Southside Community Health Services

Touchpoints That Matter: Building Trust and Control Through Telehealth

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American Heart Association. Center for Telehealth™

SOUTHSIDE Your Community Health Services

Smart Goal

Increase the number of patients who receive **home blood pressure monitors** and complete **follow-up visits with a nutritionist for nutrition education and with nurses** to review the (BP) blood pressure and (BG) blood glucose logs every 2 weeks until HTN (hypertension) and/or DM (diabetes mellitus) is controlled. Correctly code roles and educate the schedulers to select the correct visit mode for telehealth to allow the telehealth data to be captured correctly.

Drivers

1. Review and map current process for BP kit distribution to identify gaps and areas for improvement
2. Develop and standardize the process for notifying nursing staff when a follow up call is needed (2 weeks after new diagnosis or condition is determined uncontrolled.
3. Create and deliver training for nursing staff on the new follow-up process and tracker usage.
4. Monitor and evaluate the effectiveness of the tracking and follow up process & adjusting, as necessary.

Standardized BP Monitor Tracking

1. **Monitor Distribution**

   When a Medical Assistant or Provider issues a home BP monitor, they notify the Care Coordinator to add the patient to a tracking sheet.

2. **Monthly Review**

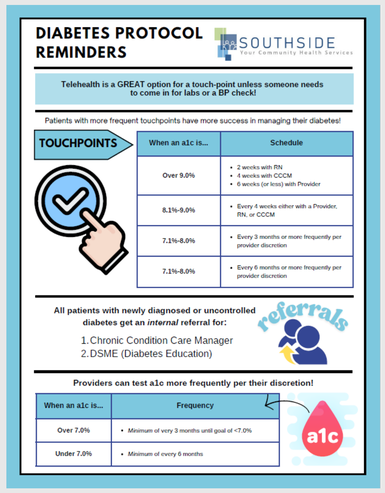
   The CCCM runs monthly **Controlled HTN** and **Uncontrolled DM UDS** reports. Patients with **BP ≥140/90 or A1c ≥9.0%** are flagged for review.

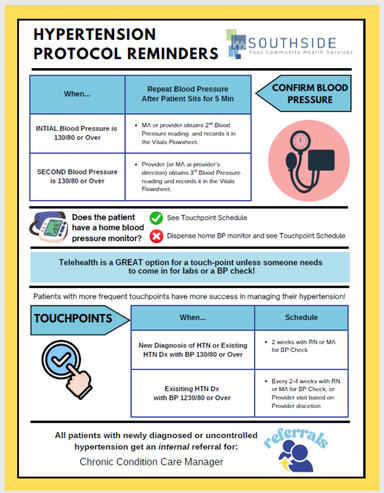
3. **Team Collaboration**

   The **RD/CDCES** review the flagged list, providing context or recommendations for outreach. The **Care Coordinator** follows up to ensure timely next steps.

4. **Follow-Up & Touchpoints**

   Patients with uncontrolled HTN or DM receive a **touchpoint every 2 weeks** until in control. **Touchpoints may include** RN BP/BG log reviews, Nutrition education with RD/CDCES, SDOH screening with Care Coordinator, and/or Provider visit. **Most touchpoints are completed by phone, ensuring accessible, ongoing support.**

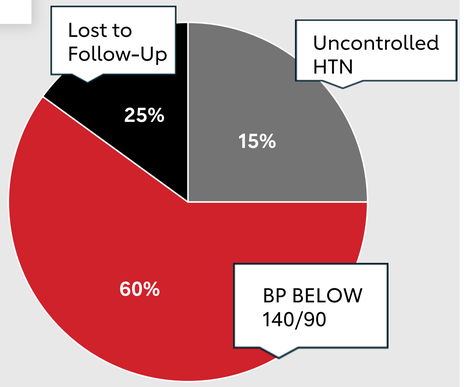




Results

Over a 6-month period, **20** people with uncontrolled HTN were given a BP monitor kit. **60%** then reached a BP **<140/90.**

We also discovered that patients who completed the DSME program, which is primarily by phone, **lowered their a1c by an average of 2.7%.**



Conclusions

We know that people with frequent touchpoints build the necessary foundation of trust in our system and providers to be able to manage their chronic conditions successfully. Being able to meet people where they are, including offering touchpoints and education via phone when they are able, plays a significant role in this.

Lessons Learned

We identified early that telehealth visits were not being captured accurately. To improve data accuracy, we implemented a specific appointment "mode" to distinguish in-person from telehealth/video visits.

We also found providers often forgot to enter internal referrals for the Chronic Condition Care Program, so we created **EMR Smart Phrases** that prompt referrals based on specific criteria.

Future Directions

- ✓ **Training:** Conducting **biannual staff training** to ensure consistent tracking and support for patients in reaching BP control.
- ✓ **Care Coordination:** Care Coordinator reviews BP tracking log and compares it with patient visit records to confirm follow-up. If a patient hasn't been seen within two weeks of receiving a BP monitor, the Care Coordinator calls to **schedule an appointment with the RN or CCCM** to review the BP log.
- ✓ **Addressing No-Shows:** When a patient is late for their in-person visit, the patient will be contacted to inquire if they want to **switch to a telehealth visit**. Patients receive automated text messages alerting them they have missed their appointment and inviting them to call to reschedule their appointment.