NATIONAL ASSOCIATION OF
Community Health Centers®

Leading Change: Transforming At-Home Care

Implementation Highlights

Leading Change and transforming at-home care using systems change to:

- *Respond* to a pandemic
- *Lead* innovation
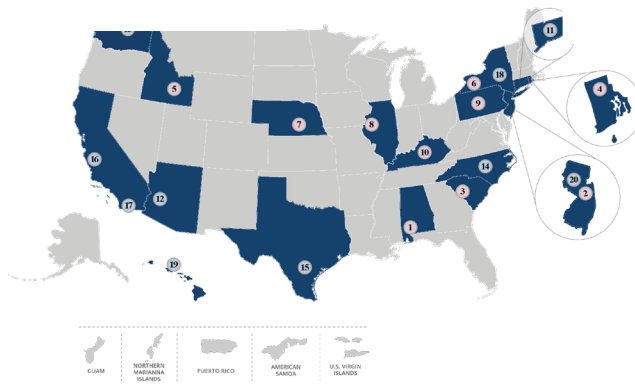- *Reinvent* virtual care

Project Overview

One of the Quality Center's newest and most groundbreaking initiatives, *Leading Change: Transforming At-Home Care*, mobilized 20 health centers in 17 states to pilot an innovative, patient-empowering model of virtual care for high-risk patients.

The central feature of this pilot was a set of self-care tools for at-home monitoring. These included a blood pressure monitor, a home colorectal cancer screening test, home A1c tests, scale, and thermometer. These tools were given to patients and coupled with educational instruction and consistent care team support provided virtually, in the comfort of patients' homes.

Each of the 20 health centers selected to participate in this pilot between September 2020 – June 2021 followed a standardized project Roadmap (see page 5). The health centers were also given the latitude to provide transformational virtual care in a manner and way that met the needs of their health center and selected patients. By participating in NACHC's Elevate learning forum, health centers enrolled in this pilot were connected to the Value Transformation Framework and its robust portfolio of tools and resources to support success.

This document outlines the *Leading Change: Transforming At-Home Care* Roadmap, highlights from participating health centers, and lessons learned.

GUAM | NORTHERN MARIANNA ISLANDS | PUERTO RICO | AMERICAN SAMOA | U.S. VIRGIN ISLANDS

1 ACCORDIA HEALTH	11 CHARTER OAK HEALTH CENTER, INC.
2 ALLIANCE COMMUITY HEALTHCARE	12 COMPREHENSIVE HEALTH CENTER-PHOENIX
3 CARESOUTH CAROLINA, INC.	13 INTERNATIONAL COMMUNITY HEALTH SERVICES
4 EAST BAY COMMUNITY ACTION PROGRAM	14 KINTEGRA
5 KANIKSU COMMUNITY HEALTH	15 LONE STAR CIRCLE OF CARE
6 OAK ORCHARD HEALTH	16 NATIVE AMERICAN HEALTH CENTER
7 ONEWORLD COMMUNITY HEALTH CENTER	17 FAMILY HEALTH MATTERS CHC
8 SHAWNEE HEALTH SERVICE	18 OPEN DOOR FAMILY MEDICAL CENTER
9 THE WRIGHT CENTER FOR COMMUNITY HEALTH	19 THE WAHIAWA CENTER FOR COMMUNITY HEALTH
10 WHITE HOUSE CLINICS	20 ZUFALL HEALTH CENTER

Project Goals

The Leading Change: Transforming At-Home Care pilot project:

- **Tested 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
- **Developed workflows and protocols for virtual care management and monitoring** offered by health centers
- **Documented 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 experience, lower costs, and improved equity.

Value Transformation Framework

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

Patient Care Kits Included

- Screening and monitoring tools for a set of common, high-cost chronic and preventive conditions:
  - Home colorectal cancer screening (stool) test
  - Home blood sugar (A1c) tests
  - Blood pressure monitor
  - Thermometer
  - Scale
- Patient educational and instructional materials
- Patient measurement and recording logs and tools

Project Implementation

Each of the 20 participant health centers followed the common project Roadmap (see page 5) while crafting a strategy that fit with their organizational culture, staffing capabilities, and patients served.

The NACHC project team guided participating health centers throughout the 10-month pilot engagement period. NACHC also provided educational and instructional materials, live training events, and relevant step-by-step written guides to support their efforts.

Participating health centers received Patient Care Kit supplies for 20 high-risk patients and were responsible for storing, assembling, and distributing the Kits.

Eligible participants were identified through a risk stratification process, using either NACHC's Risk Stratification Action Guide or an existing health center process. The health centers then extended invitations to prospective participants. The minimum eligibility criteria included individuals aged 50-75 years old with two or more chronic conditions, including diabetes. Participating health centers considered other factors, such as: patients with high blood pressure, patients due for colorectal cancer screening, and patients who would generally benefit from the at-home monitoring tools and care management or similar support. Considerations were also made for: available technology, referral by a member of the care team, or whether a patient had been seen within the last year.

A baseline visit was scheduled to provide the Patient Care Kit to each patient along with instruction and training on how to use the tools and how to report measurements over the course of the program. As part of the baseline visit, data was gathered on social risk (part of NACHC's PRAPARE® tool), depression screening (PHQ-2), drug and alcohol screening (SBIRT), and patient experience. The majority of participant health centers reported this initial visit took about an hour, with most of the health centers conducting the baseline visit in person before moving to virtual use of the Kit.

The program asked each health center to conduct at least monthly video visits and/or check-ins for the duration of the project. Many of the health centers chose to maintain more frequent contact, including weekly texts or phone calls. While some health center staff would spend up to an hour with patients during monthly visits, others would conduct a short check-in of 15 minutes or less.
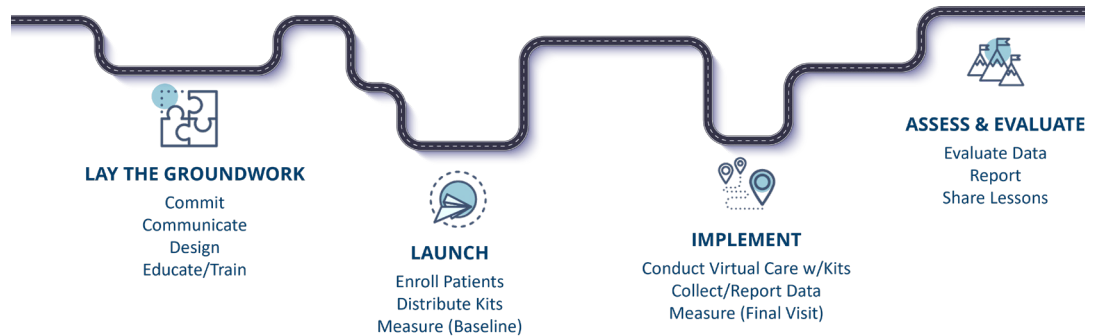
Health centers were asked to conduct a final patient visit at the close of the six month intervention window to gather final measurements, including post-data for social risk, depression screening, and patient experience.

The Journey & Lessons Learned

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
Measure (Final Visit)

ASSESS & EVALUATE
Evaluate Data
Report
Share Lessons

Health centers participating in this project were guided in four phases of program implementation (see above Roadmap). NACHC's Quality Center gathered information each step of the way to learn about each health center's experience and understand whether and how this type of initiative could be implemented on a broader, national level. The steps, defined more completely in the *Leading Change: Transform Virtual Care* guide, are summarized here with the most helpful lessons learned.

Phase 1: Lay The Groundwork

✓ **Step 1: Commit.** Identify leads. Define success.

✓ **Step 2: Communicate.** Inform all staff of efforts & goals.

✓ **Step 3: Assess.** Complete VTF Assessment to evaluate systems change over time.

✓ **Step 4: Identify eligible patients.** Complete risk stratification.

✓ **Step 5**: **Develop workflows.** Document patient visit processes and staff workflows.

✓ **Step 6: Assemble Patient Care Kits.**

✓ **Step 7: Educate and Train staff** in Kit tools & patient self-measurement.

Lessons Learned:

- **Involve & engage senior leadership from the beginning.** Consider having senior leader(s) deliver a video message to launch and endorse this effort.

- **Block time in staff schedule for this work.** Build in time for new role(s) and the work it entails; avoid viewing it as a 'side' job.

- **Communicate to the community.** Share information on your health center's new, innovative approaches via a press release or other community messaging.

- **Create a list of eligible patients** (double the size needed). Build a list of eligible patients, with recognition that some patients don't have the technology needed to have video visits, cannot be reached, or are not interested.

- **Train staff.** Consider creating a training video or recording that staff can view at their convenience. This helps ensure sustainability in times of staff turnover. Manufacturers of selected self-care tools can be a source of free training.

**Phase 1:
Lay The
Groundwork**
continued

Lessons Learned continued:

- **Choose evidence-based, easy to use devices.** Select devices for your Patient Care Kits that are easy for patients to use and are validated and/or have evidence they are effective. Offer instructional materials and troubleshooting.

- **Document workflows and job roles prior to launch.** Allow sufficient time to develop workflows, staff education, and patient instructional and educational materials.

- **Utilize staffing models that include the extended team.** Consider use of pharmacists, nutritionists, community health workers, and other extended members of the care team. Focus on a few lead providers. Having more than one provider allows for different perspectives and a way to build flexible models; while concentrating on a few leads allows for stronger coordination and efficiency.

Health Center Highlights:

The Associate Medical Director of [CareSouth Carolina, Inc.](#) (SC) used video recordings to creatively communicate to all staff about the project and to train the involved staff to use the Patient Care Kit devices and related workflows. Community Health Workers played a critical role in patient recruitment and engagement.

Staff and patient training were integral to [Zufall Health Center's](#) (NJ) program. They attribute much of their project success to a new position developed for the pilot, a 'Project Implementation Assistant'. This individual coordinated the team, which included an RN Case Manager (who identified patients), the Primary Care Physician (who identified "ready" patients), the Clinical Pharmacist (who trained staff on Kit materials), and the Director of Nursing. A Case Manager provided additional training and support to patients. The multilingual Pharmacist could conduct monthly visits when a provider visit wasn't required and assisted with data collection.

Patients at [Oak Orchard Health](#) (NY) were selected from among those enrolled in their Chronic Care Management program. To make access to virtual visits as easy as possible, the front desk staff would connect patients to the portal via a simple email link. Immediately before the virtual visit, a nurse called patients to learn about allergies and medications, update health histories, chart data for the pilot, and ensure the patient was ready for the telehealth appointment.

[OneWorld Community Health Center's](#) (NE) Clinical Pharmacist was tapped to leverage her experience with blood pressure cuffs and the other at-home monitoring tools to train patients. The Pharmacist became the health center's key advocate, project leader, and trainer for the tools in the Patient Care Kit. The Certified Diabetes Educator, an RN, teamed up with the Pharmacist to conduct monthly visits, engage in motivational interviewing, and enter data.

> *Our greatest take-away is that providing patients care for their chronic conditions remotely is possible...Through the project, our clinic was given the opportunity to provide patients care in the safety of their homes, build stronger relationships with patients, and develop and implement new workflows.*
>
> ~ [Family Health Matters Community Health Center, CA](#)

**Phase 2:
Launch**

✓ **Step 8: Invite & Enroll** patients.

✓ **Step 9: Distribute Patient Care Kits.** Educate and train patients.

✓ **Step 10: Measure.** Complete baseline visit and collect data.

Lessons Learned:

- **Ensure accountability for Patient Care Kits.** Designate a staff lead to receive the patient self-care tools and assemble/distribute the Kits.

- **Account for device failures when ordering supplies.** Allow for some overage when ordering Patient Care Kit supplies to account for device failures or inaccuracies; test all equipment with patients or staff prior to distributing.

- **Communicate provider recommendation.** When inviting patients, emphasize patient was recommended by their provider.

- **Assess patient readiness.** Utilize a tool or set of questions to assess patients' readiness to commit to long-term engagement in using self-care tools as part of virtual care. Invite patients who have been "active" in the last year.

- **Use a Patient Agreement.** Create a written document that outlines expectations for both the patient and health center, including guidance around keeping/returning of Patient Care Kit tools.

- **Launch virtual care using self-care tools with an in-person visit.** Conduct the baseline visit at the health center or in patients' home to provide the level of hands-on training and education needed for successful virtual use of self-care tools. Do a practice virtual visit while in-person.

- **Engage patients' families & support systems.** Invite family members to baseline visits and/or conduct visits in the home so that family/significant other 'buddies' are trained in devices and can help patients troubleshoot or record their data.

Health Center Highlights:

At Open Door Family Medical Center (NY), the Community Health Nurse was the frontline connection to patients enrolled in the program, which also opened the door to address patient social risks. In one example, a patient was connected to financial support for her diabetic medication, a nutritionist, and a Care Manager for ongoing diabetes education and management.

Shawnee Health Service's (IL) clinical Nursing Supervisor partnered with the Care Manager to implement this program. They went the extra step at the onset of the project to bring the Patient Care Kits to patients' home and provide personalized instruction and guidance in using all the tools. They also placed heavy emphasis on providing continuous patient encouragement and praise. When asked about recommendations regarding the contents of future Kits, they suggested including glucometers and pulse oximeters.

> " *Many of our patients work or worked in the mines. Many have lung disease so tracking their oxygen levels at home would be very helpful.* "
>
> ~ Shawnee Health Service, IL

**Phase 2:
Launch**
continued

Health Center Highlights continued:

The Director of Quality Assurance and Chronic Care Management Assistant Director at Accordia Health (AL) connected this program to their Chronic Care Management program. An alert was placed in the EMR so all staff knew a patient was participating. The Care Manager and Social Worker maintained weekly patient contact and monthly check-ins, providing support and encouragement and creating a connected, team effort.

Lone Star Circle of Care (TX) utilized a customized, structured field in their medical records to note if a patient used telemedicine and had success with it or not. Patients who felt comfortable using the patient portal could upload data themselves.

Alliance Community Healthcare (NJ) developed a new documentation system in the patient portal so information about patient education and vitals could be uploaded by the patient and care team as part of the patient's care plan. The Care Coordinator conducted weekly check-ins and sent regular texts to remind patients to upload their data.

**Phase 3:
Implement**

✓ **Step 11: Conduct monthly virtual visits with Patient Care Kits.** Collect and report data.

Lessons Learned:

- **Give patients a roadmap.** Schedule patient's check-ins (weekly, monthly, etc.) several months in advance so they have a 'map' of when follow-up will occur.
- **Be flexible with technology.** Remain flexible to meet patients where they are in their different levels of ability to interact with technology and remote monitoring devices.
- **Keep patients connected & engaged.** Utilize frequent, brief check-ins (e.g., weekly call/text/email) to keep patients connected. Incentives (e.g., groceries, gift cards, "swag" items) can help keep patients motivated.
- **Monitor whole-person needs.** Virtual visits provide a lens into patient status that may not otherwise have been known (e.g., need for medication adjustment, nutrition needs, etc.).
- **Create a feedback loop** between the provider and care team. Communicate virtual care data and experience back to the care team; use information to drive care.

Health Center Highlights:

Two days before virtual appointments, the Wahiawa Center for Community Health (HI) set up a process so patients could complete assessment/screening forms (e.g., PRAPARE®, PHQ-2, etc.) and send in their home monitoring data. Automated phone call, email, or text messages were used to remind patients. The Medical Assistant would review paperwork to ensure completeness, prepare referrals based on the social risk data, and alert the provider about issues and concerns. As needed, referrals, patient education, training, and other support were offered.

Phase 3: Implement *continued*

Health Center Highlights continued:

Charter Oak Health Center (CT) used Community Health Workers to screen patients for social determinants and identify barriers to virtual visits. The team was able to meet some of the identified needs through gift cards and food vouchers.

Kintegra Health's (NC) Director of Population Health, a lead RN, LPN, and Diabetic Navigator joined forces for this pilot. The Diabetic Navigator credits weekly touchpoints with patients as a significant part of their success, allowing them to address many issues, such as offering immediate hospitalization to one patient who was experiencing a severe psychiatric issue.

At Native American Health Center (CA), the Patient Care Kits were deployed to some individuals experiencing homelessness or unstable housing, limited access to food, and other social risks. The health center experienced how difficult it is for patients facing these many challenges to stay engaged.

Nurse Care Managers at East Bay Community Action Program (RI) conducted weekly virtual or telephone check-ins with participating patients and travelled to patients' homes monthly, if needed, to ensure equipment and technology worked properly.

Community Health Workers (CHW) were essential to The Wright Center for Community Health's (PA) program. They developed pre-visit planning protocols in the care team workflow so the CHWs could help collect data from patients, assist with follow-up between visits, and help patients with questions and their equipment. When patient engagement started to wean, a project lead from the health center added more patient touchpoints which had a positive impact.

> " *The greatest lesson we learned from this project has been to gauge a patient's readiness to make lifestyle changes before starting. I really enjoyed building strong relationships with the patients in the program and building stronger communication within clinic staff as well.* "
>
> ~ Lone Star Circle of Care, TX

**Phase 4:
Assess
& Evaluate**

✓ **Step 12:** **Report.** Evaluate and share lessons learned. During this pilot, 385 patients received Patient Care Kits and ongoing support as part of virtual care. Data (clinical, social risk, patient experience) at the local level has been used to drive ongoing care. Analysis of the overall program data is underway and will drive future national program efforts.

Health Center Highlights:

At White House Clinics (KY), the Clinical Data Analyist, Director of Clinical Services, and Community Health Worker stayed in close contact to follow-up with data collection throughout the pilot, making sure the FIT test was completed and A1c tests were performed properly. Telephone calls with motivational interviewing helped patients overcome barriers and stay engaged.

All participants at Family Matters Community Health Center (CA) were assigned a staff person to help them gather and record data. The Quality Practice Specialist, non-medical Health Scholars, Care Managers, Medical Assistants, the Medical Provider, and Pharmacy staff worked together to help keep patients on track.

Comprehensive Health Center (AZ) shared the importance of incorporating these visits and care coordination into the workflow.

> ❝ *This project opened our eyes to the intense degree of coordination needed to conduct regular virtual visits, and the training necessary to help patients with home equipment. We will utilize what was learned here in other programs throughout our clinic.* ❞

One patient's success story at Kaniksu Community Health (ID) began because she used the blood pressure monitor in the Kit to record her blood pressure daily after being trained by the Care Manager. The patient was found to have undiagnosed hypertension and was prescribed medication to address this problem.

Another success story comes from an uninsured Somali patient at International Community Health Services (WA) with high blood pressure (BP), diabetes, lipidemia, and transportation issues. Through the program, she dropped 10lbs, decreased her blood pressure, and reduced her HbA1c from 8.0 to 7.30 -- all in five months. The patient was proud of her ability to monitor her weight and blood pressure at home and is empowered to be an active participant in her care.

> ❝ *One patient who suffered from depression really appreciated the check-ins and for the chance to have a 'talk story' and receive words of encouragement.* ❞
>
> ~ The Wahiawa Center for Community Health, HI

> ❝ *Patients felt heard and supported, especially through the COVID-19 crisis, and we have been able to identify several patients in need of behavioral health support through this program.* ❞
>
> ~ Zufall Health Center, NJ

Findings

When health centers stepped away from common practice and offered patients a structured virtual care program, including carefully selected, practical tools to help patients measure and monitor their own blood pressure, blood sugar, weight, and risks for colorectal cancer, **patients became empowered**.

Both providers and patients **noticed improvements in self-care knowledge and patient wellbeing**, along with **improvements in both individual and population health metrics**.

This pilot project allowed clinic staff to **build stronger relationships with their most at-risk patients,** and develop and implement new, **successful workflows for continuous care.**

At the beginning, there was concern that the pandemic would lead to reduced care for vulnerable patients, but by participating in this program, high-risk patients were able to stay in touch with their care team and improve their health.

Analysis of quantitative data related to patient experience, staff experience, and clinical measures, is underway and will be released soon.

> *At-Home chronic care management can work!*
> ~ International Community Health Services, WA