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RESEARCH BRIEFING

How Four Organizations Trained MAs for the Advanced Medical Home

To take the medical home to the next level, you must reexamine care team roles.

For example, when given proper training, support staff such as MAs and LPNs can handle a range of care management duties that extend beyond their traditional clinical and administrative roles. This briefing details how four organizations approached this training.

Top Five Insights from MA Training Programs

1

Support care team redesign at the top, but ensure efforts are driven by the front line. Dedicated leadership teams responsible for training program development and implementation ensure consistency, standardization, and ongoing success and sustainability.

Action Steps

- Identify key leaders from both administrative and frontline staff
- Define purpose and goals for training program, team-based care, build buy-in for program
- Designate position to manage day-to-day logistics, coordinate with broader care team

2

Design programs to address goals for specific support staff positions, but engage the entire care team so they are aware of the changes and can work together as a cohesive unit.

Action Steps

- Engage physician, practice champions
- Include diverse clinic stakeholders in up-front planning discussions
- Incorporate staff feedback in curriculum design
- Use internal experts to lead training sessions
- Educate staff about benefits of care team redesign, impact on own workflow; provide continuous updates on new developments in role redesign

3

Create a shared baseline by first standardizing foundational frontline MA clinical and administrative skills and expectations.

Action Steps

- Assess level of MA performance, competencies before training to identify needs
- Create curriculum to address gaps in clinical, administrative skills
- Establish standard for basic customer service, professionalism
- Evaluate MAs post-training to track progress

4

Advance beyond clinical and administrative skills to develop targeted health coach competencies. Specific, non-clinical training can help MAs foster productive patient relationships and enhance support for primary care providers.

Action Steps

- Provide basic chronic condition education
- Invite experts to lead training on specific care management competencies
- Simulate real-life patient scenarios to practice communication, coaching skills

5

Empower continuous MA development by creating a compelling career ladder.

Action Steps

- Standardize tiers and roles in which MAs can progress to advance skill set; provide enhanced recognition and adjust compensation if necessary
- Inform all staff of role changes and resulting impact on staff and clinic workflow

Creating an in-house training program to support MA certification defined a common, foundational skill baseline at PinnacleHealth.

Profile #1 | PinnacleHealth Medical Group

- Network of over 100 primary care providers and specialists with 25 locations in central Pennsylvania; affiliated with PinnacleHealth System in Harrisburg, Pennsylvania
- Created medical home team framework that clearly delineates roles, responsibilities, and reporting structure for all clinical and administrative staff
- In 2013, required all MAs to receive formal credentialing to support broader medical home, care team development
- Initiated Credentialed MA training program to help MAs hone existing clinical skills and develop direct patient care responsibilities; as of November 2013, 180 MAs completed the training
- Emphasizes hands-on learning and evaluation of EMR and customer service skills

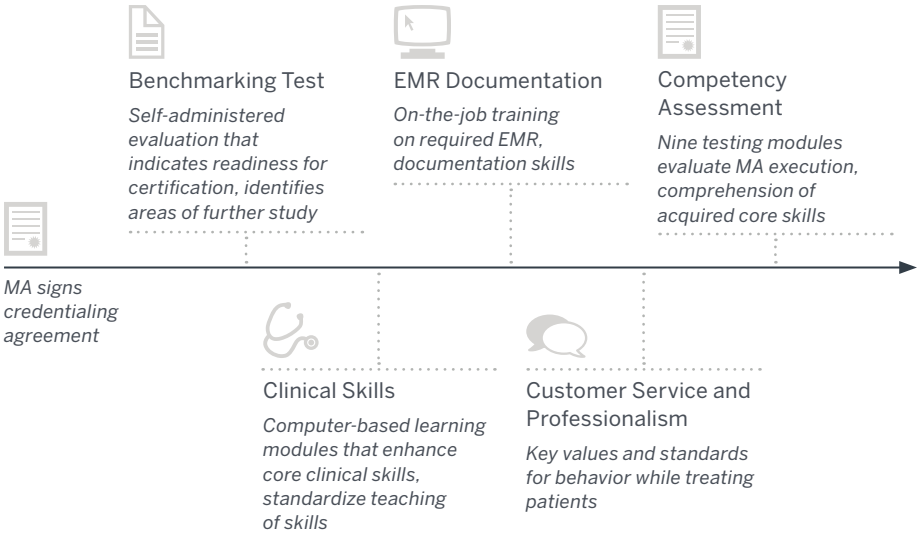
To improve consistency in the MA role, PinnacleHealth Medical Group required that all MAs receive formal certification. PinnacleHealth built its Credentialed MA training program not only to help MAs refine clinical skills, but also to include new expectations for workflow changes and patient interactions.

MAs were asked to sign an agreement stating they would pass certification either by July 2014 or within one year of completing the training. To support MAs as they pursue certification, PinnacleHealth offers to cover the cost of the certification exam.

PinnacleHealth held 13 after-hours training sessions for MAs, with a maximum of nine MAs per session. The curriculum standardized how skills are taught to MAs and how MAs work with patients, allowing for MAs to operate at the same level and be held to the same expectations across clinic sites. Training includes a competency assessment that evaluates MA comprehension of clinical skills, ability to respond to real-life patient scenarios, and newly acquired customer service skills, ensuring that MAs are thoroughly prepared to pass the certification exam.

Training emphasizes the integration of new skills and protocols into the care team's daily routine

Overview of Credentialed MA Training Process

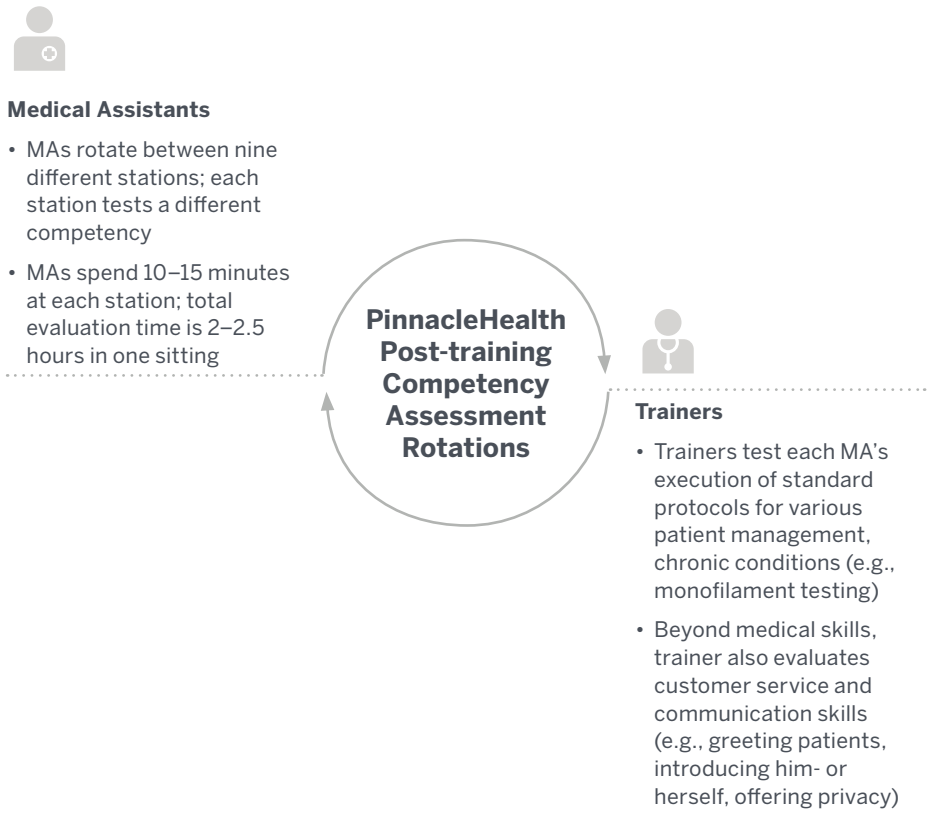


> Before MAs take the certification exam, PinnacleHealth conducts its own assessment of each MA's understanding and acquisition of new skills.

The post-training competency assessments, while mainly organized by condition or illness, focus heavily on patient management, customer service, and clinical skills.

Nurses, office managers, or other certified MAs are trained to lead the competency assessment simulations. PinnacleHealth also established remediation policies for MAs who do not pass the initial competency assessment, allowing those MAs to review results and skills that require further development with a trainer one-on-one.

Evaluating MAs on ability to communicate with patients, not just medical ability



> Of course, even when MAs are fully trained, care team members need to be comfortable giving them new responsibilities.

To assuage potential provider concerns, MAs who were certified received an official "Credentialed MA" name badge to wear as a visual indicator of enhanced skills. Leadership also recognized the extra work credentialed MAs assume and approved an increase in their compensation.

Clear designations and next steps confirm MA responsibility, credibility

Range of Credentialed MA Recognition

Team-based care can mean an overhaul of infrastructure—and that requires executive-level commitment.

Profile #2 | MaineGeneral Health

- Two-hospital, not-for-profit system with 10 primary care offices located in Kennebec Valley, Maine
- Identified need to enhance MA training and support to enable team-based care and support involvement in the statewide medical home pilot
- Developed "Excellence in Office Care" department to ensure employees at all sites are practicing at top of license, provide resources for training, improve workflow and quality
- Received Department of Labor grant in 2013 for staff training and development programs; targeted initial efforts on creating MA training curriculum to hone foundational clinical skills, prepare MAs for certification

Leaders at MaineGeneral Health wanted to better leverage and train MAs, so they actively prioritized top-of-license care by creating the "Excellence in Office Care" department and a dedicated steering committee to lead the MA training program development.

Dedicated teams provide consistent support, resources for program development

Two New Leadership Teams Oversee Staff Training and Development

"Excellence in Office Care" Department

- Serves as dedicated teaching resource to support practice transformation at all clinic sites
- Oversees all staff training and development initiatives
- Develops high-functioning care teams operating at top-of-license while increasing overall job satisfaction
- Facilitates collaboration across the system; standardizes workflows when possible

MA Training Steering Committee

- Led by primary care medical director, director of accountable care, and senior management
- Includes physician champion, PCMH educator, quality improvement specialists, practice administrative directors
- Hires, collaborates with new PCMH educator to operationalize training initiatives
- Develops MA career ladder for continuous MA growth

Time Commitment

Start-up, development phase most time consuming; met two times per month for six months, roughly 50 hours total.

Now, physician champion spends around four hours per month working with PCMH educator.

> MaineGeneral created a dedicated PCMH educator role to oversee training and curriculum development and ensure consistency of implementation.

Beyond dedicated leadership teams, MaineGeneral engaged frontline staff throughout the development and implementation process. Using a portion of the Department of Labor grant, MaineGeneral hired a dedicated PCMH educator to design an effective training curriculum for MAs.

As the educator's role evolved, she was also tasked to expand MA education and training to the broader care team to ensure alignment across staff. Given the program's success, the physician champion was able to secure a permanent source of funding for the educator role.

PCMH educator conducts MA baseline assessment to tailor training to address current gaps

PCMH Educator

Health education specialist

Defining MA Training Program Components

- Develop MA training program to identify and provide resources needed to educate medical group teams
- Assess and establish baseline inventory of current primary care MA skills, capacity
- Identify components of ongoing training for basic clinical and administrative skills
- Educate staff on basic communication techniques

Coordinating with Staff, Care Teams

- Select appropriate specialists, topic experts to lead training sessions
- Liaise with nurse managers who supervise MAs to spread awareness about training, ensure MA attendance
- Identify main contact at each practice for consistency, accountability
- Assist with any revisions in clinic workflows resulting from enhanced training
- Design education for other staff and care team members

> The curriculum's focus extended beyond foundational clinical skills to more advanced chronic disease education.

The eight-week training program consisted of nine two-hour long sessions, held in the morning before clinics opened. The curriculum included 10 modules, split evenly between skill development and chronic condition education.

Each session was led by an internal topic expert, and many modules were also hands-on. For example, the nutritionist-led diabetes module emphasized refining or developing practical skills, such as how to conduct foot exams. Some modules also used situational role playing to encourage collaboration among MAs.

In first year, 63 MAs completed eight-week training and MaineGeneral aims to train all MAs by end of 2014.

Non-clinical training helps foster productive patient relationships and enhance support for primary care providers

Overview of MaineGeneral MA Training Process

Current Skills Assessment

Baseline Assessment

Conducts inventory of primary care MAs, including number of MAs, current certification levels, and continuing education units

Benchmarking Test

Assess MA skill and competency level to serve as indication for certification readiness prior to training; pinpoints potential areas for improvement

Standardized Training Curriculum

Skills Modules

1. Primary Care Transformation
2. Risk Factors
3. Panel Management
4. Preventive Care
5. Medication Management

Chronic Conditions

1. Diabetes
2. Cardiovascular
3. Asthma/COPD
4. Behavioral Health
5. Chronic Pain

Post-training Competency Evaluation

Clinical Skills Evaluation

Evaluates learning progress, skill comprehension and delivery during in-person and paper-based skills testing

> To ensure MAs could maximize skills learned in training, the PCMH educator also engaged the rest of the staff in care model redesign and education.

MaineGeneral holds six practice-wide sessions a year for all providers. These sessions teach residents and staff about medical home competencies, promoting team-based approaches to care and increasing cohesiveness and communication across the team.

The trainings also update the team about the redefined scope of practice of other care team members, such as MAs. The sessions also help staff, especially physicians, understand how the new MA role interacts with their own position and responsibilities, ensuring MAs are properly integrated into the care team.

Informing all staff of new MA roles fosters teamwork, practice cohesiveness

Medical Home Training for All Residents, Staff

Format

- Six sessions in 2014, held every other month; each session focuses on individual topic
- Residency-based, but all staff welcome to attend
- Presentations and panel discussions, often facilitated by physicians at each practice

Topics

- Team-based curriculum for resident physicians and staff
- Topics focused on medical home education and new staff competencies, including:
  - *Community-based resources; e.g., healthy living resources, senior centers, social services*
  - *Goal setting*
  - *Motivational interviewing*
- Updates team about redefined scope of practice of other team members such as MAs

Benefits

- All staff apprised of each other's role within medical home care team
- Good role-modeling opportunities; all staff members have opportunities to become a teacher
- Best practice sharing across sites, teams, providers

Reinforce didactic learning through interactive simulation exercises that foster skill development.

Profile #3 | WellSpan Health

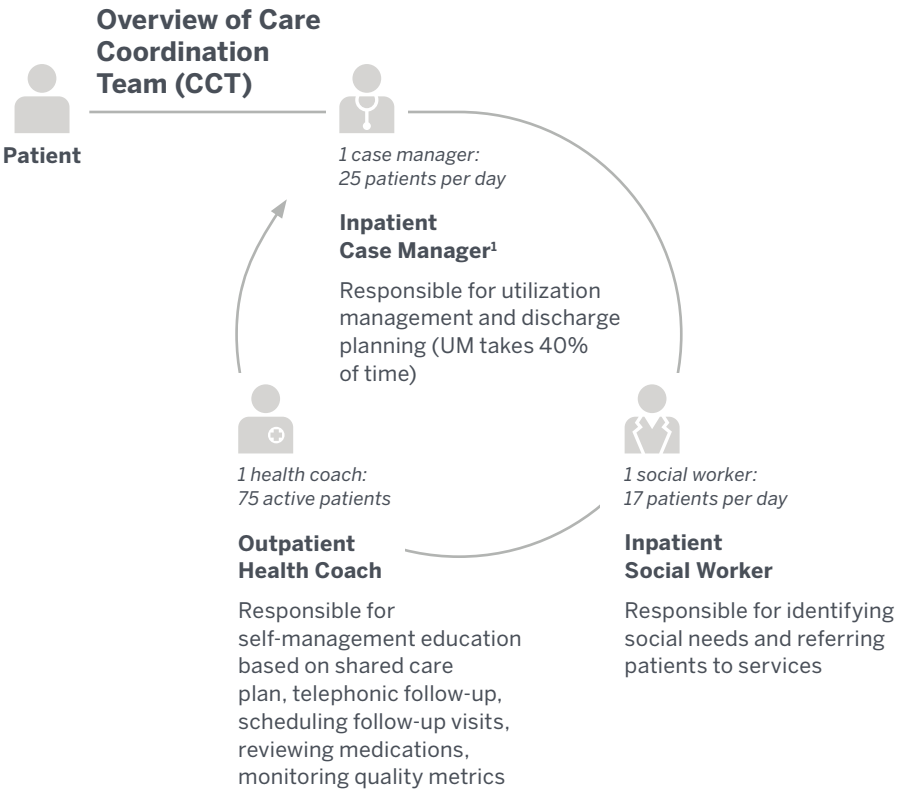
- Four-hospital health system based in South Central Pennsylvania; developed Care Coordination Team (CCT) as the core functional component of its PCMH model
- Health coaches (MAs or LPNs) paired with inpatient case manager and social worker dyad form a CCT, which engages high-risk populations to improve outcomes and facilitate care transitions for all patients at employed medical group practices
- Developed eight-day health coach training program to teach patient management skills, such as visioning and goal-setting; training first took place in November 2012 and is offered two to three times each year
- Phased addition of health coaches across eight practices in FY2013; rolling out to all 30 practices in FY2014

Health coaches are central to bridging inpatient-outpatient transition to coordinate patient care.

WellSpan Health in South Central Pennsylvania developed a practice-based model where existing care management team members work closely to manage a group of patients across the continuum—calling on LPNs/MAs to assume the health coach role.

WellSpan formed a care management triad (called the Care Coordination Team or CCT) that reconfigured inpatient case manager and social worker assignments around practices, rather than inpatient nursing units. Health coaches are embedded in the practice and serve as ambulatory care managers who work with dedicated inpatient team. This model allows the CCT to develop strong relationships with patients and each other over time.

Forming care teams to manage patients across the continuum



> WellSpan's success hinges on a training simulation for health coaches to mimic real patient scenarios.

To support this new practice-based care model, WellSpan created a homegrown health coach training program for new health coaches that includes eight sessions, each three to four hours long. The foundation of the program's curriculum is to develop communication skills, ensuring MAs/LPNs can carry out new responsibilities such as self-management and coaching techniques.

Communication and coaching skills are reinforced during the training's simulation lab (Sim Lab). Each Sim Lab session is educational, encouraging, and supportive. Sim Labs mimic real patient scenarios and train health coaches to respond to patient concerns. Scenarios include working with patients with chronic illnesses such as diabetes or hypertension, preparing coaches to address underlying social and behavioral causes of chronic conditions.

Health coach simulation labs provide real-life care management scenarios

Overview of Health Coach Simulation Lab

Trainer
"Simulated Patient"

- Assumes role of patient; presents scenario, often related to diabetes or hypertension
- Evaluates coaches' communication, goal-setting skills using checklist
- Allowed to come out of character and give live feedback

Coaches-in-Training

- Expected to respond to real patient conditions
- Guides "patient" through questions, concerns related to condition
- Assessed on ability to help patients with goal setting
- Can request additional one-on-one support

Top-of-license practice often requires formal structures that foster continuous staff growth and development.

Profile #4 | Union Health Center

- Comprehensive primary and specialty care center in New York, New York, that includes 10+ PCPs and 30+ specialists; received NCQA Level 3 recognition in 2010
- Redesigned MA training and task allocation to support team-based care, with input from all care team members and insights from assessment of UHC's current gaps and staff skills
- Fostered ongoing training and professional development through creation of three-tiered MA career ladder; career ladder defines roles and standardized responsibilities that advance MA scope of practice
- Provided education and messaging about enhanced MA roles and impact on care team interactions to all staff; ensured MAs were trusted to perform their new duties and supported throughout continual learning process

Union Health Center, a comprehensive primary and specialty care center in New York City, developed an MA training curriculum to support ongoing advancements to its team-based medical home.

Recognizing that MAs could take on more responsibilities, UHC secured two grants to develop a 12-month training curriculum for MAs focused on chronic disease and self-management support. With resources from the American Diabetes Association and the New York City Department of Health, as well as material developed in-house by providers, UHC developed its own didactic and clinical curriculum to enable MAs to take on patient education and coaching activities.

Continuous training opportunities provided at Union Health Center

Initial MA Training Curriculum

Dedicated two-hour weekly sessions held during clinic workday over nine months

- Defined scope of MA role in patient care
- Identified gaps in MA communication and clinical skills
- Reviewed basic MA curriculum, tailored to current skill levels; provided refresher on clinical facts, patient education materials, EMR templates
- Taught basic interviewing skills and principles, motivational interviewing, techniques of self-management support (e.g., goal setting, patient readiness to change)

Ongoing Commitment to Education

Weekly Team Refreshers

One-hour sessions every other week for PCAs[2] and health coaches

Continuous Process Improvement

Teams encouraged to identify inefficient processes and protocols, pilot potential solutions; successful solutions can be rolled out across the practice

Health Coach Shadowing

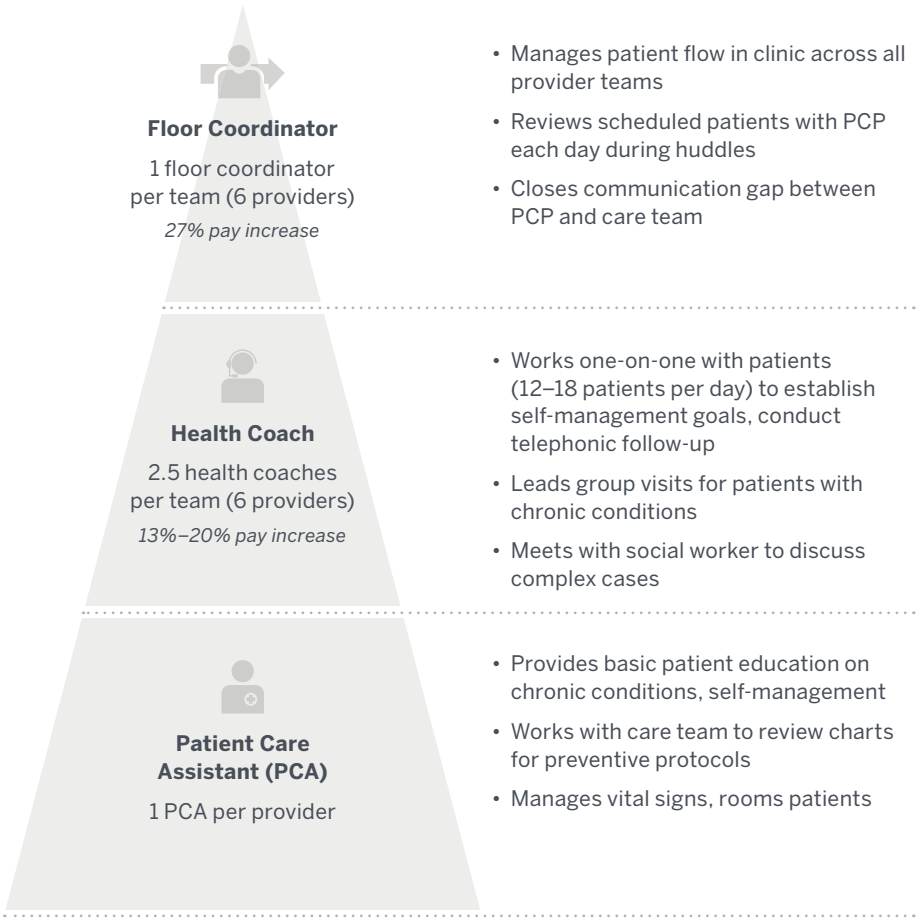
Opportunity for select PCAs with advanced knowledge to learn from health coaches, train to earn promotion

Create a compelling career ladder to empower continuous MA development.

Training staff to achieve top-of-license practice also standardized roles across sites, allowing UHC to create an MA career ladder—a career development structure that defines positions through which MAs can advance.

Standardizing staff roles also increases staffing flexibility and capacity. On days with higher patient volume or fewer staff, MAs can often fill in for one another since they all received the same training.

MA career ladder outlines opportunities for professional growth



Provider and patient education and involvement is just as important as MA training.

Leaders at UHC recognized that they would need support from the rest of the practice to implement the clinical ladder, so they provided multiple opportunities for all clinical staff to participate in training, from development to implementation.

Engaging entire care team in training, process improvement initiatives

Strategies to Improve Provider, Patient Buy-In

Engaging in Program Development

- Clinical staff actively involved in ongoing training development and supervision
- Care team RN ensures MAs are performing designated duties effectively
- Nutritionist attended a "train-the-trainer" program to learn effective teaching techniques, shared techniques with rest of team

Fostering Ongoing Collaboration, Teamwork

- Providers lead group visits, encouraged to share any patient concerns with health coach and rest of care team
- Team meetings discuss potential adjustments to health coach role; address inefficiencies, barriers in workflow
- Task forces formed to pilot potential solutions and provide update on progress at subsequent meetings

Educating Patients and Caregivers

- Providers encouraged to mitigate patient resistance to new care model through warm handoffs to health coaches and PCAs
- Patient education materials detail the benefits of the PCA and health coach involvement in patient care

> Although the up-front investment is significant, the program yields substantial returns in cost savings, clinical outcomes, and operational efficiency.

Overall, the new care team model improved clinic workflow by reducing wait times, no-shows, and walk-ins. Being able to better predict patient volume and clinic capacity ultimately resulted in more positive patient experiences. Patient satisfaction also increased given the personal relationship health coaches were able to develop with patients. Additionally, staffing across the board at UHC has stabilized and overall retention has improved.

Given these results, UHC hopes to soon create a similar career ladder for nurses and other care team members.

Outcomes of enhancing MA training and responsibilities

Metrics	Details
Program expenses	• Grant funding required to cover up-front training development costs • Required substantial dedicated staff time up-front and on a continual basis, especially for administrative and nurse trainers • Increase in compensation for health coaches, floor coordinator
Cost savings	• Data from self-insured fund showed that employees who were followed at UHC cost 17% less PMPM than those not served by UHC • Emergency room costs for employees were 50% less when seen at UHC
Clinical outcomes (diabetes)	• 36% of patients had controlled ABCs[3] in 2009 versus 13% in 2005 • Statistically significant improvement in diabetic patients with A1c at less than 7%, blood pressure below 130/80mmHg, and LDL cholesterol less than 100mg/dL
Wait times	• Redesigned patient flow and floor coordinator enhance provider and PCA workflow
Patient access	• Increased access to staff via telephone, centralized phone line • Designated time for same-day, next-day appointments • PCAs conduct appointment reminder phone calls 2–3 days prior to scheduled visit • UHC is serving nearly 3,500 more patients in 2014 than in 2010 with the same number of staff
Staff recruitment, retention	• Experienced initial decrease in retention during adoption of model • Since adoption, care team and provider staffing stabilized, MA retention improved • Number of PCAs has increased from 17 in 2010 to 31 in 2013 as a result of enhanced practice clerical efficiencies (e.g., transition to EMR, reduction in clerical staff) • Most interns from local MA training schools stay at UHC if offered position

More on the Medical Home

Five Steps to Build the Advanced Medical Home

Training MAs to be a part of the care team is one of the biggest drivers of improved efficiency in the medical home, but there are other tactics that can help you scale the model. Read this briefing for more on reevaluating care team tasks, educating patients during idle time, and more.

advisory.com/hcab/advancedmedicalhome

Advance to a Cutting-Edge Medical Home

Southwind's Chief Medical Officer Dennis Weaver, MD—a seasoned expert who led one of the country's largest accountable care demonstration projects—has a few tips for taking your medical home to the next level. By focusing on three areas, you can increase the impact of your medical home and provide better care for more patients.

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Sources

Page 23–27: UCSF Center for the Health Professions, "UNITE HERE Health Center—Pioneering the Ambulatory Intensive Caring Unit," Nov 2011; Population Health Advisor interviews and analysis.

Population Health Advisor interviews and analysis.

Endnotes

[1] Supported by LPN/MA case management assistants who fulfill administrative tasks (e.g., benefit checks for PAC referrals, DME follow-up). Three case management assistants support 40 case managers.

[2] Patient Care Assistants; MAs who have completed training are considered PCAs.

[3] A1c, blood pressure, cholesterol.

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