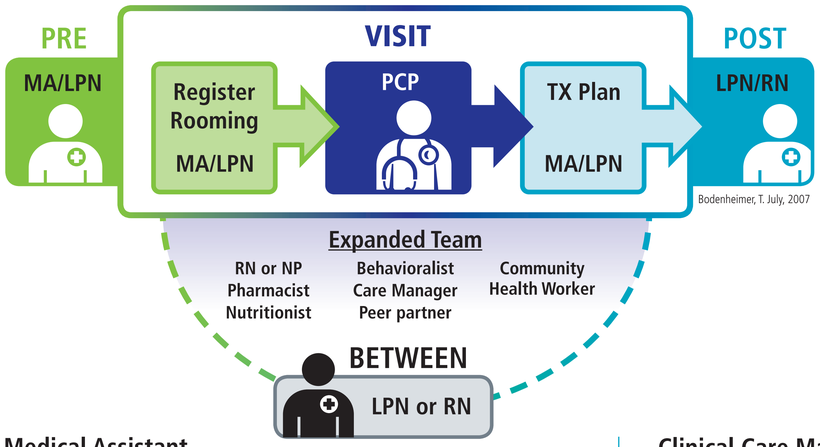
Patient and Family Centeredness

- Communication/listening
- Shared decision making
- Cultural and linguistic sensitivity/competency
- Motivational interviewing
- BH care

Multidisciplinary Team-based Care

- Inter-professional understanding, respect and appreciation
- Communication/listening
- Teamwork
- Conflict resolution and negotiation
- Leadership
- Management, supervision and administration
- Teaching and training
- Evaluation

Pro-active, Team-based Care: Roles



Community Health Worker

Public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve to provide:

- Culturally appropriate health education
- Patient and family outreach and engagement
- Informal counseling, social support, care coordination and navigation and health screenings
- Capacity building and advocacy for individuals and communities
- Linkage of patient, community and care team

Medical Assistant

Pre-visit

- Order health maintenance and chronic disease care testing using standing orders from evidence-based guidelines
- Pre-register patient
- Review patient's goals for visit
- Obtain reports
- Arrange interpreter
- Manage registries
- Huddle with care team

Visit

- Review goals for visit, chief complaint
- Conduct routine screening, risk assessment
- Initial med reconciliation
- Vital signs
- Follow-up on self management goals/treatment plan
- Communicate to PCP
- Post PCP visit: Reviews action and follow-up plans
- Provide visit summary

Nurse

- Primary contact for patients and families
- Answer patients questions/ address concerns at and between visits
- Manage registries — pro-active care, between visits
- Medication administration and reconciliation
- Educate patients — health and wellness
- Coordinate care across settings
- Arrange community-based services and visits with other team members and consultants
- Post-visit follow-up with patient — answer questions, check on implementation of care plan, discuss lab and test results
- Huddle with care team

Clinical Care Manager

- Maintain a risk stratification system to identify and keep current a list of highest-risk (HR) patients needing clinical care management
- Manage HR patients' primary risk driver(s) and physical, mental and psychosocial needs
- Evaluate and document patients' progress/risk status and care management interventions
- Coordinate care across the practice, health care system and community for HR patients
- Manage medications: prescriptions, refills, adherence, reconciliation

Behavioral Health Clinician

Patient Care

- Assessment/intervention/consultation
- Support for behavioral change
- Referrals to specialty mental health and substance use services
- Huddle with care team

Training the Care Team

- Mental health and substance use screening, diagnosis, treatment
- Health behavior change (e.g., motivational interviewing)
- Chronic disease management (pain, depression)
- Team functioning

Program Evaluation/Quality Improvement

Adapted from http://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf

NEXT STEPS

Addressing PCMH Workforce Issues

- Restructure and redesign health professions education
- Faculty development to ensure modeling of inter-professional care and education
- Health professions training in cultural competence, motivational interviewing, quality improvement
- Statewide, regional and national initiatives to support a diverse workforce

Office of Health Transformation: Coordinate Health Sector Workforce Programs: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=wolmyUUbmeY%3Dandtabid=162

BH Integration Workforce Crisis Alleviation

- **Retrain the current BH workforce; examples:**
  - Certificate Program in Primary Care Behavioral Health, UMass Medical School
  - Certificate Program in Integrated Care Management, UMass Medical School
- **Tap early adopters:** BH clinicians who are comfortable in primary care
- **Support BH internships and residencies** in primary care — at the level of primary care physician residencies
- **Stipulate that BH trainees** in approved training settings can be service providers in all future payment models

Center for Integrated Primary Care, UMass Medical School

SUMMARY

Goals of Workforce Training

- Develop and improve PCMH competencies
- Utilize team members more effectively and empower them to improve care, outcomes and patient experience
- Impact quality and performance
- Improve job satisfaction and retention

CONCLUSION

- The PCMH may solve many of the ills of our health care system
- New health care payment methods support care team member roles and services in PCMH
- An enhanced skill set for the entire care team is needed for successful implementation of the PCMH
- This will require redesign of training and education to support existing and incoming workforce
- A focus on inter-professional collaborative education is needed