

Cabin Creek Health Systems—

Medical Assistants Provide a Senior Medical Home

Cabin Creek is a small town in rural West Virginia. This mountainous and heavily wooded area is famous for its coal-mining history, most notably the West Virginia Mine War of 1912-1913, in which martial law was repeatedly declared in a violent battle between miners and mine guards over working conditions and unionization. The original Cabin Creek Health Center (later Cabin Creek Health Systems) was established by the United Mine Workers of America in 1972 in response to Black Lung and mining accidents.

Coal mining employment has plummeted since the 1980's and Cabin Creek Health Center has evolved into an FQHC that now addresses other community health concerns, including behavioral health, chronic disease, and the care of the area's growing elderly population.

Background

Prior to 2006, Cabin Creek medical assistants (MAs) primarily roomed patients, took vital signs, called in prescriptions and scheduled patients for referrals. MAs were fairly disengaged from both providers and patients. These working conditions and low pay made it difficult to recruit and retain good MAs.

In 2005, Cabin Creek had a change in senior management. The new managers recognized that although Cabin Creek was doing good work, it could be more efficient and utilize its MAs to greater advantage.

In 2006, the organization participated in a national Diabetes Health Disparities Collaborative sponsored by the Health Resources and Services Agency (HRSA). A clinical provider champion and two MAs attended a training session on diabetes self-management. This session was transformative in that it challenged both provider and MAs to re-assess

Practice Profile

Name: Cabin Creek Health Systems

Type: Federally Qualified Health Center.

Location: Four locations in rural West Virginia near Charleston.

Staffing: 127 staff members across the 4 sites:

- 17.7 FTE providers (MDs, NPs, PAs)
- 3 FTE pharmacists & 8 pharmacy technicians
- 1 FTE Dentist and 2 Dental Assistants
- 4.3 FTE Behavioral Health Consultants
- 33 medical assistants
- 3 Outreach and Enrollment Specialists
- 3 Health Coaches (MAs)
- 1 Registered Respiratory Therapists and 1 Breathing Center Nurse (Pulmonary Rehab)
- 10 billing and management staff
- 29 patient support staff (patient services representatives, referrals, housekeeping)
- 11 administrators

Number of Patients: 14,023

Number of Patient Visits: 49,080

Patient Demographics: Service area includes ten rural census tracts in which poverty rates are 50% higher than the national average. Nearly a third of residents over 25 do not have a high school diploma. The service area is predominately (95.5%) white. Persons aged 65 and older comprise 16.3% of the population (compared to 12% nationwide).

their roles in helping patients manage chronic disease.

As the organization expanded its new Electronic Health Record system (EHR), it was able to take on more special projects related to preventive medicine and chronic disease management. The organization could not hire nurses to fill the new

roles required by these projects, so it became imperative to train and retain skilled MA staff.

Administrators assessed roles and processes at the clinic and redesigned the workflow and physical layout so that providers and MAs would work more as teams. The new model entailed pairing MAs and providers to maintain continuity of care. In order to enhance this team relationship, offices were rearranged so that each provider shared an office with an MA rather than spatially separating staff by job category.

Teams currently consist of a provider and an MA, with the addition of a shared behavioral health consultant, a clinical pharmacist, and a health coach (also an MA).

In 2011, inspired by an article by Atul Gawande,¹ administrators from Cabin Creek visited AtlantiCare's [Special Care Center](#) (SCC) in Atlantic City. As a result of this visit, they decided to adopt a huddle involving all clinical staff based on what they had observed at the SCC. Cabin Creek's 30-minute huddles are facilitated by the clinic's MA health coaches and allow staff to discuss important issues they are facing with selected complex patients. Huddles include providers, MAs, health coaches, pharmacists, behaviorists, and front office staff.

Foundation Training

In addition to the Diabetes Collaborative training, all MAs were encouraged to take part in a two-day workshop on motivational interviewing. The purpose of the training was to provide evidence-based communication methods for staff working with patients who should make behavioral changes to improve their health status or reduce risks. During the workshop, MAs were trained to educate patients in self-management and goal-setting. .

➤ ¹ Gawande, A. Jan 24, 2011. The Hot Spotters - Can we lower medical costs by giving the neediest patients better care? *The New Yorker*. Pp. 41-51
http://www.iorahealth.com/wp-content/files_mf/1323966878Gawande_SCC_article.pdf

Other training included a series on behavioral health issues affecting patients; and sessions on communication to enhance teamwork and responsiveness to patients.

New Roles for Medical Assistants

Cabin Creek MAs assist with surgical procedures, immunizations, blood draws, and other clinical tasks. They can use the EHR to review medications and document calls and encounters. They use standing orders to refill non-controlled prescriptions. MAs may also administer depression and substance abuse screenings at intake and help patients use motivational interviewing to set self-management health goals.

The Senior Medical Home

Sixteen-percent of the population in Cabin Creek's service area is elderly (over 65) and many live in isolated rural areas that make it difficult for them to access care.

In 2009, the organization was contacted by researchers from West Virginia Center for Aging about the possibility of implementing a Senior Medical Home program. The goal of this program is to keep frail elders in their homes as long as possible and reduce hospitalization costs by providing seniors with resources and equipment to prevent injury and enhance health.

After an initial assessment for frail elderly status, participants receive in-home risk assessments and ongoing home visits, care coordination, and periodic office visits with providers.

Cabin Creek and two other West Virginia rural health centers received grants from the local Benedum Foundation for staff training and implementation costs to pilot this idea. The other two sites implemented their Senior Medical Homes with RNs. Cabin Creek opted to use its most experienced medical assistants.

Senior Medical Home Training

Cabin Creek is the lead agency for the Area Health Education Center (AHEC) in the four-

county region. The AHEC director had already started the process of examining MA training needs and community resources available for additional training. She found administrators at Bridgemont Community and Technical College in Montgomery willing to work with Cabin Creek and the AHEC to develop a curriculum and locate instructors.

The educators developed a 15-week course that was held from 4-5:30 in the afternoon every other week at facilities in nearby Charleston. Selected MAs were given clinical assignments which incorporated learning into their daily work. They received training in understanding the geriatric patient, how to use the Beers criteria to evaluate the risk of non-prescription medications in elderly adults, and how to conduct in-home risk assessments. Representatives from different social service agencies gave presentations on topics such as living wills, medical power of attorney, and Medicare and Medicaid. The first cohort of seven health coaches graduated in May 2010.

Implementation

Only MAs with extensive experience were chosen to participate in this program. These MAs assist in screening and identifying frail at-risk elderly patients at the clinic site. They conduct an initial assessment with a screening questionnaire for the patient, and administer a grip test and additional screening checklists.

Once a patient has been identified as at-risk, the health coach will schedule a home visit with the patient. Initiators felt that patients would feel more comfortable allowing people with whom they were already familiar into their homes. The goal for each patient is at least one contact per month, including home visits, follow-up phone calls, and in-office visits.

Most patients live in remote rural areas accessed by winding dirt roads with little or no signage. During the visits, health coaches conduct a medication review and a home risk assessment, work with patients on goal-setting, and connect

them with the Cabin Creek information and referral specialist for additional services. Health coaches document visits using a template from their EHR that includes an action plan for the patient, which is then forwarded to a licensed clinical social worker and the provider for further follow-up.

Of the approximately 620 patients in the Senior Medical Home initiative, only 80-100 receive home visits based on risk criteria. Patients in this group receive 2-3 home visits per year. Each of the three current MA/health coaches makes about 50 such visits per year. One health coach was promoted to senior medical home coordinator. In this role, she reviews charts, follows up after hospitalization, and conducts other coordination in addition to covering her own panel of seniors.

Initially developed to address the needs of frail Medicare patients, as of 2013, this initiative has been expanded to include dual-eligible Medicare and Medicaid patients—the most costly patients to care for.

Challenges

Initially, some MAs were unhappy with the more demanding roles they were asked to play. Learning the new EHR proved a tough learning curve for both staff and providers. Some providers did not think that MAs could be trusted with more advanced responsibility, and some chose to leave rather than adapt to the changes. Those who stayed or were hired subsequently are computer-proficient providers who are willing to work closely with the MAs as partners.

The Senior Medical Home presented some special challenges. Even with trainings offered during paid work hours, some of the MAs found it difficult to attend because it was they could not find anyone to cover for them at the clinic. Time constraints also made it difficult to work in home visits and meetings with providers and the caseworker about these cases in between regular medical assisting duties.

After a few years of experimenting with this model, the Senior Medical Home team realized that MAs just could not do home visits, care management, and follow up after hospitalization in addition to their regular medical assistant roles. As of 2011 the MAs working in the Senior Medical Home are now called health coaches and are not involved in day-to-day hands-on patient care. Instead they work on calling patients and following up with those who have plans of care, getting the patient and family history, reviewing hospital records, goal setting with new patients, managing dual eligible, arranging for utilization reviews, connecting patients to social services, and leading group visits.

Health coaches develop a special bond with the elderly and often low-income patients they visit, which can be both rewarding and challenging. For instance, patients may expect much more of the health coach than she can provide in terms of emotional and material support.

There are also some safety concerns about staff driving alone to remote rural areas where their cell phones and wireless laptops do not work.

Covering health coach salaries is a struggle since their services are non-reimbursable. Cabin Creek can show a decrease in hospitalizations resulting from the Senior Medical Home initiative and an improvement in provider retention, but it has been difficult to document direct cost savings to the health center itself. The decrease in hospitalizations saves money for the Centers for Medicare and Medicaid Services (CMS), but not for Cabin Creek. At the time of writing this case study, the additional services were paid through grants from the Health Resources and Services Administration (HRSA) and private foundations.

Finally, accessing hospitalization data on patients across systems can serve as a significant challenge in coordination care for these patients.

Outcomes

By expanding the number of clinic sites and increasing productivity, Cabin Creek has significantly increased patient volume. The

implementation of the EHR and the revision of the MA role have helped providers to see more patients and improve documentation.

Between 2004 and 2006, the number of patients increased by 70% while the number of patient encounters increased by 53%, and the cost per encounter decreased from \$103 per encounter to \$83 per encounter. As of 2011, Cabin Creek's rate for controlled diabetes was 78%--well above state and national averages.²

Anecdotally, the organization now has low MA turnover, but prior to the reorganization, it was "constant" due to the low pay, low-esteem, and lack of challenge.

Early results from the Senior Medical Home itself were promising: after the six month pilot, no patients were re-hospitalized within 30 days of discharge—and the average number of prescriptions dropped from 9.5 to 8.5 per person. The average cost of delivering care to this group of patients was under \$70 per patient per month.³

MA Career Impacts

MA pay overall was increased by an average of 63% from 2006-2010. Individual pay increases are based on a formula taking into account years on the job, certification, and various training modules MAs may complete. For instance, in 2010 employees received \$0.25 more per hour for participating in the Senior Medical Home model, \$0.15 more per hour for participating in motivational interview training and \$0.30 for being an electronic health record 'super-user' who can train new staff in how to use electronic health record systems. MAs receive a full package of health benefits and paid time off. Cabin Creek generally prefers to promote from within, and there are additional opportunities for

² Claude Worthington Benedum Foundation. Meeting the Health Care Challenge in West Virginia. Annual Report 2011.

³ Ibid.

MAs to serve as team leaders, care coordinators and site managers.

Moving Forward

In 2013, Cabin Creek was one of the 30 practices nationwide selected for the Robert Wood Johnson Foundation/Group Health Institute “Learning from Effective Ambulatory Practices” (LEAP Study).

While Cabin Creek still has four sites, it has increased the number of staff from 92 in 2010 to 128 in 2013 and moved its Clendenin Health Center to a larger facility. Additional services include some prenatal care and delivery and pulmonary rehabilitation. It is also in the process of implementing a new EHR.

Cabin Creek will add a fifth health center and additional staff in 2014. While they expect a change in patient volume resulting from the ACA, one administrator commented: “To be honest, we are already providing care for these patients, they are just uninsured. After the ACA, they will be insured, and that is wonderful. The lesson is that we need to use staff more efficiently and make sure they are working at the top of their license. This is a great time to think about reorganizing primary care.”