Together 2 Goal®

AMGA Foundation National Diabetes Campaign

Monthly Campaign Webinar

September 15, 2016

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - 2017 Webinar Topics
  - Goal Post August Newsletter Highlights
  - IQL Conference: Nov. 14-17
- Use a Patient Registry & Publish Transparent Internal Reports (Lehigh Valley Health Network)
  - Sameera Ahmed, MS, RHIA, CHDA
  - Nina M. Taggart, MD, MBA
- Q&A
  - Use Q&A or chat feature

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WEBINAR REMINDERS

- Webinar will be recorded today and available the week of September 19th
  - 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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INPUT REQUESTED: 2017 WEBINAR TOPICS

- Beginning planning for 2017 monthly webinars
- Email topic and/or speaker recommendations to **together2goal@amga.org**
- Self-nominations accepted

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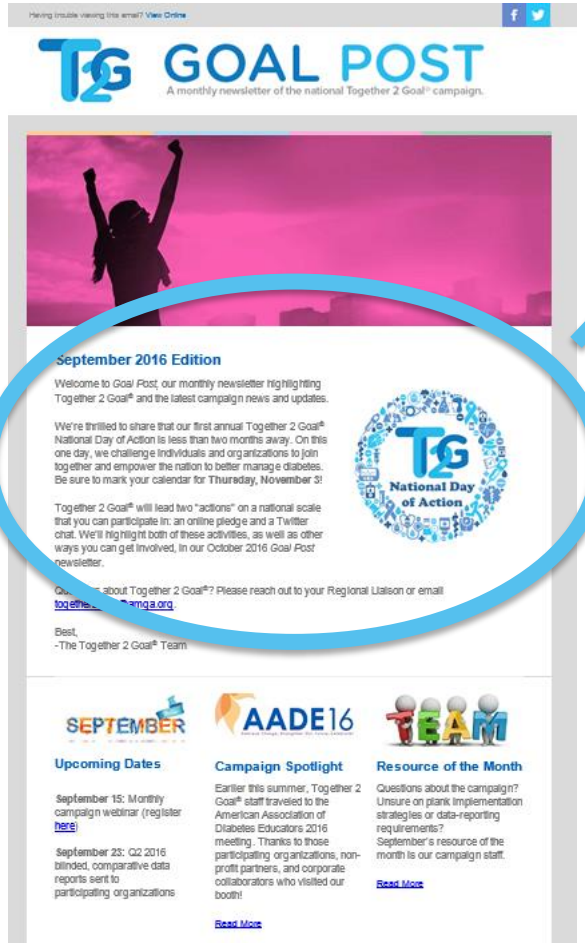
GOAL POST SEPT. NEWSLETTER HIGHLIGHTS



National Day of Action

- **Twitter chat**
  - Nov. 3, 2-3pm Eastern
  - #T2Gchat
- **Online pledge**
  - Commit to different "actions" on Nov. 3
  - Select from our ideas or create your own!

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GOAL POST SEPT. NEWSLETTER HIGHLIGHTS

Campaign Spotlight:

Resource of the Month

TOGETHER 2 GOAL® AT AMGA'S INSTITUTE FOR QUALITY LEADERSHIP (IQL)

AMGA™
Advancing High Performance Health

AMGA 2016
Institute for Quality Leadership

November 15-17, 2016
San Francisco Marriott Marquis
San Francisco, California

- **Conference Theme:** Succeeding Under MACRA and Risk-Based Payment
- **To Register:** www.amga.org/IQL2016

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TOGETHER 2 GOAL® AT AMGA'S INSTITUTE FOR QUALITY LEADERSHIP (IQL)

- **Monday, November 14**
  - Pre-Conference Session*
    - Johnson & Johnson Health Care Systems, Inc. CORE Program
- **Tuesday, November 15**
  - Chief Quality Officer/Director Leadership Council
    - Improving Care Delivery: Assessing and Addressing CVD Risk
    - Team-Based Approach to Diabetes Care
- **Wednesday, November 16**
  - Peer-to-Peer Breakout Session
    - New Approach to Improving Diabetes Care with In-Person Professional Education Training Model

*SUBJECT TO CHANGE

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TODAY'S SPEAKERS

- **Sameera Ahmed, MS, RHIA, CHDA**
  - Senior Healthcare Data Analyst, Lehigh Valley Health Network
- **Nina M. Taggart, MD, MBA**
  - Physician Administrator, Population Health, Lehigh Valley Health Network

Using Reports and Registries to Support the Management of Diabetes Patients

Nina M. Taggart, MD, MA, MBA, FAAO

Sameera Ahmed, MS, RHIA, CHDA

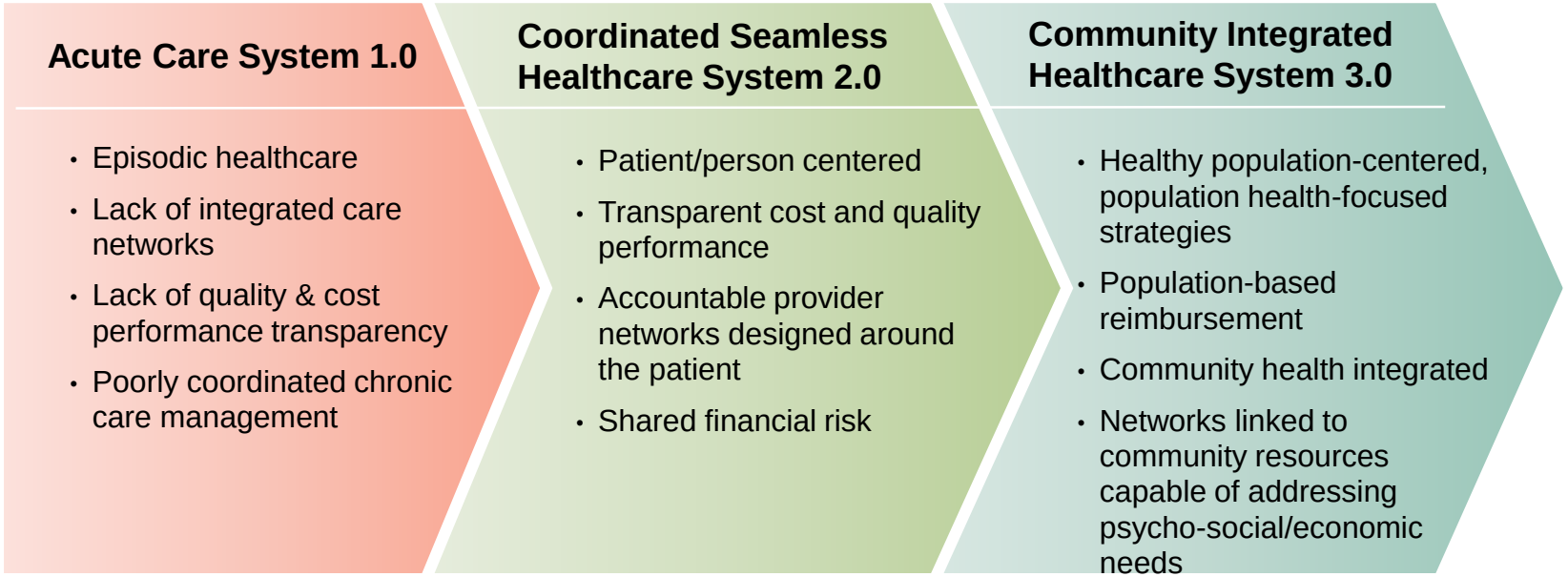
Today's Discussion

- Introduction
- LVHN's population health management strategy
- Development and deployment of patient registries using Optum One

Lehigh Valley Health Network

- Recognized by U.S. News & World Report, Fortune, Modern Healthcare, Leapfrog, others
- 5 hospital campuses, 12 Health Centers
- +10 ExpressCARE locations
- Approx. 1,161 acute care beds
- 1,340 physicians
  (700 network-employed)
- More than 13,000 employees
- Ancillary Services
- Physician Hospital Organization
- Revenues over $2 Billion

U.S. Healthcare Delivery System Evolution

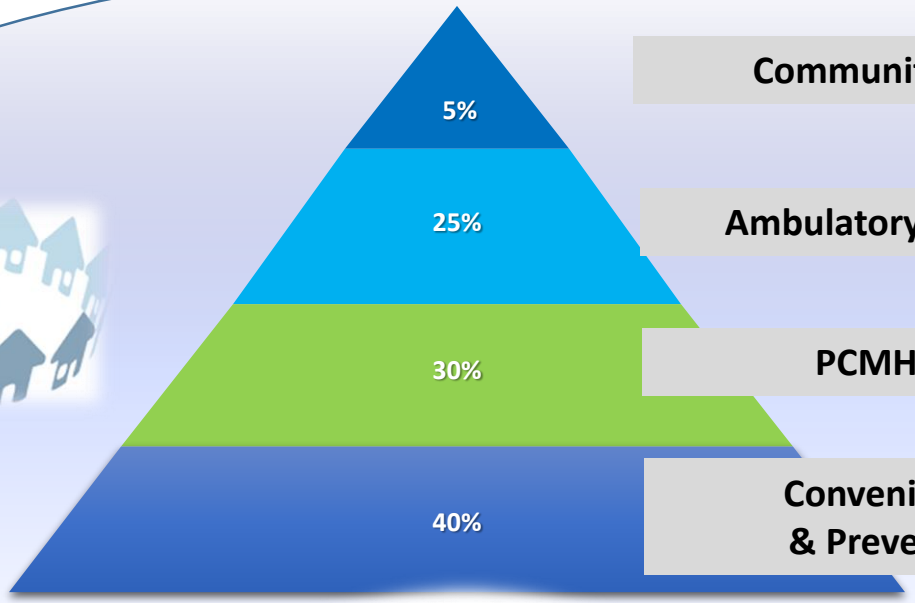


*Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. Health Affairs 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

Populytics

- Population health management and analytics firm
- Established December 2013
- Integrated services
  - Population Health Analytics
  - Clinical care coordination
- Expert professionals
  - Payer & provider informatics
  - Advanced analytics
  - Insurance and risk management

Integrated Care Management Model for a Healthier Community



Community Care Teams

Ambulatory Care Managers

PCMH Initiatives

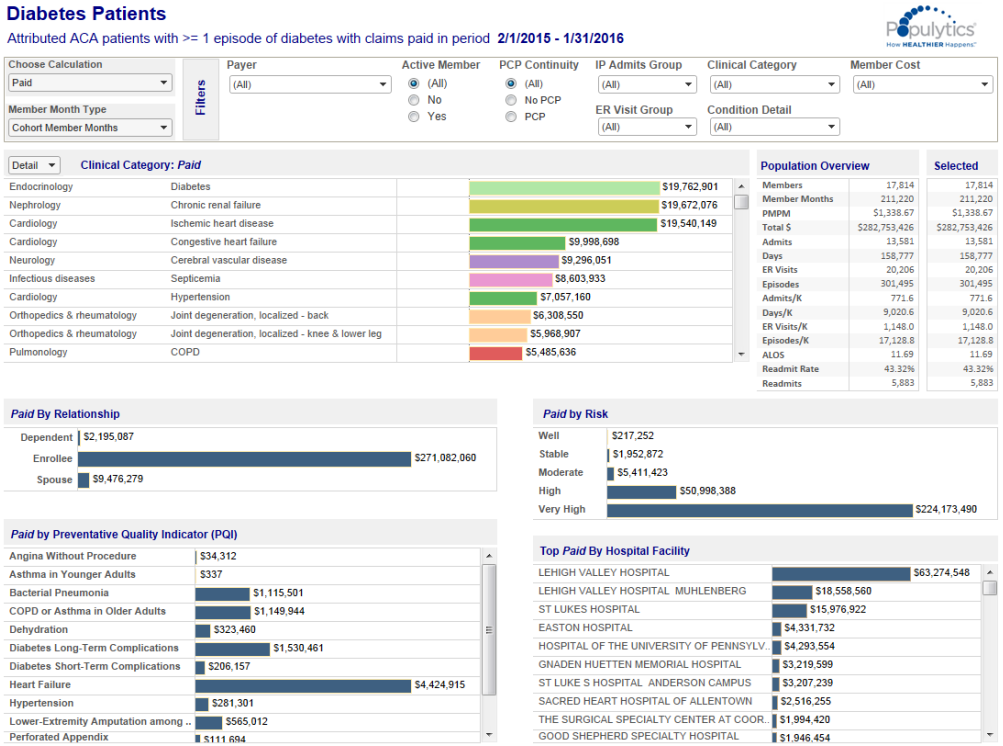
Convenience, Access & Preventative Care

Population Health Management Executive Committee

- Clinically driven, includes key network leadership
- Programmatic focus leverages clinical integration and care alignment throughout LVHN
- Shared KPIs
  - Clinical pathways
  - Costs/spend
  - Utilization (Inpatient, ED, Readmissions)
  - Pharmacy costs
- Informs and facilitates concurrent work

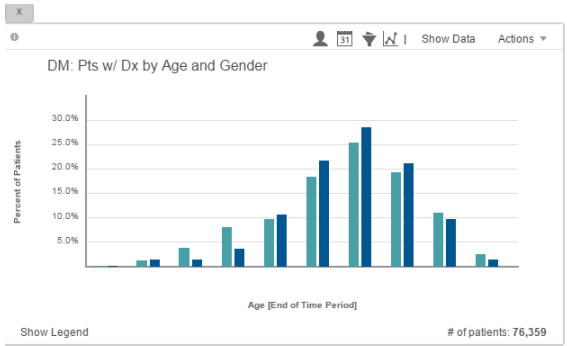
Identifying Diabetes Care and Cost Opportunities

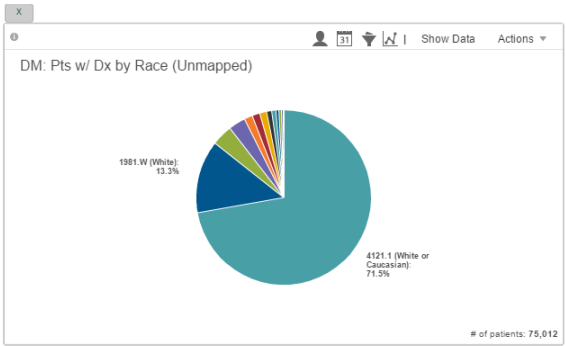
- Claims-based analytic tools used to identify cost drivers by clinical condition for attributed population
- Other measures of interest by clinical condition
  - Number of members
  - Inpatient & ER utilization
  - Comorbidities (CKD, CHF)

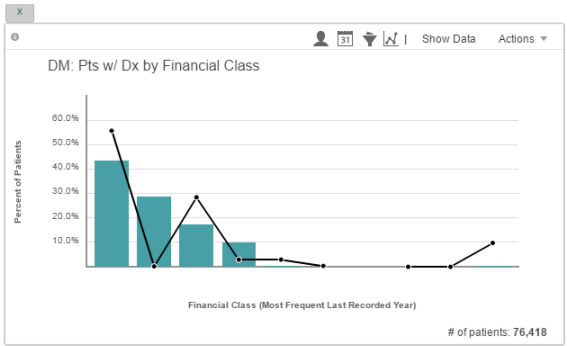


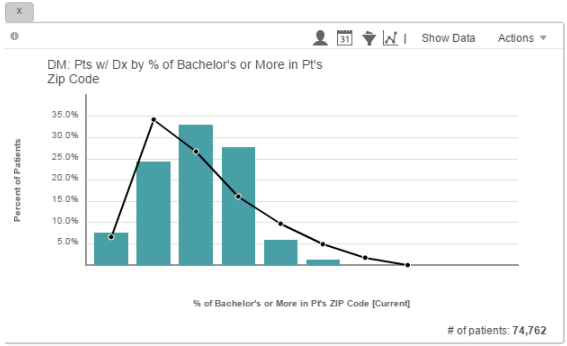
Using Clinical Data to Stimulate Discussion

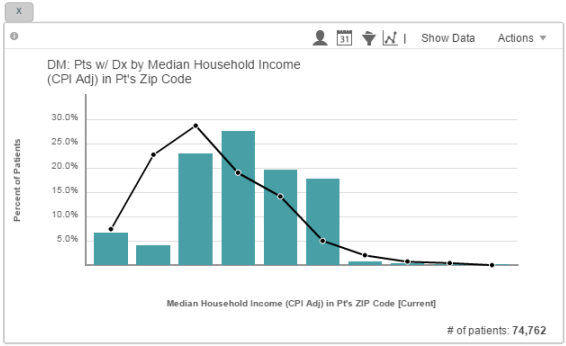
- DM Cohort Demographic Profile

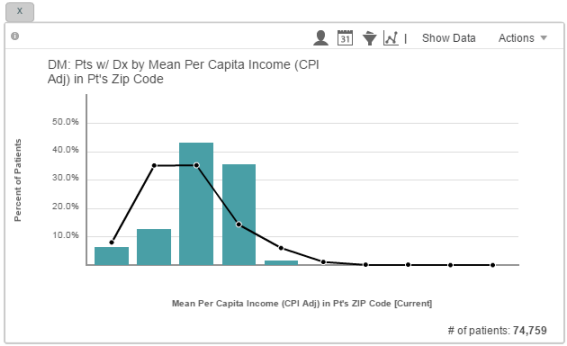






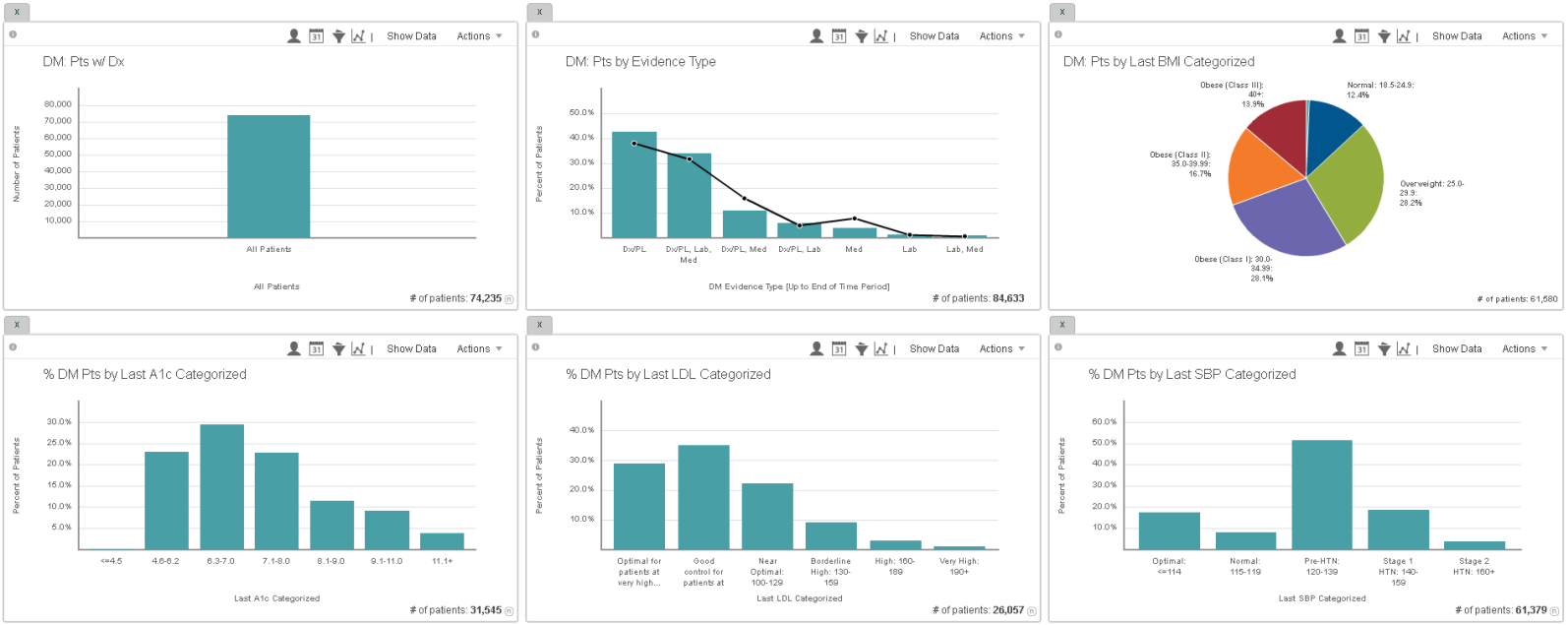






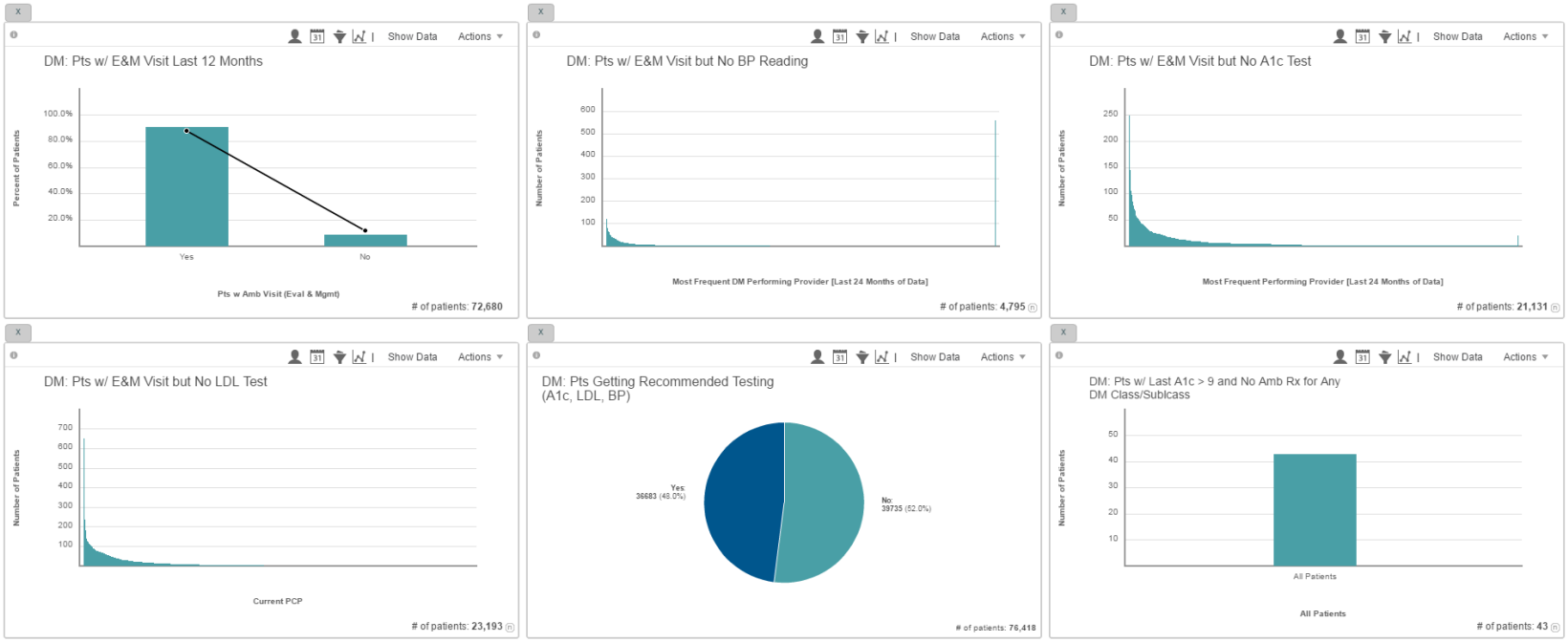
Using Clinical Data to Stimulate Discussion

- DM Cohort Clinical Profile



Using Clinical Data to Stimulate Discussion

- DM Care Gap Overview

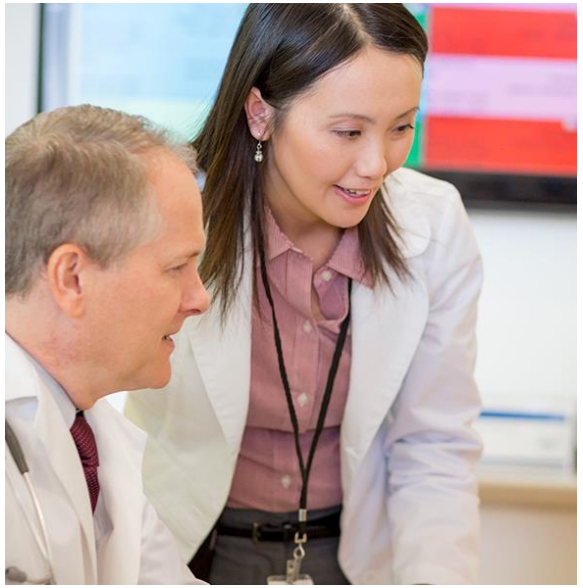


Using Clinical Data to Stimulate Discussion

- DM Predictive Risk Overview

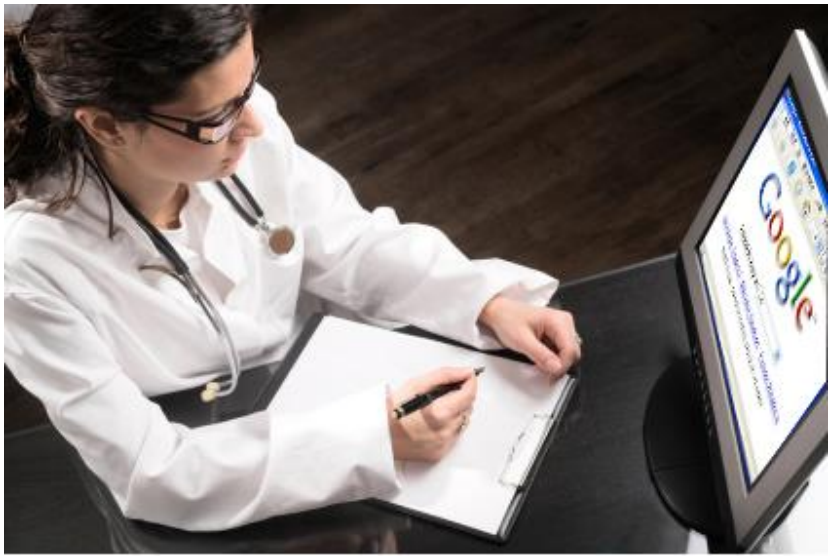
Turning Data into Actionable Information

- Engage care teams
- Identify clinical opportunities for improved care
- Determine strategy for targeted interventions
- Develop patient registries for population health and practice team



Practice Team Information Needs

- Predictive analytics
- Meaningful clinical indicators
- High utilizers (IP admits, ED Visits)
- Behavioral health information
- Social determinants

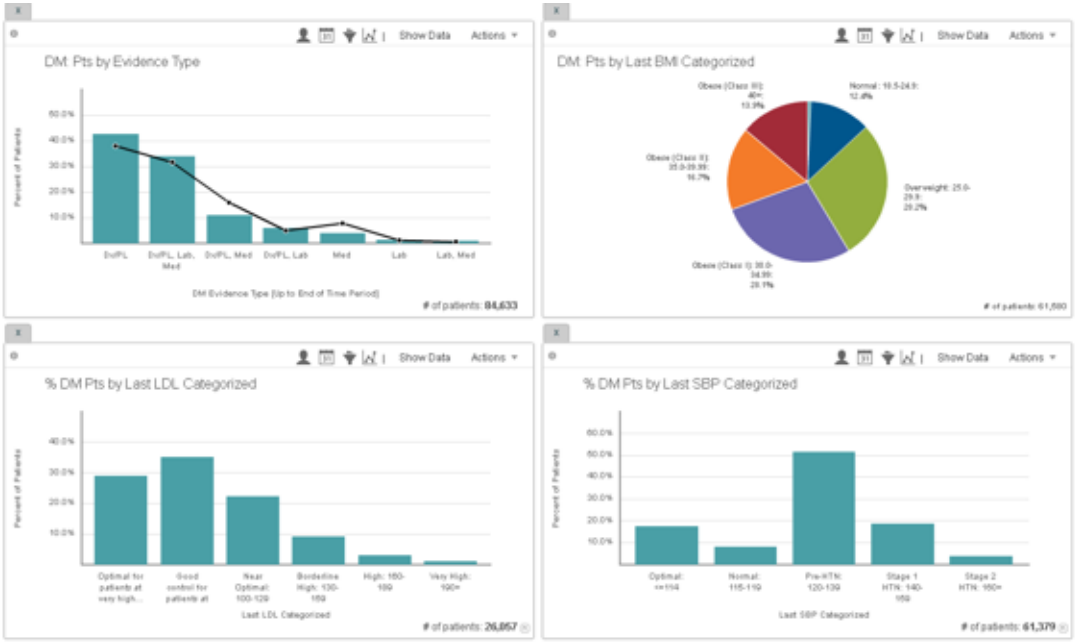


Predictive Analytics

- Prompts proactive outreach
- Predictive models assessing the likelihood of chronic-disease related admission and disease progression
  - DM
  - DM to CKD

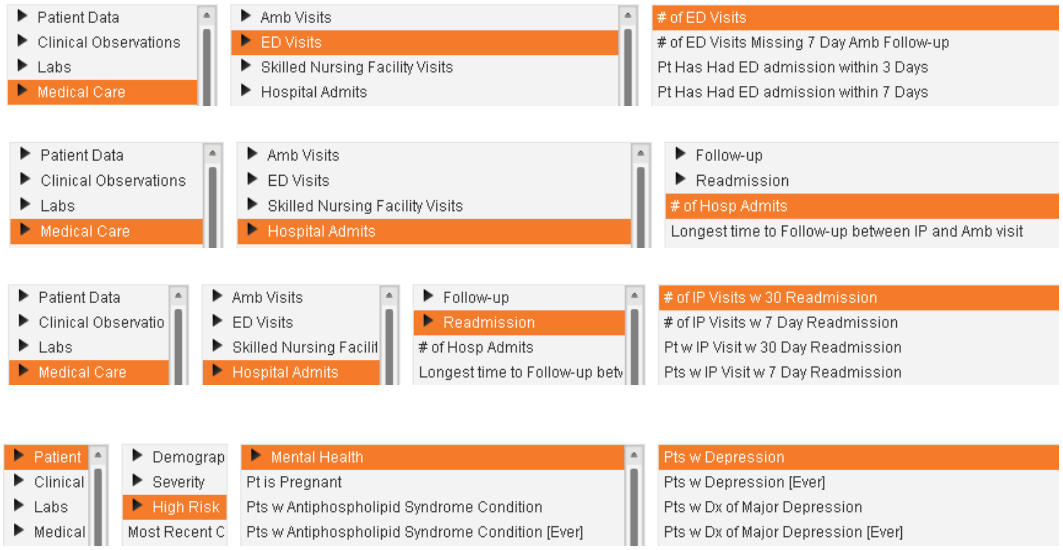
Meaningful Clinical Indicators

- DM
  - Last A1c
  - SBP/DBP
  - LDL
  - BMI
  - ACE/ARB
  - eGFR
  - Endocrinologist
  - Eye exam



Other pertinent patient information

- Frequency of ED Visits, IP admits, readmits
- Behavioral health
  - Dx of depression
  - Rx for depression
- Need for social services
  - Patient is self pay



Collaboration with users

- Review other available variables with practice team members
  - DCSI Score
  - Charlson Score
  - HCC-RAF Score
  - # Primary Care Visits
  - Has a Next Visit/Date of Next Visit
  - Clinic of Provider for Next Visit
  - Total Charges

Final List of Registry Variables

- 60+ different variables covering:
  - Patient Demographics
  - Providers
  - Utilization
  - Upcoming appointments
  - Risk Scores
  - Predictive Analytics
  - Behavioral Health
  - Costs
  - Medications
  - Clinical Observations/Labs

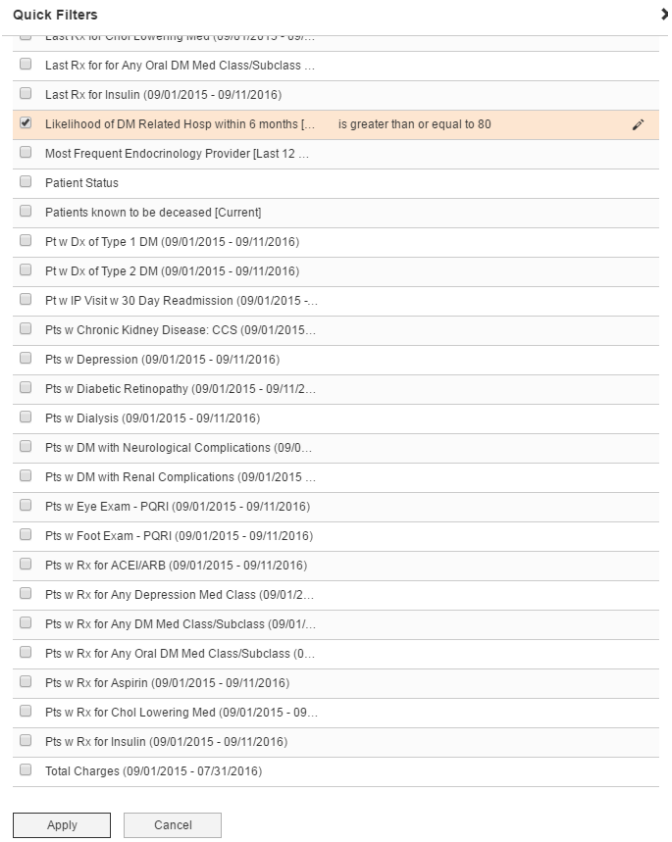
Registry View

Panel: Not Recorded ▼ **Quick Filters:** Default (Not Filtered) ▼ Showing 5,000 of 7,358 records ⓘ Columns Actions ▼

Date Added	DCSI Score [Curr…	DM Pt Likelihood of Developing CKD within …	Likelihood of DM …	HCC-RAF [Last 1…	Last A1c (09/01/2…	Date of next visit
07-20-2016	1	98	60	0.810	6.9	12-08-2016
08-13-2016	1	98	62	1.202	6.3	---
07-20-2016	0	98	63	1.050	10.1	09-28-2016
07-20-2016	5	98	76	1.015	9.4	10-27-2016
07-20-2016	2	98	83	1.342	8.0	---
08-11-2016	1	98	66	0.437	6.8	07-20-2017
07-20-2016	1	98	74	0.629	7.7	11-14-2016
07-20-2016	0	98	46	0.429	8.0	09-27-2016
07-20-2016	1	98	79	0.771	---	12-01-2016
07-20-2016	3	98	94	4.019	6.2	---
07-20-2016	2	98	94	1.420	8.6	---
07-20-2016	0	98	60	0.907	7.9	09-26-2016

Defining Standard Work

- Set standard filters to guide outreach efforts and care gap closure for DM patients
- High Likelihood of DM Related Hospitalization
  - Likelihood >= 80%
- High Utilizers
  - ED Visits >= 2, Hosp Admits >= 3 in 12 months
- High Risk, Low Spend
  - HCC-RAF in high risk range, Total Charges <= $15,000



Coordinating Patient Care

- Identify patients with comorbidities or complications
- Identify barriers to seeking care and assist in resolutions
- Connect patient to resources across settings and episodes of care
- Engage patients in ongoing plan of care with PCP/Endocrinologist

Next Steps

- Integration of tool set with Epic
  - Risk scores
  - Predictive models
  - Registries
- Include more social determinants of health in standard workflow
- Submitting data to payers to support enhanced scoring on quality measures for incentive programs

Questions?