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 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.

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, 2013 $8,508

pcmh.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf

PCMH Joint Principles
2007 - Original
2014 - Integrating Behavioral Health (BH)

Personal physician
Whole person orientation
Care coordinated
Quality and safety
Enhanced access
Appropriate payment

Home of the team
Requires BH service as part of care
Shared problem and medication lists
Requires BH on team
Includes BH for patient, family and provider
Funding pooled and flexible

Health Care Professionals:
Health care is different when they trained

Part and Present
Hospital
Provider-Centered
Individual-Independent Practice
Disease and Diagnosis

Community
Patient-Centered
Team-based Care
Care Coordination
Social Determinants of Health

Now and Future

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

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

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

Behavioral Health Clinician
• Patient Care
• Program Evaluation/Quality Improvement

BH Integration Workforce Crisis Alleviation
• Retain 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 residences
• 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

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