AHEAD Podcast 5 – QI Strategies to Address Diabetes Disparities in Primary Care

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to the AHEAD Initiative podcast series focused on sharing evidence-based practical strategies to improve diabetes outcomes and advance diabetes health equity. I'm Dr. Michael Konstan from Case Western Reserve University School of Medicine, and I serve as a principal investigator for the Northeast Ohio Quality Improvement Hub, a collaboration of Case Western Reserve University with Northeast Ohio Medical University. The Northeast Ohio QI Hub is funded by the Ohio Department of Medicaid and provides quality improvement infrastructure for primary care clinics in our region. We hope you enjoy today's AHEAD Initiative podcast.

Anne Gaglioti: Welcome to our AHEAD podcast series for the Northeast Ohio Quality Improvement Hub. My name is Dr. Anne Gaglioti, and I am the co-lead of the equity and engagement team for the Northeast Ohio QI hub. I serve as an associate professor of family medicine at Case Western Reserve University School of Medicine and the Metro Health System. I'm delighted to talk with Dr. Bode Adebambo today about a topic we are both passionate about, health equity in primary care. Dr. Adebambo also co-leads the equity and engagement team and serves as an associate professor of family medicine at Case Western Reserve University School of Medicine and the Metro Health System. She's an expert in health disparities and a practicing family physician. Thanks so much for talking with me today, Bode.

Bode Adebambo: Oh, it's great to be here to talk with you today about advancing health equity in Ohio.

Anne: Just to level set, can you talk a little bit about the impact of diabetes on population health and health care costs?

Bode: Yes, I can. 38 million, that's 1 in 10 Americans live with diabetes and 98 million, which is one in three, live with pre-diabetes. The rates of those diagnosed have doubled in the past 20 years and models suggest that one out of three people will develop diabetes in their lifetime. To date, diabetes is the primary cause of blindness, leg amputations, and kidney failure, and is the eighth leading cause of death in the nation. It cost the nation an estimated $327 billion in medical cost and lost work and wages. In fact, people with diagnosed diabetes have more than twice the average medical costs that people without diabetes have. Bringing the data closer, in Ohio, more than one million people, that is 12.2% or put it another way, 1 in eight have diabetes.

The number of people in Ohio with diabetes is higher than the national average of 10.9%. And it's estimated that an additional quarter of a million have diabetes but do not know it.

Anne: Those are really staggering numbers. Can you give us an overview of diabetes disparities in Ohio?

Bode Adebambo: As you know, Anne, disparities are preventable differences in health outcomes seen in some populations relative to others. In Ohio, there's significant racial, ethnic, and socioeconomic disparities in the prevalence of diabetes. These disparities are observed in various populations, including racial, ethnic populations, and by geographical locations. And this is the communities that are most likely to have diabetes and die from complications of diabetes such as kidney failure and cardiovascular disease. Between 2018 and 2022, the non-Hispanic black population had the highest age adjusted diabetes mortality rate of 39.4 per 100,000 population compared to 24.5 for the Hispanic population and 19.9 for the white population. Rural Ohio counties are also disproportionately impacted by poverty, lack of access to insurance, and low educational attainment. In 2019, the rate of death due to diabetes in rural Ohio counties was 33 per 100,000 versus 25 deaths per 100,000 in non-rural Ohio counties.

Anne: Those are really difficult statistics to hear Bode and I always try to pause to consider the real human impact of disproportionate human suffering caused by health inequities like those of diabetes in Ohio. But these inequities also come with costs, individuals and systems too, don't they?

Bode: Absolutely. You're right. Overall financial burden of racial and ethnic health disparities was estimated by the National Institute of Health in 2018 as $451 billion, about $1,377 per person, which is about 2% of the United States GDP. The results of previous quality improvement efforts to eliminate this disparities in diabetes did not meet expectations.

Anne: Thank you for that. Can you talk a little bit about the overall objective of the AHEAD initiative and how does it relate to addressing these disparities that have been persistent and advancing health equity?

Bode: Thank you for asking. Previous quality improvement efforts have shown that coordinated primary care collaboratives can have a strong impact on outcomes, especially if engaged in organized quality improvement projects. The achieving health equity in diabetes initiative, also known as the AHEAD initiative, consists of 26 primary care practices in northeast Ohio who see a large proportion of Medicaid patients. The aim is to reduce the number of adults with type 2 diabetes whose hemoglobin A1C is greater than 9% and eliminate the disparities in outcomes between racial and ethnic groups.

Anne: Thank you so much, Bode. And what interventions have been shown to close the health disparities gap that we see that might be spread across the collaborative?

Bode: Some evidence-based interventions as described in the diabetes quality improvement clinical toolkit that can be found at neoqihub.org. The interventions can potentially close the disparities gap and include prioritizing the use of medications that improve diabetes morbidity

and mortality, utilizing standard protocols to reduce implicit bias, and addressing medication and visit adherence. Other interventions are identifying and addressing health related social needs such as using telehealth to break transportation barriers, reaching out to those with care gaps, and building trusted relationships through communication skills building.

Anne: Thank you so much. Bode, what factors contribute to racial and ethnic health inequities and diabetes outcomes?

Bode: It's been more than 20 years since the Institute of Medicine in 2003 published the landmark book on equal treatment, confronting racial and ethnic disparities in healthcare, highlighting that people of color have the worst health outcomes even after controlling for factors such as income, access to care, insurance, and education. Basically, the data shows that the highest predictor of health disparities is race. I must emphasize that race is a social construct and not a difference supported by science. Yet, race continues to be used in medicine as a biological construct. Professional organizations such as the American Public Health Association, the CDC, and the American Academy of Family Physicians have declared racism a public health crisis, but change has been slow. It's important to note that the foundation of racism can be traced to slavery, which led to systemic injustices that is still pervasive in American society. In the last few decades, there has been much written on racism and its pervasive nature in the nation's policies, systems, processes, and structure. The resulting downstream effects of discrimination, bias, and stereotyping affects many facets of society such as the criminal justice system as well as in health care where implicit bias and racialized medicine occurs. These systems subsequently influence where people live, work, play, age, worship and perform other aspects of daily living known as the social determinants of health, which are the major drivers of health disparities.

Anne: So, Bode, how do social determinants also called social drivers of health affect the health of patients?

Bode: So social determinants or as you said social drivers make it more difficult for certain groups to attain optimal health. For example, we see the social factors affect the health of individuals in the community due to lack of transportation to appointments, the inability to afford or obtain medications, poor quality housing, living in areas with polluted air, housing insecurity, poor access to nutritious food, race related trauma, and poor social support to name a few.

Anne: Thank you so much for that overview. Bringing things back to primary care, why do you think primary care practices are needed to address the disparities and diabetes outcomes that we're seeing?

Bode: Primary care workforce mirrors the distribution of the population and serves as the first point of contact with the health system. As such, it's not surprising that primary care clinicians provide care for upwards of 90% of people with diabetes. So, we as primary care physicians are in a perfect position to move the needle and close disparity gaps in diabetes care and outcomes. Additionally, primary care clinicians have extensive knowledge about the social needs and other challenges of the community within a practice. They also are aware of the

resources available in the community to meet those needs. Primary care practices can leverage these assets to incorporate an equity focus into quality improvement efforts. Primary care teams might also have existing data infrastructure that they can use to address equity issues related to diabetes such as social determinants of health screening data and diabetes quality metrics.

Anne: Well, it sounds like primary care teams are in a great position to address these health disparities. What can teams who are engaged in quality improvement do to narrow diabetes disparities?

Bode: It is first important to understand the landscape of disparities that are impacting each practice. While the AHEAD project is mostly focused on racial and ethnic and geographical disparities in diabetes outcomes, there may be other disparities that are important to measure in some practices. For example, some practices may want to examine and collect data streams to support identification of differences in diabetes outcomes across groups based on preferred language or insurance status. Other practices understand the landscape of disparities impacting the population they serve. The next step is to think through and make some educated guesses about factors contributing to the identified disparities. This is a great opportunity to engage patients to get their perspectives on how process clinical logistics or social needs are impacting disparities. As a reminder, we have an amazing patient team on the AHEAD project that is ready to field questions like this for practices. While the patients on the patient team represent three health systems participating in the AHEAD initiative, they all have lived experience of diabetes and Medicaid enrollment. The next step is to design and test some interventions that may address some of the identified factors leading to disparities. Help ensure to measure overall outcomes for the group as well as specific impact the intervention might have on the targeted disparities. There's some great reference tools available in the AHEAD diabetes quality improvement clinical toolkit that people may find useful.

Anne: Thanks so much for that great overview, Bode, and for giving our amazing patient team a shout out. What do you think we're doing differently in the AHEAD initiative to improve the chances of success in eliminating disparities in diabetes outcomes?

Bode: To improve the chances of success, we shall use evidence-based interventions as well as a framework to advance health equity called the PETAL framework designed by Daniel Brooks. This framework starts with P prioritizing the health equity agenda, E engaging patients in the community, T targeting health disparities, A acting on the data, and L learning and improving. To address engagement, the collaborative is working with a patient care team that provides guidance, feedback, and recommendations based on their lived experience with diabetes. Collaboratives with community-based organizations to develop linkages for social care will also be crucial, as well as engagement of Medicaid managed care plans by targeting health disparities. The collaborative seeks to understand the role of social determinants of health and the underlying factors that impact individuals in the community. The continuous process of data collection that represents subgroups disproportionately impacted by disparities provides the ability to create a plan and evaluate changes. And finally, the collaborative will implement what is learned and share best practices. Practices participating in the initiative see a high volume of Medicaid patients, so there's a high potential to impact disparities in this population.

Anne: Thanks so much, Bode. That was fantastic. When we're thinking about who needs to be around the table designing a diabetes QI project focused on reducing health disparities, who are the important team members to include?

Bode: I would advocate we think about primary care teams broadly to leverage all the knowledge and human resources available. The primary care team consists of those with a common goal to improve diabetes outcomes and reduce health disparities. I would suggest a champion to take the lead on the project and keep the team accountable. And it certainly helps if the champion and clinic leadership are health equity champions as well. It's important to include first contact face-to-face staff on the team, including medical assistants and nurses. Other team members to consider are clinicians, pharmacists, nutritionists, health educators, community health workers, behavioral health clinicians, and patient and community representatives. Patient and community members that represent the groups disproportionately impacted by disparities are particularly important for integrating lived experience and direct feedback on implementing educational materials or workflows. Another critical member to consider is a data or informatics lead. This will be especially important as you design the outcome measures and the data streams for assessing the impact of the intervention. For example, if you're not currently collecting data on a particular aspect of patients identifying information that is critical to monitoring the disparity gap like preferred language or gender identity, this might be important to address early on in the project.

Anne: Thank you so much for that response. Bode, you mentioned the importance of getting everyone on the same page and motivated about addressing equity gaps through quality improvement. What are some strategies to motivate primary care teams to focus quality improvement efforts on diabetes equity?

Bode: That's a great question, Ann, because often there's a variety in lived experience knowledge and understanding of health disparities and health equity across primary care teams and it's important to do some level setting around these topics. One thing that I think is essential is strong support from clinical leadership in endorsing the importance of advancing health equity. It can also be very helpful to share the data you have with all levels of the team including longitudinal data at the national, state and local levels if available to help the team understand that this is a problem that has been persistent and deserves our attention. I would also suggest leaving some time for dialogue and to process these topics with the team. The AHEAD toolkit has some fantastic resources on cultural humility that might be helpful to support teams working on equity. Another thing to be cognizant of is that these topics may be triggering for people on the QI team who have lived experiences of racism or bias. It's important to acknowledge this and point people to resources that may be helpful to them such as the employee assistant program. It may also be helpful to have some agreed upon norms of the group to set expectations for appropriate language and ways of interacting with the team like using person first language and using I statements when in group settings. It may also involve assuming good intentions.

Anne: Those are some wonderful tips for what can be some complex discussions. And thank you so much for this discussion. Bode, are there any key take-home messages that you'd like to share before we close?

Bode: Yes, I'd like to summarize the take-home messages. Health outcomes from diabetes are worse in communities of color and rural communities despite sustained QI efforts. However, AHEAD is well positioned to advance diabetes health equity by prioritizing equity outcomes, designing interventions to impact equity that are informed by evidence, tailoring it to reach specific groups and also informed by patient lived experiences. Finally, we're collecting data that will allow practices and the collaborative to understand how interventions are impacting equity and to course correct if needed. Primary care practices are in the perfect position to do this because they serve high proportions of minority patients with diabetes as well as provide personalized care in the context of relationships over time.

Anne: Thank you so much for highlighting those important points and for your closing thoughts. I'm grateful to have had this opportunity to discuss diabetes health equity with you, Bode.

Bode: Thank you, Anne. It's been a great conversation.

Anne: Thank you for listening to the AHEAD podcast. Subscribe on your favorite podcast platform so you never miss an episode.

[Voiceover] Michael: This concludes today's AHEAD Initiative podcast. To learn more about the Northeast Ohio QI Hub, visit NEOQIHub.org. The Northeast Ohio QI Hub is part of the regional quality improvement hub project funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. Views stated in this podcast are those of the presenters only and are not to be attributed to the Ohio Department of Medicaid or to the federal Medicaid program.

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