

North County Health Services

PHLN Year 2 Project Aim

By December 31, 2019, NCHS will identify, track, and provide resources and assistance to address the key SDOH barriers for patients with poor diabetes control, as defined by Hemoglobin A1c > 9%.

Measures for Success

- # of patients who are assessed using the identified SDOH assessment tool
- # of resources provided
- # of SDOH barriers addressed amongst our patient population with poor diabetes control
- Creating workflows for using the SDOH assessment tool and care coordination that follows the process to evaluate and improve workflows.

Changes

Tested Changes

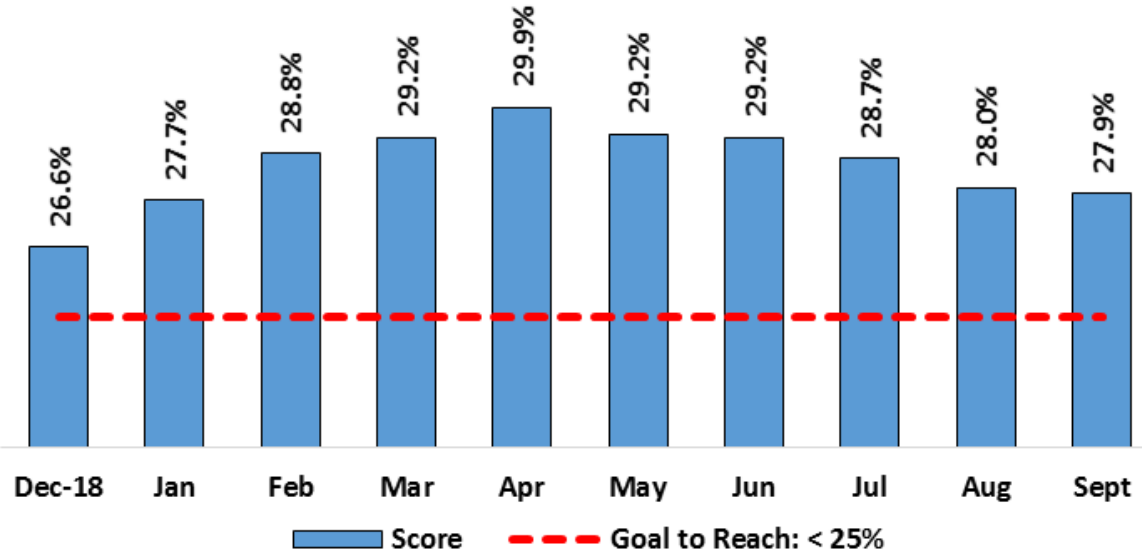
- Case Management – Care Coordinators continuing to work with diabetics with poor control by outreach, health education, self management goals, appointment scheduling and follow up with management of diabetic patients.

Implemented Changes

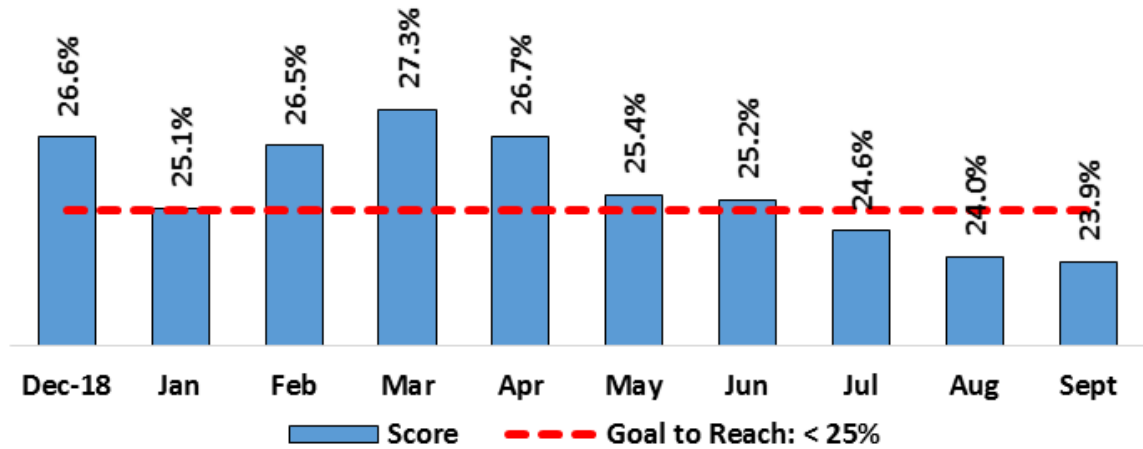
- SDOH Task force established
- Hired new RN Case Management Manager
- Adding PRAPARE tool into our E.H.R. (Intergy)
 - Training received from the CIE
 - Motivational Interviewing training
 - Trauma Informed Care Training

Using Data for Improvement

DM Poor Control - A1c > 9 or No Test (Lower is Better)
12-Month Rolling Scores



DM Poor Control - A1c > 9 or No Test (Lower is Better)
3-Month Rolling Scores



Strategies for Success

- 1 Training to Case Management Team
- 2 1:1 Mentoring with Care Coordinators in Case Management Department
- 3 Transparency of Data Outcomes
- 4 Presentations Provided to a Variety of venues; Lead Clinicians, Nursing, Support Staff, Clinical Operations, Individual Care Sites

Key Tools & Resources



Leveraged Health Homes Training and PRAPARE materials to teach the Care Coordinators motivational interviewing to help improve patient outcomes.



Utilizing the Care Plans within our EHR as a communication tool between Care Coordinator, provider, and patient.



Set self-management goals with the patient that are realistic and reachable.

Next Steps

Spreading

Piloting the tool is the first step to work out any of the challenges, barriers and positive outcomes

Sharing the project success stories for engagement & buy-in of the case stories that were found to make a difference

Implementing the tool in Intergy first to test as implementing a new EMR in June 2020

Sustaining

Sustainability is the goal.

Setting up for success is partially due to PRAPARE already interfaced with our new system – OCHIN Epic.



Current Challenges or Barriers

- 1 Utilizing care coordination team to the top of their potential and continuing education.
- 2 Viewing the diabetic denominators that onset dates for diabetics were missing and essentially affected valid outcome scores for A1c's. Care coordinators updated the list of patients that fell in to this category which gave us valid outcomes.