Raising the Pillars for Community Engagement

Session 1 - Overview of Pillars for Community Engagement
Thursday, January 28, 2021
9 am HT / 11 am PT / 1 pm CT / 2 pm ET

Welcome!
We will begin in a few minutes
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:

AAPCHO
Association of Asian Pacific Community Health Organizations

CSH

FARMWORKER JUSTICE

Health Outreach Partners

Migrant Clinicians Network

MCN

NATIONAL CENTER FOR EQUITABLE CARE FOR ELDERS

NCFH
National Center for Farmworker Health, Inc.

NCHPHA
National Center for Health in Public Housing

National Healthcare for the Homeless Council

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

NNOHA
National Network for Oral Health Access

National Nurse-Led Care Consortium

School-Based Health Alliance
Redefining Health for Kids and Teens

For more information on our NTTAP Partners, visit chcdiabetes.org
Raising the Pillars for Community Engagement

NTTAP Faculty

Albert Ayson, Jr., MPH
Associate Director, Training & Technical Assistance of AAPCHO

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Senior Program Manager, Training and Technical Assistance of MCN

AAPCHO

National Nurse-LED Care Consortium
a PHMC affiliate

Migrant Clinicians Network
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ACCESS RESOURCES AT DIABETES.AAPCHO.ORG
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<th>Webinar #1</th>
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The Special and Vulnerable Populations Diabetes Task Force is excited to announce the launch of our new website — www.chcdiabetes.org!

For any questions, contact training@chcdiabetes.org
Raising the Pillars for Community Engagement

Today's Agenda

- Welcome and Introduction (10 min)
- Icebreaker (20 min)
- Define Community Engagement (10 min)
- Identify the Pillars for Community Engagement (10 min)
- Fish Bone Diagram, CQI - Introduction (15 min)
- Activity (15 min)
- Q&A and Closing (10 min)
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Icebreaker

- Name
- Role
- Organization

What is one thing that your health center has changed/added during COVID-19 that you would like to maintain?
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Session-by-Session Overview

- **Session 1 - Overview of Pillars for Community Engagement**
  Jan 28, 2021 @ 11-12:30 pm PT / 2-3:30 pm ET

- **Session 2 - Data**
  Feb 11, 2021 @ 11-12:30 pm PT / 2-3:30 pm ET

- **Session 3 - Cultural Humility**
  Feb 25, 2021 @ 11-12:30 pm PT / 2-3:30 pm ET

- **Session 4 - Partnerships**
  Mar 11, 2021 @ 11-12:30 pm PT / 2-3:30 pm ET
Raising the Pillars for Community Engagement

Learning Objectives

1. Define the role of community engagement in addressing diabetes in a primary care setting.
2. Identify pillars for increasing and strengthening community engagement to address diabetes control.
3. Explore existing tools and resources for health centers to assess their strengths and challenges in community engagement to address diabetes in a primary care setting.
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Figure 1: HRSA Health Center Technical Assistance Partners Strategies to Address the Diabetes Continuum of Care

Raising the Pillars for Community Engagement

**Optimizing Provider & Multidisciplinary Team Interventions**
- Team Based Care
- Promote National Standards
- New Techniques for Early Detection Screening
- Case Management
- Sharing of Diabetes Management Promising Practices
- Eye, Foot, Dental, & Kidney Screening
- Provider Counseling of Patients

**Facilitating Behavior Change in Individuals at-Risk for Our Living with Diabetes**
- CHW Directed Patient Education
- Lifestyle/Self-Management
- Promote Physical Activity and Health Diets
- Address Childhood & Adult Obesity
- Increase Patient Health Literacy

**Improving Health Systems & Infrastructure Interventions**
- EHRs with Diabetes Modules
- Diabetic Informatics
- Health Information Exchange (HIE) & Telemedicine
- Patient Centered Medical Home (PCMH)
- Use Patient Portals
- Behavioral Health Integration
- Community Engagement

Reduced Health Disparities

Decreased Diabetes Risk & Complications
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Raising the Pillars for Community Engagement

- Data
- Cultural Humility
- Partnerships
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- Data
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Data-Driven Decision Making

- 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
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Plan-Do-Study-Act Cycles

Image Source: NHS Improvement PDSA Cycles
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Community Engagement

Data

Cultural Humility

Partnerships
Defining Cultural Competency

“Mandates, laws, rules, policies, standards, practices, and attitudes used to increase the quality of interactions within the public health system, thereby producing better outcomes.”

Defining Cultural Humility

“Does not require mastery of lists of different cultures and particular health beliefs and behaviors. Entails developing a respectful partnership with diverse individuals, groups, and communities.”

Source: Alameda County Public Health Department, California
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
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Data

Cultural Humility

Partnerships
So, what do we mean by partnerships?
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 partner.

4. Partnerships
   - High level of trust and communication. Roles and responsibilities of each organization are well-defined and developed.
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Root Cause Analysis - The Concept

The Weed

Problem
Above the surface, obvious

The Root

Source
Below the surface, obscured

LANGUAGE:
- Contributing factors
- Underlying issues
- Drill down
- Root out
- Dig into
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Fishbone Diagram - Introduction

Causes

Main Cause 1
Main Cause 2
Main Cause 3
Main Cause 4

Effect

Problem Statement

Source: AIDS Education & Training Centers, 2007
Technology:
- Multiple tests per day
- Equipment malfunction
- Improper use of technology
- Discomfort/Pain with testing technique

Environment:
- Homelessness
- Lack of family support
- Physical Activity - Where?
- Limited access to groceries
- Proximity to appointment
- N/s due to Weather/elements

Measurement:
- Missing data
- Data errors
- Pt. convenience of testing frequency

Knowledge:
- Understanding of diagnosis
- Inability to set goals
- Really understanding good nutrition
- Appropriate types and level of physical activity
- Understanding medications

People:
- Multiple Providers/appts to manage
- Lack of motivation
- Peer support
- Comorbidities
- Financial issues
- Social norming
- BH issues

Resources:
- Lack of time
- Staff training
- Gym memberships $$
- Transportation issues
- # of Diabetic RN educators

Source: Holyoke Health Center
The Five Whys
Problem: Recently, patients have stopped coming to diabetes group visits

Why?
Patients forget to come or are not sure when classes are happening

Why?
Staff member who usually makes reminder calls has not been making those calls

Why?
She does not have the list of patients to call

Why?
Current lists are not being created

Why?
The person assigned to create these lists from the EHR is out on leave.
Possible Actions

- Assign an additional staff person to fill in and create reports while the person responsible is out.
- Give the outreach caller direct access to the data and train her to generate her own up-to-date lists.
Develop Actions Steps

Goals should be related to identified contributing & restricting factors and root causes
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Fishbone Diagram - Template

[Data] -> [Cultural Barriers] -> [Insert Problem Statement Here]

[Partnerships] -> [Main Cause]

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
What is most challenging right now about meeting the needs of your diabetic patients?
Welcome to Moodle!

Migrant Clinicians Network

Available courses

Diabetes Continuum of Care: Raising the Pillars for Community Engagement

In this learning collaborative, experts will present on the key components of successful community engagement to address diabetes amongst special and vulnerable populations. Participants will learn about ways to adapt and strengthen their community engagement strategies in order to address diabetes during public health emergencies (i.e. COVID-19). Experts will highlight tools and resources to assess readiness for fostering community engagement and review how to begin systems change toward community engagement.

Teacher: Jillian Hopewell
Teacher: Emily Kane
Teacher: Theresa Lyons-Clampitt
If you are experiencing problems getting into Moodle please contact Jillian Hopewell (jhopewell@migrantclinician.org)
January 28, 2021

Module 1: The Pillars of Community Engagement

At the conclusion of this presentation, participants will be able to...

- Define the role of community engagement in addressing diabetes in primary care setting.
- Identify pillars for increasing and strengthening community engagement to address diabetes control.
- Explore existing tools and resources for health centers to assess their strengths and challenges in community engagement to address diabetes in a primary care setting.

How to Use the Fishbone Tool for Root Cause Analysis

Week 1 - Create Your Organizational Problem Statement
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**Source:** Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
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Upcoming Sessions

- **Session 2 - Data**
  Feb 11, 2021 @ 11-12:30pm PT / 2-3:30pm ET

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  Feb 25, 2021 @ 11-12:30pm PT / 2-3:30pm ET

- **Session 4 - Partnerships**
  Mar 11, 2021 @ 11-12:30pm PT / 2-3:30pm ET
Learning Objectives:

1. Increase patient compliance with regular testing and maintenance of diabetes
2. Demonstrate how to utilize data to obtain reimbursement and funding
3. Identify data sources to inform and determine success for short and long-terms diabetes management
Learning Objectives:
1. Define the framework and core principles of cultural humility and its relation to cultural competence in diabetes care
2. Address health care workers’ implicit biases through an exploration of one’s own lived experiences
3. Discuss key strategies to increase awareness and enhance skills to work across diverse cultures and navigate barriers in diabetes care
Learning Objectives:
1. Learn how to identify opportunities for forming strategic partnerships with other organizations to advance care for diabetic patients.
2. Explore the elements needed to insure that organizational partnerships are mutually beneficial.
3. Assess organizational readiness to engage in productive partnerships that benefit diabetic patients.
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CME/CNE Accreditation Available

- Please complete the post-session survey at the end to be eligible to receive CME/CNE units or a certificate of attendance.

- For questions, please contact Martha at malvarado@migrantclinician.org.
Raising the Pillars for Community Engagement

What are your questions and comments?
THANK YOU!

For information about the Special and Vulnerable Populations Diabetes Learning Collaborative, visit chcdiabetes.org today.

Feel free to contact our NTTAP collaborating partners and speakers from today’s session:

Albert Ayson, Jr.– aayson@aapcho.org
Joe Lee – joelee@aapcho.org
Emily Kane – ekane@phmc.org
Lauren Rockoff – lrockoff@phmc.org
Jillian Hopewell – jhopewell@migrantclinician.org
Theresa Lyons-Clampitt – tlyons@migrantclinician.org

At the end of this session, please complete the quick survey. Your feedback is greatly appreciated