



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



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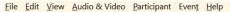


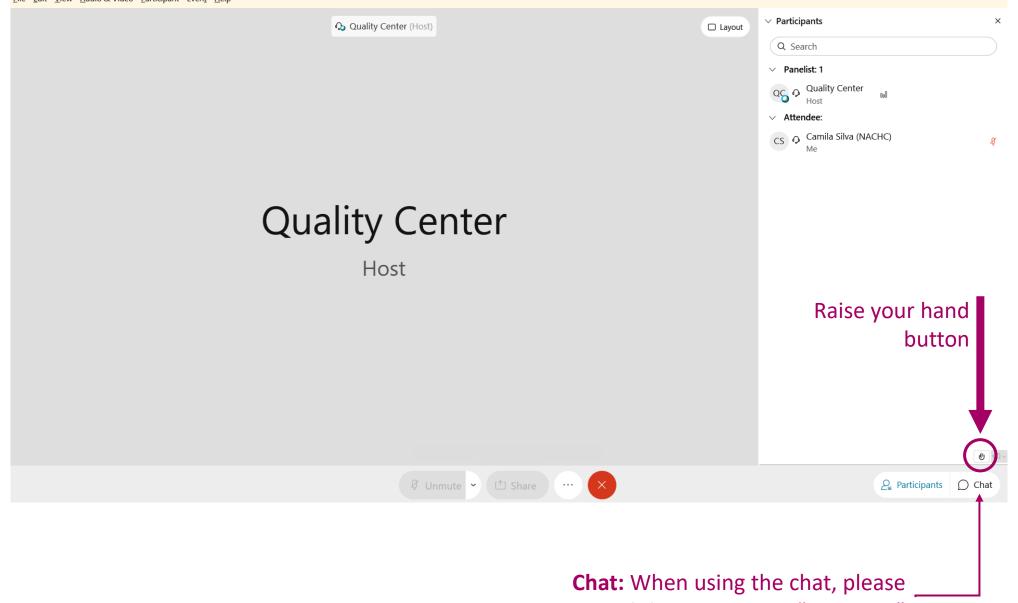
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send the message to "Everyone"

THE NACHC MISSION

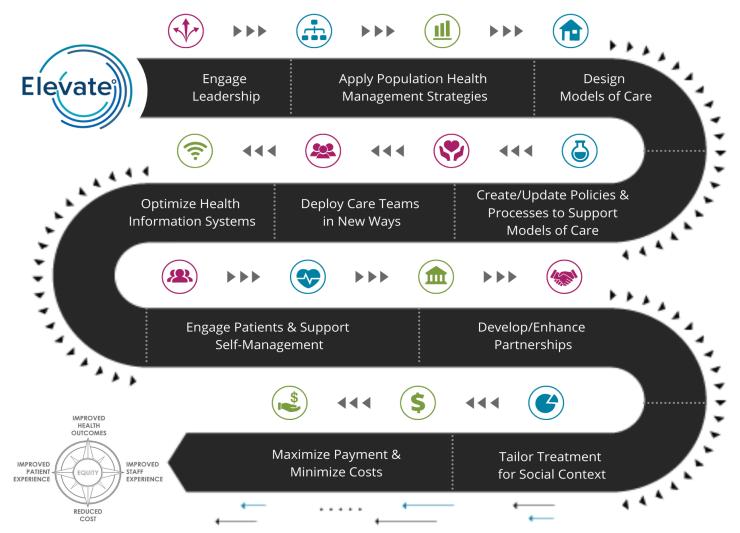
America's Voice for Community Health Care

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.





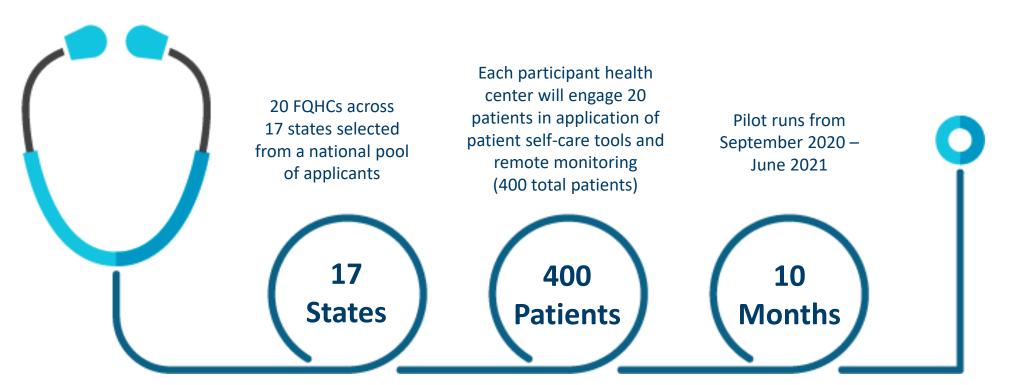
2021 Curriculum



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

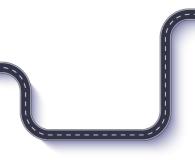


Mailable FIT testHome A1c testThermometerScalePatient Instructions and
Educational MaterialsPatient Logs and
Recording ToolsBlood pressure
monitor

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



mprovemen Strategy

Health Information Technology



. Management









Workforce



Transform Virtual Care

A step-by-step guide to integrate patient self-care tools into virtual care.

Part of a suite of resources to support your health center's journey to transform at-home care.

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

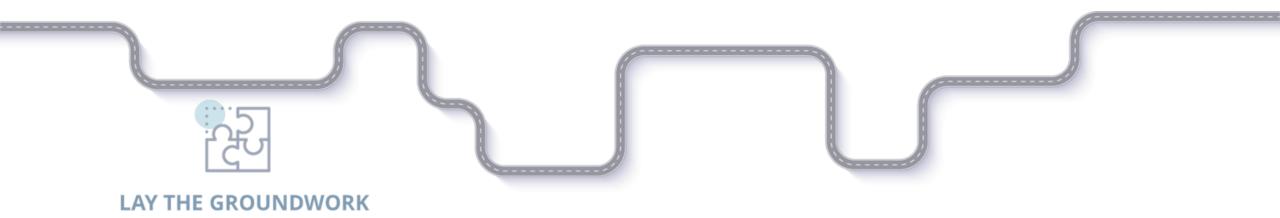
STEP 9 Distribute Kits and Provide Education and Training

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



VTF Assessment

Leadership email 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
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Patient Agreement Template

Data Collection Chart & Template

Patient Experience

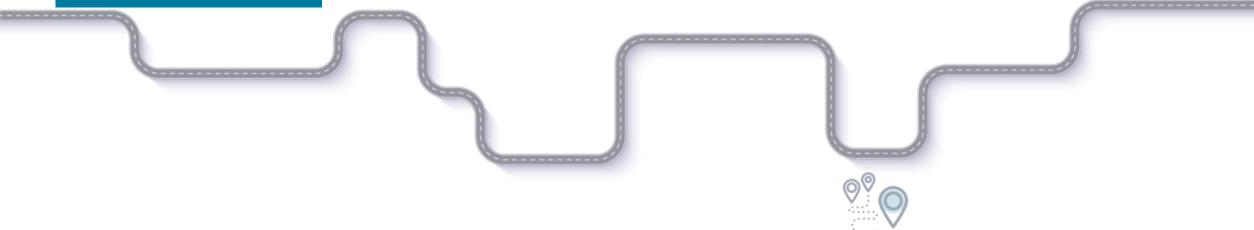
LAUNCH

STEP 8 Enroll Patients

STEP 9 Distribute Kits and Provide Education and Training

STEP 10 Complete Baseline Measurement and Collect Measures





IMPLEMENT

Patient Log

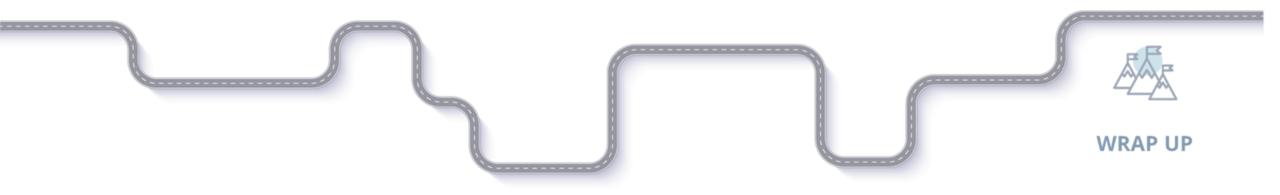


IMPLEMENT

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









Share Lessons

ASSESS AND EVALUATE

STEP 12 Report, Evaluate and Share Lessons Learned





ACCORDIA HEALTH Accordia Health

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

PRESENTING: SAMANTHA PETTAWAY, LICSW, PIP, MBA

APRIL 20, 2021



Introduction

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

IN 2018, <u>ALTAPOINTE HEALTH</u> ACQUIRED OUR FIRST FQHC LOOK-A-LIKE, <u>ACCORDIA HEALTH</u>.

SINCE THEN, <u>ACCORDIA HEALTH</u> 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#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#3: To increase overall patient engagement in their chronic health management.



2. Launch

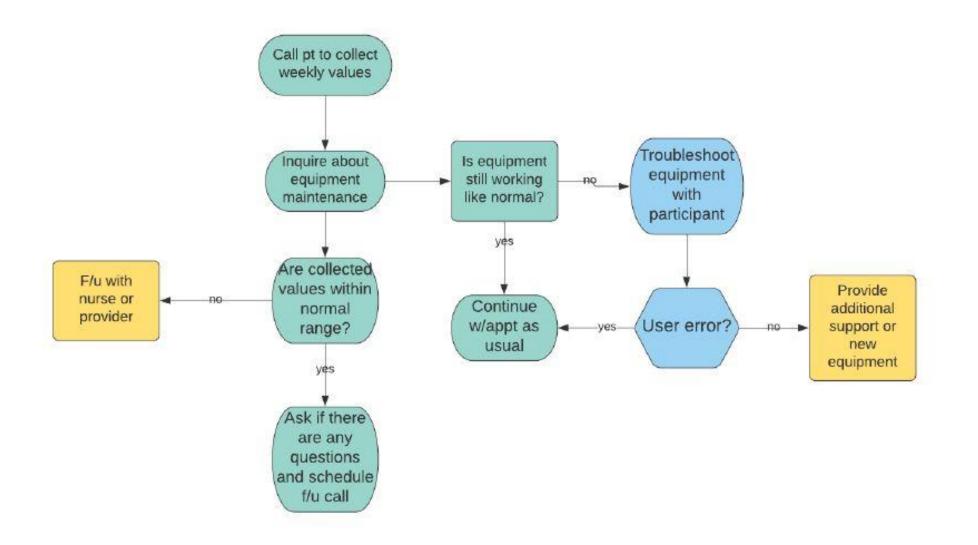
- Patient Identification and Recruitment
- Patient Care Kits
- In-clinic Baseline Visits

3. Implement



WEEKLY CHECK-INS WITH THE CARE COORDINATOR AND SOCIAL WORKER MONTHLY VIRTUAL VISITS WITH THE NURSE

FLOW CHART: Weekly Check-Ins



4. LessonsLearned andExperiences

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



A







Jeniqua Duncan, DO, MBA

Associate Medical Director





Getting Started



LAY THE GROUNDWORK



Established Team – dynamics already in place

Goal: Learn to improve the process

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Communicate!



LAY THE GROUNDWORK

Introductory video sent to entire corporation





The Back-End



LAY THE GROUNDWORK

25

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@NACHC f in Y

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







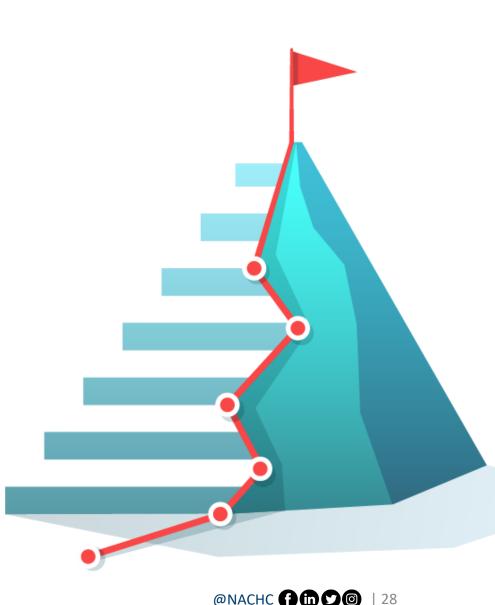
- Completed via Doxy.me
- Created HPI template in eCW to streamline documentation
- More frequent check-ins for some patients





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











ACTION GUIDE: Transform Virtual Care



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.



TANDONAL ADDICTATION OF

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.

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) <u>Value Transformation</u>. <u>Framework</u>, 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.







Transform Virtual Care

A step-by-step guide to integrate patient self-care tools into virtual care.

A suite of tools and resources to support health centers' journey to transform at-home care.

April 2021



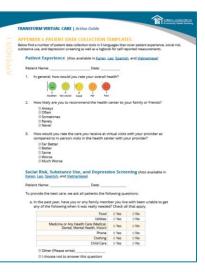
RANSFORM VIRTUAL CA	III I Consult faith Loting
KANSFORM VIRTUAL CA	ACTION GUIDE
APPENDIX F- PATIEN	AGREEMENT TEMPLATE
	ample Patient Agreement from NACHC's Leading Change: Transforming At-
Home project, click here.	the second se
Welcome to Your Patient Co	are Kid
Your provider and health cer set of tools and tips for betty	nter team are happy to give you this at home Patient Care Kit! It includes a or health.
With this Kit your health cen	ter team will.
- Teach you how to use eac	h tool at home.
· Help you eat better and s	tay active.
- Show you how to take you	ar medicine safely.
- Help you keep important	health appointments.
	the Patient Care Kit or the information you will get.
in you have questions about call	at (phone #)
Carl	et (prior tel v)
	rt Care Kit. I agree to work with my health center team to use these tools to tand this Kit is given to me as part of a program to help patients and their ter health at home.
I agree to be part of this pro	gram. I will:
- Complete one (1) colorect	tal cancer screening test.
	e Kic's blood glucose tests. (My provider will tell me how and when to do ts in the Kic. I will also continue to check my blood sugar (with fingersticks)
Use Patient Care Kit's sup	plies to measure my blood pressure, weight, and temperature.
- Write (record) my blood p	ressure, weight, and temperature in my "log".
- Report these readings to	my health center team.
Contact my doctor when:	
My blood pressure reading	g is more than
- My blood glucose reading	is more than
- My temperature is more t	han
health. If I no longer want to	s directed from [deta] - [deta]. I can keep the supplies to improve my be part of this program or use the Patient Care Kit, I can return the . If (do not use the Patient Care Kit, the health center can ask for the
I agree to participate in the I	Pacient Care Kit program:
Patient Name:	Medical Record #:
Patient Signature:	
Date:	
Staff confirming receipt and	training on Patient Care Kit (name):
Staff signature:	NUMBER OF STREET, STREE

Sample Patient Agreement

TRANSFORM VIRTUAL	CARE Act	lon Gulde			
APPENDIX G: DATA	COLLECTIO	ON CHART	& TEMPL	ATE	
The below chart provides	a list of poter	ntial data to c	ollect as par	t of your Patier	nt Care Kit
A downloadable 6-month	data collectio	on template is	available h	ere.	
	_			_	
DATA COLLECTION	Beginning of Program	As Completed	Each Visit	Ongoing/ Weekly	End of Progra
		Demographics	(UDS)		
Age	×				
Race	×				
Gender	x				
Insurance	×				
Diagnoses	×				
	1	ical (UDS), CHC	Reported		
BP	x	x			_
HbA1c	x	x			_
Body Mass Index (BMI)	×			_	_
Colorectal Cancer Screening (CRCS)	×				
Depression Screening	x	x			
		ient Generated/	Reported		
CRCS	×	x		_	_
Temp	×		x	x	_
Weight	×		x	x	_
Height	x		_	_	_
BP	x		x	x	_
Home A1c	×	3-4x			
NIO 3 (2 Occurring)		Social Risk			_
PHQ-2 (2 Questions)	×		+		
PRAPARE (8 Questions)* SBIRT screen (2 Questions)	×				-
SBIRT screen (2 Questions) Patient Experience Questions	x		+		_
Patient Experience Questions Staff Experience Ouestions			+		
	X				

Data Collection Chart & Template

Community Handha



Patient Data Collection Template

TRANSFORM VIRTUAL CARE | Action Guide

APPENDIX D: SAMPLE INSTRUCTIONS FOR STAFF Sample staff muldance includion item-builter considerations for staff instruction and training

Sample staff guidance, including item-by-item considerations for staff instruction and training, clinical guidance and resource links, and guidance around patient instructions and resource links. Note: be sure to adjust these Patient Care Kit instructions based on the specific tools and supplies in your health center's Kits.

PATIENT CARE KIT TOOL INSTRUCTIONS* (SAMPLE) Health centers can add/subtract to this set of tools based upon local needs, resources, and availability.

availability.

Sample Patient Care Kit tools address: colorectal cancer screening, diabetes, hypertension, and obesity.

Health center staff who work with patients revelving Patient Care Kits should be educated and trained to use each tool according to narrufucture instructions for use. The project implementation seam can as tup a virtual or in-person taining for all staff involved. Proper knowledge and handling of Kit supplies will be essential to providing patients with the right type of education. training, and support.

Kit instructions include references and links to clinical guidelines and NACHC resources for the clinical conditions supported by the Patient Care Kit tools used in the Leading Change. Transforming Al-Home Care plicit project. Staff may also refer to the list of suggested educational resources in the set of patient-facing materials compiled by NACHC's Quality Center.

For your health center's Patient Care Kit, consider the following items:

Category	Item	Health Center Supplied Item		
Colorectal Cancer Screening (CRCS)	Home CRCS Test	Gloves (1-2)		
Diabetes Control	Home A1c Kit	Finger stick supplies such as alcohol swabs, extra lancets, gauze pads, and Band Aids		
Blood Pressure Control	Home Blood Pressure Monitoring Device			
Weight Management	Bathroom Scale			
Temperature Monitoring	Digital Thermometer			

Staff Instructions & Training

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- Patient returns stool sample during one of the health center's drive by clinics.
 A staff member picks up the sample at the patient's home; pick-up could be in conjunction with delivery of medications, a home visit, or other services.
- 9 While patient mailing of samples back to be health center has been used in some instances, it could result in delays that render the sample invalid. The unusual size, shape, and cost of some CRCS test mailers can cause difficulty. Self mailers are NOT recommended. Tests that include pre-paid mailing labels and supplies can be used.

Examples of patient educational tools related to CRCS found in <u>NACHC's Evidence Based</u> Care: Cancer Screening Action Guide, include:

Northwestern University 5-minute video: Get Screened for Colorectal Cancer.

 Healthfinder.gov Shared Decision-Making Tool: <u>"Colorectal Cancer Screening: Which test</u> would I prefer?"

 CDC materials such as: <u>Colorectal Cancer Print Materials</u> including factsheets, booklets and brochures, and posters.

Patient Instructions

UPCOMING EVENTS



- \checkmark 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)





















Patients

Leadershij

VIRTUAL **BUSINESS CONTINUITY** INSTITUTE

WEBINAR 1: April 28, 2021 | 1-2:30 ET **Introduction to Business Continuity Planning**

WEBINAR 2: May 12, 2021 | 1-2:30 ET **Creating a Business Continuity Plan**

WEBINAR 3: May 26, 2021 | 1-2:30 ET **Ensuring a Human Resource Strategy** Scan QR code to register



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.





ement Health

Health Information Technology

4



h Patient Centered



Care







20

Workforce



dership

Partnership

Buying Home Blood Pressure Monitors to Support SMBP: How to Get Started

)illion Hearts

May 13th 12:30 pm - 2 pm ET



Scan QR code to register



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





Medical Home





Patients





Workforce



ommunity Health Centers VALUE TRANSFORMATION FRAMEWORK Action Guide @ HEALTH CENTER CARE DELIVERY (II) PEOPL

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⁽¹³⁾. 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 ⁴¹⁶. The

Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim (better

MANAGEMENT The Value addresses how health centers ca care and manage high-risk and oth lines steps health centers car igh-risk patients that meets the Medicaid Services (CMS).

CARE

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, better patient and provider experiences, and lower costs)?.

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 NAME



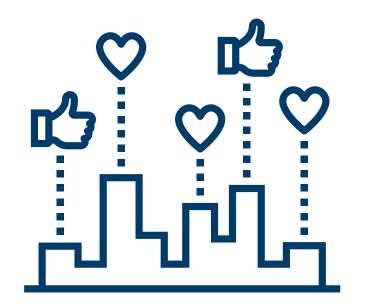
May 19th & June 2nd

Management

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:

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Next Monthly Forum Call:

May 11th, 2021 1 -2 pm ET

