Diabetes Quality Improvement

Making it work for your mobile and agricultural worker populations

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MIGRANT CLINICIANS NETWORK MCN

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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
  - UDS measures
- ✓ COVID's Impact on Diabetes Care
- ✓ Diabetes Care & MSAWs
- ✓ Improvement Methodology
- ✓ Resources

OBJECTIVES

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

- Describe the HRSA UDS measures related to diabetes and national benchmarks.
- Describe the impact of the COVID-19 pandemic on the provision of diabetes care.
- Describe relevant approaches to diabetes care for mobile populations and agricultural workers.
- Describe resources available for diabetes performance improvement.

You are not alone

Resources will be highlighted throughout this presentation…

Know your National Training and Technical Assistance Partners (NTTAPs)
https://www.healthcenterinfo.org/

HRSA's Diabetes Quality Improvement Initiative

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

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

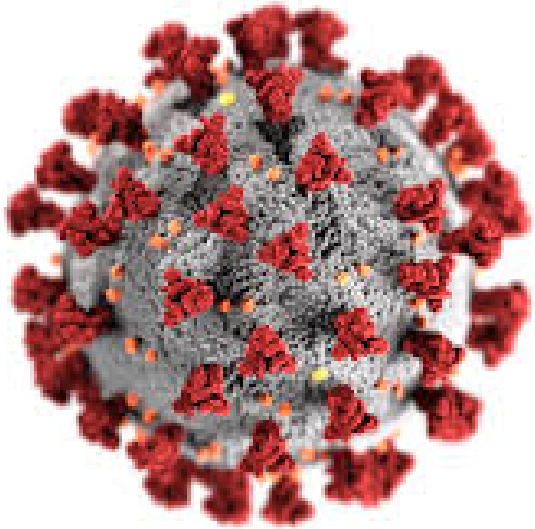
Overall Goals of the Initiative

Improve diabetes treatment and management

Increase diabetes prevention efforts

Reduce health disparities

And then COVID-19 happened…

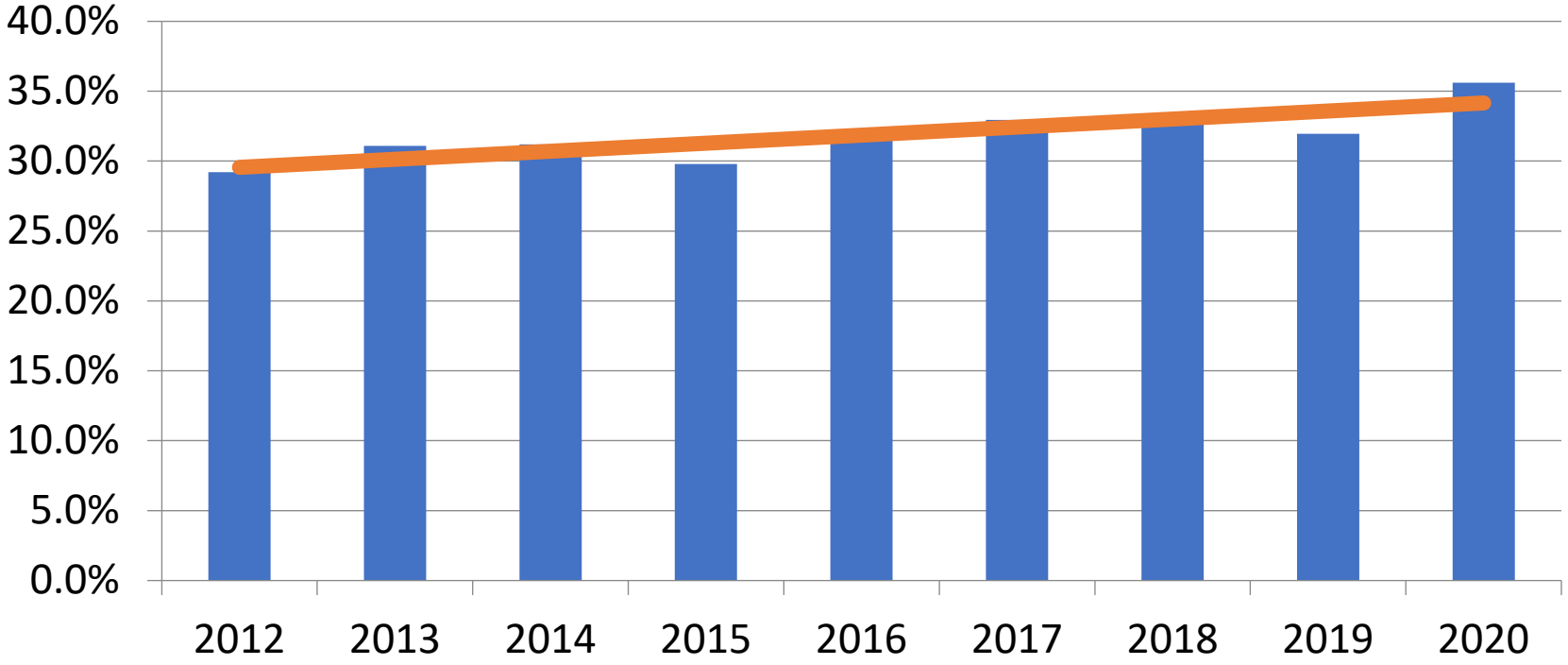


- The virtual OSV (VOSV) was designed
- Diabetes Performance Analysis is no longer part of the OSV

Current HRSA Expectations Related to Diabetes

- Operational Site Visit (OSV) no longer includes the performance analysis review of the health center's own diabetes performance.
- UDS reporting on DM control https://data.hrsa.gov/tools/data-reporting/program-data/
- Select health centers receiving TA related to DM
- Community Health Quality Recognition Awards https://bphc.hrsa.gov/qualityimprovement/community-health-quality-recognition

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 aged 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.

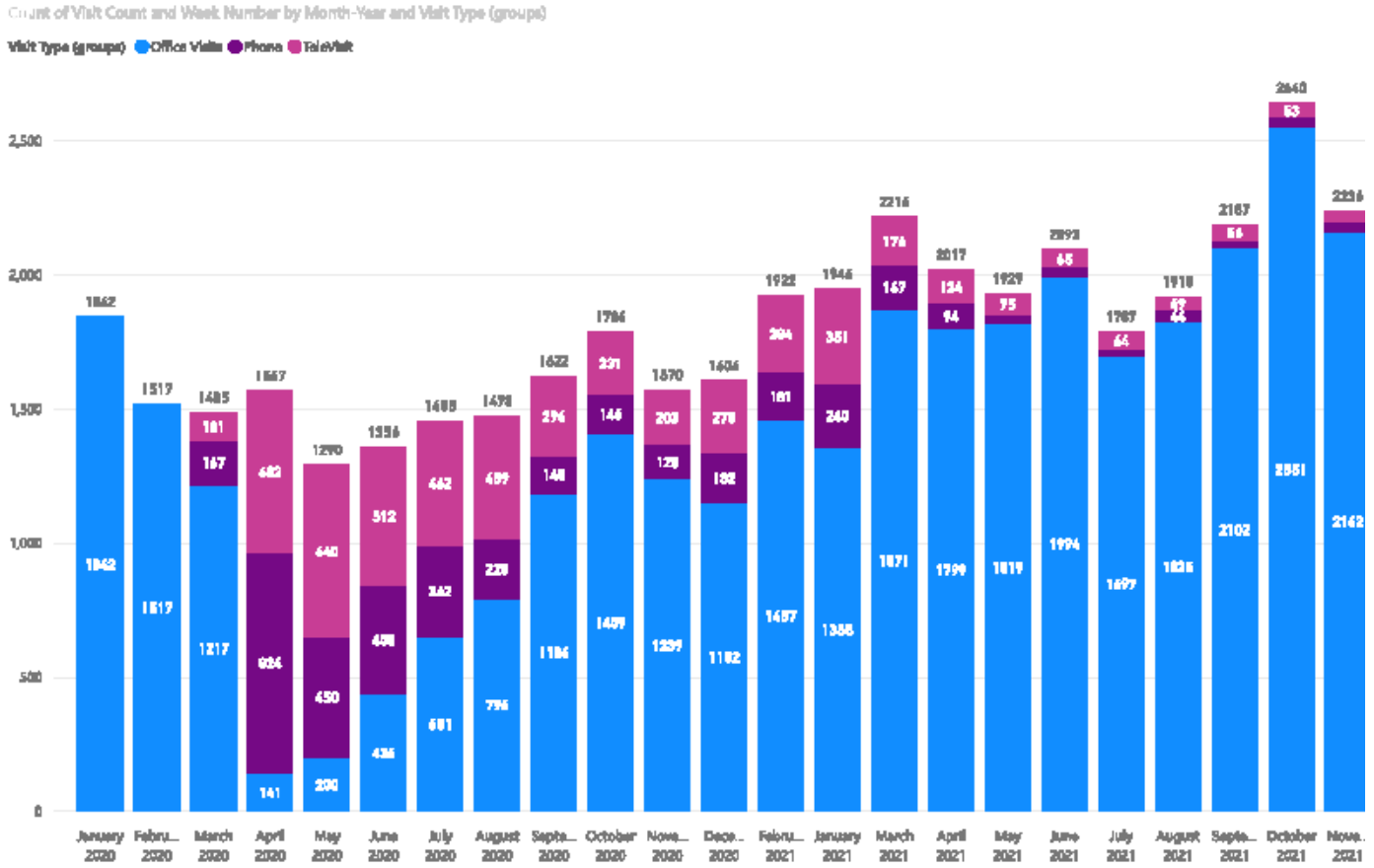
Percentage of patients aged 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the previous 12 months to that visit and, when the BMI is outside of normal, a follow-up plan is documented during the visit or during the previous 12 months of that visit.

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

Diabetes and COVID-19

- Diabetes didn’t go away….
- Chronic care management changes
  - ✓ Decreased face-to-face visits
  - ✓ Telehealth
  - ✓ Testing, medication, self-care challenges
- Revisiting our improvement efforts

One health center's experience…

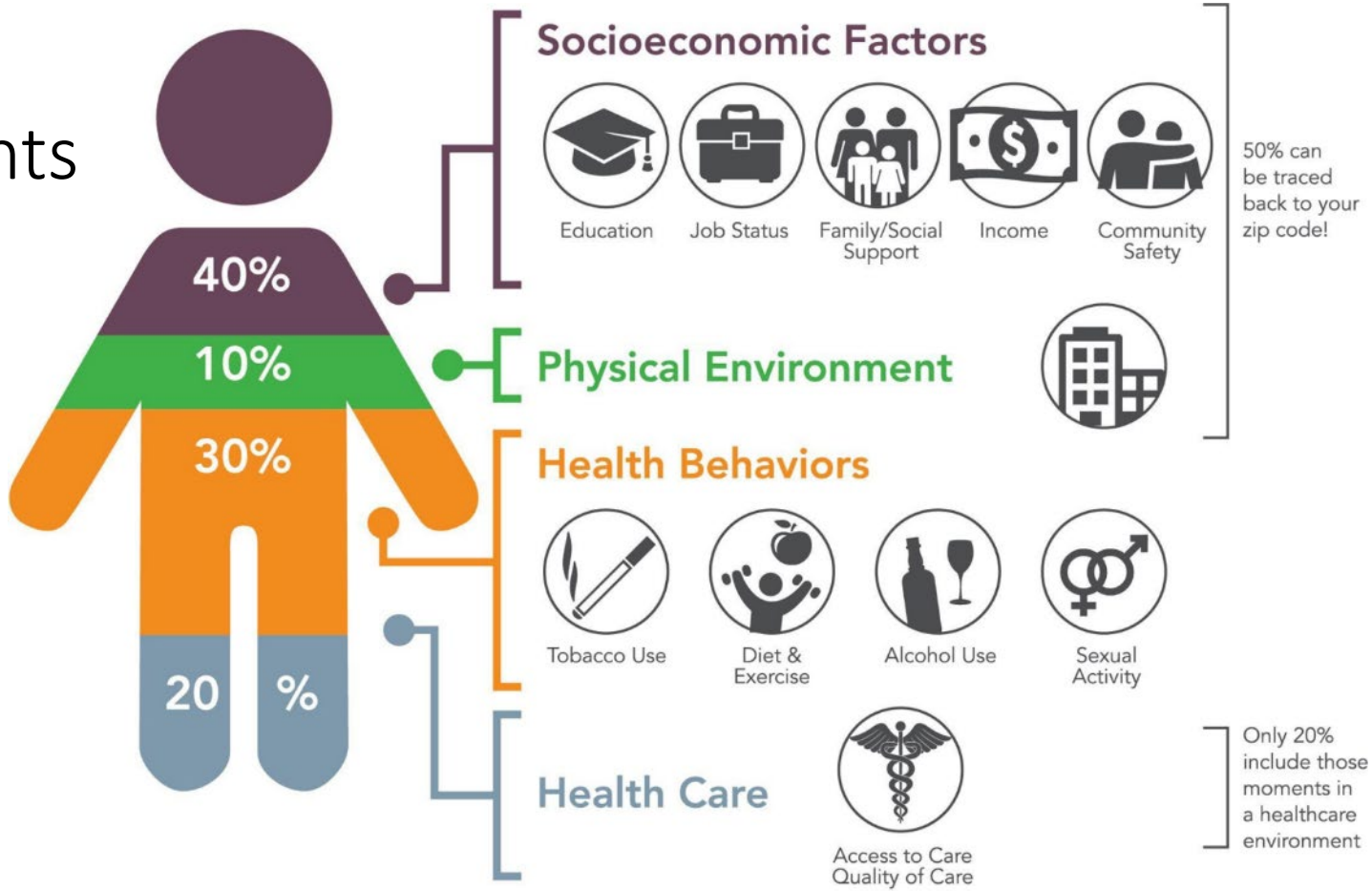


Adaptations During COVID

- Self-management training
- Telehealth appts
- Remote monitoring (ecri.org)
- CHWs
- Combinations or all of the above
- Other ideas?

Diabetes Performance Improvement and MSAWs

Social Determinants of Health

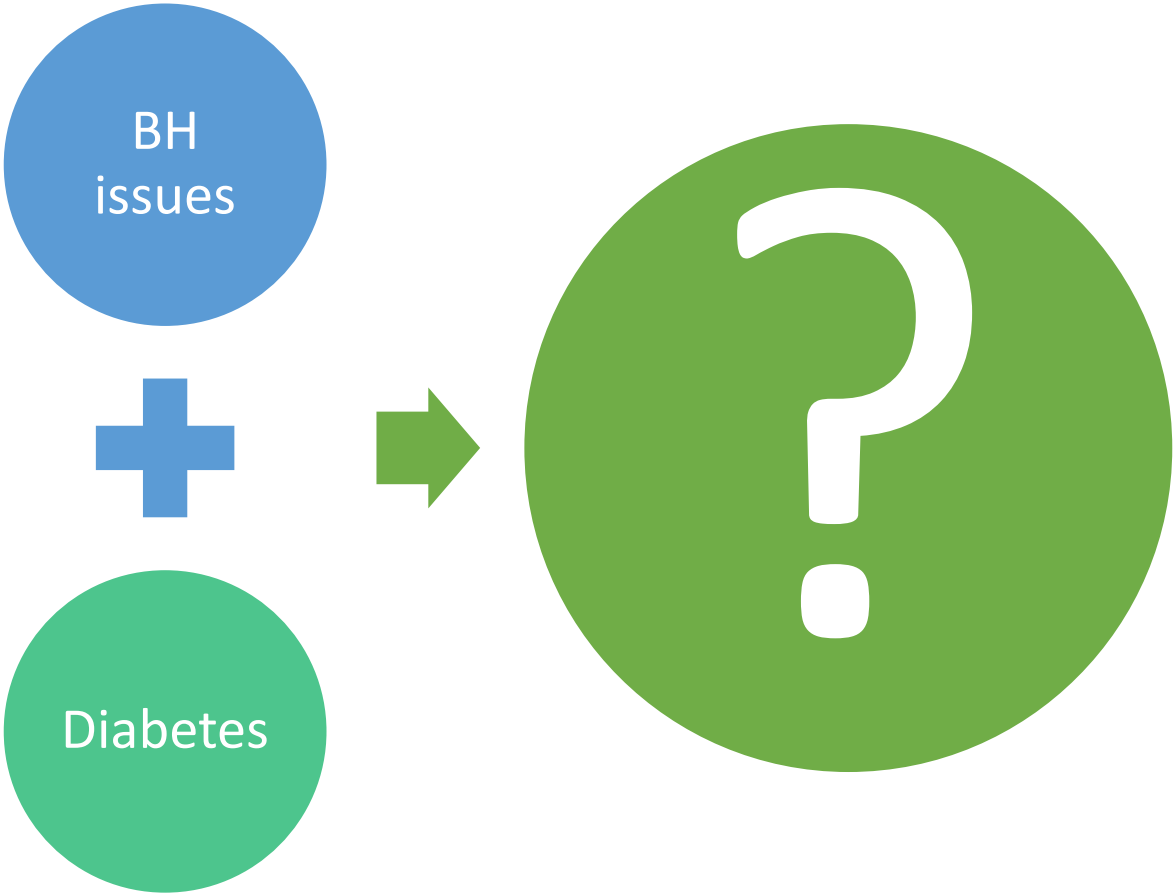


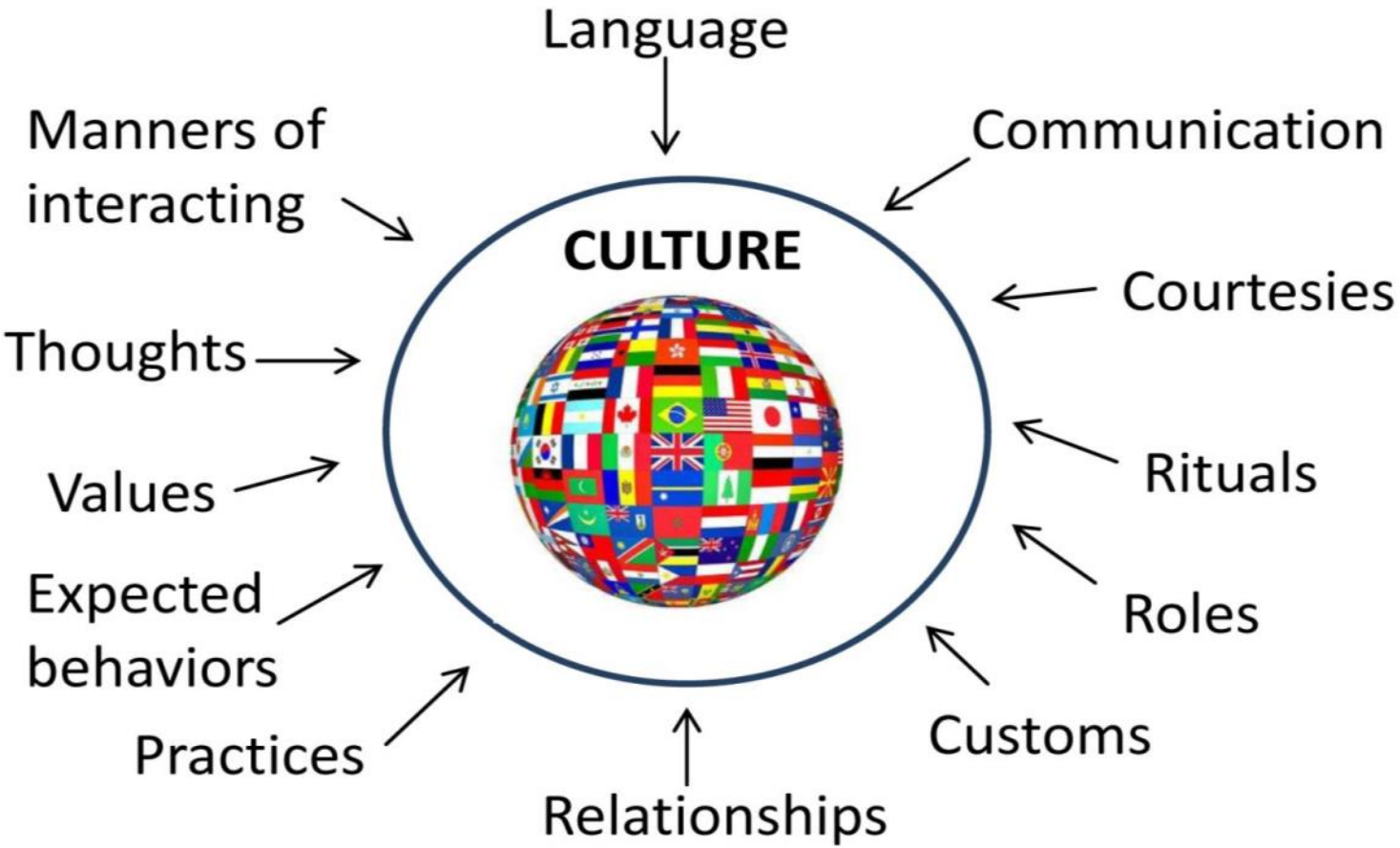
www.nachc.org/prapare

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
?



Source: National Center for Cultural Competence, 2011

CHWs and Diabetes

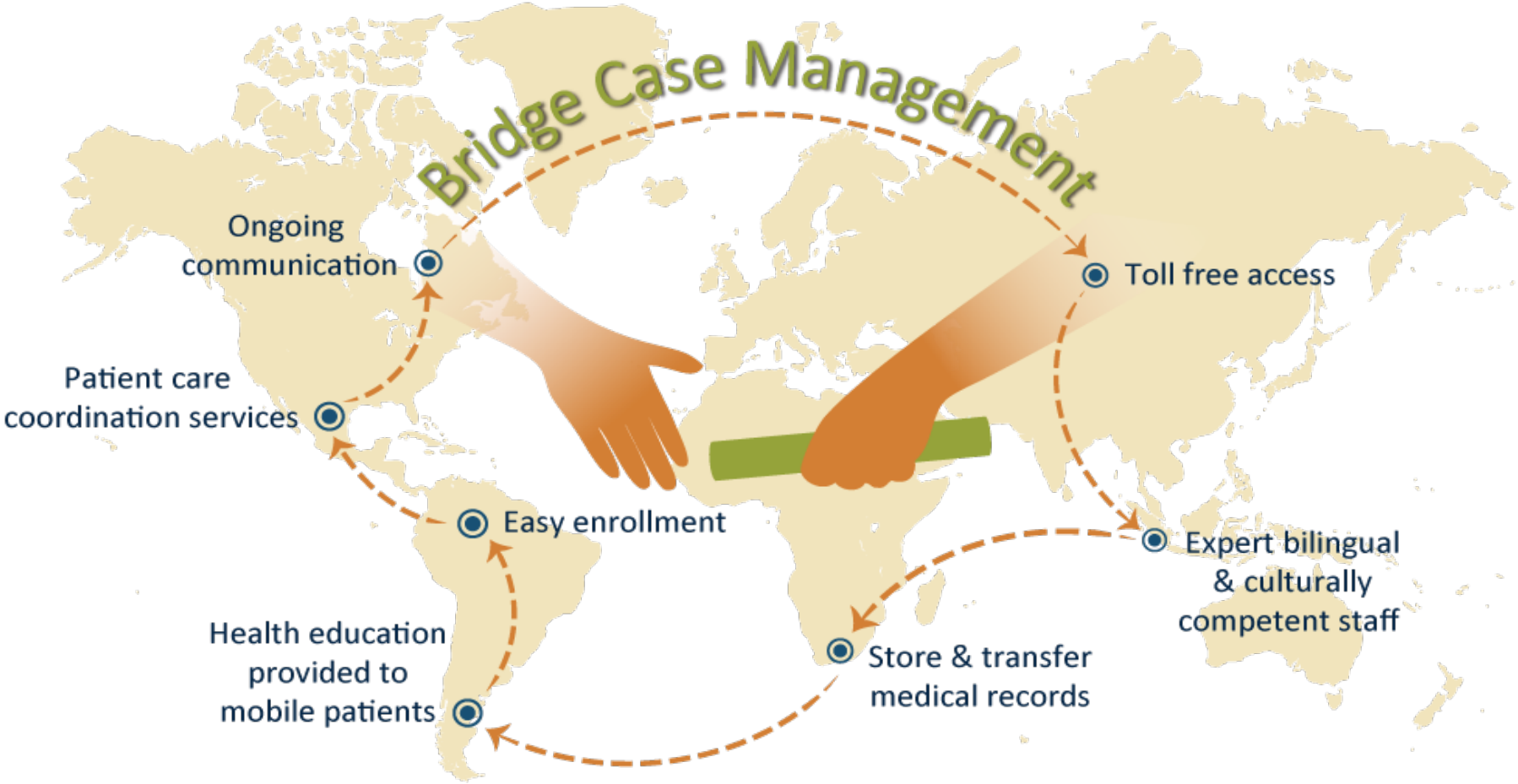
Other Solutions?

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

MCN Diabetes Resources

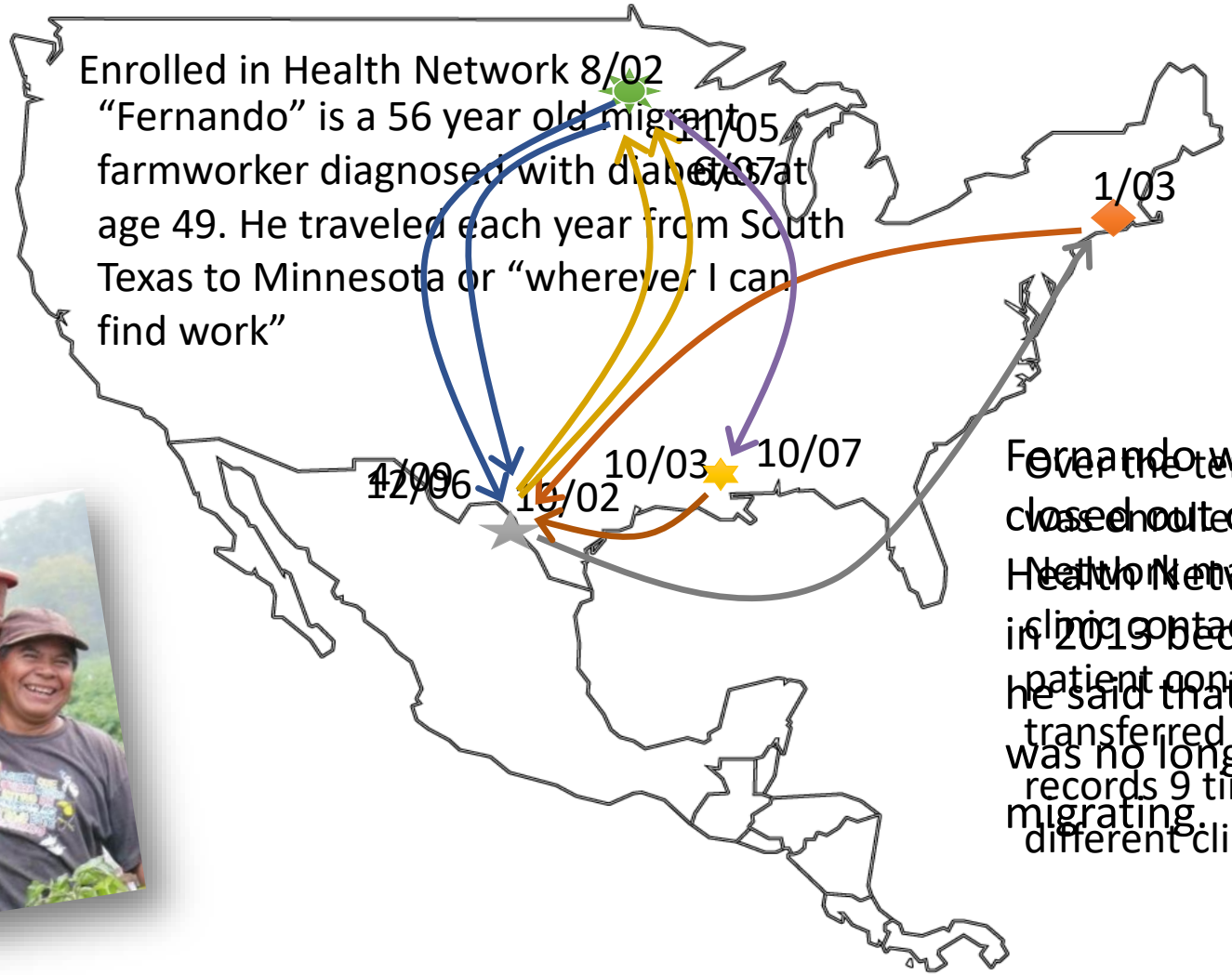
MIGRANT CLINICIANS NETWORK

HealthNetwork


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

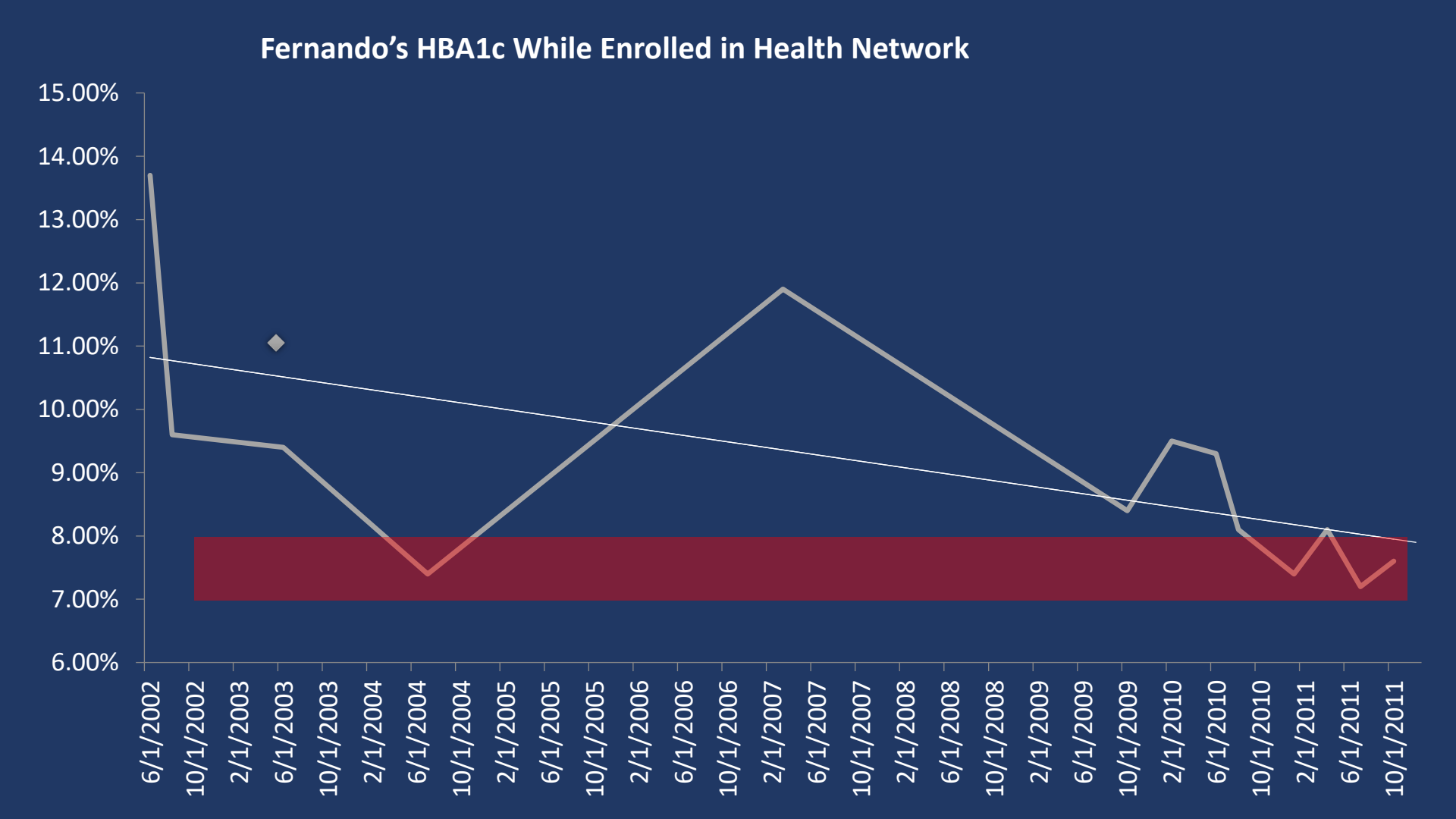
Enrolled in Health Network 8/02

"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 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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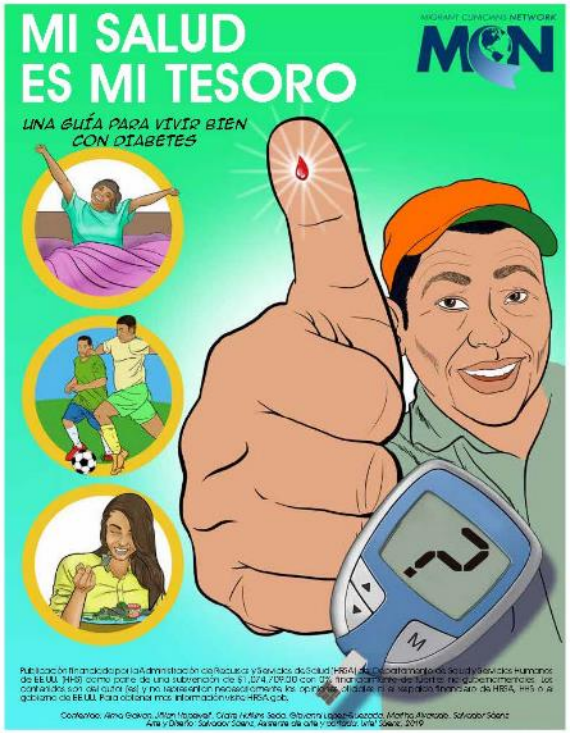


Available online at https://www.migrantclinician.org/issues/diabetes

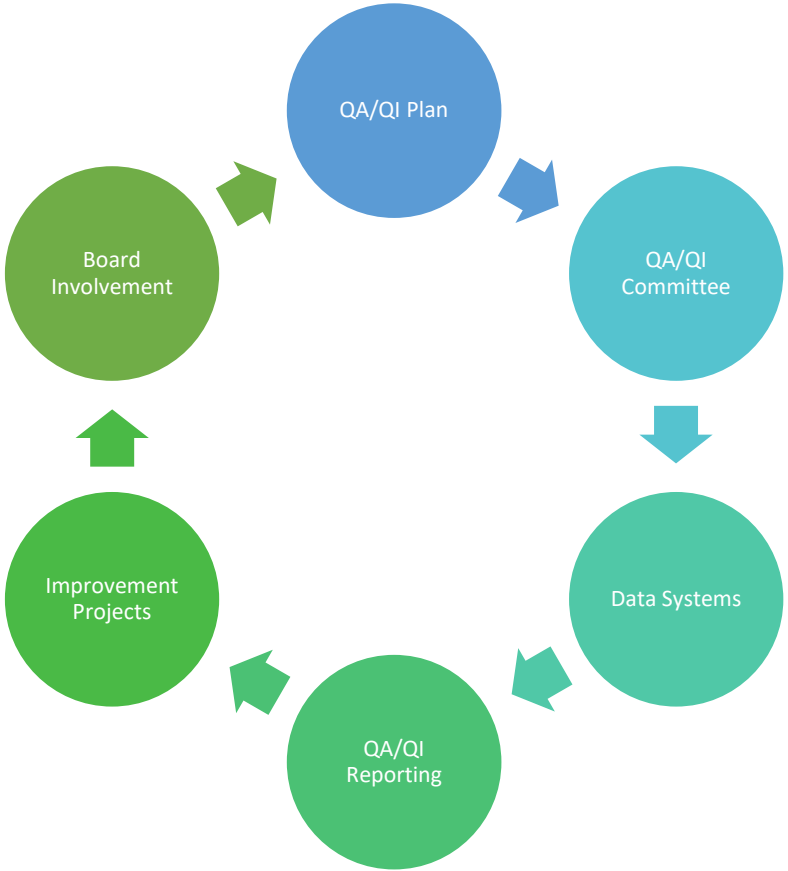
Performance Improvement Basics

"Systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups"

http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

- Root cause analysis
  - SWOT analysis
  - Fishbone
  - 5 Whys
- PDSA

Elements of the QA/QI Program



QA/QI and Special Populations

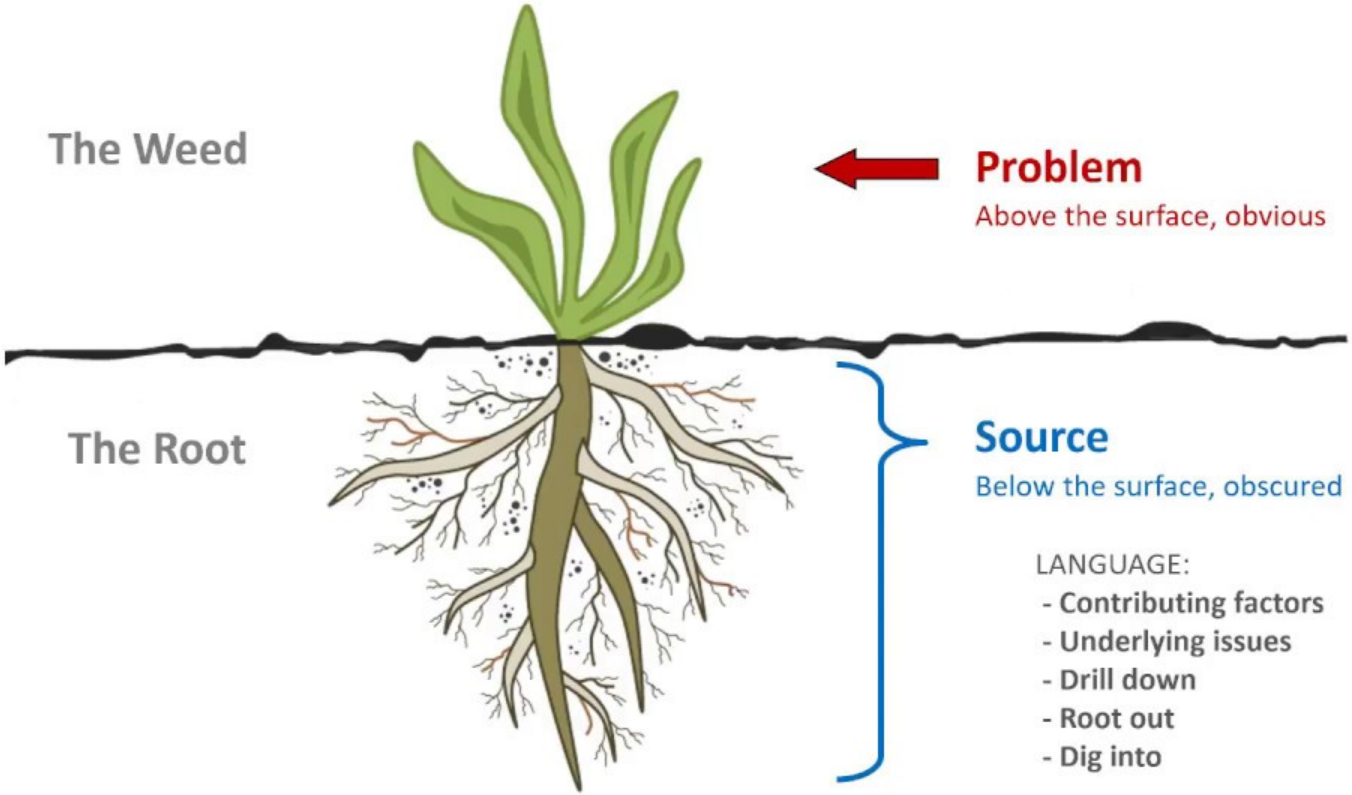
Including special populations in your QA/QI program:

- Include relevant staff on committee(s)
- Integrate special populations patients through
  - ✓ Committee/Board representation
  - ✓ Patient satisfaction surveys, suggestions
  - ✓ Focus groups
  - ✓ Interviews

May need to consider a separate performance improvement 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

Root Cause Analysis - The Concept



Strengths

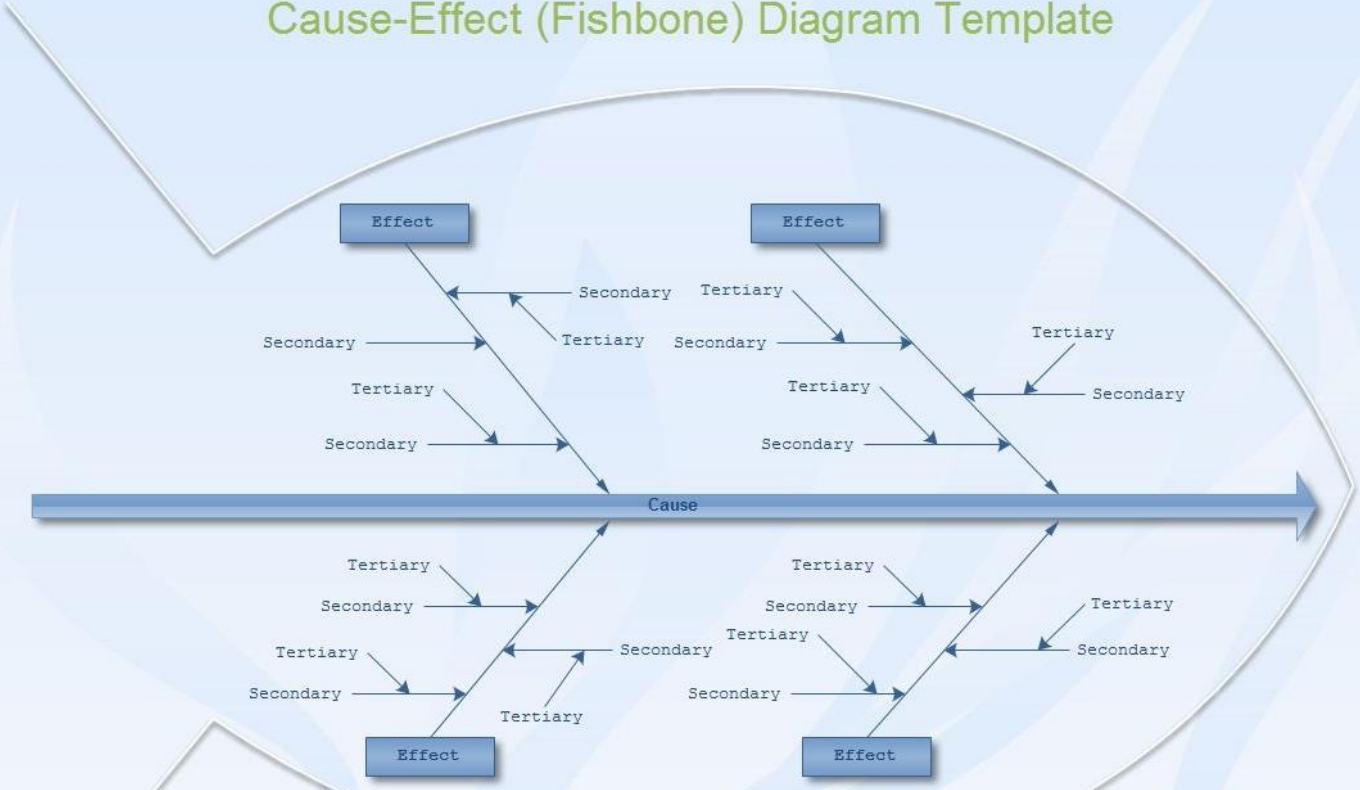
Weaknesses

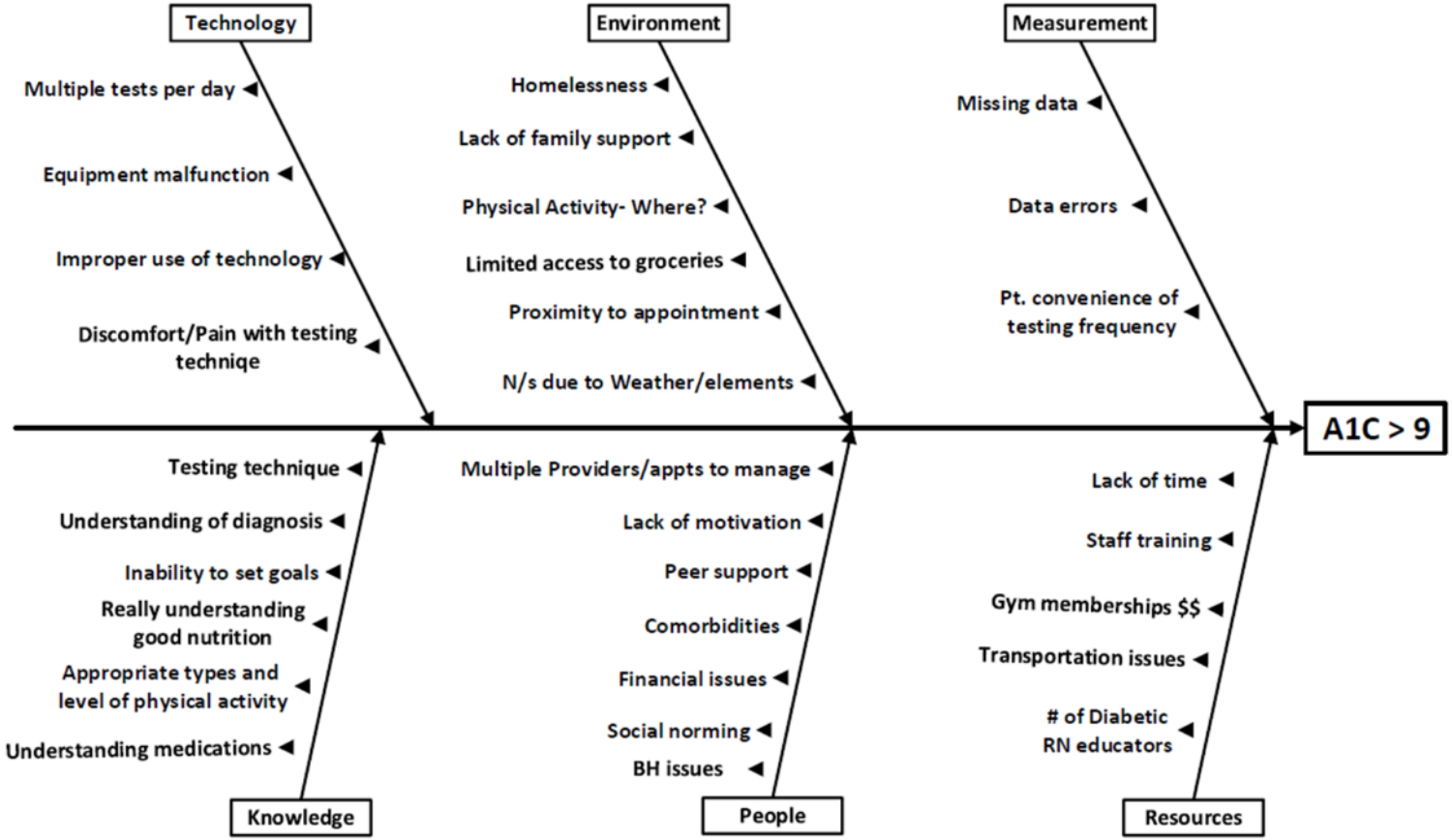
SWOT Analysis

Opportunities

Threats

Cause-Effect (Fishbone) Diagram Template

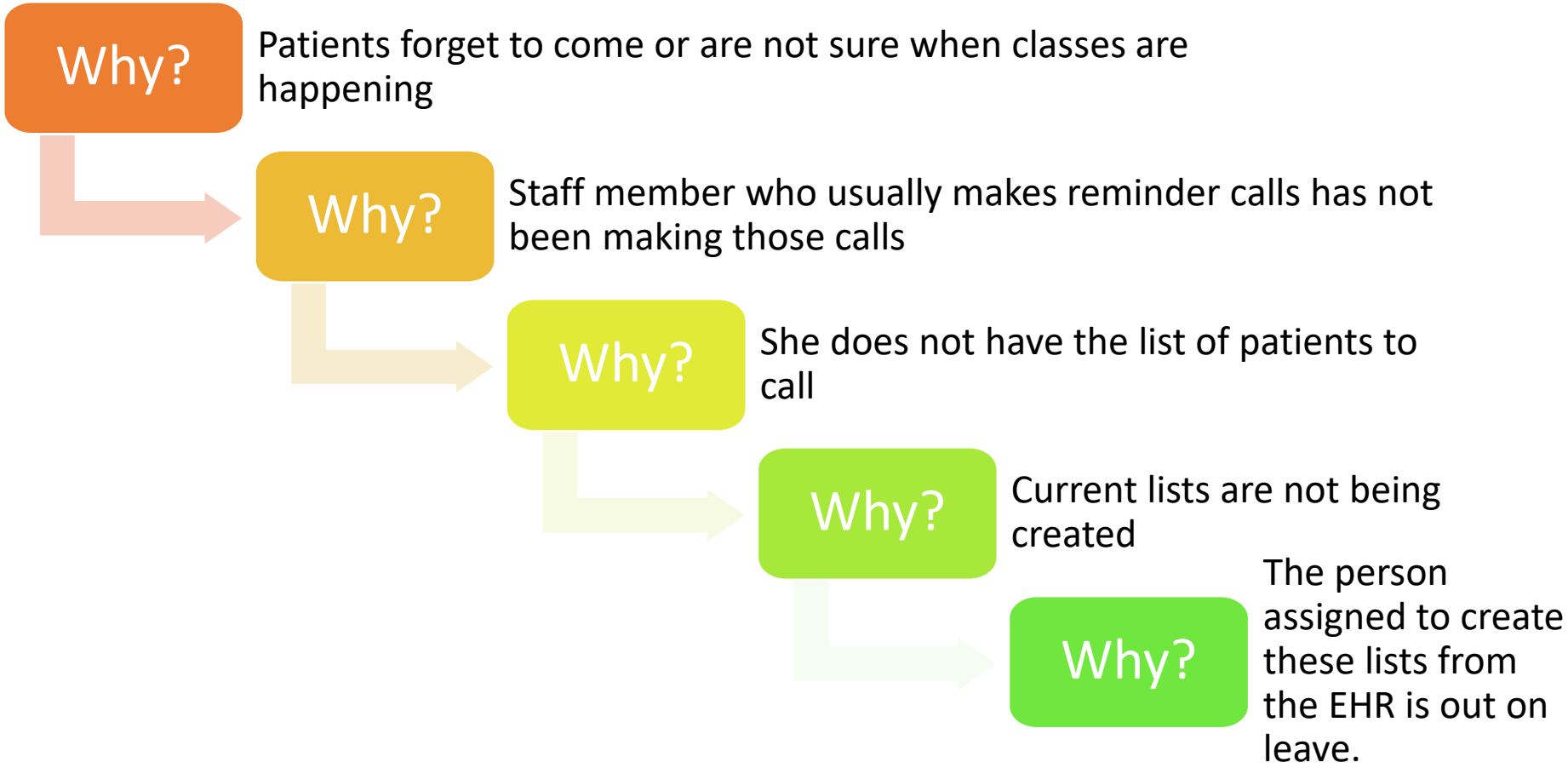




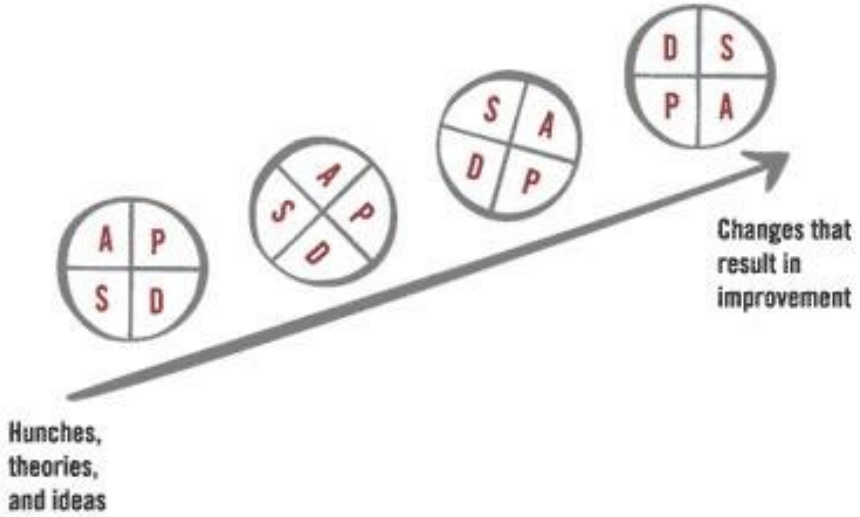
Source: Holyoke Health Center

The Five Whys

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



Plan-Do-Study-Act



Source: http://www.hrsa.gov/quality/toolbox

PDSA Documentation

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
		.	

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do **Describe what actually happened when you ran the test**

Study **Describe the measured results and how they compared to the predictions**

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**


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

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.

HITEQ Center / Friday, December 31, 2021 / Categories: Health IT Enabled QI, Improving Performance, Validating Data Accuracy, Health IT & QI Workforce, UDS Resources

Diabetes Health Center Data Validation Tool

Diabetes Control (HbA1C < 9%) Data Validation for UDS Reporting

Download the Excel Tool at the bottom of this page.

Open it and click Enable at the top, it is a macro-enabled Excel file.

hiteqcenter.org

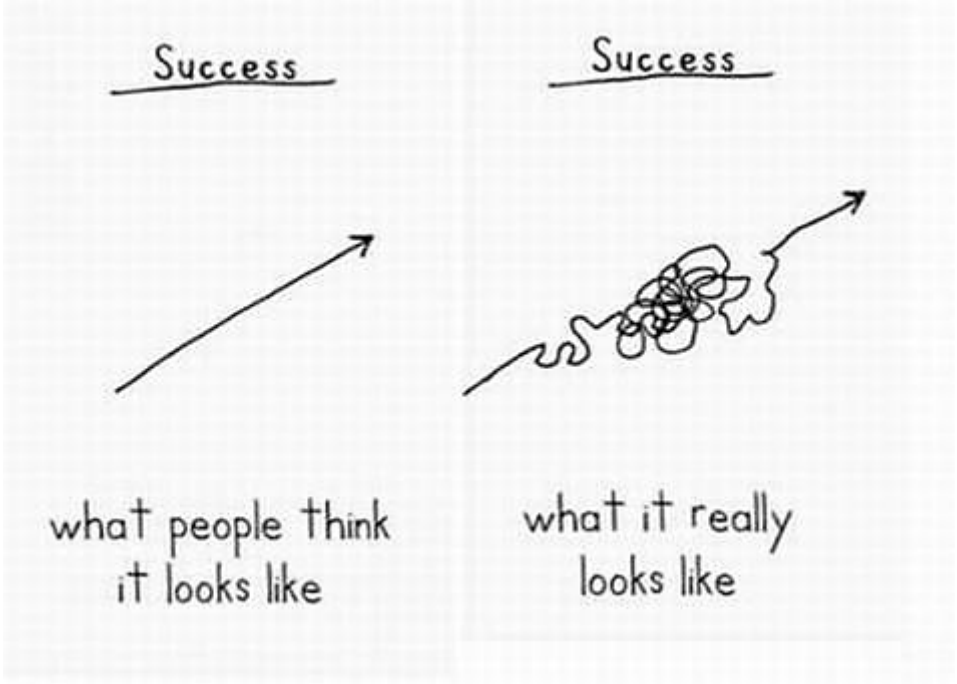
Diabetes Control (HbA1C <9%) Data Validation

- This data validation tool is specifically for the following 2021 UDS Clinical Quality Measure: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0 percent), CMS122v9. This measure is reported on Table 7, Columns 3a-3f. Review the measure beginning on Page 121 of the 2021 UDS Manual. Note that the measure reported on the UDS measures Uncontrolled Diabetes, but this tool uses CONTROLLED diabetes.

Before you jump into data validation, it may be helpful to review your recent Diabetes Control (HbA1C <9%) UDS data and reporting. Access your health center's HITEQ UDS Clinical Dashboards to see recent trends. Watch this quick video if you are new to the health center clinical quality measure dashboards, and email HITEQinfo@jsi.com with your grant number if you need your login information.

Getting Started with this Data Validation Tool for Diabetes Control (HbA1C <9%)

The Path to Success



Other Diabetes Resources

- ✓HRSA Diabetes Quality Improvement Initiative webpage https://bphc.hrsa.gov/qualityimprovement/clinicalquality/diabetes.html
- ✓Diabetes self-management tools https://www.cdc.gov/diabetes/dsmes-toolkit
- ✓National Cooperative Agreements https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/natlagreement.html
- ✓https://www.healthcenterinfo.org/results/?Combined=diabetes
- ✓NACHC Diabetes Change Package http://www.nachc.org/wp-content/uploads/2019/08/Diabetes-Change-Package_FINAL_08.13.2019.pdf

Special & Vulnerable Populations
Diabetes Task Force

DIABETES IN SPECIAL & VULNERABLE POPULATIONS: LEARNING COLLABORATIVES

DIABETES CONTINUUM OF CARE:

Evolving Roles of the Enabling Services Staff in Diabetes Management	Developing Patient-Centered Resources for Diabetes Care	Improving Diabetes Care and Health Equity in a Changing Healthcare Landscape	Addressing Diabetes Management During a Disaster (in SPANISH)
Session Dates: • Jan 26, 2022 • Feb 2, 2022 • Feb 9, 2022 • Feb 16, 2022 **Times:** 11 am-12:00 pm PT / 2-3:00 pm ET	**Session Dates:** • Jan 20, 2022 • Jan 27, 2022 • Feb 3, 2022 • Feb 10, 2022 **Times:** 11 am-12:00 pm PT / 2-3:00 pm ET	**Session Dates:** • Jan 27, 2022 • Feb 3, 2022 • Feb 10, 2022 • Feb 17, 2022 **Times:** 10-11:00 am PT / 1-2:00 pm ET	**Session Dates:** • Feb 3, 2022 • Feb 10,2022 • Feb 17, 2022 • Feb 24, 2022 **Times:** 10-11:00 am PT / 1-2:00 pm ET

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EVALUATION:

Thank you!

Questions?

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