The Medical Home Team

Primary Care Physician (PCP)
Advanced Practice Nurse (APN)
Endocrinologist
Psychologist
Podiatrist
Registered Dietitian (RD)
Ophthalmologist
Registered Nurse (RN)
Licensed Social Worker
Transitions APN
Community Health Workers
Community Ambassadors
Center For Excellence “Diabetes Management”

- **Partnership** – To partner with community and data reporting partners
- **Collaboration** – To collaborate with other diabetes initiatives (CHIP, J&J)
- **Clinical Outcomes** – To improve stage 3 and 4 measures
- **Growth** – To increase program participant
- **Revenue** – To increase billable services

Center for Excellence “Diabetes Management”
Services Offered By The Program

- Education of self management skills
- Nutritional counseling
- Medication/Insulin injections
- Education in an ADA certified DM program
- Psychological Services
- Self Blood glucose monitoring
- Medical Specialist
- Foot, Skin & Eye exam
- Follow up Care
- Support Groups
- Zumba Classes
Community Health Workers Outreach

Project Start date: April 18, 2016
Door-to-Door Canvassing:
4 Ciclovia Events, 7 Community Fairs
Total of 3,682 household visited
Total of 1,046 household responded
Community Health Workers Outreach

- Charity Care EXPANDED HOURS to accommodate late nights.

- Zumba held in community twice weekly for patients and families.
• Continue collaboration with the State of New Jersey to schedule free Eye Clinic in the future.
• Review the process monthly and revise as appropriate.
• DHC continues to monitor patients for compliance with eye exam monthly and reaches out to patients for scheduling them with Eye Clinic.

In collaboration with New Brunswick Tomorrow ambassadors the DHC community health workers prepared and distributed the flyers (see attached) for the free Eye Clinic as well as recruited 99 patients for the free eye exam. The Eye Clinic was hosted by DHC staff on September 17, 2016 at How Lane Clinic and 82 patients received eye exam and other educational material for self-management of Diabetes.

Plan

Do

Act

Study

PDSA - EYE Examination Diabetes Management

• Goal: To improve the compliance with eye exam.
• To improve ophthalmology services for patients at How Lane. In addition to providing an ongoing Eye clinic at How Lane the DHC team reached out to New Jersey State to conduct a free Eye Clinic at the site for all patients with Diabetes.

• Continue collaboration with the State of New Jersey to schedule free Eye Clinic in the future.
• Review the process monthly and revise as appropriate.

• DHC continues to monitor patients for compliance with eye exam monthly and reaches out to patients for scheduling them with Eye Clinic.

• In collaboration with New Brunswick Tomorrow ambassadors the DHC community health workers prepared and distributed the flyers (see attached) for the free Eye Clinic as well as recruited 99 patients for the free eye exam.
• The Eye Clinic was hosted by DHC staff on September 17, 2016 at How Lane Clinic and 82 patients received eye exam and other educational material for self-management of Diabetes.
Community Registered Nurse Outreach

- Patient Home Visits
- RAS Reports
- Houses of Worship
- Doctors Offices
- Glucometer/Insulin Training
- Support Groups
- Inpatient Visits
- Diabetes Conferences
Diabetes Incentive Packet

Reli On Prime Glucometer Machine

Reli On Prime Test Strips – 100 count

Reli On Prime Lancets – 100 count

Reli On Lancing Device
FARMERS MARKET
# Preventable ED Visits

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Patients</td>
<td>207</td>
<td>70</td>
<td>72</td>
<td>64</td>
<td>63</td>
<td>54</td>
<td>44</td>
</tr>
<tr>
<td>Preventable Visits</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Enrollment</td>
<td>47</td>
<td>117</td>
<td>189</td>
<td>253</td>
<td>316</td>
<td>370</td>
<td>414</td>
</tr>
</tbody>
</table>

- **Enrolled Patients (2014):** 207
- **Preventable Visits:**
  - Q1 2015: 0
  - Q2 2015: 1
  - Q3 2015: 2
  - Q4 2015: 0
  - Q1 2016: 0
  - Q2 2016: 0
  - Q3 2016: 0
- **Total Enrollment:**
  - Q1 2015: 47
  - Q2 2015: 117
  - Q3 2015: 189
  - Q4 2015: 253
  - Q1 2016: 316
  - Q2 2016: 370
  - Q3 2016: 414

**Graph:**
- Blue line: Enrolled Patients (2014 = 207)
- Red line: Preventable Visits
- Green line: Total Enrollment

The graph shows the trends in enrolled patients, preventable visits, and total enrollment from Q1 2015 to Q3 2016.
### Preventable Inpatient Admits

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Patients</td>
<td>47</td>
<td>70</td>
<td>72</td>
<td>64</td>
<td>63</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>Preventable Visits</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Enrollment</td>
<td>47</td>
<td>117</td>
<td>189</td>
<td>253</td>
<td>316</td>
<td>370</td>
<td>424</td>
</tr>
</tbody>
</table>
### Measures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients with the DX of Diabetes</td>
<td>269</td>
<td>232</td>
<td>155</td>
<td>117</td>
<td>144</td>
<td>140</td>
<td>138</td>
</tr>
<tr>
<td># of Patients referred to PCMH</td>
<td>56</td>
<td>77</td>
<td>81</td>
<td>70</td>
<td>74</td>
<td>85</td>
<td>33</td>
</tr>
<tr>
<td># of Patients Enrolled received Assessment and/or Counselling modalities</td>
<td>47</td>
<td>70</td>
<td>72</td>
<td>67</td>
<td>50</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td># of Patients Revisit to ED (Preventable Readmissions)</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td># of Patients Readmitted to Inpatient (Preventable Readmissions)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td># of Patients HbA1c done</td>
<td>48</td>
<td>53</td>
<td>59</td>
<td>65</td>
<td>281</td>
<td>297</td>
<td>54</td>
</tr>
<tr>
<td># of Patients had Foot Exam</td>
<td>9</td>
<td>47</td>
<td>96</td>
<td>119</td>
<td>264</td>
<td>281</td>
<td>92</td>
</tr>
<tr>
<td># of Patients had Eye Exam</td>
<td>9</td>
<td>24</td>
<td>55</td>
<td>50</td>
<td>105</td>
<td>63</td>
<td>86</td>
</tr>
<tr>
<td># of Patients had Lipid Profile done</td>
<td>83</td>
<td>59</td>
<td>79</td>
<td>93</td>
<td>176</td>
<td>211</td>
<td>79</td>
</tr>
</tbody>
</table>

The SPUH DHC monitors the above data points as an ongoing monitoring of the patients referral, enrollment in the project. The utilization compliance measures are monitored if needed as these are required annually.

The revisits and readmissions are monitored 30 days after the initial encounter as the transition coach follows the patient for 30 days. The Community RN and social worker also make follow up calls and/or home visits as appropriate.
Holiday Party for Patients