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Cost-Effective Staffing with Medical Assistants

Urgent message: Medical assistants (MAs) provide flexible, cost-effective clinical support for urgent care centers. With proper training and working under a physician's supervision, an MA can perform most basic support functions in this setting.

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Introduction

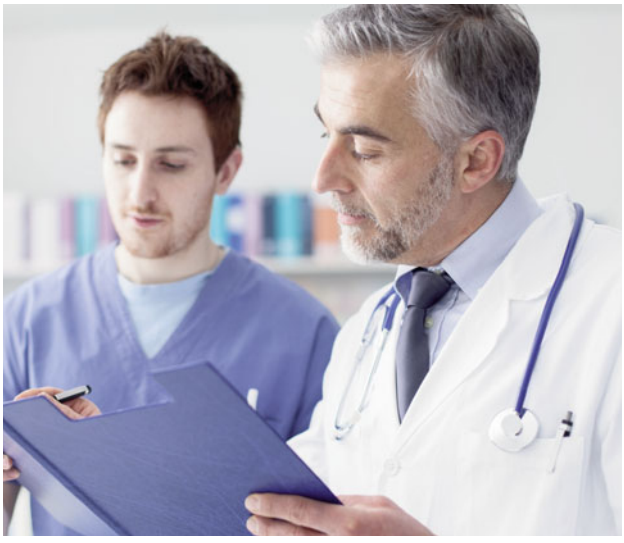
While there's a lack of verifiable data as to the total number of unsuccessful urgent care endeavors, we can presume at least one common reason urgent care centers shutter their doors and permanently cease operations: they exhaust their working capital.

Working capital funds business operations, covering expenses such as payroll, rent, and supplies. Newly opened centers are especially vulnerable to rapid insolvency, as they often lack sufficient cash deposits to quickly achieve break-even profitability. Hence, until break-even profitability is reached, an urgent care center derives its working capital from sources such as bank loans and owner's equity.

Urgent care centers cannot achieve break-even profitability until patient revenues exceed operating expenses. And whereas patient revenues can be variable, a center has much greater control over its operating expenses. So, the goal of an urgent care operator, regardless of whether a center is new or mature, is to take a hard look at expenses and identify areas of excess. While extras like lavish buildouts and amenities are easy targets for slashing, urgent care operators would do well to begin with their single largest area of expense: labor.

Staffing Models Drive Labor Costs

Payroll and benefits account for over half of the total expenses of an average urgent care center (**Figure 1**). As such, the urgent care staffing model is the starting place for identifying savings. And while cross-training and integration of midlevel providers are common approaches for keeping labor costs in check, one oft-overlooked area of consideration is the forgoing of nurses in favor of medical assistants.



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Admittedly, the notion of an MA-intensive staffing model—while immediately offering an appreciable reduction in labor expenditures—will invariably bring with it several key questions:

1. Can an MA truly perform most of a nurse's essential job functions at the same level of clinical competence?
2. If MAs can indeed competently perform most of a nurse's functions, what are the legalities involved with a physician allowing them to do so?

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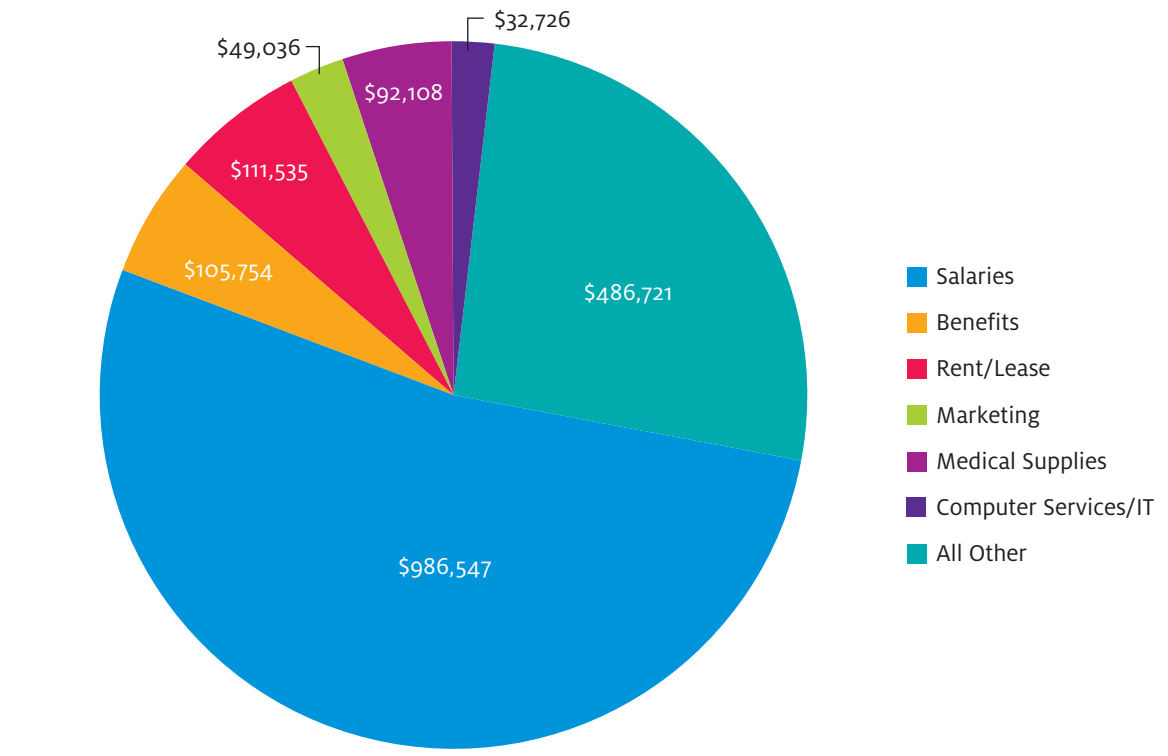
Figure 1. Expenses of Average Urgent Care Center



UCAOA Urgent Care Benchmarking Survey, 2014

3. How should a provider manage an MA who is essentially replacing a licensed registered nurse (RN)?

Unbeknownst to some urgent care operators, a medical assistant with the proper training, certifications, and licensing can indeed perform many of the clinical functions of a registered nurse.

Business Case for Medical Assistants

According to data from the Urgent Care Association of America's 2015 Urgent Care Benchmarking Survey, the average hourly pay for an RN was $27.49, compared with $14.53 for an MA. As illustrated in **Table 1**, substituting MAs for RNs results in appreciable savings. These are hardly insignificant, especially for struggling centers or those working with thin margins. In fact, the freed-up working capital gained from an MA-intensive staffing model can be used to bolster revenue-driving activities, such as the marketing budget.

Legal Considerations

Currently, there is no single national, uniform scope of practice definition of what clinical functions an MA can or can't perform by law. Rather, each state sets its own laws and customs for the MAs employed therein, and these laws and customs can vary. However, there are sev-

Table 1. Urgent Care Nurse vs MA Pay Rate Comparison*

Total open hours per year:	4,320
Number of FTEs (2,080 Hours) for one staff position	2.1
MA hourly rate ($14.53) loaded w/13.8% benefits	$16.54
RN hourly rate ($27.49) loaded w/13.8% benefits	$31.28
Hourly rate difference between RN and MA	$14.74
Hourly rate difference x 2,080 hours/FTE	$30,659.20
Hourly rate difference x 2,080 hours/FTE x 2.1 FTE	$64,384.32

*For a typical urgent care center open 12 hours per day, 360 days per year.

Table 2. Medication Administration Guidelines

Job title	Vaccines (eg, Varivax)	Injections (eg, Benadryl)	Mixing (eg, Rocephin)	Insulin (eg, Human Regular)	Controlled substances (eg, Testosterone, Morphine)
RN	Yes	Yes	Yes	Yes *(requires double-check with RN/LPN/provider)*	Yes
LPN	Yes	Yes	Yes *(requires double-check with RN/provider)*	Yes *(requires double-check with RN/provider)*	Yes
MA	Yes	Yes *(requires double-check with RN/provider)*	Yes *(requires double-check with RN/provider)*	Yes *(requires double-check with RN/provider)*	No (no access at any time)

Please note: This table reflects representative regulations; it does not apply to the regulations of every state.
(Source: Urgent Care Consultants)

eral standard MA regulations that nearly every state requires its providers to follow:

- In every case, unlike nurses, MAs are not licensed. Rather, they practice under the license of their delegating physician, who is responsible for all actions of an MA.
- The MA cannot be presented to customers or patients as a licensed practitioner.
- Any tasks delegated to an MA must be within the delegating physician's authority to perform.
- The MA to whom the clinical task is delegated must be properly qualified and trained to perform such a task.
- The MA is prohibited from re-delegating an assigned clinical task to an unlicensed individual; nor can the delegating physician transfer their supervisory obligations to anyone other than another qualified physician who is aware of and accepts that responsibility.
- The administration of drugs/medication by an MA has several additional regulations:
  - A physician is generally limited in his/her ability to delegate the administration of controlled substances, including narcotics, which MAs can never administer.
  - Delegation must occur on the physical premises of the delegating physician's offices.
  - The physician must first evaluate the acuity of the presenting patient, then evaluate the clinical competency of the MA to whom administration of medication is being delegated.

Again, this is not an exhaustive list of regulations, but rather, general guidelines. Thus, urgent care operators wishing to employ and delegate clinical duties to an MA must do their own due diligence in researching the guidelines and regulations of their respective states. It bears repeating, however, that in all cases, the licensed physician is legally and professionally responsible for the actions of the MA. Additionally, some jurisdictions provide for nurses and/or nurse practitioners to delegate clinical tasks to an MA, depending on the local nursing practice laws. Note, though, that any such delegation is always based on the legal relationship between the nurse and the MA, not a physician and the MA.

Clinical Scope of Practice

Medical assistants can loosely be described as healthcare professionals that act as an auxiliary to a licensed physician. In short, they're professionals that play a critical role in the operations of healthcare clinics, facilities, and physician offices. MAs traditionally take patient vital signs, explain and set the expectations for the visit, and prep the patient for exams. MAs also tend to work the front desk, where they can handle clerical, administrative, and patient registration tasks. While these duties are important, a properly trained and certified MA can also take on a myriad of clinical duties (upon standing physician orders). A few common examples of such clinical duties include:

1. **Perform venipuncture.** MAs can draw blood or start an IV.
2. **Operate the x-ray machine.** MAs who have basic x-ray certification (in states where permitted) can take some x-rays.
3. **Administer urine catheter.** Insert/remove straight or indwelling catheter while also performing gen-

New York State Restrictions on Medical Assistants

The tasks approved for MAs vary by state. Because a "medical assistant" is generally an unlicensed individual who performs tasks under the supervision of a physician who is responsible for their actions, there can often be ambiguity as to what tasks can be delegated to an MA. New York is one state that specifically defines the tasks that can be completed by medical assistants or unlicensed persons as:

- Secretarial work, such as assembling charts or assisting with billing
- Measuring vital signs
- Performing EKGs
- Taking laboratory specimens, including blood work
- Assisting an authorized practitioner, under the direct and personal supervision of said practitioner, to carry out a specific task, as a "second set of hands."

Further, New York restricts MAs and other unlicensed persons from performing the following tasks:

- Triage
- Administering medications through any route
- Administering contrast dyes or injections of any kind
- Placing or removing sutures
- Taking x-rays or independent positioning patients for x-rays
- Applying casts
- First-assisting in surgical procedures

In the urgent care setting, New York enables MAs to do most of the daily tasks needed (rooming patients, obtaining vitals, testing, drawing blood, performing point-of-care labs, and assisting the physician with lacerations and their clean-up), but the three things they cannot do are significant considerations for urgent care operators:

- Triage: Medical assistants cannot assess the acuity of a patient's symptoms nor direct/prioritize patient care.
- Injections: Medical assistants cannot draw up or give injections.
- IV medications: Medical assistants can bring the necessary items for a provider to start the process but they cannot monitor flow or pull the IV out.

While the provider prospectively could deal with injections and IVs (although such can be a distraction in a busy clinic), the main challenge with MAs for urgent care in New York goes to triage. A provider cannot control flow and treat patients simultaneously. In the rare instance of an emergency presentation, the physician could be liable if the MA were found to have prioritized flow based on acuity (with the assumption being the MA conducted a medical assessment). So, the recommendation in New York is that a registered or licensed practical nurse be included in the staffing model.

Outside of New York, most urgent care centers rely on standard operating procedures instead of triage. Patients are seen on a first-come, first-served basis, with standing orders to immediately pull back any patients with chest pain, shortness of breath, allergic reaction, severe pain, bleeding, etc. for a provider evaluation. Typically, the front desk will ask if a patient has any of these symptoms, upon which time the patient will immediately be taken to the back. Otherwise the patient is queued and the MA takes vitals and documents chief complaint, medical history, and current medications. Whether RNs/LPNs are needed, then, depends in large part on whether the triage process remains or whether standing orders are implemented to prioritize patients complaining of certain symptoms.

eral catheter care.

4. **Assist with medical examinations.** In concert with and in support of the delegating physician.
5. **Remove sutures and change dressings.** After physician evaluation and orders.
6. **Administer medication/vaccines/immunizations. Table 2** provides a basic overview of the medication administration guidelines for clinical staff. Note that with the exception of controlled substances, an MA can administer each medication type provided they double-check with a licensed, delegating provider first.
7. **Report lab findings/results to patients.** As long as the lab results have been reviewed and signed off by the delegating physician/provider.

In sum, the scope of clinical tasks many states allow physicians to delegate to MAs is expansive, so it's generally more useful to highlight the few tasks that *cannot* be delegated to an MA. Such a list would include:

- Complex wound care (including the administration of silver nitrate sticks)
- Double-check of high-risk medication
- Triage (telephone or in-person), assessments, diagnoses, interpretations, or evaluations
- In-depth patient education or independent medical judgements

As is always the case, state laws and regulations dictate exactly what clinical tasks a licensed provider can or cannot delegate to an MA—and the laws do vary. Regardless, the above breakdown lends credence to the assertion that an MA can perform most of the tasks that a nurse would in an urgent care setting.

Training, Licensing, and Certifications

Nationally, there is no standard educational criteria governing MAs, so healthcare employers must vet each MA applicant for clinical skills and certifications. Most healthcare employers prefer certified MAs, though, and will favor applicants credentialed through or affiliated with accredited, recognized certification programs and schools. Yet, formal career pathways can vary, from a two-year college associate degree program (in-class or offline) to a vocational school offering coursework spanning several months. One such pathway, the attainment of a Certified Clinical Medical Assistant (CCMA) certificate, is offered by the National Healthcareer Association (NHA) and is widely respected throughout the industry. The American Medical Technologists (AMT) also offers an industry-recognized Medical Assisting certification. Many other independent schools and institutions also offer MA diploma programs and certifications through both in-class and online coursework comprising in-depth curricula toward developing well-trained, highly qualified MAs.

Still, most hands-on MA clinical training actually occurs on the job by physicians, various clinicians, and even other MAs. This training can occur during a paid or unpaid internship/externship and usually involves job shadowing of both clinical and administrative staff. Exposing the intern/extern to as many functions as possible will help ensure they develop into an experienced, well-rounded MA who is a versatile and valuable care team member.

Physician Resistance

Many physicians who get into urgent care have emergenc room backgrounds wherein they're accustomed to working with nurses. In the ED, nurses tend to "manage" the physicians, so to speak—in terms of assessing patient acuity, coordinating patient flow, etc. MAs, by contrast, require active engagement and management from physicians, which some providers resist. Often set in their ways, the prospect of having to manage an assistant (and being liable for their mistakes) is unappealing, to say the least.

However, as an urgent care center can clearly benefit, financially and otherwise, from employing more cost-effective MAs, physicians would be wise to take a more open-minded approach to embracing the MA staffing model. To that end, here are a few tips for physicians on how to engage and manage MAs:

1. **Establish well-defined protocols and directions**—Undoubtedly the most important piece in working with MAs. Clear directions, well-defined protocols, and orders outlined in advance give the MA a structure of how to approach and prioritize clinical and administrative tasks. Of course, the delegating physician will still need to actively engage the MA, but with protocols, directions, and orders in place there will be far less supervising/micromanaging required.
2. **Communicate the MA's roles and responsibilities to the care team**—Team members should have a clear understanding of the MA's role, including the delegating physician's preferred prioritization of MA tasks. This type of communication takes the guesswork out of determining what the MAs should be doing at any given time, and prevents them from being pulled in multiple directions.
3. **Periodically assess the MA's work quality**—At first there may be a lot of upfront time investment in direct supervision and training, but eventually the MA should be able to work semi-independently within the framework of existing protocols. Still, the delegating provider should periodically assess the overall performance of the MA, making sure to offer constructive criticism if necessary and praise when appropriate.

While MAs will never have the latitude or autonomy of a licensed nurse, they can still perform a multitude of clinical duties that do not require the physician's constant supervision. Therefore, the success of the model hinges on the physician's open-mindedness to the practice model, and their cognizance of the financial benefits of employing cost-effective labor.

Advantage: Cross-Training

Upon close examination, it becomes clear that a well-trained MA, depending on state laws, can perform many of the clinical tasks of a radiologic technician, phlebotomist, and lab tech. And as there is generally insufficient patient volume for an urgent care to fully utilize these positions, there should be an emphasis on cross-training MAs to fill the roles when necessary.

Urgent care should utilize a lean-staffing model, using the most cost-effective resource for each task in the center.

But many urgent care centers are either part of, or following the staffing model of, hospital systems, and that's when they run into financial trouble from overstaffing. Hospitals, for example, will employ specialized labor for each task, such as an RN for meds distribution, an RT for x-rays, and a lab tech/phlebotomist for drawing blood. Many of these specialized tasks occur only a few times a day in urgent care, though, which means the unnecessary labor spikes costs to the point that the urgent care can't survive financially. Couple that with common misperceptions of what a nurse or MA "can't do"—resulting in "specialists" being brought in—and it ends up that highly paid, but unnecessary full-time equivalents (FTEs) strain the urgent care budget.

"Implemented correctly, an MA staffing model can elevate a practice to new levels of energy, cooperation, and efficiency."

Hence, cross-training is essential. The staffing model should be as lean as possible, with everyone eager to jump in and help out wherever necessary. Many states offer MA certification pathways for basic x-ray and lab tech training, and due to CLIA-waived/instant tests and the percentage of patients treated presumptively without lab testing, the lab tech might be a superfluous urgent care position anyway. MAs can and already do fulfill these roles as they occur in urgent care.

Special Considerations

Ultimately, a nurse seems to be a more highly paid FTE than is really required in urgent care. Additionally, urgent care nurses turn over frequently in pursuit of higher-paying, less stressful positions that have lower patient volumes. Or, they pursue careers in long-term care, nurse management, or go after advanced credentials such as Nurse Practitioner or Nurse Doctorate. And with the nation periodically experiencing nursing shortages, urgent care may not be the best use of those limited clinical resources.

The position of MA, on the other hand, aligns more synergistically with the urgent care model. Many medical assistants have a strong yearning to help and assist people (not that nurses don't), which turns out to be a primary reason they become MAs. The advantage to urgent care is a workforce eager to serve patients.

Thus, urgent care becomes an excellent training ground for MAs, and plays a critical role in developing the nation's clinical support resources. It's why many urgent care centers create externships with MA schools, as this allows them to shape the MA's formal training curriculum, and to interview and select from among the top students.

The drawback, of course, is that urgent care MAs become so skilled that they frequently also turn over in pursuit of higher-paying, less stressful positions. Or, they even go back to school to pursue nursing degrees. So, it behooves the urgent care to develop and nurture relationships with MA schools and vocational programs to assure a constant pipeline of high-quality MAs for the center.

Conclusion

Labor is the single largest expense in urgent care operations; in order to survive financially, urgent care operators must always employ the leanest staffing model possible. Well-trained and supervised medical assistants can perform most clinical tasks in many states, so by forgoing higher paid FTEs such as nurses and RTs in favor of MAs, a center can realize tens of thousands in yearly labor savings.

Critical to the successful implementation of an MA-intensive staffing model, however, is physician engagement. Many physicians have grown accustomed to a clinical environment where they work primarily with nurses, and frown upon having to actively manage MAs. But the time tradeoff is financially worth it to the urgent care, and with well-defined protocols in place, skilled and versatile MAs can help improve overall clinic workflow.

So it's up to urgent care operators to play an active role in the development of the nation's MAs through externships/internships with MA schools and vocational institutions. This helps urgent care centers assure they'll maintain a ready pipeline of dedicated and well-trained MAs while contributing to the development of the nation's clinical resources.

Bottom line, urgent care centers sink or swim based on how well they manage costs. The MA staffing model is a more than viable option, and when implemented correctly, can elevate a practice to new levels of energy, cooperation, and efficiency. ■