Northwestern Memorial Medical Group: Update 2014

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ABSTRACT

Northwestern Medical Group (NMG), when it was Northwestern Memorial Physicians Group (NMPG), took the unusual step of developing a clinical career ladder for its medical assistants (MAs) in 2003. Medical assistants have been the largest group of nonlicensed employees at NMPG/NMG. High turnover rates and dissatisfaction among MAs led the organization to develop a clinical career ladder for MAs to recognize their achievements, to challenge them to excel, and to improve retention. This 2014 summary updates the original 2011 case study with new information on staffing, clinical outcomes, reimbursement, and more.

(Note: As of 2013, NMG no longer has a clinical career ladder for MAs, but it has instituted a lead MA (resource coordinator) role. This new role is explained in more detail toward the end of this case study summary and update.)

Clinical ladder programs for nursing staff are relatively common in hospital settings. These programs are developed to attract, train, and retain high-quality nurses by recognizing excellence in clinical skills and patient care.[1] Nurses receive promotions up a series of career "rungs" based on their demonstration of competence and professionalism. Clinical ladders for unlicensed support staff, however, are rare, especially in ambulatory care settings.[2]

Northwestern Memorial Physicians Group (NMPG), a primary-care medical group practice owned by Northwestern Memorial Hospital, took the unusual step of instituting a clinical career ladder for its medical assistant (MA) staff in 2003.

MAs at NMPG had been dissatisfied with their pay rates and lack of opportunities for advancement, and there was high MA turnover. In addition, many MAs could not afford to go back to school for nursing degrees.

Practice Profile – 2011*

Name: Northwestern Medical Group

Type: University-affiliated medical group

Location: 33 clinics in the greater Chicago area

Staffing: 410 employees, including

- 120 providers, including
  - 6 midwives
  - 8 nurse practitioners (NPs)/physician assistants (PAs)
  - 106 physicians
- 52 nurses
- 84 medical assistants (MAs)
- 45 patient service representatives
- 109 administrative staff

Number of Patients: 250,000

Annual Patient Visits: 337,021

Patient Demographics:

60% female

Average age: 40

Most are from Chicago.

* 2014 data not available due to rapid change at NMG

Nursing supervisors met as a group and decided that a clinical ladder program for MAs would enhance their engagement and reward them for improving the quality of care at their clinics. Supervisors looked for existing models but could find no other organizations that had a clinical ladder program for MAs.

Clinical Career Ladder

To qualify for the clinical career ladder program, an MA had to have completed at least one year of employment at NMPG, be certified, and be in good standing.

In order to apply, an MA needed to complete an application and solicit letters of recommendation from supervisors. In the application, the MA proposed a special project for which there were measurable goals and objectives. Ideally, the MAs were to self-generate the proposals, but in practice writing the proposal was often a collaborative process involving the MA, providers, and supervisors. Supervisors found that many MAs needed coaching to develop focused and achievable goals.

Individuals could only apply to the program once a year during one of two application cycles. Administrators might receive between five and 10 applications per round from the pool of 84 MAs.

Applications were reviewed by a group of managers and directors chaired by the manager of clinical education. Although 80% of the applicants were accepted into the program, applications were occasionally rejected because they lacked focus or measurable goals and objectives or because MAs did not meet the tenure and good standing requirements.

Employees could attain two additional employment levels above MA—MA I and MA II—upon successful completion of clinical ladder projects.

MA I projects usually took about six months to complete. MA I goals were expected to focus on one of the following areas:

- Process improvement in the practice site or in the organization
- Implementation of an educational session for staff or active participation on a committee or task force
- Additional education or training in an area that improves the MA's practice, such as customer service, conversational Spanish, or pharmacology
- Self-improvement through various methods, including working with a mentor. [3]

MA II projects took approximately one year to complete. These were intended to foster collaboration and leadership and included emphasis in the following areas:

- Cross-training in laboratory, front desk, and medical records work
- Cross-training for coverage of other practice divisions such as Internal Medicine, Dermatology, Pediatrics, or Ob/Gyn
- Participation in evaluating other MAs' yearly competencies
- Ongoing self-improvement through formal education, mentor selection, and other methods as identified in written annual goals.[4]

Once an MA had been accepted into the clinical career ladder, she or he worked with the practice manager to arrange additional experience akin to a mini externship to obtain cross-training in a skill or practice division. Projects were intended to be practical and skill-building through everyday applications and hands-on learning.

Clinical ladder projects were extra work for the practice manager, who first had to coach the MA in developing an application and then guide the MA's work and coordinate with other clinics or departments as necessary to implement the project.

At the completion of each special project, the MA submitted documentation explaining how the project

had been completed and how the knowledge she or he had gained supported the organization's goals. The supervisor and/or the MA then presented the results to the review panel.

In order to incorporate the career ladder into the existing organizational and pay structure, the percentage change in pay was kept separate from pay increases resulting from merit or promotion. The pay increase for successful completion of one rung was set at 2%, which was half of the merit pay increase at the time (4%).

Project Descriptions: Many projects included cross-training that allowed MAs to learn laboratory, front desk, or medical records skills so that they could assist and cover for other employees. This training made the MA a more flexible and valuable employee.

Occasionally, cross-training simply allowed an MA to better understand how his or her own role impacted and was impacted by other clinic functions. For example, an MA might have studied billing and coding procedures as part of the career ladder project—not because he or she would later work as a biller but so that the MA could better understand his or her impact on billing, and vice versa.

Some MA projects led to the expansion of clinical roles for MAs who had been recognized as being particularly focused and skilled. One MA was trained to work in a Coumadin clinic run by a physician provider. She underwent six months of training with a physician. The MA was able to complete the curriculum at the same level of quality as the nurses involved did, so she was allowed more responsibility than was generally allocated to MAs. The MA then filled a care-management role utilizing software (StandingStone) with specially developed protocols to help direct her work with patients to adjust their medications.

MA Roles

In most cases, MAs were paired one-on-one with a physician. NMPG MAs performed traditional medical assistant tasks such as rooming patients, collecting and documenting vital signs and the patient's initial history, assisting with phlebotomy, and administering vaccinations. MAs also assisted with prescription refills, which may be done via e-prescribing. In some specialties, they assisted with minor procedures.

NMPG was cautious about MA role expansion due to its concern about scope of practice and usurping nurse roles. MAs did not administer any medications, nor did they do any phone triage or health coaching—all of these tasks were handled by RNs. Although some of the clinical career ladder projects pushed the envelope in terms of MA roles, those cases tended to be exceptions made for star performers.

Challenges

Finding MAs with the right skills, attitudes, and work ethic can be challenging. In order to ensure that MAs had the right skill set coming in, Human Resources (HR) instituted pre-employment testing for MA candidates. Applicants must pass a computerized aptitude test on verbal ability (including spelling and grammar), numeric competence (basic arithmetic and math), and knowledge of medical terminology.

Concern about MAs' excessive absenteeism and customer service skills prompted Human Resources to develop and incorporate a behavioral assessment tool into the pre-employment testing. HR staff and supervisors have found this tool useful when utilized in conjunction with pre-employment testing and other screening for understanding candidate aptitudes and training needs.

NMPG's reputation for high quality put particular pressure on frontline staff to keep wait times to a minimum and to provide top-notch customer service. For years, MAs tended to receive lower patient ratings than other NMPG employee groups did. Since 2004, NMPG/NMG has required new MA hires to attend customer-service training on topics such as effective patient outcomes, appropriate work dress, communication, and ways to address upset patients and not take conflicts personally.

Although the clinical career ladder had been developed to inspire and reward MAs for creativity and performance, some MAs were concerned that if they participated, they would be given more work and/or more challenging work. While participants found the new skills and responsibilities worthwhile, they did note challenges in finding the time to learn new skills while also managing their regular duties.

Ideally, supervisors were to encourage high-performing MAs to obtain nursing degrees. Administrators had advocated for a tuition reimbursement program, but the recession and lack of nursing openings at NMPG discouraged upper management from committing to this expenditure.[5]

Outcomes

Evidence of the impact of the MA clinical career ladder at NMPG was largely anecdotal. However, administrators and MAs felt that the program improved MA retention and job satisfaction as well as outcomes in individual offices.

The average tenure of MAs at NMPG was three years, although it was much longer for those in MA I and MA II positions. Administrators felt that the clinical ladder had a positive impact on retention, although the decrease in turnover may have also been related to the recession. The organization's total turnover for all positions decreased from between 8% and10% in 2007/2008 to 5% in 2009–2010. MA turnover dropped dramatically during the same period, decreasing from between 32% and 38% in 2007–2008 to between 16% and 17% in 2009–2010. Inversely, participation in the clinical ladder program increased to a high of 11% in 2010 compared with an average participation rate of 8% over the previous three years.

In 2011, Human Resources consultants noted that it costs roughly $9,000 to recruit, hire, and train a new MA. Turnover is expensive; hence, the expense associated with the clinical career ladder was considered a good investment in order to retain good MAs.[5]

MA Career Impacts

Prior to 2013, all MAs came in at the MA level, but could achieve MA I and MA II through successful completion of clinical ladder projects. With the completion of each ladder, there was a 2% permanent pay increase and title change. The Clinical Ladder I increase averaged $700 per MA annually in the, while the Clinical Ladder II increase averaged $936 per MA annually.

Employees were reviewed annually and could receive a merit raise based on that review. Completing a clinical career ladder project might enhance an employee's chances of receiving a merit raise. However, clinical ladder merits were granted independently of annual performance salary merits. Thus, an MA participating in the clinical ladder could receive both types of raises in the same year.

The number of clinical ladder participants (Level I or II) since the program's inception was 35 total (33 MAs and two others) as of 2012. About 18% of those who had completed the Clinical Ladder I step went on to complete the Clinical Ladder II step. The program tended to attract MAs with at least 10 years of professional experience.

The clinical career ladder program allowed MAs to participate in career exploration and make positive contributions to their divisions. Some MAs reported being more satisfied with their work as a result of having participated in the program and desiring further opportunities for advancement.

Moving Forward

In 2013, NMPG embarked on a number of major changes in its operations. It started to transition its electronic health record (EHR) system from Cerner to Epic. It completed a merger of its primary care/ambulatory care group and its specialties in May 2014, becoming Northwestern Medical Group (NMG). NMPG had 16 practices: the new NMG has 33 practices and is in the process of acquiring more. Although the new organization has twice the number of practices, there has only been a 6% increase in

the number of MAs because the new specialty practices employ fewer MAs than the primary care practices did. Nonetheless, MAs make up almost a third of the organization's employees overall.

NMG decided to discontinue its clinical career ladder program because it wanted to engage MAs and other frontline staff on a broader level. Completion of a clinical career ladder project had only entailed a 2% pay raise, so relatively few MAs had chosen to complete a project. Administrators felt that the project-based focus did not promote the more global integration of MAs into the work and mission of the organization.

In its efforts to gather its staff from different practices under one umbrella, NMG developed, streamlined, and standardized its training protocols and competency assessments for frontline staff. In 2011, when the initial case study was written, the organization had hired a manager of clinical education. Since that time, she has instituted a systematic review of the organization's training needs, first assessing the needs of physicians and frontline staff via a survey and then visiting and conducting competency assessments at each of NMPG's original 16 clinics. She established that frontline competencies and training were not consistent across sites and that staff would benefit from standardized and consistent training, both at the time of hire and ongoing. As the organization grew, she began recruiting and training on-site trainers at each practice to orient new staff and to conduct annual competency training and testing.

At most locations, RNs serve as the trainers. However, there are some sites with no RNs, so an experienced MA or health technician has been trained to take on this role at those. All designated trainers sit on the nursing council, an arrangement that helps the management of training and competency across clinic sites. This group helped to develop the curriculum content, which includes didactic PowerPoint presentations, online learning modules, and competency tests and quizzes.

The instruction of trainers began in November 2013, after which they had six weeks to conduct training and testing in their home offices. Existing MAs were tested on basic core competencies, including injections, vaccinations, point-of-care testing, vital signs, phlebotomy, EKGs, infection prevention, rooming and time management, and call pool management using evidence-based standards in an initial wave of competency assessments. This phase of training and testing was completed by mid-spring 2014.

MAs and technicians who are designated as trainers are often the most experienced on staff, many having been with the organization for more than 10 years. They serve as resource coordinators, a role that involves more supervisory responsibilities and a pay increase of 16%. They are chosen for this role based on their experience and leadership potential.

The main challenge has been achieving buy-in from clinic managers due to the amount of staff time needed for training and various competing projects. For example, a single MA may take an hour to complete the training on EKGs and phlebotomy. If there are five MAs in the office, that training could entail five total hours of MA time and the additional time for the trainer. Obtaining the backing of directors for training was instrumental in moving this initiative forward. Part of the incentive for conducting the trainings was meeting standards for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation. Some pressure on staff time may be relieved by the introduction of more online modules in the future to cover some training components.

Another challenge has been dealing with turnover among the trainers themselves. When almost a third of the original 22 trainers left during the initial training period, the manager of clinical education decided to prepare a pool of backup trainers so that there would always be additional trainers waiting in the wings.

Initial feedback has been positive, but the program has not been in place long enough to measure staff satisfaction or other impacts resulting from the training.

Conclusions

NMG has eliminated its clinical career ladder for medical assistants. However, the creation of the role of the manager of clinical education signals an increased commitment to staff development on a broader level. The new training programs enacted by this manager should allow the organization to reach more employees and improve quality and adherence to its mission. Some medical assistants may still be able to achieve promotions to serve as resource coordinators to train other staff, with a salary increase that exceeds the one that they would have achieved through the clinical career ladder. However, there is no longer an open-application career advancement path for medical assistants.

Notes

1. M. Zimmer, "Rationale for a Ladder for Clinical Advancement," *Journal of Nursing Administration* 2, no.6 (1972):18–24.
2. J. M. Nelson and P. F. Cook, "Evaluation of a Career Ladder Program in an Ambulatory Care Environment," *Nursing Economic$,* 26, no. 6 (2008): 353–60.
3. Northwestern Memorial Physicians Group (NMPG), "MA Clinical Ladder Requirements." 12/14/2010
4. Ibid.
5. NMPG offers tuition discounts for programs offered through Northwestern University, but the university does not have a nursing program or many other programs that would be a likely career ladder for MAs.

Acknowledgments

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To read the full 2011 case study, please see Northwestern Memorial Physicians Group—Clinical Career Ladder for Medical Assistants

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