Session 3 - Data + Cultural Humility
Thursday, February 25, 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
National Center for Equitable Care for Elders
National Center for Farmworker Health, Inc.
National Center for Health in Public Housing
National LGBT Health Education Center
National Network for Oral Health Access
National Nurse-Led Care Consortium
School-Based Health Alliance

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

Joe Lee, MSHA
Director of Strategic Initiatives and Partnerships of AAPCHO

Emily Kane, MPA
Senior Program Manager of NNCC

Lauren Rockoff, EdM
Public Health Program Manager of NNCC

Jillian Hopewell, MPA, MA
Director of Education & Communications of MCN

Theressa Lyons-Clampitt
Senior Program Manager, Training and Technical Assistance of MCN

AAPCHO

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

MIGRANT CLINICIANS NETWORK
Raising the Pillars for Community Engagement

TODAY’S GUEST FACULTY

Sophi Scarnewman | she / her
Project Manager / CQI Lead
Raising the Pillars for Community Engagement

Today's Agenda

- Welcome (5 min)
- Homework Recap + Presentation by Sophi (35 min)
  - Share Completed Fishbone Diagram - Breakouts
  - Fishbone Diagram Case Study by Sophi
- Cultural Humility and Identifying Cultural Barriers (30 min)
  - Presentation & Discussion
- Q&A (15 min)
- Closing & Homework Review (5 min)
  - Fishbone Diagram Homework Assignment
Raising the Pillars for Community Engagement

Fishbone Diagram - Template

[Data] [Cultural Barriers] [Partnerships] [Main Cause]

[Insert Problem Statement Here]

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC

Week 1 Assignment

Fillable diagram on Moodle
Raising the Pillars for Community Engagement

Fishbone Diagram - Problem Statements by LC Cohort Members

- “Better connection with potential participants not already engaged with the agencies.”
- “Better connection with potential participants that are not already engaged with our AAA (PTRC).”
- “There is no grocery store in Chester, PA”
- “Hemoglobin A1c (HbA1c) Poor Control (> 9%) is increasing for some health centers rather than decreasing to reach our Healthy 2020 goal of 16.2%.”
- Adapted from conversation: “The rate of A1c tests has decreased by 25% since the initiation of telehealth due to COVID-19.”
Raising the Pillars for Community Engagement

Fishbone Diagram - Template

[Data] [Cultural Barriers] [Partnerships] [Main Cause]

Week 2 Assignment

Fillable diagram on Moodle

[Insert Problem Statement Here]

X X X X X X X

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Raising the Pillars for Community Engagement

**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

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**Knowledge**
- Testing technique
- 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

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Source: Holyoke Health Center
Raising the Pillars for Community Engagement
Fishbone Diagram

[Data]
- Outstanding labs; whose is checking?
- # missed appointments; who is doing flu calls
- County, state DM data

[Main Cause]
- Knowledge—understand disease, treatment, medications, causes high blood glucose
- Access to healthy foods, food desserts
- Access to medications, MAP programs, FQHC prices

[Partnerships]
- Increased food prep knowledge
- Increased health food access
- Support group—hospital group (are we using it to the fullest; how do we partner?)

[Cultural Humility]
- Factor 1
- Factor 2
- Factor 3

Uncontrolled (A1c>9 or untested in past 12 months, 2020) >40% up from 1 yr ago

COVID, but previous # were >35%; we were not doing well before! COVID not a significant factor!

Observations/Questions:
- Missed flu DM appts; who monitors? Action plan?
- What drives 3 mo vs 6 mo DM flu by providers
- Outside labs not ordered by KPCHC provider not entered in EMR
- How many DM pts see RD (strong correlation b/t lower A12c)
- What other supports besides rx provided to pts? (exercise, food, rx, behavior health for DM fatigue, RD, support groups, compassion)
- A1c finger stick—do at MHK clinic why not JC? Cost, accuracy??
- Impact of healthy food rx when implemented (data)

Adapted from: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Hemoglobin A1c (HbA1c) Poor Control (> 9%) is increasing for health center A (from 44% to 50% in last 3 measurement periods) rather than decreasing to reach our Healthy 2020 goal of 16.2%.

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Raising the Pillars for Community Engagement

Community Engagement

- Data
- Cultural Humility
- Partnerships
Raising the Pillars for Community Engagement

CASE STUDY PRESENTATION - FISHBONE DIAGRAM

Sophi Scarnewman | she / her
Project Manager / CQI Lead

BRIGHTER BEGINNINGS
Every Family Matters
Background

● Brighter Beginnings Family Health Clinic is an FQHC Look-Alike in the East Bay Area
  ○ 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)

● Staff formally allocated to CQI in late 2019
  ○ Young clinic and new to CQI efforts
Lapse in Performance

- Unable to work with loss of childcare
- All administrative team attention was on keeping staff safe, follow the emerging and changing guidelines, and figuring out how to continue to care for our patients
- After getting childcare and returning to work, I discovered how much of a slide our CQMs had taken

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<td>41.7%</td>
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<td>61.1%</td>
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<td>Controlling High Blood Pressure (CMS165 v7, v8)</td>
<td>63.8%</td>
<td>68.7%</td>
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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
● Start somewhere
Both DM and HTN control CQMs are ~20 percentage points worse than this time last year.

Data

- CQMs are defined with multiple reasons someone can not meet the measure
- EHR has highly limited reporting abilities and cannot drill down
- Lack of historic CQM data makes it hard to have good benchmarks

Structural Barriers

- Patients cannot afford insulin
- Patients may not have time to attend appointments
- Lifestyle changes may be economically/practically infeasible

Partnerships

- Clinic sites in 2 different population hubs with different resources
- Lack of relationships with a "point person" can make it hard for patients to access high-demand or large programs
- New and/or part-time providers do not know what resources exist

COVID

- Patients may have harder time than ever affording meds & may be avoiding trips to pharmacy or clinic
- Shift to telemedicine at expense of BP monitoring and POC HbA1c testing
- Admin team hours for CQI lost to focus on COVID and lack of childcare

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
Both DM and HTN control CQMs are ~20 percentage points worse than this time last year.

Focus on:
What changed since last year?
What will be high impact?
Where can I do something now?

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Where to start?
- Focus on:
  - What changed since last year?
  - What will be high impact?
  - Where can I do something now?
Making the change

● Elevate 2020 (NACHC) webinars often mentioned registries
  ○ No special training or tools needed
  ○ Provides opportunity to get at the first level of “why”

● PDSA Cycle

● Collect data chart by chart and input in spreadsheet
  ○ Who was controlled, but overdue for a check? Who was already uncontrolled?

● Schedule appointments for curbside A1c and BP checks

● Experiment with risk stratification and communication methods
Analysis from Registry Spreadsheet

Diabetes Measure Compliance

- None recorded: 31.0%
- Out of range: 25.8%
- Controlled: 43.2%

HTN Measure Compliance Breakdown

- None recorded: 20.8%
- Out of range: 28.5%
- Controlled: 50.7%

“None recorded” is our missed opportunity
Impact

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

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Capitalizing on the Data Opportunity

● 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
Following Through

- Quarterly sweep conducted again in October
- Educating providers and staff on proper documentation
- Use live calls to engage patients for follow-up; SMS does not cut it
- Emphasize to staff importance of scheduling follow-up appointments

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...And get a new EHR!
Diabetes Continuum of Care: Raising the Pillars for Community Engagement

- Data
- Cultural Humility
- Partnerships
Raising the Pillars for Community Engagement

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
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

Lifelong learning and critical self-reflection
Developing institutional accountability
Recognizing and changing power imbalances

Shared responsibility for health

There should be greater emphasis on shared responsibility between patients and health professionals

Health professionals
The public

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

SAMPLE Cultural Humility Framework - Strategies for Diabetes Providers

**Lifelong learning and critical self-reflection**
- Culturally Appropriate Diabetes Health Education through MI, *and*…?

**Recognizing and changing power imbalances**
- Communicating the Value of the Patient’s Agenda + Establishing Cultural Safety

**Developing institutional accountability**
- Enabling Services Workforce Diversity + National CLAS Standards
SAMPLE Cultural Humility Framework - Strategies for Diabetes Providers

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Diabetes Continuum of Care: Raising the Pillars for Community Engagement

SAMPLE Cultural Humility Framework - Strategies for Diabetes Providers

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Recognizing and changing power imbalances
- Communicating the Value of the Patient’s Agenda + Establishing Cultural Safety

Developing institutional accountability
- Enabling Services Workforce Diversity + National CLAS Standards
Practicing Cultural Humility

- Lifelong learning and critical self-reflection
  - Work with a Pacific Islander subject matter expert
  - Utilize cultural communication practices
  - Understand and leverage existing tools/resources created by the PI region

- Recognizing and changing power imbalances
  - Use cultural strengths and practices to improve program delivery
  - Bi-directional evaluation
  - Adaptation and translation of the program curriculum

- Developing institutional accountability
  - Learn by “doing”
  - Added Pacific Islander leadership to AAPCHO’s Board of Directors
Raising the Pillars for Community Engagement

Fishbone Diagram - Template

[Data]

[Cultural Barriers]

[Partnerships]

[Main Cause]

[Insert Problem Statement Here]

Source: Special & Vulnerable Populations Diabetes Task Force, 2021 | AAPCHO, MCN, NNCC
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: Theressa Lyons-Clampitt
If you are experiencing problems getting into Moodle please contact Jillian Hopewell (jhopewell@migrantclinician.org)
Diabetes Continuum of Care: Raising the Pillars for Community Engagement

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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**Submission comments**

- [Add submission](#)

You have not added a submission yet.
Raising the Pillars for Community Engagement

Upcoming Sessions

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

Session 4 - Partnerships

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

**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.
Raising the Pillars for Community Engagement

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?

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

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Director of Strategic Initiatives and Partnerships of AAPCHO

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Theressa Lyons-Clampitt
Senior Program Manager, Training and Technical Assistance of MCN
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
   Theressa Lyons-Clampitt – tlyons@migrantclinician.org

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