The Village Approach

Maintaining Patient Centric Care During A Pandemic

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Glory Cruz
COVID-19 Enhances The Way Generations Helps Patients!

Focus on the 6 Key Concepts for Patient Centered Medical Home and be creative in how they are applied to the care provided.

➢ **Team Based Care**
   Provides continuity and communicates roles and responsibilities to organize and train staff to work at the top of their license.

➢ **Knowing and Managing your Patient**
   Provides ability to capture and analyze data to drive evidence-based care and support services.

➢ **Patient Centered Access and Continuity**
   • Assures 24/7 access to clinical advice and appropriate care after hours.
   • Empanelment supports continuity of the patient and provider relationships that is the basis for patient centric care.
## Know Your Lane

<table>
<thead>
<tr>
<th>GHCC Simulacra</th>
<th>Check In</th>
<th>App Prep</th>
<th>Provider Visit</th>
<th>Appointment Follow Up</th>
<th>Labs/ Diagnostics</th>
<th>Check Out</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Assistant</strong></td>
<td>- Full standing orders protocol as directed by provider (e.g., measles, diagnosis, lab, etc.)</td>
<td>- Full recent labs Diagnostical lab summary, etc. from hospital EMR, file for chart. Prepare for chart.</td>
<td>- Gather supplies before calling patient room or signing up for appointment. Refer to checklist, lab results, notes, orders for placement.</td>
<td>- Schedule any ordered diagnoses and repeat order or diagnosis. (Note: standard order protocol for Colds/cough, etc.)</td>
<td>- Obtain diagnostic results, scan to chart and result to provider.</td>
<td>- Encourage patient to provide data.</td>
</tr>
<tr>
<td><strong>LPN</strong></td>
<td>- Full standing orders protocol as directed by provider</td>
<td>- Review information on protocol, and obtain provider of any needed at next visit. (Note: patient or medical diagnosis as needed)</td>
<td>- Address any issues or concerns as needed.</td>
<td>- Monitor scheduled lab, film, and report results to provider</td>
<td>- Ensure all issues are documented in forms and immediately confer with chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>- Full standing orders protocol as directed by provider</td>
<td>- Review information on protocol, and obtain provider of any needed at next visit. (Note: patient or medical diagnosis as needed)</td>
<td>- Address any issues or concerns as needed.</td>
<td>- Monitor scheduled lab, film, and report results to provider</td>
<td>- Ensure all issues are documented in forms and immediately confer with chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Care Coordinator</strong></td>
<td>- Fluid &amp; Loops Admission</td>
<td>- Complete Social Determinants Form</td>
<td>- Confirm contact information for the patient.</td>
<td>- Provide needed forms and diagnostic data to chart</td>
<td>- Update chart and document in patient's chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Care Facilitator</strong></td>
<td>- Fluid &amp; Loops Admission</td>
<td>- Complete Social Determinants Form</td>
<td>- Confirm contact information for the patient.</td>
<td>- Provide needed forms and diagnostic data to chart</td>
<td>- Update chart and document in patient's chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>- Insurance Applications</td>
<td>- Complete Social Determinants Form</td>
<td>- Confirm contact information for the patient.</td>
<td>- Provide needed forms and diagnostic data to chart</td>
<td>- Update chart and document in patient's chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>- Program Intake</td>
<td>- Complete Social Determinants Form</td>
<td>- Confirm contact information for the patient.</td>
<td>- Provide needed forms and diagnostic data to chart</td>
<td>- Update chart and document in patient's chart.</td>
<td>- Send portal invite</td>
</tr>
<tr>
<td><strong>Workers</strong></td>
<td>- Fluid &amp; Loops Admission</td>
<td>- Complete Social Determinants Form</td>
<td>- Confirm contact information for the patient.</td>
<td>- Provide needed forms and diagnostic data to chart</td>
<td>- Update chart and document in patient's chart.</td>
<td>- Send portal invite</td>
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</table>
Care Management and Support
Identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Care Coordination and Transitions
practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.

Performance Measurement and Quality Improvement
establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience, and engages staff and patients/families/caregivers in quality improvement activities.

Keeping Care Patient Centered

Each site establishes Care Teams that consist of a PCP, RN, LPN, Medical Assistant, Care Coordinator Care Facilitators and Community Health Workers that provide on going communication related to the patients care.
Keeping Care Patient Centered

➢ **Care Management and Support**
Identifies patient needs to effectively plan, manage and coordinate patient care with emphasis is placed on supporting patients at highest risk.

➢ **Care Coordination and Transitions**
Practice systematically tracks results and engages in care coordination to lower costs, improve patient safety and ensure effective communication.

➢ **Performance Measurement and Quality Improvement**
Establishes a culture of data-driven performance improvement on clinical quality, efficiency and patient experience.
Accessible & Sustainable
Provider Led/Team Based
Patient Centered
Focused on Quality and Safety
Comprehensive
Coordinated

Family
Community
Resources
Culture
Determinants of Health

- Social Support Networks
- Working Conditions
- Physical Environment
- Income & Social Status
- Education
- Coping Skills
- Genetic Endowment
- Health Services
Only 20% of health status relates to those moments in the healthcare environment.
Social Determinants of Health

- Transportation
- Housing
- Financial Strain
- Food
Race and Ethnicity
Obtaining broader categories of race and ethnicity must be done with each SDOH form. 

We Ask Because We Care is a national campaign to collect more granular data related to Race, Ethnicity and Linguistic preferences using drilled down CDC codes. It is used to ensure we’re understanding and meeting the unique ethnic and cultural needs of our patients. This data collection marks an

SOCIAL HISTORY

Alcohol Usage/Treatment
- Alcohol
  - [ ] if any concerns complete a CAGE AID (3 or more drinks)
  - [ ] Therapy for Alcohol Abuse/Dependence

Drug Usage/Treatment
- [ ] if any concerns (Y) complete a CAGE AID
- [ ] Therapy for Drug and Alcohol Abuse/Dependence

HOUSING & EMPLOYMENT STATUS

Are you worried about losing your home? 

EDUCATIONAL/FINANCIAL RESOURCES/TRANSPORT

How hard is it for you to pay for the very basics like food, housing, medical care, and heating? 

What is the highest grade or level of school you have completed or the highest degree you have received? 

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. (14P)

Food

Clothing

Utilities

Child Care

Phone

Other (please specify)

Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. (15P)

Patient kept from medical appointments

Patient kept from non-medical meetings, appointments, work, or from getting things that he/she needs

Physical Activity (SAMHSA)

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? 

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled. How stressed are you?

Optional Additional Questions

In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Do you feel physically and emotionally safe where you currently live?

In the past year, have you been afraid of your partner or ex-partner?
SO... What exactly is a “Medical Home”?
Session is 10 minutes for discussion. Discuss the concepts as related to your own organizations. Do you practice the concepts? If not, what might be a way for you to bring it back to your organization?
Assign a team member to briefly share what you learned with larger group.

**Team 1**
Team Based Care

**Team 2**
Knowing and Managing your Patient

**Team 3**
Patient Centered Access and Continuity

**Team 4**
Care Management and Support

**Team 5**
Care Coordination and Transitions

**Team 6**
Performance Measurement and Quality Improvement
How Do Medical Home Concepts Apply to Farmworker Health Programs?
Engaging Patients At The Farm, Pre-COVID?

At Health Clinics

In Break Rooms
Keeping the Audience Interested!

With Games and Prizes Inside

... Or In the Fields and Greenhouses
Connecting On Mobile Health Units
The Same Quality Care received in the Office
COVID Reduces In-Person Contact

New ways to reach MSAW patients
Communication with Growers & agricultural workers can be an uphill battle.
Using Practice Analytics as an Outreach Tool

<table>
<thead>
<tr>
<th>Pat Person Nbr</th>
<th>Pat DOB</th>
<th>Patient Age</th>
<th>Worker Status Desc</th>
<th>Pat Gender Desc</th>
<th>Pat Date of Last Visit</th>
<th>Pat Cv1 Plan Code</th>
<th>Appt Svc Cntr Name</th>
<th>Appt Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7710</td>
<td>5/5/1985</td>
<td>33</td>
<td>Seasonal</td>
<td>Female</td>
<td>10/17/2020</td>
<td>BMASL</td>
<td>Generations FHC, Inc. (Willimantic - Medical)</td>
<td>Occurred</td>
</tr>
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<td>7710</td>
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<td>Generations FHC, Inc. (Willimantic - Medical)</td>
<td>Occurred</td>
</tr>
</tbody>
</table>

**Time Table:**
- **8:40 am:** VM
- **8:45 am:** VM
- **9:00 am:** VM
- **9:05 am:** VM
- **9:15 am:** VM
- **9:30 am:** VM
- **9:45 am:** VM
- **10:00 am:** VM
- **10:15 am:** VM
- **10:30 am:** VM
- **10:45 am:** VM
- **11:00 am:** VM
- **11:15 am:** VM
- **11:30 am:** VM
- **11:45 am:** VM
- **12:00 pm:** VM
- **12:15 pm:** VM
- **12:30 pm:** VM
- **12:45 pm:** VM
- **1:00 pm:** VM
- **1:15 pm:** VM
- **1:30 pm:** VM
- **1:45 pm:** VM
- **2:00 pm:** VM
- **2:15 pm:** VM
- **2:30 pm:** VM
- **2:45 pm:** VM

**Locations:**
- VM
- Block
- Lunch

**Plan Details:**
- Admin
- Social Work
- Social Services
- Clinical Services
- Other

**Generations Family Health Center**

[Logo]
Coordinating COVID Test Clinics at the Farms in 2020.

- 33% of our 2020 H2A population were tested before traveling home.
- 74% of our overall agricultural worker population were tested.
March 9th 2021 we conducted testing at one of the farms for approximately 200 incoming H2A workers and scheduled vaccines for those who wanted them.
Getting MSAW’s in for COVID Vaccines.

In February 2021 we vaccinated 170 farmworkers during special vaccine clinics and continued to have special vaccine clinics throughout March.
Engaging Patients in the “New Norm”

- Contactless PPE Delivery
- Prescription Assistance & Delivery
- Telephonic Outreach
Enhancing Access and Care Delivery

Trac Phones and Data Cards

Glucose Testing Supplies
Challenges to Managing Patients During the Pandemic

• In person visits are limited so Telehealth is on the rise.

• Point of Care Testing cannot occur with Telehealth visits.

• Video connectivity and capability may be limited.

• Dental Services cannot be provided via telehealth.
### In Person Vs Telehealth MSAW Visits

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>809</td>
</tr>
<tr>
<td>Dental</td>
<td>197</td>
</tr>
<tr>
<td>Behavioral</td>
<td>45</td>
</tr>
</tbody>
</table>

**“No Show” rate decreased to less than 10% from a pre COVID rate of 18%**

![Visit By Discipline](chart.png)

![VISIT METHOD](pie_chart.png)

- **420 visits** (40% FTF)
- **631 visits** (60% Telehealth)
Working together to make the pieces fit and close the gaps in the circle of care.
How Did COVID and Telehealth Affect Diabetes Management for Ag Workers

- Less likely to obtain glucose levels and A1c results.
- Difficulty obtaining medications.
- Limited community resources due to shutdown.
- Food insecurity forces poor diet choices.
- Isolation limits exercise options.
- Stress releases cortisol and increases blood glucose levels.
• Use Risk Stratification to Identify MSAW’s with Uncontrolled Diabetes.

• Run reports with Demographics for Outreach
### Table 7 Sec C

**Indicator:** Improve Diab control >9 A1c  
**Goal:** CRVFHP UDS 25.00%  
**Baseline Measure:** 8/22. 36.00%  
**2019 Q1 Num:** 6  
**2019 Q1 Den:** 19  
**2019 Q1 %:** 31.58%

### Special Population Breakdowns

Patient Study based on patients seen 4/1/2018 to 3/31/2019: Date Run on 6/11/2019 from PA Procedure Codes, Labs and lastly Charge Details folders

<table>
<thead>
<tr>
<th>Total Spec Pop</th>
<th>% of GFHC Universe</th>
<th>Diabetics Count</th>
<th>Diabetics % of Spec Pop</th>
<th>Makes up % of Total GFHC DM Pop</th>
<th>Diabetic Count with A1c &gt;= 9</th>
<th>Spec Pop % with A1c &gt;= 9</th>
<th>Makes up % of all DM &gt;= A1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total GFHC Universe = 20796</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>14313</td>
<td>7.77%</td>
<td>1616</td>
<td>11.29%</td>
<td>67.19%</td>
<td>366</td>
<td>22.65%</td>
</tr>
<tr>
<td>Unreported/Refused to Report</td>
<td>410</td>
<td>0.16%</td>
<td>34</td>
<td>8.29%</td>
<td>1.41%</td>
<td>11</td>
<td>32.35%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>496</td>
<td>0.46%</td>
<td>96</td>
<td>19.35%</td>
<td>3.99%</td>
<td>21</td>
<td>21.88%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>21</td>
<td>0.02%</td>
<td>4</td>
<td>19.05%</td>
<td>0.17%</td>
<td>1</td>
<td>25.00%</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>46</td>
<td>0.04%</td>
<td>8</td>
<td>17.39%</td>
<td>0.33%</td>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>1608</td>
<td>1.13%</td>
<td>234</td>
<td>14.55%</td>
<td>9.73%</td>
<td>63</td>
<td>26.92%</td>
</tr>
<tr>
<td>Asian</td>
<td>504</td>
<td>0.29%</td>
<td>60</td>
<td>11.90%</td>
<td>2.49%</td>
<td>9</td>
<td>15.00%</td>
</tr>
<tr>
<td>White</td>
<td>14871</td>
<td>8.10%</td>
<td>1685</td>
<td>11.33%</td>
<td>70.06%</td>
<td>427</td>
<td>25.34%</td>
</tr>
<tr>
<td>Unreported/Refused to report</td>
<td>3241</td>
<td>1.53%</td>
<td>318</td>
<td>9.81%</td>
<td>13.22%</td>
<td>112</td>
<td>35.22%</td>
</tr>
</tbody>
</table>
Root Cause Analysis for Diabetes

1. What proof do I have that the cause exists?
2. What proof do I have that the cause will lead to the stated effect?
3. What proof do I have that this cause actually contributed to the problem I'm looking at?
4. Is anything else needed, along with this cause, for the stated effect to occur? (Is it self-sufficient? Is something needed to help it along?)
5. Can anything else, besides this cause, lead to the stated effect? (Are there alternative explanations that fit better? What other risks are there?)
<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDOH Complete</td>
<td>14</td>
<td>34</td>
<td>41.18%</td>
</tr>
<tr>
<td>Lives Improved</td>
<td>12</td>
<td>34</td>
<td>35.29%</td>
</tr>
<tr>
<td>Lost to Care</td>
<td>7</td>
<td>34</td>
<td>20.59%</td>
</tr>
</tbody>
</table>

**A1c Results 3mos Post Improvement Project**

A1c <7: 10
A1c 7-8: 1
A1c 8-9: 2
A1c 9-10: 7
A1c >10: 6
Lost to Care: 1
<table>
<thead>
<tr>
<th>Pat Person Nbr</th>
<th>Pat DOB</th>
<th>Worker Status</th>
<th>Credited Prov Last Name</th>
<th>Proc Dia 1 Desc</th>
<th>Proc Dia 2 Desc</th>
<th>Proc Dia 3 Desc</th>
<th>Procedure Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>1952</td>
<td>9/3/1964</td>
<td>Seasonal</td>
<td>Ericksen</td>
<td>Subluxation complex (vertebral) of lumbar region</td>
<td>Body mass index [BMI]40.0-44.9, adult</td>
<td>Cervicobrachial syndrome</td>
<td>Chiro, Manipulative TX (Spinal, 1-2 regions)</td>
</tr>
<tr>
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<td>9/3/1964</td>
<td>Seasonal</td>
<td>Ericksen</td>
<td>Subluxation complex (vertebral) of lumbar region</td>
<td>Subluxation complex (vertebral) of thoracic region</td>
<td>Segmental and somatic dysfunction of sacral region</td>
<td>Chiro, Manipulative TX (Spinal, 3-4 regions)</td>
</tr>
<tr>
<td>1952</td>
<td>9/3/1964</td>
<td>Seasonal</td>
<td>Ericksen</td>
<td>Subluxation complex (vertebral) of lumbar region</td>
<td>Segmental and somatic dysfunction of sacral region</td>
<td>Other intervertebral disc degeneration, lumbar region</td>
<td>Chiro, Manipulative TX (Spinal, 1-2 regions)</td>
</tr>
</tbody>
</table>

**Checklist Diagram:**

- **Indicator:** Improve Diab control >9 A1c
- **PI or Req:** CRVFHP UDS
- **Goal:** 25.00% 36.00%
- **Baseline Measure 2018 Final:** 17 112
- **4Q Num:** 15.18%
- **4Q Den:**
- **4Q %:**

**Procedure Elements:**

- Chiro, Manipulative TX (Spinal, 3-4 regions)
- Chiro, Manipulative TX (Spinal, 1-2 regions)
- Office Visit, New, Brief
- Office Visit, New, Brief
- Office Visit, New, Brief
- Chiro, Manipulative TX (Spinal, 1-2 regions)

**Other Diagnoses:**

- Subluxation complex (vertebral) of lumbar region
- Subluxation complex (vertebral) of thoracic region
- Subluxation complex (vertebral) of lumbar region
Debit Cards For COVID Relief

Diabetes Care Kits

Trac Phones For Patients
Diabetic Control: % Pts with A1c <9

- Q4 2018 Baseline: 36%
- Q1 2019: 31.58%
- Q4 2019: 15.18%
- Q4 2020: 12.5%
Thank You!

Questions?