Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

July 20, 2017

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - August 2017 Monthly Webinar
  - Goal Post July Newsletter Highlights
- Innovative Technology in Diabetes Care
  - Dr. Philip Oravetz of Ochsner Health System
- Q&A
  - Use Q&A or chat feature

Together 2 Goal®

WEBINAR REMINDERS

- Webinar will be recorded today and available the week of July 24th
  - 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

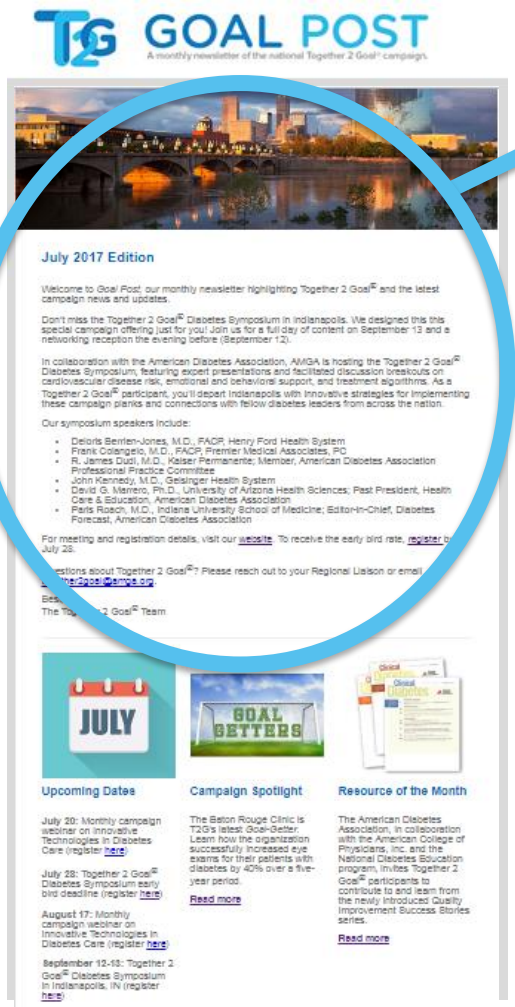
Together2Goal®

AUGUST 2017 MONTHLY WEBINAR

- **Date/Time:** Thursday, August 17, 2-3pm Eastern
- **Topic:** The Role of Community Pharmacists in Diabetes Care
- **Presenter:** Jennifer Humeniuk, Pharm.D., of Ralphs Grocery Company

Together2Goal®

GOAL POST NEWSLETTER: JULY HIGHLIGHTS


GOAL POST

A monthly newsletter of the national Together 2 Goal® campaign.

July 2017 Edition

Welcome to *Goal Post*, our monthly newsletter highlighting Together 2 Goal® and the latest campaign news and updates.

Don't miss the Together 2 Goal® Diabetes Symposium in Indianapolis. We designed this this special campaign offering just for you! Join us for a full day of content on September 13 and a networking reception the evening before (September 12).

In collaboration with the American Diabetes Association, AMGA is hosting the Together 2 Goal® Diabetes Symposium, featuring expert presentations and facilitated discussion breakouts on cardiovascular disease risk, emotional and behavioral support, and treatment algorithms. As a Together 2 Goal® participant, you'll depart Indianapolis with innovative strategies for implementing these campaign planks and connections with fellow diabetes leaders from across the nation.

Our symposium speakers include:

- Deloris Berrien-Jones, M.D., FACP, Henry Ford Health System
- Frank Colangelo, M.D., FACP, Premier Medical Associates, PC
- R. James Dudl, M.D., Kaiser Permanente; Member, American Diabetes Association Professional Practice Committee
- John Kennedy, M.D., Geisinger Health System
- David G. Marrero, Ph.D., University of Arizona Health Sciences; Past President, Health Care & Education, American Diabetes Association
- Paris Roach, M.D., Indiana University School of Medicine; Editor-In-Chief, Diabetes Forecast, American Diabetes Association

For meeting and registration details, visit our website. To receive the early bird rate, register by July 28.

Questions about Together 2 Goal®? Please reach out to your Regional Liaison or email

Best,

The Together 2 Goal® Team

JULY

GOAL GETTERS

Upcoming Dates

July 20: Monthly campaign webinar on Innovative Technologies in Diabetes Care (register here)

July 28: Together 2 Goal® Diabetes Symposium early bird deadline (register here)

August 17: Monthly campaign webinar on Innovative Technologies in Diabetes Care (register here)

September 12-13: Together 2 Goal® Diabetes Symposium in Indianapolis, IN (register here)

Campaign Spotlight

The Baton Rouge Clinic is T2G's latest Goal-Getter. Learn how the organization successfully increased eye exams for their patients with diabetes by 40% over a five-year period.

Read more

Resource of the Month

The American Diabetes Association, in collaboration with the American College of Physicians, Inc. and the National Diabetes Education program, invites Together 2 Goal® participants to contribute to and learn from the newly introduced Quality Improvement Success Stories series.

Read more

Together 2 Goal® Diabetes Symposium

in collaboration with:

American Diabetes Association®

Together 2 Goal®

GOAL POST NEWSLETTER: JULY UPCOMING DATES

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Together 2 Goal®

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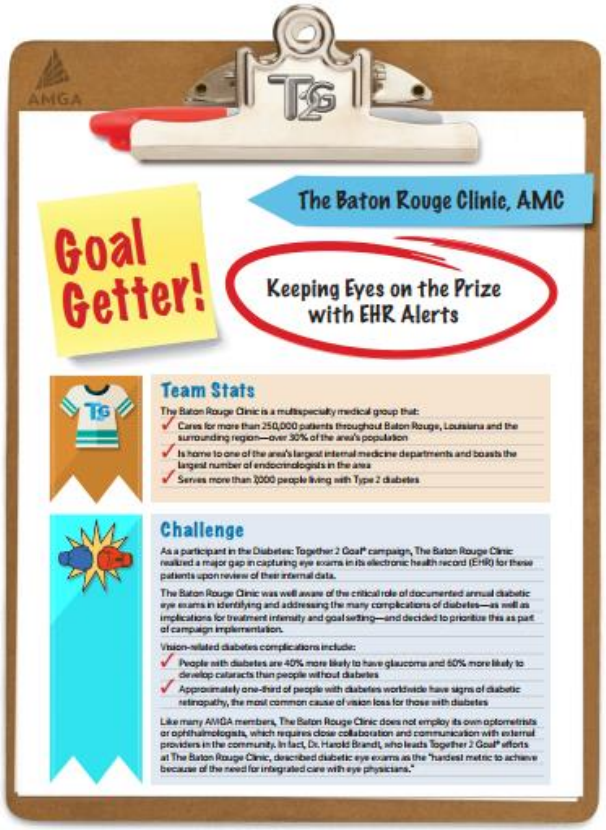

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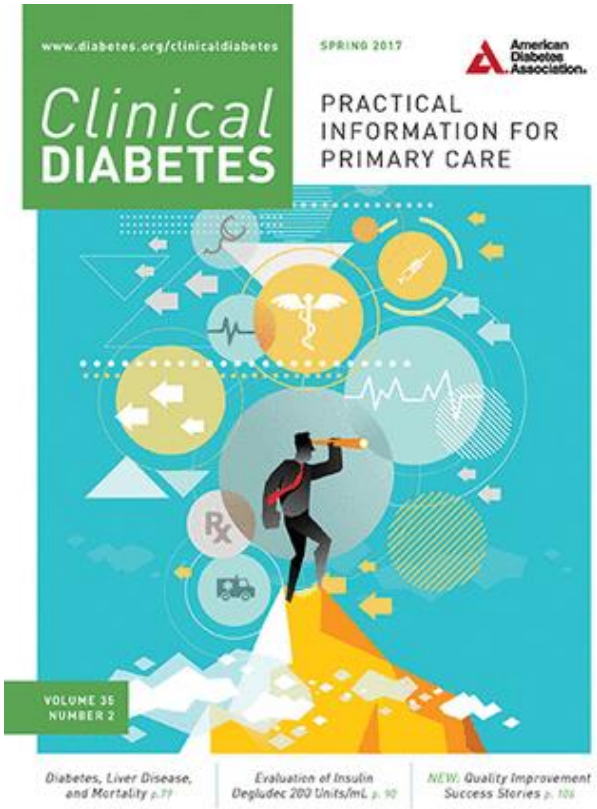
GOAL POST NEWSLETTER: JULY RESOURCE OF THE MONTH

Resource of the Month



Together 2 Goal®

TODAY'S SPEAKER

Philip Oravetz, M.D., M.P.H., M.B.A.

Ochsner Health System

Together2Goal®

OCHSNER HEALTH SYSTEM

Innovative Technologies in Diabetes Care

Philip M Oravetz, MD, MPH, MBA
Medical Director, Accountable Care

Susan Montz, BSN, MBA
Director, ACO Performance Improvement

July 20,2017

Ochsner Health System

Ochsner Health System
New Orleans, LA

Who We Are:

- Louisiana's largest non-profit, academic, health care system
- 25 owned, managed and affiliated hospitals , 1200+ group practice physicians in an integrated delivery system
- State-wide Clinical Integration network
- Significant value based portfolio
- First health system in the US to use Apple Watch for Chronic Disease Management

Ochsner™
Health System

Taking responsibility for the health and well-being of a population as defined by:

IMPROVED QUALITY	REDUCED COST	BETTER PATIENT EXPERIENCE
• Safety • Disease Management/Clinical Programming • Medication Management • Behavioral Health • Wellness/Prevention	• Care Transitions/Post-Discharge Intervention ▹ *ED, Admission/Readmission Avoidance* • Complex Care Management • Standardized Care Pathways • Referral Management • Community Partnerships/SNF	• Access • Care Coordination (Ochsner On Call, LPN-CCC) • Patient Activation/Satisfaction ▹ *HCAHPS, CGCAHPS* • Team-based Care • Palliative Care

FACILITATING CAPABILITIES

Governance • Leadership Commitment & Priority • Transparency • Advanced Analytics (Clinical + Financial) • Connectivity
Coding/Documentation Excellence • Panel Management • Aligned Incentives/Comp Model • Resource Optimization
Training & Development • Culture of Performance Improvement

Health System

Population Health Framework

Wellness and Prevention

Leadership

- Population Health Committee
- Primary Care Council
- Other (POV, IT, CCC, etc)

IT Functionality (EPIC)

- Health Maintenance
- Healthy Planet
- Patient Portal
- Kaboodle
- Dashboards

Ochsner Health System

Population Health Framework

Wellness and Prevention

Operations

- The Population Health Cycle
- LPN-Clinical Care Coordinators (CCC) Program
- Written Order Guidelines
- Care Touch (call center)
- My Panel Dashboards (registry driven)
- Physician Compensation (Value-based)

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EPIC Healthy Planet Registry List

1. Asthma	14. Headache
2. ACO	15. HIV
3. All Wellness (Adult)	16. HTN
4. ALS	17. IBD
5. Breast Cancer Screening	18. Lung Cancer
6. Cervical Cancer Screening	19. MS
7. CKD	20. Obesity
8. Hep C	21. Opioid
9. COPD	22. OPCM
10. Colorectal Cancer Screening	23. Osteoporosis
11. CJR	24. Readmissions
12. CHF	25. Tobacco
13. Diabetes	26. All Wellness (Peds)

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Updated: 12/2016

Population Health Registries
Bulk Orders and Bulk Outreach

Bulk Orders/Outreach Schedule					
	Patients	Bulk Orders	Outreach		Outreach Type
DM Registry	71,854	Weekly	Quarterly	April/July/Oct	Portal/Mail
Mammo	50,000	Weekly	Monthly	Aug/Sept/Oct/ Nov/ Dec	Portal/Mail
DM Disease Mgt Program	604	Weekly	Weekly	July	Engagement Specialist
CKD	26,623	Weekly	Weekly	July	Portal/Engagement Specialist
CRS	50,000	Fit/Kit	Monthly	October	Mail
CCS					
CLD	150,000	Twice	Once	July/August	Portal/Mail
HTN	193,302				
Tobacco	252,540				

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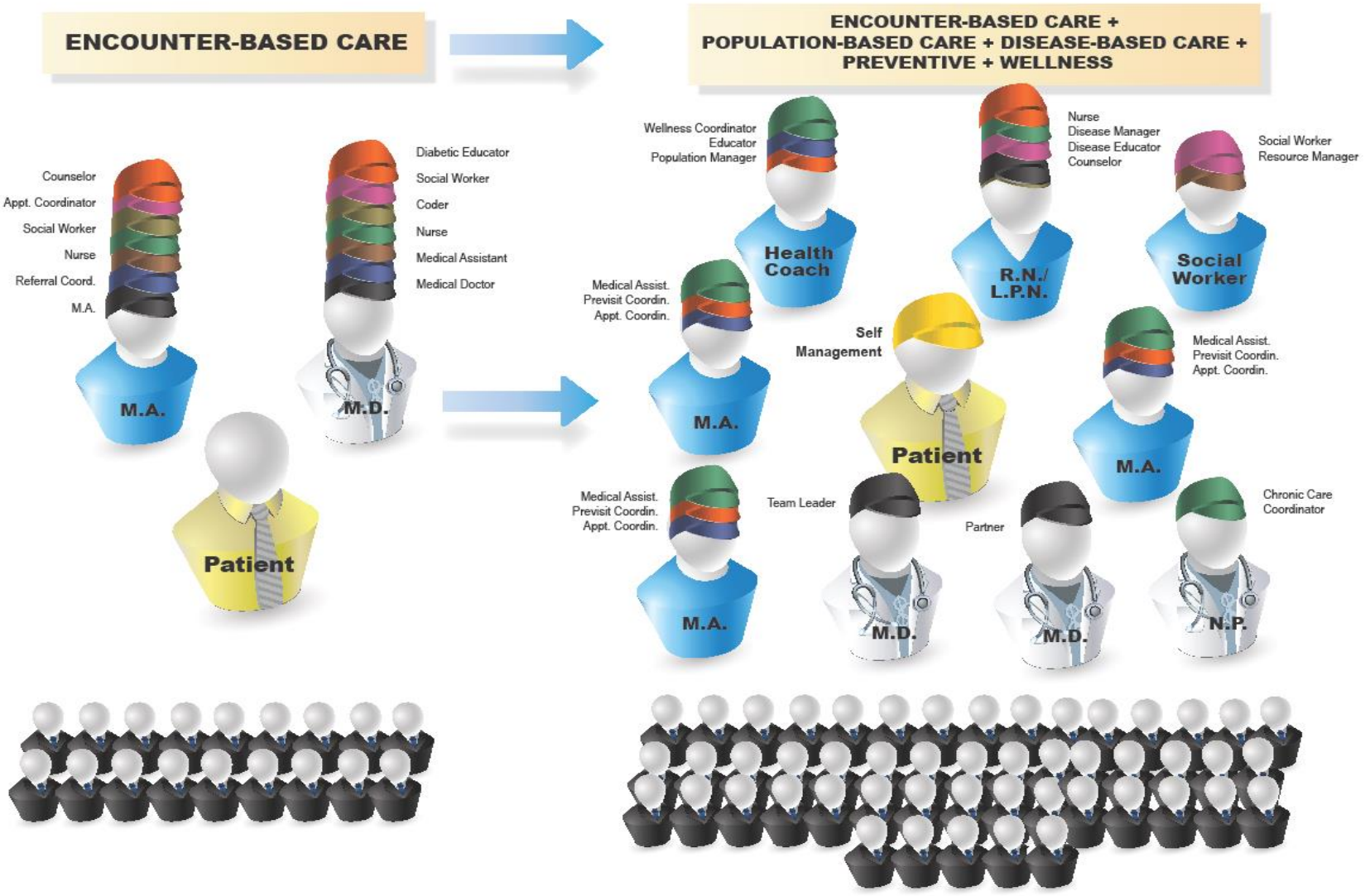
Evolution of Primary Care at Ochsner

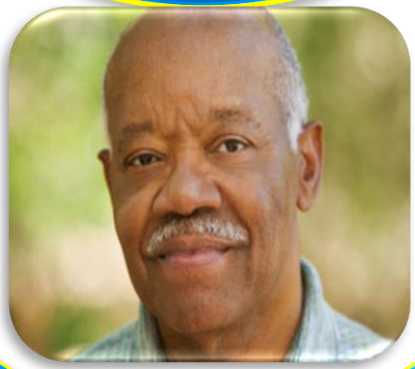


Population Health Cycle

Identify Care Gaps

Pre Visit Work

Orders placed using the Primary Care ***Written Order Guidelines***



Visit Work

Close care gaps

Population Work

Registry work – place bulk orders and patient notifications

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Diabetic Registry

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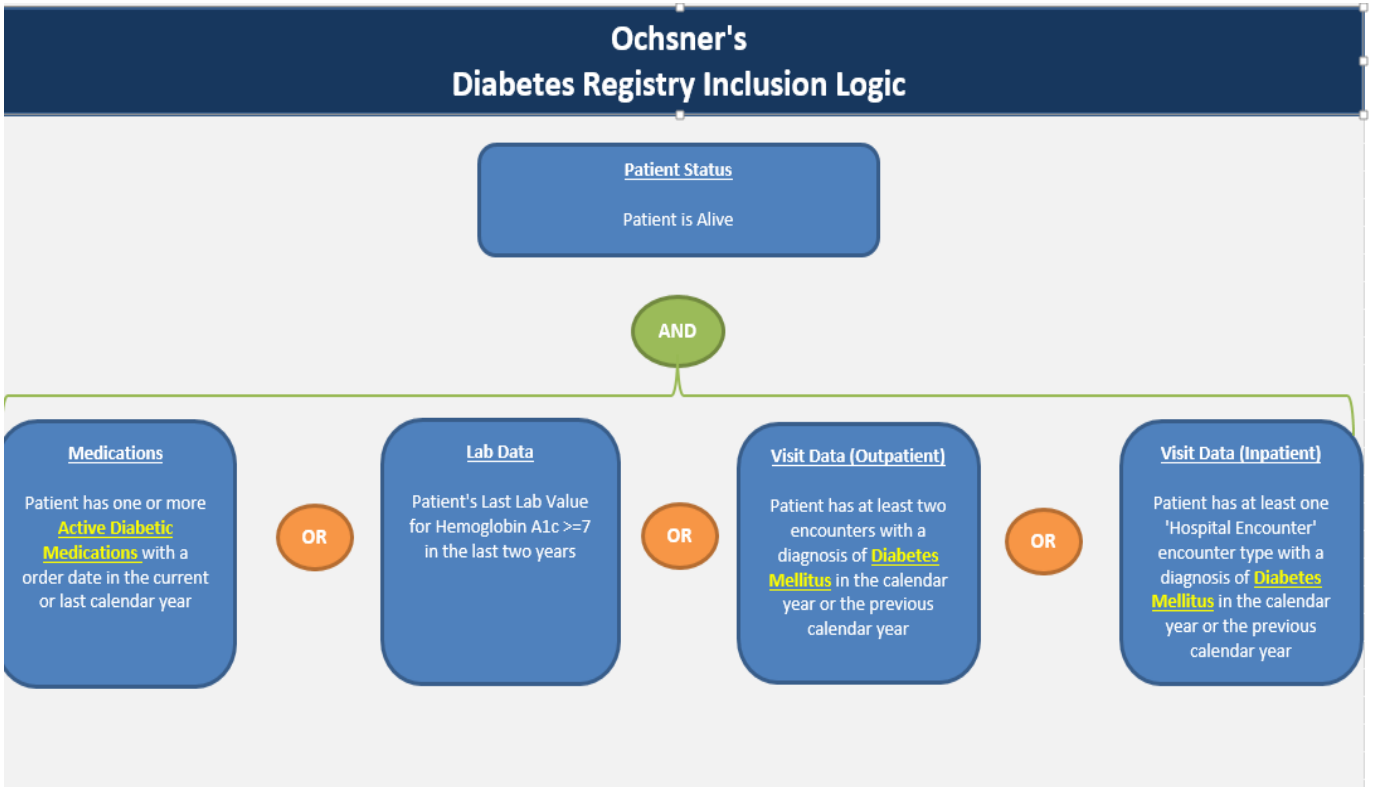
Diabetic Registry: Inclusion Criteria



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Diabetic Registry Metrics

- Hemoglobin A1C testing
- Hemoglobin A1C control <8
- LDL testing
- LDL control < 100
- BP control <140/90
- Nephrology screening
- Retinal Eye Exam
- Foot Exam
- Statin Medication*

* Adding this to registry and Health Maintenance

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Diabetes Registry: My Panel Metrics

- This metrics calculates the percentage of patients 18 to 75 years of age in the registry who had a hemoglobin A1c (HbA1c) testing done within the last 12 months. This metric references specific lab values and health maintenance activity for the last testing date.

- Data is update/refreshed daily

- Metrics are a rolling 12 months

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Healthy Planet Registries: Screenshot

Physician Scorecard: DM Registry

Healthy Planet - ST TAMMANY WEST REGION YTD October 19 2016

DIABETES M. MEASURES	Covington	Abita Springs	Mandeville	STW Region (AVG)	OHS	GOAL	5 Star	4 Star
Panel Size	2541/15438	336/3428	303/2366					Cut Points
Hemoglobin A1C Testing	96%	98%	96%	97%	91%	88%	88-100	80-87
Hemoglobin A1C control	77%	77%	74%	76%	71%	86%	86-100	80-85
Lipid Profile	88%	94%	88%	90%	82%	91%	91-100	85-90
LDL Control	50%	51%	46%	37%	47%	62%	62-100	53-61
Nephropathy Screening	93%	93%	93%	93%	90%	94%	94-100	85-93
Blood Pressure Control	66%	72%	80%	73%	66%	75%	75-100	63-74
Eye Exam	55%	48%	42%	48%	48%	77%	77-100	64-76
Foot Exam	72%	82%	62%	73%	66%	90%	90-100	70-89

Covington	Orange	Brown	Black	White	Red	Yellow	Cov. TG (AVG)	GOAL
Panel Size	357/1826	189/1044	8 out of 82	295/1603	309/1759	231/1362	1389/7676	
Hemoglobin A1C Testing	95%	95%	100%	97%	97%	93%	96%	88%
Hemoglobin A1C control	77%	73%	84%	78%	80%	72%	77%	86%
Lipid Profile	83%	83%	100%	91%	92%	73%	87%	91%
LDL Control	43%	51%	50%	57%	59%	39%	50%	62%
Nephropathy Screening	88%	92%	100%	94%	90%	82%	91%	94%
Blood Pressure Control	60%	56%	34%	68%	72%	68%	60%	75%
Eye Exam	63%	48%	50%	56%	67%	47%	55%	77%
Foot Exam	66%	70%	84%	66%	79%	59%	71%	90%

Covington	Purple	Green	Purple	Pink	Blue		Cov. MC (AVG)	GOAL
Panel Size	394/2599	208/1339	89/586	317/2089	145/1153		1153/7766	
Hemoglobin A1C Testing	98%	96%	97%	97%	98%		97%	88%
Hemoglobin A1C control	83%	77%	80%	77%	84%		80%	86%
Lipid Profile	96%	96%	92%	90%	90%		93%	91%
LDL Control	60%	43%	63%	52%	50%		54%	62%
Nephropathy Screening	94%	99%	97%	94%	96%		96%	94%
Blood Pressure Control	67%	81%	63%	66%	60%		67%	75%
Eye Exam	58%	75%	50%	47%	52%		56%	77%
Foot Exam	74%	93%	78%	71%	80%		70%	90%

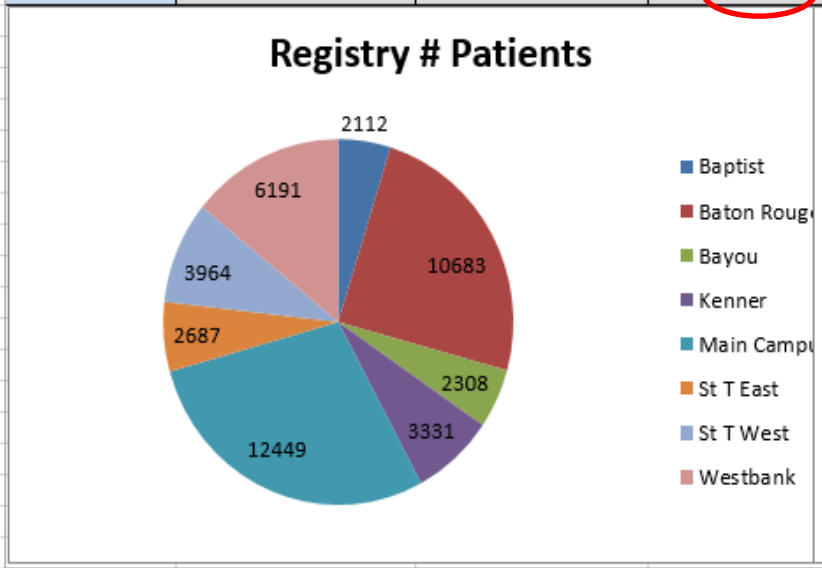
St. Tammany West

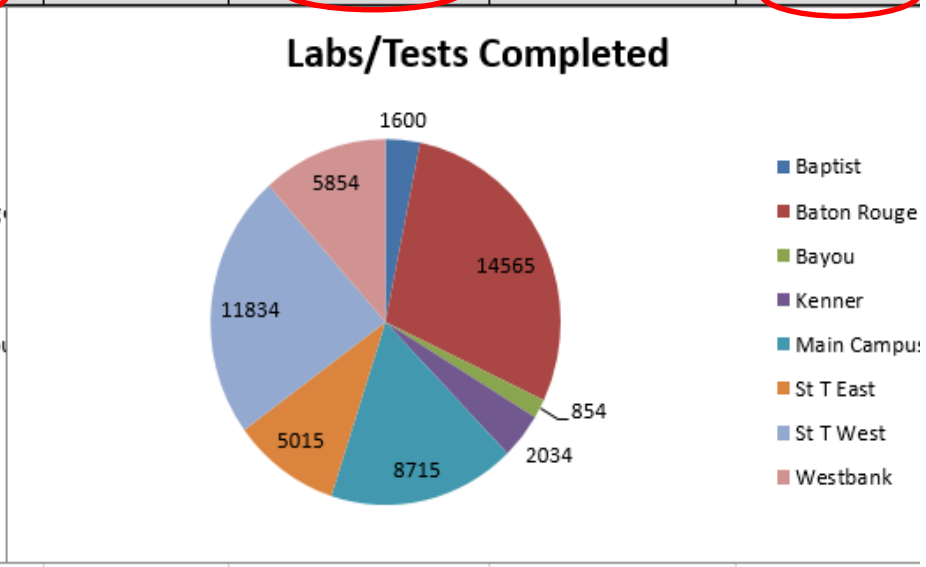
Ochsner Health System

Diabetic Registry Outreach Outcomes

January – December 2016

REGIONS	Registry # Patients	Outreach Count	Patients Receiving Outreach	Labs/Tests Completed	Unique # of Patients Completing Labs	Avg # of Labs/Tests Completed per Pt	% of Patients Completing Lab
Baptist	2112	837	568	1600	452	3.54	79.6%
Baton Rouge	10683	6849	4158	14565	3499	4.16	84.2%
Bayou	2308	665	310	854	256	3.34	82.6%
Kenner	3331	1210	701	2034	578	3.52	82.5%
Main Campus	12449	4469	2791	8715	2372	3.67	85.0%
St T East	2687	2298	1397	5015	1215	4.13	87.0%
St T West	3964	7372	2855	11834	2691	4.40	94.3%
Westbank	6191	3945	2089	5854	1746	3.35	83.6%
Totals	**43725**	**27645**	**14869**	**50471**	**12809**	**3.94**	**86.1%**





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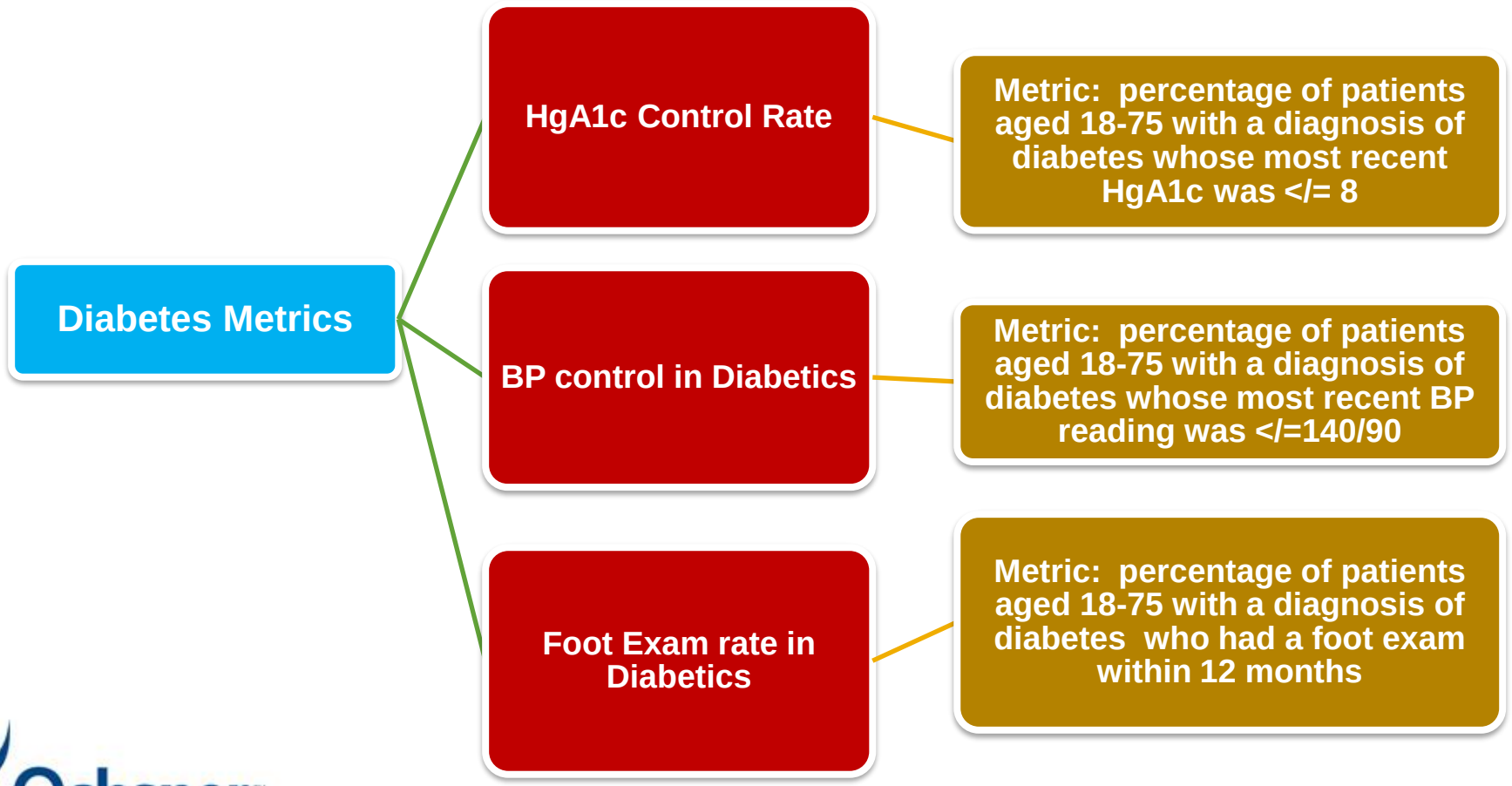
Primary Care Providers: Incentive



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Suggestions for success

- **Get to know your LPN CCCs-** they can help identify patients who need help controlling their diabetes
- Explore use of the **Digital Health Program** for patients with Hypertension- rolling out Q2 2016
- **Look at your MyPanel Dashboard** and compare your performance with your peers
- Use **Diabetes Education** as an entry point into diabetes management for patients having difficulty maintaining diabetes control
- Use **Complex Case Management** for patients with complicated medical and socioeconomic barriers
- **Provide feedback** to your leaders about which resources make the biggest impact on patient care
- **Pharmacy Assistance Program** offering support for patients having difficulty affording meds.

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DM Disease Management Program

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OHS Diabetes Care Management Program

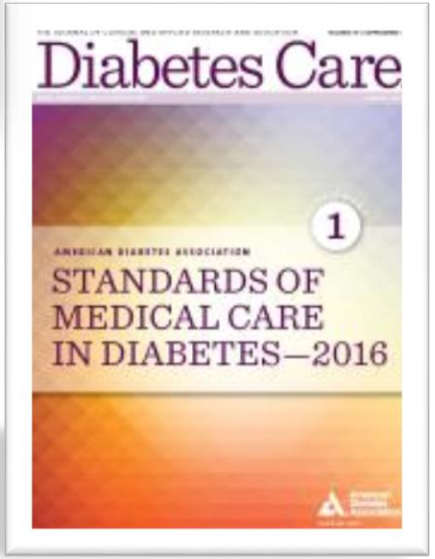
Patient-centered, team-based program developed to combine best practice standards

American Diabetes Association®

*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

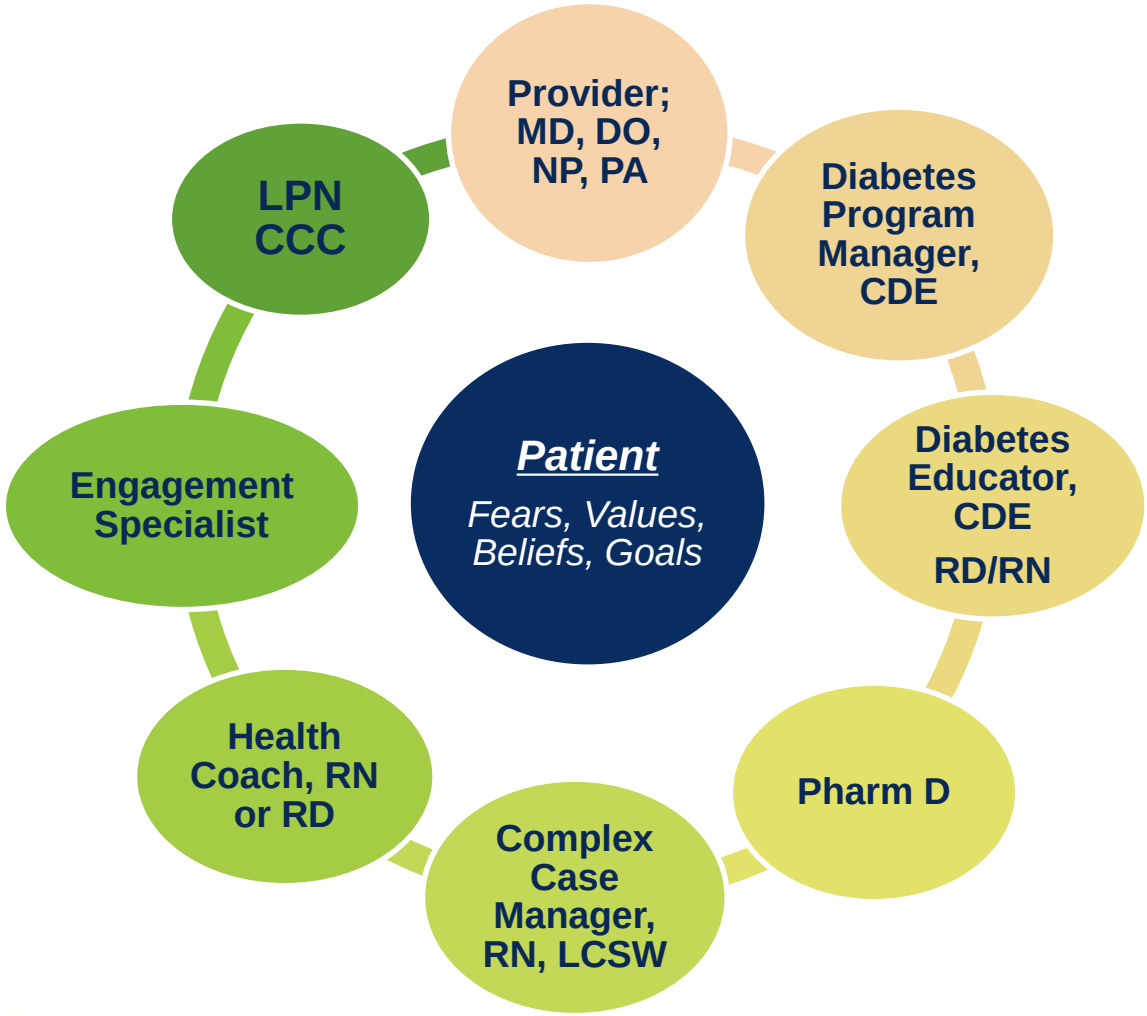
Together 2 Goal
American Medical Group Foundation
National Diabetes Campaign

NCQA
Measuring quality. Improving health care



Ochsner Health System

Multi-Disciplinary Diabetes Care Team



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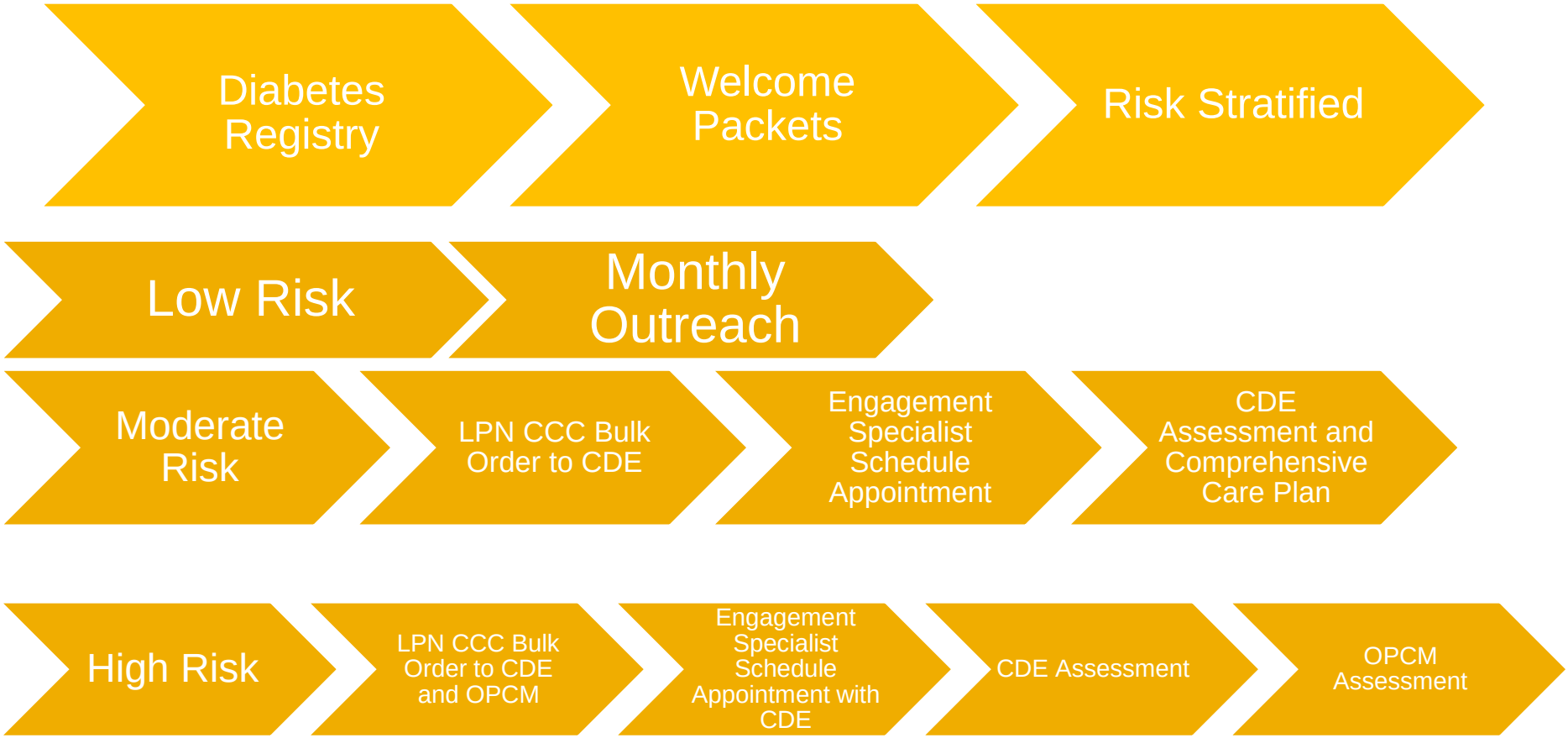
Work Flow



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Patient Centered

- Drive change! **DSME/S Programs**
- Move away from Didactic...approach
- "One size fits all"

Move Towards…

Patient with Diabetes

- Take into consideration patient needs and Values
- Fears and life experience….

- Empower the patient to make informed decisions about their own self-care
- Motivational interviewing

Improved Outcomes and Quality of Life

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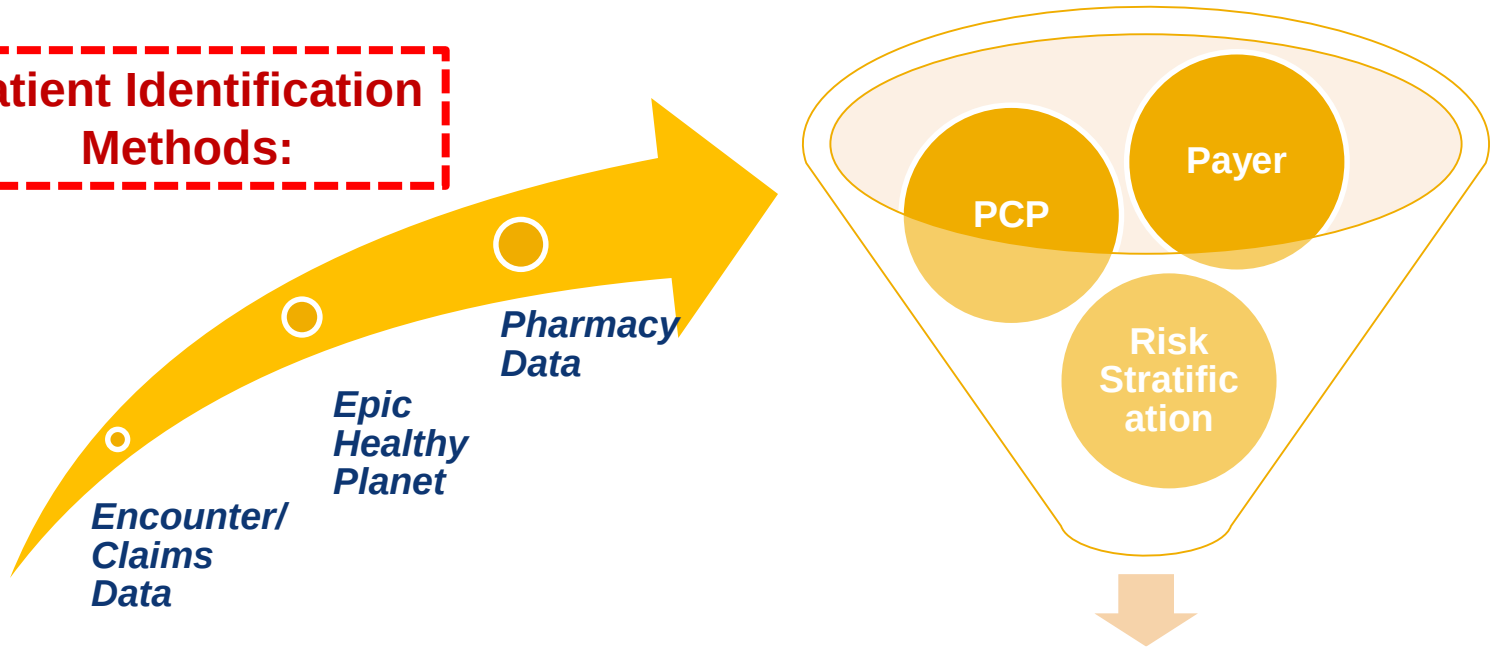
Source: Powers MA, et al. J Accad Nutr Diet. 2015;115;1323-1334.

Patient Identification

Patient Identification Methods:



Diabetes Registry

Ochsner Health System

Risk Stratification

High Risk

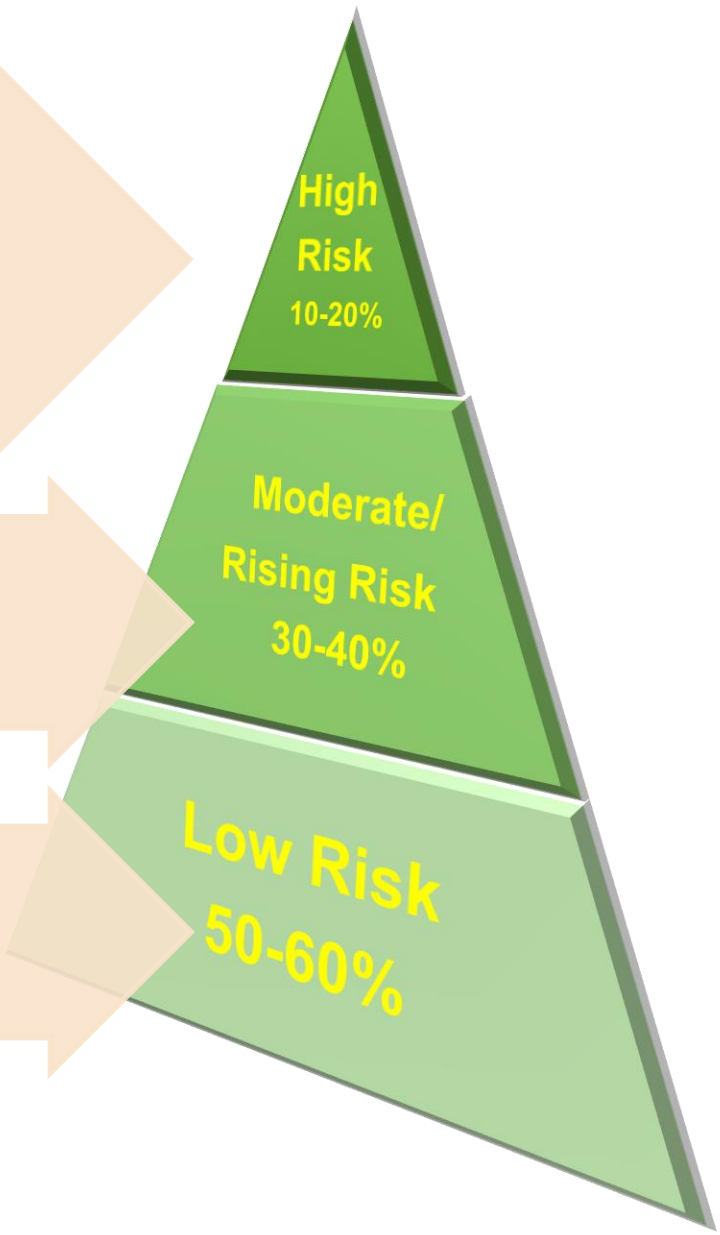
- A1c > 10%

Moderate

- A1c >7%-- </= 10% age 18-74
- A1c >/= 8%--</=10% >75

Low

- A1c </= 7%--age 18-74
- A1c < 8%--age > 75



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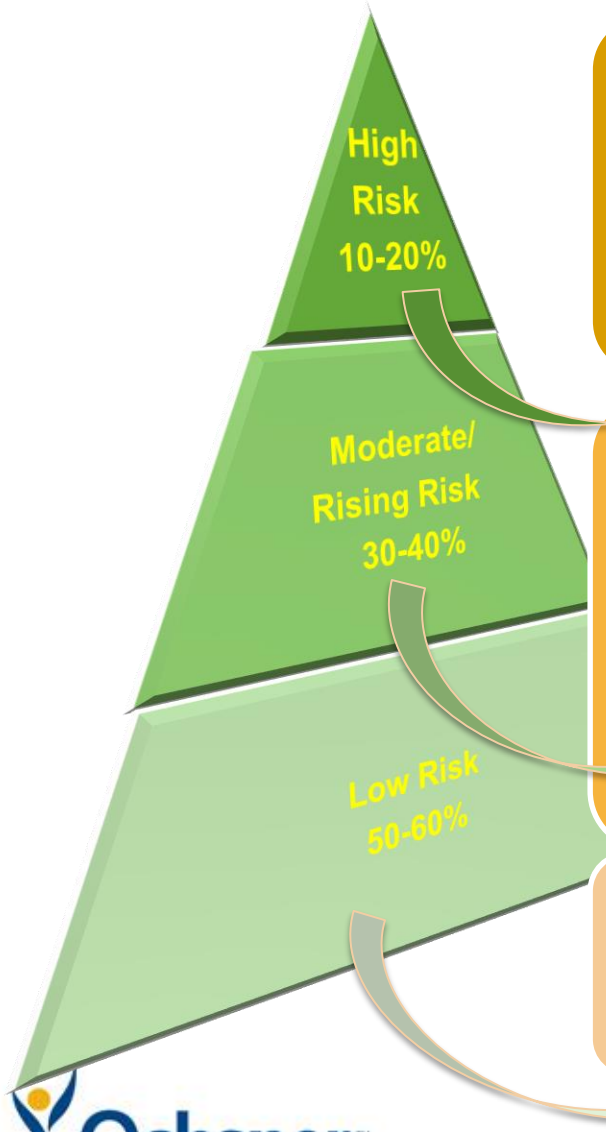
Interventions



High Risk

- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal
- Bulk order to Diabetes Education
- Education appt scheduled by Centralized Engagement Specialist
- Diabetes Education CDE visit for assessment and navigation to urgent or long-term Endocrine (if needed) or Diabetes Empowerment Clinic
- Bulk Referral to Outpt Care Management
- RN and/or Social Worker complete assessment and longitudinal care plan.

Moderate

- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal
- Bulk order placed for DM education
- Education appt Scheduled by Centralized Engagement Specialist
- Diabetes Education CDE visit for assessment and navigation to urgent or long-term Endocrine (if needed) or Diabetes Empowerment Clinic

LOW

- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal

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Pilot Data

- 60.9% of 218 referred patients attended diabetes education
- Results to date on A1c **control: n=62 pts with f/u A1c**

	# Patients	Entry A1c	Post-pilot A1c (2-6 mo)
Total	62	8.41%	7.6%
High Risk	12	11.57%	8.29%
Mod Risk	50	7.7%	7.3%

- ***Increase: Slidell's diabetes educator overall total unique patient volume***

(across all payers)

2015	178 Patients
2016	496 patients

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Leveraging Technology In Diabetes Care

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Telemedicine: Delivery of Diabetes Education

“increasing patient touch”

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American Diabetes Association®

*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

Diabetes Education offered through Telemedicine Clinic

Key points of Operation:

- Patient attends diabetes education sessions through telemedicine in their usual primary care clinic
- Educator Set up:
  - Computer with two monitors and 1 camera
  - all education materials, demo pens, meters, etc… stored at the remote location, the remote location has clinical staff that can assist as needed during patient teaching.
- Remote Site Set up:
  - an exam room with one desk top computer and a camera,

  Clinic staff MA/LPN to weigh the patient, perform the diabetes distress scale with the patient and then starts the session via Jabber and checks the patient out when education is done.

Ochsner Health System

American Diabetes Association®

*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

What have learned so far…

- Diabetes Education visits were very easy and inexpensive to implement:
- Through the web ochsner.org website https://www.ochsner.org/services/diabetes/,the educator is able to play videos and show resources during the session
- CDE able to assist in arranging for other health screening visits such as eye exam and lab visits
- Blood sugar logs and Bluetooth technology has allowed the educator to access blood sugar trends between visits
- CDE and the PCP actively discuss BG trends with the Patient and adjustments in therapy are made quicker.

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Word of mouth travels!

- Patients leave the office with a smile saying….
- “I had such a good time”
- “I can do this”
- “ I can’t wait to go home and try what I have learned”
- “So glad that this is offered”
- “When can I see you again”

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Options…

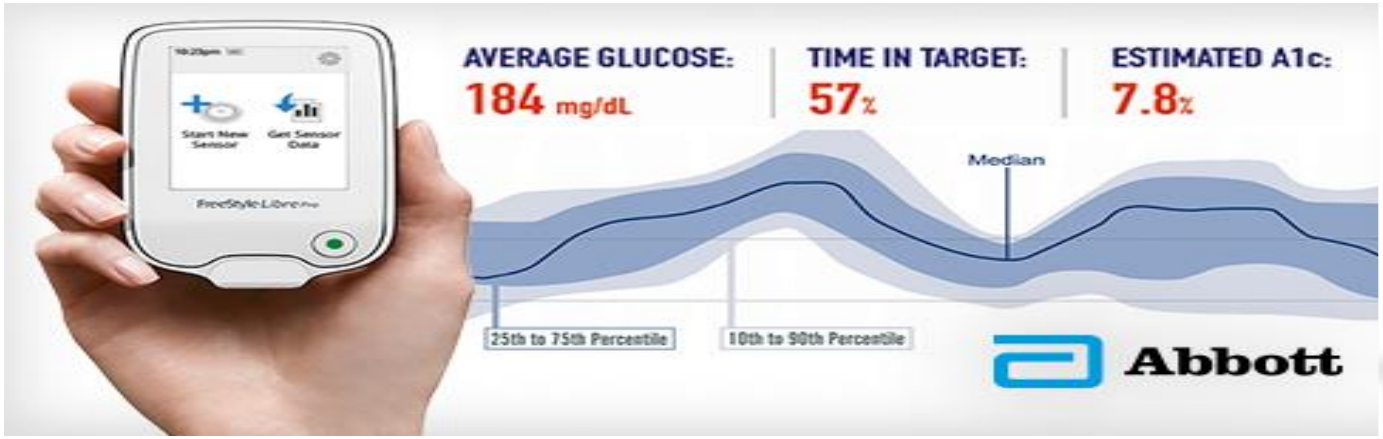
Patients and Providers have options as to how insulin is delivered, syringe, pumps, pens, V-GO etc…

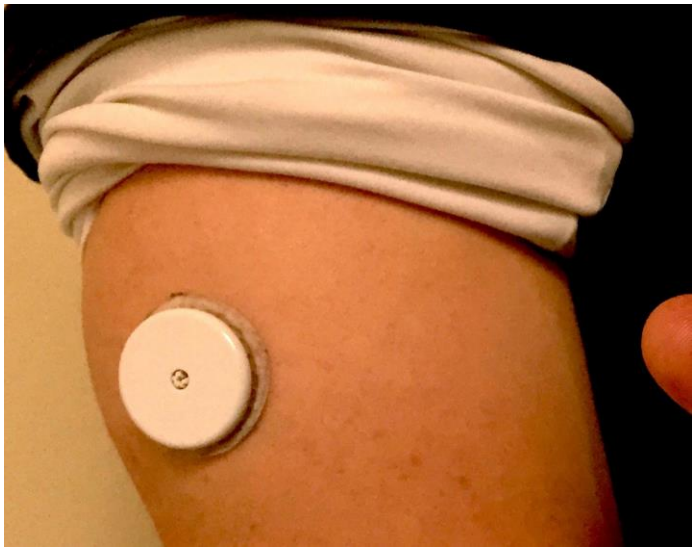
Shouldn't they have options on the delivery of their Diabetes Education too……**Telemed**, **Digital, Self-study**, **Traditional Classroom, or combination of all….**

GOAL… expand telemed offerings to multiple clinics and eventually offer educational services in patient homes on via own laptop, smartphone, or tablet.

Ochsner Health System

Professional Continuous Glucose Monitoring





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Continuous Glucose Monitors Systems (CGMS)

- Collect continuous data 24 hours on glucose trends (paired with food, activity, medication log)
- Readings are recorded every 5 minutes
- Glucose is measured by interstitial fluid with sometimes can be delayed from a finger stick--capillary sample.
- Very useful for trends and improving patient self-awareness
- Management and adjustment of the diabetes treatment plan should be based on ***glucose trends*** and not solely A1c.

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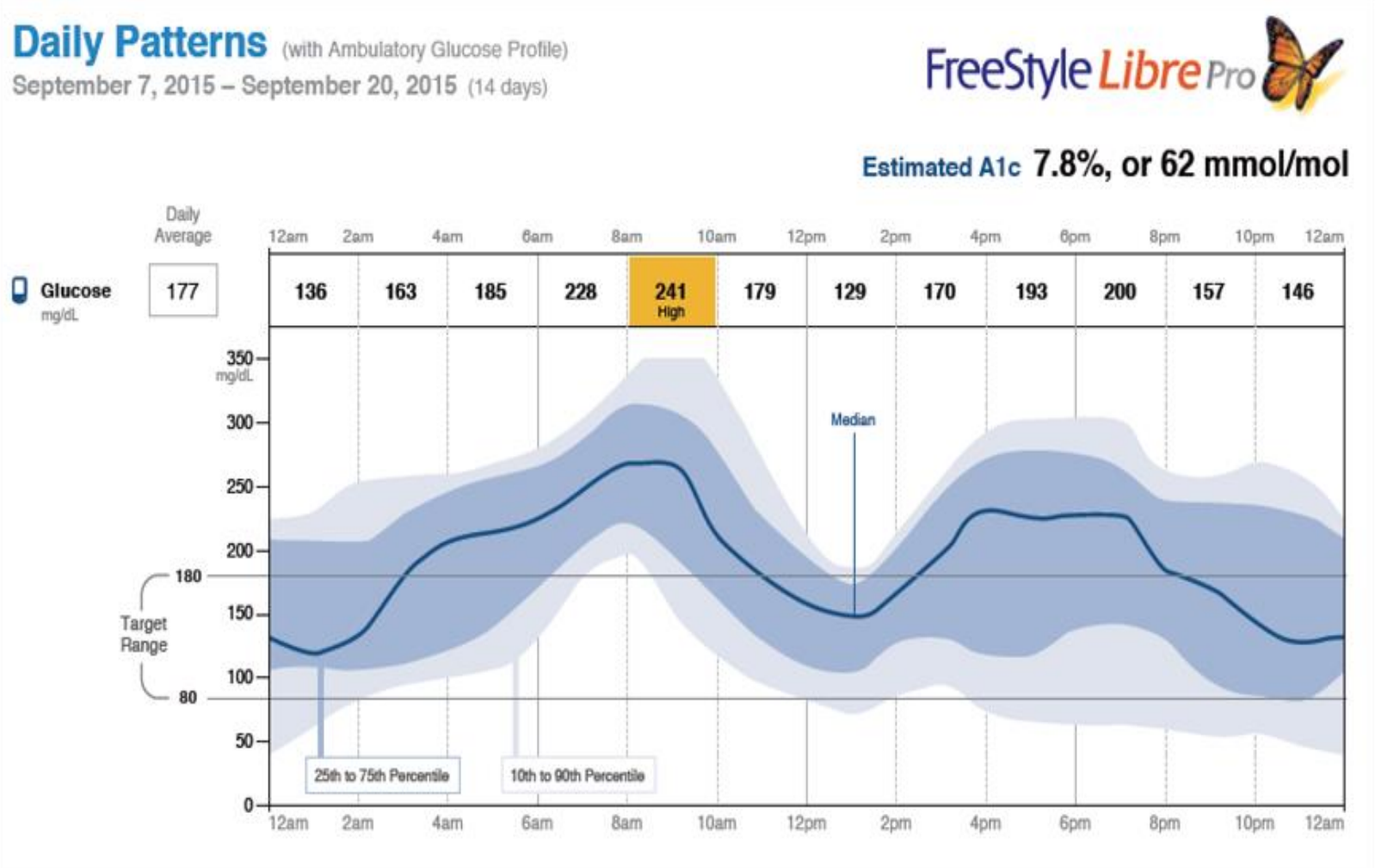
Continuous Glucose Monitoring



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CGMS Indications

- Hypoglycemia
- Variable glucose readings
- A1c not matching BG readings
- Uncontrolled diabetes
- Baseline information
- Non-adherence to self glucose monitoring
- Assistance with both changes and adjustment in treatment

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Workflow

- CGMS Order= in Epic by patient's Primary Care Provider
- Actual CGMS procedure= performed by the Endocrine Team
- Patient=wears the sensor for 7 days (records meals, activity, medications, and stress on a log)
- Completion=7 days of the sensor data is uploaded in the office and interpreted by Endocrine staff physician or nurse practitioner
- Results= primary care provider will receive the results in their Epic in basket. PCP will get unread CGMS tracings and CGM interpretation with recommendations of the diabetes treatment plan to provide to their patient.

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Workflow

- Endocrine Recommendations: based on the CGMS results there will be general recommendations and/or suggestions
  - Examples:
    - Patient needs better dietary management, refer to Diabetes Educator
    - Patient non adherent to therapy
    - Patient will need more basal coverage with a list of meds that cover basal needs
    - Patient will need more prandial coverage with a list of meds that cover basal needs
- Ordering provider can make changes based these recommendations

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Ochsner's O Bar

Serving up technology that helps keep patients engaged and out of the doctor's office

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Blood Pressure

Weight

Blood glucose

Among the tens of thousands of health apps and numerous devices, how to do decide what's effective?

Health System

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Health Innovations by **Ochsner**

- **Purpose of the O Bar?**
  - With over 100,000 health care related apps on the market today, we are clearing the noise for our patients and direct them to the best apps.

- **What happens during a patient visit to O Bar?**
  - Patients drop by before or after primary care appointments, where they are can speak to non-clinical, tech-savvy IT specialists, who are members of the primary care team, to have questions answered, walk through app tutorials, and are assisted with app downloads and technology integration.

- **Early Results?**
  - In the first six months, patients downloaded over 3,000 apps

- **What's happening now?**
  - Technology based battle against chronic disease: **Hypertensive Digital Medicine Program** enables patients to use wireless cuffs at home and blood pressure readings are streamed directly to the EMR. Congestive heart failure patients' weight can now be monitored remotely by medical professionals via a wireless bathroom scale via our **Heart Failure Digital Medicine Program**. **Diabetes monitoring**, COPD, specialized inhalers for asthma and vision monitoring for failing eyesight programs are in development.

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A closer look at the O Bar: Semi-retail space

- Bluetooth blood glucose monitors
- Wireless blood pressure monitors
- Wireless scales
- Activity trackers such at Fitbit and Jawbone
- Hundreds of physician approved health apps

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O Bar Prescription

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Bar

Ochsner Center for Primary Care and Wellness
1401 Jefferson Highway, New Orleans, LA 70121

ochsner.org/obar

Patient _____

Visit the Bar to get your apps & devices today!

Rx **Your Prescription for good health.**

Rx APPS

- ○ Nutrition
- ○ Fitness
- ○ Women's
- ○ Oncology
- ○ Diabetes
- ○ Medication
- ○ Smoking
- ○ General Health

DEVICES

- ○ Activity Monitor
- ○ Blood Glucose Monitor with Bluetooth
- ○ Wireless Scale
- ○ Wireless Blood Pressure Monitor

Physician Signature _____

"Tell me and I forget. Teach me and I may remember. Involve me and I learn." -BEN FRANKLIN

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Diabetes Digital Medicine Program

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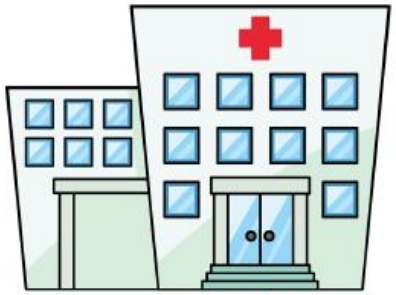
Outpatient Home Monitoring: Diabetes

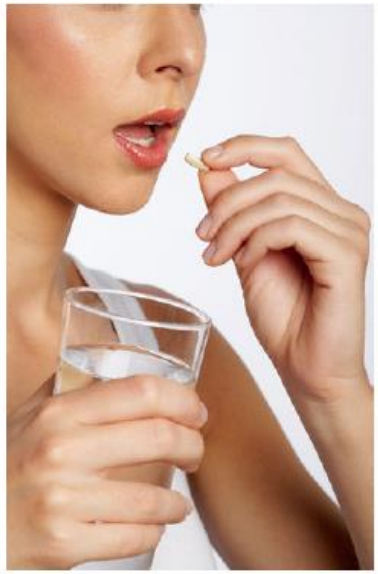


metrics scrubbed thru condition specific algorithms

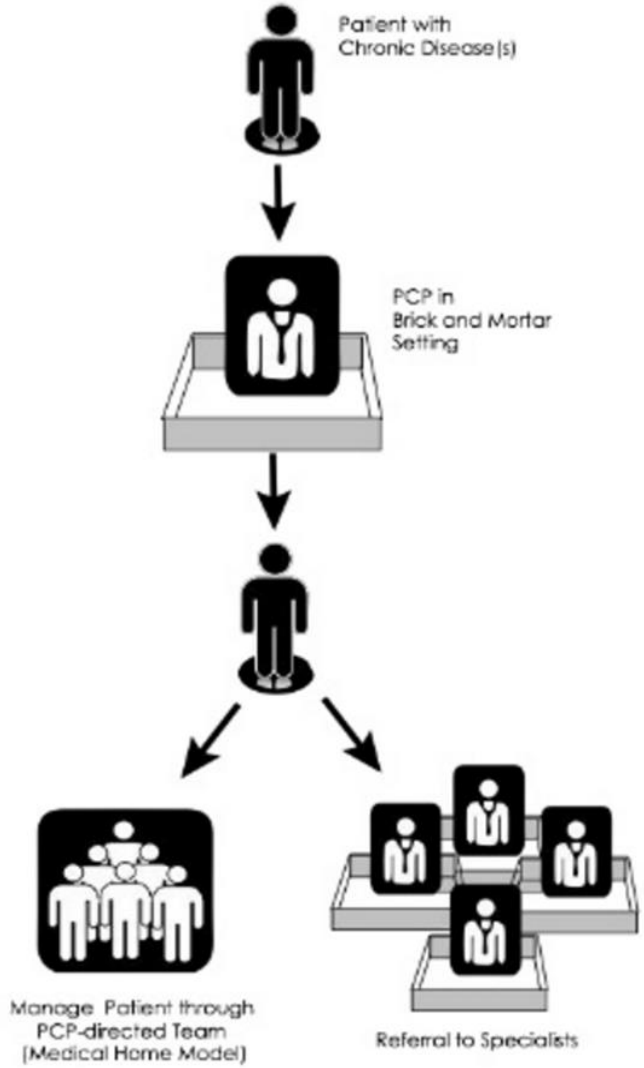
potential readmission avoided

patients stratified by risk status

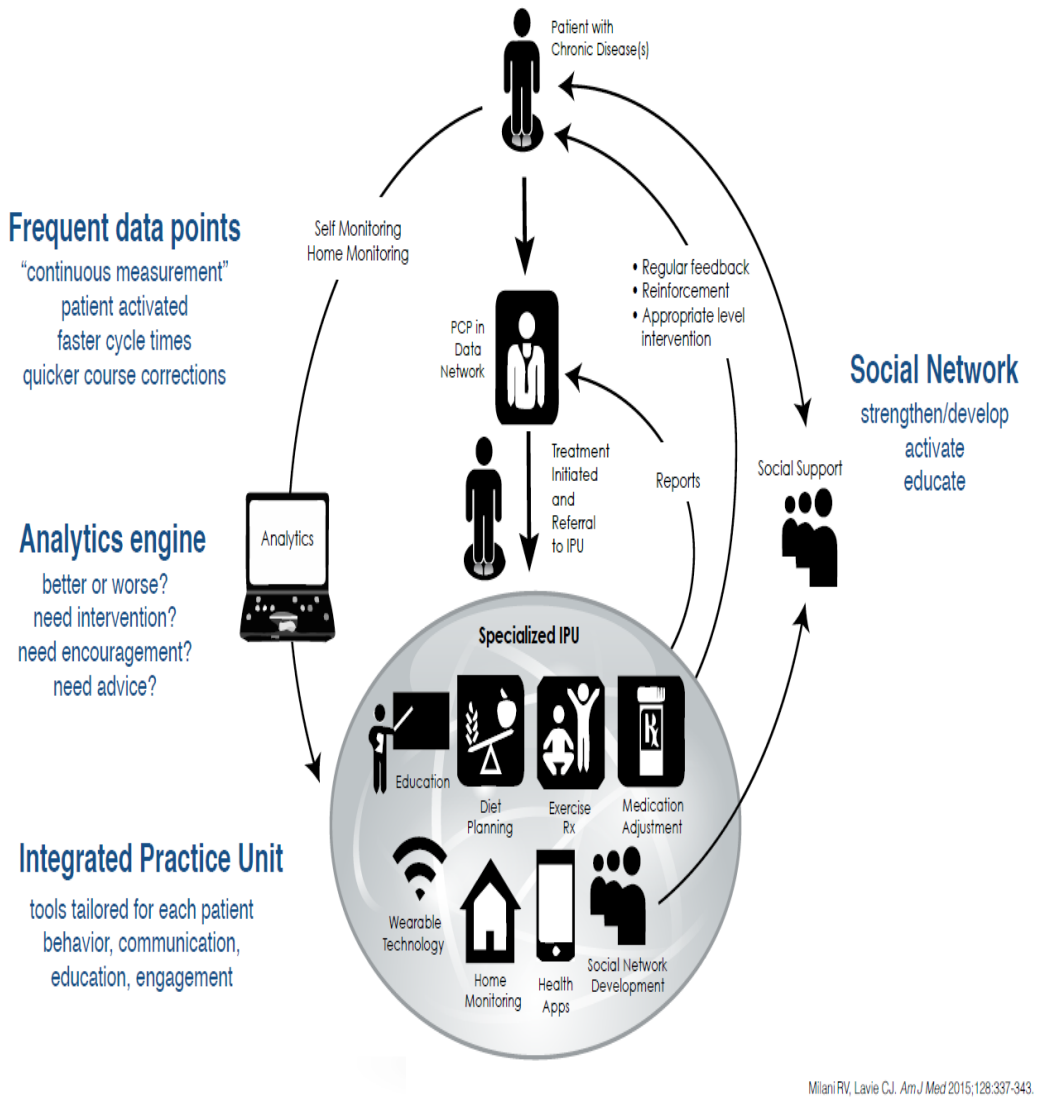
high risk patients intervened by medication adjustment and/or outpatient visit



Traditional Healthcare Model



Digital Healthcare Model



Milani RV, Lavie CJ. *Am J Med* 2015;128:337-343.

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Uniform Standards for Measurement and Ordering Strips

All reminders and ordering via smartphone

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Patient Characterization

- Onboarding
  - Dietary analysis
  - Medication adherence
  - Living circumstances
  - Medication affordability
  - Social network
  - Caregiver support
  - Sleep apnea screening
  - Depression
  - Patient activation measure
  - Physical activity index
  - Health literacy
  - Transportation issues
  - Access to care
  - Diabetes distress

Milani RV, Lavie CJ. *Am J Med* 2015;128:337-343.

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Principles of Type 2 Diabetes Management

Lifestyle therapy including medically supervised weight loss, is key to managing type 2 diabetes.
Weight loss should be considered as a lifelong goal in overweight and obese patients.
The A1C target must be individualized.
Glycemic control targets include fasting and postprandial glucoses.
The choice of therapies must be individualized on basis of patient characteristics, impact of net cost to patient, formulary restrictions, personal preferences.
Minimizing risk of hypoglycemia is a priority.
Minimizing risk of weight gain is a priority.
Initial acquisition cost of medications is only a part of the total cost of care which include monitoring requirements, risk of hypoglycemia, weight gain, safety, etc.
This algorithm stratifies choice of therapies based on initial A1C.
Combination therapy is usually required and should involve agents with complimentary actions.
Comprehensive management includes lipid and blood pressure therapies and related comorbidities.
Therapy must be evaluated frequently until stable, then less often.
The therapeutic regimen should be as simple as possible to optimize adherence.
Health maintenance should include active monitoring for complications of diabetes (eyes, renal, etc.)

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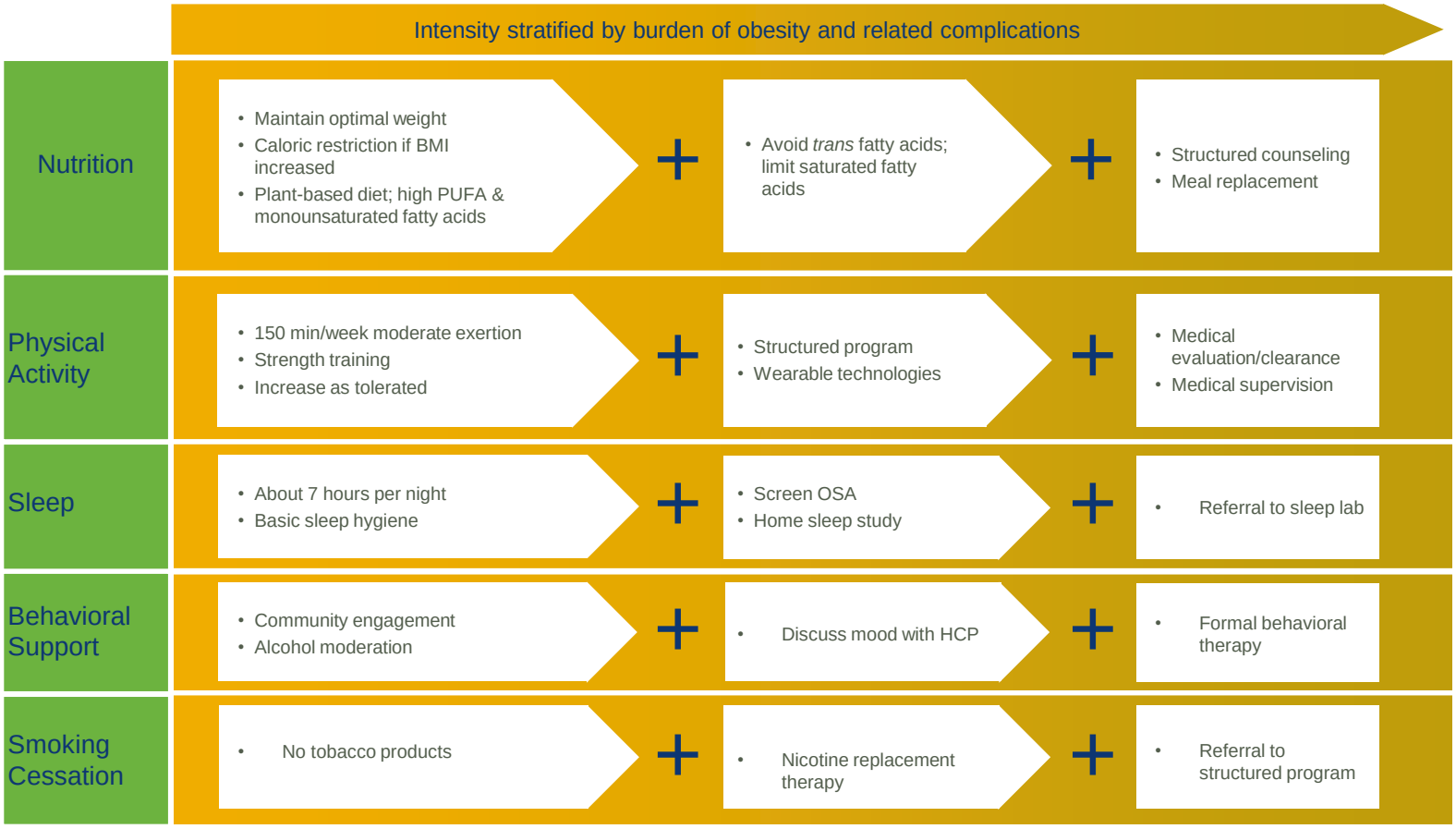
Lifestyle Therapy



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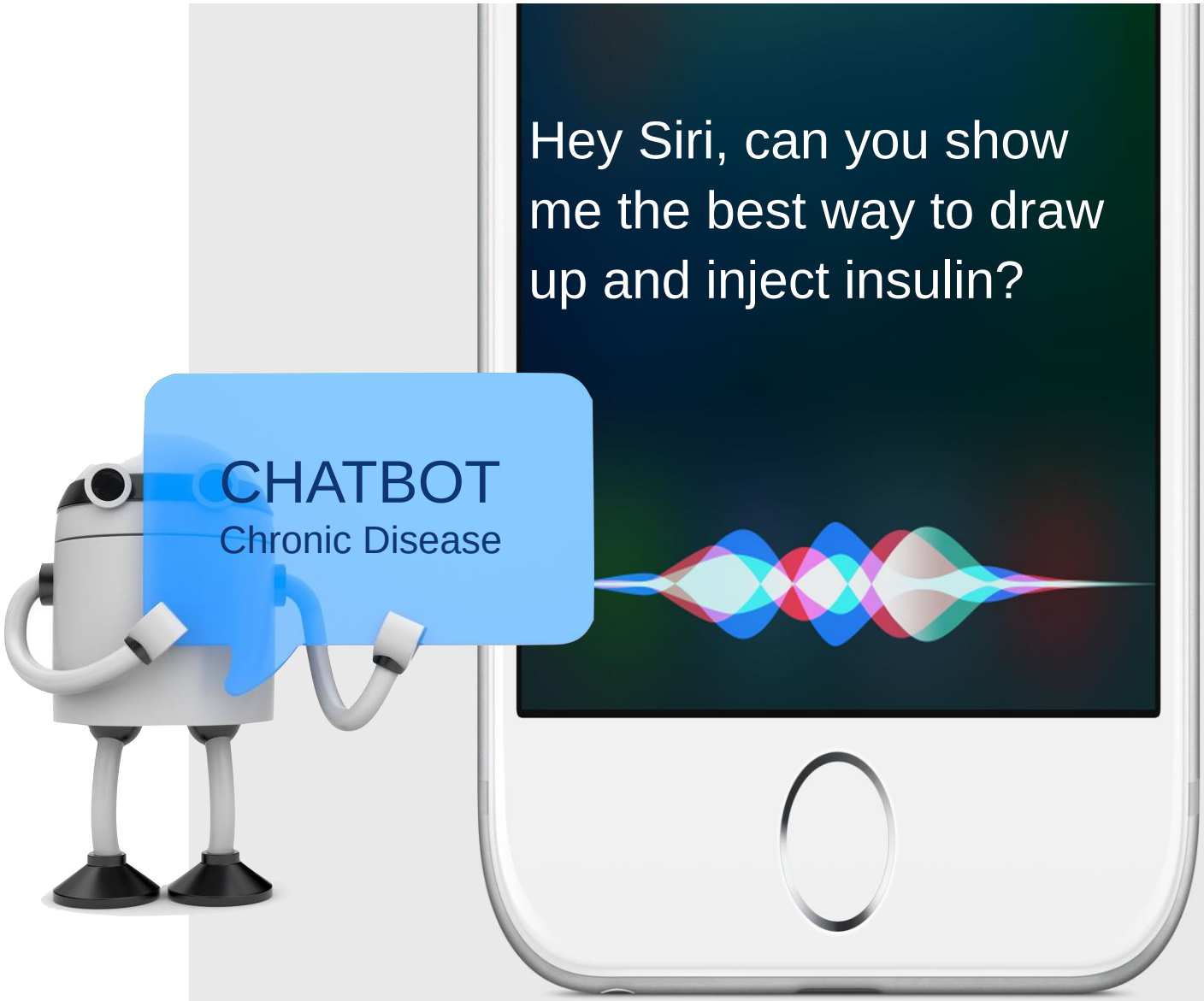

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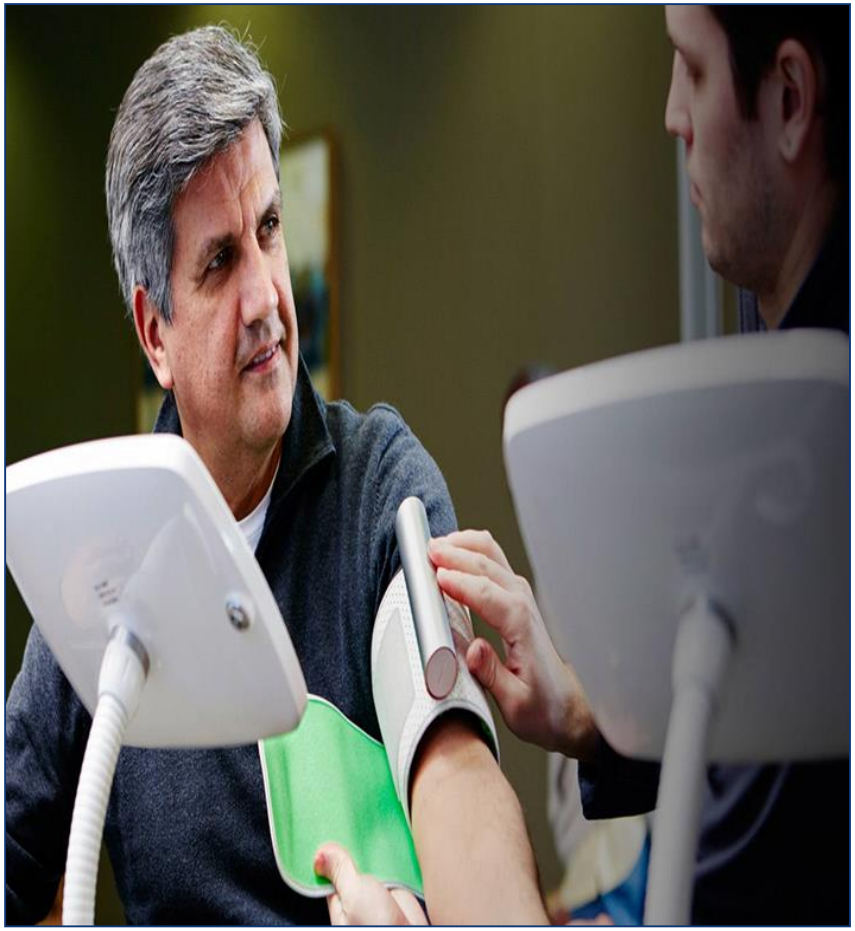
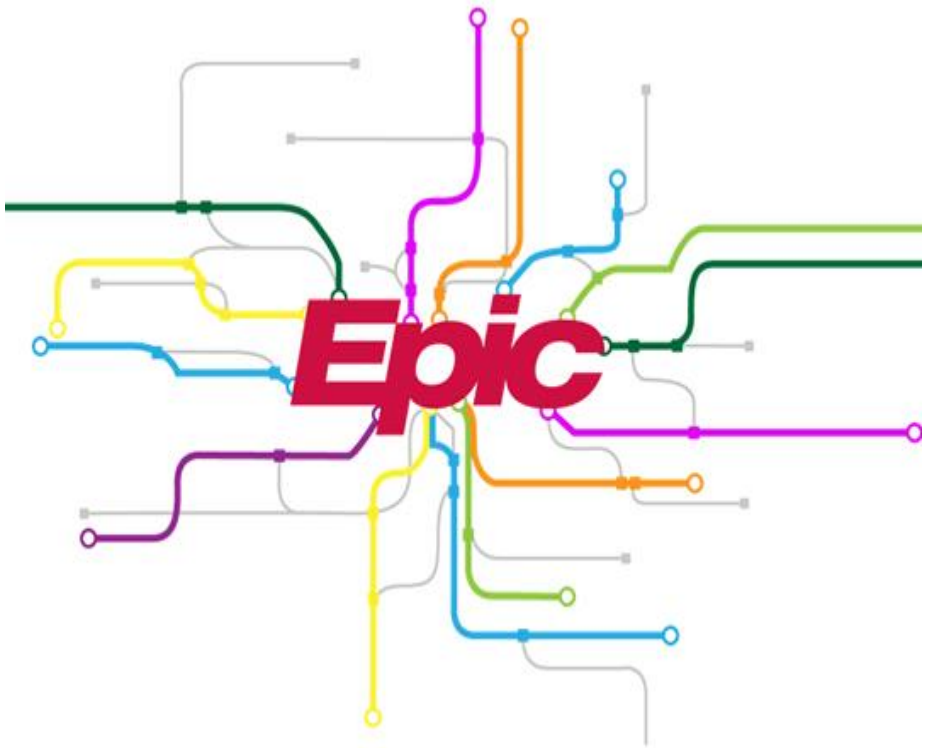
How are we able to achieve success?

- Instant Reports
  - Real-Time Data is central to iO's Digital Medicine Programs
- Warning Signs
  - Apple's Health-Kit integration with Epic allows for patient data, such as BG readings to be automatically shared with their care team.
- Treatment Adjustments
  - Completed more quickly thanks to the continuous loop of information



Lessons Learned



- Patient engagement improved
- Data integration is key
- Integration beats best in class at Ochsner
- Scalability to populations in process
- Transition in lock step with increased value-based contracts

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https://open.epic.com/

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