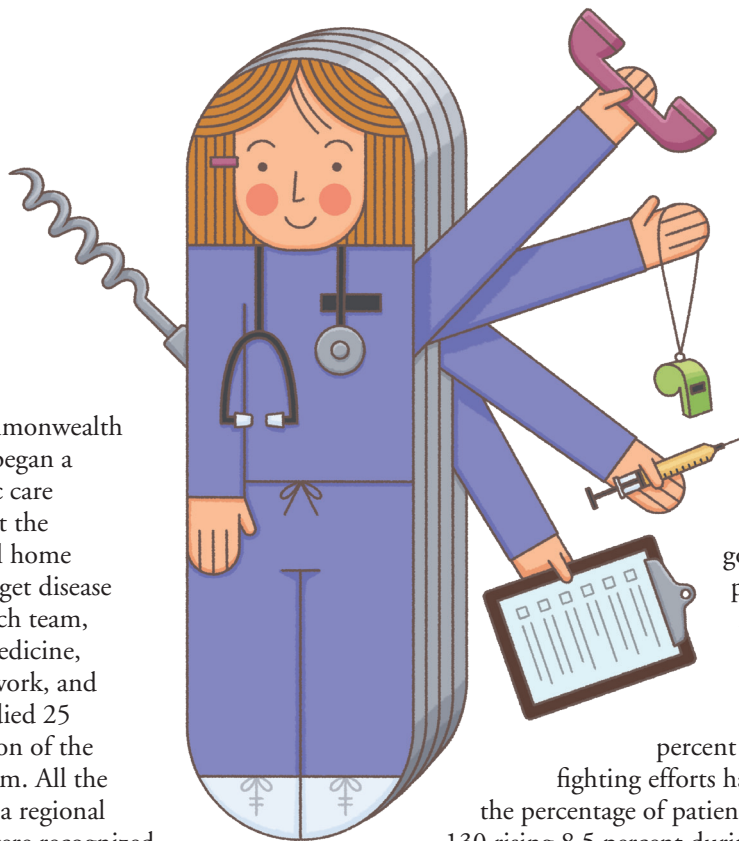


IN AN ERA OF "DO MORE WITH LESS," MAs CAN PLAY A PIVOTAL AND FLEXIBLE ROLE IN FAMILY MEDICINE PRACTICES.

Envisioning New Roles for Medical Assistants:

Strategies From Patient-Centered Medical Homes



In 2008, the Commonwealth of Pennsylvania began a statewide chronic care initiative to adopt the patient-centered medical home (PCMH). The initial target disease was diabetes. Our research team, comprising experts in medicine, communication, social work, and practice facilitation, studied 25 practices in the first region of the state to begin the program. All the practices participated in a regional learning collaborative, were recognized as PCMHs by the National Committee on Quality Assurance (NCQA),¹ and received supplemental payments from six area insurers to support their transformation. Overall, practices achieved better clinical

quality for diabetes care with an increase in the percentage of patients meeting evidence-based goals.² For example, the percentage of patients with hemoglobin A1C levels above 9 declined from 30.7 percent at the start of the initiative to 28.2 percent one year later. Cholesterol-fighting efforts had the biggest impact with the percentage of patients with LDL levels under 130 rising 8.5 percent during the year. We conducted 140 in-depth qualitative interviews during 2010 and 2011 with providers, administrators, and practice staff to understand their PCMH transformation process. The interviews revealed how adapting the roles

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MAs can be used to augment the capacity of physicians and nurses or can assume more instrumental roles in population management.

of medical assistants (MAs) enhanced the practices' ability to achieve PCMH standards and quality improvement. The aggregate focus on this profession more than others as a variable to increase practice capacity was notable and demanded our attention. With a scope of work that traverses general, administrative, and clinical responsibilities,³ MAs can be used to augment the capacity of physicians and nurses, can move into newly developing practice roles such as health coaches, or can assume more instrumental roles in population management.

Seven strategies most frequently mentioned during the interviews as being successful and central to PCMH implementation are described in this article and presented in the table on page 10. All were widely used by the practices and were shared at learning collaborative sessions. (It should be noted that we were unable to determine whether the use of MAs in the PCMH model affected the cost of providing care because we didn't have access to claims data.)

Strategy #1: Organizing MAs into provider teams

Family physicians would need to spend 21.7 hours per day to meet all the acute, chronic, and preventive care needs of their patients.⁴ This fact, as well as studies suggesting a team approach to care is the key to quality improvement,^{4,5} drove many of the practices we studied to reorganize into provider-MA

teams caring for a dedicated panel of patients. The ratios varied across practices, but they included 1:1 teamlet models,⁶ 1:1 non-assigned models, and 2:1 models. Empanelment and team-based care are cornerstones of the PCMH, as defined by the NCQA.⁷ The practices that created these teams said they saw numerous benefits, including greater efficiencies as providers and MAs adapted to one another's work styles and preferences; improved trust and communication between providers and MAs; and more frequent contact and stronger relationships between MAs and patients.

Strategy #2: Engaging MAs in population management

The practices we studied that did not have many nurses (RNs or LPNs), diabetes educators, social workers, or dietitians on staff to help the practice with quality improvement hired new MAs or trained current ones to provide a wide range of needed services. MA roles in some practices shifted to increase their responsibility for identifying when patients are due for routine tests or preventive care.

With training, MAs are following standing orders for preparing patients for these services or are actually performing some of these services themselves. In some practices, MAs are screening for smoking status, administering immunizations, and performing monofilament diabetic foot exams. Some also draw blood and collect specimens, dilate eyes,

■
MAs helped Pennsylvania practices achieve quality improvement during a statewide PCMH initiative.

■
Provider-MA teams helped increase efficiency and build trust.

■
Some practices hired or trained MAs to serve as population managers.

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take retinal photographs for ophthalmology review, and prepare referral paperwork for specialty care.

Strategy #3: Empowering MAs to own key quality measures

Conventional wisdom posits that you can't improve what you don't measure. Along with relying on MAs to track and provide routine population management services, most of the practices we studied relied on their MAs to document the services they provided, either on paper or in the electronic health record (EHR).

In many of the practices, entire sections of the EHR are now completed by MAs in a manner that allows the data to be extracted for monthly quality reports. Providers and MAs proudly shared that some key quality measures are now "owned" by the MAs, including the percentage of patients queried about tobacco use and the percentage of patients with diabetes who have had a foot exam, A1C test, LDL cholesterol test, and microalbuminuria screening.

Strategy #4: Turning MAs into health coaches

With 50 percent of patients not understanding the advice of their physician,⁸ and many patients not seeking physician input to begin with, most if not all self-management takes place outside of the medical home.⁹ Forty-two percent of primary care physicians say they do not have enough time to spend with patients,¹⁰ meaning changes are needed in how practices support patients' self-management efforts.

Most of the practices we studied helped MAs learn more about chronic diseases so they could educate patients on how to better manage their conditions through regular follow-up care, routine testing for complications, and better self-care (diet, exercise, smoking cessation, etc.). Several of the practices trained MAs to help patients set self-management goals, and some went even further and trained MAs to be health coaches.⁵

The practices reported gaining many benefits by involving MAs more often in educating and supporting patients: Patients seemed to appreciate the additional support; MAs liked interacting more with patients and liked the professional development opportunity to

learn new skills; and providers were relieved to have help with what is typically seen as time-consuming work. In practices that created new health coach positions, the change was viewed as a career development opportunity for high-performing MAs.

Strategy #5: Developing MAs as outreach workers

As part of the MAs' new population management and self-management support roles, they call patients who miss appointments, are overdue for services, or need closer follow-up based on risk assessment. Practices reported that these outreach activities have further strengthened the MA-patient relationships to the point that some patients now ask for the MAs when they call the office. MAs also have become increasingly responsible for tracking lab orders and referrals and assuring receipt of lab and referral reports.

Strategy #6: Using MAs to help manage high-risk patients

Several practices have assigned MAs to assist nurses in caring for the highest-risk patients in the practice. These MAs primarily make outreach calls, track patients who have been hospitalized or visited the emergency department, and take on preauthorization and other insurance-related work, freeing the nurses to do more intensive care management.

Strategy #7: Cross-training MAs

Some practices found that cross-training MAs to cover for one another during breaks and absences and to work in both the front and back offices worked well. Several practice leaders noted they recently decided to hire only MAs (and not additional clerical staff) to facilitate coverage between the front and back offices.

Several practices also found flexibility in training MAs for more advanced patient care roles like health coaching and panel management so the MAs could continue to fill in as needed elsewhere in the practice. MAs in some practices generally worked in the same roles every day. MAs in other practices rotated through administrative, clinical, and laboratory roles throughout the day or week. ►

■ MAs can serve as health coaches for chronically ill patients, especially those patients who are less comfortable with doctors.

■ Using MAs to handle outreach, patient tracking, and insurance-related work frees nurses to do care management.

■ Cross-training MAs to fill both front- and back-office duties gave some practices added flexibility.

Addressing barriers to change

Change is difficult, and the practices we studied faced numerous challenges related to human resources, training, buy-in, and sustainability.

Human resources challenges. Most of the practices confronted staffing challenges as they worked to become PCMHs. They noted difficulties in finding MAs who had the required skill sets, tolerance for change, and temperament for patient-centeredness. One physician said, “I do think it takes a different type of person to work in this environment. It can’t be an inexperienced MA. You throw them into a PCMH, and it’s like a deer in the headlights.”

Notably, providers and administrators critiqued MA education programs as insufficiently preparing MAs for work in PCMH settings, with the main deficits being in use of EHRs, detailed knowledge of chronic illness

care, and some aspects of patient interviewing. This has led some practices to revise their recruiting strategies. Another physician said, “You get what you pay for. We have learned it over and over again. We have had very inexperienced, low-paid MAs who did not have the right seasoning. We are restructuring for the third or fourth time. We are getting seasoned MAs.”

Likewise, some practices realized they needed to ask some long-term employees to leave when they could not accept the changes being made. As one supervisor noted, these expanded MA roles are not for everyone. Accordingly, many of the practices increased salaries for new and existing MAs in hopes of attracting and retaining strong MA staff.

Training challenges. As the practices began to envision expanded roles for their MAs, they needed to provide training on population management, documentation,

ANECDOTES TO SUPPORT THE SEVEN STRATEGIES FOR ENHANCING MA ROLES

Strategies	Representative quotes
Organizing MAs into provider teams	“One of the things the initiative allowed us to do was to have what we call a one-on-one, or an MA that’s just our person that we work with all the time. They bring the patients back to the rooms, go through the medications, take care of everything as far as seeing that they’re up-to-date with immunizations and colonoscopies and things like that, and then allow us to practice medicine and be less on the phone and dealing with insurance companies and things like that.” (physician)
Engaging MAs in population management	“Before, we would have the doctor perhaps remember to check the feet or do a urine microalbumin test, but now it’s automatic. It’s set up. Patients come in, and we have a diabetic report card that will show us if they are up-to-date with those things. If they are not, the MA sees that and will do the necessary tests and let the doctor know what was done. We’ve also made a change in our process for ophthalmology referrals. The MAs pass them off to the receptionist who will call for the results, so everybody is kind of working together.” (physician)
Empowering MAs to “own” key quality measures	“Pneumonia vaccine for our older patients is one of the indicators. The MAs thought that we were only giving it in the winter, so we had an education session on that. When we did that, the MAs began to feel like, ‘Oh, now we know what this is,’ and our graphs and scores went up. Same with microalbumin.” (practice administrator)
Turning MAs into health coaches	“I think the health coaching has been pretty great. I was introduced to some of this stuff in residency, so I had some experience with health coaching, but I wasn’t exactly sure how well it would work in our office. I think certain patients really enjoy goal-setting and checking up with phone calls and things like that. I think as far as behavior change goes, that really makes a huge difference knowing that someone is going to call you back and follow-up on the things that you are going to try.” (physician)
Developing MAs as outreach workers	“We have a patient outreach form that comes from the registry and reminds us to call the patient if they haven’t been in. If they haven’t been here in over six months, they need to come in.” (medical assistant)
Using MAs to help manage high-risk patients	“All MAs are now routinely obtaining information on hospital discharges, and all doctors are forwarding emergency department reports on high-risk patients to staff to obtain records and arrange follow-up.” (team report)
Cross-training MAs	“The nice thing about cross-training is they can see exactly what that job entails and how if you don’t do something at the in-desk, for instance, that impacts everything down the line – or vice versa, if the back staff doesn’t do something, doesn’t circle the encounter form correctly or whatever, how it filters back in the other direction. It gives people a better understanding.” (practice administrator)

Providers were relieved to have help with what is typically seen as time-consuming work.

self-management support, patient outreach, care management, and chronic diseases. Some sent MAs to the regional learning collaborative sessions that were part of our state's initiative to hear what MAs were doing in other practices. Many brought in experts to explain diabetes and self-management support. They held lunch-and-learn sessions with providers, office managers, and other staff to learn how and where to document their new chronic and preventive care responsibilities. They also did role-playing exercises and provided web-based and video training sessions. In most practices, the training is ongoing and continues to be a key need. For the most part, they said MAs found additional training personally and professionally rewarding.

Buy-in challenges. The practices eventually learned how to improve buy-in for changes in MA roles. Most MAs said they initially viewed the changes as more work but now are comfortable in their expanded roles. As one MA explained, "There are a lot of different things we have to do now that we didn't have to do before. But it's all for the patients and that's what we're here for, so everyone just falls right in the flow, and we try to spread out the work."

Regular meetings (monthly, if not weekly) appear crucial to securing buy-in across the practice. Meetings served as a primary mode of communication. They created staff cohesion around changes and were useful for confirming and clarifying processes, procedures, and workflow. MAs particularly appreciated the opportunity to discuss ideas for change before they were implemented.

Other successful strategies for securing MA support included involving MAs in the core improvement team's collaborative learning sessions; creating a safe environment for MAs to ask questions and provide feedback on what's working and what's not working; explaining the rationale for changes and the benefits to the practice and, most important, to the patients; providing ample training on new job duties; and being transparent about

changes and practice performance.

In some practices, providers were a surprising source of resistance to changing MA roles. Some were reluctant to delegate to MAs tasks they had always done. Strategies to overcome this resistance included peer meetings where colleagues described the benefits they derived from allowing MAs to provide more help to them; monthly provider review of clinical outcomes data by provider panel, which showed improvements resulting from expanded MA roles; and reminders from practice administrators that this is how the practice works now.

Sustainability challenges. Sustaining change can be as hard as making the initial change. It's easy to fall back into old habits. Successful strategies for sustaining changes included periodic monitoring of changed processes to identify slippage or missed opportunities; reviewing clinical outcomes monthly to identify downward trends indicating sustainability issues; meeting regularly to discuss problems and concerns; providing adequate supervisory oversight and support; offering ongoing training and education; codifying changes in written policies and procedures and updated job descriptions; and posting revised policies and procedures for all to follow.

Some practices also had to reconfigure their staffing, especially where MAs already had significant workloads. Some of the practices added MA positions with the supplemental payments they received for becoming PCMHs. Some reassigned tasks previously done by MAs to clerical and other staff. Others retained their staffing mix and noted they were not asking MAs to do more tasks, just more complex tasks. In the end, there was not one "new model," but a variety of configurations to address sustainability.

Getting started

Re-visioning the role of MAs in family medicine does not guarantee a smooth transition to a PCMH, but it appears to be a critical element in its evolution. In this study, pro-

■ Changing the roles of MAs creates challenges from a human resource or training perspective.

■ Regular meetings with MAs and providers to monitor progress can increase acceptance of changes.

■ Practices had to reconfigure MA duties, especially if they already had heavy workloads.

Changing MA duties is not a silver bullet to PCMH but appears to be a key factor to its success.

MAAs can contribute more to the PCMH effort than simply moving patients around.

viders, administrators, MAs, and other staff almost unanimously agreed that expanding the role of MAs facilitated quality improvement, enhanced teamwork, improved workflow, increased patient satisfaction, improved patient safety, and increased productivity of office visits. As one physician noted, MAs can be much more than “ferryboats” taking patients from reception areas to exam rooms.

A key finding of this study was the effort that practice leaders made to consider the best use of MA capacity. MAs can be a nameless presence in practices, moving patients across work areas, or they can serve as key team members seen by patients, providers, and colleagues as “go-to persons” with many roles and competencies. The national movement toward the PCMH model requires revising the MA role. **FPM**

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