National Health Disparities Series: Disparities and Care Management

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Hello, everyone. I'm Krystal Gomez from TMF Health Quality Institute. Welcome to another installment in our CPC Health Disparities Series entitled, "Equity and Care Management", provided by Finding Answers. Finding Answers is a national program of the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Chicago. First, a few announcements. Today's program is being recorded and will be posted on the collaboration website. The slides for today's presentation are available for download on the collaboration website, or by going to the file on the top toolbar, going down to "save as" and saving it as a document. We appreciate the presenter's time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products, or vendors are expressions and opinions of the person speaking, and not an opinion of, nor an endorsement by, the Centers for Medicare and Medicaid Innovation, nor TMF Health Quality Institute, nor the host of the program. To enrich your listening and participation experience, here are a few tips. All lines will remain muted throughout the session. To submit questions, click on the Q and A tab on the right-hand side of your screen.

Now, I'd like to introduce Dr. Laura Sessums. Dr. Laura Sessums is a general internist who joined the CMMI/CPC team in December, as the Division Director of Advanced Primary Care. And, here's Dr. Sessums.

Thank you, Krystal. I'm so glad you all are able to join us this week for the fourth and last in our series of webinars on reducing health disparities in the CPC initiatives. I've heard from a number of you in CPC practices about how care managers are a critical piece to solving the puzzle of the care of complex, high-risk patients, and this is certainly consistent with my own experience. In today's webinar, we'll hear more about the interaction of care managers and health care equity. Certainly in my own practice, I've worked with care managers from various backgrounds including local African-Americans, and people from the Caribbean, as well as the Philippines. And, those care managers' backgrounds reflected large — reflected that of large groups of our patients. As a result, they understood the traditional foods. Patients from those backgrounds aid and other traditions that impacted patient's health. They were certainly able to bond with patients over these shared backgrounds and provided insights to me and others about the patients and the patients' behaviors. This certainly gave all of us on the care team very actionable information. In addition, we had other care managers without those shared backgrounds, but who were very caring and empathetic people. And, those folks were also able to bond with patients, develop a dialog, and help the team really make great strides in improving our care of our patient population. So

now, I'd like to turn over the presentation to my colleagues at Finding Answers to teach us more about the issues of equity and care management.

Thanks, Dr. Sessums. My name is Rachel Voss-DeMeester, and I'm here with my colleague Mona El-Shamaa today, and to represent the Finding Answers team. We also have in the room with us several others who are from our team, Robert Nocon, Kevin McCullough, and Scott Cook, who will jump in at the end of the webinar as we do question and answers. Before we get into the actual content, I just want to remind you that you can submit questions throughout the webinar in the chat function, and that way we'll be able to get to all of them at the end.

So, for those of you who have been on the other webinars, you've seen us before. But, I want to give you one last time, these anchor-points on sort of the key messages that build the foundation for our discussion for care management and equity today. So, these are the three, sort of, core concepts from our introduction webinar on why and how to address disparities in your CPC work. First, we talked about how health equity is an integral part of quality, and that they best quality care meets the needs of all of your patients. Second, we've talked about how tailoring quality improvement interventions to the unique needs of your minority patients that can help reduce disparities and improve overall quality. And, we talked about the idea that generic quality improvement can improve care overall, but that it can also fail to address, and may even worsen, disparities between patient groups, if you're not specifically paying attention to equity. And finally, we'll talk — we have talked about how focusing on equity can maximize the impact of your CPC work, both by increasing the effectiveness of it and by increasing the reach of your activities. And so today, we'll talk specifically about how equity can maximize the impact of your care management programs.

So, just before I start going through, I just want to lay out the agenda for today. We'll talk about that link between care management and equity, and then we'll go into some of the main functions of care management. And then, we'll talk about identifying a care manager. And, in that section, we'll also talk about, sort of, creates that members of the care management team need, as well. And then, we'll be privileged to hear from the care management team at Duke University Medical Center, who will share some of the tips that they've learned from integrating equity into their care management.

So, just to orient ourselves, we know that your CPC Milestones encompasses several components of care management. And, while equity can play a role in each of these areas, we're going to focus on the patient coaching and the proactive care part of it. These are, sort of, the way that the care management team functions more day-to-day, and that's informed by your efforts in these other more population management oriented components.

So, how are care management and equity linked? One of the pillars of care management is identifying and addressing patient care needs that aren't being addressed in other ways in the clinic. And, I'm not talking about negligence; I'm talking about, obviously, the patients in your clinic where you're giving good care, but who, for some reason, need some additional help. Care management provides the unique opportunity to understand diverse needs and preferences in a different way, and some of that is because of the way care management programs are structured. First of all, care managers, the end

people who provide care management, might have a little bit of additional time and access to patients. And, this allows them to pick up on additional culturally based barriers and preferences that you might not otherwise hear about. And second, those who are providing care management are able to act as a bridge between the patient's experience in the clinic and outside of the clinic.

We can also talk about the link between care management and equity from the perspective of targeting your resources. So, another pillar of care management is providing additional navigation and support to patients who need it. Often, minority patients are overrepresented in those high-risk groups and so providing equity-focused care management allows you to reach those patients in the best way. And, now that we've talked about this link, I just want to sort of insert a caveat that when we talk about equity, we're going to mention race and ethnicity quite a bit, but that can also correspond with gender, or sexual orientation, or religion, and there are essentially many other factors that contribute to diversity. So, if you feel that you maybe don't have a lot of diversity, per se, in your clinic, we think that some of these principles are still important for you.

So, let's go now into the functions of care management. And, we'll start with patient coaching.

So, a main rule within patient coaching is advocating for patients. That is, care management teams help teach patients to ask for and pursue the care that they need. One of the ways that care management teams can do this is by identifying goals that are maybe less clinically urgent, but that are important to the patient's self-management. So, for example, let's say that a patient needs to reduce their A1C, but the patient is experiencing a lot of life stress and it's interfering with their ability to self-manage.

10:01

As the care management team understands that and advocates for addressing that stress and bringing that issue to the front, that helps to remove that barrier so that the patient can become better engaged in their self-management. Care management teams can also advocate for patients by helping them navigate interpersonal dynamics, especially any power imbalances that might exist. So, this can exist between patients and providers. Patients from some minority groups have been shown in the literature to sometimes defer to a provider's clinical expertise and prefer that they make decisions for them. But, the literature also shows that persistent encouragement can help patients become more engaged in decision-making processes and their care in general.

And then, care management teams can also work with any family and gender dynamics that are occurring. We've talked in some of our other webinars about how family involvement might be stronger or weaker for certain cultures and how you do care management can help sort of connect the dots of what patients need in this realm.

So, care management, like good clinical care, works best when done in a culturally tailored way. And, we don't mean to imply that you don't do this already in your care, but just to underscore culturally tailoring care management means identifying culturally-based barriers, motivations, desires, you know, things that might exist for patients that you're not aware of. Second, understanding, again, different values and health-related beliefs. And, finally, providing education to match those. So, for example, some minority groups may be likely to seek health information outside of your clinic. They may look to

faith-based groups, or community organizations. And, it's easier to provide education in care management that complements those resources when you are familiar with them.

So, the patient coaching function focused mostly on connecting with patients once they are in the clinic. The second function of practice care delivery focuses on connecting with patients between care episodes to avoid falling through the cracks. And so, I'll pass this over to my colleague, Mona, to go from there.

Okay. Thanks, Rachel. So, one way that the care management team can provide proactive communication is to act as a bridge between patients and the health care team. So, minority patients are at greater risk of falling through the cracks. This happens between appointments, it also happens when transitioning between clinic staff.
They may face additional barriers that were result in limited contact with the health care system. For example, minority patients tend to have higher rates of residential mobility and tend to change phone numbers and addresses more often. So, to avoid losing contact with the patient altogether, which is common, the care management team can ask for several contact numbers when obtaining patient contact information. Another way to provide proactive communication is to reach out to patients before issues occur. Minority patients proportionally have limited access to the health care system, so it's common for patients to only be treated once a health condition has escalated. So, in this case, the care management team can remind patients to take their medication, or help the patient schedule an annual preventative care visit, for example.

14:27

So, because patients only spend a small finite time at a clinic, it's important that the care management team connects the patient with community resources. It is especially important to find community resources that are culturally competent and trusted by the patient's community or social circles. So, these external resources may have a powerful impact on addressing barriers to equitable care. So, let's look at an example of a patient who feels unsafe exercising alone after work. The care management team can connect him or her to a walking group, for example, in his or her neighborhood. Or, if a Spanish speaking patient has been advised by a physician to quit smoking, the care management team can link the patient with a smoking cessation program conducted in Spanish within his or her neighborhood, as well. Community resources have the added benefit of reaching patients who may have limited access to the health care system.

Okay, now that we've talked about what the functions of the care management program and what care managers do, we'll talk about how to identify somebody or multiple people to provide care management.

So, those providing care management have the central role in understanding the patient's needs and goals and then using this as background to coordinate the team. There are specific goals that we've identified that allow them to work effectively with minority patients and serve this coordinating and bridging function.

The first trait we identified is cultural awareness and humility. Research shows that care models that incorporate cultural competency effectively increase the practitioner's awareness of how to deal with culturally diverse patients. Another trait is passion for working with a priority population. Minority patients may often feel disenfranchised, and therefore, require more time or commitment from their care manager, as Rachel described earlier. Having an enthusiasm and passion for the community allows care managers to remain engaged in order to provide the best care, and also helps them not feel as burnt out. So, another trait that we identified is flexibility and tailoring. Because each population has different cultural preferences and norms, it's important to be flexible and avoid this one-size-fits-all approach. For example, a good care management team can tailor communication, counseling, and solutions to the minority population. And, the last trait is, that we identified, is being positive and motivating. Navigating the health care system is challenging for everybody, but especially for patients who mistrust the health care system or have multiple culturally-based barriers to care, such as language or transportation. Care managers, or those providing care management, who remain positive and motivating can help patients avoid getting overwhelmed and help them stay engaged with their care.

Peer matching is another useful tool that has been shown to improve communication, especially with minority populations. To practice peer matching, try to match on — based on one aspect of the patient's identity, which is most important to the patient group. Some examples may include parental status, religion, spiritual beliefs, caring for extended family, or sexual orientation. Peer matching is not necessarily always based on race and ethnicity. While cultural and racial congruence may be helpful, it does not guarantee cultural competence or humility. So, it's important that these traits should be assessed and never assumed. Care managers who identify personally with the patient have an intimate understanding of the social norms and beliefs that influence the patient's health and health care. So, also another way that peer matching would be helpful is there may be greater trust between providers and patients from similar backgrounds, which ultimately improves communication.

And lastly, people have unique ways of interacting with the health care system. So, some cultural groups have experienced historical oppression or discrimination and may mistrust the health care system, so it's important to match based on a care manager's familiarity with these historical and cultural factors. But, like Dr. Sessums mentioned, a care manager doesn't have to be peer matched to do a great job. We understand that peer matching is not always possible. In some cases, other traits may even be more important. But, once again, we wanted to address this tool.

With these traits in mind, it is important to balance the need for these key traits with your organization's capacity to hire and train new staff.

20:06

Ideally, you would hire a new person. This would help you prioritize these traits and ensure that the new-hire won't be overwhelmed with existing or competing demands. Of course, practices may need to use existing staff to get a care management program off the ground. Once that's accomplished, then they can reconsider the idea of hiring new staff. In way of prioritizing traits, it's important to consider a care management team who has inherent parts of their personality that make them a good fit. For example, at first one can identify somebody who's passionate about working with the priority

population or someone who's flexible. These are traits that are usually pretty inherent to a person's personality. Then later, you can provide trainings to develop additional skills such as motivational interviewing or tailoring.

21:08

So, before I close out, I just wanted to add that we're going to have a cue — we're going to — address your questions — we're going to address those questions and — or answers at the end of this, but we just wanted to have you know that you can keep asking questions and we'll get to them at the end. But, for now we are happy to have care managers, Pam Gentry, Cindy Rose, and Professor Hayden Bosworth from Duke University to share their experiences integrating an equity focus into their care management program.

So, Pam and Cindy serve as care managers and will give examples of their experiences. Then, Hayden Bosworth, who has served as a principle investigator will discuss how the team was able to integrate equity on a more organizational level.

Okay, so...

Hi. This is Cindy, and our patient contacts consisted of monthly telephone calls. And, it usually it takes me several months before I get to know a patient. And, I hadn't been aware of this situation before, so it took me by surprise to have had patients tell me that they've had to wait until their monthly checks before they could pay for their prescriptions, or that their diet choices change, compared to from the beginning of the month to the end of the month. For one patient, a particular call that I had with her was towards the end of the month. And, the woman that I was talking to had recently retired as a school lunch lady, at 82 years old, and she lived in a multigenerational household. She had just been to her primary care provider and was prescribed a new blood pressure medicine. But, I asked her when she would start the medicine and then she told me she was just going to have to wait until her check came in at the beginning of the month, and that there just wasn't money for this right now. And, I asked her if the provider knew that this was going to be another couple of weeks before she could make this change, and was told she didn't know.

Another time, I had a patient who was cooking dinner for her parents. We had just been talking about making diet changes using less salt and less processed foods. And, I could hear her busy preparing the dinner; I could hear the pan sizzling. And then, she told me that the food that she was getting was from the food bank. She didn't get to pick and choose what she got. And, it wasn't that the diet information that I was going over wasn't important to her, it just wasn't possible at this time of the month. So, you know, I've learned from these patients' calls that at the end of the month, running out of money is not unusual.

Hi. This is Pam. I know one of my first phone calls with a 40-year-old man, we had gone through and gone over his medication, hypertension knowledge and all the things I needed to, and at the end, I asked him if he had any questions. And, his question to me was, would I be able to help with his blurred vision? He wasn't able to read the newspaper like he wanted to. And, so in talking to him a little bit further, I asked him what his blood sugars were doing and he said they were running mid-300s to low

400s. I kind of went and reviewed his diet and that looked okay, nothing glaring. And then, he said he was drinking about two gallons of sweet tea a day, and a two-liter bottle of Mountain Dew. So, we kind of brainstormed as far as how he could change that, and he decided that he could take the sweet tea and would drink Krystal Light. He did not like their artificial sweeteners, you know, adding to unsweetened tea. And so, when I called him a month later, he said that his blood sugars were consistently running about 140s to 150s. He had stopped drinking Mountain Dew; he had gone to diet Mountain Dew. He was drinking only Krystal Light tea, thought his surgical site was healing better. He had more energy than he did. He was able to read his newspaper. And, because of those changes he actually was now motivated. He'd been eating fried chicken five to six times a week; was now going to cut that into half, to about two to three a week. And, he was also motivated to work on other aspects of his behaviors, such as he was going to cut out rice, and he was going to change the way he eats and cooks. So, we talked about, you know, continuing to monitor his blood sugars. And, he was very positive and was happy things were going much better and could read his newspaper.

25:49

Thanks, very much, Pam and Cindy. This is Hayden Bosworth. I'm trying to... Okay. So, what I would like to do at this point is try to summarize some of what we've discussed and draw through some — move how we went from a research protocol that was funded through Robert Wood Johnson to a CMS quality improvement program, at the moment. And, the early project involved — it was called CHANGE, Cholesterol, Hypertension and Glucose Education Study. This is one of about 12 randomized clinical control trials that we have conducted. This study, in particular, had approx. — most — 359 African-Americans with type 2 diabetes. And, one of the things I just want to point out is, when we're talking about disparities, it's not just simply race. It's also literacy and income. And so, we had 49% were functionally illiterate, which meant that they had a hard time understanding the back of the *New York Times* bottle, and — a Tylenol bottle, or the back of *New York Times* article. And so, we have to be very mindful about how we convey that information and how we communicate to the individuals, but how to do that in a respectful way. The other part is that, already as Cindy alluded to that often times for the populations we're working with, we have low incomes. So, trying to make sure that it's culturally appropriate, yet that we can consider it — take into account individuals making less than $10,000 a year, and acknowledging that for many of us on the phone, for case managers, or a professor, like myself, we're all privileged and how do we understand and be able to communicate people using humility, but also not making somebody feel uncomfortable, but understanding where they are and their life experiences. So, with that we transitioned from what was a randomized clinical control trial to a CMS funded project. Now, we're not the PI on this, this is something that's being conducted locally. But, there's some lessons that can be learned from this experience. So, this is an ongoing program in four different counties; in Durham, Cabarrus County, which is more towards Charlotte, Quitman County, Mississippi, and Mingo County. And so, one of the lessons, in terms of case management and equity that we have to mindful as is that urban, rural, and literacy, and race; there's so many different components of that. And, just being mindful of the demographically diverse, underserved counties that we may be working with, and being also aware that to address issues of equity and cultural sensitivity, we — our programs are never rolled out as if it was assumed that that local community can utilize that program. And, that there's often times a need to have the case managers, particularly from the local sites, provide

some input, and making sure that it's appropriate for that community. So, as another example, we're doing some work in South Carolina. Piggly Wiggly is a big supermarket chain down there. And so, making sure that the resources, and utilizing those local resources that, in South Carolina, are different than — because we don't have Piggly Wiggly's here, up in North Carolina. So, what some of the additional comments I've wanted to just bring up is that so again, we provided an overview of how we transitioned from a research to actually quality improvement. And, I would say that a lot of the reasons why we've been able to make that transition have to do with the role of case managers, and the ability of them to engage individuals and appreciate, and the diversity of the population that they're working with. And, some of the lessons I'd like to just share with you, if I could, that both the case managers are the stakeholders, as well as the patients. And, in getting their insight and thoughts about how we can adapt a program and continue to develop these efforts. And so, I think it's really important to understand and respond to the specific needs and the preferences of the minority populations that we may be working with, and just also appreciating the local variations in the local communities and across groups. And, I think the point, too, is that early on, involving these individuals as stakeholders.

30:02

For us, for the Robert Wood Johnson funded project, our stakeholders were involved in the very beginning. So, by the time the project was ended both the case managers were advocating, as well as the patients, and it helped continue finding alternative ways to continue the program and transitioned more into a quality improvement program.

I also think it's really important, and I think, as it was mentioned before, to realize that minority patients are often overrepresented in the high-risk groups, they have a lot of challenge and comorbidities that we need to be acknowledging, and that they often need additional support. And, I think the role of care managers are key for this because, A; there's not enough time in a primary care or specialist's time, so the care manager can spend a little more time, delve a little bit further, and understand. So, that additional time is really important. But, they also really play a very important role in bridging between health care and patients, and I think that's really something important to be mindful of. As far as the good case managers, it's having cultural awareness, humility; it's a passion for working with these populations, and also really some familiarity to the community. It does not work well when you pick somebody up who hasn't had some time in the community. Not to say that you cannot hire somebody like that, but it really is an important component to go and visit the communities and understanding what's local, and just some of the history and variation.

I just want to briefly also mention a couple of other elements that I think are really important for these types of programs. One is language, and making sure that we — that's translation and attention to literacy level. And so, even though we may all speak English, again, there's local dialects, local terms, understanding those metaphors. So, when we're talking about diabetes, often times, we may use the term "bad blood". And so, I think just understanding how people refer to the things is really important. So, also ensuring you understand, as a case manager, the common language of the patients you're working with. I think cultural sensitivity's an ongoing process; it's not a simple event. It's an always ongoing, and improving, and developing. And, I think that also understanding the content, congregants with values, customs, and traditions. So, for us, we're in the South, so religion is really important. And,

you know, really being aware that individuals may say, you know, "It's all in God's hands," and so how do you, as a case manager, handle that and whether, whatever your own religious beliefs are, how do you adapt to those, where the individual is. And, that takes some effort. It's not an easy process. I think goals of understanding what's positive, and adapt to cultural values, and being mindful that it, often times, is shared decision-making. That you, me, as a care manager, hope to get a patient to some place, but they may not be ready to do that, and appreciating that, and understanding that you may be planting a seed that may eventually grow. But, that the reward may not be immediate for you. And then, the understanding, again, back to the issue of context, inclusion of relevant context, discrimination, we've done work in the Latino community, and access to care. And, there's a real problem, in terms of a fear of interacting with the health care system. And so, be mindful of those situations. So again, as back to what Cindy mentioned, responsive to resources and barriers, to providing those resources. So, if an individual's at the end of the month and may not be able to cover their medication and there are alternative methods to help support those people, dietary issues and things. And, I think that often times there just does need to be some flexibility. But, one of the things too, is to have some fidelity, in the sense that a program, hopefully, is structured so that most case managers are doing 80 to 90% of the same thing, but ability to have that flexibility that when a patient brings up something that may or may not be what your agenda is, how do you handle that but yet not shut it down? Because, that's the fastest way of disengaging an individual. But yet, doing this in an efficient, way so you can have a quick conversation.

Those are just some tidbits to think about, and we're available to answer more questions, but the only — the last point I would just emphasize is you, as a care manager, have a really unique and important role and that your, in many ways, having that opportunity to develop long-term relationships. And, I think it could be extremely powerful. And, it's almost like you're a detective. That you'll often times find things that you just want to know, but it just takes some time to figure those out. And, I think those are really powerful opportunities for you, as a case manager. So, I'm happy to answer any questions, and thanks for your time.

Thank you, so much, Hayden, Pam, and Cindy. The work that you're doing out at Duke is extremely impressive and the growth of your program from that first pilot to this sort of much larger, multicounty study really speaks to how well you've built this sort of attention to tailoring your care and care management to your specific population, how well you've built that into your program. So, this has been wonderful. Thank you.

We will go to question and answers now, so just a reminder to all the folks on the line to feel free to submit Q and A if you have that panel in the bottom right corner of your screen. And, Hayden, you mentioned the importance of language in sort of the latter part of your comments. And, we have a question about one of the clinics who mentions that they have a high volume of Spanish speaking patients and employees that speak Spanish, and a huge list of community resources, but not so much ones that supply bilingual communication. And, she's wondering how to — how you might suggest going about finding more that speak Spanish. And we know that finding folks to help with bilingual communication is pretty difficulty, generally. Do you folks have experience from your project in dealing with that? And, any tips you might be able to provide?

Sure. I mean, I think that this is a really, it's a great question and really an important one. And, I just want to clarify too, that I think if the person asking the question was alluding to. Simply because you speak Spanish doesn't mean that everybody can understand you. And, my wife is from south Florida, Miami, and so she learned how to speak Spanish because there were in a large Cuban population, which may be very different and it's much — spoken different than actual areas of Mexico. And, quite frankly, being here in North Carolina for 20 years, there are people from North Carolina I still don't understand. So, it is that ongoing issue. I think, you know, ideally just, you know, finding individuals within the community that can speak Spanish and understand the community is ideal, but that's not where reality is. I think that, you know, there's kind of this sliding scale, if you will, where you're dependent — and the parameters are limited by your resources. So, you know, you can't be in New York and have 40 different people speaking 40 different languages, because that's what typically at NYU you do. But, the hope is at least at a minimum, you're utilizing the cultural sensitivity, appreciating some of the challenges the individuals may have, some of the reticence to communicate and interact with you. My wife, as a child therapist, works out in Burlington, which is west of here. She works predominantly with African-American population, and it took her a long time to realize that among certain African-American population here, they wouldn't make eye contact with her; she would happen to be white. And, it was these lessons that she eventually had to learn, that, you know, she wasn't African-American, but she had to eventually understand and appreciate the cultural issues. So, I think the end result is, is that ongoing training, utilizing the resources. But, unfortunately, I suspect in this situation you may have somebody who happens to be a college student who learned how to speak Spanish, but it's not necessarily the dialect of where you are. And, I think there's something lost when we're referring them outside the system and the more you can engage inside, as a case manager, I think the more powerful that relationship is. But, being mindful of the local resources. So, you know, so that would be my initial response. I don't think it's a clear answer, but acknowledging the challenges that I think we're going to have to deal with, particularly as communities that we're working with become more diverse.

Thanks. And, yes, definitely, definitely a significant challenge, and one that is likely going to increase, even for practices who aren't seeing that challenge now. Scott Cook from our team at Finding Answers wanted to add a couple of thoughts to this, as well.

Yeah, everybody. Hello. This is Scott, and I don't have a whole lot to add to Hayden's excellent, excellent answer to that question. And, he's right. It's a tough situation and there's no easy answers. Just some very, sort of, focused, pragmatic ideas, and it depends on the community, of course. In terms of looking at other organizations that might provide some support to patients to come to get some help for some of those barriers that were mentioned earlier in the session. It sounds like the person who submitted the question that has some organizations they already work with that provide bilingual communication.

40:04

And, if they haven't already done so, I would approach the contacts at those organizations and see if they know of others in the community, or in the area, that perhaps the health care organization doesn't know about. So, there may be some undiscovered resources out there and I would just be sure that you're utilizing your current contacts fully to see if there's some other resources in the community. And, Hayden mentioned, or at the very end, that you know, yeah. I would not just immediately start referring

people. Of course there needs to be an assessment of any new organization that you're working with to be sure that they are culturally competent, and are providing services that are in line with the goals that you have as a health care organization and as a care manager. And then, you know, this is probably a long-shot, but if you're patient is computer literate and if they have access to the internet, that may be a last resort for finding some bilingual support, whether it's a particular health condition, in existing support groups, or educational materials that might be available to help them out.

The last thing I just said is, you know, again, and from our experiences, unfortunately, individuals that are disenfranchised, particularly from the language area, know, have some sense of some health care clinics that may have more bilingual or more support. And then, we also have community programs here that can provide outreach. But again, it's the care manager referring them outside the system to a different organization. And, sometimes that's necessary, but that the more steps removed, it becomes more challenging.

Great. This is Rachel, too, I just last thing on the — I know that we've given a lot of good answers to this question. In the rest of your CPC and some of your other Milestones, you're working on building patient and family advisory councils, particularly in your patient experience as you work to understand your patient views, and that can be a good place to bring these questions to, to ask your patient advisory council where are you going for resources? What are the organizations in the community that we should be talking to? And, they may be able to point you towards some of those bilingual resources that you are having a bit of trouble finding.

Thanks, Rachel. Yeah, that's a great point. I mean, as the folks in the practices are probably hearing from a lot of different places, all of these different aspects of delivering comprehensive primary care and becoming more like a medical home. Those are all things that need to tie together and support one another.

Looking back to the question list, we have a question about, where would you go to get cultural educational resources to help care coordinators work with certain individuals if they may not know that much about that person's culture? I'd first — Hayden, Pam, and Cindy, any thoughts on that from your experience, having sort of grown the program into different areas, and maybe having to expand into areas where you may not, as you mentioned, sort of, be a local to that area?

Yeah. So, we're doing some work in Mexico, and South Carolina, and in the United Kingdom. And, in each of those situations, before we roll the program out, we really do go out and do a, kind of, an evaluation of the community and understand what's there, the challenges. As far as the case managers, typically, we partner with those systems in that environment, or those areas, and so they're staffing it. We help train them, but they're locally hiring people. And then, we kind of, we ensure the cultural competency and abilities, and periodically evaluate that over time. So, you know, we do really rely on our partners in the local communities, wherever those may be. Even with the CMS project we mentioned, Cabarrus is two and a half hours away. There are — we're working — we work directly with the case managers that were already identified in the local community and worked with them. So, that's

been our model and it's been more — pretty — seems to work reasonably well, but that may not always work for everybody.

Thanks, Hayden. And, I think Rachel also had a point to add to that.

Yeah. Just to — I think, Hayden, what you said about working with other people, other health care providers, and other care managers who are doing that work, is really important. I know — in that — when I've worked with physician offices in electronic health records, for example, it's very common for practices to go take a field trip and see what other people are doing, and talk to other doctors to figure that out. And, I think that applies equally here. That you can go to other practices in your community that might have more experience with some of these cultures, and see how they're doing it, and see how they're doing care management and get their feedback. So, I thought that was an important point to underscore.

Great. And, Mona, it sounds like we might have some experience related to some of our Finding Answers grantees?

Yes, our equity partners. So, in addition to just kind of peer learning that you can get from local climate care managers or local practices, we have just a recent example of one of our partners that we provide technical assistance to in western New York. They work with a Somali population on a diabetes program and while their population, there's a Somali population that's large and growing, they — we've been able to connect them to an organization in Minnesota, which in Minnesota, actually has the largest Somali population outside of Somalia. And, they've been able to connect them, provide tools, resources, really, really good advice about how to build a diabetes program. And, that's also another way to — that practices can learn from each other.

Thanks, Mona. There's a question similarly about resources. One of the participants mentioned that they're a small practice with a wide variety of patients. And, they recall that their recently closed hospital had a large poster that detailed many aspects of health care across 15 major cultures, and are looking for a similar type of resource.

This is Rachel. I'll just jump in. And, I wish I could tell you that we had one for you, but what I can tell you is that sometimes public health departments will have similar sorts of things. And, I'm not sure which region of the country this question is coming from, but some health departments do an annular report on minority health care. And, that can be a great sort of at-a-glance fact sheet on where disparities lie and what sorts of opinions some of those groups may have that you might want to ask your patients about, so that's one place to look.

Great. Thanks, Rachel...

There's also the NIH Office of Minority Research, which has a terrific resource of information about different cultures and communities, and they may also be a nice place to look, as well.

Wonderful. We can follow up with the group with the links to both of those resources.

48:11

Another general question for Hayden, Pam and Cindy. We've covered a lot across this webinar, in terms of various, sort of, techniques and things to consider with the respect to incorporating equity into care management. And, one thing that might help the group is to just to — if there are any highest priority take-homes, you know, of the biggest impact things that the people should focus on. Or, you know, if they were to walk away and want to — and you would have the opportunity to sort of provide a really solid reminder of, what's the one — what are just the one or couple things that they should focus on as sort of highest priority messages? Any high priority or high impact things that you'd want the group to focus on?

This is Hayden, so I'll maybe send it back to Cindy and Pam, since they've done this for over a thousand individuals. But, you know, our goal eventually is patient engagement. And, you don't think that in one phone call, or in one interaction, we're going to solve a person's problem. The goal is just though that you get to the next step. And, the next step may be the next phone call, and then the next phone call. And so, all that deals with is patient engagement, trust, appreciating what's being offered, appreciating what the patient's struggling with, the humility, we mentioned, a little bit of therapy, just a little bit of empathy, I think. Just being able to empathize. And, I'm not — it's not sympathy, its empathy, and appreciating what each individual's challenges are. We've even, you know — chaos. So, we did this paper looking at chaos predicting non-adherence and, you know, it was this major factor, but think about how many of you could get out the door and not forget your keys, or forget your children, or forget where you're going, or lost something.

50:10

And so, I think, you know, the populations we're generally dealing with are — deal with very chaotic households and, you know, no fault of their own, but that's just what it is. And I think, understanding and appreciating that and trying to create small success. We're only looking at small behaviors over time that we can build upon. We don't want somebody to lose 50 — we want somebody to lose 50 pounds, that's not where were going to go. We're going to get them to lose one or two pounds over a couple of weeks, build upon that success. So, there are a couple things in part of that, but I underlined the goal is engagement, how do we encourage engagement? That's trust, that's humility, empathy, and just trying to reach the person where they are. I don't know if Cindy or Pam, any other further comments?

This is Cindy. I just wanted to add, one of my big concerns is patient safety, and also safety for their families. I can remember one call with a young woman in her 30s, who had several children there around the swimming pool, and she's trying to complete the phone call with me and I could hear the children in the back. And, I just needed — I did not feel comfortable with it. I said, "You know, let's reschedule this. You really need to pay attention, you know, to the kids." And so, we did schedule back at another time.

This is Pam. You just have to listen to them and find out, what is their priority? What is their most pressing piece of information? And, if for this man it was, you know, simply telling me that he couldn't read the newspaper. You know, for me, I would have pounced on his blood sugars at 300 to 400. But, for him it was because he could read, then that directly impacted his life and now he was ready to make

changes. Not that he could be on dialysis, he could, you know, all these other things. So, it's meeting them where they're at and going from there.

I think that's great to way to end — or to summarize. And, we do one example where we do patient communication, patient-provider communication. We role-play with them over the phone. And, one of the lessons we learn is, and we teach them, is to say, "Okay, you may have 20 different issues you wanted to address, the provider has 20 different issues. Could you potentially — you as the individual, you — as a care manager, here's the one thing I would like to work on or think about. And you, as the patient, what would you like to work on?" And see, you're kind of negotiating the shared decision making. If this was any other relationship, it's just really balancing where you're coming from and what they're trying to do, so.

Thank you, so much, Hayden, Pam, and Cindy. I think where we've ended up here, is sort of is a good place to, sort of, think about the sessions overall, because, as with a lot of these sessions with patient experience, with this one care management shared decision making, as Hayden mentioned. Doing things well with respect to incorporating equity, is really just doing things well a respect to quality, that we're really paying a special attention to those things that are specific to our local patient populations and our local communities. And, this sort of really, really hammers that home and also the need to sort of build it into what you're doing and think about it on a day-to-day basis. So, again, thank you to CPC on behalf of all of the Finding Answers team and all of our guest speakers and stories from the field who were able to sort of bring this content to life. Thank you for the opportunity to really share some of what we think about equity and quality and how it might affect your work in the CPC over the course of these four webinars.

So, as you'll recall, we started out talking about — really, just hammering home the message that equity is a critical part of quality. That you can't think about — or think that you're providing across the board, highest quality care without also making sure that that care is equitable, and that it's tailored to the communities and the individuals and the patients that you see. So, tailoring is a key part of that. We've talked about tailoring with respect to race and ethnicity as our particular lens, But, we want to emphasize that even for practices that don't have a lot of racial and ethnic diversity in their practices, just because you don't — and I'm lifting a line from our — one of our patient experience speakers, Brenda Battle, just because you don't have minorities in your practice doesn't mean you don't have diversity in your practice. And, that the lessons that we apply to looking at individuals and culture and how that affects their, you know, ability to pursue good health, that applies to all types of diversity. We talked about language, socioeconomic status, local culture, a number of things. So, just a reminder of that. And finally, while this series and this month has been sort of called, you know, equity, and the CPC equity and different parts of your CPC Milestones, you know, we think that just as much, this stuff about equity is about helping you do a better job, and a good job, with your existing work. And hopefully, the discussions that we've had around how to incorporate equity into shared decision making, patient experience and care management has shown that; that they should just be part and parcel of the daily work that you're doing for the program. And, we have mentioned in the past, we targeted a couple of specific areas in these webinars from, in terms of communicating messages from, or finding answers sort of resources to the group. But, we just wanted to also remind the group of our website,

www.solvingdisparities.org, which has sort of a range of resources, a road map that has some more comprehensive information about, you know, what can you do and where can you start, with a respect to building a culture of equity and a focus on equity into your organization and your work? And then, we also have sort of tools and databases and examples of grantees that we've funded to help you navigate the scientific and research literature that's out there, to come up with good ideas, see what other people have been doing. For example, the two grantees that you've heard Hayden, Pam and Cindy, and Ian and Cathy from the intro webinar from Lancaster General, were all grantees of Finding Answers and have resources there on that website that can help you understand more about their work. And so, again, thank you, all. We just — we hope that we've provided some valuable information to incorporate into your CPC work. And, please feel free to reach out to us for more information or with any questions. And, with that, I'll hand it back to Krystal.

Thank you. All right. So, what's next as for national webinars? We have our next national webinar on March 4th, and the topic will be Milestone 3, specifically, a synchronous access. We also have some education on CAHPS, and then we'll be exploring some of those options within Milestone 2. We'll be doing a *Deep Dive in Behavioral Health* and also a *Deep Dive into Self-Management Support*. So, we look forward to you joining us for those. And, thank you all for attending. We hope you found this entire series to be very informative and helpful for you and your practice. You can exit this session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You'll be taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. Again, thank you for attending.