DFD Russell Health Centers: Update 2014

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ABSTRACT

DFD Russell Medical Centers in rural central Maine involve medical assistants in quality improvement efforts through a) engaging them in small-scale testing and refinement of practice improvements (Plan-Do-Study-Act cycles, or PDSAs), b) providing them with periodic reports on quality measures directly related to their individual performances, and c) paying annual individual-level bonuses for achieving quality goals in patient care. MA team leaders assist in coaching MAs to follow protocols and meet quality standards. This 2014 summary updates the original 2011 case study with new information on staffing, clinical outcomes, reimbursement, and more.

For many decades the small town of Leeds, Maine, and its surrounding area in rural Androscoggin County was served by just one physician, Dr. Daniel Frank Davis Russell (1879–1975). A country doctor who made house calls, D. F. D. Russell was an indispensable part of the local community.

After his death in 1975, a public/private partnership was formed to start a clinic in the basement of the Leeds Community Church. Today, DFD Russell Medical Center (DFD) is a Federally Qualified Community Health Center (FQHC) with three clinics located in rural central Maine.

DFD's 11 providers now see most of their patients on-site in the clinics. Unlike the lone country doctor of D. F. D. Russell's era, today's providers have a team of support staff to assist in providing comprehensive care to the local community.

DFD's main Leeds facility is situated on a quiet country road surrounded by woods and fields, an old Grange hall, and a few farms. The countryside is beautiful, but the rural location imparts challenges. Many patients face problems with depression, substance abuse, and family dysfunction as a result of isolation and chronic disease. Transportation is particularly difficult for patients who are low-income and would have difficulty receiving services

Practice Profile

Name: DFD Russell Medical Centers

Type: Federally Qualified Health Center

Location: Leeds, Turner, and Monmouth, Maine

Staffing: 48.47 FTE, including

- 11 providers:
  - 5 physicians (MDs)
  - 2 nurse practitioners (NPs)
  - 4 physician assistants (PAs)
- 3 behavioral health providers
- 3 nurse care managers
- 1 access nurse (RN)
- 22 medical assistants (MAs)
- 1 patient assistance coordinator

Number of Patients: 10,000

Annual Patient Visits: 30,000

Patient Demographics: Most patients are from the surrounding area. About 16% of patients are seniors, and most are Caucasian, reflecting local demographics. Nearly a quarter (23%) have incomes below the federal poverty level, and 20% receive Medicaid.

Figure 1. The original site of the DFD Russell Medical Center

elsewhere due to the low reimbursement rates associated with Medicaid.

In order to provide better access to its dispersed rural population, the organization developed two additional clinics in other towns rather than expand its primary site at Leeds. It also began to explore new technology and care models to meet the needs of its patient population.

The Chronic Care Model

In 2000, DFD was one of the first health centers in Maine to implement an electronic health record (EHR). The introduction of the EHR enabled the organization to track patients and outcomes over time and made it possible for DFD to participate in the Health Resources and Services Agency's (HRSA) Health Disparities Collaboratives. The Collaboratives initiative supports federally funded health centers in adopting the "Chronic Care Model" to improve care for underserved populations. The chronic care model addresses the needs of the many Americans with ongoing chronic conditions that "require constant adjustment on the part of the patient and ongoing interactions with the health care system." The chronic care model recognizes that treating these conditions requires a different approach to health care provision, including patient self-management support, evidence-based decision support, clinical information systems to monitor outcomes, delivery system redesign (including team -based care), and community partnerships, including providing patients with linkages to community resources.

DFD first participated in the HRSA Depression Collaborative in 2004. Staff learned to use a method of piloting innovation called the Plan-Do-Study-Act (PDSA) cycle. This is a structured method of running small-scale tests by planning a workflow change, observing the results, and acting on what is learned. DFD hired several behavioral health specialists and used the PDSA cycle to develop a depression-screening protocol and a depression registry and to implement a depression-tracking tool in the EHR.

In 2005, DFD participated in HRSA's Diabetes Collaborative and integrated what it had learned into this new initiative. The team leveraged its EHR to serve as a decision support tool as well as a reporting tool, an arrangement that allows the standardization of protocols and the delegation of routine clinical tasks to nonprovider staff, especially MAs. The Chronic Care Model became the framework for all care delivery at DFD Russell Medical Centers.

The Chronic Care Model in Practice

Located in a nursing shortage area, DFD has always depended on its MAs to support providers in patient care. Prior to 2005, the MA role at DFD was fairly traditional. However, from 2005 onward, MAs have become a more integral part of the team as they have learned new skills and become involved in workflow decision making through testing workflow options using the PDSA cycle.

When DFD adopted the Chronic Care Model, the organization began pairing providers and MAs rather than allowing MAs to work with any provider who needed their assistance. Stable "teamlets" provided continuity for patients and allowed greater accountability in documenting individual staff contributions to patient-outcome measures.

Teamlets include one or two MAs assigned to one provider. Nurse care managers, the patient assistance coordinator, and several behavioral health specialists provide additional support.

The clinic has MAs work at the top of their license and has developed a number of standing orders for

medical assistants. In addition to rooming patients, taking vital signs, giving immunizations, and performing other traditional medical-assisting tasks, MAs use protocols and scripted screenings to check smoking status and monitor chronic conditions such as diabetes. They conduct the diabetic foot check and hemoglobin A1C tests and set up diabetic eye exams for patients. The Leeds center also has a CLIA-waived lab. A lab manager supervises the lab and trains the MAs to draw blood and conduct a limited number of lab tests. MAs do limited medication reconciliation with patients by reviewing and updating their medication list, preparing it for the provider to review. The MAs also administer the PHQ9 screening test at least once a year to patients age15 and older. This survey instrument helps check for depression and monitor its severity. MAs notify a provider if a patient receives a high score on the PHQ9 test. DFD has arranged its primary care and behavioral health appointment schedule so that providers can usually accomplish a "warm handoff," in which the primary care provider introduces the patient to the behavioral health specialist for immediate consultation.

Engaging patients in their own care through setting self-management goals is part of the chronic care model. Working from protocols developed for different conditions, MAs utilize motivational interviewing (MI) techniques to set and discuss patients' health goals and ways in which DFD can help the patients achieve these goals. The self-management goals and progress toward meeting them are documented in the EHR.

MAs may rotate through three distinct roles. At the time this case study was written in 2011, many MAs spent two days working with the providers "on the floor" and two days working in DFD's call center, the "Telebank," which was established in 1999 at the Leeds Clinic. The Telebank system was adopted to relieve the front desk from distractions, to keep the patient waiting area quiet and calm, and to improve communication between patients and the providers by having the MAs field and document patient calls. DFD adopted this system after patients had complained that off-site answering service operators did not know their names or understand their issues.

Outgoing calls are typically made to the patients in the MA's provider's panel. MAs handle more than 800 incoming calls per day for all three DFD sites. Providers answer after-hours calls themselves. MAs working in the Telebank review the on-call doctors' messages, document them in the patient's chart, and send them to the patient's provider for review.

As of 2013, DFD MAs have been cross-trained to cover the front desk, and most of the clerical staff have been cross-trained as medical assistants. It took six months to cross-train incumbent staff into their new roles.[1] This move created more flexibility in staffing because on busy days in the clinic, front desk staff can be pulled back to help with clinic flow or the Telebank.

Training and Performance Evaluation

There is a six- to eight-week orientation period for new employees in which new MAs are mentored by a senior MA and evaluated. After an MA has successfully completed this training period, there is a pay raise to reflect the MA's acquired skills and knowledge. MAs are also provided ongoing training at monthly staff meetings that include a breakout for clinical sessions. The team leaders meet with the MAs twice a month to go over protocols, reminders, and work-related issues. Annual MI trainings and monthly MI circles with the on-staff Licensed Clinical Social Worker (LCSW) keep everyone current.

MAs undergo an annual evaluation based on an observation of their clinical skills and a review of their individual scores on a number of quality measures. The director of clinical quality observes and scores each MA's technique with patients, including taking and documenting vital signs, working with the patient to set self-management goals, explaining the PHQ9, reviewing medications and risk factors, and documenting accurately. The laboratory technician observes and scores MAs in

[1] A few clerical staff declined cross-training due to discomfort with medical tasks.

conducting blood draws. The director of clinical quality reviews with each MA her or his individual scores on a number of quality metrics, including the MA's success at screening patients for various chronic conditions and risk factors and follow-up on exams and tests. Scores are compared with organization-wide averages and overall quality goals. Evaluations allow managers to assess training needs and are the basis for annual quality bonuses.

Challenges and Solutions

Providers initially disliked being paired with a consistent team of MAs. They wanted to pick and choose their favorite MAs from among those on the floor each day. Senior management worked to pair providers with MAs whom they thought would be a good match for them.

Pairing MAs with a single provider and adopting quality-improvement goals increased accountability. Monthly reports on outcome measures that are both organization-wide and team-specific helped MAs see their impact on patient care. A few MAs who could not meet the new quality standards were let go. MAs now strive to meet quality standards and prove themselves valuable members of the team.

DFD's expansion from one to three clinic sites created a challenge for management. To address this challenge, DFD promoted some experienced MAs to serve as team leaders, one at each site. Team leaders were selected based on the MAs' leadership skills and excellence in quality outcomes. Lead MAs were responsible for delegation of workflow and communications with administration.

However, ongoing status conflict among MAs led to the discontinuation of this position. As one administrator noted, the lead MAs had a lot of responsibility but no authority. As of 2013, the sites are now managed by administrators rather than by lead MAs, an arrangement that has improved morale.

Some providers had difficulty delegating patient care responsibilities to RNs, MAs, and behavioral health specialists. DFD instituted morning huddles in which the entire office meets to discuss the day's schedule and patient needs. The huddles helped enhance trust and communication among staff and providers, making it easier for providers to let go of some tasks.

> One of the biggest barriers for physicians 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.
>
> *-John Yindra, MD, Medical Director-*

Outcomes

DFD has had no turnover among MAs since 2010. Most of the existing staff have been with DFD for five or more years. Continuity is important for patients, who appreciate seeing the same providers and MAs over the years. However, DFD has recently lost some long-term providers, largely due to retirement.

DFD has been successful in achieving and surpassing national goals for diabetes and cardiovascular disease (CVD) care. In 2012, all eligible DFD providers achieved National Committee for Quality Assurance (NCQA) recognition through the Heart/Stroke Recognition Program (HSRP) and the Diabetes Recognition Program (DRP). One particular measure directly attributable to the MA incentive plan is the rate of childhood immunizations for children from birth to two years of age. When a reporting tool for this measure was added to the EHR so that MAs could track immunizations on their provider's panel, rates improved from 57% in July 2010 to 100% in April 2011. Since this time, DFD has maintained rates of 100%.

MA Career Impacts

In 2008, administrators developed an MA incentive plan based on quality goals MAs directly impact. If MAs score well, they receive a tiered annual bonus of several hundred dollars. The quality measures serve as a motivator, in part because of the cash bonus, but also because the employee can see and improve his/her individual impact on trends throughout the year.

MAs were pleased to have a role in quality improvement initiatives and in improving patient care. They noted that they had a voice in clinic operations, which they appreciated.

While the team leader position, which entailed a pay increase and promotion, was discontinued, DFD provides other advancement opportunities including tuition reimbursement and flex time to attend nursing school, and management opportunities at the LPN or RN level.

Moving Forward

Because of the way Maine has moved to implement the Affordable Care Act, DFD Russell has lost rather than gained patients. Instead of expanding Medicaid, Maine has rolled back eligibility from 133% of poverty level to 100%, and no longer provides a waiver for adults without children.

DFD has purchased a property that abuts Monmouth and will be ready to open a new health center if it appears there is growing demand.

Conclusions

As a small organization with a stable, long-term staff, DFD has limited options for career steps. However, it has instituted an evidence-based evaluation and incentive program to reward MAs for their individual contributions to patient care.

DFD Russell's participation in Maine's Patient-centered Medical Home (PCMH) initiative has propelled it to continue to develop workflow and technology to meet patient needs. The health center has achieved Level 3 PCMH recognition from the National Committee on Quality Improvement (NCQA).

Acknowledgments

Innovative Workforce Models in Health Care is a series of case studies showcasing primary care practices that are expanding the roles of medical assistants in innovative ways. Profiled organizations are implementing practice models that improve organizational viability and quality of care for patients while providing career development opportunities to frontline employees. This research is funded by the Hitachi Foundation as part of its Pioneer Employers Initiative.

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To read the full 2011 case study, please see:
DFD Russell Medical Centers—Engaging Medical Assistants in Quality Improvement Efforts

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