1. 9:00-9:05  Introductions—All

2. 9:05-9:40  Pre-Diabetes Provider Education Rollout—All
   • Intro/Position Letter Draft—Albert Noyes
   • Patient Education for Pre-Diabetes Drafts—Therese McIntyre
   • Community Resources Sharing Update—Rebeckah Berry
   • Plan to Roll-Out Resources (Grand Rounds on March 3, 2017)—All

3. 9:40-9:55  CMS Special Innovation Project: Integrating Evidence Based Self-Management Programs into Patient Care—Tracy Carver (HealthInsight Oregon)

4. 9:55-10:00  Action Items—All
   • Next steps

Next Meeting: December 8 from 9-10am
<table>
<thead>
<tr>
<th>Diabetes - Clinical (11)</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katie Ahern</td>
<td>OSU Extension Service</td>
</tr>
<tr>
<td>Megan Bielemeier</td>
<td>St. Charles Medical Group</td>
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<tr>
<td>Joan Goodwin</td>
<td>Volunteers in Medicine</td>
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<tr>
<td>Shana Hodgson</td>
<td>PacificSource</td>
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<tr>
<td>Sharity Ludwig</td>
<td>Advantage Dental</td>
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<tr>
<td>Therese McIntyre</td>
<td>Mosaic Medical</td>
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<tr>
<td>Eden Miller</td>
<td>High Lakes Healthcare - Sisters</td>
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<tr>
<td>Kevin Miller</td>
<td>High Lakes Healthcare - Sisters</td>
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<tr>
<td>Albert Noyes</td>
<td>Mosaic Medical</td>
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<tr>
<td>Kelly Ornberg</td>
<td>St. Charles Health Systems</td>
</tr>
<tr>
<td>Sarah Worthington</td>
<td>Deschutes County Health Services</td>
</tr>
</tbody>
</table>
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
- Fasting bloodwork (A1C or FBS)

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

**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

**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.
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.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight (lbs.)</th>
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<tbody>
<tr>
<td>4' 10&quot;</td>
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</tr>
<tr>
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<td>200-239</td>
</tr>
<tr>
<td>6' 4&quot;</td>
<td>205-245</td>
</tr>
</tbody>
</table>

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).

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

For more information, visit us at DoIHavPrediabetes.org
Pre- & Type II Diabetes Community Resource Flyer Update

☐ We have received flyers from St. Charles and Central Oregon Nutrition Consultants

☐ Sarah Worthington will get a flyer for LWW Diabetes early next year, and has offered to find DPP resources.

☐ Sarah Wilder offers counseling and support classes, she said she will make one by Thanksgiving.

☐ Katie Ahern will get one for Food Hero by Thanksgiving.

☐ HDFFA will be sending a flyer by Thanksgiving.

☐ Children’s Forest – I left a message with them and haven’t hear back (Kelsey)

☐ Warm Springs Health Education Team – I left a message with them and haven’t hear back (Kelsey)

☐ Teresa Martin (local speaker) – I left a message with her and haven’t hear back (Kelsey)

☐ VIM – I emailed them and haven’t heard back (Kelsey)
541-706-3752

**Diabetes and Nutrition Programs**
Our programs are facilitated by Registered Dietitian Nutritionists (RDN) and Registered Nurses (RN), including Certified Diabetes Educators (CDE). Based on 2015 data, as a result of participating in our programs, patients have lowered their HbA1c by an average of 2%.

**Preventing Diabetes**
(Bend, Open to Public $25)
This class is designed to help prevent diabetes by providing information and strategies that will direct your efforts to reduce risk for development of the disease. Learn to overcome obstacles and incorporate healthier habits for a long and healthy future. This class is not appropriate for people with diabetes, but is great if you have been told you have pre-diabetes.

**Comprehensive Diabetes Self-Management Program**
(Bend/Redmond/Prineville/Madras, **Physician Referral Required**)  
St. Charles Diabetes Services recognizes that when a patient understands the various aspects of diabetes, that knowledge leads to better diabetes management and control. Because we know that living with diabetes impacts more than just the patient, family members are encouraged to join in the diabetic care and educational process. This program includes BOTH individual sessions with diabetes RN and registered dietitian nutritionists, and group classes.

**Diabetes Follow Up**
(Bend, Open to Public $30)
Follow up after attendance at the Comprehensive Self-Management Program is combined with Prep to Plate cooking class. Class is held every-other month, in Bend at Bend Senior High School 230 NE 6th street.

Blood sugar check in is combined with cooking basics and healthy recipes in this "hands-on" course. Nutrition education, better blood sugars, and cooking savvy made fun, affordable and easy. This class is taught by a registered dietitian nutritionist. (RDN)

**Diabetes Support Groups**
(Bend, Free and open to the public)

**Adults**
Group meetings of the diabetes educational support group offered at St. Charles inform participants about specific aspects of diabetes and provide an opportunity for the sharing of coping techniques and feelings. They are generally offered every other month and are advertised in the local newspapers as to date, time and location. Contact Tracey Connell, Diabetes RN at 541-706-4986.

**Children and Families**
This is a quarterly support group that features activities and discussions that help support families and children coping with Pediatric Diabetes. Groups are coordinated by a parent of a Type 1 patient. Contact: Rita Shearer, Diabetes RN at 541-526-6690.
AADE* Accredited Diabetes Education Program

Individualized Diabetes Education and group classes for:

- Type 1 Diabetes
- Type 2 Diabetes
- Gestational Diabetes

We bill insurance when your insurance benefit plan allows. Covered by most insurance companies including Medicare and Oregon Health Plan.

We also provide individualized Medical Nutrition Therapy for diabetes (and other disorders).

We see individuals of all ages with diabetes.

Current classes are aimed at adults; individualized diabetes education is offered for children.

**Central Oregon Nutrition Consultants**  
516 SW 13th St Bend, OR 97702

* American Association of Diabetes Educators

**Diabetes Education Group Classes**

*Session One-- Introduction to Diabetes, Monitoring & Preventing Complications*

*Session Two- Hands on Nutrition Education and Carbohydrate Counting and Being Active*

*Session Three --Medications – Categories, Pros & Cons, Cost and Insurance Coverage; Strategies for Taking as Prescribed; Grocery Store Tour—learn to shop for healthy foods*

*Session Four--Long term Coping with Diabetes; Problem Solving—high and low blood glucose levels, illness, stress, special events and travel*

**Class instructor: Lori Brizee, MS, RDN, LD, CDE**

Diabetes class series is offered 3-4 times/year

Questions:  office: (541) 306-6801  
Referrals:  fax: (541) 312-4670
AADE* Accredited Diabetes Education Program

Individualized Diabetes Education and group classes for:

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We see individuals of all ages with diabetes.

Current classes are aimed at adults; individualized diabetes education is offered for children.

Diabetes Education group classes, series starting September 17, 2016

September 17, 9:00-11:00am--Introduction to Diabetes, Monitoring & Preventing Complications

October 1, 9-11:00--Hands on Nutrition education and carbohydrate counting and Being Active

October 15, 9-11:00 --Medications – Categories, Pros & Cons, cost and insurance coverage; Strategies for taking as prescribed; Grocery store tour—learn to shop for healthy foods.

October 29-9:00-11:00--Long term Coping with Diabetes; Problem solving—high and low blood glucose levels, illness, stress, special events and travel.

Diabetes class series is offered 3-4 times/year

Central Oregon Nutrition Consultants
516 SW 13th St Bend, OR 97702

Questions: office: (541) 306-6801
Referrals: fax: (541) 312-4670

* American Association of Diabetes Educators
Pharmacy Cold-Calls Regarding Pre-Diabetes & Type II Diabetes Counseling

Not all the more rural towns in Central Oregon have those large pharmacies in their area but I made sure to call those who did.

Summary:
Do you counsel on healthy behaviors when you see new prescriptions come through for pre diabetic and diabetic patients?
2 said yes
3 said sometimes
2 said no

Do you have materials on healthy behaviors to give to patients?
2 said yes
1 said handouts are in the waiting area
4 said no

Would you be willing to accept additional handouts/materials?
4 said yes
3 said all their handouts are from corporate and they can’t accept outside materials

Here are the full answers:

Counseling:
- Costco in Bend: Yes, we encourage healthy behaviors. Most patients are not receptive to extra counseling, they say, “I already talked to my doctor about all this, I just want to get what I’m here for and go”.
- Bi-Mart in Madras: It varies by pharmacist but we do typically have that conversation with the patient
- Walmart in Redmond: We recommend behavioral changes, but mostly just confirm that the PCP has already discussed that with them
- Safeway in Redmond: Yes, if the prescription is new. Not for refills.
- Walgreens in Bend: Not so much, no. We focus on side effects and instructions.
- Rite Aid in Prineville: Not so much, no. We focus on side effects and instructions.
- Fred Meyer in Bend: It varies by pharmacist but we do typically have that conversation with the patient

Existing Materials / Future Materials:
- Costco in Bend: We don’t hand things out at the window, we have materials like that in our waiting area. We’re happy to accept more.
- Bi-Mart in Madras: Yes we hand those out, new ones would be helpful
- Walmart in Redmond: No, we would like to have one
- Safeway in Redmond: No, we think those would be helpful
- Walgreens in Bend: No, and all our handouts are selected by corporate
- Rite Aid in Prineville: No, but we do have special handouts regarding Metformin that corporate makes; we wish that behavior information was included on there. All our handouts are selected by corporate.
- Fred Meyer in Bend: Yes we do hand those out, and all our handouts are selected by corporate

On the whole, the pharmacists I spoke to thought this was great and find this issue important (only one didn’t seem to care at all). They didn’t find the idea of “just another handout” to be cumbersome or inconvenient, though one expressed concern that handouts don’t always have strong impact on behaviors.

Hope this helps! Kelsey
Integrating Evidence-Based Self-Management Education Programs:
Special Innovation Project Opportunity

Purpose
The Centers for Medicare & Medicaid Services (CMS) has awarded HealthInsight a two-year Special Innovation Project Grant to

- Capture promising practices and emerging models from communities that are working on integrating evidence-based self-management programs into patient care through designing innovative closed-loop referral and payment models
- Better understand how integrating evidence-based self-management programs impacts the activated patient following completion of the program
- Help accelerate shared learning across communities working to achieve integrated sustainable systems for evidence-based self-management programs

The products and tools developed from this grant will help to inform future CMS funding and support for evidence-based self-management programs.

Participating case study communities will receive enhanced technical assistance from HealthInsight Oregon, and the transformation successes will be highlighted as part of a nationally shared transformation package.

Timeline
January 2016–September 2017

HealthInsight Oregon’s Role
HealthInsight Oregon will support the case study communities by

- Helping to identify clinics that are ready to refer to ESMPs
- Working with clinics, Coordinated Care Organizations and self-management delivery organizations to streamline and document a closed-loop referral process
- Working with clinics to collect key clinical outcomes for patients who complete a Stanford self-management program before and after the program
- Capturing the community story through a case study that will be part of a nationally shared transformation package that supports sustainability and spread
- Providing actionable data reports
- Providing a forum for communities to play a leadership role in informing sustainable financial models for integrating evidence-based self-management programs
Case Study Communities’ Role

- Quarterly submission of key metrics
- Participation in evaluation activities, which may include key informant interviews, focus groups and process mapping
- Partnership with HealthInsight Oregon and one or more clinical partners on capturing pre and post clinical data on patients referred to the Stanford self-management programs
- Participation in education and peer-sharing opportunities

Clinics’ Role

- Refer patients living with chronic conditions who would benefit from self-management education to the Chronic Disease Self-Management Program (CDSMP) and the Diabetes Self-Management Program (DSMP)
- Submit pre and post clinical data on patients referred to CDSMP or DSMP, including HbA1C, blood pressure, and weight
- Participate in evaluation activities, which may include key informant interviews, assessments and process mapping
- Participate in education and peer-sharing opportunities as desired

Final Products

- Data feedback reports
- Guidance tool for closed-loop referral and payment
- Case studies documenting the promising practices and lessons learned from advanced communities
- White Paper to help inform scalability and spread of recommendations from key stakeholders to be shared with local, state, and national stakeholders.
- Change package to help communities apply the lessons learned from this model, including recommendations, promising strategies and tools that were found to be the most successful

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This material was prepared by HealthInsight, the Medicare Quality Innovation Network-Quality Improvement Organization for Nevada, New Mexico, Oregon and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-SIP2-16-01-OR 1/21/16
RHIP Workgroup Updates: October

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 20 members.
- In October, the group discussed the RHIP health indicator of how they would begin to develop a baseline of successful referral and engagement in specialty care from primary care. The group will begin by working with the four primary care clinic settings throughout the region that have agreed to pilot this effort. In November, the group will be reviewing more RHIP proposals as well as continuing their involvement in the MindYourMind regional campaign.

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.
- In October the group edited and finalized a clear and standardized pathways algorithm for patients who display substance use risk within primary care settings. The group discussed additional accompanying documents that will be shared and developed along with this algorithm. A sub-group of organizations that agreed to pilot expedited referrals to treatment met for the first time this month and worked out basic action steps to begin their efforts.

Cardiovascular Disease—Clinical (Support: Rebeckah Berry)

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 11 members.
- In October this group finalized patient education documents around proper blood pressure procedures and things that raise blood pressure. These documents are being shared broadly with clinics, and the group is working to translate them into Spanish. The group also discussed the e-referral pilot for the Tobacco Quit Line, (target date of 6/30/17) and provided further input on a blood pressure control education RHIP proposal.

Diabetes—Clinical (Support: Rebeckah Berry & Megan Bielemeier)

- This group meets the second Thursday of every month from 9-10am and currently has 11 members.
- In October the group finalized a pathway algorithm for assertively addressing Pre-Diabetes within a primary care setting. Final edits have been made to this algorithm and steps to share this and additional supporting resources are being outlined for our region. The group is waiting to hear about the Grand Rounds presentation on Pre-Diabetes for Spring 2017. The group plans to roll out their educational information in alignment with Grand Rounds.

Cardiovascular Disease & Diabetes—Prevention (Support: MaCayla Arsenault & Channa Lindsay)

- This group meets the fourth Tuesday of every month from 3:30-5pm and currently has 25 members.
- In October, the workgroup went through a consensus workshop to agree on broad strategies addressing unhealthy diet and nutrition. They revisited the strategies they developed around increasing physical activity and determined they want to initially focus on promoting school based physical activity (P.A.) and education/awareness around active modes of transportation and existing programs. They also created a subcommittee to explore best ways to support increasing P.A. in schools. In the coming months the workgroup will be selecting and implementing specific strategies.
RHIP Workgroup Updates: October

Oral Health (Support: Donna Mills & Suzanne Browning)
- This group meets the third Tuesday of every month from 11-12pm and currently has 23 members.
- The workgroup reviewed the living workplan as a matter of course. This will be a recurring exercise to affirm direction and accurate reporting up to the Ops Council. A ‘fishbone diagram’ exercise was executed around the Clinical Goal of Improving Oral Health for Pre-Post Natal Women. This exercise will enable the workgroup to prioritize next action steps. The prioritization will happen over email in the month of November, as there will not be a meeting in November. Suzanne Browning is moving away due to her husband’s health; she has stepped down as the workgroup lead. MaryAnn Wren has stepped up to lead the group with the group’s endorsement.

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.
- This group did not meet in October.

Social Determinants of Health
- This group meets the third Friday of every month from 10-11:30am and currently has 28 members in Kindergarten Readiness and 32 members in Housing.

Education & Health (Support: Donna Mills & Desiree Margo)
- In October the workgroup reviewed the living workplan as a matter of course. This will be a recurring exercise to affirm direction and accurate reporting up to the Ops Council. Courtney Snead with Let’s Talk Diversity presented to the group as a matter of education. Ken Wilhelm from United Way presented on the TRACE’s steering committee’s progress. Kat Mastrangelo shared a draft version of a timeline for using data to instruct our next steps regarding which school catchment areas in which to focus first. The group will meet again in December.

Housing (Support: Bruce Abernathy & MaCayla Arsenault)
- In October, the workgroup discussed ways to coordinate their efforts with six other housing workgroups in Central Oregon. Representatives from four of the workgroups met to discuss ways to collaborate, share resources, and avoid duplication. The workgroup would also like to work with others to develop and capture stories to shape public opinion and share with the legislature. They want to broaden their research scope to identify demographics in each community by occupation to identify specific housing needs.