**CIN Partners Share:**

**Advanced Primary Care Team Models**

The California Improvement Network (CIN) partners — public and private health care organizations actively engaged in improving chronic disease care — meet quarterly to share experiences and to learn from one another. Following are highlights from the partners’ August 2013 meeting, which focused on advanced primary care team models. The meeting included presentations from the University of California, San Francisco (UCSF) Center for the Health Professions; Monarch HealthCare; and Southeast Health Center in San Francisco.

Advanced primary care models generally have similar features to patient-centered medical homes. Advanced primary care uses “a team approach, with the patient at the center. The care model emphasizes prevention, health information technology, care coordination, and shared decisionmaking among patients and their providers.”

**UCSF Center for the Health Professions**  [www.futurehealth.ucsf.edu](http://www.futurehealth.ucsf.edu)

**Who:** UCSF founded the Center for the Health Professions in 1992 to transform health care through workforce research and leadership development. The Center offers solutions to tough health care challenges through leadership programs, research, and consulting services.

**What:** With funding from the Hitachi Foundation, the UCSF Center for the Health Professions studied 14 organizations across the United States — four Federally Qualified Health Centers (FQHCs), three academic health systems, five integrated health systems, one stand-alone multispecialty care clinic, and one multispecialty medical group — to look at how each organization expanded the role of medical assistants (MAs) to improve patient outcomes, increase organizational efficiency, and enhance career opportunities for MAs. The programs each used one of three distinct models:

1. **Ambulatory intensive caring unit (A-ICU):** MA health coaches are assigned to patients with chronic conditions.

2. **Cross-trained MA team model:** Teams, with high MA-to-provider ratios, include cross-trained MAs who handle both nursing and clerical roles.

3. **Integrated multidisciplinary care team, or care coordination model:** MAs conduct daily hands-on clinical tasks, and nurses serve as care coordinators.

Each of these models requires an evolution in roles of care team members, as illustrated in the figure below.

**Changing Staff Perceptions about Roles**

<table>
<thead>
<tr>
<th>RNs</th>
<th>Providers</th>
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<tbody>
<tr>
<td>Nurses do not like other staff taking roles traditionally assumed by nurses.</td>
<td>We cannot afford to hire 40 RNs to do vital signs; RNs have enough experience and judgment to do the higher level stuff.</td>
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<tr>
<td>One of the biggest barriers . . . is giving up work to the team. You feel you need to be responsible for everything, but you need to realize that other people are capable of handling some of this work.</td>
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Source: Center for the Health Professions
Union Health Center (UHC) in New York City; High Plains Community Health Center (HPCHC) in Lamar, Colorado; and Southcentral Foundation in Anchorage, Alaska are three of the organizations studied by the Center to determine how they implemented advanced primary care team models.

**Union Health Center**

Union Health Center is an urban primary and multispecialty care center that each year sees 9,700 patients and has 68,000 patient visits. Its patient population consists of mostly non-White (87%), immigrant, low-wage workers. Most speak English as a second language, and 99% have incomes below 200% of the federal poverty level. UHC is a level three patient-centered medical home (PCMH) and has 140 staff members and providers.

UHC’s efforts to adopt a new staffing model were primarily motivated by rising costs associated with treating chronic disease, a changing patient mix, long patient wait times, and a move from fee-for-service to a capitated payment model. This environment, combined with new leadership, workflow redesign, and electronic health record (EHR) implementation, offered an opportunity for UHC to revamp its workforce model.

UHC implemented the A-ICU model and trained MAs as health coaches. A key component of UHC’s model is the use of teams, which typically consist of three providers, three MAs, two MAs/health coaches, one greeter, and one patient support services person. Team members huddle each morning to discuss patient cases and focus on how to facilitate and support patient self-management. The provider’s time is reserved for the patient’s clinical needs, and customized care protocols within the EHR templates help with task delegation.

UHC trains MAs as health coaches using an in-house curriculum that involves didactic instruction, written competency exams, and clinical shadowing. The trainers include a senior RN administrator and a dietician, and the training consists of two hours on-site every week for nine months. A defined career ladder for MAs has been established; those who pass all modules of the training are eligible for promotion. Providers are included in the competency evaluation, enhancing provider buy-in.

Results from UHC:

- Visit cycle times (time from entry to exit) have been reduced from just over 2 hours to just under 50 minutes.
- Improved chronic disease outcomes: Patients with all three markers (HbA1c, blood pressure, and cholesterol) under control increased from 13% to 36%.
- Reduced costs: Patients at UHC cost 17% less per member per month compared to patients who are union members who receive care elsewhere.
- MAs have been promoted to new positions of health coaches and floor coordinators, accompanied by a 12% to 27% pay boost.

**High Plains Community Health Center**

High Plains Community Health Center is an FQHC in a rural, mostly agricultural community and is a level three PCMH. Of its 8,000 patients, 75% are low-income and 33% are uninsured. Sixty-five percent of its patient population is White and 35% is Latino. HPCHC has a staff of 60, including 7 providers, 21 patient facilitators, and 4 to 5 health coaches. HPCHC also provides dental, mental health, and onsite pharmacy services.

At HPCHC, wait times were long, staff members were dissatisfied and their productivity was declining, and it was difficult to recruit and retain RN staff. To address these issues, HPCHC implemented an MA-team model, which included increasing the MA-to-provider ratio to 3:1 and offering robust training to MAs. At the beginning, MAs were involved in primary care workflow redesign initiatives; later MAs were offered training. They rotate through the front and back offices, and work for one week in medical records, two weeks in a clinical rotation, and occasionally rotate to reception. MAs are given opportunities to advance to positions such as health coach, patient navigator, and community health worker.
HPCHC staff embrace the idea of moving the care, not the patient: MAs take co-pays, conduct tests, and print visit summaries in the exam room. This approach also relies heavily on the use of technology, including EHRs, wireless tablets, walkie-talkies, and telemedicine.

HPCHC offers on-site and online training for staff. At one site, in addition to a four-day staff training, the redesign team spent about eight hours a week during an eight-week period meeting with staff and helping them implement small changes through a “plan-do-study-act” process.

Results from HPCHC:

- Reduced wait times for patients
- Increased provider productivity (from 1.82 patients per hour in 2000 to 2.7 per hour in 2003)*
- Professional opportunities for MAs, including new roles as health coaches (who earn approximately 42% more than MAs), community health workers, pharmacy technicians, and limited-license radiology technicians
- Savings of a minimum of $44,649 per team per year

Southcentral Foundation

Southcentral Foundation, a Native Alaskan-owned health care organization, is affiliated with the Alaskan Native Medical Center. It is a level three PCMH and has approximately 1,400 staff, including 240 providers, 100 certified MAs and licensed practical nurses, and 360 clerical staff. Southcentral serves approximately 55,000 patients, referred to as “customer-owners,” who are primarily Alaskan Native and American Indian residents from south-central Alaska, including 10,000 patients from remote villages.

Southcentral had long wait times, low levels of satisfaction among patients and staff, high employee turnover, a lack of consistency in providers for patients, and a reputation as “health care of last resort.” To address these issues, a coordinated care team model was implemented. In each of Southcentral’s six clinics, six teams were established, with each team consisting of one provider, one RN care manager, one clerical support staff member, and one MA. A behaviorist and a dietician support several teams in one clinic. Within these teams, RNs are responsible for panel management, prevention, and chronic disease management, and MAs are responsible for daily clinic tasks. There is administrative support for case management, and MA supervisors are responsible for scheduling MA workflow.

Co-location, or having staff all in one location, is an important component of Southcentral’s model; care teams share an open table instead of having private offices. Other keys to this model’s success include scheduling that allows for same-day appointments, and a relational model of care in which long-term relationships — often across generations — are built with individuals, families, and the community. Southcentral has also established a staff development center, in which staff and providers serve as faculty, to provide skill-specific trainings and educational advancement opportunities for employees.

Results from Southcentral:

- Decrease in total staff turnover from 29% in 2008 to 15% in 2011
- Increase in staff satisfaction (from 2005 to 2009)*
- 50% decrease in emergency department and urgent care visits (from 1998 to 2006)*
- 53% decrease in hospital admissions and days (from 1998 to 2006)*
- Increase in HbA1c screenings from 78% to 92% (from 1998 to 2006)*
- Increase in childhood immunizations from 80% to 93% (from 1998 to 2006)*

* most recent data available.
Monarch HealthCare  www.monarchhealthcare.com

Who: Recently acquired by OPTUMHealth, Monarch is the largest independent practice association (IPA) in Orange County, California. Monarch's 2,500 physicians care for more than 200,000 managed care and Medicare accountable care organization (ACO) patients. Monarch's physician network includes 500 primary care physicians (PCPs), 1,500 specialists, 30 employed hospitalists, and 70 employed PCPs/specialists. Its member network includes 80,000 commercial, 38,000 Medicare Advantage, 30,000 MediCal, and 16,000 ACO patients. The organization contracts with most major health plans in California and has relationships with most Orange County hospitals.

What: To address PCP work overload, improve care quality and patient access, and reduce waste within the system, Monarch implemented a program to change the role of MAs and create a team-based care model that is designed to be patient-centered, interdisciplinary, data-driven, standardized, and sustainable. In doing so, Monarch faced particular challenges, including covering a large geographic region, and providing services that would be valuable to the many small provider sites that are part of the IPA, but that have limited interaction with Monarch.

Monarch increased the role of the MA across the pre- and post-visit continuum, including participation in daily pre-visit team huddles to discuss patients. Monarch broke the patient visit into three domains — before, during, and after — and solicited input from team members about important tasks in each. Based on this feedback, a workflow was designed that emphasizes planning for and managing all aspects of the visit.

Advanced Primary Care Flow Standards

Before Visit
- Schedule visits 20 minutes before seen by doctor
- Pre-visit planning 1-2 weeks before visit
- 5-minute daily huddle

During Visit
- Check-in script
- Rooming checklist
- Use patient profile during provider visit

After Visit
- Check-out with patient plan in hand
- Referral follow-up
- Care coordination between visits

“On a day-to-day basis, doctors don’t think about population management; they focus on fixing the problem in front of them.”

To help with care coordination between visits, Monarch established physician-facilitated patient care conferences (PCCs) that are attended by virtual care teams, allowing providers who are scattered across a large geographic region to participate. Patients discussed during these conferences are identified through predictive modeling and by referral from the PCP. During conferences, care providers and front-line staff coordinate with staff from other disciplines as needed, address diagnostic and management challenges, and address quality gaps such as overdue screenings or immunizations. PCCs take place on-site or over the phone, involve a facilitation guide, and require a specific agenda.

Between January and July 2013, Monarch’s PCC model was piloted in five employed practices, and subsequently spread to two IPA primary care offices. In this period, 27 PCCs have been conducted and intervention has been provided for more than 270 high-risk patients. Preliminary data show a slight decrease in inpatient admissions and emergency department visits.
Southeast Health Center [www.sfdph.org]

**Who:** Southeast Health Center (SEHC), located in the Bayview-Hunters Point district of San Francisco, is a full-service community health center and part of the Community Health Network of the San Francisco Department of Public Health. SEHC focuses on family practice, but also provides dental and mental health services for patients of all ages.

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**Workflow Redesign**

**The Old Way... Traditional Method**

- Preventive Medical Intervention
- Chronic Disease Monitoring
- Medication Refill
- New Acute Complaint
- Test Results

**Provider**

- Health Care Support Team
- Case Manager
- Mental Health Provider
- Referral to Specialist After Assessment
- Certified Medical Assistant

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**A Better Way... Parallel Structure**

- Medication Refill
- Test Results
- Acute Mental Health Complaint
- Chronic Disease Compliance Barriers

- Chronic Disease Monitoring
- New Acute Complaint
- Preventive Medical Intervention
- Point of Care Testing

**Provider**

- Health Care Support Team
- Case Manager
- Certified Medical Assistant
- Behavioral Health Consultant

Adapted from Southeast Health Center
What: SEHC provides care to a community whose residents have life expectancies that are an average of 14 years less than their counterparts in more affluent San Francisco neighborhoods such as Russian Hill. To address these health disparities and to provide better care to its patients, SEHC established organizational goals:

- Limit the panel size to 1,200 patients per FTE
- Increase productivity to nine patients per session per provider (two sessions per day, with four providers per session)
- Reduce cycle time to less than 45 minutes
- Maintain no-show rate of less than 10%
- Improve quality and patient satisfaction measures

To help achieve these goals, SEHC moved from traditional methods of managing workflow, in which the process revolved around the provider, to a parallel workflow model focused on team-based care (see figure on page 5). SEHC began with team-based diabetes care. Using an approach taught by Coleman Associates for clinic redesign, SEHC expanded their teamlets into more robust teams that include behavioral health clinicians, an RN, and front-desk staff. This model is based on the following key principles: having people work to the height of their licenses, developing long-term relationships with patients, providing team-based care that is not physician-directed, spreading and standardizing practices across the clinic, and reducing variation. Constant communication, feedback, and continual improvement have been critical to SEHC’s success.

Quick Takes

- It is difficult to determine the optimal mix of members on a care team. Most organizations agree that the equation includes: available workforce resources in your community, needs of your patient population, and payment (or reimbursement) realities.

- Organizations that have been successful in evolving to true team-based care typically have consistent leadership support, MA-to-provider ratios that are greater than 1:1, physician involvement in the training of MAs and other team members, team members who are cross-trained to ensure coverage, and access to an EHR and other technology-based tools.

- MAs often want opportunities to develop professionally and to expand their roles, but they need the organizational systems and structure in place to allow them do more, such as time for on-site training and a defined career ladder.

- Finding time to train MAs can be challenging: trainings outside of work hours are often not well-attended. Although trainings during work hours require pulling MAs away from patient care, most organizations have found this the best option.

- Physicians are traditionally trained to be autonomous and are taught a hierarchical model of care, ideology that runs contrary to team-based care. Engaging providers in the development of new team roles can improve provider buy-in, as provider trust in MAs is a critical component to the success of team-based care.

- Staff training and professional development opportunities often lead to increased staff retention.

- Co-location of team members — in one room rather than in private offices — enhances team identification and communication, and also allows for continuous huddling throughout the day.

- Team-based care models are in place, but many existing payment models do not reimburse for care and support that occurs outside of office visits or that is not provided by a licensed provider. Payment reform, however, is facilitating this transition.

- Incentives can fuel motivation for all team members, including office staff.
Asked and Answered!

**How do you manage patients’ expectations about the increased role of the MA?**

- During the role transition, MAs need time to develop a relationship with the patient. MAs are often able to perform tasks that physicians did not have time for, so patients may be getting more attention and education than before the role transition.

- Providers and other team members should focus on patient needs and not get boxed in by traditional roles. More than two team members can be in the room at the same time, and providers can get patients from the waiting room.

- Ask patients what they think and how they would like to receive communications about changes in team roles. After speaking with patients, one organization found no resistance to MAs taking on a larger role.

- Set patient expectations so they understand that their appointment will begin with the MA.

- Physicians should demonstrate their trust of the entire care team to the patient.

**How are organizations developing team-based care?**

- CIN partner organizations are at various stages of shifting to team-based care models. Most started by expanding the role of the MA and developing an MA-provider teamlet, and moved to redefining the roles of nurses and frontline staff as core members of the care team. One organization restructured its staff by offering primary care redesign collaboratives that emphasized the roles of the MA and front desk staff as care providers on the team.

- Ambulatory settings may learn from the culture of inpatient settings, which have traditionally been more team-focused.

**How are you hiring and training MAs in these new care teams?**

- Look for soft skills such as the ability to communicate, working well with team members, and a proactive approach to customer service. Use case-based interview questions that ask candidates how they would handle specific patient and team interactions.

- Involve high performing team members from all disciplines in the interview process.

- Most MAs programs do not teach team-based care models; much of this training will take place on the job, and time should be carved out during the day for it. Set aside time for an initial training period.

**Online Resources**

Medical Assistants in California: Legal Scope of Practice

Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care
[futurehealth.ucsf.edu/LinkClick.aspx?fileticket=twQv21HRSgc%3d&amp;tabid=37](futurehealth.ucsf.edu/LinkClick.aspx?fileticket=twQv21HRSgc%3d&amp;tabid=37)

California Improvement Network Resources
[www.chcf.org/california-improvement-network/resources](www.chcf.org/california-improvement-network/resources)

**Endnotes**


2. For more on consulting firm Coleman Associates' clinic redesign model, visit [www.patientvisitredesign.com](www.patientvisitredesign.com).