Diabetes Continuum of Care: Using the CHW and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

Tuesday, April 23, 2019
8am HT / 11am PT / 1pm CT / 2pm ET
Welcome! We will begin in a few minutes.

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, behaviors, 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.
Diabetes Continuum of Care: Using the Community Health Worker and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

NLS

- Association of Asian Pacific Community Health Organizations: Albert Ayoan Jr., MPH, Senior Program Manager of Training and Technical Assistance, Kristine Alancon, MPH, Communications and Engagement Specialist, and Joe Lee, MSHA, Training and Technical Assistance Director
- Migrant Clinicians Network: Martha Alvarado, Program Coordinator of Online Education and Training; Jillian Hopper, MPA, MA, Director of Education and Communications; and Theresa Lyons-Clampitt, Senior Program Manager of Training and Technical Assistance
- MHP Salud: Estel Reyes, MPH, Program Director, and Onanay Hernandez, Program Director
- National LGBT Health Education Center: Ciel Lambert, Program Manager

AAPCHO

Association of Asian Pacific Community Health Organizations

Key Topics

- Disaggregated race/ethnicity data collection
- Social determinants of health data collection
- Culturally and linguistically appropriate services
- Enabling services data collection

http://www.aapcho.org/

Migrant Clinicians Network

MCN

Key Topics

- Access to healthcare
- Clinical quality improvement
- Diabetes and other chronic diseases

https://www.migrantclinician.org/

MHP Salud

Key Topics

- Implementation of CHW programs in hard-to-reach populations
- Return on investment for CHW programs
- Defining the differences between Community Health Workers, Outreach Workers, and other Enabling Services Staff
- Certification of end professional development for CHWs

https://mhpsalud.org/
Strategic Partners' Technical Assistance Strategies to Prevent and Manage Diabetes

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<th>Facilitating Behavior Change in Patients</th>
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<td>Address Childhood &amp; Adult Obesity</td>
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<td>Use Patient Portals</td>
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<td>Increase Patient Health Literacy</td>
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Individual or Small Group National Cooperative Agreement Diabetes Learning Collaboratives

Deactivate the percentage of patients with A1c greater than 9

Special and Vulnerable Population Diabetes Task Force

Clinical Change Package for Diabetes Care

HRSA Funded Diabetes Activities 2018-2019

NLS

Diabetes Continuum of Care: Using the Community Health Worker and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

LEARNING OBJECTIVES

1) To explore strategies around integrating Community Health Workers (CHWs) into the patient-provider relationship to improve diabetes health outcomes

2) To incorporate interdisciplinary team-based care concepts to address patients' health and social needs with diabetes

3) To understand the value of enabling services (ES) and standardized ES data collection to address social risk factors of patients with diabetes.
Diabetes Continuum of Care: Using the Community Health Worker and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

TODAY’S SPEAKERS

Diana Lady, Lead Health Promoter of Kansas Statewide Farmworker Health Program
Chara Carrasco, Care Coordinator / Community Health Worker of Western Wayne Family Health Centers
Monica Geitner, LMHC, MBA, Chief Behavioral Health Officer of Western Wayne Family Health Centers
Andrea Caracristi, MD, MPH, Chief Executive Officer of Asian American Health Coalition / HOPE Clinic
Alex Kevergian, MD, MPH, Director of Education and Training Programs of National LGTB Health Education Center

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Diabetes Continuum of Care: Using the Community Health Worker and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

CLOSING SPEAKER

Tracy Branch, DPhSc, CPH, MPAS, PA-C, DFAAPA
Commander, U.S. Public Health Service
Senior Advisor, Strategic Partnerships Division, Office of Quality Improvement
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services

NLS

Housekeeping

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 at the end of the webinar
- Interact with us on Twitter @AAPCHOtweets and use #DiabetesNationalLearningSeries
Integrating Community Health Workers into the patient-provider team

Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

APHA, 2009

The roles of CHW and the competencies that require to fulfill those roles, continue evolve in response to the changing health care delivery models and public health strategies. CHW have proven to be effective as well as cost effective.

CDC, 2011

- 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.
CHWs

Education
Advocacy
System Navigation
Health Coaching
Peer Counseling

Culturally Appropriate

Culturally Appropriate

Culturally Appropriate

Photo: Ryan K White

CHW Partnership

Safety Net Clinics/Hospitals
Federally Qualified Health Centers
Community Based Organizations
Community
**CHW Roles and Functions**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Level 1: Non-health care professionals</td>
</tr>
<tr>
<td>2</td>
<td>Level 2: Health care professional/non-diabetes educator</td>
</tr>
<tr>
<td>3</td>
<td>Level 3: Non-credentialed diabetes educator</td>
</tr>
<tr>
<td>4</td>
<td>Level 4: Credentialed diabetes educator</td>
</tr>
<tr>
<td>5</td>
<td>Level 5: Advanced level diabetes educator/clinical manager</td>
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Integration into the Clinical Team for Diabetes Management

- Understanding of population served and services provided by clinic
- Educate staff team on role and scope of practice for the CHW
- Recognizing how the needs and struggles of client with Diabetes can be coordinate with a CHW
- Define a workflow, with the CHW embedded on the clinical site, that helps to improve the outcomes of the population served.
- Integrate CHW as case manager/navigator coordinator for all clinics departments
- Place a referral process protocols for your clinic for clients with diabetes
- Close communication with partners reassuring CHW performance
More than 30 million people in the United States are affected by Diabetes. Successful programs to close the gap in diabetes-related health disparities in various racial and ethnic population are built on strengthening the link between health care providers and the community members they serve (Roe & Thomas 2002).

**Diabetes Today** curriculum
- A 6-month self-management program for patients with chronic disease who worked with lay health instructors resulted in improved health behaviors, improved health status, and fewer hospitalizations compared with usual care (Lorig et al. 1999).
- 44 clients with diabetes in St. Louis, Missouri, who accepted a home health aide to support their self-care efforts for 18 months showed improved glycemic control and attendance at eye and diabetes clinic visits, and fewer emergency room visits compared with a control group (Hopper, Miller, Birge, & Swift 1984).
- Hispanic clients who were assigned to a community health worker intervention group were more likely than those who were not to complete their diabetes education programs (Corkery et al. 1997; Brown & Harris 1999).
Managing CHW Internal Integration:

- Documentation: Provide clear way of using database managing notes for clients
- Weekly supervision: Guidance caseload, documentation, complicated cases and ways to advocate
- Emotional Support: Healing meetings conversations
- Professional Support: Access to continue education as part of the clinic integrating ongoing process
- State Education Efforts: National Learning network, MCN
- State Coalition plans: Curriculum for CHW, webinars, workshops, ECHOs

Common Roles on the Clinical Care Team
- Cultural Mediation
- Culturally Appropriate Health Education
- Care Coordination, Case Management, and System Navigation
- Coaching and Social Support
- Advocating
- Building Capacity to Address Issues
- Individual and Community Assessments
- Outreach
- Evaluation

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- Clara Carcamo, Care Coordinator / Community Health Worker of Western Wayne Family Health Centers
- Monica Godines, LMSW, MBA, Chief Behavioral Health Officer of Western Wayne Family Health Center
- Andrea Caracostis, MD, Chief Executive Officer of American Health Coalition / HOPE Clinic
- Judy Kooyman, MD, MPH, Director of Education and Training Programs of National LGBTQ Health Education Center

CHW CLINICAL INTEGRATION INTO CARE TEAMS PRINCIPLES

- Promote respect for CHWs among team members to strengthen clinical outcomes.
- Incorporate CHW core competencies into program design, including advocacy and community-based work on social determinants of health.
- Involve CHWs in integration planning and implementation at all system levels.
- Provide opportunities for CHWs to share their unique understanding and value of the community with the organization and team.
- Include CHWs in regular meetings with the full team (and more frequently with supervisor).
- Educate all members of the clinic on who CHWs are, what they do, and how they are an integral part of the team.
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- Provide CHWs access to electronic health records (EHR) that integrate CHW notes into the patient record for continuity of care.
- Include CHWs in regular meetings with the full team (and more frequently with supervisor).
CHW CLINICAL INTEGRATION INTO CARE TEAMS STRATEGIES

- CHWs and Electronic Health Record Data Entry
- CHWs Participating in Care Team Daily Huddles
- CHWs Utilized in Telehealth
- Impact of Using CHW- Collected Data in Clinical Decision Making

MHP Salud Resources:
- Making the Case for Community Health Workers Toolkit (Available)
- Community Health Worker Clinical Integration (Available May/June)

Monica Geldres, LMSW, MBA
Chief Behavioral Health Officer
MGeldres@wwfhc.org
734-941-4991

INKSTER
2500 Hamlin Court
Inkster, MI 48141
313-561-6100

LINCOLN PARK
25020 W. Outer Drive
Lincoln Park, MI 48146
313-383-1897

TAYLOR
26650 Eureka Road
Taylor, MI 48180
734-941-4991

E-mail us:
Info@wwfhc.org

WESTERN WAYNE FAMILY HEALTH CENTERS

- Established in 2004 by community leaders, to meet the health needs in the medically underserved areas of Inkster, Romulus and Taylor
- In 2017, offered 16 different classes or series, with 895 participants
- In 2017, offered weekly fitness programs for yoga, Zumba, Power Walking and Enhance Fitness twice weekly for the community and staff

SERVICES

- Primary care for all ages
- General dentistry
- Obstetrics and Gynecology
- Pediatrics
- Integrated behavioral health
- Tele-psychiatry
- Substance Abuse Recovery Treatment
- Care coordination
- Health education and coaching
- Health insurance application assistance
**CHWS ROLE AT WWFHC**

**Stage 1: 2012-2015**
- $ WWFHC Supported
- $ National Kidney Foundation

- PATH and D-PATH
- Bodyworks Classes for diabetic and hypertensive patients
- Community Outreach
- Enhance Fitness

- Medical
- Dental
- Community Members

**Stage 2: 2016-2019**
- $ WWFHC Supported
- $ New small grants

- In addition:
  - Care management
  - Support groups
  - Medication Adherence
  - MHP Salud Classes
  - Complex patients with a
    - Diabetes
    - Hypertension
    - Depression
    - Obesity

- Behavioral Health
- MAT: Medically Assisted Treatment
- Primary Care
- Dental
- Community

**Began to structure role of the CHW w/ the influx of new B.H. patients with Substance Use Disorder, Mental Health, and Medical Assistance Program (MAT) Focus on:**

- Inkster CHW
- Taylor CHW
- Lincoln Park CHW

Same services as listed above

**INTEGRATION OF CHW INTO PATIENT TREATMENT TEAMS**

- Daily Huddles
- PH Team Meetings
- MAT Team Meetings
- Clinical Consult and Learning
COMMUNITY HEALTH WORKERS

• Inkster 313–561–5100
• Taylor 743–941–4991
• Lincoln Park 313–383–1897

• Visit our website www.WWFHC.org
• Like us on Facebook: Western Wayne Family Health Centers
• E–Mail us at Info@wwfhc.org

CONTACT US

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Andrea Caracostis, MD, MPH, Chief Executive Officer of Asian American Health Coalition/HOPE Clinic
Joy Keough-Kihlan, MD, MPH, Director of Education and Training Programs of National LGBT Health Education Center

Diabetes Control
Creating a Community Coalition

Andrea Caracostis, MD, MPH
Chief Executive Officer
Asian American Health Coalition/ HOPE Clinic
Goals of the presentation

- To understand the value of enabling services (ES) and
- Importance of standardized ES data collection to address social risk factors of patients with diabetes.

Our Mission: “to provide quality health care without any prejudice to all people of greater Houston, in a culturally and linguistically competent manner.”

Our Vision: “A healthy community with quality, affordable health care for all.”

Asian American Health Coalition dba HOPE Clinic

- In 1994, the Asian American Health Coalition (AAHC) was formed to reduce health disparities in the Asian American Community.
- HOPE Clinic was established by AAHC in 2002
- 2005 Hurricane Katrina victims received HOPE Clinic’s assistance
- In 2007, HOPE Clinic moved to its current location
- Today, HOPE Clinic is an FQHC operating six days a week, in 3 sites

Our Staff 2009
Our Staff 2017

Patient Diversity

The Need for Services

Discovering Diabetes

- Asians are more likely to develop the disease even at a lower BMI
- Nearly 50% of adult men in Asian countries smoke regularly
- White rice and other refined grains a large proportion of daily energy intake
- Lack of education within the AAPI
- Asian population is diverse, no data on differences within populations.
The Model vs. The Reality
MyPlate model promotes healthy and balanced meals. However, not all cultures eat off of plates.

Many Asian cultures utilize 'family style' setting for meals and will often eat out of bowls instead of plates.

Common Misconceptions
- “Finish your food and eat until full”
  - This often leads to overeating and weight gain
- “Being overweight is a symbol of prosperity and abundance”
  - Increased risk for chronic disease
- “Eating more brown rice or other grains is better”
  - Quantity is not beneficial for glucose and weight control
- “I’m not overweight, so I must be healthy”
  - Recommended Normal Range BMI for Asians: 18.5 - 23.0

Food as identity
- Blend of Cultures
  - Celebrate our nation’s diversity and blend the cuisines of many cultures.
- Cook with others: communion
  - Prepare and share authentic recipes.
- Add a touch of spice (politoki cuisine)
  - Combinations of herbs and spices reminds us of our heritage
- Food as a way to honor your ancestors
  - Different combinations of familiar food often results in new flavors

Diabetes on problem list
- About 1400 diabetes patients at HOPE per year
- About 5% of total patients
- 50% are on some kind of medication
- 25% attend nutritional consultation
The Process

Evaluate Data around patient care

- PCP Screen A1c and Treat
- Registered Dietitian
- SDOH Community Work
- BHC Educate Change Behavior

Value of Enabling Services
- Integrating Diabetes care into the primary practice
- Greater reach and impact
- Demystifies diabetes
- Cost savings
- Greater compliance
- Collecting data that includes social determinants of health
- Patient centered medicine

Coordinated Diabetes Care

- Coordinating diabetes care through the use of multidisciplinary approach
  - Behavioral Health Consultant (BHC) and Dietitian meet with the patient using warm hand off from provider
  - BHC uses Problem Areas in Diabetes Questionnaire (PAID©) and other tools to assess barriers and challenges, nontraditional support needed
  - Chronic Disease Care Planning module in EMR allows tracking of barriers and goals for patient

- Provide wrap around support through 340B, medication assistance programs, food assistance, transportation assistance
- Standing order for A1c allows for diabetes progress to be addressed in a timely manner
- Interim visits with BHC and dietitian help keep patient on track toward goals
- Registry and recall allows for patient tracking by clinic staff
Program Development Logic

1. Understand disease burden across cultures
2. Established clinical protocols and standing orders from screening to scheduling
3. Defined financial sustainability of the program for a long term impact

The Stakeholders

- Community members
- State
- County
- City
- National Coalitions
- Other NGOs and CHC
- Research Institutions

The Future

- Create enhanced awareness
- Look for upstream solutions
- Increase screening for pre-diabetes
- Increase team based care nutritional and behavioral
- Move from Instinct to Strategy
- Start change in your own organization
- Group visit model as an alternative of care
- Food as prescription model

If you are not hungry I have not done a good job!
CREATING AN INCLUSIVE AND WELCOMING HEALTH CARE ENVIRONMENT FOR LGBTQ PEOPLE

Alex S. Keuroghlian, MD MPH
Director, The National LGBT Health Education Center at The Fenway Institute

CONTINUING MEDICAL EDUCATION DISCLOSURE

- Program Faculty: Alex S. Keuroghlian, MD, MPH;
- Current Position: Director, The National LGBT Health Education Center; Assistant Professor of Psychiatry, Harvard Medical School
- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.
Gender Identity and Sexual Orientation: The Basics

- All people have a sexual orientation and gender identity
- How people identify can change
- Terminology varies
- Gender Identity ≠ Sexual Orientation

Sexual Orientation and Gender Identity are Not the Same

- Gender identity
  - A person’s inner sense of being a girl/woman, boy/man, something else, or having no gender
  - All people have a gender identity
- Gender expression
  - How one presents themselves through their behavior, mannerisms, speech patterns, dress, and hairstyles
  - May be on a continuum

Gender Identity and Gender Expression

A complete glossary of terms is available at www.lgbthealtheducation.org/publication/lgbt-glossary/

The T in LGBTQ: Transgender

- Gender identity not congruent with the assigned sex at birth
- Alternate terminology
  - Transgender woman, trans woman, male to female (MTF)
  - Transgender man, male to female (FTM)
- Non-binary
  - Genderqueer person, gender fluid person
  - Transmasculine, Transfeminine
- Gender identity is increasingly described as being on a continuum
Sexual Orientation
- Sexual orientation: how a person identifies their physical, emotional and romantic attractions to others
- Desire
- Behavior
  - Men who have sex with men (MSM/MSMW)
  - Women who have sex with women (WSWM)
- Identity
  - Straight, gay, lesbian, bisexual, queer, other

Dimensions of Sexual Orientation:
- Identity
  - Do you consider yourself gay, lesbian, bisexual, straight, queer, something else?
- Desire
  - What gender(s) are you attracted to physically and emotionally?
- Behavior
  - What gender(s) are your sexual partner(s)?

Minority Stress Framework
- External Stigma-Related Stressors
- General Psychological Processes
- Internal Stigma-Related Stressors
- Behavioral Health Problems
- Physical Health Problems

Fig. 1. Diagram adapted from: “How does sexual minority stigma get ‘under the skin?’” (Hatzenbuehler, 2009)

Why SO/GI Data Collection?

Population Health: Ending LGBTQ Invisibility in Health Care
- Has a clinician ever asked you about your history of sexual health, your sexual orientation or your gender identity?
- How often do you talk with your patients about their sexual history, sexual orientation, or gender identity?
Appropriate Screening: Rodrigo’s Story

- 40-year-old trans man who came in with pelvic pain and spotting
- A biopsy determined that Rodrigo had cervical cancer
- No one had told Rodrigo that he needed routine cervical pap tests

Are Patients Likely to be Offended by SO/GI Questions?

- 78% of clinicians nationally believe patients would refuse to provide sexual orientation, however only 10% of patients say they would refuse to provide sexual orientation (Haider et al., 2017).
- No difference in patient attitudes toward registration forms that include SOGI questions vs. forms that do not; only 3% of patients reported being distressed, upset or offended by SOGI questions (Rullo et al., 2018).

Responding to Staff Concerns

- Some staff may need extra coaching and reassurance
- Supervisors should explain that the health center is trying to provide the best care for all patients, and staff do not need to change their own values to collect SO/GI data
- Regular check-ins with staff members will help identify and address their concerns

Guidelines for Collecting SO/GI Data
SO/GI Data Collection Demonstration Videos

Collecting SO/GI Information

Providing Information to Patients

Gathering SO/GI Data During the Process of Care

www.lgbthealtheducation.org

www.lgbthealtheducation.org

www.lgbthealtheducation.org

www.lgbthealtheducation.org
Collecting Demographic Data on Sexual Orientation (Example)

1. Which of the categories below describe your race/ethnicity? Check the one or more that apply:
   - African American/Black
   - Asian
   - Hispanic/Latino/Latina
   - Native American/Alaskan Native
   - Native Hawaiian/Other Pacific Islander
   - Other

2. Employment Status:
   - Student Full Time
   - Student Part Time
   - Employer
   - Other

3. Sexual Experience:
   - Agender/Asexual
   - Bisexual
   - Gay/Lesbian
   - Heterosexual
   - Other

4. Bi/sexuality:
   - Bisexual/Lesbian/Lesbians
   - Gay/Lesbian/Lesbians
   - Heterosexual/Heterosexuals
   - Other

5. Country of Birth:
   - USA
   - Other

6. Language(s):
   - English
   - French
   - German
   - Italian
   - Spanish
   - Other

7. Do you think of yourself as:
   - Lesbian, gay, or bisexual
   - Transgender
   - Intersex
   - Asexual
   - Extraordinary
   - Don’t Know

8. Marital Status:
   - Married
   - Engaged
   - Divorced
   - Separated
   - Other

9. Veteran Status:
   - No Veteran
   - Don’t know

10. What is your current gender identity?
    - Male
    - Female
    - Transgender Male/Trans Man/FTM
    - Transgender Female/Trans Woman/MTF
    - Gender Queer
    - Additional Category (please specify)

11. What sex were you assigned at birth?
    - Male
    - Female
    - Decline to Answer

12. What name do you use?
13. What name is on your insurance records?
14. What are your pronouns (e.g. he/him, she/her, they/them)?

Pronouns
People may use a range of pronouns, including she/her/hers and he/him/his, as well as less common pronouns such as they/them/theirs and ze/hir/hirs (pronounced zee/hear/hears).

SO/GI Reporting For Pediatric Patients

- At what age do you start asking these questions?
  - Recommend asking GI early
  - Recommend asking SO from 13+ years old
- At what age do you start reporting these data?
  - Are parents answering these questions?
  - Potential bias
Anticipating and Managing Expectations

- LGBTQ people have a history of experiencing stigma and discrimination in diverse settings
- Don’t be surprised if a mistake results in a patient becoming upset
- Don’t personalize the reaction
- Apologizing when patients become upset, even if what was said was well-intentioned, can help defuse a difficult situation and re-establish a constructive dialogue

Avoiding Assumptions

- You cannot assume someone’s gender identity or sexual orientation based on how they look or sound.
- To avoid assuming gender identity or sexual orientation with new patients:
  - Instead of: “How may I help you, sir?”
  - Say: “How may I help you?”
  - Instead of: “He is here for his appointment.”
  - Say: “The patient is here in the waiting room.”
  - Instead of: “Do you have a wife?”
  - Say: “Are you in a relationship?”
  - Instead of: “What are your mother’s and fathers’ names?”
  - Say: “What is your guardian’s name?”

Keeping Up with Terminology

- Obvious “don’ts” include
  - Use of any disrespectful language
  - Gossiping about a patient’s appearance or behavior
  - Saying things about someone not necessary for their care:
    - “You look great, you look like a real woman/real man!”
    - “You are so pretty I cannot believe you are a lesbian!”

Avoid these Outdated Terms (in English)

<table>
<thead>
<tr>
<th>Homosexual</th>
<th>Transvestite; Transgendered</th>
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</thead>
<tbody>
<tr>
<td>Transgender</td>
<td>Sexual preference; Lifestyle choice</td>
</tr>
</tbody>
</table>

Consider these Terms Instead

- Gay, lesbian, bisexual, or LGBTQ
- Transgender
- Sexual orientation

Putting What You Learn into Practice....

- If you are unsure about a patient’s name or pronouns:
  - “I would like be respectful—what are your name and pronouns?”
- If a patient’s name doesn’t match insurance or medical records:
  - “Could your chart/insurance be under a different name?”
  - “What is the name on your insurance?”
- If you accidentally use the wrong term or pronoun:
  - “I’m sorry, I didn’t mean to be disrespectful.”
**Inclusive Registration and Medical History Forms**

<table>
<thead>
<tr>
<th>Avoid these terms...</th>
<th>Replace with...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother/Father</td>
<td>Parent/Guardian</td>
</tr>
<tr>
<td>Husband/Wife</td>
<td>Spouse/Partner(s)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Relationship Status</td>
</tr>
<tr>
<td>Family History</td>
<td>Blood Relatives</td>
</tr>
<tr>
<td>Nursing Mother Female</td>
<td>Currently Nursing</td>
</tr>
<tr>
<td>Only/Male Only</td>
<td>Allow patients to choose not applicable.</td>
</tr>
</tbody>
</table>

**Gender-inclusive Diagrams**

- Images that have a specific gender may limit identification of certain medical issues.
- Use gender-inclusive images to document areas of concern.

**Clinical Decision Support (CDS)/Health Maintenance**

**Current Variables:**
- Sex
- Age
- Problems/Disease Conditions  
  - e.g. Diabetes
- Medications  
  - e.g. Coumadin
- Observations  
  - e.g. Blood Pressure> 220

**Recommended Additional Variables:**
- Sexual Orientation
- Gender Identity
- Sex Assigned at Birth
- Anatomical Inventory

**Decision Support/Health Maintenance**

- Patient Due For:
  - LDL
  - HDL
  - TRIGLYCERIDE
  - CHOLESTEROL
  - HGBA1C
  - STD
  - HEP C
  - ????
**Decision Support/Health Maintenance**

- **Sex**: Male
- **Age**: 52 yo
- **Sex assigned at birth**: Female

**Anatomical Inventory**
- Cervix
- Vagina
- Uterus
- Ovaries
- Breasts

**Patient Due For:**
- Cervical Pap Smear
- Mammogram

**Stratifying UDS Measures by SOGI**

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<thead>
<tr>
<th>Sexual Orientation Categories</th>
<th>Gender Identity Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian/Gay</td>
<td>Cis Men</td>
</tr>
<tr>
<td>Bisexual</td>
<td>Trans Men</td>
</tr>
<tr>
<td>Straight or heterosexual</td>
<td>Trans Women</td>
</tr>
<tr>
<td>Something else</td>
<td>Other (Genderqueer)</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>Not Disclosed/Unknown</td>
</tr>
</tbody>
</table>

**Table 6A**
- Line 21: HIV test
- Line 22: Mammogram
- Line 26b: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

**Table 6B**
- Cervical Cancer Screening - Patients Aged 23 through 64
- Tobacco Use: Screening and Cessation Intervention
- Screening for Clinical Depression and Follow-Up Plan
- Total Patients Aged 12 and Older

**EHR Form: Organ Inventory**
Enabling Services Data Collection Toolkit

- Needs Assessment
- Readiness Assessment
- Workflows
- EHR Integration
- Database Strategy
- Training Guidelines
- Report Cards

http://EnablingServices.aapcho.org

NLS
Diabetes Continuum of Care: Using the Community Health Worker and Enabling Services Workforce to Address Social Determinants of Health and Diabetes

CLOSING SPEAKER
Tracy Branch, DHSc, CPH, MPAS, PA-C, DFAAPA
Commander, U.S. Public Health Service
Senior Advisor, Strategic Partnerships Division, Office of Quality Improvement
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services

HRSA
Health Resources & Services Administration
WEBINAR SLIDES & RECORDINGS AVAILABLE

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

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

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

Download slides and watch the recordings 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:

Diana Lady - Diana.Lady@ks.gov
Chara Carcamo - CCarcamo@wwfhc.org
Monica Geldres, LMSW, MBA - MGeldres@wwfhc.org
Andrea Caracostis, MD, MPH - ACaracostis@hopechc.org
Alex Keuroghlian, MD, MPH - AKeuroghlian@renwayhealth.org

NCA Partners’ contact info: www.healthcenterinfo.org

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