Making Health Primary

How Family Medicine and Primary Care are Delivering on the Triple Aim

Making Health Primary in America

Delivering Comprehensive, Coordinated and Continuous Care

Emphasizing Prevention and Health Promotion

Putting Patients at the Center of Care

Improving Health Equity

Partnering with Public Health

Leveraging Technology

Ensuring a Strong Primary Care Workforce
MAKING HEALTH PRIMARY IN AMERICA

A year ago, eight leading family medicine organizations came together with a commitment to improve our health care delivery system and make America healthy. We formed a new organization—Family Medicine for America’s Health—and we rolled out an ambitious effort to strengthen the foundation of primary care and deliver on the promise of the Triple Aim: better care, better health and lower costs.

We have all heard the bad news: America has the most expensive health care system in the world, yet we rank almost last among industrialized countries in the health of our people.

But, there is good news. There are many examples where family medicine and our colleagues in primary care are transforming health care in this country. Individuals and companies across the country are building on major shifts in our system—including the Affordable Care Act, the adoption of the patient-centered medical home, and improvements in technology—to transform and improve the health of patients and communities where they work and live.

Health is Primary, our campaign to showcase the improvements that comprehensive primary care is driving in our health care system, has been on the road. The stories you will find here are just a sample of what’s happening. Our hope is that by sharing these stories we can lead the way to a better health care system, bring this transformation to scale and make America a place where Health is Primary.

So what does health care look like when Health is Primary? We believe it looks a lot like family medicine. It’s a place where:

- Doctors and patients work together in true partnership;
- Doctors have long-term relationships with their patients and see and treat the whole person;
- Technology supports and fosters the connection between doctors and patients;
- Everyone has access to a medical home where most, if not all, of their health needs can be met, and a coordinated medical neighborhood that provides additional care when needed;
- Prevention and health promotion are as important as treating disease;
- Doctors work with public health, behavioral health and community leaders to address individual and population health;
- Health disparities are reduced by increasing access to primary care; and,
- Financial incentives line up with good care and better health outcomes.

The Health is Primary campaign is just part of our effort. We are also working across family medicine and with other primary care groups, payers and policymakers to enhance and modernize the primary care system in this country.

Over the next four years, through outreach to the public and collaboration with our colleagues in family medicine and across the health care delivery system, we will work to transform our health care system and ensure the health of all Americans.
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Making Health Primary in America

Specifically, we aim to:

- Increase patient accessibility to their primary care team, including remote access to patient records, electronic communication with their care team and availability after hours.
- Encourage every practice to have a patient advisory council or similar mechanism to facilitate meaningful and ongoing patient engagement.
- Increase transparency in pricing of health care services and educate patients to better understand cost of care.
- Integrate public and mental health into the Patient-Centered Medical Home (PCMH) and add care managers, health coaches and population health professionals to the primary care team. Incorporate training to practice in a team-based setting into graduate medical education.
- Support policies that drive at least 40 percent of medical students toward primary care specialties with the goal of increasing the number of primary care physicians by a minimum of 52,000 by 2025.
- Sunset fee-for-service payment in primary care. Work with public and private payers to adopt a uniform and simplified model of comprehensive payment that encourages front-end investment in expanded practice infrastructure and technology, rewards Triple Aim goals (better care, better health and lower costs) and supports broad, team-based care. Support efforts to drive HHS goal of having 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018.

This won’t happen over night and we can’t do it alone. We invite our partners in health care—patients, payers, employers and the broader health care community—to join us in this cause. Let’s work together and make America a place where Health is Primary.

Thank you,

Glen Stream MD
President and Board Chair
Family Medicine for America’s Health
When the Health is Primary campaign held seminars with primary care doctors around the country, we heard from city docs and country docs, from freshly-minted physicians just out of school and long-timers who started out when Medicare was still a controversial new idea. Our speakers included physicians who treat children still shy of their first birthday—and hospice doctors whose patients are 90 years further along the path of life.

But for all this diversity of geography, experience, and practice, we heard a common theme repeated around the country. Over and over, primary care doctors told us: “I love my job.”

As the moderator for these panel discussions, I was surprised to hear it. It is conventional wisdom in health policy circles that primary care gets far too little respect in the American health care system. Although the friendly, familiar family doctor or pediatrician is the linchpin of American medicine, the high-powered specialists always seem to garner the most prestige (and the highest incomes). Frankly, we heard some comments along those lines in our sessions. Overall, though, I came away with a strong sense that America’s primary care doctors are proud of their central role in maintaining the nation’s health—and happy in their work.

A key reason, these physicians told us, is that the primary care doctor develops a long-term personal partnership with the patient that most specialists can only dream of. In primary care, the physician is not treating just a fractured bone or a diseased organ. Rather, she treats the whole person; she has overall responsibility for the physical and emotional well-being of a human being, often a friend whom the doctor has known for years. The primary care doctor’s office served as a “medical home” long before that concept caught on with the policymakers.

As we’ll see throughout this book, that characteristic primary care relationship leads to health care based on collaboration between doctor and patient. In our panels, doctors kept saying that they worked with the patient—not on the patient—to maintain health and to treat illness. As one physician put it, “Patient engagement is a wonder drug.”

Dr. Thomas White, a family physician in Cherryville, N.C., told us that he had learned a key lesson in health care from his patients in the local fire department. The firefighters told their doctor about a standard rule of their trade: “Two In, Two Out.” That is, a firefighter should never enter a burning building alone. Rather, there should always be at least two working together, so that one can help if the other is hurt. “And I came to realize,” Dr. White explained, “that Two In, Two Out is the correct recipe for health care as well. The doctor and the patient need to work together.”

This unique partnership helps explain why primary care is an essential element of a cost-effective health care system. By keeping tabs on their patient, by spotting potential problems early, by intervening before a patient requires costly diagnostic testing or hospitalization, the primary care physician enhances overall health and saves significant sums for the payer, whether it is a patient, an employer, or an insurer.

All over the world, health care economists and health officials recognize this value proposition. When I was studying the health care systems in the world’s other rich democracies, national health ministers repeatedly told me that they preferred to have about two primary care doctors for every one specialist. Most of the other developed countries have maintained roughly this ratio. The United States, of course, has it backward; only about one-third of American physicians are specializing in primary care. That’s a major reason why our country pays far more for health care than other developed countries, but gets far less in return.

But there are grounds for hope. More and more, health policy experts, patients, and those who pay the bills are coming to realize that an emphasis on primary care is an essential requirement for better health outcomes at lower cost. Our seminars around the country (which will continue for the next two years) are helping to emphasize a key point. Primary care doctors love their work; it’s time for America to love them back.

– T. R. Reid

Author, Documentary Filmmaker and Reporter
A strengthened primary care system can help improve the health care delivery system and the health of all Americans. Family medicine and primary care are Making Health Primary by...
Long-term relationships built on trust between patient and physician are the foundation of good health. That’s why primary care practices treat patients and their families as core members of their health care team.

Family doctors are dedicated to treating the whole person and are seen by their patients as partners. We believe every patient should have access to a health care team that understands and respects them.

A Practice Built Around the Patient—Qliance, Seattle

At Qliance, a Seattle-based direct primary care practice, patients receive 24/7 access to primary care physicians—in person and by phone or email—for a flat monthly fee comparable to a gym membership. The Qliance model is based on relationship-centered care and everything—from physician pay structure to proprietary IT systems—is built to support this focus on patients.

Physicians and care teams have more time with patients and are able to emphasize holistic care. The result: patients are empowered with the skills and information they need to make healthy choices every day and to be involved in their own care.

The Qliance model has shown comparable results across a broad and diverse customer base representing approximately 35,000 patients. In some cases, the monthly fee is covered by individuals. In others, it is paid by employers and private and public insurers. In fact, Medicaid accounts for 15,000, or almost half, of Qliance’s patients.

Better Health Outcomes through Strong Patient-Physician Relationships—Iora Primary Care, Seattle

Patients can often feel disconnected from their physicians and don’t feel motivated to participate in their own well-being. Iora Health and Humana recognized this challenge and partnered to open Iora Primary Care, a practice in Seattle dedicated to serving senior citizens.

Its model for primary care includes one-on-one health coaching as a way to emphasize preventive care for seniors and establish a dedicated advocate, confidant and friend for patients. As a result of Iora’s model, patients are receiving personalized, comprehensive care and develop strong relationships with their care team.

The Iora model of care has shown results in terms of patients’ engagement, satisfaction and outcomes. Results show that these patients are actively engaged, satisfied and very likely to recommend Iora to a friend. Iora’s patients dealing with hypertension and diabetes have had better success controlling these conditions as compared to the national average.

Home-Centered Care Reduces Costs and Hospital Admissions for the Aging Population—HomeCare Physicians, Wheaton, Ill.

People 65 years or older are the fastest growing age group in the United States, and the highest utilizers of costly hospital and nursing home services. Without a change in approach, the demand and costs for long-term services and support will increase as our society ages.

Thomas Cornwell, M.D., realized the benefit of using house call programs to serve this complex and costly patient population, and in 1997, he founded HomeCare Physicians, in Wheaton, Ill. The community hospital-sponsored house call program provides quality, affordable care in the comfort of elderly patients’ homes, including lab tests, EKGs, X-rays, ultrasounds, IVs and other

http://www.annfammed.org/content/6/1/6
modern medical technology normally offered at a hospital. Providing care in the home also ensures the patient-physician connection continues after hospital discharge, further reducing hospital readmission and health care costs.

Building off the success of his house call practice, Cornwell founded the Home Centered Care Institute in 2012, which is a collaborative, not-for-profit organization dedicated to the national expansion of house call practices and the integration of community resources.

Family Physician Uses Group Visits to Combat Diabetes—Providence St. Peter Family Medicine, Olympia, Wash.

Devin Sawyer, M.D., director of the residency program at Providence St. Peter Family Medicine in Olympia, Washington, has been using ‘mini-group visits’ (usually three patients per group) to help patients with diabetes support each other through treatment. These sessions including discussions of lifestyle changes, behavior changes and self-management to help control the disease. These group visits do not replace the patients’ regular office visits, and patients are still seen periodically between mini-group visits, which are scheduled every three or four months.

Patients in the groups benefit from the support of their peers dealing with the same condition and they regularly hold each other accountable for treatment, checking in with each other outside the office visits.

Health Plans Investing in Value-Based Care Models—Blue Cross Blue Shield of Illinois

Blue Cross Blue Shield of Illinois (BCBSIL) has been implementing local, value-based care models for more than two decades, and has continually refined and improved the model every year.

Today, the BCBSIL program works with 75 medical groups and covers more than 700,000 members under a program that rewards quality of care over volume of care. That means patients get what they need when they need it—and physicians and practices are rewarded based on outcomes.

In 2015, BCBSIL launched four new coordinated care groups in its continued effort to lower medical costs while improving health outcomes. With the addition of these new groups, BCBSIL now has nine Accountable Care Organizations in Illinois serving more than 450,000 patients.

Improving Small Business Employee Health and Bottom Line through Direct Primary Care—Nextera Healthcare, Dacono, Colo.

Left Hand Brewing Company in Longmont, Colo., offered its employees a high-deductible health plan that only covered one check-up with a primary care physician (PCP) per year. All other visits were out of pocket for employees, deterring them from seeking care. In order to improve the health care provided to its employees, the company teamed up with Nextera Healthcare—Colorado’s first direct primary care (DPC) program—to offer its employees a higher-deductible health plan with no limits on PCP visits and no bills for individual visits.

By allowing for unlimited PCP visits and eliminating bills for each visit, Nextera and Left Hand removed access and cost barriers to care for employees, encouraging them to seek preventive care and improve their overall health. Working with Nextera’s DPC program allows employees to build relationships with their PCPs, whom they can visit whenever needed and whom also provide workers’ compensation services.

Knowing that working with a DPC program leads to improved health outcomes, Left Hand’s insurance provider offered a four percent premium decrease up front. Left Hand also saw costs by deciding to become partially self-funded rather than pay 100 percent of its premium to the insurance company, because working with Nextera was having such positive effects on its employees’ health outcomes.
Leverage Value-Based Payments with Primary Care Providers to Improve Patient Care—Anthem Blue Cross and Blue Shield of Colorado

The physician-patient relationship is one of the most important components to promoting health and wellness, which is why primary care is critical. As a result, Anthem Blue Cross and Blue Shield of Colorado launched the Enhanced Personal Health Care initiative to promote patient-centered care and compensate providers for the work required to deliver this type of coordinated, personalized care.

The aim of Anthem’s Enhanced Personal Health Care program is to better align incentives in order to bring high-quality care to patients and to control costs by promoting population health management. Anthem is making a major investment in primary care by moving to these value-based arrangements, and is also offering the support of a dedicated team of experts in patient-centered care who are devoted to helping providers succeed in adopting a patient-centered care model.

Since the program launch, Anthem is now working under value-based arrangements with more than 1,100 (or one-third of) physicians from about 250 primary care practices across the state, providing primary care services to more than 160,000 Anthem members. By the end of 2015, Anthem’s goal was to contract with close to 50 percent of the state’s primary care physicians.

Improving Care by Involving Patient Perspectives—Voice of the Patient Project, Mich.

Team-based, patient-centered care lowers costs, improves care and improves outcomes by involving patients in their own care. The Greater Detroit Area Health Council (GDAHC) and the Michigan Primary Care Transformation Initiative (MiPCT) started the Voice of the Patient Project to develop Patient and Family Advisory Councils. The Patient and Family Advisory Councils partner patients and families with health care providers to offer advice on improving patient and family care experiences. The Voice of the Patient program recruits practices across Michigan to develop the advisory councils, which provide trainings and gather feedback in order to develop best practices on providing consistent, high-quality care across practices.

As a result of the program, five practices have initiated Patient and Family Advisory Councils. By incorporating patient and family perspectives into care through the councils, providers make fewer assumptions about patient needs and advisors challenge providers to think of new possibilities by asking different questions and providing unique perspectives.

Driving Improved Health Outcomes through Patient-Centered Care—Wayne State University Physician Group, Troy, Mich.

Wayne State University Physician Group (WSUPG) is the largest multi-specialty practice group in Southeast Michigan, with more than 2,000 physicians providing primary and specialty care at nearly 1 million annual patient visits. As an organization focused on patient-centered medical care, WSUPG puts the patient first, partnering since 2013 with patients and patient representatives through its monthly Patient/Patient’s Representative Advisory Council meetings. WSUPG listens, driving change and improvements operationally and clinically. WSUPG has four Blue Cross Blue Shield of Michigan-designated patient-centered medical homes. These primary care practices partner with multi-specialties and sub-specialties to facilitate and improve coordination of care.

WSUPG team members’ satisfaction and engagement with the company is a fundamental part of the process, as well. WSUPG works closely with team members to ensure they are diving deep and getting the answers everyone needs, illustrating that an innovative and scientific approach to patient-centered care really works.
CONTINUITY OF CARE, which implies that individuals use their primary source of care over time for most of their health care needs, is associated with greater satisfaction, better compliance, and lower hospitalization and emergency room use.1

AT THE END OF LIFE, GREATER CONTINUITY WITH PRIMARY CARE IS GENERALLY ASSOCIATED WITH REDUCING AVOIDABLE HOSPITALIZATIONS,2 LESS EMERGENCY DEPARTMENT USE3 AND INCREASED OUT-OF-HOSPITAL DEATHS FOR PATIENTS WITH A TERMINAL ILLNESS.4

Patients with access to coordinated, comprehensive and continuous care have better health outcomes.

Family doctors treat patients, not conditions. We want everyone to have a doctor who sees them as a whole person and provides them with quality, coordinated and continuous care. In primary care settings around the country, integrated teams of health professionals provide patients what they need when they need it in a coordinated setting.

Public-Private Partnership Delivers on the Triple Aim for Medicaid Patients and Provides Platform for Innovation in Care—Community Care of North Carolina

Community Care of North Carolina (CCNC) is a public-private partnership between the state and nonprofit community care network that serves as a ‘medical home’ for 80 percent of North Carolina’s Medicaid population. CCNC’s team-based primary care model includes 800 care managers across the state and is driving better care and better outcomes for patients. CCNC leverages its widespread reach across the state to create novel programs and partnerships to improve patient health, improve the quality of care and manage health care spending.

CCNC patient admission rates are consistently 40-50 percent lower than non-CCNC Medicaid patients and those who received transitional care were 20 percent less likely to have a readmission the following year compared to similar patients who received usual care. CCNC avoided costs amounting to nearly $1 billion from 2007-2010, contributing to North Carolina’s position as the only state with consistently declining growth rates in medical spending for more than a decade.

Working with CCNC, Robert Rich, M.D., and his staff used local network funding to provide patients with comprehensive, coordinated care. The team includes a pharmacist, who works directly with patients on medication safety and adherence, and a nurse and care manager, who focus on patient health care needs.

Integrating Mental Health into Primary Care to Transform Youth Mental Health Services—Southern Illinois University School of Medicine, Springfield, Ill.

Children’s mental health issues are common but often under-recognized and undertreated. Services are often fragmented and providers are often unaware of the wide range of community resources and how to link successfully to them. The stigma and lack of community-based mental health promotion often mean that children do not get the help they need, resulting in a greater incidence of mental illness.

Janet Albers, M.D. and family physicians at the Southern Illinois University (SIU) School of Medicine in Springfield are integrating mental health with primary care in the medical home to transform the way mental health care is provided to youth. SIU Family Medicine has focused on community outreach to public schools. This includes SIU’s Care-A-Van in Carbondale, a school and rural health center on wheels that provides teen-friendly medical and behavioral/mental health services to students at partnering schools in the region.


As a result of integrated mental health in primary care through SIU, school attendance has improved, patient engagement in care has increased and there are fewer appointment no-shows. An integrated team led by family physicians and including advanced practice professionals, behavioralists and psychiatrists within the medical home makes care seamless for children and families. Early screening of mental health is promoted and children’s stigma towards mental health is reduced.

**Making Health America**

**Improving End-of-Life Care—VITAS Healthcare, Chicago**

During the past decade, the hospice industry has experienced substantial growth in the number of hospice programs and patients served. Interdisciplinary hospice teams have helped to preserve the quality of life for those who no longer respond effectively to treatment and have a life expectancy of six months or less. These teams have helped reduce health care costs by enabling patients to be cared for primarily at home in a supportive environment or in an inpatient hospice unit whenever possible.

Family physician Javette Orgain, M.D., has been a leader in the hospice movement work with VITAS Healthcare, formally Vitas Innovative Hospice Care.

**Mental Health and Primary Care Providers Partner to Treat High-Risk Patients—Family Preservation Services of North Carolina**

Managing patients with both mental disorders and chronic diseases can be difficult especially when the medical and mental health systems are largely separate.

That’s why Family Preservation Services of North Carolina (FPS) established a co-location project with selected primary care physicians to better integrate behavioral health and primary care. Physicians participating in the project refer patients to FPS, which then works with patients on-site and handles all follow-up and insurance claims. They also evaluate each patient for therapy needs and coordinate follow-up with the primary care physician.

The coordination of services, shared location and ongoing communication helped to reduce challenges of getting patients to multiple providers and has improved care for high-risk patients.

**Strengthening Colorado’s Triple Aim Strategy to Provide Coloradans Access to Integrated Primary Care—The Colorado State Innovation Model**

While the state of Colorado has a strong, collaborative foundation for its health system, health costs continue to rise. Patients receive fragmented care and key population metrics must be improved. This is why the state applied for and received a $65 million grant from CMS to implement and test the State Health Care Innovation Plan.

The Colorado State Innovation Model (SIM) touches every aspect of Colorado’s health system. Because of its reach, SIM is able to set the stage for sweeping transformation and help Colorado get closer to achieving the triple aim of lower costs, better care and improved population health. The model also aims to make Colorado the healthiest state. A key piece to this transformation is integrating behavioral health and primary care. The model will also apply value-based payment structures, expand information technology efforts and finalize a statewide plan to improve population health.

The program has begun to integrate physical and behavioral health care and will continue to do so in 400 practices during the four-year grant period. The model aims to improve the health of Coloradans through integrating physical and behavioral health care systems with value-based payment structures for 80 percent of Colorado residents by 2019.

**Primary Care Solutions Reduce Emergency Department Visits—Greater Detroit Area Health Council, Mich.**

Patients often visit emergency departments (EDs) for conditions that could be treated by a primary care physician in the less costly office setting. As a result, the Greater Detroit Area Health Council convened a multi-stakeholder team made up of payers, purchasers, consumers and providers to develop simple, impactful primary care office management interventions for improving primary care access in order to reduce ED visits.

Through a pilot program at an independent practice association, with about 300 primary care physicians overall, solutions were implemented at selected practice sites targeted because of a historical trend of increasing ED visits for conditions likely treatable in the PCP office. The solutions included adopting telephone triage processes to direct patients to the appropriate venue for care, developing materials to communicate to patients how to obtain care when their primary care physician is unavailable and increasing appointment schedule flexibility.

The simple practice management strategies impacted ED use. A study on the program’s effectiveness found rates of ED use for likely primary care office-treatable conditions decreased from a high of 49.2 visits per 1,000 people to 7.5 visits per 1,000 people in those practices targeted for the intervention.

**Fostering Quality Rather Than Quantity of Care—Blue Cross Blue Shield of Michigan**

Blue Cross Blue Shield of Michigan (BCBSM) has transitioned from the traditional fee-for-service physician model and now pays physicians fees that are tiered based on the previous year’s performance measured at the population level. BCBSM created ‘Value Partnerships’ to actively support implementation of a patient-centered, team-based care model that has access to care information from across the health care delivery spectrum.

BCBSM partnered with physician leaders in Michigan to design and implement the country’s largest and most successful patient-centered medical home (PCMH) program. This program is contributing to the revitalization of primary care within the state and producing substantial...
improvements in quality at a lower cost. The Value Partnership program works to strengthen the performance of specialists to work effectively with their primary care colleagues as PCMH ‘neighbors’ following a framework developed by the American College of Physicians.

Together, the primary care physicians, specialists and hospitals are encouraged to act as ‘organized systems of care’ to improve outcomes of care for the population served. Taken together, these programs are facilitating a transformation in health care delivery within Michigan that has already saved $1.2 billion at BCBSM and has become a national model.

**Improving Care Coordination, Expanding Access to Quality Care—Michigan Primary Care Transformation Project**

With the rise of chronic diseases and the need for greater access to primary care services, a variety of health care stakeholders including Medicare, Michigan health plans and Michigan physician organizations partnered together to launch the Michigan Primary Care Transformation Project (MiPCT).

MiPCT is a five-year, statewide, multi-payer, patient-centered medical home (PCMH) project aimed to help improve health in Michigan, make care more affordable and strengthen the patient-care team relationship. It provides physicians resources to hire care coordinators and implement systems to effectively track and follow up with patients, expand office hours and offer same day appointments. It also rewards physicians for improving patients’ health and decreasing their need to go to the emergency room.

Since its launch, MiPCT has transformed into the largest PCMH program in the nation. It includes about 400 primary care practices and 1,800 primary care physicians and mid-level providers. It has been nationally recognized as a model for the utilization of primary care and has worked toward delivering on the triple aim of better health, better outcomes and lower costs.

**Advancing Health Through Support of Primary Care and the Patient Centered Medical Home—The Dow Chemical Company, Midland, Mich.**

The Dow Chemical Company has a long history of strong commitment to employee and public health, including onsite health services for occupational health for many decades. About 20 years ago, Dow began a journey to integrate worker protection services (toxicology, industrial hygiene, safety, occupational health and epidemiology) with services that enhance health (health benefits and health promotion). Coordination with primary care through care management and health risk appraisal programs have been in place since 2004. Dow Health Services operates in a team-based person-centered care model and is a strong partner in the medical neighborhood, coordinating with primary care for the population served. Dow Health Services also participated in the NCQA Ambulatory Care Pilot in 2014, which highlighted the importance of effective transitions of care.

A formal Dow Health Strategy was developed in 2006. Key elements of this strategy include prevention, quality and effectiveness, health care systems management and advocacy. Dow worked with its major medical plan providers to develop and implement a gain sharing model for a patient-centered medical home (PCMH) with a multi-year implementation in areas with significant employee populations spanning about 20 states. This effort included connections with national and state initiatives, specifically membership on the Patient-Centered Primary Care Collaborative Board, working with others to position Michigan positively for selection as a CMS pilot state for PCMH and outreach and education to providers and payers.

A regional community-based health approach began in 2007 when Dow provided leadership and financial support for the creation of the Michigan Health Improvement Alliance (MiHIA). In 2008, HHS designated MiHIA as a Chartered Value Exchange (CVE)—a community-based, multi-stakeholder cooperative effort at the forefront of transforming health care at the local level.
Emphasizing Prevention and Health Promotion

Patients with access to primary care are more likely to receive preventive services and timely care before their medical conditions become serious—and more costly to treat.

Family doctors work with their patients to keep them healthy. We want to ensure that all patients have access to and use regular preventive care.

Employer Implements Medical Home Model to Benefit Employees and Reduce Costs—Vanguard Furniture, Conover, N.C.

Vanguard Furniture was in search of a solution to control rising health care costs, which had become the single biggest expense facing the company.

After repeated failed attempts to rein in costs, the Conover, N.C.-based company decided to partner with local primary care practices to develop and implement a health care plan consistent with the principles of a patient-centered medical home.

Teaming employees with primary care practices led to a shift in the culture of health at the company. Patients who had previously boasted about having not seen a doctor in years were receiving regular preventive care. Within two years, the partnership with primary care dramatically reduced gaps in care, established strong employee-physician relationships and significantly reduced the cost of care for Vanguard Furniture—cutting the annual growth rate for health care costs to one percent.

Rural Family Physician Reduces Hospital Admissions by 80 Percent—Granite Falls Family Medical Care Center, Granite Falls, N.C.

Five years ago, Edward Bujold, M.D., transformed his solo family medicine practice, Granite Falls Family Medical Care Center in Granite Falls, N.C., into a patient-centered medical home. This transformation allowed the practice to put quality front and center and focus on streamlining operations.

As a result, the practice was able to increase net revenue and expand the level of services offered. An expanded care team and improved technology allow the practice to serve more patients, provide higher-quality care and deliver better health outcomes.

The practice has seen a dramatic reduction in hospital admission rates among its patients—a stunning 80 percent during the five-year period—and contributed to the closing of a local hospital.

Dental Screening Program Improves Pediatric Oral Health—Into the Mouths of Babes, North Carolina Academy of Family Physicians

North Carolina ranks 47th nationally for dentist-to-population ratio and misdistribution of the existing dental workforce.

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This deficiency inspired the North Carolina Academy of Family Physicians to partner with physicians and pediatricians in piloting the “Into the Mouths of Babes” dental screening and varnish project, which provides oral preventive care with well-child visits.

The project reduced the dental treatment needs for toddlers at 18 months by 49 percent. Into the Mouths of Babes also enabled leaders to negotiate a statewide reimbursement from Medicaid for physicians providing dental care to Medicaid-insured infants and toddlers up to age three.

Primary Care Solutions Reducing Childhood Obesity in Colorado—Fit Family Challenge, Colo.

Childhood obesity continues to be a challenge in Colorado, specifically in rural and underserved populations. As a result, family physicians across the state developed the Fit Family Challenge (FFC) to integrate childhood obesity guidelines and implement a primary care office-based intervention into clinical settings across Colorado.

The FFC program encourages children ages 6-12 who have a body mass index in the 85th or higher percentile to participate in the program. The program helps with goal setting by utilizing the child’s primary physician, arranging monthly meetings with parents and family members, and collecting weekly goals and other data. FFC also provides training and support for practice providers on how to screen for childhood obesity and patient-centered counseling.

Since the program’s launch, family physician leaders of the FFC have developed a clinical guide, facilitator and family guides for group visits and used technology specifically designed to screen kids for lifestyle habits. Across Colorado, 14 primary care clinics have enrolled in the program and 150 children have engaged in the challenge. A grant has been submitted to further expand this initiative.
Building Partnerships Between Employers and Primary Care—The Colorado Business Group on Health, Denver, Colo.

The Colorado Business Group on Health (CBGH) is a not-for-profit organization that is changing the way employers buy health care, with a focus on education, networking and programs based on best practice in high-value health care and benefit design. Members understand that the interests of employers—both as individual organizations and as community members—align most naturally with primary care professionals in communities and several of CBGH’s programs are aimed at strengthening this alliance.

Since 2007, a number of employers have paid awards to physicians who attain diabetes or cardiac recognition in the Bridges to Excellence (BTE) program. In the past three years, coalition members have paid more than $160,000 to these physicians. Another program, in Colorado Springs, has employers working directly with the major primary care practices (PCPs) in their town in order to achieve two related goals: reduce the amount of dollars spent on potentially avoidable complications, and increase enrollee selection and use of primary care physicians. Recognizing that to achieve these goals, the employers, enrollees and physician practices all needed to change certain behaviors, these employers and the engaged physicians negotiated a model of “mutual accountabilities.”

Employers commit to implementing a value-based benefit design (two or three tier) with significant financial incentive to use PCPs. Additionally, they agree to financially support administration of the Prometheus model and share savings on total cost of care (TCOC) with physicians. Enrollees commit to actively participate in managing and improving their health by selecting a PCP and maintaining compliance with care plans. Physician practices agree to participate in either the BTE or Patient-Centered Medical Home program within the first year as well as providing accessible, evidenced-based primary care for participating enrollees. In addition, practices will report biometric data. The program is being phased in during a two-year period beginning with the 2016 plan year.
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Foreword

...**IMPROVING HEALTH EQUITY**

Primary care improves health care quality and patient outcomes while reducing health disparities and costs.

Family doctors want to build a health care system in America where everyone wins.

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**New Kind of Partnership Provides More Access and Better Care for Underserved Community—Country Doctor Community Health Clinic, Seattle**

Due to high demand for urgent care, Seattle-based Country Doctor Community Health Clinic (CDCHC) patients faced long wait times and physicians were unable to focus on providing full-scope primary care for patients.

Through a partnership with Swedish Medical Center, CDCHC created an after-hours clinic that provides urgent care to patients, regardless of insurance status or ability to pay.

The after-hours clinic improves community access to care, frees up time for CDCHC to focus on providing primary care and preventive services to its patients and lowers costs by reducing emergency room visits.

**Family Physician Makes House Calls in Chicago’s South Side to Address Health Disparities—Chicago**

Chicago’s South Side is home to some of the city’s most underserved and dangerous neighborhoods, where many residents lack access to basic primary care services. In addition, many young adults from these under-resourced neighborhoods struggle to complete advanced degrees.

Family physician Fred Richardson, M.D., returned to Chicago’s South Side after medical school to become a solo practitioner, serving the same neighborhoods he grew up in and he has been making house calls for seniors and the disabled in the South Side neighborhoods since 1990. He also mentors and teaches minority students who are struggling with medical school, many of whom have been on probation or dismissed.

Richardson’s work during the past two decades has improved access to care for underserved communities, as well as helped dozens of minority students stay in medical school to finish their studies.

**Medical School Reduces Health Disparities Through Targeted Approach to Quality and Affordable Education—Brody School of Medicine at Eastern Carolina University, Greenville, N.C.**

The mission of Greenville, N.C.-based Brody School of Medicine at Eastern Carolina University is to increase the supply of primary care physicians and educate minority and disadvantaged medical students so they can return home to provide high-quality health care in their communities.

Brody achieves these goals by working with students before they’re even admitted, making medical school more affordable and accessible, providing additional curriculum designed to support these goals and measuring results.

Due to its efforts, Brody has been named the national leader in family medicine and the greatest-value medical school in the nation.

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**Urban and Rural Communities that have an Adequate Supply of Primary Care Practitioners Experience Lower Infant Mortality, Higher Birth Weights, and Immunization Rates at or Above National Standards Despite Social Disparities.**

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Direct Pay Model Levels the Primary Care Playing Field—Apex, N.C.

Uninsured and underinsured patients often pay inflated or ‘rack’ rates for health care services. Family physician Brian Forrest, M.D., of Apex, N.C., decided to design a direct-pay model that has proven to be both financially viable for his practice and affordable for his patients. Forrest's direct-pay model—where patients pay a modest ‘membership’ fee—allowed him to improve patient access to care and avoid excessive patient volume while still remaining profitable.

Extending Michigan’s Primary Care Incentive Program—Healthy Michigan

Under Michigan’s expanded Medicaid program, Healthy Michigan, nearly 600,000 additional Michiganders now have health insurance. This is a significant change for primary care providers due to the large influx of new patients seeking care. In order to meet the increased demand for primary care services expected under Medicaid Expansion and mandated insurance coverage, the Affordable Care Act provides enhanced payments for eligible primary care providers who offer certain primary care services. The federal
funding for these enhanced payments expired in 2014, leaving Michigan to create its own program to help support services for patients who were insured under Medicaid.

In order to continue to offer enhanced Medicaid reimbursement rates, Michigan was one of only 14 states to approve continuation of the Medicaid primary care fee uplift, funded entirely with state dollars. While Michigan’s program does not have rates as high as the federal program does, it continues to provide higher rates than were authorized prior to 2013.

This reimbursement model and extension of enhanced Medicaid primary care rates enable family physicians to continue providing their patients with the services they need. As a result, these patients continue to have access to essential primary care services. Michigan’s uplift program allows for physicians who work specifically in family medicine, general internal medicine and pediatric medicine to be reimbursed at about 78 percent of Medicare rates for dates of service on and after Jan. 1, 2015, for the primary care services they provide.

Because the Student-Run Free Clinic is fully financed through fundraising efforts, all services are offered free of charge. This clinic demonstrates the value of primary care in providing efficient, effective and quality care. In fact, in 2014, the clinic provided all of its services for less than $15,000.

Improving Access to Primary Care for Michigan’s Working Uninsured—Wyandotte Clinic for the Working Uninsured, Wyandotte, Mich.

There are working adults in Michigan who are uninsured, which can lead to the inability to have access to primary and preventive medical care. As a result, the Wyandotte Clinic for the Working Uninsured was created as a free clinic to provide primary care services to Michigan’s working uninsured. The patients are low income but earnings exceed the levels to qualify for Medicaid.

The clinic features family medicine and other primary care physicians, nurses, behavioral health specialists and other support services run by volunteers. Working adults 18 and older who do not have health insurance can come to the Wyandotte Clinic for primary care doctor visits, pediatric services, nutrition counseling, disease management and woman’s exams. The clinic staff provides enrollment information about assistance for prescription medicine, insurance options and other health resources. The clinic is unique as an educational resource, hosting primary care residencies, rotations, preceptor training and shadowing opportunities.

The Wyandotte Clinic for the Working Uninsured illustrates how health professionals, educational institutions and community members can come together to help working members of their community gain access to the services they need and deserve through innovative primary care. The clinic, which opened in 2005, has provided more than 20,000 patient visits during the past 10 years.

Utilizing Primary Care to Improve Community Health—Robert R. Frank Student-Run Free Clinic, Detroit, Mich.

In Detroit, there are more than 100,000 uninsured residents. In order to extend access to primary care services to this underserved population, volunteer medical students from Wayne State University School of Medicine opened the Robert R. Frank Student-Run Free Clinic in 2010.

The Student-Run Free Clinic provides free, continuous primary care to uninsured community members in Detroit and is fully staffed by volunteer Wayne State University medical students, overseen by family physicians and run in collaboration with Mercy Primary Community Care Center. The partnership allows the clinic to deliver diagnostic laboratory testing, and pharmacy and preventive care services. In addition, a grant and partnership with the Kresge Eye Institute allows ophthalmology residents to provide comprehensive eye exams and follow-up care for patients.

Everyone wins. Where health is primary.
IN THE UNITED STATES, THE STATES WITH HIGHER RATIOS OF PRIMARY CARE PHYSICIANS TO POPULATION HAVE LOWER SMOKING RATES, LESS OBESITY AND HIGHER SEATBELT USE THAN STATES WITH LOWER RATIOS.¹

POOLED RESULTS FOR ALL-CAUSE MORTALITY SUGGEST THAT AN INCREASE OF ONE PRIMARY CARE PHYSICIAN PER 10,000 POPULATION WAS ASSOCIATED WITH AN AVERAGE MORTALITY REDUCTION OF 5.3 PERCENT, OR 49 PER 100,000 PER YEAR.¹

FROM 911 TO 411: PHYSICIAN PARTNERS WITH LOCAL FIRE DEPARTMENT TO PUT AN END TO CARDIOVASCULAR DISEASE—CHERRYVILLE, N.C.

Acute cardiovascular disease is the leading cause of death among firefighters, accounting for approximately 45 percent of firefighter deaths every year.

That’s why family physician Thomas White, M.D., of Cherryville, N.C., decided to partner with the local fire department to educate firefighters about cardiovascular disease risks and preventive care.

As a result, firefighters underwent an intensive evaluation with a focus on lifestyle and measures of biomarkers of cardiovascular risk, leading to individual and group educational sessions, an exercise program and a weight loss competition. Three out of four of the 20 participants lost weight in a ‘Biggest Loser Contest’ for a total of 35 pounds over six months, and the ‘Biggest Loser’ lost 20 pounds.

FAMILY MEDICINE AND THE CITY OF CHICAGO FIGHT TO CURB TOBACCO USE—HEALTHY CHICAGO

In 2011, the city of Chicago launched its ‘Healthy Chicago’ initiative. Carolyn Lopez, M.D., and the other eight members of the Chicago Board of Health were challenged with tackling the city’s public health agenda—including curbing adult and youth tobacco and e-cigarette use. At the time, the city’s smoking rate among high school students was above 13 percent—with 80 percent of adult smokers starting at age 18 or younger.

By focusing on innovative approaches and working alongside the family medicine community to counter tobacco industry opposition, the city was able to decrease the smoking rate among high school students by 20 percent in two years.

Today, smoking rates among adults and youth are at an all-time low, resulting in notable savings for the state—thanks, in large part, to efforts like those supported by the Chicago Board of Health, Lopez and the family medicine community.

STUDENT PARTNERSHIPS IN CHICAGO’S SOUTH SIDE IMPROVE COMMUNITY HEALTH—UNIVERSITY OF CHICAGO MEDICINE’S SUMMER SERVICE PARTNERSHIP

Youth on Chicago’s South Side face critical public health issues, including obesity, violence and sexual health. As director of the University of Chicago Medicine’s Summer Service Partnership (SSP), Kohar Jones, M.D. partners medical students on teams with local youth to promote community health and address health disparities.

University of Chicago students from the Pritzker School of Medicine, Social Services Administration and pre-health college students work with high school students from the South Side on a tiered mentoring summer service-learning program. SSP empowers youth to address the social determinants of health through a community health service project, through which they learn critical skills in teamwork and community engagement.

From addressing obesity through bilingual nutrition classes at a local middle school to creating a YouTube video where teens teach...
Diabetes Complications Reduced Through Prevention and Community Collaboration—Be Well-Lake County, Lake County, Ill.

NorthShore University HealthSystem and the Lake County Health Department/Community Health Center in Lake County, Ill., recognized that many of the complications that local diabetes patients suffered could have been prevented.

The organizations joined forces to create “Be Well-Lake County,” a comprehensive diabetes management program that provides more than 1,000 medically underserved patients with disease management, subspecialty care, assistance with medication and testing supplies, on-site Hemoglobin A1C testing, an exercise training component and a community garden.

As a result of the program, overall diabetes complications were reduced. More than half of the participants lost weight while others saw decreased Hemoglobin A1C levels.

Teaching Kids that Fitness is Fun—Fitness Renaissance, Clinton, N.C.

According to 2008 data from the North Carolina State Center for Health Statistics, the childhood obesity rate in Sampson County for children ages 10-17 was far above the state average (25.4 percent vs. 17.3 percent).

Family physician, Thomas Newton, M.D., of Clinton, N.C., created Fitness Renaissance, a program that develops personalized fitness goals for K-5 students and rewards them for meeting those goals.

The program has led to improved BMI measures, higher test scores and healthier self-esteem among students.

Fruit and Vegetable Prescription Program Improving Health—Health Rx, Mich.

Lacking access to fresh fruit and vegetables is a real problem that faces too many at-risk communities across the country. As a result, the CHASS (Community Health and Social Services) Southwest Center teamed up with the Ecology Center along with support from Eastern Market’s neighborhood farm stand program and the Fair Food Network to launch Health Rx.

Piloted with 48 patients on Detroit’s southwest side in 2013, Health Rx brought together health care agencies and community food providers to connect at-risk patients in Detroit with healthy, locally grown fresh food to help reduce diet-related medical problems including obesity, diabetes and hypertension. The participants received a “prescription” from their primary care physician that allowed each patient to purchase fresh, locally grown fruits and vegetables from a farmers market for $10 each week. Participants also received support for healthier eating, including nutrition counseling and healthy cooking demonstrations at the market.

The 2013 Health Rx pilot program led to 93 percent of participants better managing their health conditions. 94 percent eating more fruits and vegetables, 88 percent reporting that talking to a health provider at the clinic helped them to eat more fruits and vegetables and 100 percent of the participating care providers agreeing that the program could benefit many of their patients. Given the successful pilot, Health Rx has grown into an expanded program now called ‘Fresh Prescription.’
WHERE HEALTH IS PRIMARY.

AND THE TREES

SEE THE FOREST

AND THE TREES

MAKE HEALTH PRIMARY BECAUSE

It will help us all

LIVE LIFE WELL

WHERE HEALTH IS PRIMARY.
Innovation at Your Service

Where Health is Primary.

...Leveraging Technology

Technology is transforming our lives and has the potential to improve our health. Primary care practices are integrating technology in a way that strengthens their connection to patients and enhances the quality of care.

Chronic Care Clinic Uses Comprehensive Coordinated Team and Technology to Deliver Better Care and Outcomes—Carolina Advanced Health, Chapel Hill, N.C.

UNC Health Care and Blue Cross & Blue Shield of North Carolina partnered to create Carolina Advanced Health, a new joint-venture primary care clinic specializing in the treatment of adults with chronic medical conditions.

The clinic provides patients with on-site access to comprehensive primary care, including tele-health specialty consultations, nutritionists, pharmacy consultations and mental health support.

This combination of team and technology has streamlined the medical process and improved patient care, while reducing costs.

EHR Enable Better, Faster, Easier Coordinated Care—Raeford, N.C.

Administrative burdens significantly reduce the amount of time physicians spend providing care to patients. That’s why Karen Smith, M.D., a solo practice family medicine physician in Raeford, N.C., was an early adopter of electronic health records (EHR) that allow authorized users instant access to patient records.

Before implementing EHR, it took 30 minutes for Smith to transmit an EKG to a hospital ER for a patient with chest pain. That same EKG is now delivered in 30 seconds, allowing faster decision making and more-effective, higher-quality care for patients.

The system allows Smith to provide more efficient and personalized care to patients, reduces her administrative workload and enables patients to actively participate in their personal care.
GET MORE FACE TIME
WHERE HEALTH IS PRIMARY.
Family medicine is working across the country to ensure the future of the primary care workforce. This means working to increase the number of primary care graduates, while training them to work effectively in teams and in rural and underserved areas.

Team-Based Practice Environments Prepare Future Health Professionals, Improve Patient Health Outcomes—Loyola University Chicago

Loyola University Chicago is transforming the way it trains future health care professionals by integrating them into team-oriented practice environments to improve population outcomes, especially in underserved communities.

The Loyola I-CARE-PATH program, funded by the Health Resources and Services Administration, provides comprehensive care to patients while helping educate nursing, medical, dietary and social work students to work as a coordinated care team through the Interprofessional Education and Collaborative Practice model. For example, as a registered dietician at Loyola University Chicago’s Marcella Niehoff School of Nursing, Mary D’Anza helps care teams provide nutritional guidance to patients, many of whom have multiple conditions. Care teams that are part of Loyola’s I-CARE-PATH program have improved health outcomes, increased access to medications and services and improved patients’ lifestyle behaviors.

Teaching the Value of Primary Care and Serving the Underserved—Teaching Health Center Residency Program, Erie Family Health Center, Chicago

Nearly 50 million people lack access to primary care because of physician shortages in their communities, with shortages projected to reach 91,500 by 2020. To maintain the status quo, Illinois will require an additional 1,063 primary care physicians by 2030, a 12 percent increase over the state’s current (as of 2010) 8,832 practicing primary care providers. These shortages hit medically underserved areas the hardest.

That’s why Deborah Edberg, M.D., and her team at a Teaching Health Center (THC) residency program at the Erie Family Health Center in Chicago, have focused on training residents for caring for these underserved communities.

Funded by the Health Resources and Services Administration, THC residents spend most of their time providing comprehensive primary care to more than 7,000 patients in Humboldt Park—a low-income, predominately Hispanic community on Chicago’s West Side. THC-trained physicians are three times more likely to work in a community health center or other safety-net primary care settings after completing the program and nearly all of last year’s graduates have chosen to remain in safety-net primary care, addressing critical provider shortages in these communities.

Community-Based Residency Program Increases Access to Care for Underserved Populations—Central Washington Family Medicine Residency Program, Yakima, Wash.

Yakima County, Washington, is historically underserved in medical care, as primary care physicians are burdened with large patient populations, often across a number of rural areas.

The Central Washington Family Medicine Residency Program (CWFMR) in Yakima provides a community-based training approach, enabling residents to work in rural clinics and encouraging them to pursue family medicine careers in underserved areas.

CWFMR has resulted in many residents choosing to remain in Yakima, increasing access to primary care for these underserved populations.

Teaching Programs Prepare Future Primary Care Leaders to Implement New Care Models and Transform Primary Care—I3 Population Health Collaborative, N.C., S.C., Va.

The Affordable Care Act has endorsed patient-centered medical homes (PCMHs) as a beneficial new approach to health-care delivery, but transforming existing primary care practices into PCMHs can be challenging.

That's why 27 primary care academic teaching programs across North Carolina, South Carolina and Virginia came together to form the I3 Population Health Collaborative. The aim: Improve care and to develop new curricula and teaching strategies related to quality improvement, practice redesign, PCMH development and population health management.

The I3 population health collaborative focuses on preparing future primary care physicians and other health professionals to lead PCMHs and strive for improvement in clinical quality and patient experience. Their work has increased access, quality and cost effectiveness of care, and trained and deployed primary care residents in advanced care models.

Local Physicians Strengthen Community Practice through Launch of Statewide Network—Community Physicians of North Carolina

Small, independent practices provide approximately two-thirds of care received by North Carolina’s Medicaid recipients.

Community Physicians of North Carolina (CPNC) was developed to give these practices economies-of-scale and leverage. This network has enhanced the long-term viability of small practices across the state.

Through CPNC, family physicians can provide coordinated primary care across communities, build stronger relationships with their patients and increase access to affordable quality care.

Supporting the Next Generation of Family Doctors in Colorado—Commission on Family Medicine, Colo.

Colorado currently has nine family medicine residency programs in the state for medical students after they graduate. All programs offer residents the opportunity to learn about team-based care, how to work with an inter-professional and how to work in a patient-centered medical home among many other skills. The family medicine residency programs play an important role in training new family physicians as demand for the specialty continues to increase across the state.

The Commission on Family Medicine (COFM) is unique to Colorado as it oversees coordination and collaboration among the state’s independent residency programs. The commission recruits medical students and faculty physicians to come to Colorado, coordinates required rural rotations for all students and advocates for the reform of Medicare and expansion of primary care training positions.

The commission has a 38-year success record. Despite the national trend of fewer medical students choosing primary care, COFM has successfully recruited high-quality medical students to Colorado. In 2014, the family medicine residencies conducted 868 interviews with 456 students from 113 medical schools across the country to fill only 68 spots. As a result of COFM’s efforts, 64 percent of graduating residents stayed in Colorado and 40 percent of those who stayed chose to practice in rural or underserved communities.

Patient-Centered Medical Home (PCMH) Curriculum Significantly Improves Residents’ PCMH Competence—University of Colorado Department of Family Medicine, Aurora, Colo.

Through a grant from The Colorado Health Foundation, the Aurora, Colo.-based University of Colorado Department of Family Medicine implemented a PCMH project with all family medicine (and one internal medicine) residency programs in the state. The Department of Family Medicine also developed an innovative PCMH e-Learning Module curriculum that is being used by Colorado residency programs and the American Board of Family Medicine.

Results from pre-and-post surveys and qualitative interviews showed active efforts by all Colorado residency programs to implement key PCMH components, and significant improvement for residents from baseline to follow-up for PCMH competency.

In addition, The Department of Family Medicine co-founded the “Collaborative of the Collaboratives,” a group that convenes all of the residency training programs working on PCMH activities.

Building the Primary Care Workforce in Rural Communities—Rocky Vista University College of Osteopathic Medicine, Parker, Colo.

Rocky Vista University (RVU) College of Osteopathic Medicine, Parker, Colo., was established in 2006 to help Colorado and other Mountain West states ease the shortage of
well-trained rural physicians. To that goal, RVU established a Rural and Wilderness Medicine Honors Track, a Global Medicine Track and a Military Medicine track. These tracks select the top 25 percent of the class academically to participate in extra skills training designed to deliver quality care with limited resources.

The Rural and Wilderness training focuses on extra procedural training in surgery, obstetrics, public health, dentistry for physicians, as well as wilderness survival training. Students interact with rural EMS services, ranchers, energy companies, critical access hospitals and rural health care providers to learn in real-time what rural life entails.

Since graduation of the inaugural class in 2012, one half of the program’s graduates have chosen to go into a field of primary care and one third of those graduating classes of 150 have chosen family medicine.

Revitalizing the Family Medicine Workforce Pipeline—Western Michigan University Homer Stryker M.D. School of Medicine, Kalamazoo, Mich.

When seeking new faculty members and family physicians to staff local community health centers, the department of family medicine at Western Michigan University Homer Stryker M.D. School of Medicine faced the national shortage of family medicine faculty and a limited local hiring pool. The department’s old faculty recruiting paradigm of hiring community physicians with at least two years of experience left a small number of community doctors who were unprepared for the scholarly activity required to be a faculty member. The Family Health Center (FHC) of Kalamazoo, the department’s local federally qualified health center, was also using a recruiting strategy of hiring search firms to identify locum tenens doctors, which was expensive and resulted in temporary employees facing a steep learning curve.

To address these issues, the department refocused its recruitment strategy to begin by encouraging family medicine residents to practice at the FHC and then hiring recent graduates from within the department, whose scope of practice actually often exceeds that of community doctors with more experience and who have had three years of residency to prove themselves. It recruited students for residency by targeting applicants who had expressed a desire to work with an underserved population, and all eight of its open positions for the family medicine class of 2016 were filled in the match.

By recruiting recent graduates from within, the department was able to fill a vacant faculty position and the FHC was able to fill two vacant staff positions. The department has also improved resident satisfaction and reduced costs associated with the hiring process.

Fostering the Primary Care Workforce through Student Loan Repayment—Michigan State Loan Repayment Plan

The burden of student loans debt facing medical students is a major challenge, which poses serious risk to primary care as students are opting for higher-paying specialties. In an effort to combat this threat, the Michigan Department of Community Health developed the Michigan State Loan Repayment Plan.

The Michigan State Loan Repayment Plan assists employers in the recruitment and retention of medical, dental and mental health care providers who demonstrate a commitment to building long-term primary care practices in underserved communities by providing up to $200,000 in tax-free funds to repay their educational debt for up to eight years.

The loan repayment program has not only provided financial relief to many in the primary specialty, but has also increased the likelihood that participants remain in underserved communities where there is a great health care need beyond their service obligation.
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