Diabetes Action Committee Minutes

Wednesday, November 20, 2024

5:00 pm - 6:00 pm

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

A. Welcome / Introductions

a. Attendance:

David Mann
Janae Logan
Marissa Smith
Matthew Balish
Nicole T. Rochester
Raghavi Anand
Taneisha Laume
Tina Backe
Kim Zientek
Ilene Cervantes del Toro
Michelle George
Olivia Massa
Snehal Gawhale

B. 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.

C. **HALT Platform Presentation**

a. Kim Zientek, HALT Success Navigator, ProVention Health

b. HALT: Healthy and lifestyle training. A free, ready to use software platform. Allows organizations to offer DPP and other chronic disease prevention interventions to people who may not attend programs in-person. There is no-cost to use the program due to the MDH having a license already.

c. Kim and Ilene can assist organizations who are interested in utilizing the software platform.

d. Tina Backe shared contact information and is looking forward to connecting with Kim.

e. Dr. Mann asked a question regarding training needed for the platform users and how the experience has been for multiple kinds of subpopulations.

    i. Kim reports they are tracking any difficulties that people may have using the platform. States in general the platform is intuitive. The curriculum is written as a 6th grade level. The technology on the interface is simple with many icons. They have found that many people use the app instead of the desktop version.

    ii. Find that the older population struggles the most with the technology. HALT has strategies and tools to help mitigate these barriers. They have created text registration to assist with barriers i.e. not using email.

        1. There is a technology team to assist if needed.

        2. When providing a session zero, includes a presentation with screenshots of the platform.

        3. Also have resources for the coaches if they are struggling.

f. Nicole Rochester asked a question regarding who has access to use the platform.

    i. MDH purchased the license. Any organization in the state can access it. If it is DPP, needs to be a CDC recognized program and trained lifestyle coaches accessing the site.

    ii. Other programs, i.e. tobacco cessation, there are no restrictions on who can utilize it. Training may be needed.

    iii. Can contact Kim or Ilene if you are interested in using the platform.

D. Diabetes Dashboard Updates

a. Snehal Gawhale, Epidemiologist for the Cancer and Chronic Disease Bureau

b. Diabetes Dashboard Updates

   i. Clinical, hospital, and population measures.

   ii. Data for hospital and population measures have been updated for 2022.

   iii. Hospital measures have been updated for 2023.

   iv. Some corrections are needed. Sne has sent to the data office.

c. NCQA Confidence Intervals Follow Up:

   i. BRFSS can get confidence intervals and can be updated on the dashboard.

   ii. NCQA gets aggregated data and because of this, they do not provide confidence intervals.

d. Hospital Measure Follow-Up:

   i. What should the focus of this data be? How is it being determined if it is a "diabetes related" visit?

      1. Have data for ED and inpatient visits for 100,000 people broken down by county and race and ethnicity.

      2. Sne has access to the ICD 10 codes and what was used to define these measures.

      3. Dr. Mann reports the issue that prompted the visit is supposed to be what the person was admitted for as the primary diagnosis and then has additional comorbidities included.

         a. SHIP has used a triggering diagnosis in the primary diagnosis spot only for hypertension, asthma, and diabetes. However, for mental health and substance use, would use if they were in the first three diagnoses.

         b. Also brings up looking at data by place versus race, though this will depend on location. Recommends looking at place versus place and also place stratified by race.

c. May depend on what the research question is that the group is trying to answer.

4. Nicole Rochester recommends not looking just at primary diagnosis but other secondary ones as well and looking at data by race.

5. For hospital visits, may want to look at PQI.

ii. Can the visits be broken down on diagnostic codes? Are there certain codes that are pre-populated to look for? Which ICD 10 codes should be a focus?

1. Not divided by primary diagnosis.

2. Have it stratified by diagnosis.

3. Dr. Mann says that hospital admissions are stratified by PQI conditions. Take a mixture of ICD codes and procedure codes. Look at visits that may be preventable with primary care.

a. This is not designed for ED visits but wondering if this could be adapted.

b. In analysis, it is better to have more levels of specificity beyond the primary diagnosis.

4. Sne can reach out to CRISP and see if they have the list of ICD 10 codes separated by primary diagnosis or not.

5. Sne shared the ICD 10 codes broken down by specific diagnosis type, i.e. kidney complications, ophthalmic complications, etc.

iii. Diabetes versus prediabetes?

1. All of the codes provided are related to diabetes, not prediabetes.

2. If want to include prediabetes codes, Sne can reach out to CRISP about it.

3. Should we include prediabetes?

a. Questioning how frequently is it coded.

b. Committee members recommended sticking with

diabetes, not prediabetes.

4. Prevalence levels:

    a. Less gap for prediabetes than diabetes among different races. This can be related to the population moving faster through steps and disparities are more recognizable when diagnosed with diabetes.

    b. Likely to dilute disparity measures if focusing on prediabetes as well.

E. CDC 2320 Co-Operative Agreement Overview:

a. Ilene Cervantes del Toro, Diabetes Lead for the Center for Chronic Disease Prevention & Control

    i. The 2320 cooperative agreement is focused on equity. Seeks to decrease the risk of diabetes among adults with prediabetes, improve self-care practices and early detection of complications for adults with diabetes, and family-centered obesity strategies to reduce the risk of diabetes.

    ii. The Center has selected 6 strategies.

    iii. At least 10% of the budget is to be focused on SDOH.

    iv. Convene priority populations or organizations that represent them through state communities and agencies to identify concerns.

        1. Minority health and health disparities has 40 community based organizations that can be engaged. Dr. Mann can connect and share information if needed.

    v. Ask for input, guidance, and expertise from the committee.

F. Review Proposed 2025 Calendar Meeting Dates: Last Wednesday of the month at 5 pm

a. January 29, 2025

b. February 26, 2025

c. March 26, 2025

d. April 30, 2025

e. May 28, 2025

f. June 25, 2025

g. July 30, 2025

h. August 27, 2025 → August 20, 2025 due to Hindu: Ganesh Chaturthi

i. September 24, 2025 → September 17, 2025 due to Jewish: Rosh Hashanah

j. October 29, 2025

k. November 26, 2025 → November 19, 2025 due to Thanksgiving Eve

l. No December Meeting

G. Next Meeting: Wednesday January 29, 2025 at 5:00 p.m