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Developing the Medical Home Workforce

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Developing the Medical Home Workforce

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Developing the Medical Home Workforce

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

PCMH Joint Principles

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

Health Care Professionals: Health care is different when they trained

- Past and Present
  - Hospital
  - Provider-Centered
  - Individual-Independent Practice
  - Disease and Diagnosis
- Now and Future
  - Community
  - Patient-Centered
  - Team-based Care
  - Care Transitions
  - 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

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

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

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

Medical Assistant

- Pre-visit: Older 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

- 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 (HI) patients needing clinical care management
- Manage HI 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 HI 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

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

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

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