CoP/Training Call: Patient Engagement Strategies: Innovations to Address Chronic Disease Disparities

Guest Speakers:
Jane Kapustin, PhD, CRNP, BC-ADM, FAANP, FAAN
Tanishah Nellom, M.S.P.H.
Terri Jowers

February 11, 2014
2:00 PM Eastern Time
Call Norms:

• All lines will be muted during the call.
• We will begin Q & A after the training portion of today’s call.
• Please submit questions via the WebEx chat box or press 14 and the monitor will call on you.
• We are recording this call, and will post slides, recording, and transcript on www.healthcarecommunities.org and www.cmspulse.org.
• Evaluation: Please fill out our evaluation at the end of today’s call.
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**Quality Improvement Organizations**

**DNCC** Disparities National Coordinating Center
Goals

- Understand chronic disease management in a real world context.
- Hear about effective patient engagement strategies that empower patients with chronic conditions while considering health literacy levels.
- Explore innovations in community outreach that reduce disparities in chronic conditions.
Jane Kapustin, PhD, CRNP, BC-ADM, FAANP, FAAN
Assistant Dean for the MS and DNP Programs
University of MD School of Nursing
and
Nurse Practitioner at UMD Medical Center for Diabetes and Endocrinology
Chronic Disease Management

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Assistant Dean for the MS and DNP Programs
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and
Nurse Practitioner at UMD Medical Center for Diabetes and Endocrinology
Chronic Disease: Diabetes

- ~26 million people in US have DM, 8.3% population
  - Vast majority have T2DM
  - ~27% people over age 65 have DM
- Costs are huge
  - $245 billion annually
  - Expenditures 2.3 times higher for people with DM

Health Literacy: Diabetes

• In diabetes, health literacy related to diabetes knowledge, self-efficacy and self-care behaviors and glycemic control

• Health literacy may also provide a better understanding of racial disparities observed in patients with diabetes

• Low level of health literacy common among patients with diabetes mellitus
  – estimates ranging from 15 to 40% depending upon the population sampled

Chronic Disease Management

• Clinical issues in primary care
  – Patients disengaged in care, passive
  – Paternalistic health care approach
  – Clinical inertia, incorrect assumptions
  – Care not always followed by patients

• Difficulty finding primary care providers

• Under-insured or no insurance
Issues in Primary Care

• Single health care provider visit: rushed, distracted, overwhelmed
  – Little time for more than one problem
  – Chronic disease--usually multiple co-morbid conditions
    • Obesity (sleep apnea, painful arthritis, sedentary)
    • Hypertension
    • Hyperlipidemia
    • Neuropathy, retinopathy, nephropathy
    • Mental health issues like depression, anxiety
Patient Related Problems

• Frustrated with visit focus
  – Provider does not listen
  – Provider too rushed
  – Goals and point of visit are not matched
  – Poor understanding
  – Feel disrespected, not valued

• Not achieving therapeutic goals of care
  – Unable to lose weight
  – Not exercising
  – Biological metrics unmet

• Pt not engaged, not motivated
Intrinsic and Extrinsic Factors

• Intrinsic Factors
  – Health beliefs, myths
  – Limited knowledge about DM
  – Limited technical skills
  – Limited physical capability
  – Health literacy issues
  – Self efficacy for behavior change

• Extrinsic Factors
  – Financial
  – Inadequate family support
  – Limited access to care

Team-Based Care

- People with diabetes benefit from team approach, multi-disciplinary
- Require intensive patient education
  - Disease
  - Treatment
  - Self management
  - Advanced therapies

Team-Based Care Principles

• Shared goals
• Clear roles
• Mutual trust
• Effective communication
• Measurable processes and outcomes
Communication

• Effective communication
  – Demonstrate respect
  – Offer assistance
  – Anticipatory guidance

• Establish relationship built on trust
University of MD Medical Center
University of MD Medical Center for Diabetes and Endocrinology

- Team based concept for DM care (chronic disease management)
- Full spectrum care offered at one facility
  - MDs and NPs
  - Health assistants
  - CDE
    - Dietitian
    - Nurse educator
  - Podiatry
  - PharmD
  - Psychiatry, therapists
Keep Patient in Center of Care
UMMCDE

• Highly functional team
• Facilitated visits
• Designed to optimize pt experience
• Shared EMR system, email communication, pt portal access
• Foster communication among HCPs
Sidney

- 58 year-old AA male, T2DM history
  - Poorly controlled on basal and prandial insulin coverage
  - A1c ~8.6% at first visit
  - Checks finger sticks 2-3 times weekly only

- Liver transplant history, HF
- Very cautious with first visit, not offering any conversation
- Keeps eye averted, no initiation of conversation
- Asked how long I would be at clinic
Sidney

• Continued to make FU appointments every 3 months
  – Brought meter to all visits
  – Brought in medication list
• Noticed coordinated care with Transplant team
• Benefited from DM classes, dietitian, and educator visits
• A1c dropped steadily over next year
Strategies that Work

- Team based care
- Group support
- Group education
- Motivational interviewing
- Self management education
- Use of technology
- Multiple levels of HC providers
Motivational Interviewing

• Foundational premises
  – Empathy
  – Collaborative approach
  – Supportive
  – Goal oriented
  – Autonomy
  – Reaching agreement to develop action plan
Case: Ernestine

• 67 year-old female, DM for 16 years
• Very frustrated with weight, DM control
  – BMI 33
  – A1c 7.9% (Metformin, glipizide)
  – Not exercising
  – Rarely testing glucose
  – Tired of “diabetes routine”
Ernestine

• Approach
  – Acknowledge her frustration, empathize
  – Explore motivation level
  – What change is she ready for?
  – One thing at a time
Ernestine

• Develop action plan
  – Specific goal for one change
  – Example
    • Stay more active
    • Better food choices
    • Test glucose at least daily
Ernestine

• Interested in seeing dietitian again
  – Food choices
  – Reading labels
  – Portion control (plate method)

• Engage in support group activities of her interest

• Group diabetes education classes
Ernestine

• Change diabetes treatment plan
• Stimulate weight loss with adding new medication
  – Exenatide BID
  – New SGLT-2 Inhibitor medication
Redesigning the Health Care Team

Diabetes Prevention and Lifelong Management
References

Tanishah Nellom, M.S.P.H.
Care Improvement Specialist
The Carolinas Center for Medical Excellence
Improving Healthcare Professionals’ Literacy on Health Literacy

Tanishah Nellom, MSPH

February 11, 2014
Social Determinants of Health

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities.

- Economic Stability
- Education
- Social and Community Context
- Health Care Access
- Neighborhood and Built Environment

Culturally Competent Providers

- Embrace cultural diversity
- Recognize and prepare for language barriers
- Build a better rapport with patients
- Understand how the SDOH impacts their patients

Effective Communication

- Fosters more health literate patients
- Helps patients better manage their health
- May prevent ADEs, ED visits and readmissions
- Improves health outcomes

The Problem

A Certified Heart Failure Nurse Practitioner was concerned that her patients were not compliant with sodium restrictions.

- Patients responded well to new educational materials
- Patients were coming in to follow-up visits within 7 days because of new care transitions program
- Patients were given nutritional tools to guide food choices
The Bright Idea…

• The hospital and most of its patients are in an urban area with no grocery stores within several miles
• There are several “Family Dollar” and “Dollar General” stores in the area where patients reported shopping
• Characteristics of these stores:
  – Accept SNAP benefits
  – Easily accessible through local transit
  – Low price
Educational Moment Turns Intervention

The nurse practitioner had never visited either of those stores.

- Visit the store to familiarize herself with the inventory
- Learn more about the challenges of eating healthy with environmental and economic factors to consider
- An opportunity to “practice what I preach” to her patients
The Challenge

Craft a full day’s menu from a local discount store for less than $6 and under 1500mg of sodium
The Discovery

- No fresh food items
- Processed foods with high sugar and sodium content
- Canned meat products
- Some sodium free veggies
- Low sodium crackers
- Tuna packed in water
The Results

• Our Certified Heart Failure Nurse Practitioner could not plan a full day of meals under 1500mg of sodium…even when cheating on the budget!

• What was learned on this mission is there are better food options available at these stores
Outcomes

This community is working to make:

• A nutritional tool with shopping lists inclusive of all income levels that includes “better option” items from stores like these

• Working to make the “Practice what You Preach” project an official intervention for clinical staff
  – Other heart failure nurses and care transitions staff have taken the 1500mg challenge-none successful so far

• Opening the eyes and minds of clinical staff to SDOH that may effect health outcomes
Summary

• Using real life experiences to create a culture of understanding in healthcare providers
• We can use evidence based interventions proven to work and find that they don’t work our communities
• Providers have to be willing to explore the unfamiliar in order to understand where disease etiology address the root cause
The Carolina’s Center for Medical Excellence

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Community Innovations

Terri Jowers
Director
Healthy Columbia
Finding Inspiration to Create Change

The Healthy Columbia Story
Every day is a good day; a GREAT day is one where you do something for someone who cannot afford to pay you back.
Our Hot Spot: 29203

- **Hot Spotters:** Area of Columbia with high disease rates
- **Limited access** to primary care services
- High healthcare costs (**$7,358 per person**)
- Strong community leadership
- Population: 46,000
- 50% Medicaid/Medicare
- 30% Uninsured
- 30.3% living in poverty
- 57.1% low income
- 11% 65+ years of age
- Per capital income is almost ½ the average of the County
Room for Improvement

- One of the highest diabetes-related amputation rates in the US
- Likely one of the highest rates for dialysis
- More that 60% of the population is overweight
- 1 in 3 residents live in poverty, twice the poverty rate of South Carolina
- Primary Care Crisis
- ACA could have adversely effect health in short-term
Healthy Columbia Mission:

Healthy Columbia uses community organizing to build leadership to enable individuals and communities to take action to lead healthier lives and to collaborate with providers to efficiently improve health and health care.
The Real Vision

A wide-spread outbreak of health in Columbia, South Carolina
Why Organizing?

- Building relationships
- Identifying, recruiting & developing leaders
- Sharing leadership & accountability
- Taking Action
- Changing the Balance of Power
  - *Power Over to Power* With
  - Population Health vs Population Medicine
Strategies for Change

(1) Pharmacies & pharmacists as care providers

(2) Neighborhood health workers with NPs, RNs, CHWs

(3) One-stop Patient-Centered Medical Home with lifestyle support space and activities

(4) Community Covenant: “Grasstops” and “grassroots” work together to redesign care access and reinvest shared savings in community health
What We’ve Done...since 6/2012

- 65 health screening events & 2 brown-bag med checks
- Over 1,650 people screened and connected to services
- Campaign to transform health science education at USC
- Campaign to open a Community Centered Health Home
- Lifestyle & exercise classes led by volunteer Health Advocates
- Men’s Team
- Healthy Happy Meals
- 5th Qtr
Secondary Outcomes

Federally Qualified Health Center received $2.4 million CMS innovation grant to develop health coach program in 29203

- Churches are expanding & enhancing Wellness Programs

- Providers involved in campaign relate to patients differently
  - Relationships built with community members transformed them
  - Ask themselves “What am I doing to work with others in the community to make changes?”

- USC is changing Health Science Education
Ongoing...

- Health screenings ➔ Personal health goal setting ➔ Primary care & lifestyle program referrals
- Leadership Trainings Volunteer Community Advocates
- Access to fresh produce
  - Garden Projects
  - Produce Vendors who will accept EBT
- Healthy Columbia Rotation for USC 3rd yr Med Students
  - Housing projects, churches, barber shops, basketball courts, parks & rec
  - Partnering with pharmacy residents, social work & public health students
Health Screenings

* Intake & Survey
* Height, Weight, Waist Circumference
* Body Fat Index & Body Mass Index
* Blood Pressure
* Random Glucose
* Check-out
* Possible Additional Screenings:
  * Fall Risk Assessment
  * Med Checks
  * Benefits Bank Screening
  * Behavioral Health
Health Screening Check-out Information

- **Team Approach:** Community Member, Medical, Pharmacy, Resource
- **Review numbers & make medical goals according to protocol**
  - e.g. BP indicates follow-up in 24 hrs, 72 hrs, etc
- **Review ChooseMyPlate.gov**
- **Stay away from “the white stuff in your diet”**
- **Discuss Self Care, Partnering Care & Crisis Care**
- **Set Health Goals, discuss barriers & strategies**
- **Set Done By Date (Valentine’s, Easter, Memorial Day)**
- **Name Support/Accountability Partner**
- **Refer to resources: Parks & Rec, Free Clinic, Food Bank, classes**
What We’ve Learned

* Deeper understanding of Access to Care
* Folks are struggling to manage, especially Seniors
  * “I can’t be compliant if…”
* Trust is earned
* Peer to Peer…There’s Power in the Group
* We should be equals
* If we want to reduce ED visits, we have to take a systems approach!!!
Aspirations

* Development of a Community-Centered Health Home
  * Medical Home in underserved area that will see Medicare, Medicaid, & uninsured.
  * Team approached partnering care
  * Lifestyle education & support led by volunteer Healthy Columbia Community Health Advocates
  * Healthy Columbia-based Community Health Workers
    * Home visits, social determinates
  * Fall-Risk
    * Assessment. Protocol & Referral. Simple training
  * Healthy Body Healthy Mind Connection
Inspiration

* Ridgewood Missionary Baptist Church
  * Healthiest Congregation in Columbia
* Hillandale Apartments
  * Jannie’s Story
What is your inspiration?
What is your vision?
Q&A

Press 14 to enter the queue to ask a question.
Useful Resources

1. **Effective Communication Tools for Healthcare Professionals**: A free online course from HRSA that provides tools to improve patient-provider relations.

2. **Healthy Columbia**: Learn more about everything Healthy Columbia is doing to reach equity in health in Columbia, SC.

3. **University of Maryland Medical Center for Diabetes and Endocrinology**: Check out all that UMD is offering to its patients.

4. **The National Standards for Culturally and Linguistically Appropriate Service in Health Care: Final Report**: These standards are widely used to provide equity in care.

5. **Effective Communication Tools for Healthcare Professionals**: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency (LEP)
Join the DNCC Community

To Join the DNCC Listserv:

- Log onto the SDPS system.
- Open Internet Explorer. Your default homepage should be qionet.sdps.org.
- At the top of the page, you should see a tab labeled “Listserve.” Click “Listserve.”
- Enter your user information at the top of the page and scroll down to “Disparities”. Join “Discussion” and “Notify”.
- Click “Subscribe”.

To Join DNCC Healthcare Communities:

- Log onto www.healthcarecommunities.org
- Sign in, or create an account.
- Scroll over the “Communities” tab, scroll down to “Available Communities” and select “QIO 10TH SOW”.
- Scroll down to DNCC and select “Join DNCC”.

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES
National Disparities Virtual Conference
Tuesday April 8, 2014
12:00-4:00pm EST
Dates to Remember

Office Hours

Wednesday February 19th & 26th
2:30-3:30pm EST

Community of Practice Call

Tuesday March 11, 2014
2:00-3:00pm EST
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