Partnering with Quality Improvement Networks to Expand Access to Diabetes Self-Management Education Programs

April 19, 2016

- Susan Fleck, Centers for Medicare & Medicaid Services
- April Holmes, Virginia Department for Aging & Rehabilitative Services
- Thelma Baker, VHQC, Maryland & Virginia Quality Innovation Network
- Tracy Carver, HealthInsight Quality Innovation Network, serving Oregon through Acumentra Health
- Laura Chisholm, Oregon Health Authority

Everyone with Diabetes Counts (EDC)

National Council on Aging

April 19, 2016

Susan Fleck, RN, MMHS
Subject Matter Expert
Lead, Everyone with Diabetes Counts (EDC)
Centers for Medicare & Medicaid Services

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

Slide Index

Topic/Title	Slide Number(s)
• QIO History	3 - 4
• Medicare Diabetes Expenditures/Diabetes Statistics	5 - 6
• History of EDC, Goals of EDC	7 – 8
• Challenge of Literacy and Health Literacy	9
• EDC Components/How to Accomplish EDC/Triple Aim	10 - 14
• Medicare Preventive Services	15
• EDC Facts and Results	16
• EDC Challenges	17
• Resources/Contact Information	18
• Words of Inspiration	19 – 20
• EDC Pictures	21 - 30

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

Quality Improvement Organizations (QIOs) History

- QIOs were established as Peer Review Organizations (PROs) in 1972 under an amendment to the Social Security Act (SSA), Sections 1152 – 1154, with an audit/inspection role for the **Medicare program.**
- In 2002, the name Peer Review Organization was changed to Quality Improvement Organization to reflect their expanding role in the area of population based quality improvement.
- The QIO mission is to improve the effectiveness, efficiency, economy, and quality of health care services delivered to Medicare beneficiaries.
- QIOs are unique, with “boots on the ground” staff.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

QIOs to QINs (Quality Improvement Networks)

- QIO program **restructured as of August 1, 2014** (CMS Press Release July 18, 2014) for the 11th scope of work (SOW) contract cycle

Changes:

- **14 organizations**, formerly QIOs, awarded QIN contracts representing 50 states, as well as Washington DC, Puerto Rico, and the US Virgin Islands
- **QINs comprised of 2 – 6 states each, not contiguous/bordering states**
- **Beneficiary and Family Centered Care (BFCC) contracts awarded to 2 organizations for the entire country to perform Medicare case review** and appeals; they cannot participate in remaining QI activities: KePro in Ohio, and Livanta, LLC in MD.
- **Work remains state-based**, but no longer limited to work just within their respective state; QI activities can now be performed across state lines within QINs
- **Contracts** changing from **3 years to 5 years**
- Results in sharing/leveraging of resources, economies of scale, cost saving

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Diabetes Prevalence/Medicare Expenditures Attributed To Diabetes

- 60% of Medicare beneficiaries have multiple chronic conditions
- 14% of Medicare beneficiaries have 6 or more chronic conditions; the **top 5 are: HTN, High Cholesterol, Ischemic Heart Disease, Arthritis, and Diabetes**
- Medicare-Medicaid beneficiaries (those with both Medicare and Medicaid coverage) are 1.4 times more likely to have diabetes (Source for all of the above: CMS Chronic Conditions Among Medicare Beneficiaries, Chartbook, 2012 Edition)
- **26.9% of Medicare beneficiaries age 65 and older (10.9 million Americans) have diabetes; they account for approximately 32% of Medicare spending** (Source: 2013 testimony by the Congressional Diabetes Caucus in the US House of Representatives and the American Diabetes Association)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

Diabetes Statistics – Over 65/Diverse Populations

- Adults aged 65 and over have the highest percentage of diagnosed diabetes, compared to any age group (CDC/NCHS Interview Survey 2013)

Diabetes Rates from the CDC National Diabetes Statistics Report 2014:

- Among non-Hispanic whites 7.6%
- Among non-Hispanic Blacks 13.2%
- Among Hispanic adults, 8.5% for Central and South Americans, 9.3% for Cubans, 13.9% for Mexican Americans, and 14.8% for Puerto Ricans.
- Among Asian American adults, 4.4% for Chinese, 11.3% for Filipinos, 13.0% for Asian Indians, and 8.8% for other Asians.
- Among American Indian and Alaska Native adults, the age-adjusted rate of diagnosed diabetes varied by region from 6.0% among Alaska Natives to 24.1% among American Indians in southern Arizona

Rural statistics:

- Diabetes is more common among beneficiaries who live in rural counties (16.7%), than among those who live in urban areas (13.5%). Source: The Rural Health Research & Policy Centers, funded by the Federal Office of Rural Health Policy

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Everyone with Diabetes Counts (EDC)

- Started as a one-state pilot 9 years ago (FL)
- Then expanded to 9 states/territories (NY, GA, LA, WV, TX, MS, MD, Washington DC, U.S. Virgin Islands)
- **National expansion** (50 states, as well as Washington DC, Puerto Rico, and US Virgin Islands) as of **August 1, 2014.** Contract ends July 31, 2019.
- **Largest national** diabetes self-management education **(DSME) Program** focused on **Medicare** beneficiaries in underserved minority/diverse, and rural populations.
- EDC is **community-based**.
- **EDC is a Program, not a Medicare benefit.**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

EDC Goals

- Improve health equity by improving health literacy and quality of care among Medicare and Medicare-Medicaid (those with both Medicare and Medicaid coverage) beneficiaries with pre-diabetes and diabetes through knowledge empowerment, enabling them to become active participants in their care **(person/patient engagement)**
- EDC is a **disparity reduction program**; target populations are minority underserved/diverse, and rural
- Engage both beneficiaries and health care providers to: Decrease the disparity in diabetes care by improving testing/measures for: **HbA1c, Lipids, Eye Exams, Foot Exams, Improve Blood Pressure control and Weight control**
- Improve actual clinical outcomes of the above measures
- **Facilitate sustainable diabetes education resources** by engaging public/private agency/organization partnerships at the community level; state level; and national level

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

Challenge of Literacy/Health Literacy

The current literacy rate in the US has not changed in 10 years.

- **14% of US adults cannot read** (defined as being below a basic level)*
- 19% of high school graduates can't read

Reading Levels - Demographics of Adults who Read below a basic level*

- Hispanic 41%
- African American 24%
- White 9%
- Other 13%

* Basic level - reading at a 4th grade level, and the person should be able to make simple inferences, and interpret the meaning of a word as it is used in the text.

Source for all of above: U.S. Dept. of Education, National Institute of Literacy, Illiteracy Statistics Dec. 2015

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

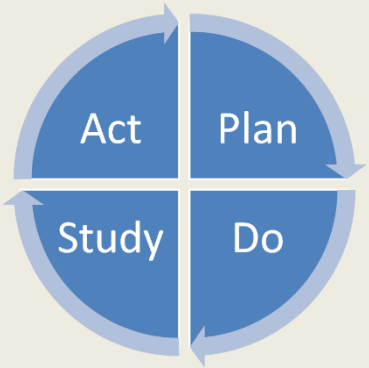
EDC Components

EDC has 5 components:

- 1.) Recruitment and education of beneficiaries
- 2.) Recruitment and education of physician practices/providers and staff
- 3.) Recruitment of community partners/stakeholders
- 4.) Data collection and analysis
- 5.) Sustainability planning/implementation

** EDC is a continuous plan/do/study/act **(PDSA)** cycle; "keep or tweak"

Short-term quality improvement cycles; usually 30, 60, or 90 days.



Think Outside the Box

New Strategies and Innovations/Interventions

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

How to Accomplish EDC

- **Recruit**, enroll, and teach **beneficiaries** utilizing evidence-based DSME curricula; Stanford, or DEEP (diabetes education empowerment program from UIC (University of Illinois, Chicago)). **Classes teach/promote:** healthy lifestyles/behavioral changes, basic anatomy, nutrition, medication adherence, medical monitoring (physician appts., labs, foot and eye exams, etc.), and self-goal setting to achieve favorable outcomes.
- DSME classes: 6 consecutive weeks, 2 ½ hours each class (12-15 hours total); **community-based sites**; **invite guest lecturers (i.e., pharmacists, dieticians)**; includes **cultural competency component**; many classes taught by community health workers **(CHWs)** who reside in the targeted community, or are members of that population group. Classes taught in the **preferred language** of the targeted population as much as possible; taught for **low literacy** populations; **family member or care-giver encouraged to attend – person and family engagement; "meet people where they are"** ****Not one size fits all****
- **Recruit physician practices, clinics, Medicare Advantage (MA) Plans, Federally Qualified Health Centers (FQHCs)** to improve their adherence to standards of care for people with diabetes; **improve their data collection** and data analysis skills; **improve their knowledge of Medicare diabetes prevention benefits, educate provider staff**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

How to Accomplish EDC continued

- **Recruit community partners/stakeholders -** "spread the word," by attending community-based activities , i.e., health fairs, to market DSME classes; partner/stakeholder venues to host classes (i.e., area agency on aging (AAA) sites, senior centers, grocery stores, pharmacies, libraries, faith-based organizations, police stations); endorsement by trusted sources in the community (i.e., local "celebrity" endorsement, church Pastor endorsement); local TV and radio coverage, i.e., public service announcements (PSAs); partner with **state depts. of health (we find many have limited infrastructure);** with local politicians for endorsement (Mayor, Senator, Governor); with **state medical societies**; with **academic institutions** (schools of Nursing, Pharmacy, Medicine, Programs in Dietetics)
- **Data** – QIN-QIO will obtain **clinical results** of diabetes measures for 10% of beneficiaries who complete DSME, and match to **Medicare claims** data, following beneficiaries longitudinally over time; pre and post DSME **Patient Activation Survey** data; use of data "hot spotting" to identify areas in need

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

How to Accomplish EDC

Sustainability Planning/Implementation

- Each QIN-QIO develops and implements a **Sustainability Plan** that includes increasing the numbers of certified diabetes educators (CDEs) in their state; increasing the numbers of lay diabetes educators in their state (by training them in Stanford or DEEP); developing train-the-trainer programs; working to facilitate the use of CHWs in their state; providing **technical assistance** to existing ADA/AADE recognized/accredited programs; and increasing the numbers of new ADA/AADE recognized/accredited diabetes education programs in each state.
- Achieving this recognition/accreditation enables the program to bill for the Medicare diabetes self-management training (DSMT) benefit, as well as potentially billing to other insurers/payers for diabetes education.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

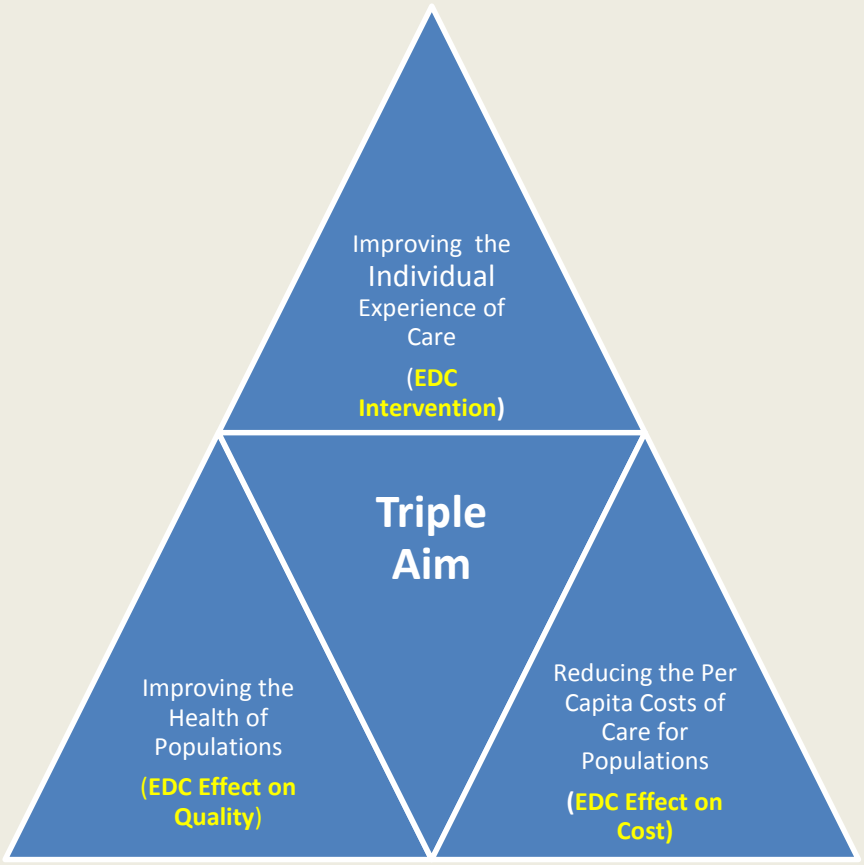
EDC
Everyone with Diabetes Counts

EDC and the Triple Aim

EDC Components:

- Beneficiary recruitment and education (DSME)
- Participating Practice (PP) recruitment and education (including PP staff)
- Community partner recruitment
- Sustainability planning
- Data collection

EDC Intervention: Beneficiary DSME Classes and PP technical assistance (T.A.)
EDC Effect on Quality: Clinical Data Results
EDC Effect on Cost: Medicare Claims Data



CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Medicare Preventive Services/Benefits

- Diabetes self-management training (DSMT) (for Medicare beneficiaries with diabetes)
- Medical nutrition therapy (MNT) (not limited to Medicare beneficiaries with diabetes)
- Diabetes and Pre-diabetes Screening (eligibility depends on risk factors for diabetes)
- Intensive Behavioral Therapy (IBT) Obesity Screening and Counseling (not limited to beneficiaries with diabetes)
- Chronic Care Management (not limited to beneficiaries with diabetes)
- Shared Medical Appointment (not limited to beneficiaries with diabetes)
- Depression Screening (not limited to beneficiaries with diabetes)

https://www.cms.gov/Outreach-and-education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

EDC Facts and Results

- **National Partners:** CDC (1305 Grantees), ACL (formerly AoA), Office of Minority Health (OMH), ADA, AADE, Stanford, U of Illinois, Chicago (UIC), AMA, NCOA
- **Stanford** – the highest level of trainers (Master-T-Trainers) certified to teach Stanford in Spanish on the East Coast of U.S. are in NY QIN-QIO
- **DEEP** – the highest level of DEEP trainers in the U.S. (Senior Trainers), outside of the UIC staff, are in the QIO Program
- To date, **> 50,000 Medicare beneficiaries in minority/diverse and rural populations** have completed DSME classes through EDC
- To date **> 30,000 physicians/health care providers** have participated in EDC
- To date, **> 3,000 lay diabetes educators** (CHWs, and lay leaders) have been trained in the DSME curricula used by the QINs
- To date **> 5,000 community-based organizations** have participated in EDC
- To date DSME classes in EDC have been hosted at **> 9,000 community based sites**
- **QIOs have Taught DSME classes in various settings**: out-patient mental health facilities; in SNF facilities; and in dialysis facilities; for visually impaired, classes with materials in Braille
- **DSME classes are being taught in Spanish, Mandarin, Swahili**

Sustainability Example: In Texas through EDC over a 5 year period:

- 14 partners have achieved accreditation for diabetes education programs;
- The numbers of new CDE applicants increased by 18% over 5 years; the numbers of actual CDEs increased by 15% in 4 years.
- 1,300 diabetes educators (lay educators) have been trained in the DEEP DSME curriculum

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

EDC Challenges

- Social determinants of health – poverty, low-literacy/illiteracy
- Language challenges, English may be second language
- Food deserts
- Lack of transportation
- Cultural beliefs: fatalistic/self-fulfilling prophecy of, “my parents died from diabetes, so will I”
- Trust issues in these communities
- Sometimes community partners request donations/payment to use space to host DSME classes
- Keeping beneficiaries and health care providers motivated and engaged – requires maximum creativity, and continuous PDSA cycles on the part of the QINs

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Resources - Websites

- http://qioprogram.org/EDC for information about EDC, Success Stories, Photos, Aggregated Data Results
- http://qioprogram.org/edc/faq for FAQ's about EDC
- http://www.qioprogram.org/contact to locate the QIN QIO in your state, and for general information about QIN QIOs
- https://www.cms.gov/Outreach-and-education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html for information about Medicare preventive services/benefits
- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-17.html for CMS OMH Mapping Medicare Disparities Tool

Contact Information:

Susan.Fleck@CMS.HHS.GOV

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Words of Inspiration

One person can make a difference, and everyone should try.
John F. Kennedy

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

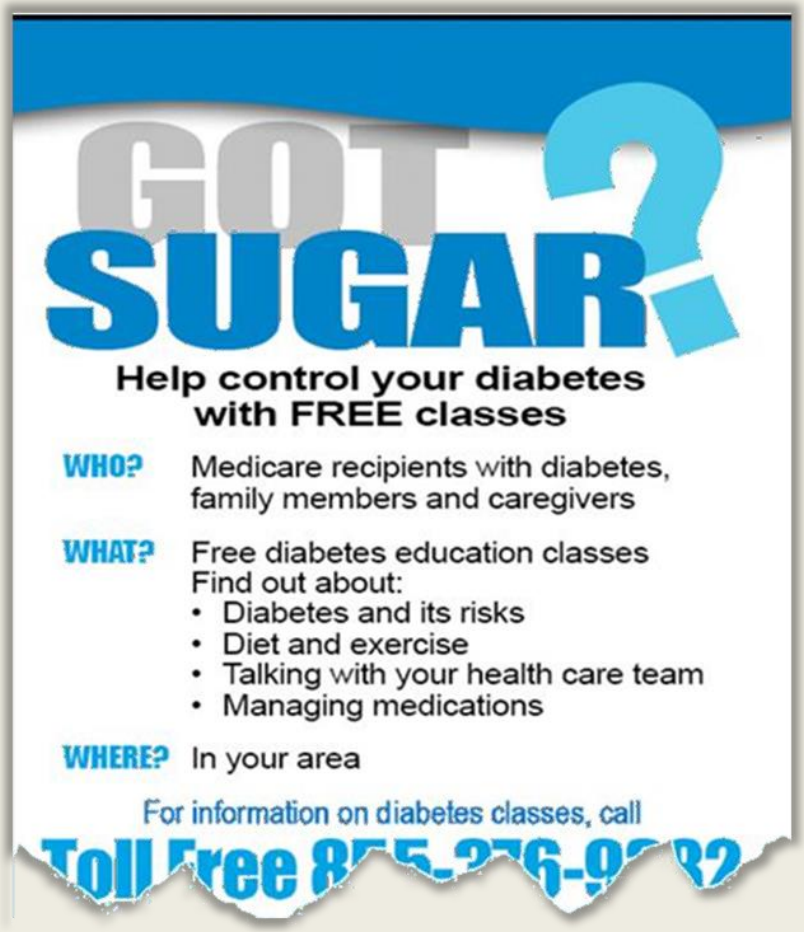
EDC
Everyone with Diabetes Counts

Words of Inspiration

We did the best we could with what we knew, and when we knew better, we did better.
Maya Angelou

EDC Pictures

Marketing Flyer for EDC Classes



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

EDC Master Trainers Class Graduates, Texas

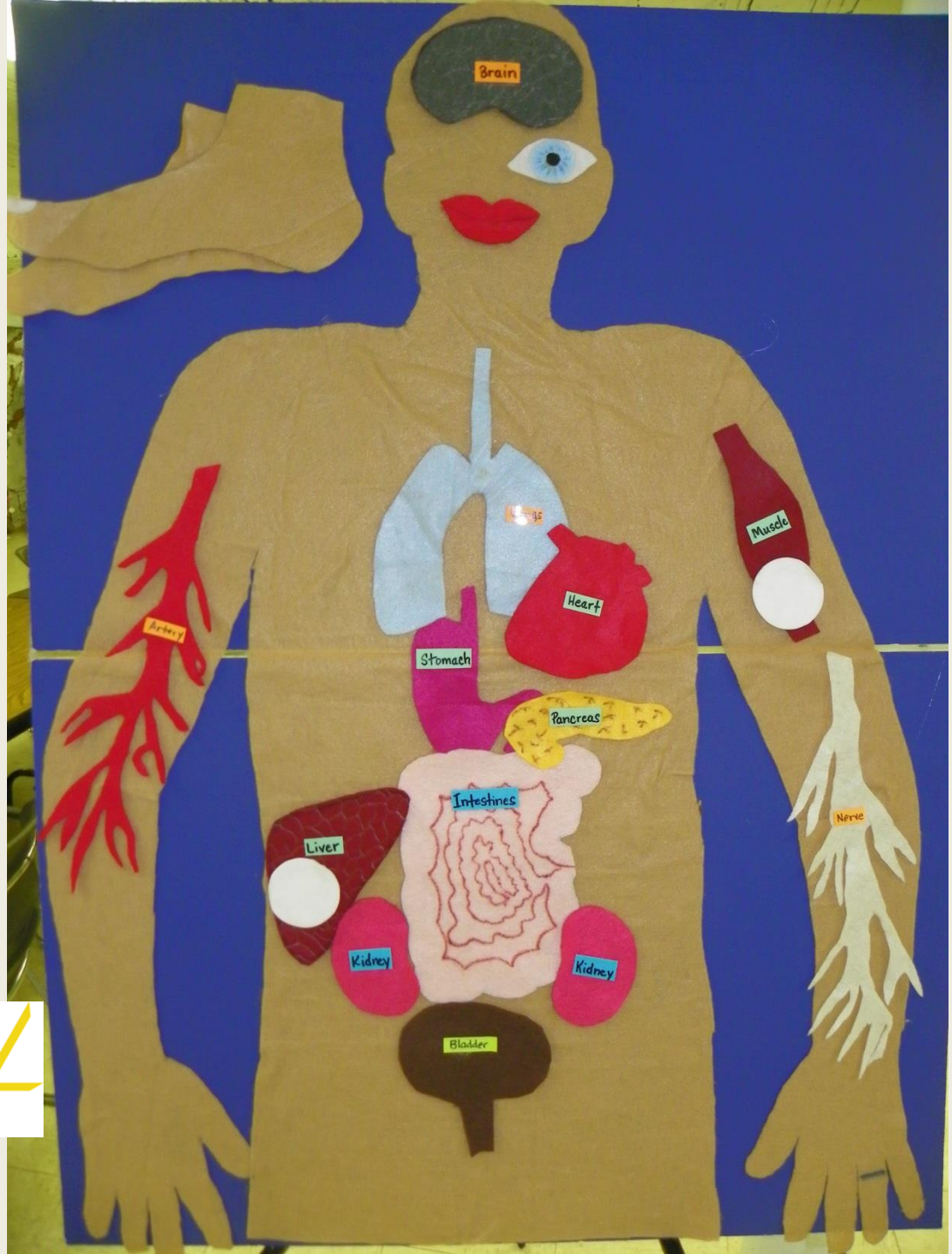
CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

EDC Medicare Beneficiaries Graduation Ceremony, Bronx, NY

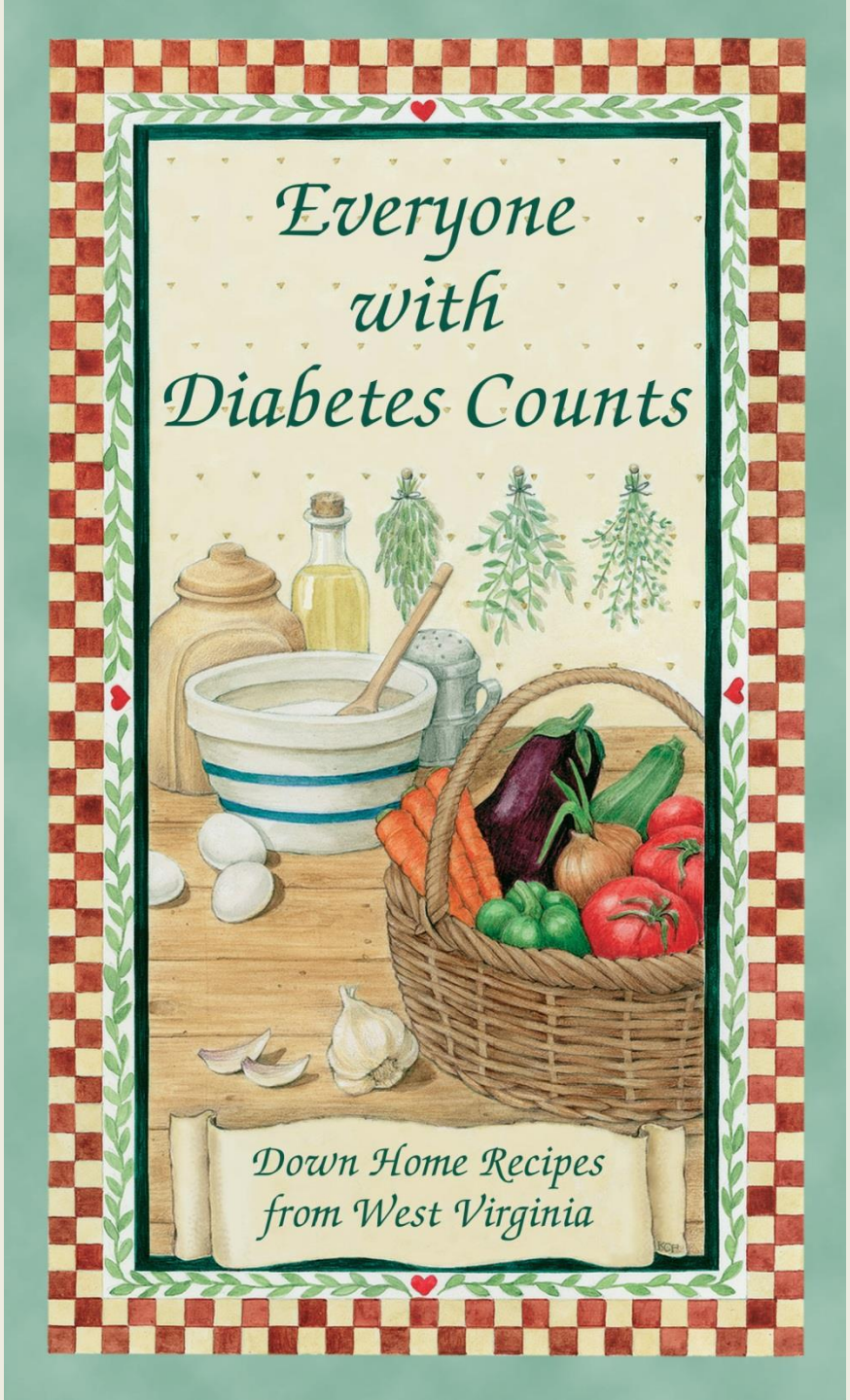
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts



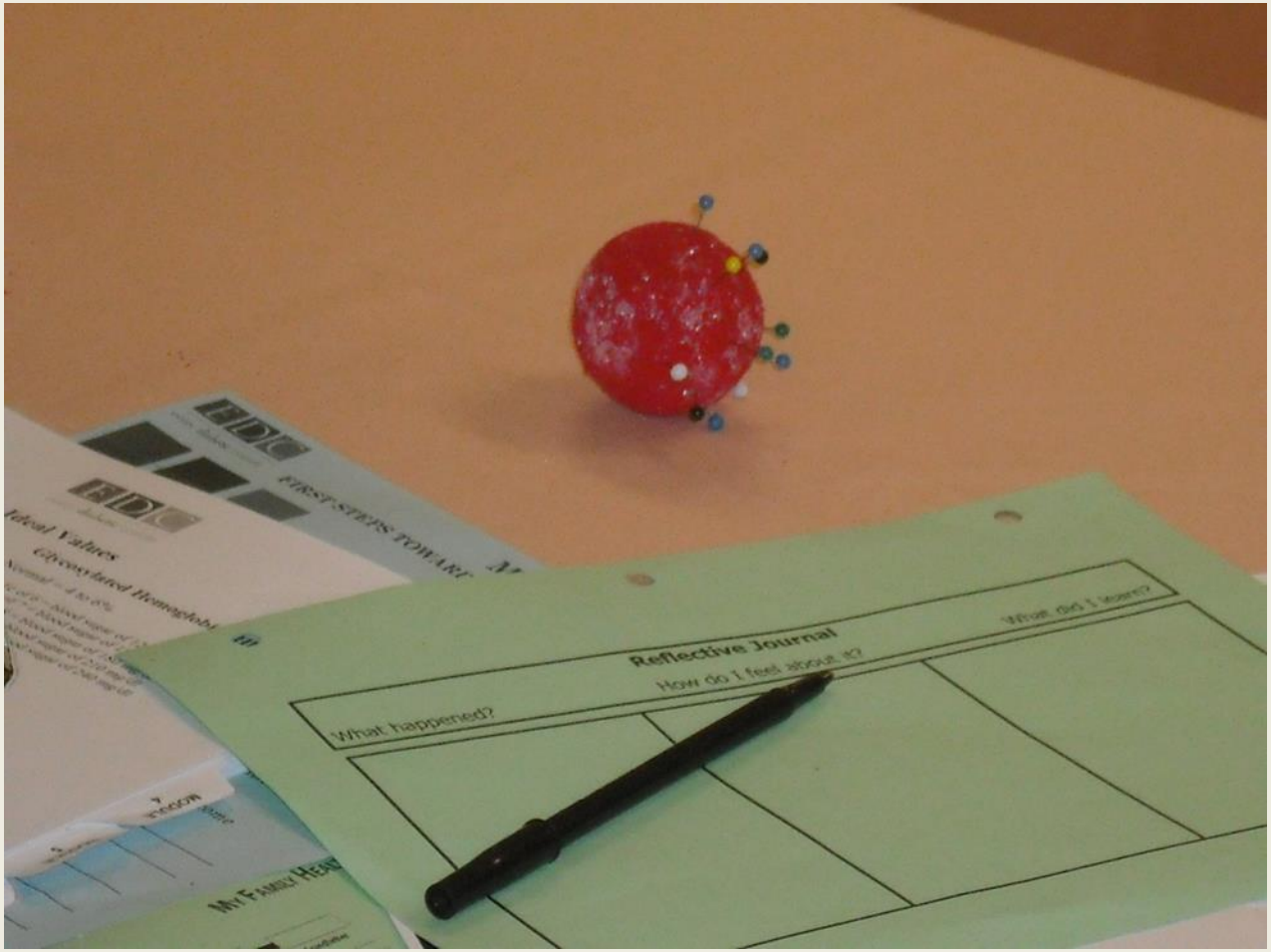
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

HbA1c Molecule



EDC on Front Page of Latino Post, New York City

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

How to Check Your Blood Sugar

1 Wash your hands with soap and warm water. Rinse well.

2 Gently rub your hands to warm them.

3 Put the test strip into your meter.

4 Prick the side of your finger.

5 Touch your blood drop to the test strip.

6 Write the results in your book.

Quality Improvement Organizations | TMF Health Quality Institute

Phone: 1-800-725-2633 • Fax: 1-877-889-1870
www.DiabetesHealthForLife.org

CMS CENTERS for MEDICARE & MEDICAID SERVICES

EDC Everyone with Diabetes Counts

Cuidando Sus Pies

Mantenga sus pies protegidos y saludables para evitar heridas en los pies y llagas abiertas.

Mantenga los pies limpios y secos.

No sumerja sus pies durante mucho tiempo.

Use calcetines limpios todos los dias y siempre use zapatos con punta y talón cerrados.

Revise sus pies diariamente por ampollas, enrojecimiento o llagas. Consulte a su médico de inmediato si tiene cualquier llaga.

Acostúmbrese a utilizar una lima para afilarse las uñas. Nunca use una navaja o cuchillo.

Mantenga los pisos y rutas de acceso libres de objetos para evitar tropiezos con la punta de sus pies.

Examine sus zapatos todos los dias.

Nunca camine descalzo(a) o use chanclas.

Quality Improvement Organizations | TMF

Phone: 1-800-725-2633 • Fax: 1-877-889-1870
www.DiabetesHealthForLife.org

This material was prepared by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, 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. 1SEDM-TX-EDC-072314

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

EDC
Everyone with Diabetes Counts

DARS

VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

Supporting Virginians' efforts to secure independence and employment

You Can! Live Well, Virginia!

Partnering with Quality Improvement Networks to Expand Access to Diabetes Self-Management Education Programs

April 19, 2016

DARS
Virginia Department for Aging and Rehabilitative Services

You Can! Live Well, Virginia!

The Virginia Division for the Aging
Department for Aging and Rehabilitative Services

Mission:

To foster the dignity, independence, and security of older Virginians by promoting partnerships with families and communities

Designated by the federal government
to oversee all state programs using Older Americans Act and the Virginia General Assembly funds

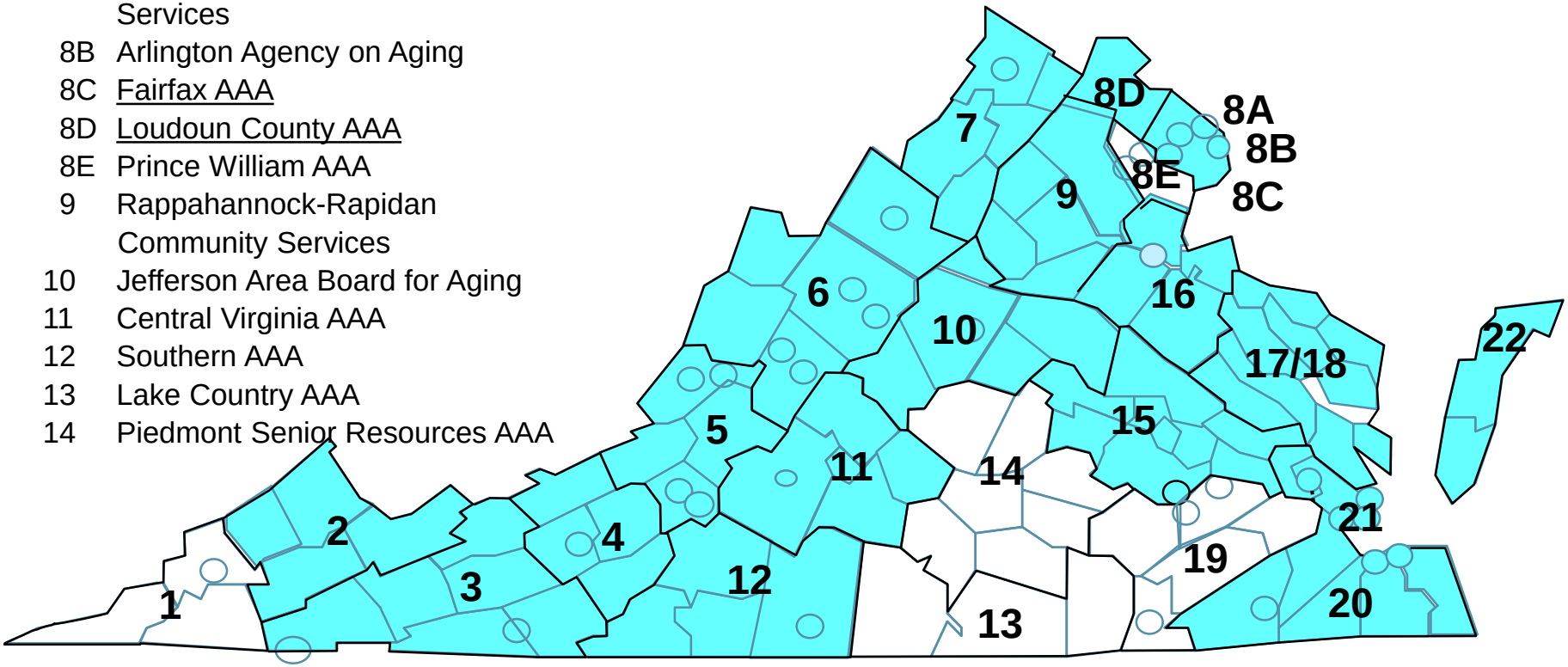
25 Area Agencies on Aging contract with the Division

History of CDSME in Virginia

- 2005: Introduced by Virginia Department of Health.
- March 2010: Two-year ARRA grants to states from US Administration on Aging to disseminate CDSM to older adults.
- September 2012: Virginia one of 22 states awarded a 3 year grant under the Prevention and Public Health Funds, Affordable Care Act.
- DARS is the lead state agency. Area Agencies on Aging are leads at the local level.

Virginia's CDSME Programs 4-19-16

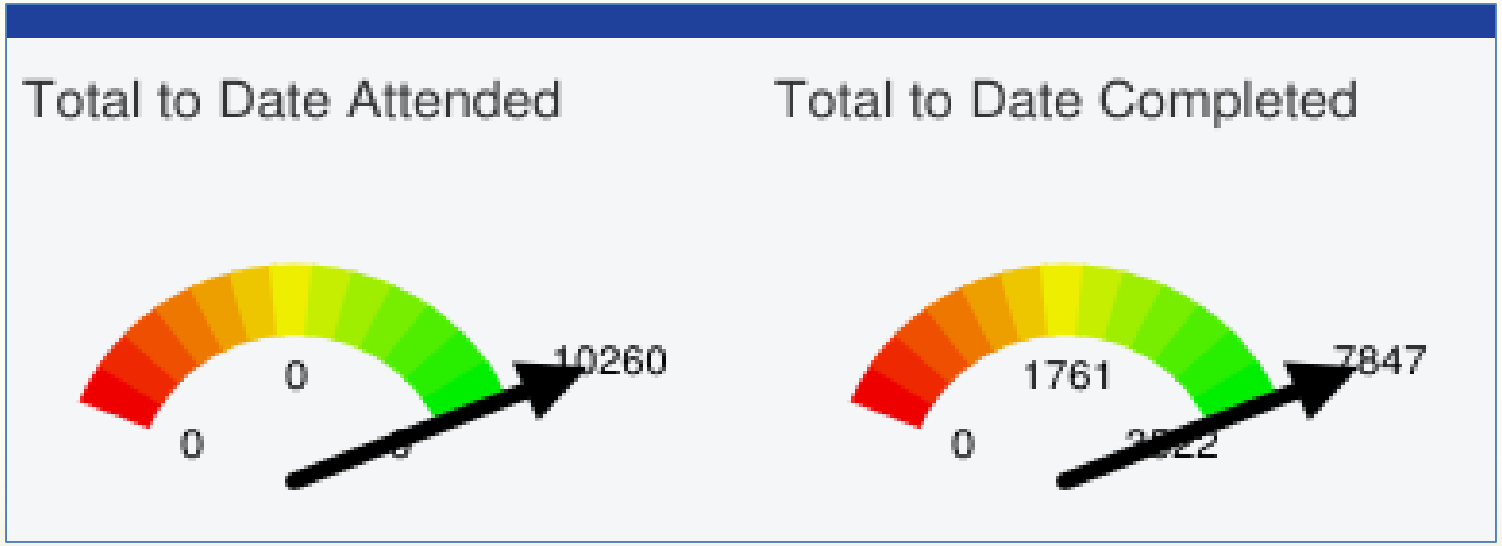
1 Mountain Empire Older Citizens
2 Appalachian Agency for Senior Citizens
3 District Three Senior Services
4 New River Valley Agency on Aging
5 LOA Area Agency on Aging
6 Valley Program for Aging Services
7 Shenandoah AAA
8A Alexandria Division of Aging and Adult Services
8B Arlington Agency on Aging
8C Fairfax AAA
8D Loudoun County AAA
8E Prince William AAA
9 Rappahannock-Rapidan Community Services
10 Jefferson Area Board for Aging
11 Central Virginia AAA
12 Southern AAA
13 Lake Country AAA
14 Piedmont Senior Resources AAA
15 Senior Connections, The Capital AAA
16 Rappahannock AAA
17/18 Bay Aging
19 Crater District AAA
20 Senior Services of Southeastern Virginia
21 Peninsula Agency on Aging
22 Eastern Shore AAA - Community Action Agency



DARS
Virginia Department for Aging and Rehabilitative Services

You Can! Live Well, Virginia!

Participation in CDSME Workshops
April 1, 2010 through April 12/2016



Accomplishments

Reached diverse populations:

- Workshops in Spanish, Chinese, Vietnamese, Korean and sign language
- Persons with disabilities
  - Embedded at Wilson Workforce and Rehabilitation Center
  - Centers for Independent Living
  - Behavioral health and recovery programs
  - Clubhouse programs
- Six state prisons
- Low income and homeless populations

- Formed lasting partnerships – locally and statewide

Our Dilemma

3 year Stanford license 6/1/12 → 5/31/15		Renew License???
	PPHF 2012 Grant 9/1/12 → 8/31/15	2015 PPHF grant award???

Enter VHQC!

DARS
Virginia Department for Aging and Rehabilitative Services

You Can! Live Well, Virginia!

Thanks for your attention!

Chronic Disease Self-Management Education programs

Contact:

April Holmes
Department for Aging and Rehabilitative Services
804-662-7631
april.holmes@dars.virginia.gov

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

VHQC

Partnering with Quality Improvement Networks to Expand Access to Diabetes Self-Management Education Program

April 19, 2016

Everyone with Diabetes Counts (EDC)

a. Contract cycle started Fall 2014
b. VHQC's Plan
    1. Stanford License for CDSME
    2. Secure Master Trainers
    3. Find community organizations and physicians; hold workshops
c. DARS infrastructure with Area Agencies on Aging (AAA) for CDSME

VHQC-DARS Partnership

VHQC

a. Maintain Stanford Multi-site CDSME License
b. Provide workshop supplies for some AAAs
c. Provide promotional materials and marketing support
d. Develop Reference Guide for EDC
e. Serve as backup for trainers when needed

VHQC-DARS Partnership, cont'd

DARS

a. Coordinating entity
b. Support to leadership of AAAs
c. Facilitate monthly conference call with AAAs and VHQC
d. Fidelity and annual technical assistance visits
e. Distribution of financial support to AAAs

VHQC-DARS Partnership Cont'd

AAAs

a. Facilitate CDSME and DSME workshops
b. Ensure paperwork/documentation to VHQC
    1. Registration logs
    2. Pre and post patient activation surveys
    3. Demographics
    4. Clinical data consent form

Contact VHQC

Thelma M. Baker

tbaker@vhqc.org

804-289-5336

www.vhqc.org

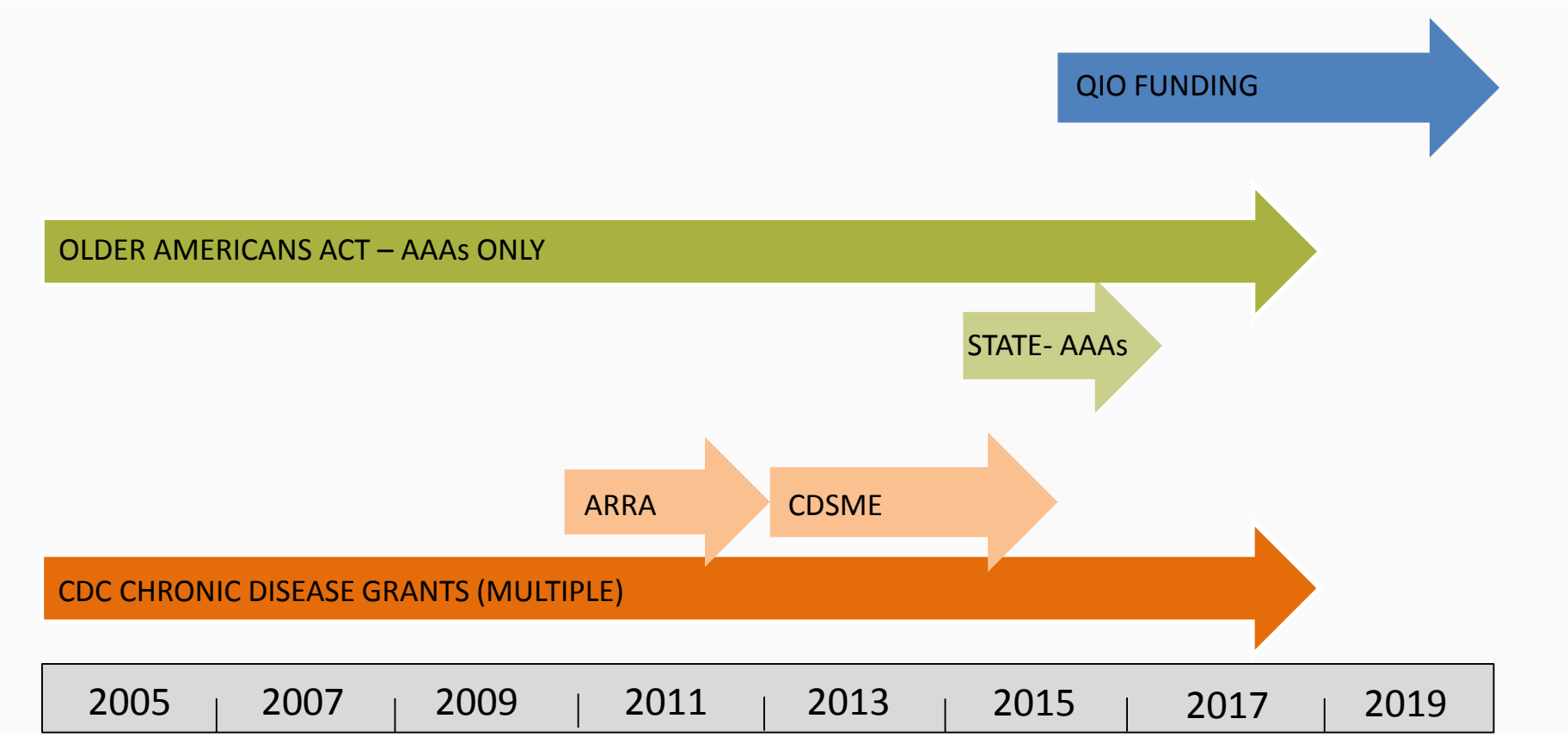
This material was prepared by VHQC, the Medicare Quality Innovation Network Quality Improvement Organization for Maryland and Virginia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. VHQC/11SOW/3/30/2016/2428

Self-Management in Oregon: Working Together for Spread and Sustainability

Public Health Division

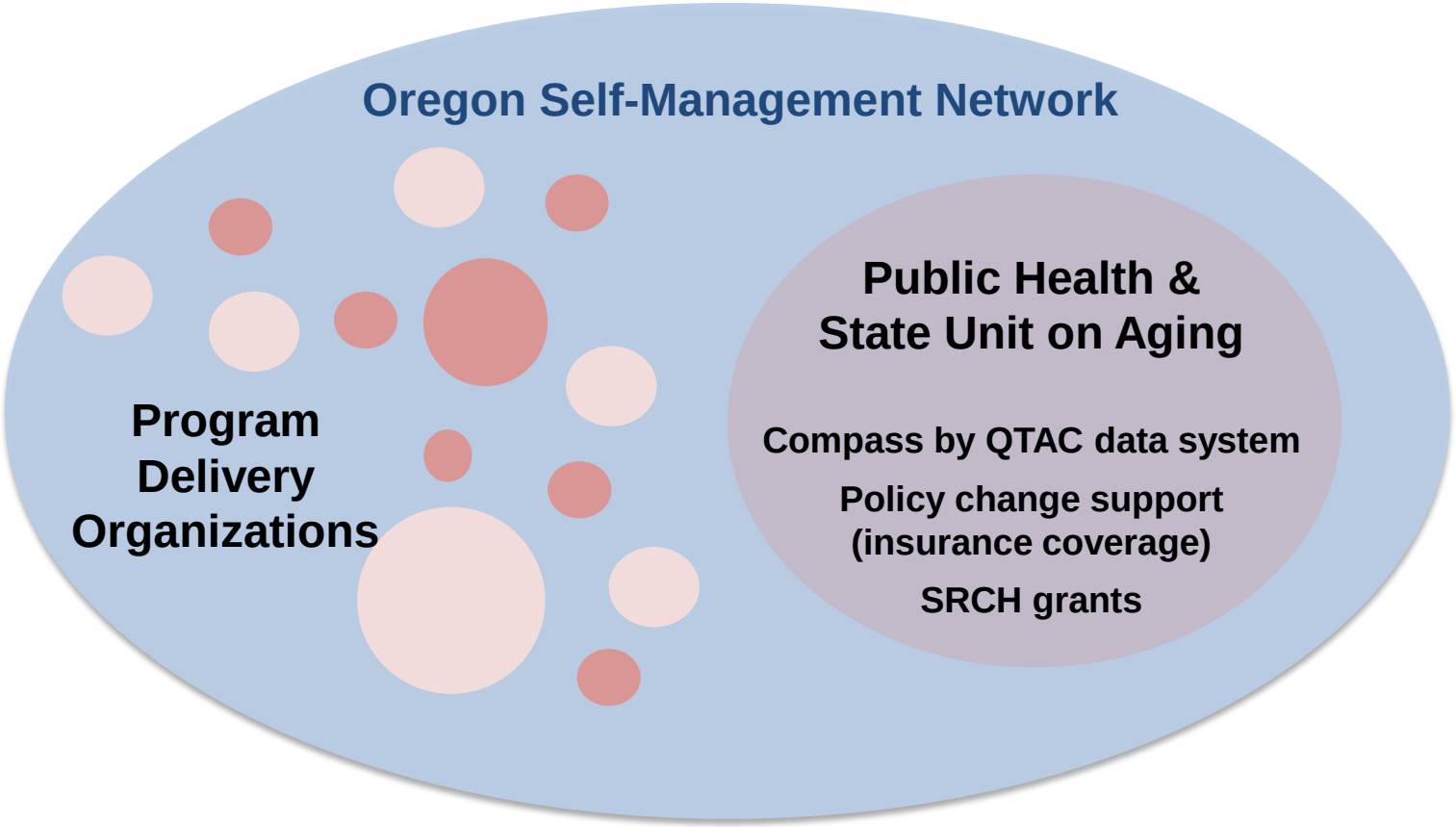
State Unit on Aging

Oregon Self-Management Funding

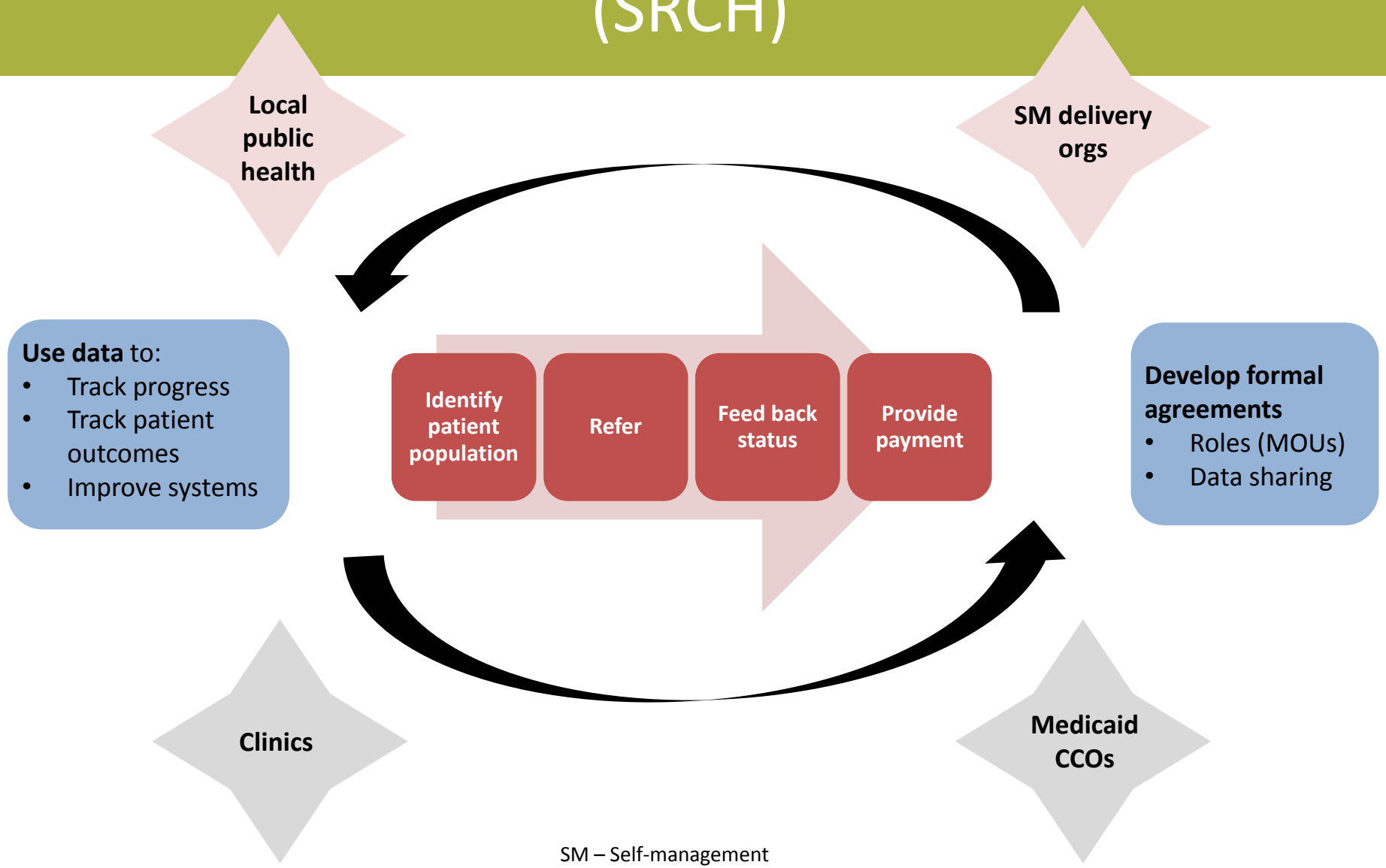


AAAs – Area Agencies on Aging
ARRA – American Reinvestment & Recovery Act
CDC – Centers for Disease Control & Prevention
QIO – Quality Improvement Organization

Oregon's Self-Management Delivery Infrastructure



Sustainable Relationships for Community Health (SRCH)

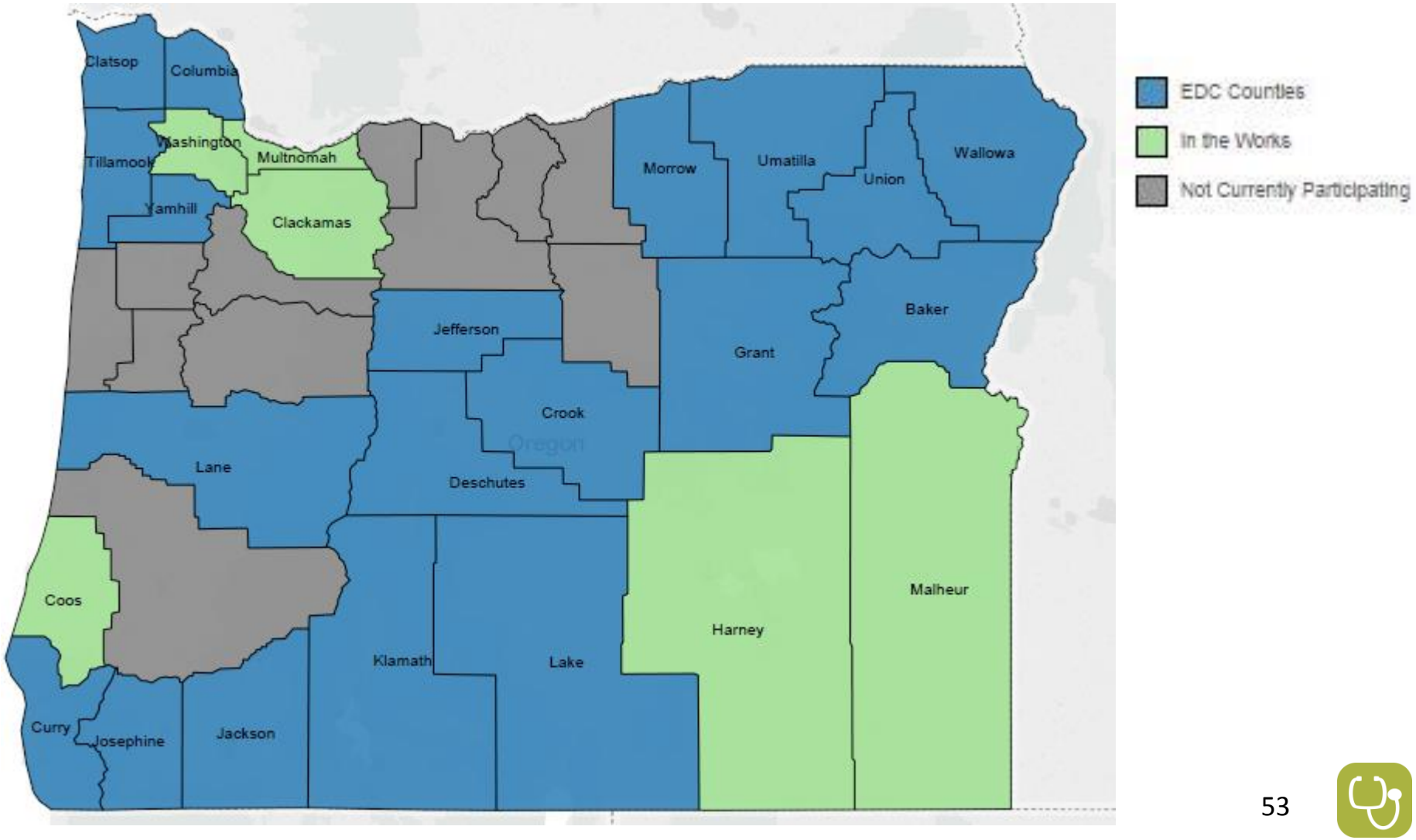


SM – Self-management
CCO - Coordinated Care Organization
MOU – Memorandum of Understanding

Oregon Partnership Roles

Public Health Div. & State Unit on Aging	Acumentra Health (QIN-QIO)
Develop initial delivery infrastructure	Develop delivery capacity in new communities
Develop initial partnership structure	Offer data utilization & process change expertise
License statewide SM data collection system	Provide value message & coaching for clinics & plans
Provide SRCH project management & funding	Broker relationships with clinical partners

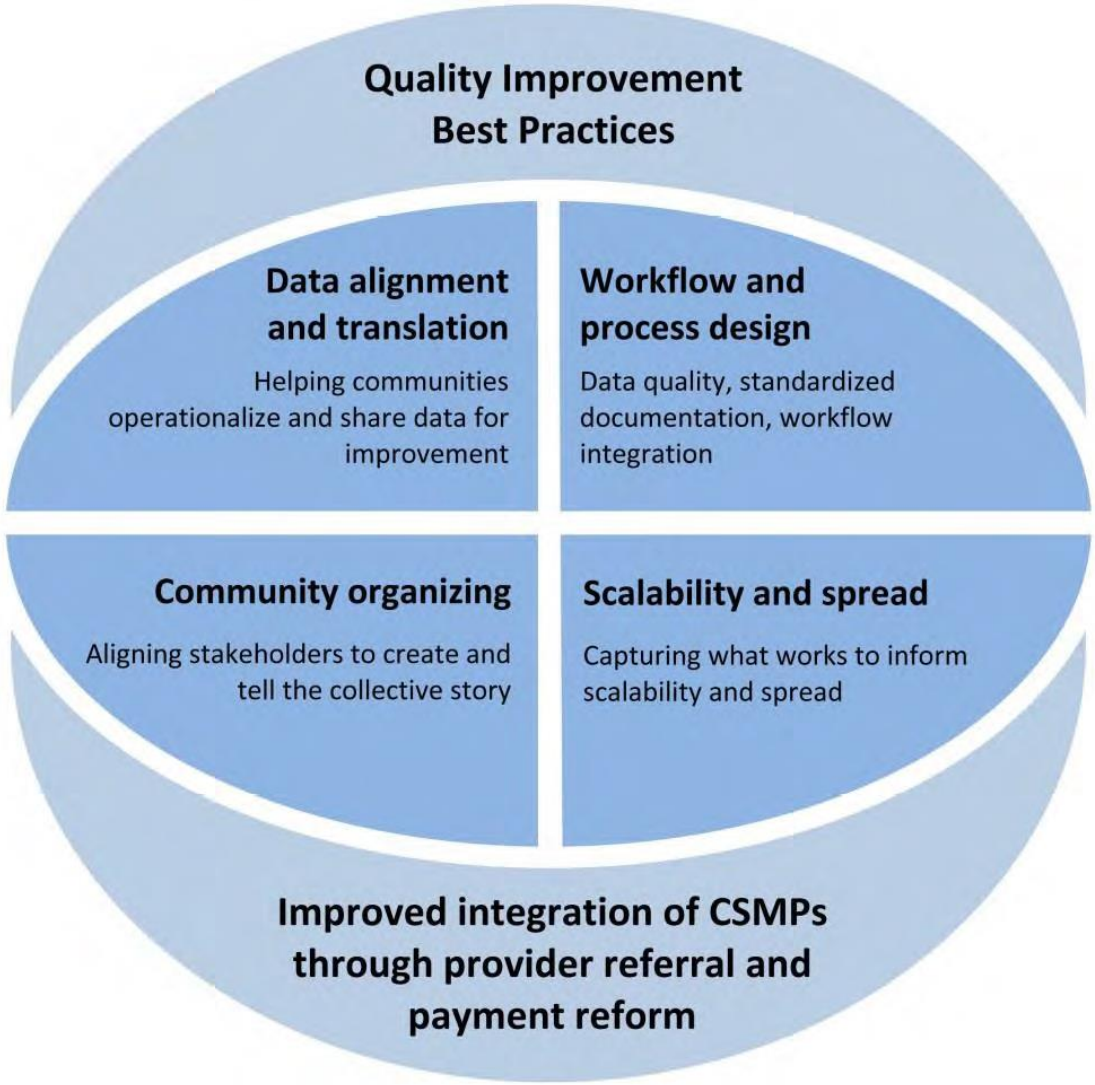
Oregon Everyone with Diabetes Counts (EDC) Communities



Partnering with your QIN-QIO

- Helping communities organize
  - Community organizing
  - Support for infrastructure development
- Process improvement coaching and data collection
- Clinical-community linkages

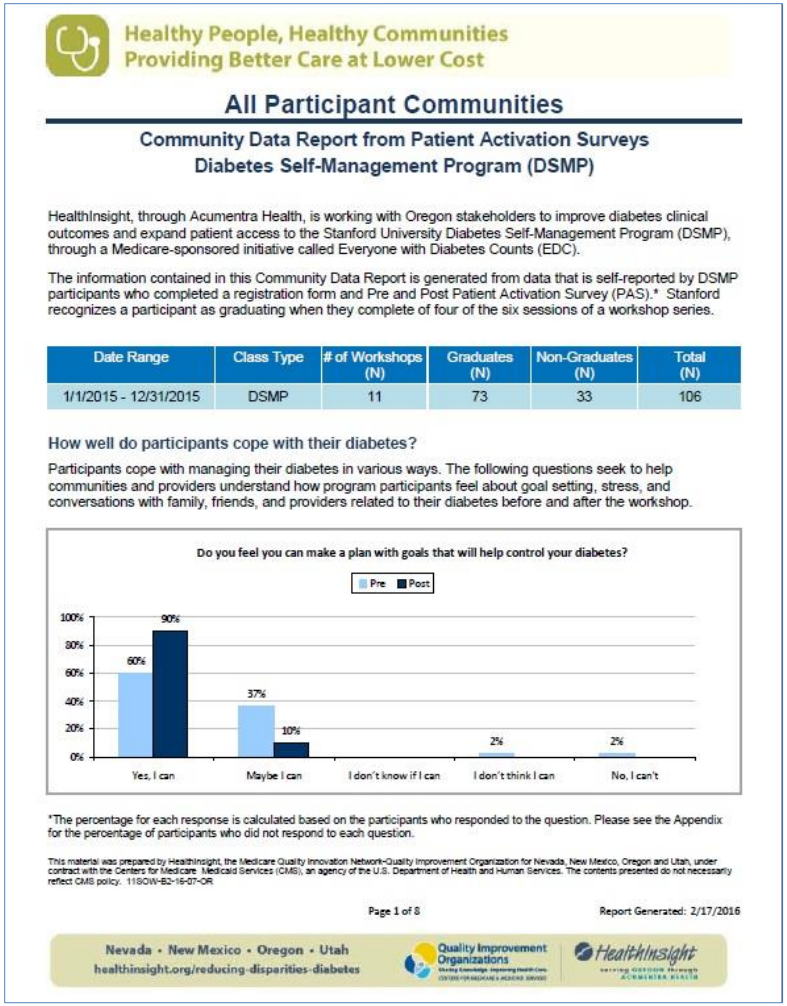
Oregon's QIN-QIO approach



Partnering with your QIN-QIO

Measurement and reporting

- Standardized data collection
- Translating data to value and action



Healthy People, Healthy Communities
Providing Better Care at Lower Cost

All Participant Communities

Community Data Report from Patient Activation Surveys
Diabetes Self-Management Program (DSMP)

HealthInsight, through Acumentra Health, is working with Oregon stakeholders to improve diabetes clinical outcomes and expand patient access to the Stanford University Diabetes Self-Management Program (DSMP), through a Medicare-sponsored initiative called Everyone with Diabetes Counts (EDC).

The information contained in this Community Data Report is generated from data that is self-reported by DSMP participants who completed a registration form and Pre and Post Patient Activation Survey (PAS).* Stanford recognizes a participant as graduating when they complete of four of the six sessions of a workshop series.

Date Range	Class Type	# of Workshops (N)	Graduates (N)	Non-Graduates (N)	Total (N)
1/1/2015 - 12/31/2015	DSMP	11	73	33	106

How well do participants cope with their diabetes?

Participants cope with managing their diabetes in various ways. The following questions seek to help communities and providers understand how program participants feel about goal setting, stress, and conversations with family, friends, and providers related to their diabetes before and after the workshop.

*The percentage for each response is calculated based on the participants who responded to the question. Please see the Appendix for the percentage of participants who did not respond to each question.

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-B2-16-07-OR

Report Generated: 2/17/2016

Nevada • New Mexico • Oregon • Utah
healthinsight.org/reducing-disparities-diabetes

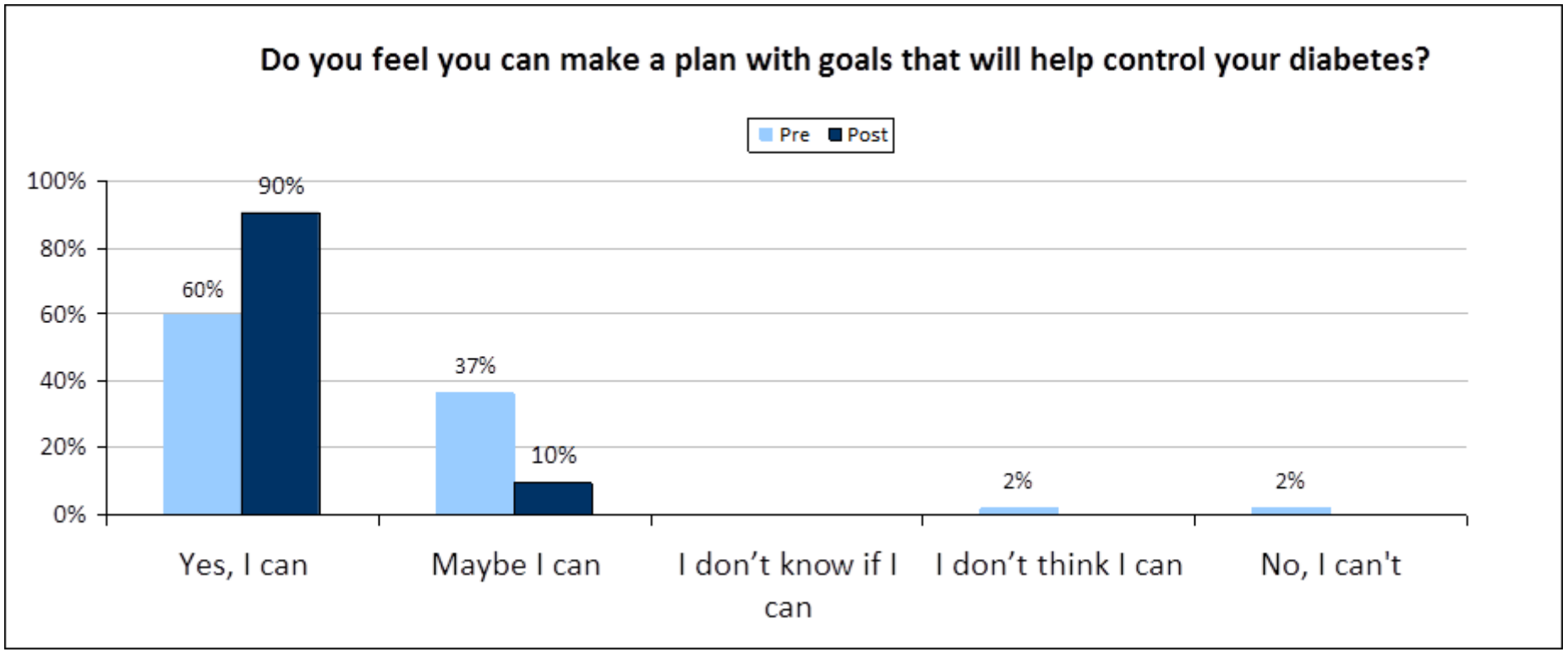
Quality Improvement Organizations

HealthInsight

DSMP Community Data Reports

- Quarterly cumulative summary for each community
- Annual analysis of DSMP data
- Pre & Post Patient Activation Survey
  - How well do participants cope with their diabetes?
  - What knowledge have participants gained?
  - In the last week, how many days…
- Participant Demographic Data

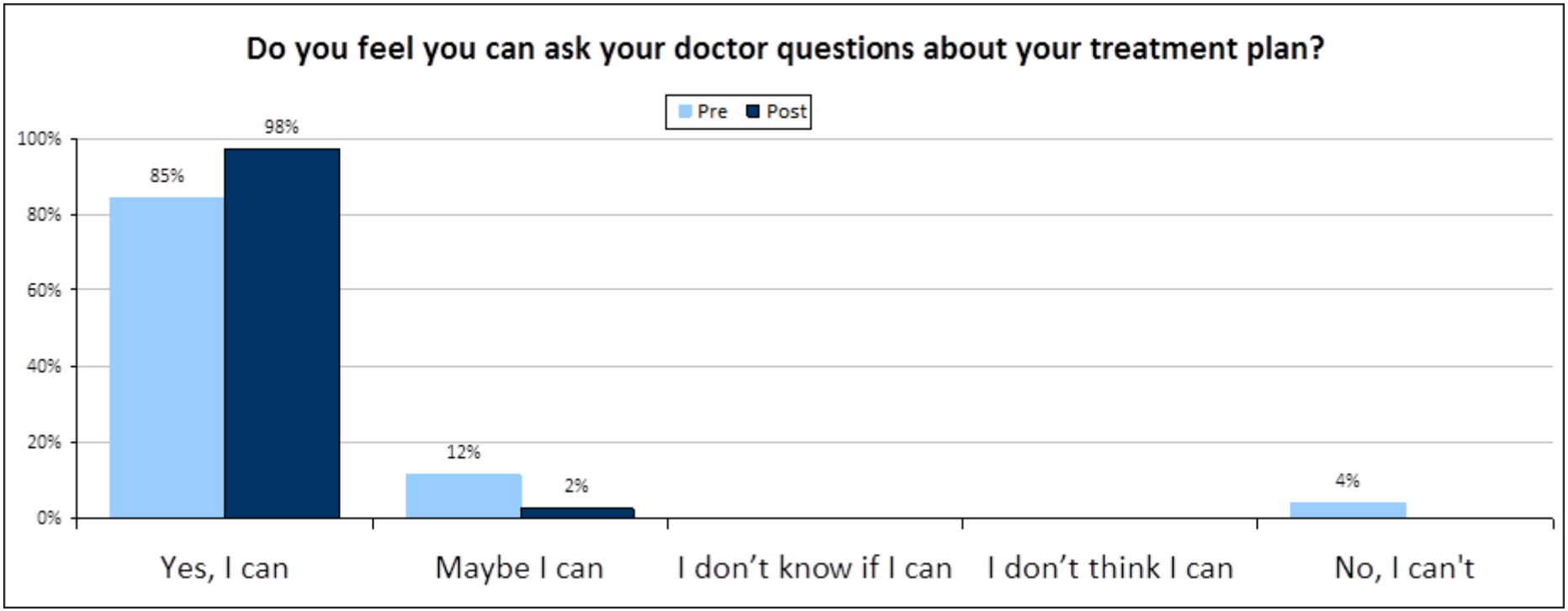
Pre/Post Graph Interpretation



Pre N=52
Post N=41

P-value: Yes: 0.001* Maybe: 0.003*
*statistically significant

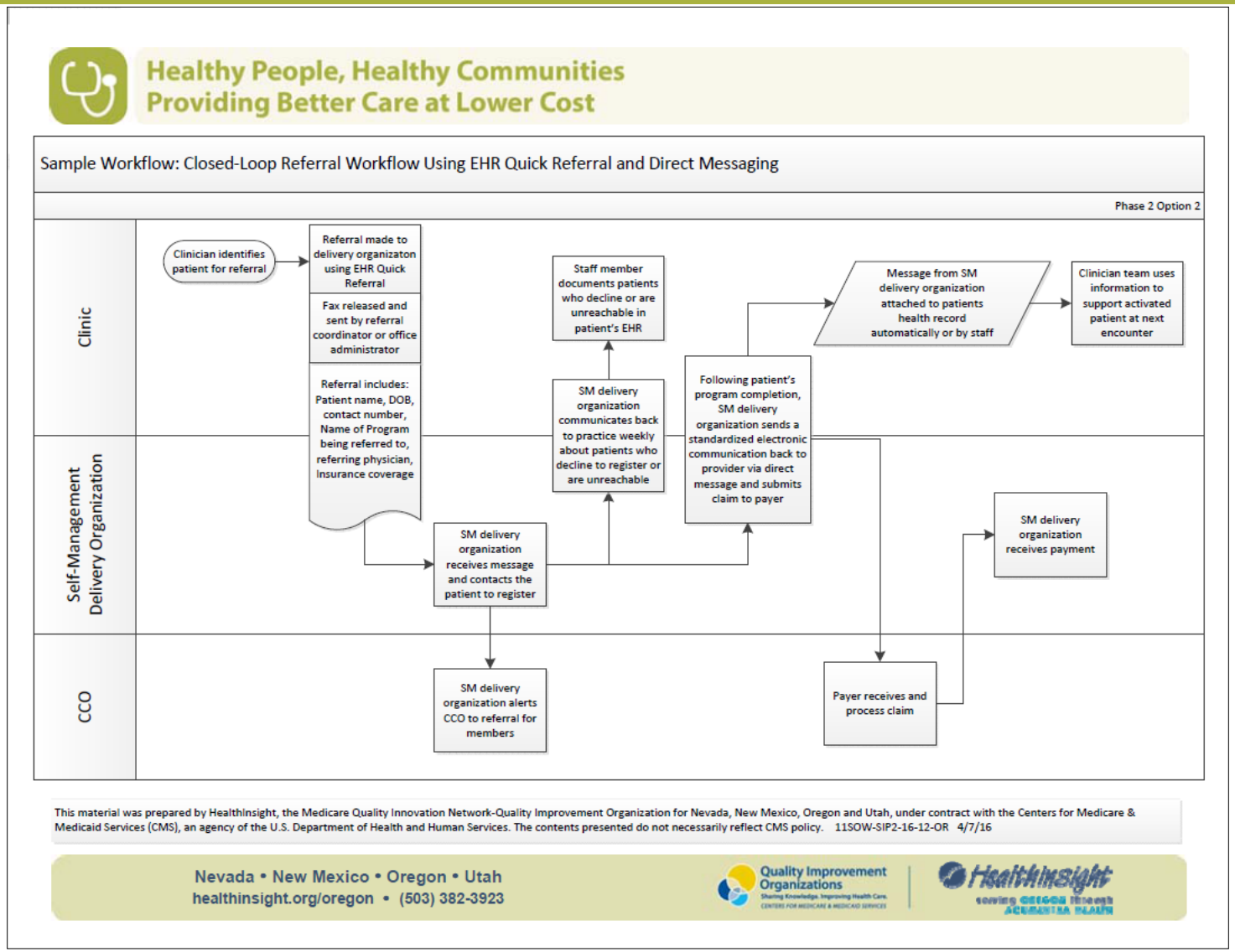
Communication with provider



Pre N=52
Post N=41

P-value
Yes: 0.036*

Creating clinical-community linkages



Contact us!

Tracy Carver, MPA
Acumentra Health
HealthInsight QIN-QIO
tcarver@acumentra.org
(503) 382-3931

Laura Chisholm, MPH, MA, MCHES
Oregon Health Authority
Oregon Public Health Division
laura.f.chisholm@state.or.us
(971) 673-0987

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-B2-16-16-OR 4/13/16

Questions & Answers

Type your question into the chat box on the lower left-hand side of your screen.

For reference, the slides and recording of this webinar will be available shortly on www.ncoa.org/cha.

Next Webinar

Register here

STEADI Implementation and Partnering with Health Care

April 27 @ 3:00 pm - 4:30 pm

Learn about how the Centers for Disease Control and Prevention's STEADI (Stopping Elderly Accidents, Deaths and Injuries) Toolkit can be used for fall prevention screening, assessment, intervention and education of older adults.

Presenters:

- **Erin Parker**, PhD, Health Scientist, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- **Bridget Talbut**, RN, Nurse Manager, Physician Practice Division, United Health Services
- **Tanya Wells**, MSEd, Injury Prevention Program Administrator, Vermont Department of Health