WHAT'S IN A STAFFING RATIO?

The spectrum of team based care with clinician-medical assistant teamlets

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DISCLOSURES

No disclosures to report.

OVERVIEW

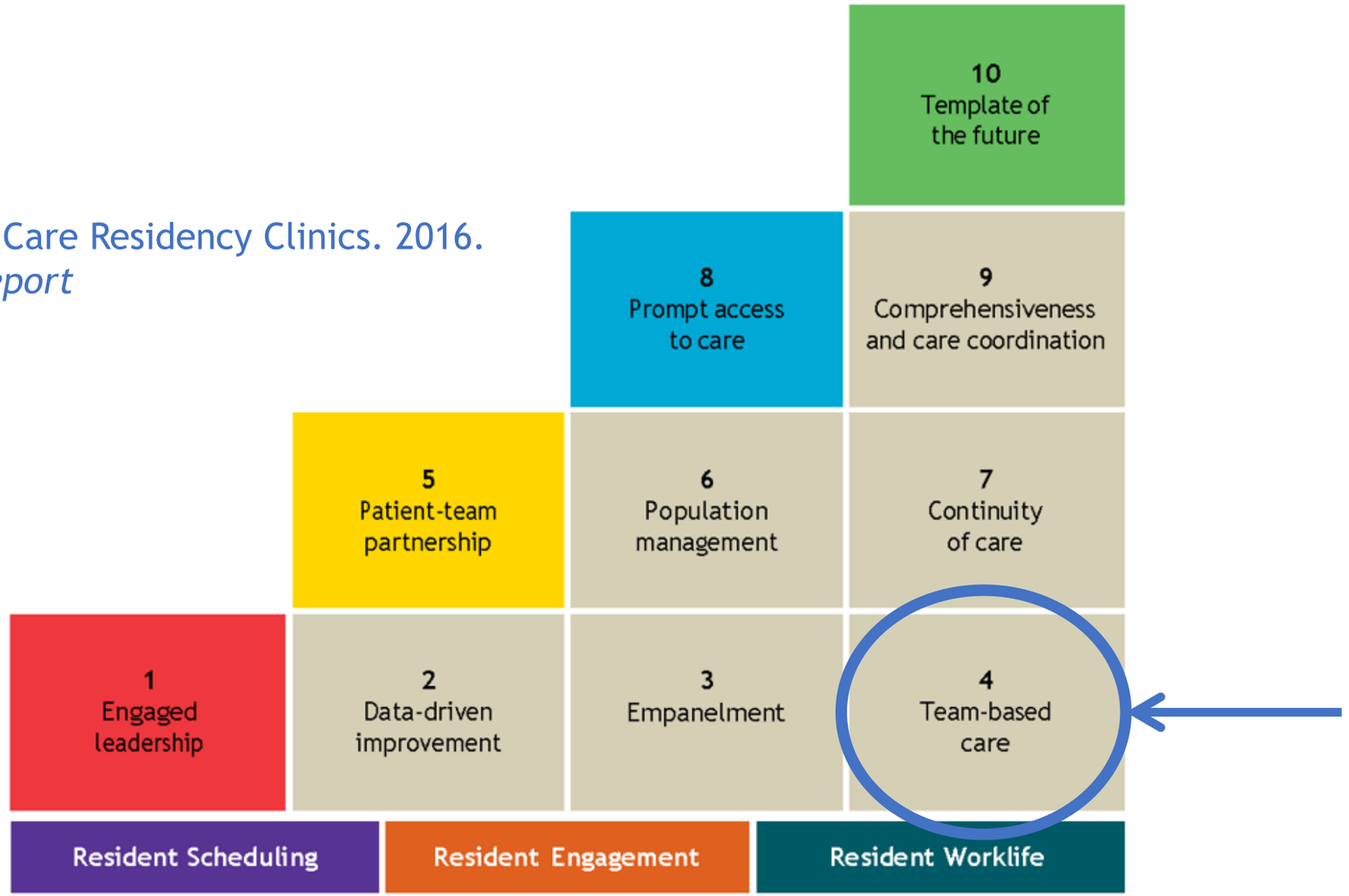
What is a teamlet?

What does the spectrum of team roles look like with different ratios of MAs to clinicians?

How do I use this to advocate for and build stronger teams?

10+3 BUILDING BLOCKS

CEPC. High-Functioning Primary Care Residency Clinics. 2016.
www.aamc.org/buildingblocksreport

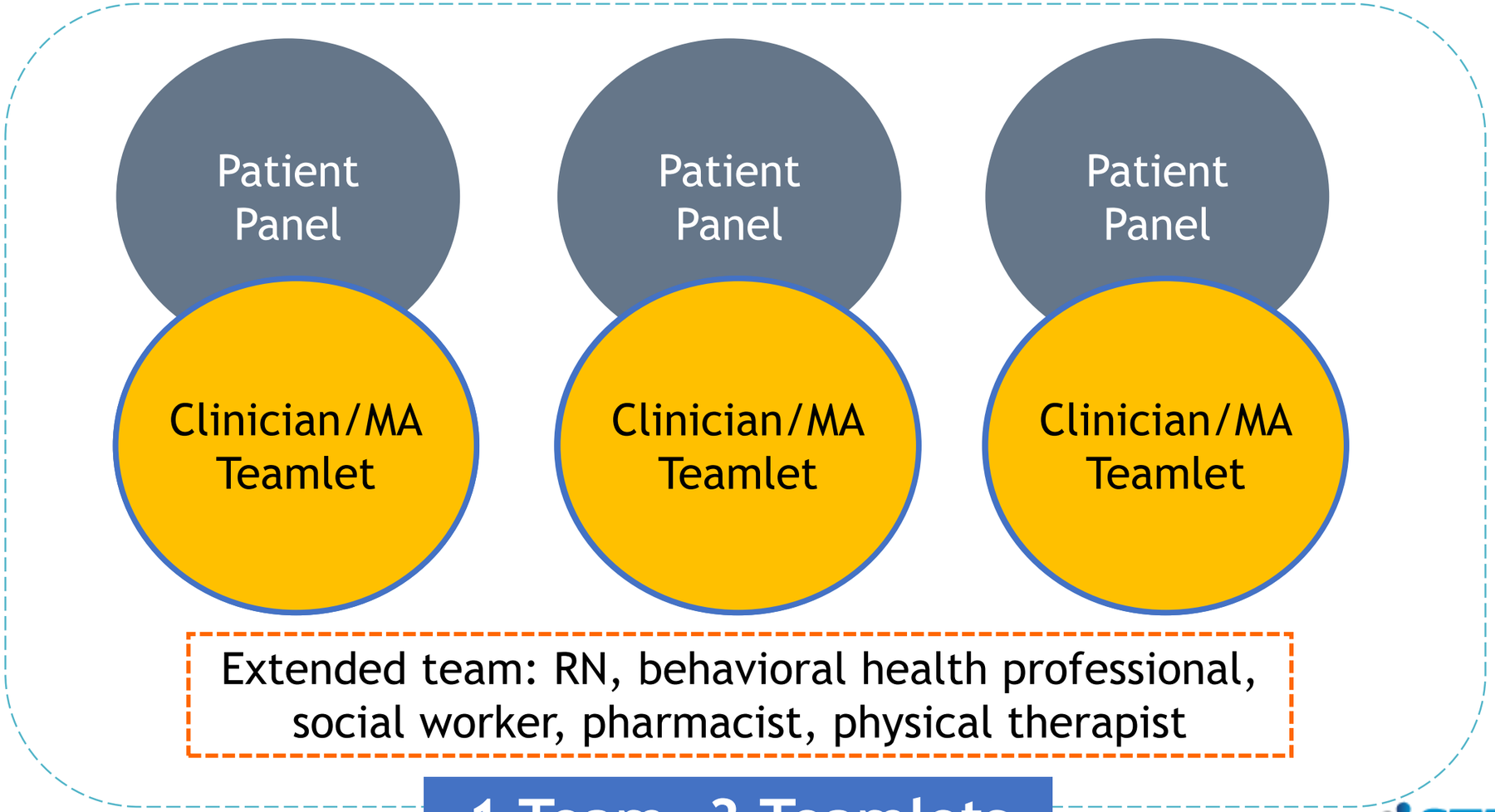


the 9 elements of high-performing teams

stable team structure	co-location
team culture: share the care	defined roles with training and skills checks
standing orders	defined workflows
staffing ratios adequate to allow new roles	ground rules
communication: team meetings, huddles, minute-to-minute interactions	

Ghorob and Bodenheimer, Team-building guide, Families, Systems, and Health 2015;33:182-192

Core teams (teamlets) and extended care teams



STAFFING RATIOS IN PRIMARY CARE

- One study looking at staffing ratios in primary care clinics estimated that the staffing ratios per 1 FTE (full-time equivalent) of a primary care clinician would need to increase from a base of 2.68 FTE to **4.25 FTEs** of overall staff to support a patient-centered medical home model of care.
  - **1.33** of these would be an MA/LPN
  - (Patel MS et al. Am J Manag Care. 2013 Jun;19(6):509-16.)
- Another study analyzing ratios needed for high quality, comprehensive primary care found that **1.375** MAs would be needed per 1.0 FTE of a clinician, with a range of 1.1-2.1 depending on population needs.
  - (Meyers D et al. J Gen Intern Med 2018; Oct;33(10):1774-1779.)

WHAT ABOUT TEACHING CLINICS?

Faculty physicians and residents often spend only 1 – 2 half-days in teaching clinic

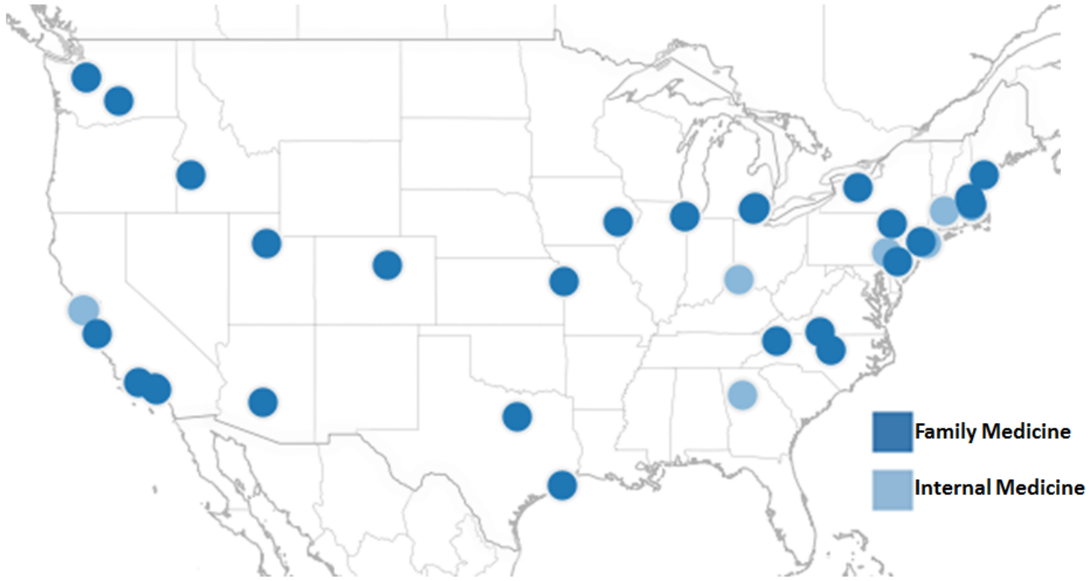
Leads to challenges with:

- Continuity
- Access
- Team based care

TEACHING CLINIC STUDY

45 primary care family medicine, internal medicine, and pediatric residency practices

CEPC Site Visits to Teaching Clinics 2013-2017



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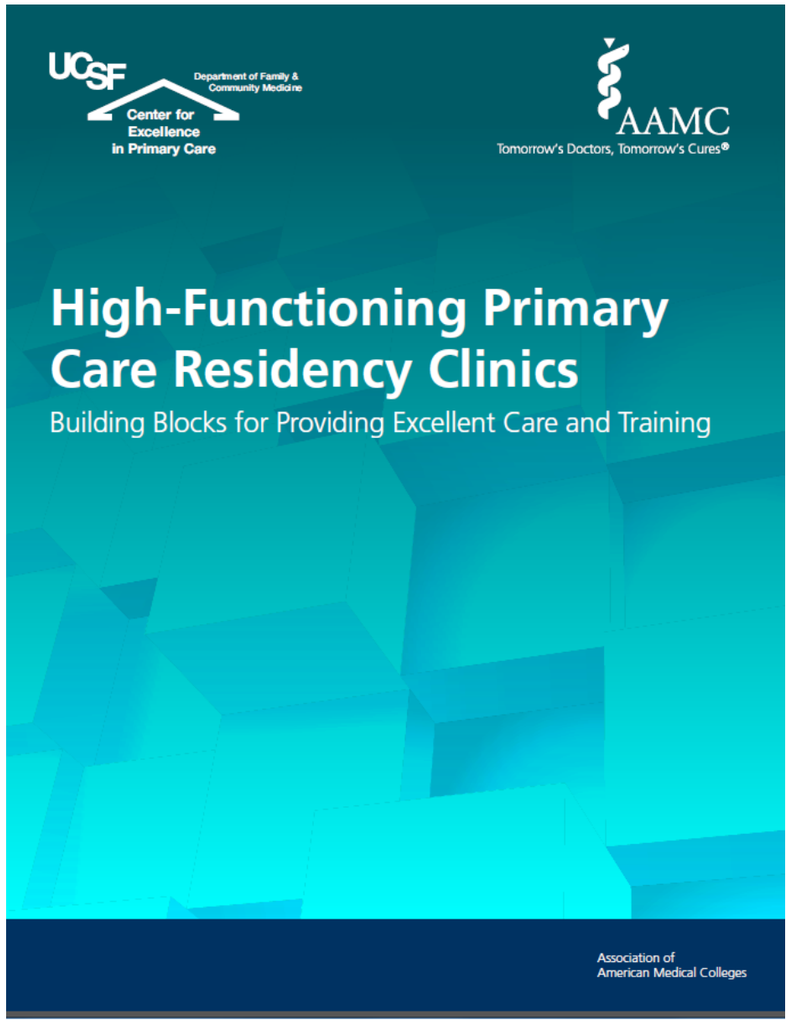
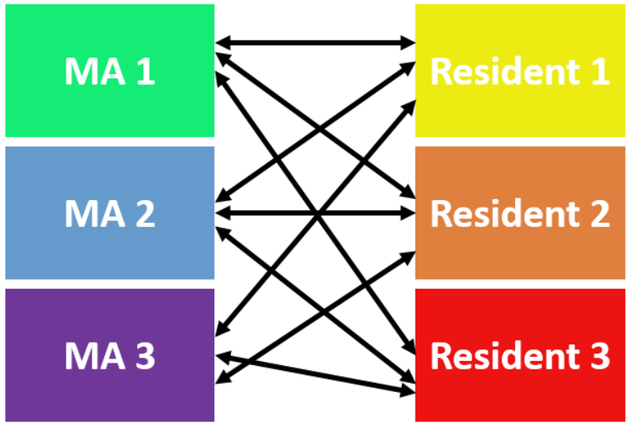


Detailed report available at:

cepc.ucsf.edu/residency-teaching-clinics

TRADITIONAL VS. TEAMLET MODEL



Traditional model

Teamlet model

Over the week:

SPECTRUM OF STAFF RATIOS AND TEAM ROLES

We will review 3 different staffing ratio scenarios in day-to-day clinic to illustrate the level of team-based care possible in each ratio.

Less than 1 MA per clinician

1:1 MA per clinician

2+ MA per clinician

WHAT CAN A TEAMLET DO WITH <1:1 MA PER CLINICIAN?

- Many clinics operated with less than 1 MA per clinician in clinic
- With these models, MA roles were often primarily rooming patients and taking vital signs, some basic screenings, room turnover, stocking/inventory
- Sometimes also providing phlebotomy
- Often requires clinicians to order and request routine immunizations, healthcare maintenance items piecemeal
  - If shorter staffed or in a busy clinic, these may not get done consistently
- Patient discharges with very variable levels of patient navigation as to their discharge plan (reviewing visit summary, when/where to make next appointments, etc.)
- Often limited engagement with the patient or awareness of the care plan

WHAT CAN A TEAMLET DO WITH 1:1 MA PER CLINICIAN?

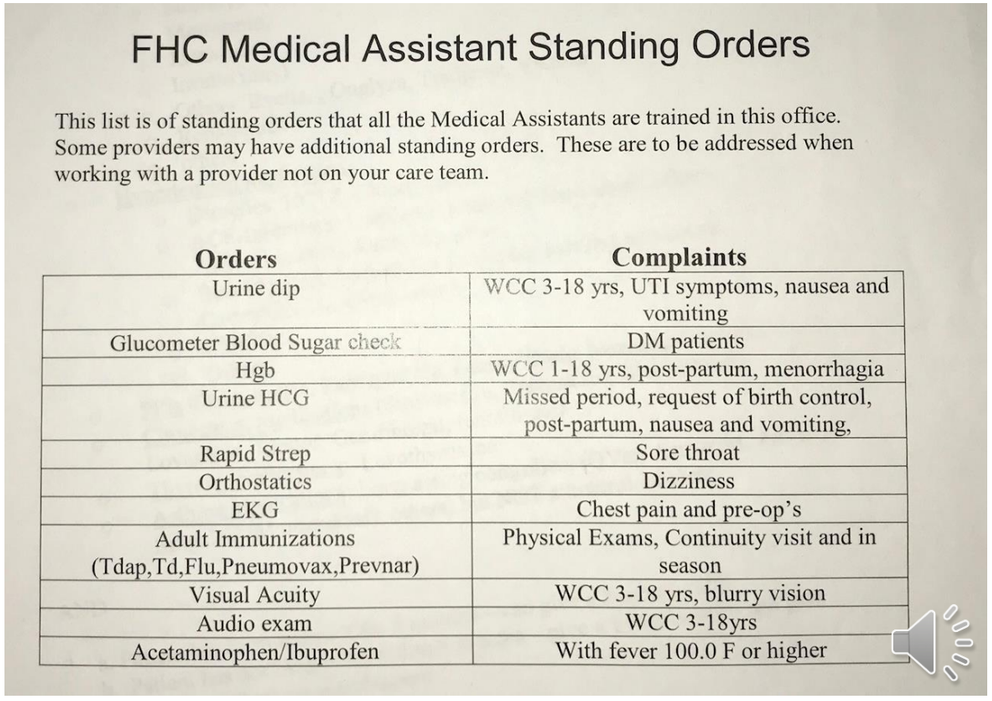
- Traditional roles plus much higher involvement in population management, patient navigation, and directing clinic flow
- MAs at several clinics were trained to review the charts for patients coming to clinic in advance
  - To identify care gaps for routine and chronic health maintenance
  - To identify visits that were unneeded or should be rescheduled
  - To strategize at huddle about anticipated needs or delays for the clinic session
- If care gaps were identified or orders were discussed at huddle, standing orders allowed MAs to complete IZs, start orders for and/or complete healthcare maintenance tasks (ex. Pend orders for mammograms or complete diabetic foot exams), or additional screenings without further clinician initiation
- More detailed patient education and navigation, care coordination roles
- Helping with in-basket messages/calling patients
- Higher engagement with patients and building relationships

1:1 AT UNIVERSITY OF NORTH CAROLINA

- MAs do medication reconciliation on the computer as part of intake
- Can do rapid strep tests, EKGs, O2 administration, orthostatic blood pressures, diabetic retinal photography, and diagnosis/treatment of hypoglycemia – all under standing orders
- Can ask patients with 2 or more chronic conditions if they want to be signed up for Medicare chronic care management with one of the 2 care manager RNs. If the patient is interested, the CMA may do a warm handoff to the care manager.
- MAs also sign patients up for the patient portal and for children, they provide Reach-out and Read books.

1:1 AT WHITE MEMORIAL FAMILY MEDICINE

- Intake includes informing patient of expected wait times, checking if notes for work/school needed
  - Can review PCP's last note to review the last care plan with patient
  - Can preload problem list into the days note and add complaints based on patient's agenda for the visit
  - Can enter basic information about patient's current symptoms into the HPI for provider to review
- Between patients, MAs follow up on referrals/ notes from specialists, patient messages, prior authorizations, other care coordination
- Know the patients well over time, act as contact person/patient advocates when resident not available, supports patients when residents graduate



FHC Medical Assistant Standing Orders

This list is of standing orders that all the Medical Assistants are trained in this office. Some providers may have additional standing orders. These are to be addressed when working with a provider not on your care team.

Orders	Complaints
Urine dip	WCC 3-18 yrs, UTI symptoms, nausea and vomiting
Glucometer Blood Sugar check	DM patients
Hgb	WCC 1-18 yrs, post-partum, menorrhagia
Urine HCG	Missed period, request of birth control, post-partum, nausea and vomiting,
Rapid Strep	Sore throat
Orthostatics	Dizziness
EKG	Chest pain and pre-op's
Adult Immunizations (Tdap,Td,Flu,Pneumovax,Prevnar)	Physical Exams, Continuity visit and in season
Visual Acuity	WCC 3-18 yrs, blurry vision
Audio exam	WCC 3-18yrs
Acetaminophen/Ibuprofen	With fever 100.0 F or higher

1:1 AT CROZER-KEYSTONE FAMILY MEDICINE

PATIENT CENTERED MEDICAL HOME ROUTING SLIP

TODAY'S DATE:_____

PATIENT'S NAME:_____

DOB:_____

FOLLOW UP APPOINTMENTS NEEDED AT CFH

ISSUE (MA completes with doctor)	WHEN NEEDED with WHOM (MA completes with doctor) (communication w/front desk)	APPT DATE and TIME (Front Desk Completes) Must have future flag or appt date
Follow Up Appt for Today's issue:		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
DM Office Visit appt: DM Eye Exam:		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
Pap appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
HTN appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
AWV, CPX, WCC appt		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
MA Visit: (circle one) Lab Immunizations/PPD		1. Future flag 2. Appt:_____ 3. Already flagged for this issue
Referrals	Order in EMR: (check): ___	
Request Request	Records release needed : (check)____	
Portal Sign Up	Portal needed: (check) ____	

FOLLOW UP APPOINTMENTS MADE FOR CANCER PREVENTION SCREENINGS

CANCER SCREENING NEEDED	WHEN NEEDED (MA Completes)	APPT DATE/TIME/LOCATION (Front Desk Completes)
Colonoscopy or FIT (circle one) Order in EMR: yes/no		
Mammography Order in EMR: yes/no		
Dexa Scan order in EMR: yes/no (females over age 65, 1x only)		
FEV1 order in EMR: yes/no (COPD patients, 1x only)		

THE MA CHECK IN PROCESS

MA Check- IN Sheet: Every Patient, Every Time

- ☐ -Write chief complaint and other complaints in HPI
- ☐ -Verify and update Pharmacy if needed, check if patient needs refills
- ☐ -Collect all forms from patient
- ☐ -Extra History 1, dot risk
- ☐ -Risk factors, review
- ☐ -Vital signs when appropriate

  Every visit: BP, HR,RR, Weight, Temp, LMP

  CPX: every visit above AND vision, height, hearing (under 18 yo only)

  Blurry Vision: vision acuity

  COPD/CHF/Breathing issue/Asthma: pulse ox

  Dizzy: orthostatics

  DM: microalbumin (yearly), A1C (3-6mos), Lipid (6mos), Eye Exam (yearly), Monofilament (yearly), finger stick for glucose (verify payment)

  Ear pain/hearing loss: tympanogram, audiogram?

  HTN: take BP, print report card, if > 140/90 note in reason for visit

  Urinary complaints: UA
- ☐ -Pro-Active Care Form
- ☐ -Self Management Goal (need motivational interviewing training)
- ☐ -Set up room as needed

  -peak flow, ear, eye, gyn tray,
- ☐ -Obtain specimens as needed (e.g. urine)
- ☐ -Print DM and HTN Report cards, must be done after today's BP
- ☐ Review forms patient brought with them, make sure they fill out their part
- ☐ Keep other patients informed of delays, if doctor is ready to see patient, complete MA tasks later

THE MA CHECK OUT PROCESS

MA Check OUT Sheet: Every Patient, Every Time

- ☐ **-Complete the Routing Slip with the follow up appointments, review with patient, give to patient**
- ☐ **-Make sure patient is signed up for patient portal (using patient portal script)**
- ☐ **-Educate about appropriate use of ER and minute clinic, after hours availability scripting**
- ☐ **-Give patient clinical visit summary**
- ☐ **-Print out work/school notes**

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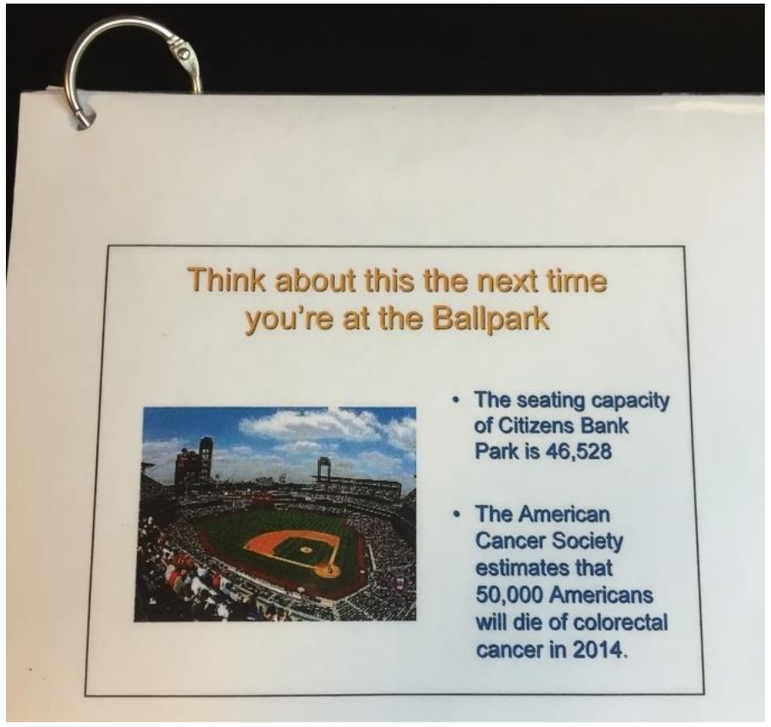
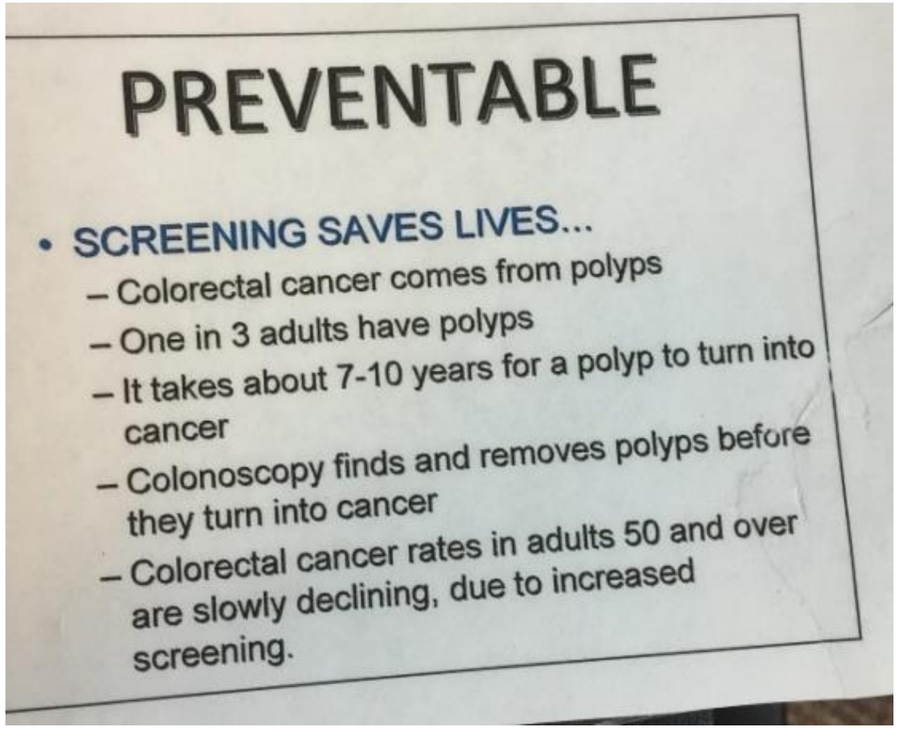
1:1 AT CROZER-KEYSTONE FAMILY MEDICINE

- MAs engaged in health education for patients, by giving them education sessions ("Lunch and Learn") about topics like colorectal cancer screening so they are empowered to discuss this with patients.
- One MA felt inspired to make a flipchart to help educate patients:





WHAT CAN A TEAMLET DO WITH 2:1 MA PER CLINICIAN?

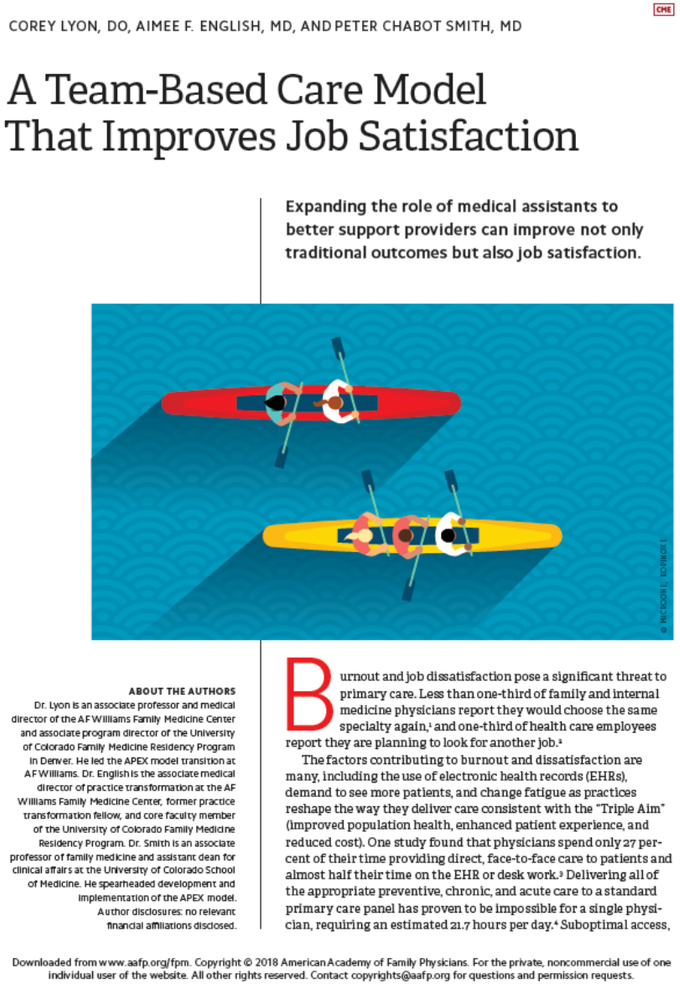
- University of Colorado AF Williams Family Medicine Clinic: 2-2.5:1 MA to clinician ratio, team visit model
- MA stays with patient throughout the visit
  - Takes history using templated questions based on patient's symptoms
  - Does med rec, pre-visit assessments, identifies/pends orders to close care gaps
  - Gives warm handoff to clinician when clinician enters room
  - Sits/stands at EMR documenting (scribing) while clinician is with patient
  - Pends EMR orders, referrals, labs, refills, new meds during the visit
  - When clinician leaves, MA makes sure patient understands care plan using AVS, does patient education, "have all your questions been answered?"
  - After patient leaves, MA completes documentation/charge entry
- Meanwhile, another MA does same workflow, assisting same clinician
- All in-basket messages go to MA pool, only routed to clinicians if necessary
- MAs can be much more helpful in patient care because they are in the visit and are learning about the patient and the care plan

2+:1 AT UNIVERSITY OF COLORADO

- Training via MA Academy: 3-4 weeks of observations, videos, power point trainings. MAs take about 6 months to get comfortable.
  - MA ladder to MA2 promotion: based on passing written exam and performance audits
- Burnout decreased to half of what it was before
- Quality, patient satisfaction, and access improved
- Because clinicians no longer spend extensive time on documentation, they can see an additional 2 patients per half-day which pays for the increased staff.

(Lyon C et al. Fam Pract Manag. 2018 Mar/Apr; 25(2):6-11.)

(Sinsky CA and Bodenheimer T. Ann Fam Med 2019 July; 17(4)367-371.)



COREY LYON, DO, AIMEE F. ENGLISH, MD, AND PETER CHABOT SMITH, MD

CME

A Team-Based Care Model That Improves Job Satisfaction

Expanding the role of medical assistants to better support providers can improve not only traditional outcomes but also job satisfaction.

ABOUT THE AUTHORS

Dr. Lyon is an associate professor and medical director of the AF Williams Family Medicine Center and associate program director of the University of Colorado Family Medicine Residency Program in Denver. He led the APEX model transition at AF Williams. Dr. English is the associate medical director of practice transformation at the AF Williams Family Medicine Center, former practice transformation fellow, and core faculty member of the University of Colorado Family Medicine Residency Program. Dr. Smith is an associate professor of family medicine and assistant dean for clinical affairs at the University of Colorado School of Medicine. He spearheaded development and implementation of the APEX model.

Author disclosures: no relevant financial affiliations disclosed.

Burnout and job dissatisfaction pose a significant threat to primary care. Less than one-third of family and internal medicine physicians report they would choose the same specialty again,[1] and one-third of health care employees report they are planning to look for another job.[2]

The factors contributing to burnout and dissatisfaction are many, including the use of electronic health records (EHRs), demand to see more patients, and change fatigue as practices reshape the way they deliver care consistent with the "Triple Aim" (improved population health, enhanced patient experience, and reduced cost). One study found that physicians spend only 27 percent of their time providing direct, face-to-face care to patients and almost half their time on the EHR or desk work.[3] Delivering all of the appropriate preventive, chronic, and acute care to a standard primary care panel has proven to be impossible for a single physician, requiring an estimated 21.7 hours per day.[4] Suboptimal access,

2+:1 AT UNIVERSITY OF COLORADO - TIERED MODEL FOR RESIDENTS

R1: MA updates PMSFH

R2: MA updates PMSFH and does HPI and ROS templates

R3: Full model (same as faculty) with in room documentation support (scribing)

WHAT ELSE NEEDS TO BE CONSIDERED IN THE RATIO?

- The day-to-day staffing ratio (i.e. who is working in clinic in a given clinic session) will not necessarily be the same as for the overall clinic
- Extra staffing to cover for vacations/sick call; floating MAs to help busy teamlets
- Time for other duties outside of direct patient care:
  - Panel management and/or care coordination (individual or with team members)
    - Univ of Arizona Banner FMR – 2 dedicated population health MAs
    - Tufts/Cambridge Health Alliance and Natividad FMR – weekly hour-long team time for teamlets to work on population management outreach
  - Team/staff meetings
  - Involvement/leadership in clinic quality improvement
    - Tufts/Cambridge Health Alliance – MAs rotate on the clinic's Practice Improvement Team
  - Teaching – residents or other MAs
    - Orienting residents to clinic, teaching them about clinic flow
    - Univ of Colorado – lead MA roles to help onboard and guide clinic MAs

WHAT ELSE DO WE NEED?

- A robust staffing ratio is necessary but not sufficient to achieve high-functioning teams
- Training, training, training (on the ground)
- Standing orders and defined workflows empower and protect team members
- Knowledge of local scope of practice issues
  - Find out what the actual regulations are and if standing orders with supervision and skills checks can work around them
- Coping with turnover
  - "Hardwire" the clinic's protocols – standardized, written, robust training and workflows for team roles minimizes impact of turnover
  - Advocate for systems changes (adequate pay/benefits, career ladder) by estimating lost value/productivity in turnover
  - The nature of work in expanded team based roles is different – may lose some staff, may attract/retain others who find expanded roles with more patient care impact fulfilling

stable team structure

co-location

team culture: share the care

defined roles with training and skills checks

standing orders

defined workflows

staffing ratios adequate to allow new roles

ground rules

communication: team meetings, huddles, minute-to-minute interactions

THE COVID-19 ERA

- Co-location with social distancing – spreading out, rethinking room usage
- Rethinking team roles with telehealth and reduced in-person visits
  - Modifying roles or staff ratios for virtual visits
  - Short term and long term changes
  - Patients will ultimately still need care that may be temporarily delayed
- Potential new roles for MAs:
  - Front door symptom screeners
  - Calling to reschedule/change to virtual visits for patients who don't need to come in
  - Outreaching to patients needing care
  - Educating patients on COVID-19 related information/protocols
  - Educating/setting patients up with telehealth
  - Increased schedule scrubbing, doing long screening questions over phone with patients beforehand to reduce in-person time (ex. Well child or Medicare wellness visits)
- Losing staff to budget cuts and redeployment
  - May need to scale down team roles and be ready to scale back up in future

BUILDING "A BUSINESS CASE"

- Start with the full staffing model (FTEs) that you'd like to aim for
- Translate the benefits and costs into terms pertinent to leadership
- Project how this staffing model will meet the needs of the organization
  - Increased capacity and ACCESS
  - Impact on quality metrics of value to the clinic/health system, ex. pay for performance payments
  - Show the numbers, frame in terms of returns on investment in staff
- Include the costs of NOT improving the staffing model
  - Burnout, turnover (Friedman JL and Neutze DN. J Am Board Fam Med 2020;33:426-430.)
  - Reduced market share by not meeting the needs of the patient population
- Can start small – pilot with one or two teamlets to demonstrate the benefits

TAKE HOME POINTS

- With less than 1 MA per clinician, MA roles are often limited to traditional duties of rooming and taking vital signs
- With 1 MA per clinician, MA roles can have much higher involvement in population management, patient education and navigation, care coordination, and directing clinic flow strategically
- With 2+ MAs per clinician, a model of advanced team care with in-room support allows MAs to be fully integral to the patient's care while decreasing burnout
- Training, standing orders, and defined workflows are important for maximizing team functioning
- Advocate for the investment in a robust staff ratio by doing the math of how it will pay off in terms that speak to the priorities of systems leaders

FURTHER RESOURCES

Toolkits and Resources for Primary Care Teaching Clinics

CEPC is developing to a series of toolkits to guide primary care teaching clinics with implementing the Building Blocks of Primary Care.

- Empanelment Toolkit
- Continuity Toolkit
- Access Toolkit

For additional resources including resident curricula and faculty development materials, please visit https://fcm.ucsf.edu/practice_transformation

High-Functioning Primary Care Residency Clinics Report

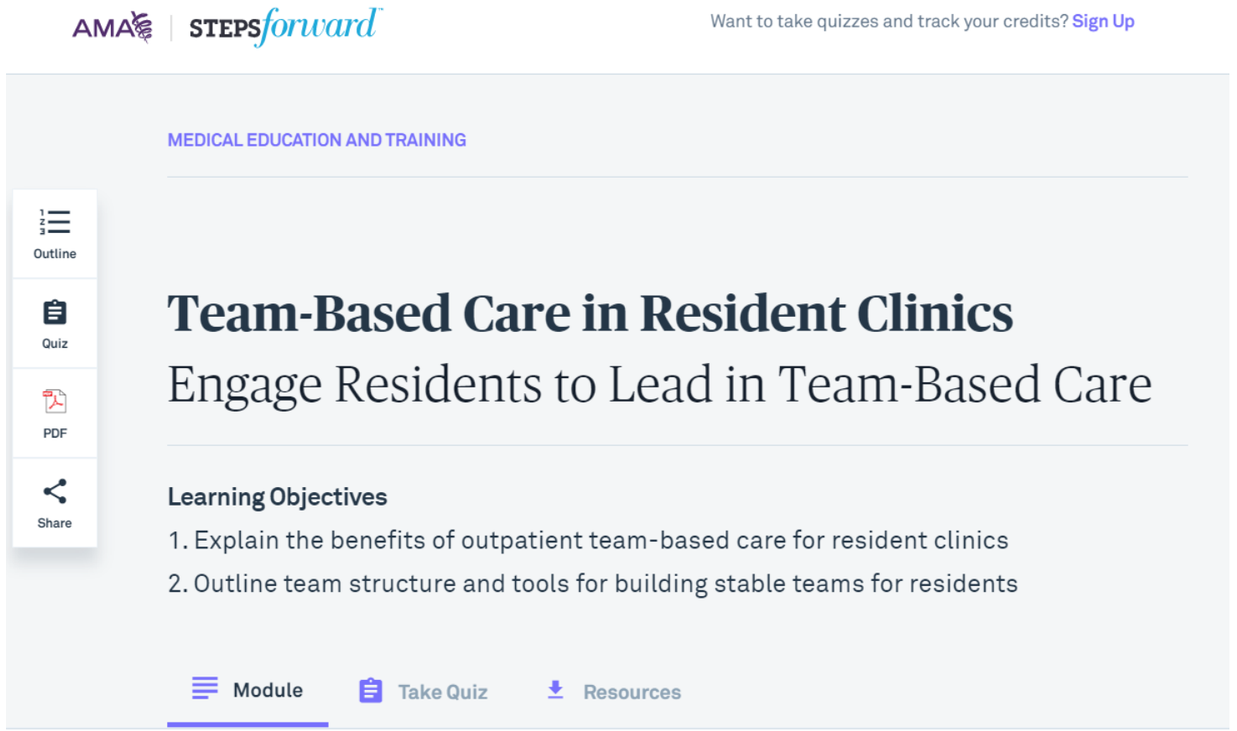
In October 2016, CEPC published a groundbreaking report, *High-Functioning Primary Care Residency Clinics* based on an initial wave of teaching clinic site visits. The 53-page report proposes a model to assist residency teaching clinics to transform themselves, using many case examples from well-organized teaching clinics around the country.

The free report is available here:

AAMC CEPC TeachingClinicsReport_ (002).pdf

See also:

In-depth profiles from three residency sites



Team-based Care toolkit
cepc.ucsf.edu/residency-teaching-clinics

AMA StepsForward Module
edhub.ama-assn.org/steps-forward/module/2757859

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Good education for tomorrow's workforce requires excellent care for today's patients

- Residency Program Director

THANK YOU

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