GENERATING STAFF BUY-IN FOR THE PATIENT-CENTERED MEDICAL HOME

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In this article…

Five strategies help transform a group of practices into patient-centered medical homes.

THE PATIENT-CENTERED MEDICAL HOME (PCMH) is an approach to providing comprehensive primary care to patients at all stages of life. This model of care has gained significant momentum as an alternative model for primary care health service delivery under U.S. health care reform.[1]

Like so many quality improvement and practice transformation change efforts, becoming a PCMH requires a level of buy-in among staff sufficient to support the magnitude of change required.[2] However, skepticism and resistance to change are commonly cited obstacles to PCMH transformation,[3,4,5] as are lack of physician buy-in and engagement.[6,7,4,8]

Forty-five practice sites were selected in 2011 to participate in a PCMH initiative in Massachusetts. As part of an evaluation of this initiative, we conducted 28 interviews with clinical leaders and support staff at eight different practice sites.

The interviews largely focused on the facilitators and challenges to PCMH transformation and revealed not only how important getting staff buy-in was to the success of the Initiative, but also some specific strategies undertaken to generate this buy-in among all staff. We believe these strategies can be applied widely to a variety of practice transformation efforts undertaken at primary care sites.

1. ESTABLISH VISIBLE LEADERSHIP SUPPORT — A central theme reported by most respondents was the value of visible support from executive leaders of the organization in creating staff buy-in for the change effort. This was manifested in several ways.

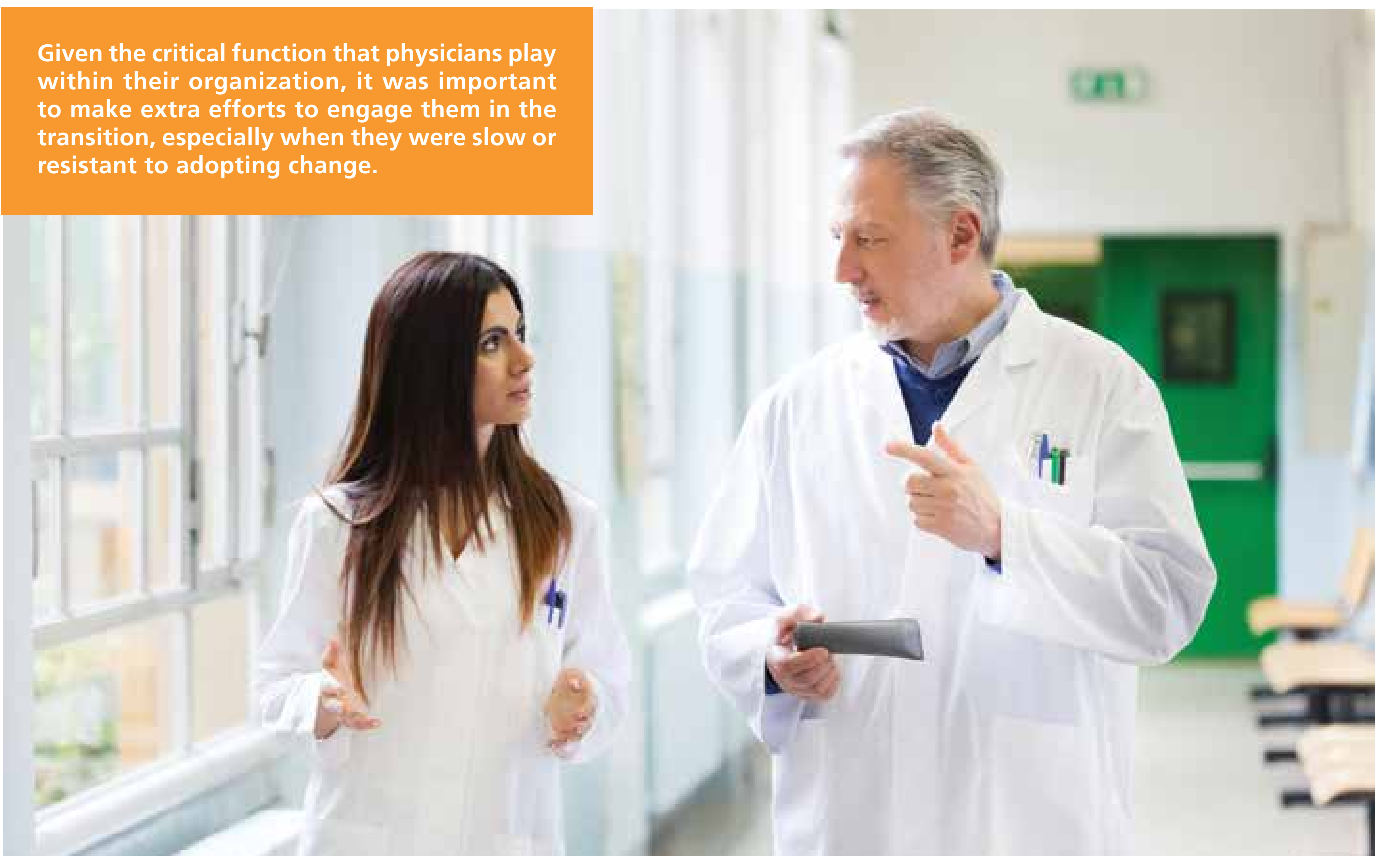
In some practices, executive leaders made clear their support for the PCMH model by addressing it in staff meetings and incorporating it into strategic planning sessions. In other practices, leaders made it clear that PCMH was part of the larger organizational vision and backed this up with the necessary financial and human resources in order to implement the necessary changes.

Successful leaders were able to get staff excited about the transition by providing enthusiasm and support for the work being done and by recognizing accomplishments.

It was also important for leaders to give a clear message to staff about the practice's commitment to becoming a PCMH. Respondents reported that not all staff were initially convinced of the value of PCMH but when they recognized that leaders were committed to it and were not faltering in their support for the initiative, these reluctant staff either bought into the model or left the organization.

About a year into the PCMH project one of the practices, despite many efforts, had made minimal clinical performance improvement and little to no headway on its self-reported transformation progress report.

During this period, staff morale was low, and they also suffered from lack of executive and physician champion lead-



Given the critical function that physicians play within their organization, it was important to make extra efforts to engage them in the transition, especially when they were slow or resistant to adopting change.

ership. This state of affairs remained constant until an executive from out of state was hired to oversee the project and a physician inside the practice was promoted to step into the role of physician champion.

Within months the executive leader, who was a physician, made it clear that the PCMH was part of the strategic vision while allocating resources to upgrade their electronic medical record, adding functionality necessary to report on several PCMH clinical measures.

In addition, he attended and actively participated in regular physician and staff meetings as well as all practice retreats organized by the physician champion. Within a year, practice morale advanced, clinical performance increased and transformation progress improved.

2. EDUCATE STAFF ABOUT THE TRANSITION — Respondents indicated that an important step to generating staff support for PCMH was education on the model and its various components. This education was done informally within the organization and formally, with select staff attending formal PCMH learning sessions hosted by the initiative.

Second, it was critical to educate staff members on how this transition would affect their roles within the organization, as well as how it would positively impact patient care. Staff members also had to be informed of the organization's commitment to PCMH. This education occurred in multiple ways, including during staff meetings and in the course of patient care.

The quality and content of this education on multiple levels is what made it meaningful and uplifting to staff. When staff could see the potential for PCMH to make their jobs more fulfilling, as well the opportunity to improve patient care, the likelihood of their commitment to change efforts increased.

The most effective practices held regular all-staff meetings as well as subgroup meetings that involved a great deal of open and ongoing discussion about what was working and what was not while actively soliciting ideas for improvement from every level. The huddle (a short, task-driven meeting) proved to be one of the most valuable and successful patient care interventions and was widely used by practices for planning for each visit, reviewing the day's schedule and sharing knowledge among team members.

3. INVOLVE STAFF IN DECISION-MAKING — There are multiple organizational shifts that must occur when a practice is transitioning to become a PCMH. Respondents reported that using a top-down approach from practice leadership to the staff resulted in a failure to gather meaningful staff input about the types of changes to be made and how these changes should be implemented.

It led to resentment from some staff and an unwillingness to adapt to different ways of doing things. Conversely, respondents from organizations that solicited staff input early on through retreats and meetings reported that their practices benefited from an increase in morale and commitment to the project. Staff wanted to see the project succeed and felt invested. Additionally, soliciting ideas from all levels of the practice enhanced the quality of the transformation.

Respondents noted that practices benefited when staff input was sought throughout the project as well. Most of the practices involved implemented plan-do-study-act (PDSA) cycles. Having staff participate in these small tests of change allowed them to provide input and insight into how to implement or adjust changes leading to true transformation rather than an externally driven, superficial change.

TRANSFORMATION FROM TRADITIONAL PRIMARY CARE TO THE PCMH MODEL IS AN ENORMOUS UNDERTAKING.

One practice decided to use this principal for maximum effect by kicking off team-based care in a unique manner. Prior to the official launch, they conducted mock patient visits where staff members took turns playing the roles of patients. This simulation resulted in many beneficial improvements solicited from all staff while building momentum for changing the way things are done.

When team-based care was officially launched by the practice, physicians and staff alike felt a sense of eager anticipation and a competence resulting from their previous experience.

4. EXPAND STAFF ROLES — A central tenet of the PCMH model is team-based care, where a defined set of multi disciplinary staff work together to care for a panel of patients. Respondents reported that moving to team-based care was a significant shift from the traditional physician-centric model of care.

The opportunity to take on new responsibilities or delegate traditional tasks contributed to staff buy-in for the PCMH model. With these newly configured teams, staff members had to figure out each others' roles and how to best capitalize on strengths and skill sets.

Many respondents reported that staff initially were feeling overwhelmed with all of the new PCMH requirements (e.g., care plan development, self-management goal setting with patients, pre-visit planning.)

This feeling lessened when they realized the opportunity to share responsibility for these tasks across the team thereby eliminating duplication of efforts and misunderstandings. Nonphysician staff reported being able to do more meaningful work and feeling more involved in patient care as a result of this shift, while physicians appreciated delegating more tasks.

Examples of new tasks taken on by nonphysicians included working with patients on self-management goals, participating in daily meetings with providers, and setting up referral appointments for patients. Practices that took time away from business as usual to train people in their new roles, complemented by mentoring and feedback throughout the day, were the most successful.

5. PROVIDE ONE-ON-ONE COACHING — Given the critical function that physicians play within their organization, it was important to make extra efforts to engage them in the transition, especially when they were slow or resistant to adopting change. Some of these slow adopters simply needed more time to warm up to the idea. Others needed some practical guidance around new tasks like huddles and care plan development. Still others needed a clear message of the organization's expectations of the physician's role within the PCMH model.

Each practice had identified a physician champion whose role was to lead and support clinical staff in PCMH implementation efforts. The role of the physician champion also included doing some individual coaching with staff who were considered late adopters by being supportive, not punitive.

One practice used a combination of physician group training and peer encouragement as an initial approach to work with late adopters. In the case of the few physicians who either could not or would not become actively involved in the PCMH transformation, the physician champion then set up several one-on-one coaching opportunities to ensure their participation. Taking the time to encourage physicians was especially rewarding when the resisting physicians turned into avid supporters.

LESSONS LEARNED — As PCMH spreads, understanding the importance of staff buy-in, as well as strategies for generating and increasing buy-in, will be an invaluable asset to other primary care practice sites undertaking PCMH transformation and other quality improvement efforts.

Transformation from traditional primary care to the PCMH model is an enormous undertaking. Practices need sufficient time to understand, digest and navigate the large-scale and wide-spread role changes, system integration and new medical innovations.

Perhaps most important, we learned that executive leadership needs to be visible at the practice level with actions that follow the words. Health systems with executives who consistently addressed the importance of PCMH to staff at meetings were particularly effective at generating buy-in.

It was also important to make it clear that opting out is not an option by clearly delineating how PCMH fit within the overall organizational goals and priorities.

Last, executives demonstrated their commitment by allocating the time and financial resources necessary to get the job done and generating enthusiasm for the hard work being done by staff. This executive position made it possible for practice leadership to be effective in their role.

We are still in the early stages of learning what works best in primary care transformation. Investing time and effort at the beginning to involve staff and gain their input into transformation efforts has the potential to result in an easier and more successful long-term transformation. The good news is that the elements that foster staff buy-in are not complicated but for the most part basic and straightforward. Using these five strategies makes it highly likely that the change will be more enjoyable, eliminate unnecessary change fatigue and be sustainable.

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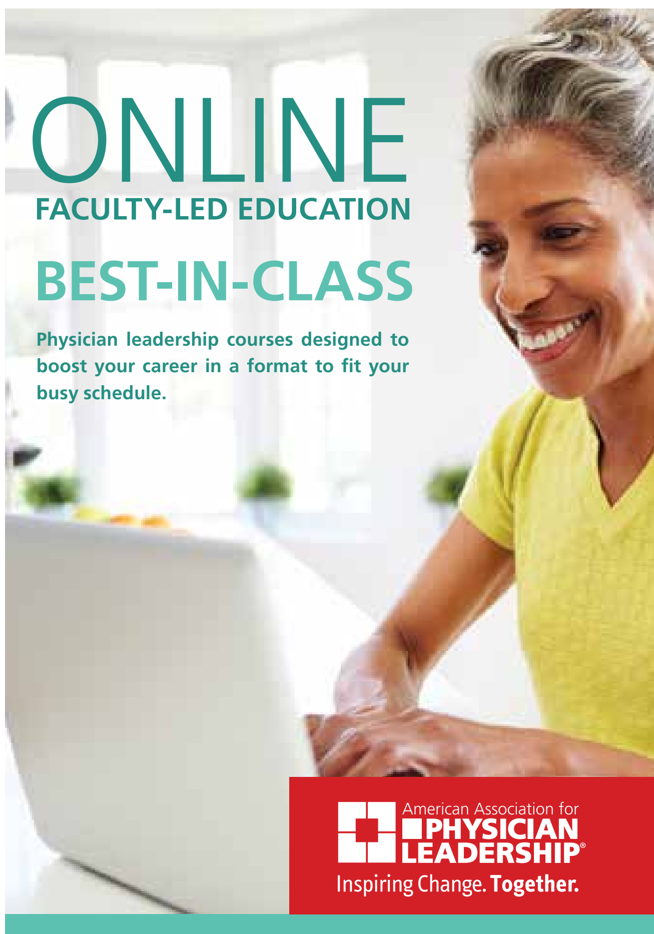

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