WACMHC

Washington Association of Community & Migrant Health Centers

WACMHC QI Roundtable

QI Strategies to Address Diabetes and Hypertension

August 3, 2018

Welcome

Thank you for joining us for our third quarterly roundtable of 2018!

Facilitator:

Hannah Stanfield

WACMHC Practice Transformation Coordinator

Housekeeping

- Your lines are currently muted

- We will address questions at the end of each section of the presentation, followed by peer discussion at the end of the session.

- You can ask a question or offer an answer in the following ways:

Raise Your Hand Function – Your line will be unmuted and you can ask the question verbally

Questions Function – You can type your question into the box and facilitator will read it out loud

- This webinar is being recorded. A recording will be sent to you in a follow-up email after the presentation.

Presenters

Stephanie Tarry Yoo, MS, RD, CDE – Lead CDE

Marcus Rempel, MD – Chief Medical Officer

Valerie Kurbis, MHPA – Quality Improvement Specialist

Deborah Wiser, MD – Chief Medical Officer

Learning Objectives

- Describe the status of diabetes & hypertension management among state & national FQHC populations

- Examine differences in diabetes and hypertension diagnosis & control between racial & ethnic groups at Washington FQHCs

- Explain how two health centers use data, centralized teams, & standard work to approach diabetes & hypertension management

- Network with FQHC peers to discuss challenges & successes in managing hypertension & diabetes

State and National Landscape: Diabetes and Hypertension Management

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Introduction

- Based on 2016 UDS data

- Report supported by 1305 grant: aims to explore consistency of hypertension and diabetes management between racial and ethnic groups in WA FQHCs

- Compares state to national hypertension and diabetes management measures

National FQHC

Hypertension – Patient population 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period with a medical visit during the measurement period (excludes patients with evidence of end stage renal disease, dialysis, or renal transplant before or during the measurement period, excludes patients with a diagnosis of pregnancy during the measurement period)

Controlling High Blood Pressure – Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period (patients with no recorded blood pressure during the measurement period are assumed "not controlled")

Diabetes – Patient population 18-75 years of age with diabetes diagnosis and with a medical visit during the measurement period (includes active diagnosis of Type 1 or Type 2 diabetes, excludes diabetes as a secondary diagnosis)

Diabetes: Hemoglobin A1c Poor Control – Patient population 18-75 years of age with diabetes diagnosis and HbA1c > 9% or no test during the year

State FQHC

Hypertension – Patient population 18-84 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period with a medical visit during the measurement period (excludes patients with evidence of end stage renal disease, dialysis, or renal transplant before or during the measurement period, excludes patients with a diagnosis of pregnancy during the measurement period)

Controlling High Blood Pressure – Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period (patients with no recorded blood pressure during the measurement period are assumed "not controlled")

Diabetes – Patient population 18-74 years of age with diabetes diagnosis and with a medical visit during the measurement period (includes active diagnosis of Type 1 or Type 2 diabetes, excludes diabetes as a secondary diagnosis)
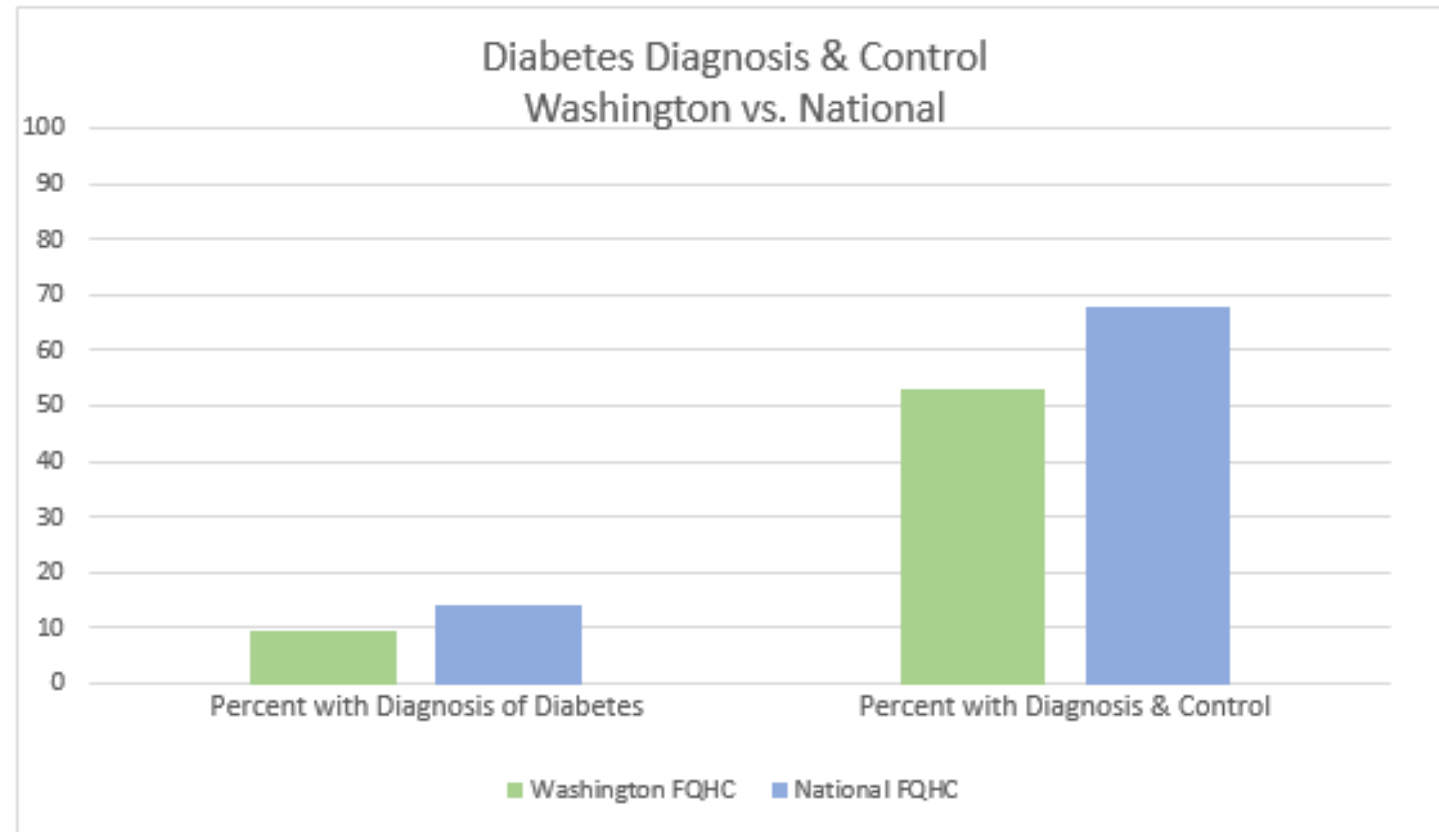
Diabetes: Hemoglobin A1c Control – Patient population 18-74 years of age with diabetes diagnosis and HbA1c < 8% or no test during the year

Diabetes: National & State

WASHINGTON FQHC	Total
Patients with Diagnosis of Diabetes	9.35%
Patients with Diagnosis & HbA1c <8%	53.15%

NATIONAL FQHC	Total
Patients with Diagnosis of Diabetes	14.30%
Patients with Diagnosis & HbA1c <9%	67.9%

- WA FQHCs have a lower percentage of patients diagnosed with diabetes than National FQHCs

- FQHCs in WA have a lower percentage of patients with their condition under control than National FQHCs

    - May be due to differences in measurement – unknown number of diabetic patients with HbA1c between 8% and 9%

Diabetes Diagnosis & Control
Washington vs. National

Diabetes by Ethnicity

| WASHINGTON FQHC	Total	Hispanic	Non-Hispanic
Patients with Diagnosis of Diabetes	9.35% (Range 1% - 15%)	9.96% (Range 2% - 15%)	9.34% (Range 1% - 15%)
Patients with Diagnosis & HbA1c <8%	53.15% (Range 17% - 76%)	48.94% (Range 1% - 100%)	55.5% (Range 2% - 76%)

NATIONAL FQHC	Total	Hispanic	Non-Hispanic
Patients with Diagnosis & HbA1c <9%	67.9%	66.62%	70.41%

- Difference in diabetes diagnosis across ethnicities is low

- A slightly greater percentage of those identifying as Hispanic have a diagnosis of diabetes

- A lower percentage of the Hispanic FQHC population has HbA1c below 8% than the Non-Hispanic FQHC population

Diabetes Diagnosis & Control : Ethnicity
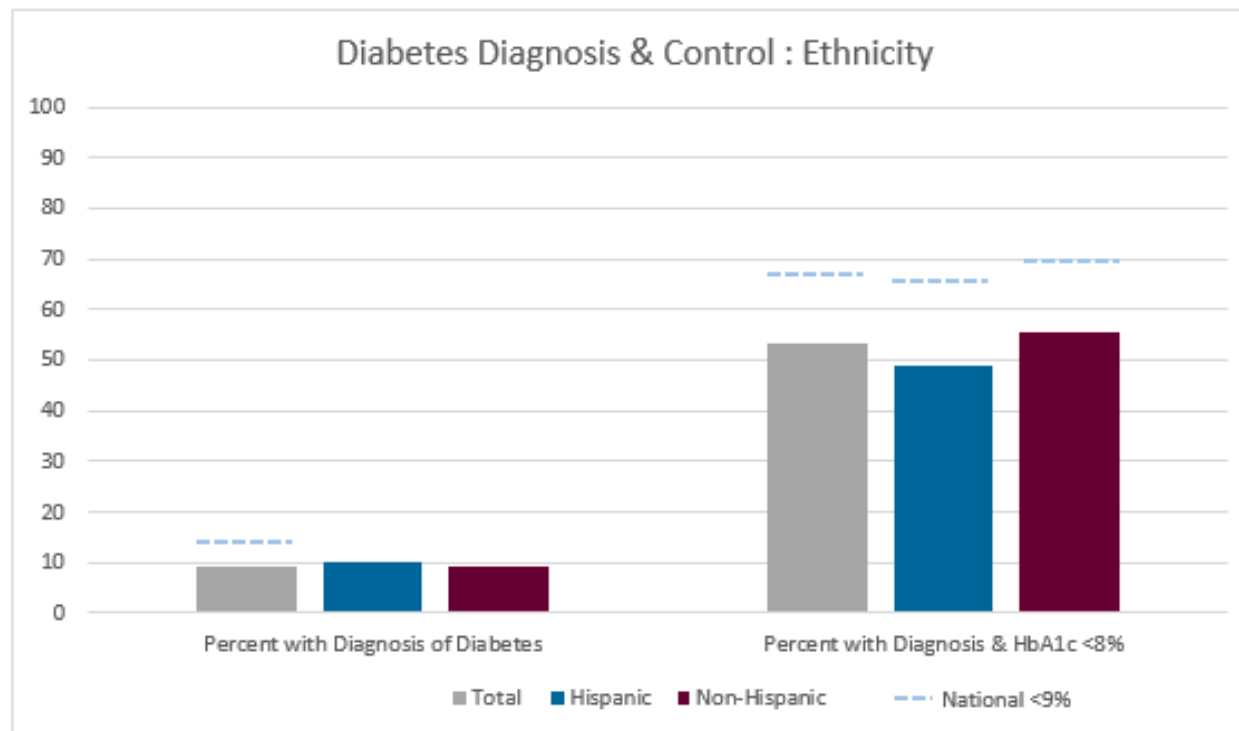
Diabetes by Race

- The proportion of FQHC patients with a diagnosis of diabetes is higher among the Other Pacific Islander, Hawaiian, Asian, and American Indian/Alaska Native populations

- The proportion of FQHC diabetic patients with HbA1c below 8% is lower for Hawaiian, Other Pacific Islander, Multiracial, and American Indian/Alaska Native populations

|	State Patients with Diagnosis	State Patients with HbA1c <8%	National Patients with HbA1c <9%
Total	9.35% (Range 1.39% - 13.86%)	53.15% (Range 1.71% - 75.71%)	67.9%
More than one race	7.21% (Range 0% - 25.31%)	48.71% (Range 0% - 100%)	70.54%
White	8.81% (Range 1.53% - 14.95%)	53.40% (Range 1.28% - 75.63%)	68.82%
Black/African American	8.85% (Range 0% - 19.79%)	53.56% (Range 0% - 100%)	65.62%
AI/AN	10.28% (Range 0.96% - 26.38%)	50.94% (Range 33.33% - 100%)	62.12%
Asian	11.49% (Range 0% - 24.29%)	68.34% (Range 0% - 100%)	77.52%
Hawaiian	13.16% (Range 0% - 46.69%)	35.44% (Range 0% - 100%)	60.98%
Other Pacific Islander	13.85 % (Range 0% - 79.62%)	40.63% (Range 0% - 100%)	57.37%

Diabetes Diagnosis & Control : Race
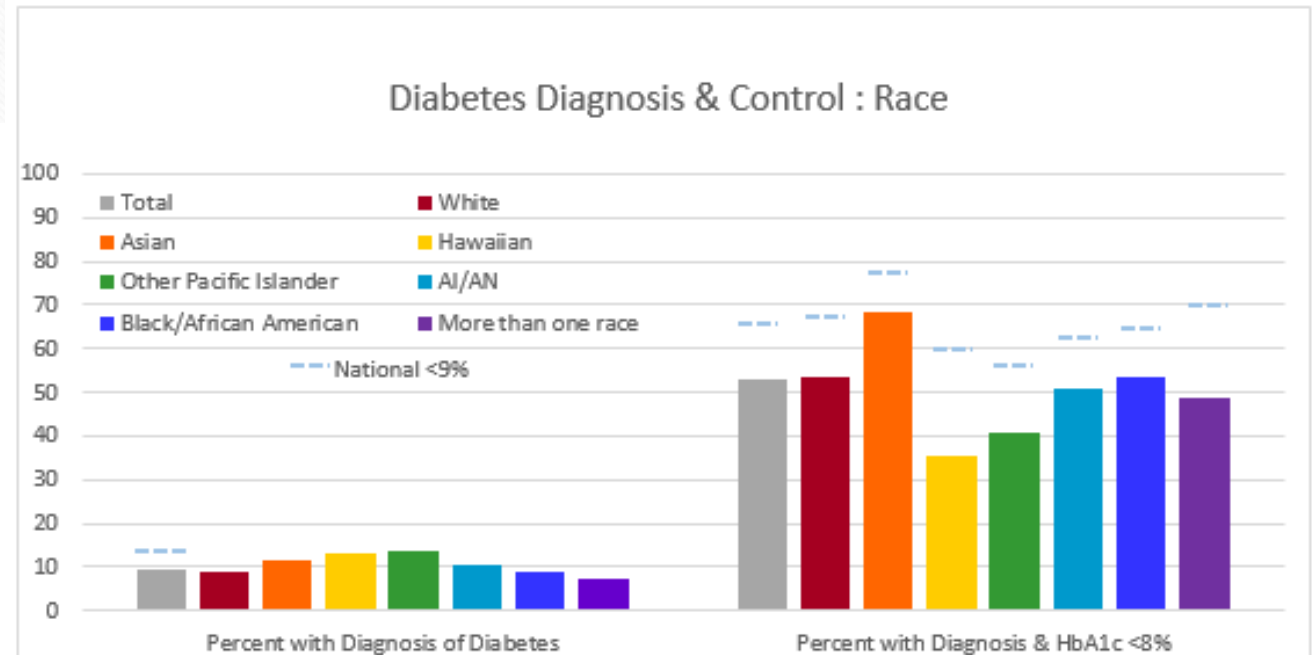
Hypertension: National & State

WASHINGTON FQHC	Total
Patients with Diagnosis of Hypertension	16.81%
Patients with Diagnosis & Control	64.76%

NATIONAL FQHC	Total
Patients with Diagnosis of Hypertension	26.22%
Patients with Diagnosis & Control	62.39%

- WA FQHCs have a lower percentage of patients diagnosed with hypertension than National FQHCs

- WA FQHCs have a higher percentage of hypertensive patients with control than National FQHCs

Hypertension Diagnosis & Control
State vs. National
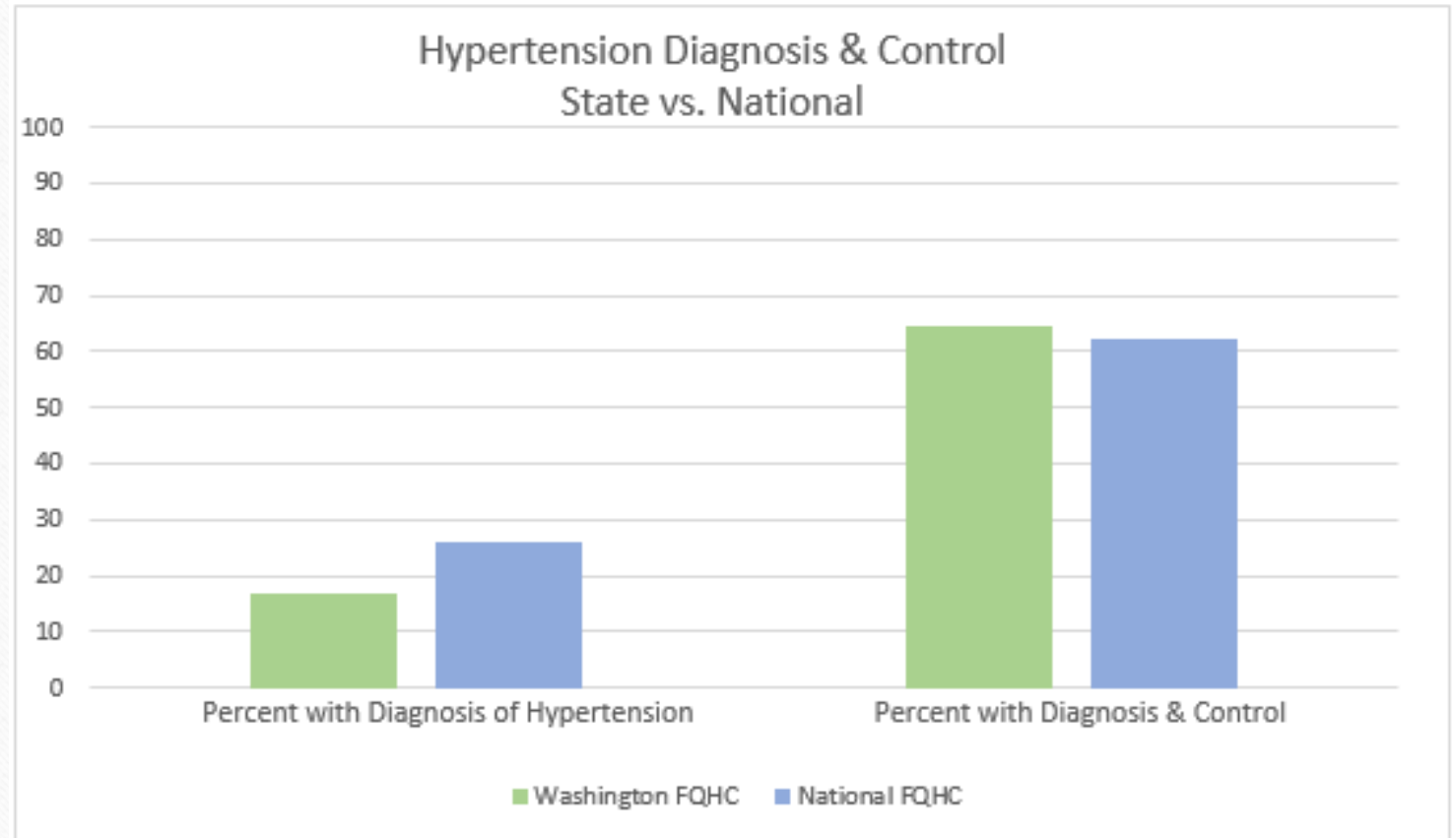
Hypertension by Ethnicity

- Differences across ethnicities in hypertension diagnosis are more pronounced than in diabetes diagnosis

- A higher percentage of the Non-Hispanic FQHC population has a diagnosis of hypertension

- A lower percentage of the Hispanic FQHC population with hypertension has control

- Difference in diagnosis is more pronounced than difference in control

| WASHINGTON FQHC	Total	Hispanic	Non-Hispanic
Patients with Diagnosis of Hypertension	16.81% (Range 2.1% - 30.26%)	12.82% (Range 1.72% - 18.70%)	19.42% (Range 2.33% - 34.47%)
Patients with Diagnosis & Control	64.76% (Range 9.14% - 77.59%)	62.61% (Range 0% - 77.78%)	65.24% (Range 9.00% - 77.45%)

NATIONAL FQHC	Total	Hispanic	Non-Hispanic
Patients with Diagnosis & Control	62.39%	64.85%	61.66%

Hypertension Diagnosis & Control : Ethnicity
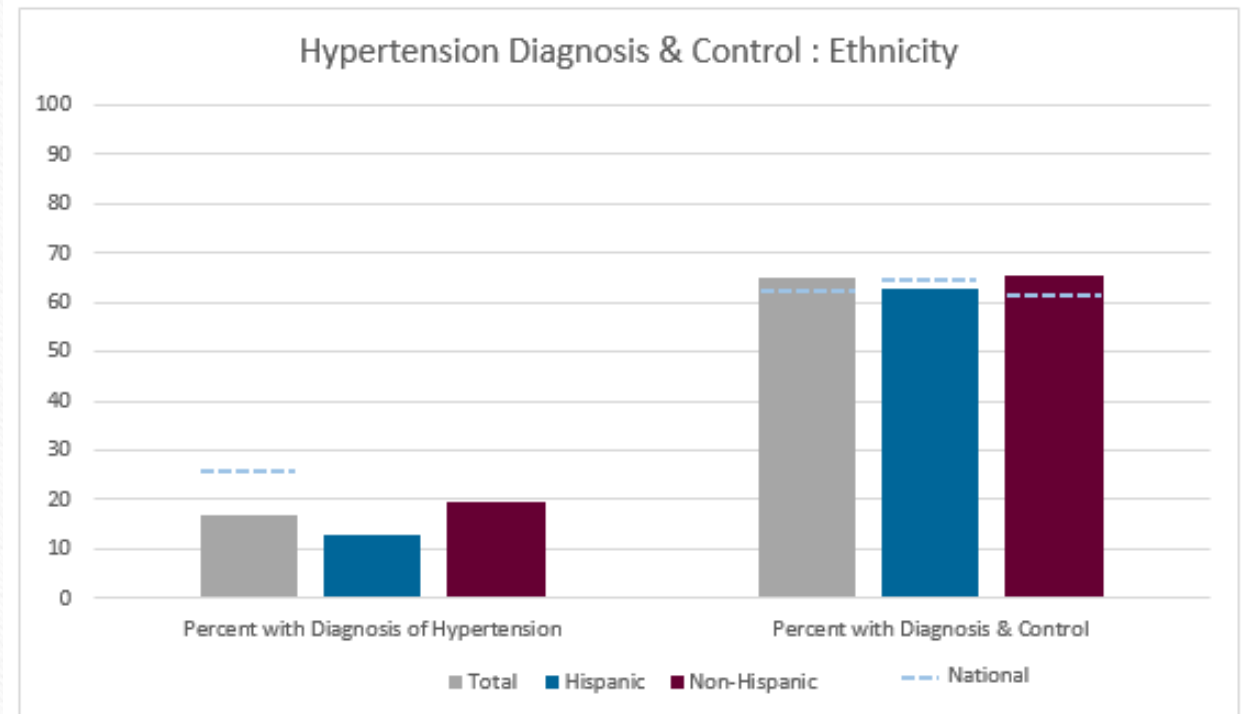
Hypertension by Race

- The proportion of FQHC patients with a diagnosis of hypertension is higher among the Asian, White, and Hawaiian populations

- The proportion of FQHC hypertensive patients with control is lower among Hawaiian, Black/African American, and American Indian/Alaska Native populations

	State Patients with Hypertension	State Patients with Control	National Patients with Control
Total	16.81% (Range 2.1% - 30.26%)	64.76% (Range 9.14% - 77.59%)	62.39%
More than one race	9.84% (Range 0% - 17.12%)	66.50% (Range 0% - 73.02%)	66.33%
Other Pacific Islander	15.42% (Range 0% - 79.32%)	65.44% (Range 0% - 75.86%)	62.03%
AI/AN	15.48% (Range 7.10% - 52.98%)	61.71% (Range 11.11% - 80.37%)	60.23%
Black/African American	16.47% (Range 0% - 41.64%)	60.72% (Range 0% - 71.43%)	56.00%
Hawaiian	17.64% (Range 0% - 37.8%)	53.55% (Range 0% - 75.00%)	58.41%
White	18.27% (Range 6.79% - 39.13%)	64.93% (Range 8.1% - 77.84%)	64.76%
Asian	21.11% (Range 0% - 46.00%)	70.34% (Range 0% - 89.47%)	67.27%

Hypertension Diagnosis & Control : Race
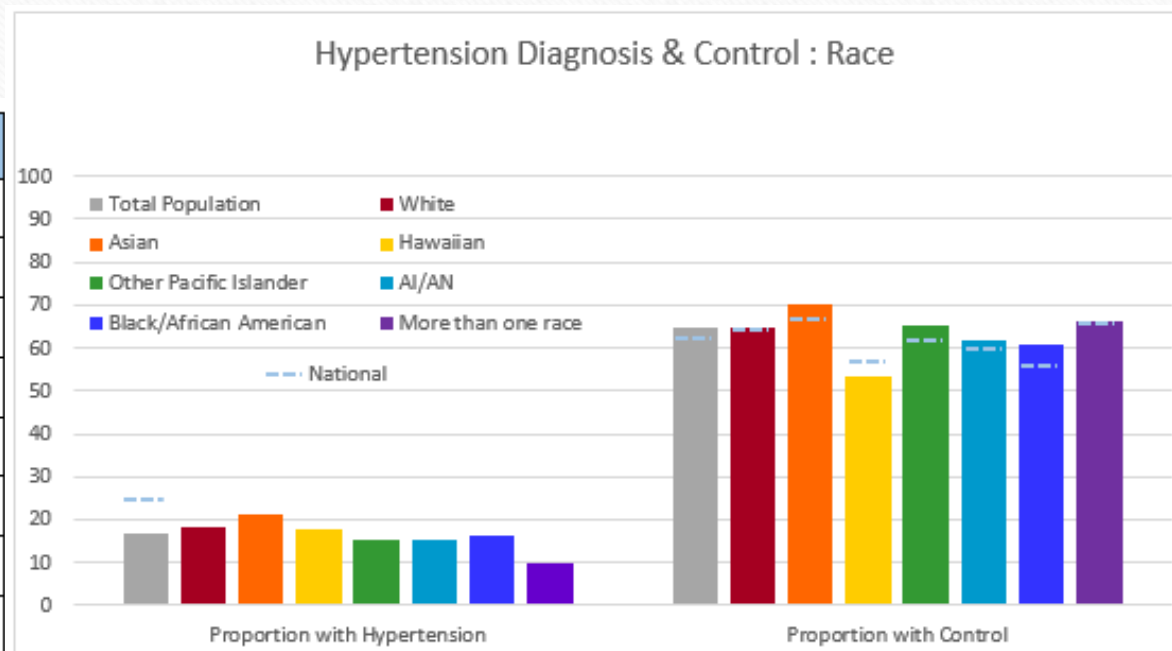
Diabetes and Hypertension Management Strategies

Stephanie Tarry Yoo, MS, RD, CDE– Lead CDE

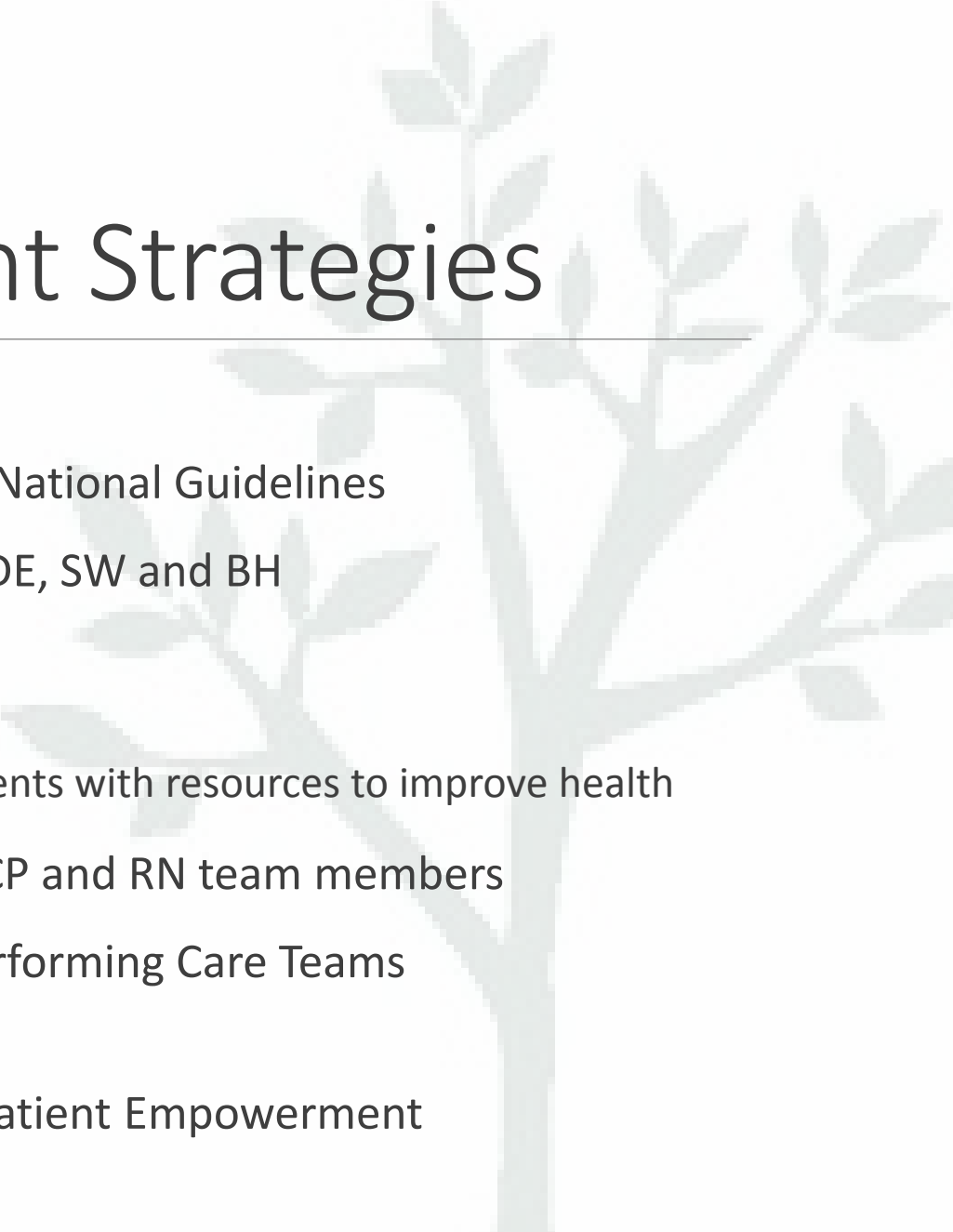Marcus Rempel, MD – Chief Medical Officer

neighborcare health

Neighborcare Health

❖ We are a FQHC system located in King County with most clinics in Seattle

  ❖Medical, Dental, School-Based and Homeless Clinics

  ❖340B Pharmacies at 5 out of 8 Medical Clinics

  ❖Integrated services

    ❖ King Co. Public Health, WIC, Valley Cities BH

    ❖ BH, SW, Eligibility

❖> 75,000 Patients Served Annually

  ❖>55% at or below 100% of poverty

  ❖~ 17% homeless or recently homeless

    ❖ Serve more homeless or near homeless than any other FQHC in King Co.

  ❖~ 18% language other than English

  ❖~ 18% uninsured

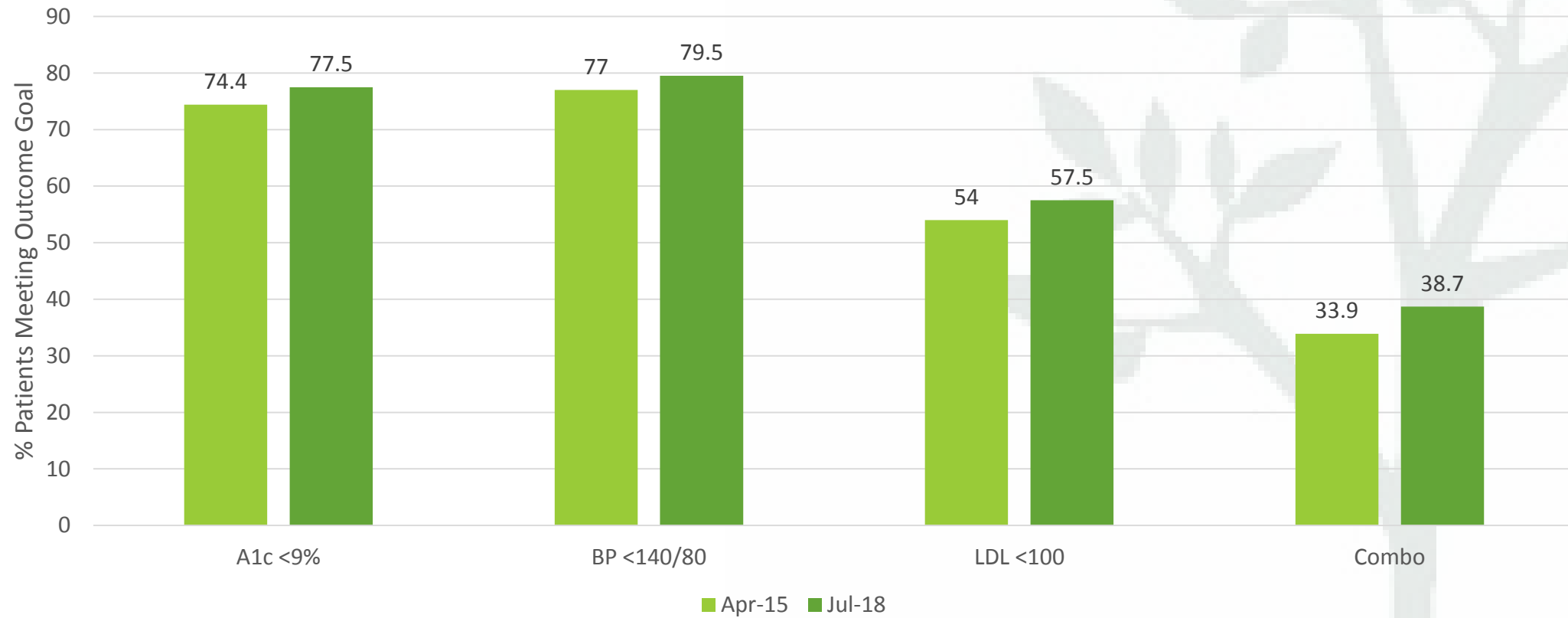# DM and HTN Management Strategies

At the Medical Provider Level:

❖ Updated DM and HTN Protocols and Guidelines to reflect National Guidelines

❖ Integrated the Care Teams to include PSR, MA, RN, PCP, CDE, SW and BH
  ❖ Goal: address all patient barriers to self-care

❖ Regular DM panel review
  ❖ Goal: identify patients with gaps in care and better match patients with resources to improve health

❖ Lead CDE provides regular DM updates and trainings to PCP and RN team members

❖ RN QI Champions help spread best practices from high performing Care Teams

❖ Focus on DM and HTN Complication Prevention through Patient Empowerment
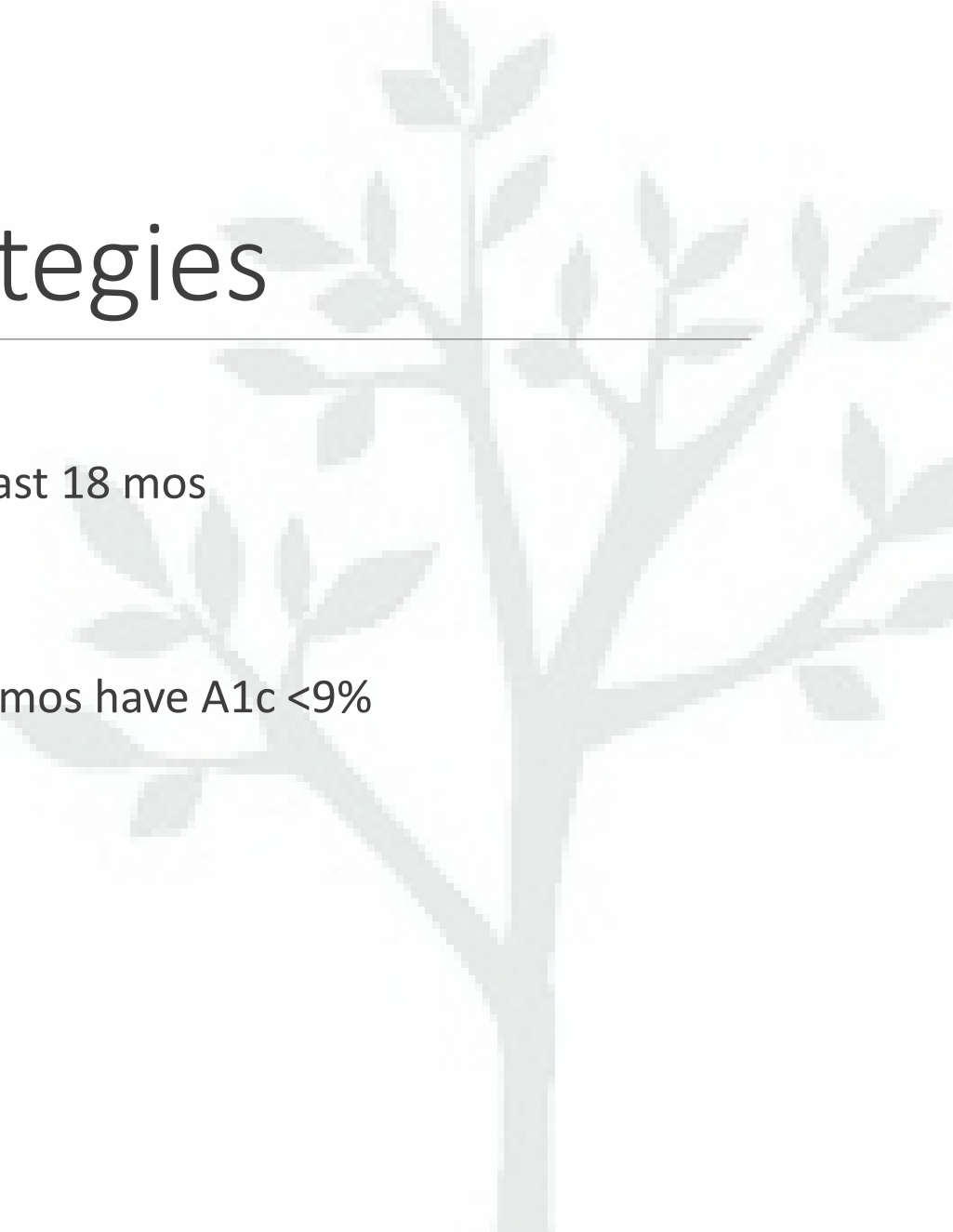
DM and HTN Management Strategies

At the Patient Self-Management Level:

❖Registered Nurses trained in DSME Basics and HTN Mgt at all clinics

❖Certified Diabetes Educators (CDE) at 7 of 8 Medical Clinics

❖Health Education appointments are free with RN and CDE

❖RNs and CDEs use NCH DM Protocols to evaluate glucose patterns and adjust DM meds between DM appts with PCP

❖RNs use NCH HTN Protocols to evaluate BP patterns and adjust HTN meds between PCP appts
   ❖Addressing "white coat syndrome"
      ❖Pts self-monitor BP at home or in local pharmacy and bring log to RN or PCP appts
      ❖Provider, RN or MA recheck elevated BP levels at end of appt.

Outcomes of Current Strategies - DM

Outcomes of Current Strategies

❖ 74.54% of all patients with HTN have controlled BP over past 18 mos
  ❖ n= 2467 patients with HTN

❖ 77.5% of patients with DM and 2+ PCP visits over past 18 mos have A1c <9%
  ❖ n= 3284 patients with DM

❖ Of patients with DM and HTN – 79.5% have BP <140/90

Questions?

CHAS Diabetes and Hypertension

CHAS QI Structure

- Administration Office
  - Director of Quality Improvement
  - 4 Quality Improvement Specialists
  - 1 Clinical Trainer
- Clinics
  - 1 QI coach in each clinic
  - 1 QI coach for both urgent cares

Quality Improvement & Business Intelligence

- Integration between two departments
- Website combines quality and operational reports in one location
- QI Specialists have access to create clinical data reports available for all staff

CHAS Initiatives

- Each initiative lasts 2 years
- Each clinic is given autonomy to create incentives and processes
  - Best practices are shared and always events created
- First Initiative: Blood pressure control
- Second Initiative: Quit Happens!
- Third Initiative: Diabeat-It

Blood Pressure Control

- Room ergonomics
  - Feet flat on floor
  - Patient sitting up
  - Support patient arm
- Double Checks
  - If a patient is uncontrolled, recheck in 10 minutes
- BP Check Timing
  - Take blood pressure at the end of intake after patient has been sitting
  - Eliminates a portion of double checks

Diabeat-It

- Budgets
  - Each clinic is given an employee incentive and patient incentive budget
  - Random acts of reward given by the Diabeat-It team
  - Year one and two winners
- Reports
  - Diabetes Dashboard created for QI and staff
  - Missed opportunities reports
- Standing Orders
  - Created for Mas: workflow for diabetes patients
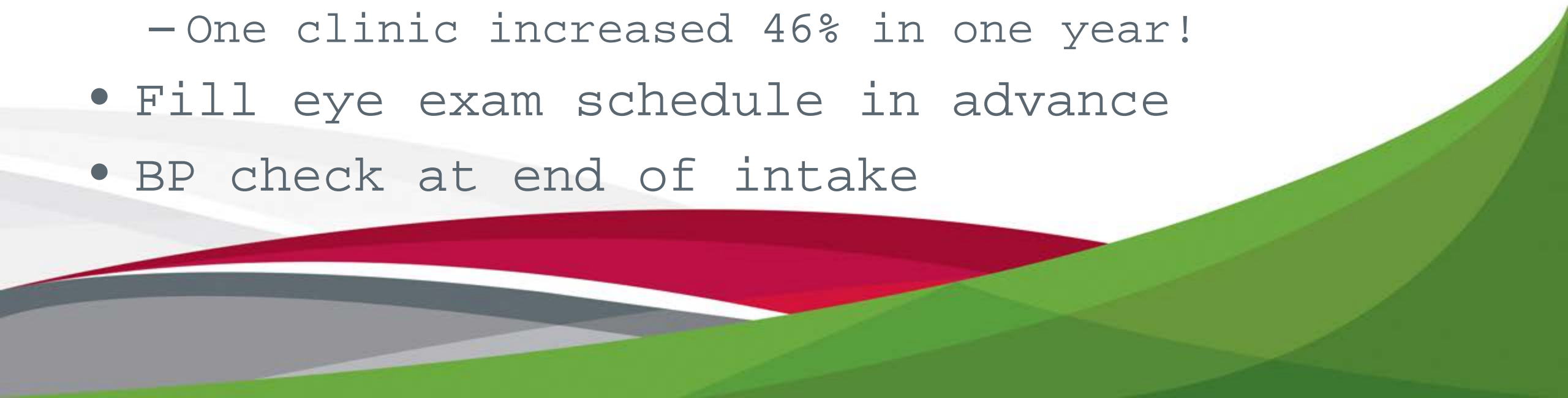
Diabeat-It Goals

- Decrease average A1C by 1%
- Gather 80% of the following metrics:
  - Eye Exam
  - Foot Exam
  - Dental Exam
  - Blood Pressure Control
  - Controlled A1C

Reports

- Diabetes Dashboard
  - Includes percent complete on each measure by clinic and provider
- Diabetes Dashboard Trend
  - Trend line of each measure by clinic and provider
- Foot Exam Missed Opportunities
  - Shows percentage of missed opportunities weekly

Best Practices

- Capture A1C at any visit type
- Ask all diabetic patients to take their shoes off during intake and leave them off to remind providers
  - One clinic increased 46% in one year!
- Fill eye exam schedule in advance
- BP check at end of intake

Diabetes Day

- One day twice a month
- Incorporates Multidisciplinary staff
  - BH Provider
  - Dietician
  - Retinal Scanner
  - Provider
  - MA
  - Dentist

YMCA Connection

- Shared medical visits at the YMCA
- Promotes pathways to a healthier life
- A medical exercise program
- Encouraging group environment classes
- Educational component each week (nutrition, exercise, goal setting)
- 8 week program-required to work out 3 times a week
- Started first session 7/11/18

Discussion

How do you approach barriers in communication of chronic vs. acute disease in a culturally diverse population?

Discussion

Do you use a registry to manage patients? If so, what tools do you use?

Discussion

How are you using QI staff in the clinic?

Discussion

What practices have been helpful for patient outreach and/or engagement?

Discussion

Have you had success in capturing patient-generated data such as pharmacy or home BP cuff measurements?

Discussion

Is anyone using the Treat to Target AHA program? How do you get staff to wait 5 minutes to take blood pressure?

Questions

Thank you

Upcoming WACMHC Learning Events

Putting PCMH into Practice: Care Management and Support (CM)
August 8 | 12:00 – 1:00
REGISTER

Lean Boot Camp: Office Hours
August 14 | 12:00 – 1:00
REGISTER

NAHQ Certified Professional in Healthcare Quality (CPHQ) Review Course
August 16 – 17 | Seattle, WA
REGISTER