The QB system reduces physician EHR workload and enhances BOTH the patient experience and physician wellness, while maintaining Neutrality in BOTH Staffing Budget and Patient Access.

RESULTS

There was a significant decline in the Primary Endpoint, the average monthly volume of patient messages for each physician. Linear regression analysis shows a 31% decrease (p=0.001) at QB site compared to 18% at matched control (Fig 1).

In the Intervention (QB) group, there was a significant reduction of 33% in the Average Message Turnaround Time during the pilot period (Fig 3). The Control group had no significant change in TAT.

There was no significant impact on patient access scores, our balancing measure, suggesting that removing physicians/nurses from clinic to perform message management duties in the QB system results in an ‘access neutral’ state (Fig 2)

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Physician satisfaction with the QB pilot was high and associated with improvements in self-rated Wellness scores (Fig 4). A total of 17 out of 31 physicians (55% response rate) completed the questionnaire and most noticed a significant impact in their daily EHR burden.

DISCUSSION

• PCPs in the Intervention (QB) group saw a significant reduction in their IB volumes, compared to a control site. The control site also saw improvement likely due to other organization-wide initiatives to reduce IB volume.

• Access was not affected even though there were fewer physicians/nurses to see patients at the QB site. This is almost certainly attributable to a reduction in unnecessary appointments.

• No extra staff were hired for the QB pilot; no budget was impacted by this.

• Reductions seen in QB group were lower than expected. This may be explained by the fact that non-patient driven messages (e.g., lab, pharmacy, or radiology) were not screened by the QB team but entered directly into the PO's inbox folder. However, site physicians generally perceived (anecdotally) much higher reductions in their IB workload than measured.

• Wellness scores improved significantly following the implementation of QB teams at the pilot sites. We hope these will be longstanding changes that will translate into lower burnout rates among POs in our large integrated health system.

LIMITATIONS

• Possible response bias with survey

• Control Site was not ideal but only practical options due to asynchronous roll-out of QB pilot across our large health system across San Diego

FUTURE DIRECTIONS

Based on these findings, the QB pilot has been widely adopted as a best practice across the Southern California Permanente Medical Group. This model is well-adapted to suit both large and small primary care groups with sufficient staffing to develop QB teams.

REFERENCES


