

Introduction to AHRQ for the Council on Graduate Medical Education

David Meyers, M.D.

AHRQ Deputy Director

July 17, 2020

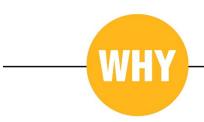
Our Goal







Improve the lives of patients



Our Aim



Our Goal



Improve the lives of patients



To help healthcare systems and professionals deliver care that is

- High Quality
- Safe
- High Value





Our Competencies



Our Goal

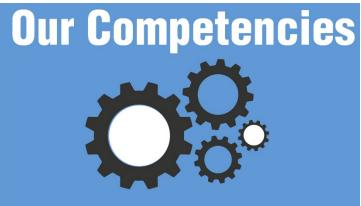


Improve the lives of patients



To help healthcare systems and professionals deliver care that is

- High Quality
- Safe
- High Value



- Health Systems
 Research
- Practice Improvement
- Data & Analytics







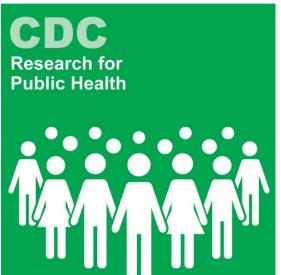
AHRQ's Role











"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



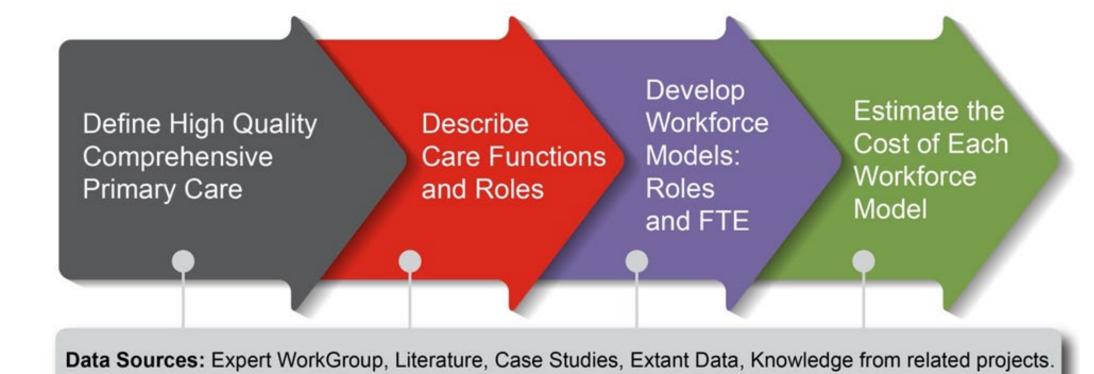
AHRQ's work on rural primary care workforce



- 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



Primary Care Workforce Configurations for 2020 A Conceptual Framework

Environmental/System Factors That Affect Workforce Configuration:

- Degree of Integration of Care (other providers and community)
- Availability of Personnel (labor pool and training)
- Payment Models (e.g. value-based, fee-for-service)
- System Infrastructure (e.g. quality improvement support)

Environmental/External Factors That Affect Population/Patient Needs:

- Demographic Characteristic
- Socioeconomic Factors
- Medical and Behavioral Care Availability and Access
- Social Service Availability and Acces
- Environmental and Occupational Hazards

Characteristics of High-Quality, Comprehensive Primary Care*

Capacity for Quality Care

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

Care Functions/Competencies

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

*Barbara Starfield's core features of primary care.

The fourth feature comprehensiveness is enabled by the Care Functions in aggregate.

Primary Care Workforce Configurations

Model







Population/Patient Panel Characteristics and Needs

Contextual Factors

- Common Primary Care Diagnoses
- Intensity of Social Needs
- Intensity of Clinical and Behavioral Needs
- Ethnic and Language Diversity
- Support of Family and Caregivers

Individual Person-Driven Care

- A Comprehensive Care Plan That Considers Social and Behavioral Needs
- Sustained Relationship With Care Team
- Open Communication With Care Team That Promotes Shared Understanding of Care Needs and Capabilities
- High-Quality Care That Leads to Optimal Person-Driven Outcomes

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 <u>adults</u> 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-tominute 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

