Working with the HRSA Diabetes Quality Improvement Initiative

Making it work for your mobile and agricultural worker populations

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Conflict of Interest Disclosure

We have no real or perceived vested interests that relate to this presentation nor do we have any relationships with pharmaceutical companies, biomedical device manufacturers and/or other corporations whose products or services are related to pertinent therapeutic areas.

AGENDA

- ✓ Introduction
- ✓ Objectives
- ✓ HRSA Diabetes Quality Improvement Initiative
  - Overview
  - Goals
- ✓ The Onsite Performance Analysis Activity
- ✓ Diabetes Care & MSAWs
- ✓ Data Needs
- ✓ Resources

OBJECTIVES

At the conclusion of this activity, participants will be able to:

- Describe the intent of the HRSA Diabetes Quality Improvement Initiative.
- Develop a strategy for participating in the onsite Diabetes Performance Analysis activity.
- Define the elements of a SMART goal.
- Describe at least one unique approach for improving diabetes outcomes for MSAW patients.
- Access tools presented while conducting Diabetes Quality Improvement activities.

HRSA's Diabetes Quality Improvement Initiative

2017 Data Comparison

HRSA-Funded Health Centers Versus National Averages

Higher Prevalence

vs.

1 in 7 health center patients has a diagnosis of diabetes (Uniform Data System (UDS)).

The national average is 1 in 10 people have diabetes (National Committee for Quality Assurance (NCQA)).

Better Outcomes

vs.

67% of health center patients had controlled diabetes (A1C < 9%) (UDS).

59% is the national average of patients with controlled diabetes (A1C < 9%) (NCQA).

https://bphc.hrsa.gov/qualityimprovement/clinicalquality/diabetes.html

Also…

High Cost: 2.3 X cost of non-diabetic patients

Complex condition

Overall Goals of the Initiative

Improve diabetes treatment and management

Increase diabetes prevention efforts

Reduce health disparities

The HRSA Diabetes Quality Improvement Initiative measures: by 2020…

- **Reduce by 5%** the number of patients who develop diabetes.
- **Reduce by 5%** the number of patients with diabetes with an HbA1c value greater than 9%.
- **Increase by 5%** the number of adult patients who receive weight screenings & counseling.
- **Increase by 5%** the number of pediatric patients who receive weight screenings & counseling.
- **Reduce by 1%** the disparities gap between racial and ethnic groups with the highest and lowest rates of diabetes.

Health Center Program and Diabetes

1 in 7 health center patients has diabetes—compared to a national average of 1 in 10

Of those, 1 in 3 has uncontrolled diabetes (A1C > 9%)

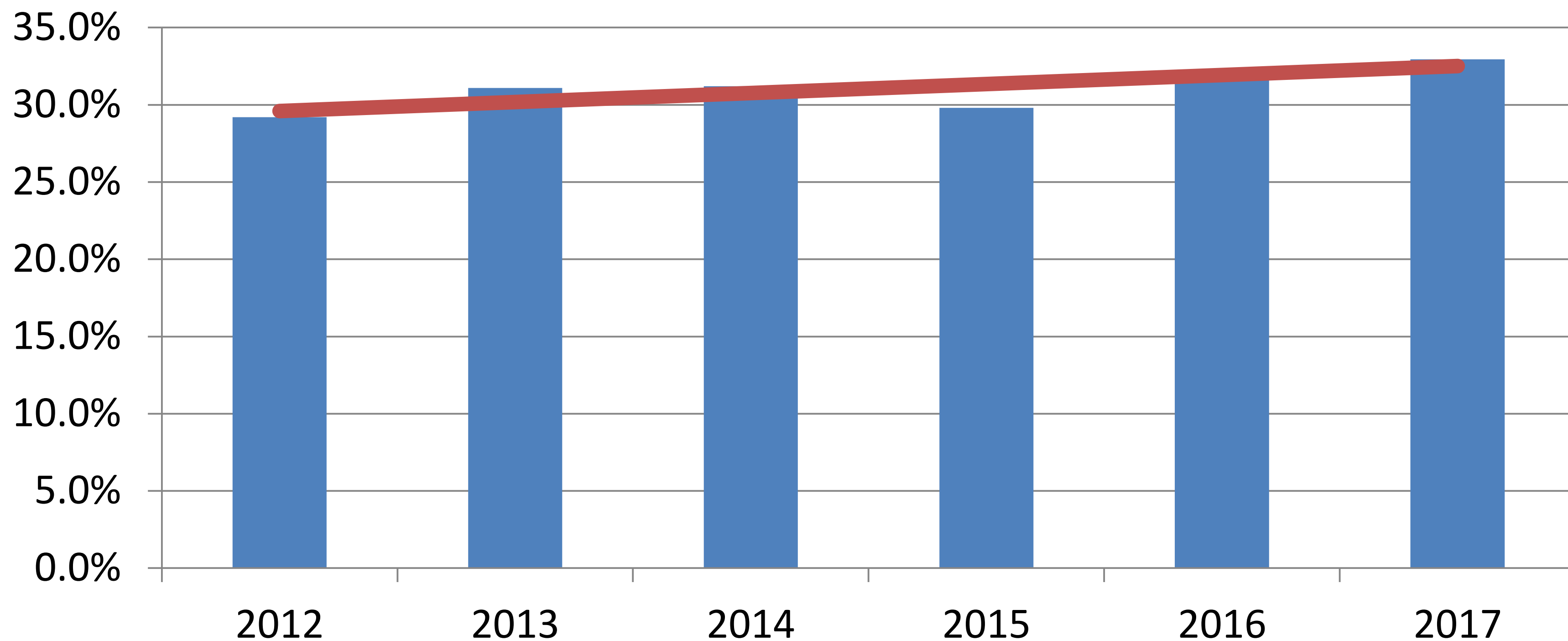
Health centers can help you manage your diabetes. Find a health center.

Sources: 2017 Uniform Data System and 2016 National Committee for Quality Assurance

#Diabetes

HRSA
Health Resources & Services Administration

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period



Quality of Care Indicators

Percentage of patients age 2 - 17 who had a visit during the current year and who had Body Mass Index (BMI) documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented*

Note: Normal parameters: Age 18 years and older BMI greater than or equal to 18.5 and less than 25 kg/m2

The Diabetes Performance Analysis

Health Center Operational Site Visit (OSV) now includes a review of the UDS diabetes measure and the health center's own diabetes performance.

The goal of the performance analysis is to assist health centers to develop an organizational action plan for improving performance in diabetes outcomes.

Elements of the Performance Analysis

- Review of UDS diabetes measure
- Review of health center’s diabetes measure, trends & goals
- Review of past and/or current PI efforts
- Root Cause Analysis
- Restricting and contributing factors
- 3 Action steps

Are you ready?

Advance Preparation	Review previous diabetes-related data and reported contributing & restricting factors
	Discuss changes since last BPR/SAC
	Document any recent/ongoing diabetes performance improvement efforts
	Identify participants (CEO, Quality Director, CMO, HRSA rep, key clinical staff involved in diabetes care)

Documents

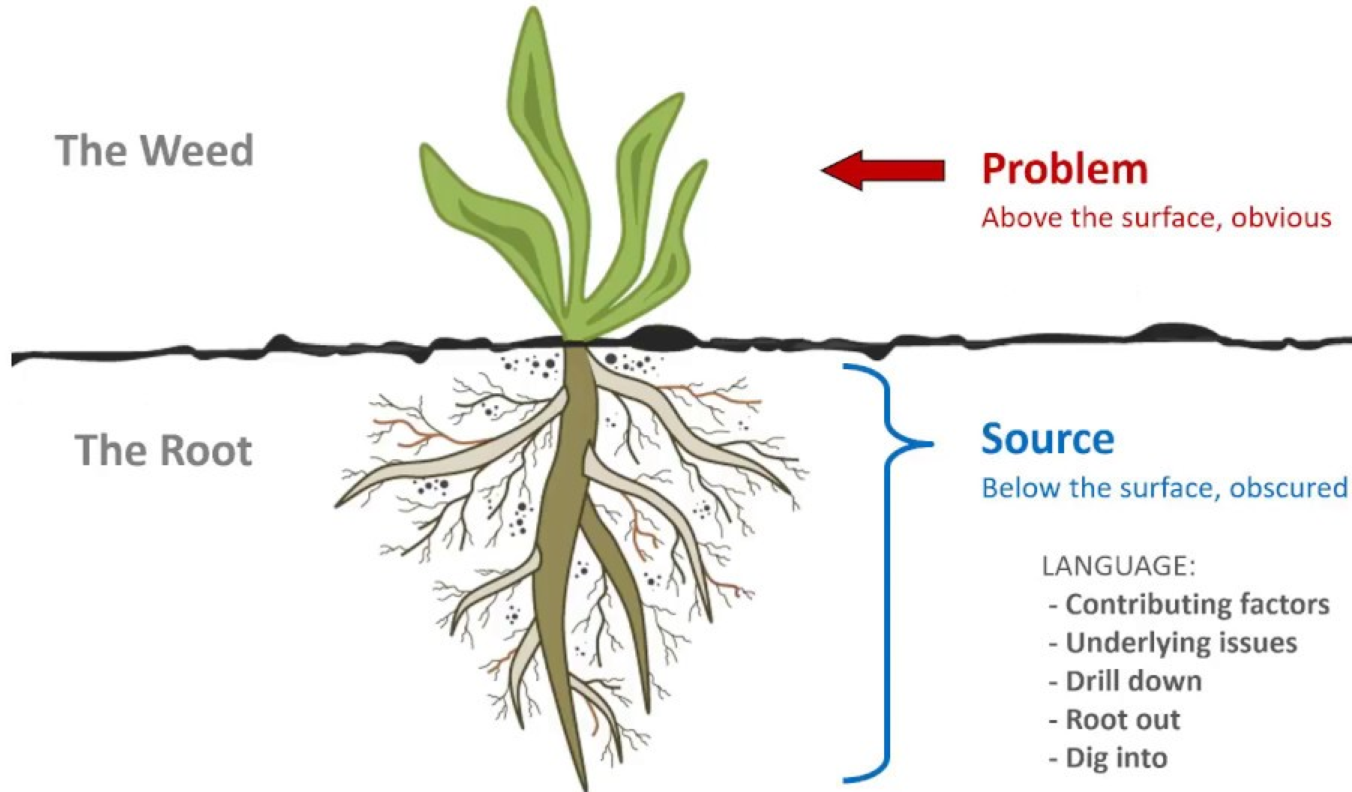
Prior to Visit

- UDS Summary Report
- UDS Trend Report
- UDS Performance Comparison
- Clinical performance measure from most recent SAC
- Progress report from most recent BPR

Provided at start of visit

- Examples of the center's performance improvement activities (e.g., staff training, patient interventions, collaborative partnerships)
- QI/QA reports/data (e.g., PDSA cycle data, diabetes control data from center)
- List of TA and/or other self identified needs.

Root Cause Analysis - The Concept



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- SWOT analysis
- Fishbone
- 5 Whys

Strengths

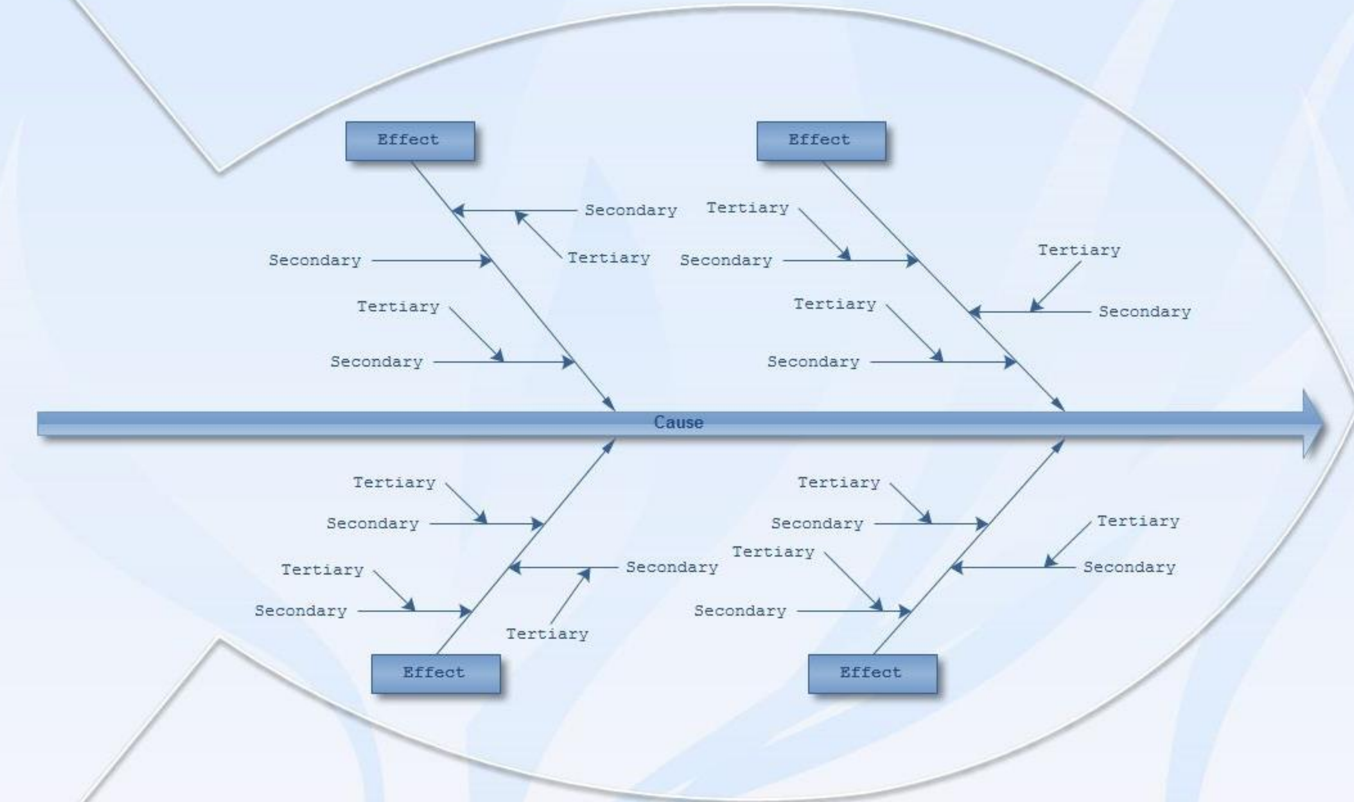
Weaknesses

SWOT
Analysis

Opportunities

Threats

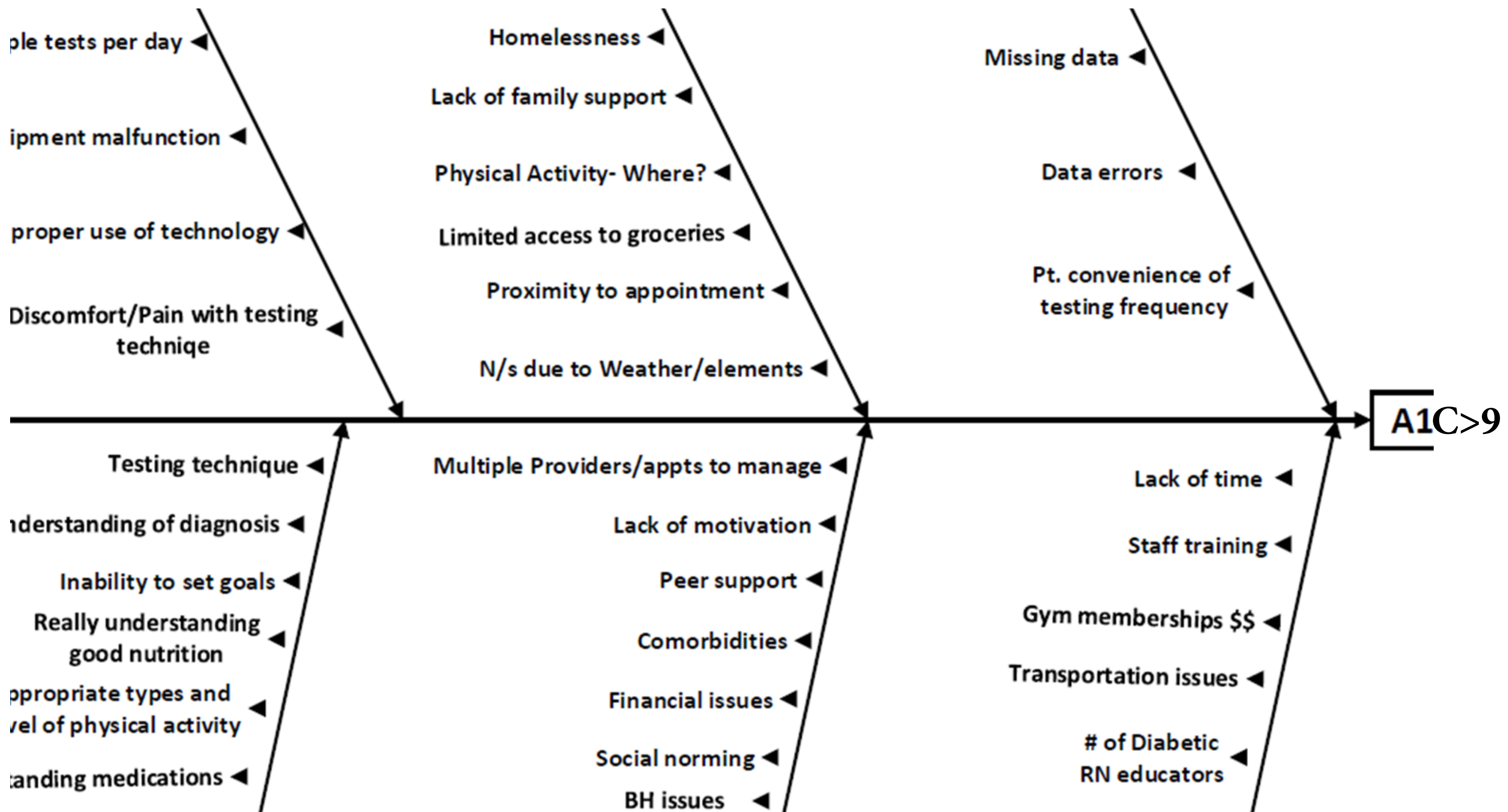
Cause-Effect (Fishbone) Diagram Template



PATTERN. What’s been happening? Define the problem as a pattern by selecting a poor performance factor

STRUCTURE. Why is it happening? What are the tangible and intangible structures determining the results we see?

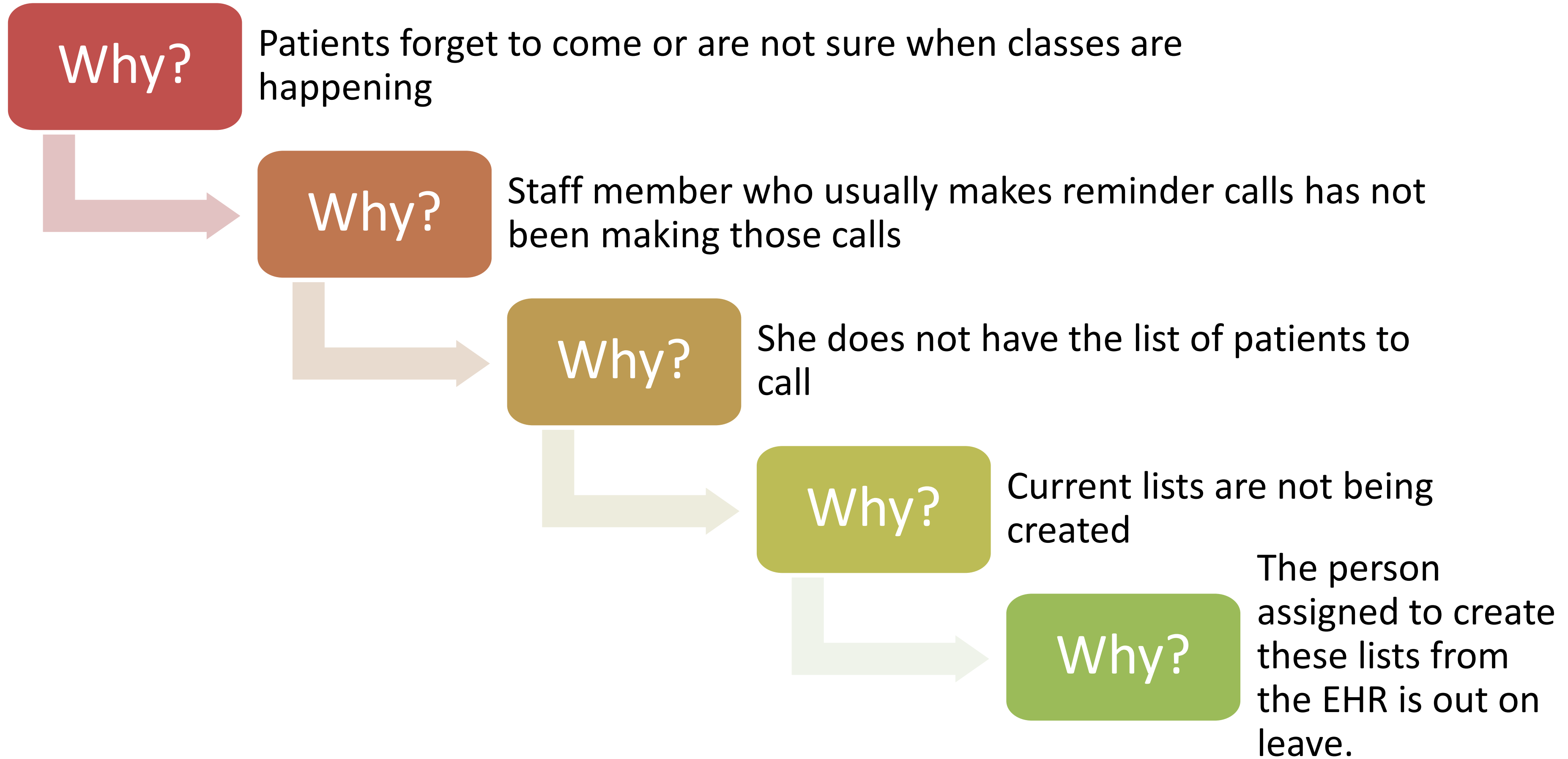
ACTION. What are the implications for action? What can you do to change the results?



ple tests per day
ipment malfunction
proper use of technology
Discomfort/Pain with testing techniqe
Homelessness
Lack of family support
Physical Activity- Where?
Limited access to groceries
Proximity to appointment
N/s due to Weather/elements
Missing data
Data errors
Pt. convenience of testing frequency
A1C>9
Testing technique
nderstanding of diagnosis
Inability to set goals
Really understanding good nutrition
ppropriate types and
vel of physical activity
anding medications
Multiple Providers/appts to manage
Lack of motivation
Peer support
Comorbidities
Financial issues
Social norming
BH issues
Lack of time
Staff training
Gym memberships $$
Transportation issues
# of Diabetic RN educators

The Five Whys

Problem: Recently, patients have stopped coming to diabetes group visits



Possible Actions

- Assign an additional staff person to fill in and create reports while the person responsible is out.
- Give the outreach caller direct access to the data and train her to generate her own up-to-date lists.

Contributing and Restricting Factors

- Review most recent reported factors (SAC/BPR)
- Revise if needed
- Internal and external / current and anticipated factors
- Rank in order of importance

Develop 3 Actions Steps

Goals should be related to identified contributing & restricting factors and root causes

Specific

- State what you'll do
- Use action words

Measurable

- Provide a way to evaluate
- Use metrics or data targets

Achievable

- Within your scope
- Possible to accomplish, attainable

Relevant

- Makes sense within your job funcion
- Improves the business in some way

Time-bound

- State when you'll get it done
- Be specific on date or timeframe

Examples of SMART Goals

- ✓ Initiate self-management goal setting. Develop materials and work flow in order to begin implementation by Q1. Complete implementation and evaluation of this intervention by Q4.
- ✓ In order to increase timely follow-up appointments with diabetics, patients due for a visit or testing will be contacted and scheduled. The baseline percentage of diabetics who are current with their visits will be calculated and that percentage will be increased by 10% per quarter over the next year.

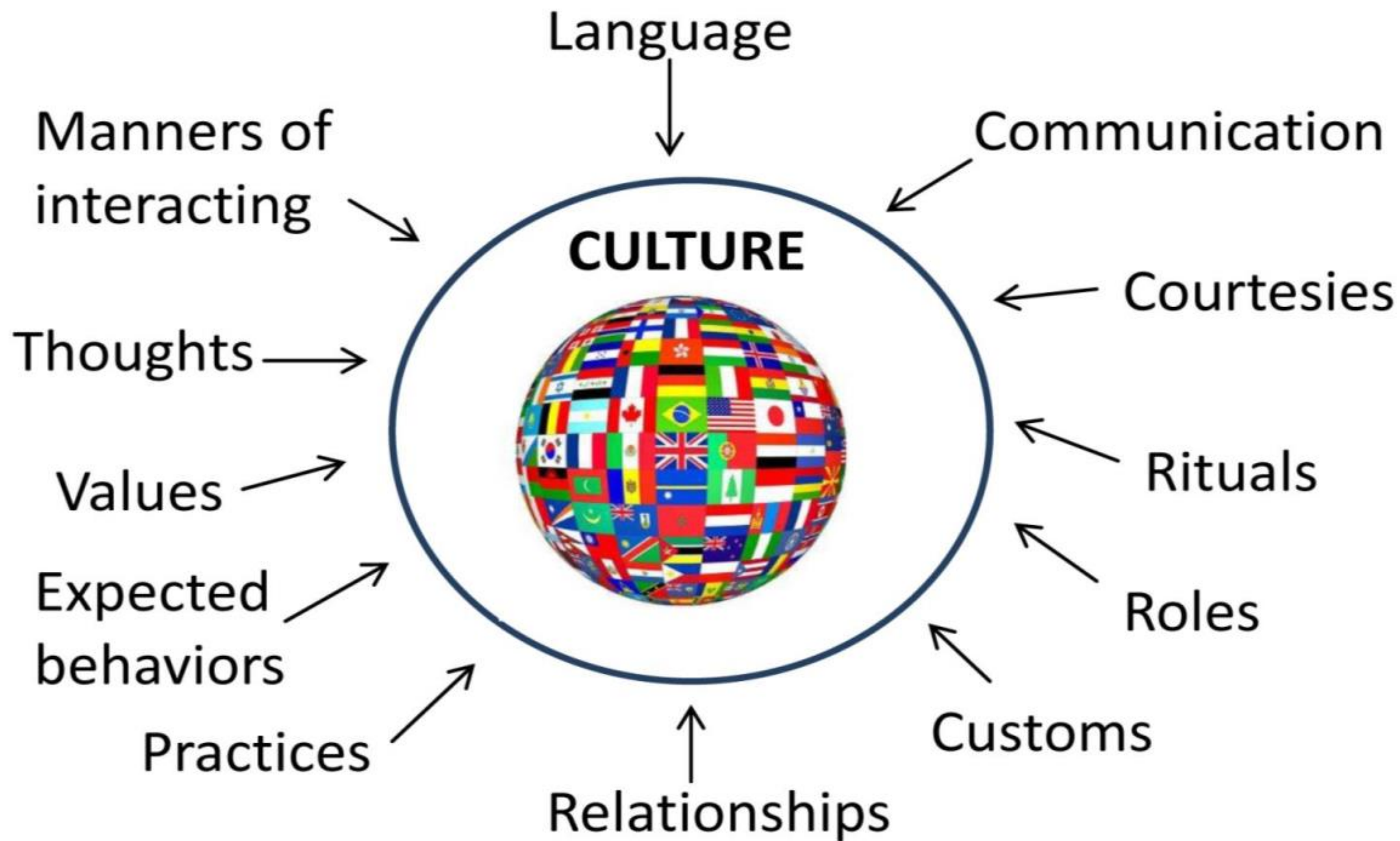
Diabetes Performance Improvement and MSAWs

May need to consider a separate performance analysis process and goals for your MSAW population:

- Stratify and compare your data (please!)
- Culturally and linguistically appropriate care
- Role of CHWs and outreach
- Continuity of care for mobile patients

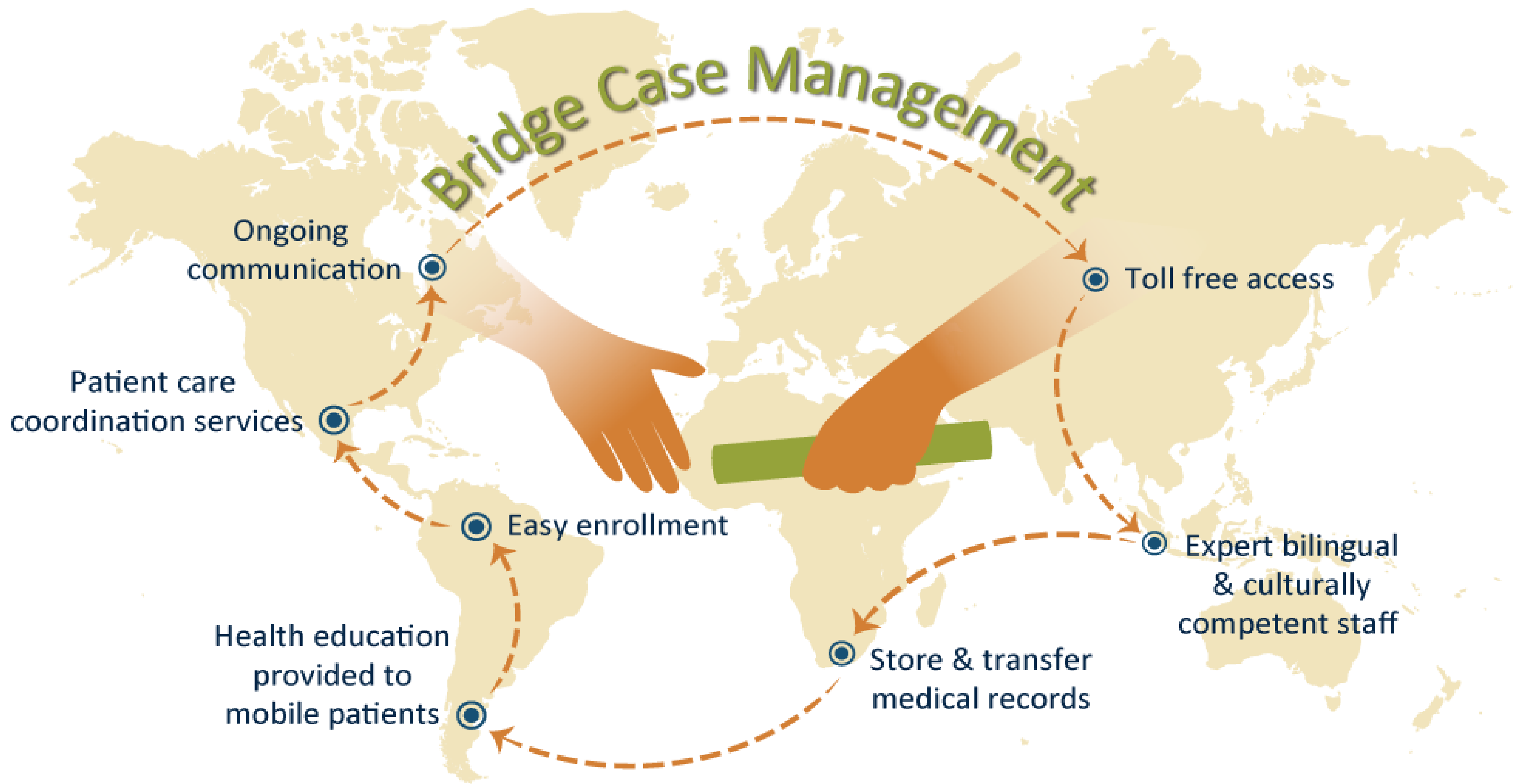
Data Needs

- Create a MSAW diabetes registry
- Accurate identification of MSAWs!
- Clearly define your metrics and goals
- Establish baselines before starting improvement efforts
- Documentation training for staff
- Reporting capabilities
- Documentation of efforts and results—PDSAs, minutes, etc.



Source: National Center for Cultural Competence, 2011

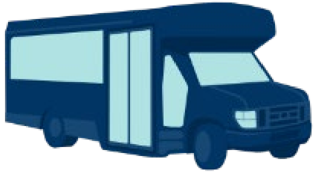
CHWs and Diabetes



Bridge Case Management
Ongoing communication
Toll free access
Patient care coordination services
Easy enrollment
Expert bilingual & culturally competent staff
Health education provided to mobile patients
Store & transfer medical records

Contacts patients on a scheduled basis (monthly for TB patients/ dependent on travel plans)

Contacts clinics monthly



Assists patients in locating clinics for services and resources. Transportation/Scheduling

Reports back to the enrolling clinic and notifies them of outcomes

Enrolled in Health Network 8/02

“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”

11/05

6/07

1/03

4/09

12/06

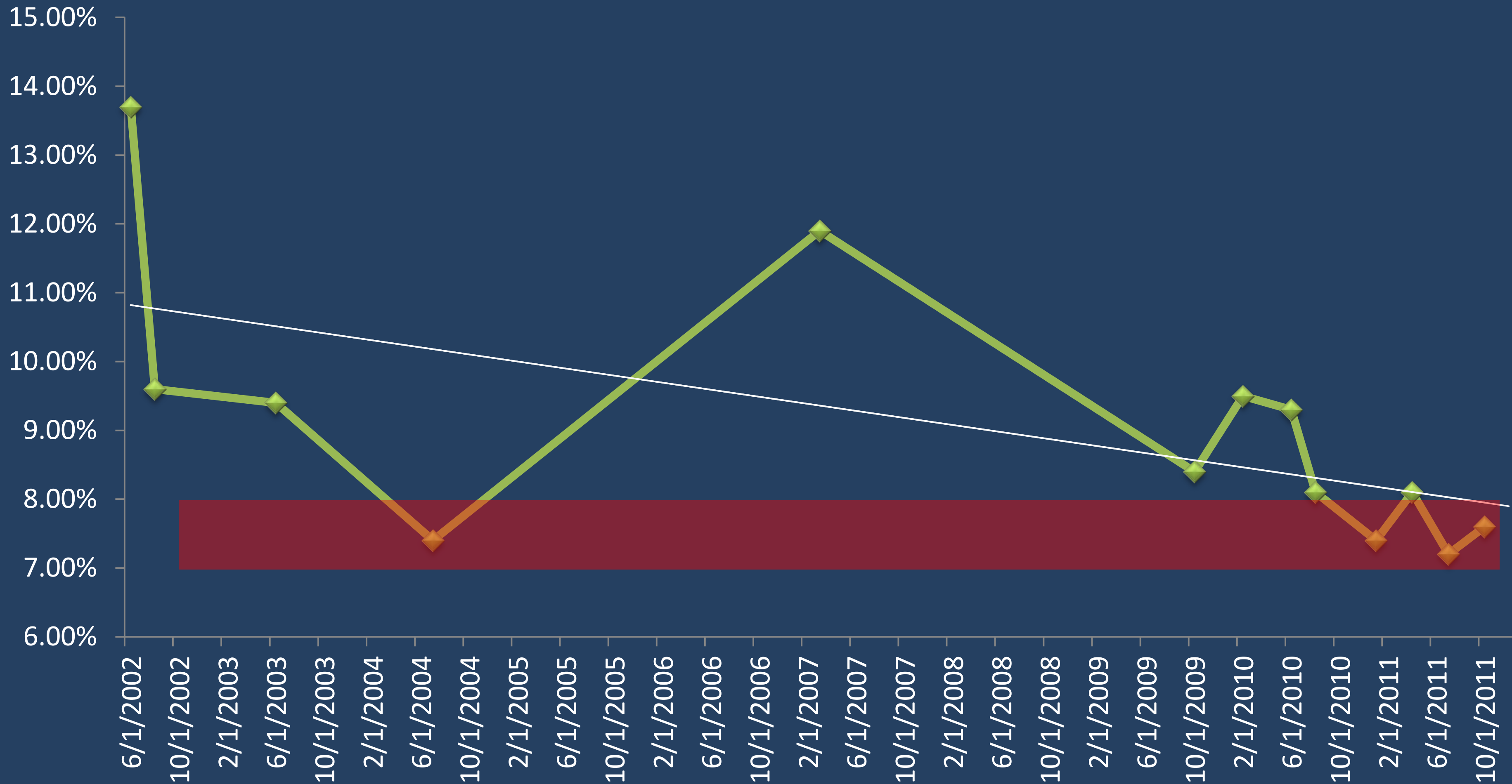
10/02

10/03

10/07

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's HBA1c While Enrolled in Health Network
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%
9.00%
8.00%
7.00%
6.00%
6/1/2002
10/1/2002
2/1/2003
6/1/2003
10/1/2003
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10/1/2004
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6/1/2011
10/1/2011

MCN Diabetes Resources

Webinars

MCN is committed to providing high quality continuing education to health care providers serving migrant farmworkers. MCN's comprehensive clinical education program helps to develop excellence in practice, clinical leadership, and the dissemination of best models and practices.

Seminarios virtuales en Español

Learning Collaborative
Team-Based Diabetes Care for Federally Funded Health Centers

Team-Based Diabetes Care for Federally Funded Health Centers

Next session: Thursday, May 23 @ 10am (PST) / 1pm (EST)

▸ Details & registration

Working with the HRSA Diabetes Quality Improvement Initiative

Wednesday, May 22 @ 10am (PST) / 1pm (EST)

▸ Details & registration

Menu

- WHO WE ARE
- CLINICIAN EMPLOYMENT
- PUBLICATIONS
- OUR WORK
  - Continuing Education
    - Upcoming Webinars
    - Archived Webinars
    - Project ECHO
  - Health Network
  - ENVIRONMENTAL AND OCCUPATIONAL HEALTH
  - Technical Assistance
  - Family Violence Prevention

Announcements

Continuing Education Credit (CEU)

We are pleased to offer 1 hour of CNE or CME* credit at no cost to participants.

Migrant Clinicians Network is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

*Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

MIGRANT CLINICIANS **NETWORK**

HealthNetwork

This summer MCN has a series of patient education materials on diabetes written by MCN and designed by Salvador Saenz. Indicate on your evaluation if you would like an email when these are available.

MIGRANTCLINICIAN.ORG/BLOG

LATEST NEWS IN HEALTHCARE FOR THE UNDERSERVED

Other Diabetes Resources

- ✓ HRSA Diabetes Quality Improvement Initiative webpage
  https://bphc.hrsa.gov/qualityimprovement/clinicalquality/diabetes.html
- ✓ Root cause analysis methodology tools—5 Whys, Fishbone Diagram
  www.IHI.org
- ✓ Diabetes self-management tools
  https://www.cdc.gov/diabetes/dsmes-toolkit
- ✓ National Cooperative Agreements
  https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/natlagreement.html

Questions?

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