ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

Redesigning the Care Team:
The Critical Role of Frontline Workers and Models for Success

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Introduction

With health expenditures totaling $2.8 trillion and accounting for 17% of the US economy, issues of cost containment and quality improvement are a high priority.[1] With millions more patients entering the health care system as a result of health insurance expansion, an increasing prevalence of chronic disease and significant aging population, it makes sense that health care organizations and the workforce are continuously strained to meet an overwhelming demand for services. However, it is widely recognized that developing and supporting a productive workforce is essential to bending the cost curve and improving quality of care.

Recent estimates predict a shortage of 130,000 physicians and 260,000 registered nurses by 2025.[2] In an effort to balance the supply of clinicians and staff amid overwhelming demand for health care services, many organizations are transitioning to a team-based model of care; a model that has demonstrated significant improvements in the quality, delivery and efficiency of care across care settings.[3] To ensure that the team is accommodating the entire spectrum of a patient's needs—physical, mental, and social—it is important for an organization's care team model to embrace an interprofessional approach. For example, a care team may include physicians, nurses, and physician assistants, as well as psychologists and social workers, depending on the patient's needs.

Equally as important to rounding out the care team are **frontline health care workers.** This group represents an estimated 50% of the 18 million individuals employed in the U.S. health care workforce, and includes medical assistants (MAs), patient navigators, and community health workers.[4] These individuals often serve as the initial point of contact and/or ongoing peer support for patients and caregivers throughout their health care experience.

It is well known that the transition to a team-based model will be a challenging one. It will require significant investment in human resources, changes in workflow, adoption of new technologies, and strategies for dealing with change management. Fortunately, many organizations will benefit from efforts already being made by thousands of health providers throughout the U.S., including those operating as **accountable care organizations (ACOs)** or **patient-centered medical homes (PCMHs).** Both models strongly emphasize a care-team model and the inclusion of frontline workers.

The purpose of this toolkit is to define the role of frontline health care workers, and also provide case studies from organizations that have implemented team-based care models with frontline workers. In **Section 1**, we define the roles and responsibilities of frontline workers and in **Section 2**, we capture the experiences and lessons learned from four organizations that have implemented these models.

Defining New Care Delivery Models

Patient-Centered Medical Home (PCMH): A PCMH is a model for organizing primary care that is comprehensive, patient-centered, coordinated, accessible, and dedicated to quality and safety.
For more information, visit www.pcmh.ahrq.gov.

Accountable Care Organization (ACO): ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
For more information, visit www.cms.gov.

What is a Frontline Health Care Worker?

The term "frontline workers" describes health care workers that provide routine and essential services in a medical practice.[5] According to the Frontline Health Workers Coalition, "They are often based in the community and come from the community they serve, they play a critical role in providing a local context for proven health solutions, and they connect families and communities to the health system. They are the first and often the only link to health care for millions of people, are relatively inexpensive to train and support, and are capable of providing many life-saving interventions."[6]

They also take on a range of responsibilities. Oftentimes they will serve as the first point of contact for patients, families and caregivers when answering phones, scheduling appointments, coordinating patient follow up, and arranging transportation for patients, and may even take basic vital signs. According to the Bureau of Labor Statistics Occupational Classification, 26 occupations can be categorized as frontline workers. Examples of common roles include administrative support, customer service, and direct care in preventive services, health education, rehabilitative care, and chronic disease management (additional examples can be found in **Table 1.1**).[7] These workers also have important roles in a number of different settings or facilities, including long-term care, physician practices, community-based organizations, mental health facilities, and hospitals.

Table 1.1: Frontline Health care Occupational Categories[8]

Category	Occupation
Administration	Administrative assistants, medical records and health information technicians, medical transcriptionists, office clerks, and receptionists
Direct Care	MAs, cardiovascular technicians, dental assistants, emergency medical technicians, laboratory technicians, licensed practical and vocational nurses, nursing aides, pharmacy aides and technicians, physical therapy assistants, respiratory therapy technicians, and surgical technicians
Community and Public Health	Health educators, social and human services assistants
Long-term Care	Personal and home care aides
Mental Health	Mental health counselors, orderlies, psychiatric aides, and substance abuse counselors
Other	Dietetic technicians, medical equipment preparers, occupational therapy assistants and aides, and recreational therapists

Key Characteristics

The projected growth rate for all frontline health care workers between 2010 and 2020 is 25%, well above the national average. Across all categories, home health aides and personal care aides have the highest projected growth at 70% and% 69%, respectively.[9] Physical therapy assistants and aides, and occupational therapy assistants are also among the top 20 occupations with the highest projected growth. [10] In addition, all but four occupations—Respiratory Therapy Technicians, Medical Transcriptionists, Secretaries and Administrative Assistants, Medical and Clinical Laboratory Technicians—are above the national average.[11]

Table 1.2: Average wages of frontline health care workers

	10th Percentile	25th Percentile	Median	75th Percentile	90th Percentile
Average **Hourly** Wages	$11.84	$13.15	$15.69	$19.13	$22.64
Average **Annual** Wages	$24,625	$27,345	$32,625	$39,792	$46,255

Despite an increase in demand, compensation for these positions has decreased over the last decade. Frontline workers earn on average earn less than $40,000 annually, and typically have lower than a bachelor's degree education.[12] The median annual wage for the selected frontline workers is just over $32,000, while the median hourly wage is just over $15.[13] MAs, for example, earn less than $14 per hour. A Robert Wood Johnson Foundation study found that 79% of the frontline health care workforce is female, many of whom are often working more than one job.[14] The same study also found that one-third of the frontline health care workforce represents racial and ethnic minorities, including 18% African American, 10% Hispanic, and 4% Asian.[15]

SECTION 2:
The Impact of Frontline Workforce Development

The proper development of a frontline health care workforce has significant social, economic, and organizational benefits for a range of stakeholders, including the local communities and businesses that employ frontline workers, including those described below.

Health Care Delivery Organizations

Organizational Efficiency: As mentioned earlier and illustrated throughout the case studies in **Section 3**, the integration of frontline workers may lead to greater efficiency by allowing each member of the care team to operate at the "top of their license." Frontline workers can help accomplish routine tasks, clerical work, communicate with the patient's other providers, and even spend time with a patient to better understand his or her cultural/linguistic needs, potential social service needs, etc. By balancing some of the workload of physicians and clinicians, patients may experience shorter waiting times and the practice may increase the number of patients that are treated.

Staff Satisfaction: Career development programs and career pathways that target frontline workers can improve career satisfaction, thereby improving employee retention. Cost savings accrue due to reductions in the cost of recruiting and on-boarding.

Community Development: Organizations that invest in the development of their frontline workforce can become vehicles for community development. Directing educational resources to lower-level professionals will help refocus the educational pipeline, while supporting community college education will enhance retention of students and help meet workforce demands.

Financial Performance: Efficient frontline workers can also have a positive impact on a practice or organization's financial bottom line. For example, MAs trained in coding and billing can help improve the billing process by more accurately documenting receipt of services and procedures.

Providers

ACOs rely on physicians to provide access, wellness and prevention, health management, and care coordination services to improve the quality of care and leverage cost savings. A well-trained MA can offer a substantial amount of clinical support to physicians. Few states have a legal scope of practice that details the specific tasks that MAs can perform. Instead, they work under the physician's direct supervision. Trained MAs can perform basic triage, measure vital signs, administer medications, draw blood, remove sutures, and more. MAs may also be responsible for preparing medical instruments and collecting samples for testing. In helping with the administrative and clinical tasks, frontline workers can help improve provider productivity and assist in their workload.

Reforming the payment and delivery systems also requires strong physician leaders. Providers may be asked to take an active role in new responsibilities, including managing payer/provider contracts, developing a methodology to distribute shared savings, analyzing data trends, developing evidence-based guidelines, and encouraging practice redesign and care coordination. Front office clerks, MAs, and other clerical staff can help take on a number of the administrative responsibilities.

Payers

Any tools or services that improve workflow efficiencies, ease access to clinical information, increase care coordination, and enhance communication should be of interest to payers. Payers participating in ACOs and PCMHs will be incentivized to implement strategies that not only decrease the total cost of care, but also help providers hit quality metrics and improve health outcomes. Only when both conditions are met will payers receive a share of the savings accrued in reform efforts. Training the frontline staff to assist with care coordination, care management, and patient engagement significantly impacts resource utilization, workforce productivity, hospital and emergency room admissions, and patient experience.

Patients and Caregivers

Having access to frontline health workers is also important for patients and their families and caregivers. For example, patients with chronic conditions like diabetes have also experienced significant improvement in their conditions through health coaching and having better to access to the care team. More often than not, MAs are local to the practice's community, which allows the workforce to mirror the diversity of the community. This is important when delivering care that is culturally and linguistically appropriate.

SECTION 3:
Case Studies of Team-Based Care Models

This toolkit highlights several organizations that are using effective models for embedding frontline workers within their team-based care models. We conducted interviews with leadership, clinical and administrative staff from each organization to help articulate the business case for investing in frontline staff and integrating them into the care team. The interviews captured key strategies and success factors, costs and resources required to implement the redesign, and the redesign's clinical and financial outcomes.

Summary of Case Studies

- **Arizona Connected Care:** Provides a detailed example of Arizona Connected Care's use of MAs in a hospital ambulatory network and a primary care practice.

- **AtlantiCare:** Discusses AtlantiCare's Special Care Center, which uses MAs as health coaches to help deliver quality, coordinated care and lower health care costs.

- **Cornerstone Health Care:** Describes Cornerstone's use of MAs as patient care advocates to drive patient satisfaction, improve the quality of care, and reduce total expenses.

- **Lancaster General Health:** Explores Lancaster's use of MAs to coordinate care and reconcile medications for high-utilizers in the Medicaid program.

Case Study

Arizona Connected Care

Tucson, Arizona | www.azconnectedcare.org

Arizona Connected Care ("ACC") is a physician-led Accountable Care Organization in southern Arizona that includes Tucson Medical Center, four federally qualified health centers (FQHCs), and a growing network of physicians. ACC is also a recognized PCMH, and was one of the first health systems to participate in the Centers for Medicare and Medicaid Services (CMS) ACO Shared Savings Program. It recently expanded its services to more patients through a second shared savings contract with UnitedHealthcare in January 2013. Collectively, the two contracts cover an estimated 17,400 beneficiaries.

14,000 Medicare patients

2,800 high-risk Medicare patients

798 high-risk hospital admissions

5.5 to 8 hours of work per hospital admission

$300,000 –$430,000 annual cost in salaries

Strategies for Maximizing MAs in Ambulatory Care: Tucson Medical Center's Office of Care Coordination

The Office of Care Coordination at ACC's Tucson Medical Center is a key to achieving efficient and quality care. The office is an ambulatory program run by Innovative Practices, a medical services organization that ACC contracts to support physicians with care coordination, practice transformation, analytics, contracting, and general management services. The Office has a separate governing board with both physician and hospital representatives.

The Office designed two programs with detailed clinical and administrative workflows that enhance care coordination, particularly for high-risk populations. These programs include the **Care Transitions Program** and the **Care Advocacy Program**, both of which maximize the role of MAs to coordinate care

Care Transitions Program

The goal of the Care Transitions Program is to ensure continuity for patients as they move across care settings, including primary care, inpatient, home health, and specialists. The program pays special attention to patients that are at high-risk for readmissions and helps facilitate their transition from the hospital to the home or a post-acute care facility. Workers collaborate with patients to develop self-management plans, conduct in-home reviews of discharge medications, and provide continuous reporting for 30 days post-discharge. Of the 17,000 plus ACO beneficiaries, roughly 100 per month are screened for this program and on average 25-30 are selected to participate.

MAs play an important role in the Care Transitions Program. They are responsible for pulling information from a patient's history and doctor's notes, and populating individual data points in a risk assessment tool to assess likelihood for readmission. The MA shares the initial analysis for readmission with the team and assigns highest-risk patients to a transition nurse. Sample criteria for participation include a history of prior hospitalizations, high emergency department use, acuity of admission, complex medication management or discharge needs, and behavioral health status.

Care Advocacy Program

In the Care Advocacy Program, MAs help providers assess whether a patient should be directed to a social worker or a nurse, and includes care management, care advocacy, and coaching services. The program also provides in-home and telephone reviews of medication and self-management plans, patient status reports, and referrals to condition-specific resources. The MA provides outreach to patients and performs an initial phone assessment. The MA then directs the patient to the appropriate program, either nursing or social work, and may also connect the patient to the care team.

Financial and Clinical Impact

Tucson Medical Center provided the financial resources necessary for additional staffing and training (e.g., two weeks of intense training for the MA). Before implementing the Care Transitions Program, the Office of Care Coordination did a cost analysis. The first step was determining the size of the targeted patient population (the number of high-risk Medicare hospital admissions), which was identified to be 20-30% of their 14,000 Medicare fee-for-service and Medicare Advantage patients. The weighted average rate of admission for Medicare ACO patients was approximately 285 patients per 1,000 patients.

A conservative analysis suggests that there were approximately 2,800 high-risk Medicare ACO beneficiaries at Tucson Medical Center and 798 high-risk hospital admissions within that group. It was then estimated that each unique hospital admission would require 5.5 to 8 hours of work from the Care Transitions team. The Office of Care Coordination decided to hire 3 full time employees. The final cost for the Care Transitions Program was estimated to be between $300,000 and $430,000 annually. ACC estimates that 25% of future savings shared at ACC will go to funding similar efforts.

During the initial cost-benefit analysis, the Office of Care Coordination estimated that the Care Transitions Program could save $5,000 per patient in medical expenses. When applying this figure to the number of admitted high-risk ACO beneficiaries, the Care Transitions Program could save an estimated $2.6M to $4M. Early evidence already suggests meaningful decreases in avoidable emergency department use and hospital readmissions.

Strategies for Maximizing MAs in Primary Care: New Pueblo Medicine's Workforce Redesign

At ACC, New Pueblo Medicine offers a second example of a cost efficient staffing model that leverages frontline staff. New Pueblo Medicine is a private internal medicine practice and includes a staff of approximately 60 health professional, including seven internal medicine physicians, two certified nurse practitioners, 20 MAs, and 10 front office staff. As a recognized PCMH and participant in a UnitedHealthcare pilot, New Pueblo was able to negotiate a gain-sharing contract, which provided the initial funding necessary to add these positions. At the close of their PCMH pilot program in 2011, they had hired and/or created four full time employee positions, including a care coordinator, scheduler, and two MAs. In total, the practice spends more than $100,000 per year on these new staff additions.

Recently New Pueblo Medicine assembled groups of providers, patients, and staff to work together on a MA care redesign project. Physicians and MAs made a list of tasks that could be delegated to others in an effort to improve patient and provider experiences. As a result of this effort, MAs are now taking on more responsibilities for care management and care coordination.

New Pueblo Medicine's: Clinical and Financial Impact

New Pueblo Medicine strongly attests to the success of these programs in improving the quality of care and patient experience, while simultaneously lowering total cost. With 40% of the practice's revenue in 2012 coming from the PCMH and gain-sharing contract, the practice is confident it saw an increase in revenue. However, New Pueblo Medicine has no objective way of showing financial savings after implementation of this staffing model.

Improvements in provider engagement and performance can be partly attributed to the administrative and clinical support offered by the MAs. New Pueblo Medicine saw improvements in meaningful use reporting measures and saw a dramatic improvement in Risk Adjustment Factor Scoring, indicating overall improvements in the health status of the population. The practice believes its team approach, has resulted in higher staff retention rate.

Arizona Connected Care: Critical Success Factors

>> Encouraging an organizational culture of learning. All practices benefited from a culture that embraces learning and quality, and one in which the staff is responsible for mentoring others. Frontline workers benefit from tuition advancement and schedule flexibility for those taking classes. The practice creates individualized plans for development and includes questions regarding professional growth in performance reviews.

>> Using practice leaders to drive change management. Commitment from practice leaders was essential to driving change within the practice. ACC attributes much of its success to physician champions who helped implement these changes within each medical office.

>> Developing specific policies and protocols. ACC relies on protocols that outline specific clinical action steps when transitioning MAs to new roles and responsibilities. Using these as templates, organizations can create training materials and decide on the most important measures.

>> Engaging technical assistance support. ACC employed a consulting firm to help implement a number of accountable care solutions, including strategy development, augmenting services, and adoption of new technologies. New Pueblo Medicine took advantage of the resources available to them as part of the UnitedHealthcare PCMH pilot.

>> Collecting baseline quality and performance metrics. New Pueblo Medicine did not collect the appropriate metrics or establish the necessary baseline data to appropriately share its success in an objective way – an important lesson learned during this journey of workforce redesign. For example, New Pueblo Medicine wanted to track improvements in hypertension detection based on more regular testing. Metrics and data points would have allowed New Pueblo Medicine to illustrate its success in through data.

Future Opportunities

Leveraging great leaders, a collaborative spirit, and a partner willing to share risk, Arizona Connected Care was highly successful in implementing an innovative staffing model that integrates frontline health care workers. Tucson Medical Center is focused on bringing similar coordination and advocacy services to all of its patients post-discharge, while several other primary care practices within the ACO are looking to model their workforce processes after New Pueblo Medicine. The Office of Practice Transformation is currently working with New Pueblo Medicine to help replicate and scale these innovative staffing models.

Case Study

AtlantiCare
Southeast New Jersey | www.atlanticare.org

AtlantiCare is an integrated health system with more than 5,000 employees, including 600 employed and affiliated physicians across 70 locations. A number of AtlantiCare's 33 primary care practices are recognized PCMHs. The system is transitioning away from traditional fee-for-service reimbursement by implementing a number of shared savings contracts with commercial plans, including a Medicare Advantage program with Blue Cross Blue Shield of New Jersey. AtlantiCare is also a participant in the Medicare ACO Shared Savings Program.

Strategies for Ensuring Comprehensive Care: Using MAs as Health Coaches at The Special Care Center

The Special Care Center at AtlantiCare was originally established in 2007 to care for chronically ill health system employees and casino hotel employees covered by a union health and welfare fund. Today, the center is a recognized PCMH and cares for 2,600 chronically ill patients. Approximately 10% are beneficiaries in the Medicare Shared Savings Program. The center offers comprehensive services, including primary care, specialty care, pharmacy, behavioral health, nutrition, and laboratory. The center operates on a per-member per-month capitation payment model.

The Center's multidisciplinary care team includes physicians, nurse practitioners, pharmacists, health coaches, social workers, behavioral health workers, and other clerical staff. Modeled after the Ambulatory Intensive Care Unit (A-ICU), the Center developed a team care model that expands the role of MAs within the practice and uses them as health coaches.[15] Patients are assigned a health coach who is responsible for providing continuous contact, patient education, social service intervention, and cultural and linguistic support.

The entire team participates in a 30 minute huddle each morning to review patient cases and discuss care plans. The teams operate according to a "teamlet" model,[16] which includes an initial visit with the health coach and dedicated time with the clinician. The health coach also provides follow up and between-visit care.[16] The center estimates that more than 50% of all patient encounters are conducted solely with health coaches. Health coaches are also able to perform specific clinical tasks include A1c tests, glucose monitoring, blood pressure monitoring, and exercise counseling. The health coaches are also responsible for coordinating care between providers and their sites of care.

Critical Success Factors

>> Choosing the right staff for the patient population. The center places a strong emphasis on recruiting the right talent for these critical positions. Specifically, they look for individuals that reflect the demographics and cultural and linguistic qualities of the patient population. In addition, the on-boarding process requires that all new health coaches meet 30 core competencies, shadow current health coaches, and participate in one hour weekly training sessions.

>> Redesigning care with a top-down, bottom-up approach. Implementing new work processes and care teams requires formal top-down interventions and bottom-up job redesign from the workers themselves. Macro-level strategic priorities at the executive level helped create an environment and

culture that fosters innovation and progress. A bottom-up approach to care redesign also helps improve care delivery and patient-provider interactions.

>> Engaging physicians as leaders. For redesign to be effective, AtlantiCare also recognizes that all physicians must be comfortable with a team-based approach and delegating responsibilities to frontline staff. Moreover, physicians must be involved in the training of the health coaches.

>> Developing health IT tools to support the care team. Electronic medical records and health registries are needed to support the function of every staff member. During the morning huddles, patient charts are opened on laptops to discuss the clinical notes and create evidence-based care plans. Each health coach walks with a laptop to document medical histories, record care plans and medication protocols, and assist in patient scheduling.

Clinical and Financial Impact

AtlantiCare committed a substantial sum of money to this transformation project. A subset of that effort was dedicated to clinical transformation, specifically the hiring of frontline personnel and care managers. To assess financial impact, AtlantiCare hired an outside firm to perform an actuarial analysis. Prior to the center's redesign there was an increased spending rate of 12%. Over the last year, that rate was cut in half and is currently at -1.8%. Several independent studies indicate decreases in health care spending for patients at the Special Care Center.

An analysis by Harvard Medical School found that enrollees had 23% fewer outpatient procedures, 41% fewer inpatient hospital admissions, and 48% fewer emergency department visits during a one year period when compared to members of a control group. Collectively, these improvements contributed to a decrease in net health care costs of 12.3% during that first year. Another independent study compared health care costs and spending patterns for patients at the Special Care Center with a similar cohort of patients in Las Vegas. Analyses indicate short term savings of about $208 per member per month.

The center's internal data also demonstrates reductions in 30-day hospital readmissions, which is regularly less than 6%. In addition, health coaches at the center are improving point of care testing while reducing costs. For example, anticoagulation testing has achieved 93% cost savings, while A1c point of care testing has achieved 96% cost savings when compared to traditional charges.

The center has a number of metrics that demonstrate tangible improvements in patient health outcomes. Patients with systolic blood pressure greater than 140 dropped an average of 26 points after being in the practice for six months. Constant communication between the health coach and the on-site pharmacy help keep prescription fill rates for patients between 97 and 99%.

Finally, the center's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results demonstrate dramatic improvements across all domains related to patient experience. For example, 94% of all Special Care Center patients felt their provider spent enough time with them. This is particularly important when considering more than half of all patient encounters are solely with a health coach. The center also boasts a 95% patient retention rate, an indication of high patient satisfaction.

Future Opportunities

Building on the success of the Special Care Center, AtlantiCare is looking to export this model to other primary care practices. They are also looking at how to expand current activities to new sites of care (e.g., hospitals and skilled nursing facilities).

Case Study

Cornerstone Health Care

North Carolina (statewide) | www.cornerstonehealth.com

Cornerstone Health Care is a fully integrated multispecialty group with 85 locations and 1,800 employees throughout North Carolina. Approximately 20% are physicians and mid-level health professionals. Each primary care practice at Cornerstone is a recognized PCMH and all of the system's commercial and Medicare Advantage contracts are in value-based gain-sharing arrangements. Cornerstone is a Medicare Shared Savings ACO and participates in several commercial shared savings contracts, covering 56,000 lives.

5,528 Patient Care Advocate calls

1,816 new appointments, 999 of which were kept

115 additional referrals to specialists

$200 additional revenue per appointment

Cornerstone redesigned its care team model to control costs, and improve patient satisfaction and quality. Cornerstone has 330 clerical frontline staff and 249 certified and non-certified MAs. Part of their redesign includes training MAs to be patient advocates and health navigators.

Strategies for Enhancing Care for High-Risk Populations: The Patient Care Advocate Program

The Patient Care Advocate Program designates MAs as patient advocates, to provide outreach and support for high-risk patients. These patients are identified using sophisticated analytics tools. Once a high-risk patient is identified, the patient advocate initiates a conversation with the patient via phone and sets up an appointment with their primary physician. All patient encounters are documented and tracked in a database. Since it started with only two MAs, the program has since expanded 11 certified MAs and one administrative assistant.

Critical Success Factors

>> Investing in continued education and training. In addition to creating new positions for the frontline staff, Cornerstone invests in continued education and training. Cornerstone developed interactive videos on a number of educational concepts (e.g., PCMHs, ACOs, and team-based care). All employees are required to participate in the video series and receive a certificate designating them as a medical home professional. Cornerstone offers performance excellence training to all frontline staff and tuition reimbursement of up to $500.00 per semester for local university, college, or online programs.

>> Change management and leadership buy-in. Leadership buy-in was instrumental in getting staff committed to implementing the redesign. The redesign included a number of changes to daily routines, workflows, and technologies that were sometimes viewed as disruptive. However, with support from the Chief Medical Officer and the Division Operations Directors, physicians and others were encouraged to buy-in to the changes.

>> Leveraging tools and technical assistance. Cornerstone used an external consultant who analyzed every aspect of the care team and the different ways employees at all levels contribute to patient satisfaction. The American College of Physician Executives offered leadership training and Cornerstone used Press Ganey's Consumer Assessment of Health Care Providers and Systems Public Reporting System to measure patient satisfaction.

Clinical and Financial Impact

To measure their financial return, Cornerstone calculated the revenue generated from new office visits. During the first six months of the Patient Care Advocate Program, the team made 5,528 calls. Of those calls, 1,816 resulted in scheduled appointments, and 1,128 of them were scheduled within the same six month window. Of the calls scheduled, 999 appointments were kept and 115 calls resulted in additional referrals to specialists. With Cornerstone recouping an estimated $200 per appointment the program is now paying for itself.

Cornerstone has traditionally benefited from a low staff turnover rate of approximately 8-9% across all positions. However, the position with the highest turnover was the check-in/checkout clerical staff and, in an effort to improve employee satisfaction within that cohort, Cornerstone implemented an excellence program. In 2011, turnover among clerical frontline works was down to 5.2%. Cornerstone offers financial incentives to the entirety of its staff – providers, nurses, MAs, and front office staff. Ten percent of payments earned from the federal government's meaningful use of electronic health records program is used as incentive bonuses for practices with high patient satisfaction.

Cornerstone also created two task forces to develop standards, training, and workflow changes needed to improve the quality of chronic diseases management, specifically diabetes and hypertension. These task forces have provided frontline staff with the training and skills necessary to check blood pressure, measure blood glucose levels, and other required care processes.

Future Opportunities

Cornerstone is committed to optimizing care teams and transforming the way care is delivered. Near term activities include expanding the Patient Care Advocate Program to service recovery and training MAs as health navigators. In addition, Cornerstone is partnering with Rite-Aid to implement a pilot program that will use health coaches in six different pharmacies.

Case Study

Lancaster General Health

Lancaster, PA | www.lancastergeneralhealth.org

Lancaster General Health ("Lancaster") is a nonprofit health system that includes Lancaster General Hospital, the Women and Babies Hospital, Lancaster General College of Nursing and Health Sciences, VNA Community Care Services, Lancaster Rehabilitation Hospital, numerous outpatient and urgent care centers, and a medical group with more than 100 primary care physicians and specialists. Six of Lancaster's primary care practices are PCMHs, four of which are Level III NCQA-certified, while the other two are part of a Highmark multi-state pilot program. By 2014, the goal is to have all primary care practices recognized as PCMHs.

Strategies for Coordinating Care for Medicaid Populations: A Health Navigator Model for MAs and EMTs

Lancaster has redesigned career paths for the frontline staff as part of a broader effort to improve employee satisfaction and quality of care. It is also piloting a model that targets high-utilizers within the Medicaid population. Frontline workers are responsible for providing a comprehensive care network to this patient population, supporting care coordination and reconciling medications. In this program, high-risk Medicaid patients are identified, removed from the PCMH, and then enrolled in a new care coordination program. Once the patient can manage their illnesses more effectively, they can eventually transition back into the PCMH. The frontline staff plays a key role in offering care coordination and medication reconciliation services to these patients.

Lancaster launched a health navigator program in April 2013 to help Medicaid patients navigate the many resources available to them. In some cases, these patients did not have the most complex illness, but suffered with difficult social issues. Lancaster is working with the state and county governments to align behavioral health workers, agencies, community support systems, and others. The program first trained Emergency Medical Technicians (EMTs) and paramedics as navigators, but is now expanding the program to include MAs, community workers, and other frontline staff. These staff members will assist those patients who may need help filling out forms and help staff a call center.

Strategies for Ensuring Medication Compliance: Pharmacy Technicians as Medication Specialists

Lancaster's pharmacy technicians or medication specialists are available 24/7 to make sure patients receive appropriate medication upon discharge. On average they spend 30 minutes with each patient to identify risk factors for non-compliance. For example, if cost is an issue, they will work with financial services to identify lower cost medications or provide resources to get the patient the medication they need.

Strategies for Redesigning Career Paths: Offering Upward Mobility for Technicians and Therapists

Lancaster is redesigning career paths and adding opportunities for frontline workers to advance within various departments. Lancaster developed a career ladder within each department with well-defined roles and responsibilities, providing opportunities for frontline workers to be promoted. For example, the sterile processing department suffered from high turnover, as most positions were viewed as dead-end jobs. During the redesign process, they developed a career ladder with four distinct levels and defined roles and responsibilities. At the entry level, transporters push carts to the operating room and

can train further to become a sterile processing technician. Sterile process technicians are responsible for decontamination, sterilization, and set assembly. Further along the continuum, they can choose to train for a team leader or shift leader position that has more management responsibilities.

Figure 1: Sample Career Ladder at Lancaster Health

There are additional clinical ladders in place for surgical technicians, physical therapy technicians, cardiovascular technicians, physical medicine and rehabilitation, physical therapy, occupational therapy, and speech and language therapy.

Critical Success Factors

>> Fostering a Culture of Learning. Supporting the staff and mentoring recent graduates is commonplace at Lancaster. Lancaster encourages the staff to consider the future of their careers and looks for ways to help employees transition into new positions.

>> Learning from Peer Organizations. Lancaster worked with Boston Children's Hospital in the Standardized Clinical Assessment and Management Plans (SCAMPS) program to create standardized care and assessment programs. Sharing common knowledge was important for successful implementation at Lancaster. Lancaster also visited Healthcare Partners in Los Angeles, a health system that has over one million patients in capitated contracts and benefitted from their job descriptions and basic templates for roles and responsibilities.

Clinical and Financial Impact

Lancaster's workforce redesign project cost approximately $2M. Major expenses included hiring of 1.5 FTE physicians, four navigators, additional nurse practitioners, social workers, case managers, and practice managers. Lancaster also worked with an innovation company to find new ways to model care and redesign the care workflow. Lancaster also worked with consultants to redesign workflows and is now working with five managed care organizations to develop gain-sharing incentives. They are also looking to experiment with other payment models. Overall, the effort has improved employee satisfaction. The sterile processing department, as one example, has also observed better compliance since the incorporation of the career ladder.

Future Opportunities

Lancaster is looking to expand the scope of its current activities by introducing pharmacy technicians to new departments, and expanding the scope of practice for its health navigators. Further, Lancaster's primary care practices are all on track to be recognized PCMHs, and they intend to participate in the Medicare ACO Shared Savings Program.

Appendix 1: Helpful Resources & Tools

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Appendix 2: Categories of Frontline Workers

Table 1: Frontline Worker Occupations from the Bureau of Labor Statistics

Using the Bureau of Labor Statistics Occupational Classification, twenty-six occupations were identified as frontline health care positions. Source: *2012-2013 Occupational Outlook Handbook.* Bureau of Labor Statistics. U.S. Department of Labor. 02 February 2013. http://www.bls.gov/ooh/

Occupation	Median Wages (2010)	Hourly wage (2010)
Cardiovascular Technologists and Technicians	$49,410	$23.75
Dental Assistants	$33,470	$16.09
Dietetic Technicians	$27,060	$13.01
Emergency Medical Technicians and Paramedics	$30,360	$14.60
Health Educators	$45,830	$22.03
Home Health Aides and Personal Care Aides	$20,170	$9.70
Licensed Practical and Licensed Vocational nurses	$40,380	$19.42
Medical and Clinical Laboratory Technicians	$46,680	$22.44
MAs	$28,860	$13.87
Medical equipment preparers	$29,490	$14.18
Medical Records and Health Information	$32,350	$15.55
Medical Transcriptionists	$32,900	$15.82
Nursing Aides, Orderlies and Attendants	$24,010	$11.54
Occupational Therapy Assistants and Aides	$47,490	$22.83
Office Clerks	$26,610	$12.79
Pharmacy Aides	$21,430	$10.31
Pharmacy Technicians	$28,400	$13.65
Physical Therapist Aides and Assistants	$37,710	$18.13
Psychiatric Aides and Techs	$26,880	$12.92
Receptionists (Physician Offices, Dentist Offices, Personal Care Services)	$25,240	$12.14
Recreational Therapists	$39,410	$18.95
Respiratory Therapy Technicians	$45,210	$26.10
Secretaries and Administrative Assistants (Health Practitioners)	$34,660	$16.66
Social and Human Services Assistants	$28,200	$13.56
Substance Abuse and Behavioral Disorder Counselors	$38,120	$18.33
Surgical Technologists	$39,920	$19.19

Appendix 3: Workforce Templates

Listed below are templates (e.g., job descriptions and training sheets.) provided by the Special Care Center at AtlantiCare.

Job Description: Health Coach

Position Summary: The Health Coach participates as a member of the care team by assisting in the planning, providing, and evaluating of patient care and education under the direction of the Nurse Practitioner or Provider.

The Health Coach participates with the multidisciplinary treatment team by assisting in the development of the multidisciplinary plan according to departmental standards. This position provides direct patient care as needed, to include patient orientation to the unit, health education related to disease, medication and activities of daily living, taking vital signs, reporting observations to the nurse and members of multidisciplinary team.

This position delivers care in a prompt and professional manner, always maintaining the highest level of confidentiality and respect. The Health Coach works as part of the multidisciplinary team to meet the needs of the customer and to support departmental objectives. This position provides quality customer service, participates in performance improvement efforts and assumes responsibility for professional growth and development.

Qualifications:

- **Education:** MA Certification
- **License/Certification:** BLSHCP certification required.
- **Experience:** 1-2 years hospital clinical or physician office experience preferred. Proficiency in Clinical Applications preferred at time of hire; incumbents within position will be trained appropriately and then skill will be required for this position within 30-60 days from date of hire.

Performance Expectations

Demonstrates the competencies as listed on the Assessment and Evaluation Tool for this position.

Work Environment

Potential for exposure to the hazards of the hospital environment, such as exposure to infectious disease, blood-borne pathogens, hazardous waste, and potential injury. This position requires considerable standing, reaching and walking. The ability to lift up to 50 lbs is required.
Essential functions of this position are listed on the Assessment and Evaluation Tool.

Appendix 3: Workforce Templates (cont'd)

Template Health Coach Training Sheet

Sr. No	Task	Minimum Number	Employee Initial	Trainer Initial	Date Completed
1	Huddle				
2	Welcome visit				
3	Planned visit				
4	BGM				
5	Glucometer training				
6	BP check				
7	Meds reconciliation				
8	Pap / pelvic				
9	Exercise counseling				
10	Weight				
11	Peak flow				
12	Foot exam / edema				
13	EKG				
14	A1c & Glucose test in house				
15	INR				
16	Urine dip / clean catch				
17	Eye chart				
18	Nebulizer set up				
19	Inhaler teaching				
20	Ace wrap				
21	Pulse and pulse ox				
22	Patient education				
23	Referrals to specialist				
24	Documenting & Locking notes in ECW				
25	Scanning				
26	Docsite				
27	FMLA				
28	Stocking of rooms				

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