Developing the Medical Home Workforce

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Developing the Medical Home Workforce

AIMS
- Objective 1: Identify key skills and competencies for the Patient-Centered Medical Home (PCMH) workforce.
- Objective 2: Delineate the roles of the interdisciplinary 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
<table>
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<tr>
<th></th>
<th>Quality of Care</th>
<th>Effective Care</th>
<th>Safe Care</th>
<th>Coordinated Care</th>
<th>Patient-Centered Care</th>
<th>Access</th>
<th>Cost Related Problem</th>
<th>Timeliness of Care</th>
<th>Efficiency</th>
<th>Equity</th>
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Health Care Professionals:
Health care is different when they trained
<table>
<thead>
<tr>
<th>Past and Present</th>
<th>Community</th>
<th>Now and Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Provider-Centered</td>
<td>Patient-Centered</td>
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<td>Individual-Independent Practice</td>
<td>Team-based Care Integrated Care Transitions</td>
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<td>Disease and Diagnosis</td>
<td>Social Determinants of Health</td>
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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

PCMH Joint Principles
- 2007 - Original
  - Personal physician
  - Whole person orientation
  - Care coordinated
  - Quality and safety
  - Enhanced access
  - Appropriate payment
- 2014 - Integrating Behavioral Health (BH)

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

POST
- MA/LPN
- LPN/RN
- Community Health Worker

Medical Assistant
- Pre-visit
- Use of 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

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

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

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

Conclusions
- 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