Special & Vulnerable Populations

Diabetes Task Force

Improving Diabetes Care and Health Equity in a Changing Healthcare Landscape

DIABETES CONTINUUM OF CARE | JUNE 2022

INTRODUCTION

As part of the collaborative effort of the Special and Vulnerable Populations Diabetes Task Force to improve health outcomes for patients living with diabetes, the National LGBTQIA+ Health Education Center, the Corporation for Supportive Housing (CSH) and the National Center for Equitable Care for Elders (NCECE) developed a four-session learning collaborative. The learning collaborative convened 23 participants from 13 health centers to explore how COVID-19 has affected access to diabetes care and management for LGBTQIA+ people, older adults, and people with housing instability or those experiencing homelessness.

The learning collaborative: Improving Diabetes Care and Health Equity in a Changing Healthcare Landscape included four sessions over the course of one month. Participants engaged in dialogue on best and promising practices for reaching and supporting patients who face significant barriers to diabetes care and management, beginning with an introductory session that set the foundation for the relationship of intersectionality to LGBTQIA+ health, particularly for older LGBTQIA+ adults, and LGBTQIA+ people experiencing homelessness. In addition to this foundational session, health centers were asked to consider investing in three overarching implementation strategies to improve services in diabetes care and management in health centers, exploring the following topics in-depth:

- A commitment to examining the work of diabetes care and management through a racial equity lens, noting racism as a root cause of disparities and an exacerbation of inequity in health outcomes during a pandemic.
- The evaluation of telehealth programming to increase access to diabetes care, particularly for LGBTQIA+ people, LGBTQIA+ older and older adults, and LGBTQIA+ people experiencing homelessness.
- Investment in the creation of meaningful and sustainable partnerships with local, community-led organizations to improve outreach, care, and retention LGBTQIA+ people, older adults and people experiencing homelessness.

KEY FACTS

- **As of 2020, 26.8% of adults aged 65 and older in the United State are living with diabetes.[15] Older adults are more likely to experience complications related to diabetes, such as hypoglycemia and kidney failure than their younger counterparts.[16]**
- **LGBTQIA+ people, especially people of color,[17] are more likely to experience medical mistrust due to the discrimination and stigma faced when seeking care.[18]**
- **Compared with the general population, adults receiving housing assistance have higher rates of chronic health conditions[19] and need greater access to care**

SESSION ONE: FOUNDATIONS OF DIABETES CARE AND MANAGEMENT DURING COVID-19

The ongoing COVID-19 pandemic has further exposed the United States' diabetes crisis, revealing and exacerbating pre-existing challenges within diabetes care management and service efforts aimed at reducing disparities in diabetes care. In a pan-European survey of diabetes specialist nurses undertaken by the Foundation of European Nurses in Diabetes, it was found that the COVID-19 pandemic posed both physical and mental health risks for patients with diabetes, with providers reporting increased observances of acute diabetes events and new diagnoses of anxiety and depression in patients.[1] Additionally, 83% of diabetes nurses surveyed reported that overall care provision decreased either moderately, quite severely, or extremely at the height of COVID-19.[1] In the clinical setting, patients have experienced delays and disruptions in care, timely access to community services, and community programming that facilitated clinical care.[1] Lack of access to consistent diabetes care management had and continues to have consequences for health center patients. Diabetes co-occurs with other chronic conditions such as hypertension and chronic obstructive pulmonary disease (COPD) (30% and 13%, respectively),[1] further affecting overall health, wellness, and prescribed care of the patient.

The COVID-19 shutdown prompted an increase in sedentary and unhealthy eating behaviors, lack of motivation, and challenges in maintaining mental health and eliminating major stressors leading to new diabetes cases.[2] There are 1,375 health centers in the United States with over 13,550 unique sites. Across all health centers, there were 2,683,700 patients diagnosed with Diabetes in 2020, resulting in 8,743,412 health center visits for diabetes care and management.[3] Additionally, cases of Type 2 diabetes doubled among youth.[4] The pandemic also required patients with diabetes to self-manage an ongoing condition in the confines of their homes. In 2020, it was reported that 2,447,380 patients aged 18–75 with diabetes had hemoglobin A1C (HbA1c) greater than 9.0 amongst health centers.[3]

Effects of the COVID-19 pandemic on diabetes care and management for LGBTQIA+ people, particularly older adults and those experiencing homelessness or housing instability

At the onset of the COVID-19 pandemic, social distancing and stay at home orders increased isolation for older LGBTQIA+ adults who are more likely than non-LGBTQIA+ older adults to live alone and have limited to no familial support.[5] Individuals experiencing housing instability or homelessness have higher rates of mental illnesses and substance use disorders. They face significant barriers to diabetes care and health management because of a lack access to infrastructure and support needed to utilize telehealth resources during the COVID-19 pandemic.[6]

They also face overall higher rates of mortality and morbidity. Older adults have experienced disruptions in diabetes care management, through avoidance of routine and/or specialty care, due to concern for their safety throughout the ongoing pandemic. Older adults also experienced disruptions in diabetes care management by lack of equitable access to telehealth services due to factors such as low technology literacy and inconsistent or limited access to it.[7]

SESSION TWO: THE IMPACT OF RACISM ON DIABETES CARE AND MANAGEMENT DURING COVID-19

As part of the learning collaborative, diabetes care and management were evaluated through the lens of racial equity. Racism contributes to disparities during the COVID-19 pandemic, and it amplifies inequities in the health outcomes of racial and ethnic minorities who may also be older adults, homeless, or LGBTQIA+. While disparities in health outcomes effect all minorities in the United States, this learning collaborative focused on the health disparities faced by Black people who are disproportionately more likely to contract and die from COVID-19 and diabetes than white people.[8,9]

These racial disparities in health outcomes are not only the result of unequal social, economic, and political burdens[8] faced by Black people, but also a result of the barriers to care caused by the racial bias present in healthcare systems, front line staff, and medical providers. In a poll conducted by The Undefeated and the Kaiser Family Foundation (KFF), 70% Black people reported being unfairly treated in a medical setting because of their race.[10] Black people also reported more unfavorable experiences with the healthcare system than White people, including not being believed by their doctors, being denied treatments or tests they thought were necessary, and being denied pain medicine.[10] Due to these experiences, Black people are more likely to mistrust the medical system and medical providers, making them less likely to adhere to treatment programs and seek out recommended services that are necessary for the successful management of diabetes.[10]

To address these inequities and improve the care and management of diabetes for Black patients and other racial minorities, health centers must acknowledge the individual and systemic factors that cause racial inequity to persist in their health centers and the direct impact it had on the wellbeing of their patients. Implicit bias, microaggressions (the everyday verbal, behavioral, and environmental slights that communicate hostile, derogatory, or negative attitudes toward stigmatized or culturally marginalized groups) and the consequences of racist policies in the healthcare environment lead directly to disparities in treatment and health outcomes. To combat this, health centers should provide physicians with proper in-depth, mandatory, anti-bias training to reduce incidents of provider bias and increase the ability of providers to establish trusting relationships with patients who feel heard and believed.

KEY MESSAGE

While Black people are more likely to have chronic conditions, such as diabetes, when they seek care, they are less likely to have their provider listen to them or answer their questions.[10] To improve health outcomes, health centers must commit to and invest in policy reviews and provide mandatory anti-bias training to providers to reduce racial bias.

SESSION THREE: OPPORTUNITIES AND CHALLENGES FOR TELEHEALTH

Another topic of consideration for the learning collaborative was the use of telehealth to increase access to care. Telehealth services became a popular solution to disrupted in-person care following the COVID-19 pandemic. Since this shift has provided both efficiency and convenience, both providers and patients have benefited from its use. Patients are less likely to be inconvenienced by transportation costs or barriers to physical attendance, their time away from work has decreased, and the overall experience of receiving care has improved. A study on patient experiences of telehealth during the pandemic done by the COVID-19 Healthcare Coalition found that without telehealth, 54.5% believed that they would delay their care and 28.3% would have self-treated.[11]

These findings display the necessity of telehealth in providing access to care. This is further confirmed by the 81% of patients that felt telehealth provided them with greater access and continuity of care.[11] However, telehealth services are not always accessible to everyone, particularly those who experience barriers to healthcare. Individuals experiencing housing instability or homelessness may not have had reliable access to the technical support necessary to utilize telehealth resources.[6] Older adults may also have neither consistent access to technical devices nor the technical literacy to successfully access telehealth care.[12] This lack of access to consistent management care had, and continues to have, consequences for health center patients. Therefore, telehealth is not a complete solution for all patients, so all measures should be taken to reduce or eliminate these barriers when possible.

Despite these limitations, there are solutions that health centers can implement to reduce barriers to accessing telehealth services. Health centers should leverage communication with patients who use their telehealth platform to determine how services are reaching patients, especially vulnerable populations, to determine what their needs are and what is missing. This as well as further internal audits may help health organizations determine problems and priorities that can improve telehealth services. There should be further considerations for removing financial barriers, providing digital literacy training, accessible services that support patients and providers transitioning to a telehealth platform, and an inclusive design that considers language barriers as well as visual and auditory impairment (see the resource section for more information).

KEY MESSAGE

To reduce barriers to accessing health care for patients who cannot afford telehealth, have telehealth and mask-wearing options at the health center as well as referrals to services that provide masked and physically distant home visits.[5]

SESSION FOUR: COMMUNITY PARTNERSHIPS ARE ESSENTIAL TO IMPROVING DIABETES CARE

The root causes of uncontrolled diabetes and other chronic conditions experienced by populations such as the unhoused, LGBTQIA+, People of Color and older adults can be traced back to social determinants. Building and sustaining effective partnerships between health and housing providers is essential for diabetes care but also the broader delivery of quality primary health care, mental health, substance use and housing needs. Community responses to the COVID-19 pandemic such as shelter-in-place, quarantine, testing, and management of strained health resources have elevated the necessity and value of effective health and housing partnerships to address the needs of vulnerable patient populations.[13,14]

The Corporation for Supportive Housing (CSH) identifies a four-stage best practice that leads from determining why health center and supportive housing collaborations work, how to build them and ultimately make them last.

Stage I: Make the Case starts with your awareness and capacity to lead a partnership, being very realistic about the commitment and value a partnership or collaboration would bring.
Stage II: Make it Happen guides you in exploring your community to identify and assess organizations that might fit with your needs and goals.
Stage III: Make it Work challenges you to start conversations and connect with potential partners, share information, and design and implement a plan with partners who are a fit.
Stage IV: Make it Last ensures you take steps to make a collaboration that can be sustained

A key best practice to ensure continued partnership and care coordination is to leverage current cross-sector workgroups to advance on joint projects and funding requests that could support and maintain care coordination successes. Alternatively, referral relationships can be a starting point for organizations not yet ready to engage in a formal partnership. This approach is loosely structured and requires a low degree of collaboration; as referrals do not require a large-scale partnership plan or written agreements. Successful referrals involve communication between direct service staff at all partnering agencies to ensure a “warm hand-off” for clients. Referrals work well for low-acuity populations, as clients must access services without intensive support. It is important to consider that many referral relationships evolve into more collaborative partnerships as community systems become further integrated and providers are challenged to meet needs that span these systems.

KEY MESSAGE

To prepare for any future public health emergency, a memorandum of understanding (MOU) should be drawn up between health and housing providers now, to identify roles and protocols for addressing the health needs of staff and residents in housing and education, infection control, testing, isolation/quarantine, and re-housing strategies.

SPOTLIGHT:
BEST PRACTICES IN TELEHEALTH
FENWAY HEALTH, BOSTON MA

"As long as I can remember, I hoped I would be able to speak with my doctor over the phone or virtually. This has been a godsend for me and makes it much easier to prioritize my health."

-Patient, Fenway Health

- **Assess your health center's readiness for telehealth implementation, beginning with an internal audit to determine gaps in care, and the potential for telehealth to fulfill or uphold the vision, mission, and strategic plan. Organizational buy-in is key and whenever possible, include patients in the design process**
- **In addition to the privacy and security of patient information, consider technology and platform choice to include interoperability, ease of use, reliability, and scalability**
- **Establish a solid plan to address equity and quality improvement, including continuous team-driven Plan-Do-Study-Act (PDSA) systems for monitoring program metrics, workflow maps, and documented policies and procedures**

RESOURCES

- Diabetes and Coronavirus (COVID-19) | ADA
- Recognizing the Role of Systemic Racism in Diabetes Disparities
- Structural Racism: What Can I Do as a Diabetes Care and Education Specialist?
- Racism is a Public Health Crisis
- Bridging the Digital Divide: Problem Solving Barriers to Virtual Care
- Electronic Patient Engagement Tool Selection Rubric
- Telehealth Playbook
- Health and Housing Partnership (12/9/21)
- COVID-19: A Framework for Health and Housing Partnership During the Pandemic

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NATIONAL TRAINING & TECHNICAL ASSISTANCE PARTNERS

National LGBTQIA+ Health Education Center
https://www.lgbtqiahealtheducation.org/

The Corporation for Supportive Housing
https://www.csh.org/hrsa

National Center for Equitable Care for Elders
https://ece.hsdm.harvard.edu/

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