



Diabetes Integration Project

Summary

April 2019 to September 2021

The CareOregon Innovation Team spearheaded the Diabetes Integration Project (DIP) after Health Share of Oregon provided two years of funding to support this work. The project sought to prioritize integrated treatment for a complex population: **CareOregon members with diagnoses of type II diabetes and severe and persistent mental illness.**

Cascadia Behavioral Healthcare, a DIP partner, cites statistics that make the case for integrated care: 20% of its clients also have diabetes or prediabetes; only 8% of those clients had a dental cleaning in the previous year; research shows that those with diabetes have a two-to-three-fold risk of periodontal (gum) disease. Gum disease increases the risk of heart disease and mortality.

Doing a good job of managing the care of these members is important to meeting CareOregon's commitment to integrate physical, dental and behavioral health care, and to meet the Triple Aim: improving health outcomes, improving the health care experience and lowering costs.

Health Share and CareOregon set three goals for the overall project:

1. Identify and resolve operational and plan barriers to integration of care.
2. Increase engagement among the focus population in primary care, oral health and active behavioral health treatment.
3. Improve performance in two of the Oregon Health Authority's quality improvement metrics:
 - » Poor control of HbA1c (incentive measure).
 - » Oral evaluation of adults with diabetes (incentive measure).



The three sites taking part in DIP aimed to:



- ▶ Improve the treatment of identified members.
- ▶ Increase the members' engagement in their care.
- ▶ Collaborate with each other and coordinate these patients' diabetes care, oral health services and behavioral health programs.



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The study sites' methodical approach of analysis, workflow modifications, and increased collaboration and care coordination delivered encouraging results.

- ▶ The sites began by assessing 13 components of systemized coordinated care, which fell into three groups of characteristics: organizational, treatment and care coordination.
- ▶ Staff rated the 13 components again, after 18 months of DIP work.
- ▶ An average of 64% of the components improved from January 2020 to July 2021. (See more in the "Assessment" section.)



Because COVID-19 greatly interrupted clinic operations in 2020, CareOregon stepped in with a six-month funding extension that enabled the Diabetes Integration Project sites to continue creating and refining workflows through September 2021.

About the sites

The participating sites spanned primary care, dental and behavioral health services. They included Cascadia Behavioral Healthcare, Clackamas Health Centers (primary care and specialty behavioral health), LifeWorks NW in partnership with Wallace, and three dental care organizations: CareOregon Dental, ODS and Willamette Dental Group.

About the CareOregon Innovation Team

We're a multidisciplinary CareOregon team that's ready to support you in integrating physical, dental and behavioral health care. Here's how:

Practice facilitation. We can act as facilitators for your teams as you develop workplans, engage in brainstorming activities, and integrate concepts into your organization.

Coaching. We can offer one-on-one coaching and be your thought partner throughout your integration journey.

Convening. We can create space for your teams to come together with other organizations and other CareOregon staff members who can support your process.



Get in touch! For more information, contact your innovation specialist or email innovation@careoregon.org

For additional resources: Visit careoregon.org/providers



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Step 1: Assessment

Sites' self-analysis points up priorities

Each Diabetes Integration Project (DIP) site conducted a comprehensive integration assessment at the start of the project, and again 18 months later.

The self-reflective process illuminated sites' current state and helped them identify areas of strength that could support integrated care, areas to nurture, and areas that were beyond their control. Those results guided their goal-setting.

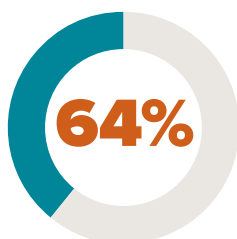
Tips for using the Integration and Program Assessment tool

- ▶ Invite team members from varying roles in the organization to take part. For example, include different levels of leadership, frontline workers and various disciplines.
- ▶ Assemble assessment teams of three to six members.
- ▶ Ask team members to answer the assessment questions independently. After they've rated their answers individually, the team can come together to review as a group.
- ▶ If you find discrepancies that surface among individual answers, reach consensus as a group.
- ▶ Take good notes during the group discussion.
- ▶ Emphasize that the tool doesn't have right or wrong answers. It's simply a way to help the team identify areas of interest and where to focus their attention. Areas with low scores may be too big of a project. Areas with high scores may hold particular lessons. All scores have value. *(Tips adapted from findings from the Diabetes Integration Project's sites. Assessment tool adapted from Integrated Primary Care & Behavioral Healthcare at Case Western Reserve University)*

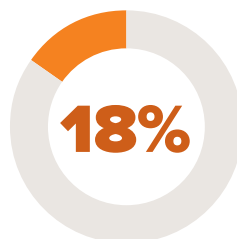
Value of the assessments

- ▶ Identify what to focus on and track.
- ▶ Help break a large project into smaller priority areas to tackle.
- ▶ Enable clinics to tailor their workplans to their specific situation.

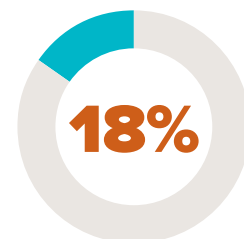
Changes at second assessment



64% of components were rated higher.



18% of components were rated the same.



18% of components were rated lower.



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About the self-assessments and resulting work plans

Evolving self-expectations. Initially, the participants' responses to the assessment concentrated on whether or not they were doing a certain activity. When we looked at the assessments at the end of the project, we saw more nuances. Responses had moved beyond "yes/no" to a more-demanding, "Yes – and can we do it better?" This led to some scores decreasing as self-expectations for the work changed.

Behind the numbers. The components that ended up on work plans varied by clinic. Items that scored low may have been left out of a work plan because they didn't align with other strategic areas. Items that scored higher at the outset already enjoyed momentum; the Diabetes Integration Project presented an opportunity to further that.

Assessment findings

Sites' initial self-assessment identified three areas in which to focus their efforts:

Staff training



Service matching



Care coordination





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Step 2: Staff training

Skills training supports Cascadia Behavioral Healthcare staff

About skills training

Staff training was informed by input from staff, along with research and data related to integrated health care and diabetes.



The resulting training:

- ▶ Featured interdisciplinary collaboration.
- ▶ Was adaptable to other physical health issues using the framework of health care integration.
- ▶ Fit into existing structures.
- ▶ Used educational tools that partners created and shared with each other.
- ▶ Equipped staff to coach members on how to maximize their appointments:
 - » Helped members prepare for primary care appointments.
 - » After appointments, helped members address barriers.

Workflow changes:

- ▶ Supported member engagement.
 - ▶ Supported services for members.
 - ▶ Supported care coordination and information-sharing between behavioral health and primary care.
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Step 3: Service-matching

Sites identify each targeted member's needs

About service matching

Service-matching involves clinic staff:

- ▶ Identifying patients' needs.
- ▶ Making sure they are receiving appropriate services.
- ▶ As appropriate, transitioning patients to a clinic that can better meet their needs.

Diabetes Integration Project's best practices

Identify. Sites had a mechanism to identify patients in the project's target population.

Document. The sites documented the information about the project's patients in their electronic health record.

Evaluate. Sites had a workflow that evaluated the level of care needed. The evaluation used a standard set of criteria based on accepted published guidelines and clinical assessment.

Transition. Patients could receive care from multiple providers and in a variety of settings. In those cases, it was essential for everyone involved in their care to be up-to-date on their care plan, particularly at transition points between levels of care.

Best practices implemented

Here are key elements of integration that the Diabetes Integration Project sites put in place.

- ▶ Programs that tracked patients for outreach.
- ▶ A Diabetes Integration Project dashboard that tracked and coordinated patients' engagement in care.
- ▶ Bidirectional referral pathways among dental, primary care and behavioral health clinics.
- ▶ Diabetes self-management classes and support groups for patients.
- ▶ Direct scheduling workflows and procedures so behavioral health practices could schedule dental appointments.
- ▶ During the pandemic, prompted by the move to teledentistry, exploring more trauma-informed care approaches in dental.
- ▶ Multidisciplinary care coordination meetings and huddles held across areas of care and agencies.
- ▶ Patients' informed choice assured by listening and tailoring interventions to meet their goals.



“The more I learn, the more value I see in integrating care for folks with co-occurring disorders. I love it, and I'm proud to be part of it. . .”

– Cascadia staff member



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Step 4: Care coordination

Care coordinators work across longstanding silos

Project funding included supporting care coordination, in various ways, at the sites.



Tips for care coordinator success



Define the care coordinator role. Share that information with clinical teams.



Make sure the care coordinator attends team meetings across all areas of care: primary care, oral health and behavioral health.

Care coordination best practices

Coordinating with external partners can be difficult due to continued silos of primary care, oral and behavioral health. The following practices helped care coordinators successfully obtain medical records from outside providers:



Batching of faxes. A batch of fewer than 10 records requested from primary care usually took a week to receive. A batch of more than 10 records requested could take more than a week. **TIP: On your fax cover sheet, note that the HIPAA Privacy Rule permits a covered entity to disclose PHI to another covered entity for its own health care operations purposes.** Case management and care coordination are among the activities listed in the definition of health care operations.



Form relationships with as many peers as possible at collaborating clinics and agencies. There's always someone with whom you can have a friendlier relationship, in service of our shared patients. Run reports and find out with which clinics you share the most patients. Some systems have monthly care coordination meetings between staff (e.g. mental health therapists and BHCs) to assure stronger care coordination.



Call the primary care clinic directly to request the A1c value. Use the provider back line if one is available; this process goes the most smoothly and quickly when the care coordinator speaks directly to someone on the care team vs. the Medical Records Department.



Obtain a signed ROI. Even if an ROI is not required, it never hurts to ask a patient to sign one. An ROI can make agencies more comfortable with sharing information. It also creates trust and informed consent between provider and patient about their health care.



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Focus on: Oral health

Dental plan partners share their learnings

Key accomplishments

Relationship building

- ▶ Interdepartmental
- ▶ Cross-organizational
- ▶ Multidisciplinary

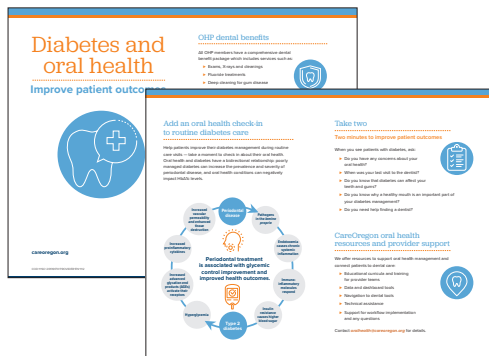
Member-centric initiatives

- ▶ Diabetes Integration Project flag added to monthly member clinic assignment roster.
- ▶ Conducted targeted outreach and coaching.
- ▶ Built extensive resource database.

Knowledge sharing

Use tech to improve cross-agency communication

- ▶ Maximize use of Collective Medical: collectivemedical.com
- ▶ Use HIT Commons: oralhealthleadershipcouncil.org/hit-commons



CareOregon created a flyer for primary care clinics, with an at-a-glance summary of dental benefits. It lays out the relationship between periodontal disease and diabetes, recommends questions to ask members with diabetes, and lists CareOregon oral health resources.

A handout for diabetes patients explains the two-way relationship between taking care of their gums and taking care of their diabetes.

CareOregon invites clinics to use them as a resource when contemplating their own integration project. Email oralhealth@careoregon.org





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Behavioral health upskilling within dental

Dental is exploring new ways for a more trauma-informed approach to care (teledentistry video visits, patient questionnaires). Greater understanding results from this approach.

- ▶ Understanding members' behavioral health (BH) engagement, recent inpatient BH history, and from whom they are receiving care gave dental partners a better idea of members' risk levels.
- ▶ Understanding the structure in accessing dental care for behavioral health and primary care members, as well as care coordination workflows and processes for BH and dental, was transformational because this awareness did not exist before the DIP.
- ▶ Having team members from BH or primary care, such as care coordinators or BH clinicians, allowed for better care coordination. It improved patient outcomes and collaboration across disciplines. DIP care coordinators attended dental team meetings. In addition, BH clinicians piloted an effort to provide brief interventions and warm hand-offs within the dental clinics.

Oral health upskilling within primary care & behavioral health: Suggested steps

- ▶ Leverage current work in primary care and behavioral health for diabetes care management by adding oral health questions, dental navigation and education to existing workflows and processes.
- ▶ Develop and share resources to educate and advocate on the importance of oral health and diabetes with key messaging being that oral health is part of routine care and an integral part of diabetes management.

Integrate trainings on the importance on oral health and the connections among oral health, physical health and behavioral health into staff onboarding across all disciplines.

Oral health partners

This work was done in collaboration with the following dental plan partners: ODS, Willamette Dental Group and CareOregon Dental.



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Focus on: Data-driven

CareOregon monthly data identifies the project cohort

Every month CareOregon sends the Diabetes Integration Project care coordinators the DIP roster. This roster is invaluable; it identifies all the patients in the DIP cohort and includes a number of data points. We know that data helps to stimulate and evaluate improvement.

In the future, the roster will include A1c values. Sites told us that addition is critical to sustainability.

DIP roster data points

- ▶ Evaluation for diabetic adults metric – numerator and denominator flags
- ▶ Oral evaluation date
- ▶ Last primary care provider visit date
- ▶ Count of diabetes admits in previous 12 months, and date of last admit
- ▶ Most-recent mental health service date
- ▶ Count of emergency department visits in previous 12 months



Possible future additions

- ▶ Most-recent A1c lab date
- ▶ Lab result value
- ▶ Lab name
- ▶ Recent A1c claim date
- ▶ CPT code
- ▶ CPT description (gives a range value)



Using A1c values

Behavioral health (BH) clinicians and support staff like to have this data to inform how to support or counsel the patient.

- ▶ Some sites add the A1c value into the patient's chart in the BH electronic health record.
- ▶ BH clinicians are more empowered and comfortable with talking directly to clients about their diabetes management. They appreciate the care coordinator/peer supporting the conversation.
- ▶ They can assist and encourage getting an A1c test based on date of last test.
- ▶ The value provides a common language/indicator among physical, behavioral and oral health and diabetes.
- ▶ It helps with risk segmentation and outreach prioritization.





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How sites use data day-to-day

LifeWorks NW and Clackamas Health Centers dig into data

Data gains its power when it's wrapped into the day-to-day challenges and aspirations of an organization. Here's a look at how two DIP sites put data to work in serving CareOregon members.

LifeWorks NW: Creating benchmarks for care coordination

Creating benchmarks for work helps create standardization across multi-site agencies and can be the first step in sustainability. For LifeWorks NW, care coordination had target objectives in five areas.

Target objectives

1. Clients complete a wellness assessment.
2. Clients have a PCP identified.
3. Clients have a dental group identified.
4. Post hospital discharge, clients have a documented health care coordination note.
5. Post ED visit, clients have a documented health care coordination note.

Care coordination measures are monitored and, if targets are not met, are brought back into specification using Continuous Quality Improvement methods.

Resources to support the work



- ▶ Standardized workflows
- ▶ EHR and dashboard tools
- ▶ Training
- ▶ Supervision

Clackamas Health Centers: Advantages of a DIP dashboard

Learnings

- ▶ A shared EHR allowed for communication and sharing for all areas of care.
- ▶ Engagement in one area of care was a catalyst to overall engagement.
- ▶ This visual demonstrated the impact on how individual interactions have ripple effects for the individual's overall health and experience of the health care setting.
- ▶ The referral page within the dashboard illustrated the positive impact of assigning a care coordinator to focus on DIP.
- ▶ DIP clients have a lower A1c value compared to clients who have diabetes and are not part of the DIP cohort.
- ▶ Staff training takes time, but it lays an essential foundation for workflow changes that allow integrated care to become sustainable.



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Dashboard fast facts



- ▶ **Technology used:** Microsoft Power BI
- ▶ **Data source:** DIP roster and OCHIN Epic
- ▶ DIP billing code dropped **974 times**

Face sheet contains:



- ▶ Current A1c value
- ▶ A1c trend over time
- ▶ Average days between A1cs
- ▶ Patient Health Questionnaire-9 (PHQ-9)
- ▶ Most-recent body mass index value (BMI)
- ▶ Patient's care team

“ I’m a little more open about talking about physical health since I started seeing my primary care doctor. I’ve always been open with my mental health providers, but having a doctor that works with them is stress-relieving ”

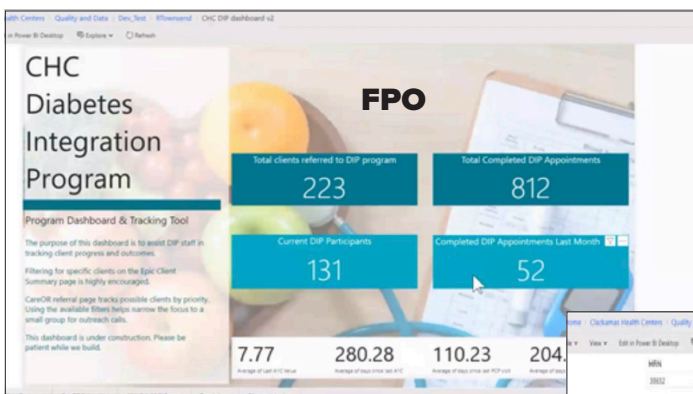
– Diabetes Integration Project patient

Referral page

Two categories - Low/Moderate and Moderate/High

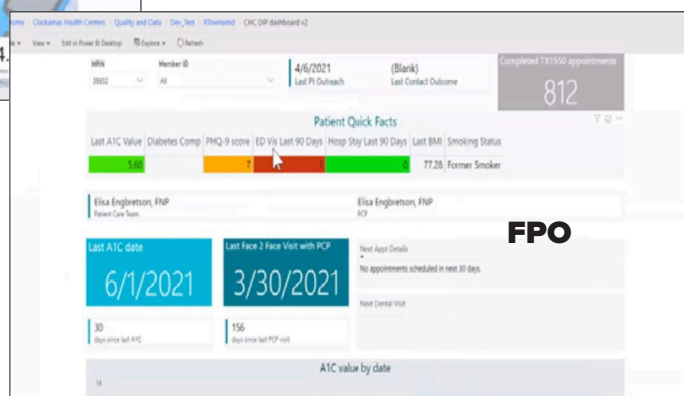


- ▶ High priority: One diabetes hospital admit OR more than two ED visits
- ▶ Ability to compare DIP clients to regular diabetes patients



A1c data is an important feature of the DIP dashboard.

The DIP dashboard captured the ripple effects of different individual interactions across health care settings.





Diabetes Integration Project

Learnings about process

CareOregon shares integration best practices

Engaged leadership

Leadership needs to be engaged early and often. High-performing practices have leaders who are fully engaged in the process of change and have leadership at all levels of the organization. Medical assistants, receptionists, clinicians and other staff take on the mantle of changing how they and their colleagues do their work.

Multidisciplinary team members

Include members from all pertinent departments on your team. Multidisciplinary teams create stronger, more-robust projects. Remember your back and front office staff who play an important role in keeping the work moving.

Regular check-ins

Regularly check in with sponsors and with each other as a team. Establish reoccurring meetings and open lines of communication with all members of the project team.

Spaces to collaborate and learn

Dedicate time to collaborate and learn with other agencies as well as within your own agency. The Diabetes Integration Project had many spaces for collaboration, including biannual collaboratives, quarterly care coordinator meetings, and monthly office hours with the CareOregon Innovation Team.



“ Because I work in a mental health agency, I have found the knowledge I have gained to be very helpful in relating to both diabetes and mental health, which interact. Having this additional knowledge has enabled me to increase engagement and collaboration with the clients I work with so that they do better self-care. ”

– Cascadia Behavioral Healthcare staff member



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Obstacles

Patience in planning yields real progress

Make time for Integration



Collaborating across areas of care takes time. Unforeseen circumstances will always arise, getting in the way of progress. Plan ahead, and honor the time together with your teams.

Staff training



Developing and executing integration training that applies across all areas of care is a big lift but is worthwhile in the long run. Involving staff in the development creates buy-in and relevancy.

Data & EHR functionality



Data is limited, and you likely will experience hiccups with your data sources along the way. Similarly, making changes to EHR functionality can be limited and slow-moving. Be patient, and try to focus on what is available.

Service matching



Available resources and your goals for patients may not always align. This is where the care coordinator role is crucial. They can find creative solutions to meet the needs of their patients.

Care coordination



The scope, goals and definition of care coordination vary widely. This variation can lead to role confusion as well as miscommunication among care team members.

For smooth care coordination:

- ▶ Research common definitions and practices. The National Council for Behavioral Health offers info on care coordination best practices: [samhsa.gov/section-223/care-coordination](https://www.samhsa.gov/section-223/care-coordination)
The Agency for Healthcare Research and Quality is another good source: [ahrq.gov](https://www.ahrq.gov)
- ▶ Decide on key functions and the scope of work you'd like your care coordinator roles to include.

Share this information across the organization so everyone can properly use and support the care coordination staff.



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Reflections

Our partners share some closing thoughts



Reflection



Change models: Off to destinations unknown

What types of change did we experience?

DIP participants reported, unanimously, that they experienced all three type of change throughout the project:

Developmental change



You're seeking to improve things that already exist.

Transitional change



Your leaders know where you are going, and your end state is defined.

Transformational change



You're unsure what the end state will look like, and when you look back, the old state is no longer recognizable.

Key insights

- ▶ “Integration can spread with dedicated staff and willing relationships.”
 - ▶ “Go slowly and be patient. Remember to keep refreshing your skills and approach with training and innovation.”
 - ▶ “Disruption can move us forward. Learn and share, and learn and share some more. Always keep in mind that we are making these changes so we can help our members be healthier.”
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