Central Oregon Health Council

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

Agenda: October 12, 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. 9:05-9:25 **POC Experiment Updates & Group Recommendations—Shiela Stewart**

3. 9:25-9:55 **Review Final Draft of A3 to Prepare for Operations Council Presentation—All**

4. 9:55-10:30 **Next Steps/Tying Up Loose Ends—All**
   - **Vote on Next Algorithm to Develop: A1C of ≥ 9, A1C of 7-9, or A1C of 6.5-7**
   - **2nd Edition Diabetes Booklet: Include For-Profits?**
   - **Pre-Diabetes Survey: When to send out?**

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

Next Meeting: November 9, 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 Self-Management Education and Support for Adults with Type 2 Diabetes: **ALGORITHM of CARE**

ADA *Standards of Medical Care in Diabetes* recommends all patients be assessed and referred for:

NUTRITION
Registered dietitian for medical nutrition therapy

EDUCATION
Diabetes self-management education and support

EMOTIONAL HEALTH
Mental health professional if needed

FOUR CRITICAL TIMES TO ASSESS, PROVIDE, AND ADJUST DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

1. **AT DIAGNOSIS**
2. **ANNUAL** ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS
3. WHEN NEW **COMPLICATING FACTORS** INFLUENCE SELF-MANAGEMENT
4. WHEN **TRANSITIONS** IN CARE OCCUR

WHEN PRIMARY CARE PROVIDER OR SPECIALIST SHOULD CONSIDER REFERRAL:

1 AT DIAGNOSIS

- ☐ Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S
- ☐ Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals

2 ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS

- ☐ Needs review of knowledge, skills, and behaviors
- ☐ Long-standing diabetes with limited prior education
- ☐ Change in medication, activity, or nutritional intake
- ☐ HbA_{1c} out of target
- ☐ Maintain positive health outcomes
- ☐ Unexplained hypoglycemia or hyperglycemia
- ☐ Planning pregnancy or pregnant
- ☐ For support to attain or sustain behavior change(s)
- ☐ Weight or other nutrition concerns
- ☐ New life situations and competing demands

3 WHEN NEW COMPLICATING FACTORS INFLUENCE SELF-MANAGEMENT

CHANGE IN:

- ☐ Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen
- ☐ Physical limitations such as visual impairment, dexterity issues, movement restrictions
- ☐ Emotional factors such as anxiety and clinical depression
- ☐ Basic living needs such as access to food, financial limitations

4 WHEN TRANSITIONS IN CARE OCCUR

CHANGE IN:

- ☐ Living situation such as inpatient or outpatient rehabilitation or now living alone
- ☐ Medical care team
- ☐ Insurance coverage that results in treatment change
- ☐ Age-related changes affecting cognition, self-care, etc.

Powers MA, Bardsley J, Cypress M, Duker P, Funnell MM, Fischl AH, Maryniuk MD, Siminerio L, Vivian E. Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Care 2015; 38:1372-1382; The Diabetes Educator 2015;41:417-430; Journal of the Academy of Nutrition and Dietetics 2015;115:1323-1334. (Adapted August 2016)

American Diabetes Association. | AADE American Association of Diabetes Educators | eat right. Academy of Nutrition and Dietetics

Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes:
ALGORITHM ACTION STEPS

Four critical times to assess, provide, and adjust diabetes self-management education and support

AT DIAGNOSIS	**ANNUAL** ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS	WHEN NEW **COMPLICATING FACTORS** INFLUENCE SELF-MANAGEMENT	WHEN **TRANSITIONS** IN CARE OCCUR

PRIMARY CARE PROVIDER/ENDOCRINOLOGIST/CLINICAL CARE TEAM: AREAS OF FOCUS AND ACTION STEPS

☐ Answer questions and provide emotional support regarding diagnosis ☐ Provide overview of treatment and treatment goals ☐ Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) ☐ Identify and discuss resources for education and ongoing support ☐ Make referral for DSME/S and medical nutrition therapy (MNT)	☐ Assess all areas of self-management ☐ Review problem-solving skills ☐ Identify strengths and challenges of living with diabetes	☐ Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals ☐ Discuss impact of complications and successes with treatment and self-management	☐ Develop diabetes transition plan ☐ Communicate transition plan to new health care team members ☐ Establish DSME/S regular follow-up care

DIABETES EDUCATION: AREAS OF FOCUS AND ACTION STEPS

Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how: ☐ Medication – choices, action, titration, side effects ☐ Monitoring blood glucose – when to test, interpreting and using glucose pattern management for feedback ☐ Physical activity – safety, short-term vs. long-term goals/recommendations ☐ Preventing, detecting, and treating acute and chronic complications ☐ Nutrition – food plan, planning meals, purchasing food, preparing meals, portioning food ☐ Risk reduction – smoking cessation, foot care ☐ Developing personal strategies to address psychosocial issues and concerns ☐ Developing personal strategies to promote health and behavior change	☐ Review and reinforce treatment goals and self-management needs ☐ Emphasize preventing complications and promoting quality of life ☐ Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands ☐ Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes	☐ Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications ☐ Provide/refer for emotional support for diabetes-related distress and depression ☐ Develop and support personal strategies for behavior change and healthy coping ☐ Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change	☐ Identify needed adaptations in diabetes self-management ☐ Provide support for independent self-management skills and self-efficacy ☐ Identify level of significant other involvement and facilitate education and support ☐ Assist with facing challenges affecting usual level of activity, ability to function, health benefits and feelings of well-being ☐ Maximize quality of life and emotional support for the patient (and family members) ☐ Provide education for others now involved in care ☐ Establish communication and follow-up plans with the provider, family, and others

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RHIP Workgroup Updates: September

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

- This group meets the fourth Tuesday of every month from 8:15-9:15am and currently has 18 members.
- In September, 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 ensuring an effective and timely response. The group completed a gap analysis in box 4, then created and vetted a draft survey which will be sent out to primary care, women's health, school based health centers, and Indian Health Service to collect baseline data that will be used as a starting measurement for their work plan.

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 23 members.
- In September, the group continued their A3 process with the aim of all Central Oregonians with a substance use disorder that enter the hospital will receive engagement, treatment, or harm reductions services. The group finalized initial state and target state metric boxes, and will design a survey for the hospital to gather baseline data to be used as a starting measurement for their work plan. In addition, the group began a gap analysis in box 4

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 September this group continued their work on their first A3 around asking, engaging, and providing services/support to decrease youth tobacco use in Central Oregon.

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 September this workgroup completed a draft of their A3 which they will finalize at their October meeting and present to Ops on October 20th. The group also reviewed survey results asking clinics if they have or want Point of Care testing machines. The results concluded that a need exists and this strategy will be included in their Box 6 experiments. The group also edited a survey to measure the dissemination and usefulness of the prediabetes materials developed earlier this year.

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 13 members.
- In September this workgroup completed boxes 5-8 of their A3, and are planning a pilot to establish a referral system for providers to prescribe physical activity to youth. They will be presenting their A3 to Ops on October 20th.

RHIP Workgroup Updates: August

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

- This group meets the third Tuesday of every month from 11-12pm and currently has 24 members.
- In September the OH WG met and continued their discussion around the two proposals submitted from Kemple Clinic and Advantage Dental. The discussion concluded and a motion was made to approve the Kemple clinic proposal for one year ($50k). The A3 surrounding sealants is before the Operations Council on 10/6/17. Next month, after Ops review, the workgroup will move into the implementation stage of their A3.

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.
- In September the RMCH workgroup met in September and continued their work on the A3 relative to 'unintended pregnancies'. A presentation was given on the program of the Regional Immunization Rate Improvement project, known as AFIX. The up-to-date immunization rate for 24 month olds improved an average of 7% among participating clinics after the first year of participation. The group committed to bringing data to the next meeting that can/could inform, unintended pregnancies by age bracket, to support pilot projects.

Social Determinants of Health

- This group meets the third Friday of every month from 10:30-11:30am and currently has 27 members in Kindergarten Readiness and 24 members in Housing.

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

- In September the HE group (formerly Kindergarten Readiness) met in September and heard a presentation from Friends of the Children. The A3 surrounding social and emotional supports was reviewed by the Operations Council on September 1st and ready for specific tactics to meet their aim. The workgroup discussed and reviewed the proposal and a motion was made to approve and fund the proposal ($75k). Next steps include a meeting with the COHC Quality Manager.

Housing (Support: Bruce Abernethy & MaCayla Arsenault)

- In September the Housing workgroup discussed proposals for their Box 6 experiments intending to help meet the aims of their data & chronic homelessness stabilization A3s.