Improvement Happens: an Interview with Christine Sinsky, MD

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Medical Associates Clinic (MAC) of Dubuque, Iowa, has generated a lot of buzz for a medium-sized group practice located in a small Midwestern city. At a time when primary care has been declared in crisis, MAC has received national attention for delivering high quality, patient centered primary care. Evidence of high performance comes not just in standard metrics like end-of-year revenue-to-expense ratios and Pneumovax immunization rates, but also in astoundingly low turnover of physicians and staff.

Christine Sinsky, MD, practices general internal medicine and leads the clinic's medical home initiative. In this first installment of Improvement Happens (a new, periodic feature of JGIM sponsored by the California HealthCare Foundation), JGIM spoke with Dr. Sinsky about how MAC achieves its results and what lessons might be useful to other practices.

Figure 1 Christine Sinsky, MD

JGIM: Can you start by telling JGIM readers something about your practice?

Christine Sinsky: We're a multi-specialty group of approximately 120 physicians and around 30 "midlevel" providers. And we are the oldest clinic in Iowa. We grew up together as a multi-specialty clinic, as opposed to being a loosely organized group of pre-existing clinics.

I'm not sure I recognized how good it was here until I started to interact with others on a national level and visited other groups and saw some of the challenges different practices face. It's helped me appreciate where we are.

JGIM: If you had to pick out one distinguishing feature of your practice, what would it be?

CS: I think the most important part of our practice is that it is built on sustained relationships, so, for example, every one of our primary care physicians is partnered with a registered nurse (RN) or licensed practical nurse (LPN) who is their primary nurse. There's also a second nurse attached to each team. Those relationships are fairly long-lasting. Overall, annual staff turnover is less than 5%. My current nurse has been with me for 12 years; my husband—also a member of the practice—worked with the same nurse for close to 10 years and then with another for 8 years. We've found that ability to work together and form a relationship with the nursing staff is really important.

JGIM: I can hear our academic readers shifting in their seats. How much of this really applies to academic general internal medicine clinics, where many JGIM readers practice?

CS: I think stable nurse-physician teams make even more sense in an academic setting where you have that divided mission and you have more challenges in terms of continuity. The role of the nurse is particularly important when there's discontinuity amongst providers, so in an academic setting, enabling nurses to provide stability and continuity may be even more important. It can be done.

JGIM: Any examples?

CS: I'll give you two. One is at the University of Cincinnati where they "traded up" from eight medical assistants to five registered nurses and are starting to see transformative results in their teaching clinic. Another is the University of South Carolina, where a simple architectural redesign put the nurse in the geographical center of the flow of care. The result is not just better care, but happier nurses.

JGIM: So for many nurses, the key to professional fulfillment is to fully utilize their skills and training.

CS: Exactly. In visiting other medium-sized and large practices—academic and non-academic—I noticed that the nurses are often really unhappy with their professional roles. Often times they spend their entire day doing prior authorizations and prescription refills off in a cubicle, away from patients. So part of the reason I mentor the nurses and give them more responsibility is because that helps me, but it also helps them achieve a much better and more satisfying professional career.

JGIM: And what about the doctors?

CS: Well, if I can get on my soapbox for a minute, the work of primary care is so important, and we have physicians across the country who, despite their heroic efforts, often feel as if they are floundering, because they're working in chaotic, unsupported environments. So as a result, there are few people signing up to do it. Can you blame them? You can make a strong business case for providing physicians with the support personnel needed

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to help them with the non-physician tasks of the day. And while this is particularly true under pre-paid models of care, it also applies to fee-for-service.

JGIM: So in broad outline, what should we be saying to our clinic directors and department chairs?

CS: We do not ask our surgeons to go into the operating room and gather all the instruments out of the cabinets; we don't ask them to scrub the operating site; we don't ask them to fill out the demographic part of the pathology requisition slip. We recognize that this would be a misuse of a limited resource. However, in primary care, and in many cognitive specialties, the physician is doing the equivalent of gathering the instruments and filling out the pathology slips, and I think that's really unfortunate. It does not make sense to have people who've been so highly trained filling out demographic information or typing their notes or going through a ten-click process to order a test or medication. Those are things we've worked to have our staff do.

JGIM: What is a typical day like for a general internist at Medical Associates Clinic?

CS: I can tell you what a typical day is like for me. I get up in the morning and go online to see what happened to my hospitalized patients overnight. We start seeing patients in the office at 8:30 a.m. Sometimes I see my hospital patients before that, sometimes after. The hospital is adjacent to the clinic so it's easy to do. Yesterday, with lots of support from my two nurses, I saw 20 patients, two of them new to the practice. I finished up in the office by mid-afternoon, then went to the hospital to check up on my two inpatients, then came back to pick up messages from my nurse, look over journals, and check e-mails. That's pretty much it.

JGIM: Twenty patients in 6 hours—that's a pretty good clip, especially for an internist with a—how to put this—a maturing practice.

CS: It has a lot to do with teamwork and with thoughtful distribution of the tasks of care. If you look at the way physicians spend their time, my guess is that about 60% of a primary physician's day is spent gathering, organizing, and processing information, or doing other kinds of clerical work. We have tried very deliberately to minimize the amount of rework and redundancy. The idea is to allow the physician to spend his or her time building a relationship with the patient and making decisions with the patient. I want to spend most of my time looking the patient in the eye, focusing on what brings them in to see me. And I have found that if most of the information we think we'll need is available and accessible before I go into the room, if I don't have to keep looking for paper or electronic data, and if I can go into the room once, without bouncing back and forth, I can spend my time focusing on the patient and it's a better appointment. It feels more coherent and I feel like there's more room for meaningful conversation with the patient.

One of the key things I do for new patients is to take them out to my primary nurse before they leave the office. By design, Deb sits in the pathway leading towards the exit. I'll introduce her and her pivotal role. "This is Deb," I'll say. "She'll be your main contact if you have any trouble. Any questions that come up between appointments, I want you to call her. She'll help you decide what needs to be done, if you need to come in, that sort of thing." That way they know that she is my close partner and can physically meet her.

JGIM: Do any of your patients balk at the idea of a nurse-gatekeeper?

CS: Nurses in our practice are not gatekeepers, and patients don't see them that way. I could not possibly field every call, nor do I need to. My nurse is the first contact for patients or families when they have questions that arise between visits, and she is very accessible to them. She helps answer questions and runs past me anything that is not straightforward. This provides a very workable balance of access and efficiency. My patients aren't left talking to a triage nurse whom they may not know, nor do they have to leave a message with a secretary.

JGIM: How are your nurses trained and prepared to take on these new roles?

CS: Most of our nurses have been with the practice a long time. The majority are graduates of 2-year AA (Associate of Arts) programs, and they start as so-called "help" nurses. Help nurses room patients, take vital signs, record chief complaints, take preliminary histories and go over medications. They also assist the primary nurse with care coordination and practice management. Over time they learn to do those tasks better. They'll learn that if there's a question about the patient's medication, they call the pharmacy and try to sort it out. Or if the patient was recently hospitalized, the nurse gets that discharge medication list and compares it to what the patient says he is taking.

After a few years of experience in the role of "help nurse," many are ready to move up. By this time, most have had experience working as a primary nurse when the regular primary nurse goes on leave or vacation. So when a primary nurse position opens up, the help nurse will apply for it. At that point we do very little in the way of formal, didactic training. Experienced help nurses already know the work flow, already know the clinic organization, and can step into new responsibilities pretty easily.

JGIM: And at that point, they are prepared to provide phone advice, interact with consultant office staff, and perform follow-up telephone calls with chronically ill patients? Sounds like magic.

CS: It's certainly not magic. My colleagues and I mentor the nurses extensively. I frequently give them articles about things we see, and we incorporate education into bi-weekly team meetings. Last time the topic was H1N1 (influenza A), and the time before that it was about diabetes. Previously we've discussed different aspects of prevention; next time it will be menopause. So that's the way we educate the staff more formally.

JGIM: That's enough about doctors and nurses for the moment. What is the experience at Medical Associates Clinic like for patients?

CS: We've adopted a slogan from ThedaCare in Wisconsin: "the next visit begins today." So let's take the example of Mrs. S, a 56-year-old woman with several chronic health concerns who is due for her annual comprehensive care visit. Before the patient comes to see me, she's already been to the lab and the mammography suite 2 days before. By planning the lab ahead of time and so having the results at the time of the appointment, we are able to close the decision making loop at the time of the visit, reduce the rate of missed abnormals, and avoid time-consuming follow-up calls and letters. On the day before the visit the nurse prepares the chart. She notes that the patient is up-to-date with tetanus but due for colonoscopy. The patient checks in with the receptionist, and the nurse is notified electronically. She brings Mrs. S. back to the

exam room, records the main concern or complaint, looks over the patient's pre-appointment questionnaire, and reconciles the medications so that an accurate list is available to me when I go into the room. Then she reviews the results of lab tests with the patient. Since Mrs. S. is due for a colonoscopy, the nurse discusses why the test is needed, and with the patient's permission, checks off "colonoscopy" on the post-appointment order set so that it will be scheduled by the receptionist at check out. She might also provide written information on weight loss, calcium, and smoking cessation.

JGIM: What if one of the tests shows that the patient is HIV positive, or has a severe, unanticipated microcytic anemia, or has a suspicious cluster of microcalcifications on her mammogram?

CS: The nurses will go over the standard things, including abnormal results such as a high cholesterol or low potassium. I'll then come in the room and often ask the patient to tell me how their numbers looked. I am the one who ultimately manages the results with the patient, but if the nurse does the initial review, the patient has time to think about the result and formulate questions (and answers!). Anything out of the ordinary, such as results of a diagnostic workup, that's entirely my job.

JGIM: The patient tells you how the numbers looked?

CS: The patient will often say something like, "My cholesterol is much better, that simvastatin is really working!" Or "My A1c is climbing up, and I'll be honest I haven't really been watching my diet." I've found that asking the patient to tell me about their labs has changed how we interact. Patients are more engaged in their own care.

Doing labs ahead of time also improves safety. I had a patient not long ago who was being treated with a diuretic for hypertension. We got into a conversation about all kinds of things, and later on the patient said, "What about that potassium thing that's 3.2 the nurse told me about? She said it was low." Well, I had been distracted by all the other things and could have easily missed that. The nurse and the patient were part of the safety net.

JGIM: So is there some kind of handoff as you prepare to see the patient yourself?

CS: Yes, we usually touch base in the hallway right before I'm ready to go into the room. The nurse will stop me and say "the patient's here because you changed her diuretic last time; she's weak and dizzy from it and doesn't really like it. Oh, and also she's feeling down, as two of the other nuns in her order were killed in a car accident 2 days ago."

I need to know that! I still review my note from the last visit, but the nurse helps me focus. She highlights the patient's concerns, and she keeps me from going into the room singing, "Hello! How are you this beautiful day?" Because that's not where this patient's at.

JGIM: And what happens when you're done?

CS: As needed, the nurse will come in and do additional education such as how to use an inhaler. Or she might review medication instructions with the family. For a frail elderly patient with medication changes she'll print up an updated medication list and review the details. From there the patient goes to the receptionist to schedule whatever it is that we've decided should be the next step.

JGIM: The patient-centered medical home has taken center stage as part of health care reform. In what ways does MAC of Dubuque emulate the ideal of a medical home?

CS: Our clinic was recognized by NCQA as a level 3 patient-centered medical home (PCMH) in 2008. While we lack some elements of a PCMH (for example, a robust registry and patient portal, both planned for 2010), we do have many—an electronic health record, 24-hour access, team-based care, care management, and test tracking.

JGIM: Despite the high demand for their services, many generalists in office practice are struggling financially, at least compared to their sub-specialist colleagues. How are you paid?

CS: Our financial structure is entirely production based, and so we all pay into the overhead and we all cover direct and indirect expenses, but basically, we are a productivity based organization. Everything is based on collections. So if one of my partners sees twice as many patients as I and another partner sees half as many, as long as they're paying into the overhead and they're taking their share of night and weekend calls, that's ok.

JGIM: And everyone pays the same overhead?

CS: No, we each decide how much nursing support we want to pay for. Personally, I've found that 1.75 nurses is about right. I'm much happier with 1.75 nurses than with 1.0, and I also feel my productivity is better and the bottom line more favorable.

JGIM: Does the focus on collections rather than volume or RVUs affect the ability or willingness of physicians to provide care for Medicaid patients or for the uninsured?

CS: I don't think insurance status is much of an issue, but I suspect that is partly because our percentage of Medicaid and uninsured patients is low compared to many other regions of the country.

JGIM: And by the same token, isn't a pure fee-for-service payment model exactly what health policy wonks have been railing against? Aren't all the incentives slanted to encourage physicians to provide more and more medical services—regardless of value?

CS: At the physician level, fee-for-service works ok for us. That said, I would like to see more equitable fees for similar service lines across specialties. Not to mention a care management fee to cover all of the out-of-office care and coordination we provide. But remember, in our organization, we wear three hats. We are the providers, but we're also the business owners, and we're the payers for one-third of our population. So in a sense we have a built-in rudimentary hybrid payment system.

JGIM: How so?

CS: Aside from being a multispecialty group practice, Medical Associates Clinic and Health Plans is also an insurance company. We sell prepaid health care to several of the major employers in the area. And I think that is probably good because it helps the docs stay sensitive to cost. I think that having an in-house plan and being concerned about expenditures for part of the population actually extends to the whole population. In this way I guess you could say we have some of the features of the accountable care organization model currently under discussion as part of health care reform.

JGIM: Are you saying that having an in-house plan functions as an antidote to the otherwise perverse incentives of fee-for-service? Why not just dump fee-for-service entirely?

CS: Fee-for-service may not be the problem. Or at least not the whole problem. The bigger issue from my perspective is that fee-for-service is inequitable across specialties, and it isn't really aligned with what patients need. Patients need prevention and care coordination and end-of-life counseling. Those things aren't highly reimbursed in our current fee-for-service environment, but that isn't the fault of fee-for-service. The real problem is the

relative rate of reimbursement for different services.

JGIM: What are some of the important challenges your practice has faced?

CS: One of the biggest was when our health plan lost the contract with the largest employer in town—John Deere, the tractor manufacturer. That was 15 to 20% of our total clinic business and 35% of my own personal practice. This was an economic crisis for us, and the instinctive reaction was to standardize everything, to make everyone the same, to have everyone arrive at 8:00 a.m and leave at 5:00 p.m. But some of us resisted, arguing that our strength is that we allow physicians to have job control and decision authority within their own working environment.

JGIM: And that argument won the day?

CS: Not only did it carry, it led to some other changes which have made a big difference in the long run. First, we started to offer same day access to our patients. We developed a scheduling system that allows patients to see their own doctor the very day they call in to report a problem. Second, we prevailed upon most of the subspecialty departments to agree to see patients within 1 to 3 days of referral. Both initiatives have been very successful, and I don't know that we'd have been able to implement them had we not been forced to act by the crisis.

JGIM: No matter what the shape of insurance reform, real progress in improving the quality and value of care is going to happen at the level of *practice* reform. What have you learned at Medical Associates Clinic that might be of value to physicians seeking to improve their practices?

CS: In my experience two of the most important ways to drive quality are to develop an organized system of care and to improve access and continuity with patients' personal physicians. In our practice this means planned care appointments, pre-appointment labs, thoughtful distribution of the tasks among a small team, and same-day access appointment schedules.

At Medical Associates Clinic we are by no means "there" when it comes to practice reform. Comprehensive primary care is a tall order. And every day we fall short of our best intentions. I believe it is important to be willing to fail as you try to make things better. Not every innovation we've tried has worked. But that's ok. We keep working to improve. And that has been fun.

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