

Asian Health Services: Medical Assistants Improve Language Access and Patient-Centered Care

by Lisel Blash and Susan Chapman

© April 2015 Center for the Health Professions at UCSF

ABSTRACT

Asian Health Services (AHS) is an urban federally-qualified health center in Oakland, California. It has developed new roles for medical assistants and other frontline staff to capitalize on their language capacity and other skills to provide health coaching and health navigation services to an extremely diverse patient population with many different cultural and linguistic backgrounds.

Background & Inspiration

Asian Health Services (AHS) is located in Oakland, California's Chinatown, an area rich in history. Chinese laborers first developed communities in Oakland and San Francisco after they were driven from the California gold fields by anti-Asian violence in the 1850's. The community has continued to this day despite many challenges.

In the late 1800's, the Chinese American Exclusion barred Chinese immigration from the US, resulting in a declining population. This trend reversed in 1906 when the San Francisco earthquake drove fleeing residents of San Francisco's Chinatown to Oakland.

In the 1960's and 1970's, thousands of refugees from Southeast Asia, some of them ethnic Chinese, came to California due to the liberalization of immigration laws and the end of the Vietnam War. Oakland's Chinatown, while still predominantly Chinese, became an increasingly diverse Asian community.

Asian Health Services was founded in 1974 to address the need for culturally and linguistically competent care for this diverse community. In addition to health care, AHS provided advocacy and community organizing around health care funding for the safety net and language access.¹

Practice Profile

Name: Asian Health Services

Type: Federally Qualified Health Center

Location: Oakland, California

Staffing: (full-time equivalents)

- 25.38 MD Clinicians
- 4.29 Dental Providers
- 7.61 Behavioral Health Providers
- 0.96 Physician Assistant
- 6.69 Nurse Practitioner
- 2.90 Clinic Nurse Manager
- 23.78 RNs/Triage Nurse
- 54.94 MA / Health Coach / Health Navigator
- 9.04 Interpreters
- 1.14 Nutritionists
- 13.04 Patient Navigators
- 2.02 Chronic Care Assistants

Number of Patients: 24,387

Number of Annual Visits: 105,545

Patients:

- 90% are served in a language other than English
- 98% earn an annual income that is less than 200% of the federal poverty level (about \$46,100 a year for a family of four)
- 38% are uninsured
- 35% receive MediCal
- 20% are under 15 years of age
- 20% are over 65 years of age

Today AHS is a federally-qualified health center composed of three primary care medical homes, two school-based clinics, one integrated mental health/primary care site, and two oral health clinics. The organization provides vital care to many of the area’s Asian/Pacific Islander low-income uninsured and underinsured patients. AHS provides interpretation and translation services and houses its own practice-based clinical research department.

Asian Health Services strives to serve as a “one-stop shop” for patients’ health and social service needs. It provides full-service dental, fully integrated behavioral health, acupuncture, case management, social services, and more.

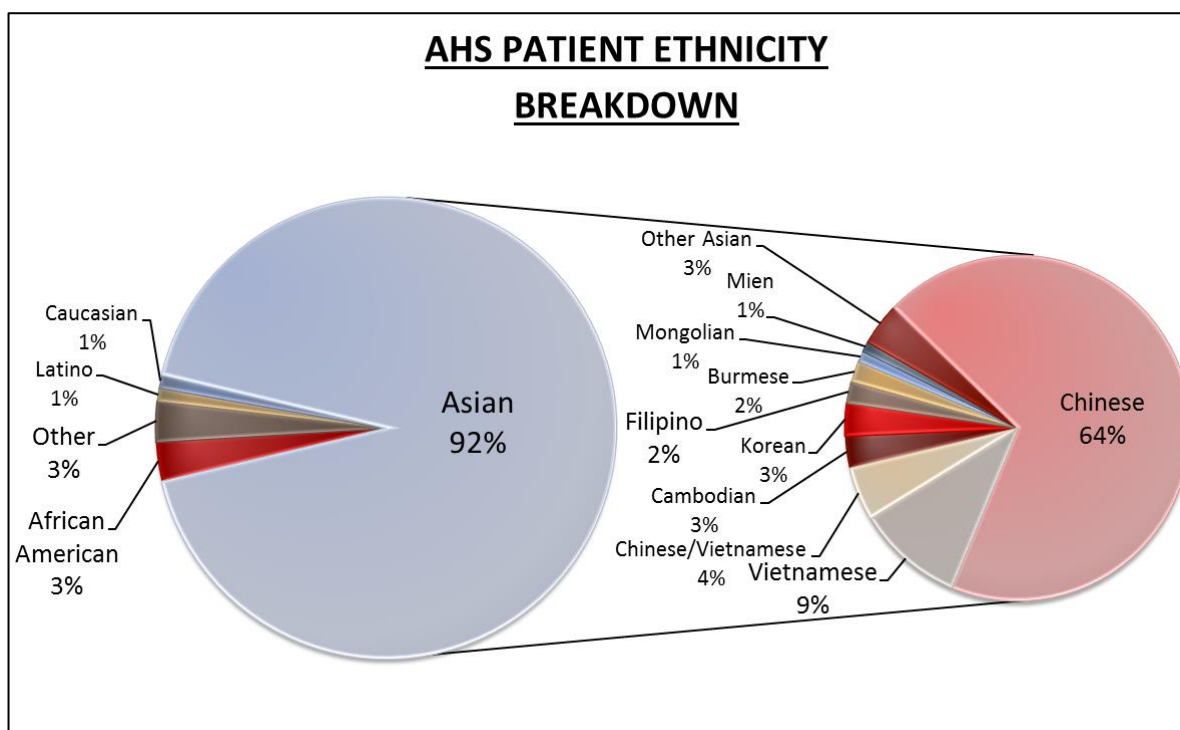
Because of its scope, AHS faces special challenges. Much of the population it serves has limited English proficiency (LEP); AHS’s patients speak more than 12 different languages including Cantonese, Mandarin, Vietnamese, Korean, Tagalog, Mongolian, Khmer, Mien, Burmese, Karen, and Karenni. In addition, AHS serves a large senior population.

Developing Model of Care

In 2009-2012, AHS participated in the California HealthCare Foundation’s “Team Up for Health” (TUFH), a three-year initiative aimed at helping participating clinics improve their delivery of care for people with chronic diseases before, during, and after the medical visit. Participating clinics focused on developing a “patient-centered culture of improvement” that utilized practice improvement teams to develop new workflows and models of care. Key elements included engaging patients in quality improvement, improving provider and staff communication skills, and redesigning practice to support self-management. This work utilized PDSAs, or Plan-Study-Do-Act cycles, to engage teams in testing and refining practices that work in the clinical setting.

Asian Health Services piloted the program with one unit at their main clinic, 818 Webster, and spread activities to another unit at that site in a second phase. MAs were trained in health coaching through a year-long program led by UCSF’s Center for Excellence in Primary Care. Medical assistants

Figure 1. AHS Patient Ethnicity 2014 ³



(MAs) were trained as health coaches to work with diabetic patients who were empaneled based on risk and chronic disease profile. The training focused on teaching the MAs strategies to help these patients develop self-management skills.

The team composition in this pilot program included 1.5 to two health coaches per provider and a chronic care assistant (CCA) who supported four to six providers. The CCA served as a panel manager monitoring patient registries and risk stratification, coordinating care and reporting data on quality measures.

Implementing the TUFH Initiative at AHS

In this model, when a patient arrived for an appointment, the health coach conducted a 15-20 minute pre-visit meeting with the patient. This might involve agenda-setting—helping the patient prioritize the issues they wanted to address when they saw the provider. The health coach reviewed with the patient the prescription and non-prescription medications the patient was taking and updated the list on file. The health coach asked the patient if he or she knows what each medication was for, what the dosage was, why it was being taken, and if the patient was experiencing any side effects.

Health coaches also conducted basic screening tests with diabetic patients, such as an HbA1c test, and could check current scores against prior scores in the electronic health record (EHR). Health coaches also conducted traditional MA tasks such as taking vitals and rooming the patient.

After the pre-visit meeting, the health coach informed the provider of the patients' top three priorities. The health coach also conveyed any important information, such as medication reconciliation, resulting from the conversation with the patient. Because patients tend to be more

comfortable with the MAs and health coaches, they often told them more than they told the providers about their health concerns. Since the provider only had fifteen minutes with the patient, these reports were very useful in focusing the provider's time during the visit.

After the visit, the MA health coach printed a patient visit summary that included the diagnosis, the list of medications, any new prescriptions, and any health maintenance items. The after-visit summary also included any health management goals the health coach had set with the patient.

“We can't have MAs and providers using different skillsets and protocols for different populations of patients and switching back and forth. We can't be creating an unequal system within our own walls. We need to have care equality and break down barriers to access.”

—Susan Huang, Medical Director—

AHS achieved improvement in a number of chronic disease indicators as a result of its participation in TUFH. Provider satisfaction with a) the impact of self-management support on patient treatment, and b) the impact on the patient-provider relationship also improved.³

Current Sites and MA Roles

Based on the successful experience with TUFH, Asian Health Services explored spreading and broadening this model of care to other parts of the organization.

The intent was to expand the model beyond patients with chronic diseases in order address all patients as part of AHS's patient-centered medical home implementation. Each of AHS's three main clinics started out with a slightly different model to address patient needs.

The **818 Webster Clinic** was the original implementation site for the TUFH health coaching pilot. The clinic continued with the TUFH health coaching model for several years after the pilot. However, many of the original health coaches went on to other jobs or additional education, leaving the remaining coaches to help train in new staff.

In 2010, AHS opened a second clinic at a more remote site on East 18th Street. This clinic, the **Frank Kiang Medical Center**, is outside of the

Chinatown area and in a very diverse neighborhood. This Center adopted an innovative approach utilizing frontline staff as health navigators who assist with patient advocacy and make referrals in multiple languages.

The health navigator (HN) role is that of a “health coach plus”. The health navigator is a medical assistant who also serves as a member of the chronic care management team, providing patients with information to navigate the health system. It is a multi-function role that includes medical assisting, health coaching, medical interpretation, referrals, and care coordination.

This site adopted the HN model because it sees patients from many smaller language groups, including Khmer, Korean, Mongolian, and Tagalog.

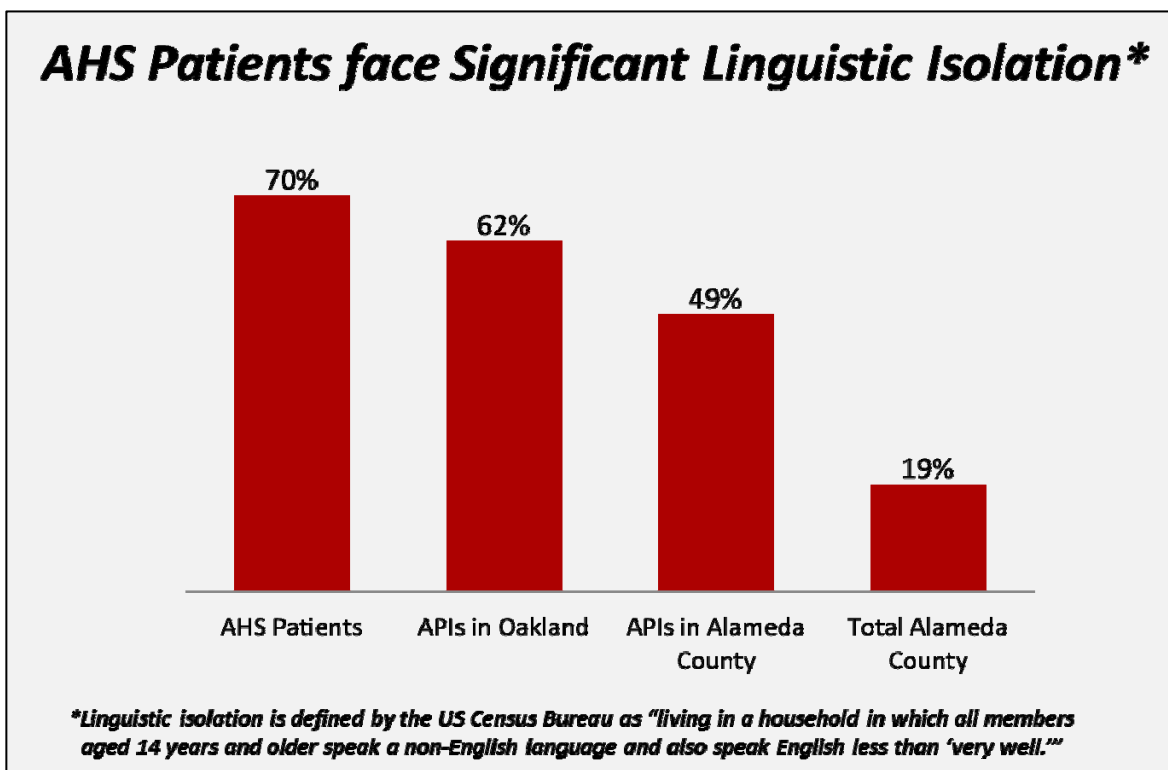
In the spring of 2012 AHS expanded into **835 Webster Street**, a new building across the street from their primary clinic. Officially the **Rolland and Kathryn Lowe Medical Center**, the “Silver Dragon” site, a former Chinese restaurant, offered the

opportunity to experiment with a new spatial arrangement to enhance team-based care. A first floor entry lobby utilizes movable furniture to allow the space to be easily re-arranged for community events and gatherings. The first floor handles reception and calls; all clinic space is on the second and third floors.

The second floor of the Silver Dragon clinic serves geriatric patients from the clinic’s main language groups, Cantonese, Mandarin, and Toisanese. Clinic space includes a series of exam rooms, 3 per provider, around the perimeter of the floor encircling an octagonal ring of work spaces where MAs and providers are co-located. A third floor focusing on family medicine provides service to patients from a more diverse age range.

The Silver Dragon served as the pilot site for an updated model workflow incorporating a more robust version of health coaching. The goal was to achieve a ratio of 1.3 to 1.5 health coaches per provider, which would allow health coaches to meet

Figure 2. AHS Patient Linguistic Isolation 2014



with patients individually and possibly stay through the visit.

In order to work as an MA at Asian Health Services, MAs must obtain certification within 12 months of hire. MAs must be fluent in English and bilingual in at least one of the Asian languages commonly spoken by members of the patient population. Those who are qualified can apply to move up to the health coach level. The expectation for all new hire MAs is that they be able to work up to the health coaching level.

As of 2015, all MAs have received standardized training as health coaches based on lessons learned from the TUFH and Silver Dragon pilots.

MA Roles and New Workflow

The day before the visit, health coaches scrub the charts to identify care gaps and to see what the provider needs ahead of time. This might be screening tests such as a pap smear or pelvic exam, fall screening for elderly patients, depression screening (PHQ5 or PHQ9 questionnaires), and the mandatory “Staying Healthy” Assessment screening required by MediCal (California’s Medicaid program). Ideally, each teamlet huddles every morning to discuss the day’s patients and their needs.

The day of the visit, health coaches help patients fill out necessary forms and update the electronic health record. They work with patients to prepare individualized health management plans, and can provide action plans and exercise sheets in the appropriate language. They also do medication reconciliation with patients, documenting what medications patients are taking and reviewing that against the medical record and transmitting that information to the provider. At the end of the visit, the health coach may review provider instructions with the patient.

Post-visit, health coaches conduct follow-up phone calls to check on how the patient is doing with his or her action plan including checking up on the patient’s exercise and diet. Health coaches also ask about medication adherence, follow-up on referrals

to specialists, and may also check on glucose levels or other relevant clinical measures.

As with medical assistants, AHS is working on using nurses more effectively. LVNs round out the team as floor coordinators who can meet individually with geriatric patients to conduct gait and vision assessments to determine whether patients are high-risk for falls, and then forward that information on to the provider. While the original goal was for MAs to conduct these visits, it was found to be a better match for LVN skills and competencies.

RNs can see more high-risk patients: for example, the diabetic patient who needs more intensive insulin adjustments. These visits allow the RN to assess high risk patients, review important health management information with the patient, and then share information with a provider who can make a clinical judgment on necessary treatment. Utilizing nurses in this respect allows patients who need extra assistance to meet with an RN every week or two, and check in with the provider every six to eight weeks, reserving provider time for more complex issues.

There are also behavioral health staff onsite so that the team can do a “warm handoff”—directing a patient directly from a medical visit to a mental or behavioral health provider as needed.

AHS has sought to maximize the number of “touches” complex or at-risk patients receive between regular provider visits in order to improve care while decreasing the burden on provider time;

Cross-site Support

A centralized quality improvement team supports teams at all of the clinics. Chronic care assistants (CCAs), a position developed during the TUFH implementation, are staff who are trained to review, analyze, and report patient data for use in grant writing, quality improvement, and panel management. The role of the CCAs is to offload some of the front end work of the clinical teamlets by focusing and redirecting care based on the data they provide. They provide information on the day’s patients and their needs to the clinical teams for

daily huddles. CCA's main qualifications are familiarity with clinic operations and an interest in computer and data skills. This is a role that has sometimes been filled by former unit clerks and medical assistants. CCAs report to the Quality Improvement Analyst.

TRAINING

Administrators noted that due to the specialized skills needed for health coaching and health navigator jobs at AHS, the clinic has to have its own in-house training program. While AHS has formed alliances with various outside groups that train MAs, the programs do not entirely prepare MAs for these specialized new roles.

The 2009 TUFH initiative led the organization to start developing its own extensive in-house curriculum to address health coach training geared towards a diverse Asian American population.

Health Coaching Curriculum

Prior to 2014, each AHS site had somewhat different training protocols and care models developed to address the diverse language needs of its patients. During late 2014 through early 2015, AHS adopted a new EHR system, which allowed it to standardize its health coaching protocols, facilitating training across sites. Standardizing protocols and curriculum have allowed the clinic to develop a stronger in-house training component and an in-house pipeline for the career ladder.

The curriculum currently includes seven chronic care modules. Topics include medication reconciliation and adherence, medications for chronic disease management, diabetes and cardiovascular risk reduction, action planning and agenda setting with patients, using templates and standing orders in the EHR, and other topics related to operationalizing the AHS care model.

In addition, health coaches receive training in motivational interviewing to elicit patient-generated strategies to improve and maintain their own health.

The geriatric syndromes curriculum currently under development includes:

- Falls prevention & intervention
- Polypharmacy in the elderly
- Cognitive impairment/dementia
- Care goals communication & advanced care planning
- Sleep issues for the elderly
- Care transitions
- Urinary incontinence
- Oral Health in the elderly
- Mood disturbances and behavioral health issues

A provider developed and conducts initial training sessions on various topics for MA health coaches and other staff. The format for these sessions has included didactic and participatory methods, including an online module and a Jeopardy-style game. To date, modules have been conducted during a monthly meeting. Trainings have entailed a

Figure 3. AHS 835 Webster Clinic



two to three hour time commitment per session. There are also training sessions for providers, nurses, interpreters and others to work in this model.

For example, MA health coaches are trained to understand the purpose of the different common medications so they can explain them to the patient. Providers are trained to write clear directions for the MA on this topic.

Nurse managers at each site have been trained to lead monthly review sessions with incumbent health coaches. These two hour-long lunchtime training sessions reinforce the material covered in the initial staff training and help MAs apply the concepts they learned in their initial training to their daily work. In addition, health coaches receive mentoring, learning assessment, and rigorous performance evaluations to help identify areas of strength as well as areas for improvement. They also shadow other staff to learn from observing.

In addition to health coach training, health navigators are required to complete the in-house LCAP (Language and Cultural Access Program) medical interpretation course and the medical interpreter exam within 12 months of employment. All health coaches were previously required to complete the LCAP program, this requirement proved too costly and has been discontinued. While health coaches are required to be bilingual, formal interpretation is handled by trained medical interpreters.

RESOURCES

Team Up for Health was funded out of a grant from the California HealthCare Foundation. Grantees received \$25,000 for a six month planning phase, and then \$150,000 over two years for implementation.⁴ Sites were also provided technical assistance in practice change.

In 2011 AHS also received \$150,000 from Kaiser Permanente's community benefit program to implement a PHASE (Prevent Heart Attacks and Strokes Everyday) program which helped to expand

the health coaching model into additional focus areas beyond diabetes.⁵

Currently, health coach salaries and training are paid for out of a mix of grants and general operating funds.

Challenges

There is a limited candidate pool of fluently bilingual MA/health coaches. The number of language groups AHS services introduces additional complexity.

AHS has experienced some staff turnover, partially because their bilingual, well-trained MAs are in high demand. A number of health coaches from the original cohort of the TUFH initiative have moved on to other opportunities, including nursing school and employment with larger health systems. Retaining health coaches is particularly vital as the agency grows. The need to hire and provide basic training to several new health coaches interrupted ongoing training and curriculum development, which delayed expansion of the health coach role. While the plan for the care model at the Silver Dragon clinic called for two health coaches for every provider, the ratio is often 1:1—a situation which required revising workflow plans to include LVN floor coordinators.

Freeing up nurse managers to learn to train, and then provide ongoing training to staff, has been a challenge.

Some providers have been reluctant to let go and trust the health coach to take on some of the rudimentary screening and education tasks associated with the patient visit. However, as training progresses, this reluctance is starting to diminish.

Health coaches note their own challenges. For example, working with geriatric patients can be difficult because these patients are more likely to be hard of hearing and forgetful. This requires that health coaches to provide constant reminders and raise their voice in order to be heard. Sometimes patients do not pick up refills or take their medications, which is frustrating to health coaches

who are deeply invested in improving their patients' health.

Finally, the implementation of the new NextGen EHR in 2014 initially slowed clinic processes and postponed health coach training and curriculum development. However, as it has rolled out, it has enhanced the ability of providers to delegate tasks to health coaches and other staff using messaging functions and standing orders.

OUTCOMES

Patient Health Outcomes

AHS was able to document improvement in chronic disease outcomes resulting from its initial health coaching initiatives. For instance, the percent of patients receiving health coaching whose HbA1C level was less than seven went from just a little over 20% in September of 2009 to close to 55% in December 2010. Medication compliance for patients with cardiovascular risk also improved from 2009 through 2011.

AHS continues to hit high marks in patient outcomes measures. As of October 2014, AHS was exceeding Healthy People 2020 goals, including in the following areas:

- Diabetes: The percentage of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is $<9\% = 92.9\%$
- Hypertension control: The percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90 = 78.7%

MA Career Impacts

MAs at AHS are unionized through SEIU Local 1021. The AHS Human Resources department worked with the union to ensure they could put the health coaches at a higher pay scale. AHS worked out a protocol with the union for recruitment, training, and evaluation of health coaches.

MAs are required to become certified within 12 months of hire. Upon receiving national-level certification, such as Certified Medical Assistant (CMA), they receive an additional \$3,000 bonus.

Language skills are an important qualification for employment as an MA at AHS. If MAs use their language skills in the course of their work, they receive a \$600 annual bonus.

There are several career steps possible for MAs. Incumbent MAs must apply for these steps. The first is the entry level MA position. MAs that go through the training and progress to the Health Coach I level receive a 6% pay raise from base. Those that become Health Navigators, or progress to Health Coach II, receive another 2% pay raise. This puts them at a wage scale approximately 8% higher than the MA base wage..

Beyond the career advancement opportunities, medical assistant health coaches working in this model expressed a great deal of investment in their patients and engagement in the care model:

"People were happy, of course, that they got a pay raise. But most important, we had the chance to learn more skills,"

–AHS Health Coach–

"I don't see it as more work. It is so satisfying watching the patient's A1C go down."

–AHS Health Coach–

Provider and Nurse Satisfaction

Anecdotally, providers and nurses are generally pleased with the additional support they receive from the health coaching model of care. Evaluation surveys conducted during the TUFH pilot indicated significant increases in provider satisfaction with self-management support over a two-year period.

Organizational efficiency

Administrators are still assessing the cost benefit of this model of care and fine-tuning the incentive and training structure. The number of patients would need to increase by just 0.2 visits per hour to cover the costs of hiring an additional health coach per

provider. Ideally, once fully established, the model should more than pay for itself in productivity gains.

The evolving career ladder has been good for retention because the clinic can offer competitive pay and advancement opportunities, which is very important in an expensive market like the San Francisco Bay Area.

Moving Forward

With EHR up and running and related staff training now complete, the organization is moving to complete the development of its health coaching curriculum. This has allowed AHS to standardize and expand its training protocols, and standardize the care model developed at 835 Webster across the entire system in 2015.

The new EHR allows AHS to improve its ability to track and analyze utilization, conduct more advanced cost/revenue analyses, and further fine-tune its care model. The EHR will also allow the organization to develop and launch a patient portal. Finally, it allowed the organization to build in protocols that allow delegation of tasks, further freeing provider time.

Replication and Lessons Learned

Asian Health Services has demonstrated considerable improvements in patient care as a result of its initial health coaching pilot. It continues to innovate to address the needs of its community and provide culturally competent care. The following are factors the organization's medical director identified as contributing to their success.

- Engage top leadership for best results .
- Set a clear vision for change and align it with organizational priorities.
- Develop multidisciplinary and cross-component collaborations within the organization.
- Allocate sufficient lead time and seed funds for development and planning for pilot projects
- Plan and budget for ongoing training needs as well as new staff onboarding.

- Performance evaluation and competency testing for MAs has to encompass different modalities .
- Define clear outcomes and document progress.
- Career ladders need to be thoughtfully structured to enhance recruitment and retention.
- Careful staff screening and training build provider trust and allow providers to feel more comfortable in delegating tasks.
- Workflow redesign should be conducted parallel to training staff and providers so that trainees can practice what they learned immediately or very soon after training.

Notes

1. "Language access refers to ensuring that persons who are not proficient English speakers are able to meaningfully access and participate in programs and activities at a level equal to proficient English speakers." Alanen, Julia. "Language Access: Effectively Serving Limited- and Non-English Speakers" From a webinar Held October 5, 2010, Catholic Legal Immigration Network, Inc.

2. Huang, S. (2013-2014). *Asian Health Services – Innovative Workforce Models in Healthcare* slide presentation for the Community Clinic Association of Los Angeles County (CCALAC) annual symposium, March 7, 2014.

3. Emont, S. (2011). *Evaluation of the California HealthCare Foundation's Team Up for Health Initiative*. A report to the California Health Care Foundation.

4. California HealthCare Foundation. (2008). *Request for Proposals Team Up for Health: Supporting Patients for Better Chronic Care*. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RFPTeamUpForHealthBCDC.pdf>

5. Konstantinovskiy, M. (November 15, 2011). "New grant from Kaiser could help more Oakland residents manage chronic illnesses." *OaklandNorth*.

Acknowledgements

This research is funded by the Hitachi Foundation. The Hitachi Foundation is an independent philanthropic organization established by Hitachi, Ltd. in 1985. The Foundation's mission is to forge an authentic integration of business actions and societal well-being in North America. (www.HitachiFoundation.org)

This case study is part of the *Innovative Workforce Models in Health Care* series of case studies prepared by the UCSF Center for the Health Professions. These case studies highlight organizations that are expanding the roles of medical assistants and other frontline health care workers in new directions that benefit both the organization and its patients while providing career development opportunities to the employees.

We would like to thank the Hitachi Foundation and study participants from Asian Health Services for their assistance in preparing this case study.

Views expressed in this case study are those of the authors and do not necessarily reflect those of the Center for the Health Professions; the University of California, San Francisco; the Hitachi Foundation, or Asian Health Services.



© 2015 *Center for the Health Professions, UCSF*

The mission of the Center for the Health Professions is to transform health care through workforce research and leadership development.



University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
(415) 476-8181
<http://futurehealth.ucsf.edu>