Diabetes Continuum of Care: Using Referrals, Outreach, and Care Coordination to Address Oral Health and Diabetes

Thursday, March 14, 2019
8am HT / 11am PT / 1pm CT / 2pm ET

Welcome!
We will begin in a few minutes.
Diabetes Continuum of Care: Using Referrals, Outreach, and Care Coordination to Address Oral Health and Diabetes

MODERATORS & ORGANIZERS

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AAPCHO
Association of Asian Pacific Community Health Organizations

MCN
Migrant Clinicians Network
ABOUT THE SERIES

Diabetes affects more than 30 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 medically underserved racial and ethnic minority populations. In addition to higher prevalence, ethnic and racial minority patients with diabetes have higher mortality and higher rates of diabetic complications.

To combat and continue the national conversation around diabetes, 13 National Cooperative Agreement (NCA) organizations have partnered to create a four-part national learning webinar series to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase foundation knowledge of effective strategies to prevent, treat, and manage diabetes among special and vulnerable Health Center Program patients.

This year’s national learning series is focused on co-morbidities associated with diabetes (e.g., oral health, behavioral health, substance abuse disorders, obesity, and social determinants of health). This series complements with HRSA’s working draft of the “Diabetes Clinical Change Package” (to be published this year).

Register for the National Learning Series today at diabetes.aapcho.org.
WEBINAR FACULTY

NATIONAL COOPERATIVE AGREEMENT (NCA) ORGANIZATION PARTNERS

Association of Asian Pacific Community Health Organizations
Corporation for Supportive Housing
Farmworker Justice
Fenway Health
Health Outreach Partners
MHP Salud
Migrant Clinicians Network
National Center for Equitable Care for Elders
National Center for Farmworker Health
National Center for Health and Public Housing
National Health Care for the Homeless Council
National Network for Oral Health Access
National Nurse-Led Care Consortium
School-Based Health Alliance

FOR MORE INFO ON OUR NCA PARTNERS, VISIT DIABETES.AAPCHO.ORG.
HRSA Funded Diabetes Activities 2018-2019

- Individual or Small Group National Cooperative Agreement Diabetes Learning Collaboratives
- Special and Vulnerable Population Diabetes Task Force
- Decrease the percentage of patients with A1c greater than 9
- Diabetes Quality Improvement (DQI) Peer Learning Team
- Clinical Change Package for Diabetes Care
Strategic Partners’ Technical Assistance Strategies to Prevent and Manage Diabetes

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

**Optimizing Provider & Multidisciplinary Teams**
- 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 Patients**
- CHW Directed Patient Education
- Lifestyle/Self-Management
- Promote Physical Activity and Healthy Diets
- Address Childhood & Adult Obesity
- Increase Patient Health Literacy
LEARNING OBJECTIVES

1) To describe why accessing oral health care for patients with diabetes is both essential and difficult.

2) To identify the roles and responsibilities integral to a patient-centered, multi-disciplinary care team.

3) To describe the function of outreach workers in care coordination and on a care team.
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TODAY'S SPEAKERS

Irene Hilton, DDS, MPH
Dental Consultant

Emily Kane, MPA
Senior Program Manager

Diana Lieu
Senior Manager

NNOHA
National Network for Oral Health Access

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.
NLS Housekeeping

Viewer Window

AAPCHO Webinars
Organizer: AAPCHO Meetings | Presenter: AAPCHO Meetings

Control Panel
Questions & Comments

- Questions can be submitted via the GoToWebinar ‘Questions’ screen at any time.
- We will address questions and comments at the end of the webinar.
- Webinar slides and video recording will be emailed to all participants after the end of the webinar.
- Interact with us on Twitter @AAPCHOtweets and use #DiabetesNationalLearningSeries.
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.

For questions, please contact Martha at malvarado@migrantclinician.org.
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Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.
Accessing Oral Health Care for Patients with Diabetes

You cannot have good health if you have bad teeth!
Strategic Partners’ Technical Assistance Strategies to Prevent and Manage Diabetes

### Improving Health Systems & Infrastructure
- EHRs with Diabetes Modules
- Diabetes Informatics
- Health Information Exchange (HIE) & Telemedicine
- Patient Centered Medical Home (PCMH)
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### Optimizing Provider & Multidisciplinary Teams
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Oral Manifestations of Diabetes

• Periodontal (gum) disease
• Dry mouth
• Dental cavities
• Tooth loss
• Oral Candidiasis
• Burning mouth syndrome
• Alterations in taste
Diabetic Periodontitis
Area Foot Ulcer < Area Ulcerated Infected Periodontal Pockets
What we Know...

• Persons with diabetes have higher prevalence of periodontal disease, more severe disease

• Periodontitis can adversely affect glycemic control in diabetics

• Periodontal treatment had short-term effect on lowering A1c (baseline A1c 7-9)
HRSA Integration of Oral Health and Primary Care Practice (IOHPCP)


Oral Health Core Clinical Competency Domains

1. Risk assessment
2. Oral health evaluation
3. Preventive interventions
4. Communication & education
5. Interprofessional collaborative practice
Mrs. Garcia

- 70 y/o
- Recently diagnosed
- Discussing healthy food choices
- She states she cannot really eat fresh fruits & vegetables because her teeth hurt
Assess: Ask...

• Are you having any dental problems...pain, bleeding gums, problems eating?

• When was your last dental examination?

• Where do you usually go?
Evaluate: Signs of Oral Disease

**Periodontal Disease**
- Bleeding, red, swollen gums
- Pus
- Bad breath or bad taste
- Teeth loose or separating
- Changes in bite

**Dental Cavities**
- Holes in teeth
- Pain when eating or to hot or cold foods
Referral: Interprofessional Collaboration

• Mrs. Garcia says it’s been 5 years since her last dental visit for an extraction
• Your state Medicaid adult dental benefit only covers emergency extractions

What do you do?
Challenges - Funding

- Medicare does not cover dental treatment
- State Medicaid programs may not cover adult dental care or may not cover periodontal treatment
# State Medicaid Dental Benefits

<table>
<thead>
<tr>
<th>Dental Benefits Category</th>
<th>Offered to Medicaid Base Population</th>
<th>Offered to Medicaid Expansion Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dental benefits</td>
<td>3 states: AL, DE, TN</td>
<td>2 states: DE, ND</td>
</tr>
<tr>
<td>Emergency-Only</td>
<td>14 states: AZ, FL, GA, HI, ID, ME, MD, MS, NV, NH, OK, TX, UT, WV</td>
<td>6 states: AZ, HI, MD, NV, NH, WV</td>
</tr>
<tr>
<td>Limited</td>
<td>17 states: AR, CO, IL, IN, KS, KY, LA, MI, MN, MO, NE, PA, SC, SD, VT, VA, WY</td>
<td>10 states: AR, CO, IL, IN, KY, LA, MI, MN, PA, VT</td>
</tr>
<tr>
<td>Extensive</td>
<td>17 states: AK, CA, CT, DC, IA, MA, MT, NJ, NM, NY, NC, ND, OH, OR, RI, WA, WI</td>
<td>14 states: AK, CA, CT, DC, IA, MA, MT, NJ, NM, NY, OH, OR, RI, WA</td>
</tr>
</tbody>
</table>

[16] https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_011618.pdf
Challenges - Capacity

• 78% of health centers have at least one dental site/contractor

BUT

• Capacity of health center dental programs is 26% of primary care capacity
Increasing Access to Dental Care

- Brick & mortar expansion
- Mobile programs
- Teledentistry/VDH
- Contracting
- Academic partnerships with dental education programs
- Integration of Oral Health and Primary Care Practice
Accessing Oral Health Care & other Services for Patients with Diabetes

The Role of Team-based Care and Care Coordination
Resources


Contact Us!

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Health Outreach Partners
Healthy People. Equitable Communities.
Teams and Teamwork in Primary Care
Does your health center operate with a team-based care model?

- Yes
- No
- Not sure
“The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”

National Academy of Medicine
<table>
<thead>
<tr>
<th>Patient &amp; Family Outcomes</th>
<th>Team Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>Satisfaction</td>
</tr>
<tr>
<td>Engagement</td>
<td>Productivity</td>
</tr>
<tr>
<td>Adherence</td>
<td>Accurate problem identification</td>
</tr>
<tr>
<td>Self-care</td>
<td>Fewer errors</td>
</tr>
<tr>
<td>Fewer missed visits</td>
<td>Less turnover</td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td></td>
</tr>
</tbody>
</table>
Quadruple Aim Framework

- Better care
- More satisfied patients
- Lower total medical costs
- More satisfied providers
Defining Team Roles and Responsibilities
Roles and Responsibilities for Effective Teamwork

• All roles are understood and respected

• Scope and responsibilities of each role are explicit

• Each team member understands how his/her role fits in the work of the team
Role Clarity

- Competencies
- Scope of practice
- Licensure
- Values and ethics
- Education / accreditation standards
The patient’s role on patient-centered primary care teams

- Provide information about own health and experience
- Describe and report changes in health status
- Share response to self-care and treatments
- Identify factors that help and hinder engagement and achieving health goals
Mrs. Garcia identifies other aspects of her life that impact her care. She reports dental pain and symptoms, including pain eating fruits and vegetables. She discusses some of her other health concerns, isolation, etc. She describes the resources she has access to in the community.
Swim Lane Diagramming

A swim lane diagram assists with role clarification and efficiency.
Example: Swim Lane Diagram for a Physician Assistant Office Visit

Adapted from “Physician Assistant (PA) Office Visit” available at:
RACI Matrix

- Responsible, Accountable, Consulted, Informed
- Defining these roles for a task improves clarity, ownership and communication
- Identify functional roles (e.g., front desk, RN, etc.)
- Identify activities or decisions
- Good for QI projects or introducing new EBIs
## RACI Matrix Example – Academic Dentistry Partnership

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Medical Director</th>
<th>RN</th>
<th>MA</th>
<th>Executive Director</th>
<th>Admin Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research best practices for academic partnerships</td>
<td></td>
<td>I</td>
<td></td>
<td>A</td>
<td>R</td>
</tr>
<tr>
<td>Create registry of patients with oral health comorbidities</td>
<td>I</td>
<td>R</td>
<td></td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Create/adopt screening tool for patients in need of oral health services</td>
<td>R</td>
<td>C</td>
<td></td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Create workflow for partnership implementation</td>
<td>R</td>
<td>I</td>
<td>I</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Create materials promoting new services to patients</td>
<td></td>
<td></td>
<td>I</td>
<td>C</td>
<td>R</td>
</tr>
<tr>
<td>Create and execute MOU with academic institution partner(s)</td>
<td>C</td>
<td></td>
<td></td>
<td>R</td>
<td>I</td>
</tr>
</tbody>
</table>
Roles and Responsibilities: It Takes a Team!

http://links.asu.edu/fm3
Optimizing Team Roles
Optimizing Team Roles

Demand

Team composition
Visit scheduling
Workflows
Optimization Principles

• All team members work to their highest level of expertise, skill and licensure

• Team composition driven by:
  – Patient/family/population needs and
  – Characteristics of practice

• Look for potential for cross-training to maximize flexibility and flow
## Team Redesign

<table>
<thead>
<tr>
<th>Primary care team members</th>
<th>Redesign examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td>• Expanded care coordination and education</td>
</tr>
<tr>
<td></td>
<td>• Health promotion, chronic illness management</td>
</tr>
<tr>
<td>Medical assistant</td>
<td>• Expanded responsibility for procedures</td>
</tr>
<tr>
<td></td>
<td>• Workflow oversight</td>
</tr>
<tr>
<td>Behavioral health professional</td>
<td>• Co-located, integrated</td>
</tr>
</tbody>
</table>
For additional reference on role re-design

https://www.niddk.nih.gov

https://www.brookings.edu
For additional reference on Primary Care Team Re-design: Project LEAP: Learning from Effective Ambulatory Practices

http://improvingprimarycare.org/
Final Questions
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[Logo]

Health Outreach Partners
The Role of Outreach/Community Health Workers in Care Coordination
What is Care Management?
“Evidence-based, integrated clinical care activities that are patient-specific and ensure that every patient has a coordinated plan of care and services. At the center of this is a care plan, developed collaboratively by the patient and care providers.”

What is Care Coordination?
“Deliberately organizing patient care activities between two or more participants (including the patient) involved in patient care to facilitate and ensure that delivery of health services is appropriate, safe, and efficient. Organizing care involves the exchange of information among participants responsible for different aspects of care.”
IMPROVE PATIENT HEALTH

HEALTH CARE SYSTEM

PRIMARY CARE PROVIDER

SPECIALTY CARE

MENTAL HEALTH SERVICES

PATIENT

FAMILY

NURSE

PHARMACIST

COMMUNITY HEALTH WORKER
Mrs. Garcia is a Primary Care Provider, a Behavioral Health Community Health Worker, a Registered Nurse, a Diabetes Educator, and an Oral Health Provider. She is part of a broader system that includes family. Additionally, she is associated with Health Outreach Partners and the National Nurse-Led Care Consortium.
Who Are Community Health Workers?

“A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”

- American Public Health Association
Other Titles

- Outreach Worker
- Peer Educator/Peer Health Educator
- Community Health Representative
- Health Coach

- Health Aide
- Patient Navigator
- Promotora de Salud
Why Include CHWs in Care Coordination?

- Liaisons to the community
- Language and Cultural Competency
- Improved quality of care
- Cost Savings
  - Supports Clinical Efficiency
  - Meet PCMH/PCHH or pay-for-performance incentives
The most frequently reported CHW roles on care teams are:

- Helping people gain access to medical services (86%)
- Advocating for individual needs (86%)
- Teaching people how to use health care and social services (78%)
- Helping people manage chronic conditions (77%)
### The Role of Outreach in Care Coordination

<table>
<thead>
<tr>
<th>Role</th>
<th>Tasks</th>
</tr>
</thead>
</table>
| Community Outreach          | • Work in communities, neighborhoods, or client homes  
• Serve as liaison between clinical and community settings  
• Translate across linguistic and cultural boundaries  
• Identify potential barriers to information or physical care |
| Resource Navigation         | • Inform and enable access to available community services and support groups  
• Refer and provide warm handoff to appropriate health care and social services providers |
| Health Literacy Support     | • Inform client about health promotion and illness prevention  
• Identify knowledge gaps and inaccurate information about the health system, eligibility, or benefits  
• Fill knowledge gaps or assist client in correcting inaccurate assumptions |
| Client Engagement           | • Assess the client’s readiness through motivational interviewing techniques  
• Support client in goal setting, prioritization, and attainment  
• Encourage and support healthful behavior change  
• Facilitate client self-management according to a shared plan of care |
| Logistic Support            | • Manage multiple appointments  
• Provide transportation assistance  
• Accompany clients to appointments for cultural and linguistic translation if appropriate  
• Assist client in ensuring continual supply of medications, equipment and supplies, as well as meals |
A CHW’s Role on a Care Team

• On a care team, CHWs are the experts in the patient’s environment and culture

• CHWs should be treated as peers to other team members

• CHWs do not have a clinical role on a team
Healthy Teeth Healthy Communities

• Cross-sector collaboration led by Alameda County to help Medicaid eligible children access dental services

• Employs 26 Community Dental Care Coordinators at health centers and social service organizations.

• Help families and children make dental appointments and connects them to a dental health home

• Supports with continuity of care through follow-ups with dental providers

• Trained to work with a variety of providers and to provide referrals for other issues they encounter.
Benton County Health Services

- CHWs are an integral part of BCHS' delivery of quality care.
- 22 CHWs serving as health navigators who are heavily involved with care coordination.
- Roles: outreach and enrollment, clinic support, connecting students and families to social services, policy and advocacy.
- Care teams work/sit in the same work space and are composed of physicians, registered nurses, medical assistants, pharmacists, behaviorists, and CHWs.
- CHWs discuss with the care team barriers that prevent patients from taking medication or accessing care.
- Care team provides treatment by working closely with CHWs.
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What are your questions and comments?

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HEALTHY PEOPLE, EQUITABLE COMMUNITIES.
DIABETES IN SPECIAL & VULNERABLE POPULATIONS: A NATIONAL LEARNING SERIES

WEBINAR TOPICS

WEBINAR #1
Thursday, March 14
Diabetes Continuum of Care: Using Referrals, Outreach, and Care Coordination to Address Oral Health and Diabetes

WEBINAR #2
Tuesday, April 9
Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

WEBINAR #3
Thursday, April 18
Diabetes Continuum of Care: Using Health Promotion/Behavior Change to Address Childhood and Adult Obesity and Diabetes

WEBINAR #4
Thursday, April 23
Diabetes Continuum of Care: Using the CHW and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

REGISTER TODAY AT DIABETES.AAPCHO.ORG
SAVE THE DATE FOR WEBINAR #2

Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

NCA Faculty

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REGISTER TODAY AT DIABETES.AAPCHO.ORG
THANK YOU!

For more information about the Diabetes National Learning Series, visit diabetes.aapcho.org today.

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

Irene Hilton - irene@nnoha.org
Emily Kane - ekane@nncc.us
Diana Lieu - diana@outreach-partners.org

At the end of this webinar, please complete the evaluation form. Your feedback is greatly appreciated.