EVALUATION OF THE COMMUNITY MEDICAL CLINIC

OCTOBER 2019 - OCTOBER 2021

CMC

COMMUNITY MEDICAL CLINIC
OF KERSHAW COUNTY
OUTREACH - ACCESS - MEDICAL HOME

Executive Summary

The Community Medical Clinic of Kershaw County's ultimate goal is to create a healthier Kershaw County for everyone.

CMC provides direct medical services at no cost to patients living in Kershaw County. In addition, CMC leads the charge with county and state partners to make Kershaw County the healthiest county in South Carolina. The leadership of CMC believes strongly that good health goes beyond healthcare and is committed to **"helping people thrive, and not just survive."**

The evaluation of the CMC focused on a single question: **"Describe the CMC Model and demonstrate how it is different than existing free clinic models."** It is apparent that CMC was a forerunner in addressing root causes, equity, social determinants of health and data-driven decision making. As of March, 2020, only 12% of free clinics across the nation are addressing social determinants of health through an equity lens.

Iron Sharpens Iron Consulting examined select domains closely to examine how CMC differentiates itself from others. In this evaluation report, you will find data and narrative related to a school-based health center, diabetes management, use of Community Health Workers, professional staff development, and the use of telehealth. It is important to recognize that this evaluation report does not capture all of the activities and initiatives that take place at CMC, including AccessKershaw, LiveWell Kershaw Coalition, and several of the activities related to primary care, medication, and care coordination. This evaluation report is intended to highlight some of the efforts and also document key decisions made and a sampling of the short-term and intermediate outcomes that have resulted from these efforts.

Unlike a typical free clinic, the **three primary drivers** of CMC from the 2019-2021 time period were: **1) partnerships, 2) professional staff development, and 3) technology and patient communication.** Providing direct medical services is a priority for CMC, but it is not the only priority. The leadership of CMC over the past eight years have been very intentional in broadening their definition of health and creating and executing strategies to change systems and move "upstream" while at the same time treating "downstream" symptoms. CMC believes that health includes "mental, physical, social and spiritual wellbeing." (WHO adaptation). CMC leadership recognized that even though downstream actions are easier to see and measure, organizations have to go upstream if problems would ever be prevented. The leadership recognized that this process would be slower and broader and yet are committed to continue the journey which will lead to lasting changes for generations in Kershaw County.

This evaluation report demonstrates how CMC surrounds problems by attracting team members and patients to examine issues, work on creating goals, and then begin quickly collecting data for learning. Maureen Bisognario notes that we need to "be impatient for action but patient for outcomes." The CMC team demonstrates time and time again that decisions are made for the "long-game" and focus on system changes that often take longer to implement.

The Community Medical Clinic of Kershaw County continues to implement innovative and collaborative ways to improve the health of the community. They are the only free clinic in South Carolina that has established school based health centers in county high schools.

Virginia Ann Mullikin
Executive Director
SC Free Clinic Association

Recommendations:

1. **Maintain the positive momentum.** Be sure to orient new Board members and team members to ensure that the upstream and patient-centered approach is embraced, understood and applied by all.
2. **Be intentional about documentation.** Quarterly collect key documentation in the following areas: primary care, chronic disease management, medications, care coordination, telehealth, professional and staff development and community engagement.
3. **Celebrate your incredible success.** Carve out time to reflect and celebrate reaching key milestones; this is crucial in long-term systems work.

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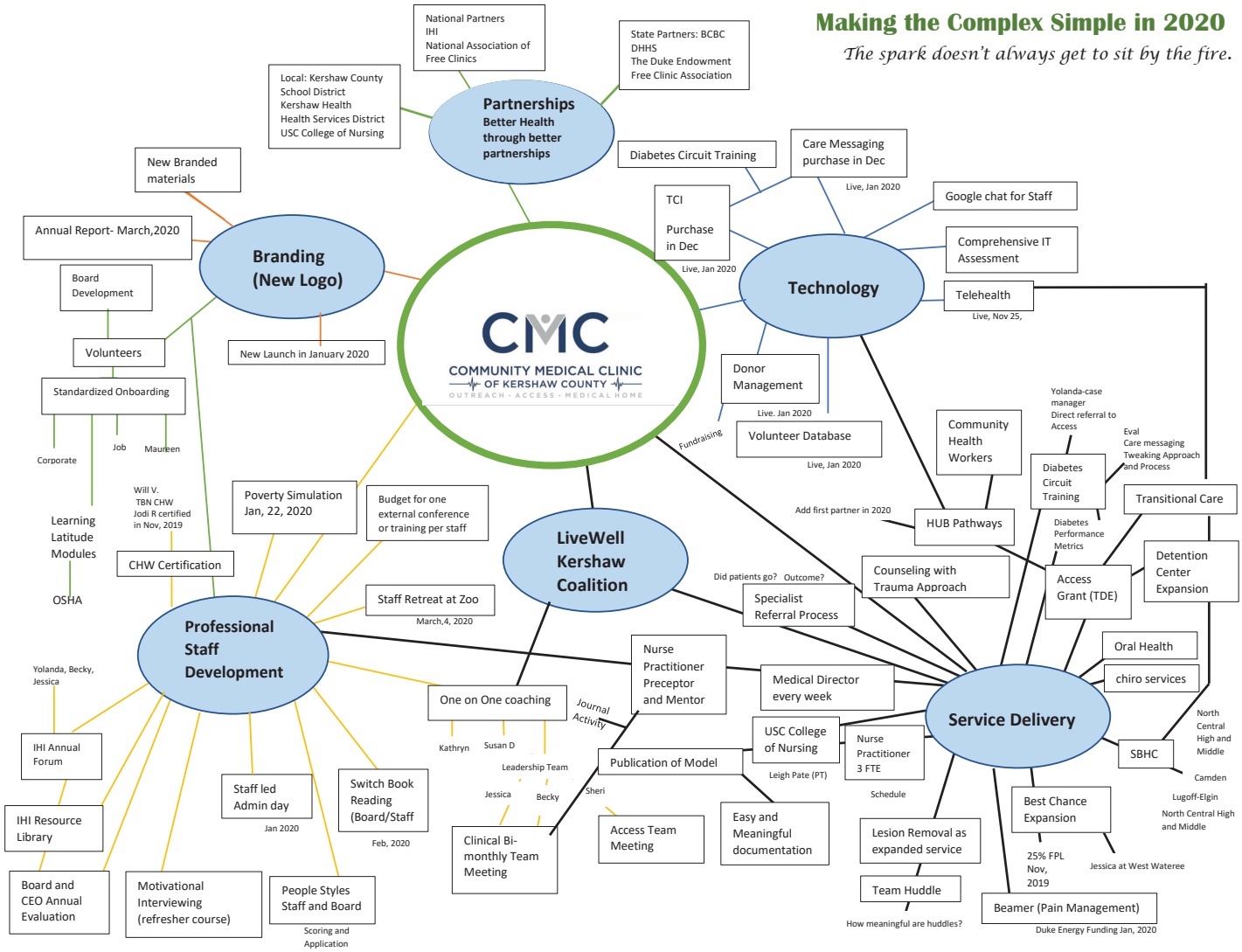
Mind Map and Logic Model

It is critical to understand that the Community Medical Clinic of Kershaw County (CMC) is not a typical free clinic only providing direct medical services at no cost to patients. **The mission of the clinic is two fold: 1) provide direct medical services and 2) lead the charge to improve population health.**

The mindmap and logic model show how CMC is operationalizing its vision of "a healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being.

In 2020, significant investments were made in deepening partnerships, expanding professional staff development and utilizing new technology and patient communication platforms. The 2019-2021 Strategic Plan's four strategic directions are integrated in both the logic model and the mind map. All activities and inputs are geared to addressing short-term, intermediate, and long-term outcomes.



CMC Logic Model

Our mission is to provide medical care and connect resources to achieve a healthier Kershaw County

Priorities

- Same page, same patient
- One team, one dream
- Maximizing people power
- Expanding resources based on needs

Local Partners	State Partners	National Partners
USC College of Nursing Kershaw Health Health Services District Kershaw County	BCBS DHHS The Duke Endowment Free Clinic Association	Institute for Healthcare Improvement

- Medical Director
- Nurse Practitioners
- Community Care Coordinators
- Community Health Workers
- Community Navigator
- Medical Assistants
- Volunteers
- Certified Diabetic Educators
- Nurses
- Spanish Translators
- Specialists (oral health, chiropractic and pain management)
- Development Director
- Administration
- Board of Directors

Primary Care
- Medical home for patients
- Specialist referrals
- Lesion Removal
- Chiropractic services
- Pain Management
- Best Chance Network

Chronic Disease Management
- Diabetes Circuit Training
- Diabetic supplies (glucometer and BP cuffs)
- Phone consultants

Medications
- Prescription Assistance Programs
- Well Vista

Care Coordination
- Case Management (AccessKershaw)
- Expansion to Detention Center
- Transitional Care

Telehealth
- School-Based Health Center at 3 high schools and 1 middle school
- Kershaw County Library tele-health site
- Phone medical visits

Professional Staff Development
- Switch Application
- People Styles Application
- Motivational Interviewing
- CHW Certification
- Admin Days and Annual Staff Retreat

Community Engagement
- LiveWell Kershaw Coalition

Long-Term Outcomes
- Increased quality of life
- Increased life expectancy

Intermediate Outcomes
- Management of chronic diseases
- Reduction of inappropriate use of emergency room
- Lifestyle Changes

Short-term Outcomes
- Reduction in key clinical indicators (blood pressure, A1C, Cholesterol)
- Reduction in no-shows
- Increase in patient and provider satisfaction
- Achievement of goals set by patients

Inpatient Hospitalizations and Emergency Room Visits

One of CMC's intermediate outcomes identified in the logic model is to reduce the inappropriate use of the emergency room. It is important to note that Kershaw County's hospital changed their charity care policies which was a major factor in the increase in inappropriate Emergency Room usage.

As part of our evaluation efforts, inpatient hospitalizations and emergency room visits are analyzed annually to determine if key outcomes are being impacted among patients of the Community Medical Clinic of Kershaw County. The first objective was to determine if there were changes in the rate of inpatient hospitalizations and emergency department visits among CMC patients one year prior and one year after the intervention. Using data from the South Carolina Office of Revenue and Fiscal Affairs, we calculated the change in inpatient hospitalizations and emergency department visits from one year of utilization prior to enrollment in CMC and one year of utilization post enrollment in CMC. Each change was calculated by cohort: those enrolled from July 2014 to June 2015, July 2015 to June 2016, July 2016 to June 2017, and July 2017 to June 2018. The overall composite score was calculated using the prevention quality indicator.

The prevention quality indicator overall composite score includes admission for someone 18 years or older with one of the following conditions: diabetes with short or long-term complications, uncontrolled diabetes without complications, diabetes with lower extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection (AHRQ measure 2008).

Table One: Percent Reductions in Inpatient Hospitalizations and ED Visits

	Percentage Reduction* (July 2014-June 2015)	Percentage Reduction (July 2015-June 2016)	Percentage Reduction (July 2016-June 2017)	Percentage Reduction (July 2017-June 2018)
Inpatient Hospitalization Discharges	60%	-50%	38%	11%
Emergency Department Visits	36%	10%	41%	-55%

*Positive is desired. Negative means a percentage increase

Statistically significant reductions in inpatient hospitalizations occurred from July 2016 to June 2018 ($p<0.05$). Positive percent reductions are the goal (see Table One). There was a 38% reduction in inpatient hospitalizations among the CMC cohort between the year pre-intervention and the year post-intervention in 2017 and an 11% reduction in 2018. For emergency department visits, there was a statistically significant reduction in ED visits between 2016 and 2017 ($p<0.05$). There was a statistically significant increase in ED visits from July 2016 to June 2018 ($p<0.05$).

To estimate avoided costs due to program implementation, we calculated the median costs of an inpatient hospitalization visit in South Carolina. The median charge of an inpatient hospitalization in South Carolina in 2016 was $26,600; 2016 is the last year HCUP has data published (HCUP). After applying a previously obtained cost-to-charge ratio of .29, the estimated median cost of an inpatient hospitalization is $7,714. **For every inpatient hospitalization avoided by visiting the nurse practitioner through CMC there is a healthcare utilization savings of $7,714.**

There was an 8% increase in inpatient hospitalization charges between July 2016 and June 2017. Thus, with three additional discharges for an inpatient stay from 2016 to 2017, there was an increased cost of $23,142.

Behavioral health was the most common condition for an inpatient hospitalization, as well as an ED visit, followed by diabetes and cardiovascular disease. The length of stay in the hospital had a minimum of zero days to a maximum of 46 days, with the median stay at 3 days.

References:

Farquhar, M. (2008). AHRQ Quality Indicators.

HCUP Cost-to-Charge Files. https://www.hcup-us.ahrq/gov/db/state/costtocharge.jsp

Table Two: Percent Reduction in Charges for Inpatient Hospitalizations and Emergency Department

	Percentage Reduction* (July 2014-June 2015)	Percentage Reduction (July 2015-June 2016)	Percentage Reduction (July 2016-June 2017)	Percentage Reduction (July 2017-June 2018)
Inpatient Hospitalization Charges	36%	30%	51%	-8%
Emergency Department Charges	33%	22%	67%	27%

*Positive is desired. Negative means a percentage increase

Evaluation of Community Health Workers

The definition of a Community Health Worker often differs based on context. The American Public Health Association has adopted the following definition of a CHW: "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

The list of roles for a CHW are growing and numerous. From our research, toolkits, articles, and resources reviewed, below are the roles that have emerged most prominently in the literature.

Roles include:

- Bridge the gap between communities and health and social service systems
- Assist with insurance coverage
- Monitor health status and adherence to treatment, health promotion and health coaching, referrals to medical providers or social services, assist in transitional care
- Grow individual and community capacity, community/cultural liaison
- Conduct community outreach and mobilization, cultural mediation
- Implement individual and community assessments

The following titles are often included under the CHW umbrella: health outreach worker, community health worker, community health advocate, community liaison, health worker, lay health advisor, client navigator, patient navigator, peer counselor, peer educator, promator/a, resource mother, community organizer and case manager. It is important to note that health systems often have their own unique titles for these positions. Some of the titles listed above may not be reflective of a CHW; the scope of work of the individual matters (i.e. community organizer and case manager).

Based on the initial evaluation finding described in this report, CMC implemented changes to clarify the role of CHWs within the clinic setting. With new leadership and comprehensive training opportunities in October, 2020 and May, 2021, the CHW role became embedded into the clinical team, supporting women's health through the Best Chance Network and the diabetes program. CHWs are now responsible for conducting outreach and initiating pathways addressing social determinants of health, providing support, and connecting to the medical team on non-clinical issues. CMC is acutely aware that health is more than clinical care.

To : Lindsey Kilgo, AccessKershaw and the Community Medical Clinic of Kershaw County
From: Holly Hayes, Iron Sharpens Iron Consulting Group
Date: September 9, 2020
Subject: Community Health Worker Evaluation

As part of the evaluation of the Community Medical Clinic, the role of the Community Health Worker is being examined. One of the funders, the Department of Health and Human Services, is particularly interested in the evolving role of the Community Health Worker and how they are being used in various settings. For this evaluation, two Community Health Workers were part of the team – CHW 1 and CHW 2. Some of the evaluation questions included:

- Are CHWs part of our model? Should they stay or go?
- What do CHWs do during a typical day?
- In what ways do CHWs complement case management?

Methodology included:

- Interviewing CMC team members
- Interviewing Community Health Workers
- Observing Community Health Workers
- Examining data entered for the Hub and Pathway System
- Collecting a case study from each Community Health Worker
- Literature review

The tables following show April, 2020 snapshots to use as baseline of activities documented in the Hub and Pathway System.

In April of 2020, the evaluator examined contacts and pathways that were active by all team members in AccessKershaw. This data was pulled from the Hub and Pathway system. This can be viewed as a baseline to see what changes occur with new leadership, models, and standardization of processes.

Table One: Types of Contacts Made in April 2020
Table Two: Snapshot of pathways in April 2020
Table Three: Activity Breakdown in April 2020

Table One: Types of Contacts made in April 2020

Coordinator	# of contacts	Phone Call	Left Msg	Attempted	Email	In-Person	Postal Mail	Fax	Text
Team Member 1	143	56	30	30	2		12	12	
Team Member 2	164	81	23	8	9	1	2		40
Team Member 3	75	48	11	15		1			
Team Member 4	111	45			3	2	12		49
Team Member 5	149	142			2	2	2	1	

Table Two: Snapshot of Pathways in April 2020

Coordinator	# of Pathways	Types of Pathways	Social Service Type	Program Type
Team Member 1	**41**	**Education 18 Health Insurance 1 Medical Home 7 Medical Referral 3 Medication Assessment 1 Social Service Referral 11**	**Food Assistance 1 Financial Assistance 1 Healthy Outcomes Plan 4 Medical Debt Assistance 2 Medication Assistance 3**	**Access Kershaw 24% Access Kershaw/Transitional Care 22% Case Management 5% Healthy Outcomes 49%**
Team Member 2	**43**	**Education 3 Health Insurance 7 Medical Home 4 Medical Referral 1 Social Service Referral 28**	**Food Assistance 4 Financial Assistance 1 Healthy Outcomes Plan 3 Insurance Assistance 1 Medical Debt Assistance 7 Medication Assistance 11 Not identified 1**	**Access Kershaw 88% Healthy Outcomes 12%**
Team Member 3	**59**	**Behavioral Health 1 Health Insurance 2 Medical Home 3 Medical Referral 5 Medication Assessment 5 Social Service Referral 26**	**Food Assistance 1 Financial Assistance 6 Healthy Outcomes Plan 9 Medical Debt Assistance 4 Medication Assistance 4 Other 2**	**Access Kershaw 17% Access Kershaw/Transitional Care 7% Case Management 14% Healthy Outcomes 36% Transitional Care 12%**
Team Member 4	**29**	**Education 1 Health Insurance 2 Medical Home 5 Medical Referral 2 Medication Assessment 2 Social Service Referral 17**	**Food Assistance 2 Legal Assistance 1 Medical Debt Assistance 2 Medication Assistance 8 Translation Assistance 3 Other 1**	**Access Kershaw 66% Case Management 3% Healthy Outcomes 14% Transitional Care 14% Unknown 3%**
Team Member 5	**20**	**Education 3 Medical Home 1 Medical Referral 2 Medication Assessment 1 Social Service Referral 13**	**Food Assistance 1 Financial Assistance 1 Medical Debt Assistance 8 Medication Assistance 2 Other 1**	**Access Kershaw 20% Case Management 35% Healthy Outcomes 25% Transitional Care 20%**

Table Three: Activity Breakdown in April 2020

Coordinator	Team Member 1	Team Member 2	Team Member 3	Team Member 4	Team Member 5
# of Contacts	143	164	75	111	149
Appointments	12	7			
Apps	1	17		3	
HOP	21	14	6		29
KH	4	8		1	12
Payments		1			
PCP	10	7	3	8	2
Referral	7		1	3	1
Referral CMC	20		9		
Referral Hospital	20		11		6
Referral EUC	1			7	
Referral Medical		1			
CM	3		28		19
Resource	42		4	16	3
TC	6		11		17
WV	6	17		4	4
Follow Up				59	36
Return Mail					2
Santee		2			
Service		2			
SNAP		6		4	
Specialty Care		3	1		
Cell Phone		1			
Extra Help		1			
Diabetes		2			
Lions Club		3			
Medicaid		5		3	1
Mental Health		3			
MUSC		3			
Lexington Uro					1
Ortho		1			
Neurology					1
PAP		1			
DM Education					2
New Client					1
RX					1
MAIP				2	
Mail					7
Unemployment		6			
Other		53			3

Case Studies from CHWs

Case Study from CHW 2

John, a 56-year-old, white male, has faced a difficult journey. Alcoholism led to estrangement from his family members and has coincided with mental health issues. He was unable to see his daughter or grandchild because of his ongoing issues and, as a result, was continually depressed. On John's journey, he bounced from place to place and was consistently in and out of jail.

John was connected to Access Kershaw in March 2018 but was met with some apprehension from the staff due to his heavy drinking and showing up to his appointments intoxicated. However, the team was able to work through this to help him address the issue he was facing at that time, which was losing his home. Kershaw County Mental Health had provided him with a place to stay while in their care but due to his success in the program, he was not able to continue living there. He was desperate for any help that Access could provide in securing a new place for him to stay.

CHW 2, a Community Health Worker, was able to set in motion a plan to help John with his current housing need and more. They were able to establish him as a patient at the Community Medical Clinic and connect him to Welvista. John was already receiving SNAP benefits and continued to see his counselor at the Kershaw County Mental Health Clinic. He was referred to Food for the Soul to learn about additional food supports and to check on Men's Transitional Housing through the United Way of Kershaw County.

In November 2019, John was finally approved to receive disability benefits. With this income, he could afford to pay for a hotel room to stay in. While not ideal, it is a temporary solution. With support, John has stopped drinking and as a result, has repaired relationships with family members. He is now able to see his daughter and grandchild. John also shares that his sister is now willing to transport him to his medical and social service appointments. Staff on the Access Kershaw team note that John's entire demeanor has changed as a result of the support that he now has as a result of the care, connection, and encouragement that he was provided.

Case Study from CHW 1

Maria, a 32-year-old female with a six-year-old daughter, found herself in dire need of help from the Access Kershaw team in early 2020.

Earlier in the year, Maria's neighbor had attended an outreach event at Blaney Elementary School and learned about the assistance that Access Kershaw can provide. This information was critical for Maria after taking her daughter to Elgin Urgent Care with symptoms of abdominal pain, vomiting, and fever. She was prescribed medication for constipation but after just two days, the child's condition was not improving.

Neither Maria nor her daughter had medical insurance and do not qualify for Medicaid. Worried about her daughter's condition, Maria followed the recommendation of her neighbor and sought help from the Access Kershaw team in locating a pediatrician for her daughter.

Access Kershaw was able to secure an appointment for Maria's daughter with Sandhills Medical Foundation for the following day. At this appointment, the child was rushed to Richland County where she would undergo surgery for a ruptured appendix. After spending several days in the hospital, the child was released from care.

The outreach event that was conducted at Blaney Elementary was the beginning of a lifesaving story for Maria's child. With the expertise of Access Kershaw, Maria's child is alive today. As a follow up, the Access Kershaw team was able to establish Maria as a patient at the Community Medical Clinic and her daughter with a pediatrician at Sandhills Medical Foundation. In return, Maria has paid it forward by referring many of her friends and family to the team for medical assistance.

Observations & Interviews with Community Health Workers

Iron Sharpens Iron 1
CHW 2

On May 1, 2020, CHW 2 was interviewed by phone to discuss their position as a CHW at the clinic. They have been working with CMC for the past three years. They define a CHW as "someone working with people in communities and to improve their quality of life."

CHW 2 shared that they used to do a lot more outreach than currently and used to be more involved in the schools. They feel that both outreach and working with patients are important pieces to their role. Even though they are "not a social butterfly" they recognize the importance of communication and increasing awareness.

When asked what their strengths were, CHW 2 described themselves as being very patient and letting individuals just talk. They are a good listener, empathetic, and care a lot about the patient. CHW 2 feels that they have a connection with their patients and believes in them and recognizes that hardship can fall on anyone.

Pre-COVID-19, CHW 2 would spend four hours at CMC (Camden site) every morning with scheduled appointments and linking patients with providers. CHW 2 shared that "since I'm at CMC now, I feel like I can talk to the providers and the providers have come to me about clients. We have much better communication now." They would spend the afternoon at the West Wateree office, Refuge Baptist Church, or another satellite. On an average day, they saw four patients at CMC and two patients at West Wateree, and then spent the rest of the day finishing up documentation and following-up with patients.

At CMC, CHW 2 case manages some patients and spends most of their time helping patients as new needs arise, most frequently by helping with applications (SNAP, Welvista, hospital charity, CMC new patient). They communicate regularly with Becky Yarborough who completes the initial intake on potential new CMC patients. After helping patients with their needs, they may receive other calls from the patient. The patient typically calls CHW 2 if they need help with clothing, mental health, food resources, housing, or medical supplies (i.e. colostomy bag, catheters). They noted that a majority of the patients they see are suffering from depression and anxiety. CHW 2 has two to three patients who call her regularly just to have someone to talk to.

During the COVID-19 pandemic, CHW 2 is calling patients and making sure they are OK, ensuring they have food, helping (if needed) with receiving their stimulus check, and mailing or emailing applications. They really miss seeing patients in person. CHW 2 shared that she has heard relief in the patient's voice while talking with them.

They noted that they are continuing to "track everything" in the Hub and Pathway system and that at least one time a week they call people on their caseload. They find the question prompts in the system to be helpful and appreciates the questions that Sheri Bates has provided related to care for diabetics (dental, vision questions). CHW 2 hopes that communication paths stay open, and that trust continues to be built between everyone on the team.

Observation
CHW 2 and CHW 1

On June 30, 2020, I observed CHW 2 in the morning at West Wateree and CHW 1 at the Community Medical Clinic in Camden site in the afternoon. The purpose of the observations were to see the CHWs in their natural environment, observe interactions with other team members, and ask them a few questions.

CHW 2
During CHW 2's observations, they were sitting

at the front desk of the West Wateree office. At this point due to COVID-19, there were very limited in-person visits. CHW 2 is a very friendly and approachable person. They appeared to be very comfortable in their role as a Community Health Worker. At the front desk that morning, CHW 2 made calls for Best Chance. This apparently had been something Bethany Gilliand, a Medical Assistant, had previously been doing. CHW 2 said that they really liked working with Jessica Wilkes, Nurse Practitioner. In addition, they have been updating patient information for CMC by phone. I overheard them making several of these calls to patients.

As an evaluator, I asked myself: How can these updates be used to address other pathways for a patient? Connect the patient to other resources? In one of the update calls, the patient's mother answered the phone and shared that the patient had been evicted and had moved into a storage shed. Jodi commented how nice some of the new storage sheds were and then hung up the phone.

When asked what they were most proud of recently as a Community Health Worker, they mentioned the Prescription Assistance Program. By helping with the paperwork, they are able to help get patients free 90-day supplies of their blood-pressure medication. As of this interview, they had helped ninety patients, with a total savings of $1,932.90 per patient/per year.

CHW 1

On May 1, 2020, I interviewed CHW 1 by phone to discuss his position as a CHW at the clinic. They have been working with CMC for ten months. They define a CHW as a "liaison and front-line worker who connects the community with resources and deals with social determinants of health."

CHW 1 describes themselves as very outgoing, knows people by name, asks lots of questions and wants to help people. They also likes to work on a team and shared that there is "no way I can do my job without the expertise of everyone else." They described a lady needing a gynecologist and they went back with Jodi Rodgers, Yolanda Roary, Sheri Bates and Erica Watkins to help make that happen. They shared that they are very comfortable communicating with Nurse Practitioners and considers themselves the social link between the medical and the patient.

Pre-COVID, CHW 1 shared that their caseload was between 60-75 people per week. In a typical day, they are out in the community looking for people to help and considers their territory to be the entire county. They shared that they are focusing more on the Hispanic population and the rural areas (Cassatt and Bethune). They have consistently found that nine out of ten people they reaches out to do not need help. Their outreach has included planned presentations (Council on Aging, Police, PASOS, Alpha Center, United Way- Mobile Nutrition Center), and community activities and events.

CHW 1 has worked a lot outside of traditional work hours and on the weekends. They try to get as many people as possible to sign a consent, so they can follow up with them the week after. CHW 1 noted that getting the consent signed has been a challenge. If they can reach 20-25 Hispanics at an event, usually they are only able to reach half of those the next week. Additional outreach activities among Hispanics include vising Hispanic stores and restaurants, putting signs in doors, passing out brochures, and visiting a Hispanic store in Cassatt. CHW 1 says on average, they have a 30% success rate of following up with Hispanics after an initial contact is made at an outreach event.

CHW 1 also shared that pre-COVID, they were working on getting into the detention center and helping inmates before their release. They emphasized that they are not just qualifying the inmates for medical services but also referring them to other agencies (medical food, etc).

In a typical week (pre-COVID), CHW 1 spends Mondays at Elgin Urgent Care and the hospital and the afternoon at Cassatt Baptist Church. On Tuesday they work one-on-one with clients in the morning and at the police station in Bethune in the

afternoon. They noted that the culture in Bethune is "entirely different" and notes that there is a lot of mistrust in the area about anything that is free. Particularly among Hispanics who are worried about their immigration status, CHW 1 has found it difficult for them to trust the free clinic. In addition, culturally, he has found that people do not want to take from others who may need the help more than themselves. This includes getting free food from the Mobile Nutrition Center.

Some of the top needs among Hispanics identified by CHW 1 include: fear of the system, medical services ,and managing chronic diseases. For non-Hispanics, they see that needs are more for specialized care for pre-existing conditions (i.e., orthopedics) and helping complete new applications (SNAP, Medicaid, vision, new patient, free phones). On Wednesday mornings, they typically are at the food pantry in Elgin and spend the afternoon at the West Wateree office. They noted that they have invested a lot of time in building a relationship with the food pantry and looks for opportunities to discuss medical needs with some of the individuals.

On Thursdays and Fridays, they typically are at the office in West Wateree working on documentation or meeting with someone. CHW 1 shared that it is helpful to see the aging of caseloads and pathways in the system and patients who do not have an initial checklist completed in the Hub and Pathway system.

Observation

I observed CHW 1 in a clinic office at the Camden location in the afternoon of June 30, 2020. CHW 1 is very personable, loud, and almost over the top at times. During CHW 1's observations, they were on the phone following up with patients who had missed appointments or wanting to follow up with needed resources. During the observations, they spoke to a man in Spanish and then mailed him some resources. They ended up calling the man three times, and this took approximately twenty minutes. They wanted to make sure the man knew that they were not able to fax the information.

CHW 1 also shared that they are working with a woman who is five months pregnant, and not seeing an obstetrician-gynecologist. They said that they have been spending his time assisting with the CMC renewal paperwork.

When asked what they are most proud of right now in their role as a CHW, they responded that they do not want anyone going to bed hungry and wants to help share resources with people before they even get in a crisis situation.

Observations & Interviews with Leadership

The CEO, Susan Witkowski was interviewed on April 29, 2020. During this time, she was interested in finding out in what practical ways CHWs are being used? How does CMC envision using CHWs in the future? What is their "real" job description? What is their role in the community and what is their role in the schools?

Susan shared that it seems that CHW 1 does a lot of outreach but it translates into fewer outcomes, and that CHW 2 does very little outreach but is very good with one-on-one interaction. Susan also shared that Team Member 4,, a Licensed Practical Nurse, is a hybrid between a CHW and a patient navigator. They were not interviewed because they had only been working at CMC for the past three months.

Community Care Coordinator, Sheri Bates, was interviewed on May 4, 2020. She believes that CHWs can be a valuable asset to any organization and that training is very important. Sheri shared her frustrations with the CHWs for not "going outside of the box" and the "need to evolve" to meet the patients. She believes that both CHW 2 and CHW 1 are very task-oriented and not using critical thinking skills to go "deeper with a clients." CHW 1 will do anything that you ask them to do, but you have to specifically ask them to do it. This is very time consuming, and Sheri has noted that the follow-up is not very good. She has created scripted sheets for them with specific questions for them to ask. She has found that CHW 2 has been working with a client for multiple years and never documented that the client was a diabetic. With the peer-review process activated and documentation being a focus, she hopes that reports can improve. She considers the April report to be "awful." She believes that the ideal CHW is charismatic, easy to talk to and also focused on ensuring outcomes. Sheri wonders, "maybe we are making a CHW more than what they are? Maybe our expectations are too high."

Literature Review

In an effort to look at the growing field of CHWs, a literature review was conducted. During the months of June and July, 2020 a team from CMC was assigned to review the articles and present to the team. All full PDF articles and their team PowerPoint presentation shared at the August Admin Day are found in the CMC Google shared folder at: *https://drive.google.com/drive/folders/1u4zZqHRgG2bB5IuHS9stHpTxX3GLFR42?usp=sharing*

The role of the CHW is still evolving, and for many the role of the CHW may be under-utilized and not fully fleshed out. CHWs are unique liaisons that interact with various players and requires unique competencies, hiring, training, supervision, and working with others. Several different models exist ranging from generalists to much more specialized (i.e. diabetes). In one of the articles (Harzler, et al., 2018) referenced, the authors analyzed thirty studies and identified twelve functions of CHWs (ie, care coordination, health coaching, social support, health assessment, resource linking, case management, medication management, remote care, follow-up, administration, health education, and literacy support) and three prominent roles representing clusters of functions: clinical services, community resource connections, and health education and coaching.

Table: CHW Articles

All articles can be found in the Google share folder link below:
https://drive.google.com/drive/folders/1u4zZqHRgG2bB5IuHS9stHpTxX3GLFR42?usp=sharing

Community Health Workers		
Topic:	**Notes:**	**Source:**
Case Coordinator/Manager Model	Provides examples of models and toolkits	Link: https://www.nais.org/magazine/independent-school/spring-2018/teach-to-lead/
Program Sustainability Assessment Tool	An online interactive guide to assessing a program's sustainability and factors that promote sustainability. • *(Could also take a look at this tool for the employee toolkit)*	Link: https://sustaintool.org/psat/
Core Competencies and a Workforce Framework for Community Health Workers: A Model for Advancing the Profession	Workforce framework delineates three categories of CHWs based upon training, workplace, and scope of practice. • Figure 1 of page 322 has a good graphic displaying the differences • Page 325 shows an assessment used to understand what level of knowledge each CHW holds	PDF in file.
CHWs as an Extension of Care Coordination in Primary Care	1. Shares different models and the key activities of the CHW within each model	PDF in file.
Top 10 Things You Need to Know to Run CHW Programs: Lessons Learned from the Field	1. Determining a Program's Approach 2. CHW Services and Roles 3. Referral Process 4. CHW Hiring 5. CHW Training 6. CHW Skill Reinforcement 7. CHW Supervision 8. CHW Caseloads 9. CHW Should Empower Clients and Build Coping Skills 10. Client "Graduation"	PDF in file.
Roles and Functions of CHWs in Primary Care	Analysis of 30 studies identified 12 functions of CHWs (ie, care coordination, health coaching, social support, health assessment, resource linking, case management, medication management, remote care, follow-up, administration, health education, and literacy support) and 3 prominent roles representing clusters of functions: clinical services, community resource connections, and health education and coaching.	PDF in file.

CMC Toolkit

With new team members being added regularly, it is important for key trainings and information to be shared with all members. CMC created an online toolkit that is being transitioned into a Google Classroom. The online toolkit is a critical element for standardization and sustainability. The toolkit is used for orientation of new team members but also to revisit key information related to policies and procedures, the context and history of CMC, and key professional development trainings. It is evident from the contents of the CMC Toolkit that team members are taking an "upstream" approach to health and working on preventative factors and addressing root causes and social determinants of health.

Table of Contents for CMC Toolkit

What tools need to be in an employee toolkit for standardization and sustainability?

Section One: Nuts and Bolts

- Policies and Procedures
- Employee Handbook
- CMC Overtime Policy and Authorization Request
- OSHA, HIPAA training
- Google Chat for Staff
- Documentation requirements
- Database Summary
  - IMS
  - Hub and Pathway System
- Organizational chart and six-word story
- Contact sheet
- Phone Tree
- COVID Protocols

Section Two: Our Context

- What are the main components? Our updated logic model
  - CMC
  - AccessKershaw
  - LiveWell Kershaw
- Who are the main players?
- History of the organization
- Most recent strategic plan
- Most recent annual report
- Volunteers and their role
- Board members and their role
- Key partners
- Historical evaluation reports
- Most comprehensive SBHC evaluation
- Most recent Community Health Needs Assessment
- Community Health Improvement plan

Section Three: Professional Development

- People styles
- Broad definition of health
- Community of Solutions PowerPoint (5 Leadings)
- Wellness Bus Tour
- Poverty simulation
- Race, racism, and equity
  - Implicit bias
  - Image shift
  - Resources
- Making behavior change
  - Resources from the CDE
  - Switch book
  - Upstream book
  - Decisive book
- Motivational interviewing
- Quality improvement
  - Aim statements
  - Model for improvement
  - PDSA cycles
- Planning
  - Work plans
  - Driver diagrams
  - Action plan template
  - Human-Centered Design
  - Adaptive leadership/Distributive leadership model

Case Studies

It is often difficult to fully grasp the complexity and breadth of CMC by simply reviewing the logic model, a dashboard, or data from the electronic medical record. CMC strives to be holistic and patient-centered in its approaches all the way from initial intake to becoming a patient, to creating outside referrals. The case studies below provide a snapshot into the lives of patients and their interaction with various CMC team members along the way.

Case Study One

Shandra, a fifty-year-old African American female recently moved to Kershaw County. Upon relocation, Shandra found herself homeless and sleeping in her car.

With no access to primary care for regular medical visits, she was admitted to KershawHealth where she learned that she would not only need to have surgery but is also a Type 2 diabetic. Shandra needed guidance and support. While admitted, Shandra received a visit from a Transitional Care Team nurse from the Community Medical Clinic who walked her through what supports she would receive by being a part of the Transitional Care program. After discharge, Shandra visited the Transitional Care Team at Access to meet with a Community Health Worker who helped her complete various applications, as well as a nurse who then continued education concerning diet and lifestyle changes for a newly diagnosed diabetic. The team tasked Shandra with keeping track of her food intake and blood sugar levels over the next two weeks so that they could review them at her next visit. In two weeks, Shandra returned with an informative food diary containing all the items the team asked her to provide; proving that she is working diligently to comply with her new diabetic diet.

Shandra now lives with a blind relative and has received additional education from a neighbor who has been a diabetic for many years. This patient has benefited greatly from the case management provided by the Transitional Care Team and is currently completing paperwork to receive primary care through the Community Medical Clinic. She is now highly motivated to improve her health.

Case Study Two

Keanna, a fifty-six-year-old African American woman met with a Transitional Care Nurse from the Community Medical Clinic after being admitted to KershawHealth with pneumonia. Prior to her admission, Keanna had recently quit smoking after a 40-year history of smoking half a pack of cigarettes a day. While admitted, she was also diagnosed with respiratory failure and congestive heart failure.

Through conversation with Keanna, the Transitional Care Team nurse learned that she had been so sick during the previous month she was unable to work and is struggling to pay her utility bill. While various United Way agencies are providing some assistance with Keanna's rent and utilities, the remaining balance was still large. Upon discharge, Keanna needed access to oxygen on a daily basis, meaning that losing electricity would put her life at risk. The Transitional Care Team enlisted help from other community

resources: Christian Community Ministries, New Day on Mill, and Wateree Community Action to provide support for Keanna. The combined financial aid from these resources ensured the electricity would not be terminated.

Keanna's continued oxygen was a medical expense that would cost over one hundred dollars per month. Leveraging an existing relationship the Transitional Care Team nurses have with AeroCare, a new medical supply company that had recently moved to Kershaw County, the team was able to secure a refurbished oxygen concentrator for home use. AeroCare also agreed to give the patient the monthly oxygen she would need for any time spent away from home.

The Transitional Care team provided Keanna with various levels of support to ensure all her needs were met. A food stamp application was completed, as well as a Welvista application to offset the cost of her new medications. Her relationship with the team is ongoing, as she will continue with case management because of her congestive heart failure diagnosis.

Case Study Three

Laura, a 55-year-old white female who was already a patient at the Community Medical Clinic, was recently admitted to KershawHealth. Prior to her admission, Laura had not been able to work for several months due to illness and as a result, was now facing eviction from her home. In addition, she was behind payment on her utility bill. With various medical and social service needs present, the Transitional Care team began to contact community resources that could assist Laura with getting back on her feet after getting out of the hospital. One organization, New Day on Mill, was able to pay several months of overdue rent on Laura's behalf, as well as cover the utility bill with the help of Christian Community Ministries. A Welvista application was also completed to enable the Laura to receive free medications. Laura was already receiving food stamps, but the Transitional Care team was able to submit an updated application on her behalf. Because Laura currently had no income, the dollar amount of support she received monthly significantly increased.

The care team not only worked with Laura to make sure her social service needs were met, but also continued to meet medical needs and educational support for managing her conditions. After being discharged, Laura was visited by the Transitional Care team nurse in her home to continue diabetic education and case management. As a result of the education received, Laura decided to make much needed dietary changes to better manage her diabetes. At last check-in, her hemoglobin A1C has moved from 13.2 to an impressive 6.7. Laura will continue with case management for ongoing support and education.

Case Study Four

In order to increase awareness around existing services provided by the Community Medical Clinic, members from the care team oftentimes do community outreach. For one such event, team members went to Vocational Rehabilitation to conduct a presentation detailing all the various services they provide.

The following day, Christy, a 57-year-old who had attended the presentation, visited the Access office. Through conversation with the Care Coordination team, they discovered that Christy and her family were dealing with several medical and social service related hardships. Several months earlier, her husband had a stroke and was unable to work. As a result, Christy's family had no income and was 3-4 months behind on rent. They also had a large unpaid utility bill. A nurse on the Care Coordination team called Duke Power and received a one-week grace period for the

family. Immediately following, she contacted Wateree Community Action who were able to help with the electricity bill. Other assistance was provided in the form of completed rental assistance application through the Governor's Program, saving the family from eviction and a SNAP Application, providing food stamps for the family.

Not only could the Care Coordination Team provide connections and resources to address the social service hardships Christy's family faced, but also the need for a primary care provider. Christy's husband was a Sandhill's patient. However, Christy and her disabled son have received no medical care because they cannot afford medical care. The Care Coordination Team nurse and Community Health Worker (CHW) helped both Christy and her son become Community Medical Clinic patients. The CHW also filled out a Welvista application to ensure that their medications could be obtained at no cost. When Christy's son developed a terminal disease several months later, the Care Coordination team filed a Medicaid application on his behalf and advised the family while they completed an extensive application for disability benefits. Once Christy's son began receiving Medicaid, the team helped him transition from the Community Medical Clinic to Sandhills.

Currently, Christy's husband works part-time and the family is still receiving some rental assistance through the community connections previously established. The Care Coordination team was instrumental in navigating this family through difficult circumstances in order to improve not only their health but also address critical social needs that impacted their well-being.

Case Study Five

In 2011, Sandhills Medical Foundation requested case management for one of their patients. Charles, a 45-year old African America diabetic patient, had a history of drug and alcohol abuse. Occasionally, he would utilize services provided by Kershaw County Mental Health because of his anxiety, depression and schizophrenia. However, Charles was not compliant with his mental health regimen, even though it was court ordered.

Upon meeting with the Care Coordination Team nurse, Charles determined that he needed to make lifestyle changes to improve his mental health and substance abuse issues. With group support and counseling from mental health, he was able to stop his alcohol and drug abuse. Charles became compliant with his mental health drugs and relinquished friends that encouraged his substance abuse.

The next step in Charles' health improvement journey was to better manage his diabetes. While Charles took an active role in setting boundaries to better control and manage his substance abuse issues, the Care Coordination team coached Charles on how to bring his blood sugar levels to more manageable state. The nurse on the Care Coordination team was able to solve an issue regarding his high blood sugar levels. After some investigation, the nurse was determined that the insulin pen that Charles was using was defective and not delivering the amount of insulin as indicated. This issue was solved with a new box of properly functioning needles. Immediately, Charles and the team saw improvement in his blood sugar levels.

Charles continues to receive support from the entire Care Coordination team. The anniversary of his sobriety is celebrated by all. He benefits from the encouragement he receives from Kershaw County Mental Health, his family, and the Community Medical Clinic Care Coordination team. At last check, Charles' A1C has gone from 14 to 8. He proactively communicates milestones

and struggles with the team. The team is aware that Charles struggles with his diet - starting with the State Fair and continuing through Thanksgiving and Christmas. Everyone in his support group is now aware of these annual times of increased temptation and offer additional help during this two-and-a-half-month time period. It is the team support and their enthusiasm that have aided Charles throughout his journey. Charles and the Care Coordination team just recently celebrated his four-year sobriety milestone.

Case Study Six

A New Path

Sometimes, assistance from others can completely change the trajectory of your life. Carlos, a patient of the Community Medical Clinic of Kershaw County and a client of Access Kershaw has experienced this sort of change.

Carlos, a 57-year-old, white male is described by the clinic team as friendly, hard-working, and kind, but he suffers from several issues including asthmatic episodes brought on by uncontrolled anxiety, as well as COPD. Carlos works two jobs and walks nearly everywhere that he has to go because he is without transportation. "One of my jobs is only part-time, but you have to start somewhere," shares Carlos. If you were to travel to the place he calls home, you would find a sign out front stating, "CONDEMNED" and an electrical cord running to a neighbor's home for power. No matter, Carlos is proud of where he lives regardless of having no door, windows, heating, cooling, or refrigerator, and looks forward to making improvements to his home as he is able.

Staff at the clinic have worked with Carlos off and on for nearly 15 years addressing his COPD, asthma, and anxiety issues. Early on, two staff members became critical in shaping a new path forward for Carlos. "I pulled up in the clinic parking lot and I told Mary Lee I was at the end of my rope mentally. She connected me to mental health counseling through Christie at the clinic. They both brought be back from a very dark place." From there, Carlos' journey continued with various members of the clinic team.

Over the past year, Carlos' needs have become more pronounced during the pandemic and with a referral to Access Kershaw, the team has been able to address more of his basic needs. Through coordinated efforts, community partnership, and intentional relationship building, both CMC and Access Kershaw have addressed the following needs for Carlos: medical care, applying for SNAP benefits, housing, utilities, gas vouchers, specialty referral, mental health follow-up, medication assistance, emotional support, and assistance in applying for disability benefits. The team is committed to caring for the whole person and is concerned about all of the pieces, and not just a defined few. "When you talk to them, they really listen and care. It is nice to know you can call on them and they will help you," shared Carlos.

> *When you talk to them, they really listen and care. It is nice to know you can call on them and they will help you.*
>
> Carlos, a CMC patient and Access Kershaw client

Recently, Carlos was admitted to KershawHealth with COVID-19 while he was living at Food for the Soul during the summer months due to extreme heat and no cooling at his home. Once released from the hospital, Becky Yarborough followed up to ensure that Carlos would be able to get his medication from Medisave. Becky picked up the medication and drove it to his home while Carlos gave her step-by-step directions on how to get there since he has no mailbox or identifying

information marking his home. Becky's first-hand view of the place that Carlos calls home prompted her to link arms with Access Kershaw to determine what social resource needs could be addressed.

While the team worked with Carlos to manage his COPD and asthma by providing a new nebulizer in combination with medical care, Sheri Baytes from Access Kershaw began to form a relationship with him. "Initially, it was hard to get him to call me back or follow up, but that has changed with some persistence on our end and now we are talking a few times a week," shared Sheri. The relationship that the clinic and Access Kershaw have built with Carlos has allowed them to address more than just his medical needs. "They stay on me and I talk to them a lot. Becky has helped me a lot with my meds and getting doctors appointments. She also connected me to Sheri who has helped me with a lot of paperwork and working through processes, like getting into Mental Health," noted Carlos.

"I have keys," Carlos said to Sheri on a phone call one day. This simple statement was the declaration of a monumental moment for Carlos. To reach this moment, Sheri had been working with New Day on Mill to gain entry for Carlos to the Men's Shelter. After working through the application process and writing referral letters for him, Sheri was pleased to hear that Carlos now had safe housing. Even so, the team continued to work with Carlos on making improvements to his home to bring it to a more livable condition with the help of Santee-Lynches.

The most critical aspect of Carlos' story is the art of listening by the clinic and Access team to truly hear and act based on the goals of the patient. The ability of the team to serve Carlos with both respect and dignity is evident in how his human needs were held in equal importance to his medical needs. When the team reflects on the way they serve community through collaboration, staff indicate that their puzzle-piece approach is unique. "Only CMC and Access are addressing these pieces in collaboration. Last year, Carlos was in a dark place and without our help I truly feel that he would be lost in the system of resources and could even be dead without management of his medical conditions," said Sheri. "Knowing that we are there to help and really do care, means everything to our patients. We have many people that will simply just stop by to say hello and let us know how they are doing because they know we are here and that we care what happens to them," noted Becky.

Working in collaboration with other agencies, CMC and Access Kershaw view human needs as equally important as medical needs.

Another important part of Carlos' story is the ability of the team to work with community partners to advocate for clients and patients for improved overall well-being. The team spent countless hours working on referrals, completing paperwork, and contacting partners, all while addressing immediate medical needs. The ability to see the bigger picture of health and what is possible for patients and clients is a distinguishing factor in the assistance that the Community Medical Clinic of Kershaw County and Access Kershaw is providing for residents of Kershaw County.

In reflecting on the help, he has received over the past 15 years, Carlos shares, "When I showed up at the clinic, the team intervened and set me on a different path."

Case Study Seven

Staying the Course

Todd, a 64-year-old, white male is described by staff at the Community Medical Clinic of Kershaw County as "very nice, always pleasant, and easy-going." Aside from his friendly demeanor, Todd is living with several chronic conditions including, hypertension, Type 2 diabetes, and kidney disease.

Todd has been a patient of the clinic since 2012 but in 2019, he was sent to KershawHealth after a visit with Nurse Practitioner Sarah Beth Bradley revealed a blood sugar level higher than 14. A normal A1c for his age would be less than 7. Todd's A1c was so high, it would not even register the actual amount. Over the course of the next several hours at the hospital, Todd received diabetes education and learned about medication management, as from that day forward, he would be on insulin twice a day.

Moving forward, Kim Cogdill, another Nurse Practitioner, at the clinic worked with Sarah Beth to help manage Todd's diabetes, as well as educate and coach him on lifestyle modifications. Three months later, in December 2019, Todd's A1c went from 14 to 6.8. "That is huge," said Kim and clinic staff were pleased with the progress Todd was making in managing his diabetes.

As time went on throughout the year of 2020 and the COVID-19 pandemic led to shifts in the provision of care to patients, Kim suddenly realized that the team had not heard from Todd in several months. She had conducted a phone consult with him in April but it was now October and she had not seen him in person since June 2020. The only contact the team had with Todd had been for his phone calls requesting refills on medications. Kim reached out to set up an appointment with Todd.

On November 8, 2020, Kim was scheduled for a phone visit with Todd to discuss lab work the team had him complete to see where he was with his blood sugar levels. Kim was expecting to discover that his blood sugar levels were elevated, especially with the stress and uncertainty with the ongoing pandemic. Much to her surprise, Todd's A1c was at 6.6. Kim inquired about Todd's daily habits and routine to better understand how he was able to keep his blood sugar levels within normal range. He reported that he has been keeping close watch over his portions and shared that he will occasionally have a little bit of Coke to drink. "He was doing exactly what he needed to be doing," Kim proudly stated. Todd was able to apply his diabetes management knowledge and maintain them even throughout the duration of a pandemic.

Case Study Eight

A Specialty Visit That Was Not Meaningful

A patient of CMC reported blood in their urine for the past six months and needed to be seen by a specialist. The patient, who spoke Spanish as a first language, lacked transportation to be seen by a urologist in Lexington. Susan Witkowski from CMC drove the patient to the specialist on February 14, 2020 and shared her experiences. From this case study, the CMC team hopes to reduce "waste of time" visits to the specialists and increase the number of meaningful specialists visits.

Prior to Appointment:

Nurse Practitioner called for appointment with Lexington Urology and was able to get an appointment two weeks out. The provider has a strict policy that if you are ten minutes late, you will not be seen.

February 14, 2020

6:00 am: Patient and Susan left Camden and drove to Lexington

7:45 am Arrived at Lexington Urology

9:35 am Taken back to be seen by Urologist.

- Vitals, pulse, urine sample and KUB (x-ray)
- Urologist noted that there was no urine culture and CAT scan with IV
- Susan called Bethany at CMC and requested she fax the lab work over for the Urologist to see
- Fax line was busy, Urologist looked at results on Susan's phone
- CAT scan was greater than two months old and only had urine analysis and not urine culture
- Urologist and Bethany spoke over the phone to understand what was needed and Bethany scheduled the order to get both procedures done at KershawHealth on February 19

11:30 am Left office

1:15 pm Arrived back in Camden

February 19, 2020

Patient goes to labs at KershawHealth

February 21, 2020

Urine culture reports are sent to CMC

Jessica forwards reports to Urologist

February 24, 2020

- Someone from the Urologist office calls and says report is wrong (cannot use the word trace, but we need a number)
- Two hours spent between Becky Y and Jessica to figure out why report was wrong
- Jessica ordered the report correctly (Microscopy), but KershawHealth said the order was wrong
- Becky orders the test again with the specific word in the order
- Becky took four calls to KershawHealth to talk to Lementra (put back in voice mail repeatedly, walk the phone number back) to truly understand what is needed to input the order
- Becky asked Maria, volunteer, to call the patient to explain that test has to be re-run, and to go back to KershawHealth for urine culture a third time

February 27, 2020

- Patient goes back to KershawHealth for urine culture

Insight

Form relationship with key players for all referred providers and specialists; relationship is between specialist and patient (heightens patient anxiety).

MAKING THE SWITCH

COMMUNITY MEDICAL CLINIC
OF KERSHAW COUNTY
OUTREACH - ACCESS - MEDICAL HOME

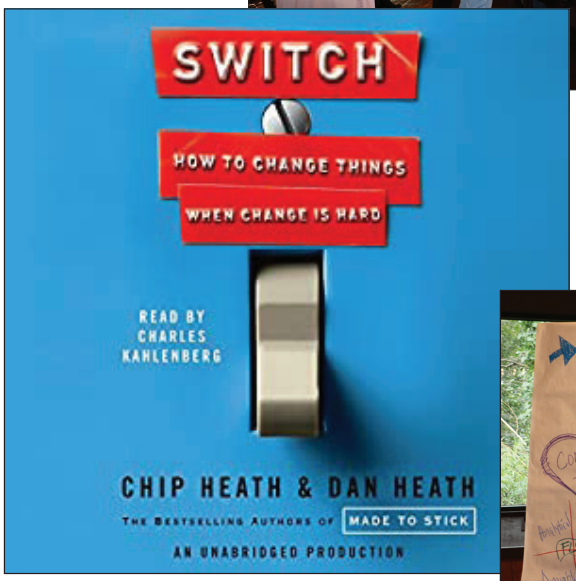
OVERVIEW

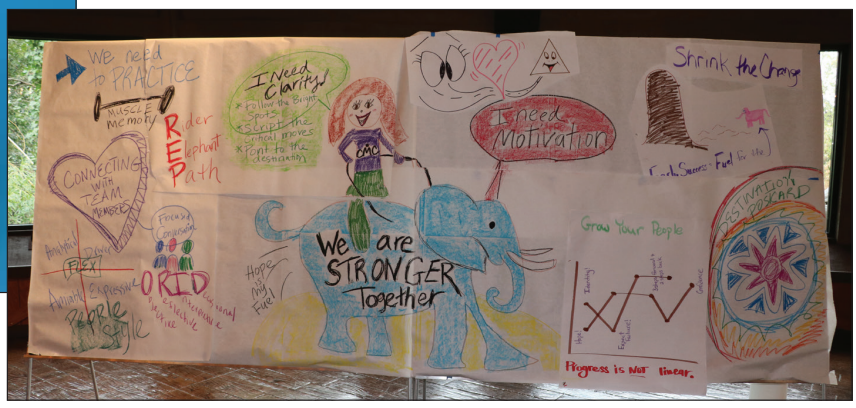
CEO Susan Witkowski had one singular goal in mind for the year 2020. **Maximizing people power.**

This goal moved from a few lines written in CMC's 2019-2021 strategic plan into detailed action steps, including a team off-site retreat (on March 4, 2020) to over forty meetings and conversations. Throughout 2019 and into 2020, one question was posed over and over: **How can the CMC team effectively work together as a high-performance team?**

Efforts in the past had included understanding individual personality styles, reviewing the focused conversation method, discussing image shifts and values, and recognizing Parker Palmer's Five Habits of the Heart.

The CEO had been particularly impacted by the book ***Switch: How to Change Things When Change Is Hard*** by Chip and Dan Heath. She was convinced that if the team all went on a journey to read, discuss, and apply a framework outlined in the book, that goal could—and would—be achieved. Change would happen, trust would increase, and teamwork would be strengthened. Not by spending thousands of dollars going to a conference or even by bringing in a motivational speaker from Cambridge, MA...but simply by applying a book written in 2010. And do you know what? **Mission accomplished.** CMC has successfully maximized people power, even during a global pandemic.





WHAT IS THE SWITCH FRAMEWORK?

Throughout their book, Chip and Dan Heath ask one question.

Can you get people to start behaving in a new way?

After all, behavior change is hard. Chip and Dan Heath argue that for someone to start acting differently, you need to engage both the rational and emotional brain, while also presenting a clear path forward. You will be much more successful by engaging all three components in any endeavor. The chart below summarizes the steps employed to identify and implement these critical steps to change. For a more in-depth discussion of this process, check out this video on YouTube:

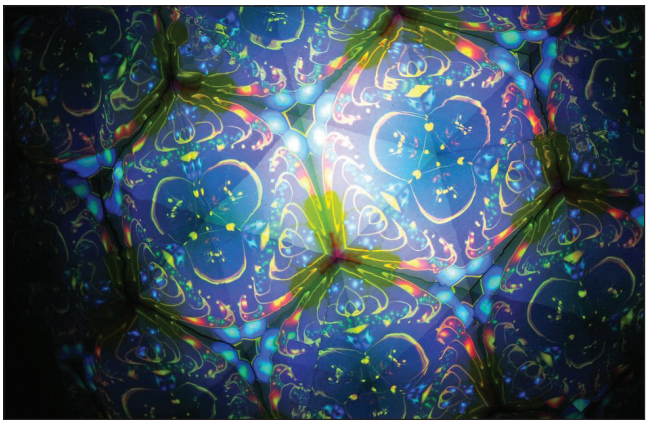
Holly Hayes | Change: It Doesn't Have to Be So Dang Hard

COMPONENT	STRATEGIES
Direct the Rider	Follow the bright spots
	Script the critical moves
	Point to the destination
Motivate the Elephant	Find the feeling
	Shrink the change
	Grow your people
Shape the Path	Tweak the environment
	Build habits
	Rally the herd

WHAT WAS THE FIRST STEP AT CMC?

CREATING A DESTINATION POSTCARD

CEO Susan Witkowski wanted her team to be crystal-clear about what the future looked like. Chip and Dan Health encourage readers to create a *destination postcard*. What vivid picture represents our future as a high-performance team? The CMC team selected this image of a kaleidoscope to describe their near-term future of everyone working together as an integrated and united body serving CMC patients and residents of Kershaw County.



What actions took place?

- Every team member received and read a copy of the book, and also received a personalized CMC "Cliff Notes" booklet summarizing key components
- 14 team members began and completed improvement projects using the three-part Switch Framework and integrated this into their annual performance review
- All team members participated in one-one-one meetings with the CEO discussing the framework and best ways to apply the book principals in their improvement project
- "Booster" sessions related to each component were given during specific admin days and also virtual learning labs
- Detailed work plans were documented and updated in Google Drive
- Informal conversations were strongly encouraged to increase adoption of the framework

We were able to come together with the common goal and talk about what worked, frustrated us, or did not work.

I enjoyed creating something that would be useful and organized for others.

I learned that it really was easy to make a small change that provided a great impact for our patients.

WHAT WERE THE OUTCOMES?

- **Streamlined and standardized processes** (AccessKershaw consent forms, HUB and IMS note integration, telehealth training and policies, technical issues trouble-shooting, and medical supply inventory and ordering)
- **Improved data collection and increased patient pathways** (quarterly patient contacts, monitoring pathway report, time management, training)
- **Increased volunteer, patient and coalition member engagement** (virtual action teams, volunteer retention, Best Chance Network engagement)
- **Strengthened teamwork, enhanced work productivity, increased critical thinking and solving challenges as a team, maintained strong trusting relationships, increased flexibility and adaptability based on changes, greater awareness of the "big picture" and deeper appreciation for team member's gifts and skills**
- 13 out of 14 team members surveyed indicated that **leading an improvement project using the Switch Framework was beneficial to their role at CMC**

SWITCH BRIGHT SPOTS FROM TEAM MEMBERS

Erica Watkins, Community Care Coordinator

What: Used the psycho-social assessment to "dig deeper" to address issues other than initial reason at intake and worked to ensure that at least three pathways were assigned to a patient at enrollment.

Patient Win: Patient now has a job as a truck driver. Erica probed deeper and has since made several Vocational Rehab referrals for patients who have stated that they really would like to work.

Biggest Aha: Adjusting my schedule and chunking my day has increased my productivity. Building the habits are critical.

Most Important Concept: Shaping the Path

Susan Didato, Development Director

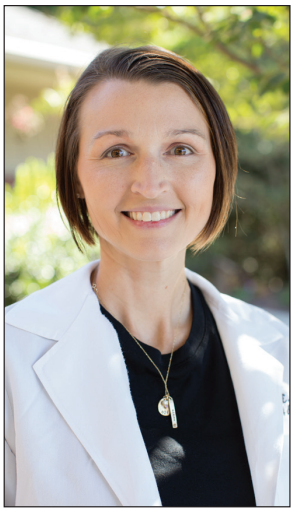
What: Implemented various strategies (i.e. town hall meetings, mask making, garden clean-up, garden tour) to engage volunteers in a meaningful way.

Volunteer Win: Over 40 volunteers engaged in a project, gained 5 new volunteers and 70% of volunteers have opened emails/videos/electronic engagements.

Biggest Aha: Don't focus on one metric (i.e. attendance at a virtual event). We need to examine the data and look at all of the components together to see what outcomes were made. Adopting a quality improvement mindset is critical.

Most Important Concept: Shrink the Change. Don't look at the elephant; look at the toe.

Dr. Jessica Wilkes, Nurse Practitioner



What: Creating a clear written process (assigned team roles, outreach) for women to be enrolled in the Best Chance Network.

Patient Win: CMC has already surpassed the number of women receiving pap smears in 6-months of 2020 compared to 12 months of 2019 (in a COVID pandemic). 124 women served from July 1, 2020-December 31, 2020 compared to 114 women in July 1, 2019-June 30, 2020. Still working to reach 180 women.

Biggest Aha: Even though numbers are important, it is important to engage the emotional side, and shape the path. Not everyone is moved by numbers.

Most Important Concept: You need all three pieces (rider, elephant, path) to get results. Documenting strategies in the categories is very helpful.

Kathryn Johnson, LiveWell Kershaw Coalition Director

What: Executed messaging strategies to activate and engage action team members working on the Community Health Improvement Plan

Member Win: Shifted immediately to virtual meetings with COVID; saw consistent member engagement in monthly Coalition meetings (avg. 27), emotional health team grew, and the healthy eating/ active living and access to care action team maintained momentum.

Biggest Aha: Behavior is predictable. Once you identify the pattern, you can insert strategies to modify the behavior. Coalition members received free smoothie certificates for signing-in on time for meetings.

Most Important Concept: Any message you shape should touch the head, heart, and path.

WHERE DOES CMC GO FROM HERE?

The adoption of the Switch Framework is here to stay.
CMC is integrating the framework into its Employee Toolkit and the orientation of the concepts will be shared with all new team members and Board members. The CEO and Founder shared that she is the "most proud working with the Clinic this year in 2020 than ever before." The CEO congratulated each team member individually regarding their improvement projects and plans to work on ways to expand and scale some of the projects clinic-wide.

Going deeper with quality improvement and iterative changes are part of the plans for 2021. Team members identified that they would like to examine the following concepts more in 2021 including: grow your people, shrink the change, build habits, and rally the herd. Team members are responding to changes differently and working together in a different way. **People power at CMC has been maximized.**

CMC Board of Directors

Torill Nelson, Board Chair
Shelley Janssen, Medical Director
Hank Green, Treasurer
Cathy Forrester, Secretary
Tim Hudson
Roy Fakoury
Harvey Galloway
William Cox
April Wach

CMC Staff Members

Carol Baker
Sheri Baytes
Sarah Beth Bradley
Kamela Clackum
Kimberly Cogdill
Susan Didato
Haylin Duran
Mary Hill
Kathryn Johnson
Lindsey Kilgo
Felecia Mumford
Jodi Rodgers
Latrice Simmons
Erica Watkins
Jessica Wilkes
Susan Witkowski
Becky Yarborough

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Board Survey Findings

In the spirit of continuous quality improvement, the CMC Board of Directors completed a survey to determine key areas of improvement and growth over the next few years. The Board of Directors continue to view the dual mission (providing direct services and leading population health) a vital to the overall health of Kershaw County,

CMC

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Community Medical Clinic of Kershaw County Board Survey Results

Tuesday, April 20th, 2021

PREPARED BY IRON Sharpens IRON

Overview

The Community Medical Clinic of Kershaw County is led by a Board of nine individuals. In order to determine areas of improvement and growth for the Board over the upcoming year, a survey was developed to assess Board members' views of the Board as a whole, their own individual ability to fulfill responsibilities, and assess fellow members ability to fulfill responsibilities.
The survey was sent to Board members on April 15th. Of the nine Board members, six members completed the survey. The results of the survey are compiled below.

Assessment of the Board as a Whole

Of the six responses to the survey, over half (3) feel that the Board fulfills its governance responsibilities. Other responses indicate that the Board does a good job (2 responses) or a fair job (1). Participants were asked to rate their confidence in various governance functions performed by the Board, including: mission, CEO, programs, planning, financial oversight and viability, policies, legal, evaluation, and board effectiveness.
Areas that members rated high confidence in the Board's ability to perform were: mission, planning, financial oversight, policies, and legal. Areas that members rated more neutral or were split in level of confidence of governance capability were: CEO, programs, evaluation, and board effectiveness.

While members praise the organization's ability to be run effectively, there is an indicated need for role and responsibility development and ownership among the Board members.

Overall, Board members express high levels of satisfaction regarding board composition and processes in place that support board effectiveness.
Areas indicated by Board members to have high levels of satisfaction include the following:

- Clear policy on the responsibilities in fundraising (1 response not satisfied)
- Clear understanding of board responsibilities
- Appropriate ranges of diversity and expertise
- Levels of trust, support, and respect among board members
- Effective board meetings (1 response not satisfied)

Areas indicated by the Board to have varying levels of satisfaction or low levels of satisfaction were found in:

- Ability of board to regularly assess its own work
- Ability of board to recruit, orient, and train new board members and remove members not fulfilling their responsibilities
- Placement of individuals that are willing and able to help board fulfill governance and support functions

Assessment of Individual Fulfillment of Responsibilities

Board members were asked to share how satisfied they are with their personal fulfillment of support responsibilities. From the areas of fundraising, public relations, volunteerism, and credibility, only one area had responses that indicated lower levels of personal satisfaction. Fundraising and the ability to participate in fundraising adequate resources was the only area that members express lower levels of satisfaction (2 responses). Board members indicate that they do understand their responsibilities, understand the mission of the organization, and are prepared to follow through on commitments made at meetings.

Assessment of Board Colleagues' Fulfillment of Responsibilities

Board members were asked to share an assessment of fellow members' ability to fulfill their support responsibilities. Of the responses, four members indicate a rating of excellent, followed by good (1) and fair (1).
In reflecting on the accomplishments and impacts of the Board this year, members indicate these areas as the

greatest highlights:

- Supporting the CEO and staff throughout the COVID crisis, along with maintain essential services Establishing an endowment
- Virtual sponsorships and fundraisers
- Policies and procedures were updated
- Maintaining the same standard during COVID

Board members were asked to reflect on their own personal contributions to the organization. The following contributions were noted:

- Assisted in securing financial support through endowment funds
- Chairing a virtual fundraiser that grossed approximately $20,000
- Personal giving, assisted in corporate giving efforts along with strong support of CEO for continued encouragement
- Participation in fundraising

Board members were asked to share changes or improvements that could be implemented. The following responses were shared:

- Our Board is committed to the mission and no changes are required. Continued support should be maintained.
- We need to find time when Board members can really participate in meetings. We need more Board members engaged in full functioning committees and more diverse Board members.
- More direct focus on items in the allowed time frame. We should also gather for more open discussion and opportunity for fellowship.

Board members were asked to share any additional thoughts regarding performance of the Board or their service as a board member. The following ideas were shared:

- I love what we do
- I have felt more engaged over the past two years as I have been given some specific responsibilities. I am frustrated at the lack of engagement and in some cases lack of attendance by other board members. This is an ongoing issue and I do not know how to solve it. This doesn't seem to be a non-profit org that warrants a lot of formal and fully functioning committees. That seems a bit overkill, but we need something.

Appendix 1. CMC Board Survey

Annual CMC Board Assessment

Instructions:
Please complete this assessment of the Community Medical Clinic Board. Your answers will be kept anonymous and the aggregated results will be shared at our upcoming Board meeting on Tuesday, April 20th. Please complete this survey no later than Friday, April 16th.

Section 1: Assessment of the Board as a Whole

1. Overall, how well do you think the board fulfills its governance responsibilities?

4 Excellent	3 Fair	2 Good	1 Poor	
○	○	○	○	○

2. Rate your confidence in the following governance functions performed by the board:

	4 Very Confident	3	2	1 Not at all Confident
Mission: The board understands the mission and purpose of the organization.	○	○	○	○
CEO: The board monitors and evaluates the performance of the CEO on a regular basis, and delegates the day-to-day management to the CEO.	○	○	○	○
Programs: The board approves the annual operating plan, monitors implementation, and makes sure there are program evaluations to measure impact.	○	○	○	○
Planning: The board participates with staff in determining program and administrative strategies and overall long-term priorities.	○	○	○	○

	4 Very Confident	3	2	1 Not at all Confident
Financial Oversight and Viability: The board safeguards assets from misuse, waste, and embezzlement through financial oversight and making sure that effective internal controls are in place. The board makes sure that organization has an overall fundraising strategy to support the effective delivery of services, and monitors the implementation of the funding plan. The board ensures a realistic budget that maximizes use of resources.				
Policies: The board approves governing policies and reviews them periodically to ensure policies are up to date and relevant.				
Legal: The board ensures the organization is compliant with federal, state, and local regulations and fulfillment of contractual obligations, including payment of payroll taxes and filing of required reports.				
Evaluation: The board regularly assesses whether the organization is achieving its purpose (effectiveness) at what cost (efficiency), and is meeting the needs of the community.				
Board effectiveness: The board ensures effective governance through evaluation of the board itself, committees, and its leadership, and ensures the board's own continuity.				

3. How satisfied are you regarding board composition and processes in place that support board effectiveness?

	4 Very Satisfied	3	2	1 Not at all Satisfied
The board has a clear policy on the responsibilities of board members in fundraising.	○	○	○	○
Board members clearly understand their board responsibilities, and fulfill them.	○	○	○	○
The board currently contains an appropriate range of expertise and diversity to make it an effective governing body.	○	○	○	○
The board regularly assesses its own work.	○	○	○	○
The board actively recruits, orients and trains new board members, and removes those members who are not fulfilling their agreed upon responsibilities.	○	○	○	○
The board encourages and supports individuals to treat fellow board members and staff with trust, respect, and understanding.	○	○	○	○
Board and committee meetings are interesting, well run, and effective.	○	○	○	○
The board has the necessary effective board leadership-- an individual and/or group of individuals who are willing and able to help the board fulfill its governance and support functions.	○	○	○	○

4. Please share any comments regarding your responses above:

Section 2: Assessment of Your Fulfillment of Responsibilities

5. How satisfied are you with your fulfillment of your own support responsibilities?

	4 Very Satisfied	3	2	1 Not at all Satisfied
Fundraising: I participate with staff and fellow board members in raising adequate financial and other resources.	○	○	○	○
Public Relations: I act as an ambassador to the community on behalf of the organization and its clients.	○	○	○	○
Volunteerism: As needed, I volunteer to assist staff and/or recruit new volunteers.	○	○	○	○
Advises staff in areas of expertise: I act as a sounding board for the CEO and other executive staff upon request and when invited.	○	○	○	○
Credibility: I lend my name and personal reputation to the organization to use in brochures, grant proposals, and other marketing materials.	○	○	○	○
I understand and fulfill my **governance and support responsibilities** as a member of the board.	○	○	○	○
I am **knowledgeable** about the **organization's mission, programs and services.**	○	○	○	○
I come **prepared** to board and committee meetings and **follow through** on committments.	○	○	○	○

6. Comments regarding any of your ratings above:

Section 3: Assessment of Your Board Colleagues' Fulfillment of Responsibilities

7. Overall, how well do you think your board colleagues do in fulfilling their support responsibilities? (Fundraising, public relations, volunteerism, advising as needed, adding credibility, understanding roles, knowledgeable about programs and services, and following through on committments?)

4	3	2	1
Excellent	Fair	Good	Poor
○	○	○	○

8. What have been the greatest accomplishments and impacts of the Board this past year?

9. How have you personally contributed to those accomplishments and impacts?

10. What changes or suggested improvements do you have for the board?

11. Any other comments regarding the performance of the board or your service as a board member?

Thank you for participating in this survey!

CMC Response to COVID-19

People all over the globe turned to their health care providers for hope and intervention when COVID-19 upended the worldwide status quo. Camden reported one of the first cases of coronavirus in South Carolina on March 6, 2020. By the end of that month, Kershaw County was ranked in the top 10 of COVID cases per capita nationally, and remained there for some time.

CMC continued operations throughout the period by providing care over the phone, secure video conferencing and in-person visits. CMC did close satellite offices located in local churches as well as the School Based Health Center. CMC's CEO led the team in making quick changes and adaptations as the pandemic evolved over time. Even with phone visits, patients were still able to report critical vitals to their medical team by having personal blood pressure cuffs and glucometers at their home. The pandemic also accelerated CMC's goals to fully integrate telehealth. Patients appreciated telehealth; this technology removed the transportation barrier and also reduced the number of times a patient had to miss work. CMC was able to expand reach of primary care through telehealth with the MUSC Telehealth Alliance. The mission of the clinic remained the same in 2020 and in 2021, and several of the adjustments and iterations will continue post-pandemic.

CMC would have been unable to carry out its mission without investing tremendous energy in needed infrastructure, systems and processes throughout 2020 and 2021. Prior to the pandemic, the Community Medical Clinic had never worked remotely. CMC leadership believed it was critical to maintain consistent communication with staff and ensure that all their equipment and other needs were being met. Ensuring that CMC team members felt connected, motivated and safe were top priorities.

Coronavirus Reflections at CMC
April 1, 2020

Erica Watkins

First of all, I'm very proud of the decision CMC made early on to better protect the wellbeing of staff and patients/clients. What has surprised me, however, is how many cases and how quickly it's spreading. With residents of our county, city, and state not doing as they need to be, it surprises me how our governor has not yet issued a stay-at-home order. I feel that closing "essential" businesses, when so many are labeled "essential" is not going to flatten the curve as quickly as a stay-at-home order would. Roughly two weeks vs MONTHS if it continues as is. My father is immunocompromised, JUST BEAT CANCER, and I would much rather be able to see him and celebrate versus waiting months.

Sarah Beth Bradley

I was pleasantly surprised with how fast Susan acted to keep all staff safe with the outbreak. Over the weekend, from our first case, Susan came into the office on a Monday with a plan to keep everyone safe and decrease anxiety. I was surprised how willing Susan was to work with me given my heightened anxiety with this pregnancy. It was wonderful to see how everyone in the office stepped up and flexed to do whatever was necessary.

We've adjusted our daily routines and it really has been pretty seamless. We're working with cardiac/HTN patients with BP cuffs, looking at scales, and getting patients to report their glucose levels at home. We've made handouts of OTC medications to put out for patients. Our assists have shifted and called patients with updates on the way the clinic is running. The NPs have still been in tough over the phone to help answer each other's questions. Everyone's willingness to help and do what needs to be done is overwhelming.

What surprised me:

1. We live in a in such an advanced country yet cannot provide our front line workers of this pandemic with proper protective equipment.
2. CDC endangers health care workers by changing their recommendations on appropriate protective equipment in response to equipment shortage.
3. Seeing how our small community has come together to support each other. i.e. curbside pickup, people supporting small businesses, grocery stores offering first hour of shopping to high risk population.
4. Seeing how a few individuals continue to put others at risk with noncompliance of recommendations set forth by the government and continue to act selfishly.

Interaction with patients:

1. Seems to be less "no shows" as most people are answering the phone.
2. Several patients have voiced how they appreciate how we have taken steps to insure their safety by doing telephone call visits.
3. Patients seem very satisfied with care provided over the phone and feel as though they still have access to care.
4. I did have one patient that did not have wi-fi or internet access who could not use the free virtual visit but was able to go the local hotline number for COVID-19 testing at Sandhills Medical Foundation.

Community Care Coordinator

Despite the decline in the daily "business" of Access due to our doors being closed for face-to-face visits, our clients have adapted to our new schedule and method of operation. A new level of trust has been gained as we are now free to contact previous clients from years back and show that we are concerned about their wellbeing and needs during this pandemic.

Recently, a patient just discharged from KershawHealth emergency department came to Access seeking supplies. He expressed that he was told he had pneumonia and to go home and they would follow up with him in three days. He was tested for COVID-19 and was not happy about it. I explained the importance of isolation during this time and that home was the best place for him. Unfortunately, we were unable to assist him because he was not an active client in our system; this is an example of how we remain on the front lines, although we are not open for face-to-face visits.

Fund Development Director

For me personally, I appreciated how quickly Susan and our team worked to reduce exposure for all of the staff, volunteers, and our patients. As an organization, we were doing our part from the very beginning which made me really proud. I have loved seeing all the teamwork, everyone pitching in to help wherever it is needed.

Nurse Practitioner

What surprised me during this time is the level of panic that the coronavirus invoked on our community. People were rushing to the stores and stocking up for the apocalypse. Yet they did not follow recommendations for hand washing, sanitizing, and social distancing. And even after the virus has spread throughout the state, people continue not to observe social distancing appropriately. It is simple but people do not seem to understand what it actually entails.

With keeping this surprise and lack of social distancing in mind, I have a patient interaction that I would like to share. This patient seems to truly understand her risk and what/how to social distance. I had a telephone visit with a lady last week. She has severe COPD, heart failure, and h/o MI. She is doing fairly well during all of this. She explained to me that her birthday is this week. She told me she has told both of her children to not come visit. She said, "I told them, I know you love me, but we need to be safe." She said they don't have to see me on my birthday for me to know they are thinking of me. She is upbeat about staying at home and Lysoling her husband when he comes home from work. This patient is always a pleasure and our telephone visit reassured me that she is doing everything she can during this time.

Clinical Operations Director

I was surprised at the amount of our patients that know how to "think outside the box" to get their documentation updated with the Clinic, Welvista, and Patient Assistance Programs. One of our patients (C.P.) offered to scan her payroll checks and send them to me via email so that her Lilly Cares account would not expire. She actually took a photo of her checks that I was able to print. I spoke with Lilly Cares who agreed to take the photographed check stubs faxes from me in the renewal packet. (Not completed this task yet, feeling hopeful!)

Coalition Director

Since March 6th, the LWK Coalition has figured out new ways to interact with our members through new mediums in order to continue our work on the Community Health Improvement Plan.

We have engaged our coalition and action teams in

Zoom meetings to keep the camaraderie and work alive. Moving forward, we plan to keep these online options available for all meetings, as we have seen high engagement by having this additional option available.

One surprise seen through watching our community go through this trial is the amazing sense of togetherness for Kershaw County as a whole. Churches, government, local business, and nonprofits are coming together in ways they have not done before in order to reach a common goal. I am also extremely impressed by the way Kershaw County leadership has been proactive in leading the charge as a collective unit and source of information for citizens through innovative methods. I see our whole community on its on switch journey.

Nurse Practitioner

I was surprised (but not surprised) that we made such radical changes in operations within three days (one business day) of the first case being diagnosed. Compared to other organizations—healthcare and non-healthcare—we were definitely ahead of the game in trying to flatten the curve. I feel this is where our ability to change pace quickly with minimal hiccups and being flexible really helped us to limit our exposure as individuals, and minimize stress and chaos as an organization (which is why I was not surprised).

Business Office Manager

I was surprised by just how easily my transition was. I was very nervous about working from home, had never done this before and was afraid of the unknown. Once I got all the necessary equipment (proper chair, etc...) worked out, things are just fine. Really it's not that much different. When I break it down, I have always worked "remotely" for those who are located in our Lugoff office. I am not there physically for them on a daily basis, but I have always been able to support them. The same now goes for the Camden office, I simply support them remotely.

Medical Director

My greatest surprise was how quickly we changed our focus from traditional hands-on medicine to virtual medicine. People everywhere have amazed me with their adaptability and resilience. Patient encounters have been so much more revealing. When you're not as focused on the physical aspects, you have much more capacity for the emotional and spiritual aspects of an interaction.

Bilingual Patient Advocate

In these times of confusion, there have been many surprises that we have all faced. As a society and as individuals we've all been hit with this sense of uncertainty. I believe that one of the main surprises that have impacted me the most was that even in moments of uncertainty and fear, many people are still being very selfish in their way of thinking. An example would be people panic buying food, toilet paper, soap, and hand sanitizer. It feels almost as though they don't care about anyone else but themselves.

It's a bit disheartening, but there's also this beautiful light that shines on all of the people that do a little extra to help others that has surprised me even more than the selfishness that has been displayed. The light of people donating extra masks, the nurses and doctors working harder than ever before to make sure that they take care of as many people as possible. Even something as simple as all of the people that are staying home trying to also help keep others and themselves safe. In moments of uncertainty and confusion, even though there are people that are careless and reckless there are even more people that will try to outweigh the bad and that is the most beautiful surprise that I've experienced during this time.

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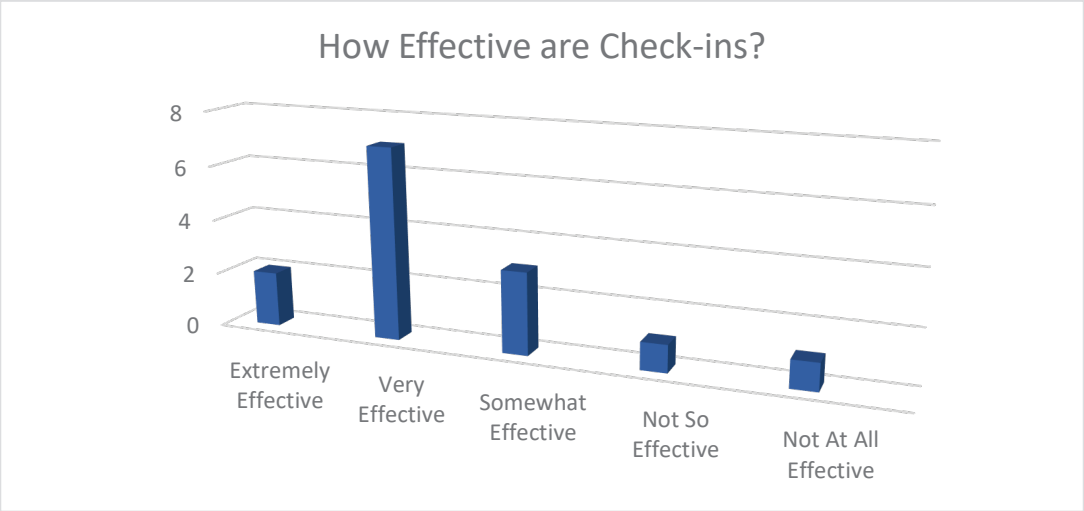
Check-In

Survey Results

May 4, 2020

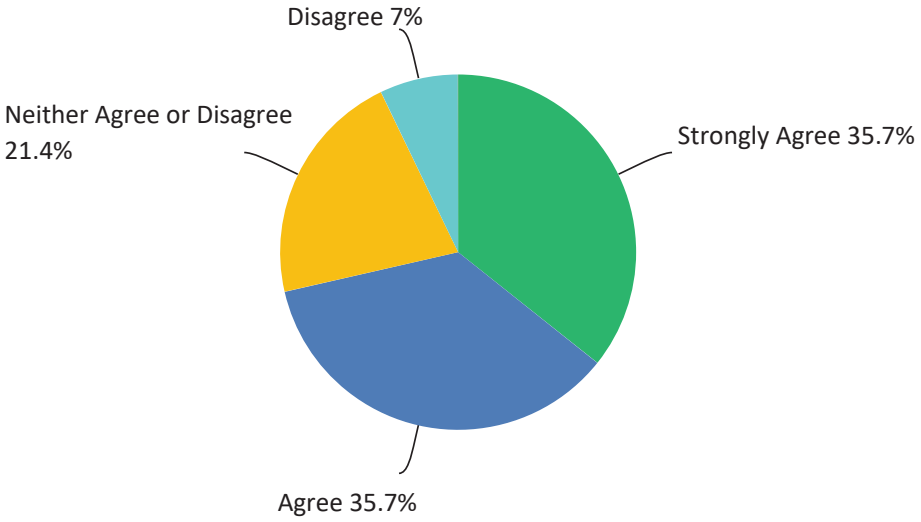
A report compiling the results from the CMC Check-in survey questions.

In order to gather feedback on the impact and the overall opinions of the daily check-ins at the Community Medical Clinic, a survey was disseminated to employees. The information gathered from this survey will inform discussion at the next team meeting and provide direction for future check-in meetings. A total of 14 individuals participated in this survey. Participants were reminded that the purpose of the daily check-in is to keep them connected and keep them moving forward with their mission. **They were asked how effective they felt the check-ins are.**
Of the 14 participants, 64% (9), felt the check-ins are extremely or very effective, while 21.4% (3), rated the check-ins as somewhat effective, and 14% (2) felt that they are not so effective or not at effective at all.



Participants were asked if check-ins last about ten to twelve minutes.

All 14 participants answered and 71.4% (10), either strongly agreed or agreed that check-ins lasted ten to twelve minutes, while 7% (1), disagreed, and 21.4% (3), neither agreed or disagreed.

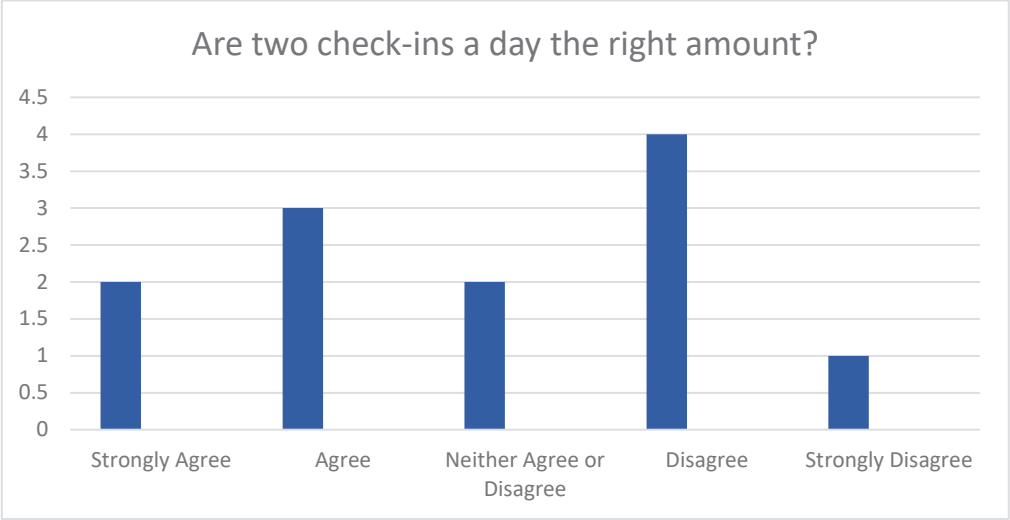


Survey respondents were asked if they enjoy the "high-low" sharing.

Of the 14 respondents 71.4% (10), either agreed or strongly agreed that they enjoyed the "high-low" sharing, while 21.4% (3), neither agreed or disagreed, and 7% (1), strongly disagreed.

Participants were asked if having two check-ins a day was just the right amount.

Participants were very split in their ratings for this question, with the most at 28.6% (4), disagreeing.



Survey respondents were asked if they felt more connected with team members than they did three months ago.

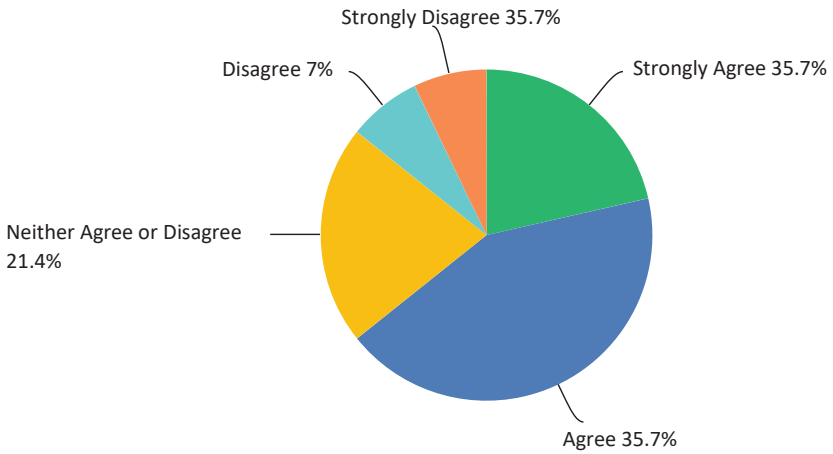
Of the 14 participants 50% (7), strongly agreed or agreed that they felt more connected with team members, while 21.4% (3), neither agreed or disagreed, 21.4% (3) disagreed, and 7.1% (1) strongly disagreed.

Participants were asked if daily check-ins helped them work better as a team.

Of the 14 participants, most 64.3% (9), strongly agreed or agreed that check-ins helped them work better as a team, while 21.4% (3) neither agreed or disagreed, and 14.3% (2) either disagreed or strongly disagreed.

Participants were asked if the check-ins improved patient outcomes for the complex patients.

While most 64.3% (9), strongly agreed or agreed that check-ins improve patient outcomes for complex patients, 14.3% (2) disagreed or strongly disagreed, and 21.4% (3) had no opinion.



Participants were asked if they found the Wednesday 4:30 check-ins to be helpful in doing their job.

Of the 14 participants 57.2% (8), strongly agreed or agreed that they felt the Wednesday check-ins to be helpful in doing their job, 21.4% (3), neither agreed or disagreed, 14.3% (2) disagreed, and 7.1% (1) strongly disagreed.

Participants were asked what recommendations they had for improving the morning or afternoon check-ins or the longer check-ins on Wednesday afternoons.

Of the 14 participants, nine answered and their responses are as follows:

- Twice daily is a little frequent. Wednesday afternoon's longer check-ins are good because it helps keep everyone on the same page with where we are and where we are going.
- I think once a day is good. Many of us have 8:00am appointments. The 4:30 Wednesday meeting is extremely helpful.
- The check-ins work well.... I cannot honestly say there is a good or bad to Wednesdays
- I would like to see just one check in a day or maybe two a couple of times a week maybe Monday and Wednesday
- I feel like once a day would be enough at this time
- It's important to know about the changes at the clinic, that is shared on Wednesdays. I would prefer the daily check-in to be changed to a weekly check-in at lunchtime.
- I think it would be best to check in only once a week for a longer duration. Maybe keep the 4:30 meeting. Twice daily and outside of my work schedule has been a struggle.
- Check ins don't seem patient related. Check in seems to be done on individual and personal level and don't necessarily benefit a specific patient unless a specific patient is brought up. Check in on a personal level twice a day seems too much. I would prefer to check in first thing Monday morning and maybe mid day or just before the end of the day on Thursday.
- One check in daily in the afternoon would be helpful to complete the day and get organized for the following day.

Participants were asked if they have connected with other team members using Google Meet to discuss other issues.

Of the 14 participants, 57.4% (8), have not used Google Meet to connect with other team members, while 42.3% (6) respondents have.

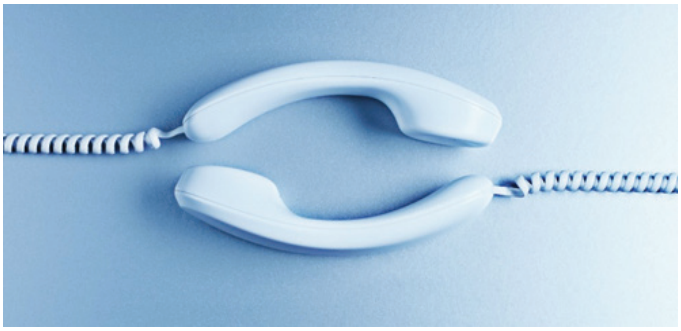
Survey respondents were asked to share any feedback from quality improvement lens and the comments are as follows:

- One third check in early and chat and the rest are ready to go on time.
- Overall, the meetings are good. Most people have 8:00 am appointments though which causes me to feel like I'm starting the day behind.
- I think this was a good way to connect.
- I would prefer the daily check-in to be changed to a weekly check-in at lunchtime.
- If we keep the daily check-in, only once per day is needed and ideally not at 8:00 am.

Check-ins are vital for connecting with other staff members and exchanging needs and ideas, but preferences as to day and time vary.

ONE SIMPLE SOLUTION

December 3, 2020



Sometimes a simple phone call is just what the doctor—or nurse practitioner—ordered. This is the story of how that happened, and of the impact it continues to have on our patients.

The eruption of COVID-19 in March of 2020 shuttered much of what we know. Healthcare has been particularly hard hit, but the problem is more than overwhelmed hospitals with overworked staff and insufficient supplies. More than challenges with testing or treatments or the intense pressure to develop a vaccine. For those of us at the Community Medical Clinic, the biggest challenge became how to care for our patients with chronic conditions when our clinic needed to limit regular face-to-face visits. We knew it was imperative we find a way to keep in touch with our patients. The solution developed was simple, expedient, cost-effective, and ultimately, enormously popular. **The answer? A simple phone call.**

While the pandemic has been little more than a long, tiring irritation for many, for others it has been, quite literally, life-threatening. Community Medical Clinic patients are, for the most part, members of the working poor – those with no insurance and limited resources. In short, the most vulnerable members of our society. There's a misconception that the majority of those utilizing the CMC are unemployed. However, many of our patients do work, and if they are unemployed, it is often due to a medical reason, and they have a deep desire to get back to work. Those of our patients who work in essential industries like fast food, grocery or retail, as well as those who are self-employed, had little option but to continue working throughout the crisis. Accessing healthcare became just another challenge for them.

Just three days after the identification of the first Covid-19 patient in Kershaw County, the CMC instituted protocols to limit exposure of patients and staff. Clinic face to face visits were drastically reduced, and patients were seen strictly on an as-needed basis. Staff – including the clinic's nurse practitioners – worked from home almost exclusively. Grant money was used to provide patients with blood pressure cuffs and glucometers, allowing them to track these vital numbers

Community Medical Clinic Nurse Practitioners

Jessica Wilkes

Kim Cogdill

Leigh Pate

Sarah Beth Bradley

and report them to during calls with the providers. As nurse practitioner Jessica Wilkes notes "Compared to other organizations, we were definitely ahead of the game in trying to flatten the curve. I feel this is where our ability to change pace quickly and being flexible really helped us to limit our exposure and minimize stress and chaos."

CMC began these calls as a way to engage patients safely during the pandemic. The four CMC nurse practitioners – Sarah Beth Bradley, Kim Cogdill, Jessica Wilkes, and Leigh Pate – identified patients with chronic conditions most likely to need ongoing contact with a healthcare provider. By late March, they had begun making regular phone calls to patients to discuss how they were feeling, any concerns about their health, to provide guidance and education on potential issues, and any other topics which might come up. The calls ranged from 20-45 minutes in length to keep with visit schedule of the typical office visit. Patients connected with the nurse practitioners from the comfort of their own home or workplace. It is important to note that these were phone calls only. There were no video calls. No telehealth. No high-tech gadgetry required. Just a simple phone call.

After nine months of calls, we decided to interview a number of patients to gauge their response to this innovation. Did the calls work? If so, why did they work? Would it make sense to continue them in the future – even after life returns to so-called normal? What follows is a composite of those discussions with fourteen of our patients. We interviewed six men and eight women, including two whose primary language is Spanish (their calls and interviews were conducted with the aid of a translator). The majority live in Camden, with others from Elgin, Lugoff, and Buffalo. All have close family ties – to a spouse/significant other, children or grandchildren, siblings, or parents – that are especially important to them. Most have hobbies, which include watching movies or sports, crafts, fishing, reading, going to the park, and spending time with family. Nine of the group are diabetics, while several others have high blood pressure, asthma, or depression/anxiety. Only two have no chronic medical issues. Virtually all of the patients have a phone plan with unlimited talk/text, and most also have video capability, although few of them are comfortable using it.

The results of our interviews have been overwhelmingly positive. Patients have developed a rapport with the nurse practitioners they feel is essential to their continued health. They find the calls a welcome adjunct to in-person clinic visits and absolutely want them to continue even after COVID-19 is merely a memory.

Two particular points stood out during our conversations. First, the phone calls are both convenient and informative. Second – and perhaps most important – is that the patients feel they have been able to develop a significant personal relationship with the providers.

Convenience is an important factor to all the patients. It involves more than just the time spent traveling to the clinic or sitting in a waiting room. "I work at the Dollar Tree...I can just step outside and talk to the doctor," said one patient. For hourly employees, requesting time off for a doctor visit is more than an inconvenience – it may mean lost wages. Others remarked that they don't have to leave children or family members, or deal with transportation issues (this is especially challenging for those living in rural parts of Kershaw County). One patient noted that money is always tight, and though

they have a car, it's always a challenge to fit a mortgage, insurance, food money, and the cost of gas into their budget. And finally, those dealing with the burdens of chronic diseases or depression/anxiety simply face good days and bad days. As one noted, "I have better days and rough days – and I can always do the phone call. If it was a rough day and in-person, I probably would have to cancel."

Particularly when dealing with chronic conditions, information and education are key factors. Several patients remarked that the nurse practitioners have spent time explaining lab results, or changing a medication to better treat an issue, or helping with referrals to specialists or other agencies for assistance. One noted the nurse practitioner had been working with them on some health goals, while another remarked on their discussions about food choices and medication changes. The majority of patients remarked how the nurse practitioners have been both patient and persistent – explaining the importance of blood sugar or blood pressure numbers, helping them with diet and lifestyle changes, and asking specific questions to get at the root of issues. Over and over again, patients have stressed how important this ongoing support has been to both their physical and emotional health.

As one patient noted, "I've grown close to them – it's not a doctor-patient thing anymore...it's not about just the sickness, but about life. They remember me talking about my mom. They'll take time for me to vent and say how I'm feeling."
As CMC medical director Dr. Shelley Jansen expressed it, "My greatest surprise was how quickly we changed our focus from traditional hands-on medicine to virtual medicine. People everywhere have amazed me with their adaptability and resilience. Patient encounters have been so much more revealing. When you're not as focused on the physical aspects, you have much more capacity for the emotional and spiritual aspects of an interaction."

The nurse practitioners are all enjoying the phone calls and are finding their patients to be more open with them, although they are not certain why that might be. And though they would love to see patients in person, this is the "next best thing." They all agree on several positive points – that there seem to be fewer "no shows" with the phone calls, as most patients will answer their call; that patients repeatedly voice how much they appreciate the steps taken to ensure their safety during the pandemic; and that they are very satisfied with the care they receive over the phone and feel as though they still have access to the care they need. And finally, all of the nurse practitioners were gratified by the extra time they have to interact with patients and the opportunity to address physical and emotional needs. The phone calls have provided the kind of in-depth patient interaction they appreciate, and which is often difficult to accomplish in the office visit.

> "I have better days and rough days – and I can always do the phone call. If it was a rough day and in-person, I probably would have to cancel."
> CMC patient discussing phone calls with nurse practitioners

That is not to say there haven't been challenges. Spanish-speaking patients require a translator, and access to one can limit their access to the nurse practitioners. With phone calls, the translator must speak with the patient and nurse practitioner separately – relaying information from one to another. Only one patient—who is Spanish-speaking only—indicated they would always prefer in-person visits. With an in-person visit, they said, they are able to read facial expressions, which enriches what is heard here through the translator. With phone visits,

that is entirely missing. It is likely that more frequent visits with Spanish-only speaking patients would help to mitigate this issue.

Moving forward, it will be critical to arrange scheduling at the clinic to balance in-person patient visits with regular phone calls. We are already looking at ways to address this, as the overwhelmingly positive response to this simple innovation is clear evidence of its importance to the continued care of our patients.

Diabetes

As part of the three-year strategic plan and detailed operations plans, managing chronic diseases, especially diabetes, has always been a priority at CMC. Nurse practitioners, case managers, nurses and team members work together to help patient's manage their chronic diseases (which is often more than one), create sustainable lifestyle changes and also reduce the inappropriate use of the Emergency Room. The detailed logic model shows key activities that the team has engaged in over the past year. Every quarter, an analysis of outcomes is completed for the 150 patients in the diabetes cohort. The team is reaching some remarking outcomes with individuals who have diabetes. The first patient advisory group formerly met on September 23, 2021 and will continue this work as co-designers. Patients are guiding the next iteration of the "year of diabetes" and will also be reviewing data and determining key next steps. Despite the tremendous strides this past year, CMC recognizes that an intentional and consistent approach to educating, managing and preventing diabetes is a continual need for the present and also the future. CMC understands even more fully the connection to resources needed to support the whole person. CMC continues to refine their processes to ensure the necessary connections are made throughout the community.

"The Year of Diabetes" - Logic Model – 5.25.2021

From February 1, 2021 to December 31, 2021, our clinic will decrease the number of uncontrolled diabetes by half.

Priorities

- Connect needed resources with an equity lens
- Provide medications and vaccines
- Increase understanding of healthy eating
- Communicate through technology
- Conduct meaningful visits

Our Resources	Our Activities	Our Outcomes
• Medical Director • Nurse Practitioners • Community Care Coordinators • Community Health Workers • Community Navigator • Medical Assistants • Volunteers • Certified Diabetic Educators • Nurses • Spanish Translators • Specialists (oral health, chiropractic and pain management) • Development Director • Administration • Board of Directors	**Equity Lens** • Convene organizations addressing food insecurity • Identify patient-specific food gaps • Provide access to needed resources **Medications and Vaccines** • Provide medication resources • Medication management • Immunize patients for pneumovax, Tdap, and shingles **Knowledge of Healthy Eating** • Teach the skills (portions, hypoglycemic index) through a medical provider • Encourage lifestyle change • Show patients where to get food **Patient Engagement** • Patient Advisory Group • Communication initiated by provider (text messages, phone calls, virtual visits, diabetes circuit training) • Communication initiated by patient (text messages, IMS portal) **Meaningful Visits** • Communicate spectrum of services • Adjust format based on patient need • Conduct baseline measurements and distribute diabetes education packet	**Long-Term Outcomes** • Increased quality of life • Increased life expectancy **Intermediate Outcomes** • Patients managing their diabetes effectively • Patients managing their medications effectively • Lifestyle Changes (nutrition, exercise, mental health) **Short-term Outcomes** • Reduction in key clinical indicators (A1c, blood pressure) • Reduction in no-shows • Increase in patient and provider satisfaction • Increase in the % of meaningful visits • Achievement of goals set by patients

Local Partners	State Partners	National Partners
KershawHealth MediSave Pharmacy United Way Mobile Nutrition	BCBS Duke Endowment Food Share SC Thrive WellVista	Direct Relief NAFC

Focusing on persons with diabetes at CMC – Our Upstream Strategy Compass	Individual & Services (patient level)	Institutional & community (CMC and partners)	Structural & Societal (legislative/advocacy, county, state and nation)
Primary Prevention (Prevent and Strengthen) – trying to prevent yourself from getting a disease	Immunize patients for pneumovax, Tdap and shingles	Provide referrals to local Veggie Rx program for all CMC and Access patients	Advocate for food network best practices, streamlined measurement, and shared outcome development w/ food insecurity learning collaborative team
Secondary Prevention (Detect and Treat) – trying to detect a disease early and prevent it from getting worse	Screen and identify patients with pre-diabetes Conduct meaningful visits with NP with follow-up	Follow up for additional resources (food stamps, transportation, Medicaid, diabetes, etc) Refer to specialists Provide referrals to local Veggie Rx program for all CMC and Access patients	Support LiveWell Kershaw Coalition and the Healthy Eating Active Living action team - CHIP, support Vision2030, and activities of ESMM
Tertiary Prevention (Manage and Recover) – trying to improve your quality of life and reduce the symptoms of a disease you already have	Educate on healthy nutritional options Educate and assist with management of medications Conduct meaningful visits Communicate effectively through technology (Doxy.me, text, phone, patient portal) Convene virtual Diabetic Circuit Trainings	Follow up for additional resources (food stamps, transportation, Medicaid, diabetes, etc) Refer to specialists Celebrate lifestyle changes with family and community Provide referrals to local Veggie Rx program for all CMC and Access patients	Collect and distribute data on patients with diabetes to be used at the SC Free Clinic Association and the National Association of Free Clinics Advocate to pharmaceuticals on behalf of patients with diabetes

1st Quarter Analysis
January – March, 2021
5.13.2021

There were 66 unique patients with diabetes, with an average A1c of 8.1 The sample included 30 females and 30 males. Two-thirds of the patients with diabetes were 50 years of age or older. Nearly two-thirds (64%) of the visits had a primary diagnosis related to diabetes management. Patients in this data set had an average of three visits per quarter; there was no difference by race or ethnicity.

There were 27 patients with a diabetes prescription during this period of time, with one individual having an increase in medication dosage.

The patient breakdown by location was Camden (30), Lugoff (10), Cassatt (10), Elgin (7), Bethune (5) and Kershaw (4).

1) When does A1c begin to decline? After how many visits?
We may begin to answer this question when we get the next data pull in the second quarter, since one A1c per patient was given in this data pull. We do not yet have the ability to examine A1c over time. I will do that once we receive quarter 2 data.

2) Medication- how often are medications adjusted?
See above project narrative. In quarter 1, there were 27 patients with a diabetes prescription during this period of time, with one individual having an increase in medication dosage.

3) What differences exist by race, ethnicity and language?
Of the 66 unique patients with diabetes, 52.3% (N=33) were African American, 31.7% (N=20) were White and 15.9% (N=10) were Hispanic. The average A1c was 10.2 for Hispanics versus 14.5 for non-Hispanics; Hispanic patients had a lower A1c on average than their non-Hispanic counterparts ($p<0.03$). Only two of the patients spoke Spanish as their primary language; there was no difference in clinical outcomes. In addition, there was not a statistically significant difference in visit count by race or language.

4) Using the procedure names, do patient's visits decrease after that have had the diabetes class (DC-Education) or do they stay the same?

We will be able to examine this closer when we have the second quarter data.

Quarter 1:
Pt A- Diabetic Education (DE) and 2 visits
Pt B- DE and 4 visits
Pt C- DE and 3 visits
Pt G- DE and 4 visits
Pt H- DE and 4 visits
Pt Ja- DE and 6 visits
Pt Jo- DE and 5 visits
Pt M- DE and 6 visits
Pt P- DE and 3 visits

2nd Quarter Analysis – 8.10.2021

There were 71 unique patients with diabetes, with an average A1c of 7.97. This is slightly lower than last quarter's average A1c of 8.1 but is not statistically significant. Two patients had an improvement in their A1c since the last quarter.

The sample included 36 females and 35 males; 75%

of the patients with diabetes were 50 years of age or older. Just over half of the patients were African-American (52.1%), followed by White (31.0%), Hispanic (12.7%), and Other (4.2%). Over two thirds (68%) of the visits had a primary diagnosis related to diabetes management. Patients in this data set had an average of 3.3 visits per quarter; there was no difference by race or ethnicity.

Prescription medication information not included this quarter.

The patient breakdown by location was Camden (32), Lugoff (13), Cassatt (7), Elgin (8), Bethune (3), Kershaw (4), Bishopville (1), Heath Springs (1) and Ridgeway (1).

1) When does A1c begin to decline? After how many visits?
Two patients had an improvement in their A1c since the last quarter.

2) Medication- how often are medications adjusted?
Prescription medication information was not included this quarter.

3) What differences exist by race, ethnicity and language?
Just over half of the patients were African-American (52.1%), followed by White (31.0%), Hispanic (12.7%), and Other (4.2%).

The average A1c was 8.4 for Hispanics patients versus 7.8 for non-Hispanics. For this quarter, Hispanic patients had a higher A1c on average than their non-Hispanic counterparts ($p<0.01$). As in the previous quarter, there was not a statically significant difference in visit count by race or language.

4) Using the procedure names, do patient's visits decrease after they have had the diabetes class (DC-Education) or do they stay the same?

There is not yet a statistically significant change in the number of visits that a patient has after receiving diabetes education.

Patient Advisory Group Session Notes
September 23 2021

Patients Present:
- Patient L
- Patient I
- Patient R was unable to attend but wants to attend the next one
- Patient M did not attend (we didn't learn why at the time)

Design Team Members Present:
- Kamela
- Sarah Beth
- Eune'ce
- Susan

For reference – the Session Presentation Deck we used to lead the discussion is here: *https://docs.google.com/presentation/d/1K1Z14gZWOgpVVMqBXhZ3j2pLIUTphzLtBNL03iRWQoA/edit#slide=id.p*

Executive Summary / High Level Take-Aways:

- More menu ideas for different food cultures (ex: Mexican, Italian)
- Though this wasn't explicitly said – there seems to be general interest in figuring out how to help patients get the people they live with and eat with/

prepare food for/with (their family, partners, spouses etc) more involved/ knowledgeable/ "bought in" about diabetes and food planning/ menu planning. The pain point both patients shared was that their spouse/family doesn't eat the same type of food they (the patients) are supposed to eat – and it makes it really hard to have a diabetes menu and a not diabetes menu of food in the home.

- Ideas for recipe food prep time hacks: More ideas for how to prep food only once, but take some of the food and apply it to a diabetes friendly menu and other part of the same prepared food to use it for menu that isn't for someone with diabetes
- Ideas of "on the go snacks" that are diabetes friendly and those that can't melt in hot temperatures
- Ideas for helping people understand "what you have in your pantry already" and how x item can be used with a, b, c to be more diabetes friendly. General ideas for how to switch / substitute ingredients for a healthier option.
- Ideas for more protein when you don't eat a lot of meat
- The patients are open to having daily text messages of encouragement and support, ideas, recipes etc. They were open to any form of "contact" as long as it would help them stay motivated and offer ideas for how to continue managing life with diabetes.

Logistical Take-Aways

- The Group is happy to keep the name "Patient Advisory Group" – they said they were fine with the name and couldn't think of a better one. They offered that perhaps at future meetings they will think about a name that works
- The group wants to meet on October 14th 1-2pm on doxy.me again

Quotes + Questions

"My sugars dropped and no one knew what to do!"

- What could educating the people around a diabetes patient do about diabetes? What could that do to support the patients?

"Mexican cooking is completely different than diabetes cooking"
"My husband is Italian. I'm Korean. He is used to eating a lot of meat, pasta and potatoes."

- How might our diabetes menu planning, recipes, and cooking ideas support the different cultural cooking norms that patients have in their homes?
- How might the CMC screen for and/or have a conversation with a patient to understand the types of cooking norms/ food norms that household has? And how could the CMC programming empower patients to use their knowledge about diabetes menu planning to also embrace their cultural cooking norms?

"How do I cook for them and me?"

- How might we support and offer encouragement focused on time saving tools and ideas?

"I'm hesitant to go out anymore"

- The end of a story from Lottie about how she didn't have diabetes friendly snacks with her while she was out with friends and her sugars dropped. She felt terrible and no one in her friend group knew how to help her. Lottie wants to be empowered with healthy snacks that can match her diet needs but not melt since it can be so hot outside.

Possible Ideas to Prototype: Early Thought Starters
To be discussed at our next meeting.

- **Program re-design for patients at different "levels" of their diabetes journey.** Some kind of "level" system to support patients as they move through the type of support the CMC can offer, depending on where that patient is in their diabetes journey. The patients who attended the session on September 23rd are further along in their diabetes journey and they aren't brand new to diabetes. They aren't really "beginners" just learning about their disease—rather they are actively trying to adapt, plan, and change their day to day lifestyle to ensure they can follow a healthy diabetes plan.
- **Is there an opportunity for thinking about The Diabetes Group in Levels or stages?** Where Level 1 is the first class/coaching session where patients learn x and do, then they "graduate" to Level 2 once they have done xxx and changed the way they are thinking about xxx. Then in Level 3, they move into a support group where patients are talking about how the solve for challenges they are having sticking to their plan etc. There's more to be cooked on here and for us all to think about.

- **Support Campaign:** Contacting patients with encouragement/ support ideas. Perhaps some kind of text message/email support/encouragement program. Daily text messages etc.

- Recipes and videos that offer ideas for food preparation, time saving techniques in the kitchen, how to choose healthier options (choosing between x and y, choose y and here's why), cultural food norms and how to adapt for a diabetes menu, "on the go" diabetes friendly snack ideas.

- Support groups for patients who are "further along" in their diabetes journey – could they help each other? Maybe have a NP present but let the patients raise some of the specific challenges they have and see how the might be able to coach/ support one another? The NP could lead or support conversation form the sidelines

Teach/Include Family and Close Friends in the Diabetes Education Journey. What if we hosted/ organized some kind of meeting with the people who live with and/or are closest with the diabetes patient so they could learn about the disease and how to help their family/friend?

2021 CMC Diabetes Improvement Project

A. What are we trying to accomplish?

From February 1, 2021 – December 31, 2021, our clinic will decrease the number of patients with uncontrolled diabetes by half. CMC will provide comprehensive approach of education, meaningful clinical visits, medications, technology tools and connection of resources to all diabetics. This initiative is specifically focused on patients with diabetes and an A1c of greater than 6.4 and a diagnosis of diabetes.

B. Why is it important to work on now?

Upon careful review of Electronic Health Record data, CMC has identified 150 patients with diabetes. Diabetes leads to the most co-morbid conditions including organ failure, eye sight damage, and many other conditions. The burden of diabetes has impact on both quality of life and financial implications that continue to increase without appropriate intervention. According to the South Carolina State Health Improvement Plan (SCSHIP), thirteen percent of South Carolina adults had diabetes in 2016 and the disease was higher in those with an annual household income of less than $25,000 than those with an annual household income of $50,000 or more. Obesity-related health spending in South Carolina is estimated to be $8.6 billion per year and growing. If South Carolina could halt the increase in the prevalence of diabetes at today's levels, we could save $818 per adult, or $3 billion annually.

C. What are the expected outcomes?

- Patients managing their diabetes effectively
- Patients managing their medications effectively
- Positive changes in clinical indicators: A1C, blood pressure
- Lifestyle changes: nutrition, exercise, mental health
- Increased patient satisfaction
- Increased provider satisfaction

D. Who is on the team?

Project Sponsor: Susan Witkowski, CEO

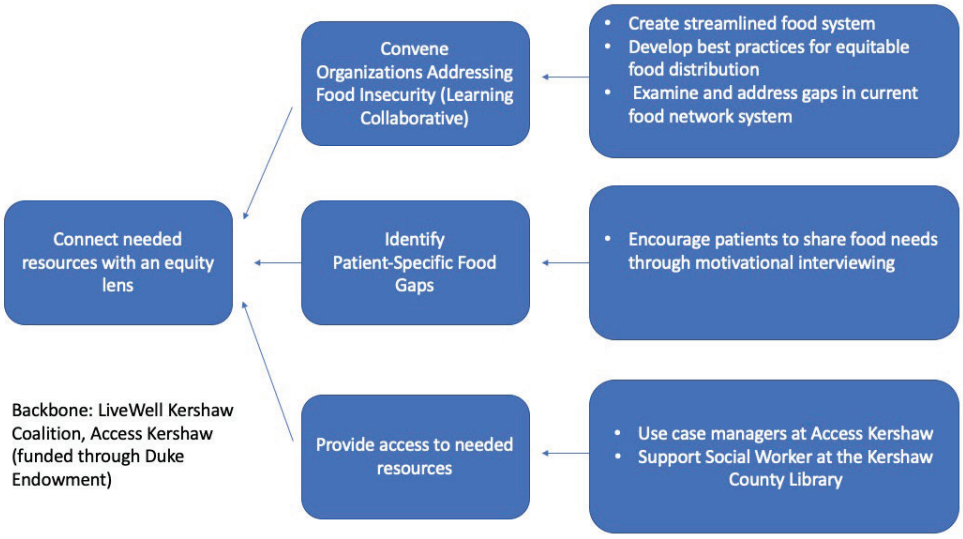
Team Members: Sara Beth Bradley (circuit training, food share), Kimberly Cogdill, Jessica Wilkes (meaningful visit), Kamela Clackum, Felicia Mumford, Jodi Rogers, Lindsey Kilgo (equity), Becky Yarbourough (meds and vaccines), Erica Watkins (education) and Sherri Bates and , Kathryn Johnson (equity)

E. What interventions will be tested and monitored?

A comprehensive set of interventions have been selected to test and monitor throughout the project. Interventions have been selected based on their ability to achieve greatest possible impact on patient health outcomes, as well as address diabetes education from all angles. This multi-pronged approach enlists the use of meaningful visits, equity-based solutions, health education, medication provision, and communication through technology. All interventions have been broken down to include the primary drivers for successfully accomplishing each intervention, as well as the activities that will take place to move the intervention forward. All enlisted interventions are outlined below.

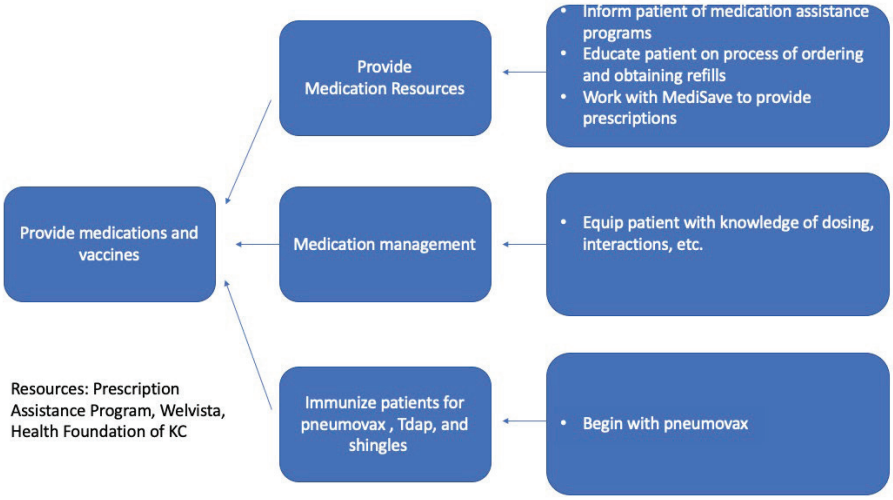
Connect Needed Resources With an Equity Lens

The LiveWell Kershaw Coalition, along with Access Kershaw will lead the effort to connect patients to resources through an equity lens. One of the main strategies includes convening organizations that are addressing food insecurity through the SC Roadmap Learning Collaborative. Secondary drivers include creating a streamlined food system, developing best practices for equitable food distribution, along with examining and addressing gaps in current food system. Another primary driver aims to identify patient-specific food gaps by encouraging patients to share food needs through use of motivational interviewing. The third primary driver of this intervention is to provide access to needed resources by use of case managers at Access Kershaw, as well as supporting the social worker at the Kershaw County Library.



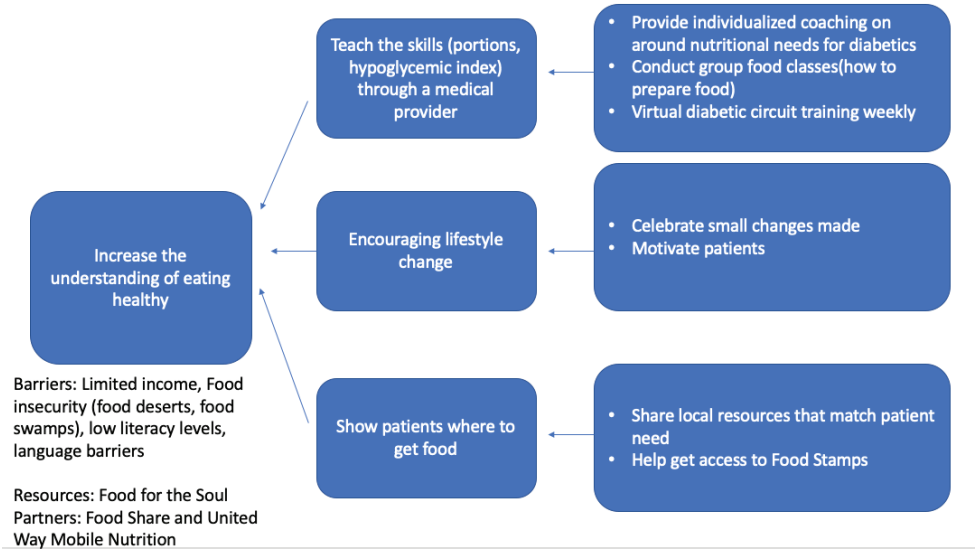
Provide Medications and Vaccines

The team will seek to provide medications and vaccines through support from the Prescription Assistance Program, Welvista, and the Health Foundation of Kershaw County. A primary driver of this intervention will be to provide medication resources. Associated secondary drivers of this will include: informing patient of medication assistance programs, educating the patient on the process of ordering and obtaining refills, as well as working will MediSave to provide prescriptions. Medication management will also be critical to this effort and will require equipping patients with knowledge of dosing and interactions. This intervention will also include immunizing patients with pneumovax, Tdap, and shingles vaccines. This process will begin with the pneumovax.



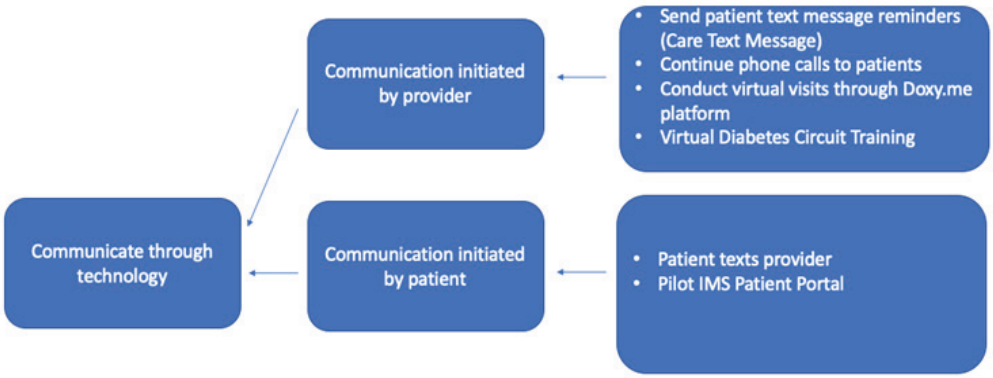
Increase Understanding of Eating Healthy

The team will utilize community resources such as Food for the Soul, FoodShare and the Mobile Nutrition Center to increase patient understanding of health eating. The team will teach the skills and tools to do so through individualized coaching around nutritional needs for diabetics, group classes, and virtual diabetic circuit training. The team will encourage lifestyle changes through continual motivational patient-centered activities, as well as celebrating even the smallest of changes made. The team will also direct patients to where food resources are located by sharing resources that match individual patient need, as well as assist in getting access to food stamps.



Communicate through Technology

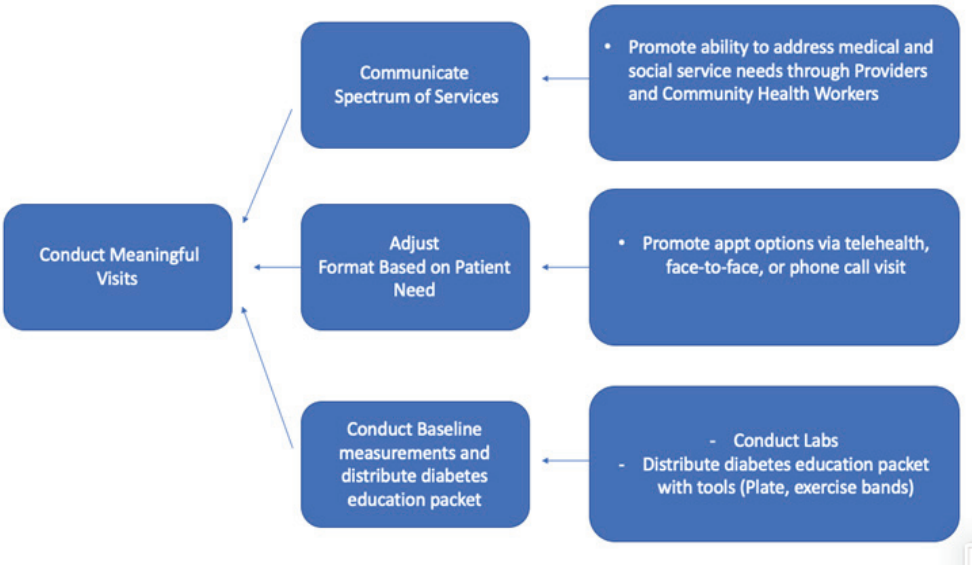
Through a critical partnership with MUSC, the team will communicate with patients via technology mechanisms. There are two feedback loops that will be incorporated into this intervention, 1. Provider-initiated communication and 2. Patient-initiated communication. Providers will communicate with patients via text message reminders, phone calls, virtual visits, and virtual Diabetes Circuit training. Patients will initiate communication with providers via text and an IMS patient portal.



Resources: MUSC

Conduct Meaningful Visits

The team will aim to conduct meaningful visits through a variety of mechanisms. One will include the communication of the wide variety of services provided. This will include the promotion of the ability to address medical and social service needs through Providers and Community Health Workers. The team will incorporate flexibility in visits through adjusted format based on patient need with options via telehealth, face-to-face, or a phone call visit. The team will also conduct baseline measurements via labs and distribute a diabetes education packet. Included in the packet will be tools, as well as exercise equipment.



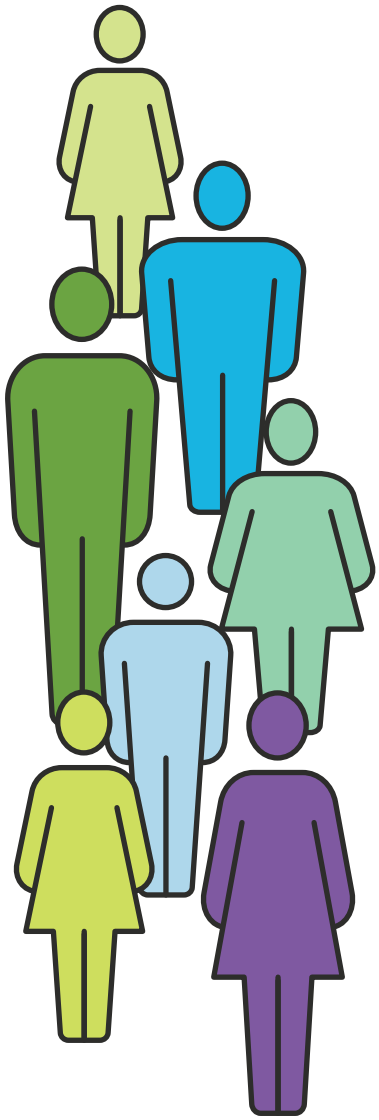
F. How will the interventions and outcomes be monitored and evaluated?

Quarterly analysis of data and also monthly team meetings.

Key Performance Indicator Dashboard

In March of 2019, CMC Board of Directors adopted a new three-year strategic plan for the clinic. The Board of Directors, CEO, and team members committed to addressing four strategic areas. To ensure that all team members were held accountable to the goals and objectives set forth, a key performance indicator was developed.

Unfortunately, 67% of strategic plans fail. CMC did not want to be in this majority. At the August, 2021 CMC board meeting, the Board of Directors and team celebrated completing the entire strategic plan including all goals and objectives.



COMMUNITY MEDICAL CLINIC OF KERSHAW COUNTY
OUTREACH · ACCESS · MEDICAL HOME

2021 KEY PERFORMANCE INDICATORS

Primary Care Home — Goal 325

42	76	109	227
JAN-MAR	APR-JUN	JUL-SEPT	TOTAL

Specialty Referrals — Goal 50% show rate

65%	47%	39%	51%
JAN-MAR	APR-JUN	JUL-SEPT	TOTAL

Diabetic Group — Goal ↑ knowledge

No change	No change	No change	No change
JAN-MAR	APR-JUN	JUL-SEPT	TOTAL

Best Chance Network — Goal 180

158	21	46	225
JUL-MAR	APR-JUN	JUL-SEPT	TOTAL*

Transitional Care — Goal 173

29	35	35	99
JAN-MAR	APR-JUN	JUL-SEPT	TOTAL

Average Donor Gift — Goal $1,010

$1,240	$1,371	$1,580	$1,580
JAN-MAR	APR-JUN	JUL-SEPT	AVERAGE

Patient Impact

Phone interviews	Satisfaction survey	Racial equity with Hispanic veggie Rx boxes	Engaged
JAN-MAR	APR-JUN	JUL-SEPT	

*Grant funding is from July 1- June 30. Goal of 180 reflects the goal for fiscal year, not calendar year.

2019-2021 STRATEGIC PLAN: planning graph

VISION

A healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being.

MISSION

To provide medical care and connect resources to achieve a healthier Kershaw County.

SAME PAGE, SAME PATIENT

1.1 Enhance accountability framework to create successful leaders
- Establish check-ins with team leaders (Y1)
- Create monitoring strategy for all team leaders (Y1)

1.2 Implement daily case management huddles across all satellites
- Design strategy for huddles (Y1)
- Utilize service gap analysis when gaps are identified (Y1)

1.3 Monitor communication feedback loops across system
- Implement volunteer-shift reports (Y1)
- Adopt Google Chat across all sites (Y1)

COMPLETED

ONE TEAM, ONE DREAM

2.1 Create unified branding
- Adopt new name, mission, logo (Y1-Y2)
- Update marketing materials (Y2)

2.2 Create and deliver messaging based on targeted audience (Y1-Y3)
- Apply for Culture of Health Award (Y1-Y2)
- Engage funders outside Kershaw County (Y1-Y3)
- Serve and support as backbone for LiveWell Kershaw Coalition (Y1-Y3)

2.3 Engage an effective Board
- Revise, approve, and comply with by-laws (Y1)
- Create and follow Board development plan (Y1-Y3)
- Create tools for and conduct annual Board and CEO evaluations (Y1-Y3)

COMPLETED

MAXIMIZING PEOPLE POWER

3.1 Develop high-performance teams
- Assign and train volunteers to spearhead volunteer teams (Y1)
- Conduct skill-set assessment annually for staff and volunteers (Y1-Y3)
- Recognize teams for service (Y1-Y3)
- Maximize Mental Health Counselor (Y1)

3.2 Recruit volunteers who align and support the culture
- Train Development Director (Y1)
- Create new application and interview process (Y1)
- Utilize electronic volunteer database (Y2)

3.3 Provide a high-performance team in every satellite based on need
- Secure additional funding for personnel (Y1-Y3)
- Create back-up plan and cross-training strategy (Y1)
- Conduct regular case management meetings (Y1-Y3)

3.4 Test and Implement chronic-disease specific circuit training (i.e. CVD, HTN) (Y2)
- Educate and train pre-diabetics (Y1-Y3)

COMPLETED

EXPANDING RESOURCES BASED ON NEEDS

4.1 Implement medical tele-health across Kershaw County
- Conduct comprehensive assessment of IT needs and Wi-Fi coverage (Y1)
- Install telehealth equipment in two schools and two church satellites (Y1-Y2)

4.2 Deliver needs services in a timely manner
- Provide Women's Health Services in other satellites (Y2)
- Secure Nurse Practitioners to provide acute care in School-Based Health Center (Y2)

4.3 Conduct outreach for needed specialty-care services (i.e. increase in COPD, HIV) (Y1-Y3)

COMPLETED

Patient Satisfaction Survey

As part of continuous quality improvement efforts, CMC team members assessed patient satisfaction. Team members will monitor patient satisfaction two times a year and make necessary changes to optimize patients' experiences.

CMC
COMMUNITY MEDICAL CLINIC
OF KERSHAW COUNTY
OUTREACH - ACCESS - MEDICAL HOME

Community Medical Clinic of Kershaw County
Patient Satisfaction Survey Results

July 9, 2021

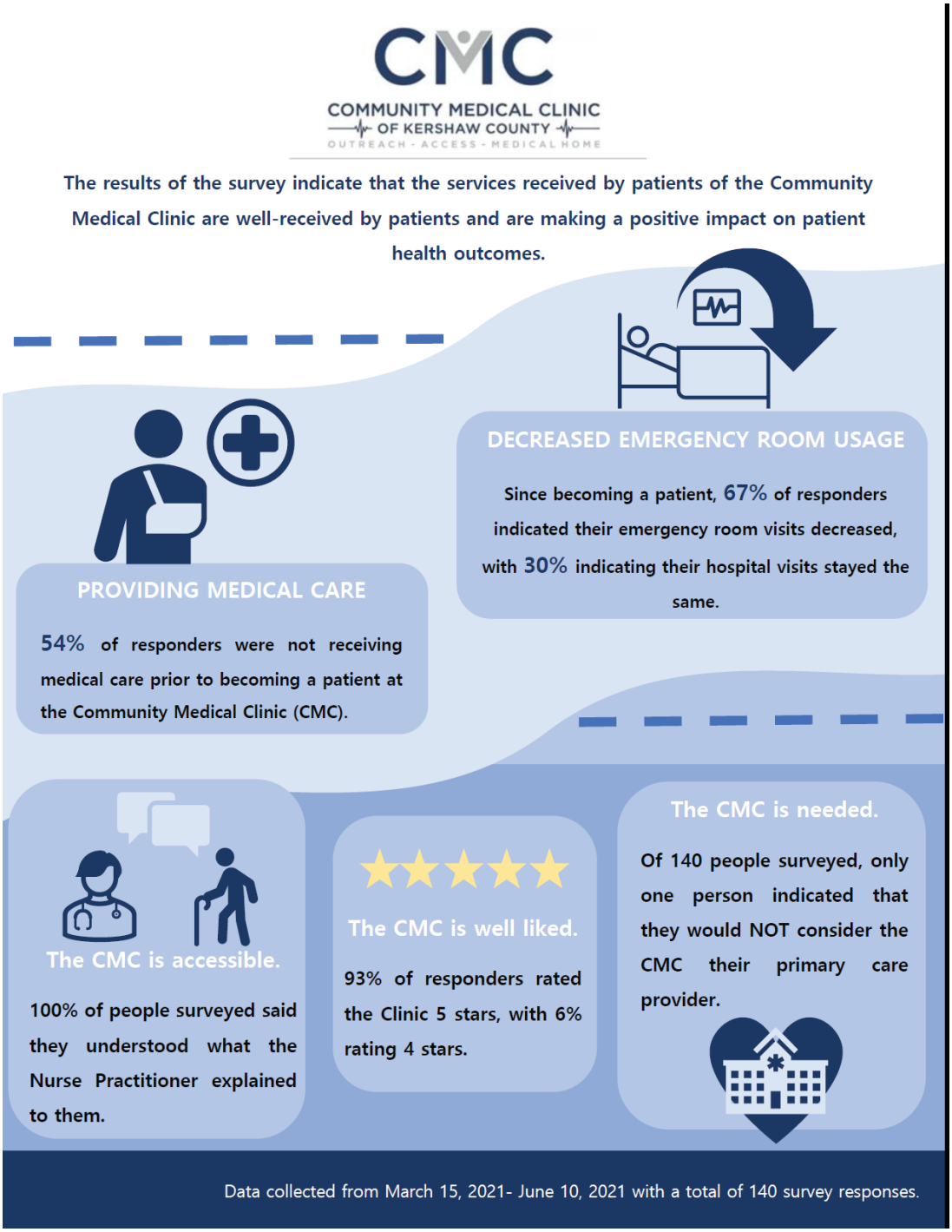
PREPARED BY IRON Sharpens IRON

Overview

The Community Medical Clinic of Kershaw County provides medical care and case management services to patients that are uninsured. To ensure accessibility of services to their patients, CMC provides care via in-person visits and by phone. In order to best understand the impact of services provided and patient satisfaction regarding services received, the team conducted a patient satisfaction survey.

Methodology

The patient satisfaction survey was made available from March 15, 2021, to June 10, 2021 via SurveyMonkey link on iPads for in-person visits and by text message for all phone visits. A total of 140 patients completed the survey with 112 responses from the Camden location, 19 via text message, and nine from the West Wateree location.



Your Health Is Our Priority.

100% of patients surveyed said they understood what their nurse practitioner explained to them.

Take advantage of our 5 star services and ask your CMC health care provider a question today!

CMC
COMMUNITY MEDICAL CLINIC
OF KERSHAW COUNTY

Results

The survey contained ten multiple choice questions for patients to complete (See instrument in the appendix). While there were 140 responses to the survey, it is important to note that not all participants answered every question. The following represents the results of the survey.

Patients were asked to share how they reached their appointment. Of the responses, the majority (60%) indicate that they made it to their appointment by their own car. Other responses included by family friend (20%), didn't have to travel (virtual) (15%), walk/ bicycle (4%), or other (2%). The two participants who responded "other" entered phone call and phone appointment.

Patients were asked to share how long they have been a patient at the clinic. The majority of patients have been with the clinic one to five years (38%), followed by more than five years (24%), and three months to one year (22%). Only 16% of responses indicate that they are a new patient and have been with the clinic one to three months.

Patients were asked to share if they consider the clinic to be their primary care provider. Of the 140 responses, only one patient indicated that they would not consider the clinic to be their primary care provider.

Patients shared where they received services prior to becoming a patient at the clinic. Of the 138 responses to this question, the majority (54%) of patients indicate that they were not receiving care. Others indicate they received services from a private doctor (20%), the emergency room (18%), or the local health department (9%).

Patients were asked to rate their overall healthcare on a scale from excellent to poor. The majority (46%) of patients indicated their healthcare is excellent. Other responses rate their healthcare as very good (27%), good (16%), fair (10%), or poor (1%). Please note that patients could have misinterpreted this question. In future surveys, this question will be changed to read: Rate your personal health on a scale from excellent to poor.

Patients were asked to rate the quality of care they received at the time of their visit. The majority (93%) of patients rated their care received as "5 stars" or the highest quality of care. Other responses included 6% with "four stars" and 2% with "1 star" or the lowest quality of care. The two participants who rated one star may have inverted the ranking scale, believing that one was the best. The average overall rating of care is 4.9 out of 5.

Patients were asked to share if the Nurse Practitioner explained things in a way that was easy to understand. Of the 140 responses, 100% of patients felt that they could understand what was explained to them.

Patients were asked to share if their visits to the emergency room have increased or decreased since becoming a patient of the clinic. Of the 138 responses, 67% of patients indicate that their emergency room visits have decreased while 30% indicate that their amount of visits have stayed the same. Only 4% indicate that their number of visits have increased.

Patients were asked to share if their overnight hospital admissions have increased or decreased since becoming a patient of the clinic. Of the 134 responses, 61% of patients indicate that their emergency room visits have decreased while 53% indicate that their amount of visits

have stayed the same. No patients indicated that their number of visits have increased.

Recommendations

The results of the survey indicate that the services received by patients of the Community Medical Clinic are well-received by patients and are making a positive impact on patient health outcomes. It is recommended that this survey be conducted once every six months to continually assess satisfaction ratings. In addition, some of the survey questions need to be changed for future use.

Question 6: In general, how would you rate your overall personal health?

Consider re-wording the hospital and ER visit question – several indicated there was no change. How can you change the responses to be easier for the patient to understand? It is believed that most likely there has been more of a decrease in ER and hospital usage than is shown from these survey findings.

Add an additional question to the survey: What additional feedback would you like to share with the CMC team?

Appendix 1. Patient Satisfaction Survey

Patient Satisfaction Survey

1. Which location did you visit today?

- ( ) Camden
- ( ) West Wateree Medical Complex (ACCESS)
- ( ) Virtual (phone or video)

2. How did you get here?

- ( ) Own car
- ( ) Family friend
- ( ) Bus
- ( ) Walk/Bicycle
- ( ) Didn't have to come in (virtual visit)
- ( ) Other (please specify)

3. How long have you been a patient with the clinic?

- ( ) New Patient (less than 3 months)
- ( ) 3 months - 1 year
- ( ) 1-5 years
- ( ) More than 5 years

4. Do you consider our clinic to be your primary care provider?

- ( ) Yes
- ( ) No

5. Where did you get your healthcare before you were a patient at our clinic?

- ( ) I was not getting care
- ( ) Nearest emergency room
- ( ) Private doctor
- ( ) Local health department

6. In general, how would you rate your overall healthcare?

- Excellent
- Very Good
- Good
- Fair
- Poor

7. Overall, how would you rate the Quality of Care you recieved today?

Lowest Quality Highest Quality

8. Did the provider (Nurse Practitioner) explain things in a way that was easy for you to understand?

- Yes
- No

9. Since becoming our patient, has the number of your Emergency Room visits...?

- Decreased
- Increased
- Stayed the same

10. Since coming to our clinic, has the number of your overnight hospital admissions...?

- Decreased
- Increased
- Stayed the same

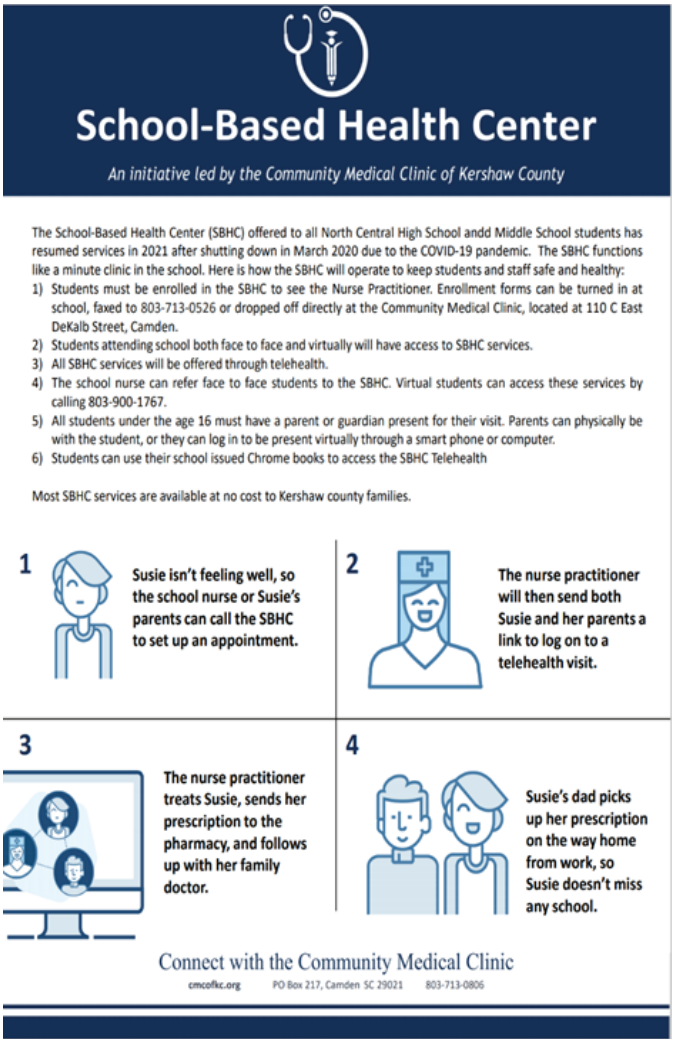
Thank you for completing this survey!

School-Based Health Center

The School-Based Health Canter (SBHC) initiative began at CMC in February 2015 as a strategy to maximize population health in all of Kershaw County. Earning a high school diploma is the primary indicator of good health for an individual. Students must be healthy to be educated and educated to be healthy. CMC adapted to COVID-19 barriers and was able to offer telehealth services to all SBHC registered students in Kershaw County.

Evaluation of the School-Based Health Center (2020-2021)

The LiveWell Kershaw initiative was funded through a contract provided by the South Carolina Department of Health and Human Services from July 1, 2020, to June 30, 2021. The purpose of this contract was to continue maximizing population health in the northeastern part of Kershaw County and to expand those efforts county-wide. The overall goal of the initiative is to reduce health disparities by identifying and addressing major health needs, service gaps, and health priorities. The purpose of this report is to evaluate the School-Based Health Center at Camden High School, Lugoff-Elgin High School, North Central High School and North Central Middle School during the 2020-2021 academic school year. The Community Medical Clinic of Kershaw County contracted with Iron Sharpens Iron Consulting to conduct an evaluation of the School-Based Health Center.



With the onset of a pandemic and impact of a tornado, the Kershaw County School District and the Community Medical Clinic of Kershaw County had to be very flexible during the 2020-2021 school year. When a EF-2 tornado struck North Central High School on January 11, 2020, most of the school was unsalvageable. Kershaw County School District and first responders worked together to clear the site, rehome classes to a temporary location in an unused vocational school, and resume normal operations without students having to miss a single day of school. In a true test of resiliency, not even two months after the tornado, South Carolina received one of its first coronavirus diagnoses from

Camden. This meant North Central students, faculty, and staff went from business as usual, to a temporary facility, to virtual learning and lockdown in the span of three months. Virtual learning coming together smoothly was the only way to get everyone through the abrupt transitions. Camden reported one of the first cases of coronavirus in South Carolina on March 6th, 2020. By the end of that March, Kershaw County was ranked in the top 10 of COVID cases per capita nationally for some time.

All of these challenges created an enormous burden on the school and clinic administration, teachers, students, parents and especially school nurses. The Community Medical Clinic of Kershaw County remained committed to providing School-Based Health Care (SBHC) services despite the COVID-19 challenges. In June of 2020, a detailed staffing plan was in place for a Nurse Practitioner to be available in-person or via telehealth at all three high schools and one middle school. Mental Health counseling provided by the University of South Carolina was not continued as in past years. A detailed timeline of the key milestones reached during the academic year can be found in Figure One. Even with the "relaxed attendance policy," CMC and the School District believed offering SBHC services to students would be very helpful to students and their families. How did CMC engage students and parents during a COVID pandemic? What changes were made throughout the process to increase efficiencies? What communication patterns existed between CMC and each school, administration, school nurse and the District Office?

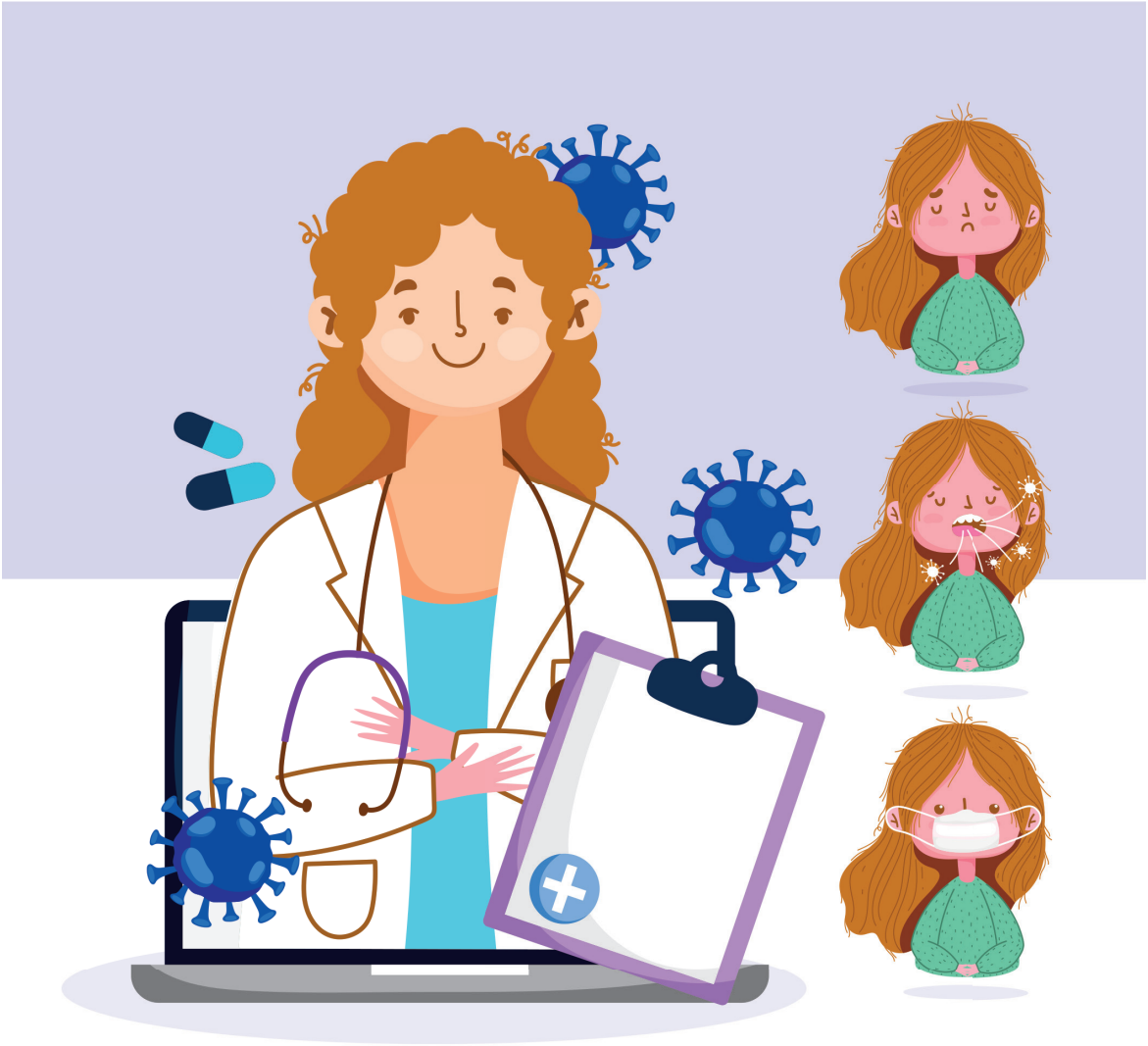
CMC committed to working closely with school administration, school nurses, and parents throughout the academic year. Not surprisingly, the initial plans of the SBHC changed several times due to changes at the school and District level. Clinical team meetings were held in-house with the CMC CEO, Nurse Practitioner and Licensed Nurse. In addition, meetings were held between CMC and School Superintendent Dr. Shane Robbins and the Director of Communications, Mary Ann Byrd. Additional meetings between with CMC Nurse Practitioner and individual schools were held throughout the school year.

On October 22, 2021, CMC team members met with the principals and school nurses to discuss the detailed plan of a Nurse Practitioner being provided either in-person or through tele-health beginning on November 1, 2020. Emphasis was placed on school administration and school nurses to promote the SBHC and answer any questions from parents and students and encourage students to opt into the SBHC program. All registered students for the SBHC were inputted in CMC's Electronic Medical Record.

Efforts to reach parents and encourage them to register their child for the SBHC, and increase the awareness of the telehealth opportunity included an automated call to all parents and a flier that went out via Peach Jar. In addition, a modified online SBHC registration form was created in collaboration with the Director of Communications.

The Nurse Practitioner reached out to school administration and nurses regularly to remind them of the SBHC and being able to visit students via telehealth. The school nurses at all of the schools were under significant strain during the 2020-2021 academic school year. Even though the nurses saw tremendous value in the SBHC, they did not have additional hours to refer students and promote the SBHC. School nurses were very busy serving students, conducting COVID contact tracing and working well into the night on required paper to the Department of Health and Environmental Control.

On July 18, 2021, the CMC clinical team and the school nurses of all of the schools convened for an in-person meeting. The school nurses again highlighted the importance of the SBHC and believe it is extremely valuable and want to continue offering SBHC services next year. A detailed plan was made which will include the use of a school nurse or health room assistant who will be using a telehealth cart to interact with a CMC Nurse Practitioner. The clinical team plans to continue using the secure doxy.me platform and conduct a training on the use of the telehealth carts with all school nurses.



CMC School Based Health Center:

Project Timeline
June 2020 - May 2021

CMC
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OF KERSHAW COUNTY
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Program Rollout

June 2020

Robust Implementation and Staffing Plan in Place

A Nurse Practitioner and nine mental health counselors are to be at all three high schools and one middle school either in-person or via telehealth.

August 2020

Student Participation

The District Office will have a relaxed attendance policy, and the CMC can access the portal to see students who have opted-in.

August 13, 2020

Clinical Team Meeting

Kim and Susan are working with North Central High and Middle to open SBHC. The plan is to be in all schools by November 1, 2020.

September 8, 2020

Getting Started

Classes resume, both in-person and virtual, and the CMC is working to set up all telehealth connections to begin SBHC services. The mental health contract was not renewed.

October 6, 2020

Key Decision Making

Meeting with with Dr. Shane Robbins and Donnie Wilson confirms SBHC will be opening at all three high schools and NCMS on November 1 with detailed schedules of the Nurse Practitioner provided to the schools.

October 22, 2020

Met with Principals

Susan, Kim, Camella and Holly meet with school princip als from CHS, LEHS, NCHS, NCMS, school school nurse Regina Bowers, and nurses from CHS and LEHS

December 1, 2020

MOU Signing

The MOU was officially signed on December 1st.

February 2021

Training and Parent Notification

Entire team is trained and ready to use Doxy.me; students under 16-years-old have to have a parent present. A robocall and updated Little Susie Flyer went out on the 21st to parents of NCHS and NCMS.

March 18, 2021

Virtual Meeting

Meeting held this week on the SBHC form (electronic) with with District Nurse Elizabeth Starling, and 5 district personnel.

May 2021

Begin Seeing Students

Total of three students are seen the week of May 3rd.

June 14, 2021

Academic School Year Ends

July 13, 2021

Prepping Begins

School nurses meet with CMC team to plan for the upcoming school year at all four participating schools.

How many students were served by CMC? What type of student were they at the time of the encounter? (Data Source: IMS, medical excuses) How many medical excuses were given?

CMC served three students during the academic school year; one from North Central High School and two from North Central Middle School. All three students were referred to the SBHC by the school nurse. The CMC Nurse Practitioner used the doxy.me platform, which allowed for a secure video conference call to take place. Due to the small sample size, limited details can be shared. Student one was given a prescription and able to go back to school two days later with a medical excuse. Students two and three were given a medical excuse for the class time missed. Technical difficulties occurred during one of the student interactions and the student communicated with the Nurse Practitioner using the chat feature.

What resources were expended by CMC to provide SBHC from January-May?

The ability to offer telehealth services to three high schools and one middle school required the use of a Nurse Practitioner and one part-time licensed practical nurse. In addition, the CEO of CMC spent several hours planning and discussing options based on the COVID procedures. Additional school resources included meetings with school administration and school nurses. In addition, storage costs were incurred due to the tornado at North Central High School.

Overall, the model of one Nurse Practitioner and one part-time licensed practical nurse serving the three high schools and one middle school with the telehealth model is extremely cost-effective. The Community Medical Clinic calculates them as:

- 1 FT NP (110) and 1 PT LPN (32), 15% of CEO (100)
- Storage costs (275/month), tornado
- Financial, manpower, etc.

Recommendations

Based on the findings from the evaluation, the following recommendations are being made for the upcoming academic year (August, 2021 – May, 2022).

- Sign MOU between the Community Medical Clinic and the School District
- Ensure regular communication between school administration, school nurses and the Community Medical Clinical team and make pivots as needed to increase awareness and the usage of the SBHC services available to students
- Provide quarterly testimonials to school administration and school nurses related to "de-identified" cases and how the SBHC has increased student attendance
- Provide training and continual monitoring of the use of the tele-health carts to school nurses
- Write an article describing the implementation and learnings of telehealth in a School-Based Health Center setting and submit for publication

Memorandum of Understanding Between

Kershaw County School District

and

Community Medical Clinic of Kershaw County

Purpose

Community Medical Clinic of Kershaw County (CMC) and Kershaw County School District are entering into this Memorandum of Understanding (MOU) for the provision of minute clinic health care services to the students of ***Kershaw County*** in school-based health centers from ***November 1, 2020 to June 30, 2021***. This MOU addresses services at ***Camden High School, Lugoff-Elgin High School, North Central High School and North Central Middle School.***

Responsibilities of the Parties

The Parties (Community Medical Clinic of Kershaw County and Kershaw County School District) understand that each should be able to fulfill its responsibilities under this Memorandum of Understanding (MOU) in accordance with the provisions of law and regulation that govern their individual activities. Nothing in this MOU is intended to negate or otherwise render ineffective any such provisions or the operating procedures of either Party. If at any time either Party is unable to perform its functions under this MOU consistent with such Party's statutory and regulatory mandates, the affected Party shall immediately provide written notice to the other seeking a mutually agreed upon resolution.

Community Medical Clinic of Kershaw County **will:**

1. Provide administration and oversight to the SBHC(s) in accordance with the terms of this MOU.
2. Provide a year-end evaluation report detailing scope of project and outcomes.
3. Be responsible for the hiring and supervision of all SBHC(s) staff and/or consultants. Provide documentation of all required licensure and professional insurance.

4. Obtain consent and enrollment information from parents or legal guardians so that students can access the SBHC(s).
5. Establish and maintain medical records for students who receive services at the SBHC(s).
6. Provide and oversee episodic medical services that are referred to the SBHC by the school nurse in a timely

manner which may include screenings, sports physicals, acute care, and referrals regardless of insurance coverage. (No student will be charged for services).

7. Maintain requirements to provide telehealth as stated in the CMC partnership with MUSC. CMC will train all personnel on using the telehealth equipment.
8. Participate in at least two meetings with ***Kershaw County School District*** each year with the SBHC principals (NCHS, NCMS, LEHS and CHS) and school nurses to discuss SBHC(s) operations and usage of the SBHC by students.
9. Provide all materials, supplies, equipment and other items necessary to the provision of students' health care services, with the exception of phone, internet, and exam room which has been provided by ***Kershaw County School District***.
10. Deliver all services described in this MOU in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and regulations promulgated thereunder, and other governing state and/or federal laws and regulations.

Kershaw County School District **will:**

1. Provide in-kind staff support to the SBHC operations including, but not limited to, triaging students to the SBHC, referring students to the SBHC and providing data needed for reporting.
2. Provide a school nurse who will assess students for referral to SBHC(s). Ensure that all school nurses receive training on the telehealth equipment. School nurses will use the telehealth equipment to initiate telehealth visits between a student and the ***Community Medical Clinic of Kershaw County*** Nurse Practitioner.
3. Participate in at least two meetings with the ***Community Medical Clinic of Kershaw County*** each year with the SBHC principals (NCHS, NCMS, LEHS and CHS) and school nurses to discuss SBHC(s) operations and usage of the SBHC by students.
4. Provide the adequate space, utilities and equipment including but not limited to internet services at SBHC(s) adequate for the provision health care services. Provide telephone and IT support for the SBHC(s) purposes.
5. Provide training and documentation related to emergency policies and health and safety procedures.
6. Provide SBHC enrollment and registration forms on the KCSD website and report all enrollment data to the ***Community Medical Clinic of Kershaw County*****.**
7. Comply with the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR Parts 160 and 164, Related Excerpts from the Preamble and Final Regulation Text Amended as of August 14, 2002:

160.102 Applicability and 164.504 Uses and Disclosures: Organizational Requirements *(a) Definitions Health Care Component and Hybrid entity,* (b) *Standard: health care component, (c) (2) Standard Requirements, and (c) (3) Responsibilities of the Covered Entity.*

8. Comply with the Family Education Rights and Privacy Act, (FERPA), *as amended*, 20 U.S.C. 1232g, Distinguishing Education Records from Health Records, and Access to and Use of School-Based Student Health Information, U.S. Department of Health and Human Services, "Standards for Privacy of Individually Identifiable Health Information,

   Federal Register 65, no. 250 (December 28, 2000): 82483, 82496, and 82595.

9. Share student information with ***Community Medical Clinic of Kershaw County*** as necessary for the provision of services, administration of the SBHC and accountability to the extent allowable and in accordance with governing state and/or federal laws and regulations.
10. Notify ***Community Medical Clinic of Kershaw County*** *of* any unauthorized possession, use, knowledge, or attempt thereof, of any protected health information data files or other confidential information; promptly furnish to ***Community Medical Clinic of Kershaw County*** *full* details of the unauthorized release of such confidential information; and assist with the investigation or prevention of the further release of such information.

Professional Liability

The Parties shall each be responsible for their respective acts or omissions in the performance of medical services under this MOU and neither party shall incur any liability for the performance of the other party. ***Kershaw County School District*** affirms that it carries a professional liability insurance policy as required by law in sufficient amounts to cover any personal injury or loss that may occur through the provision of services by its medical staff under this MOU. ***Community Medical Clinic of Kershaw County*** affirms that it has professional liability insurance coverage under the Federal Tort Claims Act (FTCA) in levels and amounts as required by law for any HHC staff providing services under this MOU.

General Liability

The Parties shall each be responsible for their respective professional liabilities consistent with the preceding provision. As to personal and property damage unrelated to the provision of medical services under this MOU, ***Kershaw County School District*** affirms that it carries a general liability insurance policy sufficient in amount and coverage which will apply to any personal injury or loss or property damage that may occur on the SBHC's property.

Termination

Either Party may terminate this MOU by giving written notice of termination to the other Party at least 60 days prior to the intended date of termination. Any equipment purchased prior to the signing of this MOU, and still within its useful life, shall be returned to ***Kershaw County School District*** in good operating condition. Any equipment purchased subsequent to this MOU shall be kept by ***Community Medical Clinic of Kershaw County***.

Extension

Kershaw County School District and ***Community Medical Clinic of Kershaw County*** SBHC collaborative team agree to review this MOU annually, at least 60 days prior to its expiration date. Extension of this MOU for a specified period of time must be by mutual agreement of ***Kershaw County School District*** and ***Community Medical Clinic of Kershaw County*** and must be put in writing.

Suggestions for recommended changes, clarifications, deletions or additions will be discussed at the bi-monthly SBHC collaborative team meeting. Mutually agreed upon extensions of this MOU for a specified period of time and changes to the MOU must be incorporated into an addendum which must be signed by the authorized representatives of ***Kershaw County School District*** and ***Community Medical Clinic of Kershaw County***.

Amendment

This MOU shall not be altered, changed or amended except by instrument in writing executed by the Parties hereto.

Notice of Failure to Perform

If either of the Parties to this MOU is dissatisfied with the performance by the other Party of any obligations imposed under the terms of this MOU, the dissatisfied Party shall request in writing that its grievance(s) be placed on the monthly meeting agenda of the SBHC collaborative team meeting for discussion, action and resolution. The performing Party shall have 10 working days in which to correct any failure to perform the duties so specified or to communicate with the dissatisfied Party, and/or to resolve any disagreement between the Parties. The grievance procedure will be executed in accordance with the *SBHC Non-Performance Policy and Procedure*.

Scope of Agreement

This MOU incorporates all the agreements, covenants and understandings between the Parties hereto concerning the

subject matter hereof, and all such covenants, agreements and understandings have been merged into this MOU

Duration of MOU

This MOU shall be in force from ***November 1, 2020, to June 30, 2021.***

Signatures

IN WITNESS WHEREOF, the duly authorized representatives of the Parties have executed this MOU effective as of the date first above written.

Dated:_____, 2020 BY: _____

CEO, ***Community Medical Clinic of Kershaw County***

Dated:_____, 2020 BY: _____

Superintendent, ***Kershaw County School District***

Questions regarding the specific activities outlined in this report can be directed to:

Susan Witkowski

Community Medical Clinic of Kershaw County

switkowski@cmcofkc.org

803.900.1468

Questions regarding the evaluation of CMC can be directed to:

Holly Hayes

Iron Sharpens Iron Consulting

803.920.1736

holly@sharpertogether.com