



NATIONAL ASSOCIATION OF  
Community Health Centers®

# Leading Change: Transforming At-Home Care

## Case Studies



## Introduction

The four Case Studies outlined in this document are based on interviews conducted in August 2021 with a sample of health centers participating in the *Leading Change: Transforming At-Home Care* pilot project.

Interviews were conducted at the end of NACHC's 10 month pilot initiative, just as new waves of the COVID-19 pandemic were peaking for many of the communities served by participating health centers. Health center staff were feeling the heavy stress, exhaustion, and intensity of providing care to their high-need patients amid a global pandemic. Despite being pushed to their limits, health centers utilized the *Leading Change* initiative to enhance their systems and workflows for virtual care, and ultimately provide higher-quality virtual care to patients at a crucial moment. Additionally, many health center staff reported positive experiences in applying this new model of care to high-risk patients.



## Project Goals

The *Leading Change: Transforming At-Home Care* pilot project was designed to:

- **Test the impact of self-care tools** (called a 'Patient Care Kit') offered to patients in connection with care team support, monitoring, and follow-up in a virtual care setting.
- **Develop workflows and protocols for virtual care management and monitoring** offered by health centers.
- **Document best practices for Patient Care Kits in the virtual setting**, as well as implementation experiences to benefit health centers nationally.

The project was built on the foundation of NACHC's Value Transformation Framework (VTF), offered as part of the national Elevate learning forum, to guide health center systems change with the aim to achieve better health outcomes, better patient and staff experiences, lower costs, and improved equity.

### Value Transformation Framework



HEALTH CENTER		
INFRASTRUCTURE	CARE DELIVERY	PEOPLE
IMPROVEMENT STRATEGY	POPULATION HEALTH MANAGEMENT	PATIENTS
HEALTH INFORMATION TECHNOLOGY	PATIENT-CENTERED MEDICAL HOME	CARE TEAMS
POLICY	EVIDENCE-BASED CARE	LEADERSHIP
PAYMENT	CARE COORDINATION AND CARE MANAGEMENT	WORKFORCE
COST	SOCIAL DETERMINANTS OF HEALTH	PARTNERSHIPS

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*The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, the CDC, HRSA, or the U.S. Government.*



Case Study #1:  
Accordia  
Health

**Rallied a team approach and connected patients to phones or WiFi for virtual care**

[Accordia Health](#) provides adult, pediatric, and behavioral health care in the southern Gulf Coast counties of Mobile and Coosa, Alabama. They partner closely with AltaPointe Health for mental and behavioral health services. Nearly 52% of Mobile’s population is Black/African American, with 92% of Accordia’s patients living at or below 200% of the Federal poverty level. They also care for many Lao and other immigrant patients.

**What worked well?**

Accordia’s Health Center Director led implementation of the *Leading Change* initiative with the Director of Quality Assurance. They engaged a number of staff in pilot efforts.

“ *Gaining insight from a group including clinical staff, quality staff, providers, nurses, and social workers, made it a lot easier for everyone to meet these patients where they were, and to see the big picture.* ”

NACHC’s [Risk Stratification Action Guide](#) was used to select patients for the program. Most were older adults and didn’t have phones or access to cell phone data. Accordia staff helped patients fill out paperwork to get federal support for cell phone access or found other ways to help patients access technology needed to participate in virtual care.

The Care Manager and Social Worker played a critical role in maintaining weekly contact and providing support and encouragement. Motivational interviewing helped staff address patient challenges and break down barriers.

**What unique solutions were introduced?**

- Patient group training reinforced how to use at-home monitoring equipment.
- Accordia staff added a brochure about USDA’s My Plate to help diabetic patients learn about better eating and reach nutrition goals.
- As an incentive, participants were entered into a lottery to win a \$50 Visa gift card each time they participated in weekly virtual visits.
- Regular conversations helped encourage patients, cheer them on, and support their efforts.
- Patient education materials were translated into Lao and other appropriate languages.
- The Kit’s home A1c strips were hard for patients to use on their own, so patients were invited to come to the clinic to complete the test with a nurse.

**What was the impact for Accordia Health patients?**

“ *We had several patients really turn their health around. They also enjoyed the check-ins by staff.* ”

- 18 of 20 patients in the pilot self-reported lower stress levels and an increased perception of how to achieve better health after participating in this program.
- Several patients saw a decrease in weight and A1c levels.
- Individual patients learned how to manage their diabetes better, access additional services after a positive colorectal screening test, or just felt better through participation in this at-home care program.



**Case Study #2:  
Shawnee  
Health Services**

**Delivered Kits to patients' homes for person-centered, effective training**

[Shawnee Health Services](#) delivers care in rural areas of southern and southwestern Illinois. Though 90% of the residents nearby are white, 24% of Shawnee's patients belong to ethnic or racial minoritized groups. Shawnee provides a full range of family medicine, pediatrics, dental, behavioral health, addiction counseling, and specialty care. Nearly 67% of Shawnee's patients live below 200% of poverty, and/or work in the nearby coal mines. Many can't afford home monitoring equipment and lack access to transportation and WiFi/smart phones.

**What worked well?**

Shawnee's Chronic Care Manager (CCM) initiated the pilot with the Clinical Nursing Supervisor. The CCM facilitated patient's engagement, including helping patients use Zoom and collecting data from self-monitoring logs. She knew how to reach patients and adjusted her schedule to connect at a time convenient for them. She monitored each patient's clinical and quality measures, and provided health coaching—even in person at patients' homes—to keep patients connected.

Patients participating in this program were offered flexible schedules and visit types. When video visits weren't possible, phone calls or in-person home visits were used.

**“ We've learned that patients open up more over the phone than face to face. People fear health clinics, so telephone conversations are easier. ”**

**What unique solutions were introduced?**

- The Care Manager personally delivered Patient Care Kits to the participating patients' homes. There, she could train each patient to use each tool and help with monitoring.
- Telephone calls were often more useful than virtual video visits.
- Texting was used to remind patients of appointments and was also a great way to reinforce care management activities at no cost to patients.
- Positive reinforcement on every call kept patients engaged.
- Because many of the health center's patients are current or former coal miners with COPD, the Shawnee team recommends including pulse oximeters in future Kits.

**What was the impact for Shawnee Health patients?**

**“ Even if a patient loses just a few pounds or learns to use a monitoring tool – praise their efforts. Encourage them on every call. ”**

- Several patients were able to lower their A1c from 9 to 7. This program held them accountable and educated them.
- Doing colorectal cancer screening at home was a huge benefit for this group of patients, many of whom would never have gotten screened without the intervention.
- The patients needed simple instructions and pictures (infographics) to use monitoring tools.
- Teaching patients to use the at-home monitoring equipment was more difficult and took longer than expected. Only 20% of their patients could use the home A1c kits on their own.



**Case Study #3:  
Zufall Health  
Center**

**Created a staff position focused on successful virtual care implementation  
Leveraged this virtual care model to expand model to more sites and patients**

[Zufall Health Center, Inc.](#) maintains Patient-Centered Medical Home sites throughout several suburban and urban areas in New Jersey. Over 82% of their patients are from racial and/or ethnic minoritized groups, with 72% identifying as Hispanic (61% of whom do not speak English). Zufall’s clinics offer a full range of family medicine, and they specialize in dental care, pharmacy, nutrition, diabetes care, cancer screening, behavioral health, HIV care, and more.

**What worked well?**

A special ‘Project Implementation Assistant’ position was developed to lead the project team. Zufall’s Medical Director told us,

*“ We already know that to be successful, a program can’t depend on one person or one who’s super busy. I invented this position to be an extender ... to keep the wheels turning for our larger team so we can implement this important population health program. ”*

Training was essential. The multilingual Clinical Pharmacist was tapped to train staff and patients on Kit materials along with the Director of Nursing. The Case Manager helped educate patients to use the Kit and record readings. Technical support staff stayed on hand to ensure connectivity and help troubleshoot technical/hardware problems.

Initial visits were in-person. For the monthly Zoom or Doximity virtual visits, the Zufall team delivered a full range of services. Screening with the PRAPARE® questionnaire helped identify patients in need of support and, in some cases, crisis care.

**What unique solutions were introduced?**

- “Mirroring” was a great way to teach patients how to use the equipment and address the continuum of patient capabilities to interact with technology.
- The health center added glucometers to the Kits to help patients take frequent blood sugar readings.
- Zufall developed a rubric for ‘high risk’ patients with the Tableau data reporting system.
- Zufall applied for the SNAP-Ed program and integrated nutrition education and food stamps into this pilot program.
- By engaging a wide range of staff, the health center was able to more flexibly support patients when they needed it.

*“ Patients felt heard and supported, especially through the COVID-19 crisis. We were able to identify several patients in need of behavioral health support through this program. ”*

**What was the impact for Zufall Health patients?**

- This program model, and the lessons learned, has the potential to help many more patients than those engaged in the pilot. The health center is currently expanding the model to more sites and patients.
- Many of the participating patients experienced improvements, including improvement in A1c and self-reported stress, enhanced relationships with members of the care team, and increased access to community services.



**Case Study #4:  
CareSouth  
Carolina**

**Created engaging videos to train staff on this new virtual care program**

CareSouth Carolina, Inc. is a Patient-Centered Medical Home with clinics in the northeastern corner of South Carolina, an area that contains the traditional homelands of the Pee Dee Tribe. Over 56% of their patients are Black/African American and experience high levels of poverty. CareSouth offers some unique programs, including school-based dental programs and mobile services, along with a full range of family practice and aging services, pharmacy, counseling, dental care, chiropractic, HIV care, and more.

**What worked well?**

The Associate Medical Director led this program with two Registered Nurses.

*“ Our team was small, just three of us, but it worked. ”*

Azara software helped the Associate Medical Director identify patients suitable for this pilot. Patients were invited to pick up Kits from the clinical site where they regularly received care. During that first visit, patients were taught why and how to use the Kits and record data. This *“gave the providers a chance to pick-up cues that would be used to help patients in the virtual setting.”*

The project leads created a training video to teach staff about the pilot and explain how it worked. The video explained “How will this affect me?” and taught staff what to expect and how to enter data into the EHR. Since many staff members are also patients, or have family members who are patients, this informational video became a helpful tool for recruitment as well.

**What unique solutions were introduced?**

- Creating a training video helped with staff training and well as patient recruitment.
- Offering Patient Care Kits to patients with out-of-control biometrics led to greater investment.
- Text messages proved to be useful to remind patients to participate in their virtual visits.
- Community Health Workers and Patient Advocates partnered to reduce social barriers to care, identified by the RNs, for participating patients.

**What did CareSouth Carolina learn?**

*“ Community health workers and advocates are so helpful. Their positive relationships get more patients to submit their colorectal cancer screening test or get a colonoscopy done, for example. ”*

- This program helped the health center think about their processes, and how to conduct a larger roll-out for patient monitoring with 7,000 patients.
- CareSouth Carolina succeeded at achieving their project goals to:
  - o Understand staffing and workflow to execute at-home care on a larger scale.
  - o Increase the % of patients with have A1c <9 by the end of the pilot.
  - o Increase the % of patients with hypertension under control by the end of the pilot.
- The health center recommends that future Kits include glucometers. The A1c tool was difficult for patients to administer on their own.