Module 2: Working With Safety Net Practices

Clinica Family Health Services Case Study

Note: *This case study was developed by Tom Bodenheimer, M.D., Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California, San Francisco, and is used with permission. It has not been modified or edited except to correct typographical errors, grammatical errors, or misspellings. Questions may be addressed to TBodenheimer@fcm.ucsf.edu.*

Clinica Family Health Services

Notes from April 18, 2011 visit

History and Demographics of Clinica by Thomas Bodenheimer

Clinica Family Health Services is a non-profit Federally Qualified Health Center serving the area northwest of Denver, Colorado.

Clinica was founded by Alicia Juarez Sanchez, a woman with a serious chronic condition who assisted other patients, driving them to their medical care providers. She realized that Latinos in Colorado needed a clinic to care for them, and organized community members to open a clinic which began one night a week in her kitchen. A local physician volunteered his time, and a nurse practitioner began seeing patients regularly. Within a year the clinic had moved to a store front, and was open 5 days a week. The nurse practitioner continued working for 30 years with the community as the organization grew. In 1981 the clinic became a federally funded community health center. The clinic was initially called Clinica Campesina, since many of its patients were farmworkers (campesinos). More recently, "campesina" was removed from the name since urbanization changed the occupations of most patients from farmworkers to service workers.

Since its inception, Clinica has grown enormously, now caring for one-third of low-income people in the communities in which it is situated, with 40,000 active patients, 170,000 visits per year, 46 physical health providers, 13 behavioral health providers, 4 dental providers, 2 full pharmacies, and a total staff of 320. Clinica has 4 sites, Pecos and Thornton in Adams County, and Lafayette and People's in Boulder County.

Fifty percent of Clinica's patients are uninsured, 40% are Medicaid recipients, and 3% have Medicare. 56% are below the federal poverty line and 98% are below 200% of the federal poverty line. The majority are Spanish-speaking only, and all providers and staff working directly with patients are bilingual.

In 1998, Clinica began its never-ending improvement journey, joining the Health Disparities Collaborative sponsored by the federal Bureau of Primary Health Care and led by the Institute for Healthcare Improvement and the MacColl Institute for Healthcare Innovation. Clinica worked on improving chronic illness care for patients with diabetes by focusing on making appointments available, tracking patients with diabetes with a registry, and implementing evidence based guidelines for delivering indicated care. In 2000 Clinica initiated more far-reaching changes in the clinic, redesigning its entire care model by drastically improving access to care, prioritizing continuity of care as the bedrock of the clinic, creating care teams, and instituting group visits. From 2001 to 2004, Clinica re-designed its care of chronic conditions

and preventive services based on its care teams, and changed the internal architecture of its clinics to allow co-location of care teams. A series of non-stop improvements followed, including behavioral health integration, a nurse and pharmacist-run anti-coagulation service, the implementation of the NextGen electronic health record with changes in dozens if not hundreds of workflows associated with a computerized primary care clinic, population management to provide outreach to patients overdue for chronic or preventive services, improved care coordination with specialists and hospitals, and the addition of case managers to care teams to provide self-management support to all patients with chronic conditions.

Clinica has amassed much wisdom that other primary care clinics and practices could learn from. This summary of how Clinica functions is based on an April, 2011 visit to Clinica's Pecos site.

Continuity of Care and Access to Care

Every patient is empaneled to a primary care provider (PCP -- physician, nurse practitioner or physician assistant) and a care team (called a pod). Each pod has a color, and patients know their pod by its color. Continuity of care is measured regularly by determining the percentage of patient visits that are visits to the patient's own PCP or to the patient's pod. Clinica's goals are 70% PCP continuity and 90% pod continuity, goals that are often reached.

PCP continuity is most easily achieved by having providers who work at least 80% time. Because of the difficulty recruiting excellent primary care providers, Clinica has chosen not to demand full-time status of its providers, and about half are part time, with others occasionally absent due to maternity leave or vacations. Given these conditions, 70% PCP continuity is about as good as one could get.

The secret to achieving continuity of care—which is important because it improves care, reduces costs, increases patient and provider satisfaction, and reduces unnecessary demand—lies in how clinic staff are trained. Clinica has a call center, located in the Pecos site, serving all four sites. The call center attendants, who are generally high school graduates trained by the call center director, have clear instructions how to balance the needs for both continuity and access. When a patient calls, the attendant will offer an appointment with the patient's PCP. Only if the patient wants to be seen today or tomorrow and the PCP is unavailable those days, will the patient be given an appointment with another provider on the same pod. In many practices, staff answering phones say to patients something like: "If you want to see your doctor, the next appointment is in 2 weeks, but you can see a different doctor tomorrow." This message essentially prioritizes access over continuity, while the Clinica message prioritizes continuity but allows patients to choose access if their PCP is not available promptly. All clinic personnel understand that continuity of care is the bedrock of good primary care. Clinica has a continuity of care improvement team, and the call center director participates on that team.

If achieving continuity of care is like climbing a 5,000-foot mountain, sustaining prompt access to care is like scaling one of Colorado's 14,000-foot peaks. For over ten years, Clinica has been able to provide almost all care to its patients within 5 days of their request for an appointment, usually within 2 days. How is this done?

The first challenge is to provide reliable phone access, which is done through the call center, which has sufficient call center attendants to handle a huge volume of calls, 1200-1500 per day,

with a peak of 1100 calls before 11 AM Monday mornings. 98 to 100% of calls are handled (not dropped), and 80% are picked up within 90 seconds, with these metrics followed on a regular basis.

Call center attendants are well trained in the pod system, the NextGen EMR, how to use the clinical protocols, how to refer callers to outside resources, and customer service. The call center director listens to a certain percentage of calls and mentors the attendants. Initial training takes 2 weeks, and new attendants work with a trainer until they are ready to take calls alone. The attendants have protocols, for example, to have the patient call 911 in case of chest pain or other emergent symptoms, to call the cell phone of the RN on the patient's pod in case of urgent but not emergent symptoms, to send an electronic message to the RN on the pod for non-urgent clinical matters, and to make appointments using the continuity of care priority.

After phone access comes prompt access to appointments. Clinica measures Third Next Available Appointment (TNA), a well-recognized access metric. The appointment template is opened up for only 2 weeks; no appointments are made after 2 weeks. This allows all providers' schedules to be empty, meaning that TNA cannot exceed 14 days. Moreover, the no-show rate with schedules open for 2 weeks is about 8%. Clinica has experimented with opening up schedules for 3 weeks, but the no-show rate jumps to about 30%. Clinica attempts to fill providers' schedules only from 8 to 10 AM and to leave the remainder of the schedule open for same or next day appointments. This is not always possible during the first week, but for most providers many slots are open the second week. Clinica-wide, TNA in 2010 ranged from 2 to 6 days, often higher in flu season and in August/September with back-to-school physicals. TNA is also measured for each site, each pod, and each provider.

Call center attendants, in addition to their understanding that continuity is the first priority, are instructed that they never say No to a patient. Either patients receive an appointment within 2 weeks, or if patients request a later appointment they are asked to call back close to the time when they want the appointment, or their call is forwarded to the pod to squeeze them in that day.

Providers, when they are in clinic, have appointment slots every 20 minutes from 8:20 through 12:20—13 patients in the AM. Lunch is from 1-2 and huddle from 2-2:20. The afternoon runs from 2:20 to 5 with the last patient seen at 5. On days when the clinic is open until 8, many providers work 12-hour shifts, from 8 to 8. Those having evening clinic do not work in the morning. Providers have one 20-minute slot for each 5 slots for catch-up and care coordination, but many transfer that slot to the end of the day to get home earlier. Many do part of their documentation from home.

Full-time providers are expected to see 100 patients per week, a necessity because Clinica depends on visit-based FQHC reimbursement for patients on Medicaid. 80% providers need to see 80 patients per week. Providers can vary their schedule templates as long as they see enough patients per week. When a provider is participating in a group visit, the schedule is blocked for the time in the group visit.

An important policy supporting continuity of care is that providers are expected—within reasonable limits—to squeeze patients into their schedule for their patients, but not for another

provider's patients. The RN on the pod, who also functions as pod coordinator, would receive a request from the call center to squeeze a patient in, and depending on the acuity of the patient and how backed up the providers are, would decide whether to squeeze in the patient or have a nurse encounter (in person or by phone).

If patients want appointments in, for example, 2 months, they are told to call back the week they want the appointment. If providers want to make appointments for their patients in 3 months, that is not possible, but two mechanisms are available to ensure that those patients will not drop through the cracks. First, many patients are entered into a chronic disease registry (see below under Panel Management), and will be called by a panel manager when they are due for care. Second, providers can task themselves or task the front desk (with an e-mail message through the EMR) to contact a patient who needs an appointment in 3 months—essentially an electronic tickler system within the EMR. In this way, providers are not anxious about patient needs being dropped. To allow this access policy to work, patients are informed about it on their first visit to Clinica, and by now patients are used to the policy and accept it.

Clinica is able to keep its TNA under a few days by matching demand and capacity, which is done in four ways: 1) limiting panel size to control demand, 2) adding capacity through RN and case manager care (see below under Care Teams), 3) adding capacity by extending the interval between visits if medically appropriate, and 4) adding capacity through group visits (see below under Group Visits).

Demand for appointments is determined by risk-adjusted panel size. Risk-adjustment is done by determining the number of visits per year of different strata in the clinic's population; for example, infants, young women (who often become prenatal patients) and the elderly require more visits per year. Clinica has made the decision to provide high-quality, comprehensive primary care with prompt access to its patients (40,000 of them) rather than to provide lower-quality urgent care to everyone. In other words, you cannot take care of the whole world, and if you have too much work, you simply have too much work and you cannot do it well. This is a policy decision each primary care clinic/practice needs to make. As a result, Clinica has a waiting list sometimes reaching 4,000 patients, who would like to receive care but cannot do so because panels are full. Average active panel size is about 1200, which takes into account the large number of infants and prenatal patients who require frequent visits. Panels are reviewed and tweaked regularly to determine if patients are actually seeing the provider to whom they are empaneled and whether a provider is over- or under-paneled. Patients who have not been to the clinic for 18 months are removed from active panels because many of these patients never return to the clinic.

Access to care must also balance the needs of patients with the needs of the clinic and clinic personnel. Clinica sees patients from 8-6 Mondays, 8-8 Tuesday, Wednesday, Thursday, and 8-5 Fridays. It is closed weekends. When the clinic is closed, a nurse line (run by the municipal Denver Health system which is paid by Clinica for this service) picks up calls and forwards them to the call center by e-mail or pages Clinica's on-call provider.

The clinic is closed from 1 PM to 2:20 PM, with one hour for lunch and 20 minutes for the afternoon huddle on each pod. Phones are also closed during this time, and call center attendants also have their huddle from 2 to 2:20, discussing any changes in scheduling or protocols,

reviewing training, and going over problems that might have arisen. While the phones are off, the Denver Health nurse line picks up calls and forwards them to the call center by e-mail. Each call center attendant has a 15-minute break in the AM, but no break in the PM because the PM phone hours are 2:20 to 5 (2:20 to 4 on Fridays).

Using these policies and protocols, Clinica has been able to balance the goals of continuity and access, a huge challenge for any primary care organization.

Pods (Care Teams)

All clinical activity at Clinica centers around the pod. For patients, the pod (the same thing as the care team) is where they receive care. It is well known that patients prefer to receive their care in smaller health care settings. Breaking down a larger organization into smaller units—in the case of Clinica, pods—allows patients to feel comfortable because the members of the pod know them and they know the people on their pod. Clinica patients see themselves as patients of the Green Pod or the Blue Pod or the Purple Pod. Because Clinica is a good place to work, many physicians, nurses and medical assistants have worked there for 12 or 15 years, making longitudinal continuity of care possible and allowing pod members to truly know the patients on their panels.

Each of the four Clinica sites has several pods. The walls of each pod reveal the pod's color. Pods are both physical entities and organizations of people. Architecturally, each pod consists of a central open area—either a rectangle or a circle—surrounded by patient exam rooms. Pod members are co-located, working right next to one another so it is very easy to communicate. Not only can pod members easily interact with one another, they can also see all the patient rooms, which have multicolored flags (black is the MA, red is the provider, blue is the behavioral health provider, green is the case manager) telling everyone on the pod who is in which room.

The suborganization of the pod consists of a provider (physician, nurse practitioner or physician assistant) always (with rare exceptions) working with the same medical assistant (MA). The provider and MA sit facing each other on the pod. Each of the thirteen pods at Clinica's four sites has 3 full-time equivalent providers (generally 4 people due to part-timers), 3 MAs (one per provider at each session), 1 behavioral health professional, 1 RN, and 1 case coordinator, and one medical records person. Front desk personnel are part of the pod, and geographically sit between the physical pod and that pod's waiting room. The same people always (with rare exceptions created by vacations or other absences) work on the same pod. Patients are empaneled both to a pod and to a provider/MA dyad. For each dyad, a colorful business card shows patients the name of their provider and MA.

From 8 to 8:20 and from 2 to 2:20, each pod has a huddle, going over the patients scheduled for the day—the schedule is available in hard copy to take notes on—to plan what each patient might need. For example, the behavioral health provider and the case coordinator will gain an idea of which patients are likely to need their time, and MAs will know who will need a procedure. If a group visit is scheduled, everyone will know which provider, RN and/or MA involved in the group visit will be off the pod for a certain period of time.

Two people on each pod have leadership roles. One MA is half-time MA and half-time MA team manager (training and supervising MAs, handling their time sheets, and doing their performance reviews). The pod's RN is also the flow coordinator, making sure that all runs smoothly and intervening to solve problems. Because everything can be seen from anywhere in the pod, problems that arise are easily seen. An example of a flow problem might be a provider who is running an hour behind due to unexpected complicated patients. In that case, the RN will initiate the visit with patients who are waiting, allowing the provider time to be greatly shortened. However, patients empaneled to a stressed provider are not switched to another provider in order to preserve the all-important continuity of care.

A striking visual impression of a Clinica pod is that everyone—providers, MAs, RNs, behavioral health providers—carries a laptop everywhere they go. The laptops are like a third arm, and no one dares go anywhere without them. In this way, the electronic medical record goes with each team member rather than having care team personnel go back to a computer to document care that is given.

Patient flow on the pod seems calm and organized. After patients have checked in with the pod's front desk person, that patient's MA receives an electronic message in her in-box, and she brings the patient into the exam room. Since each provider has 3 exam rooms, everything—pre-visit, visit, immunizations, lab work, behavioral health discussions, goal setting with the case manager—all happen in the same exam room.

Two pods share a procedure room, which focuses on obstetric ultrasounds (read by primary care providers), sigmoidoscopies, culposcopies, vasectomies, circumcisions, skin biopsies, and IUD insertions and removals. While Clinica has plenty of complex patients, a large number of its patients are young women and children, which explains the predominant types of procedures needed. MAs set up the procedure room, using a detailed manual that describes exactly what is needed for each type of procedure, and assist with the procedures. Each provider does each type of procedure in the same way, demonstrating the standardization of care processes so evident at Clinica.

Medical assistant role

The MA brings the patient into the room, does vital signs, checks smoking status, and takes a detailed history using the template on the NextGen EMR. Templates exist for well child checks (templates may vary by age), diabetes, ADHD, asthma, anticoagulation, prenatal care, tobacco cessation, SBIRT screening, and complaint-specific history of present illness. In the case of patients with diabetes overdue for an HbA1c (done by a point-of-care machine) or a foot exam, or an appointment for a retinal exam (done with a retinal camera as a group visit), MAs perform those tasks. After the MA enters the history into the templated EMR, the EMR provides the history in a form easily reviewed by the provider. For children, the EMR includes decision support on which immunizations are needed, and the MA draws up the immunizations while the provider is seeing the patient and gives the shots in the post-visit. Providers are not involved in providing immunizations. MAs do not have time to do medication reconciliation or behavior change counseling; those functions, if indicated, are provided by the case manager immediately following the provider visit. The MA pre-visit takes 10-15 minutes.

If the provider wants the MA to do a post-visit (immunizations, blood draws, or other activities), an electronic message is sent to the MA and the black flag is put into the MA-needed position. If an appointment is needed within 2 weeks, the MA would make the appointment.

RN role

Many primary care practices do not have RNs, and for other practices, the RN role may not fully utilize the depth and breadth of skills possessed by RNs. RNs at Clinica have clearly defined roles that allow and require them to work at the very top of their license. The RN role has three interrelated parts: 1) addressing situations that arise everyday in primary care, situations needing skill in assessment and decision-making, 2) handling less complex clinical matters that can be protocolized with physician-written and approved standing orders, and 3) serving as pod flow coordinator.

For the first area of work, RNs receive electronic or phone messages from the call center regarding clinical problems faced by patients. A patient may call about abnormal uterine bleeding, a severe headache, or a medication refill; a family may call because grandmother has fallen or suffered a brief episide of right leg weakness. Hundreds of such situations arise, and RNs need the clinical acumen to assess what is needed: 911? Emergency room? Appointment today? Prescription called into the pharmacy? Physician to call the patient within the hour? Clinica RNs make dozens of these decision everyday.

The second area of work is the management of certain specified acute problems. Clinica physicians have approved standing orders for RNs to treat positive strep throat infections, uncomplicated conjunctivitis and ear infections, head lice, sexually transmitted diseases such as chlamydia and gonorrhea, uncomplicated urinary tract and respiratory infections, and the management of warfarin dosing for patients needing anti-coagulation. Some of these problems can be diagnosed and treated by the RN—without the provider—based on a phone call or face-to-face RN visit. Others come to the RN's attention through certain lab results that are channeled to the RN's EMR in-box ("RN labs"), for example, positive strep cultures, urine cultures, or chlamydia cultures. The RN would call these patients, provide patient education, and order the appropriate medications according to the standing orders. Thus the RN is not diagnosing, but is initiating treatment based on a diagnosis provided by the lab. RNs taking on these responsibilities allows providers to spend more time caring for complex diagnostic and management problems, and building relationships with their patients.

RNs also take care of warfarin dosing for patients on anti-coagulation, checking the INR lab results (with an on-site INR machine) and titrating warfarin doses according to a dose calculator. Pharmacy students review the warfarin registry to look for drug interactions, patients who may be missing timely INR checks. As part of Clinica's robust self-management support philosophy, patients are asked to write down their warfarin doses and INR results on their personal anti-coagulation card, and are asked how confident they are, on a 0-10 scale, that they can self-manage their anti-coagulation treatment. Having patients do these simple things themselves helps activate them as participants in their care.

The RN role as pod flow coordinator often involves RNs performing patient visits if a patient drops in, if no appointments are available, or if a provider is running far behind. If the RN visit involves a clinical problem with an RN treatment protocol (standing order), the RN can do that

visit herself. More often, these visits turn into co-visits with the patient's provider coming at the end of the visit to confirm a diagnosis, and approve, change, or make a care plan.

The RN is constantly assessing how things are going on the pod, checking her EMR in-box, making outgoing phone calls or taking incoming calls. At Clinica, RNs do not work as chronic care managers because they do not have time. For less complex patients, the pod's case manager assumes that function, and for more complex patients the task remains largely with the provider.

Case manager role

Case managers could also be called health coaches and navigators. They meet with patients with chronic conditions, doing patient education and smoking cessation counseling, providing health-related resources, and collaboratively setting goals and action plans with patients. In the twice-daily huddle, or in the provider visit, patients are identified who need a planned visit with the case manager. These visits ideally take place immediately after the provider visit. Because case managers are on the pod, they often hear or see things—for example, an overweight or obese patient or a patient with diabetes whose HbA1c is high on point-of-care testing—that indicate the need for case manager services that day. A case manager might spend from 5 to 30 minutes with a patient.

Clinica has created a self-management support template on the NextGen EMR, which case managers use for almost every patient. The template includes the patient's goal, the name of the patient's support person, the level of importance (0-10) the patient places on healthy behavior change, the specific action plan, the patient's level of confidence (0-10) in being able to achieve the action plan and the goal, and the barriers the patient anticipates. The case manager prints the action plan for the patient on a form that allows the patient to write how well he/she implemented the action plan each day.

The percentage of patients with diabetes who set goals has improved from 28 to 46% and continues to improve as the case managers place a priority on goal setting.

The EMR has the capacity to print out an after-visit summary, but for some patients with low literacy this summary is not so helpful unless the case manager reviews it with the patient. For patients who want the summary, the provider reviews it with the patient; in the future Clinica would like to have more case managers with one of their functions being to make sure that patients understand the care plan provided in the after-visit summary.

Behavioral health integration

Clinica has integrated behavioral health into primary care, with one behavioral health professional (licensed clinical social worker, psychologist, or licensed professional counselor) per pod. Behavioral health professionals (BHPs) have some 30-40 minute appointments, but are available much of the time for warm handoffs—providers introducing patients to the BHP who conducts a 10-15 minute unscheduled visit done in the exam room after the provider visit. Warm handoffs may be planned during the morning or afternoon huddle or may take place when the provider uncovers a behavioral health problem. Common issues are depression, anxiety, and psychosocial problems. Like case managers, BHPs work with patients on goal setting and action plans. MAs taking patients' history may uncover depression symptoms and do the PHQ-9

depression screening questionnaire, and then contact the BHP, who would follow patients with positive depression screens over time by phone or follow-up visit. Providers would be involved if medications are indicated. Not all patients are screened for depression, but all postpartum women are screened. BHPs also have English and Spanish group visits for patients with anxiety, 1½ hour sessions for 6 weeks. Under the payment guidelines for federally qualified health centers, a BHP visit can be billed, but a provider and BHP visit on the same day can be billed only once. A psychiatrist comes to Clinica 2 days per month, each day seeing 3 new patients and 4 follow-ups in addition to consulting with providers and BHPs.

Front desk

Each pod has its own front desk staff, though they are generally situated between the pod space and the pod's waiting area. The front desk does not handle telephones, which are separated from the pods in the call center; the absence of constantly ringing phones contributes to the calm atmosphere at Clinica. Front desk staff check patients in, collect copays before the visit (uninsured patients are on a sliding scale), and may make follow-up appointments though MAs often perform that function during their post-visit. Front desk staff also make confirmation calls to remind patients of appointments, call to inform patients of normal lab or x-ray results, and comb lists and registries to do outreach panel management calls to remind patients with care gaps (see below under panel management).

Referrals

Each of the four Clinica sites has at least one referral coordinator, whose job is to arrange and track specialty and imaging referrals. Referrals are a challenge for Clinica because few specialists will accept Medicaid and fewer will take uninsured patients. Referral coordinators have a database of these specialists, arrange appointments, send clinical information to the specialist, inform the patient, and track in the EMR whether the referral was made, appointment kept, and specialty consultation referral letter returned to Clinica. A tracking report is run every week and if no consultation letter has arrived, the referral coordinator follows up to determine if the patient no-showed or if the letter has not yet been sent. Clinica does not arrange for referrals for patients who request referrals but whose providers do not feel that specialty care or imaging is indicated. A similar tracking program has been implemented for laboratory results.

Group Visits

Group visits are a central feature of care at Clinica, with well-designed group visit rooms at every site. Group visits are offered for prenatal care, well-child care, diabetes, chronic pain, cold/flu, allergy, anxiety, and other chronic conditions. Patients always have the option of receiving care in a group or one-on-one.

Different groups are led by different staff people—MA, RN, BHP, case manager—with a provider present in the group for most of the time. Each type of group visit has clear protocols and delineation of responsibilities and an established length (generally 1 or 1½ hours). The scheduling of personnel for group visits is carefully meshed with the one-on-one pod schedules. Because providers spend some time with each group visit patient, the group visits are billable. A small exam room is available to the side of each group visit space for care requiring privacy.

An initial prenatal group is offered in English and Spanish to bring newly diagnosed pregnant women into care as early in their pregnancy as possible. Currently, 80% of women at Clinica receive their first prenatal visit during the first trimester, up from 30% in the past; this statistic is associated with better pregnancy outcomes. Clinica providers—with obstetric backup—deliver about 2,000 babies each year (almost six per day).

Following the initial prenatal group, pregnant women can choose to receive their prenatal care in a Centering Pregnancy group or one-on-one. Well child care can be done in a Centering Parenting group or one-on-one. For the Clinica's Pecos site, 10% all care and 14% of prenatal care takes place in groups. The Pecos site does 850 group visits per year (between 2 and 3 each day). During the time that providers are seeing patients in groups, they are 30-40% more productive (patients seen per hour) than seeing patients one-on-one. Thus groups are good not only for patients, who interact with other patients like themselves, but also for Clinica financially.

Pharmacy

Two of the four Clinica sites have full-service pharmacies. For patients at the other 2 sites, medications are sent by courier. Medications are sold at cost plus a $12 dispensing fee, with a sliding scale for very low-income families. Clinica receives pharmacy assistance from University of Colorado pharmacy students and some PharmD residents. Sometime in the future, Clinica would like to place pharmacists on the pods.

Dental

Two Clinica sites have dental suites with dentists, hygienists, and dental assistants. Clinica provides fillings and comprehensive dental exams, and acute care for dental emergencies, but its priority is prevention, especially for the three groups covered by Colorado Medicaid: children, pregnant women, and patients with diabetes.

Panel Management

Clinica has set up systems to improve the chronic and preventive care not only of its patients who come for appointments, but for all patients empaneled to Clinica's sites, pods, and providers. This is done by providing outreach to patients who are overdue for periodic services recommended by well-accepted clinical practice guidelines, for example, women between 50 and 75 years who have not had a mammogram in the past two years or patients with poorly controlled diabetes who have not had an HbA1c lab test in the past 3 months. This activity is known as panel management—managing the care of Clinica's panels of patients.

Outreach is done by making reminder phone calls to patients with care gaps, meaning patients overdue for a guideline-recommended service. Outreach could be performed with mailings, but in the low-income population served by Clinica, letters are relatively ineffective in reaching people. Cell phones work better. Outreach calls are entered into the registry and tracked. Pod members share the outreach work—some calls are done by the front desk, others by case managers, others by BHPs. The patients needing outreach are identified through Clinica's many registries and lists.

Registries are lists of patients with a particular chronic condition (Clinica has registries for ADHD, anti-coagulation, asthma, chronic pain, depression, diabetes, abnormal Pap tests, and hypertension) or a life situation requiring monitoring (prenatal care and parenting). Registries include patients' demographic information and clinical data, including the dates when each indicated test or service was last done, with prompts indicating what is overdue. Clinical practice guidelines are embedded into the registries. Lists are simpler; for example, a mammogram list includes all patients overdue for the mammogram. The designated pod member responsible for outreach to patients identified on the registries and lists as having care gaps calls those patients to close the care gap. Providers are not involved in this routine work, thereby freeing up more time for providers to address patients' acute complaints and complex management issues. Currently, Clinica's IT department is working to unify the disease-specific registries into one large registry. Clinica does prioritize which care gaps are addressed since there is not time for outreach to every patient overdue for a service.

Panel management can also be done through in-reach, meaning that care gaps are addressed when patients come to the clinic. Clinica's NextGen EMR does have a health maintenance screen that shows care gaps in red; thus far MAs and case managers are regularly not using that screen to address care gaps when patients come to the clinic. Clinica is hoping to add in-reach to its panel management activities at some point in the future.

Complex care management

In most health care organizations 10% of patients incur about 70% of health care costs; these are usually patients with several chronic physical and mental health conditions who frequently use the emergency department and are admitted to the hospital. It is widely believed that with excellent primary care, many of these emergency department and hospital costs could be avoided, and Clinica is well situated to reduce these costs.

Clinica has plans to devote more resources to these patients by increasing the number of case managers and focusing on prompt follow-up for patients seen in the emergency department or discharged from the hospital. A pilot program for complex care management is starting with a Colorado Medicaid Accountable Care Collaborative.

EMR Implementation

Clinica adopted the NextGen electronic medical record in 2006. No one at Clinica would ever imagine going back to paper charts; the EMR has been a key contributor to the improvements in Clinica's workflows. When Clinica made the transition from paper to electronic records, only a small amount of data was transferred to the EMR: diagnoses, medications, allergies, and immunizations. As providers saw patients, they could flag other pieces of information they wanted in the EMR, for example, lab results, imaging reports, patient consents, advance directives, hospital discharge summaries, and specialty consults. These could be scanned, but more commonly providers would highlight the key conclusions of these reports and indicate where in the EMR the information should go, and medical records personnel would input the information. If a paper chart has not been pulled for 18 months, it is sent to storage.

Clinica wisely kept its medical records staff, who now work on each pod to input information requested by providers. Because many institutions with which Clinica interacts are not

electronic, a large amount of paper continues to enter Clinica and medical records personnel are needed to input provider-highlighted information.

With its disease-specific templates for conditions commonly seen at Clinica, and its decision support tools which make clinical practice guidelines quickly available to providers, the EMR has helped to standardize how common conditions are handled by Clinica's providers and care teams. Some practice guidelines were written by Clinica's physician leaders; others are available from Colorado HealthTeamWorks, which has developed a rigorous process for writing, approving, and disseminating guidelines.

Clinica is currently initiating a web portal so that patients and care team members can communicate electronically, which is expected to streamline care for those patients with access to computers.

Creating Workflows

Every process in primary care has an invisible or visible workflow: what are the steps in the process, who does each step, and how do the steps fit together to make the process function smoothly? Clinica has tried to make hundreds of workflows, which naturally changed after EMR adoption, as visible as possible to every person working in the organization.

Creating smooth workflows is a long, slow journey, in part because primary care is composed of so many specific workflows. Take incoming phone calls as an example. Who receives the call, what script is used to answer the call, and how are emergent, urgent, and non-urgent requests handled? What can be handled by the call center attendant, what needs to be referred to the RN (which ones by phone, which by e-mail), or to someone else? If the call is for an appointment how is that appointment made, how is the call documented, and how is the quality of the call (how long the phone rang before being picked up, how satisfied was the caller) measured and how were those measurements entered into the clinic's database? Multiply the steps in that workflow by the hundreds of workflows taking place in primary care; improve, try out, improve again, spread, and make visible and provide training on each step of each workflow: one can begin to appreciate how much effort is involved in elevating a clinic to a high level of efficiency and quality.

Not only does each clinic function (e.g., managing the appointment template to ensure prompt access, optimizing continuity, drawing blood, reviewing lab results, refilling prescriptions, and on and on and on) require workflow design, but for a couple of dozen common primary care clinical conditions, visible workflows are needed (e.g., for diabetes, creating the EMR template for the MA to follow, deciding who does foot exams, eye exams, HbA1c lab tests, who and how the diabetes registry is managed, which medications are available in the pharmacy, who does patient education and activation and how it is done, how and how often and by whom diabetes care is measured and discussed among the clinic staff, to mention a few of the many steps required).

Clinica has created, tested, improved, and implemented hundreds of workflow redesigns, taking one workflow at a time, requiring years of continuous improvement that never ends. Yet Clinica has found that the very act of improving a workflow, which needs to involve everyone taking part in that workflow, builds teamwork and makes visible how each person's job interacts with

the job of one's teammates and reveals the part that each person plays in providing care to Clinica's patients.

Performance Data

For many years, Clinica has kept run charts that demonstrate how the organization as a whole, each site, each pod, and each provider has performed on a number of metrics. Moreover, a databoard on the wall of each pod shows everyone whether or not performance has reached Clinica-set goals and where improvement is needed. The databoards are updated every couple of weeks with metrics such as continuity of care, documentation of smoking status, percentage of smokers receiving counseling, and process and outcome measures associated with diabetes, hypertension, prenatal care, and other conditions. The twice-daily huddles are used to discuss areas needing improvement. Clinica is a data-driven organization.

		2006	2008	2010	YTD 2011	HEDIS Medicaid
Continuity for Patients with Diabetes	PCP	58.00%	63.25%	69.07%		
	Team	82.00%	78.75%	84.75%		
Access	Time to Third Available Appointment (Days)	6	4.9	4	3.6	
Prenatal	Trimester of Entry to Care (Patients Entering Care in 1st Trimester)	66.00%	58.95%	79.69%	82.74%	83.40%
	Low Birth Weight	6.07%	5.93%	6.00%	5.57%	
	C-section rates		20.34%	20.25%	20.40%	
	Pap Test in Last 3 Years (Women age 24-64)		76.51%	82.87%	83.76%	
	2 Year Old Immunizations		62.52%	81.30%	91.84%	
	Diabetes Patients with A1c < 7%		33.86%	39.92%	41.32%	33.90%
	Diabetes Patients with A1c > 9%		21.81%	20.67%	22.71%	44.90%
	Hypertension Patients with BP <140/90		56.40%	67.38%	67.69%	59.80%

Total number of medical visits for 2010 was 145,596.
HEDIS Medicaid is the average score for all Medicaid health plans in the US in 2009 (www.ncqa.org).
National data on % of births with low birth weight for Hispanics in 2008 = 7.0%.
National C-section rate among US Hispanics 2007 = 30%.

NCQA medical home accreditation

Community health centers across the United States are debating whether to seek NCQA designation as a patient-centered medical home. In some states, such designation brings increased revenue, in others not. Clinica decided to become NCQA accredited even without the payment incentive, feeling that the exercise of gaining designation forces a primary care practice

to think about the areas in which improvement is needed. For Clinica, accreditation was simple because all NCQA elements were already in place.

Pay for performance

From 2003 to 2007, Clinica utilized a pay-for-performance system. The clinic did not receive additional external payments for high quality; rather the organization held some of its revenues in a pool to create internal incentives for improvement. In contrast with most organizations that bonus only providers for improved performance, Clinica gave bonuses to every person on high-performing pods, thereby demonstrating that improvement is made possible by the efforts of the team, not only the provider. Recently, Clinica put a hold on its pay-for-performance system because of debate whether the pod-level data is sufficiently accurate. Discussions of the effectiveness of financial incentives are ongoing.

Financing Clinica

Clinica, like all community health centers in the United States, has a complex system of financing. As a federally qualified health center (FQHC), Clinica receives an enhanced payment for Medicaid because FQHCs are required to care for the uninsured, and the Medicaid payments provide funds that help to offset the losses incurred in caring for the uninsured. In addition, Clinica has received Public Health Service Act Section 330 grants, raises funds from local foundations and benefactors, collects sliding-scale payments from some uninsured patients, and benefited for years from the Colorado tobacco tax moneys. In the changing world of post-Accountable Care Act politics combined with federal and state budget crises, Clinica joins all community health centers in navigating through an uncertain world.

Learning From Clinica

Clinica has solved many of the problems facing primary care clinics and practices, and continues to confront the challenges that still remain. For clinics and practices whose improvement journey began later than that of Clinica, Clinica has much to teach. Why was continuity of care made the centerpiece? How was prompt access achieved and sustained for so many years? Who should be on care teams, how many of each job category, what are their job roles, what are the workflows, and why is co-location such an important feature of a successful care team? How is care for each common condition provided? How does care become a shared responsibility of all care team members rather than the sole responsibility of providers, and how does the shift from provider to team improve the quality of care for patients and the work life of clinic personnel? How is population-based care carried out, and measured, and how does data drive improvement? No clinics or practices will blindly copy Clinica’s answers to these questions, but all can learn from Clinica’s leadership.