PROMISING PRACTICES

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 with their goal being long-term sustainability of important services in their community, and seamless patient access to comprehensive care. 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

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 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.

INNOVATIONS IN VISIT TYPE

To demonstrate the success of their team-based care model, FHC improved the way they tracked visit and now tracks team-based care co-visits, RN flip visits, and normal primary care visits, tracking patient engagement and outcomes. This allows the QI team to look at meaningful metrics.

- RN flip visits are acute, urgent access visits in which an RN can "flip" or triage the visit to a provider as needed
- 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.

LESSONS LEARNED, LOOKING FORWARD

- Return on investment of this work is not in any billing code, but in increased patient engagement and improved health outcomes
- Patients that work with health educators are more engaged in care, coming in more often over the course of a year.
- 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.



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
Read the full report at wacommunityhealth.org/promising practices

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