Together 2 Goal®

AMGA Foundation National Diabetes Campaign

Monthly Campaign Webinar

May 19, 2016

WEBINAR REMINDERS

- Webinar will be recorded today and available the week of May 23rd
  - Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  - Email distribution
- Participants are encouraged to ask questions using the "Chat" and "Q&A" functions on the right side of your screen

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BASELINE DATA REPORTING DEADLINE: JUNE 1

REPORTING TIMELINE:

	Measurement Periods (Defined by Quarters)	Measurement Periods (Defined by Months and Days)	Reporting Deadline	Blinded, Comparative Reports Sent to Participating Organizations
T2G Baseline:	2016 Q1 (2015 Q2 - 2016 Q1)	2016 Q1 (2015 Apr 1 - 2016 Mar 31)	June 1, 2016	July 15, 2016

For data assistance, contact DataHelpForT2G@amga.org.

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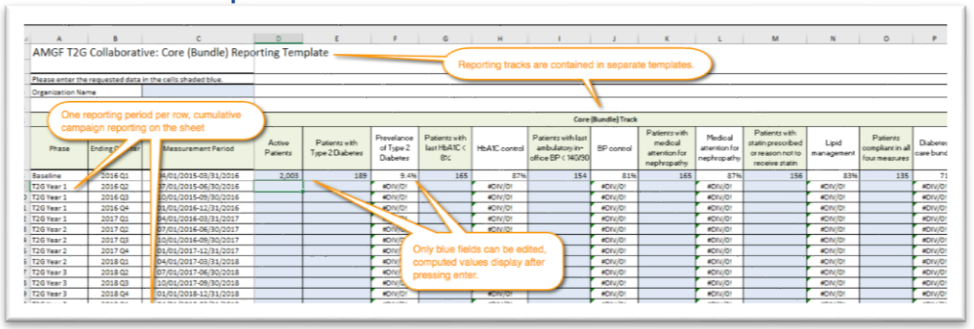
DATA REPORTING INFORMATION

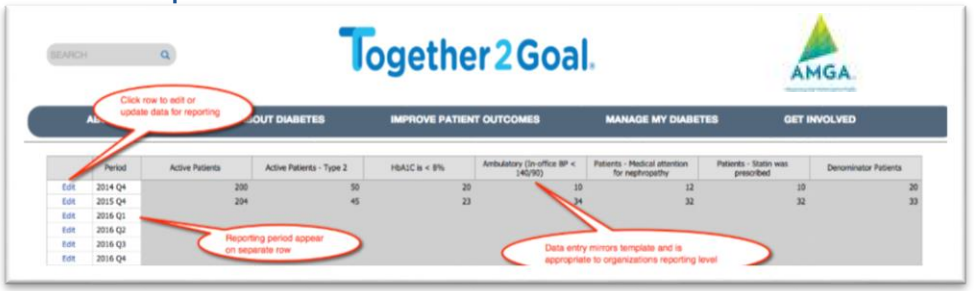
April email included:

- Excel template
- Data portal
- User guide
- Reporting deadlines
- Measurement specs

Excel template:



Data portal:



**Note: As a benefit to Anceta participants, AMGA Analytics (Anceta) will automatically report data on your organization's behalf according to the Core Track. Anceta will reach out in advance of the reporting deadline to review your data.*

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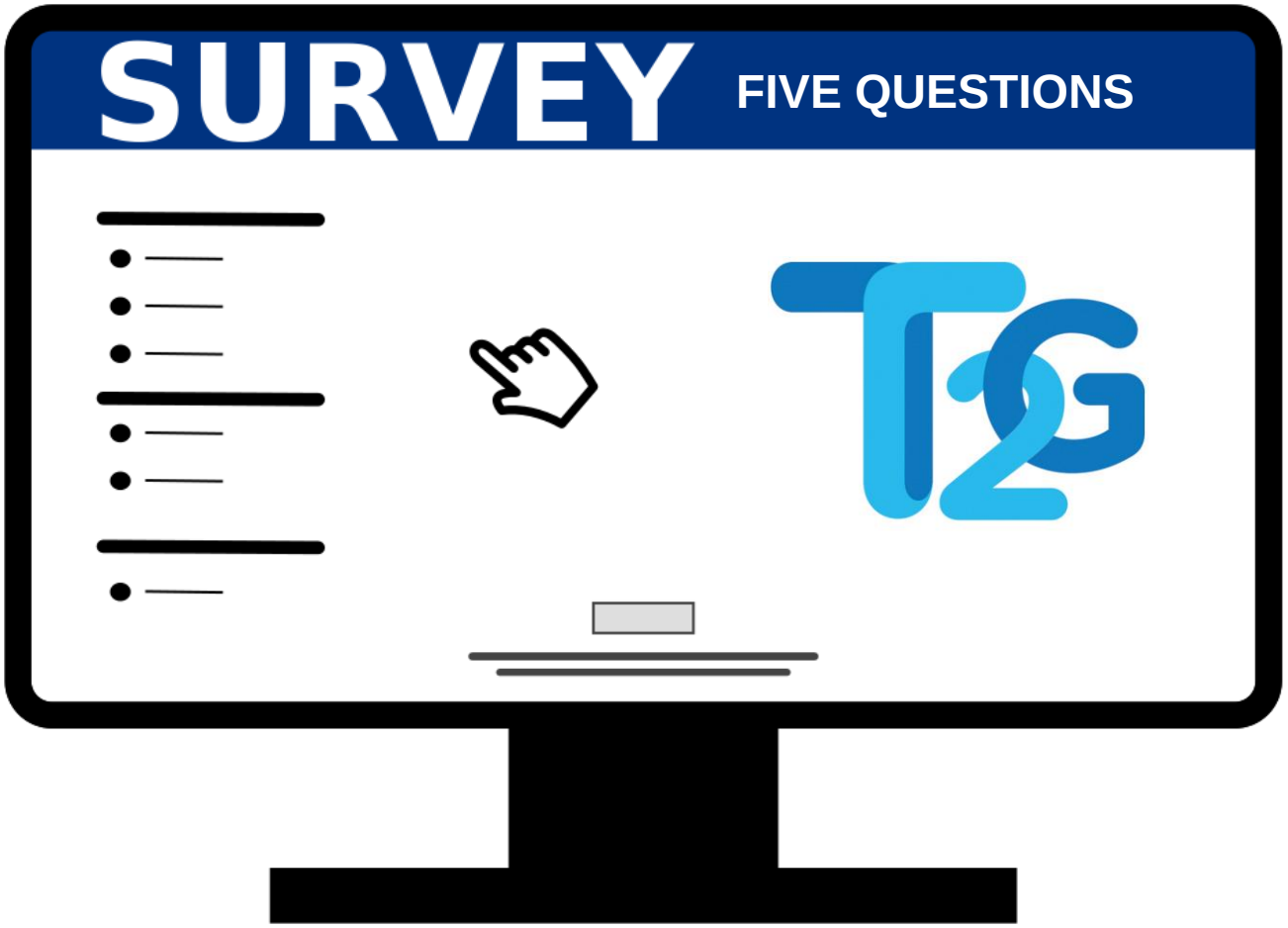
SURVEY DEADLINE: MAY 27



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NOT RECEIVING OUR EMAILS?

To assist with delivery of campaign emails, please add the following addresses to your "Approved Senders" list:

- together2goal@amga.org
- messenger@webex.com
- amga-t2g@amgalist.org
- Domains ending in @amga.org

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TODAY'S SPEAKER: DR. PARAG AGNIHOTRI

- Medical Director for Continuum of Care for Sharp Rees-Stealy Medical Group in San Diego
- Focuses on reforming the delivery of health care by building multidisciplinary teams to implement the 'three part aim' for improving the health of the population.
- Recognition
  - California Health Care Foundation Fellow
  - Center for Medicare and Medicaid Innovation Innovation Advisor
  - Board certified in Internal Medicine and Geriatric Medicine

Improving Care for the Population with Diabetes

"Measure HbA1c every 3-6 Months"

Parag Agnihotri, MD
Medical Director, Continuum of Care

Sharp Rees-Stealy Medical Group, San Diego

Agenda

How to promote team-based care

Address practice variation

How remote patient monitoring…

…creates patient engagement

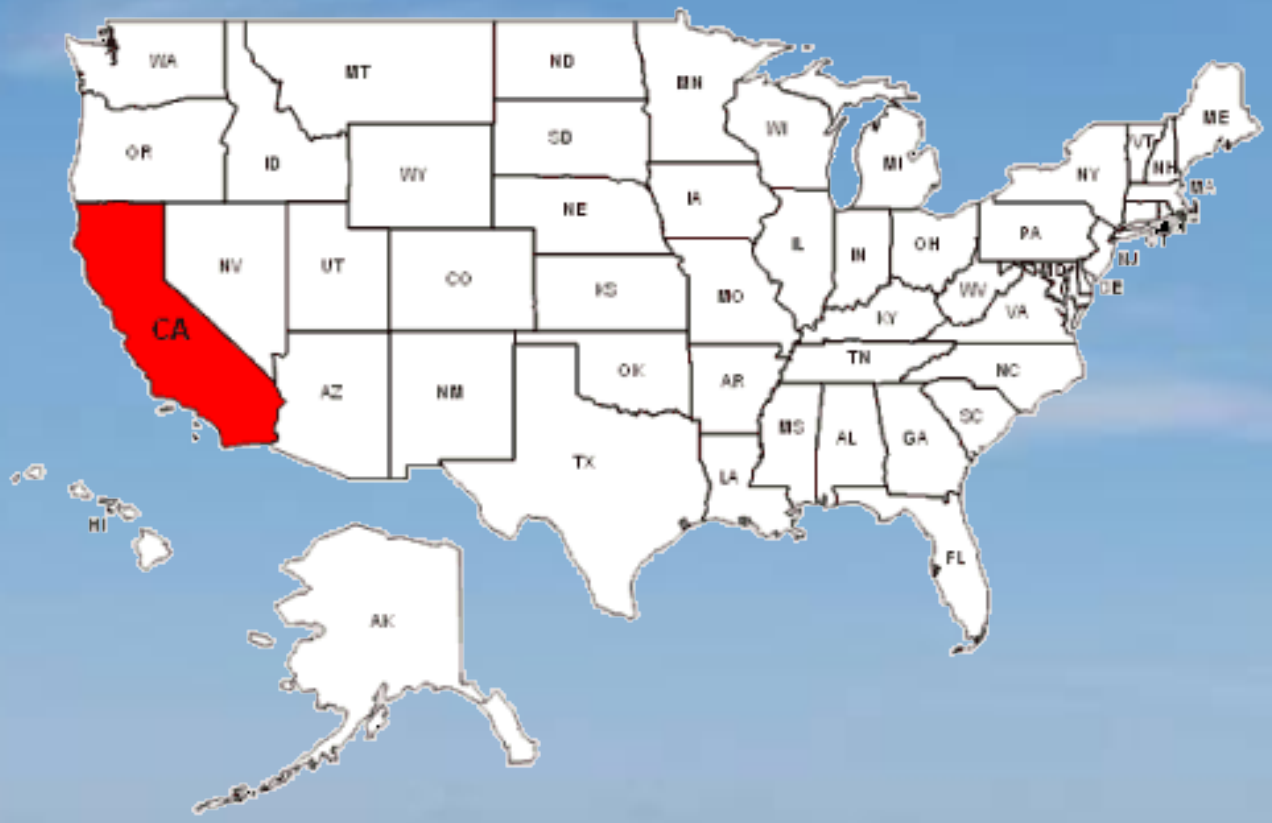
Q&A

SHARP Rees-Stealy Medical Group

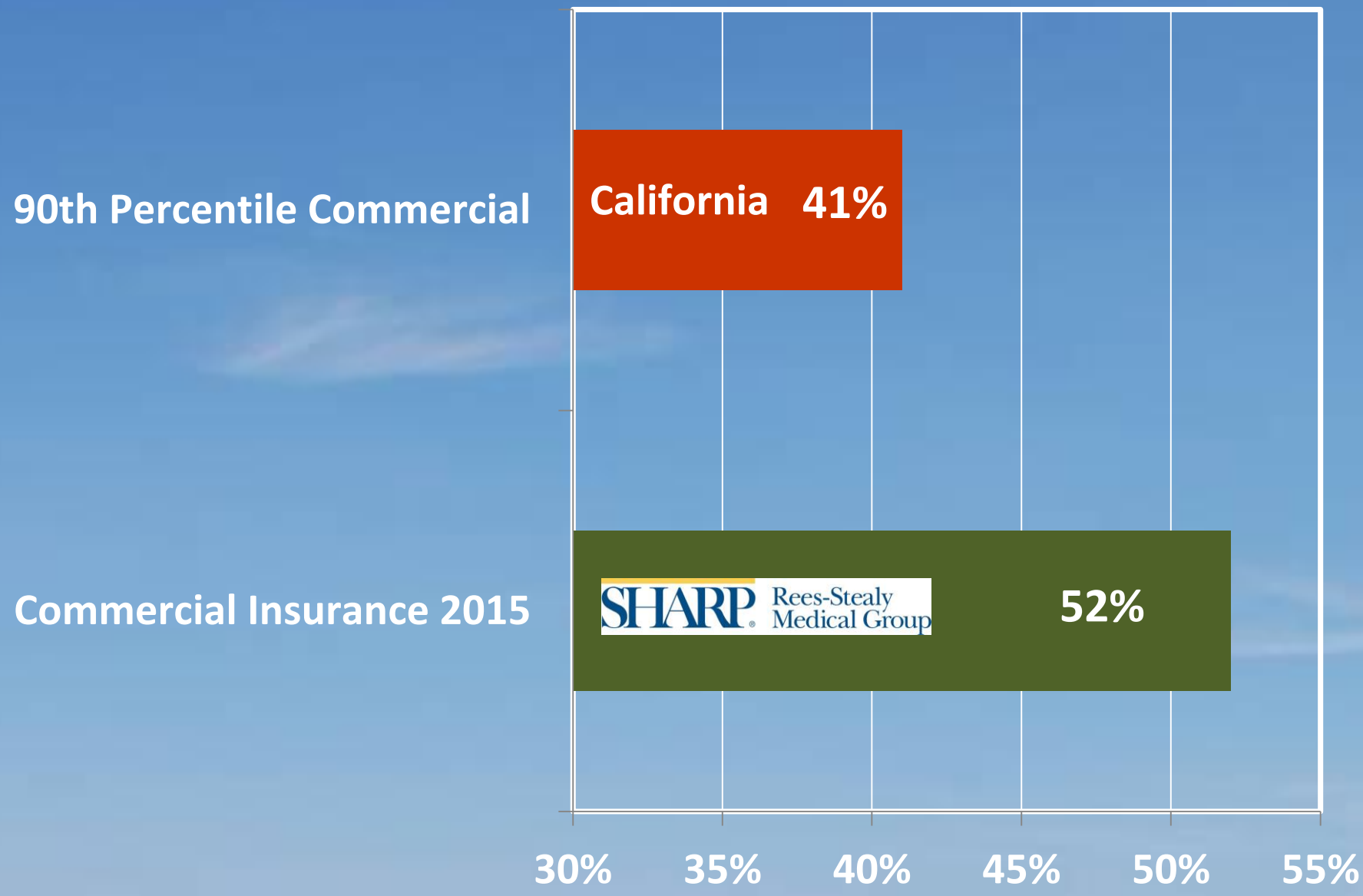
Success in Controlling Diabetes

SHARP Rees-Stealy Medical Group

Top 2 in California
Above national 90th percentile

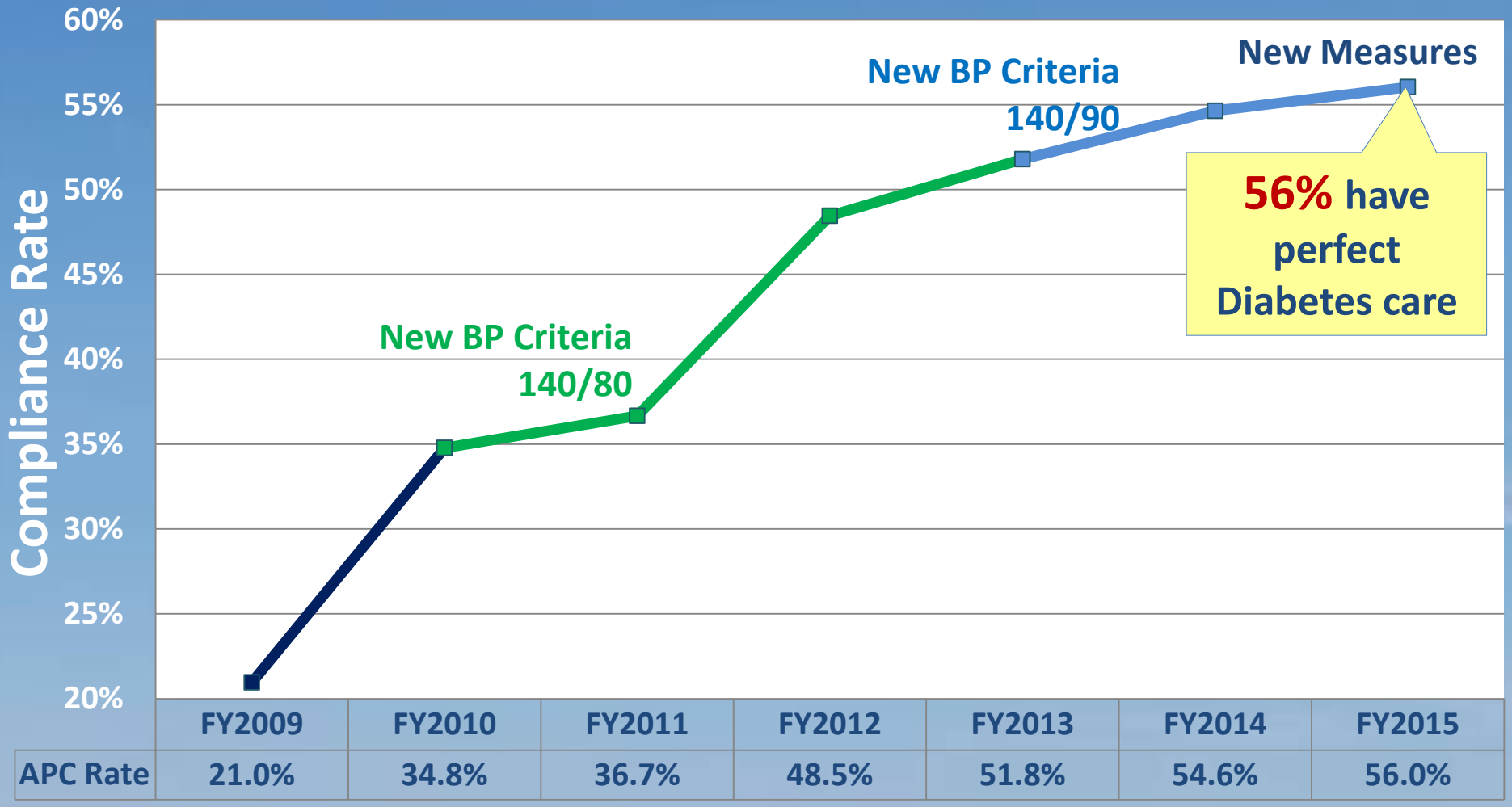


Optimal Diabetes Care Bundle



SHARP Rees-Stealy Medical Group

21,000 Patients with Diabetes :A1c<8%, LDL<100, Blood Pressure <140/90, and Nephropathy Screening
Added to Current Measures 2 A1cs and LDL>100 on Active Statin



	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
APC Rate	21.0%	34.8%	36.7%	48.5%	51.8%	54.6%	56.0%

Methodology: 12 month inclusion period Datasource: Diabetes Datamart

How do you address this in a large multispecialty medical group with …

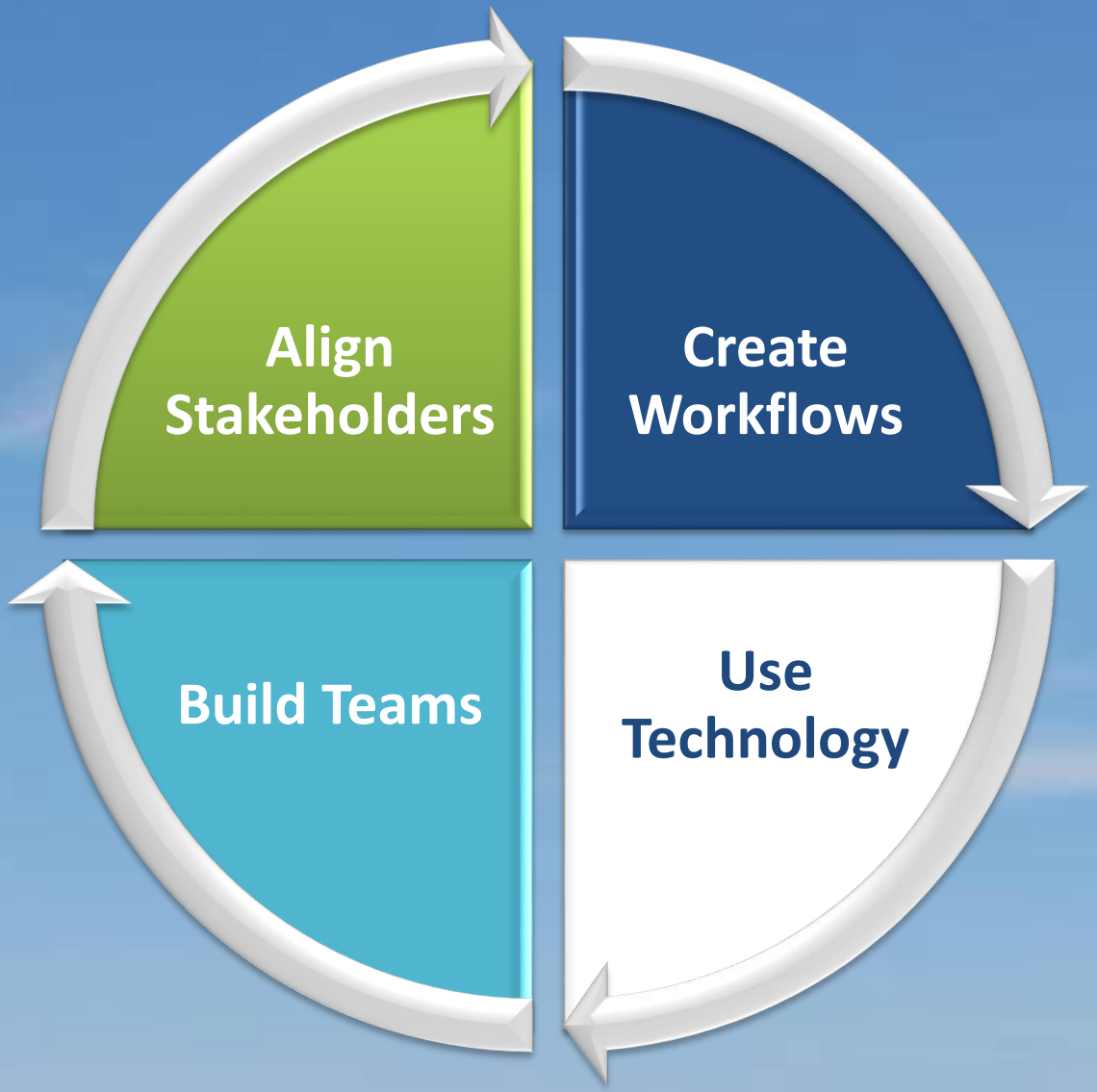
- 1.3 million visits
- 250,000 assigned patients
- 500 Physicians & 60 NP/PA
- 2000 Clinic staff
- 22 Clinic locations

21,000 population with Diabetes

Diabetes Care Success: Three Simple Rules

1. Appointment every 4 weeks until achieve goal A1c
2. Laboratory every 4 weeks until at goal A1c
3. Titration of medication every 4 weeks until at goal A1c

Our Successful Methods



Diabetes Care Measures are on the Organization Scorecard

Staff

President

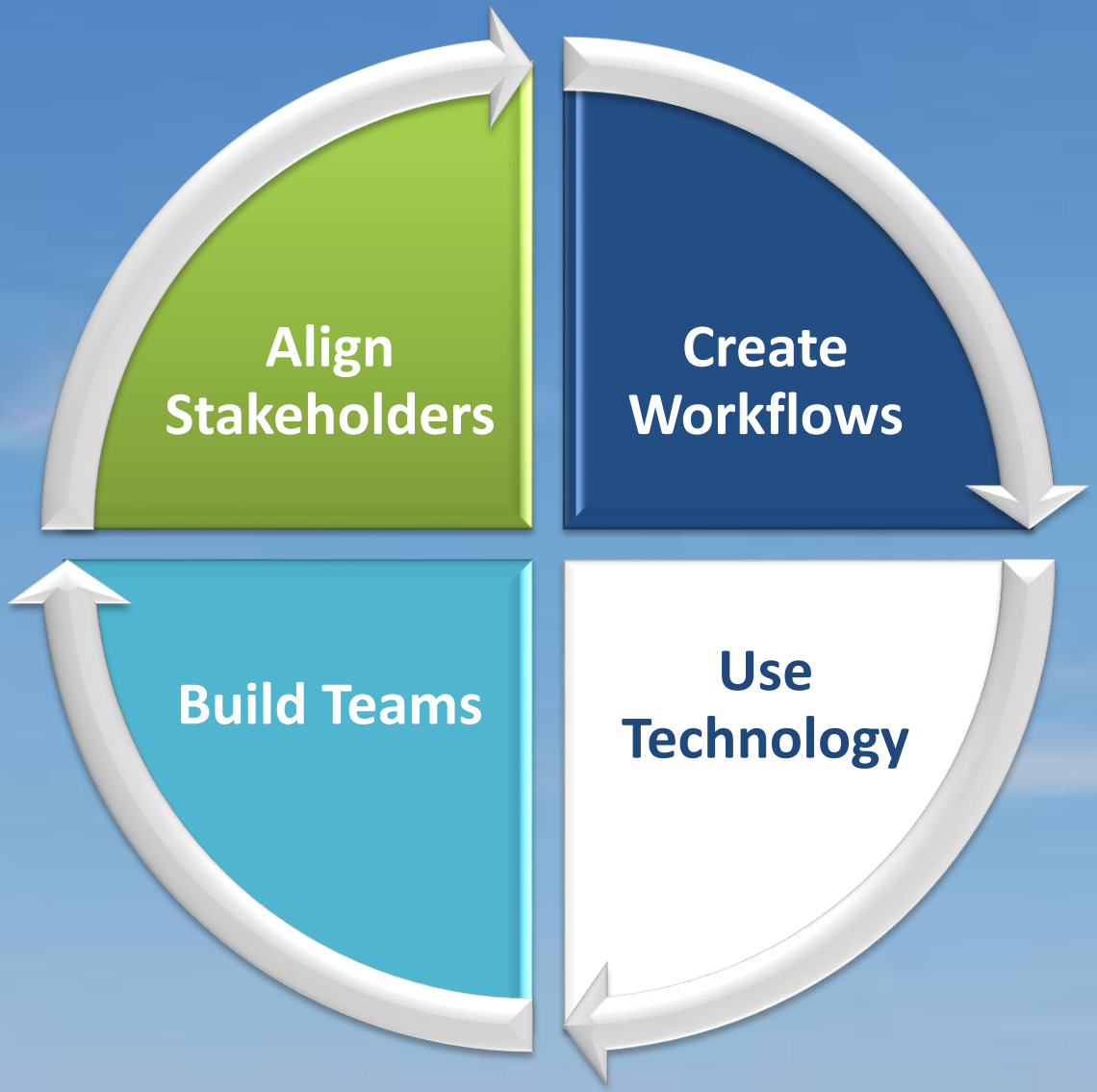
Physicians

CEO

Board

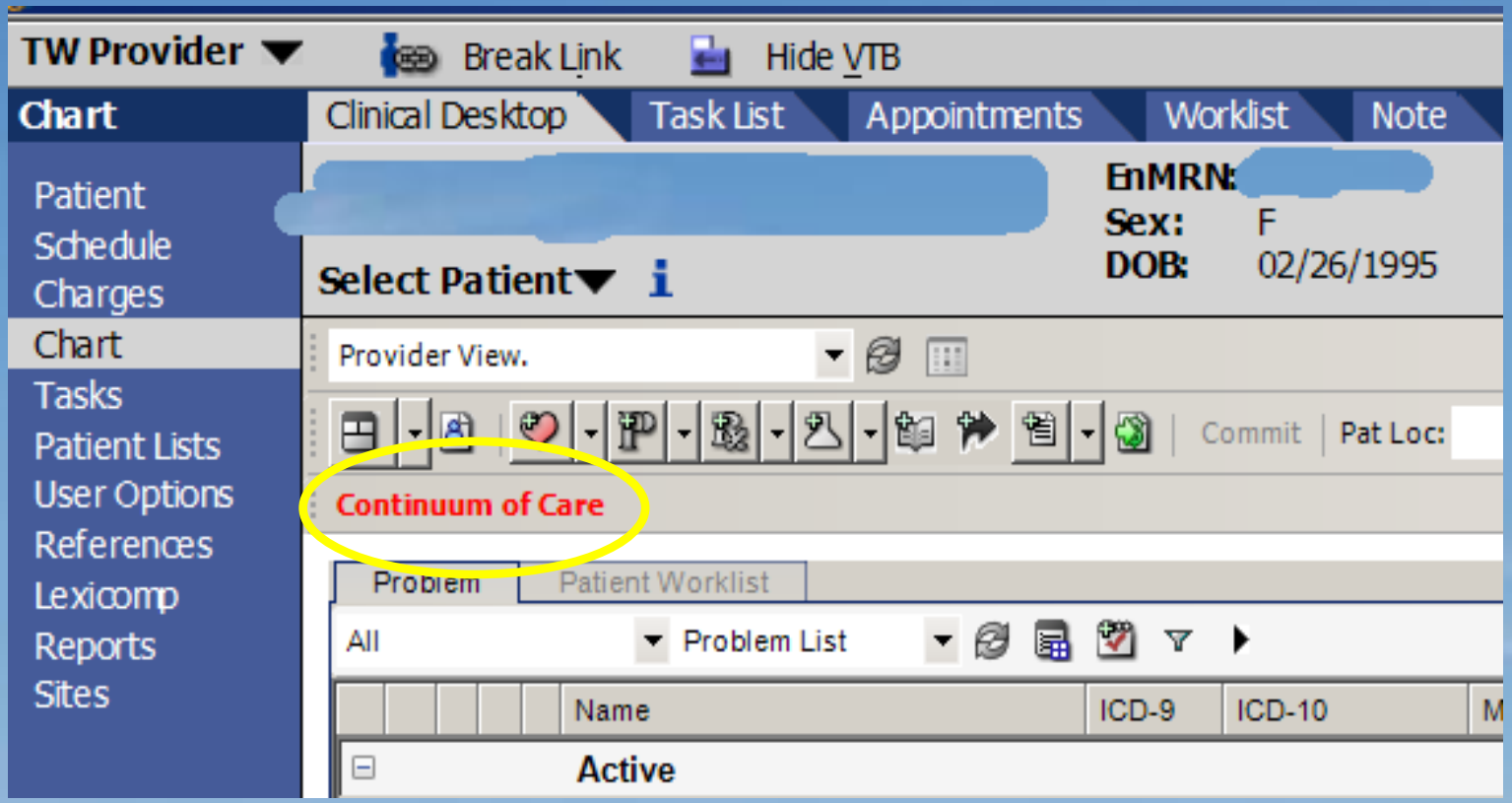
Senior VP

Our Successful Methods



Have a Common EHR Platform

Find us in Touchwork



The Registry: Shows all needed clinical components

Last PCP	Last Endo	Last HA1c	HA1c Date	Last LDL	LDL Date	BP2	BP1	BP Date
4/1/2014		5.8	7/7/2014	144	7/7/2014		92/62	9/9/2014
3/8/2013	9/10/2014	7.6	8/20/2014	105	8/20/2014		124/76	9/10/2014
2/24/2014	3/5/2014	6.9	6/9/2014	82	8/25/2014		149/68	9/2/2014
4/1/2014		6.8	3/20/2014	65	3/20/2014		158/75	9/4/2014
8/29/2014		6.5	7/23/2014	123	7/23/2014		122/76	8/29/2014
6/24/2011	5/27/2014	6.6	5/21/2014	117	5/21/2014		110/60	6/9/2014
9/8/2014	8/1/2014	5.1	7/17/2014	112	7/17/2014		115/68	9/8/2014
6/11/2014	3/1/2013	6.5	6/19/2014	70	6/19/2014		142/83	9/3/2014
9/5/2014		6.9	1/24/2014	41	1/24/2014		150/80	6/6/2014
8/27/2014		7.1	8/27/2014	113	8/27/2014		128/76	8/27/2014
2/7/2014		6	8/7/2014	129	8/7/2014		126/84	2/7/2014

The Registry: Needs to be Accurate

Last PCP	Last Endo	Last HA1c	HA1c Date	Last LDL	LDL Date	BP2	BP1	BP Date
4/1/2014		5.8	7/7/2014	144	7/7/2014		92/62	9/9/2014
3/8/2013	9/10/2014	7.6	8/20/2014	105	8/20/2014		124/76	9/10/2014
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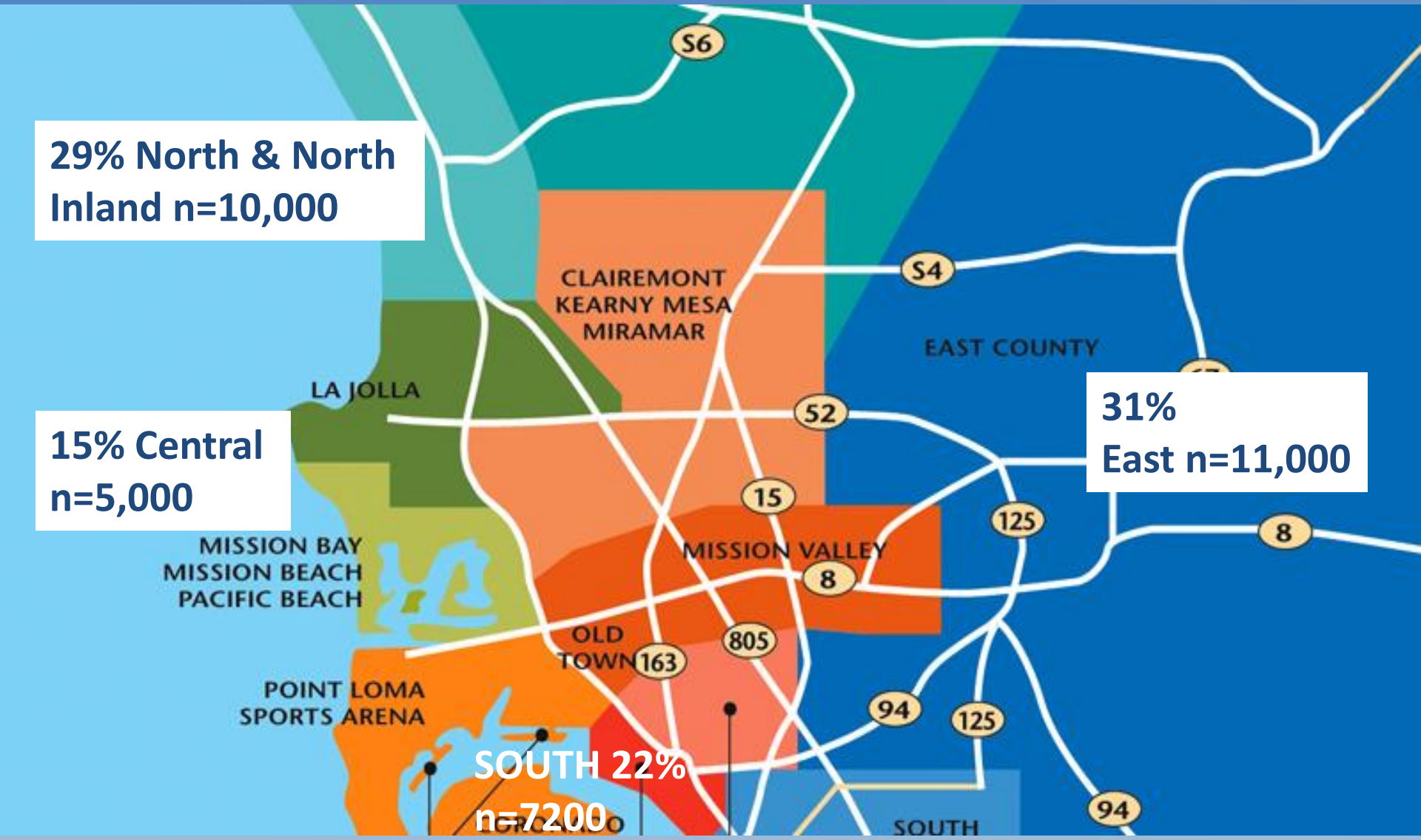
9/5/2014		6.9	1/24/2014	41	1/24/2014		150/80	6/6/2014
8/27/2014		7.1	8/27/2014	113	8/27/2014		128/76	8/27/2014
2/7/2014		6	8/7/2014	129	8/7/2014		126/84	2/7/2014

- All necessary labs
- Color coded for out of range
- Current medication
- Last Appointment
- Next Appointment

Hot Spotting of HTN in San Diego Population



1

List 1
Diabetes Disease Managers

1. A1c $\geq$ 8.5%
2. List of DM patients not seen in past year

Workflow:

Manage the Diabetes care

Schedule f/u appointments

2

List 2
Diabetes Nurses

1. LDL> 100 or
2. BP >140/90
3. A1c 8% to 8.4%

Workflow: Targeted Intervention

- Manage LDL as per protocol.
- BP recheck appointments and
- No appointment within two months

3

List 3

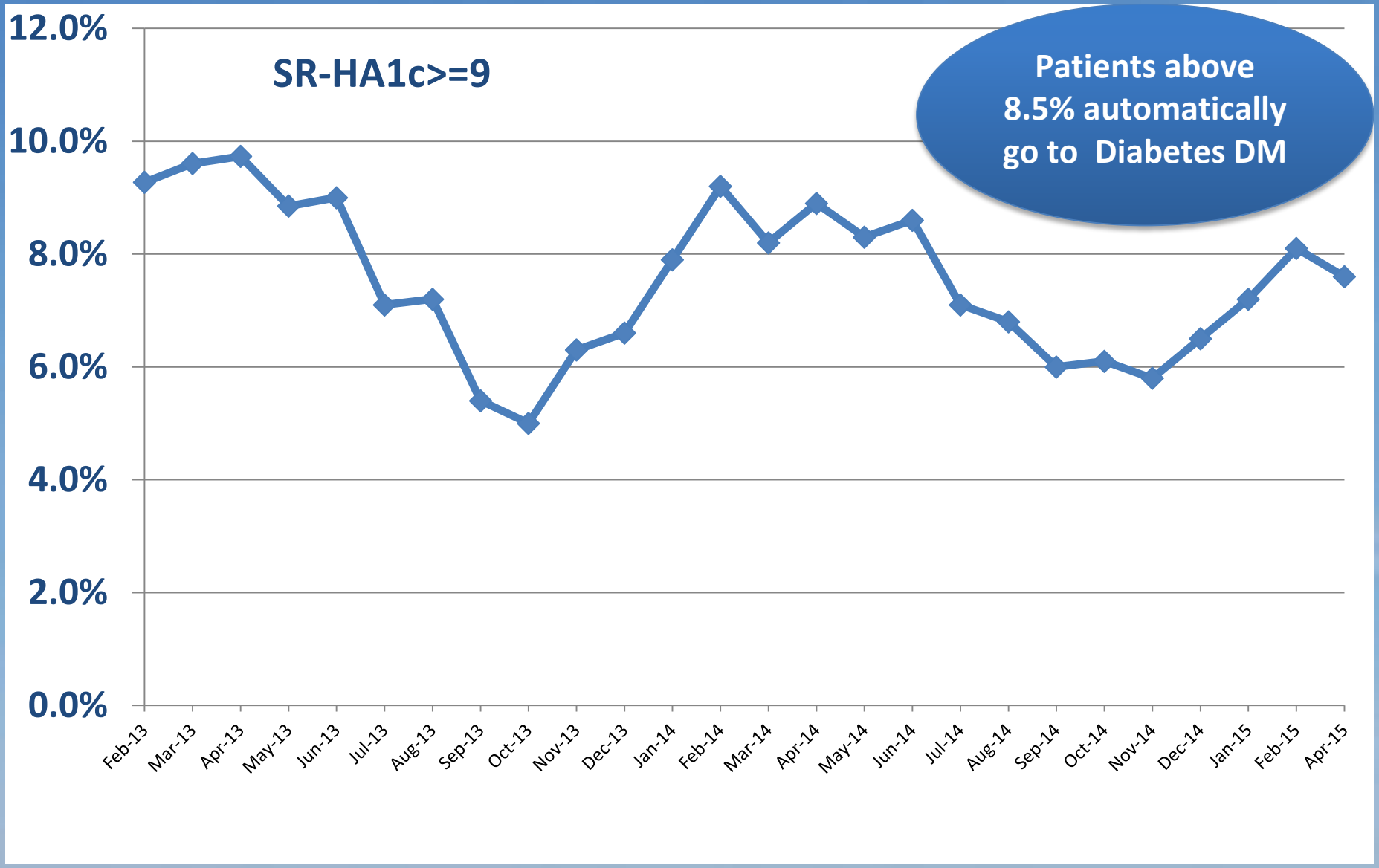
Care Specialist and Data team

1. Missing lab values
   - A1c, LDL, Microalbumin
2. No appointment with PCP 6 months

Workflow

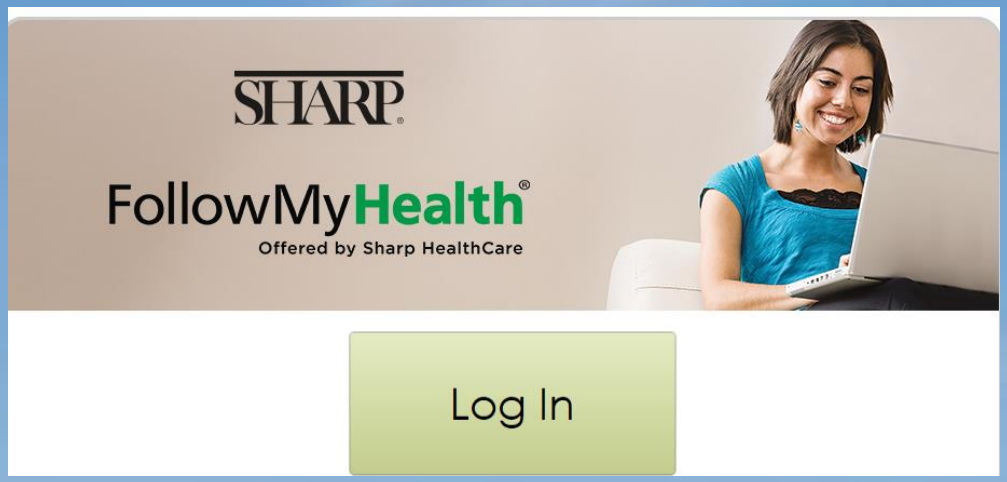
- Automated Phone calls
- Web Portal messaging
- Care Specialist will schedule with PCP

Create Workflows with Automation

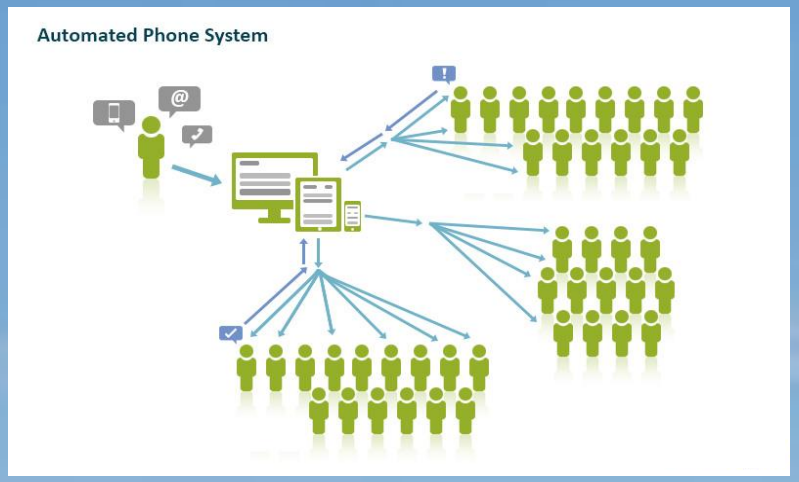


Outreach in Multiple Ways

Outreach using *Follow My Health* web portal and Nuance telephonic outreach messages



Minimize the number of lists which go out to the Physicians and Clinic sites



Our Successful Methods

Continuous Improvement Process
Centralized Process

11 Diabetes Disease Managers A1c> 8%

3 Dedicated RNs for Targeted DM Intervention

→ Call patients to make sure they are taking meds

- Then ensure labs have been tested
- Not taking meds -- Task physicians

2 Care Specialists obtain appointments

Engage the Patient: *Partner with me*

- Form personal connection
- Face to face interaction
- Step-by-step wellness plan
- Coordination of care across the system
- Patient specific education material
- Shared care plans
- Medication adherence reporting
- Use HIT to engage all patients not just present

Questionnaire for Diabetes Patients
Self Efficacy

Self Efficacy

16) How well do you feel that you are currently able to manage your Diabetes?

Fair

17) What is your biggest concern right now about your Diabetes?

How am I going to do everything I need to do

44 of 1000 Characters Used, 956 Remaining

18) Does your current cultural heritage or spiritual/personal beliefs conflict with your doctor's recommendations for treatment?

No

19) I can prevent complications:

Disagree

20) Feelings about health/diabetes:

Frustrated

Patient Engagement

Diabetes Care Goals

Measurements	Goal	My Latest Result:
HbA1C: A measure of the average blood sugar over the past 3 months. HbA1c 7% = Avg BS 154 8% = Avg BS 183 9% = Avg BS 212 	2 A1C measurements in past 12 months	☐
	Latest A1C=7.0% or Less	_____
Blood Pressure 	139/89 or Less	_____
Taking Statin Medication to Lower LDL: LDL is the bad cholesterol that can increase the risk of heart disease and stroke. 	LDL =The lower the better	_____
Urine Microalbumin Annual screening for kidney disease 	Screening annually or taking an ACE or ARB medication	☐

1. **Contact the following Sharp Rees-Stealy programs:**
   - ☐ Diabetes Education and Training (858) 499-2700
   - ☐ Healthier Living Class 1-800-82-SHARP (1-800-827-4277)
   - ☐ Diabetes Texting Program (Text MYTEXT to 63141)
   - ☐ Health Education Programs (619) 590-3300
2. **If your A1C is 8.0% or greater, talk to your doctor about checking your A1C again in 4-8 weeks.**

Measure the Engagement Rate

Sample Month **Program Engagement Rates: Rolling 12 Months**

Program Type	Overall Engagement	Previous Month
Diabetes	**68.5%**	65.1%
COPD	**75.5%**	75.3%
CHF	**62.9%**	62.4%
CKD	**22.9%**	22.9%
Complex Case Management	**31.1%**	31.8%
Chronic Care Nursing	**78.8%**	78.3%
Senior Enhanced Care Management	**57.2%**	58.6%
Behavioral Health	**29.2%**	28.3%
Health Coaching	**34.4%**	26.6%
Overall Engagement	**52.1%**	**51.1%**

Graduation into Self-Management: Healthier Living Classes 2015 YTD

15 workshops
118 participants

63% completion rate

Physician Engagement Strategy

1. What do you want your Physicians to do?
2. Do they know how to do the work?
3. Do they have the resources to do the work?
4. Are physicians motivated to do the work?

Ralph Jacobson is founder and principal of The Leader's Toolbox and author of "Leading for a Change: How to Master the Five Challenges Faced by Every Leader." He is also a faculty member of the Physician's Leadership College. He can be reached at www.theleaderstoolbox.com

Diabetes Care Success: Three Simple Rules

1. Appointment every 4 weeks until achieve goal A1c
2. Laboratory every 4 weeks until at goal A1c
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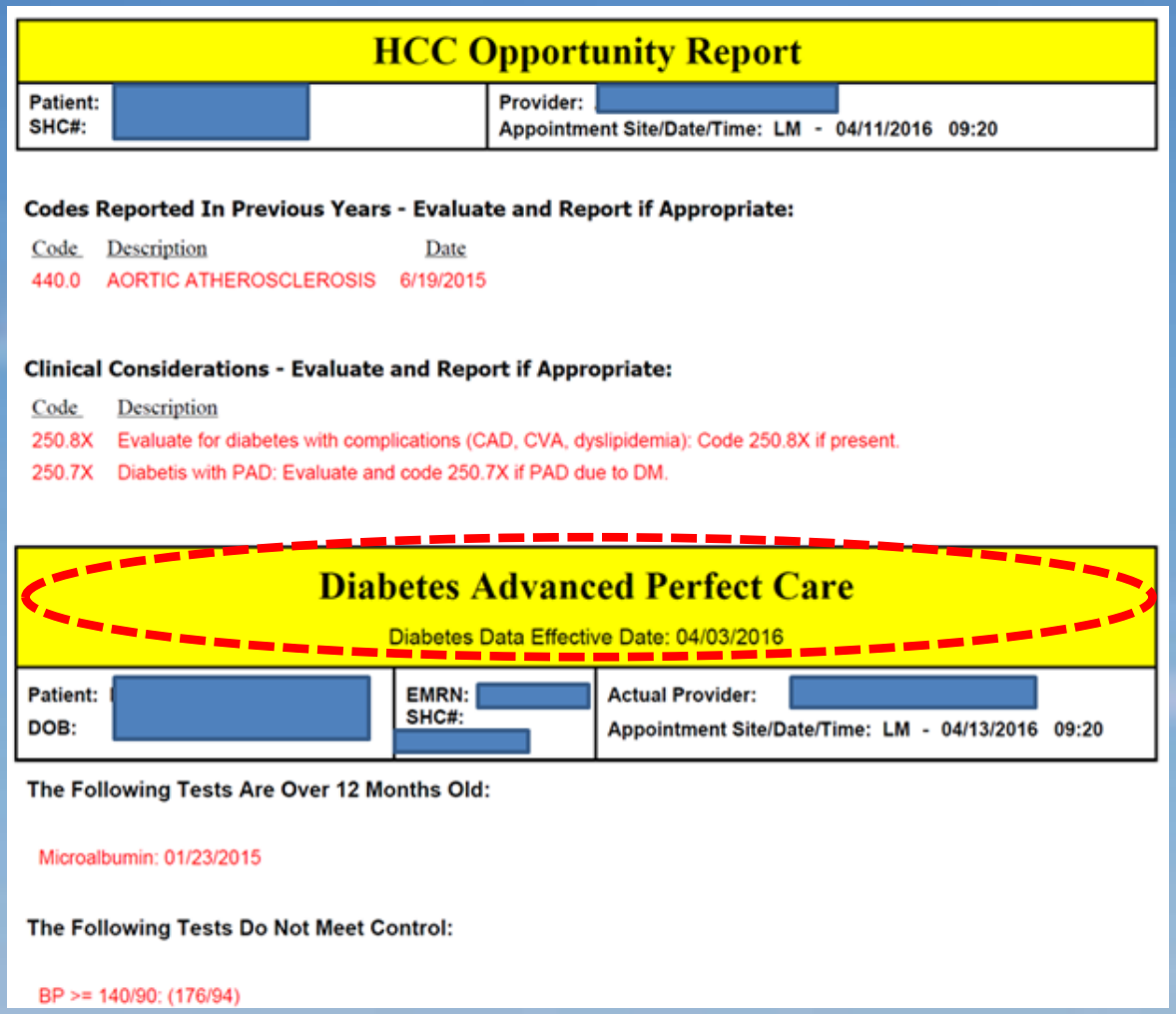
Tools to help with Panel Management
Point of Care Tool via EHR



HCC Opportunity Report

Patient: [redacted]
SHC#:

Provider: [redacted]
Appointment Site/Date/Time: LM - 04/11/2016 09:20

Codes Reported In Previous Years - Evaluate and Report if Appropriate:

Code	Description	Date
440.0	AORTIC ATHEROSCLEROSIS	6/19/2015

Clinical Considerations - Evaluate and Report if Appropriate:

Code	Description
250.8X	Evaluate for diabetes with complications (CAD, CVA, dyslipidemia): Code 250.8X if present.
250.7X	Diabetis with PAD: Evaluate and code 250.7X if PAD due to DM.

Diabetes Advanced Perfect Care

Diabetes Data Effective Date: 04/03/2016

Patient: [redacted]
DOB:

EMRN: [redacted]
SHC#:

Actual Provider: [redacted]
Appointment Site/Date/Time: LM - 04/13/2016 09:20

The Following Tests Are Over 12 Months Old:

Microalbumin: 01/23/2015

The Following Tests Do Not Meet Control:

BP >= 140/90: (176/94)

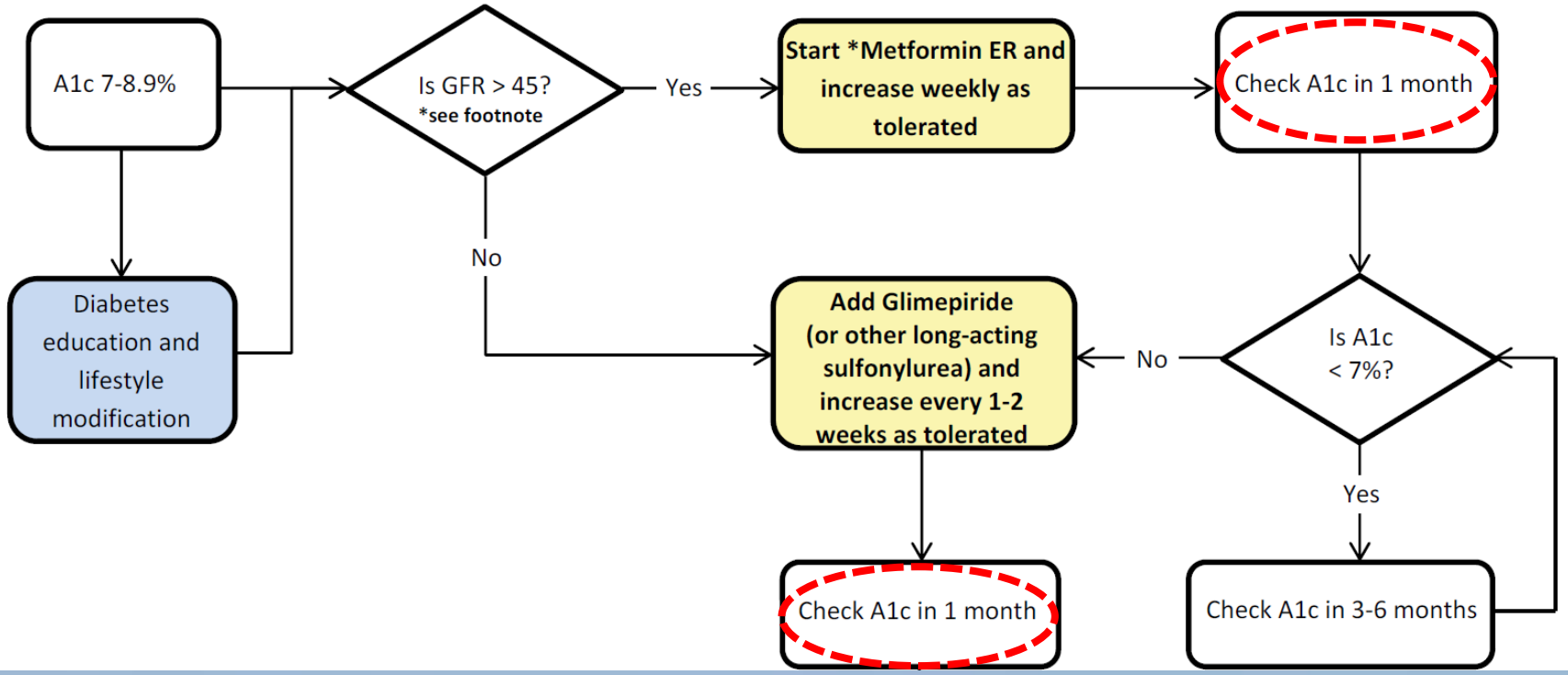
Diabetes Management Guidelines

SHARP
REES-STEALY CLINICAL GUIDELINES COMMITTEE

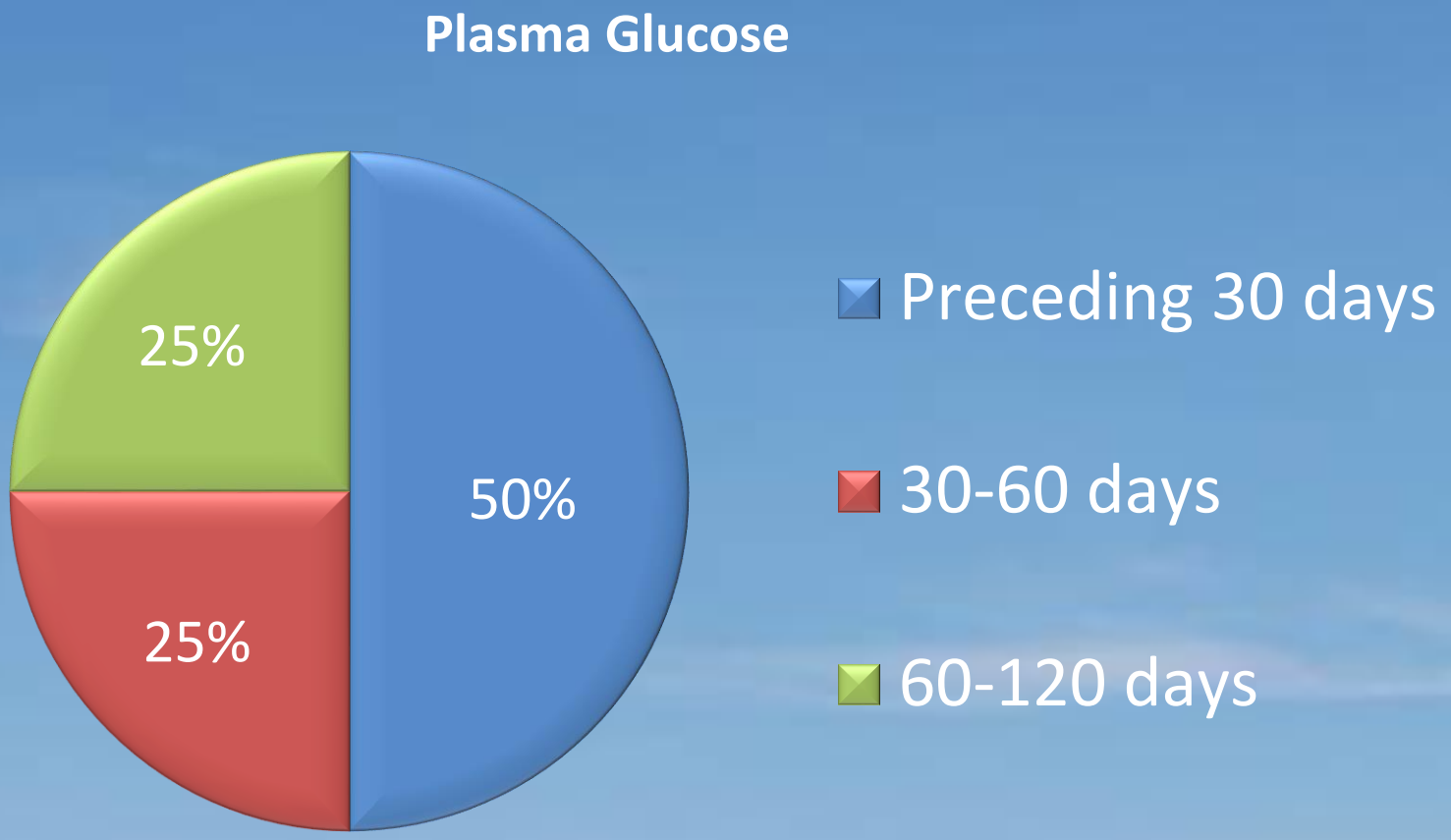
Title: Diabetes Medication Management Guidelines for Patients w/A1c 7-8.9%	Original Date: 10/30/2012 Revision Date: 1/29/15

Disclaimer: Sharp Rees-Stealy clinical guidelines are designed to assist clinicians in the evaluation and treatment of the more common medical problem. They are not intended to replace clinical judgment or establish a protocol for all patients. The clinical approach described by this guideline will not fit all patients and will rarely establish the only appropriate approach to a problem.

SRS Diabetes Medication Management Algorithm for HbA1C 7-8.9%



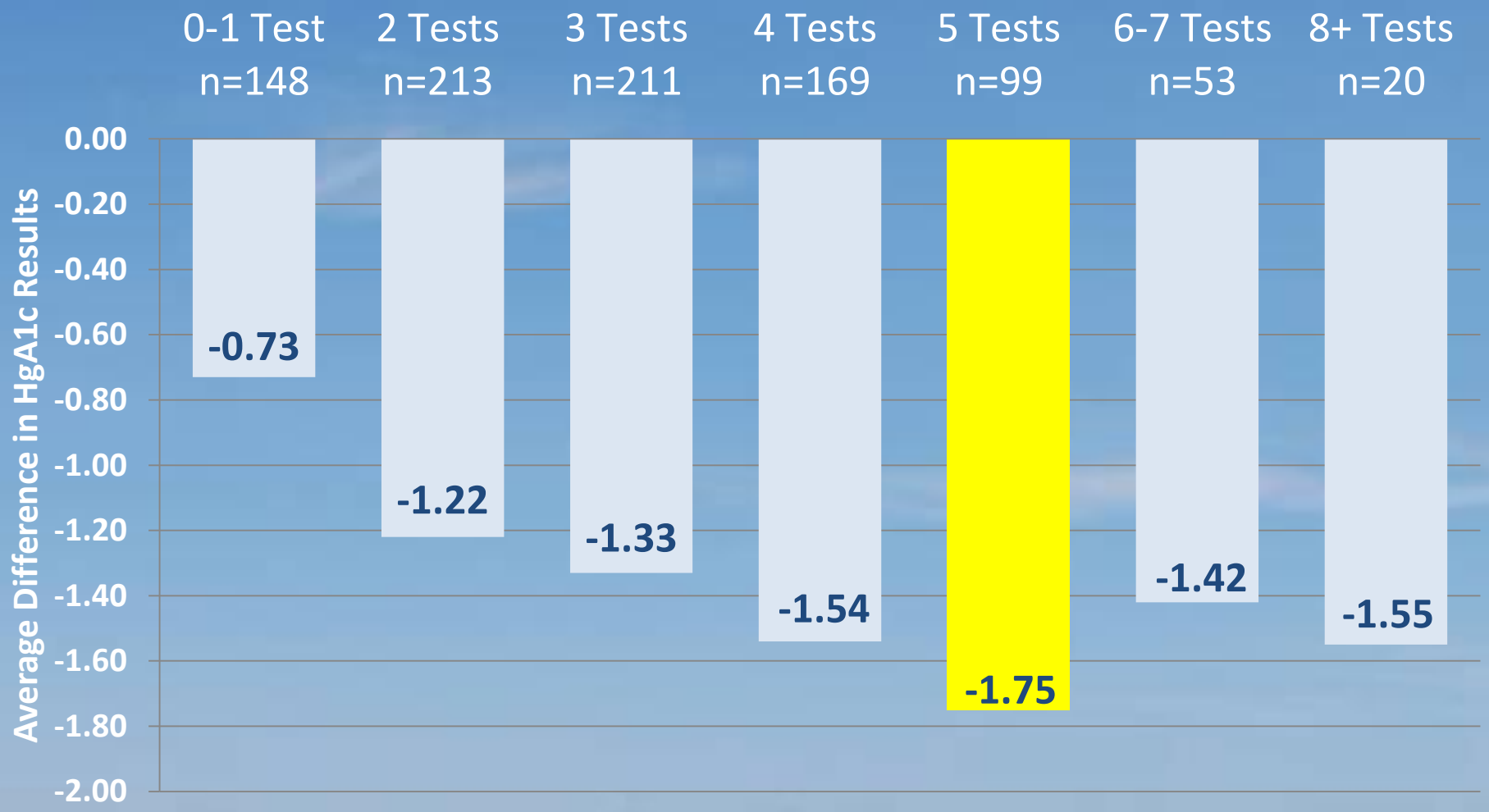
HbA1c is a weighted average of Blood Glucose levels during the preceding 120 days



Defining the Relationship Between Plasma Glucose and HbA_{1c} Analysis of glucose profiles and HbA_{1c} in the Diabetes Control and Complications Trial Curt L. Rohlfing, BES, et al 0.2337/diacare.25.2.275Diabetes Care February 2002vol. 25 no. 2 275-278
Tahara Y and Shima K. The Response of GHb to stepwise plasma glucose change over time in diabetic patients. Diabetes Care 1993;16:1313-14.

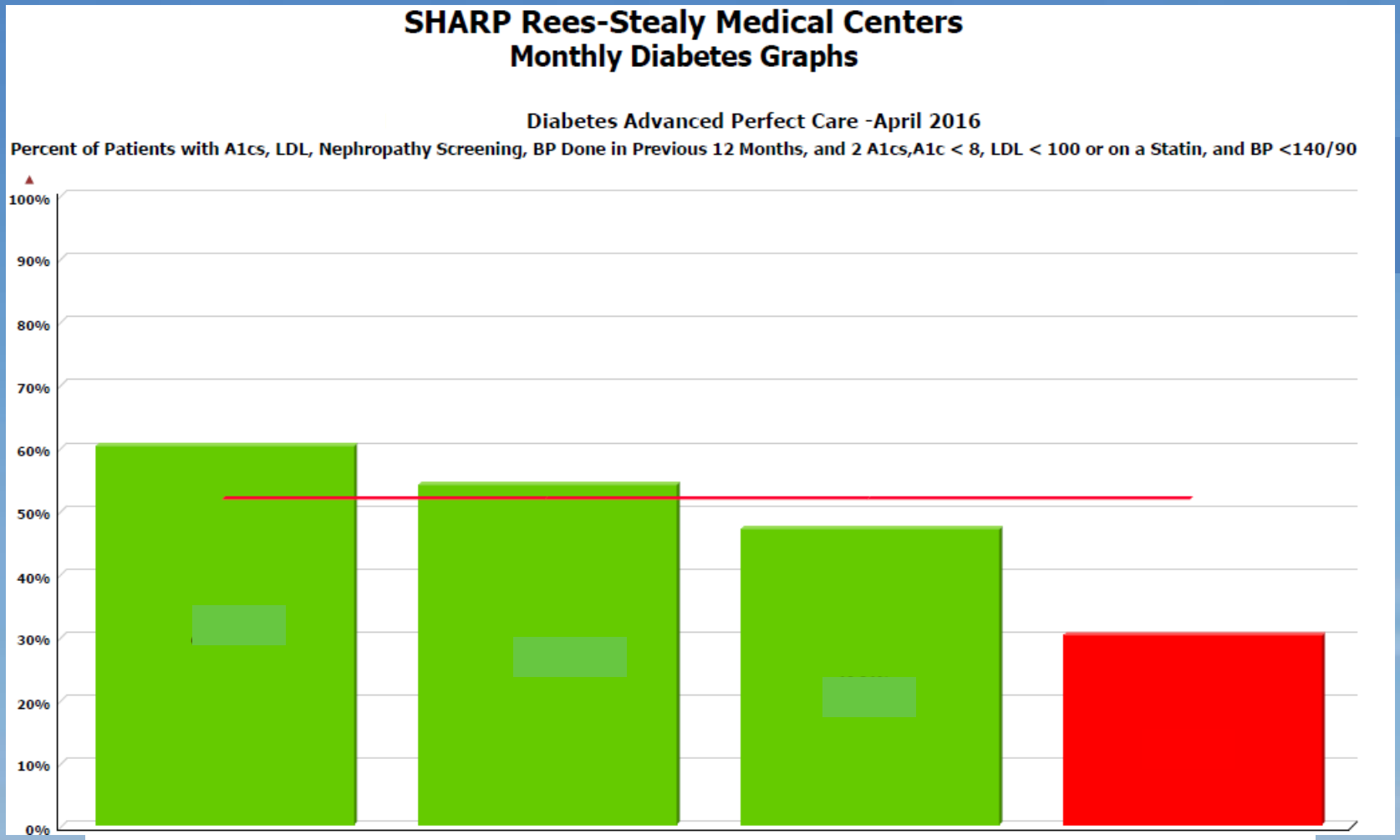
Uncontrolled Diabetics need at least 5 A1c labs …every 2-3 months…

Optimal *Frequency of A1c tests/year for Diabetic population whose baseline HgA1c result were >=9%*

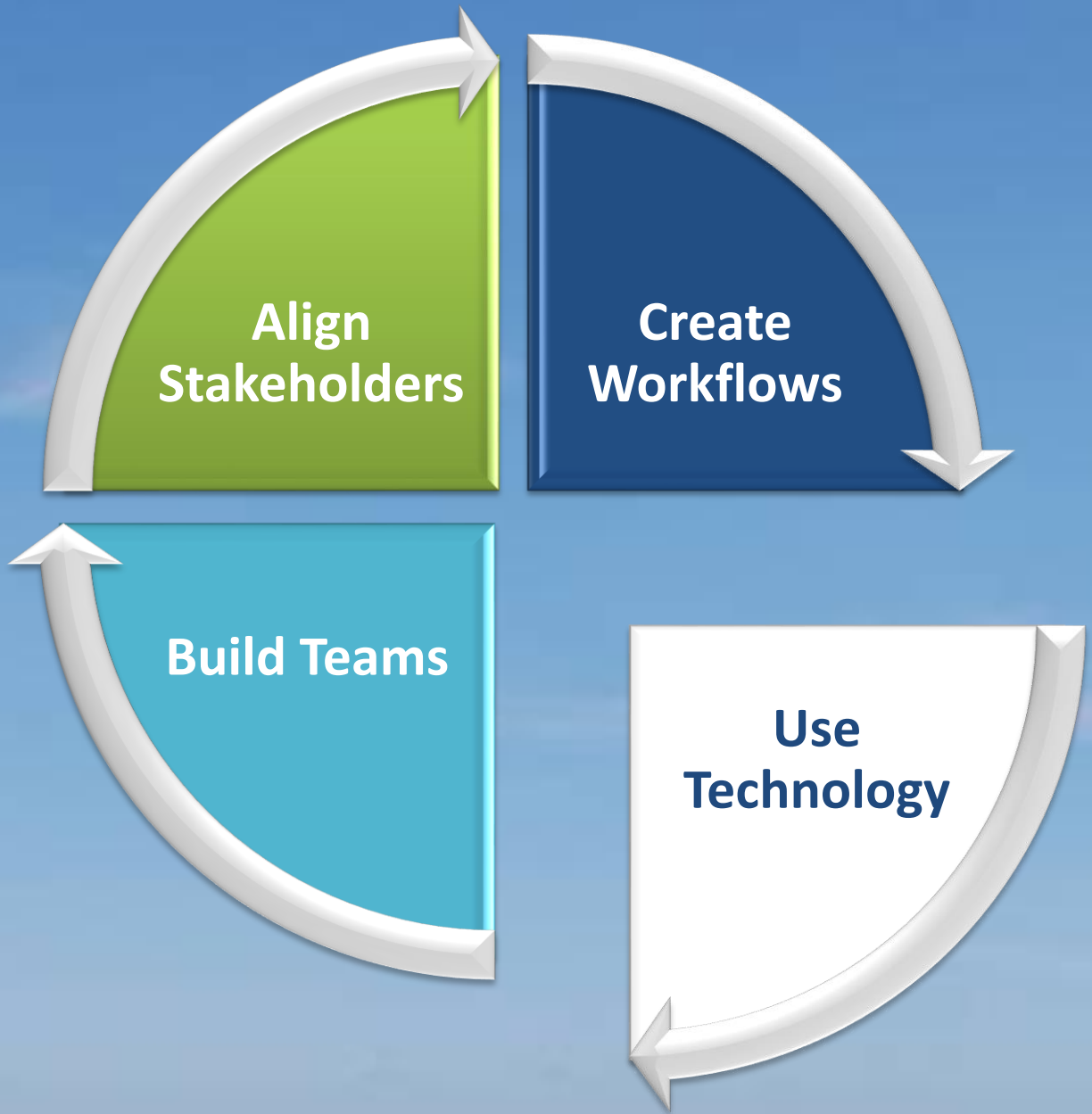


Actionable Peer Review

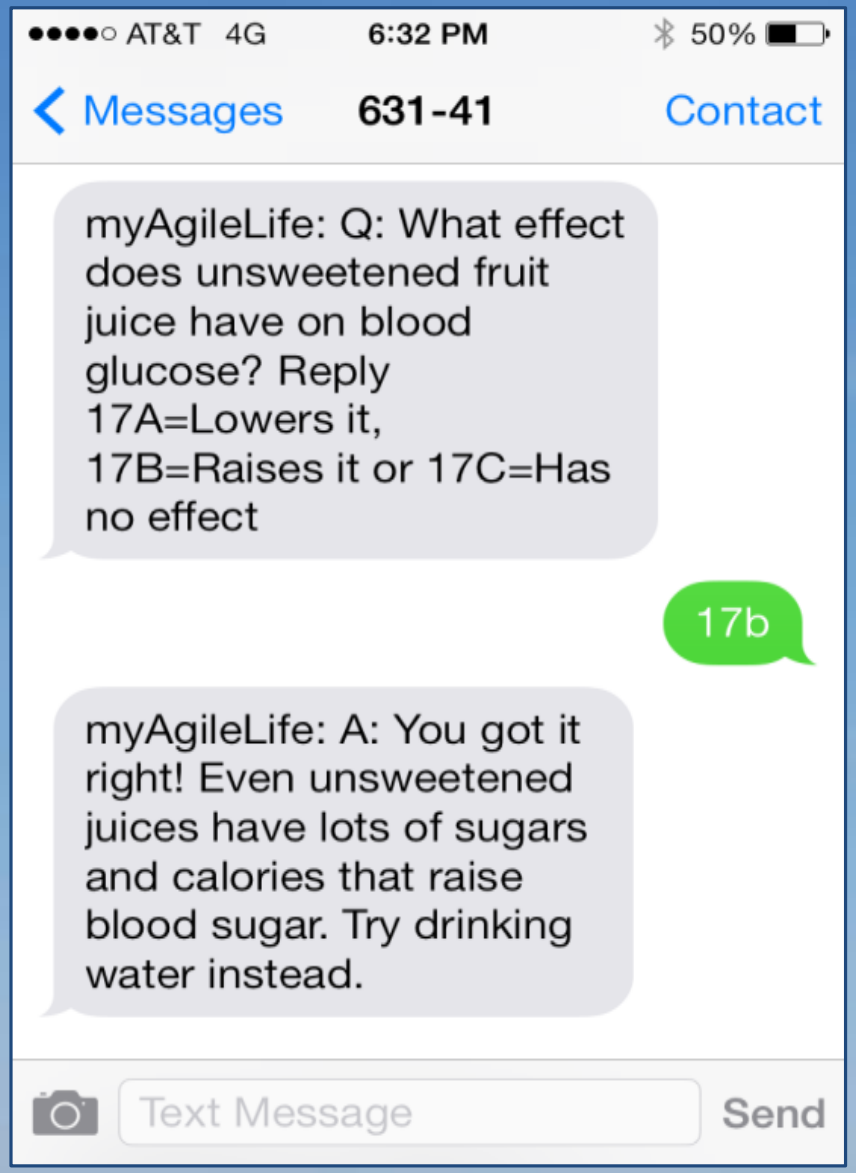
Transparent reports based on disease registries



It is all about Teamwork!


Align Stakeholders
Create Workflows
Build Teams
Use Technology

Diabetes Texting Program

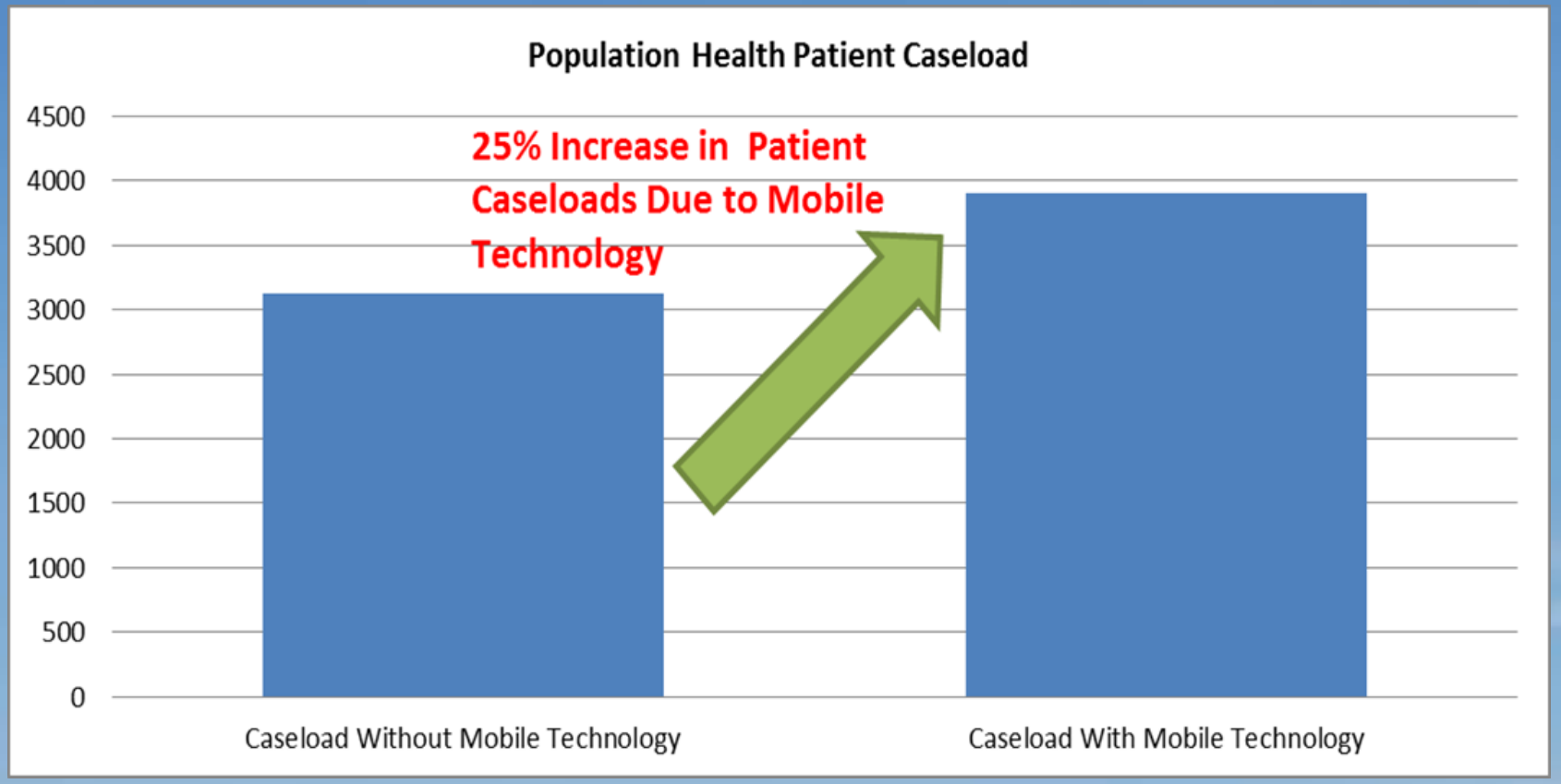


Has expanded Case Manager reach for moderate risk patients

Uncontrolled Diabetic Costs are $14,000 per year

Future Pilots
Wireless Glucometers

Increase Patient Caseload with Mobile Technology



Clinical Effectiveness

Population Identification

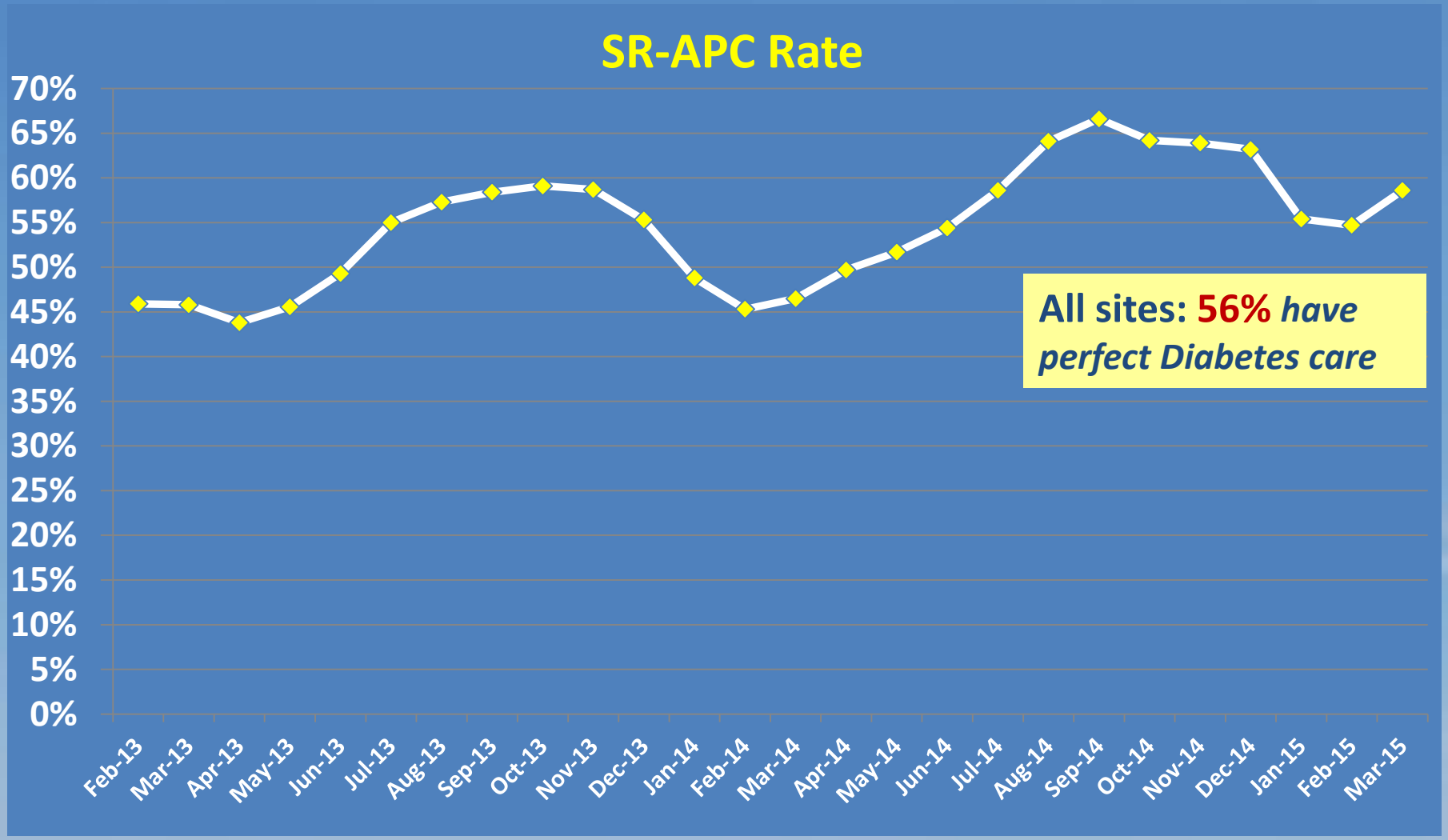
Population Management

Measurement of Clinical Effectiveness

Continuous Improvement Process

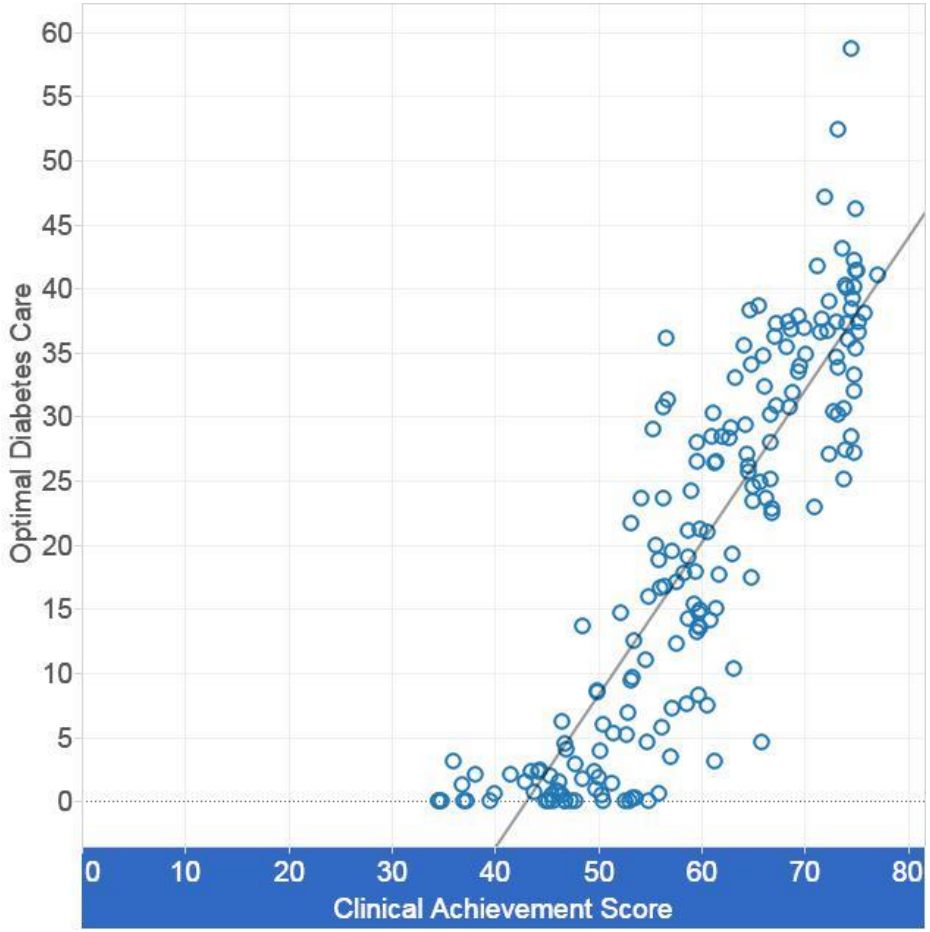
Optimal Diabetes Bundled Care

Diabetic patients with A1c < 8%, 2 A1c/yr., LDL <100 or active statin, BP<140/90



Correlation between Diabetes Care and Overall Clinical Care

PO performance on the Optimal Diabetes Care measure is highly correlated with overall clinical achievement



Integrated Healthcare Association

Effectiveness of Diabetes Care Interventions

For every **82 Diabetics in control** for three years, you will prevent **1 MI**

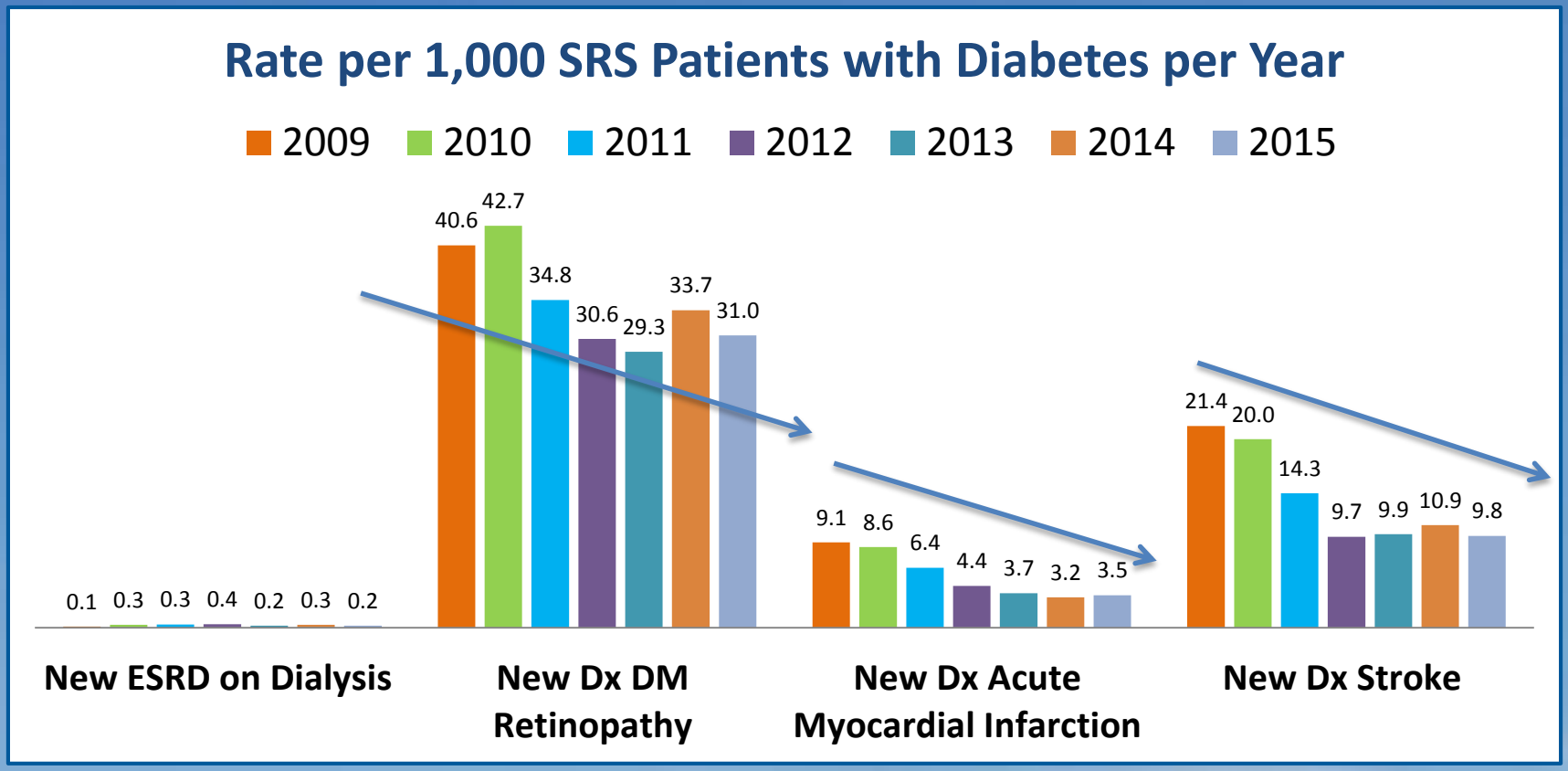
For every **178 Diabetics in control** for three years, you will prevent **1 Stroke**

For every **151 Diabetics in control** for three years, you will prevent **1 Retinopathy**

Average hospital admission cost for MI and Stroke is **$20,000**

Source: HCUP; Source: Geisinger Health System, www.ajmc.com

Clinical Outcome Measures for Patients with Diabetes



Stroke Cost Savings in 2015	
CY 2014 per 1,000 Members per Year:	13.30
2015 (Jan-Jun) per 1,000 Members per Year:	12.10
Reduction in Admissions per 1,000:	1.20
Mean Cost of Stroke Hospitalization (HCUP)	$20,000
Estimated Cost Savings for 2015	**$487,584**

Team Based Care Community Partnership

be there.
san diego

The campaign to make San Diego a heart attack and stroke-free zone.

Heart Attack and Stroke are preventable. See your doctor today to find out your risk for heart disease and stroke and to get on the right treatments to reduce your risk for premature death.

Take charge of your health today and visit:
www.betheresandiego.org

be there.
san diego

The campaign to make San Diego a heart attack and stroke-free zone.

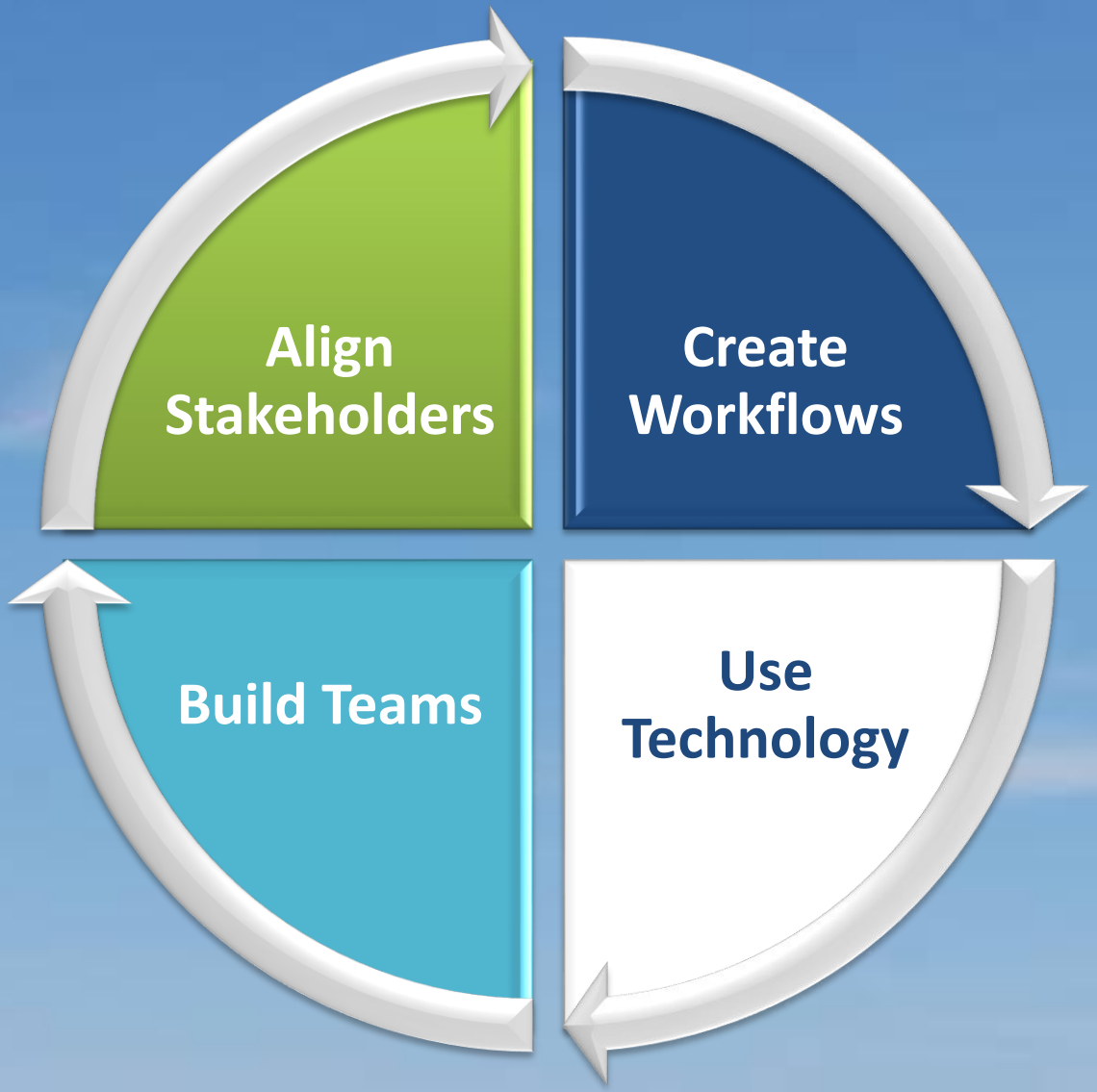
Friday Fun Facts

Fun Fact

Laughing regularly may lower your blood pressure by 5 mmHG

≤139/89

Our Successful Methods



Lessons Learned

SHARP Rees-Stealy Medical Group

Registry	• Common EHR
Physician Engagement	• Transparent peer review of data
Team Based Healthcare	• Keep core team centralized
Patient Engagement	• Measure effectiveness of Health Coaching
A1c testing	• A way to drive performance & engagement
Technology	• Leverage it
Change is hard	• Together 2 Goal collaborative

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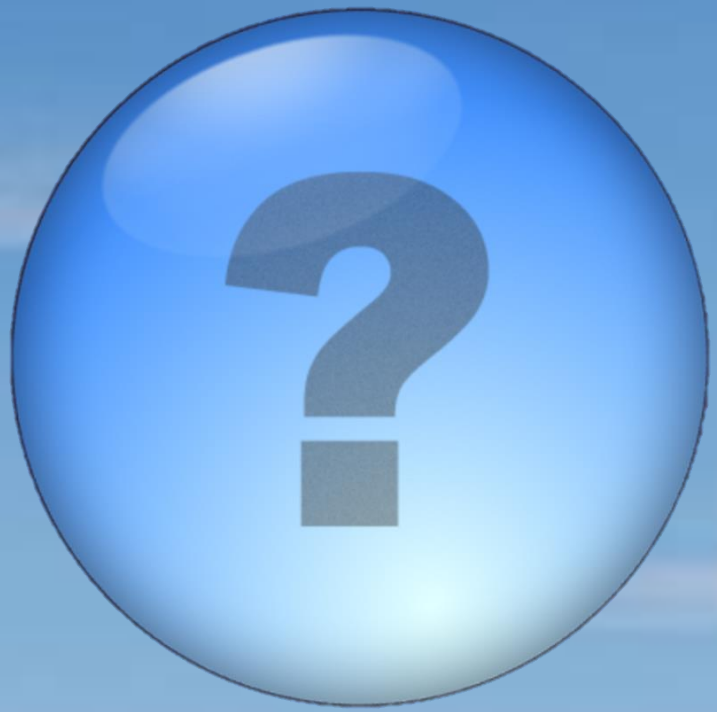
3. Titration of medication every 4 weeks until at goal A1c

SHARP Rees-Stealy Medical Group



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