



PREVENTING HEART ATTACKS  
& STROKES EVERY DAY



CCI  
CENTER FOR CARE  
INNOVATIONS



## INTEGRATE (Implementation of integrated care for Diabetes Mellitus) Elica Health Centers

Team Members:

Scott Needle CMO

Lucia Albu Provider Champion

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Case Management

Tim Le Pharmacy

Victoria Lewis

David Hughes

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# [Our Desired Future for PHASE/TC3]

- By Dec 2021 Elica Health Centers at Marysville clinic will improve the health and maintain 74% of diabetic patients with controlled HbA1c under 9%
- By Dec 2021 Elica Health Centers at Marysville clinic will maintain the health of African American patients with diabetes by keeping the percentage of those with uncontrolled HbA1c >9% at below 33.3%



# [Why It's Not Possible Now]

- Increase in no-show rate because of pandemic
- Labs/HgA1c not being completed
- Workforce issues/staffing shortage
- Lack of patients' accessibility and capability to use internet
- Transportation issues

# [Learnings that Will Inform Our Desired Future]

## [Bright Spots/Accomplishments]

- Improved controlled HbA1c <9% results from 75% to 86% at Marysville clinic.
- Improved Team based care eg: involving case management and pharmacist
- Increased patient engagement
- Improved outreach efforts
- Improved team collaboration/communication

## [Activities We will Keep Doing Based on Learnings]

- Continue qtr f/u with controlled diabetic patients and monthly with uncontrolled diabetic patients
- Continue w/ patient engagement by involving case management team to use motivational interviewing techniques
- Continue to involve the outreach team for appt reminders



# [What Else is Possible?]

- Remote monitoring for blood pressure
- Creating a registry for all diabetic patients
- Dashboards by site/provider
- Training MAs to perform foot exam prior patient seeing the provider if due
- Improve internal external referral process by getting more specialists to be part of Elica Health Centers
- Scale up the project by involving other providers from different EHC clinics

# [Benefits of Achieving Desired Future]

- Decrease morbidity and improve quality of life among diabetic population
- Shrinking the disparities between populations
- Decrease referral cycle time leading to improved patient access and improved patient outcomes



# [Challenges if We Don't Move Forward with Solution]

- Increase morbidity among diabetic population
- Increase financial burden/total cost of care on organization
- Decrease in P4P (Value based payments)
- Patient- Provider trust and respect will decrease
- Deteriorating community relationship: health plans/IPAs

# [What We Need from Our Leaders to Make it Happen]

- More support staff 2 (MAs):1 (provider) ratio
- Use population health management tool to manage data such as azara
- Set dedicated time for monthly clinical meetings
- Inspire/encourage other providers to get involved



# Thank you for your time!

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