The Community Integrated Network of Oregon's

Health Care Team Engagement Toolkit

Introduction

The Community Integrated Network of Oregon (CINO) is a network of diverse partners focused on building the statewide infrastructure to deliver and sustain evidence-based health education programs and interventions. This toolkit is to support organizations who deliver evidence-based self-management and lifestyle change programs and their partners to engage health care teams to refer their patients to the programs available in Oregon though the CINO's statewide referral hub operated by Oregon Wellness Network (OWN). Programs open to referrals and included in this toolkit include Chronic Disease Self-Management Education, Diabetes Self-Management Education, National Diabetes Prevention Program (National DPP), and Walk With Ease. OWN is prepared to receive referrals and connected to local program delivery sites and networks statewide to support enrolling referred patients in the most appropriate health education class for them. Often, referred patients will be enrolled in a local in-person program within their community. If a local in-person program is not available, virtual programs are open to participants statewide.

Below are two resources to understand and track statewide and local data on chronic conditions to demonstrate the impact of these conditions in the state/locally.

- Area Deprivation Index (ADI) and Administration for Community Living (ACL) Grant Program Map
  - This map uses Area Deprivation Index (ADI) data and program workshop locations.
- Behavioral Risk Factor Surveillance System (BRFFS)
  - This resource from the Centers for Disease Control and Prevention (CDC) provides state level prevalence data for a variety of chronic conditions including diabetes, arthritis, and cardiovascular disease.

Comagine Health

CINO Community Integrated Network of Oregon

Oregon Wellness Network

Contents

Introduction....1
Frequently Asked Questions....3
How to Make a Referral or Register for a Workshop....10
1. Pathways for Referrals....10
2. Supporting Clinical Documentation....10
3. Connect Oregon Referral Materials and Process....11
4. Compass Online Data Portal....12
Quality Measures....15
Program Overviews and Other Materials....20
Contact Information and Acknowledgements....20
Appendix A: OWN's Provider Referral Form....21
Appendix B: Compass Data Portal, Tracking Referral Source....22

Frequently Asked Questions

1. What programs are considered for inclusion in this guide?

I. Self-Management Resource Center (SMRC) Programs, including

- **The Chronic Disease Self-Management Program (referred to as CDSMP or Living Well with Chronic Conditions) and Tomando control de su salud**
  - A six-week self-management education program developed by Stanford University and now overseen by the Self-Management Resource Center.
  - This program is available in English and Spanish, as well as in-person and online.
  - People with chronic conditions and their caregivers are invited to participate in this program. This program is designed to help participants successfully manage chronic conditions.
  - Topics include:
    - Techniques to manage frustration, fatigue, pain, and isolation
    - Exercising at your level
    - Appropriate use of medications
    - Proper nutrition
    - How to evaluate new treatments
    - Communicating effectively with family, friends, and health professionals
- **The Diabetes Self-Management Program (referred to as DSMP or Living Well with Diabetes) and Programa de manejo personal de la diabetes**
  - A six-week self-management education program developed by Stanford University and now overseen by the Self-Management Resource Center.
  - This program is available in English and Spanish, as well as in-person and online.
  - This program is designed for people with type 2 diabetes and teaches healthy eating, appropriate exercise for maintaining and improving strength and endurance, how to use glucose monitoring to make day-to-day decisions and to manage sick days, appropriate use of medication, and reducing risk for other health conditions while learning to cope with the unique challenges of living with diabetes. Caregivers are also welcome.

II. Walk With Ease (WWE) and Camine con gusto

- An evidence-based physical activity program, developed by the Arthritis Foundation. It is proven to reduce pain associated with arthritis and improve overall health.
- In Oregon, the program is offered in-person, virtually, and as a self-directed program through the Oregon State University Extension Service.
- It is available in English and Spanish.
- All participants receive a free Walk with Ease guidebook.
- The essential program components are:
  1. Walking: 10-35 minutes walking duration
  2. Health Education Information: Both the guidebook and the corresponding lecturettes conducted during the group sessions provide basic information on arthritis, managing pain and stiffness, tips on proper clothing and equipment, self-monitoring for physical problems, what to do when exercise hurts, and how to anticipate and overcome barriers to being physically active.
  3. Stretching and Strengthening Exercises: Both the individual and the group participants are encouraged to do stretching exercises when they walk and strengthening exercises twice a week.

- Both the individual and the group format are structured as an 18-session, six- or nine-week walking program.
    1. Self-directed: Individuals using the workbook on their own are encouraged to work up to walking at least three times a week and to utilize all of the resources in the workbook over a six or nine-week period.
    2. Group-led: The group classes meet three times a week for six weeks, or two times a week for nine weeks (a total of 18 sessions).

III. The National Diabetes Prevention Program (National DPP)

- A yearlong evidence-based lifestyle change program available in English and Spanish.
- Patients work with a trained lifestyle coach and other participants to learn the skills to make lasting changes. They will learn to eat healthy, add physical activity to their life, manage stress, stay motived, and solve problems that can get in the way of healthy changes. The program uses a CDC-approved curriculum and focuses on weight management, increasing physical activity and reducing the risk for developing type 2 diabetes.
- This lifestyle management program starts with 16 weekly sessions, followed by one session every 2 weeks for the remaining 8 months. The program is available in-person and virtually.

2. How much do these programs cost the patient?

Most programs are free and at no cost to the patient through their health plan, scholarship, or grant funds. Depending on the program, OWN may submit for insurance payment from a health plan but there is typically no co-insurance. Programs that are covered by insurance include the Medicare Diabetes Prevention Program (MDPP), the National DPP for Oregon Health Plan Members and Diabetes Self-Management Education for Medicare beneficiaries who have not used their education benefit.

3. How long does a referral take to submit?

Many referrals can be made in less than a few minutes depending on the level of patient counseling and the pathway for referral. If the referral is occurring through OWN, referred patients are contacted within three business days and an OWN representative will help them find a class that best fits their needs and schedule.

4. What are the registration and enrollment requirements for these programs?

I. CDSMP

- CDSMP is for adults with living with one or more chronic health conditions such as arthritis, diabetes, heart disease, lung disease, and other ongoing health problems.
- The program may be particularly beneficial for people who have more than one chronic health condition, whose health problems have begun to interfere with their valued life activities, or who have had difficulty following the recommendations of their health care team.

II. DSMP

- DSMP is for adults with a diagnosis for Type 2 diabetes.

III. WWE

- WWE was originally designed for people with arthritis but it iso appropriate for all people who need to start or increase physical activity, including senior adults.

- Anyone who can move for 10 minutes can participate in this program.
    - The Arthritis Foundation recently released Walk With Ease® Disability Adaptation Guide. This toolkit will be updated accordingly.
- Evidence shows that this program decreases disability, improves arthritis symptoms, and increases self-efficacy, perceived control, balance, strength and walking pace.

IV. National DPP

- Be at least 18 years old and
- Be overweight (Body Mass Index (BMI) ≥25; ≥23 if Asian) and
- Not be pregnant and
- Have no previous diagnosis of type 1 or type 2 diabetes and
- Have a blood test result in the prediabetes range within the past year:
    - Hemoglobin A1C: 5.7–6.4%
    - Or Fasting plasma glucose: 100–125 mg/dL
    - Or Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL
    - Or have a previous clinical diagnosis of gestational diabetes
    - Or take the Prediabetes Risk Test and receive a screening result of high risk for type 2 diabetes

5. What are the benefits of these programs? How effective are they?



National Council On Aging (NCOA) Video**: Improving Quality of Life and Health Care Outcomes through Chronic Disease Self-Management Education Programs**

I. Chronic Disease Self-Management Program (CDSMP)

Summary of Key Points

- According to the CDC, CDSMP aims to help adults with chronic health conditions build confidence and self-efficacy to manage their health, including decision making, problem-solving, and action planning.

- A Meta-Analysis Of Health Status, Health Behaviors, And Health Care Utilization Outcomes Of The Chronic Disease Self-Management Program provides a quantitative synthesis of 23 studies evaluating CDSMP and found that participants experienced significant improvements in self-efficacy, health distress, social limitations, and cognitive symptoms. They observed statistically significant increases in aerobic exercise, cognitive symptom management, and communication with their physicians after 4-6 month follow up, while stretching and strengthening exercise improved after 9-12 months.
- A National Study Of Chronic Disease Self-Management: Six-Month Outcome Findings explicitly studied how CDSMP can facilitate Triple Aim goals (better health, better health care, and better value). Significant improvements were observed for all six "better health" outcome variables from baseline to 6- and 12-month follow up, which included self-assessed health status, fatigue, pain, depression, unhealthy physical days, and unhealthy mental health days. Significant improvements were also observed for communication with physician scores, health literacy, and medication adherence. The majority of CDSMP health outcomes were sustained and often strengthened after 12 months.

Articles published about effectiveness of CDSMP

1. A Meta-Analysis Of Health Status, Health Behaviors, And Health Care Utilization Outcomes Of The Chronic Disease Self-Management Program
2. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes
3. Chronic Disease Self-Management Program: From Development To Dissemination
4. Effect Of A Self-Management Program On Patients With Chronic Disease
5. Effects Of Chronic Disease Self-Management Programs For Participants With Higher Depression Scores: Secondary Analyses Of An On-Line And A Small-Group Program
6. Evidence Suggesting That A Chronic Disease Self-Management Program Can Improve Health Status While Reducing Hospitalization: A Randomized Trial
7. Impact Of A Translated Disease Self-Management Program On Employee Health And Productivity: Six-Month Findings From A Randomized Controlled Trial
8. Impact Of Chronic Disease Self-Management Programs On Type 2 Diabetes Management In Primary Care
9. National Study Of Chronic Disease Self-Management: Six-Month Outcome Findings
10. Outcomes Of Border Health Spanish/English Chronic Disease Self-Management Programs
11. Self-Management At The Tipping Point: Reaching 100,000 Americans With Evidence-Based Programs
12. Strategies For Recruiting Populations To Participate In The Chronic Disease Self-Management Program (CDSMP): A Systematic Review
13. Successes Of A National Study Of The Chronic Disease Self-Management Program: Meeting The Triple Aim Of Health Care Reform
14. The Components Of Action Planning And Their Associations With Behavior And Health Outcomes

15. The Impact Of Chronic Disease Self-Management Programs: Healthcare Savings Through A Community-Based Intervention

II. Diabetes Self-Management Program (DSMP)

Summary of Key Points

- Following DSMP, the self-management cohort experienced significant reductions for diabetes mellitus–associated comorbid conditions, with the postintervention disease burden being significantly lower compared with the control cohort and patients in the intervention group experienced reduced all-cause health care utilization and costs were found in Evaluation Of A Diabetes Self-Management Program: Claims Analysis On Comorbid Illnesses, Health Care Utilization, And Cost.
- Statistically significant improvements were seen for the Diabetes Distress Scale (P = 0.0017), the Diabetes Self-Management Questionnaire (P <0.0001) and the 10-item Patient Activation Measure (P <0.0001) in Evaluating The Implementation Of The Diabetes Self-Management Program In A Rural Population.
- A Diabetes Self-Management Program: 12-Month Outcome Sustainability From A Nonreinforced Pragmatic Trial found that DSMP participants had small but significant improvements in 13 of 15 outcome measures, including HbA1c.

Articles published about effectiveness of DSMP

1. A Diabetes Self-Management Program: 12-Month Outcome Sustainability From A Nonreinforced Pragmatic Trial
2. Benefits Of Diabetes Self-Management for Health Plan Members: A 6-Month Translation Study
3. Community-Based Peer-Led Diabetes Self-Management
4. Evaluating The Implementation of The Diabetes Self-Management Program In A Rural Population
5. Evaluation Of a Diabetes Self-Management Program: Claims Analysis On Comorbid Illnesses, Health Care Utilization, And Cost
6. Evaluation Of a Short, Interactive Diabetes Self-Management Program By Pharmacists For Type 2 Diabetes
7. Latino Health Access: Comparative Effectiveness Of A Community-Initiated Promotor/A-Led Diabetes Self-Management Education Program
8. Participation Of Latinos in The Diabetes Self-Management Program And Programa De Manejo Personal De La Diabetes
9. Self-Management Program Participation By Older Adults With Diabetes

III. Walk With Ease (WWE)

Summary of key points

- Walk With Ease participants reported significant reductions in pain and fatigue and increased physical activity after completing the program in a 2016 study.
- Impact of the Arthritis Foundation's Walk With Ease Program on Arthritis Symptoms in African Americans found that individualized and group formats of the WWE program improved arthritis-

related pain, fatigue, and stiffness in African Americans. Culturally appealing arthritis interventions ultimately may increase the use of existing arthritis interventions.

- A 2023 study found that the WWE program offers good value for inactive and insufficiently active individuals. Payers may consider including such a program to increase physical activity in individuals with knee osteoarthritis (Zimmerman et al., 2023).

Articles published about effectiveness of WWE

1. Walk With Ease: About the Program
2. Effectiveness of a Scaled-Up Arthritis Self-Management Program in Oregon: Walk With Ease
3. Evaluation of group and self-directed formats of the Arthritis Foundation's Walk With Ease Program
4. Evaluation of the Arthritis Foundation's Camine Con Gusto Program for Hispanic Adults With Arthritis
5. Impact of the Arthritis Foundation's Walk With Ease Program on Arthritis Symptoms in African Americans
6. Overcoming Barriers to Walk With Ease Implementation in Community Organizations
7. Walk with ease for knee osteoarthritis: A cost-effectiveness analysis

IV. National Diabetes Prevention Program (National DPP)

Summary of Key Points

- The Diabetes Prevention Program was a randomized clinical trial funded by the National Institutes of Health (NIH) and supported by the CDC that began in 1996. A total of 1,079 participants experienced a lifestyle intervention that resulted in a 58% reduction in the rate of diabetes. The goals of the intervention were a 7% reduction in weight and 150 minutes a week of physical activity. It featured individual coaching, a 16-session core curriculum, supervised physical activity, and other supports.
- After about 3 years into the initial research study, the National DPP showed that participants lowered their chances of developing type 2 diabetes by 58 percent compared with participants who took a placebo. The program was effective for all participating racial and ethnic groups and both men and women; it worked particularly well for participants ages 60 and older, lowering their chances of developing type 2 diabetes by 71 percent.
- In 2018, the Centers for Medicare and Medicaid Services (CMS) translated evidenced-based intervention into policy by extending coverage of the National DPP lifestyle change program to Medicare beneficiaries through the Medicare Diabetes Prevention Program (MDPP).
- In a 2020 study, researchers used the Knowledge to Action framework (K2A) to understand how the National DPP lifestyle change program was translated from research into a Medicare covered benefit. The researchers identified four milestones:
    1. Strong evidence base: Evidence of the National DPP lifestyle change program's efficacy is based in the DPP Clinical Trial, a randomized clinical trial with 10-year and 15-year follow up data. trial. Follow-up studies and international studies have spanned different implementation types and settings to confirm the effectiveness of this intervention in preventing or delaying type 2 diabetes.
    2. Cross-sector engagement to create a national infrastructure: CDC gathered public, private, academic, and community institutions to develop a sustainable infrastructure for delivery of the National DPP lifestyle change program and to create quality

standards. When the program became a Medicare-covered benefit, CMS was able to largely rely on CDC for quality assurance through this infrastructure.

3. Evidence of effectiveness with the Medicare population: CMS funded 17 YMCA-USA sites to deliver the National DPP lifestyle change program to Medicare beneficiaries, which demonstrated significant cost savings and reductions in inpatient stays and emergency department visits.
4. Extensive public input into the MDPP: Stakeholders submitted thousands of comments across two rulemaking cycles to inform the details of the model. CMS was required to respond to the comments and either make policy changes or describe why certain policies could not be modified, and consequently established multiple policies in response to the public comments.

Articles published about the effectiveness of National DPP

1. National Diabetes Prevention Program (National DPP) Coverage Toolkit - Evidence
   - This resource has lists of extensive research and evidence supporting National DPP including original clinical trial studies, cost studies, statistics and burden reports, effectiveness of telehealth offerings, as well as additional benefits.
2. Can diabetes prevention programs be translated effectively into real-world settings and still deliver improved outcomes? A synthesis of evidence
3. Diabetes Prevention Programs: OHSU Center for Evidence-Based Policy Report
4. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study
5. The 10-Year Cost-Effectiveness of Lifestyle Intervention or Metformin for Diabetes Prevention: An intent-to-treat analysis of the DPP/DPPOS
6. Translating the Diabetes Prevention Program into the community. The DEPLOY Pilot Study

How to Make a Referral or Register for a Workshop

1. Pathways for referrals

There are several options for sending a referral to the statewide referral hub for health education programs. Options include:

I. Healthcare team referral

- **Connect Oregon** is a coordinated care network of health and social service providers. Partners in the network are connected through Unite Us' shared technology platform, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. To refer to OWN through Connect Oregon follow the steps below in section 3. Connect Oregon Training Materials and Processes.
- **Oregon Wellness Network**
  - **Online HIPAA-compliant referral** form. Complete this form in its entirety to refer thorough OWN's website.
  - **Secure email** is available for sending referrals. Email health.promotion@nwsds.org and include the appropriate form (Appendix A) and documentation.
  - **Fax** is available for sending referrals. Fax the program specific referral form (Appendix A) with supporting documentation to (503) 304-3465.
  - **Call** OWN at 833-ORE-WELL (833-673-9355) to discuss a patient referral over the phone.

II. Self-registration

- Complete OWN's Contact Us Form. - after completing this form in its entirety on OWN's website, a program coordinator will contact the patient who completed the form.
- Compass Online Portal – this portal can be used to search for programs in your area. For more information see section below.
  - *Note:* When a participant self-refers or registers through Compass, a request may be sent to their provider to obtain additional information such as their diagnosis, which is required for some program registrations. The participant will need to provide information on contacting their health care provider at the point of registration or first day of the programs.

III. Other:

There may also be a local program or network of local programs open to receiving referrals directly from health care teams in their community. If you would like information on a local delivery program, please call OWN at 833-673-9355.

2. Supporting Clinical Documentation

When referring to the following programs please include the supporting documentation. The documentation requirements are also included in the referral form:

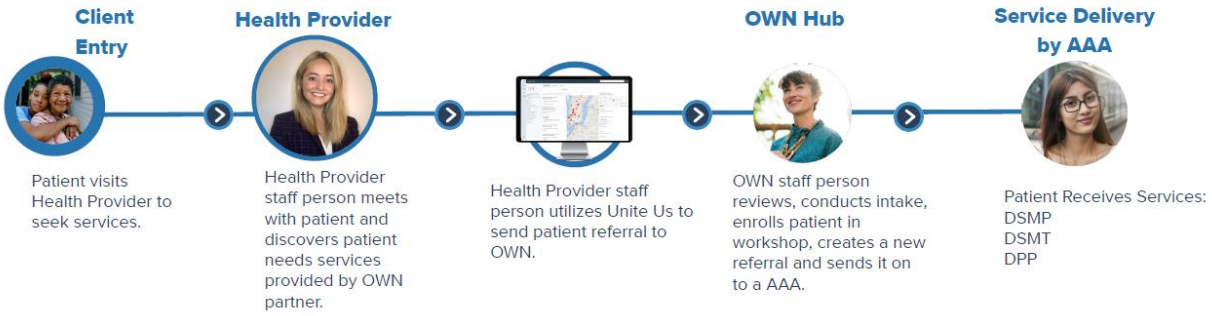
- **National DPP**:
  - Have no previous diagnosis of type 1 or type 2 diabetes
  - Have a blood test result in the prediabetes range within the past year:
    - Hemoglobin A1C: 5.7–6.4%
    - Or Fasting plasma glucose: 100–125 mg/dL
    - Or Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL
    - Or have a previous clinical diagnosis of gestational diabetes

- Or take the Prediabetes Risk Test and receive a screening result of high risk for type 2 diabetes
- For Medicare beneficiaries to enroll in the MDPP, confirmation of qualifying lab values is required.
- For Oregon Health Plan members, documentation of a pre-diabetes, overweight, or obesity diagnosis is required.

- **DSMES**: documentation of diabetes diagnosis and referral order from provider

3. Connect Oregon Referral Materials and Process

I. Connect Oregon referral pathway

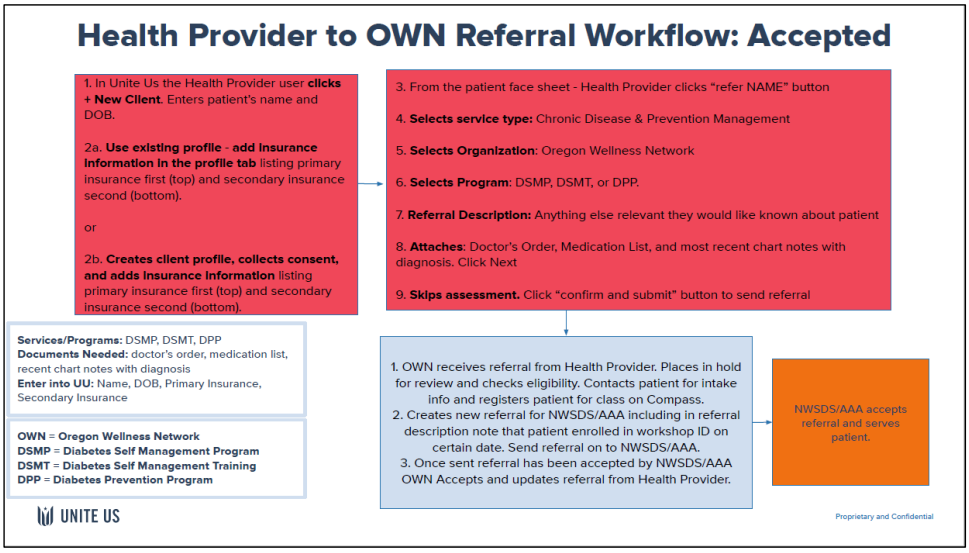


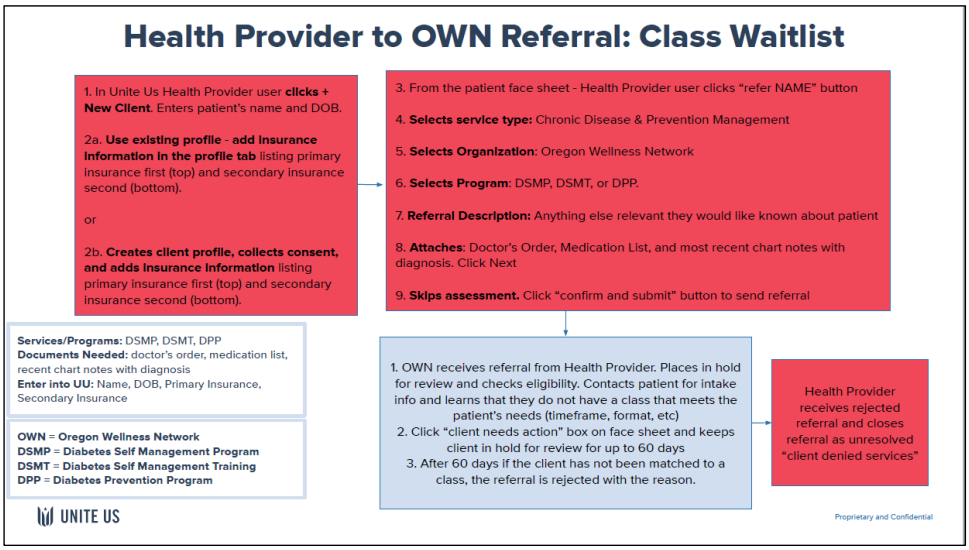
II. How to send a Referral to OWN for the National DPP, DSMP, DSMT?

- Log into Unite Us, select or create a client, and start a new referral
- Select service type: **Chronic Disease & Prevention Management**
- Select Organization: **Oregon Wellness Network**
- Select Program: **National DPP, DSMT, or DSMP**

  ***note:** users can also refer to CDSMP and WWE through Unite Us, they are simply not included in these particular workflows.

  ***note**: DMST refers to Diabetes Self-Management Training – the Medicare benefit.
- Attach: Doctor's Order, Medication List, and most recent chart notes with diagnosis.





4. Compass Online Data Portal

I. What is the Compass Data Portal?

- Centralized workshop calendar for CDSME programs in Oregon
  1. Search for in-person, virtual, and self-directed workshops
  2. Register for scheduled workshops
  3. Reach out for more information about programs
- Free, HIPAA-compliant tool for workshop and data management
  1. Manage workshop schedules and participant registrations
  2. Communicate with participants and track attendance
  3. Collect participant data with automated forms
  4. Track list of program leaders and other delivery staff
  5. Generate reports for leadership, funders, etc.
- Available as a free resource for CDSME program delivery partners in Oregon



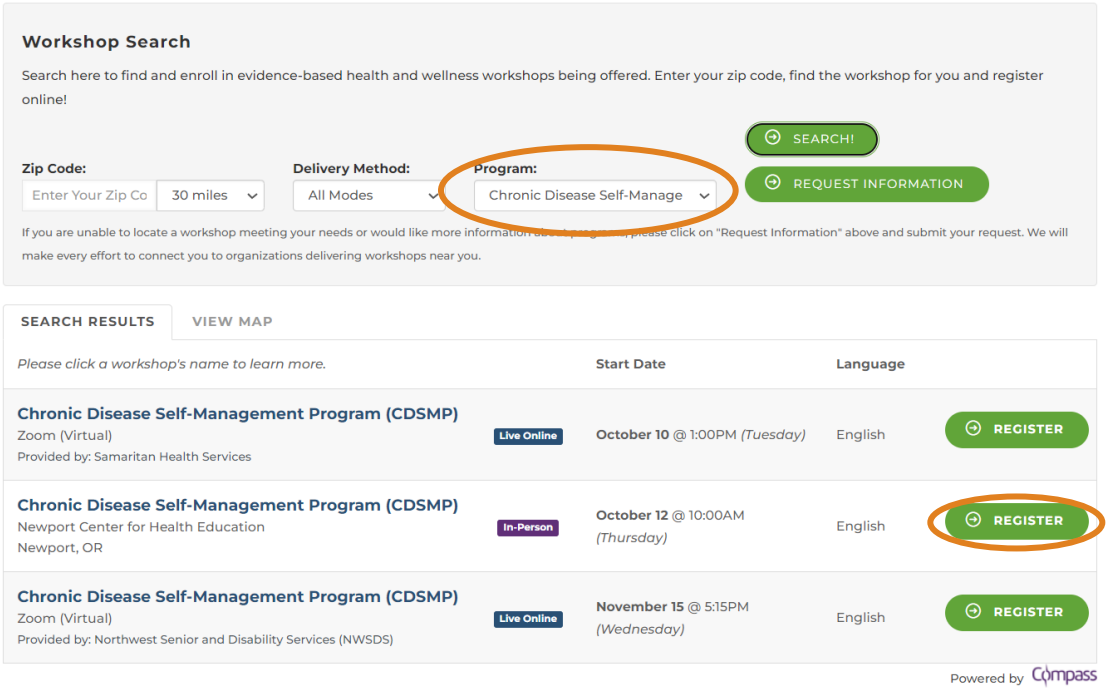
The public Find-a-Workshop search can be added to any website

Example: oregonwellnessnetwork.org/join

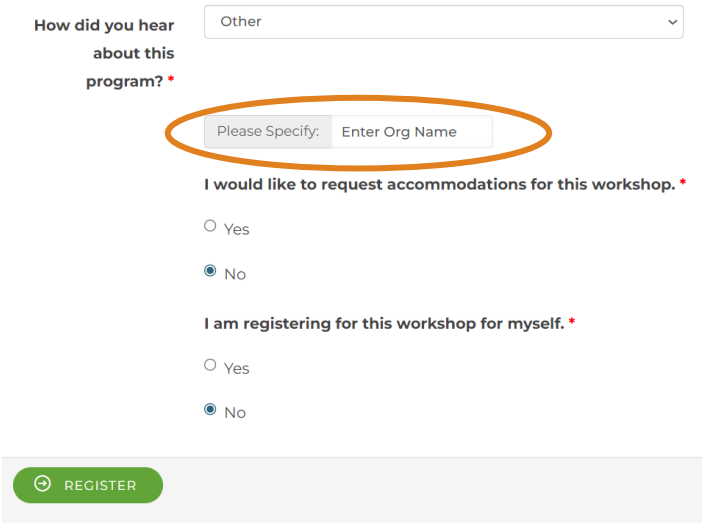
II. Accessing Oregon Compass Data Portal to Self-Refer or to Assist a Participant in Registering

- Anyone can use Compass to find and register for workshops in their area.
- Visit the Compass Workshop Search
- Filter your search by location/Zip code, delivery method, and/or specific program

- Once you've selected the correct program, click the "register" button.



- Complete the registration form with all of the relevant information for the participant.
  - If a provider is assisting a participant make sure to pay attention to the final question.
    - Select "other" from the drop-down menu and specify the program delivery name in the open space.
    - Select "No" for the final question.



III. Accessing the Oregon Compass Data Portal for partnering Program Delivery Organizations

- Compass is free to organizations delivering CDSME programs in Oregon
  1. Must complete Memorandum of Understanding (MOU) and data-use agreement with Comagine Health
- Secure user logins provided for program delivery staff
- Users can be set up with different permissions to enter and view data:

1. Program Coordinator
2. Sub-Coordinator
3. Implementation Site Staff
4. Peer Leader/Lifestyle Coach
5. Master Trainer

Questions? Please contact Comagine Health at CompassOR@comagine.org

- Oregon Compass Guidance: Tracking Participant Referral Sources
- To review information on how to track the referral source for participants please view Appendix B.

Quality Measures

1. What are Quality Measures? Why use them?

Quality measures are tools that help to measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. According to CMS, these goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Measures inform about how the health care system is performing. Measures help identify weaknesses, prioritize opportunities, and can be used to identify what works and doesn't work to drive improvement. Measures can also prevent the overuse, underuse, and misuse of health care services and can identify disparities in care delivery and outcomes. The American Academy of Family Physicans' (AAFP) states that measures are used for quality improvement, benchmarking, and accountability. Measures are becoming increasingly important relative to payment as the U.S. health care system shifts away from traditional fee-for-service toward payment focused on the value of care.

Data on quality measures are collected or reported in a variety of ways, such as claims, assessment instruments, chart abstraction, registries.

> For more in-depth information about quality measures, how they're developed, used, and maintained please visit this CMS resource.

2. Components of a Quality Measure

A measure has several parts, including:

- **Measure ID**: Measures can have several different IDs:
    - The National Quality Forum (NQF) ID number is a universal ID that is given to measures that have been vetted through the NQF and found to meet stringent criteria leading to endorsement.
    - CMS assigns an ID to each measure included in federal programs, such as MIPS.
    - Electronic clinical quality measures (eCQMs) have a unique ID and version number.
    - Many measures are also approved and vetted by the National Committee for Quality Assurance (NCQA).
- **Denominator**: The given population to which a measure applies (i.e., the number of people who should have received an action or service). The denominator is the lower part of a fraction used to calculate a rate. (Example: Women 52-74 years as of December 31 of the measurement year).
- **Numerator**: The subset of patients in the denominator for whom a clinical action or service has been provided or for whom a particular outcome has been achieved (i.e., the number of people that actually received an action or service). The numerator is the upper part of a fraction used to calculate a rate. (Example: Women who received a mammogram to screen for breast cancer.)
- **Exclusions/Exceptions**: The terms exclusions and exceptions are often used interchangeably, although there are subtle differences. An exclusion is a condition that removes a defined group of patients from the denominator because the measure would not appropriately apply to them. Exceptions depend on clinical judgment and remove patients from both the numerator and denominator. Exceptions are due to medical reasons, patient reasons, and system reasons. Example: Women who had any of the following: bilateral mastectomy; unilateral mastectomy with a bilateral modifier (same claim); two unilateral mastectomies with service dates 14 days or more apart; history of bilateral mastectomy.

- **Measurement Period**: The timeframe in which the clinical action or outcome of interest may be accomplished. Example: Women who received one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
- **Value Sets**: The numerical values (codes) and human-readable names (terms), drawn from standard vocabularies such as SNOMED CT®, RxNorm, LOINC, CPT, and ICD-10, which are used to define clinical concepts used in clinical quality measures. Value sets are available through the Value Set Authority Center (VSAC) of the U.S. National Library of Medicine.

Source: The American Academy of Family Physicans' (AAFP)

3. Quality Measures Associated with CDSME programs

I. Patient Centered Primary Care Home (PCPCH) requirements

- NQF0421 - BMI Screening and Follow-up - Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter
- NQF0059 - Comprehensive Diabetes Care: Hemoglobin poor Control (>9.0%) - Percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
- NQF0018 - Controlling High Blood Pressure - Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.
- NCQA - Statin Therapy for Patients with Diabetes - Percentage of adults 40-75 years of age who have diabetes and who do not have clinical ASCVD, who received and adhered to statin therapy
- NCQA - Statin Therapy for Patients with Cardiovascular Disease - Percentage of males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy

II. Coordinated Care Organization (CCO) Metrics

- *State Quality measures* are outlined in Oregon's 1115 waiver; the Oregon Health Authority (OHA) is accountable to report these metrics to CMS.
- *CMS Core measures,* which promote alignment of measure use and collection across payers in both the public and private sectors.
- The following fall under both state quality measures and CMS core measures categories:
    - CMS122v11 - Comprehensive diabetes care: HbA1c poor control (Electronic Health Record or EHR) - Eligible Clinician electronic Clinical Quality Measure (eCQM)
    - CMS 165v11 - Controlling high blood pressure (EHR) - Eligible Clinician electronic Clinical Quality Measure (eCQM)
    - PQI 01: Diabetes short-term complication admission rate – Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators
    - PQI 08: Congestive heart failure admission rate=- AHRQ Prevention Quality Indicators

III. National Quality Forum (NQF)

- NQF0059 - HbA1c poor control (>9.0%) - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year.

- STEWARD: National Committee for Quality Assurance
- Found in the following portfolios
  - 2016 Accountable Care Organization (ACO) Quality Measures
  - 2016 Medicaid Adult Core Set
  - Ambulatory Care Measures
  - Ambulatory/Outpatient Measures – All
  - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals
  - NCQA Healthcare Effectiveness Data and Information Set (HEDIS) Health Plan Measures
  - Primary Care and Chronic Illness

- NQF0575 - HbA1c control (<8.0%) - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.
  - Steward: National Committee for Quality Assurance
  - Found in the following portfolios.
    - 2012 MAP Diabetes Family of Measures
    - Ambulatory Care Measures
    - Ambulatory/Outpatient Measures – All
    - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals
    - NCQA HEDIS Health Plan Measures
    - Primary Care and Chronic Illness
- NQF0055 – Comprehensive Diabetes Care: Eye exam (retinal) performed - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.
  - Steward: National Committee for Quality Assurance
  - Found in the following portfolios.
    - 2016 ACO Quality Measures
    - Ambulatory Care Measures
    - Ambulatory/Outpatient Measures – All
    - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals
    - NCQA HEDIS Health Plan Measures
    - Primary Care and Chronic Illness
    - Oregon Health Care Quality Corporation Publicly Reported Measures
- NQF0061 – Blood Pressure control (<140/90 mm Hg) - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.
  - STEWARD: National Committee for Quality Assurance
  - Found in the following portfolios
    - Ambulatory Care Measures
    - Ambulatory/Outpatient Measures – All
    - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals
    - NCQA HEDIS Health Plan Measures
    - Primary Care and Chronic Illness
- NQF0018 - Controlling High Blood Pressure - The percentage of adults 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
  - STEWARD: National Committee for Quality Assurance
  - Found in the following portfolios

        - 2012 MAP Diabetes Family of Measures
        - 2016 ACO Quality Measures
        - 2016 Medicaid Adult Core Set
        - HHS Million Hearts Initiative
        - Ambulatory Care Measures
        - Ambulatory/Outpatient Measures – All
        - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals
        - NCQA HEDIS Health Plan Measures
- NQF0729 – Optimal Diabetes Care [Composite measure]
    - The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving ALL of the following:
        - HbA1c less than 8.0 mg/dL
        - Blood Pressure less than 140/90 mmHg
        - On a statin medication, unless allowed contraindications or exceptions are present
        - Non-tobacco user
        - Patient with ischemic vascular disease is on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present
    - STEWARD: MN Community Measurement
    - Found in the following portfolios
        - 2012 MAP Diabetes Family of Measures
        - Ambulatory Care Measures
        - Ambulatory/Outpatient Measures – All
        - MAP Dual Eligible Beneficiaries Family of Measures
        - Primary Care and Chronic Illness
- NQF0076 - Optimal Vascular Care [Composite measure]
    - The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed during the measurement period as defined by achieving ALL of the following:
        - Blood pressure less than 140/90 mmHg
        - On a statin medication, unless allowed contraindications or exceptions are present
        - Non-tobacco user
        - On daily aspirin or anti-platelet medication, unless allowed contraindications or exceptions are present
    - STEWARD: MN Community Measurement
    - Found in the following portfolios
        - Ambulatory Care Measures
        - Ambulatory/Outpatient Measures – All
        - Cardiovascular
- NQF0056 - Diabetes: Foot Exam - The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.

  STEWARD: National Committee for Quality Assurance
    - Found in the following portfolios
        - Ambulatory Care Measures
        - Ambulatory/Outpatient Measures – All
        - Cardiovascular
        - Meaningful Use - Medicare and Medicaid EHR for Eligible Professionals

        - NCQA HEDIS Physician Plan Measures
        - Primary Care and Chronic Illness
- NQF2607 - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) - The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%.
    - STEWARD: National Committee for Quality Assurance
    - Found in the following portfolios
        - Ambulatory Care Measures
        - Ambulatory/Outpatient Measures – All
        - Behavioral Health and Substance Use
        - MAP Dual Eligible Beneficiaries Family of Measures

Program Overviews and Other Materials

1. Informational Referral Quick Start Guide for Providers

CINO Health Education Referral Quick Start Guide

2. Steering Toward Health

The Oregon Medical Association (OMA) and Oregon Health Authority (OHA) have partnered to launch the Steering Toward Health campaign, a multiyear initiative that aims to reduce the incidence of lifestyle related chronic conditions in Oregon. Below are resources that connect clinicians and public health professionals to resources, tools, and evidence-based lifestyle change programs.

- Diabetes and Prediabetes
- Hypertension
- Physical Activity and Arthritis
- Tobacco Cessation Resources

3. Informational 1-pagers to share with patients and participants

- DSMES (DSMP & MNT)
- CDSMP
- WWE
- National DPP
- 2022 HealthEd LivingWell Final.pdf
- 2022 HealthEd All Workshops Final.pdf

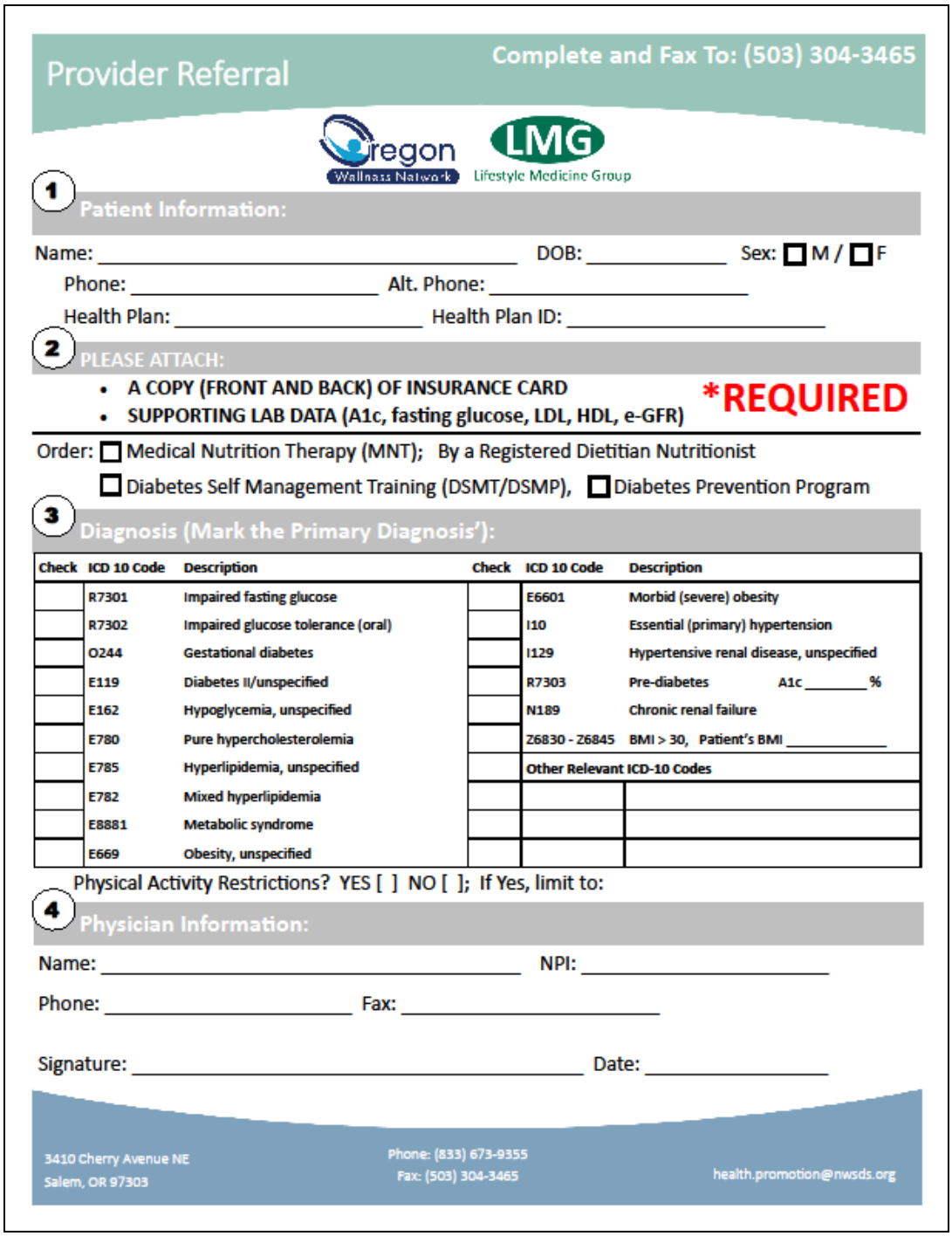
Contact Information and Acknowledgements

For additional information or to learn more about CINO, please email **CINO@comagine.org**.

Thank you to the CINO Health System and Clinical Referral Subcommittee members for contributing and reviewing the content of this toolkit. The subcommittee includes members from CareOregon, Comagine Health, Familias en Acción, Legacy Health, Newport 60+ Activity Center, Oregon Primary Care Association, Oregon Wellness Network, Samaritan Health Services, and Connect Oregon.

Appendix A: OWN's Provider Referral Form

OWN Provider Referral Form



Provider Referral

Complete and Fax To: (503) 304-3465

Oregon Wellness Network | LMG Lifestyle Medicine Group

1 Patient Information:

Name: _____ DOB: _____ Sex: ☐ M / ☐ F

Phone: _____ Alt. Phone: _____

Health Plan: _____ Health Plan ID: _____

2 PLEASE ATTACH:

- **A COPY (FRONT AND BACK) OF INSURANCE CARD**
- **SUPPORTING LAB DATA (A1c, fasting glucose, LDL, HDL, e-GFR)**

***REQUIRED**

Order: ☐ Medical Nutrition Therapy (MNT); By a Registered Dietitian Nutritionist

☐ Diabetes Self Management Training (DSMT/DSMP), ☐ Diabetes Prevention Program

3 Diagnosis (Mark the Primary Diagnosis'):

Check	ICD 10 Code	Description	Check	ICD 10 Code	Description
	R7301	Impaired fasting glucose		E6601	Morbid (severe) obesity
	R7302	Impaired glucose tolerance (oral)		I10	Essential (primary) hypertension
	O244	Gestational diabetes		I129	Hypertensive renal disease, unspecified
	E119	Diabetes II/unspecified		R7303	Pre-diabetes A1c _____ %
	E162	Hypoglycemia, unspecified		N189	Chronic renal failure
	E780	Pure hypercholesterolemia		Z6830 - Z6845	BMI > 30, Patient's BMI _____
	E785	Hyperlipidemia, unspecified		Other Relevant ICD-10 Codes	
	E782	Mixed hyperlipidemia			
	E8881	Metabolic syndrome			
	E669	Obesity, unspecified			

Physical Activity Restrictions? YES [ ] NO [ ]; If Yes, limit to:

4 Physician Information:

Name: _____ NPI: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

3410 Cherry Avenue NE
Salem, OR 97303

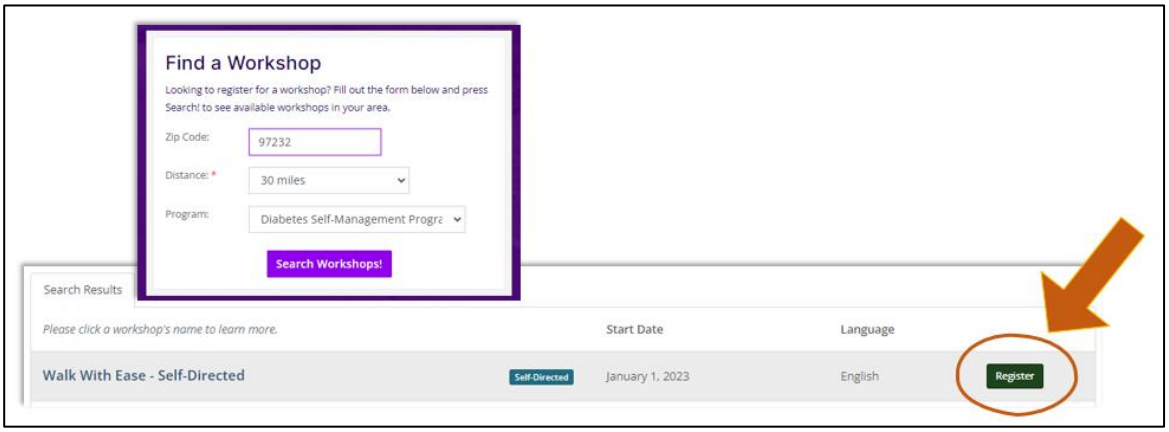
Phone: (833) 673-9355
Fax: (503) 304-3465

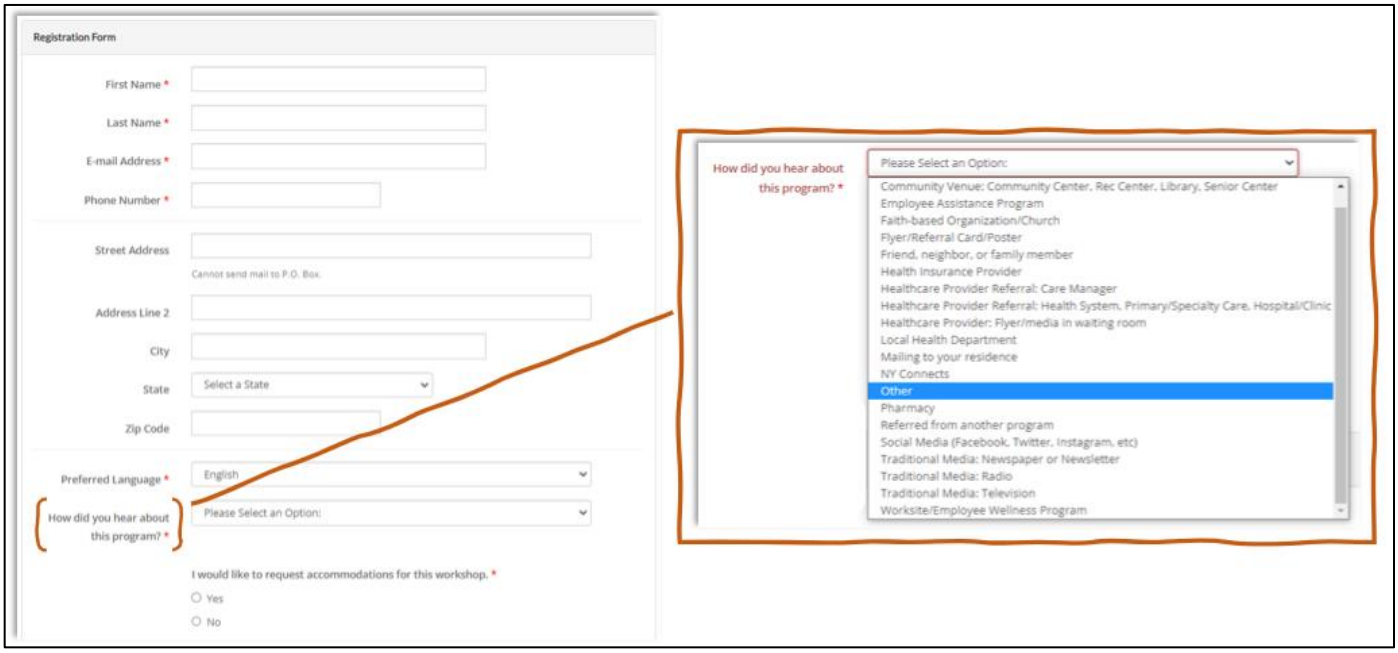
health.promotion@nwsds.org

Appendix B: Compass Data Portal, Tracking Referral Source

Tracking Referral Source

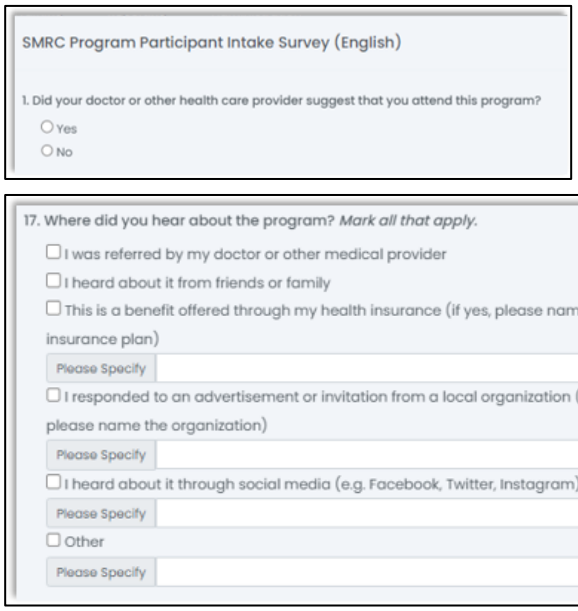
1. **Workshop Registration Form**
   - The online form used when someone registers for a workshop
   - The same form is used for **all** workshops, regardless of program





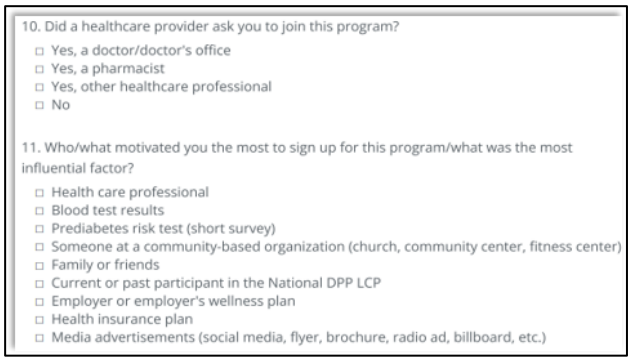
2. Participant Intake Survey

- The electronic form that can be sent to participants via Compass **after** they have registered for a workshop
- Different programs have different intake surveys:
  1. **Walk With Ease** (WWE) and the **Self-Management Resource Center** (SMRC) suite of programs utilize the same participant intake survey
  - Available in English and Spanish
  - Referral source questions include:
    - *Did your doctor or other health care provider suggest that you attend this program?*
    - *Where did you hear about the program?*



  2. **National Diabetes Prevention Program** (National DPP) utilizes an intake survey designed to meet CDC 2021 DPRP Standards
- Designed to meet the CDC's most recent 2021 DPRP Standards
- Available in English and Spanish
- Referral source questions include:
  - *Did a healthcare provider ask you to join this program?*

- *Who/what motivated you the most to sign up for this program/what was the most influential factor?*

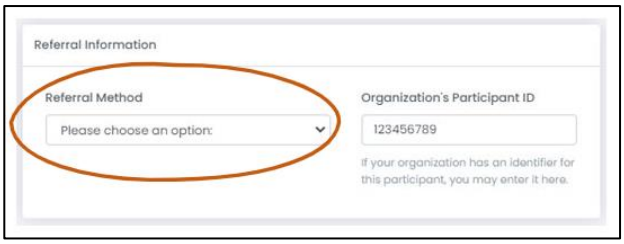


Adding/Updating Referral Source Information

1. Workshop Registration Form

- Data collected from the Workshop Registration Form are located within a participant's record and can be updated via the 'Edit' button





2. Participant Intake Survey

- Data from the Participant Intake Survey can be updated in two different places within a workshop.

