Workforce Roles in a Redesigned Primary Care Model

Executive Summary

In September 2011, the American Hospital Association (AHA) convened a roundtable of clinical and health systems experts to examine the future primary care workforce needs of patients, as well as the role hospitals and health care systems can play in effectively delivering primary care.

The AHA chose to focus on primary care access in light of the *Patient Protection and Affordable Care Act* (ACA), which will provide access to insurance coverage to an estimated additional 32 million Americans, beginning in 2014. The roundtable members included nine physician and nurse leaders who were asked to develop a set of recommendations that hospitals and health care systems could use as they plan workforce strategies to meet the upcoming demands for primary care services.

The findings presented in this white paper reflect this group's discussion and recommendations on two fronts: first, how to define workforce roles for a new primary care environment; and second, developing a new, more effective model of primary care delivery that encompasses the birth to end-of-life continuum. These recommendations take into account a variety of facility resources, including those related to finances and staffing, that must be considered if the redesign is to be successful.

Recommendation Summary

Workforce

1. **All health care professionals should be educated within the context of inter-disciplinary clinical learning teams.** Clinical education system redesign should include curricula that support inter-disciplinary, team-based learning. These changes are necessary to prepare a workforce able to function well in integrated, multi-disciplinary care teams. Perhaps an even greater challenge is the re-education of the current workforce to work in a team-based model of care.

Primary Care Delivery Model

1. **Primary health care should be centered around the patient and family in a user-driven design, in all aspects of practice.** This recommendation is at the core of primary care redesign and, without it, all other recommendations for redesign may not be sustainable.

2. **Hospitals should evolve from traditional "hospitals" to "health systems," partnering with community organizations and patients in order to advance the community's wellness and health needs.** The roundtable recognized that efforts have been made in the past to configure a new system. However, this recommendation is different in that it emphasizes that without effective linkage with the community, this evolution will not be successful.

3. **Hospitals, or health systems, can serve as catalysts for linking and integrating the various components of health and wellness together for patients in a way that provides a sustainable infrastructure of health care for patients and the community.** The roundtable underscored the fundamental and pivotal role of health systems in redesigning primary care due to their status in— and responsibility for—the communities they serve.

4. **In order to mitigate rising health care costs, a fundamental shift in reimbursement will need to occur.** This means patients and organizations alike will need to transition from the episodic, fee-for-service model of reimbursement to a new model that will reimburse for and encourage wellness and care across the health service continuum. By preventing and better managing the chronic conditions that afflict our population—or identifying them earlier in their course—the patient care experience can improve, providers will be better able to deliver quality care and, overall, costs can be reduced. The primary care clinical workforce is in an excellent position to influence this change in significant ways. The roundtable noted that this shift will require significant legislative and reimbursement reform, involving broad participation by the health care community.

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Guiding Principles Summary

Based on these recommendations, the roundtable developed this set of guiding principles to help stakeholders address primary care workforce issues and the necessary redesign of primary care delivery systems:

1. In partnership with the patient, the primary health care team is guided by what is best, needed and helpful to the patient and family.

2. **Workforce:** The workforce must change how it functions on multiple levels. Care must be provided by inter-professional teams where work is role-based, not task-based, and the team must be empowered to create effective approaches for delivering care.

3. **Primary Care Delivery Model:** Hospitals can serve as conveners and enablers in primary care delivery. Primary care should be integrated into current and future care systems and hospitals should form effective partnerships with the community and patients in a way that provides the infrastructure primary care teams need to deliver quality care.

Accountability-Based Primary Care Workforce Model Summary

In putting forth a new primary care workforce model, the goal was not to set rigid systems and constraints, but rather to set forth a framework that would encourage further dialogue, and from that, let the model further evolve to meet the needs of individual communities.

The design developed by the roundtable, the Accountability-Based Primary Care Workforce Model (see page 12), is a hub-and-spoke model, with the patient, family and healthy community at the center. Radiating out from this are different health care roles

and professionals who each deliver care within their scope of practice and work collaboratively in a team-based model.

In this model, the interface between and among team members is well-defined as well as their individual responsibilities. Within this framework, team communication becomes more effective and providers can be appropriately matched with both service demands and patient population needs. One example of this model in current practice is the "health home."

Overview

The American Hospital Association (AHA) convened a roundtable of clinical and health systems experts to examine the future primary care workforce needs of patients, as well as the role hospitals and health care systems can play in effectively delivering that care.

The AHA chose to focus on primary care access in light of the *Patient Protection and Affordable Care Act* (ACA), which will provide insurance coverage to an estimated additional 32 million Americans, beginning in 2014. The roundtable members included nine physician and nurse leaders who were asked to develop a set of recommendations that hospitals and health care systems could use as they plan workforce strategies to meet the upcoming demands for primary care services.

What is the current state of the primary health care workforce and delivery system? What is working? What might be challenging?

Roundtable members discussed the current state of primary health care and outlined a basic set of assumptions.

Workforce

1. **The professional workforce in the future will be smaller, and the work itself will be different than it is today.** Projections for nursing shortages and primary care physician shortages have been published widely, and the shortage of primary care physicians will only be exacerbated by increased demand for their services by 2014. This will be due to the aging population, the addition of an estimated 32 million patients into the system as a result of ACA, and the increasing movement of chronic disease care into the ambulatory arena.

2. **To function as seamless, efficient teams, all health care professionals (both current and future) need to be trained in inter-professional educational settings.** This represents a major challenge for our centers of professional education to innovate in the redesign of both pre-clinical and clinical curricula.

Primary Care Delivery Model

1. **With growing health needs, the financial cost of health care could continue to increase.** The current reimbursement system is based on a fee-for-service model. However, to mitigate health care costs, a business case must be made for a value-driven model. This new model reflects the potential fiscal impact of evidence-driven health and wellness, not simply late-stage, tertiary acute and episodic care.

2. **The health care community must begin work now to design community-based care focusing on achieving and sustaining wellness instead of only intervening and treating illnesses.** This will require a sophisticated information technology (IT) infrastructure that will allow population management, severity adjustment, targeted screening and preventive care. The way patients, providers and the community discuss access to care should now be refocused on the need for a fundamental structural shift in the way primary care is understood and delivered.

3. **Finally, all care going forward must reflect the specific health service needs of the patient and family, in all aspects of clinical practice.** This will require a profound cultural shift in order to educate and engage patients as true partners in charting their course through the health care system, and to move away from the paternalistic model that has too often characterized the relationship between clinical professionals and patients.

Attributes that Contribute to Success

The roundtable also discussed the benefits of effective redesigned primary care systems and attributes that help make them successful. Examples of these attributes include:

Workforce

- Use of culturally aware care coordinators to manage patient needs.

- Clear role delineation, education and development for each member of the health care team.

- Trust and respect among the health care team members and an environment that allows them to practice to the full scope of their license, respectfully share differing views and collaborating in order to deliver the highest quality care to the patient.

- Team roles that can expand and/or be modified to fit the specific characteristics and needs of the population being served.

- Senior leaders present at the point-of-service to provide support to the care team, especially decision-making.

- Clear practitioner understanding of his or her role. All practitioners are 100 percent accountable to the team and the patient.

Primary Care Delivery Model

- Well-integrated health IT that provides patient disease registry functionality, inter-operability and is mobile.

- A system infrastructure that allows efficient and effective communication among the primary health care team to promote coordinated care.

- Assurance that the patient and family are always at the center of all discussions and decisions, and are the center of the locus of control for plans of care.

- Strategies that recognize patient ownership of care and actively engage patients in managing their own care.

- Accessible care when and where the patient needs it (i.e., after-hours visits, online communication tools such as patient portal sites, email addresses of health care providers, etc.).

- An evidence-based, outcomes-oriented safety and quality improvement culture that is supported by meaningful measurement.

- Data collected by the practice, not the practitioner, which enables the entire team to access that information to provide better quality care.

Issues that are Impacting Progress

The roundtable acknowledged the issues that are limiting the progress of change. These include:

Workforce

- The current state licensing acts that restrict some practitioner's full scope of practice.

- Some discipline-specific desires to protect their autonomy of practice.

- Lack of progress on the part of schools and universities to prepare health care practitioners for team-based care.

- Pipeline issues including nursing and advanced practice registered nurse (APRN) faculty shortages.

- The cap on Medicare/Medicaid-funded residency programs.

Primary Care Delivery Model

- The fee-for-service structure that is not value-based, which impedes the ability of providers to create better integrated services that focus on coordination of care rather than discrete billable services.

- Lack of adequate orientation and education for patients to manage their expectations of a redesigned system.

- Regulatory barriers that get in the way of clinicians coordinating care across the continuum.

- The fear of change and resistance to change.

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Emerging Provider Roles Can Help Strengthen System

One common characteristic of these high-functioning primary care systems is the emergence of new team members who help connect patients with providers and community resources such as health coaches, health care navigators, population assistants, "promotoras de salud" or community health aides. Some receive formal training while others are trained on the job by a clinician and work through community health clinics. Oftentimes, these individuals also train new recruits interested in a similar position.

There is compelling data that shows these new team members can have a positive impact on adherence to treatment plans, can help make links to community resources, contribute to better outcomes, and help lower costs. These roles are still being fully defined as to the level of education needed or desired. In most cases, their education has grown organically based on the community and its needs and seems to work well when the training is geared towards a particular community organization.

Future Primary Care Workforce

The Accountability-Based Primary Care Workforce Model (see page 12) depicts the various members of the primary care team. The **physician's** role is to diagnose, oversee the plan of care and care for complex patients. The **physician assistant** diagnoses and oversees the plan of care under physician supervision. The **advanced practice registered nurse** diagnoses and provides the plan of care. The **registered nurse** triages patients, provides education and overall care management. The **medical assistant** provides direct patient care. The **pharmacist** manages medications and helps educate patients and families about prescribed medications. The **psychiatrist or psychologist** provides behavioral health management for patients and families. The **clinical social worker** provides case management and supports community linkages for patients and families. The **nutritionist** oversees and manages dietary-related issues for patients. The **dentist** is part of the team addressing oral health issues. The **health coach** is a liaison between the patient/family and the community and the primary care provider(s). Health coaches may not necessarily be clinicians and some could be more formally educated than others, depending on the setting in which they work.

Each of these team members has a role to play in the health of the patient, family and community. There are also specialists, such as hospitalists, internists, OB/GYNs and geriatricians, who may play important roles in primary care depending on the needs and preferences of the patient.

Impact of Information Technology (IT)

The work of the roundtable would be remiss without acknowledging the critical impact of IT on the future of health care. The roundtable discussed how technology can enhance a patient's experience but if it is not introduced correctly or used within certain boundaries, technology can also adversely affect the patient experience. The question is not "if" we will use technology to advance care but "how." We need to keep in mind that technology will impact care even more in the near future. The challenge will be to use technology to enhance the patient experience and not replace the skill of the personal interaction with a caregiver, to use all of the tools, including social media and telehealth, to communicate effectively with patients and communities, and use it as a catalyst for interacting with and creating healthier communities. Information technology will ultimately inform and provide the basis for even newer and more innovative models of primary care delivery.

Primary Care in Rural Areas

Rural hospitals, by nature of their location, availability of caregivers and modest assets, have already been forced to provide primary care in new and innovative ways. With the impending primary care physician shortage and the existing nursing shortage, along with the proposed cuts to rural hospitals contained in the president's deficit-reduction proposals, rural hospitals will be even more challenged to provide basic primary care to their patient population.

One of the challenges is to connect with the community and to ensure that the care offered is what is needed by that community. This is true in urban settings, as well, but in a rural area, with diminishing resources, targeted programs to assess health care needs are especially critical. In northeast Wisconsin, the ThedaCare health system, launched a Community Health Action Team (CHAT) that participated in a "plunge" event to identify community health issues in the local farming community. Many farmers were uninsured thereby skipping needed check-ups or treatments for chronic conditions, and their families felt disconnected from the community due to financial hardships. For the past eight years, rural health coordinators (nurses specially trained for this work) have visited more than 325 farms to provide health information, screenings and connect families to the health and social services they need. These nurses have been able to identify more than 200 people in need of acute care for chronic conditions and have referred almost three times that number of people to non-health related social services. This is an approach that demonstrates that innovative and non-mainstream processes and programs can work well for rural hospitals, many of whom can serve as models for other hospitals (rural and non-rural) that are striving to do more with fewer resources.

Other Considerations

In preparation for redesigning primary care, some additional guidelines to consider are:

Workforce
- Hospital senior management teams, especially the CEO, should be involved in value-driven redesign efforts.
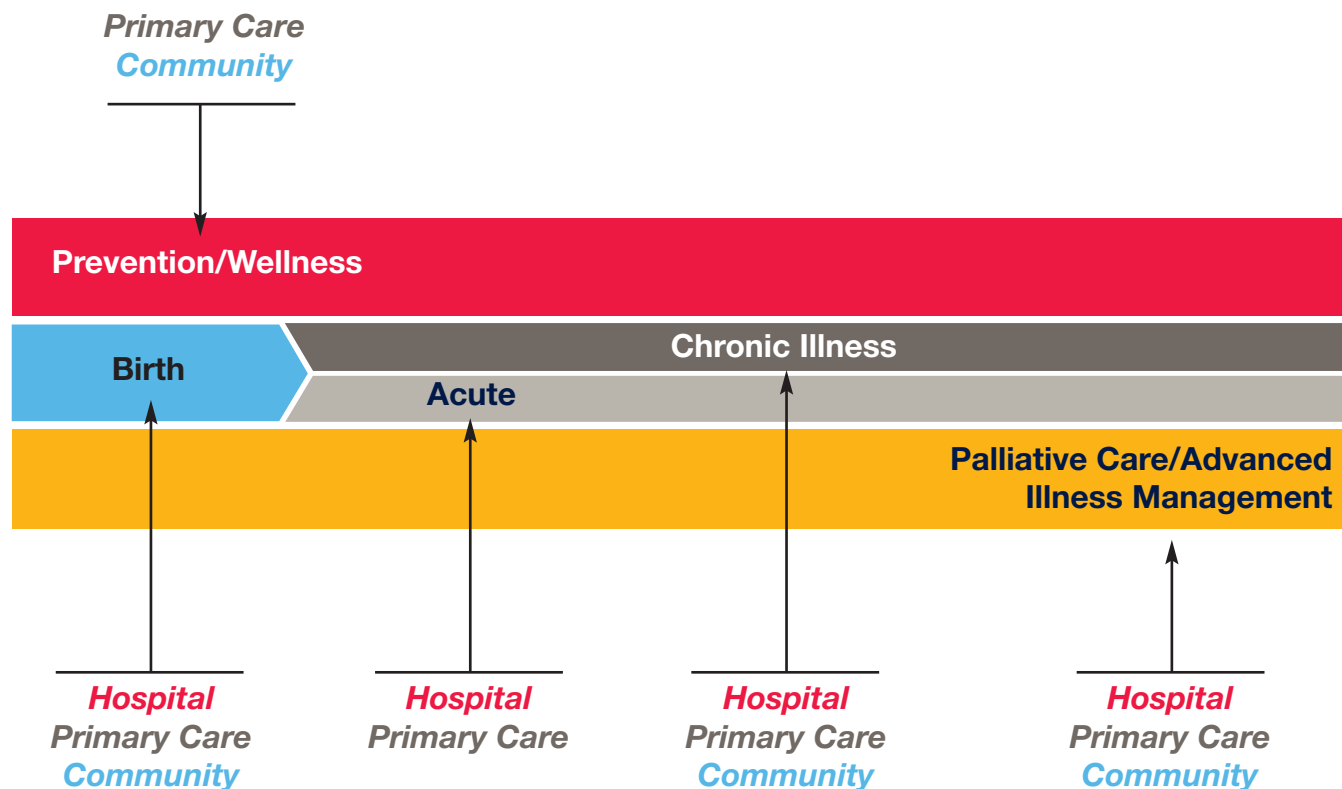
Primary Care Delivery Model
- Primary care must reflect good patient outcomes and values that impact the achievement of targets for health.
- What helps the patient helps strengthen the entire system of care.
- The economic and financial business case must reflect that health and wellness is both cost-effective and provides meaningful return on investment beyond that which is obtained simply by focusing on acute or episodic care.
- Hospitals should evolve into "health systems," demonstrating partnership with community organizations and their patients as they collaboratively advance the community's wellness and health.
- Primary care models in hospitals and health systems serve as catalysts for integrating each component of health and wellness for consumers—they create an effective infrastructure for providing health care to patients and the community.

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Continuum of Care

To help illustrate the primary health care access points for the general population and to show where hospital and community primary care can work together, the roundtable developed the following "continuum of care" model addressing health issues and advancing community-centered services from birth to the end of life.

Primary Care
Community

Prevention/Wellness

Birth

Chronic Illness

Acute

Palliative Care/Advanced Illness Management

Hospital
Primary Care
Community

Hospital
Primary Care

Hospital
Primary Care
Community

Hospital
Primary Care
Community

It is important to note that the continuum illustrates how prevention and wellness span its length to mitigate future effects of chronic illness or acute episodes on the health care system. Additionally, palliative care and advanced illness management span the continuum. Often viewed as needed only when someone is old or on the verge of death, palliative care and advanced illness management might be needed at any point during an acute or chronic illness, regardless of age. These are key concepts in understanding the critical nature of the interface of primary care with that of acute care and care for chronic illness.

Using this model, the roles and responsibilities of primary care are described under each section of the continuum. For each section, the roundtable identified key components needed (listed in red), and described how those components could work in a redesigned primary care system (listed in blue).

Key components: education and coaching; screening and preventive services; community resources; behavioral health; individual advance directives documentation.

■ **Education and Coaching**

- Offer classes to patients on site or other convenient places.
- Offer virtual learning and educational websites.
- Assess and address educational needs of clients.
- Create infrastructure to do assessments.
- Assess and promote health literacy.
- Promote self care.

■ **Screening and Preventive Services**

- Offer health fairs; screening on site or at community sites.
- Teach self-screening.
- Identify personal health practices.
- Offer access to screening equipment.
- Provide screening for evidence-based preventive care and educate patients on value.

■ **Community Resources**

- Create the capacity to identify and link patients to community resources.
- Provide or identify transportation, exercise facilities and options, focusing on wellness and how to access these resources.
- Create a central informational resource for patients and families in geographic areas that is available to everyone.
- Train community members and health care "navigators" to support easy access to services and resources.
- Create partnerships among community entities that can help individuals create personalized health and care options.
- Develop and support primary care educational liaisons to work with schools and other community-based organizations to expand the reach of wellness and preventive care education.

■ **Behavioral Health**

- Provide behavioral health assessments for patients receiving care in the health system.
- Engage psychiatrists, geriatricians and APRNs in primary care practices to serve as behavioral health consultants and educators.
- Identify depression and other behavioral disorders early to improve impact on patient health, and support access to mental health services in the community.

■ **Individual Advance Directives Documentation**

- Obtain data early on in the primary care setting, versus in the hospital, where the decision-making process may be rushed or more difficult for the patient.
- Keep copies of all documents so they are readily available, and include this documentation in the EHR, if one is available.
- If the patient wants to change their directives, be sure to update the documentation immediately.
- Refer community members to resource specialists or lawyers if they are looking for expertise in estate planning.
- In conversations with the patient and family, emphasize the patient's values and goals for end-of-life care so that they are reflected in the document.

■ **New Models**

- Build "health neighborhoods," distinct from a "health home," which are collaborative relationships between clinical specialists and primary care, that connect and coordinate all aspects of the community-grounded health care system.

The roundtable emphasized the critical importance of having prevention and wellness span the full continuum, which encourages behavioral health screening and assessments to be integrated into all primary care prevention and wellness conversations.

Acute Care

Key components: 24/7 access to care; improved communication among care team, home care, transition, "in between" care, post-acute care; urgent (minor) and chronic disease exacerbations; partnership/bridging around diagnosis; "warm hand-off;" shared decision-making; coordinated and comprehensive discharge.

Imagine a patient seeking care at her local community health center, which serves 15,000 residents. When she arrives seeking care (regardless of the time of day), she is seen by a clinician. Within the new accountability-based primary care model, here are the general steps that patient would follow, as she makes her way through the system:

■ The first step is determining who should evaluate her; this is best achieved through a registered nurse triage system, made readily available to patients.

■ This evaluation would happen at the health center itself, or an affiliated primary care practice, urgent care clinic or ED.

■ The triage system would then determine the best location for the evaluation, by fitting the patient need with the services available.

■ If she cannot be evaluated at one of these clinics, she would be transferred to the associated ED. Doing this should require a single phone call.

■ The patient's medical record is readily available to those who need it. The health system should have an efficient system for sharing patient care information along the full continuum of care.

■ After the decision to transfer is made, the patient is admitted directly to the hospital under the care of a partner care team, led by a practice-linked hospitalist or a practitioner in a similar role. For this "warm hand-off" to happen seamlessly, an established, trusted partnership must exist between the primary care provider at the community health center and the hospitalist or hospital provider.

■ After the patient is admitted, the primary care team member meets with the hospitalist or hospital provider to begin discharge planning and can suggest community services benefiting the patient after discharge. This clinician might be designated as the care manager on the primary care team.

■ With this model, there is an established link between the primary care team and the local hospital, which is the ultimate goal in acute care treatment.

A benefit to this model is that young people without clinical education can fill these new roles and gain experience and learn more about the medical field. This puts them in an excellent position to become future nurses, physicians, social workers and other health care providers who will be needed to fill these roles. When this strong link exists, individuals who are not trained health care providers can still be a part of the system and strengthen it, by serving as health care navigators or others who help make the connections between the community and the hospital.

Key components: services to support chronic disease management; team approach; registry; care managers; metrics; home care; health IT; patient education; self-management; medical/health neighborhood; evidence-based practices.

- In this accountability-based model, the patient and family are in control, connecting with acute care when needed.

- Care teams communicate with each other to determine the best ways to work collaboratively to treat the patient.

- Patient care teams should be accountable for coordinating and integrating care rather than a single primary care provider. Care will be consistently delivered collaboratively, with patient needs put at the forefront.

- Teams that manage patients with chronic illness must clearly understand their roles. When they do, they work most efficiently, cost-effectively and deliver the best quality care to the patient.

- These teams use tools and take specific actions in order to deliver the highest quality care. This includes referencing patient registries, ensuring appropriate measures of disease outcomes to monitor status, and making regular visits to patients to assure better outcomes.

- There is an emerging role within this new accountability-based model, the "health coach" who can serve the patient as well as strengthen the health care team. This individual communicates with the patient and encourages the patient to take charge of his or her health. In addition, the health coach helps establish valuable links between providers, patients and community resources.

- Patient education can be delivered individually or in groups, using emerging strategies designed to better engage patients in self-care (i.e., "Shared Medical Appointments").

- Provider-driven teams strive to reduce the number of patients unnecessarily admitted to the ED or hospital.

- Providers who work with patients with chronic illness educate their patients to focus on proactive and preventive care and better management of their chronic disease. Doing this not only helps patients, but strengthens the health care system as a whole, since it helps reduce high costs associated with preventable disease complications.

- Incentives should be provided to the primary care team to invest in chronic care management. As we move toward payment and delivery system reforms, as well as population health, a portion of the savings from these initiatives should be shared with providers.

- Establish portal for patients to access their health record, track and input their health data.

Palliative Care / Advanced Illness Management

Key components: identify patient values; cure and comfort coordination; shared decision-making; include five principles of palliative care: physical, psychological, social, spiritual and financial. Death should occur in the most appropriate space.

- Ensure that patient values are clearly understood. What are the patient's wishes and goals regarding their end-of-life care?

- Ensure the patient has a living will and/or advance directive. If not, help the patient access resources so he or she can create one. If the patient already has a living will and/or advance directive, review it with the primary care provider at regular intervals to see if any updates are needed.

- The primary care team diagnoses and offers recommendations regarding life-threatening illnesses. The patient participates by communicating his or her wishes regarding his or her end-of-life care. Together, decisions are made regarding how to best move forward.

- Monitor progress during patient treatment that happens outside of the clinician's immediate control. This is an ideal role for a care manager. During this monitoring, it is helpful to have established relationships and collaboration amongst all care providers to ensure quality, consistent care continues to be delivered.

- Patient comfort should be assessed at every point of contact and appropriate comfort measures instituted.

- Ensure primary care team members continue to provide and refer the patient to needed resources, including referrals to hospice/home care as appropriate.

- Share decision-making with the patient and family and assist them with difficult end-of-life decisions.

- Ensure the five principles of palliative care are being met:
  - Social: Led by social worker
  - Spiritual: Led by care manager/pastoral care
  - Physical/comfort: Led by primary care practitioner
  - Psychological: Led by a psychologist linked to the primary care team
  - Financial: Led by social worker and family

- The social worker and care manager provide information about bereavement programs for family.

Decisions about advance directives or palliative care can come at unexpected moments, whether one is old or young, so integrating advanced illness management into primary care prevention and wellness is imperative. Furthermore, opportunities for monitoring and treating behavioral health and wellness in such a continuum are enormous and should be taken advantage of as we design new ways of integrating key services in primary care along the entire continuum.

Attributions of Team
- Role Clarity
- Role Training
- Working to top of practice
- Team communication
- Subject experts for patient population

Driven by patient needs

Guiding Principles

The guiding principles developed by the roundtable are:

1. In partnership with the patient, the primary health care team is guided by what is best, needed and helpful to the patient and family.

2. **Workforce:** The workforce must change how it functions on multiple levels. Care must be provided by inter-professional teams where work is role-based, not task-based, and the team must be empowered to create effective approaches for delivering care.

3. **Primary Care Delivery Model:** Hospitals can serve as conveners and enablers in primary care delivery. Primary care should be integrated into current and future care systems and hospitals should form effective partnerships with the community and patients in a way that provides the infrastructure primary care teams need to deliver quality care.

In developing this primary care workforce model, the goal was not to set rigid systems and constraints, but rather to set forth a framework that would encourage further dialogue, and from that, let the model further evolve to meet the needs of individual communities.

The design developed by the roundtable, the Accountability-Based Primary Care Workforce Model, is a hub-and-spoke model, with the patient, family and healthy community at the center. Radiating out from this are different health care professionals who each deliver care within their scope of practice and work collaboratively in a team-based model.

In this model, the interface between and among team members is well-defined as well as their individual responsibilities. Within this framework, team communication becomes more effective and providers can be appropriately matched with both service demands and patient population needs.

The model depicts one way of looking at a redesigned system with a core primary care team. Core team members' roles are adjusted based on the unique needs of the particular population they serve. This model serves as a starting point for future discussions; it is one suggested mechanism of catalyzing the movement toward a redesigned system.

The roundtable felt strongly that redesigning care around an integrated, inter-professional team— in addition to its benefits for access, quality and patient satisfaction—also represents a sound strategic and fiscal investment for health systems preparing to function in a cost-constrained environment. In a reformed, primary care-grounded health system scenario, hospitals will be able to offset their financial risk for providing poorly reimbursed care in the in-patient and emergency department setting by proactively providing that care by primary care teams in the ambulatory setting.

Best Practices

Following are some forward-thinking organizations that already have accountability-based primary care models in place. The work they are doing can help inform the task of redesigning primary care.

■ Clinica Campesina, near Denver, Colo., is a community health center with three sites serving a primarily Latino population. Their goal is continuity of care, and they have made it their mission to systematically redesign primary care services over the last several years. Clinica Campesina uses high-functioning primary care teams with high LPN involvement and credits "co-location"—a distinguishing feature of how they locate the team to work in close proximity with each other in what they call "pods"—as part of their success. Patient satisfaction scores are high, and the ability to see more patients per clinician is a result of the close proximity of the care team whose members share functions as needed in order to expedite visits and answer questions via telephone.

■ Geisinger Health System is a physician-led, not-for-profit, integrated delivery system headquartered in Danville, Penn. It serves a population of 2.6 million people in 43 counties, employs almost 800 physicians, has 50 practice sites including 40 community clinics and manages Geisinger Health Plan, which offers individual, group and Medicare coverage. This system has led the field in electronic health record (EHR) development and usage, and has piloted a medical home model, known as ProvenHealth Navigator, developed to redesign care processes for more effective use of the primary health care team. Geisinger has also pioneered a new relationship with its physicians: they are employees of the health system and salaried, with bonuses paid on outcomes-based performance.

■ Harbor-UCLA Medical Center's Family Health Center in Los Angeles, Calif., is staffed by faculty and physician residents of the UCLA Department of Family Medicine, and delivers care to more than 30,000 primary care patients annually. Of these visits, 35 to 40 percent are diabetes related. A physician who completed her residency at Harbor-UCLA organized a community-based program for the prevention and treatment of obesity, a significant factor contributing to diabetes. This program is run by Promotoras, trained community members who work in the community or in a clinic or both. Promotoras are either trained on the job or at a community college. They serve as health care "navigators" for community residents in need. Examples of how they serve include: providing health education at a clinic or at local elementary and high schools; assisting patients with understanding physician orders; and helping physicians better understand the population they are serving. Promotoras at the Harbor-UCLA Family Health Center focus specifically on obesity treatment and prevention, combining education about nutrition with realistic behavior-change goal setting.

■ Kaiser Permanente Northern California adopted a cardiovascular prevention program known as PHASE (Prevent Heart Attacks and Strokes Everyday). The strategy focuses on seven diagnoses, including diabetes, coronary heart disease and chronic kidney disease and utilizes panel management for individual patients and each physician's entire panel of patients with these diagnoses. One of the medical centers pioneered a new role called the Population Management Assistant (PMA) to assist the care team in managing patients with cardiovascular risk factors and this was their sole responsibility. The PMAs work with patients, carrying out a physician's orders, and follow up with patients for return visits or additional therapies. PMAs have had so much success that they have also taken on additional preventive and wellness services for patients. Though implemented differently at different Kaiser sites, the program has enabled detailed follow-through with more patients and has leveraged physicians' time.

■ Group Health Cooperative of Puget Sound has 20 primary care clinics in Western Washington. At Group Health Cooperative, a registered nurse sees all routine care diabetes patients for their appointments, and also is responsible for educating them and helping them manage their care. Registered nurses also work closely with patients who are recently discharged from the hospital. Group Health has its employees participate in regularly scheduled team building exercises and provides dedicated training in communication and conflict resolution skills.

A Call to Action

We are living at a moment in time where life as we know it is changing radically, and at a rate that is unprecedented. Change, no matter where it occurs, always brings with it both challenge and opportunity.

Regarding primary health care, there are indeed challenges ahead, and, at times, it can be difficult to shift our focus away from those challenges when it seems we are faced with them almost daily.

However, the opportunities inherent in this change can also transform and strengthen the primary health care system. New, more effective roles are being created; patients are beginning to better understand their role and take greater ownership of their health; new resources, better systems, innovative technologies and a host of new possibilities that will strengthen our health care system are being revealed daily.

Our focus should be on this potential, and now is the time to embrace change and determine how we can best contribute and take action.

It is important to work together to design more value-driven, primary, health and wellness-based services. We need to begin today to evaluate and redesign our primary care models and approaches. It is vital to reach out to the community and partner with them to develop a seamless and accountable health and wellness care experience. It is important to engage patients even further in our dialogue to demonstrate to them the important role that they play. The future of primary care is now in our hands.

How do we begin this important work?

Here are some starting points suggested by the roundtable. The AHA will continue to develop more tools to assess primary care.

■ Assess your current workforce and future trends. One resource is AONE's Workplace Environment Assessment Survey, which examines both leadership and staff nurse opinions of the work environment, based on nine principles of a healthy work environment. Please find the link to the survey and additional information at www.healthcareworkforce.org and click on the "Work Environment" page.

■ Assess your relationship with the community and community leaders to begin the network of linking hospital services with those in the community. An important resource currently available is from the AHA's subsidiary, the Association for Community Health Initiatives (ACHI). Their Community Health Assessment Toolkit, found at www.assesstoolkit.org, is a guide for planning, leading and using community health assessments to better understand – and ultimately improve – the health of communities.

Future tools will include how to:

■ Assess your current model of care.

■ Engage your workforce in designing what your new model of care will look like.

■ Engage patients and families in this dialogue and design.

Additional information can be found at AHA's workforce website: *www.healthcareworkforce.org*.

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AHA Primary Care Workforce Roundtable List of Members