



HOUSE CALLS

Some Portland doctors and nurses want to do more than just treat patients—they want to fix the broken US health care system. Here's how a group of community clinics is cutting costs, improving their clients' health, and transforming the doctor's office into a place where patients feel at home.

**by JILL
DAVIS**

PHOTOGRAPH by ADAM LEVEY



tions that new refugees need—and lined on both sides by exam rooms, twenty-six in all. When I remark with surprise at the size of the place, Cockrell responds with a laugh. “Well,” she says, “we’re pretty busy.”

That turns out to be something of an understatement: the Mid-County Health Center, which opened in 1993, is the busiest community clinic in the metro area. Its twelve doctors and nurse practitioners, nine registered nurses, two licensed social workers, and two licensed practical nurses see, on average, 150 people per day; in 2008, the clinic was on schedule to have logged some forty thousand patient visits.

Given the many challenges the clinic faces every day (the volume of clients, the logistical problem of finding someone who can say “blood sugar test” in an East African language), it seems an unlikely setting from which a major health care innovation might emerge. But in summer 2007, the clinic decided to implement an entirely new approach to caring for its many patients by joining Primary Care Renewal, a project funded and led by [CareOregon](#), the Portland-based nonprofit medical plan administrator that serves Oregon Health Plan enrollees. (Mid-County was joined by four other health centers: Central City Concern’s [Old Town Clinic](#), which primarily serves Portland’s homeless population; [Virginia Garcia’s Cornelius Center](#), which serves migrant and low-income families in Washington County; Oregon Health & Science University’s [Family Medicine Clinic at Richmond](#); and [Legacy Emanuel’s internal medicine clinic](#), both resident clinics).

Primary Care Renewal’s goals are deceptively simple: the clinics want to prove that they can improve their patients’ overall health as opposed to simply treating acute problems like the flu; make doctors and patients happier with their health care experience; and, perhaps most important, reduce costs to the health care system overall. “It makes sense that if you can keep people healthier, then your costs will be under control, because primary care is relatively inexpensive compared to hospital stays or emergency care,” says CareOregon medical director David Labby, who helped design and launch the project. If this new model for primary care, called the “medical home” or the “primary care home,” proves successful, these five clinics could become showcases for primary care reform around the country.

Before embarking on the project, Mid-County Health Center took care of its patients the way many primary care clinics do—including those that accept only patients with private health insurance. Its doctors, whose schedules were “filled to overfilled,” as Cockrell puts it, saw as many patients as possible in a day, a necessity because of the high demand for appointments, and because Medicaid, like most health insurance plans, reimburses clinics only for the visits in which patients actually see physicians.

During the twenty minutes allotted for each appointment, Mid-County’s doctors treated everything from lacerations and rashes to chronic conditions like Type II diabetes, hepatitis C, and hypertension. Patients rarely met with their designated doctors, and they certainly didn’t know nurses or medical assistants by name. Even more troubling, the doctors and nurses and medical assistants didn’t know their patients as well as they could have; staff had no big-picture strategy for monitoring, say, whether a fifty-year-old patient with Type II diabetes was current with blood sugar tests. “We didn’t put a lot of attention into tracking chronic conditions,” Cockrell says. With demand for the clinic’s

services so great, “We were just focused on trying to get people who needed an appointment in to see someone.”

It might be tempting to see Mid-County’s situation as symptomatic of just another overburdened public-health clinic. But that is not the case. The quality of primary care in the United States is deteriorating at all levels, according to numerous studies. Supported by the so-called “fee-for-service” insurance system, harried primary care physicians, in order to make a living, must rush from room to room to room, flipping through charts at the last possible minute, a mode of practice that an oft-quoted [2000 editorial](#) in the British Medical Center’s journal, *BMJ*, dubbed “hamster health care.” (“Doctors are miserable because they feel like hamsters on a treadmill,” the piece begins. “They must run ever faster just to stand still.”) In a 2006 *New England Journal of Medicine* article titled “[Primary Care—Will It Survive?](#)” Thomas Bodenheimer, a doctor at the University of California, San Francisco, and one of the most prolific writers on primary care’s problems, summed up the system’s dysfunctions: “Patients are increasingly dissatisfied with the care and the difficulty of gaining timely access to a primary care physician; many primary care physicians, in turn, are unhappy with their jobs, as they face a seemingly insurmountable task; the quality of care is uneven; reimbursement is inadequate; and fewer and fewer US medical students are choosing to enter the field.” In a report the same year, the [American College of Physicians](#) put it even more bluntly: “Primary care, the backbone of the nation’s health care system, is at grave risk of collapse.”

Cockrell leads me to an office area where Dr. Deane DeFontes works literally elbow-to-elbow with a nurse, a medical assistant, and a team assistant, a spatial arrangement that is integral to the clinic’s medical home model. While doctors once worked alone in one room, they now work in teams; “co-location” fosters increased communication among team members. Each team manages a specific roster, or panel, of clients, addressing not only urgent issues but also any chronic conditions, a task made easier by the center’s electronic health records system. Doctors still rush from room to room (demand for appointments hasn’t dropped, and each

PATIENTS WHO ONCE WAITED WEEKS TO GET AN APPOINTMENT NOW CAN USUALLY GET ONE WITHIN THREE DAYS. THEY ALSO KNOW WHO THEIR DOCTOR IS AND WHICH NURSES AND MEDICAL ASSISTANTS WILL TREAT THEM.

team’s roster of patients is 10 percent too large), but instead of trying to glean essential information about patients while loping down the hall, the teams now “scrub” the schedules each morning in order to make sure records are in order and to make sure all of the patient’s preventive care, such as pap smears, mammograms, and cholesterol checks, has been performed.

Each month, Cockrell pulls data for teams covering everything from the percentage of patient no-shows (a statistic that can point to inefficiencies) to how often patients see their designated pri-

mary care physician (as opposed to a substitute). She also pulls preventive health numbers: the percentage of diabetics who have had their blood sugar tests within six months, for example, or the number of hypertensive patients whose blood pressure is under control. “One team just hit 91 [percent],” Cockrell says, referring to the percentage of diabetics who are up to date on their blood sugar tests. “It used to be, OK, well, if you need one of those tests, come back in three weeks,” says Suzanne Maroon, a registered nurse and one of DeFontes’s teammates. “Now it’s like one-stop shopping. . . . It’s a much better service for patients.”

Patients who once waited weeks to get an appointment—a time lag itself is a barrier to providing good health care—now can usually get one within three days. Patients also know who their doctor is, and even which nurses and medical assistants will treat them. “It’s what care should have been all along,” DeFontes says.

After beginning the project with one team, Mid-County has spread the model throughout the clinic. Now Multnomah County is implementing the model at its East County clinic in Gresham. “The question was, Can we give good, affordable care when our resources are more limited?” DeFontes says.

The answer seems to be yes.

THE PRIMARY CARE Renewal project really began in 2002 and 2003—years when CareOregon’s future looked bleak. A recession had recently hit, and then the Oregon Health Plan announced severe cuts to its rolls. “We were facing a problem of nearly going out of business,” says CareOregon’s Labby. “We knew we couldn’t just expect more money [from the government] just because medical costs were rising. We had to have a long-term, sustainable business model.”

Patients with difficult, chronic medical problems were by far the most expensive to treat. Twelve percent of CareOregon’s clients used some 60 percent of the funding. “Data shows that when you have two, three, four medical conditions, costs skyrocket,” Labby says. CareOregon wondered whether it could reduce the money spent on these patients by helping community health centers, which serve many of CareOregon’s clients, focus on those with chronic conditions. “The more you can help these people stay healthy, the more you have a chance of keeping them out of the costly emergency room and out of the hospital. That’s good for them and good for you,” Labby says.

Labby, a general internist, anthropology PhD, and close follower of health care theory, had been reading about [Southcentral Foundation’s](#) Anchorage Native Primary Care Center, a clinic that was doing things differently. Located in Anchorage, Alaska, the clinic once faced precisely the kinds of problems that many health centers do: patients had to wait weeks—even months—for an appointment, which increased demand for costly urgent appointments and prevented patients from getting the health care they needed.

Then a new administrator came in and insisted the clinic could, and would, deliver world-class health care to the region’s Native Americans. Over a period of years, the staff jettisoned the old way of working and, together with patients, rewrote a primary model focused on giving every patient the kind of care he needed—and wanted—when and how he wanted it. “They call their patients ‘customer owners,’” Labby says of the patient-centered approach. “Because if you think about where the money comes from, it comes from employers and taxpayers.” Not only did the clinic work to improve its customers’ physical health, but it also worked on their mental and behavioral health problems—a practice known as whole-person care in popular medical parlance.

In 2006, Labby and thirty others—CareOregon staff, local community health center managers, and even state legislators—took a trip to Alaska. It’s not an exaggeration to say the trip had a profound effect. “I took three pages of notes in the first hour,” says

you happen to have private health insurance through your employer, you won’t come to Multnomah County’s [Mid-County Health Center](#) for medical care. The clinic is housed in a concrete box of a building on SE Division Street near 127th Avenue—its exterior unembellished save for the blue-and-green *M* that is the county logo. Just past the entrance, a security guard watches over the parking lot; another sits near the intake bays of the waiting area, just beneath the sign reading “Welcome to Mid-County Health Center” in five languages.

The Mid-County Health Center is one of the Portland metro area’s seventy-five community health clinics—those nonprofit or community-run clinics that are eligible for federal funding and serve very low-income people as well as the uninsured. Between 70 and 75 percent of the patients on its roster are enrolled in the [Oregon Health Plan](#), the state’s Medicaid program, which covers some 386,000 people. The other 25 percent (besides the small number of patients on Medicare) have no insurance at all.

Owing to the clinic’s contract with the US Department of Health and Human Services, refugees who settle in Oregon receive their very first medical checkups in the United States here, and many stay on as long-term patients. At last count, Mid-County was serving clients who spoke fifty-two different languages; to manage this diverse pool of patients, it employs five full-time interpreters.

One morning in November, I meet Mid-County’s program manager, Deborah Cockrell, in one of the clinic’s two large waiting areas, where fifty or so chrome-and-plastic chairs line the walls and sit in long, economically arranged rows. Thanks to a federal grant, the space is getting a face-lift. (“And boy, we needed it,” Cockrell says.) Wood beams, new intake desks, and warmer colors will transform the institutional space into a friendlier one.

Cockrell leads me through a door marked “Employees Only” (in English, Spanish, and Russian this time) and down a long hall decorated with posters—one that’s titled “Peoples of Mainland Southeast Asia,” one listing the immuniza-

For more information on the subjects in red, go to this story on [portlandmonthlymag.com](#) and click on the links.

Craig Hostetler, executive director of the [Oregon Primary Care Association](#). “Everything they did was centered on a strong relationship with the patient and the family—not just cranking a patient through.”

And the resulting data was staggering: by employing phone consultations and allowing patients to see nurses in lieu of doctors for certain procedures, the clinic drove down wait times so that every patient who needed an appointment could be seen the very day he or she called. As the number of regular visits with family physicians rose, the number of costly urgent care visits dropped. (The clinic logged some 3,300 urgent care visits in July 2002, before the changes took full effect, and just some 2,000 in July 2007, an all-time low.) The number of emergency room visits also fell, from fifty-nine per one thousand patients in January 2000 to thirty-five per thousand in January 2008. Southcentral, which serves fifty-five thousand Native Americans at every income level, now is recognized as a model for how health care systems should function.

But Southcentral had some advantages that Portland’s community care centers do not—it receives a set amount of money per patient from Indian Health Services and other agencies (along with some other fee-for-service funding), which means that clinic leaders can spend the money as they see fit. Also, Southcentral is affiliated with a hospital and a mental health center. This makes whole-person care a bit easier to manage. Was it possible, CareOregon and Portland clinic directors wondered, to replicate the excellent care within the limits of a fee-for-service system? “Ultimately, we agreed that we couldn’t not try it,” Labby says.

CareOregon offered a grant to the five community health centers to work on Primary Care Renewal, which would be guided by five principles: it would be a customer-driven system instead of a schedule-driven one; it would focus on the relationship between the clinic staff and the client; employ a team-based approach; embrace proactive care so that instead of, say, waiting for a fifty-five-year-old woman to call and schedule a mammogram, the clinic would call her; and it would integrate behavioral health. Behavioral health turns out to be important, since, as Labby puts it, the way a patient takes care of himself between doctor visits is what’s most important to health.

The foundations for the idea of medical home began in the late 1960s, when parents of kids with complex health problems complained that their children’s medical records were scattered among many physicians and locations. “The system was fragmented; no one was in charge,” Labby says. In response to the problem, the [American Academy of Pediatrics](#) coined the phrase “medical home” in 1967, arguing that what parents needed was a centralized place for medical records and a coordinating doctor.

With its definition much expanded and primary care in shambles, the medical home model today is being hailed as a way to solve the health system’s problems. It’s been touted by the four largest trade associations representing primary care doctors, including the American Academy of Pediatrics and the American College of Physicians, and even by President-elect Barack Obama. The medical home also figured into the 2007 Healthy Oregon Act, which directed the Oregon Health Fund Board to revamp the Oregon Health Plan and develop a state health program that, among other things, emphasizes preventive care and chronic disease management and “promotes a primary care medical home.”

But a considerable knowledge gap remains between the medical home as a theory and a practice. Few clinics have tried to implement the model, which means that no one really knows how or if it could work on a large scale. Locked into a fee-for-service insurance system, clinics have no incentive to hire medical assistants and nurses, who are integral to the team-based approach to care. “... [The] current policy buzz may be stimulating unrealistic expectations about the medical home’s immediate potential,” a group

of doctors, including two from the respected Washington, DC-based think tank the [Urban Institute](#), wrote in the September/October issue of [Health Affairs](#), noting that the medical home model requires successful demonstrations showing how it might operate in a day-to-day clinical setting. “It would not be the first time that a good health policy idea was judged to be a failure because of premature promotion.”

That’s why Labby and other medical home enthusiasts argue that projects like CareOregon’s are so important. Without evidence that it can and will work, the medical home, which on paper reads like a perfect antidote to primary care’s ills, may remain theory alone.

WHEN JENINE NAPOLI, forty-six, walks through the halls of Central City Concern’s Old Town Clinic on W Burnside Street downtown, the nurses, doctors, and medical assistants stop to chat with her. It’s hard not to: Napoli is a habitual smiler, a waver and a gabber, the sort who asks *How you doing?* and won’t settle for a one-word answer. She’ll talk about anything—including the problems that brought her to the Old Town Clinic in the first place, namely an addiction to crack and alcohol. Low on funds to support her habit, she wrote some bad checks and eventually ended up, for the second time, in Hooper, Central City Concern’s detox center.

“This place is a God shot,” she says of Central City Concern. “It really is.” After twenty-one months of sobriety, Napoli is studying nursing at Portland Community College and lives in an apartment in Central City’s Richard L. Harris Building, around the corner from the clinic. She tells me that her primary care doctor is Barbara, her acupuncturist is Chuck, her medical assistant is Patty. “These guys helped save my life,” she says. On the day I meet her, her doctor has just taught Napoli a song to help her remember the parts of the nervous system for physiology class.

“Our primary commodity is relationships,” explains Ted Amann, Central City’s director of health care. “With no relationships, nothing happens.” Old Town Clinic’s clients, 45 percent of whom have no health insurance and many of whom are homeless, love the clinic not only because they don’t feel judged here, but also because they know their needs come first. Old Town is the closest thing to a home many of its clients have. “Even if my situation changes and I have a good job,” Napoli tells me, “this is where I’m coming [for care]. Barbara is my doctor, and she always will be.”

Since implementing the medical home model, Old Town beefed up its staff for a period of time until it cut its average wait-time for an appointment from seventeen days to three; routine exams and preventive checkups that once fell lower on the priority list now are considered as important as acute problems. The staff works in three teams—Team Burnside Bridge, Team Skidmore Fountain, Team Park Block Pioneers—and each patient knows which team he or she belongs to. Team members’ names are displayed at the intake desk.

Other aspects of the medical home have been more difficult to manage. For one thing, because many of Old Town’s clients are homeless, it’s harder for staff to summon them for regular checkups or remind them about appointments. Old Town lacks the funds to buy an electronic health records system, which can cost some \$1 million; this leaves staff to pore over paper files that can stack a couple of inches thick. And while behavioral health consultants at other clinics primarily may help patients with simple concerns like how to set goals for a weight-loss program or how to handle

stress that might prevent someone from taking his medication on time, that sort of counseling can have little effect on someone who is worried about where he’ll sleep tonight. “Most people have no family, no nothing,” says Eryn Joyce, the clinic’s behavioral health consultant, who also has treated people who are suicidal, or high on methadone, or in extremely abusive relationships.

Perhaps most difficult is changing the culture of the offices themselves. Each clinic in the Primary Care Renewal project faces a unique set of circumstances (serving immigrants, the homeless, working with a revolving cast of medical residents) that makes it impossible to prescribe a single model that works in every setting. Change, for many staffers, is difficult. “We can only move at the speed of relationships,” says Maryna Thompson, who manages Legacy Emanuel’s internal medical clinic. She adds that developing trust among team members is crucial. “There just isn’t a book out there that says, ‘This is how thou shalt do primary care renewal.’”

Even learning how to manage seemingly minute details requires an endless process of trial and error. When Multnomah County decided to switch off the automated appointment reminder system, for example, teams at Mid-County had to figure out how to make the calls themselves. (No small task considering the language barriers involved.) On DeFontes’s team, one person agreed to coordinate the Spanish calls with an interpreter; one bilingual medical assistant agreed to call the Russian clients; calls made in English fell to the team assistant (and the whole team agreed to create space and time for him to do it); calls in other languages, like Burmese or Arabic, would be funneled through the Multnomah County lan-

SINCE THE CLINIC BEGAN THE PRIMARY CARE RENEWAL PROJECT, THE NUMBER OF DIABETICS WHO MISS THEIR SCHEDULED BLOOD SUGAR TESTS HAS DROPPED BY 26 PERCENT.

guage line. But not everyone was happy with their new administrative duties. “You have to have buy-in, which is true of all change,” says DeFontes, noting that even the medical home doubters have to be brought along.

MARYNA THOMPSON, Legacy Emanuel’s internal medicine clinic manager, calls herself a “crusty old nurse,” but that’s a cover. She’s a small, high-energy woman of fifty-five with dark hair that’s crisply bobbed. A former CareOregon board member, she came to the teaching clinic two years ago to implement the medical home here.

“Sometimes I liken the [old way of doing things] to [throwing] a party, but you didn’t know how many guests would show up or what they wanted,” she says. She shows me the screening tool her staff created to improve their chronic care management—essentially a checklist of preventive tests, immunizations, and labs. Stored in the patient’s file and updated at every visit, the sheet is an example of how simple changes can have a big effect. Since the clinic began the

Primary Care Renewal project, the number of diabetics who miss their scheduled blood sugar tests has dropped by 26 percent.

Most impressive is how the clinic has saved CareOregon money. By pulling claims data, Thompson found that out of the clinic’s nearly four thousand patients, about fifty were chronically going to the emergency room; after interviewing them, Thompson found they were overusing the ER for a variety of reasons. “Maybe it was for chronic pain or psychosocial issues, or maybe just because they didn’t want to wait to be seen here,” she says. The nurses, behavioral health consultant, and pharmacists decided, as a group, to give those patients even more attention—in some cases, Thompson called members of the patient’s family and invited them to participate in discussions about the patient’s health plan. “We had to get them back and get them engaged with us,” she explains.

The results are paying off. By getting just fifteen to twenty of those patients to use the emergency room less frequently, the clinic is saving CareOregon about \$1 million per year. Thompson’s group did the same for no-shows. They pulled a list of patients who chronically missed appointments and called each one—not once, but twice. The no-show rate has dropped by 20 percent.

Those figures seem to prove that the medical home model can improve care. Then again, these clinics are highly motivated. Not all doctors *want* to change the way they care for patients, or reorganize their offices. Plus, there is the more pressing matter: if it weren’t for the CareOregon grant, there would be no incentive, other than magnanimity, for these clinics to make such radical adjustments. The truth is, even if these five clinics prove the model can work, insurance companies must support primary care in a way that actually promotes better health care. “We’re still operating in a widget-based system,” Labby tells me. “[CareOregon] started with the simple idea that [a doctor’s] job is the health of the population. Your job is not your schedule. If your job is your schedule, then your job is not health but [rather] only the number of people who are coming through the door.”

This year, CareOregon will begin paying each clinic not just for visits but also for outcomes. But if the medical home is going to become the standard for primary care, then most, if not all, health insurance companies will have to restructure their businesses. “We might be able to demonstrate the outcomes, but the question is, Can the payment system change to support us?” says Thompson. “We’re locked into a pay-per-visit system, and changing that is the key to transformation.”

The difficulties of cultural change apply just as strongly to the health insurance industry, though. “There is skepticism about whether [the medical home] saves money, about whether the delivery system is capable of change,” says Ralph Prows, senior medical director of [Regence BlueCross BlueShield](#) of Oregon, which has been funding what Prows calls a “medical-home light” pilot project of its own. Yet increasingly, insurers are realizing that the fee-for-service system isn’t working for their bottom lines, either. “Double-digit increases in medical costs are not sustainable,” Prows says. “And we’re meeting recommendations [for patient care] about half the time. It’s like a coin toss.”

Perhaps, as Labby hopes, clinics that prove costs are lower, patients are more satisfied with their care, and health outcomes are better under the medical home model will gain a competitive advantage and cause a kind of systemwide shift in approach. Or perhaps the change will happen in a more dramatic fashion.

Hostetler, of the Oregon Primary Care Association, once sat on a panel about the future of Oregon health care. When asked what he hoped for, his response shocked the audience. “I said I hope the system gets so bad that we have to throw it out,” he recalls.

If it does, perhaps community health centers—those safety nets for the toughest cases—will be recognized and copied for embracing a model of care that actually makes people healthier. ♡