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| Scope of Practice: Pediatric Care Facilitators |
| Task 3 Deliverable Draft |



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# Executive Summary

In August 2019, Atrius Health engaged healthcare consulting firm AHP to review and codify competencies, work standards, and best practices for three non-licensed paraprofessional roles in Atrius’s practices. Previously, AHP conducted a series of interviews and other assessment activities to establish the current state of responsibilities, functions, and competencies of these three staff roles—pediatric care facilitators (PCFs), behavioral health care facilitators (BHCFs), and population management coordinators (PMCs). This report recommends the next step in that process: a detailed scope of practice for each role to perform optimally in the Atrius Accountable Care Organization (ACO) environment.

PCFs, BHCFs, and PMCs at a Glance

***Pediatric Care Facilitators (PCFs)*** support pediatric patients, their families, and providers with care coordination and navigation around complex medical and social needs.

***Behavioral Health Care Facilitators (BHCFs)*** support adults and some children with behavioral health diagnoses from all payers but primarily a Medicaid population.

***Population Management Coordinators (PMCs)*** serve adult patients with chronic illnesses, address gaps in preventive care, and focus on quality metrics in the practices.

## Approach to Development of Scopes of Practice

A scope of practice describes the procedures, actions, and processes that an individual is permitted to undertake according to regulations and licensure, if applicable. Developing a scope of practice for a non-licensed paraprofessional like the PCF, BHCF, or PMC involves understanding how they can best contribute to the healthcare process and align that with activities that do not require licensure or other credentials that might be in the scope of a licensed colleague, such as a nurse or social worker, for instance.

In order to develop these scopes of practice, AHP conducted an environmental scan of evidence-based and best practices and competencies for same or comparable positions. In this report, those are presented as a detailed set of competencies and knowledge, skills, and abilities (KSAs) that will enable these paraprofessionals to optimally perform their jobs for the good of Atrius and its patients.

This report is organized to best outline competencies and how they apply to Atrius’s environment. Key points for each role include:

* highlights of the evidenced based and best practices for each facilitator role,
* the ideal competencies and related KSAs that should be associated with each role,
* how the role can be used within the context of the Atrius organization, and
* if there can be/should be any career ladders.

This version of the report focuses exclusively on the PCF scope of practice.

# Pediatric Care Facilitators (PCFs)

## Evidence-Based Practices and Best Practices

A brief nationwide environmental scan of best practice standards, competencies, and skills across positions similar to that of a Pediatric Care Facilitator (PCF) included a review of literature related to staff positions such as practice facilitator, care coordinator, patient navigator, family navigator, and resource specialist. It was found that the PCF position most closely aligned with those of a care coordinator and a patient/family navigator.

Two prominent best practices that most closely resemble the work of a PCF emerged.

**1. The guiding framework for delivering high performing pediatric care coordination** is themost notable and widely cited promising practice associated with the work of PCFs. Competencies described in this framework include:

* developing partnerships,
* communicating proficiently,
* using assessments for intervention,
* facility in care planning skills,
* integrating all resource knowledge,
* possessing goals/outcome orientation,
* taking an adaptable and flexible approach,
* applying team building skills, and
* proficiency with information technology (AAP, 2014; Antonelli, 2009).

**2. Patient or family navigation,** which is defined as “an evidence-informed strategy intended to guide families through and around barriers in the health care system so that they may overcome obstacles faced when accessing or receiving care” (AMCHP, 2018) is also closely aligned with the work of the PCF. In many cases, patient/family navigation is considered an aspect of care coordination and care coordination is considered an aspect of family navigation. The following are competencies for non-clinically licensed patient navigators developed by George Washington University (GW) Cancer Institute (Pratt-Chapman, 2014):

* Patient care
* Knowledge for practice
* Practice-based learning and improvement
* Interpersonal and communication skills
* Professionalism
* Systems-based practice
* Interprofessional collaboration
* Personal and professional development

Lastly, the service descriptions for both care coordination and patient navigation vary widely. However, some commonalities have emerged and informed the following proposed definition of PCF derived from the EBPs and best practices.

PCFs manage a process aimed at mitigating systemic and socioeconomic barriers to ensure that patients can access and utilize medical, behavioral health, and social services and associated resources across multiple, often fragmented, service delivery settings. PCFs utilize a set of core competencies and associated knowledge, skills and abilities that serve as the foundational approach with which they conduct standard work processes and other tasks in service to assisting the primary care practice in achieving optimal health outcomes for vulnerable populations. PCFs are system of care subject matter experts who consult to primary care team members and help patients navigate complex medical, behavioral health, and social service systems of care and attain local services and resources to address social determinants of health (SDOH) and behavioral health needs.

## Ideal Competencies and Associated KSAs

A brief environmental scan of care coordination and family navigation practices was conducted with the goal of identifying a set of competencies specific to PCFs. The method for conducting an environmental scan and arriving at a core set of competencies included performing semi-structured interviews and focus groups with key informants, as well as a review of the literature on pediatric care coordination and family navigation. The literature review included journal articles, white papers, research reports, government and private sector documents, guides, “tool kits” and competency sets relevant to this process. (See [Appendix A](#_Appendix_A:_Literature) for full list of sources.) Each of these sources yielded potential content for inclusion in the below PCF competency set, which includes:

1. Using Independent Judgement and Professionalism
2. Communicating Effectively
3. Collaborating and Fostering Teamwork
4. Practicing Cultural Relevance
5. Understanding and Assessing Patient and Family Needs
6. Navigating Systems of Care
7. Strengthening Patient Access to and Use of Providers, Services, and Resources
8. Improving Quality and Outcomes

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| Competency: Using Independent Judgement and Professionalism  While working under the general supervision of a primary care provider, acts autonomously and discerns when to involve a clinician. Acts with integrity, politeness, confidence, and humility and demonstrates self-awareness and a willingness to accept and resolve mistakes in a mutually agreeable manner. |
| **Demonstrates knowledge of:**   * Scope of practice of each primary care team member. * Differences in each primary care team member’s role. * Ethical and professional obligations. * Patient rights. * Emotional Intelligence. * Organizational and time management tools. * Department and organization policies and procedures. * Professional etiquette and attitudes. |
| **Demonstrates the skill & ability to:** |
| * Exhibit the emotional intelligence needed to positively impact desired healthcare outcomes. * Show sensitivity and responsiveness to a diverse patient population including but not limited to gender, age, culture, race, religion, abilities, and sexual orientation. * Build trust by being accessible, reliable, accurate, and supportive. * Demonstrate accountability to patients, members of the primary care team, and others. * Apply knowledge of and act within professional boundaries and scope of practice. * Use organizational skills, time management, problem solving, and critical thinking to assist patients efficiently and effectively. * Respond to patient needs over personal self-interests. * Use tact and a cooperative attitude in all forms of communication. * Promote PCF role, responsibilities, and value to patients, providers, and the larger community. * Adhere to ethical principles of healthcare. * Actively participate in professional growth and learning activities. * Employ self-care strategies and healthy coping mechanisms. * Perform duties accurately and efficiently. * Incorporate feedback from supervisor and team members to improve daily performance. * Have awareness of the things one doesn’t know and seek out consultation and learning opportunities to fill the gaps. * Practice speaking with both confidence and humility. * Maintain composure and politeness even in the face of a difficult or tense situation. * Reliably act with integrity and take responsibility for one’s own actions. * Work to resolve mistakes as soon as possible. * Assertively express one’s professional opinions; encourage and actively listen to other team members opinions. * Resolve differences of opinion or conflicts quickly and without acrimony. * Respectfully respond to others. * Accept and give feedback discreetly. * Build relationships and connections with critical decision makers in the primary care setting and Pediatric Department. * Apply insight and understanding about human emotions and responses to create and maintain positive interpersonal interactions. |

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| Competency: Communicating Effectively  Establishes rapport quickly; communicates in a confidant, warm, and open manner with primary care team members, patients, their family members and others in a variety of settings (e.g., meetings, huddles, phone calls, emails, warm handoffs, curbside consultations and medical records). |
| **Demonstrates knowledge of:**   * Active listening skills. * Terminology common to the pediatric primary care setting. * Medical office procedures and terminology. * The general impact of Social Determinant of Health on (SDOH) on patient health. * Basic understanding of pediatric growth and development. * Basic understanding of medically complex needs. * Basic understanding of behavioral health and substance use disorders. |
| **Demonstrates the skill & ability to:** |
| * Listen actively; paraphrase or repeat key points back to demonstrate understanding. * Ask open ended questions to gain additional information. * Ask specific questions to seek clarification. * Convey information to patients/family in a polite, jargon-free, non-judgmental manner. * Adapt to the preferred mode of communication of the patient and family. * Demonstrate concern and a desire to help. * Relay all pertinent information from patient to provider or vice versa. * Express openness to the ideas, opinions, and feedback of others. * Express one’s knowledge and opinions about a patient’s situation to primary care team members in a sensitive, respectful, and clear manner. * Summarize a patient’s problems and PCF action steps succinctly in both verbal and written communications. * Communicate information to patients/families using terms that are easy to understand and culturally acceptable. * Use language that is appropriate to the patient’s age and education level. * Address the patient using culturally appropriate terms, in the patient’s preferred language, using qualified interpreters when necessary. * Establish rapport rapidly. * Demonstrate the ability to quickly grasp presenting problems, needs, and preferences communicated by others. * Clearly convey relevant information in a nonjudgmental manner about behavioral health, general health, and socioeconomic concerns. * Remain solutions-oriented in interactions with patients, families, and members of the primary care team. * Encourage active communication between patients/families and health care providers. * Demonstrate empathy, integrity, honesty, and compassion in all communications. * Effectively exchange information with patients, parents, and members of the primary care team. * Communicate effectively across a variety of socioeconomic and cultural backgrounds. * Appropriately document information regarding the delivery of PCF services. * Engage in timely communication and follow up with referring provider, parents, and other providers. * Compose minutes, letters, emails, and reports using proper rules of grammar, spelling, and punctuation. * Explain to patient and family the roles and responsibilities of each team member and how they will work together to provide services. * Adapt the style of communication to account for the impact of health conditions on a patient/family’s ability to process and understand information. * Provide materials that are appropriate to the literacy of the family and that reinforce information provided verbally during visit. |

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| Competency: Collaborating and Fostering Teamwork  Works together with primary care team members (i.e., primary care providers, nurses, community health workers (CHWs), behavioral health providers, and other partners), as well as patients/family members to achieve common goals and complete tasks in the most effective and efficient way possible. |
| **Demonstrates knowledge of:**   * When and how to request and obtain consultation from team members. * Case presentation skills. * When to offer input to primary care clinician and others. * Which family circumstances/dynamics to inform primary care team members about. * Principles that guide teamwork. * Principles of shared decision making. * Roles and responsibilities of each pediatric care team member. * Process to consult and confer with Pediatric Department, Development Behavioral Pediatrics (DBP), Behavioral Health Department, Internal Medicine and other specialty departments. |
| **Demonstrates the skill & ability to:** |
| * Express recognition, respect, and value for the expertise of all primary care team members (parents/family, primary care team members and other service and resource providers). * Show understanding and valuing of each care team member’s roles and responsibilities. * Solicit and show appreciation for input from team members. * Share responsibility for patient care and outcomes. * Engage in shared decision making and care planning. * Outreach family, primary care team members, specialty providers and relevant external supports (Department of Children & Families [DCF], school, etc.) when necessary to determine if a patient’s needs have changed. * Recognize the limits of one’s knowledge and skills and seek assistance from others. * Share new/changed healthcare problems, behavioral health concerns, and socioeconomic concerns reported by family in order to inform the plan of care. * Encourage collaboration across the primary care team. * Act as a subject matter expert consulting to patients and primary care team members regarding local services and resources to address social determinants of health and behavioral health needs and the process of navigating complex medical, behavioral health, and social service systems of care. * Share relevant information with external parties as authorized by the patient/family and as permissible under HIPAA and related laws, regulations, and policies. * Implement process improvement strategies aimed at enhancing teamwork. * Demonstrate practicality, flexibility, and adaptability in the process of working with others. * Respond immediately, whenever possible, to requests to meet or contact a patient. * Respond promptly to all requests form primary care team members. * Be flexible, working autonomously and as part of a team. * Communicate with people from different backgrounds, professions, and cultures with tact and diplomacy. * Advocate for patient’s needs. * Communicate and follow up with parents, referring provider, and other providers. * Act as bridge between family and provider. * Demonstrate an understanding of clinician recommendations. * Hold primary care team’s goals/agenda alongside the patient’s goals/agenda, which may be in conflict. * Form realistic views of goals. * Demonstrate co-accountability for the achievement of goals and tasks in a patient’s care plan. * Take an adaptable, flexible approach. * Establish and maintain timely communication with primary care team members sharing progress on agreed-upon tasks. * Troubleshoot and problem solve with primary care team members to complete tasks and address challenges/barriers preventing task completion. * Share patient expressed beliefs, concerns, and questions with primary care team members. * Acts as bridge between family and clinician. * Develop and maintain effective working relationships with diverse individuals, including patients, family members, and other providers. |

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| Competency: Practicing Cultural Relevance  Acquires an understanding of cultural identities (such as racial, ethnic, religious, sexual orientation, gender identity, economic, social, educational status, and other affiliate groups), values, beliefs, attitudes, traditions, personal circumstances, conditions, and experiences that may influence a patient’s access to and use of providers, services, supports, and resources. |
| **Demonstrates knowledge of:**   * The impact of culture on health practices, health beliefs, and participation in treatment. * The role of community environment and family dynamics in health practices, health beliefs, and treatment adherence. * The impact of behavioral health stigma on healthcare. * Disparities in healthcare access and quality across diverse populations. * How diverse populations being served by the primary care practice view illness and treatment. * National standards for culturally and linguistically appropriate services (CLAS) in Health and Health Care. |
| **Demonstrates the skill & ability to:** |
| * Develop relationships with community organizations that offer culturally relevant resources. * Communicate with compassion, sensitivity, and cultural attunement to patients/families. * Acknowledge power and privilege differences and similarities between and among groups of people and uses this knowledge to work effectively with all people. * Adapt to language preferences and cultural norms of the family. * Inform patient and family about the desire to honor their boundaries while also connecting them to culturally relevant services and supports which may include racial, ethnic, religious, sexual orientation, gender identity, immigrant/ refugee, or other groups with which they identify or feel an affiliation. * Explore patient and family beliefs and perspectives on the best way to address physical health, behavioral health, substance use, social, and other concerns. * Seek out and link families to cultural relevant services and supports that were discussed with family. * Be flexible and quickly adapt approach based on cultural factors. * Understand culturally sensitive relationships and dynamics. * Identify the need for and obtain culturally relevant consultation and supervision. * Share patient beliefs and cultural norms during care planning conversations with primary care team. * Respectfully share concerns with primary care team members regarding observed actions that appear insensitive to youth/family culture or experience. |

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| Competency: Understanding/Assessing Patient and Family Needs  Builds relationships by actively listening and expressing empathy, sensitivity, compassion, and respectful curiosity about patient and family needs, strengths, and culture. Establishes an expectation of shared decision making in which the patient and family’s perspective, experiences, and opinions about their needs are sought and validated. |
| **Demonstrates knowledge of:**   * Active listening skills. * Verbal/nonverbal de-escalation strategies. * Basic parenting practices and family systems. * Basic child development. * Patient’s rights and responsibilities in healthcare. * Motivational interviewing. * Adverse childhood experiences (ACE) and their impact on patient health. * Social determinates of health. * Emotional attunement (the ability to understand and engage with another's emotional state). * Stress management. * Medical, social, and behavioral needs common to patients seen at the primary care practice. |
| **Demonstrates the skill & ability to:** |
| * Gain patient and parent trust. * Explore patients’ needs with referent and patient/family. * Elicit medical, behavioral, social concerns from patients and their families. * Grasp the essence of a problem or challenge from patient’s perspective. * Confirm patient/family understanding of the reason for PCF referral. * Explore patient needs (as applicable) with CHW, other primary care team members, DCF, etc. * Assess patient/family’s stage of readiness to address needs. * Explore appointment and treatment adherence and barriers. * Explore patient/family’s reluctance to participate in services/treatment to address needs. * Use motivational interviewing to increase the patient’s readiness to address needs. * Ensure patients and families understand next steps to address their healthcare needs (i.e., next appointment, obtain paperwork, call specialist, etc.). * Provide patients with self-management encouragement and support. * Answer patient/family questions and/or obtain consult get questions answered. * Suspend judgement and speak calmly especially with agitated patients/families. * Facilitate communication between patient/family and provider as warranted. * Encourage patient/family to communicate with the primary care practice regarding their socioeconomic worries, medical concerns, and behavioral health needs. * Encourage patient/family to ask questions. * Identify family’s social needs. * Assess the family’s ability to utilize services on their own verses the need for support to do so. * Monitor patient/family needs. * Obtain and record accurate information from patients. * Educate parents on the process of managing their personal medical records including schedules, reports, treatment plans, bills, and prescriptions. * Review information sheets with patient/parent that cover topics addressed by their provider and ensure that clinical questions are referred to the appropriate provider. * Listen for patient preferences and treatment priorities and share this information with the primary care team. * Demonstrate compassionate and respectful interactions with patients and parents. * Bring together families and multiple providers. * Interact in an empathic manner especially with overwhelmed families displaying challenging behavior. |

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| Competency: Navigating Systems of Care  Maintains working knowledge of processes and procedures to access, apply for, and receive healthcare, behavioral healthcare, dental, social services, and other supportive services/resources from and array of complex and sometimes fragmented medical, behavioral health, and social service systems of care. Educates patients/families about these procedures and helps them move through the processes to obtain/maintain services, supports and resources in order to improve overall health outcomes. |
| **Demonstrates knowledge of:**   * Atrius healthcare system, Development Behavioral Pediatrics Department, and other specialty departments internal and external to Atrius. * The array of behavioral health and substance use services patients have access to based on their insurance plan (e.g., outpatient therapists, psychiatric prescribers, Children’s Behavioral Health Initiative [CBHI] services, etc.). * Department of Mental Health (DMH) services and application process. * Department of Development Services (DDS) services and application process. * Department of Children & Families (DCF) services and child protection mandate. * Department of Transitional Assistance (DTA) services and application process. * Social Security Disability Insurance (SSDI) benefits and application process. * Local resources to address SDOH. * Dental providers and dental insurance coverage. * Process to maintain and reinstate MassHealth insurance. * Individual education program (IEP), core evaluation, and other processes for obtaining special education accommodations. * Process to obtain baby formula, durable medical equipment, and other resources. * Process to join local support groups for parents of children with special needs. * Process to join local support groups for siblings of children with special needs. * Guardianship process for developmentally delayed children transitioning to internal medicine. |
| **Demonstrates the skill & ability to:** |
| * Develop strategic relationships with system partners in order to establish an integrated network of resources. * Establish and maintain an electronic file/binder of local resources and family friendly information sheets (i.e., autism resources, afterschool/camps available for special needs children, dentists, resources for the SDOH such as food/clothing/utilities resources, etc.). * Distribute condition-specific health educational resources to families as approved by their provider. * Provide family with financial, educational, and socioeconomic resource information. * Assess the level of support a patient/parent needs to navigate the system: determine whether parent is able to navigate system with encouragement and coaching, needs PCF to complete aspects of the process with them, or needs PCF to complete processes for them (make calls, fill out applications, etc.). * Provide the right level of support to the patient/family in navigating the system of care based on patient/parent’s comfort, knowledge, skill, and ability to follow the processes of that system. * Educate parents about the process for obtaining development behavioral pediatric assessment, special education accommodations, guardianship processes; state agency services; insurance funded services, etc. * Coach parent in the skills to navigate complex systems of care (development behavioral pediatric assessment, special education accommodations, guardianship processes; state agency services; insurance funded services, etc.). |

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| Competency: Strengthening Patient Access to and Use of Providers, Services and Resources  Educate patients/parents about services and resources and help them locate, obtain, and access needed medical, behavioral health, social, dental, and educational services and related resources in support of their healthcare goals. |
| **Demonstrates knowledge of:**   * Ways to cut through “red tape” to expedite solutions. * Ways to identify and build relationships with “go to” people and agencies, medical, behavioral health, social service providers and related resources * Warm handoff processes. * Transportation resources. * Medical specialty services. * Types of behavioral health services such as psychotherapy, in home therapy, psychiatry, intensive care coordination and the referral criteria/populations they serve. * Special therapies (PT, OT, etc.). * Early intervention services and supports available to babies and young children with developmental delays and disabilities and their families. * Special education services. * Home care services. * Financial support services. * Housing, clothing and food resources (food pantries etc.). * Legal advocacy organizations. * Support groups. * Childcare resources. * Camp/afterschool programs. * Resources/process to obtain durable medical equipment, formula, diapers, etc. * Qualification for, how to access, and what is covered by the Women Infant and Children (WIC) program and supplemental Nutrition Assistance Program (SNAP). |
| **Demonstrates the skill & ability to:** |
| * Assess barriers to care and engage patients and caregivers in creating potential solutions to financial and social challenges. * Advocate for patient’s needs. * Arrange for, set up, and coordinate referrals and track and monitor referral results. * Identify and troubleshoot barriers that prevent patients/families from accessing and utilizing services and resources. * Identify and connect families to appropriate and credible resources that are responsive to patient needs (practical, social, physical, emotional) and communicate them in a way that patients and caregivers understand. * Assess barriers to patients attending appointments/following through with processes. * Coordinate transportation. * Identify patients who are at risk for low appointment attendance or resource utilization, track their attendance/utilization of resources and remind them of appointments. Follow up with patient/family when they missed an appointment in order to explore barriers, ensure appointment is rescheduled, and resolve barriers to attending in the future. * Follow up on referral/waitlist status, patient attendance to appointment, and use of resources. Update primary care team, document, respond to changes accordingly. * Determine need for and when warranted, draft and offer parent core evaluation/IEP request letter on behalf of patient, explain the process to parent for submitting request, next steps and timeline that school is obligated to follow. * Initiate and follow up on referrals. * Follow-up with patients to support adherence to agreed-upon goals/action items. * Develop a collaborative relationship with healthcare providers, social service organizations, resource entities in order to reduce patient care barriers. * Provide family with financial, educational, and socioeconomic resource information. * Determine when to arrange services and when to educate/guide patient so that they can arrange services for themselves by assessing patient/family’s readiness to and level of support needed to ensure the patient will effectively access medial, behavioral healthcare, financial, educational, social, services, resources, providers, etc. Provide that level of individualized support as warranted for patient/family (e.g., arranging for and scheduling services and resources on family’s behalf, together with them, encouraging them to do so on their own and following up to learn about the outcome). * Promote family self-care skills and independence by identifying need for and providing relevant coaching/education to the patient/family. * Monitor patient’s knowledge of and ability to access services over time; intervene as needed and document in care plan. * Facilitate communication between service/treatment settings. * Transfer relevant information/knowledge between service/treatment settings. * Engage in warm handoffs (i.e., directly introduces the patient/family to a new service provider during which all three parties are present either in person or telephonically) in order to support transition to Internal Medicine or other department within Atrius or to bridge the connection to a new service or provider outside of Atrius. Determine need for and then coordinate, as warranted, in person, telephonic or virtual “warm” hand offs. |

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| Competency: Improving Quality and Outcomes  Strengthens and advances PCF service delivery and outcomes by participating in professional growth opportunities, continuous self-assessment, program evaluation, and implementation of best and promising practices. |
| **Demonstrates knowledge of:**   * Policies, procedures, standard work. * Continuous learning opportunities. * Limits of own knowledge, skills, and expertise and how to fill gaps in knowledge/skills. * Metrics and benchmarks the PCF program is measured on. * PCF staff performance metrics and benchmarks staff are held accountable to. * Reports, registries, etc. that contain data relevant to PCF work. * Ways to practically apply and make use of available data, reports, and registries in day to day work and an understanding of any expectations to do so. * Basic computer knowledge. * Basic knowledge of MassHealth ACO accountable care benchmarks related to pediatrics. |
| **Demonstrates the skill & ability to:** |
| * Collaborate with Pediatric Department leadership, primary care team members, and PCF team members around PCF service improvements and impact on patient outcomes. Keep all three parties informed about plans to implement PCF improvements and share successes and challenges. * Assist in creating quality improvement measures to strengthen the role of PCF in improving patient outcomes. * Collect data regarding consumer satisfaction, PCF program performance, healthcare outcomes, etc. * Maintain and use patient records and other data collection tools to report timely patient interactions, barrier resolution, and other evaluation metrics to administrators and funding agencies. * Recognize and rapidly address errors and assist in implementing policies and procedures to reduce future errors. * Safeguard patient privacy and confidentiality. * Collect and submit data/reports as requested by Pediatric Department, Supervisors and others. * Document all contacts and attempted contacts with or on behalf of the patient. * Seek out mentoring, coaching, consultation and training to address gaps in one’s own knowledge. * Advocate for quality patient care and optimal patient outcomes. * Recognize and describe how day to day tasks and activities promote patients’ positive health outcomes. * Prioritize work activities that are most likely to directly impact health outcomes, Children’s Hospital warm handoffs, and other pertinent quality measures. * Recognize and manage personal biases related to patients, families, health conditions, and healthcare delivery. * Use electronic health records efficiently and effectively. * Assess and evaluate PCF outcome measures, such as decreasing barriers to care and population health disparities, while improving patient encounters, resource provision, and collaborative relationships. * Use available data, reports, registries in a manner that improves access to care for the most vulnerable patients and optimizes patient health outcomes. |

### How competencies tie to quality metrics

The eight competency areas described above and their associated skills, abilities, and fields of knowledge are the foundation on which to build a PCF approach that can be leveraged to improve overall health outcomes and related quality measures in relation to the following domain areas common to ACOs (McDonald, 2014):

* Patient care experience
* Prevention and wellness
* Chronic disease management
* Behavioral health/substance use disorder
* Long-term services and supports
* Integration across physical health, behavioral health, long-term services and supports (LTSS), and health-related social services
* Avoidable utilization

While standard work documents describe the steps PCFs follow, core competencies represent the fundamental underpinnings or the manner in which a PCF conducts those steps. The core competencies, skills, and abilities support optimal programmatic performance and link most directly to process-oriented metrics. Process measures focus on the steps that, when executed well, will likely increase the probability of a desired outcome. Process and outcome-oriented measures will be considered further in future deliverables. Current PCF process-oriented measures focus on the following areas:

* roster reviews and associated action items

**PFCs and Quality Improvement**

The establishment of a specific “quality improvement” competency for PCFs helps affirm the significance of their role and the potential impact of their responsibilities, standard work, and day to day tasks on the improvement of patient outcomes and overall quality of care.

* work touches (defined as every piece of work related to a patient, i.e., booking appointing, touching base with school or specialty, speaking with patient, and related follow up work)
* successful “patient touches”
* initiated and completed care plans
* scheduled face-to-face interactions with patients
* same day referral face-to-face interactions with patients
* walk-in face-to-face interactions with patients
* Patient Family Advisory Council meetings

Process measurement related to PCF standard work warrants further consideration of those processes deemed most likely to promote a positive outcome. This has potential implications for the establishment of future metrics and enhancements to standard work process.

### The context in which this role is performed

Throughout the United States the titles used to describe a PCF vary and are often use interchangeably. They include such titles as practice facilitator, care coordinator, patient navigator, family navigator, and resource specialist. There is no universally accepted definition of a PCF and there is an absence of any governing authority dictating the scope of practice or activities that a PCF is permitted to undertake in the state of Massachusetts. Additionally, there are no national or state required training, licensing, certification, credentialing standards or regulations guiding the work of (PCF). In the absence of these legal and systemic drivers, this document proposes an ideal PCF scope of practice for use by Atrius Health.

PCFs are integrated members of the primary care team and a vital component of clinical care. They improve patient health outcomes by facilitating patient access to medical and mental health treatment, encouraging adherence to treatment and addressing social and economic conditions that are associated with poor health outcomes. PCF’s scope of work overlaps with other primary care team members, such as clinical social workers, nurses, and CHWs. Differentiating the PCF role from others can be helpful in further clarifying the PCF’s scope of work.

To that end it is worth noting that as a non-licensed member of the primary care team, PCFs do not provide clinical assessments, clinical treatment, or clinical consultation. These activities are more likely to be within the scope of physicians, nurses and clinical social workers. Additionally, PCFs may overlap in their scope of work with some CHW. However, PCFs do not provide health screenings. Health education, information dissemination and other activities similar to CHW are limited by the restriction of office-based rather than community outreach-oriented service delivery conducted by CHWs.

Of note, in Massachusetts there are four credentialing levels for social workers. While the PCFs’ scope of work overlaps minimally with a master’s level social worker, it does align more closely with the scope of work commonly carried out by individuals holding an associate’s or bachelor’s level degree in social work or other human services field (Hoge, 2014; Kinman, 2015).

### How the scope of practice can be optimally used

This document provides a foundation for further developing the PCF workforce. The core competency set listed previously can be used in the following ways:

1. **Employee recruitment:** The competencies can be used in the development of advertisements and other materials to help target the recruitment of prospective employees.
2. **Onboarding and ongoing supervision:** The competencies can be used by supervisors as a guide to orient new employees to their role and responsibilities. Additionally, supervisors and employees can jointly review the competencies, identify proficiencies and areas for additional training, mentoring, and coaching.
3. **Job descriptions:** The competencies can be used in the development of PCF job descriptions for internal human resource purposes. Additionally, they can be used to create a description for disseminating to patients, families, and other staff in an effort to promote greater engagement with and clarity regarding how PCF can assist families.
4. **Workforce training:** The competencies can be used to shape content for training PCF and orienting primary care team members to the work of PCF. It can be used to develop staff curriculum, training manuals, workshops, and in-service events.
5. **Performance appraisal:** The competencies can be a foundation upon which performance is assessed. To this end, the competencies can be incorporated into employee self-assessment tools and formal performance reviews.

## Possible Career Ladder

Establishing a career ladder can further strengthen workforce development by building a work environment that encourages ongoing professional development, exemplary employee performance, and staff retention. A career ladder allows employees to advance their career to higher levels of salary, responsibility, or authority within the organization, thus incentivizing them to remain within the organization. This has the potential to save on expenses related to turnover, recruitment, and training. Opportunity for advancement can motivate employees to perform well and acquire new knowledge and skills. Below are two potential options for developing a PCF career ladder.

| Option A | Option B |
| --- | --- |
| This career ladder operates under the direct supervision of a manager or director, as described below. | This career ladder operates under the direct supervision of site operations managers and is guided by a team lead as described below. |
| **PCF I:** Associate’s degree in a human services field with some experience navigating and collaborating with child and family oriented behavioral health and other service providers; or an associate degree in an allied health filed with two years’ experience navigating and collaborating with child and family oriented behavioral health and other service providers. | **PCF I:** Associates degree in a human services field with one year of experience providing care coordination or case management for children, adolescents or families. |
| **PCF II:** Bachelor’s degree in a human services field with some experience navigating and collaborating with child and family oriented behavioral health and other service providers. | **PCF II:** Bachelor’s degree in a human services field with one year of experience providing care coordination or case management for children, adolescents or families. |
| **PCF Manager/Director:** Master’s degree in a human services field and licensed at the independent level such as a Licensed Independent Clinical Social Worker (LICSW) or a Licensed Mental Health Counselor (LMHC). Has two years’ experience working with children, adolescents, or families preferably within a medical setting. Supervisory experience preferred. | **PCF Team Lead:** Bachelor’s degree in a human services field with 3 years of experience providing care coordination or case management to children, adolescents, or families. |

Establishing a career ladder in which a Master’s level behavioral health clinician supervises, mentors, and coaches PCFs in performance of core competencies, standard work, and the applications of evidence-based approaches (such as motivational interviewing) may allow for the hiring of staff who have less knowledge, skill, and abilities than is optimal. This career ladder represents an ideal path for new hires. The current staff who don’t hold the minimum required credentials (e.g., associate’s degree) could be grandfathered in and/or encouraged to pursue a degree in a human service field with support from Atrius’s tuition reimbursement program.

Using a team lead instead of a behavioral health clinician may warrant the need for PCFs to have a greater amount of experience, fund of knowledge, and established skills and abilities. A team lead can be promoted from within or be an external hire. It is important to note that a manager or director with the right aptitude should be able to develop the necessary knowledge, skills, and abilities in less competent staff who are eager and willing to learn. A team lead however, cannot be expected to develop staff’s gaps in skill and ability in the same way a master’s level clinician would.

As part of developing the career ladder, we recommend that Atrius review retention methods and evaluate and reevaluate standard hiring criteria to align these with the competencies outlined in the previous section. If Atrius commits to retention, career development, and advancement for PCFs, key elements to incorporate include:

* **Recognition programs,** i.e., motivating and rewarding individuals and groups for excellence in support of the organizational mission and goals with the outcome of increased job performance and staff retention.
* **Training,** i.e., enhancing existing skills, knowledge, and experience of employees and providing hands-on education to develop competency in areas of identified weakness. (These will be identified during the AHP gap analysis process that results in the Task 4 deliverable.)
* **Professional development,** i.e., supporting employees, through time, logistical support, or dedicated funds for instance, as they work toward credentials, degrees, or other educational opportunities that support their career advancement.

# Next Steps

Upon Atrius review of the findings in this report, the AHP team will use this information, along with that obtained in Task 2: Summary of Responsibilities, to conduct a gap analysis and develop a plan for building capacity and further developing this workforce. The team will:

* Compare ideal scope of practice with current state defined in this report to identify gaps for each role.
* Develop a plan for how Atrius can train the three roles to be able to meet the competencies necessary for the ideal scopes of practice.
* Develop a plan for how Atrius can measure the performance of the three roles to confirm compliance with scopes of practice and ensure continuous quality improvement in the roles.

# Appendix A: Literature Review Citations

American Academy of Pediatrics. (2014). Policy Statement: Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. *Pediatrics, 133,* 31451-e1460. [DOI: 10.1542/peds.2014-0318](http://pediatrics.aappublications.org/content/133/5/e1451)

Antonelli, R., McAllister, J., Popp, J. (2009). *Developing Care Coordination as a Critical Component of a High Performance Pediatric Health Care System: Forging a Multidisciplinary Framework for Pediatric Care Coordination*. Washington, DC: The Commonwealth Fund.

Antonelli, R.,C., Huth, K., Rosenberg, S., Bach, A. (Eds.) (2019). *Pediatric Care Coordination Curriculum: An Interprofessional Resource to Effectively Engage Patients and Families in Achieving Optimal Child Health Outcomes.* (2nd ed.) Boston, MA: Boston Children's Hospital.

Association of Maternal & Child Health Programs. (March, 2018). *Family Navigation Strategies Implemented in Title V and Community-Based Programs to Better Serve Children and Youth with Special Health Care Needs and their Families* (Issue Brief). Retrieved from <http://www.amchp.org/programsandtopics/CYSHCN/projects/spharc/LearningModule/Documents/Final%20issue%20brief_3.12.pdf>

Hoge, M.A., Morris, J.A., Laraia, M., Pomerantz, A., & Farley, T. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care.* Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions

Kinman, C.R., Gilchrist, E.C., Payne-Murphy, J.C., Miller, B.F. *Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review.* (March 2015.) (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality.

Massachusetts Department of Mental Health. (n.d.). Children Behavioral Health Knowledge Center. (Website). Retrieved from <https://www.cbhknowledge.center/caringtogethercontinuumoverview>

McDonald, K.M., Schultz, E., Albin, L., Pineda, N., Lonhart, J., Sundaram, V., Smith-Spangler, C., et al. (June, 2014). *Care Coordination Atlas Version 4* (Prepared by Stanford University under subcontract to American Institutes for Research on Contract No. HHSA290-2010-00005I). Rockville, MD: AHRQ Publication No. 14-0037- EF

National Center for Care Coordination Technical Assistance. (2015). National Center for Care Coordination Technical Assistance Pediatric Care Coordination Activities. (Fact Sheet.) Retrieved from <https://medicalhomeinfo.aap.org/tools-resources/Documents/NCCCTA%20Environmental%20Scan.pdf>

Patient Centered Education and Research Institute. (2015). Professional Patient Navigator Competencies. Retrieved from <http://www.patient-institute.org/uploads/3/4/4/6/3446156/ppn-competencies-8-15.pdf>

Pratt-Chapman, M.L., Willis, L.A., Masselink, L. (2014). *Core Competencies for Non-Clinically Licensed Patient Navigators.* Washington DC: The George Washington University Cancer Institute Center for the Advancement of Cancer Survivorship, Navigation and Policy.

West Virginia: Health Improvement Institute. (n.d.) *Care Coordinator Job Description Compendium.* Compendium Developed for the Tri-State Children's Health Improvement Consortium. Retrieved from <https://bit.ly/2QE48rt>

