Health and Housing Partnerships

A Call for Reinforcements in Diabetes Care:

Maximizing the Role of Non-Clinical Staff and Partners

Successful diabetes care for vulnerable populations demands a multi-prong approach, deploying direct health interventions, medications, and support from a range of community resources to address the social determinants, which impact diabetes. Utilizing an interdisciplinary team of providers that interact with individuals on a regular basis and the community resources they have access to, can support consumers' self-management and in-turn diabetic control.

Over the past several years, CSH in collaboration with other technical assistance providers have joined with health centers and housing providers to listen to and share successful strategies and best practices for diabetes management for individuals facing the challenges of homelessness and other vulnerable populations. A strong voice heard in these sessions came from non-clinical staff of health centers and homeless housing and service organizations on their role as essential frontline connections to consumers of health, housing and social services. As we engaged in this work their message emphasized that non-clinical practitioners lack sufficient training to comfortably address the breadth of health concerns associated with diabetes.

This brief will highlight, through case studies and program descriptions, the important role of non-clinical staff in both the health center and housing setting to support individuals and families struggling to prevent and keep diabetes conditions under control. Key promising practices for the reader to apply are:

- Deploying the expertise, engagement tactics and interdisciplinary rapport to connect with consumers in a range of environments;
- Building skills and confidence of non-clinical staff to create and update protocols that advance diabetes care and self-management that work for consumers and their communities; and
- Advancing opportunities to engage people with lived experience as part of the non-clinical peer team connecting with residents and consumers on diabetes care.

In 2018-2019 CSH, in partnership with the National Healthcare for the Homeless Council (NHCHC), implemented a series of conversations with health centers and supportive housing providers on strategies to advance diabetes care for vulnerable populations facing homelessness, housing instability and other social indicators that may induce diabetes or create barriers to diabetes management. Summary recommendations and resources from those sessions are provided in **Lessons Learned in Diabetes Care, 2018**[1]. Several of the key needs and barriers to diabetes care identified in those sessions were:

- Building trusting connections between health system and consumer
- Implementing health literacy and understanding of the disease for support staff and consumers
- Improving access to healthy foods, medications and other social determinants impacting health, and
- Advancing strategies to overcome isolation and helplessness to combat the disease

To address these barriers, the teams explored program designs that focus on **Outreach, Integrated Care and Nutrition.**

[1] https://www.csh.org/resources/lessons-learned-in-diabetes-care-for-homeless-populations/

OUTREACH

Authentic and sustained connections and communications between providers and patients is essential to achieve positive health outcomes. The strategies highlighted from frontline providers recommended:

- Invigorating engagement to include 1-to-1 and group listening sessions with patients and providers,
- Motivational interviewing training for staff,
- Increased frequency of contact points with consumers to stay connected and updated, and

Opportunities to incorporate peers as part of integrated care team.

Case Study: Reaching the Consumer of Health, Housing, and Social Services

Health Center Partner: Care for the Homeless New York (CFH NY)[2] operates over 20 FQHC sites in four boroughs of New York City where they provide primary, behavioral health, podiatry, dental, and optometry services. CFH NY has developed a strong link with the homeless service community with clinics located in shelters, drop-in centers and soup kitchens where they are serving a common consumer, those facing homelessness and unstable housing. With that strong link, CFH NY has developed a good understanding of the prevalent health conditions, including diabetes, impacting their patients. In January 2020, CFH NY shared information about their diabetes Initiative via a webinar on **Breaking the Cycle of Intergenerational Diabetes**.[3]

Goal Statement: The CFH NY Diabetes Initiative seeks to address two primary barriers, 1) unstably housed and transient consumers make consistency in care difficult, and 2) limited access to resources in the community to support a diabetes healthy lifestyle.

Team: Health practitioners, outreach and enabling service staff, interns, and homeless service staff.

Approach/Program Components: Central to this diabetes initiative is expanding opportunities to engage with residents "where they are at". CFH NY implements 'point of care A1c testing' for existing patients at most of their health and housing co-locations. This increased access enables clinical staff to conduct A1c testing with immediate results thus eliminating the time delays that interfere with follow-up care for patients. In addition to real time review of results, the care team reviews next steps and the individualized service plan with patients. On an ongoing basis, the care team works closely with housing staff and community providers through shared learning to educate the team and patients on diabetes self-care and community resources to support healthier lifestyle.

CFH NY also partners with the non-clinical housing and community providers to host population health events for current patients, other residents in shelters, and the broader community. These events focus on both general health and specific conditions providing opportunities to couple education with engagement. Diabetes focused events address testing, self-management strategies like monitoring of other diabetes body reactions, healthy eating, and connecting the broader community to health services impacted by diabetes like vision testing, dental care and podiatry. These events enable the care team to gather with the patient's family to share strategies for diabetes prevention and control. Implementation of the National Diabetes Prevention[4] program at several sites is also deploying non-clinical coaches to work with peer groups in the community in discussions of pre-diabetes healthy lifestyle change.

[2] https://www.careforthehomeless.org/
[3] https://cshcloud.egnyte.com/dl/M26GuUw0Ba
[4] https://www.cdc.gov/diabetes/prevention/index.html

Take-Aways: Technology and data collection support the CFH NY diabetes initiative by providing feedback on both health outcomes and effectiveness of program components. A new technology platform, implemented by non-clinical health center staff is currently being piloted to utilize automated texting to keep in touch with patients about their appointments and self-management progress. Point of care A1c testing and other shelter clinic results are connected to electronic health records (EHR), and are used to evaluate diabetes prevalence across various demographic segments of the population served. Initial risk stratification and analysis looks at data by A1c levels, co-morbidities with additional chronic health conditions, and other SDOH factors.

INTEGRATED CARE

Diabetes as a disease rarely exists in isolation. Numerous studies[5] highlight diabetes co-morbidities including dental disease, cardio and respiratory ailments, and most recently the dangerous impact of COVID-19 among patients with underlying diabetes conditions.[6] Health centers are partnering to bring a broad range of health disciplines and community services to connect with individuals and families with the right tools for comprehensive diabetes and self-managed care.

To fully understand the potential of integrated care teams to support diabetes care, it is important to highlight the key components of diabetes self-management and types of support for the patients' control of their diabetes.

- Education increases the patient's ability to make informed decisions about their care and health outcomes
  - Diabetes self-management is vested in a patient empowered to take leadership to set their personal goals with support from the diabetes care team
  - The patient, along with the care team, define and assume accountability to support and meet the plan goals.
- Care team supports for patient self-management
  - Empower the patient with skills to lead their program
  - Encourage discussion and questions that will expand the patient's understanding of the disease and their own opportunities to improve their health
  - Peer and support groups can be effective environments to expand this knowledge
  - Connections to resources in the community to address access to SDOH and impact behavior and life style are key resources for diabetes self-management
  - Include the full care team, with the patient, in the analysis of clinical tests and progress to provide important feedback and benchmarks to support diabetes self-management

[5] https://www.healio.com/news/endocrinology/20160425/prevalence-of-comorbidities-high-in-type-2-diabetes
[6] https://www.diabetes.org/coronavirus-covid-19

Case Study: Community Roles in Diabetes Care

Health Center Partner: For 20 years Health Care for the Homeless Houston (HHH) has been providing primary health care, dental, vision, behavioral health and pharmacy services to the community facing homelessness and housing instability.[7] In 2011, the State of Texas authorized a Medicaid 1115 waiver[8], which provided incentives for local communities to adopt flexible service delivery models to meet the needs of their vulnerable populations. The **Integrated Care for the Chronically Homeless Initiative**[9] launched in Houston brought together community health, service and housing providers with city government to leverage the new Medicaid flexibility and funding to improve coordination of care and services for the high need target population cycling through the crisis systems in the community.

Goal Statement: The initiative imbeds protocols across health and housing sectors to connect chronically homeless populations to stable permanent housing with comprehensive services, in order to achieve better health and housing outcomes, and address the high system costs of care for this vulnerable population. Integrated care teams are designed to bring together the expertise of cross sector partners to support individuals with complex health conditions and to navigate multiple levels of care and service to meet quality of life needs.

Team: HHH is a leader on the team providing health services and needs assessment.[10] SEARCH, a homeless service provider connects the initiative to the homeless continuum of care, and New Hope, Inc. provides direct housing and tenancy supports for target homeless individuals and households. The expansion of the program to focus on diabetes care broadened the protocols to include programming from the Houston Department of Health and from Texas A&M University.

Approach/Program Components: The Houston Integrated Care for the Chronically Homeless Initiative is built on the core tenets of permanent supportive housing - affordable housing without time limitations combined with access to comprehensive voluntary services - to support and enable individuals to remain stable in independent living and address complex health conditions. While independent living is a goal, success generally incorporates valuable social interactions and collaboration in service delivery. Key to the approach is a single integrated care plan developed and supported by all team members.

Building on the initial collaboration in place, the team partners sought to enhance efforts to specifically address chronic health conditions across the residents identified by the integrated care team, and specifically diabetes care. A key voice in the integrated program design and implementation is the consumer advisory council that includes people with lived experience counseling the integrated care team on existing barriers to care, culturally sensitive approaches, and prioritizing incentives to address barriers. Additions to the collaborative care team included the Houston Department of Health's Diabetes Awareness and Wellness Network (DAWN)[11] education programming with community health workers and peers working directly with program participants. The staff from the Texas A&M **Wisdom, Power, Control Program** [12] helped the team emphasize racial and ethnic cultural awareness and interactivity into the diabetes training and programming. Topics for their training sessions focused on diabetes facts and myths, understanding the testing tools, healthy eating and physical activity. In addition to the direct health services for diabetes testing, medication and follow-up, the overall program addresses SDOH

[7] https://www.homeless-healthcare.org/
[8] https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources
[9] https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2016/01/HoustonFrequentUserInitiativeProfile_Jan16.pdf
[10] https://static1.squarespace.com/static/55ef039fe4b0c89198cbd391/t/5a022048f9619a0c2f685b05/1510088778953/Highlights-from-the-HHH-Needs-Assessment.pdf
[11] http://www.houstontx.gov/health/Community/dawn/#
[12] https://fch.tamu.edu/programs/diabetes-management/wisdom-power-control/#:~:text

barriers through transportation, access to hygiene products, and links to community food and recreational activities. Community health workers and peers encourage group meetings and support among the participants. Participants provide feedback on both program design and effectiveness in meeting their needs.

Take-Aways: The Integrated Care for Chronically Homeless greatly benefitted from evaluation assistance from university partners and the ability to apply lessons learned. [13] The promising outcomes for the diabetes self–management of people residing in permanent supportive housing was recently released from the Academic lead, the University of Texas Health Science center school of Public Health.[14] For those who completed the program they reported an increase in knowledge about diabetes and their role in managing their diabetes. A1c levels also declined for those that completed the program. The integrated team is continuing to examine how to improve the completion rate of the program with a focus on greater input into program design with the goal of addressing scheduling conflicts, a key reason for high drop out and inconsistent participation in the program.

NUTRITION

Research data reveals that a combination of factors impacting pre-diabetes and diabetes conditions include genetic, environmental, and lifestyle[15] [16] [17]. Many families and households in low income communities or facing housing instability have limited income that force them to make choices between housing costs, food, medicines, transportation and other expenses. The link to both healthy environment and lifestyle is greatly tied to the availability of community resources like grocery stores with fresh produce and healthy food choices, safe parks and recreation locations for physical activity, and opportunities to learn and connect through community supports.

Case Study: Communities Connect to Healthy Eating

Community Health Center: Unity Health Care, Inc. Washington DC

Goal Statement: The *Yes We Can* program at Unity Health Care in Washington DC is designed to address the prevalent data indicating 1 in 3 children in Washington DC are obese or overweight (a potential precursor to development of diabetes, combined with 1 in 10 low income families having difficulty accessing healthy foods due to lack of grocery stores with healthy food options.[18] Unity Health Care adapted the *We Can* national education program from the National Heart Lung, Blood Institute (NHLBI) and joined with partners in a community approach to engage intergenerational consumers to raise awareness and provide access to the healthy eating resources.

[13] file:///H:/HRSA%20ALL/HRSA%20Rnd%202/Year%203%20Rnd%20II/Publications/Diabetes%20Case%20Study/February-2019-AJPH_PSH%20article_2019.pdf
[14] https://drive.google.com/file/d/1XIN1WnDAz5c87qcVM9DFOe-r4JZF7Fa7/view
[15] https://pubmed.ncbi.nlm.nih.gov/26154605/;
[16] https://www.nature.com/articles/nature18642
[17] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223998
[18] https://cshcloud.egnyte.com/dl/M26GuUw0Ba/

United Health Care presented their diabetes program on a national webinar **Breaking the Cycle of Intergenerational Diabetes,** January 20, 2020.[19]

Team: The cross-sector clinical care team includes providers, medical assistants, dieticians, who work closely with the non-clinical team of activity trainers, farmer's market and food pantry organizations.

Approach/Components: The multi-prong approach includes clinical wellness check-ups combined with peer group learning on healthy eating and cooking, and physical activities. The family group wellness visits promote a promising intervention to expand understanding, access, and peer support, and highlight the value of strong community partnerships. All of these approaches work to enhance retention and increase support for families towards achieving their healthy lifestyle goal. Families are referred to the six-week program by their providers. The referral is based on identified health conditions, combined with SDOH screening results. Each peer group includes 5-15 families, with targeted activities designed to engage both adults and children. Weekly sessions include one-to-one time with a clinician to review health data and progress on the individualized program plans. These visits are structured as billable consultations and enable some financial support for the program. Group activities focus on healthy cooking guided by the nutritionist and highlights roles for both adults and children, recipe sharing, and journaling by all participants. Physical activities are also a primary focus with outings to local parks. The Produce Rx program is a key component that connects the health provider and consumer to programming operated by the local Farmers market and food pantry.

Take-Aways: Participation in the group program includes both self-reporting on life style changes and health data points. Reporting from the early cohorts of the program included: BMI, A1c, other related health measures, and monitoring of prescription utilization.

- Over 90% of participating households completed the program
- 50% reduced their BMI percentiles
- 94% prescription redemption

Self-reporting includes food diaries, activity reports, and knowledge gained/ satisfaction surveys.

- 92% agreed to invest in their own healthier lifestyle
- 46% reported better health for their children
- 30-38% reported gaining knowledge on where to access and prepare fresh foods.

CONCLUSION

Engaging non-clinical staff in positions with direct connections with vulnerable populations can provide valuable outreach, education and activities to address pre-diabetes and diabetes control. Key promising practices highlighted by the health center case studies emphasize:

- Deploying the expertise, engagement tactics and rapport of multi-disciplines to connect with consumers in a range of environments
- Building skills and confidence of non-clinical staff to create and update protocols that advance diabetes care and self-management that work for their consumers and their communities, and
- Advancing opportunities to engage people with lived experience as part of the non-clinical peer team connecting with residents and consumers on diabetes care.

[19] https://cshcloud.egnyte.com/dl/M26GuUw0Ba/

About CSH

CSH is the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families by helping communities create over 335,000 real homes for people who desperately need them. CSH funding, expertise and advocacy have provided $1 billion in direct loans and grants for supportive housing across the country. Building on nearly 30 years of success developing multi and cross-sector partnerships, CSH engages broader systems to fully invest in solutions that drive equity, help people thrive, and harness data to generate concrete and sustainable results. By aligning affordable housing with services and other sectors, CSH helps communities move away from crisis, optimize their public resources, and ensure a better future for everyone. Visit us at www.csh.org

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