# The Roles and Competencies of Care Enhancers (CE)

Alexander Blount, EdD, Director

New Hampshire Primary Care Behavioral Health Workforce Initiative

The concept of a role called "Care Enhancer" has been endorsed by members of the NH Primary Care Behavioral Health Workforce Initiative. The term was created as a way to organize the array of different job titles and job descriptions for the many roles in primary care that are not licensed Behavioral Health Clinicians (BHC) or a Primary Care Providers (PCP), but that are involved in providing behavioral aspects of care in primary care settings. The Assessment of the Primary Care Behavioral Health Workforce, done in 2016 by the NHPCBH Workforce Initiative, https://integratedprimaryc.wixsite.com/nhpcbhworkforce/reports needed some way to convey both the complexity of the numbers and types of roles, and a rubric that would allow us to describe this crucial and growing aspect of primary care behavioral health services. Since the Workforce Initiative created the term to encompass a number of pre-existing primary care behavioral health jobs, no agreed upon set of duties or competencies yet exists for the CEs role. The authors of the Workforce Assessment listed four sets of duties that fall within the CE role: 1) Create and maintain patient engagement in care within and across healthcare settings, 2) Address issues of health literacy, adherence, and healthy living, 3) Address social and economic barriers that patients face in caring for their health and receiving healthcare (the social determinants of health), and 4) Keep information flowing between the patient and the rest of their healthcare team.

Taking this work one step further, a participatory process of the Workforce Initiative resulted in the list of core competencies:

1. Relationship building with both patient and care team, including their extended team in the health system,
2. Creating a common language between patients and providers,
3. Facilitating the creation of a common plan of treatment,
4. Motivational Interviewing skills,
5. Knowledge of trauma informed care (TIC) and social determinants of health,
6. Knowledge of suicide risk screening and assessment,
7. Knowledge of community resources,
8. Health system knowledge for navigation,
9. Ability to advocate internally and externally for patients and their families.

To ground the CE concept within the naturalistic context of health centers serving high need populations in NH, the Workforce Initiative obtained CE-relevant job descriptions from two large and successful FQHCs, one in the north and one in the south of the state. Between the two sites, we obtained over 30 different position descriptions with titles such as "Care Manager" and "[insert another example here]." We created a master-list of all the job duties or competencies across the descriptions. On average, each duty or competency appeared in 5 job descriptions. We consider the following duties or competencies that appeared in at least 10 job descriptions as "core:"

1. Enters intake info into EMR templates
2. Contacts patients for scheduling
3. Coordinates inter-agency services
4. Stays current with community resources
5. Care coordination, facilitates communication among patients, referrals, and providers
6. Attends behavioral health primary care staff meetings
7. Serves as patient advocate
8. Participates in quality improvement programs
9. Insures services meets state and federal agency requirements
10. Documents services and progress in the EMR
11. Identifies patients' psychosocial barriers
12. Monitors patients' and team's goals for patients
13. Assists patients in navigating community resources
14. Provides health behavioral teaching
15. Conducts needs assessments of individuals and the community
16. Creates and tracks the progress of the care plan
17. Keeps current by attending workshops and seminars
18. Provides direct services to patients
19. Offers family interventions
20. Makes referrals
21. Patient teaching about their illness and treatment
22. Works in ways informed by sensitivity to culture and diversity

Other than interacting with the EMR, none of these core duties would be classified as "medical" – they are almost entirely behavioral in nature. Only two duties that would require medical training, such as injections, nebulizer treatments, dressings, and sutures, appeared in a job description. Clearly, competencies centered on effective relating and communicating with team members, patients and the community predominate CE role expectations.

In the future, this trend is likely to continue or accelerate. In a growing number of settings, the duties of CEs, formerly thought of as mostly medical, such as Medical Assistants, are being expanded to involve much more complex responsibilities in the care of each patient. The concept of the "teamlet" was developed by Bodenheimer (2007). His model has the Medical Assistant, in addition to taking vitals and asking about the presenting complaint, preparing the patient to meet with the doctor (what questions to ask, what information the doctor may want), being the scribe in the visit so the doctor does not need to enter information into the EMR, and working with the patient after the visit to be sure s/he understood the information offered in the visit and to support motivation for the patient to adhere to the suggested treatment. The increasingly popular "APEX" model involves Medical Assistants covering their own panel of patients, made up of a portion of the panel that belongs to the physician on whose team they work. In this model, there are 2.5 to 3 MAs working with each doctor. The MAs meet "their" patients in the waiting room. Their duties include:

- Eliciting a comprehensive patient agenda.

- Collecting or updating elements of the patient's past medical, surgical, social and family history in the EHR.
- Conducting detailed medication reconciliation . . .
- Using templates to document the history of the illness or complaint that was the reason for the visit (History of Present Illness) and asking standard questions covering other aspects of the patient's health (Review of Systems).
- Using protocols, initiate certain clinical tasks such as rapid strep or urinalysis.
- Reviewing preventive care gaps such as screenings or immunizations and either arranging for them or marking the gaps for the physician's review.

(paraphrased from Lyon, English & Smith, 2018, pp. 7-8)

In another model in practice at Union Square Health Center of Somerville, MA and other health centers of the Cambridge Alliance Health System, the entire team has enhanced behavioral duties and training needs (Jain, Okanlawon, Meisinger, et al., 2018):

- Medical receptionist: Frontline staff represented the local community and served as cultural ambassadors for the clinic, helping bridge language barriers. Receptionists were familiar with each team's patients and could schedule immunizations and appointment for the whole family. They helped ensure consistent follow-up, leveraging mobile technology like secure texting to contact patients.
- Medical assistant (MA): Considered the "boss" during clinic sessions, MAs managed clinic flow and guided patients through blood pressure checks, immunization and other activities. Before a clinic session, the MA coordinated with the physician around care needs for patients visiting that day. The MA also had a panel of patients to outreach for screening and prevention.
- Registered nurse: Nurses facilitated chronic disease management, developing relationship with patient through longitudinal educational visits. They also undertook outreach to complex patients and managed transitions of care, following patients after discharge from the hospital.
- Physician: Because other team members handled many of the screening, prevention, education, and administrative efforts that often consume physician time in primary care practices, physicians at Union Square focused on the work of diagnosing, treating, and developing relationships with patients.
- Physician assistant: Physician assistants shared a panel of patients with physicians. Patients could choose the kind of provider they wanted to see, and many received care solely from PAs. For example, Haitian patients on one physician's team might opt to see a PA who was fluent in Haitian-Creole.

The growing popularity of such models is predicated on the assumption that team-based care maximizes the impact of a dwindling PCP workforce, by ensuring they spend most of their time working to the top of their degree/training – diagnosing and treating patients.

As we compare the competencies listed or discovered, we find we have a rough confluence of the competencies and duties listed by multiple sources in outlining the roles of CEs both currently and in the future. The list from the members of the NH PCBH Workforce Initiative, the work of impromptu focus groups of knowledgeable professionals, the current job

descriptions of two large and successful FQHCs in New Hampshire, and the descriptions of innovative models that are springing up around the country, give us a great deal of information about the competencies that will be needed by Care Enhancers in the future. Below is our attempt to articulate and group these competencies.

Care Enhancer Competencies – Listed by Type and Domain of Practice[i]

| Domains | Professional | Patient Care |
|---|---|---|
| Relationship to Healthcare Team | 1. Appreciative Inquiry with team members.<br>2. Facilitating team engagement with patients.<br>3. Professional and narrative modes of information exchange | 1. Passing the relationship.<br>2. Maintaining engagement<br>3. Using Open Notes and open clinical conversation |
| Patient's Relationship to Health and Healthcare | 1. Knowledge of common chronic medical and behavioral conditions.<br>2. Ability to work in EMR and to access other informational resources. | 1. Motivational interviewing.<br>2. Empowerment and Activation Interviewing<br>3. Patient teaching about chronic medical and behavioral conditions<br>4. Health literacy<br>5. Cultural Competency |
| Relationship to Patient's Social Network, especially Family | 1. Patient-centered family communication.<br>2. Family interviewing. | 1. Family problem solving. (with an individual and/or family group). |
| Relationship to Health System and Community Resources | 1. Appreciative Inquiry for relationship with selected sites in H.S. and C.R.s.<br>2. Maintenance of engagement for team with C.R.s.<br>3. Facilitating H.S. & C.R.'s engagement with patient. | 1. Knowledge of social determinants of health in patient's life.<br>2. Knowledge of administrative processes for accessing SDOH.<br>3. Articulation to patient of importance of H.S. or C.R. sites and advocacy for patient with those sites. |
| Role-specific competencies, (e.g., medical, nutrition, pharmacy) | 1. Consulting to team members in areas of unique competence. | 1. Articulating importance of role specific duties and competencies to patient in context of the patient's overall needs, treatment plan and preferences. |

References:

Blount, A. (2019) Growing and retaining an expert team, In A. Blount, *Patient-Centered Primary Care: Getting from Good to Great*. Springer, New York.

Bodenheimer, T. (2007a). *Building teams in primary care: Lessons learned*. San Francisco: California Healthcare Foundation.

Cooperrider, D. L., Whitney, D. (2005). *A Positive Revolution in Change: Appreciative Inquiry.* Berrett-Koehler Publishers, Oakland, CA.

Jain, N., Okanlawon, T., Meisinger, K., and Feeley, T. W. (2018). Leveraging IPU principles in primary care. *NEJM Catalyst*, June 27, 2108.

Lyon, C., English, A. F. & Smith, P. C. (2018). A team-based care model that improves job satisfaction. *Family Practice Management, 25(2)*, 6-11.

[i] Appreciative Inquiry – Appreciative Inquiry (Cooperrider and Whitney, 2005) is an organizational approach that can be very helpful in building the culture of a team. It is a way of studying what works in an organization, of focusing on what people do well. It tends to both elevate and activate team members. When people are "caught in the act" of doing well, they tend to become energized to continue to do well. They become more confident, more willing to try to improve.

Narrative vs. professional information exchange – Professional language is designed to convey very specific descriptions in the fewest possible words. The language is neutral, not conveying emotional experience. Narrative language conveys the story of an experience, leading both teller and hearer to experience some same feelings of the people in the story, conveying the affective aspect of patients and professionals caring for them.

Passing the relationship – Passing the relationship is a process in which one professional who has been working with a patient, introduces a new professional, describes why she has decided to involve this new professional in the patients care, talks about the history of her work with the patient, and describes what she thinks the new professional can add to the patient's care, all in front of both the new professional and the patient.

Open Notes and open clinical conversation – OpenNotes is a piece software and a movement to allow all patients to read their physicians' notes in their medical record. Open clinical conversation is the practice of having inter-professional conversations about a patient in the presence of the patient.

Empowerment and Activation interviewing – are methods, drawn from trauma Informed care and solution focused interviewing, of talking to patients in ways that build their self-efficacy so they are more likely to be a full partner in their own healthcare.