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

Agenda: January 12, 2017 from 9:00am-10:30am

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

1. 9:00-9:05 Introductions—All

2. 9:05-9:50 Pre-Diabetes Provider Education Rollout
   • Intro/Position Letter Draft
   • Patient Education for Pre-Diabetes Drafts
   • Community Resources Booklet Draft
   • Insurance Coverage Options at Grand Rounds?

3. 9:50-10:00 Plan to Roll-Out Resources (Grand Rounds on March 3, 2017)—All
   • Only ONE More Meeting Before Grand Rounds!

4. 10:00-10:05 Is Anyone Missing From Our Workgroup?—All
   • Organizations, Specific Individuals, or Roles

5. 10:05-10:25 Tracking Dissemination & Referrals—All
   • Potential Tracking Opportunities with 211info—Emily Berndt
   • Other Opportunities—All

6. 10:25-10:30 Action Items—All
   • Next steps

Next Meeting: February 9, 2017 from 9-10am
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katie Ahern</td>
<td>OSU Extension Service</td>
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<tr>
<td>Megan Bielemeier</td>
<td>St. Charles Medical Group</td>
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<td>Shiela Stewart</td>
<td>Central Oregon IPA</td>
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<tr>
<td>Sarah Worthington</td>
<td>Deschutes County Health Services</td>
</tr>
</tbody>
</table>
Dear Central Oregon Provider,

Diabetes is a common but serious medical condition with severe health implications over a person’s lifespan. Currently there is no reliable cure for diabetes, and unfortunately the incidence of this disease is climbing\(^1\). While management of diabetes is a key priority to prevent health complications in those diagnosed, the only way to reverse the rising tide of diabetes in our communities is to focus on preventing onset of the disease in the first place. This means focusing on patients with pre-diabetes.

The Centers for Disease Control estimates that pre-diabetes is currently one of the most prevalent medical conditions in the US. Epidemiology studies suggest that among adults 20 years of age or older, one in three persons have pre-diabetes.\(^2\) Among adults age 65 years or older, the prevalence increases to one out of every 2 persons, or half of all adults over 65. Based on a combined population within Deschutes, Jefferson, and Crook counties, this amounts to around 80,000 adults with pre-diabetes in our region. Diabetes prevalence has been increasing in the US and Oregon. In 2013, diabetes affected an estimated 287,000 adults in Oregon.\(^3\) The CDC estimates that about 37% of adults with pre-diabetes are not aware they have it. That translates to about 1.1 million adults in Oregon living with pre-diabetes.\(^4\) The age-adjusted mortality rate for diabetes in the US was 21.2/100,000 population.\(^5\) Jefferson County had a higher diabetes mortality rate than did Oregon or the US (Figure 24). Males in Oregon and Deschutes County had higher mortality rates due to diabetes than females in those regions (Figure 24).

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2 Ibid, pp. 3.
4 Ibid, pp. 3
Fortunately not all cases of pre-diabetes progress to type 2 diabetes. Abundant evidence supports the success of early interventions for preventing the progression of pre-diabetes to type 2 diabetes. By coordinating our efforts and attention on prevention, generational change in the serious impact of type 2 diabetes can be accomplished. While healthcare professionals work to treat and support patients with the disease, the best way to reverse its impact on future generations is to bring appropriate screening and treatment of pre-diabetes to the forefront. Successful intervention will require contributions from multiple community partners, clinicians, patients, families, employers, retailers, legislators and others.

The Regional Health Improvement Plan’s (RHIP) Clinical Diabetes workgroup has developed a primary care pathway to assist providers with screening, treating and referring patients with pre-diabetes. We are sharing this pathway, along with other supporting resources, because we believe screening, effective treatment in the primary care setting and, when appropriate, referral to community learning opportunities are essential to creating a healthy community. We are asking you to consider implementing a consistent and thorough pathway for pre-diabetes within your primary care clinic, while ensuring the process can accommodate your clinic’s circumstances and needs.

We hope that these resources serve as a foundation of support for screening and assertively educating about pre-diabetes. Should you have questions, please connect with our workgroup through: rebeckah.berry@cohealthcouncil.org.

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Thank you for your involvement and support,

The RHIP Clinical Diabetes Workgroup

<table>
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<td>Marielle Gold</td>
<td>High Desert Food &amp; Farm Alliance</td>
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PRE-DIABETES ALGORITHM: CENTRAL OREGON

RISK FACTORS
- BMI >25 (BMI >23 in Asian Americans)
- 1st degree relative with diabetes
- HDL cholesterol level >35 mg/dL
- Hypertension / history of CVD
- Physical inactivity
- High risk race / ethnicity (e.g. African American, Latino, Native American, Asian American, Pacific Islander)
- Women with polycystic ovary syndrome
- Women who delivered a baby weighing >9lbs or were diagnosed with gestational diabetes
- Other clinical conditions associated with insulin resistance (severe obesity, acanthosis nigricans)

ORIGINATING VISIT
- Non-PCP screening (dentist, specialist, community event)
- Referred to PCP
- PCP visit
- Fasting bloodwork (A1C or FBS)

DIAGNOSIS
- A1C of 5.7 - 6.4 (FBS 100-125)
- PCP Diagnosis of Pre-Diabetes
- Assess comorbidities
- Tobacco use
- Obesity
- Sedentary lifestyle
- CKD-eGFR
- CVD
- Congestive heart failure
- Retinopathy
- Peripheral vascular disease
- Stroke
- Sleep apnea
- Neuropathy
- Depression or chronic disease-related depression
- Anxiety
- Poor dental hygiene or dental disease
- Refer to external resources as appropriate

PCP FOLLOW-UPS
- Schedule follow-up: Check A1C in 3 months
- Follow-up appointment
- Schedule appropriate follow-up based on results

TREATMENT PLAN
- Discuss diagnosis, develop treatment plan, and refer to care coordination (RNCC, CHW, PharmD)

Care Coordination Discussion & Education
- Refer to community resources (exercise groups, cooking classes, WIC, etc.)
- Refer to Registered Dietitian
- If a prescription is involved, refer to Pharmacist. Request: "New diagnosis, please educate on prevention."
- Refer to Clinical Pharmacist or Medication Therapy Management (MTM). Provide basic diabetes prevention info.
- Assess for Social Determinants of Health:
  - Food insecurity
  - Ability to pay bills
  - Safe housing
  - Social support
  - Language/literacy
  - Culture
  - Transportation to appointments
- Refer to Diabetes Prevention Program (DPP) based on patient readiness.

REFERRALS
DO YOU HAVE
PREDIABETES?
Prediabetes Risk Test

1. How old are you?
   - Less than 40 years (0 points)
   - 40—49 years (1 point)
   - 50—59 years (2 points)
   - 60 years or older (3 points)

2. Are you a man or a woman?
   - Man (1 point)
   - Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?
   - Yes (1 point)
   - No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?
   - Yes (1 point)
   - No (0 points)

5. Have you ever been diagnosed with high blood pressure?
   - Yes (1 point)
   - No (0 points)

6. Are you physically active?
   - Yes (0 points)
   - No (1 point)

7. What is your weight status?
   (see chart at right)

Write your score in the box.

Add up your score.

If you scored 5 or higher:
You're likely to have prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latinos, American Indians, Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).

For more information, visit us at DoIHavePrediabetes.org

Lower Your Risk
Here's the good news: it is possible with small steps to reverse prediabetes - and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit DoIHavePrediabetes.org for more information on how to make small lifestyle changes to help lower your risk.

Height

Weight (lbs.)

4' 10” 119-142 143-190 191+
4' 11” 124-147 148-197 198+
5' 0” 128-152 153-203 204+
5' 1” 132-157 158-210 211+
5' 2” 136-163 164-217 218+
5' 3” 141-168 169-224 225+
5' 4” 145-173 174-231 232+
5' 5” 150-179 180-239 240+
5' 6” 155-185 186-246 247+
5' 7” 159-190 191-254 255+
5' 8” 164-196 197-261 262+
5' 9” 169-202 203-269 270+
5' 10” 174-208 209-277 278+
5' 11” 179-214 215-285 286+
6' 0” 184-220 221-293 294+
6' 1” 189-226 227-301 302+
6' 2” 194-232 233-310 311+
6' 3” 200-239 240-318 319+
6' 4” 205-245 246-327 328+
(1 Point) (2 Points) (3 Points)

You weigh less than the amount in the left column (0 points)

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009.
Original algorithm was validated without gestational diabetes as part of the model.
• Prediabetes means blood sugar levels are high but not high enough to be called diabetes.

• People with prediabetes don’t usually have any symptoms.

• About 79 million Americans over the age of 20 have prediabetes. That’s about one in every three people!

• Women who have had diabetes during pregnancy are at increased risk for developing diabetes in the 10 to 20 years after pregnancy.

• Diabetes is a leading cause of heart disease, stroke, blindness, kidney disease and nerve damage.

Take the RISK TEST inside this brochure to find out if you are at risk for type 2 diabetes or prediabetes. Prediabetes is a serious health condition that can lead to diabetes, heart disease, and stroke. Most people with prediabetes don’t know that they have the condition.

Talk to your provider today about ways you can prevent diabetes!

This brochure developed by the Central Oregon Health Council Regional Health Improvement Plan diabetes prevention and control team.

v 1.0 · 11/16
Diabetes Risk Test

If you answer YES to any item write the number in the POINTS column. Add your points and write the number in the box next to TOTAL.

<table>
<thead>
<tr>
<th>DIABETES RISK TEST</th>
<th>YES</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I had a baby weighing more than nine pounds at birth OR I have had diabetes during pregnancy.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I have a sister or a brother with diabetes.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I have a parent with diabetes.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I am overweight. (See the At-Risk Weight Chart on the right)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>I am younger than 65 years of age AND get little or no exercise in a typical day.</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>I am between 45 and 64 years of age.</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>I am 65 years of age or older.</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL POINTS**

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A score of nine or higher means you are at-risk for prediabetes or diabetes.

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**At-Risk Weight Chart**

If your weight is at or over the weight listed next to your height add 5 points on the chart.

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>4'10&quot;</td>
<td>129 lbs.</td>
</tr>
<tr>
<td>4'11&quot;</td>
<td>133 lbs.</td>
</tr>
<tr>
<td>5'0&quot;</td>
<td>138 lbs.</td>
</tr>
<tr>
<td>5'1&quot;</td>
<td>143 lbs.</td>
</tr>
<tr>
<td>5'2&quot;</td>
<td>147 lbs.</td>
</tr>
<tr>
<td>5'3&quot;</td>
<td>152 lbs.</td>
</tr>
<tr>
<td>5'4&quot;</td>
<td>157 lbs.</td>
</tr>
<tr>
<td>5'5&quot;</td>
<td>162 lbs.</td>
</tr>
<tr>
<td>5'6&quot;</td>
<td>167 lbs.</td>
</tr>
<tr>
<td>6'0&quot;</td>
<td>172 lbs.</td>
</tr>
<tr>
<td>6'1&quot;</td>
<td>177 lbs.</td>
</tr>
<tr>
<td>6'2&quot;</td>
<td>182 lbs.</td>
</tr>
<tr>
<td>6'3&quot;</td>
<td>188 lbs.</td>
</tr>
<tr>
<td>6'4&quot;</td>
<td>193 lbs.</td>
</tr>
<tr>
<td>6'5&quot;</td>
<td>199 lbs.</td>
</tr>
<tr>
<td>6'6&quot;</td>
<td>204 lbs.</td>
</tr>
<tr>
<td>6'7&quot;</td>
<td>210 lbs.</td>
</tr>
<tr>
<td>6'8&quot;</td>
<td>216 lbs.</td>
</tr>
</tbody>
</table>

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**The good news is that lifestyle changes can prevent or delay diabetes in more than half of people with prediabetes.**

**Here are some ideas to get started!**

- Learn about healthy food choices and start to make diet changes
- Increase your physical activity
- Learn coping skills to keep eating healthy and stay active!

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**Was your score 9 or higher?**

A score of 9 or above does NOT mean you have diabetes but there are important steps you need to take next!

1. Schedule an appointment with your provider for a diabetes blood test.
2. Talk with you primary care team about ways to prevent diabetes.
3. Know there is good news if you have prediabetes!

Ask your care team about resources to help prevent diabetes today!
Meal Planning - Plate Method

The plate method is easy!

- Start with a 9” plate
- Fill 1/2 with non-starchy vegetables
- Fill 1/4 with a protein
- Fill 1/4 with a carbohydrate

Portion sizes are key!

= protein portion size
= carbohydrate portion size

Drink water with every meal!

See the back for more portion size information
Meal Planning - Sample Servings and Portion Sizes

Planning meals when you are trying to lose weight doesn’t have to be hard or include special “diet” food. Balanced meals with the right portion sizes is one of the best ways to help lose and control your weight. Changing how and what you eat will help you take the weight off for good. Your RN Care Coordinator can help you plan meals that fit your diet and life.

**Sample Servings**

**Carbohydrates**
Choose any 3 servings at each meal.
Choices include breads and starches, fruits, some vegetables and some dairy items

Here are some examples of one serving of carbohydrates:

- Breads and starches
  - 1 slice bread, tortilla, or small roll
  - 1/3 cup rice or pasta
  - 1/2 cup cooked cereal
  - 3/4 cup dry cereal
  - 1/2 cup corn, peas, or potatoes

- Fruits
  - 1 piece, such as a medium pear or apple
  - 1 cup fresh fruit
  - 1/2 cup canned fruit

- Milk
  - 1 cup skim or lowfat
  - 1 cup sugar-free lowfat yogurt

**Meats and Proteins**
Choose 1-3 servings per meal.
Examples of one serving of protein:

- 1 ounce lean meat, poultry or fish
- 1 egg
- 1 ounce cheese
- 1/4 cup lowfat cottage cheese
- 1/2 cup tofu
- 1/4 cup of cooked beans (black, kidney, or pinto)

**Vegetables (non-starchy)**
Choose 3 servings

- 1 cup raw or 1/2 cup cooked

- Broccoli, lettuce, cucumbers, squash, peppers, celery, carrots, mushrooms, tomatoes, eggplant, cabbage, cauliflower, and onions.

**Fats**
Use only a little

- 1 teaspoon margarine, oil, or mayonnaise
- 1 tablespoon salad dressing or cream cheese

**Portion Sizes**

- = 1 cup
- = 1/2 cup
- = 3 ounces
- = 1 ounce
- = 2 tablespoons
- = 1 teaspoon
## Benefits Summary from PacificSource, CMS & FFS Medicaid (Courtesy of Shana Hodgson)

<table>
<thead>
<tr>
<th></th>
<th>Commercial</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lab testing</td>
<td>Medication coverage</td>
<td>Diabetic Monitors &amp; Supplies</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Coverage falls under current benefit. There is no enhanced benefit. See pre-authorization grid for services/items that need approval in advance: <a href="https://pacificsource.com/provider/preauthorization/">https://pacificsource.com/provider/preauthorization/</a></td>
<td>Diabetes Self-Management Training Services (DSMT): G0108, G0109</td>
<td>No preauthorization required</td>
<td>Medical Nutrition Therapy (MNT): G0270, G0271</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
| Medicare covers follow-up training under the following conditions:  
• No more than 2 hours individual or group training per beneficiary per year; | Diabetic Self-Management Training Services (DSMT): G0108, G0109 | No preauthorization required with PacificSource | Initial MNT - CMS Guidelines | Follow-Up - CMS Guidelines |
| Additional hours are considered to be medically necessary and covered if the Limitations: DSMT and MNT initial and subsequent years without decreasing either benefit as long as DSMT and MNT are not provided on the same date of service. | for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR §410.130 is three hours, of administration | Medical Nutrition Therapy (MNT): G0270, G0271 | Silver&Fit |
| PacificSource Medicare members are eligible for the Silver&Fit® Exercise and Healthy Aging Program. Once members enroll and pay a member fee, they will have access to the tools and resources they need to be fit and live well. From interactive online programs to fitness club memberships or home fitness programs, the Silver&Fit program is a key to healthier living. | | | PacificSource Medicare members are eligible for the Silver&Fit® Exercise and Healthy Aging Program. Once members enroll and pay a member fee, they will have access to the tools and resources they need to be fit and live well. From interactive online programs to fitness club memberships or home fitness programs, the Silver&Fit program is a key to healthier living. |

**Lab testing and Medication coverage**

- Y: Yes
- Y: Yes
- Y: Yes
- Y: Yes
- Y: Yes
- N: No

- OAR 410-130-0595
  - Is available for clients who have at least one of the following conditions:
  - Chronic disease such as diabetes or renal disease
  - Gestational diabetes

- OAR 410-122-0520
  - OHP Ancillary Guideline A2
  - Table 410-122-0520 - Diabetic Supplies
  - External Insulin Infusion Pump
  - OAR 410-122-0525
You can take steps to Prevent Diabetes with the Prevent T2: Diabetes Prevention Program

Becoming more active and losing a moderate amount of weight can help you change your health and your life. The Prevent T2: Diabetes Prevention Program will help you take steps to prevent diabetes.

PreventT2 groups meet for a year – weekly for the first six months, then once or twice a month for the second six months to maintain healthy lifestyle changes. You will learn to:

• Eat healthy
• Add physical activity to your life
• Manage stress
• Stay on track when eating out

Join a group near you today. Take the first step toward lasting change.

Location: Deschutes County Health Svcs., 2477 NE Courtney Dr, Bend
Start Date: Thursday, January 19, 2017
Time: 1:00-2:00pm
For more information: Deschutes.org/preventdiabetes
Contact: (541) 322-7446 or email: sarahw@deschutes.org

To request this information in an alternate format, please call (541) 617-4747 or send email to ken.harms@deschutes.org.
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- Eat healthy
- Add physical activity to your life
- Manage stress
- Stay on track when eating out

Join a group near you today. Take the first step toward lasting change.

**Location:** Redmond Senior Center, 325 NW Dogwood Ave.

**Start Date:** Tuesday, January 24, 2017

**Time:** 1:00-2:00pm

**For more information:** Deschutes.org/preventdiabetes

**Contact:** (541) 322-7446 or email: sarahw@deschutes.org
RHIP Workgroup Updates: December

**Behavioral Health: Identification & Awareness** (Support: Rebeckah Berry & Steve Strang)
- This group meets the fourth Tuesday of every month from 8:15-9:15am and currently has 19 members.
- This workgroup did not meet in December due to their regularly scheduled meeting falling so close to the holidays. In January, the group will begin discussions around depression screenings and follow-up care.

**Behavioral Health: Substance Use and Chronic Pain** (Support: Rebeckah Berry & Rick Treleaven)
- This group meets the third Wednesday of every month from 4-5pm and currently has 23 members.
- This workgroup did not meet in December due to their regularly scheduled meeting falling so close to the holidays. In January, the group will finalize their introduction/position letter introducing the clinical algorithm for screening and referring for SUD, and accompanying resources. This workgroup is also supporting beginning efforts of regional MAT presentations by Dr. LeBlanc and Dr. Pennavaria within primary care clinics.

**Cardiovascular Disease—Clinical** (Support: Rebeckah Berry)
- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- This workgroup did not meet in December due to their regularly scheduled meeting falling so close to the holidays. In January, the group will discuss updates for regional blood pressure control presentations, regional testing within EPIC for e-referrals to the tobacco Quit Line, and the development of a ICD-10 laminated sheet that provides clinical codes for ECU, prenatal care, pre-diabetes, A1C, hypertension, SBIRT, and tobacco.

**Diabetes—Clinical** (Support: Rebeckah Berry & Megan Bielemeier)
- This group meets the second Thursday of every month from 9-10am and currently has 14 members.
- In December, the group continued to develop and decide on supporting resources to share with their pre-diabetes algorithm of care that will be rolled out at a Grand Rounds on pre-diabetes on March 3, 2017. These resources will also be shared with the broader provider community simultaneously. In January, the group will finalize their introduction letter, and they will review a first draft of a regional community resource booklet for pre-diabetes and type II diabetes that both providers and community members can utilize to encourage healthy behaviors that support preventing and/or managing type II diabetes.

**CVD & Diabetes: Prevention** (Support: MaCayla Arsenault, Sarah Worthington, & Sean Ferrell)
- This group meets the fourth Tuesday of every month from 3:30-5pm and currently has 27 members.
- In December, the group met to review the survey they created to disseminate to P.E. teachers in Central Oregon in order to inform the best way to support and promote physical activity within schools. Commute Options discussed their For Every Kid Campaign to support dedicated funding for Safe Routes to School in every Oregon school district. The group received postcards to support the cause that will be sent to legislators in 2017.
**RHIP Workgroup Updates: December**

**Oral Health (Support: Donna Mills & Suzanne Browning)**
- This group meets the third Tuesday of every month from 11-12pm and currently has 24 members.
- The workgroup met in December to discuss the outcomes of the survey tool provided over the October/November timeframe. The survey results provided great insight into where the workgroup should focus their efforts. These top categories were discussed at length and some preliminary outcomes were produced. The group will reconvene January 17th.

**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 23 members.
- The RMCH workgroup heard a presentation in December from the Central Oregon Breast Feeding Coalition. Tricia Gardner from PacificSource provided an update on the Prenatal Coding Pilot; PSCS has confirmed that the pilot as launched with two providers is producing positive results. They will continue to monitor and report out in January. The workgroup will meet again on January 10th and continue their work on the prenatal coding pilot.

**Social Determinants of Health**
- This group meets the third Friday of every month from 10-11:30am and currently has 30 members in Kindergarten Readiness and 36 members in Housing.

**Education & Health (Support: Donna Mills & Desiree Margo)**
- The workgroup did not meet in December due to inclement weather. The group will reconvene January 20th.

**Housing (Support: Bruce Abernathy & MaCayla Arsenault)**
- This group did not meet in December due to inclement weather. In January, they will discuss, among other things, unintended consequences of 90 day no-cause evictions and effective advocacy and dissemination of collected stories. They will also revisit modifications and additions to their work plan’s target metrics and timelines.