CENTER FOR THE HEALTH PROFESSIONS

RESEARCH BRIEF

DFD Russell Medical Centers—Engaging Medical Assistants in Quality Improvement Efforts

by Lisel Blash, Susan Chapman, and Catherine Dower, Center for the Health Professions at UCSF
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ABSTRACT

DFD Russell Medical Centers in rural central Maine involve medical assistants in quality improvement efforts through a) engaging them in small scale testing and refinement of practice improvements (PDSAs), b) providing them with periodic reports on quality measures directly related to their individual performance, and c) annual individual-level bonuses for achieving quality goals in patient care. MA team leaders assist in coaching MAs to follow protocols and meet quality standards.

Background

For many decades, the small town of Leeds, Maine, and its surrounding area in rural Androscoggin County was served by just one physician, Dr. Daniel Frank Davis Russell (1879-1975). A country doctor who made house calls, DFD Russell was an indispensable part of the local community.

After his death in 1975, a public/private partnership formed to start a clinic in the basement of the Leeds Community Church. Today, DFD Russell Medical Center is a Federally Qualified Community Health Center (FQHC) with three clinics located in rural central Maine: Leeds (population 2,000), Turner (population 4,972) and Monmouth (population 3,785).

While DFD's ten providers (MDs, NPs, and PAs) now see most of their patients onsite in the clinics, some of the long-term providers still make house calls to local residents in need. Unlike the lone country doctor of DFD Russell's era, today's providers have a team of support staff to assist in providing comprehensive care to the local community. Under the leadership of CEO Laurie Kane-Lewis, DFD has developed strategies to engage its entire staff in its founder's commitment to community-oriented care.

Practice Profile

Name: DFD Russell Medical Centers

Type: Federally Qualified Health Center

Location: Leeds, Turner, and Monmouth, Maine

Staffing: 48.47 FTE, including

- 5 physicians
- 3 nurse practitioners
- 2 physician assistants
- 3 behavioral health providers
- 2 nurse care managers
- 13 medical assistants
- 1 patient assistance coordinator

Number of Patients: 10,000

Annual Patient Visits: 30,000

Patient Demographics: Most patients are from the surrounding area. About 16% of patients are seniors, and most are Caucasian, reflecting local demographics.

Nearly a quarter (23%) is below poverty level, and 20% receive Medicaid.

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Inspiration

Figure 1. The original site of the DFD Russell Medical Center

DFD's main Leeds facility is situated on a quiet country road surrounded by woods and fields, an old grange hall, and a few farms. The countryside is beautiful, but the rural location imparts challenges. The health center provides services to a dispersed population. Many patients face problems with depression, substance abuse, and family dysfunction as a result of isolation and chronic disease, which is also prevalent. Because of the traditional farming-based economy, many patients are self-insured. Transportation can be difficult, particularly for the many patients who are low-income and would likely have difficulty receiving services elsewhere due to the low reimbursement rates associated with Medicaid.

These issues have propelled the adoption of a number of measures to address patient needs. In order to provide better access to its dispersed, rural population, the organization developed two additional clinics in other towns rather than expand its primary site at Leeds. The health center also built an ambulance bay in Leeds, the most rural site.

In addition to its primary care providers and support staff, the organization now employs behavioral health specialists, nurse care managers and a patient assistance coordinator to address patients' behavioral health and social needs. DFD's participation in the Health Resources and Services Administration's (HRSA's) Health Disparities Collaboratives inspired it to integrate a team-based, coordinated care approach to chronic disease management, which has been adopted as DFD's overall model of care. This model has had considerable impact on MA roles.

Working with the Chronic Care Model

HRSA's Health Disparities Collaboratives support federally funded health centers in adopting the Chronic Care Model to improve care for underserved populations. A "collaborative", in this context, is an "intensive, concentrated effort to facilitate breakthrough transformations in the clinical and operational performance of clinical teams and their organizations based on what already works." [i]

The Chronic Care Model is intended to address the needs of the many Americans with ongoing chronic conditions that "require constant adjustment on the part of the patient, and ongoing interactions with the health care system." [ii] The growing incidence of chronic conditions such as diabetes, hypertension, obesity, asthma, and depression has strained the health care system because these conditions require ongoing and often intensive monitoring and care that providers do not have time to address adequately in the traditional 15-minute office visit. The Chronic Care Model recognizes that treating these patients requires a different approach to health care provision including patient self-management support, evidence-based decision support, clinical information systems to monitor outcomes, delivery system redesign (including team-based care), and community partnerships including providing patients with linkages to community resources. [iii]

Implementing the Chronic Care Model

Information Technology: DFD has been a high achiever in terms of quality and innovation. In 2000, DFD was one of the first health center in Maine to implement electronic health records (EHRs). [iv] It has also implemented ePrescribing, physician order entry, and a new (June 2011) secure email system and patient portal.

The introduction of the EHR enabled the health center to track patient records and automate and delegate tasks. The ability to track patients and outcomes over time also made it possible for DFD to participate in HRSA's Health Disparities Collaboratives.

Delivery System Redesign: DFD first participated in the HRSA Depression Collaborative in 2004. Over the course of one year the DFD collaborative team, with the support of their Board, took the first steps to incorporate behavioral health

issues into primary care. They developed a depression screening protocol, a depression registry, and implemented a depression tracking tool in the EHR.

However, these changes required a great deal of development. DFD learned to use a method of piloting innovation called the "Plan-Do-Study-Act (PDSA) cycle. This is a structured method of running small-scale tests by planning a workflow change, observing the results and acting on what is learned. [v]

The depression collaborative required many PDSA cycles to determine the best workflow for using the depression screening tool they had chosen to use, the PHQ9 (Patient Health Questionnaire 9). The PHQ9 is a nine-item survey instrument that allows clinicians to screen for depression and monitor its severity. MAs received extensive training to help them gain the skills they needed to administer the PHQ9 successfully. MAS were also trained to help patients pick a self-management goal (SMG) in order to engage them in their own care. Determining when the PHQ9 should be done and what should be done when certain scores were obtained also required many PDSA cycles.

In 2005, DFD was accepted to participate in HRSA's Diabetes Collaborative. DFD now had a year's worth of experience with the PDSA cycle and implementing change. DFD integrated what it had learned from the depression collaborative into the diabetes initiative. As a result, MAs now administer the PHQ9 annually and work with the patients on setting self-management goals at each visit. DFD incorporated more literature for patients and more protocols for MAs so that they had a checklist on what needed to happen for each diabetic visit (labs, PHQ9, self-management goals, eye and foot exams).

Tracking and documentation of progress in meeting self-management goals and clinical outcomes was key to enhancing buy-in from providers and medical assistants. The ability to report back data, such as immunization rates and diabetes, depression, and blood pressure screening rates, made it possible to link quality improvement directly to staff's daily work.

The team leveraged their EHR to serve as a decision support tool as well as a reporting tool, which allowed the standardization of protocols and the delegation of tasks to non-provider staff, especially MAs. Their goal was to make the Chronic Care Model idea the framework for *all* care delivery.

> "The electronic medical record and computer systems have helped increase the quality of care…The reports we get on our patients for tracking help us work harder at improving quality care. I am proud of the hard work we do here."
>
> *--Belinda Peabody, MA Team Lead—*

Chronic Care Model in Practice

Medical Assistants: Located in a nursing shortage area, DFD Russell has always been largely dependant upon its medical assistants (MAs) to support providers in patient care. Prior to 2005, the MA role at DFD Russell was fairly traditional. Participation in the HRSA Health Disparities was the biggest factor driving the expansion of MA roles. From 2005 onward, MAs have become a more integral part of the team as they have learned new skills and become involved in workflow decision making through testing workflow options using the PDSA cycle.

DFD does not require that MAs be certified or have formal medical assistant training. Some MA staff have received all of their MA training on the job, while others have received training from local community colleges such as Central Maine Community College.

MAs are assigned to a single MD, NP, or PA provider. This was not the case prior to 2004/2005, when MAs were available to work with any provider who needed their assistance. When the organization began adopting the Chronic Care Model and working with the Health Disparities Collaboratives, CEO Laurie Kane-Lewis and COO Denise Breer helped steer the organization back to pairing providers and MAs as a quality improvement measure. They found that stable teams provided continuity for patients, and allowed greater

accountability in documenting individual staff contributions to patient outcome measures.

Each MA is part of a team or "teamlet" (small team) that includes one to two MAs working with one provider; a physician, nurse practitioner or physician's assistant. Teamlets typically see 11 patients in the morning and 11 patients in the afternoon. Nurse care managers, the patient assistance coordinator, and several behavioral health providers provide additional patient support.

MAs are involved with planning and participating in the daily "huddle" where the entire office meets to discuss the day's schedule and patient needs. Huddles take place early in the morning and include primary care physicians, nurses, MAs, behavioralists, and others. The institution of the morning huddle started with DFD's participation in the Patient-Centered Medical Home Pilot.

MAs work four long days rather than the standard 5-day week, following the schedule of the provider with whom they are paired. DFD has extended evening and weekend hours to enhance accessibility.

Some MAs rotate through two distinct roles, spending two days working with the providers "on the floor", and two days working in DFD's call center, the "Telebank".

When they are working with the providers, MAs take on many tasks often assigned to RNs in other clinics. In addition to rooming patients, taking vital signs, giving immunizations, and other traditional medical assisting tasks, MAs use protocols and scripted screenings to check smoking status and chronic conditions, and to assist patients in setting management goals.

Engaging patients in their own care through setting self-management goals is part of the chronic care model. Utilizing motivational interviewing techniques,[vi] MAs may start by asking patients "What goal do you have for yourself?" Working from protocols developed for different conditions and goals, they may ask new patients when and how they intend to start working towards a new health goal, or how patients are doing with an existing goal they have set for themselves and whether there is anything health center staff can do to help the patient to achieve his or her goals. Self-management goals and progress towards meeting them are documented in the EHR.

The MAs also administer the PHQ9 screening test, which is a brief survey meant to identify depression. DFD MAs administers the PHQ9 for any patient who is being seen for depression, at least annually for patients with chronic illnesses, anytime the last PHQ9 score was over 15 and at least once a year for patients 15 years and older. MAs notify a primary care or behavioral health provider if a patient receives a high score on the PHQ9 test. Because DFD has staggered behavioral health and primary care appointments and left space for walk-in appointments for behavioral health every other appointment, the center can usually accomplish a "warm handoff", in which the primary care provider introduces the patient to the behavioral health specialist for immediate consultation.

MAs use a diabetes protocol to prepare diabetic patients for their visit with the provider. They are trained to conduct the diabetic foot check and hemoglobin A1C tests, and they may set up diabetic eye exams for patients.

MAs open the clinical portion of the visit; check-in is handled by the front desk unless the patient comes to an evening session. While the health center has a computer in every room, there are not printers in the exam rooms. Thus the visit is closed by the staff at the front desk, who collect fees and schedule appointments.

The Leeds center also has a CLIA-waived lab. A lab manager supervises the lab and trains the MAs to draw blood and conduct a limited number of lab tests. One MA is scheduled as a lab tech and works mostly in the lab.

In 1999, DFD Russell established a call center called the Telebank at its Leeds Center. The Telebank system was adopted to relieve the front desk of distractions, to keep the patient waiting area quiet and calm, and to improve communication between patients and the providers by having the MAs field and document patient calls.

The Telebank is a sunny room with several work stations with computers and phones for the MAs to use in making and receiving patient calls. Outgoing calls are typically made to the patients in the MA's provider's panel. These include scheduling follow-

up visits. MAs may refer patients to a care manager as appropriate.

Provider's answer after-hours calls themselves on their DFD-assigned cell phones. DFD instituted this system to address patient complaints resulting from the group's past use of an offsite answering service for after-hours calls. Patients complained that the answering service operators did not know their names or understand their issues. Now MAs working in the Telebank that day review the on-call doctors' messages and make sure they are documented in the chart and sent to the patient's provider for review.

The phone lines come on at 8 am, and incoming calls are handled by Telebank staff. MAs handle calls for all three DFD sites, totaling more than 800 calls per day. The MAs schedule appointments, conduct follow-up calls on lab results, get refill requests sent to providers, process prior authorizations, and answer patient questions or forward them to the provider as necessary. There is an SOP manual at each station containing Telebank protocols. These include protocols covering documentation of phone notes in the EHR, how to handle new patients, and how to handle emergency situations, particularly those that might indicate a heart attack. In between calls, MAs may utilize downtime to catch up on other administrative tasks such as maintaining disease registries.

MAs may be assigned, along with their teamlet, to work on a PDSA or "plan-do-study-act" cycle to pilot test innovations in their care model. A current PDSA is a pilot on tracking referrals. The group also did a recent PDSA on medication reconciliation.

New Roles

Team Lead MA: When DFD expanded to three clinic sites, it created a challenge for management, which could not be at all three locations at once. To address this challenge, DFD recently created a new position for some medical assistants to serve as team leaders. There are currently three team leaders, one at each site. Supervisors selected these MAs for promotion based on the MAs' perceived leadership skills, and excellence in quality outcomes.

The team leader does not have supervisory authority, but is responsible for the delegation of workflow and communication with administration about any workflow or personnel issues that need to be addressed. Team leaders also direct the huddle in the morning, are responsible for ordering supplies, and coordination with the front desk. The team leaders arrange bi-monthly MA meetings. They are involved with the annual performance evaluations of MAs. Team leaders report to the chief operating officer, an RN with considerable experience in the field.

Training and Performance Evaluation

There is a six- to eight-week orientation period for new employees in which new MAs are mentored by a lead MA and evaluated. They receive training on lab draws, immunizations, blood pressure readings, blood draws, PCMH issues, and HIPAA regulations. After the MA has successfully completed this training period, there is a pay raise to reflect the acquired skills and knowledge.

MAs are also provided ongoing training at monthly staff meetings which include a breakout for clinical sessions. The team leaders meet with the MAs twice per month to go over protocols, reminders, and work-related issues.

MAs receive an annual evaluation based on an observation of their clinical skills and a review of their individual scores on a number of quality measures. The COO observes and scores the MA's technique with patients, including taking and documenting vital signs, working with the patient to set self-management goals, explaining the PHQ9, reviewing medications, reviewing risk factors, and accurate documentation. The laboratory technician observes and scores MAs in conducting blood draws. The COO reviews with each MA her or his individual scores on a large number of quality metrics, including the MA's success at screening patients for various conditions such as depression, diabetes, and risk factors, and follow up on exams and tests. Scores are compared to current organizational-wide averages and overall quality goals. These evaluations allow managers to determine whether MAs need additional training, and are the basis for annual quality bonuses. The COO is responsible for developing evaluation measures, MA training plans, and EHR-based protocols for MAs to use in patient encounters.

MAs have also received specialized training to take part in different initiatives. During the behavioral health integration initiative, the entire center was closed for two days so that staff could take part in motivational interviewing training held onsite with by an outside trainer. MA staff have occasionally taken part in offsite trainings, meetings, and conferences as part of their participation in the HRSA collaboratives.

When DFD was spreading the chronic care model, administrators held weekly informal lunch meetings with MAs to provide ongoing support, share ideas, and identify additional training needs.

"The original evaluation just told them they looked good, acted professional and got here on time; there was really nothing to strive for… [Now] they know what they need to strengthen. Expectations are clear.

-Denise Breer, RN, BSN, Chief Operating Officer-

Resources

CEO Laurie Kane-Lewis has spearheaded the organization's many quality improvement initiatives since 2004. Because of the success of these initiatives, DFD has been successful at applying for and receiving grant funding and community support.

Financing: As a federally qualified health center (FQHC), DFD receives a base grant for the delivery of primary care and enhanced Medicaid and Medicare reimbursement.

When DFD expanded in 2001 with the two additional centers in Turner and Monmouth, both sites were built with community support and the land for Monmouth was donated. While there was a large fundraising effort, no additional federal funds were used.

DFD was able to obtain low-cost licenses to adopt GE's Centricity EHR through a collaborative purchase with the Central Maine Medical Center in Lewiston.

In 2006 and 2007, DFD received a Harvard Pilgrim Health Care Quality Grant to expand use of health information technology in rural communities.

The Maine Health Access Foundation, a conversion foundation, provided DFD with a grant in 2007 to integrate behavioral health services. [vii] The organization was then able to hire behavioral health consultants. Another grant from the same funder, Safe at Any Dose, allowed DFD to hire a nurse care manager to cover transitions in care, medication reconciliation, and some home visits.

In 2009, the organization received federal funding to build an ambulance bay at its Leeds site, purchase a new phone system for the Telebank, provide a secure patient portal for communication between providers and patients, and renovate the MA office at the Leeds site. Another award allowed DFD to retain the patient assistance coordinator to address increasing demand for assistance due to the economic downturn, IT staffing to support the organization's (growing) IT infrastructure as it moved to implement ePrescribing and the patient portal.

Participation in Maine's 3-year Patient Centered Medical Home Pilot provides additional funding from Anthem, Aetna, Harvard Pilgrim, and MaineHealth (insurers).

MA development: While there has been no funding specific to MA training and development, most initiatives involve some MA staff training. The ongoing training and evaluation of the MA staff takes up a considerable amount of time on the part of the chief operating officer. The organization has been able to continue providing training and quality bonuses to MAs despite the impact of the recession on health center revenues.

Challenges

Several staff and providers noted that change in general was difficult for some of the center's employees. However, many staff compared their current roles favorably to prior experiences working in practices where they had no input in decision-making. One observed, "You can help your people change if you keep them involved."

Medical Assistants: The switch to pairing MAs with a single provider and the subsequent adoption

of quality improvement plans and goals increased accountability and workload. A few MAs who could not meet the new quality standards were let go.

However, sharing information and planning helped enhance staff engagement in the process of changing models of care. Morning huddles improved communication. Monthly reports on outcome measures that are both organization-wide and team-specific helped MAs see their impact on patient care.

> "Prior to this, they (MAs) were more geared towards getting tasks done; now they are more quality-oriented. This is about patient care, not about busy work."
>
> *-Denise Breer, RN, BSN, Chief Operating Officer-*

Because most of the MAs do not have education beyond the high school or associate's degree level, they may not have enough background or training in medical terminology and health care to take on some tasks. For example, some providers wanted MAs to do medication reconciliation with patients. However, after conducting some PDSAs on this, administrators were concerned that the MAs did not have enough training and background to do this without extensive supervision.

Finally, administrators noted that the Telebank can be challenging work as dissatisfied patients vent their anger on the MAs who staff the phones during difficult times of the week, such as just before or after a long weekend.

Instituting Team Leads: The transition to a structure with team lead MAs was "rough" according to several staff. Up until approximately one year prior to this report, all MAs were at the same level in the organization. Promotion within the ranks was primarily through selection rather than through open posting and application. Many MAs reportedly did not understand the justification for the promotions, which were based on some less objective and tangible measures such as perceived leadership skills, as well as objective measures such as high performance in meeting quality goals.

The three MAs selected to serve as team leads were sent to additional training in management and conflict resolution. This training was then put to good use as team leads worked to clarify their new role, which could be seen as something more like that of a coach who is held to the same standards as other MAs, rather than that of a supervisor. After a period of adjustment, MAs settled into cohesive teams.

Providers: Providers initially had some difficulty with the idea of being paired with a consistent team of MAs. They wanted to choose and work with their favorite MAs on the floor. The CEO and COO wanted to bring all of the MAs up to quality standards by assigning them to work consistently with one provider. They showed the providers data that suggested that continuity was productive for patient experience, and they worked to pair providers with MAs that they thought would be a good match for them in terms of personality. In the end, this system has worked well as MAs have striven to meet quality standards and prove themselves valuable members of the team.

Some providers also had reservations about the integration of the behavioral health component into the care delivery model, however the integration is now well accepted and appreciated.

Giving up responsibility for some aspects of patient care could be a challenge for providers. Providers feel ultimately responsible for their patient's care. CEO Laurie Kane-Lewis credits the introduction of the morning huddle with enhancing trust and communication between staff and providers, and primary care providers and behavioral health providers.

> "One of the biggest barriers for physicians is giving up work to the team. You feel you need to be responsible for everything, but you need to realize that other people are capable of handling some of this work."
>
> *-John Yindra, MD, Medical Director-*

Information Technology: While the adoption of the EHR spurred and facilitated the expansion of MA roles and improved quality in patient care, it introduced some challenges. Provider order entry and ePrescribing increased provider workload, at least initially. Staff noted that occasionally the system got very slow and froze. There have been a series of fixes to the system which have helped somewhat but occasionally EHR system challenges still occur. One MA noted that when there is a long computer delay, she just strikes up a conversation with the patient and the situation works itself out.

Outcomes

DFD Russell has used its EHR to track and report outcomes over time. The organization has a quality assurance committee made up of providers, administrators, clinical staff and board members to monitor and evaluate outcomes, including those related to efficiency, access, patient satisfaction, administrative processes and clinical outcomes.

Productivity: DFD Russell took a number of steps to improve its phone system for patients, including instituting the Telebank, and purchasing a new phone system in 2009. The organization was able to decrease on average the number of abandoned calls by 3.1%, and overall increase the number of calls received by 7.9%, over the last year.

Patient Satisfaction: Providers report that MAs often know more about their patients than the providers do because the patients are more comfortable with the MAs. Staff and providers report that continuity is important for patients, who appreciate seeing the same providers and MAs over the years.

Provider Satisfaction: Three of DFD's core providers have been with the organization for more than 25 years and two started as National Health Service Corps Scholars. Typical of many rural health centers, DFD has many providers who have chosen to work in a medically underserved area in exchange for federal reimbursement of their medical school loans. DFD has faced some turnover in recent years as many providers reached the end of their required term and left for more lucrative opportunities and/or to work in more urban settings.

It is unclear what impact changes in workflow have had on provider satisfaction and retention, although anecdotally providers appreciate working with a dedicated team of MAs and sharing some of their workload with clinical support staff.

Recruitment and Retention: DFD Russell has little staff turnover and they often have two and three year periods where they do no recruiting at all. Half of the existing staff has been with them for ten or more years, and most of the others have been there for at least five years. There are no private practices in the area, although there is hospital based care in the cities of Lewiston (Central Maine Medical Center) and Augusta (MaineGeneral Health). Both of these organizations hire medical assistants, but there is little local competition for MAs.

Clinical Outcomes: DFD Russell has been successful in achieving and surpassing national goals for diabetes care. Between 2002 and 2007, DFD was able to exceed the national standard of care in 7 out of 8 measures, including the percent of diabetes mellitus patients setting self management goals, percent of DM patients with blood pressure <130/80, percent of DM patients with lipid screen & LDL <100, percent of DM patients 55 or older on ACEs or ARBs, and percent of DM patients 40 or older on statins.

One particular measure directly attributable to the medical assistant incentive plan is the rate of childhood immunizations for children from birth to two years of age. When a reporting tool for this measure was added to the EHR so that MA's could track immunizations on their provider's panel, rates improved from 57% in July 2010 to 100% in April 2011.

As of December of 2010, DFD Russell continued to meet or exceed nearly all NCQA target goals for diabetic outcomes, and heart / stroke measures for patients with a CVD diagnosis (See tables 1 & 2).

Table 1 is a Heart/Stroke report for all providers and all patients with a CVD diagnosis as defined by NCQA. Starred and bolded items are those items that MAs directly impact. MAs are responsible for administering smoking status assessments and providing smoking cessation information.

Green = at or above goal;
Yellow = almost at goal;
Red = below goal.

Table 1. Heart Stroke Report

12/1/2010

MEASURE	GOAL (%)	ALL (%)
BP < 130/80	25	50
BP < 140/90	75	77
LIPID PROFILE	80	80
LDL < 100	50	59
LDL < 130		72
SMOKING STATUS *	**80**	**93**
CESSATION ADVICE *	**80**	**96**
ASA OR ANTITHROMBOTIC	80	86

Source: DFD Russell Medical Centers

Table 2 is a Diabetic Outcomes report representing all 10 providers and close to 700 diabetic patients seen by providers at DFD. Starred and bolded items are those items that MAs directly impact. MAs are responsible for administering PHQ9 tests and smoking status assessments, providing smoking cessation information, working with patients to set self-management goals, and conducting foot and eye exams.

Green = at or above goal;
Yellow = almost at goal;
Red = below goal.

Table 2. Diabetic Patient Report

12/1/2010

MEASURE	GOAL (%)	ALL (%)
BP < 130/80	25	48
BP < 140/90	65	75
EYE EXAM *	60	59
FOOT EXAM *	80	81
HbA1c < 7.0	40	48
HbA1c < 8.0	60	75
HbA1c < 9.0	85	88
LDL < 100	36	58
LDL < 130	63	74
MICROALB	80	93
SMOKE STATUS *	80	96
CESSATION ADVICE *	80	98
GOOD CONTROL A1C/BP/LDL	30	16
Self Management Goals set *	80	91
PHQ9 *	70	85

Source: DFD Russell Medical Centers

MA Career Impacts

Staff noted that MAs were vitally engaged in patient care and in strategizing about how to improve processes. As a clinician pointed out, “They [MAs] are not shy about pointing out issues.”

Certification: MAs are not required to be certified, nor is there any incentive for certification. As noted earlier, MAs do not have to have formal medical assisting education to work as MAs at DFD Russell. If a candidate has good communication and computer skills, he or she can receive on the job training onsite to work as an MA.

Performance and Evaluation: In 2008, administrators developed an incentive plan for medical assistants as part of a retention plan. The MA incentive plan is based on quality goals MAs directly impact such as immunization rates, blood pressure checks, diabetic foot exams, PHQ9 surveys, and self-management goal documentation. If MAs score high on some of these NCQA measures, they receive an annual level 1 or level 2 bonus of several hundred dollars. The COO can use these assessments to determine who needs more training in which areas.

MAs generally scored well on these assessments. In 2010:

- 40% received the level 2 bonus
- 50% received the level 1 bonus

MAs themselves report that these measures are fair and not a surprise because they can track their progress on meeting these goals throughout the year. The quality measures serve as a motivator, in part because of the cash bonus, but also because the employee can see and improve her individual impact on trends.

Benefits: Besides the bonus, MAs get a 4 day instead of a 5 day work week. They each work 34-40 hours per week, and there are some weekend shifts for which staff can receive overtime.

DFD tries to promote wellness for staff as well as patients. It removed the candy machine from its break room in an attempt to promote healthy eating. A workout room with exercise equipment adjacent to the break room is available to staff and is reportedly especially convenient in winter months when outdoor recreation is limited.

There is a combined PTO policy based on years of service, and 12 paid holidays per year.

All staff get 100% of their health insurance covered and can purchase in for their family. Primary care is offered free onsite for staff and their children. There is optional dental, long and short-term disability, and life insurance.

Tuition reimbursement is budget-dependent and offered on a first-come, first-served basis. The organization typically covers one class per semester.

Staff at DFD Russell are not a part of any union.

Promotional Opportunities: DFD Russell is a small organization, so opportunities for advancement within the MA role are limited. Three MAs have been promoted to team lead MA, and one was assigned to lab tech. Promotion entailed an increase in pay and for the team leaders and a move from an hourly to a salaried position.

> “I like doing patient care and making sure patients stay as healthy as they can stay. I love being a medical assistant; I like working with the patients.”
>
> *-Debora Pratt, Medical Assistant-*

Satisfaction & Aspirations: MAs noted that they were pleased to have a role in quality improvement initiatives and in improving patient care. They noted that they had a voice in clinic operations, which they appreciated.

MAs reported overall satisfaction with their jobs. Many staff commented on how different current roles were from MA roles at DFD in the past and at other organizations at which they had worked. Major differences were the level of responsibility and the opportunity to have a voice in decision-making.

The organization offers tuition reimbursement for employees seeking further education. One MA who was considering using the tuition reimbursement program wanted to enter nursing school, but noted that she hoped there would a nursing position for her at DFD Russell because she preferred working there.

Future Plans

DFD's CEO, COO and Medical Director have an ongoing commitment to quality improvement. They are continuing their work in the Maine's patient-centered medical home pilot program, and working to include the Medicare population in that pilot. They are also expanding the quality measures they can impact and track, including ER utilization and re-hospitalization rates, since they are connected to the CMMC hospital system.

In the future, the DFD may add another nurse care manager so they can have one at every site and cut the travel time of the current two care managers. This would further enhance continuity in care for patients, especially if they can have the care managers meet one-on-one with the patients rather than just working telephonically.

DFD is working to qualify for "meaningful use" designation and funding. As a result of the Health Information and Technology for Economic and Clinical Health (HITECH) Act, health care organizations may be able to qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve objectives specified by the US Department of Health and Human Services." [viii] These include use of the EHR for disease management, clinical decisions support, support for patient access to their health information and quality measurement.

Continuing to expand patient engagement in self management is an important organizational goal. The administrative team has just instituted a patient portal to provide patients access to their own health information and is exploring the feasibility of creating a health coach position.

Replication and Lessons Learned

The MA incentive plan and the Telebank may be unique to DFD Russell. They are both replicable and DFD has had prior requests for their incentive plan. Both of these components are part of a larger picture of successive quality improvement.

Major success factors identified by staff include the following:

- The development of a good EHR system for tracking and reporting patient outcomes allows the organization to improve patient care and track outcomes system-wide and by staff member.
- The experience and tenure of the medical staff provides continuity in patient care and a high level of experience and commitment.
- Successful grant writing and strong leadership, coupled with the ability to track and improve outcomes, allows the organization to innovate and build on its successes.
- The morning huddle is a vital opportunity for administrators, staff and providers to communicate, and it builds trust across disciplines and roles.
- Engaging staff in quality improvement by inviting them to test and develop innovations and allowing them to see their individual impact on patient outcomes is a powerful motivator.

As a small organization with a stable, long-term staff, DFD has limited options for career steps. However, it has developed leadership roles for MAs, and has instituted an evidence-based evaluation and incentive program to reward MAs for their individual contributions to patient care.

> "I call DFD my working family. I consider the patients that I work with my patients too. The patients know me and know I am here to help provide the quality health care they deserve. After you come into DFD as an employee it's hard to leave because of the working family."
>
> *--Belinda Peabody, MA Team Lead—*

Notes

i. Calvo, A. (2005). HRSA Health Disparities Collaboratives: Integrating Towards a National Primary Health Care Collaborative (PHCC). A PowerPoint presentation to the Health Start Program, November 15, 2005. US Department of Health and Human Services, Health Resources and Services Administration. Accessed May 6, 2011. https://www.powershow.com/view/179b0c-N2YyY/HRSA_Health_Disparities_Collaboratives_Integrating_Towards_a_National_Primary_Health_Care_Collabora_flash_ppt_presentation
ii. Improving Chronic Illness Care Website. The Chronic Care Model. Supported by Robert Wood Johnson Foundation. Website accessed May 6, 2011. http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
iii. Ibid ii
iv. GE Centricity.
v. Institute for Healthcare Improvement, "Testing Changes" web page, Accessed June 6, 2010. http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm
vi. "Motivational interviewing is a client-centered method based in non-directive counseling which utilizes reflective listening to elicit the patient's intrinsic motivation for change. The purpose is to engage patients in evaluating their own behavior and resolving ambivalence that behavior and the achievement of self-defined health goals." Rollnick S, & Miller, W.R. (1995). What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23, 325-334.
vii. Health Conversion Foundations are funding organizations that resulted from the conversion of non-profit health organizations to for-profit entities. These foundations came into being because federal law requires that "proceeds from the sale of assets of tax-exempt entities be directed towards charitable purposes." Grant Space website, Accessed May 12, 2011. http://grantspace.org/Tools/Knowledge-Base/Funding-Resources/Foundations/Health-conversion-foundations
viii. See "CMS Finalizes Definition Of Meaningful Use Of Certified Electronic Health Records (EHR) Technology". July 16, 2010. Accessed May 24, 2011.

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Center for the Health Professions
University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
http://futurehealth.ucsf.edu