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DIABETES IN SPECIAL & VULNERABLE POPULATION: Learning Collaborative

Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management- *Referrals and Care Coordination*

Session #4
Wednesday, February 16, 2022
9 am HT / 10 am MT / 11 am PT / 1pm CT / 2pm ET

Welcome!
We will begin in a few minutes

ABOUT THE LEARNING COLLABORATIVE

Diabetes affects more than 34 million people in the United States. Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for special and vulnerable populations, which have unique characteristics that affect culturally and linguistically competent health care access and utilization. According to 2018 Uniform Data System (UDS), diabetes poses a unique challenge for the HRSA Health Center Program because 1 of 7 patients has diabetes and nearly 1 in 3 of those has uncontrolled diabetes.

To elevate the national conversation around diabetes, **14 National Training and Technical Assistance Partner (NTTAP) organizations** formed the Special and Vulnerable Populations Diabetes Task Force to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase knowledge of effective strategies that address diabetes among people experiencing homelessness, residents of public housing, migratory and seasonal agricultural workers, school-aged children, older adults, Asian Americans, Native Hawaiians and Pacific Islanders, LGBTQIA+ people, and other health center patients.

The Learning Collaboratives are **sponsored by HRSA** and will take a deeper dive into issues related to the roles of enabling services staff, developing patient-center resources, improving diabetes care and health equity, and management during a disaster in diabetes care and management.

For information about the Diabetes Task Force, visit **chcdiabetes.org** today.

Special and Vulnerable Populations Task Force Members:

For more information on our NTTAP Partners, visit chcdiabetes.org

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Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management

NTTAP FACULTY

Albert Ayson, Jr., MPH
Associate Director, Training & Technical Assistance of AAPCHO

Cindy Selmi
Executive Director
Health Outreach Partners

Hansel O. Ibarra, MPA
Program Director II
MHP Salud

Irene Hilton, DDS, MPH
Dental Consultant
NNOHA

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MHP Salud
OUTCOME-DRIVEN • EXPERIENCED • INNOVATIVE

NNOHA
National Network for Oral Health Access

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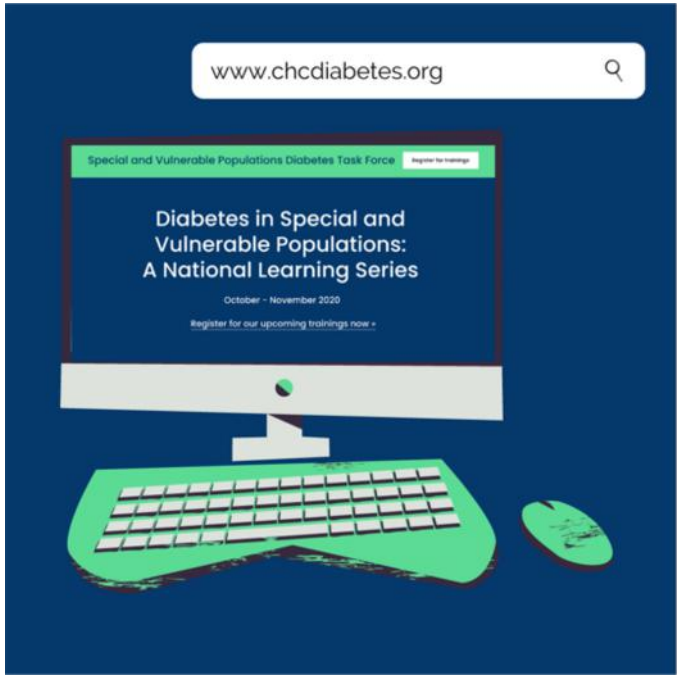
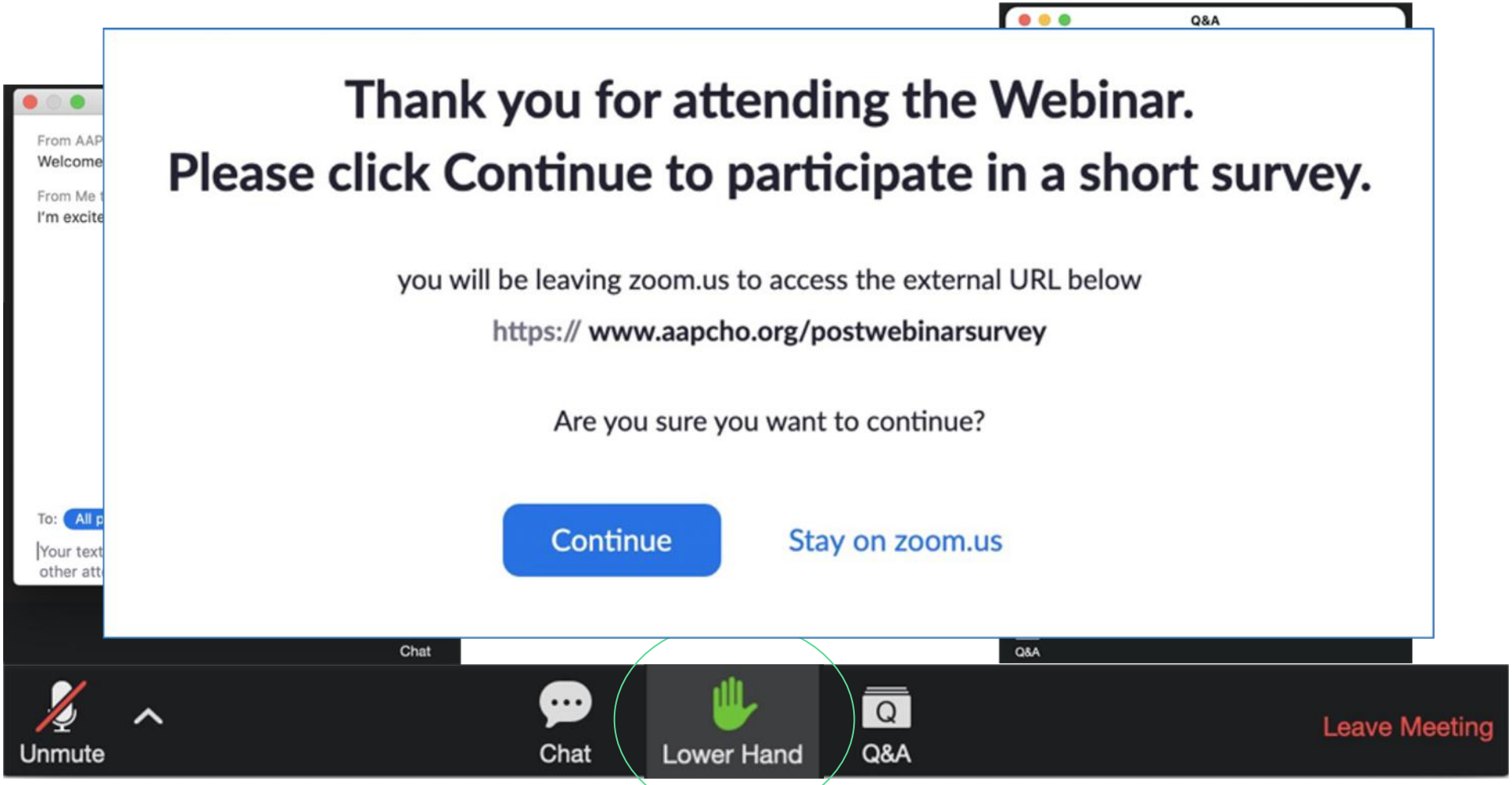
Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management

Compendium of Resources

The Special and Vulnerable Populations Diabetes Task Force is excited to have a website — www.chcdiabetes.org!

For any questions, contact training@chcdiabetes.org




Q&A
Thank you for attending the Webinar.
Please click Continue to participate in a short survey.
you will be leaving zoom.us to access the external URL below
https:// www.aapcho.org/postwebinarsurvey
Are you sure you want to continue?
Continue
Stay on zoom.us
Chat
Q&A
Unmute
Chat
Lower Hand
Q&A
Leave Meeting

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CME/CNE Accreditation Available

- **Please complete the post-webinar survey** at the end to indicate whether you would like to receive CME/CNE units or a certificate of attendance.
- Please indicate whether you'd prefer an electronic or hard copy of your certificate and provide your contact information
- For questions, please contact Martha at **malvarado@migrantclinician.org**.

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Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management- *Referrals and Care Coordination*

Introductions

- Name
- Title/Role
- Organization

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Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management- *Referrals and Care Coordination*

Session 4

Feb 16, 2022 @ 11-12pm PT/2-3pm ET

Learning Objectives:

1. Explore how enabling services staff can facilitate clinical referrals within/outside the health center
2. Discuss the importance of patient education for successful referrals
3. Learn one health center's referral and care coordination workflows

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Roles of the Enabling Services Staff in Diabetes Management

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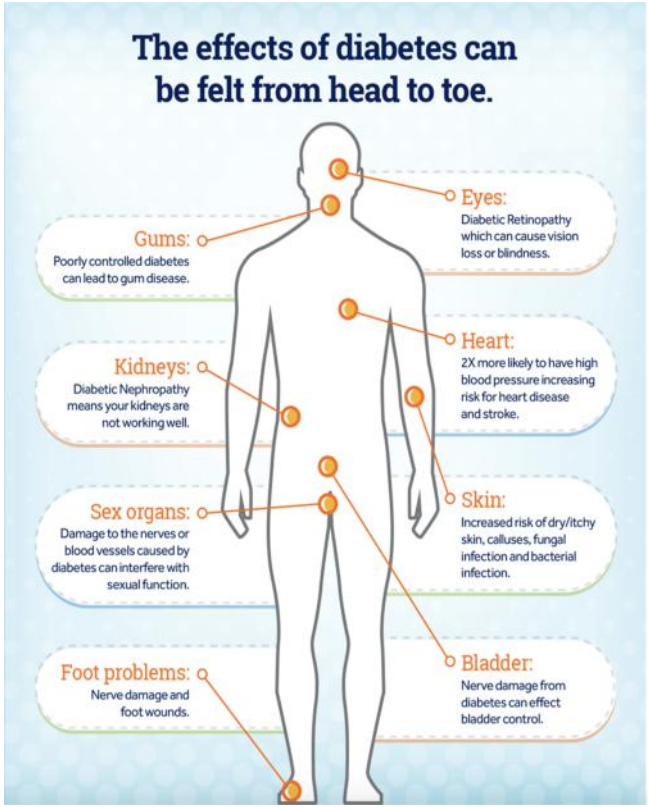

Clinical Referral and Care Coordination for Patients with Diabetes

- Optometrist/opthamologist
- Dentist/dental hygienist
- Cardiologist
- Nephrologist/Dialysis
- Dermatologist
- Urologist
- Podiatrist/Wound healing

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Referral and Care Coordination for Patients with Diabetes

- Food support
- Healthy eating
- Smoking cessation
- Physical activity support
- Behavioral health
- Legal assistance/housing/IVP

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✅ = Successful Referral?

- Literacy/Understanding
- In-house vs. External
- Cost
- Acceptability

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Care Coordination

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Care coordination addresses potential gaps in meeting patients' interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness…according to patient preferences.

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Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management- *Referrals and Care Coordination*

Today's Guest Speakers

Dana Kilinski, BS, CHW
Community Health Worker

Madison Smith, BS, CHW
Community Health Worker

Jennifer Kerns, BS, RDH
Dental Outreach Coordinator

NORTHWEST MICHIGAN
Health Services Inc

NORTHWEST MICHIGAN
HEALTH SERVICES INC

Referrals and Care Coordination

Heal. Smile. Breathe.

Sanar. Sonreír. Respirar.

NORTHWEST MICHIGAN
HEALTH SERVICES INC

Dedicated to providing quality healthcare through a wide range of health services to the people in our communities, always serving with dignity and compassion.

BRING WELLNESS TO LIFE.

NORTHWEST MICHIGAN
HEALTH SERVICES INC

Last year, we served over **7,500** patients, providing close to **30,000** medical, dental and behavioral health visits.

10%
Patients who are agricultural workers

22%
Patients without health insurance

20%
Mental health, substance use disorder visits

We' re making health care more accessible for everyone!

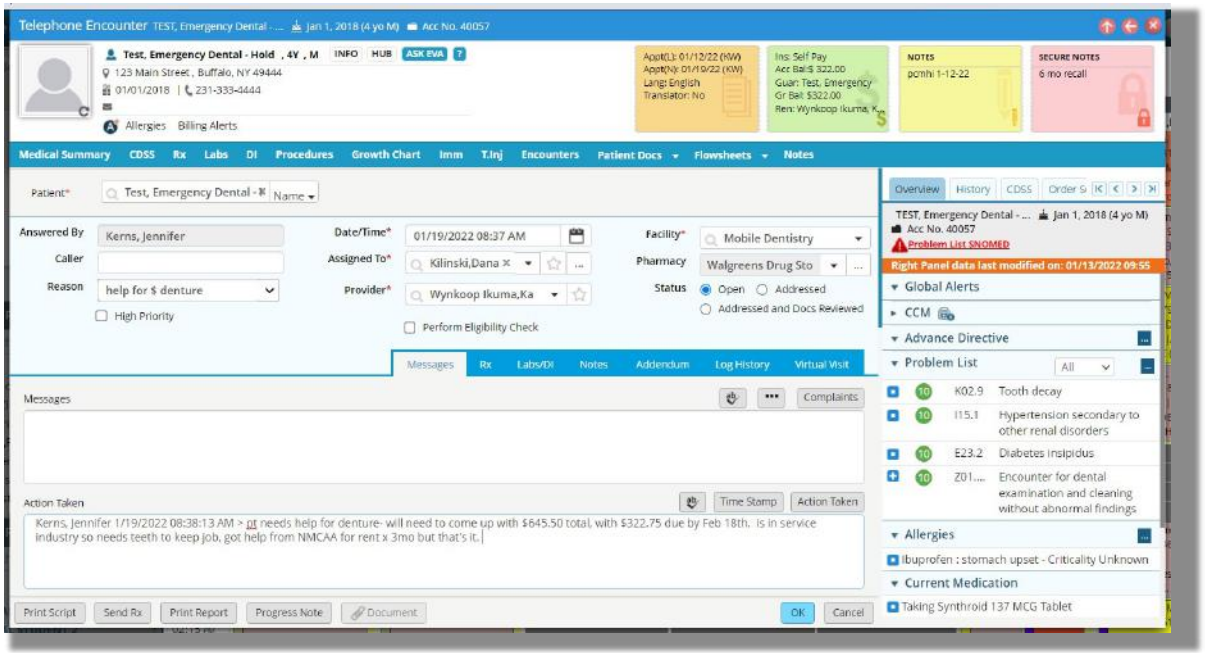
5 Health Centers **2** School-based Clinics **2** Mobile Clinics

NORTHWEST MICHIGAN
HEALTH SERVICES INC

Traverse City

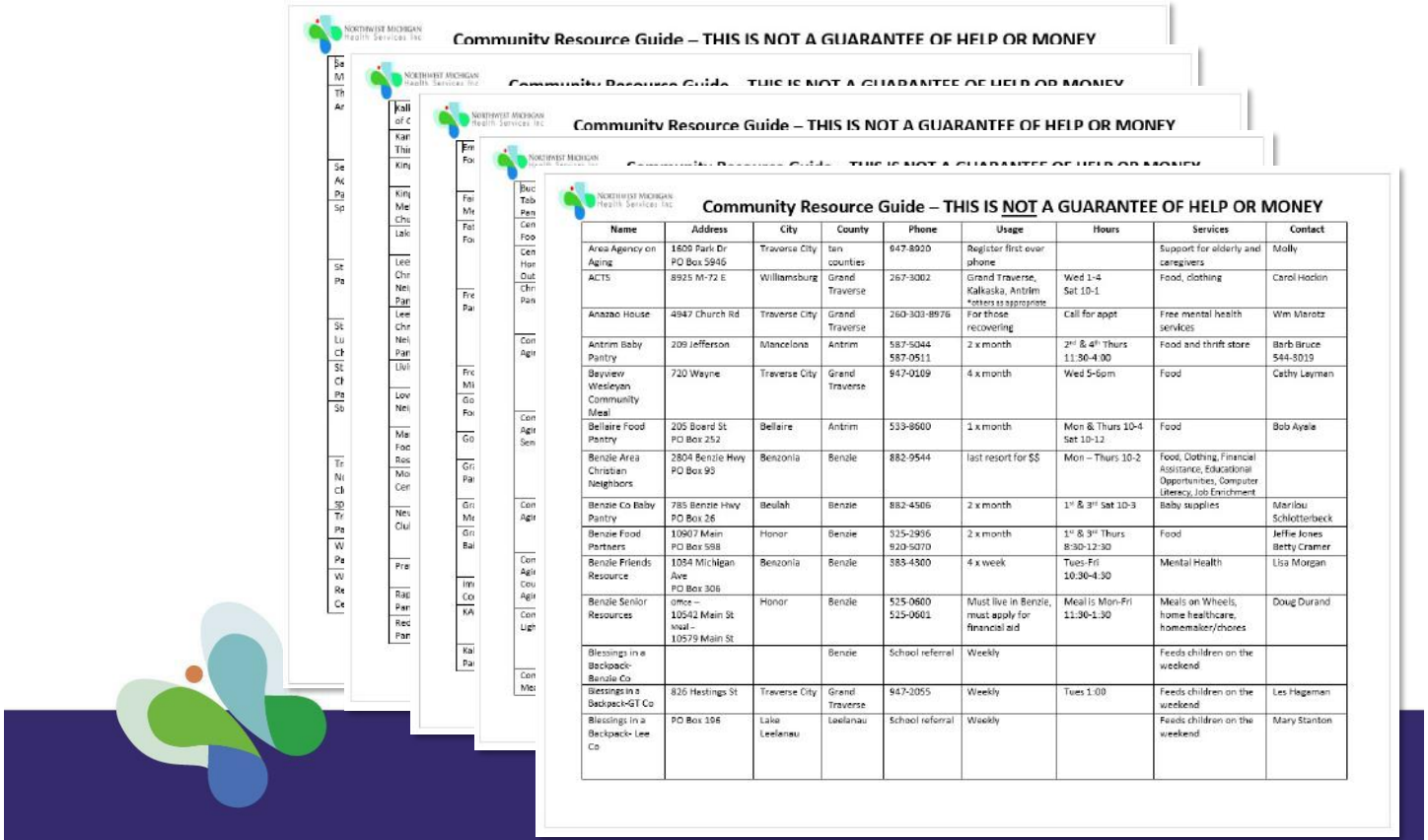
CHWs and Dental Clinic Staff

Patient Referral for Help



Healthcare Provider □ Patient Chart “jelly-bean” □ CHW

Community Resource Guide (5 pages)

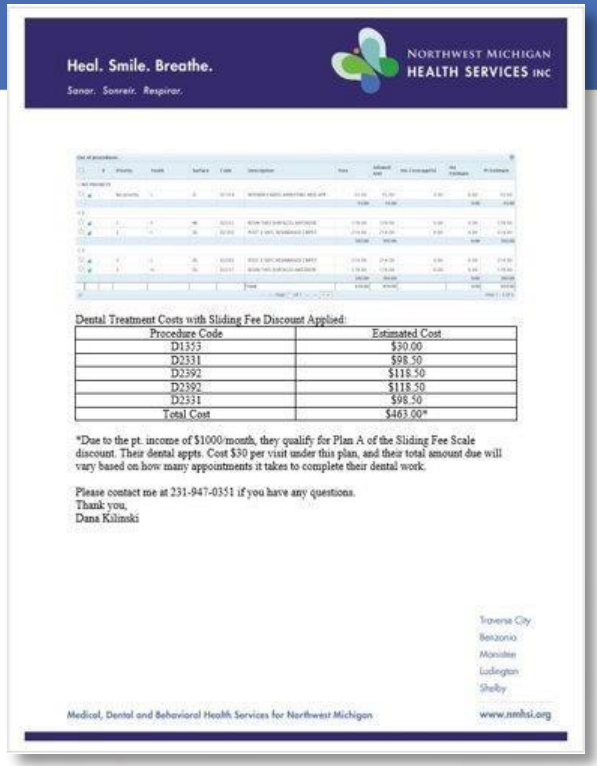


Name	Address	City	County	Phone	Usage	Hours	Services	Contact
Area Agency on Aging	1609 Park Dr PO Box 5946	Traverse City	ten counties	947-8920	Register first over phone		Support for elderly and caregivers	Molly
ACTS	8925 M-72 E	Williamsburg	Grand Traverse	267-3002	Grand Traverse, Kalkaska, Antrim *enters as appropriate	Wed 1-4 Sat 10-1	Food, clothing	Carol Hockin
Anazao House	4947 Church Rd	Traverse City	Grand Traverse	260-303-8976	For those recovering	Call for appt	Free mental health services	Wm Marotz
Antrim Baby Pantry	209 Jefferson	Mancelona	Antrim	587-5044 587-0511	2 x month	2nd & 4th Thurs 11:30-4:00	Food and thrift store	Barb Bruce 544-3019
Bayview Wesleyan Community Meal	720 Wayne	Traverse City	Grand Traverse	947-0109	4 x month	Wed 5-6pm	Food	Cathy Layman
Bellaire Food Pantry	205 Board St PO Box 252	Bellaire	Antrim	533-8600	1 x month	Mon & Thurs 10-4 Sat 10-12	Food	Bob Ayele
Benzie Area Christian Neighbors	2804 Benzie Hwy PO Box 95	Benzonia	Benzie	882-9544	last resort for $$	Mon – Thurs 10-2	Food, Clothing, Financial Assistance, Educational Opportunities, Computer Literacy, Job Enrichment	
Benzie Co Baby Pantry	785 Benzie Hwy PO Box 26	Beulah	Benzie	882-4506	2 x month	1st & 3rd Sat 10-3	Baby supplies	Marilou Schlotterbeck
Benzie Food Partners	10907 Main PO Box 598	Honor	Benzie	525-2936 920-5070	2 x month	1st & 3rd Thurs 8:30-12:30	Food	Jeffie Jones Betty Cramer
Benzie Friends Resource	1034 Michigan Ave PO Box 306	Benzonia	Benzie	383-4300	4 x week	Tues-Fri 10:30-4:30	Mental Health	Lisa Morgan
Benzie Senior Resources	office – 10542 Main St Meal – 10579 Main St	Honor	Benzie	525-0600 525-0601	Must live in Benzie, must apply for financial aid	Meal is Mon-Fri 11:30-1:30	Meals on Wheels, home healthcare, homemaker/chores	Doug Durand
Blessings in a Backpack- Benzie Co			Benzie	School referral	Weekly		Feeds children on the weekend	
Blessings in a Backpack-GT Co	826 Hastings St	Traverse City	Grand Traverse	947-2055	Weekly	Tues 1:00	Feeds children on the weekend	Les Hegeman
Blessings in a Backpack- Lee Co	PO Box 106	Lake Leelanau	Leelanau	School referral	Weekly		Feeds children on the weekend	Mary Stanton

Letter of Request for Help

Patient Information + Treatment Plan

1. Referral to CHW
2. Patient Interview
3. Letter of Request
   - Patient Contact Information
   - Treatment Plan
   - Highlight out of pocket funds needed
   - “Story” about patient need
4. Letter of Intent-to-Pay received
5. Schedule appt for treatment
6. Other help as needed
7. Follow up



Heal. Smile. Breathe.

Sanar. Sonreir. Respirar.

NORTHWEST MICHIGAN HEALTH SERVICES INC

Dental Treatment Costs with Sliding Fee Discount Applied:

Procedure Code	Estimated Cost
D1353	$30.00
D2331	$98.50
D2392	$118.50
D2392	$118.50
D2331	$98.50
Total Cost	$463.00*

*Due to the pt. income of $1000/month, they qualify for Plan A of the Sliding Fee Scale discount. Their dental appts. Cost $30 per visit under this plan, and their total amount due will vary based on how many appointments it takes to complete their dental work.

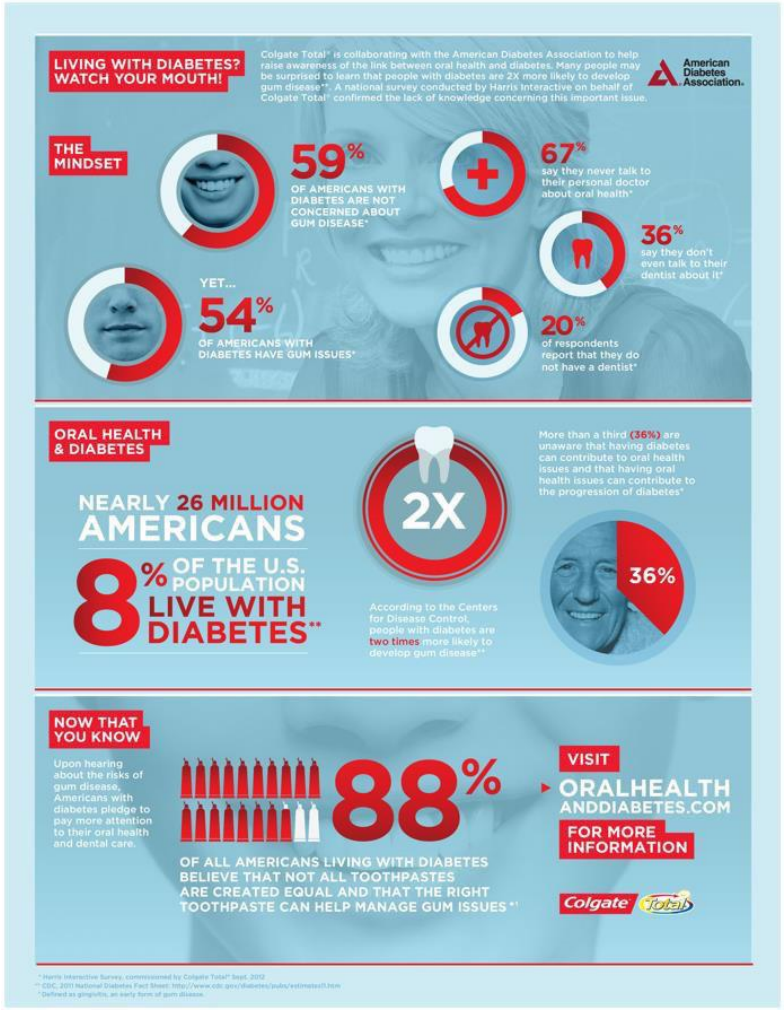
Please contact me at 231-947-0351 if you have any questions.
Thank you,
Dana Kilinski

Traverse City
Benzonia
Manistee
Ludington
Shelby

Medical, Dental and Behavioral Health Services for Northwest Michigan

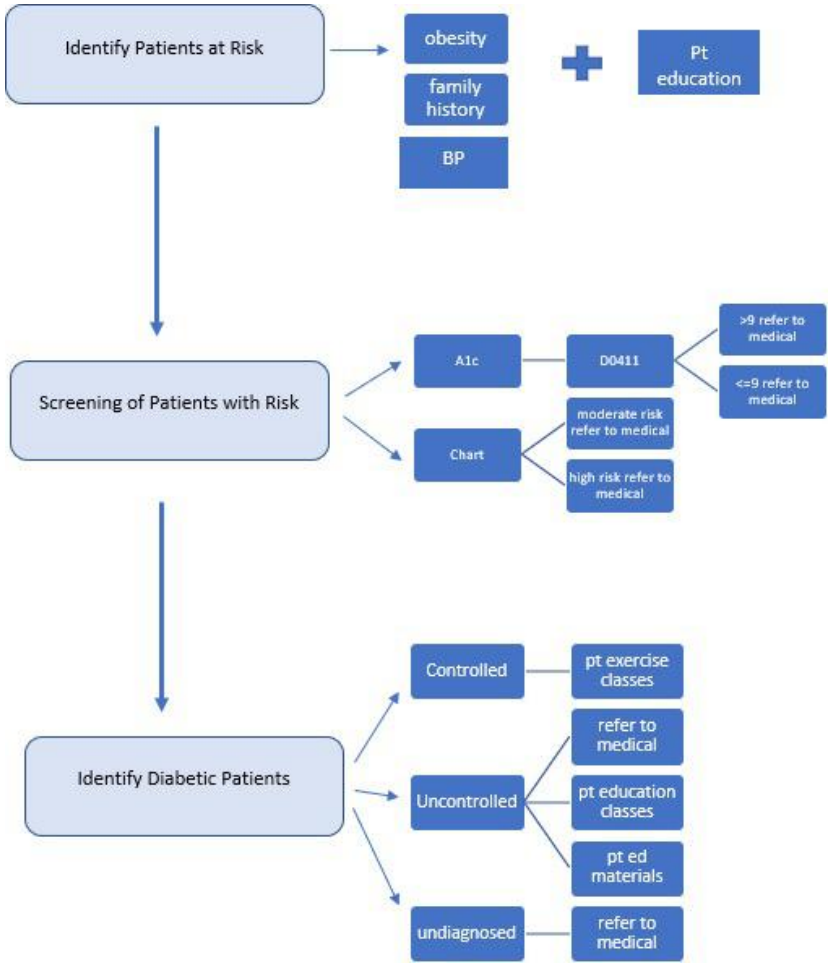
www.nmhsi.org

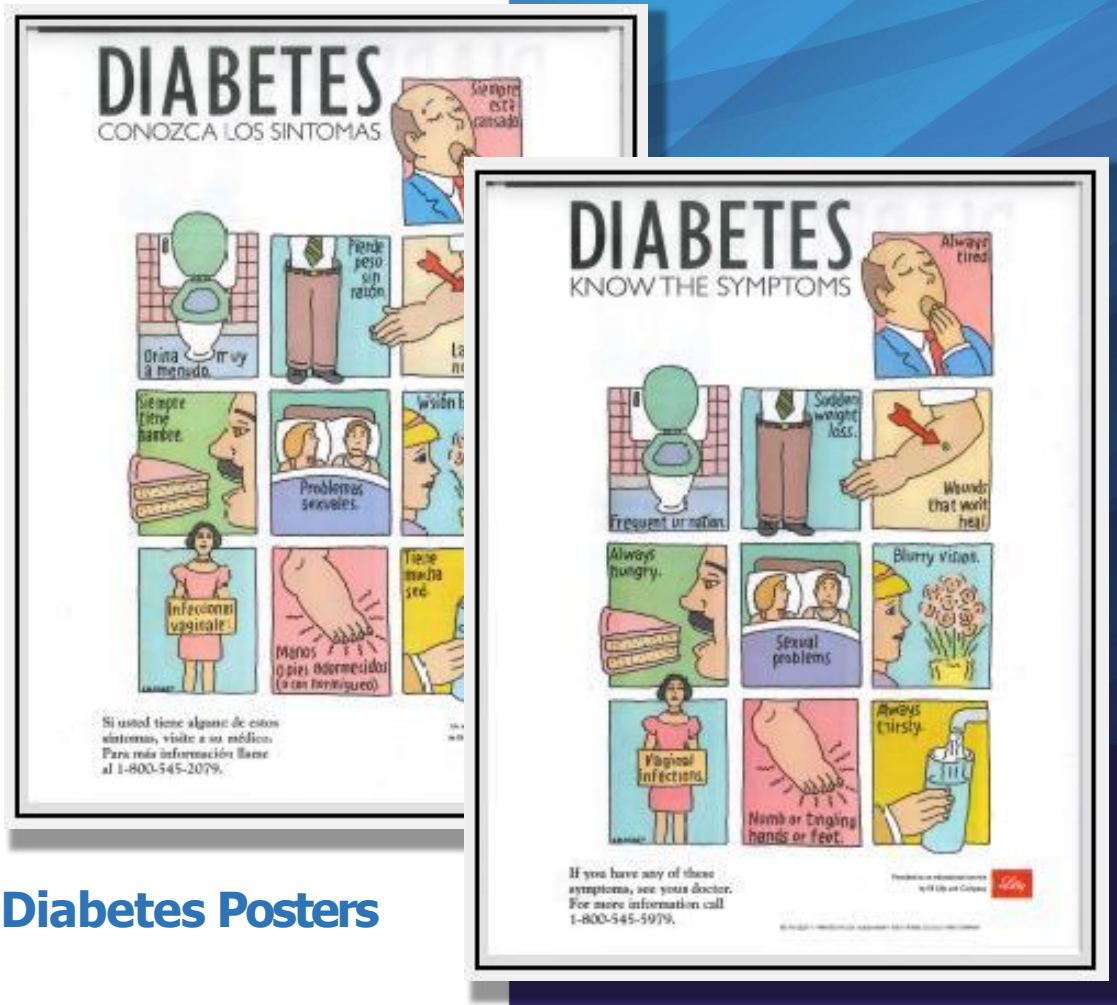
Diabetes and Oral Health



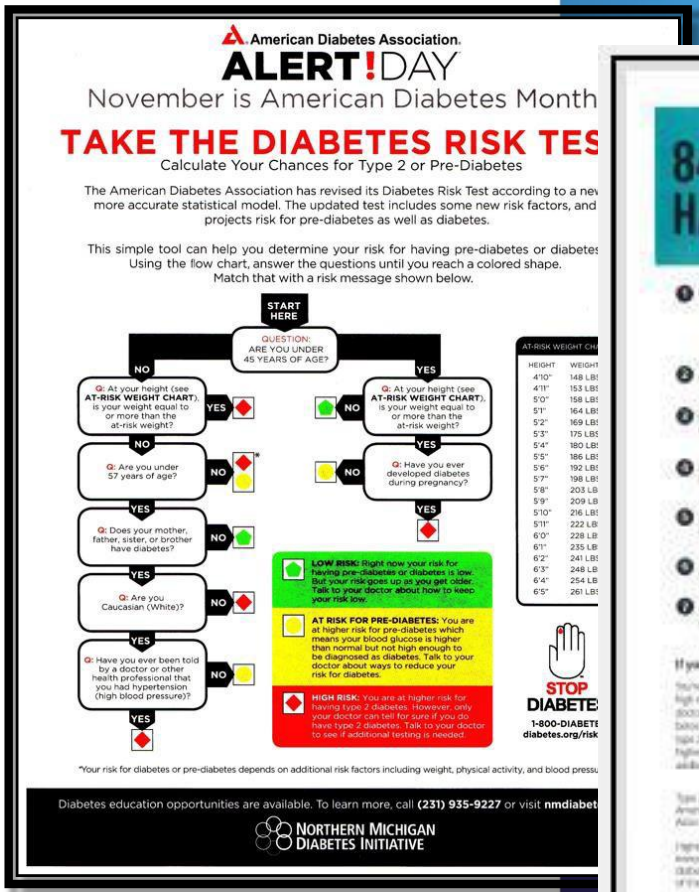
Dental Workflow

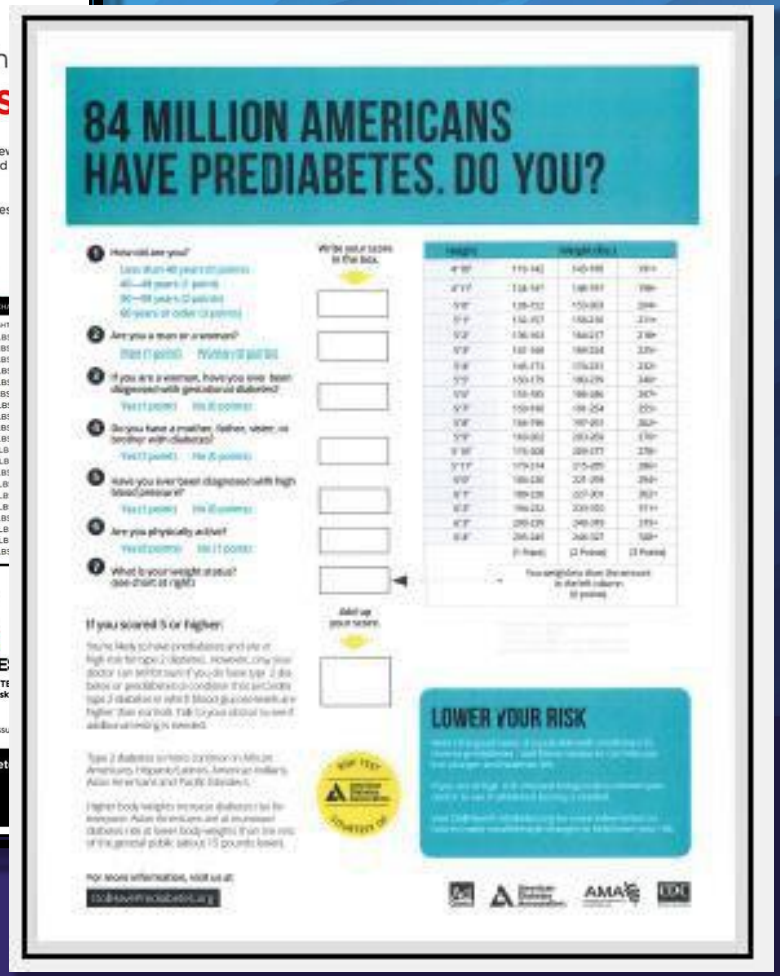
for Diabetes





Diabetes Posters





Diabetes Screening Tools

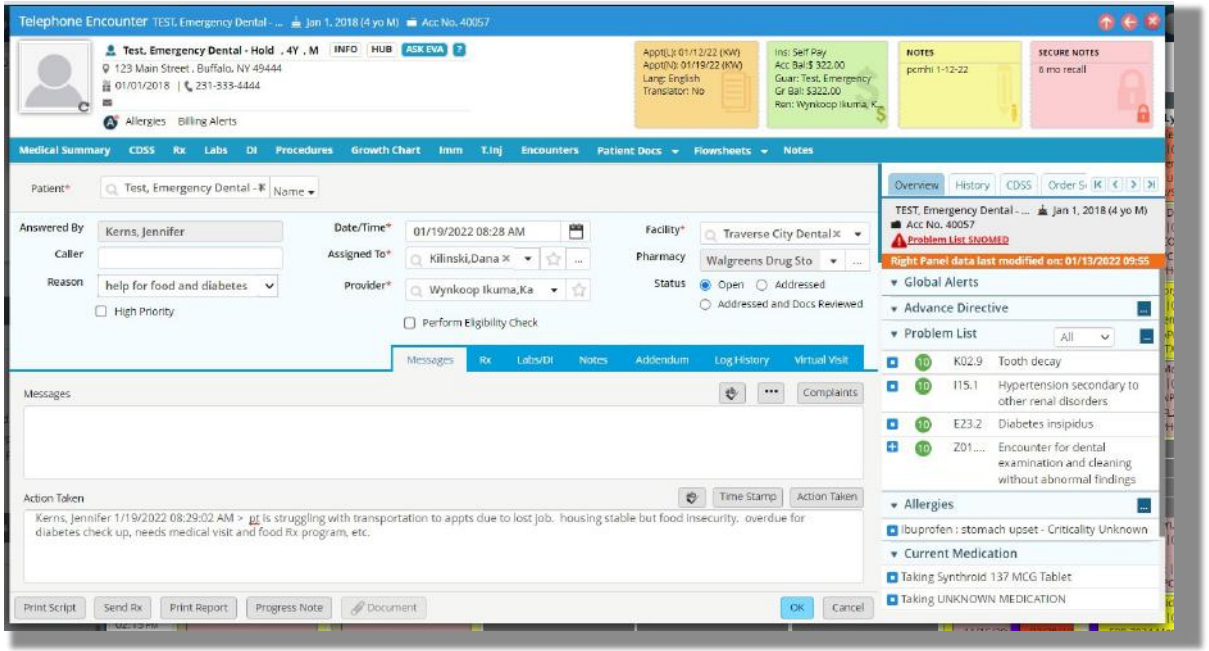
1. **Are they taking their medications appropriately?**
   a. Oral glucose lowering meds include:
      i. Metformin (Glucophage)
      ii. Glipizide, Glimepiride, Glyburide
      iii. Pioglitazone (Actos), Rosiglitazone (Avandia)
      iv. Acarbose, Miglitol
      v.Nateglinide, Repaglinide vi.
      vii. Alogliptin /(Nesina), Saxagliptin (Onglyza), Linagliptin (tradjenta), Sitagliptin (Januvia) Ertugliflozin (Steglatro), Dapagliflozin (Farxiga), Canagliflozin (Invokana), Empagliflozin (Jardiance)
      viii. Exenatide (ER -Bydureon), Exenatide (Byetta), Dulaglutide (Trulicity), Semaglutide (Ozempic), Liraglutide (Victoza)
      ix. Colesevelam
      x. Bromocriptine
      xi. Pramlintide
   b. Insulin:
      i. Rapid acting: Lispro, Glulisine, Lispro, Aspart
      ii. Short-acting: Human regular
      iii. Intermediate-acting: Human NPH
      iv. U-500
      v. Basal: Glargine, Detemmir, Degludec
      vi. Premixed: NPH/Regular 70/30, Lispro 50/50, Lispro 75/25, Aspart 70/30
   c. Any side effects?
   d. If not taking, what is the reasoning? (i.e., access, financial, lack of knowledge, etc.)
2. **If on 2+ oral medications or insulin, are they checking their blood sugar?**
   a. Fasting sugar should be <130, closer to 100 the better
   b. Check for hypoglycemia (too low of sugar) - <70 – how frequent?
      i. Schedule appt
   c. Check for hyperglycemia (too high of sugar) - >400 – how frequent?
      i. Schedule appt
   d. If not, what is reason for not? (i.e., lack of access, financial aspects, need additional education, etc.)
   e. We do have glucometers in the office
3. **When were they last seen?**
   a. If A1c not at goal - ideally <7% - should be seen every 3 months
   b. If A1c at goal - should be seen every 6 months
   c. If it has been longer than recommended time frame, please assist them in scheduling an appt.
4. **Blood pressure – do they have a diagnosis of high blood pressure?**
   a. If have a diagnosis, are they checking their BP?
      i. If so, target of less than 140/90 mmHg
      ii. If higher than this, please assist pt in scheduling an appt.
5. **Cholesterol – When is the last time they had their cholesterol checked?**
   a. LDL goal < 100
6. **Diabetic retinal exam?**
   a. Should be yearly
   b. If they have had, do we have a record release signed so we can get a copy of the results?
7. **Dental?**
   a. Do they have dental?
   b. Should be at least yearly
8. **Have they been or are they interested in diabetes education?**

https://www.munsonhealthcare.org/services/diabetes-education/diabetes-education

Classes Available at:

- Cadillac Hospital - Outpatient Services400 Hobart St.Cadillac, MI 49601
- Kalkaska Memorial Health Center - Outpatient Services419 S. Coral St.Kalkaska, MI 49646
- Grayling Community Health Center1250 E. Michigan Ave.Grayling, MI 49738; 989-348-0550
- Munson Professional Building1221 Sixth St.Traverse City, MI 49684
- Paul Oliver Memorial Hospital - Outpatient Services224 Park Ave.Frankfort, MI 49635
- Roscommon Community Health Center234 Lake St.Roscommon, MI 48653; 989-275-1200
- Prudenville Community Health Center2585 W. Houghton Lake Dr.Prudenville, MI 48651; 989-366-2900

Patient Referral for Help



Healthcare Provider □ Patient Chart “jelly-bean” □ CHW

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QUESTIONS? CONTACT US!

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Diabetes Continuum of Care: Evolving Roles of the Enabling Services Staff in Diabetes Management- *Referrals and Care Coordination*

- *Introductions*
- *How are ES staff utilized your Health Center to support external & internal referral for patients with diabetes?*
- *What would you like to change or implement to better support care team referrals-utilizing ES staff?*

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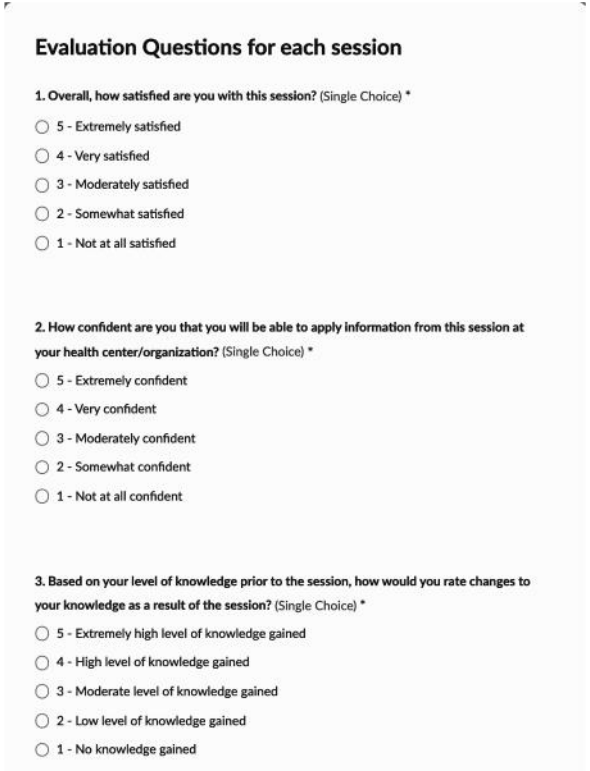
Session Evaluation

Before signing-off, please complete our quick session poll to help us evaluate how today's session went for you.



Evaluation Questions for each session

1. Overall, how satisfied are you with this session? (Single Choice) *

- 5 - Extremely satisfied
- 4 - Very satisfied
- 3 - Moderately satisfied
- 2 - Somewhat satisfied
- 1 - Not at all satisfied

2. How confident are you that you will be able to apply information from this session at your health center/organization? (Single Choice) *

- 5 - Extremely confident
- 4 - Very confident
- 3 - Moderately confident
- 2 - Somewhat confident
- 1 - Not at all confident

3. Based on your level of knowledge prior to the session, how would you rate changes to your knowledge as a result of the session? (Single Choice) *

- 5 - Extremely high level of knowledge gained
- 4 - High level of knowledge gained
- 3 - Moderate level of knowledge gained
- 2 - Low level of knowledge gained
- 1 - No knowledge gained

THANK YOU!

For information about the Special and Vulnerable Populations Diabetes Learning Collaborative, visit **chcdiabetes.org** today.

Feel free to contact our NTTAP collaborating partners and speakers from today's webinar:

Cindy Selmi - cynthia@outreach-partners.org
Albert Ayson, Jr. - aayson@aapcho.org
Hansel Ibarra - hibarra@mhpsalud.org
Irene Hilton - irene@nnoha.org

At the end of this webinar, please complete the evaluation form. Your feedback is greatly appreciated