Central Oregon Health Council

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

Agenda: August 10, 2017 from 9:00am-10:30am

Goals

Clinical Goal: Improve control of type 2 diabetes.

Prevention Goal: Decrease the proportion of adults and children at risk for developing type 2 diabetes.

Health Indicators by 2019	QIM Measure	State Measure	Healthy People 2020
1. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Baseline: Oregon BRFSS 2010-13).			√
2. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively, to 13% and 14%, respectively (Baseline: Oregon Healthy Teens, 2013).			√
3. 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).	√		√
4. 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. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Baseline: Oregon State Core Performance Measure, MBRFSS 2014).		√	√

1. 9:00-9:05 **Introductions—All**

2. 9:05-10:10 **Selecting the First A3 Experiment—All**
   Aim: 95% of all Central Oregonians with Type 2 Diabetes will have an HbA1c of <9%

3. 10:10-10:20 **Point Of Care Testing in Central Oregon Primary Care Clinics—Shiela Stewart**

4. 10:20-10:30 **High Desert Food & Farm Alliance's Survey Results—Marielle Slater**

5. 10:30 **Action Items—All**
   - **Next steps**

Next Meeting: **September 14, 2017 from 9-10:30am**

Diabetes - Clinical (12)	Organization
Megan Bielemeier, MSN, BSN, RN, CCM	St. Charles Medical Group
Erin Fitzpatrick, PA-C	PacificSource
Patty Kuratek, RN, MSN, CDE	La Pine Community Health Center
Therese McIntyre	Mosaic Medical
Eden Miller, DO	High Lakes Healthcare - Sisters
Kevin Miller, DO	High Lakes Healthcare - Sisters
Albert Noyes, PharmD, CDE, BC-ADM	Mosaic Medical
Kelly Ornberg, RD, LD	St. Charles Health Systems
Marielle Slater, PhD	High Desert Food & Farm Alliance
Shiela Stewart, RN, BSN	Central Oregon IPA
Crystal Sully, BSN, RN	Deschutes County Health Services
Sarah Worthington, MPH, RD	Deschutes County Health Services

Diabetes Clinical Box 5 Survey Results

AIM: 95% OF CENTRAL OREGONIANS WITH TYPE 2 DIABETES WILL HAVE AN HBA1C OF <9%

This survey revealed clear alignment of priorities among the Diabetes Clinical RHIP workgroup (11 out of 12 members responded to the survey). The following four "hows" & their corresponding "whats" were identified as the highest priority tactics for achieving the AIM:

HOWS	WHATS
Early involvement of Behavioral Health, Nutritionist & Diabetes Educator (whole team)	Decrease Co-morbidities
RHIP algorithm for type 2 diabetes management	Consensus/Standard of Care/Guidelines in Tx & Diagnosis
A1c awareness	Patient Understanding of Diagnosis & Education
Standardized testing	A1c Test Access

See following pages for detailed results and comments.

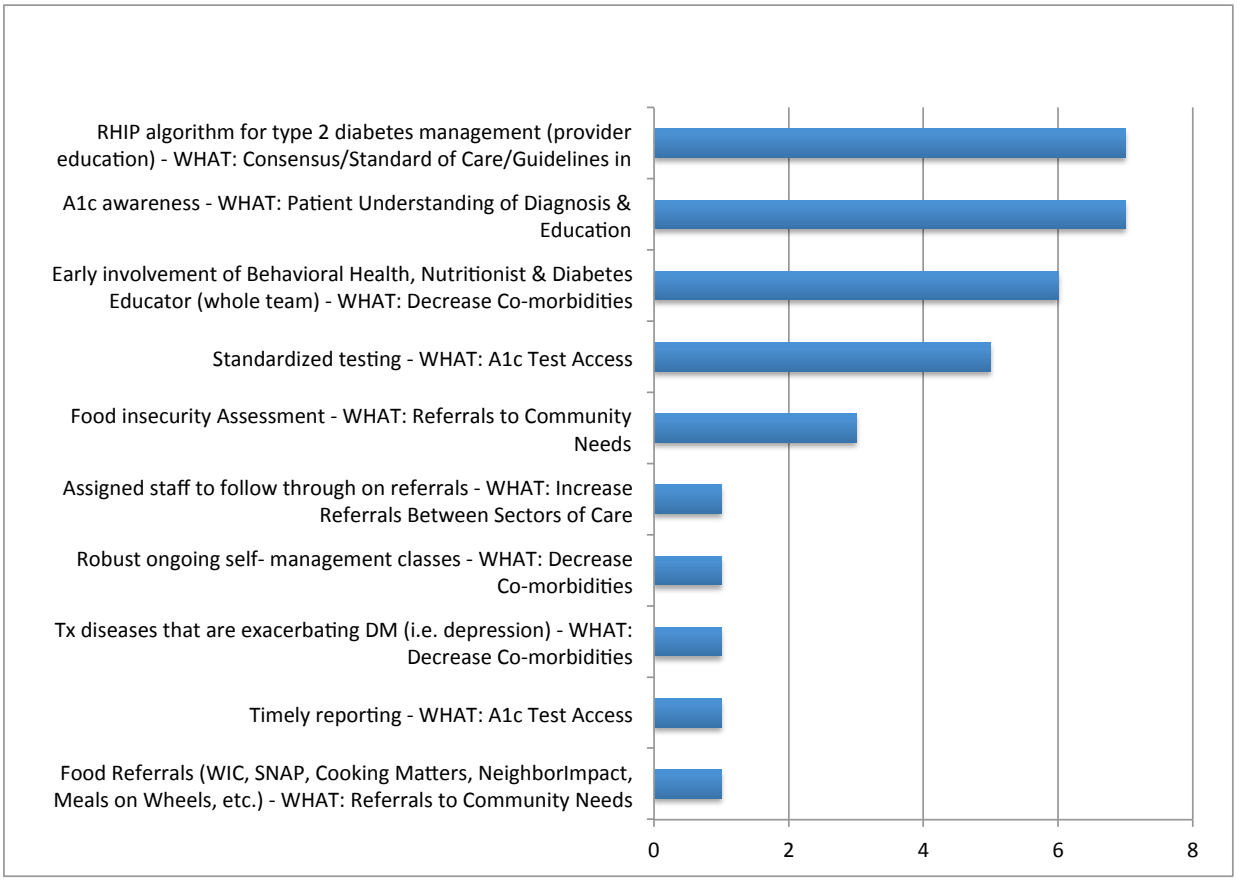
Question 1: Please rank the priority of each "how" as it relates to the AIM

Scores are aggregated to reflect group consensus.

Early involvement of Behavioral Health, Nutritionist & Diabetes Educator (whole team) - WHAT: Decrease Co-morbidities	**2.64**
Somewhat happening, but still very siloed *seems to fit into the team-based care approach identified to be effective by CDC*	
RHIP algorithm for type 2 diabetes management - WHAT: Consensus/Standard of Care/Guidelines in Tx & Diagnosis	**2.55**
This is a huge priority!! *Great feedback on the pre-diabetes algorithm; lets continue that momentum!* *the CDC already has recommendations : identify at risk individuals (eg: Food insecure, A1c testing), refer to food and exercise programs (eg: DPP and community programs such as CM), monitor with team-based approach (team-based care).*	
A1c awareness - WHAT: Patient Understanding of Diagnosis & Education	**2.55**
Standardized testing - WHAT: A1c Test Access	**2.55**
like this as another screen to identify at risk individuals *Many clinics that are not equipped with POC testing will benefit from this!*	
Nutrition opportunities - WHAT: Patient Understanding of Diagnosis & Education	**2.45**
Increase alternative visits (telemedicine, home visits, etc.) - WHAT: Increase Access to Resources in Rural Settings	**2.36**
Timely reporting - WHAT: A1c Test Access	**2.36**
Tx diseases that are exacerbating DM (i.e. depression) - WHAT: Decrease Co-morbidities	**2.36**
Clinical: Behavioral health engagement services - WHAT: Support/Encourage Non-Engaged Patients	**2.09**
Currently happening at St. Charles	
Social norming/ media messaging - WHAT: Motivate Patients	**2.00**
Assigned staff to follow through on referrals - WHAT: Increase Referrals Between Sectors of Care	**2.00**
part of team-based approach shown to be effective (CDC)	
Awareness of benefits of resources available to patients (insurance, programs, etc.) - WHAT: Minimize Overall Cost to the patient	**1.91**
I think people are aware of their options but still can't access needed therapy despite all these programs. That is the root problem as I see it.	
Food insecurity Assessment - WHAT: Referrals to Community Needs	**1.91**
HDFFA is currently doing an assessment *High priority, but this will happen by the start of 2018 through the Healthy Communities Project* *would be great to identify at risk individuals through SDoH screening-as a QIM measure*	
Ask patients - WHAT: Motivate Patients	**1.82**
Ask what they need and what barriers they have	
Robust ongoing self- management classes - WHAT: Decrease Co-morbidities	**1.82**
The Living Well SMP classes are ramping up with plans for a comprehensive yearly calendar and training. Both Mosaic and St. Charles have committed CHW hours for leader training and workshop facilitation that will enable a more robust schedule. Still a deficit of Spanish speaking leaders. *Training all St. Charles CHE's to teach these classes at the clinics* *DPP is already happening, again better promotion and perhaps including as part of algorithm may help*	
Annual wellness clinics - WHAT: Increase Access to Resources in Rural Settings	**1.73**
Seems like this, although positive and worthwhile, doesn't reach a large volume of patients-small impact on the RHIP metrics *Not sure how big of a bang we'll get for our buck*	
Exercise Referrals (Walk with Ease, Parks & Rec, Silver Sneakers, Etc.) - WHAT: Referrals to Community Needs	**1.73**
Currently happening, but could be more robust *I think this can also be part of our new algorithm and should be fairly simple to educate providers/staff to do.*	
Food Referrals (WIC, SNAP, Cooking Matters, NeighborImpact, Meals on Wheels) - WHAT: Referrals to Community Needs	**1.73**
This is not being done consistently throughout the region and there is no regional calendar that is up to date for providers to access. *Currently happening, but could be more robust* *While these programs are already in effect, I do believe we can improve promoting the classes and perhaps include this into our next algorithm.*	
Flex Funds (Medicaid) - WHAT: Referrals to Community Needs	**1.73**
Not utilized as much as it could be *Most care navigators are familiar with this program, it does have it's own issues that are beyond this groups control*	
Identify programs that are free or minimal cost to patient - WHAT: Minimize Overall Cost to the patient	**1.73**
Pharmacy access - WHAT: Increase Access to Resources in Rural Settings	**1.73**
Pharmacists in St. Charles clinics	
Nutrition opportunities - WHAT: Motivate Patients	**1.64**
Ensure comorbidities are assessed - WHAT: Decrease Co-morbidities	**1.64**
Patients unaware of ins. availability and options - WHAT: Access to Insurance	**1.45**
pacificsource announcement -will efficacy of intervention be measured by pacificsource?	
OHP re-enrollment awareness & process - WHAT: Access to Insurance	**1.00**
Big problem, but not sure it's as valuable for the clinical RHIP group to work on *pacificsource announcement -will efficacy of intervention be measured by pacificsource?*	

Question 2: Please select the top 3 items you believe are of the highest priority to achieve the AIM

This graph represents all votes cast.



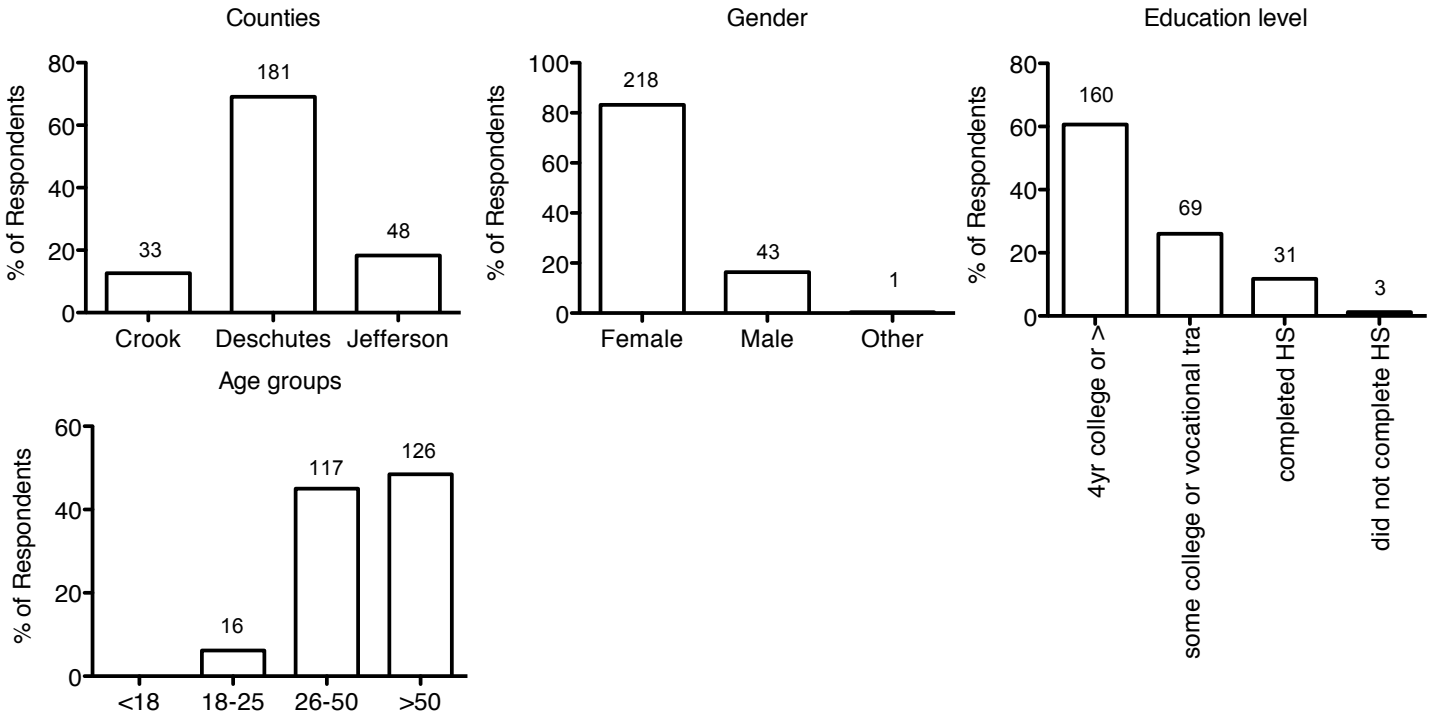
No other "hows" received any score on this question.

The High Desert Food and Farm Alliance (HDFFA), with funding from the Central Oregon Health Council, is performing an assessment of nutritional programs in Central Oregon. To define the current state as well as the needs and opportunities around nutritional programs we have performed surveys, interviews, and focus groups with the following 3 target groups:
1.Central Oregonians that potentially use nutritional programs.
2.Providers or individuals who refer Central Oregonians to nutritional programs.
3.Implementers of programs in Central Oregon.

This document summarizes specific findings from the survey targeting Central Oregonians. Although we are only beginning the analyses from our studies we wanted to share these preliminary findings to potentially inform how to address the needs of food insecure individuals with regard to health and nutrition.

We designed a survey to find out if Central Oregonians were aware of or had participated in nutritional programs, if they were interested in joining them and what they wanted to learn if they joined a program. Both web and paper surveys were distributed.

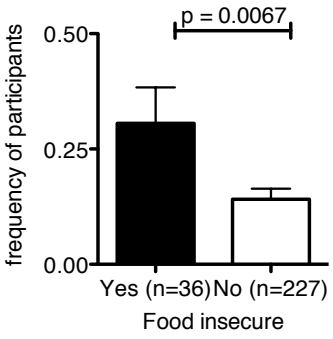
The following represents some of the demographics of the 281 respondents.



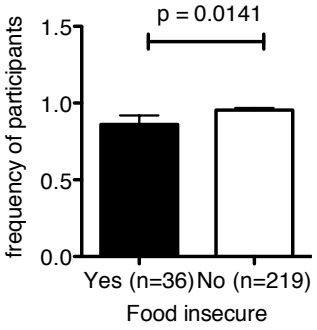
In order to better assess the needs of food insecure residents we divided respondents based on a USDA food insecurity question we included in the survey: "Within the last 12 months, did the food you bought not last and you didn't have enough money to get more?"

13.5% of survey respondents answered "Yes" to this question and were therefore considered food insecure. The following analysis represents specific comparisons from food insecure versus food secure survey respondents.

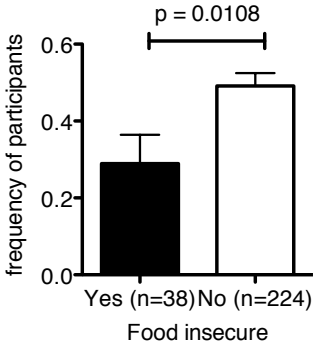
Individuals who are food insecure are 2.2X more likely to be diagnosed with diabetes and/or CVD



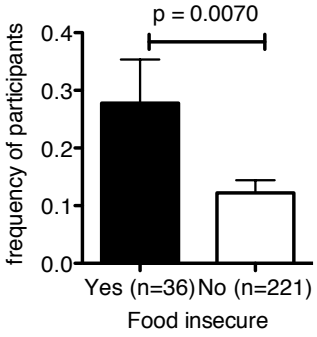
Individuals who are food insecure are 3X more likely to not have health insurance



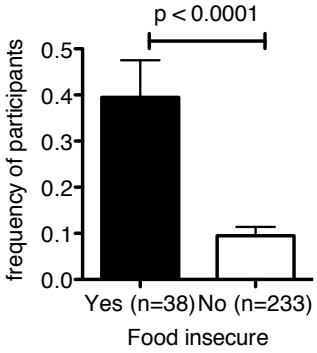
Individuals who are food insecure are almost half as likely to eat veggies and fruits 3 times per day



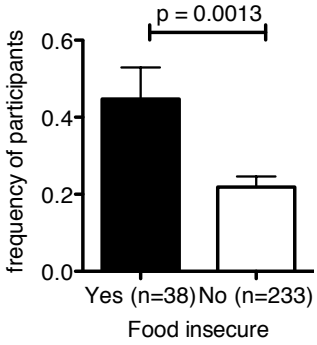
Individuals who are food insecure are 2.3X more likely to have been referred to a nutritional program



Individuals who are food insecure are 4.2X more likely to have participated in WIC



Individuals who are food insecure are 2X more likely to be highly interested in knowing more about nutritional programs



n represents the number of respondents
p represents the probability value and is used to quantify the idea of statistical significance of evidence. The smaller the number, the less like the result represents a chance event.

Please feel free to contact Marielle Slater at marielleslater@gmail.com if you have any questions.

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RHIP Workgroup Updates: July

Behavioral Health: Identification & Awareness (Support: Rebeckah Berry & Nikki Lemmon)

- This group meets the fourth Tuesday of every month from 8:15-9:30am and currently has 21 members.
- In July, the group continued their A3 process with the aim of identifying and engaging 100% of individuals in Central Oregon that have a behavioral health need, and ensure an effective and timely response. The group is finalizing their current state and target state measurements and will finalize these in August. Dr. Franz and invited guests also shared an update on the collaborative care psychiatric pilots occurring with children at COPA and Mosaic.

Behavioral Health: Substance Use and Chronic Pain (Support: Rebeckah Berry & Rick Treleaven)

- This group meets the third Wednesday of every month from 3:45-5pm and currently has 27 members.
- In July, the group continued the work of evaluating how to measure their metrics for the Substance Use & Chronic Pain area of focus. The group also began their first A3 which will focus on making SUD engagement services available at hospitals (including E.D.) and primary care clinics.

Cardiovascular Disease—Clinical (Support: Rebeckah Berry & Shiela Stewart)

- This group meets the fourth Tuesday of every month from 3:45-5pm and currently has 10 members.
- In July, this workgroup reviewed the current successes and challenges around the smoking prevalence incentive measure. The group also discussed the future evolution of this incentive measure with the state Metrics and Scoring Committee Chair.

Diabetes—Clinical (Support: Rebeckah Berry & Shiela Stewart)

- This group meets the second Thursday of every month from 9-10:30am and currently has 12 members.
- In July, this workgroup continued their A3 process with the aim of 95% of Central Oregonians with Type 2 Diabetes will have an HbA1c of < 9%. In August this group will select their first experiment to "test" in hopes of working toward their aim.

CVD & Diabetes: Prevention (Support: MaCayla Arsenault, Sarah Worthington, & Steve Strang)

- This group meets the fourth Tuesday of every month from 3:30-5pm and currently has 26 members.
- Leaders of the workgroup decided reschedule this meeting during August due to scheduling conflicts.

RHIP Workgroup Updates: July

Oral Health (Support: Donna Mills & Mary Ann Wren)

- This group meets the third Tuesday of every month from 11-12pm and currently has 23 members.
- The Oral Health Workgroup did not meet in July.

Reproductive Health/Maternal Child Health (Support: Donna Mills & Muriel DeLaVergne-Brown)

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- The Reproductive Maternal/Child Health Workgroup did not meet in July.

Social Determinants of Health

- This group meets the third Friday of every month from 10:30-11:30am and currently has 26 members in Kindergarten Readiness and 37 members in Housing.

Education & Health (Support: Donna Mills & Desiree Margo)

- The Kindergarten Readiness workgroup did not meet in July.

Housing (Support: Bruce Abernethy & MaCayla Arsenault)

- In July, this workgroup met to discuss whether or not to proceed with a Housing First pilot project and prepared to present their A3 at Operations Council on August 4, 2017.