

North Shore Physicians Group Primary Care Redesign

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“The physician cannot do this work alone,” notes Lindsay Gainer, Director of Clinical Services and Innovations at North Shore Physicians Group (NSPG) a 200 provider, 16 site organization. Hired in 2008 as part of a primary care redesign grant, Gainer’s role is to facilitate system-wide change from a traditional physician-centric delivery model, where the physician is responsible for all elements of care, to a team-based model, where the care is shared among a group of closely aligned professionals.

After first addressing patient experience of care, leaders at NSPG came to realize the importance of also improving staff and physician experience of care. “At the grassroots level we had a convergence of forces: we looked at physician satisfaction with the quality of their work life, and began hearing about innovations elsewhere. We knew our physicians were dissatisfied with the quality of the interaction with the patient because of all the things they had to do in the exam room that were non-physician work” adds Sharon Lucie, VP for Operations.

After three years NSPG has redesigned its primary care model and changed its culture. In a time of primary care physician shortage the group has successfully recruited 28 new primary care physicians as well as reduced their annual employee turnover from 25% to 12%. Physicians are requesting to be brought into the new model of care. From 2008 to 2010 provider satisfaction increased 14%, employee satisfaction improved by 26% and the percentage of patients who rate their care “excellent” has risen from 53% to 74%.

How did NPSG do this and what can we learn from their experience?

Why Change?

The burning platform for change at NSPG included patient complaints of poor access and long wait times; staff concerns about suboptimal patient flow; workflow changes brought on by their EHR implementation, which caused staff to spend less time with patients; competition from disruptive external innovations such as minute clinics and employer based clinics; and the need to prepare for new global models of reimbursement. “We needed to move beyond a widget model of care” says Steven E. Kapfhammer, NSPG president. In 2012 the group will no longer be under a strictly fee for service payment model; 70% of patients will be covered under global payment contracts, either through Medicare’s Pioneer ACO program or Blue Cross/Blue Shield’s Alternative Contract.

Starting at the Top

The traditional organizational chart was not going to provide strong enough leadership for the whole sale cultural and delivery model change the leaders envisioned. NSPG, therefore, created new leadership positions including Director of Clinical Services and Innovation, Associate Medical Director of Patient Safety and Quality, Medical Director of Information Systems, and Director of Revenue Integrity. Champions of cultural and process change throughout the organization were also identified at administration, provider and staff level

Programming

NSPG developed several new programs, including Shared Medical Appointments, which are offered in 3 specialties (primary care, endocrinology, neurosurgery); Urgent Care Centers, to provide access to care outside of traditional office hours and thus decrease ER visits; nurse practitioners as consistent nursing home providers; Patient and Family Advisory Councils, and most significantly, a program was insituted to train Medical Assistants (MA) for an expanded role in primary care.

Expanding Team Care Capacity: a Enhanced Role for MAs

NSPG received funding from their parent organization, Partners HealthCare, to build a team-based model of primary care. The model builds on an expanded role for MAs “so that the physicians wouldn’t have to shoulder all of the work.” Dr. Beverly Loudin, who directed the initiative, began by interviewing physicians regarding the skills and responsibilities they would want in a highly functional MA. Once the role was designed Dr. Loudin and Gaines developed a week long training program, assuring that all MAs in the system would have the same skill set, aligned with their new responsibilities. (Their training curriculum was subsequently purchased by Qualis Health and is available on line at <http://www.qualishealth.org/about-us/our-services> .)

During the summer of '09 Loudin and Gaines trained 80 of NSPG’s MAs in the new model of care, teaching basic clinical skills, critical thinking, health coaching, patient self-management techniques and population management. Because improving work while doing the work is seen as an essential strategy going forward, MAs are also trained in process improvement. Lucie adds “Process improvement is now how we run our business; front line people need that skill set.”

The MA role has been transformed from a person who answers phones, escorts patients and obtains vitals, to a partner capable of team based care. The prior 3 minute rooming process has been expanded to an 8 minute process, and now includes recording current medications and allergies, agenda setting, form completion and closing care gaps. For example, the MAs review all health monitoring reminders, give immunizations and proactively book appointments for mammograms and DEXAs. The goal is to meet all of the needs of the patient while in the room, rather than leaving loose ends to be addressed through a more time consuming process at the back end.

The MA also assumes responsibility for a greater portion of visit note data entry. Gaines reports “a huge part of the change has been having the MA put extensive information into EHR.” The MA starts the note, performing most of the structured text data entry components of the visit. The provider will later edit these entries for accuracy, and document the narrative portion of the note.

Form Assists Function: Flow Stations

The basic building block of the care team is a teamlet of 1 MA and 1 provider, who sit side-by-side in “flow stations.” “This change in geography has resulted in enormous cultural change” reports Gainer. No information goes to the provider unless it comes to the MA first. The MA is tasked with sorting and filtering electronic and paper information to reduce the burden on the physician. One of the early adopters was an established physician with a large panel, 2500 patients with high complexity. Prior to the new model and co-location he was taking 2-3 hours of work home each night, now that he and his MA have committed to Lean principles of “one piece flow” and “doing today’s work today” and XX, he routinely leaves work with all of his work completed. His personal time is truly his own again.

Channels of Communication

NSPG has established a Council of Medical Assistants, with one MA from each practice site. Through this mechanism MAs have significant input into new programs and processes.

Nursing Redesign: From Triage to Care Management

Prior to care model redesign nurses were employed primarily for triage, with some nurses functioning in a capacity similar to the traditional medical assistant role, answering phones and doing vitals. A new role is under development for nurse care managers; these nurses are to assume a more active role in chronic illness care and transitions of care. About half of the clinic sites now have such nurse care managers. Responsibilities include chronic disease management, working with diabetic patients on referral from physicians, for example, making monthly phone calls, and teaching self-management support skills. The nurse care managers also intervene at transitions of care, making follow-up phone calls after every hospital discharge and ED visit.

NSPG is preparing to deploy a robust registry which will provide population dashboards by site or by physician. Nurse care managers will receive task lists from this registry to help identify high risk patients who are not receiving the care they need. The organization also plans to use this registry to push health promotion campaigns out to patients, such as invitations to take an electronic health risk assessment, come to a shared medical appointment or watch a patient education video. The registry will also allow NSPG to compare their performance data to national benchmarks as well as payer incentive benchmarks.

What is the training and experience needed for nurse care managers? Lucie envisions that a new graduate nurse would need 3-5 years experience before stepping into this role. Although the role is envisioned for an RN, at two of those sites, LPNs have transitioned to the role “and are wildly successful.” The goal is to have 1 nurse care manager for every 5 FTE physicians, yet Lucie recognizes that some practices will do best with a higher ratio of care manager to provider.

Multiple In-House Pilots

NSPG is experimenting with different care team compositions at different sites. “We are piloting a social worker working side by side with a nurse care manager, because psychosocial issues impact so much of the care. Often the best task-skill alignment is with a social worker, who is especially capable at crisis management, coordinating elder services and care giver respite” reports Lucie. Another pilot involves a pharmacist in the care team, and a third an embedded behavioral health professional. The bottom line: “physicians cannot continue to do this work alone” says Gainer.

Results

“Now providers are begging us to get them started in the new model” Gainer reports. Staff are happier and feel more empowered as well; in retrospect it is apparent that some MAs and nurses previously felt under-utilized and even bored. There has been a system wide attitudinal change, “everyone is energized” says Kapfhammer.

Improvement inspiration and guidance

NSPG began its change with a primary care grant from its parent organization. This started them on an improvement journey which has continued beyond the duration of the funding. NSPG has recently begun working with Virginia Mason Institute (VMI) to incorporate Lean principles into its organizational culture. The first step was hosting an on-site VMI workshop “Creating Flow in the Ambulatory Clinic.” NSPG has subsequently established an ongoing mentorship relationship with VMI, consisting of biannual on-site visits and between visit calls.

Work with VMI and Lean “has given a new lens to everyone, a true process improvement focus.” Lean thinking allows staff and physicians to realize “It’s not that things are terrible, it is that processes are broken, and there is waste in the system.” We can fix that.

Spread: Neighbor to Neighbor

NSPG has learned from others and is now sharing its experience in return. Grainer reports “We have become quite a tourist destination” The leadership team has hosted other medical groups embarking on transformation. Teams from the local Boston area, as well as Hartford, CT and the Maine Medical Center, for example, have paid a visit. During the one hour formal presentation, a tour of one of the practice sites, and an hour to debrief, other clinics can learn, and avoid completely reinventing the wheel as they take the first steps on their own primary care redesign.

Looking back

Sharon Lucie, Vice President for Operations, reflects on the improvement journey at NSPG: “One of the principle things we learned four years ago when we tried to move to template standardization and advanced access is that it wasn’t sustainable. And the reason it wouldn’t stick is because we were layering it in on top of a clinical work flow that was so inefficient, providers were loathe to give up any control that they felt they had over their work life.

We had to do work flow redesign prior to schedule standardization . The journey to ambulatory flow with Virginia Mason was the foundation that needed to be put in place and with it, we have then been able to move towards open access architecture templates with standardization. We have seen this time and time again with the providers who are truly in flow.

Conclusion

The leaders of NSPG embarked on an improvement journey in response to internal incentives, such as employee turnover and physician work-life satisfaction, as well as external motivators, including competition from minute clinics and opportunities with new payment models. Three years later there has been a culture change, improvement is the way the organization operates. Kapfhammer reports “there is a different feel within the organization. There has been an attitudinal change. Everyone is energized.” One can’t help but believe that no matter how the internal and external forces of healthcare change in the next decade, the work this group has done in the past 3 years will serve it well going forward.

