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Using Innovation and Population Health Management to Protect High Risk and Chronic Disease Patients from Covid-19 by Federally Qualified Health Centers (FQHCS)

Miku Sodhi*

Deputy CEO, Shasta Cascade Health Centers, 1632 Christian Way, USA

*Corresponding author: Miku Sodhi, Deputy CEO, Shasta Cascade Health Centers, 1632 Christian Way, Mount Shasta, California, USA

Commentary

Many reports on media outlets and social platforms in last few weeks have mentioned that if one could hold his or her breath for 10 seconds without coughing, discomfort, or tightness, it proves there is no Fibrosis in the lungs, and indicates no COVID infection. Many patient are believing this. This off course is not fully true, and people therefore need correct clinical information from reliable sources rather than social media about coronavirus in stressful times. There are not many public health experts, doctors or health professionals who at this time are thinking of proactively preventing COVID-19 from population management stand point or population health analytics stand point to ensure that the most vulnerable at-risk patients don't slip through the cracks during this emergency. Here's how using telehealth and Electronic Health Record tools to do innovative work during the crisis can protect high risk patients in rural and urban population from corona virus.

On and Beyond Telehealth Foundation

Before the COVID-19 crisis hit, telehealth played minor in patient care. Telephone visits were minimally utilized by most primary care clinics, FQHC's, rural health clinics, safety nets, including private primary care practices. COVID times saw sudden transition to telephone encounters, virtual visits and use of telehealth as main stay. The primary goal of transition to telephone and virtual house calls was to reduce the spread of COVID-19 in healthcare setting. However, clinics can see other major benefits, which are not talked yet. One of the important one is that it can be very taxing to get to an in person appointment especially if the patient is sick or lives far away, and have to drive to rural clinics. The faster the clinics can get on to changing workflows and starting telephone encounters, beginning extensive virtual health, the faster it can help patients. Government is giving coordinated support for the same with clinics having fewer resources. FQHC's must understand that this can be a huge source of patient services revenues and income, with relaxations by CMS to reimburse for the such services in emergencies.

Innovation for Proactive Protection against Covid-19 in High Risk, Chronic Disease Patients

Rural and urban primary care practices and FQHC's serving vulnerable population can learn innovative lessons from the United Kingdom's National Health Service (NHS), to go beyond previously scheduled telephone visits to support patients at high risk for COVID complications. For example, before influenza season, NHS clinics reach out to patients with chronic diseases (Diabetes, Hypertension, Heart Disease, Asthma) and offer them medication refills and basic disease counseling. This prevents high risk patients from coming to clinics for non-urgent needs, which reduces their exposure to influenza. The important point to note is the proactive process here by health professional and physicians for patients with otherwise known high risk chronic diseases, without acute symptoms, much before-hand the virus period or transmission starts, or any vaccines given. This prevents high risk patients from coming to Primary care providers and they can stay at their home till the virus season goes (up to three months). This proactive method could be easily translated and be used to addressing COVID-19 in those who haven't been yet impacted with it.

Using Population Health Management, Health Analytics for Covid-19 Protection

It is suggested that primary care physicians and nurses built chronic disease registries for patients at high risk of COVID complications and develop a protocol, along with frontline staff for medical assistants and other staff calling those patients. Callers should provide basic education about COVID, then ask some simple questions to help find out if a patient's disease is poorly controlled - for instance, if a patient with diabetes is having symptoms of low blood sugar. All chronic disease patients should be offered telephone appointments with their primary care provider. People with concerning symptoms should be routed more urgently to a nurse. Extensive outreach is second crucial innovative piece to this, and suggested with patients who have heart failure, diabetes, asthma, chronic obstructive pulmonary disease and HIV, patients with other immune- compromising conditions, kidney disease and children with chronic illnesses.

The key is to keep a check on those people who are high risk and vulnerable, including those patients who don't speak English or have low literacy levels. Many primary care practices, Federally Qualified Health Centers (FQHCs), safety net clinics serve patients that are highly vulnerable also need housing and food – which can be offered via strong outreach.

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If pandemic was seen coming, health centers would have equipped many patients with a glucometer and a scale, for example. This was not the possibility, as health professionals could not predict it, but if patients are interested in, say, getting a home blood pressure monitor, health centers can easily arrange to have one shipped to their house. This is much easier to do since lot of community health centers and primary care centers already are good in disease management and education and many already have done a lot of work with hypertensive population, in general –such as teaching patients to use blood pressure cuffs etc, and have laid the foundation. On a population health level, it may be too early to tell what kind of effect outreach will have, but it is promising. In addition, there is a strong financial case for both telephone visits in general and outreach in particular. Federally Qualified Health Centers are struggling for revenue as they cancel outpatient in-person visits, and telephone visits are one of the only remaining sources of revenue. While providers don't bill for the outreach, they are able to bill for the phone visits, which helps prevent a drastic shortfall in revenue.

A critical part of this effort has to be towards creating electronic chronic disease registries and teaching front-line staff how to use them. Population health management tools are now available on most of the electronic medical records in primary care practices today. This is the time to advance them, use analytics tool embedded in EHRs, train to change clinical workflows for chronic disease and high risk vulnerable patients. Population health tools can have real value in COVID-19 when trying to reaching large number of such patients, in less time.

It is important to know that flattening the curve of a pandemic means prolonging the emergency restrictions, and eventually people with chronic illnesses are going to suffer, no matter what. The longer normal healthcare operations are disrupted, the more likely chronic illnesses will be exacerbated. It is imperative that primary care health centers, FQHC's continue to check in on people to make sure they are proactively protecting the high risk, vulnerable and chronic disease patients. These are the patients that can add health care costs due to mortality, but more importantly will surely add to long term morbidity costs of health care in weeks to come.

*Corresponding author: Miku Sodhi, miku_sodhi@hotmail.com

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