Improving Diabetes Care through Health IT

Thursday, June 17, 2021| 12 – 1 PM

WELCOME

Hannah Stanfield
Care Improvement &
Innovation Manager

FEATURED PRESENTER

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Quality Consultant
The HITEQ Center

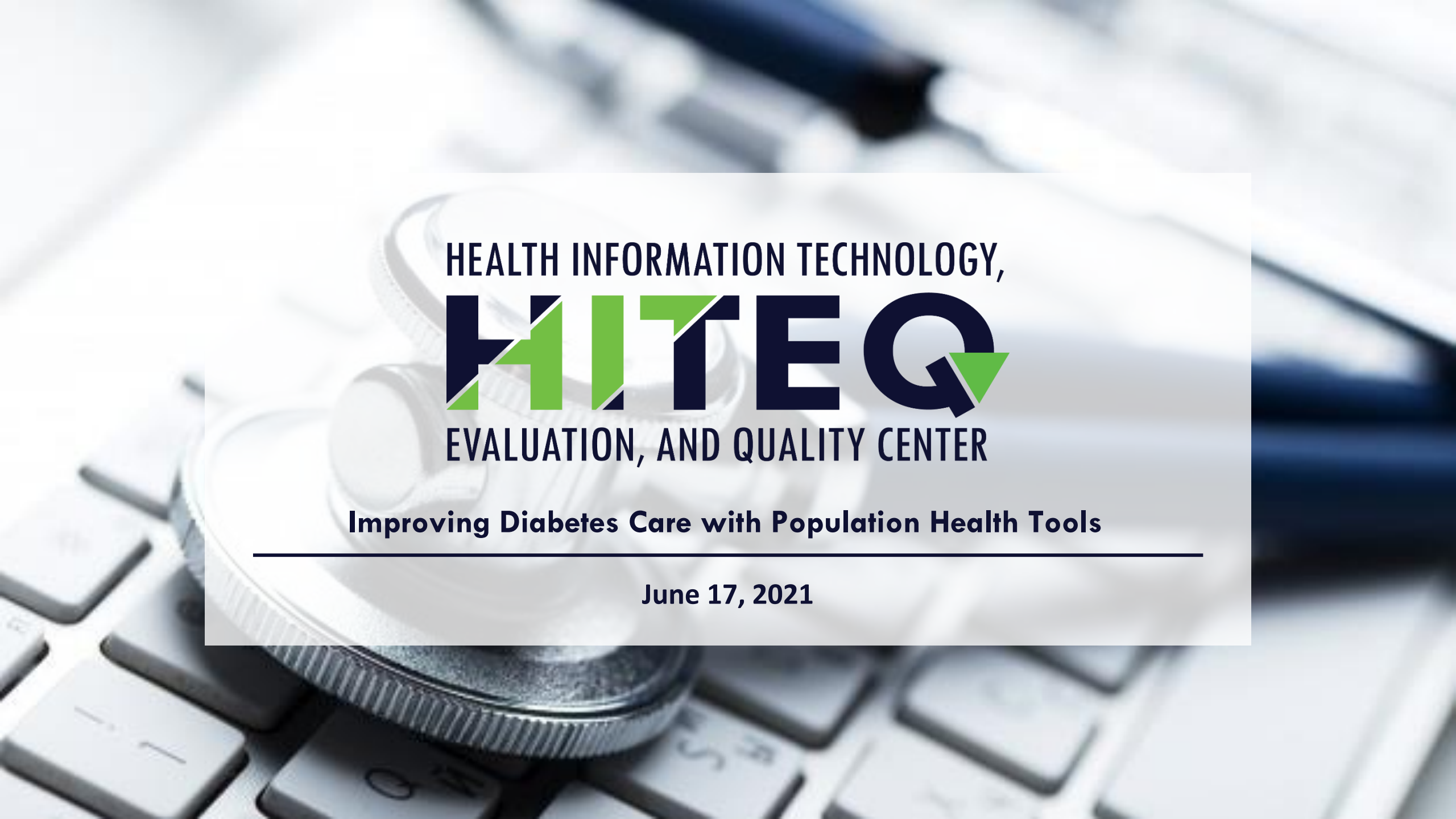
Housekeeping

Your lines are currently muted.

You can raise your hand to have your line unmuted, or type into the *Chat* or *Questions* boxes.

This session is being recorded.

Slides and a recording will be available after the webinar.



HEALTH INFORMATION TECHNOLOGY, EVALUATION, AND QUALITY CENTER

Improving Diabetes Care with Population Health Tools

June 17, 2021

About The HITEQ Center

The HITEQ Center is a HRSA-funded National Training and Technical Assistance Partner (NTTAPs) that collaborates with HRSA partners including Health Center Controlled Networks, Primary Care Associations and other NTTAPs to engage health centers in the optimization of health IT to address key health center needs through:

- A **national website** (**www.hiteqcenter.org**) with health center-focused resources, toolkits, training, and a calendar of related events.
- **Learning collaboratives, remote trainings**, and **on-demand technical assistance** on key topic areas.

JSI Westat

HITEQ Topic Areas

Access to comprehensive care using health IT and telehealth

Privacy and security

Advancing interoperability

Electronic patient engagement

Readiness for value based care

Using health IT and telehealth to improve Clinical quality and Health equity

Using health IT or telehealth to address emerging issues: behavioral health, HIV prevention, and emergency preparedness

Agenda

- Introduction
- Use of PHM
- Data and report confidence
- Utilization of diabetes data
- Getting Started!

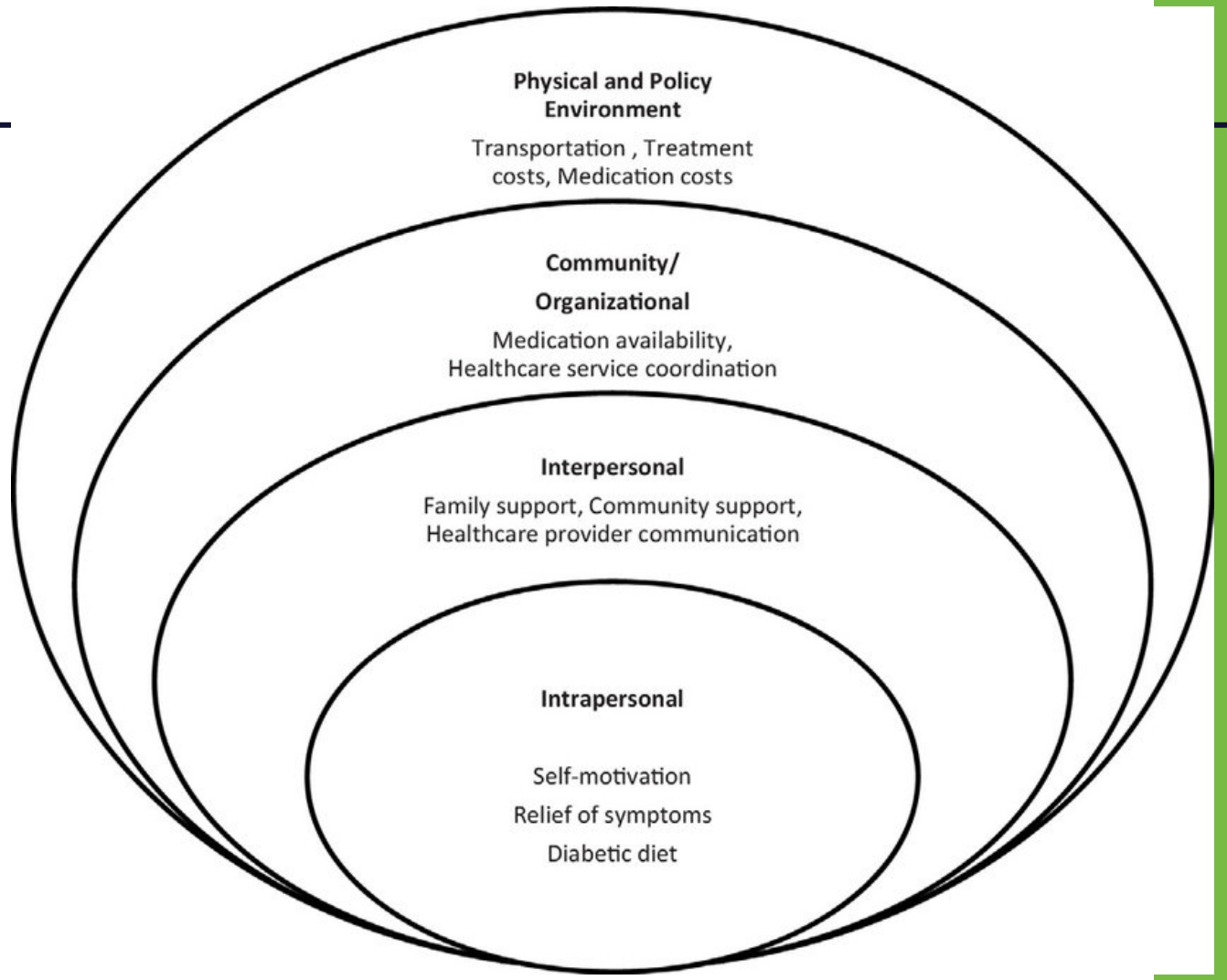
Our Work Together Today

- Optimize your population health management system
- Build on your current actionable data
- Utilize your reports for multiple purposes
- Amplify each other’s work!

Use of Population Health Management

PHM Overview

- Changing face
- Human Centered Design
- CDS
- Pt/prov
- Org/pop level
- Comm level



Source: Mentock et al, April 2017, Diabetes and Metabolic Syndrome Clinical Research and Reviews

Changing Face of Diabetes

Human Centered Design

International Organization of Standards:

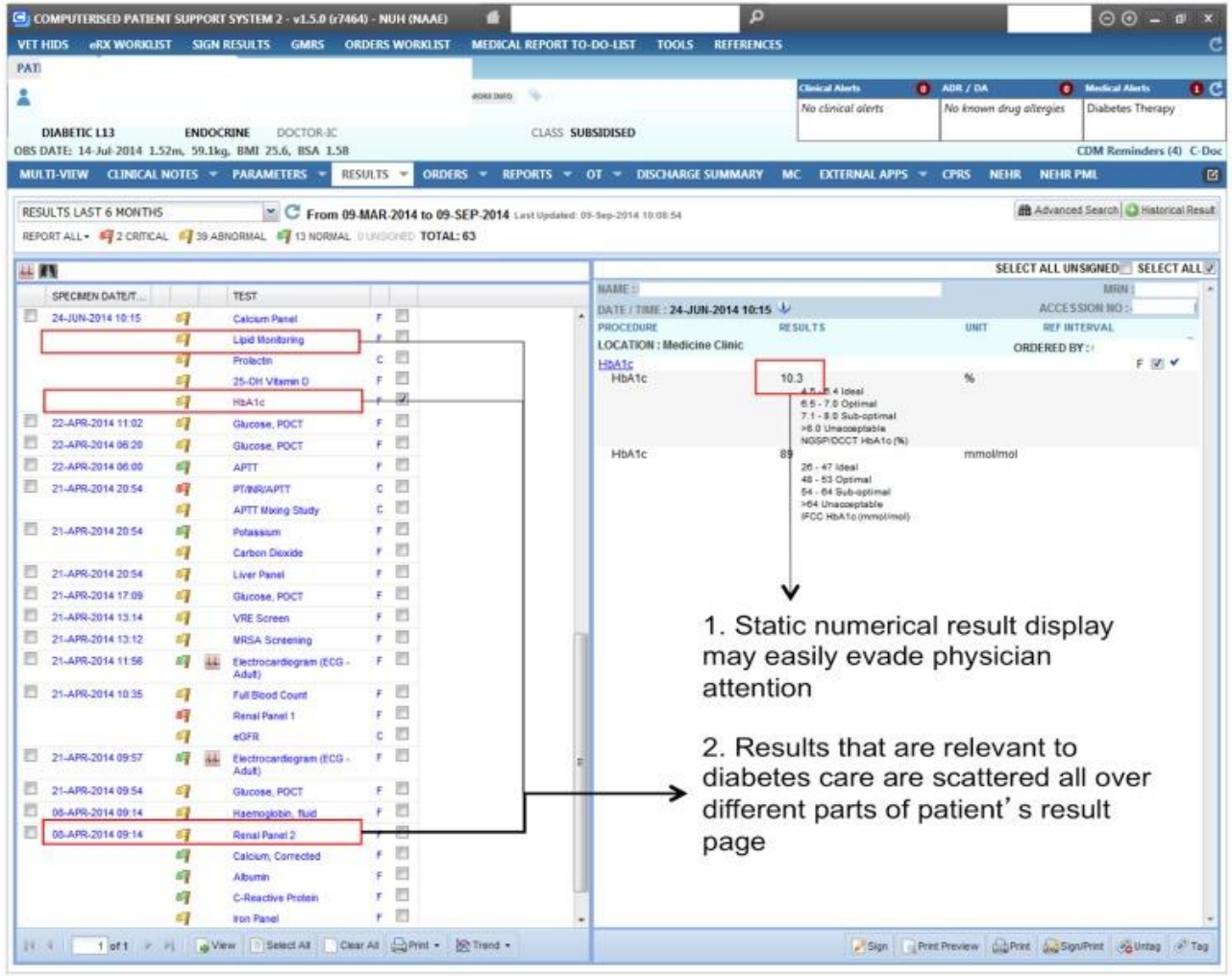
*'…an **approach** to interactive systems development that aims to make systems usable and useful by focusing on the users, their needs and requirements, and by applying **human** factors/ergonomics, usability knowledge, and techniques'*

INSPIRATION
In this phase, you'll learn how to better understand people. You'll observe their lives, hear their hopes and desires, and get smart on your challenge.

IDEATION
Here you'll make sense of everything that you've heard, generate tons of ideas, identify opportunities for design, and test and refine your solutions.

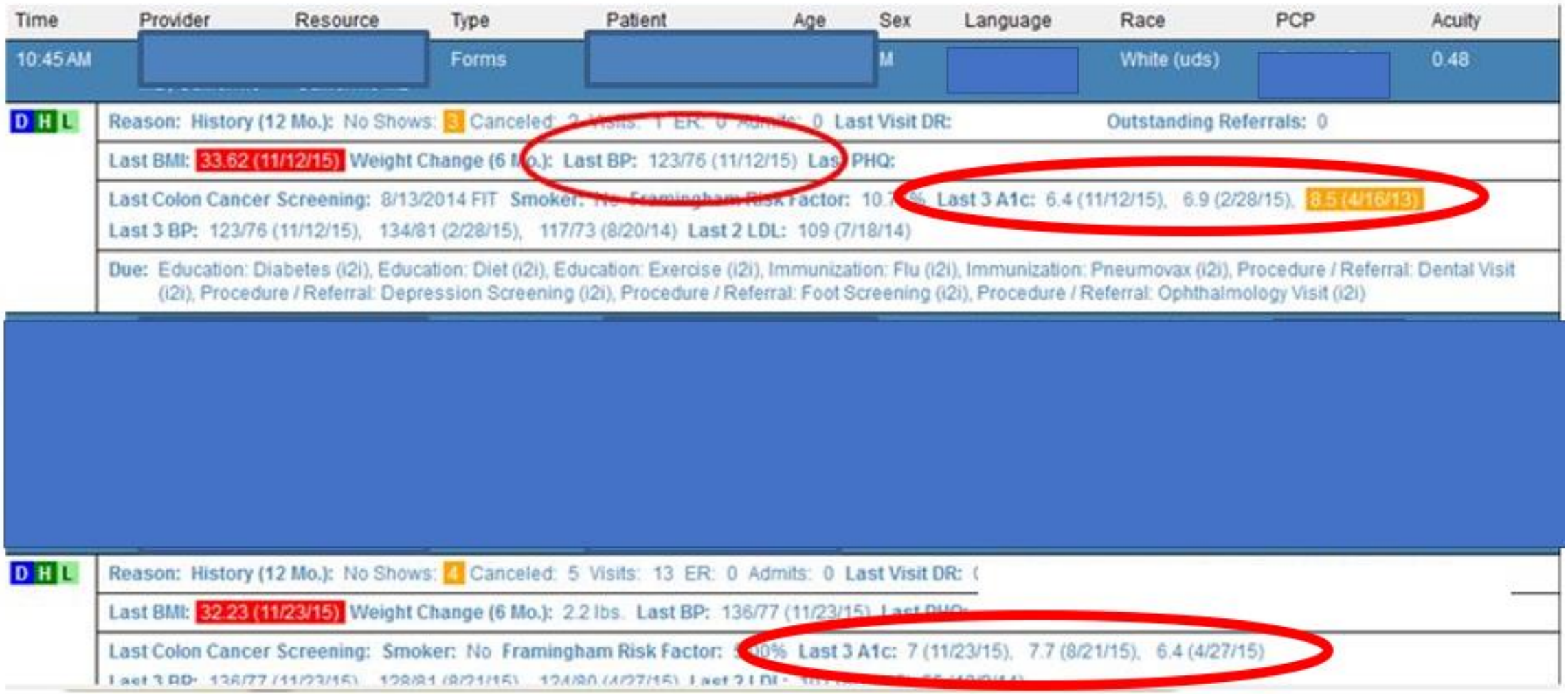
IMPLEMENTATION
Now is your chance to bring your solution to life. You'll figure out how to get your idea to market and how to maximize its impact in the world.

CDS


COMPUTERISED PATIENT SUPPORT SYSTEM 2 - v1.5.0 (r7464) - NUH (NAAE)
VET HIDS
eRX WORKLIST
SIGN RESULTS
GMRS
ORDERS WORKLIST
MEDICAL REPORT TO-DO-LIST
TOOLS
REFERENCES
MULTI-VIEW
CLINICAL NOTES
PARAMETERS
RESULTS
ORDERS
REPORTS
OT
DISCHARGE SUMMARY
MC
EXTERNAL APPS
CPRS
NEHR
NEHR PML
RESULTS LAST 6 MONTHS
From 09-MAR-2014 to 09-SEP-2014
TOTAL: 63
1. Static numerical result display may easily evade physician attention
2. Results that are relevant to diabetes care are scattered all over different parts of patient's result page


NUH Laboratory Medicine
Diabetes Dashboard - ID: 1
Patient details
Summary Dashboard
Alerts
Table
Interactive graphs
HbA1c
Fasting Glucose
Total Cholesterol
HDL-C
LDL-C
Triglycerides
TG/LDL Ratio
eGFR
U.Alb/Creatinine Ratio

Preparing for the Visit



Self-Management

- How are you tracking your self-management and patient engagement?
- Patient engagement
  - Mobile Phone Diabetes Program
  - Connecting to Community Resources
  - Blood Glucose Devices
  - Online Health Coaching
  - Mayo's Diabetes Medication Choice Decision Aid

Population Level

HEDIS Comprehensive Diabetes Care

- What are the difference in your practice?
  - Site
  - Care team
  - Other (e.g., dedicated resources)
- How well are your recalls working?
- Are care gaps met consistently?
- Are outcomes improving?

Data and Report Confidence

Diabetes Reports: UDS

Section C: Diabetes: Hemoglobin A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
	Hispanic or Latino/a			
1a	Asian			
1b1	Native Hawaiian			
1b2	Other Pacific Islander			
1c	Black/African American			
1d	American Indian/Alaska Native			
1e	White			
1f	More than One Race			
1g	Unreported/Refused to Report Race			
	Subtotal Hispanic or Latino/a			
	Non-Hispanic or Latino/a			
2a	Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2c	Black/African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Refused to Report Race			
	Subtotal Non-Hispanic or Latino/a			
	Unreported/Refused to Report Race and Ethnicity			
h	Unreported/Refused to Report Race and Ethnicity			
i	**Total**			

Diabetes Reports

- **UDS**
  - Control by race over time
  - Control by ethnicity over time
  - Disparities in control
  - Disparities in prevalence
- **HEDIS Comprehensive Diabetes Care**
  - A1C
  - Foot exam
  - Eye Exam
  - Nephropathy
  - Blood pressure

Report Stratification

- Race/ethnicity/language
- Insurance status
- Income/poverty
- Transportation (access to care and healthy behaviors)
- Social Support
- Ability to afford Rx
- Zip code (what resources available? Safety?)

PRAPARE/SDH Screening

If screening does not occur in clinic, there still are opportunities to look at community data

SDH Data

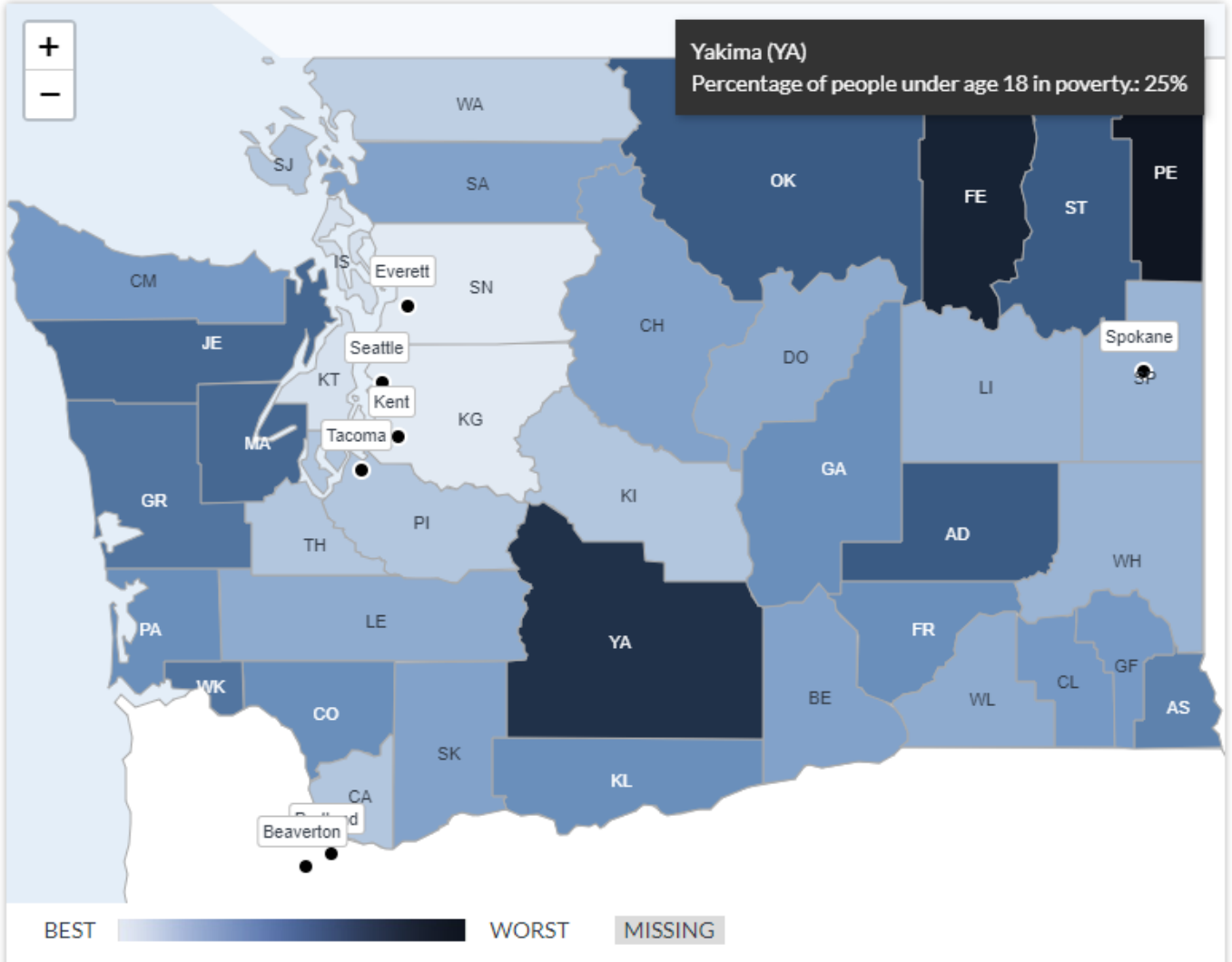
countyhealthrankings.org/app/washington/2021/measure/factors/24/map

Information

Top U.S. Performers:	10% (10th percentile)
Range in Washington (Min-Max):	8-27%
Overall in Washington:	12%

Years of Data Used:
2019

Map | Data | Description | Data Source | Strategies



Trust in Data

Measure:							Report Period:	
	Total Cohort							
	# Charts Reviewed	0						
	# in Compliance	0						
#	Patient ID or MRN	Compliant/Non-Compliant	Issue	Form	Obs Term	Solution	Assigned To	D R
Example	*12345*	*Not Compliant (service complete)*	*No tobacco cessation completed*	*Tobacco screening form*	*Tobacco use = Yes*	*Add value options for smoking cessation counseling*	*Data Analyst*	
1								
2								
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4								
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6								
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12								
13								
14								
15								
16								
17								

Instructions | Issue IdentificationResolution | **Audit Tool** | Randomization

UDS Flags

Note: Table 7 Cross-Table Considerations:

- Patients with medical visits on Table 5 are generally eligible for inclusion in eCQMs reported on Table 7.
- The relationship between the denominators on Table 7 should be verified as reasonable when compared to the total number of patients by age on Table 3A, patients by race and ethnicity on Table 3B, and the proportion of medical patients on Table 5.
- The count of patients by diagnosis reported on Table 6A will not be the same counts as on Table 7, due to differences in criteria that must be met for inclusion on Table 7.

- Is your medical population primarily older or pediatric?
- Do you have a higher (or lower) prevalence of diabetes in your geographic area?
  - Access to food
  - Access to exercise
  - Housing issues/Redlining
- Is access to care equitable in your area?

Disparity Reports

healthequitytracker.org/exploredata?mls=1.diabetes-3.53&demo=race_and_ethnicity

Investigate rates of Diabetes in Washington

Diabetes Cases By Race And Ethnicity In Washington

Race And Ethnicity	Diabetes Cases Per 100K People	Share Of Total Diabetes Cases	Population Share
All	9,400	100.0%	100.0%
American Indian and Alaska Native (Non-Hispanic)	15,200	1.7%	1.1%
Asian (Non-Hispanic)	8,400	7.6%	8.5%
Black or African American (Non-Hispanic)	13,200	5.1%	3.7%
Hispanic or Latino	9,800	13.2%	12.7%
Native Hawaiian and Pacific Islander (Non-Hispanic)	⚠	⚠	0.6%
Some other race (Non-Hispanic)	12,900	0.2%	0.2%
Two or more races (Non-Hispanic)	11,700	6.0%	4.8%
White (Non-Hispanic)	9,000	65.6%	68.5%

Rows per page: 10 1-9 of 9

Sources: America's Health Rankings (updated 2019) American Community Survey 5-year estimates (updated 2019)

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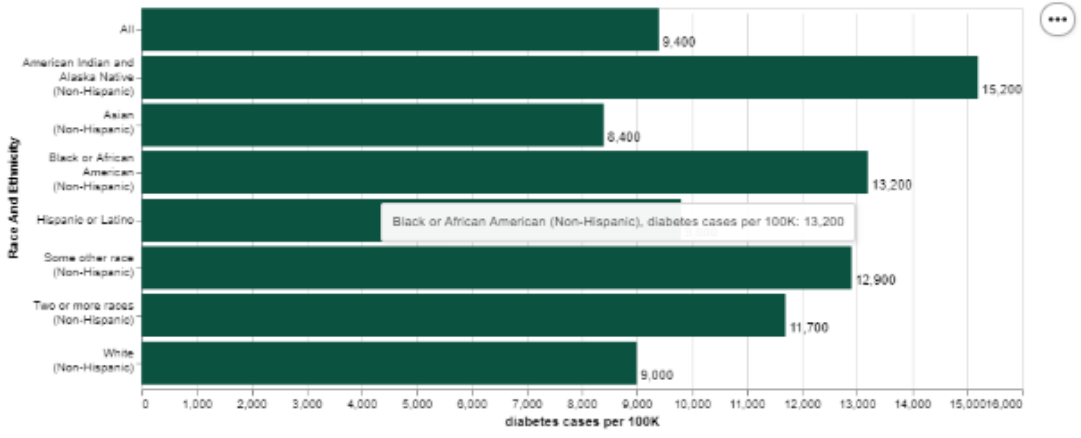
Diabetes Cases Per 100K People By Race And Ethnicity In Washington



Sources: America's Health Rankings (updated 2019) American Community Survey 5-year estimates (updated 2019)

Share Of Total Diabetes Cases vs. Population By Race And Ethnicity In Washington

Putting Disparity Reports into Action

- Programmatic data will ≠ surveillance data

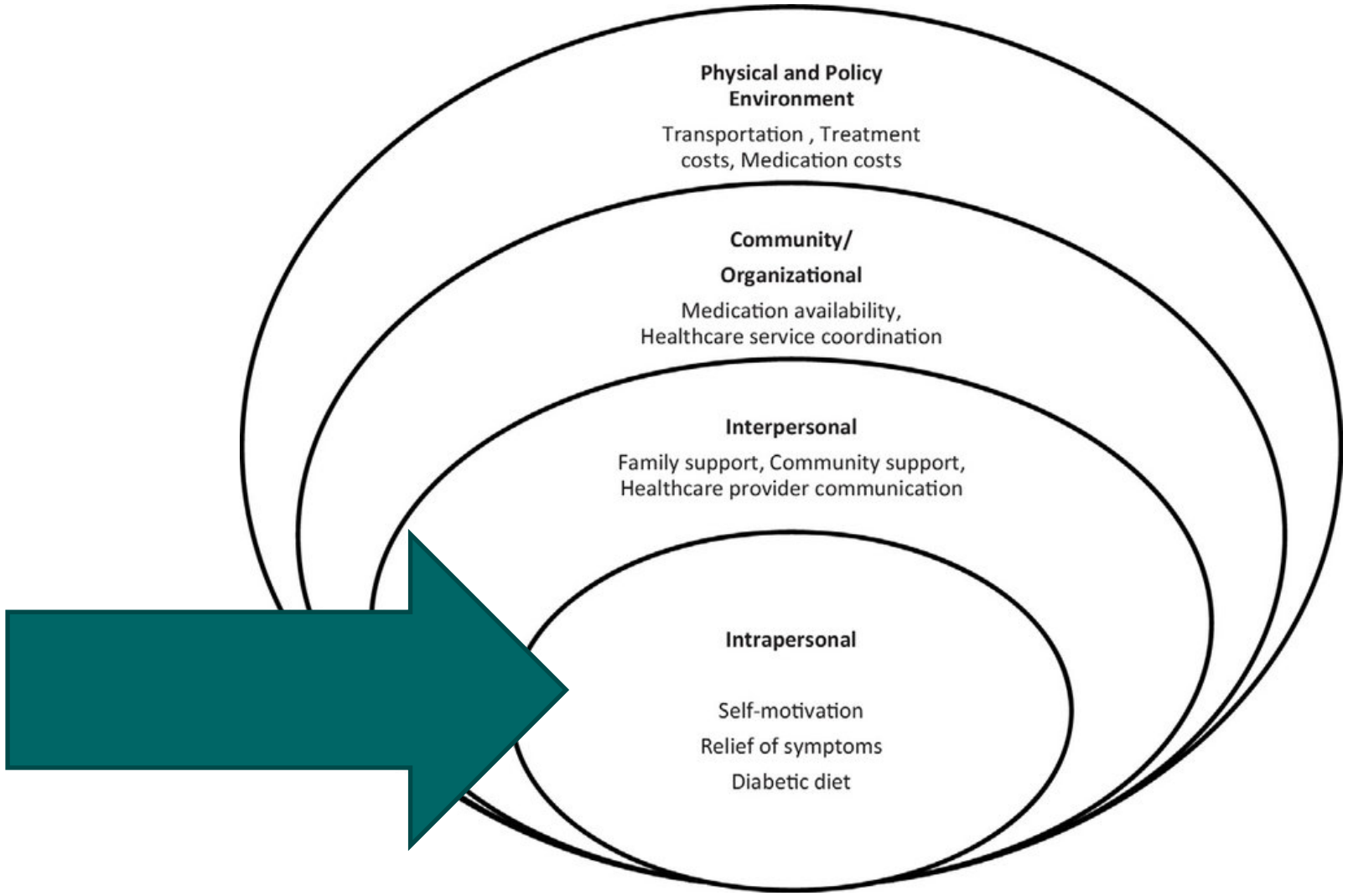
BUT

- Dig into validation of data
- Look for root causes (school, housing, justice policies)
- Access to healthy behaviors
- Opportunity for patient engagement

Use of Diabetes Data

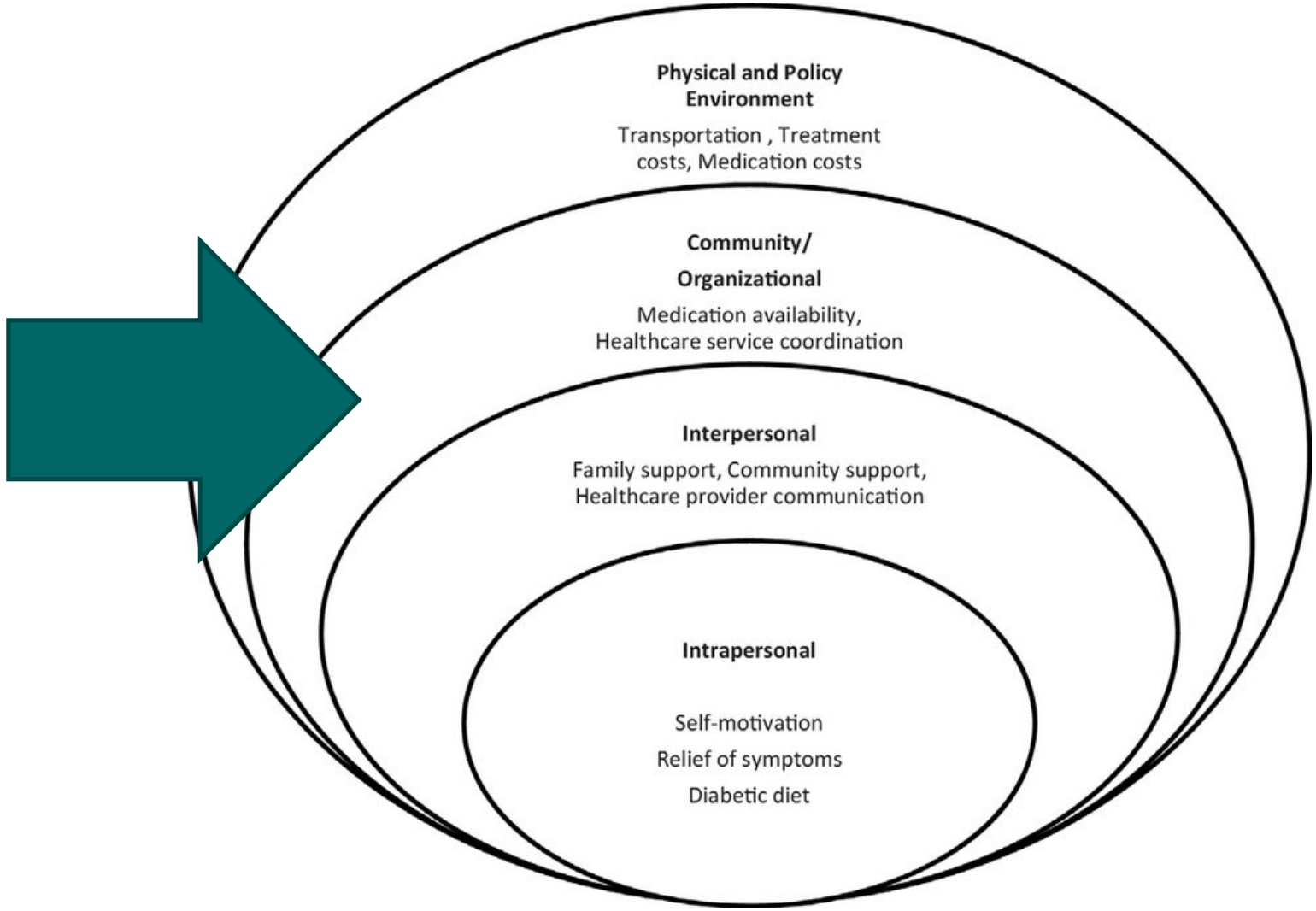
Use of Data at Individual Level

- Patient level
  - Self management
  - Prediabetes
- Provider level
  - Patient panel
  - Therapeutic inertia
  - Prediabetes



Organizational and Community Data

- Org level
  - Staffing
  - Supportive services
  - Resource Mapping
- Community level
  - Advocacy
  - Resource allocation
  - Improved surveillance systems



Questions? Feedback?

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Collaborative Screening: Guidance for Person-Centered Inquiry

June 21, 23 & 25, 2021

9am-12pm PDT

Please complete our short evaluation.

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

hstanfield@wacommunityhealth.org