Diabetes Action Committee

Date: Wednesday, May 1, 2024
Time: 5:00 pm
Location: Virtual

Attendees:

1. Darryl Heggans
2. Dr. David Mann -MDH-
3. Dr. Laurence Polsky
4. Elizabeth Chung
5. Eric Sullivan
6. Jesus Aguilar -MDH-
7. Kimberly Hiner -MDH-
8. Lisa Marr -MDH-
9. Michelle George -MDH-
10. Nicole T. Rochester, MD
11. Pamela R. Williams -MDH-
12. Raghavi Anand -MDH-
13. Snehal Gawhale -MDH-
14. Sohail Qarni -MDH-
15. Tina Backe -MDH-
16. Traci la Valle

Introductions:

Michelle George commenced the meeting with introductions of the committee members, 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.

Review Public Health Services Metrics:

Michelle presented the Public Health Services Metrics and the corresponding Strategic Plan that was developed in 2023, approved in January 2024 and goes through January 2027. There is a priority area that focuses on diabetes:

- Strategic Priority: Chronic Disease Prevention, with an initial focus on Diabetes - to increase efforts in the promotion of maintaining healthy weight and diabetes prevention, with enhanced focus on communities disproportionately affected by difficulties in maintaining healthy weight and preventing diabetes.

Four Goals with Objectives and Performance Metrics that correspond with Diabetes:

1. Goal 6: Use community-wide approaches to implement multi-faceted, multi-sector collaborations to make healthy eating and active living accessible, affordable, and convenient.
    a. Objective 6.1: By January 31, 2025, increase access to healthy nutrition, with specific focus on areas with inadequate or limited access, to improve equitable access.
        i. Performance Metric 6.1.1: Number of stores that participate in the MD Healthy Corner Store Initiative
        ii. Performance Metric 6.1.2: Number of participants that benefit from the MD Healthy Corner Store Initiative
        iii. Performance Metric 6.1.3: Number of food distributors connected to the MD Healthy Corner Store Initiative
        iv. Performance Metric 6.1.4: Number of farmers that participate in access to SNAP-EBT
        v. Performance Metric 6.1.5: Number of LHDs that develop and implement an access to healthy food plan
        vi. Performance Metric 6.1.6: Number of LHDs that develop and implement a Healthy Heart Ambassador program
        vii. Performance Metric 6.1.6: Health outcome data from the Healthy Heart Ambassador Program focusing on a) BMI and b) Blood Pressure
        viii. Performance Metric 6.1.7: Number of LHDs to develop and implement a lifestyle change program
    b. Objective 6.2: By January 31, 2027, achieve and maintain recommended physical activity levels for Marylanders.
        i. Performance Metric 6.2.1: Number of participants in lifestyle change programs
        ii. Performance Metric 6.2.2: Number of participants in lifestyle change programs achieving a BMI reduction (or Blood pressure reduction)
        iii. Performance Metric 6.2.3: Number of participants in lifestyle change programs following CDC recommended physical activity guidelines
2. Goal 7: Reduce overweight and obese populations in Maryland.
    a. Objective 7.1: By January 31, 2027, improve clinical care services for overweight and obese children and adults by increasing referrals of patients to lifestyle change programs.
        i. Performance Metric 7.1.1: Number of patients enrolled in the Adult Oral Health Obesity Screening Program

ii. Performance Metric 7.1.2: Number of patients enrolled in the Pediatric Oral Health Obesity Screening Program
iii. Performance Metric 7.1.3: Health outcome data in the Adult and Pediatric Oral Health Obesity Screening Programs focusing on BMI

b. Objective 7.2: By January 31, 2027, implement and expand the availability of healthy lifestyle options and programs for overweight and obese adults.
    i. Performance Metric 7.2.2: Number of referrals and attendees to lifestyle change programs

c. Objective 7.3: By January 31, 2027, improve the availability of healthy lifestyle options and programs for overweight and obese children.
    i. Performance Metric 7.3.1: Number enrolled in the Pediatric Oral Health Obesity Program
    ii. Performance Metric 7.3.2: Number of community gardens developed that encourage pediatric participation
    iii. Performance Metric 7.3.3: Lifestyle change program for pediatrics developed through the Center of Chronic Disease Prevention and Control

3. Goal 8: Increase screening for prediabetes and diabetes in adults.
    a. Objective 8.1: By January 31, 2025, increase awareness of one's risk of prediabetes through the MDH Prediabetes Communication Campaign
        i. Performance Metric 8.1.1: Number of people that completed the "Know Your Risk" survey
        ii. Performance Metric 8.1.2: Number of people identified as being at risk for prediabetes and diabetes through the "Know Your Risk" survey that are referred to a primary care provider
        iii. Performance Metric 8.1.3: Number of website impressions/transit views of the MDH Prediabetes Communications Campaign
    b. Objective 8.2: By January 31, 2027, increase the number of healthcare providers caring for women with a history of gestational diabetes during the postpartum period that screen for prediabetes and diabetes and facilitate referrals to lifestyle change programs.
        i. Performance Metric 8.2.1: Number of providers trained in best practices for treating women with gestational diabetes during the postpartum period through the MD Primary Care, Family Practice, and OB/GYN offices
        ii. Performance Metric 8.2.2: Number of women receiving postpartum blood sugar testing during their postpartum period *
        iii. Performance Metric 8.2.3: Number of referrals of women with a history of gestational diabetes to diabetes prevention programs (e.g., the National Diabetes Prevention Program, Diabetes Self-Management Education and Support Program, and additional lifestyle change programs)
    c. Objective 8.3: By January 31, 2027, link to community resources and clinical services that support self management and lifestyle change to address social determinants that put priority populations at increased risk for diabetes.

        i. Performance Metric 8.3.1: Number of individuals receiving transportation access for appointments to lifestyle change programs
        ii. Performance Metric 8.3.2: Number of food access incentives provided to participants of lifestyle change programs
    d. Objective 8.4: By January 31, 2027, increase the number of providers from the MD Primary Care Program and Medicaid that refer at-risk patients to diabetes prevention programs to prevent progression to type 2 diabetes and improve management for patients diagnosed with diabetes.
        i. Performance Metric 8.4.1: Number of providers receiving education concerning available referral programs
4. Goal 9: Improve the use of standardized quality of care for people with diabetes at all levels of the health care system.
    a. Objective 9.1: By January 31, 2027, increase the number of providers in MD Primary Care and Medicaid that utilize the American Diabetes Association's (ADA) 2019 Standards of Medical Care in Diabetes.
        i. Performance Metric 9.1.1: Number of providers in MD Primary Care and Medicaid participating in ADA training*
    b. Objective 9.2: By January 31, 2027, charge the Diabetes Quality Task Force to develop a Diabetes Dashboard.
        i. Performance Metric 9.2.1: Creation of the Diabetes Dashboard
    c. Objective 9.3: By January 31, 2027, implement and expand Diabetes Self Management, Education, and Support (DSMES) Programs in the state.
        i. Performance Metric 9.3.1: Number of organizations offering DSMES Programs
        ii. Performance Metric 9.3.2: Number of participants in DSMES Programs
    d. Objective 9.4: By January 31, 2027, provide education and quality improvement technical assistance to primary care providers in Maryland (e.g., via MDPCP network, other primary care networks) to promote best practices that improve diabetes outcomes.
        i. Performance Metric 9.4.1: Number of educational opportunities or technical assistance provided to primary care providers
        ii. Performance Metric 9.4.2: Number of individuals with diabetes with A1C<7
        iii. Performance Metric 9.4.3: Number of individuals with diabetes with A1C>9
    e. Objective 9.5: By January 31, 2025, reduce the number of hospitalizations and emergency department visits, each by 5 percent, for people with diabetes in the state of Maryland.
        i. Performance Metric 9.5.1: Number of hospitalizations for people admitted for diabetes
        ii. Performance Metric 9.5.2: Number of ED visits for people with a chief complaint related to diabetes

NCQA Measures for Diabetes Data Dashboard:

Michelle presented the NCQA measures that the Bureau would be purchasing for the Diabetes Data Dashboard for FY2024. The measures are stratified by commercial payers, Medicaid, and Medicare. Some of the data measures can be stratified by age but none can be stratified by race/ethnicity, zipcode, SES, etc due to the method that NCQA receives the data.

Measures include

1. Blood Pressure Control for Patients With Diabetes
2. Eye Exam for Patients With Diabetes
3. Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)
4. Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control
5. Statin Therapy for Patients With Diabetes - Received Statin Therapy
6. Statin Therapy for Patients With Diabetes - Statin Adherence 80%
7. Kidney Health Evaluation for Patients With Diabetes (Total)

Additionally, we plan to purchase the following data to capture pediatric BMI stratified by Commercial and Medicaid.

8. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17)
9. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11)
10. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)

Next steps for NCQA measures

- Purchasing the “code book/definition manual” to have access to how each of the measures are collected and calculated.
- Dr. Mann vocalized the idea of having the payers submit the data directly to the State and bypass NCQA completely since the payers are already collecting the data.

Next Diabetes Action Committee Meeting is on May 29, 2024 at 5:00 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