NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Patient-Centered Medical Home

PCMH & Resiliency During the Pandemic

September 14, 2021

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

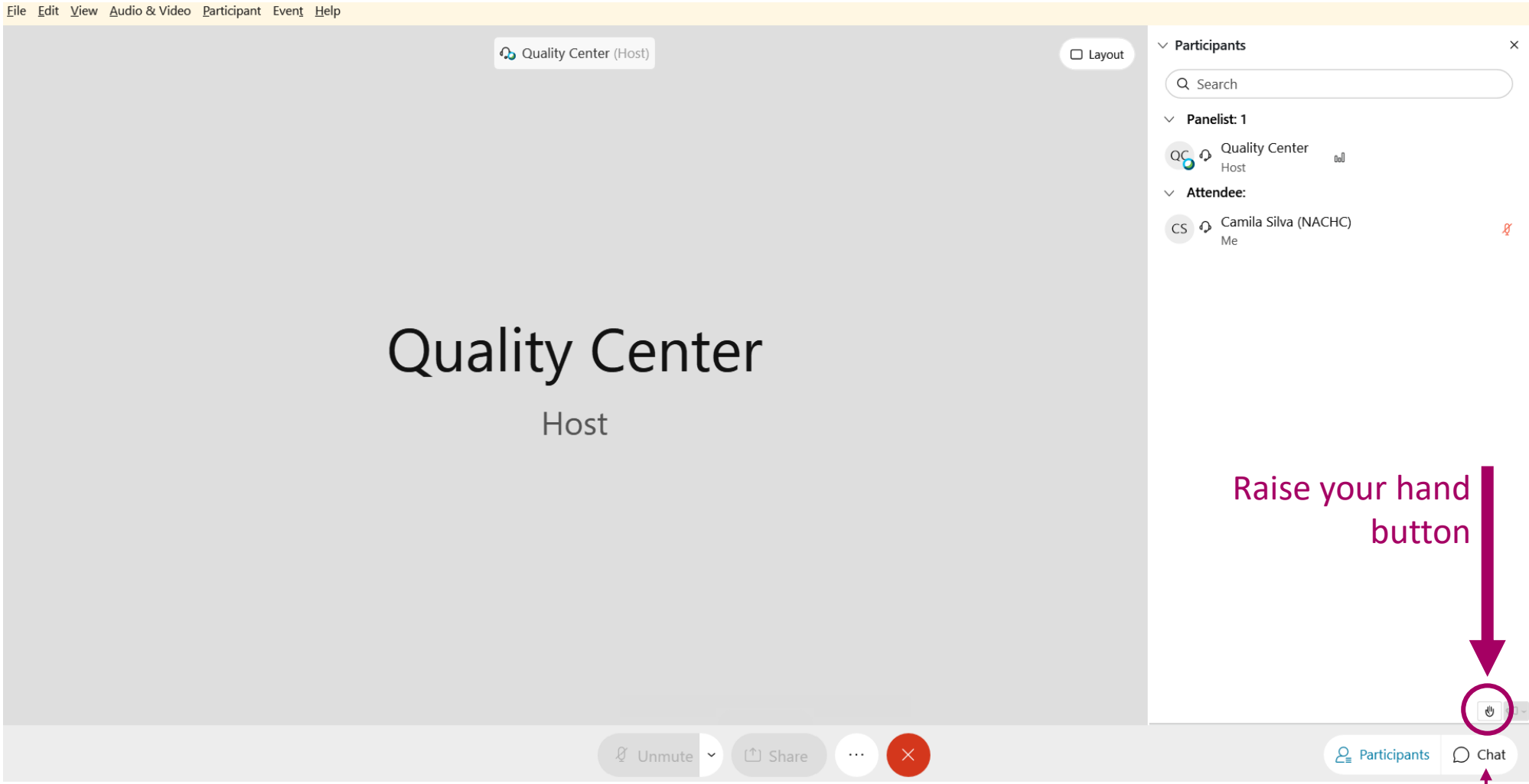
Lizzie Utset

Specialist,
Quality Center

Camila Silva

Transitioning:

Deputy Director,
NACHC's Innovation Center


File Edit View Audio & Video Participant Event Help
Quality Center (Host)
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Panelist: 1
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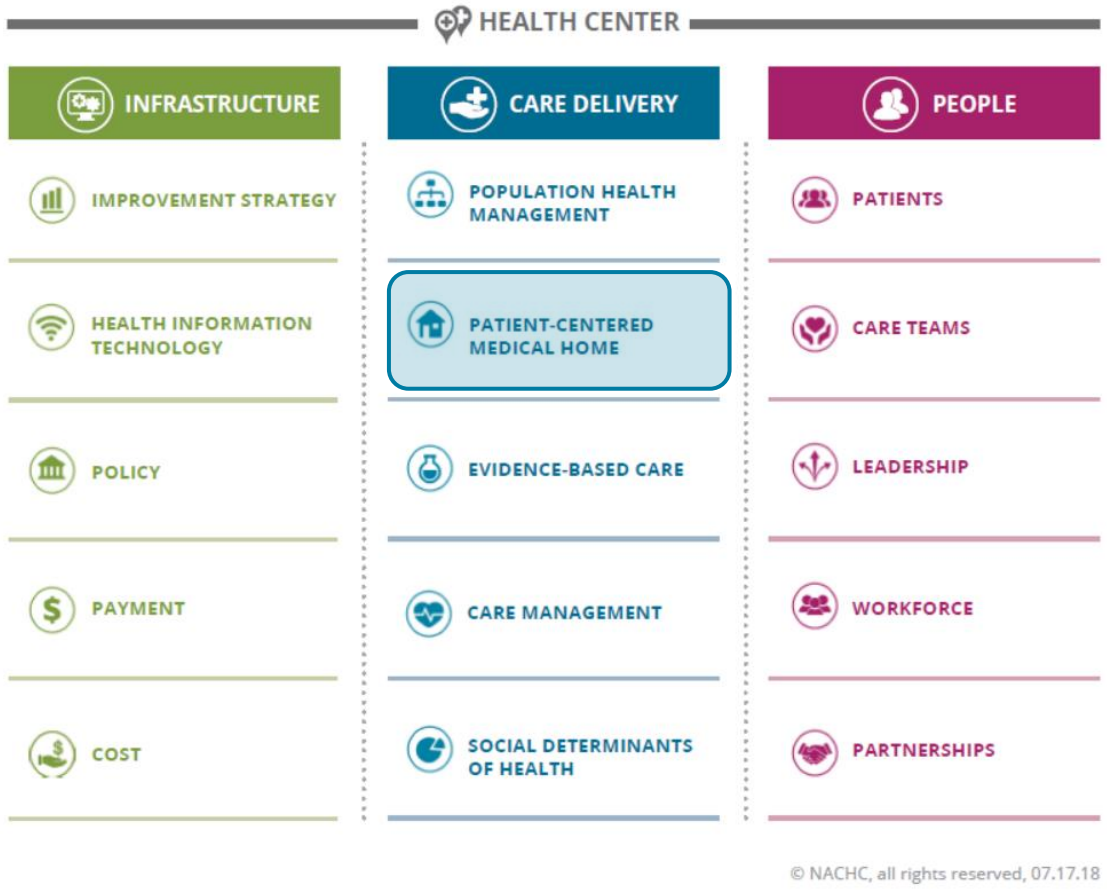
Camila Silva (NACHC)
Me
Raise your hand button
Unmute
Share
Participants
Chat
Chat: When using the chat, please send the message to “Everyone”

Value Transformation Framework



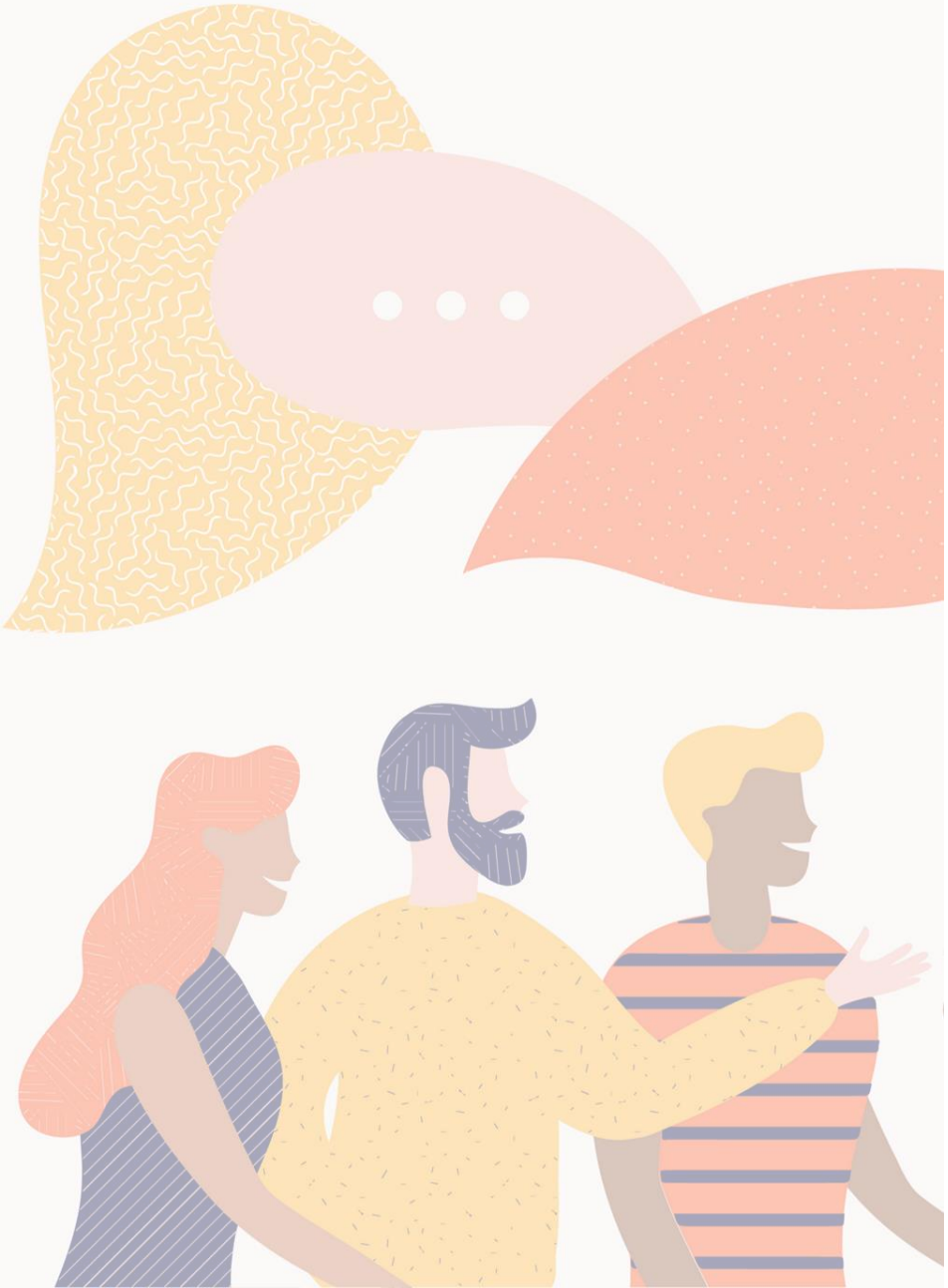
https://www.nachc.org/clinical-matters/value-transformation-framework/

Today's Objective:

- Discuss how the PCMH model can help to strength health care systems and resiliency during the COVID-19 pandemic.
- Hear how health centers have leveraged PCMH core concepts to adapt and respond to challenges during the pandemic
- Focus on strengthening strategies in three PCMH concept areas:
  - Team-Based Care & Practice Organization
  - Knowing & Managing Your Patients
  - Patient-Centered Access & Continuity

PATIENT-CENTERED MEDICAL HOME

Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.



Polling Question

STEP 1 A “Multimedia Viewer” popup will open on the left-hand side of your screen to redirect you to an external site (Mentimeter polling)

STEP 2 Scroll down and click the blue “Continue” button

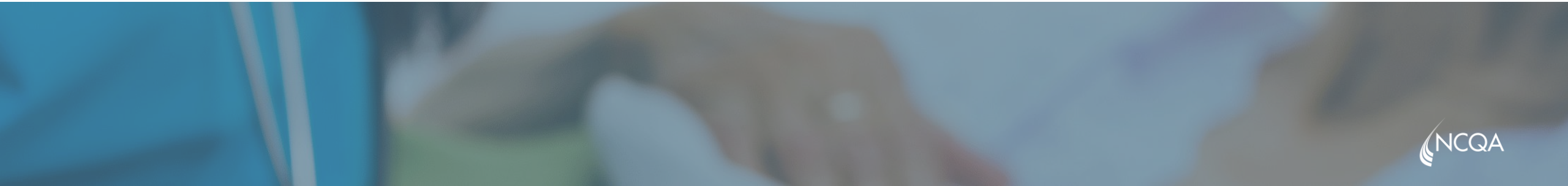
STEP 3 Type in your response to the polling question and click “Submit” (submit as many responses as you would like)

National Committee for Quality Assurance (NCQA)

COVID Resiliency and the PCMH Model: A Discussion

William F. Tulloch
Director, Quality Solutions Group
tulloch@ncqa.org

PCMH Concepts



A Challenging Time

Let's take a virtual step back & acknowledge, it's been a time

COVID-19 pandemic has provided enough challenges and stresses to last a lifetime:

- Illness & death
- Economic harm
- Disruption to all aspects of "regular life"

But today we want to focus on the positive:

- **How has the medical home model allowed health centers to adapt & respond to the myriad challenges?**

PCMH Standards

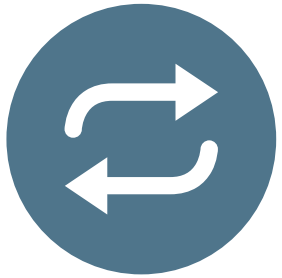
Concepts

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)



Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)

NCQA

What We've Heard from the Field

These Concepts have been areas of strength during the Pandemic

Team-Based Care and Practice Organization

- Practice leadership
- Care team responsibilities
- Orientation of patients/ families/caregivers

Knowing and Managing Your Patients

- Data collection
- Medication reconciliation
- Evidence-based clinical decision support
- Connection with community resources

Patient-Centered Access and Continuity

- Access to practice and clinical advice
- Care continuity
- Empanelment

Team Based Care and Practice Organization

How did the Medical Home Model help?

- Reshuffling of responsibilities
- Redeployment of staff
  - Ex: administrative staff delivering home-based monitoring equipment
- Most important: Creating a team willing/able to make these changes quickly, keeping patient care paramount

Generations Family Health Center

Health Center Perspective:
Team-Based Care & Practice Organization

Judith Gaudet
Systems of Care Director
jgaudet@genhealth.org

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Looking Through a Medical Home Lens Changes Our Approach to Care During a Pandemic

- IT team quickly acquired the necessary number of laptop computers and encrypted them for each employee.
- Deployed a new communication system with electronic faxing solutions.
- 3 day per week work from home schedules which required redeployment of staff with signed work from home agreements.
- Changes in work assignments.

***Systems of Care staff provided with patient reports to reach out telephonically to assess and address psychosocial issues.**

Selected Item	Pat Person Nbr
Calculation	Count
Contact:	16023
Telephone interaction	13737
Face-To-Face interactions	1326
Outreach:	513
Social Determinants of Health Assessment	4483
Coordination of Care Services	8967
Case Management Follow-Up	5982
Eligibility Assistance:	7477

Selected Item	Pat Person Nbr
Calculation	Count
Contact:	16023
PRAPARE Lack of Transportation Medical	4174
PRAPARE Patient Unable To Get Medicine or Any Health Care	3755
PRAPARE Eval Patient Unable To Get Food	4226
PRAPARE Eval Patient Unable To Get Phone	3856
PRAPARE Eval Patient Unable To Get Child Care	3265
Applications/Income (SNAP, SSI)	2738

How Did We Address Psychosocial Issues For Our Patients

We partnered with 4-CT, a non-profit organization to provide **emergency fund debit cards up to $900** for persons affected by COVID needing help with rent, food, childcare or unexpected expenses.

We received **personal care items** via donations through Direct Relief, community partners, and community members that allows us to provide patient kits to those that need them.

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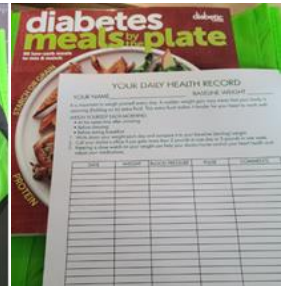
Innovative Practices To Improve Patients Lives

Blue Tooth Scales

Exercise Bands



Diabetic Cookbook

BP Cuff

Health Tracker Book with Daily Logs

Pulse Ox

Tracfone w/ Data Card

- **Provided self-care tools through contactless delivery.**
  Reducing a BMI from 40 to 35, or perhaps an A1C from 14 to 12, is still an uncontrolled diabetic by clinical standards but a significant improvement in the life of the patient.

- **Supported recording of blood pressure readings at home.**
  Providers receive more data to better understand patients' hypertensive state. In turn, the provider can develop a comprehensive treatment plan with the patient to promote better hypertension control.

- **Purchased Tracfones and data cards.**
  Care Coordinators and Outreach workers delivered to patients who did not have a phone or data to access telehealth services. The 30-day data cards were uploaded and care coordinators worked with eligible patients to get them set up with Safelink, the "Obama Phone" to assure they can continue to have access to telehealth visits with providers.

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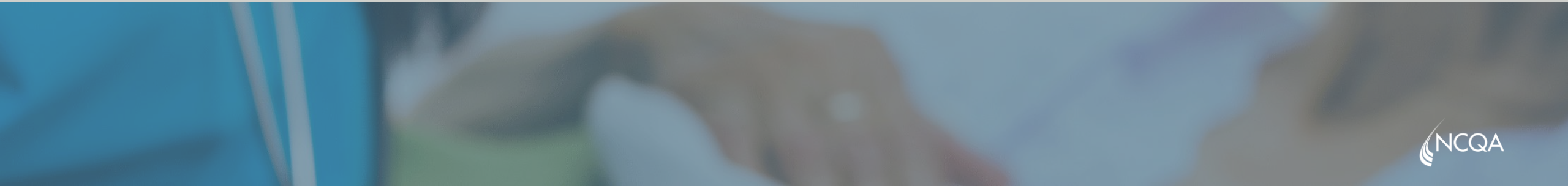
Discussion



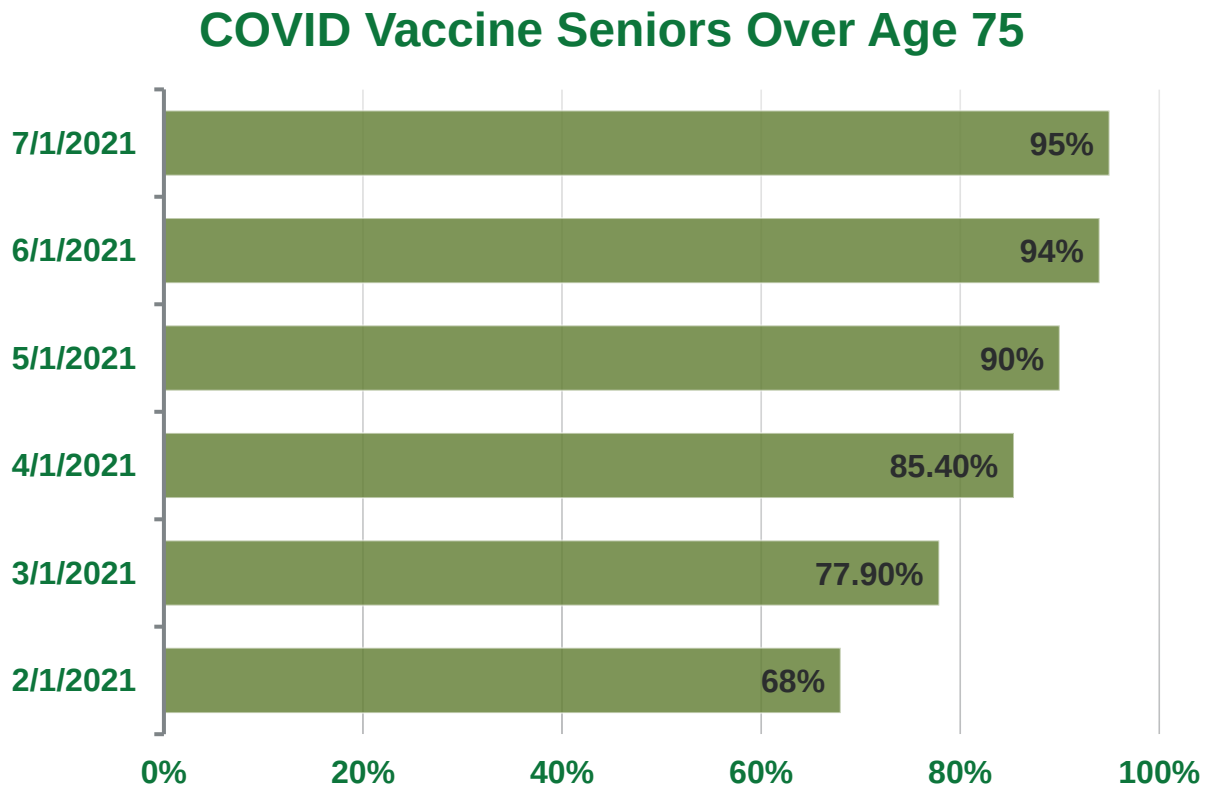
Knowing and Managing Your Patients

How did the Medical Home Model help?

- Keen understanding of patients' social determinants of health allowed centers to craft specific interventions to meet challenges
- Health centers also were key to the vaccine roll out, to ensure vaccines moved to communities in need

How Do We Get Shots In Arms In Rural Transportation Deserts

- Informatics team creates lists.
- Staff call all patients in age group to schedule vaccine appt.
- Negotiated with local transit to have a dedicated shuttle loop around senior living centers to get elderly patients to the health center in small groups to be vaccinated.
- If not in transit routes, utilize gas cards or patient assistance funds to pay for transportation to get the vaccine.



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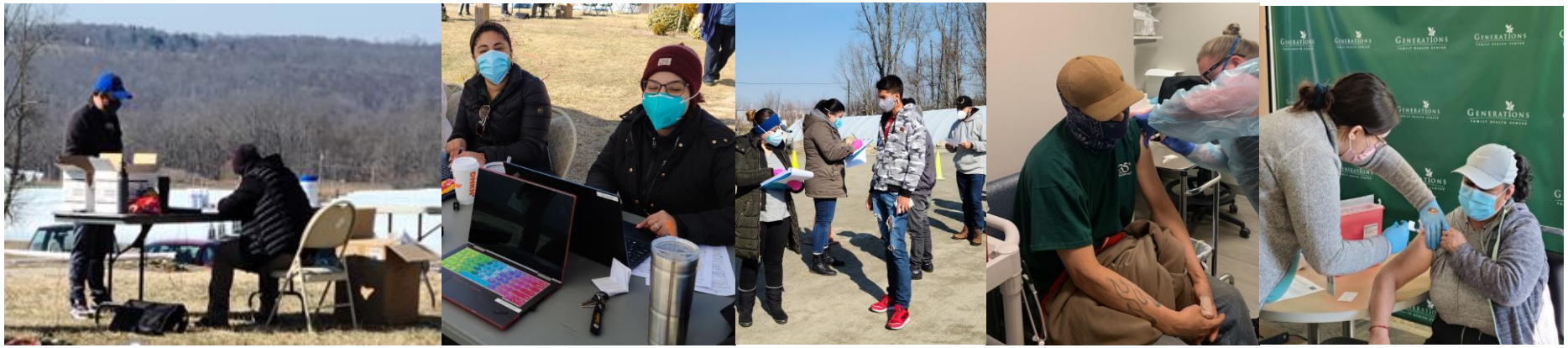
Assuring Vaccine Equity in Special Populations



Special Populations	Number of Patients (a)
Total Agricultural Workers or Dependents	289
Calculation	Count
Global Query Vaccinated	285
COVID-19 J&J, Janssen, vector non-replicating, reco	95
COVID-19 Moderna, mRNA, LNP-S, PF, 100 mcg/0.5 mL dose	181
COVID-19 Pfizer, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose	9

Transportation and insurance are psychosocial issues that create barriers to care for migrant and seasonal agricultural worker population. Long days in the field make it difficult to attend appointments.

Scheduling **weekend & evening clinics** for our farmworker patients, **working with growers and owners** and **coordinating transportation**, we were able to assure **98.5% of our ag worker patients who had qualifying visits have received their COVID Vaccines**.

Thank You!

Judith Gaudet, Systems of Care Director
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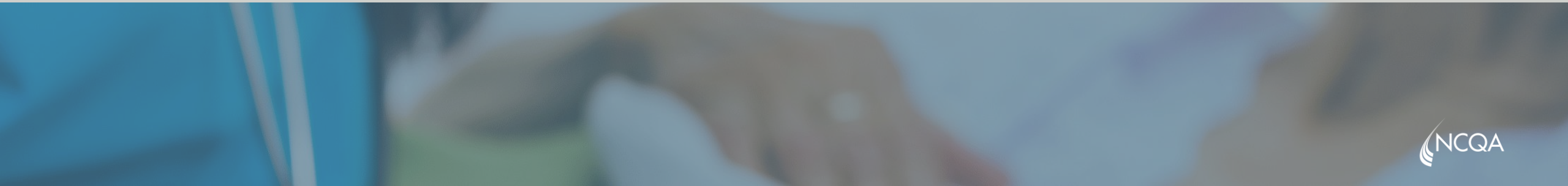
Discussion



Patient-Centered Access & Continuity

How did the Medical Home Model help?

- Move to technology-based appointments
  - Telemedicine
  - Telephonic
  - Creative solutions (health center parking lot-based visits for those w/out WiFi at home).
- Consolidation of physical locations
  - Concentrating in-person appointments
  - Freeing up staff to handle technology-based care
- At Home Care

Coastal Family Health Center

Health Center Perspective:

Navigating Patient-Centered Access During the COVID-19 Pandemic at CFHC

Stacey Curry

Director of Clinical Quality Management

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AS THE PANDEMIC HIT

Alternative visit types needed!

March 2020
Virtual Check-ins & Telehealth Implemented

By June 2020
Virtual Check-ins ~ 17% of visits
Telehealth ~ 17 %

Changed to integrated system in August 2020

AS THE PANDEMIC CONTINUED

- **COVID-19 Care Visits**
  - A list of patients that tested positive sent daily to designated medical providers.
    - Providers called the patient to check in and to see if he/she would be interested in a telehealth visit.
    - The patient received a **telehealth visit** to address medical needs related to COVID-19 at three care points.
  - Patients interested in talking with behavioral health providers to address additional resource needs were provided a second telehealth visit.
  - Approximately **420 visits** were initiated with this program.

SOMETHING WAS STILL MISSING…

While telehealth services provided a means to see patients with acute and chronic conditions, our uncontrolled diabetes measure was still being negatively impacted by Covid-10.

- Unknown A1Cs made up a large portion of the uncontrolled diabetes population.
- Patients were unable to come in for routine A1C checks.
- There was a difficulty adequately managing diabetes care without proper testing.

CURB-SIDE A1C TESTING AND TELEHEALTH FOLLOW-UP

In April 2021, implemented a **curb-side A1C testing** and telehealth follow-up pilot for uncontrolled diabetes patients.

- Diabetic patients were scheduled for a curb-side A1C test and same-day telehealth diabetes follow-up appointment.
- Enrollment was highest in May & June 2021.
- The overall cohort has had a **19.5% decrease in A1C >9** or unknown between May 2021 and August 2021.

Coastal Family Health Center

Questions?

Contact Information:

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Director of Quality Management

Coastal Family Health Center

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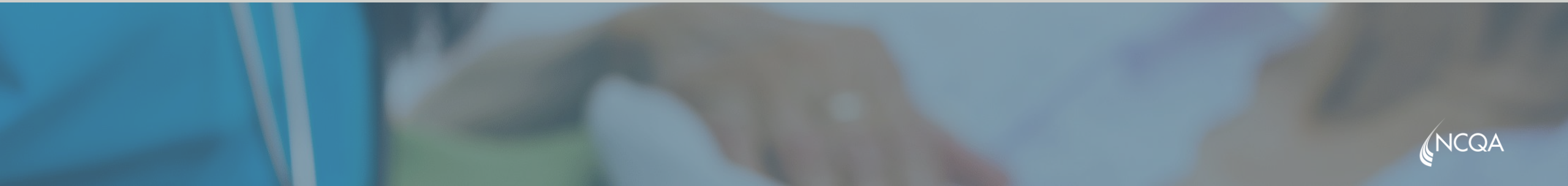
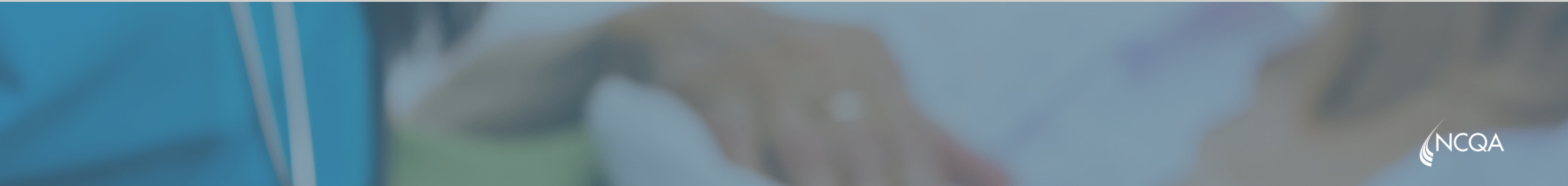
Discussion



Wrap-Up



UPCOMING EVENTS

October 2021

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

12. Monthly Forum

SAVE THE DATE

Elevate 2022 Registration Opens!

New webinars coming soon…

Scan QR code to register

Million Hearts® LEARNING LAB

A bi-monthly mixed methods learning series focused on cardiovascular disease prevention and management topics.
CME credits available.

NATIONAL ASSOCIATION OF Community Health Centers®

AMA AMERICAN MEDICAL ASSOCIATION

SESSION 1 | 9/15/2021 | 3:00 - 4:00pm ET
Cholesterol Management/Optimal Use of Statin Therapy

SESSION 2 | 11/17/2021 | 3:00 - 4:00pm ET
Intensifying Treatment to Achieve Blood Pressure Control

More sessions to come! Details coming soon.

REGISTER TODAY!

Access required session resources and learn more about the Million Hearts® Learning Lab

Texting to Support Community Health Centers' Outreach

CAREMESSAGE

NATIONAL ASSOCIATION OF Community Health Centers®

Tuesday, September 21 | 1:00-2:00pm EDT

The CareMessage team will share recommendations for outreach to patients around COVID-19, gaps in care management, and social determinants of health.

PRESENTERS:

Vineet Singal | Co-Founder and CEO, CareMessage

Julia Skapik, MD, MPH | Medical Director, Informatics
National Association of Community Health Centers

REGISTER TODAY!

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Director, Quality Center
National Association of Community Health Centers
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Next Monthly Forum Call:

October 12th, 2021
1 -2 pm ET

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Together, our voices elevate all.

The Quality Center Team
Cheryl Modica, Camila Silva, & Lizzie Utset
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