# DIABETES IN SPECIAL & VULNERABLE POPULATION: A NATIONAL LEARNING SERIES

## Diabetes Continuum of Care: Raising the Pillars for Community Engagement

Tuesday, November 10, 2020
9 am HT / 11 am PT / 1 pm CT / 2 pm ET

*Welcome!*
*We will begin in a few minutes*

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

## MODERATORS & ORGANIZERS

**Albert Ayson, Jr., MPH**
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*Director of Education & Communications of MCN*

# Thank you for attending the Webinar.

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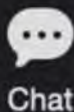
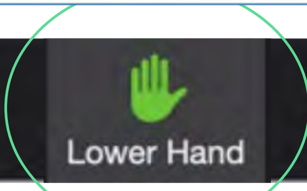
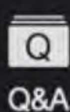







Leave Meeting

# ABOUT THE SERIES

**Diabetes affects more than 34 million people in the United States.** Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for special and vulnerable populations, which have unique characteristics that affect culturally and linguistically competent health care access and utilization. According to 2018 Uniform Data System (UDS), diabetes poses a unique challenge for the HRSA Health Center Program because 1 of 7 patients has diabetes and nearly 1 in 3 of those has uncontrolled diabetes.

To elevate the national conversation around diabetes, **14 National Training and Technical Assistance Partner (NTTAP) organizations** formed the Special and Vulnerable Populations Diabetes Task Force to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase knowledge of effective strategies that address diabetes among people experiencing homelessness, residents of public housing, migratory and seasonal agricultural workers, school-aged children, older adults, Asian Americans, Native Hawaiians and Pacific Islanders, LGBTQIA+ people, and other health center patients.

This Fall's national learning series is **sponsored by HRSA** and will take a deeper dive into issues related to patient health literacy, community engagement, and team-based care.

For information about the Diabetes National Learning Series, visit **chcdiabetes.org** today.

## Special and Vulnerable Populations Task Force Members:

For more information on our NTTAP Partners, visit chcdiabetes.org

# DIABETES IN SPECIAL & VULNERABLE POPULATION: A NATIONAL LEARNING SERIES

## WEBINAR TOPICS

**WEBINAR #1**
Tuesday, October 20

Diabetes Continuum of Care: Bridging the Health Literacy Gap to Improve Diabetes Outcomes

**WEBINAR #2**
Tuesday, October 27

Diabetes Continuum of Care: Increase Patient Technology and Digital Health Literacy

**WEBINAR #3**
Tuesday, November 10

Diabetes Continuum of Care: Raising the Pillars for Community Engagement

**WEBINAR #4**
Tuesday, November 17

Diabetes Continuum of Care: Building Successful Teams During the COVID-19 Pandemic

**REGISTER TODAY AT CHCDIABETES.ORG**

# Webinar Slides and Recordings Available

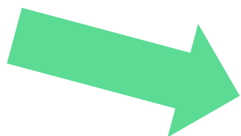
## Webinar #1

Diabetes Continuum of Care:

**Bridging the Health Literacy Gap to Improve Diabetes Outcomes**

## Webinar #2

Diabetes Continuum of Care: **Increase Patient Technology and Digital Health Literacy**



**Download slides and watch the recordings at chcdiabetes.org**

## CME/CNE Accreditation Available

- **Please complete the post-webinar survey** at the end to indicate whether you would like to receive CME/CNE units or a certificate of attendance.
- Please indicate whether you'd prefer an electronic or hard copy of your certificate and provide your contact information
- For questions, please contact Martha at malvarado@migrantclinician.org.

## LEARNING OBJECTIVES

1. Demonstrate key components of successful community engagement to address diabetes amongst special and vulnerable populations
2. Identify ways to adapt and strengthen community engagement strategies to address diabetes during public health emergencies (i.e. COVID-19)
3. Highlight tools and resources to assess readiness for fostering community engagement

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

## NTTAP Faculty

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*Director of Education & Communications of MCN*

## Diabetes Continuum of Care: Raising the Pillars for Community Engagement

### TODAY'S GUEST SPEAKER

Sophi Scarnewman | she / her
Project Manager / CQI Lead

BRIGHTER BEGINNINGS
*Every Family Matters*

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement



Figure 1: HRSA Health Center Technical Assistance Partners Strategies to Address the Diabetes Continuum of Care

## Diabetes Continuum of Care: Raising the Pillars for Community Engagement

Community Engagement

Data

Cultural Humility

Partnerships

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

Community Engagement

Data

Cultural Humility

Partnerships

# From April's webinar....

- Socio-economic data about local communities
- SDOH data (food environment, incarceration rate, etc.)
- Patient outcome data from health centers and other providers
- Community needs assessments

# Now what?

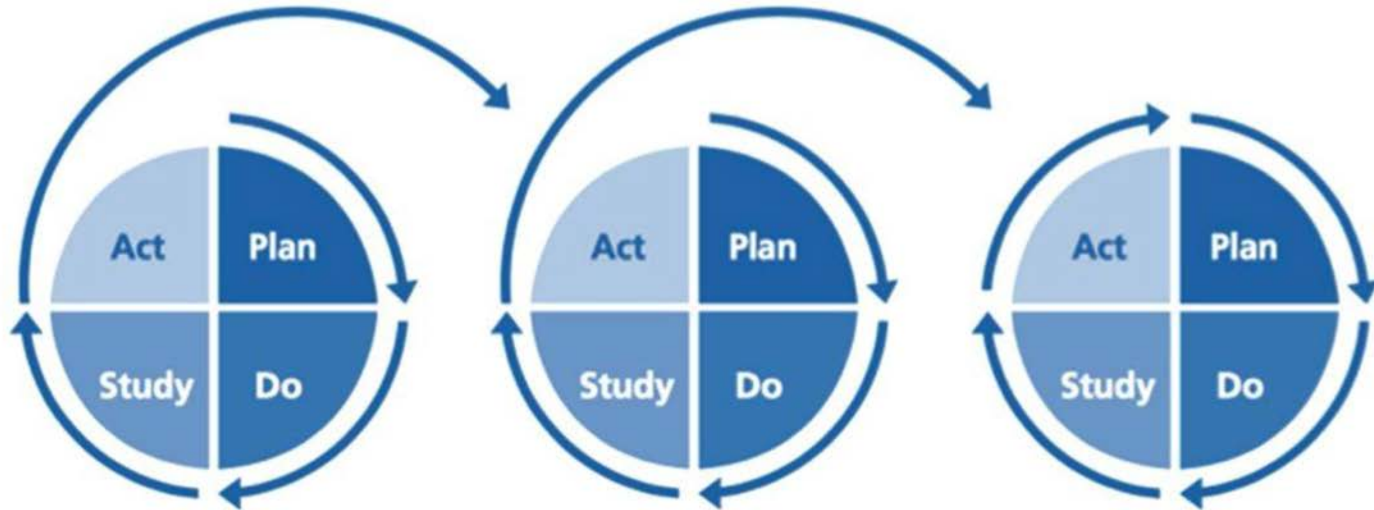



Image Source: NHS Improvement PDSA Cycles

# PLAN - Determine Your Action Plan

- Assess readiness
  - Organizational readiness
  - Community readiness
  - Partner readiness
    - Collaborative Practice Inventory (JSI Tool)
      https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14333&lid=3
- Conduct informational interviews with fellow health centers
- Join a learning community
- Develop SMART goals

# DO - Evidence-Based Interventions

- Select **evidence-based interventions** that correspond to needs identified by your patients and community through **data**
- Engage patients in **diabetes prevention** programming and **self-management** goal setting
- Promote **health literacy** among your patients, including digital health literacy and use of technology
- Build a **team-based care** culture and practice **cultural humility** amongst your staff, providers, and community partners

# STUDY - Improvement Measures

- Short-term (0-3 months)
  - Patient satisfaction
  - Provider satisfaction
  - Increased screenings and prevention efforts
- Intermediate to Longer term (3+ months)
  - HbA1C Control
  - BP Control
  - Tobacco Cessation

# POLL

## How do you evaluate your health center's performance?

- Patient surveys
- Provider surveys
- UDS/HEDIS measures
- Instruments designed by CQI/operations staff
- All of the above
- None of the above

# ACT - Revise Your Strategy as Needed

- Ask yourself the following questions:
  - Have selected measures improved? If not, what was the cause?
  - What worked well?
  - What could be changed to better suit the needs of the community and partners?
- Evaluation for patient focus group and partners
  - CDC guidance: https://www.cdc.gov/healthyYouth/evaluation/pdf/brief4.pdf

# Don’t Forget...

- Create data-sharing agreements with partners (MOUs, etc.)
  - In the chat: do you currently have MOUs in place with your partners?
- Your board: a focus group for engagement
  - In the chat: do you engage your board in CQI processes?
- Identify opportunities for community and partner engagement in your clinical improvement efforts
  - In the chat: has COVID-19 changed your clinical improvement priorities?

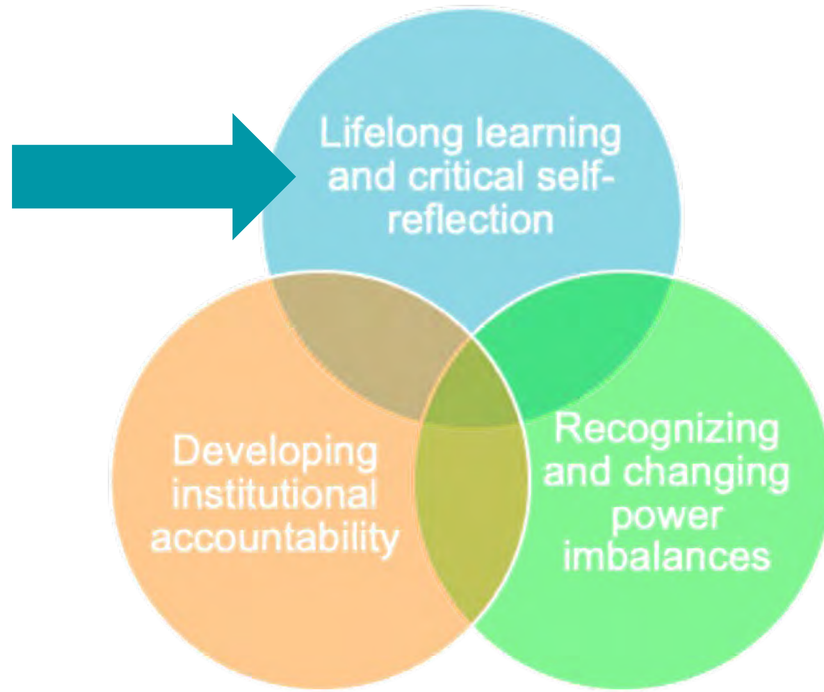
# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

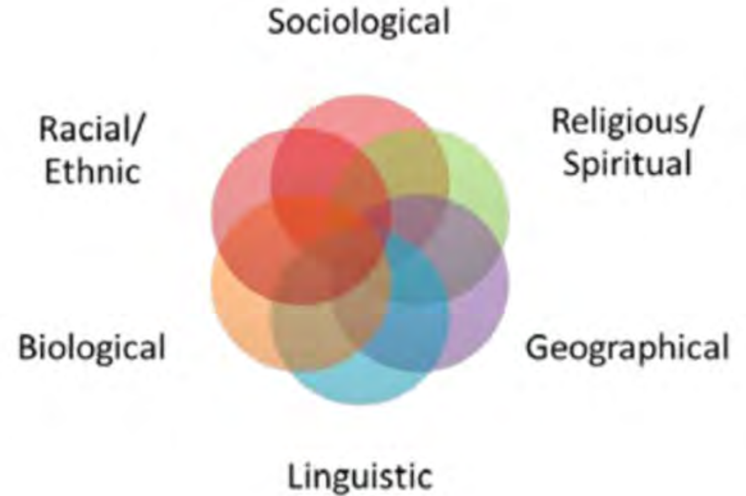
## Diabetes Continuum of Care: Raising the Pillars for Community Engagement

**Using the Cultural Humility Framework to strengthen community engagement and achieve health equity for special and vulnerable populations at-risk for diabetes**

Source: Tervalon and Murray-Garcia, 1998

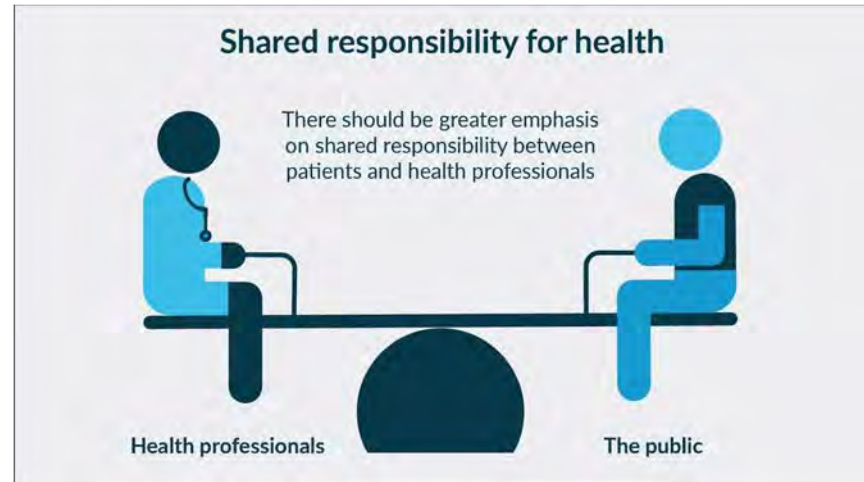
# Diabetes Continuum of Care: Raising the Pillars for Community Engagement




Source: Tervalon and Murray-Garcia, 1998; Graves, 2011

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement



Sources: Tervalon and Murray-Garcia, 1998; Buck et al 2018

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

Sources: Tervalon and Murray-Garcia, 1998; Dahlgren and Whitehead, 1991

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

## Cultural Humility Framework Strategies - Learning Collaborative Opportunity

| Strategy | Opportunity |
| --- | --- |
| **Lifelong learning and critical self-reflection** | • Culturally Appropriate Diabetes Health Education through Motivational Interviewing |
| **Recognizing and changing power imbalances** | • "Patient as Expert" Approach for Diabetes Prevention, Management, and Control |
| **Developing institutional accountability** | • Enabling Services workforce with shared history, lived experiences, and knowledge |

# Diabetes Continuum of Care: Raising the Pillars for Community Engagement

Community Engagement

Data

Cultural Humility

Partnerships

# Partnership Engagement

## Diabetes Continuum of Care: Raising the Pillars for Community Engagement

# The Partnership Continuum

1 **Coordination**

Learn about the services and clients served by the other organization. A lot of organizational independence.

2 **Cooperation**

Cooperation brings increased understanding of target audiences and motivations. Joint strategies start to emerge.

3 **Collaboration**

Increased recognition of the values of each organization, trust, respect, a clear understanding of the benefits for each partners.

4 **Partnerships**

High level of trust and communication. Roles and responsibilities of each organization are well-defined and developed.

| | Cooperation | Collaboration | Partnership |
|---|---|---|---|
| Partnership Continuum | • Informal relationships<br>• Shared information only<br>• Separate goals, resources and structures | • Long-term effort around a project or task<br>• Some planning and division of roles<br>• Some shared resources, rewards and risk | • Durable and pervasive relationships<br>• New structure with commitment to common goals<br>• All partners contribute resources and share rewards & leadership |
| Examples | Community center promotes health center services; health center promotes community center services/events | Health center operates as guest speaker in a health class on diet and physical activity in a school to meet academic requirements | MOU between health center and a community garden to develop food distribution and nutrition classes jointly. |

Virginia Garcia Memorial
**HEALTH CENTER**

# Team Based Diabetes Care

Eva Galvez, MD and
Kevin Alfaro-Martinez

# Readiness for Partnerships

The first step is to know your own organization's strengths and weaknesses.

# Key Steps to Implementing Partnerships

1. Identify and engage stakeholders
2. Establish personal relationships and begin to build trust
3. Clarify the goals and objectives each partnership wants to accomplish
4. Choose and implement a partnership that is mutually beneficial
5. Establish governance, procedures, ground rules, and decision-making structure.

# Organizational Readiness Assessment Tool

Engaging Your Community: A Toolkit for Partnership, Collaboration, and Action; John Snow, Inc. (JSI)

https://publications.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14333&lid=3

BRIGHTER BEGINNINGS
*Every Family Matters*

# Improving DM and HTN CQMs at an FQHC-LAL

Prepared and Presented by
Sophi Scarnewman, CQI Lead

# Background

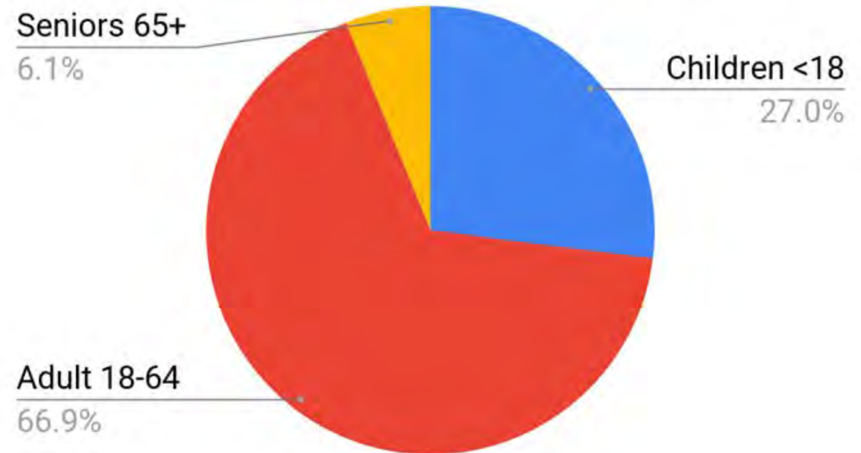
- Brighter Beginnings Family Health Clinic is an FQHC Look-Alike in the East Bay Area
  - The larger Brighter Beginnings organization of social programs was founded in 1984 to reduce disparities in Black infant health
  - The clinic began in 2013 and became an FQHC Look-Alike in 2015
- Locations in Antioch and Richmond
  - Suburban-urban areas in the Bay Area with disproportionate poverty versus the overall region
  - Large immigrant population, including undocumented individuals

# Our Patients by the Numbers

**2,766** patients in 2019

- ➔ **15.2%** of patients have **HTN**
- ➔ **14.6%** have **type 2 diabetes**
- ➔ **93%** of patients are a **racial or ethnic minority**
- ➔ **38%** of patients are **uninsured**
- ➔ **52%** of patients **best served in a language other than English** (typically Spanish)

Patient Ages



# Measure Refresher

# **CMS 165:** Controlling High Blood Pressure

Patients whose **most recent** blood pressure during the measurement period is **adequately controlled (< 140/90)**

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( Patients 18-85 years of age with a medical visit who had a diagnosis of essential hypertension overlapping the measurement period – Pts with ESRD, >65 with advanced illness, >65 in institution, in hospice )

# CMS 122: Hemoglobin A1c Poor Control (> 9%)

Patients whose most recent HbA1c level (performed during the measurement period) is **>9.0%** OR patients with a Dx of DM1 or 2 whose **HbA1c was not tested** in the measurement period

( Patients 18-75 years of age with Type 1 or Type 2 diabetes with a visit during the measurement period − Patients in hospice in measurement period )

# DM & HTN Registry Project

# Impact of COVID on CMS 122 and CMS 165

- Limits on high-quality historic data and EHR reporting capabilities
- Comparison of similar Year-to-Date ranges suggested COVID underlay at least some of the losses
  - Very few in-person appointments, so this made sense

| Quality Measure | 2019 CA LAL Median | 2019 Jan 1-Aug 22 | 2019 Overall | 2020 Jan 1- Jun 30 |
|---|---|---|---|---|
| **Uncontrolled Diabetes** (CMS122 v7, v8) | 33.4% | 41.7% | 38.6% | 61.1% |
| **Controlling High Blood Pressure** (CMS165 v7, v8) | 63.8% | 68.7% | 69.4% | 46.9% |

# Approaching the Problem

- First thoughts: 😣😧😱😰
- Next thoughts: **if we can figure out where the breakdown is occurring, we can make changes to improve the process**
- Elevate 2020 (NACHC) webinars often mentioned registries
  - No special training or tools needed
  - Provides opportunity to get at the first level of “why”
- Model for Improvement tools on IHI website
  - PDSA Template for download

# PDSA: Plan

- Questions and Predictions
  - What will go into making a registry?
  - What action steps make sense to take based on the registry?
  - What are the reasons people are out of compliance?
- Who, What, When, Where
- Plan for Collecting Data
  - Spreadsheet with row for each patient and columns for date of last value and the value(s) in question (i.e., date of last BP check, SP, and DP)

# PDSA: Do

*Describe what happened. What data did you collect? What observations did you make?*

- Creating the registries was straightforward
  - Volunteer intern reviewed each individual chart to get the values and enter on the spreadsheet
  - Making the registries surfaced documentation issues with A1c; fixing those made an improvement
- Simple goal to schedule everyone for a curbside check
- Complex execution
  - Attempt to risk stratify
  - SMS versus live call versus message to provider

# PDSA: Do

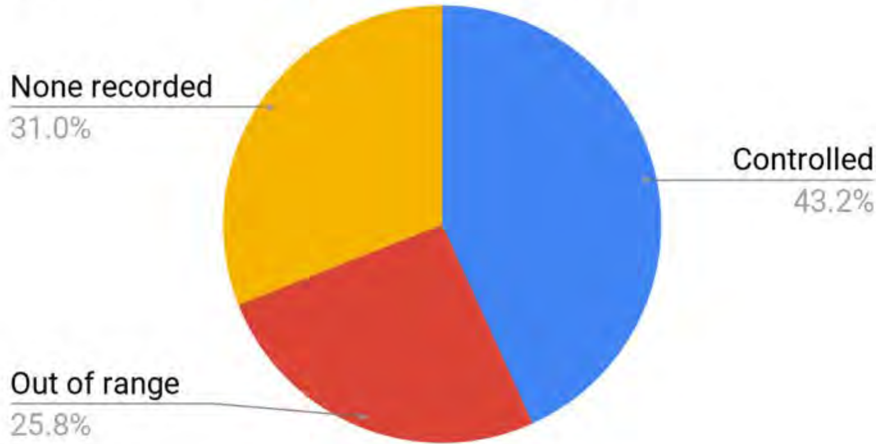
Approach based on whether patient had an upcoming appointment and their HCC risk score:

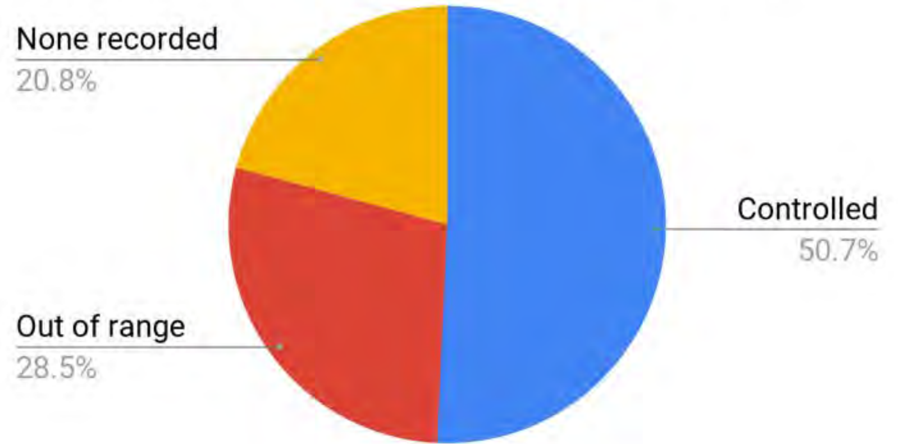
| Status | Action |
| --- | --- |
| No appointment<br>**Low** HCC risk | SMS message with call to action to schedule a curbside check |
| No appointment<br>**High** HCC risk | Call from RN to schedule a curbside check |
| Upcoming appointment<br>Any risk | Reminder EHR message to PCP that the patient was due for a check, which could be conducted or discussed at their next visit |

Outreach calls provided an opportunity to introduce PRAPARE to patients, which we sent via SMS (link to a secure JotForm).

# PDSA: Study

*Analyze the results and compare them to your predictions.*




"None recorded" is our missed opportunity

# PDSA: Study

- Differences between measures make sense
  - Vitals at every visit, A1c only every 3-6 months
- Getting values for someone without them will **never** hurt measure performance

| **Reason for Measure Noncompliance** | **Diabetes** | **Hypertension** |
|---|---|---|
| Value Out of Range (BP≥140/90, A1c > 9.0%) | 45.4% | 57.8% |
| No Value in Measurement Period (since 1/1/2020) | 54.6% | 42.2% |

The objective of CQMs is **shaping our care** so that patients receive **evidence-based preventive services**, NOT to try to squeeze patients into a numerator

# PDSA: Study

- ➔ Making the registry identified documentation mistakes that improved rates
- ➔ Outreach to get folks in the clinic had an obvious, swift impact

| Quality Measure | 2020<br>Jan 1- Jun 30 | 2020<br>Jan 1 -<br>Reg Creation | 2020<br>Jan 1- Aug 24 |
| --- | --- | --- | --- |
| **Uncontrolled Diabetes** (CMS122 v7, v8) | 61.1% | 56.9% | 51.0% |
| **Controlling High Blood Pressure** (CMS165 v7, v8) | 46.9% | - | 52.2% |

# PDSA: Study

➔ Another look at the same results

| Quality Measure | Outcome |
| --- | --- |
| **Uncontrolled Diabetes** (CMS122 v8) | Improved from 61.1% to 51.0%<br>10.1 **percentage point*** improvement<br>16.6% ***percent change**** improvement |
| **Controlling High Blood Pressure** (CMS165 v8) | Improved from 46.9% to 52.2%<br>5.3 **percentage point** improvement<br>11.3% ***percent change*** improvement |

***Percentage point change**: the actual numeric change between the final and initial percent values
****Percent change:** the change between initial and final percentages relative to the initial value

# PDSA: Study (Bonus!)

- All the data was there, so why not analyze it a bit?
  - Is there a correlation between panel size and overall control? HCC risk and A1c/BP values?
- Surprising results
  - Neither panel size nor HCC risk had any correlation with control
  - Caveat that some groups were small, so it's hard to know how significant these findings are
- Nothing fancy, just Google Sheets functions
  - COUNTIFS: tells you how many rows of a list match the criteria you set, such as patients whose provider is Dr. Peter who are marked as uncontrolled
  - PEARSON: calculates the correlation coefficient for a set of data with two variables, such as panel size and percent controlled
  - VLOOKUP: uses a unique identifier such as a patient ID to look up information in a range that's organized by that identifier, such as a patient's last visit date

# PDSA: Act

*Based on what you learned from the test, make a plan for your next step*

➔ This approach leads to meaningful improvement, so let's keep doing it!
➔ Utilize the Call Center to schedule everyone without an appointment for an in-person follow-up
➔ Leave future-date reminders for providers for patients with upcoming visits
➔ All outreach that will be carried out based on registry findings needs to be arranged and prepared ahead of time
    ◆ Text messages, call center time and scripts, messages to leave on charts
➔ Providers and staff should be refreshed regularly on proper documentation

# Latest Findings & Takeaways

# Where Are We Now?

- ➔ Increased in-clinic services has been hugely helpful, and the October round of registry and outreach was what got many of those patients in the clinic again
- ➔ Registries expose bugs in the EHR reports - excited to be migrating in Jan!
  - Gestational diabetes counted in CMS 122 when it should NOT be
  - CMS 165 report marks out-of-control if a patient's last visit was telehealth and there is no BP, even if the last recorded BP in 2020 was <140/90!

| Quality Measure | June 30 2020 YTD | | Aug 24 2020 YTD | Sep 30 2020 YTD | | Nov 4 2020 YTD |
|---|---|---|---|---|---|---|
| **Uncontrolled Diabetes** (CMS122 v8) | 61.1% | Registry and outreach | 51.0% | 50.0% | Registry and outreach | 43.7% |
| **Controlling High Blood Pressure** (CMS165 v8) | 46.9% | | 52.2% | 52.9% | | 53.7% |

# Takeaways

- ➔ Data almost always exists, but you may need to provide the structure
  - ◆ Spreadsheets are your friend, and formula tutorials abound
  - ◆ Volunteers and interns, including remote ones, can do this data entry
- ➔ Health Centers' involvement in outreach is more critical than ever
  - ◆ Patients dealing with difficult social determinants of health--exacerbated by the pandemic--may not have the bandwidth to be tracking their healthcare
- ➔ Live calls from a Call Center are a cost-effective way to do this
  - ◆ PPS rates vary, but you can do simple math to figure out how many patients would correspond to x hours of Call Center time
- ➔ Listen to webinars 😉 and get the ball rolling sooner rather than later

# Tying It All Together

- **Data**: Think about downstream and upstream data at the same time, and build data structures that can link them
  - Addressing care gaps like a missing A1c is critical (downstream)
  - Screening for the social determinants of health can get at **why** you're seeing some of those gaps (upstream)
  - Spreadsheets with a unique identifier allow you to move between any data you gather easily
- **Cultural Humility**: Earning and maintaining your patients' trust will require understanding the challenges they may be facing
  - Outreach via SMS (convenient) and live calls (personal) demonstrates your commitment to their health
- **Partnerships**: You may already have partnerships that can support your efforts
  - We are all part of our service area communities **and** the health center community
  - HCCNs, PCAs, consortia, etc.--put in what you want to get out

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## What are your questions and comments?

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| | **WEBINAR #4**<br>Tuesday, November 17 | Diabetes Continuum of Care: Building Successful Teams During the COVID-19 Pandemic |

**REGISTER TODAY AT CHCDIABETES.ORG**

# SAVE THE DATE FOR WEBINAR #4

## Diabetes Continuum of Care:
## Building Successful Teams During the COVID-19 Pandemic

### NTTAP Faculty:

NATIONAL LGBTQIA+ HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

**TUESDAY, November 17, 2020**

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# THANK YOU!

For information about the Diabetes National Learning Series, visit **chcdiabetes.org** today.

Feel free to contact our NTTAP collaborating partners and speakers from today's webinar:

Albert Ayson, Jr.– aayson@aapcho.org
Joe Lee – joelee@aapcho.org
Emily Kane – ekane@phmc.org
Jillian Hopewell – jhopewell@migrantclinician.org

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