Submission Id: 3689

Title

Determining the usability and Updating AHRQ's Primary Care Staffing Index Model

Priority 1 (Research Category)

Healthcare Services, Delivery, and Financing

Presenters

Deborah Cohen, PhD, Tamar Wyte-Lake, DPT, MPH, Jennifer DeVoe, MD, DrPH, FAAFP, DPhil, Johanna Warren, MD, Leah Gordon, MPH, Michelle O'Connell, MPA, John Rugge, MD, MPH, Katherine Bensching, Eliza Hayes Bakken, Daisuke Yamashita, MD

Abstract

Context: In 2018, AHRQ developed staffing models with panel sizes, functions, ratios and financing approaches for 3 types of comprehensive primary care clinics. We used this model in an academic health system serving people of differing ages, medical complexity and social risk. Objective: Determine the usability and update the model for post-pandemic academic primary care. Study Design and Analysis: Mixed methods cross-sectional observational study; comparative analysis. Setting: 9 clinics: 2 safety-net, 1 internal medicine, 4 family medicine, 2 pediatric. Population studied: Clinic faculty and staff. Intervention/Instrument: Panel size, full time equivalents (FTEs) by function, encounter volume; interviews with a sample of each clinics' members, with representation across functions. Outcome Measures: Identification of staff functions, panel sizes, staffing ratios, encounter numbers. Results: AHRQ's model was usable in academic primary care, but needed to be modified to align with the blended populations served by clinics. A supplementary tool was needed to identify FTE gaps by function and support planning among clinic and system administration. Using this tool, we found that clinician panel sizes were similar to AHRQ model recommendations, but clinics were short staffed by an average of 9.5 FTE/clinic (range 1-22 FTE). Functional gaps were identified in complex care/care transitions, care coordination, and behavioral health (BH), the latter of which was an increased need since the pandemic. Non-visit-based telephone and portal encounters grew by 73,000 (32%) from 2019 to 2021 and are now approximately double the number of visit-based encounters. These communications take multiple touches and team members to complete, not all of which were counted. The explosion of non-visit-based work, according to staff, contributed to a spiral of work, burnout, and attrition. Conclusion: AHRQ's staffing model is useful in primary care, with the addition of a tool to operationalize this model for leaders and decision makers. The model, however, requires expansion for pediatrics, where not all functions are equally needed, to account for non-visit-based work, and patients expanded BH needs. This expansion requires careful consideration of financing, as clinics are experiencing a double-hit (short-staffed and seeing an explosion of work) and examination of the impact

of the expanded staffing model on meaningful outcomes (e.g., patient experience of comprehensive care).