

Cleveland Clinic

Improving Access, Quality and Satisfaction with “Turbo Practice”

Notes from a conversation with Kevin Hopkins, MD of the Cleveland Clinic-Stonebridge

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Patients Turned Away

Kevin Hopkins recalls overhearing triage nurses just outside his office tell patient after patient “I’m sorry, we can’t see you today, you’ll have to go to Urgent Care.” A family physician trained in the importance of the ongoing doctor-patient relationship, Hopkins strove for continuity, yet he was spending so much of his day documenting care on the patients he did see, that many of his other patients were being turned away.

Hopkins joined the Cleveland Clinic six years ago, just out of residency. “My training program didn’t have an EHR, so after my first two weeks here I wanted to dump the computers, it was so frustrating.” Even later, when the EHR “became my friend” and was indispensable, Hopkins felt he was putting his focus in the wrong place. “I was staring at the computer screen rather than looking at the patient. I was spending more time on documentation than listening to, talking with or touching patients.” He wasn’t the only one to notice. “This is one of the biggest complaints we get from patients.”

“One day I realized if I didn’t have to do this documentation I would really like my work.” Slowly he resolved to make changes. “I was tired of feeling like I was doing all of the work. I had an extremely capable MA whom I knew would do well in this setting. I wanted more freedom, less time feeling chained to a computer. I was spending all my time in a room with a patient staring at my fingers trying to type instead of focusing on them as a person.”

Inspired to Change

In 2008 Hopkins read an article by another family physician, Peter Anderson of Fairfax, VA, who had taught his MAs and nurses to help with visit note documentation and orders. <http://www.aafp.org/fpm/2008/0700/p35.html> Anderson wrote that most patient visits can be broken down into four distinct components, and that traditionally doctors do all four components themselves.

Stage 1: Data gathering,

- Stage 2: Analysis of data and pertinent physical exam,
- Stage 3: Decision making and development of a plan,
- Stage 4: Implementation of the plan and patient education.

Anderson had developed a model where an assistant, either an MA or a nurse, did most of the data gathering and data organization, and was responsible for implementing the plan and instructing the patient (Stages 1 and 4), allowing the physician to concentrate on the higher level work of data analysis and exam, decision making and plan (Stages 2 and 3).

Hopkins saw how his lack of task delegation limited his efficiency. “If I am spending time typing in the EMR or filling out papers and forms that do not require my expertise that is time I am not spent seeing patients and generating income for the practice.”

Turbo Practice Model

After a two-day Innovation trip to Anderson’s practice Hopkins developed his own version of the model, which he dubbed “Turbo Practice” and described in a proposal to his department’s leadership.

The pertinent history is documented by the clinical assistant as it is collected. Once Stage 1 of the visit is complete, the physician enters the exam room and greets the patient. The physician, clinical assistant, and the patient remain in the exam room together. The pertinent history is shared with the physician by the assistant. The physician can then ask more directed, specific questions of the patient and perform the pertinent physical exam. This additional data, including pertinent exam findings, are shared with the assistant so that he or she can document it in the EHR. The physician then formulates a diagnosis and plan which are discussed verbally, and possibly documented in writing, with the patient and clinical assistant. An opportunity is given for the patient to ask questions to assure understanding, and then the physician politely exits the exam room. The clinical assistant remains to close the visit with the patient by reinforcing the physicians instructions, providing prescriptions and referral information, performing patient education, answering questions, and arranging appropriate follow-up. In this manner, the physician can leave one exam room and directly enter the next where another clinical assistant has performed Stage 1 of the office visit with the next patient and the process repeats.

Next Hopkins developed a business plan. He calculated that he would need to see 2 more patients per day to cover the costs of the added MA. Once he got the green light from leadership he began training his staff.

Staffing

The total staffing in his practice is approximately 2.75 clinical assistants per doctor, consisting of the same two MAs each day, and his share of the department's phone triage, prescription refill and floor nurses. "The MAs are more directly involved in care than they have ever been" and Hopkins sees the benefit for nurses as well. "Much of what we ask nurses to do now in the outpatient setting isn't real nursing--one doesn't go to nursing school to be a phone secretary." The Turbo Model offers MAs and/or nurses the opportunity to be more fully engaged in patient care and to have more direct and meaningful patient contact.



Implementation and Training

Hopkins and his MAs set up medication preference lists and improved EHR note templates. He taught the MAs how to use the health maintenance reminders and to place orders for screening mammography, labs and immunizations.

In addition minor workspace modifications were made, with curtains offering patient privacy while the MA remains in the examining room, and a computer workstation in the hallway to allow him to do minor note editing between patients.

During the first month the team intentionally did not increase their patient volume, giving them the chance to get used to the flow and work out some of the bigger bugs. Hopkins had to learn to delegate. "One of the challenges for me was letting go of some of the control, especially control over the computer. We also had to figure out ways for the MA to pull up information I wanted on the screen when I wanted it. It has been a challenge to work on their multi-tasking skills. They need to be typing, listening to me, and watching what parts of the exam I am doing all at the same time. We trained them with shadowing and then repetition."

Hopkins and his team are continually refining their processes. "We set aside 1 hour every Friday morning to go over the week: what worked well, what didn't, what changes do we need to make. We edit our note templates during those meetings as well. We do some education-why do we do microalbumins on diabetics etc. Learning why we do certain things gains buy-in."

Hopkins cautions that it takes an upfront investment in training and improving workflow processes to make the model work. Initially Hopkins spent 1-2 hours per day editing the MAs notes to ensure they accurately reflected the work and the medical decision making. Now, after 7 months of continual refinement, he reads and edits a day's charts in 30 minutes.

Third Person in the room

What about a third person in the room? "One of the first obstacles we faced was getting the MAs comfortable remaining in the room; initially they would sit in corner and stare at the computer screen. I encouraged them to be a part of the team, to interact with the patient and be a part of the conversation. I told them 'if you think of something and I don't, feel free to bring that up.' We are making this into a real team care model."

Patients have accepted this team model well. "We haven't gotten push back from patients about having another person in the room, no one has refused."

An added benefit of the MA remaining in the room has been their increased knowledge about medical care in general, and about their individual patients in particular. "When patients call back the MA is better able to field their questions and might say to the patient 'when we were in the room together Dr. Hopkins said...".

Paper Persistence

Although Hopkin's practice is fully wired they are not dogmatic about being completely paperless. "Some of our best practices involve using paper. I jot down my thoughts as well as diagnoses and things for the MAs to order. They then use it as a worksheet to make sure everything is in the EMR that I wanted."

Outcomes

Access: Hopkins is able to offer patients 6-7 more appointment slots per day. Prior to Turbo Practice Hopkins saw an average of 21 pts per day, now he averages 27-28 patients per day.

Productivity: The team sees 100-150 more patients per month in the new model, resulting in a 20-30% increase in practice revenue. This has more than covered the costs of the additional MA.

Satisfaction: "Our patient satisfaction numbers are up. Our MAs are more directly involved with the patient then they ever have been and enjoy their work."

Quality: Quality metrics, including health maintenance measures, have improved.

Dreams

What does Hopkins dream of next? “It would be fantastic to share a common space. Currently I have a traditional office and the MAs are at the nurses’ station. Even just putting the computer work station in the hall, outside of the exam rooms, has kept me in closer proximity.”

Hopkins also feels this would be a terrific training model. Residents could see how primary care could be practiced and would more likely be drawn to primary care specialties.

Spread

Hopkins also sees great opportunity for spread. His team is currently helping train 10 more primary care physician-2 MA teams.

Is the “Turbo Practice” model applicable beyond family medicine? Hopkins feels it might work even better in other specialties, including general internal medicine and the medical subspecialties. “The more specific your practice the more useful model can be.”

Conclusion

Hopkins reflects on how this new model of team-based care has affected his work-life satisfaction: ““I used to make myself leave the office at 6pm, to go home with my family, and then I would still do an hour or so of charting after the kids went to bed. Now I leave by 5:15-5:20 and seldom take work home, despite seeing 30% more patients. My productivity is up 20-30% compared with last year. I am far more satisfied. I leave work earlier every day and have a very fulfilling relationship with my team.”

