EMPLOYED PRACTICE

Maximizing Your Medical Assistant's Role

R. Scott Eden, MD

Delegation, technology, and training enabled our MAs – and doctors – to grow.

The "Triple Aim" envisioned by the Institute for Healthcare Improvement in 2008[1] and now embraced throughout our industry describes efforts to simultaneously improve population health, decrease per capita health care costs, and improve the patient experience of care. With rates of burnout among physicians now topping 50 percent, an additional dimension – improving the primary care provider experience – has further shaped a "Quadruple Aim."[2]

Multiplying documentation demands and population health goals that make us responsible for the health of patients who don't see us feel particularly overwhelming. But there is reason for hope. A large percentage of what needs to be done does not require a medical degree. If we can develop support staff to manage most of our administrative work, then we can attain higher levels of productivity and work-life balance and enhance the care and experience of our patients. The challenge, of course, is how to make it work financially.

I was searching for ways to increase the capacity of the clinic where I serve as medical director when I heard Dr. Peter Anderson speak about having registered nurses take the initial patient history and review of systems and then act as scribes for the provider. (See "A New Approach to Making Your Doctor-Nurse Team More Productive, *FPM*, July/August 2008, http://www.aafp.org/fpm/2008/0700/p35.html). He also had broken away from the traditional model of one clinical assistant and two exam rooms per provider, increasing to two assistants and three exam rooms per provider, with clinical and financial success.

The idea of delegating work to a support team was attractive, but the model would have to be adjusted to our reality. We would be working with medical assistants (MAs), and it would be unreasonable to expect them to take medical histories. We subsequently implemented a model that leverages the broad abilities of our MAs, customized electronic health record (EHR) templates, and comprehensive and ongoing training. Here are the key characteristics.

Delegate a broad scope of tasks

First, don't underestimate the importance of making the MA feel like an integral part of your care team. This isn't just a task to check off when getting to know a new coworker but rather an ongoing responsibility that will directly affect your effectiveness and satisfaction. The most important factor in an MA's development is ongoing feedback from the provider with whom they closely work, and taking time to constructively deliver this feedback is a good way to show that you value the MA's role. (See "A Feedback Tool to Improve Physician-Medical Assistant Communication," *FPM*, May/June 2014, http://www.aafp.org/fpm/2014/0500/p5.html.)

Gradually and only after providing careful training (more on that later), we have delegated the following administrative tasks to our MAs:

- Manage incoming messages with the provider during brief huddles between visits,
- Manage incoming lab and radiology results,
- Track labs for no-shows and cancellations,
- Research refill requests – provide dates of last labs, last visit, and next visit to aid decision making,
- Inform patients of lab results and next steps as directed by provider,
- Arrange urgent appointments and coordinate with care managers,
- Identify pre-op clearance appointments and collect all information needed,
- Identify opportunities for add-on visits for tomorrow's schedule and inform schedulers,
- Identify ED and hospital discharges, contact patients and offer follow-up as directed, document transitional care. ➤

About the Author

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Family Practice Management®

Use EHR templates to guide MAs' history-taking

Of course our MAs have patient care responsibilities as well, including history-taking, which is facilitated by more than 300 templates I have written using our EHR. If your EHR doesn't allow you to write custom templates, press your vendor to provide that functionality. My templates each focus on a chief complaint, providing questions in dropdowns with space to fill in answers for the initial HPI and ROS. For example, if a patient presents with abdominal pain, the MA enters ".abdominalpain" in the note, which populates the note with the pertinent questions. (See an example in the online version of the article at http://www.aafp.org/fpm/2016/0500/p5.html.)

The MA asks the patient the questions prompted by the template and enters the answers. When I enter the room and the MA leaves, I review the information with the patient, correcting and elaborating on the information as needed. I then perform the exam, explain my assessment and plan, and leave the room. In this example, my MA prints an ultrasound request and instructions on scheduling it and gives it to the patient. I finish the note, leaving it open if other referrals or vaccines are needed, for the MA to finish. This approach gives me complete control over the note, with nothing more to review after I close it.

The MAs perform other tasks in the EHR as well:
- Document chief complaint and vital signs,
- Reconcile medications,
- Review preventive services and provide referrals,
- Set up refills,
- Complete routine screening assessments according to protocol established by the provider,
- After the provider sees the patient, write up referrals and work/school excuses, and provide patient education.

Provide comprehensive, ongoing training

Most MAs have variable knowledge and abilities. Even for graduates of MA certification programs, it is beneficial to provide training aimed at standardizing skills, whether this involves refreshing basic knowledge or retraining in higher level tasks that were part of the MAs' education but not their recent experience. (A list of training session topics is available with the online version of this article.)

Effective training can occur in highly organized, large group settings or five-minute sessions between a single physician-MA team. The smaller scale can be advantageous. The ability to use the equipment in your own office is helpful, and competency can be more easily demonstrated and tested. Lecture material can sometimes be reviewed more effectively in one-on-one or small groups as well.

My employer, Anne Arundel Medical Center, a regional health system headquartered in Annapolis, Md., offers regular training sessions for the more than 100 MAs who serve

its multispecialty groups. Large group sessions occur on Saturday mornings. A light breakfast is served and the MAs are paid for their time. They break into groups and work their way through hands-on competency stations, video learning, and small groups sessions; we try to keep lectures to a minimum. As much as possible, they are given the opportunity to demonstrate their knowledge so their competencies can be documented.

We've learned quite a few lessons about how to increase the value of these training sessions:

- Make the sessions fun as well as informative. For example, showing how *not* to do certain tasks can be educational and humorous.
- Stations where the MAs work with real equipment and medical mannequins seem most effective.
- The more interaction, the more effective the teaching.
- Mix MAs from different sites to enhance community and increase participation.
- Use talented MAs as teachers.
- Limit the sessions to 4 hours on Saturdays, and 2 hours on weekdays.
- Ask for and act on feedback.
- Communicating the training to physicians, to build confidence in and use of the MAs' full abilities, is important but challenging.

Costs and benefits

We started using two MAs and three exam rooms per provider in January 2011. To measure the impact of these changes, we tracked the number of visits per year and the RVUs per hour of patient contact. Both have increased for the providers working in the model. The other physicians have seen the value in this model and are in various stages of moving to it, having already seen variable but significant improvement in their RVUs per hour and their patient volumes.

Using data on MA compensation and our income per office visit, we determined we needed 2.5 more patient visits per day to pay for the second MA. Our visits per day increased by 4 to 5 patients per day with the new model, so our income actually increased. It is important to note that you need large enough patient panels to create the demand for the extra appointments. A practical way to measure the demand is to count how many patients are turned away per day for several weeks. That should give a good estimate of the excess demand for that provider's services. Practice styles vary so much that it is hard to generalize about panel sizes.

Providers at both of our locations report feeling busy but well supported. MAs feel they are an important part of the care team and much more engaged with patients. Patient satisfaction scores were excellent before the changes and have remained so. Patients appreciate having a team to take care of their needs, and especially like the increased care coordination.

We have far to go to achieve the Triple Aim, much less the Quadruple Aim, but we are headed in the right direction and have identified the next steps on our journey. An expanded health care team, with highly trained MAs performing the key roles described in this article and physicians providing leadership and feedback, will help us get there. FPM

1. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood).* 2008;27(3):759-769.

2. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12(6):573-576.

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