Community Benefit Program Evaluation Example

CHIP-Chronic Health Improvement Project

I. Program Description

A. Community problem the program is addressing:
The aim of the Chronic Healthcare Improvement Project (CHIP) is to provide enhanced outreach and prevention and to apply best-practice approaches to diabetic treatment for the at-risk population in local metropolitan area. The area has a high rate of diabetes, 9.4%, compared to statewide averages, 7.2%.

B. Program Theory:
The local Community Health Project’s Diabetes Network has a successful history of providing screenings and education for area residents, conducting African American outreach events through churches and other venues, and teaching chronic disease self-management classes for diabetes. The goal for CHIP will be to improve measurable clinical outcomes for the underserved diabetic patients served by a community health center (CHC) through a multi-disciplinary redesign process, partnering with the local Community Health Project, the county Diabetes Network, and community hospital.

C. Program Objective(s) 1. By the end of the year:

Goal 1: Reduce disparities in quality of care for diabetic patients.
   - **Objective 1**: Implement group visits for diabetic patients of CHC.
   - **Objective 2**: Improve process and outcomes measures for CHC diabetic patients:
     - Diabetic patients who receive a dental screening in last 12 months – goal is 70%
     - Diabetic patients with a documented foot exam in past 12 months – goal is 90%
     - Diabetic patients with dilated retinal exam past 12 months – goal is 70%
     - Diabetic patients with documented self-management goal – goal is 70%
     - Diabetic patients with two HgbA1C tests in past 12 months – goal is 90%
     - Average HgbA1C for all diabetic patients – goal is less than 7
     - Fasting LDL value less than 100 – goal is 70% of diabetic patients (previously listed in error as <130)
     - Blood pressure reading less than 130/80 – goal is 40% of diabetic patients (previously listed in error as goal of 70%)

Goal 2: Reduce disparities in access to care based on insurance.
   - **Objective 1**: CHC will assure 100% of patients have glucometers and strips throughout project
   - **Objective 2**: CHC and the local Community Health Project will ensure access to diabetic patients for diabetic medications and supplies by filling 500 diabetic prescriptions through its 340B discount drug program, assisting in processing 100 pharmaceutical drug program assistance applications annually throughout grant period, and supplementing with the Health Project’s Diabetes Walk prescription fund.
Goal 3: Improve health literacy.
- **Objective 1**: By 12/31/2007, CHC will have produced four brief educational DVD’s with basic education for diabetic patients.

Goal 4: Provide culturally-competent care
- **Objective 1**: By 5/1/2007 culturally-appropriate written patient educational materials will be developed/acquired for diabetic patient use in consultation with Health Project Outreach staff.
- **Objective 2**: By 12/31/07, 20 or more presentations/screenings at local African-American churches by local Community Health Project staff on diabetes self-care

Goal 5: Improve care coordination for diabetic patients.
- **Objective 1**: Access to specialty care for CHC diabetic patients will be provided through wrap-around services provided in a group visit setting by 9/1/07
- **Objective 2**: Care management services will be in place for CHC diabetic patients by 6/1/07
- **Objective 3**: By 3/1/07 CHC will hire a full-time, qualified RN to serve as a Chronic Healthcare Improvement Coordinator
- **Objective 4**: By 11/1/07 local Community Health Project will have trained 6 CHC staff in Stanford model, and will provide CME provider trainings for 25-30 providers.

Goal 6: Improve health education.
- **Objective 1**: By January 2008, one annual community African-American Diabetes health conference will take place, as organized by local Community Health Project Outreach staff members, and attended by at least 500 community members and Diabetes Network partners.

Goal 7: Decrease service gaps.
- **Objective 1**: By 9/1/06, CHC will have process in place with community hospital to offer diabetic labs at no cost to CHC low-income patients
- **Objective 2**: CHC underinsured and uninsured diabetic patients will have access to podiatry, pharmacy, ophthalmology and dentist specialty services through local Community Health Project “Project Access” volunteer referral network.

**II. Evaluation**

**Who are the stakeholders in the evaluation?** (Who asked for evaluation, is involved will use results?) the local community, the community hospital, local Community Health Project, local County Diabetes Network, partner physician hospital organization and the Bureau of Primary Health Care National Health Disparities Collaborative.

**What questions did the evaluation seek to answer?** (what do you want to know about the program?)
- Comparing providers on their patient outcomes for practice change.
- Improvements in care measures.
- Acceptance of the program by community participants.

**What method of evaluation:**
- Wellcentive chronic disease registry
- Monthly progress reports
Self-report data from participants
Laboratory data
Billing reports

What data was collected? Clinical diabetes measures (e.g. cholesterol, HbA1c, blood pressure), status reports, patient satisfaction information.

What were major findings?
- 6.7% of diabetic patients received a dental screening in last 12 months up from 0%.
- 27.9% of diabetic patients received in dilated retinal exam past 12 months up from 2.2%.
- 66.3% of diabetic patients had a documented foot exam in past 12 months up from 0.9%.
- Local Community Health Project Staff provided 26 non-clinical case management patients with a total of 308.3 hours of patient contact.
- Lab voucher system developed in partnership with the community hospital.
- Central location set up at each site for providers to access vouchers
- 305 labs were offered for total of $11,775.

How were findings reported? Data was provided to the hospital’s Community Benefit Office and internal project leadership for process improvements and modifications.

How were findings used to make decisions? The findings helped to provide ideas for project improvement. A review of the outcomes helped identify errors in the way blood pressure was recorded. An electronic medical record (EMR) system upgrade has prohibited clinical data from being reported into the chronic disease registry. As a result of this review, staff has been able to connect with the software company to modify this interface with the EMR and the chronic disease registry. As a result, proper outcomes can be recorded for the blood pressure measure.