Enhanced Medical Assistant Role – Implementing an Expanded Role in an Emerging Model of Care

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Who will I be speaking about?

- Family Medicine residency clinics (4) in Minneapolis and St. Paul
- Urban, underserved population
- Many interpreted visits
- EMR = Epic

What will I be presenting?

- Care coordination is vast and varied
- Care coordination activities are completed by various members of the care team
  - Care coordinator
  - Medical provider
  - Patient care staff: CMA, LPN, RN, lab
  - Clinical pharmacist
  - Behavioral health provider
  - Social worker
  - Scheduling/check-in staff

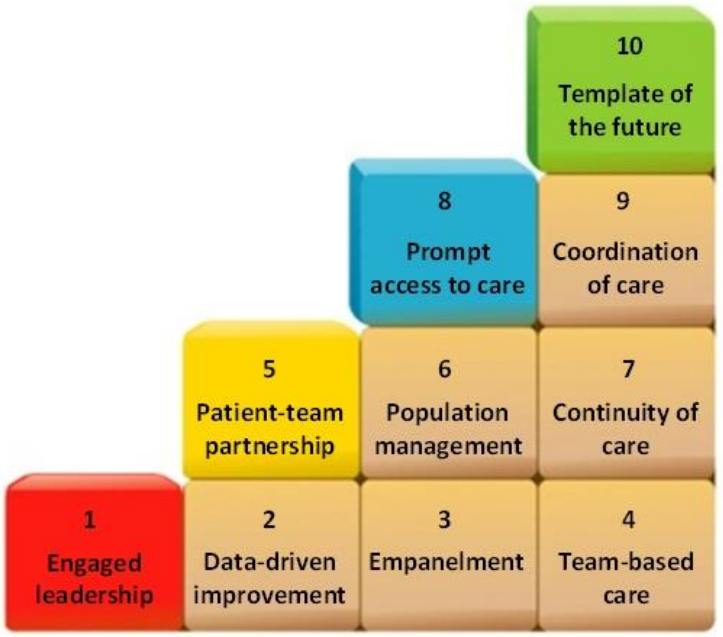
Why is the enhanced medical assistant role important?

- *In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices,* Sinsky, et al. Ann Fam Med May/June 2013 vol. 11 no.3 272-278

- *The 10 Building Blocks of High-Performing Primary Care,* Bodenheimer, et al. Ann Fam Med March/April 2014 vol. 12 no.2 166-171

Team-based care

- To increase capacity, need to “Share the Care”
- Change the culture
  - Spread the work
  - Empower the team
    - Standing orders
    - Defined workflows



Sharing the care exercise

Sharing the Care exercise

Place an X in the column of the person/people who can do the task. Circle the X of the person who should do the task.

Task	MD/DO	RN	CMA	Care coordinator	PharmD	Behaviorist	Patient representative	Referral coordinator	HIM staff
1. Discussing and ordering mammograms for women 50-75 years									
2. Alerting/acting on critical values									
3. Documenting Physical Exam									
4. Documenting Assessment and Plan									
5. Documenting family and social history									
6. Capturing/setting visit agenda									
7. Identifying and ordering chronic disease labs									
8. Performing medication reconciliation									
9. Entering orders in the EMR									
10. Wrapping up the visit (providing AVS and education)									

What did we do with the info?

- Offload work from providers and moved around other work
- Shift some ownership to CMA's (from providers)

What’s the new model?

Enhanced Medical Assistant role

- CMA's and LPN's in our clinics
- Divided model into two sections
  - Enhanced rooming
  - Visit assistance

Enhanced rooming

- Vitals
- Preventive health needs/immunizations/chronic disease labs
- Medication reconciliation
- Family/social history
- Agenda capture
- MyChart sign-up
- Hand-off to provider

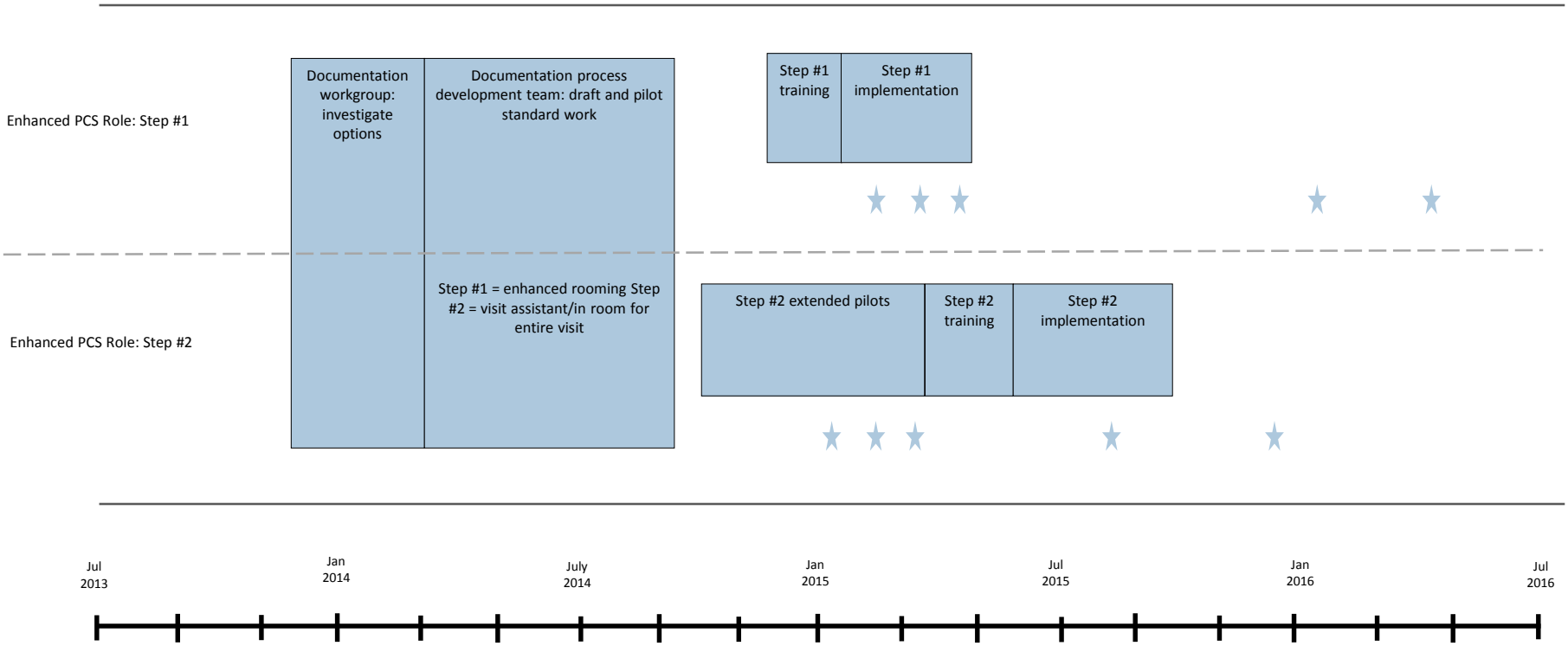
Visit assistance

- Stay in room for entire visit
- Upon callout, place orders (with read back)
- Upon callout, write patient instructions (with read back)
- Assist with scheduling follow-up/referrals
- Complete visit wrap-up (after-visit summary)

- **Document portions of visit with templates**
- **Upon callout, document ROS and PE**

How did we get from sharing the care to the final model?

Timeline


Enhanced PCS Role: Step #1
Documentation workgroup: investigate options
Documentation process development team: draft and pilot standard work
Step #1 training
Step #1 implementation
Enhanced PCS Role: Step #2
Step #1 = enhanced rooming Step #2 = visit assistant/in room for entire visit
Step #2 extended pilots
Step #2 training
Step #2 implementation
Jul 2013
Jan 2014
July 2014
Jan 2015
Jul 2015
Jan 2016
Jul 2016

Documentation workgroup

- Multidisciplinary leadership team to review the 4 options for documentation assistance
- Pushback from providers about scribing (did NOT want)
- Ultimately decided to proceed with assisting providers with orders and patient instructions

Doc. process development team

- One dyad (MD/CMA) from each clinic
- Drafted, simulated, and revised standard work
- Piloted it with individual patients
- Revised standard work again
- Trained additional PCS and provider (2 PCS working with 1 provider)
- Piloted with all patients during a clinic shift (1/2 day)

PCS = patient care staff (CMA, LPN)

Pilot outcomes

- Divide the standard work into two sections (enhanced rooming and visit assistance)
- Roll out enhanced rooming to all immediately
- Continue extended pilots for visit assistance (spread to more PCS and providers) – hire temps to fill in for PCS doing pilots

PCS = patient care staff (CMA, LPN)

Enhanced rooming implementation (Dec. 2014)

- Trained all PCS in person
- Trained providers via written communication
- Conducted standard work audits
  - Self
  - Peer
  - Supervisor
- Conducted satisfaction surveys

PCS = patient care staff (CMA, LPN)

Visit assistance extended pilot outcomes

- Mixed satisfaction
- Do more and will get better, keep training a few at a time

- Central Leadership Team said SPREAD!

Visit assistance implementation (Summer 2015)

- Trained all PCS
- Trained all faculty and Nurse Practitioners
  - Shadow shifts
  - Shifts with already trained
- Conducted standard work audits
- Conducted satisfaction surveys

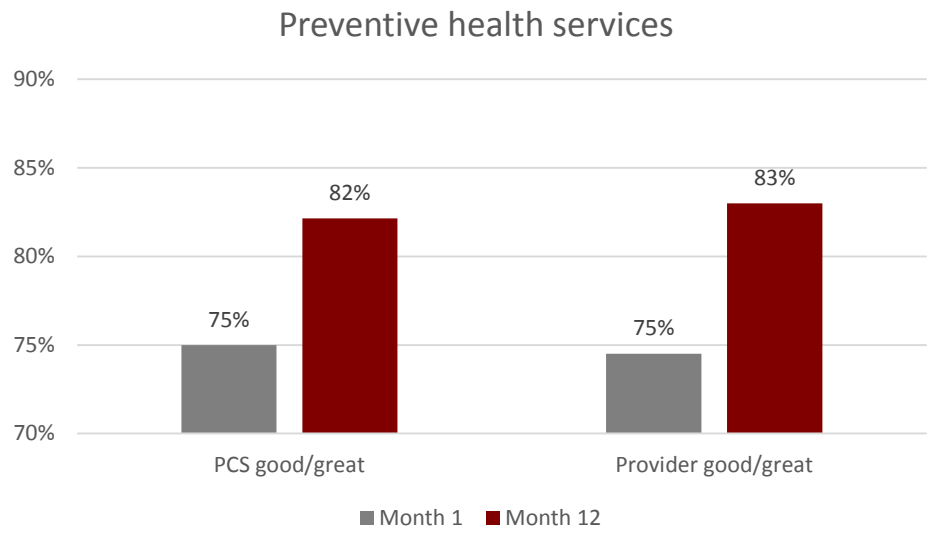
PCS = patient care staff (CMA, LPN)

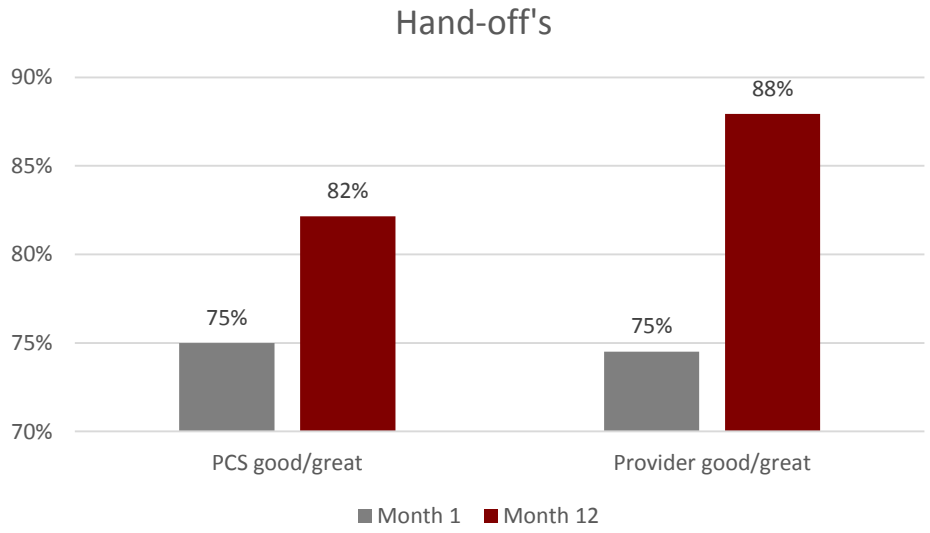
Measures for success

PROCESS: Patient satisfaction

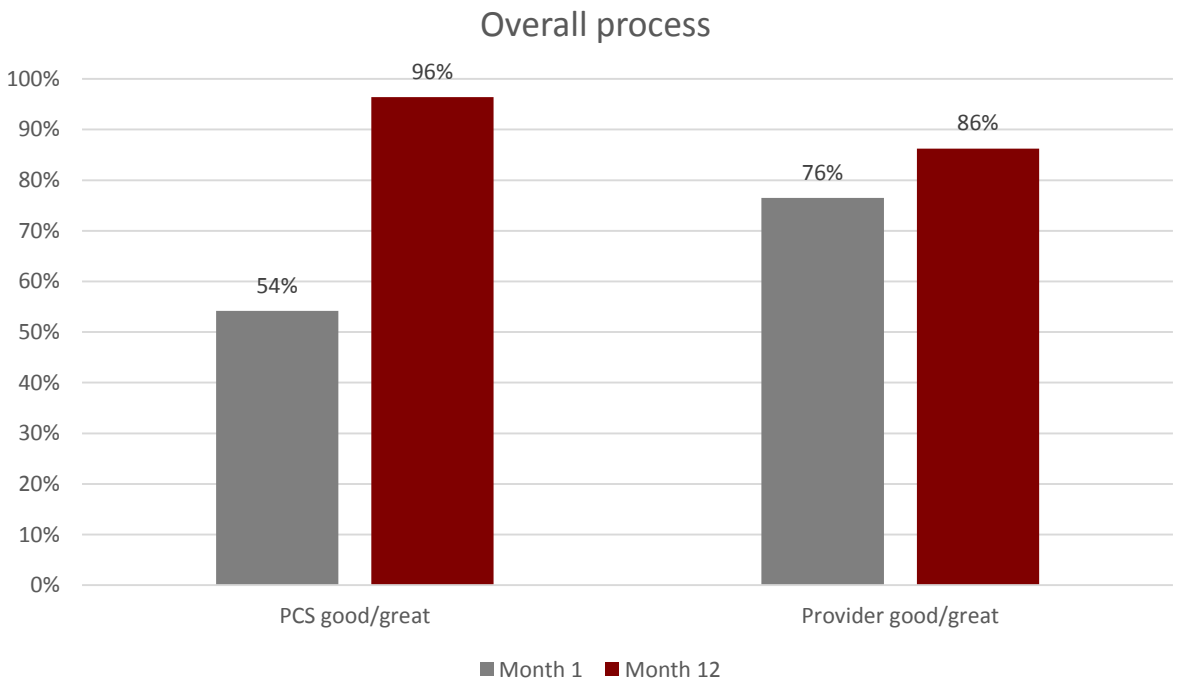
- Surveyed patients during model development
- Overwhelmingly positive results – allowed us to continue moving forward

PROCESS: enhanced rooming staff/provider satisfaction

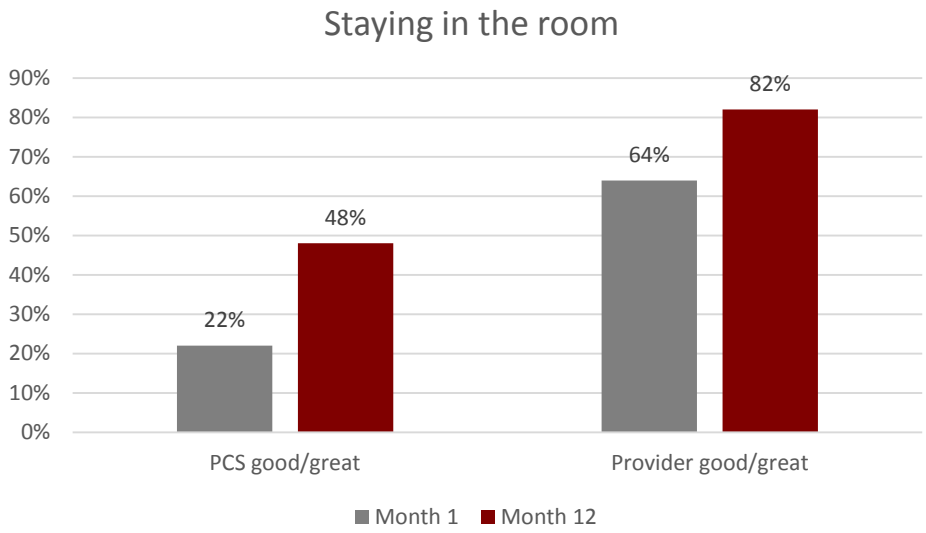


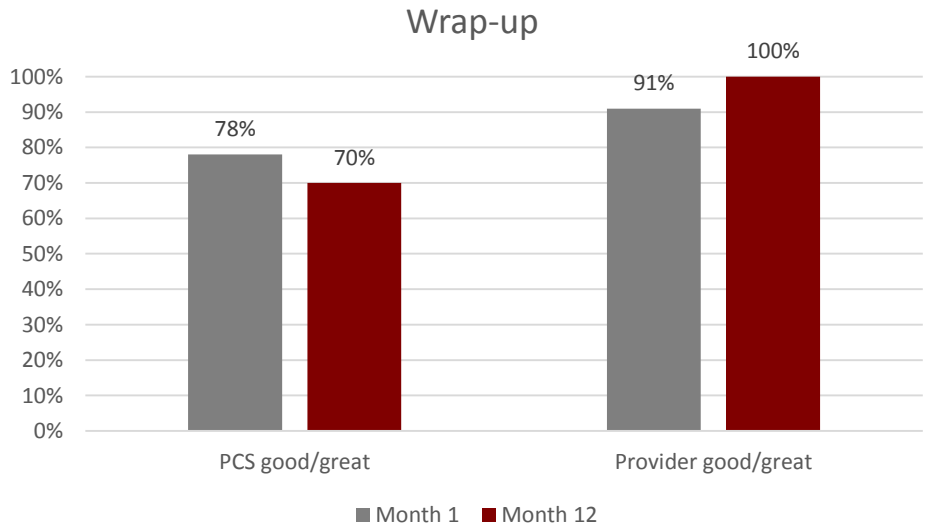


PROCESS: enhanced rooming staff/provider satisfaction

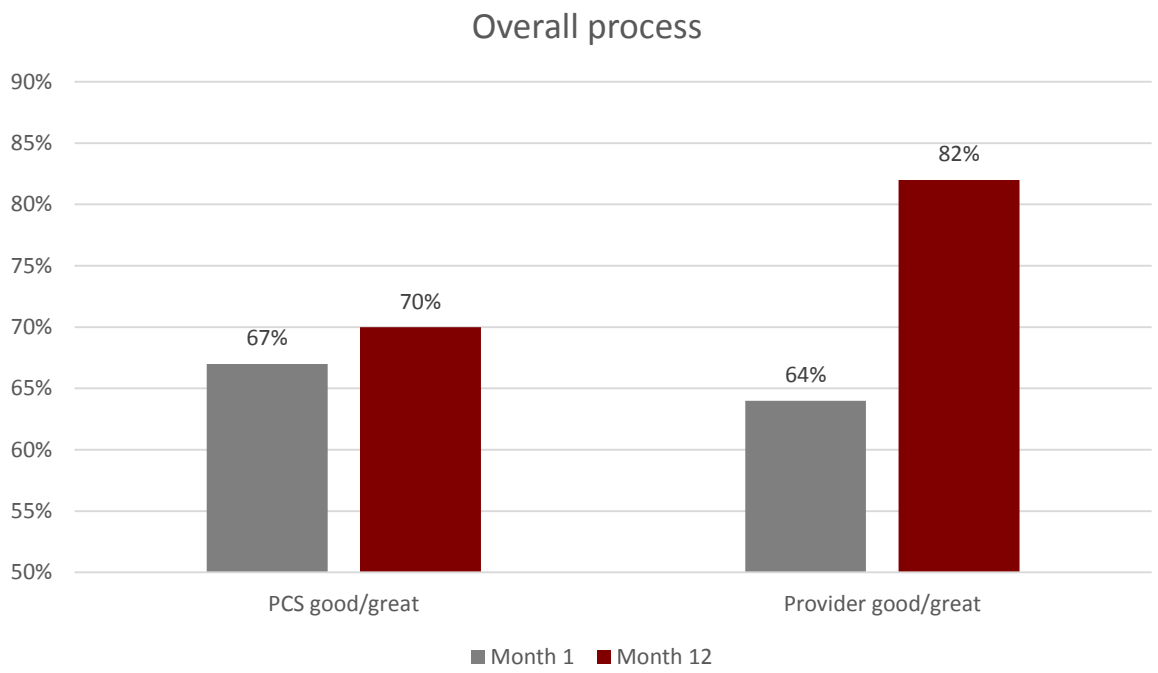


PROCESS: visit assistance staff/provider satisfaction





PROCESS: visit assistance staff/provider satisfaction



OUTCOME: enhanced rooming

- Mammogram order rate increased

OUTCOME: visit assistance

- Turn-around time decreased during these shifts compared to “usual care” shifts
- After-visit summary (AVS) print rate increased

Lessons learned - PCS

- Can do this and they like it
- Vulnerability
  - Listened
  - Understand vulnerability when training
  - Needed to train medical provider on PCS vulnerability
- Quicker to see value
  - Continuity
  - Doing it more than providers
  - Get better quicker
- More resilient
  - Stuck with it
  - Found the value
  - Moving to scribing

PCS = patient care staff (CMA, LPN)

Lessons learned – medical providers

- Deconstruction of visits
- Autonomy vs standard work
- Owning the note
  - Whole note
  - Assessment and Plan
- Overt communication
- Those who doesn't work well
  - Highly invested in after-visit summary
  - Highly invested in beautiful notes
  - High psychosocial complexity

Lessons learned - leadership

- Build followership / clear direction
  - Worth the time before starting
- Authorship vs "Build it for me"
  - Straw dog vs blank sheet of paper
  - Small group to pre-build
- Time vs pressure to change
  - Let process mature before changing
- Train medical provider about PCS vulnerability

PCS = patient care staff (CMA, LPN)

Still trying to figure out…

- Level loading of medical providers
- Hiring/training new staff and medical providers
- Will this model allow us to see more patients?

Questions?