CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

In partnership with:

THE OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

COLLEGE OF MEDICINE AND LIFE SCIENCES THE UNIVERSITY OF TOLEDO

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OHIO COLLEGES OF MEDICINE GOVERNMENT RESOURCE CENTER

Ohio Department of Medicaid

Medicaid Statewide Diabetes Quality Improvement Project: Results and Lessons Learned

Shari Bolen, MD, MPH

Co-PI, Cardi-OH

Professor of Medicine

Founding Director, Population Health Research Institute

The MetroHealth System and Case Western Reserve University

Panelists

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The MetroHealth System and Case Western Reserve University

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Cleveland Clinic

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CareSource

Erin Brigham, MPH, CPH-Q

Disclosures

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Our speakers (listed below) have no financial relationships with any commercial interest related to the content of this activity.

- Shari Bolen MD, MPH
- Joseph Daprano MD
- Cristina Sanders MSN, BA, APRN-CNP
- Shannon Knapp BSN, RN, CDCES
- Erin Brighan MPH, CPH-Q

Objectives

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- Identify evidence-based strategies to improve blood sugar control within primary care practices
- Discuss payer-practice collaborations to improve blood sugar control
- Determine mechanisms to improve diabetes outcomes within your organization

Agenda

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Time	Activity	Presenter
10:45-10:50 am	Welcome/Goals of the Day	Shari Bolen MD, MPH
10:50-10:55 am	Appreciative Inquiry Exercise	All
10:55-11:10 am	Diabetes QIP Overview and Results	Shari Bolen MD, MPH
11:10-11:30 am	Practice and Payer Highlights/Q&A	Panelists
11:30-11:40 am	Small Group Activity	All
11:40-11:45 am	Wrap Up	Shari Bolen MD, MPH

Appreciative Inquiry Exercise

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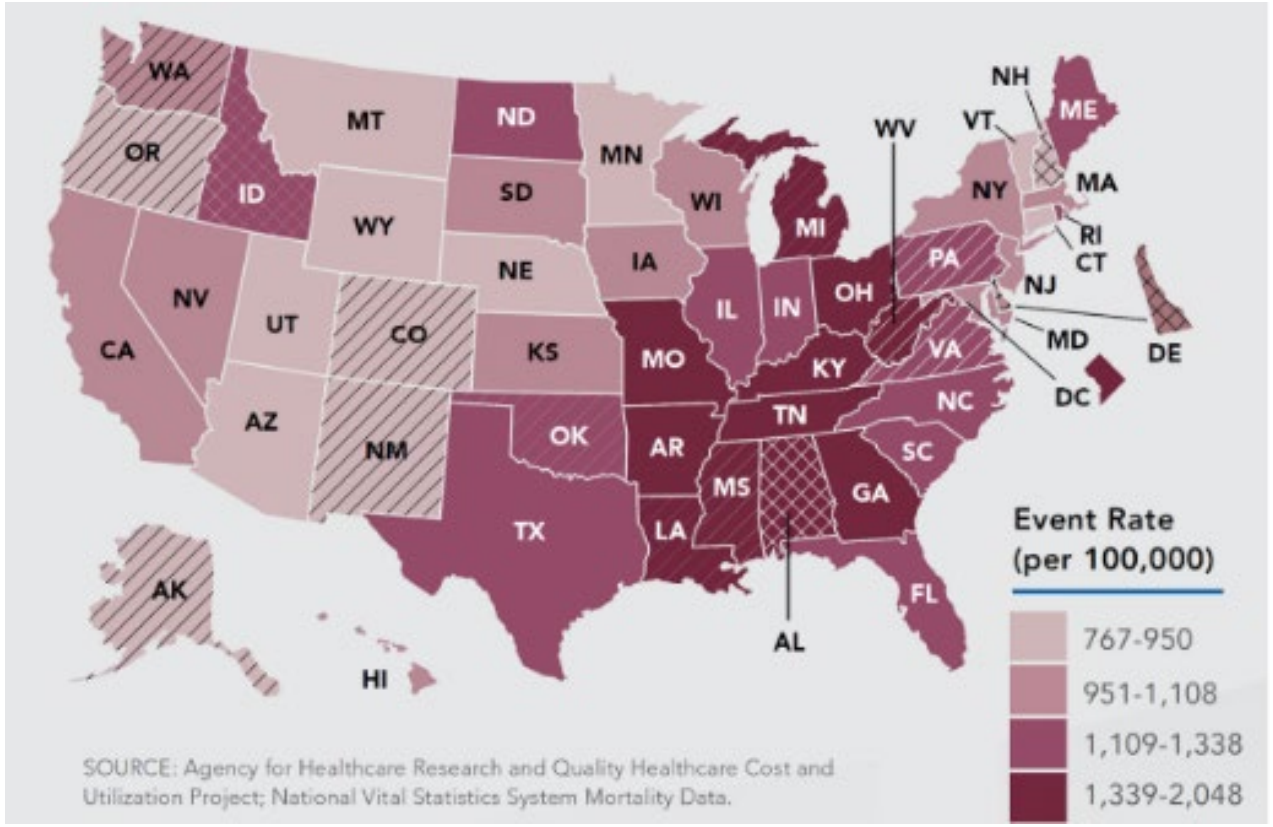
- Introduce yourself to someone new
- Share a story about how you or your organization has been able to improve the health of someone with diabetes
- What made that interaction a success?

Background

- Cardiovascular disease (CVD) is the leading cause of death in Ohio
- Using RWJF rankings, Ohio ranks:
  - 44 out of 50 states for adult smoking
  - 42 for life expectancy
  - 41 for adult obesity
  - 40 for insufficient physical activity
- Disparities exist with higher rates of uncontrolled hypertension, diabetes, and CVD events among Black populations compared with Whites

2016 CVD Event Rates per 100,000



RWJF County Health Rankings, 2020

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RWJF Health Outcomes defined as:

Length of Life

Premature death

(years of potential life lost before age 75)

AND

Quality of Life

Self-reported health status

Percent of low birthweight newborns

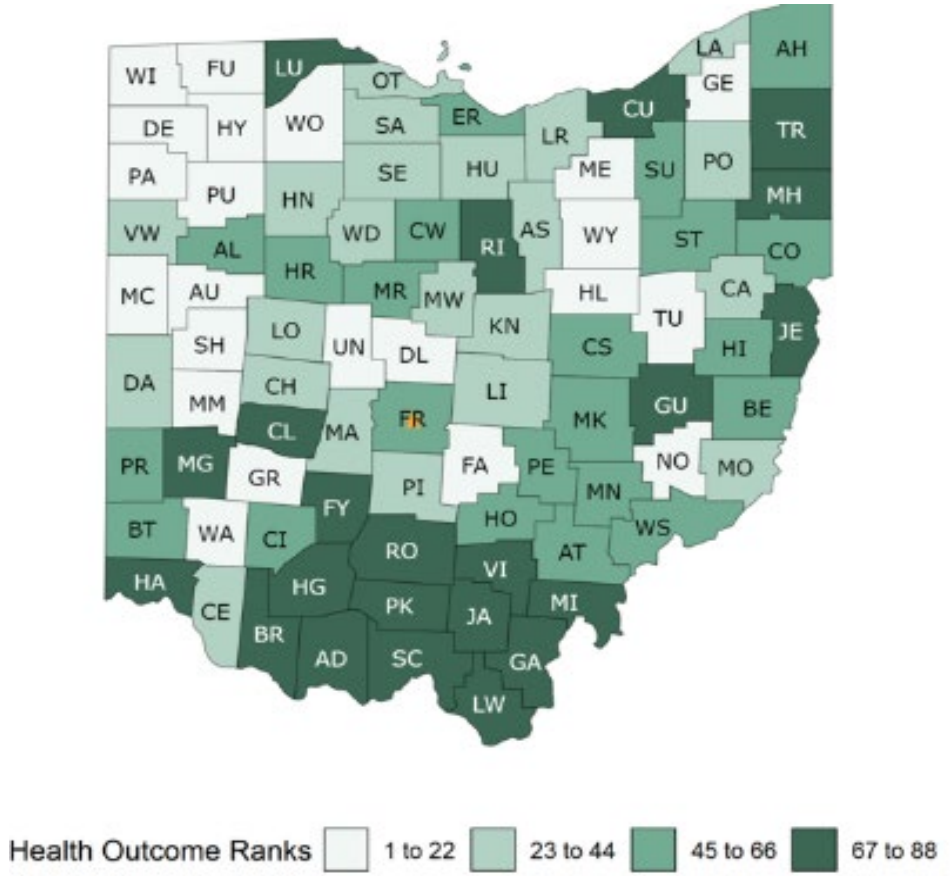

Image available at: https://www.countyhealthrankings.org/reports/state-reports/2020-ohio-report

About Cardi-OH

Founded in 2017, the mission of Cardi-OH is to improve cardiovascular and diabetes health outcomes and eliminate disparities in Ohio's Medicaid population.

CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

WHO WE ARE: An initiative of health care professionals across Ohio's seven medical schools.

WHAT WE DO: Identify, produce and disseminate evidence-based cardiovascular and diabetes best practices to primary care teams.

HOW WE DO IT: Utilize monthly newsletters and an online repository of resources at Cardi-OH.org, podcasts available on Cardi-OH Radio, webinars, and the Project ECHO® virtual training model. Informed by an annual needs assessment. Aligned quality improvement projects.

Learn more at Cardi-OH.org

Webinar | Wednesday, November 16, 2022 | 12 - 1 p.m. ET

COVID-19 and Cardiovascular Health:
Managing Patients and Incorporating a Telehealth Framework

KEYNOTE SPEAKER

Tamanna K. Singh, MD
Assistant Professor, Cleveland Clinic Lerner College of Medicine
Case Western Reserve University
Co-Director, Sports Cardiology Center
Post-COVID Cardiovascular Recovery Center and reCOVer Clinic
Cleveland Clinic

OBJECTIVES

- Identify cardiovascular complications of COVID-19 infection
- Screen and treat patients for COVID-19 cardiovascular complications
- Use telehealth with post-COVID patients as a means of managing cardiovascular care

Register at Cardi-OH.org

CME credit provided at no cost.

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Spring 2023 ECHO Clinic

Innovations in Diabetes and Cardiovascular Health

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Project ECHO®

Date: Thursdays, 8 - 9 a.m. ET
January 12 to March 30, 2023

How Does it Work?

- Uses a hub-and-spoke model to share best practices with Ohio primary care teams
- Features expert-led didactic and interactive case-based learning discussions

Why Join?

- Professional development and continued learning
- Knowledge sharing with practices across the state
- Increased efficiency and joy in work
- Improved patient retention and health outcomes

Register at Cardi-OH.org
Free CME credits

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Diabetes Quality Improvement Project (QIP)

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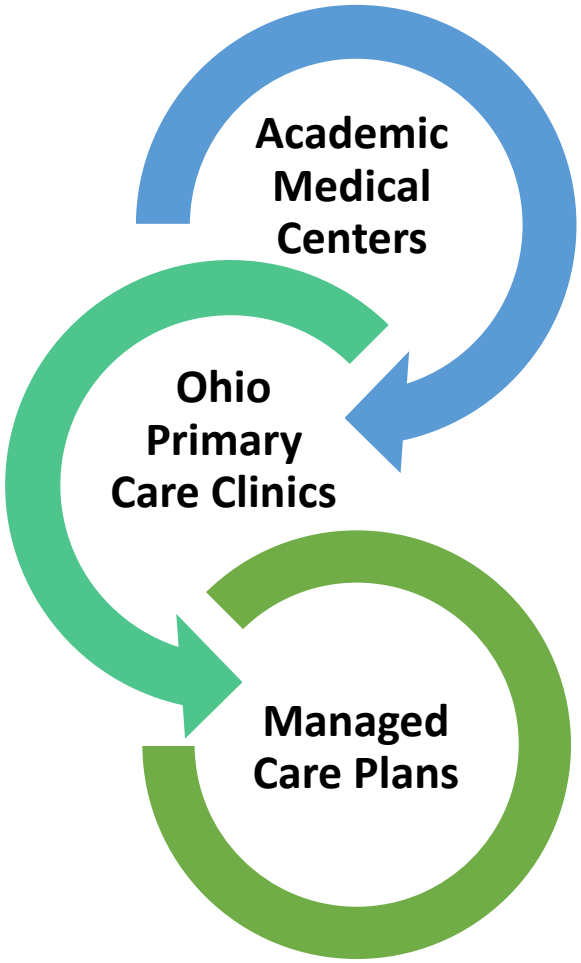
Identification & Education of Best Practices and Processes

Testing, Modifying & Implementing Best Practices

Facilitating access to best practice, addressing non-clinical barriers



SMART Aim

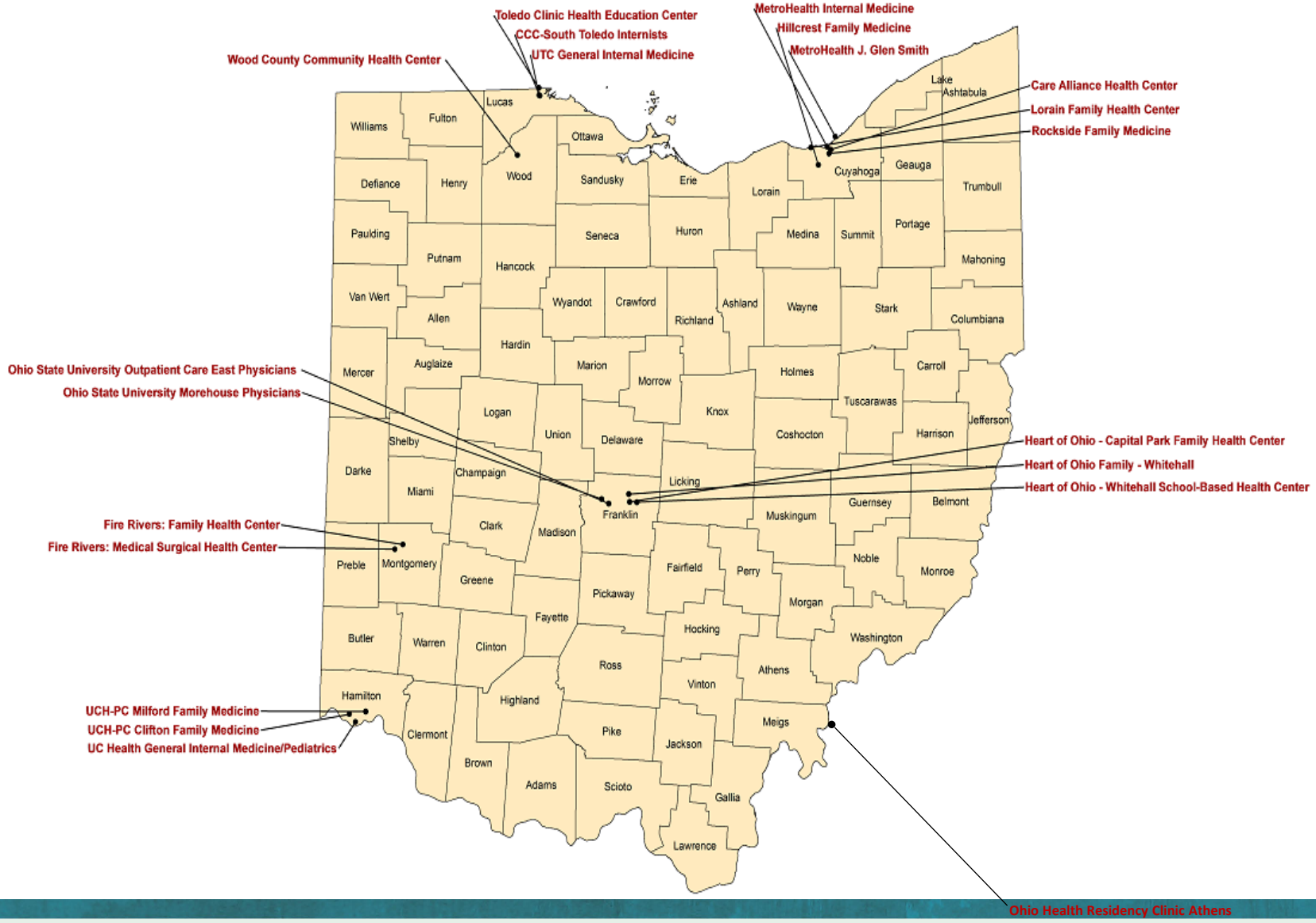
- Reduce the % of adults with type 2 diabetes whose A1c > 9% by 15% from 24.96% to 21.22% by June 30, 2022.

Strategies

- IHI Model for Improvement
- Clinical and Patient Education Toolkit
- Monthly Action Period Calls
- Monthly QI Coaching
- Leverage EHR data for improvement
- Partner with Medicaid Managed Care Plans to address barriers

Ohio Department of Medicaid

Diabetes QIP Practice Sites



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Project Leader(s): CWRU, GRC

Revision Date: 5/8/20 V.11

Legend
- Potential intervention
- Active intervention
- Adopted intervention
- Abandoned intervention

Global Aim

Reduce complications associated with poorly controlled type 2 diabetes while addressing health equity

SMART Aim

Reduce the percentage of adult patients enrolled in Medicaid with type 2 diabetes whose hemoglobin A1c (HbA1c) was poorly controlled (>9%) by 15% from 24.96% to 21.22% by June 30, 2022.

Reduce the percentage of poorly controlled A1c (>9%) in the Hispanic and NHB populations by 20% from 25.87% to 20.7% by June 30, 2022.

Population

Adult (18-older) Medicaid patients diagnosed with type 2 diabetes at participating practices

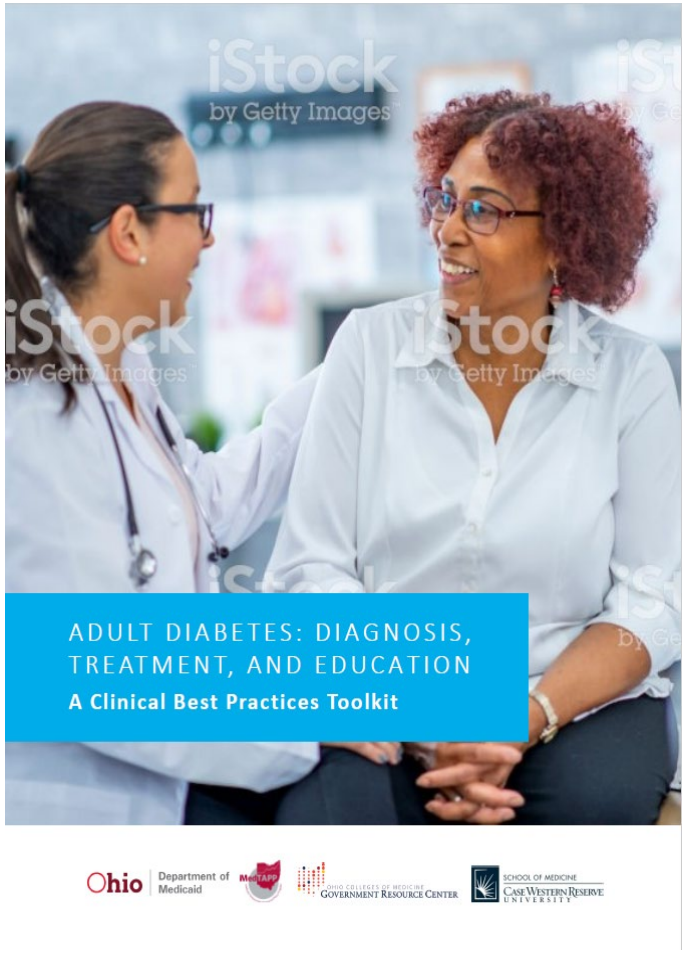
Key Drivers

- **A:** Appropriate and Timely Treatment
- **B:** Access to High Quality Coordinated Care
- **C:** Patient Engagement, Healthy Lifestyle and Self-Efficacy
- **D:** Screened and Well Managed Behavioral Health
- **E:** Effective Supportive Relationships
- **F:** Healthy Equitable Environment for Care

Interventions

- Provider: Optimize medication regimen across conditions (A, B, E, F)
- Provider/Payer: Consistent Access to Medication/Supplies/Equipment (A, B, C)
- All: Diabetes self-management education (A, B, C, D, E, F)
- Payer: Expand Reimbursement: e.g., Community based DSME using evidence-based model (B, F)
- Provider: Coordinated comprehensive individualized medical treatment plan (B, C, D, E)
- Provider: Standardized office processes for the healthcare delivery system (B, C, E)
- Provider: Screening and integration of behavioral health services within primary care (D, E, F)
- Provider/Payer: Screening for social determinants of health and linkage to community resources and or CHWs (D, E, F)
- Payer: Provision of MCP Services (B, C, E, F)

Clinical Best Practice Toolkit



- Appropriate and Timely Treatment
- Access to High Quality Coordinated Care
- Patient Engagement, Healthy Lifestyle, and Self-Efficacy
- Screened and Well Managed Behavioral Health
- Effective Supportive Relationships
- Healthy Environment for Care

***Available on Cardi-OH website at:
https://www.cardi-oh.org/qip/diabetes

Patient Education Resource Toolkit

Main Educational Resource

- What is Diabetes? (Booklet)

Supplemental Material as Handouts

- Diabetes medications
- Blood glucose monitoring
- Hypo- and hyperglycemia
- Healthy eating
- Physical activity
- Prevention of long-term complications
- Diabetes Sick Day Plan

Available at : Diabetes QIP | Cardi-OH

DM QIP Primary Interventions

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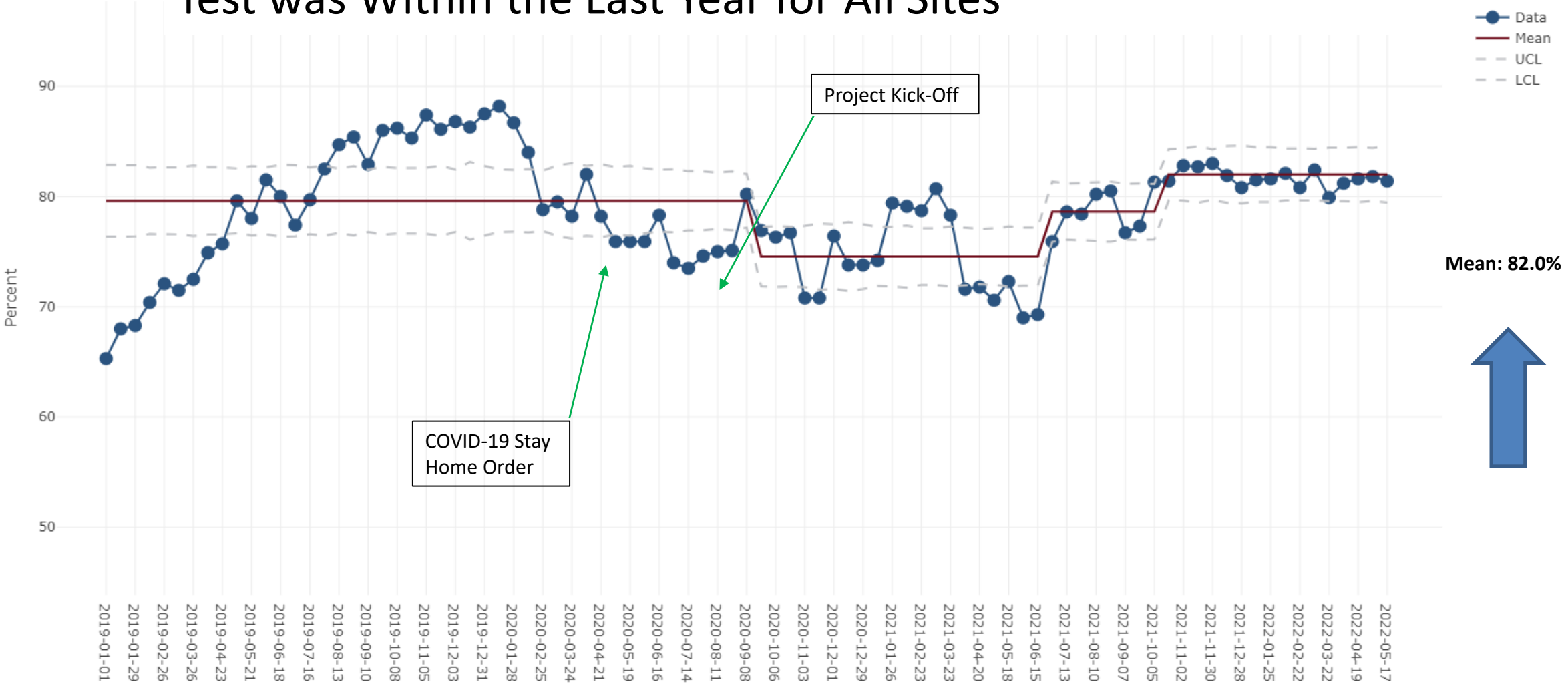
- **A1c Testing:** point of care testing, outreach to patients to come for labs
- **Monthly Followup in Team-based Care** (if A1c >8 or >9): clinical pharmacists, diabetes self-management education, multidisciplinary diabetes team visit
  - Patient input – reasons for no shows
- **Outreach:** to patients 1-2 times a year who have A1c>8.5 or 9 and no scheduled followup within 1 month
- **Social Drivers of Health:** referral to community resources, CHWs, telehealth

Ohio Department of Medicaid

Percent of Patients with Diabetes Whose Most Recent A1c Test was Within the Last Year for All Sites

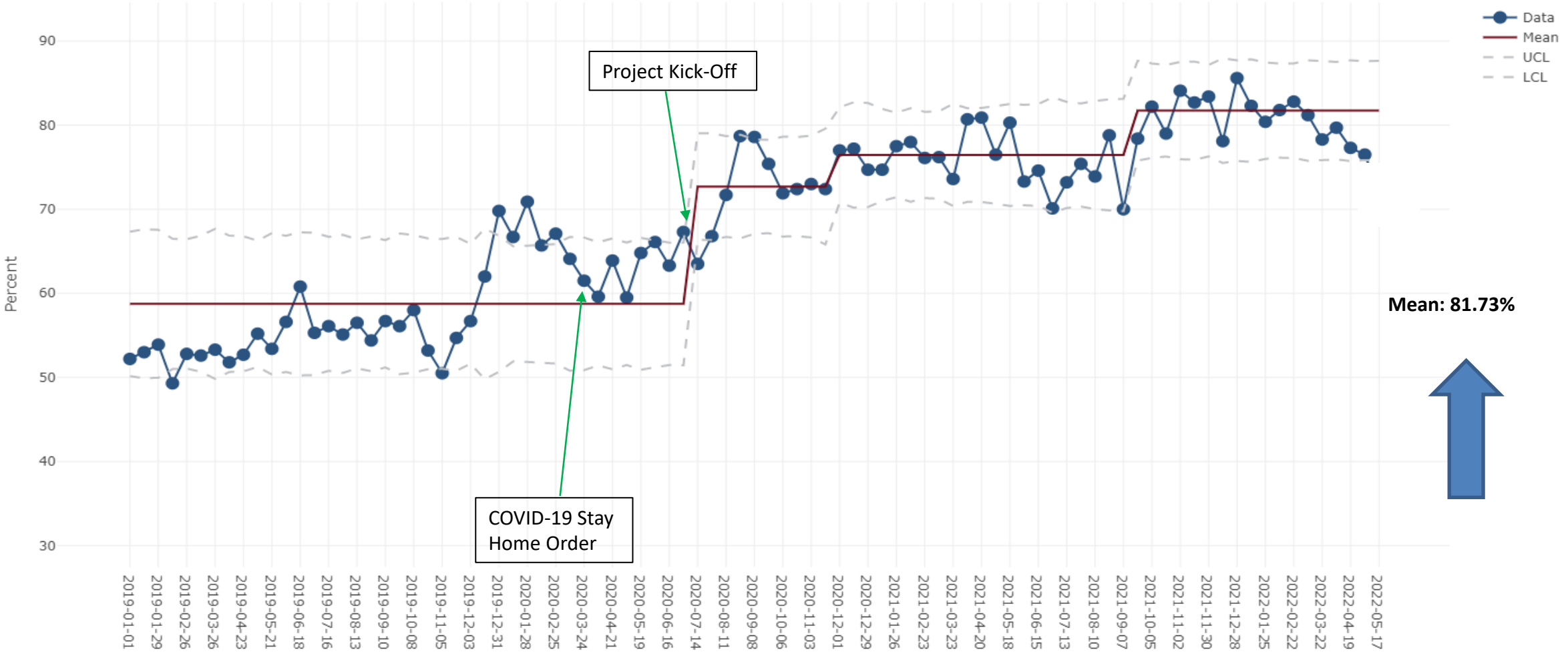


Mean: 82.0%

Sample Size: Median=1995
Min=1179, Max=2763

Note that measures with denominators (n) <20 are suppressed

Percent of Diabetes Patients With A1c >9 Who Had a Scheduled Follow-up Visit for All Sites

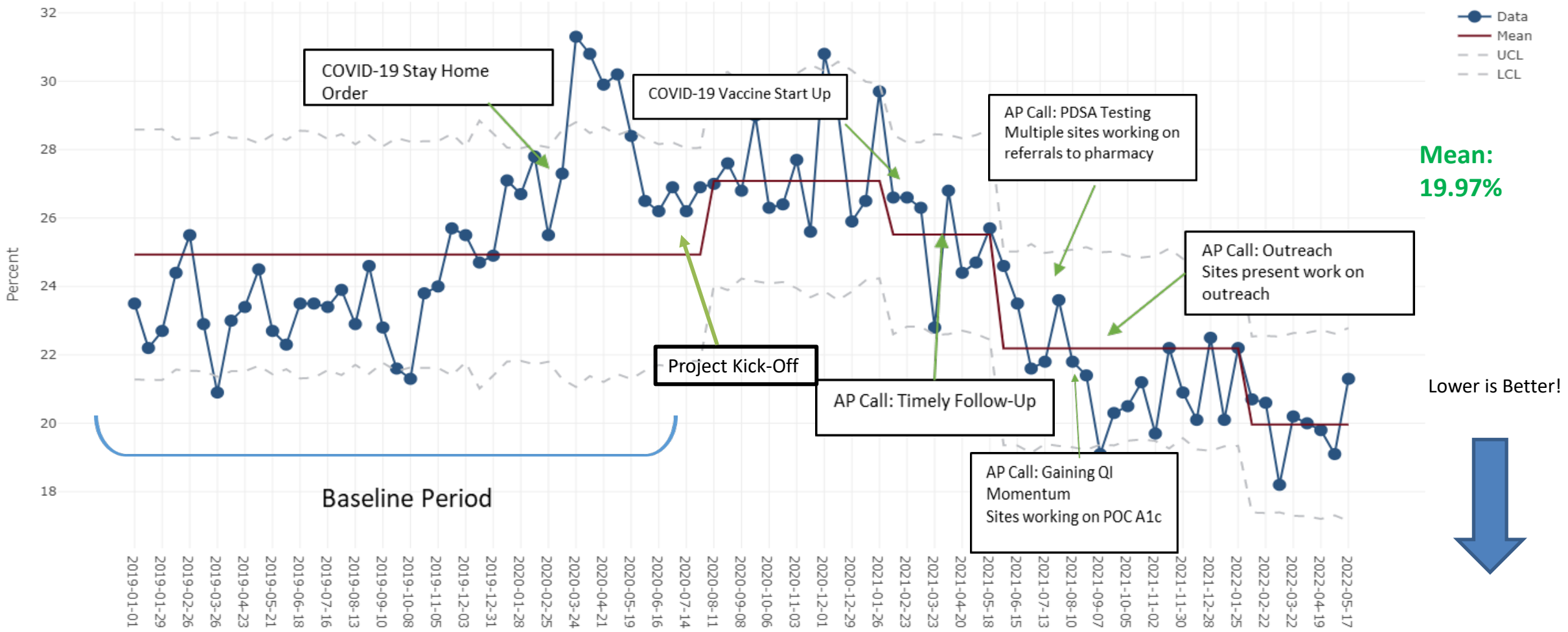


Mean: 81.73%

Sample Size: Median=391
Min=271, Max=644

Note that measures with denominators (n) <20 are suppressed

Percent of Patients With Diabetes Whose Most Recent A1c>9% for All Sites



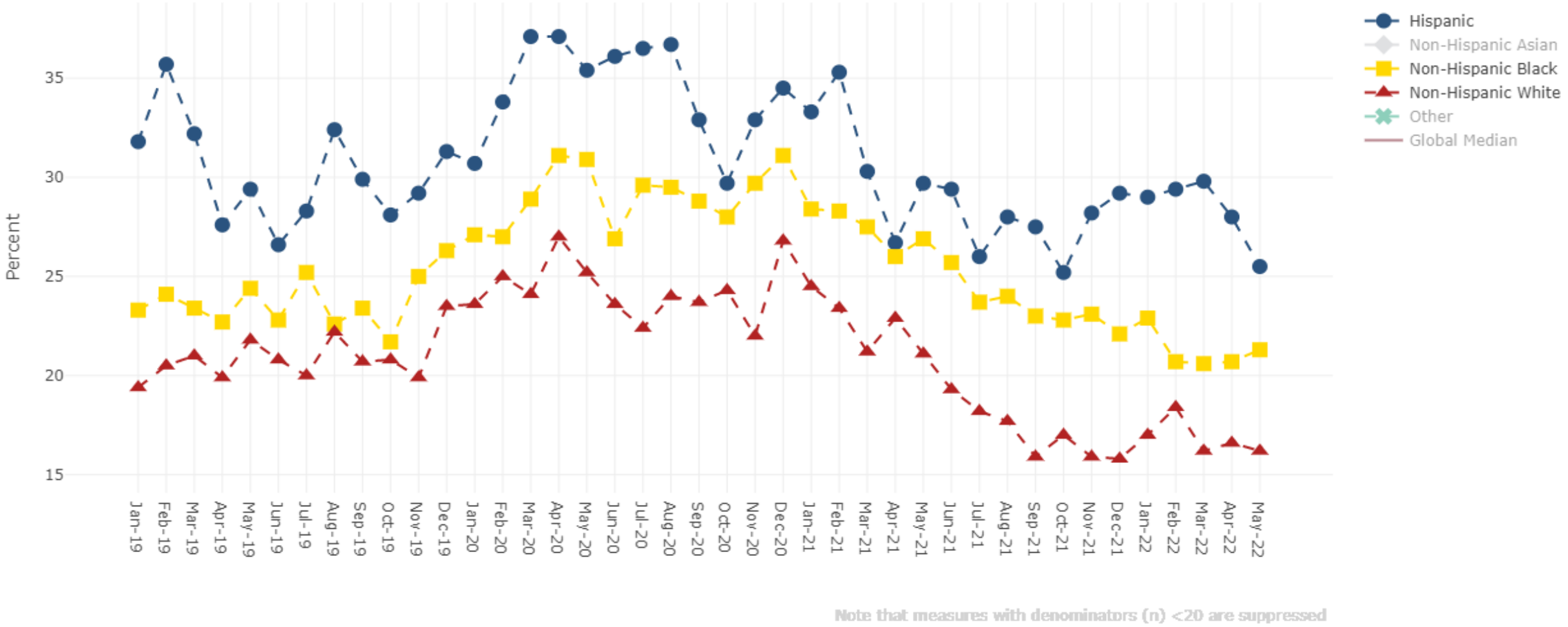
Mean: 19.97%

Lower is Better!

Sample Size: Median=1730
Min=1099, Max=2361

Note that measures with denominators (n) <20 are suppressed

Percent of Patients With Diabetes Whose Most Recent A1c>9% Stratified by Race/Ethnicity for All Sites



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- Cardi-OH and QIP Team Members, partner organizations, and primary care clinics.
- The views expressed in this presentation are solely those of the author and do not represent the views of the state of Ohio, federal Medicaid programs, AHRQ, the US Department of Health and Human Services or any other funder.

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Partner Exercise

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- How can you take things you learned here back to your organization to improve diabetes outcomes?
- How can your organization work towards eliminating disparities in diabetes outcomes?

Quote

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“ I have not failed. I have just found 10,000 ways that won’t work.”

- Thomas Edison

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Thank You!