Diabetes Action Committee

Date: Wednesday, July 31, 2024
Time: 5:00 pm
Location: Virtual

Attendees

David Mann -MDH-
Gene Ransom
Ilene Cervantes del Toro -MDH-
Maisha DouyonCover
Matthew Balish
Michelle George -MDH
Nicole T. Rochester, MD
Nkossi Dambita
Pamela Williams -MDH-
Snehal Gawhale -MDH-
Sohail Qarni -MDH-
Taneisha L.
Tina Backe -MDH-

Introductions:

Michelle George commenced the meeting with reviewing the agenda and introductions of the presenters for the meeting: Snehal Gawhale and Ilene Cervantes del Toro, including their affiliations.

Michelle read the Mission Statement:

The mission of the Maryland Diabetes Action Committee is to improve the health of the communities we serve through a coordinated and meaningful initiative to address the prevention and management of diabetes in Maryland. As a collaboration of organizations and partners, across multiple sectors, we come together to identify opportunities to improve health outcomes in those identified as at risk for diabetes or diabetes complications. We will act in our areas of influence to align efforts and resources to reduce the burden of diabetes.

Diabetes Dashboard Presentation by Snehal Gawhale

Snehal gave an overview of the Diabetes Dashboard interactive Tableau platform that displays the population measures, the clinical measures, and the hospital measures. The interactive platform allows various views of the data including breakdown by race/ethnicity, county, and year. Viewers can also download the data to view additional information. Both hospital measures are up to date, population measures are partially up to date with a few pending, and

the clinical measures are pending receipt of the NCQA data. When the dashboard is ready it will be posted on the MDH webpage with the other dashboards.

- Nkossi Dambita pointed out that the “other category” for the race/ethnicity was consistently coming up with the highest rates. Snehal provided additional information on the other category that includes those who do not disclose, those who do not identify as the listed categories (NH, Black; NH, White; Hispanic), or somebody who selected other. There may be value if it is possible to break down the other category more.
- Matthew Balish pointed out that the lower Eastern Shore has a heavy rate of Emergency Department visits and suggested we should break down the diagnosis code if possible. Snehal brought up that the data was collected from CRISP to see if there were specific emergencies or diagnostic codes associated with the visits. Nicole Rochester also emphasized that we should not stop at race/ethnicity and we should be careful of wording when referencing race/ethnicity regarding rates/percentages. There is an interest in zip code data but unfortunately not all data sets allows for zip code due to low numbers.

DSMES/DSMP Presentation by Ilene Cervantes del Toro

- At the last meeting, the group voted almost unanimously to address the population measure “Increase enrollment into a Diabetes Self-Management Program (either DSMES or DSMP).
- Ilene presented on the Center for Chronic Disease Prevention and Control’s (CCDPC) efforts surrounding DSMES and DSMP including providing background details on both programs.
    - DSMES (Diabetes Self-Management Education Support Services)
        - Caroline, Somerset and Dorchester do not have DSMES programs
        - Matthew Balish brought up that there might be some correlation between the lack of DSMES programs in these jurisdictions and the high rates of diabetes Emergency Department visits
    - DSMP (Diabetes Self Management Program)
- Referrals for both programs have continued to be a struggle across the board as well as with other lifestyle change programs (National DPP, TOPS, Healthy Hearts Ambassadors)
    - State funding is available to develop relationships and referral mechanisms between providers, programs, CBOs/Non-profits, and hospital systems
    - There has continued to be barriers with translating referrals into active enrollments
    - Dr. Mann raised the point of if there are available slots in open programs or is there waiting lists? This pertains to the activity of do we focus on increasing programs or increasing enrollments into existing programs.
        - From what the State has seen - this has very much so varied depending on the county and program. There are some counties who have an excellent referral process in place that leads to waitlist for Lifestyle change programs and there are others that do not have the same referral processes in place so their referrals are lower.

Review the Diabetes Resources Page

- Last year, the previous Diabetes Quality Task Force's Community Clinical Linkages group had developed a diabetes resources page. Michelle revisited the page to update links and add additional links. Michelle will be sending out the resource page to the group for review.

Selection of the Hospital Measure Poll

- Which of the following Hospital Measures do you think we should develop goals, objectives, and activities for?
    - Diabetes Emergency Department Visits (8 votes)
    - Diabetes In-Patient Visits (1 vote)
- Of note, the Healthy People 2030 for the hospital measures are
    - Reduce emergency department visits for insulin overdoses
    - Reduce the rate of hospital admissions for diabetes among older adults

Next Meeting

- Wednesday, August 28 · 5:00 – 6:00pm
- Google Meet joining info
- Video call link: https://meet.google.com/gpc-ujbq-bki
- Or dial: (US) +1 319-343-8708 PIN: 922 930 975#
- More phone numbers: https://tel.meet/gpc-ujbq-bki?pin=3030973245413