Diabetes in Special and Vulnerable Populations: A National Learning Series

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AAPCHO

MCN
Learning Objectives:

1. Better understand the national T/TA efforts to support health centers in addressing diabetes

2. Gain insight on important lessons learned from the previous National Diabetes Collaborative work
About AAPCHO

• The Association of Asian Pacific Community Health Organizations (AAPCHO) was formed in 1987
• National association of 35 community health organizations serving Asian Americans, Native Hawaiians, and other Pacific Islanders (AA&NHPIs)
• Dedicated to improving the health status and access for these medically underserved communities
• BPHC funded NCA to provide T/TA to AA&NHPI serving health centers
MIGRANT CLINICIANS NETWORK

“To be a force for health justice for the mobile poor”

Environmental and Occupational Health
Continuity of Care
Clinical Expertise
Violence Prevention
Training & Technical Assistance Services
MCN’s primary constituents

- Migrants, Mobile Patients, Other Vulnerable Workers
- Clinicians
  - Health educators
  - Nurses
  - Primary care providers
  - Dentists
  - Social workers
  - CHWs
  - Outreach workers
  - Medical assistants
- Federally funded Migrant & Community Health Centers
- State and local health departments
Participating NCAs in Special and Vulnerable Populations Diabetes Task Force

• Association of Asian Pacific Community Health Organizations (AAPCHO)
• Corporation for Supportive Housing (CSH)
• Farmworker Justice (FJ)
• Health Outreach Partners (HOP)
• Migrant Clinicians Network (MCN)
• MHP Salud
• National Association for Community Health Center (NACHC)
• National Center for Farmworker Health (NCFH)
• National Center for Health in Public Housing (NCHPC)
• National Center for Equitable Care for the Elderly (ECE)
• National Health Care for the Homeless Council (NHCHC)
• National LGBT Health Education Center
• National Network for Oral Health Access (NNOHA)
• National Nurse-Led Care Consortium (NNLCC)
• School-Based Health Alliance (SBHA)
Housekeeping

AAPCHO Webinars
Organizer: AAPCHO Meetings | Presenter: AAPCHO Meetings
Questions and Comments

- We will address questions and comments at the end of the webinar
- Please enter your questions and comments in the Question field
Webinar Recording

• In case of technical difficulties- yours or ours- Relax! We are recording the webinar and will make the recorded session along with presentation and any resources available.
Questions?

- Please enter your questions and comments in the Question field
2017-2020
HRSA Focus
on Diabetes
HRSA Funded Diabetes Activities 2017-2018

Decrease the percentage of patients with A1c greater than 9

Individual or Small Group National Cooperative Agreement Diabetes Learning Collaboratives

Special and Vulnerable Population Diabetes Task Force

Diabetes Quality Improvement (DQI) Peer Learning Team

Clinical Change Package for Diabetes Care
Special and Vulnerable Population Diabetes Task Force

Decrease the percentage of patients with A1c greater than 9

Chaired by MCN

Members
- SBHA
- AAPCHO
- NCHPH
- CSH
- MHP Salud
- NCFH
- NNOHA
- NHCHC
- ECE
- NNCC
- Nat’l LGBT Health Education Center
- HOP
- MCN
- FJ

Activities Include: 4-part webinar series; HC Learning Collaborative to test strategies across special/vulnerable populations; Resource compendium (coordinated with overall National Resource Center)

Clinical Change Package for Diabetes Care

Individual or Small Group National Cooperative Agreement Diabetes Learning Collaboratives

Diabetes Quality Improvement (DQI) Peer Learning Team
What is your experience with the health disparities collaboratives?
What were the collaboratives?
Not a band aid or cookbook approach

- Quality improvement model
- Redesign of processes to improve delivery of care
- Standards of care - quality of care
- Nationally benchmarked indicators
Key Elements

Change primary health care practices (clinical, clerical and administrative) in order to...

Improve the health care provided to everyone and to...

Eliminate health disparities.

Quality improvement initiative integrating:

- Delivery systems design
- Organization of health care
- Clinical information systems
- Community resources and policies
- Self-management principles
- Decision support

Not time-limited
Community Resources and Policies

- **Identify Community Resources**
- **Make patients aware of community resources and make community resources easily accessible**
- **Participate (collaborate) with community agencies**
- **Assess the needs of the community**
Are you included in your annual business plan/health care plan (federal grant) and in the organization’s strategic plan?

Collaborative goals incorporated in the mission and vision statements

Performance improvement model for the organization

Performance appraisals and job descriptions

Senior leadership commitment - CEO, Medical Director, other management/leadership levels

Health System Organization
Evidence-based guidelines integrated into clinical practice

- ADA guidelines for care
- foot exams
- 2 A1c’s >3 months <12 months apart
- A1c less than 8
- annual retinal exam
- lipids
- bp < 130/80
Decision Support

Protocols for Diabetes Care

How do you integrate generalists and specialists care? (referrals, feedback)

How do you get buy-in from your providers for following guidelines and making appropriate referrals?
Community
Resources and Policies

Health Systems
Organization of Health Care

Self-Management Support

Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes
Proactive, well patient diabetes visits instead of crisis management and sick/acute visits
Redesign patient visit to integrate team care, better patient flow, better quality of care
Team concept of care

- nutritionist
- dental
- podiatrist
- office staff
- nurses
- MAs
- front office staff
- provider
- outreach workers (CHWs)
Clinical Information Systems

Identify your population of focus

☑ Target population
☑ How do you find 250.xx patients

This was a real issue in late 1990s before broad EHR implementation
Registry- DEMS/CVDEMS/PECS
Visit notes, queries, reports
Are you doing anything with the data?
Do you data used for individualized care planning, patient recall, etc?

Paper Charts are CIS, too!
Documentation of delivery of evidenced-based care
Self Management Support

Self-management contracts

The patient is accountable for disease management and health outcomes.

Education increases the patients ability to make informed decisions about the care received and health outcomes.

Goals set by the patient
Self-management support

Labs, etc. provide feedback to the patient

Peer/support groups (CHWs huge help)

Behavior change programs (smoking, weight control)

Empower the patient to talk/ask questions of the provider

Informed, activated patient
Community Resources and Policies

Self-Management Support

Health Systems Organization of Health Care

Delivery System Design

Decision Support

Clinical Information Systems

Informed, Activated Patient

Prepared, Proactive Practice Team

Productive Interactions

Improved Outcomes
**Decreased wait times**

- Patients have 2 A1cs
- Patients have appropriate referrals
- Patients have documented foot checks

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**Clinical Outcomes**

- Patient A1c is less than 8
- Blood pressure is <130/80
- Patient takes ASA
- Patient stops smoking

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**Functional Outcomes**
Diabetes 1:
- 88 health centers participated in the first Diabetes Collaborative
- 16,000 people with diabetes enrolled in registries

Diabetes 2
- 115 health centers participated
- 40 health centers and school-based health centers participate in the Asthma and Depression Collaboratives.

Final Numbers ????
Transform practice: Models

- **Chronic Care Model**: a population-based model that relies on knowing which patients need care, assuring that they receive knowledge-based care and actively aids them to participate in their own care.

- **Improvement Model**: How to test changes in a system of care in a fast and efficient way, ensures that changes are an improvement, and expand the changes throughout the practice.

- **Learning Model**: A performance-based learning method that supports a community of learners to apply, adapt, share, and generate knowledge, and spread positive change.
Phase 1

Select Topic

Planning Group

Identify Change Concepts

Pre-work

Time for setting aims, allocating resources, preparing baseline data leading to the first 2 day meeting.

Action period 1: Adapt and test the ideas for improved system of care

Action period 2: Further develop the system of care at the pilot site and spread the system to other sites

Congress & beyond

Supports

E-mail
Assessments
Senior Leader Reports

Phase 2

1. Sustain and Spread
2. Continued reporting and progress toward national goals
3. Integration of models into the organizational structure
4. Increasing registry size
5. Continued support and interaction
Collaboratives Areas of Focus

- Diabetes: 334 Health Centers
- Cardiovascular: 54 Health Centers
- Asthma: 60 Health Centers
- Depression: 53 Health Centers
- Cancer pilot: 12 Health Centers
- Prevention pilots: 10 Health Centers
<table>
<thead>
<tr>
<th>Outcomes at a glance....</th>
<th>Almost 60,000 patients in clinical MIS to track/manage care</th>
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<tbody>
<tr>
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<td>Major improvement in glucose control</td>
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<td>Improved blood pressure control</td>
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<td>Appropriate use of drugs for asthma</td>
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<td>High rates of follow-up and improved symptoms for depression</td>
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<td>Increase in patient self-management</td>
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Number of Health Center Patients* in Clinical Information Systems

*From Diabetes I, II, III, CVD I, and Asthma II

DM1 (51% of teams reporting)  
DM2 (61% of teams reporting)  
DM3 (94% of teams with CVD)  
Asthma II  
CVD (94% of teams combined with DM3)  
TOTAL

54,815
Improved Outcomes

Year 1
- Started with average HGBA1C of 9.8
- Ended with 8.0

Year 2
- Ended with 7.8

Year 3
- Ended with 7.4 average
Do you know the percentage of your health center’s diabetic patients whose HA1c is > 9?
In 2016 the percentage of diabetic health center patients with an \textbf{A1c} > 9.0 was 32.1\% and has not gone below 30\% in the last four years.

6.5\% of health centers in 2016 were at or below the Health People 2020 goal of 16.2\% of diabetic patients with an A1c below 9.0.
Comparative Data in the Private Sector

Ethnic Disparities in Diabetic Complications in an Insured Population

*JAMA, May 15, 2002—Vol. 287, No. 19*

<table>
<thead>
<tr>
<th>HbA1c Level, mean (SD)</th>
<th>Black</th>
<th>Asian</th>
<th>Latino</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.9 (1.8)</td>
<td>8.7 (1.8)</td>
<td>8.8 (2.0)</td>
<td>8.4 (1.8)</td>
</tr>
</tbody>
</table>

That same year, health center diabetic patients in the collaborative averaged a HA1c of 7.4.
21 Years of innovation
HEALTH NETWORK

Bridge Case Management

- Ongoing communication
- Care coordination services
- Store & transfer medical records
- Health education
- Toll-free access
- Expert, bilingual, culturally-competent staff
Health Network Enrollment Criteria

1. **Patient is:**
   - Already mobile OR
   - Likely to move

2. **Patient is in need of a clinic for follow-up of ANY health condition**

3. **Clinic Must:**
   - Complete Enrollment Registration
   - Have patient sign Consent/Send
   - Send Medical Records
Contacts patients on a scheduled basis (monthly for TB patients)

Contacts clinics monthly

Assists patients in locating clinics for services and resources

Reports back to the enrolling clinic and notifies them of outcomes
2,951 total clinics in U.S. and over 111 countries
Over 11,461 total HN enrollments
“Fernando” is a 56 year old migrant farmworker diagnosed with diabetes at age 49. He traveled each year from South Texas to Minnesota or “wherever I can find work.”

Enrolled in Health Network 8/02
10/02
1/03
10/03
10/07
Enrolled in Health Network 8/02
10/02
11/05
6/07

Fernando was closed out of Health Network in 2013 because he said that he was no longer migrating.

Over the ten years he was enrolled, Health Network made
46 clinic contacts,
124 patient contacts,
transferred medical records 9 times to 6 different clinics.

Fernando was closed out of Health Network in 2013 because he said that he was no longer migrating.
Fernando’s HBA1c While Enrolled in Health Network
Health Network IMPACT

- Bridge between patients and their providers
- Fewer patients lost to follow up
- Higher % of patients completing treatment
- Treatment completion reports
- Improved patient participation
Pearls from the Collaboratives

Need to not only obtain clean accurate data but ANALYSE AND ACT on the results

Focus added effort/resources on individuals with poor diabetic control

Remember this is a “team sport” each individual has an important role to play

Self-management is your most cost effective and most powerful tool in your clinical toolbox
Questions?
Contact

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Housing Instability & Diabetes Outcomes in Agricultural Workers and LGBT Communities

Upcoming Webinar - SAVE THE DATE!
Thursday December 14, 2017
11:00am -12:00pm PST; 1:00pm – 2:00pm EST
REGISTER: https://register.gotowebinar.com/#register/7861271030958727427
Upcoming Webinar - SAVE THE DATE!
Monday January 29, 2018
9:00-10:30am PST; 12:00 -1:30pm EST
REGISTER:
https://attendee.gotowebinar.com/register/8527482718589205506
Diabetes Clinical Management & Periodontal Care for Diabetes Patients & Individuals Experiencing Homelessness

Upcoming Webinar - SAVE THE DATE!
Thursday February 22, 2018
11:00 – 12:30pm PST; 2:00 -3:30pm EST
REGISTER

https://attendee.gotowebinar.com/register/4856568535686299137
Thank You!

For more information, please visit our websites:

• www.aapcho.org/
• http://www.migrantclinician.org/

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