Workforce Training for PCMH: What are We doing to Equip the Team?

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Goals

- Examine current workforce training in practice transformation/patient centered medical homes for the broad spectrum of healthcare professions needed for PCMH Teams
- Suggest key skills and competencies
- Examine strengths and gaps
- Stimulate discussion and action
“Ideal Primary Care” goes Medical Home 2011

Unfortunately, no-one has any training or background

They search the internet, find “consultants”, spend $25,000, plus another $10,000 for the promise of NCQA certification, purchase a $120,000 medical record, and join 4 chronic care collaboratives

Bedlam ensues:

None of it seems to work, the staff begins to revolt, the partners begin to bicker, the patients get poorer care from the demoralized and disorganized practice, ...which closes 10 months later
What if…

...the Congress and the Administration mandated Patient Centered Medical Homes to open around the country in one year....

• We would first celebrate....
Then realize that we have few trained clinicians, administrators, or teams to staff them and few educational programs designed to specifically train for the medical home.

But there is more to the story...
Hope is on the way

- Rapid expansion phase in educational, training, and consultation services
- More demonstration projects on local, state, and regional
  - more experience
  - more mentors
- New models on the horizon
- New efforts to collect & disseminate curricula
STAGES OF CHANGE

pre-contemplation

contemplation

relapse

preparation

maintenance

action
Data Collection

- What is out there today?
- What is in the planning stages?
- What new models are emerging?

- Nurses
- Nurse Practitioners
- Physician Assistants
- Pharmacists
- Psychologists
- Social Workers
- Physicians
  - AAP, AAFP, ACP, AOA

Disclaimer: apologies if your program or interdisciplinary group was missed – rapidly changing arena
Framework of Training Possibilities

When can we reach the learners?

- Professional School
- Graduate education
- Residences
- Fellowships & Post-Docs
- Continuing Education/Professional Development
- Certification/Recertification
**Essential Skills for PCMH**

“Domains of Competency” from PCMH Principles

**Essential Skills**

*enable* people to perform tasks required by their jobs as well as adapt to change

- Patient Centered/Whole person care
- System-based care
- Practice-based learning
- Communication & Professionalism
- Teamwork
- Chronic disease management
- Practice & Population Management
- Coordination & Transitions of Care
- Integration of Care
- Quality, Performance, & Practice Improvement
- Information Technology
- Behavioral Health
Additional Skills required…

Other Key Attribute for PCMH: Adaptive Reserve

- **Leadership** facilitative vs. authoritarian
- **Aligned vision** for clinical care, operations, and financial function
- **Healthy relationships** rich communication, shared trust and regular, protected time to reflect and learn


- Learning culture
- Mindfulness
- Reflection
- Sense Making
- Respectful Interaction

- *Facilitating Change: Lessons from the TransforMED National Demonstration Project.* Slide Presentation from the AHRQ 2009 Annual Conference, Elizabeth Stewart
Competencies: Conceptual Frame

**Foundational**
- Inter-professional understanding and appreciation
- Relationships/team work
- Efficient and effective communication
- Individual and cultural diversity

**Functional**
- Assessment / Diagnosis
- Intervention
- Consultation
- Research / Program evaluation
- Supervision / Teaching
- Management / Administration
Please briefly add any further insights into model programs & curricula that you know about as we go...including ones in development.
Nursing

- Many essential skills intrinsic to training and role

- MA/MOA, LPN, RN, CNA

- Masters Programs
  - *Pediatric Nursing Leadership and Special Needs*
    (Univ Colorado; Univ Minnesota)

- Nurse Practitioners
  - American Academy of Nurse Practitioners
  - American College of Nurse Practitioners
  - National Association of Pediatric Nurse Practitioners
Physicians Assistants

“AAPA supports the medical home concept as a means to expand access and improve the quality of patient care.”
[Adopted 2008 and amended 2010]

- CME sessions offered at educational conferences
- Journal and newsletter articles
- Many essential skills intrinsic to training and role
  - team-based practice
  - coordination
  - integration of care
Pharmacists

Innovative Educational Programs at select schools of pharmacy (Ohio, New Jersey, Minnesota, Washington, others)

Interdisciplinary team training common

Expanded roles to include provider/medical service functions

- Patient-Pharmacist-Physician Collaborative Relationship
- Pharmacist as Physician Extender

- Evidence based practice
- Chronic disease management
Psychologists, Social Workers, and Behavioral Health

- Collaborative practice & inter-professional teams
- Psychological services to be “key in primary care initiatives”

APA has multiple initiatives to train the psychology workforce


- Society of Teachers in Family Medicine Annual Conference (April 27- May 1, 2011 in New Orleans, LA)
Psychologists

- Collaborative practice & inter-professional teams
- Psychological services to be “key in primary care initiatives”

APA has multiple initiatives to train the psychology workforce

VA has major initiative in integrate psychology into medical homes

Graduate Psychology Education funds available through HRSA

Relevant conferences
  - Society of Teachers in Family Medicine (April 27- May 1, 2011 in New Orleans)
Psychologist Roles

- Service delivery
  - Assessment/Intervention/Consultation

- Research methods / Program evaluation / Quality improvement

- Training others in disease prevention and chronic disease self-management
  - mental health
  - health behavior change (MI, BA, ACT)
  - chronic disease management (pain, CAD)
  - professional team functioning
Training in Primary Care Psychology

- Not a formal specialty in psychology ...yet

- Increasing number of formal training experiences
  - Postdoctoral fellowships
  - Rotations on internship
  - Practicum experiences at doctoral level

- Postgraduate certification/training programs
  - UMASS Medical Center
  - Fairleigh Dickinson University
  - University of Rochester
Social Work

- Social workers and psychologists have overlapping but distinct roles

- Social workers look at the whole person, within the context of their support system -- medically, socially, psychologically, functionally and economically

- Assess, intervene, consult at multiple levels – individual, family, community

- Know the services in the community and know how to access them

Social Work

The Affordable Care Act and its relevance to social work

- Readmissions (Section 3025) and Community Based Care Transitions (Section 3026)
- Independence at Home (Section 3024)
- Patient Centered Medical Homes and Interdisciplinary Community Health Teams (Section 3502)

Medical and Osteopathic Students

**Osteopathy (DOs)**
- Exposure at select PCMH clinical sites
- Discussion about curriculum

**Allopathy (MDs)**
- Exposure at select PCMH clinical sites
- C4 Core Clerkship Content Curriculum
- Growing number of clerkship programs in place & scores in planning phase
- Presentations
Best Practice: University of Oklahoma - Tulsa

- 2009 announcement of OU President: “...new models of care such as patient centered medical home...must be taught to physicians in training if we are to create a high quality and more efficient health care system in the US.”
PCMH Educational Initiative: Ohio

House Bill (Ohio) 198, June 2010

- PCMH education pilot project will convert 44 practices to the PCMH model of care

- 40 practices led by physicians; 4 by advanced-practice nurses

- The 40 physician-led practices must be affiliated with one of several Ohio MD or DO schools: Wright State, University of Toledo, Northeastern Ohio, Ohio University

- The Deans of the Ohio medical schools will develop a proposal to create as many as 50 scholarships each year for medical students who participate in PCMH training and agree to practice primary care for at least three years in Ohio after residency
Residency Education & PCMH

- Individual & Networked Program Development: Pediatrics, Family Medicine, Internal Medicine
  - Washington State Medical Home Collaborative (11 residencies)
  - I3 Collaborative: South & North Carolina and Virginia (23 programs: FM, IM, Peds)
  - Colorado (7 FM programs)

- AOA developing PCMH modules for graduate medical education
Preparing the Personal Physician for Practice

- Designed to inspire and examine innovation in family medicine residency training and prepare “personal physicians of tomorrow”

- 14 residencies selected from 84 applicants

- Intensive evaluation of outcomes

- Different innovative approaches include general PCMH models and specific PCMH competencies

Sponsors: American Board of Family Medicine, the Association of Family Medicine Residency Directors, and TransforMED. http://transformed.com/p4.cfm
PCMH Practice Transformation

- Facilitated practice transformation to PCMH
- Created model training environment for residents
- Applied for NCQA Level 3 PCMH recognition

Implementation

- Mature EHR with patient web portal
- Improved patient access to care
- Multi-disciplinary QI Teams implementing PDSA Cycles
- Multiple practice improvement initiatives underway
- Increased practice income from improved efficiency & accuracy of coding
- Extracting accurate data from EHR registry is difficult
- Change is never easy!

Hypothesis: Residents’ ability to practice New Model care will improve

Results:

Resident exposures to New Model Practice elements:

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<td>8</td>
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<tr>
<td>2010</td>
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33% increase in total exposures
75% increase in exposures to mature elements

(based on results of Status of New Model of Family Medicine Survey)
Best Practice
Lehigh Valley Health Network Family Medicine Residency Program
Allentown, PA

Integration of Team Based Learning & Practice

Brief Description
- Organize residents and faculty into Continuity Care Teams at each Community Care Site that are responsible for a shared patient panel and implementing PCMH changes

- Implementation
  - Must have scheduled regular meetings built into schedules of all team members,
  - Teams become more effective as they developed a defined structure (setting goals, agendas for meetings, designated leaders, communication)
  - First year schedules minimize their feeling connected to CCT
  + Incorporated group dynamics, leadership theory, SPPI tools into Learning Labs to support skill development of faculty and residents
  + Teams of 1 resident per year, at least 1 faculty, 1 nurse, and 1 office staff

- Related hypotheses
  - Graduates with Increased Relationship Centered Generalist Care Competency
  - Increased empowerment, life satisfaction, happiness, and life long learning for whole system and individuals within system
Best Practice:
Seattle (Swedish) FM Residency Site

- Ballard health center opened its doors March 2009

- Primarily staffed by family medicine residents (2/2/2) and 2 FTEs of faculty

- Meets NCQA and other criteria

- Payment Reform a key component: negotiated flat rate with 2 private payers and uninsured pay 50% ($45 per month)
Medical & Osteopathic Fellowships

- Broad Range of PCHM programs???
- “There are currently no [PCMH fellowship] opportunities.” (April 2011)

PCMH Essentials:
- Health Services Research
- Quality improvement & chronic disease management
- Medical Informatics
  - (Veteran Administration; University of New South Wales in Australia)
Continuing Education

Major opportunity for intervention – *life-long learning*

- Nurse Practitioners (esp. pediatric)
- Pharmacists
- Physician Assistants
- Physicians
  - AOA, AAFP, ACP, AAP
- Psychologists
  - UMASS, Farleigh Dickinson Univ, Univ Rochester
- Social Workers
Continuing Education: Companies

THE COMPLETE ONLINE MEDICAL HOME TRAINING PROGRAM IS NOW AVAILABLE

- Includes:
  - Background readings (available online)
  - Streaming Video of entire Medical Home Summit with synchronized PowerPoint presentations (18 hours of content) (6 months of access - 24/7)
  - Online examination with certificate of completion

- Integrates easily into corporate compliance training program

- **Purchase individually** for $595

- Or **license multiple seats** as follows:
  - 5 or more for $395 each
  - 10 or more for $295 each
  - 15 or more for $195 each
  - 20 or more for $95 each
Certification/Recertification

- **Family Physicians**: Maintenance of Certification: *Performance in Practice*

- **Internists**: Evaluation of Performance in Practice; Recertification Resources - *PIM* Practice Improvement Module

- **Pediatricians**: Maintenance of Certification: - *EQIPP* enhancing quality improvement in pediatric practice (launch in 2010)
Advanced Models of Training

Distance learning
- Teleconferences
- Podcasts
- Webinars
- Virtual consultants

Local Assistance & Facilitation

New Models
- On-line collaborative networks
- Cooperative Extension Services
American Academy of Pediatrics
Transformation Initiatives:

National Center for Medical Home Initiatives

- Promotes quality improvement & standards
  - Toolkit
  - Self-instructed “Building Blocks”
  - Podcasts, teleconferences, CME webinars
  - List-serve
  - Limited technical assistance
  - Branching out from focus on just children with special needs to all children

Building Blocks:
- Care Partnership Support
- Clinical Care Information
- Care Delivery Management
- Resources & Linkages
- Practice Performance Measurement
- Payment & Finance
Broader Pediatric

Information, tools, and resources to improve care of Children and Youth with Special Health Care Needs

Toolkit and consultations

- On-line & on-site
- Pediatric & Adult care
American College of Physicians

On-line practice assessment & dynamically linked resources

- Self-paced program guides through the ACP Practice Biopsy, then directs to resources & case studies for achieving goals
- For individuals, groups, teams, practices, demonstration projects, IPAs, multi-organizational efforts, & residency training programs
- Incremental quality improvement changes to significant transformation
- Available for CME credit (internists)

Practice Biopsy & Modules
- Patient-Centered Care & Communication
- Access & Scheduling
- Organization of Practice
- Care Coordination & Transitions in Care
- Use of Technology
- Population Management
- Quality Improvement & Performance Improvement
The TransforMED Approach

- Practice-based Care Team
- Practice Management
- Quality and Safety
- Continuity of Care Services
- Health IT
- Care Management
- Access to Care and Information
- Practice Services

Primary Care

Great Outcomes

- Practice Organization
- Quality Measures
- Patient Experience
Medical Home Transformation

- Web-based toolkit
  - evaluates current medical home status
  - develops a strategy for transformation
- Links to tools and resources for practice re-design
- Coaching, facilitation, tailored training –on-site
- Practice retreats
- Delta Exchange: online, collaborative network
Why Facilitation is Important

Figure. Change in adaptive reserve for facilitated and control practices, baseline to 28 months

Change in Adaptive Reserve*

*Adaptive reserve includes measures of leadership, sensemaking, diversity, mindfulness, communication, respectful interaction, learning culture, reflection and general work environment. Baseline vs. 28 months for facilitated group is statistically different. (p<0.01)
Cooperative Extension Program

- Similar to agricultural extension services
- Providing the expertise to organize PCHM
- Based on New Mexico & other state models

UNFUNDED...but AHRQ is pilot funding 3 in 2011

IN THE SENATE OF THE UNITED STATES

TITLE IV—HEALTH CARE WORKFORCE

Sec. 455. Primary care extension program.

“(A) Health extension agent.—The term ‘Health Extension Agent’ means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways,
Solutions – for Discussion

- Sound educational models need to be developed for different disciplines at different stages of training
- Professional schools to select, support, and train PCMH-ready clinicians
- Team work/interdisciplinary training
- Life-long learning of key skills to all clinical groups
- Broad education/consultancy models that are on-line and on-the-ground – available everywhere
- Linked payment reform
- Other......
“Ideal Primary Care” goes Medical Home 2012...

All members of the interdisciplinary team received PCMH training at each stage.

Local PCMH practices offer to mentor them.

Premier consultancy agency provides on-line and on-the-ground guidance.

Cooperative extension service sends their extension agent to provide continuing advice and assistance.

Insurers change their compensation model.

The practice successfully makes the transition to the PCMH, increases not only the satisfaction of patients and clinicians, but health outcomes and the bottom line.

They become mentors and their children join the 4H club (health, humanism, (medical) home, and happiness) and win first prize at the State Health Fair.
The Hope: a medical home in every community and an educated, competent team for every home.

Thanks!