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# Expanding Roles of Medical Assistants in the Patient Centered Medical Home

Christopher W. Eldridge

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# Expanding Roles of Medical Assistants in the Patient Centered Medical Home



Muskie School of Public Service  
At the  
University of Southern Maine

By  
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6/1/2013  
For HPM 699 Capstone requirement; Elise Bolda, Faculty Advisor

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# Change in Care

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The Patient Centered Medical Home (PCMH) is a new model of care endorsed in 2007 by the four major primary care physician associations:

- [American Academy of Family Physicians \(AAFP\)](#)
- [American Academy of Pediatrics \(AAP\)](#)
- [American College of Physicians \(ACP\)](#)
- [American Osteopathic Association \(AOA\)](#)

There are over 300,000 physicians' currently delivering care using this model and it has been implemented in multiple states across the country including New Hampshire, Rhode Island, Alabama, Iowa, Kansas, Maryland, and Maine.

The PCMH is an approach to providing comprehensive primary care for children, youth, and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians, and, when appropriate, the patient's family as defined in the 2007 document *Joint Principles of the Patient-Center Medical Home*. The five key principles as defined in the article are:

- 1) *Physician Directed Medical Practice* in which the personal physician leads a team to provide ongoing care for patients.
- 2) *Whole Person Orientation* in which the physician is responsible for taking care of all the patient's needs such as acute care, chronic care, preventive services, and end-of-life care.
- 3) *Care is Coordinated and/or Integrated* across health systems and the community

- 4) *Quality and Safety* in which patients actively participate in decision making; feedback is sought to ensure patients' expectations are being met.
- 5) *Enhanced Access* to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.<sup>1</sup>

It is a model which coordinates the care of patients across all spectrums of the health care market and is founded on four main ideas; primary care, patient-centered care, new-model practice, and payment reform.<sup>2</sup>

Building on innovations emerging from the relatively recent era of continuous quality improvement, patient safety, transparency, and accountability, these 21<sup>st</sup> century practices are called on to incorporate evidence-based processes of care. This includes population-based care management facilitated by patient registries, performance measurement and improvement, point-of-care decision support, and information technology.<sup>3</sup> Use of information technology (IT) has further widened the scope of such practice innovations, holds the promise of involving patients more effectively in the management of their own health, and can relieve access pressures and reduce costs.

An example of the positive effects of this type of change towards a PCMH was seen in Seattle where a primary care practice was encountering problems with physician burnout and declines in quality. The clinic added a physician to its staff in order to decrease each physician's caseload from 2,300 to 1,800 each. The clinic also added, to its complement of medical

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<sup>1</sup> "Joint Principles of the Patient-Centered Medical Home." *Patient Centered Primary Care Collaborative*. N.p., n.d. Web. 15 Dec. 2012.

<sup>2</sup> Rittenhouse, Diane R., and Stephen M. Shortell. "The Patient-Centered Medical Home, Will It Stand the Test of Health Reform?" *The Journal of the American Medical Association*, n.d. Web.

<sup>3</sup> Rittenhouse, Diane R., and Stephen M. Shortell. "The Patient-Centered Medical Home, Will It Stand the Test of Health Reform?" *The Journal of the American Medical Association*, n.d. Web.

assistants, licensed practical nurses, physician assistants, and nurse practitioners, in a team that also included a clinical pharmacist. E-mail and interactive IT were also used to provide patients with new self-management tools. The added staff relieved physicians of many routine duties, reducing the number and increasing the duration of daily patient encounters. Enhanced communications resulted in a reduction in office visits, and health improvements resulted in fewer hospitalizations among the clinic's patients, which helped offset the costs of increased staffing. Emergency room visits by the clinic's patients were 29 percent lower than at comparable clinics that were not included in the experiment, and net per-patient costs averaged \$10.30 less per month after nearly two years.<sup>4</sup> This experiment has proven that this type of model of care can work and benefit not just patients, but the physicians and clinical staff as well yet has shown a heavy reliance on non-physician staff for success, especially Medical Assistants.

## Medical Assistants

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With the adoption of the PCMH model, the demand for competent, trained employee medical assistants has risen and the increased job responsibilities and education continues to be a focus. One clear example of this is how Electronic Health Records (EHRs) are changing medical assistants' jobs. More and more physicians are adopting EHRs, moving all their patient information online. This results in the need for assistants to learn the EHR software that their office uses.

The American Association of Medical Assistant Board of Trustees adopted the following definition "A Medical Assistant is a multi-skilled allied health professional, dedicated to

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<sup>4</sup> Margolius, David, Richard Baron, Don Klitgaard, and Steven Wartman. "Forum Session." *Transforming Primary Care: Implications for Practice Design and Workforce*. National Health Policy Forum, n.d. Web. 15 Dec. 2012.

assisting in all aspects of a medical practice under the supervision of a physician." The medical assistant assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a Medical Assistant communicate effectively, adhere to ethical and legal standards of medical practice, recognize and respond to emergencies, and demonstrate professional characteristics.<sup>5</sup>

The need for medical assistants began when doctors experienced increasing demand on their time. Specialized health professionals were needed to help meet the demands. In 1934, Dr. M. Mandl founded the first school, training individuals to work specifically in doctor's offices. By 1955, standards for educational programs were a must; therefore, The American Association of Medical Assistants (AAMA) was founded to standardize educational programs and offer accreditation to those meeting specific criteria. In 1978, the United States Department of Health Education and Welfare formally recognized the Medical Assistant as an allied health profession.<sup>6</sup>

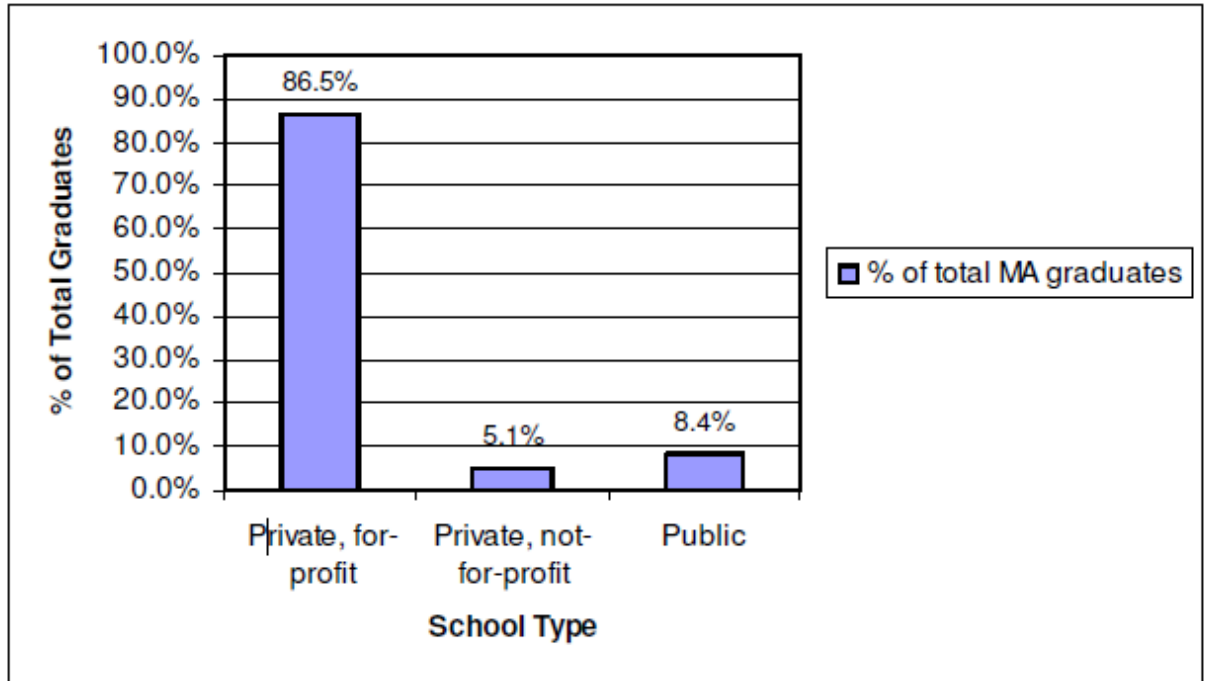
Medical assistants typically have a high school diploma or equivalent. There are no formal educational requirements for becoming a medical assistant in most states. However, some medical assistants graduate from formal education programs, and employers may prefer such training. Programs are available from community colleges, vocational schools, technical schools, or universities and take about 1 year to complete. These programs usually lead to a certificate or diploma. Some community and junior colleges offer 2-year programs that lead to an associate's degree. All programs have classroom and laboratory portions that include lessons in anatomy and basic medical terminology. Some states may require assistants to graduate from an accredited

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<sup>5</sup> "History and Purpose of Medical Assisting." *Waketech.edu*. Wake Tech Community College, n.d. Web.

<sup>6</sup> "History and Purpose of Medical Assisting." *Waketech.edu*. Wake Tech Community College, n.d. Web.

program or pass an exam or both in order to do advanced tasks, such as taking x-rays and giving injections.<sup>7</sup>



Source: Integrated Postsecondary Education Data System (IPEDS), 2006

Medical assistants are not required to be certified. However, many employers prefer to hire certified assistants. The CMA (AAMA) credential represents a Certified Medical Assistant (CMA) who has achieved certification through the American Association of Medical Assistants (AAMA). The CMA (AAMA) must graduate from an accredited postsecondary academic program; pass a national examination administered by the National Board of Medical Examiners, and recertify every five years.<sup>8</sup>

<sup>7</sup> Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Medical Assistants

<sup>8</sup> Balasa, Donald A. "New Roles for the Certified Medical Assistant." *Aama-ntl.org*. American Association of Medical Assistants, Mar.-Apr. 2008. Web.



# Problem

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A restructuring of the practice and expanding the roles primary care practice staff play is one area of improvement needed in conjunction with the PCMH model. Advanced practice nurses, physician assistants, medical assistants, and other non-physicians may be able to provide routine services for patients whose needs are not acute or complex enough to require a physician's attention.<sup>9</sup>

With the introduction of the PCMH model and the expanding roles of primary care practice staff, new demands are being placed on medical assistants. "The medical assistant is becoming more and more important as medicine has been changing," said Dr. Rachel Wanne, a family practice physician at Bellingham Bunks Medical Center in Bellingham, Washington. "Doctors are relying more and more on their MAs to do more of the information gathering, more counseling with their patients, and dealing with all kinds of phone issues and medication issues."<sup>10</sup> This is especially true of the Maine Quality Counts Patient Centered Medical Home Pilot that is occurring in the State of Maine which states that one essential role in the PCMH is that of the Medical Assistant (MA) or Clinical Assistant (e.g., LPN). MAs in particular take on new and enhanced responsibilities for patient care in the PCMH Model. For PCMH transformation, elevating the involvement of and expectations for MAs, and the level of confidence of providers in MAs, is a key element of success.<sup>11</sup>

A medical assistant's day can encompass scheduling appointments over the telephone, greeting patients in the office, taking vital signs, administering shots, authorizing prescription

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<sup>9</sup> Margolius, David, Richard Baron, Don Klitgaard, and Steven Wartman. "Forum Session." *Transforming Primary Care: Implications for Practice Design and Workforce*. National Health Policy Forum, n.d. Web. 15 Dec. 2012.

<sup>10</sup> Vinson, Mark. "Charting New Career Choices in Medicine." *Business Pulse* Dec. 2006: n. pag. Web.

<sup>11</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web

refills by phone, doing lab work, scheduling referrals to specialists and acting as liaison with insurance carriers.<sup>12</sup> Many of the core principles described in the new PCMH model are centered around and can apply to the day to day job of a medical assistant.

An evaluation of the Colorado Family Medicine Residency PCMH Project included iterative qualitative analysis of field notes, interviews, and documents to identify early barriers to change and strategies to overcome them. Issues experienced by medical assistants, as well as clinical and public services representatives within this project, included

- 1) Resistance and skepticism about change were expressed through cynicism aimed at change or ability to change
- 2) Unproductive team processes were reflected in patterns of canceled meetings, absentee leaders, or lack of accountability,
- 3) Knowledge gaps about the Patient-centered Medical Home (PCMH) were apparent from incomplete dissemination about the project or planned changes from leadership.
- 4) EHR implementation distracted focus or stalled improvement activity
- 5) Traditional role expectations and structures resulted in insufficient staff participation<sup>13</sup>

Barabara Marchelletta, Medical Assistant Program Director at Beal College in Bangor, Maine mentioned additional challenges facing medical assistants as well as the clinical staff they work alongside including:

- 1) Working with uncertified medical assistants; those medicals assistants who have graduated from an accredited medical assistant program but opted out of taking the certification exam.

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<sup>12</sup> Vinson, Mark. "Charting New Career Choices in Medicine." *Business Pulse* Dec. 2006: n. pag. Web.

<sup>13</sup> Fernald, Douglas H., Nicole Deaner, Caitlin O'Neill, Bonnie T. Jortberg, Frank V. DeGruy, and Perry Dickinson. "Overcoming Early Barriers to PCMH Practice Improvement in Family Medicine Residencies." *Family Medicine* 43.7 (2011): 503-09. Web.

- 2) Having the physician gain confidence in their (the MA's) critical thinking skills, patient education skills and
- 3) Having enough medical assistants that are certified on staff.

The problem with medical assistants within a PCMH model is a lack of adequate training, inconsistent professional certification, workplace resistance to change, and a lack of support from practice leadership. These demands may also include inconsistent roles and responsibilities profession-wide.

This project will explore the effects of the increased roles and responsibilities the newly accepted and adopted PCMH model has on the field of professional medical assistants. It will explore MA competence relating to new or increased roles and any deficiencies in overall preparedness. It will explore MA training, challenges coming out of educational programs, whether they are able to handle the changes in this model of care, whether the practice leadership (physicians, nurses, management) are willing to accept the change in model of care as it pertains to medical assistants, and what areas of an MAs education and role in the model could be improved.

## Approach

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### Primary Data

The information presented came from various sources. My research was mainly qualitative in nature. I conducted several interviews with constituents from a primary care practice. Among those I interviewed included primary care physicians and medical assistants from a practice that is currently in the process of implementing the patient centered medical home model in their practice. This practice was chosen as it was one of the practices selected to

participate in the Maine Quality Counts Patient Centered Medical Home Pilot, had a fairly large number of Medical Assistants on staff, and was open to the idea of discussing not only its challenges but it's triumphs as well, relating to the pilot and their medical assistants within this model of care. In addition, I interviewed administration from an accredited medical assistant program in the state of Maine.

## Secondary Data

Secondary data sources included scholarly articles utilizing various internet search engines and databases as well as the University of Southern Maine's and Maine Medical Center's library. The areas of information gathered came from the interviews and articles regarding Medical Assistants in the PCMH model including:

- Costs Savings of Medical Assistants
- Workflow Increases
- Patient Satisfaction
- Medical Assistant Satisfaction/Dissatisfaction
- Preparedness
- Educational Gaps
- Overall Benefits of Medical Assistants
- Physician satisfaction with Medical Assistants
- Time Savings
- Disadvantage of Medical Assistants

# Findings

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## Maine Quality Counts

Recognizing the essential role of primary care in our healthcare system, the Dirigo Health Agency's Maine Quality Forum (MQF), Maine Quality Counts, and the Maine Health Management Coalition has been working together to lead the Maine Patient Centered Medical Home (PCMH) Pilot. The participating practices include a diverse mix of adult and pediatric practices from around the state that were selected for their demonstrated leadership for and commitment to the principles of the PCMH model.<sup>14</sup>

As part of their participation in the Pilot, practices are expected to implement a set of ten "Core Expectations" addressing key practice changes, and will be supported in their continued efforts to transform to a more patient centered model of care through participation in a PCMH Learning Collaborative. The ultimate goal of this effort is to sustain and revitalize primary care both to improve health outcomes for all Maine people and to reduce overall healthcare costs<sup>15</sup>

In addition leaders of the Pilot are also committed to measuring changes in the clinical quality of care delivered to patients in Pilot practices. They have identified a set of thirty-one clinical quality measures that assess quality of care for chronic conditions such as diabetes and cardiovascular care, and preventive health, such as immunizations and cancer screening

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<sup>14</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web

<sup>15</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web



## Core Expectations

***Pilot practices are committed to achieving the following Core Expectations:***

1. Demonstrated physician leadership for improving care & implementing the PCMH model in the practice
2. Team-based approach to care
3. Population risk stratification and management of patients who are at risk for adverse outcomes
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families in implementation of PCMH model
8. Connection to community – connect with local Healthy Maine Partnership and other community resources to help patients meet goals
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration of health information technology (HIT) to support improved communication with and for patients

### PCMH LEARNING SESSIONS

Since the start of the Pilot in January 2010, leadership teams from each of the Pilot practices have been participating in a PCMH “Learning Collaborative”. This Collaborative is a program of structured learning that includes day-long educational “Learning Sessions” where teams from each practice come together to learn from each other and from subject matter experts every few months thereby learning about best practices and sharing experiences. In the first half of this effort, Pilot leaders sponsored six Learning Sessions, each featuring these nationally- recognized experts, who share lessons learned and best practices concerning a wide array of improvement topics. The Learning Sessions receive high marks from practice teams, with over 100 members of the Pilot practice teams, including patients, attending each of the Learning Sessions to date.<sup>16</sup>

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<sup>16</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web

### **QUALITY IMPROVEMENT COACHES**

Pilot practices are provided with many resources to help them improve care for their patients. Building on the education and support they receive in the Learning Sessions, practice teams receive tailored technical assistance and one-on-one coaching for quality improvement from a statewide network of external coaches, who receive training and support from Pilot staff and from the Maine Practice Improvement Network, a network supporting education and development of quality improvement coaches. Between Learning Sessions, coaches work directly with Pilot practices to identify areas for improvement, develop plans for change, and help assess their impact on the practice.<sup>17</sup>

### **TECHNICAL ASSISTANCE AND DATA FEEDBACK REPORTS**

Help doesn't stop there. In addition to Learning Sessions and coaching, Pilot participants are provided with many other support and education activities, including regular conference calls, regional meetings with their peers, site visits, webinars and a user-friendly web site offering a wide array of resources. Practice teams can tap into technical assistance experts in key areas, such as finding ways to better coordinate behavioral health needs for their patients and ways to directly engage patients in their improvement efforts. Practices also receive performance reports that compare their performance with peers, focusing on key utilization measures and areas for improvement.<sup>18</sup>

### **PRACTICE CHANGES**

The last component of the Pilot evaluation examines the processes that practices have used to effect change during the course of the Pilot, and factors that may contribute to their success in achieving its goals, including the practices' organizational culture and staff stress

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<sup>17</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web

<sup>18</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web

levels. Results from a baseline survey of practices showed strengths in teamwork, use of health information technology, knowledge and use of community resources, openness/ability to change, and patient safety-oriented culture. Over the first eighteen months of the Pilot, all practices have reported progress, and many have made substantial gains in a short period. Practices have identified learning from each other as critical to this growth and change.<sup>19</sup>

### **Primary Care Physicians Interview**

The second portion of my research involved the interviewing of physicians from a single small to medium sized primary care practice that has implemented the Patient Centered Medical Home model and is currently involved in the Maine Quality Counts Pilot. I was interested to see if there were variants of understanding regarding the PCMH model, how things have changed since they implemented the model of care into their practice, how they saw the current and future role of the Medical Assistants as well as how they used them in their practice, and what barriers and/ or struggles they saw the Medical Assistants experiencing before and after implementation.

I had originally planned on holding a focus group with all of the providers in order to gain some consensus on responses to interview questions, but due to scheduling conflicts individual interviews had to be held. However, due to the one-on-one setting I was given with the providers I was able to discover differing and revealing responses from each of respondents.

I interviewed three different providers each of whom had varying educational backgrounds, years of experience, and length of time at the practice of interest. A majority of the responses that were given were consistent among all three providers including need for medical assistants, who they hire for medical assistants, and medical assistant job duties.

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<sup>19</sup> *Maine Patient Centered Medical Home Pilot Project Halfway Report*. Rep. Maine Quality Counts, 2012. Web



## PROVIDER CONSENSUS

### *Medical Assistant Need*

All three providers highly valued the role of the Medical Assistant, seeing them as, in some way or another, the eyes and ears of the practice. They believed that it was much more cost efficient to hire on Medical Assistants instead of hiring more costly clinical staff, especially for tasks that are often seen as rudimentary. This is a perfect reflection of June 2006 data from the Bureau of Labor Statistics where mean earnings for MAs were \$26,843, placing them well below many other health personnel, including nurses, clinical lab technicians, and radiographers. Therefore, if MAs can perform many of the basic clinical procedures as well as front-office functions, it is much more cost-effective for employers to hire them rather than employ higher-paid health professionals to perform many of the same functions. In addition, rather than having to hire a clinical lab technician, a radiographer, and a larger number of nurses for a small- to medium-size primary care practice, an MA can function in a multi-skilled role and at a lower cost.<sup>20</sup>

### *Hiring of Medical Assistants*

When hiring new MAs they hold peer interviews which include eight to ten staff members in the room asking the applicants scripted questions. This gives the practice the ability to read the interviewee's reactions to specific questions and situational examples or scenarios.

All three providers believed that what is most important to them and to the practice in general when hiring a new medical assistant was not necessarily the level of education the medical assistant had but more on how well they fit with the practice culture. Of course hiring a medical assistant that had graduated from a credible medical assistant program was a

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<sup>20</sup> "From Education to Regulation: Dynamic Challenges for the Healthcare Workforce." Ed. Denise E. Holmes. Association of Academic Health Centers, 2008. Web

requirement; they truly valued an MA that had a personality, was motivated, and most importantly hard working. One provider did value certain characteristics of new hires more than the other two, most specifically:

- The MA has a 2 year degree and graduated from a Medical Assistant program
- The MA has practical experience from previous jobs (not necessarily healthcare related)
- The MA has experience in how a doctor's office runs, what the doctors need are, and what the patients need are
- Sound recommendations from either previous employers or school faculty members

Once hired, medical assistants at the practice go through additional practice specific training by either the nurse manager, nurses, or seasoned medical assistants and often times, when placed on one of the doctor's teams, provider specific training. This alludes to the fact that the training of MAs is not uniform. For example, one of the Medical Assistants interviewed, works under a provider who sees patients addicted to certain prescription medications, the MA never having been fully trained in this area.

As previously mentioned, educational programs exist in the form of short-term or one-year programs in vocational or technical schools, or in a two-year associate degree in a community college. Some educational programs for MAs in community colleges and elsewhere offer, on a continuing education or credit basis, modules in areas such as coding for billing or specialized clinical tasks. Thus, even within the MA field, specialization is occurring. The lack of consistent training may lead to calls for greater standardization and as a result, create a push toward greater credentialing. Even though MAs can add flexibility to staffing and utilization, the broad and variable scope of practice and the inconsistency in MA training raise concerns about

evenness in the quality of care they provide. The dichotomy arises, then, as to whether there should be more standardization and uniformity in their educational preparation and their scope of practice.<sup>21</sup>

Greater standardization would lead to incorporating various forms of credentialing, such as requiring the MA to go through a formal education program and requiring that program to be professionally accredited in order to qualify the MA as eligible for certification. The state could require employers to hire only MAs who hold national certification if they are to perform certain tasks, or even ratchet up the regulatory process and license MAs.<sup>22</sup>

#### *Medical Assistant Responsibilities*

In response to their understanding of what the medical assistants at their practice had for job duties they all came to some consensus. Job duties discussed included:

- Rooming Patients
- Data Entry
- Phone Responses
- Coordinating Results (Ex: Pap Smears)
- Tracking Immunizations (Seen as a burden)
- Asking safety and falling at home questions
- Helping refill medications (Working the refill telephone line)
- Talking to patients about problems (Strictly in office)
- Health Screening
- Giving injections and/or immunizations

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<sup>21</sup> "From Education to Regulation:Dynamic Challenges for the Healthcare Workforce." Ed. Denise E. Holmes. Association of Academic Health Centers, 2008. Web

<sup>22</sup> "From Education to Regulation:Dynamic Challenges for the Healthcare Workforce." Ed. Denise E. Holmes. Association of Academic Health Centers, 2008. Web

- Getting to know all patients (team approach)

### PROVIDER DIFFERENCES

However, there were three responses in particular that the providers differed on and I saw as most concerning when put in the context of the demands on Medical Assistants in the Patient Centered Medical Home model of care. The three areas the providers differed on were:

- The Understanding of the PCMH Model
- Demand on Medical Assistants
- Medical Assistant Role Expansion

#### *Understanding the PCMH*

One of the first few questions I asked each provider (in order to set the context of the remainder of the interview) was:

*“What is your understanding of the Patient Centered Medical Home?”*

The first two providers interviewed had been at the practice of interest for over ten years, one of which was the medical director for the facility. Both of these providers had a relatively good understanding of the details of the Patient Centered Medical Home; however, one of the two interviewed showed general concern and slight doubt for how effective this model of care will be long-term as well as what cost savings would come from it.

The third and last provider interviewed was not familiar with what the PCMH model of care was supposed to accomplish or more simply was about. He understood that in a patient centered medical home there is some level of coordination regarding the patients care. However, he showed extreme doubt about the effectiveness of the pilot and saw it more as “filling out more paperwork for doing the same type of work”. In the same breath, he expressed frustration as he

believed it was simply more work for the medical assistants since they were seen as the ones who were really having to “check all the additional boxes”.

It is concerning that there was varying levels of understanding from those individuals that, from a PCMH standpoint, are seen as leading the way for this type of model of care. This is somewhat reflective of the first common challenge that three primary care practices in Connecticut discovered when they implemented the PCMH model.

| Common Challenges                                     | Solutions   |
|---|---|
| Motivation and prioritization across the organization | <ul style="list-style-type: none"> <li>&gt; Strong administrative and clinical leadership</li> <li>&gt; Designate staff to optimize work flow</li> <li>&gt; Make PCMH an organizational priority</li> <li>&gt; Avoid competing projects</li> </ul>                  |
| Cost  | <ul style="list-style-type: none"> <li>&gt; Streamlined work flows allowed for greater productivity</li> <li>&gt; Practice management/electronic billing in-house</li> <li>&gt; Government and insurance incentives</li> </ul>                                      |
| Coordinating care within the practice and beyond      | <ul style="list-style-type: none"> <li>&gt; Effective use of EMR systems</li> </ul>   |
| Training  | <ul style="list-style-type: none"> <li>&gt; “train, maintain, retrain”</li> <li>&gt; Create practice handbooks that explicitly describe internal processes so that anyone in the practice can look up questions, and any new employees can learn quickly</li> </ul> |

To quote Cheryl Lesarbeau, the Vice President of Clinical Performance for ProHealth Physicians, “Clinical leadership and engagement are critical success factors.”<sup>23</sup>

<sup>23</sup> Kushner, Kimberly, and Hannah Munson. "Patient Centered Medical Home First Adopters: Lessons from Three Connecticut Practices." *Cthealthpolicy.org*. N.p., May 2011. Web.

### *Demand on Medical Assistants*

The second question I posed to the three providers raised some concern, as again, they had somewhat different responses.

*“Do you demand a lot from your Medical Assistants?”*

Similarly, the first two providers interviewed did not feel that they demanded a great deal from the medical assistants that worked under them. However, the third provider demanded quite a bit from his Medical Assistants.

During our discussion he informed me that he relies heavily on his medical assistants especially when it comes to getting his patients seen on time. He felt that many medical assistants are intimidated when they begin working with him but generally learn to cope with his demands.

One noticeable difference between this provider and the other two interviewed was that he did not change the quantity of patients seen during the day from when they became part of the Patient Centered Medical Home Pilot. The other two providers reduced their patient load in order to stay on time and spend more time with their patients thus reducing the medical assistant’s stress that accompanies the demand of keeping the providers on schedule.

### *Medical Assistant Role Expansion*

The last noticeable response difference between the providers was when I asked the question:

*“Do you see their role expanding in the future?”*

Each provider had their own interpretation on the future role of the medical assistants at their practice specifically and in general. One provider in particular, although he highly values the medical assistant profession, was adamant that medical assistants should not be doing more

than they are allowed and does not believe that their roles should be expanded. He believed that due to their lack of clinical knowledge that any addition to their responsibilities or role expansion is troublesome.

The other two providers, on the other hand, believed that the role of medical assistants could be expanded and in some aspects *should* be expanded to better assist the practice and the providers, especially in PCMH model of care. One believed that the medical assistants had untapped skills that could truly benefit their practice and the medical assistants career. For example, one provider believed that the Medical Assistant role has the potential of interacting more with the electronic medical record (an integral piece of the PCMH model) in order to provide the doctors additional time with their patients. This practice took it as far as piloting a project where medical assistants acted as scribes during visits in order to allow the doctors to focus on the patient and not on looking at a computer screen (which many patients disliked).

As this shows, there are many ongoing discussions about opportunities to utilize medical assistants in innovative ways that could help improve solo and small group practice. However, there is little preparation or additional training for those expanded roles. Greater investment in MA training, development of new skills, and retention is needed to effectively integrate MAs into a team model of care.<sup>24</sup>

## **Primary Care Medical Assistants Interview**

The third portion of the interview process was with individual medical assistants at the same primary care practice as those physicians interviewed. Of the eight medical assistants that

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<sup>24</sup> Chapman, Susan, Angela Marks, and Melanie Chan. "The Increasing Role of Medical Assistants in Small Primary Care Physician Practice: Key Issues and Policy Implications." *The Increasing Role of Medical Assistants in Small Primary Care Physician Practice: Key Issues and Policy Implications*. The Center for Health Professions at UCSF, Feb. 2010. Web

were on staff that day, five were interviewed, each having varying backgrounds and number of years of experience as medical assistants.

Most responses received were fairly similar between the five medical assistants when it came to their job role and activities that they did on a daily basis. These included:

- Rooming the patient
- Taking patient vitals
- Checking allergies
- Checking blood pressure
- Performing ear flushes
- EKGs
- Stocking supplies
- Refilling medications

The medical assistants interviewed were unfamiliar with the details of the Patient Centered Medical Home model of care and what their expectations were. They were aware that there were a few staff members at the practice that had received training, yet they themselves were neither trained at their respective medical assistant programs nor did they have training at the practice if they were a new hire or seasoned medical assistant.

Three noticeable areas for concern discovered during the interviews with the medical assistants were:

- Struggle for time
- Challenge with patient communication
- Challenge of working as a team



One common theme was that the medical assistants felt that they were frequently pressed for time, and that it was often stressful to keep the doctors on schedule. This issue was mentioned by physicians and medical assistants alike with little to no feedback on how exactly they were going about resolving it.

The second area that medical assistants discussed as a challenge was effectively communicating with patients especially in the clinical context. The medical assistants at this practice are often required to answer patient phone calls as well as the medication refill line which leadsto clinical specific questions that the medical assistants are unable to handle. Although they generally deflect these questions to the appropriate staff, this is one area that medical assistants desired additional training on. Aside from the challenge with clinical communication, one medical assistant described her difficulties communicating with or simply working with those patients that are addicted to prescription medications as it was one area that she was never fully trained on.

The third and final challenge that was discussed is at the heart of the PCMH model of care in that for some medical assistants it can be a challenge working as a team. One medical assistant noted that it can be a struggle in that everyone can have such different personalities that it sometimes gets in the way of working cohesively. Another medical assistant also brought up the issue that it is not uncommon for new hires to be trained by different staff members. I learned that practice specific training can be conducted by either the nurse manager, other nurses, or seasoned medical assistants each having their own way of performing tasks. Pairing this with the varying levels of training they have received (MA program specific, organization specific, and provider specific) there seems to be some level of non-standardization that occurs. One medical

assistant found this to be a real challenge when trying to work and/or communicate with other teams in the practice.

Like many PCMH practices the healthcare organization must understand how changing positions and working together within the practice brings new experiences to all of their current members and how these experiences can potentially affect their capability of delivering care. These changes, if left unaddressed, can result in unfocused care. For instance, in the Air Force, many nurses in the PCMH transition shift from positions where they have not been exposed to patients to being required to evaluate patients face to face regularly; this new interaction created anxiety among these nurses.<sup>25</sup> In addition to providing new training for nurses, it is important also to train front office staff in their new roles as they play a part in carrying out several PCMH principles, such as ensuring greater access and increased communication. Both clerical and clinical staff members are encouraged to develop a more sophisticated level of decision-making skills, which may require additional training on the PCMH principles, new workflow processes in the office, and increasingly integrated responsibilities to patients and each other.<sup>26</sup>

### **Interview with MA Program Director**

The qualitative portion of my research began from the professions' foundations, the educational institutes that offered a Medical Assistants program. I interviewed the program director to get their interpretation of the struggles that MA's are experiencing with the implementation of the Patient Centered Medical Home in the state as well as general problems that MAs are struggling with. This program director, before becoming an instructor, had

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<sup>25</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

<sup>26</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

personally worked in physician’s practices and has worked very closely with dozens of MAs throughout the years. This was beneficial as it not only gave a ground level point of view of what the director had seen but also the feedback that MAs had given after having the left the program.

The program, which is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), prepares students to perform duties and responsibilities in a variety of medical settings which can include: drawing blood, administering injections, assisting with exams and surgical procedures, taking vital signs, direct patient care, performing electrocardiograms, patient education, telephone triage, receptionist skills, filing, insurance reimbursement and billing procedures, medical coding, and correspondence and scheduling appointments.<sup>27</sup> The list of competencies that MAs are required to have before leaving the program is provided by the CAAHEP. The program culminates with a 160-hour practicum during which theory learned in the classroom is applied in an actual medical practice environment.<sup>28</sup>

*Course Sample*

| Course Number                                       |
|---|
| Medical Terminology                                 |
| Medical Office Procedures                           |
| Introduction to Medical Assisting and Allied Health |
| Disease Pathology/Diagnostic Lab Tests              |
| Clinical Office Procedures                          |
| Billing Procedures and Administration               |
| Electronic Medical Records                          |
| Medical Ethics and Law                              |
| Medical Office Administration                       |
| Medical Assisting Practicum                         |
| Pharmacology  |
| Anatomy & Physiology I and II with Lab              |
| English Composition                                 |
| Introduction to Literature                          |
| Introduction to Psychology                          |
| Developmental Psychology                            |
| Fine Arts/Humanities and Mathematics electives      |

<sup>27</sup> "Medical Assisting." *Medical Assisting*. Southern Maine Community College, n.d. Web.

<sup>28</sup> "Medical Assisting." *Medical Assisting*. Southern Maine Community College, n.d. Web.

One area of improvement that the program faces is that there is little discussion of the Patient Centered Medical Home model of care that so many physicians' practices are implementing. However the director informed me that it will become a bigger part of the curriculum as Medical Assistants will need to become more familiar with how this will change the care offered to patients as well as what their expectations will be.

Throughout the interview we discussed several challenges and issues that are currently facing medical assistants. These included:

- Doctors being confused over what tasks MAs can or can't do compared to Registered Nurses (RNs)
- Work stress and life management
- Relationship with Nurses (Nurses feeling threatened by MAs)
- Increases in educating the patient
- Handling and communicating with complex patients

## Conclusion

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Overall, this practice expressed a somewhat optimistic attitude towards the patient centered medical home model and the medical assistants they had on staff. It was shown that, for this practice specifically, there was no extreme increase in responsibility or demands on the medical assistants with the implementation of this new model of care. However, what was revealed was that there were slight variations in training for medical assistants which poses the question of whether there needs to be more uniform standards for assessing training or performance. The burden of responsibility for ensuring specialty training falls on individual employers. It is even shown that many physicians are not aware that MAs are practicing under

their license and are consequently not vested in the level of supervision legally required of them by state boards<sup>29</sup>

There were not only gaps in understanding of the model itself as shown by the medical assistants and doctors alike but also some level of doubt expressed by staff members in the effectiveness of this model of care. These changes, if left unaddressed, can result in unfocused care. As in the example above, the Air Force has addressed this issue through additional training programs so nurses can better understand their new relationship with patients.<sup>30</sup> The utilization of these types of training programs could be beneficial to all staff members of the practice, especially medical assistants.

Lastly, staff relations, communication, and workflow efficiency were areas for potential improvement in relation to medical assistants. Studies have shown that it can be beneficial to utilize the knowledge of outside practices that are more efficient and well defined in order to improve staff understanding and practice workflow. Take for example, the rural Federally Qualified Health Center in Colorado which redesigned its workflow to increase productivity by increasing the number of support staff per provider in addition to having the Medical Assistants (MAs) 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.<sup>31</sup>

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<sup>29</sup> Tache, Stephanie, and Susan Chapman. "The Expanding Roles and Occupational Characteristics of Medical Assistants: Overview of an Emerging Field in Allied Health." *Journal of Allied Health* 35 (2006): 233-37. Print.

<sup>30</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

<sup>31</sup> Blash, Lisel, Catherine Dower, and Susan Chapman. "High Plains Community Health Center -- Redesign Expands Medical Assistant Roles." *Futurehealth.ucsf.edu*. The Hitachi Foundation, Nov. 2010. Web.

Training standardization seems a plausible solution to addressing the variation that has been seen yet studies have shown that increased regulation by an oversight agency would not be an easy feat to accomplish as physicians' practices are accustomed to the lack of oversight on MA functions and seem to be willing to take on the risk of training and supervising MAs. Regulations mandating minimal requirements for training and performance standards through certification will most likely translate into increased costs in the form of higher wages. Strong economic incentives might be the reason for limited regulation and mechanisms for establishing and enforcing more uniform standards of training and performance levels for the occupation.<sup>32</sup>

PCMH demonstrations, like this one, show there is still much work to be done, particularly through educating medical assistants the medical community in general about the benefits of the model.<sup>33</sup> Although it was not fully explored for this practice, PCMH demonstrations have shown that this method of care can improve the quality of life for patients, such as reducing the patient's frequency of ER visits and hospital admissions, as well as reducing health care costs.<sup>34</sup>

The practice and the medical assistants specifically were a great example of how the PCMH holds a great deal of potential in addressing the broken healthcare system in the United States, but at the same time, it also faces many obstacles in terms of payment reform, professional support, and patient participation.<sup>35</sup>

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<sup>32</sup> Tache, Stephanie, and Susan Chapman. "The Expanding Roles and Occupational Characteristics of Medical Assistants: Overview of an Emerging Field in Allied Health." *Journal of Allied Health* 35 (2006): 233-37. Print.

<sup>33</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

<sup>34</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

<sup>35</sup> Green, Ellen P., John Wendland, M. Colette Carver, Cortney Hughes Rinker, and Seong K. Mun. "Lessons Learned from Implementing the Patient-Centered Medical Home." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 30 Aug. 2012. Web. 22 May 2013

## PARTICIPANT PHONE RECRUITMENT SCRIPT

Hello:

My name is Christopher Eldridge and I am a student at the University of Southern Maine working on my Graduate Capstone Project.

The goal of the project is to learn about the demands that are being placed on the Medical Assistants (MA) profession with the newly implemented Patient Centered Medical Home model in primary care practices and to find if there are opportunities for improvement surrounding the topics of MA education, competencies, and expectations.

As part of the project I am requesting interviews from subject matter experts so that I may better understand the demands that are being placed on MAs.

Would you be willing to meet with me in order to discuss your professional practice and any challenges you may have encountered? The interview would include a standard set of questions and would last no more than 30 minutes. Your participation will be strictly confidential. I will not share your identity or anything we discuss with anyone except my Capstone advisor without your permission. To minimize risks associated with disclosure of confidential information, we will ask you to discuss issues you may have encountered only in hypothetical terms, so that no particular individuals or organizations can be identified by us or by other project participants.

Are you willing to participate? Can we schedule a place and time now? If possible, I would prefer to meet at your workplace.

Please respond with a place and time that you would like to meet. If you have any questions or concerns about this request or the interview, feel free to contact me at

celdridge924@gmail.com or by phone at 207-240-7827 or my Advisor David Hartley at davidh@usm.maine.edu.

### FOCUS GROUP INTRODUCTION

“Hello, my name is Christopher Eldridge and I am a graduate student at the University of Southern Maine’s Muskie School of Public Service studying Health Policy and Management. I am currently on my final semester of the program and am doing a study on Medical Assistants as pertaining to the implementation of the Patient Centered Medical Home in the state of Maine. I would like to ask you a series of questions that will greatly contribute to my project.”

### CONSENT FORM

#### *Introduction*

- You are being asked to participate in a research study on Medical Assistants in the State of Maine. This study is being conducted as part of a graduate course at the University of Southern Maine’s Muskie School of Public Service.
- Please read this form. You may also request that the form is read to you. You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. Your participation is voluntary.

#### *Purpose*

- To learn about the demand on medical assistants as part of the implementation of the Patient Centered Medical Home model.
- To propose a solution for those services that require additional improvements.

#### *Participants*

- There are three participants and one focus group involved in the study.



- You were asked to participate in this research due to your personal/professional experience and/or expertise in this field of study

#### *Participation/Withdrawal*

- If you agree to participate in this study, I would ask to interview you today, and request that you answer the interview questions to the best of your ability.
- Your participation will contribute to my education and understanding of the medical assistant profession within the state of Maine and more specifically to the issues and needs of this population
- If at any time during the interview you feel uncomfortable answering a question or would like to completely withdraw you are free to do so for whatever reason.
- Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University.

#### *Confidentiality*

- Information discussed during this interview may be kept private and confidential at the request of the interviewee. In addition, if desired, any identifying information will not be shared per request of the interviewee.

#### *Contacts and Questions*

- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Professor David Hartley at 207-780-4513.
- The researcher conducting this study is Christopher Eldridge. For questions or more information concerning this research you may contact me at 207-240-7827 or [celdridge924@gmail.com](mailto:celdridge924@gmail.com)

### *Statement of Consent*

- I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily

### MEDICAL ASSISTANT QUESTIONS

- 1) How long have you all worked here?
- 2) Is MA turnover an issue here?
- 3) Tell me about your typical day, how many patients do you see, what type of activities do you do?
- 4) What was your experience like in the MA training program?
- 5) Were there parts of the MA program that you would want to improve? Are there suggestions that you would make? Were there things that you wanted to learn but didn't?
- 6) Do you feel that the program prepared you for working in a doctor's office?
- 7) How many of you received your certification?
- 8) Do you know what a Patient Centered Medical Home is?
- 9) Are there noticeable differences from before you implemented the PCMH model to after?
- 10) Do you feel that your role as an MA has expanded since your practice has implemented the PCMH model? If so, what new duties do you have and how are you handling it?
- 11) Do you feel the doctor's demand a lot from you? Too much? Not enough?
- 12) Do doctors and nurses value your contribution?

### PROVIDER FOCUS GROUP QUESTIONS

- 1) How many medical assistants do you have on staff? Are they all CMA or are there some that do not have their certification?

- 2) What do you look for when you hire new MAs? Do you hire MA's right out of programs or ones that have more experience?
- 3) Do you believe MAs are beneficial? How so? Do they improve the overall practice and how it runs?
- 4) Do you think the physicians (the practice) demand(s) a lot from the MAs?
- 5) Does your practice experience a lot of MA turnover?
- 6) What do you think the obstacles are for MAs and what suggestions would you make for improving their training?
- 7) Do you see areas where medical assistants struggle during day to day activities?
- 8) What is your level of understanding of the Patient Centered Medical Home?
- 9) Have there been any noticeable differences in job responsibilities or duties and how they perform them since you implemented the PCMH model in your practice?
- 10) Are there substantial cost savings by hiring MAs over other clinical staff? What are the overall benefits of hiring MAs? Do you see their role expanding in the future?

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