Tri-City Health Center

TRI-CITY HealthCenter
Our Community. Your Health.

PHLN Year 2 Project Aim

Improvement in glycemic control of a TCHC panel of DM patients

- Lower HbA1C in ten percent (10%) of a panel of 360 patients with uncontrolled DM from baseline reading by providing social linkages and diabetes class education.

Measures for Success

- **36 patients will improve their HbA1C reading after receiving Diabetes Class education.**
- **The administration of PRAPARE survey to identify Social determinants of health, will allow us to assist patients and provide resources for the linkages needed.**
- **Patients will show improvement in HbA1C after diabetes teaching and social factors are addressed.**

Changes

Tested Changes

1. **Recruitment/enrollment.**

2. **Classes structure**

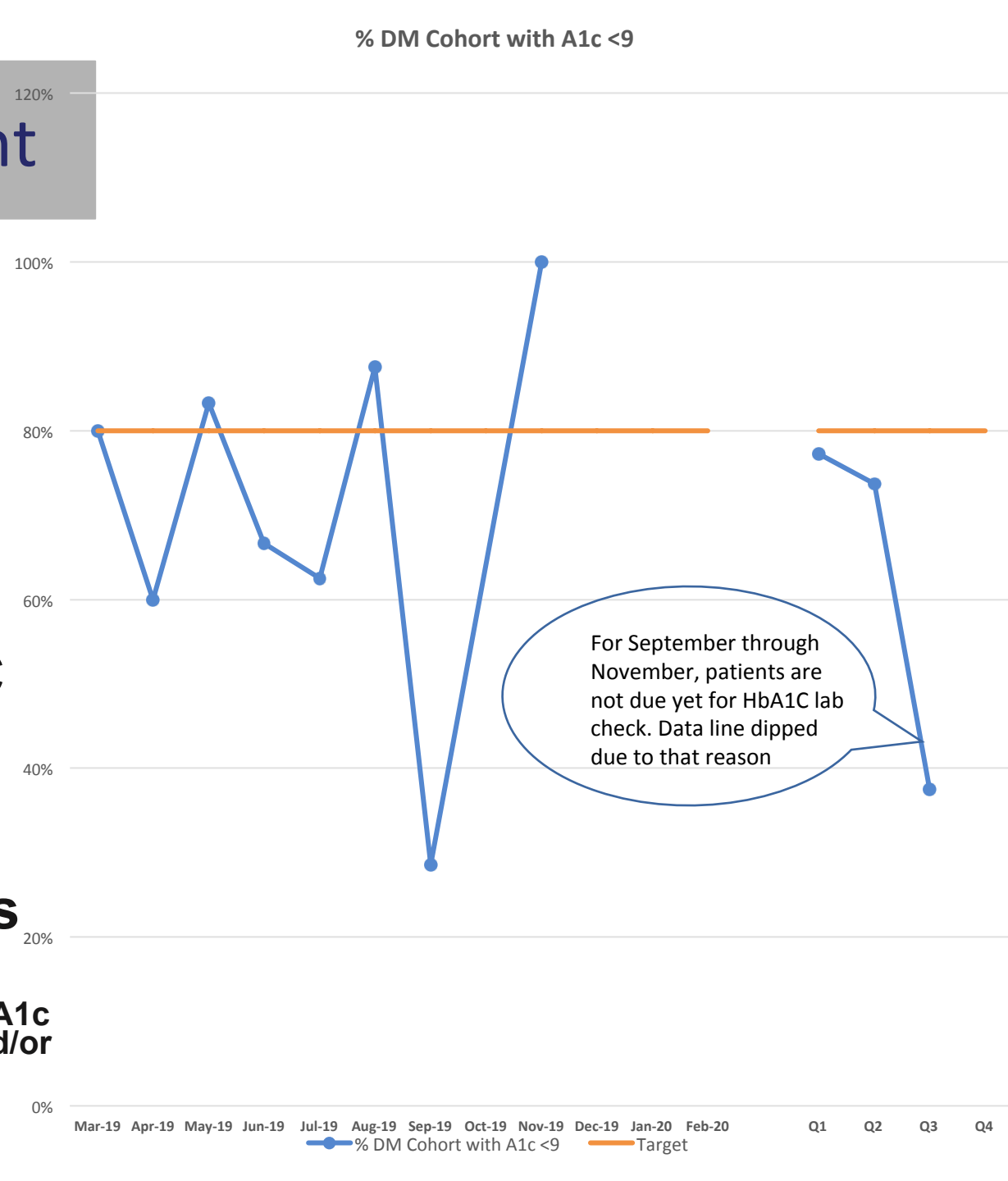
3. **Implementation of PRAPARE SURVEY**.

Implemented Changes

- Provided gift card incentive for patient to attend Diabetes Group Class.
- Remind Providers and MAs to offer classes to patients.
- 3 classes → 1 class
  (comprehensive class with all the elements of Diabetes, Exercise/Medication and nutrition).
- Implemented PRAPARE survey to identify Social Determinants of Health (SDOH)

Using Data for Improvement

- **Data collected over the Q1 and Q2 reflect that over half of the patients have improvement in HbA1C after linkage to a social resource and after class education on Diabetes.**
- **Q3 data shows a decline in A1C control for the patients due to September –November HbA1C labs are not due yet.**
- **After review of Q3 data, patients will be called for case management (medication reconciliation, HBA1c labs, diet and exercise teaching, further education and/or nutritional referral).**



Strategies for Success

1. **Small Group** to manage PRAPARE screening tool for SDOH and provide linkages to resources
2. **Dedicated team member** to follow-up with patients from the Diabetes Group Class.
3. **Monthly check-ins** with patients from DM group Class.
4. **Some resources are provided in-house so patients are linked immediately** to social resources (Food Farmacy, BH, Medical concerns/appts, Transportation

Key Tools & Resources

TRI-CITY HealthCenter
Our Community. Your Health.

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

	English
	Language other than English (please write)
	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

I choose not to answer this question

7. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?

Street: _____
City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

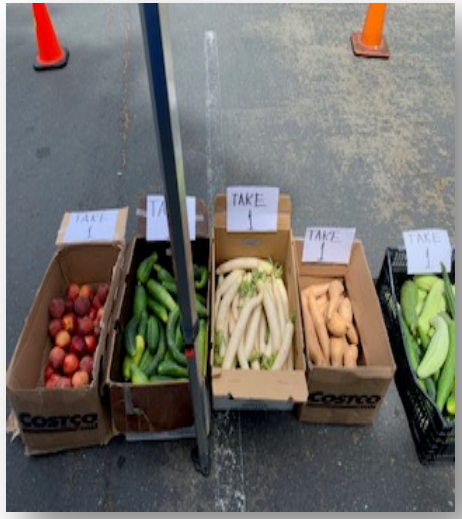
12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

PRAPARE Screening Tool- paper format.

Diabetes Group Class

On-site resource- Food Farmacy



Next Steps

Spreading

The PRAPARE survey implementation will be spread through small departments (such as BH, HIV, Outreach Dept., continue Chronic Care Dept.) through Tri- City Health Center.

We have buy-in from upper management to initiate administration and collection of SDOH data from the PRAPARE survey.

Sustaining

The Diabetes Group classes will continue as part of the Wellness team duties. Gift card Incentives for the classes will continue through a small grant from Health Pac that will partially cover the cooking demonstration and nutrition part of the class

PRAPARE survey implementation will be done by the staff in each Department A Budget is being created to have 2-3 CHWs hired to manage SDOH linkages and follow-up with the patients to check resources were received by patients.

Current Challenges or Barriers

1. Recruitment for Classes- Low recruitment/turnout for classes (average size- 6-10 patients)

2. Tracking linkages to resources- Currently tracking in Excel spreadsheet. Need EHR to help track linkages (EPIC conversion currently)