

MINUTES

Diabetes Learning Collaborative Kick-Off

7/17/2018
 11:30AM – 3:00PM
 Portland State Office Building

Action Items

Item	Who	By When
Build charter + send to participants for feedback	Akira	7/31/18
Begin developing Diabetes Tool Library (will be updated and finalized throughout collaborative)	Akira/Dani	7/31/18
Conduct session follow up (e.g. events page, send materials/survey, invites to future collaborative sessions)	Dani	7/20/18
Complete Pre-Collaborative Survey	All participants	ASAP
Accept listserv invite	All participants	ASAP
Send Akira story sheet	Webcam participants	ASAP

Agenda

Topic	Time	Expected Outcome
1. Registration	11:00-11:30 AM	Grab lunch!
2. Facilitated Networking Lunch <ul style="list-style-type: none"> • Clinic successes/challenges 	11:30-12:30 PM	Get to know your peers and their diabetes improvement work
3. Welcome! <ul style="list-style-type: none"> • Introductions 	12:30-12:50 PM	Review why we are here and goals of day
4. Co-Design: Dimensions of the Collaborative <ul style="list-style-type: none"> • Reflective discussion • Sharing of clinic priorities 	12:50-1:35 PM	Brainstorm topical areas for future collaborative sessions
5. Break	1:35-1:45 PM	Grab a snack!
6. Co-Design: Structure of the Collaborative <ul style="list-style-type: none"> • Expectations and goals • Additional scoping 	1:45-2:30 PM	Discuss key components and activities of the collaborative

7. Wrap-up	2:30-3:00 PM	Review next steps and evaluation
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Handouts

1. Diabetes Infographic
2. Agenda
3. Upcoming OPCA Events Bulletin
4. Upcoming Partner Events List
5. OHA Transformation Center TA Opportunities

Notes/Minutes

- **Facilitated Networking Activity: Clinic Success/Challenges**
 - Challenges
 - Make patient reach out attempts a sustainable workflow. When patients come to the clinic they have a lot of acute issues going on so diabetes becomes a lower priority. Need a holistic perspective.
 - Acute issues takes precedence over diabetes. Trying to have better engagement with patients (same day visit), using motivational interviewing to ask patient “what do you need” more often. Would love to see the metrics on engagement.
 - Need increased education for staff and support system for staff uncomfortable with motivational interviewing and intervention.
 - Need to encourage nurses to talk with patients and have those conversations.
 - Need to ensure the touches we have with patients contains a continuity of care. Previously tried to educate patients on diabetes self-care within an hour, but found that the patient wouldn't retain this information. Continually re-educating.
 - Mosaic – Trying a comprehensive approach: Elevate the level of education around chronic conditions for all levels of staff, increasing continuity of care.
 - Need to study what the patient is doing after the visit, to see what they and their family are doing to manage chronic conditions.
 - Have more from the patients point of view
 - Level of commitment at the home
 - Would love to know which clinics are doing well with diabetes poor control, and what their best practices are:
 - How to execute and sustain best practices?
 - Which have the best quality scores?
 - **OPCA Note: We will look at 2017 UDS data and try to engage those who are doing well throughout the collaborative. Once the charter is compiled, we will send out blinded data charts so that you can see the range of quality scores for the 2017 UDS diabetes poor control measure.**
 - Practices to consider:
 - Winding Waters: Using EHR more efficiently and dividing groups into tier levels and reaching out to folks and planning visits. If someone was doing well, they would be put into a rotation to be contacted in 6 months. If an individual was doing poorly connecting them with the appropriate staff member and doing a warm hand-off to see them sooner.
 - Mosaic: Completed a curriculum for behavioral health staff on hypertension and diabetes metrics. This has empowered staff.
 - PAM (Patient Activation Measure) - Tool to see where patients are in terms of their activation.
 - Finding more targeted EHR assistance, depending on which system you're using.
 - How are folks using their data to prioritize services – EHR assistance
 - Incentivizing patients seems to be a great motivation tool to encourage self-management.
 - Trying to get a pilot started around an incentivizing program for patients
- **Co-Design: Dimensions of the Collaborative**

- **Priorities for Collaborative:**
 1. Clinical Pathways (Patient Journey) – 8 votes
 2. EHR Support/Optimization – 7 votes
 3. Patient Education/Motivation – 3 votes
 4. Developing Tools/Resources/Partnerships – 3 votes; this will likely happen as a result of the collaborative anyway; may not need to be its own goal in the charter
 5. Implementing/Operationalizing Workflows – 3 votes; this will likely be included naturally into presentations and conversations; may not need to be its own goal in the charter
 - **Advocated Point: Team-base Care (connects with pathways and can be combined)**
 - This includes all individuals that interact with patients (both providers and medical assistants)
 - Perhaps call it Patient Journey (so that it's not confused with CHW Pathways Model)
 - **Advocated Point:** Bring Community Partnerships into the discussion to create a bank of tools and resources
- **Co-Design: Structure of the Collaborative**
 - Share which clinics in Oregon who's a good reference and what their best practices are.
 - Group Visits to those clinics
 - Getting the Patient perspective: Patient-Centered Approaches
 - **What's Virginia Garcia doing?** Heard they have good diabetes control
 - **OPCA Note:** They have explicitly opted out of this initiative for internal reasons. We will look at 2017 UDS data and try to engage those who are doing well throughout the collaborative.
 - Create a brief survey for patients as part of this collaborative and reviewing those results
 - Multi-cultural inclusion
 - Bring in Community Partners who are doing well
 - Helpful to have pre-work that's then discussed in the calls as an accountability measure
 - Continue providing examples from other clinics regarding what they're currently doing regarding the different metrics
 - Personalized site visits (OHSU Richmond has good diabetes control)
 - Grouped by patient population and size
 - Possibly group by EHR type
 - Applying Risk stratification (e.g. Healthy People via EPIC)
 - Would help inform the work of clinics
 - Inform collaborative of OPCA Data Warehouse work as it progresses
 - Please keep it simple – Don't focus too much on one tool or set of tools
 - **Clinic Feedback: I like; I wish; I wonder...**
 - *Like...*
 - In person folks were grouped ahead of time to facilitate conversation
 - The free time to discuss current work from different clinics
 - Walking through the dimensions on what the collaborative will be working
 - Food was good!
 - Diversity of the group
 - *Wish...*
 - To have a summary of the research that being done on Diabetes poor control
 - To have a session focused on problem solving
 - *Wonder...*
 - How to engage the high performers to actively participate in the room (they may not have been in the room because they're already doing well)

Adjourned: 3:00PM