University of California, Davis Family Practice Center: Update 2014

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ABSTRACT

In response to long wait times and low patient satisfaction scores, the University of California, Davis, (UC Davis) Medical Center Department of Family and Community Practice redesigned its residency-based Family Practice Center into a Patient-Centered Medical Home (PCMH). This model expanded the role of medical assistants (MAs) by providing them with additional training and responsibilities. Because of their relative permanency, MA staff serve an integral role in teaching residents how to work in a PCMH. UC Davis is one of the first residency programs in California to incorporate the PCMH model into its training. This 2014 summary updates the original 2011 case study with new information on staffing, clinical outcomes, reimbursement, and more.

Prior to 2008, patients at the UC Davis Family Practice Center (FPC) often faced long wait-times. Clinic hallways were a hectic bustle as staff and providers scrambled to provide patient care while training the next generation of doctors, physician assistants, and nurse practitioners.

The long patient wait-times, low productivity, interstaff conflict, and concerns over patient privacy spurred the group to look at making physical and workflow changes in the clinic.

The FPC is a residency-based clinic with 25 exam rooms, 17 ongoing part-time faculty providers, and approximately 50 part-time residents who rotate through in three-year cohorts. Residents have changing clinic schedules based on the different phases of their residency. Medical assistants (MAs), on the other hand, are full-time permanent staff with institutional knowledge of day-to-day clinic operations.

Background and Inspiration

The Family Practice Center at the UC Davis Medical Center is the central ambulatory training site for the university's Department of Family and Community Medicine.

Practice Profile

Name: UC Davis Family Practice Center

Type: Residency-based academic primary care practice

Location: Sacramento, California

Staffing: 67 providers, approximately 8 to14 per half-day session:

- 17 faculty providers
- 50 residents
- A total of 34 staff, including
- 14 medical assistants (MAs)
- 1 practice manager
- 1 MA supervisor
- 1 medical office service coordinator (MOSC) supervisor
- 1 senior licensed vocational nurse (LVN) supervisor
- 1 medical director
- 2 LVNs
- 13 FTE clerical/administrative staff

Annual Patient Visits: 32,000

Patient Demographics: Diverse ages, incomes, and ethnicities, including new immigrants and refugees. One half receives Medicaid.

Around 2005 or 2006, FPC administrators made some changes to improve the patient experience. They revised the center's scheduling and appointment policies to enhance access and introduced an electronic health record (EHR) to manage patient records. These changes led them to systematically examine their entire workflow design and develop a more patient-centered and efficient practice.

The group visited innovative practice sites and adopted an emerging approach to health care: the Patient-Centered Medical Home (PCMH).

The Patient-Centered Medical Home

The PCMH model of care is gaining popularity across the United States in the wake of the passage of the Affordable Care Act. The model encompasses a number of key principals, including providing each patient with a personal physician who coordinates patient care in a team-based model utilizing health information technology to plan and document care and measure performance. Ideally, the PCMH also enables enhanced access and communication between patients and practice staff and providers. An especially important component of the PCMH is the idea that payment should reflect the work that "falls outside of the face-to-face visit," including the work of ancillary staff providing care.

Since 2013, the FPC has been exploring applying for recognition as a medical home through the National Center for Quality Assurance (NCQA). This recognition is important in the changing health-care environment because PCMH recognition may qualify organizations for additional payment.

Laying the Foundation

Inspired by the University of Utah Community Clinics' Care-by-Design model and lean production principles and by the Disney business model, FPC managers started making a number of changes to the physical infrastructure of the FPC that facilitated workflow redesign.

Information Technology: The FPC adopted the EPIC electronic health record system in 2006. In 2008, the organization placed computer terminals and printers in each of its 24 exam rooms. Doing this allowed clinicians to print out an after-visit summary and patient education materials to discuss with the patient in the privacy of the exam room.

Around 2011, the FPC introduced MyChart and tasked a team largely staffed by MAs and medical office service coordinators MOSCs with developing ways to educate patients about the portal. The MAs help patients sign up for MyChart in the exam room. If the patient has MyChart and knows how to use it, the MA does not need to print out an after-visit summary. For those who need a hard copy of the summary, the MAs can now print out a two-sided copy because the clinic had all of the in-room printers set up to make double-sided prints.

Scheduling: The FPC adopted same-day access scheduling, which allows patients to be seen on the same day that they request an appointment, and increased the length of all visit slots to 30 minutes.

Staffing: The FPC began redesigning its workflow in late 2008. The clinic currently has 32 full-time equivalent (FTE) staff positions, and this arrangement has not changed over the last several years. What *has* changed is the configuration of the staffing.

The FPC enhanced productivity by more than tripling the number of MAs on staff. Initially, the FPC had four MAs, four RNs, and 27 FTE clerical and administrative staff. As RNs and clerical staff left for new positions or retired, they were replaced with MAs when appropriate, and the FPC now has 15 MAs. MAs are not permanently teamed with a provider due to the need to rotate them between residents and faculty.

Instead of an RN supervisor, the FPC has an operations supervisor who oversees the clerical and medical office services coordinators, an MA supervisor who oversees the MAs, and a licensed vocational nurse (LVN) supervisor who oversees the two LVNs and the billing and coding staff.

MAs have learned new administrative skills, starting with scheduling and patient discharge. They will be

Incumbent MAs were initially overwhelmed by the additional work. Because their practice management and EHR software systems had not been fully integrated, MAs had to learn InVision for scheduling and discharge and EpiCare for check-in and recording vitals. Eventually more MAs were hired to take up some of the workload, and staff helped each other learn the new computer systems.

Some clerical staff and nurses were replaced by MAs as they retired or sought other employment. The "no layoff" policy helped ensure buy-in from both staff and providers and helped to avoid complaints from AFSCME (American Federation of State, County & Municipal Employees), the union representing MAs and nurses. However, supervisors in other departments at UC Davis did express some concern about the MA role's usurping the RN role within the system. The goal of having MAs replace clerical staff is no longer a goal as the university health system moves to streamline and standardize operations. The number of clerical staff (MOSCs) at clinic sites may decrease because the system is moving to centralize their functions, not because their positions will be replaced with medical assistants.

While the initial workflow redesign was based on the University of Utah model, which included having MAs collect copayments in the exam room as well as conduct more previsit planning and panel and chronic disease management, these changes have been placed on hold pending broader changes at the system level.

Outcomes

The ability to provide nearly all patient care and after-visit summaries in the exam room has enhanced patient privacy and decreased traffic and noise in the rest of the clinic. The introduction of MyChart has reduced waste and produced cost-savings for the clinic as well as enhanced patients' access to their medical records.

Reducing wait time was one of the initial drivers of the redesign process. The cycle time in late 2010 averaged 57 minutes, down from an average of 2.62 hours in January 2008. Total individual appointment time in early 2011 averaged 30 minutes.

Having a greater proportion of full-time equivalent positions (FTEs) filled by MAs cross-trained in clinical and clerical roles has resulted in cost-savings since FTEs can be applied when and where they are needed. Clinical staff can be called upon to cover for clerical tasks, but the same is not true of clerical staff. Previously, having specialized and separate functions for clerical and clinical support staff had resulted in redundancies and delays.

By July 2010, 78% of patients rated their overall quality of care as "excellent" compared with about 59% who rated their care that way in July 2009. In July 2010, 88% of patients reported that they had been able to schedule timely appointments, up from 29% of patients who said that in February 2009.[1]

MA Career Impacts

Within the UC system, there is a limited career ladder for MAs, which includes MA I, MA II, and MA supervisor positions. Promoting staff to the MA II level required establishing that MAs were performing work that meets the specifications of the higher classification. The FPC worked carefully with its Human Resources (HR) Department to reclassify existing staff and hire qualified new staff at the MA II level.

MAs at the FPC have been promoted to or hired at the MA II level, which entails a pay increase of 5%. One MA was promoted to MA supervisor.

> "[Now] I feel more a part of the team. I feel like I give 110%. I feel much more important."
>
> *-Dorinda Olson, MA II-*

MAs reported having greater satisfaction with their role and enhanced communication with providers. Patients have also noticed a difference: overall patient ratings of teamwork have improved from

trained to do simple referrals in the exam room. This training will be facilitated by expanding the clinic's use of its EHR to its full capacity, something that is scheduled to take place in 2014.

The role of the remaining nursing staff, the LVNs, is to conduct clinical tasks that are outside of the scope of medical assistants, such as administering immunizations and various other procedures.

Start-up and Training

In 2008, the FPC piloted this model for about six months with the staff at one of their three nursing stations before rolling it out to the entire clinic. Staff was kept informed of the changes via numerous meetings with providers and administrators and were encouraged to contribute ideas.

All start-up training was done on work time and arranged so as not to interrupt workflow. The initial training for the original 14 MAs was done in 2- to 4-hour blocks for payer training and training on scheduling software. One hour per topic was required for specialized competencies such as diabetic retinal screening and PHQ9 depression screening. Staff received training on the new EHR with Information Technology (IT) trainers. Staff designated as EHR "super-users," leadership staff, and providers trained first so that they could mentor others.

Additional competencies were added to the MAs' annual clinical competency exams to reflect work in the new model, including diabetes retinal screening, scheduling/ registration, and PQH9 depression screening.

The Medical Home in Practice

Each shift begins with a 15-minute team huddle, which includes residents, faculty, and all staff. A "Huddle Bulletin" covering topics for the week is distributed, and a resident selects a topic from the newsletter to discuss in detail. Clinical supervisors, billing staff, and MAs contribute to the discussion by providing updates and announcements. At the end of the huddle, providers meet with their MAs individually to discuss the day's patient schedule.

There are two provider shifts per day. A typical shift includes 14 providers, of which 10 are residents, and four are practicing faculty providers. Three or four additional faculty serve as preceptors.

MAs are assigned to a team of 3 or 4 residents that rotates through in half-days, although each MA only works with one provider per shift. An MA will generally stay with the same two exam rooms all day while faculty and resident providers rotate through. The MAs serve as guides, helping the residents to learn the procedures of the practice.

The MAs also provide continuity of care by escorting the patient through the entire visit. The goal is to bring all the care to the patient in the exam room rather than to move the patient and to cover as much as possible in one visit. Ideally, patients should receive all necessary testing and screening and have a referral in-hand or a follow-up visit scheduled by the time they leave the office.

MAs perform traditional MA tasks such as escorting patients to the exam room and documenting vital signs. MAs also stage prescription refills, retinal screenings for diabetes, and vibration perception threshold (VPT) tests to check for loss of protective sensation in diabetic patients. MAs administer a smoking cessation questionnaire and a race and ethnicity questionnaire at intake and administer the PHQ-9 depression screening and patient satisfaction questionnaires at every visit. Although MAs do not do any medication reconciliation, they have developed creative ways to remind providers to do so, resulting in high completion rates for this activity.

Challenges

Faculty providers were quite positive about the workflow and design changes, especially the concept of having a printer in each room. The faculty is invested in preparing residents to work effectively in practice. Because many of the residents will go on to work with Kaiser Permanente, which uses a similar EHR and workflow model, the redesign provides them with a residency experience more aligned with their likely future employment.

54% giving a rating of “excellent” in 2009 to 66% rating it as “excellent” in 2010.

Emerging Considerations

In 2014, the clinic will fully integrate its EPIC system to include reception, scheduling, and billing functions that were formerly handled in InVision. Integration of these tasks into the same system used in the back office should facilitate efficiency and the ability to cross-train.

Like many clinics, the FPC lost patients during the economic downturn, so it is difficult to project how the implementation of the Affordable Care Act will impact it. While the number of patients per provider has grown somewhat, the growth still fails to make up for the deficit resulting from the recession. The clinic itself will not move or grow spatially, but administrators project room for growth in the number of patients it can absorb.

Over the next two years, the UC Davis Health System as a whole will change as it works to streamline and standardize operations, instituting systemwide process flow changes.

Notes

[1] The organization now uses Press Ganey rather than Professional Research Consultants, Inc., to conduct its satisfaction surveys, making it difficult to compare more recent results with past results.

Acknowledgments

Innovative Workforce Models in Health Care is a series of case studies showcasing primary care practices that are expanding the roles of medical assistants in innovative ways. Profiled organizations are implementing practice models that improve organizational viability and quality of care for patients while providing career development opportunities to frontline employees. This research is funded by the Hitachi Foundation as part of its Pioneer Employers Initiative.

Special thanks to the staff, providers, and administrators at the UC Davis Family Practice Center for their ongoing assistance with this project.

To read the full 2011 case study, please see UC Davis Family Practice Center—Medical Assistants Anchor Residency-Based Medical Home

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