Levering Alternative Care Delivery Models, Data, and Technology to Maintain Access to Care

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CCI health & wellness services

Audience Participation

Chat

Polling

mission/vision

We are a **group** practice, **empowering** patients to partner with staff for an **unparalleled** healthcare experience. Through **integrated** teams in a learning environment, we deliver high **quality**, affordable **care** to **every** patient during all stages of **life**.

105,056
Visits

33,445
Community Members Served Annually

337
Employees

13
Pratice Sites

Payor Mix

- 50% Medicaid
- 38% Uninsured
- 8% Private Insurance
- 4% Medicare

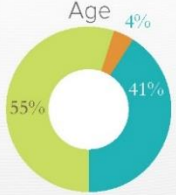
Maryland WIC
Better Nutrition Brighter Future

We served
29,947
WIC Participants.

Our Breastfeeding initiation rate was
88.2%
the highest in the state of Maryland.

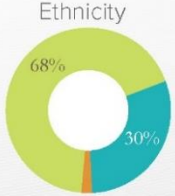
Who We Serve

Age



- Children <18
- Adults 18-64
- Older Adults 65+

Ethnicity



- Non-Hispanic Latino
- Hispanic / Latino
- Unreported

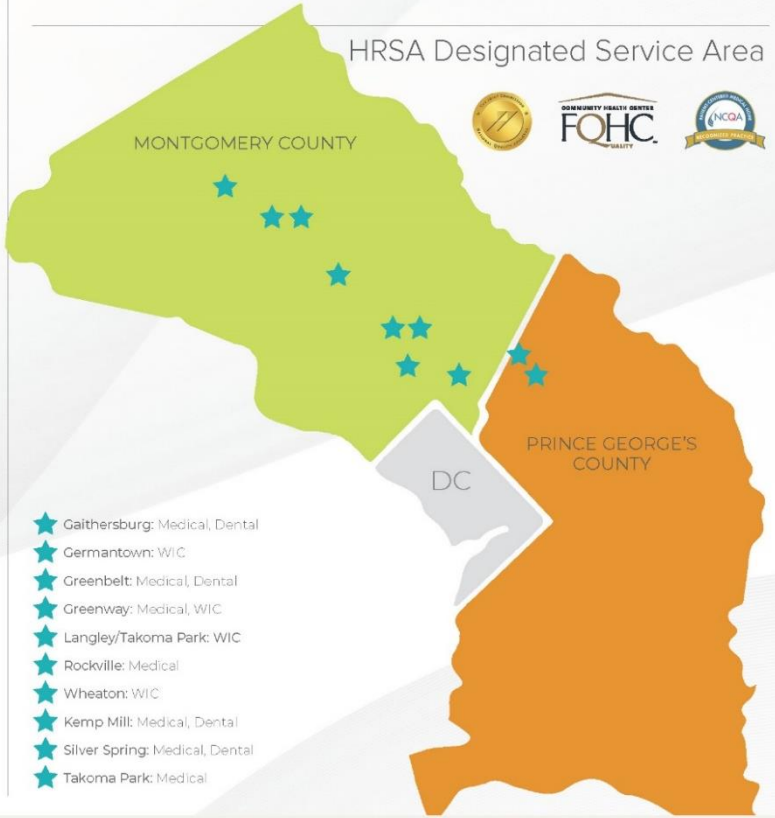
Race

38% White
30% Unreported
17% Black / African American
9% American Indian / Alaska Native
4% Asian
0% Native Hawaiian
1% More than one race

66% of our patients best served in a language other than English

Visits by Service

HRSA Designated Service Area



- Gaithersburg: Medical, Dental
- Germantown: WIC
- Greenbelt: Medical, Dental
- Greenway: Medical, WIC
- Langley/Takoma Park: WIC
- Rockville: Medical
- Wheaton: WIC
- Kemp Mill: Medical, Dental
- Silver Spring: Medical, Dental
- Takoma Park: Medical

Centering®

Centering

CenteringPregnancy is an innovative model of group prenatal care that integrates individual health assessments and interactive education on prenatal and infant care topics. CenteringPregnancy brings together a group of 8 to 12 patients in close gestational age to receive care together in ten two-hour sessions over a six-month period.

CenteringParenting **picks up right where CenteringPregnancy leaves off** – after delivery, groups of 6-8 moms and babies gather together for the first two years of the infant's lives to continue the interactive learning, health assessments, and community building fostered in CenteringPregnancy.

In 2015, CCI's prenatal team launched CenteringPregnancy. CCI is one of four accredited Centering® sites in Maryland and the only accredited site in Prince George's County by the Centering Healthcare Institute®.

Centering: Outcomes

Mothers who Received Early Prenatal Care

54.7% Prince George's County Black, non-Hispanic/Hispanic

67% CCI Centering Patients

Live Births Born Preterm

10.8% Prince George's County

6.8% CCI Centering Patients

Low Birth Weight

9.8% Prince George's County

5.5% CCI Centering Patients

COVID-19

COVID-19

- **COVID in Maryland**
  - **On March 5th**, Larry Hogan, the Governor of Maryland, reported the first three confirmed COVID-19 cases in Montgomery County.
  - **On March 9th**, Prince George's County Executive Angela Alsobrooks announced the first three positive cases in Prince George's County.
  - **Week of March 16th** CCI began working to establish its telehealth program to ensure patients had continuous access to services.
  - **On March 17th**, a single-day 54% increase in confirmed COVID-19 cases. The following two weeks, the number increased by 523.8%.
- **The need for services**
  - Important to try to maintain normal operating procedure due to the high volume of high-risk patients, no shows, and lack of County operated services
- **Pre-COVID: Where we were with Telehealth**

How?

Centering

- **Technology Platforms**
  - Zoom vs. Doxy
- **Team Engagement**
- **Piloting semi virtual care with the October & November Cohorts**
  - Purchased 25 fetal dopplers, blood pressure cuffs, and weight scales

COVID Centering Cohorts

- **March 2020:** 6 active cohorts at the start of COVID

- **April 2020:** 2 hybrid cohorts
  - Brought in only for pertinent visits
  - Patient alternated telemedicine sessions and in person sessions.

- **April 2020:** 4 cohorts transitioned to one-one visits with providers and then would have a video session for their “circle up” time.
  - Initially, video sessions would be on the following week from the one to one appointments. It was expressed by providers having video sessions on same day as one-one would be more manageable.
  - Adjusted: now have 1:1 sessions in the am and the video session in the afternoon from 1pm-2pm.

Technology Training: Staff & Patients

- **Staff**
  - Zoom Overview
  - Leveraged outside training

- **Patients**
  - Created handouts
  - MAs and CHW played an intricate role in assisting patients with downloading and learning how to log into zoom
  - PR staff assisting with outreaching to patients to get onto session
  - Recently added the MCH Programs Coordinator to be the Zoom facilitator to handle all technical issues with zoom

Challenges

Challenges

- **Technology**
  - Patient connection
  - Site ability to connect

- **Scheduling**
  - Video sessions on alternating days proved tiresome and difficult to keep up with on all ends.
  - Coordination of the videos and scheduling troublesome with the new virtual format- sometimes team members not on the same page
  - Patients not being scheduled on the days they should

Successes!

Successes

- **Incentives in a virtual format**
  - Instead incentivizing the in-person appointment we now incentivize the video sessions to increase attendance and participation
- **Virtual group participation**
  - Increased group participation max amount of participants on one session to date 10!!!
- **Provider by in**
  - Push on the providers end to encourage patients to join virtual groups has been successful. Providers know the benefits.

Lidia Cabrera Hernandez, a member of the CenteringPregnancy July Cohort, expressed that she was really happy with the video session. She states she was able to stay home without having to go outside during the pandemic.

She loved that everyone had an opportunity to speak and respected each other time to talk.

She expressed that “everything was great. There is nothing I would say needs to change. I enjoyed it all.”

Lessons Learned

Lessons Learned

- **Technology**
  - Invest in microphones and speakers
- **Messaging to Patients**
  - Creating a “how to” guide for Zoom
  - Stressing the importance of attending video sessions
- **Incentivizing patients**
- **Let go of perfection**

“Many times what we perceive as an error or failure is actually a gift. And eventually we find that lessons learned from that discouraging experience prove to be of great worth.”

— **Richelle E. Goodrich**

Transitioning Comprehensive Diabetes Care during COVID-19

Presented By: Kaely Burgess

Health Ministries Clinic
COMMUNITY HEALTH CENTER

Objectives

- Provide a background of HMC's Diabetes management program
- Provide actionable steps to implement sustainable process improvement
- How to use a population health management and analytics system to respond to Social Determinants of Health (SDOH) data
- Discuss the process for transitioning diabetes care during COVID-19

Health Ministries Clinic

To promote and improve the quality of life by providing integrated healthcare services to the entire community in the name and spirit of Christ.

- FQHC for Harvey County, KS
  - Operates 4 Locations
- Services Provided:
  - Medical
  - Dental
  - Behavioral Health
  - Pharmacy
  - Various Assistive Services

Background

- Grant for pilot project in 2019
  - Sunflower Health Plan
  - Community Care Network of Kansas
- Initial target—Hispanic patients with diabetes
  - Services were available to all patients
- Provide comprehensive diabetes care with an emphasis on SDOH

COMMUNITY CARE NETWORK OF KANSAS

Health. Equity. Justice.

sunflower health plan™

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Goals for Project

- HMC would provide
  - Educational opportunities
  - Clinic-based coaching
  - Behavioral and process changes to achieve measurable improvement
- Process transformation included
  - Integration of evidence-based, best practices into clinic workflow
  - Educational opportunities
  - Launch and utilization of a SDOH collection tool

Hiring

- Initial Request for Proposal—Community Health Worker (CHW)
  - “The CHW will establish relationships with the target population, identify barriers, coach patients to manage their diabetes, and help them access resources. The CHW will also provide for related staff education, and help design changes in workflow that will support evidence-based practices to improve outcomes.”
- Nurse
  - Bilingual
  - Knowledge of the community

Steps for Implementation

- Referral Workflow
  - Warm Hand-off
- Care Coordination
  - Develop a integrated and collaborative relationship
- Develop education format
  - Tailoring education to patient
    - Not just giving patients general folder
    - Making changes specific to patient (i.e., taking culture into account, habits, etc.)
- Implementing SDOH screening

SDOH

- "Medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population."
- PRAPARE
- Action Plan—Determine how to best accomplish task, and potential barriers to broader implementation
- Gather data

Social Determinants of Health Action Plan

Health Ministries Clinic

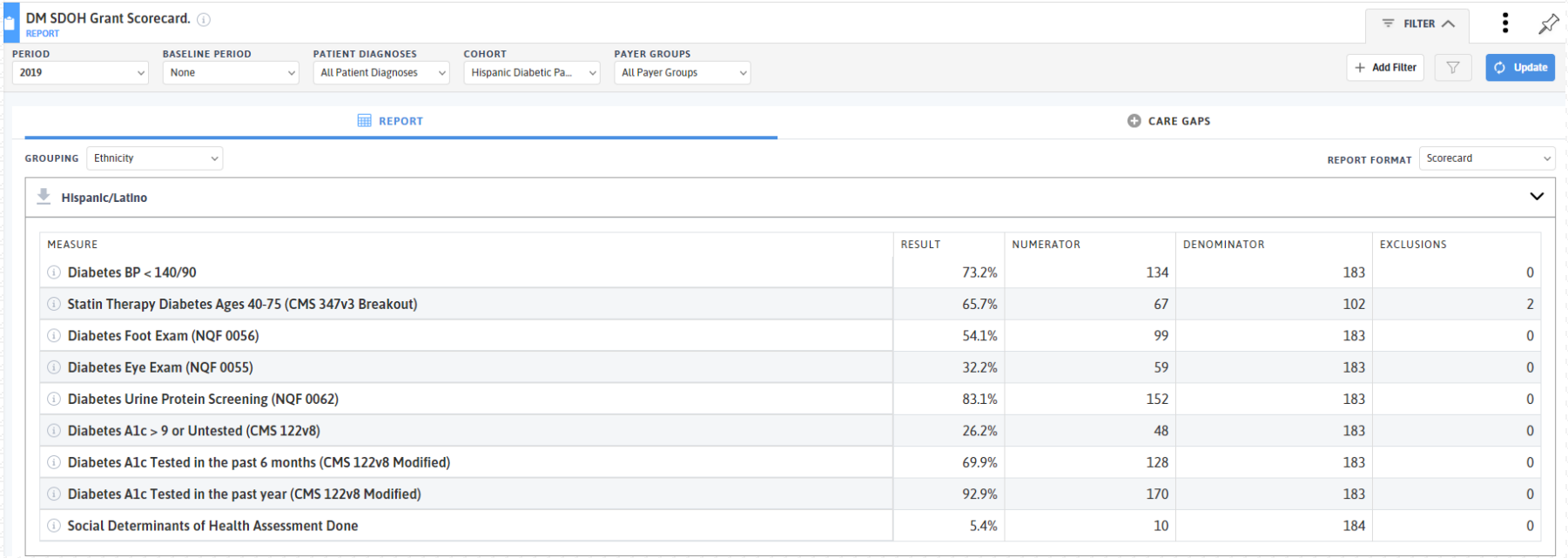
2019

Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201710c

Leveraging Data

- Azara—Data Reporting & Visualization System “DRVS”
  - Access data in a quick and efficient manner
  - Build Scorecards, Data Sets, Cohorts, etc.
- Notifications in Pre-Visit Planning
  - Required for Maintenance of Diabetes
  - SDOH identified

Data Sets



MEASURE	RESULT	NUMERATOR	DENOMINATOR	EXCLUSIONS
Diabetes BP < 140/90	73.2%	134	183	0
Statin Therapy Diabetes Ages 40-75 (CMS 347v3 Breakout)	65.7%	67	102	2
Diabetes Foot Exam (NQF 0056)	54.1%	99	183	0
Diabetes Eye Exam (NQF 0055)	32.2%	59	183	0
Diabetes Urine Protein Screening (NQF 0062)	83.1%	152	183	0
Diabetes A1c > 9 or Untested (CMS 122v8)	26.2%	48	183	0
Diabetes A1c Tested in the past 6 months (CMS 122v8 Modified)	69.9%	128	183	0
Diabetes A1c Tested in the past year (CMS 122v8 Modified)	92.9%	170	183	0
Social Determinants of Health Assessment Done	5.4%	10	184	0

DM SDOH

DASHBOARD

FILTER

PERIOD: 2019

RENDERING PROVIDER: All Rendering Provid...

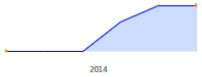
ETHNICITY: All Ethnicity

Add Filter | Update

Total Diabetic Patients

1,410

Pts w/ Diabetes



DM Active Patient, No Visit

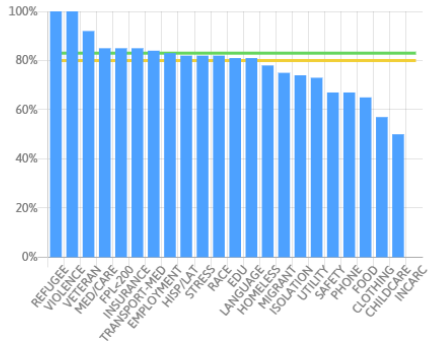
347

Pts without Qualifying Encounter in past 12 months

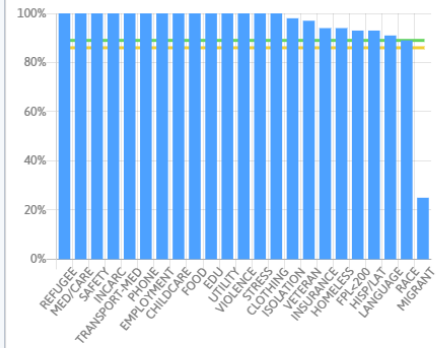
No-Show

SERVICE LINE	RESULT	NUM	DENOM
Behavioral Health	0.0%	0	8
Dental	25.0%	1	4
Ignore	5.0%	583	11,631
Primary Care	1.4%	8	583
Specialty	0.0%	0	1

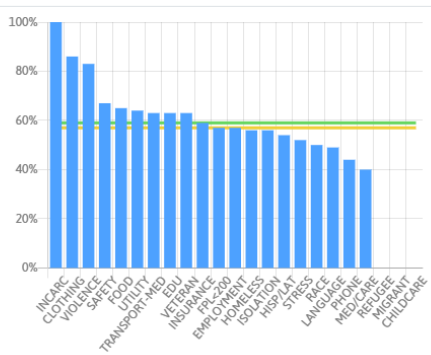
Microalbumin by SDOH



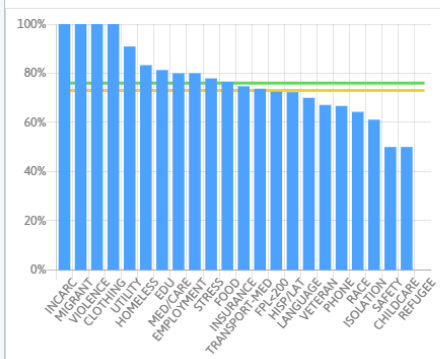
A1C by SDOH



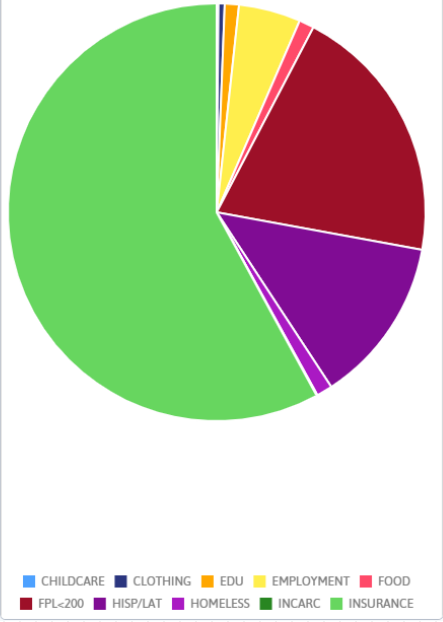
LDL by SDOH (<130)



Blood Pressure SDOH



DM By SDOH



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Health Outcomes

Outcomes are based on target population for project.

Measure	Initial	End
Diabetes: Eye Exam	21.4%	54.8%
Diabetes: Foot Exam	12.5%	52.0%
Diabetes: HbA1c Poor Control (>9%) (Inverse Measure)	100%	87.1%
Diabetes: HbA1c Testing	10.7%	83.9%
Diabetes: Medical Attention for Nephropathy	32.1%	80.7%
Controlling High Blood Pressure	0.0%	0.00%
Diabetes Screening for people with Schizophrenia/Bipolar who are antipsychotic medications	0.0%	87.5%
Weight assessment and counseling for nutrition and physical activity for children and adolescents	0.0%	49.2%
Gather SDOH Data	0	334
Goal was a 5% improvement for all measures		

Stories

- 48-year old Hispanic female:
  - Spoke only Spanish
  - Uninsured
  - Family history of diabetes
  - Overweight
- HMC Provided:
  - Counseling and resources in her native language
- Patient was able to:
  - Reduce her A1c level from 10.5% to 6.4% in 3½ months
  - Resolve hyperglycemic symptoms
  - Reduce diabetes medications from twice a day to once a day

Stories

- 65-year-old Caucasian Male
  - Insured
  - No family history of diabetes
  - Numerous chronic conditions
  - “noncompliance for years”
- HMC Provided:
  - Tailored resources
  - Education about using blood glucose to make decisions regarding diet/exercise.
- Patient was able to:
  - Reduce A1c level from 9.8% to 7.6% in 4½ months
  - Reduce CMP glucose level from 334 to 148 in 4½ months
  - Control his blood pressure

Intersection of Health and Social Determinants

- Relationship between overall health and life factors is crucial
- Account for patient's lifestyle to make lasting change

COVID-19

- Patient Visits reduced by 30% at worst point
- Highest number of no-shows and cancelations less than 24 hours for Diabetes Management appointments
- Telehealth/Phone appointments became necessity

Program Considerations

Engage patients in a meaningful way

Address SDOH

Preventative care is not being neglected

TeleVisits—COVID-19

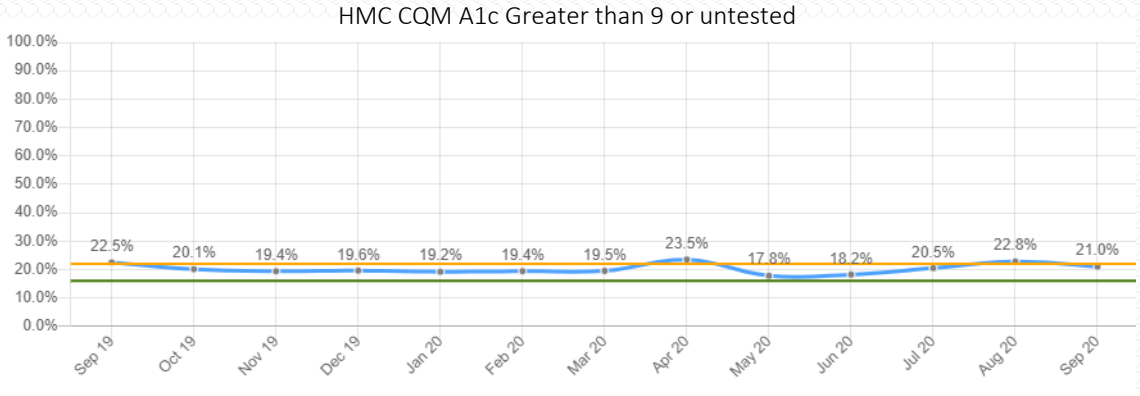
- March 2020
  - Previously no telehealth utilization
  - Maintain access, while also keeping patients safe
- Barriers
  - Not all patients had reliable internet connectivity
    - Endemic issue to service area
  - Way that telehealth is part of EHR, can only be tied to provider visits
  - What type of visit is appropriate for a Televisit.

Solution

- 2 Software options for telehealth
  - 1 tied to EHR
  - 1 is separate program
- Other is separate software (available to non-providers)
- Phone Counseling
- In-person visits

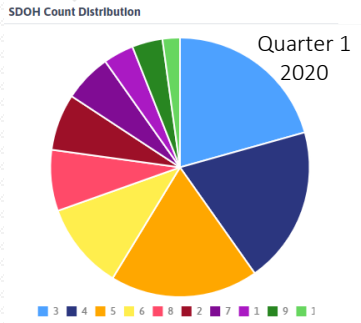
Maintaining Patient Care

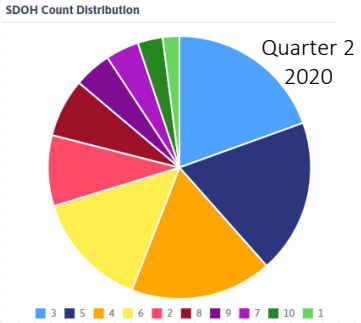
- Patient symptoms
- Focus on still getting lab work, especially for A1c's

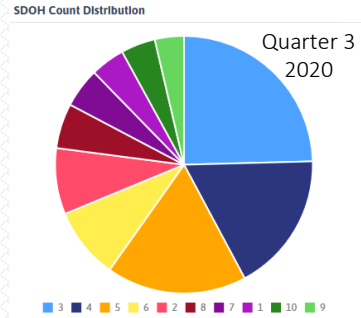


Changes for Patients—SDOH

- Expected to see significant difference in scores
- Saw significant changes in type of patient needs
  - Anxiety
  - Isolation
  - Food Access (using up resources)
- Insurance
- Increase in patients calling into the Health Center







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Continuing Care

- Telehealth continued to be offered
- Alternative appointments offered (ex. phone)

Lessons Learned

- Addressing patients health is not the responsibility of one person
- Facilitating a high level of communication is crucial
- Explore alternative avenues to provide care
- One size does not fit all

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