CCHN 2021 Value Based Care Podcast Series
Transcript for Episode 3: The Future of CHC Workforce in Value-Based Care

Shannon Connell [00:00:00] Hello, and welcome to the Colorado Community Health Network value-based care Podcast, this short podcast series is hosted by the Colorado Community Health Network, or CCHN. CCHN is the collective voice for Colorado's 20 Community Health Centers, or CHCs, and the patients they serve. Colorado's CHCs provide a health care home to more than 847,000 of their community members, one in seven people in Colorado, from 63 of the state's 64 counties. This is a three-part podcast series meant to provide short, digestible introductions on how to work at Colorado's CHCs is changing in response to new models of care and payment in Medicaid. Each episode could be accessed at any time through CCHN's website. This series is not a comprehensive guide of what it means to operate under a value-based care framework. Instead, it provides an introduction to the topic of value-based care and investigates how the workforce at Community Health Centers will be impacted by this model. I'm Shannon Connell, and in this episode, we're going to be exploring more about the value-based care framework with those who know it best. I spoke with Dr. Tilman Farley, the Executive Vice President for Medical Services for Salud Family Health Centers. Dr. Farley and I discussed how value-based care is and will impact the roles and duties of clinical staff. As well, Dr. Farley shares his thoughts on the skills and expertise that will be more important to prioritize in the future because of value-based care initiatives.

Tilman Farley [00:01:40] My name is Tilman Farley, I'm a family physician by training, I'm the Chief Medical Officer at Salud Family Health Centers and I've been in that position since 1996, so just about to finish my twenty fifth year.

Shannon Connell [00:01:54] Wonderful. And what brought you to Salud and working with Community Health Centers in general?

Tilman Farley [00:02:00] To go all the way back, my mom was a family physician and she always well she spent a lot of my childhood working in a Community Health Center. I kind of grew up thinking of Community Health Centers as very positive things. Before I came to Colorado, in this position, I was in far west Texas where I opened a couple of Rural Health Clinics, sort of FQHC lookalikes. When I was ready to leave Texas, I was debating between an academic position at the University of Texas or this Chief Medical Officer job at Salud and drank enough of that Health Center Kool-Aid when I was a kid that that the Health Center won out.

Shannon Connell [00:02:43] So, now kind of getting into value-based care and your role in value-based care at Salud, when you started working with CCHN on value-based care, you shared with us that an interest in value-based care models was because you had hoped for an impact in the CHC the workforce staff. How do you think value-based care will impact the CHC workforce and staff as the CMO?

Tilman Farley [00:03:07] It's harder and harder to recruit for primary care, physicians particularly. So, we need to do, you know, everything we can to compete for what seems like an ever shrinking pool of applicants, to compete with the private sector for that shrinking pool. Value-based care, I think is, I hope is, the future. I would say that pretty much anyone who went into medicine for something other than just trying to maximize their income, has complained forever about the widget based model. Right, where you just get paid on a productivity basis and really value doesn't come into it at all. Everyone has complained about that forever. So, I think to the extent that health centers can develop, or

the extent that any entity can develop, a health care delivery model, that just makes a lot more sense and is geared towards good health outcomes and doing whatever needs to be done to provide that health outcome. Whether it's a face to face visit or some other thing, that innovative delivery system is going to, I think, going to compete well against the widget based system for the shrinking pool of applicants.

Shannon Connell [00:04:27] And at the start of value-based care with Salud, were there particular types of staff or certain roles that you thought would be most impacted by this work?

Tilman Farley [00:04:37] The folks that for whom we previously could not bill for services, so, you know, in the widget based model, there's a very limited number of licensed types that can bill for services. But, in a value-based care model where things are not where not everything is based on a face to face visit with one of those five provider types, then you can you can look at clinical pharmacists, and RNs, and transitions to care people, and all sorts of other stripes of folks that can contribute significantly to the overall health outcome of a patient. But historically have not been provided, have not been able to provide billable services.

Shannon Connell [00:05:21] So now that you actually have been doing the APM 2 model, have you seen those roles be impacted?

Tilman Farley [00:05:29] Yeah, we have clinical pharmacists on staff that we use pretty extensively, but we have not gone to an RN model at this point, but we have we use our behavioral health providers extensively. We have a lot of care managers. We now even have medical legal partnership. So, there's you know, there are lawyers involved in care for patients that have legal issues that are negatively impacting their health around income and benefits, housing, education, legal status, or family stability. So, yeah, we've definitely taken advantage where we can of those other types of providers.

Shannon Connell [00:06:13] As Salud has engaged in payment reform activities, have there been new staff roles or duties identified that you have already started to hire for that you'll aim to hire for in the future? You kind of started talking about that.

Tilman Farley [00:06:27] We have put a tremendous amount of time into developing this new care model. You know, at this point, we're not we're not fully in that model. You know, my understanding, if we're talking about the state, the model we've been working on for the last, I don't know, four years or so, that has not been fully approved yet. So, we have not expanded those roles. We have them identified, but the idea would be that by shifting workload off of my schedule, on to, let's say, a clinical pharmacist to handle chronic disease management of patients with diabetes or hypertension via clinical protocols, which they're able to do, and that open space up on my schedule for additional new patients. So that one physician in the new model, one physician overseeing a team of care providers, can manage many more patients, then I would be able to do by myself in the old model. So, yeah, you know, clinical pharmacists take a big load off of my plate.

Shannon Connell [00:07:34] Do you feel that there are any other new roles or duties that will be brought on if the state does fully push out the value-based care model?

Tilman Farley [00:07:42] Yeah, you know, one of the most important ones I see is the transition of care program that I mentioned a minute ago. The way Salud did that in the past was through an AmeriCorps program and the AmeriCorps program went away. But it

was a tremendously successful program. We basically hired college graduates so, you know, smart, passionate people and trained them to round with the discharge planning teams on our patients and patients who were hospitalized and risk stratify those patients as to risk of readmission and the ones who stratified as high risk and the transitions of care folks would round on those patients at home after they got discharged and they would do an environmental safety assessment, and go through their medications and make sure they were taking them right, make sure they understood their discharge plan, make sure they were reconnected to a clinic for a post hospitalization, a follow up visit. And that program cut our rehospitalization rates in half. It was a very successful program at a very low cost. So, yeah, that I think that's a critically important program for us to rebuild. The way I think of this is that that we're constrained in a number of ways. One of the ways we're constrained has been by those five provider types right, physician, PA, nurse practitioner, dentist or dental hygienist, the five types that we can bill for as we've been at now, we've been able to add behavioral health provider into that's another six providers that we can bill for. But that's still a constraint. There's a lot of providers we cannot bill a lot of provider stripes that we can't build for. The other big constraint is that we all build these bricks and mortar clinics and then we sit inside them, and we feel like we can't go outside those walls. And that also is a constraint. A lot of patients can be served in better ways at various times by not having to come into the clinic. A robust telehealth system addresses some of that, but there's also many other ways for the transitions of care is a good example. But there's other ways that we can get out to take our care outside of the clinic walls and try to do a better job of getting care to people where they're at. But it depends on the additional flexibility that the PM model affords us.

Shannon Connell [00:10:03] Are there any other departments that you think value-based care will impact in terms of new staff or new duties for staff?

Tilman Farley [00:10:10] Yeah, I would say data analytics. You know, the more information we can get on our patients who have either dropped out of care or who are getting their care in other places, the more we can understand about total cost of care, the more we can understand how non, things that have been traditionally considered non health related, like, oh, I don't know, child care, for example, how those things impact people's health. The more we can get data on that, the more we can tailor our interventions to actually affect cost, but more importantly, affecting costs in such a way that that health outcomes are improved. You know, we have a lot of silos in data analytics right now that we need to remove. So, for example, let's say we have a really robust team-based care model where we could employ clinical pharmacists and behavioral health providers working together on patients with severe and persistent mental illness. You know, maybe one indicator of the success of that program is how many days that those patients miss at work, you know, so not just E.R. utilization or medication costs or hospitalizations, but cast that evaluation net a little wider to look at other things that are expensive and impacts society again, such as lost days of work or evictions from housing or whatever it might be. So, yeah, I would think data analytics would be an important department in the hopefully where we get to in this new delivery model.

Shannon Connell [00:11:55] In thinking about the future of Salud and payment reform, are there any types of skills or expertise do you think you'll be prioritizing when recruiting new staff

Tilman Farley [00:12:07] If this thing were funded the way the I think it should be funded in a way that I hope it is eventually funded. Yeah, we would start recruiting for you know, we would probably we would probably have enough physicians. So since physicians are

very hard to recruit, if, you know, if right now a physician has a panel of 1500 patients, but in the new world, a physician can have a panel of 5000 patients because a big part of what the physician does is oversee the other members of the team, then we won't be recruiting for as many physicians will be recruiting more for clinical pharmacist transitions of care workers, community health outreach workers, patient educators, folks like that. So that that frees my schedule up to continue to take new patients so I can expand my, you know, the panel that I take care of with the help of those team members pretty substantially and that fits with the workforce, right? If we have fewer primary care providers available than we have to figure out how to do the same work, hopefully better work, with fewer primary care providers.

Shannon Connell [00:13:22] How do you think that value-based care initiatives will support Salud's diversity, equity and inclusion efforts for recruitment and retention of staff?

Tilman Farley [00:13:32] Well, in terms of diversity, equity and inclusion, I think if you if you can open your workforce up to a wider variety of types of service provider, you'll have access to a larger population or a larger pool of applicants. And hopefully a larger pool of applicants would include a greater diversity, greater diversity. You know, for example, we could train community members in our low-income communities to do that transition to care work, so we'd be hiring people from the community and hopefully, hopefully reflecting the diversity of that community. So, I think that's how it would help a more diverse workforce. And I very strongly believe that everybody at every level, everywhere benefits from a more diverse workforce, even if the population we serve isn't diverse. I think diversity at every level is good for everybody. In terms of recruitment and retention, well recruitment is easier because we can recruit for provider stripes that are perhaps less scarce. I know in Colorado, I know I keep talking about clinical pharmacists, but they are particularly valuable in this new model. But pharmacists are easier to hire right now than physicians. So, transitions of care, a job description gives college graduates an opportunity to try out the medical field and see if it's something they actually want to go into or pursue with a deeper level or whatever. So, it makes recruitment easier because you have more diversity of positions that you can recruit for. And as far as retention goes, I think burnout is a multifactorial problem, but part of it, I think, is not being able to work at the top of your training. And when, you know, when physicians have to spend a lot of time doing things for which we're not trained, such as a social work function or a care management function, I think that detracts from overall job satisfaction. So, to the extent that we can get do a better job of getting the right patient to the right person at the right time and in the right modality, I think that will improve job satisfaction across the board and hopefully that improves retention. And then if we if we could ever get into a cost gain sharing agreement, where we get if we save the system money, we get to share in some of those savings, then that will allow us to perhaps get our wages up closer towards the median so we can be a little more competitive across, again, across a wide variety of provider types.

Shannon Connell [00:16:22] Are there any capabilities of software, knowledge, equipment that you would want to share with any other CHCs when they start payment reform efforts?

Tilman Farley [00:16:33] I think, again, this gets back to the bricks and mortar thing and the telehealth thing. The more we can create value in a visit that does not require the patient to come to the clinic, in other words, the more we the more systems we can develop, they get me the information I need to adequately take care of a patient, and even if he or she maybe isn't available at the time that I'm trying to take care of them. So, in other words, asynchronous forms of health care, the more we can develop those systems,

the better, the better the overall system is going to be. So, you know, for example, right now, if I need to adjust a patient's diabetes meds, let's say I can call them on the phone and find out what their blood sugar has been doing over the last few days and make adjustments on that. But, it would even be better information if I had a continuous glucose monitor readout so I could see exactly what that patient's blood sugar has been doing continuously over the past couple of weeks, that I can make much more informed decisions and with access to that than the patient doesn't need to come in and get her blood drawn. Same thing with blood pressure. If I ever have a home blood pressure monitor that gives me blood pressure and averages over the previous two weeks. And the patient doesn't need to come in for blood pressure, you know, scales that one can weigh him or herself on and I get that reading directly into my electronic health record. Without a doubt, there are innumerable people in their basements right now working on ways to make you know, you make your cell phone into a really powerful tool for telehealth visit. You know, your cell phone could be a stethoscope, so I can listen to your heart across, you know, across any distance through that kind of application. So, we know about some of those apps, others just being developed. Now, part of the trick going forward is going to be sort of separating the wheat from the chaff and figure out which of those products that are under development actually have potential.

Shannon Connell [00:18:40] Are there any areas related to payment reform and value-based care that you're starting to incorporate into your teaching and precepting?

Tilman Farley [00:18:49] Well, yeah, we have you know, we have a large team-based model at Salud. So, we try to make sure our students understand the role of everybody on the team. We even try to have them spend some of their time working with those other providers so they might spend time with a clinical pharmacist they might spend time with the care manager or a behavioral health provider to really get an understanding of how everyone on the team works. We're not doing it right now, but in the past, we have sent students out on home visits with our Transitions to Care Team to try to get an understanding of how that process works. And that was very well received. Lots of opportunities for this, you know, getting students involved in telehealth visits that was particularly amenable to teaching because you can just do a three-way call, bring the student and the preceptor and the patient all together, you know, in one telehealth feed. So, yeah, we are working on that. We have a long ways to go still, but we consider that we're still developing this model we'll teach it at the level that the model has evolved to as it evolves.

Shannon Connell [00:19:56] How are you working with future leaders to ensure that they are prepared for the future of health care under patient reform?

Tilman Farley [00:20:03] Mostly in that way, you know, working with students, getting them to understand the new model, it's all about change management. So, we're also spending a lot of time working with our own providers, the widget based system, although it was inefficient and led to poor health outcomes, it was still what we were used to. That rubber band is always wanting to snap back. So, we do have to work with our own providers to make sure they understand the new model that we're moving towards and why we want to do that. At Salud, we tend to form close relationships with other innovative and progressive health centers so we can learn from each other around a lot of these issues. So, I'm always kind of gratified when I hear folks from those health centers talk about these exact same things that I'm talking about. So, you know, I think the ideas are clearly spreading. You know, it's a good idea when it when it comes up independently in many different places. And I think that's what we're seeing here.

Shannon Connell [00:21:08] Thank you all for listening and thank you to our speaker for sharing. Don't forget to listen to all the CCHN value-based care podcast episodes. Take a moment to check out further resources on this topic found on CCHN's website and leave us a review by filling up the evaluation form on this series in our email communications. Questions about this podcast can be sent to Shannon Connell at sconnell@cchn.org. Have a great day and thank you for your time.