Quality Improvement
Targeting Diabetes Metrics
TOOLKIT

Moving the needle on important diabetes metrics and improving health for people with diabetes

- **HbA1c Poor Control**
- **Oral Evaluation for Adults with Diabetes**

ORPRN
Oregon Rural Practice-Based Research Network

Table of Contents

ORPRN
Oregon Rural Practice-Based Research Network

Summary

Using this toolkit will help your organization move the needle on important diabetes metrics and improve health for people with diabetes.

The Quality Improvement Targeting Diabetes Metrics Toolkit is designed for primary care practices and dental practices to use when working on two incentive metrics: HbA1c Poor Control and Oral Evaluation for Adults with Diabetes. The toolkit showcases actionable improvements including:

- Evidence-based best practices for diabetes care
- Key quality improvement tools
- Real-world improvement projects done by clinics to drive change

The toolkit is filled with hyperlinks to internal examples within the toolkit and external resources.
Hover over the word, press control and click.

For questions regarding this toolkit, contact:
Orprn_TA@ohsu.edu
For questions on diabetes measures, contact:
Transformation.Center@dhsoha.state.or.us

ORPRN
Oregon Rural Practice-Based Research Network

Jump-starting quality improvement

Your organization's successful quality improvement strategy includes:

- ✓ Protecting time for improvement work
- ✓ Valuing QI as a workplace skill: train up staff
- ✓ Designating a champion and lead organizer
- ✓ Gathering a team with multiple roles across the clinic (for example, clinic manager, provider, medical assistant)
- ✓ Setting a regular meeting time with defined meeting objectives
- ✓ Utilizing quality improvement tools
- ✓ Defining the aim of the work
- ✓ Checking for group consensus and buy-in
- ✓ Deciding: What information or data will drive decisions and allow you to benchmark progress?

Did you know? Literature shows successful quality improvement (QI) initiatives feature: committed leadership, organizational culture, data and information systems, QI experience, dedicated resources, measurement and feedback, and accountability. For more information, see the DHHS Health Resources and Services Administration guide on Quality Improvement.

Diabetes HbA1c Poor Control eCQM & CCO Incentive Measure (CMS 122v9)

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during themeasurement period.

Numerator: Number of patients whose most recent hBA1c (performed in measurement period) is over 9.

Denominator: Patients 18–75 years of age with diabetes with a visit during the measurement period

Exclusions: patients in hospice care, patients over 66 living long tern in an institution for more than 90 days, or 66 and older with advanced illness. Patients with dx of secondary DM due to another condition.

Telehealth eligible

A lower score is better!

For more information:

CCO Incentive Measure Specification Sheet

https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics /2021-specs-(Diabetes-Poor-Control)-12-18-20.pdf

eCQI Resource Center

https://ecqi.healthit.gov/ecqm/ep/2021/cms122v9

Oral Evaluation for Adults with Diabetes (CCO Incentive Measure)

Percentage of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year identified by any of the following CDT codes: D0120, D0150, or D0180

Numerator: Unduplicated number of adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation.

Denominator: Unduplicated number of adults with diabetes

Exclusions: patients in hospice, palliative care, patients 66 and older enrolled in an institution, age 66 and older with advanced illness/frailty

A higher score is better!

For more information:

CCO Incentive Measure Specification Sheet

https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-2021-Specs-(Oral-Evaluation-for-Adults-with-Diabetes)-20201222.pdf

DQA Measure Specifications: Administrative Claims-Based Measures

https://www.ada.org/~/media/ADA/DQA/2021_AdultswithDiabetesOralEvaluation.pdf?la=en

Five ways to increase Oral Evaluation for Adults with Diabetes

1. **Patient Access**: Identify common barriers to why patients with diabetes may not be able to access dental care.
2. **Patient Education**: *How* do patients know if they have coverage for dental care? And *why* is dental care important?
3. **Close the loop on referrals**: Identify where referrals get stuck
4. **Utilize common resources for integration**: Share methods across teams and organizations: use common platforms, EHRs, tracking/registries, staff and patient messaging.
5. **Increase collaboration pathways**: Build bridges between primary care and dental clinics.

Five ways to decrease HbA1C Poor Control

1. **Get patients in:** Increase the number of diabetes annual exams
2. **Labs results**: Ensure all results, including from specialists (ophthalmology, endocrinology) are recorded consistently.
3. **Standardize** diabetes management visits and education using a visit checklist and consistent educational materials.
4. **Meet patient needs, and barriers**: Connect patients to their coordinated care organization (CCO), dental care organization (DCO) and resources for diabetes education and management.
5. **Complete behavioral health and social needs screenings** and refer all newly diagnosed patients as indicated.

Evidence-based Practices

1. Record all test results as structured data.
2. Relay results and other relevant data to patient's physician or appropriate health care provider.
3. Compile resources for patients who do not have a regular physician or dentist so they may find one.
4. Use the ADA Components of the comprehensive diabetes medical evaluation at initial, follow-up, and annual visits checklist.
5. Team-based approach: Engage nurses, dietitians, diabetes educators, traditional health workers and pharmacists in care management.
6. Schedule diabetes annual visits in the first 6 months of the year to allow time for intervention.
7. Utilize staff members such as medical assistants, traditional health workers and care managers to provide active follow-up for treatment evaluation and missed appointments.
8. Integrate screening for social or emotional barriers to diabetes management, which may be exacerbated by COVID-19, and identify support.

Telehealth

1. Utilize technology to increase touchpoints and monitoring. Telehealth, texting, patient portals, etc.
2. Leverage telehealth to make scheduling more frequent follow ups easier for patients.

Evidence-based Practices
Patient Navigation

1. Follow-up appointments
   Schedule all follow-ups, including next oral health exam before appointment ends. Schedule all referrals if possible before appointments end for a warm "virtual" handoff.
2. Use automatic appointment reminders in a method that works for the patient (call, portal message, text message, reminder letter).
3. Follow up directly with patients who miss appointments, if timing permits change
4. Utilize self-monitoring
   - Consider automatic reminders for patients self-monitoring and recording glucose levels

8. Arrange more frequent follow-up diabetes appointments based on A1C data; E.g., every 6-8 weeks >9%, 2-3 months 7>8.9%, 3-6 months <7%.

Sources: ADA Best Practices Framework, ADA Guide to Point of Care Diabetes Testing and Reporting, ADA Comprehensive Medical Evaluation and Assessment of Comorbidities: *Standards of Medical Care in Diabetes – 2021*, ADA Standards of Medical Care in Diabetes – 2020 Abridged for Primary Care Providers

Improvement Tools Quick Guide

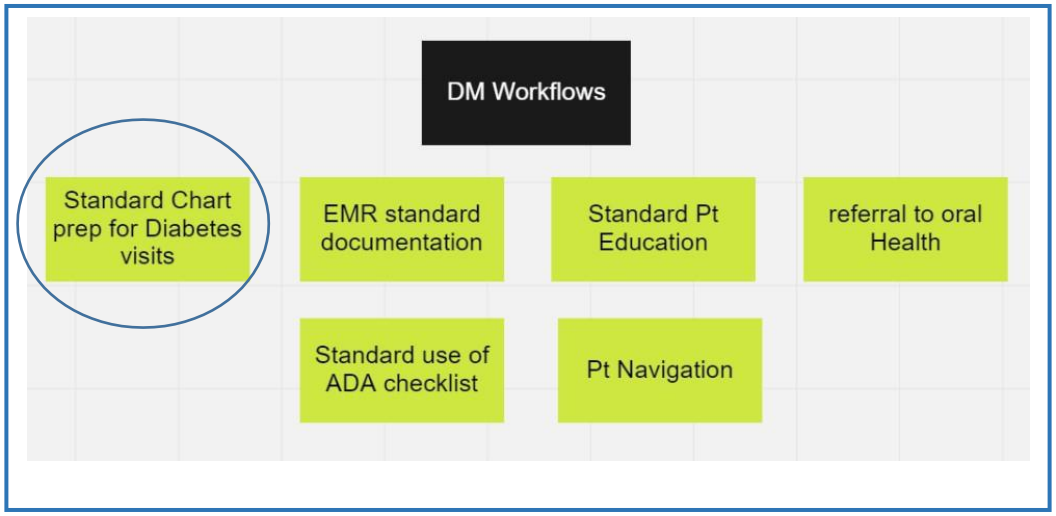
	What is it?	Why to use it?	When to use it?	Also known as
Work Breakdown Chart	A visual deconstruction of a project. Displays all elements ideas and can include deadlines	See the bigger picture of a project with deliverables and deadlines in mind	After aim/outcome identified when brainstorming ideas	Work Breakout
Driver Diagrams	A visual display of factors contributing to an outcome	Outline what elements are "driving" a process	Once an outcome is identified as suboptimal; when factors have not been named	
Fishbone Diagram	A visual representation of factors, grouped by category, which contribute to a certain outcome, whether desired or not	Identify the type(s) of factors leading to suboptimal outcomes (e.g., people, physical resources, technology)	Once an outcome is identified as suboptimal; when factors have not been named	Ishikawa Diagram, Cause and Effect Diagram
Workflow Mapping	A visual sequence of actions, decisions, and processes that deliver an outcome	Illustrate the order of operations that generate a specified outcome	When factors have been named, to identify potential spots for improvement	Flowcharts, flow maps, flow diagrams, flow sheets and process maps
Aim Statement & Goal Setting	A goal to help guide a project	Keep projects on task and solve what needs to be solved	Once a problem has been identified to define clear parameters to measure progress	SMART or SMARTIE Goals
Plan Do Study Act Cycle	Rapid, small-scale cycles of change to test interventions	To allow changes to be implemented and tested before deciding to adopt, adapt, or abandon	When an aim has been created to test small changes intended to address the problem	PDSA Cycle Small Test of Change

ORPRN
Oregon Rural Practice-Based Research Network

Work Breakdown Structure Diagram: documenting the whole improvement picture with planned outcomes. Organize ideas into subcategories to identify all resources, deliverables and timelines.

A primary care practice aims for consistent diabetes care across provider teams. First, they decided to improve diabetes care workflows. Here was their process:

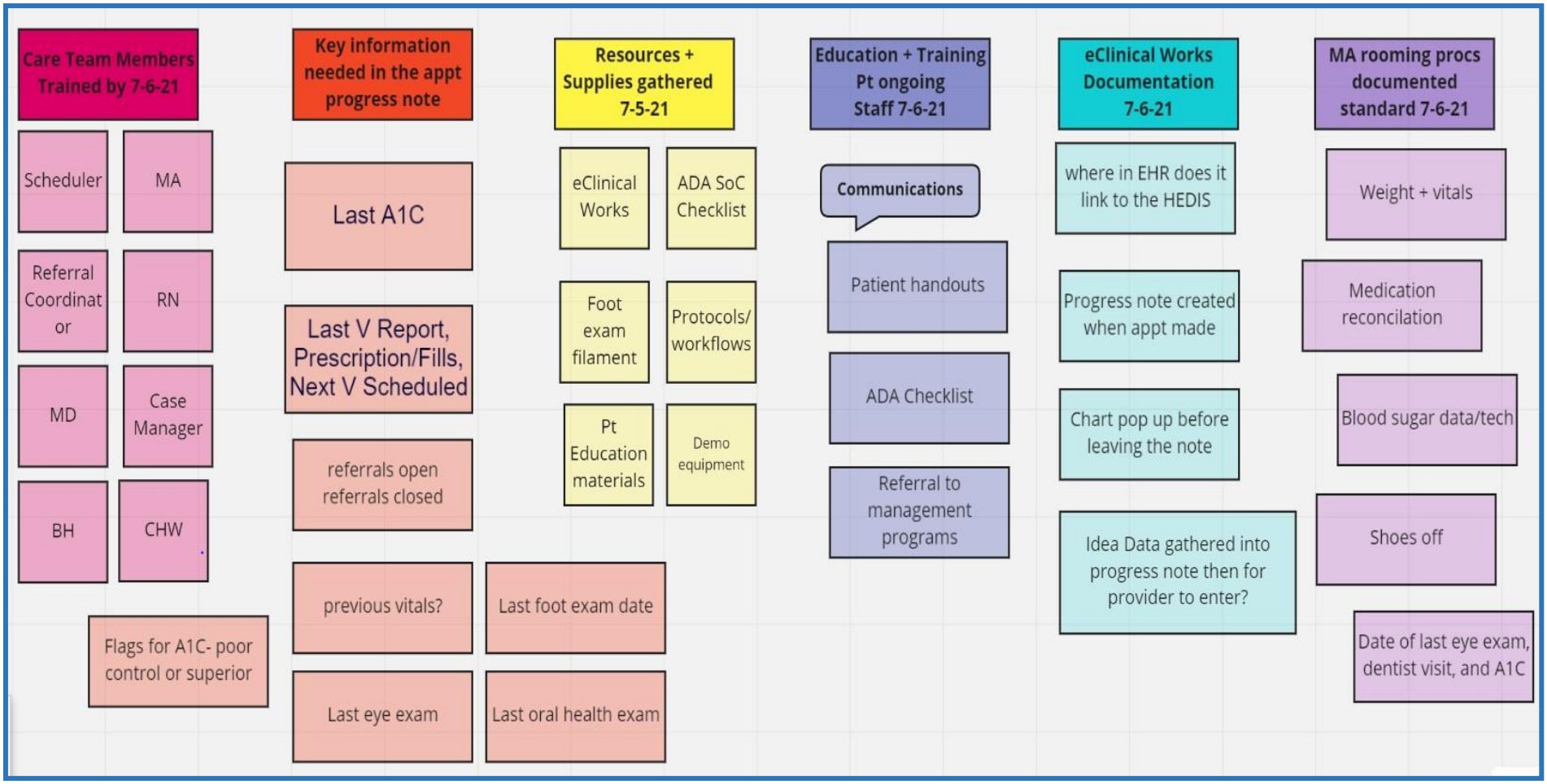
1. Define a final deliverable or tangible thing to gain- (*Wanted: Diabetes Workflows)*
2. Brainstorm areas for improvement (*What about workflows do you want to improve upon?*)
3. Sequence by priority first to last. (*Chart prep was first priority for this group*)
4. Take first priority and break down each area chosen of improvement into subcategories that include: people involved, materials needed, training, timeframe and deliverable. (*See the subcategory break down on next page.*)



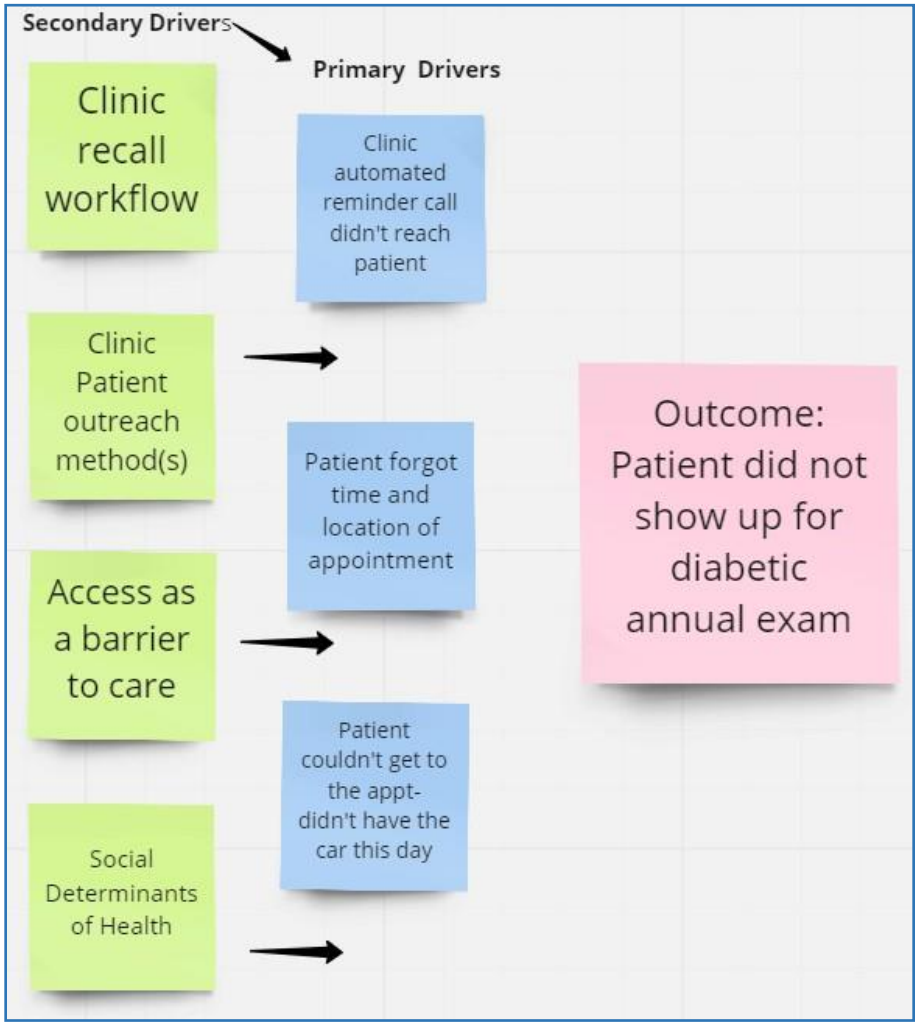
For more information on WBS see: Visual Paradigm

ORPRN Oregon Rural Practice-Based Research Network

Work Breakdown Structure Diagram: Standardizing Chart Preparation/Scrub for DM Visit



Driver Diagram: a visual display of factors contributing to an outcome.

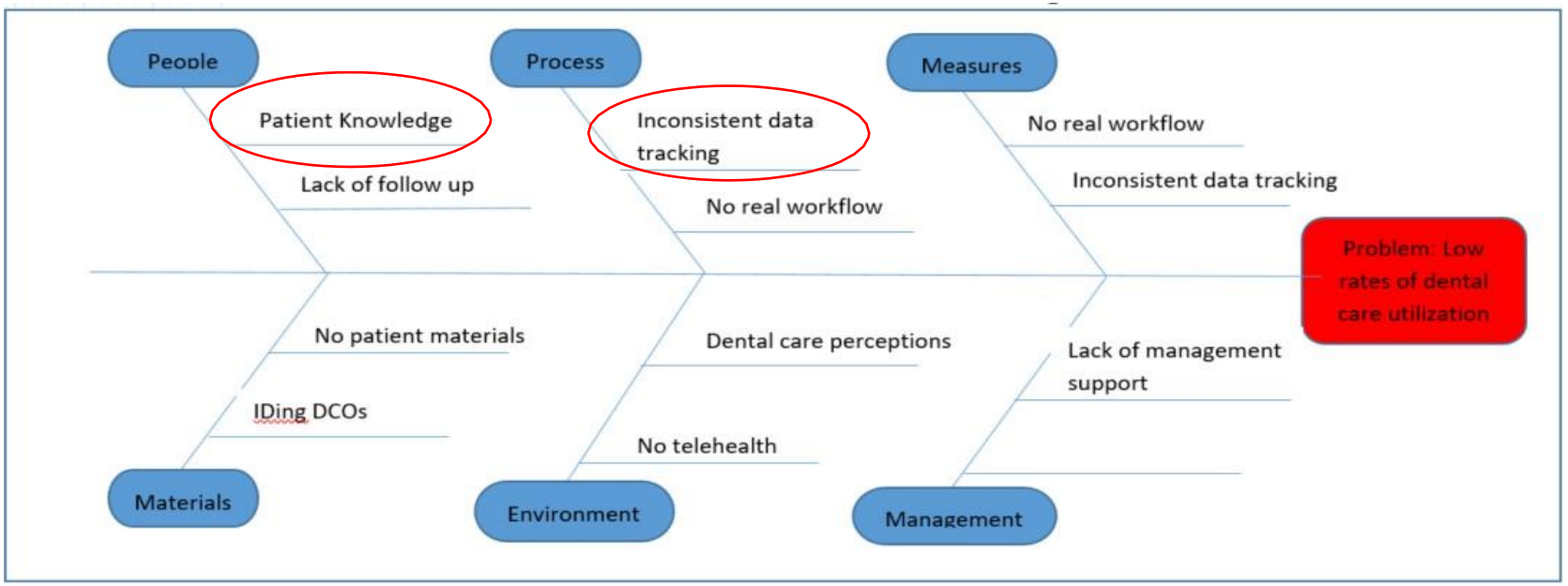


1. Start by defining the outcome to tease apart: In this example, why are patients missing their annual exam appointments?
2. Next, list primary drivers: what would cause a patient to miss any appointment.
3. For secondary drivers, consider what factors contribute to the primary drivers listed.

Fishbone diagram: defining cause and effect

Step 1: define the problem (the head of fish) (*Low rates of dental care utilization*)

Step 2: Determine the areas to brainstorm causes (the ribs of the fish). Standard categories are Materials, Methods, Equipment, Environment, and People.



Step 3: Fill in the potential causes. Keep in mind that there may be some overlap in certain sections. Causes that pop up in more than one section often indicate a higher area of need.

Step 4: Identify themes across the categories and determine areas for improvement.

SMARTIE Aim Statements

Aim statements guide the project by keeping it on task and working towards a singular objective goal. Good aim statements are SMARTIE:

Specific – Target a single area of improvement
Measurable – Quantify an indicator of progress
Attainable – Ensure it is achievable by assigning responsibility for individual tasks
Relevant – Ensure it will help achieve the vision or address the problem
Timebound – Specify when the result will be achieved
Inclusive – Bring marginalized populations into activities and programs
Equitable – Address systemic injustice, inequity, and oppression

To increase / decrease: _____ (process/outcome)
from: _____ (baseline %, rate, #, etc.)
to: _____ (goal/target %, rate, #, etc.) by:
_____ (date, 3-6 month timeframe)
in: _____ (population impacted)

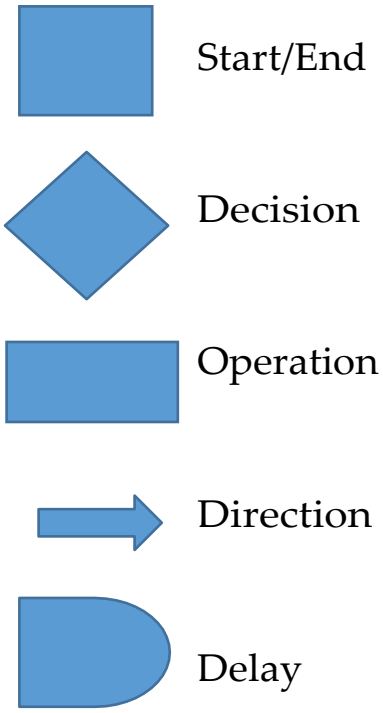
Examples

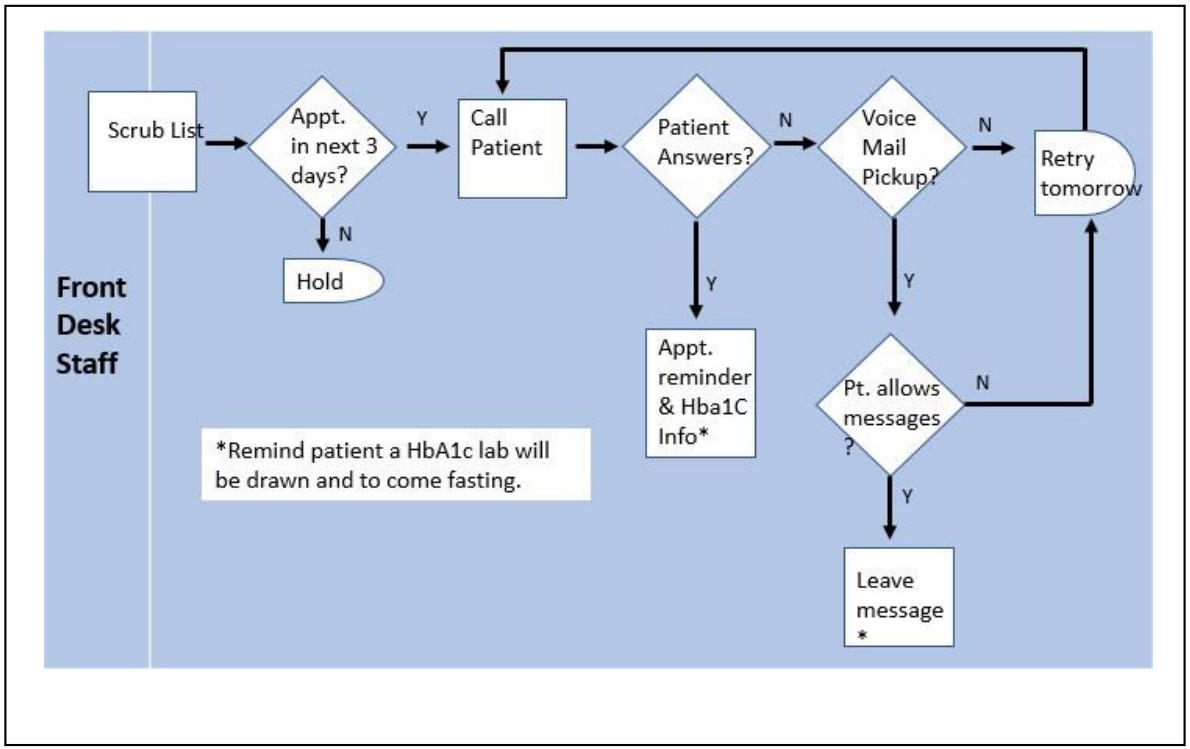
- Increase follow-up phone calls to monitor HbA1c levels of Latinx/o/a patients with diabetes from 20-40% by March 31, 2021
- Decrease number of appointment no-shows by conducting 20 new telehealth visits with targeted patients by May 31, 2021

Workflow Mapping

Create a visual representation of a defined process. A workflow includes each step from beginning to end. Mapping how work gets done allows confirmation of the process and identifies areas for improvement. Many of these symbols are available in Microsoft Office applications and internet applications like Lucid Chart or MiroBoard.

Start by deciding what symbols to use:



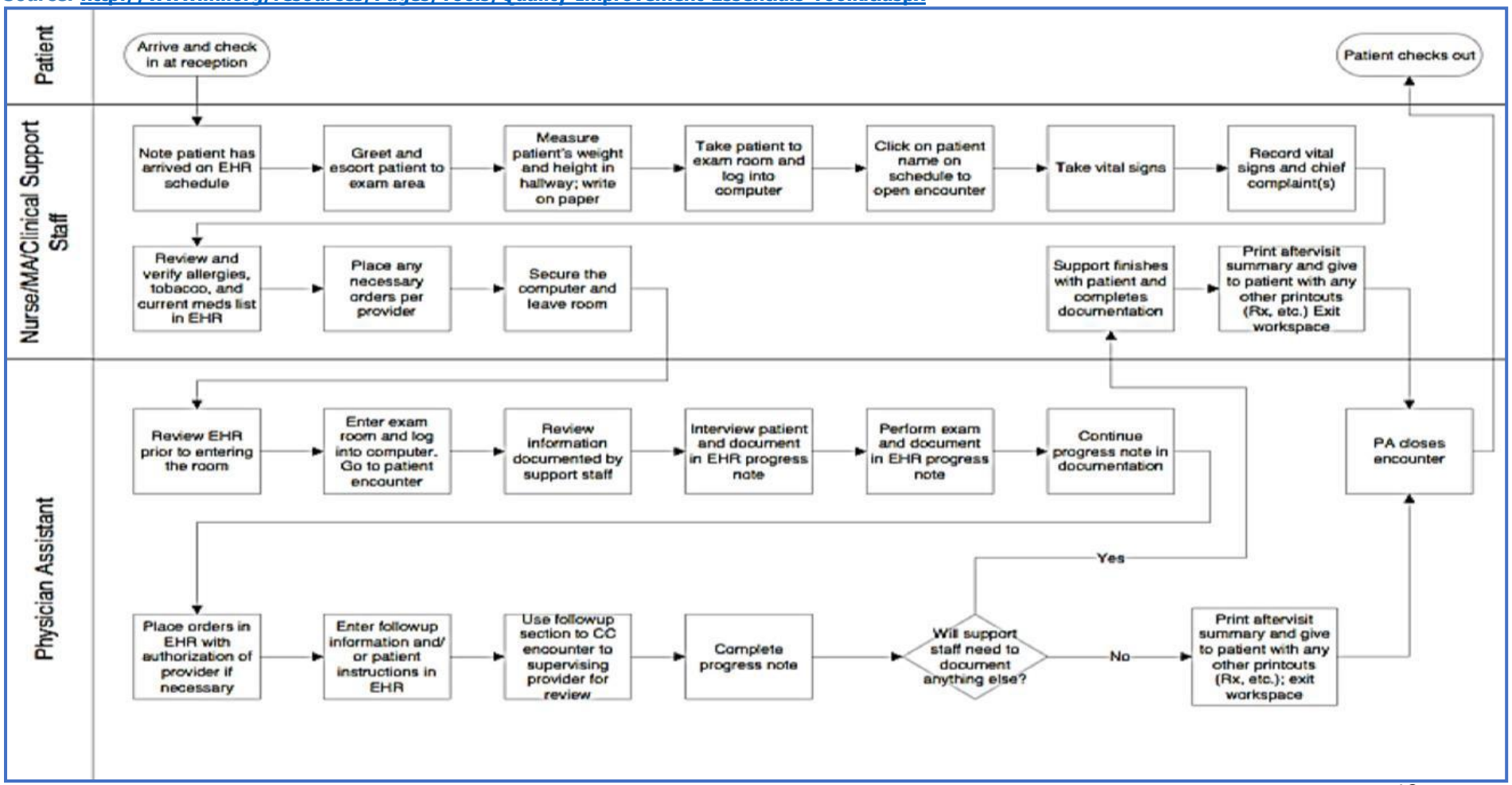


ORPRN Oregon Rural Practice-Based Research Network

Swim Lane Workflow

Step 1: Decide what the workflow is showing: *patient experience and handoffs*
Step 2: Identify the roles (swim lanes) involved in the workflow (*patient, staff, and provider*)
Step 3: List tasks, in order by role
Step 4: Connect with arrows to show movement and direction

Source: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx



PDSA Cycles

The Plan, Do, Study, Act (PDSA) cycle is a simple, step-by-step process to test changes and document outcomes. Use the PDSA cycle once you have an aim statement and ideas of what to try changing.

Step 1 Plan: Make a plan for a small test of change.

- Define a timeline, usually 1-4 weeks depending on howquickly the plan can be implemented
- Define the objective of the plan and data/measures
- Outline questions and predictions about the plan
- Determine the who, what, when, and where for the plan

Step 2 Do: Conduct the test

- Carry out the plan
- Document problems and unexpectedobservations
- Collect data or supporting measures

Step 3 Study: Analyze the results

- Complete the data analysis
- Compare the data to predictions
- Summarize learnings

Step 4 Act: Adopt, adapt, or abandon the change. Determine changes to make anddecide if you do another cycle.

QI Tool: PDSA Cycle: Oral exam example

TIMEFRAME: 11-12-20 to 12-3-20

CHANGE CONCEPT: Standardization, find and remove bottlenecks

PLAN: Not many dental referrals currently occur, despite there being a referral system. Identify patients with diabetes with upcoming appointments who need a dental referral, document so provider knows and incorporates referral conversation into their appointment.

DO: MA will pre-scrub the chart prior to appointment and add a note if dental referral needed.

STUDY:

- PRIMARY OUTCOME: Number of total dental referrals were made in the timeframe.
- PROCESS MEASURE: How many charts were scrubbed in a day?
- BALANCING MEASURE: Could providers incorporate the conversation into their patient visits? Did they know when a referral was needed? Did pre-scrubbing take too much time? Is the EHR set up to hold this information where it can be easily found?

Data Management

Registries track practice populations across a set of diseases and risk states identifying gaps in care. They can be simple (for example, an excel spreadsheet) or complex (for example, automated reports generated from the EMR).

When designing a registry, consider:

- What is the purpose?
- What information will registry hold (for example, name, DOB, most recent A1c, etc.)?
- What questions will the registry answer (for example, are visit no-shows decreasing?)
- How will patients be identified? (for example, ICD-10 codes, medication lists)
- Who maintains the registry? Build in time for a designated registry czar to keep current.

Here is an example of a comprehensive tracker:

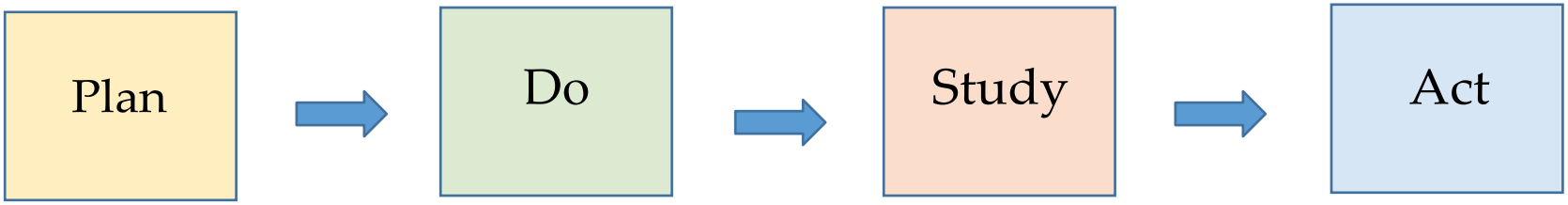
Diabetes Tracking Worksheet

NOTE: DO NOT COPY AND PASTE DATA FROM CELL TO CELL AS THIS MAY UNDO IMPORTANT FORMATTING.

KEY: A1c = hemoglobin A1c; DFE = dilated fundoscopic exam; BMP = basic metabolic panel; BP = blood pressure

Patient name	Sex	Date of birth	ID number	Provider	A1c	Date of last A1c	Date of last DFE	Date of last foot exam	Date of last BMP	LDL	Date of last lipids test	Systolic BP	Diastolic BP	Date of last BP	Co-morbidities
Adams, Jane	F	03/14/56	111-11-1111	Smith	6.5	1-Dec-18	1-Dec-18	1-Dec-18	1-Dec-18	75	1-Dec-18	140	90	1-Dec-18	HTN, obesity
Baker, John	M	10/05/70	222-22-2222	Smith	5.7	24-Feb-18	24-Feb-18	24-Feb-18	24-Feb-18	90	24-Feb-18	110	75	24-Feb-18	
Brown, Jane	F	02/22/63	333-33-3333	Smith	6.3	23-Jan-18	23-Jan-18	23-Jan-18	23-Jan-18	103	23-Jan-18	105	85	23-Jan-18	HTN, Retinopathy, DJD
Carter, John	M	07/05/73	444-44-4444	Smith	7.8	16-Feb-18	16-Feb-18	16-Feb-18	16-Feb-18	98	16-Feb-18	131	75	16-Feb-18	
Doe, Jane	F	08/06/66	555-55-5555	Smith	6.8	24-Oct-18	24-Oct-18	24-Oct-18	24-Oct-18	88	24-Oct-18	120	80	24-Oct-18	
Douglas, John	M	07/01/49	666-66-6666	Smith	7.5	6-Aug-18	6-Aug-18	6-Aug-18	6-Aug-18	87	6-Aug-18	130	80	6-Aug-18	HTN
Jones, Jane	F	10/01/42	777-77-7777	Smith	6.2	19-Dec-18	19-Dec-18	19-Dec-18	19-Dec-18	99	19-Dec-18	128	77	19-Dec-18	
Lane, John	M	01/01/64	888-88-8888	Smith	6.4	31-Jan-18	31-Jan-18	31-Jan-18	31-Jan-18	67	31-Jan-18	115	80	31-Jan-18	
Smith, Jane	F	07/31/38	999-99-9999	Smith	6	17-Dec-18	17-Dec-18	17-Dec-18	17-Dec-18	100	17-Dec-18	130	80	17-Dec-18	
White, John	M	02/28/53	000-00-0000	Smith	7	12/29/2001	12/29/2001	12/29/20018	12/29/20018	76	12/29/20018	120	75	12/29/20018	

Case Study PDSA Examples



Examples from technical assistance conducted between November 2020 and May 2021:

- Get patients in: Increase the number of diabetes annual exams
- Standardize diabetes visits with a checklist
- Define diabetes workflows: Prepare charts for annual exams
- Close external referrals
- Improve communications with the nearest dental practice
- Prioritize diabetes patient outreach for scheduling
- Ensure staff time for quality improvement efforts
- Educate staff in quality improvement techniques

Goal: Increase the Number of Diabetes Annual Exams

Narrative

The number of patients missing scheduled appointments reached up to 20% per week. The primary care clinic wanted to reduce this to below 10%. The clinic first created a work break down structure to identify reasons and improvement areas for missed appointments: automated reminder calls may not work, staff needed training in reminder call communication, convert cancellations or reschedule requests into same-day telemedicine appointments.

Strategy

Reduce annual exam no shows by improving reminder mechanisms and converting cancellation requests to same day telehealth visits. Step 1 work break out/process map.

Plan

Track in person reminder call success rates vs automated. Develop script to offer same day telehealth visits when patients cancel.

Do

One provider team called in person and rest use automated reminders. Offer same day telehealth visits.

Study

How many in person reminder calls reached the patient? Are providers available for same day telehealth?

Act

Adopt, adapt, or abandon?

Goal: Standardize Diabetes Management Visits with a Checklist

Narrative

As a chronic condition, diabetes management is often addressed at visits where other health issues are also broached. While all health issues are interrelated, "free styling" diabetes management introduces the opportunity for factors to be missed.

Strategy

Use a diabetes management visit checklist including lab orders, health assessments, questions during the visit such as recent diet and physical activity levels, use of insulin, testing frequency.

Plan

Create a checklist indicating what labs needed, who will order, and what factors provider should ask about.

Do

A care team pilot tests the list with all diabetes annual visits.

Study

Can MAs access labs? Does provider have time to ask about all items?

Act

Adopt, adapt, or abandon?

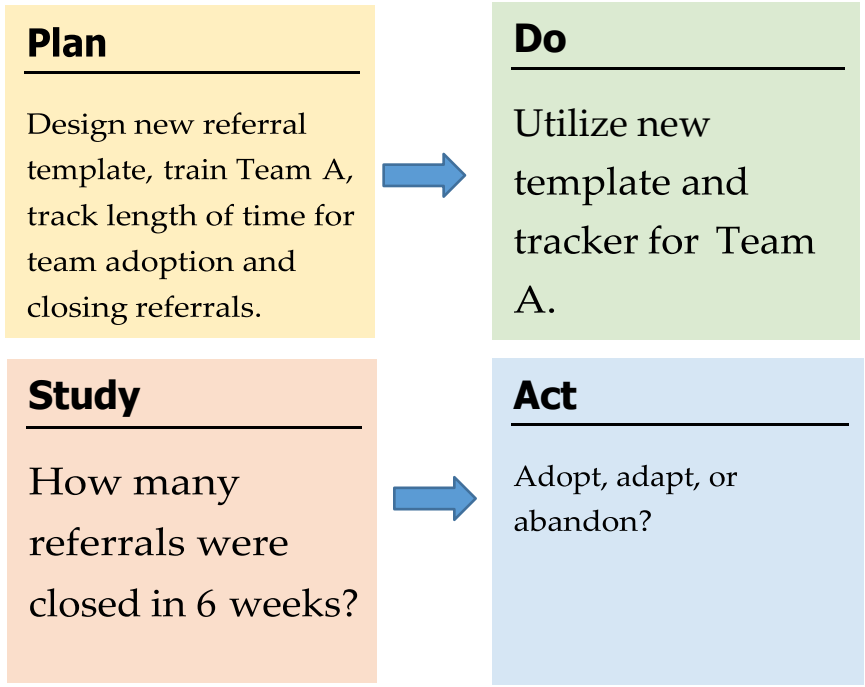
Goal: Close External Referrals

Narrative

The clinic's current electronic health record (EHR) does not have an external referral template nor consistent tracker and closing referrals is taking too much time. In 6 months, the clinic will change to a new EHR that has a template. The clinic wants to start using an external referral template before adoption of the new EHR. They will devote staff time to assist the referral coordinator design a template, train staff and implement a tracking system.

Strategy

Design a template that aligns with the new EHR external referral template and train one provider team to use. Referral coordinator will track time via excel spreadsheet and connect with referral partners to close referrals on a weekly basis.



Goal: Increase Patient Receptivity and Knowledge for Oral Health Exams

Narrative

A CCO panel manager regularly calls clients with diabetes to check in about oral health needs and encourage them to see a dentist for their yearly oral health exam. Many of the patients do not know that they have dental coverage through Oregon Health Plan (OHP) and are not sure who to callto get a dental appointment that would be covered by their dental care organization.

Strategy

Increase messaging to focus on patient education about coverage; incorporate dental coverage conversation with all OHP clients during diabetes annual exams.

Plan

Gather all DCO contact numbers, patient education materials and list of covering local dental providers

Do

Add oral health to DM annual exam check list- provide information to each patient with their after-visit summary.

Study

How many patients received oral health coverage info in 1 week?

Act

Adopt, adapt, or abandon?

Goal: Increase communication pathways between primary care and dental clinics in same area.

Narrative

Primary care providers refer diabetic patients for oral health exams but don't track whether patients complete these visits. Dental practices aren't routinely informed of patients referred to them, and can't contact patients who are not yet established with their practice.

Strategy

Initiate a monthly check-in to reconcile completed oral exams so that referrals can be re-issued if necessary.

Plan

Build a relationship between primary care and dental staff with a monthly check-in to reconcile referrals

Do

PC staff contact dental practice, introduce self, and propose referral reconciliation meeting

Study

Was dental practice amenable to plan? Did reconciliation call prevent staff from completing other necessary duties?

Act

Adopt, adapt, or abandon?

Goal: Prioritize Diabetes Patient Outreach for Scheduling

Narrative

Some patients are behind on their essential diabetes management visits and A1c testing, but the clinic lacks a way to quickly identify all these patients.

Strategy

Run a report in the EMR including all patients with a diagnosis of diabetes and their three most recent A1c results.

Plan

Write a report including three most recent A1c scores and dates.

Do

Run report monthly to identify who needs attention.

Study

Were staff able to create a report for future use that is accurate? Can the report be re-run?

Act

Adopt, adapt, or abandon?

Goal: Complete behavioral health and social needs screenings and refer all new diagnoses as indicated.

Narrative

A new diagnosis of diabetes is upsetting to many patients. A referral (ideally with a warm handoff) to a behavioral health consultant (BHC) can give patients space to address the emotional impact of their diagnosis one time, or in an ongoing way. Screening for diabetes distress and/or social determinants of health such as income, housing, and relationship safety can help a provider build a treatment plan that is attainable.

Strategy

Identify a BHC in clinic who will meet with all newly diagnosed patients. Make the Health-Related Social Needs (HRSN) Screening Tool available in exam rooms.

Plan

Name BHC who will meet with patients. Store copies of the HRSN Screening Tool in rooms.

Do

Make referrals to BHC. Have patients complete the HSRN Screener.

Study

Was BHC available? Could patients complete screener in timely manner?

Act

Adopt, adapt, or abandon?

Goal: Ensure Staff Time for Quality Improvement Efforts

Narrative

Leadership want and staff voice a need for quality improvement but no one has the time or duty built in to their role. To plan for success and align office culture with stated goals, make leading QI efforts part of someone's official duties with dedicated resources such as weekly protected time to do the work.

Strategy

Consider which office role is the most natural fit for QI duties; redistribute .2 FTE non-QI duties to other staff to truly protect this time.

Plan

Assign QI leadership to one staff member. Adjust job description to reflect this.

Do

Trial QI work for four weeks. Document tasks.

Study

Are QI efforts now included in someone's job description? Are necessary activities neglected in the name of QI work?

Act

Adopt, adapt, or abandon?

Goal: Ensure all lab results, including from specialists (such as endocrinology) are recorded consistently

Narrative

Lab results aren't always recorded in the electronic medical record (EMR), where providers can see and use them, even if patients follow through and complete requested tests. Making results available to providers before/during a patient visit empowers the provider to make decisions based on the best current lab information.

Strategy

During patient visit reminder call, confirm that patient completed requested lab tests, and look up results, copying them into patient visit note.

Plan

MA confirms patient completed labs, looks up results and copies into visit note.

Do

Create space to populate in visit note for lab results.

Study

Are patients reliably reporting lab completion? Can MA find lab results?

Act

Adopt, adapt, or abandon?

Goal: Train Staff in Quality Improvement Skills

Narrative

Current staff lack QI skills and need an introduction and basic training.

Strategy

Train one staff member by sending them to an Institute for Healthcare Improvement (IHI) training, after which they will "teach back" QI basics to others in an all-staff meeting.

Plan

Send one staff to an intro to QI for healthcare training

Do

Register staff for training. Block 10-minute chunks in all staff meetings for "teach back"

Study

Did staff attend training? Can staff meetings accommodate 10 mins for QI?

Act

Adopt, adapt, or abandon?

Diabetes Quality Improvement: Mission and Parameters Worksheet

Complete this form when you launch your QI efforts and return to it regularly to ensure alignment with your clinic's mission and capacity.

QI Team Members *Who will meet to do this work?*	
Regular Meeting Time *Pick a standing meeting time to maintain momentum.*	
Timeframe *How long will you spend? Can be open-ended or time-limited.*	
Topic *Briefly describe the process or system to be addressed.*	
Tools *Circle those you plan to use.*	Work Breakdown Chart Driver Diagram PDSA Cycle Fishbone Workflow Mapping Aim Statement

Resources and Appendix

Oral Evaluation for Adults with Diabetes - Measure information
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-2021-Specs-(Oral-Evaluation-for-Adults-with-Diabetes)-20201222.pdf

Diabetes: HbA1c Poor Control (CMS122v9)
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2021-specs-(Diabetes-Poor-Control)-12-18-20.pdf

NCQA HEDIS Comprehensive Diabetes Care (CDC)
https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

CDC National Diabetes Statistics Report 2020
https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html

Telehealth Guidance for Electronic Clinical Quality Measures (eCQMs) for Eligible Professional/Eligible Clinician 2021 Quality Reporting
https://ecqi.healthit.gov/sites/default/files/2021-eCQM-Telehealth-Guidance-Document-With-QRDA-Update-508.pdf

ADA policy on Tele-dentistry
https://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/statement-on-teledentistry

Guiding Principles for the Care of People With or at Risk for Diabetes (NIH)
https://www.niddk.nih.gov/health-information/professionals/clinical-tools-patient-management/diabetes/guiding-principles-care-people-risk-diabetes

Patient handout: Take Charge of Your Diabetes: Healthy Teeth

TAKE CHARGE OF YOUR DIABETES

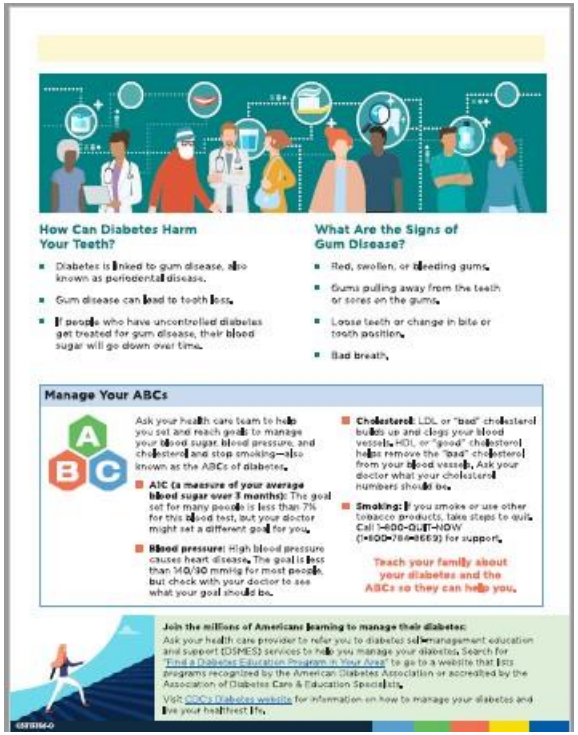
Healthy Teeth

Did you know that diabetes can harm your teeth and gums? The good news is that you can take steps to help keep your teeth healthy. You've already taken an important step by finding this guide!

Tips to Keep Your Teeth Healthy

- **Get a dental exam once a year or more often if your dentist says you need it. At your exam, your dentist or dental hygienist can:**
  - Explain how diabetes affects your teeth and gums and check for problems, like cavities or gum disease.
  - Treat any problems you have with your teeth or gums.
  - Teach you how to check for signs of gum disease at home (see next page).
  - Provide care, like a fluoride treatment, to keep your mouth healthy.
  - Tell you how to treat problems, such as dry mouth.
- **Work with your dentist to create a health plan for your teeth.**
  - Ask your dentist how to take care of your teeth at home and how often to come in for a dental visit.
  - Ask what to do if you start having problems with your teeth or gums.
  - Ask your dentist to send your exam results to your other doctors after every visit.
  - Be sure to keep your next dentist appointment!

- **Take care of your teeth at home.**
  - Brush with a soft-bristled toothbrush two times a day or more.
  - Use toothpaste with fluoride and floss once a day.
  - Check your mouth for red or swollen gums, bleeding gums, loose teeth, a change in how your bite feels, or bad breath.
  - Visit a dentist if you think you have gum disease.
  - Limit food and drinks that are high in sugar.



How Can Diabetes Harm Your Teeth?

- Diabetes is linked to gum disease, also known as periodontal disease.
- Gum disease can lead to tooth loss.
- If people who have uncontrolled diabetes get treated for gum disease, their blood sugar will go down over time.

What Are the Signs of Gum Disease?

- Red, swollen, or bleeding gums.
- Gums pulling away from the teeth or sores on the gums.
- Loose teeth or change in bite or tooth position.
- Bad breath.

Manage Your ABCs

Ask your health care team to help you set and reach goals to manage your blood sugar, blood pressure, and cholesterol and stop smoking—also known as the ABCs of diabetes.

- **A1C (a measure of your average blood sugar over 3 months):** The goal set for many people is less than 7% for this blood test, but your doctor might set a different goal for you.
- **Blood pressure:** High blood pressure causes heart disease. The goal is less than 140/90 mmHg for most people, but check with your doctor to see what your goal should be.
- **Cholesterol:** LDL or "bad" cholesterol builds up and clogs your blood vessels. HDL or "good" cholesterol helps remove the "bad" cholesterol from your blood vessels. Ask your doctor what your cholesterol numbers should be.
- **Smoking:** If you smoke or use other tobacco products, take steps to quit. Call 1-800-QUIT-NOW (1-800-784-8669) for support.

Teach your family about your diabetes and the ABCs so they can help you.

Join the millions of Americans learning to manage their diabetes:

Ask your health care provider to refer you to diabetes self-management education and support (DSMES) services to help you manage your diabetes. Search for "Find a Diabetes Education Program in Your Area" to go to a website that lists programs recognized by the American Diabetes Association or accredited by the Association of Diabetes Care & Education Specialists.

Visit CDC's Diabetes website for information on how to manage your diabetes and live your healthiest life.

Find this printable handout here: https://www.cdc.gov/diabetes/pdfs/library/Diabetes-Teeth-h.pdf

Healthy Teeth

Did you know that diabetes can harm your teeth and gums? The good news is that you can take steps to help keep your teeth healthy. You've already taken an important step by finding this guide!

Tips to Keep Your Teeth Healthy

- **Get a dental exam once a year or more often if your dentist says you need it. At your exam, your dentist or dental hygienist can:**
  - Explain how diabetes affects your teeth and gums and check for problems, like cavities or gum disease.
  - Treat any problems you have with your teeth or gums.
  - Teach you how to check for signs of gum disease at home (see next page).
  - Provide care, like a fluoride treatment, to keep your mouth healthy.
  - Tell you how to treat problems, such as dry mouth.
- **Work with your dentist to create a health plan for your teeth.**
  - Ask your dentist how to take care of your teeth at home and how often to come in for a dental visit.
  - Ask what to do if you start having problems with your teeth or gums.
  - Ask your dentist to send your exam results to your other doctors after every visit.
  - Be sure to keep your next dentist appointment!

- **Take care of your teeth at home.**
  - Brush with a soft-bristled toothbrush two times a day or more.
  - Use toothpaste with fluoride and floss once a day.
  - Check your mouth for red or swollen gums, bleeding gums, loose teeth, a change in how your bite feels, or bad breath.
  - Visit a dentist if you think you have gum disease.
  - Limit food and drinks that are high in sugar.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

How Can Diabetes Harm Your Teeth?

- Diabetes is linked to gum disease, also known as periodontal disease.
- Gum disease can lead to tooth loss.
- If people who have uncontrolled diabetes get treated for gum disease, their blood sugar will go down over time.

What Are the Signs of Gum Disease?

- Red, swollen, or bleeding gums.
- Gums pulling away from the teeth or sores on the gums.
- Loose teeth or change in bite or tooth position.
- Bad breath.

Manage Your ABCs

Ask your health care team to help you set and reach goals to manage your blood sugar, blood pressure, and cholesterol and stop smoking-also known as the ABCs of diabetes.

- **A1C (a measure of your average blood sugar over 3 months):** The goal set for many people is less than 7% for this blood test, but your doctor might set a different goal for you.
- **Blood pressure:** High blood pressure causes heart disease. The goal is less than 140/90 mmHg for most people, but check with your doctor to see what your goal should be.
- **Cholesterol:** LDL or "bad" cholesterol builds up and clogs your blood vessels. HDL or "good" cholesterol helps remove the "bad" cholesterol from your blood vessels. Ask your doctor what your cholesterol numbers should be.
- **Smoking:** If you smoke or use other tobacco products, take steps to quit. Call 1-800-QUIT-NOW (1-800-784-8669) for support.

Teach your family about your diabetes and the ABCs so they can help you.

Join the millions of Americans learning to manage their diabetes:

Ask your health care provider to refer you to diabetes self-management education and support (DSMES) services to help you manage your diabetes. Search for "Find ai DDd:i:tirniEBSHiJtjurrati:mTI RIr(]ffIBITT1 ii1n'MIILrrf.X'te:a3"' trngJD1:rncE weiir.IBtte ttratt IImts programs recognized by the American Diabetes Association or accredited by the Association of Diabetes Care & Education Specialists.

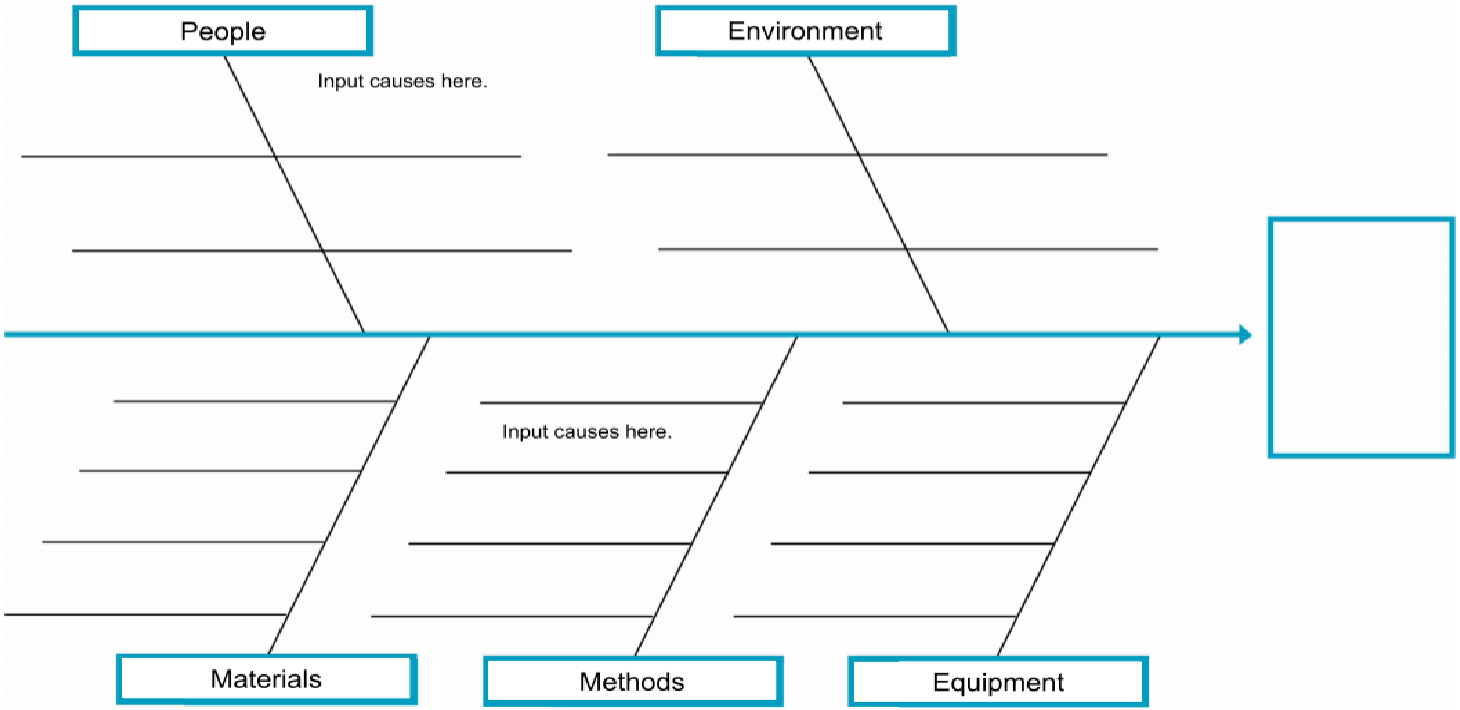
Visit CDC's Diabetes website for information on how to manage your diabetes and live your healthiest life.

Institute for Health Care Improvement QI Essentials Toolkit: ready-to-use QI tool templates

Template: Cause and Effect Diagram

Team: _____ **Project:** _____

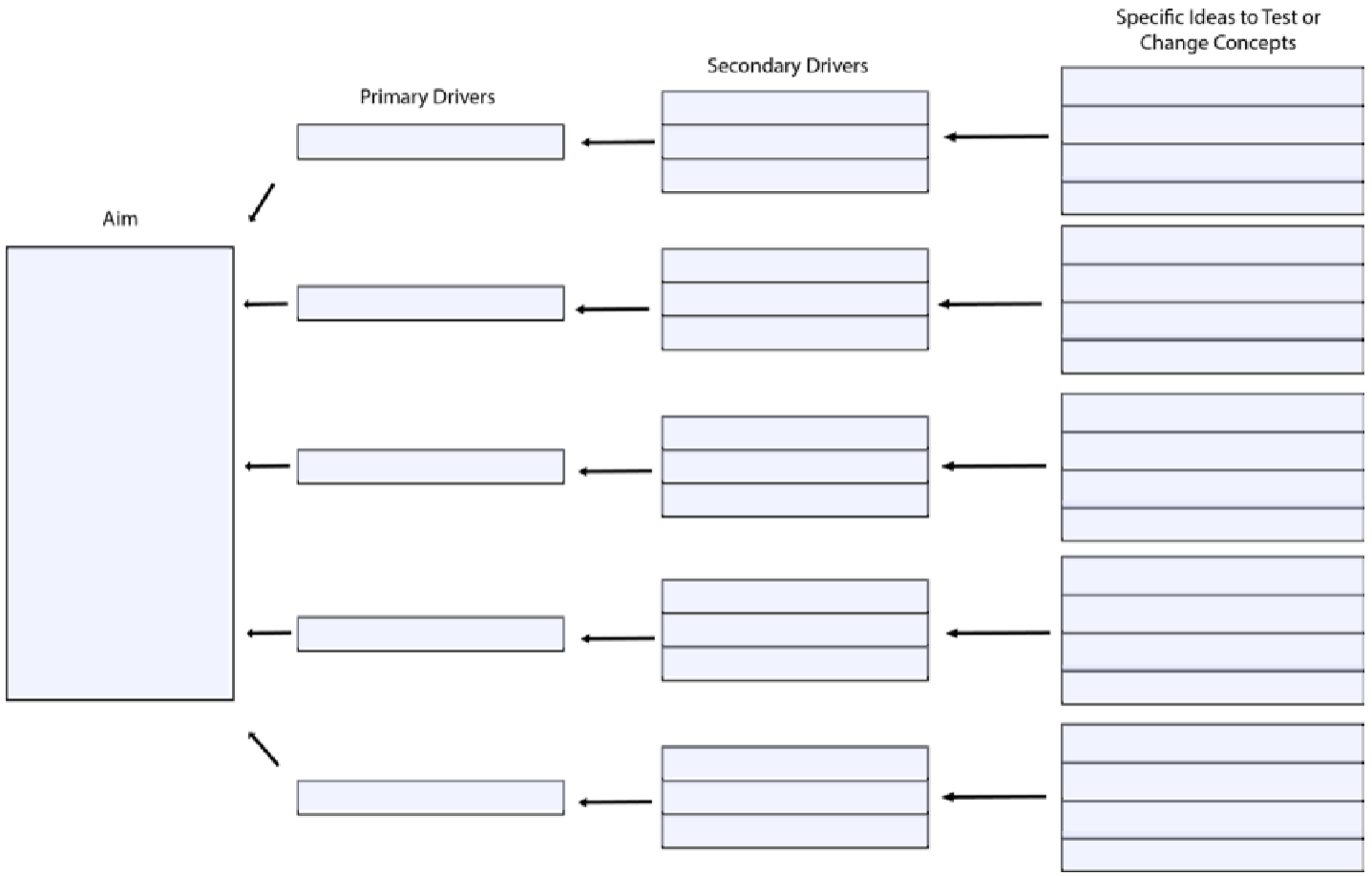
1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.



Institute for Healthcare Improvement · ihi.org

ORPRN Oregon Rural Practice-Based Research Network

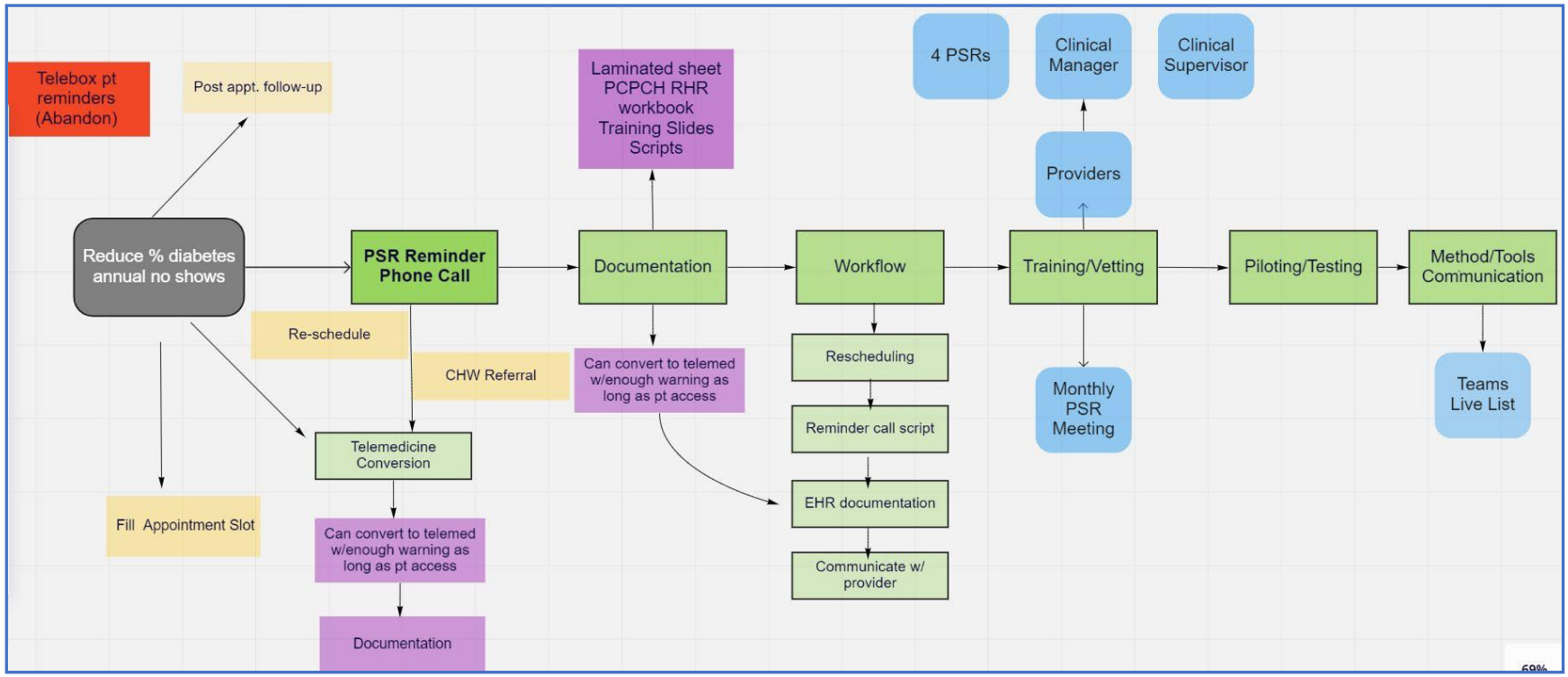
Template: Driver Diagram



Institute for Healthcare Improvement · ihi.org

ORPRN
Oregon Rural Practice-Based Research Network

Work breakdown process map example from previous PDSA workflow example



ORPRN
Oregon Rural Practice-Based Research Network

This toolkit was created by practice facilitators from the Oregon Rural Practice-based Research Network and funded by the Oregon Health Authority Transformation Center.

Contributors include:

Laura Ferrara , Tiff Weekley, Cort Cox, and Steph Hyde

June 30, 2021

Questions? Email ORPRN_TA@ohsu.edu

ORPRN
Oregon Rural Practice-Based Research Network