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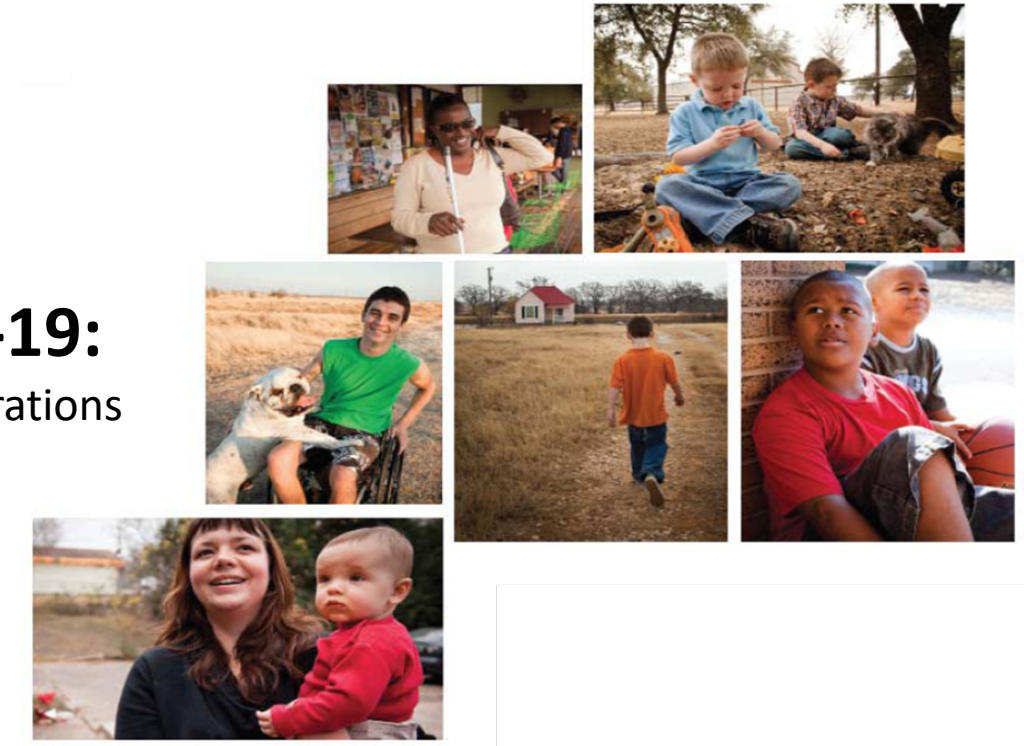


Patient Centeredness in the Age of COVID-19:

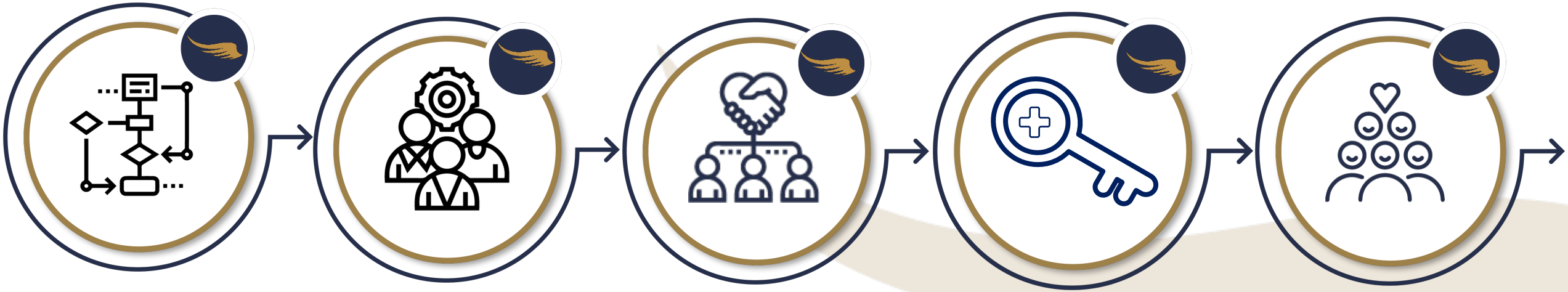
A Comprehensive Webinar Series for Sustaining Medical Home Operations

Webinar 1/5: Practice Operations Challenges

Patient Centeredness in the Age of COVID-19: Today's Presenter

Patient Centeredness in the Age of COVID-19:

A Comprehensive Webinar Series for Sustaining Medical Home Operations



Webinar 1:
Practice Operations
10/15;
2pm CT

Webinar 2:
Personnel Challenges
10/22;
2pm CT

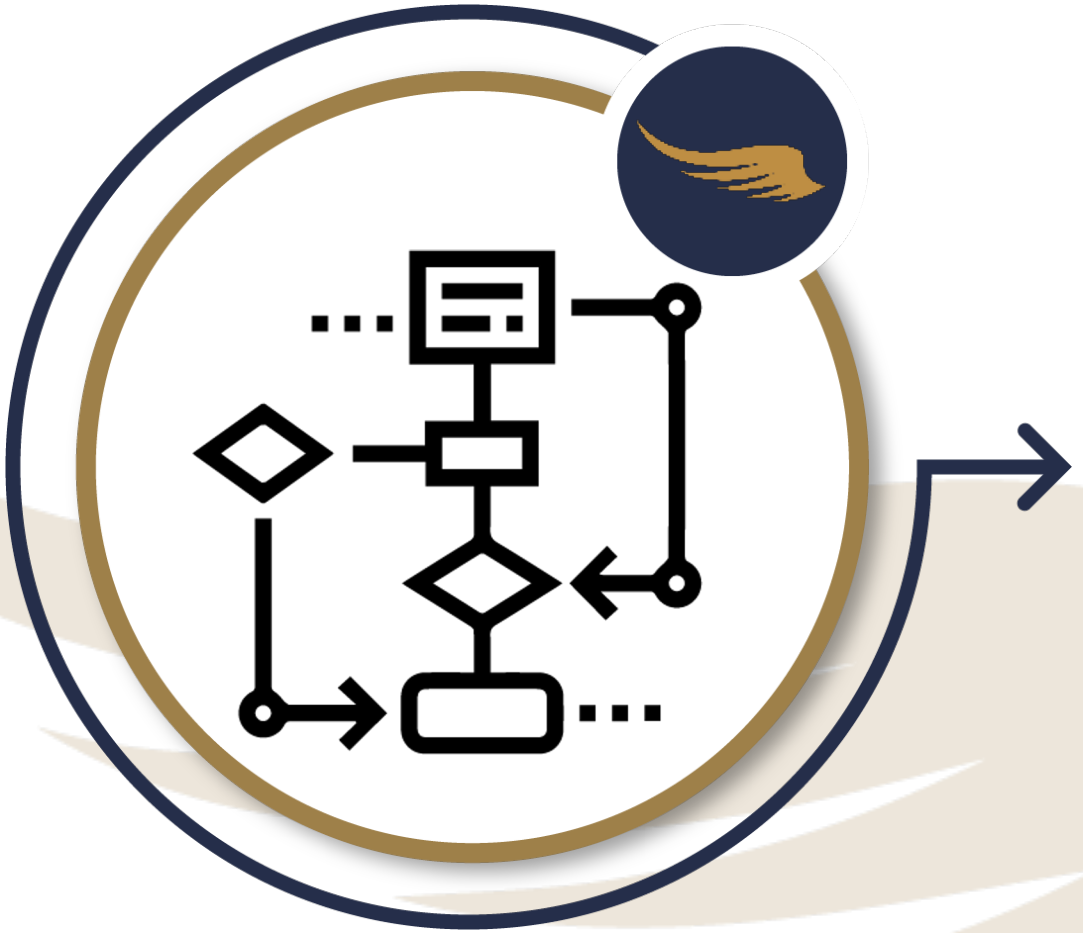
Webinar 3:
Care Management
10/29;
2pm CT

Webinar 4:
Patient Access
11/5;
2pm CT

Webinar 5:
Office Morale & Safety
11/12;
2pm CT

Patient Centeredness in the Age of COVID-19: Practice Operations

- Communication
- Population Management
- Pre-Visit Planning



Patient Centeredness in the Age of COVID-19: Practice Operations: Communication

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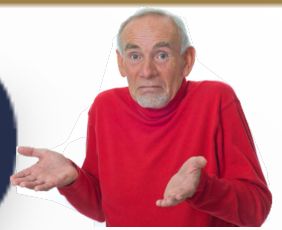
What Do Patients Want to Know About COVID-19?

Risk?

What is COVID 19?

- Is COVID-19 real?
- Why is it dangerous?
- Can I die from it?
- Am I at risk?
- Is my family at risk?
- What are the symptoms?
- Is there a vaccine?

Protection?



How do I Protect Myself?

- Are masks necessary?
- Where do I get them?
- Are they affordable?
- What kind do I get?
- Does my kid need one?
- Do I wear it outside?
- Can I go out to eat / bar?
- Do I need gloves?

Sick?

What Happens if I Get Sick?

- Where do I get tested?
- What happens if I'm positive?
- What if it's negative and I still feel bad?
- How is COVID treated?
- Do I need to quarantine?
- How long?
- Who do I need to contact?

Safety?

Are Doctor Visits Safe?

- Can I get sick at the doctor's office?
- Should I wait until after COVID is over to visit?
- What precautions have been implemented?
- Can we Zoom?
- Are phone visits feasible?
- Recommended readings?

Practice Operations: Communication: PCMH TC09, KM21-22

TC 09 (Core) Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.

GUIDANCE	EVIDENCE
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. The practice explains to patients the importance of maintaining comprehensive information about their health care and describes how and where (e.g., specialty practice, primary care office, ED) to access the care they need. At minimum, materials include: • Names and phone numbers of practice points of contact. • Instructions for reaching the practice after office hours. • A list of services offered by the practice. • A list of resources for patient education and self-management support. • Indication that the practice uses evidence-based care. If appointments are conducted using telehealth, the practice may consider a process for informing patients about telehealth availability, including how and when to use the technology.	• **Documented process** ***AND*** • **Evidence of implementation**

KM 22 (1 Credit) Access to Educational Resources: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.

GUIDANCE	EVIDENCE
Giving patients access to educational materials, peer support sessions, group classes and other resources can engage them in their care and teach them better ways to manage it, and help them stay healthy. The practice provides three examples of how it implements these tools for its patients. • **Educational programs and resources** may include information about a medical condition or about the patient's role in managing the condition. Resources include brochures, handout materials, videos, website links and pamphlets, as well as community resources (e.g., programs, support groups). • **Self-management tools** enable patients to collect health information at home that can be discussed with the clinician. Patients can track their progress and adjust the treatment or their behavior, if necessary. Such as a practice gives its hypertensive patients a method of documenting daily blood pressure readings.	• **Evidence of Implementation**
The practice provides or shares available **health education classes,** which may include alternative approaches such as **peer-led discussion groups** or **shared medical appointments** (i.e., multiple patients meet in a group setting for follow-up or routine care). These types of appointments may offer access to a multidisciplinary care team and facilitate patients to interact with and learn from each other.	• **Evidence of implementation**

Practice Operations: Communication: COVID-19 Communication Platforms

- Educational Resources
- COVID Testing
- COVID Treatment
- PPE Access
- Mental Health Support

- Encourage “following” and “friending”
- Alternative Appointments
- Video Postings for check-in process, patient cycle, wait room safety, and personal protection
- Informational Webinars

- Parking Lot
- Entry way
- Patient registration
- Waiting Room
- Exam Rooms

- Patient Outreach
- Appointment Scheduling
- Transportation Support
- Value Added Benefits for Quality Metrics
- Overall Population Mgmt.

Clear Indicators of COVID-19 Safety, Pre-Caution, Organization, and Activism will ease patients and encourage them to return

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- Communication
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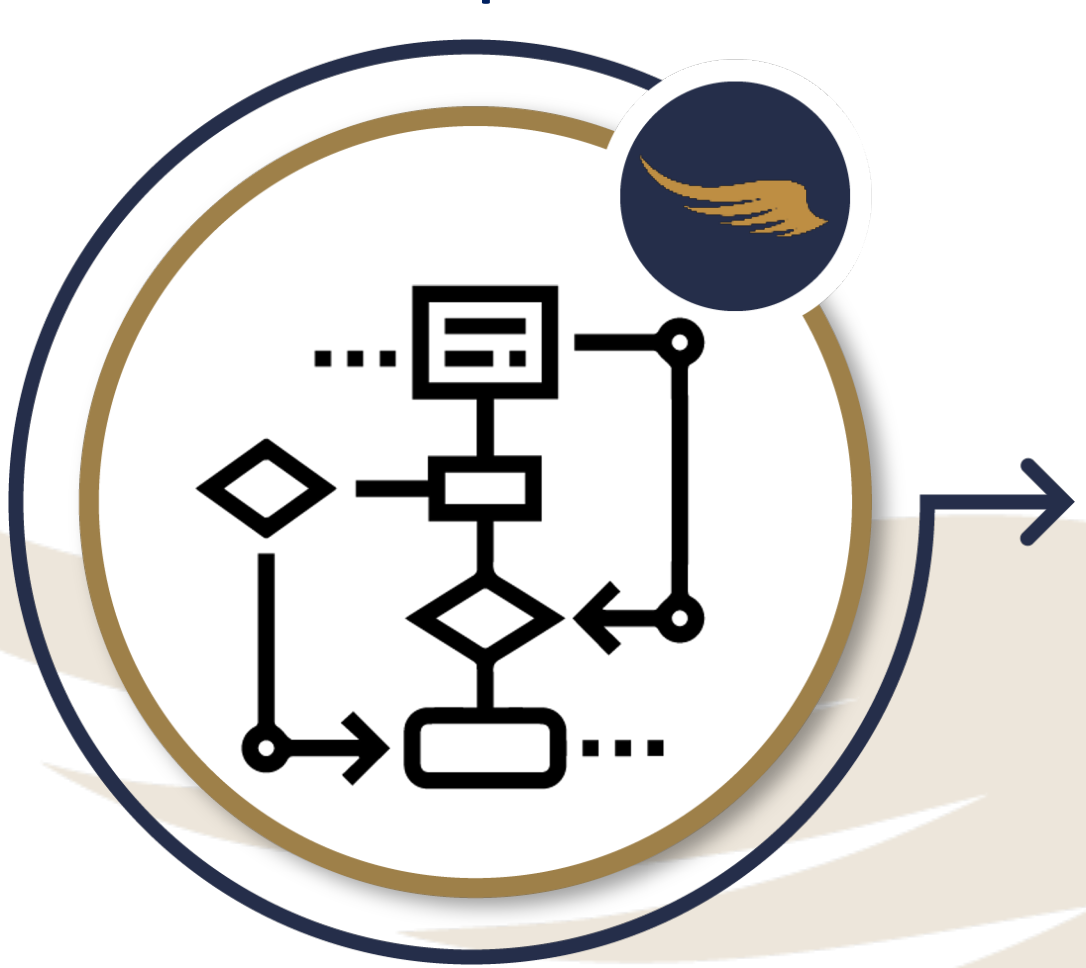
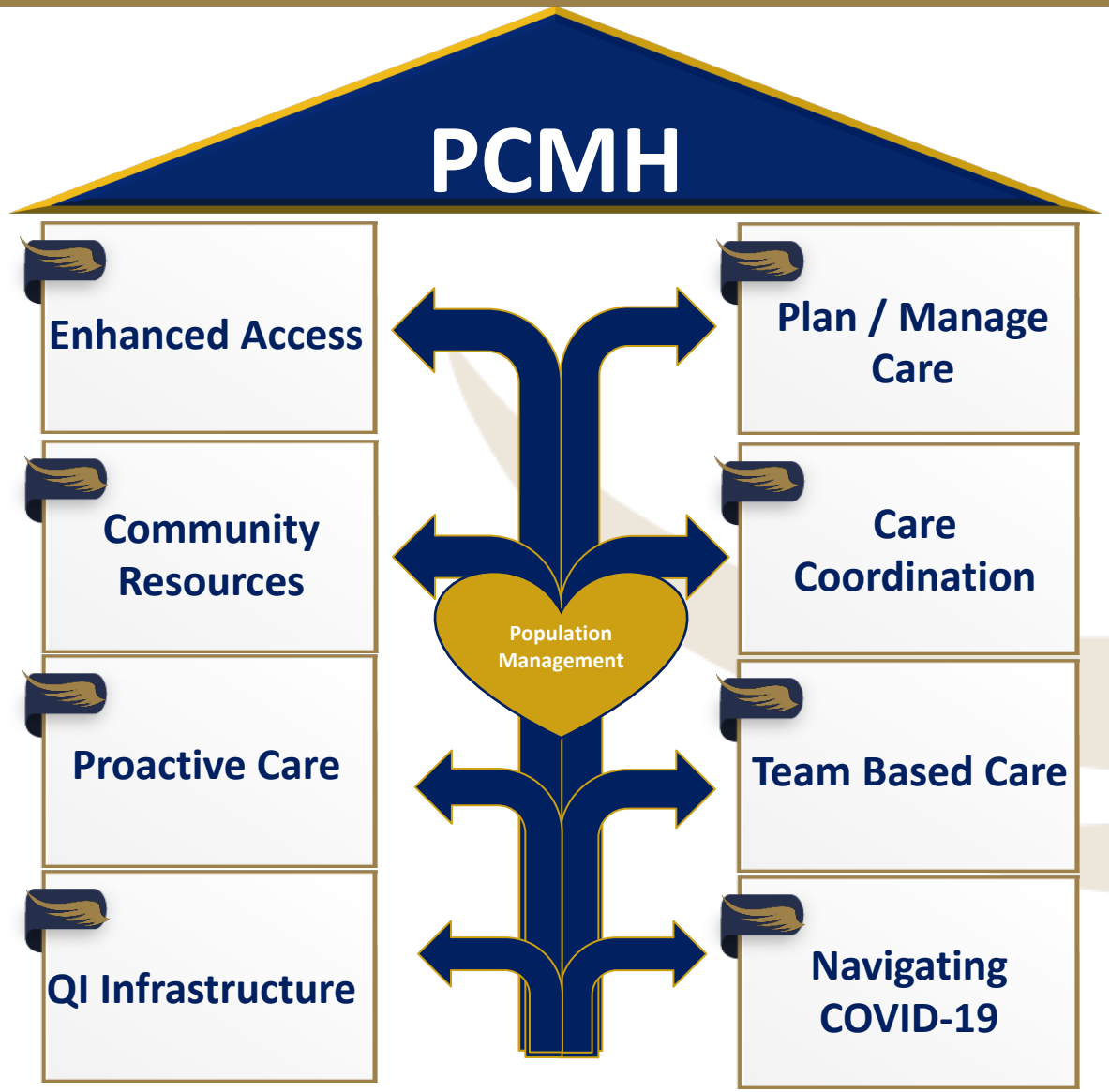
- Pre-Visit Planning



Patient Centeredness in the Age of COVID-19: Practice Operations: Population Management



Practice Operations: Population Management: PCMH KM12

KM 12 (Core) Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers about needed services (must report at least three categories):

A. Preventive care services.

B. Immunizations.

C. Chronic or acute care services.

D. Patients not recently seen by the practice.

GUIDANCE	EVIDENCE
The practice uses lists or reports to manage the care needs of specific patient populations. Using collected data on patients, the practice addresses a variety of health care needs using evidence-based guidelines, including missing recommended follow-up visits. The practice implements this process at least annually to proactively identify and remind patients, or their families/caregivers, before they are overdue for services.	• **A, B, D: Report/list *and*** • **A, B, D: Outreach materials** • **C: Report/list *and*** • **C: Outreach materials** ***OR*** • **C: KM 13**

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Population Management in Action

- Identify and Utilize Care Gap Reports
- Leverage EHR to Conduct Proactive Care/Outreach
- Organize a Call Team
- Solicit Patient Feedback to Identify Barriers

Patient Centeredness in the Age of COVID-19: Practice Operations

- Communication
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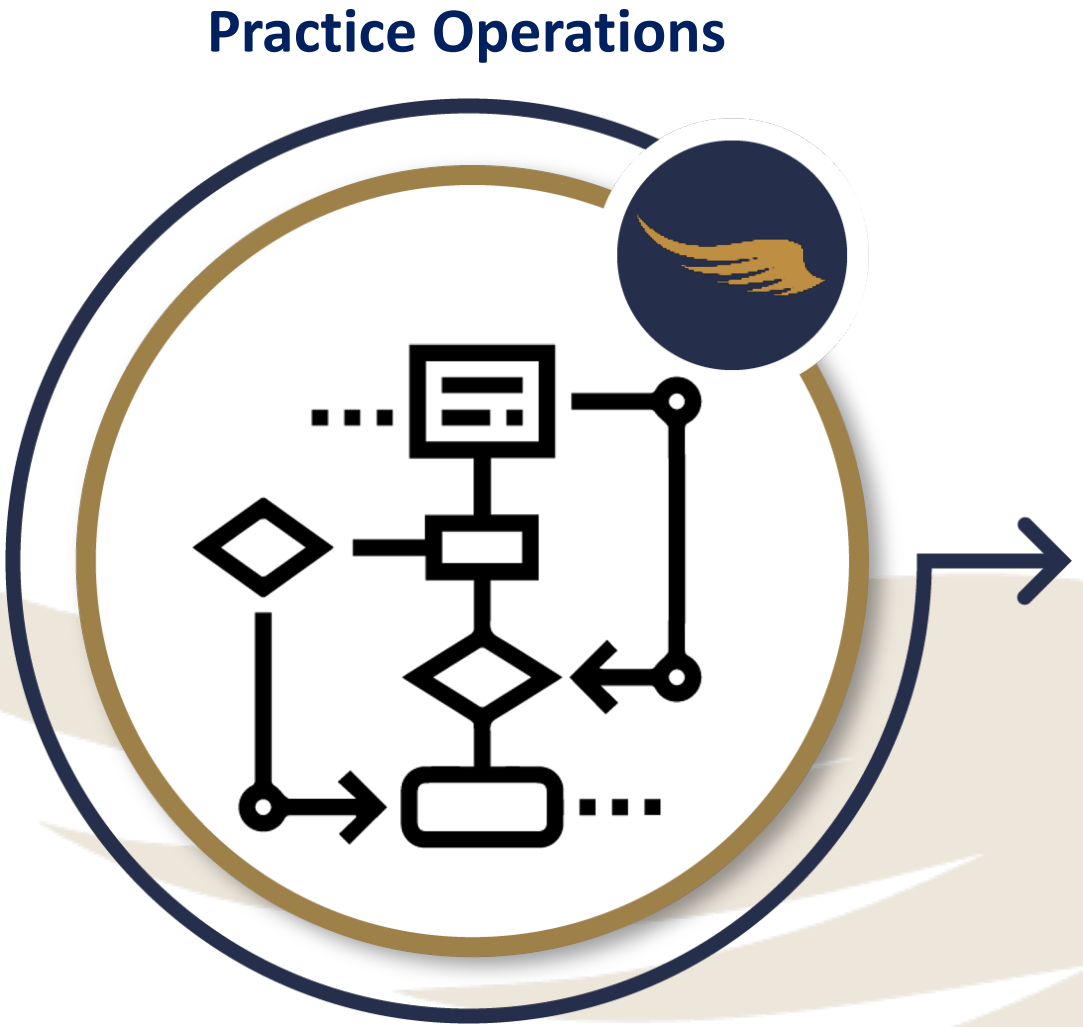
- Pre-Visit Planning



Practice Operations: Pre-Visit Planning: Benefits

Pre-visit planning is a proactive approach to care that ensures each visit is meaningful and well-organized by shifting administrative tasks out of a patient's appointment time so team members can focus on the patient — not paperwork.

Practice Operations: Pre-Visit Planning: TC06: Daily Care Team Huddles

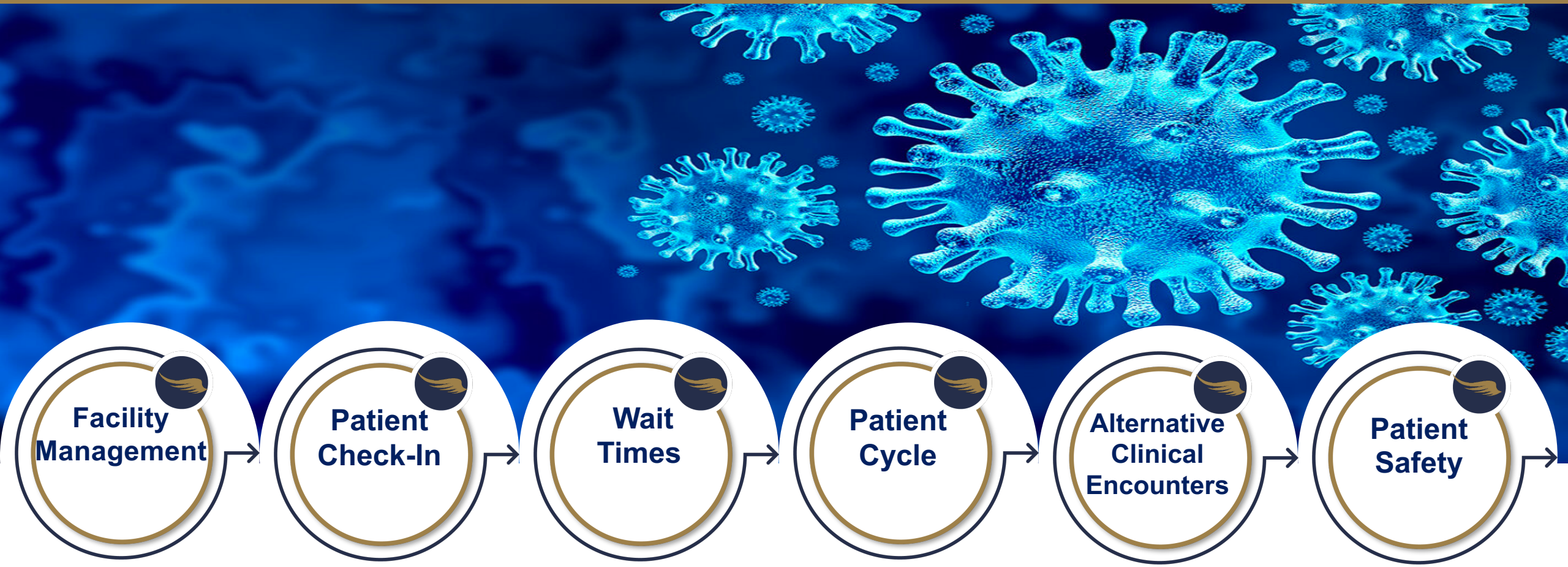
TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.

GUIDANCE	EVIDENCE
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• **Documented process** ***AND*** • **Evidence of implementation** ***Documented Process Only***

Practice Operations: Pre-Visit Planning: Huddle Checklist

- Adequate Daily Staffing
- Test Results / Consult Notes
- High Risk Patients
- Care Gaps
- Patients Requiring More Time
- Adequate Medical Supply to meet Patient Demand

Practice Operations: Pre-Visit Planning: COVID Implications



Practice Operations: COVID-19 Resources

National Institute for Occupational Safety and Health
https://www.cdc.gov/niosh/index.htm

Substance Abuse and Mental Health Services Administration:
https://www.samhsa.gov/coronavirus

National Institutes of Health
https://www.covid19treatmentguidelines.nih.gov/

Centers for Disease Control and Prevention
https://www.coronavirus.gov

Louisiana Department of Health
https://ldh.la.gov/index.cfm/subhome/66

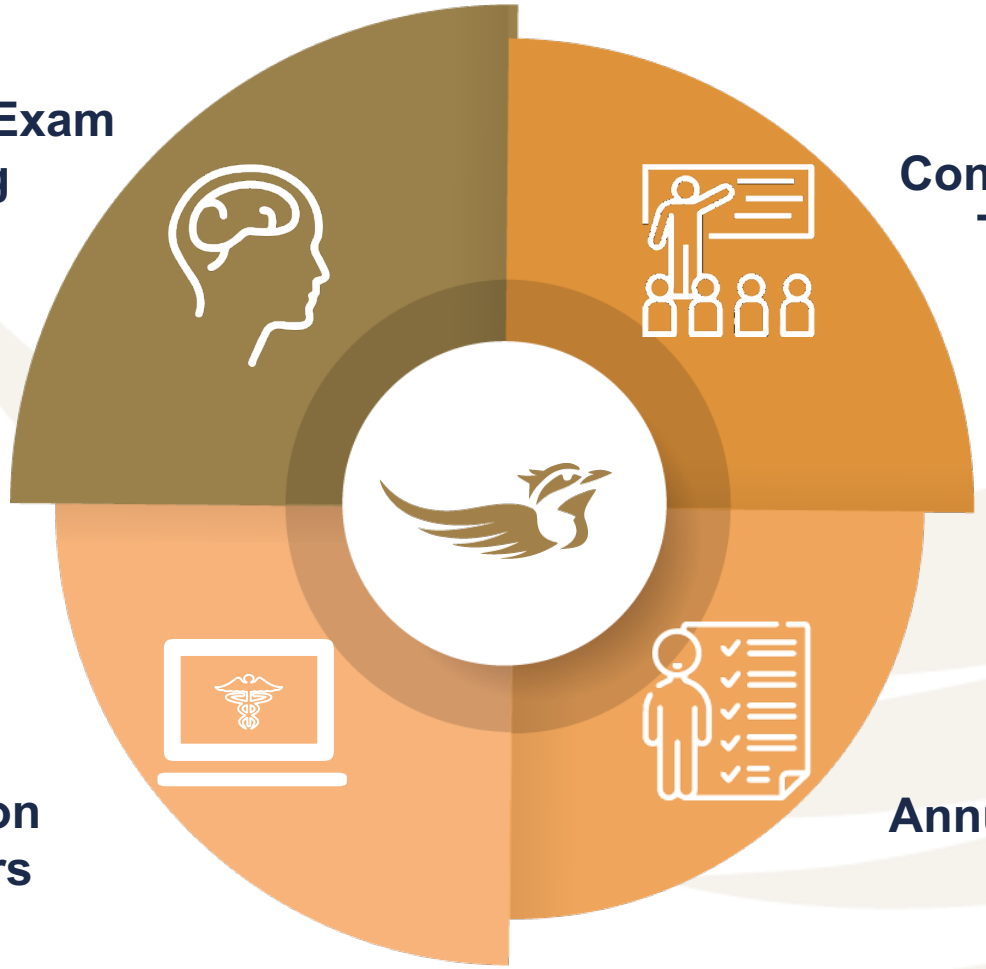
Health Center Controlled Networks (HCCN)
https://bphc.hrsa.gov/program-opportunities/hccn

Thank You

Honnete Consultation Support

PCMH CCE Exam Training

PCMH Consultation & Training



Education Webinars

Annual Reporting Support

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