

**Bree Collaborative | Diabetes**  
October 12th, 2023 | 8:00 – 9:30 a.m.  
**Virtual**

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**MEMBERS PRESENT**

Kate Foster, RN, Diabetes Prevention  
Coordinator, Mt. Baker Foundation  
Norris Kamo, MPP, Virginia Mason Medical  
Center **(chair)**  
Mamatha Palanati, MD, Kaiser Permanente  
Washington Family Medicine, Medical Director  
Diabetes Program

Nicole Treanor, MS, RD, CD, CDCES, Virginia  
Mason Franciscan Health  
Robert Mecklenburg, MD, Virginia Mason  
(retired)  
Sharon Eloranta, MD, Medical Director WHA  
Vickie Kolios, MSHSA, CPHQ, Surgical & Spine  
COAP

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**STAFF AND MEMBERS OF THE PUBLIC**

Elizabeth (Beth) Bojkov, MPH RN, Bree Collaborative  
Karie Nicholas, MA, G.C., Bree Collaborative

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**WELCOME**

Beth Bojkov, Bree Collaborative, welcomed everyone to the Bree Diabetes Care workgroup. The group reviewed and approved the September meeting minutes. The group corrected misspellings and incorrect credentials.

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**PRESENTATION: INDICATORS/MEASURES/METRICS**

Karie Nicholas (Bree Collaborative) discussed that the Bree is attempting to establish a new framework for implementation and evaluation of the guidelines. The framework is divided into three domains (capacity and programs, screening requirements and reimbursements, and insurance coverage and payments). Dr. Mecklenberg asked Dr. Kamo to comment on the framework, and Dr. Kamo mentioned the Donabedian framework for labeling how to measure quality (structure, process and outcome) and making a distinction between what kinds of data will be collected (attestation, quantitative, etc). Karie went on to present an overview of potential measures that the workgroup would want to include. Sharon agreed that structure, process and outcome framework is a gold standard so she supports that. Dr. Kamo mentioned that the quantitative measures should be cross-walked with CMS and other reporting requirements to make it easier, and he highlighted that CMS doesn't require food insecurity screening so that might have to rely on attestation. Karie showed measures required by HEDIS, and Dr. Kamo shared that CMS is a huge driver, so CMS measures should be included. Dr. Mecklenberg emphasized to include measures that are tied to payment and contracts, as that will provide more incentive. Karie recommended avoiding asking for one question on a screener instead of the whole screening tools, as it is more difficult to get that information from health systems. However, it doesn't offer the level of detail that we want. Dr. Kamo mentioned the Type 2 Diabetes Recognition program, and Karie mentioned that we need to know where we can get that data from. Karie then asked the group to add their feedback on the framework, and reminded them to think about where to get the data from and if it will be accessible to the Bree. Dr. Kamo mentioned that the way measures are created right now incentivizes providers to take on patients with less severe diabetes because they are easier to meet the benchmark. Sharon mentioned that the WHA stratifies quality measures by area deprivation index, which could be a way to stratify by proxy. Think about whether we want everyone to hit a certain

benchmark, or if we want everyone to show achievement and improvement. Dr. Kamo also mentioned that we might be able to utilize hospital data on utilization. The group mentioned that they want to find some mechanism to incent health systems for performance and improvement, to get around “gaming the system.” A group member mentioned that another way to risk-stratify is to do it by healthcare utilization, which would be data available from the payer perspective. The group mentioned that it is difficult to get health plans to report their data, and that might be something to consider that the HCA requires data reporting for certain elements. The group felt that starting with the healthcare authority would be a way to move towards transparency.

Action items for Bree staff:

- Restructure the framework around the Donabedian framework and to include methodology (attestation, quantitative measurement, etc)
- Include CMS measures for diabetes
- Identify screeners for food insecurity for potential of recommendations

Action items for Workgroup

- Provide feedback on indicators/measures/metrics are useful for inclusion in the report

Karie will be on vacation during the next meeting, so she will connect back with the workgroup in December to make sure to wrap up the discussion on metrics/measures/indicators before final publication in January. At future meetings, the workgroup will need to identify what metrics/measures/indicators are important to prioritize for this report.

## **PRESENTATION: NEW EVIDENCE**

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Beth began a brief presentation and discussion around new evidence that was included in the evidence table.

Community Outreach: three citations were added to the evidence table, two of which were appraised as 3/C evidence by Dr. Mecklenberg and Mary Beth. The evidence suggests community outreach events and community-based screenings are useful for identification of patients with diabetes or prediabetes; however, there was little evidence to suggest follow-up plans were made when individuals tested positive.

Affordability: One study (2/B tier) that used claims data to show that lower out of pocket costs for patients increased medication adherence in type 2 diabetes. There is a dose response relationship between copay and adherence.

EHR: there are heterogenous studies that show EHR's have value but are not able to pick out specific kinds of tools that are helpful for diabetes care specifically. Therefore, recommendations are going to be vaguer than use of a specific kind of EHR or clinical decision tool.

Shared Medical Appointments: reviewed one systematic article that showed shared medical appointments with a primary care provider, clinical pharmacist and registered nurse were more effective at lowering HgA1c and controlling blood pressure than 1-1 medical care.

## **DISCUSS: RECOMMENDATIONS**

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Beth continued the discussion of the recommendations, beginning by reviewing changes to the clinician audience. Norris asked to include links directly in the recommendations. Phrases under the chronic care model were slightly adjusted.

Dr. Mecklenberg highlighted the importance of nurse-pharmacist-registered teams with dietician support for type 2 diabetes should be emphasized, with less reliance on the primary care provider. They

also use telephonic methods to manage care successfully, and the group wanted to include the patient in the team as well, so wording was adjusted.

Dr. Kamo asked to review the assessment tools for self-management of diabetes, specifically PAID. Regarding recommendations for hospitals, Norris commented that the Leapfrog quality measures are more structure and process, not outcome. He advocated that hospitals should be tracking outcomes such as readmissions, amputations, and other outcomes for patients with diabetes that should be referenced. Dr. Kamo requested that next time we begin discussion with the comment about 6 visits with dietician/nutritionists.

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#### **DISCUSS: GROUP TIMELINE**

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Beth reviewed with the group that commonly workgroups end at the end of the year. However, they may go longer as needed by the group and related to the cadence of the Bree Member meetings to approve of report for public comment and publication. As the report is open to receive public comment, Bree staff would like to work with the workgroup to discuss implementation and metrics.

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

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At the next workgroup meeting, the workgroup will continue to refine current recommendations and address comments. The workgroup's next meeting will be on Thursday, November 9<sup>th</sup> from 8:00 – 9:30 AM.