SONOMA COUNTY
INDIAN HEALTH PROJECT

Optimizing Care Team Roles for PHASE Program Patients

2017 Symposium on the Future of Complex Care
Gallery of Promising Practices

PROMISING PRACTICE OVERVIEW

American Indian/Alaskan Native (AI/AN) populations are nearly 2.5 times as likely to be diagnosed with Diabetes than Non-Hispanic Whites[1]. Because we understand this disparity, Sonoma County Indian Health Project Inc. (SCIHP) has had a robust diabetes management program for many years, however, when implementation of its PHASE program began in February 2017, SCIHP staff wanted to try a new approach based on the model passed down from Kaiser through RCHC. Through trial and error of various intervention techniques, SCIHP has found success in utilizing an approach of PCP-referral to a focused PHASE clinic, comprised of a Clinical Pharmacist, an RN, and a scribe.

Since implementing this model of care patients have expressed confidence that they have the ability to make necessary changes, enrollment has increased, and medication adherence has improved dramatically.

AIM

The purpose of the SCIHP PHASE clinic is to improve the quality of life and life expectancy of patients who are identified as having an increased risk of cardiovascular events.

MEASURES

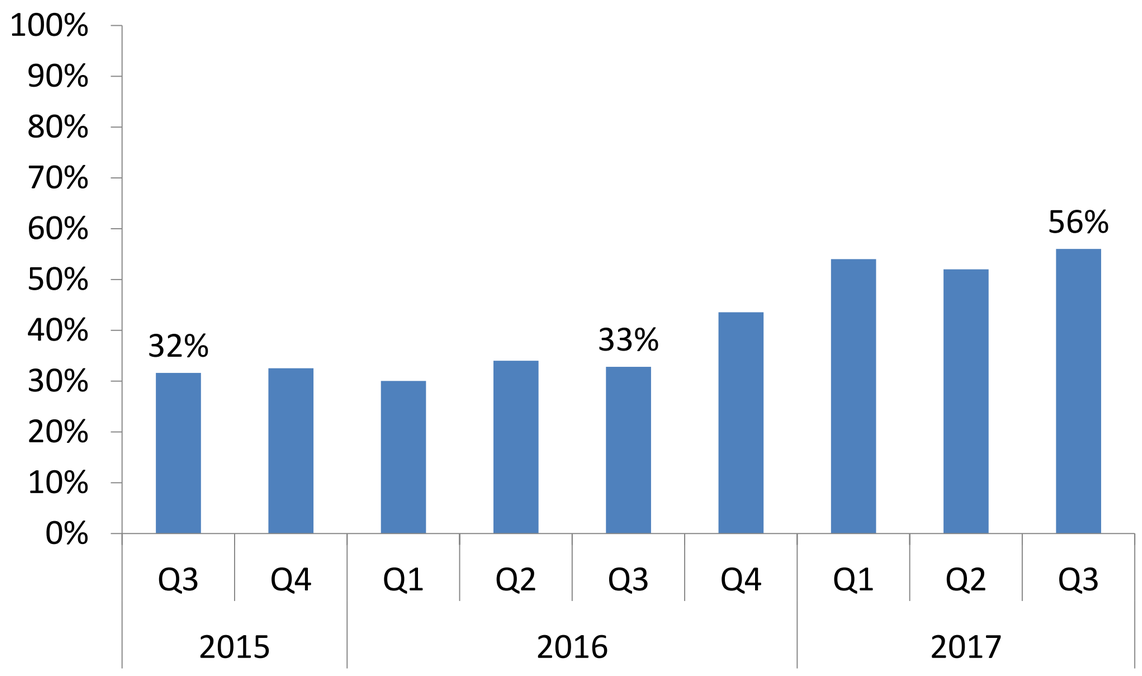
Access and Referral to PHASE Clinic.
Measurement: Total number of patients enrolled in the PHASE clinic.

Blood Sugar Management as measured by A1C.
Denominator: PHASE clinic patients who are diabetic.
Numerator: Patients in the denominator with A1C ≤9.

Blood Pressure Management.
Denominator: All PHASE clinic patients.
Numerator: All PHASE patients with BP <140/<90

Medication Compliance.
Denominator: All PHASE clinic patients.
Numerator: All PHASE patients who are currently taking an ACEI or ARB and a Statin.

PATIENTS TAKING A STATIN AND ACEI OR ARB



ACTIONS TAKEN

- January 2016: PHASE protocols implemented with all medical staff (using protocols for medication and treatment)
- February 2017: Separate PHASE Clinic concept began, utilizing Nurse, Dietician, Health Educator, Provider, MA
- October 2017: Expanded PHASE Clinic to 2 days a week

WORKFLOW

PCP REFERRAL
Patient is identified as a PHASE candidate by PCP

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WARM HAND-OFF
RN Case manager introduces the PHASE clinic to the patient and schedules an appointment.

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PHASE CLINIC

Clinical Pharmacist meets with the patient to discuss barriers to medication adherence

RN discusses patient's health goals

Dietician educates patients on diagnosis-specific nutrition tools.

PHASE Team helps patient with an action plan

RESULTS TO DATE

Access:
56 patients have been seen in the PHASE Clinic to date.

Blood Sugar Management
82% have an A1C ≤ 9.0
45% of PHASE Clinic patients have lowered their A1C this year

Blood Pressure Management
71% have BP <140/<90

Medication Compliance
56% of All PHASE-eligible SCIHP patients are currently taking a Statin AND ACEI or ARB (increase from 33% one year ago!)

LESSONS LEARNED

- ✓ Taking the time to let patients set their own goals and supporting them in working towards goals yields a patient who is engaged and motivated to make the changes necessary to improve their health.
- ✓ Clear education about how to use medications properly and simplifying medication regimens are especially important in the beginning when patients need to feel in control of their condition while they tackle difficult life changes.

[1] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=33