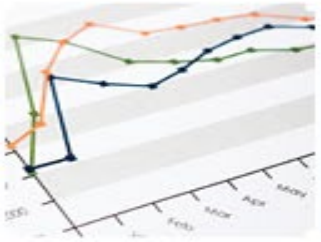
HRSA Outreach Program

Western Oklahoma Wellness

May 25, 2023



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Agenda

- Housekeeping Items
- HRSA Outreach Program – Western Oklahoma Wellness – Saundra Burchill, OFMQ
- Why is Health So Hard? - Sarah Yount, PharmD, CDCES, Assistant Professor, Department of Pharmaceutical Sciences, Diabetes Prevention Program Coordinator, SWOSU College of Pharmacy
- Questions & Closing

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About WOW

- Western Oklahoma Wellness is a program to advance rural healthcare through increased access to care, education, and opportunities to reduce the onset of diabetes and other chronic conditions.

- Counties We Work In:
  - Beckham, Greer, Kiowa, Washita, Roger Mills

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Funded Through HRSA

- We Work With:
  - **ONIE Project**: The Oklahoma Nutrition Information and Education (ONIE) Project promotes healthy living through innovative and creative strategies for communities, families and individuals.
  - **SWOSU Rural Health Center**: The RHC develops programs for community-based healthcare services collaborating with local pharmacies and hospitals for the advancement of the health and well-being of the medically underserved population in Oklahoma.
  - **Community Partners**: County-Specific Health Departments, State Health Department, OSU Extension, Town of Granite, Mangum Regional Hospital, Elkview General Hospital, Cordell Memorial Hospital, Roger Mills Hospital, City of Elk City
- WOW is funded through the HRSA Rural Health Care Outreach Services Program, Grant No. D04RH40277

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Sarah Yount, PharmD, CDCES

Sarah has been with SWOSU's College of Pharmacy since 2015. As a clinical pharmacist, she has provided Annual Wellness Visits, Chronic Care Management, Remote Physiological Monitoring, Diabetes Self-Management Education and Support, Medication Therapy Management, Antimicrobial Stewardship, and the National Diabetes Prevention Program (NDPP). Sarah is currently delivering her 14th NDPP cohort since 2016 and became a Master Trainer *Select* in 2018 through Emory University's Diabetes Training and Technical Assistance Center (DTTAC). The DTTAC Master Trainer *Select* program allows her to train pharmacists, nurses, dietitians, community healthcare workers, physicians, and others as Lifestyle Coaches to help expand awareness and availability of NDPP in Oklahoma. She became a Certified Diabetes Care and Education Specialist in 2019. She began serving as the Assistant Professor for the COP Department of Pharmaceutical Sciences in Fall 2022. Her desire is to help individuals prevent and manage their disease state(s), and to equip and encourage students to find their passion and serve their patients well.

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Why is Health so Hard?

SARAH YOUNT, PHARM.D., CDCES

SOUTHWESTERN OKLAHOMA STATE UNIVERSITY COLLEGE OF PHARMACY

ASSISTANT PROFESSOR PHARMACEUTICAL SCIENCES

DIABETES PREVENTION PROGRAM COORDINATOR

Relevant Disclosures

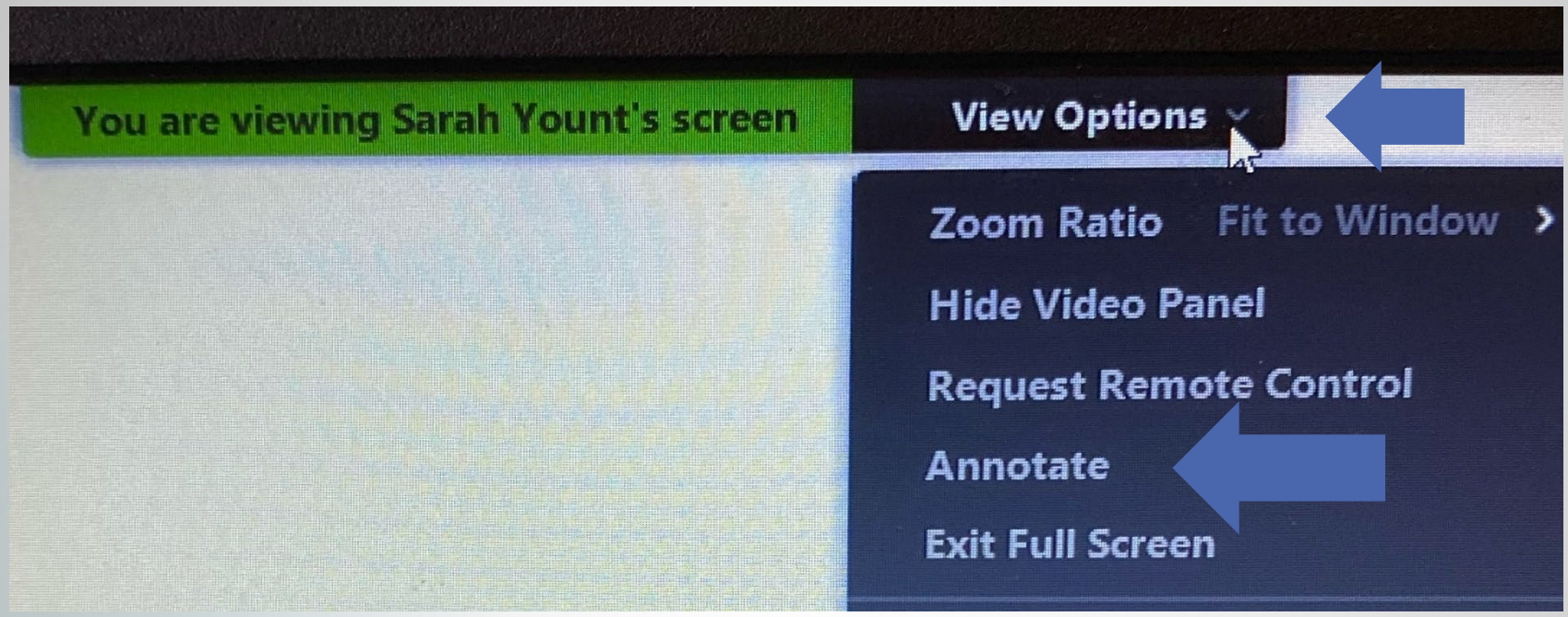
Under the Oklahoma State Medical Association CME guidelines disclosure must be made regarding relevant financial relationships with commercial interests within the last 24 months.

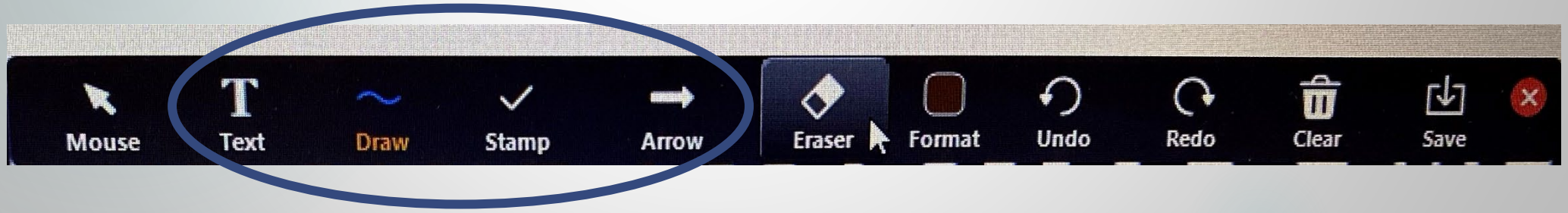
Sarah Yount has no financial relationships or affiliations to disclose.

Objectives

- Recognize population needs in Western Oklahoma
- Identify existing resources within specific Western Oklahoma counties
- Describe opportunities for improving accessibility and utilization of resources in the state

Interactive Discussion Tools





How many adult patients do you see in your practice setting?

A. 1-99

B. 100-250

C. 251-500

D. 501-1000

E. >1000

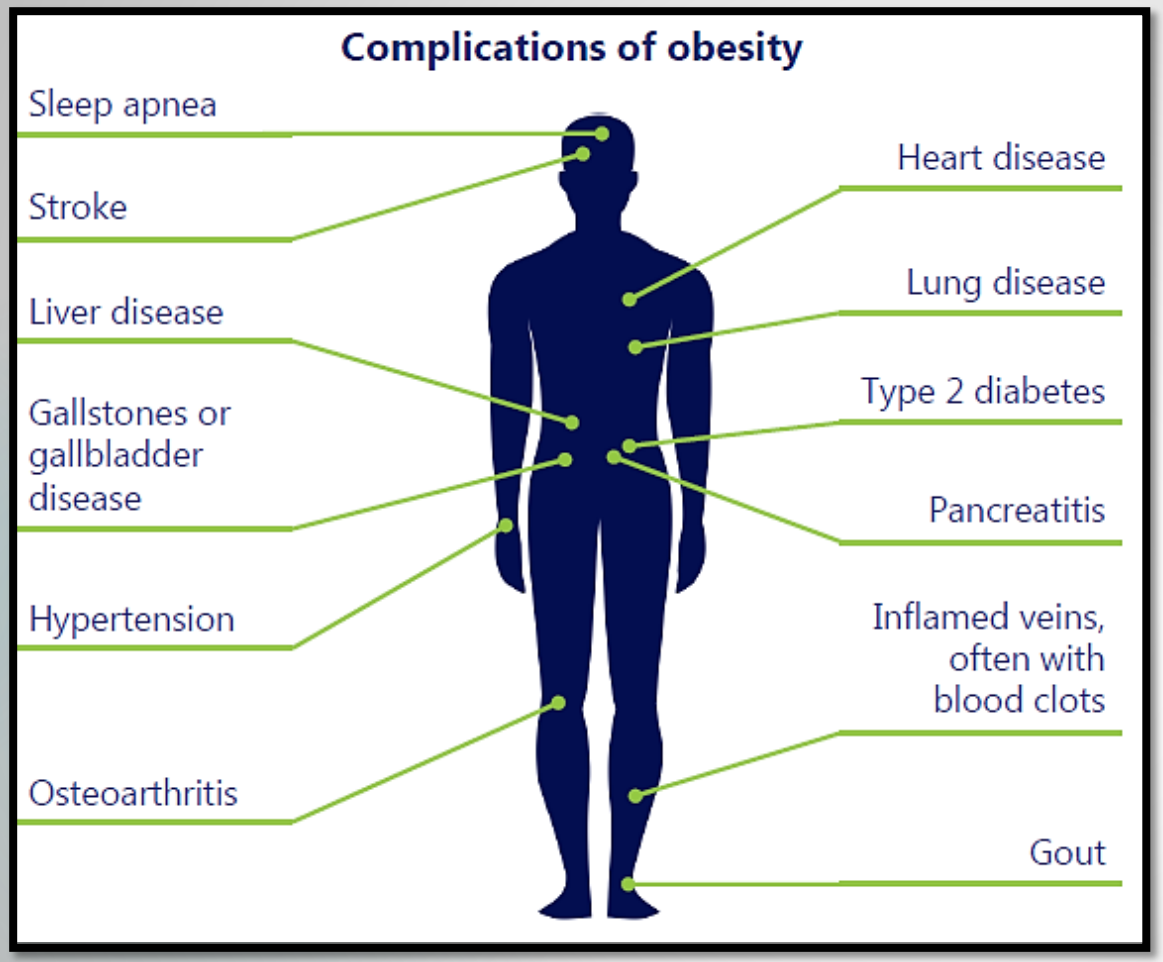
County Statistics

ABCs of Diabetes Management

County	Diabetes (%)	High Blood Pressure (%)	High Cholesterol (%)	Obesity (%)
Beckham	12.5	39.5	32.4	45.1
Greer	12.4	45.1	34.5	38.7
Kiowa	14.9	39.1	42	33
Roger Mills	13.8	45.4	46	37.8
Washita	11.8	37.7	38	41.3

Counties - State of the State's Health Report (ok.gov)

Impact of Obesity



OSDH Burden of Obesity in Oklahoma August 2020

- $1.7 billion in healthcare costs in Oklahoma
- Certain types of cancer [Obesity and Cancer Fact Sheet - National Cancer Institute]
- Pregnancy problems
- **Depression**

Obesity in Oklahoma: Impact on Overweight and Obesity | Shape Your Future (shapeyourfutureok.com). Health Risks of Overweight & Obesity | NIDDK (nih.gov).

County Statistics

County	Depression (%)	No Insurance Coverage (%)	Poverty (%)	No Physical Activity (%)
Beckham	25.6	16.7	13.6	36.6
Greer	25.3	22.8	23.7	43.1
Kiowa	26.6	15.6	21.1	43.8
Roger Mills	20.5	12.6	10.6	40.3
Washita	25.6	9.6	15.8	36.4

Counties - State of the State's Health Report (ok.gov)

2022-2023 WOW Screening Results

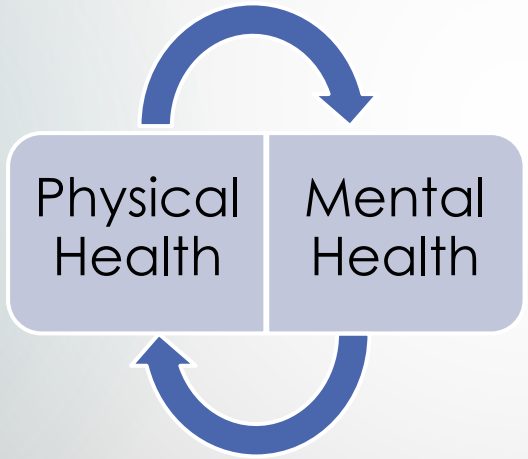
Seven Screenings in Five Counties

- 141 people served
- Ages 24-81
- 82% Female
- 83% White, 13% Hispanic, 3% Black, 3% American Indian
- Screened with abnormal blood glucose/A1c
  - **Prediabetes = 26**
  - Diabetes = 7
- Screened with abnormal cholesterol/lipid levels = 67
- Screened with elevated body weight
  - Overweight = 29
  - Obesity = 58
  - Morbid Obesity = 12

Patient Challenges

Biopsychosocial Perspective

- Biological
- Psychological
- Behavioral



What is your approach to addressing behavioral health?

Leading Causes of Death in Oklahoma

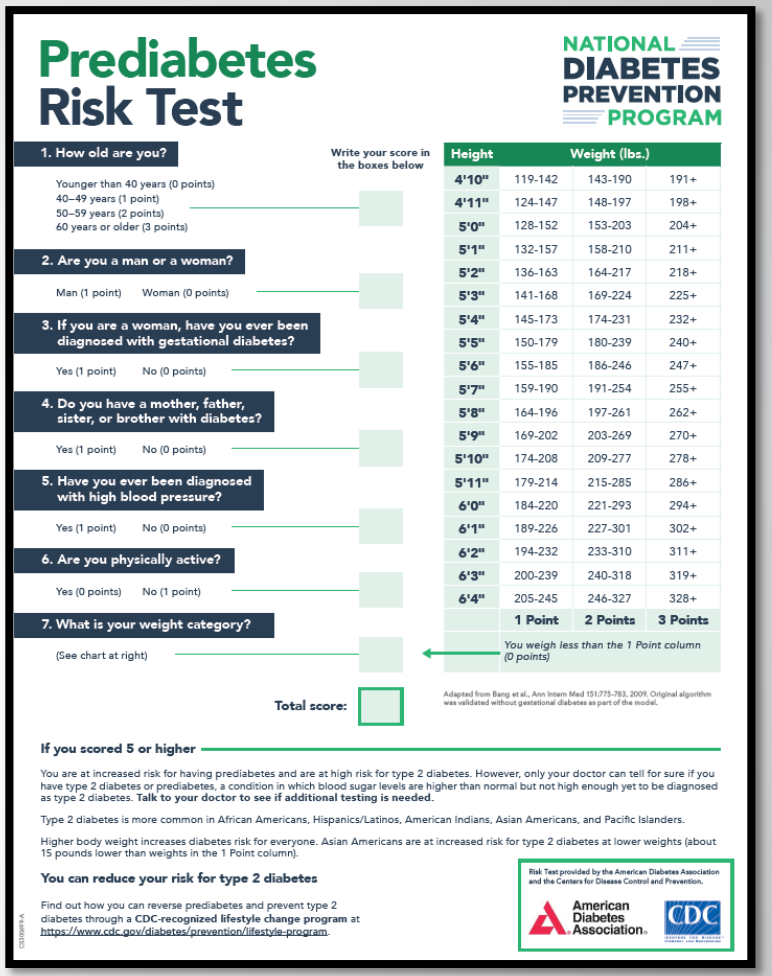
#1	#6	#7
Heart Disease	Stroke	Diabetes

Stats of the State of Oklahoma (cdc.gov)

Prediabetes

Precursor to type 2 diabetes

- Diagnosed through:
  - Blood Test
  - History of Gestational Diabetes
  - CDC/ADA Risk Test
- Impacts 1 in 3 adults
- Effects over 1 million Oklahomans
- 8 in 10 do NOT know



Prediabetes Risk Test

NATIONAL DIABETES PREVENTION PROGRAM

1. How old are you? — Write your score in the boxes below

Younger than 40 years (0 points)
40–49 years (1 point)
50–59 years (2 points)
60 years or older (3 points)

2. Are you a man or a woman?

Man (1 point) Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?

Yes (1 point) No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?

Yes (1 point) No (0 points)

5. Have you ever been diagnosed with high blood pressure?

Yes (1 point) No (0 points)

6. Are you physically active?

Yes (0 points) No (1 point)

7. What is your weight category?

(See chart at right)

Total score:

Height	Weight (lbs.)		
4'10"	119-142	143-190	191+
4'11"	124-147	148-197	198+
5'0"	128-152	153-203	204+
5'1"	132-157	158-210	211+
5'2"	136-163	164-217	218+
5'3"	141-168	169-224	225+
5'4"	145-173	174-231	232+
5'5"	150-179	180-239	240+
5'6"	155-185	186-246	247+
5'7"	159-190	191-254	255+
5'8"	164-196	197-261	262+
5'9"	169-202	203-269	270+
5'10"	174-208	209-277	278+
5'11"	179-214	215-285	286+
6'0"	184-220	221-293	294+
6'1"	189-226	227-301	302+
6'2"	194-232	233-310	311+
6'3"	200-239	240-318	319+
6'4"	205-245	246-327	328+
	1 Point	2 Points	3 Points

You weigh less than the 1 Point column (0 points)

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009. Original algorithm was validated without gestational diabetes as part of the model.

If you scored 5 or higher

You are at increased risk for having prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition in which blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes. **Talk to your doctor to see if additional testing is needed.**

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, Asian Americans, and Pacific Islanders.

Higher body weight increases diabetes risk for everyone. Asian Americans are at increased risk for type 2 diabetes at lower weights (about 15 pounds lower than weights in the 1 Point column).

You can reduce your risk for type 2 diabetes

Find out how you can reverse prediabetes and prevent type 2 diabetes through a **CDC-recognized lifestyle change program** at https://www.cdc.gov/diabetes/prevention/lifestyle-program.

Risk Test provided by the American Diabetes Association and the Centers for Disease Control and Prevention.

American Diabetes Association. CDC

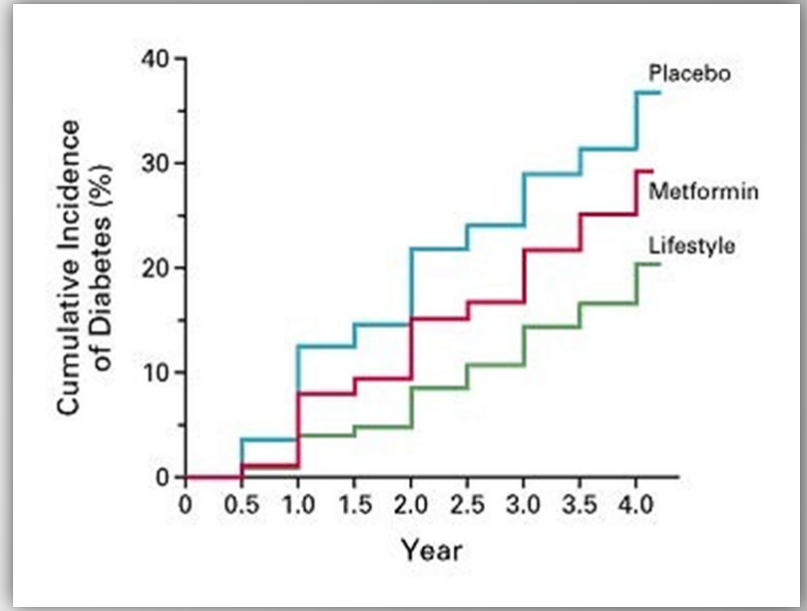
National Diabetes Prevention Program

- Centers for Disease Control and Prevention
  - Study findings released 2002
  - Released first curriculum 2012
- Southwestern Oklahoma State University

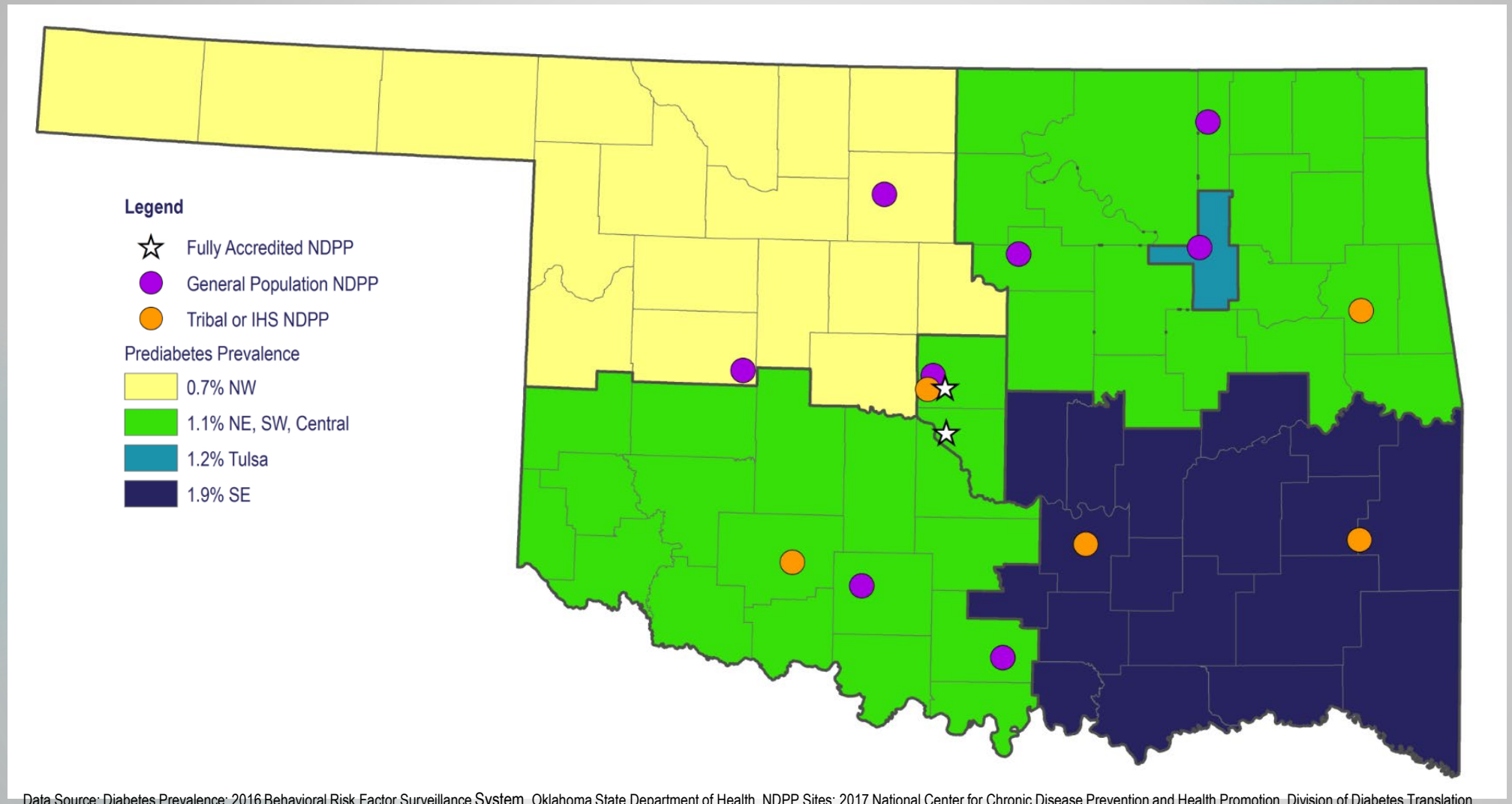
August 2016 program begins

January 2020 HealthChoice adopts NDPP

March 2020 shift to distance learning



As of September 2017, there were **15 National Diabetes Prevention Program (DPP) Sites** across the state.



15 DPP Sites:

- **2 Fully Recognized**
- **8 General Population**
- **5 Tribal**

Data Source: Diabetes Prevalence: 2016 Behavioral Risk Factor Surveillance System, Oklahoma State Department of Health. NDPP Sites: 2017 National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation.

Oklahoma Program Activities

National Diabetes Prevention Program (National DPP)

CDC-recognized organizations offering the lifestyle change program

Medicare Diabetes Prevention Program suppliers

Participants enrolled in the National DPP lifestyle change program

Oklahoma Medicaid program **does not have** some level of Medicaid coverage for the National DPP lifestyle change program

Missing 99.6%

Missing 96.5%

Diabetes Self-Management Education and Support (DSMES)

Recognized/accredited **DSMES service providers**

People with diabetes with at least one encounter at a recognized/accredited **DSMES service**

Oklahoma Diabetes Profile | Diabetes | CDC

True or False

All patients with diabetes should be screened for chronic kidney disease (CKD) with urine albumin-creatinine ratio (uACR) and estimated glomerular filtration rate (eGFR).

True

False

In addition, every patient with hypertension and patients over 60 years of age should also be screened with both tests.

Screening for CKD

- Oklahoma Screening in Medicare Patients:
  - 28.4% - DM and HTN
  - 3.81% - HTN only
  - 21.5% - DM only
- Southwest Oklahoma:
  - 6.36% of Medicare beneficiaries receive both uACR and eGFR tests
- Project ECHO® - Chronic Kidney Disease | National Kidney Foundation
  - **Target audience:** Primary care providers as well as any healthcare professionals involved in the care of patients living with chronic disease

Chronic Care Management (CCM)

- Collaborative Care Clinical Service
  - Requires Clinical Services Agreement (CSA)
- Performed by Pharmacist, Billed by Provider
- Pharmacist considered Auxiliary Personnel or Clinical Staff
- **Non-face-to-face** service under **general supervision**
- **Subject to copay/deductible**

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Accessed June 13, 2022.

CCM Eligibility

Medicare Part B beneficiaries with **two or more chronic conditions** expected to last **at least 12 months** or until the patient's death and or that place them at significant risk of death, acute exacerbation and or decompensation, or function decline, including but not limited to:

- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- **Cardiovascular disease**
- **Depression**
- **Diabetes**
- **Hypertension**
- Chronic Obstructive Pulmonary Disease (COPD)

56% of Medicare patients have ***2 or more chronic disease states***

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Accessed June 13, 2020.
https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm. Accessed July 13, 2022.

CCM Enrollment

- Beneficiaries must have been seen within the last 12 months
  - Evaluation and Management (E/M)
  - Initial Preventive Physical Exam (IPPE)
  - AWV
- Consent required *(written or verbal)*
  - Availability of services
  - Possible cost *(copays and deductibles)*
  - One practitioner providing and billing services per month
  - Right to cease service

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Accessed June 13, 2022.

CCM Components

- Record patient health information using certified EHR technology (PI)
- Creation of person-centered, electronic, comprehensive care plan for all health issues with focus on managing chronic conditions
- 24/7 access to care and continuity of care

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

MLN909188 – Chronic Care Management (cms.gov)

Remote Physiological Monitoring (RPM)

- Collaborative Care Clinical Service
  - Requires Clinical Services Agreement (CSA)
- Performed by Pharmacist, Billed by Provider
- Pharmacist considered Auxiliary Personnel or Clinical Staff
- **Non-face-to-face** service under **general supervision**
- Subject to copay/deductible
  - ***No copay during pandemic***

RPM Eligibility

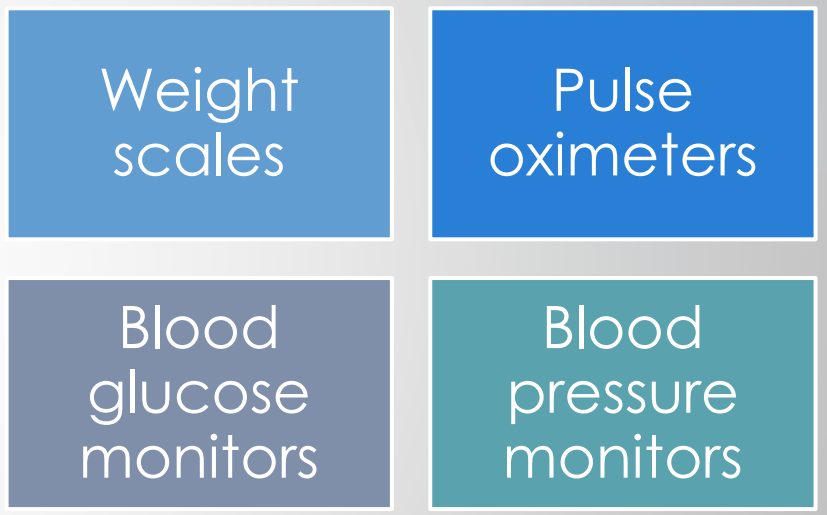
Established patient with one diagnosis – <u>ACUTE or CHRONIC</u>

- Diabetes
- Hypertension
- COPD
- Asthma
- Covid
- Kidney disease

85.6% of Medicare patients have at least ***1 chronic condition***

RPM Enrollment and Delivery

- Consent
- Device setup and education (99453)
- Data collection for a minimum of 16 days out of 30 days (99454)
  - Covid exception – *2 days*
- **20 minutes** per month (99457)
  - Monitoring RPM results
  - Interacting with patient and/or caregiver
  - Treatment plan adjustments
  - Additional 20 minutes (99458)



RPM Benefits

Medicare Part D Star Ratings

- CMS creates plan ratings that indicate the quality of Medicare plans on a scale of 1 to 5 stars
- Five Pharmacy Quality Alliance measures will be included in the 2023 Medicare Part D Star Ratings:
  - Medication Adherence for Diabetes Medications
  - Medication Adherence for Hypertension (RAS antagonists)
  - Medication Adherence for Cholesterol (Statins)
  - MTM Program Completion Rate for CMR
  - Statin Use in Persons with Diabetes

Provider Challenges

- What is challenging about providing additional services to your patients?
- What community and/or state collaborations are you involved in?
- What barriers do you face in implementing care coordination?

Resources

- **OSDH Community Health Workers (CHWs)**
  - Community services
  - Program referrals
  - Financial assistance
- **OSDH Health Educators**
  - Adverse Childhood Experiences (ACEs) – chronic disease impacts
  - Chronic Disease Prevention – prediabetes and diabetes, heart health
  - Mindfulness/Stress Management
  - Nutrition
  - Physical Activity

Resources

- **Diabetes Prevention Programs**
  - Diabetes Prevention Recognition Program Registry | CDC
- **Diabetes Self-Management Education and Support Services**
  - Find a Diabetes Education Program | ADA
  - https://nf01.diabeteseducator.org/eweb/DynamicPage.aspx?Site=aade&WebCode=DEAPFindApprovedProgram

Questions?

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Upcoming Events!

- **WOW Consortium Meeting**
  - Thursday, June 22, 2023 (11:00 a.m. – 1:00 p.m.)
  - SWOSU Pioneer Cellular Event Center
  - Lunch provided by HoganTaylor Technology Services

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For more information on WOW and to join our consortium:

Email jnoble@ofmq.com

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