Strategy. Capacity. Sustainability.

Rural Health Clinic COVID-19 Vaccine Distribution Program

COVID Medical Homes for Rural Health Clinics

-The Webinar Will Begin Shortly-

Community Health Systems Development

Strategy. Capacity. Sustainability.

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First Things First

- Closed captioning is available. Click the CC symbol at the bottom of the screen.
- This recording, information on the program and a pdf of the slides will be available at: https://ruralhealthlink.org/vaccine-distribution/
- Type questions in the Q&A box.

Community Health Systems Development

Who am I?

- Carla Freeman, Technical Assistance Consultant
- One of the team members providing technical assistance to the Rural Health Clinic COVID-19 Vaccine Distribution Program.

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Today we will...

- Describe what the Rural Health Clinic COVID-19 Vaccine Distribution Program is and how to enroll.

- Learn about COVID Medical Homes for Rural Health Clinics.

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The Rural Health Clinic COVID-19 Vaccine Distribution Program

- HRSA and the Centers for Disease Control and Prevention (CDC) jointly administer the Rural Health Clinic COVID-19 Vaccine Distribution Program (RHCVD Program).
- The purpose of the RHCVD Program is to address the novel coronavirus disease (COVID-19) in rural communities by increasing COVID-19 vaccine availability and improving COVID-19 vaccination rates.

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The Rural Health Clinic COVID-19 Vaccine Distribution Program

- This is done by distributing COVID-19 vaccines.
- HRSA's Federal Office of Rural Health Policy (FORHP) enrolls interested RHCs to receive direct shipments of COVID-19 vaccines (this allocation is separate from your state allocations).

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June 28, 2022

COVID Medical Home for Rural Health Clinics

Managing COVID mitigation and hesitancy through your PCMH Processes

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Kate Hill, RN VP Clinic Division
Kristen Ogden, RN Director of Quality Improvement

Meet the PCMH Presenters

Kate Hill, RN
VP of Clinic Division,
The Compliance Team

Kristen Ogden, RN
Director of Quality Improvement

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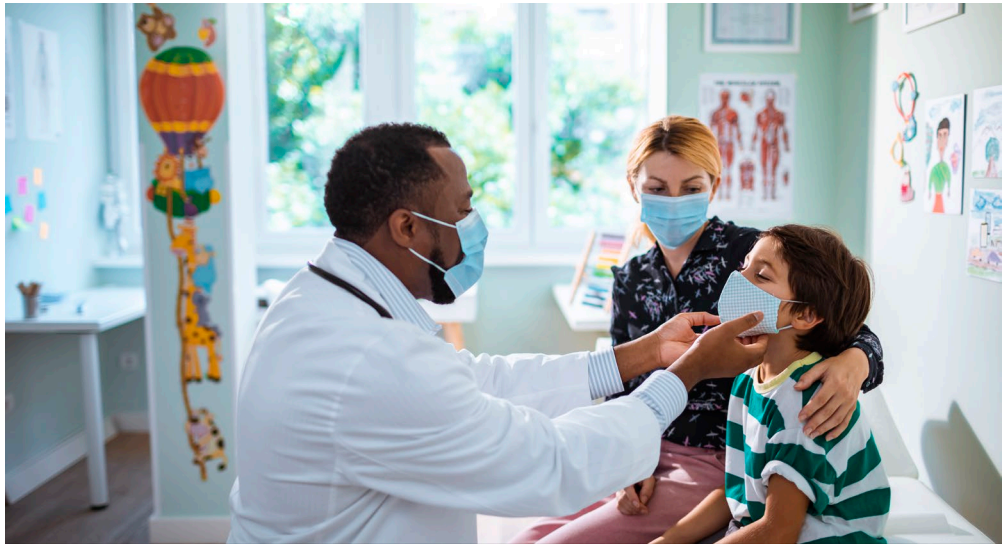
Learning Objectives



- Build understanding of COVID medical homes in Rural Health Clinics
- Explain how COVID medical homes raise the quality of care in Rural Health Clinics
- Provide action steps for getting started

What is a COVID Medical Home

The COVID Medical Home delivers an expanded and integrated approach to improve rural primary care delivery systems. By developing processes that integrate COVID and telemedicine outreach, engagement and education, clinics address the unique needs and vulnerabilities of rural patients and communities. This focused care management approach serves as the foundation for the development and implementation of COVID-related education, prevention, testing, confidence, vaccine distribution and mitigation strategies.

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Basic Elements of a Patient Centered Medical Home

Adapted from the AHRQ definition, TCT describes the medical home as an approach to the delivery of primary care that is:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.

- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.

- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health IT innovations.

- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

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The Challenges

We would love to hear some challenges you face or foresee as you transition.

Rethinking PCMH

PCMH is a patient care focus!

Efficiency in daily operations allows providers to concentrate on “What Matters Most”, to the patient!

What Matters Most: Why are you not vaccinated?

What is the patient’s reason?

It’s a Winning Approach for both Clinics and Patients.

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How does PCMH Benefit My Patients?

Examples of PCMH patient care improvements:

- Same day appointments for urgent illness and expanded appointment hours for testing and vaccinations
- Process for educating the community on COVID mitigation
- A specific plan to handle all types of patient communication
- After-hours triage service and phone access to an on-call provider
- Implementation of a team-based approach to coordinated care
- Assigned care coordinator who develops relationships with patients and provides direct access to the care team

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The Elements of PCMH

- The organization utilizes a team-based approach for patient-centered coordinated care.
- The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.
- The organization provides patient education and self-management tools to patients and their family/caregivers.
- The organization provides advanced access to its patients.
- The organization provides patient follow-up.
- The organization evaluates its quarterly performance and improvement quarterly.
- The organization ensures patient health records are complete.
- The organization understands the impact of social determinants of health and health equity.
- The organization collects data for patient satisfaction, dissatisfaction, and complaints.
- The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

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Are There Any Benefits for Staff?

Staff Satisfaction:

PCMH provides rewards not just to the patients but also to your providers and staff when everyone is engaged and truly understands the ‘why’ behind the model. In talking with clinics currently designated as patient centered medical homes, staff engagement was often cited as the hardest hurdle to accomplish.

However once PCMH was fully implemented, most clinics report a much higher level of provider/staff satisfaction along with higher patient satisfaction ratings.

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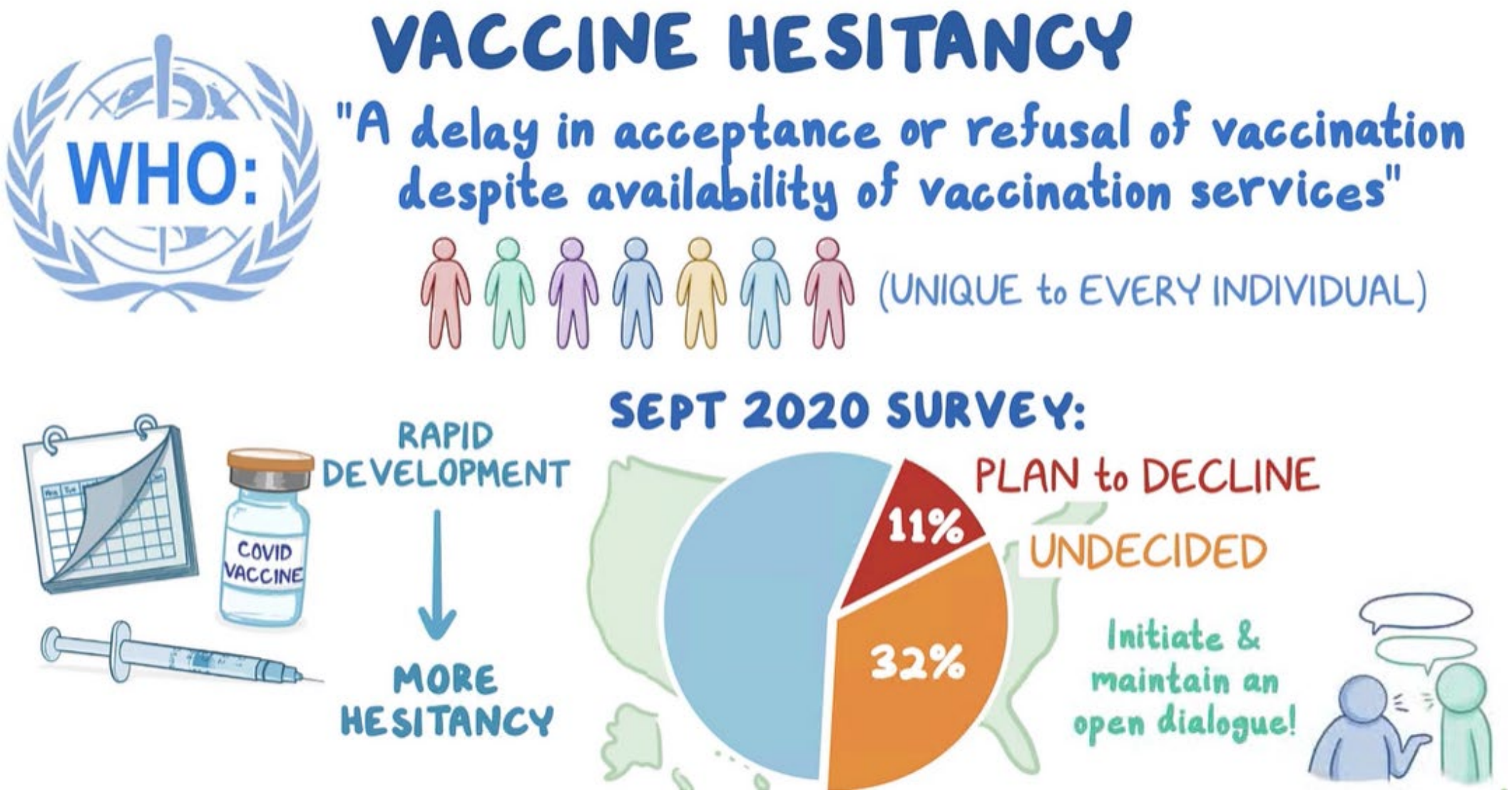
Emerging Infectious Diseases (EID)



Twelve New EID Standards

- Scope of service documentation
- Policies and procedures, staff training
- Staffing needs based on disease prevalence
- Point of care testing process
- Quality control plan for testing
- Patient education on testing and mitigation
- Vaccination program
- Policies and procedures for vaccine administration
- Storage and handling of vaccines
- Infection control policy
- Community Mitigation strategies
- Safe work environment per current OSHA regs

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Preparation Timeline

What is a Realistic Goal for PCMH Readiness?

- Each clinic has a unique timeline.
  - 90-120 days is average.
- Remember, it's a journey because it's continuous quality improvement.
- The important thing is to implement as you move forward, especially as it relates to COVID.

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Successful Implementation Teams…

- Include Clinic/Practice Manager and Care Coordinator at a minimum
- Read the Standards before Training
- Attend Training Calls
- Develop an Implementation Plan and Timeline
- Find Provider Champion(s)
- Invite Other Staff to Participate
- Delegate Duties and Set Deadlines
- Utilize Web Templates and Webinars
- Read About PCMH Innovation
- Reach Out to other Practices

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Preparation and Implementation

The next step is survey. The survey is an open book test. Use the standards and checklist to develop a plan to prepare the clinic to become a PCMH and to implement the process.

Important areas to pay close attention are:

- EMR
- Expanded Hours Can you test and vaccinate for COVID at off hours?
- Care Coordination and follow up: Are we reaching out to patients at risk for COVID?
- Patient Care Teams: Are we huddling to get the best info on our community?
- Patient Care Plans and Education: Do we have tools such as “Why Vaccinate” etc.?
- Community Resources: How can we enlist the community to join our plan?

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EMR and HIPAA Compliance

Is your EMR system PCMH compatible?

Pharmacy information and care coordination notes?

Does EMR have HIPAA compliant functions?

Time out to protect PHI?

Will your EMR produce after visit summaries?

Will your EMR generate care plans?

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Advanced Access

Do you currently provide expanded hours to fit the needs of your patients?

How will you expand hours of operation?

How can patients access the provider after business hours?

Can patients ask questions regarding COVID after hours?

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Patient Care Teams:

Do you currently identify patient care teams?

Do you conduct daily team huddles?

Do you utilize Behavioral Health professionals?

- This is especially important during quarantine and the PHE in general.

Do you communicate with pharmacists about medication compliance?

Are your patients aware of the COVID treatment options and locations?

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Care Coordination and Patient Follow-up

Do you currently have a Care Coordinator/Navigator?

If not, who will be responsible?

Do you provide follow-up for transitional care, missed appointments, diagnostic results, etc.?

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Care Coordination

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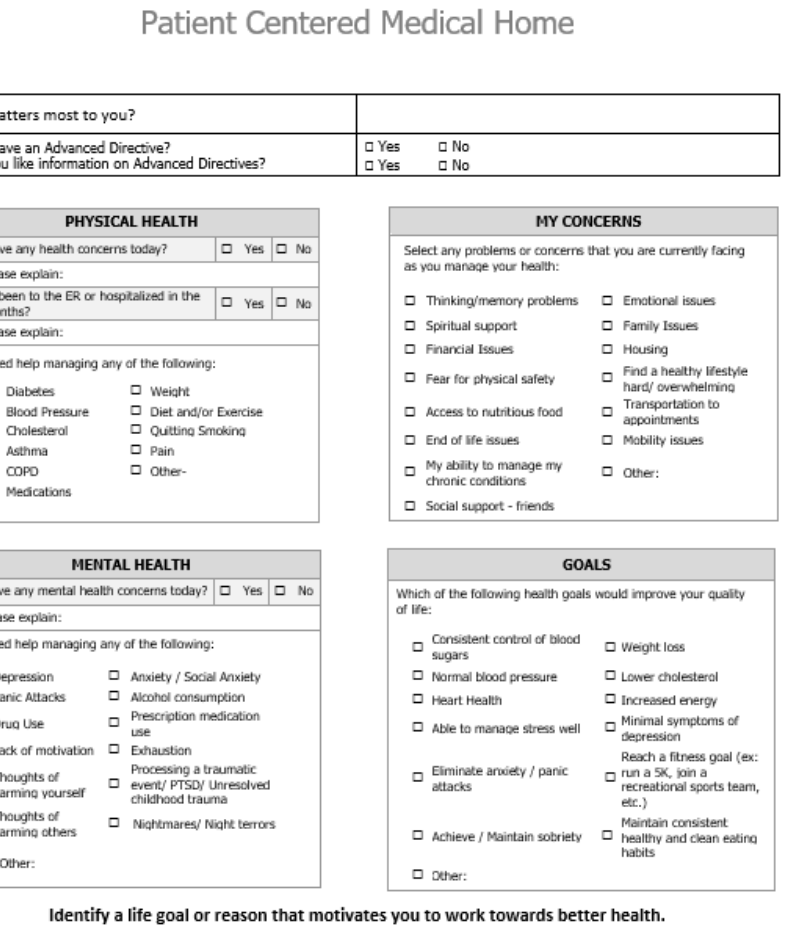
Patient Care Plans and Education



Patient Centered Medical Home

What matters most to you?	
Do you have an Advanced Directive? Would you like information on Advanced Directives?	☐ Yes ☐ No ☐ Yes ☐ No

PHYSICAL HEALTH

Do you have any health concerns today?	☐ Yes	☐ No
If yes, please explain:		
Have you been to the ER or hospitalized in the last 12 months?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Diabetes
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Medications
- ☐ Weight
- ☐ Diet and/or Exercise
- ☐ Quitting Smoking
- ☐ Pain
- ☐ Other-

MY CONCERNS

Select any problems or concerns that you are currently facing as you manage your health:

- ☐ Thinking/memory problems
- ☐ Spiritual support
- ☐ Financial Issues
- ☐ Fear for physical safety
- ☐ Access to nutritious food
- ☐ End of life issues
- ☐ My ability to manage my chronic conditions
- ☐ Social support - friends
- ☐ Emotional issues
- ☐ Family Issues
- ☐ Housing
- ☐ Find a healthy lifestyle hard/ overwhelming
- ☐ Transportation to appointments
- ☐ Mobility issues
- ☐ Other:

MENTAL HEALTH

Do you have any mental health concerns today?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Depression
- ☐ Panic Attacks
- ☐ Drug Use
- ☐ Lack of motivation
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Other:
- ☐ Anxiety / Social Anxiety
- ☐ Alcohol consumption
- ☐ Prescription medication use
- ☐ Exhaustion
- ☐ Processing a traumatic event/ PTSD/ Unresolved childhood trauma
- ☐ Nightmares/ Night terrors

GOALS

Which of the following health goals would improve your quality of life:

- ☐ Consistent control of blood sugars
- ☐ Normal blood pressure
- ☐ Heart Health
- ☐ Able to manage stress well
- ☐ Eliminate anxiety / panic attacks
- ☐ Achieve / Maintain sobriety
- ☐ Other:
- ☐ Weight loss
- ☐ Lower cholesterol
- ☐ Increased energy
- ☐ Minimal symptoms of depression
- ☐ Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
- ☐ Maintain consistent healthy and clean eating habits

Identify a life goal or reason that motivates you to work towards better health.

The Patient-Centered Medical Home is an approach to primary care that is built around YOU! You are the most important member of your healthcare team! We want to meet your goals and needs. We know that health is not achieved in a clinic; but rather built in our homes, schools, workplaces and communities. Help us get to know you and your healthcare needs by completing the form below.

- Do you discuss “What Matters Most” with the patient and set health goals?
- Do you develop a Patient Care Plan?

We call them PCHIPS!

- How do you identify high risk patients who need a PCHIP?
- How do you identify patients in need of behavioral health services?
- Do you provide education regarding diagnosis and treatment for COVID?

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What Matters Most

"What matters most" to the Patient

Patient would like to….. But is unable to do this due to…

- Walk a flight of stairs
- Play on the floor with grandchildren
- Drive a car

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Community Resources

Do you discuss socio-economic determinants with your patients that may impact their health? Why?

Do you provide information to your patients regarding community resources available to them? Ride share for a vaccination, meals on wheels….

Do you have a list of community resources available for patients in need?

https://www.findhelp.org/

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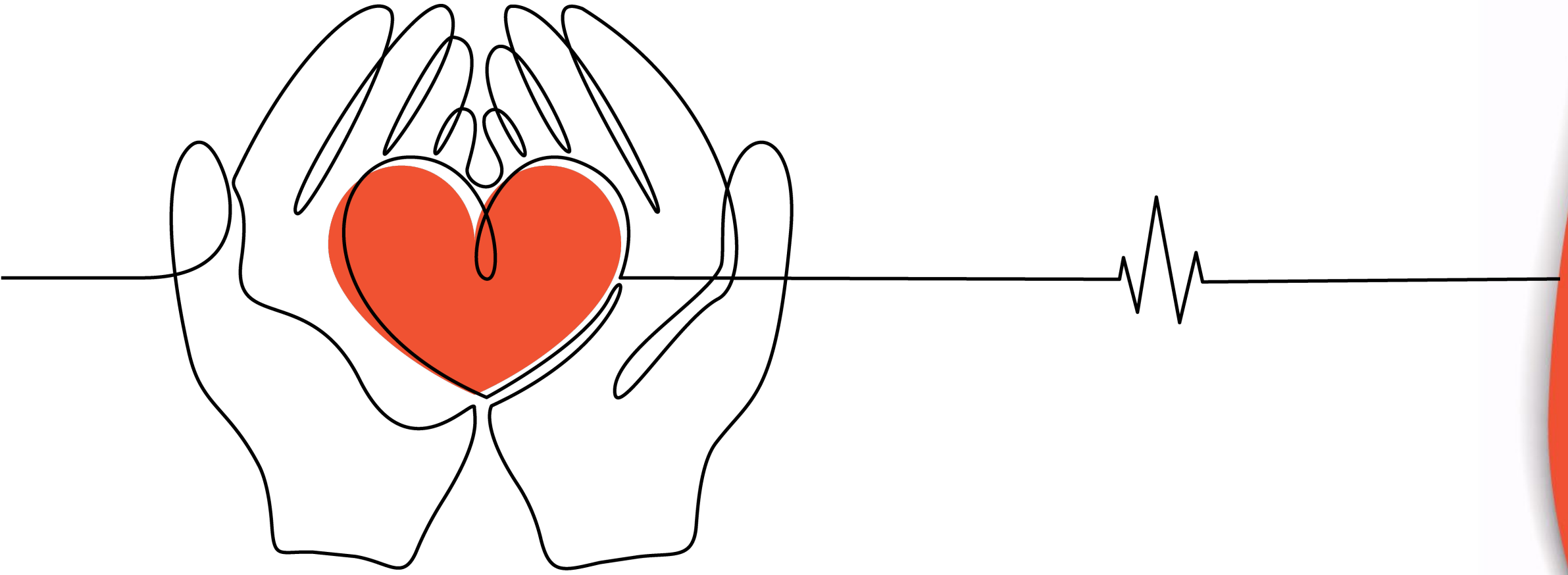
Thank You For All You Do!



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Questions?

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Keep In Touch

- To enroll: RHCVaxDistribution@hrsa.gov
- This recording and a pdf of the slides will be available at: https://ruralhealthlink.org/vaccine-distribution/
- Join us for our next webinar:

  July 13th at 3 p.m. ET

  Leveraging Resources to Do Big Things

Community Health Systems Development