Welcome and thank you for joining us. The presentation will begin shortly.

Dial-In Number: 888/822-3280
Participant Code: 604620

Please MUTE your lines, but DO NOT put your phone on hold. While on hold, other participants will be able to hear your background music/message.

Slides are available in the “Handouts” pod in GoToWebinar and will be posted on MHA’s website with the recording of this presentation.
Health Equity Series: Disparity in Diabetes

Webinar Two of Four in a Series
May 2016
Diabetes Focus and Opportunities to Promote Health Equity

Leslie Porth
National campaign goals to increase:

- The collection and use of race, ethnicity and language preference data
- Cultural competency training
- Diversity in governance and leadership

MHA Support

- Data Analysis
  - Race, ethnicity and language accuracy
  - Disparities in diabetes
- Webinar Series
  - The Case for Health Equity
  - Disparity in Diabetes
  - Improving Health Equity Through REaL Data Collection and Analysis
  - Strategies for Cultural Competence
#123forEquity Pledge to Act
Organizations Pledged: 1098
SHAs Pledged: 40
Metros Pledged: 5

www.equityofcare.org
Hospital Action Steps

- Participate in MHA webinars
- Focus on diabetes
- Participate in MHA quality initiatives
- Facilitate internal education and process improvement to increase accuracy of data collection
Today’s Speakers

Alison Williams, MBA-HCM, BSN, R.N., CPHQ
Vice President of Clinical Quality Improvement
awilliams@mhanet.com
573/893-3700, ext. 1326

Mat Reidhead, M.A.
Vice President of Research and Analytics
mreidhead@mhanet.com
573/893-3700, ext. 1331
Program Welcome and Overview

• Focused study of diabetes
  ➢ Population and county-based data
  ➢ Hospital and emergency department visits and utilization data
  ➢ Known disparities

• Diabetes management
  ➢ Best practices and recommendations
  ➢ Addressing disparities
Health disparities and inequalities exist when notable differences in health factors and/or health outcomes are observed between different populations.
### U.S. vs. Top 10 Developed Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
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<td>7</td>
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<td>Quality</td>
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<td>9</td>
<td>8</td>
<td>7</td>
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<td>Effective</td>
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<td>9</td>
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<td>11</td>
<td>10</td>
<td>8</td>
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<td>Safe</td>
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<td>9</td>
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<td>Cost-Related</td>
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<td>3</td>
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<td>11</td>
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<tr>
<td>Timeliness</td>
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<tr>
<td>Efficiency</td>
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<td>Equity</td>
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<td>2</td>
<td>11</td>
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<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
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<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

| Health Expenditures/Capita, 2011** | $3,800 | $4,522 | $4,118 | $4,495 | $5,099 | $3,182 | $5,669 | $3,925 | $5,643 | $3,405 | $8,508 |

*Note: The highlighted cells indicate the rank comparison between the U.S. and the Top 10 countries in terms of the overall ranking and health expenditure per capita.*
# U.S. Regional Prevalence Disparity

<table>
<thead>
<tr>
<th>Region</th>
<th>2006 Age-Adjusted Prevalence</th>
<th>2010 Age-Adjusted Prevalence</th>
<th>Relative Difference from the Northeast</th>
<th>Relative Difference from the Northeast</th>
<th>Relative Difference 2006 to 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>6.2%</td>
<td>6.3%</td>
<td>-</td>
<td>-</td>
<td>1.6%</td>
</tr>
<tr>
<td>West</td>
<td>6.6%</td>
<td>7.3%</td>
<td>6.5%</td>
<td>15.9%</td>
<td>10.6%</td>
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<tr>
<td>Midwest</td>
<td>7.1%</td>
<td>7.9%</td>
<td>14.5%</td>
<td>25.4%</td>
<td>11.3%</td>
</tr>
<tr>
<td>South</td>
<td>7.1%</td>
<td>8.8%</td>
<td>14.5%</td>
<td>39.7%</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

*Source: CDC, 2013*  
Disparities in Hospital-Based Diabetes Diagnoses in Missouri

Mat Reidhead
Racial Distribution of the Population and Hospital Utilization in Missouri

2014 Missouri Population by Race (6,063,589 Total)

- White: 83.5%
- Black or African American: 11.8%
- Two or More: 2.1%
- Asian: 1.9%
- American Indian/ Alaska Native: 0.5%
- Native Hawaiian/ Pacific Islander: 0.1%

Source: U.S. Census Bureau, Missouri QuickFacts

Distribution of All Missouri Hospital Visits in FY2015 Compared to the Total Population by Race

- White: 74.4% (Treat & Release ED: 20.5%, Population: 83.5%, Inpatient: 79.4%)
- Black: 8.9% (Treat & Release ED: 11.8%, Population: 15.0%, Other: 5.6%)
- Other: 5.1%

Sources: Hospital Industry Data Institute, 2015 Hospital Inpatient and Outpatient (ED) Discharge Databases. U.S. Census Bureau, Missouri QuickFacts.
Ten-Year Trend in Hospital-Based Diabetes Diagnoses in Missouri by Race

Missouri Hospital Inpatient and ED Visits for Diabetes: Rate per 1,000 by Race

Frequency of Hospital-Based Diabetes Diagnoses in Missouri by Age, Race & Gender

FY2015 Missouri Percent of Inpatient Hospitalizations with a Diabetes Diagnosis by Age, Race and Gender

Source: Hospital Industry Data Institute, 2015 Hospital Inpatient Discharge Databases.
## Risk of Being Diagnosed with Diabetes in a Hospital Setting Prior to Age 65

### Frequency by Race

<table>
<thead>
<tr>
<th></th>
<th>Black Male</th>
<th>Black Female</th>
<th>White Male</th>
<th>White Female</th>
<th>Total</th>
<th>Odds Ratio</th>
<th>P-Value</th>
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</thead>
<tbody>
<tr>
<td>Unique Patients 18-64</td>
<td>77,280</td>
<td>107,124</td>
<td>321,034</td>
<td>394,572</td>
<td>928,138</td>
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<tr>
<td>Diagnosed Diabetes</td>
<td>12.5%</td>
<td>12.4%</td>
<td>11.5%</td>
<td>10.0%</td>
<td>11.0%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Model Covariates

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Average Age</th>
<th>Black Male</th>
<th>Black Female</th>
<th>Diagnosed Obesity</th>
<th>Diagnosed Smoker</th>
<th>Diagnosed Alcohol Abuse</th>
<th>Medicaid Status</th>
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<tbody>
<tr>
<td></td>
<td>38.3</td>
<td>37.4</td>
<td>41.2</td>
<td>40.3</td>
<td>40.0</td>
<td>100.0%</td>
<td>0.0%</td>
<td>6.9%</td>
<td>49.3%</td>
<td>8.9%</td>
<td>21.1%</td>
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<td></td>
<td>0.0%</td>
<td>0.0%</td>
<td>10.6%</td>
<td>34.8%</td>
<td>3.1%</td>
<td>36.9%</td>
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<td></td>
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<td></td>
<td>0.0%</td>
<td>100.0%</td>
<td>6.5%</td>
<td>43.6%</td>
<td>7.8%</td>
<td>14.5%</td>
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<td>11.5%</td>
<td>37.6%</td>
<td>3.7%</td>
<td>24.8%</td>
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<td></td>
<td>11.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Model Results:

- **R² = 0.231**
- **C = 0.798**

Sources: Hospital Industry Data Institute Analysis of 2015 Hospital Inpatient and Outpatient (ED) Discharge Databases.
Percent of the Missouri Population Diagnosed with Diabetes During a Hospitalization or ED Visit During FY2015 by Age, Race and Gender

Sources: Hospital Industry Data Institute, 2015 Hospital Inpatient and Outpatient (ED) Discharge Databases. 2015 Nielsen-Claritas PopFacts Premier.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18-34</th>
<th>35-64</th>
<th>65+</th>
<th>All Ages 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>1.3%</td>
<td>3.5%</td>
<td>7.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>White</td>
<td>0.5%</td>
<td>2.4%</td>
<td>8.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Other</td>
<td>0.3%</td>
<td>2.4%</td>
<td>8.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>1.9%</td>
<td>3.5%</td>
<td>8.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td>White</td>
<td>0.8%</td>
<td>2.4%</td>
<td>8.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Other</td>
<td>0.4%</td>
<td>2.4%</td>
<td>8.6%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Total

<table>
<thead>
<tr>
<th>Age Group</th>
<th>18-34</th>
<th>35-64</th>
<th>65+</th>
<th>All Ages 18+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>1.6%</td>
<td>3.5%</td>
<td>7.9%</td>
<td>4.0%</td>
</tr>
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<td>White</td>
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<td>2.4%</td>
<td>8.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>0.4%</td>
<td>2.4%</td>
<td>8.6%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Percent of the Adult Population Diagnosed with Diabetes in 2015 During an Inpatient Hospitalization or ED Visit

Total Population 18+

Black Population 18+

Sources: Hospital Industry Data Institute, 2015 Hospital Inpatient and Outpatient (ED) Discharge Databases. 2015 Nielsen-Claritas PopFacts Premier. Data for counties with fewer than 100 black adult population withheld.
2015 Diabetes Hospital Utilization Rates and Population Density by Race for Metro-Area Census Tracts

Sources: Hospital Industry Data Institute, 2015 Hospital Inpatient and Outpatient (ED) Discharge Databases. 2015 Nielsen-Claritas PopFacts Premier.
Disparities in Diabetes-Related Health Outcomes in Missouri
Diabetes-Related Readmission Rates in Missouri by Age, Race & Gender

Missouri Diabetes-Related 30-Day Readmission Rates by Age, Race and Gender: September 2012 to August 2015

Source: Hospital Industry Data Institute, 2012-2015 Hospital Inpatient Discharge Databases.
Diabetes-Related Mortality Rates in Missouri by Age, Race & Gender

FY2015 Missouri Rate of Diabetes-Related Deaths per 1,000 Hospitalizations by Age, Race and Gender

Source: Hospital Industry Data Institute, 2015 Hospital Inpatient Discharge Database.
The Role of Patients’ Community-Level Risk in Adverse Health Outcomes

10 Miles Away A World Apart

THE SOCIOBIOLOGICAL CYCLE OF DIABETES

Clayton, MO 63105

North St. Louis City, MO 63106
Social Determinants of Health

CLAYTON

<10% Percent of ZIP Within Low Income Census Tract and >½ Mile or Greater Access to a Supermarket

77% Percent of People With a Bachelor’s Degree or Higher

$560k Median Home Value

NORTH ST. LOUIS CITY

>90% Percent of ZIP Within Low Income Census Tract and >½ Mile or Greater Access to a Supermarket

7.6% Percent of People With a Bachelor’s Degree or Higher

$89k Median Home Value
Biological and Psychological Response

BIO/PSYCHOLOGICAL RESPONSE

Psychiatric/Substance Abuse Hospital Diagnosis per 1,000

Heart Disease Hospital Diagnosis per 1,000

Hypertension Hospital Diagnosis per 1,000

Obesity Hospital Diagnosis per 1,000

Diabetes Hospital Diagnosis per 1,000

CLAYTON

133.8

120.9

9.6

15.7

18.3

241

385.6

67.1

125

4x

2x

3x

7x

8x

NORTH ST. LOUIS CITY
Social Consequences

**CLAYTON**
- Average Life Expectancy: 85 years
- Health Outcomes Rank: 11 out of 967
- Health Factors Rank: 10 out of 967

**NORTH ST. LOUIS CITY**
- Average Life Expectancy: 67 years
- Health Outcomes Rank: 965 out of 967
- Health Factors Rank: 957 out of 967
Cost Implications

- 26 million U.S. adults 20 and older have diabetes
- The total costs of diagnosed diabetes have increased 41% over a 5-year period
  - In 2007, the total cost was $174 billion
  - In 2012, the total cost was $245 billion*
- 1 in 10 U.S. health care $$ spent on diabetes care

Total estimated MO burden = $5.1 billion*

*2012 data; CDC BRFSS data
Diabetes Management and Strategies to Address Disparities

Alison Williams
AHA’s Recommendations

• Addressing overall health disparities requires
  ➢ Leadership buy-in, both administrative and clinical, to achieve sustained improvement
  ➢ Consistent and recurring training of clinicians and staff to reinforce behaviors and processes
  ➢ Incorporation of initiatives to eliminate health disparities into the overall quality improvement and strategic plans

Addressing Health Disparities for Patients with Diabetes

- Identify and stratify — know your population
- Increase access and affordability
- Increase screening and prevention opportunities and resources
- Understand recommended guidelines and individualize care to criteria, education and resource support
- Listen to the voice of the patient and engage disparate communities to increase self-management
Population Health Across the Lifespan

Health Across the Lifespan - Changes Across Developmental Levels

FY2015 Missouri Percent of Inpatient Hospitalizations with a Diabetes Diagnosis by Age, Race and Gender

Purpose of the Intervention Also Matters...Diabetes interventions from a population health improvement perspective change over the lifespan
Know Your Population

• Identify and stratify
  ➢ Common data sources
    – Community Health Needs Assessment
    – REaL data collection
    – Health literacy screenings
    – Web resources (CDC, RWJ, Mapping Medicare Disparities Tool)

• What we already know
  ➢ Certain communities experience disparities in diabetes research, education and treatment
  ➢ These communities have a higher risk of complications such as lower limb amputations, retinopathy and kidney failure than non-Hispanic whites

Source: American Diabetes Association
Case Study: Analyzing REaL Data to Improve Quality of Care

- University of Mississippi Medical Center

Results:
- Improved AMI and heart failure core measures for all patients from 74% to 82% in two years
- Established an outpatient heart failure management clinic with an APN who helps support patients post-hospitalization
- Efforts were made to refer clients meeting criteria for at-risk disparities to the clinic
- One year from clinic opening, the readmission rate for clinic patients was ZERO percent!
Increase Access and Affordability

- Health care coverage is key
- Primary care provider links
  - Effective/efficient provider referral networks (particularly from inpatient status)
- Unconventional delivery methods

- MO lacks Medicaid expansion seen in other states.
- ACA: 20 million Americans have gained coverage.
- Access: Disparities continue … the gap has not closed.
- ACA increased coverage for screenings.
- Increase in community-based prevention programs.
Increase Access and Affordability

• ACA-led initiatives
  ➢ Mostly focused on Medicare and Medicaid beneficiaries
    – Support of diabetes prevention programs
    – Support and testing of alternative payment models (ACOs, advanced primary care, Medicare Shared Savings Program, etc.)
    – CMMI funding for Medicaid incentives for the prevention of chronic disease
    – Increased preventive services coverage without coinsurance or deductibles (medical nutrition therapy, smoking cessation, free “annual wellness visit”)
    – Plans to close the “donut hole” for prescriptions in Medicare by 2020, increasing affordability
    – Funding to build and expand programs in Community Health Centers and Primary and Behavioral Health Care Integration grant program
    – Funding for ongoing research to improve care
"Strong clinical leadership and guidance coupled with improved self-management is an overarching strategy to combat a diagnosis of T2DM and/or prevent worsening of the condition."

2016 ADA Guidelines
Screening and Prevention Resources

CHWs

Living With Type 2 Diabetes Program

Resources for Screening, Testing, and Referral

These tools can help you incorporate into your practice screening and testing for prediabetes and referral of patients with prediabetes to CDC-recognized diabetes prevention lifestyle change programs.

M.A.P. to Diabetes Prevention for Your Practice  [PDF - 315KB]
Use this document to help determine roles and responsibilities for identifying adult patients with prediabetes and referring to community-based diabetes prevention programs.

Patient Flow Process  [PDF - 328KB]
This infographic provides a high-level overview of how office staff can facilitate point-of-care identification of patients with prediabetes.

Point-of-Care Prediabetes Identification Algorithm  [PDF - 404KB]
Use this infographic to adapt/incorporate a prediabetes identification and referral process into your workflow.

Retrospective Prediabetes Identification Algorithm  [PDF - 343KB]
Use this infographic to adapt/incorporate an identification and referral process into your electronic health records and generate a registry of patients at risk for type 2 diabetes.

Sample Patient Referral Form/Table for Calculating Body Mass Index  [PDF - 364KB]
This form makes the referral process easier, helps engage patients, and prepares lifestyle change program providers to engage with patients as well.

Commonly Used Current Procedural Terminology and ICD Codes  [PDF - 361KB]
Enables physician practices to obtain reimbursement for prediabetes screening.

These tools are part of the Preventing Type 2 Diabetes Toolkit. Download the entire toolkit  [PDF - 1.29MB].
Addressing Prediabetes as a Strategy

- A person with prediabetes has a blood sugar level higher than normal, but not high enough for a diagnosis of diabetes, and is at higher risk for developing Type 2 diabetes and other serious health problems, including heart disease and stroke.

- Without lifestyle changes to improve their health, 15 to 30 percent of people with prediabetes will develop Type 2 diabetes within five years.

- Data show in Missouri, potential disparities in those with prediabetes ages 45-74 and with less than a high school education most at risk.
Prediabetes Screening Tools

- Age, weight, low activity earn more points
- Score 3-8 — low risk for prediabetes, make lifestyle changes
- Score 9+ — high risk for having prediabetes

**IF YOUR SCORE IS 3 TO 8 POINTS**
This means your risk is probably low for having prediabetes now. Keep your risk low. If you're overweight, lose weight. Be active most days, and don’t use tobacco. Eat low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes.

**IF YOUR SCORE IS 9 OR MORE POINTS**
This means your risk is high for having prediabetes now. Please make an appointment with your health care provider soon.

**HOW CAN I GET TESTED FOR PREDIABETES?**
- **Individual or group health insurance:** See your health care provider. If you don’t have a provider, ask your insurance company about providers who take your insurance. Deductibles and copays may apply.
- **Medicaid:** See your health care provider. If you don’t have a provider, contact a state Medicaid office or contact your local health department.
- **Medicare:** See your health care provider. Medicare will pay the cost of testing if the provider has a reason for testing. If you don’t have a provider, contact your local health department.
- **No Insurance:** Contact your local health department for more information about where you could be tested or call your local health clinic.
American Diabetes Association: 2016 Clinical Guidelines Summary of Revisions

• Treatment should be tailored to address vulnerable populations and those with health disparities due to ethnicity, culture, sex or socioeconomic status
• No one diagnostic test is preferred over another; screening ages and risk factors were revised
• Integrate medical care and patient engagement for behavior and lifestyle modifications
• Technology has potential to play a significant role in self-management and clinical oversight
American Diabetes Association: 2016 Clinical Guidelines Summary of Revisions

- Glycemic targets were adjusted for those 65+
- Obesity reduction strategies through behavior modification and pharmacotherapy are highlighted
- Addressing cardiovascular disease prevention related to diabetes through pharmacotherapy
- Better defined diabetic kidney disease and diabetic retinopathy with therapy recommendations
American Diabetes Association: 2016 Clinical Guidelines Summary of Revisions

- Management of the geriatric patient should be individualized — functional status, care setting and end-of-life care needs
- T2DM management for youth focuses on self-management education and support, addressing psychosocial issues and fasting lipid profiles
- HgA1C and pharmacotherapy recommendations for women with pre- and gestational diabetes
- Comprehensive section on inpatient care needs
- Prevention and management in the school setting
Individualize and Focus

Approach to the management of hyperglycemia. Depicted are patient and disease factors used to determine optimal HbA1c targets. Characteristics and predicaments toward the left justify more stringent efforts to lower HbA1c level, and those toward the right suggest less stringent efforts. Adapted with permission from Inzucchi and colleagues (18) and the American Diabetes Association. HbA1c = hemoglobin A1c.

Tailor and Individualize Education

- Assess health literacy levels — health literacy is the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (that are best for them).

**REALM-SF Score Sheet**

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Patient ID #: ____________ Date: ____________

Behavior _____
Exercise _____
Menopause _____
Rectal _____
Antibiotics _____
Anemia _____
Jaundice _____

TOTAL SCORE _____

**Suggested Introduction:**

"Providers often use words that patients don't understand. We are looking at words providers often use with their patients in order to improve communication between health care providers and patients. Here is a list of medical words."

Starting at the top of the list, please read each word aloud to me. If you don’t recognize a word, you can say 'pass' and move on to the next word."

Interviewer: Give the participant the word list. If the participant takes more than 5 seconds on a word, say “pass” and point to the next word. Hold this scoring sheet so that it is not visible to the participant.

**Score Grade range**

- 0 Third grade and below, will not be able to read most low-literacy materials. Will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.
- 1-3 Fourth to sixth grade; will need low-literacy materials, may not be able to read prescription labels.
- 4-6 Seventh to eighth grade; will struggle with most patient education materials; will not be offended by low-literacy materials.
- 7 High school; will be able to read most patient education materials.

**REALM-SF Validation study:** Arozullah AM, Yarnold PR, Bennett CL, et al. Development and validation of a short-form, rapid estimate of adult literacy in medicine. Med Care 2007 November;45(11):1026–33. PMID: 18049342
Engage Toward Self-Management

- Methods, settings and platforms
- Timing and capacity — “chunk it up”
- Community settings
- Community health workers, lay persons

Multimedia

PreDiabetes: An Overview
https://www.acponline.org/practice-resources/patient-care-resources-and-tools/education
Closing Comments
Key Messages

• Diabetes prevalence and incidence continue to show an upward trend

• Disparities appear to exist for black males and females, those with less than a high school education and those over age 65

• Hospital and ED utilization rates are disproportionately higher for those of black race, both for prevalence and incidence of diabetes

• There is a knowledge gap of evidence noting further health equity disparities
Key Messages

• Education, prevention and management strategies should cover the lifespan to maximize quality of life and reduce health care costs
• Missouri has “hot spots” to scope and direct diabetes prevention and management strategies toward, that would be opportunities for pilot initiatives
• Importance of tracking data, over time, with collaborative interventions
• Disparate populations should be identified and addressed
Questions and Discussion
Upcoming Education

WEBINAR #2
Disparity in Diabetes
11 a.m. Wednesday, May 11

WEBINAR #3
Improving Health Equity Through REaL Data Collection and Analysis
2 p.m. Tuesday, June 7
11 a.m. Monday, June 13

WEBINAR #4
Strategies for Cultural Competence
2 p.m. Wednesday, July 6
11 a.m. Thursday, July 7
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