

# New Models of Primary Care Workforce and Financing

Case  
Example  
**6**

## Henry Ford Health System



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## Case Example #6: Henry Ford Health System

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## Introduction

The Agency for Healthcare Research and Quality (AHRQ) contracted with Abt Associates and its partners, the MacColl Center for Health Care Innovation and Bailit Health Purchasing, to conduct research on innovative ways to configure primary care workforce teams that can deliver fully comprehensive, high-quality care to the U.S. population. The purpose of the research is to offer models of primary care teams and the associated costs for consideration and discussion by policymakers and providers in the field of health services delivery. To explore existing innovative workforce configurations, AHRQ and the Abt project team conducted a literature review, explored extant data sources, convened a Technical Expert Workgroup of national experts in primary care workforce, and conducted site visits to primary care practices with innovative workforce configurations.

The case example report which follows provides an in-depth look at the workforce configuration of primary care health care delivery at Henry Ford Health System (HFHS), a Michigan-based, not-for-profit, integrated health system. The information is from a site visit that included visits to Clinic K-15 at Henry Ford Hospital (located at 2799 W. Grand Blvd., Detroit, MI 48202), the Community Health and Social Services Center (CHASS) (located at 5635 W. Fort St., Detroit, MI 48206), and PACE Southeast Michigan (located at 800 W. Outer Dr., Ste. 240, Detroit, MI 48235). The site visit included meetings with key HFHS leaders who are incorporating community health workers (CHWs) into primary care and with teams from HFHS-based community paramedicine and school-based health centers and a pediatric mobile clinic. The site visit team also toured the mobile clinic (HFHS Headquarters, 1 Ford Pl., Detroit, MI 48202). Team members visited the practice on September 23–24, 2015. The data discussed below were collected on or prior to the visit and reflect calendar year 2014.

## Why Henry Ford Health System?

HFHS provides an array of health and wellness services to a diverse, inner-city patient population. As a large, integrated system, HFHS has developed programs and partnerships with community agencies to tailor care to the needs of the community. The site visit team observed care and interviewed providers and staff at K-15, a hospital-based ambulatory clinic serving inner-city families; a CHASS clinic operated in partnership with HFHS as a Federally qualified health center (FQHC) serving a primarily Hispanic population; and a program of all-inclusive care for the elderly (PACE) clinic serving seniors. We also learned about HFHS programs that work for quality-of-life equity for underrepresented racial/ethnic populations and other underserved groups to eliminate health care-related disparities.

## Overview of the Practice

HFHS is a not-for-profit corporation governed by a 21-member Board of Trustees. HFHS comprises hospitals, medical centers, and one of the Nation's largest group practices—the Henry Ford Medical Group—with more than 1,200 physicians practicing in more than 40 specialties. HFHS is specialty dominated, with only 250 primary care physicians. Primary care has been

influenced by Blue Cross Blue Shield, whose Primary Group Incentive Program (PGIP) drives practice improvement in primary care clinics across the State by supporting primary care practices to become patient-centered medical homes (PCMHs). PGIP participation demands that a clinic have enhanced access for patients, case managers, diabetes coordinators, measurement for quality improvement (QI), patient registries, and participation in a health information exchange. HFHS also benefits from the Michigan Primary Care Transformation Project (MiPCT), a 5-year, multipayer initiative to improve health in the State, make care more affordable, and strengthen the patient-care team relationship.

## **Patient Population Description and Practice Panel Size**

The total HFHS primary care population is approximately 280,000 people. The K-15, CHASS, and PACE clinics all are in urban, underserved neighborhoods. Each serves patient populations with high social needs.

The aim for clinic-level panels is 4,000 patients, with approximately 2,000 patients per physician. Physician assistants (PAs) are not empaneled. Each care manager has approximately 200 patients. At K-15, a total of 34,909 unique patients received care in the last 12 months.

HFHS has transformed the physician-compensation plan to include management of panels; 25 percent of pay is based on panel size. HFHS will soon be adding a variable for how well the physician cares for the panel to its quality measurement set. HFHS is also currently working on an effective acuity adjuster.

HFHS panels include inner-city populations, where young people have greater morbidity than other areas covered by HFHS. Interviewees said that current risk models don't capture this difference well, so HFHS is looking at social determinants and possibly literacy scores as a proxy.

## **Model of Care**

All HFHS clinics except one are certified PCMHs, including Detroit's K-15. K-15, an internal medicine residency clinic and the largest primary care clinic in Detroit, has developed a PCMH model they call Academic Patient-Centered Team Care (A-PCTC). The stated mission of K-15 A-PCTC is to advance the health and wellbeing of the community it serves and to educate health care leaders for the future.

“Together, we create confidence and trust by innovating reliable care and education that addresses each patient's medical, behavioral, and social needs. This means that we provide a patient and care team experience that meets the patient's needs every time through continuous patient and care team engagement in both in-office and between visits.”

–A-PCTC Vision Statement

## A-PCTC Strategies

- Define top-of-license roles for each care team member for patient care, learning, and QI.
- Provide reliable chronic disease and preventive care to every patient by improving clinical workflow.
- Provide feedback data to providers on clinical quality and efficiency to drive improvement.
- Develop a “social health program” to provide social work tools to all team members.
- Continue to be an innovation center for medical education and evidence-based primary care delivery.
- Maintain fee-for-service revenue and growth.
- Build skills for QI and an outcomes-based, high-value care reimbursement model.

## A-PCTC Elements

Supporting activities and infrastructure include team care and education, and patient input; quality and safety; health IT; patient activation, and access to care and information; and practice management. Academic activities include the Continuity, A-PCTC (K15), and Transition of care clinics, and research. Patient care activities are described for three risk levels: routine healthy patients and those with uncomplicated chronic disease, complicated at-risk patients with uncontrolled chronic disease, and patients with multiple chronic diseases.

# Workforce Configuration

**Exhibit 1: K-15 clinic team FTEs and roles**

<b>FTE</b>	<b>Clinical Staff Workforce Category/Role</b>	<b>Comments</b>
14.25	MD	
1	PA	One physician per shift supervises the PA.
7	RN	
0.3	RN Supervisor	
18	MA	
1	Behavioral Health Clinician	PhD-level clinical psychologist.
0.4	Behavioral Health Intern	
0.3	Clinical Pharmacist	Ambulatory pharmacy support for K-15 is co-located with clinic.
2	RN	Insurer-employed RN case manager.
0.5	Social Worker	Insurer-employed case manager.
13.8	MD Resident Trainee	
X	Smoking Cessation Counselor	Centralized service provided by HFHS.
<b>FTE</b>	<b>Business Operations Support Workforce Category/Role</b>	<b>Comments</b>
1	RN Manager	
0.7	RN Supervisor	
1	Scheduler	Creates the provider schedule grid.
0.5	IT	
10.5	Call Center	Centralized service provided by HFHS which has 35 FTEs; 10.5 is estimated from K-15's portion of total call volume (~30%).

X	Centralized IT, including EHR/Portal and Advanced Analytics/Registry	Centralized service provided by HFHS.
<b>FTE</b>	<b>Front Office Support Workforce Category/Role</b>	<b>Comments</b>
X	Customer Service Representative	Provided by hospital.
3	Medical Secretary, Transcriber	
X	Panel Manager	Centralized service provided by HFHS.

MD=medical doctor; PA=physician assistant; RN=registered nurse; MA=medical assistant; HFHS=Henry Ford Health System; IT=information technology; FTE=full-time equivalent; EHR=electronic health record

The core configuration for primary care at all HFHS sites is the teamlet—a physician, a medical assistant (MA) and a registered nurse (RN) at 0.25 full-time equivalents (FTEs). The HFHS clinics have been reducing the number of RNs and increasing the responsibilities of MAs to the highest levels of their license.

The K-15 clinic is the largest primary care site at HFHS, located in Henry Ford Hospital, the main HFHS hospital in downtown Detroit. The clinic began restructuring in 2012 to invigorate and recharge patient-centered team care. The K-15 care model is A-PCTC (see Model of Care section) using PCMH concepts. This approach was adopted to promote integration of services across the continuum of care, realign resources and services to meet the needs of at-risk segments of the population, and improve reliability and reduce variation in care delivery. The team-care focus is to get all staff working at top of license.

At K-15, each teamlet is supported by a secretary who is part of back office staff and does prior authorizations and other administrative work. RNs do more care coordination and management than direct patient care. Residents are part of the care team for one core faculty physician a day, with four residents per core physician and four teams centered around four pods in the clinic. Residents are trained in patient-centered team care, interdisciplinary chronic care management, motivational interviewing, between-visit management, awareness of high-value care, quality indicators, and benchmarking. At HFHS, social work is a limited, shared resource. K-15 has an onsite social worker 3 days per week.

HFHS has a diabetes self-management program called the Diabetes Care Center. One of the programs is diabetes in active control (DIAC), which delegates authority to DIAC coaches. Coaches are RNs or clinical pharmacists trained in motivational interviewing, with protocols for titrating medication. At K-15, an RN rather than an advanced registered nurse practitioner is piloting this work to bring the service closer to this inner-city population. Providers make electronic referrals to the RN through MyChart, a secure messaging patient portal, or by phone. Providers send pre-programmed “smart set” messages to the RN to specify interventions and the type of insulin to use. The RN does an initial introduction call or spends time in clinic with the referred patient, then uses a basal insulin titration protocol for adjustments between visits. The RN gives the patient a grocery shopping guide and insulin injection grid, and does followup calls every 1 or 2 weeks using a nurse followup protocol created in Epic, the HFHS electronic health record (EHR). Followup activities include promoting healthy eating and exercise and scheduling a followup series with repeat blood tests to confirm that blood sugar is at optimal levels. Preliminary results show a 2 percent drop in hemoglobin A1C measurements for patients after



working with the diabetes education RN. The RN proactively refers patients to programs for reduced-price insulin, provides glucometers, and organizes transportation to clinic or other appointments. The diabetes education program currently has 177 patients and is almost completely telephonic.

## **Care Coordination/Transitions and Care Management**

HFHS has a staffed central call center for all physicians. The call center makes appointments, including for referrals or followup or discharge. Call center staff perform some care coordination and nurse triaging at night; they are the first line of response for questions from patients. Call center staff are entry-level clerks, with some RNs for making clinical decisions.

At HFHS, case management is centrally managed, but case managers are peripherally deployed, and some work in specific clinics. Until recently, all of the care/case managers have been RNs. HFHS recently hired two social workers as case managers to focus on the high social needs of Detroit's central population. Their job is to help patients connect with services so they can ultimately manage their own health better.

The case management service began with Blue Cross Blue Shield funding, but HFHS now also provides financial support. The HFHS insurance system also has case managers who help in the clinics and are typically called care managers. These staff are located in the clinics as full team members who partner with physicians. Central management helps ensure that their model and training are consistent. Central management also facilitates HFHS tasks such as determining risk stratification and developing common pathways. Care managers are primarily focused on transitions of care, with some management for diabetes care, smoking cessation, and behavioral health services. Each care manager has approximately 200 patients. HFHS has tried to make case management more "insurance blind," with some management by disease state and some determined by insurance provider. Interviewees said that HFHS recognizes that a payer-specific model is not ideal and is working on a "universal model," including working with payers to provide funding for the model. Interviewees said that HFHS expects better results and resource utilization when it can care for patients from all or most payers.

HFHS provides social-service support through a central social service team that helps connect patients with social service programs, especially insurance or governmental programs for financial coverage options.

HFHS uses risk stratification to determine high-risk patients. Algorithms vary somewhat depending on source of funding for care management services. High-risk patients are placed on a care coordinator's list, and often a case manager will start interacting with patients on this list without prior provider interaction. A visit navigator documents care management in the Epic EHR, filling in fields for medication reconciliation and care planning that are sent to a primary care provider (PCP) for review. When case managers are in clinic, they can also interact with PCPs and may have established weekly meetings with them. If a PCP is seeing a patient under case management, the provider brings the manager in to meet the patient. Although most primary

care clinics use hospitalists, K-15 is located at a hospital so its primary care doctors do both inpatient and outpatient primary care.

## **Population Management**

Panel managers are nonmedical staff located centrally at HFHS who search for gaps in care. Panel managers run reports on panels at the clinic level, send letters to patients due for testing, and arrange for patient-specific outreach. Currently, HFHS employs 10 FTEs of panel managers, who typically have BA or BS degrees and excellent computer skills, doing population management for all of its primary care clinics. The analytics determining the measureable impact of new models and programs such as the DIAC care manager work will determine the appropriate use of pilot programs such as the placement of CHWs.

As part of the residency training program, the K-15 clinic runs a Transitions of Care clinic as a bridge to home discharge. A standard process detects patients who are being discharged. A team of resident physicians and MAs manages the care transition, usually in a single visit, and hands the patient off to a PCP. Formerly, patients would see their PCP upon discharge, but often weren't seen immediately, which interviewees said was problematic. The transitions clinic sees patients transitioning out of the emergency room (ER), observation or inpatient services. MAs call patients after discharge following a protocol for transition care management. MAs schedule appointments with PCPs for patients if needed. Residents follow up with patients who don't keep appointments. The clinic can see patients multiple times in 1 week, if necessary, to prevent readmissions. Interviewees said the most important aspects of the transitions of care experience are medication reconciliation and the opportunity to educate patients on home care.

## **Pharmacy Integration**

K-15 has an onsite ambulatory pharmacy. A clinical pharmacist partners with PCP teams to analyze services for patients, mail medications, provide medication adherence counseling, monitor polypharmacy, help with social issues (such as substituting medications that are less-expensive alternatives to brand-name prescriptions), and build relationships with patients.

## **Behavioral Health Integration**

K-15 has a 0.8-FTE PhD-level psychologist who also has 0.2 FTE to direct a psychology intern program. The psychologist supervises a 0.4 FTE psychology intern who also sees patients in the clinic. These behavioral health consultants take referrals from any PCP in the clinic. In addition, MAs tell PCPs or behavioral health consultants directly about patients with a high depression score on standard depression assessments. Reasons for referral include depression and anxiety, but behavioral health consultants also work with diabetes patients on treatment adherence, provide behavioral pain management, and run a 6-week behavioral weight management clinic. Behavioral health appointments are scheduled around patients' clinic visits using a "warm handoff" model. Patients can make future appointments if needed, but the consultants' schedule is not set up for phone followup.

The psychologist does brief, onsite interventions to determine needs and levels of followup. Assessment emphasizes motivational interviewing and includes issues such literacy, cognition, and medication before deciding on plans and goals for patients. Patients requiring advanced followup are referred to a centralized HFHS specialist for behavioral health resources.

The psychologist has collected data on getting patients into behavioral services, tracking referred patients, and followthrough. K-15 has 55 percent followthrough with appointments. The psychologist says the clinic sees more behavioral health issues in this high social-need population with resource limitations, and this might affect medication uptake or adherence.

**Exhibit 2: K15 Team Tasks and Roles**

<b>Tasks</b>	<b>Roles Included</b>
Pre-visit planning, chart scrubbing	MiPCT team does this for their members; otherwise this is not generally done at K-15, although RNs do a quick morning review of the day's schedule.
Greeting the patient	CSR registers patient, checks benefits, tees up MyChart conversation, gives patients after-visit summaries.
Ordering lab tests and collecting vital signs	MA collects vital signs and initiates lab orders; provider signs for tests that are due per EHR
Delivery of routine preventive services	MAAs initiate orders for vaccines and DM labs for provider to sign. Panel manager can order routine screenings per protocol (e.g., mammograms for women aged 50 and over) by sending a letter to the patient and placing the order.
Medication reconciliation or management	MA standard workflow includes asking patients if they are taking all medications on their list. PCP completes medication reconciliation. Clinical pharmacist is involved for patients with polypharmacy and recently discharged from hospital. RNs do medication renewals and BP medication titration by protocol. For out-of-range BP, RN titrates medication per protocol. RNs teach patients about starting insulin.
Reviewing and reconciling problem list	PCPs do this.
Patient navigation	Some senior support is available through Medicare.
Self-management goal setting and action planning	PCPs, case managers, BH providers, DM coach perform this role. All RNs are currently in training for an program to start in October 2015.
Patient telephone/email followup	See triaging phone calls, below.
Injections and venipuncture	MAAs do vaccinations and B12 injections. RNs administer intravenous fluids.
Triaging phone calls and emails	From the call center, calls are routed to team.
Care and transition management of high-risk patients	Care management is by RN case managers. Care transition management is by a central data analysis group that creates a daily spreadsheet of patients who need followup, which is expected within 48 hours. An MA and backup MA are dedicated to following up and scheduling patients for care-transition visits, which are longer than typical visits and include medication reconciliation and coordination of home health services.
Referral management	All referrals are within HFHS through a shared EHR; PCPs can see specialist notes in the EHR.
Medication titration	PCPs do this. For DM patients, RNs and the RN DM coach use a basal insulin protocol.

Tasks	Roles Included
Independent visits by nonproviders (RN, MA, health coach)	RN visits for BP checks. RN visits for DM education, medication reconciliation, injections, and treatment planning.

MiPCT=Michigan Primary Care Transformation Project; CSR=customer service representative; RN=registered nurse; MA=medical assistant; EHR=electronic health record; DM=diabetes mellitus; PCP=primary care provider; BP=blood pressure; BH=behavioral health

## Community Health Workers

### Community Health Workers at HFHS

HFHS has been applying a CHW model since 1998. The model was initiated through a Centers for Disease Control and Prevention Racial and Ethnic Approaches to Community Health (REACH) grant to the University of Michigan and the CHASS clinic; HFHS was a subcontractor. At the time, the project was considered a new, cutting-edge concept to make CHWs a reimbursable health care model. About 5 years ago, the Michigan CHW Alliance was established to work on policy to ensure CHWs become a sustainable and reimbursable health care option in Michigan. Interviewees said that HFHS is considered an optimal platform for testing innovative solutions such as use of CHWs in primary care because of the Detroit area's diverse patient population and integrated network of providers. CHWs are seen as ways to extend quality, equitable care; address diverse population needs; and connect patients to health care options in their own communities.

“Health occurs where people live, learn, work, play, and pray.”

– Dr. Kimberlydawn Wisdom, HFHS senior vice president of community health and equity and chief wellness officer; first Surgeon General, State of Michigan

Key CHW pilot projects and programs at HFHS include:

#### **Women-Inspired Neighborhood (WIN) Network: Detroit**

WIN Network: Detroit aims to reduce infant mortality in the Detroit population by connecting existing programs with the people who need them. Network staff have identified at least 100 infant mortality-reduction programs in the Detroit metro area, yet disparities in infant survival are still large. Interviewees said that the aim of WIN Network: Detroit is to “tighten a loose net of disconnected medical and social services” so women can “improve the conditions that lead to infant survival through the first year of life.” Using CHWs, called community neighborhood navigators in this program, 364 pregnant women and 900 nonpregnant women and their children were connected to a variety of health services, local neighborhood resources, and phone-based or Web-based information sources. Pregnant women received intensive interventions, such as home visits and monitoring, and strengthened social support. HFHS providers were also given health care-equity training to better understand the unique racial and socioeconomic factors that contribute to poor outcomes in their patients. As a result, WIN Network: Detroit has had zero infant deaths in their pilot population, and preterm weights are better than the city average. Interviewees said that participating women are now completing General Education Development programs and engaging in improving their own and their community’s wellness.

## **Diabetes Care Center Pilot**

This pilot works in “hub sites” based on the HFHS population of patients with diabetes. The pilot engages patients who are hard to reach, inconsistent about following through with lab tests and medication refills, and don’t keep appointments. An initial survey identified key barriers, including: medication cost to patients; structural difficulties (transportation, ease of walking into the building); and organizational issues (afraid of the doctor or test results). Based on survey results, the pilot engaged CHWs to help with patient behavioral change and goal setting by providing behavioral support and coping mechanisms, and conducting patient outreach through phone calls. The pilot is still in progress, but interviewees said that initial results are positive, and the HFHS Diabetes Care Center is considering moving toward the CHW model.

## **CHWs in K-15 and Advanced Care Centers**

Advanced Care Centers (ACCs) are a new strategic approach at HFHS to promote the integration of clinical services across the continuum of care, realign resources and services to more efficiently serve at-risk segments of the population, and improve reliability in clinical care delivery. The ACCs are moving toward a model of having an onsite CHW as part of the primary care team. Currently, the ACCs are developing interventions for high-risk patients that include eventually having CHWs in clinics. The CHW will work closely with the care team to explore a patient’s needs, develop a more comprehensive and robust care plan, and assist with the RN case manager load as appropriate. Interviewees said that this model will also help the care team learn how to train and interact with CHWs, which will enhance the overall CHW and patient experience.

## **Other Community Programs**

### **PACE Southeast Michigan**

This comprehensive primary care facility for older residents is in urban Detroit. The facility includes an onsite primary care clinic, meals, recreation facility, rehabilitation facility, secure room for dementia clients, and transportation services. The goal of PACE is keeping patients in their home environment as long as medically and safely possible. The onsite care team includes a PCP; rehabilitation services; nursing, behavioral health, and social work staff; and a clinical pharmacy. The PACE model includes home health nursing visits, regular transportation services, insurance services, and 24-hour care. Patients transfer their primary care to PACE upon joining, but members can see their previous primary care doctor twice yearly.

Patients are divided into three groups that determine visit structure: longevity patients are mentally and physically mobile and agile, functional patients have limited physical or mental impairment, and frail patients primarily receive comfort care. End-of-life issues are addressed directly through the behavioral health team with regular patient memorial services and counseling available to patients and families dealing with loss and grief.

“The focus is not the disease, the focus is the patient.”

– Dr. Gwendolyn Graddy, PACE Southeast Michigan medical director

Patients are deemed PACE eligible by the onsite health care leadership team if their mental and physical condition allows them to stay healthy and safe in their home environment with a combination of onsite and home care. Patients who do not meet these criteria might move out of the PACE program and into a long-term care facility.

Health care workers interact with patients during recreational times and might identify potential health needs that can be addressed onsite at the primary care clinic. Patients can also be referred to HFHS specialists or admitted to the HFHS hospital. PACE providers make regular hospital rounds with the attending physician to monitor patient needs and plan for the transition back to home care.

### **HFHS School and Community-Based Health Network**

In the Detroit area, this network has 7 school-based sites; 10 community-based sites, often in community centers; and two roving mobile units. School-based sites have a dedicated staff of one or two nurse practitioners, a social worker, an RN, and one or two MAs providing primary care and behavioral health services. Mobile units contain a physician-level provider, a nurse practitioner, an MA, and a driver. The chief of medicine rotates at one site per month. An RN is on call for night shifts. All sites are linked with HFHS’s EHR. Approximately 17,000 unique visitors were seen in 2014. Clinics, including the mobile clinic, take all insurance types; most patients are Medicaid eligible with the rest of funding from Michigan State. Interviewees said the program is aiming to expand, but struggles with Detroit school closings due to shifting demographics. The program is considering installing mobile units at schools until the patient population stabilizes.

### **Community Health and Social Service Clinic**

CHASS Center, Inc. is a community-based, not-for-profit organization that develops, promotes, and provides comprehensive, accessible, and affordable quality primary health care and support services to all community residents. CHASS places special emphasis on the underserved African-American and Latino populations. As a FQHC, the CHASS clinic cannot be owned by HFHS. HFHS provides six full-time family physicians on staff who are paid by HFHS to provide primary care services. Staff and other clinicians are paid by CHASS. HFHS also provides care that is out of PCP scope at CHASS-specialty care; this includes imaging and lab services, irrespective of the patient’s insurance status. The aim of this service is keeping patients out of the ER and ensuring they see appropriate providers. Interviewees said that ER utilization has been steadily decreasing as the community is educated that CHASS is their primary care home.

CHASS services include prenatal care, adult medicine, counseling, pediatric/adolescent care, dental care, affordable specialty care through HFHS, family planning, and pharmacy. Wellness services include community education classes; nutrition counseling and group education; a

partnership with LA VIDA, a domestic violence prevention, support, and education program; a partnership with REACH Detroit; and a Women, Infants, and Children program.

Before the Affordable Care Act, HFHS was supporting CHASS with approximately \$10 million per year. CHASS has now shifted many patients to insured status through expanded Medicaid, and the patient population went from 86 percent uninsured to approximately 55 percent uninsured by the end of 2014. The FQHC board is required to be 51 percent users, which implies significant community input. CHASS is currently applying for PCMH recognition.

### **HFHS Community Paramedic Pilot**

The community paramedic pilot started at the HFHS Wyandotte clinic to serve high-risk patients discharged from the hospital. The goal of the pilot is reducing the number of high utilizers and readmissions by providing followup care for patients discharged to their homes. Patients are eligible for paramedicine if they don't qualify for or refuse home health; often these patients will allow a paramedic into their home because they trust first responders. This pilot enrolls patients who have a discharge diagnosis of coronary heart disease, chronic obstructive pulmonary disease, or pneumonia. Patients are enrolled in a 30-day program that provides a followup visit within 4 hours of hospital discharge. A community paramedic performs a medical assessment and answers questions about prescribed medications or other details about the discharge. The paramedic will also transport the patient to their PCP, deliver prescriptions, and link the patient to emergency response if needed.

## **Team Building and Training**

The K-15 staff all provided input on the A-PCTC vision statement. The clinic staff designed a plan to work toward team care, including providing specific training and generating a culture of team care. In K-15 meetings, the clinic staff standardize care and workflows across all four clinics and for the RN, secretary, and MA groups.

K-15 recently implemented MA leads who train staff on standard rooming workflow and test them on group competencies. The MAs have monthly staff meetings. PCPs and staff meet separately, building intentional agendas around training issues raised throughout the month. K-15 has a staff retreat twice a year for all staff. Staff have access to university-level online or in-person training. Regular reports are posted in the clinic about in-clinic QI projects, protocols, and processes.

# Access, Comprehensiveness, and Quality

## Access

HFHS serves approximately 280,000 people, mostly in urban, underserved neighborhoods. A central call center is the first line of response for patients. Staff at the call center make appointments, as well as perform some care coordination activities and nighttime nurse triaging.

## Comprehensiveness

### Community Linkages

HFHS is an integrated health system with extensive community connections (see sections on community workers and programs in Workforce Configuration section). HFHS aims to bring primary, secondary, and tertiary care together, augmenting services with community-based programs. For a cohesive strategy to centralize improvement, a Care Team Forum of system leaders discusses how to tackle QI issues and QI implementation. Decisions are not made by individual sites or QI specialists but are part of central, standard operations. Each clinic sends representatives to Care Team Forum meetings to take decisions back to their site for implementation. The group uses Lean methodology, plan-do-study-act cycles, workflow diagrams, and other tools. A data analyst provides clinic-specific audits, outcomes, and data about processes.

## Quality

Interviewees said that some “bright spot” clinics implement new care practices with agility. HFHS has found that small clinics with a dedicated MA and physician, a high level of personal engagement, good direct outreach, and personal relationships with patients are better at following through and making changes. Interviewees said that rolling out QI changes to other clinics will help determine factors that aren’t specific to patient population. For example, HFHS is working on QI programs for inner-city, low-resource-population clinics, recognizing that these populations may need additional support. Data analytics are identifying population needs. An example is the Hamtramck clinic, which serves an Arabic-speaking population with high rates of cervical but low rates of breast cancer screening. Interviewees said that factors affecting QI at this clinic are lack of nurse practitioners and onsite mammography, and transportation issues.

## Implications for Primary Care Staffing Models

Functions of primary care that are managed centrally, such as care management services, can be effective if consistent and efficient communications mechanisms exist between the centers and each primary care team.

Large, integrated systems can provide the foundation for services and programmatic resources needed by local populations by implementing programs like PACE model centers for seniors and by forming partnerships with FQHCs in neighborhoods with high social needs.



CHWs can effectively intervene with specific populations such as pregnant women or high-risk infants in the community and work within the clinic setting to collaborate with patients on care planning.

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