July 12, 2024

HEALTH EQUITY Diabetes
Funding Opportunity (July 2024 - February 2026)

Dear Healthcare Partner,

As part of a grant funded by the Centers for Disease Control and Prevention (CDC), the Montana Department of Public Health and Human Services is announcing a NEW health equity-related funding opportunity for health care systems, primary care, and community based organizations who serve individuals with or at risk for diabetes in selected areas of the state. The goal of this project is to track selected social determinants of health (SDOH) data and build partnerships to address health disparities. Additionally, clinics will collect population health data, with a focus on patients who have diabetes or are at risk for diabetes.

Eligibility
This is a **one-time** sub-award. Eligible organizations include Montana Community Health Centers, Urban Indian Health Centers, and Tribal Health clinics.

Award amount
The participating organizations will each receive $7,500 total. Up to two sites may be awarded in this 18-month grant cycle.

Deadlines
Applications must be received (in-hand) by the Montana Diabetes Program by 5:00 p.m. **July 29th, 2024.**

The project period will run approximately August 2024 to February 2026. We hope you consider applying. For more information, contact Melissa House, Program Manager, Diabetes Program, melissa.house@mt.gov, (406)444-9154 OR Margaret Mullins, Determinants of Health Program Coordinator, margaret.mullins@mt.gov, (406)444-6968

Sincerely,

Melissa House

Melissa House, MS
Diabetes Program Manager

Health Equity Diabetes Funding Opportunity
PROJECT BACKGROUND

Project Requirements – Funded clinics must address these action items:

1. *Train all clinic staff who will be participating in this project to improve comfort and competence addressing issues encountered when administering and responding to SDOH screeners.* These topics can include empathic inquiry, implicit bias, and cultural competency. The Diabetes Program (MDP) staff will organize this training option. Any new staff members that begin during the 18-month project must be trained.

2. *Administer a validated SDOH Screener to all priority populations (Rural/Frontier; American Indian (AI); Medicare/Medicaid; people living with disabilities, veterans) at a minimum at all annual visits, as well as patients with or at risk of diabetes. In your application, you can specify a more frequent schedule.* The SDOH screener may be used with other populations as well. Review the screener to identify positive responses and discuss patient needs.

   *note: If your health care facility is located in a rural area, you can not choose this group as your priority population.

3. *Document SDOH data into the EHR to enable tracking, analysis, and reporting.* If a process does not currently exist, MDP staff will work with your clinic to create the workflow.

4. *Map SDOH data to the following Z codes (at a minimum)* Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes (cms.gov):
   - *Food insecurity*, **Z59.4** (Lack of adequate food and safe drinking water, https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65/Z59-/Z59.4)
   - *Housing insecurity,* **Z59.0** (housing subcategories: Z59.00 -59.3, Z59.89 and Z59.9)
   - *Transportation insecurity* **Z59.82** (https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65/Z59-/Z59.82)

   OPTIONAL:

   Z codes that can be collected to enhance patient SDOH data:
   - *Unemployment unspecified* **Z56.0** (https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65/Z56-/Z56.0)
   - *Problems Related to Living Alone* **Z60.2** (https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65/Z60-/Z60.2)

5. In addition to SDOH and Z code data, *collect and document pre/post Hemoglobin A1C (HbA1c) for all adult (18 years and older) patient with or at risk of diabetes. In addition, collect the following demographic data for all adults (aged 18 and older) patients.* See https://healthitanalytics.com/news/which-healthcare-data-is-important-for-population-health-management:
   - Age
   - Sex
   - Zip code

- Payer type (Medicare, Medicaid, un/underinsured, private, government (e.g., IHS))
- Race (White, Black, AI, Asian, etc.)

Examine data in a comprehensive manner to assess any inequities in care delivery. Determine if there are racial/insurance coverage disparities in health outcomes. Set goals and targets to improve health outcomes.

6. *Provide a list of existing partners with whom you address social determinants. During the grant period, work with the MDP Program to enhance your community connections, build referral partner networks and develop a multi-directional referral process.* See the American Hospital Association's Community Partnership Toolkit at: https://ifdhe.aha.org/system/files/media/file/2021/08/ifdhe_community_partnership_toolkit.pdf

OPTIONAL:

7. *Examine existing clinic protocols/processes* (HbA1c, possible eye exams and retinopathy screening, social determinants and supportive services referrals) to ensure they do not put any patient at a disadvantage. For example, this could include:
    - assure that all screeners and all referrals to supportive/preventive/educational services are given to all patients regardless of perception of whether they will be able to follow through. Identify reasons for not following through and work on potential solutions.
    - assure that all patients are flagged in the EHR for an annual follow-up.
    - assure that all communication materials are written at a sixth-grade level/meet health literacy guidelines/meet inclusivity guidelines.
    - establish a patient advisory council (PAC) to give input on policies, products, and protocols to promote equity. Include the PAC in external advisory activities.

Use of Funds:

- The grant funding provided by the MDP Program may **NOT** be used to buy food, equipment or to pay for patient copays.
- The grant funding can be used to offset staff time to plan/implement/evaluate the project. Funds can also be used for outreach, copying or printing costs, or purchasing applicable education material.

Project Updates: About every six weeks, we will have a short technical assistance call with funded sites to discuss progress and barriers.

Project Deliverables: Participating organizations will be asked to submit the following (we will provide report templates):

a) Due approximately January 2025: Interim Report (invoice $2,500)
    - Progress made on implementing your project plan.
    - Number of patients who have participated in the project so far.
    - Successes, challenges, and facilitators to date.

b) Due July 2025: 2nd Interim Report (invoice $2,500):
    - Progress made on implementing your project plan.
    - Number of patients who have participated in the project so far.
    - Any additional successes, challenges, and facilitators to date.

c) Due Jan 2026: Final Report (invoice $2,500):
    - Key successes, facilitators, challenges, and lessons learned during the project.
    - How the project will be sustained beyond the project period.
    - Number of patients with hypertension and/or cholesterol impacted by the project.
    - Baseline and post-project lab values or vitals.

Health Equity Diabetes APPLICATION
(due July 25, 2024)

NOTE: This project will run approximately August 2024 - January 2026.

For this project, clinics must collect a set of Z codes for priority adult patient populations defined as Rural/Frontier, American Indian (AI), Medicare/Medicaid, Veterans, Persons with disabilities, as well as patient with or at risk of diabetes.

1. Please indicate if you are able to identify these sub-groups within your patient population and are able to generate a report of the Z code findings for these groups:
   ☐Yes ☐ No

   Verify you will establish a validated SDOH screener and collect the following Z codes: **Z59.4** (Lack of adequate food and safe drinking water), **Z59.0** (housing subcategories: Z59.00 -59.3, Z59.89 and Z59.9) to address housing-related issues, and **Z59.82** (Transportation insecurity):
   ☐ Yes ☐ No

   Indicate if you can include one or both of these optional Z codes:

   1a. Problems Related to Living Alone **Z60.2** ☐ Yes ☐ No
   1b. Unemployment unspecified **Z56.0** ☐ Yes ☐ No

2. In addition to those patients with or at risk of diabetes, determine which two priority populations identified in question #1, your clinic can focus on:

   Rural/Frontier, American Indian (AI) Medicare/Medicaid, Veterans, Persons with disabilities

3. For the priority populations identified in question #2, can your clinic collect data on race and insurance coverage to determine if there are disparities in health outcomes?
   a. ☐ Yes for the overall priority population
   b. ☐ Yes for the priority population, categorized by whether they have diabetes or are at risk for diabetes
   c. ☐ No
   d. ☐ Don't know

Client Population

4. Please estimate the number of adult clients (18 years and older) in your organization's patient population in calendar year 2022.
5. Of the population in #4, estimate the <u>number</u> of adult clients (18 years and older) who have a current diagnosis of diabetes
6. Of the population in #4, estimate the <u>number</u> of adult clients (18 years and older) who have a current diagnosis of prediabetes.

Project Plan *Include responses to question #6 on a separate page.*

7. In at least two paragraphs, describe the overall approach your clinic will take for this health equity project:

a. What is your clinic currently doing related to addressing health equity or SDOH?
b. How will you ENHANCE what your clinic already is doing related to health equity or SDOH?
c. How will you track patients in your EHR who complete an SDOH screener and have an associated Z code?
d. What is your potential plan to enhance your work with community partners?
e. Are you able to establish a bi-directional or multi-directional referral process with community providers?

Budget

8. Please describe how the grant funding will be used. If it will cover a portion of FTE, include the hourly rate.

Project Leads/Staffing

9. List which staff will be involved with the project and what their role(s) will be during the planning and/or implementation.

10. If your organization receives a sub-award and the lead staff person on the project is unable to continue working on the project, do you have a transition plan to assign another person as the lead?
    - ☐ Yes
    - ☐ No (If no, you will need a transition option by the time the project starts)
    - ☐ Not sure (If not sure, please consider transition options)

Each organization must list the providers that will be seeing and discussing positive SDOH screener questions with patients. We require that each provider review this funding opportunity and sign the attached agreement below acknowledging their participation.

Applicant Contact Information

Project lead at your organization: Position:
e-mail address: work telephone number:
Organization name:
Organization's mailing address (please include a street address, city, zip):

Organization's Tax ID:

Provider #1 Signature

Provider #2 Signature

Provider #3 Signature

* Add any additional provider signatures below as needed

Thank you for your time. Please return the completed application (one submission per organization) to Margaret Mullins, Social Determinants of Health Program, margaret.mullins@mt.gov, fax (406) 444-7465 BY 5:00 p.m. July 25, 2024 (must be in-hand). If you fax your application, please call Stephanie Hernandez at (406) 444-6677 to ensure we receive it.