Tri-City Health Center

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

Diabetes Group Class

On-site resource- Food Farmacy

PRAPARE Screening Tool- paper format.

Social determinants of health
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)