

# Family Doctor

*A Journal of the New York State Academy of Family Physicians*



Fall 2026

Volume fifteen, Number two

*Focus:*

## Practice Management



### FEATURE ARTICLES:

- Financial Wellness and Career Readiness in Family Medicine: A Practical Guide for Medical Students, Residents, and Fellows
- Practice Management Strategies for Building Behavioral Health Integration (BHI) in Primary Care
- Practice Management Improvements in an Academic Outpatient Primary Care Practice; Concentrating on Split Billing, G2211 Modifier, Advanced Primary Care Model, and Resident Education
- Practice Management—Yet Another Area Where It is Easier with Direct Primary Care

*Family Doctor: A Journal of the New York State Academy of Family Physicians* is published quarterly. It is an online only journal and members are eligible for CME credit through the AAFP.

**New York State Academy of Family Physicians**  
99 Washington St., Suite 402  
Albany, New York 12210  
www.nysafp.org  
Phone: 518-489-8945  
Fax: 518-888-7648

Letters to the Editor, comments or articles can be submitted by email to penny@nysafp.org

Editor: Penny Ruhm, MS

**Editorial Board**  
William Klepack, MD  
Louis Verardo, MD  
Jocelyn Young, DO  
Ani Bodoutchian, MD  
Mary Kristine Ellis, MD  
Lovedhi Aggarwal, MD

**New York State Academy Officers**  
President: Wayne Strouse, MD  
President-elect: Ani Bodoutchian, MD  
Vice President: Jocelyn Young, DO  
Secretary: Marten Peterson, MD  
Treasurer: Cean Mahmud, MD

**Staff**  
Executive Vice President:  
Vito Grasso, MPA, CAE vito@nysafp.org  
Director of Education:  
Kelly Madden, MS kelly@nysafp.org  
Director of Finance:  
Donna Denley, CAE donna@nysafp.org  
Journal Editor:  
Penny Ruhm, MS penny@nysafp.org

**For Advertising Information**  
Contact Vito Grasso at 518-489-8945  
or vito@nysafp.org

*Content of articles does not necessarily express the opinion of the New York State Academy of Family Physicians. Acceptance of advertising and/or sponsorship does not constitute an endorsement by NYSAFP of any service or product.*

## Articles

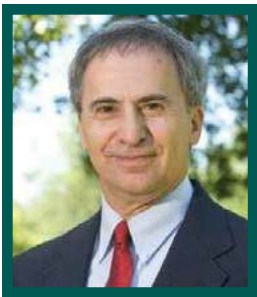
|                                                                                                                                                                                                                                                               |    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| <b>Financial Wellness and Career Readiness in Family Medicine: A Practical Guide for Medical Students, Residents, and Fellows</b><br>By Christine Persaud MD,MBA, FAAFP, FAMSSM; Laurenie Louissaint MD, MS; Darshit Patel DO; Gaurav Majmudar, MD, MPH ..... | 15 |
| <b>Practice Management Strategies for Building Behavioral Health Integration (BHI) in Primary Care</b><br>By Erin K. Ferenchick, MD.....                                                                                                                      | 20 |
| <b>Practice Management Improvements in an Academic Outpatient Primary Care Practice; Concentrating on Split Billing, G2211 Modifier, Advanced Primary Care Model, and Resident Education</b><br>By Michelle Lombardo, MD and Sangrok (Rikki) Oh, MD .....     | 25 |
| <b>Practice Management—Yet Another Area Where It is Easier with Direct Primary Care</b><br>By Wayne Strouse, MD.....                                                                                                                                          | 28 |
| <b>Implementing AI Ambient Scribes in an Urban Community Health Center to Achieve the Quadruple Aim</b><br>By Mellisa A. Pensa, MD, MPH; Hyung Paek, MD, MSEE and Laura Macleod, BSN, MED, RN .....                                                           | 30 |
| <b>Home-Based Primary Care: a Professionally Satisfying Practice Setting</b><br>By Konstantinos Deligiannidis, MD, MPH, FAAFP, FAAHCM, DABFM.....                                                                                                             | 36 |
| <b>Implementing Self-Collected HPV Screening in a New York State FQHC: Organizational and Operational Considerations for a New Testing Modality</b><br>By Anna Kaoutskaia, MD; Colleen Quinn, MD and Ephraim Back, MD, MPH.....                               | 38 |
| <b>Has the Much-Loved, Cash-Poor, Village Physician been Replaced?</b><br>By Thomas C. Rosenthal, MD .....                                                                                                                                                    | 44 |

## Departments

|                                                                                                                                                                       |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| From the Executive Vice President: Vito Grasso .....                                                                                                                  | 3 |
| President's Post .....                                                                                                                                                | 4 |
| Advocacy: Reid, McNally & Savage .....                                                                                                                                | 5 |
| <b>Two Views: Improving Clinic Operations</b> .....                                                                                                                   | 8 |
| <b>View One:</b> Why Clinics Run Late: Operational Analysis and Insights for Family Medicine<br>By Lewis Wong, MD                                                     |   |
| <b>View Two:</b> Root Causes of No-Shows from the Patient Perspective<br>By Joanne Dempster, MD, MHA; Alexia Cha, MPH; Alixandria James, MPH and David Rosenthal, PhD |   |

## Index of Advertisers

|                |    |
|----------------|----|
| Geisinger..... | 46 |
| MLMIC .....    | 47 |



## From the Executive Vice President

By Vito Grasso, MPA, CAE

The emergence and success of the democratic socialist movement has dramatically altered our political landscape. Although concentrated in the Democrat Party, the democratic socialist movement has had a broader impact on our political discourse and has captured the attention of even casual observers of politics.

Comparisons have been made to the tea party movement a generation ago which led to a dramatic shift to the right in the Republican Party and created the foundation for the MAGA movement and the elevation of Donald Trump to the presidency.

There are similarities in the tea party movement and the democratic socialist movement that are worth consideration as we contemplate the long-term impact of the DSA successes in Democratic primary elections. Both movements found impetus in festering public discontent with status quo politics. The success of the tea party movement is evident in the electoral success of conservative Republicans which has led to control of the Presidency, both Houses of Congress, and the Supreme Court by conservatives.

What, then, can we expect from continued electoral success of the democratic socialist movement within the Democrat Party? It remains to be seen whether the successes of the democratic socialists in several Democratic primaries will translate into success in general elections.

In NY, the Democrat Party controls the Executive and both Houses of the legislature. Success of several democratic socialists in primary elections will result in an increase in progressive members in both the Senate and Assembly. Single payer health care is a foundational objective of the progressive movement and the increase in vocal support for a single payer health system in NY could have significant impact on the disposition of the NY Health Act in the 2027 session of the Legislature. This is something we will watch closely as the need for systemic reform grows incessantly.

Profits of health insurance companies continue to grow with shareholder dividends diverting resources from patient care. Health systems continue to dominate and implement business practices which erode the professional independence of physicians. Costs continue to shift to patients and the growing burden of those cost shifts and the loss of premium subsidies in the public market has dramatically increased the population of uninsured and impacted patient behavior in using health care services.

Despite substantial support of the NY Health Act among Assemblymembers and Senators, strong opposition by the insurance industry, hospitals and public employee unions has dissuaded the legislative leaders from allowing the legislation to come to a vote in the Senate. It remains to be seen how the arrival of several new legislators with definitive socialist credentials and values will affect operations in general. The Assembly Speaker and Senate Majority Leader will be challenged to act on some progressive priorities to appease their new members. Given the significant support of the NY Health Act by so many incumbent Democrat legislators, it may be that passing the landmark single payer bill would become more palatable for the leaders than continuing to appease the insurance and hospital industries and the public employee unions. If that calculus proves to be accurate, we could see the NY Health Act or a compromise bill that moves significantly closer to a single administrative health care system, in the year ahead.

*Health systems continue to dominate and implement business practices which erode the professional independence of physicians.*



## President's Post

By Wayne Strouse, MD, FAAFP

This issue's topic—practice management, is a perennially “topical topic.” Much of practice management centers around getting paid for all the work you do. Unfortunately, a disproportionate amount of personnel effort and overhead cost is focused on this non-clinical area. It shouldn't have to be that way. Our colleagues north of the border (Canada)—with a single payer, non-corporate healthcare system spend one-quarter of what we do in time and money that is devoted to getting paid.

Of course, practice management also involves so much more—optimizing office scheduling, minimizing waiting times, getting prior authorizations for procedures, medications, and sometimes even consultations, as well as scheduling patients for consults with subspecialists, and practice marketing. These all keep physicians and staff unnecessarily busy, while distracting them from providing good patient care. And perhaps the epitome of practice management is creating a practice environment that is a great place to work! This keeps both physicians and patients happy, causes word of mouth advertising to flourish, and reduces turnover (of both physicians and patients).

Although this issue of *Family Doctor* doesn't focus on clinical care, it is designed to assist with maintaining our practices so that we can provide excellent clinical care. We ignore practice management at our peril. I have told my patients that “I am a doctor first, and a businessman second. However, I must be a businessman, for if not, I won't be able to be a doctor.” I have often wondered how many more physicians, and especially young physicians, would be in independent practice today if practice management weren't so daunting.

I thank those who have authored articles for our journal, and in doing so contributed to this vital area of medicine.

*Although this issue of Family Doctor doesn't focus on clinical care, it is designed to assist with maintaining our practices so that we can provide excellent clinical care.*

# Albany Report

By Reid, McNally & Savage  
September 21, 2026

As we head into the fall and quickly move closer to Election Day, New York's gubernatorial race between Governor Kathy Hochul and Republican Nassau County Executive Bruce Blakeman is heating up. The cost of living, public safety, and President Donald Trump are prominent concerns along with energy policy and immigration. While the [latest polls](#) continue to show that the Governor leads Blakeman, her advantage has narrowed from earlier in the year and this will certainly be a contest to watch given a major focus on affordability and New York's last gubernatorial election was much closer than expected.

Considering the broader political and policy landscape, New York and Washington are entering a consequential period shaped by many of the issues mentioned above as well as the looming significant changes coming to Medicaid. Some impacts have already begun as federal changes have left just over 175,000 New York residents without Essential Plan health coverage. Looking to the 2027 legislative session, which will start in early January, New York policymakers will have to confront a projected multi-year budget gap while balancing growing costs for several programs and the impact of federal funding and policy decisions.

Below we have provided an update on the Medical Aid in Dying (MAID) Law as well as a summary of ongoing advocacy efforts and priorities that we will continue to work with NYSAFP to address.

## **MAID Law In Effect and Related State Department of Health (DOH) Regulations Issued**

Following Governor Hochul signing the bill into law in February, DOH issued proposed [regulations](#) this summer, adding Part 1008 and section 35.7 to Title 10 NYCRR, ahead of the law's effective date of August 5, 2026.

The regulations, summarized below, focus primarily on physician reporting, prescription requirements, confidentiality, and death-certificate procedures and supplement the many broader MAID eligibility and process requirements.

**1. Reporting** – The regulations require that the attending physician who prescribes the MAID medication to electronically submit information to DOH within five days of issuing the prescription. Information reported to DOH would include:

- A unique patient identifier;
- Name, professional license title and New York State (NYS) license number of the attending physician, consulting physician, and mental health professional;
- The patient's terminal illness or condition;
- Information contained in the prescription including the medications prescribed, strength, and dosage form;
- Patient age and gender;
- Patient's care setting (such as facility or private residence) and NYS county of residence; and
- An affirmation regarding the involved professionals' compliance with the MAID law requirements

DOH would also be permitted to request additional information to determine utilization and compliance with the law.

continued on page 6

2. **Prescription Requirements** – A prescription issued for MAID must include a designation identifying it as “MAID.” The prescription must also indicate that it cannot be filled until five days after it was written unless the attending physician determines that the patient is likely to die within that period, as detailed in the underlying law.
3. **Death Certificates** – When a patient dies after self-administering MAID medication, the patient’s underlying terminal illness or condition is to be identified as the cause of death on the death certificate. If a death certificate does not properly identify this, DOH may notify the medical provider responsible for the certificate and the provider would then be required to correct it.
4. **Self-Administration** – Providing additional guidance on what qualifies as self-administration, a patient may use a tool or assistive device to help self-administer the medication, but the patient must perform the final physical act that results in administration. It cannot be an injection, infusion, or administered by another person as noted in the underlying law.
5. **Confidentiality and State Reporting** – Information collected by DOH through the reporting process is intended to allow the State to assess utilization and compliance with the MAID law. The DOH Commissioner is responsible for the privacy and security of this data which will be used to prepare the annual report to the Legislature. The report will also be posted on DOH’s website.

**Other Provisions and Clarifications** – Concerning individuals who may have a financial conflict of interest that prevents them from serving as a witness or interpreter in connection with a MAID request, DOH provides the following examples of individuals who would benefit:

- Those who would inherit as an heir under a will;
- A distributee of a patient who dies intestate; or
- A beneficiary of a life insurance policy covering the patient

These restrictions also apply to anyone who may interpret for a patient who requires interpretation of information into a language other than English. Additionally, unused MAID medication must be disposed of in accordance with existing requirements governing the disposal of unused narcotics.

We again thank NYSAFP and all members for your advocacy and dedication to this key priority. This major achievement could not have happened without NYSAFP’s leadership and support and will ensure that terminally ill patients in NYS, now and for years to come, have bodily autonomy and choices.

## Ongoing Advocacy

**Vaccines:** NYSAFP and RMS continue to lead a vaccine coalition in New York (Let’s Get Immunized NY (LGINY)) to help support education and advocacy around immunizations for children and adults and have been working diligently to ensure vaccine access and coverage in NYS given ongoing uncertainty with federal vaccine changes. In August, the Trump administration issued an [Executive Order](#) introducing a new federal vaccine framework: recommending routine childhood vaccination for only 11 diseases, calling for vaccines to be administered during separate visits rather than giving several during the same appointment, and proposing splitting the MMR vaccine into three separate immunizations. LGINY issued a [statement](#) urging New York lawmakers to remain committed to backing the safety and importance of vaccines. Positively, State Health Commissioner McDonald confirmed New York is rejecting those changes and medical organizations including the AAFP, AAP, ACOG and others, continue to issue evidence-based vaccine guidance independently of the federal government.

Additionally, amid the ongoing spike in measles cases across New York and many states across the U.S, NYS DOH launched a new [measles database](#) this month. Sharing in a recent [press release](#) that many of the cases are in upstate New York and are associated with both local transmission and domestic travel, State Health Commissioner McDonald emphasized the work DOH is doing to track and contain the uptick. He also encouraged New Yorkers to check their vaccination status to protect themselves and their families.

As Let’s Get Immunized New York moves into year 6 in 2027, and considering the aforementioned evolving situations, we’ll continue to work with partners to provide New Yorkers with reliable and trustworthy information and advance the bill requiring adult vaccine reporting to the State Immunization Registry. We’ll also remain vigilant of efforts to weaken New York’s vaccine laws and oppose them if they arise.

**Primary Care Recruitment and Training:** The Academy has long supported legislation to establish a personal income tax credit for clinicians who provide preceptor instruction to students, S7701/A2230. While the Senate passed the bill in the final days of the 2026 legislative session, it was held in the Assembly’s Ways & Means Committee. Given the need for funding, NYSAFP leaders recently met with partners to strategize ahead of the 2027 budget process. Details still need to be decided, however the group came to a consensus that creating a 3-year pilot program would help to overcome initial fiscal concerns, build greater support, and gather evidence of the effectiveness of the concept.



**Insurance & Payment Reforms:** We are continuing to advocate for a single payer system (S3425/A1466) and pursue greater investments in primary care by supporting legislation to require a minimum investment of the health care spend in the State for primary care (S1634-A/A1915-B). We also will continue in 2027 to advocate for insurance simplification and reforms to remove insurance barriers to access to care and time-consuming processes imposed on physician practices.

At the federal level, NYSAFP recently submitted comments in opposition to a regulation proposed by the Centers for Medicare and Medicaid Services which includes a proposal to reduce pay for services reporting on the same day with Modifier 25. The comments emphasized the strain denying separate compensation for two distinct services would put on physicians, the negative impacts it would have on patients, and ultimately, respectfully urged that this proposal not be implemented to prioritize value-based care. NYSAFP members were also called to action to provide individual comments when this cut was initially proposed in 2019 and the amount of pushback CMS received led to them withdrawing it.

Additionally, ahead of the 2026 midterm elections and given concerns about rising insurance premiums and healthcare access, Medicare for All is gaining renewed attention. We have heard that long-time advocate U.S. Rep. Pramila Jayapal (D-WA) plans to press her colleagues to consider the bill when Congress returns in October. While enactment is not expected in the immediate future, she shared with [Politico](#) that this effort will hopefully sort out any disagreements about the legislation and lay the foundation for progress with changes in leadership coming in the next years.

**Reproductive & Gender-Affirming Care:** NYSAFP has signed on to a letter issued by the New York Civil Liberties Union to Governor Hochul urging her to sign the NY Health Information Privacy Act as soon as possible given unprecedented attacks on abortion access and LGBTQ communities. More specifically, this [legislation](#) establishes a framework for New Yorkers to reclaim and retain control of their healthcare information, and is broken into two sections. The first ensures that companies can do what they need to do with people's data for things that consumers would expect, such as providing the requested good or service or keeping their website on the internet. The second prong however, requires that companies ask for permission to do anything non-essential with consumers' information such as targeted advertising, AI utilization, and more, and enables people to opt-out without losing functionality.

We are also continuing to monitor federal [developments](#) as courts and the FDA consider potential changes to mifepristone prescribing rules. The Fifth Circuit Court of Appeals is reviewing a challenge that could ultimately reinstate requirements for in-person dispensing and restrict the use of telehealth and mail delivery, while the FDA is conducting a review of mifepristone and its prescribing requirements. NYSAFP and our firm are connected with a network of groups who can work with lawmakers to update, for example, New York's shield laws if issues are brought to our attention.

We would like to thank the NYSAFP Board, Advocacy Commission, Home Office and the full membership for your strong advocacy this year. We look forward to continuing to work with you to pursue priorities of import to family physicians and your patients into 2027.

## Upcoming Events

### 2026

**Board Meeting - Virtual;  
Commission meet virtually prior  
Oct. 31**

### 2027

**Winter Weekend in Lake Placid  
Jan 15-17**

**Winter Cluster  
Feb 21**

**Advocacy Day  
Feb 22**

# TWO VIEWS: IMPROVING CLINIC OPERATIONS

## VIEW ONE:

### WHY CLINICS RUN LATE: OPERATIONAL ANALYSIS AND INSIGHTS FOR FAMILY MEDICINE

By Lewis Wong, MD

At my New York City FQHC, our scheduling template gives fifteen minutes to acute visits and thirty minutes to preventive wellness visits. This timing provides several challenges. By the end of the morning session, we are routinely running thirty minutes behind, a deficit we absorb by working through lunch rather than by fixing the schedule. The afternoon session accumulates another thirty-minute deficit of its own, resolved only because our final patients of the day are scheduled as telehealth visits, flexible enough to be conducted an hour after clinic hours officially end. In other words, our clinic does not run on time. It runs on uncompensated overtime labor at the margins of the day to accommodate the current scheduling template. Recently, there have been proposals to switch our model to a different one: 20-minute flat models that our colleagues across town use.

So which template is preferable? Or, more precisely: are 15/30-minute or flat 20-minute templates better supported by how long primary care visits take in practice, or do they simply externalize the time deficit onto physicians' lunch breaks and evenings? I decided to test this directly, using national data, rather than treat either option as simply "the standard."

### TESTING THE TEMPLATES AGAINST REAL VISITS

I turned to the CDC's National Ambulatory Medical Care Survey (NAMCS), a nationally representative sample of U.S. outpatient visits collected annually.<sup>1</sup> Pooling the 2018 and 2019 public-use files and restricting the sample to family medicine and general practice visits yielded 6,083 visits (5,837 non-preventive and 246 preventive), weighted to represent typical annual national volume across those two years. For each visit, NAMCS records the physician's actual face-to-face time with the patient, which let me compare real-world visit lengths against three benchmarks: the 15-minute acute slot, the 30-minute preventive slot, and the proposed flat 20-minute slot.

Nationally, the average face-to-face time was 20.8 minutes for acute (non-preventive) visits and 22.8 minutes for preventive visits, meaning acute visits alone already sit at the edge of a flat 20-minute template before any other factor is considered. Breach rates sharpen the picture: 35 percent of all visits ran longer than 20 minutes, 56 percent of acute visits ran longer than their 15-minute slot, and only 12 percent of preventive visits ran longer than their 30-minute slot. As Figure 1 shows, visit durations cluster tightly right at the edge of each allotted slot rather than comfortably inside it; there is essentially no margin built in before a visit becomes a breach. The pattern extends beyond visit type: even among visits with a single diagnosis, average time approaches 20 minutes, and there is little additional time gained beyond three diagnoses (Figure 2).

## VIEW TWO:

### ROOT CAUSES OF NO-SHOWS FROM THE PATIENT PERSPECTIVE

By Joanne Dempster, MD, MHA; Alexia Cha, MPH; Alexandria James, MPH and David Rosenthal, PhD

### INTRODUCTION

No-shows, or missed appointments without notification of the provider or system, have serious consequences for patients, providers, and healthcare systems as they lead to delays in care, decreased continuity of care, wasted clinical resources and reduced practice revenue, increased costs, and reduced access to services. The global rate of no-shows is as high as 23% with an estimated cost in the United Kingdom of 750 million pounds per year.<sup>2</sup> While a number of studies have examined the reasons for no-shows, they continue to be a persistent issue for many health care systems. A number of interventions have been developed, for example, reminder systems, phone calls, and penalty fees for missing an appointment have all been implemented but the rate of no shows has stubbornly refused to decrease significantly.

In order to effectively reduce no-shows, we must first understand the reasons patients miss appointments and include the patient perspective. This examination must also go beyond patient reasons and also look at how our clinics are structured to assess whether they are a contributing factor to current no-show concerns. Once all factors are better understood, specific interventions can be developed to reduce rates that appear to be having a dramatic impact on many practices.

The purpose of this study is to examine the root causes of no-show rates from a patient perspective in a primary care practice. Patients from a family medicine practice site were interviewed after missing their appointments, to better understand the *why* from their perspectives. If the true root causes are not being addressed, systemic fixes will likely have very little effect. This paper offers some insight into this very important topic.

### METHODOLOGY

Data collection was conducted by two research assistants at an urban family medicine teaching practice affiliated with a large academic health system. Most of the patients receiving care at the clinic were Medicaid or Medicare beneficiaries. A total of 24,627 (monthly visits ranged from 1,774 to 2,377) primary care appointments were made for the year of the study. A total of 5,168 (21%) visits no-showed for the year.

Between September and April, the research assistants identified missed appointments from the electronic medical records via EPIC and contacted patients by phone approximately 1 to 3 weeks after

continued on page 9

continued on page 10

**Figure 1.** National distribution of face-to-face visit duration by visit type (2018–2019 NAMCS, N = 6,083). Dashed lines mark the 15-, 20-, and 30-minute template thresholds.

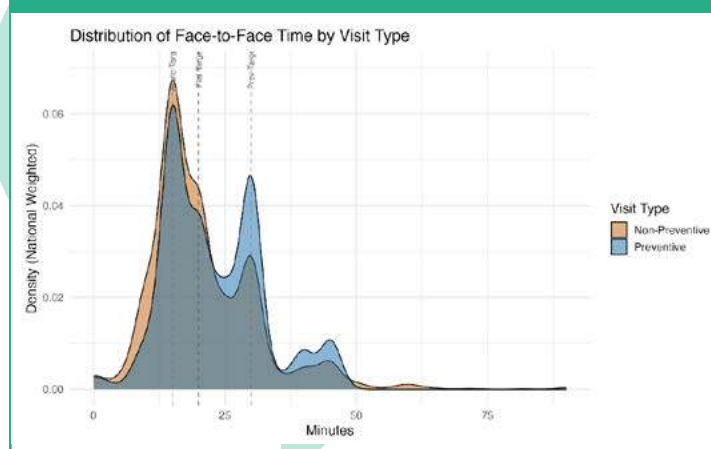
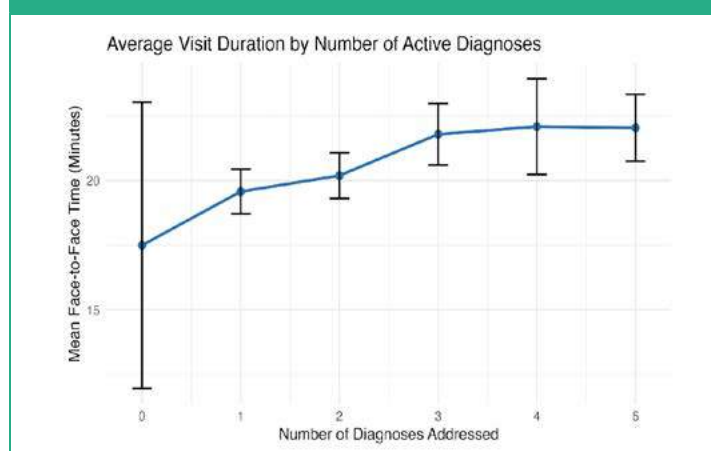


**Figure 2.** Mean face-to-face time by number of active diagnoses, with 95% confidence intervals (2018–2019 NAMCS).



## THE MYTH OF CAPACITY BALANCING

The split 15/30 template rests on an assumption I had never actually seen tested: that the extra time “saved” during shorter preventive visits is large and frequent enough to absorb the overruns generated by acute visits. If it isn’t, the split model fails for the same structural reason the flat model does. It just flies under the radar as the averages can look reasonable on paper even while the day falls apart in the exam room.

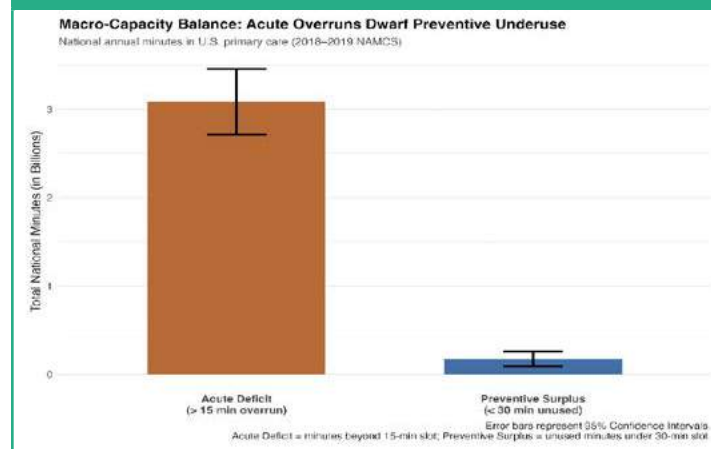
To test this, I calculated national annual minutes in two categories: minutes acute visits ran over their 15-minute allotment (the “acute deficit”), and minutes preventive visits finished under their 30-minute allotment (the “preventive surplus”). In other words, for every acute visit that ran long, I counted the extra minutes; for every preventive visit that ended early, I counted the unused minutes, then summed those nationally across the full year. If the split-template logic holds, these two figures should be roughly comparable, with surplus time on the preventive side offsetting deficit time on the acute side.

They are not close. Acute visits generated an estimated 3.09 billion minutes of national overrun annually. Preventive visits generated only 176 million minutes of unused capacity — an acute deficit 17.5

times larger than the preventive surplus. Even under the most favorable possible reading of the data (the high end of the preventive surplus against the low end of the acute deficit), the split-template system still runs a net national deficit of well over two billion minutes a year (Figure 3). Preventive visits, averaging 22.8 minutes, simply do not run short often enough, or by enough minutes, to rescue acute visits from running long.

This is not an argument that physicians are managing their time poorly. It is closer to the opposite: it is empirical confirmation of something many of us already feel — that the scheduling infrastructure itself lacks the structural surplus it assumes exists. The “surplus” side of the ledger is too small and too rare to matter at national scale, which mirrors the informal absorption mechanisms — lunch-hour catch-up, after-hours telehealth — that many practices, including mine, already depend on to make the template appear to function.

**Figure 3.** National acute-visit time deficit versus preventive-visit time surplus, in billions of minutes, with 95% confidence intervals (2018–2019 NAMCS).



## WHY THIS MATCHES WHAT WE ALREADY EXPERIENCE

These findings sit inside a growing body of research on time scarcity in primary care. Physicians consistently report a mismatch between the work expected of them and the hours available to do it, forcing daily tradeoffs between quality care and personal time.<sup>2</sup> This scarcity has been tied to rigid scheduling, large panels, and short visit lengths, with downstream effects on burnout, job satisfaction, and patient safety.<sup>3</sup> Independent time-motion research estimates that fully delivering guideline-recommended preventive, chronic, and acute care to a standard patient panel would require far more hours than a clinical workday actually contains.<sup>4</sup> National electronic health record (EHR) log data suggests each scheduled clinical hour requires meaningfully more total physician time once work completed outside that hour is counted.<sup>5</sup> Documentation alone has been estimated to add nearly twenty additional minutes to a standard visit,<sup>6</sup> and primary care physicians spend roughly three-quarters of their between-visit time working inside the EHR rather than with patients.<sup>7</sup> None of this shows up in a template built around a single number of minutes per visit type. It helps explain why the deficit identified in the NAMCS data likely doesn’t resolve itself at the end of a session — it compounds with EHR-based work that shifts into evenings and lunch hours, exactly the pattern many of us already live with.

continued on page 11

their missed appointment. During these calls, patients were asked a series of questions focused on understanding why they were unable to attend their scheduled visit. This list of patients was separated by visit type to identify primary care visit types vs. specialty visit types. The team focused on the primary care visit types such as well child visits, adult follow up visits, pediatric follow up visits, OB follow up visits and new patient visits. In total, 365 patients were contacted, with 164 participating in the survey (see Table 1).

Responses to the questions were gathered and reviewed by the first researcher who then created a list of categories that best described the reason for the missed appointments. The responses and categories were then reviewed by two other members of the research team who finalized the list of categories that best described the responses from the study participants.

At the time of the study, the clinic already had the following strategies in place to address no-shows:

1. Appointment reminders - Patients receive reminder messages 1 month, 2 weeks then days before their scheduled visits via text messages and telephone calls.
2. Continuity with primary care provider when possible - Attempts are made by the scheduler, when possible, to schedule a patient with their assigned primary care provider.

3. Appointment self-cancellations - Patients have the ability to cancel their appointments in EPIC.

While utilizing these strategies, the no-show rate at the clinic at the time of the study was 21%.

## RESULTS

The reasons for missed appointments were variable. A large portion of patients simply forgot to cancel their appointments. Another group of patients expressed difficulty with canceling their appointments or responded that the clinic itself actually cancelled the visit or provided confusing information regarding their appointments. Some patients specifically tried to call or reach out using mychart in advance to indicate that they could not make it to their scheduled appointment but were unsuccessful. Others provided reasons including having some type of emergency either work, health or family. Transportation issues with getting to the appointment was a concern for some patients. Finally, a number of patients said they had no awareness of their appointment. Table 2 overviews patient responses.

## STUDY LIMITATIONS

There are many gaps and limitations with this study. Telehealth sessions were not separated to determine whether this helped with

**Table 1 Describes the Sample Population.**

| Characteristic         | n (%)      | Insurance Coverage                     |           |
|------------------------|------------|----------------------------------------|-----------|
| <b>Gender</b>          |            | Healthfirst Medicaid                   | 74 (45.1) |
| Female                 | 121 (73.8) | Affinity Molina Medicaid               | 19 (11.6) |
| Male                   | 39 (23.8)  | Fidelis Medicaid                       | 17 (10.4) |
| Missing                | 4 (2.4)    | Medicare/Medicaid                      | 5 (3.0)   |
| <b>Language</b>        |            | Health Plus Amerigroup Medicaid        | 4 (2.4)   |
| English                | 95 (57.9)  | Healthfirst Essential Plan             | 4 (2.4)   |
| Spanish                | 40 (24.4)  | 1199 National Benefit Fund             | 3 (1.8)   |
| Other Language*        | 4 (2.4)    | Emblem HIP Medicaid                    | 2 (1.2)   |
| Missing                | 25 (15.2)  | Medicaid Computer Sciences Corporation | 2 (1.2)   |
| <b>Age Group</b>       |            | NY Medicaid                            | 2 (1.2)   |
| Adult                  | 113 (68.9) | Self- Pay                              | 2 (1.2)   |
| Child                  | 22 (13.4)  | VNS Medicare                           | 2 (1.2)   |
| Senior                 | 14 (8.5)   | Other Insurance Types                  | 12 (7.3)  |
| Adolescent             | 10 (6.1)   | Missing/None Listed                    | 16 (9.8)  |
| Missing                | 5 (3.0)    | <b>Appointment Time</b>                |           |
| <b>Visit Type</b>      |            | Morning                                | 74 (45.1) |
| Follow-Up Primary Care | 90 (54.9)  | Afternoon                              | 58 (35.4) |
| Follow-Up Pediatrics   | 19 (11.6)  | Evening                                | 7 (4.3)   |
| Follow-Up OB           | 15 (9.1)   | Missing                                | 25 (15.2) |
| New Patient Visits     | 9 (5.5)    |                                        |           |
| Same-Day/Urgent Visits | 11 (6.7)   |                                        |           |
| Video Visits           | 9 (5.5)    |                                        |           |
| Other Visit Types      | 6 (3.7)    |                                        |           |
| Missing                | 5 (3.0)    |                                        |           |

\*Other languages included Haitian Creole, Soninke, Arabic, and bilingual English/Spanish responses.

Total sample size: N = 164

continued on page 12

These operational pressures have consequences. Clinics that run late create prolonged cycle times that strain staff satisfaction and patient experience,<sup>8</sup> disrupt continuity and reduce patient compliance,<sup>9</sup> and damage patient trust and perceptions of care quality.<sup>10</sup> These are not isolated events; they are downstream effects of the same structural mismatches. When a template guarantees clinicians will run behind all day, it becomes a structural driver of clinical strain with no slack for the visits that need it most.

### WHAT CLINICS CAN ACTUALLY DO ABOUT IT

None of this means physicians should simply be told to “work faster,” and it doesn’t mean scheduling templates should be abandoned overnight. It means the fix has to address the structure, not just the individual visit.

Three evidence-based strategies emerge. The first is pre-visit planning (PVP), where the care team closes care gaps—labs, screenings, and missing measures—before the patient arrives, so the physician is not spending the first 5–10 minutes figuring out what is needed. This reallocates administrative minutes toward direct patient care.<sup>11</sup> The second is medical scribes or in-room EHR support, where a scribe or trained medical assistant absorbs real-time documentation, freeing the physician to work with the patient instead of the keyboard. This improves productivity, provider efficiency, and satisfaction without harming the patient experience.<sup>12</sup> The third is frontline scheduling autonomy, where care teams set visit length using a complexity rubric with guardrails and a monthly review process (see framework below). This improves efficiency, continuity, and outcomes versus a fixed slot length.<sup>13</sup>

The third strategy, scheduling autonomy, deserves a closer look. Without structure, it can devolve into uneven scheduling that creates its own inefficiencies. A practical framework includes three components.

**First**, adopt a complexity rubric anchored in the NAMCS time-by-diagnosis analysis. The data show a clear gradient: visits with zero diagnoses average 17.5 minutes, one to three diagnoses average 19–22 minutes, and four or more diagnoses average 22 minutes or more. Translating this into operational tiers: Tier 1 (~15–18 minutes) for medication refills, simple test result follow-ups, or other visits with no new diagnosis coded (the zero-diagnosis bucket in the NAMCS data); Tier 2 (~19–22 minutes) for one to three problems or well-controlled chronic disease follow-ups; and Tier 3 (~22+ minutes) for patients with multiple comorbidities, complex care coordination, or known high utilization. Frontline staff apply this rubric at the time of scheduling using information from the patient’s chart and the stated reason for visit.

**Second**, ensure the frontline staff are trained in the rubric. Instead of basing the schedule on just acute versus preventive visit type, the frontline staff makes the initial slot assignment using the complexity rubric. Physicians retain the authority to override the assignment when they know a specific patient requires more or less time than the rubric suggests. This preserves clinical judgment while offloading scheduling decisions from the clinical team.

**Third**, create a monthly review loop to continue the work this research started. While the NAMCS analysis provides a national benchmark, local tracking of overruns and early finishes generates the data needed to set practical guardrails such as caps on Tier 3 slots, float slots, or a time floor, and to adjust the rubric to your specific population. Over time, the clinic builds its own empirical understanding of its patient population’s complexity distribution, moving beyond our data analysis to a practice-specific model.

The first two strategies can be implemented inside a rigid template right now, and they largely explain why some practices weather a 15/30 or flat 20-minute schedule better than others. They reduce administrative minutes competing with clinical minutes rather than trying to compress clinical minutes themselves. The third is the longer-term fix, and it’s the one this data most directly supports: a fixed number of minutes per visit type, whether 15, 20, or 30, is a primarily top-down administrative choice that does not reflect clinical reality. Offered above is a framework that provides a better alternative, built for the complexity of actual patient care.

### CONCLUSION

I started this project because my own clinic is actively deciding whether to keep our 15/30 split template or move to a flat 20-minute model, and it would have been easy to treat either option as simply “the standard.” Running the numbers made concrete what I had only experienced anecdotally: the split model’s surplus-absorbs-deficit logic does not survive contact with national data, and that failure is not a rounding error as it is a seventeen-and-a-half-to-one imbalance. A scheduling template, like a clinical guideline, is a human choice, and it deserves the same scrutiny we would apply to any other protocol before we let it shape our days, our lunch hours, and our evenings. For clinics like mine still weighing this decision, the honest starting point is admitting that no fixed-minute template reflects how long primary care actually takes, and investing in the supports that close that gap, rather than assuming the schedule will balance itself.

A few caveats are worth noting. NAMCS is a cross-sectional survey of visits, not a longitudinal record of any one clinic’s day, so it cannot directly measure the lunch-hour or after-hours catch-up described above; that is motivating context, not something the dataset itself proves. It also captures only face-to-face time in the exam room, not charting or inbox work, so if anything these figures likely understate the true time burden. Findings are specific to U.S. primary care visits in 2018–2019 and may not generalize to other specialties or care settings.

### Endnotes

1. National Center for Health Statistics, National Ambulatory Medical Care Survey, 2018 and 2019 Public Use Data Files (Hyattsville, MD: Centers for Disease Control and Prevention, 2021).
2. M.-L. T. Nguyen et al., “Primary Care Physicians’ Experiences With and Adaptations to Time Constraints,” *JAMA Network Open* 7 (2024): e248827.
3. S. Satterwhite et al., “‘Good Care Is Slow Enough to Be Able to Pay Attention’: Primary Care Time Scarcity and Patient Safety,” *Journal of General Internal Medicine* 39 (2024): 1575–82.

continued on page 13

**Table 2 – Responses to No-Show Questions**

| Category                           | Number of Times Used | Definition                                                                                                                                                                                                                    | Examples                                                                                                                                                                     |
|------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Forgets to cancel "A lot going on" | 32                   | Respondent is aware of their appointment and an inability to make it yet does not remember or attempt to cancel in advance due to multiple factors. The respondent is overwhelmed with responsibilities and forgets to cancel | "Too busy/ overstimulated/ disorganized"<br>"I was out of the country"                                                                                                       |
| Clinic Issue                       | 23                   | Respondent cites issue on the clinic's end including receiving/acknowledging last minute cancellations, rescheduling, inaccurate documentation or unclear information provided regarding appointment rules/requirements       | "I attended the video visit"<br>"I received many confirmations and then one hour before they cancelled the appointment"                                                      |
| Attempted Cancellation             | 21                   | Respondent reports having attempted to call the practice or record in mychart in advance that they could not make it to their scheduled appointment                                                                           | "Tried to call, was put on hold then the call ended"<br>"I tried calling twice and left a message on mychart but did not get through"                                        |
| No Awareness of Appointment        | 20                   | Patient was not aware of their scheduled appointment or forgot about it with no other reasoning besides this                                                                                                                  | "It was not on my chart"<br>"I did not receive a text message"<br>"Mom is in grad school and Edward does not have phone"                                                     |
| Medical Emergency                  | 11                   | Respondent describes a last-minute medical issue as the reason why they did not show up to their scheduled appointment                                                                                                        | "I was in the hospital in labor"                                                                                                                                             |
| Child/Family Care                  | 10                   | Description of last-minute child or family care responsibilities as the reason they did not show up                                                                                                                           | "I had an emergency- mother was sick upstate"                                                                                                                                |
| Transportation/Mobility Issue      | 10                   | Respondent cites issues with transportation as the reason they could not make it                                                                                                                                              | "Got to the clinic 15 minutes late due to traffic"<br>"Did not have money for transportation"                                                                                |
| Work Emergency                     | 6                    | Respondent cites an unpredictable work event as the reason they missed their appointment                                                                                                                                      | "I got out of work late that day"                                                                                                                                            |
| Insurance Issue                    | 6                    | Issues related to insurance coverage preventing respondent from seeing or getting to their doctor                                                                                                                             | "Insurance was not accepted upon arrival"<br>"Waiting to receive car service from Medicaid; Needed a letter from the DR and it took a long time; over a month for an answer" |

decreasing no-show rates. The definition of "no-show" as marked in the EMR seemed to include last minute cancellations and inaccurate documentation. The patients were contacted between September and April and there may be variations in seasons and time of year that may affect no-show rates and may not have been captured. Expanding the study to a full year would likely provide a

more accurate sample. Additionally, there was no review of the length of time between scheduling and the patient's appointment to identify potential reasons why some patients "forgot" that they had an appointment. Some studies show that the longer the gap, the more likely that patients will no-show.<sup>3,4,5</sup>

continued on page 13

4. J. Porter, C. Boyd, M. R. Skandari, and N. Laiteerapong, “Revisiting the Time Needed to Provide Adult Primary Care,” *Journal of General Internal Medicine* 38 (2022): 147–55.

5. Christine A. Sinsky, Lisa Rotenstein, A. Jay Holmgren, and Nate C. Apathy, “The Number of Patient Scheduled Hours Resulting in a 40-Hour Work Week by Physician Specialty and Setting: A Cross-Sectional Study Using Electronic Health Record Event Log Data,” *Journal of the American Medical Informatics Association* 32 (2024): 235–40.

6. Richard A. Young, Sandra K. Burge, Kavita A. Kumar, Janiece M. Wilson, and Danielle F. Ortiz, “A Time-Motion Study of Primary Care Physicians’ Work in the Electronic Health Record Era,” *Family Medicine* 50, no. 2 (2018): 91–99.

7. S. A. Deeds, S. L. Hagan, S. E. Kath, et al., “Electronic Health Record Time Allocation Among Primary Care Clinicians at the Veterans Health Administration Using Virtual Observations,” *Journal of General Internal Medicine* (2025).

8. J. Robinson, M. Porter, Y. Montalvo, and C. J. Peden, “Losing the wait: improving patient cycle time in primary care,” *BMJ Open Quality* 9 (2020): e000910.

9. K. F. Alrasheedi, M. AL-Mohaithef, H. H. Edrees, and S. Chandramohan, “The Association Between Wait Times and Patient Satisfaction: Findings From Primary Health Centers in the Kingdom of Saudi Arabia,” *Health Services Research and Managerial Epidemiology* 6 (2019).

10. M. Mayo-Smith, L. E. Radwin, H. Abdulkerim, and D. C. Mohr, “Factors Associated With Patient Ratings of Timeliness of Primary Care Appointments,” *Journal of Patient Experience* 7 (2020): 1203-10.

11. Christine Sinsky and Denise Althaus, “Putting Pre-Visit Planning into Practice,” *Family Practice Management* 22, no. 6 (2015): 34–38.

12. Health Workforce Technical Assistance Center, “The Use of Medical Scribes in Primary Care Settings: A Literature Synthesis,” PubMed Central, 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8428869/>.

13. James C. Matulis and Rozalina G. McCoy, “Patient-Centered Appointment Scheduling: A Call for Autonomy, Continuity, and Creativity,” *Journal of General Internal Medicine* 36, no. 2 (2020): 511–14.

*Lewis Wong, MD, is a director of the New York State Academy of Family Physicians, and one of the chairs for both the Membership Commission and the Medical Humanities Committee at the NYSAFP. He currently serves as a vice clinical lead at a community health center in Queens, New York and also a columnist for Family Physician Today.*

DISCUSSION

The purpose of this study was to examine the root causes of no-show rates from a patient perspective in a primary care practice. There are many implications for no-shows in any outpatient medical clinic including those that have an impact on the health of the patient, financial consequences, and potential clinician burnout due to strategies such as overbooking. Solutions won’t work if there isn’t a consideration of the *why* from a patient perspective, which at times is overlooked. If the true root causes are not being addressed, systemic fixes will likely have very little effect.

The patients surveyed in this study, described reasons why they missed their scheduled appointments. This study confirms that the patient perspective is multifactorial. No single intervention would be successful at significantly decreasing the no-show rates in this clinic. It is important to recognize however that based on patient responses, improving the systems for cancelling appointments may be an important intervention. These types of systems interventions are often overlooked as we focus on patient behaviors, but might be helpful for improving the overall functioning of the clinic.

Though this wasn’t an interventional study, it aims to provide the patient perspective and insight into a significant problem. The existing literature suggests that no single intervention works universally. Some interventions proven to be effective include predictive model-based reminders,<sup>2,6,7</sup> open-access and self-scheduling,<sup>3,4,5</sup> and telehealth visits.<sup>8</sup> Ongoing studies on ways to improve no-show rates should include patient experiences and consider a combination of population specific interventions and predictive modeling. Practices that layer risk prediction with targeted, population-specific outreach (not just automated reminders) will likely see the greatest improvements. Table 3 overviews potential strategies to improve no-show rates.

| Table 3: Practical Strategy Considerations to Improve No-Show Rates |                                            |
|---------------------------------------------------------------------|--------------------------------------------|
| Strategy                                                            | Best for                                   |
| SMS reminders                                                       | High-volume, tech-accessible patients      |
| Open access scheduling                                              | Primary care, high-demand specialties      |
| Telehealth hybrid options                                           | Primary care, chronic disease management   |
| Predictive risk stratification + navigator outreach                 | Safety-net, high-risk populations          |
| Overbooking (algorithm-guided)                                      | High no-show practices with clear capacity |
| Patient portal enrollment                                           | Underserved, Medicaid, uninsured patients  |

## CONCLUSION

No-shows decline most when clinics move beyond generic reminders and instead identify high-risk patients before intervening. Predictive models built on electronic health record data can flag patients likely to miss visits, and pairing this with live telephone outreach has shown strong results.<sup>1</sup> One randomized trial found targeted calls reduced no-shows from 29.2 percent to 22.8 percent.<sup>2</sup> A quality improvement initiative using model-driven live outreach lowered no-show rates from 36 percent to 33 percent overall, with Black patients seeing the largest gain (42 percent to 36 percent), narrowing racial disparities in attendance.<sup>3</sup> A systematic review similarly found that combining risk stratification with live outreach outperforms blanket automated reminders, though effectiveness varies by setting.<sup>4</sup> Qualitative research on patients' own reasons for missing appointments, such as transportation and scheduling conflicts, supports why these targeted interventions succeed.<sup>5</sup>

Structural access changes complement reminder-based strategies. Automated self-scheduling has been linked to lower no-show rates than staff-scheduled appointments (2.7 percent versus 4.6 percent in one case study).<sup>6</sup> A systematic review of open-access scheduling, which shortens the interval between booking and visit, found this associated with lower no-shows across most studies, though the effect size varied.<sup>7</sup> Telehealth has also shown benefit: one study found a 29 percent reduction in no-show odds compared with in-person visits, with the strongest effect among Black patients and those in socially vulnerable areas.<sup>8</sup> Overall, evidence suggests that no single intervention is sufficient; clinics combining predictive targeting, live reminders, and structural access improvements are best positioned to sustainably reduce no-show rates.

## Endnotes

1. Alkomos, A., Mendez, D., Mazzel-Pifano, D., Shafeek, F., (2020) Patients perspectives for missing scheduled clinic appointments and their solutions at a major urban-based academic medical center, *Journal of Community Hospital Internal Medicine Perspectives*, Vol, 10, #5, 426-430.
2. Oikonomidi, T., Norman, G., McGarrigle, L., Stokes, J., van der Veer, S. N., & Dowding, D. (2022). "Predictive model- based interventions to reduce outpatient no-shows: a rapid systematic review." *Journal of the American Medical Informatics Association (JAMIA)*, 30(3), 559–569. DOI: 10.1093/jamia/ocac242
3. Woodcock E, Sen A, Weiner J. "Automated patient self-scheduling: case study." *Journal of the American Medical Informatics Association (JAMIA)*, 2022;29(9):1637–1641. doi: 10.1093/jamia/ocac087
4. Mazaheri Habibi MR, Mohammad Abadi F, Tabesh H, et al. (2024). "Evaluation of no-show rate in outpatient clinics with open access scheduling system: A systematic review." *Health Science Reports*, 7(7). doi:10.1002/hsr2.2160
5. Shour AR, Jones GL, Anguzu R, Doi SA, Onitilo AA. "Development of an evidence-based model for predicting patient, provider, and appointment factors that influence no-shows in a rural healthcare system." *BMC Health Services Research*, 2023;23:988. doi: 10.1186/s12913-023-09969-5

6. Tarabichi, Y., Higginbotham, J., Riley, N., & Kaelber, D. C. (with Watts, B.). (2023). "Reducing Disparities in No Show Rates Using Predictive Model-Driven Live Appointment Reminders for At-Risk Patients: a Randomized Controlled Quality Improvement Initiative." *Journal of General Internal Medicine*, 38(13), 2921–2927. DOI: 10.1007/s11606-023-08209-0
7. Shah SJ, Cronin P, Hong CS, et al. (2016). "Targeted Reminder Phone Calls to Patients at High Risk of No-Show for Primary Care Appointment: A Randomized Trial." *Journal of General Internal Medicine*, 31(12):1460–1466. doi:10.1007/s11606-016-3813-0
8. Sumarsono A, Case M, Kassa S, Moran B (2023). "Telehealth as a Tool to Improve Access and Reduce No-Show Rates in a Large Safety-Net Population in the USA." *Journal of Urban Health*, 100(2):398–407. doi:10.1007/s11524-023-00721-2

**Joanne Dempster, MD, MHA** is Assistant Professor and Interim Director in the Center for Family and Community Medicine at Columbia University. She has held many leadership roles while at Columbia University, is core faculty of their family medicine residency program and has published in professional journals and books.

**Alexia Cha, MPH** is a public health professional with a background in health policy, management, and social determinants of health. She earned her MPH from Columbia's Mailman School of Public Health and currently serves as Associate Business Consultant at Veeva, where she works at the intersection of healthcare, life sciences, and technology.

**Alixandria James, MPH** is a Program Services Subject Matter Expert with the National Rural Health Association, where she leads initiatives focused on strengthening organizational capacity and advancing rural health innovation. She earned her MPH in health policy and management from Columbia University Mailman School of Public Health.

**David Rosenthal, PhD** is Associate Professor (in the Center for Family and Community Medicine) of Health Policy and Management in the Mailman School of Public Health, Columbia University. Dr. Rosenthal has published in a number of professional journals, written book chapters and books and has taught family medicine residents for over 30 years.

# Financial Wellness and Career Readiness in Family Medicine: A Practical Guide for Medical Students, Residents, and Fellows

By Christine Persaud MD, MBA, FAAFP, FAMSSM; Laurenie Louissaint MD, MS; Darshit Patel DO; Gaurav Majmudar, MD, MPH

## Overview

Financial literacy is arguably one of the most critical non-clinical skills an early-career physician can develop, yet it remains largely absent from most medical education curricula. Despite graduating with significant educational debt and facing complex financial decisions early in their careers, many medical students and residents receive little formal education in budgeting, debt repayment, real estate investments, retirement planning, insurance, contract negotiation, or practice management. As a result, studies consistently show that many residents transition into their early career with minimal financial literacy or confidence needed to navigate these challenges. This unfortunately contributes to financial stress and ultimately affects a physician's well-being, and may influence important career decisions, including fellowship training, practice setting, and long-term specialty retention. These challenges are especially relevant in New York State, where strengthening and retaining the family medicine workforce remains a growing priority. Additionally the cost of living in New York is significant so having this guidance is important.

In this review, we examine the current evidence on financial literacy education in graduate medical education and its impact on physician wellness, financial confidence, and career preparedness. We discuss practical topics including student loan management, public service loan forgiveness (PSLF), investing, disability, life and malpractice insurance, employment contract negotiation, and early-career financial planning. The available evidence suggests that integrating a longitudinal financial literacy curriculum into post-graduate training represents a practical, high-value strategy to improve physician well-being, support informed career decisions, and prepare residents for successful careers beyond training.

## Introduction

While medical education prepares physicians to tackle increasingly complex medical problems, it leaves a critical gap: the financial literacy needed to navigate life as a high earning physician. Medical students and residents may graduate with substantial educational debt while receiving little instruction about budgeting, loan repayment, investing, insurance, retirement planning, taxes, or employment contracts.<sup>1,8-10</sup>

This gap does not end when medical school ends. Physicians move from medical school to residency, fellowship, and eventually independent practice, making increasingly complicated financial decisions along the way.

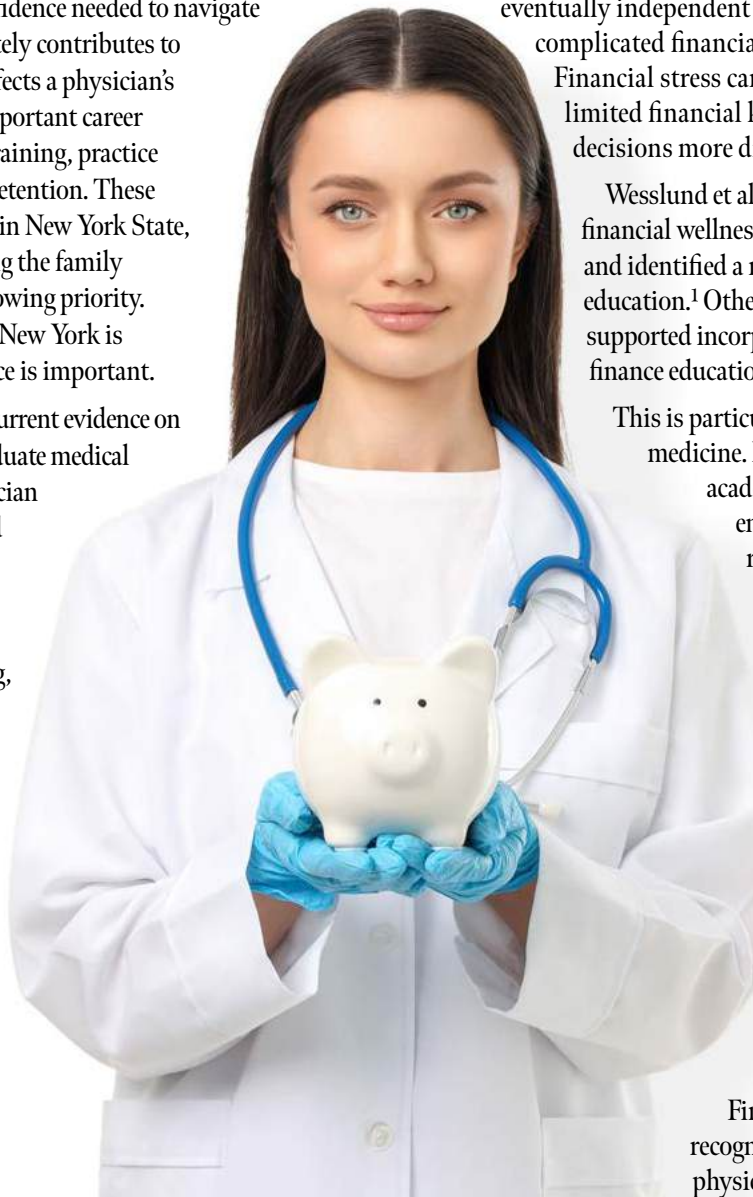
Financial stress can affect well-being, while limited financial knowledge can make these decisions more difficult and less comfortable.<sup>2,3,6</sup>

Wesslund et al found substantial variation in financial wellness curricula for medical trainees and identified a need for more consistent education.<sup>1</sup> Other reviews have similarly supported incorporating structured personal finance education into residency training.<sup>8,9</sup>

This is particularly relevant in family medicine. Family physicians may choose academic medicine, hospital-employed practice, private practice, rural or underserved practice, or additional fellowship training. Because these paths can have very different financial implications, financial literacy should be considered part of career readiness. Physicians should have the knowledge to understand the financial tradeoffs involved in deciding where and how they practice in addition to their passion for their specialty.

## Financial Wellness and Physician Well-Being

Financial stress is increasingly recognized as one contributor to physician distress. In a longitudinal



continued on page 16

pilot study, Anaebere et al found that a personal finance education course was associated with improved financial confidence and changes in markers of financial stress among medical residents.<sup>2</sup> Cawyer et al similarly demonstrated the potential role of financial education in physician wellness among obstetrics and gynecology residents and fellows.<sup>6</sup>

A nationwide survey of medical students, residents, and attending physicians also found a relationship between financial literacy and well-being.<sup>3</sup> Financial education cannot address the systemic causes of physician burnout. However, it may give trainees greater confidence and reduce some of the uncertainty that comes with important financial decisions.

## Educational Debt and Career Decisions

Educational debt can play a role in how physicians think about their careers. Phillips et al found an association between educational debt and family medicine residents' practice and fellowship intentions. Subsequent research also demonstrated continued growth in educational debt among family medicine residents.<sup>4,5</sup>

For family medicine trainees, financial considerations may influence decisions about:

- Pursuing fellowship
- Choosing a practice location
- Academic versus private practice
- Rural or underserved practice
- PSLF-eligible employment
- The timing of major financial decisions

These financial considerations should complement, rather than replace, professional and personal goals.

## Fellowship Opportunity Cost

The reality is that residency and fellowship require physicians to spend an additional 3–7 years in training with relatively modest compensation, delaying their ability to build wealth while many peers in other professions have already begun advancing in their careers, saving, and investing. While fellowship training can provide valuable clinical expertise and new career opportunities, it also means another year of trainee-level income; delaying attending compensation. This is particularly relevant to family physicians pursuing sports medicine and other fellowships.

Trainees should consider:

- Career opportunities after fellowship
- Geographic cost of living
- Fellowship compensation
- Existing educational debt
- Loan repayment strategy
- PSLF eligibility
- Expected attending compensation
- Personal/Financial obligations

Understanding the above does not mean reducing fellowship to a financial calculation. Instead, it gives trainees additional factors to consider in order to make an informed career decision.

## Student Loans and Public Service Loan Forgiveness (PSLF)

Student loan management is one of the highest-yield areas for financial education. A curriculum should introduce trainees to federal versus private loans, income-driven repayment, PSLF, loan consolidation, refinancing, interest accumulation, and loan forgiveness.<sup>8-10</sup>

PSLF may be particularly relevant to family physicians who pursue academic, nonprofit, or other qualifying employment. However, eligibility depends on specific requirements involving the borrower's loans, repayment plan, employment, and qualifying payments.

There is no single repayment strategy that is right for every physician. A physician planning to work for a nonprofit organization may approach debt differently from a physician entering private practice with a high income. Trainees should understand these differences before making decisions such as refinancing federal loans.

## Building a Financial Foundation During Training

Financial wellness education should begin before graduation rather than waiting until a physician becomes an attending.

### Budgeting

Residents and fellows should understand basic cash flow and learn to distinguish between essential expenses, financial priorities, and discretionary spending. Building an emergency fund and developing sustainable spending habits can provide a foundation for future financial planning.

### Investing and Retirement

Trainees should learn the basic concepts behind:

- Compound growth
- Diversification
- Risk and return
- Retirement accounts
- Roth versus traditional contributions
- Employer retirement matching

The goal is not to teach trainees how to choose individual investments. Instead, the goal is to provide enough knowledge for them to make informed long-term decisions.<sup>1,8,9</sup>

### Protecting Income

Financial education should also include disability, life, and malpractice insurance.

Trainees should understand basic disability insurance terminology, including own-occupation coverage and benefit periods. Life insurance should be considered in the context of dependents and financial obligations.

Physicians should also understand whether a future employer provides occurrence-based or claims-made malpractice coverage.

## Employment Contracts and Compensation

Contract negotiation is an important career skill for residents and fellows preparing to graduate. Carr and Spang specifically addressed contract negotiations in sports medicine, but these principles also apply broadly to family medicine.<sup>7</sup>

### Employment agreements may include:

- Base salary
- RVU or productivity incentives
- Quality bonuses
- Signing and relocation bonuses
- Retirement contributions
- CME allowance
- Malpractice coverage
- Tail coverage
- Vacation
- Call responsibilities
- Administrative or academic time
- Noncompete provisions
- Termination clauses

Physicians should look at total compensation rather than salary alone. A lower salary may come with stronger retirement contributions, paid malpractice coverage, greater CME benefits, or a lower workload.

Trainees should also understand how they will actually be compensated before accepting a position. Important questions include:

- How is productivity measured?
- What relative value unit (RVU) threshold is required?
- What is the conversion factor?
- Are bonuses based on individual or group productivity?
- How are procedures compensated?
- Is call separately compensated?
- What clinical volume is expected?

These questions matter in both general family medicine and sports medicine.

## Sports Medicine as a Family Medicine Example

Sports medicine provides an example of how financial education can be tailored to a particular family medicine career path.

A family physician pursuing sports medicine may face additional financial and employment considerations related to fellowship opportunity cost, team coverage, procedures, orthopedic group employment, academic practice, and hospital-employed sports medicine.

Team coverage should be clearly defined in an employment agreement. Physicians should understand the number of events, evening and weekend responsibilities, travel requirements, malpractice coverage, and whether coverage is separately compensated.

Procedural responsibilities should also be understood in relation to productivity expectations and compensation.

The broader lesson applies to all family physicians: additional responsibilities should be evaluated in terms of both professional value and financial expectations.

## Geographic Cost of Living

Salary should always be considered in the context of geographic cost of living.

A higher salary does not necessarily mean greater financial well-being if housing, taxes, transportation, childcare, and other expenses are substantially higher. This is particularly relevant when comparing positions in high-cost regions such as New York State with positions in lower-cost areas.

When comparing opportunities, trainees should consider: total compensation, including taxes, housing, transportation, insurance, and major expenses to approximate financial position.

Geography is only one part of the decision. Trainees should also consider proximity to family, community preferences, career opportunities, and quality of life.

## Practice Management

Financial literacy should extend beyond a physician's personal finances. Family physicians may eventually participate in practice leadership, partnership, or ownership.

### Basic education should include:

- Practice overhead
- Coding and billing
- RVUs
- Payer mix
- Staffing costs
- Revenue cycle management
- Practice ownership
- Partnership agreements
- Basic accounting

Reviews of physician financial education have emphasized the importance of including practice management and broader financial concepts in residency curricula.<sup>8,9</sup>

Physicians do not need to become business experts. However, understanding basic practice economics can help them evaluate employment and ownership opportunities.

## A Practical Financial Wellness Curriculum

Financial education is likely to be most useful when it is delivered longitudinally rather than as a single lecture (see Table 1).<sup>1,8,10</sup>

**Table 1. Proposed Financial Wellness Curriculum for Family Medicine Trainees**

| Training Stage     | Core Topics                                                                              |
|--------------------|------------------------------------------------------------------------------------------|
| Medical Student    | Budgeting, credit, student loans, basic investing, specialty specific financial planning |
| PGY-1              | Loan repayment, PSLF, emergency savings                                                  |
| PGY-2              | Retirement accounts, disability and life insurance                                       |
| PGY-3              | Employment contracts, compensation, malpractice, practice model training                 |
| Fellow             | Contract negotiation, benefits, cost of living, specialty-specific responsibilities      |
| Graduating Trainee | Comparing employment offers and total compensation                                       |
| Early Career       | Taxes, investing, practice management, partnership                                       |

Case-based education may be particularly useful. For example, residents could compare two family medicine employment offers with different salaries, retirement benefits, RVU structures, and malpractice arrangements. Sports medicine fellows could also evaluate team coverage and procedural responsibilities.

## Barriers and Implementation

Several barriers may make financial education difficult to implement. Medical education curricula are already crowded, trainees begin residency with different levels of financial knowledge, and financial policies can change over time.<sup>1,8-10</sup>

A practical curriculum should therefore be brief, longitudinal, and focused on financial principles that remain useful over time. Programs may collaborate with qualified financial educators, student loan specialists, tax professionals, attorneys, or institutional financial wellness programs.

Financial education should also remain educational rather than promotional. Programs should disclose conflicts of interest and clearly distinguish general financial education from individualized financial advice.

## Measuring Success

Financial wellness programs should measure more than attendance. Potential outcomes include:

### Knowledge

- Financial literacy
- Student loan knowledge
- Contract knowledge
- Retirement planning knowledge

### Confidence

- Financial decision-making confidence
- Contract evaluation confidence
- Loan repayment confidence

### Behavior

- Emergency savings
- Retirement contributions
- PSLF documentation
- Insurance review
- Contract review

### Well-being

- Financial stress
- Perceived financial preparedness
- Career confidence

Prior studies demonstrate the feasibility of evaluating financial confidence and financial stress following financial education interventions.<sup>2,6</sup>

## Discussion

Financial literacy is an important but underdeveloped part of physician education. Existing literature demonstrates a need for greater financial education among medical trainees, while emerging intervention studies suggest that structured programs can improve financial confidence and may reduce financial stress.<sup>1-3,6,8-10</sup>

For family physicians, financial literacy involves more than personal budgeting. Educational debt may influence decisions about fellowship and practice. Compensation models, employment contracts, malpractice coverage, and benefits can also change the financial and professional value of a position.<sup>4,5</sup>

Sports medicine provides one example. Fellowship means an additional year of training, and future employment may include team coverage, procedures, and different compensation structures.<sup>7</sup> However, the same principles apply across family medicine, including rural and underserved practice, academic medicine, and private practice.

Financial wellness education should not replace efforts to address systemic issues such as educational debt, physician compensation, workload, and administrative burden. Instead, it should give physicians the knowledge they need to navigate these challenges and make informed decisions.

A simple framework is:

## Earn → Protect → Manage → Grow → Decide

- **Earn:** Understand compensation and benefits.
- **Protect:** Understand insurance and malpractice coverage.
- **Manage:** Budget and manage debt.
- **Grow:** Invest and plan for retirement.
- **Decide:** Apply financial knowledge to career and employment decisions.

## Conclusion

Financial literacy is an important part of physician wellness and career readiness, but it remains inconsistently addressed during medical education. Medical students, residents, and fellows face complex decisions involving educational debt, loan repayment,

continued on page 19

investing, insurance, retirement planning, employment contracts, and practice management. Evidence suggests that structured financial education can improve financial confidence and may reduce financial stress.<sup>1,3,6</sup>

For family physicians, financial considerations can influence fellowship decisions, practice setting, geographic location, and long-term career planning. Sports medicine provides a useful example of how fellowship training and specialty-specific responsibilities can create additional financial considerations.

A longitudinal financial wellness curriculum can give trainees practical skills without adding a substantial educational burden. Introducing foundational financial education during residency and career-specific topics before graduation may help physicians enter independent practice with greater financial confidence and preparedness.

**Financial literacy should be considered not simply a personal finance skill, but an important component of physician wellness, career readiness, and sustainable family medicine practice.**

## Endnotes

1. Wesslund HM, Payne JS, Baxter JD, Westmark DM, Bartels K, Bailey KL, Krutsinger DC. Personal Financial Wellness Curricula for Medical Trainees: A Systematic Review. *Acad Med*. 2023;98(5):636-643. doi:10.1097/ACM.0000000000005136.
2. Anaebere TC, Hernandez MG, Wood DB, et al. The Impact of a Personal Finance Education Course on Financial Confidence and Markers of Financial Stress among Medical Residents: A Longitudinal Pilot Study. *J Med Educ Curric Dev*. 2024.
3. Jardaly M, Antoun J, Sakr R, Doumiati H, Shaarani I. Financial Literacy and Wellbeing Among Medical Students, Residents, and Attending Physicians in Lebanon: Results From a Nationwide Multi-Centered Survey. *Inquiry*. 2024;61:469580241294135.
4. Phillips JP, Peterson LE, Fang B, Kovar-Gough I, Phillips RL Jr. Debt and the Emerging Physician Workforce: The Relationship Between Educational Debt and Family Medicine Residents' Practice and Fellowship Intentions. *Acad Med*. 2019;94(2):267-273. doi:10.1097/ACM.0000000000002468.
5. Phillips JP, Morgan ZJ, Bazemore AW, Peterson LE. Debt of Family Medicine Residents Continues to Grow. *J Am Board Fam Med*. 2021;34(3):663-664. doi:10.3122/jabfm.2021.03.200567.
6. Cawyer CR, Blanchard C, Kim KH. Financial Literacy and Physician Wellness: Can a Financial Curriculum Improve an Obstetrician/Gynecologist Resident and Fellow's Well-Being? *AJP Rep*. 2022;12(1):e64-e68. doi:10.1055/s-0041-1742268.
7. Carr JB 2nd, Spang R. Navigating Contract Negotiations. *Clin Sports Med*. 2025;44(1):21-26. doi:10.1016/j.csm.2024.03.028.
8. Gianakos AL, Semelsberger SD, Saeed AA, Lin C, Weiss J, Navarro R. The Case for Needed Financial Literacy Curriculum During Resident Education. *J Surg Educ*. 2023;80(4):597-612. doi:10.1016/j.jsurg.2022.12.007.
9. Igu JA, Zakaria S, Bar-Or YD. Systematic review of personal finance training for physicians and a proposed curriculum. *BMJ Open*. 2022;12(12):e064733. doi:10.1136/bmjopen-2022-064733.
10. Ng P, Raghavan S, Zhang C, Pan JY, O'Rourke P, Wong R. Money Talks: Pilot Financial Wellness Programs to Promote Positive Financial Planning Behaviors Among Residents. *Acad Med*. 2022;97(3):380-384. doi:10.1097/ACM.0000000000004429.

**Christine Persaud MD, MBA, FAAFP, FAMSSM** is a board-certified family and sports medicine physician, a Diplomate of the American Board of Obesity Medicine, a Menopause Society Certified practitioner, and program director of a sports medicine fellowship. She serves as Medical Director of the Sports Medicine Division at SUNY Downstate Health Sciences University and is the founder of TruAlly Medical and TruAlly Wellness LLC.

**Lauren Louissaint, MD, MS** is Assistant Professor in the Department of Orthopedics at SUNY Downstate. She completed her medical school training at Ross University School of Medicine, followed by residency in physical medicine and rehabilitation and fellowship training in sports medicine and interventional spine at the Icahn School of Medicine at Mount Sinai.

**Darshit Patel, DO** is a sports medicine fellow at SUNY Downstate Health Sciences University. He completed his internal medicine residency in the Atlanta area and is passionate about musculoskeletal medicine and the diverse applications of ultrasound.

**Gaurav Majmudar, MD, MPH** is a sports medicine fellow specializing in physical medicine and rehabilitation, with clinical interests spanning musculoskeletal care and regenerative medicine. His writing and academic work explore the intersection of medicine, rehabilitation, and the broader experiences that shape physicians and their patients, with a particular interest in thoughtful, evidence-based approaches to improving health and medical education.

# Practice Management Strategies for Building Behavioral Health Integration (BHI) in Primary Care

By Erin K. Ferenchick, MD

## Introduction

Family doctors are well positioned to address behavioral health needs because they provide continuous, comprehensive care across the life course.<sup>1</sup> Behavioral health encompasses mental health and substance use conditions, as well as life stressors, stress-related physical symptoms and health behaviors.<sup>2</sup> Many family physicians already address these needs through medication management, brief counseling, motivational interviewing and follow-up, providing a foundation for more systematic behavioral health integration (BHI).

However, effective BHI requires more than individual clinical skills. Brief visits, competing priorities, limited behavioral health resources and fragmented referral pathways can make it difficult for primary care practices to provide timely, coordinated care.<sup>3,4,5</sup> Practices need reliable systems for identifying behavioral health needs, defining team roles, coordinating care, monitoring patients, and financing the work.

BHI brings medical and behavioral health care together to address the factors affecting a patient's health and well-being.<sup>2</sup> Importantly, BHI is not simply the addition or co-location of behavioral health services. It requires behavioral health care to become part of how the practice routinely organizes and delivers care. As such, BHI can present a practice-management challenge. Practices can develop the organizational capabilities along a continuum,<sup>6</sup> selecting approaches that fit their patients, workforce, resources, partnerships and readiness for integration over time. When implemented effectively, BHI can advance the broader goals of the Quadruple Aim.<sup>7</sup>



## Five Questions Every Practice Should Answer

Successful BHI requires changes in how care is organized and delivered. Table 1 presents five questions that can help practices determine where to begin and what capabilities they need to develop.

**Table 1. Five Operational Questions for BHI**

| Question                                         | Practice Management Actions                                                                                                                                          |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. What behavioral health needs will we address? | Define priority conditions, populations, and services. Determine what can be managed within primary care and what requires specialty or community partnerships.      |
| 2. Who needs behavioral health care?             | Define who will be screened or assessed, select appropriate tools and intervals, and establish workflows for responding to positive findings and ensuring follow-up. |
| 3. Who does what?                                | Define team roles, competencies, supervision and consultation needs, referral criteria, and responsibility for follow-up.                                            |
| 4. How will we coordinate and monitor care?      | Establish referral pathways, communication and documentation processes, warm handoffs where feasible, and standardized approaches to follow-up and measurement.      |
| 5. How will we finance the work?                 | Identify reimbursement and other funding sources and align staffing, infrastructure, and workflows with available payment mechanisms.                                |

These questions apply across practice settings, but the answers will differ according to patient population, workforce, resources, and existing capabilities. The Agency for Healthcare Research and Quality (AHRQ) Behavioral Health and Primary Care Playbook and related resources can help practices assess their current capabilities and identify practical opportunities for improvement.<sup>8</sup>

## Building BHI Along a Continuum

The Continuum-Based Framework for Behavioral Health Integration in Primary Care conceptualizes integration as the development and strengthening of organizational capabilities over time rather than the adoption of any single, fixed model of care.<sup>6</sup> This perspective is consistent with broader frameworks from the SAMHSA-HRSA Center for Integrated Health Solutions (now the

continued on page 21

Center of Excellence for Integrated Health Solutions) and AHRQ, which similarly describe integration in terms of organizational functions, capabilities and varying levels of maturity.<sup>9,10</sup> Practices may begin by strengthening referral networks and, as capacity grows, develop team-based care, more systematic population management, or other approaches. Importantly, however, progression along the continuum is not necessarily linear. Practices may combine approaches or develop different capabilities at different rates. See Table 2.



**Table 2. Practice Management Approaches Across the BHI Continuum**

| Approach                                    | Key Priorities                                                        | Capabilities Strengthened                                                                                                 |
|---------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| Screening, referral, and care linkage       | Case finding, screening, assessment, referral, feedback and follow-up | Identification, referral management, care coordination, linkage to specialty/community care                               |
| Team-based care                             | Shared responsibility, communication and coordinated care             | Defined team roles, warm handoffs, shared documentation/care plans, interdisciplinary communication and case review       |
| Population-based, measurement-informed care | Systematic management of a defined population and treatment response  | Registries/tracking, measurement-based care, proactive follow-up, care management, decision support, treatment adjustment |
| Cross-cutting capabilities                  | Infrastructure and organizational conditions that support integration | Information systems, workforce development, quality improvement, community partnerships, financing/sustainability         |

The goal is not necessarily to reach the most intensive model. Instead, practices should build the capabilities needed to provide appropriate, accessible, and coordinated care for their patient population.

## From Referral Networks to Integrated Teams

### *Strengthen Screening, Referral and Care Linkage*

For many smaller or independent practices, strengthening screening and referral processes may be the most practical approach. For larger practices, it may be the entry point. Practices can establish preferred behavioral health partners, clear referral and urgent-referral protocols, referral tracking, and responsibility for follow-up. At the same time, family doctors also have an important role in addressing behavioral health needs within the scope of primary care. Providing brief behavioral interventions, psychoeducation and support for behavioral change, when appropriate, rather than relying on referral for every identified need is essential for person-centered care.<sup>11</sup> These relatively simple changes can improve continuity and help practices identify barriers to accessing specialty care when needed, without requiring additional staff.

Strong referral networks also create a foundation for more advanced integration. Community partnerships may include behavioral health providers, Certified Community Behavioral Health Clinics, substance use treatment programs, telepsychiatry services, crisis programs and other community organizations.<sup>12,13</sup> Clear referral pathways, defined responsibilities, bidirectional communication and appropriate information exchange are essential.

### *Build Team-Based Behavioral Health Care*

As practices expand their capacity, models such as Primary Care Behavioral Health (PCBH) can embed behavioral health clinicians (e.g., psychiatrist, psychologist, social worker, etc.) within primary care teams. These clinicians may provide brief assessment and intervention, behavioral consultation, support for behavior change and chronic disease self-management and care coordination. The key management challenge here is not simply adding a behavioral health clinician but integrating that role into the primary care team. This requires clear responsibilities, shared documentation, communication, referral criteria and appropriate training in the pace and scope of primary care. The broader primary care team may also need training in behavioral health screening, warm handoffs, team communication and shared workflows.<sup>14</sup> It is important to emphasize that co-location alone does not automatically lead to integration.<sup>6</sup> Effective team-based care requires behavioral health clinicians and primary care clinicians to work from shared workflows and clinical goals rather than functioning as parallel services.<sup>6,10</sup>

### *Add Population-Based Collaborative Care*

Collaborative Care is one of the most extensively studied approaches to BHI.<sup>15</sup> Unlike PCBH, which is designed to provide behavioral health support to a broad range of primary care patients, Collaborative Care typically focuses on defined conditions such as depression and anxiety and uses standardized measures, such as the PHQ-9, to monitor symptoms and guide treatment over time. The model combines multidisciplinary teamwork with proactive

continued on page 22

population management, using registries to track patients between visits, measurement-based care to monitor symptoms, care managers to coordinate treatment, and psychiatric consultation to support treatment decisions.<sup>16</sup> It also relies on a structured clinical relationship between the primary care team, behavioral health care manager and psychiatric consultant. Depending on the workforce and jurisdiction, the care manager may be a social worker, licensed marriage and family therapist, nurse, or other appropriately trained professional, with clinical responsibilities and supervision structured according to applicable professional and regulatory requirements. This approach shifts practice management from episodic, visit-based care toward proactive population management. Implementation requires substantial workflow, measurement, consultation and financing infrastructure.<sup>17,18</sup>

## Financing the Work

Financing should align with the capabilities and services a practice is prepared to support. Earlier-stage approaches may rely primarily on traditional fee-for-service reimbursement, while more systematic BHI models can use care-management, Collaborative Care, Advanced Primary Care Management (APCM), value-based, or population-based payments. See Table 3.

**Table 3. Payment Mechanisms That May Support BHI**

| Practice Approach                      | Examples of Payment Mechanisms* that may Support this Approach                                                                                                                                      |
|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Screening and referral                 | E/M services (99202–99205, 99211–99215); brief emotional/behavioral assessment (e.g., 96127); other behavioral health services when provided within the practice and clinically appropriate         |
| Co-located behavioral health           | E/M services; psychotherapy when clinically appropriate (90832, 90834, 90837 and applicable add-on codes); health and behavior assessment/interventions (HBAI) services; SBIRT (99408, 99409)       |
| General BHI                            | General BHI (99484); Medicare management services general behavioral health conditions delivered by psychologists or clinical social workers (G0323); other care-management payments                |
| Collaborative Care (CoCM)              | Medicare CoCM (99492–99494, G2214); NYS Medicaid monthly CoCM payments (99492, 99493, 99494, T2022; rate codes 5246 and 5261); Medicaid managed care and commercial payor programs, where available |
| Advanced primary care integration      | APCM base payments plus behavioral health integration and Collaborative Care add-on codes (G0568, G0569, G0570)                                                                                     |
| Infrastructure and broader integration | Medicaid and commercial payor programs; grants and other supplemental funding; value-based or population-based arrangements where available                                                         |

\*Payment mechanisms<sup>19,20,21</sup> do not correspond neatly to discrete stages of integration, and practices may combine several approaches. Coverage, eligibility, and same-day billing requirements vary by payer and should be verified when designing workflows.

Fee-for-service reimbursement can support behavioral health assessment and treatment when applicable requirements are met. As practices develop more systematic approaches, BHI and Collaborative Care payments can help support activities that occur between visits, including care management, registry maintenance, monitoring, and psychiatric consultation. More mature models may require multiple funding sources because fee-for-service payments alone may not cover the organizational infrastructure required for sustained integration. Medicaid and commercial payers also use quality requirements, care-coordination expectations, and payment strategies to promote integrated physical and behavioral health care.<sup>22</sup> In New York, value-based payment initiatives similarly emphasize whole-person care and population health across physical health, behavioral health, and social care.<sup>23</sup> BHI may be particularly valuable in these arrangements because improved identifications, coordinated treatment and management of behavioral and psychosocial factors can support broader goals related to outcomes, quality, avoidable utilization and total cost of care.

The central practice-management challenge is aligning financing with the services, workforce and infrastructure required to deliver the chosen approach.

## Lessons From New York State

New York provides examples of two complementary approaches to BHI.

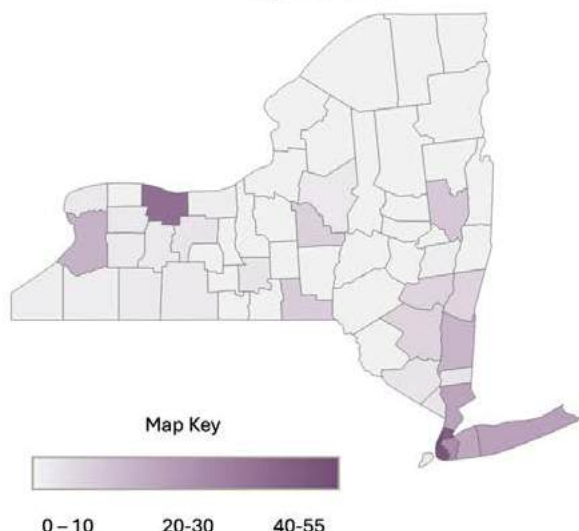
The New York State Medicaid Collaborative Care Program supports a population-based model in which eligible practices establish core infrastructure, including a patient registry, behavioral health care manager, psychiatric consultation, measurement-based care, and systematic follow-up, to receive reimbursement for Collaborative Care services.<sup>24</sup> In September 2025, NYS Medicaid increased the monthly reimbursement rate and introduced an additional payment for extended care-management time. As of July 2026, 440 practices across 44 counties had been approved for NYS Medicaid Collaborative Care reimbursement.<sup>25</sup> New York's earlier Collaborative Care Initiative also offers lessons about sustainability. Collaborative Care was implemented across 32 academic-affiliated primary care practices, incorporating depression screening, measurement-based care, registry tracking, care management and psychiatric consultation. Experience from the initiative suggests that dedicated behavioral health staffing, structured psychiatric collaboration, and redesigned clinical processes are important to sustaining Collaborative Care over time.<sup>26</sup> See Table 4 on page 24.

The University of Rochester Medical Center (URMC) PCBH model illustrates a complementary pathway along the integration continuum. Implemented across 6 primary care practices in Western New York through New York State's Delivery System Reform Incentive Payment program, the model embedded behavioral health clinicians directly within primary

Table 4<sup>28</sup>

## CoCM in NYS

- NYS first state to offer Medicaid reimbursement
  - Procedure/rate code development
  - Provider certification process
- Started in 2015 with 33 practices in academic medical centers
- 440 practices providing CoCM in NYS
  - Still only ~6% of primary care
- NYS data aligned with RCTs (see slide 4)
- Average 13,000 Medicaid patients receive CoCM each year

Sites Approved for NYS Medicaid CoCM Reimbursement  
July 2026 n=440

OFFICE OF MENTAL HEALTH 2

New York State Office of Mental Health. CoCM Overview. July 2026

care teams. Program evaluation demonstrated that embedded behavioral health integration was associated with changes in healthcare utilization among patients with behavioral health conditions.<sup>27</sup> This experience highlights how practices can expand behavioral health capacity through embedded team-based care, even when they do not yet have the infrastructure required for a full Collaborative Care model. Its effectiveness, however, depends on clearly defined clinical roles and preparing behavioral health clinicians to work within the pace, consultation style and interdisciplinary workflows of primary care.

## Conclusion

BHI is the development of practice capabilities that allow primary care teams to identify behavioral health needs, provide or connect patients to appropriate care, coordinate services and monitor outcomes. Practices can begin with stronger referral networks and build toward team-based or population-based approaches as their workforce, infrastructure, partnerships, and financing permit. The goal is not to adopt the most intensive model, but to build the capabilities the practice needs to provide accessible, coordinated and sustainable care.

*Acknowledgments: The author would like to thank Dr. Miriam Tepper and Dr. Jay Carruthers from the New York State Office of Mental Health, and Dr. Nataliya Pilipenko and Ms. Judy Almonte from Columbia University's Center for Family and Community Medicine, for their review and valuable contributions.*

## Endnotes

1. Kieu A. Now more than ever, mental health care needs family medicine. *Fam Pract Manag.* 2021;28(3):11A-11C.
2. Agency for Healthcare Research and Quality (AHRQ) (n.d.). What is integrated behavioral health? Accessed on August 23, 2026. <https://integrationacademy.ahrq.gov/about/integrated-behavioral-health>
3. Grazier KL, Smith JE, Song J, Smiley ML. Integration of depression and primary care: barriers to adoption. *J Prim Care Community Health.* 2014;5(1):67-73. doi:10.1177/2150131913491290
4. Chea A, Heo M, Zeller TA. Family Medicine Physician Readiness to Treat Behavioral Health Conditions: A Mixed Methods Study. *J Prim Care Community Health.* 2024;15:21501319241275053. doi:10.1177/21501319241275053
5. Outland BE, Greenlee C, Vimalananda V, Candler S, Bering H, Arbaje AI. *Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration.* Philadelphia, PA: American College of Physicians; 2022. Position paper. Accessed July 27 2026. [https://www.acponline.org/sites/default/files/acp-policy-library/policies/beyond\\_the\\_referral\\_position\\_paper\\_2022.pdf](https://www.acponline.org/sites/default/files/acp-policy-library/policies/beyond_the_referral_position_paper_2022.pdf)
6. Chung H, Rostanski N, Glassberg H, Pincus HA. *Advancing Integration of Behavioral Health Into Primary Care: A Continuum-Based Framework.* New York, NY: United Hospital Fund; 2016. Accessed July 27 2026. [https://media.uhfnyc.org/filer\\_public/a6/8e/a68eb9d0-514c-4198-8225-clc195264c28/framework\\_052616\\_final1.pdf](https://media.uhfnyc.org/filer_public/a6/8e/a68eb9d0-514c-4198-8225-clc195264c28/framework_052616_final1.pdf)
7. Christian E, Krall V, Hulkower S, Stigleman S. Primary Care Behavioral Health Integration: Promoting the Quadruple Aim. *N C Med J.* 2018;79(4):250-255. doi:10.18043/ncm.794.250

continued on page 24

8. Agency for Healthcare Research and Quality. Behavioral Health and Primary Care Playbook. Rockville, MD: Agency for Healthcare Research and Quality; 2024. Accessed August 23, 2026. <https://integrationacademy.ahrq.gov/products/playbooks>
9. The Commonwealth Fund. Integrating Primary Care and Behavioral Health to Address the Crisis. September 2022. Accessed July 31, 2026. <https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis>
10. Peek CJ; National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. Rockville, MD: Agency for Healthcare Research and Quality; 2013. AHRQ Publication No. 13-IP001-EF. Accessed July 27, 2026. <https://integrationacademy.ahrq.gov/sites/default/files/2020-06/Lexicon.pdf6>
11. Larzelere MM. Behavioral interventions for office-based care: interventions in the family medicine setting. *FP Essent*. 2014;418:11-19.
12. Thornton M, Durant D, Hester A. How Community Engagement Can Support Whole-Person Primary Care. Rockville, MD: Agency for Healthcare Research and Quality; September 2024. Accessed July 28, 2026. <https://integrationacademy.ahrq.gov/products/topic-briefs/community-engagement-for-whole-person-care>
13. Network of the National Library of Medicine Region 6. *Toolkit for Establishing and Maintaining Community Partnerships for Mental Health Information Outreach*. National Network of Libraries of Medicine; 2024. Accessed July 28, 2026. <https://www.nlm.gov/offices/region6/mental-health-information-community-partnerships-toolkit>
14. Society of Teachers of Family Medicine. Behavioral Science (BS) Curriculum: Module 1.6: Introduction to Models of Care Delivery. Society of Teachers of Family Medicine. Accessed August 23, 2026. <https://onlinecourses.stfm.org/BS01-06/#/>
15. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev*. 2012;10(10):CD006525. Published 2012 Oct 17. doi:10.1002/14651858.CD006525.pub2
16. AIMS Center. Registries for Collaborative Care. University of Washington Department of Psychiatry and Behavioral Sciences; published 2023. Accessed July 27, 2026. <https://aims.uw.edu/registries-for-collaborative-care/>
17. Unützer J, Harbin H, Schoenbaum M, Druss B, eds. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*. Center for Health Care Strategies; 2013. Accessed July 27, 2026. [https://www.chcs.org/media/HH\\_IRC\\_Collaborative\\_Care\\_Model\\_052113\\_2.pdf](https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model_052113_2.pdf)
18. Reist C, Petiwala I, Latimer J, et al. Collaborative mental health care: A narrative review. *Medicine (Baltimore)*. 2022;101(52):e32554. doi:10.1097/MD.00000000000032554
19. Centers for Medicare & Medicaid Services. *Behavioral Health Integration Services*. Baltimore, MD: Centers for Medicare & Medicaid Services; 2026. Accessed July 28, 2026. <https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf>
20. Centers for Medicare & Medicaid Services. Health and Behavior Assessment/Intervention—Medical Policy Article (A52434). Medicare Coverage Database. Updated April 1, 2026. Accessed August 22, 2026. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52434>
21. New York State Department of Health, Office of Mental Health, Office of Addiction Services and Supports. *Medicaid Collaborative Care Program Billing Guidance*. Updated June 2025. Accessed July 29, 2026. <https://aims.uw.edu/nyscc/wp-content/uploads/2025/06/CoCM-Medicaid-Billing-Guidance-FINAL-6-8-25.pdf>
22. Pincus HA, Fleet A. Value-based payment and behavioral health. *JAMA Psychiatry*. 2023;80(1):6-8. doi:10.1001/jamapsychiatry.2022.3538
23. New York State Department of Health. *Value Based Payment: Roadmap Update*. Albany, NY: New York State Department of Health; 2026. Accessed July 28, 2026. [https://www.health.ny.gov/health\\_care/medicaid/redesign/vbp/roadmaps/2026/vbp\\_roadmap.htm](https://www.health.ny.gov/health_care/medicaid/redesign/vbp/roadmaps/2026/vbp_roadmap.htm)
24. University of Washington AIMS Center. Collaborative Care Medicaid Program (CCMP). New York Center for the Advancement of Behavioral Health Integration. Accessed August 23, 2026. <https://aims.uw.edu/nyscc/collaborative-care-medicaid-program-ccmp/>
25. New York State Office of Mental Health, CoCM Overview presentation, written communication, July 2026.
26. Moise N, Shah RN, Essock S, Jones A, Carruthers J, Handley MA, Peccoralo L, Sederer L. Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implement Sci*. 2018;13:128. doi:10.1186/s13012-018-0818-6.
27. Maeng DD, Poleshuck E, Rosenberg T, et al. Primary Care Behavioral Health Integration and Care Utilization: Implications for Patient Outcome and Healthcare Resource Use. *J Gen Intern Med*. 2022;37(11):2691-2697. doi:10.1007/s11606-021-07372-6
28. New York Center for the Advancement of Behavioral Health Integration. (2026). *Collaborative Care Medicaid Program (CCMP)*. University of Washington, AIMS Center. <https://aims.uw.edu/nyscc/collaborative-care-medicaid-program-ccmp/>

*Erin K. Ferencchick, MD is Assistant Clinical Professor of Medicine in the Center for Family and Community Medicine at Columbia University Vagelos College of Physicians and Surgeons, and Department of Health Policy and Management at Columbia University Mailman School of Public Health.*



# Practice Management Improvements in an Academic Outpatient Primary Care Practice; Concentrating on Split Billing, G2211 Modifier, Advanced Primary Care Model, and Resident Education

By Michelle Lombardo, MD and Sangrok (Rikki) Oh, MD

Balancing practice management, quality measures, and optimizing reimbursement are challenging in any outpatient primary care setting in the face of growing nuance of insurance payments. This often is even more complex at an academic outpatient primary care practice where resident physicians account for a large percentage of patient care. We have focused on three areas to address these concerns: Use of “split billing” annual wellness visits with an E/M code when appropriate including use of the G2211 modifier, providing structured education about billing habits to resident physicians with individualized feedback, and considering implementation of an advanced primary care model (APCM) into the patient centered medical home.

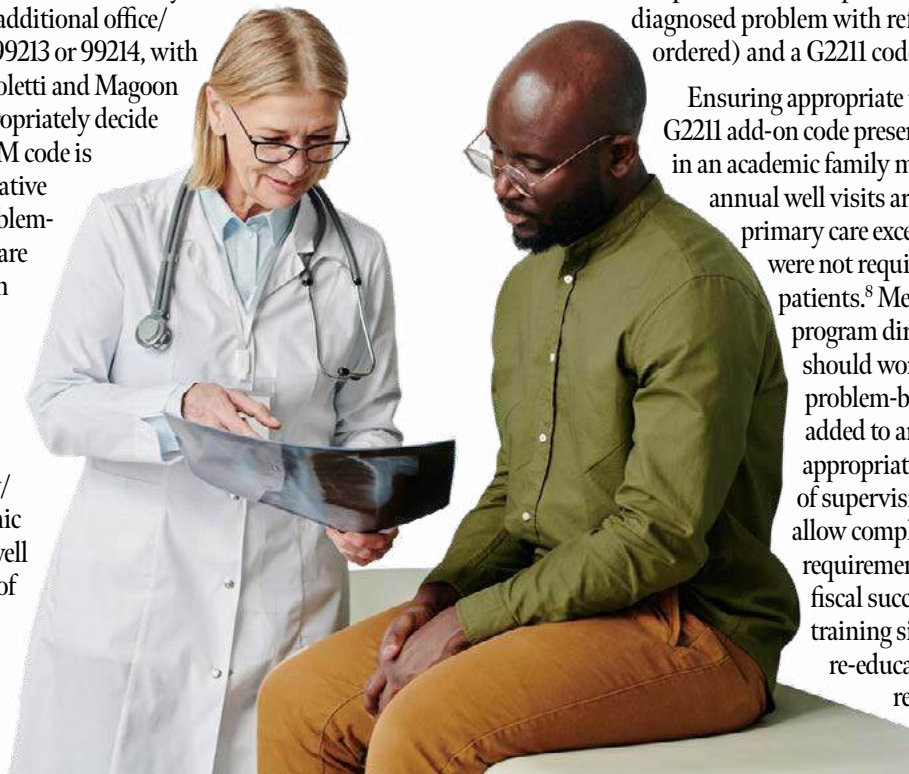
Annual wellness visits remain a crucial part of preventative health and counseling for all our patients. However, it is quite common for an acute or chronic medical problem to be brought up, discussed, and evaluated during these annual well visits. These topics are frequently discussed during the annual wellness visit and appropriate billing for such should be coded. If the additional problem-oriented work is significant, separately identifiable, and medically necessary, Medicare allows an additional office/outpatient E/M code, such as 99213 or 99214, with modifier -25.<sup>3</sup> Table 1 from Nicoletti and Magoon offers guidance on how to appropriately decide whether a problem-focused E/M code is appropriate to add to a preventative visit code. By omitting the problem-focused E/M code, physicians are leaving reimbursable dollars on the table. Many of the more complex, elderly patients have multiple medical problems which are addressed during an annual well visit. Even if these problems are stable, the review/management of multiple chronic medical problems during the well visit qualifies for the addition of a 99214 code.<sup>7</sup>

In addition, the use of the G2211 add-on code adds an additional 0.33 work RVUs. This code reflects the

cognitive and administrative complexity of being responsible for a patient's care over time<sup>4</sup> and is really designed for the primary care provider to capture the longitudinal relationship with patients. As of 2025, the G2211 add-on code is payable with preventative codes so long as an E/M code is also billed for the same day.<sup>4</sup>

What does this look like practice? For example, a 68yo female with hypertension comes in for her Medicare wellness visit and brings home blood pressure readings which are noted to be elevated. The physician decides to increase her anti-hypertensive dose and orders follow-up labs for two weeks. This would be billed as the Medicare Wellness Subsequent (G0439) plus a 99214 (one poorly controlled problem) and a G2211 code with a -25 modifier. This does not only apply to patients with Medicare. Another example is a 29yo healthy male comes in for his annual exam. The physician reviews the depression screening questionnaire and notes moderate depression. After discussing with the patient, the physician diagnoses major depressive disorder, gives a referral to counseling, and starts an SSRI. This should be billed as the age appropriate well visit for an established patient (99395) plus 99214 (newly diagnosed problem with referral and medication ordered) and a G2211 code with a -25 modifier.

Ensuring appropriate use of split-billing and G2211 add-on code presents an added challenge in an academic family medicine practice, as annual well visits are included under the primary care exception, thus preceptors were not required to see these patients.<sup>8</sup> Medical directors, program directors, and preceptors should work to ensure proper problem-based E/M codes are added to annual well visits when appropriate and the proper level of supervision is available to allow compliance with these requirements to best support the fiscal success of the residency training site. This may involve re-education of preceptors, re-evaluating and



continued on page 27

**Table 1. One Visit or Two? A Guide to When to add Problem-Focused Code.**

## ONE VISIT OR TWO?

In many cases, a 99213 or 99214 can be billed with a Medicare wellness visit or preventive medicine visit as long as the physician or billing clinician documents the extra work done for the evaluation and management service. (If patients are sick enough to justify a 99215, it's unlikely clinicians can also fit in a wellness or preventive medicine visit.)

|                                                                                | <b>Patient's status or medical history includes:</b>                                                                                                                                                                                                                                                                                                           | <b>The HPI says things like:</b>                                                                                                                                                                                                                                                                                                                  | <b>Exam findings indicate:</b>                                                                                                                                                                                                                                                                                                                                                          | <b>Assessment and plan include:</b>                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Bill only preventive or wellness code</b>                                   | <ul style="list-style-type: none"> <li>• In good health, with no chronic problems (basically "well").</li> <li>• Stable chronic illnesses (not addressed during visit).</li> <li>• Would not have come in based on their symptoms, except that they had an annual exam scheduled.</li> </ul>                                                                   | <ul style="list-style-type: none"> <li>• Patient is well at home and has no complaints.</li> <li>• Patient needs prescription refills.</li> <li>• Chronic illness listed but not described, or described only in a few words.</li> </ul>                                                                                                          | <ul style="list-style-type: none"> <li>• Exam findings are normal or unchanged from previous exams.</li> </ul>                                                                                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>• No change in treatment; scheduled screenings; refilled prescriptions.</li> <li>• Conditions listed but not evaluated or managed.</li> </ul>                                                                                                                                                                                                               |
| <b>Bill 99213 (or 99203 for new patients) with preventive or wellness code</b> | <ul style="list-style-type: none"> <li>• An acute, uncomplicated illness at time of visit.</li> <li>• An active, stable medical problem.</li> <li>• Two minor problems.</li> </ul> <p><i>Remember to document significant, additional work beyond wellness visit requirements.</i></p>                                                                         | <ul style="list-style-type: none"> <li>• Patient describes onset of acute, uncomplicated problem, or two minor problems.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Status of existing chronic conditions significantly reviewed, not just listed.</li> </ul>                                                           | <ul style="list-style-type: none"> <li>• Exam findings are normal or unchanged from previous exams.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• There may be an unexpected abnormal finding on exam.</li> </ul>                                                                                                                                                | <ul style="list-style-type: none"> <li>• Order labs; refill existing prescriptions.</li> <li>• Follow up in 3-6 months or less.</li> <li>• Treatment for acute problem.</li> </ul> <p><i>Remember to show management of chronic problem.</i></p>                                                                                                                                                   |
| <b>Bill 99214 (or 99204 for new patients) with preventive or wellness code</b> | <ul style="list-style-type: none"> <li>• New problem with an uncertain prognosis, e.g., acute complicated illness.</li> <li>• A significant exacerbation of one or more chronic illnesses.</li> <li>• Scheduled follow-up visit for multiple significant but stable problems.</li> </ul> <p><i>Remember to show extra work to justify 99214 vs. 99213.</i></p> | <ul style="list-style-type: none"> <li>• New headache, dizziness, abdominal pain, or dyspnea on exertion.</li> <li>• Multiple stable chronic problems significantly reviewed (current problems — not medical history).</li> </ul> <p><i>Remember to review status of stable problems and describe symptoms of poorly controlled problems.</i></p> | <ul style="list-style-type: none"> <li>• Exam findings are normal or unchanged from previous exams.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• There may be an unexpected abnormal finding on exam.</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Patient's physical condition may have deteriorated since previous visits.</li> </ul> | <ul style="list-style-type: none"> <li>• Changes to treatment; x-ray or lab tests for diagnosis (not screening); referral to a consultant.</li> <li>• Review of treatment plan for multiple problems with no changes <i>if</i> complex, multiple medications, and moderate risk of morbidity.</li> <li>• Follow up on findings/patient's condition may be scheduled in following weeks.</li> </ul> |
| <b>Bill E/M office visit only</b>                                              | <ul style="list-style-type: none"> <li>• So acutely ill or with so many exacerbated chronic medical problems that you do not have time to also do a wellness visit.</li> </ul>                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Patient has had a severe increase in symptoms.</li> </ul>                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>• Markedly abnormal exam.</li> </ul>                                                                                                                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>• Reschedule physical exam; initiating treatment changes or ordering immediate diagnostic tests; close follow up scheduled.</li> </ul>                                                                                                                                                                                                                      |

Nicoletti B, Magoon V. Combining a Wellness Visit With a Problem-Oriented Visit: a Coding Guide. Fam Pract Manag. 2022 Jan-Feb;29(1):15-20. PMID: 35014777.

changing the preceptor work-flow, or restructuring preceptors other responsibilities.

Reimbursement and revenue characteristics among academic family medicine primary care clinics with substantial resident physician numbers vary significantly from private practice or attending only primary care offices. Evans et al showed that residents coded fewer high-complexity visits than expected, and bill below the national benchmark resulting in an estimated \$481,654 in annual revenue loss across the programs studied.<sup>56</sup> It is imperative that resident physicians understand coding and billing. This will drive the success of their future practice and reimbursements, support the needs of the residency program and comply adequately with Medicare/Medicaid billing requirements. By providing residents with individualized quarterly reports of their own billing habits, they will receive feedback about the level of complexity of their billing habits and can compare to established benchmarks.

In discussion with our resident physicians, we found that resident physicians are more likely to bill 99213 lower complexity visits than 99214 visits for several reasons. These include misunderstanding of the requirements for each complexity level visit, utilization of the primary care exception which allows residents to see low-complexity visits without the presence of a teaching attending,<sup>8</sup> and lack of preceptor discussion around billing level at the time of precepting. By moving toward a more universal precepting model (where the preceptor sees each patient initially), other groups have seen a 8-10% increase in 99214 billing.<sup>5</sup>

If either of the above mentioned examples (68yo female with HTN for Medicare wellness visit with anti-hypertensives adjusted, and 29yo male with wellness visit and new depression) were seen by resident physicians, the preceptor would need to see these patients in order to appropriately bill the wellness visit with the E/M modifier and G2211 codes. This is one of the largest gaps we see in our residency practice, that residents are failing to identify annual visits where E/M codes should be added.

Maximizing revenue while maintaining appropriate billing compliance is critical for continued financial success of academic primary care practices. The Advanced Primary Care Model (APCM) is a new Medicare payment mechanism for a defined set of advanced primary care services that are often already being provided as part of a patient-centered medical home (PCMH). Rather than relying solely on traditional fee-for-service billing for individual office visits, APCM uses monthly bundled payments to recognize the ongoing work required to manage patients with complex or chronic conditions.<sup>1</sup> Three APCM codes—G0556, G0557, and G0558—are stratified according to patients' medical and social complexity. Eligible services may include care management, medication management, care coordination, development of a comprehensive care plan, patient engagement, and 24/7 access to the care team.<sup>2</sup> APCM therefore offers an opportunity to convert a portion of this existing, uncompensated work into a predictable monthly revenue stream when patients meet eligibility requirements and the practice satisfies the applicable billing and documentation requirements.<sup>1,2</sup>

For academic primary care practices, APCM may be particularly valuable because many of the required activities are already integrated into routine workflows, including resident continuity care, faculty supervision, team-based care, population health activities, and management of patients with multiple chronic conditions. The primary financial opportunity is therefore not necessarily to create

new services, but to identify services already being delivered, ensure that documentation and patient eligibility requirements are met, and develop workflows that consistently capture the associated reimbursement.<sup>1,2</sup> The largest barrier we anticipate considering implementation of this, is that Medicare patients may accrue a co-pay to enroll in APCM services, most of which they are already receiving without an additional charge, simply by being a patient at an academic primary care office. A thorough cost/benefit analysis will need to be conducted prior to implementation of this model.

We have shared some practical strategies to improve financial sustainability and operational efficiency in an academic outpatient primary care practice, with particular emphasis on opportunities to capture appropriate reimbursement for services already being delivered. By reviewing split billing, the G2211 complexity add-on code, participation in the Advanced Primary Care Model, and resident education as complementary approaches to optimizing revenue while maintaining high-quality, patient-centered care, we hope to provide some tools for readers to implement at their own institutions, especially those responsible for teaching resident physicians.

## Endnotes

- Centers for Medicare & Medicaid Services. "Advanced Primary Care Management Services." CMS, updated January 26, 2026. <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services>
- Centers for Medicare & Medicaid Services. "Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule." CMS, November 1, 2024. <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule>
- Centers for Medicare & Medicaid Services, "Annual Wellness Visit," CMS.gov, accessed August 20, 2026. CMS Annual Wellness Visit
- Centers for Medicare & Medicaid Services, "How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211," *MLN Matters*, MM13473 Revised, May 1, 2025.
- Evans DV, Cawse-Lucas J, Ruiz DR, Allcut EA, Andrilla HA, Norris T. Family Medicine Resident Billing and Lost Revenue: A Regional Cross-Sectional Study. *Fam Med* 2015;47(3):175-181.
- Harper PG, Adam P, Wooten M, Smithson A, Martin C, Carlson S, Paddock AM, Satin DJ. Financial Impact of Universal Precepting in Family Medicine Residency Clinics. *Fam Med*. 2020 Jan 4;52(1):24-30. doi: 10.22454/FamMed.2019.690858. Epub 2019 Nov 4. PMID: 31689356.
- Nicoletti B, Magoon V. Combining a Wellness Visit With a Problem-Oriented Visit: a Coding Guide. *Fam Pract Manag*. 2022 Jan-Feb;29(1):15-20. PMID: 35014777.
- Palmeter M, "Primary Care Exception in Brief," *AAPC Knowledge Center*, February 8, 2019. <https://www.aapc.com/blog/45699-primary-care-exception-in-brief/>

*Michelle Lombardo, MD is Clinical Assistant Professor of Family Medicine at the Jacobs School of Medicine and Biomedical Sciences at the State University of New York at Buffalo. She completed residency at the Larner College of Medicine (University of Vermont) Family Medicine Residency in 2018. She currently serves as Medical Director of UBMD Primary Care Amherst.*

*Sangrok (Rikki) Oh, DO is Clinical Assistant Professor Family Medicine at the Jacobs School of Medicine and Biomedical Sciences at the State University of New York at Buffalo. He completed residency at the University at Buffalo Family Medicine Residency in 2016. He currently serves at the Family Medicine Clerkship Director and the Vice Chair of Clinical Operations for UBMD Primary Care.*

# Practice Management—Yet Another Area Where It is Easier with Direct Primary Care

By Wayne Strouse, MD

Practice Management requires attention to the “Quadruple Aim.” Long ago (2008),<sup>1</sup> family medicine introduced the Triple Aim of improving the health of populations, enhancing our patients’ experience of care, and reducing the per capita cost of care. However, once adopted, it became difficult to achieve, due to “the stressful work life” of clinicians and staff, leading Bodenheimer and Sinsky<sup>1</sup> to propose the Quadruple Aim—which considers the wellbeing of the physicians and the care teams that provide the Triple Aim.

One relatively new and rapidly growing answer is to change the payment system to simplify and reduce administrative work and costs with the goal of allowing doctors to have more time with their patients and less time with their computers. The change is called DPC—direct primary care.

DPC is an alternative model of primary care delivery. Patients enroll in a membership plan whereby they make monthly payments and receive primary care services from that practice. Most DPC models (there are several iterations) do not participate in insurance and thus receive significant cost savings in billing. DPC practices tend to have longer appointments (typically 30 – 60 minutes) and have smaller patient panels (400 – 600 patients). Patients see their physician as often as needed and typically can be accommodated on the same or next day. Waiting times in the office also tend to be shorter, all because of the smaller patient panels. The potential for this type of practice to reduce physician burnout is clear, as demonstrated by Boylan and Hurley.<sup>2</sup>

Tecco et al<sup>3</sup> did an evidence-based analysis of a theoretical DPC vs. FFS (fee for service) primary care practice and demonstrated that “DPC practice can yield upwards of \$25,000 in annual cost savings over the FFS practice while also providing more personalized patient care.” They argue that “the cost-effectiveness and value-based approach of DPC positions the model as a transformative force in reshaping the American health landscape towards a more patient-centric, accessible, and resilient future.”

An unexpected evaluation of DPC came from the Society of Actuaries. In their report: “Direct Primary Care: Evaluating a New Model of Delivery and Financing,” they acknowledge the



importance of primary care, and the fact that it is in crisis. Their assessment states this is “characterized by physician burnout, large PCP patient panels, low pay for PCPs relative to other physician specialties, increased administrative burden, longer work hours without increased reimbursement, an increased risk of mental health conditions and suicide, and ultimately a PCP shortage relative to market demand. DPC is an approach to delivering and financing primary care that attempts to respond to many of

these challenges.” In their evaluation, they followed an employer who offered a DPC option to their employees (the other option was a PPO). Followed for 2 years, they found that “the introduction of a DPC arrangement could be done on a cost-neutral basis or may potentially lead to overall cost savings for the employer.... A DPC option may give employees and dependents increased access to primary and urgent care services, from the same provider at no cost....”<sup>4</sup>

Having managed my solo, rural family medicine practice for over 20 years, I was intimately involved in all aspects of practice management. I found billing, or more specifically getting paid, the most daunting part. But, like many independent physicians, I tended not to give this area its proper attention, and as a result, I lost money to insurance companies who were only too happy to use their usual tactics to avoid payment. I remember thinking I had to earn my income twice. Once when I did the actual work, and once while jumping through all those hoops to get paid.

That all changed when I reached my frustration limit and decided that there really was a way out—DPC.

In addition to DPC adding newfound (re-found?) joy to practicing again, with simple, easy to use patient care notes, plenty of time for each visit, fewer prior authorizations, and the chance to really get to know my patients... it made getting paid a piece of cake!

No coding needed, no back and forth with the insurance company, no modifiers, no downcoding. In fact, I do not have a biller working for me! I reduced my staff down to 2—a nurse and a receptionist. With DPC, you run a credit card once a month for each patient and

continued on page 29

billing is completed. Sure, we have an occasional credit card that does not go through (as every office does), but it's usually a quick fix by calling the patient. I will take that over fighting an insurance company any day. With DPC, doctors can give patients the time they need and deserve. Patients love that (as do doctors), so they want to fix any payment issues that do occur. This allows me to focus on the other parts of practice management without distraction, and without loss of income.

Also, other practice management issues become easier to manage as well. You can optimize scheduling more easily when you are seeing 6 - 12 patients a day—instead of 25 - 30. When you have 30—60 minutes per appointment, you are less likely to fall behind, which makes for happier patients who appreciate that you respect their time. It also makes it easier to keep up with your notes (which are succinct and easy to write since they only contain what you need to care for your patients, not the useless information that the insurance company demands). It also makes for notes that are easier to review when you next see your patient.

You can give better care—because you have the time to provide it. I even ask that question that most of us were told never to ask: “Is there anything else you want to discuss today?”

DPC also helps with another critical area of practice management: staff. Because the practice isn't overwhelmed, your staff are not overwhelmed. The practice is more relaxed, and the personnel aspect of practice management is that much easier. Your staff knows they are doing important, high quality work and are happy to do it.

I have been asked questions about my specific practice, which I'll address here. As I previously alluded, there are several versions of DPC. I have a hybrid DPC practice. My patients have a choice of whether to use the DPC option or to “pay as you go,” and many—who tend not to see me often - opt for the latter.

There's an unfortunate confusion of DPC and concierge practice. Those of us with DPC practices tend to balk when we are called “concierge.” Concierge practices charge fairly high fees—some in the thousands of dollars a month. I charge \$100 per month. As opposed to concierge practices that only the wealthy can afford, a large majority of my practice is Mennonite farmers and craftsmen—folks who travel in horse and buggies and pinch pennies. They come to me because they receive excellent care from a doctor who knows and respects their culture—at a price that is less than the other corporate practices available to them (I'm the only independent doctor in my county). I can charge lower fees because I don't pay for the overhead that practices burdened by insurance do.

I've been asked about vacations. Yes, I take them and it is no different than when I was in solo rural practice and took insurance. I have been on call 24/7 for 14 years now. I tend to get between 0 to 4 calls per week, so it does not impede my vacation. I do phone triage and use a local urgent care when necessary (or ER if the

circumstances dictate). I know my patients well, so sometimes I'll call in Rx's, if warranted. My patients would rather have me take a vacation now than have me burned out later.

What sticking points have I encountered? DPC does not fix all the woes of our current “system” of healthcare. I don't have good answers for Medicaid patients, and it was difficult losing my prior Medicaid patients. Nor do I have an answer for well insured patients who need childhood vaccines. Well child checks are covered under a lower cost DPC fee (\$40) for children, but it doesn't cover the cost of vaccines. I have also run into the occasional insurance company that won't let me order some labs, CTs, or MRIs. To fix that, I send some patients to specialists sooner than I normally would, in order for the specialist to order the tests that I want (another example of the stupidity of insurance companies spending more money in the supposed goal to save money). Finally, the transition to DPC was difficult, as I lost a number of long time patients.

Direct primary care is the fastest growing type of primary care. DPC doctors are returning to the joy of medicine, and patients are willing to pay extra to get truly excellent care. There is far less work managing the practice, which can be done with fewer staff. Until we have the needed changes to our entire medical system, this is a liberating way to escape burnout and manage a practice.

## Endnotes

1. Bodenheimer T, Sinsky C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider *Ann Fam Med*. 2014 Nov;12(6):573-576.
2. Boylan M, Hurley D. Comparison of Burnout and Fulfillment Rates Between Physicians in Direct Primary Care and Other Practice Models. *South Med J*. 2025May;118(5):275-280.
3. Tecco H, Faraan OR, Pooja L, Sandeep P. Direct Primary Care: Financial Analysis and Potential to Reshape the US Healthcare Landscape. *J Gen Intern Med*. 2024 Sep 25;40(2):448-452.
4. Busch F, Grzeskowiak D, Huth E. Direct Primary Care: Evaluating a New Model of Delivery and Financing. Society of Actuaries Report, 2020.

*Wayne Strouse, MD, FAAFP is a solo, rural, family physician practicing in Penn Yan, NY in a hybrid DPC practice. He is the current NYSAFP President.*

# Implementing AI Ambient Scribes in an Urban Community Health Center to Achieve the Quadruple Aim

By Mellisa A. Pensa, MD, MPH; Hyung Paek, MD, MSEE and Laura Macleod, BSN, MEd, RN

## Introduction

With the health system's universal adoption of the electronic health record, clinician documentation burden compounded. Primary care clinicians spend an hour documenting for each hour of patient care.<sup>1</sup> Documentation burden has frequently been cited as a cause of clinician burnout, an epidemic that threatens primary care access.<sup>2,3</sup>

Community Health Centers (CHCs) are charged with providing access to vulnerable populations. Tasked with providing access to patients with complex medical and social needs, clinicians working in CHCs commonly fall behind on documentation, which can prevent CHCs from billing for services provided. The issue of documentation creates a quadrangle for improvement inclusive of cost (open encounters), quality (patient satisfaction), access (high volume of visits), and healthcare worker well-being best described as the "quadruple aim."<sup>4</sup> As in person and virtual scribes have previously demonstrated reduced documentation burden, improved clinician work satisfaction, and improved patient satisfaction,<sup>5,6</sup> we chose to implement the new AI Scribe technology when it became available to our CHC. Our goal was to reduce documentation burden for clinicians and reduce open (nonbillable) encounters. The purpose of the article is to describe the ambient AI scribe implementation experience of an urban CHC and initial outcomes.

## Methods

This quality improvement study was completed from February 2025-June 2026 at Fair Haven Community Health Care (FHCHC) in New Haven, CT. FHCHC utilizes the Epic® electronic health record (EHR) System as a community connect partner with Yale New Haven Health System (YNHHS). Abridge Ambient AI scribe

(Abridge AI, Inc) was the program that was utilized/embedded into the EHR. The Yale University Institutional Review Board determined the study to not be human participant research as we utilized aggregated data for the purposes of quality improvement.

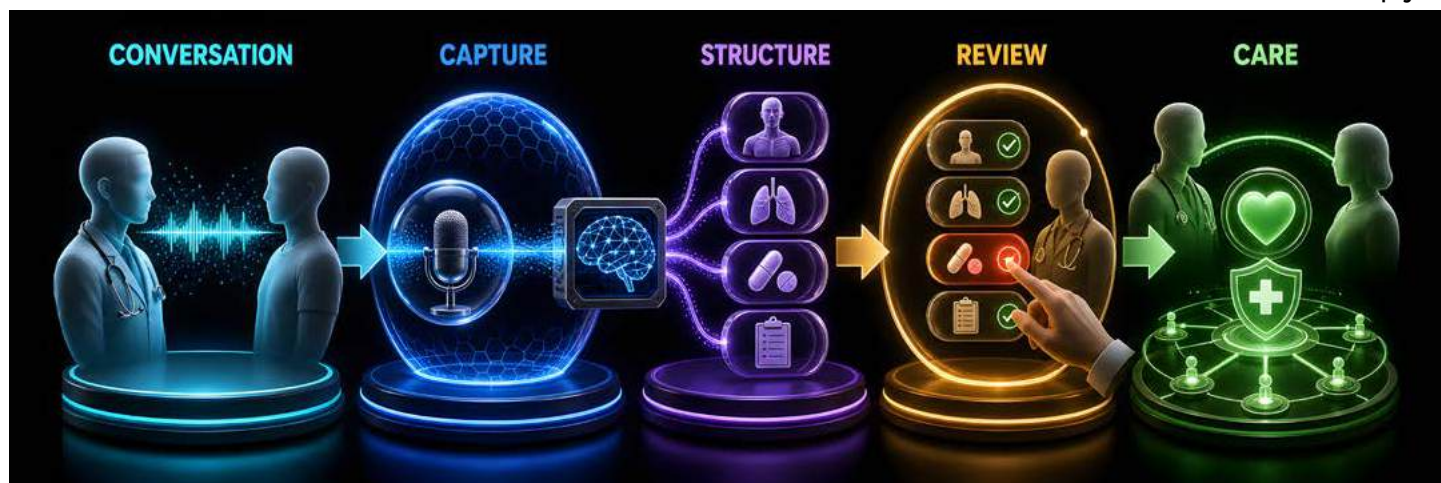
We sought clinician volunteers from three main sites to implement the ambient listening AI scribe. All clinicians received tip sheets and as-needed technical assistance from our EHR support staff. Volunteers received a pre- and post-implementation survey assessing satisfaction with patient interactions, documentation, and experience with the AI scribe via Microsoft Forms.

The Abridge Ambient AI scribe records the clinician-patient interaction during a clinical encounter and within seconds, drafts the clinical documentation on a HIPAA-compliant portal. The clinician edits the documentation as desired and uploads it to the electronic health record. Patients are notified of clinician use of the program and given an opportunity to opt-out at the beginning of the encounter. The Abridge Ambient AI scribe records in multiple languages, translates, and drafts the documentation in English.

After an initial pilot phase of 10 weeks, we rolled out the AI scribe to any clinician who desired the program. We monitored the use of the AI program, time in notes, and time spent on documentation and inbox work through a database affiliated with the EHR (Epic Signal). Clinicians were notified that their use of the electronic health record would be monitored for the purposes of understanding the impact of the AI scribes.

To evaluate how an AI ambient scribe affects clinician documentation burden, we tracked workload metrics over time across a study population of 26 clinicians. These clinicians were divided into three groups: eight early adopters who started using the

continued on page 31



AI scribe in February 2025, eight later adopters who started in July 2025, and a concurrent control group of ten clinicians who did not use the tool during the study period.

Data was collected over 19 consecutive months, from October 2024 to April 2026. Monthly averages were calculated for each group to examine four specific time-based measures of EHR burden. Our primary outcome was time-in-notes-per-day, which captured the average daily minutes a clinician spent actively writing notes. We also tracked three secondary outcomes: pajama time, defined as the minutes spent charting outside standard weekday working hours (7:00 AM to 5:30 PM) or on weekends; time-on-unscheduled-days, representing the minutes a clinician spent in the system on days without scheduled patients; and time-outside-scheduled-hours, reflecting EHR work occurring strictly outside a clinician's scheduled shift times.

To understand the tool's impact, we compared the two AI adopter groups against the non-adopting control group using a time-series analysis. This statistical approach allowed us to answer two distinct clinical questions: whether there was an immediate drop in charting time right after the AI tool was introduced, and whether that new trajectory of time spent charting was maintained in the months that followed. Crucially, comparing the AI users against a concurrent control group allowed us to filter out routine background changes that affect the whole clinic, such as seasonal patient volume spikes or holiday schedule shifts. This ensured that we isolated the true impact of the AI scribe rather than general clinic trends.

Because testing multiple secondary outcomes simultaneously increases the risk of finding a false positive by pure chance, we applied a strict statistical penalty (the Benjamini-Hochberg false discovery rate correction) to the three secondary metrics. The primary outcome was evaluated using standard significance testing. Across all tests, a p-value of less than 0.05 was considered statistically significant. All analyses were conducted using R software version 4.6.1 and RStudio 2026.06.0.

A third-party vendor (Crossroads Group, Inc) randomly selects a portion of patients to complete a satisfaction phone survey after an office visit. We used the clinician's AI scribe implementation date as proxy for use and assessed the correlation between patient satisfaction and scribe use using standard statistical techniques.

We assessed existing organizational records of open encounters to determine if there was a difference post-implementation of the AI scribe. We used standard descriptive statistics to compare pre and post data sets and used a student's t-test to assess a statistically significant difference between groups.

## Results

Eleven clinicians, including family physicians, family nurse practitioners (FNPs), one pediatrician, one medicine-pediatrics physician, and one midwife elected to partake in the pilot. Of the eleven who elected to partake, nine utilized the program and completed the pre-and post-implementation surveys. The nine clinicians who completed the 10-week pilot universally reported their desire to continue utilizing the AI scribe and desire to support other

clinicians in using the program. Seven out of nine clinicians reported they could better listen to patients during a clinical visit with the use of the AI scribe. Pre-implementation, 20% of clinicians were very satisfied with their ability to write orders and complete documentation while meeting with patients, 60% were somewhat satisfied, and 20% were somewhat dissatisfied. Post-implementation, 88% were very satisfied post-implementation and none were dissatisfied. Pre-implementation, 60% of clinicians were somewhat satisfied with their documentation, 20% were somewhat dissatisfied, and 20% were very dissatisfied. At the end of the 10-week pilot, 77% were very satisfied with their documentation and 23% were somewhat satisfied.

After the initial pilot, we invited existing clinicians and newly onboarded fully ramped-up clinicians to access the AI scribe. Between February 2025 and December 2025, a total of thirty primary care physicians, FNPs, and midwives elected to utilize the AI scribe. The following analyses demonstrate utilization and documentation patterns in sixteen adult and family clinicians, including family physicians, medicine-pediatrics physicians and FNPs who signed onto implementation by July 2025. We observed these clinicians for a total of 19 months. We did not include the analyses for the clinicians who signed up after July 2025 due to inadequate follow-up. We also did not include analyses for our midwives or pediatricians as their use was confounded by two factors: first, due to affiliations with the parent hospital EHR, these practitioners had access to the AI scribe prior to implementation at our CHC, and, second, our midwives regularly work 24-hour call shifts, disallowing our ability to accurately assess time worked outside of clinic.

## Utilization and Documentation Time

Adoption of the AI scribe increased from zero percent of visits at baseline to 80% of visits at the end of the 19-month observation period (Figure 1). For the February rollout cohort, daily time-in-notes-per-day demonstrated an immediate post-implementation level drop of -21.20 minutes per day (95% CI: -33.63 to -8.77;  $p = 0.0023$ ), with no significant change in the post-rollout trend slope (+0.04 min/month; 95% CI: -1.42 to +1.50;  $p = 0.9580$ ). The July rollout cohort showed a similar immediate level drop of -29.70 minutes per day (95% CI: -37.64 to -21.76;  $p < 0.0001$ ), along with a slight positive post-implementation trajectory slope change (+1.81 min/month; 95% CI: +0.33 to +3.29) (Figure 1). Mean time-in-notes-per-day decreased significantly among clinicians who adopted the AI scribe (Figure 2). Across all secondary outcomes, including pajama-time, time-on-unscheduled-days, time-outside-scheduled-hours, no model term maintained statistical significance (Figure 3).

## Patient Satisfaction

Patient surveys were analyzed for the cohort pre-Abridge and post-Abridge implementation. There was a trend toward improved patient-rated quality of care, clinician listening, and clinician explanations that was not statistically significant (Table 1). There was no change in the patient perception of being included in health care decisions (Table 1).

## Encounter Closure

The number of open encounters varies week to week across departments. We specifically assessed encounters that were >4 and <30 days old. The average number of open encounters across all departments week to week from July-December 2024 was 305.92 ( $\pm 54.26$ ), and the average number during the same six-month period in 2025 was 218.00 ( $\pm 70.99$ ). The mean difference pre-post implementation was 87.92 ( $p < 0.001$ ), meaning week-to-week, there were an average of 88 more charts closed post AI scribe implementation compared to pre-implementation.

## Discussion

In the last year, multiple studies have demonstrated reduced documentation burden, improved clinician work satisfaction, reduced perceived cognitive load, and reduced burnout in clinicians utilizing AI scribes.<sup>7-14</sup> Our study adds to this literature by suggesting that reduction in time-in-notes-per-day, reduction in pajama-time, and improved presence by way of patient listening may be contributing causes.

continued on page 34

**Figure 1. Adoption, Time in Notes, and Pajama-Time**

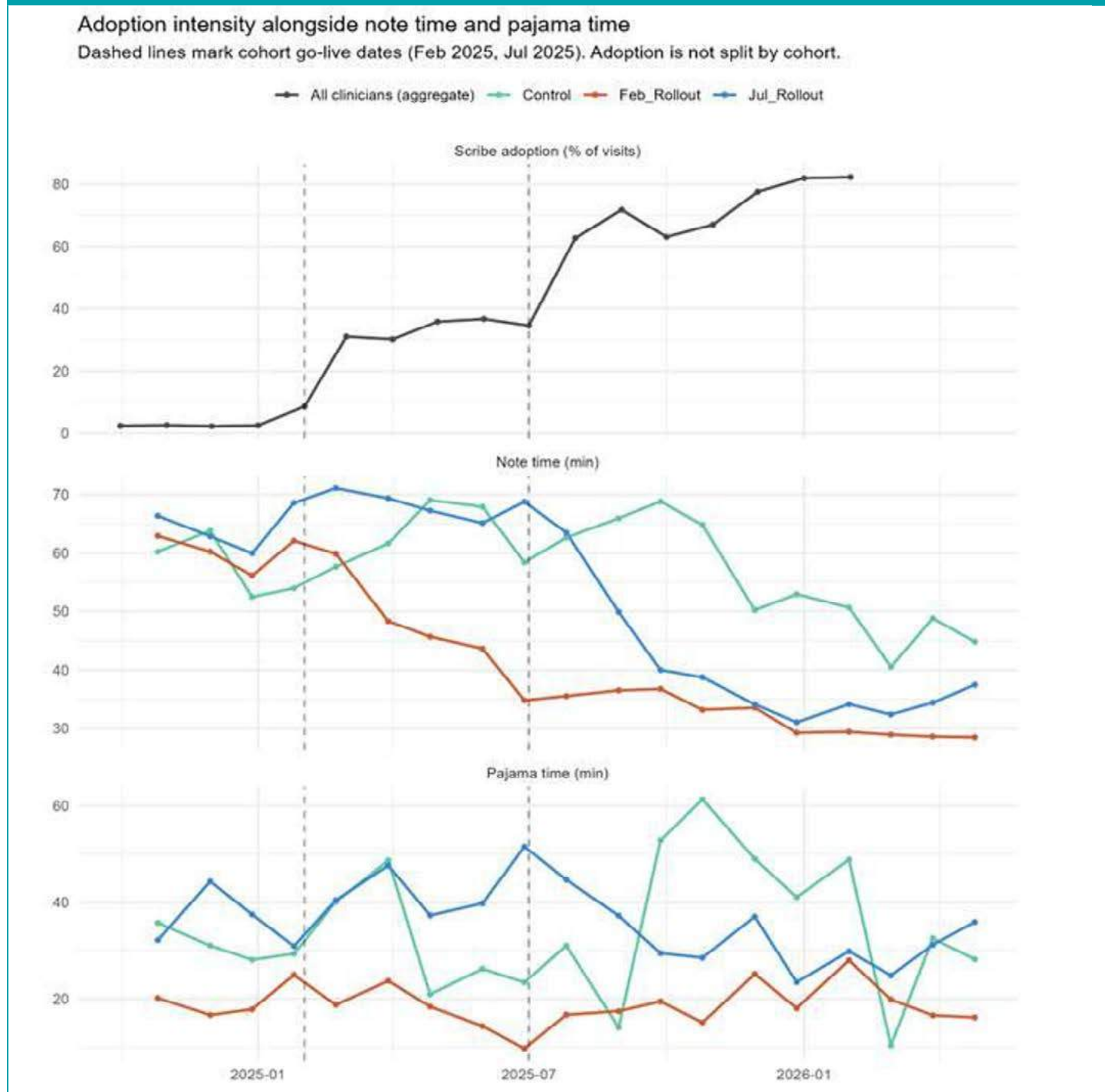


Figure 2. Mean Clinician Workload Measures by Study Group

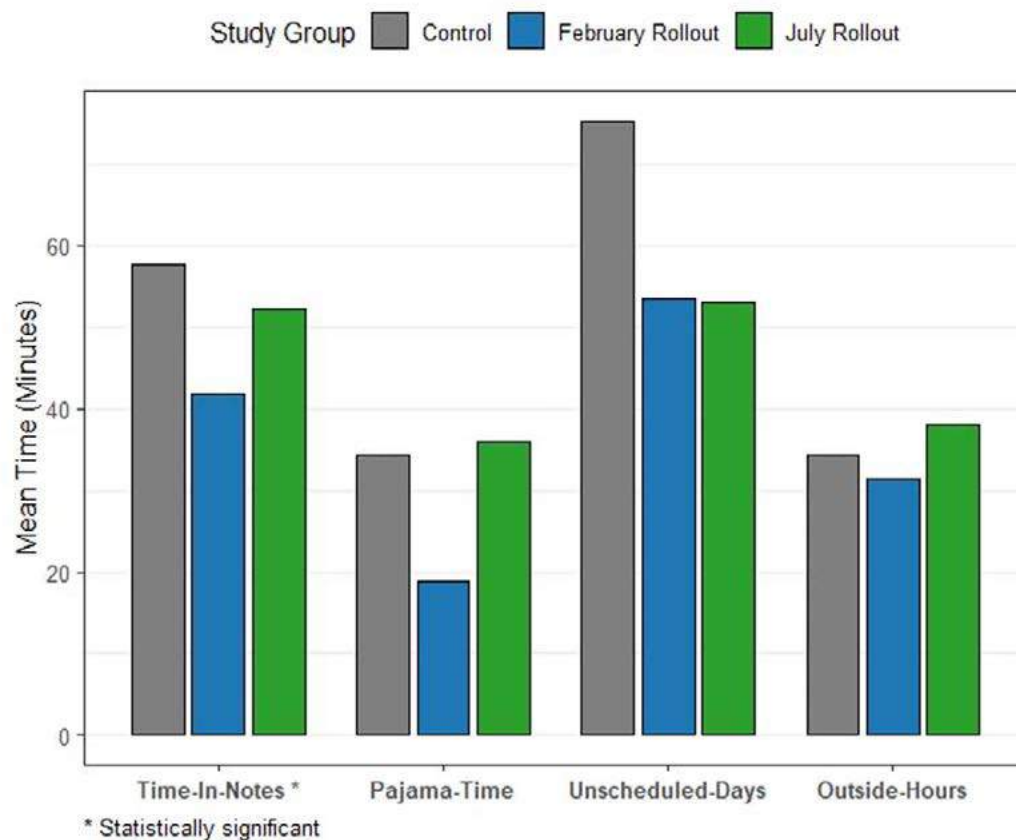
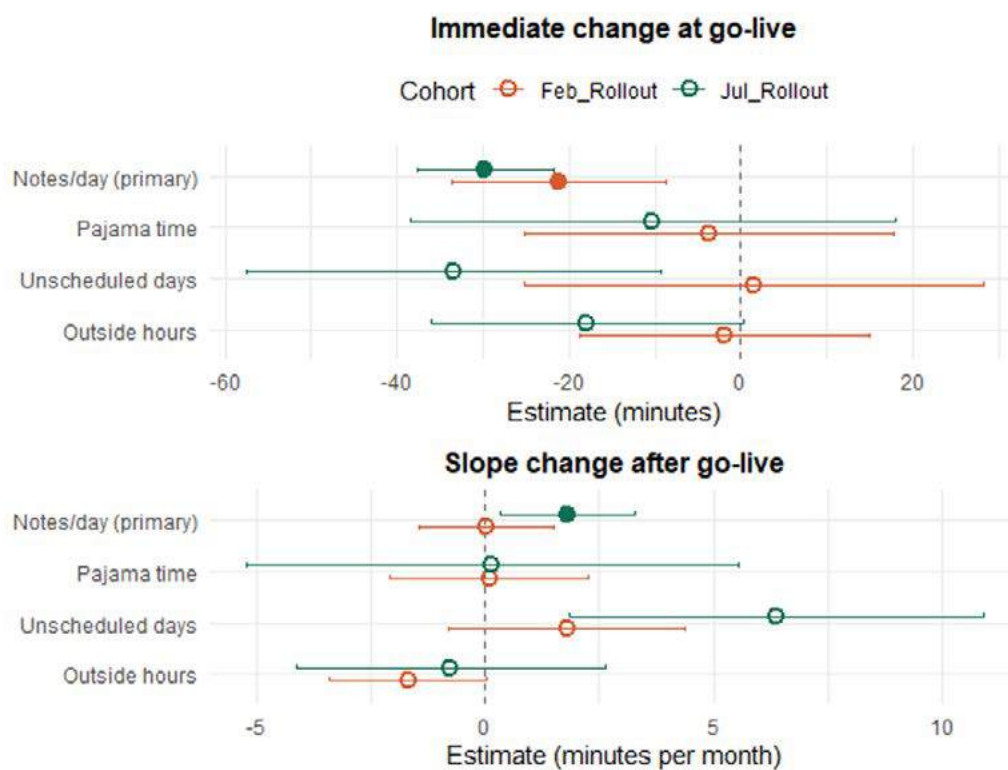


Figure 3. Estimated Immediate Changes and Post-adoption Slope Changes Associated with AI-scribe Rollout



Point = estimate, whiskers = 95% CI.  
 Solid point = FDR-significant ( $p < .05$ ), hollow circle = not significant.  
 Primary outcome (notes/day) shown with unadjusted p-value; others FDR-adjusted.

Using date of initial AI scribe access as a proxy for use, we did not demonstrate a meaningful difference in patient satisfaction, although there was a slight trend toward improvement. Our data were limited in that we did not have encounter-level AI scribe utilization data to merge with the patient surveys. Others have demonstrated improved patient satisfaction and increased trust in their clinicians when virtual scribes were used.<sup>15</sup> Shah et al. (2026) demonstrated patient satisfaction with clinician AI scribe use. In a survey of 2000 patients in the outpatient setting, 73% desired repeat use of the AI scribe.<sup>16</sup>

Our analysis demonstrated a meaningful reduction in open encounters across the organization since AI scribe implementation. A limitation of our study is the pre-post design, as we cannot account for other potential temporal causal factors. Studies have demonstrated a business case for the AI scribes in ways we did not measure. Rotenstein et al. (2026) found that clinicians utilizing AI scribes expanded patient access by seeing an additional one patient every 2 weeks.<sup>17</sup> In another observational study, Holmgren et al. (2026) found clinicians who had adopted AI scribes billed an additional 1.81 RVUs per week on average.<sup>18</sup>

Our experience with AI scribe implementation was quite favorable. We achieved reduced open encounters while simultaneously improving clinician wellbeing by way of satisfaction and reduced time-in-notes-per-day. Our data suggest patient satisfaction is at best neutral and likely improved, as others have demonstrated. With coming advancements in the AI scribe technology, there are likely to be additional productivity gains.

## Endnotes

1. Tai-Seale, Ming, Cliff W. Olson, Jinnan Li, Albert S. Chan, Criss Morikawa, Meg Durbin, Wei Wang, and Harold S. Luft. "Electronic Health Record Logs Indicate That Physicians Split Time Evenly between Seeing Patients and Desktop Medicine." *Health Affairs* 36, no. 4 (April 2017): 655–62. <https://doi.org/10.1377/hlthaff.2016.0811>.
2. Kroth, Philip J., Nancy Morioka-Douglas, Sharry Veres, Stewart Babbott, Sara Poplau, Fares Qeadan, Carolyn Parshall, Kathryn Corrigan, and Mark Linzer. "Association of Electronic Health Record Design and Use Factors with Clinician Stress and Burnout." *JAMA Network Open* 2, no. 8 (August 16, 2019). <https://doi.org/10.1001/jamanetworkopen.2019.9609>.
3. Li, Calandra, Camilla Parpia, Abi Sriharan, and Daniel T Keefe. "Electronic Medical Record-Related Burnout in Healthcare Providers: A Scoping Review of Outcomes and Interventions." *BMJ Open* 12, no. 8 (August 2022). <https://doi.org/10.1136/bmjopen-2022-060865>.
4. Bodenheimer, T., and C. Sinsky. "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider." *The Annals of Family Medicine* 12, no. 6 (November 1, 2014): 573–76. <https://doi.org/10.1370/afm.1713>.
5. Earls, Stephen T., Judith A. Savageau, Susan Begley, Barry G. Saver, Kate Sullivan, and Alan Chuman. "Can scribes boost FPs' efficiency and job satisfaction." (2017).

**Table 1. Patient Satisfaction Among Abridge Users Pre and Post Implementation**

| Survey Domain & Response                       | Encounters with Pre Implementation (n = 769) | Encounters Post Implementation (n= 877) | p value |
|------------------------------------------------|----------------------------------------------|-----------------------------------------|---------|
| <b>Quality of Care</b>                         |                                              |                                         | 0.137   |
| Excellent                                      | 529 (68.68%)                                 | 643 (73.3%)                             |         |
| Good                                           | 217 (28.2%)                                  | 219 (25.0%)                             |         |
| Fair                                           | 19 (2.5%)                                    | 11 (1.3%)                               |         |
| Poor                                           | 4 (0.5%)                                     | 3 (0.3%)                                |         |
| N/A                                            | 0 (0.0%)                                     | 1 (0.1%)                                |         |
| <b>Clinician Listening</b>                     |                                              |                                         | 0.174   |
| Excellent                                      | 584 (75.9%)                                  | 697 (79.5%)                             |         |
| Good                                           | 169 (22.0%)                                  | 166 (18.9%)                             |         |
| Fair                                           | 13 (1.7%)                                    | 7 (0.8%)                                |         |
| Poor                                           | 2 (0.3%)                                     | 5 (0.6%)                                |         |
| N/A                                            | 1 (0.1%)                                     | 3 (0.2%)                                |         |
| <b>Clinician Explanation</b>                   |                                              |                                         | 0.612   |
| Excellent                                      | 673 (74.4%)                                  | 678 (77.3%)                             |         |
| Good                                           | 185 (24.0%)                                  | 183 (20.9%)                             |         |
| Fair                                           | 8 (1.0%)                                     | 2 (1.4%)                                |         |
| Poor                                           | 3 (0.4%)                                     | 3 (0.3%)                                |         |
| N/A                                            | 1 (0.1%)                                     | 1 (0.1%)                                |         |
| <b>Clinician Involved Patient in Decisions</b> |                                              |                                         | 0.997   |
| Yes                                            | 728(94.7%)                                   | 830 (94.6%)                             |         |
| No                                             | 25 (3.4%)                                    | 29 (3.3%)                               |         |
| N/A                                            | 16 (2.1%)                                    | 18 (2.1%)                               |         |

6. Shultz, C. G., and H. L. Holmstrom. "The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions." *The Journal of the American Board of Family Medicine* 28, no. 3 (May 1, 2015): 371–81. <https://doi.org/10.3122/jabfm.2015.03.140224>.
7. Pearlman, Kevin, Wen Wan, Sachin Shah, and Neda Laiteerapong. "Use of an AI Scribe and Electronic Health Record Efficiency." *JAMA Network Open* 8, no. 10 (October 10, 2025). <https://doi.org/10.1001/jamanetworkopen.2025.37000>.
8. Lukac, Paul J., William Turner, Sitaram Vangala, Aaron T. Chin, Joshua Khalili, Ya-Chen Tina Shih, Catherine Sarkisian, Eric M. Cheng, and John N. Mafi. "Ambient AI Scribes in Clinical Practice: A Randomized Trial." *NEJM AI* 2, no. 12 (November 26, 2025). <https://doi.org/10.1056/aioa2501000>.
9. Rotenstein, Lisa, Edward R. Melnick, Christine Iannaccone, Jianyi Zhang, Aqsa Mugal, Stuart R. Lipsitz, Michael J. Healey, et al. "Virtual Scribes and Physician Time Spent on Electronic Health Records." *JAMA Network Open* 7, no. 5 (May 24, 2024). <https://doi.org/10.1001/jamanetworkopen.2024.13140>.
10. Ma, Stephen P, April S Liang, Shreya J Shah, Margaret Smith, Yejin Jeong, Anna Devon-Sand, Trevor Crowell, et al. "Ambient Artificial Intelligence Scribes: Utilization and Impact on Documentation Time." *Journal of the American Medical Informatics Association* 32, no. 2 (December 17, 2024): 381–85. <https://doi.org/10.1093/jamia/ocae304>.
11. Shah, Shreya J, Anna Devon-Sand, Stephen P Ma, Yejin Jeong, Trevor Crowell, Margaret Smith, April S Liang, et al. "Ambient Artificial Intelligence Scribes: Physician Burnout and Perspectives on Usability and Documentation Burden." *Journal of the American Medical Informatics Association* 32, no. 2 (December 5, 2024): 375–80. <https://doi.org/10.1093/jamia/ocae295>.
12. Olson, Kristine D., Daniella Meeker, Matt Troup, Timothy D. Barker, Vinh H. Nguyen, Jennifer B. Manders, Cheryl D. Stults, et al. "Use of Ambient AI Scribes to Reduce Administrative Burden and Professional Burnout." *JAMA Network Open* 8, no. 10 (October 2, 2025). <https://doi.org/10.1001/jamanetworkopen.2025.34976>.
13. Alboksmaty, Ahmed, Reham Aldakhil, Benedict W.J. Hayhoe, Hutan Ashrafian, Ara Darzi, and Ana-Luisa Neves. "The Impact of Using AI-Powered Voice-to-Text Technology for Clinical Documentation on Quality of Care in Primary Care and Outpatient Settings: A Systematic Review." *eBioMedicine* 118 (August 2025): 105861. <https://doi.org/10.1016/j.ebiom.2025.105861>.
14. Guo, Yawen, Jiayuan Wang, Di Hu, Steven Tam, Charles Gilman, Emilie Chow, Danielle Perret, Deepti Pandita, and Kai Zheng. "Evaluating Ambient Artificial Intelligence Documentation: Effects on Work Efficiency, Documentation Burden, and Patient-Centered Care." *Journal of the American Medical Informatics Association* 33, no. 2 (October 16, 2025): 273–82. <https://doi.org/10.1093/jamia/ocaf180>.
15. Stephens, Jennifer, Nyann Biery, Autumn Kieber-Emmons, Roya Hamadani, Nicole Allen, and Grant Greenberg. "Association of Asynchronous Virtual Scribe Services: Patient Experience in Primary Care." *The Journal of the American Board of Family Medicine* 39, no. 1 (August 2026): 165305. <https://doi.org/10.3122/jabfm.2026.260173r0>.
16. Shah, Shreya J, Kirsten Naumann Murtagh, Danton Char, Yejin Jeong, Trevor Crowell, Margaret Smith, Stephen P Ma, et al. "Patient Perspectives on Clinicians' Use of Ambient AI Scribes." *JAMIA Open* 9, no. 3 (May 5, 2026). <https://doi.org/10.1093/jamiaopen/ooag104>.
17. Rotenstein, Lisa S., A. Jay Holmgren, Robert Thombly, Aditi Sriram, Reema H. Dbouk, Melissa Jost, Debbie Aizenberg, et al. "Changes in Clinician Time Expenditure and Visit Quantity with Adoption of Artificial Intelligence–Powered Scribes." *JAMA* 335, no. 16 (April 28, 2026): 1408. <https://doi.org/10.1001/jama.2026.2253>.
18. Holmgren, A Jay, Cynthia L. Fenton, Robert Thombly, Hossein Soleimani, Rhiannon Croci, Orianna DeMasi, Maria E. Byron, Sara G. Murray, Julia R. Adler-Milstein, and Jinoos Yazdany. "Ambient Artificial Intelligence Scribes and Physician Financial Productivity." *JAMA Network Open* 9, no. 1 (January 9, 2026). <https://doi.org/10.1001/jamanetworkopen.2025.53233>.

**Mellisa Pensa, MD, MPH** is a family physician, the Associate Medical Director of Montefiore's Family Health Center, and an Associate Professor of Family and Social Medicine at Montefiore. She recently relocated from Connecticut, where she was the Director of Medicine at Fair Haven Community Health Care. After earning her medical degree at the University of Connecticut, Mellisa completed residencies in family medicine and preventive medicine at Oregon Health and Science University and completed a fellowship in occupational and environmental medicine at Yale University School of Medicine.

**Hyung Paek, MD, MSEE** is currently Director of IT for Fair Haven Community Health Center in New Haven, CT, combining clinical practice with leadership in health information technology. He has extensive experience implementing and optimizing electronic health record systems in inpatient and outpatient settings, and his work focuses on leveraging clinical informatics, artificial intelligence, and decision support to improve provider workflows, enhance patient safety, and support high-quality care.

**Laura Macleod, BSN, MEd, RN** is a registered nurse and the Electronic Health Record Clinical Operations & Optimization Manager at Fair Haven Community Health Care in New Haven, CT. Laura works with clinical staff to optimize the electronic health record and trains clinical staff how best to utilize the operating systems. Laura is passionate about making system-level improvements to ease work burdens and improve patient care.

# Home-Based Primary Care: a Professionally Satisfying Practice Setting

By Konstantinos Deligiannidis, MD, MPH, FAAFP, FAAHCM, DABFM

## Introduction

As our patient population ages, the desire to age at home with dignity becomes paramount. However, progressive chronic conditions often render individuals homebound, and sometimes bedbound, making traditional office-based visits challenging or impossible. This often leads to reliance on emergency department visits for acute issues or exacerbations of chronic diseases, often resulting in avoidable hospitalizations and skilled nursing facility (SNF) stays that may not align with patient goals. This pattern not only places immense stress on patients and their caregivers but also contributes to significant healthcare costs.

Home-based primary care (HBPC) offers a vital alternative mode of healthcare delivery. Unlike the traditional “house call” which might be an added service performed in the midst of clinical workday, HBPC is a systematic, practice-based approach of addressing the comprehensive needs of this vulnerable homebound population. HBPC providers, nurse and social work care managers are solely dedicated to the care of this population, while embodying the principle of “the right care, at the right place, at the right time” to avoid unnecessary, and often unwanted, facility-based interventions. Across the country, HBPC models vary widely, from small solo practices and academic programs to large multi-state insurance-backed initiatives and those within the Veterans Affairs (VA) system. However, regardless of the practical model of HBPC, the provision of care at home helps not only the patient and caregiver, but also the healthcare provider.

## The Patient and Caregiver Perspective

As patients age, their disease burden can get to the point where they can no longer see their healthcare provider in the community, and they are rendered homebound, but not necessarily appropriate for hospice. For patients in this “advanced illness” space, HBPC bridges a critical gap between traditional outpatient chronic disease management and hospice care. The status quo for many homebound individuals is often an ED visit for physical assessment, with labs and imaging. In contrast, HBPC programs, by providing in-home, and primarily in-person, care, spare patients and caregivers the immense burden of ED visits and their associated logistical challenges, while

also reducing overall healthcare expenditures.<sup>1,2</sup> HBPC teams (providers and care managers) also supplement their diagnostic workup with the provision of home labs (blood work, urine/stool test, nasal swabs, wound cultures, for instance) as well as in-home portable radiology (e.g. x-rays, EKGs, echocardiograms, and ultrasounds).

While telehealth has its place, the in-person HBPC visit offers a superior comprehensive assessment. It allows providers to conduct a more complete physical exam, observe non-verbal cues, and gain a deeper understanding of the patient’s home environment. This direct insight into daily life, resources, and needs fosters a deeper, more authentic patient-provider relationship. Patients and caregivers can openly share the realities of their daily existence, enabling their PCP to develop a care plan that is truly patient-centered, tailored and responsive to their unique circumstances.

## The Provider Perspective: Rediscovering Professional Fulfillment

From a provider perspective, HBPC resonates deeply with the foundational principles that attract many of us to medicine, especially family medicine. A core tenet of family medicine is the focus on the whole person, integrating one’s personal and family history, and their context (home life, community factors) to build long-term relationships and offer personalized, continuous care.

In the office-based setting, however, we often experience a “façade” of the patient which is what is reported or demonstrated. The home environment, conversely, reveals the true context of their needs and resources. Disorganized pill bottles might instantly signal medication adherence challenges. Hand-drawn cards on a nightstand can offer immediate insight into crucial family connections and the patient’s priorities, profoundly informing goals of care discussions. These observations allow us to see the patient as a complete individual within their lived reality, rather than a

collection of symptoms in a clinic room.

Moreover, HBPC rekindles the intellectual exercise of diagnostic reasoning. A comprehensive history and physical examination remain foundational to accurate diagnosis, historically accounting for 80-90% of diagnostic certainty.<sup>3-5</sup> In busy office settings, time constraints often lead to



continued on page 38

either an abbreviated history and physical, with subsequent reliance on extensive, costly downstream testing; or a thorough history and physical that causes providers to run late and erode personal time. Both scenarios can diminish professional satisfaction, either by contributing to systemic inefficiencies and follow-up burdens or by encroaching on work-life balance.

HBPC embraces a different model. Visits are typically allotted an hour, significantly more than the 10-20 minutes common in an office setting. This extended time, which factors in travel, is crucial for maximizing the patient encounter. It is essential given the complexity of advanced illness, multiple comorbidities, and polypharmacy prevalent in this population. The extended duration also allows for deeper rapport-building, trust, and a thorough exploration of social determinants of health, which are often overlooked in time-pressured environments but critically impact patient well-being.<sup>6</sup> This extended time is best maximized when providers have less travel time and more face-to-face time, so practices schedule based on geography in order to mitigate the inefficiencies and costs of excessive travel time.

## Sustaining the Practice: Value-Based Care and Meaningful Metrics

Due to the longer, more complex visits, HBPC practices are not sustainable under a traditional volume-driven fee-for-service (FFS) model. As mentioned above, in order to address the complexity of advanced illness, multiple comorbidities, polypharmacy, advanced care planning, and other important issues, visits are typically allotted an hour. In a FFS model, this is not financially sustainable. Instead, value-based arrangements, often involving per member per month (PMPM) payments linked to specific quality metrics (both process and outcome measures), provide financial viability<sup>7</sup>

While quality metrics can be a source of frustration for many providers who view them as poor proxies for holistic health, thoughtfully designed metrics aligned with HBPC's mission and patient population can be professionally rewarding. For example, as HBPC centers on goal-concordant care, metrics related to goals of care conversations and advance care planning are highly relevant and meaningful. Proactive, early, and frequent goals of care discussions not only identify patient preferences but also align the clinical team and patient-caregiver dyad with the aim of maximizing days at home and aging in place. This process, when effectively implemented, translates into measurable outcomes, such as reduced hospitalizations and increased days spent at home.<sup>8</sup> Achieving these patient-centered outcomes fosters a profound sense of purpose and accomplishment for providers.

Furthermore, this comprehensive care model thrives on a team-based approach. Incorporating nurses, social workers, and other allied health professionals allows for specialized attention to acute nursing needs and social determinants of health, ensuring coordinated and efficient care from multiple team members. This collaborative environment supports the physician and enhances the overall quality and reach of HBPC.

## Conclusion

Ultimately, HBPC offers family physicians a deeply satisfying return to the core principles of our discipline. By providing comprehensive, person-centered care in the patient's home, we not only improve patient outcomes and system efficiency but also rediscover the profound professional fulfillment that drew us to medicine. It is a practice setting where continuity, empathy, and intellectual rigor converge to deliver meaningful care for our most vulnerable patients, all while offering unparalleled insight into their lives. This model represents a vital and professionally enriching path for family physicians committed to holistic patient care.

## Endnotes

1. Zimbroff RM, Ornstein KA, and Sheehan OC. "Home-based primary care: A systematic review of the literature, 2010-2020." *J Am Geriatr Soc* 2021; 69(10):2963-2972. <https://doi.org/10.1111/jgs.17365>
2. De Jonge KE, Jamshed N, Gilden D, et al. "Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders." *J Am Geriatr Soc* 2014; 62(10): 1825-1831, 2014. <https://doi.org/10.1111/jgs.12974>
3. Hampton J. R., Harrison M. J., Mitchell J. R., Prichard J. S., Seymour C. Relative contributions of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients. *Br Med J*. 1975 May 31;2(5969):486-489. doi: 10.1136/bmj.2.5969486.
4. Peterson MC, Holbrook JH, Von Hales D, Smith NL, Staker LV. Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. *West J Med*. 1992 Feb;156(2):163-5. PMID: 1536065; PMCID: PMC1003190.
5. Paley L, Zornitzki T, Cohen J, Friedman J, Kozak N, Schattner A. Utility of Clinical Examination in the Diagnosis of Emergency Department Patients Admitted to the Department of Medicine of an Academic Hospital. *Arch Intern Med*. 2011;171(15):1393-1400. doi:10.1001/archinternmed.2011.340
6. Leff B, Lasher A and Ritchie CS. Can Home-Based Primary Care Drive Integration of Medical and Social Care for Complex Older Adults?. *J Am Geriatr Soc*, 2019; 67: 1333-1335. <https://doi.org/10.1111/jgs.15969>
7. Lally T, Johnson E, Deligiannidis KE, et al. *Falling behind: The growth of frail, high-need beneficiaries receiving home based primary care in traditional Medicare 2014-2021. J Am Geriatr Soc*. 2024; 72(6): 1909-1912. doi:10.1111/jgs.18820
8. Valluru G, Yudin J, Patterson CL, et al. Integrated Home- and Community-Based Services Improve Community Survival Among Independence at Home Medicare Beneficiaries Without Increasing Medicaid Costs. *J Am Geriatr Soc*, 2019; 67: 1495-1501. <https://doi.org/10.1111/jgs.15968>

**Konstantinos "Kosta" Deligiannidis, MD, MPH, FAAFP**, is Associate Professor of Family Medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, and the Medical Director of Northwell Health's House Calls program, a home-based primary and palliative care program in the largest health system in New York, and participant of CMMI's Independence at Home, High-Needs ACO-REACH, and LEAD programs. As a member of the National Home-Based Primary Care Learning Network, he led many quality improvement initiatives, including improving his program's influenza vaccination outreach, which became the basis of their homebound COVID-19 vaccination program. He advocates for the field through the American Academy of Family Physicians, and the American Academy of Home Care Medicine, where he serves on the board of directors.

# Implementing Self-Collected HPV Screening in a New York State FQHC: Organizational and Operational Considerations for a New Testing Modality

By Anna Kaoutskaia, MD; Colleen Quinn, MD and Ephraim Back, MD, MPH

## Introduction/Background

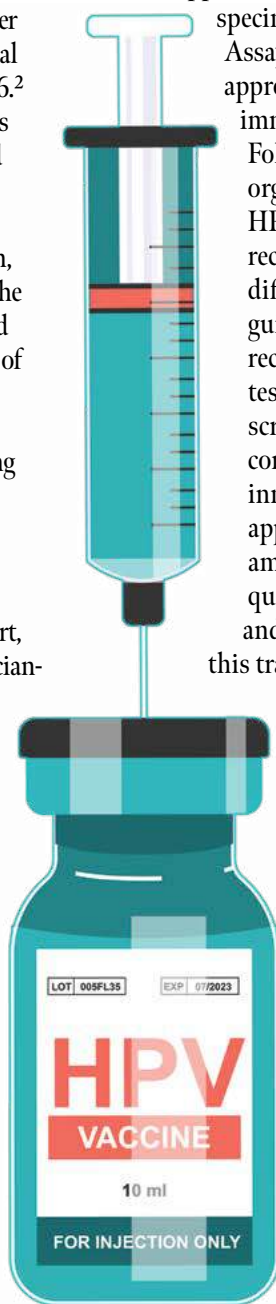
Cervical cancer is among the most preventable malignancies, yet it imposes a significant global and national health burden. It is the fourth most common cancer worldwide among individuals with a cervix, accounting for an estimated 660,000 new cases and 350,000 deaths in 2022.<sup>1</sup> In the United States, the American Cancer Society estimates that 13,490 new cases of invasive cervical cancer and approximately 4,200 deaths will occur in 2026.<sup>2</sup> Most incident cases of cervical cancer in the United States are attributable to inadequate screening.<sup>3</sup> Despite marked reductions in cervical cancer incidence and mortality following widespread implementation of cervical cancer screening and human papillomavirus (HPV) vaccination, only approximately 75%–76% of eligible individuals in the United States are up to date with guideline-recommended screening, falling short of the Healthy People 2030 target of 79.2% (revised from 84.3% prior to 2023) and leaving nearly one in four individuals unscreened.<sup>4,5</sup> Screening disparities are most pronounced among individuals living in rural communities, those with lower socioeconomic status or educational attainment, Medicaid beneficiaries, and those facing transportation or healthcare access barriers.<sup>6</sup> Psychosocial factors including prior sexual trauma, adverse childhood experiences, pain or discomfort, fear, embarrassment, and negative experiences with clinician-performed pelvic examinations - can further limit participation in routine screening.<sup>6,7</sup> Together, these structural and psychosocial barriers perpetuate inequities in cervical cancer screening and contribute to preventable cervical cancer morbidity and mortality among medically underserved populations.

HPV self-collection has emerged as a strategy to address many of these barriers while maintaining high diagnostic accuracy. A systematic review and meta-analysis of 16 paired studies demonstrated that PCR-based HPV testing performed on self-collected vaginal specimens achieved 90% sensitivity for detecting CIN2+, compared with 93% for clinician-collected HPV testing and 87% for clinician-collected cytology.<sup>8</sup> Clinical validation studies submitted in support of FDA approval further demonstrated comparable performance between self- and clinician-collected specimens.<sup>9,10,11</sup>

This evidence supports HPV self-collection as a clinically valid screening approach and highlights implementation within routine primary care as an important next step.

In May 2024, the U.S. Food and Drug Administration (FDA) approved the first HPV tests authorized for self-collected vaginal specimens in a health care setting: the BD Onclarity HPV Assay and the Roche Cobas HPV Test.<sup>9,10,11</sup> Regulatory approval represented an important milestone but did not immediately translate into widespread clinical adoption. Following FDA approval, national professional organizations progressively incorporated self-collected HPV testing into cervical cancer screening recommendations, although adoption occurred at different times and with varying implementation guidance (see Table 1).<sup>12-16</sup> Together, these recommendations largely establish self-collected HPV testing as an accepted component of cervical cancer screening while implementation recommendations continue to evolve. As with many evidence-based innovations in primary care, movement from regulatory approval to routine clinical practice requires alignment among clinical guidelines, reimbursement policies, quality measurement systems, laboratory infrastructure, and local health system practices. For many innovations, this translational phase becomes the rate-limiting step between regulatory approval and routine clinical adoption. These challenges are particularly relevant in federally qualified health centers (FQHCs), where new clinical initiatives must be integrated within resource-constrained environments while maintaining access, quality, and operational efficiency.

The implementation of HPV self-collection therefore represents more than adoption of a new cervical cancer screening modality; it illustrates the broader challenge of translating evidence-based innovation into routine family medicine practice. The objective of this paper is to examine the organizational and operational considerations required to integrate new technologies into primary care, using the implementation development of HPV self-collected testing as a model. We highlight the implementation principles that may be generalizable to future innovations across similar practice settings.



continued on page 39

**Table 1. Selected 2025–2026 recommendations regarding self-collected HPV testing**

| Organization                                             | Self-collected HPV recommendation                                                                                                                                                |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Enduring Consensus Guidelines, (ASCCP) <sup>1</sup> 2025 | Acceptable for primary screening in asymptomatic, average-risk individuals; clinician-collected preferred; repeat every 3 years after a negative result                          |
| American Cancer Society, 2026                            | Acceptable primary HPV screening for average-risk individuals age 25–65 years; every 3 years                                                                                     |
| WPSI <sup>2</sup> /HRSA, <sup>3</sup> 2026               | Option for average-risk individuals age 30–65 years; additional testing may be required to complete screening                                                                    |
| ACOG, <sup>4</sup> 2026                                  | Patient-collected hrHPV may be considered for average-risk individuals age 30–65 years every 3 years when appropriate documentation and follow-up infrastructure are established |
| USPSTF, <sup>5</sup> draft                               | Self-collected or clinician-collected primary HPV testing recognized as a screening option for age 30–65 years                                                                   |

<sup>1</sup>ASCCP = American Society for Colposcopy and Cervical Pathology; <sup>2</sup>WPSI = Women's Preventive Services Initiative; <sup>3</sup>HRSA = Health Resources and Service Administration; <sup>4</sup>ACOG = American College of Obstetricians and Gynecologists; <sup>5</sup>USPSTF: United States Preventive Services Task

## Methods (Implementation Process)

Successful adoption of new technologies in primary care depends on organizational readiness and workflow compatibility as much as clinical evidence.<sup>17,18</sup> The implementation process is designed to address several considerations including practice setting, patient selection and outreach, clinician and staff preparation, specimen collection and laboratory processing, documentation, quality measurement and regulatory considerations that were central to developing the implementation approach and are described below. We have developed a protocol, and the project is currently in the implementation-planning phase, with the clinical and operational processes being established before final rollout begins, as discussed below.

### *Practice Setting*

Federally qualified health centers (FQHCs) are an important setting for implementation of cervical cancer screening strategies because they serve populations disproportionately affected by screening gaps, including individuals with lower incomes, limited access to care, and public insurance or no health insurance.<sup>6</sup> This makes these settings particularly relevant for interventions designed to improve screening uptake. HPV self-collection may help address some barriers associated with clinician-collected screening, including discomfort with pelvic examination, transportation, time, and access to care.<sup>19,20,21</sup>

Recent work has highlighted patient-level factors, including health literacy, language, transportation, and communication, that may influence implementation within FQHC populations.<sup>20</sup> A national analysis demonstrated the substantial role of FQHCs in serving under-screened populations and identified HPV self-collection as a potential strategy to improve cervical cancer screening in these settings.<sup>22</sup>

The planned implementation is designed as a single-site quality improvement pilot at an FQHC located in a health professional shortage area, serving small city and rural communities in New York State's Southern Adirondack region. The single-site approach provides an opportunity to establish the clinical and operational workflow before potential expansion to additional sites.

### *Patient Selection and Outreach*

Eligible patients are identified through the electronic health record and population health tools based on cervical cancer screening history. The initial implementation intentionally focuses on patients who fall outside the population captured by established cervical cancer screening quality measures. Concerns regarding how self-collected HPV testing would be recognized within existing quality measures inform the decision to target patients with more prolonged screening gaps.

The initial target population includes individuals with a cervix who are generally aged 28 years or older, have not undergone cytology or HPV testing for more than 7 years, and are appropriate candidates for self-collection under current screening recommendations. Patients will be contacted by telephone, patient portal, mail, or during an in-person visit. When feasible, outreach will also identify factors contributing to prior screening gaps, including discomfort with speculum examination, prior trauma, time constraints, transportation barriers, and privacy concerns. This targeted approach prioritizes patients with substantial unmet screening needs while allowing the practice to establish the workflow within a defined population before considering broader implementation. Prior FQHC research similarly supports tailoring outreach and implementation strategies to the health literacy, communication needs, and barriers experienced by the populations served.<sup>20,22</sup>

### *Clinician and Staff Preparation*

Clinicians receive education on the evidence supporting HPV self-collection, patient eligibility, the implementation workflow, and relevant cervical cancer screening quality definitions. Training also covers placement of the HPV-only order in the electronic health record and documentation of specimen collection and results with a standardized dot phrase. Clinicians may opt-out of conducting patient outreach while self-collection remains available within the practice.

Nursing and medical assistant staff receive additional training in patient education, specimen collection, troubleshooting, and specimen handling. Standardized materials are provided to

continued on page 40

support consistent patient and staff education. Nursing responsibilities include assisting with specimen collection and coordinating shipment to the designated laboratory. These responsibilities address several of the workflow and staffing considerations identified in prior FQHC implementation studies.<sup>20,23</sup> In a Bronx-based safety net setting, both patients and clinicians identified additional education as an important facilitator of HPV self-collection, with patients emphasizing clear information about self-sampling and clinicians identifying resources to support adoption.<sup>21</sup>

#### *Specimen Collection and Laboratory Processing*

Self-collection is to be performed in the clinical setting using an FDA-approved HPV assay and collection device. Patients will receive standardized instructions from trained clinical staff and perform the vaginal specimen collection themselves in the clinic.

Before implementation, the clinical team will coordinate with the specimen processing laboratory to establish a standardized process for receiving and processing self-collected specimens and differentiating them from clinician collected samples. It is important for the practice to identify these tests separately for tracking of specimen receipt, processing, results, and follow-up. The laboratory process is established in coordination with the laboratory service used by the clinic, including evaluation of the appropriate processing platform and specimen requirements. This separation also supports subsequent assessment of implementation performance and quality-measure implications.

A positive HPV result triggers follow-up according to current cervical cancer screening and management recommendations. Because self-collected specimens do not provide a cytologic specimen for immediate evaluation, the workflow includes a mechanism for arranging subsequent clinician-collected cytology or colposcopic evaluation when indicated. This additional step is an important operational consideration when implementing self-collection, particularly in rural settings where access to follow-up care may be limited.

#### *Electronic Health Record Integration, Documentation*

The electronic health record workflow is established before patient outreach begins. An HPV-only order is used for self-collected specimens, with standardized documentation of the collection date, test type, and result. A dedicated documentation template supports consistent recording of self-collected specimens and facilitates tracking throughout the screening process. The EHR will also incorporate a standardized documentation statement addressing the purpose and limitations of self-collection, the importance of completing recommended follow-up, and the possibility that a positive or otherwise abnormal result may require subsequent clinician-performed examination, additional testing, or diagnostic evaluation.

Self-collected HPV tests are to be tracked separately during the implementation period to distinguish the intervention from conventional screening and to monitor specimen collection, processing, documentation, and follow-up. EHR functionality and integration, along with billing and quality-measure requirements, are important considerations when implementing HPV self-collection.<sup>20,23</sup>

Implementation will be monitored using process and outcome measures that assess both patient participation and workflow performance. The primary outcome is the proportion of eligible patients who are offered and accept self-collection. Process measures include the proportion of eligible patients successfully contacted, the proportion who complete self-collection, and the proportion of returned specimens that are successfully processed and deemed adequate. Additional measures include kits distributed, specimen adequacy, and completion of recommended follow-up after a positive HPV result.

#### *Quality Measurement, Reimbursement, and Regulatory Considerations*

The implementation protocol required consideration of quality measurement, reimbursement, and regulatory requirements in addition to clinical eligibility. Prior FQHC research identified uncertainty regarding the effect of HPV self-collection on cervical cancer screening performance measures and the financial implications of implementation as important considerations for adoption.<sup>23</sup> In the present implementation, these factors need to be reviewed before expanding self-collection beyond the initial target population. Quality measurements are particularly relevant because cervical cancer screening is a core quality metric in FQHCs. NCQA guidance is still somewhat vague regarding self-collection and continues to be evolving.<sup>25</sup> Notably, the HEDIS Measurement Year 2026 Technical Update, released after this project began, expanded the existing High-Risk HPV Lab Test Value Set to include self-collected vaginal samples reflecting updated cervical cancer screening guidelines from the American Cancer Society.<sup>26</sup>

Reimbursement is considered separately from quality-measure recognition. Coverage and billing requirements may vary by payer and may change as self-collected HPV testing becomes more established. Le A et al identified financial uncertainty as a potential barrier to implementation, particularly in settings operating with limited resources.<sup>20,23</sup> Accordingly, reimbursement and payer requirements are reviewed as part of implementation planning rather than assumed to be uniform across patients.

The regulatory environment is similarly incorporated into the implementation process. The FDA's 2024 authorization of clinician-supervised self-collected HPV testing established the regulatory basis for use of these assays in healthcare settings, while subsequent professional society recommendations have continued to define appropriate patient populations and follow-up.<sup>9,16</sup> The implementation will therefore use an FDA-authorized assay, and will follow current screening and management recommendations, with the workflow remaining adaptable as regulatory, guideline, quality-measurement, and reimbursement requirements evolve.

#### *Institutional Review Board (IRB) Exemption*

The Albany Medical Center IRB has determined that this project constituted a quality improvement study and is exempt from full IRB review.

## **Discussion and Practical Considerations**

The implementation process of HPV self-collection demonstrates that adoption of a new screening model requires more than evidence

of clinical validity. A novel intervention must fit within existing workflows, staff roles, EHR systems, quality measures, laboratory processes, reimbursement structures, and follow-up pathways. This is consistent with implementation science, in which organizational context and readiness for change matter as much as the strength of the underlying evidence.<sup>17,18</sup> Several practical considerations emerge from the implementation process of the current study.

Defining a targeted (or limited) population may simplify workflow development and allow practices to identify operational problems before broader expansion. In this setting, targeting patients with prolonged screening gaps (>7 years) is intended to direct the intervention toward those with the greatest unmet screening need. This approach is consistent with FQHC research identifying overdue patients as an important population for self-collection strategies.<sup>19,20</sup>

Patient education should be incorporated into the intervention itself. FQHC populations may face differences in health literacy, language, transportation access, communication, and familiarity with HPV testing.<sup>20</sup> Clear instructions and trained staff are therefore necessary components of the workflow rather than optional educational enhancements. The experience of other safety-net settings supports combining self-collection with active outreach and navigation when appropriate.<sup>21,24</sup>

Implementation requires early attention to infrastructure. Specifically, EHR functionality, laboratory processes, documentation, quality measures, reimbursement, and follow-up should be addressed before patient outreach begins.<sup>19,20</sup> A clinically effective intervention may still be difficult to implement if the practice cannot reliably identify eligible patients, order and track the test, document results, or ensure diagnostic follow-up.

Finally, implementation plans should allow for adaptation. The regulatory and guideline environment surrounding HPV self-collection changed substantially between the 2024 FDA approvals and the subsequent 2025–2026 recommendations by professional societies. Quality-measure specifications and insurance coverage continue to evolve.<sup>9,12-16,25,26</sup> A workflow designed around fixed assumptions may therefore become outdated as external requirements change. An adaptable protocol allows practices to modify eligibility, documentation, outreach, and follow-up without redesigning the entire intervention.

The aforementioned considerations are not unique to HPV self-collection. Primary care practices routinely adopt new diagnostics, preventive technologies, and evidence-based interventions within established workflows and competing priorities. The experience described here suggests that early attention to patient selection, workflow design, EHR infrastructure, staff preparation, quality measurement, reimbursement, and follow-up may facilitate adoption of similar innovations in FQHCs and other resource-constrained settings.

## Takeaways for Other Clinics

Development of the HPV self-collection protocol identified several operational considerations that may be relevant to primary care practices, particularly FQHCs and resource limited practices,

implementing a novel intervention. In a qualitative study of 6 FQHCs, staff identified workflow disruption, limited clinic time, uncertainty regarding quality-measure recognition, and financial implications as important barriers to implementation.<sup>19</sup>

*Identify a narrow starting population.* A clearly defined target population can provide a practical starting point for implementation. Rather than pursuing practice-wide rollout, clinics may begin with patients who have a clearly defined and measurable unmet need, such as prolonged gaps in screening or care. A limited initial rollout can help identify and address workflow barriers before expansion to a larger population.

*Integrate clinician and patient education into the workflow.* Staff and patient education should be established before rollout. Clear, standardized instructions and staff training can help patients understand how an intervention is performed and what follow-up may be required. In a safety-net setting, patients and providers identified education as an important component of implementing HPV self-collection.<sup>21</sup> The PRESTIS randomized clinical trial found that combining self-collection with patient navigation increased cervical cancer screening participation in a safety-net population.<sup>24</sup>

*Anticipate evolving quality-measure and reimbursement requirements.* Quality-measure specifications and payer coverage policies may continue to evolve as new interventions are incorporated into clinical practice.<sup>23,25,26</sup> Practices should assess these requirements before rollout and develop workflows that can be modified as specifications change. Target population selection should also account for how the intervention will be captured within existing performance measures.<sup>23,25,26</sup> Implementation protocols should include a mechanism for periodic review and revision as requirements change and practical experience accumulates. Responsibility for reviewing and updating the workflow should be clearly designated.

*Engage relevant operational teams early.* Processes for ordering, documentation, specimen or product handling, data capture, and result reporting should be established before patient-facing implementation. For interventions involving laboratory testing, specimens should be identifiable throughout processing and be distinguished from standard testing when necessary. Early coordination among clinical, laboratory, information technology, and administrative staff can help identify logistical barriers before rollout. Prior FQHC research has identified EHR functionality, staffing, workflow, and organizational adaptation as important implementation considerations.<sup>19,20</sup>

*Designate clear responsibility for follow-up.* Interventions that generate results requiring additional action should have a defined pathway for follow-up. Clinics should determine in advance who is responsible for initiating follow-up, tracking completion, and re-engaging patients who do not return. Clear ownership is particularly important when follow-up requires coordination across clinicians, departments, or care settings.

*Establish predefined outcome and process measures for monitoring.* Implementation should be accompanied by predefined measures that allow practices to identify workflow problems as the process is

continued on page 42

established. Depending on the intervention, measures may include patient outreach and acceptance, completion of the intervention, adequacy or successful processing, result documentation, and completion of recommended follow-up. Establishing these measures before rollout can help practices identify operational barriers and refine the workflow before broader implementation.

## Limitations

This implementation has several limitations. First, it is a single-site quality improvement initiative within a semi-rural FQHC, and the workflow may not be directly transferable to practices with different staffing models, EHR systems, laboratory arrangements, or patient populations. Second, implementation is ongoing; therefore, patient acceptance, screening uptake, specimen adequacy, and follow-up outcomes are not yet available. The manuscript describes the development and implementation of the protocol rather than its effectiveness. Third, the implementation environment continues to change, particularly with respect to quality measurement, reimbursement, and screening recommendations. The workflow described here may therefore require modification as external requirements evolve. Finally, the initial target population is intentionally narrower than the full population eligible for cervical cancer screening, limiting the ability to assess broader implementation at this stage.

## Conclusion

Beginning with a defined high-need population and an adaptable workflow provides a practical approach to evaluating self-collection within a single primary care clinic before broader expansion. The experience may offer a useful model for FQHCs and other practices seeking to integrate evidence-based preventive technologies into routine care.

## Endnotes

1. World Health Organization. *Cervical Cancer*. Geneva: World Health Organization, 2024.
2. American Cancer Society. *Cancer Facts & Figures 2026*. Atlanta: American Cancer Society, 2026.
3. Perkins, Rebecca B., Nicolas Wentzensen, Richard S. Guido, and Mark Schiffman. "Cervical Cancer Screening: A Review." *JAMA* 330, no. 6 (2023): 547–558.
4. Office of Disease Prevention and Health Promotion. "Increase the Proportion of Females Who Get Screened for Cervical Cancer (C-09)." *Healthy People 2030*. U.S. Department of Health and Human Services. Accessed August 19, 2026. [https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-females-who-get-screened-cervical-cancer-c-09.]
5. Sabatino, Susan A., Trevor D. Thompson, Jennifer M. Croswell, Maria A. Villarroel, Juan L. Rodriguez, Emily E. Adam, and Lisa C. Richardson. "Use of Cancer Screening Tests, United States, 2023." *Preventing Chronic Disease* 22 (2025): E52.
6. Fuzzell, Lindsay N., Rebecca B. Perkins, Shannon M. Christy, Paige W. Lake, and Susan T. Vadaparampil. "Cervical Cancer Screening in the United States: Challenges and Potential Solutions for Underscreened Groups." *Preventive Medicine* 144 (2021): 106400.

7. Wilding, Sarah, Sarah Wighton, Daisy Halligan, Robert West, Mark Conner, and Daryl B. O'Connor. "What Factors Are Most Influential in Increasing Cervical Cancer Screening Attendance? An Online Study of UK-Based Women." *Health Psychology and Behavioral Medicine* 8, no. 1 (2020): 314–328.
8. Phillips, Sarah A., S. Denoël, Nicolas Wentzensen, and Marc Arbyn. "Accuracy of HPV Self-Collection Compared with Clinician-Collected HPV Testing and Cytology: A Meta-analysis." *Cancer Epidemiology, Biomarkers & Prevention* 34, no. 9 (2025): 1467–1471.
9. U.S. Food and Drug Administration. "FDA Approves HPV Tests with Self-Collection in a Health Care Setting." May 14, 2024.
10. U.S. Food and Drug Administration. "BD Onclarity HPV Assay; Premarket Approval P160037/S017." May 14, 2024. [https://www.fda.gov/medical-devices/recently-approved-devices/bd-onclarity-hpv-assay-pl60037s017]
11. U.S. Food and Drug Administration. "cobas HPV for 5800/6800/8800 Systems—P190028/S009." May 14, 2024. [https://www.fda.gov/medical-devices/recently-approved-devices/cobas-hpv-580068008800-systems-p190028s009]
12. Wentzensen, Nicolas, L. Stewart Massad, Megan A. Clarke, Francisco Garcia, Robert Smith, Jeanne Murphy, Richard Guido, et al. "Self-Collected Vaginal Specimens for HPV Testing: Recommendations from the Enduring Consensus Cervical Cancer Screening and Management Guidelines Committee." *Journal of Lower Genital Tract Disease* 29, no. 2 (2025): 144–152.
13. Perkins, Rebecca B., Andrew M. D. Wolf, Timothy R. Church, Elena B. Elkin, Steven J. Skates, Ruth D. Etzioni, Carmen E. Guerra, et al. "Self-Collected Vaginal Specimens for Human Papillomavirus Testing and Guidance on Screening Exit: An Update to the American Cancer Society Cervical Cancer Screening Guideline." *CA: A Cancer Journal for Clinicians* 76, no. 1 (2026): e70041.
14. Vosooney, Alex, Catherine T. Witkop, Amy G. Cantor, Heidi D. Nelson, Carla Picardo, Sarah Son, Nancy Byatt, et al. "Screening for Cervical Cancer: A Recommendation from the Women's Preventive Services Initiative." *Obstetrics & Gynecology* 148, no. 1 (2026): e3–e13.
15. American College of Obstetricians and Gynecologists. "Screening for Cervical Cancer." Committee Statement No. 28. *Obstetrics & Gynecology* 148 (2026): e63–e67.
16. U.S. Preventive Services Task Force. "Draft Recommendation: Cervical Cancer: Screening." December 10, 2024. [https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/cervical-cancer-screening-adults-adolescents?utm\_source=chatgpt.com]
17. Damschroder, Laura J., David C. Aron, Rosalind E. Keith, Susan R. Kirsh, Jeffery A. Alexander, and Julie C. Lowery. "Fostering Implementation of Health Services Research Findings into Practice: A Consolidated Framework for Advancing Implementation Science." *Implementation Science* 4 (2009): 50.
18. Weiner, Brian J. "A Theory of Organizational Readiness for Change." *Implementation Science* 4 (2009): 67.
19. Le, Amanda, Catherine Rohweder, Stephanie B. Wheeler, Jennifer Elston Lafata, Randall Teal, Kara Giannone, MaryShell Zaffino, and Jennifer S. Smith. "Self-Collection for Primary HPV Testing: Perspectives on Implementation from Federally Qualified Health Centers." *Preventing Chronic Disease* 20 (2023): 230056.

20. Le, Amanda, Liisa S. Smith, Stephanie B. Wheeler, Kara Giannone, MaryShell Zaffino, Jennifer Elston Lafata, and Jennifer S. Smith. "Implementing Self-Collection for Primary Human Papillomavirus Testing: Perspectives on Implications for Federally Qualified Health Center Patient Populations." *Women's Health* 21 (2025): 17455057251362581.
21. Roth, Stella, Breanne Lott, Jerlin Garo, Jordan Allen, Sara Krivacsy, Emily Buttigieg, Jessica Atrio, et al. "Taking Health into Your Own Hands: Evaluating Patient and Provider Perspectives of Human Papillomavirus Self-Sampling for Cervical Cancer Screenings and Opportunities for Education." *Journal of Cancer Education* 40, no. 5 (2025): 733–740.
22. Amboree, Trisha L., Prajakta Adsul, Haluk Damgacioglu, Kathleen M. Schmeler, Elizabeth Y. Chiao, Roxana Cruz, Kalyani Sonawane, Ashish A. Deshmukh, and Jane R. Montealegre. "National Outcomes of Increasing Cervical Cancer Screening in Federally Qualified Health Centers." *JAMA Network Open* 8, no. 10 (2025): e2538593.
23. Le, Amanda, and Stephanie B. Wheeler. "Self-Collection for HPV Testing: Potential Issues Related to Performance Measures and Quality Improvement among Federally Qualified Health Centers." *Journal of Public Health Management & Practice* 30, no. 5 (2024): 688–700.
24. Montealegre, Jane R., Susan G. Hilsenbeck, Shaun Bulsara, Susan L. Parker, Trisha L. Amboree, Matthew L. Anderson, Maria Daheri, et al. "Self-Collection for Cervical Cancer Screening in a Safety-Net Setting: The PRESTIS Randomized Clinical Trial." *JAMA Internal Medicine* 185, no. 9 (2025): 1119–1127.
25. National Committee for Quality Assurance. "HEDIS FAQ: Vaginal Specimen Source for the CCS and CCS-E Measures." 2025.
26. National Committee for Quality Assurance. *HEDIS MY 2026 Volume 2: Technical Update*. 2026.

**Anna Kaoutskaia, MD**, is a board-certified family medicine physician who completed the Saratoga Hospital Family Medicine Residency Program in June 2026. She served as Chief Resident during her final year of training and will begin practicing full-spectrum family medicine with the Hudson Headwaters Health Network in Upstate New York. Her clinical and academic interests include preventive health, quality improvement, and improving access to evidence-based care.

**Colleen Quinn, MD**, is Associate Program Director of the Saratoga Hospital Family Medicine Residency Program. The program partners with Hudson Headwaters Health Network (HHHN), a federally qualified health center where she served as Chief of Wellness and Medical Education until 2025. Dr. Quinn is a 2022 graduate of the AAFP Leadership Physician Wellness Program and completed the Master Certified Development Coach Program through the Physician Coaching Institute.

**Ephraim Back, MD, MPH**, is a Clinical Professor of Family Medicine who recently retired from the Saratoga Hospital Family Medicine Residency Program where he was the inaugural program director. He is currently working part-time for Hudson Headwaters Health Network at a rural health center. His interests include medical education, public health, and addiction medicine.

# Save the Date

## Winter Weekend & Scientific Assembly

January 15-17, 2027

Lake Placid, NY



# Has the Much-Loved, Cash-Poor, Village Physician been Replaced?

By Thomas C. Rosenthal, MD

Through the nineteenth-century, village physicians operated solo, cash-poor, credit-heavy practices in which the doctor personally handled accounts, extended credit to patients, bartered for goods and services, purchased drugs by mail-order and dispensed them directly to patients. They maintained an income by being always available. Their "office" was a room in their home or a back room if they operated a drugstore. The business model depended on a horse or buggy for daily house calls and flexible payment arrangements. Cash was welcomed, and careers depended on a good community reputation.

Starting in 1806, New York had attempted to license allopathic physicians and define minimum training. Other providers, including midwives, barbers, bone-setters, lithotomists, homeopaths, and Thomsonian botanical practitioners<sup>1</sup>, protested vigorously; each asserting their devotion to patient needs. This much competition made mobility important, so doctors rode a horse or buggy twenty miles a day to make house calls. Some moved from town to town until they found one where their practice could feed their families.

continued on page 45



## LEDGER Dr. Jabez Allen, Village Physician, Town of Aurora

ACCOUNTS RECEIVABLE: March 1860

Deloran Matson, Farmer (North Road)

Jan. 3 — Visit to wife in confinement (2 hours) ... \$1.00

Jan. 3 — Delivery, including night attendance ... \$2.00

Jan. 4 — Laudanum, 1 oz ... \$0.18

Jan. 10 — Dressing infant's sore eyes ... \$0.25

Feb. 2 — Visit for ague, 4 miles travel ... \$0.50

Balance: \$3.93

Received Mar. 12 — ½ cord maple wood (valued at \$1.00)

Received Mar. 12 — 10 lbs. Ham (valued at \$0.80)

Remaining due: \$2.13

Mrs. Mercie Black (Widow, Village Main)

Jan. 14 — Visit for pleurisy, 1 mile ... \$0.25

Jan. 14 — Blistering plaster applied ... \$0.20

Jan. 15 — Calomel & jalap powder ... \$0.10

Jan. 16 — Second visit ... \$0.25

Total: \$0.80

Remitted: \$0.80 (Indigent)

Isaac Habersol, Storekeeper (Church Street)

Jan. 22 — Extraction of molar ... \$0.50

Jan. 22 — Tincture of opium, ½ oz ... \$0.12

Feb. 3 — Visit for child's croup, 2 miles ... \$0.35

Feb. 3 — Emetic mixture ... \$0.15

Total: \$1.12

Received Feb. 20 — Store credit \$1.12

Capt. Benjamin Riley (West Parish)

Feb. 10 — Vaccination of two children ... \$0.50

Feb. 10 — Travel 3 miles ... \$0.15

Total: \$0.65

Received Feb. 28 — Weaving services (valued at \$0.65)

Joseph Pitler, Laborer (Porterville Road)

Feb. 18 — Visit for frozen foot, 5 miles ... \$0.75

Feb. 18 — Dressing & liniment ... \$0.20

Total: \$0.95

Received Mar. 5 — Two days' labor repairing fence (valued at \$1.00)

Overplus credited: \$0.05

Mrs. Eunice Brickmore, Schoolteacher (EA District)

Mar. 1 — Visit for influenza ... \$0.25

Mar. 1 — Dover's powder ... \$0.10

Total: \$0.35

Unpaid

## SUMMARY FOR QUARTER (Jan-Mar 1860)

Total accounts receivable: \$12.80

Collected in cash: \$2.12

Collected in kind: \$6.45 (wood, pork, weaving, labor, store credit)

Outstanding: \$3.43

Isolation was real, and not made any better by the 1847 AMA Code of Ethics that specifically discouraged partnerships.<sup>1</sup> The code was specific, even defining the size of the shingle physicians were to hang outside their offices (2 inches tall, black with gold lettering). Most healthcare took place in the home, with the occasional tonsillectomy being done on a kitchen table. The office was where supplies were stored, ledger books were kept, and drugs were compounded. Many doctors held second jobs as schoolteachers, tavern owners, farmers, or took political jobs just to support their families.

An accounts receivable ledger reconstructed from practice documents in New England and New York State might have looked like the ledger example on page 44.<sup>2,3</sup>

Village physicians received approximately \$500 a year in cash for their services. It wasn't much, but the average laborer was paid approximately \$5 a week or \$260 a year if he could find continuous employment. Subsistence farmers often provided well for their families, but cash was rare unless they could produce excess goods or their wives produced sellable crafts. Milk, wood, meat, hams, grain, cheese, maple syrup, and labor services were common barter.

House visits granted physicians valuable insight into the family's circumstances. In difficult times, the physician could come up with inventive barter that made a family, or a widow with children, feel that they were pulling their weight. Dr. Cyrenius Chapin of Buffalo often read stories to children to encourage them to stay in school and was known to return to their homes at night to leave food at a family's doorstep.<sup>3,4</sup>

Medicine was simple, local, and personal. Physicians had autonomy; no insurance, no prior authorization, and no corporate oversight. Almshouses and hospitals were owned by charities and stayed in business because of donations or subsidies from local governments. Amazingly, little changed until the 1960s, when physician incomes became more secure and predictable. With it came complexity, regulation, and the administratively demanding, business-like atmosphere of today.

The horse and buggy model was also challenged by the advent of X-ray machines, sterile surgical suites, and laboratory equipment that saw significant expansion following World War II. These critical devices required capital beyond donations and demanded new strategies for financial sustainability. Step by step, healthcare shed its traditional cost center model for a profit-based business model.

The first big step occurred in 1965 when Medicare and Medicaid introduced federal dollars into a cost-plus medical payment model. Then, in 1973, President Nixon signed the Health Maintenance Organization Act (HMOs) into law. The legislation was aimed at controlling the soaring healthcare costs that Medicare had helped ignite. Instead of paying for each service, HMOs flipped the incentive from doing more to allowing a profit for doing less and overrode state laws that had required medical organizations to be owned and operated by licensed physicians. The next move occurred in 1983 when hospitals were also moved from cost-plus reimbursement to prospective payments based on Diagnosis-Related Groups (DRGs). Once again, if the provider (in this case the

hospital) spent less, it kept the difference.<sup>5</sup> Cost-cutting meant opportunity for profit, and non-profit insurers began converting to for-profit models through the 1990s, markedly increasing the role for investors in health coverage.

The 1983 reforms did not invent for-profit hospitals, but they made the for-profit model more competitive. Blue Cross/Blue Shield plans offer an example. As the market adjusted, many Blue Cross and Blue Shield plans abandoned their historical non-profit status in the 1990s and moved from a mutual-benefit model with a mission of public-service to allowing for-profit companies to hold BCBS licenses. The policy change resulted in a series of conversions and mergers, many of which crossed state lines.<sup>5</sup>

Converting was not cheap. Assets that had accumulated while under not-for-profit status had to be transferred into independent charitable foundations to serve the public good. Some of these foundations held huge assets, but freed the remodeled insurers to adopt a business-styled governance with a knack for following earnings reports and stock prices. Local boards gave way to centralized corporate management with less tolerance for unprofitable services like psychiatric wards and rural obstetrical units.<sup>5</sup>

Corporations operate under Securities and Exchange Commission rules with revenue broken out by payer type (Medicare, Medicaid, private insurance), occupancy rates, outpatient surgery volumes, debt levels, and earnings trends; hard numbers with the tears wiped off.

Private equity firms can push commercialization even further. They use high amounts of debt to acquire provider systems with a plan to sell at a profit in a few years. One tactic is the "sale-leaseback." Here, the health provider's real estate is sold to a real estate investment trust. Cash is generated, some of which is used to improve profitable aspects of the practice, and some goes into the pockets of the investors. The medical facility gets an immediate cash infusion and looks good for sale, but leaves long term, rent obligations that forever strain finances.<sup>5</sup>

To be fair, these for-profit entities must comply with laws governing anti-kickback schemes and false claims. Also, every hospital with an emergency department that takes part in Medicare must screen and stabilize anyone who shows up, regardless of ability to pay. This emergency obligation is one of the last legal remnants of the charitable model, and can be a significant cost in for-profit systems. For-profit entities also risk a federal investigation if non-physician executives set patient volume targets or tie physician compensation to purely revenue benchmarks.<sup>5</sup>

Today, the AMA reports that 70% of American physicians are salaried. Income stabilization has made the profession much better compensated than it was in the 1950s. Increasingly, hospital networks or private-equity-backed companies control the practice environment, including everything from the patient's initial appointment to the final bill. Corporate executives do not make clinical decisions, but they do set staffing levels, equipment budgets, and patient flow processes fed by systems that optimize billing and collection.<sup>ii</sup>

The time when a doctor hung a two-inch shingle and answered only to patients, community, peers, and conscience has evolved. However, no one has removed the intimate little 8 by 10 exam rooms. There, encounters are still defined by proximity, vulnerability, connection, and trust. It is where the family physician's clinical gaze mingles with the patient's narrative in a goal of shared understanding. It is the essence of medicine, regardless of the corporation. Without us, there is no them.

## Endnotes

1. AMA, *Code of Ethics of the American Medical Association*, A.M. Association, Editor. 1847, Collins: Philadelphia.
2. Riznik, B., *The Professional Lives of Early Nineteenth-Century New England Doctors*. Journal of the History of Medicine and Allied Sciences 1964. 19(1): p. 1-16.
3. Rosenthal, T.C., *Bloodletting and Germs: A Doctor in Nineteenth Century Rural New York*. 2020, Philadelphia: BookBaby.
4. Rosenthal, T., *Cyrenius Chapin, Buffalo's First Doctor and War of 1812 Hero*. 2025, Albany: SUNY Press.
5. LegalClarity. *When Did Health Care Become For Profit in the U.S.?* Health Care Law 2026; Available from: [https://legalclarity.org/when-did-health-care-become-for-profit-in-the-u-s/?utm\\_source=copilot.com](https://legalclarity.org/when-did-health-care-become-for-profit-in-the-u-s/?utm_source=copilot.com).

- i. Thomsonian practitioners were followers of Samuel Thomson who sold books claiming that once the reader had completed the book, they were now a doctor of the Thomsonian method. Most of his remedies included lobelia which is a hallucinogen. The movement was popular in the years 1820 to 1860. President Andrew Jackson endorsed the sectarian fad.
- ii. For more details readers are directed to the following titles: *The Social Transformation of American Medicine*, the 1982 work by Paul Starr; *The Care of Strangers*, a 1987 text by Charles E. Rosenberg; and the three-volume series *Learning To Heal* [1985], *Time To Heal* [1999], and *Let Me Heal* [2015], all authored by Dr. Kenneth Ludmerer.

**Thomas Rosenthal, MD** is Professor and Chair Emeritus of Family Medicine at the University at Buffalo. His newest book is titled "Cyrenius Chapin: Buffalo's First Physician, War of 1812 Hero."

**"Born at Geisinger and growing up as a patient inspired me to return and expand healthcare access for our community."**

Kathleen Finn George, MD  
Geisinger Buckhorn

## Care that comes full circle.

Geisinger Primary Care empowers physicians to deliver coordinated, evidence-based care that shapes a healthier future for our communities.

### Opportunities:

- Staff physician
  - Primary Care
  - CommunityCare, FQHC Look-Alike affiliated with Geisinger
- Teaching opportunities
  - Milton Med/Peds Ambulatory Site Director
  - Kistler Family Medicine Residency Core Faculty

"My goal is to improve the long-term health of this population so we can continue to thrive for generations to come." Kathleen Finn George, MD - Geisinger Buckhorn

### Support designed to make the biggest impact:

- Abridge & UpToDate access
- 24/7 nurse call center
- Centralized prescription refill team
- Integrated, value-based care



**Physician-led. Community-focused. Built for the long term.**

Geisinger

Follow Geisinger Primary Care on  



**ATTENTION NYSAFP MEMBERS!**

## **Did you know?**

**The New York State Academy of Family Physicians  
exclusively endorses MLMIC for its Medical Professional Liability Insurance.**

Since 1975, MLMIC Insurance Company has been providing New York medical professionals from Buffalo to the Bronx with claims protection and 24/7 access to New York-specific risk management advice, guidance, and resources. Their policyholders enjoy benefits and expertise not found anywhere else - supported by concierge-level service every step of the way.

**For medical malpractice insurance in New York,  
nothing compares to MLMIC.**



a Berkshire Hathaway company



**SCAN  
TO LEARN  
MORE**

**To learn more about MLMIC's coverage and discounts,  
visit [MLMIC.com/PSP](https://www.mlmic.com/PSP) or call (800) 275-6562.**



## Re**MEMBER** your **BENEFITS!**

- NYSAFP Membership Provides:
- Advancing our Specialty, Saving Members Time, Maximizing Values of our Dues
- Representation at the AAFP
- Representation of the local county chapters at the NYSAFP Congress of Delegates
- Promotion of family medicine in the medical schools and support of student programs
- Support of family medicine residency & fellowship training programs
- Representation of family medicine in the federal & state legislatures and policy makers through the PAC
- Saving Members Time
- Hosting of relevant and interactive CME workshops
- Hosting of ALSO instructor and provider courses
- Opportunity to interact with fellow family physicians throughout the state
- Reliable source of relevant and current events
- Weekly e-NewsBrief
- Quarterly peer reviewed journal – Family Doctor
- Timely access to current events of Academy via social media (NYSAFP Facebook | NYSAFP Twitter)
- Maximizing the Values of our Dues
- Sponsorship of students and residents to Academy meetings (Winter Weekend, Regional Family Medicine) and the Congress of Delegates
- Cultivation of the next generation of family physicians by offering scholarships and awards to pre-medical students, medical students, and residents to participate in family medicine conferences and programs
- Support of residents and new physicians in development of leadership skills and practice opportunities
- AAFP Member Services: <http://www.aafp.org/online/en/home/membership/resources.html>
- A list of the AAFP professional resources
- A list of the AAFP "Member Advantage"
- Additional Partnerships: <http://www.nysafp.org/index/resources-6/partner-programs-106.html>
- Jobs Board