Central Oregon Health Council

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

Agenda: March 8, 2018 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. 9:05-9:30 **Finalize Algorithm Development of A1c of > 9—All**
3. 9:30-9:55 **Begin First Draft of A1c 6.5-8.9 Algorithm—All**
4. 9:55-10:30 **HDFFA Veggie Rx Proposal Follow-Up**
   - **Presentation (15 minutes)—Katrina Van Dis**
   - **PacificSource Foundation Funding (5 minutes)—Marian Blankenship**
   - **Q&A (15 minutes)—All**
5. 10:30 **Action Items—All**
   - **Next steps**

Next Meeting: **April 12, 2018 from 9-10:30am (PacificSource Bldg.: Sparks Room)**

Diabetes: Clinical (13)	Organization
Megan Bielemeier, MSN, BSN, RN, CCM	Caravan Health
Patty Kuratek, RN, MSN, CDE	La Pine Community Health Center
Sharity Ludwig, EPDH, MS	Advantage Dental
Therese McIntyre, MPH, CPH	Mosaic Medical
Kevin Miller, DO	High Lakes Healthcare - Sisters
Sara Mosher, RN, BSN, MHA	St. Charles Medical Group
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
Ginger Walcutt, MPH	PacificSource
Sarah Worthington, MPH, RD	Deschutes County Health Services

TYPE 2 DIABETES A1C ≥ 9 ALGORITHM:
CENTRAL OREGON

ORIGINATING VISIT

- Non-PCP screening (i.e. dentist, specialist, community event)
- Labs:
  - A1c > 6.4
  - Blood glucose > 200
- Refer to PCP

DIAGNOSIS

- PCP visit
- A1c ≥ 9
- PCP Diagnosis of uncontrolled diabetes

PCP ROLE

- Review medications/associated labs and clinical findings
- AACE recommended medications (refer to reverse side)
- Assess comorbidities
- Address hypertension, hyperlipidemia, renal function (microalbuminuria, G.F.R., serum creatinine) cardiovascular risk reduction
- Referral to Specialty Care where needed:
  - Behavioral Health
  - Certified Diabetes Educator
  - Dental
  - Endocrinologist
  - Opthamologist
  - Podiatrist
  - Registered Dietitian Nutritionist
- Motivational Interviewing (MI)
  - Lifestyle advice
  - Nutrition
  - Exercise
- Orders During Visit:
  - Order next A1c: 3 months out
  - Schedule care team or PCP visit in **4-6 weeks**
  - Place order for Registered Dietitian Nutritionist visit

CARE TEAM ROLES

CARE COORDINATION

- Vital to Assess for Social Determinants of Health:
  - Food insecurity
  - Ability to pay bills
  - Stable housing
  - Social support
  - Interpersonal Safety
  - Language/literacy
  - Culture
  - Transportation to appointments
  - Work environment
- Ensure patient has/ obtains glucose monitoring supplies
- Confirm A1c test is ordered every 3 months until A1c at goal
- Schedule Care Team appointment in **4-6 weeks**

EDUCATION

- Use MI and Teach-Back to discuss:
  - Medication adherence
  - Glucose targets
  - Hypoglycemia prevention
  - Risk reduction
  - Goals & treatment plan
  - Lifestyle
  - Tobacco cessation
  - Self-monitoring of blood glucose

REFERRALS

- Behavioral Health
- Certified Diabetes Educator
- Clinical pharmacist
- Community classes: Diabetes Self-Management (DSM), etc.
- Community resources (exercise groups, cooking classes, tobacco cessation classes, WIC, etc.)
- Dental
- Registered Dietitian Nutritionist
- Retinal Eye Exam

FOLLOW UP

- Ensure follow-up visit with care team is scheduled at **4-6 week intervals**
- Review/continue education (see relevant education topics above)
- Confirm referrals are scheduled (see relevant referral list above)

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This document was developed by the RHIP Diabetes Clinical Workgroup. For more information visit www.cohealthcouncil.org/diabetes-clinical, or email: info@cohealthcouncil.org, or call: (541) 306-3523.

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TYPE 2 DIABETES A1C 6.5-8.9 ALGORITHM:
CENTRAL OREGON

ORIGINATING VISIT

- Non-PCP screening (i.e. dentist, specialist, community event)
- Labs:
  - A1c > 6.4
  - Blood glucose > 140
- Refer to PCP

DIAGNOSIS

- PCP visit
- A1c 6.5-8.9
- PCP Diagnosis of diabetes

PCP ROLE

- Review medications/associated labs and clinical findings
- AACE recommended medications (refer to reverse side)
- Assess comorbidities
- Address hypertension, hyperlipidemia, renal function (microalbuminuria, G.F.R., serum creatinine) cardiovascular risk reduction
- Referral to Specialty Care where needed:
  - Behavioral Health
  - Certified Diabetes Educator
  - Dental
  - Endocrinologist
  - Ophthalmologist
  - Podiatrist
  - Registered Dietitian Nutritionist
- Motivational Interviewing (MI)
  - Lifestyle advice
  - Nutrition and Exercise
- Orders During Visit:
  - Order next A1c: 3 months if not at goal, 6 months if at goal
  - Schedule care team or PCP visit based on A1c **(refer to reverse side)**
  - Place order for Registered Dietitian Nutritionist visit

CARE TEAM ROLES

CARE COORDINATION

- Vital to Assess for Social Determinants of Health:
  - Food insecurity
  - Ability to pay bills
  - Stable housing
  - Social support
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  - Language/literacy
  - Culture
  - Transportation to appointments
  - Work environment
- Ensure patient has/ obtains glucose monitoring supplies
- Confirm A1c test is ordered every 3 months until A1c at goal, 6 months if at goal
- Schedule Care Team appointment based on A1c **(refer to reverse side)**

EDUCATION

- Use MI and Teach-Back to discuss:
  - Medication adherence
  - Glucose targets
  - Hypoglycemia prevention
  - Risk reduction
  - Goals & treatment plan
  - Lifestyle
  - Tobacco cessation
  - Self-monitoring of blood glucose
  - **A1c to eAG conversion on reverse**

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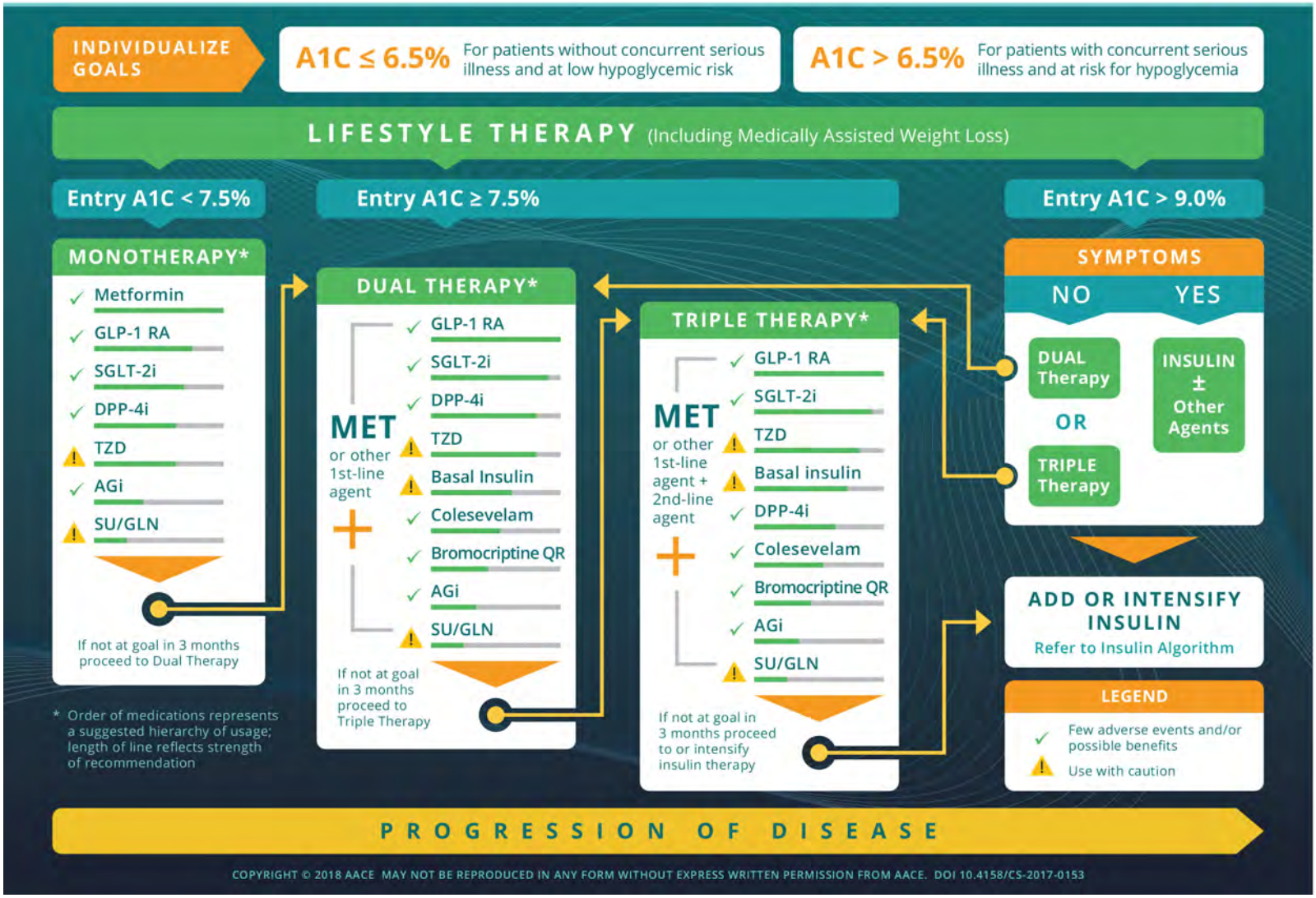
Glycemic Control Algorithm



A1c Patient Follow-up

A1c	Recommended Visit Frequency
↑9	every 4-6 weeks
8-9	every 2 months
7-8	every 3 months
↓7	every 6 months

A1c (%)	eAG (mg/dL) Estimated Average Glucose
6.0	126
6.5	140
7.0	154
7.5	169
8.0	183
8.5	197
9.0	212
9.5	226
10.0	240

American Diabetes Association: www.diabetes.org/professional/eAG