

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

The Audacity To Be Bold: Addressing Diabetes in the Homeless Population

Tuesday, October 23, 2018

1:00-2:00 pm Central

Poll Questions

Quality | Access | Justice | Community | nhchc.org

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

- The Audacity To Be Bold



Share
Our
Selves



Presenters:

Karen McGlinn, CEO

Mary Ann Huntsman, PharmD, CQIO

Anna Tiongco, Quality Manager



OUR Mission

We are servants who provide care and assistance to those in need and act as advocates for systemic change.

OUR Values

- Dignity
- Service
- Excellence
- Justice

FOUNDED ON Justice

SOS was founded with the purpose to advocate for change in the structures and systems that unjustly affect the vulnerable.

SOS Health Center Sites:

NEWPORT BEACH

Medical Health Centers

SOS Children & Family Health Center

Dental Health Center

SOS Beauchamp Children & Family
Dental Center

Behavioral Health

SOS Children & Family Health Center

SOS Center for Health & Innovation

COSTA MESA

Medical Health Center

SOS Community Health Center

SOS Harbor Health Center

Dental Health Center

SOS Community Health Center

Behavioral Health

SOS Community Health Center

SOS Harbor Health Center

Social Services

SOS Community Health Center

Center of Care for the Homeless

SOS Community Health Center

Pharmacy

SOS Community Health Center

SANTA ANA

Medical Health Centers

SOS – El Sol Wellness Center

Behavioral Health

SOS – El Sol Wellness Center

Pharmacy & Social Services

SOS – El Sol Wellness Center

LAKE FOREST

Medical Health Center

SOS & PEACE Center Health Clinic

Mission : We are servants who provide care and assistance to those in need and act as advocates for systemic change

JANUARY 2018 - JUNE 2018

6 MONTHS AT SOS



We provided
25,408 Bags of
Groceries



We had
3,110 Financial
Aid Visits



We cared for
20,409 Medical
Clinic Patients



We cared for
7,884 Dental
Patients



We dispensed
16,900
Prescriptions



We had
2,360 Behavioral
Health Visits



We provided services for
1,442 Homeless
Individuals



We had
465 Case Management
Appointments

Center of Care for the Homeless:

SOS stabilized care for 1,760
homeless clinic patients in 2017



PO Box for Homeless

National Collaborative

SOS Foundation

Social Determinants of
Health



https://www.youtube.com/watch?v=gsGmeQ5_Eio&feature=youtu.be

Operational Site Visit Summary



Operational Site Visit

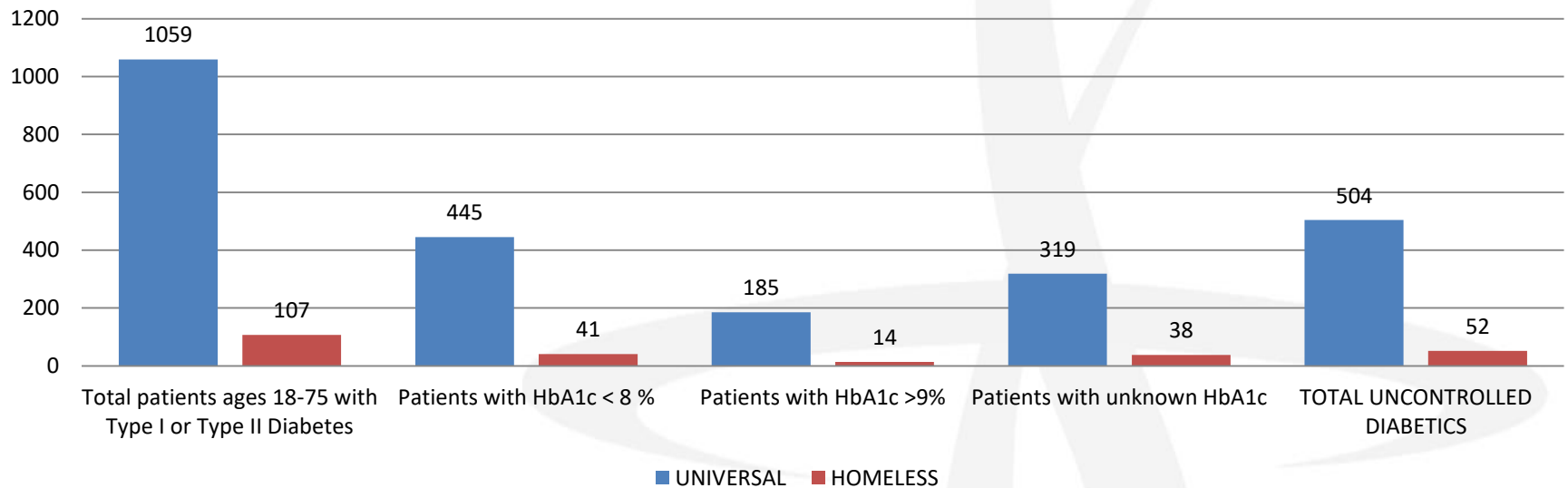
- Evaluate our compliance with statutory and regulatory requirements of the Health Center Program
- Reviewed Governance, Clinical, Financial, and Management/Administration
- Performance Analysis – Focus on Diabetes Improvement
- Promising Practice
- Outcome: 100% Compliance to new compliance manual



Performance Analysis to Ensure Equity in our Diabetic Population



Uncontrolled Diabetes Universal vs. Homeless



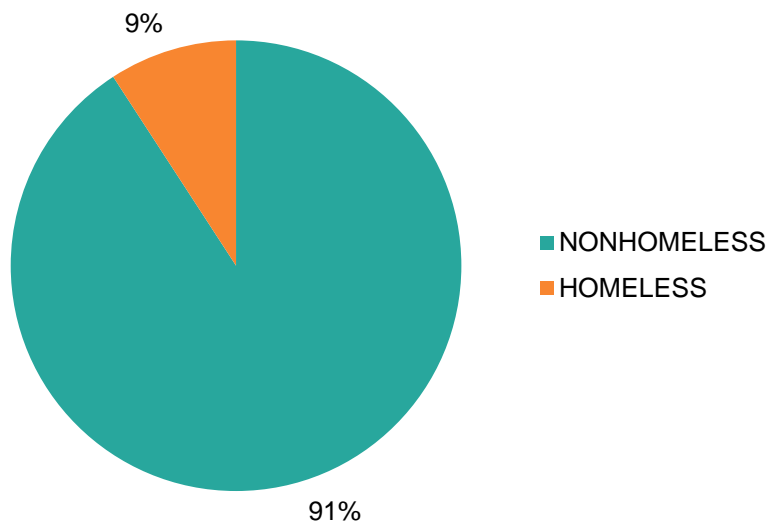
	TOTAL POPULATION	HOMELESS
Total patients ages 18-75 with Type I or Type II Diabetes	1059	107
Patients with HbA1c < 8 %	445	41
Patients with HbA1c >9%	185	14
Patients with unknown HbA1c	319	38
TOTAL UNCONTROLLED DIABETICS	504 (48%)	52 (49%)



• Patients Diagnosed with Diabetes

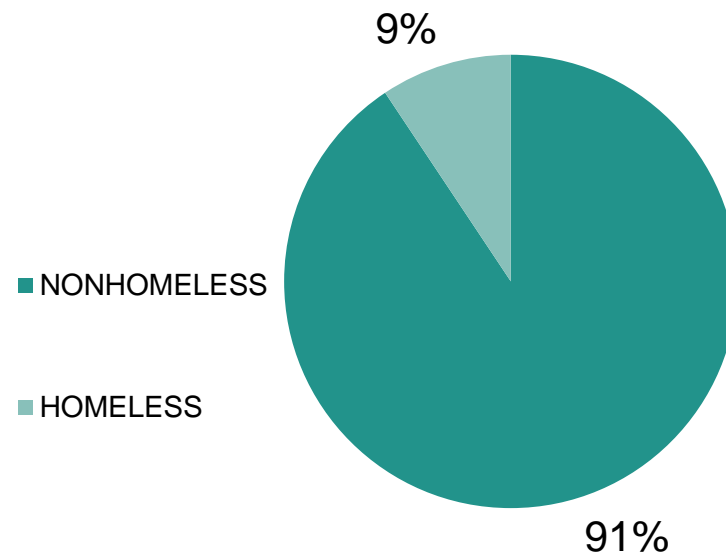
Homeless Diabetic Population

Total patients ages 18-75 with Type I or Type II Diabetes



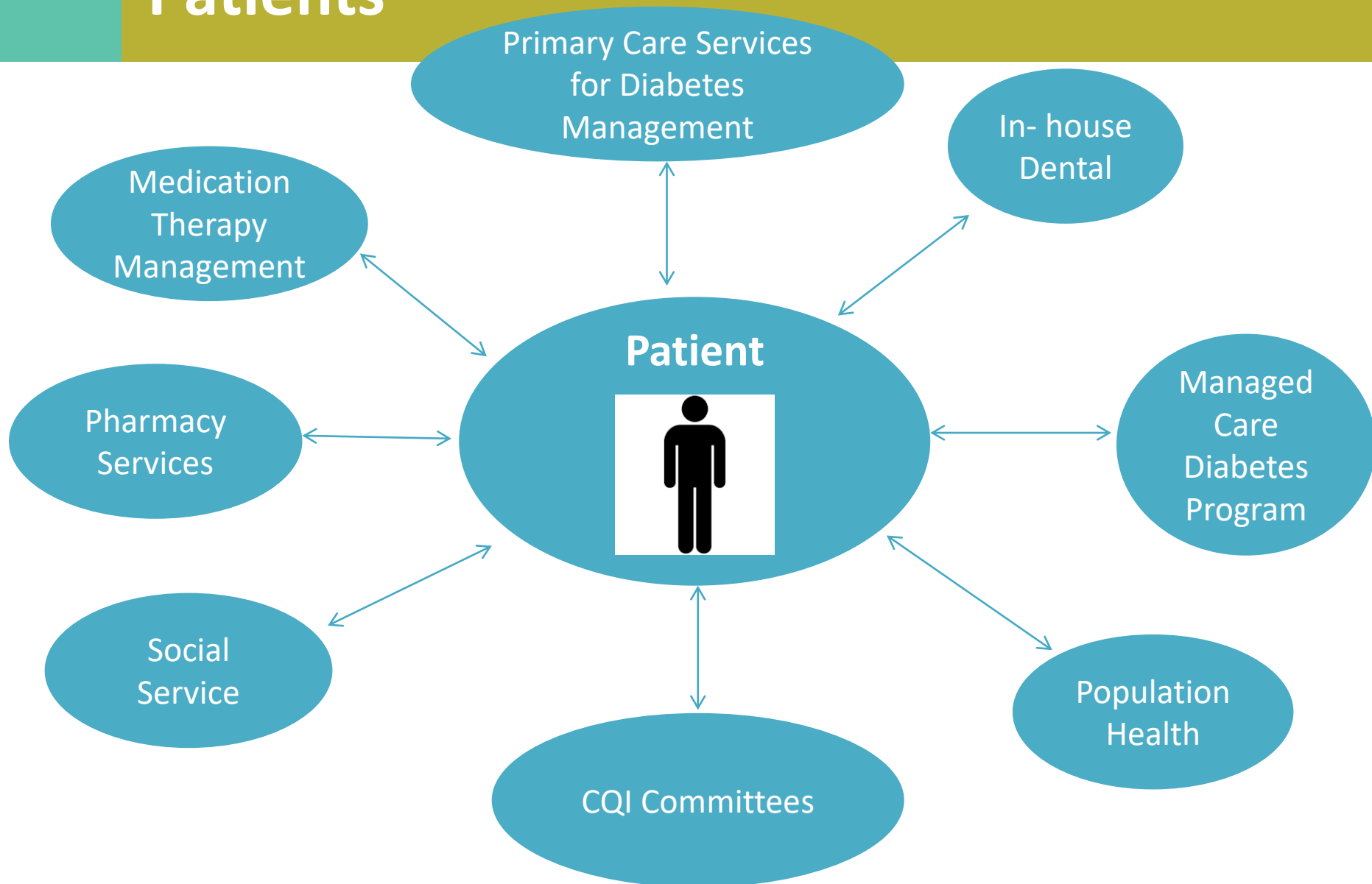
% of Uncontrolled Diabetic Patients

TOTAL UNCONTROLLED DIABETICS



* Uncontrolled Diabetes = A1C \geq 9 or an unknown A1C

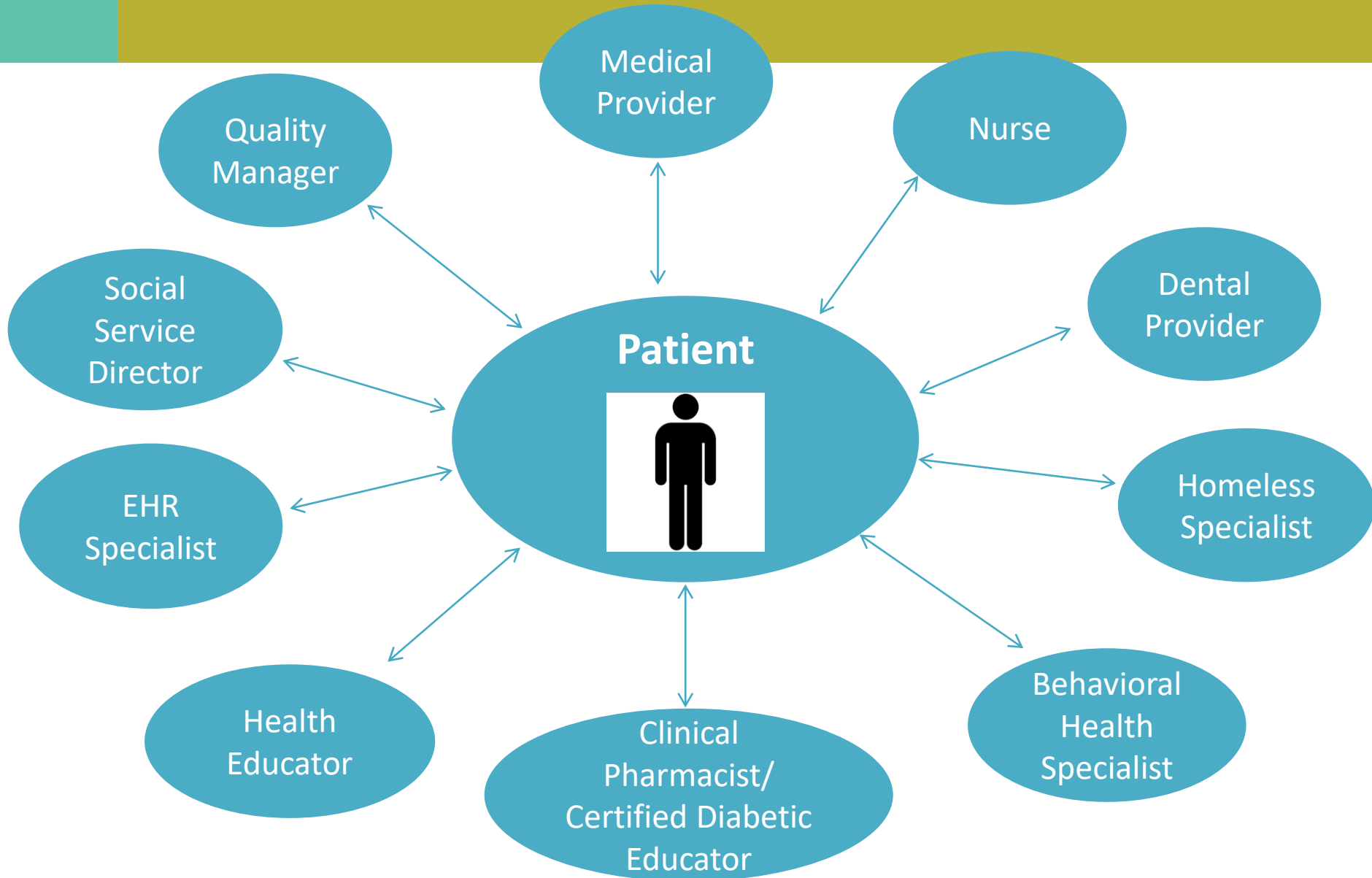
SOS Clinical Care Activities for Diabetic Patients



Performance Analysis



Root Cause Analysis Session Preparation



• LEAN Tools for Quality Improvement

- A3
- Root Cause Analysis
- Fishbone Diagram
- PDCA Cycles
- Run Charts



Tools Used

A3 Approach

A3 No. and Name	Team members (name & role)	Stakeholders (name & role)	Department	Organisation objective						
	1.	1.								
	2.	2.								
Team Leader (name & 'phone ext)	3.	3.		Start date & planned duration						
	4.	4.								
1. Clarify the problem	4. Analyse the Root Cause		7. Monitor Results & Process							
Is:										
Is not:										
Problem statement:										
2. Breakdown the problem	5. Develop Countermeasures		8. Standardise & Share Success							
	<table border="1"> <thead> <tr> <th>Countermeasure</th> <th>Impact on target</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> </tr> <tr> <td>2</td> <td></td> </tr> </tbody> </table>		Countermeasure	Impact on target	1		2			
Countermeasure	Impact on target									
1										
2										
3. Set the Target	6. Implement Countermeasure									
1										
2										

A3: Background / Problem



SOS DIABETES MANAGEMENT

Background:

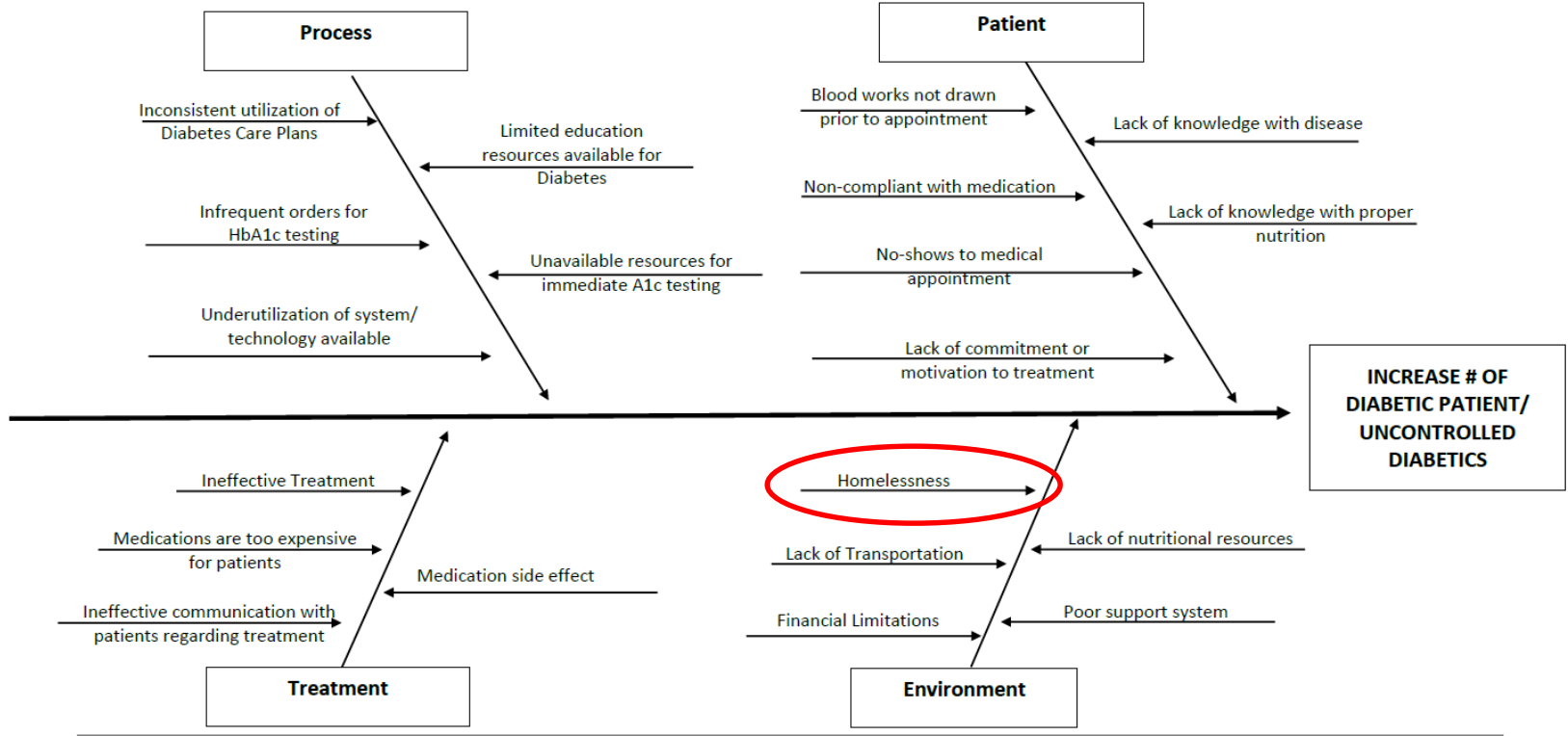
Diabetes is reported to be one of the most complex, chronic illness that requires continuous medical treatment along with multifactorial risk-reduction strategies beyond glycemic control (ADA, 2018). In 2017, the Center for Disease Control reports that about 30.3 million people have diabetes in the United States and 23.1 million or 76% of patients with diabetes are properly diagnosed. Unfortunately, about 7.2 million or 24% diabetics in the US remain undiagnosed. Common risk factors for diabetes include: smoking, obesity, sedentary lifestyle, high blood pressure, and high cholesterol level. For these reasons, CDC reports that diabetes is the seventh leading cause of death in United States in 2015.

In 2017, Share Our Selves provided services to a total of 15, 549 patients. About 1,609 (10%) of those patients that are between the age of 18-75 are diagnosed with diabetes. Unfortunately, about 576 (36%) of those diabetic patients are uncontrolled or who have HbA1c of >9% or have unknown A1C. As part of SOS' quality improvement program, the organization continues to provide evidence-based treatments to patients with diabetes as well as adherence to best practices.

• A3: Root Cause Analysis (Fishbone Diagram)



SOS DIABETES MANAGEMENT FISHBONE DIAGRAM



A3: PDSA Study

PDSA Study

PLAN	<ul style="list-style-type: none">● Continue Implementation of Care Plan for Diabetic Patients● Increase MTM Referrals● Increase available in-house educational resources for diabetic patients● Increase utilization of system or technology available● Provide other resources for diabetic patients such as transportation
DO	<ul style="list-style-type: none">● Provider to complete diabetic patient's care plan every follow-up visits● Provider utilizes i2i recall list to identify patients with no A1c within the last 3 months● Non-compliant diabetic patients are referred to MTM● Health educator conducts nutrition and fitness classes for patient with HbA1c >9% including group visits● For diabetic patients with transportation issues, taxi voucher/ bus passes/ gas cards will be provided. Homeless Specialist to provide transportation as well if necessary● Look into possible implementation of telemedicine● Provide in-house A1C testing & BMI machine

Performance Improvement Action Items

In- house HbA1c testing on all sites

- Informed staff of need for in-house A1c testing
- Establishing workflow
- Go Live in October 2018



Utilize i2i to understand diabetic population

- Gathered input from all sites
- Assessed daily huddles to incorporate i2i reports to identify quality care gaps
- Modify current state and optimize reporting



Lessons Learned:

- Prepare! Prepare! Prepare!
- Team-based Approach
- Use Process Improvement Tools (PDSA, Fishbone, etc.)
- Be receptive to suggestions/recommendations from subject matter experts
- Action! Action! Action!



Questions?



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