

TriHealth Diabetes

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TriHealth Diabetes Physician Champion
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TriHealth System Overview

- 7 Hospitals (Dearborn County Hospital – Independent Affiliate)
- Nationally recognized for clinical integration and quality
- 140+ total sites of care (most on EPIC EMR)
- 550+ employed partner physicians
- 40 PCP offices with PCMH coordinators
- 246 PCP's and mid-level providers
- CPCI (Comprehensive Primary Care Initiative)
 - 19 practices
 - Manage HCC codes thru EMR for high risk patients.
- 8 endocrinologists
- 12,000 employees



Community Health
& Wellness



Medical Home
& Primary Care



Urgent
& Ambulatory Care



Acute Care: Emergent,
Secondary, Tertiary



Post-Acute Care



Home Health
& Hospice

Tri-Health Diabetes Resources

- General Ambulatory
 - CDE/RN one on one diabetes education
 - Prediabetes group classes
 - Medical Nutritional Therapy
 - Pharmaceutical CDE led group visits at 9 locations
 - Certain offices have Pharmacists on site
 - Diabetes manual
- Patient Centered Medical Homes (PCMH) coordinators at all PCP offices work the Clinical Data Warehouse (CDW) and look for HEDIS gaps.
- Employee health (PHO) program- diabetes health coaches, free medications, supplies, etc
- Tri-Health inpatient diabetes model of care team
- Diabetes PFAC-Patient Family Advisory Council
- Diabetes Website



Quality Measures and Value Based Medicine

- Process and outcome measures
 - Retinal eye exams, nephropathy screens (MAB), etc
- HEDIS (Healthcare Effectiveness Data and Information Set)
 - developed and managed by the National Committee for Quality Assurance (NCQA).
 - 81 measures across 5 domains of care
 - makes it possible to compare the performance of health plans
- Star Ratings Medicare
- Public reporting of physicians/system
- P4P

Quality Measures and Value Based Medicine (con't)

- PCMH (Patient Centered Medical Home)
 - Model of care that emphasizes care coordination and communication
 - Leads to higher quality and lower total costs
 - P4P-differential pay structure
 - Require NCQA (National Committee for Quality Assurance) recognition
 - Private/non-profit organization
 - Accredits health plans in every state
 - » Covers 70.5% all Americans with private insurance

The “D5” reporting

- Minnesota Community Measurement Collaborative - 2003, an early adopter for this composite diabetes measure
 - Blood pressure <140/90 mm Hg
 - LDL-C <100 mg/dL
 - A1C <8%
 - No tobacco use
 - Daily aspirin, if appropriate
- 2004 public reporting for HCP’s started
- AF4Q (Aligning Forces for Quality) vs TPEC and our CDW
- Studies have proved that combined quality measures decrease costly ED visits, hospital and ICU admissions, mortality



Health outcomes in diabetics measured with Minnesota Community Measurement quality metrics

Diabetes Metab Syndr Obes. 2015; 8: 1–8. 2014 Dec 16. Paul Y Takahashi et al

Clinical Data Warehouse (CDW)



CDW Dashboard-TPEC

[Maximize Scorecard](#)



Reporting Period
2016

ALL > ALL > ALL > D4 (A1C8, BP140/90, Tobacco, ASA for IVD)

Total Patient Population: **33,989**

Total Points Earned: **66**

Service Area

ALL

Department

ALL

Physician

ALL

Condition

- Diabetes (TPEC)
- Heart Stroke (TPEC)
- PSA (TPEC)
- Hypertension (TPEC)
- Hyperlipidemia/Dyslipidemia
- Colorectal CA (TPEC)
- Preventive Health Care Females
- Preventive Health Care Males

Submit

Measure Group	Measure Description	Patient	Patient Population	Patient %	Target (of Pop)	Possible Points	Points Earned
Combined Measures	D5+ (A1C8, BP140/90, Statin, Tobacco, ASA for IVD/ASCVD>10%)	6,678	33,989	19.64%			
Combined Measures	D5 (A1C8, BP140/90, LDL100, Tobacco, ASA for IVD)	10,979	33,989	32.30%			
Process Measures	Use of Statin (Age 40 - 75)	10,500	26,338	39.86%			
Poor Control Measures	BP poor control >= 140/90	9,141	33,989	26.89%	<=35%	30	30
Poor Control Measures	LDL poor control >= 130	10,136	33,989	29.82%			
Process Measures	Eye Exam	17,009	33,989	50.04%	>=60%	12	0
Process Measures	Nephropathy Exam	29,224	33,989	85.98%	>=85%	7	7
Process Measures	Foot Exam	21,813	33,989	64.18%	>=80%	7	0
Process Measures	Smoking status & cessation advice	32,207	33,989	94.76%	>=85%	12	12

D4 (A1C8, BP140/90, Tobacco, ASA for IVD)

[Legend](#)



0 10 20 30 40 50 60

D4 (A1C8, BP140/90, Tobacco, ASA for IVD)



AF4Q/CDW DATA:

- PCMH coordinators disseminate D5 results to PCP's especially after June and often every other week.
- Competition within and between offices highly recommended/effective
- Emails posting office and individual comparative results sent to PCP's and Care managers monthly by myself.
- Calls to practices managers unusually low on scores

Afinion AS100 POC A1C analyzer enhancing the “D5”

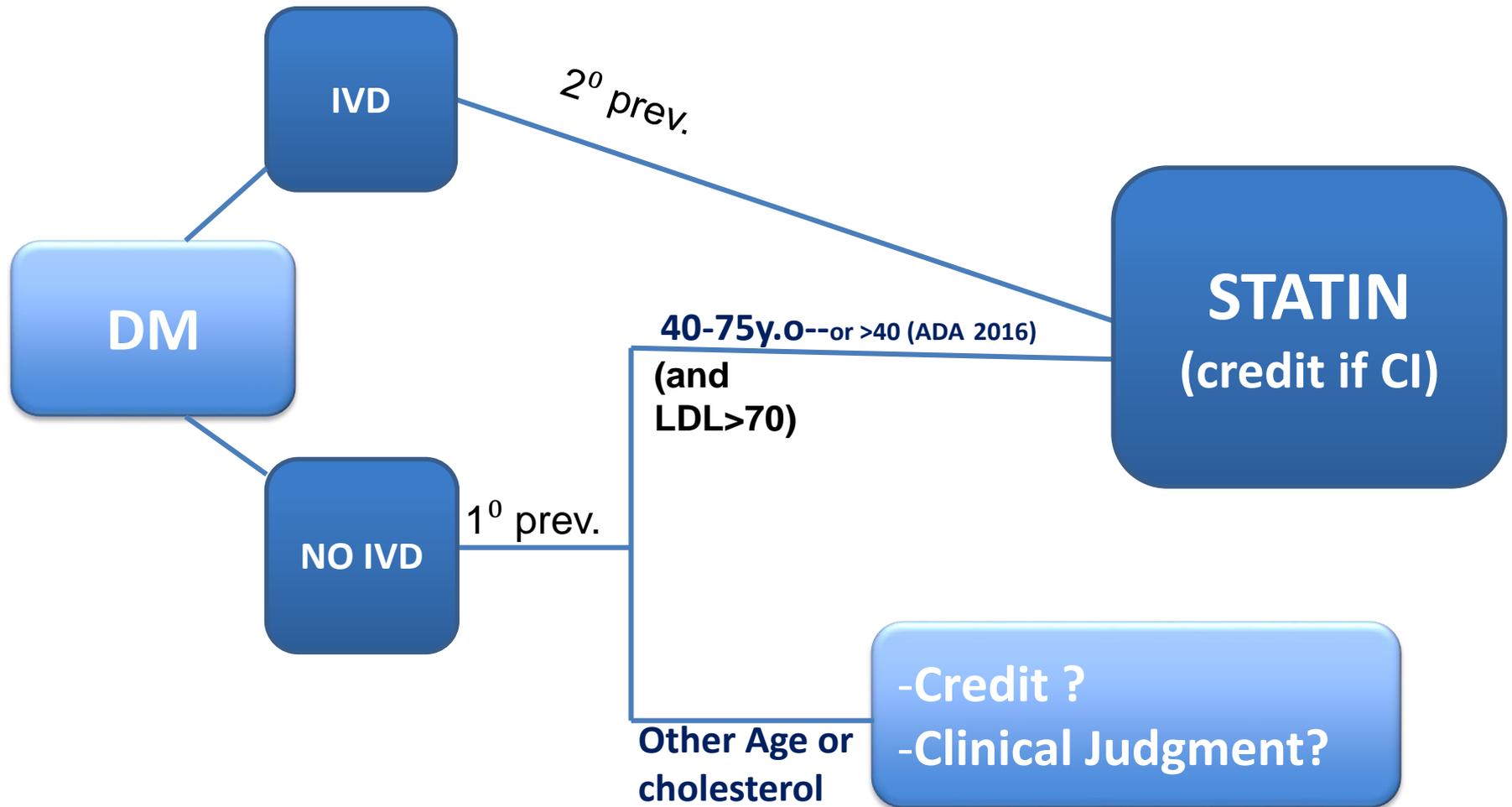


D5 (old) to D5 “plus” (2017)

(Nov. 2013 updated AHA/ACC/ADA guidelines)

- BP < 140/90
- A1c < 8
- Non-smoker
- **LDL < 100** → Statin (updated)
- **ASA if IVD** (updated)

CDW BASIC STATIN ALGORITHM



ADA. Cardiovascular Disease and risk management. Standards of Medical Care in Diabetes-2016. Diabetes Care 2016;39 (Suppl. 1); S60-S71.

Stone NJ, et al. 2013 ACC/AHA Blood Cholesterol Guideline. <http://circ.ahajournals.org>

ASCVD (Moderate vs High Statin Dosing Accuracy)

Chart note

The 10-year ASCVD risk score (Goff DC Jr., et al., 2013) is: 13.3%

Values used to calculate the score:

Age: 59 years

Sex: Male

Is Non-Hispanic African American: No

Diabetic: Yes

Tobacco smoker: No

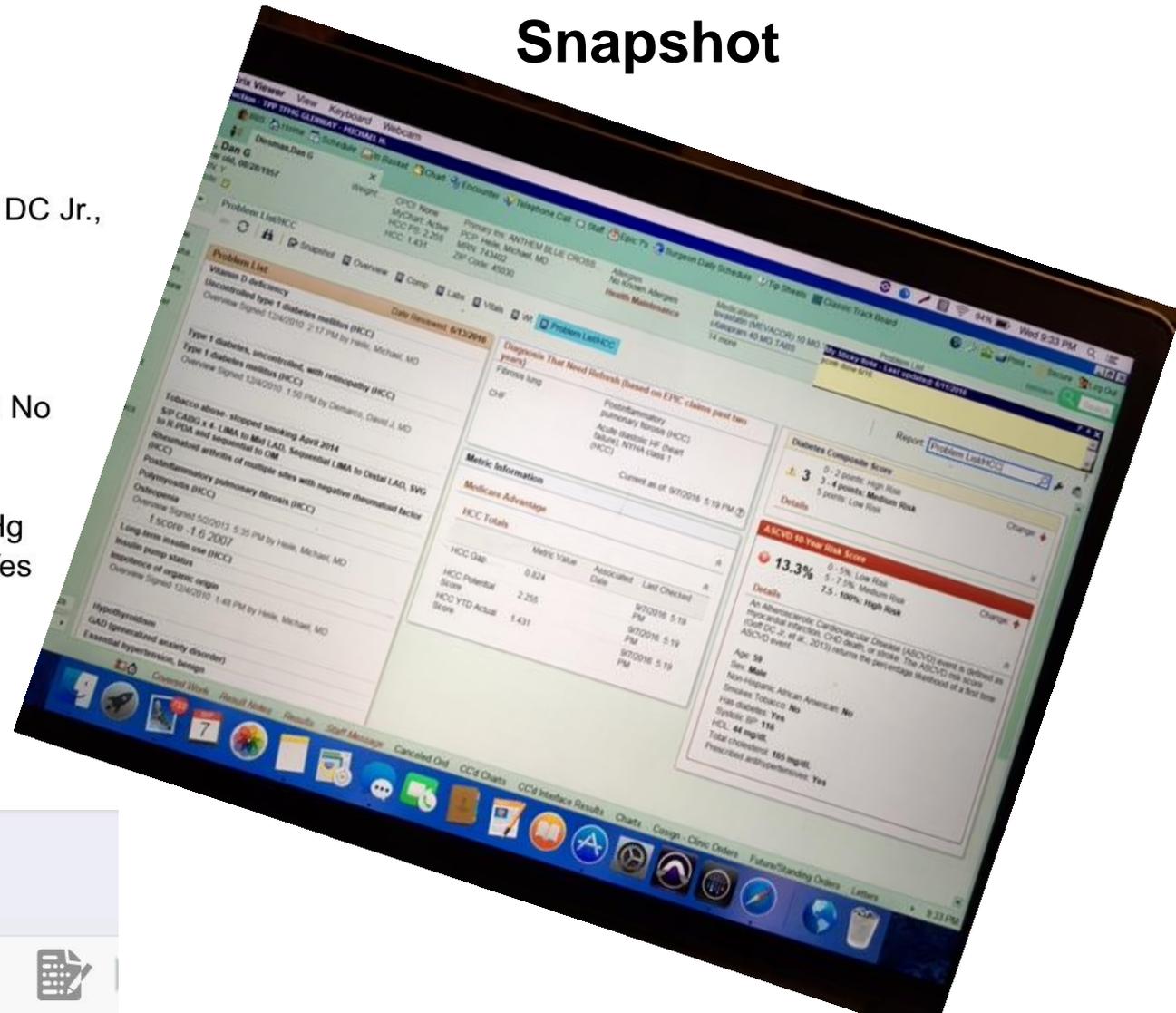
Systolic Blood Pressure: 116 mmHg

Is Prescribed Antihypertensives: Yes

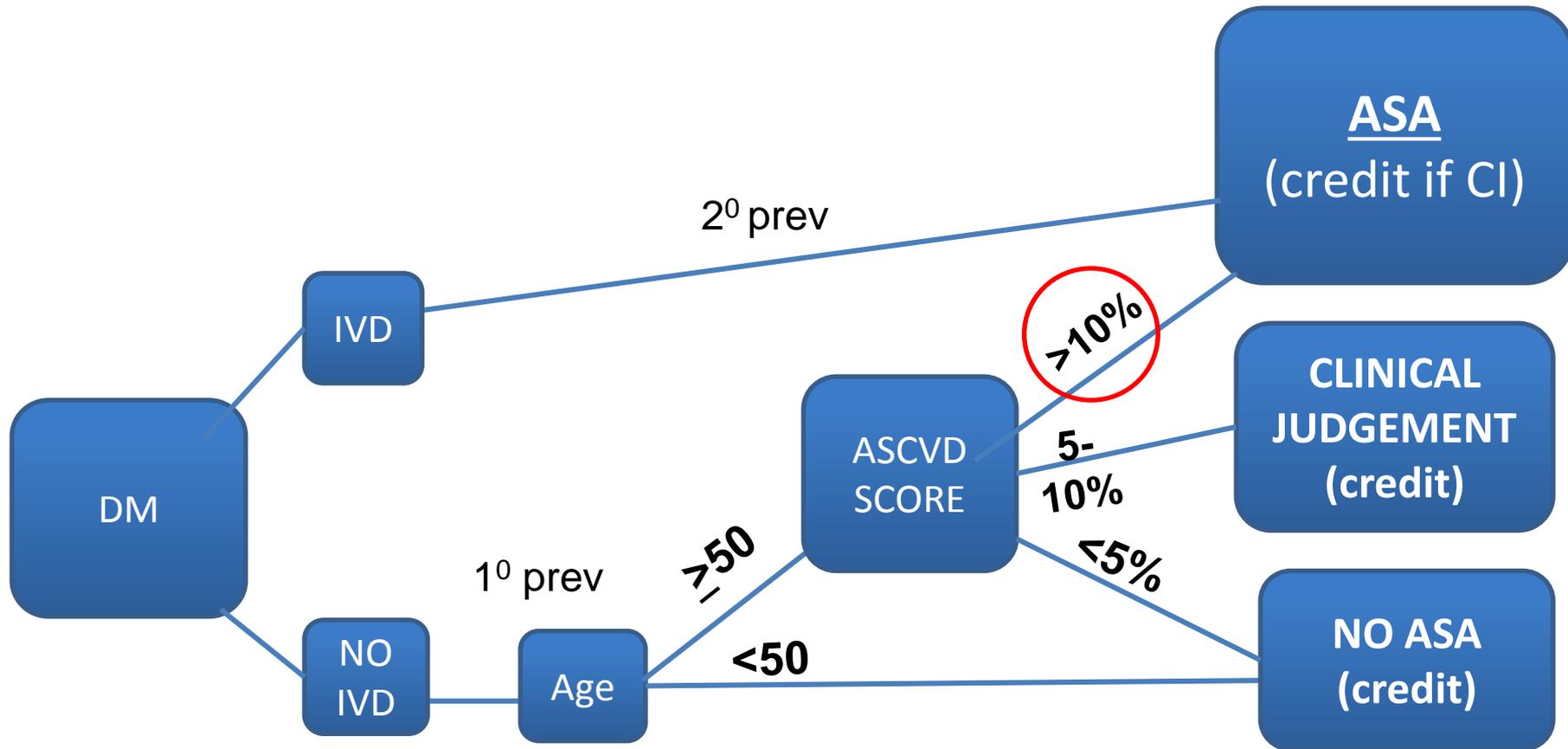
HDL Cholesterol: 44 mg/dL

Total Cholesterol: 165 mg/dL

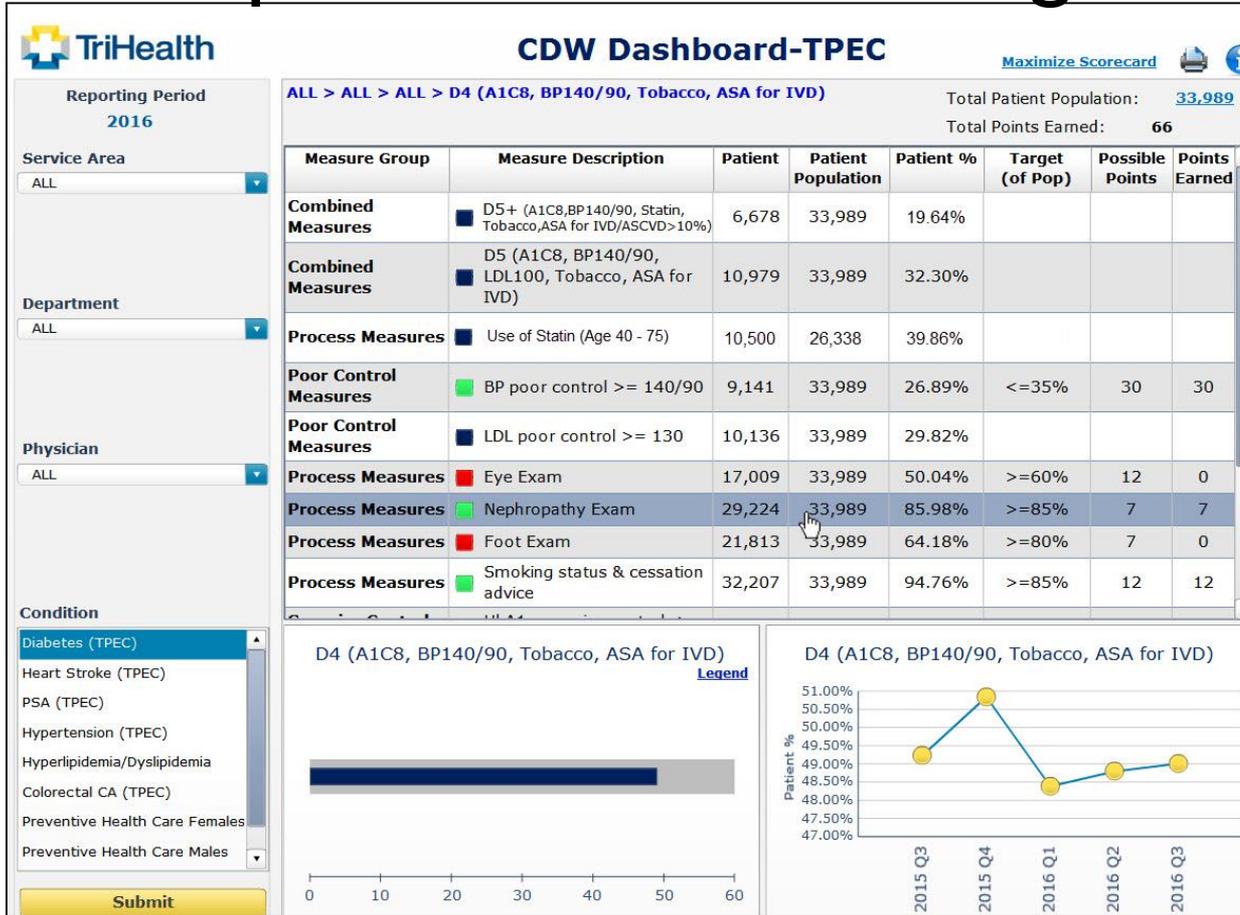
Snapshot



ASA CREDIT AND DIABETES



Proposed CDW Changes & Additions



← NEW D5+

← ADD new Process Measure

Add new columns to drilldown report:

- 1) D5+
- 2) ASCVD Score
- 3) Statin Use
- 4) Statin Dose (verifying it's available)

All Measures by Patient Name - Diabetes (TPEC), Report Of: Diabetes (TPEC)

Patient Name	Last Office Visit Date	Diabetes D5 indicator	D5+ Indicator	ASCVD Score	Statin Use	Statin Dose	Aspirin Use	Aspirin Assessment Date	Anti-thrombotic Use	Anti-thrombotic Assessment Date	Contra-indication to Aspirin/Antithrombotic	Contra-indication to Aspirin Date	Aspirin Credit
test 2	07/18/2016	NO	NO	10.1	YES	TBD	YES	08/02/2016	NO		NO		YES
test 3	04/18/2016	YES	YES	11.5	YES	TBD	YES	04/18/2016	NO		NO		YES
test 4	08/04/2016	NO	YES	8	NO		NO		NO		YES	08/04/2016	YES

THANK YOU!





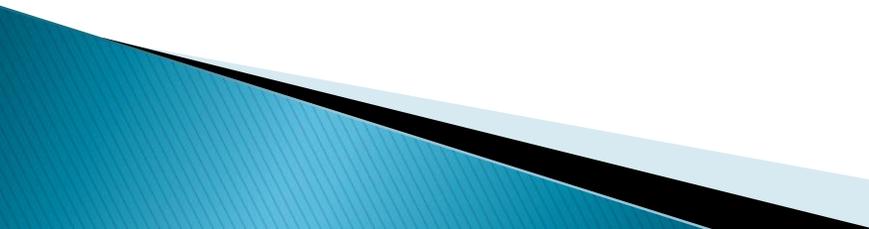
NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES (NEON)

DIABETES MANAGEMENT EMPOWERMENT PROGRAM

NEON WHO?

- ▶ Federally Qualified Health Center started in 1967 (Originally called Hough Norwood)
 - ▶ Seven health centers on the east side of Cleveland and East Cleveland.
 - ▶ Offers comprehensive Primary Care, Dental and Behavioral Health Care to over 30,000 patients annually.
 - ▶ Additional services Optometry, Podiatry, Nutrition, Social Work, Pharmacy, Mammography, x-ray and lab.
 - ▶ NEON is PCMH Level 3 certified
- 

NEON WHO(Service Areas)?

- ▶ 21 urban communities
 - ▶ 19 Statistical Planning Areas within the City of Cleveland, the City of East Cleveland and three census tracts within the inner ring suburb of Maple Heights.
 - ▶ According to the US Census, service area residents are predominantly African-American (85%). Whites, Asians and Hispanics represent the other racial/ethnic groups in the area.
 - ▶ Six primary care Health Professional Shortage Areas (HPSA's) in the service area that demonstrate significant access barriers for residents.
 - ▶ Target population: residents without a medical home, the uninsured, residents eligible for public assistance and those at risk of experiencing health disparities.
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WHO WE SERVE



NEON FINANCIAL MIX

▶ Self Pay	10.80%
▶ Medicaid	69.46%
▶ Medicare	4.47%
▶ Medicare FQHC	5.54%
▶ Commercial	6.82%
▶ Commercial Job Corp	1.02%
▶ Dental Contracts	1.69%
▶ Others	0.20%

Diabetes Patients

As of 11/1/2016 NEON has 2,625 diagnosed diabetes patients

Ages	Number of Patients	Percentage
12-20	29	1%
21-40	289	11%
41-64	1,473	56%
65+	834	32%

IN THE BEGINNING

- ▶ Review of our QI measures as it relates to A1C and hypertension
 - ▶ Approached by Health Services Advisory Group, a Quality Innovation Network–Quality Improvement Organization (QIN–QIO) serving multiple states including Ohio.
 - ▶ HSAG (Everyone with Diabetes Counts) to service Senior patients.
 - ▶ HSAG trained (4) peer educators using the DEEP model.
 - ▶ Started with three of our health centers (Hough, Southeast, and Collinwood)
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IN THE BEGINNING (Continue)

Who's involved in this program?

Medical Director, Dr. Anita Watson

NEON QI Committee

DEEP Peer Educators*

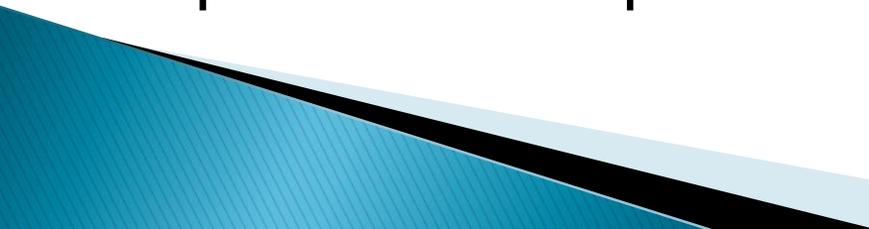
NEON Providers

Diabetes Coordinator–Kathy Boysaw, MBA

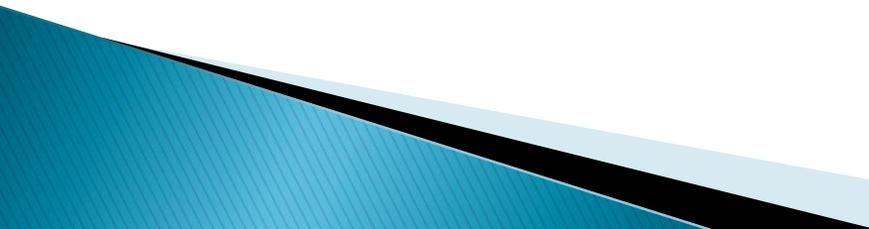
*Chief Pharmacist, Michael Sreshta, RPh

*Assoc. Dir. of Hlth Svs, Rhonda McLean, MBA.

DEEP PROGRAM

- ▶ Developed by the Midwest Latino Health Research, Training and Policy Center at the University of Illinois at Chicago;
 - ▶ Built on previous efforts by Latino Health Access in Santa Ana, California;
 - ▶ Format includes a training-of-trainers and an educational curriculum;
 - ▶ Training-of-Trainers targets community health workers;
 - ▶ Educational curriculum designed to engage community residents in self-management practices for prevention and control of diabetes;
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DMEP GOALS

- ▶ To reduce diabetes risk factors
 - ▶ To increase knowledge of diabetes and its risk factors
 - ▶ To increase self-management skills
 - ▶ To facilitate short-and long-term behavioral change.
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NEON DMEP (FOUR COMPONENTS)

- ▶ 1) Chronic disease management
 - 2) Coordinated shared appointments
 - ▶ 3) Pharmacy consultation visits
 - ▶ 4) Group empowerment education
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DMEP PROGRAM

Chronic disease management

- ▶ Using a PCMH model, diabetic patients have access to a wide range of services.
- ▶ Comprehensive Primary Care is the foundation

Other Services Include:

- ▶ Laboratory
- ▶ Nutrition
- ▶ Optometry
- ▶ Behavioral Health Services
- ▶ Pharmacy
- ▶ Podiatry
- ▶ Dentistry

DMEP PROGRAM

Shared appointments

- ▶ Pre-arranged multiple appointments on the same day.
 - ▶ Usually the primary care appointment is coupled with nutrition, podiatry or optometry.
 - ▶ NEON piloted this program in 2015.
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DMEP PROGRAM

Pharmacy Consultations

- ▶ Also piloted in 2015 diabetic patients are able to meet with the pharmacist for Medication Therapy Management (MTM)
 - ▶ Aimed at improving the collaboration and communication among the pharmacist and the primary care team.
 - ▶ Pharmacists encourages patients to take an active role in managing their medications for better outcomes.
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DMEP PROGRAM

Group empowerment education

- ▶ Includes diabetics, pre-diabetics and caregivers of diabetics
 - ▶ Seniors on Medicare is our target audience
 - ▶ The DEEP program is a peer-to-peer program that offers a series of six (6) sessions that are 120 minutes each.
 - ▶ Workbooks are provided
 - ▶ Very interactive and participatory classes.
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DMEP PROGRAM

Group empowerment education (Continue)

- ▶ Six classes(8 modules)

- 1: Beginning session– Understanding the human body;
- 2: Understanding diabetes and its risk factors;
- 3: Monitoring your body;
- 4: Get up and Move! The importance of physical activity;
- 5: Health management through nutrition;
- 6: Diabetes complications: Identification and prevention;
- 7: Medication and medical care– Communicating with your provider;
- 8: Stress and Coping – Mobilizing your family and friends.

- ▶ Each week patients set goals for themselves called a Weekly Action Plan

SUCCESSSES

- ▶ Five classes this year (over 40 patients graduated)
 - ▶ New NEON patients
 - ▶ A1C's are improving
 - ▶ Patients becoming advocates of the program and sometimes come back to the class
 - ▶ Partnerships with community organizations
 - ▶ Patients are feeling empowered.
 - ▶ Letters and cards of thanks
 - ▶ Data and feedback as to how to reach more people.
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BEST PRACTICES

- ▶ Combining Pre-Diabetics, Diabetics and Care Givers in one class.
 - ▶ Written correspondences from their doctor or the Medical Director.
 - ▶ Class flexibility
 - ▶ Off site classes
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CHALLENGES

- ▶ Transportation
 - ▶ Billing for shared appointments (FQHC)
 - ▶ Funding for the program
 - ▶ Staffing
 - ▶ Ongoing support for class participants
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WHAT'S NEXT

- ▶ Expanding the program to include all ages
 - ▶ More community based classes and partnerships
 - ▶ Focus groups
 - ▶ Cooking demonstrations
 - ▶ Ongoing support “developing a community”
 - ▶ Expanded service area
 - ▶ Seeking additional funding
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THANK YOU FOR YOUR TIME

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For more information about the DEEP Program contact

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