2016-2019 Central Oregon Regional Health Improvement Plan Work Plan

RHIP Priority: Diabetes (Clinical Focus)

RHIP Goal: Improve control of type 2 diabetes

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
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).	**Develop targeted strategies to improve Diabetic Medication Adherence (i.e.: refrigeration, MedMinders, etc.)**	1. Embedded Clinical Pharmacist who identifies and works with patients needing assistance with medication adherence at St. Charles and Mosaic locations. 2. Implement Collaborative Drug Therapy Management protocols between clinical PharmD and PCP's to allow the clinical pharmacist prescriptive authority for diabetes management, insulin orders, testing supplies, routine lab work, etc. 3. RNCC/CHE help with MedMinders, etc. at St. Charles Family Care locations. Volunteers in Medicine is looking at this structure. 4. Patient, provider, and pharmacist education that refrigeration is not an issue for the injectable agents many of them last up to 60 days outside the fridge, increasing medication compliance can be accomplished by getting combo meds approved less pill burden as well as long-acting GLP 1 that are once weekly. 5. Care managers remind patients that many diabetic meds can be taken at any time of the day even	1. Ongoing 2. Mosaic will pilot this effort beginning August 2016. 3. SCHS is ongoing and VIM to consider this structure by February 2017. 4. To begin by January 2017. 5. To begin by January 2017. 6. Currently happening but could be increased. 7. By July 2017. 8. Begin March 2017.

		if it is forgotten in the a.m. (exception is some types of insulin). Offer community-wide education for providers, pharmacists, and patients. 6. Diabetes medications discussed in 1:1 outpatient diabetes nurses in SCHS. Involve clinic pharmacists, RNCC's, and CDE nurses to cover diabetes medications during appointments with teach back instruction. 7. Create an online forum for patients in Central Oregon to ask questions. Explore this option for our region. 8. Develop a common messaging that can be shared across disciplines, such as dental, ophthalmology, and podiatry.	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
St. Charles, Mosaic Medical, Volunteers in Medicine, La Pine Community Health Center, PacificSource, COHC, and COIPA.	1. Percentage of patients on diabetes medication receiving medication adherence education. 2. Assess if the collaborative drug therapy management workflow is successful and duplicate. 3. Assess if the RNCC/CHE model is successful and duplicate. 4. Number of clinics and pharmacies throughout the region receiving highlights on requirements to store diabetes medication. 5. Same as above. 6. Percentage of patients with diabetes receiving 1:1 education. 7. Baseline research to assess	1.	

	options for a community forum for patients with diabetes. 8. Number of providers organizations common messaging is shared with.		
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Increase referrals to diabetes self-management and prevention programs.**	1. HealthInsight Special Innovation Project: Integrating Evidence-Based Self-Management Programs into Patient Care. DCHS, SCHS, LPCHC, Mosaic, and PSCS. 2. SCHS is developing a choice for hospitalists to select that they would like a referral to the outpatient diabetes program. Goal is to get the patient set up with a referral/appointment before discharging from the hospital. This process will be improved with the switch to the new EMR EPIC. 3. Primary Care clinics and other providers (dental, ophthalmology, and podiatry) throughout the region partner to refer patients to regional diabetes prevention programs at SCHS, through the county health departments, and other diabetes prevention/intervention programs. 4. The workgroup will develop four standardized pathways for A1c ranges: (1) 5.7-6.4, (2) 6.5-7, (3) 7-9, and (4) 9 and above. These pathways will be shared with the provider community.	1. Now through September 1, 2017 2. Began July 2016 but will be improved in the next 18 months. 3. By February 2017. 4. August 2016-December 2016.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	

Deschutes County Health Services, St. Charles, Mosaic Medical, La Pine Community Health Center, Primary Care Providers, Dental Providers, Eye Exam Providers, Podiatry Providers, PacificSource, and COHC.	1. By September 2017, successfully implement a closed loop referral between Living Well and DPP programs and primary doctors at SCHS, Mosaic, and LPCHC, as well as dental, ophthalmology, and podiatry. 2. Percentage of SCHS doctors referring to outpatient diabetes programs. 3. Percentage of clinics referring to diabetes programs within the community. 4. Number of clinics receiving the standardized pathways.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Improve medication adherence among patients with diabetes.**	1. Embedded Clinical Pharmacist who identifies and works with patients needing assistance with medication adherence within SCHS and Mosaic. 2. RNCC/CHE help with MedMinders, etc. within SCHS. VIM will explore this model for their organization. 3. SCHS will pilot group visits within clinic settings to allow for one time opportunity to see many specialists to manage diabetes. 4. Implement culturally appropriate common messaging that can be used across disciplines, such as, dental, ophthalmology, and podiatry. 5. Support and encourage motivational interviewing opportunities for providers throughout the region. 6. Develop and share community-	1. Ongoing 2. SCHS is ongoing and VIM to consider this structure by February 2017. 3. Pilot to begin by January 2017. 4. Begin March 2017. 5. Begin January 2017. 6. Begin June 2017.

		wide messaging resources to support increased engagement and education for individuals with pre- and type II diabetes.	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
St. Charles, Mosaic Medical, Volunteers in Medicine, La Pine Community Health Center, PacificSource, COHC, and COIPA.	1. Percentage of patients on diabetes medication receiving medication adherence education from a credentialed educator or clinical pharmacist. 2. Assess if this model is successful and duplicate. 3. Assess successes and barriers of pilot and opportunity to duplicate. 4. Number of providers organizations common messaging is shared with. 5. Number of attendees participating in motivational interviewing workshops. 6. Number of community organizations, work places, and clinics that receive educational materials.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Increase the use of case management interventions for patients with diabetes with CCO support for clinic innovations**	1. Work with PSCS to offer a monthly complex member report to PCPs. This will help to identify patients at high risk with a diagnosis of diabetes. 2. Develop a follow-up process where a "trouble shooter" case manager contacts patient and finds out what the barriers are for their care (copay cost, remembering the meds, testing, diet, etc.).	1. By January 2017. 2. By March 2017. 3. By January 2017. 4. By January 2017. 5. By March 2017.

		3. SCHS to pilot group visits within clinics. 4. SCHS will work with case management in the inpatient setting to refer to diabetes programs. 5. Explore opportunities to refer to additional support systems, such at dental, eye exams, and podiatry.	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
St. Charles, Mosaic Medical, La Pine Community Health Center, PacificSource, Advantage Dental, COHC, and COIPA.	1. Number of PCPs receiving monthly complex member reports. 2. Number of clinics following up on complex member reports. 3. Percentage of diabetes program referrals from inpatient settings. 4. Number of referrals from case management to dental, eye, and podiatry preventative exams.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Increase provider and community referrals to the Spanish language Tomando Control chronic disease self-management program.**	**1.** HealthInsight Special Innovation Project: Integrating Evidence-Based Self-Management Programs into Patient Care. Closed-loop referral process with county health departments, SCHS, Mosaic Medical, La Pine Community Health Center, and PSCS. 2. Develop pamphlets or posters for provider rooms and to distribute at churches, community centers, and other community locations.	1. Now through September 1, 2017 2. By June 2017.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Deschutes County Health Services, St. Charles, Mosaic Medical,	1. By September 2017, successfully implement a closed loop referral	1.	

Volunteers in Medicine, La Pine Community Health Center, PacificSource, COHC, and COIPA.	between Living Well and DPP programs and primary doctors at SCHS, Mosaic, and LPCHC. 2. Number of diabetes participants referred from posters or pamphlets.		
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Engage health systems to implement EHR referrals to diabetes self-management and prevention programs.**	1. SCHS is transitioning to Epic HER. Mosaic and LPCHC are currently creating these referrals options.	1. By January 2018
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
St. Charles, Mosaic Medical, La Pine Community Health Center, PacificSource, and COHC.	1. Mosaic, LPCHC, and SCHS implemented an EHR referral process for diabetes and Living Well programs.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Same as above.	**Improve provider and community awareness of diabetes self-management programs.**	**1.** HealthInsight Innovation Project: Integrating Evidence-Based Self-Management Programs into Patient Care. 2. Research offering classes in community centers and churches where individuals can easily participate. 3. Primary Care organizations and community partners (dental, ophthalmology, podiatry, prevention and self-management programs) partner to provide free screenings to capture community members who may have diabetes but have not established care. 4. The workgroup will develop four standardized pathways for A1c ranges: (1) 5.7-6.4, (2) 6.5-7, (3) 7-9, and (4) 9 and above. These	1. Now through September 1, 2017 2. By December 2016 3. By July 2018. 4. August 2016-December 2016.

		pathways will be shared with the provider community.	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
St. Charles, Mosaic Medical, Volunteers in Medicine, La Pine Community Health Center, PacificSource, COHC, and COIPA.	1. Percentage of referrals to diabetes program coming from providers or clinics, including dental providers. 2. Assess opportunities for venue or locations of programs and ease of access and participation by clients. 3. Number of screenings completed. 4. Number of clinics receiving the standardized pathways.	1.	

Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
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).	**Improve coordination between medical and dental providers to offer tools and education needed around the correlation between oral health and diabetes (i.e.: Dental Medical Integration (DMI) Project).**	1. Develop and share a standardized care pathway for individuals with pre- and diabetes within Central Oregon. This pathway will include accessing oral health as well as medical health. 2. SCHS will pilot group visits within clinic settings to allow for one time opportunity to see many specialists to manage diabetes. 3. Develop a process for referring from oral health to medical and visa versa. 4. The workgroup will develop four standardized pathways for A1c ranges: (1) 5.7-6.4, (2) 6.5-7, (3) 7-9, and (4) 9 and above. These pathways will be shared with the provider community.	1. By July 2017. 2. By January 2017. 3. By July 2017. 4. August 2016-December 2016.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Advantage Dental, St. Charles,	1. Number of organizations that	1.	

Mosaic Medical, Volunteers in Medicine, La Pine Community Health Center, PacificSource, COHC, and COIPA.	standardized pathways are shared with. 2. Assess successes and barriers of pilot and opportunity to duplicate. 3. Advantage Dental and Mosaic will pilot referral process. 4. Number of clinics receiving the standardized pathways.	