ELEVATING THE ROLE OF THE MEDICAL/CLINICAL ASSISTANT:

Maximizing Team-Based Care in the Patient-Centered Medical Home

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The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute.

Introduction

There is mounting evidence demonstrating that health care is most effectively delivered by a team of providers with multi-dimensional skill sets. In fact, a 2006 evidence review of diabetes interventions found that providing team-based care was the single most effective intervention in improving intermediate diabetes outcomes.[1] Unless supported by a care team, physicians simply do not have the time to provide ideal care for all their patients, and many burn out trying. Recent evidence has also shown that many care and care coordination activities are better provided by non-physician members of a care team.[2, 3]

- Providing all of the evidence-based preventive and chronic illness care to an average panel of patients would take a single primary care provider 18 hours a day.[4]
- Most physicians only deliver 55% of recommended care[5] and 42% report not having enough time with their patients.[6]
- Providers spend 13% of their day on care coordination activities and only 50% of their time on activities using their medical knowledge. [7, 8]

Implementing care teams is a critical element of transforming a practice into a patient-centered medical home (PCMH). In the team-based care model, all care team members contribute to the health of the patients by working at the top of their licensure and skill set. For example, nurses can conduct complex care management, front desk staff can call patients who need evidence-based care and invite them in, medical assistants can provide patient self-management support, and pharmacists can support complex medication reconciliation. Costs decrease and revenue increases.[9]

In a PCMH, teams deliver comprehensive, first-contact care, and address the needs of patients and families through a broad range of services delivered by multi-disciplinary professionals. One essential role in the PCMH is that of the Medical Assistant (MA) or Clinical Assistant (e.g., LPN). MAs in particular take on new and enhanced responsibilities for patient care in the PCMH Model. For PCMH transformation, elevating the involvement of and expectations for MAs, and the level of confidence of providers in MAs, is a key element of success.

Embracing the PCMH model involves cultural shifts on the part of leadership and clinicians.

Through the training curriculum provided in this manual, MAs will learn to work side-by-side with providers, and learn to do more during the rooming process, from reviewing medications, to goal setting, to patient education. Offering this MA training in a practice communicates to every member of the organization that the MA is an important team member, that when MAs share responsibility for the clinical care of patients, it maximizes the efficiency and quality of care, and that leadership supports the elevated role of the MA within the care team.

The Safety Net Medical Home Initiative's (SNMHI) Continuous, Team-Based Healing Relationships Implementation Guide illustrated why and how providers cannot deliver recommended care working alone. The guide provides methods to develop and support multi-disciplinary care teams that can meet the health care needs of patients as individuals, promote population health, and maximize practice efficiency.

Change Concepts

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a Patient-centered Medical Home for the Safety Net Medical Home Initiative. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. Over the course of SNMHI, we have covered each of these Change Concepts through implementation guides and other relevant materials designed to help safety net clinics transform into a PCHM model. This manual is a training guide for maximizing the role of the Medical Assistant, and is closely aligned with the Continuous and Team-based Healing Relationships Change Concept.

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement (QI) Strategy
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care

Building the Care Team Through Training

What will allow MAs to perform in an enhanced capacity as a member of the care team? Education and hands-on training. This manual provides the tools for an intensive, week-long training session designed to provide MAs with a baseline level of enhanced expertise, and to empower them with the practical tools to succeed with greater responsibility and accountability for patient care.

When using this toolkit, it is important for practice leaders and trainers to adapt the curriculum to the specific needs of their clinic or practice. For instance, if a clinic has a large percentage of non-English speakers, it will be useful to include training on how to best use translators to support quality patient interactions. In practices with large elderly populations, the curriculum can be tailored to fit the specific educational needs of MAs caring for elderly patients, for example addressing limited mobility. In other cases, it may be necessary to streamline the training to fewer than four days.

What else is needed to optimize the role of the MA? Provider and leadership engagement.

As a first step to implementing any training curriculum that would enhance or optimize the role of the MA, review the curriculum and the concept of an enhanced role with providers and others on the care team. If a provider does not support the idea of the MA taking a stronger role on the care team, then the training is not a good use of time. Consider how the entire team will react to the new role of the MA and actively solicit input, then modify the training curriculum accordingly. Also consider how the new role of the MA will affect other care team members' roles, responsibilities, and available time. For example, if MAs take on responsibility for activities previously conducted by nurses, the practice should consider these impacts and re-evaluate nursing responsibilities.

How Does a Practice Implement this Curriculum?

Develop a Training Implementation Strategy

Smaller organizations may not need a formal training implementation strategy, especially if providers and management are supportive of optimizing the MA's role on the care team. However, in larger organizations, this may be necessary. This section describes a comprehensive plan for field-testing, adapting, and disseminating training to all MAs or other clinical assistants in an organization. This plan should be modified to meet the needs of your organization, as each organization has a different vision of the MA's role in patient care and each has different resources.

PHASE A. Establish Buy-In at the Site-Level

Host Focus Groups

A key learning from North Shore Physicians Group (NSPG) [Refer to case study on page 6] is that a necessary first step is to share the training curriculum with providers, office managers, staff supervisors, and staff that will attend the training to make sure that they feel the information is valuable. Leadership (providers and managers) must support the staff in using their new skills. For example, if a provider is not supportive of having MAs provide initial medication reconciliation, then this portion of the training may not be a valuable use of time. Below is an example of a focus group agenda. This focus group serves as the beginning of a discussion of modifications to job descriptions, incorporation of new responsibilities into performance reviews, and support for ongoing training.

Sample Focus Group Agenda:

Objective: To solicit input and generate support for training team members, particularly MAs, in team-based care so that care delivery will be more efficient, effective, safer and patients will have an improved experience.

- Background: Why did the site decide to train/re-train staff?
- Discuss the teaching approach
    - Small groups of 10 or less trainees at a time
    - Combination of didactic sessions, clinical competency (hands-on), and discussion
- Review of the SNMHI training curriculum
    - Share objectives and short descriptions for each module
    - Review 'how' and 'why' curriculum has been modified based on NSPG experience and expected needs of the safety net setting
- Open discussion
    - What do you find valuable in this training curriculum?
    - What concerns, if any, do you have about this content?
    - What modifications do you feel are necessary to meet the needs of our practice?
- Wrap-up
    - Share proposed dates of the training program
    - Review expectations and accountability of all team members
    - Review next steps

PHASE B. Establish Training Infrastructure

Modify the Curriculum Based on Focus Group Input

Input from the focus group should be incorporated into the training curriculum, and practices should take the time to customize the training materials so that the curriculum best meets practice needs and culture. This may require follow-up sessions with the focus group participants or a subset of the group and key leaders in the organization.

Once there is support for the modified curriculum, a point-person responsible for all aspects of coordinating and managing the training should be assigned. This person does not necessarily need to serve as faculty (i.e., content teacher/skill coach) for any of the modules. The lead education coordinator:

- Provides logistical support for each training, such as selecting site and timing, in coordination with leadership;
- Assists with recruitment of staff to be trained;
- Describes the training to staff, and, with support from leadership, reinforces the importance of training;
- Produces training materials; and,
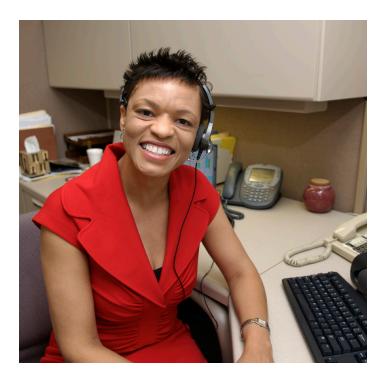- Provides evaluation support.

The lead education coordinator (with input from the lead faculty) will need to determine the length of the training, the order of the modules, and time allocated for each module. An example is provided in Appendix A. Not all practices will be able to afford to have staff out of the office for four consecutive days, so consider alternatives such as one day a week for four weeks, or two days a week for two weeks.

Identify Faculty and Support for Training Program

The next step is for the lead education coordinator to identify two lead faculty members, preferably a physician/provider and nurse. The lead education coordinator and lead faculty positions may be covered by the same person. Additional faculty can be identified as guest speakers on specialty topics, and will vary at each of the practices, based on availability of experts. For example, if a nursing school or residency program is nearby, your practice may ask students to serve as faculty for some of the modules. Other examples include using an Infection Control Specialist to teach the modules on Personal Protective Equipment, Infection Control, and Hand Hygiene, or using a clinical pharmacist to teach the Medication Management module.

The following is a list of characteristics to consider when recruiting lead faculty:

- Clinically knowledgeable
- Experienced, effective teacher/trainer
- Strong facilitation skills to engage the audience in discussion/interaction
- Style that includes:
    - Sense of humor
    - Energy (not monotone)
    - Positivity and respect (not pejorative)
- Inclusive and engaging

PHASE C. Train Faculty and Guest Speakers

Conduct a Train-the-Trainer Program

One approach to training the lead faculty and guest speakers is to conduct a train-the-trainer program or mock session of the entire training. The lead faculty will run the mock session and will move through the modified training curriculum providing teaching tips, questions to anticipate, etc. SNMHI sites can request technical assistance from their Regional Coordinating Center or Medical Home Facilitator.

Lead faculty and guest speakers will receive the Microsoft PowerPoint presentations as well as the training guide. Further modifications to the presentation slides may need to be done to allow the presenter (lead faculty or guest speaker) to "make them their own."

PHASE D. Conduct Medical/Clinical Assistant Trainings for MAs and Relevant Staff

Soon after the lead faculty and guest speakers complete their training on the content, they should be expected to lead an initial training for 8-10 Medical/Clinical Assistants. This will reinforce the curriculum and likely lead to further modifications. Once the curriculum is finalized, all Medical/Clinical Assistants in the organization should be trained.

Case Study: North Shore Physicians Group

The materials in this manual were developed by Dr. Beverly Loudin and Lindsay Gainer, RN, MSN, of the North Shore Physicians Group (NSPG) in Salem, Massachusetts. The content was used to train 80 staff members at NSPG's 10 primary care sites in 2010, including Medical Assistants (MAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs). Since that time, NSPG has also trained new hires in the program. Dr. Loudin, who served as Director of Patient Safety and Quality at NSPG, says the curriculum was developed as part of a leadership commitment to PCMH transformation. "Our leadership is very visionary. We saw where health care and health care reform were headed. We needed to get to a medical home model, and we saw care teams, and specifically increasing the role of the MA within the care team, as a practical, logical way to get there," she says.

Lindsay Gainer, Director of Clinical Services and Innovation, says the MA training curriculum fit their need to elevate efficiency without adding new resources. At NSPG, the training created a baseline competency for staff that didn't exist before, and that's created a platform on which to build the PCMH model. "We feel that team-based care is how we are going to get to PCMH," she says. "We want MAs to be elevated to a whole new level in the office and we're giving them the tools to do that."

Gainer says the training for MAs worked best in small groups of about 8 to 10 people, with a combination of didactic presentation and hands-on clinical skills work.

"I can't say enough about the staff response to this project," says Gainer. "MAs work very hard, they are passionate about what they do and they love their patients. MAs have traditionally been undervalued and underutilized. They really appreciated that we were making this kind of investment in their careers and professional development. A year later, I am seeing the effects on the workflow in the office and on the patients too." Anecdotally, Gainer says that staff retention is strong at NSPG, and this could be because of the positive response to the training.

"In the end, this training enabled everyone on the care team to have more confidence in the MA's abilities, including the MAs themselves. We've acknowledged how much they know and what an important part of the care team they are," Gainer says.

References

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Faculty and Administrator's Note

This curriculum was developed, and then modified, in order to provide a foundation for training Medical Assistants, LPNs, and other clinical staff to support the patient and care team in a Patient-centered Medical Home.

The materials herein should be used as a guide and should be revised to suit the individual needs of the organization conducting the training. The curriculum offers background notes indicating specifically when content is likely to be organization-specific; however, faculty should make any modifications they feel are necessary and/or appropriate.

Users of this curriculum should first assess their organizational needs and then select from the modules and content provided to create a customized training program appropriate for their organization.

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Handout #1.1.5	Article by Tom Bodenheimer, Coordinating Care — A Perilous Journey through the Health Care System, NEJM 358: 1064-71 www.nejm.org March 6, 2008.	N/A

Section 2.0 Improving Care Processes		
Module 2.1	2.1 The Virginia Mason Production System & Clinical Redesign.ppt	45
Handout #2.1.1	Article by Christine Sinsky, Improving Office Practice: Working Smarter, Not Harder -- Seemingly simple strategies can transform, FPM, November/December 2006, pp. 28-34, www.aafp.org/fpm.	N/A
Module 2.2	2.2 Standardizing Clinical Process Workflows.ppt	15
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Handout #2.5.1*	Article by Daryle J. Gardner-Bonneau & June Isaacson Kailes, Accessible Health Care: More Than Just Getting Through the Door, Ergonomics in Design, Winter 2010, pp. 5-10.	N/A
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Handout #5.1.2	Article by The Accord Study Group, Effects of Intensive Blood-Pressure Control in Type 2 Diabetes Mellitus, NEJM 362;17: 1575-85, April 29, 2010.	N/A
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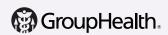| Description	Filename or Reference	Number of Pages
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