Primary Care Redesign - Outcomes of a clinic model transformation in a Family Medicine Residency clinic

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Conflict of Interest Disclosure

I have no conflicts and nothing to disclose

Objectives

1. Understand all the components of the Primary Care Redesign clinic model
2. Advocate for their providers and patients to their health system to increase support in clinical workflows
3. Implement components of the Primary Care Redesign model to enhance team-based care in a residency clinic
Background – Issues with the Current State

How do providers spend their day? What do providers do in the room?


Don’t Forget About......

Date Night

1-2 hours of charting per night
Setting
AF Williams Family Medicine Clinic
  - former medical director
  - 18,600 active patients\46,000+ visits annually
  - EMR = Epic
  - 180% empanelment growth over the last 5 years
  - 46 providers covering ~11 FTE; 24 MD faculty, 2 APP, 20 residents
  - 1.0 integrated practice coach
  - 3 BH providers covering 1.0 FTE plus trainees
  - 1 clinical pharmacist faculty covering 0.5 FTE plus trainees
  - 2.5:1 MA: provider ratio (ideal state, typically more like 2-2.5:1)
  - 4 RNs
  - 1.5 FTE RN Care Management
  - 1.0 FTE SW Care Management

UCHealth System
  - 9 hospitals (UCH and UCHMG)
  - 50+ outpatient clinics in Denver metro area
  - 60+ outpatient clinics in UCHMG

Primary Care Redesign: Key Changes
  - Optimize roles & structures
    - Increased MA: Provider ratio 2.5:1
      - Enhanced team: more and different practice support (MA, RN, CM, SW, etc.)
    - MA's moving towards operating at top of clinical scope
    - Improved MA functions
      - Expanded rooming
      - In-room support
      - Post-exam
      - In-basket support
    - Increased patient access, and experience
The Old Way

Provider sees patient

Patient waits

Patient waits

MA 1: quick rooming

Patient 1 Visit

Provider manages own inbox

MA 1: post-exam work

Patient 2 Visit

Provider sees patient

Practice Transformation

MA 3 manages pod

MA 1: expanded rooming

MA 1: in-room support

MA 1: post-exam

Patient 1 Visit

Provider sees patient

MA 2 expanded rooming

MA 2: in-room support

MA 2: post-exam

Patient 2 Visit

Provider sees patient
PCR Model Overview – Expanded Rooming

- **PARTy** - 20 minute rooming time
- Introduce clinic model
- Agenda setting
- Initial HPI collection (Brief HPI)
- Update medical/surgical/social/family histories
- Medication reconciliation
- Gaps in Care capture
- Complete tasks via protocol
- Screenings (PHQ2, SDOH)
- Advanced directives
- Vitals collection

Brief HPI

- Templated questions asked by MA based on top 2 agenda items
- Added to progress note during visit

Expanded rooming – Med Recon

Detailed medication reconciliation:
- Removes (via protocol):
  - Patient Reported Meds no longer taking
  - Meds placed in error
  - Duplicate (ie same med, but 2 doses)
  - Therapy completed
  - Old prescriptions (original Rx >12 months)
  - “Flags” other medications
  - Pt reports taking differently
  - Pt reports not taking
  - Pends medications needed refilled
Expanded rooming - Protocols

- Completes orders and tasks based on multiple protocols
  - UA
  - HCG
  - Strep
  - A1c - POC
  - Pulse Oximetry
  - Flu vaccine
  - Peak Flows
  - Monofilament exams
  - Adult immunizations
  - Peds – iron screen, vision screen

Expanded rooming - gaps in care

- Gaps in care - Orders and pends (if not a protocol) any test/services overdue based on the Health Maintenance Module in EMR
  - Preventative services or chronic disease monitoring
    - Lipids screening
    - DM2 screening
    - Colon cancer screening
    - Mammograms
    - Cervical cancer screening
    - TSH monitoring - for pts with hypothyroidism
    - DM monitoring tests - A1c, monofilament, microalbumin, lipid, eye exam
    - Hep C screening
    - DEXA scans
    - AAA screening
    - Immunizations
    - HIV screening

In-Room Support

- Structured warm handoff outside the room
- MA documentation assistance in the room
  - Additional HPI collection
  - Physical exam
  - Place orders
  - Patient instructions
Physical Exam Macro

- Physical exam verbalized by provider
- Documented by MA via check
  - box exam template

Goals of In-Room support:

- Provider-patient engagement
  - Without a computer in-between
- Decrease distraction during visit
  - Present with the patient
- Documentation support (75-90% of HPI, exam, ROS)
  - No turnover needed for post-exam
    - No need to leave the exam room, look for MA, communicate the post-exam needs

Post Exam

- Completes post exam task in the exam room
- No turn-over needed; MA stays with patient
  - Lab draws
  - Immunization
  - Make follow up appointments
  - Print and reviews after visit instructions
  - Escort patient to lobby (no check out)
In-Basket Management

- All messages (except symptomatic triage calls) go to MAs
- MA address as much as possible
  - Call pt for more information
  - Pend any orders
  - Draft pt requested letters
  - Redirect messages as needed
  - Can manage about 30-40% of messages
- Then forward to provider as needed for sign offs, additional information, etc.

Outcomes--
Statistical Process Control Charts

- AKA “Shewhart Charts” or “Statistical Process Control Charts”
- Invented by Walter Shewhart (1891-1967)
  - “Grandfather of Quality Improvement Science”
  - Inventor of “PDSA” method of quality improvement (aka Shewhart Cycle)
- Components:
  - Historical population Mean
  - Sigma, or Standard deviation of that mean (σ)
  - Control Limits (Mean +/- 3 times the standard deviation)
    - Upper Control Limit ("UCL") = \( +3\sigma \)
    - Lower Control Limit ("LCL") = \( -3\sigma \)
Other UCHealth primary care clinics

HTN control; pilot vs wave 2 clinic
Residents in the Model

1st years – Expanded rooming except Brief HPI collection
  (4-6 patients/session)
  - 2 MAs:2 interns (ie 2 interns = 1 senior resident/faculty)
2nd year – Include initial HPI with ROS collection (8 patients/session)
  - 2 MAs:1 R2
3rd year – Full model – all of the above + in room documentation support (scribing) (10-11 patients/session)
  - 2 MAs:1 R3

Teaching Practice Transformation:
Provide Time & Teaching

Year 2: Practice Transformation Foundations Month

Didactics and workshops
  - QI
  - Population Management/Data
  - Care Coordination
  - SMS
  - Leadership
  - Dedicated time
  - Practice transformation/PCR model description

Start working in the “Full Model”
  - orientation to in-room support
  - practice before patient volume increases
Teaching Transformation: Provide Time & Teaching

Year 3: Practice Transformation Leadership Month

- Leading Class Quality Improvement Project
- Clinic leadership meetings
- Care Team
- High risk population meeting
- Clinic wide QI/team meetings

Longitudinal Experience

- Dedicated admin time 6/12 months
- Attendance at CO Residency Practice Collaborative

Teaching the Model to Medical Student and Residents

1. Meet with Student, Discuss Patients and Goals
2. Provider sees 1st patient, student enters room with MA during rooming of 2nd patient
3. Provider ends 1st visit, meets with student and answers any questions about patient 2
4. MA completes rooming and leaves, med student completes H&P
5. MA completes rooming and leaves, med student completes H&P
6. MA completes rooming and leaves, med student completes H&P
7. MA completes rooming and leaves, med student completes H&P
8. MA completes rooming and leaves, med student completes H&P
9. Provider enters room, meets with student and completes H&P

Resident testimonials

- “I love coming to clinic”
- “I was so glad today was a clinic day”
- “In what world is it acceptable to not have 2 MAs”
- “The peds clinic is so strange, their MAs don’t even start the progress note”
- “I just ask my MA, they know about everything”
Challenges
- Growing MA staff
  - More people, more personalities, more working together
- Training MAs
  - MAs do not receive this training
- MA skillset varies
- Providers giving up control
- Provider expectations on rooming and in-room support
- Learning to communicate as a team
- Learning to assist with documentation

Summary
- Adding staff and training to their scope of practice will improve clinic efficiency, improve metrics, and decrease burn out
- Training residents and student in this team based model will train them to lead transformation efforts in their future
- Transformation efforts are difficult, but the extra support is worth the work.

Questions?

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