National Center for Health in Public Housing

# Clinical Quality Advisory Group

Meeting Notes
October 24, 2017

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## Inside This Issue



*17.6% of HUD-assisted adults have diabetes compared to 9.5% of adults in the general population.*

## Diabetes Prevention Learning Collaborative: Focusing on the Social Determinants of Health

While diabetes has declined nationally, the prevalence of diabetes and rates of uncontrolled diabetes for patients in Health Centers remains high. Diabetes prevalence increased from 12.7% in 2014 to 14.3% in 2016 and uncontrolled diabetes increased from 31.2% to 32.1% during that same time frame (Health Resources and Services Administration 2016).

Residents of public housing are particularly at risk for developing diabetes and diabetes-related complications due to the many social factors that impact their health. A recent HUD publication indicates that HUD-assisted adults have the highest prevalence of a diabetes diagnosis, with 17.6% reporting ever having been told they had diabetes compared to 9.5% of adults in the general population (U.S. Department of Housing and Urban Development 2017). Health Centers located in or immediately accessible to public housing should provide diabetes management programs and utilize strategies to address education and support, nutrition, physical activity, smoking cessation, and the psychosocial issues affecting public housing residents.

During this learning collaborative, participants discussed ways to manage diabetes through programs that address education and support, nutrition, physical activity, smoking cessation, and psychosocial issues.

EL RIO HEALTH CENTER

TCA HEALTH, INC.

*On the call:*

*Perrin Braun, Massachusetts League of Community Health Centers*

*Rita Glaab, TCA Health, Inc.*

*April House, San Ysidro Health Center*

*Joy Muckabee, El Rio Health Center*

*Subarna Mukherjee, South End Community Health Center*

*Sonia Tucker, La Maestra Health Center*

## Diabetes Prevention Programs

Dr. Rita Glaab, Medical Director from TCA Health, discussed the efforts of the health center to offset childhood obesity through programs that improve access to fresh fruits and vegetables, including the Green Veggie Bus, a mobile van that sells vegetables once a week at the health center. TCA Health is located directly on a housing development site, so the van provides healthy foods predominantly to public housing residents and accepts WIC coupons as payment.

La Maestra Health Center has a community garden and a health educator that teaches patients how to plant and grow their own food, and provides nutrition and cooking education to the members of the community. The Health Center has a Food Pantry for the homeless that exclusively stocks healthy foods, nothing with high salt or sugar contents.

The pediatricians at El Rio Health Center started a farm program. Patients travel by bus from the Health Center to the farm where they are able to grow food and attend family cooking classes. The Health Center also offers a Park Prescription Program in collaboration with the National Parks Service. Patients travel to parks in the area for exercise.

Another factor that Health Center staff must consider and navigate is community violence. Dr. Glaab explains that patients do not like to go out after dark, so TCA Health Center hours reflect that. TCA also offers a Wellness exercise program twice a week in the early evening.

## Using Social Determinants of Health Data

Some Health Centers collect data on social factors that influence health for each patient and use that information to determine appropriate follow up and referral services. For example, El Rio Health Center uses a kiosk-based survey of social determinants of health for all patients in the waiting room. Depending on the responses, patients are linked to nutrition and exercise programs.

*LA MAESTRA HEALTH CENTER*

La Maestra Health Center has been collecting social determinants of health data for the last 20 years. It is embedded in their EHR system. The EHR vendor, NextGen has a social determinants of health template that serves as a central point to gather and input data on items such as transportation and language. La Maestra customizes the template for their own needs and uses the data to target outreach. They have incorporated the pharmacy into the design to tailor treatment plans for patients with certain characteristics. As a result, their compliance rate for diabetes has increased by 5-6%. El Rio Health Center also uses the Prapare Template to connect individuals to services.

*SAN YSIDRO HEALTH CENTER*

Other Health Centers take a different approach. San Ysidro Health Center surveyed the social determinants of health data in the community and identified areas that were most in need for certain services. Using grant funding, they hired and trained promotoras, or community health workers, to bring programs into the community.

## Addressing Pre-Diabetes

Health Centers are aggressive in identifying prediabetic patients and providing appropriate follow up care. When patients at the La Maestra Health Center are diagnosed with prediabetes, they are seen by a registered nurse case manager. The case manager assesses patient knowledge and determines if more health education is needed. If appropriate, patients are enrolled in a six-class program that provides diet and exercise education on topics such as how to read labels, count calories, and lose weight. Patients report that the program has been helpful.

To improve attendance and participation in exercise programs, El Rio Health Center incorporated other services into the program. They currently have a 6-week exercise program for beginners and advanced patients that meet twice a week. The Health Center also uses an evidence-based weight management program that integrates lifestyle, medication, and surgery. The program sets realistic goals for patients, recognizing that a 5% weight loss can be very impactful to health. Providers attend CME training and get certified as obesity care providers.

## Community Collaborations

Health Centers have formal and informal relationships with other community organizations to provide services to vulnerable populations. For example, one Health Center sends teams of outreach workers to local homeless shelters to provide services and link them to the health center.

La Maestra partnered with the police department and other health and social services providers during the recent Hepatitis outbreak in San Diego. Providers went into the homeless population and provided needed care on site and tried to overcome barriers to receiving care.

South End Health Center in Boston has provided basic outreach to residents living in housing project developments nearby, including sharing information on the types of services available at the clinic. They are currently exploring ways to partner in the future.

*SOUTH END COMMUNITY HEALTH CENTER*

## Common Barriers and Solutions

- **Transportation-** El Rio Health Center is located in an urban area, but many of the nutrition and exercise programs are located away from the health center. Transportation can be an issue. The Health Center uses grant funds to provide bus transportation to their patients.
- **Language**- La Maestra serves a diverse community. Over 28 different languages and dialects are spoken at the health center. The Health Center employs people from the community that understand patient needs and their barriers.
- **Funding**- Some Health Centers need help in identifying what services are reimbursable by health insurance providers and finding ways to cover services that are not. La Maestra clinic works with partners and grants for funding sources.

References:
Health Resources and Services Administration. 2016. *2016 National Health Center Data: National Public Housing Primary Care Data.* https://bphc.hrsa.gov/uds/datacenter.aspx?fd=ph.
U.S. Department of Housing and Urban Development. 2017. *A Health Picture of HUD-Assisted Adults: 2006-2012*. Washington: U.S. Department of Housing and Urban Development.

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