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FEATURED INTERVIEW

Primary Care Teams at Clinica Campesina: An Interview with Carolyn Shepherd
By Tom Bodenheimer

Clinica Campesina, a community health center near Denver, Colorado, has instituted well-functioning primary care teams. Carolyn Shepherd, Medical Director and innovation leader, received her MD degree at University of California at Davis and did her residency in family practice at Merced Community Medical Center, an affiliate of the University of California at Davis. Tom Bodenheimer spoke with her in June 2006.

TB: Please give a bit of background on Clinica Campesina.

CS: We have 29,000 active patients, 68% uninsured, 70% below poverty level. We are growing rapidly. We have 3 sites near Denver, Pecos, Lafayette, and Thornton.

TB: How are your teams organized?

CS: We call our teams “pods.” Pecos has 4, Lafayette 2, and Thornton 3 pods. Each pod has a color. The patients know that they are in the Red or Blue or Orange pod. The walls of the pods are in the pod’s color and we used to have our charts colored according to pod. Now that we are implementing an EMR, there will be an icon on the initial screen with the pod’s color. For a population that has very low English proficiency and limited health literacy, the colors are really important.

Each pod has 3 FTE providers – physicians, nurse practitioners or physician assistants. The physicians take hospital call and deliver babies, so they are not in the clinic full-time. Most NPs and PAs work nearly fulltime, and are an important glue providing continuity of care. NPs and PAs have their own panels of patients and work exactly like physicians although the acuity of the patients is often different.

Medical assistants almost always work in the same pod and generally work with the same clinician. Pods also have Licensed Practical Nurses (LPNs); RNs are almost impossible to recruit.

Pods share a referral case manager, social worker, office manager, and financial screener. The referral case managers, often high school graduates whom we train, relieve clinicians of the time-consuming job of helping patients navigate the specialty system -- poorly accessible to uninsured patients -- by arranging appointments and negotiating payment deals.

TB: You have instituted “collocation.” What in the world is collocation and what’s so great about it?

CS: Collocation refers to the organization of our clinics’ architecture so that the people in each pod work in as close and as comfortable physical proximity with each other as possible. It’s a big deal to change the architecture.

Everyone on the pod sits in the same room, right next to each other, and everyone can see the patient rooms that are on a circular hallway around the room where the pod personnel sit. Everyone can see everything going on.

When we did collocation, we increased the number of patients served per FTE clinician by 21%. Visits went from 14/day to 17.5 per day for the average clinician. It wasn't just collocation that accounted for that change. We also instituted advanced access at the same time. But not having to look for other people on the team – because everyone sits in the same room – means we don't have to waste time looking for people. People talk to each other all the time. Collocation doesn't guarantee a high-functioning and happy pod; you also need people who are team players. But proximity is critical for teamwork.

TB: How large are the patient panels of each pod?

CS: Each clinician has a panel of 1200 to 1500 patients. We need to adjust panel sizes especially at Pecos. An astounding 40% of Pecos' patients are pregnant women, who take a great deal of time; Pecos panels should have fewer patients. Panel size is crucial for advanced access, which we have been successful at achieving and sustaining. Lafayette patients can get appointments the same day, Thornton patients within 2 days, but for Pecos the wait is 7-10 days.

TB: Is the receptionist involved in the work of the pods?

CS: A major issue for primary care teams is incoming calls. We decided to have those calls routed to a centralized call center. Only calls requiring clinical triage (rare since advanced access virtually eliminates the need for triage) are forwarded to the pod receptionist. Taking appointment scheduling away from the pod gives the receptionist time to call patients with normal lab results and check patients in and out of their visits without interruption. They can also help manage the chronic disease registries.

TB: How about calling patients with abnormal lab results?

CS: We have the LPN or MA do that, using our protocols or on instructions from the clinician. Without that change in the division of labor, clinicians would have an hour or more of extra phone work each day or the work would not get done.

TB: What other division of labor changes have you made?

CS: LPNs can treat simple UTIs or URIs. They get a urine culture, rapid strep, or Chlamydia test, contact the patient, and give appropriate antibiotics by protocol, if indicated. But the main work of the LPN is to serve as pod coordinator. They are the extra hand on desk, keeping an eye on the flow, expediting things or changing things around if a clinician has patients in 3 rooms and another waiting. They do health education, and they supervise the MAs. They are the quarterback of the pod, moving our team members where they need to be.

MAs do vital signs, room patients, draw blood, LEAP (Lower Extremity Amputation Prevention) exams for diabetics and do depression screens. Working with receptionists, they manage the chronic disease registries, ordering the tests that are overdue. In some pods the MA is the registry-responsible person, in others the receptionist – working the registry to make sure patients are contacted to do the chronic care or prevention tasks that are due. Some registry data inputting is done centrally, not a pod responsibility.

TB: A key to forming teams is changing job descriptions of team members. That's not easy. How did you do it?

CS: When we went to a pod system we changed provider job descriptions a lot. We have a bonus plan. Any pod that realizes for a month 1) increased number of visits, 2) continuity of care over 80%, and 3) chronic disease measures such as 80% HbA1c done every 3 months, immunization rates, etc. -- then everyone on the pod gets a bonus. Not just the physicians. That makes everyone want to contribute to getting the work done.

TB: What has been the result of all these innovations?

CS: Continuity of care with the patient's primary care provider, which we feel is extremely important, is 90% for well care, 83% of diabetes care, and 77% of acute asthma visits. As mentioned above, prompt access to care has improved markedly and is 2 days or less for 2 of our 3 clinics. Our patients have improved HbA1c levels, more

patients with persistent asthma are on controller medications, women are entering pre-natal care earlier in their pregnancy, and our immunization rates are higher. Re-organizing our health centers has had excellent results for our patients.

ABSTRACTS

Primary care – will it survive?

Bodenheimer T. Primary care – will it survive? NEJM 2006;355:861-864

Primary care is the backbone of the health care system but is in crisis. Primary care physicians can no longer perform all the functions they are expected to perform – acute, chronic, and preventive care, coordination with the remainder of the health system, and being a trusted counselor to a large panel of patients. Because the job of delivering primary care is so difficult, and because primary care payment is so much lower than payment for specialty care, the number of US medical graduates entering primary care careers is dropping rapidly. A number of practices are making improvements, but in order for those improvements to be sustainable, the larger health care system needs to invest in primary care.

Effect of enhanced feedback and brief educational reminder messages on laboratory test requesting in primary care: a cluster randomised trial.

Thomas R, Croal, BL, Ramsay, C, Eccles, M, Grimshaw J. Effect of enhanced feedback and brief educational reminder messages on laboratory test requesting in primary care: a cluster randomised trial. T. Lancet. 2006 Jun;367(9527):1990-1996.

Available online 15 June 2006.

Summary

Background

Laboratory services play an important part in screening, diagnosis, and management of patients within primary care. However, unnecessary use of laboratory tests is increasing. Our aim was to assess the effect of two interventions on the number of laboratory tests requested by primary-care physicians.

Methods

We did a cluster randomised controlled trial using a 2x2 factorial design, involving 85 primary-care practices (370 family practitioners) that request all laboratory tests from one regional centre. The interventions were quarterly feedback of practice requesting rates for nine laboratory tests, enhanced with educational messages, and brief educational reminder messages added to the test result reports for nine laboratory tests. The primary outcome was the number of targeted tests requested by primary-care practices during the 12 months of the intervention. This study is registered as an International Standard Randomised Controlled Trial, number ISRCTN06490422.

Findings

Practices that received either or both the enhanced feedback and the reminder messages were significantly less likely than the control group to request the targeted tests in total (enhanced feedback odds ratio 0.87, 95% CI 0.81–0.94; reminder messages 0.89, 0.83–0.93). The effect of the interventions varied across the targeted tests individually, although the number of tests requested for both interventions was generally reduced. Neither intervention was consistently better than the other.

Interpretation

Enhanced feedback of requesting rates and brief educational reminder messages, alone and in combination, are effective strategies for reducing test requesting in primary care. Both strategies are feasible within most laboratory settings.

Primary care – the best job in medicine?

Woo B. Primary care – the best job in medicine? NEJM 2006;355:864-866.

Developing long-term relationships with patients and assisting them with their health-related challenges is a wonderful reward that primary care physicians can cherish. However, when medical students ask “Do you like being a primary care doctor?” the answer is a mixed one. On the one hand, being the primary physician for patients is the best job in medicine. On the other hand, primary care physicians are under pressure to see patients faster than before, with increasing responsibility but inadequate financial reimbursement. Patients need a healthy primary care sector and need to have continuing relationships with a trusted clinicians. “Although the line of students signing up for a career in primary care is getting shorter, the line of patients in need of primary care doctors is getting longer every day.”

Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey

Lasser K, Himmelstein D, Woolhandler S. Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey. *AJPH*. 2006 July 96(7):1300-1307

Karen E. Lasser, David U. Himmelstein, and Steffie Woolhandler are with the Department of Medicine, The Cambridge Health Alliance and Harvard Medical School, Cambridge, Mass.

Objectives. We compared health status, access to care, and utilization of medical services in the United States and Canada and compared disparities according to race, income, and immigrant status.

Methods. We analyzed population-based data on 3505 Canadian and 5183 US adults from the Joint Canada/US Survey of Health. Controlling for gender, age, income, race, and immigrant status, we used logistic regression to analyze country as a predictor of access to care, quality of care, and satisfaction with care and as a predictor of disparities in these measures.

Results. In multivariate analyses, US respondents (compared with Canadians) were less likely to have a regular doctor, more likely to have unmet health needs, and more likely to forgo needed medicines. Disparities on the basis of race, income, and immigrant status were present in both countries but were more extreme in the United States.

Conclusions. United States residents are less able to access care than are Canadians. Universal coverage appears to reduce most disparities in access to care.

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