



**"Reconnecting chronic disease  
patients into primary care"**

Ravenswood Family Health Center

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# Ravenswood Family Health Center



## PHLN Year 2 Project Aim

Ravenswood Family Health Center will improve the health of its members by decreasing the number of out of care patients with chronic diseases (diabetes, hypertension, and high cholesterol) by 15% by December 31<sup>st</sup>, 2019.

## Measures for Success

- Patients that received out reach by a health coach/panel coordinator
- Patients that were scheduled for a PCP appointment upon being called
- Patients attended their PCP appointment
- Patients who self reported insurance issues and received outreach from a Community Health Advocate (Eligibility Department)

# Changes

## Tested Changes

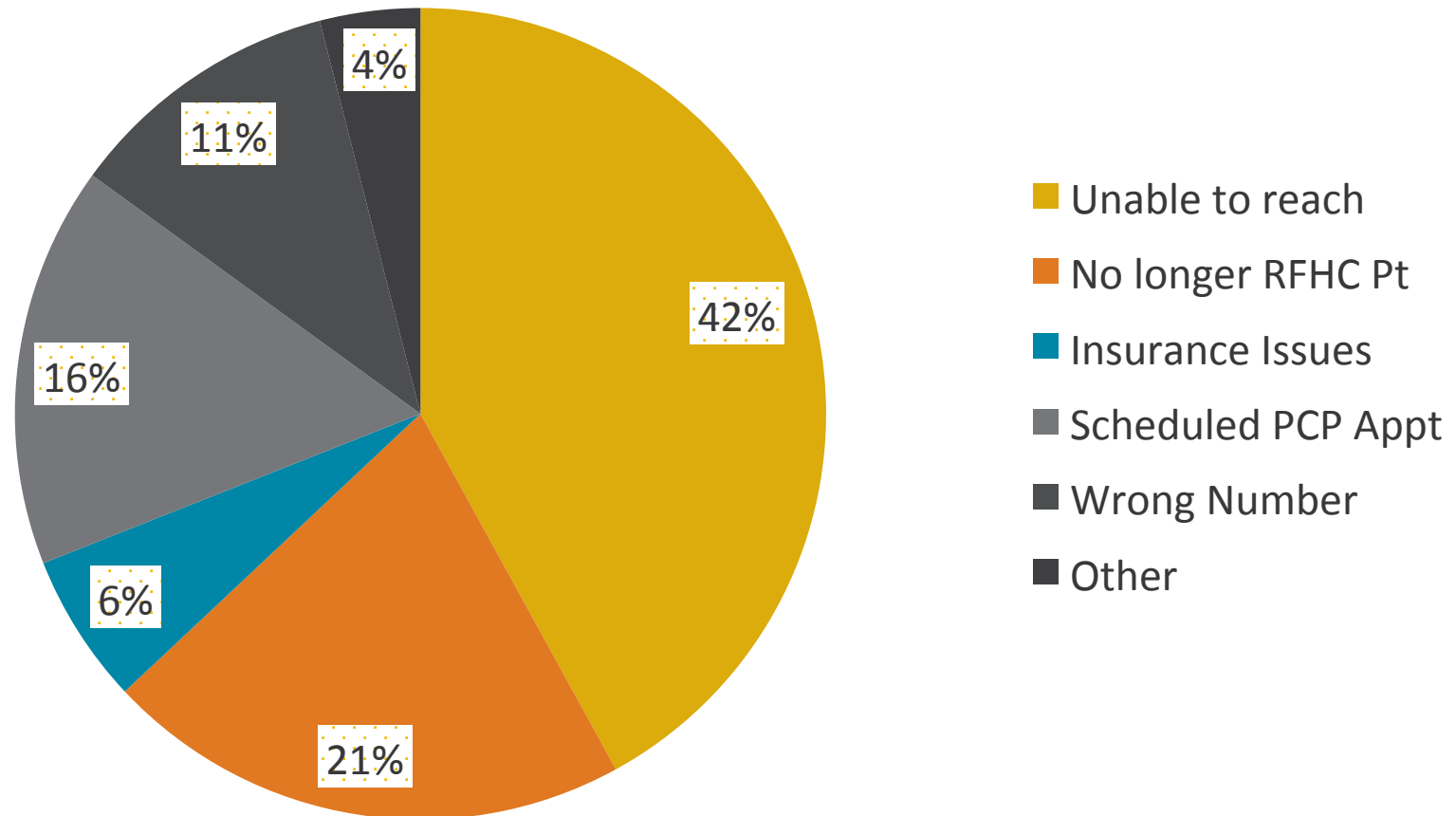
- With the health coach/panel coordinators, tested the out of care process in a cohort of 108 patients, last seen in 2017 with a chronic disease (diabetes, hypertension, and high cholesterol)
  - Included process for validation of data
  - Developed a tracking tool to document status of out of care patients

## Implemented Changes

- Implemented the out of care out reach process
- Documented attempts to reach patients and what the results were of these efforts
  - Unable to reach
  - No longer an RFHC patient
  - Insurance Issues

# Using Data for Improvement

Out of Care Results



# Strategies for Success

1

PDSA on the use of the Out of Care Process

3

Validation of existing RFHC patients

2

Embedding this process within the scope of a health coach

4

Allocating time for health coaches to do panel coordination

# Key Tools & Resources

## Developing out of care process

- Validating patient list
- Process on documenting out of care list
- Establishing a process for those patients that have insurance issues

## Using existing tools to document efforts

- Care coordination template on E.H.R
- Tracking sheet that tracks status of each attempt

# Next Steps

## Spreading

As the focus of this project was on developing a structure for panel coordination, next steps are:

- Standing orders for Health Maintenance screenings and other chronic disease related care guidelines
- Evaluating what other tools are available to communicate with out of care patients (text messaging)

## Sustaining

Further develop the role of the health coach to do panel coordination

- Align efforts with other clinical efforts, like P4P and HRSA diabetic related projects, in order to obtain sufficient support and resources

# Current Challenges or Barriers

- 1 What processes do other organizations have in place for reaching out of care patients? At what point do you do another round of outreach when first attempt was unsuccessful?
- 2 What type of electronic tools are used to track attempts to reach out of care patients (examples: tracking sheet, i2i, E.H.R)