# Making the Business Case For Well-being and the Office of the Future

Staffing Model – Its not **only** about visits

DATE: February 13th, 2019 PRESENTED BY: Megan McGhean, Department Administrator

# Primary Care History at **OHSU**

Independent Department/ Division/ Center

- Internal Medicine
- General Peds / Adolescent Medicine
- Family Medicine
- Center of Women's Health Primary Care

Formed an Office of Primary Care and Population Health (2017)

# Subgroup of the PC Finance Committee: Staffing Model Committee

- Purpose:
  - Evaluate current staffing model practices
  - Develop a Primary Care wide staffing model
- Executive Sponsor:  Kevin O'Boyle, VP of Ambulatory Care

# Value-based not Volume-based

Follows the new payment structure

- CPC+
- Global payments
- Pay for Performance
- Risk-based contracts
- Additional value work has been added to the care teams

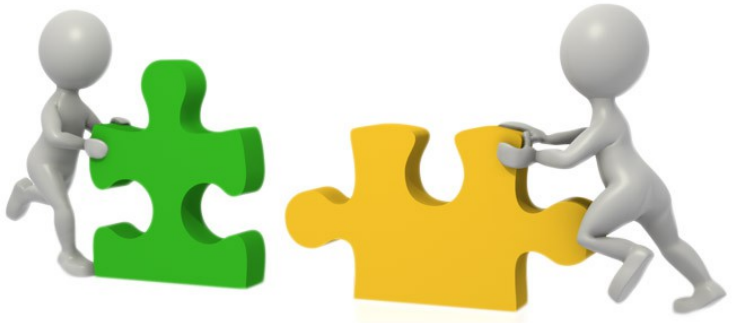
# The Process and Journey

**Connected with Others:**

- Within OHSU
- Within Oregon
- Across the country
  - Thank you to everyone who responded on the ADFM list serve.

**Literature Searches**

- Conducted a literature search to see who else had insight into our situation.
- What could we learn from others?
- Areas of interest:
  - Staffing models
  - Risk stratification
  - Provider and staff burnout



In the End….. We decided to build a model that would fit our needs.

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# Principles

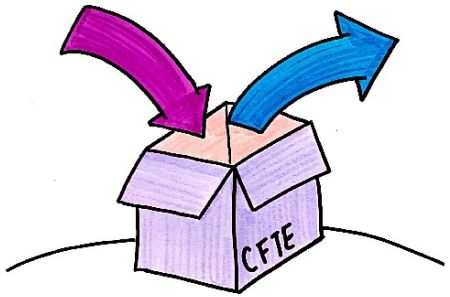
Developed 2017

- Take care of patients on the panel and in the clinic
- Clear panel size model
- Risk stratify/adjust
- Entire care team – define roles, quantity of staff, flexibility in the model.
- One model across all of Primary Care
  - Data driven with flexibility
- Allow for future growth and trends
  - Changing work
  - Changing reimbursement

# Our Process

- We needed a common language
  - CFTE (we all defined it differently)
  - Staffing classification and how they are used in the clinics.
    - Example: Panel/team coordinators
      (Medical Assistant vs. front office)
- Included vs excluded in the model
- Financial arrangements with the Hospital and School
  - Each group's is different
  - How do we fund the staff in the new model?
- Added ad hoc members to our team
  - Clinic managers and medical directors, supervisors, leads, and team reps

# Example: CFTE definition for the staffing model work agreed to by all of Primary Care




| Clinic Based - CFTE | | | |
|---|---|---|---|
| | Included | Excluded | |
| Private Clinic Session (aka - seeing pts) | x | | |
| Patient care admin time | x | | |
| Precepting (faculty time to precept residents) | | x | |
| Consults (outpatient only) | | x | exclude if not embedded in primary practice clinic and take external referrals |
| Resident clinic session (aka - seeing pts) | x | | |
| Inpatient | | x | |
| Teaching | | x | |

# "More Better" Model

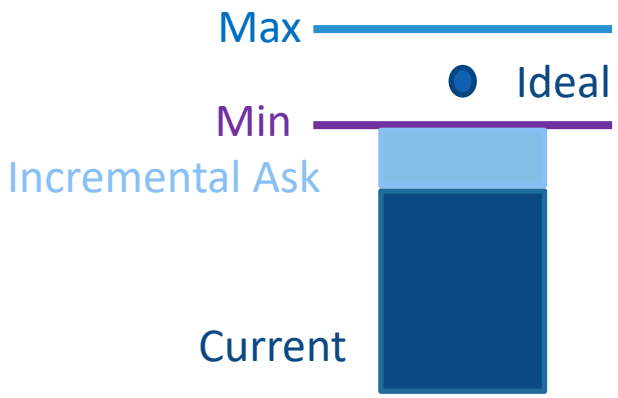
- Recommend incremental ask to get all of our practices up to the minimum
- Will provide a range within the ratio to allow for flexibility
- Allows formula driven increase in staffing when panel sizes are increased

## Example: Bring up to the minimum

| More Better - Part 1 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | MA | | Front Office | | RN | | Provider CFTE |
| | 1/1/2019 | More Better Model | 1/1/2019 | More Better Model | 1/1/2019 | More Better Model | 1/1/2019 |
| Staff / 1000 lives | 1.17 | 1.42 | 0.87 | 1.29 | 0.17 | 0.47 | 0.86 |
| *Min* | *0.60* | *1.21* | *0.43* | *1.10* | *0.07* | *0.40* | *0.55* |
| *Max* | *1.42* | *1.63* | *1.29* | *1.48* | *0.47* | *0.54* | *1.13* |
| Total # of staff | 101.67 | 149.98 | 75.83 | 112.42 | 14.92 | 40.96 | 74.99 |
| Increase | | 48.31 | | 36.59 | | 26.04 | |

## Example: Adding 10,000 new patients

| More Better - Part 2 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | MA | | PAS | | RN | | Provider |
| Additional lives | | 10,000 | | 10,000 | | 10,000 | 10,000 |
| Number of staff | | 14.20 | | 12.90 | | 4.70 | 8.60 |

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# New Metrics

(Focused on MA, Front office, RN and Clinicians during phase 1)

- Staffing/lives covered
  - Staffing/1000 lives
- CFTE/lives covered
  - CFTE/1000 lives
- Comparison
  - To each other
  - Other institutions
  - Models from the literature
- Metrics/Goals to determine how we are doing

# Metrics/Goals

| Category | Metric | Purpose | Measurement | Goal |
|---|---|---|---|---|
| Patient Experience | NRC Health question: Would recommend Provider/NPS | Indicator for word of mouth referrals | NRC Health Score by clinic (measured monthly) | OHSU Goal for ambulatory 84.0 |
| Care Team Metric | In basket message completion turnaround time | Addressing patient needs in a timely manner and team work between the care team members | EPIC in basket closure time. | Average closure time less than 4 hours |
| Employee Engagement | Press Ganey Survey: I feel burned out from my work | Burn out rate for staff and providers | Reduce burnout rate by 5% between FY 18 and FY 19 survey | 5% decrease |



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# Other Considerations

- Space
- Cost
- Risk adjustment
    - Age, sex, payer
- Panel size work (being worked on by another sub-committee)
- Monthly adjustments

# Next Steps: *This is just the beginning*

- Get final approval from Hospital and SOM Leadership
- Work with Clinic Managers to apply this staffing ratio to FY 20 budget
- Implement MA, Front Office, RN and Provider ratio's
- Evaluate the staffing model
- Work on next classification groups
- Learn from the "more better" staffing model and make changes (we know that this is step one, in a long line of steps).

Special **Thank You** to the Primary Care Staffing Model Committee Core:

Shelly Fields – Pediatrics and Adolescent Medicine

Elaine King – Center for Women's Health

Clea Cadham – Internal Medicine

Paige Perry – Internal Medicine

Michael Martin – Family Medicine