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Perspective

Lessons from the Trenches — A High-Functioning Primary Care Clinic

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Clinica Family Health Services is a community health center serving a low-income, largely Latino population near Denver. Since its inception 30 years ago in founder Alicia Sanchez's kitchen, Clinica has grown to serve 40,000 patients at four sites. Fifty percent of these patients are uninsured; 40% have Medicaid. Like many community health centers, Clinica is financed by augmented Medicaid fees, federal grants, sliding-scale payments from uninsured patients, and energetic local fundraising.

Clinica's story reveals that U.S. primary care is undergoing two revolutions. The first, catalyzed by the Chronic Care Model, targets specific diseases such as diabetes or asthma. The second, coming on the heels of the first, entirely transforms primary care delivery. Starting in 1998, Clinica was an activist in the first primary care revolution with its work on diabetes. After 2000, Clinica initiated the second revolution, redesigning its entire care model to become a patient-centered medical home. Clinica's experience demonstrates how such medical homes can be constructed out of three fundamental building blocks — continuity of care, prompt access to care, and care provided by teams — and the ways in which primary care practitioners (physicians, nurse practitioners [NPs], and physician assistants [PAs]) adapt to the resulting changes in their work life.

Clinica's medical director, family physician Carolyn Shepherd, grasped early on that continuity of care between patients and their primary care practitioner is associated with better preventive and chronic care, improved experiences for both patient and practitioner, and lower costs.¹ Implementing a culture of continuity requires that patients be assigned to the panel of a specific practitioner, who is available most days of the week. These clinicians must be willing to squeeze their patients — but not other clinicians' patients — into their schedules if same-day attention is needed. Staff members answering the phone must prioritize such continuity.

If achieving continuity is like climbing a 5000-ft mountain, sustaining prompt access to care is like scaling one of Colorado's 14,000-ft peaks. For 10 years, Clinica has provided most appointments within 6 days of patients' requests, and usually within 2 days. Clinica fills primary care practitioners' schedules from 8 a.m. to 10 a.m., leaving many slots for same-day access. Staff members who answer the phones are not allowed to say no to patients, whose requests are addressed with appointments, "squeeze-ins," or visits with a registered nurse (RN). Schedules are created for only 2 weeks at a time, to ensure that appointment slots will remain open. If clinicians request appointments for their patients beyond the next 2 weeks, electronic reminders generate calls to those patients on the appropriate date.

Adequate access requires an equilibrium between demand for visits and capacity to provide

them. At Clinica, this balancing act is accomplished by eliminating unnecessary demand and adding capacity. Continuity of care reduces demand because if patients see other clinicians, an additional appointment is often scheduled with their own clinician for the same problem.² Demand is also reduced by increasing the intervals between visits, which has been shown in most cases not to harm the quality of care.³ Capacity is increased by offering patients visits with RNs for less complex problems and through group visits, which allow clinicians to see 30 to 40% more patients per hour.

Embracing continuity and improved access requires clinicians to accept a truly patient-centered approach to care: to see patients most days of the week, to cede to their patients control over their daily schedules, and to be willing to see their own patients who drop into the office and not expect other clinicians to do so. Why might clinicians agree to such changes in their work life? Clinica’s practitioners have accepted the priorities of continuity and access partly because persuasive medical leaders had the courage to say “this is the way it’s going to be,” partly because they see these policies benefiting their patients, and recently because Clinica has been recruiting new clinicians who already agree with these principles.

	2009	2008	2007	2006	2005
Diabetes					
# patients with diabetes	18	21	28	33	38
# care practitioners (N)	32	35	39	42	45
Diabetes appointment (days)					
During the calendar year (%)	36	38	39	40	41
Within 30 days (%)	6	6	6	6	6
Within 90 days (%)	28	28	28	28	28
Within 180 days (%)	41	41	41	41	41
Hypertension					
# patients with hypertension (N)	34	36	40	44	48
# hypertension appointments (N)	32	33	35	37	39
# patients with hypertension (N)	30	31	33	35	37

Clinica's Performance Data (as Compared with Average 2009 HEDIS Scores for All Medicaid Health Plans, Where Available).

Clinica has moved boldly from a doctor-based model to a team-based model.⁴ All clinical activity centers around the “pod” (care team), which includes at one location three primary care practitioners and three medical assistants (MAs, each working with a single clinician), plus an RN, a case manager, a behavioral health professional, and medical-records and front-desk staff. Clinicians don’t have their own offices; each pod has a central area surrounded by exam rooms. Pod members easily interact with one another and can see all patient rooms, whose doors are marked with colored flags showing who is inside. In each pod, performance data are displayed on a wall, and any deficiencies are discussed at team “huddles.” Clinica’s quality of care often exceeds national Medicaid performance (see table) — especially impressive given that Clinica’s data include the 50% of its patients who have no insurance.

Every team member shares responsibility for the team’s patients. MAs take histories using electronic medical record (EMR) templates and give immunizations according to protocols, without involving physicians, NPs, or PAs. Designated team members handle most preventive and much chronic care through panel management — combing registries and arranging for patients who are found to be overdue for mammograms, colorectal cancer screening, or diabetes laboratory work to receive these services. RNs, using standing orders, treat patients with ear

infections or positive streptococcal, urine, gonorrhea, or chlamydia cultures and manage warfarin dosing — all without involving primary care practitioners, who sign off later in the EMR. As much as possible, clinicians spend their time providing complex diagnosis and management, with routine functions performed by other team members. Only through a team approach can primary care, with its clinician shortage, meet population-wide needs.

To make the transition to team care, Clinica reconfigured hundreds of workflows, detailing who would do what and how, for such functions as receiving incoming phone calls, updating clinician schedules, informing patients of laboratory results, and refilling prescriptions. For common clinical conditions and well-child care, specific workflows were created and job roles were redefined using standing orders, with the goal of standardizing guideline-driven care while dividing responsibility among team members.⁵

Team-based care requires fundamental changes in clinicians' mindset. Many practices claim to have teams, but the physician provides all care and delegates specific tasks (fax this form, do an EKG) to others. At Clinica, the entire team shares responsibility for the health of the patient panel. Entire work areas, though overseen by an MD, NP, or PA, are performed independently by RNs, MAs, or case managers. For clinicians to accept this shift from "I" to "we," team members must have their roles authorized through protocols and be trained to perform them competently. Clinicians must have confidence that all team members are doing a good job in order to feel relief that they have time for more complex tasks.

Clinica will next focus on controlling costs by reducing unnecessary emergency department visits and hospital admissions. Achieving this goal will require a deepening of team care, with care managers assisting patients who have complex, high-cost conditions. This step awaits a new funding stream, which requires participation in an accountable care organization in which Clinica will share the savings from reduced downstream costs.

Clinica has confronted basic primary care challenges and answered key questions: How can continuity of care be made the centerpiece of a medical practice's ethos? Can a policy of providing prompt access be sustained? Who should be included in care teams, who should perform which work, and how central to team function are colocation, workflows, and standing orders? How should care for common conditions be standardized?

Ultimately, clinicians' acceptance of the primary care revolutions will be sustainable only if their work life is more satisfying than it was before. Understanding that necessity, Clinica's leaders have created an organization that serves patients well while retaining a group of loyal clinicians.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://www.nejm.org).

Source Information

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5. Details of Clinica's care model ("Clinica Family Health Services") are available at <http://familymedicine.medschool.ucsf.edu/cepc>.

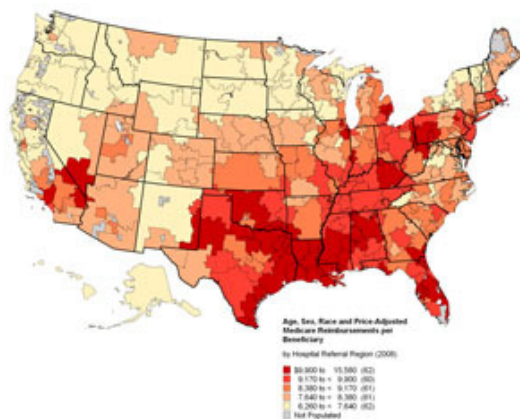
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The Sixth Circuit Court of Appeals issued an **opinion** on June 29 upholding the Affordable Care Act's individual mandate. Two of the judges on the court's three-judge panel, including Jeffrey Sutton, a George W. Bush appointee and former clerk for Supreme Court Justice Antonin Scalia, held that regulating the decision to purchase health insurance falls within Congress's commerce power because of the unavoidable effects of the uninsured on the interstate market for insurance. The third judge, Reagan appointee James Graham, issued a partial dissent, finding that allowing the individual mandate would leave Congress's commerce power virtually unlimited.

Advisors Oppose Avastin for Breast Cancer

An FDA advisory panel recommended unanimously that the agency withdraw its approval of the use of Avastin (bevacizumab) for treating breast cancer, finding that studies have failed to demonstrate its effectiveness. The FDA may, but rarely does, decide not to follow the panel's recommendation; the agency will make a final decision later this year. Whatever the FDA's verdict, however, Medicare and Medicaid will continue to cover Avastin for beneficiaries with breast cancer, at least for the time being, and private insurers may follow suit. Because the drug will remain on the market for the treatment of other cancers, off-label use for breast cancer is likely to continue if insurers are willing to cover Avastin's substantial cost.

Enhanced Medicaid Matching Funds Expire

Enhanced federal Medicaid matching funds, authorized by the Recovery and Reinvestment Act of 2009, expired on June 30, requiring state legislatures to find ways to stretch their strained budgets even further. In response to high unemployment rates, which raise Medicaid enrollment while decreasing state revenues, the 2009 law increased the percentage of Medicaid costs borne by the federal government and required states to maintain the 2008 Medicaid eligibility standards. Intended as a temporary response to the economic crisis, the increased rates were first set to expire in December 2010 and later extended through June 2011. With unemployment still high, however, their expiration will put pressure on many states, especially those with high federal matching rates, to limit Medicaid eligibility and benefits.

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