

Group Health, Olympia Medical Center site visit report

October 2011

History and Demographics

Group Health Cooperative began in 1947 as a community coalition dedicated to making quality health care available and affordable. Today it is one of the few health care organizations in the country governed by its own patients, through an 11-member Board elected by Group Health patients. Group Health provides medical coverage and care to over 670,000 residents in Washington State. In Western Washington, Group Health is an integrated system (except for hospitals) including a health plan, 25 medical centers, and 1055 physicians.

Olympia, Washington is home to the largest Group Health medical center, with 46,000 patients. For most of their operating costs, each Group Health clinic receives a global budget based on the number of patients adjusted using the Diagnostic Cost Group (DxCG) adjustment model that gives more weight to elderly patients and those with multiple diagnoses. Olympia's primary care clinicians include 36 family physicians and 6 mid-levels (NP and PA). Many clinicians are 1.0 FTE, some 0.8 or 0.7, and a few 0.5. Half-time physicians have a practice partner who cares for each others' panel on the days they are not in clinic. Group Health has been using the EPIC EMR for about 10 years.

In 2006, Group Health initiated a primary care transformation initiative, starting with its medical center in Factoria. To reduce physician burnout, improve access, and provide more time for patient-clinician interaction, panel sizes per full-time physician were reduced from an average of 2200 to 1800. Visits were lengthened, and patients were encouraged to utilize substitute e-mail and phone visits to complement face-to-face visits. The transformation was successful in improving care, boosting patient satisfaction, reducing clinician burnout, and cutting overall costs of care compared to controls by cutting down on emergency department visits and hospital admissions [1,2,3]. In 2009, Group Health began to roll out the medical home transformation to the remaining medical centers.

Empanelment and Panel Size

Most Group Health members are empaneled to a primary care physician. Panels are closed when the physician reaches 2000, and are re-opened when the panel size falls to 1800. If a physician is very stressed by workload, his or her panel can be closed. Mid-level practitioners are not empaneled. They tend to see same-day patients, though some share a physician's panel and essentially care for a subpanel of their own.

Continuity of Care

Receptionists at Group Health's Primary Care Appointing Center are trained to value continuity of care, though a higher priority is patient preference. If a patient asks for Dr. X and the PCP is Dr. Y, the appointment is made with Dr. X. To enhance

continuity, physicians are strongly encouraged to add on their patients (but not the patients of other physicians) for same day encounters if at all possible.

Access to Care

Group Health has moved dramatically to reduce the amount of care provided through face-to-face clinician visits. During 2011, Olympia Medical Center primary care patients utilized about 1800 secure message (e-mail via MyGroupHealth patient portal) encounters, about 300 phone encounters, and about 1200 face-to-face visits per week.

Most patients can obtain a face-to-face clinician visit within 2 or 3 days, many within 1 day. 6 out of 14 slots per clinician per day are saved for same day appointments, which is usually sufficient because of the panel size reduction from 2200 to 1800, with smaller panels generating less demand. If the slots are used up (later in the day), calls are forwarded to the team; the clinician makes the decision whether to add on the patient.

3 years ago, physicians generally provided 22 face-to-face visits per day; this number is now 14, plus 4 telephone visits each day. Phone encounters involve the clinician calling the patient at a pre-arranged time. In addition, time slots are available for desk-top medicine, which includes responding to patient-generated e-mails, sending secure messages to patients, coordinating care with specialists and hospitalists, and addressing the many staff messages coming from other members of the team. A typical hour on the template may involve 2 pre-scheduled 20-minute visits, and one 20-minute slot for desk-top medicine and phone calls. A challenge is the sheer volume of messages that arrive in the physician's in-box. Many physicians report spending time each evening catching up on their documentation tasks, including addressing their in-box messages.

Many primary care practices work hard to improve appointment access but neglect phone access. Group Health has placed high priority on phone access, with great success. Formerly, patients leaving a phone message might expect a call-back in 10 hours; now the goal for call backs is 2 hours. Olympia's goal is that calls are answered within 30 seconds 80% of the time. An important patient-centered metric is first call resolution, which means that the patient's problem is addressed before the patient hangs up. This metric cannot be expected to reach 100% since many calls require clinician input. Each team member receiving an incoming patient call documents on the telephone encounter as to whether or not they were able to resolve the call. The goal is to meet the patients' needs on that first call at least 65% of the time. First call resolution not only helps patients, but assists the team in reducing the wasted work required by taking messages, notifying clinicians to call the patient back, and repeating the process if the patient calls again before receiving a callback. Incoming calls to the team are usually picked up by the LPN, but anyone on the team, including physicians, can open their phones and receive calls. Physicians are encouraged to take calls for the first half hour of the morning so that patient questions can be resolved right away. Call management requires daily attention from clinic managers, who can track who is answering how many calls and whether they are being resolved.

Group Health in Olympia offers urgent care until 11 PM on weeknights and from 9 am to 9 pm Saturday and Sunday. In addition, Group Health operates a 24/7 consulting

nurse service with back-up physicians. As a result of Olympia's appointment, phone, and night/weekend access, emergency room visits dropped by 50% in the past few years.

Care teams

Olympia's primary care is divided into 3 large teams, each serving about 15,000 patients (the 3 teams handle 46,000 patients total). Clinician-MA dyads are the foundation for the teams, which also have RN, LPNs, a clinical pharmacist, and a complex care manager RN for high-utilizing patients. Olympia's teams are only partially co-located because the facility was built before co-location became the gold standard for the architectural design of team-based primary care. For future facilities, Group Health will create co-located primary care teams with all team members including clinicians sitting in one open space, making communication easier.

Communication among the primary care team takes place in huddles, brief discussions during the day, and via staff messages. At 8 am, each large team has a 5 minute stand-up huddle, at which the team's practice manager announces new policies, lists which personnel are absent today, how dyads might be altered due to absences, and reviews appointment access and other performance measures. The huddle is announced with the ringing of a bell or the playing of music. On the day of our site visit, all team members including physicians arrived at the huddle on time. Huddles are not considered to be optional. Following the large team huddle, each clinician/MA dyad huddles for a few minutes, reviewing the schedule for the day and doing pre-planning. Teams have a longer meeting every month to discuss new initiatives or quality improvement.

The same MA works with same clinician to the extent possible. MAs are responsible for in-reach and outreach panel management for their patient panel. The MA does the work of chronic and preventive care panel management and the clinician finalizes the order. Group Health has not empowered MAs to enter orders themselves. The advantage of having outreach conducted within the dyad rather than from a central location is that the MA knows the patients and can easily discuss with the clinician cases in which the MA feels that outreach would be inappropriate. MAs do medication verification, foot exams for patients with diabetes, and. For certain conditions and for pediatric well-child visits, MAs can enter the history for well-child visits using EPIC's templates. MAs do not do chronic care coaching; that role is provided by the RN and clinical pharmacist.

LPNs address the multiple issues coming from incoming patient phone calls, patient-generated secure messages, or staff messages. When the phone rings on the team, usually the LPN answers it. One LPN estimated that she can resolve about 25% of calls and messages from patients; 75% are sent on to the patient's clinician. LPNs review lab results and sort out normals from abnormal. Most clinicians do not want to see normal lab results, and LPNs or MAs can inform patients of normal labs. Abnormal labs are sent to the patient's clinician via a staff message, and clinicians inform patients.

The priority for RNs is chronic care management and hospital discharge follow-up calls, but some days RNs are needed to help "putting out fires," assisting LPNs with the volume of phone calls and in-box messages relating to acute needs. For calls with

clinical content, RNs, LPNs and MAs have access to the Healthwise Knowledgebase. RNs do not sign medication refills; these are all routed to the patient's clinician. Group Health's policy of transferring most phone responsibilities to the LPN allows RNs time to work with patients with chronic conditions.

Clinical pharmacists share the task of chronic disease management with the team RN. Clinical pharmacists can initiate and intensify oral medications, particularly metformin, for patients with diabetes under 80 years of age, and statins for patients with diabetes or coronary heart disease. The first chronic care management visit is in-person and includes patient education, setting goals, lifestyle change counseling, and medication adherence counseling. Follow-up is generally done by phone or e-mail.

Group Health has been somewhat cautious in adopting standing orders. RNs can order urine studies for patients with uncomplicated urinary tract symptoms and can order rapid strep tests for patients with sore throats, but cannot order antibiotic treatment for these conditions. RNs can titrate insulin doses for patients with diabetes. Medical assistants who are certified by the state as health care assistants can give flu shots. Pharmacists, who usually know more about medications than physicians, can only order and titrate oral diabetic medications and statins based on collaborative drug therapy agreements, but not other medications. LPNs and RNs can separate normal from abnormal lab results and inform patients of normal results. Only clinicians can do prescription refills. LPNs are generally quite familiar with commonly-prescribed medications, but forward all medication issues to the clinician.

Work life satisfaction

Employee satisfaction and retention, particularly for physicians, is an important issue for Group Health. Every year employees anonymously fill in the Gallup 12 questions that measure staff satisfaction; the results are analyzed for each medical center and managers do quarterly check-ins with staff and with clinicians. Reducing physician burnout was a major factor in Group Health's decision to reduce panel size and cut the number of face-to-face visits scheduled per day. While these changes have considerably improved physician worklife, problems still remain. Phone visits scheduled for 10 minutes often take longer. Time slots reserved for addressing in-box e-mails may be filled up by other things. The volume of in-box messages, reaching 100 per day per physician, cannot be thoughtfully addressed in the time available, leading many Group Health physicians to spend an hour or two each night on in-box messages.

Future Plans

Group Health has created an Integrated Care and Facility Design warehouse to design architectural and workflow redesigns for facilities that will be replaced over the next few years. future Group Health teams will co-located. Colored stickies adorn large white boards with workflow maps of a myriad of processes. Meetings of leaders and front line team members, with input from patients, engage in discussions of these workflows. Group Health is determined to continue on its never-ending improvement journey.