ABOUT OTHER FORMS OF TEAM-BASED CARE

SOUTH DAKOTA CARDIOVASCULAR COLLABORATIVE

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Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are nonprofit community-based organizations that deliver primary care services and preventive care to medically underserved areas or populations, regardless of age, ability to pay, or health insurance status. FQHCs qualify for specific reimbursement systems under Medicare and Medicaid and include federally designated Health Center Program awardees, and certain outpatient clinics associated with tribal organizations.[23]

"FQHCs can be Community/Migrant Health Centers (C/MHC), Community Health Centers (CHC), and 330-Funded Clinics."

FQHCs receive funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide services in underserved areas. FQHCs must meet stringent requirements, including providing care on a slide fee scale based on ability to pay and operating under a governing board that includes patients:[24]

In order to be a qualified entity in the Federal Health Center Program, an organization must:[25]

- Offer services to all, regardless of the person's ability to pay
- Establish a sliding fee discount program
- Be a nonprofit or public organization
- Be community-based, with the majority of its governing board of directors composed of patients
- Serve a medically underserved area or population
- Provide comprehensive primary care services
- Have an ongoing quality assurance program.

Cooperative Health Care Clinics

The Cooperative Health Care Clinic (CHCC) model is an outpatient group visit model where health care is provided to patients in a group setting. The CHCC model was developed under a research grant by Kaiser Permanente in 1991 as an alternative to the conventional one-on-one doctor-patient interactions. The CHCC model can be applied across the spectrum of medical care and has been used for well-baby groups, disease management programs, and special groups for patients with diabetes, congestive heart failure, and fibromyalgia.[24]

"CHCC appointments typically consist of a two-hour session attended by seven to ten patients and the physician."

Compared with the conventional model, the Cooperative Health Care Clinic model has shown improvement in patient and provider satisfaction, as well as improved quality of care and cost effectiveness.[25] CHCC are being replicated in other sites under a research grant from the Robert Wood Johnson Foundation.

Benefits of the CHCC model.[27]

- Patients are afforded the opportunity for extended contact with the physician.
- The physician can efficiently provide more detailed information to more patients than is feasible in a brief one-to-one visit.
- Patients have the opportunity to socialize with, and learn from, other participants in the group.

Warm Handoffs

A warm handoff is a way for one member of a health care team to transfer a patient to another member of the health care team.

"That transfer happens in-person, in front of the patient, and includes the patient as a team member so that he or she can hear what is being discussed about the clinical problem, current status, and plan of care."

Typically, one member of the health care team introduces another team member to the patient, explaining why the other team member can better address a specific issue with the patient and emphasizing the other team member's competence:[28] A warm handoff can be used between any two members of a health care team such as clinicians, medical assistants, behavioral health providers, front and back office staff, and members of the extended care team such as including a pharmacist, diabetic nurse educator, and social worker. A warm handoff engages the patient in the communication between members of the health care team, which can add an extra layer of protection against communication breakdowns that can result in medical errors. Successful warm handoffs require open communication and teamwork[28] and help to strengthen the relationship between patient and provider.