Central Oregon Health Council

RHIP Diabetes Workgroup
Deschutes County Health Services—Stan Owen Room
2577 NE Courtney Drive, Bend

Agenda: June 9, 2016 from 9:00am-10:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 9:00-9:05 **Introductions—All**

2. 9:05-9:15 **Diabetes Workgroup w/ Clinical Focus—Rebeckah Berry**
   - **Defined focus of this workgroup moving forward**

3. 9:15-9:20 **Monthly Meeting Day/Time—Rebeckah Berry**
   - **Is the second Tuesday from 9-10am still the best time to meet?**

4. 9:20-9:55 **Regional Clinical Diabetes Focus: Improve Control of Type 2 Diabetes—All**
   - Decrease the percentage of OHP participants 18-75 years of age with diabetes who had HbA1c >9.0% from a baseline of 14.7% to 11% (Baseline: QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014).
   - Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (Baseline: NQF 0057 - Oregon State Performance Measure, 2014).

5. 9:55-10:00 **Action Items—All**
   - **Next steps**

Next Meeting: July 14 from 9-10am

Diabetes - Clinical (12)	Organization
Katie Ahern	OSU Extension Service
Megan Bielemeier	St. Charles Medical Group
Mary Deeter	La Pine Community Health Center
Joan Goodwin	Volunteers in Medicine
Shana Hodgson	PacificSource
Ken House	Mosaic Medical
Sharity Ludwig	Advantage Dental
Therese McIntyre	Mosaic Medical
Eden Miller	High Lakes Healthcare - Sisters
Kevin Miller	High Lakes Healthcare - Sisters
Albert Noyes	Mosaic Medical
Kelly Ornberg	St. Charles Health Systems

Diabetes

Goals

Clinical Goal(s): Improve control of type 2 diabetes

Decrease the percentage of OHP participants 18-75 years of age with diabetes who had HbA1c >9.0% from a baseline of 14.7% to 11% (QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014).

1. What initiatives/projects do you know of that are currently in place to assist with this indicator? Is the project regional, in one county, in one town?

Kelly Ornberg: outpatient counseling- we get several covered visits per year were we can work with OHP patients 1:1 to set goals and improve diabetes control. Tri-county and at each campus.
Kelly Ornberg: we offer our Comprehensive Diabetes Self-Management class in Bend, Redmond, and Prineville. OHP covers most of the cost of this class. We've shown a reduction in A1C of almost 2% after attending. This includes a 1:1 with the diabetes nurse and 1:1 with a dietitian, plus a year of follow up
Jules Moratti-Greene: Offering Cooking Matters with Diabetes Class: this is Chef lead and Diabetic
Albert Noyes: Central Oregon Nutrition Consultants in Bend is a Diabetes Education and Prevention program accredited through AADE.
Albert Noyes: St. Charles Medical Center Diabetes Program Bend & Redmond accredited through ADA.
Megan Bielemeier: Diabetes group classes at St. Charles Family Care (SCFC) Redmond and Bend clinics
Megan Bielemeier: Case management interventions
Megan Bielemeier: CCO QIMS
Sarah Worthington: Living Well with Diabetes Self-Management programs (tri-county)
Kevin & Eden Miller: DIME program ours that is not currently being implemented in any clinic

2. How are initiatives/projects mentioned above currently being measured?

Kelly Ornberg: We have documentation for both items listed above.
Jules Moratti-Greene: Currently we have not offered this program.
Megan Bielemeier: Individual patient tracking- HbA1c levels
Megan Bielemeier: Percent of OHP participants with Diabetes with HbA1c control
Sarah Worthington: Participation rates, surveys, and soon-to-be Acumentra project with further eval.
Kevin & Eden Miller: We query the patient with highest a1c every quarter for each provider, give them the list of names and have an appt within that quarter. We identify these patients are not at goal and at next appt therapy is augmented not just talked about.

3. Please indicate which individuals/organization(s) are involved in each initiative/project mentioned above.

Kelly Ornberg: Nutrition and Diabetes department and primary care physician.
Jules Moratti-Greene: HDFFA (Jules Greene, Jess Weiland, and Jane Sabin Davis)
Megan Bielemeier: Family care clinical team (providers, RNCC, behavioral health specialist)
Sarah Worthington: Deschutes County Health Services
Kevin & Eden Miller: High Lakes Healthcare in central Oregon Diabetes Nation and Evergreen Family

4. What do you feel is missing and needs to be focused on with this indicator (consider referring to the potential strategies in your chapter of the RHIP)?

Diabetes

Kelly Ornberg: Other diabetes programs have decreased some of the patients from our class. It would be good to know what programs are out there and how we can better align vs. compete for the same population. I think we have good opportunities improve our collaboration.
Albert Noyes: Mosaic Medical is working on AADE accreditation. More coordinated work between programs to join-efforts may translate into better delivery to shared patients.
Megan Bielemeier: Low referrals for diabetes self-management and prevention programs
Megan Bielemeier: Communication between care providers once referral placed
Kevin & Eden Miller: If you don't know who your out of control patients are except for random stumbling upon them how can you be proactive.

5. Which person(s) in your organization or other organizations do you feel need to be approached if we were to undertake this new RHIP strategy?

Jules Moratti-Greene: HDFFA (Katrina Vandis, Jess Weiland, Jules Greene)
Albert Noyes: Coordinators of group classes, and sharing of teaching resources. For example, get the word out among multiple health systems about group classes and peer-support events to boost attendance and participation.
Megan Bielemeier: Diabetes educators
Kevin & Eden Miller: PCP and the Patient also the clinic organization and E H R system to query the

Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (NQF 0057 - Oregon State Performance Measure, 2014).

1. What initiatives/projects do you know of that are currently in place to assist with this indicator? Is the project regional, in one county, in one town?

Kelly Ornberg: Megan the Registered Nurse Care Coordinator would be the best contact for this from a clinics perspective.
Jules Moratti-Greene: Cooking Matters Classes for Adults and Teens, Cooking Matters Classes with Diabetes, and Cooking there is English and Spanish version
Megan Bielemeier: CCO QIMS
Megan Bielemeier: Case management interventions
Kevin & Eden Miller: our DIME program measure this as well but it doesn't need to be that complex

2. How are initiatives/projects mentioned above currently being measured?

Jules Moratti-Greene: Currently we have not offered this program.
Kevin & Eden Miller: quarterly querying the data measuring all patients with a1c in last 6 mos those over 9 under 9 and less than 7 those without a1c in 6-9 mos time frame. Also encouraged point of care a1c measuring in the office through rapid kit or fingerstick in office a1c

3. Please indicate which individuals/organization(s) are involved in each initiative/project mentioned above.

Jules Moratti-Greene: HDFFA (Jules Greene and Jess Weiland , Jane Sabin Davis)
Megan Bielemeier: Family care clinical team (providers, RNCC, behavioral health specialist)
Kevin & Eden Miller: High Lakes Healthcare, Diabetes Nation, Evergreen Family medicine

Diabetes

4. What do you feel is missing and needs to be focused on with this indicator (consider referring to the potential strategies in your chapter of the RHIP)?

Jules Moratti-Greene: Stepping beyond Cooking Matters for Adults and offering Cooking Matters for the family, Cooking Matters for diabetes in the tri county state
Megan Bielemeier: Accurate data (i.e. identify diabetic patients, identify those who have no had an
Kevin & Eden Miller: pretty simple, find out who hasn't had a1c, get them in, and then also brining the a1c test to the providers office to get a rapid at the office greatly increases the value of the appt and

5. Which person(s) in your organization or other organizations do you feel need to be approached if we were to undertake this new RHIP strategy?

Kelly Ornberg: transportation? Getting patients with limited access a way to get to appointments.
Jules Moratti-Greene: HDFFA (Katrina Vandis, Jess Weiland, Jules Greene)
Kevin & Eden Miller: PCP, Nurse in the office gets a1c at the office visit if not done last 6 mos or >7 in

RHIP Workgroup Updates: May

Behavioral Health: Identification & Awareness

- This group meets the fourth Tuesday of every month from 9-10am and currently has 20 members.
- In May, the group agreed to provide technical assistance for the Mental Health Prevention & Promotion grant for Central Oregon. This grant will work to normalize the public's perception of accessing resources for depression, anxiety, suicidal ideation, and substance use. The group also reviewed the minimum standards required to be able to bill for behavioral health integration in primary care. In June, the group will develop the elements of workflow necessary to screen and properly code for SBIRT/CRAFFT within clinics.

Behavioral Health: Substance Use and Chronic Pain

- This group meets the third Wednesday of every month from 4-5pm and currently has 19 members.
- During the May meeting, the group discussed the differences between at Behavioral Health Consultant with addictions experience and the Peer Support Specialist or Recovery Mentor roles. The group reviewed the SUD resource list for providers. This document will be finalized and placed on the COHC website for reference, with updates provided every six months. In June, the group plans to develop a treatment algorithm to support primary care toward better addressing substance use. This group will also develop strategies to address the second and third health indicators in their section.

Cardiovascular Disease—Clinical

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- During the May meeting the group decided that their year one focus will be on blood pressure standardization along with patient education around proper blood pressure checks. In June, the group will discuss standardization in greater detail and plans to invite other clinics to the table for the discussion (i.e., High Lakes Health Care, BMC, Weeks Family Medicine, La Pine Community Health Center, Dr. Burkett, among others).

Diabetes—Clinical

- This group meets the second Thursday of every month from 9-10am and currently has 12 members.
- This group will meet for the first time on June 9 to focus solely on the clinical goal of improving control of type 2 diabetes.

Cardiovascular Disease & Diabetes—Prevention

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 25 members.
- In May both prevention groups met separately to prepare to combine their efforts moving forward. Both CVD & Diabetes believe that their prevention efforts align very well and the strategies and organizations that need to be at the table are the same in order to meet the prevention goals for these two areas. Diabetes is still developing a resource document that will eventually be shared with providers and throughout the community. Cardiovascular Disease discussed ideas of how to increase physical activity throughout Central Oregon.

RHIP Workgroup Updates: May

Oral Health

- This group meets the third Tuesday of every month from 11-12pm and currently has 19 members.
- The Oral Health workgroup has begun to 'assign' potential projects/actions to their work plan. They continue to scrub their Spectrum document to better refine the services, and projects currently in use in the Tri-county area. Advantage Dental presented on a Public Service Announcement that had been previously sunset. The group may be interested in dusting it off and revitalizing. In June, the group will receive training/education relative to the 'One Key Question' initiative. Mosaic will provide an overview of their model for the new Dental Hygienist they have hired.

Reproductive Health/Maternal Child Health

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- In May a presentation was given around AFIX (immunization program). A favorable report was given relative to capturing (coding) the 1st trimester visits outside of the global pregnancy benefit. Discussion continues on the Perinatal Care Continuum project, the group felt a bit more finessing of the proposal was necessary. Next month, the group will review data surrounding Adverse Childhood Experiences (ACEs).

Social Determinants of Health

- This group meets the third Friday of every month from 10-11am and currently has 27 members in kindergarten readiness and 26 members in housing.

Education & Health

- The group collectively identified strategic strategies that would increase School Readiness (as identified by the 5 Dimensions of Readiness) discussed in last months meeting. Current, in use, strategies were shared out with the rest of the team. The June meeting will have an in-depth presentation on our Region's Kindergarten Readiness data. The goal is to collectively prioritize a strategy or strategies the team wants to include in their work plan.

Housing

- In May, the workgroup discussed ways they could add value with out duplicating the work of other agencies and groups like the Homeless Leadership Coalition (HCL). The workgroup determined that they could focus their efforts on advocacy, policy, and resource development. The workgroup additionally decided to form a small task force to review the updated 10 Year Plan to End Homelessness (High Desert Home) strategies to identify specific activities they could take on.