Health Promotion and Chronic Disease: Advocating for Chronic Disease Management and Prevention

Rahul Gupta MD, MPH, FACP
Commissioner & State Health Officer
Academy of Family Physicians Conference
April 16, 2015
Partnerships in Public Health

Using a Systems Approach

- Public health is the science of protecting and improving the health of families and communities
- Promoting healthy lifestyles, providing disease and injury prevention, and detecting and controlling infectious diseases

Bureau for Public Health

Other State Agencies
Health Care Providers
Local Health Departments
Schools
Community Non-Profits

Healthier Lifestyles
Disease Prevention
Injury Prevention
Controlling Disease

Healthier Residents
Integrating Primary Care & Public Health

Primary Care

Public Health

Linking Resources

Align public & private sectors

What works for WV?
Link public health more effectively with health systems:

• Using community resources and supportive environments to complement and strengthen delivery of clinical care
Health System Changes

Moving from Sick Care to Preventive Care

Challenges
Expanded Chronic Care Model

Community
- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action

Health Systems
- Self-Management/Develop Personal Skills
- Delivery System Design/Re-orient Health Services
- Decision Support
- Information Systems

Activated Community
Informed Activated Patient

Prepared, Proactive Practice Team
Prepared, Proactive Community Partners

Productive Interactions & Relationships

Population Health Outcomes / Functional and Clinical Outcomes
Rahul Gupta, MD, MPH, FACP
Commissioner and State Health Officer
Bureau for Public Health

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Advocating for Chronic Disease Management and Prevention

Jessica Wright, RN, MPH, CHES
Director
Health Promotion & Chronic Disease
Academy of Family Physicians Conference
April 16, 2015
Objectives

- Increase knowledge of the Division of Health Promotion and Chronic Disease

- Highlight how small changes can have big impact
  - Patient Awareness Project
  - National Diabetes Prevention Program

- Bureau for Public Health Practice Transformation Project

- Partner Resources available to AFP members
West Virginia Division of Health Promotion and Chronic Disease (HPCD)

Mission:

“Advocate for chronic disease management and prevention”
Vision
Making healthy choices the easy choice where you live, work, play and pray

- **Community Mobilization:** Support and help drive community action by providing resources for implementing healthy community environments

- **Health Systems:** Support and sponsor health care provider training and technical assistance to implement quality improvements for chronic disease practice

- **Community-Clinic Linkages (Policy):** Build connections between clinicians and community programs for enhanced referrals and reimbursement
Project Background

- **Purpose:** Increase patient awareness of prediabetes and hypertension
- **Tools:** CDC Prediabetes Screening Test; Million Hearts Blood Pressure Stoplight Card; Patient survey
- **Locations:** Randolph County Health Department, Grant County Health Department and Mineral County Health Department
- **Duration:** 1-3 months
- **Goals:** Awareness, education, referrals, establishment of a screening algorithm for health departments, and creation of a local health department hypertension/prediabetes awareness model
Hypertension

WV Health Department Pilot Outcomes - Blood Pressure Readings in Person Not Previously Diagnosed with High Blood Pressure - 2014

- BP reading - Prehypertension
- BP Reading - Hypertension
- Total At Risk

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<th>Prehypertension</th>
<th>Hypertension</th>
<th>Total At Risk</th>
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<tr>
<td>Combined</td>
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Prediabetes

Percentage of Persons by County and Combined who scored > 9 on the CDC Prediabetes Risk Assessment - 2014

- Randolph County HD: 38%
- Grant County HD: 48%
- Mineral County HD: 53%
- Combined: 47%

Percentage at Risk
What is the National Diabetes Prevention Program?

- 22 session, year long intensive lifestyle change program
- For 18 and older with pre-diabetes or at high risk for diabetes
- Based on 3 year research study led by the National Institutes of Health and funded by CDC
- Participants lost 5-7% of their body weight with improved nutrition & increased physical activity
- Reduced their risk of developing type 2 diabetes by 58%
- Blood pressure, triglyceride, & LDL levels decreased
- CDC and others translated original research into program delivered in group setting by trained “lifestyle coach”
National Diabetes Prevention Program

Prevent Diabetes STAT

- 86 million American adults have pre-diabetes & 9 out of 10 don’t know they have it
- HPCD, CDC, & AMA are calling on you to Screen, Test, & Act Today
- **Screen your** patients for pre-diabetes using the CDC Pre-diabetes Screening Test (or the American Diabetes Association Diabetes Risk Test)
- **Test your** patients for pre-diabetes using one of three blood tests (A1C, FBS, OGTT)
- **Act today** by referring your patients with pre-diabetes to the National Diabetes Prevention Program
New Toolkit for Clinicians Developed by AMA and CDC

- Fact sheets about research studies & evidence base for the program
- Diabetes risk assessment, poster, patient handouts, sample patient letter, email, & phone script
- Point-of-care & retrospective pre-diabetes identification algorithms
- Commonly used CPT and ICD codes
- And much more...

- Check it out here: http://www.ama-assn.org/sub/prevent-diabetes-stat/toolkit.html
CDC-Recognized Diabetes Prevention Programs in WV

Brooke County Health Dep’t
Cabell-Huntington Health Dep’t
Diabetes Learning Center of Mon General Hospital
Grant Memorial Hospital
Hancock County Senior Services
Kanawha-Charleston Health Dep’t
Mid Ohio Valley Health Dep’t
Pocahontas Memorial Hospital
Potomac Valley Hospital
WVU Extension Service
No Diabetes Prevention Program In My Area

• Screen all adults who are overweight or obese and have one or more risk factors

• Patients with pre-diabetes should be given counseling on weight loss as well as instruction for increasing physical activity

• Identify and, if appropriate, treat other CVD risk factors

• Monitor for development of type 2 diabetes at least annually
• Seeking to make it easier for you to identify DSME programs in your communities

• Two questions for you to respond to:
  • Are you referring patients to DSME programs?
  • What prohibits referrals to DSME programs?
Partnerships to address hypertension, diabetes and pre-diabetes

- Provide technical assistance in the use of health information systems
- Provide tools for quality improvement
- Strengthen referral processes to community based programs
- Engage pharmacists and employers as members of team based care and to offer self management programs
Practice Transformation

Improve prevention and management for hypertension, diabetes and prediabetes

- Academy of Family Physicians
  - EHR
  - Quality Improvement
  - Referral Process

- WVU School of Pharmacy
  - Team-Based Care
  - Self-Management Programs

- WVU-OHSR
  - HIT
  - Quality Improvement
  - Referral Process

- Wellness Council of WV
  - Team-Based Care
  - Self-Management Programs

Practice Transformation

Data sharing

Increase EHR and HIT to improve performance

Utilize and monitor quality measures at provider and systems level

Increase use of team-based care

Increase access, referrals and reimbursement for DSME and NDPP programs

Medication adherence/ Self-management
Partnerships to address hypertension, diabetes and pre-diabetes

- Academy of Family Physicians/CE City
- WVU Office of Health Services Research
- WVU School of Pharmacy Wigner Institute
- Wellness Council of WV
- Roane Family Health Care
Improving Diabetes and Hypertension Through a Registry Based Solution

WVAFP Annual Meeting
April 16, 2015

Dan Gold
Sr. Configuration and QA Specialist
CECity
CECity Overview
The leading cloud-based, enterprise registry solution for Pay for Performance and Value-based Reporting, Professional Certification and Performance Improvement

“3 Ps”
Value-based Payment | Performance Improvement | Professional Certification

Patent Pending Platform Technology

Trusted and Exclusive Partnerships

- American Board of Internal Medicine
- American Board of Medical Specialties
- NBME
- AAMC
- Pharmacy Quality Alliance
- Johns Hopkins Armstrong Institute for Patient Safety and Quality
- Bridges to Excellence
- AMA
- ACA
- Schumacher Group
- RITE AID
- APOGEE Physicians
- athenahealth
- CVS/pharmacy
- ACP
- Humana
- UPMC Health Plan
- Genentech
- Pfizer
CECity PQRS Registry-PQRSwizard

CECity’s PQRS Solutions: PQRS\textit{wizard}

- #1 Cloud-Based PQRS Registry Platform
- #1 Payment Success Rate (>99.5%)

### #1 Cloud Based Registry for PQRS Reporting*

<table>
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<td>70.5%</td>
<td>90.0%</td>
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* Over 99.5% Success Rate!**


* Ranking based upon utilization, professional organization recommendations, and eligible provider success rates.
** >99.5% of eligible professionals that relied on PQRS\textit{wizard}, submitted correct NPI/TINs and provided correct data, received their incentive payment.
# PQRS and Value-Based Modifier Incentives and Payment Adjustments: 2015 Reporting Period

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<td>-2%</td>
<td>-4%</td>
<td>Negative, Neutral or Upward Adjustment (-4.0% to +4.0)</td>
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Diabetes and Hypertension Program Improvement Goals

- Improve the quality of diabetes and hypertension patient care delivery;
- In the ambulatory physician practice setting;
- To improve the health of the diabetes and hypertension patient population;
- As evidenced by standard group of NQF endorsed diabetes and hypertension performance measures;
- That align across meaningful value-based and professional incentive programs (MA Stars, PQRS, MOC, BTE)
Benefits of the Diabetes/Hypertension Registry

- Opportunity to continuously view your quality measures and identify gaps in care
- View benchmarking versus peers and colleagues
- Link to interventions for improvement to close gaps in care
- View follow-up data results on a continuous basis
- Align with pay-for-performance and pay-for-reporting requirements such as PQRS, Bridges to Excellence (BTE), and professionalism requirements such as CME
Walkthrough of the Registry
Registry MedConcert Platform
Home Page

Click here to access the Getting Started Wizard!
You can also access the Getting Started Wizard in My Account.

Private Messages

"Private Messages" are secure communications between you and another MedConcert® user. These users do not have to be your colleague or in your networks. Click Compose to get started.

NewsWire switch to My Wire

"Wire" is where you can publicly share messages, post cases and broadcast events to all your Colleagues/Networks or to those whom you specify. You may also read, comment on, like and share your colleagues’ and Networks’ Wire posts, pending permissions.

Population Health

- 17 Patients with Alerts
- 2 Apps with Alerts
- 6 Measures with Alerts

Notifications

- Martin Kennedy is now a colleague of Denise O'Brien
- Martin Kennedy is now a colleague of Sandra Wilkins
- Martin Kennedy is now a colleague of Alex Tyson

Things To Do

- Manage Your Portfolio
Measure performance and identify gaps

Address gaps through interventions

Compare performance with other participants, specialties, networks

Use data for quality reporting

Registry Overview

Welcome to the American College of Physicians Diabetes Registry

What You Can Do

Enter Data
Add or upload your eligible patient data to your registry.

Review Measure Results
Once you have entered your patient data, review your performance rate.

Find Ways to Improve
Once you have reviewed your performance, find education, resources, and tools to improve your practice.

MOC: ACP Practice Advisor for ABIM
Learn how to use your registry data toward American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) Self-Evaluation of Practice. Performance credit using ACP Practice Advisor.

PQRS
Use your eligible patient data to participate in the PQRS 2014 Incentive program. As a participant of the ACP Diabetes Registry, you have access to PQRSWizard for the PQRS 2014 reporting period.

Bridges to Excellence
Bridges to Excellence (BTE) provides payers incentives for participation in a diabetes performance program in certain states. Download your patient data to the BTE site or upload your data from BTE to MedConcert.

Patient Survey
The Patient Survey module provides participants a way to integrate patient feedback and use the resulting data to take actions to improve care.

Measures
This registry allows you to assess your performance related to the following measures:

- **Hemoglobin A1c Poor Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.

- **Low Density Lipoprotein (LDL-C) Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL).

- **High Blood Pressure Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).

- **Dilated Eye Exam**
  Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam.

- **Medical Attention for Nephropathy**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit during 12 months.

- **Foot Exam**
  Percentage of patients aged 18 through 75 years with diabetes who had a foot examination (visual inspection, sensory exam with monofilament, and/or pulse exam).

- **Body Mass Index (BMI) Screening and Follow-up**
  Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI was outside of normal parameters, a follow-up plan was documented during the encounter or during the six months prior to the encounter.

- **Tobacco Use: Screening and Cessation Intervention**
  Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months.
How to Enter Data

ACP Diabetes Registry
The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resources (View more)

If you intend on using the chart data for submission to Bridges to Excellence (BTE), you must answer all chart questions (including those not-required) and you must enter at least 25 patients.

Manage My Patients and Encounters.

Add a New Patient
Add a new patient into your master patient list and into this registry

Add an Existing Patient
Add a patient from your master patient list to this registry

Upload Patients and/or Data
This will take you to the Upload page, where you can upload patients or Patient Encounters to this registry

My Patients (199)

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<th>Gender</th>
<th># of Encounters</th>
<th>Date Created</th>
<th>Last Updated</th>
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Add New Patient

Add a New Patient
You are about to add a new patient to your Master Patient List and enroll this patient into ACP Diabetes Registry

Patient ID: *
16774886
Auto-generate

First Name: Paula

Last Name: Small

Date of Birth: 3/13/1945

Gender:
- Female
- Male
- Other

Contact Information
Email Address: Optional
Enter Patient Email

Phone Number: Optional
Enter Patient Phone Number

Address: Optional
Address Line 1
Address Line 2
City
State
Zip Code

Submit
Add Existing Patient
Enter Chart Data

Patient Encounter

Patient ID: 1012138
Location: West General Medical Center

* Indicates Required Field / Question

Diabetes Patient Entry

Patient ID: 1012138
Patient Visit Date: 1/8/2015
Patient Age: 66 yrs
Birth Date: 3/31/1949
Patient Gender:
- Female
- Male

Race/Ethnicity:
- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Unknown/Other

What was the most recent Hemoglobin A1c level within 12 months?
- Most recent hemoglobin A1c (HbA1c) level < 7.0% (30 mmol/mol)
- Most recent hemoglobin A1c (HbA1c) level ≥ 7.0% and ≤ 9.0% (30 mmol/mol)
- Most recent hemoglobin A1c (HbA1c) level > 9.0% (30 mmol/mol)
- Hemoglobin A1c level was not performed during the performance period (12 months) (3046F-8P)

Most recent HbA1c level: 0.3
HbA1c assessment date: 1/8/2015

What was the most recent LDL-C level within 12 months?
- LDL-C < 100 mg/dL (3.0 mmol/L)
- LDL-C ≥ 100 and ≤ 129 mg/dL (3.0 mmol/L)
- LDL-C ≥ 130 mg/dL (3.3 mmol/L)
- LDL-C was not performed during the performance period (12 months) (3046F-8P)

Most recent LDL level: 134
LDL assessment date: 1/8/2015

What was the most recent systolic blood pressure measurement taken within 12 months?
- Systolic blood pressure < 140 mmHg (G8752)
- Systolic blood pressure ≥ 140 mmHg (G8753)
- Blood pressure measurement was not performed or documented (20006-8P)

Most recent systolic level: 122

What was the most recent diastolic blood pressure measurement taken within 12 months?
- Diastolic blood pressure < 90 mmHg (G8754)
- Diastolic blood pressure ≥ 90 mmHg (G8755)
- Blood pressure measurement was not performed or documented (20006-8P)

Most recent diastolic level: 80
Enter Additional Patient Visits

ACP Diabetes Registry
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If you intend on using the chart data for submission to Bridges to Excellence (BTE), you must answer all chart questions (including those not-required) and you must enter at least 25 patients.

Manage My Patients and Encounters.

Add a New Patient
Add a new patient into your master patient list and into this registry

Add an Existing Patient
Add a patient from your master patient list to this registry

Upload Patients and/or Data
This will take you to the Upload page, where you can upload patients or Patient Encounters to this registry

My Patients (199)
How to enter data

ACP Diabetes Registry

If you intend on using the chart data for submission to Bridges to Excellence (BTE), you must answer all chart questions (including those not-required) and you must enter at least 25 patients.

Manage My Patients and Encounters.

Add a New Patient
Add a new patient into your master patient list and into this registry.

Add an Existing Patient
Add a patient from your master patient list to this registry.

Upload Patients and/or Data
This will take you to the Upload page, where you can upload patients or Patient Encounters to this registry.

My Patients (199)
Upload Your Data

Upload Patients

You are about to upload new patients to your Master Patient List. You may upload patients to either 1) Your personal patient list or 2) A patient care organization network of which you are a member.

Associate patients with:

- My Personal Patient List
- ACP Diabetes Registry

Select the network or app to associate your patients with.

STEP 1 Download the Patient Template

To begin the upload process, please download the Patient Template. The file is a Microsoft Excel Spreadsheet that contains the correct column headers which correspond to the data elements required to build your Master Patient List. After downloading the file, enter the appropriate data into the template or generate a report from your existing system, that is exactly the same as this template, and ensure that the columns match properly. A Definition File is also available for download (see below) if you need assistance with understanding the data in the Patient Template.

Patient Encounter Template

Download Definition File

STEP 2 Upload My Patients

To upload your completed Patient Template, click the "Browse..." button. Locate and select the file you wish to upload, and then select the "UPLOAD A FILE" button.

Patient Encounter

UPLOAD A FILE
## Upload Your Data

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<td>3046F</td>
<td>6.8</td>
<td>10/19/2014</td>
</tr>
</tbody>
</table>
Upload Your Data

Your patient list is being uploaded.

Review Your Upload

The file(s) you have uploaded appear in the queue below. Please review to ensure that your file(s) uploaded successfully.

If you encountered any errors in your file upload (see column labeled "Errors Encountered"), you should select "Download Error Log" to view the list of errors. To correct your errors, select "Download Error File". This file contains only the records from your original file that need to be corrected. Once you have made the appropriate corrections, save this file and re-upload it into the system.

Note that after making corrections you may re-upload the entire file, our system will block any duplicate patient entries.

<table>
<thead>
<tr>
<th>Date Created</th>
<th>File Type</th>
<th>Status</th>
<th>Total Records</th>
<th>Records Processed</th>
<th>Processed Successfully</th>
<th>Errors Encountered</th>
<th>Reports</th>
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</thead>
<tbody>
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<td>4/7/2015 5:29:36 PM</td>
<td>XLSX</td>
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<td>4</td>
<td>Download Error Log</td>
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</table>
Your Personal Dashboard View by Measure

Performance measures and benchmarks are calculated nightly. Data added to Apps will not be reflected in the calculations below until the following day.

1 - 5 of 8 Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Report Period</th>
<th>My Performance</th>
<th>How Do I Compare?</th>
<th>Outliers</th>
<th>How Do I Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated Eye Exam</td>
<td>04/12/2015</td>
<td>view chart</td>
<td>Actual 87.93%</td>
<td>1 gap</td>
<td>-</td>
</tr>
<tr>
<td>Body Mass Index (BMI) Screening and Follow-Up</td>
<td>04/12/2015</td>
<td>view chart</td>
<td>Actual 91.95%</td>
<td>0 gap</td>
<td>73%</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>04/12/2015</td>
<td>view chart</td>
<td>Actual 79.89%</td>
<td>0 gap</td>
<td>83%</td>
</tr>
<tr>
<td>Hemoglobin A1c Poor Control</td>
<td>04/12/2015</td>
<td>view chart</td>
<td>Actual 6.03%</td>
<td>0 gap</td>
<td>70%</td>
</tr>
<tr>
<td>High Blood Pressure Control</td>
<td>04/12/2015</td>
<td>view chart</td>
<td>Actual 90.95%</td>
<td>0 gap</td>
<td>88%</td>
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</tbody>
</table>
Ways to Improve is linked right from your dashboard

```
<table>
<thead>
<tr>
<th>Title</th>
<th>Type</th>
<th>Rating</th>
<th>% Users Improved</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADA Effects of Quality Improvement</td>
<td>Activity</td>
<td>🌟🌟🌟🌟🌟</td>
<td>N/A</td>
<td>LAUNCH</td>
</tr>
<tr>
<td>CDC Cost-Effectiveness of Interventions to Prevent and Control Diabetes Mellitus: A.</td>
<td>Activity</td>
<td>🌟🌟🌟🌟🌟</td>
<td>N/A</td>
<td>LAUNCH</td>
</tr>
<tr>
<td>AAO Diabetic Retinopathy</td>
<td>Activity</td>
<td>🌟🌟🌟🌟🌟</td>
<td>N/A</td>
<td>LAUNCH</td>
</tr>
</tbody>
</table>
```
Ability to submit for PQRS 2015 at no charge

ACP Diabetes Registry
The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resources (view more)

PQRSwizard
Report on at least 20 diabetic patients seen in 2014, 11 of whom must be Medicare Part B Fee-for-Service patients. Physicians who do not report to PQRS in 2014 will receive a 2 percent penalty on all 2016 allowable charges.

You can use your eligible patient data collected in the ACP Diabetes Registry to participate in the CMS PQRS incentive payment program. There is no need to re-enter your data. As a participant in the ACP Diabetes Registry you have access to PQRSwizard at no cost for the 2014 reporting period. PQRSwizard is an easy-to-use online tool to help physicians and other eligible professionals to easily and quickly report to PQRS. PQRSwizard will walk you through a few easy steps to get your eligible patients from your ACP Diabetes Registry submitted.
Bridges to Excellence

ACP Diabetes Registry
The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resources (view more)

Bridges to Excellence™
Bridges to Excellence (BTE) is the largest private (commercial) payer pay-for-performance program, recognizing and rewarding clinicians who deliver superior patient care. BTE programs measure the quality of care delivered in provider practices. BTE places a special emphasis on managing patients with chronic conditions who are most at risk of incurring potentially avoidable complications. Physicians, nurse practitioners, and physician assistants who meet the Bridges to Excellence performance benchmarks can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers fund these payouts from the savings they achieve through lower health care costs and increased employee productivity.

Use the data you have entered in your Diabetes Registry to participate in the BTE Diabetes Care Recognition Program.

START NOW

Once you have reached the Data step in the BTE Program, please contact us to have your ACP Diabetes Registry Data extracted for the BTE Program. We will notify you once your data has been extracted.

REQUEST DATA EXTRACTION

How to Participate:
1. Click the Start Now button to access the BTE App, register to the Diabetes Care Recognition Program, and follow the program wizard. Use the discount code ACPBTE2015 when you reach the payment screen.
2. Once you have reached the Add Data step, you must return to the BTE tab of the Diabetes Registry and click the Request Data Extraction button.
3. You will be notified via email once your data has been successfully extracted from your registry to the BTE Program.
4. Review the data extracted within the BTE app and update as necessary to fulfill the BTE Program requirements.
5. Once you have met the requirements you can submit your data for scoring.
How to Participate

- Contact Gerry Stover at 304-549-8086
- CECity will register you in the MedConcert platform. You will receive your registration information with a link. Click the link and you will be taken directly to MedConcert where you will be prompted to log in.
THANK YOU!
Adam Baus, PhD, MA, MPH | West Virginia University School of Public Health
Assistant Director | Office of Health Services Research
Network Coordinator | West Virginia Practice Based Research Network
Goal: Improving population health
Starting with primary care

- Patients with or at-risk for a chronic health condition need to have a primary care provider – a medical home
- Electronic health record (EHR) uptake by primary care continues to increase
- EHRs are designed primarily for documenting patient-level care – not population health management
- EHRs provide clinical decision support, but it’s not feasible for a provider to address all patient needs during a brief office visit
Health analytics and practice facilitation support to primary care

- Providing technical assistance for health care providers in using health information systems
- Making use of EHR data for population health management
  - Quality improvement needs
  - Required reporting needs
  - Data quality
Tools for quality improvement to adapt practice protocols

- An example: Finding patients undiagnosed with hypertension
  - Started as a by-product of helping centers report on blood pressure outcomes of patients with diagnosed hypertension
  - Led us to more closely look at data quality
### Table: Hypertension Diagnosis and Missed Patients

<table>
<thead>
<tr>
<th>Primary Care Center</th>
<th>A: Patients with Hypertension: ICD-9-CM Coding</th>
<th>B: Patients with Hypertension: ICD-9-CM Coding Plus Free Text</th>
<th>C: Patients with Hypertension: ICD-9-CM Coding Plus Free Text Plus Last 2+ Blood Pressure Readings ≥140/90 mm Hg</th>
<th>Percent Missed Based on ICD-9-CM Coding Only (100% – A/C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5,124</td>
<td>5,270</td>
<td>5,535</td>
<td>7.4%</td>
</tr>
<tr>
<td>B</td>
<td>1,605</td>
<td>1,868</td>
<td>1,945</td>
<td>17.5%</td>
</tr>
<tr>
<td>C</td>
<td>476</td>
<td>505</td>
<td>596</td>
<td>20.1%</td>
</tr>
<tr>
<td>D</td>
<td>658</td>
<td>660</td>
<td>724</td>
<td>9.1%</td>
</tr>
<tr>
<td>E</td>
<td>852</td>
<td>859</td>
<td>884</td>
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</tr>
<tr>
<td>F</td>
<td>313</td>
<td>313</td>
<td>325</td>
<td>3.7%</td>
</tr>
<tr>
<td>G</td>
<td>228</td>
<td>418</td>
<td>438</td>
<td>47.9%</td>
</tr>
<tr>
<td>H</td>
<td>396</td>
<td>407</td>
<td>446</td>
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</tr>
<tr>
<td>I</td>
<td>666</td>
<td>714</td>
<td>749</td>
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<tr>
<td>J</td>
<td>1,143</td>
<td>1,217</td>
<td>1,526</td>
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<tr>
<td>K</td>
<td>1,458</td>
<td>1,586</td>
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<tr>
<td>Sum</td>
<td>12,919</td>
<td>13,817</td>
<td>14,893</td>
<td>13.3%</td>
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<tr>
<td>Mean</td>
<td>1,174.45</td>
<td>1,256.09</td>
<td>1,353.91</td>
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<tr>
<td>Standard Deviation</td>
<td>1,386.60</td>
<td>1,424.08</td>
<td>1,492.58</td>
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<tr>
<td>95% CI, Lower</td>
<td>1,150.49</td>
<td>1,232.26</td>
<td>1,329.93</td>
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<tr>
<td>95% CI, Upper</td>
<td>1,198.31</td>
<td>1,279.74</td>
<td>1,377.87</td>
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</table>

- 13.3% of patients missed by ICD-9 coding alone
- 47.9% of patients with hypertension were undiagnosed in one clinic
Figure 1: Increase in Count of Patients with Hypertension, by Search Criteria

Note: Figure shows statistically significant increases in identification of essential hypertension cases using three search criteria methods.
Strengthen referral processes to community-based programs

Referral Process for Domain 4 – Community-Clinical Linkages (Strategies 1 – 4)

Community

Identification
- Occurs at the primary care center
- All patients
- Target pops

Recruitment
- Target pops are referred
- Contacted by CHWs
- Assessed for readiness

Intervention
- Those identified as ready are linked with approved programs

Outcome
- Participants are assessed
- Use of clinical information

Information flow to the primary care center

Notes:
1. This is a referral process that identifies target populations from either the community or the primary care center.
2. The referral process supports the Patient-Centered Medical Home model and Meaningful Use of electronic health record data.
3. This model helps address the needs of the entire population, and target subsets of patients by health conditions for preventive services.
4. This model helps to provide motivation for the primary care center to participate in community initiatives and activities.
Thank you!

Adam Baus, PhD, MA, MPH | West Virginia University School of Public Health
Assistant Director | Office of Health Services Research
Network Coordinator | West Virginia Practice Based Research Network
Phone: 304-293-1083 | Fax: 304-293-6685
Krista Capehart, PharmD, MSPharm
Director of the Wigner Institute,
kdccapehart@hsc.wvu.edu
Wigner Institute for Advanced Pharmacy Practice, Education, and Research

The mission of the Wigner Institute for Advanced Pharmacy Practice, Education, and Research at the West Virginia University School of Pharmacy (WVU SOP) is to advance pharmacy practice by providing education, training, and resources to pharmacy stakeholders in order to optimize health outcomes in West Virginia.

EDUCATION: To serve as a pharmacist care and professional development resource center for pharmacists in West Virginia to advance pharmacy practice.
RESEARCH: To evaluate the impact and expansion of pharmacist-delivered services on patient outcomes.
POLICY: To assist West Virginian stakeholders including patients, health care professionals, policy makers, and payers in making informed decisions about drug therapy and utilization of health care resources.
SERVICE: To establish partnerships to facilitate recognition of the value of pharmacist-provided services in West Virginia.
PATIENT CARE: To expand the implementation of innovative, sustainable practice models throughout West Virginia

Krista Capehart, PharmD, MSPharm
Director of the Wigner Institute, kdcapehart@hsc.wvu.edu
304-347-1385
Increase the number of American Association of Diabetes Educators (AADE) accredited programs in WV
Currently only 7 AADE programs in WV
- Located in Lewisburg (2), Beckley, Petersburg, Fairmont, Spencer, and Whitehall
- All but one are in community pharmacies
- Goal of adding three (3) additional sites this year
  - Locations: Morgantown, Moundsville, One TBD
- Provide free registration for 4 pharmacists to attend the WV Diabetes Symposium 2014

Wigner Institute
- Evaluates the site and services currently offered for Diabetes self-management that are interested
- Assists in becoming accreditation ready
  - Assists in completion of the accreditation process
Work with the pharmacies providing diabetes self management education in the primary focus areas to increase with referrals

- Multi-directional
- Improve communication throughout healthcare process
- Ensure patient remains center of process
- Establish an easier mechanism for recording education provided and recommendations made
Evaluate the current Diabetes Self-management Services available in WV pharmacies

Increase Pharmacist Education about Diabetes Self-management and Referrals

- Provide Web-based continuing education for pharmacists on the benefits of diabetes and hypertension self-management education programs

- Provide registration to training on diabetes self-management (the American Pharmacists Association Diabetes Care Program) for 10 pharmacists
Thank you!

Krista Capehart, PharmD, MSPharm
Director of the Wigner Institute,
kdcapehart@hsc.wvu.edu
304-347-1385
Adam Flack, Executive Director
WV Wellness Council
Who are we?

• Membership based Organization

• Benefits
  • Awards Process
  • Consulting
  • Networking
  • Education
  • Events
The Case for Prevention

• The U.S. Spends more on healthcare than any other industrialized nation

• In the US more money is spent per person for healthcare

• U.S. citizens are NOT the world’s healthiest
The Case for Prevention

Health care spending has taken up a greater share of total benefit costs: 2014??
How Do Companies Respond?

• Increased Participant Costs

• Increased Deductibles

• Increased Co-pays for Rx

• Bid Out Insurance

• Offer Wellness Program
Employee Wellness Teams

• Wellness Team
  • 8 – 15 team members
  • Appointed & Volunteers
  • Diverse
  • Representative of Organization
  • Meet Regularly
  • Written Agenda/Minutes
  • Accountable to Management & Employees
Initial Assessments

• HRA
• Needs & Interests
• Employee Satisfaction
• Claims
• Workers Comp
• Absenteeism
• Productivity
• “Readiness”
Initiative Planning

• Focus on RESULTS not ACTIVITIES

• Address issues found in assessment

• Consider business goals
The Case for Prevention

• The U.S. Spends more on healthcare than any other industrialized nation

• In the US more money is spent per person for healthcare

• U.S. citizens are NOT the world’s healthiest
Enacting Initiative

• *Common* Program Areas
  • PCP
  • Tobacco Cessation
  • Physical Activity
  • Nutrition
  • Blood Pressure
  • Alcohol/Drug Abuse
  • Seatbelt Usage
  • Self-Care
  • Stress Management
  • Personal Finances
  • Immunizations
  • Ergonomics
Enacting Initiative

• *Uncommon* Programs
  • Farmers Market on site weekly
  • “Low Cost” healthy choices in cafeteria
  • On site chair massages
  • “Healthy” pot luck lunches
  • “Audit” vending machines
  • Blended Families
  • Problems at home can be problems at work...
  • Internet Security
Enacting Initiative

Sending the message...

• Awareness
  ▪ posters, flyers, mailings, pay stubs, emails

• Education
  ▪ classes, lunch & learns, meetings

• Behavior Change
  ▪ nicotine replacement, walking program, “healthy” choices on site
Wellness Council of WV

Assessment of Progress

Program Review

• Evaluate Everything
  • 4-5 questions with “easy” answers
    • Focus on content & process
  • Open-ended final question
  • “Room to write”
  • Do NOT take responses personally...
Assessment of Progress

The Numbers

• Biometric Screening
  • Vitals
  • Tobacco Affidavit
  • Blood Glucose
  • Cholesterol

• Market for Screenings Yields Redundancy of PCP Services.
Assessment of Progress

After The Numbers

• Insurance Premium Discounts
  • Hierarchy system
  • Rewards current health as well as attempts to better health.

• PCP Initiatives
  • Program referrals
  • Exercise Rx
  • Bi-annual checkups.
Carroll Christiansen, MD
Roane County Family Health Care
The Million Hearts® Hypertension Control Challenge is a competitive challenge to identify practices, clinicians, and health systems that have worked with their patients to achieve hypertension control rates at or above 70%.

Roane County Family Health Care achieved 73.8% control rate during year 2014 and 72.7% in 2013.
Implementation

- Setting a goal for performance
- Robust quality improvement program with the ability to extract accurate data and build queries
- Common lists in the EHR for efficient diagnosis
- Care Coordination for outreach to patients and ensure timely follow-up- Having the ability to generate lists of patients who have not kept routine appointments
- Nursing standing orders
- Provider feedback- How well are we doing?
- Use of coders
Barriers

- Lack of unified definitions for care measures – ie. UDS, CDC, PQRS, Meaningful Use

- Time constraints

- Inefficient data entry processes

- The EHR is a billing platform- not conducive to clinical workflow
Thank you!

Carroll Christiansen, MD
Roane County Family Health Care
Improve prevention and management for hypertension, diabetes and prediabetes

**Practice Transformation**

- **WVU School of Pharmacy**
  - Team-Based Care
  - Self-Management Programs

- **WVU-OHRSR**
  - HIT
  - Quality Improvement
  - Referral Process

- **Academy of Family Physicians**
  - EHR
  - Quality Improvement
  - Referral Process

- **Data sharing**

**Practice Transformation**

- Increase EHR and HIT to improve performance
- Medication adherence and Self-management

**Data sharing**

- Increase access, referrals and reimbursement for DSME and NDPP programs
Your Role

- Share data with referring providers and collaborating partners to improve health outcomes
- Use Quality Improvement processes to adapt practice based protocols and referral systems
- Use team based care to include pharmacists, employers, others, etc.
- Refer patients to the National Diabetes Prevention Program
- Refer patients to ADA or AADE education programs
Thank You

Presenters

• Rahul Gupta, MD, MPH, FACP, Commissioner and State Public Health Office, WV Bureau for Public Health
• Jessica Wright, RN, MPH, CHES, Director, Health Promotion & Chronic Disease, WV Bureau for Public Health
• Dan Gold, CE City
• Adam Baus, PhD, MA, MPH Assistant Director, WVU Office of Health Services Research
• Krista D Capehart, PharmD, MSPharm, AE-C, Director of the Wigner Institute for Advanced Pharmacy Practice, Education and Research, WVU School of Pharmacy,
• Adam Flack, MPH, Executive Director, Wellness Council of WV
• Carroll Christiansen, MD, Roane County Family Health Care

Questions?
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(304) 356-4229