Community Healthcare Network

Activating Clinical Care and Support Staff To Improve Patients' Health Outcomes Through Medication Adherence

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Community Healthcare Network

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Annual Impact-CHN

- 85,000+ patients
- 36,000 patients with one or more chronic conditions
- 250,000+ medical visits
- 11,200+ behavioral health visits
- 3,000 wellness classes attended

- 10,000 nutrition visits
- 34,000 HIV tests
- 40,000 visits for STI testing and counseling
- 45,000+ family planning visits
- 5,500 back-to-school physicals
- 1,600 New Yorkers helped with insurance

Communities We Serve

QUEENS
- CHN Jamaica
- CHN Sutphin Boulevard
- CHN Long Island City

MOBILE HEALTHCARE
- Community Healthcare Network operates a fleet of mobile health centers that travel to areas providing weekly visits to schools and community organizations in Manhattan, Queens and Brooklyn.

BRONX
- CHN Tremont
- CHN South Bronx

BROOKLYN
- CHN Williamsburg
- CHN Crown Heights
- CHN East New York

MANHATTAN
- CHN Lower East Side
- CHN Harlem
- CHN Washington Heights
- Seward Park School Based Health Center
- Phoenix School Based Health Center

Embracing an Integrated Care Model

- Integrated care is a model that addresses the entire patient utilizing a multidisciplinary approach
- Community Healthcare Network has improved outcomes by:
  - Utilizing team based care model
  - Empanelment
  - Improving Access to care
  - Population health management

Embracing an Integrated Care Model

Team based care

- Nurse – Provider – Medical Office Specialist
- Pre-visit planning, teamlet huddles, chart preparation
- Increases the efficiency, effectiveness and communication
- Multidisciplinary approach providing comprehensive care

Empanelment

- Continuity of care plays a big role in medication and treatment adherence
- Builds a trusting relationship with patients and family members
- Patient centered care approach
- Consistency with treatment plans

Embracing an Integrated Care Model

Access to care

- Extended hours
- RN Visits
- Walk in availability, same day and provider driven appointment slots
- Decrease ER visits

Population health Management

- Target specific measures improving patient outcomes within a specific group
- Address Social Determinant of Health (SDH)

Example-Diabetics patients focused care approach:

- Retinavue Eye Screenings
- HGBA1C Monitoring
- Monofilament Foot Exams

Pre-visit Planning Checklist

Pre-visit Planning Checklist	
Chart Review	• Review follow-up plan (from last 2 visits) • Copy follow-up plan and paste into chief complaint
Labs/DI	• Review labs/DI & identify any “abnormals” to address; document in chief complaint • Review future ordered labs & remind patient to come for labs • Reschedule or time apt based on status of result • Instruct patients to come fasting for visit if labs indicate need
Outside Referrals	• Review referrals and determine if patient went to apt. (if necessary call patient) • Review DI/Documents to determine if report is back • Suggestions: Make contacts within radiology department or call site referral coordinator to help out with this
In-house Specialty & Referrals	• Nutrition, Podiatry, Dental, Mental Health, Health Homes, GYN, etc • Have they followed-up with Health homes? • Have they kept scheduled appointments? • Use RN visit
Nursing Actions	• Anticipate vaccines, EKGs, Peak flows, Glucose checks and schools forms (prefill when appropriate) • Review needed templates and pre-load
Telephone Encounters	• Review previous telephone encounters • Review messages, recalls, patient requests, prescription requests
Recalls	• Review Letter logs and identify missed recalls • Review Labs/DI and document in CC
DRVS	• Print off DRVS same day

Patient Reminders	• Call patient when needed to remind them to…
	  ○ Logs: DM & HTN
	  ○ Medications
	  ○ ED discharge papers
	  ○ Records: immunizations, Consults, Imaging

Protocols and Policies

- ADA guidelines
- Guidelines and algorithms are reviewed annually by internal and external consultants
- Self-study through on-line modules (TED)

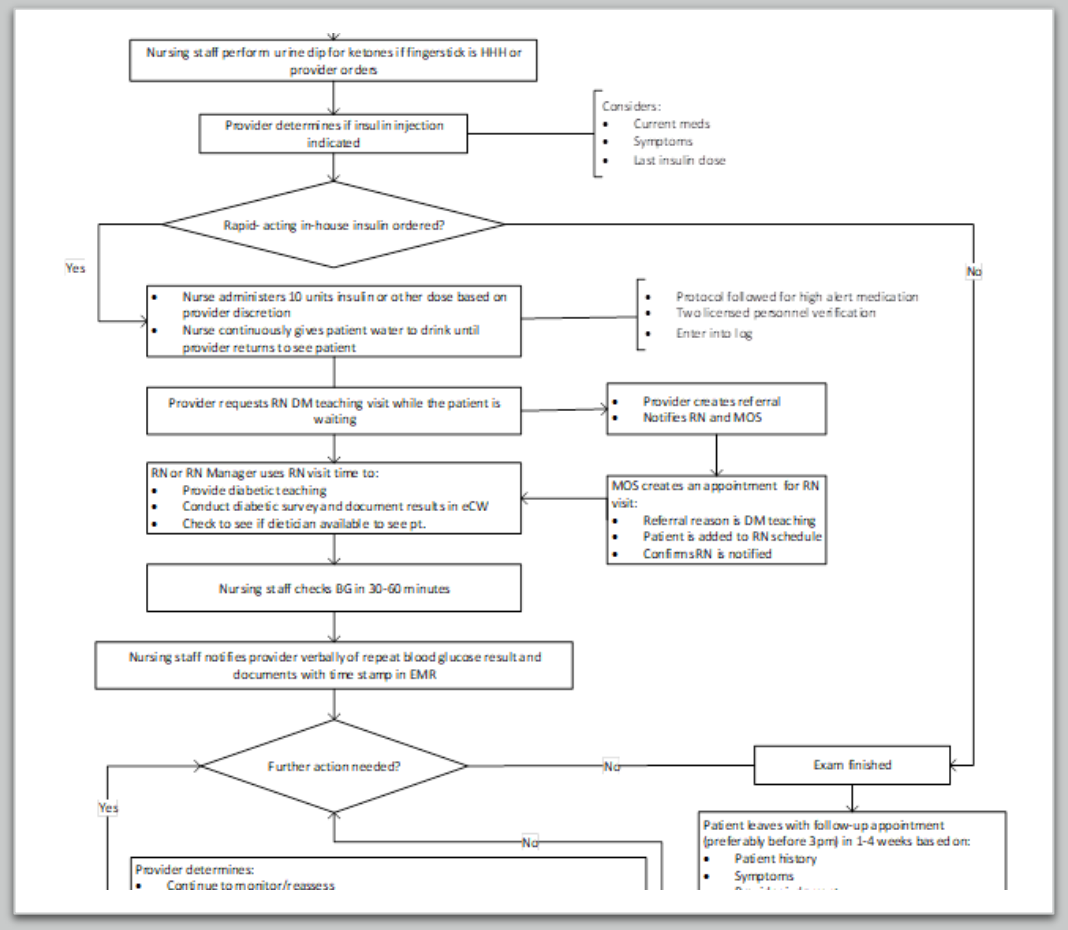
In addition:

- Chart reviews are conducted
- Mount Sinai E-consults
- Rubicon MD
- MAVEN-coaching and consult

- Case conferencing conducted for high risk patients with multiple co-morbidities.
- Multidisciplinary team consists of: (Nurse, Social Worker, Nutritionist, Behavioral health Therapist, and the provider)
- Treatment adherence team

Community Healthcare Network

Diabetic Workflow (HHH)



Medication Adherence Strategy

Medication Adherence is the responsibility of the entire care team

- Providing education and counseling
- Standardized documentation in the EHR to improve medication reconciliation
- Outreach and recalls; nurse BP checks, and diabetes education

Describing improved outcomes through data:

- Quantitative: clinical dashboards and internal data team
- Qualitative: patient surveys expressing satisfaction
- Quality improvement meetings
- Monthly Provider and Nursing Meetings

Barriers / Limitations / Challenges

- *Staffing (RN Availability, schedule and cost)*
- Establishing trust between care team, patient and family
- Staff buy-in
- Staff working to the top of their license
- Accountability
- Standardization of workflows
- Communication between care team
- Space in the center for a conducive environment
- Patient compliance to coming for their RN visit

Ah-ha Moments

Setting: South Bronx Health Center

Patient: A 48 year old male diagnosed with schizophrenia, type 2 diabetes (uncontrolled) and hyperlipidemia.

Pre-intervention: Patient Mr. X arrived at our center wearing his royal crown to his first RN visit with a 9.2 HgbA1c. After a couple RN visits and interventions from the care team, we were able to bring his HgbA1c down to 6.2!

Interventions: The Registered Nurse and Mr. X discussed his concerns, reconciled medications, checked fingerstick log and reinforced teaching on how to use the glucometer. The patient was referred to nutrition and offered an exercise regimen.

Outcomes: Mr. X now bikes to the center for his appointments 30 pounds lighter with his crown set high on his head.

Key Takeaways

- Invest in the Registered Nurse
- Invest on improving Education for employees
- Involve patients and families in their care
- Assign specific task to care team members
- Involve staff on workflow changes
- All staff should practice at the top of their license
- No “I” in team
- Treat the patient as a whole patient
- Have a targeted approach for better outcomes
- Group meetings and follow ups

Questions & Answers

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