Sixteenth Street Community Health Center

Linkage to Care Diabetes Reengagement Program

Case study prepared by Charles E. Sepers, Jr.,[1] Jerry A. Schultz,[1] and Holly Nannis[2]

[1]Work Group for Community Health and Development at the University of Kansas
[2]Sixteenth Street Community Health Center

PROJECT OVERVIEW

The Sixteenth Street Community Health Center (SSCHC) in Milwaukee, WI is a dual-site Patient Centered Medical Home (PCMH) with a 40-year history of engaging difficult-to-reach populations with a diverse set of healthcare programs to address challenges related to language, culture, and social class. Using lessons learned in a previously-implemented HIV Linkage to Care Model, this project sought to identify diabetes patients that had fallen out of treatment and reengage them in comprehensive primary care and diabetes self-management education (DSME).

Using the Diabetes Registry, diabetes patients that had fallen out of care were identified and reengaged through a variety of outreach efforts (e.g., home visits, phone calls). Once reengaged, patients received coordinated, comprehensive medical, social, nutrition, and mental health services to improve type 2 diabetes control and associated clinical health outcomes. A collaborative team, led by SSCHC's Director of the Asthma and Diabetes Program, consisted of a Physician Champion, Assistant Director of Nursing, Quality Improvement Director, Registered Dietician/Diabetes Educator, Registered Nurse/Diabetes Educator, Diabetes Education Specialists, Community Health Workers (CHW), and Registry Database Coordinator that provided enhanced approaches for diabetes management, including DSME, patient glucose monitoring, blood pressure management, cholesterol level control, and provided specialty care that included neuropathy foot and retinal eye exam screenings and behavioral health services.

CONTEXT AND PARTNERS

The SSCHC is the primary community health center on the south side of Milwaukee serving the Walker's Point/Fifth Ward and Bay View neighborhoods. These communities are the most densely populated area in Wisconsin and is home to a burgeoning Hispanic population. As many as 87% of SSCHC patients are Hispanic and 78% of all patients are below the federal poverty level. As many as 26% of SSCHC's clients are without health insurance. The SSCHC serves 2,437 patients with diabetes, of which only 78% (1,895) had met the definition of "active," defined by having visited their primary care provider twice within 12 months.

ASSESSMENT AND PLANNING

The development of the SSCHC diabetes reengagement program is an extension from the HIV Linkage to Care model previously developed for those living with HIV/AIDS. This program featured the use of case management and a linkage to care coordinator that developed a list of those individuals that had been overdue for clinic follow-up for 6 months or more. Lessons learned from the delivery of this model were used to develop the diabetes reengagement program. The HIV/AIDS Linkage to Care model identified common barriers patients face and

strategies to effectively manage and prevent patients falling out of care, such as medication side effects, enjoying periods without symptoms, lack of transportation/access, incompatible work hours, and dissatisfaction with primary care provider. This model took an individualized approach to addressing identified barriers (e.g., transportation, depression, seasonal residency) and reengagement that would be replicated in the diabetes reengagement program.

INTERVENTION

Core intervention components of the reengagement project were the development and implementation of new or modified policies and practice changes aimed at reducing system-oriented and patient-oriented barriers to appointment scheduling, patient retention, and access to primary and specialty care. Further, changes to workflow management and Electronic Health Record utilization aided the process of discernment from those that had truly fallen from care rather than patients that were seeking care elsewhere, or had moved from Milwaukee. Reengaged patients received the standard of care available to patients at Sixteenth Street, which features a comprehensive DSME program that included certified diabetes educators, medical assistants, and community health worker volunteers to ensure tailored and appropriate care for each patient.

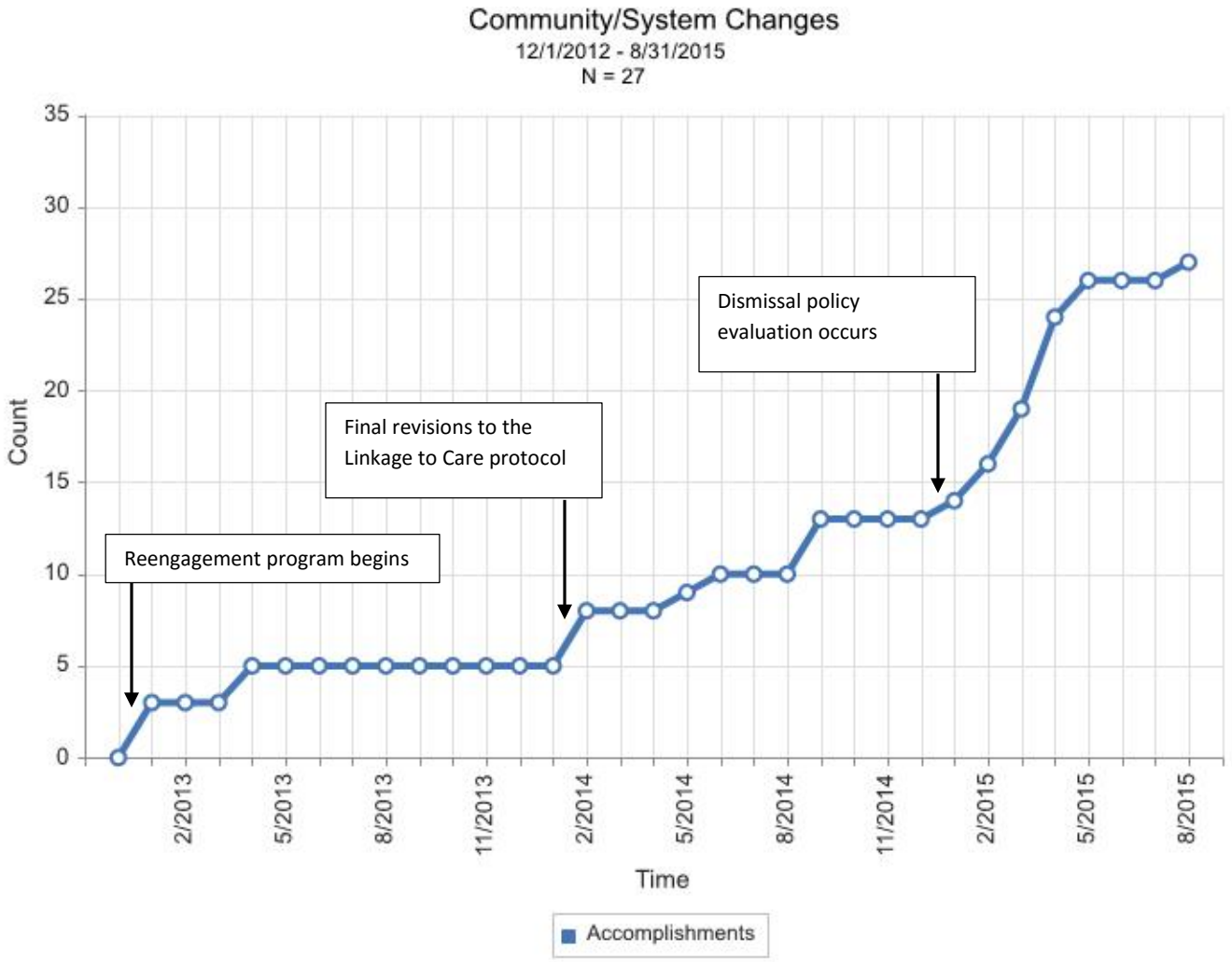
INTERVENTION COMPONENTS	SPECIFIC ELEMENTS (what was done)	MODE OF DELIVERY (by whom and how)
Diabetes Self-Management Education	Comprehensive diabetes self-management education (DSME) program that included patient-centered instruction that included glucometer and insulin teaching, insulin titration, and physical activity and dietary goal planning.	Clinic staff
Support for Managing Diabetes and Distress	Implemented the new practice of stocking centralized clinic areas with diabetes self-management materials to make them more accessible to providers as they enter exam rooms.	Clinic staff
Enhanced Access/Linkage to Care	Implemented a new policy of providing in-person "warm transfers" of newly diagnosed patients from general practice to the diabetes clinic.	Clinic staff
Improve Quality of Care	Implemented the practice change of having staff from the call center reschedule chronic care appointments, rather than the providers having to make the calls themselves.	Call center staff
Community Organization, Mobilization, and Advocacy	Implemented the practice change of expanding the amount and kind of services available on a same-day basis. Services expanded to include insulin teaching, gestational diabetes education, glucometer teaching, basic nutrition, and nutrition education.	Clinic staff
Health System and Community Transformation	Implemented the practice change of providing ophthalmology screening to diabetes patients during DSME visits.	Clinic staff

EVALUATION RESULTS AND FINDINGS

Data on Project Implementation

Figure 1 below displays program implementation – the unfolding of services provided to the program's clients over time. (Note: In a cumulative chart, each new activity is added to all prior activities.) The data show steady implementation of services provided throughout the course of the grant period with an acceleration of services occurring in February 2015. This acceleration in community and systems changes was associated with the evaluation and associated adjustments (e.g., new programs, policies, practices) made to the dismissal policy.

Figure 1: Community/System Changes implemented within the primary care reengagement intervention.



Data on Clinical Outcomes

Clinical data are pending.

WHAT WE ARE LEARNING

Key lessons learned include:

- Using a tested approach, the AIDS linkage to care model, to reengage diabetes patients that have fallen out of care was integral to the success of the reengagement efforts.
- Optimizations made to clinical practice, patient contact workflows, and policies defining patient eligibility were impactful in the reengagement of patients that had fallen out of care, and for preventing new patients to be defined as having fallen out of care.

MOVING FORWARD AND PLANS FOR SUSTAINABILITY

The Linkage to Care Diabetes Reengagement Program included the following tactics of sustainability:

TACTICS OF SUSTAINABILITY	SPECIFIC EXAMPLES
1) Apply for grants - Consider time and resources that will be necessary for success, and the need for reapplication.	The SSCHC staff leveraged the Together on Diabetes grant to secure local funding from the GE Foundation for a total of $350,000 to partially support staff of the diabetes team, increase access to comprehensive services, improve patient-provider interactions, and improve the use of group services to serve more patients through improved efficiencies. The Goldstein Foundation provided grant funds totaling $30,000 to support a partnership between our Gestational Diabetes Mellitus self-management education program and the health centers Parenting Resource Center to support healthy birth outcomes. The Wisconsin Primary Care Association gave a grant of $4,500 to support improvement programming that could be shared and promoted in other community health centers. Due to a request from the State of Wisconsin, Division of Public Health, Chronic Disease Prevention Unit the SSCHC was given permission to implement the CDC National Diabetes Prevention Program. Grant money totaling $10,000 was provided for supplies.
2) Solicit in-kind support - Seek goods and services the organization would otherwise have to purchase (e.g., donations of office supplies from a local business).	The SSCHC staff recruited and trained CHWs from among their diabetes patients to offer DSME and linkage-to-care services. These lay health workers went on to further recruit additional CHW volunteers from among the patient population.

PROJECT PUBLICATIONS AND MATERIALS

- Program Website: http://sschc.org/health-community/chronic-conditions-health-education/

PROJECT CONTACT INFORMATION

Holly Nannis, Director
Asthma & Diabetes Programs
Sixteenth Street Community Health Center
1032 S. Cesar E. Chavez Dr.
Milwaukee, WI 53204
Email: holly.nannis@sschc.org
Phone: (414) 385-3362

EVALUATION CONTACT INFORMATION

This case study was prepared by the Work Group for Community Health and Development team (Charles E. Sepers, Jr., Ithar Hassaballa, & Jenna Hunter-Skidmore) at the University of Kansas http://communityhealth.ku.edu, in collaboration with the Whittier Street Health Center, and as part of the evaluation of the BMSF's Together on Diabetes Program.

Jerry Schultz, Co-Director
Work Group for Community Health and Development, University of Kansas
Email: jschultz@ku.edu
Phone: 785-864-0533

Charles E Sepers, Jr, Together on Diabetes Evaluation Coordinator
Work Group for Community Health and Development, University of Kansas
Email: jmhunter@ku.edu
Phone: 785-864-0533