

Chronic Health Disparity	Goal	Objective By 2015	Indicator	Evaluation	Update 2014 Action / Measurement / Impact
Diabetes	Improve clinical outcomes of diabetic patients with Hgb A1C>9 in Duval County that participate in the CCD programs sponsored by UF Health Jacksonville.	85% of Diabetic pts. have Hgb A1C<9	22% of pts. had diabetes. 19% of diabetic pts. had A1C>9.	<p>Process: # pts. (in registry) received self-mgt edu. (DRAP)</p> <p>Short Term: # pts. visit DPCs for RN edu.</p> <p>Long Term: # pts. with Hgb A1C>9 enrolled in self-mgt edu with improved clinical outcomes.</p>	<p>Action: Patients averaged 2 visits per month for education on diabetes self-management, nutritional influences, and behavioral modification</p> <p>Measurement: FY13 - 2,026 patients with diabetes received education (2 visits/month) - this represents 40.17% of pts. with chronic disease for FY13 that received education</p> <p>Impact: FY13 - 79.03% of the diabetic patients population of the CCD have an A1C <9</p>
Heart Disease	Improve outcomes for patients with LDL>100 in Duval County that participate in CCD clinical programs sponsored by UF Health Jacksonville.	70% of pts. have LDL<100	60% of pts. had hypertension. 32% had BP>140/90. 38% had hyperlipidemia. 32% had LDL>100.	<p>Process: # pts. with dx of coronary artery disease, hypertension, diabetes mellitus.</p> <p>Short Term: # pts. w/ poorly controlled diabetes mellitus enrolled in self-mgt RN edu.</p>	<p>Action: Pts. received REACH education - behavior modification and disease, management from the RN at least 2.5 times per month</p> <p>Measurement: FY13 – 115 pts. with A1C>9 received</p>

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Heart Disease (cont.)				<p>Long Term: # pts. with elevated LDLs that receive self mgt edu and have improved clinical outcomes.</p>	<p>education - this represents 27.06% of the total number of disease managed pts.</p> <p>Impact: FY13 - 81.13% of the hyperlipidemia patient population have a LDL<100</p>
Stroke	Decrease cardiac risk factors for pts. at risk for stroke.	70% of pts. will have BP<140/90	<p>38% of pts. had hyperlipidemia</p> <p>32% had LDL>100</p>	<p>Process: # pts. with dx of coronary artery disease, hypertension, diabetes mellitus.</p> <p>Short Term: # pts. that receive one-on-one edu from RN edu.</p> <p>Long Term: # pts. with SBP>140/90 that demonstrate improved clinical outcomes.</p>	<p>Action: Patients were actively identified and received one on one REACH education with RN - averaged 2 visits a month of education with the RN on disease information, nutritional influences, and physical activity</p> <p>Measurement: FY13 – 1289 pts. with chronic disease received RN 1:1 education</p> <p>Impact: FY13 - 81.25% of the high risk cardiac patient population had blood pressure <140/90</p>

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<p>Childhood Obesity</p>	<p>Establish early intervention screenings and promotional guidelines for children in Duval County that participate in the CCD clinical programs sponsored by UF Health Jacksonville.</p>	<p>Increase # of children in Duval County that practice healthy eating habits, healthy lifestyles, and physical activity</p>	<p>1,000+ at-risk children for obesity-related diseases identified in UF Health Jacksonville clinics.</p>	<p>Process: # pts. with BMI 85th-95th percentile.</p> <p>Short Term: # pts. with BMI>25. 50% of pts. will be enrolled in program w/in 6 mo. of query.</p> <p>Long Term: Enrollment promotes decreased BMIs and decreased risk of developing chronic diseases associated with obesity.</p>	<p>Action: Invitation to enroll in the K.I.M program was offered to the newly identified children with BMI between >85% and <95% and BMI >95%</p> <p>Note: K.I.M program offers education, physical activity, and nutritional support to promote a decrease of the BMI & risk for developing chronic diseases</p> <p>Measurement: <u>FY13</u> – 8 of the newly identified children enrolled in K.I.M. program.</p> <p>33 pts. with BMI >25 (BMI>85% - <95% and BMI>95%)</p> <p>Impact: <u>FY13</u> - 24% (8) of the newly identified children enrolled in K.I.M. program</p>

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Mammogram Screening	Increase # of patients in Duval County referred for mammogram screenings	50% of women in Duval County that participate in the CCD clinical programs will be referred for a mammogram screening	<p>8% of women > 40 yr. were referred for mammograms.</p> <p>Note: Guidelines and reimbursement has changed – current recommendation for screening Mammogram is women > 50yrs.</p>	<p>Process: # pts. that receive a mammogram referral.</p> <p>Short Term: Review pt. records for women at each visit to determine need for referral.</p> <p>Long Term: All females > 40 yr. will be referred for a mammogram.</p>	<p>Action: Identified and referred patients age > 18 yrs. For a mammogram</p> <p>Provided education or education material regarding breast health and mammograms to 1981 community women</p> <p>Actively referred patients, women age > 40 yrs. Old, for first screening mammogram</p> <p>Measurement: <u>FY13</u> – 191 new patients were referred for mammogram screening</p> <p>Impact: <u>FY 13</u> - 30% of new patients were referred for a mammogram screening or had a mammogram within the year</p>
Cervical Cancer	Increase access to timely cervical cancer screening for female pts.	65% of all new adult female pts. in Duval County that participate in the CCD clinical programs will have pap	FY12: 57% of new age appropriate female pts. received pap smear w/in 1st year of initial visit.	Process: Track via registries female patients' last visit and health maintenance notes.	<p>Action: Patients are activity identified and referred for screening services</p> <p>Measurement:</p>

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					since CY10 (pediatric TBIs = 78)
Nutrition	Educate patients about healthy food choices that are low cost and culturally sensitive.	Provide nutritional education to 50% of patients with chronic diseases in Duval County that participate in the CCD clinical programs.	<p>236.8/100,000 people in health zone 1 are diagnosed with heart disease.</p> <p>116/100,000 people in health zone 1 are diagnosed with diabetes.</p> <p>80% of individuals in Health Zone 1 are African Americans.</p>	<p>Process: Track pts. that receive Diabetes education</p> <p>Short Term: Patients that attend class will make healthier food choices.</p> <p>Long Term: Assess impact of education on clinical outcomes.</p>	<p>Action: Chronic disease patients were provided nutritional education – educational lectures & the Culturally Conscious Cooking class</p> <p>Measurement: <u>FY13</u> –</p> <p>1373 patients received nutrition education</p> <p>199 patients received diabetes management education</p> <p>Impact: <u>FY13</u> - 42.79% of pts. identified with chronic diseases received nutrition education</p>
Behavioral Health	Provide resources that target patients with depression and anxiety in Health Zone 1 of Duval County.	Pts. in Health Zone 1 that participate in the CCD clinical programs will have increased access to behavioral health programs.	Depression and anxiety disproportionately affect African Americans. African Americans face greatest barriers to mental healthcare.	<p>Process: Track # of pts. receiving anxiety and/or depression resources.</p> <p>Short Term:</p>	<p>Action: New Anxiety/Depression patients identified and given scheduling priority for visits with clinical psychologists</p>

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					Program participants' babies were born at an average of 6lbs 15oz.