

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ

Introduction to AHRQ for the Council on Graduate Medical Education

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Our Goal

Improve the lives of patients

WHY

Our Aim

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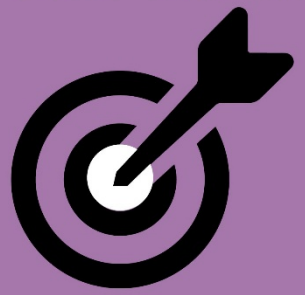
Our Aim



To help healthcare systems and professionals deliver care that is

- **High Quality**
- **Safe**
- **High Value**

WHY

WHAT

Our Competencies

Our Goal

Improve the lives of patients

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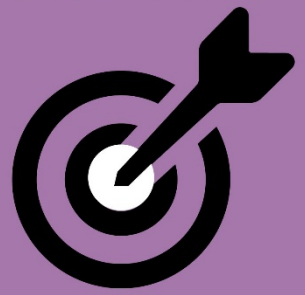

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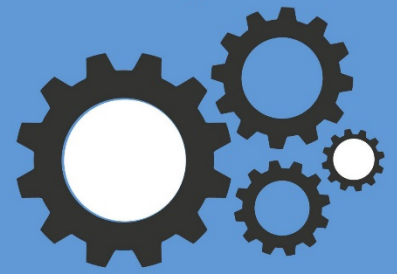


- Health Systems Research
- Practice Improvement
- Data & Analytics

HOW

AHRQ's Role

"**Cure** and **Care** are two sides of the same coin."

—Gopal Khanna
Director, AHRQ

AHRQ's Mission

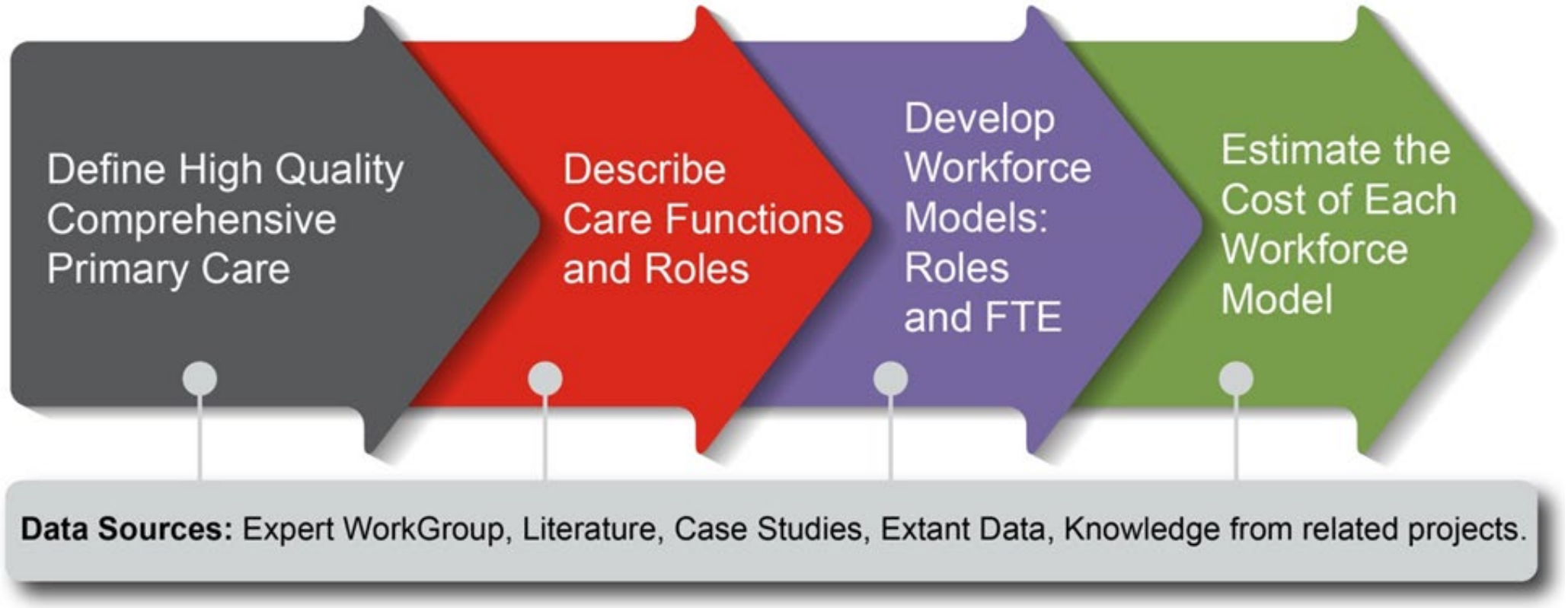
- "… to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used."

Deep Dive

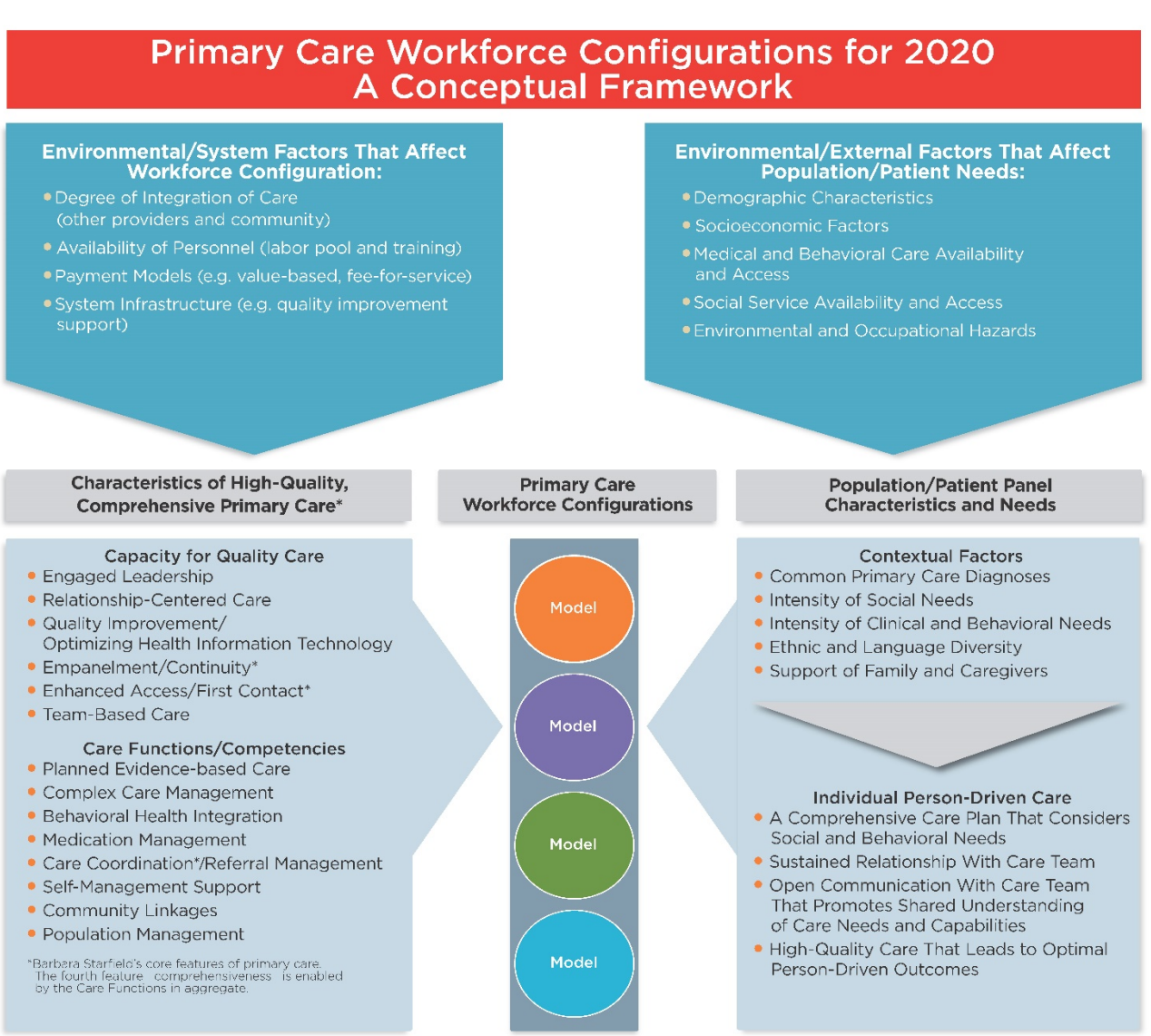
AHRQ's work on rural primary care workforce

- In 2018, AHRQ published a set of inter-related materials exploring the workforce needed to provide high-quality, comprehensive primary care
  - As part of this effort, AHRQ developed a staffing model for rural primary care practices
  - The AHRQ work did not consider issues of training, but may be a a useful foundational reference for COGME
  - Together, we may want to explore if 'training' is an additional core function of primary care practice and if so how this may effect staffing needs and how this function may effect practice satisfaction, quality, and resiliency.

Model Building Methods



Conceptual Framework



High-quality, Comprehensive Primary Care Requires

Capacities

- Engaged Leadership
- Relationship-Centered Care
- Quality Improvement/Optimizing Health Information Technology
- Empanelment/Continuity*
- Enhanced Access/First Contact*
- Team-Based Care

Functions

- Planned Evidence-based Care
- Complex Care Management
- Behavioral Health Integration
- Medication Management
- Care Coordination*/Referral Management
- Self-Management Support
- Community Linkages
- Population Management

Assumptions for Building the Index Model

- Practice size = 10,000 adults of average risk
- 32% of patients have multiple chronic conditions
- Growing over 65 population (17% Medicare in 2020);
- Currently 20% Medicaid
- The capacities in the framework are present
- Assume high functioning team-based collaboration and organization: expanded roles, standard work
- Communication including, team meetings, huddles, and minute-to-minute interaction
- Behavioral health (BH) and medication management integrated (in all models)
- Relationships with Community Organizations

Workforce Configurations of 4 Models

	Index Model	High Geriatric and/or High MCCs Model	Rural Model	High Social Need Model
Total Practice Size (Adults)	10,000	10,000	5,000	10,000
PCP Actively Managed Patients	MD: 1,333; NP: 1,000	MD: 900; NP: 700	MD: 1,250; NP: 1,250	MD: 1,100; NP: 900
Practice Function and Staffing				
Planned, Evidence-Based Care (PCP)	8 (6 MD/DO & 2 NP/PA)	12 (7 MD/DO & 3 NP/PA)	4 (2 MD/DO & 2 NP/PA)	10 (5 MD/DO & 5 NP/PA)
Planned, Evidence-Based Care (RN/LPN or LVN)	1.5 (1 RN & 0.5 LPN/LVN)	1.5 RN	1 LPN/LVN	2.5 RN
Planned, Evidence-Based Care (MA/LPN or LVN)	9 MA	12 MA	6 MA	10 MA
Complex Care Management/ Transition Management	2.5 RN	3.5 RN	1.5 RN	3 RN
Behavioral Health Integration	2.5 (1.5 LCSW & 1 Master's-level Therapist)	3 LCSW	1.75 LCSW	4 (1 PhD-level Psychologist, 2 LCSW, & 1 Substance Abuse Counselor)
Medication Management Therapy	1 Pharmacist	1 Pharmacist & 1 Pharmacy Assistant	0.5 Pharmacist	1 Pharmacist & 1 Pharmacy Assistant
Care Coordination/ Referral Management	2 (1 MA & 1 Layperson)	4 (2 MA/1 Layperson & 1 Patient Navigator)	1 MA/Layperson	4 (2 MA/Laypersons & 2 Patient Navigators)
Self-Management Support	1.5 (1 MA & 0.5 RN)	2.5 (1 MA & 1.5 RN)	1 MA/Layperson	2 (1 MA & 1 RN)
Community Linkages (CHWs)	This role is performed by other staff in the model.	This role is performed by other staff in the model.	1 CHW	2 CHW
Front Desk Administration - Reception, Intake, etc.	8 Clerks	11 Clerks	4 Clerks	10 Clerks
Quality Improvement and Optimizing HIT (Leadership)	0.3 MD/DO	0.3 MD/DO	0.2 MD/DO	0.3 MD/DO
Population Health (Leadership)	0.5 RN	0.5 RN	0.3 RN	0.5 RN
Total FTE Per Year	**36.8**	**52.3**	**22.3**	**50.3**

Costs Associated with 4 Models

Model	Index Model			High Geriatric and/or High MCCs Model			Rural Model			High Social Need Model		
Compensation Level	Low	Medium	High	Low	Medium	High	Low	Medium	High	Low	Medium	High
Panel Size	10,000			10,000			5,000			10,000		
Total FTE Per Year	36.8			52.3			22.3			50.3		
Primary Care Provider (PCP) to Non-PCP FTE Ratio	1:3.6			1:3.6			1:4.6			1:4.0		
Total Staffing Cost Per Year	$2,985,000	$3,411,000	$4,039,000	$4,205,000	$4,795,000	$5,664,000	$1,552,000	$1,773,000	$2,102,000	$3,656,000	$4,217,000	$5,039,000
General Operating Cost Per Year[1, 2]	$1,287,000	$1,767,000	$2,486,000	$1,930,000	$2,651,000	$3,728,000	$643,000	$884,000	$1,243,000	$1,608,000	$2,209,000	$3,107,000
Business Operating Staffing Cost Per Year[1,3]	$132,000	$188,000	$267,000	$198,000	$282,000	$400,000	$66,000	$94,000	$133,000	$165,000	$235,000	$334,000
Total Cost Per Year	$4,403,000	$5,366,000	$6,791,000	$6,333,000	$7,728,000	$9,793,000	$2,261,000	$2,751,000	$3,478,000	$5,429,000	$6,661,000	$8,480,000
Total Cost Per Patient Per Month	$37.00	$45.00	$57.00	$53.00	$64.00	$82.00	$38.00	$46.00	$58.00	$45.00	$56.00	$71.00

Resources

- Citation: Meyers D, LeRoy L, Bailit M, Schaefer J, Wagner E, Zhan C. Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices. *J Gen Intern Med*. 2018;33(10):1774-1779. doi:10.1007/s11606-018-4530-7

- AHRQ website: https://www.ahrq.gov/ncepcr/primary-care-research/workforce-financing/index.html

- Interactive cost tool: https://www.pcpcc.org/resource/primary-care-workforce-study

Discussion