Guam Department of Public Health and Social Services

Presented by:
Linda Unpingco-DeNorcey, M.P.H.
Guam CHC Executive Director

FQHC GOALS:

- To ***increase access*** to primary care services by expanding medical and physical capacity

- To ***reduce disparities*** at the primary care setting…

by providing **self management education** to improve disease control and reduce long-term complications associated with the disease

through **collaborative partnerships** in establishing

a successful, "cost-effective" non-communicable disease self management education program.

FQHC Performance Measures-NON-Communicable Diseases

- Diabetes (HbA1c levels <=9%)
- Cardiovascular Disease (Hypertension)
- Blood Pressure < 140/90)
- Cancer

  (PAP Smear Test Women 21-64 yrs)

  Colorectal Cancer Screening

- Body Mass Index (Overweight, Underweight)

FQHC Performance Measures

- Tobacco Assessment & Counseling
- Tobacco Cessation Counseling
- Coronary Artery Disease (Lipid Therapy)
- Ischemic Vascular Disease (Aspirin Therapy)
- Asthma (Pharmacological Therapy)

What are the barriers to health care?

- **Linguistic**- Micronesians

  (Lack of CHC Interpreter on site)
- **Cultural**-Lifestyles, fiestas (type of food)
- **Transportation** (No ride to the CHC, unreliable public transportation)
- **Financial** (Lack of Insurance, cannot afford supplies/medications, lab tests)
- **CHC barriers**

  testing availability on site)

  CHC Providers not actively involved in making patients accountable in their diabetes care)

Increased access to care :

- ***Expansion of:***

Clinic hours of operation (from 40 to 56 hrs/week)
(Mon-Thurs 7:30AM-6PM; Fri & Sat (7:30AM-1:30PM)

- ***NRCHC /SRCHC Sites***

- ***Cultural Sensitivity-Hiring Chuukese Translator, Perinatal Care Coordinator, Kosrean Nurse***
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Accomplishments:

- ***Technical Assistance from HRSA***
  - Cultural Competency (Micronesian Population)
  - Behavioral Modification (Adopt Healthy Lifestyles)
  - Development of educational materials in various languages

Accomplishments:

- ***Clinicians making patients more accountable***

  in adopting healthy lifestyle changes:

  weight loss, HbA1c testing, blood sugar and blood pressure monitoring, nutrition, physical activity, smoking cessation

- Medication Compliance

Accomplishments:

- ***Health Screenings*** (blood pressure & blood glucose)
  Referral to CHCs

Patients chose Self-Management Goals

-given glucometers & test strips (monitor glucose-200)

- ***Education***
  -Group sessions
  -"one to one counseling (insulin administration, medication management)

-nutrition education "Living with Diabetes"

-Brief Tobacco Intervention (***smoking cessation classes)***

Accomplishments:

- HbA1c test barriers: transportation to DLS, financial constraints to pay for tests
- ***HbA1c & Microalbumin tests available/accessible***

  Charge a minimal fee

  Add HbA1c and Microalbumin tests to proficiency testing for CLIA approval
- ***Policy Changes*:**

  -Adjusted charges for HbA1c & microalbumin tests ($1 for uninsured and MIP)

  -Tobacco Free Site, Tobacco Enforcers

  -Sliding Fee application processing at Mayor's Offices

Accomplishments:

- ***Community Partnership***

  Guam Diabetes Association

  Guam Diabetes Coalition

  Guam Cancer Care (Non-profit)

  Non-Communicable Disease Consortium (DPHSS

  Guam Micronesia Area Health Education Center (University of Guam School of Nursing/GCC)

- ***Portable Clinical Care***

  "Extended Clinic" Bring CHC to the poor by minimizing financial, transportation, cultural, and linguistic

- ***Community Outreach Education***

Next Steps:

- **Tobacco Free Environment**

  Brief Intervention Services

  Tobacco Enforcement

- **Electronic Health Record Implementation**
  - Data integration
  - Analyze Disease trends
  - Evaluate CHC Clinical Performance Measures
  - Exchange of Health Information

  -Meet "Meaningful Use

  -Research

Next Steps

- Joint Commission Primary Care Medical Home
  - Patient-Centered Care
  - Comprehensive Care
  - Coordinated Care
  - Superb Access to Care
  - A Systems based Approach to Quality and Safety

Next Steps:

- **Joint Commission Primary Care Medical Home (PCMH)**

  Patient Centered Care

  (cultural, linguistic, and educational needs of pts)

  Patient involvement in establishing treatment plan

  Support for patient Self management

  Comprehensive Care

  (Acute, Preventive, and Chronic care)

  Interdisciplinary team

  Disease management

  Care that addresses phases of patient's lifespan

Next Steps:

Coordinated Care

(Health Care Systems: hospitals, home health care, specialty care)

Use of internal and external resources to meet patient needs

Team-based Approach

Superb Access to Care

Shorter wait times; flexible appointment hours

A Systems based approach to Quality and Safety (Health Information Technology,

Patient involvement in performance monitoring and improvement

- **Community Involvement/Partnership** collaborate with federal programs, non-profit organizations, educational institutions, church groups, FSM Consulate
- **Community Empowerment (Centers for Micronesian Empowerment-**Train unskilled immigrant for the workforce

  GCA Trades Academy and GCC
- **Implement Educational Programs**

- **Financial Support-** share & leverage resources