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| Scope of Practice: Population Management Coordinator |
| Task 3 Deliverable Draft |



TABLE OF CONTENTS

[Executive Summary 3](#_Toc25328286)

[Approach to Development of Scopes of Practice 3](#_Toc25328287)

[Population Management Coordinators 4](#_Toc25328288)

[Evidence-Based Practices and Best Practices 4](#_Toc25328289)

[Ideal Competencies and Associated KSAs 5](#_Toc25328290)

[How competencies tie to quality metrics 18](#_Toc25328291)

[The context in which this role is performed 19](#_Toc25328292)

[How the scope of practice can be optimally used 20](#_Toc25328293)

[Possible Career Ladder 20](#_Toc25328294)

[Next Steps 23](#_Toc25328295)

[Appendix A: Literature Review Citations 25](#_Toc25328296)

[Population Management Coordinators 25](#_Toc25328297)

# 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 PMC scope of practice.

# Population Management Coordinators

## Evidence-Based Practices and Best Practices

Through a literature review, AHP has established a core set of evidence-based practices (EBPs) and best practices (BPs) in population health management that should be within the skillsets of coordinators or similar population health roles. These EBPs and BPs are most often aligned with roles of similar title and responsibility as the population management coordinators (e.g., population health managers or population health coordinators), along with care coordinator roles and those associated with public health.

These EBPs and BPs help create a framework and infrastructure for the ideal performance of individuals in these roles. In some cases these EBPs may not performed directly by a staff member with an exact match for skills, education, and responsibilities to an Atrius PMC, but they are critical to the successful and optimal execution of this role. These EBPs and BPs are supported by the appropriate competencies and KSAs outlined in the next section. EBPs and BPs for optimal and successful population health management include:

**1. Community/population assessment and surveillance** to identify demographics, health resource needs and concerns, availability of and access to services to address needs, and values and assets of a community (Jacobs, 2012). This can be done through internal data derived from EHR records or other health system and clinical data, creation and monitoring of patient registries, and to some extent public surveillance systems with aggregate state-, county- or national-level data (best analyzed in partnership with data analytics department support).

**2. Optimization of clinical care and treatment,** through strategies that include

* care management activities, i.e., “managing an identifiable panel of patients, including prevention, chronic disease management, and complex care management” (Stout, 2018)
* improved access to needed health services and treatments,
* relationship building and continuity of care for patients,
* evidence based practices and interventions for disease and chronic care management,
* risk stratification of patients most in need, and
* performance improvement activities, including
	+ data utilization: identifying and and tracking clinical quality measures at the system, practice, and
	+ patient panel levels and using this data to identify, drive, and sustain performance improvement.
	+ evaluation: regularly reviewing care provided to individuals against key measures and evidence-based practice guidelines, and reviewing care for safety, effectiveness, timeliness, equity, and patient-centeredness.
	+ improvement methods and tools: using an improvement approach to identify and test changes to improve clinical care and treatment" (Stout, 2018).

**3. Patient outreach and other programs for high-risk or high-need populations,** including those with chronic conditions, through such strategies as:

* establishing relationships with internal partners to ensure continuity of care (e.g., the laboratory, diabetes nurse, or BH Department);
* creating connections to outside services and community providers (e.g., transportation services, support groups); and
* instituting processes such as call-back programs for patients who miss appointments to ensure patients are not “lost to follow-up” or otherwise have gaps or interruptions in their chronic disease care (Shenkin, 2019).

4. **Disease monitoring activities,** such as creating and monitoring patient registries.

**5. Evidence-based population health interventions,** such as diabetes prevention and control activities, including evidence-based case management interventions to improve glycemic control, disease management programs, and self-management education (Secretary’s Advisory Committee, 2010).

**6. Quality improvement through data analysis and benchmarking** on performance (AHRQ, 2018), which can:

* provide teams information on key indicators and outcomes for patients,
* compare performance over a time period,
* compare performance to national and local standard, and
* help identify gaps in services.

## Ideal Competencies and Associated KSAs

The method for conducting the environmental scan and arriving at a core set of competencies for PMCs included a review of the literature on population health management best practices, public health and population health competencies, care coordination resources, survey results from paraprofessionals in the field, national best practice studies, and job descriptions and competencies for similar position.

A competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform their job successfully. Competencies describe “how” a job is done. Knowledge describes an individual’s mastery of facts and range of information in a subject matter area. Skills are proficiency, expertise, or competence in given area. And finally, abilities are defined by demonstrated performance using knowledge and skills when needed. When an individual has the appropriate KSAs for a role, they have the attributes to competently and effectively perform their job.

The PMCs at Atrius have a complex role that includes serving as a partner to the PCP, working to close care gaps, managing quality reporting, and participating in quality initiatives. In a review of national and Boston-area population health coordinator positions, Atrius’s PMCs shared many responsibilities and competencies with their peers at other organizations. PMCs also do work that is often associated with care coordination positions, although without the clinical responsibilities that might be expected of a medical assistant or nurse. Performing the various functions required of PMCs requires competency in a number of areas and a diverse range of KSAs.

The competencies include:

1. Professionalism and Interpersonal Relationships
2. Communication
3. Collaboration and Teamwork
4. Prioritization and Judgement
5. Data Entry, Aggregation, Analysis, and Reporting
6. Healthcare Performance and Process Improvement
7. Care Coordination

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| Competency: Professionalism and Interpersonal RelationshipsSeamlessly interfaces with many people at many different levels within and outside of the Atrius organization, including patients, families, physicians, Quality/Performance Improvement Department staff and leadership, and Triad team. Possesses keen awareness of, and responsiveness to, the needs, feelings, and capabilities of others.  |
| **Demonstrates knowledge of:*** Atrius policies and procedures.
* Active listening skills.
* Conflict resolution.
* Interpersonal relations.
* Cultural competence.
* Emotional Intelligence.
* Professional etiquette and attitudes.
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| **Demonstrates the skill & ability to:** |
| * Listen actively; paraphrase or repeat key points back to demonstrate understanding.
* Deal with conflicts, confrontations, and disagreements in a positive manner.
* Facilitate and participate in meaningful dialogue.
* Work professionally and independently with staff at all levels of the organization.
* Effectively work with others in both favorable and unfavorable situations regardless of status of position.
* Build relationships with peers, patients, and families.
* Maintain confidentiality and adhere to all patient privacy and related hospital, state, and national policies and laws.
* Seek out mentoring, coaching, consultation and training to address gaps in one’s own knowledge.
* Demonstrate professional etiquette and attitudes.
* Actively participate in professional growth and learning activities.
* Perform duties accurately and efficiently.
* Incorporate feedback from supervisor and team members to improve daily performance.
* 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.
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| Competency: CommunicationEstablishes 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 internal medicine setting.
* Medical office procedures and terminology.
* The basics of behavioral theories such as the Health Belief Model or Stages of Change Model.
* The general impact of Social Determinant of Health on (SDOH) on patient health.
* Basic understanding of chronic disease management.
* Basic understanding of medically complex needs.
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| **Demonstrates the skill & ability to:** |
| * Listen actively; paraphrase or repeat key points back to demonstrate understanding.
* Practice speaking with both confidence and humility.
* 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.
* 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 status and next 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.
* 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 and members of the primary care team.
* Communicate effectively across a variety of socioeconomic and cultural backgrounds.
* Appropriately document information regarding the delivery of services.
* Engage in timely communication and follow up with partners and collaborating departments or ancillary services.
* Compose minutes, letters, emails, and reports using proper rules of grammar, spelling, and punctuation.
* Explain clearly to patient 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’s ability to process and understand information.
* Provide materials that are appropriate to the literacy of the patient and that reinforce information provided verbally during visit.
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| Competency: Collaboration and TeamworkWork in partnership with staff at various levels of authority and within different departments. Collaborate operationally at the site level with physicians and other clinical staff in coordinating care for patients and across levels through the Triad Team meetings. Effectively partner and collaborate with high-risk chronic disease patients in their care.  |
| **Demonstrates knowledge of:*** Active listening skills.
* Organizational culture, structure, and operations in order to optimally participate in team activities
* Effective communication and engagement, such as motivational interviewing.
* Barriers and solutions to successful teamwork across multidisciplinary teams.
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| **Demonstrates the skill & ability to:** |
| * Listen actively; paraphrase or repeat key points back to demonstrate understanding.
* Problem solve.
* Confidently make decisions based on limited information or in short time frames.
* Facilitate and engage in the open exchange of ideas.
* Establish effective working relationships with partners at all levels of the organization.
* Present and express ideas and information clearly and appropriately.
* Coordinate, facilitate, and lead meetings.
* Engage in telephonic, virtual, and in-person outreach.
* Apply insight and understanding about human emotions and responses to create and maintain positive interpersonal interactions.
* 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.
* Respond to patient needs over personal self-interests.
* Use tact and a cooperative attitude in all forms of communication.
* Promote PMC role, responsibilities, and value to patients, providers, and the larger community
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| Competency: Prioritization and Judgement Ability to juggle many responsibilities across a given day or week. Involvement in multiple initiatives across the organization, while continuously addressing care gap and partnering with PCPs for patient care. Possesses ability to assess importance and prioritize tasks. Independently judge the urgency and importance of competing requests for attention and prioritize these as part of their regular work.  |
| **Demonstrates knowledge of:*** Departmental and organization-wide priorities and expectations.
* Scope of practice of each primary care team member.
* Differences in each primary care team member’s role.
* Clinical information that may define a need as urgent versus non-urgent.
* 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:** |
| * Use organizational skills to proficiently manage work responsibilities.
* Employ time management strategies problem solving, and critical thinking to assist patients efficiently and effectively.
* Make decisions accurately and in a timely manner.
* Reason and problem-solving.
* Review documentation and scheduled visits and appropriately escalate when needed.
* Quickly shift gears, change focus, and adapt to changing priorities.
* Sustain and attention with multiple distractions.
* Exhibit the emotional intelligence needed to positively impact desired healthcare outcomes.
* Demonstrate accountability to patients, members of the primary care team, and others.
* Apply knowledge of and act within professional boundaries and scope of practice.
* Adhere to ethical principles of healthcare.
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| Competency: Data Entry, Aggregation, Analysis, and Reporting Interact with clinical and quality data at various points in the data life cycle, including entering it into the electronic health record (HER) and running reports. Use data to gather meaningful information and create recommendations and plans based on data. |
| **Demonstrates knowledge of:*** Data systems used across Atrius, including Epic EHR and population health data systems.
* Basics of qualitative and quantitative data collection and reporting.
* How informatics and information technology can be used to access, collect, analyze, use, maintain, and disseminate data and information.
* Data stratification methodology.
* The population health evidence base (e.g., community-based participatory research, existing best practices).
* Disease registries.
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| **Demonstrates the skill & ability to:** |
| * Perform data entry.
* Use Microsoft Excel and other standard office programs.
* Apply ethical principles in accessing, collecting, analyzing, using, maintaining, and disseminating data and information.
* Conduct content analysis of qualitative data to identify themes.
* Interprets quantitative and qualitative data.
* Stratify and aggregate data.
* Scrub data.
* Troubleshoot issues with data systems and data gathering.
* Ensure accuracy of data and reports.
* Work with canned Epic queries.
* Using clinical data to identify existing problems and gaps in care.
* Create and use patient registries from EHR and other population health software.
* Conduct pre-visit chart reviews.
* Complete roster reviews, generate reports, and track activities in EHR.
* Collect and manage qualitative and quantitative patient data.
* Use data to develop recommendations, course of action, and perform follow up.
* Analyze patient registry data.
* 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.
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| Competency: Healthcare Performance and Process Improvement Take responsibility for performance-related interventions around disease management and at-risk patients.  |
| **Demonstrates knowledge of:*** Standards of healthcare performance improvement.
* Payer reform and alternative payment methods and value-based care/value-based reimbursement.
* Atrius benchmarks for performance.
* Why and how quality metrics are developed.
* ACO quality measures and other relevant metrics (e.g., ACQ metrics, HEDIS).
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| **Demonstrates the skill & ability to:** |
| * Describe and champion performance improvement initiatives at Atrius.
* Evaluate metrics and outcomes reports.
* Develop course of action for improvement activities based on performance.
* Provide insight on process improvement recommendations.
* Participate in Triad Team meetings.
* Serve as quality and performance initiative champion.
* Perform clinical quality assurance activities.
* Follow up and coordinate resources for patients identifying for performance improvement activities (e.g., blood pressure recheck, mammography, etc.).
* Standardize processes and workflows to improve performance around individuals with chronic disease.
* Collaborate with Internal Medicine leadership, primary care team members, and PMC team members around PMC service improvements and impact on patient outcomes.
* Champion performance improvement project plans at Atrius.
* Assist in creating quality improvement measures to demonstrate the role of PMC in improving patient outcomes.
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| Competency: Care CoordinationTake responsibility for care coordination around chronic conditions and at-risk patients, including diabetes and hypertension. Perform roster review activities, such as preparing, scheduling, reviewing charts, patient outreach, and documentation of the roster review.  |
| **Demonstrates knowledge of:*** Clinical conditions within target patient population, such as diabetes, hypertension, and cancer.
* Chronic disease management and preventive care.
* Physician/provider roster and schedule.
* Available resources to address care gaps in target population.
* Laboratory tests and processes and procedures relevant to target population.
* Best practices in care coordination and patient outreach and engagement.
* Motivational Interviewing and stages of change.
* The general impact of Social Determinant of Health on (SDOH) on patient health.
 |
| **Demonstrates the skill & ability to:** |
| * Identify high-priority or “poor compliance” patients in order to fill care gaps.
* Engage patients in their own care.
* Scrub charts and complete required documentation.
* Establish relationships with patients and coordinate patient needs.
* Share care plans with patients.
* Document in the medical record.
* ·Safeguard patient privacy and confidentiality.
* Document all contacts and attempted contacts with or on behalf of the patient.
* Interact with laboratory and other clinical support areas, including placing lab orders.
* Develop collaborative relationship with other healthcare team members in order to reduce patient care barriers.
* ·Coordinate care with various service providers.
* ·Schedule appointments.
* ·Motivational Interviewing and stages of change.
* Obtain and record accurate information from patients and educate them and caregivers on the process of managing their personal medical
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### How competencies tie to quality metrics

Operating under the ideal set of competencies outlined previously and working with the best practices identified, the PMC helps break down barriers to care for patients in the IM service line and facilitates improvement in important chronic disease quality measures and key performance indicator (KPI) goals and benchmarks.

Because the populations of patients served is unique, each Atrius site with a PMC may have their own unique set of performance goals tied to quality metrics. Metrics that inform which patients are of greatest priority may include:

* the IM top tier quality goals (chronic disease outcomes, cancer screening, process metrics, and appropriate use, etc.),
* IM and Atrius KPIs, and
* MassHealth ACO measures, ACQ metrics, and others.

There is great opportunity to bring more standardization to both the metrics and performance expectations and workflows the PMCs work within. They may include establishing workflows and performance expectations that identify frequency of activities, with standard work, decision points, decision criteria, and related resources, for processes such as:

* Outreach, for instance, setting a logic and schedule for outreach (based on A1C, last appointment, etc.), methods of outreach (e.g., by telephone), approach to barriers (e.g., patient doesn’t answer or call back), Atrius-level resources and community resources available and when to access them, and expected outcomes.
* Roster review or chart review, defining frequency, when and how to engage colleagues or support, (e.g., case management, laboratory, etc.), documentation expectations, etc. This may be supported by the use of a computerized clinical decision support systems (CDSS)/clinical decision support tools integrated into the EHR. (For instance see the federal government’s tools at HealthIT.gov <https://www.healthit.gov/topic/safety/clinical-decision-support>)
* Triad meeting, such as how often they occur, the PMCs role and expectations, objective measures of performance of related performance

While the PMCs currently focus primarily on diabetes and hypertension, their focus can include other chronic diseases and at-risk patients aligned with quality goals, for instance, those tied to the five chronic disease management MassHealth ACO measures shown below, or others defined by internal Atrius quality or performance initiatives.



Atrius may consider other metrics to measure the impact of the PMC’s work on patient outcomes, such as the AHRQ Care Coordination Quality Measure for Primary Care (CCQM-PC), which is a survey of adult patients’ experiences with care coordination in primary care settings. The CCQM-PC is designed to be used in primary care research and evaluation, with potential applications to primary care quality improvement: <https://www.ahrq.gov/ncepcr/care/coordination/quality/index.html>.

### The context in which this role is performed

The PMC works as a quality champion within a multidisciplinary team in IM practices. PMCs are vital members of a well-functioning system of care that focuses on providing comprehensive care to Atrius patients. This includes ongoing communication and partnership between PMCs, medical assistants, nurses, doctors, pharmacy coordinators, and ancillary departments, such as the laboratory and radiology. While the PMC is a non-clinical, non-licensed professional, they play a critical support role to the clinical staff.

In creating this scope of practice, we relied on the definition used by the Federation of State Medical Boards (FSMB): “…rules, regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a … specifically defined field,” with the understanding that a PMC is not a “practitioner” *per se,* but rather a professional performing a number of important roles related to clinical scopes of practice but not within them.

There is no universally accepted definition of a PMC and, because it is an unlicensed position, there is no state or national licensure standard or required credential articulating the work or activities that a PMC is permitted or required to perform. The literature search did not turn up any well-known national or state standards around training, certification, or credentialing.

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

With the full set of competencies and KSAs outlines above, PMC’s work enables Atrius to proactively manage a population of patients with chronic conditions (e.g. diabetes, hypertension) or those who are high-need or high-risk. This enables the IM service line and the organization in general to achieve enhanced clinical quality outcomes through quality improvement and intradepartmental coordination.

Optimally, this requires a deep understanding and aptitude with available data and data systems in use at Atrius, along with knowledge of healthcare quality and gaps in case. PMCs need a structure within which to perform their care gap activities: that is, standardized workflows in which their touchpoints are clearly articulated and defined expectations for frequency of outreach and other patient activities. And finally, PMCs should not be called upon for data management, reporting, or other activities that are not distinctly tied to closing care gaps in the management of chronic disease or at-risk patients so as to keep their focus on population health.

This scope of practice 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 PMC job descriptions for internal human resource purposes. Additionally, they can be used to create a description for disseminating to patients and their families in an effort to promote greater engagement with and clarity regarding how PMCs can assist patients.
4. **Workforce training:** The competencies can be used to shape content for training PMCs and orienting primary care team members to the work of PMCs. 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

Atrius has identified recruitment, retention, and on-boarding as significant challenges with the PMC role. A career ladder – that is, a structured advancement plan for PMCs within the Atrius system – can help address all of these challenges. Research shows the benefits of having a career ladder:

* **Employee retention**—career ladders illustrate the potential for advancement, which serves as an incentive for employees to stay with organizations or within a field. Employers save on costly turnover, recruitment, and training expenses.
* **Performance incentives**—the opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills.
* **A career development program**—a clear career ladder serves as a tool to assist individuals in career planning and decision-making; including decisions to stay at a current employer when clear opportunities for advancement exist.

Based on the current job description and responsibilities of Atrius PMCs, along with best practices in population health management and comparable positions in other locations, there are three primary tracks to advancement within Atrius for PMCs. AHP recommends that, regardless of career ladder/advancement track, Atrius considers providing:

* Lean Six Sigma training to at least a green belt or similar healthcare process and performance improvement training (e.g., those offered by Agency for Healthcare Research and Quality [AHRQ] and the Institute for Healthcare Improvement [IHI]; and
* Certificates, credentials, or trainings in data analysis, such as the healthcare information management credential (RHIT) or certified health data analyst (CHDA) credential, if applicable.

| Possible Career Ladders for PMCs |
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|  | Track 1: Advanced Population Health Management | Track 2: Care Coordination Track | Track 3: Data and Informatics Track |
| Description | In this first track, PMCs remain in their unique position as both a partner to the IM department in closing care gaps and a quality reporting champion and quality initiative participant. | This track would advance PMCs to a position/positions that focus more intensely on clinical care coordination and perhaps moves some of their work away from the quality monitoring and champion focus. | This track would advance PMCs to a position/positions that focus more intensely on data analytics and informatics.  |
|  Considerations | This track would create a senior population health coordinator or population health manager position that would report up to the population health regional supervisor. Promotion or advancement to the senior/manager position would include more and greater involvement as a quality reporting and initiative champion, through training and educating peers and spreading the quality message through the institution. | This track may prepare PMCs to advance through a care coordination pathway with the goal to move into a case manager or social worker position at Atrius. This could involve the creation of a senior PMC/care coordinator role, that is primarily focused on filling care gaps through activities such as* Outreach to patients with recent hospitalizations
* care transitions
* Medication reconciliation and adherence
* Coordination of referrals and test results

These senior care coordinators would focus on patient- and family-centered, team-based activities to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the health care system. The care coordinators would work to directly address potential gaps in meeting patients' interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences. This would be done to a greater and more involved extent than the “junior” PMCs. The senior care coordinator would serve as a support and a resource for the junior PMCs. | With this advancement track, PMCs would move to more senior positions within Atrius Data/Analytics department. |
| Dependencies | This advancement path would require continuing education in “soft skills” of engaging individuals in their care, along with ongoing education on healthcare reform and payment structure.While this advancement would not require additional formal education, tuition reimbursement may be offered toward bachelor’s or master’s degrees, e.g., in Public Health, Health Care Administration, Business, or Social Sciences/Social Work.Ultimately these PMCs may advance upward into the Performance Excellence Department. | This advancement opportunity would likely require obtaining a clinical degree, such an RN or MSW. Ultimately these care coordinators may advance to case managers or social workers, which would move them out of the PMC reporting structure and into a clinical pathway. | For PMCs with this goal, Atrius can support obtaining advanced education (bachelor’s or master’s degree) in Health Informatics, or Data Science. |

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 PMCs, 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

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