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



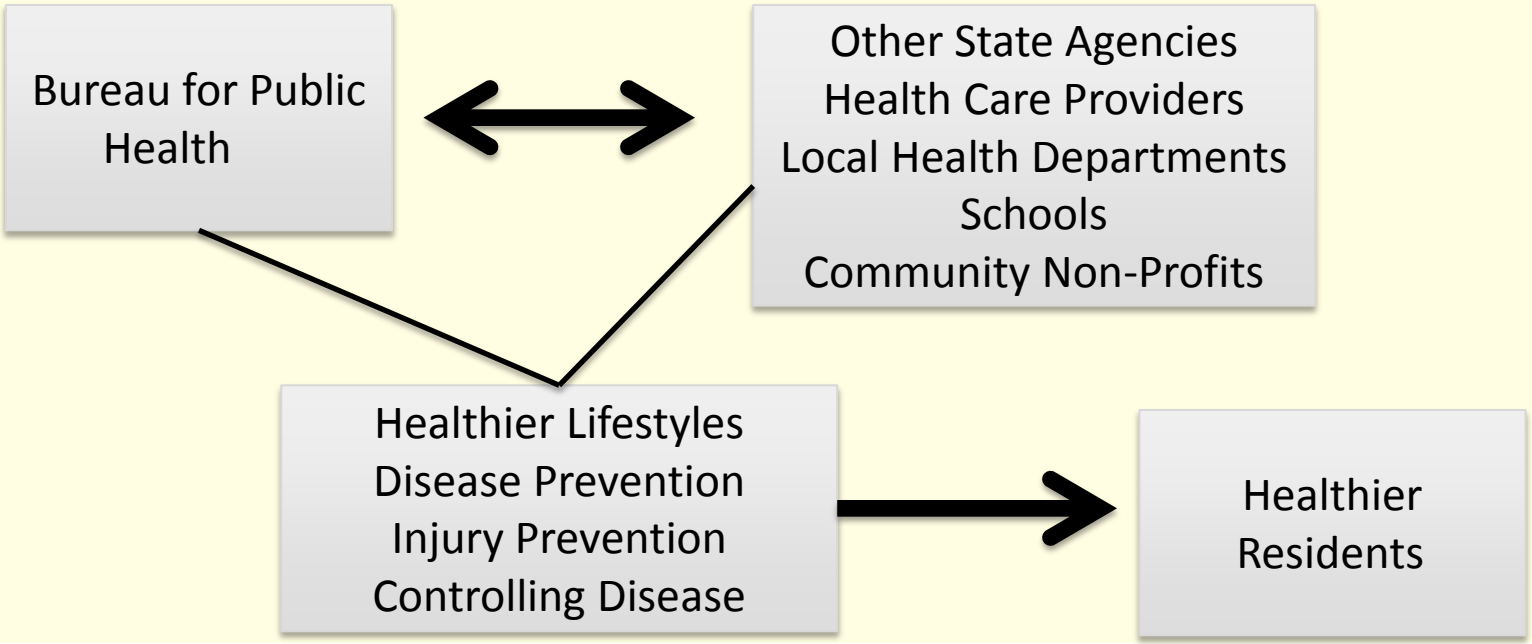

**Rahul Gupta MD, MPH, FACP**
**Commissioner & State Health Officer**
Academy of Family Physicians Conference
April 16, 2015

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

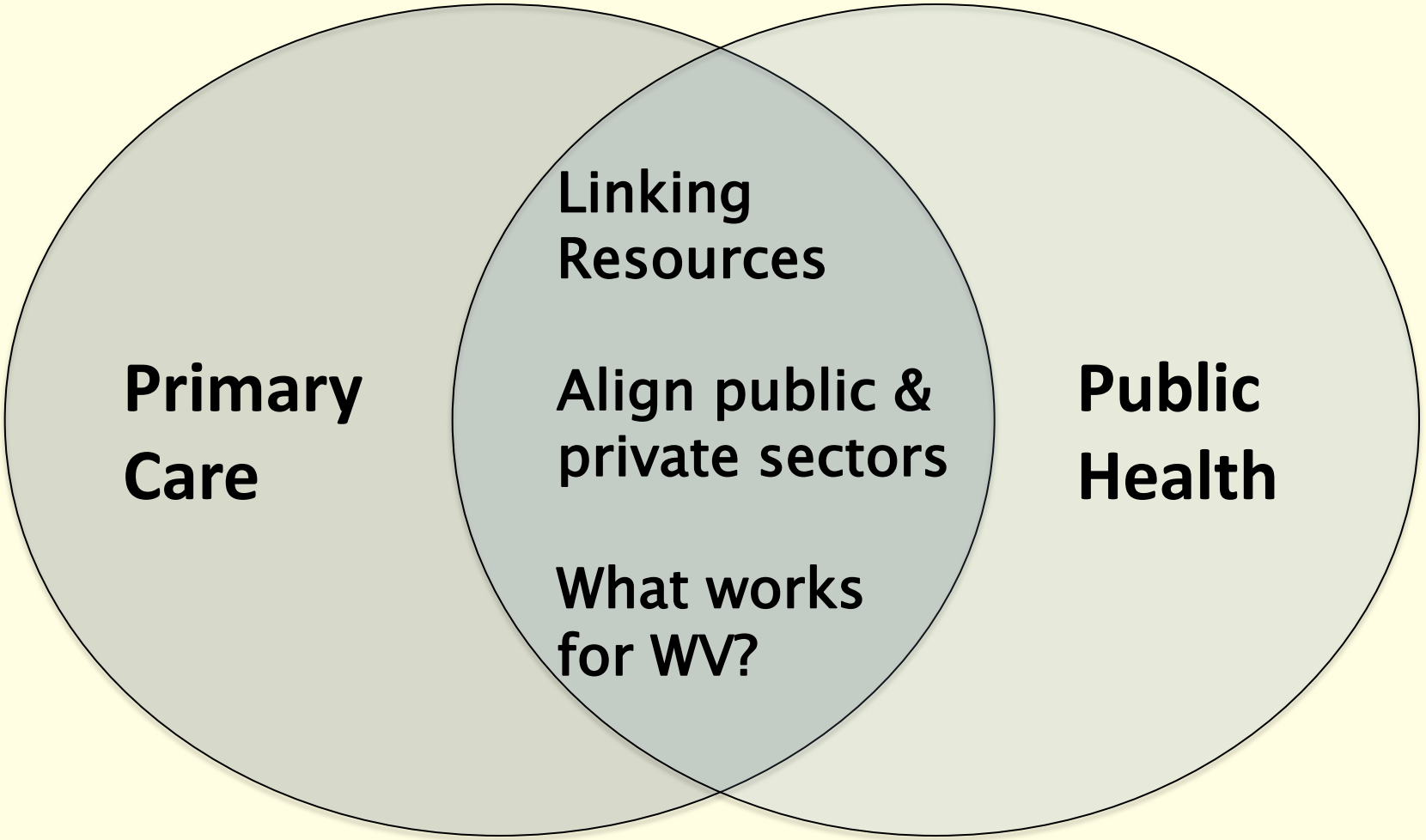
# Partnerships in Public Health

## 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**



# Integrating Primary Care & Public Health



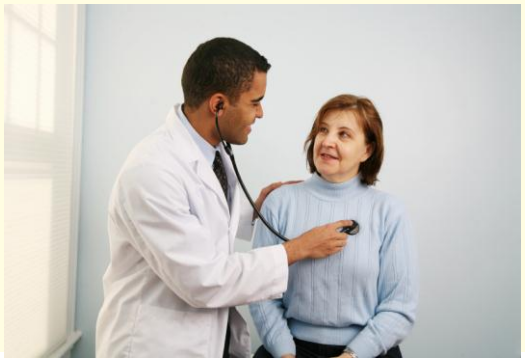
# CDC's Charge to States

**Link public health more effectively with health systems:**

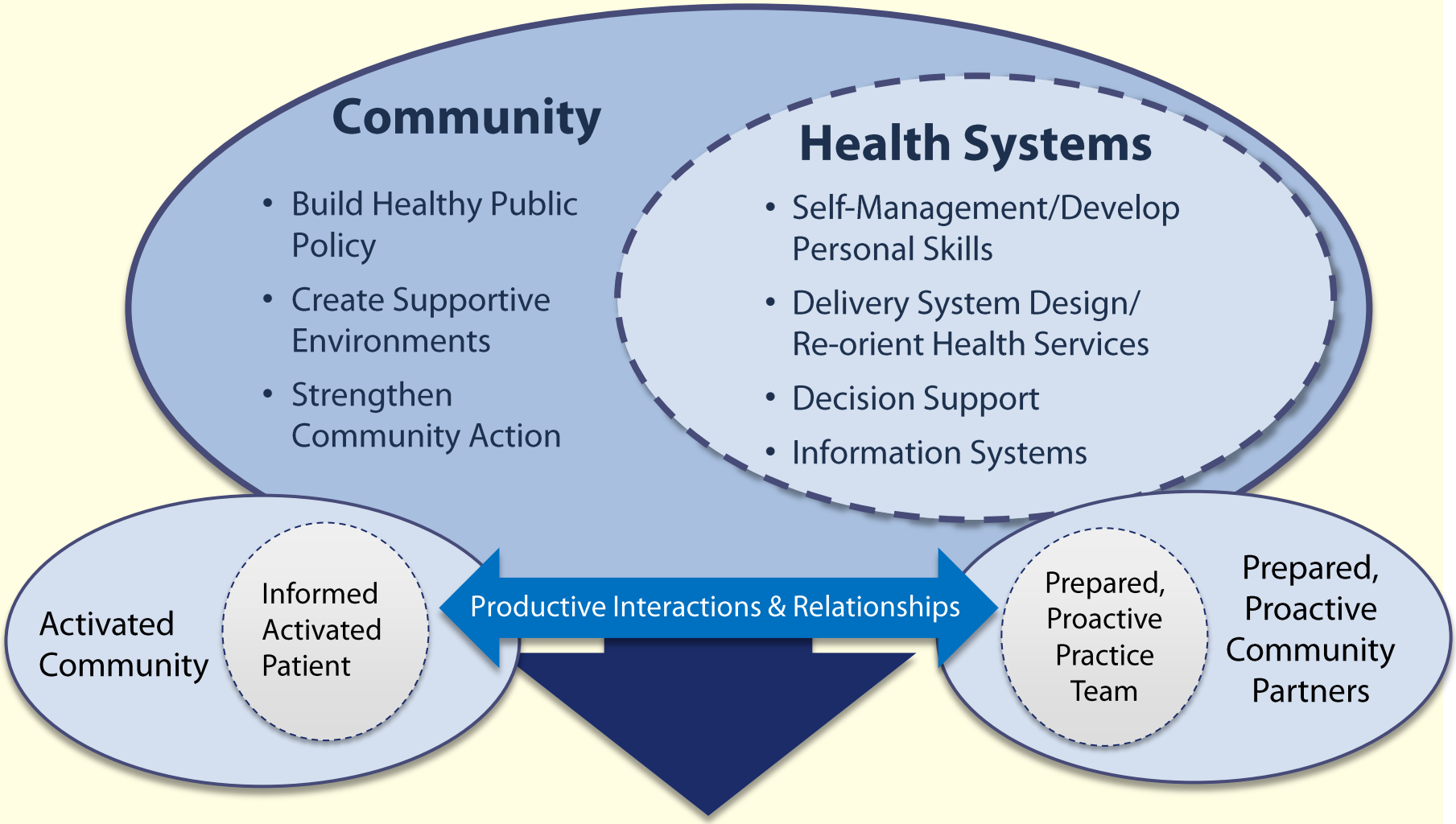
- **Using community resources and supportive environments to complement and strengthen delivery of clinical care**

# Moving from Sick Care to Preventive Care

## Challenges



# Expanded Chronic Care Model



# Contact Information

**Rahul Gupta, MD, MPH, FACP**
**Commissioner and State Health Officer**
**Bureau for Public Health**

**West Virginia Department of Health and Human Resources**
**350 Capitol Street Room 702**
**Charleston, WV 25301**

**(304) 558-2971**

**Rahul.Gupta@wv.gov**

# 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

WEST VIRGINIA Department of Health & Human Resources
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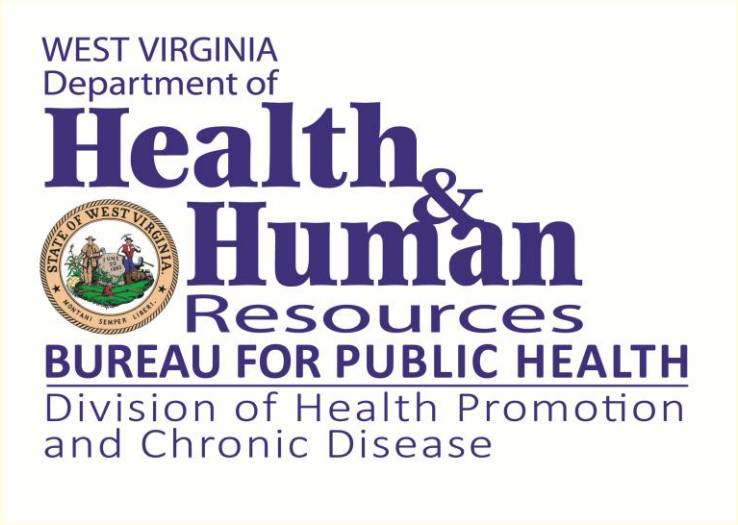
# Objectives

- **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"*



# HPCD: **H**elping **P**revent & Manage **C**hronic **D**isease

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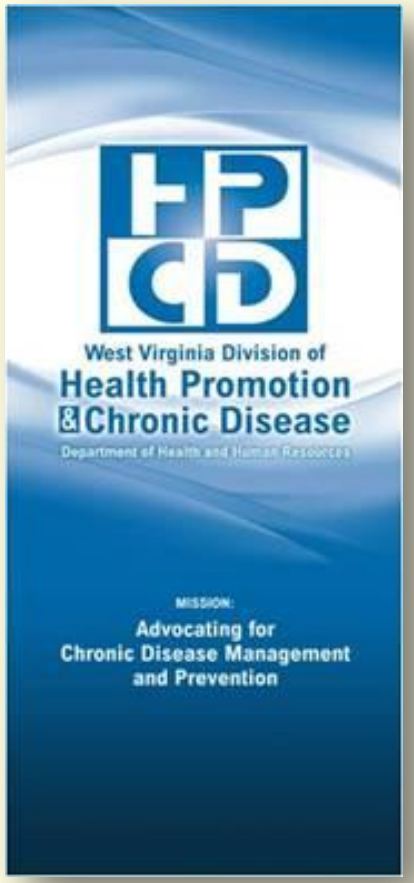
## Vision

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

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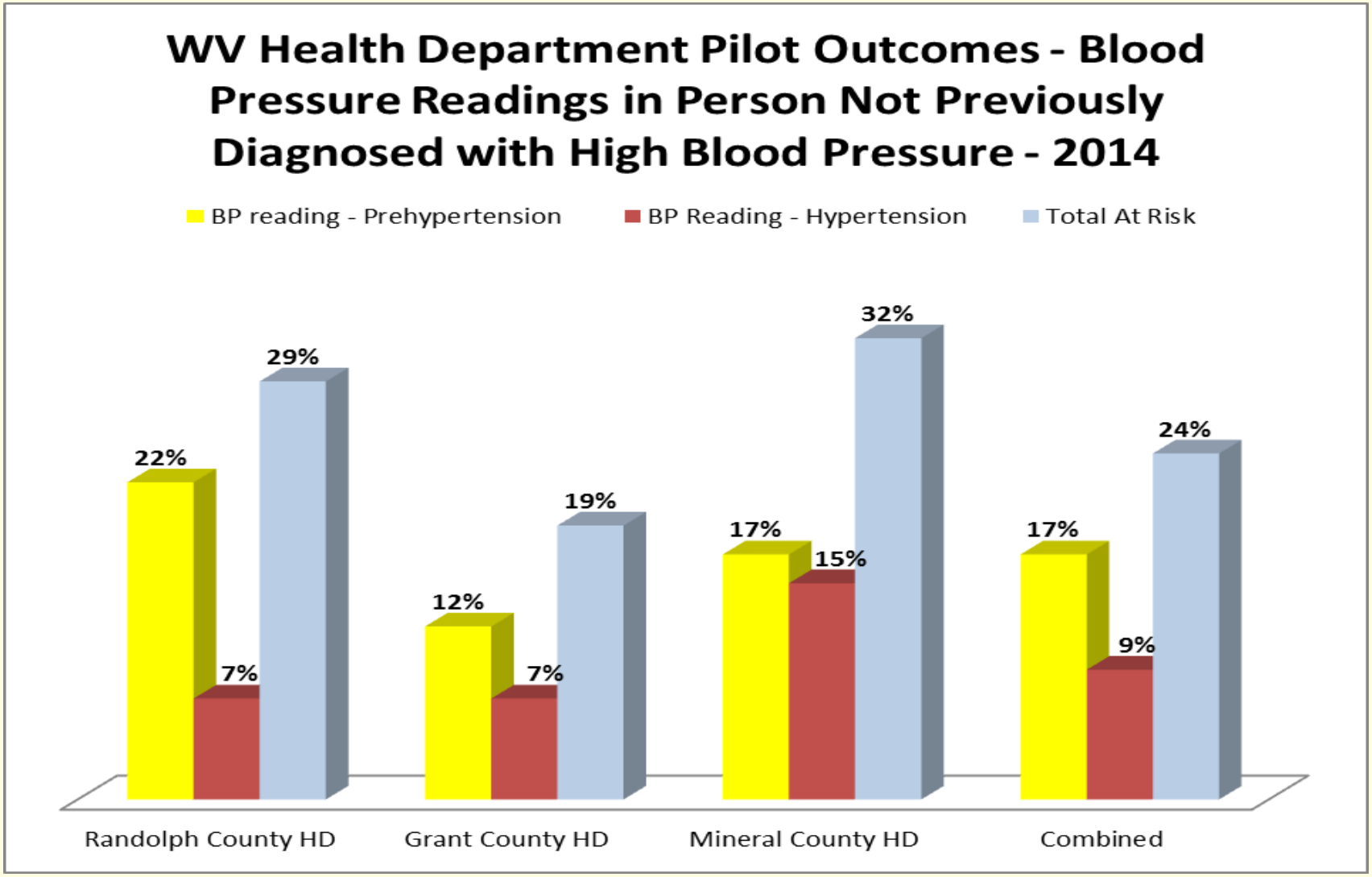
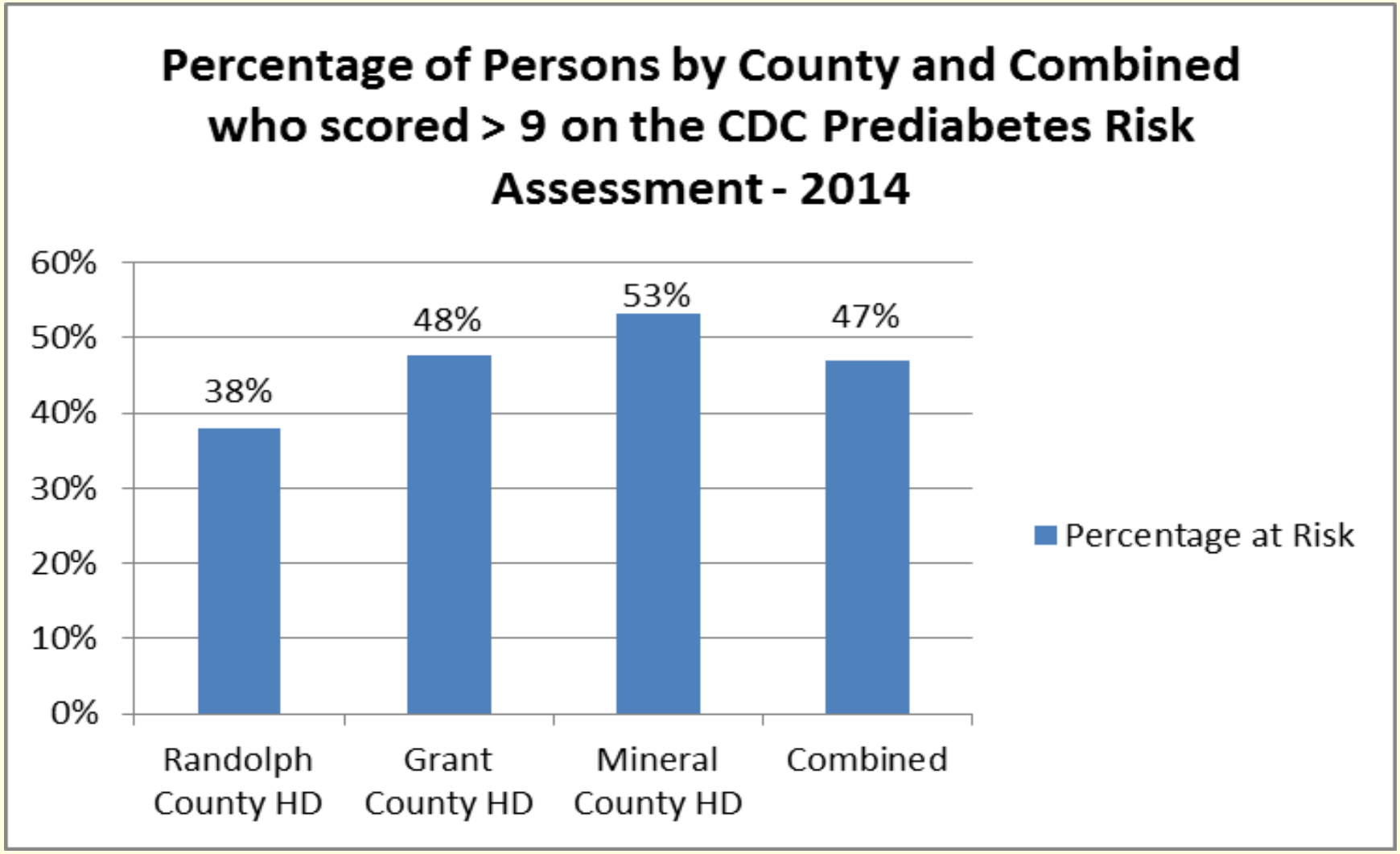
# Hypertension



## Prediabetes



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## 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

# National Diabetes Prevention Program

## 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

# Diabetes Self Management Education

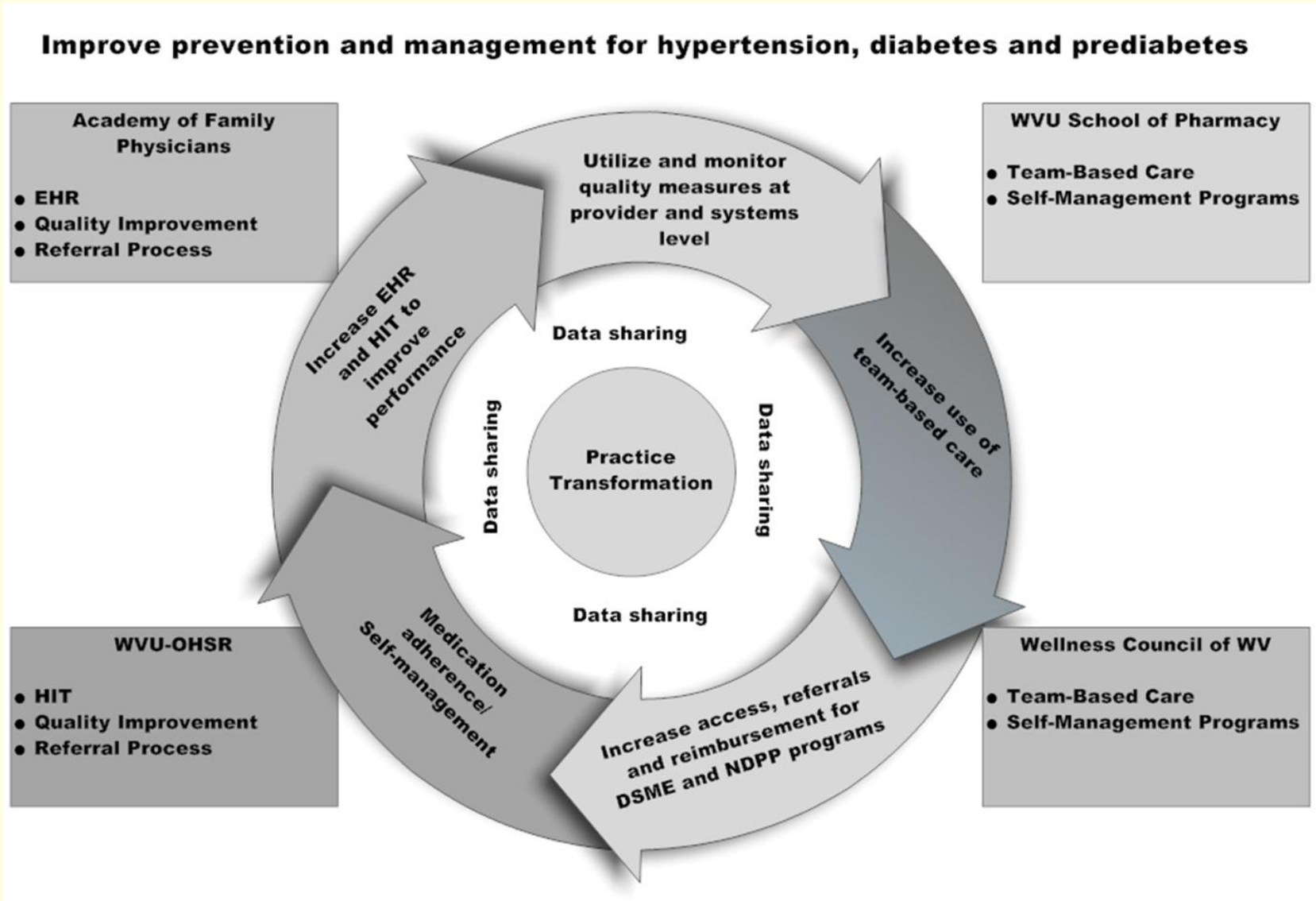
- Seeking to make it easier for you to identify DSME programs in your communities
- Two questions for you to respond to:
  - Are you referring patients to DSME programs?
  - What prohibits referrals to DSME programs?

# Practice Transformation Project

**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



# Practice Transformation

**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

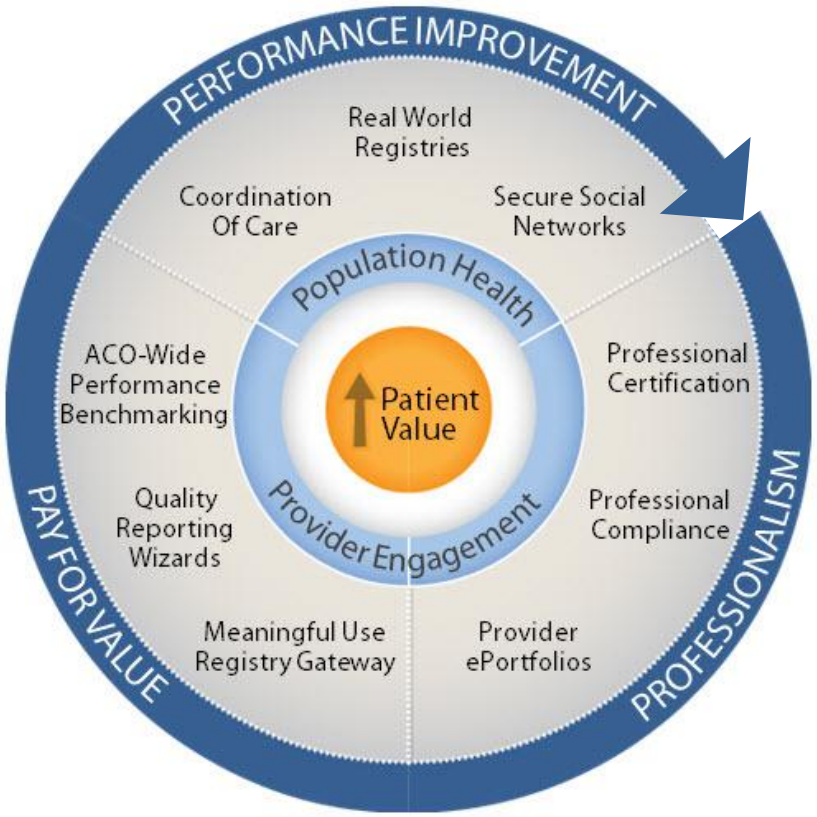
# CECity Overview

## 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
Higher standards. Better care.®
NBME
AAMC
Federation of STATE MEDICAL BOARDS
PQA
Pharmacy Quality Alliance
JOHNS HOPKINS MEDICINE
ARMSTRONG INSTITUTE FOR PATIENT SAFETY AND QUALITY
BRIDGES to Excellence
Rewarding Quality across the Healthcare System
AOA
AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA
AMA
AMERICAN MEDICAL ASSOCIATION
AGA
Schumachergroup
APOGEE PHYSICIANS
athenahealth
RITE AID PHARMACY
CVS/pharmacy
WILEY
ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | Doctors for Adults
HUMANA.
UPMC HEALTH PLAN
Aetna™
MERCK
Genentech
Pfizer
WEST VIRGINIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR WEST VIRGINIA

# CECity PQRS Registry-PQRSwizard

## CECity's PQRS Solutions: PQRS*wizard*

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


*Reference: United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS); 2011 Reporting Experience Including Trends (2008-2012). CMS, 26 Mar. 2013. Web. 11 Apr 2013. (www.cms.gov/pqrs)*

* Ranking based upon utilization, professional organization recommendations, and eligible provider success rates.
** >99.5% of eligible professionals that relied on PQRS*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

| Physician Group Size | Perfor-mance Year | Value Modifier Year | PQRS Penalty for Non-PQRS Reporters | VBM Penalty for Non-PQRS Reporters | Value-Based Modifier Adjustment | % of Medicare Reimbursements At Risk |
|---|---|---|---|---|---|---|
| 1-9 | 2015 | 2017 | -2% | -2% | Neutral or Upward Adjustment (+0.0% to +2.0) | 6% |
| 10-99 | 2015 | 2017 | -2% | -4% | Negative, Neutral or Upward Adjustment (-4.0% to +4.0) | 10% |
| 100+ | 2015 | 2017 | -2% | -4% | Negative, Neutral or Upward Adjustment (-4.0% to +4.0) | 10% |

# 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)**

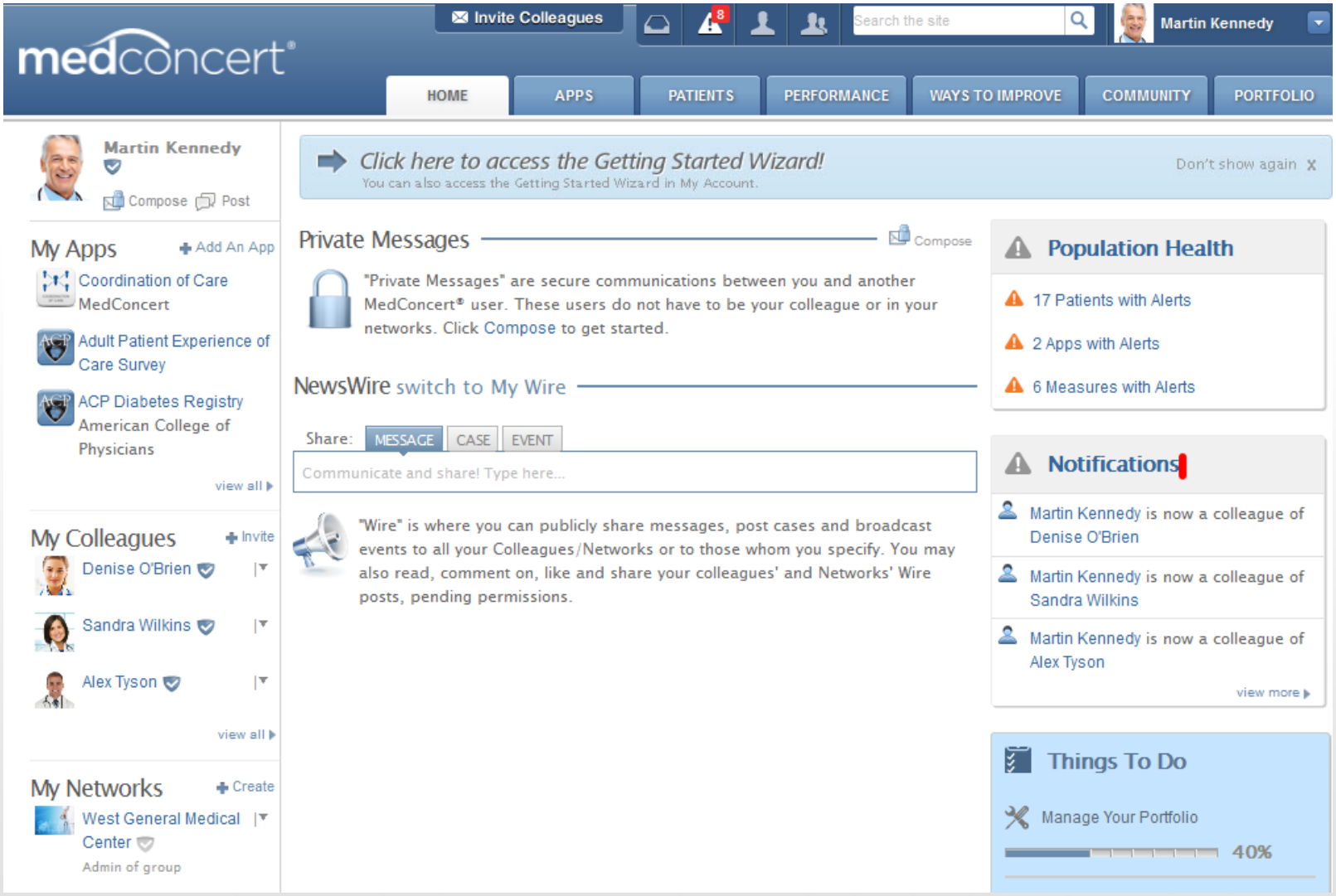
# Benefits of the Diabetes/Hypertension Registry

- **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



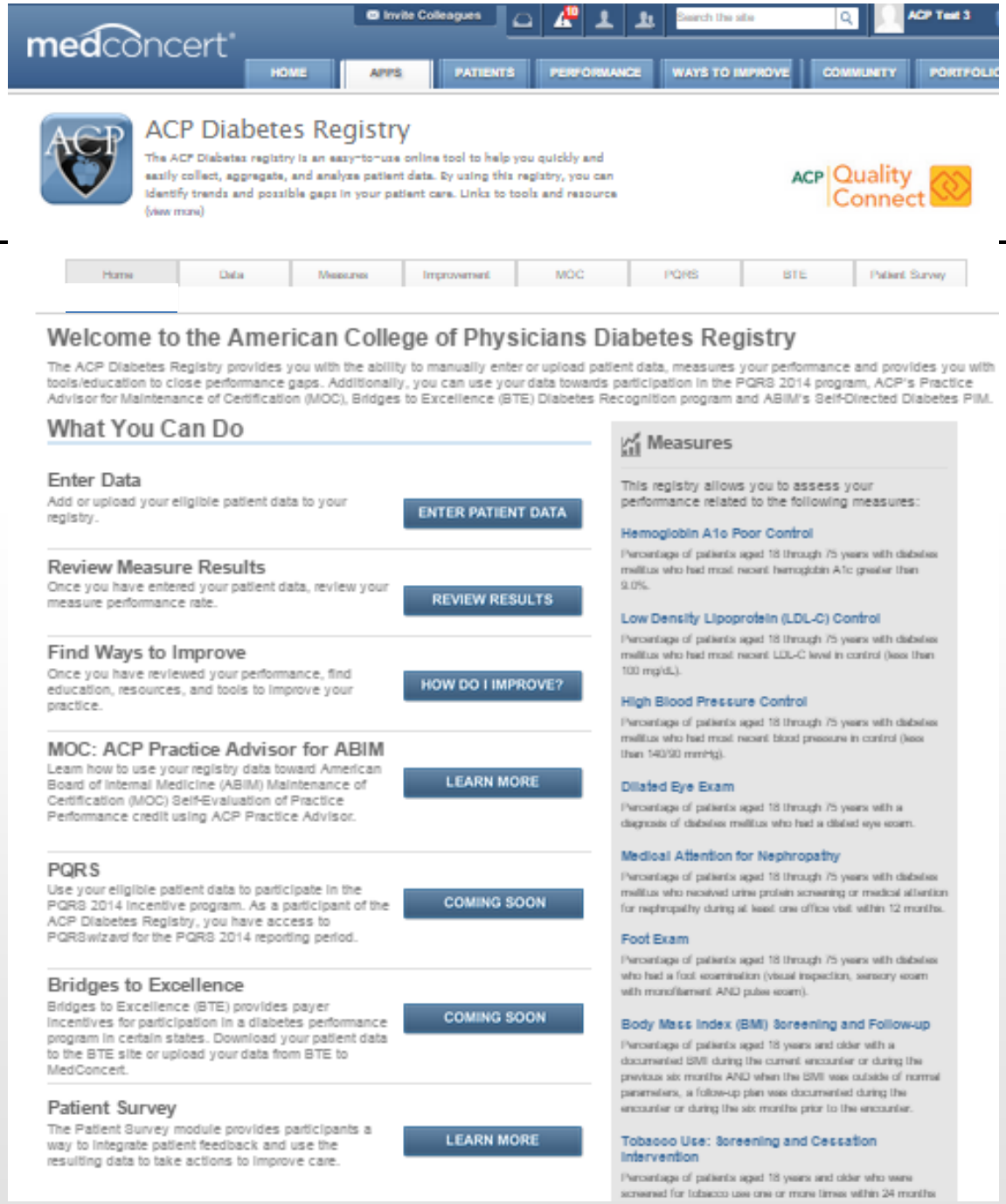
# Registry Overview

Measure performance and identify gaps

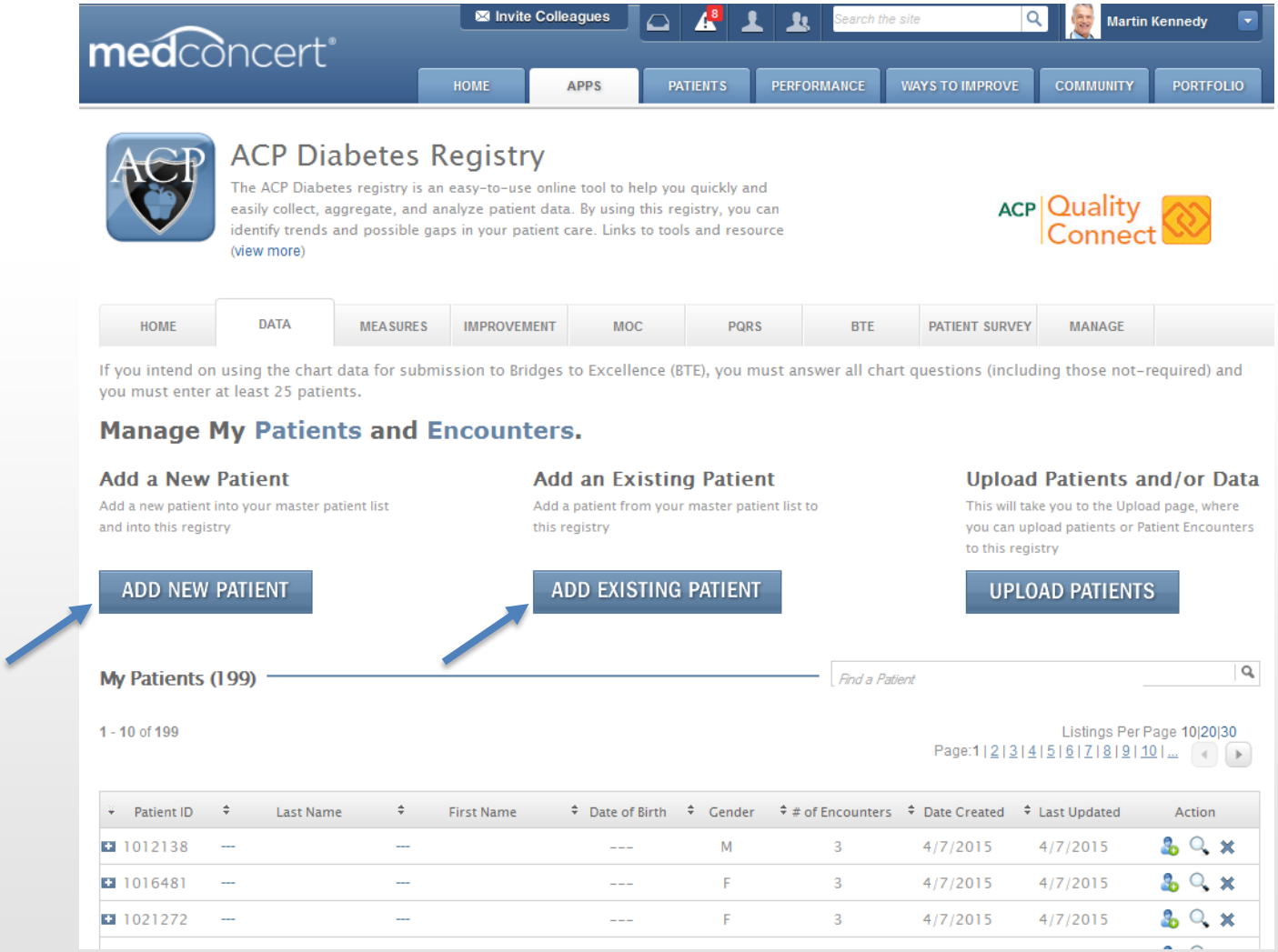
Address gaps through interventions

Compare performance with other participants, specialties, networks

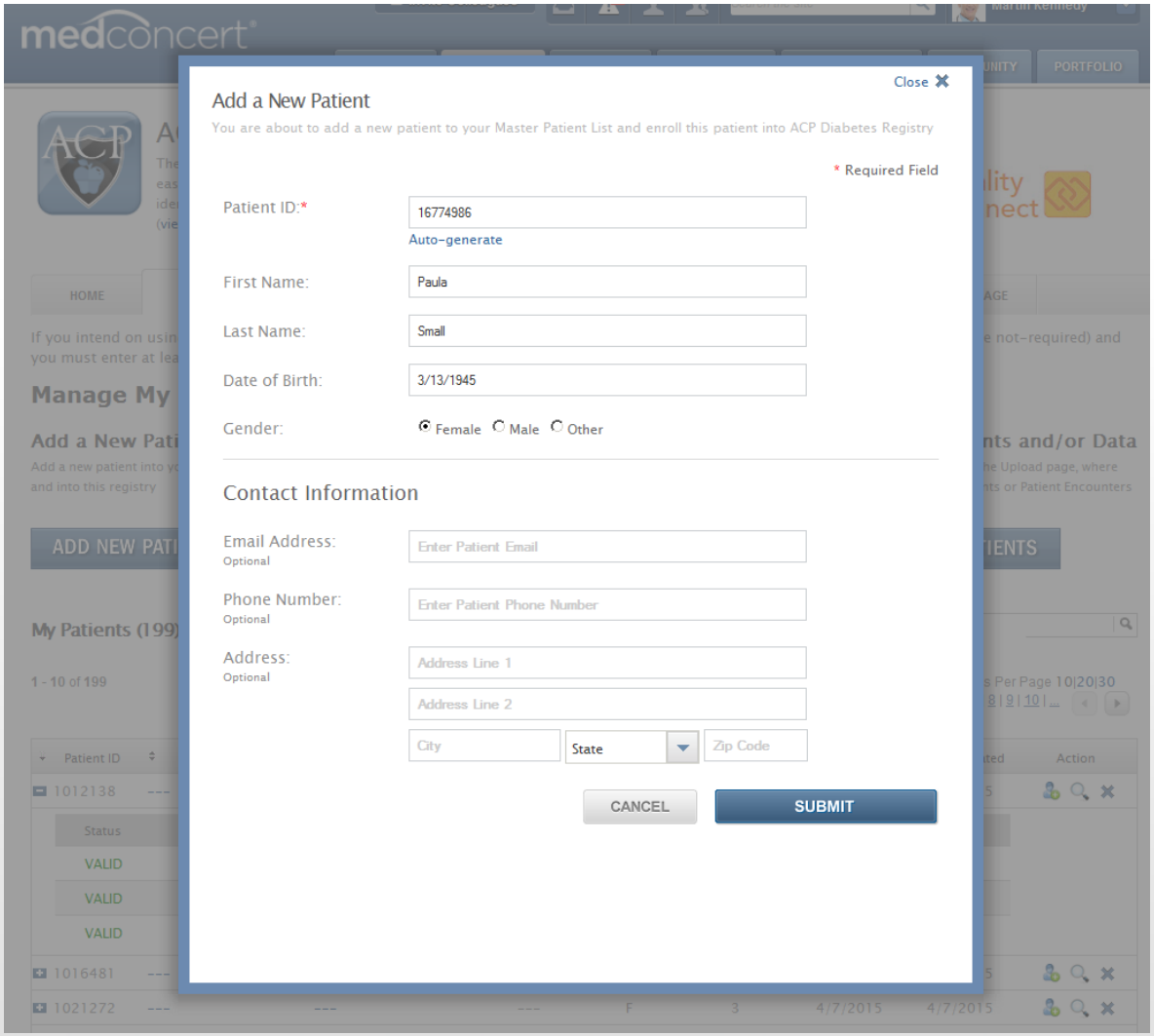
Use data for quality reporting



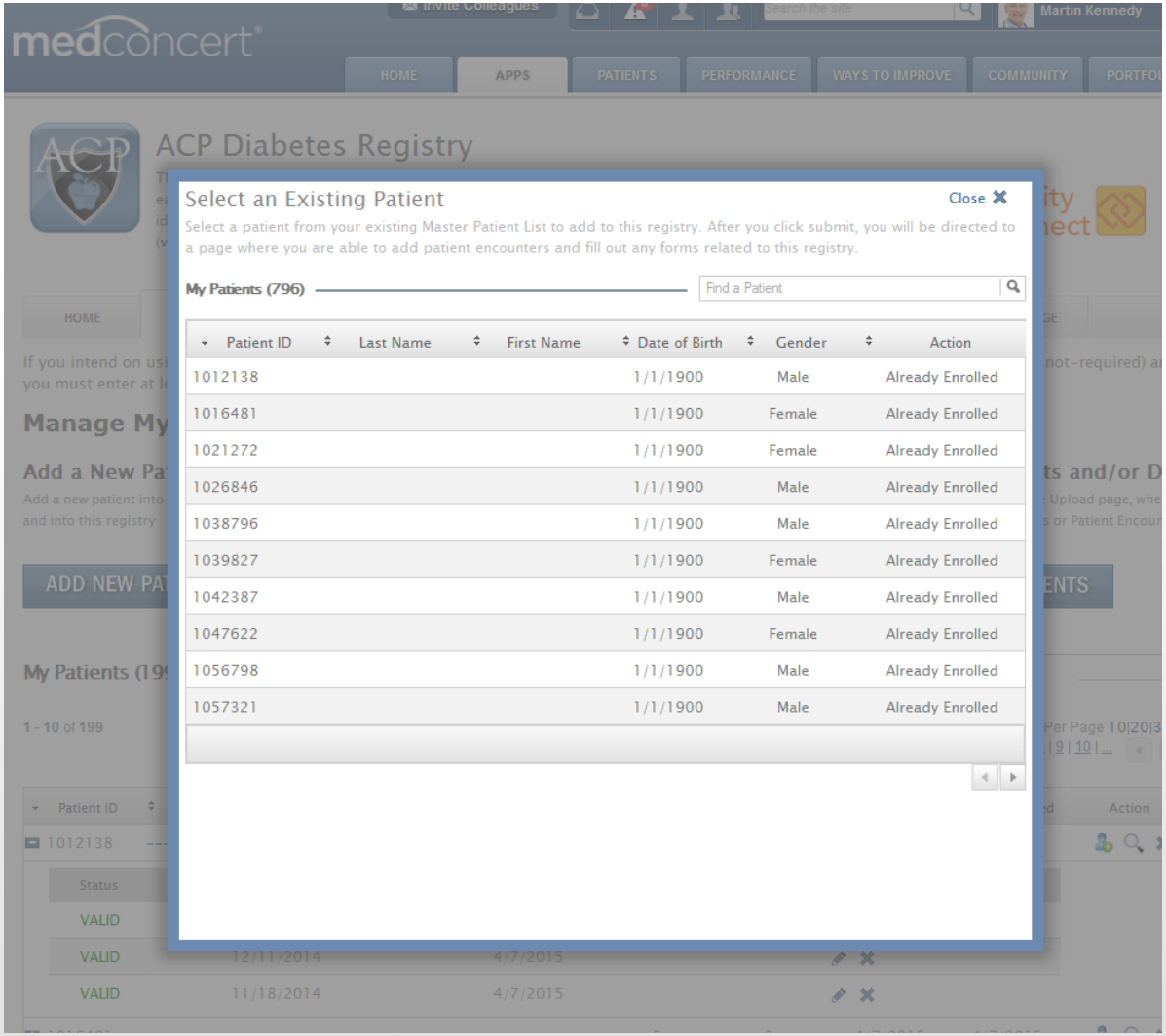
# How to Enter Data



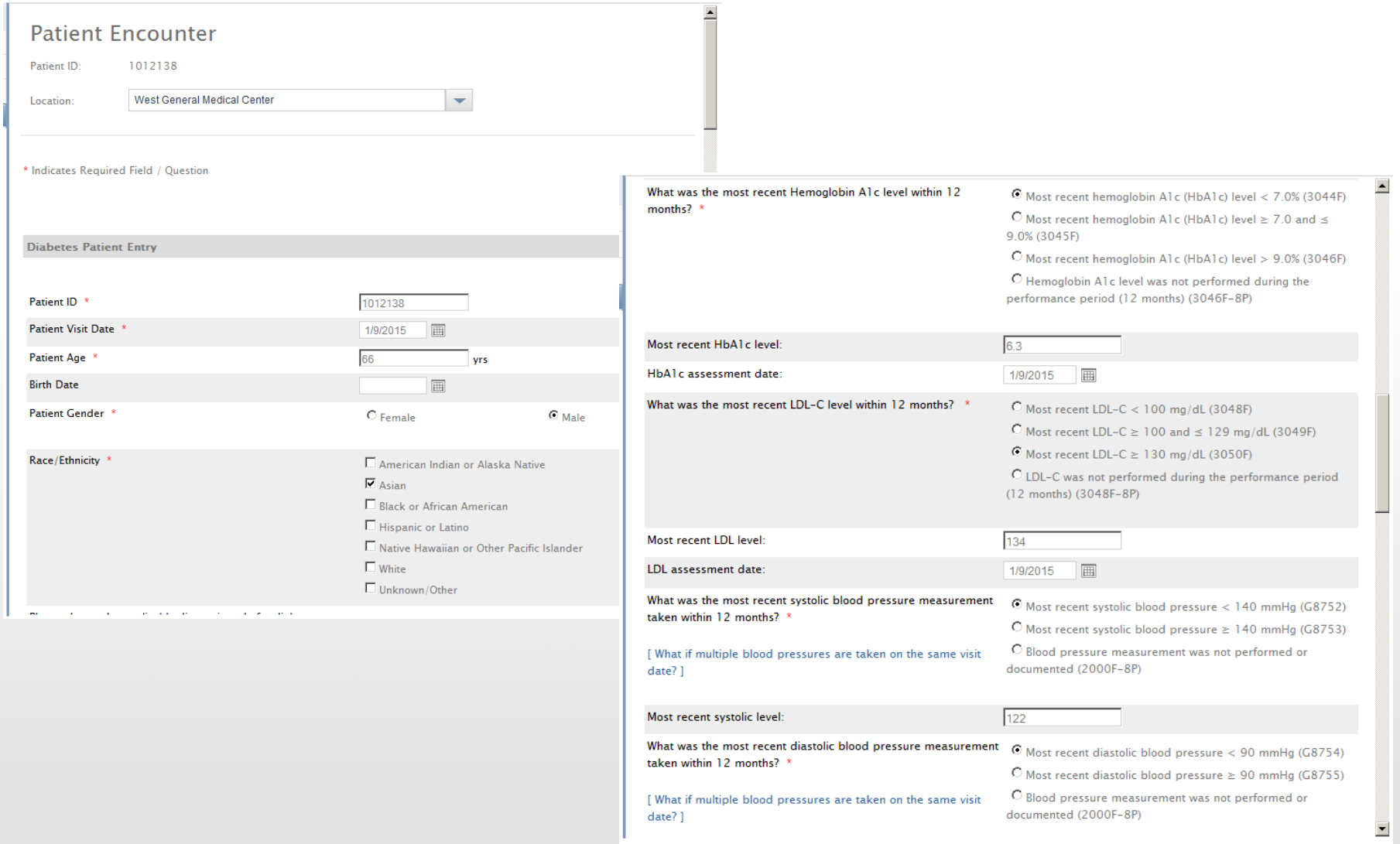
# Add New Patient



# 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 * 1/9/2015

Patient Age * 66 yrs

Birth Date

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% (3044F)
- Most recent hemoglobin A1c (HbA1c) level ≥ 7.0 and ≤ 9.0% (3045F)
- Most recent hemoglobin A1c (HbA1c) level > 9.0% (3046F)
- Hemoglobin A1c level was not performed during the performance period (12 months) (3046F-8P)

Most recent HbA1c level: 6.3

HbA1c assessment date: 1/9/2015

What was the most recent LDL-C level within 12 months? *
- Most recent LDL-C < 100 mg/dL (3048F)
- Most recent LDL-C ≥ 100 and ≤ 129 mg/dL (3049F)
- Most recent LDL-C ≥ 130 mg/dL (3050F)
- LDL-C was not performed during the performance period (12 months) (3048F-8P)

Most recent LDL level: 134

LDL assessment date: 1/9/2015

What was the most recent systolic blood pressure measurement taken within 12 months? *

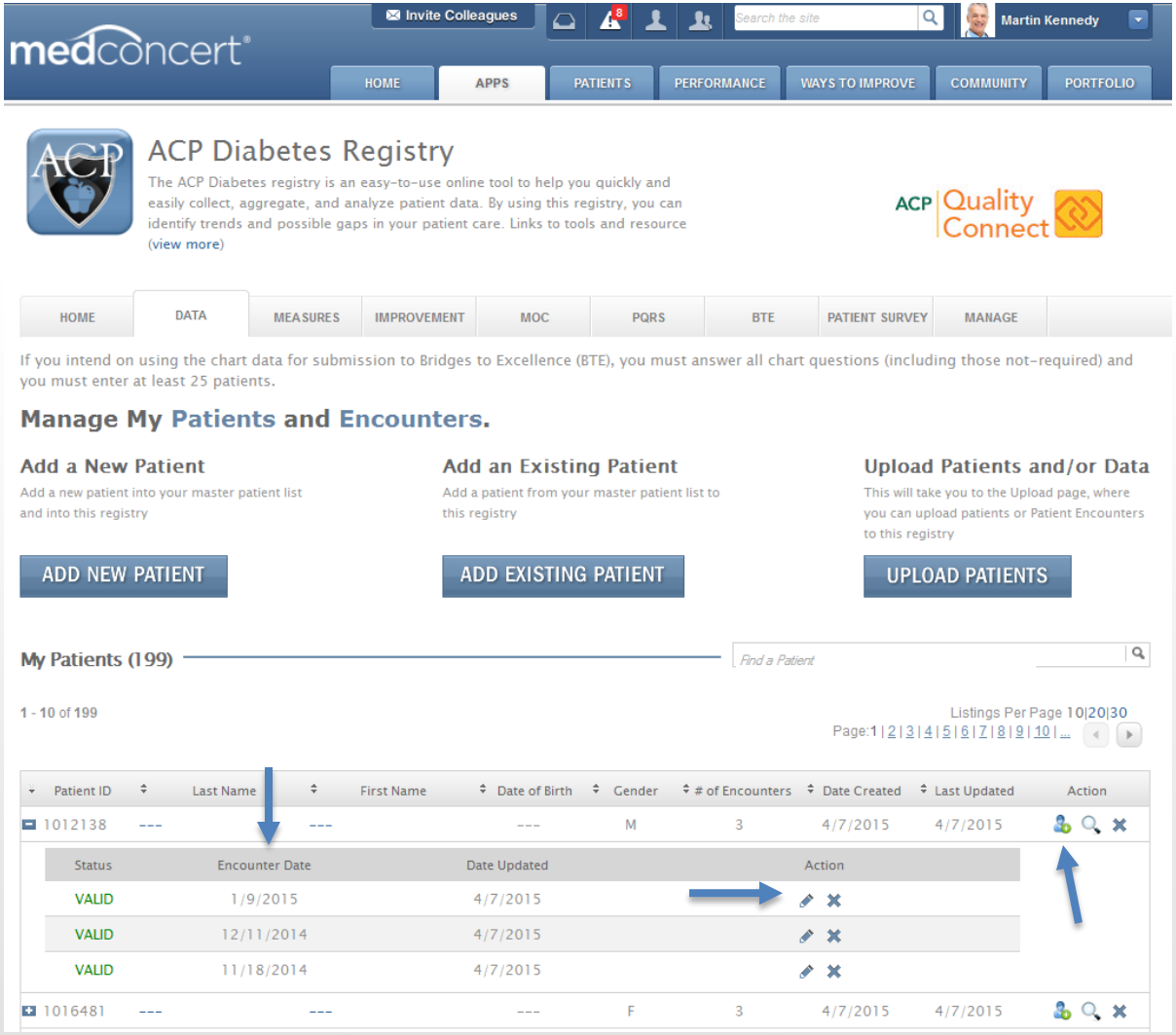
[ What if multiple blood pressures are taken on the same visit date? ]
- Most recent systolic blood pressure < 140 mmHg (G8752)
- Most recent systolic blood pressure ≥ 140 mmHg (G8753)
- Blood pressure measurement was not performed or documented (2000F-8P)

Most recent systolic level: 122

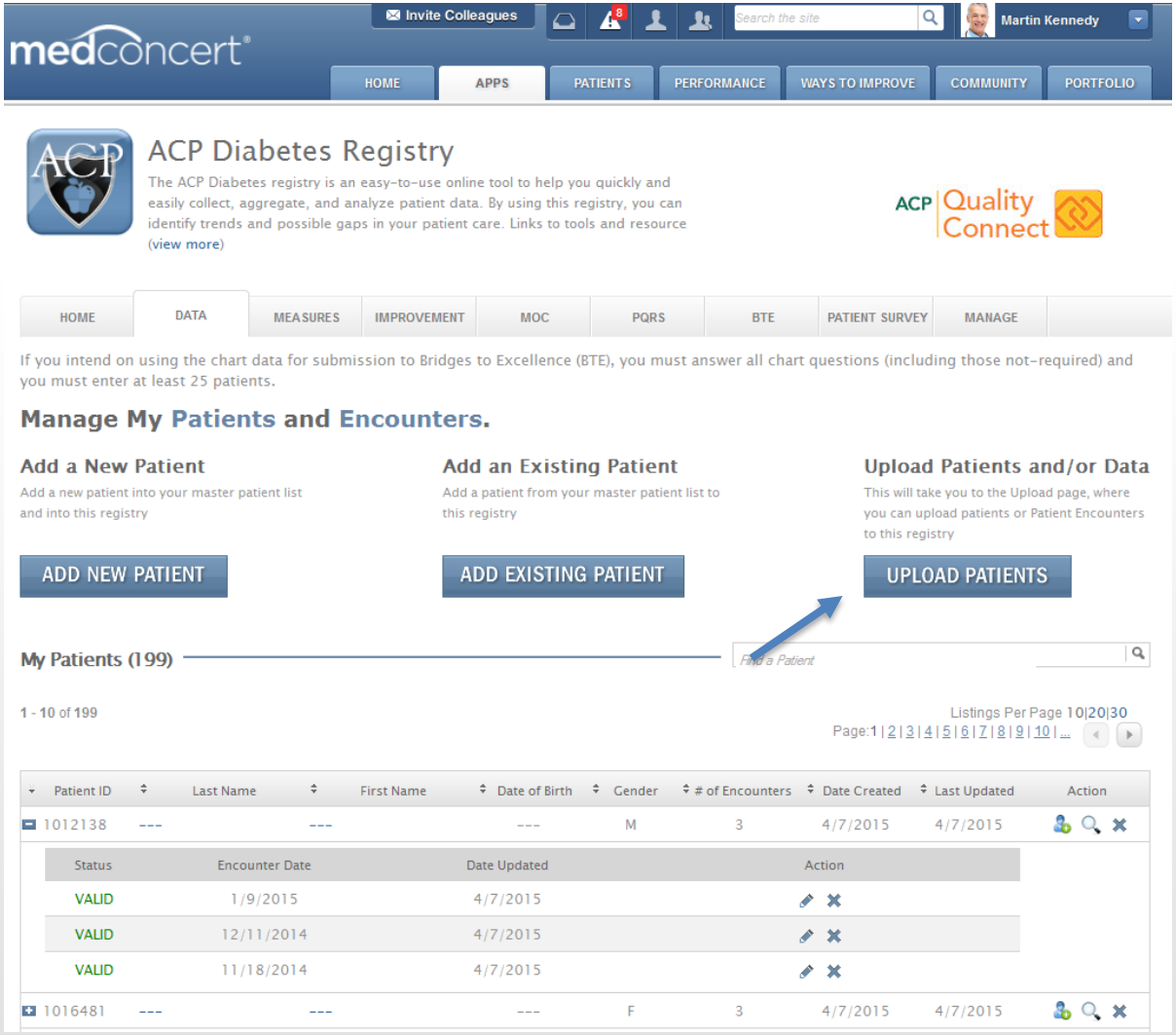
What was the most recent diastolic blood pressure measurement taken within 12 months? *

[ What if multiple blood pressures are taken on the same visit date? ]
- Most recent diastolic blood pressure < 90 mmHg (G8754)
- Most recent diastolic blood pressure ≥ 90 mmHg (G8755)
- Blood pressure measurement was not performed or documented (2000F-8P)

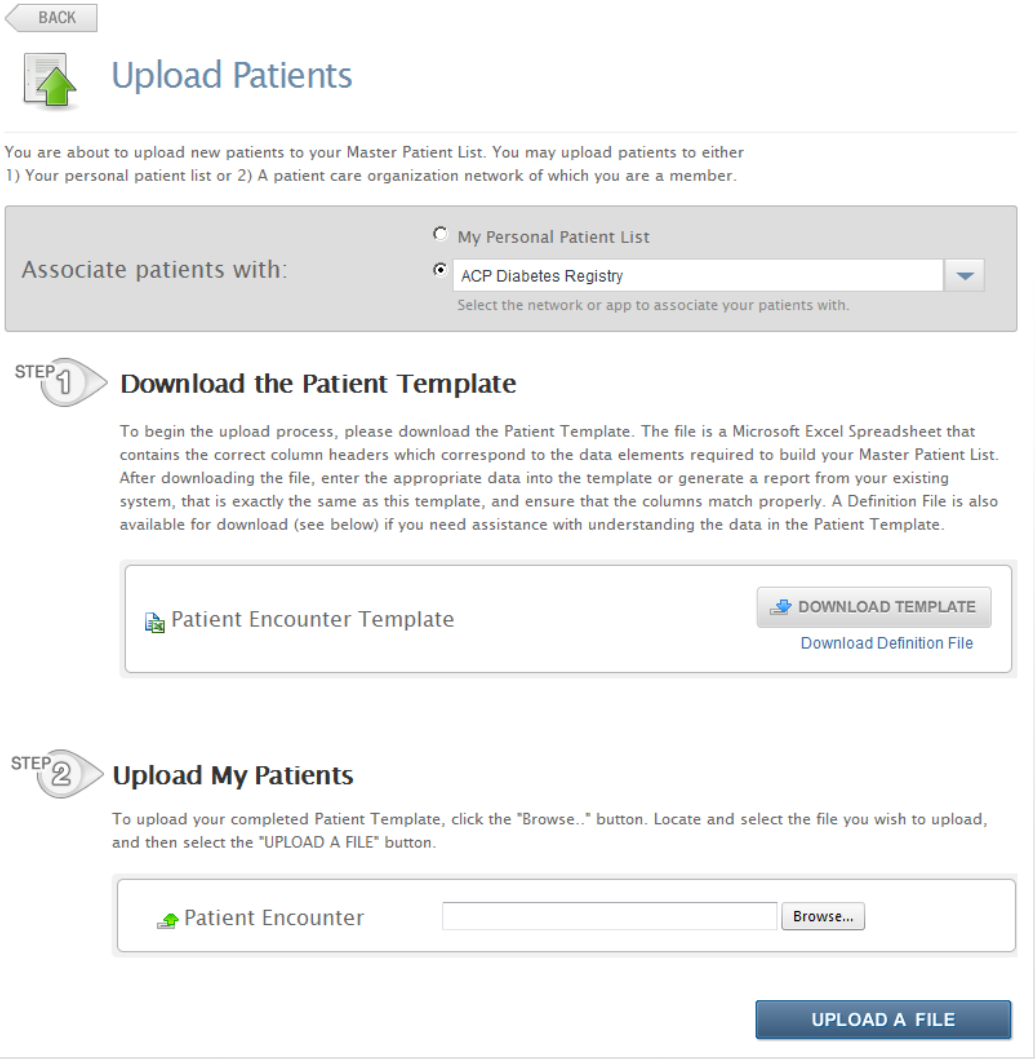
# Enter Additional Patient Visits



# How to enter data



# Upload Your Data



# Upload Your Data

| | A | B | C | G | H | I | J | K | L |
|---|---|---|---|---|---|---|---|---|---|
| 1 | PATIENT_IDENTIFIER | PATIENT_VISIT_DATE | PATIENT_AGE | ACP_Diabetes_Diagnosis_Code | ACP_Diabetes_Encounter_Code | ACP_Diabetes_Medicare | ACP_Diabetes_Hemoglobin | ACP_HbA1c_Level | ACP_HbA1c_Date |
| 2 | 2001325 | 10/9/2014 | 55 | 250.00 | 99201 | Yes | 3044F | 6.8 | 10/9/2014 |
| 3 | 2001325 | 11/1/2014 | 55 | 250.00 | 99215 | Yes | 3044F | 6.8 | 11/1/2014 |
| 4 | 2001325 | 12/1/2014 | 55 | 250.00 | 99232 | Yes | 3044F | 6.8 | 12/1/2014 |
| 5 | 2002462 | 10/10/2014 | 57 | 250.40 | 99204 | Yes | 3046F | 9.2 | 10/10/2014 |
| 6 | 2002462 | 11/2/2014 | 57 | 250.40 | 99212 | Yes | 3044F | 6.8 | 11/2/2014 |
| 7 | 2002462 | 12/1/2014 | 57 | 250.40 | 99217 | Yes | 3045F | 8.3 | 12/1/2014 |
| 8 | 2003893 | 10/11/2014 | 61 | 250.62 | 99325 | Yes | 3046F | 9.2 | 10/11/2014 |
| 9 | 2003893 | 11/3/2014 | 61 | 250.62 | 99341 | Yes | 3046F | 9.2 | 11/3/2014 |
| 10 | 2003893 | 12/1/2014 | 61 | 250.62 | 99344 | Yes | 3044F | 6.8 | 12/1/2014 |
| 11 | 2002217 | 10/12/2014 | 63 | 250.10 | 99201 | Yes | 3046F | 9.2 | 10/12/2014 |
| 12 | 2002217 | 11/4/2014 | 63 | 250.10 | 99215 | Yes | 3046F | 9.2 | 11/4/2014 |
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| 19 | 2002333 | 12/4/2014 | 60 | 250.40 | 99344 | Yes | 3046F-8P | | |
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| 21 | 2001976 | 11/7/2014 | 59 | 250.62 | 99215 | Yes | 3046F | 9.2 | 11/7/2014 |
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| 26 | 2001957 | 10/17/2014 | 67 | 250.00 | 99325 | Yes | 3046F | 9.2 | 10/17/2014 |
| 27 | 2001957 | 11/9/2014 | 67 | 250.00 | 99341 | Yes | 3046F | 9.2 | 11/9/2014 |
| 28 | 2001957 | 12/7/2014 | 67 | 250.00 | 99344 | Yes | 3044F | 6.8 | 12/7/2014 |
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| 30 | 2003646 | 11/10/2014 | 66 | 250.40 | 99215 | Yes | 3044F | 6.8 | 11/10/2014 |
| 31 | 2003646 | 12/8/2014 | 66 | 250.40 | 99232 | Yes | 3044F | 6.8 | 12/8/2014 |
| 32 | 2003540 | 10/19/2014 | 64 | 250.62 | 99204 | Yes | 3046F | 9.2 | 10/19/2014 |

# Upload Your Data

**Your patient list is being uploaded.**

## Review Your Upload

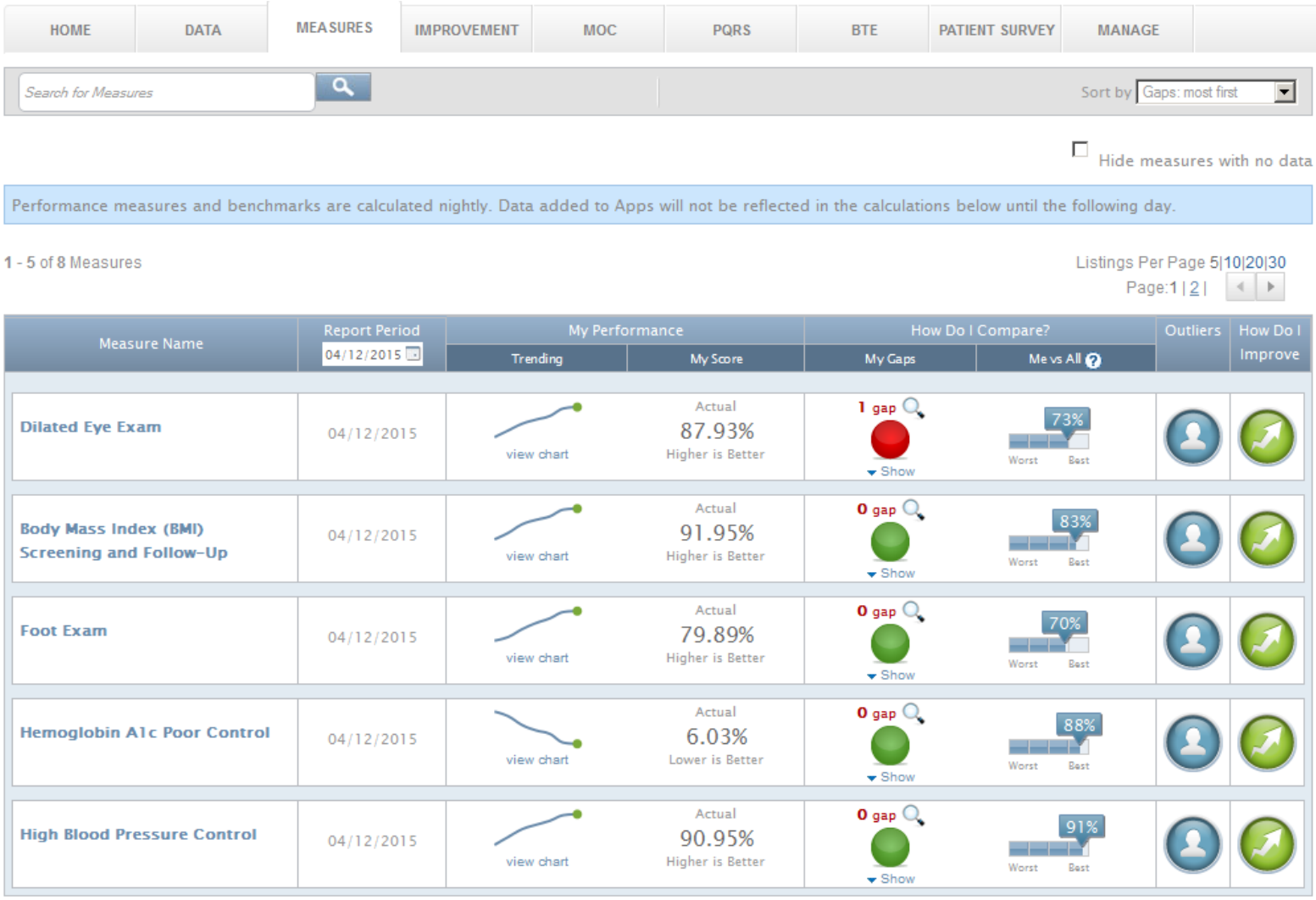
The file(s) you have uploaded appear in the queue below. Please review to ensure that your file(s) uploaded successfully.

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.

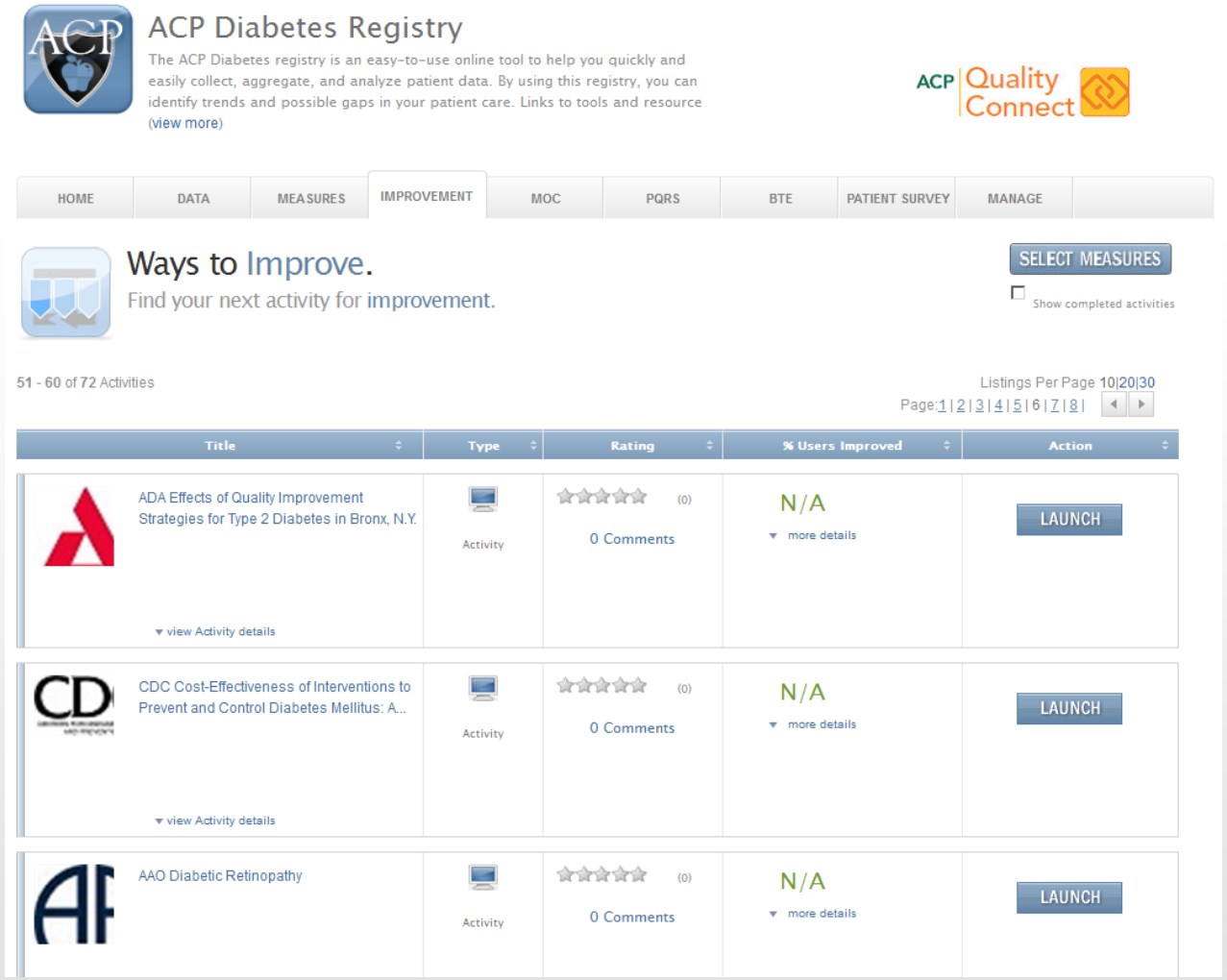
Note that after making corrections you may re-upload the entire file, our system will block any duplicate patient entries.

| Date Created | File Type | Status | Total Records | Records Processed | Processed Successfully | Errors Encountered | Reports |
|---|---|---|---|---|---|---|---|
| 4/7/2015 5:31:33 PM | XLSX | Complete | 597 | 597 | 597 | 0 | Download Original |
| 4/7/2015 5:29:36 PM | XLSX | Failure | 597 | 4 | 0 | 4 | Download Original<br>Download Error Log<br>Download Errors |

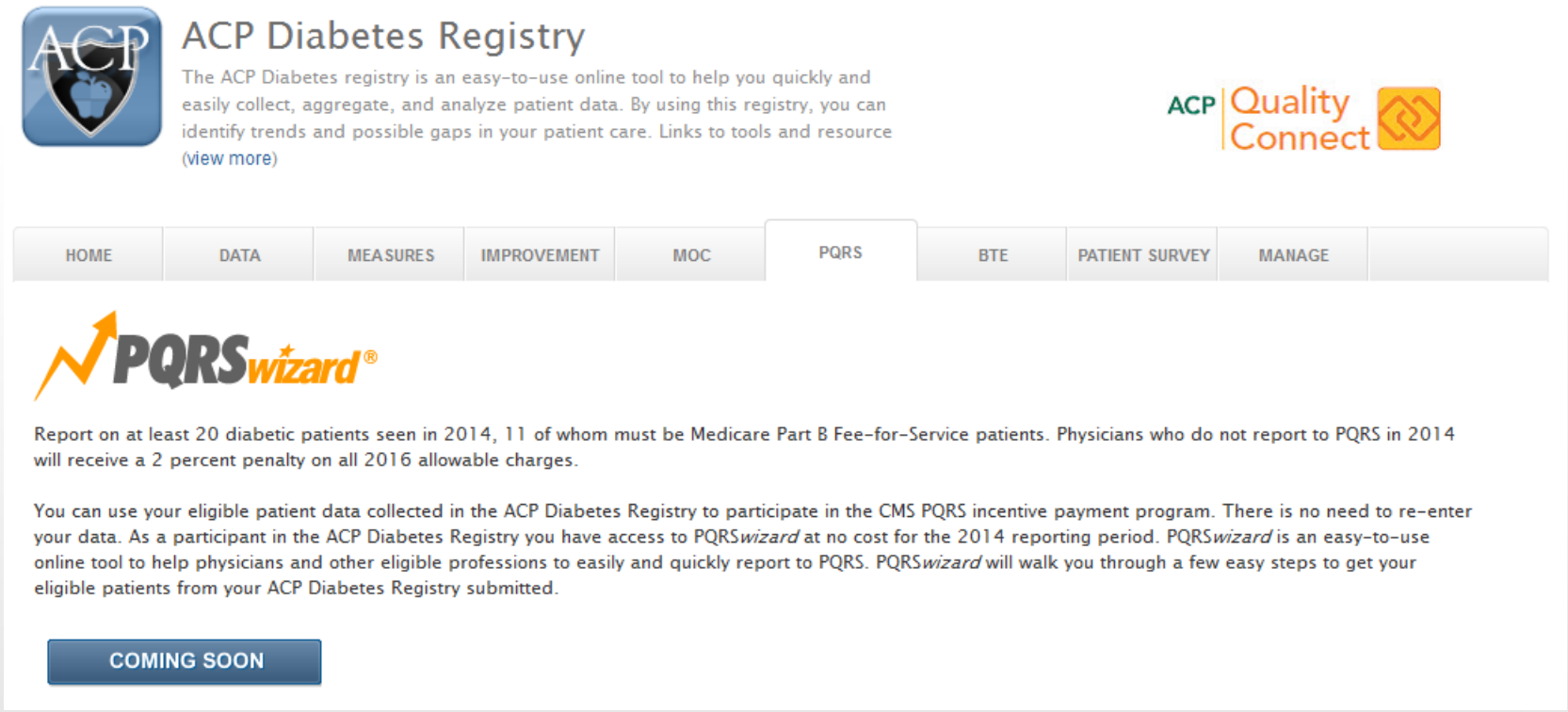
# Your Personal Dashboard View by Measure



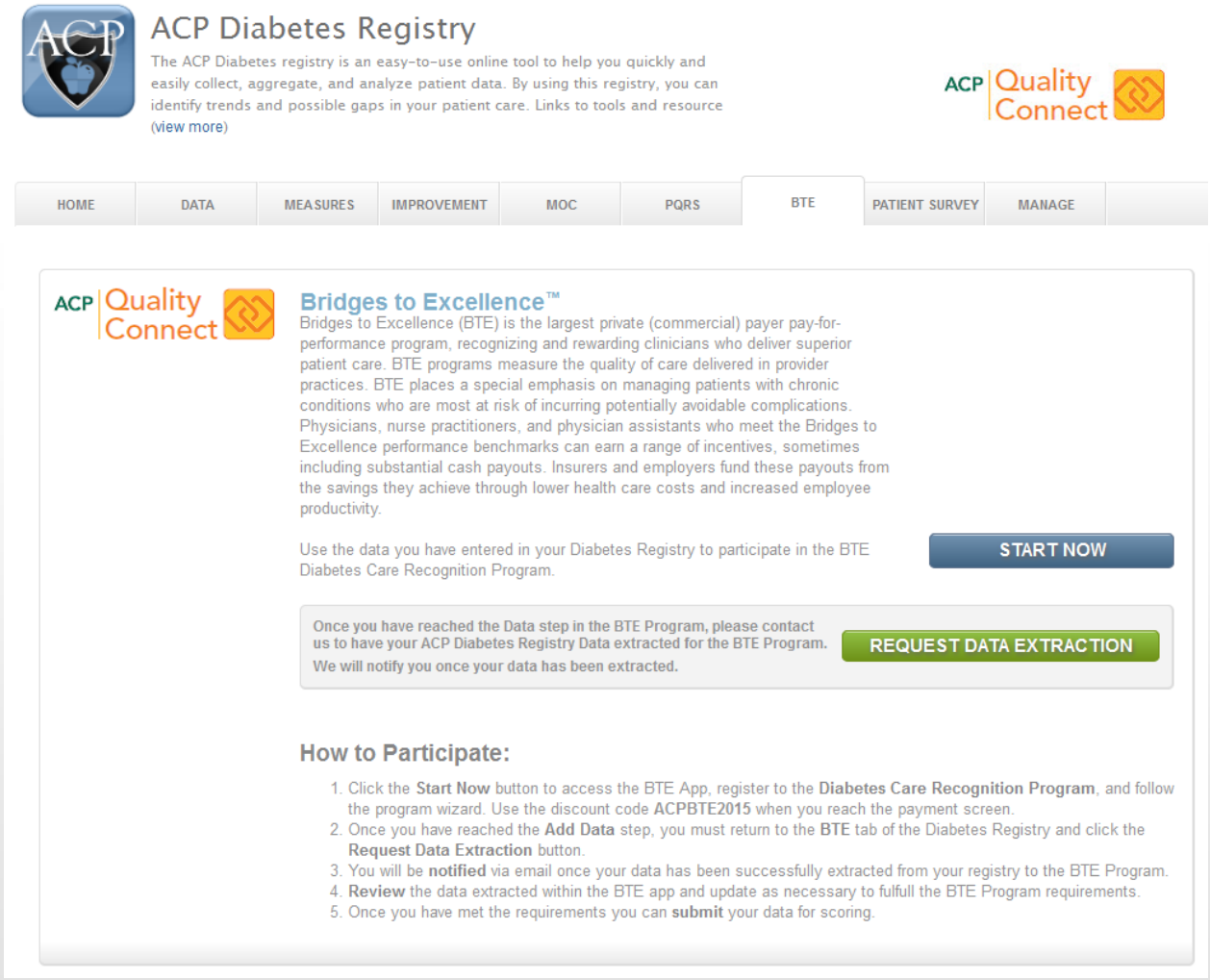
# Ways to Improve is linked right from your dashboard



# Ability to submit for PQRS 2015 at no charge



# Bridges to Excellence



# 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!

# HIT ; Quality Improvement; Referrals

**Adam Baus, PhD, MA, MPH | West Virginia University School of Public Health**

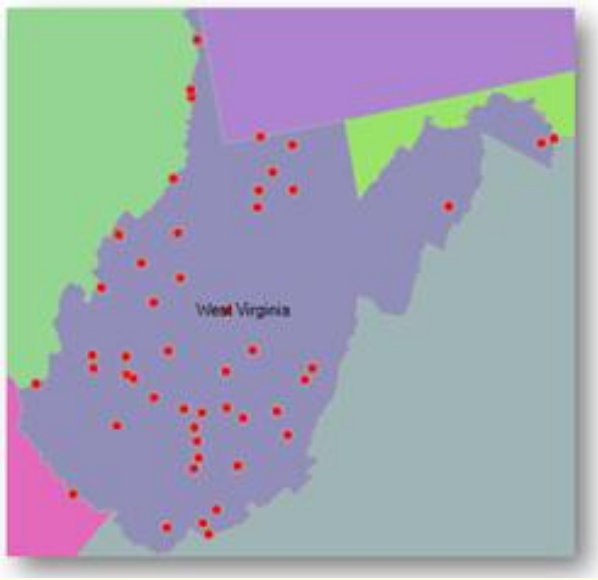
**Assistant Director | Office of Health Services Research**

**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



# WVU Office of Health Services Research

**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**

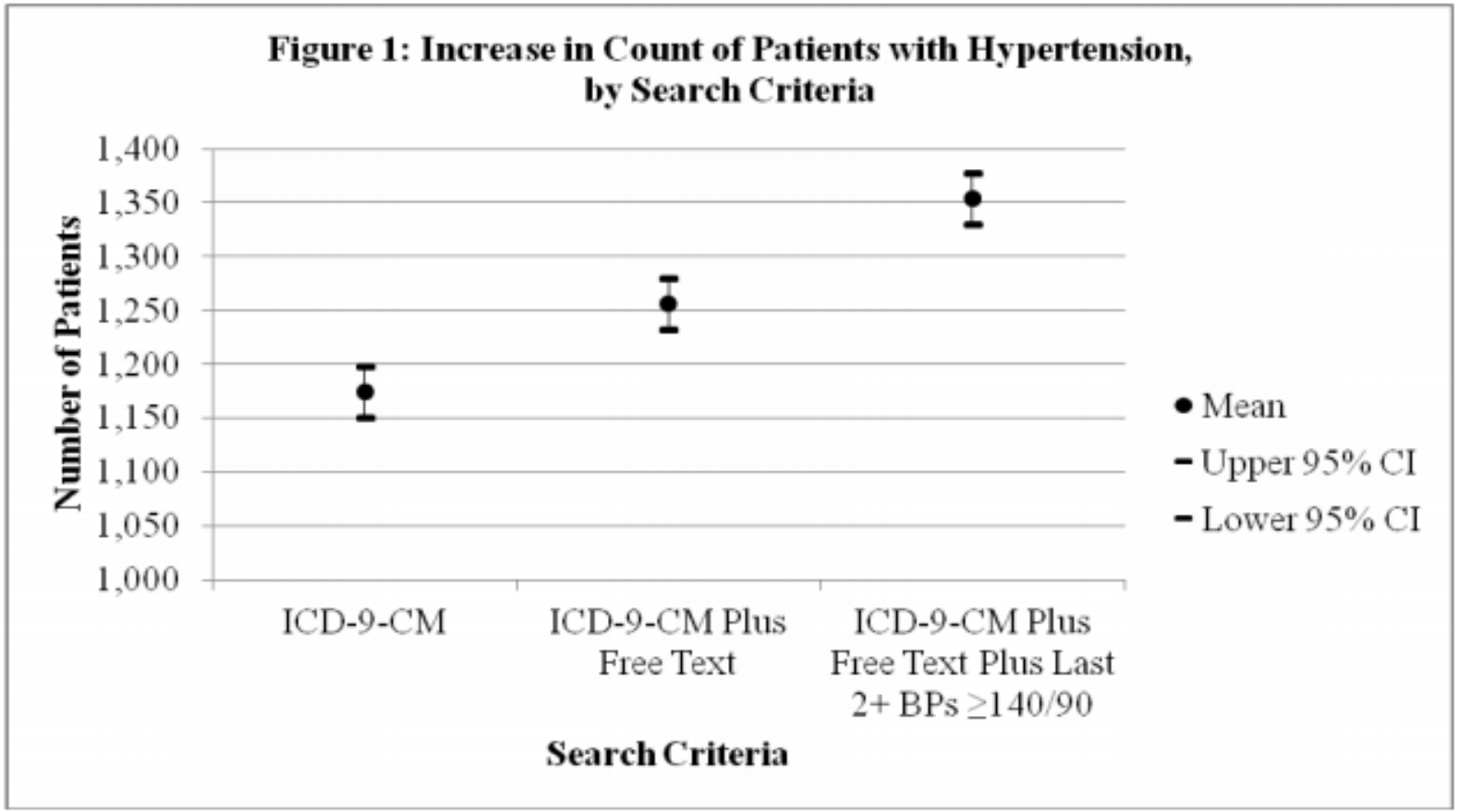
- An example: Finding patients undiagnosed with hypertension
  - Started as a by-product of helping centers report on blood pressure outcomes of patients with diagnosed hypertension
  - Led us to more closely look at data quality

# WVU Office of Health Services Research

| Primary Care Center | A: Patients with Hypertension: ICD-9-CM Coding | B: Patients with Hypertension: ICD-9-CM Coding Plus Free Text | C: Patients with Hypertension: ICD-9-CM Coding Plus Free Text Plus Last 2+ Blood Pressure Readings ≥140/90 mm Hg | Percent Missed Based on ICD-9-CM Coding Only (100% − A/C) |
|---|---|---|---|---|
| A | 5,124 | 5,270 | 5,535 | 7.4% |
| B | 1,605 | 1,868 | 1,945 | 17.5% |
| C | 476 | 505 | 596 | 20.1% |
| D | 658 | 660 | 724 | 9.1% |
| E | 852 | 859 | 884 | 3.6% |
| F | 313 | 313 | 325 | 3.7% |
| G | 228 | 418 | 438 | 47.9% |
| H | 396 | 407 | 446 | 11.2% |
| I | 666 | 714 | 749 | 11.1% |
| J | 1,143 | 1,217 | 1,526 | 25.1% |
| K | 1,458 | 1,586 | 1,725 | 15.5% |
| Sum | 12,919 | 13,817 | 14,893 | 13.3% |
| Mean | 1,174.45 | 1,256.09 | 1,353.91 | |
| Standard Deviation | 1,386.60 | 1,424.08 | 1,492.58 | |
| 95% CI, Lower | 1,150.49 | 1,232.26 | 1,329.93 | |
| 95% CI, Upper | 1,198.31 | 1,279.74 | 1,377.87 | |

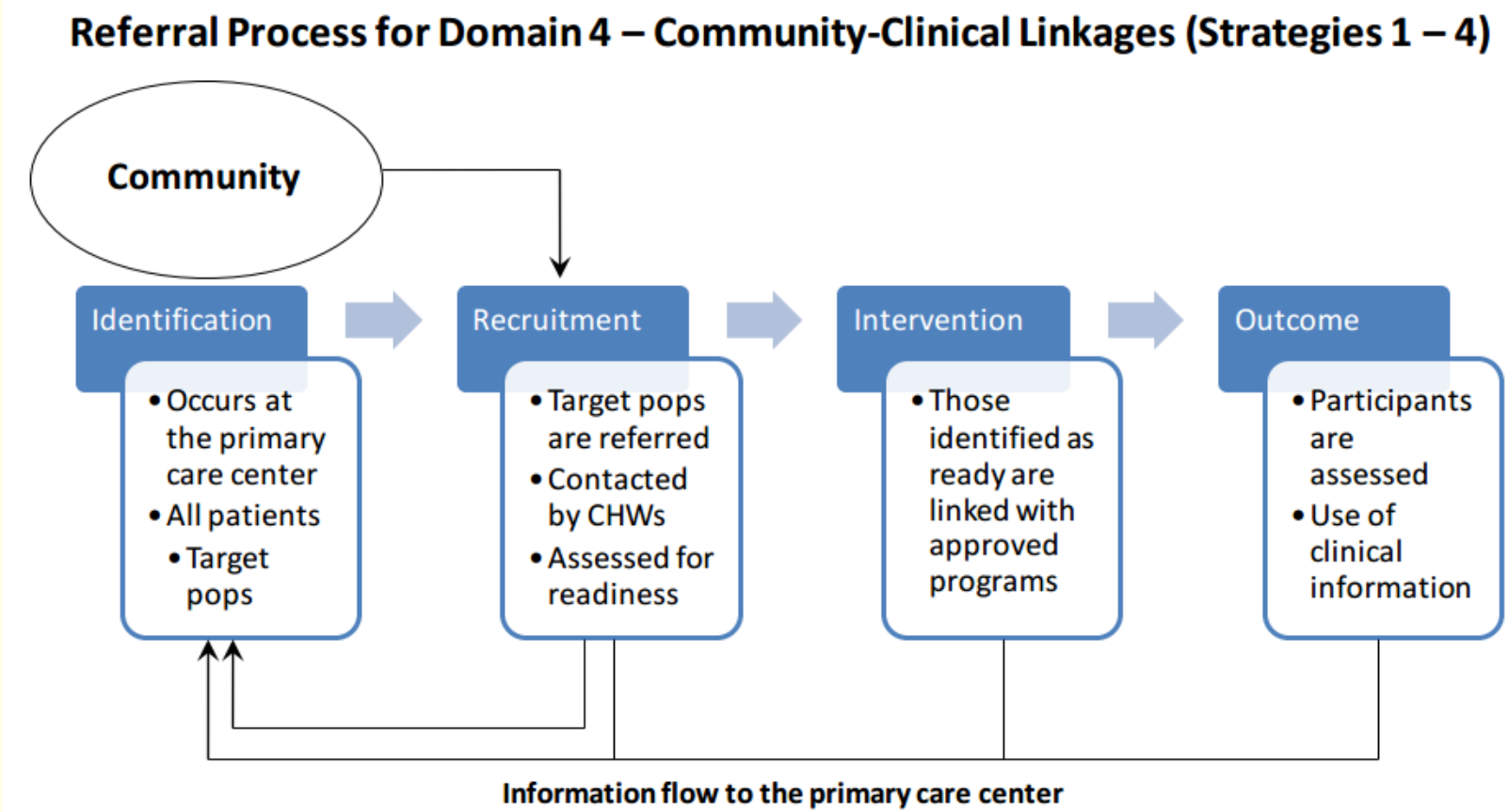
- 13.3% of patients missed by ICD-9 coding alone
  - 47.9% of patients with hypertension were undiagnosed in one clinic

# WVU Office of Health Services Research




*Note*: Figure shows statistically significant increases in identification of essential hypertension cases using three search criteria methods.

# Strengthen referral processes to community-based programs




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**

# Team-Base care; Self-Management Programs

Krista Capehart, PharmD, MSPharm

Director of the Wigner Institute,

kdcapehart@hsc.wvu.edu

# WVU School of Pharmacy – Wigner Institute

## 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

# WVU School of Pharmacy – Wigner Institute

**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

# Wellness Council of WV

# Who are we?

- **Membership based Organization**

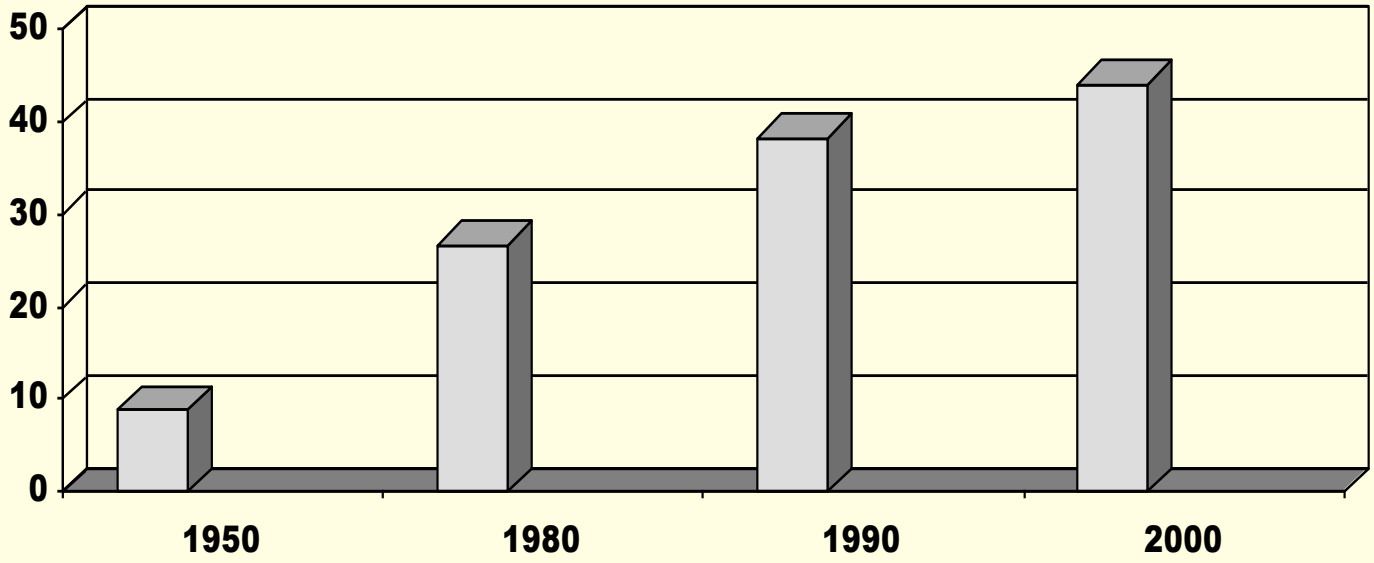
- **Benefits**
  - Awards Process
  - Consulting
  - Networking
  - Education
  - Events

# 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

# 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.

# Wellness Council of WV


## Wellness Council of WV

**806 B Street**

**St. Albans, WV  25177**

**(304) 722-8070**

**info@wcwv.org**

**www.wcwv.org**

# Putting it all together!

**Carroll Christiansen, MD**

**Roane County Family Health Care**

# View from Primary 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**

# View from Primary Care

## 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

# View from Primary Care

## Barriers

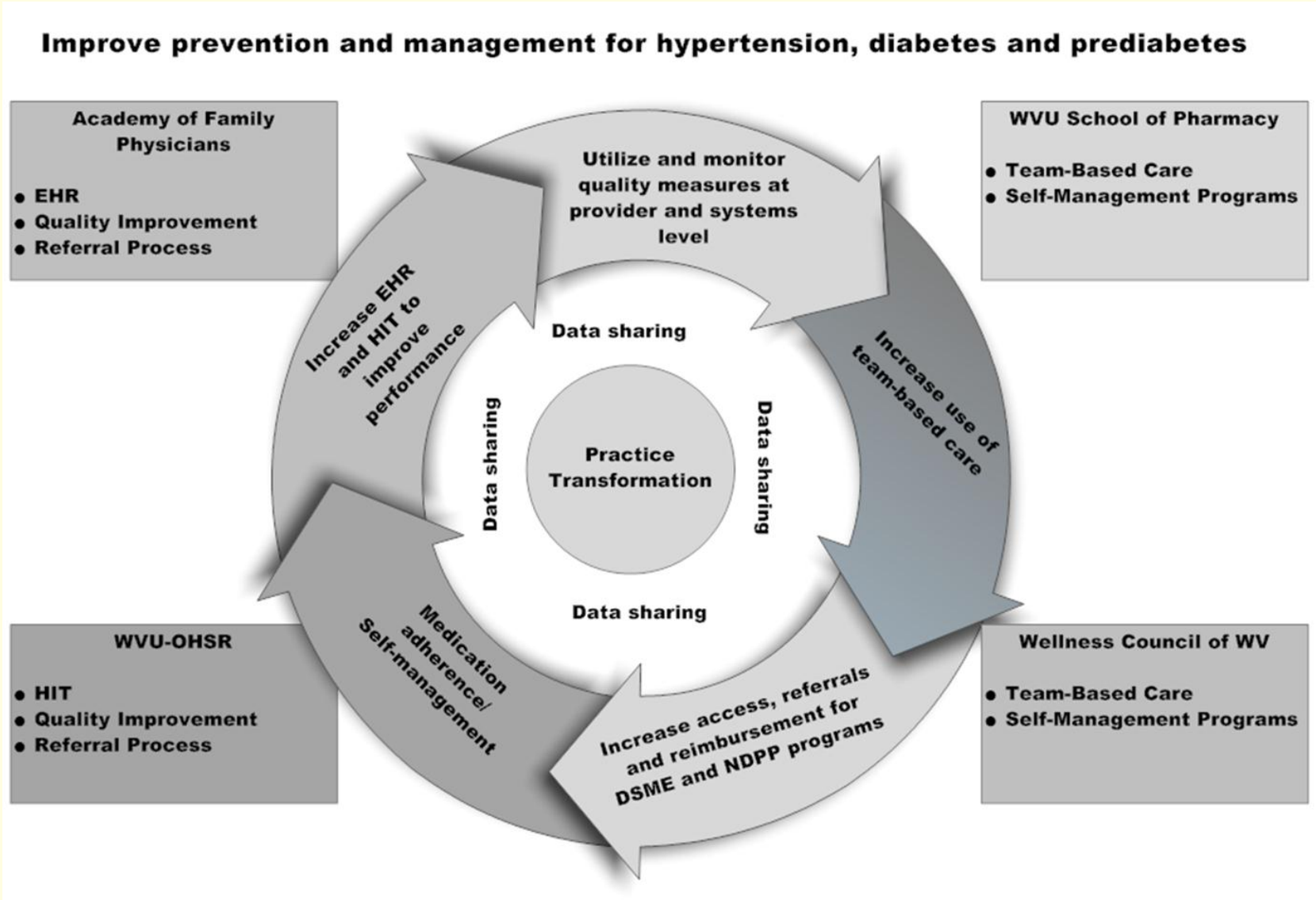
- **Lack of unified definitions for care measures – ie. UDS, CDC, PQRS, Meaningful Use**
- **Time constraints**
- **Inefficient data entry processes**
- **The EHR is a billing platform- not conducive to clinical work-flow**

# Thank you!

**Carroll Christiansen, MD**

**Roane County Family Health Care**

# Practice Transformation



# 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**

# Questions & Answers

# 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?**

**Jessica.G.Wright@wv.gov**
**(304) 356-4229**