PATIENT PROGRESS METRICS

Measures to watch	Success Metric	Action	Time Period
Barriers to Care	Elimination/Mitigation of Identified Barrier(s) to Care Food insecurity questions:	Address the following barrier: Child care, employment, financial hardship, Insurance, homelessness, translation and transportation • 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.	Every visit Refer food –insecure families to community resources
Medication Adherence	Timely Refill Ordering/ Renewal Requests	Ask patient specific questions to better assess medication adherence. • Have you taken your medications today? If not, why? • How many times in the past week have you missed a dose of your medications? These answers will be documented in medication reconciliation picklist. (i.e. rarely misses doses or frequently misses doses)	Every Visit
Diabetes management - HbAc1 Reduction	Medication Adherence, Appointment Attendance, Blood Sugar Monitoring, Weight Loss through Diet & Exercise, Retinal, Dental and Podiatry exams	• Home blood sugar monitoring – Paired glucose reading - fasting in the morning and Post-prandial, 2 hours after a meal • Check HBA1c • Discuss self-management goals • Diet – low sugar (low carb diet) • Medications • Exercise to reduce weight • Stop smoking • Foot exam – check daily for sores (patients) • Dental – dental check up	• 3 Day care touch follow-up • 2-3 weeks after the initial diagnosis; • One month – Provider visit; • HBA1C – uncontrolled - every 3 months, but CC - a monthly follow-up call to check –in with patients; • Controlled - every 6 months. • Dental exam – every 6 months; • Foot exam – Every 6 months; • Retinal Exam – Once a year; • Podiatry – Once a year
Hypertension Management	Medication Adherence,	If BP remains elevated for the 2nd check, ask the patient specific questions to better	Every 3-6 months

- 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	
Multiple Hospital/ER admission follow-ups	Medication Adherence, Appointment Attendance	• 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?	• Follow-up on patients who were last hospitalized in previous 30 days; • Depending on the condition, need weekly follow up to start
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, 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	• 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	• 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	• 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