

TYPE 2 DIABETES IN ADULTS

A QUALITY IMPROVEMENT TOOLKIT FOR CLINICAL PRACTICE SITES IN RURAL APPALACHIA

2023



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BACKGROUND

SOUTHEASTERN OHIO REGIONAL QI HUB

Lying at the foothills of the Appalachian Mountains, our community embraces the values of Appalachian culture: kinship, loyalty, generosity, and caregiving. We understand that family extends beyond blood to include our neighbors, business owners, and leaders. Just as every member of the family is expected to contribute to the community, our area healthcare providers are dedicated to treating all patients like part of the family.

We recognize that diabetes is one of the most significant chronic conditions affecting our community. We also know that barriers pervasive to our region interfere with people's ability to manage their diabetes. Therefore, the Southeastern Ohio Regional Quality Improvement Hub is here to support primary care providers, specialists, pharmacists, behavioral health experts, diabetes educators, and community health workers to meet the needs of people in our region experiencing unequal diabetes care. Our overarching goal is to provide high quality diabetes care services to optimize the health and well-being of all members of the southeastern Ohio community.

HEALTH DISPARITIES

In 2017, diabetes was the 7th leading cause of death in Ohio, and Ohio's diabetes age-adjusted death rate was ranked 9 out of the 50 states, at 25.2% (3,740 deaths)². Approximately 981,195 adults in Ohio have been diagnosed with diabetes and it is estimated that 2 million more have prediabetes.

The estimated prevalence of adult diabetes in all of Ohio is 11% as compared to 19.9% in rural southeastern Ohio. Here, 17% of the population lives below the poverty line as compared to 13% of the United States and 14% of Ohio.

All of the counties in southeastern Ohio are designated health professional shortage areas for primary care, dental care, and mental health providers. Furthermore, the people living in southeastern Appalachian Ohio are more likely to be unemployed, have lower educational achievement, and limited access to transportation.

Additionally, people with diabetes are more likely to be diagnosed with macrovascular and microvascular complications, lower limb amputations, and depression, which contribute to a diabetes mortality rate that is 28.4% higher than the national average.

Given the added challenges of geographic isolation, most individual healthcare clinics and organizations lack the capacity to address these barriers directly without additional support. Through the collaboration of clinical leaders and state partners, the Southeastern Ohio Regional Quality Improvement Hub addresses the system of care for diabetes to achieve equitable health outcomes for people living with diabetes.

ABOUT HUB SUPPORT

Sponsored by the Ohio Department of Medicaid (ODM) in partnership with Ohio Colleges of Medicine Government Resource Center (GRC), the Southeastern Ohio Regional Quality Improvement Hub aims to improve the health of people living with diabetes in southeastern Ohio. The Southeastern Ohio Regional Quality Improvement Hub will use quality improvement science to address diabetes outcomes. Clinical practice sites will develop and enhance quality improvement interventions designed to impact Hemoglobin A1c goal achievement.

USE OF THE TOOLKIT

This toolkit is to introduce specific clinical and quality improvement concepts, practices, tools, and methods to work together in learning and performing best-evidence practices. This toolkit is a guide to how we will start. We will work together to determine how we will implement and sustain improvement.

Your role is to understand and apply relevant toolkit information necessary for improvement while always considering the perspective and needs of your patients and staff.

The toolkit includes specific content (best-evidence summaries, guideline recommendations) and Quality Improvement tools (Key Driver Diagrams, Plan-Do-Study-Act worksheets). The toolkit will highlight what the collaborative is to accomplish with the improvement initiative, what best-evidence practices have already been identified, what interventions might be tested, what measurements have been identified to demonstrate improvement, and how the measurements will be monitored to demonstrate success.

HOW TO USE THE TOOLKIT

Hub clinical leads, QI leads, QI coaches and trainers may use the toolkit with your team as a guide and reference source for initiating the early steps to improvement with each spoke site. Discuss the toolkit content together for learning and planning steps about the improvement initiative. Also use the toolkit as a repository framework to insert new learning, improvement summaries, and results. The intent is to use this same or similar framework for an eventual change package to assist other sites.

ABOUT QUALITY IMPROVEMENT (QI)

QI STAGES

1. Discover

- A. Learning about the problem and best-evidence practices
- B. Collect quantitative and qualitative baseline data

2. Understand

- A. Map our processes
- B. Learn what successes and failures look like
- C. Refine our change theory

3. Continual Improvement

- A. Testing what works and doesn't work here
- B. Emphasize closing disparities
- C. Use data and story to monitor improvement

4. Habitual Excellence

- A. Implement what works
- B. Sustain improvements

5. Dissemination

- A. Share what we've learned

QI TOOLS AND METHODS

1. Discover

- A. Best-evidence practice review
- B. Depict quantitative and qualitative baseline data

2. Understand

- A. High level process map
- B. Simplified Failure Mode & Effects Analysis
- C. Pareto Chart
- D. Key Driver Diagram

3. Continual Improvement

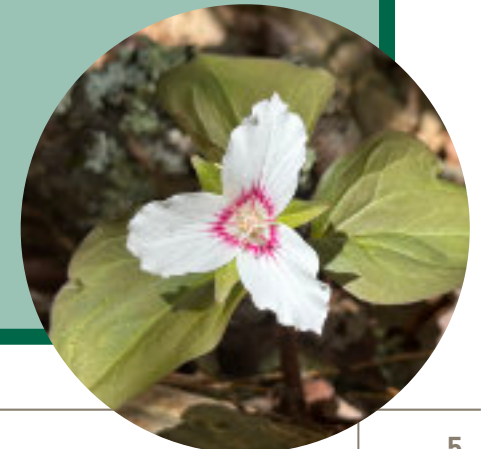
- A. PDSA worksheets
- B. PDSA ramps
- C. Empathy maps

4. Habitual Excellence

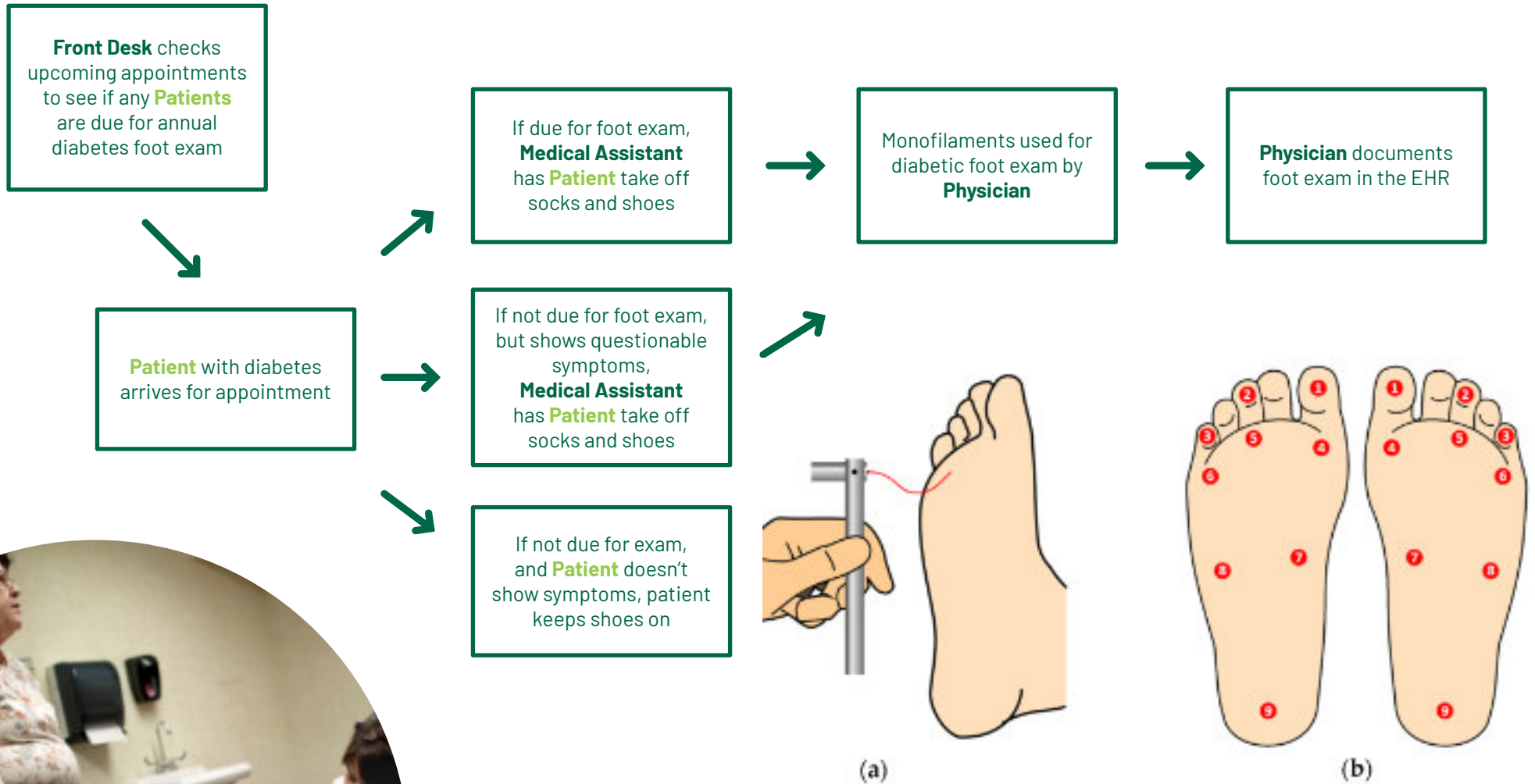
- A. Standardization
- B. Monitoring

5. Dissemination

- A. Change package
- B. Presentations

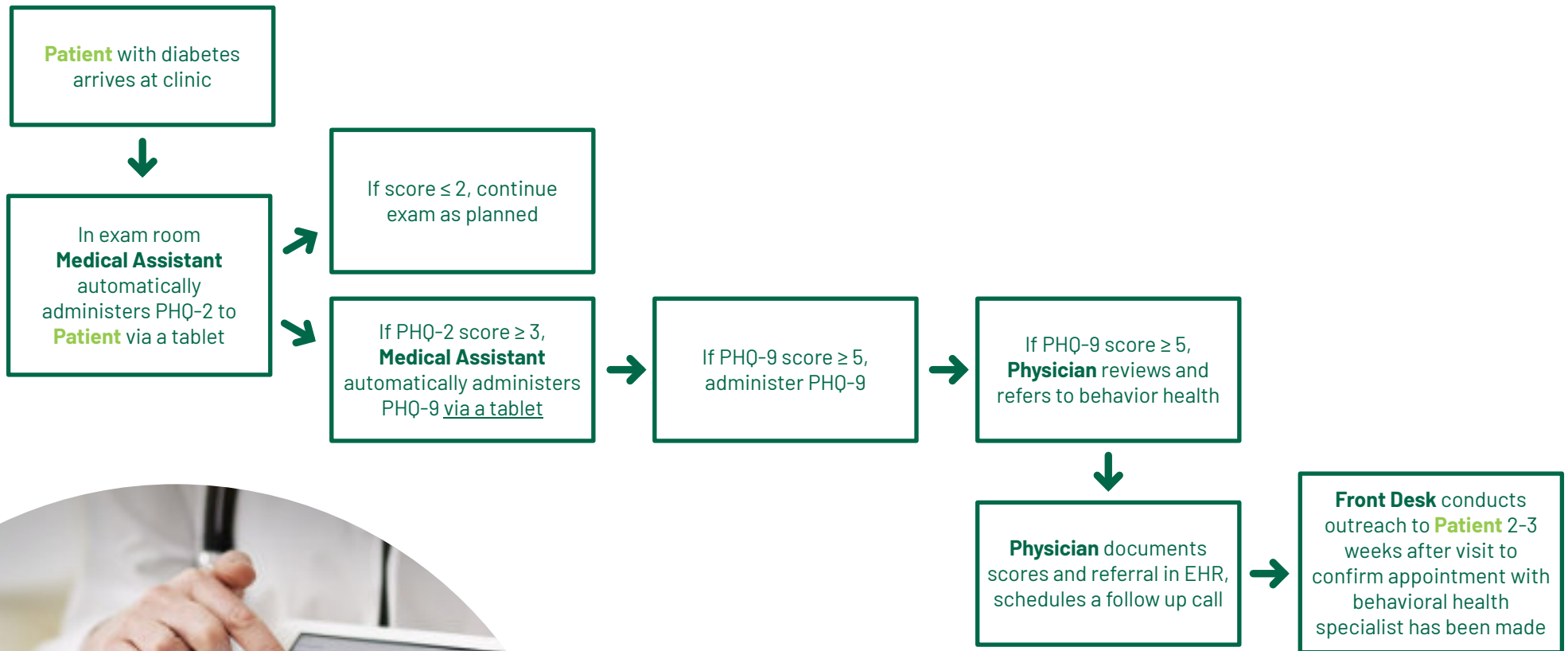


FOOT EXAM PROCESS MAP



[How to administer a Diabetic Foot Examination \(video\)](#)

DEPRESSION SCREENING PROCESS MAP



These exams should be given via a tablet or laptop which would auto calculate the results and encourage more honest responses by the patient.

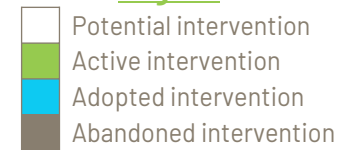
[PHQ-2 and PHQ-9 Exam Questions](#) (link)

KEY DRIVERS DIAGRAM (KDD)

Project Leaders: OU, GRC

Revision Date: 3/1/23

Legend



Global Aim

Reduce complications associated with hemoglobin A1c (HbA1c) >9% in type 2 diabetes while addressing health equity

SMART Aim

Reduce the percentage of adult patients enrolled in Medicaid with type 2 diabetes whose HbA1c was >9% by 15% from X% to X% by June 30, 2027

Reduce the percentage of adults with type 2 diabetes with an HbA1c >9% in Medicaid population in southeastern Ohio by 10% by June 30, 2027

Population

Adults (18-older) Medicaid patients diagnosed with type 2 diabetes at participating practices

Key Drivers

A: Appropriate and timely treatment

B: Access to High Quality Coordinated Care

C: Screened and Well Managed Behavior Health

D: Patient Engagement, Healthy Lifestyle, and Self-Efficacy

E: Effective Supportive Relationships

F: Healthy Equitable Environment for Care

Interventions

Consistent Access to Medication/Supplies/ Equipment/ Technology (A, B, D, F)

Diabetes self-management education (A, B, C, D, E, F)

Coordinated comprehensive individualized medical treatment plan (B, C, D, E, F)

Standardized office processes for the healthcare delivery system (B, D, E, F)

Screening and integration of behavioral health services within primary care (C, E, F)

Screening for social determinants of health and linkage to community resources and/or CHW's (C, E, F)

Optimize medication regimen across conditions (A, B, E, F)

Establish patient and family advisory committees (D, E, F)

2nd Tier Interventions

- Focus on Continuous Glucose Monitor Uptake
- Focus on access to newer medications with CVD and CKD benefits
- Coverage of continuous glucose monitoring for A1c >9%

- Referral to DSMES
- Diet
- Exercise
- Medication-taking
- Smoking cessation
- Sleep
- Stress management
- Coping/Problem solving

- Diabetes Distress
- Generalized Anxiety Disorder
- Depression
- Substance Use

- Foot exams
- Eye exams
- Coordinate with specialists
- Individual treatment goals
- Yearly vaccinations

- Establish registry
- Follow-up every few weeks if A1c above goal
- Outreach if A1c >9%
- Referral to DSME for all patients
- Standardized ID, tracking and follow-up with patients

- Provider Education
- Treatment Algorithm
- Shared decision making approach
- Monitoring medication adherence

EMPATHY MAP

An **Empathy Map** is a qualitative data summary which examines the points of view of others when setting goals with patients.

Here is a sample goal...

How Might We:

Ensure follow up appointment is made before patient leaves clinic

Patient perspective

Describe their perspective on the challenge:

Provider perspective

Describe their perspective on the challenge:

Scheduler perspective

Describe their perspective on the challenge:

Medical Assistant perspective

Describe their perspective on the challenge:

Devise a plan with key individuals perspectives in mind



STANDARD WORK

Best-Evidence Standard Work

Standard work is based on current best-evidence practice and is considered as the core content of the change package intended for adoption of all engaged.

Diabetes

American Diabetes Association Standards of Care (ADA) 2023: diabetesjournals.org/care/issue/46/Supplement_1

American Academy of Clinical Endocrinology (AAACE) 2023: pro.aace.com/clinical-guidance/diabetes

American Academy of Family Physicians (AAFP) 2020: www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-guidance-diabetes.html

Center for Disease Control and Prevention 2022: www.cdc.gov/diabetes/professional-info/index.html

Cardi-OH Collaborative: www.cardi-oh.org/

Why does standard work matter?

Overall improves office efficiencies and qualities as well as increases patient outcomes.

What needs to happen?

There needs to be buy-in with key participants and training on processes.

(Describe the specific practices, behaviors, processes, or steps designed to achieve the desired results)

Example

When does the provider give a foot exam?

When does the provider give a depression exam?

Continual Learning is always part of QI

1. Learning from the Study in PDSA
2. Learning from qualitative assessments
3. Learning from new publications
4. Learning from innovation

CONSISTENT ACCESS TO

MEDICATION / SUPPLIES / EQUIPMENT / TECHNOLOGY

GLUCOSE METERS AND TESTING SUPPLIES

There are multiple brands of glucose meters available on the market. (Note: see next section for CONTINUOUS glucose monitors [CGMs]).

Included in the box with the handheld glucose monitor device are approximately 10 – 20 test strips, a lancet device, and about 10 to 20 lancets.

Most test strips and lancets are not interchangeable across devices or brands. A prescription for a glucose meter should be written ‘generically’ (e.g. ‘glucose meter’ or ‘glucose monitor’) because the pharmacist will be able to select a device that is either covered on the patients’ plan, dispense the least expensive option, or allow the patient to choose which meter they prefer.

If there is not a ‘generic’ option in the EHR, find a brand of glucose meter and write a note to the pharmacist to allow for substitution to allow for what is covered, least expensive or patient preference.

There will also need to be a separate prescription for test strips and lancets (specific to the monitor or ‘generically’ written).

A 90-day supply is recommended as it may improve adherence, be less expensive and the patient has less chance of running out.

CONTINUOUS BLOOD GLUCOSE MONITORS

Continuous glucose monitors (CGMs) were first available in 1999 with a full first wave of CGMs in the early 2000s. CGMs measure interstitial fluid to provide a measure of plasma blood glucose every 5 minutes.

This means that patients need to be hydrated when wearing CGMs to have accurate readings.

The latest wave of CGMs all have alarms that alert to hyperglycemia, hypoglycemia, losing connection, and other alerts key to diabetes management. These alarms are available on CGM specific readers, cell phones, and Automated Insulin Delivery (AID) insulin pump systems.

Unlike using blood glucose meters, CGMs “fill in blanks”. For example, with CGMs there are overnight readings and trends that are often missed by blood glucose meter usage.

CGMs are widely regarded as the most innovative diabetes technology on the market. The ADA standards of Care state that CGMs are “essential” for diabetes management. CGMs are related to lower A1Cs and higher quality of life.

Despite the availability of this diabetes technology, there is minimal CGM uptake in the Medicaid population. Even more so, in the rural Medicaid patient population.

CURRENTLY AVAILABLE CONTINUOUS GLUCOSE MONITORS (CGM'S)



Dexcom G6

Sensor lasts 10 days, integrated with tandem pump and omnipod

G7

Sensor lasts 10 days, not currently integrated with insulin pumps

FreeStyle Libre 3

Sensor lasts 14 days, the world's smallest and thinnest sensor (smaller than two stacked pennies), optional real time glucose alarms

Dexcom G7 Sensor	Dexcom G6 Sensor
10-day lifespan	10-day lifespan
Smallest Dexcom sensor	Small Sensor
All-in-one sensor and transmitter	
30-minute warm up	2-hour warm up
12-hour grace period	
Can be used during pregnancy	
Waterproof 2.4 - up to 24 hours	Water resistance 2.4 - up to 24 hours
Alerts	Alerts
Customizable sound and volume	Customizable sound and volume
High and Low alerts	High and Low alerts
Urgent Low alert	Urgent Low alert
Urgent Low soon	Urgent Low soon
Delay 1 st alert	
Alert schedule	Alert Schedule
Dexcom G7 app	Dexcom G6 app
Follow app - share with up to 10 people	Follow app - share with up to 10 people
Clarity app - connect with healthcare professionals	Clarity app - connect with healthcare professionals
Connectivity	Connectivity
Smartphone iOS and Android	Smartphone iOS and Android
Smartwatch when connected with a smartphone	Smartwatch when connected with a smartphone
Dexcom G7 Receiver	Dexcom G6 Receiver
Compatible connected partners like digital health apps	Connects as part of an AID system with compatible insulin pumps

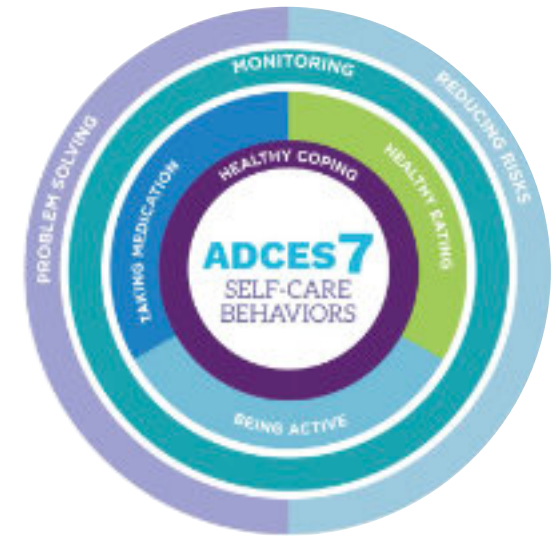
Features	FreeStyle Libre 2	FreeStyle Libre 3	Dexcom G6
Alarms/Alert	Most are optional	Most are optional	Most are optional
Glucose Reading Frequency	1 minute	1 minute	5 minutes
App	FreeStyle Libre 2 app	FreeStyle 3 app	Dexcom G6 CGM app
Sensor Warm-up Time	1 hour	1 hour	2 hours

DIABETES SELF-MANAGEMENT EDUCATION & SUPPORT (DSMES)

Diabetes Self-Management Education and Support (DSMES) gives people with diabetes the knowledge, skills, and confidence they need to successfully manage their condition.

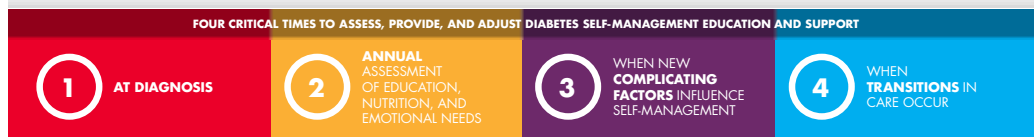
According to the ADA Standards of Care, DSMES is associated with improved diabetes knowledge and self-care behaviors, lower A1C, lower self-reported weight, improved quality of life, reduced all-cause mortality risk, positive coping behaviors, and reduced health care costs.

Diabetes Self-Management Education and Support focuses on seven self-care behaviors that promote successful and effective diabetes self-management, known as the ADCES7 from the Association of Diabetes Care and Education Specialists.

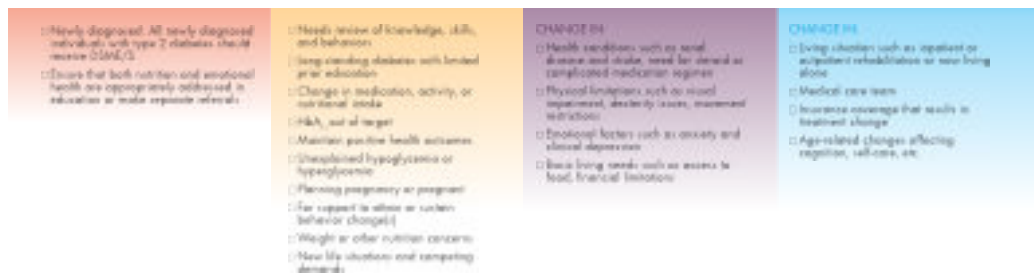


Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: ALGORITHM of CARE

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



WHEN PRIMARY CARE PROVIDER OR SPECIALIST SHOULD CONSIDER REFERRAL:

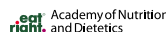


WHEN TO REFER TO DSMES

Four critical times to consider referral to DSMES: at diagnosis, annually when not meeting treatment goals, when new complicating factors arise, and when transitions in life and/or care occur.

For DSMES services to be reimbursable, referrals should be made to programs that are accredited by one of the two National Accrediting Organizations for CMS, the American Diabetes Association (ADA) and the Association of Diabetes Care and Education Specialists (ADCES). These programs meet national standards for quality DSMES.

Adapted August 2016: DSMES in Type 2 DM: A joint position paper of the ADA, AADE and AND; Powers MA, Brackley J, Cypress M, Drake P, Ford DM, Fucci JC, Marzani MO, Srinivas S. 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. Diabetes Care. 39(12):1392, 2016.



COORDINATED COMPREHENSIVE INDIVIDUALIZED MEDICAL TREATMENT PLAN (CCIMTP)

INDIVIDUALIZED A1C TARGETS

- What best meets patients' needs (includes but not limited to: age, overall health, other conditions, weight, ability to adhere to dietary/physical/medication regimen, etc.)
- Assessing causes of High A1C at any visit type - Common Issues
 - Person with diabetes deciding not to take insulin or diabetes medications when blood glucose is normal
 - Going out to eat several times a week and not bringing medications along
 - Falling asleep "forgetting" evening medications
 - Going to the fridge to eat during the night
 - Drinking carbohydrates throughout the day
 - Forgetting air shot (pen) priming in low doses of insulin
 - Overuse of basal insulin instead of adding mealtime insulin
 - Consider 2-week CGM (continuous glucose monitor)

WEIGHT MANAGEMENT

ADA Standards of Care 2023: ([Obesity and weight management link](#))

- Current recommendations are:
 - BMI 25-26.9: nutrition, physical activity, and behavioral counseling
 - BMI 27-29.9: first recommendation plus pharmacotherapy
 - BMI 30+: first two recommendations plus metabolic surgery
- Healthy food choices
- Food tracking
- Physical activity
 - Most adults with diabetes should engage in 150 min or more of moderate to vigorous intensity aerobic activity per week, spread over at least 3 days/week, with no more than 2 consecutive days without activity. Shorter durations (minimum 75 min/week) of vigorous intensity or interval training may be sufficient for younger and more physically fit individuals.
 - Adults with diabetes should engage in 2-3 sessions/week of resistance exercise on nonconsecutive days.

CCIMPT CONTINUED

- All adults, and particularly those with type 2 diabetes, should decrease the amount of time spent in daily sedentary behavior. Prolonged sitting should be interrupted every 30 min for blood glucose benefits.
- Weight loss medications
- Bariatric Surgery

Medical Nutritional Therapy (MNT): “nutrition-based treatment provided by a registered dietitian nutritionist.” It includes “a nutrition diagnosis as well as therapeutic and counseling services to help manage diabetes.” Academy of Nutrition and Dietetics. [How an RDN Can Help with Diabetes](#). (01 November 2018)

IMPROVING COMMUNICATION

- Motivational Interviewing
 - AAFP 2011: Encouraging Patients to Change Unhealthy Behaviors with Motivational Interviewing
- Shared Decision Making
 - AHRQ Strategy 61: Shared Decision Making
- Health Literacy

Health Literacy: is a key component to patient care and health outcomes. Understanding the medication(s), provider instructions, and overall health conditions affects all aspects of the healthcare continuum. According to the National Assessment of Adult Literacy, only 12% of the adult populations in America are health literate, which means that 88% of Americans have difficulty understanding health information.

Personal Health Literacy: is “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”

Organizational Health Literacy: is “the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”

Numeracy: is “the is ability to understand and use number and math skills in daily life.”

As health care providers, we must make the information of diabetes accessible, user-friendly, and written in plain language. This means using familiar concepts, words, and numbers in ways that make sense to the people who need the information.

- Make the layout logical. Put the most important at the beginning of the first paragraph. Use headings and sub-headings and subheadings that are easy to follow and provide information.
- Use short sentences and limit to a few main points. Focus on what will help the reader take the desired action(s).
- Use every day, simple words that are familiar to the reader. If medical terms are needed, be sure to explain them in plain language.

STANDARDIZED OFFICE PROCESSES

FOR THE HEALTH CARE DELIVERY SYSTEM

There are many important topics during a limited appointment time with a patient with diabetes: self-monitoring, diet/exercise, obtaining blood glucose data and review, reviewing/setting A1c goals, medication-taking, gaps in care measures such as foot/eye exam and renal screen, social needs, cardiovascular risk reduction (e.g., weight management, hypertension, cholesterol, tobacco/nicotine, alcohol use, substance use), and mental health/diabetes distress.

The following are templates that can be used or modified to meet your clinic and person with diabetes needs.

Electronic Health Record (EHR) Tools

- Referral trackers
- Patient Portals
- Remote Monitoring
- Computerized Provider Order Entry

Standard Office Procedures

- Engage office personnel and delegate tasks
- Automate processes (e.g., patient reminders, automatic prescription dispensing services)
- EHR voice recognition and transcription software
- Formalize office procedures and follow them.
- Create patient flow chart.
- Templates may be helpful in reviewing and/or improving the patient visit process. Although these templates may or may not be able to be added to an EHR, they may provide ideas of how to best utilize the people and electronic processes of an office visit.
- Group Visits

Telehealth Tips

- Setting up a telehealth call takes some planning as well as wrapping up and preparing for the next visit.
- Following a “general visit template” will work fine for the main content of the call.

OPTIMIZE MEDICATION REGIMEN ACROSS CONDITIONS

It is necessary to evaluate the medication regimen of the patient with type 2 diabetes initially, regularly, and consistently.

The National Institutes of Health (NIH) considers more than five medications to be polypharmacy. Completing a medication review and deprescribing should be explored if patients are taking over five chronic medications. It may be beneficial to use medications to treat multiple conditions.

- An approved SGLT2 inhibitor in patients with type 2 diabetes, hypertension, cardiovascular and renal risks.
- An ACE or ARB for blood pressure in patients with type 2 diabetes.
- A GLP1 in patients with type 2 who may also benefit from weight loss.

The ADA recommends reviewing cardiovascular, renal, retinopathy, neuropathy and foot care guidelines.

Selecting appropriate medications for treatment and de-prescribing medications that are no longer needed is beneficial.

RESOURCES FOR MEDICATION OPTIMIZATION AND MEDICATION-TAKING:

It is recommended to follow ADA Standards of Care 2023 for initial treatment.

Medication-taking: Remember, there are numerous reasons why patients may not take their medications:

- Fear, cost, misunderstanding, too many medications, lack of symptoms, mistrust, worry, depression

Non-profit pharmacy: Rising Suns Pharmacy is a non profit pharmacy in southeast Ohio for uninsured and underinsured. After verifying eligibility, they provide free medication; this includes insulin, glucose supplies, and generic diabetes medications. It is more difficult to obtain new, more costly diabetes medications such as GLP1s and SGLT2s.

Patient assistance programs: Most brand name medications have patient assistance programs set up by the manufacturer. These also have eligibility requirements.

Prior Authorizations: Prior authorizations may be challenging to have newer medications covered by insurance.

Collaborate with a pharmacy / pharmacist to help in navigating these medication concerns.

SCREENING FOR PSYCHOSOCIAL ISSUES

WITHIN PRIMARY CARE

People with diabetes are more likely to experience psychosocial issues, including depression and diabetes distress.

DEPRESSION AND DIABETES

- 1 in 4 people with diabetes have elevated depressive symptoms and major depression.
 - Mean number of lifetime episodes of major depression: 1.8
 - Mean episode duration of major depression: 23-27 months
 - Mean lifetime exposure to all depression diagnoses: 43-61 months
- Depressive symptoms and major depression are associated with fewer self-care behaviors, higher A1C levels, increased complications, decreased physical functioning, hospitalization, and mortality.
- Recommendations:
 - Screen all patients annually:
 - PHQ-9 (Spitzer et al.)
 - Beck Depression Inventory (Beck et al.)
 - Center for Epidemiologic Studies – Depression (CES-D)
 - Refer patients with a positive screen to mental health providers with experience using CBT, interpersonal therapy, or other evidence-based treatments.
 - Incorporate physical activity into self-care if feasible.

DIABETES AND DIABETES DISTRESS

- Diabetes distress refers to the emotional stress of living with diabetes.
- 18-45% of people with diabetes experience diabetes distress.
- Diabetes distress is associated with fewer self-care behaviors, higher A1C levels, increased morbidity, and decreased quality of life.
- Recommendations:
 - Routine monitoring with validated measures:
 - Problem Areas in Diabetes (PAID)
 - Diabetes Distress Scale (DDS)

SOCIAL DETERMINANTS OF HEALTH IN SE OHIO

Rural Americans, like the people in southeastern Ohio, face numerous social drivers of health (SDoH). Below we focus on the most pertinent SDoH impacting the people of southeastern Ohio:

Lack of Access to Care and Specialty Care: Southeastern Ohio has 30% fewer primary care physicians, 41% fewer mental health providers, 65% fewer specialty physicians, and 33% fewer dentists compared to the rest of the state.

Lack of Transportation: A lack of public transportation, unpaved roads, and extreme weather conditions limits some from accessing health care. Here, people are less likely to have timely access to emergency medical services, hospitals, clinics.

Financial/Employment/Housing Instability: Southeastern Ohio is struggling with limited employment opportunities and industrial diversification. Here, 17% of the population lives below the poverty line compared to 13% of the United States and 14% for Ohio. The counties with the highest poverty rates are located in southeastern Ohio. Finally, long-term financial and employment instability contribute to unstable and/or unsafe housing.

Food Insecurity: Ohio ranks 45th in the United States for food insecurity. Approximately 16% of Ohioans or 1 in 6 adults live in food-insecure households. Athens County, where Ohio University is located, has the highest food insecurity rate in the state (20.4%).

Social Isolation: The geographic region of southeastern Ohio lies at the foothills of the Appalachian Mountains and the Appalachian Plateau. The forests and rough terrain contribute the ruralness and sense of isolation in the region.

The American Academy of Family Physicians recommends routine screening for SDoH:

1. *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE)*: a 15-item screener with 5 supplemental questions that can be directly uploaded into many electronic health records.
2. *Social Needs Screening Tool*: an 11-item screener available in English and Spanish and endorsed by the American Academy of Family Physicians.
3. *Health-Related Social Needs Screening Tool*: a 10-item screener created by the Centers for Medicare & Medicaid Services.

Referrals to Resources:

- Refer to *Ohio Department of Health Community Health Worker Programs*
- Refer to *Unite Ohio* - an online social needs referral platform

PATIENT & FAMILY ADVISORY COMMITTEE

Establishing a Patient and Family Advisory Committee

The Southeastern Ohio Regional Quality Improvement Hub formed the Southeastern Ohio Patient and Family Advisory Council (PFAC). The overarching goal of the Southeastern Ohio PFAC is to solicit ideas, input, and insights to guide the quality improvement initiatives of the Southeastern Ohio Regional Quality Improvement Hub.

The Southeastern Ohio PFAC aims to:

- Identify and communicate the needs of the community.
- Promote the culture of Appalachian Ohio.
- Reduce barriers to primary care services in southeastern Ohio.
- Enhance the delivery of high quality and safe diabetes care.

Southeastern Ohio PFAC Vision: To strengthen collaboration among people with diabetes, families, and the health care team to promote person-centered and family-centered diabetes care.

Southeastern Ohio PFAC Mission: To improve the delivery of high quality, safe care by providing a means for people with diabetes and their families to collaborate with health care providers, staff, leadership, and public health.



EFFECTIVE SUPPORT RELATIONSHIPS

Peer Support

- Social support is key for diabetes management.
- In the right form and amount, social support and supportive relationships can exert a positive effect on disease management. This relationship is well established. Professional support (provided by healthcare professionals) and family support are both related to improvement in blood glucose management.
- Support from family and friends promotes overall disease management by encouraging both optimism and self-esteem, as well as lowering stress and reducing symptoms of depression.
- Social support is key for psychological adjustment, maintaining mental health and physical health.

Team-Based Care Workflow

- Team-based care workflow is a collaborative approach to healthcare delivery that involves a group of healthcare professionals working together to provide coordinated and comprehensive care to patients.
- The team may include doctors, nurses, physician assistants, pharmacists, social workers, and other healthcare professionals.
- In a team-based care workflow, each team member plays a specific role in the patient's care plan, and there is frequent communication and coordination among team members to ensure that the patient's needs are met.
- The workflow to identify the patients' needs and goals includes the following steps:

The workflow to identify the patients' needs and goals includes the following steps:

- 1) Development of a care plan that includes input from all team members
- 2) Assignment of tasks to team members based on their roles and expertise
- 3) Ongoing communication and collaboration among team members to ensure that the care plan is being followed and any changes to the plan are communicated to all team members
- 4) Regular review of the patient's progress and adjustment of the care plan as needed
- 5) Team-based care workflows have been shown to improve patient outcomes and satisfaction, reduce healthcare costs, and increase provider job satisfaction



BURNOUT PREVENTION

Burnout prevention for healthcare providers is essential for maintaining the health and wellbeing of those who care for others. Burnout is a state of physical, emotional, and mental exhaustion that can result from long-term stress, particularly in jobs that involve caring for others, such as healthcare providers.

Here are some strategies to prevent burnout:

Self-care: Healthcare providers need to prioritize their own physical and mental health. This can include regular exercise, healthy eating habits, getting enough sleep, and taking breaks throughout the day.

Work-life balance: Finding a healthy balance between work and personal life is crucial. Healthcare providers should establish boundaries between work and personal time and prioritize activities outside of work.

Social support: Connecting with colleagues and friends can help reduce feelings of isolation and provide emotional support.

Mindfulness: Practicing mindfulness can help healthcare providers manage stress and promote mental wellbeing. Mindfulness techniques such as meditation and deep breathing can be practiced during short breaks throughout the workday.

Positive work environment: A positive work environment can help reduce stress and prevent burnout. Healthcare organizations can promote a positive work culture by providing resources and support for their employees.

Training and education: Providing healthcare providers with ongoing training and education can help them stay up to date on the latest healthcare practices and technology, which can reduce stress and prevent burnout.

By implementing these strategies, healthcare providers can better manage stress and reduce their risk of burnout, leading to better health outcomes for both providers and patients.

APPENDIX

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DEPRESSION SCREENING EXAMS

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of PHQ-9.

- The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression in a “first step” approach.
- Patients who score ≥ 3 should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name: _____ Date of visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed or hopeless	0	1	2	3

Total Score _____ = _____ + _____ + _____ + _____

Guide for Interpreting PHQ-2 Scores

Score	Depression Severity	Action
0-2	None-minimal	None
3-6	Further evaluation necessary	If the score is 3 or greater, major depressive disorder is likely. Patients should be further tested with PHQ-9 or direct interview to determine whether they meet criteria for a depressive disorder.

The Patient Health Questionnaire-9 (PHQ-9)

Patient Name: _____

Date of visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total Score _____ = _____ + _____ + _____ + _____

Guide for Interpreting PHQ-9 Scores

Score	Depression Severity	Action
0-4	None-minimal	Patient may not need depression treatment.
5-9	Mild	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
10-14	Moderate	Use clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15-19	Moderately severe	Treat using antidepressants, psychotherapy or a combination of treatment.
20-27	Severe	Treat using antidepressants with or without psychotherapy.

FAILURE MODES DESCRIPTIONS

Process Failure Modes with an...
FMEA, sFMEA, or similar tool

<Enter process name here> sFEAv						
Last update: <i>MM/DD/YYYY</i>						
(1st) High-Level process Map						
(2nd) Failure Modes						
(3rd) Why						
(4th) Brainstorm Interventions						

PLAN DO STUDY ACT (PDSA) WORKSHEET

Project: _____

Ramp #: _____ Test#: _____

Project SMART Aim:

Associated Key Driver:

Test Objective:

PLAN

What is the test?

What will you measure and how will you collect the data?

What would success look like?

What is your prediction?

DO

Was the test carried out as planned? Yes/No

Date Test Started:

Data & Observations:

Unexpected Results?

Patient/customer feedback:

STUDY

Did the results match predictions? Yes/No

New Learning:

ACT (select one)

_____ Adopt - Changes selected for implementation

_____ Adapt - Change idea needs improved/edited or need to test across different conditions

See Ramp # _____ Test # _____

_____ Abandon - Changes discarded

Tasks to be Completed	Person Responsible	Due Date

PDSA RAMPS

PDSA Ramp Planning and Reporting Tool

Project Name:

Associated Key Driver:

Ramp #1		Ramp 1, Test 1	Ramp 1, Test 2	Ramp 1, Test 3
Planning	What date did the test start?			
	What is the test?			
	What is the prediction?			
	Where will the testing occur?			
	How many providers/ patients/rooms/etc. will the test involve?			
	Duration of test (#hrs/shifts/days/etc.)?			
Reporting	What were the results? (Qualitative, quantitative, from pts/customers)			
	Did the results match the prediction?			
	What did we decide (Adapt, Adopt, or Abandon)?			

PATIENT ASSISTANCE PROGRAMS

The following are links to Patient assistance programs which could be utilized by staff in primary care as well. Created 6/27/23.

DRUG COMPANY	DIABETES MEDICATIONS	WEBSITE
Eli Lilly	Basaglar Humalog Trulicity Baqsimi	https://www.lillycares.com/
Novo Nordisk	Levemir Tresiba Victoza	https://www.novocare.com/diabetes/help-with-costs/pap.html
Sanofi Aventis	Lantus Apidra	https://www.sanofipatientconnection.com/patient-assistance-connection
Merck	Januvia	https://www.merckhelps.com/?gclid=EAlaI0obChMI_b0JsIrc_wlVxyytBh0V6wLfEAAySAAEgKcDfD_BwE&gclid=EAlaI0obChMI_b0JsIrc_wlVxyytBh0V6wLfEAAySAAEgKcDfD_BwE
Boehringer Ingelheim	Jardiance Tradjenta	https://www.google.com/search?q=boehringer+ingelheim+patient+assistance&og=B&gs_lcrp=EgZjaHJvbWUqBggBEEUYOzIGCAAORRg5MgYIARBFgDsyBwgCEAAyGAAQyBwgDEAAyGAAQyEwgEEC4YgwEYxwEYsQMY0QMYgAAQyBggFEEUYPTIGCAYORRg8MgYIBxBFGDzSAQg0MjY2ajBqNKgCALACAA&sourceid=chrome&ie=UTF-8
Janssen	Invokana	https://www.janssen.com/us/patient-resources/patient-assistance
Astra Zenica	Byetta Bydureon Farxiga Onglyza	https://www.azandmeapp.com/prescriptionsavings/?screenName=showHCPPage

ODM PREFERRED DRUG LIST (PDL)

ENDOCRINE AGENTS: DIABETES - HYPOGLYCEMIA TREATMENTS	
PREFERRED	NON-PREFERRED
Baqsimi ^{QL} Glucagen Hypokit ^{QL} Glucagon Emerg Kit [Labeler 00002] ^{QL} Gvoke ^{QL} Zegalogue ^{QL}	Glucagon Emerg Kit [Labeler 00548 & 63323] ^{QL}
Link to Criteria: <i>Endocrine Agents: Diabetes – Hypoglycemia Treatments</i>	

ENDOCRINE AGENTS: DIABETES - INSULIN	
PREFERRED	NON-PREFERRED
Apidra Humalog 50-50 Humalog 75-25 Humalog U-100 Kwikpen, Vial ^{QL} Humulin 70-30 Humulin R U-500 ^{QL} Insulin Aspart ^{QL} Insulin Aspart Protamine/Insulin Aspart Insulin Lispro ^{QL} Lantus ^{BvG QL} Levemir Novolog 70-30 Novolog U-100 ^{QL} Toujeo Tresiba ^{BvG ST}	Admelog ^{QL} Afrezza Basaglar ^{QL} Fiasp ^{QL} Humalog U-100 Tempo Pen Humalog U-200 ^{QL} Humulin N U-100 Humulin R U-100 Insulin Degludec Semglee ^{BvG QL} Lyumjev Novolin 70-30 Novolin N U-100 Novolin R U-100
Link to Criteria: <i>Endocrine Agents: Diabetes – Insulin</i>	

AR = Age Restriction QL = Quantity Limit ST = Step Therapy Required PA - Clinical Prior Authorization Required BvG = Brand Preferred over Generic
 Ohio Medicaid Unified PDL effective July 1, 2023

ODM PDL CONTINUED

ENDOCRINE AGENTS: DIABETES - NON-INSULIN	
PREFERRED	NON-PREFERRED
Acarbose ^{QL} Actoplus Met XR Byetta Farxiga Glimepiride ^{QL} Glipizide ^{QL} Glipizide/Metformin ^{QL} Glyburide ^{QL} Glyburide/Metformin ^{QL} Invokamet Invokana Janumet Janumet XR Januvia Jardiance Jentadueto Metformin IR, ER ^{QL} (Generic of Glucophage XR) Miglitol Nateglinide ^{QL} Pioglitazone ^{QL} Pioglitazone/Metformin ^{QL} Repaglinide Repaglinide/Metformin Synjardy Tradjenta Trulicity ^{QL} Victoza ^{QL}	Adlyxin Alogliptin Alogliptin/Metformin Bydureon Bcise Glimepiride/Pioglitazone Glucophage Glyxambi Invokamet XR Jentadueto XR Kombiglyze XR Metformin ER ^{QL} (Generic of Fortamet, Glumetza) Metformin Sol Mounjaro Onglyza Ozempic Pioglitazone/Alogliptin Qtern Rybelsus Segluromet Soliqua Steglatro Steglujan Symlinpen Synjardy XR Trijardy XR Xigduo XR Xultophy
Link to Criteria: <i>Endocrine Agents: Diabetes – Non-Insulin</i>	

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