

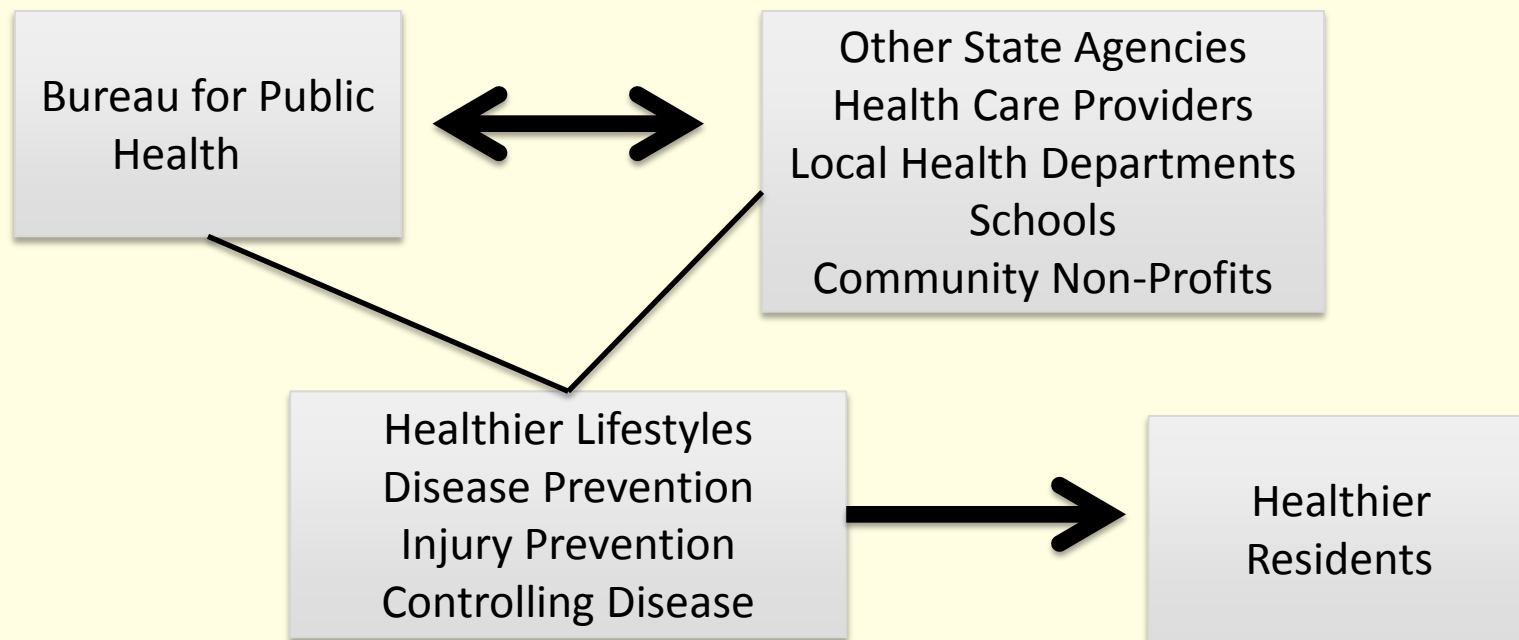
Health Promotion and Chronic Disease: Advocating for Chronic Disease Management and Prevention

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

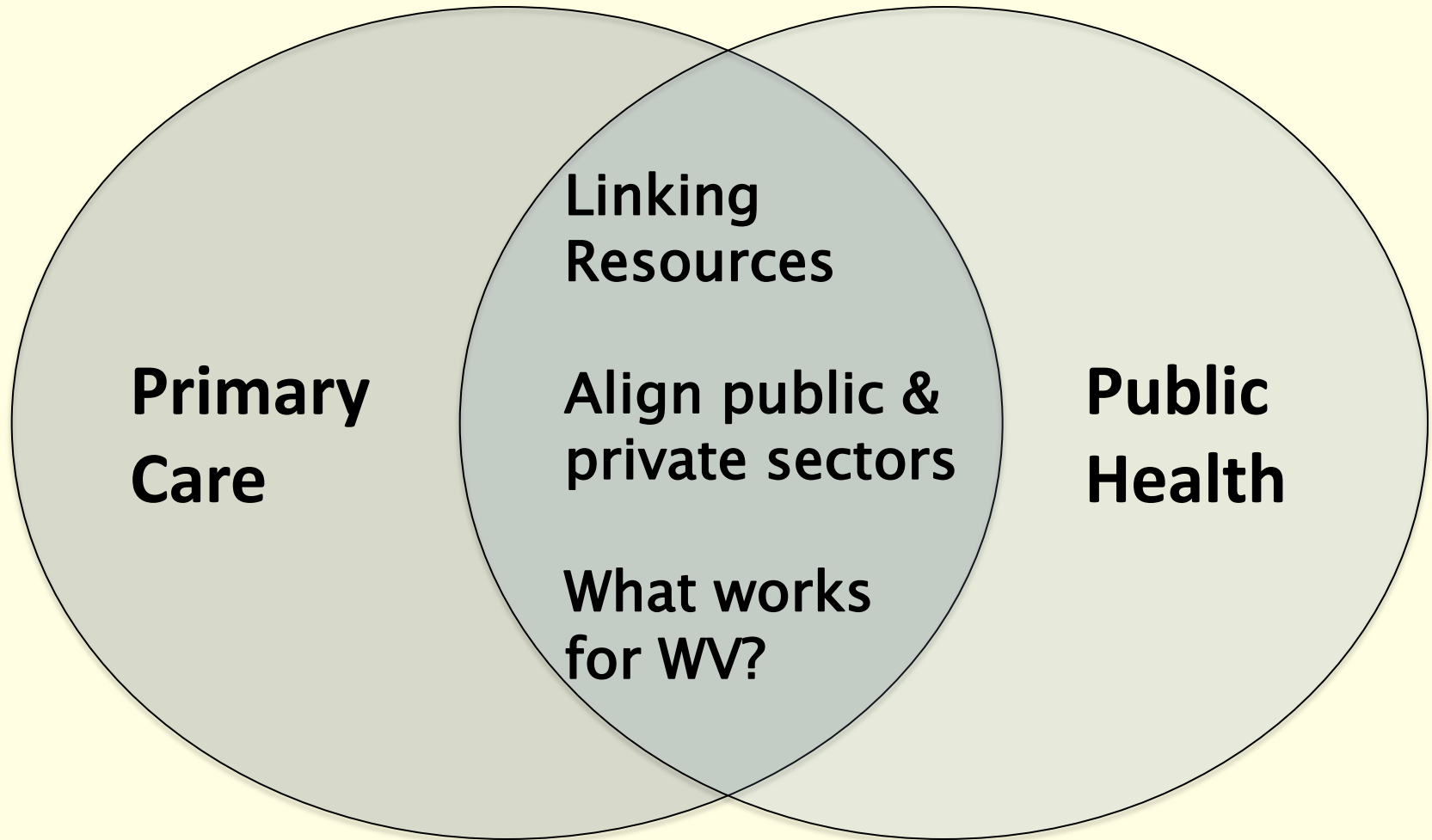


Using a Systems Approach

- 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

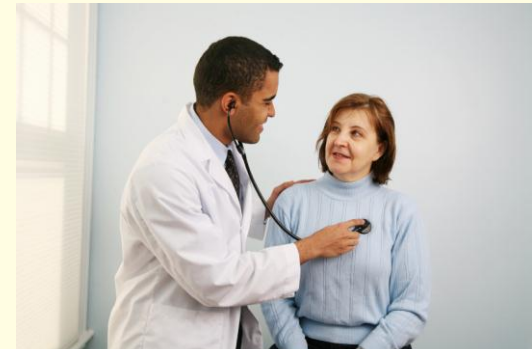


Link public health more effectively with health systems:

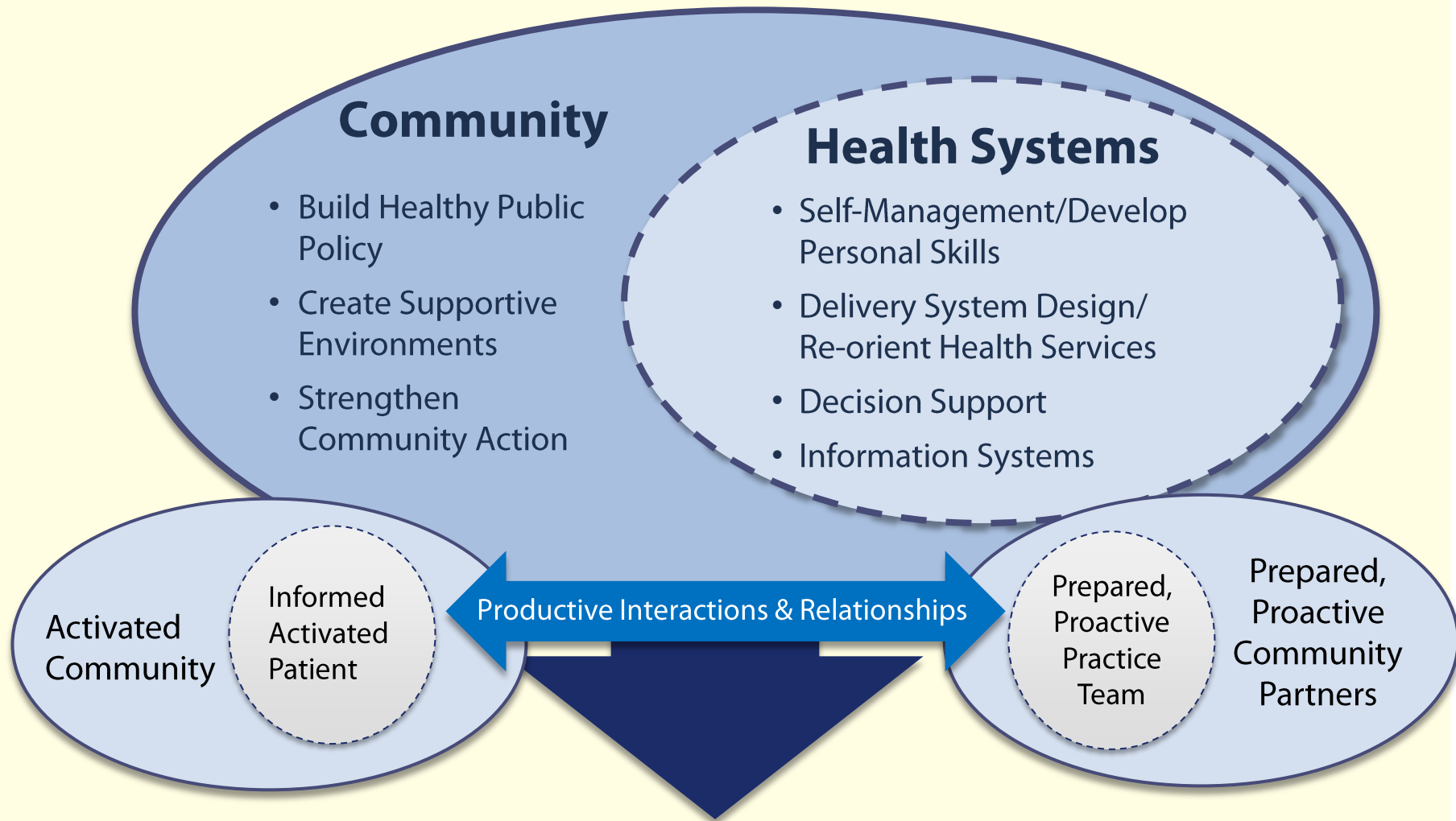
- **Using community resources and supportive environments to complement and strengthen delivery of clinical care**

Moving from Sick Care to Preventive Care

Challenges



Expanded Chronic Care Model



Population Health Outcomes /Functional and Clinical Outcomes

Contact Information

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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



- 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

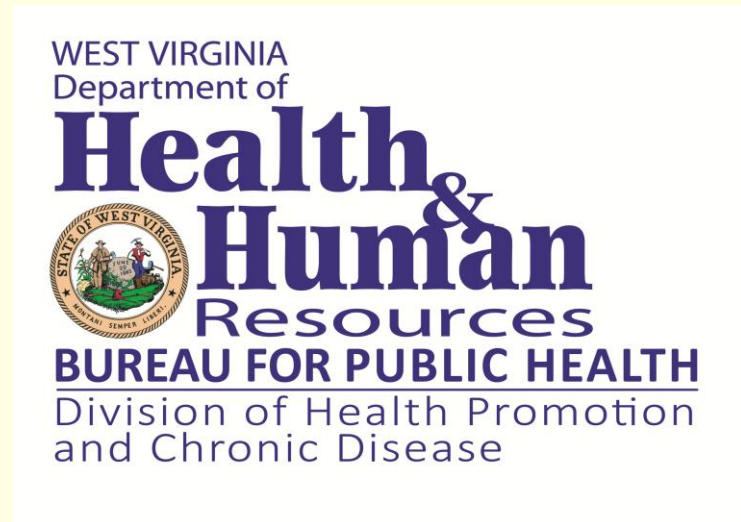
- Bureau for Public Health Practice Transformation Project**

- Partner Resources available to AFP members**

West Virginia Division of Health Promotion and Chronic Disease (HPCD)

Mission:

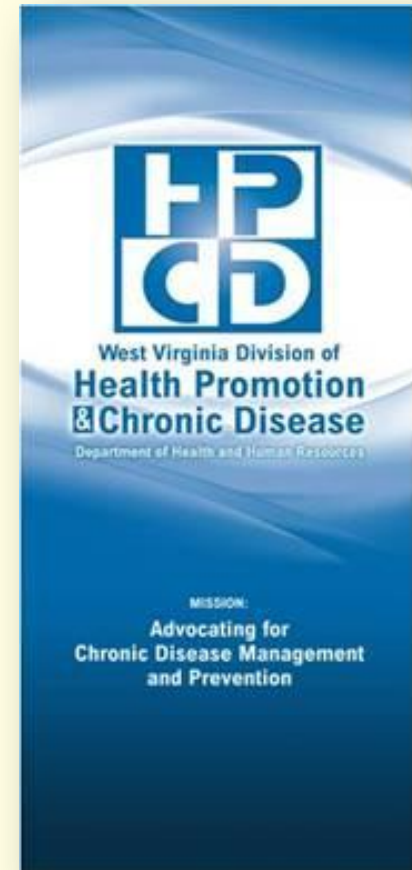
*“Advocate for
chronic disease
management and
prevention”*



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



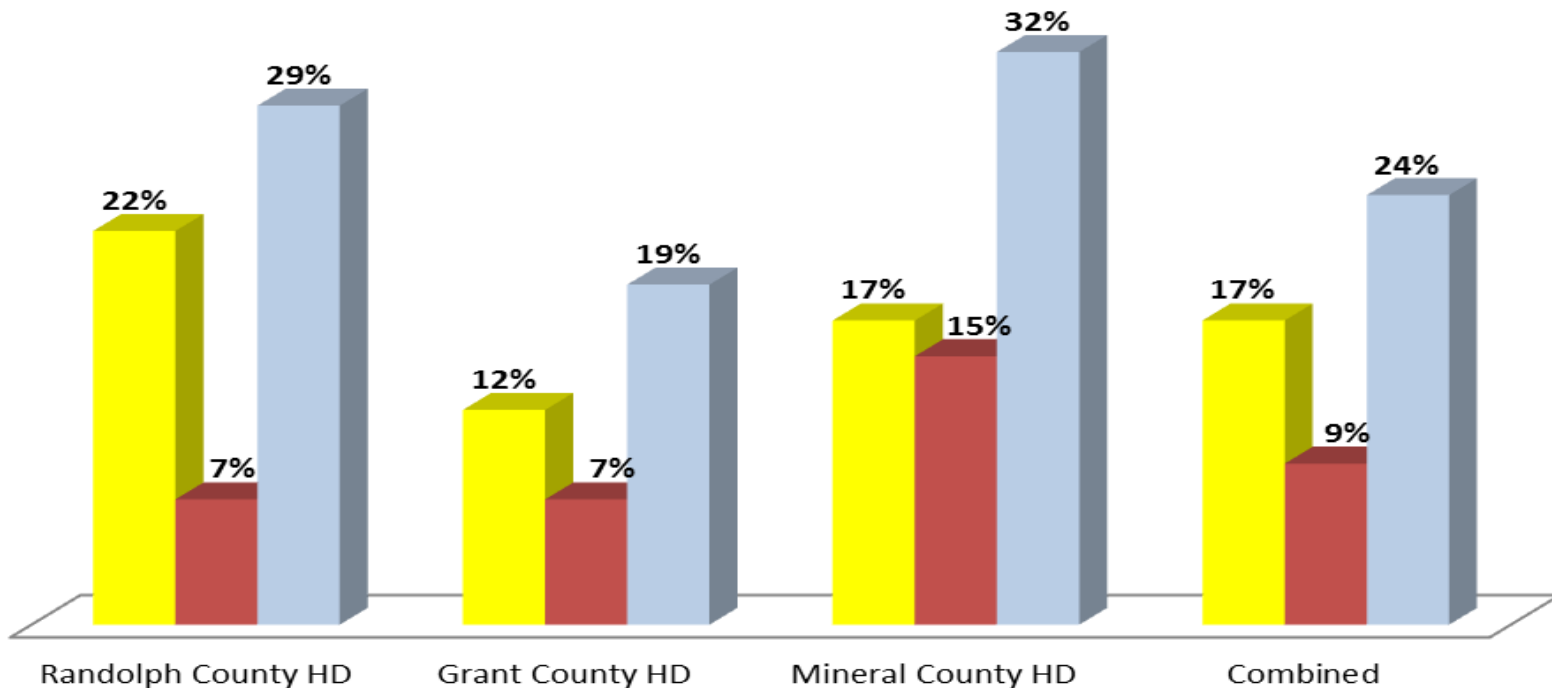
Project Background

- **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

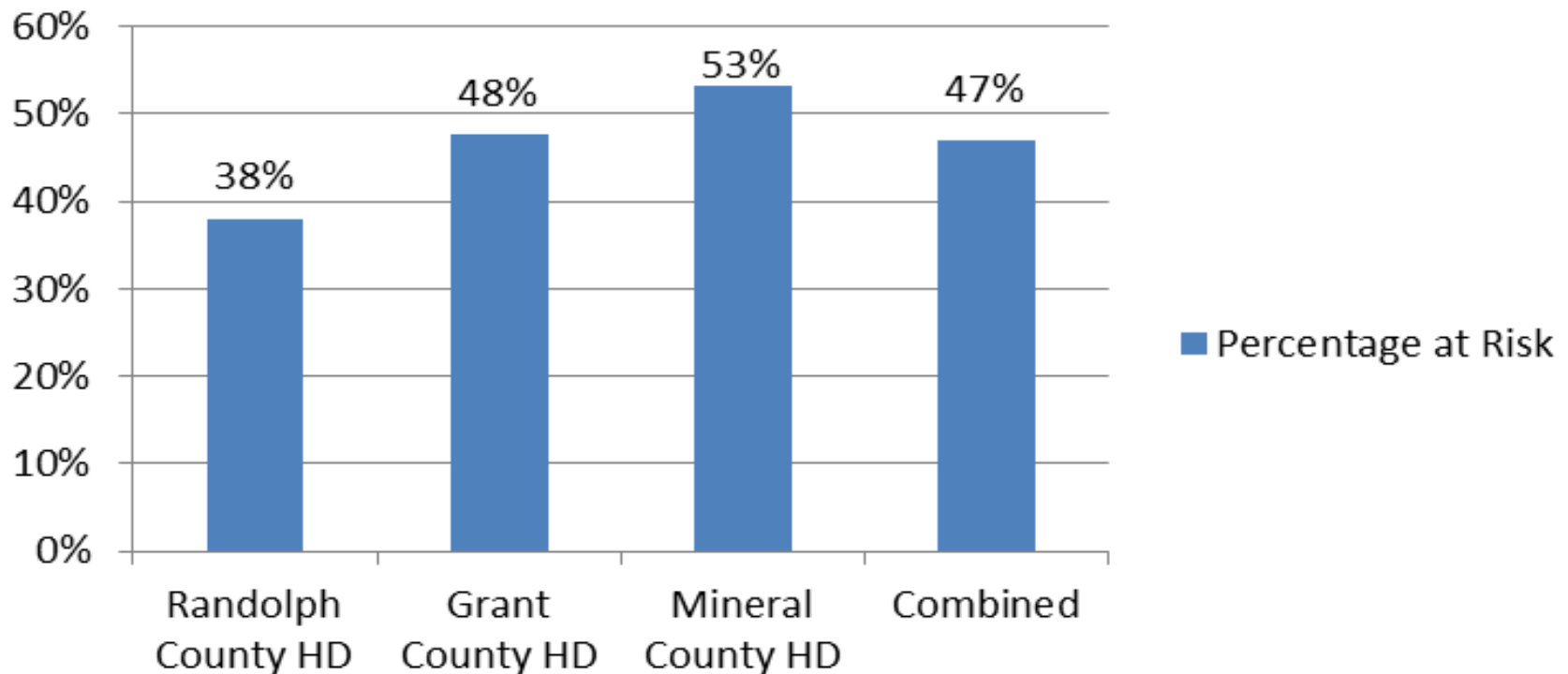
WV Health Department Pilot Outcomes - Blood Pressure Readings in Person Not Previously Diagnosed with High Blood Pressure - 2014

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



Prediabetes

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



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”

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 **S**creen, **T**est, & **A**ct **T**oday
- **S**creen **y**our patients for pre-diabetes using the CDC Pre-diabetes Screening Test (or the American Diabetes Association Diabetes Risk Test)
- **T**est your patients for pre-diabetes using one of three blood tests (A1C, FBS, OGTT)
- **A**ct **t**oday 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

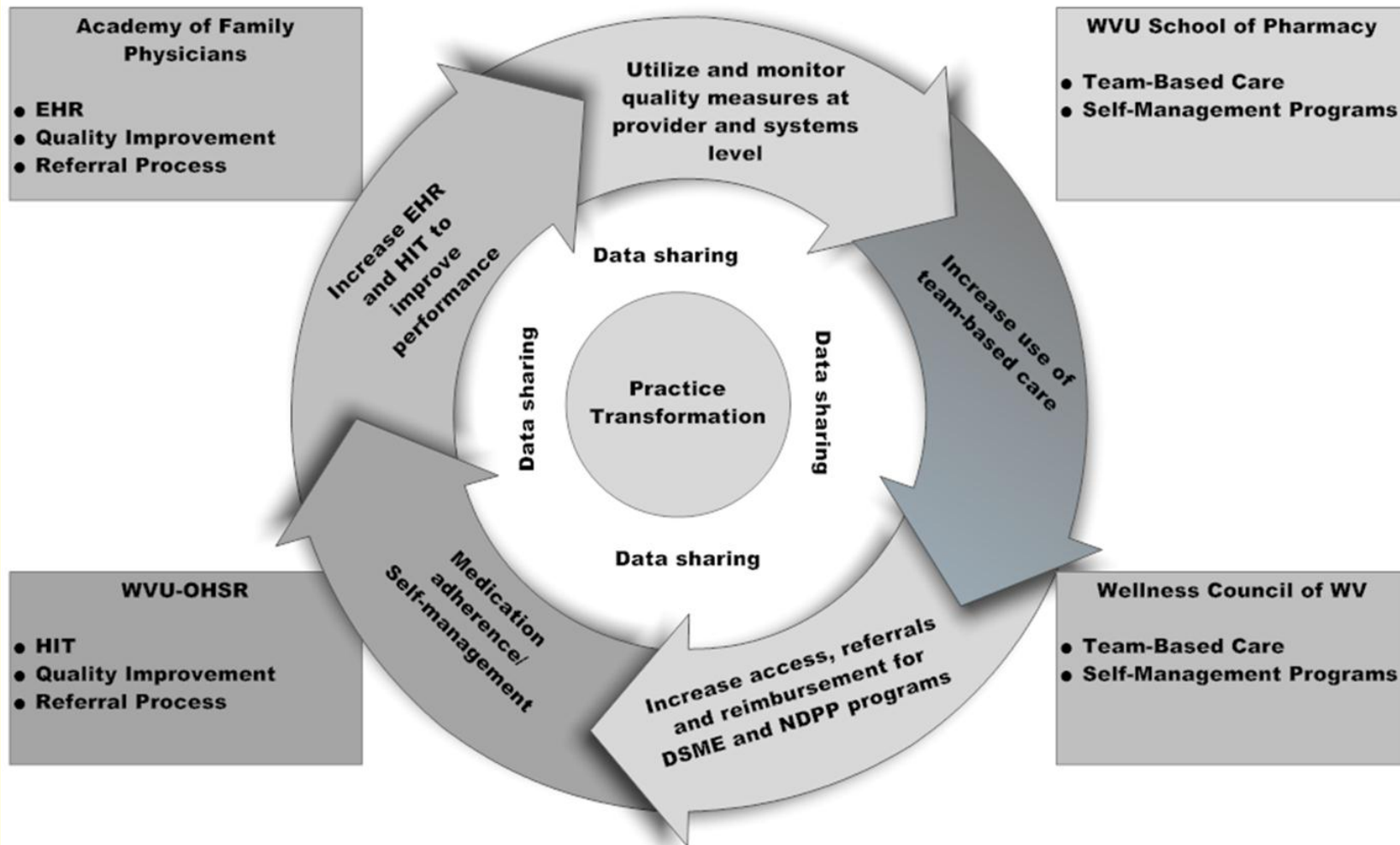
- Seeking to make it easier for you to identify DSME programs in your communities
- Two questions for you to respond to:
 - Are you referring patients to DSME programs?
 - What prohibits referrals to DSME programs?

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



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

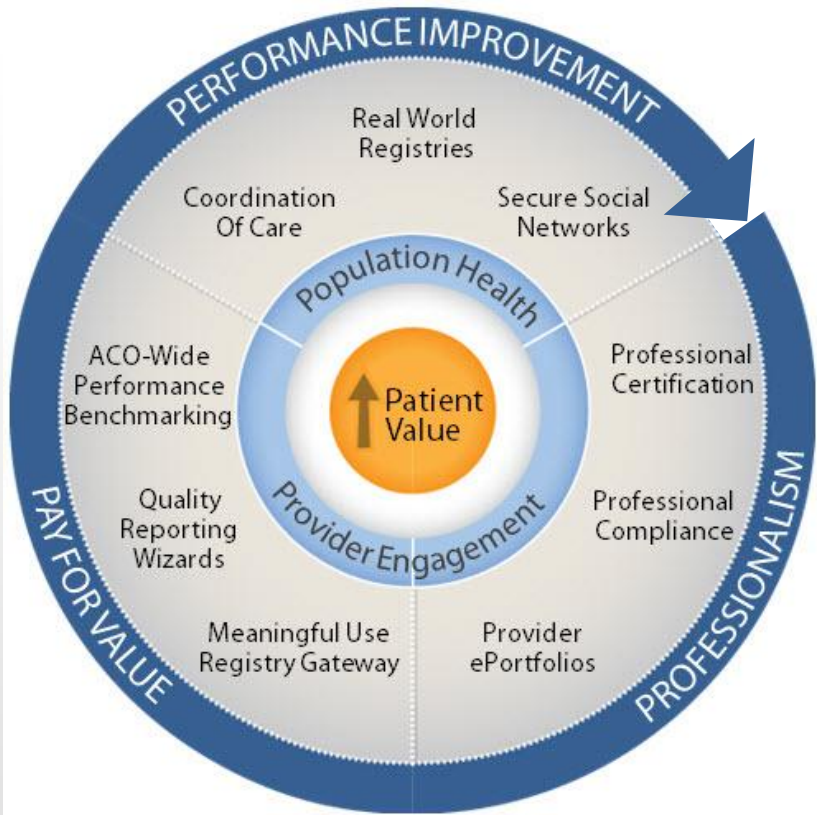
Dan Gold
Sr. Configuration and QA Specialist
CECity

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

A collection of logos for trusted and exclusive partnerships, including:

- American Board of Internal Medicine (ABIM)
- American Board of Medical Specialties (ABMS)
- NBME®
- Federation of State Medical Boards (FSMB)
- AAMC
- PQA (Pharmacy Quality Alliance)
- JOHNS HOPKINS MEDICINE
- ARMSTRONG INSTITUTE FOR PATIENT SAFETY AND QUALITY
- BRIDGES to Excellence
- AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)
- STRONG MEDICINE FOR AMERICA
- AMERICAN MEDICAL ASSOCIATION (AMA)
- Schumachergroup
- athenahealth
- RITE AID PHARMACY
- CVS/pharmacy
- ACCP (American College of Physicians)
- INTERNAL MEDICINE | Doctors for Adults
- HUMANA
- UPMC HEALTH PLAN
- Aetna™
- WEST VIRGINIA ACADEMY OF FAMILY PHYSICIANS
- STRONG MEDICINE FOR WEST VIRGINIA
- MERCK
- Genentech
- Pfizer
- WILEY

CECity PQRSwizard Registry-PQRSwizard

CECity's PQRS Solutions: PQRSwizard

- #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 PQRSwizard, 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	Performance 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



medconcert Invite Colleagues 8 Martin Kennedy

HOME APPS PATIENTS PERFORMANCE WAYS TO IMPROVE COMMUNITY PORTFOLIO

Martin Kennedy
Compose Post

Click here to access the Getting Started Wizard!
You can also access the Getting Started Wizard in My Account. Don't show again X

Private Messages Compose

"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

Share: **MESSAGE** CASE EVENT

Communicate and share! Type here...

"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.

My Apps Add An App

- Coordination of Care MedConcert
- Adult Patient Experience of Care Survey
- ACP Diabetes Registry American College of Physicians

[view all](#)

My Colleagues Invite

- Denise O'Brien
- Sandra Wilkins
- Alex Tyson

[view all](#)

My Networks Create

- West General Medical Center
Admin of group

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

[view more](#)

Things To Do

- Manage Your Portfolio

40%

Registry Overview

The screenshot shows the ACP Diabetes Registry website. At the top, there is a navigation bar with 'medconcert' logo, 'Invite Colleagues' button, and a search bar. Below the navigation bar are tabs for 'HOME', 'APPS', 'PATIENTS', 'PERFORMANCE', 'WAYS TO IMPROVE', 'COMMUNITY', and 'PORTFOLIO'. The main content area features the 'ACP Diabetes Registry' logo and a brief description: '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 resource (view more)'. To the right is the 'ACP Quality Connect' logo. Below this is a horizontal menu with tabs: 'Home', 'Data', 'Measures', 'Improvement', 'MOC', 'PQRS', 'BTE', and 'Patient Survey'. The main heading is 'Welcome to the American College of Physicians Diabetes Registry'. The text below reads: 'The ACP Diabetes Registry provides you with the ability to manually enter or upload patient data, measures your performance and provides you with tools/education to close performance gaps. Additionally, you can use your data towards participation in the PQRS 2014 program, ACP's Practice Advisor for Maintenance of Certification (MOC), Bridges to Excellence (BTE) Diabetes Recognition program and ABIM's Self-Directed Diabetes PIM.' The 'What You Can Do' section lists several actions with corresponding buttons: 'Enter Data' (ENTER PATIENT DATA), 'Review Measure Results' (REVIEW RESULTS), 'Find Ways to Improve' (HOW DO I IMPROVE?), 'MOC: ACP Practice Advisor for ABIM' (LEARN MORE), 'PQRS' (COMING SOON), 'Bridges to Excellence' (COMING SOON), and 'Patient Survey' (LEARN MORE). On the right side, there is a 'Measures' section with a list of metrics and their descriptions: 'Hemoglobin A1c Poor Control', 'Low Density Lipoprotein (LDL-C) Control', 'High Blood Pressure Control', 'Dilated Eye Exam', 'Medical Attention for Nephropathy', 'Foot Exam', 'Body Mass Index (BMI) Screening and Follow-up', and 'Tobacco Use: Screening and Cessation Intervention'.

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

medconcert Invite Colleagues Search the site Martin Kennedy

HOME APPS PATIENTS PERFORMANCE WAYS TO IMPROVE COMMUNITY PORTFOLIO

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 resource \(view more\)](#)

ACP Quality Connect

HOME DATA MEASURES IMPROVEMENT MOC PQRS BTE PATIENT SURVEY MANAGE

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

ADD NEW PATIENT **ADD EXISTING PATIENT** **UPLOAD PATIENTS**

My Patients (199) Find a Patient

1 - 10 of 199 Listings Per Page 10|20|30 Page:1|2|3|4|5|6|7|8|9|10|...

Patient ID	Last Name	First Name	Date of Birth	Gender	# of Encounters	Date Created	Last Updated	Action
1012138	--	--	---	M	3	4/7/2015	4/7/2015	
1016481	--	--	---	F	3	4/7/2015	4/7/2015	
1021272	--	--	---	F	3	4/7/2015	4/7/2015	

Add New Patient

medconcert

ACD

HOME

If you intend on using this patient, you must enter at least one address.

Manage My Patients

Add a New Patient

Add a new patient into your Master Patient List and enroll this patient into this registry.

ADD NEW PATIENT

My Patients (199)

1 - 10 of 199

Patient ID	Status
1012138	VALID
1016481	VALID
1021272	VALID

Add a New Patient Close X

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

* Required Field

Patient ID:* [Auto-generate](#)

First Name:

Last Name:

Date of Birth:

Gender: Female Male Other

Contact Information

Email Address: Optional

Phone Number: Optional

Address: Optional

CANCEL **SUBMIT**

Add Existing Patient

The screenshot displays the medconcert ACP Diabetes Registry interface. A modal window titled "Select an Existing Patient" is open, providing instructions and a list of patients. The background interface includes a navigation menu with options like HOME, APPS, PATIENTS, PERFORMANCE, WAYS TO IMPROVE, COMMUNITY, and PORTFOLIO. The main content area shows the ACP logo and the text "ACP Diabetes Registry". Below the modal, there are buttons for "HOME", "Manage My Patients", "Add a New Patient", and "ADD NEW PATIENT". A "My Patients (199)" section is visible at the bottom left, showing a list of patient records with columns for Patient ID, Status, and dates.

Select an Existing Patient Close X

Select a patient from your existing Master Patient List to add to this registry. After you click submit, you will be directed to a page where you are able to add patient encounters and fill out any forms related to this registry.

My Patients (796)

Patient ID	Last Name	First Name	Date of Birth	Gender	Action
1012138			1/1/1900	Male	Already Enrolled
1016481			1/1/1900	Female	Already Enrolled
1021272			1/1/1900	Female	Already Enrolled
1026846			1/1/1900	Male	Already Enrolled
1038796			1/1/1900	Male	Already Enrolled
1039827			1/1/1900	Female	Already Enrolled
1042387			1/1/1900	Male	Already Enrolled
1047622			1/1/1900	Female	Already Enrolled
1056798			1/1/1900	Male	Already Enrolled
1057321			1/1/1900	Male	Already Enrolled

1 - 10 of 199

Patient ID	Status	Date	Action
1012138	VALID		
	VALID	12/11/2014	4/7/2015
	VALID	11/18/2014	4/7/2015

Enter Chart Data

Patient Encounter

Patient ID: 1012138

Location: West General Medical Center

* Indicates Required Field / Question

Diabetes Patient Entry

Patient ID *

Patient Visit Date *

Patient Age * 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 \geq 7.0 and \leq 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:

HbA1c assessment date:

What was the most recent LDL-C level within 12 months? *

- Most recent LDL-C < 100 mg/dL (3048F)
- Most recent LDL-C \geq 100 and \leq 129 mg/dL (3049F)
- Most recent LDL-C \geq 130 mg/dL (3050F)
- LDL-C was not performed during the performance period (12 months) (3048F-8P)

Most recent LDL level:

LDL assessment date:

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

- Most recent systolic blood pressure < 140 mmHg (G8752)
- Most recent systolic blood pressure \geq 140 mmHg (G8753)
- Blood pressure measurement was not performed or documented (2000F-8P)

[What if multiple blood pressures are taken on the same visit date?]

Most recent systolic level:

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

- Most recent diastolic blood pressure < 90 mmHg (G8754)
- Most recent diastolic blood pressure \geq 90 mmHg (G8755)
- Blood pressure measurement was not performed or documented (2000F-8P)

[What if multiple blood pressures are taken on the same visit date?]

Enter Additional Patient Visits

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HOME APPS PATIENTS PERFORMANCE WAYS TO IMPROVE COMMUNITY PORTFOLIO



ACP Diabetes Registry

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UPLOAD PATIENTS

My Patients (199)

Find a Patient

1 - 10 of 199

Listings Per Page 10|20|30
Page: 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ...

Patient ID	Last Name	First Name	Date of Birth	Gender	# of Encounters	Date Created	Last Updated	Action
1012138	---	---	---	M	3	4/7/2015	4/7/2015	
Status	Encounter Date	Date Updated			Action			
VALID	1/9/2015	4/7/2015						
VALID	12/11/2014	4/7/2015						
VALID	11/18/2014	4/7/2015						
1016481	---	---	---	F	3	4/7/2015	4/7/2015	

How to enter data

The screenshot shows the medconcert ACP Diabetes Registry interface. At the top, there is a navigation bar with the medconcert logo, an 'Invite Colleagues' button, a search bar, and a user profile for Martin Kennedy. Below the navigation bar are tabs for HOME, APPS, PATIENTS, PERFORMANCE, WAYS TO IMPROVE, COMMUNITY, and PORTFOLIO. The main content area features the ACP Diabetes Registry logo and a description: '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 resource (view more)'. To the right is the ACP Quality Connect logo. Below this is a secondary navigation bar with tabs for HOME, DATA, MEASURES, IMPROVEMENT, MOC, PQRS, BTE, PATIENT SURVEY, and MANAGE. A text block explains that for submission to Bridges to Excellence (BTE), users must answer all chart questions and enter at least 25 patients. A section titled 'Manage My Patients and Encounters.' contains three columns: 'Add a New Patient' with an 'ADD NEW PATIENT' button, 'Add an Existing Patient' with an 'ADD EXISTING PATIENT' button, and 'Upload Patients and/or Data' with an 'UPLOAD PATIENTS' button. A blue arrow points to the 'UPLOAD PATIENTS' button. Below this is a search bar for 'My Patients (199)' with a 'Find a Patient' button. A pagination bar shows '1 - 10 of 199' and 'Listings Per Page 10|20|30'. The main table displays patient data with columns for Patient ID, Last Name, First Name, Date of Birth, Gender, # of Encounters, Date Created, Last Updated, and Action. Two patient records are visible: one for Patient ID 1012138 (Male, 3 encounters) and one for Patient ID 1016481 (Female, 3 encounters). Each record has a detailed view of encounters with columns for Status, Encounter Date, Date Updated, and Action.

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Invite Colleagues

Search the site

Martin Kennedy

HOME APPS PATIENTS PERFORMANCE WAYS TO IMPROVE COMMUNITY PORTFOLIO

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		Status	Encounter Date	Date Updated	Action			
		VALID	1/9/2015	4/7/2015				
		VALID	12/11/2014	4/7/2015				
		VALID	11/18/2014	4/7/2015				
1016481	---	---	---	F	3	4/7/2015	4/7/2015	

Upload Your Data

BACK



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 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

Browse...

UPLOAD A FILE

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
13	2002217	12/2/2014	63	250.10	99232	Yes	3044F	6.8	12/2/2014
14	2003886	10/13/2014	62	250.00	99204	Yes	3046F	9.2	10/13/2014
15	2003886	11/5/2014	62	250.00	99212	Yes	3044F	6.8	11/5/2014
16	2003886	12/3/2014	62	250.00	99217	Yes	3044F	6.8	12/3/2014
17	2002333	10/14/2014	60	250.40	99325	Yes	3046F	9.2	10/14/2014
18	2002333	11/6/2014	60	250.40	99341	Yes	3046F	9.2	11/6/2014
19	2002333	12/4/2014	60	250.40	99344	Yes	3046F-8P		
20	2001976	10/15/2014	59	250.62	99201	Yes	3046F	9.2	10/15/2014
21	2001976	11/7/2014	59	250.62	99215	Yes	3046F	9.2	11/7/2014
22	2001976	12/5/2014	59	250.62	99232	Yes	3045F	8.3	12/5/2014
23	2005283	10/16/2014	65	250.10	99204	Yes	3046F	9.2	10/16/2014
24	2005283	11/8/2014	65	250.10	99212	Yes	3044F	6.8	11/8/2014
25	2005283	12/6/2014	65	250.10	99217	Yes	3044F	6.8	12/6/2014
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
29	2003646	10/18/2014	66	250.40	99201	Yes	3046F	9.2	10/18/2014
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  Download Error Log  Download Errors

Your Personal Dashboard View by Measure



HOME DATA MEASURES IMPROVEMENT MOC PQRS BTE PATIENT SURVEY MANAGE

Search for Measures Sort by Gaps: most first

Hide measures with no data

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

Listings Per Page 5|10|20|30

Page: 1 | 2 |

Measure Name	Report Period 04/12/2015	My Performance		How Do I Compare?		Outliers	How Do I Improve
		Trending	My Score	My Gaps	Me vs All		
Dilated Eye Exam	04/12/2015	view chart	Actual 87.93% Higher is Better	1 gap Show	73% Worst Best		
Body Mass Index (BMI) Screening and Follow-Up	04/12/2015	view chart	Actual 91.95% Higher is Better	0 gap Show	83% Worst Best		
Foot Exam	04/12/2015	view chart	Actual 79.89% Higher is Better	0 gap Show	70% Worst Best		
Hemoglobin A1c Poor Control	04/12/2015	view chart	Actual 6.03% Lower is Better	0 gap Show	88% Worst Best		
High Blood Pressure Control	04/12/2015	view chart	Actual 90.95% Higher is Better	0 gap Show	91% Worst Best		

Ways to Improve is linked right from your dashboard



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 resource (view more)



- HOME
- DATA
- MEASURES
- IMPROVEMENT**
- MOC
- PQRS
- BTE
- PATIENT SURVEY
- MANAGE



Ways to Improve.




Find your next activity for improvement.

SELECT MEASURES

Show completed activities

51 - 60 of 72 Activities

Listings Per Page 10|20|30
Page: 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

Title	Type	Rating	% Users Improved	Action
 <p>ADA Effects of Quality Improvement Strategies for Type 2 Diabetes in Bronx, N.Y.</p> <p>view Activity details</p>	Activity	<p>☆☆☆☆☆ (0)</p> <p>0 Comments</p>	<p>N/A</p> <p>more details</p>	<p>LAUNCH</p>
 <p>CDC Cost-Effectiveness of Interventions to Prevent and Control Diabetes Mellitus: A...</p> <p>view Activity details</p>	Activity	<p>☆☆☆☆☆ (0)</p> <p>0 Comments</p>	<p>N/A</p> <p>more details</p>	<p>LAUNCH</p>
 <p>AAO Diabetic Retinopathy</p>	Activity	<p>☆☆☆☆☆ (0)</p> <p>0 Comments</p>	<p>N/A</p> <p>more details</p>	<p>LAUNCH</p>

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 resource [\(view more\)](#)



HOME	DATA	MEASURES	IMPROVEMENT	MOC	PQRS	BTE	PATIENT SURVEY	MANAGE	
------	------	----------	-------------	-----	------	-----	----------------	--------	--



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 professions 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.

COMING SOON

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 resource [\(view more\)](#)



HOME	DATA	MEASURES	IMPROVEMENT	MOC	PQRS	BTE	PATIENT SURVEY	MANAGE
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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

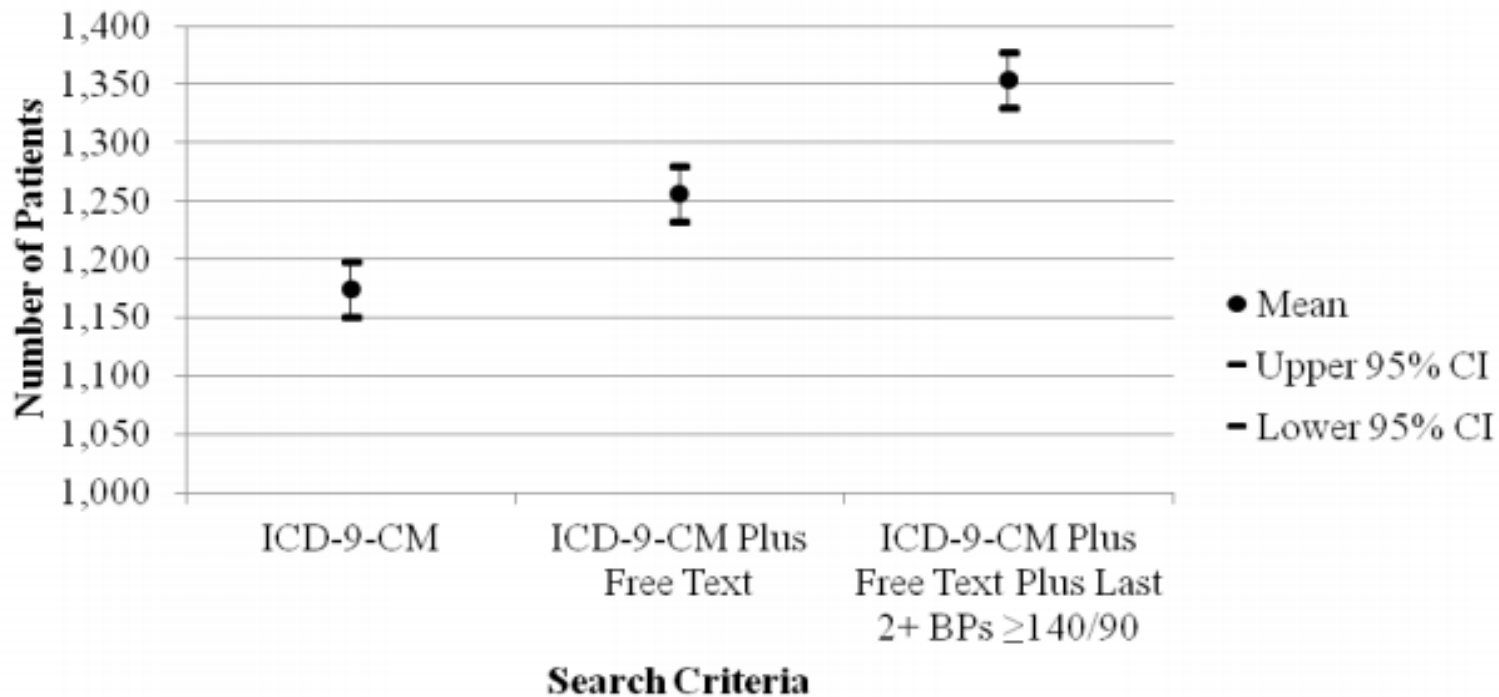
- An example: Finding patients undiagnosed with hypertension
 - Started as a by-product of helping centers report on blood pressure outcomes of patients with diagnosed hypertension
 - Led us to more closely look at data quality

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 $\geq 140/90$ 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

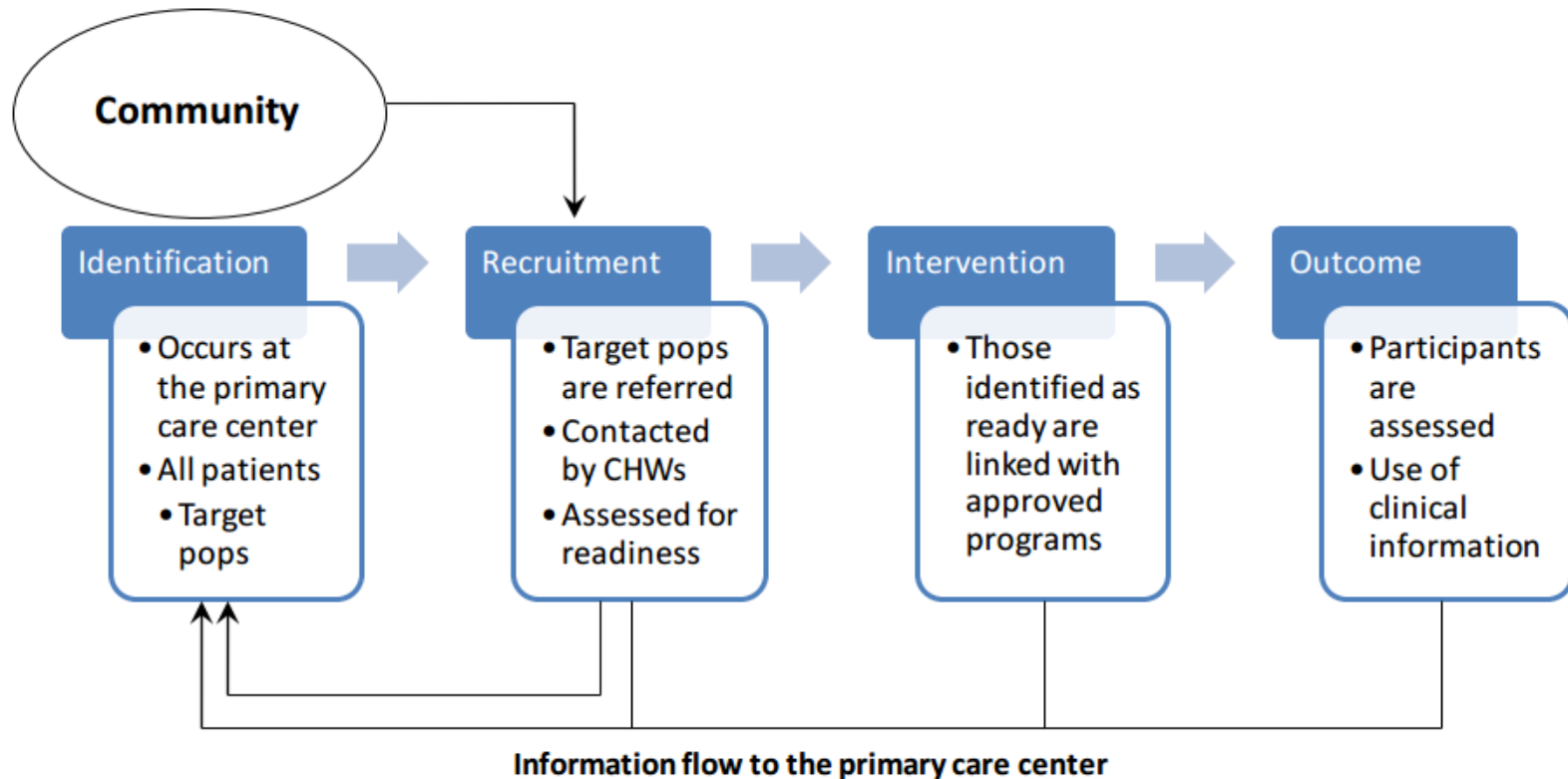
Figure 1: Increase in Count of Patients with Hypertension, by Search Criteria



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)



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,
kdcapehart@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



WCWV

Who are we?

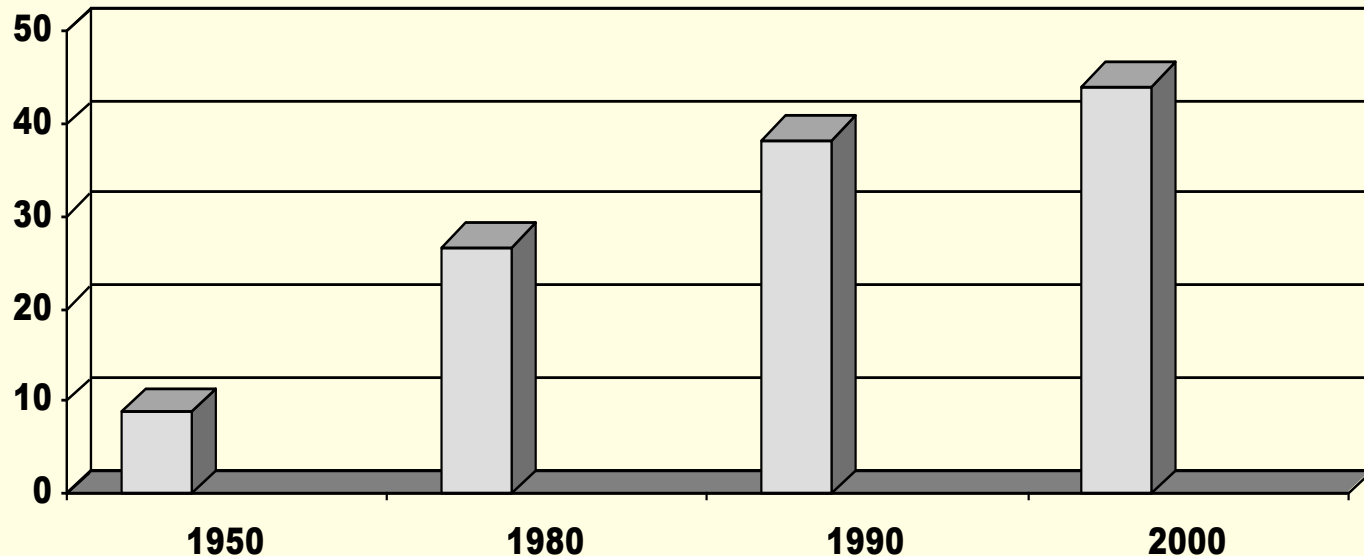
- **Membership based Organization**
- **Benefits**
 - Awards Process
 - Consulting
 - Networking
 - Education
 - Events

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

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



- **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**

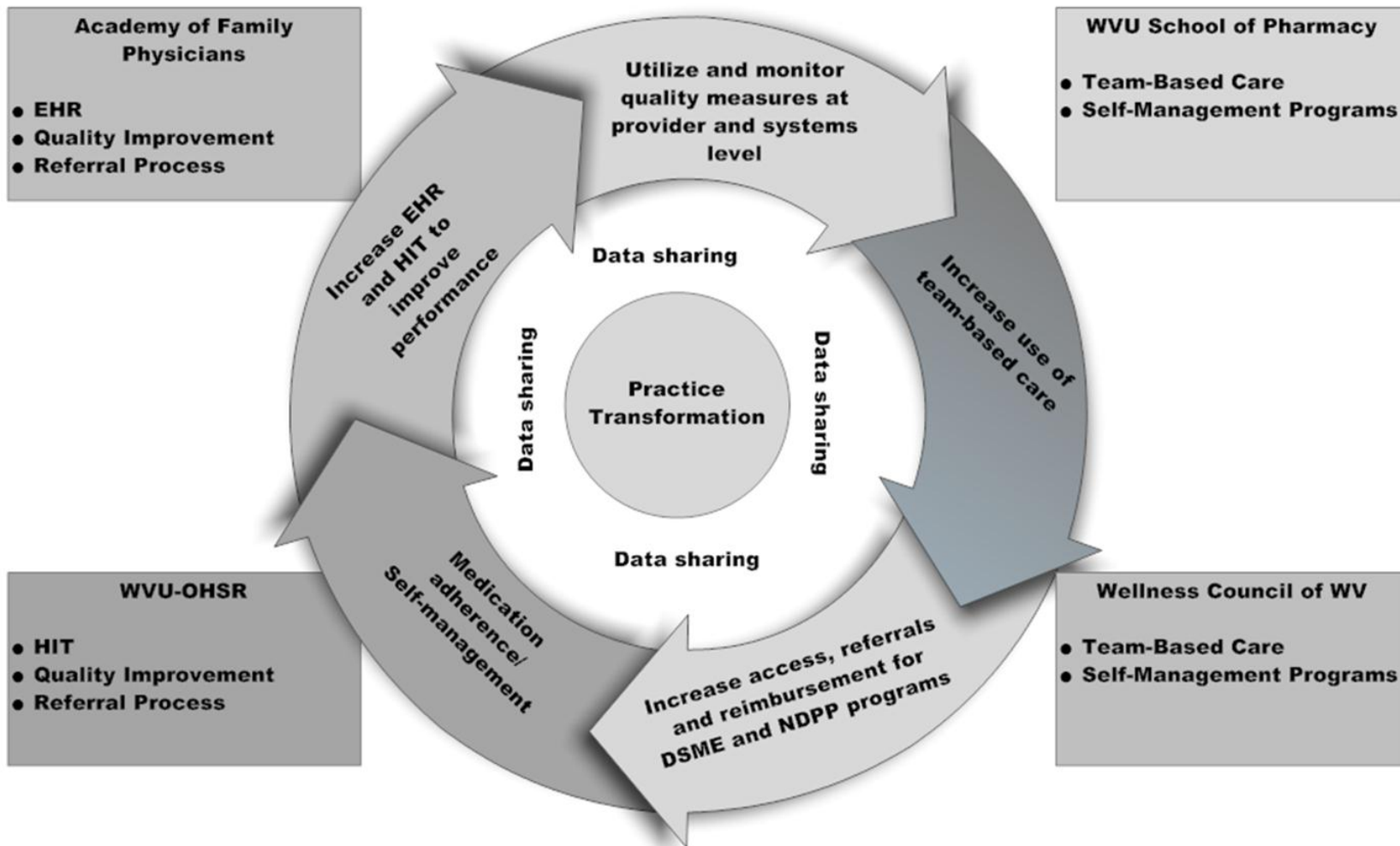
Thank you!

Carroll Christiansen, MD

Roane County Family Health Care

Practice Transformation

Improve prevention and management for hypertension, diabetes and prediabetes



- **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?

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(304) 356-4229