The AccessHealth Spartanburg

Mission:

To improve access to healthcare for the uninsured of Spartanburg, Cherokee and Union counties
Medicaid non-expansion state
22,432 low-income, uninsured individuals
Minimal care coordination
No care management
No focus on SDoH
Poor health outcomes
Creation of AccessHealth Spartanburg

Non-profit, grant-funded community organization focused on building a network of care for the uninsured, using a community case management structure.

✓ To address the following:
  ✓ Access to primary care
  ✓ Access to specialty care
  ✓ Access to dental health
  ✓ Access to behavioral health
Program Approach

Care Navigation, Coordination, and Care Management

- 4 Registered Nurses
- 1 Medical Social Worker
- 8 Community Health Workers
- Support Staff

- Determine eligibility
- Assess SDoH
- Prioritize needs
- Establish goals
- Develop careplan
- Connect to resources
- Care management
### Social Determinants of Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently employed?</td>
<td></td>
</tr>
<tr>
<td>Does your employer offer health insurance?</td>
<td></td>
</tr>
<tr>
<td>What is keeping you from getting a job?</td>
<td></td>
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<tr>
<td>How far did you go in school?</td>
<td></td>
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<tr>
<td>How often do you need help understanding medical information?</td>
<td></td>
</tr>
<tr>
<td>What are your current living arrangements?</td>
<td></td>
</tr>
<tr>
<td>Have you received assistance from any of the following resources in the past month?</td>
<td>Disability  Food Stamps  Food Pantry  Social Security  Other  SSI  Unemployment</td>
</tr>
<tr>
<td>Do you have access to healthy food?</td>
<td></td>
</tr>
<tr>
<td>Do you have a safe place to exercise?</td>
<td></td>
</tr>
<tr>
<td>Are you interested in any of the following?</td>
<td></td>
</tr>
<tr>
<td>Employment assistance  Healthy Eating  Other  Personal Finances  Family Finances  Exercise</td>
<td></td>
</tr>
<tr>
<td>Do you have a regular doctor?</td>
<td></td>
</tr>
<tr>
<td>Are you interested in getting the flu shot?</td>
<td></td>
</tr>
<tr>
<td>In the past 12 months, have you had any of the following?</td>
<td></td>
</tr>
<tr>
<td>Mammogram  Flu Shot  PAP Smear  Colonoscopy  Prostate Exam</td>
<td></td>
</tr>
<tr>
<td>Are you planning to have a pregnancy in the next 12 months?</td>
<td></td>
</tr>
<tr>
<td>Do you need more information on preventing pregnancy and/or STIs (Sexually Transmitted Infections)?</td>
<td></td>
</tr>
<tr>
<td>What medications do you take?</td>
<td></td>
</tr>
<tr>
<td>Do you have any problems getting your medications?</td>
<td></td>
</tr>
<tr>
<td>Have you been connected to Welvista?</td>
<td></td>
</tr>
<tr>
<td>What medical problems have you been diagnosed with?</td>
<td></td>
</tr>
<tr>
<td>Have you recently been hospitalized or had surgery?</td>
<td></td>
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<tr>
<td>If yes, did you receive follow up care?</td>
<td></td>
</tr>
<tr>
<td>How many times have you been to the ER in the past year?</td>
<td></td>
</tr>
<tr>
<td>Do you have any problems with your teeth or gums now?</td>
<td></td>
</tr>
<tr>
<td>Do you have any vision or eye problems now?</td>
<td></td>
</tr>
<tr>
<td>Have you ever been treated for a mental health disorder?</td>
<td></td>
</tr>
<tr>
<td>When and where were you treated?</td>
<td></td>
</tr>
<tr>
<td>Do you smoke or use tobacco products?</td>
<td></td>
</tr>
<tr>
<td>Have you ever been treated for drug/alcohol abuse?</td>
<td></td>
</tr>
<tr>
<td>Do you feel lonely and/or isolated?</td>
<td></td>
</tr>
<tr>
<td>Who do you call when you need help?</td>
<td></td>
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<tr>
<td>What makes you happy or proud?</td>
<td></td>
</tr>
</tbody>
</table>
AccessHealth Program Outcomes

- Advance health equity
  - 54% BIPOC
  - 22% Spanish speaking
  - Prison release program

- Engage community partners
  - 291 volunteer primary care providers
  - 210 volunteer specialty care providers
  - 50+ community-based partners across three counties
  - 100% connected to primary care
  - 89% of specialty referrals completed

- Better use of resources
  - Prevent duplication of services
  - Improved care transitions

- Improve health outcomes
  - Shift from “crisis care” to preventative care and chronic disease management
  - Reduction in Hgb A1c

- Reduce healthcare costs
  - 50% reduction in ED utilization
  - 20% reduction in hospital admissions

- Connection to gainful employment
  - 25% obtain health care coverage and/or increase household income
Lessons Learned

- **Collaboration is key**
  - End the silos
  - Steal shamelessly and share relentlessly
  - Collect all the data and measure everything
    - Disaggregate data
- Communicate
  - Providers need to know about their “non-compliant” patients
  - Outcomes to the community
- Involve people with lived experience to guide programming
  - Client advisory committee
  - Focus groups
  - Client surveys
Reaching the Uninsured Through Telehealth Services During the Pandemic

-November 2021-
Trusted Pillar of Community-Based Health Services that:

- has served Mecklenburg County since 1955
- provides affordable, high-quality health services
- extends access to the un- and underinsured
- offers holistic continuum of care, birth to end-of-life
Care Ring is uniquely positioned to provide a wide range of low-cost healthcare services to those who cannot afford care.

**What We Do**

- **Low-Cost Clinic**
  Primary care for people most in need

- **Physicians Reach Out**
  Comprehensive care for people with limited resources

- **Nurse-Family Partnership**
  Personalized support for at-risk moms

- **Community-Based Care**
  Meeting people where they are
19% of Adults in Mecklenburg report being diagnosed with depression (2018 BRFSS)

Low-income adults are 2X as likely to report having diabetes or cardiovascular disease than higher income adults

13% of Mecklenburg residents are uninsured (2017 US Census)

160K residents in Meck Co. report not being able to see a doctor due to cost

Black infants are 5X more likely to die in year 1

64% of Adults in Meck Co. are either overweight or obese
People with less education and income tend to live in neighborhoods which lack access to nutritious foods and safe places to exercise. In addition to facing increased advertisements of tobacco, alcohol and high-calorie foods, residents of low income neighborhoods may also be exposed to risk factors that increase their chances for chronic diseases later in life.
PEOPLE OF COLOR

93%

OF INDIVIDUALS SERVED
IDENTIFY AS A PERSON OF
COLOR (BLACK, LATINX*,
ASIAN).

*63% Limited English Capacity

$17k

Average Annual Income
(17% FPL for Family of 4)

PRIORITY HEALTH ZIP CODES*

47%
NFP

33%
PRO

36%
CLINIC

*Through June 2021

*Through June 2021
2020-2021 YEAR IN REVIEW

7,670 Patients

MORE PEOPLE SERVED IN A YEAR THAN EVER BEFORE

Completed

2,056 VIRTUAL VISITS

138 BABIES Born in NFP

Reached

6,200 PATIENTS

Saved

$15M

Type 2 Diabetes Participation Award and recognition for helping to improve blood pressure among served patients

NAFC Gold Standard

Healthcare Leadership Council Redefining American Healthcare award

Charlotte Business Journal’s Healthcare Heroes Award

$51.3M in donated charges to supported PRO

Community-Based Healthcare provided in communities, including our local jail

Community-Based Healthcare provided in communities, including our local jail

up slightly from last year and nearly 10% increase in home visits

within PRO 42% growth trend over the last 4 years

In avoidable ED and hospital charges as a result of our Access to Care programs (Clinic + PRO)

• Type 2 Diabetes™ Participation Award and recognition for helping to improve blood pressure among served patients

• NAFC Gold Standard

• Healthcare Leadership Council Redefining American Healthcare award

• Charlotte Business Journal’s Healthcare Heroes Award

6,200 PATIENTS Reached

42% growth trend over the last 4 years

$15M Saved

In avoidable ED and hospital charges as a result of our Access to Care programs (Clinic + PRO)
Virtual Management of Diabetes & Hypertension
What is Telehealth?

“Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health care”. – Mayo Clinic

• **Real-Time:**
  • Video or phone conferencing
  • See and interact face-to-face
  • Closest to traditional visit

• **Store-and-Forward:**
  • Health information gathering (demographic data, medical history, lab results, etc.)
  • Expedient sharing with other healthcare orgs
  • Holistic care

• **Remote Patient Monitoring:**
  • Wireless wearable technology that gathers data for remote monitoring (cuffs, scales, smart watches, glucose monitors)
  • Encourages self-management/independence

• **Secure Messaging**
Why Telehealth?

- Addresses provider shortages
- Provider training and education
- Improved patient engagement
- Location diversity
- Increases access to services
- Lowered cost
- Heightened quality of care
- Scalability
- Deepened insight into living environment and circumstances
- Reduced usage of Emergency Departments

“Fifty-three percent of patients are too afraid to visit their doctor in person due to COVID-19” – Sara Heath PatientEngagementHIT, April 20, 2020.
Telemedicine Is Being Used in Many Scenarios During the COVID-19 Pandemic:

- A patient with mild respiratory symptoms needs evaluation, but has been told not to go to the emergency room.
- A patient has no symptoms of COVID-19, but had contact with someone infected by the novel coronavirus and wants to be evaluated.
- A patient needs care for an unrelated reason (e.g., management of chronic health condition), but cannot go in-person due to clinic closure or fear of coronavirus exposure.
- A provider has been quarantined due to COVID-19, but can continue to see patients from their home via virtual visits.
- A patient with severe symptoms of COVID-19 is hospitalized, and needs a specialty consult with an infectious disease doctor in a remote location.
Our Clinic’s Use of Telehealth

Prior to COVID, 0% of Provider Visits were Telehealth

- FY21: 54% of all provider visits (2056/3058) provider visits
  - frequent telehealth follow-up with high-risk COVID patients, including weekends
- Overall, 95% of telehealth clients are people of color and/or racial/ethnic minorities
- Bilingual providers available for Spanish-speaking patients
- Of patients served with telehealth during COVID, 16% received care from us for a COVID diagnosis
- 94% of all of Care Ring COVID patients are Hispanic/Latino
Results/Outcomes

- April 2020-March 2021:
  - 8% of all patients served were NEW pts established via telehealth
  - 77% of ALL Clinic patients had at least one telehealth visit.

<table>
<thead>
<tr>
<th>Low-Cost Clinic</th>
<th>FY21</th>
<th>FY22</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of diabetic patients with A1c &gt;9% (highly uncontrolled)</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>% of hypertension patients with controlled blood pressure</td>
<td>62%</td>
<td>71%</td>
</tr>
</tbody>
</table>
Qualitative Survey Data

“I was satisfied with my telehealth experience at Care Ring.”
– 90% strongly agree or agree

“During my telehealth visit, I felt like my doctor gave me the same care that I get in the office.” – 95% strongly agree or agree

“Without telehealth visits at Care Ring during the pandemic, my health would have gotten worse.”
– 67% strongly agree or agree

“I’ll schedule virtual visits in the future to manage my health needs.”
–73% strongly agree or agree
Challenges

- Patients assume there’s a cost
- Technology gaps
- Translation support
- Balancing staff responsibilities
- Lack of access to EHR-integrated remote patient monitoring devices due to cost
- Overcoming industry stigma regarding use with low-income populations
- Organization’s cost
“We have to think about accessibility to meet all of the people we are serving. Otherwise, we run the risk of leaving a whole section of people behind at a particularly tenuous time during this pandemic.”

Adaeze Enkwechi, PhD, MPP
President, IMPAQ

#RevelHealth “Social Determinants Up Close and Personal,” August 25, 2020
OUR SHARED GOAL:

We envision a community that promotes, protects and improves the health and wellbeing of all people. Care Ring is a vital link in achieving this vision.
Care Ring is more than just a provider of direct services - we work to address the health disparities and inequities that exist for racial and ethnic minorities through listening and trust-building.
“It’s not an overstatement at all to say that Care Ring is the picture of what American healthcare needs to be right now.”

– Mary Grealy, President, Healthcare Leadership Council
To Learn More: www.careringnc.org

To Give:

[QR Code Image]
NM EMSC Child Ready
Virtual Pediatric Emergency Department
Telehealth Network

Robert E. Sapien, MD, MMM - Principal investigator
Jeffrey Bullard-Berent, MD, FAAP – Medical Director
Sara Daykin, DNP – Education Director
Katherine Schafer, BS – Program Manager
Our Grant Funders

• EMS for Children State Partnership Grant - MCH HRSA

• Rural Child Health Poverty Telehealth Network Grant - Office for the Advancement of Technology - HRSA

This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Overview: Regionalization

“A process of organizing resources within a geographic region to ensure access to medical care of a level appropriate to a patient’s needs, while maintaining efficient use of available resources.”

Right care, right place, right time
Overall Goal

Reduce pediatric morbidity and mortality by ensuring communities have the resources and capabilities to provide effective care:

Areas of Focus
a. Preparedness
   1. Child Ready
   2. National Initiatives
b. Telehealth
c. Education
   1. Personalized
   2. Child Ready ECHO

Prepare for the ordinary to be prepared for the extraordinary

Helping prepare the community for the ill or injured child from scene to system
A “Child Ready” Model
Things we considered for a recognition system…

Involves overlapping communities or catchment areas
Includes schools, EMS, various health care providers
May cross state borders
Telehealth – Building a Virtual Pediatric Emergency Department
Regionalization of Care – Telehealth Example
Originating site

RURAL OR TRIBAL FACILITY

Distant site

UNM HOSPITAL
What is a Virtual Pediatric ED?

TELEMEDICINE VS TELEHEALTH

Access to Pediatric Emergency Nurses for nurse-to-nurse consultations

Educational opportunities: challenging case discussion, QA/QI, ED clinical rounds, mock codes with simulation
A Virtual Pediatric ED

Direct patient care, consultation and co-management of children in rural and tribal EDs (originating sites)

Designated Medical Director

Patients registered and receive medical record number

Documentation in our EHR as well as at originating site

All consulting physicians are credentialed and privileged at originating sites
A Virtual Pediatric ED

Creating a culture of “on-shift” together

Consultation and co-managing in situ of acute ill or injured children with rural, general EDs (for low to high acuity)

Access to Pediatric Emergency specialists

Access to child abuse and behavioral health experts
Active sites

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artesia General Hospital</td>
<td>244 mi</td>
</tr>
<tr>
<td>Crownpoint Healthcare Facility, IHS</td>
<td>134 mi</td>
</tr>
<tr>
<td>Gila Regional Medical Ctr, Silver City</td>
<td>235 mi</td>
</tr>
<tr>
<td>Guadalupe Co. Hospital, Santa Rosa</td>
<td>116 mi</td>
</tr>
<tr>
<td>Lovelace Regional Hospital, Roswell</td>
<td>244 mi</td>
</tr>
<tr>
<td>Mescalero Indian Hospital, IHS</td>
<td>214 mi</td>
</tr>
<tr>
<td>Northern Navajo IHS, Shiprock</td>
<td>212 mi</td>
</tr>
<tr>
<td>Roosevelt General Hospital, Portales, NM</td>
<td>227 mi</td>
</tr>
<tr>
<td>Sandoval Regional Medical Ctr, Rio Rancho</td>
<td>29 mi</td>
</tr>
<tr>
<td>Sierra Vista Hospital, ToC, NM</td>
<td>150 mi</td>
</tr>
<tr>
<td>Union Co. General Hospital, Clayton</td>
<td>272 mi</td>
</tr>
<tr>
<td>Zuni Comprehensive Health Ctr, IHS</td>
<td>150 mi</td>
</tr>
</tbody>
</table>
Savings

- 13 different healthcare facilities participated
- 95 telehealth consults
- 75% of patients stayed in their own communities
- 18,302 patient miles saved
- $2.156 million in transport cost savings
- 24 nurse education modules delivered
- $11,520 given in no-cost CEUs to nurse participants

Compared to air transfer at an average cost of $38,500:
- 25% rural
- 11% suburban
- 64% tribal

*Based on average cost of air transfer at $38,500
Thank you!

For more information, please email:

HSC-ChildReady@salud,unm.edu

Or Call
505.269.0347
REDEFINING AMERICAN HEALTH FOR AN AGING POPULATION
PROBLEM: HOW DO WE REFRAME AGING IN A CHANGING WORLD

Solution: through collective action....

“Good news, honey—seventy is the new fifty.”
Healthy Aging is the process of developing and maintaining the functional ability that enables wellbeing in older age.

Functional ability is about having the capabilities that enable all people to be and do what they have reason to value.
Board of Regents Approved Center, November 2016
More than 90 Faculty Affiliates internationally
About 15 staff, students, and post-doctoral fellows
Certified for another five years

https://cpha.tamu.edu/
"AGE IS AN ISSUE OF MIND OVER MATTER
IF YOU DON’T MIND, IT DOESN’T MATTER."

Mark Twain, Author
CENTER FOCAL AREAS AND PERSPECTIVES

Data & Training
Evidence-based Health Wellness Programs
Health Care
Economics & Policy
Technological Innovations

C4: Clinical-Community-Corporate COLLABORATION
TRANSLATION EVALUATION

Active for Life®
Making Moves WITH DIABETES
Live Healthy, Work Healthy
TEXERCISE
ACL

TEXAS FOR LIFE COALITION
Comprehensive effort to reduce preventable diseases and their consequences in a 27-county region

Leverages existing resources that focus on the delivery of prevention and outreach services

Combines the strengths of Texas A&M Health Science Center and Texas A&M AgriLife Extension Service

*Highlighted in our award application. https://healthytexas.tamu.edu/*
HEALTHY SOUTH TEXAS DIABETES EDUCATION PROGRAM*

- A collaborative community-clinical approach
- Reach large numbers of underserved persons
- Improve many health and wellness indicators
- Maintain gains over time
- Challenges/lesson learned: how to keep population engaged

Lessons Learned:

- DSME is beneficial
- Make education more interactive and problem solving
- Offer different delivery modes
- Fit into institutional mission, structures and resources

*Example of campus-corporate partnership with BCBS
Wandering is a major concern for caregivers of PLWD

How to balance independence and safety issues?

Usability study of “smart wearable watch” with enhanced features of GPS and two-way communication

Lessons Learned

- Responses to technological supports not monolithic
- Opportunities & challenges during pandemic

*Example of campus, clinical, community, corporate partnership*
MAINTAINING INDEPENDENCE : AUTONOMOUS VEHICLES

- Can free taxi and telemedicine services be implemented and sustained in rural communities?
- How to make features more senior friendly?

Lessons Learned:
- Community engagement essential in introducing innovations
- Older adults will use AVs in transit deserts
- Still concerned if totally autonomous

*Envisioning the Neo-traditional Development by Embracing the Autonomous Vehicles Realm.
Concern with the time it takes to get research into practice—and make a difference

New E-book: Use of the RE-AIM Framework: Translating Research to Practice with Novel Applications and Emerging Directions

Updated Website: www.re-aim.org
Aligning Social Care and Health Care
June Simmons, CEO
PARTNERS IN CARE FOUNDATION

A Mission-Driven Organization

Our Mission
Partners shapes the evolving health system by developing and spreading high-value models of community-based care and self-management
Our Partnership

• Partners collaborates with hospitals, physician groups, health plans, community-based organizations, and government agencies to deliver services that support adults with complex health and social services needs and their caregivers and families

• Evidence-based programs demonstrated to significantly reduce costly hospital readmissions, ED visits, and nursing home placements
Our Focus on Innovation

• We shift the emphasis from illness care to preventive care, reducing costs and improving quality of life for those with chronic conditions

• NCQA accredited for Complex Care Management as defined by CMS.
A Statewide Network
In a Large Geographic Footprint

Building inclusive models of care:

- Evidence-Based Self-Management Workshops
- Social Care Service Coordination
- Caregiver Education & Support/Respite
- Workforce development
The Social Determinants Specialists
Aligning Social Care & Health Care

CalAIM

Enhanced Care Management — Special Populations
- Outreach & Engagement
- Comprehensive Assessment and Care Management
  - Member and Family Supports
  - Coordination and referral to services
- Health Promotion
  - Evidence Based Programs a component

Community Support Services
- Arranged and paid services
Aligning Social Care & Health Care

SHARPS Conundrum
(Social Health Access Referral Platforms)
➤ Referrals without payments

Network Lead Entities
➤ CBO Hubs
  ▪ Contracting
  ▪ Billing
  ▪ Analytics
  ▪ QA
  ▪ IT, etc.
A broad coalition of health plans and CBOs co-designing the next system:

✓ **Goal I:** Co-design a plan, with engagement from CBO network leads, health plan/systems, and diverse consumers, to build the capacity of CBO networks to provide measurable health-impacting social services.
  - CBO Network Credentialing
  - TA and Training Approaches to Strengthen CBOs for this New Role
  - Create a streamlined model for interface between CBOs and plans/systems

✓ **Goal II:** Co-design common standards for effective and sustainable partnerships between CBO networks, health plans, and health systems.
  - Best Business and Service Practices
    - IT Element and Solutions
    - TA and Advocacy
    - Coding
    - Contracting
    - Infrastructure Needs and Funding
Partnership. Innovation. Impact
The Social Determinants Specialists

Partners in Care
Partners at Home
Accredited NCQA Case Management
Thank You!

For more information, please contact:

June Simmons
President and CEO
jsimmons@picf.org
818-837-3775 x101

The Social Determinants Specialists.