

# High Plains Community Health Center— Redesign Expands Medical Assistant Roles

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## ABSTRACT

A rural Federally Qualified Health Center in Colorado redesigned its workflow to increase productivity by increasing the number of support staff per provider. Medical Assistants (MAs) are cross-trained to rotate through front and back office roles in a team-based model. MAs are given a number of opportunities for training and advancement within the MA role, and may advance to positions such as Health Coach, Patient Navigator and Community Health Worker. This initiative not only increased productivity but produced cost-savings for the organization as well as a number of other beneficial outcomes for patients and staff.

## Inspiration & Background

High Plains Community Health Center (High Plains) is located in the small town of Lamar in Prowers County, Colorado. Prowers County is largely rural, with just eight people per square mile. The town of Lamar is surrounded by rolling plains, fields of corn, alfalfa and wheat, and cattle ranches. Prior to 1995, the county's population of 14,000 was served by just two primary care physicians.<sup>i</sup>

High Plains opened in 1995 as the result of a volunteer effort to address the lack of health care in the area. Because of the high demand, High Plains expanded rapidly to include dental and behavioral health and an onsite pharmacy as well as basic primary care services.

However, productivity was not keeping pace with demand. By 2001, patient wait times were long, productivity was low, and the organization was starting to face financial difficulties. This situation was exacerbated by tension between front and back office staff over roles and responsibilities. As one administrator noted, "We were just struggling to break even."

In 2002 in response to this situation, High Plains administration, with the support of its Board, sought

## Practice Profile

**Name:** High Plains Community Health Center

**Type:** Federally Qualified Health Center

**Location:** 5 sites based in rural southeastern Colorado: Main medical site in Lamar, CO.

**Staffing:** 60 staff and providers, including

- 7 medical providers (3 MDs, 3 NPs, 1 PA)
- 21 medical patient facilitators
- 11 Outreach/Education staff, including 4 health coaches
- 14 dental office staff, including 2 dentists and 9 dental patient facilitators
- 1 onsite mental health clinician
- 9 administrative/fiscal/billing staff

**Number of Patients:** 8,000

**Number of Patient Visits:** 30,000

**Patient Demographics:** Approximately 75% of patients qualify as low-income, and 33% are uninsured. Sixty-five percent (65%) of patients are White non-Hispanic, and 35% are Hispanic.

and received funding to participate in a Patient Visit Redesign Collaborative sponsored by the federal Health Resources and Services Administration (HRSA). This entailed a radical revision of roles in the office, resulting in a largely MA-driven support staff.

### **Patient Visit Redesign**

The goals of the HRSA sponsored Patient Visit Redesign Collaboratives are to:

1. Reduce the amount of time patients spend in the health center while simultaneously maintaining or enhancing the amount of quality interaction with staff.
2. Reduce costs by increasing provider and staff productivity.
3. Increase productivity by reducing rework, eliminating waste, and simplifying the system.<sup>ii</sup>

High Plains was coached by HRSA consultants Coleman Associates to select a redesign team from amongst existing staff and develop a plan. The team determined that increasing productivity would include shifting as many support tasks as possible from the clinical provider (MD, NP or PA) to less expensive staff, who were to be cross-trained to perform numerous roles in a team-based model of care.

The team developed and piloted a new model including three support staff to every provider with the goal of seeing 90% of all patients in 30 minutes or less. In their pilot tests, the team was able to nearly double their productivity, achieving an average of 3.5 patients per provider per hour.

As a result of their success, High Plains took this model organization-wide. Because of the number of support staff needed to implement this initiative, the decision was made to use medical assistants rather than nursing staff to keep costs down.

All front office and back office support staff were cross-trained and given the title of patient facilitator (PF). High Plains no longer has roles such as receptionist, medical record clerk, medical assistant, licensed practical nurse, or registered nurse. Staff rotates through the various roles, performing all tasks such as processing medical records, answering phones, greeting patients, triage and clinical support-

related tasks. As required under Colorado laws, clinical providers supervise and authorize the delegation of these tasks

In 2008, High Plains implemented electronic dental and medical records and became part of the Safety Net Medical Home Initiative demonstration project, which is sponsored by the Commonwealth Fund, Qualis Health and the MacColl Institute for Healthcare Innovation. In 2009 and 2010 High Plains received a number of grants addressing chronic disease management and health disparities, which allowed them to hire four health coaches, a patient navigator and a community health worker. These initiatives expanded promotional and training opportunities for patient facilitators.

“Colorado is recognized as the healthiest state in the nation. However, the area in which High Plains is located has the worst disparities in the state in terms of health indicators such as incidence of obesity, diabetes and cardiovascular disease. Our goal in all of the things we do is to make this area look more like the rest of Colorado. Then we will have made a difference.”

*-Jay Brooke, Executive Director-*

### **Training**

In 2002, members of the initial High Plains redesign team took part in consultant-led training to learn how to implement workflow changes. Key staff came up with ideas individualized to their site, including developing the “Plan-Do-Study-Act” cycle.<sup>iii</sup>

The team adopted a philosophy of “hire for attitude, train for skills”. They decided that it was more important for patient facilitators to have good customer service skills to fit the patient-centered model than to have medical training or certification, which they could offer onsite.

Ongoing patient facilitator training is integrated into working hours. There is a formal one-hour training held every Tuesday conducted by provider staff or by the registered dietitian. Topics include workflow, the Health Insurance Portability and Accountability Act, and medical terminology.

New hires receive a competency check-off list of skills and knowledge they need to acquire, which is reviewed and initialed by a supervisor as they move through the training. A new patient facilitator attends the weekly trainings with the other patient facilitators and works one-on-one with providers and supervisors to learn skills and may shadow more experienced patient facilitators.

Patient facilitators take part in ongoing station training in which they are asked to demonstrate their skills and competency via hands-on activities such as placing EKG leads and placing and removing casts. Patient facilitators are tested in each area and surveyed to test their comfort level in performing each activity so that supervisors can identify additional training that may be needed. It takes three to six months for a new patient facilitator to be fully trained into the position.

High Plains is also a certified healthcare training institution for the Certified Clinical Medical Assistant credential offered through the National Healthcareer Association and has an approved eight-week formal curriculum. Employees that have completed one year at High Plains are eligible to register to take a three-hour exam to receive the CCMA credential. High Plains provides a three-week study group, mock tests, and review. The organization has an approved proctor and can offer the exam onsite. While this training is currently on-hold due to lack of provider time to teach the courses, a number of patient facilitators have received their CCMA certification at the clinic.

High Plains makes additional training and promotional opportunities open to staff. For instance, several patient facilitators took a consultant-led course to become certified as limited-license radiology technicians. Three patient facilitators also took a correspondence course to become pharmacy technicians in order to run the in-house pharmacy. Finally, a number of staff members are taking beginning Spanish classes offered onsite via an instructor or teleconference. High Plains is paying

for the instructor although employees participate on their own time.

**Health Coaches:** High Plains currently has four Health Coaches. Much of the onsite training for this position is conducted by the staff dietitian, and includes information on diseases, symptoms, outcomes, nutrition, physical activity, motivational interviewing, self management, and connecting to resources. Health coaches also received formal health educator training in Denver, and a 16-hour motivational interviewing course taught in-town at the Lamar Cultural Events Center.<sup>v</sup> Health coaches may receive in-person or online training in leadership, cultural competency, SBIRT (Screening, Brief Intervention, and Referral) and other topics.<sup>iv</sup> Finally, the two health coaches for the health disparities program have participated in a five-week interpreter training course.

The on-site training of patient facilitators may have an additional practical component beyond the ability to select for attitude and customer service skills and customize training to fit the organization's needs. High Plains is in a relatively remote section of the state and the local community college does not have programs in medical assisting, radiology, or pharmacy, perhaps requiring a "grow your own" approach to staffing.

## Redesign in Practice

Most non-licensed staff at High Plains start as patient facilitators. Patient facilitators receive ongoing training and opportunities for advancement through expanding their skills as patient facilitators or through promotion to other positions within the organization.

When a position offering higher pay and responsibility opens up, it is offered in-house first. There are a number of positions filled by former patient facilitators, including health coach, community health worker, patient navigator, and a now defunct team leader position, which has been replaced by quality improvement coordinator and medical operations supervisor, both filled by former patient facilitators.

**Patient Facilitators:** There are seven teams, each comprised of one provider and three patient facilitators. The patient facilitators rotate through all responsibilities. Each patient facilitator puts in two

weeks on the floor with the provider and a third week working in medical records before returning to the floor again. Patient facilitators may also be called upon to serve as greeters and front desk reception.

These teams are static so patients become familiar with the patient facilitators associated with their provider. High Plains has largely done away with their phone tree—any patient facilitator associated with the provider can answer patient calls and can get answers for patients' questions. The office is wireless, so the patient facilitators have access to patient records via laptop computers they carry with them throughout the day. Because of this, any patient facilitator can look up information for patients. The patient might need a call back only if there is difficulty scheduling an appointment.

High Plains tries to provide all patient care in one room instead of moving the patient from room to room, adhering to the policy "Organize your work around the patient rather than organizing the patient around your work." Interviewees report that this makes for better customer service. Not only are medical procedures and tests such as EKGs, blood draws and injections performed in the exam room—the patient facilitator also collects the co-pay and insurance information in the exam room. However, the facilitator does not stay in the room through the visit.

"When I was a patient facilitator, I applied for several positions here...I applied for team leader, I got that... Later there was a posting for a community health worker, and I did that. Then there was a posting for health coach in August, so that is what I do now...It does feel like there are other opportunities here; there is always room for growth."

*-Miriam Chavira, Health Coach-*

Patient facilitators do "more than assisting patients with their medical needs." They schedule appointments, greet patients at the front door, provide information about insurance coverage and

co-pays, facilitate specialist referrals, refer patients to lab tests, report the results of lab tests to patients, take triage calls, and assist the patient in accessing community resources.

**Patient Navigator:** The patient navigator is a part of High Plains' health disparities collaborative team. The patient navigator is responsible for calling patients in the registry and helping them gain access to care by scheduling appointments and assisting them with insurance and transportation issues.

**Community Health Worker:** The community health worker provides comprehensive cardiovascular disease (CVD) risk factor and diabetes education at local venues such as community centers, barbershops, worksites, and churches. At-risk individuals receive case management to ensure entry into health care and/or lifestyle modification programs and retesting at six-to-twelve months to document health improvement.

**Health Coaches:** There are currently four health coaches on staff. A patient might be assigned to a health coach if he or she has a chronic disease such as diabetes or heart disease. The provider identifies the patient and meets with the health coach to determine what to cover with the patient and how. There is roughly one health coach for every three providers. All of the health coaches are also cross-trained as patient facilitators and may work in that capacity as needed. As noted earlier, High Plains prefers to promote from within partially because internal hires already know the clinic and its patients. Two of the health coaches were internal hires or promotions.

A health coach might see seven patients a day as well as taking and making phone calls. There is also a weight loss program Thursday nights from 5-7 pm. Patients can come in and get weighed and follow up with a health coach. This is held in conjunction with a Thursday night late clinic.

Health coaches meet with the patient to develop an action plan for that patient's self-management goals, including healthy eating, active living and disease prevention. Health coaches work to refer patients as needed to clinic and community resources to assist the patient in achieving their health goals and develop a follow up plan with them. The health coach utilizes motivational interviewing during all

patient interactions. Both of the health disparities coaches speak Spanish and can serve as interpreters and translators and provide culturally and linguistically competent care to Hispanic patients.

High Plains offers a number of free health classes in English and Spanish for the community, some of which are taught by the dietitian and a nurse practitioner who is a certified diabetes educator, while others are taught or co-taught by the health coaches, community health worker and/or patient navigator. Classes are a collaborative effort amongst staff. For instance, providers may encourage patients to attend, patient facilitators often tell patients about classes and register them for the class in the electronic health record system, and health coaches work to connect all patients to the resources they need to work on their goals which often times includes classes.

## Resources

**Financing:** In 2001, High Plains received a HRSA grant to take part in the Patient Visit Redesign Collaborative in order to revise the way it scheduled patients and employed staff. The grant paid for planning time and training to implement the reengineering of workflow processes. Participant organizations were required to spend approximately \$5,000-6,000 to send staff to training sessions. This process resulted in the current configuration of staffing with a high ratio of support staff (patient facilitators) to provider. All patient facilitators are salaried and paid through the organization's regular operating budget.

In 2009, High Plains received a three-year HRSA grant for Rural Health Outreach to “reduce obesity and chronic diseases by promoting good nutrition and increased physical activity for all Prowers County residents.”<sup>vi</sup> This grant of approximately \$333,000 dollars over three years includes funding to cover the costs of health coaches and training for these staff members.

In 2010, High Plains received a two-year grant of approximately \$290,260 from the Colorado Office of Health Disparities for participation in a Health Disparities Collaborative. This grant funds the positions of health disparities coaches and patient navigator. High Plains also received a one-year grant from the Colorado Department of Public Health

and the Environment for the community health worker position.

Grant funding also covers the positions of quality improvement coordinator, nutritionist, and X-ray technician.

**Training Resources:** Part of the initial training was paid out of the grant funding, and part was paid out of the general operating costs.

Formal education or training takes about one hour per week of the time of the health coaches and a leading provider. However, it is more difficult to quantify the informal training conducted by providers and other staff on a daily basis.

Grants pay for specialized training for health coaches, community health worker and patient navigator.

## Challenges

Major challenges include recruiting and retaining appropriate providers, soliciting provider buy-in to this model, gaining staff acceptance of new roles and models of care, and ensuring sustainability of staff positions required to provide comprehensive preventative and self-management services.

**Providers:** It is difficult to find enough clinical providers (medical doctors and nurse practitioners) willing to relocate to rural Colorado. Many of the providers who work at the clinic only stay for two years or long enough to qualify for HRSA's National Health Service Corps Loan Repayment.

This rapid turnover is difficult because the organization has tried to build a team ethic. Patient facilitators have to re-learn the requirements of each new provider. The turnover disrupts continuity of care and can distress patients, although consistent patient facilitator staff may help to alleviate this problem. It also hurts productivity as it takes time for new providers to get up to speed and hit productivity goals. Teams receive bonuses for hitting productivity goals, so turnover also hurts patient facilitators and other team members in that they may no longer receive productivity bonuses.

Some providers have difficulty with the cross-training and rotation model and would prefer that their

favorite patient facilitators work with them on the floor and not rotate to working as a greeter or to medical records. High Plains has tried to ensure provider buy-in by letting them customize some of the training their team receives rather than standardizing all training across the system so that providers can get the individualized support they need.

Defining the new role of health coach and building trust between the health coach and the provider may also be a challenge.

**Other Staff:** The constant innovation requires a particular type of personality. High Plains lost a number of staff during the initial redesign. Some patient facilitators prefer to work at only one function or another and find it difficult adjusting to changing roles. As the organization moves to implementing the Patient Centered Medical Home model, it may again be faced with some staff loss.

**Patients:** Although patients were initially confused by the redesign, they grew to like it because they could be seen by *any* available provider, which allowed quick and easy access to appointments. Now, with the Medical Home model, patients are being assigned just one provider for continuity of care. Some patients are frustrated because they are being put on a wait list for visits, which is a change from the rapid turnaround they grew to expect. However, administrators are confident that within six months of full implementation, this will stabilize and the Medical Home model will bring an improvement in patient care.

**Information Technology:** Adopting the electronic health record system has slowed staff down somewhat due to the amount of time needed to input and process information, and due to the staff and provider learning curve. Some providers lack computer skills to work with the electronic health record system. Staff has worked to train these providers on their system. Patient facilitators are required to have computer skills as a qualification for employment. While the clinic leadership can afford to refuse to hire patient facilitators with no computer skills, they cannot take the same measure with hard-to-recruit providers.

**Financing:** As the organization strives to provide more comprehensive services for patients and to provide additional promotional opportunities for staff,

it must also search for sustainable funding for 'soft-money' positions. While patient facilitators are paid out of the clinic's general operating budget, the patient navigator, health coach and community health worker positions are grant-funded. Staff who might have previously worked in more financially secure positions take a risk in applying for the grant-funded positions and may need to revert to lower paid jobs, if available, once grant funding has expired. High Plains is looking at Medical Home certification as a way to enhance funding for comprehensive services and possibly sustainable funding to retain some of these positions.

## Outcomes

Despite some challenges, High Plains has realized a number of beneficial outcomes for staff, patients and the organization as a whole.

**Productivity:** As a result of participating in the Patient Visit Redesign Collaborative, High Plains was able to bring its productivity up from 1.82 patients per provider hour on average in 2000 to about 3.0 in 2002/2003. Due to some of the challenges noted above, this rate is now down to about 2.6-2.7, which according to interviewees is still very high compared to statewide figures.

**Cost Savings:** At first staffing costs went up as a result of bringing on new staff to support providers, but this was balanced by the increase in productivity. Administrators estimated costs savings for the initiative by examining the income provided by each additional patient visit per provider hour balanced against the costs of bringing on new support staff and equipment purchase. Increasing the number of patients seen from 1.82 to 2.7 per provider hour translates into roughly \$67K more per year per team, or almost \$500K per year for all seven teams.

**Clinical Outcomes:** The Health Center uses registries and its electronic health record system to track patient needs and outcomes. Employees are informed of clinical goals and outcomes, which are posted in the staff lounge and distributed around the office. An additional incentive to meet these goals has been a bonus program for teams meeting clinical goals. Patient facilitators and others note that they are very aware of the need to track patient outcomes over time and their progress in meeting them.

**Table 1. Health Outcomes for Cardiovascular Patients**

CVD Measures	August	August	August	July	Goal
	2001	2004	2006	2010	
% patients with controlled blood pressure	<i>not tracked</i>	<i>not tracked</i>	46.30%	67.90%	>50%
Percent CVD Patients with Self-Management Goal (12 months)	46.00%	62.60%	79.80%	91.90%	>70%
Percent of CVD Patients with BMI>25 Who Have Lost 10 Pounds (12 Months)	<i>not tracked</i>	<i>not tracked</i>	12.70%	15.70%	>30%
Percent CVD Patients with Two BP tests (12 months)	77.00%	84.40%	89.80%	91.80%	>90%

**Table 2. Health Outcomes for Diabetes Patients**

DM Measures	June	June	June	June	Goal
	2001	2004	2006	2010	
Average HbA1c for DM Patients	8.7	8.1	7.7	7.7	<7.0
Percent DM Patients with Two HbA1c tests (12 months)	66.50%	64.30%	79.80%	91.90%	>90%
Percent DM Patients with Self-Management Goal (12 months)	62.50%	72.40%	88.90%	96.90%	>70%
Percent DM Patients with BP < 130/80 (12 months)	<i>not tracked</i>	37.50%	42.10%	63.20%	>40%

Tables 1 & 2 below demonstrate some areas in which patient outcomes have improved over time as a result of a number of measures adopted by the High Plains, including participation in a Diabetes Collaborative (1999), Patient Visit Redesign (2002), adoption of electronic health records and the Patient-Centered Medical Home model (2008), Health Disparities and Rural Health Outreach grants (2009 & 2010), which instituted health coaches as a part of their operations.

### MA Career Impacts

**Promotional Opportunities:** All of the 21 patient facilitators are salaried and may receive increases in pay as a result of taking part in specialized training

such as pharmacy technician or radiology technician certification. Both of these certifications resulted in a 25-cents per hour raise in pay for participating patient facilitators. Both frontline and administrative staff noted that pay rates at High Plains are already relatively high compared to other entry level jobs in the community.

Patient facilitators may also receive bonuses if their teams hit certain productivity targets. For instance, if the team averages 18 patients per day for a month, the provider receives \$500 and the patient facilitators receive \$100 each. If the team averages 22 patients per day, the provider receives \$1000 and the patient facilitators receive \$200 each.

Patient facilitators can also advance by applying for promotion to new positions such as health coach, community health worker or patient navigator. Health coaches, for example, earn approximately 42% more than patient facilitators and receive additional pay if they are bilingual.

**Benefits:** Patient facilitators and other staff receive what most described as generous benefits, including health, dental and life insurance, a 401K retirement plan, 20.5 days of annual paid time off, and 12 paid holidays per year.

**Satisfaction & Aspirations:** While some patient facilitators seek the challenge of new positions within the organization, others are satisfied with the role of patient facilitator, which allows room for growth without changing job categories. Patient facilitators noted that “the benefits are great” and that the pay is “the most I’ve ever made in this town.” The opportunity for learning and growth and interaction with patients were also cited as benefits. One patient facilitator commented, “I love what I do.”

“We are happy to have them succeed.  
We expect them to grow.”

*-Jessica Medina, QI Coordinator-*

High Plains encourages learning and education and has helped staff obtain scholarships from sources such as the Colorado Community Health Network. Some staff have gone on to the local community college for nursing degrees.<sup>vii</sup> Many patient facilitators have also become CCMA credentialed through High Plains, which gives them skills and education that is portable to other health care organizations should they seek employment elsewhere.

**Retention:** Initially High Plains lost a number of staff when it implemented the patient visit redesign model in 2001/2. Retention of patient facilitators over the last year has been approximately 70-75%.

**Recruitment:** Staff reports little difficulty in recruitment of patient facilitators due to relatively high salaries and good benefits.

## Future Plans

In addition to continuing all of the successful elements of its current design, High Plains will also apply to become a Patient Centered Medical Home. It is also breaking ground on a new adult health center across the street from the main clinic.

## Replication and Lessons Learned

Staff from other clinics visit High Plains to learn about their implementation of their electronic health record system in particular. A clinic in a neighboring community has been working with High Plains to implement parts of the High Plains model. Staff agrees that this model could be replicated elsewhere and notes the following success factors:

- *Maintaining consistent leadership* willing to “stick with the program” over time has allowed High Plains to continue with this model and other innovations; interviewees noted that many clinics that adopted redesign either found it “too painful” to implement, or fell prey to backsliding.
- *Implement change in enough measure to “make it stick”*—starting out with total change or minimal change would not work because one is overwhelming and the other is too little to foster culture change or document impact.
- While ensuring buy-in and investment was necessary to implement the model, High Plains opted for more *streamlined decision-making* to initiate the process, selecting a small number of qualified people to make key decisions about changes to different processes.
- *Electronic health record system implementation* was a key to success because they could automate functions, document outcomes and fine-tune as they went along.<sup>viii</sup>
- Productivity can be improved by *increasing the ratio of support staff per provider*. High Plains reportedly has the highest number of support staff to provider of any clinic in the state and new providers note the difference this support makes in enhancing their productivity.
- Finally, *cross-training* medical assistant staff allows them to cover for one another across roles and teams. If one staff member leaves or becomes temporarily unavailable, others can



cover for them.

High Plains Community Health Center adopted a radical reorganization of its operations in order to boost productivity and morale. High Plains cross-trained all of its medical assisting staff to fill both front and back office roles, rotating MAs (patient facilitators) through responsibilities on a periodic basis. Because the organization has adopted a “grow-your-own” strategy, it offers MAs numerous additional opportunities for training and growth. These changes have provided considerable benefits to the organization, its staff, and the patients it serves.

July 30, 2010 from the Rural Assistance Center website: [http://www.raconline.org/pdf/2009outreach\\_directory.pdf](http://www.raconline.org/pdf/2009outreach_directory.pdf)

- vii. High Plains will hire LPNs as patient facilitators, but does not currently have roles for RNs.
- viii. High Plains uses eRx from Electronic Health Solutions.

“Here we are in this small little town, but it seems like we are ahead of the game. People (elsewhere) have these ideas that we are already implementing. You would think they would already have it in the big city.”

*-Miriam Chavira, Health Coach-*

## Notes

- i. Prowers County is both a Medically Underserved Area and Health Professional Shortage Area.
- ii. Patient Visit Redesign Collaboratives Policy Information Notice, Retrieved August 26, 2010 from HRSA website: <http://bphc.hrsa.gov/policy/pin0107/redesign.htm>
- iii. “Plan-Do-Study-Act” or PDSA—a plan for testing ideas intended to create improvement. The overall cycle requires developing a plan to test the change (Plan), implementing the test (Do), observing and learning from the consequences (Study), and determining what to change according to the results of the test (Act).
- iv. SBIRT refers to “Screening, Brief Intervention, Referral”, a public health approach to the delivery of early intervention and treatment services for persons with substance use disorders or at risk of developing these disorders.
- v. Motivational interviewing is a client-centered method based in non-directive counseling which utilizes reflective listening to elicit the patient’s intrinsic motivation for change. The purpose is to engage patients in evaluating their own behavior and resolving ambivalence between that behavior and the achievement of self-defined health goals.
- vi. HRSA. (2009). *HRSA Outreach Projects, Rural Health OUTREACH Grantee Directory, FY 2009*. Retrieved

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