Best Evidence Statement (BESt)

Date: 11/11/2011

Title: The Use of Unlicensed Assistive Personnel in the Ambulatory Setting

Clinical Question:

In Ambulatory Care Clinics, does the use of unlicensed assistive personnel in addition to licensed health care providers versus licensed health care providers only improve clinic flow?

Definitions:

Licensed health care providers include:
- Advanced Practice Nurses
- Registered Nurses
- Licensed Practical Nurses

Unlicensed Assistive Personnel include:
- Certified Medical Assistants
- Patient Care Attendants

Clinic Flow is influenced by:
- the amount of clinician/patient interaction time
- patient wait time
- number of patients seen
- procedures performed per session

Target Population:

Inclusion: Any Ambulatory Care Clinic, including specialty and primary care.

Recommendation:

There is insufficient evidence and a lack of consensus to make a recommendation to support the use of any one best combination of unlicensed assistive personnel and licensed health care providers affecting clinic flow in the ambulatory care clinic setting.

> **Note:** Evidence supports the implementation of a team approach in clinical settings with clearly defined roles for the professional and assistive staff (Dickson, 2010 [4b]; O'Connor, 2010 [4b]; Bodenheimer, 2007 4b]; Aita, 2001 [4b]; Myers Schim, 2001 [4b]).

Discussion/Summary of Evidence related to the recommendation:

As advances in health care have improved over the last century, the roles of the physician, the professional nurse and unlicensed assistive personnel have evolved and expanded. Determining appropriate staff workloads and scope of practice for the professional staff while building effective strong teams is a time consuming but necessary process to ensure coordination of patient care (Dickson, 2010 [4b]; Myers Schimm, 2001 [4b]). Descriptive studies and expert opinion indicate that a "team" approach to efficient office/clinic practices and high quality patient care is the most effective strategy to achieve timely patient flow (O'Connor, 2010 [4b]; Bodenheimer, 2007 4b]; Aita, 2001 [4b]).

Building a strong effective team is a very complex process with variables that are unique and specific to each office or clinic. "The leadership and philosophies (values and goals) of the institution, administrators and the physicians shapes hiring practices, staffing patterns and the expectations of the staff roles. The geography, demographics and diversity of the patients seen in each clinic or office practice also influences the expectations of staff roles. As does availability of trained staff, the location and physical set up of the clinic or office affects the staff roles and responsibilities" (Aita, 2001 [4b]).

O'Connor 2010 noted in studying patient flow, improvements in the number of patients seen per clinic session was increased by implementing "dyading". The Physician and Medical Assistant were paired up as a team and together provided patient care for each scheduled appointment. This strategy increased provider availability without increasing the workload for the clinic staff.

In taking the time to define workloads and scope of practice, implement delegation strategies, evaluate clinic flow and effectively use the electronic medical record, patient care productivity and safety can be improved upon. "The benefit in turning team of experts into an expert team on behalf of patient care quality and safety is significant" (Webster, 2008 [5a]).

An in-depth literature search reveals that very little research has been done on patient outcomes in the ambulatory care setting.

Reference List :

Aita, V., Dodendorf, D. M., Lebsack, J. A., Tallia, A. F. & Crabtree, B. F. (2001, October). Patient Care Staffing Patterns and Roles in Community-Based Family Practices. *Journal of Family Practice*, *50.* Retrieved March 22, 2011 from: http://www.jfponline/Pages.asp?AID=2348&issue=Octoberr2001&UID. [4b]

Bodenheimer, T. (2007, July). Building Teams in Primary Care: Lessons Learned. *California Health Care Foundation,* pp. 1-15. [4b]

Dickson, K., Cramer, A. & Peckham, C. (2010, January-February). Nursing Workload Measurement in Ambulatory Care. *Nursing Economics*, *28*, 37-43. [4b]

Myers Schimm, S., Thornburg, P. & Kravutske, M. E. Time, Task and Talents in Ambulatory Care. *Nursing Economics*, *31*, 311-315. [4b]

O'Connor, M. E., Spinks, C., Mestas, T. A., Sabel, A. L. & Melinkovich, P. (2010, July). "Dyading" in the Pediatric Clinic Improves Access to Care. *Clinical Pediatrics*, *49*, 664-670. [4a]

Tache, Stephanie, Chapman, Susan. (2006, Winter). The expanding Roles and Occupational Characteristics of Medical Assistants: Overview of an Emerging Field in Allied Health. *Journal of Allied Health*, *35,* 233-237. [5a].

Webster, John, King, Heidi, Toomey, Lauren, Salisbury, Mary, Powell, Stephan, Craft, Brigetta, Baker, David & Salas, Eduardo. (2008, August). Understanding Quality and Safety Problems in the Ambulatory Environment: Seeking Improvement with Promising Teamwork Tools and Strategies. *NCBI Bookshelf.*

Retrieved May 3, 2011 from: http://www.ahrq.gov/downloads/pub/advances2/Vol3/Advances-Webster_76.pdf [5a]

Supporting Information

Background / Purpose of BESt Development:

This clinical question was developed around the recent change in hiring practices in the ambulatory specialty clinics. Unlicensed assistive personnel in the form of certified Medical Assistants will now be utilized in many of the specialty clinics. The scope of work for the certified medical assistant is currently not well defined. In making staffing changes, the flow of patients in clinic and the effects on patient outcomes need to be considered.

There is a general consensus that the ambulatory care settings are the most rapidly growing aspect of the current health care system, but the least studied. As health care costs have risen rapidly and as nursing shortages persist, the implementation of unlicensed assistive personnel in the ambulatory settings has expanded. The impact of this on patient outcomes and the quality of care delivered by unlicensed assistive personnel has not been well studied (Aita, 2001 [4b]).

Applicability Issues:

Each office practice/clinic is unique and different unto itself, requiring careful consideration of each health care provider's scope of work or practice and the complexity of the needs of patient care. It is not possible to generalize about what "works" for one office/clinic can be applied to another office/clinic (Aita, 2001 [4b]).

The literature points out; unlicensed personnel can be well trained to meet the needs of the individual clinic setting, but their education, training and lack of clinical experience limits their ability to adapt to multiple specialty settings (Tache, 2006 [5a]).

Outcome or Process Measures:

Possible process improvement flow measures may include:

1. Decreasing the average time patients spend waiting in the lobby to be placed in exam room.
2. Decrease the wait time to be seen by the provider.
3. Maintain adequate total "touch time" with the clinic staff and physician.

Search Strategy:

Keywords: Certified Medical Assistant, Medical Assistants, Unlicensed Assistive Personnel, ambulatory care and safety in ambulatory care

Databases: CINAHL, PubMed, Cochrane, Database of Systematic Reviews, Nursing Reference Library and Google Scholar

Limits and filters: English, All articles published prior to 2000 were excluded
Date Range: 2000 -2011, Last literature search was May 15, 2011

Relevant CCHMC Evidence-Based Documents

Guidelines, other BESts, policies, procedures, Knowing Notes, or Health Topics – None were found

Group/Team Members

Group/Team Leader

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Conflicts of Interest were declared for each team member:

☒ No financial conflicts of interest were found.
☐ The following financial conflicts of interest were disclosed:

Note: **Full tables of evidence grading system available in separate document:**

- Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality *(abbreviated table below)*
- Grading a Body of Evidence to Answer a Clinical Question
- Judging the Strength of a Recommendation *(abbreviated table below)*

Table of Evidence Levels *(see note above)*

Quality level	***Definition***
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

Table of Recommendation Strength *(see note above)*

Strength	***Definition***
It is strongly recommended that… It is strongly recommended that… not…	There is consensus that benefits clearly outweigh risks and burdens (or visa-versa for negative recommendations).
It is recommended that… It is recommended that… not…	There is consensus that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation…	

Dimensions for Judging the Strength of the Recommendation			
Reflecting on your answers to the dimensions below and given that more answers to the left of the scales indicates support for a stronger recommendation, complete one of the sentences above to judge the strength of this recommendation. *(Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)*			
1. Grade of the Body of Evidence	☐ High	☐ Moderate	☒ Low
2. Safety / Harm (Side Effects and Risks)	☒ Minimal	☐ Moderate	☐ Serious
3. Health benefit to patient	☐ Significant	☐ Moderate	☒ Minimal
4. Burden on patient to adhere to recommendation	☐ Low	☒ Unable to determine	☐ High
5. Cost-effectiveness to healthcare system	☒ Cost-effective	☐ Inconclusive	☐ Not cost-effective
6. Directness of the evidence for this target population	☐ Directly relates	☐ Some concern of directness	☒ Indirectly relates
7. Impact on morbidity/mortality or quality of life	☐ High	☐ Medium	☒ Low
Comments on Dimensions (optional):			

Copies of this Best Evidence Statement (BESt) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.
Website address: http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm
Examples of approved uses of the BESt include the following:

- copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- hyperlinks to the CCHMC website may be placed on the organization's website;
- the BESt may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at EBDMinfo@cchmc.org for any BESt adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

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This Best Evidence Statement has been reviewed against quality criteria by 2 independent reviewers from the CCHMC Evidence Collaboration.

For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at EBDMinfo@cchmc.org.

Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.