Institute for HEALTHCARE DELIVERY DESIGN

Medical Assistant (MA) Roles and Responsibilities

- stakeholder interview
- on-site observation
- behavioral analysis
- sense-making
- strategic communication

September - December, 2022 | 10 weeks

PROJECT OVERVIEW

Background:

Family and Community Medicine at UI Health has engaged the Institute for Healthcare Delivery Design with the goal of identifying opportunities to improve patient, provider, and staff satisfaction, patient health outcomes, and revenue streams in the clinic.

A design sprint conducted in late July and early August 2022 culminated in a potential project to develop clinic roles and responsibilities for medical assistants for better in-clinic collaboration.

Project goals:

1. **Understand current MA roles and responsibilities** and surface differences in understanding about them among key stakeholders.

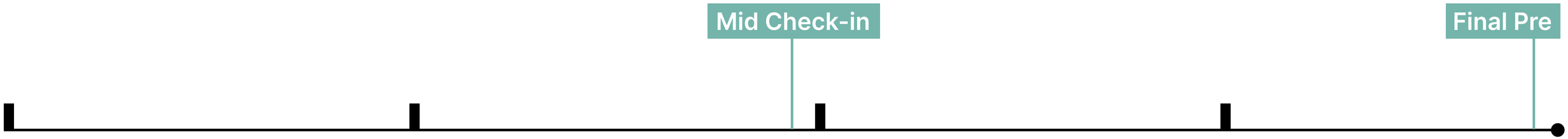
2. Collaborate with MAs and clinic leadership to formalize and standardize MA roles and responsibilities with an emphasis on **MA engagement and ownership.**

3. **Identify and propose mechanisms for feedback** and accountability, adaptability and responsiveness, and continued engagement and ownership from MAs to ensure consistency over time.

RESEARCH PROCESS

RESEARCH PLANNING

10-week research
25 stakeholder interviews
3 on-site observations



1st round of interviews and observations

Gather data from different stakeholders on current workflow and challenges of MAs.

- *What do MAs' current day-to-day responsibilities look like?*
- *What's not working?*
- *What would MAs like their roles to ideally look like?*

Articulation of the current state

Use frameworks to analyze data and generate meaningful insights. Propose possible directions.

2nd round of interviews

Zoom into the focus area and collect different stakeholders' ideas for solutions.

- *How might we measure or recognize the contribution of MAs?*
- *How might we empower MAs in workflows and feedback?*
- *What could be the mechanisms that hold people together?*

Recommendation delivery

Finalize proposals. Create prototypes and rubrics for clients to build upon.

DATA ANALYSIS

Interview transcripts and observation notes

Amalia_0927.m4a

Archit [00:00:00] So tell me, what what did your day to day look like?

Amalia [00:00:03] Okay, so today I was working with Dr. Honda and I am a certified medical assistant, so I have a little bit more duties. But beginning my day, I started at 745 and I did I do controls and and, you know, the peels. And then after that, I make sure the computers are working, open the ruins, make sure they're clean. Sometimes they're not. Sometimes they leave labels, they leave the bed dirty. And I also clean up after the one previous, you know, that's a problem. And so when Dr. Hundred came, I had already two patients in the room, plus the other doctor, which also had patients. So I was running in the morning with two with two doctors, putting them in the room. So once the other Emma came, she was able to stay with her doctor and I stayed with my doctor and of course, certified medical assistance. We do more because we give shots, so we give flu and tetanus. Those are the only two that we give, whereas other inmates don't give shots and some other maze. The inmates that start late at nine or 930, they don't get to do positifs. I mean the controls because they start late.

Archit [00:01:24] Yeah. Controls is just that. Yeah.

Amalia [00:01:26] So the very beginning because we start clinic at 820, they have to be done and sometimes you know when an m is running behind and she's in early Emma, unforeseen occurrences befall all of us. But sometimes it's a repetition of always being late. Yeah, and if you're always late, then the controls aren't done before a patients needs an agency or a urine or whatever. You can't do it.

Archit [00:01:58] The control isn't in.

Amalia [00:01:59] Right? So now we have to wait for somebody do the controls. Patient has to wait. The doctor has to wait. So it it starts getting everybody behind, you know. So for me, I'm okay with it because, you know, I start my day. I know what I have to do and, you know, and I do it. If somebody else needs help, I'm more than happy to jump in. I like to to help everybody who I can. Sometimes they do take advantage of that situation. And

- The physician gives the label to the MA and verbally confirms the task.
- Go to the vaccine room to prepare the vaccine. Grab an introduction sheet from the station.
- Enter the patient's room and give the vaccine.
- Update the record in the system.

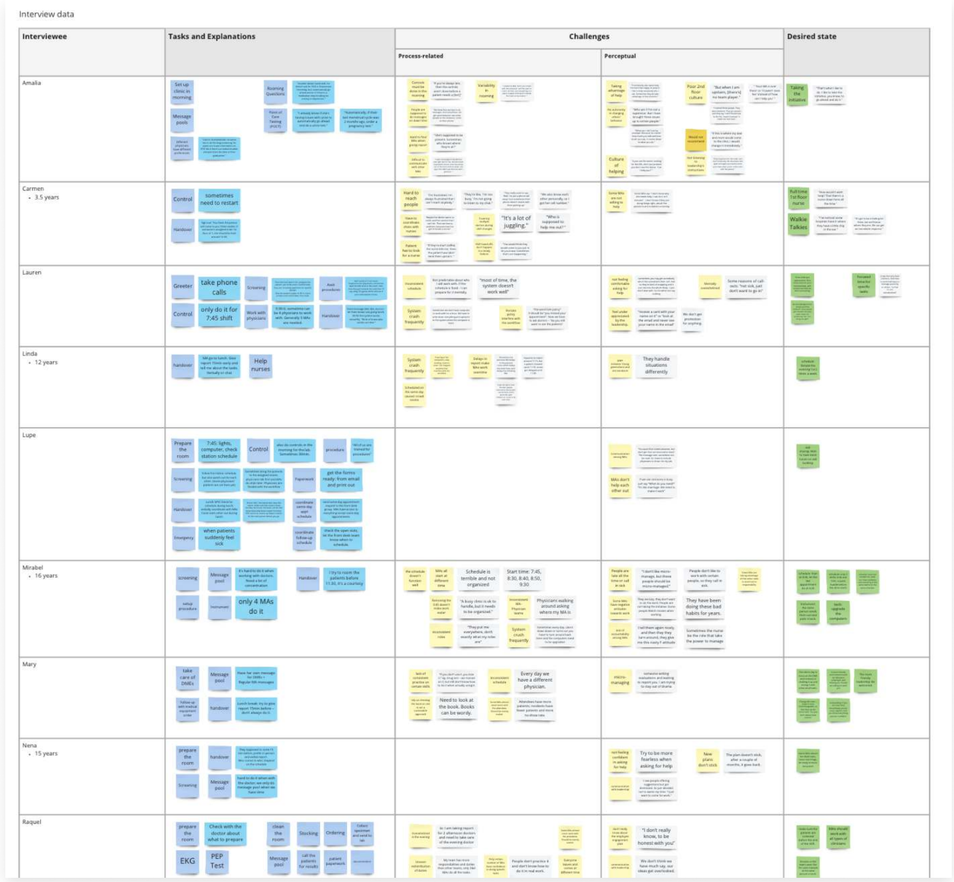
– Clean and stock the room (supposed to check the stock every time)

- Check if the patient left.
- Clean the room and collect the used instruments.
- Put the instruments in the instrument room.
- Check the drawers for the quantities of supplies. Memorize the items that need to be refilled.
- Go to the supply room. (crowded) Find the supplies.
- Organize the supplies in the room.
- *If the MA couldn't find extra supplies in the room. Send a message to the MA that takes charge of ordering.

– Shift handover (flexible)

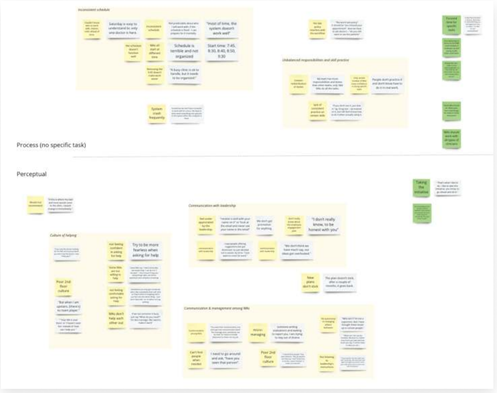
- Check who will report to me from the schedule sheet.
- Check her patient status in the system (upcoming, wait to check in, already checked in)

Cluster data into information groups



Clusters:

- MA tasks and their interpretations
- Process-related challenges
- Perceptual challenges
- Desired state

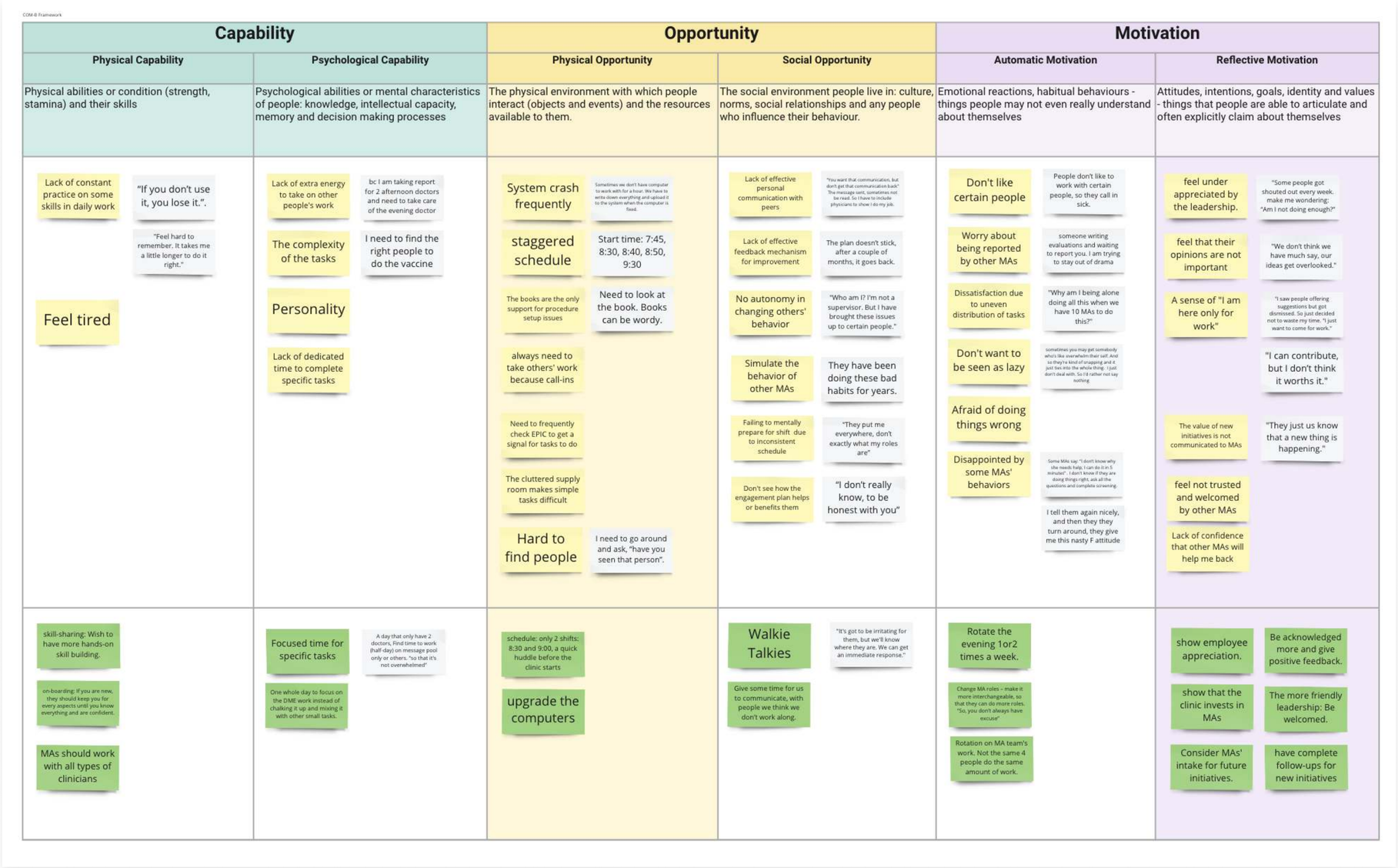


BEHAVIORAL ANALYSIS

Use **COM-B model from behavioral science** to analyze specific behavior challenge:

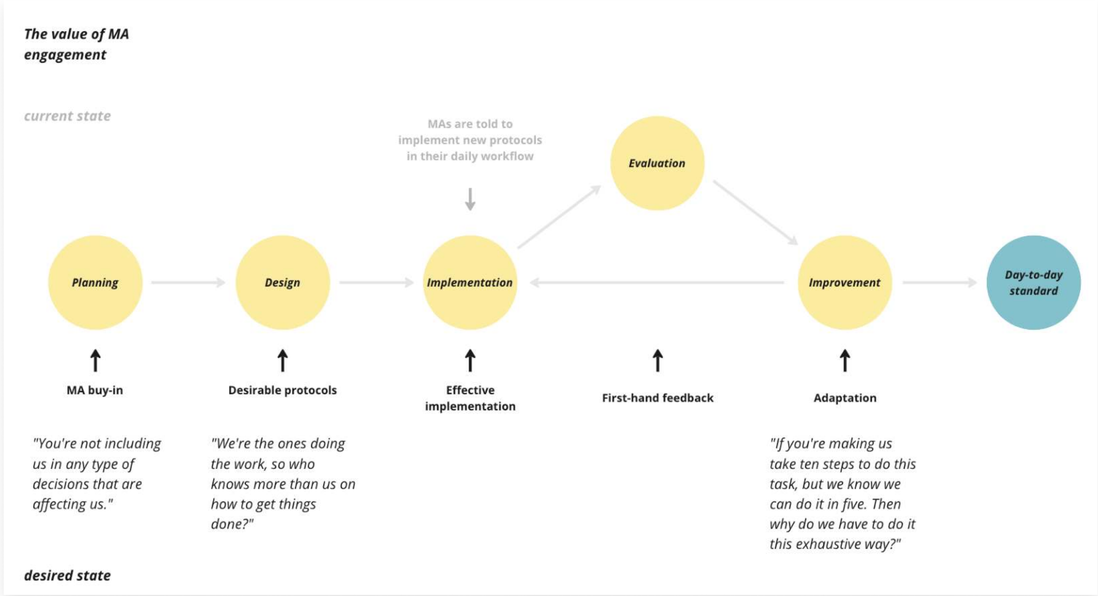
Why don't MAs offer help while sitting at MA stations?

- Capability
- Opportunity
- Motivation

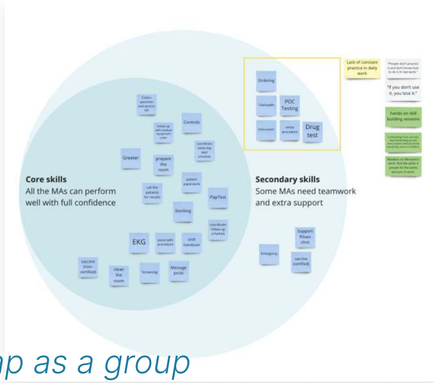


SENSEMAKING

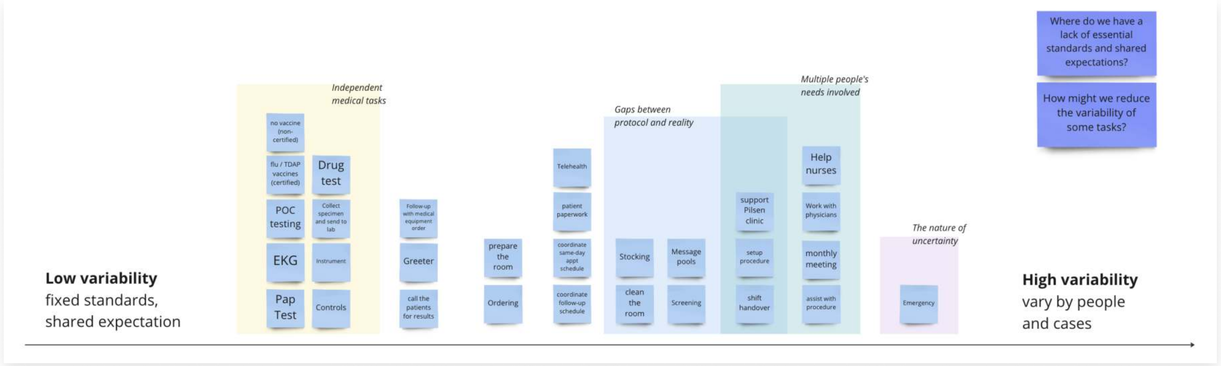
Create frameworks to communicate current states and help generate meaningful insights.



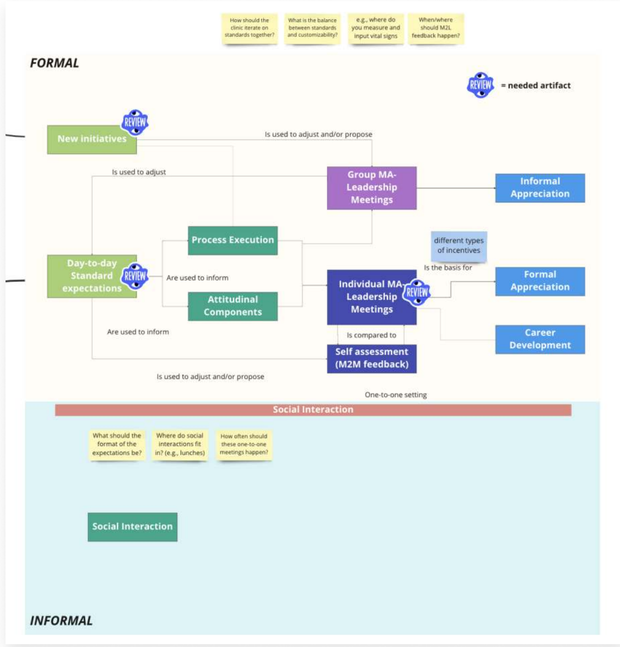
MA's engagements in new initiatives



MA's skill map as a group



inconsistency in MA tasks



system map of the desired state

RESEARCH FINDINGS AND INSIGHTS

DESIGN CONTEXT

Policy-related

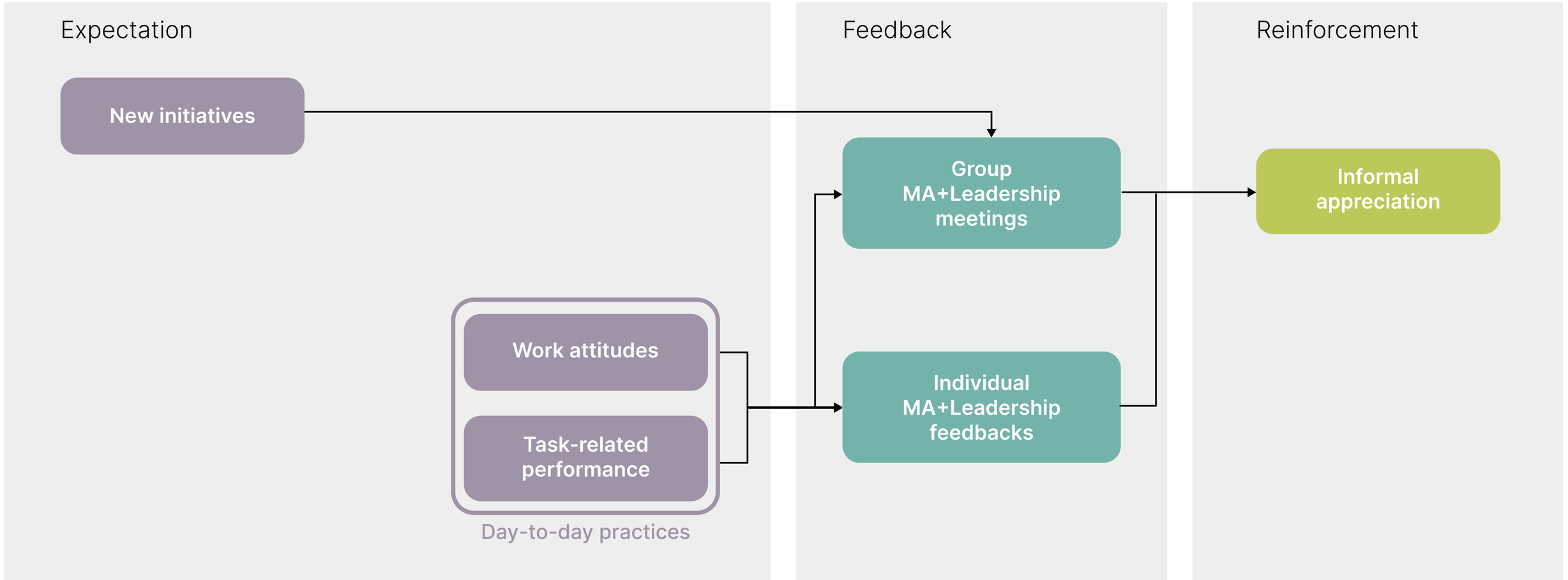
- Workplace restrictions significantly narrow the scope for disciplinary action
- MA pay is not closely tied to performance, making direct incentivization of behaviors difficult

Culture-related

- Sustainability of new initiatives has been a historic barrier within the Family Medicine clinic
- Current MA behaviors and habits are deeply entrenched and difficult to forcefully change

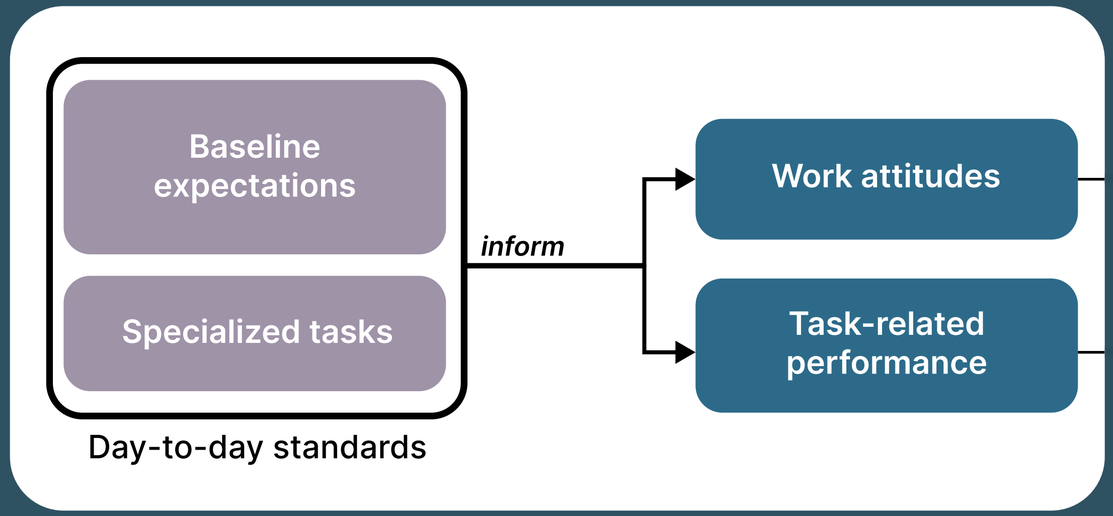
“People become complacent. It becomes the culture and places. They're just used to things being a certain way.”

MODEL OF THE CURRENT STATE



Existing components that are informally practiced

Group social activity



Clear and tangible day-to-day standard expectations to inform process execution and attitudinal components.

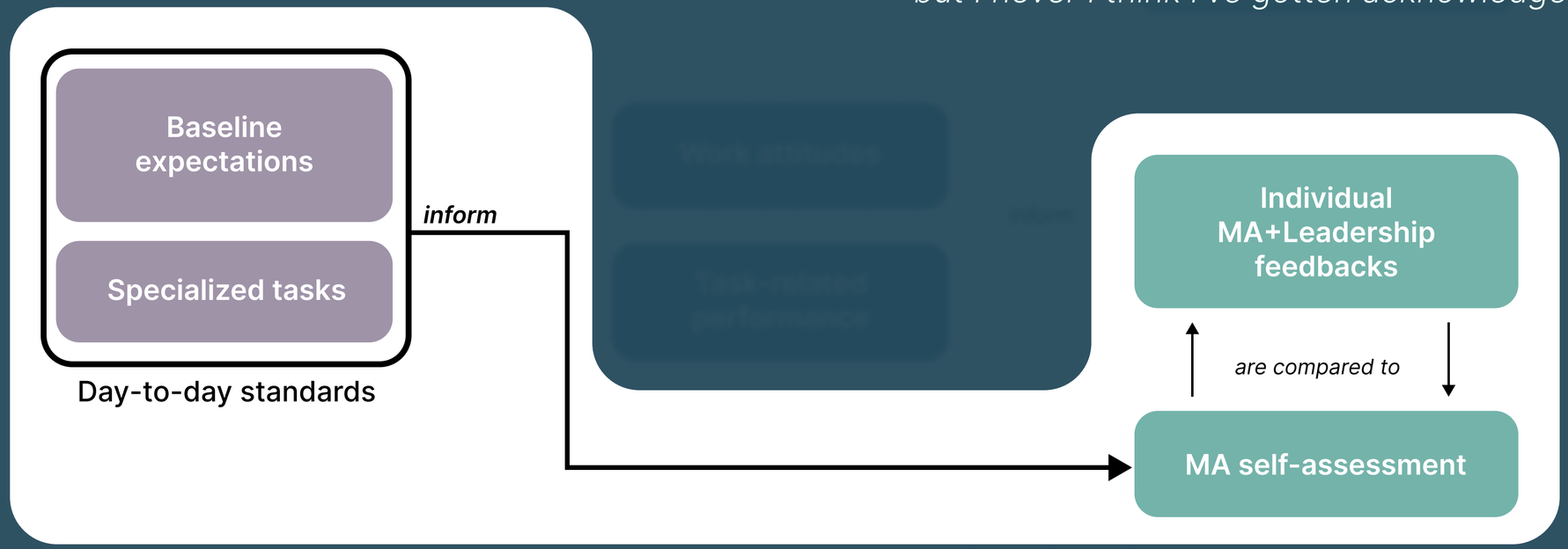
“We hear about this stuff that we should have to do or don’t have to do. No one’s really on the same page.”

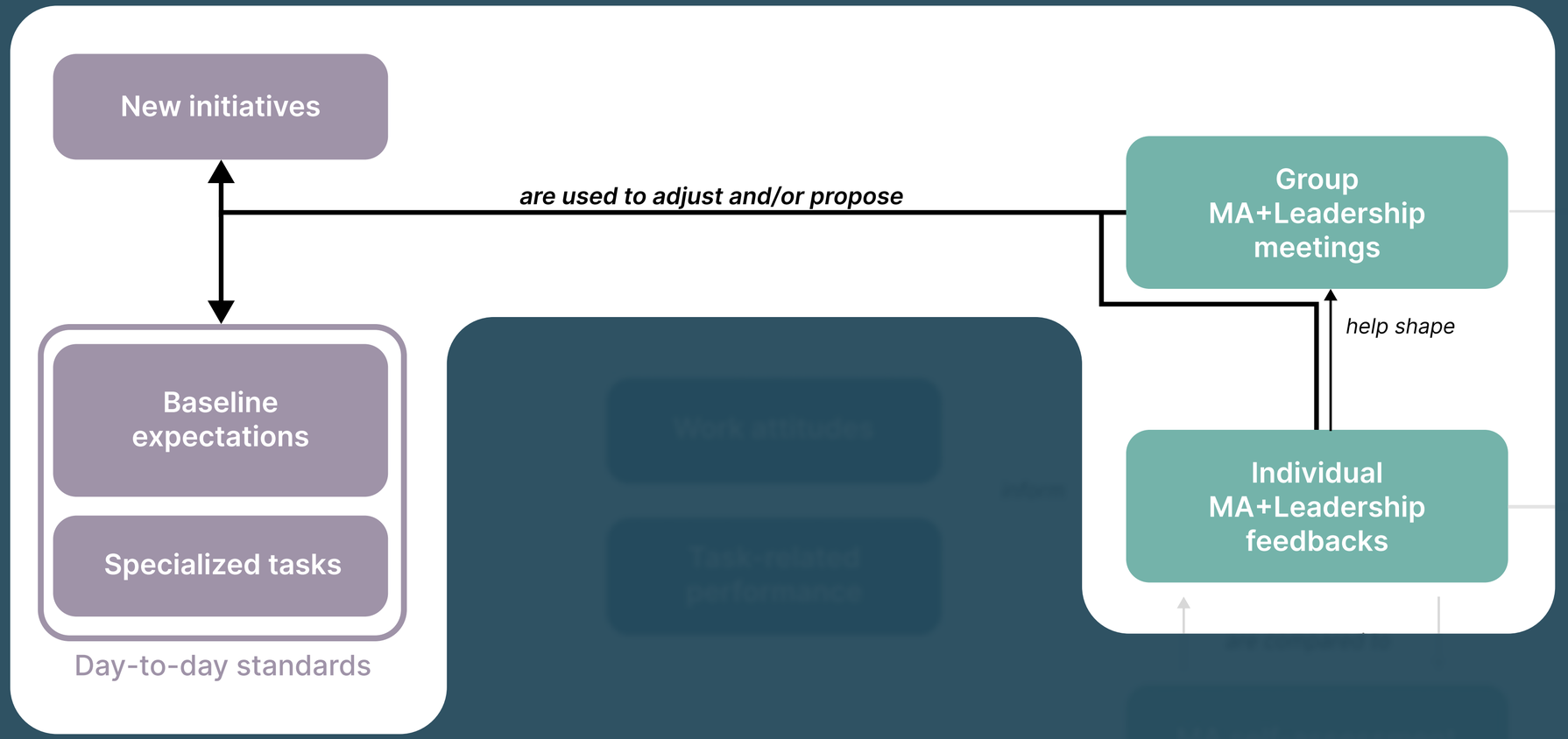
“There's no easily accessible version of, ‘What are we currently doing? What are the current expectations?’”

MAs are given tools and space to self-reflect on their current performance before engaging in reviews with leadership.

“I see in the email ‘we want to give kudos to so-and-so because of this’ and I think I do that all the time.”

“I’ll stay with doctors when a nurse is supposed to have stayed. I've done a lot of things to help, but I never I think I've gotten acknowledged.”





Feedback loops allow MAs to voice concerns with new initiatives and day-to-day expectations that they disagree with

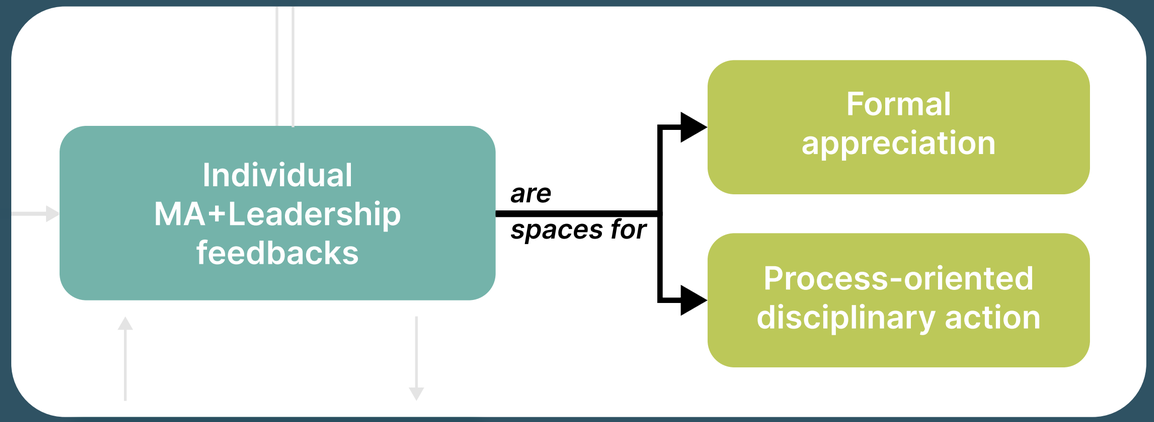
“If we have concerns or ideas on how to better do workflows or anything like that, it would be nice if we were heard.”

“They hear what we are saying. But they’re not really listening.”

Outputs of individual meetings are geared towards:

- positive reinforcement for high-performing MAs
- formal disciplinary action from repeated deviations from ambulatory standards such as rooming guidelines

“There’s no room for growth here. So, once you’re in that position, you’re stuck in that position.”



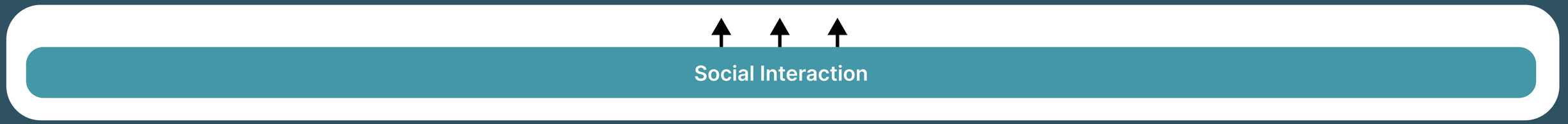
“When things are not done properly, then people need to be held accountable.”

“We used to do those half days that let people get to know each other.”

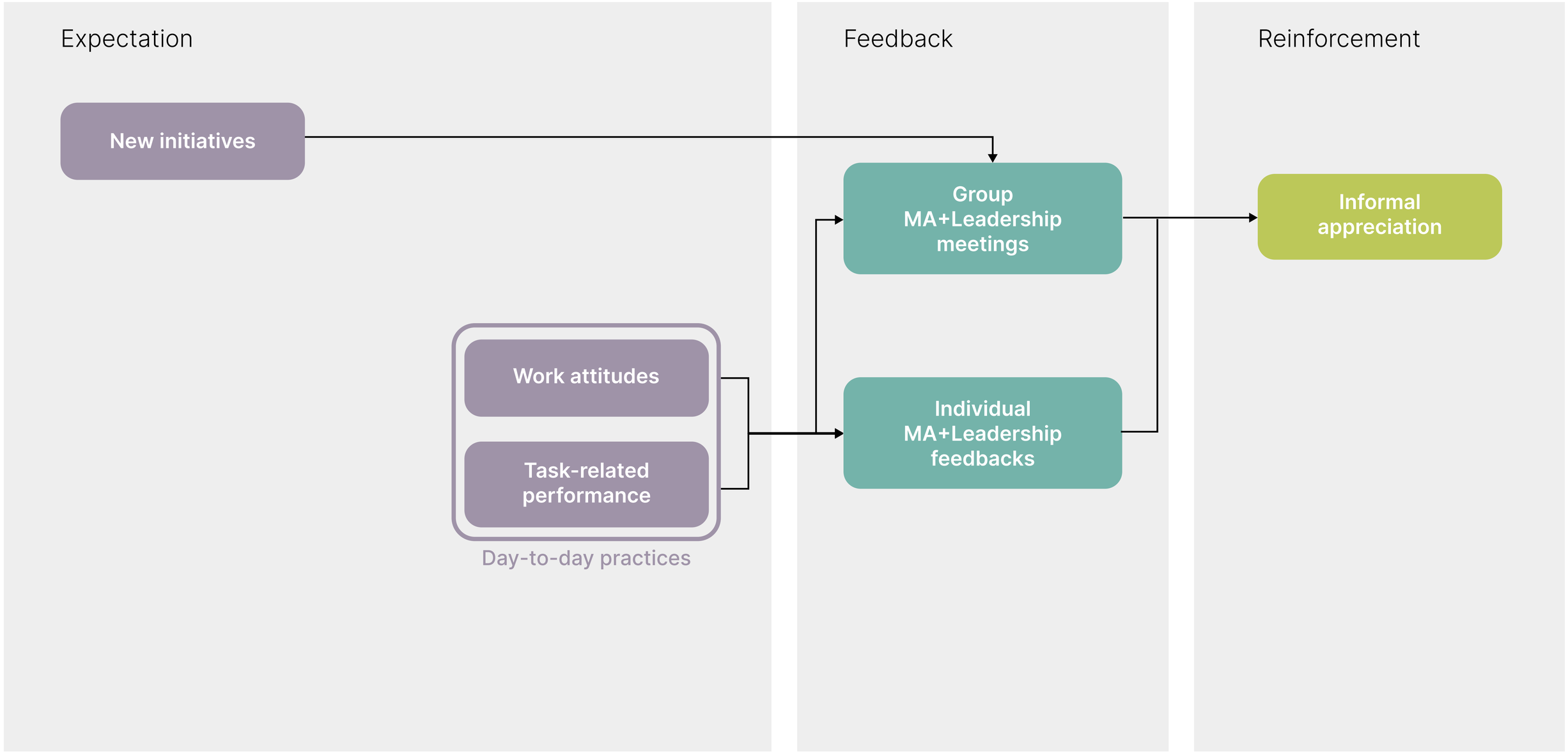
“Just give some time for us to communicate with other MAs we think we don’t work with well.”

“Have time for the doctors and the staff to just interact with each other because a lot of them don’t know who we are.”

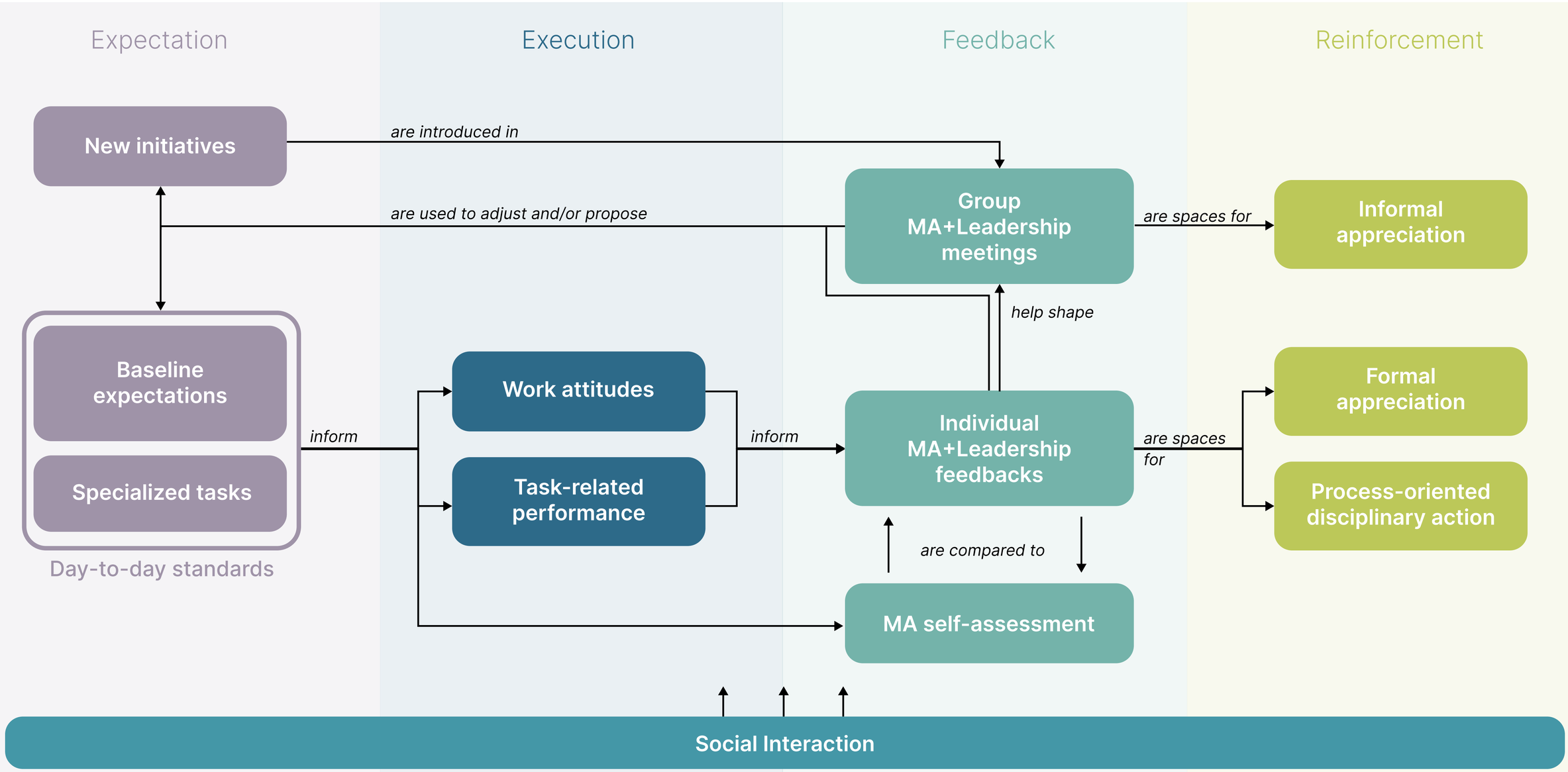
Gated areas for social interactions (e.g., group lunches, half days) allow understanding outside work and focus while working



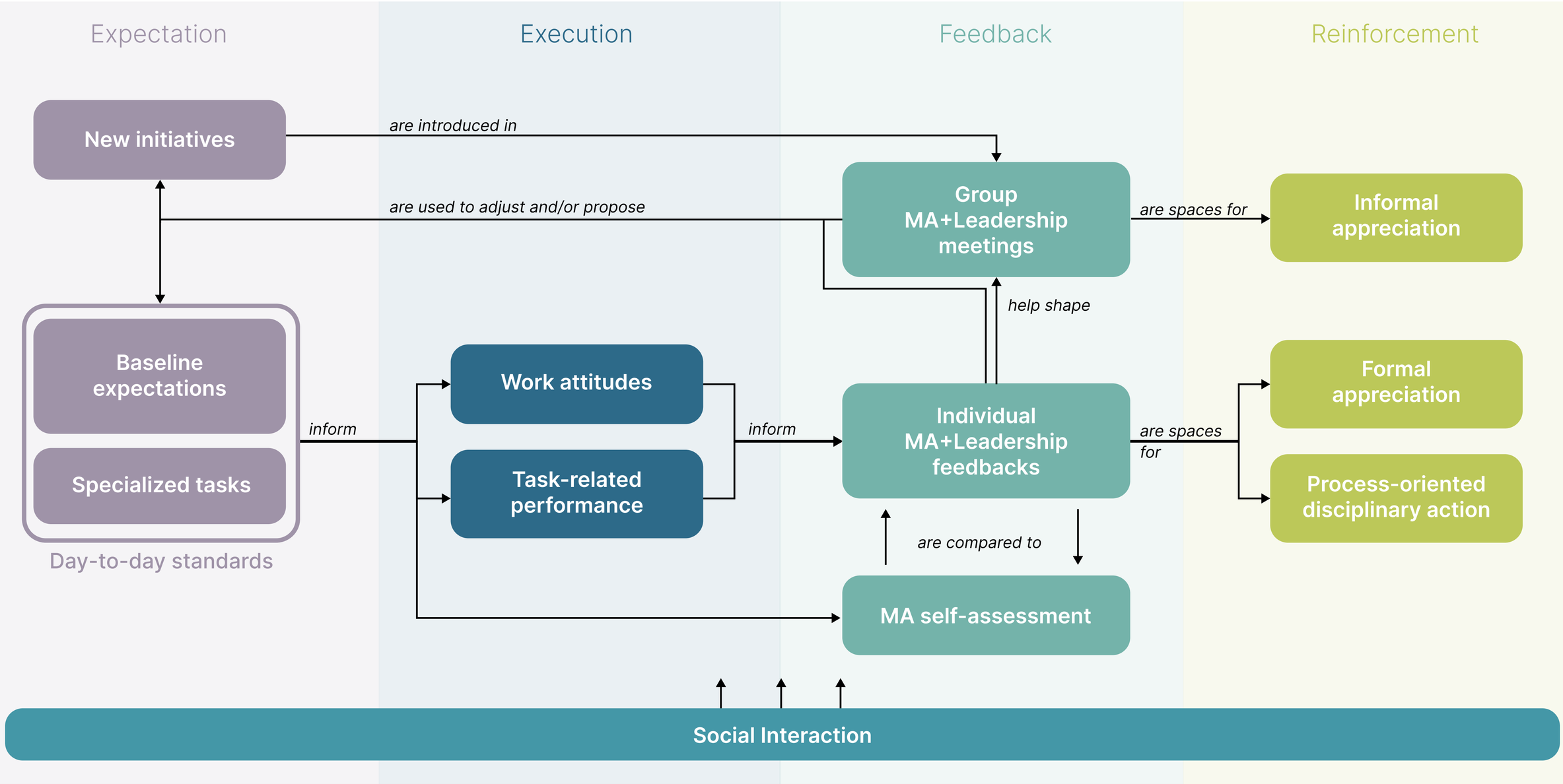
Model of the current state



The ideal flow of information and feedback



THE FLOW OF INFORMATION AND FEEDBACK



PROPOSALS IN-DEPTH

Proposal:

Expectations should be visible and tangible to be relevant to MAs' day-to-day work.

Expectations should promote alignment and initiate conversations instead of serving as a tool for punishment.

DIFFERENT FORMS OF EXPECTATIONS

During...

Training/learning

As the first step to introduce new initiatives or onboard

- Step-by-step
- Detailed and comprehensive

“We all went through the same training. How I was trained becomes my standards.”

Day-to-day practice

As a handy tool that reminds MAs about the key checkpoints of every tasks.

- Clear and straightforward
- Oriented to key results
- Less focused on individual steps and processes

“You want to do it the best way you can, as long as you’re checking off the boxes.”

Self-assessment

As a guide that helps MAs understand and communicate their performance

- Tangible discussion points
- Oriented towards career development

“They don’t see what we do down here.”

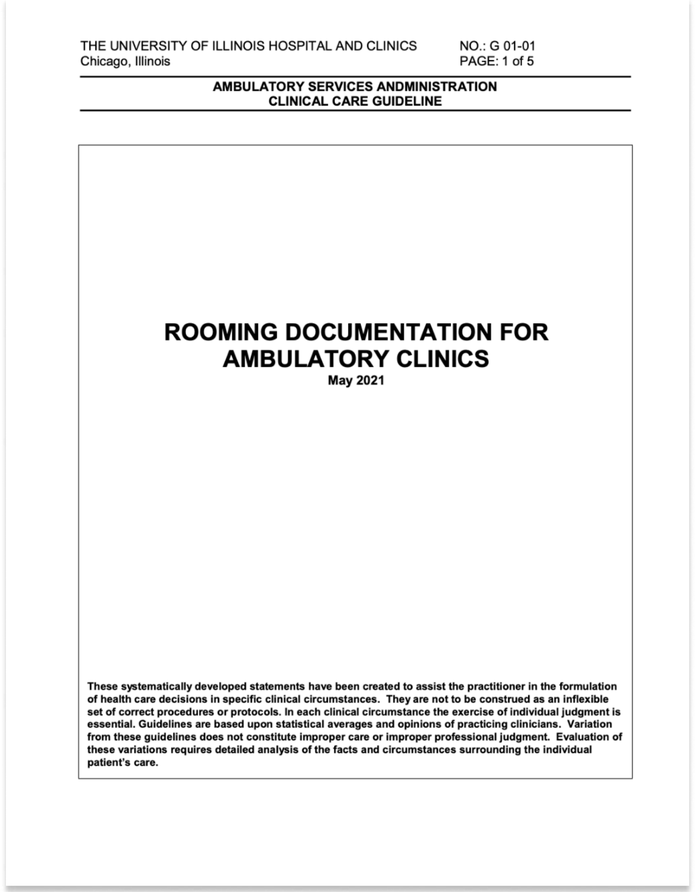
DURING LEARNING

Building a thorough understanding of the responsibilities and process.

- Similar in structure to the “bluebook” of procedures
- Contains step-by-step, explicit instructions
- Document contains version number and date last updated

“Just teach me how to do it because I don't even know what the kit looks like. I don't know how to do it, how to start it, how to end it, what to chart.”

------ MA



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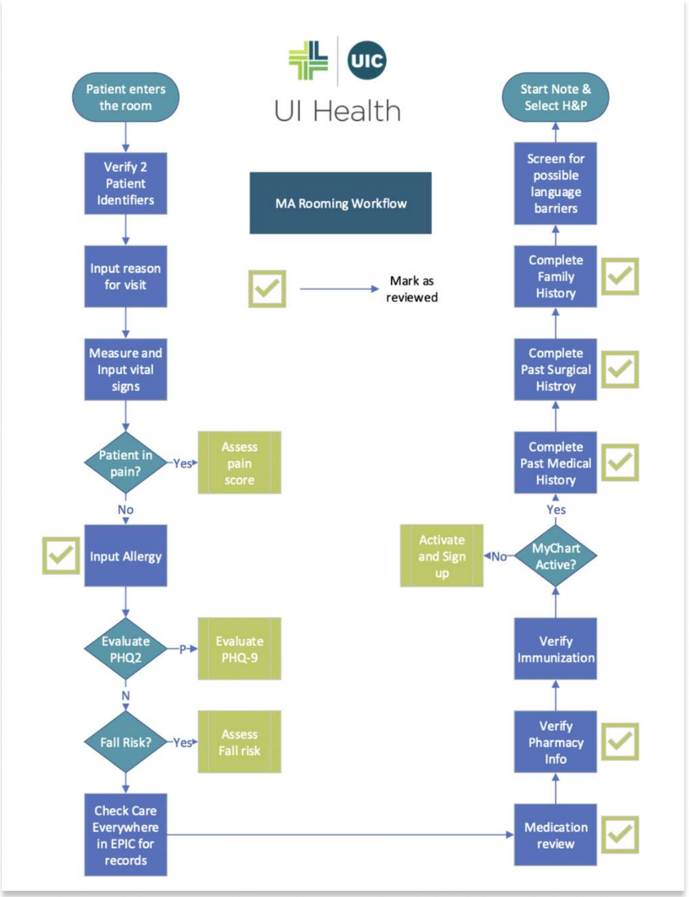
AMBULATORY SERVICES ANDMINISTRATION
CLINICAL CARE GUIDELINE

ROOMING DOCUMENTATION FOR AMBULATORY CLINICS
May 2021

These systematically developed statements have been created to assist the practitioner in the formulation of health care decisions in specific clinical circumstances. They are not to be construed as an inflexible set of correct procedures or protocols. In each clinical circumstance the exercise of individual judgment is essential. Guidelines are based upon statistical averages and opinions of practicing clinicians. Variation from these guidelines does not constitute improper care or improper professional judgment. Evaluation of these variations requires detailed analysis of the facts and circumstances surrounding the individual patient's care.

UI HEALTH - Rooming documentation for ambulatory clinics



FAMILY MEDICINE - Rooming workflows

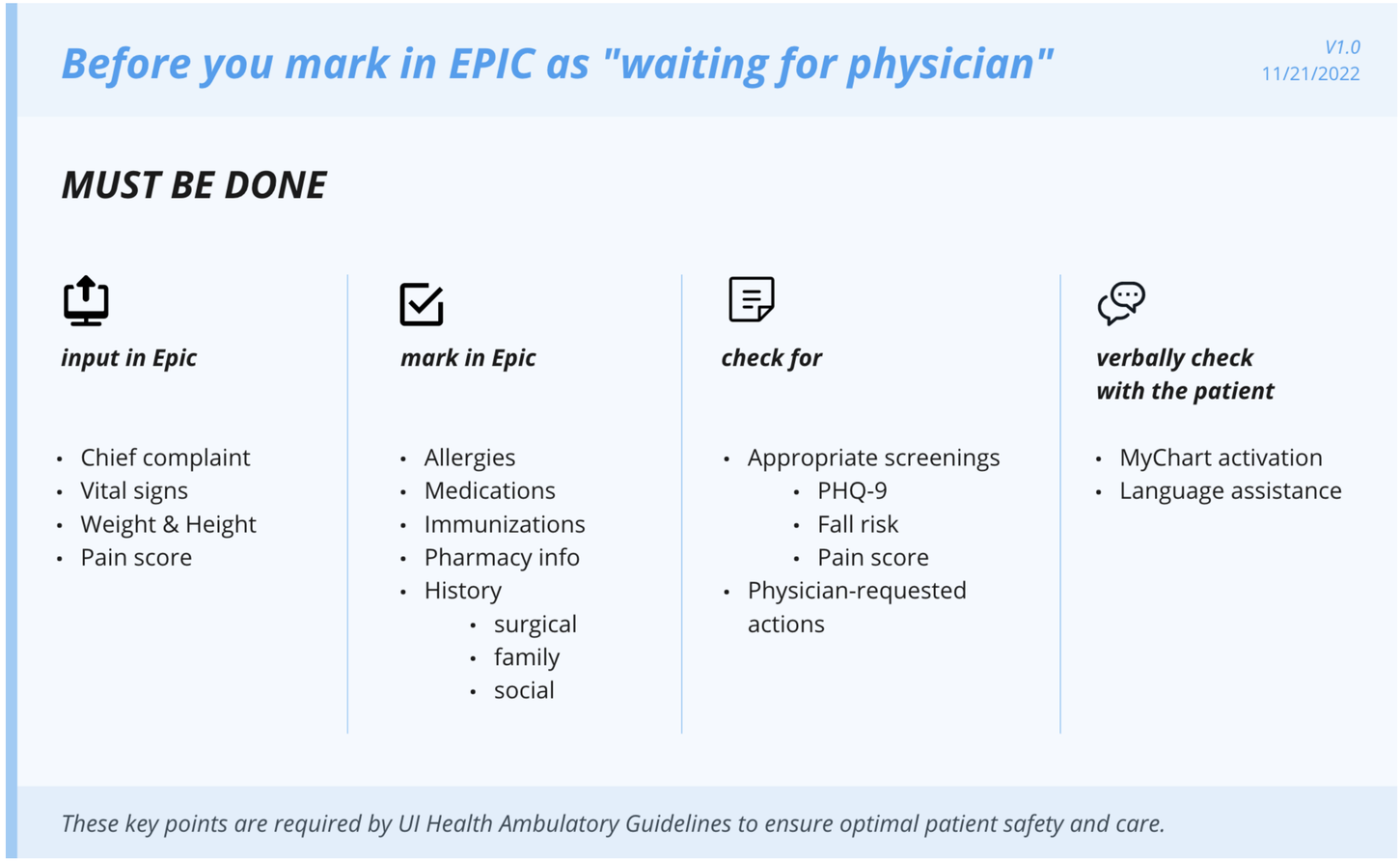
DURING DAY-TO-DAY PRACTICE

A checklist of daily reminders helps augment the workflow

- Reminder of all required information
- Tangible document is widely available throughout the clinic
- Explicitly mentions ambulatory guidelines when appropriate – regular deviation may result in disciplinary action

“I think that our staff don’t have a good understanding of what our policies are, why they’re important, where to find them, when to find them, and how often they should be reviewing them.”

------ Interim Chief Medical Officer



Before you mark in EPIC as "waiting for physician"

V1.0
11/21/2022

MUST BE DONE

input in Epic

- Chief complaint
- Vital signs
- Weight & Height
- Pain score

mark in Epic

- Allergies
- Medications
- Immunizations
- Pharmacy info
- History
  - surgical
  - family
  - social

check for

- Appropriate screenings
  - PHQ-9
  - Fall risk
  - Pain score
- Physician-requested actions

verbally check with the patient

- MyChart activation
- Language assistance

These key points are required by UI Health Ambulatory Guidelines to ensure optimal patient safety and care.

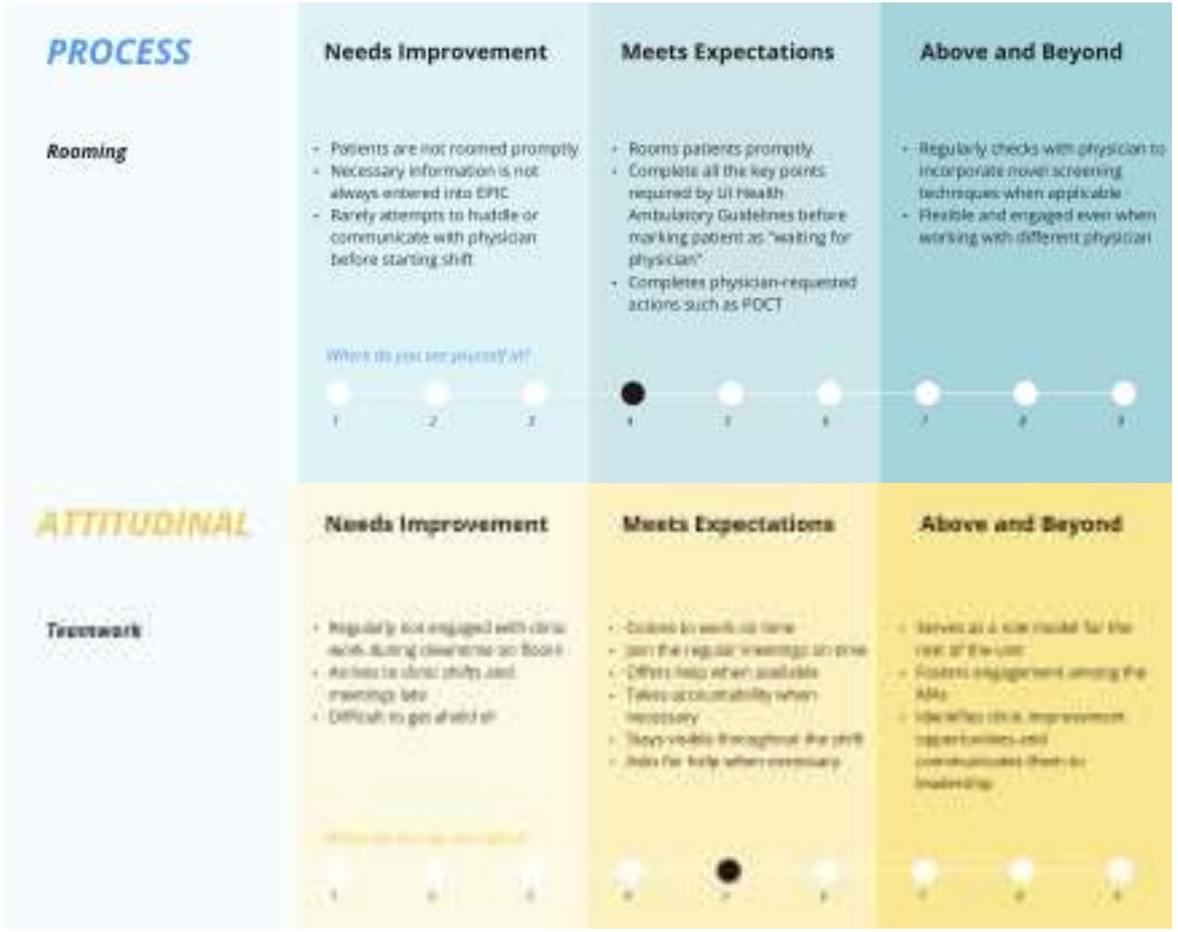
Example

DURING SELF-ASSESSMENT

Self-assessment ahead of formal performance reviews to facilitate goal-setting

- Clear descriptions of the three levels of performance with room for self-interpretation for sub-levels
- Allow MAs to evaluate themselves in ranges instead of yes/no questions
- Guide MAs to reflect and prepare for the 1:1 leadership & MA conversations

”Hold that person accountable and therefore they will be more aware.”
----- MA

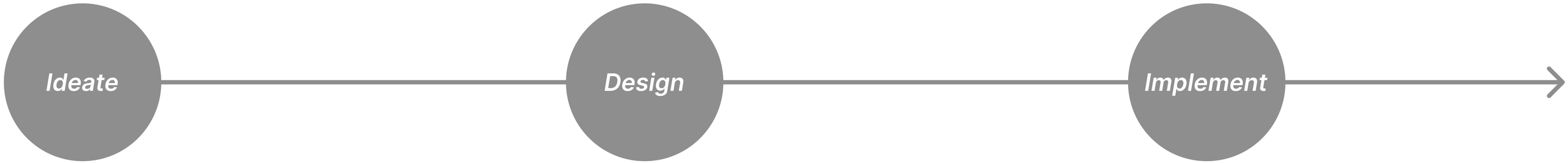


Example

Proposal:

Increasing MAs' involvement in the lifecycle of a new initiative is not only key to the sustainability of innovations but also leverages the expertise of high-performing MAs

THE CURRENT STAGES OF A NEW INITIATIVE



What happens:

A new proposal for a workflow is introduced to the medical manager either via new ambulatory guidelines or an individual physician.

What doesn't work:

"You're not including us(MAs) in any type of decisions that are affecting us."

What happens:

The proposal is workshopped into a coherent workflow by the leadership and the physicians.

What doesn't work:

"You're making us(MAs) take ten steps to do this task, but we know we can do it in five. So why do we have to do it this exhaustive way?

What happens:

The workflow is introduced to the MAs in a monthly meeting and implemented.

What doesn't work:

"Sometimes they(leadership) implement something new but there's no specification as far as how long this is going to happen."

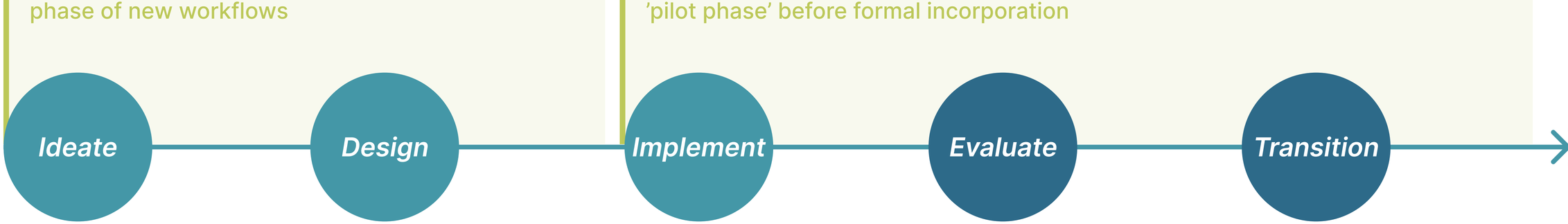
PROPOSED FUTURE STATE

Design Phase

Leverage high-performing MAs in the design phase of new workflows

Pilot Phase

Clearly communicate what initiatives are in a 'pilot phase' before formal incorporation



Ideate

Provide a formal space for MAs to introduce new ideas directly to Rita or Dr. Leifer

Incorporate patterns of MA feedback from group or individual settings

Design

Formally incorporate a high performing MA in early design conversations

Implement

Introduce the initiative to the MAs in the group setting.

Ensure associated learning materials are visible and tangible

Emphasize components of workflows from Ambulatory guidelines

Evaluate

Continue soliciting MA feedback in informal and formal spaces (e.g., initiative lead / track)

Communicate initiative timeline

Add discussion of ongoing initiatives as a line-item in individual meetings

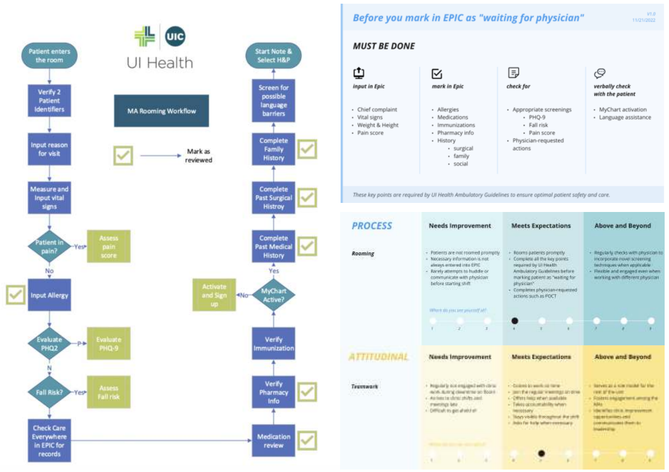
Transition

Communicate target date for transition into day-to-day expectations

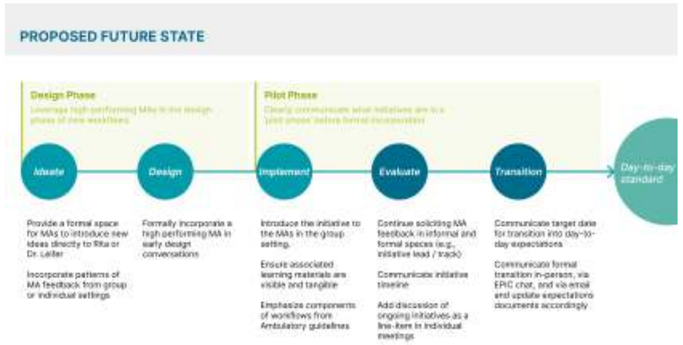
Communicate formal transition in-person, via EPIC chat, and via email and update expectations documents accordingly

SUMMARY

01
Have three tiers of expectation information for learning, day-to-day practice, and self-assessment



02
Integrate high-performing MAs in the initial design process of workflows and regularly communicate state of initiatives



03
Regularly use expectations documents in formal, individual meetings and promote opportunities for feedback