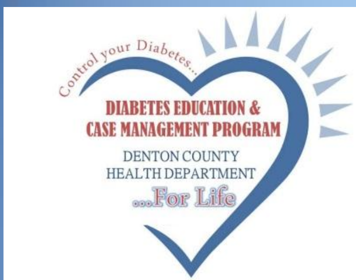


Healthcare Collaboration: A Focus on Diabetes Across the County

Joe Paul Gallo, RN, WHNP BC-E, MSN Ed
Director, DSRIP Program for Chronic Disease Management
Denton County Health Department

Kathy Srokosz, MS, RN
Director, Outpatient and Chronic Care Services
Texas Health Presbyterian Hospital Denton

Denton County Health Department

<u>DSRIP Projects</u>

Diabetes Chronic Care Management

Adult Immunization Program

Diabetes Chronic Care Management

- Diabetic Educator/Case Managers (4)
- Nurse (1)
- DY4 Target: 200
- Individualized and Group Education Denton and Lewisville
- Community Support Group

Patient Assistance

Glucometer	*Metformin (Bottle 100)*
Strips	*Glipizide (Bottle 100)*
Lancets	*Novolin 70/30 (Vial)*
Transportation	*Needles*
$5.00 Walmart Gift Card	

Adult Immunization Program

- Program Coordinator (1)
- Administrative Specialist II (1)
- Nurse (1)
- DY4 Target: 3000 individuals vaccinated

Hepatitis A
Hepatitis B
Meningococcal (MCV4)
Flu
Measles, mumps, rubella (MMR)
Tetanus, diphtheria, pertussis (Tdap)
Human papillomavirus (HPV)
Chicken pox (Varicella)
Zoster (Shingles)

DSRIP Team

- Julie Dvonne Wright, BS, CHW
- Angelia Lee Bratcher, LBSW, CHW
- Flory Susana Garcia, CHW
- Erika Ivonne Reyes Saenz, CHW
- Jane Louise Schumann, BS, CHW
- Dariela Maricella Lopez, LVN
- Fabiola Patricia Vanegas, BS, CHW
  (Not Pictured)

Results To Date DY4

- 175 Case Managed Patients
- 98% Hispanic
- Baseline A1c: 11.2
- Average A1c: 9.4
- 23% A1c < 8
- 57% Completed First Eye Exams
- 25.3% Completed Dental Exam

Texas Health Presbyterian Hospital Denton

<u>DSRIP Projects</u>

Diabetes Chronic Care Management

ED Navigation

Texas Health Denton

- **Diabetes Chronic Care Management**
  - Diabetes Educator (1)
  - DY 4 Target: 125 patients/participants
  - Individualized Patient Education
  - Community Classes
- **ED Navigation**
  - RN ED Navigators (2)
  - Nurse Practitioner (1)
  - DY 4 Target: 225 patients
  - Individualized Plan based on needs assessment

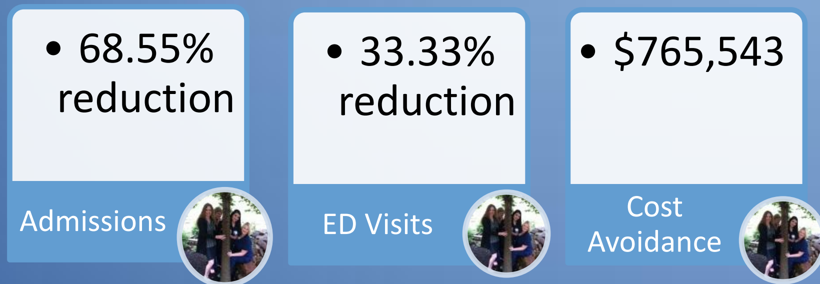
DSRIP Team
Melony Maloy, APRN
Deana Stephens, BSN, RN ED Navigator
Meenaz Charaniya, MSN, RN Navigator
Dana Kennedy, BSN, RN Diabetic Educator

Processes → Results

ED Navigation

- Beyond the original plan
- Individualized caring
- Positive results

DY 3 90 Day Impact



DY 4 YTD: Similar Results

Diabetes Chronic Care Management

- Individualized patient education and management
- Community classes
- Accessible for questions and support of decision-making, self-management needs

DY 4 YTD: 37% reduction in A1cs in population with > 9.1 initially

Denton County
Diabetes Community Care Collaborative

Background:

- 26.6% of the Denton population is reported below 200% FPL
- 22% of population is uninsured
- Denton community growth rate is 19.8% vs. Texas 3%; growing population of transient homeless
- Increasing prevalence of diabetes in the population
- 53% of all THDN patients have diabetes as a primary or secondary diagnosis

Denton Courthouse

Community Partnerships…*the evolution in Denton*

- Charitable Clinics Coalition of Denton County with active membership
- New Denton programs with common needs and sometimes common patients met to discuss and share information related to basic community resources for unfunded/underfunded patients with chronic diseases
- Common patient issues related to chronic care management identified
- Brainstorming session (Texas Health Denton, Denton County Health Department, MHMR Center for Integrated Health, Denton Community Health Clinic) focused on the variations in diabetes care management observed in the community
- *Thus, the Denton County Diabetes Community Care Collaborative was created……!*

Components Associated With Effective Disease Management*

Component	Description
Health System	• Securing resources and removing barriers to care
Delivery system design	• Coordinating care processes
Self management support	• Facilitating skills-based learning
Clinical information systems	• Supporting tracking and outcome reporting
Decision support	• Providing guidance for implementing evidence-based care
Community resources and policies	• Sustaining care by using community-based resources and public health policy

*Stellefson M, Dipnarine K, Stopka C. The Chronic Care Model and Diabetes Management in US Primary Care Settings: A Systematic Review. Prev Chronic Dis 2013;10:120180. DOI: http://dx.doi.org/10.5888/pcd10.120180External Web Site Icon

Initial Steps

- **Review evidence-based clinical practice guidelines and standards and understand the practice variations**
- **Organize a team of clinical and community stakeholders**
- **Identify the key, evidence-based practices that should be included in a diabetic patient's home management plan of care**
- **Develop a community based care plan template incorporating the key elements identified to support effective patient self-management and decision-making in the community**

AIM

Improve consistency and quality of
diabetic patient self-management plans
across Denton County by the end of 2016
through the development and implementation
of a standardized, evidence-based,
community plan of care template
for use by providers in varied settings.

Work in progress……..