Assessment of Primary Care Teams in Federally Qualified Health Centers

December 2014

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Executive Summary

I. Introduction

Today’s health care has been called a “team sport”\(^1\). While to some degree this has always been true, a deeper and more sophisticated Team mentality is rapidly finding its way into all health care settings, perhaps due in part to the ascendance of the Patient Centered Medical Home (PCMH) model of care in which the patient is at the center of a defined team of providers and support staff. This is especially true in the field of primary care – and, thus, for the nation’s network of Community Health Centers and other FQHCs (hereafter referred to as “health centers” or “centers”), which are mandated to achieve formal PCMH recognition by 2016.

Partly as a result of this new imperative, the National Association of Community Health Centers (NACHC) felt a need to investigate the changing nature of the primary care workforce, as well as related training and technical assistance demands, on behalf of health centers around the country. Accordingly, NACHC undertook a study with the following purpose:

“To learn about Primary Care Team models currently used by health centers; to determine what training and technical assistance health centers need to strengthen/expand their Primary Care Teams in support of transformation to Patient Centered Medical Homes; and to gain a better understanding of how to retool the clinical workforce to support practice transformation and improved quality outcomes.”

This study is entitled Assessment of Primary Care Teams in Federally Qualified Health Centers (referred to here as the “Assessment” or “project”). It was funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS); additional support was provided by The Hitachi Foundation, whose interest is to better understand Primary Care Teams, specifically with respect to the use of – and potential future programs regarding – Medical Assistants (MAs) and Community Health Workers (CHWs) as part of the Primary Care Team movement.

II. Methodology

As this project developed, decisions were made that resulted in creation of two specific components of what would become the overall Assessment of Primary Care Teams in Federally Qualified Health Centers.

\(^1\) hoag (a member of St. Joseph Hoag Health Alliance, Newport Beach CA) - web site. http://www.hoag.org/Why-HOAG/News-Publications/Pages/Fall-2013/Health-care-is-a-team-sport.aspx
A. The first component, carried out in Summer 2014, was a quantitative assessment in the form of a statistically-oriented questionnaire to be sent to a representative sample of health centers largely selected on the basis of size (number of patients), setting (urban vs. rural), and location (via geographic Regions developed by the US Department of Health and Human Services).

The questionnaire consisted of 36 questions, of which eight were for health center identification and the remainder were designed to elicit information from each participating entity regarding the existence, structure, dynamics, and developmental needs of Primary Care Teams. The vendor contracted for analysis of quantitative assessment results was Insightlink Communications, a firm specializing in employee surveys.

The specific methodology used to carry out this quantitative assessment is described in detail in Attachment A; the questionnaire itself is shown as Attachment B.

B. A complementary component was a follow-up set of qualitative interviews, conducted in late 2014. These were held with nine health centers, carefully selected based on their responses to the quantitative assessment. A template featuring 17 questions, each containing multiple content probes, was developed as the instrument for conducting these telephone interviews. (One interviewee responded to the interview template in writing due to lack of availability for a phone conversation.)

Interviews of roughly an hour in duration were held during the final few months of 2014. Results were then collated and analyzed to generate additional information that would supplement the quantitative assessment results.

The methodology for conducting these interviews and the selection of participants is described in Attachment C. The list of specific interviewees and their organizations is included as Attachment D.

III. Findings and Conclusions

The multiple findings, from both the quantitative and qualitative processes, are described in detail in the Expanded Narrative. Overall, four main conclusions surfaced:

- The concept of Primary Care Teams is currently quite fluid; that is, there is no specific model that is either preferred or has been shown to be optimally effective. The composition and workings of Primary Care Teams in health centers is essentially context-dependent; the familiar adage "If you see one
health center, you’ve seen one health center” proves as true in the development of Primary Care Teams as in most other areas.

- One factor that provides a possible key to understanding the various types of Primary Care Teams is what could be termed the “formalization” of Team development; that is, the presence of job descriptions that specifically address Team roles and responsibilities do appear to be correlated with a number of variables studied in this Assessment.

- Medical Assistants (MAs) and Community Health Workers (CHWs) are clearly part of most health center Teams, especially expanded Teams that go beyond what could be termed the “core” model of MD and/or Advanced Practice Provider (APP), RN, and Medical Assistant. But while the term Medical Assistant is generally consistent, CHWs can go by a number of different titles and fill a number of differing roles. This can make defining a standard Team even more difficult.

- As noted in the attached Methodology descriptions, in several ways the overall project developed as it went, due to various dynamics. At the outset, the project team in essence “didn’t know what it didn’t know”, leading to some semantic shifts as the project unfolded. The model of expanded Primary Care Teams is clearly emerging and unfolding within an ever-changing health care environment; thus, there naturally is still much to investigate, assess, and learn about the implementation and future directions of these Teams. NACHC’s Primary Care Teams Work Group concurs that the subject clearly deserves additional study; as this is undertaken, clear and consistent study goals/objectives from the outset, as well as early and active participation by statistical experts in study design, will help strengthen both the investigative process and the resultant findings.

Finally, it should be noted that this project was intended from the beginning to be descriptive, rather than prescriptive. As experience with Primary Care Teams unfolds nationally, further studies may well be undertaken to formalize “best practices” for such Teams.
Extended Narrative

I. General

As noted in the Executive Summary, the Assessment of Primary Care Teams in Federally Qualified Health Centers project consisted of two complementary components: an initial quantitative assessment via questionnaire, and a follow-up qualitative assessment via telephone interviews with health center representatives.

1. The former component resulted in more than 250 completed questionnaires, providing detailed statistical information from a variety of settings which was then analyzed by Insightlink Communications.

2. The latter component yielded nine detailed follow-up interviews (eight by telephone, and one in writing), as conducted with a wide range of health center types that run the gamut from small rural centers to large urban entities. Among these organizations, total staff range from 19 to 350; total provider numbers range from 5 to 25; and total patients served cover a range of roughly 1,200 to nearly 38,000.

Participants in this project were provided with the following NACHC definition of a Primary Care Team:

“A Primary Care Team is a multi-disciplinary group of primary care staff members (both provider and non-provider) who collectively care for and take responsibility for a defined group (panel) of patients assigned to it.”

II. Findings: Quantitative

Following are the main quantitative assessment findings. Parenthetical numbers at the end of each summarized finding indicate the page number in Addendum 1 (“Quantitative Assessment: Detailed Findings”) on which the specific finding is further described via text and graphics. Pages 2, 3, and 4 of Addendum 1 show the settings, geographic location, and size (by patient numbers) of all health centers participating in the quantitative assessment; many of the subsequent pages address findings for health centers that specifically indicated having some form of Primary Care Team(s). For a number of findings, Addendum 1 breaks out specific detail by degree of formality (sometimes referred to here as “formalization”) of Primary Care Team development, suggested by the relative formality of an organization’s staff job descriptions.

Below are the primary quantitative assessment findings:
• Roughly 9 in 10 participating centers report having a Primary Care Team. (5)
• A majority of health centers report having made some degree of formal change to their job descriptions and related roles in order to address Team concepts. (Most of the other centers report having made changes, but informally.) (6)
• Substantial development of policies and procedures around Team concepts is found in 84% of centers. (7)
• In terms of center demographics, formalization tends to be more prevalent in larger centers; setting (urban/rural) does not appear to have a major effect on Team development; and geographic location does not seem to be a factor in Primary Care Team dynamics. (8)
• Most centers with Teams report having Primary Care Teams at a majority of their sites; this is most likely to occur in centers with greater formalization. (9)
• Centers with more formalization generally contain more Teams. (10)
• Health Centers with greater formalization tend to have more members on their Teams. (11)
• Centers with more formalization generally show a greater diversity of Team membership. (12)
• A cluster analysis indicates that 40% of all respondents with Teams have what could be termed “core” Teams (MDs and/or Advanced Practice Providers, RNs, and MAs), while 60% show “expanded Teams” encompassing additional job categories. The same analysis indicates that degree of formalization in a center does not appear to be a significant driver of actual Team composition. (13)
• MDs lead most Teams, especially those with greater degrees of Team formalization. (14)
• In terms of actual Team reporting, roughly half of the centers indicate that the Team reports to the Chief Medical Officer (CMO), with most others indicating that Teams report to CEOs, COOs, or QI Directors (with some centers showing “divided” reporting structures). (15/16)
• Primary Care Teams undertake a wide range of activities, with the top two being “Linking patients to available services and resources in the community”, and “Daily huddles to organize work.” (17/18)
• Most centers with a high degree of Team formalization indicate that they have received PCMH recognition from a recognized entity. (19)
• As might be expected, 96% of centers with Primary Care Teams report actively addressing Quality Improvement and Patient Safety issues. (20)
Individual-level training on using data to improve patient care is reported by 74% of centers having Teams. (21)

In 80% of these centers, use is made of specific measurable goals. (22)

In the area of Transformation/Quality Improvement, service integration – specifically in the area of Behavioral Health – is an important activity for all health centers. Working on PCMH recognition and upgrading of EHRs round out the top three noted activities. (23/24)

Empaneling (assigning patients to specific providers) was reported by 81% of centers with Teams. (25)

Some degree of active cross-training of Team members is reported by 82% of these centers. (26)

The top five ranked areas RE: “Importance for Primary Care Team Implementation / Sustainability” are HIT (including EHRs); leadership support; availability of data for patient care improvement and Team functioning; a Quality Management infrastructure; and funding for extended Teams. (27-29)

The top three “Support Needs” regarding Team implementation are funding for expanded Teams; optimizing Team roles and configurations; and using data for improving patient care and Team functioning. (30/31)

Finally, statistical analysis of overall quantitative assessment results shows correlations indicating the following drivers of types of Primary Care Teams: cross-training of Team members, use of specific measureable goals, Team-based policies, and empaneling of patients. It is unclear, however, whether these variables reflect actual causality, or complementarity (as explained in Addendum 1). (32)

III. Findings: Qualitative

Following are the main findings from the nine qualitative assessments carried out via interviews. (While eight interviews were conducted by phone, one was completed in writing, due to lack of time for a phone conversation on the part of the interviewee.) These begin with “Overall Team Findings”, in part to place subsequent findings regarding MA’s and CHW’s into an appropriate context.

A. Overall Team Findings

**PCMH Recognition:** All nine interviewees either now had formal recognition or were actively working toward it via the National Committee for Quality Assurance (NCQA) or specific state-based recognition.
• **Empanelment:** Six interviewees said they had some degree of systematic empanelment (with one noting that empanelment was “our most recent Team-based change”). Only two of the centers reported an empanelment process using the formal “Four-Cut Method” or something close to it. **NOTE:** See the “Primary Care Teams (General)” section of Attachment E for links to: (1) an explanation and discussion of Empanelment by the Safety Net Medical Home Initiative, and (2) an article by Mark Murray, MD, MPA describing the formal “Four-Cut Method” empanelment mechanism.

• **Incentive Program:** Health centers are increasingly adopting formal staff programs (with center-specific variations) to incentivize greater productivity and improved quality. Interviewees for this project were asked if they had instituted any such program, especially Team-based. Of the nine interviewees, a majority responded “No”. However, two centers said “Yes”, while another two reported that such a system was being developed. One interviewee specifically noted, “We want to incentivize good outcomes but we do not want to incentivize numbers over quality. We are figuring out how to do both.”

• **Team Model:** An interesting finding is that one interviewee reported having no MAs, while another reported not having RNs as part of the clinical Team. (The rest of the interviewees reported having these positions on the Team.) Also, one interviewee specifically indicated that the organization no longer used Receptionists, with MAs or others taking over this function. One respondent indicated that a number of MDs were members of each Team.

• **RNs:** As noted, one interviewee reported that RNs were not part of the clinical Team. Three appear to use RNs mainly in management roles. One respondent said that the organization at one time had an RN-based clinic model but has since moved to an MA-based model.

• **Functional Overlaps:** When asked if there was any significant overlap, especially among MA and CHW positions, four interviewees reported “No”. However, another four responded “Yes”, with three suggesting that this was actually intentional as part of instilling a true Team mentality (perhaps thinking in another way about “cross-training”, as addressed later in this Narrative).

• **Team Training:** Interviewees were asked if Team concepts were addressed as part of staff training, especially for MAs and CHWs. Five respondents answered “Yes”; one said that a special Team Training Day had been held (with another being planned). Two interviewees responded “No”, while the remaining two suggested that Team skills were part of the general training, but on a more informal basis.

• **Career Ladder:** Of the nine interviewees, only one had a formalized career ladder; it is for MAs (only) and consists of two Levels, with Level II being allowed to be in charge of special projects.
- **Patient as Part of Team**: While Teams are generally considered to be patient-centric (especially for organizations with formal PCMH recognition), all but one of the interviewees had not indicated on the quantitative assessment that the patient was actually considered part of the Team. One of these respondents, however, stated in the *qualitative* interview that the patient was indeed considered a Team member.

- **Team Fluidity**: Three of the interviewees described a basically stable Team structure, while six noted some degree of fluidity in the Teams to accommodate patient or staffing needs. Two respondents specifically noted the use of what could be termed “specialty-based Teams”, including defined Dental Teams, Pediatrics Teams, and Behavioral Teams. One interviewee stated, “Our HIV/AIDS Team is probably the most robust of all our Teams.”

- **Team Development**: All but one interviewee indicated that Teams had actually been in place – although perhaps in a slightly different configuration – before the relatively recent formalization of Team concepts and mandates (and before PCMH recognition was being emphasized). One respondent noted the use of Teams as far back as 2001. This might suggest that health centers have traditionally used at least generic team concepts simply as a normal “way of doing business”, perhaps as part of their unique mission and related philosophies and/or constraints.

- **Public Health Interaction**: Regular and strong Team interaction with the broader public health system, especially by health center CHWs and/or MAs, was reported by five of the nine interview respondents. Three of the remaining four suggested that formal interaction was on an “as needed” basis, while one did not specifically respond.

- **Integrated Services**: While little interview time was spent uncovering patterns with respect to integration of services, it was noted that all interviewees are addressing active integration of Behavioral Health and Dental services (in some cases alongside integration of other services such as HIV/AIDS programs). While these service providers are often brought into the Teams on an as-needed basis, several interviewees did indicate that Behavioral Health professionals especially were part of the basic Primary Care Team structure.

- **Facility Design as a Team Factor**: Significantly, all nine interviewees indicated that physical space and structure were important factors in facilitating a Team mentality, with one respondent stating, “Architecture is crucial”. Several either stated or implied that Teams were essentially *defined* by space; physical Team “pods” were noted several times as a significant Team facilitator.
• **Cross-training**: When asked whether or not their Team members were generally cross-trained (with other functions they were capable of addressing), eight of the nine interviewees responded that their Teams were “fully” or “formally” cross-trained. The remaining respondent suggested that while cross-training did occur, it was not formalized.

• **Team Training Linked to PCMH**: Seven of the nine respondents indicated that training of their Team members did include links to concepts regarding the Patient Centered Medical Home care model, while one interviewee reported actively working to ultimately make this happen. The remaining respondent stated that no specific link had been made.

• **“Team” Value**: Significantly, all nine respondents strongly stated that the Team concept has major value in and of itself and would ultimately have been implemented without regard to mandates or formal PCMH recognition. Direct quotes from several interviewees underscore this important idea:
  - “Team-based care is critical as we move into the future, for both optimal patient care and to drive new payment mechanisms.”
  - “With Teams, everyone does their best, is the most valued, and gives the best value to patients.”
  - “We would be doing this anyway, because integrated Teams just work!”
  - “We have been doing Team functioning for a while and would be doing it anyway, since it results in better care, improved outcomes, and better job satisfaction.”

• **Funding**: Two respondents indicated that while additional Team-based funding would be welcome, their organizations were generally functioning well with their current budget. The other seven, however, indicated that additional funding would be of significant help in optimizing their Teams, especially by enabling additional staff or providing more training.

• **“Top Team Characteristics”**: When asked about the most important characteristics of a high-functioning Team, respondents of course gave a variety of answers. However, four specific characteristics were repeated at least several times:
  ✓ Good Communication – Maintaining clear, consistent, and effective communication among Team members. (NOTE: This was the most universal comment, being noted by seven of the nine interviewees.)
  ✓ Mission – Keeping the mission paramount at all times, and focusing all Team efforts around it.
✓ Role Clarity – Ensuring that all staff are sure about their roles as Team members.
✓ Respect – Ensuring that all Team members respect one another.

• “Main Best Practices”: The interviewees were queried regarding “best practices” for effective Teams; while – as would be expected – there was again a variety of responses, three ideas were raised at least several times:
  ✓ Optimize space factors – Emphasize physical proximity of Team members.
  ✓ Use data – Routinely collect and share data (including via EHRs) to optimize care and Team functioning.
  ✓ Utilize “huddles” – Employ these daily to ensure work clarity, Team cohesiveness, and optimal efficiency.

• “Top Lessons Learned”: With some exceptions, interviewee responses to this question tended to center on interpersonal factors, with most-repeated responses being:
  ✓ In making changes, include everyone affected in the process.
  ✓ Work toward a Team with no formal leader (essentially a “flat” team). This was underscored by one interviewee who stated:
    - “We’re like a basketball team, where everyone does whatever is needed, when it’s needed – and not always in lockstep… some team members go right, some go left, no one is ‘assigned’ to anyone and everyone is ‘assigned’ to everyone – and it works!”
  ✓ Don’t devalue any position or person.
  ✓ Be sure to bring all providers along in development of a Team mentality. (Several respondents implied that this could sometimes be difficult.)
  ✓ Finally, one interviewee provided an interesting conceptual schematic regarding where true Teams should be heading:
    - “Integrated Teams have been wonderful – but integration always goes deeper than you think. We need to be thinking in terms of three ever-deeper levels of Team integration: (1) Multi-disciplinary Teams, in which different functions work together; (2) Inter-disciplinary Teams, in which different functions share responsibilities; and (3) Trans-disciplinary Teams, where everyone on the Team thinks alike.”

B. Additional Medical Assistant (MA) Findings

Medical Assistants have taken a prominent place in both core and expanded Teams within health centers; one interviewee specifically noted that in her organization,
MAs “are a kind of hub.” Their multiple roles in support of their Team’s providers can include triage, check-in and rooming of patients, patient check-out, drawing of blood, testing and screenings of various types, assisting with procedures, taking patient histories, checking vital signs, etc. Unlike Community Health Workers, terminology is rarely an issue – these staff members are generally known simply as Medical Assistants. Recalling that one center indicated a lack of MAs altogether, several entries in the “Overall Team Findings” section above refer either directly or indirectly to MAs; in addition, the qualitative interviews uncovered the following MA-specific findings for the eight respondents that do include MAs as part of the Team:

- All eight described the role of MAs as being to some degree fluid or flexible, depending on Team composition and need.
- All eight also indicated that “core competencies” were to some degree formalized as part of MA training, via such instruments as detailed checklists, lengthy orientation processes and/or job shadowing, and in one instance “professional educational objectives” developed by the center’s QI staff.
- When asked whether or not MAs were permanently assigned to providers, five respondents said that MAs were largely assigned (with some fluidity); three said that no specific assignments were made.
- Of the eight interviewees having MAs, five indicated that the identification and hiring of MAs had changed as the result of increasing emphasis on Primary Care Teams; several noted recent expansions of MA roles and/or numbers. Three reported no change.
- When asked if more funding is needed for Teams, two centers specifically noted a need for new money for MA expansion. One center, however, noted specifically that more MA funding was not needed.
- Only one respondent reported a formalized career ladder for MAs.

C. Additional Community Health Worker (CHW) Findings

Community Health Workers can pose a somewhat thorny problem, in that generic CHW identification includes multiple potential job titles, roles, and functional models. The literature suggests that there are more than 25 job titles which fall into the broad category of “Community Health Worker”, and HRSA\(^2\) lists six CHW program models (noted as being “not mutually exclusive”): Promotora/Lay Health Worker Model, Member of Care Team Model, Care Coordinator/Manager Model, Health Educator Model, Outreach & Enrollment Agent Model, and Community Organizer & Capacity Builder Model. Suffice to say that both official parlance and professional semantics

\(^2\) Community Health Workers Evidence-Based Models Toolbox. HRSA Office of Rural Health Policy: August 2011 (pp. 6-9)
can make it difficult to identify if and how CHWs are in fact included as part of a
given Primary Care Team.

That said, the following were identified as specific findings relating to CHWs (in
addition to references in the “Overall Team Findings” section, above):

- Of the nine qualitative interviewees, eight said that their Teams did include
  CHWs. Only two centers specifically titled these staff members “Community
  Health Workers”; other job titles included Outreach & Enrollment
  Representative, Outreach Worker, Client Advocate, Patient Navigator, HIV
  Outreach Worker, and others. The remaining respondent said that the center
does not use CHWs, but job titles within the organization suggest that
perhaps it does.

- Primary CHW functions included serving as in-community resource links,
  liaisons between patients and the health system, enrollment in Medicaid
  and/or other health insurance, referral/tracking duties, and health coaching.

- While the question was not a part of the formal qualitative interview
  instrument, four respondents voluntarily stated that they required bi-lingual
  skill as a CHW job prerequisite.

- When asked if CHWs were permanently assigned to specific providers, two
  interviewees said “Yes”, while six responded “No”. (The written interview
  response did not specifically address this issue.)

- In answer to a query regarding whether or not formal “core competencies”
  were part of CHW training, eight interviewees responded “Yes”.

- All respondents reported that no formal career ladder existed for CHWs.

- All but one respondent indicated that targeted grant funding, such as from
  State or ACA sources, largely paid for CHWs. The remaining respondent said
  that the health center paid for these positions on its own.

- When asked if additional funding is needed to optimize Team functioning,
  one interviewee specifically noted a funding need for more CHWs; one stated that
  additional funds for CHW training would be extremely helpful; and one
  specifically noted that additional funding for CHWs was not needed.

- Only one respondent specifically noted that the organization placed a limit on
  the number of cases handled by a given CHW. This interviewee said that the
  limit was in the range of 60-80, and that the purpose of this was “to spread
  available resources as far as possible”. 
IV. Summary

As noted in the Executive Summary, Teams in health centers cannot at present be readily fit into a standardized “optimal” model. The simple fact is that Primary Care Teams vary considerably across health centers, according to many center-specific variables such as size, setting, budget, number of sites, architectural considerations, local community needs and constraints, state regulations and enabling legislation, constraints by specific funding sources, and the developmental history of the health center itself. In addition, the multiple titles and numerous potential roles of what are generically known as Community Health Workers makes standardization even more difficult.

The qualitative assessment component of this project generally bears out these difficulties. Among the many variables addressed by the quantitative assessment, only the degree of Team formalization (via job descriptions) appears to have a meaningful correlation to the way in which a health center Team is structured and implemented. While there are several variables that could potentially be considered (at least to some degree) “drivers” of types of Teams in health centers, Addendum 1 makes clear that it is not certain whether these reflect actual causality or simply complementarity.

One thing can be asserted with certainty, however. As eloquently put by Dr. Thomas Bodenheimer, adjunct professor in the Department of Family and Community Medicine at the University of California, San Francisco:

“Groups of health care personnel working together in an office, clinic, or hospital floor are generally called teams. But they can truly qualify as a team only by demonstrating actual teamwork.”

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3 Building Teams in Primary Care: Lessons Learned (Bodenheimer, Thomas). California HealthCare Foundation – web site
Attachment A

Quantitative Assessment: Methodology

December 2014
Quantitative Assessment: Methodology

- A main project objective was to explore what Primary Care Team models are currently used by health centers. In Summer 2014, email invitations to participate in a quantitative Primary Care Team assessment were sent to CEOs of 885 health centers – a random sample stratified to accurately reflect overall organizational center distribution RE: numbers of patients, geographic region, and whether the setting was rural or urban.

- The quantitative questions were drafted by NACHC’s Clinical Affairs Division per the original purpose of the overall Assessment (as framed against the backdrop of a mandate that all health centers be formally recognized as Patient Centered Medical Homes, or PCMHs, by 2016): "To learn about Primary Care Team models currently used by health centers; to determine what training and technical assistance health centers need to strengthen/expand their Primary Care Teams in support of transformation to Patient Centered Medical Homes; and to gain a better understanding of how to retool the clinical workforce to support practice transformation and improved quality outcomes."

- The proposed quantitative questions were reviewed and approved by NACHC’s internal Survey Approval and Research Collaboration Workgroup.

- The quantitative assessment was designed to capture a snapshot in time, and to begin exploration of expanded Primary Care Teams as an emerging concept.

- It was decided that the quantitative questions would be sent to a nationally representative sample of health centers. Insightlink Communications helped generate this sample.

- Insightlink created a random data file by selecting N=420 records from a file of all health centers (provided by NACHC). With an anticipated response rate of 60%, this was expected to generate about N=250 responses.
Quantitative Assessment: Methodology

- Insightlink Communications double-checked and, as expected, found that the smaller random file almost exactly matched the full file in terms of the following demographics:
  - Setting (Urban vs. Rural)
  - Region (10 HHS regions)
  - Size (six groupings by number of patients)

- A communications/promotion plan was developed to help increase the quantitative assessment response rate.
  - A brief announcement about the overall Assessment was included in several editions of NACHC’s bi-weekly PCA Update
  - Emails were sent to the CEOs of the 420 selected health centers to “prime the field”, noting the upcoming quantitative assessment form that would come via Qualtrics. (Very importantly, these emails were sent from a NACHC email account in the name of Dr. Ron Yee, Chief Medical Officer of NACHC, to elevate the importance of the quantitative assessment.)

- The quantitative assessment was sent (through the Qualtrics survey solution) on June 30 ’14 to the 420 CEOs or designees. Reminders were sent on July 10 and July 16.
Quantitative Assessment: Methodology

- The total number of respondents was 140.

- For almost three-quarters (72%) of participating health centers, the CEO completed the quantitative assessment. In the remaining health centers, respondents held a wide range of titles, with the most popular being Medical Director/Chief Medical Officer.

- Given the original goal of 250 respondents, it was decided that the quantitative questions would be sent to a “second wave” of health centers, using location as a main variable.

- A second sample of N=475 records was then generated.

- The communications/promotion plan used for the original sample was implemented similarly for Wave #2. Also, it was determined at this point that this was not intended to be a research project requiring such strict adherence to protocols as would be required by a peer-reviewed publication.

- The quantitative assessment questionnaire was sent to Wave #2 on August 14. Reminders were sent on September 4 and September 10.

- The total number of respondents to Wave #2 was 125.

- The decision was made, based on recommendations from Insightlink, that there was no need to separate Wave #1 and Wave #2 results. All results would be based on the combined dataset.
Quantitative Assessment: Methodology

- In summary, from a total sample of 885 centers, 265 actually participated in the quantitative assessment, for a participation rate (rounded) of 30%.

- The demographics of these 265 health centers (size, setting, and location) were checked against those of all health centers to determine if there was a need for weighting of results to adjust for demographic misalignment. The comparative results were so close that no need was found for additional weighting.
Thank you for participating in this Assessment of Primary Care Teams in Federally Qualified Health Centers. The purpose of this Assessment is to learn about primary care team models currently used by health centers; to determine what training and technical assistance health centers need for patient centered medical home recognition/accreditation; and to gain a better understanding of how to retool the clinical workforce to support practice transformation and improved quality outcomes.

All responses are confidential. Only NACHC will have access to individual responses. Analysis of results and related reports will be summarized in such a way that you or your health center cannot be individually identified.

Funding for this Assessment has been provided by the Health Resources and Services Administration/Bureau of Primary Health Care. The Assessment has been reviewed and approved by NACHC’s Internal Survey Approval and Research Collaboration Workgroup.

**Quick Instructions/Tips**

1. The Assessment is designed to be completed by the health center CEO or designee.
2. Completion time is approximately 15 minutes.
3. The link that you used to open the Assessment is unique to your organization. You may open the link as many times as you would like until you submit your final responses. Thus, you may start the Assessment and return to it at another time. Your responses will automatically be saved (except those that are on a partially completed page). Please note that once you hit the final NEXT button you will not be able to access the Assessment again or share it with anyone else in your organization.
4. If you need to step away from the Assessment while you are working on it, the system will automatically time out after 30 minutes of inactivity. If you were in the middle of the page, your responses on that page will not be saved.
5. You may use the back button to review your responses.
6. Based on how you respond to the questions, there may be times when one or more questions do not display.
7. If you wish for someone else in your health center to respond to some or all of the Assessment, you may forward the unique link to him or her.
8. Kindly submit your responses by Friday, July 18th.
I. Health Center Contact Information

Please provide the following information about your health center organization (i.e., grantee organization, parent organization for multi-site health centers).

1. Health Center Name
2. UDS Number/BHCMIS ID
3a. CEO Name (LAST Name)
3b. CEO Name (FIRST Name)
4. CEO Email Address
5. Are you the CEO completing this Assessment?
   - Yes
   - No
6a. Name of person completing this Assessment (if not the CEO) (LAST Name)
6b. Name of person completing this Assessment (if not the CEO) (FIRST Name)
7. Title of person completing this Assessment (if not the CEO)
   - Medical Director
   - Director of Nursing
   - Chief Financial Officer
   - Chief Operating Officer
   - Other (please specify) ______________________
8. Email address of person completing this Assessment (if not the CEO)

II. Health Center Organization Funding

The following questions are about different funding sources your health center organization currently receives.

9. Does your health center organization receive funding from the following sources?

<table>
<thead>
<tr>
<th>Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Supplemental Funding for Quality Improvement in Community Health Centers (Bureau of Primary Health Care)?</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>b. Title X Family Planning?</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>c. School Based Health Center?</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
10. Does your health center organization receive funding for health professional and residency training?
   ☑ Yes
   ☑ No (SKIP to Q12)

11. From which of the following sources does your health center organization receive funding for health professional and residency training? (check all that apply)
   ❑ Medicaid Graduate Medical Education (GME), including pass-through payments
   ❑ Medicare GME, including pass-through payments
   ❑ Title VII, Section 747 (Primary Care Training Grants)
   ❑ Title VII, Section 748 (Primary Care Training Grants Supporting the Education and Training of Dentistry)
   ❑ Title VII, Section 756 (Mental and Behavioral Health Education and Training Grants)
   ❑ Other Title VII Programs
   ❑ Title VIII, Section 811 (Advanced Education Nursing Grants)
   ❑ Title VIII, Section 846 (Nurse Loan Repayment and Scholarship Programs)
   ❑ Affordable Care Act Teaching Health Center Funding
   ❑ Other Federal Funding
   ❑ Other State Funding
   ❑ Private Foundation/Grant Funding
   ❑ Hospital Contributions
   ❑ University/School/Program Funding
   ❑ Other (please specify) __________________

12. Does your health center participate in the National Health Service Corps (NHSC)?
   ☑ Yes
   ☑ No (SKIP to Q14)

13. As part of participation in the National Health Services Corps (NHSC), does your health center organization host one or more clinicians who are: (check all that apply)
   ❑ Receiving NHSC loan repayment?
   ❑ Fulfilling an NHSC scholarship commitment?
   ❑ NHSC alum (fulfilled a loan repayment and/or scholarship commitment and are currently working at your health center)?
   ❑ Receiving loan repayment from a state program?
   ❑ None of the above

III. Health Center Meaningful Use/PCMH and Practice Transformation

The following questions are about current Meaningful Use and Patient Centered Medical Home (PCMH) activities at your health center organization.
14. What percentage of providers in your health center organization are eligible for Meaningful Use?
   ♣ 0 percent (SKIP to Q16)
   ♣ 1 or more percent (please enter a percentage) ________________

15. Of your total number of providers eligible for Meaningful Use, what percentage have attested to each of the following stages? (Please provide a percentage in each answer below even if the answer is 0 percentage.)
   a. Attested to AIU (Adopt, Implement, Upgrade) ________________
   b. Attested to Stage 1 ________________
   c. Attested to Stage 2 ________________

16. Does your health center organization have an internal team that is responsible for optimizing the use of your Electronic Health Record (EHR) for improved quality outcomes (e.g., upgrades, clinical decision support tools, staff training)?
   ♣ Yes
   ♣ No (SKIP to Q18)

17. Which of the following staff members sit on your internal team responsible for optimizing the use of your EHR? (check all that apply)
   ♣ IT Director/staff
   ♣ Informatician
   ♣ Medical Director
   ♣ Primary Care Physician
   ♣ Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)
   ♣ Behavioral Health staff
   ♣ Oral Health staff
   ♣ Quality Improvement Director/staff
   ♣ Office Manager
   ♣ Front Desk staff
   ♣ Chief Executive Officer
   ♣ Chief Operating Officer
   ♣ Chief Financial Officer
   ♣ Other (please specify) ________________

18. Are any of your health center organization’s sites (i.e., locations, practice sites, service locations) formally recognized as a Patient-Centered Medical Home (PCMH) by a national or state entity? (e.g., National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Committee (URAC), The Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC- Triple A), or official state qualification standards)
   ♣ Yes, all of our sites
   ♣ Yes, some of our sites
   ♣ No, none of our sites
19. In which of the following practice transformation/quality improvement activities is your health center organization currently engaged? (check all that apply)

- Upgrading EHR
- Working toward PCMH Recognition/Accreditation
- Reducing Patient Cycle Time (length of visit)
- Integrating Behavioral Health with Primary Care
- Integrating Oral Health with Primary Care
- Integrating HIV Prevention and Treatment with Primary Care
- Participating in a Learning Collaborative (i.e., a short-term learning system that brings together teams from multiple organizations to work on improvement in a focused topic area) with external partners (please specify)
- Other (please specify) ______________

IV. Care Teams Questions

The following questions ask about the current use of Primary Care Teams in your health center organization. A Primary Care Team is a multi-disciplinary group of primary care staff members (both provider and non-provider) who collectively care for and take responsibility for a defined group (panel) of patients that is assigned to it.

20. What percentage of your health center organization’s sites (i.e. locations, practice sites, service locations) currently implement Primary Care Teams?

- 0 percent (SKIP to Q35)
- 1 to 24 percent
- 25 to 49 percent
- 50 to 74 percent
- 75 to 100 percent

21. Does your health center organization have administrative, personnel, clinical, or other policies/procedures in place that directly support implementation of Primary Care Teams?

- Yes
- No

When answering the following set of questions, think about Primary Care Teams at the largest site of your health center organization. If only one site is currently implementing Primary Care Teams, please think of that site.

22. How many Primary Care Teams are there at your largest site? (Enter number only)

23. How many different staff members (regardless of FTE) are on a typical Primary Care Team at your largest site?

- 2-3
- 4-6
- 7-8
- More than 8
24. Which of the following staff comprise a typical Primary Care Team at your largest site? (_check all that apply_):

- Physician
- Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)
- Nurse (e.g., RN, LPN)
- Medical Assistant
- Behavioral/Mental Health Provider
- Social Worker
- Pharmacist
- Nutritionist
- Dietitian
- Care Coordinator/Referral Coordinator
- Patient Navigator
- Case Manager
- Outreach Worker
- Interpreter
- Clerical Assistant
- Patient/Family Member
- Other (please specify) ____________________

25. Who is the team leader of a typical Primary Care Team at your largest site? (_Select ONE_)

- Physician
- Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)
- Nurse (e.g., RN, LPN)
- Medical Assistant
- Behavioral/Mental Health Provider
- Social Worker
- Pharmacist
- Nutritionist
- Dietitian
- Care Coordinator/Referral Coordinator
- Patient Navigator
- Case Manager
- Outreach Worker
- Interpreter
- Clerical Assistant
- Patient/Family Member
- Other (please specify) ____________________
26. To whom do Primary Care Teams at your largest site report?

- Chief Executive Officer
- Chief Operating Officer
- Chief Medical Officer
- Quality Improvement Director
- Other (please specify) ________________

27. Does your largest site empanel or assign patients to a specific Primary Care Team for their routine care and the majority of their acute care?

- Yes
- No (SKIP to Q29)

28. How many patients are empaneled or assigned to a typical Primary Care Team at your largest site?

29. How have roles and responsibilities for Primary Care Team members at your largest site been defined?

- Formal revisions to job descriptions that have been completed organization-wide
- Small or incremental changes to staff job descriptions that have been completed for just a few sites to potentially inform organization-wide formal job description changes
- Defined roles and responsibilities of team members have been established informally among teams members
- Other (please specify) ________________

30. In which of the following activities are Primary Care Teams at your largest site engaged? (check all that apply)

- Daily huddles to organize work
- Routine scheduled meetings to discuss the Team’s functioning, structure, roles, responsibilities
- Structured communication to improve patient care and teamwork
- Coordinate patient care with other healthcare providers across different settings
- Link patients to available services and resources in the community
- Teach patients or link patients to educational resources to self-manage care (e.g., diet, exercise, taking medications, symptom recognition)
- Identify internal processes to improve delivery of patient care and work with staff to implement these processes
- Use standing orders
- Participate in the hiring process for new team members
- Other (please specify) ________________

31. Do Primary Care Teams at your largest site engage in quality improvement and patient safety activities (e.g., activities to reduce no-show rate, increase the number of patients with diabetes under control, improve documentation of current medications in the chart)?

- Yes
- No
32. Do Primary Care Teams at your largest site have specific goals that are measureable (e.g., 90 percent of patients will leave the health center no more than one hour from entry time, increase by 20 percent the percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine)?

☐ Yes
☐ No

33. Which of the following types of individual level training do Primary Care Team members at your largest site receive to support their function/role on the Team? (check all that apply)

☐ How to work as a team (e.g., evidence based practices such as Team STEPPS, conflict resolution training)
☐ How to maximize health information technology (HIT)
☐ Motivational Interviewing
☐ How to use data for improved patient care
☐ Other (please specify) ___________________________

34. Are Primary Care Team members at your largest site cross-trained to support Team functioning in cases of absences, staff vacations, or periodic heavy demands on one part of the Team?

☐ Yes
☐ No

35. Please indicate how important each of the following factors are to supporting Primary Care Team implementation and sustainability for your health center organization. (Select ONE answer for each question.)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Extremely Important</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Very Important</th>
<th>Not at all Important</th>
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<tbody>
<tr>
<td>Peer Review</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Credentialing and Privileging</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>PCMH Recognition and Transformation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Leadership support</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Empanelment</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Policies and Procedures and Standing Orders</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Quality Management infrastructure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health Information Technology (EHR, patient registries, patient portal)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Availability of data for improved patient care and team functioning</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Physical space and design</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Team role definition and optimization</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adequate team coverage</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Funding for extended care team members (e.g., patient navigators, outreach workers)</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
36. Looking at the following list of topic areas, please mark the top THREE in which your health center organization would welcome training/mentoring/peer support to improve skills in supporting and strengthening Primary Care Teams. (Select up to THREE)

- Skill Building for PCMH Recognition and Transformation
- Funding for Expanded Care Team Members
- Empaneling Patients to Primary Care Teams
- Leading Organizational Culture Change
- Designing and Implementing Policies and Procedures
- Building a Quality Management Infrastructure
- Optimizing Health Information Technology (e.g., EHR, patient registries, patient portal)
- Capturing and Using Data for Improved Patient Care and Team Functioning
- Designing Physical Space to Support Team Functioning
- Defining and Optimizing Team Roles and Team Configuration
- Recruiting and Retaining the Right Members for your Team
- Onboarding and Training Team Members
- Engaging Patients in the Primary Care Team Model
- Other (please specify) _______________
Attachment C

Qualitative Interviews: Methodology

December 2014
Qualitative Interviews: Methodology

As part of the initial promotion for the overall Assessment of Primary Care Teams in Federally Qualified Health Centers project, participants completing the quantitative assessment were told that a follow-up qualitative interview process would also be undertaken. This was carried out via telephone interviews in November / December 2014, with the intent of building on the statistical foundation provided by the quantitative assessment.

Between the development of the quantitative assessment and the follow-up qualitative interviews, the focus of the overall project shifted from broad to narrow. Initially, the project was described as focusing on clinical workforce/health professions and training – an expansive topic. The narrowing of focus occurred with a subsequent decision to more specifically address expanded Primary Care Teams, acknowledging that: a) the Team approach to care is a basic tenet of the Patient Centered Medical Home (PCMH) model; b) health centers are moving in the direction of Teams as a key element of practice transformation generally; and c) competition for Team members is growing, resulting in a recognition that health centers will increasingly need to be able to “grow their own.”

A further narrowing of focus came with involvement of The Hitachi Foundation. The Foundation expressed interest in learning more about Medical Assistants (MAs) and Community Health Workers (CHWs) as specific members of expanded Primary Care Teams. While the quantitative component of the Assessment did not explore these two positions in any detail beyond simply asking if they were included on Teams, the follow-up qualitative interviews could provide the opportunity to dig deeper regarding functions/roles, funding, training, core competencies, hiring, etc. for these two groups. Ultimately, The Hitachi Foundation was interested in future programming to help advance the utilization of these specific team members.

Thus, a decision was made by NACHC officials to include, as part of the qualitative interviews, questions addressing issues specific to MA and CHW members of Primary Care Teams.

In addition, NACHC was itself interested in gaining a broader understanding of the way Primary Care Teams were constructed and utilized in the health center world by attempting to find general patterns, reveal primary issues, and discover potential correlations within and among health center Teams. In concert with the findings of the quantitative assessment, this would help NACHC better understand the needs of health centers for training and technical assistance specifically around Primary Care Team and Patient Centered Medical Home issues.
With these dynamics as background, a standardized interview template was proposed. After review by the Primary Care Team Assessment Work Group, which included both high-level NACHC staff and selected health center and State Primary Care Association officials, a template was approved. In its final form, it included 17 primary questions, with multiple content probes within each. As noted on the template, each interview would begin with a statement of the following primary Interview Focus:

“Medical Assistants (MAs) and Community Health Workers (CHWs) as part of Primary Care Teams, and what influences – if any – the Patient Centered Medical Home model and related recognition have on Team development and functioning.”

The recommended time for each interview was one hour; while a few interviews exceeded this, most were able to be conducted within that timeframe. (One interviewee responded in writing via the template questionnaire, due to lack of availability for a telephone interview.)

The next step was selection of interviewees; a target of six health center interviews was set. After multiple discussions that included the President of Insightlink Communications, it was decided that final interviewees would be chosen based on a generally representative sampling – health center size, setting (urban/rural), and geography – of centers from two groups:

**Group #1:** Centers that, on the quantitative assessment, had indicated the existence of Primary Care Teams with seven or more members, but who had not reported formal recognition as Patient Centered Medical Homes.

**Group #2:** Centers that had indicated the presence of some form of outreach worker.

Ultimately, three centers were selected from Group #1, and seven were selected from Group #2, for a total of 10 health centers. It was anticipated that of these 10, the desired number of six centers would actually agree to an interview. It turned out that the NACHC team was able to generate nine interviews from the 10 recommendations. As had been hoped, these nine centers represented a broad diversity in size, location, setting (urban/rural); of course, each had its own individual circumstances that would be explored in the interviews.
Attachment D

Qualitative Interviews: List of Interviewees

December 2014
Organizations / Interviewees
(Organizations by Alphabetical Order)

- Albuquerque Health Care for the Homeless (Albuquerque, NM)
  Matias Vega, MD – Medical Director

- High Plains Community Health Center (Lamar, CO)
  Jay Brooke – Executive Director

- Lana’i Community Health Center (Lanai City, HI)
  Diana Shaw, PhD, MBA, MPH, FACMPE – Executive Director
  Joseph Humphry, MD – Medical Director

- Little River Medical Center (Little River / Myrtle Beach, SC)
  Pamela Davis, RN, MSN – CEO
  Karen Cagle – COO

- Montana Migrant and Seasonal Farmworkers Council (Billings, MT)
  Carol Townsend – Executive Director

- Sacopee Valley Health Center (Porter, ME)
  Maryagnes Gillman – Executive Director

- Susquehanna Community Health & Dental Center (Williamsport, PA)
  Ellen Krajewski – President & CEO

- Total Health Care (Baltimore, MD)
  Arethusa Kirk, MD – Vice President of Medical Affairs

- United Family Medicine (St. Paul, MN)
  Brian Nasi – CEO
  Melissa Parker – COO
Attachment E

Additional Resources

December 2014
Primary Care Teams (General)

Building Teams in Primary Care: Lessons Learned (Bodenheimer, T. – California HealthCare Foundation: July 2007)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

Continuous and Team-Based Healing Relationships: Improving Patient Care through Teams (Safety Net Medical Home Initiative: May 2013)

Continuous Team-Based Healing Relationships (Safety Net Medical Home Initiative – Change Concepts)
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships

Empanelment (Safety Net Medical Home Initiative)
http://www.safetynetmedicalhome.org/change-concepts/empanelment

Health Care’s Transition to a Team Sport (Grumbach, K. – UCSF Department of Family & Community Medicine: 2014)

Health Care is a Team Sport (hoag web site - a member of St. Joseph Hoag Health Alliance, Newport Beach CA)
http://www.hoag.org/Why-HOAG/News-Publications/Pages/Fall-2013/Health-care-is-a-team-sport.aspx

Health Center Staffing Patterns a Model? (NACHC blog on recent study published in Health Affairs)
http://blogs.nachc.com/hcnews/health-center-staffing-patterns-a-model/

Integration of Primary Care and Public Health (American Academy of Family Physicians – Position Paper: December 2014)
http://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html

National Academy for State Health Policy – web site (Home Page)
http://www.nashp.org/

Panel Size: How Many Patients Can One Doctor Manage? (Murray, M., et. al. – Family Practice Management, online: April 2007)


The Primary Care Team: Learning from Effective Ambulatory Practices (“The LEAP Project: Capturing and Sharing Innovative Practices in Primary Care Delivery” – Robert Wood Johnson Foundation)

Thinking Outside the Box In Workforce (Two Issues Briefs by The Hitachi Foundation and NACHC)

Watch Team Based Primary Care in Action (Meisinger, K. – KevinMD.com: October 8, 2012)

Your Primary Care Team Will See You Now (Lin, K. – US News and World Report, Health: Nov. 19, 2010)

Medical Assistants (MAs)

CN Partners Share: Advanced Primary Care Team Models (California Improvement Network / California HealthCare Foundation: October 2013)

Elevating the Role of the Medical/Clinical Assistant: Maximizing Team-Based Care in the Patient-Centered Medical Home (Safety Net Medical Home Initiative: August 2011)

Innovative Workforce Models in Health Care: Expanding the Roles of Medical Assistants in Primary Care (The Center for Health Professionals at UCSF / The Center for Care Innovations / The Hitachi Foundation: July 2013)
http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=twQv21HRSc%3d&tabid=37

Innovative Workforce Models in Health Care: Utilizing Medical Assistants in Expanded Roles in Primary Care (Sutter Health University (CA) / Center for the Health Professions: March 28, 2014)
http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=VmvGREawnTU%3D&tabid=37

More Physician-MA Trust Needed to Facilitate Team-Based Care (Beaulieu-Volk, D. – FiercePracticeManagement, online: March 11, 2014)


What a Medical Assistant Can Do for Your Practice (American Academy of Family Physicians – Family Practice Management, online: April 2005)

Community Health Workers (CHWs)

http://journals.lww.com/ambulatorycaremanagement/Abstract/2011/07000/Community_Health_Workers_101_for_Primary_Care.3.aspx


Community Health Workers Evidence-Based Models Toolbox (HRSA Office of Rural Health Policy: August 2011)

Community Health Worker National Education Collaborative (web site)
http://www.chw-nec.org/

http://journals.lww.com/ambulatorycaremanagement/Abstract/2011/07000/Community_Health_Workers_Then_and_Now_An_Overview.6.aspx
Community Health Works (web site)
http://www.chwg.org/

Core Competencies for Community Health Workers (Massachusetts Board of Certification of Community Health Workers: August 13, 2013)


http://www.bls.gov/oes/current/oes211094.htm

State Certification Programs for CHWs and other CHW resources (Rural Assistance Center web site)
http://www.raconline.org/communityhealth/chw/module3/certification

Summary of State Community Health Worker Laws (Centers for Disease Control and Prevention: July 2013)
Addendum 1

Quantitative Assessment: Detailed Findings

December 2014
Overall Health Center Settings

*Breakdown for all participating health centers, regardless of Primary Care Team status*

- Urban 54%
- Rural 46%

**Total**
- Urban (140) 54%
- Rural (120) 46%
Overall Health Center Region

*Breakdown for all participating health centers, regardless of Primary Care Team status:*

<table>
<thead>
<tr>
<th>Region</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT, MA, ME, NH, RI, VT</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>NJ, NY, PR</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>DC, DE, MD, PA, VA, WV</td>
<td>31</td>
<td>12%</td>
</tr>
<tr>
<td>AL, FL, GA, KY, MS, NC, SC, TN</td>
<td>50</td>
<td>19%</td>
</tr>
<tr>
<td>IL, IN, MI, MN, OH, WI</td>
<td>33</td>
<td>13%</td>
</tr>
<tr>
<td>AR, LA, NM, OK, TX</td>
<td>31</td>
<td>12%</td>
</tr>
<tr>
<td>IA, KS, MO, NE</td>
<td>19</td>
<td>7%</td>
</tr>
<tr>
<td>CO, MT, ND, SD, UT, WY</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>AZ, CA, HI, NV</td>
<td>46</td>
<td>18%</td>
</tr>
<tr>
<td>AK, ID, OR, WA</td>
<td>15</td>
<td>6%</td>
</tr>
</tbody>
</table>
Overall Health Center Size (Number of Patients)

Breakdown for all participating health centers, regardless of Primary Care Team status

- Up to 999: 1%
- 1,000 up to 4,999: 20%
- 5,000 up to 9,999: 20%
- 10,000 up to 14,999: 17%
- 15,000 up to 24,999: 16%
- 25,000 or more: 27%
Presence of Primary Care Teams in Health Centers

- Based on a definition of a Primary Care Team as “a multi-disciplinary group of primary care staff members (both provider and non-provider) who collectively care for and take responsibility for a defined group (panel) of patients that is assigned to it,” almost 9 in 10 health centers report that they have Primary Care Teams in at least one of their sites. Given such a high proportion of health centers with such Teams, there likely is a variety of ways in which Primary Care Teams are being implemented and staffed.
Formalization of Primary Care Teams’ Roles & Responsibilities

Q: “How have roles & responsibilities for Team members at your largest site been defined?”

An important difference in the way Primary Care Teams are being implemented relates to how formally or informally Team member roles and responsibilities are defined. About ¼ (27%) of health centers with Primary Care Teams have introduced formal revisions to job descriptions organization-wide. The same proportion (also 27%) have so far made only small changes to job descriptions, perhaps as a step toward more formal implementation of Teams in the future. However, more than 4 in 10 centers (42%) appear to have implemented Primary Care Teams in a much less formal manner, without making any direct changes to specified roles and responsibilities.

NOTE: %’s based on all health centers with Primary Care Teams

“Formalization” – Survey Definitions:

- **Formal revisions** = Formal revisions to job descriptions that have been completed organization-wide
- **Small/incremental changes** = Small or incremental changes to actual staff job descriptions that have been completed for just a few sites, to potentially inform organization-wide formal job description changes
- **Roles defined informally** = Defined roles/responsibilities of Team members have been established informally
Policies/Procedures to Support Primary Care Teams

Q: “Does your health center organization have administrative, personnel, clinical, or other policies and procedures in place that directly support implementation of Primary Care Teams?”

Although a very high proportion (84%) of health centers with Primary Care Teams have administrative, personnel, clinical, or other policies and procedures to support those Teams, these results are highly correlated with how formally Teams have been implemented. Almost all centers with formal Teams also have these types of support policies and procedures in place.

<table>
<thead>
<tr>
<th>HAVE POLICIES AND PROCEDURES IN PLACE?</th>
<th>% of TOTAL w/PC Teams</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>84%</td>
<td>96%</td>
<td>85%</td>
<td>78%</td>
</tr>
<tr>
<td>No</td>
<td>16%</td>
<td>4%</td>
<td>15%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Primary Care Teams: Setting, Region, & Size (by # Patients)

The health centers with more formalized Primary Care Teams tend to be larger, while those with no Teams tend to be smaller. Being urban or rural does not appear to strongly influence the development of Primary Care Teams. There are only some slight differences in the distribution of Primary Care Teams by region.

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>Formalization of Primary Care Teams</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of TOTAL (all centers)</td>
<td>Formal revisions</td>
</tr>
<tr>
<td>SETTING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Rural</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>REGION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT, MA, ME, NH, RI, VT</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>NJ, NY, PR</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>DC, DE, MD, PA, VA, WV</td>
<td>12%</td>
<td>5%</td>
</tr>
<tr>
<td>AL, FL, GA, KY, MS, NC, SC, TN</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>IL, IN, MI, MN, OH, WI</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>AR, LA, NM, OK, TX</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>IA, KS, MO, NE</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>CO, MT, ND, SD, UT, WY</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>AZ, CA, HI, NV</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>AK, ID, OR, WA</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>SIZE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 999 (patients)</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>1,000 up to 4,999</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>5,000 up to 9,999</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>10,000 up to 14,999</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>15,000 up to 24,999</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>25,000 or more</td>
<td>27%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Percentage of Sites with Primary Care Teams

Q: “What % of your sites (locations, service sites) currently implement Primary Care Teams?”

The many health centers with any type of Primary Care Team are most likely to implement these Teams at a majority of their sites. This is especially true of organizations with the most formalized Teams, as introduced into at least 75% of their sites. Those centers which, so far, have made only “Small / incremental changes” to the roles / responsibilities of Team members are also less likely to have implemented such Teams throughout their organizations.

![Pie chart showing the percentage of sites with Primary Care Teams]

<table>
<thead>
<tr>
<th>PERCENTAGE OF SITES W/ PRIMARY CARE Teams</th>
<th>% of TOTAL (all centers)</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 percent</td>
<td>13%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>1 – 24 percent</td>
<td>10%</td>
<td>7%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>25 – 49 percent</td>
<td>8%</td>
<td>4%</td>
<td>11%</td>
<td>13%</td>
<td>0%</td>
</tr>
<tr>
<td>50 – 74 percent</td>
<td>13%</td>
<td>13%</td>
<td>16%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>75 – 100 percent</td>
<td>56%</td>
<td>76%</td>
<td>53%</td>
<td>63%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Number of Primary Care Teams

Q: “How many Primary Care Teams are there at your largest site?”

To some degree, the number of Primary Care Teams within a health center is related to how formally these Teams have been adopted, as those health centers which have made formal revisions to job roles and responsibilities also tend to have more Teams in place.

![Pie chart showing distribution of Primary Care Teams.]

<table>
<thead>
<tr>
<th># OF Teams</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>2</td>
<td>18%</td>
<td>15%</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>3</td>
<td>18%</td>
<td>7%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>4</td>
<td>17%</td>
<td>13%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>5 – 9</td>
<td>20%</td>
<td>31%</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td>10 or more</td>
<td>8%</td>
<td>15%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Average</td>
<td>4.1</td>
<td>4.8</td>
<td>3.4</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Size of Typical Primary Care Team

Q: "How many different staff members (regardless of FTE) are on a typical Primary Care Team at your largest site?"

Perhaps as would be expected, the health centers with the most formalized Primary Care Teams generally also have more Team members than the health centers whose Primary Care Teams have been implemented more informally.

Formalization of Primary Care Teams

<table>
<thead>
<tr>
<th># OF Team MEMBERS</th>
<th>% of Total (W/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3</td>
<td>24%</td>
<td>22%</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>4-6</td>
<td>47%</td>
<td>35%</td>
<td>47%</td>
<td>55%</td>
</tr>
<tr>
<td>7-8</td>
<td>18%</td>
<td>18%</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>More than 8</td>
<td>11%</td>
<td>25%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Average</td>
<td>5.3</td>
<td>6.1</td>
<td>5.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Composition of Typical Primary Care Team

**Q:** "Which of the following staff comprise a typical Primary Care Team at your largest site?"

The more formal Primary Care Teams are not only larger overall, they also have a wider diversity of members.

<table>
<thead>
<tr>
<th>PRIMARY CARE TEAM MEMBERS</th>
<th>On What % of Teams?</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>94%</td>
<td>100%</td>
<td>93%</td>
<td>91%</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>86%</td>
<td>91%</td>
<td>85%</td>
<td>81%</td>
</tr>
<tr>
<td>Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)</td>
<td>79%</td>
<td>84%</td>
<td>78%</td>
<td>76%</td>
</tr>
<tr>
<td>Nurse (e.g., RN, LPN)</td>
<td>76%</td>
<td>80%</td>
<td>87%</td>
<td>66%</td>
</tr>
<tr>
<td>Care Coordinator/Referral Coordinator</td>
<td>57%</td>
<td>67%</td>
<td>67%</td>
<td>47%</td>
</tr>
<tr>
<td>Behavioral/Mental Health Provider</td>
<td>46%</td>
<td>51%</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Clerical Assistant</td>
<td>29%</td>
<td>35%</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>Case Manager</td>
<td>26%</td>
<td>38%</td>
<td>13%</td>
<td>24%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>24%</td>
<td>31%</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>20%</td>
<td>25%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Outreach Worker</td>
<td>17%</td>
<td>25%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Interpreter</td>
<td>15%</td>
<td>22%</td>
<td>20%</td>
<td>7%</td>
</tr>
<tr>
<td>Patient/Family Member</td>
<td>15%</td>
<td>24%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Navigator</td>
<td>13%</td>
<td>15%</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>Nutritionian</td>
<td>11%</td>
<td>11%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Dietitian</td>
<td>9%</td>
<td>11%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Health Educator (added)</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Health Coach (added)</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Clinic Manager (added)</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>4%</td>
<td>9%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Composition of Typical Primary Care Team

Q: "Which of the following staff comprise a typical Primary Care Team at your largest site?"

A statistical “cluster” analysis of the results on Primary Care Team membership suggests that:

- Four in 10 health centers (40%) have implemented what might be best described as “core” Primary Care Teams. Almost all of these Teams include Physicians and/or Advanced Practice Providers, Nurses, and Medical Assistants, but few of these Teams have members that extend beyond these functions.

- In contrast, 6 in 10 health centers (60%) appear to have implemented “expanded” Primary Care Teams, since their Teams encompass a much wider range of disciplines than the core Teams. In some health centers, a large majority of their Teams include Behavioral/Mental Health Providers, as well as having reasonably high proportions of Case Managers, Patient Navigators, and either Nutritionists or Dietitians.

- Within other health centers, the expanded Primary Care Teams are characterized by specific inclusion of Care/Referral Coordinators and, in some instances, Patients and/or Family Members are considered Team members, as well.

Importantly, the use of either core or expanded Teams does not vary by the degree of formalization of Primary Care Team. This suggests that the composition of the Primary Care Teams – in terms of the number and type of Team members – is likely driven mainly by the health center’s particular circumstances (location, patient base, etc.) and is not affected by how they formally or informally decide to implement their Teams.
**Team Leader of Typical Primary Care Team**

*Q: "Who is the Team leader of a typical Primary Care Team at your largest site?"*

Physicians tend to lead most Primary Care Teams, especially in the health centers with the most formalized Teams.

<table>
<thead>
<tr>
<th>TEAM LEADER</th>
<th>% of Total (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>68%</td>
<td>73%</td>
<td>62%</td>
<td>67%</td>
</tr>
<tr>
<td>Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)</td>
<td>13%</td>
<td>9%</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Nurse (e.g., RN, LPN)</td>
<td>7%</td>
<td>7%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Care Coordinator/Referral Coordinator</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Case Manager</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>4%</td>
<td>11%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Regardless of how formally their Primary Care Teams are constructed, approximately one-half report to the Chief Medical Officer.

**Table: Reporting Structure for Primary Care Teams**

<table>
<thead>
<tr>
<th>Teams REPORT TO:</th>
<th>% of Total (W/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>11%</td>
<td>7%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td>51%</td>
<td>51%</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Quality Improvement Director</td>
<td>7%</td>
<td>7%</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
<td>25%</td>
<td>27%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Diagram: Formalization of Primary Care Teams**

- Chief Executive Officer (19) 9%
- Chief Operating Officer (23) 11%
- Chief Medical Officer (108) 51%
- Quality Improvement Director (15) 7%
- Other (46) 22%
Reporting Structure for Primary Care Teams

Q: "To whom do Primary Care Teams at your largest site report?"

Of the health centers with Primary Care Teams, about 1 in 5 have created a reporting structure that is not based on the CEO, COO, CMO, or Quality Improvement Director.

Some of these health centers have a “divided” reporting structure (for example, “Providers report to CMO, and all support staff report up and through to COO”).

A few of these health centers have no formal reporting structure, while for the others, there is a range of different positions mentioned. Some of the more common include Site Medical Director / Site Clinical Director, Clinical Site Leader, Director or Administrator, and Practice Manager.
Activities of Primary Care Teams

**Q: “In which of the following activities are Primary Care Teams at your largest site engaged?”**

Primary Care Teams engage in a fairly wide range of activities. Some of the most popular include linking patients to available services and resources in the community, having daily huddles to organize work, coordinating patient care with other providers, using standing orders, helping patients with self-managed care, and seeking ways to improve the delivery of patient care.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link patients to available services and resources in the community</td>
<td>82%</td>
</tr>
<tr>
<td>Daily huddles to organize work</td>
<td>81%</td>
</tr>
<tr>
<td>Coordinate patient care with other healthcare providers across different settings</td>
<td>76%</td>
</tr>
<tr>
<td>Use standing orders</td>
<td>76%</td>
</tr>
<tr>
<td>Teach patients or link patients to educational resources to self-manage care (e.g., diet, exercise, taking medications, symptom recognition)</td>
<td>74%</td>
</tr>
<tr>
<td>Identify internal processes to improve delivery of patient care and work with staff to implement these processes</td>
<td>71%</td>
</tr>
<tr>
<td>Structured communication to improve patient care and teamwork</td>
<td>62%</td>
</tr>
<tr>
<td>Routine scheduled meetings to discuss the Team’s functioning, structure, roles, responsibilities</td>
<td>55%</td>
</tr>
<tr>
<td>Participate in the hiring process for new team members</td>
<td>27%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>
Activities of Primary Care Teams

Q: "In which of the following activities are Primary Care Teams at your largest site engaged?"

More formalized Primary Care Teams also engage in more activities than less formal Teams, especially in terms of coordinating patient care with other healthcare providers across different settings.

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link patients to available services and resources in the community</td>
<td>82%</td>
<td>93%</td>
<td>75%</td>
<td>79%</td>
</tr>
<tr>
<td>Daily huddles to organize work</td>
<td>81%</td>
<td>87%</td>
<td>76%</td>
<td>80%</td>
</tr>
<tr>
<td>Coordinate patient care with other healthcare providers across different settings</td>
<td>76%</td>
<td>91%</td>
<td>65%</td>
<td>74%</td>
</tr>
<tr>
<td>Use standing orders</td>
<td>76%</td>
<td>82%</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>Teach patients or link patients to educational resources to self-manage care</td>
<td>74%</td>
<td>80%</td>
<td>64%</td>
<td>75%</td>
</tr>
<tr>
<td>Identify internal processes to improve delivery of patient care and work with staff to implement these processes</td>
<td>71%</td>
<td>80%</td>
<td>69%</td>
<td>65%</td>
</tr>
<tr>
<td>Structured communication to improve patient care and Teamwork</td>
<td>62%</td>
<td>80%</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>Routine scheduled meetings to discuss the Team’s functioning, structure, roles, responsibilities</td>
<td>55%</td>
<td>65%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td>Participate in the hiring process for new Team members</td>
<td>27%</td>
<td>36%</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>0%</td>
<td>7%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Recognition as PCMH

Q: “Are any of your organization’s sites (i.e., locations, practice sites, etc.) formally recognized as a Patient-Centered Medical Home (PCMH) by a national or state entity?”

In total, about 2/3 of all health centers have been formally recognized as a PCMH in at least one of their sites. This proportion, though, rises to more than 8 in 10 health centers having formal Primary Care Teams, but decreases as the definition of Primary Care Teams becomes more informal. To an even greater degree, among the few centers without Primary Care Teams, just 4 in 10 have been formally recognized as a PCMH.

Formalization of Primary Care Teams

<table>
<thead>
<tr>
<th>PCMH RECOGNITION</th>
<th>% of TOTAL (all centers)</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 2 (&quot;all&quot; or &quot;some&quot;)</td>
<td>69%</td>
<td>82%</td>
<td>75%</td>
<td>67%</td>
<td>39%</td>
</tr>
<tr>
<td>Yes, all sites</td>
<td>31%</td>
<td>40%</td>
<td>38%</td>
<td>27%</td>
<td>15%</td>
</tr>
<tr>
<td>Yes, some sites</td>
<td>38%</td>
<td>42%</td>
<td>36%</td>
<td>41%</td>
<td>24%</td>
</tr>
<tr>
<td>No sites</td>
<td>31%</td>
<td>18%</td>
<td>25%</td>
<td>33%</td>
<td>61%</td>
</tr>
</tbody>
</table>
Use of Quality Improvement (QI) and Patient Safety Activities

Q: "Do Primary Care Teams at your largest site engage in QI and patient safety activities (e.g., to reduce no-show rate, improve documentation of current medications in the chart, etc.)?"

Almost all Primary Care Teams engage in quality improvement and patient safety activities, with no variation by the types of Teams that are in place.

<table>
<thead>
<tr>
<th>USE QI AND PATIENT SAFETY ACTIVITIES?</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>No</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Almost all Primary Care Teams engage in quality improvement and patient safety activities, with no variation by the types of Teams that are in place.
Use of Individual Level Training for Primary Care Teams

Q: "Which of the following types of individual training do Primary Care Team members at your largest site receive to support their function/role on the Team?"

Three-quarters of health centers with Primary Care Teams use individual-level training on how to use data for improved patient care, while about 1/2 train on maximizing HIT and 4 in 10 train on Motivational Interviewing and how to work as a Team. More formalized Teams are slightly more likely to train on HIT and on Motivational Interviewing.

<table>
<thead>
<tr>
<th>INDIVIDUAL LEVEL TRAINING TOPICS</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to use data for improved patient care</td>
<td>74%</td>
<td>75%</td>
<td>66%</td>
<td>78%</td>
</tr>
<tr>
<td>How to maximize health information technology (HIT)</td>
<td>54%</td>
<td>64%</td>
<td>47%</td>
<td>51%</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>40%</td>
<td>45%</td>
<td>34%</td>
<td>39%</td>
</tr>
<tr>
<td>How to work as a Team (e.g., evidence based practices such as Team STEPPS, conflict resolution training)</td>
<td>38%</td>
<td>36%</td>
<td>36%</td>
<td>39%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
<td>18%</td>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Goal Setting for Primary Care Teams

Q: "Do Primary Care Teams at your largest site have specific goals that are measureable (e.g., increase by 20% the percentage of patients 65+ who have ever received pneumococcal vaccine)?"

Exactly 8 in 10 Primary Care Teams have set specific goals that are measurable. This result varies only slightly by how formally the Teams have been implemented.

<table>
<thead>
<tr>
<th>SPECIFIC MEASURABLE GOALS?</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80%</td>
<td>85%</td>
<td>82%</td>
<td>76%</td>
</tr>
<tr>
<td>No</td>
<td>20%</td>
<td>15%</td>
<td>18%</td>
<td>24%</td>
</tr>
</tbody>
</table>
Practice Transformation/Quality Improvement Activities

Q: "In which of the following practice transformation/quality improvement activities is your health center organization currently engaged?"

Among all health centers, almost 8 in 10 are working to integrate Behavioral Health with primary care, while about 6 in 10 are working toward PCMH recognition, upgrading their EHR system, reducing patient cycle time, and integrating Oral Health with primary care. To a much smaller degree, just 1/3 are participating in a Learning Collaborative with external partners, and just 1 in 5 are integrating HIV prevention and treatment with primary care.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating Behavioral Health with Primary Care</td>
<td>78%</td>
</tr>
<tr>
<td>Working toward PCMH Recognition/Accreditation</td>
<td>62%</td>
</tr>
<tr>
<td>Upgrading EHR</td>
<td>61%</td>
</tr>
<tr>
<td>Reducing Patient Cycle Time (length of visit)</td>
<td>55%</td>
</tr>
<tr>
<td>Integrating Oral Health with Primary Care</td>
<td>55%</td>
</tr>
<tr>
<td>Participating in a Learning Collaborative (i.e., a short-term learning system that brings together teams from multiple organizations to work on improvement in a focused topic area with external partners)</td>
<td>33%</td>
</tr>
<tr>
<td>Integrating HIV Prevention and Treatment with Primary Care</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
</tr>
</tbody>
</table>

Learning Collaboratives mentioned include:

- Various local Collaboratives and PCAs (together, these are the most frequent mentions)
- PCMH Collaboratives
- Diabetes Collaboratives
- Pain Management Collaboratives
Practice Transformation/Quality Improvement Activities

Q: “In which practice transformation/QI activities is your organization currently engaged?”

In many cases, adoption of various practice transformation and Quality Improvement activities within health centers is not directly related to the implementation of Primary Care Teams or how formally those Teams have been constructed. There are three exceptions: (1) centers with Primary Care Teams are much more likely to be integrating Behavioral Health with primary care than those with no Teams, (2) those with Teams are a little more likely to participate in Learning Collaboratives, and (3) centers with the most formal Teams are much less likely to be working toward PCMH recognition.

<table>
<thead>
<tr>
<th>PRACTICE TRANSFORMATION/QUALITY IMPROVEMENT ACTIVITIES</th>
<th>% of TOTAL (all centers)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating Behavioral Health with Primary Care</td>
<td>78%</td>
<td>78%</td>
<td>83%</td>
<td>80%</td>
<td>64%</td>
</tr>
<tr>
<td>Working toward PCMH Recognition/Accreditation</td>
<td>62%</td>
<td>51%</td>
<td>62%</td>
<td>67%</td>
<td>70%</td>
</tr>
<tr>
<td>Upgrading EHR</td>
<td>61%</td>
<td>58%</td>
<td>66%</td>
<td>59%</td>
<td>61%</td>
</tr>
<tr>
<td>Reducing Patient Cycle Time (length of visit)</td>
<td>55%</td>
<td>58%</td>
<td>58%</td>
<td>55%</td>
<td>48%</td>
</tr>
<tr>
<td>Integrating Oral Health with Primary Care</td>
<td>55%</td>
<td>53%</td>
<td>57%</td>
<td>50%</td>
<td>64%</td>
</tr>
<tr>
<td>Participating in a Learning Collaborative with external partners</td>
<td>33%</td>
<td>31%</td>
<td>36%</td>
<td>35%</td>
<td>18%</td>
</tr>
<tr>
<td>Integrating HIV Prevention/Treatment w/ Primary Care</td>
<td>22%</td>
<td>27%</td>
<td>21%</td>
<td>16%</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>11%</td>
<td>11%</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCMH RECOGNITION</th>
<th>% of TOTAL (all Centers)</th>
<th>Working Toward PCMH Recognition</th>
<th>Not Working Toward PCMH Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, all sites</td>
<td>31%</td>
<td>17%</td>
<td>54%</td>
</tr>
<tr>
<td>Yes, some sites</td>
<td>38%</td>
<td>39%</td>
<td>35%</td>
</tr>
<tr>
<td>No sites</td>
<td>31%</td>
<td>44%</td>
<td>11%</td>
</tr>
</tbody>
</table>
Empanelling/Assigning Patients to Specific Primary Care Teams

Q: "Does your largest site empanel or assign patients to a specific Primary Care Team for their routine care and the majority of their acute care?"

About 8 in 10 Primary Care Teams empanel patients to a specific Team, with little difference in this result by the method of Team implementation.

### Formalization of Primary Care Teams

<table>
<thead>
<tr>
<th>EMPANEL?</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>81%</td>
<td>85%</td>
<td>80%</td>
<td>78%</td>
</tr>
<tr>
<td>No</td>
<td>19%</td>
<td>15%</td>
<td>20%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Use of Cross Training for Primary Care Teams

Q: “Are Primary Care Team members at your largest site cross-trained to support Team functioning in cases of absences, staff vacations, or periodic heavy demands on one part of the Team?”

About 8 in 10 Primary Care Teams are cross-trained to support Team functioning, with such training occurring slightly more within health centers having the more formalized Team structure.

![Pie chart showing percentage of Primary Care Teams cross-trained](image)

<table>
<thead>
<tr>
<th>CROSS-TRAIN?</th>
<th>% of TOTAL (w/PC Teams)</th>
<th>Formal revisions</th>
<th>Small/ incremental changes</th>
<th>Roles defined informally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>82%</td>
<td>87%</td>
<td>85%</td>
<td>79%</td>
</tr>
<tr>
<td>No</td>
<td>18%</td>
<td>13%</td>
<td>15%</td>
<td>21%</td>
</tr>
</tbody>
</table>
**Importance for Primary Care Team Implementation/Sustainability**

Q: "Please indicate how important each of the following factors are to supporting Primary Care Team implementation and sustainability for your health center organization."

Three-quarters of all health centers (with or without Primary Care Teams) rate **Health Information Technology** (HIT) and **Leadership support** as extremely important to supporting Primary Care Team implementation and sustainability in their centers; this is followed by **availability of data** for improved patient care and Team functioning. Adequate Team coverage is of secondary, rather than primary, importance.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Extremely Important</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Very Important</th>
<th>Not at all important</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Information Technology (e.g., EHR, patient registries, patient portal)</td>
<td>75%</td>
<td>22%</td>
<td>3%</td>
<td></td>
<td></td>
<td>97%</td>
</tr>
<tr>
<td>Leadership support</td>
<td>73%</td>
<td>25%</td>
<td>2%</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>Availability of data for improved patient care and Team functioning</td>
<td>67%</td>
<td>31%</td>
<td>3%</td>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td>Quality Management infrastructure</td>
<td>57%</td>
<td>37%</td>
<td>6%</td>
<td></td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Funding for extended care team members (e.g., patient navigators, outreach workers)</td>
<td>53%</td>
<td>36%</td>
<td>8%</td>
<td>2%</td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>PCMH Recognition and Transformation</td>
<td>49%</td>
<td>34%</td>
<td>13%</td>
<td>3%</td>
<td></td>
<td>83%</td>
</tr>
<tr>
<td>Credentialing and Privileging</td>
<td>48%</td>
<td>29%</td>
<td>14%</td>
<td>9%</td>
<td>1%</td>
<td>77%</td>
</tr>
<tr>
<td>Adequate team coverage</td>
<td>46%</td>
<td>47%</td>
<td>7%</td>
<td></td>
<td></td>
<td>93%</td>
</tr>
</tbody>
</table>
**Importance for Primary Care Team Implementation/Sustainability**

Q: "Please indicate how important each of the following factors are to supporting Primary Care Team implementation and sustainability for your health center organization."

Health centers assign less importance to such factors as Policies, Procedures, and Standing Orders, Team role definition and optimization and patient understanding of the Care Team Model, in terms of what factors are key to supporting Primary Care Team implementation and sustainability.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Extremely Important</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Very Important</th>
<th>Not at all Important</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and Procedures and Standing Orders</td>
<td>43%</td>
<td>44%</td>
<td>12%</td>
<td></td>
<td></td>
<td>87%</td>
</tr>
<tr>
<td>Team role definition and optimization</td>
<td>38%</td>
<td>47%</td>
<td>14%</td>
<td>1%</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>Patient Understanding of Care Team Model</td>
<td>38%</td>
<td>42%</td>
<td>19%</td>
<td>1%</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Peer Review</td>
<td>33%</td>
<td>39%</td>
<td>22%</td>
<td>7%</td>
<td></td>
<td>72%</td>
</tr>
<tr>
<td>Empowerment</td>
<td>33%</td>
<td>38%</td>
<td>23%</td>
<td>4%</td>
<td>2%</td>
<td>71%</td>
</tr>
<tr>
<td>Physical space and design</td>
<td>27%</td>
<td>53%</td>
<td>17%</td>
<td>2%</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Other</td>
<td>29%</td>
<td>13%</td>
<td>4%</td>
<td>4%</td>
<td>50%</td>
<td>42%</td>
</tr>
</tbody>
</table>

[Insightlink Communications Analysis Report]
Importance for Primary Care Team Implementation/Sustainability

Q: "Please indicate how important each of the following factors are to supporting Primary Care Team implementation and sustainability for your health center organization."

The factors that are most important to all health centers, such as HIT and leadership support, are even more important to those health centers with the most formalized Teams. Not surprisingly, they also rate Team role definition and optimization as being more important than it is to all other health centers.

<table>
<thead>
<tr>
<th>EXTREMELY IMPORTANT FACTORS</th>
<th>% of TOTAL (all Centers)</th>
<th>Formal revisions</th>
<th>Small/incremental changes</th>
<th>Roles defined informally</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Information Technology (e.g., EHR, patient registries, patient portal)</td>
<td>75%</td>
<td>91%</td>
<td>67%</td>
<td>77%</td>
<td>59%</td>
</tr>
<tr>
<td>Leadership support</td>
<td>73%</td>
<td>82%</td>
<td>69%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Availability of data for improved care and Team functioning</td>
<td>67%</td>
<td>75%</td>
<td>51%</td>
<td>71%</td>
<td>66%</td>
</tr>
<tr>
<td>Quality Management infrastructure</td>
<td>57%</td>
<td>69%</td>
<td>51%</td>
<td>51%</td>
<td>53%</td>
</tr>
<tr>
<td>Funding for extended care Team members (e.g., patient navigators, outreach workers)</td>
<td>53%</td>
<td>65%</td>
<td>58%</td>
<td>45%</td>
<td>39%</td>
</tr>
<tr>
<td>PCMH Recognition and Transformation</td>
<td>49%</td>
<td>56%</td>
<td>50%</td>
<td>50%</td>
<td>34%</td>
</tr>
<tr>
<td>Credentialing and Privileging</td>
<td>48%</td>
<td>49%</td>
<td>45%</td>
<td>49%</td>
<td>44%</td>
</tr>
<tr>
<td>Adequate Team coverage</td>
<td>46%</td>
<td>52%</td>
<td>49%</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td>Policies and Procedures and Standing Orders</td>
<td>43%</td>
<td>51%</td>
<td>49%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Team role definition and optimization</td>
<td>38%</td>
<td>53%</td>
<td>37%</td>
<td>27%</td>
<td>38%</td>
</tr>
<tr>
<td>Patient Understanding of Care Team Model</td>
<td>38%</td>
<td>46%</td>
<td>42%</td>
<td>30%</td>
<td>38%</td>
</tr>
<tr>
<td>Peer Review</td>
<td>33%</td>
<td>36%</td>
<td>33%</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>Empanelment</td>
<td>33%</td>
<td>43%</td>
<td>33%</td>
<td>22%</td>
<td>38%</td>
</tr>
<tr>
<td>Physical space and design</td>
<td>27%</td>
<td>35%</td>
<td>22%</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Other</td>
<td>29%</td>
<td>33%</td>
<td>14%</td>
<td>60%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Top Three Support Needs

Q: “From the following list, mark the top THREE in which your organization would welcome training/mentoring/peer support to improve skills in supporting /strengthening Primary Care Teams.”

More than 1/2 of all centers are looking for funds to support expanded care Teams. About 3 in 10 want support for defining Team roles, using data to improve Team functioning, and engaging patients in the Team model.
Leading support needs do not vary much by Primary Care Team formalization; however, as would be expected, the centers with the most formal Team structure are less likely to want support in defining and optimizing Team roles and configuration.

<table>
<thead>
<tr>
<th>LEADING SUPPORT NEEDS</th>
<th>% of TOTAL (all centers)</th>
<th>Formal revisions</th>
<th>Small/ Incremental changes</th>
<th>Roles defined informally</th>
<th>(No Primary Care Teams)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding for Expanded Care Team Members</td>
<td>52%</td>
<td>55%</td>
<td>58%</td>
<td>49%</td>
<td>44%</td>
</tr>
<tr>
<td>Defining and Optimizing Team Roles and Team Configuration</td>
<td>35%</td>
<td>25%</td>
<td>40%</td>
<td>34%</td>
<td>34%</td>
</tr>
<tr>
<td>Capturing and Using Data for Improved Patient Care and Team Functioning</td>
<td>31%</td>
<td>36%</td>
<td>24%</td>
<td>30%</td>
<td>38%</td>
</tr>
<tr>
<td>Engaging Patients in the Primary Care Team Model</td>
<td>30%</td>
<td>36%</td>
<td>22%</td>
<td>36%</td>
<td>19%</td>
</tr>
<tr>
<td>Optimizing Health Information Technology (e.g., EHR, patient registries, patient portal)</td>
<td>23%</td>
<td>20%</td>
<td>25%</td>
<td>27%</td>
<td>19%</td>
</tr>
<tr>
<td>Leading Organizational Culture Change</td>
<td>21%</td>
<td>25%</td>
<td>16%</td>
<td>26%</td>
<td>9%</td>
</tr>
<tr>
<td>Skill Building for PCMH Recognition and Transformation</td>
<td>19%</td>
<td>13%</td>
<td>27%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>Onboarding and Training Team Members</td>
<td>19%</td>
<td>29%</td>
<td>11%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Recruiting and Retaining the Right Members for your Team</td>
<td>16%</td>
<td>16%</td>
<td>15%</td>
<td>16%</td>
<td>22%</td>
</tr>
<tr>
<td>Building a Quality Management Infrastructure</td>
<td>14%</td>
<td>15%</td>
<td>20%</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>Designing Physical Space to Support Team Functioning</td>
<td>13%</td>
<td>11%</td>
<td>11%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Empaneling Patients to Primary Care Teams</td>
<td>13%</td>
<td>5%</td>
<td>18%</td>
<td>10%</td>
<td>22%</td>
</tr>
<tr>
<td>Designing and Implementing Policies and Procedures</td>
<td>8%</td>
<td>9%</td>
<td>5%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
The Key Drivers of Primary Care Teams in Health Centers

• In an attempt to uncover any additional themes or insights on implementation of Primary Care Teams, various correlation analyses indicate that:

1. PCMH recognition is moderately correlated with the presence of any Primary Care Teams within health centers. However, these findings indicate that PCMH recognition is of itself not statistically correlated with how formally or informally these Primary Care Teams are implemented. Thus, while health centers with more formal Teams are indeed more likely to have achieved PCMH recognition, having such recognition does not appear to be a meaningful factor in the creation of more formalized Teams.

2. The factors that are most highly correlated with the type of Primary Care Teams in place include:
   - Cross-training Team members to support Team functioning,
   - Setting specific and measurable goals,
   - Having administrative, personnel, clinical, or other policies in place to support Primary Care Team implementation
   - Empaneling or assigning patients to specific Primary Care Teams.

   It is not clear, however, whether these relationships reflect causality (for example, setting measurable goals for Primary Care Teams leads to more formalized Teams or vice versa) or complementarity, which means that these functional characteristics of Primary Care Teams fit naturally together when implementing formal Teams.

3. In contrast, some of the other functional characteristics of Primary Care Teams – such as the number of Teams and the size of those Teams, as well as using daily huddles to organize work and regularly linking patients to available services in the community – appear to play some role in determining Team structure but are clearly not primary drivers of Team composition or implementation.

4. Finally, there are some characteristics that appear to play little or no role in determining how formally or informally Primary Care Teams are implemented, including such factors as who leads the Primary Care Teams, whether the health center uses “core” or “expanded” Teams, and the particular demographics of the health center (including number of patients, region and whether it is a rural or urban health center).
Addendum 2

Quantitative Assessment: Background Data Exhibits

December 2014
Background Data Exhibits

• The following exhibits are from the initial quantitative assessment findings. As the scope of the Assessment of Primary Care Teams in Federally Qualified Health Centers project narrowed, it was determined that responses to a number of the original quantitative questions – while offering good background information – were not ultimately necessary to consider as part of the main body of primary findings.

• The following exhibits provide potentially useful background regarding selected characteristics of all health centers that participated in the quantitative assessment process (regardless of the existence or “shape” of individual Primary Care Teams). The exhibits are simply for additional information.
### Health Center Funding Sources

**Q:** "*Does your health center organization receive funding from the following sources?"*

#### All participating health centers

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Funding for Quality Improvement in Community Health Centers</td>
<td>45%</td>
</tr>
<tr>
<td>(Bureau of Primary Health Care)</td>
<td>55%</td>
</tr>
<tr>
<td>Title X Family Planning</td>
<td>21%</td>
</tr>
<tr>
<td>School Based Health Center</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>84%</td>
</tr>
</tbody>
</table>
Q: "Does your health center organization participate in the National Health Service Corps (NHSC)?”

All participating health centers

Yes 93%

No 7%

Total

Yes (241) 93%
No (18) 7%
Percentage of Providers Eligible for Meaningful Use

Q: "What percentage of providers in your health center organization are eligible for Meaningful Use?"

All participating health centers

- 0 percent: 4% (9 providers)
- 1 to 24 percent: 3% (7 providers)
- 25 to 49 percent: 5% (13 providers)
- 50 to 74 percent: 15% (39 providers)
- 75 to 100 percent: 74% (189 providers)
### Stages of Meaningful Use

**Q:** "Of your total number of providers eligible for Meaningful Use, what percentage have attested to each of the following stages?"

**All participating health centers**

<table>
<thead>
<tr>
<th>Stages</th>
<th>Attested to AIU (Adopt, Implement, Upgrade)</th>
<th>Attested to Stage 1</th>
<th>Attested to Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14%</td>
<td>26%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>63%</td>
<td>42%</td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- 0 percent
- 1 to 24 percent
- 25 to 49 percent
- 50 to 74 percent
- 75 to 100 percent
Team to Optimize Use of EHR

Q: "Does your organization have an internal team responsible for optimizing use of your Electronic Health Record (EHR) for improved quality outcomes (e.g., upgrades, decision support tools, etc.)?"

All participating health centers
EHR Team Members

Q: "Which of the following staff members sit on your internal team responsible for optimizing use of your EHR?"

All participating health centers

<table>
<thead>
<tr>
<th>Staff Member</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>84%</td>
</tr>
<tr>
<td>IT Director/staff</td>
<td>81%</td>
</tr>
<tr>
<td>Quality Improvement Director/staff</td>
<td>80%</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>49%</td>
</tr>
<tr>
<td>Advanced Practice Provider (e.g., Nurse Practitioner, Physician Assistant, Certified Nurse Midwife)</td>
<td>46%</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>44%</td>
</tr>
<tr>
<td>Office Manager</td>
<td>36%</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
<td>36%</td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>31%</td>
</tr>
<tr>
<td>Behavioral Health staff</td>
<td>26%</td>
</tr>
<tr>
<td>Oral Health staff</td>
<td>24%</td>
</tr>
<tr>
<td>Informaticsian</td>
<td>23%</td>
</tr>
<tr>
<td>Front Desk staff</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>30%</td>
</tr>
</tbody>
</table>

NOTE: Percentages calculated only on those who have EHR teams
EHR Team Members

Other Mentions

Nursing Director
Nurse Manager
HIM Specialist
Medical Assistant
Clinic Manager
Department Supervisor
Compliance Officer
RNs
Administrative Director
EHR Specialist
Billing Manager
Health Information Services Manager
Medical Records
Medical Assistant Supervisor
Student Interns
Chief Medical Information Officer
Clinic Coordinator
Dental Manager
Informatics Medical Director
Trainer
Report Writer
Chief Information Officer
IT Consultant
Practice Management Director
Informatics Staff Nurse
EHR specialist
Office Manager
Social Services
Nutritionist
Data Manager
Compliance Officer

Chief Administrative Officer
Health Center Management
VP, Clinical Services
Patient Care Coordinator
Director of Clinical Services
Lab Director
Nursing Supervisor
Managed Care
PCA
Non-clinical Administrative Staff
Decision Support Manager
Laboratory Staff
Quality Improvement Team
Providers
Billing Director
Director of Operations
Revenue Enhancement Specialist
Nurse Coordinator
Outreach & Enrollment
IT Contractor
Executive Assistant
Health Coach
LPN
Learning & Development Department
Clinical Team Leader
Medical Director of Behavioral Health
Dental Director
Clinical Trainer
Training Dept. Supervisor