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

Agenda: November 2, 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. 9:05-10:25 **Regional Algorithm Development for Management of A1C of ≥ 9—All**

3. 10:25-10:30 **Updates/Action Items—All**
   - **Next steps**

Next Meeting: December 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 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: October 2017

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 17 members.
- In October, 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 is working to finalize their baseline survey which will be sent out to primary care, women's health, school based health centers, and Indian Health Services, and is intended to help prioritize their experiments.

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 22 members.
- In October, the group continued their A3 process with the aim of all Central Oregonians with a substance use disorder that enter the hospital setting, including the ED, will receive engagement, treatment, or harm reductions services. The group began the process of designing a survey to gather baseline data as a starting measurement to help prioritize their experiments.

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

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 11 members.
- In October, this group continued their work on their first A3 around asking, engaging, and providing services/support to decrease youth tobacco use in Central Oregon. The group is very close to selecting their experiment and finalizing their A3.

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 October, this workgroup completed their A3 which they presented to Operations Council on October 20th. The workgroup also submitted a QIM proposal to pilot Point of Care testing machines in just over a dozen clinics of various sizes throughout the region. In November, the group will begin the development of their second algorithm that will focus on supporting primary care in the management of patients with A1Cs >9.

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 October, the workgroup presented their A3 to Ops. They are launching a pilot to prescribe and connect children to organized physical actives. They have now turned their focus to promoting active modes of transportation and are currently brainstorming strategies. They will use a PICK chart to gauge these activities in November and select a strategy.

RHIP Workgroup Updates: October 2017

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 October, the workgroup discussed the future focus of their efforts. They concluded that they would like to work on gathering enough data on geriatric dental care for it to be included in the next RHIP. They discussed their opportunities to partner with another workgroup and decided Diabetes Clinical could have a strong connection. They will be reaching out to that workgroup through a shared member.

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 October, the workgroup met and spent their time reviewing the latest reports from the State regarding Unintended Pregnancies/Teenage Pregnancies and the report published by OHA that provided a case study of the Central Oregon Perinatal Care Continuum program, funded by the Central Oregon Health Council. A subcommittee has been established to work on the gap analysis for Unintended Pregnancies and coordinate with the RHIP Oral Health Workgroup.

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 October, the workgroup met and chose to evaluate a name change to better reflect their vision versus a metric. The group heard a proposal from the TRACEs subgroup in the amount of $18k. An electronic vote will be taken regarding approval. Kim Hatfield with Friends of the Children gave an update on the efforts around standing up their program.

Housing (Support: Bruce Abernethy, Elaine Knobbs-Seasholtz & MaCayla Arsenault)

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