PROMISING PRACTICES

Washington Association for Community Health

FAMILY HEALTH CENTERS
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The Association Promising Practice reports aim to support Community Health Centers in leading and developing disruption and innovation by identifying successful innovations and communicating promising practices to the statewide network

FAMILY HEALTH CENTERS SHARES PROMISING PRACTICE: LEVERAGING TEAM-BASED CARE TO IMPROVE POPULATION HEALTH

Family Health Centers (FHC) has implemented a new model of care, prioritizing the integration of population-specific services through team-based care quality improvement (QI) efforts. Their work's goal is the long-term sustainability of important services in their community, and seamless patient access to comprehensive care. After working with their Accountable Community of Health (Thriving Together North Central Washington), FHC applied their experience in learning cohorts to develop their new care model emphasizing team-based care and population health. Several populations of focus were already being served under grant-funded special programs, such as the Opioid Treatment Network (OTN) and Title X Family Planning. Major developments in FHC's improved care model included the broad use of Community Health Workers (CHWs), cross-training staff to fill new roles on the care team, and redefining and tracking visit types.

INTEGRATING COMMUNITY HEALTH WORKERS

CHWs are an essential part of this work, and their integration was one of the first changes to the FHC clinical team. The role of CHWs has continued to evolve in the organization to best support care teams in providing comprehensive, coordinated services. The COVID-19 pandemic and associated changes in the healthcare system allowed FHC to deploy CHWs into many different settings - participating in vaccine events and education in the field, and emphasizing Health Related Social Needs (HRSN) work in the clinic. CHWs were incorporated into special programs – for example, as peer recovery coaches supporting the Opioid Treatment Network.

FHC found that the CHW role became an excellent tool for community-based workforce recruitment into the healthcare field. Chief Quality and Compliance Officer Brendan Smith noted, "Our CHW program started with public outreach and then evolved by bringing CHWs into the clinic setting. A lot of the CHWs who moved into other positions at the organization expressed that the CHW role was a more accessible entry into healthcare. They didn't feel like many local jobs provided the credentials to enter directly into patient care support roles. In our rural area we brought quality to patient care with CHWs and created economic opportunity and advancement to our rural community. The CHW program is helping recruit local talent and "grow our own" in a way that really improves the overall health of the community."

STAFFING FOR SUSTAINABILITY

FHC's team-based care model includes recovery coaches, case managers, behavioral health professionals, and community health workers being able to engage in care with a patient. They've added remote RN case managers for follow-up transitions of care. The existing role of patient navigator acted as a referral specialist, so FHC began broadening their scope to include assessing and addressing HSRN. Clinical Champions were identified for each grant-funded initiative, coordinating across the organization for each patient involved. FHC identified this practice as an essential factor in successfully integrating population-focused programs into team-based primary care.



QI efforts track alongside team-based care, watching for areas of improvement and running PDSAs on the systems supporting the different subgroups of patients being served. The palliative care program is an example of how a clinical champion embraced team-based care QI grant initiatives around population-based services. Our QI program works to go from grants to promote sustainability and integration into core FHC services. FHC received a grant to provide palliative care to its patient population, filling a growing need in their rural community. FHC could pay for a nurse and forgo reimbursement for visits while the grant was active, but their focus was on the sustainability of this program long-term. As the grant closed, the QI team assessed how this service fits into our team-based care model and the overlap with care management, telehealth, and even the Making Care Primary initiative to ensure the high quality care is maintained as grant funds end.

Innovations in Visit Types

To demonstrate the success of their team-based care model, FHC improved the way they tracked visits. This effort involved building out infrastructure in their EHR to track different visit types and monitor the use of those types over time. FHC now tracks team-based care co-visits, RN flip visits, and normal primary care visits, essentially creating registries to track patient engagement and outcomes. This allows the quality improvement team to look at meaningful metrics like utilization of team-based care co-visits, completed referrals into health education, or improvements in population-specific quality measures. For instance, tracking patients with diabetes who engage in the team-based care model and receive health education allows FHC to compare their trajectory of preventative measures compared to patients that don't utilize the full support of team based care.

RN flip visits are acute, urgent access visits in which an RN can “flip” or triage the visit to a provider as needed. Flip visits have increased in number since FHC began tracking, and they have played an important role in patient access and provider productivity amid workforce shortages. Flip visits also allow providers to work at the top of their license, soothing burnout as work becomes more satisfying.

Team-based care co-visits are prospective visits in which a patient is seen for follow up, seeing both a provider and a health educator simultaneously. In the co-visit model, the health educator and provider work together within the same visit, with the health educator being employed as an intervention. Co-visits are more convenient for the patient due to increased coordination, and easier for the provider since they have the support of a health educator.

Lessons Learned, Looking Forward

The return on investment of this work is not in any billing code, but in increased patient engagement (providing revenue in increased meaningful encounters) and improved health outcomes (providing revenue within value-based contracts). An important perspective shift came when FHC began thinking in terms of “team-based encounters”, rather than trying to make the case for sustaining a program solely with CHWs billing for assessment or education. Patients that work with health educators are more engaged in care, coming in more often over the course of a year. The quality measures have shown that these increases in primary care visits provide value. FHC’s team-based care model has been used for over 300 patients with hypertension who participate in the self-monitored blood pressure program, using co-visits to receive coaching and follow up – and blood pressure measures are better than they’ve ever been.

By tracking engagement in the team-based care model and monitoring health outcomes based on specific population health measures, FHC makes the case that the whole team's worth should not be hindered by siloing into existing reimbursement structures. Increasing patient access and participation in primary care saves money downstream, though the financial value of this preventative work is within the healthcare system and communities as a whole - not just within the primary care center.

Director of Programs, Tawn Thompson, shares her future vision for this work, “When you come to Family Health Centers, there is no wrong door for whatever your needs are. We will connect you to the right spot and will do the right thing for you regardless of our reimbursement rate. Your needs will be met regardless of social or healthcare need.”

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