## PATIENT PROGRESS METRICS

<table>
<thead>
<tr>
<th>Measures to watch</th>
<th>Success Metric</th>
<th>Action</th>
<th>Time Period</th>
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</thead>
<tbody>
<tr>
<td>Barriers to Care</td>
<td>Elimination/Mitigation of Identified Barrier(s) to Care Food insecurity questions:</td>
<td>Address the following barrier:</td>
<td>Every visit</td>
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<td></td>
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<td>- Within the past 12 months, we worried whether our food would run out before we got money to buy more.</td>
<td>Refer food–insecure families to community resources</td>
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<td>- Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more</td>
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<td>Answering “yes” to either of these questions indicates that a family is struggling with food insecurity.</td>
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<tr>
<td>Medication Adherence</td>
<td>Timely Refill Ordering/ Renewal Requests</td>
<td>Ask patient specific questions to better assess medication adherence.</td>
<td>Every Visit</td>
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<tr>
<td>Diabetes management - HbA1c Reduction</td>
<td>Medication Adherence, Appointment Attendance, Blood Sugar Monitoring, Weight Loss through Diet &amp; Exercise, Retinal, Dental and Podiatry exams</td>
<td>- Home blood sugar monitoring – Paired glucose reading - fasting in the morning and Post-prandial, 2 hours after a meal</td>
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<td></td>
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<td>- Check HBA1c</td>
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<td></td>
<td></td>
<td>- Discuss self-management goals</td>
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<td>- Diet – low sugar (low carb diet)</td>
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<td>- Medications</td>
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<td>- Exercise to reduce weight</td>
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<td>- Stop smoking</td>
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<td>- Foot exam – check daily for sores (patients)</td>
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<td>- Dental – dental check up</td>
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<tr>
<td>Hypertension Management</td>
<td>Medication Adherence,</td>
<td>If BP remains elevated for the 2nd check, ask the patient specific questions to better</td>
<td>Every 3-6 months</td>
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### Barriers to Care

1. **Food insecurity questions:**
   - Within the past 12 months, we worried whether our food would run out before we got money to buy more.
   - Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.
   - Answering “yes” to either of these questions indicates that a family is struggling with food insecurity.

2. **Elimination/Mitigation of Identified Barrier(s) to Care:**
   - Refer food–insecure families to community resources.
| Controlled BP Monitoring Compliance | Nursing BP Clinic Attendance (Co-led Visits) or Home; Diet, Exercise Adherence | assess medication adherence  
- Schedule patient for an appt for “BP recheck” as reason for visit before they leave the clinic.  
- Home BP log  
- Discuss self-management goals  
- DASH Diet or Low sodium diet  
- Exercise to reduce weight  
- Stop smoking |
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<td>Multiple Hospital/ER admission follow-ups</td>
<td>Medication Adherence, Appointment Attendance</td>
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- Address barriers to care  
- Medication adherence  
- Check and see if they have any DME they may need?  
- Do they have any appointments with specialist and do they need any assistance with them? |
| Depression | Medication Adherence, referrals |  
- ALGEE: A – Assess for risk of Suicide or harm - Ask - Are you having thoughts of suicide? or Are you thinking about killing yourself?  
- L - Listen Non-judgmentally  
- G – Give reassurance and information  
- E - Encourage appropriate professional help  
- E – Encourage self-help and other support strategies  
- Help the patient stay on medication and keep appointments. Offer support and encouragement to stay on medication  
- Help patient set up self –management goals  
- Do they have any appointments with specialist and do they need any assistance with them?  
- Provide crisis information in San Diego County  
- 211,1-888-724-7240, website: [http://www.up2sd.org/connect](http://www.up2sd.org/connect), Exodus Recovery for urgent walk ins 760-758-1150@524 W. Vista way, Vista CA 92083  
- Text line # 724724  
- Smart phone apps:  
  - ASK  
  - Safety Plan  
  - You are not alone  
  - Stay alive  
  - Mood triggers  
  - Sit with us  
  - oscER San Diego–Adults  
  - oscER Jr San Diego - Adolescents |  
- Follow-up on patients who were last hospitalized in previous 30 days;  
- Depending on the condition, need weekly follow up to start  
- If on medication, call the patient in 1-2 weeks to check adherence issues, side effects or other problems  
- Continue calling and follow-up with these patients for the next 4-6 weeks  
- Recommend more frequent visits over 6-12 months |
### Asthma Control

**Medications – control and quick relief medicine adherence, referrals**

- Triggers – identify, discuss ways to avoid or manage triggers
- Educate about second hand smoke and pets
- Exercises – Premedication and exercise modifications
- Discuss Asthma action plan
- Discuss self-management goals
- Discuss Asthma flow sheet

**Referrals**

- Once every 3 months or
- Two times a year

### ADHD Medication Adherence, referrals

- Medication adherence - Parents must call CC at least a week before the patient is out of medication to request a refill. CC will task the physician through the telephone template using “Medication Request” option and notify parent.
- SANDAP follow-up questionnaire forms
- VCC ADD therapy agreement – if on medication
- Discuss self-management goals
- Discuss ADHD Flow sheet

**Referrals**

- Appointment after initial diagnosis – from 2 weeks to 1 month
- Follow-up at the discretion of the provider and at least twice each calendar year

### Diabetes Care Schedule:

**Uncontrolled Diabetes:**

- 3-day care touch
- 2-3 weeks after the initial diagnosis
- Follow-up call once a month by CCs

**Every 3 months:**

- A1C blood test (if your blood sugar is too high)
- Blood pressure check
- Weight check
- Foot check

**Every 6 months:**

- A1C blood test
- Teeth and gum exams by your dentist

**Every year:**

- Physical check up
- Complete foot exam
- Check cholesterol and other body fats
- Complete eye exam
• Kidney tests