

**Bree Collaborative | Diabetes**  
February 9<sup>th</sup>, 2023 | 8:00 – 9:30 a.m.  
**Virtual**

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**MEMBERS PRESENT**

Norris Kamo, MD, MPP, Virginia Mason Medical Center (chair)  
Cyndi Stilson, RN, BSN, CMM, Community Health Plan of Washington  
Jonathan Harrison, Tri Cities Community Health Center  
Mary Beth McActeer, MLIS, Virginia Mason Franciscan Health  
Mark Haugen, MD, Walla Walla Clinic and Surgical Center

Mamatha Palanati, MD, Kaiser Permanente  
Nicole Treanor, RD, Virginia Mason Franciscan Health  
Robert Mecklenburg, MD, Virginia Mason (retired)  
Sharon Eloranta, MD, Washington Health Alliance  
Susan Buell, YMCA of Tacoma Pierce County  
Vickie Kolios, MSHSA, CPHQ, Foundation for Health Care Quality

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**STAFF AND MEMBERS OF THE PUBLIC**

Nick Locke, MPH, Bree Collaborative  
Emily Robson, DNP, RN, Bree Collaborative  
Karie Nicholas, MS, Bree Collaborative

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**WELCOME**

Nick Locke, Bree Collaborative, welcomed everyone to the Bree Diabetes Care workgroup. Those present briefly introduced themselves and welcomed new members since the January meeting. Mr. Locke also updated workgroups members that the charter was approved by the full Bree Collaborative and reminded members to complete OPMA training.

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**DISCUSS: DIABETES WORKGROUP GOALS AND THE QUINTUPLE AIM**

Mr. Locke reviewed the conversation at the end of the January meeting about determining workgroup goals based on the Quintuple Aim. The workgroup reviewed the SMARTIE goals framework and a draft spreadsheet that outlined goals based on the quintuple aim. Workgroup members discussed edits and additional goals.

- Cost/Value: We should also aim to understand financial barriers and mitigate policies that prevent people from accessing preventative and treatment services.
  - When we talk about rising costs, we should include costs outside of insulin, including technology (glucose monitoring, etc) and education programs.
- Care Experience: we should be more specific about “high-quality diabetes care”
  - We could use existing diabetes metrics like A1C screening rates or excess morbidity to measure.
  - If we choose specific measures we should ensure that the metrics are not hollow, that they are actually creating change and improving quality of life.
  - We can find more measures through the ADA standards of care and established literature.
- Population Health: although the population health aim includes a goal for prevention, we should integrate preventative activities in the other aims as well.

- We should focus on specific preventative activities including funding for prevention activities, risk identification, and coverage of pre-diabetes screening.
- Equity: the workgroup considered additional concerns for equity, especially related to social needs.
  - Our recommendations should address food access and the built environment, concerns that can lead to worse outcomes.

Workgroup members discussed additional opportunities for impact including the opportunity to send recommendations to the HCA to reduce barriers and the opportunity to use data to improve care processes.

## **DISCUSSION: BRAINSTORM AND SUB-GROUPS**

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Mr. Locke continued the brainstorming conversation with questions that the workgroup did not have time to cover in the January meeting.

- What are the main problems for diabetes care and who are the priority populations?
  - Members discussed how to gather information on the epidemiology of diabetes, including complications like chronic kidney disease, loss of vision, and CVD. Members suggested looking to the DOH or CDC for data.
  - In addition to collecting data on complications, workgroup members suggested collecting data about the costs of diabetes complications to make the business case for investment in prevention.
  - Priority populations include those with higher rates of diabetes, including males, Black, Hispanic, American Indian/Alaskan Native, and the 65+ population.
- What are the risk factors/social factors contributing to poor outcomes
  - The workgroup discussed many social needs during the goals discussion.
  - Additional risk factors include smoking, substance use, and mental health (as a barrier to self-efficacy for diabetes management).
  - Other topics include caregiver burden, the impact of the pandemic, and rural vs. urban settings.
- What are some solutions to improving high-quality diabetes care? What are the barriers to implementing these solutions?
  - One solution could be altering plans (moving from high-deductible plans to plans with \$0 copays)
  - Diabetes education programs have been successful in managing outcomes.
  - Prescreening for prediabetes can improve prevention
  - Barriers that prevent high quality diabetes care include workforce concerns and a lack of community resources.

Dr. Kamo presented potential sub-groups to guide future work. Three potential sub-groups could be split by diabetes diagnosis, healthcare stakeholder, or the quintuple aim goals.

- Workgroup members agreed that it makes sense to split into subgroups and discussed the best way to split.
- Members decided not to split by diabetes diagnosis, as there is a lot of overlap between Type 1 and Type 2 treatment courses.
- Members decided not to split by healthcare stakeholders, as they want to ensure cross-sector representation and collaboration across workgroups.
- Instead, members decided to split sub-groups based on the Quintuple Aim. Mr. Locke will send out sign-ups after the workgroup meeting. Members should choose which sub-group they would

like to participate in, and come to the March meeting with 3-5 potential goals for each workgroup.

#### **PUBLIC COMMENT AND GOOD OF THE ORDER**

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Mr. Locke invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team will solidify sub-groups and determine a timeline for next steps, as well as review existing resources and literature for diabetes care. The workgroup's next meeting will be on Thursday, March 9<sup>th</sup> from 8:00 – 9:30 AM.

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