Working with the HRSA Diabetes Quality Improvement Initiative

Making it work for your mobile and agricultural worker populations

Candace Kugel, FNP, CNM, MS

February 12, 2020

MIGRANT CLINICIANS NETWORK MCN

Migrant Clinician Network (MCN) is accredited as an approved provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

- To receive continuing education credits for this activity, the participant must complete a post-activity evaluation.
- Once successful completion has been verified, each participant will receive a letter and certificate of successful completion that details the number of contact hours that have been awarded.
- The planning committee members, presenters, faculty, authors, and content reviewers of this CNE activity have disclosed no relevant professional, personal, or financial relationship related to the planning or implementation of this CNE activity.
- This CNE activity receives no sponsorship or commercial support.
- This CNE activity does not endorse any products.

FOR QUESTIONS OR ADDITIONAL INFORMATION PLEASE CONTACT:
JILLIAN HOPEWELL – jhopewell@migrantclinician.org

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 control measures for 2020…

- **Increase by 5%** the number of adult and pediatric weight screenings & counseling.
- **Increase by 5%** the number of health centers meeting Healthy People 2020 goals.
- **Reduce by 5%** the number of new diabetes diagnoses.
- **Reduce by 5%** the number of patients with diabetes with an HbA1c value greater than 9%.
- **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%)

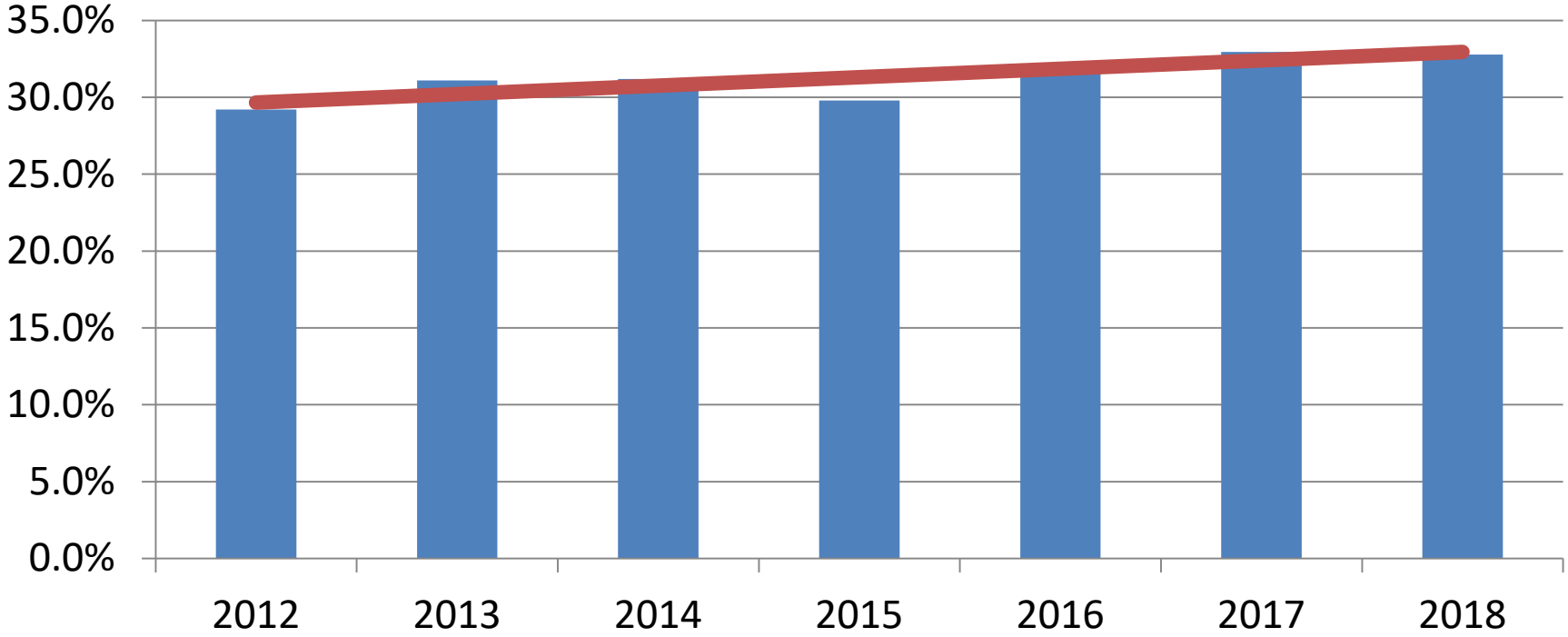
Health centers can help you manage your diabetes. Find a health center.

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 3 - 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 2018-2020 goal of the performance analysis is to assist all 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

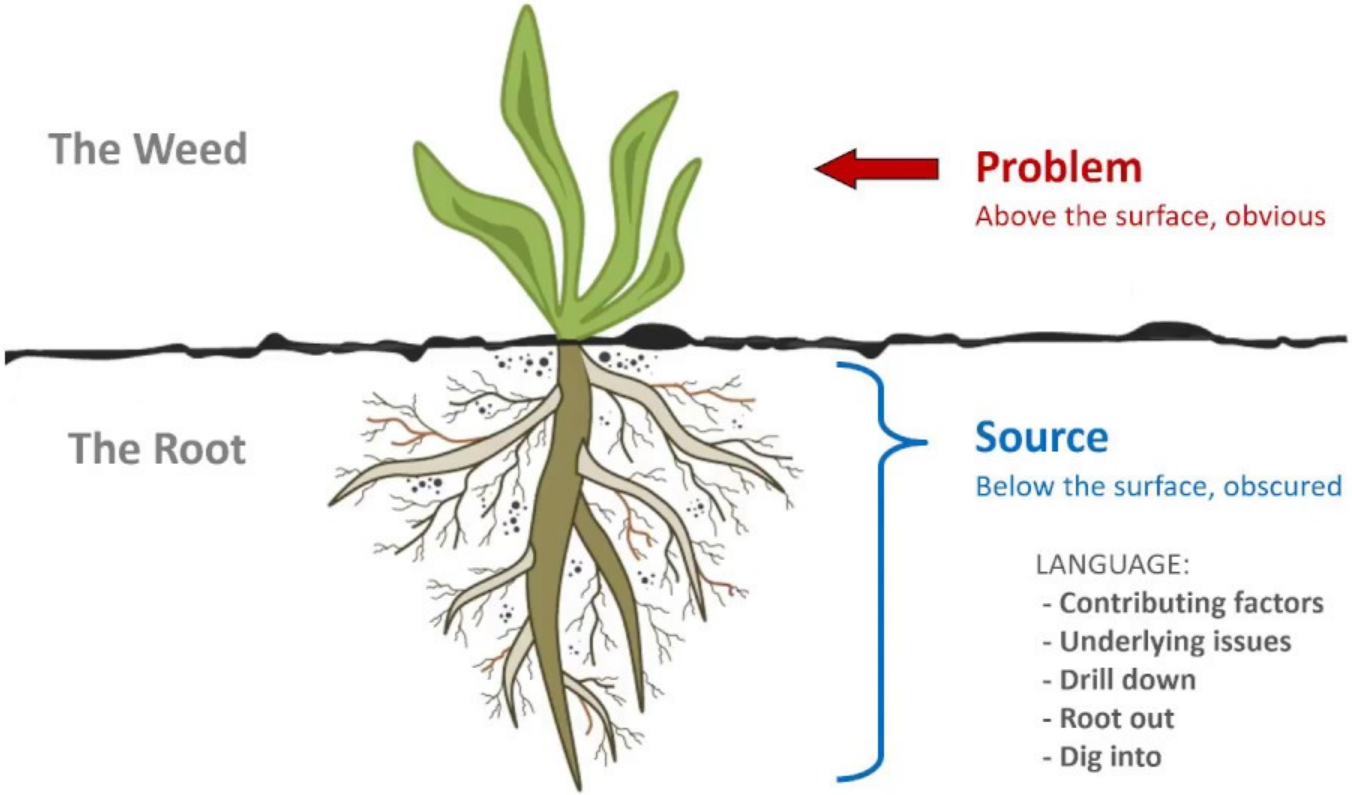
Prior to Visit

- 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); current year stats
- List of TA and/or other self identified needs.

Root Cause Analysis - The Concept



- SWOT analysis
- Fishbone
- 5 Whys

Strengths

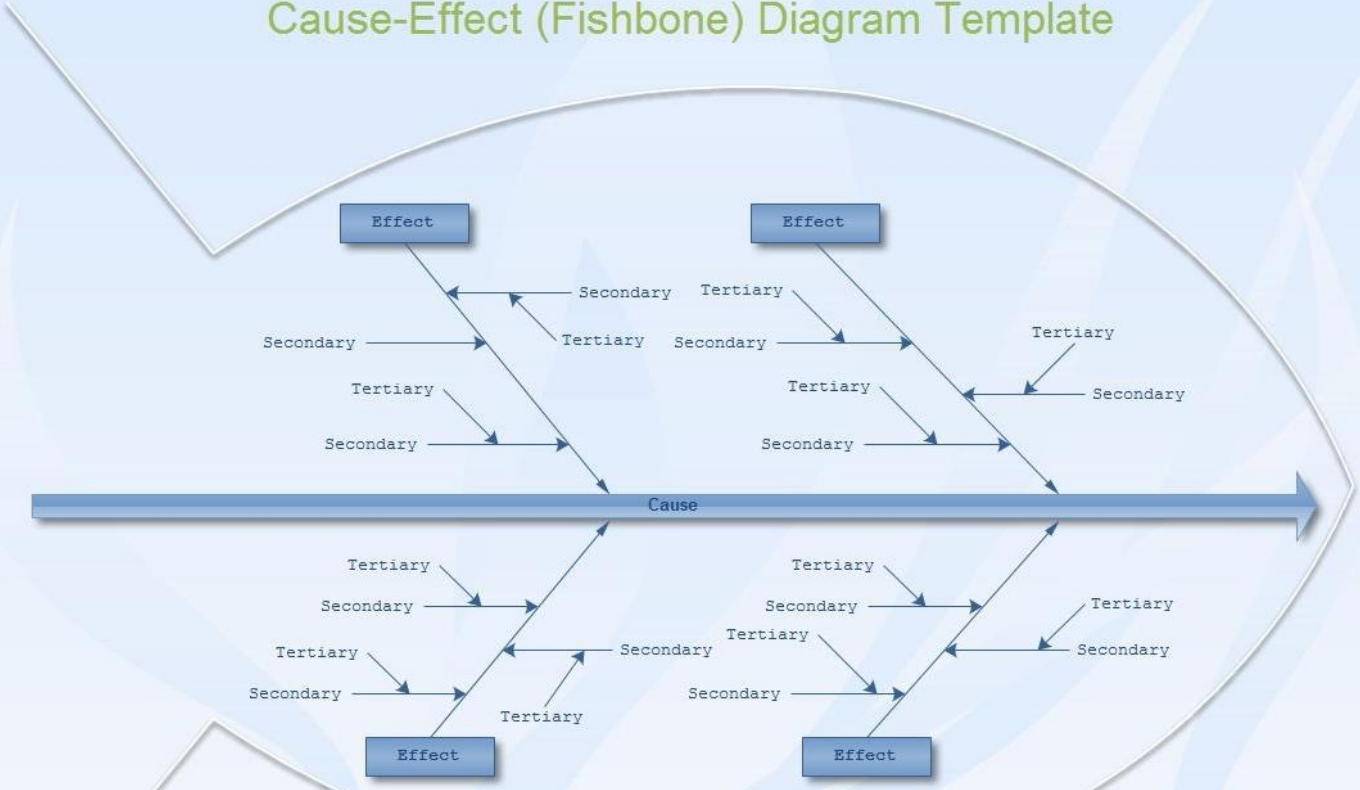
Weaknesses

SWOT Analysis

Opportunities

Threats

Cause-Effect (Fishbone) Diagram Template

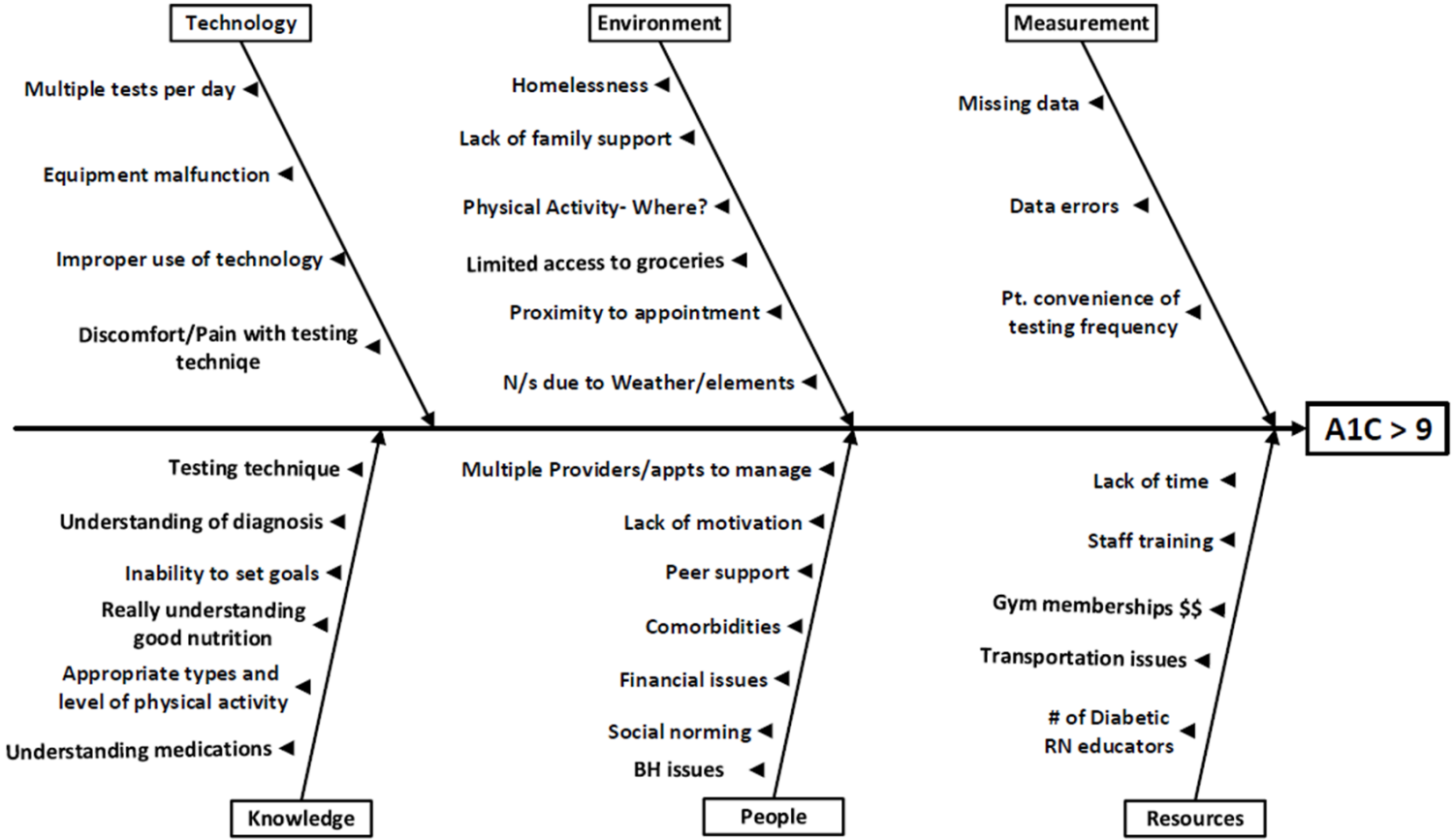


EVENT. What happened? Define the problem as an event

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?

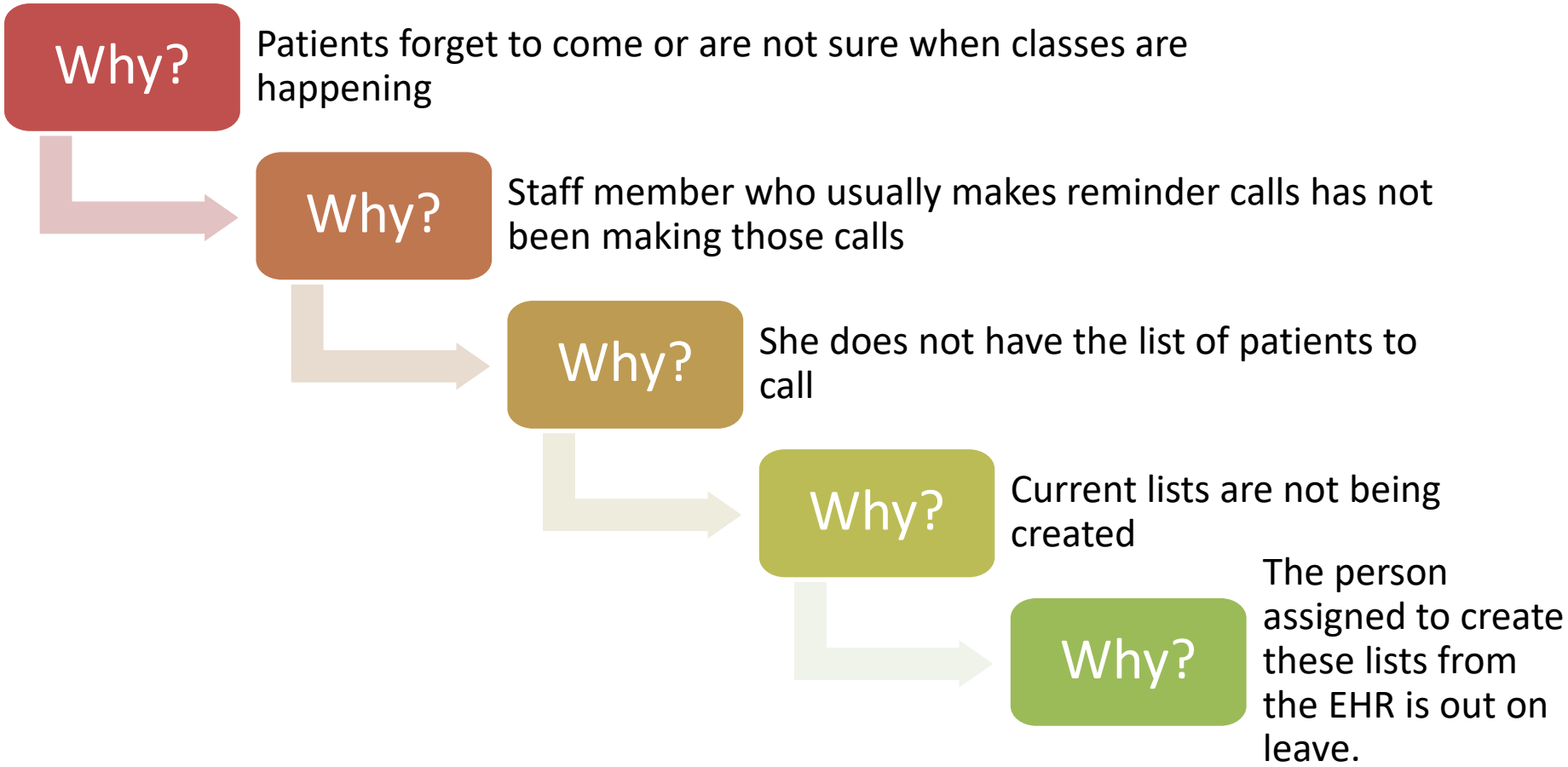
ACTION. What are the implications for action? What can you do to change the results?



Source: Holyoke Health Center

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

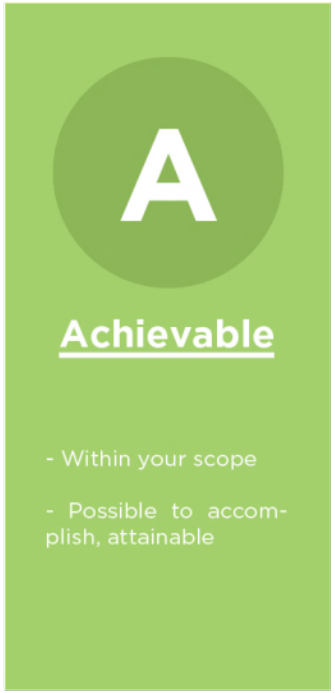
- Review most recent reported factors (SAC/BPR)
- Revise if needed
- Internal and external / current and anticipated factors
- Rank in order of importance

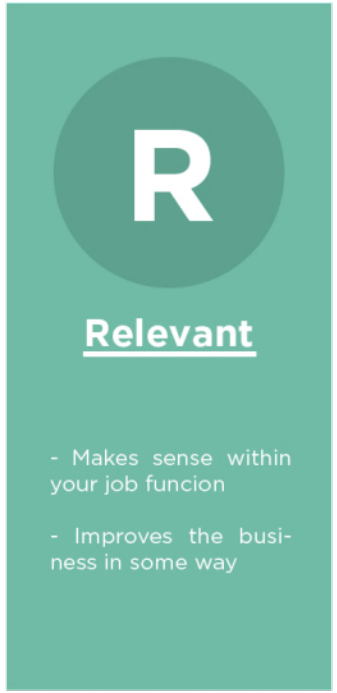
Develop 3 Actions Steps

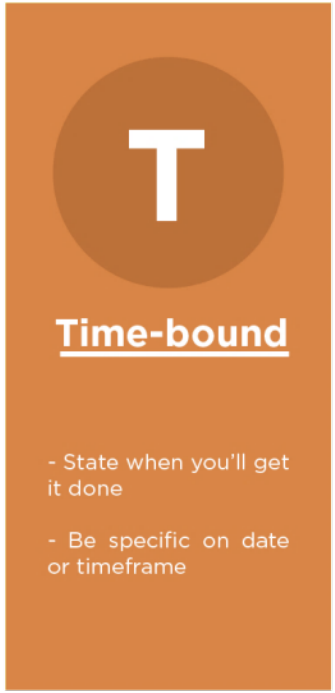
Goals should be related to identified contributing & restricting factors and root causes


S
Specific
- State what you'll do
- Use action words


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


A
Achievable
- Within your scope
- Possible to accomplish, attainable


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

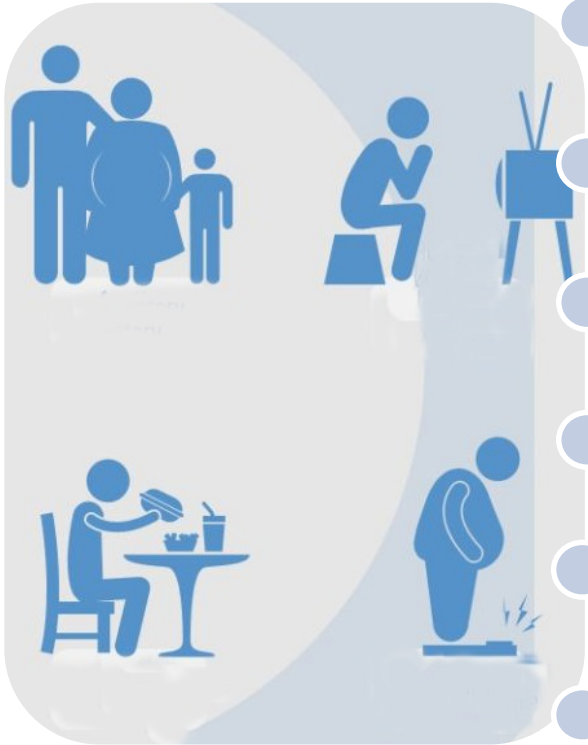

T
Time-bound
- State when you'll get it done
- Be specific on date or timeframe

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

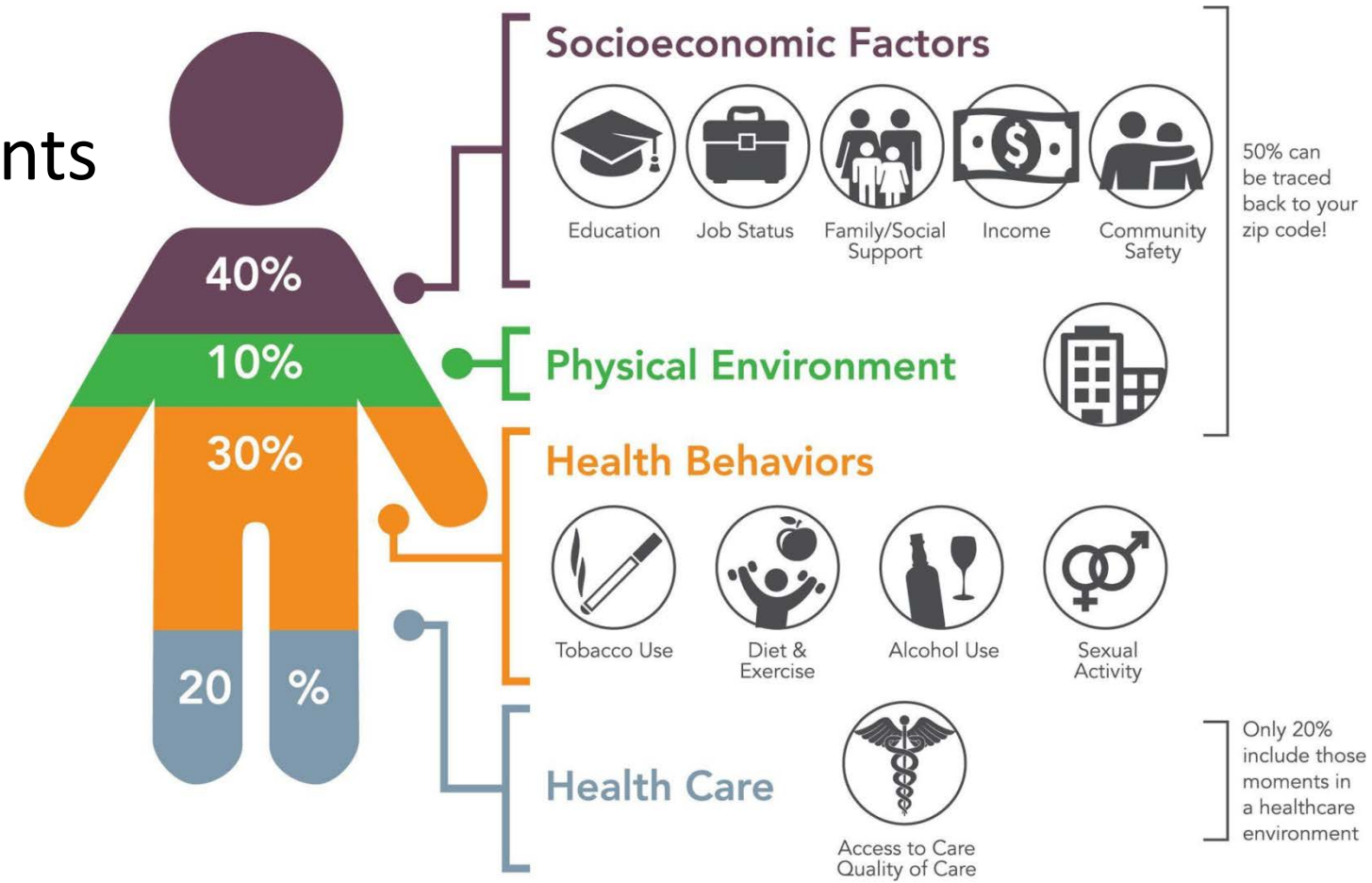
Diabetes Risk Factors



- Family history of diabetes
- Obesity increases the risk of type 2 diabetes
- Race: it's unclear why, but blacks, Hispanics, American Indians and Asian-Americans — are at higher risk.
- High cholesterol
- Smoking and high blood pressure
- Sedentary lifestyle

http://www.idf.org/node/26455?language=es

Social Determinants of Health

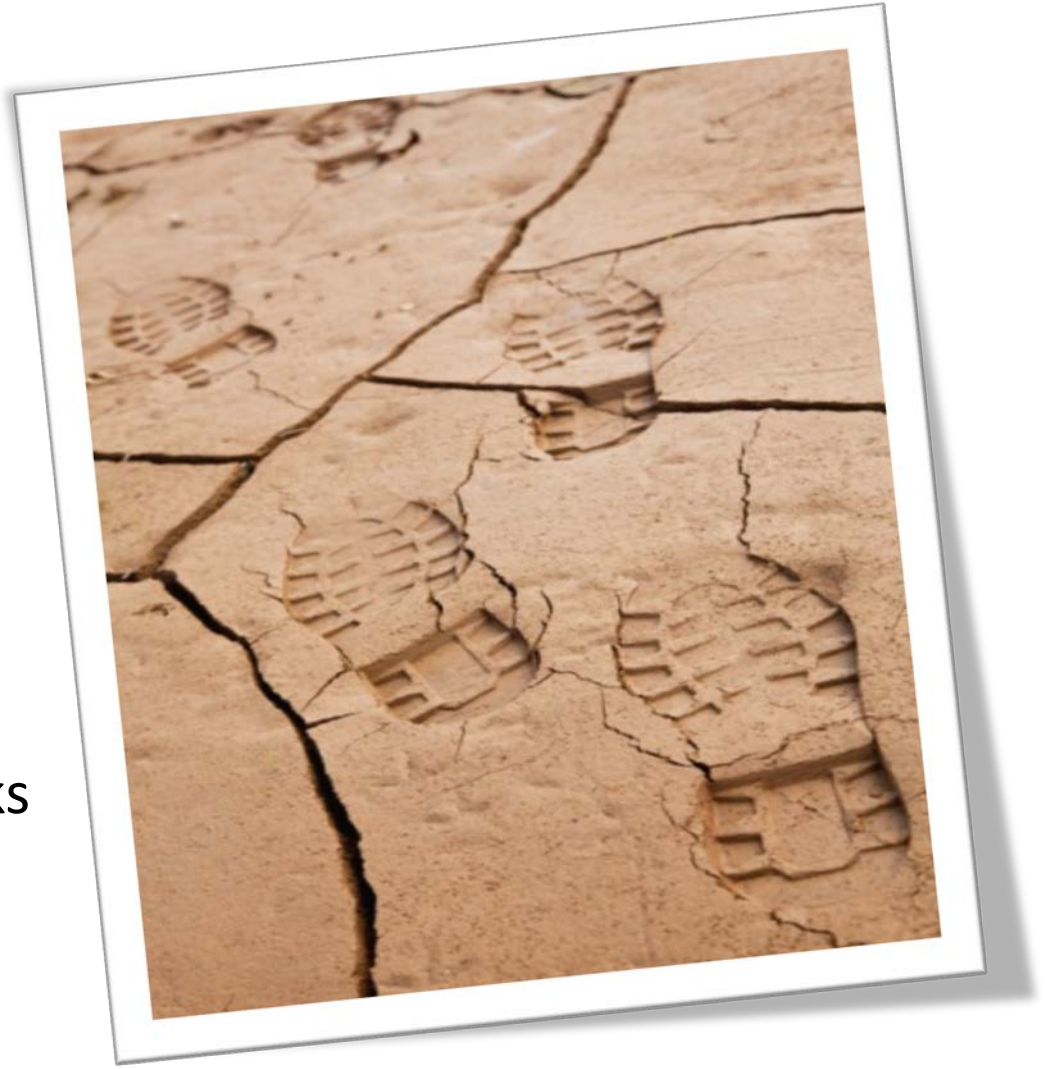


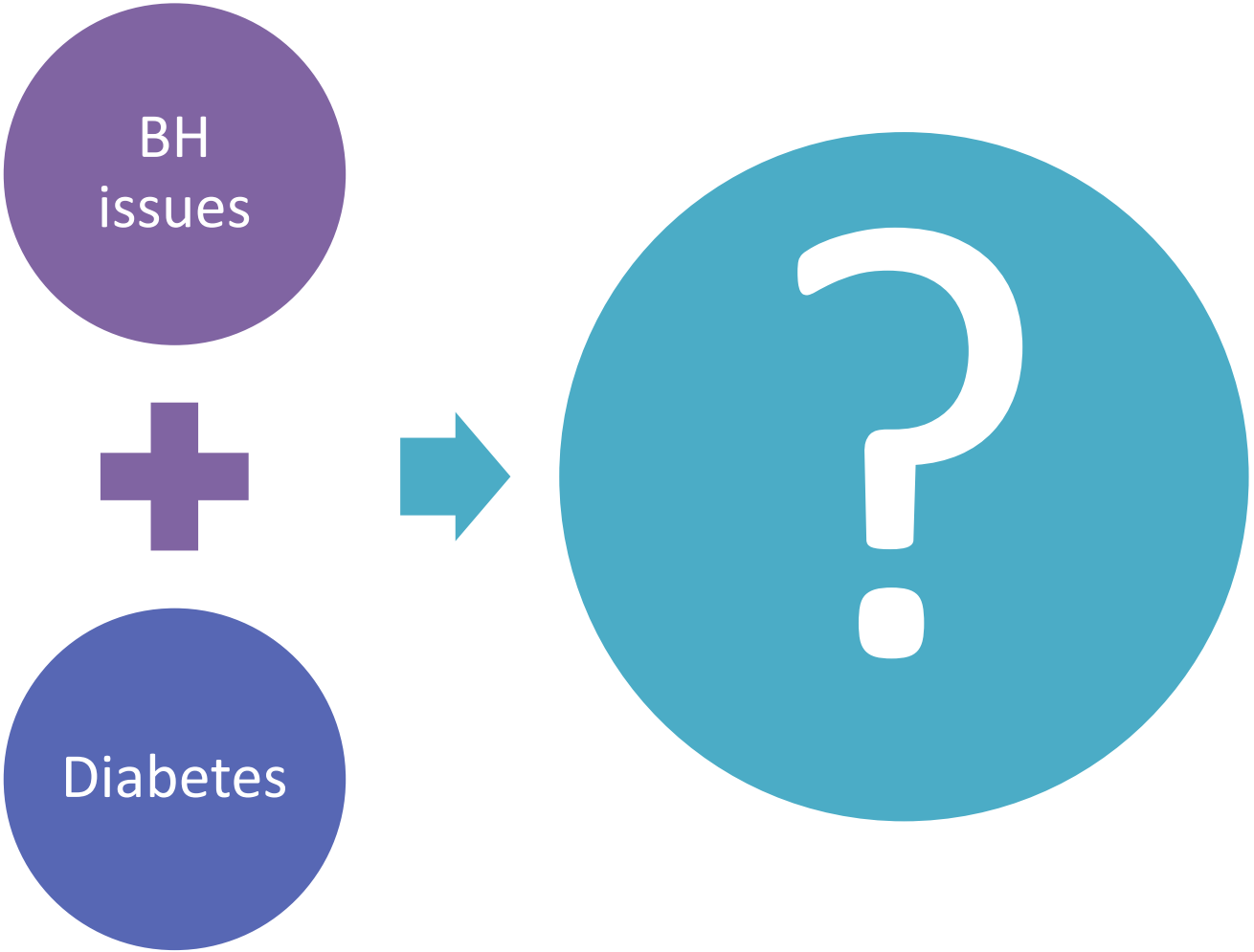
www.nachc.org/prapare

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Migration…

- Loss of family and social network
- Threats of violence from fellow travelers, locals and law enforcement
- Isolation from social networks as well as from social service and healthcare providers



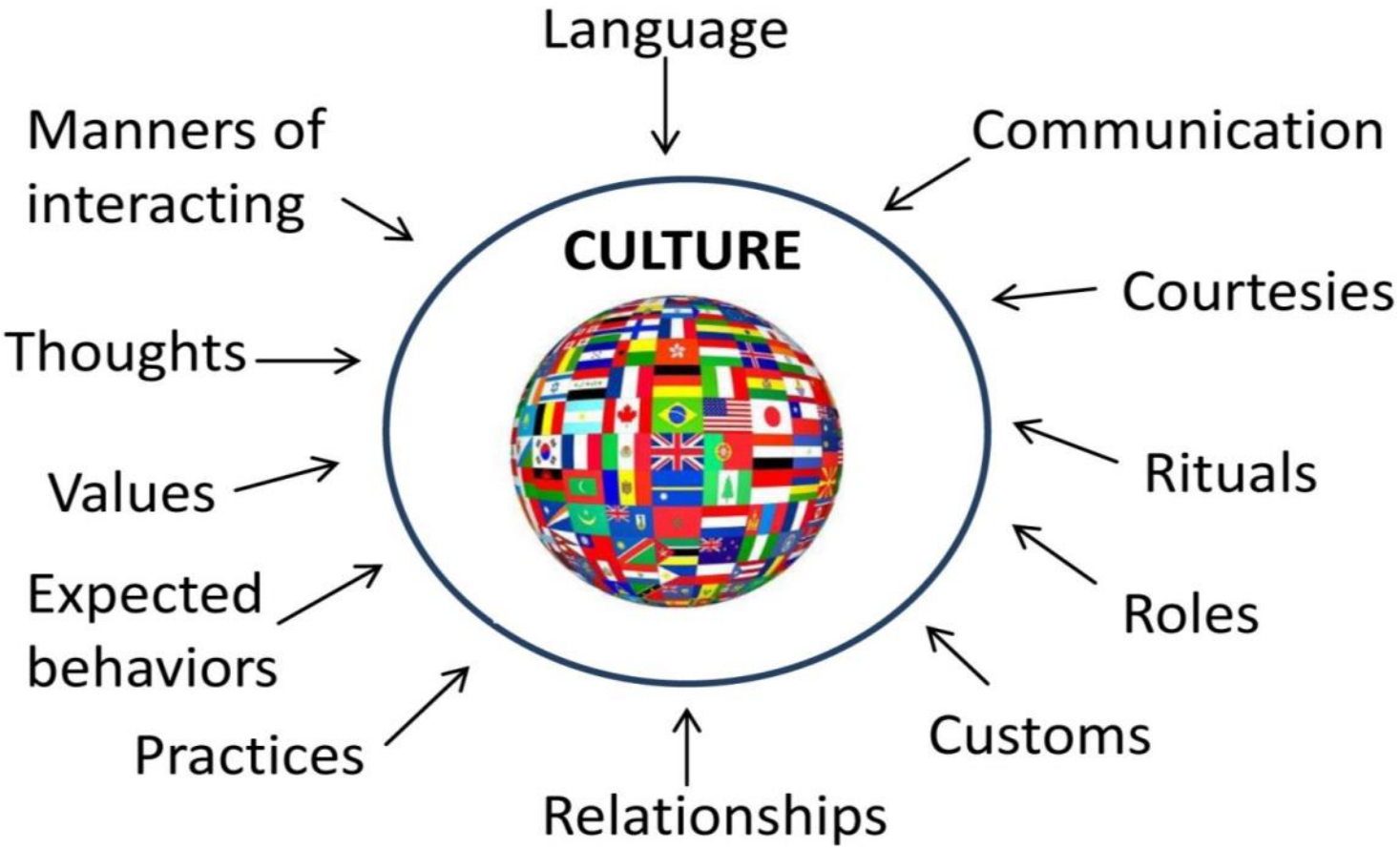

BH issues
Diabetes
?

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.

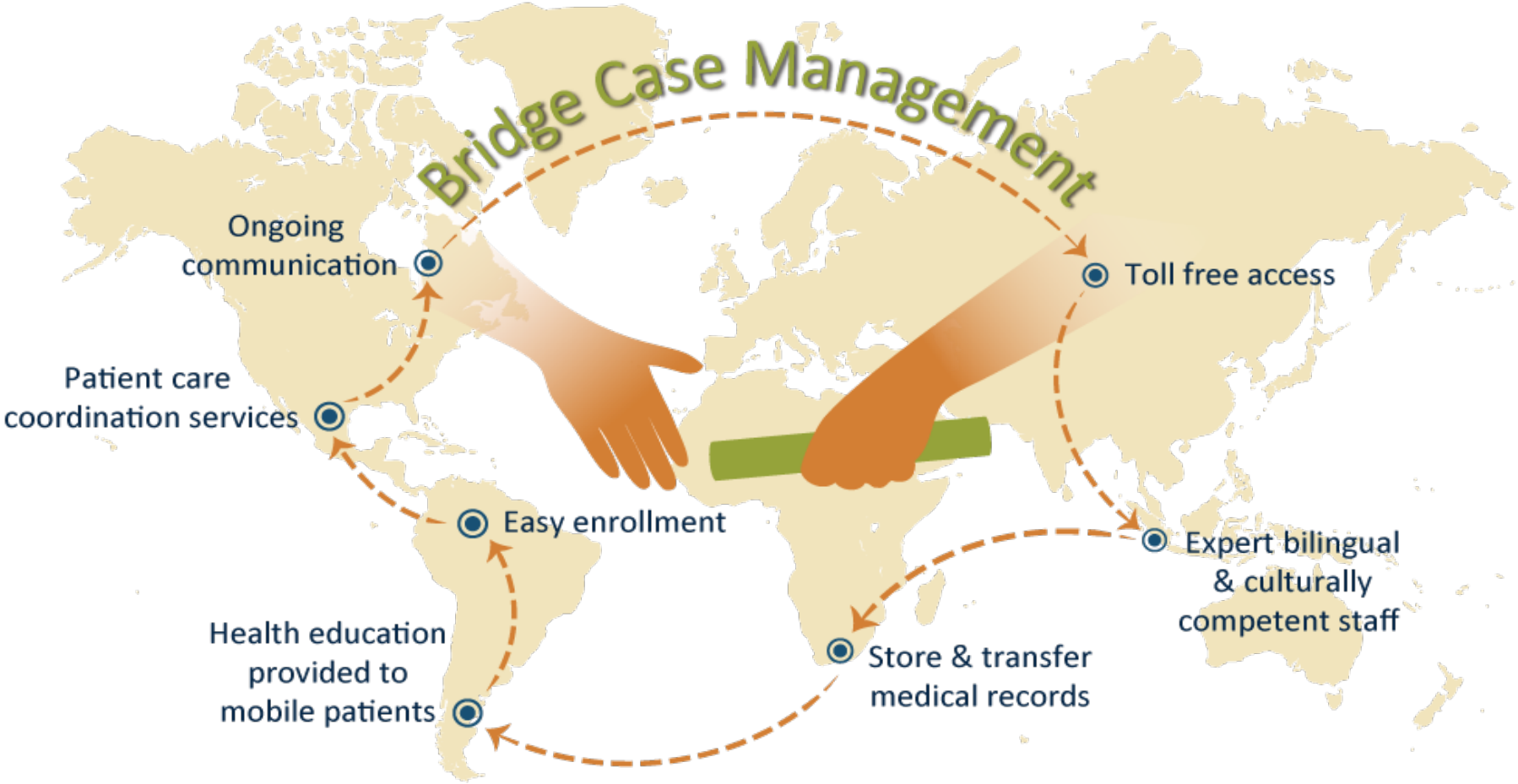


Source: National Center for Cultural Competence, 2011

CHWs and Diabetes

Other Solutions?

- Staff trainings
- Screening tools—PRAPARE, TIC, Depression
- Patient education
- Systems changes—service integration, mobile care, employer collaboration


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)

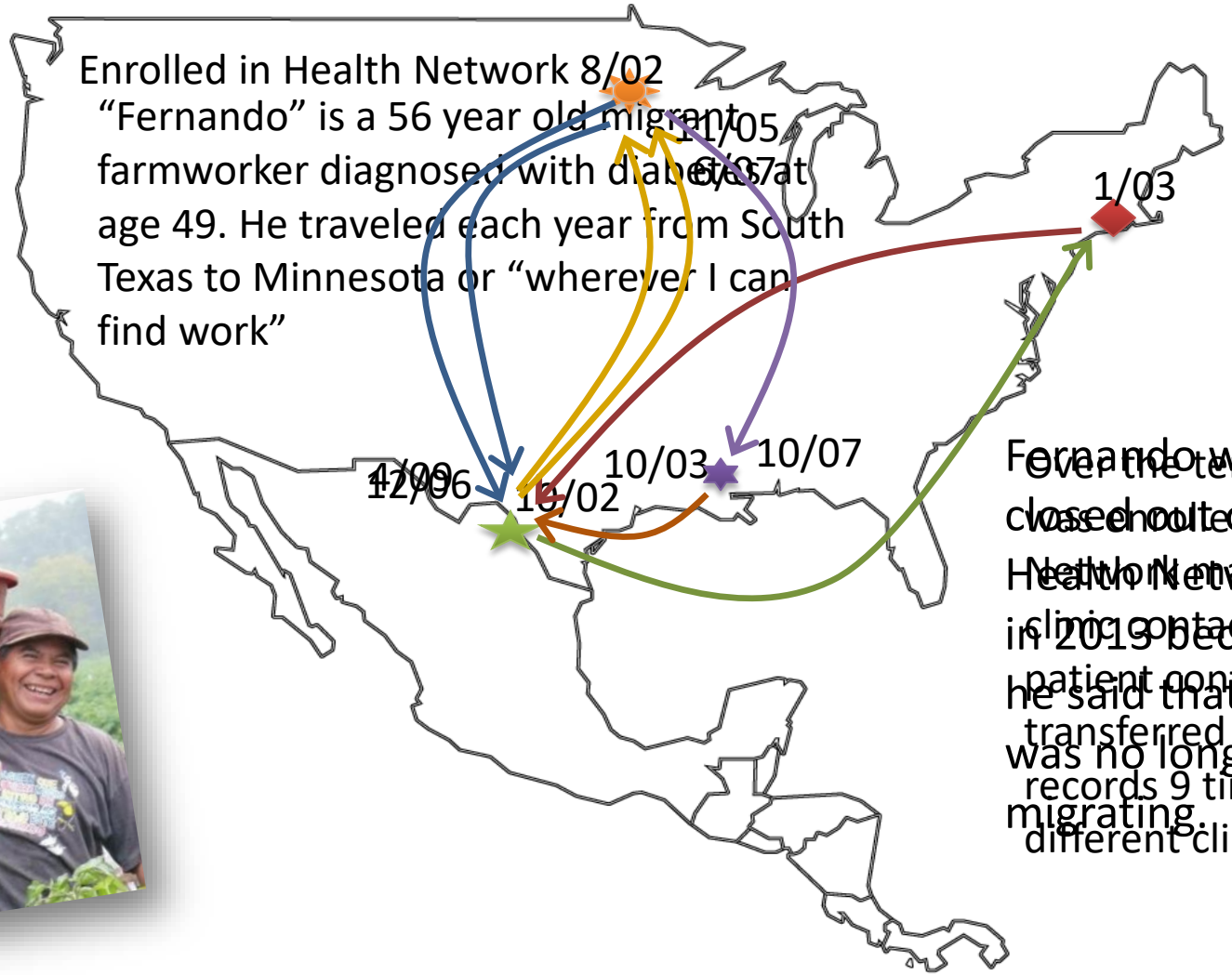
Contacts clinics monthly

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

Reports back to the enrolling clinic and notifies them of outcomes

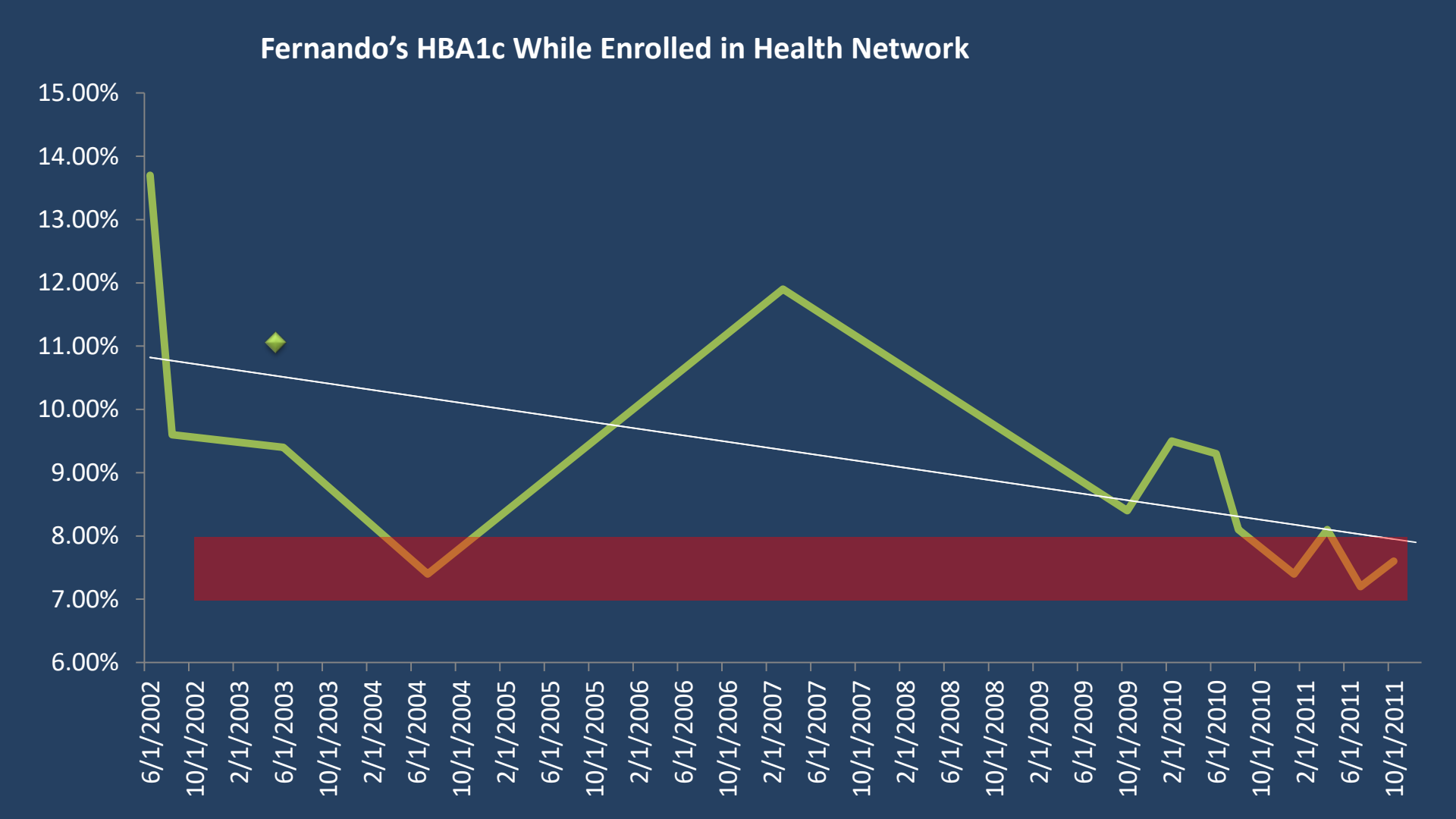
Enrolled in Health Network 8/02

"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"

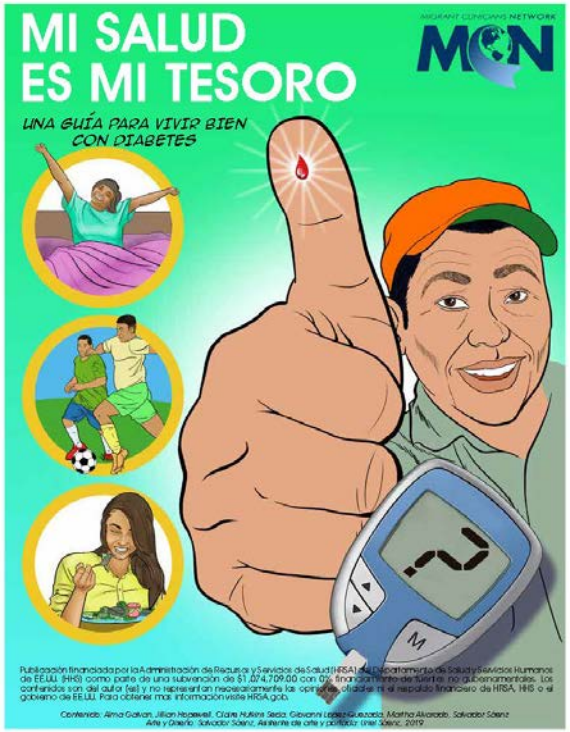


Fernando was enrolled in Health Network in 2013 because he said that he was no longer migrating.

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
2/1/2004
6/1/2004
10/1/2004
2/1/2005
6/1/2005
10/1/2005
2/1/2006
6/1/2006
10/1/2006
2/1/2007
6/1/2007
10/1/2007
2/1/2008
6/1/2008
10/1/2008
2/1/2009
6/1/2009
10/1/2009
2/1/2010
6/1/2010
10/1/2010
2/1/2011
6/1/2011
10/1/2011

MCN Diabetes Resources



New resource will be available online by the end of February 2020

Project ECHO

An innovative learning and knowledge sharing platform

[La versión en español se encuentra abajo]

You are invited to participate in the free ECHO Diabetes and Hypertension series

In 2020 MCN continues its efforts to examine two related conditions, diabetes and hypertension, by offering a unique **Spanish language only** learning opportunity for community health workers, promotoras de salud, outreach workers, and case managers who work with diabetic patients within the Hispanic/Latino populations, including migrant and immigrant workers and/or their families.

MIGRANT CLINICIANS NETWORK

HealthNetwork

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
  - ✓ Diabetes Promising Practices https://bphc.hrsa.gov/qualityimprovement/promising-practices/index.html#diabetes
- ✓ 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?

Candace Kugel, CRNP, CNM, RN
Clinical Specialist
Migrant Clinicians Network
ckugel@migrantclinician.org

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,094,709.00 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.