NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Models of Care:
Virtual Care & Patient Self-Care Tools

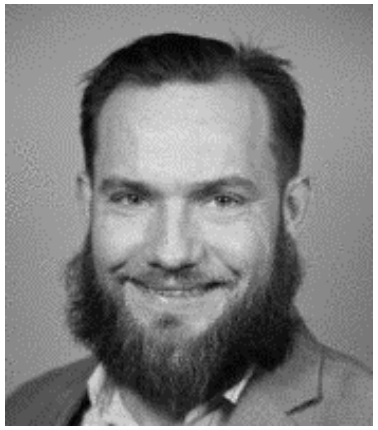
04.20.21

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

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center



Luke Ertle

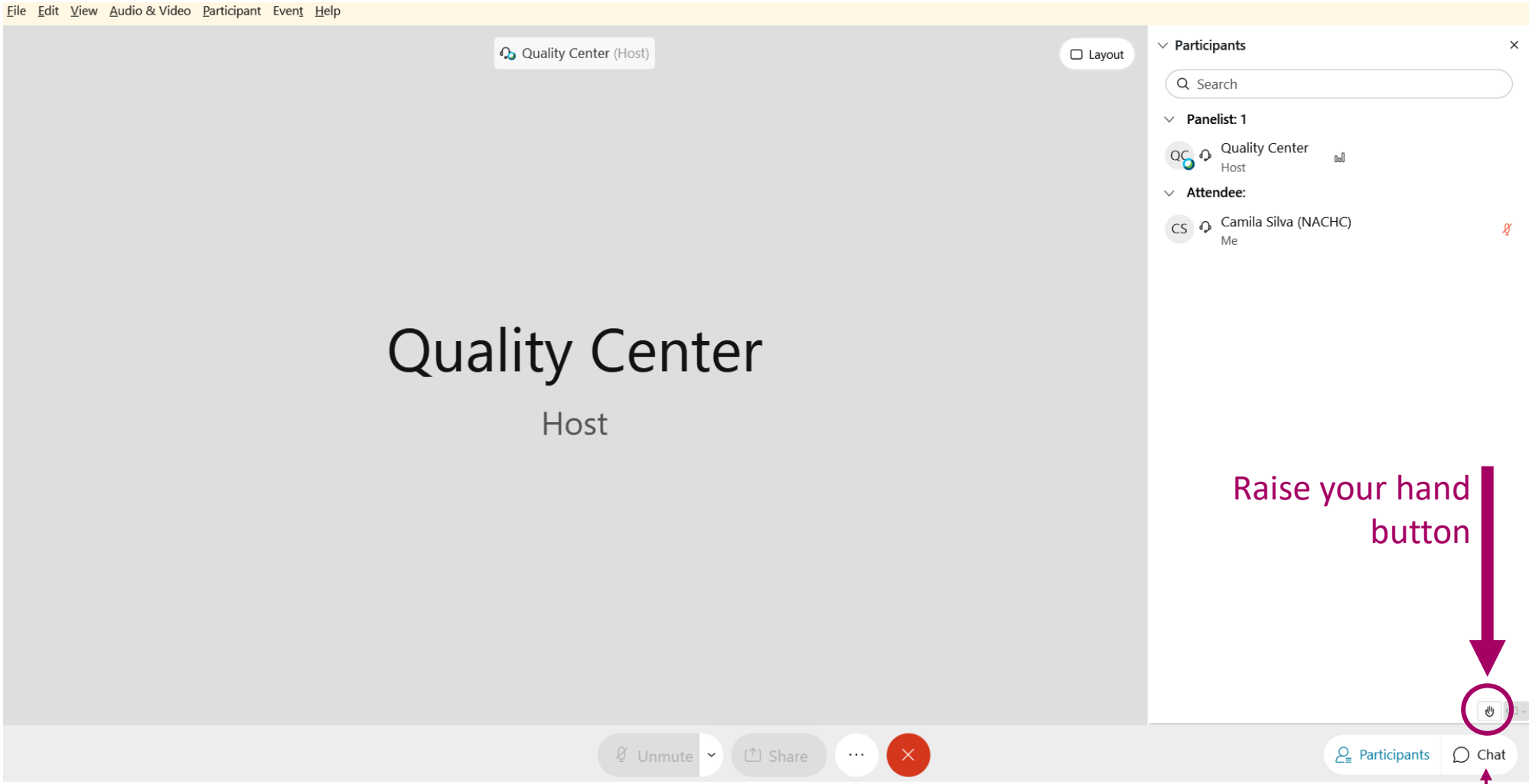
Manager,
Quality Center

Camila Silva

Manager, Quality Center
Training & Curriculum

Lizzie Utset

Specialist, Health Science
Content


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

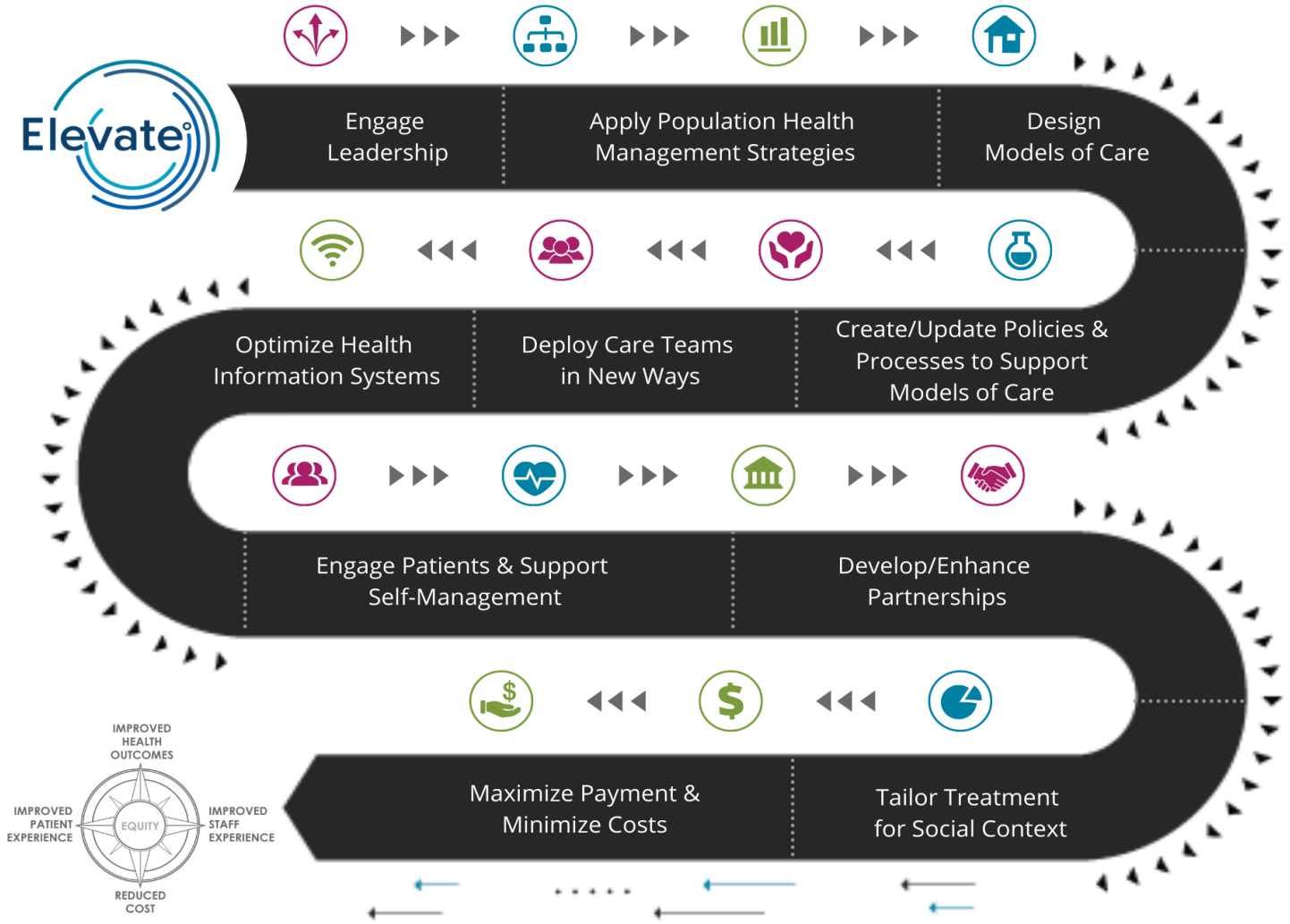
THE NACHC MISSION

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®

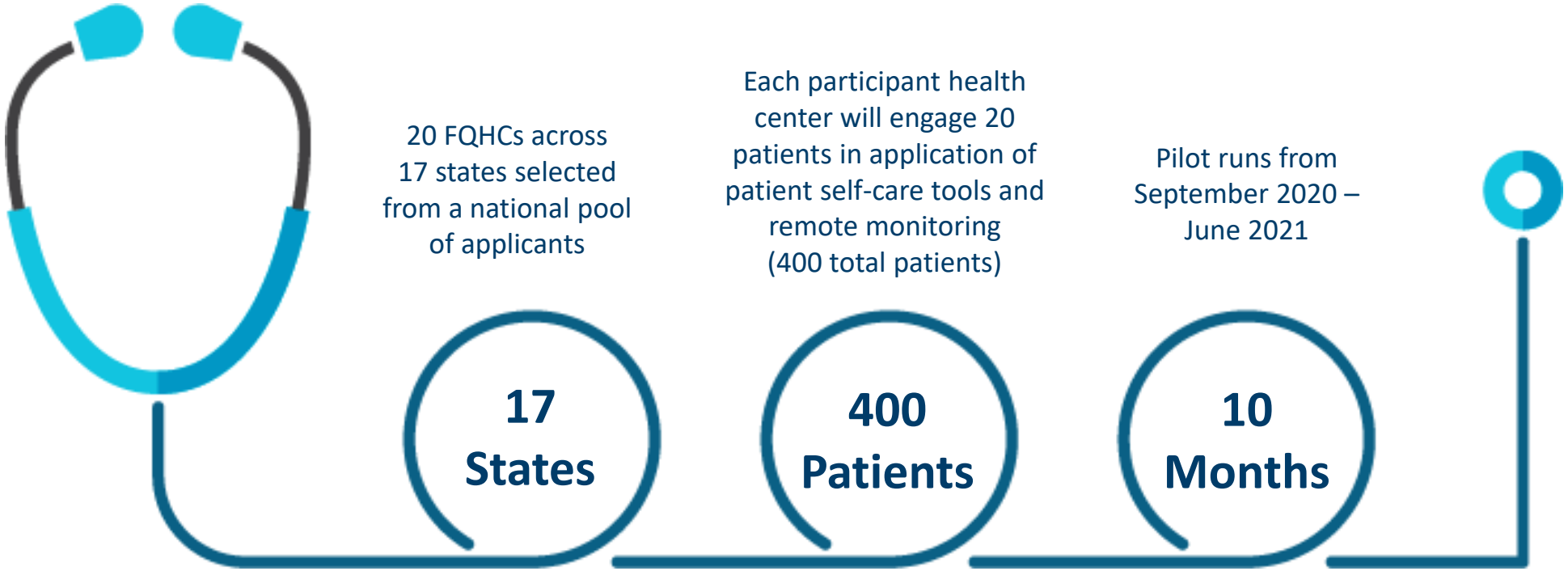
2021 Curriculum



The Elevate 2021 curriculum is designed to support health centers in application of the 15 Change Areas of the Value Transformation Framework and transformation toward value-based care. It outlines a path the Elevate learning forum will take over the year while recognizing that transformation is not linear and that organizations will adopt and apply the curriculum in a manner and order that fits their individual needs and circumstances.

Leading Change: Transforming At-Home Care

As health care providers more fully transition to virtual models of care delivery and explore new and advanced ways to **expand medical capacity and patient care while reducing the spread of COVID-19**, NACHC's Quality Center is leading a health center pilot project to provide medically underserved patients the tools they need to manage their health safely in their home.



Leading Change: Transforming At-Home Care

PILOT PROJECT GOALS:

- Test the impact of providing patient self-care tools (supplies, instructions, education), combined with follow-up and coaching, on health outcomes, patient experience, staff experience, and cost.
- **Develop models and workflows for health center use of Patient Care Kits and remote patient monitoring**

Mailable FIT test

Home A1c test

Thermometer

Scale

Patient Instructions and Educational Materials

Patient Logs and Recording Tools

Blood pressure monitor

Roadmap

LAY THE GROUNDWORK

Commit
Communicate
Design
Educate/Train

LAUNCH

Enroll Patients
Distribute Kits
Measure (Baseline)

IMPLEMENT

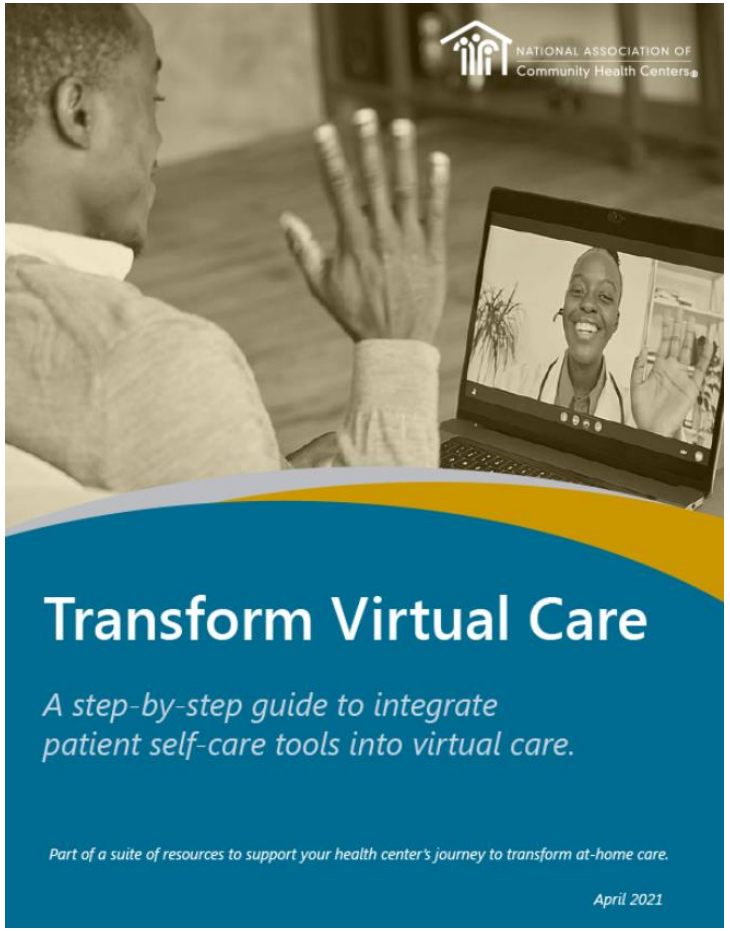
Conduct Virtual Care w/Kits
Collect/Report Data
Exchange (Peer-to-Peer)

WRAP UP

Report/Evaluate
Share Lessons

Today's Deep Dive

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | **Population Health Management** | Patient Centered Medical Home | **Evidence-Based Care** | **Care Coordination & Management** | Social Determinants of Health | **Patients** | **Care Teams** | Leadership | Workforce | Partnerships



NEW Action Guide

LAY THE GROUNDWORK

STEP 1 Commit to Use Patient Care Kits, Assemble Your Team, and Define Success

STEP 2 Communicate with Staff About the Patient Care Kit Initiative and Goals

STEP 3 Complete the Value Transformation Framework Assessment

STEP 4 Identify Patients to Receive Patient Care Kits. Complete Risk Stratification

STEP 5 Develop a Patient Virtual Care Workflow that Includes Patient Self-Measurement and Monitoring

STEP 6 Designate a Place and Process to Receive, Store, Assemble, and Test Patient Care Kits

STEP 7 Educate and Train Staff in Patient Care Kit Tools and Patient Self-measurement and Monitoring

LAUNCH

STEP 8 Enroll Patients

STEP 9 Distribute Kits and Provide Education and Training

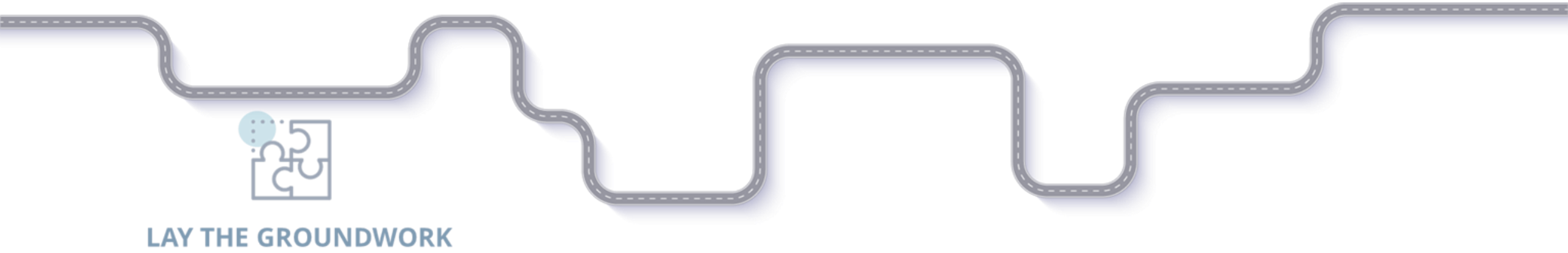
STEP 10 Complete Baseline Measurement and Collect Measures

IMPLEMENT

STEP 11 Conduct Monthly Virtual Visits, Data Collection, and Reporting

ASSESS AND EVALUATE

STEP 12 Report, Evaluate and Share Lessons Learned



LAY THE GROUNDWORK

HIGHLIGHTS

- VTF Assessment
- Leadership email template
- Press release template
- Workflows
- Sample instructions for staff

LAY THE GROUNDWORK

STEP 1 Commit to Use Patient Care Kits, Assemble Your Team, and Define Success

STEP 2 Communicate with Staff About the Patient Care Kit Initiative and Goals

STEP 3 Complete the Value Transformation Framework Assessment

STEP 4 Identify Patients to Receive Patient Care Kits. Complete Risk Stratification

STEP 5 Develop a Patient Virtual Care Workflow that Includes Patient Self-Measurement and Monitoring

STEP 6 Designate a Place and Process to Receive, Store, Assemble, and Test Patient Care Kits

STEP 7 Educate and Train Staff in Patient Care Kit Tools and Patient Self-measurement and Monitoring

LAUNCH

HIGHLIGHTS

- Patient Agreement Template
- Data Collection Chart & Template
- Patient Experience

LAUNCH

STEP 8 Enroll Patients

STEP 9 Distribute Kits and Provide Education and Training

STEP 10 Complete Baseline Measurement and Collect Measures

HIGHLIGHTS

- Patient Log
- Data Collection Chart & Template

IMPLEMENT

STEP 11 Conduct Monthly Virtual Visits, Data Collection, and Reporting

WRAP UP

HIGHLIGHTS

- Report & Evaluate
- Share Lessons

ASSESS AND EVALUATE

STEP 12 Report, Evaluate and Share Lessons Learned

Accordia Health

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

PRESENTING: SAMANTHA PETTAWAY, LICSW, PIP, MBA

APRIL 20, 2021

Introduction

FOUNDED IN 1957, ALTAPOINTE HEALTH SERVES AS THE DESIGNATED COMMUNITY MENTAL HEALTH CENTER FOR SEVEN COUNTIES.

IN 2018, ALTAPOINTE HEALTH ACQUIRED OUR FIRST FQHC LOOK-A-LIKE, *ACCORDIA HEALTH*.

SINCE THEN, *ACCORDIA HEALTH* HAS BEEN AWARDED FULL FQHC STATUS AND OPERATES A TOTAL OF FOUR FQHC'S IN ALABAMA.

1. Lay the Groundwork

- Announcements and communication to staff and the community
- Used NACHC's Risk Stratification to select patients
- Identified designated staff to assist with the process of patient care for the pilot project
- Workflow, care kits, education

Goal	Goal#1: 70% of patients diagnosed with diabetes who have an initial hemoglobin A1c of >9.0% will have an A1c reduction by at least 3% at their final medical visit by the end of the pilot.
Goal	Goal#2: To support participants in decreasing their BMI by 3% by the end of the program.
Goal	Goal#3: To increase overall patient engagement in their chronic health management.

2. Launch

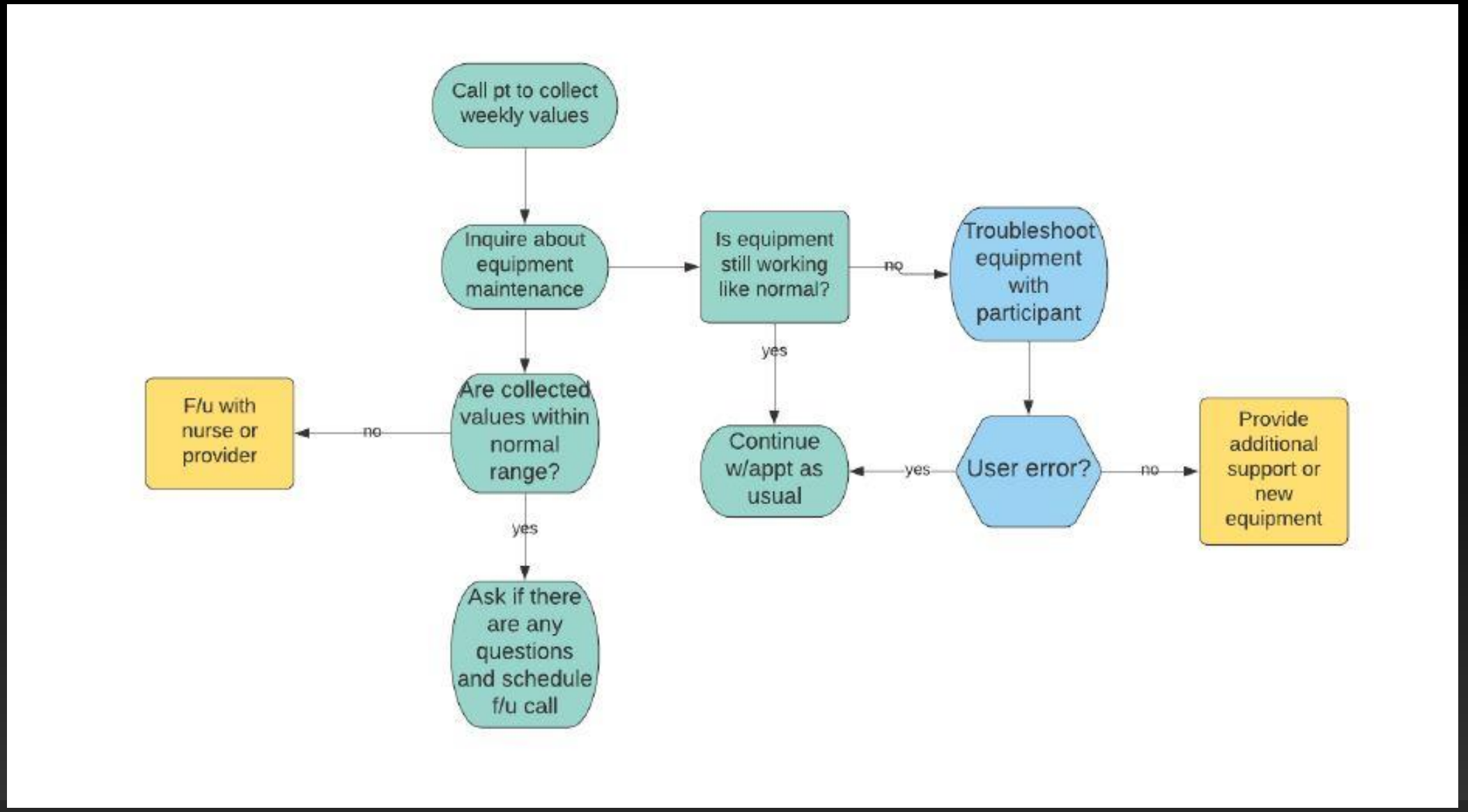
- Patient Identification and Recruitment
- Patient Care Kits
- In-clinic Baseline Visits

3. Implement

WEEKLY CHECK-INS WITH THE CARE COORDINATOR AND SOCIAL WORKER

MONTHLY VIRTUAL VISITS WITH THE NURSE

FLOW CHART: Weekly Check-Ins



4. Lessons Learned and Experiences

- Motivation
- Technology
- Support System
- Changes and Flexibility
- Bridge the Gap
- Savings
- Team Support System
- Whole Person Care

Discussion

Jeniqua Duncan, DO, MBA

Associate Medical Director

NATIONAL ASSOCIATION OF Community Health Centers®

Getting Started

LAY THE GROUNDWORK

Established Team – dynamics already in place

Goal: Learn to improve the process

Communicate!

LAY THE GROUNDWORK

Introductory video sent to entire corporation

The Back-End

LAY THE GROUNDWORK

Pass 1 – Utilized Azara and built a custom registry

Pass 2 – Provider (PCP) Recommendation

Preparing the Visits

LAUNCH

- RNs completed final enrollment and scheduling call
- In-person visit to distribute, train, and practice telehealth technology

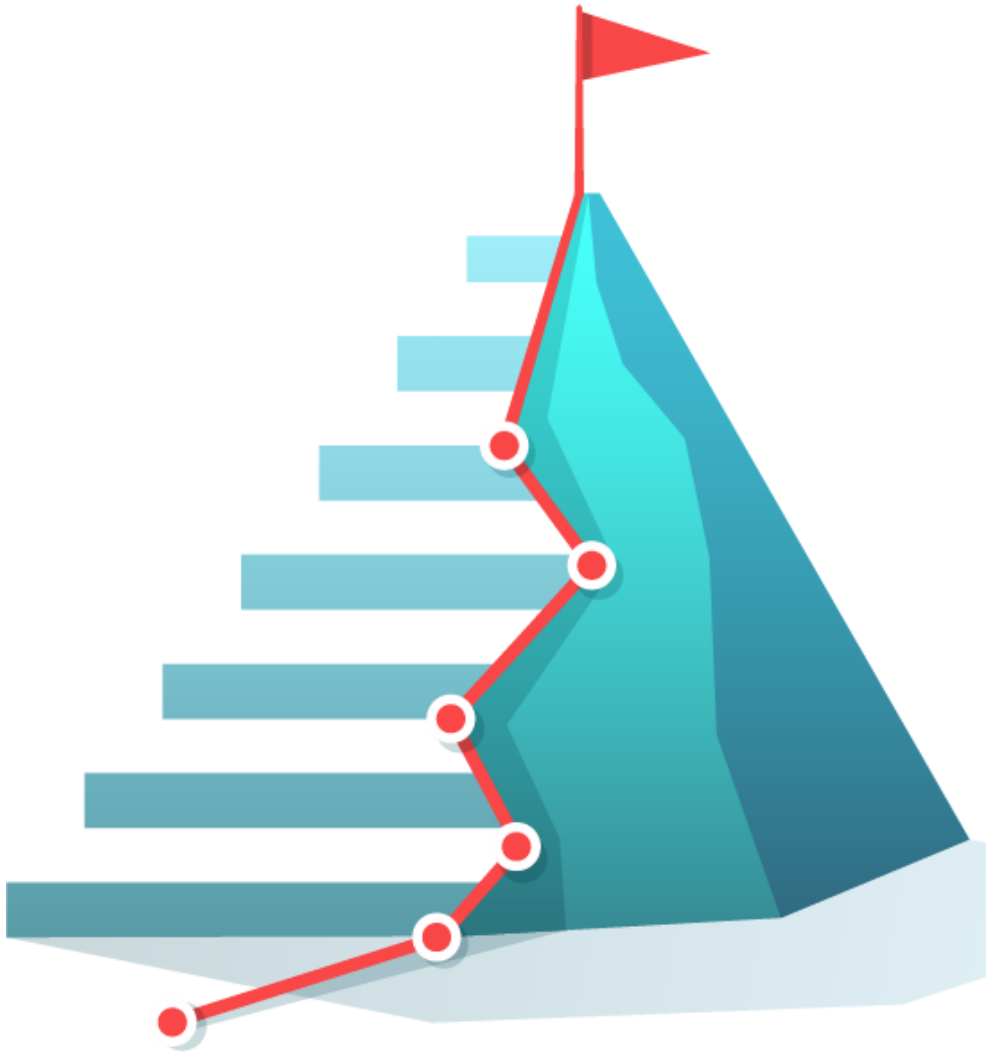
Virtual Visits Under Way

IMPLEMENT

- Completed via Doxy.me
- Created HPI template in eCW to streamline documentation
- More frequent check-ins for some patients

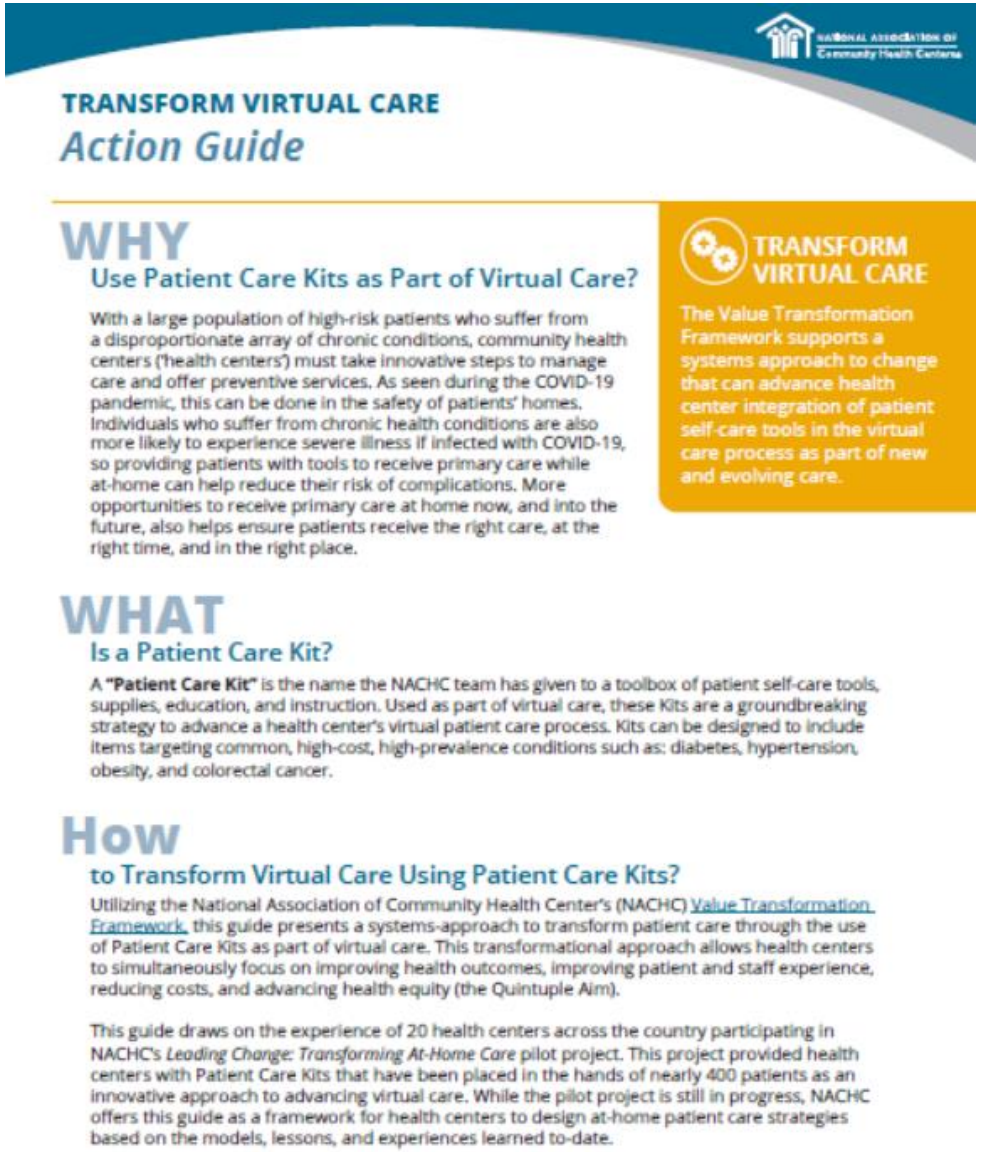
Lessons Learned

- A **small team** worked for us – refer when needed
- "**Name Dropping**" (trusted team member) is successful
- Expect some positive iFOB tests
- Patients were responsive to iFOB – purchase additional using grant funds
- Report out at the highest levels
- Many take-aways that are being applied to HRSA HTN grant and future remote patient monitoring development



Discussion

ACTION GUIDE: Transform Virtual Care



TRANSFORM VIRTUAL CARE

Action Guide

WHY

Use Patient Care Kits as Part of Virtual Care?

With a large population of high-risk patients who suffer from a disproportionate array of chronic conditions, community health centers ('health centers') must take innovative steps to manage care and offer preventive services. As seen during the COVID-19 pandemic, this can be done in the safety of patients' homes. Individuals who suffer from chronic health conditions are also more likely to experience severe illness if infected with COVID-19, so providing patients with tools to receive primary care while at-home can help reduce their risk of complications. More opportunities to receive primary care at home now, and into the future, also helps ensure patients receive the right care, at the right time, and in the right place.

TRANSFORM VIRTUAL CARE

The Value Transformation Framework supports a systems approach to change that can advance health center integration of patient self-care tools in the virtual care process as part of new and evolving care.

WHAT

Is a Patient Care Kit?

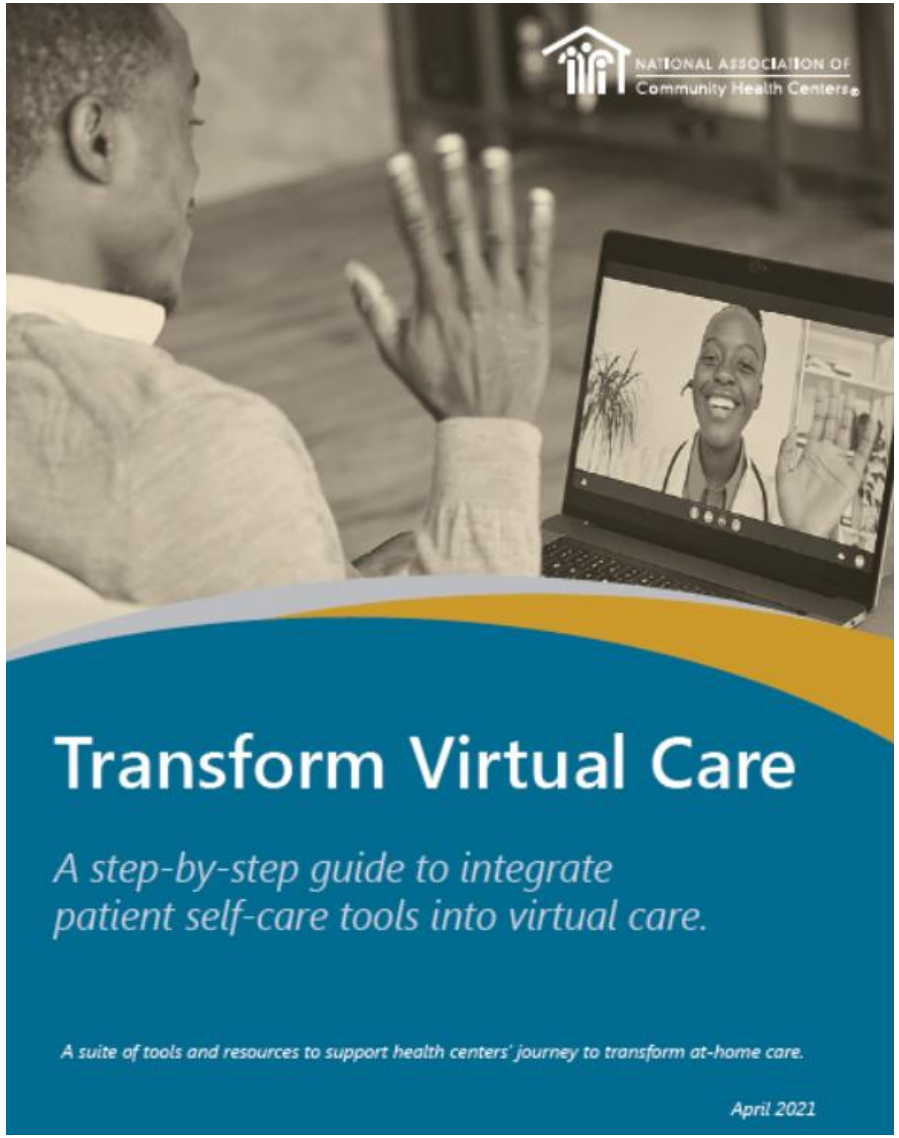
A **"Patient Care Kit"** is the name the NACHC team has given to a toolbox of patient self-care tools, supplies, education, and instruction. Used as part of virtual care, these Kits are a groundbreaking strategy to advance a health center's virtual patient care process. Kits can be designed to include items targeting common, high-cost, high-prevalence conditions such as: diabetes, hypertension, obesity, and colorectal cancer.

How

to Transform Virtual Care Using Patient Care Kits?

Utilizing the National Association of Community Health Center's (NACHC) Value Transformation Framework, this guide presents a systems-approach to transform patient care through the use of Patient Care Kits as part of virtual care. This transformational approach allows health centers to simultaneously focus on improving health outcomes, improving patient and staff experience, reducing costs, and advancing health equity (the Quintuple Aim).

This guide draws on the experience of 20 health centers across the country participating in NACHC's *Leading Change: Transforming At-Home Care* pilot project. This project provided health centers with Patient Care Kits that have been placed in the hands of nearly 400 patients as an innovative approach to advancing virtual care. While the pilot project is still in progress, NACHC offers this guide as a framework for health centers to design at-home patient care strategies based on the models, lessons, and experiences learned to-date.



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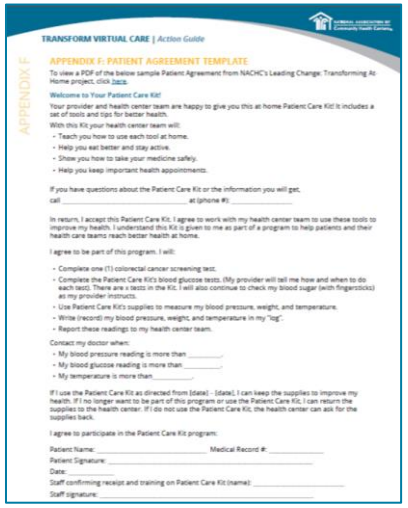
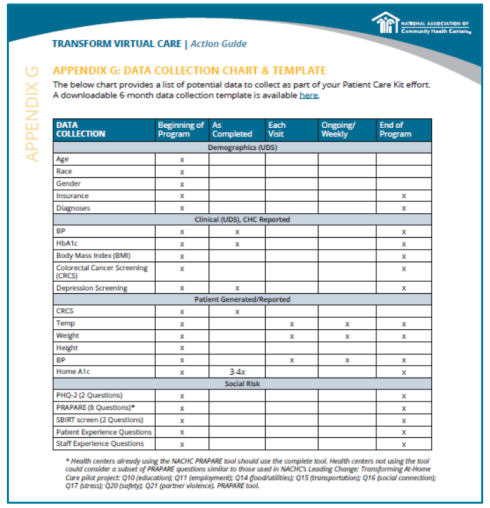
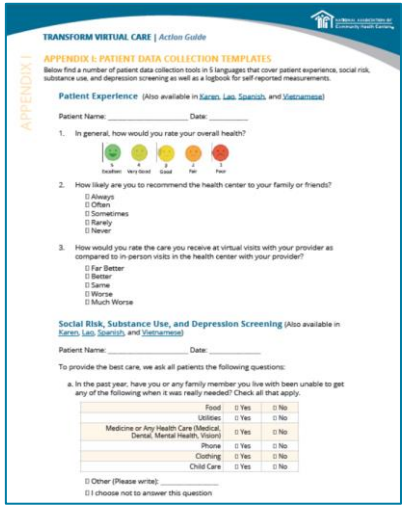


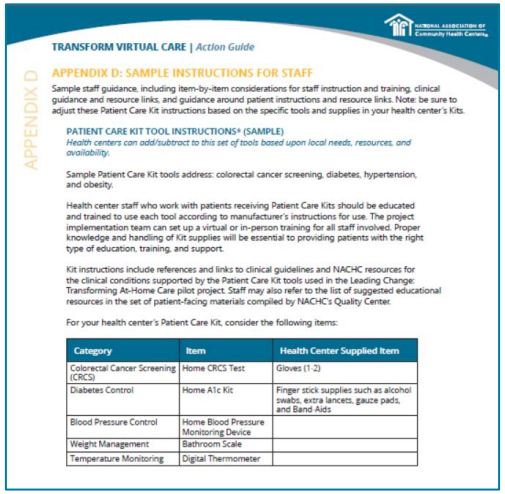
Sample Patient Agreement



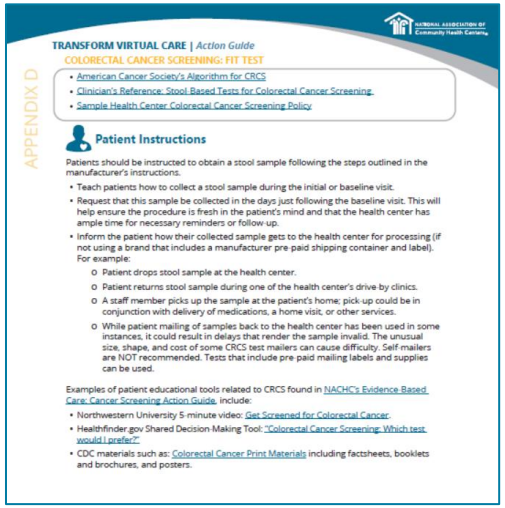
Data Collection Chart & Template



Patient Data Collection Template



Staff Instructions & Training



Patient Instructions

UPCOMING EVENTS

April 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	

May 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					

- ✓ **01. RegLantern Trial Starts**
- ✓ **13. April Elevate Core Webinar**
- **15. IHI Open School Scholarship Deadline**
- **20. Models of Care: Virtual Care & Patient Self-Care Tools** *(Deeper Dive)*
- **28. Business Continuity, Part 1 of 3** *(Deeper Dive)*

- **01. IHI Open School Scholarships Starts**
- **11. May Elevate Core Webinar**
- **12. Business Continuity, *Part 2 of 3*** *(Deeper Dive)*
- **19. Care Management, Part 1 of 2** *(Deeper Dive)*
- **26. Business Continuity, *Part 3 of 3*** *(Deeper Dive)*

Dive Deeper

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | Evidence-Based Care | Care Coordination & Management | Social Determinants of Health | Patients | Care Teams | **Leadership** | **Workforce** | Partnerships

A business continuity plan is a critical tool that helps manage the business operations of an organization during such an event and supports faster and more complete recovery following a disruption. This 3-part series will guide organization through the development of a Business Continuity Plan.

Dive Deeper

Improvement Strategy | **Health Information Technology** | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | **Evidence-Based Care** | Care Coordination & Management | Social Determinants of Health | Patients | Care Teams | Leadership | Workforce | Partnerships

Invited Panelists:

Centers for Disease Control and Prevention (CDC), NACHC, Health Federation of Philadelphia, American Medical Association (AMA), Hillrom-WelchAllyn, Omron, & A&D

Dive Deeper

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | Evidence-Based Care | **Care Coordination & Management** | Social Determinants of Health | Patients | Care Teams | Leadership | Workforce | Partnerships

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE MANAGEMENT

WHY

Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risk associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim (better care, better patient and provider experiences, and lower costs)[7].

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

CARE MANAGEMENT

The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

WHAT

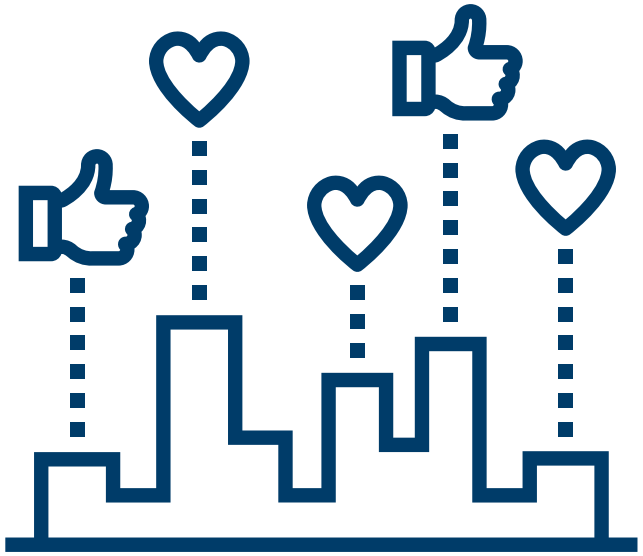
Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

May 19th & June 2nd

Join us for a special series around Care Management! Learn how you can apply NACHC's Value Transformation Framework to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

Scan QR code to register



Provide Us Feedback

Calling All Partners

Share your evidence-based interventions, projects, tools, or resources on an Elevate learning forum! Contact us @

bit.ly/Elevate2021Partnership

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Next Monthly Forum Call:

May 11th, 2021
1 -2 pm ET