Grant Outcomes Report

Improving the Treatment and Outcomes of Diabetes for the Chinese Communities in Flushing and Lower Manhattan

KEY INFORMATION:

GRANTEE
Charles B. Wang Community Health Center

GRANT TITLE
Chinatown Diabetes ACTION (Accelerating Collaboration to Improve Health Outcomes Now)

DATES
January 1, 2008–December 31, 2009

GRANT AMOUNT
$230,000

FUNDING
2007 Setting the Standard: Advancing Best Practices in Diabetes Management RFP

The Problem:

Diabetes is a growing epidemic, particularly in Asian communities. By 2010, almost one in 10 New Yorkers had diabetes (NY: 8.9%, U.S.: 8.7%). In Asian communities, the diabetes prevalence rate is higher, particularly among adults born in South Asia. With proper management, diabetes can be controlled; however, medically underserved and disadvantaged groups, such as Asian Americans, often have difficulty managing the disease.

Charles B. Wang Community Health Center (CBW) is the major provider of primary health services for Chinese communities in Flushing and Lower Manhattan. CBW proposed *Chinatown Diabetes ACTION* to further improve its care for its patients with diabetes.

Chinatown Diabetes ACTION was funded as part of a set of grants under the New York State Health Foundation's (NYSHealth's) 2007 RFP *Setting the Standard: Advancing Best Practices in Diabetes Management*. The goal of *Setting the Standard* was to move New York State's primary care system to adopt and spread best practices in disease management and establish them as the universal standard of care for patients with diabetes. At the time, multiple diabetes management programs already existed throughout New York State along with established collaboratives working to maximize the impact of these programs. Thus, the Foundation expected the grants made under the RFP to advance these programs and build systemwide capacity to support, sustain, and institutionalize these efforts. The Chronic Care Model—a highly respected and accepted framework for approaching the improvements sought through this initiative—was a major reference point in the RFP.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York, NY 10018 WEB: www.NYSHealth.org

Grant Activities & Outcomes

In focusing on diabetes, CBW sought to do the following with NYSHealth funding: develop and integrate diabetes registry functions into its electronic medical record (EMR) system; improve and expand diabetes self-management through group visits; and enhance its capacity to bill for diabetes education and self-management services by becoming accredited by the American Diabetes Association (ADA).

Prior to the NYSHealth grant, CBW had participated in numerous programs to improve care for people with chronic illness: the U.S. Bureau of Primary Health Care *Health Disparities Collaborative* (asthma), the New York City Department of Health and Mental Hygiene's (DOHMH's) *Chronic Disease Collaborative* (diabetes and depression), and the Primary Care Development Corporation's (PCDC's) *Redesign Collaborative and Open Access and Revenue Maximization Collaborative*. Thus, CBW was well positioned to continue implementing better care for people with chronic conditions. CBW's leadership and clinicians had a firm grasp of improvement techniques, including how to administer them, when and how to use small tests of change, how to engage a multidisciplinary care team in quality improvement, and how to use data both to support and assess improvement.

CBW identified social and cultural barriers to improving diabetes care and took a systemwide approach to address quality improvement through advanced use of its electronic medial records. The project team created a diabetes registry, a diabetes management flowsheet, and certified diabetes educator (CDE) encounter forms to integrate within the EMR. These enhancements allowed CBW to take advantage of the population management and decision support tools to test new workflow approaches and determine which patients needed to improve their diabetes management. Working within the EMR improved workflow and increased productivity. The care team began to work differently, which made them more effective in patient care because of increased communication between patient and care manager; these changes became embedded in daily practices.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York, NY 10018 WEB: www.NYSHealth.org

CBW hosted focus groups to understand and better address the impact of Chinese culture on diabetes care and self-management. Results from these groups emphasized engaging patient families and members of social networks to improve diabetes self-management. CBW established a diabetes education and self-care skills support group utilizing a curriculum based on the ADA guidelines for diabetes care. The support groups included patients, their families, friends, and other members of their social network. However, patient participation was low and coordinating the clinical visits was administratively complex. Billing for these visits continues to be a challenge, so CBW is re-examining if the groups will be beneficial.

As a result of its system improvements, CBW was able to track clinical outcomes for patients and found improvements in blood pressure and cholesterol control that were sustained through June 2010 (last known report). There was no meaningful change in hemoglobin A1c control; however, this was an area where CBW already had strong outcomes.

CBW understood the need to financially sustain its patients' clinical improvements so the leadership team assessed the system's capability of achieving ADA certification. The assessment led CBW to apply for—and receive—the ADA certification so that visits to a certified diabetes educator are now billable events. In addition, CBW achieved National Committee for Quality Assurance patient-centered medical home certification, which enhanced its Medicaid Managed Care rates.

NYSHealth also supported an outside evaluation of 10 of the original *Setting the Standard* sites. In addition to observing whether each grantee advanced against its proposed objectives, the evaluators also assessed how each grantee performed along dimensions of the Chronic Care Model (CCM). From the evaluator's perspective, CBW was well prepared to implement elements of the CCM based on CBW's past experiences in the Disparities Collaborative, the DOHMH Chronic Disease Collaborative, and PCDC's Collaboratives. Again, these past experiences put CBW's leadership and clinical staff in a strong position to continue implementing aspects of the Chronic Care model.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York, NY 10018 WEB: www.NYSHealth.org

The Future

CBW will continue its efforts to improve diabetes care of vulnerable, low-income, medically underserved Chinese and Asian Americans in the New York City metropolitan area. This initiative has allowed CBW to build a foundation for continuous tracking and improvement of diabetes management activities with its adoption of the Chronic Care Model. With these changes and enhancement of infrastructure, CBW can now sustain management activities.

CBW created protocols to incorporate workflow changes to include case management, nursing education, and comprehensive foot exams. The diabetes registry will continue to be utilized for tracking and identifying patients in need of diabetic services. CBW hopes to both standardize and increase case management activities, and continue to promote diabetes self-management education (DSME).

The Chinatown site of CBW has been recognized for three years by the ADA for the DSME program, which includes one-on-one sessions and group education sessions. With this recognition, CBW hopes to receive financial reimbursement for education visits by CDEs, which will help expand CBW's efforts. Attaining ADA recognition for the Flushing, Queens site is also a future endeavor. Internal recruitment of bilingual/bicultural staff into CDE positions will help CBW attain recognition for this site as well as increase access to DSME.

In 2010 the Diabetes Collaborative Care Team piloted a diabetes support group. In 2009, CBW surveyed 70 patients with diabetes; 25% of these patients expressed interest in joining a support group. The support group will meet every month and will be facilitated by a CDE.

CBW is also considering expanding the Chronic Care Model to address other chronic conditions, such as depression and hypertension.

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York, NY 10018 WEB: www.NYSHealth.org

BACKGROUND INFORMATION:

ABOUT THE GRANTEE

The Charles B. Wang Community Health Center is a community-based, primary health care facility whose mission is to provide quality, culturally relevant, and affordable health care and education for Asian Americans in the New York City area. In 2010, the Wang Center served 39,000 patients with more than 204,000 medical and dental visits across three sites in Manhattan and one site in Queens. The Wang Center provides internal medicine, pediatrics, women's health, dentistry, mental health, social services, and health education.

GRANTEE CONTACT

Regina Lee
268 Canal St.
New York, NY 10013

Phone: (212) 379-6988, (212) 379-6936
E-mail: rlee@bwchc.org
Web address: http://www.cbwchc.org

NYSHEALTH CONTACT

Jacqueline Martinez

GRANT ID

2007-1898319

VOICE: 212-664-7656 FAX: 646-421-6029 MAIL: 1385 Broadway, 23rd Floor, New York, NY 10018 WEB: www.NYSHealth.org