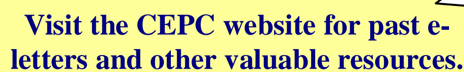
A collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group

Primary Care e-Letter *June 2008, Issue 17*

UCSF | CEPC - Home



Visit the CEPC website for past e-letters and other valuable resources.

In This Issue

- **Featured Article: *Interview with Dr. Jason Cunningham, DO***

Interview with Jason Cunningham, DO
Director of the Sebastopol Community Health Center New Model Pilot Project

In May 2008, Dr Cunningham was interviewed by Dr. Walter Mills, President of the Sonoma Chapter of the Academy of Family Physicians, regarding the Sebastopol Community Health Center's experiment in implementing the Future of Family Medicine's New Model.

WM: Tell us about your experiment.

JC: I am a family physician at West County Health Centers in Sonoma County, California (north of San Francisco). Our clinics at Russian River and Occidental recently established a new site in Sebastopol. Palm Drive District Hospital in Sebastopol noted that its emergency room was being impacted by patients who did not need emergency care but had no other source for care. Together the hospital and health centers established a new clinic to provide a medical home for those in need.

WM: That seems like a common scenario these days, but what is different about your experiment?

JC: The hospital awarded us an adjacent 3,000 square foot old office that had been a family physician's office who had to leave practice because of worsening finances, like so many in primary care. I was excited by this opportunity, but adamant that we needed to use it to do dramatic clinical practice re-design, and not just jump in with the same old systems that weren't working very well in our other clinics.

I convinced my medical director, executive director, and board of directors that we should use the site for a six month experiment. I explained what a perfect Patient Centered Medical Home (PCMH) should look like. My organization agreed to support the experiment, use the lessons learned and eventually implement the New Model to change the paradigm for care at all West County clinics. The intent is to improve our patient care, provider/staff satisfaction, and finances as predicted in the literature.

WM: When did the new clinic open its doors to patients?

JC: We have been seeing patients since January 2008. We opened as an "intermittent clinic" of Russian River Health Center and we are therefore open 20 hrs a week as we apply to be a fully licensed site.

WM: How many people work in the clinic?

JC: Our clinicians include a FNP and myself. Each of us works with a MA who interacts with our patient panels during the office visit and during population management communication. We are supported by one front office staff person. We share administrative support including billing services with other clinics within West County Health Centers. We will increase clinicians and staff carefully as we expand our hours and patient population.

WM: What have you learned so far in implementing the PCMH?

JC: First, change is difficult and should not be underestimated, just as was learned in the two year TransforMed National Demonstration Project that I understand was just completed. That said, we've managed to move forward rapidly because of the small scale of our pilot. Starting small is one strategy that should be considered, as we would never have been able to make the changes across all our clinics at once.

WM: What is the biggest 80/20, most important change you've implemented?

JC: The care team. At its core is what I call the "care teamlet" borrowing a bit from Dr. Tom Bodenheimer's concept out of UCSF. The patient is at the center of our team made of a medical provider and medical assistant whom the patient knows and trusts.

WM: You feel strongly about the importance of patients interacting with a team they know and trust.

JC: Yes, all my patients know they belong to me and Harriet, my MA. Actually we call the MA the care team coordinator. Let me walk through the average patient visit. First, Harriet checks the patient in by bringing the patient directly from the reception room, using the computer in the room and initiating the progress note in the electronic chart. When I'm finished, Harriet performs the discharge portion. She makes the follow up appointment, referral, lab orders, patient education and patient summary.

WM: What is the patient summary?

JC: We call it the "Hey, Honey what happened note". The idea is that the patient should be able to respond to an inquiring, caring family member when they ask "Hey Honey what did the doctor say at your visit?" Patients takes a printed After Visit Summary with them to ensure understanding and follow-through to our jointly constructed care plan. The electronic health record prints it and my MA (care team coordinator) reviews it with the patient as the formal discharge summary.

WM: The visit sounds novel and I assume more pleasant for the patient. Tell us more about the PCMH?

JC: It is about relationship, as I noted, but it is very proactive and aimed at expanding our care from episodic, acute care to managing chronic conditions and preventing disease. Our EHR, eClinical Works, searches our database and calls the patient into our outreach. For example I can review all those diabetics using certain metrics, like last A1C, or all with A1Cs not at target.

WM: You seem excited about this but is there money to do this model?

JC: Yes, the third leg (in addition to improving patient care and provider/staff satisfaction) is that medical information should be accurate, verifiable, and accessible -- viewable by the patient online and portable. For example if the patient is visiting across the country or in an emergency room the chart should be viewable. This will improve safety, efficiency, and reduce cost.

WM: You are in a fee for service system, correct?

JC: We get paid for number of Medi-Cal visits at $140 per visit regardless of the issues addressed, but uninsured and sliding scale patients either don't pay or pay a little bit.

WM: Isn't this model expensive with more overhead?

JC: Actually, we believe this may lower overhead. In our pilot office the ratio is 1 provider to 1.5 staff while our other clinics have ratios twice that. We want to reduce all non-clinical overhead so we can staff for the PCMH appropriately.

WM: How many patients does the clinic have? What is your panel size? (If 1 doctor, then panel size is same as number of clinic patients). Older, younger, most healthy, many with chronic illness, mixture?

JC: Patient panel size has been a very important part of our discussions about the Patient Centered Medical Home. Without active management of panel size, timely access to care, and active population management, patients' needs will be compromised. With our electronic health record, we are able for the first time to accurately place patients on a provider's panel. Even more, we are able to get accurate data regarding the clinician's panel such as demographic information and medical complexity, as well as information on what is required to care for them such as number of phone calls, number of visits, referral information, etc. Historically, our other health centers have panels of 1200 – 1500 patients per FTE clinician. We don't know yet exactly how many patients we can manage in our new system but we will monitor and manage the panels as the practice evolves.

WM: If a patient needs an appointment the same day, can they get a same day appointment? What about care nights and weekends?

JC: In the lobby of our clinic, we posted a document called "Your Medical Home". In that document we outlined what we think our patients should expect to experience at our clinic. One line states, "We believe in timely access to your own medical provider when a medical need arises." If at all possible, patients should be seen by their medical provider, and interact with their particular care team members when they are seen at the clinic. We utilize the concepts of "open access scheduling" to achieve this. Continuing to offer this will be determined by our ability to match the capacity of our clinic with the needs of our patients. Patient needs outside the office or after hours are met by the on-call physician whose duties are shared by our other two clinics.

WM: How many patients are seen each day, and how long are the visits – for the physician, and for the physician plus care team coordinator?

JC: Our new patient and preventive visits are 30 minutes, and routine office visits are 20 minutes.

WM: Can 1 care team coordinator do all the MA duties plus do the extra work that she is supposed to do?

How long does the care team coordinator take in pre-visit, and how long in post-visit?

JC: A 1:1 clinician to care team coordinator ratio has worked well at our clinic. The time needed for the pre and post visits depends on the type of visit and complexity of the patient. On average it takes 10 minutes for the pre-visit and 5-10 minutes for the post visit. Our front office staff has been cross-trained and can step in if the care team coordinator is tied up with a procedure or extra help is needed. The care team coordinator has dedicated time away from patient care to perform population management tasks. Initially we have budgeted for 1 hour per day of uninterrupted time for each care team coordinator. This time is an absolute priority for us and we will staff our clinics appropriately to allow enough time for active management of our patients.

We quickly understood the value of care teams and are in the process of implementing the concept in our other two clinics. As a pilot clinic, Sebastopol has been invaluable for our management staff to lead a smooth transition in this process and other clinics personnel have shadowed staff in Sebastopol.

WM: Is there a chronic disease registry, and if so, how is it used? Is there a panel manager (probably an MA) who works the registry on a regular basis?

JC: Our EHR, eClinical Works, has imbedded population management capabilities. Each care team can instantly generate a list of patients that are due for recommended tests or procedures and that list has the patient's phone number, last visit, and next visit included. Letters can be easily generated or phone calls made. Because the population management alerts are imbedded within the EHR, and an interface has been established with our lab company, minimal manual data entry is required to manage the patient panel and time can be spent with actual patient interaction.

WM: How do you deal with patients with complex healthcare needs (over 5 diagnoses, multiple meds, etc.)? Do you have any assistance from an RN care manager perhaps from the hospital, because these patients take a lot of time and needs a lot of care coordination.

JC: As with most safety-net clinics, our patients have complex medical, social and financial needs. We actively use nurse case managers at our existing sites and have piloted using a nurse case manager for my patients. Because our EHR can be viewed from multiple locations, this nurse case manager works remotely from one of our other clinics. We anticipate hiring a full-time nurse case manager at the Sebastopol site, to be shared by three to four FTE providers, as we grow. We have spent considerable time clearly articulating the responsibilities for each care team role, including the nurse case manager. In our approach, patients are automatically referred to a case manager if they have recently been discharged from an inpatient facility, have a new diagnosis of a major illness or cancer, or have a critically abnormal lab value. Patients who need more assistance in meeting their healthcare needs can be referred by the care teamlet as well.

WM: How do you deal with continuity of care? You talk about relationships, but relationships work best when the patient sees the same person each time they need care. Do you know about what percent of visits for the average patient are with the same provider?

JC: Our clinic is small and it is therefore easier to manage and we see our own patients with rare exception. Again, management of panel size and utilization of open access scheduling will be critical in maintaining this trend. But we don't just stand on this concept internally; we tell patients of our intentions and we trust that they will help us to be accountable to this vision.

WM: Are the patients getting to trust Harriet also? What does Harriet do that encourages patients to trust

her? Does she do any phone calls to patients a few days after visits to see how things are going?

JC: Receiving the trust of a patient is an amazing thing and we don't take it lightly. We know, however, that trust is built slowly and occurs when expectations are met over time. We hope that the MA will benefit from receiving some trust as an extension of the clinician and will develop their own trust as patients become familiar with them. We hope that by creating "micro-practices" within our system, patients will become familiar preferentially with their care team members and that this will aid in improving the patient experience and trust over time.

WM: Do you do anything to improve medication adherence and patients' understanding of the medications prescribed?

JC: One of the workflows for the care team coordinator during the pre-visit is verifying the medications within the EHR. To do this, we have actively cultivated a culture where the patients bring their medication with them to EVERY visit. The patient then helps the care team coordinator with verifying the data by reading the medications names. We are confident that this process will improve patient safety within our clinics and hope that it will also add in patient understanding and ownership of their medications.

WM: What is it about this clinic that you like, and can you contrast it with other experiences you have had doing primary care?

JC: My wife came to visit me in my clinic last week and said, "You have a great thing going here." She said this because she experienced a calm environment with friendly and happy staff and she saw me give a hug to a patient who has been very special to me over the past 3 years. She hears me talking all the time about my passion for proactive, relational care and I think she would agree that it is really working. I have felt blessed to work in my previous positions and locations, but here, it finally feels as though we are gaining traction in providing primary healthcare in a manner that is critical to improving the lives of our patients. What an awesome time to be in this field.

WM: How are the economics of the clinic working? Is it financially stable?

JC: We are a Federally Qualified Health Center and with it we have unique financial pressures and opportunities. We have an established rate for our Medicaid, Medicare and county health insurance patients. We receive this rate regardless of the complexity of the visit or time spent with the patient. We do not have a large managed care population and therefore are not tied to capitated rates for our financial revenue. And although this mandates that we see our patients to get paid, it separates us from the need to have large patient panel sizes to remain financially viable. Our patient panels can be set at whatever size we determine as long as it generates enough visits to fill our slots. If the reactive urgent care, which we have become accustomed to providing, doesn't generate enough visits, we can move toward proactive, preventive visits generated by our care team. This is really only true for our Medi-Cal and Medicare patients. For the uninsured we lose money on every visit!

We have recently hired our wonderful FNP and are rapidly moving towards the productivity that we project for our clinic. With the low-overhead setup, we are confident that we will be generating a net financial gain over the next few months. We feel that this model is scalable and will allow us to grow while maintaining financial viability. This is a critical point – we have to figure out a system that allows us to care for our patients in a manner similar to the concepts outlined by the patient-centered medical home but still allows us to be financially viable. Without it, our primary care system will continue to move forward only in theory.

WM: What is an important thought you want to leave with us?

JC: We need leadership to support the implementation of medical homes. We need to support innovation and use the lessons learned, write about them, do site visits, find ways to move this forward by demonstrating there is real value to this venture. I will need to demonstrate to our Board of Directors, management, and physician partners that there is value to this new paradigm. And that aside from the change management stress, it is worth moving the experiment to our entire organization.