Together 2 Goal®

American Medical Group Foundation
National Diabetes Campaign

Data Orientation Webinar

February 16, 2016

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AGENDA

- Background
- Scope of Together 2 Goal® campaign
- Measurement tracks
- Measurement periods and reporting timeline
- Numbers to be reported
- Data submission options
- Questions

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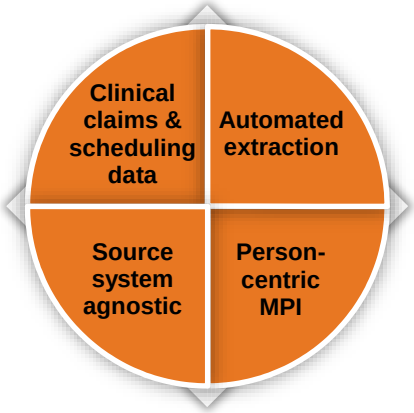
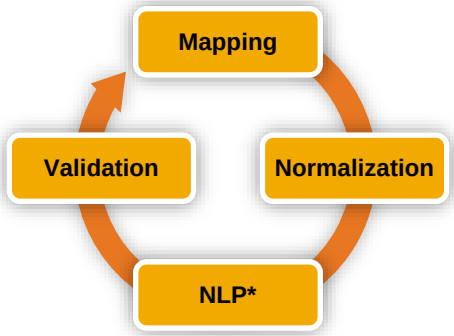
BACKGROUND

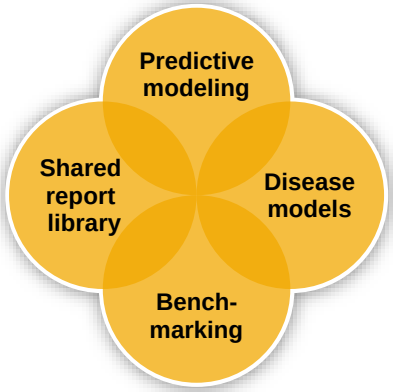
- Based on NCQA's HEDIS 2016 Technical Specs for Physician Measurement
  - Comprehensive Diabetes Care (CDC)
  - Statin Therapy for Patients with Diabetes (SPD)
- NCQA has granted permission to use their value sets for Together 2 Goal®
  - Provided in an Excel document accompanying the specs
- Some differences are inevitable, mainly in constructing the denominator
  - Together 2 Goal® focuses just on patients with type 2 diabetes, while HEDIS includes all patients with diabetes mellitus.
  - Differences between the measures for Together 2 Goal® and HEDIS 2016 are described throughout the specification document.
- Draft measurement specifications available online
  - Can access at: http://www.together2goal.org
  - Direct link: https://www.amga.org/wcm/AboutAMGA/CF/AMGF/Diabetes/draftSpecs.pdf

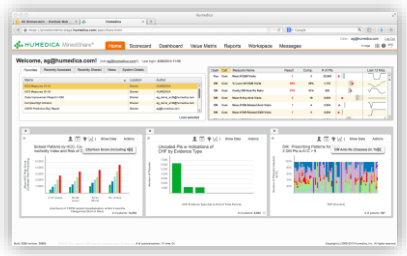
AMGA'S ANCETA COLLABORATIVE

Aggregate data across the continuum → Clean, normalize and validate data → Transform data into insight → Make insights actionable









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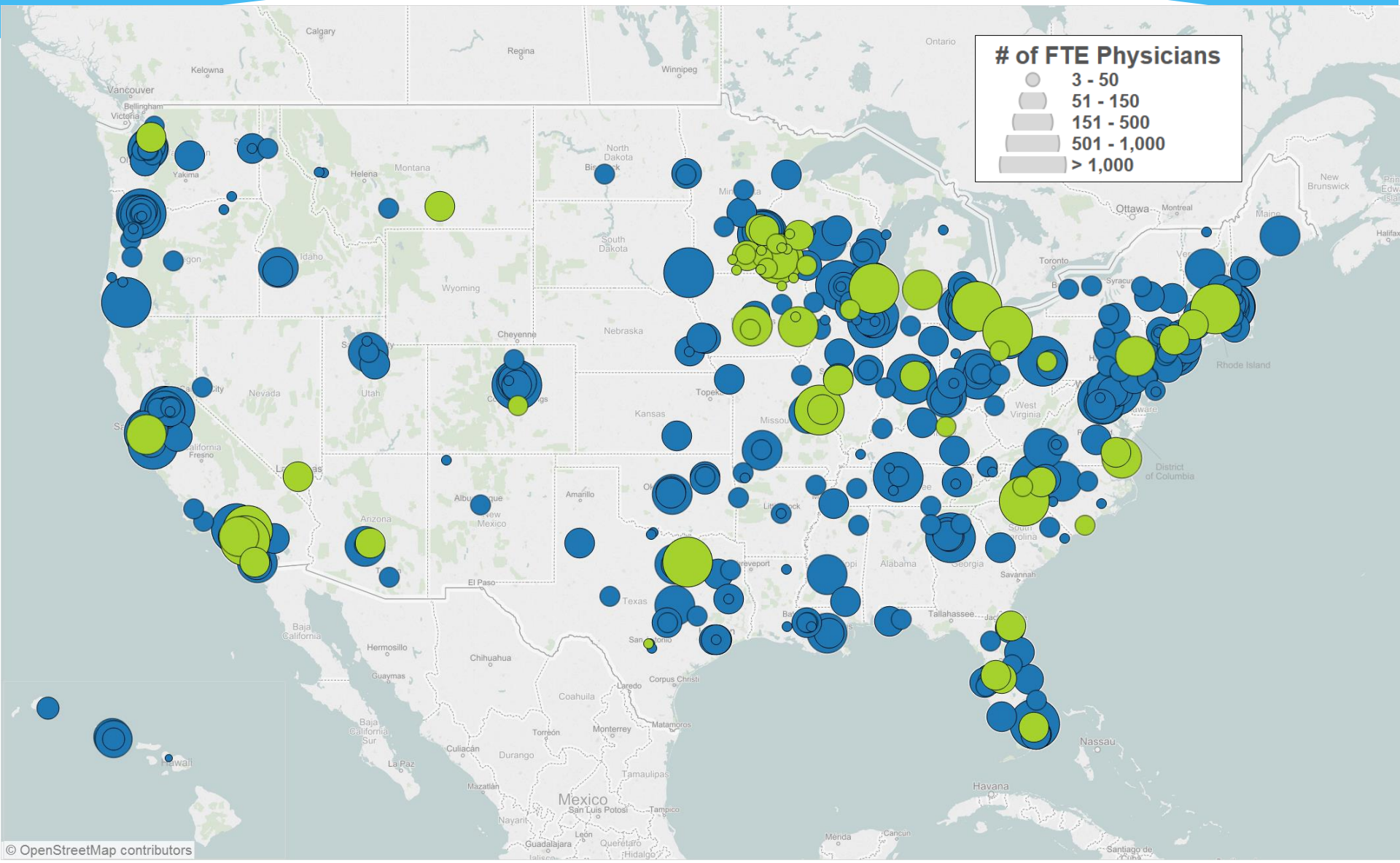

SCOPE OF CAMPAIGN

- Patients with type 2 diabetes
  - Differs from industry-standard measures, which encompass all patients with diabetes
  - Requires diagnosis code on a claim or specified on patients problem list in EHR
- Use age range from industry-standard diabetes measures: 18–75 years
  - Groups are encouraged to improve care for patients of all ages with type 2 diabetes
- Excluded from campaign: pregnancy
  - Optional exclusions: polycystic ovary syndrome, gestational or steroid induced diabetes, or palliative care, hospice, or an order to discontinue diabetes treatment

MEASUREMENT TRACKS

	Basic	Core (Bundle)	Innovator
HbA_{1C} control < 8 percent	Optional	√	√
BP control < 140/90 mmHg		√	√
Lipid management		√ Statin prescribed	√ Statin adherence
Medical attention for nephropathy		√	√
Non-smoking status			?
Body mass index			?
Foot exam performed			?
Eye exam performed			?
Other (e.g., patient engagement, functional outcomes, quality of life, overuse measurement)			√

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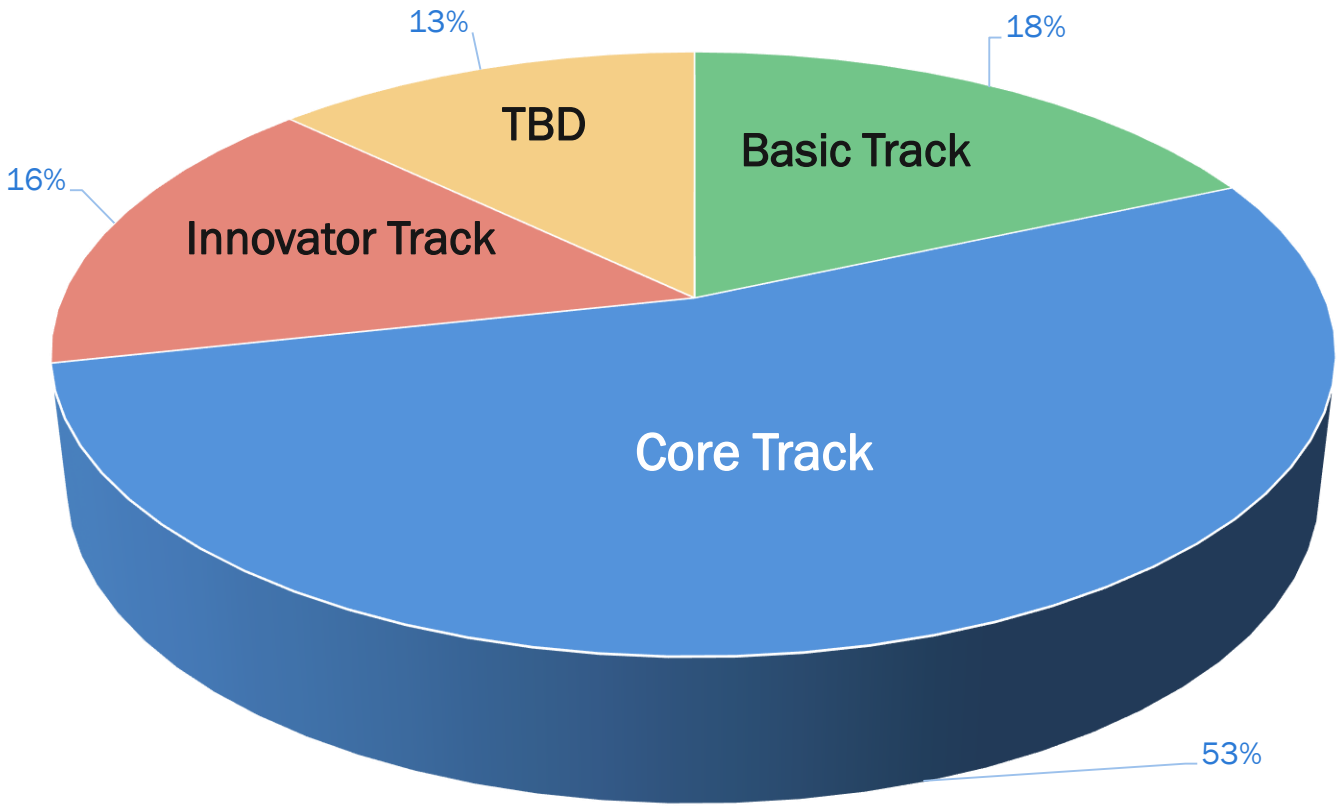
CAMPAIGN PARTICIPANTS BY DATA REPORTING TRACK



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CAMPAIGN PARTICIPANTS: CORE TRACK

- AHS Oklahoma Physician Group, LLC dba Utica Park Clinic
- Arizona Community Physicians
- Austin Diagnostic Clinic, P.A.
- Baptist Medical Group
- Billings Clinic
- Carle Physician Group
- Christie Clinic, LLC
- Colorado Springs Health Partners
- Community Physician Network
- Confluence Health
- The Everett Clinic
- Geisinger Health System
- Guthrie Clinic, Ltd.
- Hattiesburg Clinic, P.A.
- HealthEast Care System
- Henry Ford Health System
- Henry Ford Medical Group
- The Iowa Clinic, P.C.
- Kelsey-Seybold Clinic
- Lehigh Valley Health Network
- Lehigh Valley Physician Group
- Lexington Clinic, P.S.C.
- Mercy Clinic-East Communities
- Mercy Clinic-Southwest Missouri Communities
- Mercy Clinic-Springfield Communities
- Mercy Fort Smith
- Mercy Medical Group (CA)
- Mount Kisco Medical Group
- Mountain View Medical Group, P.C.
- Northeast Georgia Physicians Group
- Norton Medical Group
- Olmsted Medical Center
- Our Lady of the Lake Physician Group, LLC
- Piedmont Clinic, Inc.
- Piedmont HealthCare, P.A.
- The Polyclinic
- PriMed Physicians
- Revere Health
- Riverside Health System
- Riverside Medical Group
- Rockford Health Physicians
- Rockwood Clinic
- Scripps Clinic Medical Group
- Scripps Coastal Medical Group
- Sentara Medical Group
- Southeastern Integrated Medical
- Spectrum Health Medical Group
- SSM Health (including Dean Health Plan)
- ThedaCare Physicians
- Tulane University Medical Group
- Union Associated Physicians Clinic, LLC
- UnityPoint Clinic
- University of South Florida Health
- Watson Clinic, LLP
- Weill Cornell Physician Organization
- Westchester Health Associates
- Wheaton Franciscan Medical Group
- Wilmington Health

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CAMPAIGN PARTICIPANTS: ADDITIONAL TRACKS

BASIC TRACK

- Baptist Health Medical Group
- Bassett Healthcare
- Boice-Willis Clinic, P.A.
- Centura Health Physician Group
- CHRISTUS Physician Group
- Coastal Carolina Health Care, PA
- Essentia Health - Central Region
- Essentia Health - East Region
- Essentia Health - West Region
- Essentia Health System
- Signature Partners
- PIH Health Physicians
- Prevea Health Services
- Quincy Medical Group
- Riverside Medical Clinic
- Saint Francis Health System / Warren Clinic
- Sharp Community Medical Group
- Susquehanna Health Medical Group
- UMass Memorial Health Care – Office of Clinical Integration/Population Health
- Unity Health Care

INNOVATOR TRACK

Austin Regional Clinic, P.A.

Columbia St. Mary's Physicians - Ascension Health

Cornerstone Health Care, P.A.

Esse Health

Harbin Clinic, LLC

Horizon Family Medical Group

New West Physicians, P.C.

Ochsner Health System

The Portland Clinic

Premier Medical Associates, P.C.

Sharp Rees-Stealy Medical Group, Inc.

Springfield Clinic

Summit Medical Group, P.A.

SwedishAmerican Health System

Wellmont Medical Associates

Western Montana Clinic

WESTMED Medical Group, P.C.

TO BE DETERMINED

- Aurora Health Care
- Baptist Health Medical Group
- Excela Health Medical Group
- Franciscan Missionaries of Our Lady Health System
- Intermountain Healthcare
- Meritage Medical Network
- Novant Medical Group
- Our Lady of the Lourdes Physician Group
- Palo Alto Medical Foundation
- Park Nicollet HealthPartners Care Group
- St. Elizabeth Physicians (LA)
- St. Francis Medical Group
- Sutter Health
- University of Utah Community Clinics
- USMD Health System

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MEASUREMENT PERIODS AND REPORTING TIMELINE

- Quarterly reporting
- Almost 2/3 of patients have at least one visit in last quarter of the measurement period
- Over 1/4 of patients have at least 2 visits in last quarter

	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
T2G Year 1:	**2016 Q2** (2015 Q3 - 2016 Q2)	**2016 Q2** (2015 Jul 1 - 2016 Jun 30)	September 1, 2016	September 23, 2016
	2016 Q3 (2015 Q4 - 2016 Q3)	**2016 Q3** (2015 Oct 1 - 2016 Sep 30)	December 2, 2016	December 22, 2016
	2016 Q4 (2016 Q1 - 2016 Q4)	**2016 Q4** (2016 Jan 1 - 2016 Dec 31)	March 1, 2017	March 24, 2017
	2017 Q1 (2016 Q2 - 2017 Q1)	**2017 Q1** (2016 Apr 1 - 2017 Mar 31)	June 1, 2017	June 23, 2017
T2G Year 2:	**2017 Q2** (2016 Q3 - 2017 Q2)	**2017 Q2** (2016 Jul 1 - 2017 Jun 30)	September 1, 2017	September 22, 2017
	2017 Q3 (2016 Q4 - 2017 Q3)	**2017 Q3** (2016 Oct 1 - 2017 Sep 30)	December 1, 2017	December 22, 2017
	2017 Q4 (2017 Q1 - 2017 Q4)	**2017 Q4** (2017 Jan 1 - 2017 Dec 31)	March 1, 2018	March 23, 2018
	2018 Q1 (2017 Q2 - 2018 Q1)	**2018 Q1** (2017 Apr 1 - 2018 Mar 31)	June 1, 2018	June 22, 2018
T2G Year 3:	**2018 Q2** (2017 Q3 - 2018 Q2)	**2018 Q2** (2017 Jul 1 - 2018 Jun 30)	September 4, 2018	September 21, 2018
	2018 Q3 (2017 Q4 - 2018 Q3)	**2017 Q3** (2017 Oct 1 - 2018 Sep 30)	December 3, 2018	December 21, 2018
	2018 Q4 (2018 Q1 - 2018 Q4)	**2018 Q4** (2018 Jan 1 - 2018 Dec 31)	March 2, 2019	March 30, 2019
	2019 Q1 (2018 Q2 - 2019 Q1)	**2019 Q1** (2018 Apr 1 - 2019 Mar 31)	June 3, 2019	June 28, 2019

OVERVIEW

- Values to report every quarter (7 Total)
  - a) Active initial population
    - Patients 18–75 with at least 2 visits in an ambulatory setting with a PCP, Endocrinologist, Cardiologist, or Nephrologist
  - b) Active initial population with type 2 diabetes (T2G cohort, denominator)
  - Type 2 diabetes (T2G cohort, denominator) and
  - c) HbA_{1C} control (measure #1)
    - Most recent HbA_{1C} < 8.0%
  - d) Blood pressure control (measure #2)
    - Most recent BP < 140/90
  - e) Medical attention for nephropathy (measure #3)
  - f) Lipid management (measure #4)
    - Statin prescribed or had documentation of a reason not to receive a statin
  - g) Diabetes care bundle control (measure #5)

OVERVIEW CONTINUED

- Using the numbers reported by participating organizations, Together 2 Goal® and the AMGF team will calculate and track the following measures

Measures to be tracked	Formula
Prevalence of type 2 diabetes	$\frac{Patients\ with\ type\ 2\ diabetes\ (b)}{Active\ initial\ population\ (a)}$
HbA1C control	$\frac{Patients\ with\ \mathrm{HbA1C}\ Control\ (<8\%)(c)}{Patients\ with\ type\ 2\ diabetes\ (b)}$
Blood pressure control	$\frac{Patients\ with\ BP\ control\ (<\frac{140}{90})\ (d)}{Patients\ with\ type\ 2\ diabetes\ (b)}$
Medical attention for nephropathy	$\frac{Patients\ with\ medical\ attention\ for\ nephropathy\ (e)}{Patients\ with\ type\ 2\ diabetes\ (b)}$
Lipid management	$\frac{Patients\ with\ lipid\ management\ (f)}{Patients\ with\ type\ 2\ diabetes\ (b)}$
Diabetes care bundle	$\frac{Patients\ with\ diabetes\ care\ bundle\ control\ (g)}{Patients\ with\ type\ 2\ diabetes\ (b)}$

ACTIVE INITIAL POPULATION

- Patients aged 18–75 with two or more face-to-face encounters
  - During the 12 month measurement period plus the prior 6 months (18 months total)
  - With a PCP, Endocrinologist, Cardiologist, or Nephrologist
  - In an ambulatory setting (e.g., office visits, urgent care, and “retail” clinics)
  - Two visits do not need to be with the same provider or provider specialty
- Used to calculate and track increases in prevalence of type 2 diabetes over time as additional patients are discovered

CPT/HCPCS CODES TO IDENTIFY VISITS

Table 1: Codes to Identify Visits

CPT/HCPCS Codes	Description
99201–99205, 99211–99215	Evaluation & Management Office Visit
99241–99245	Evaluation & Management Office Consultation
99381–99387, 99391–99397	Evaluation & Management Preventive Visit
99401–99404	Preventative Medicine: Individual Counseling Visit
99411–99412	Preventative Medicine: Group Counseling Visit
99420, 99429	Other Preventive Medicine Services
G0402	Initial Preventive Physical Examination (“Welcome to Medicare” Visit)
G0438, G0439	Medicare Annual Wellness Visit
G0463	Hospital outpatient clinic visit for assessment and management of a patient
T1015	Clinic visit/encounter, all inclusive

EXCLUSIONS

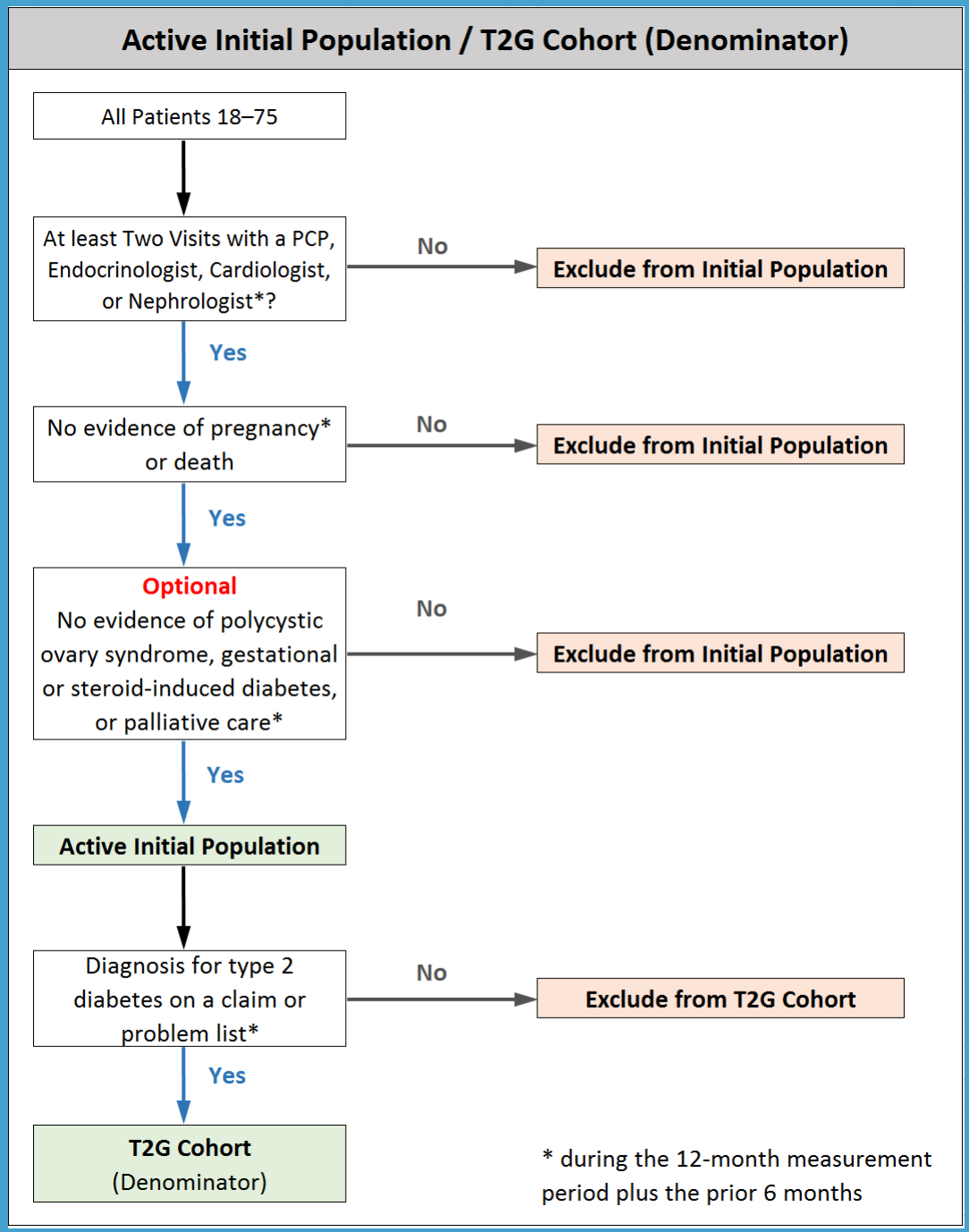
- Together 2 Goal® has required and optional exclusions
  - It is up to the participating organization to determine whether there are compelling reasons to use the optional exclusions
  - Optional exclusions will allow organizations who use these exclusions internally to reflect them in their reporting for Together 2 Goal®
- Required exclusions
  - Diagnosis for pregnancy (on a claim or problem list)
  - Patient died
- Optional exclusions
  - Polycystic ovary syndrome
  - Gestational or steroid-induced diabetes
  - Palliative care, hospice, or an order to discontinue diabetes treatment

DENOMINATOR

- Patients from active initial population with evidence for type 2 diabetes
  - on a claim for a face-to-face visit in an ambulatory setting or the patient's problem list

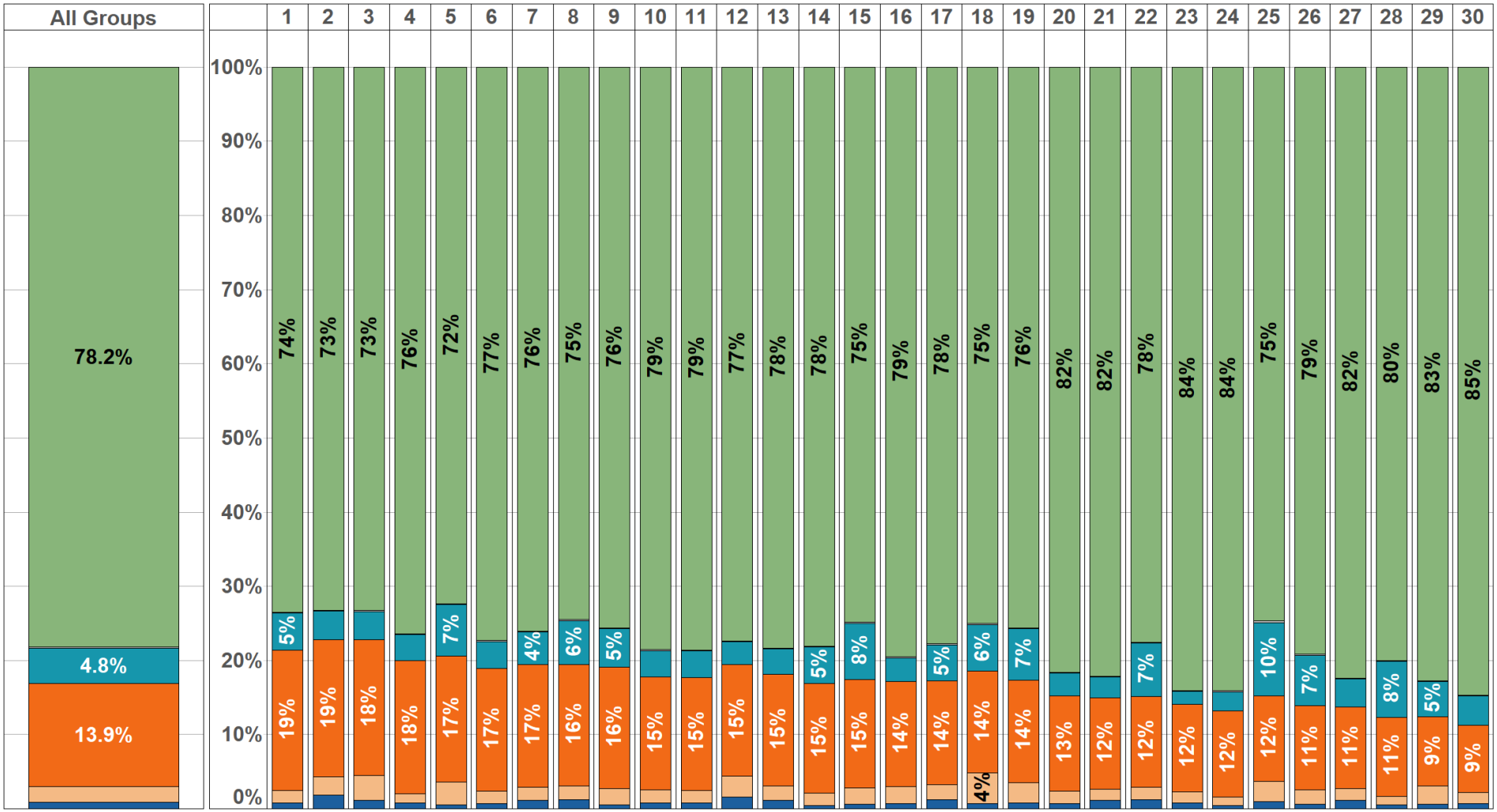
	Codes
ICD-9	250.*0 or 250.*2, where * is any valid character
ICD-10	E11.*, where * is any valid character string

- Patients with pharmacy evidence of diabetes without a diagnosis are not included
  - many patients who have only pharmacy evidence of diabetes cannot be definitively classified as having type 2 diabetes
- Groups have the option to exclude patients who also have evidence of type 1 diabetes
  - using data from organizations participating in AMGA's Anceta collaborative, ~4.7% of patients included in the campaign denominator (i.e., evidence of type 2 diabetes) also had evidence of type 1 diabetes

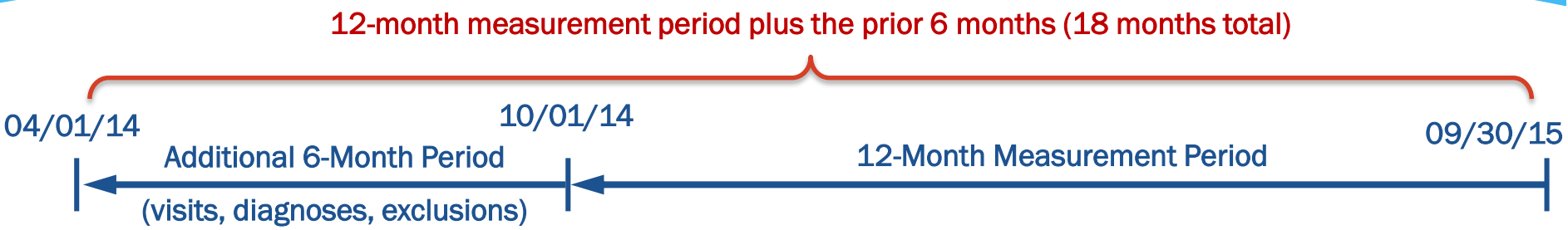

Active Initial Population / T2G Cohort (Denominator)
All Patients 18–75
At least Two Visits with a PCP, Endocrinologist, Cardiologist, or Nephrologist*?
No
Exclude from Initial Population
Yes
No evidence of pregnancy* or death
No
Exclude from Initial Population
Yes
Optional
No evidence of polycystic ovary syndrome, gestational or steroid-induced diabetes, or palliative care*
No
Exclude from Initial Population
Yes
Active Initial Population
Diagnosis for type 2 diabetes on a claim or problem list*
No
Exclude from T2G Cohort
Yes
T2G Cohort
(Denominator)
* during the 12-month measurement period plus the prior 6 months

PREVALENCE OF TYPE 2 DIABETES

- 5.03 million patients, aged 18–75, across 30 medical groups, with at least 2 visits (04/01/2014-09/30/15)
- No pregnancy, polycystic ovary syndrome, or secondary diabetes (campaign exclusions)
- Range in prevalence of type 2 diabetes by medical group: 9.0%–18.9%



12 MONTHS VS. 18 MONTHS



- Defined in the 18-month time period
  - face-to-face encounters for inclusion in active initial population
  - evidence of type 2 diabetes for inclusion in denominator
  - exclusions
- Numerator compliance for the individual measures are almost exclusively calculated in the 12-month measurement period

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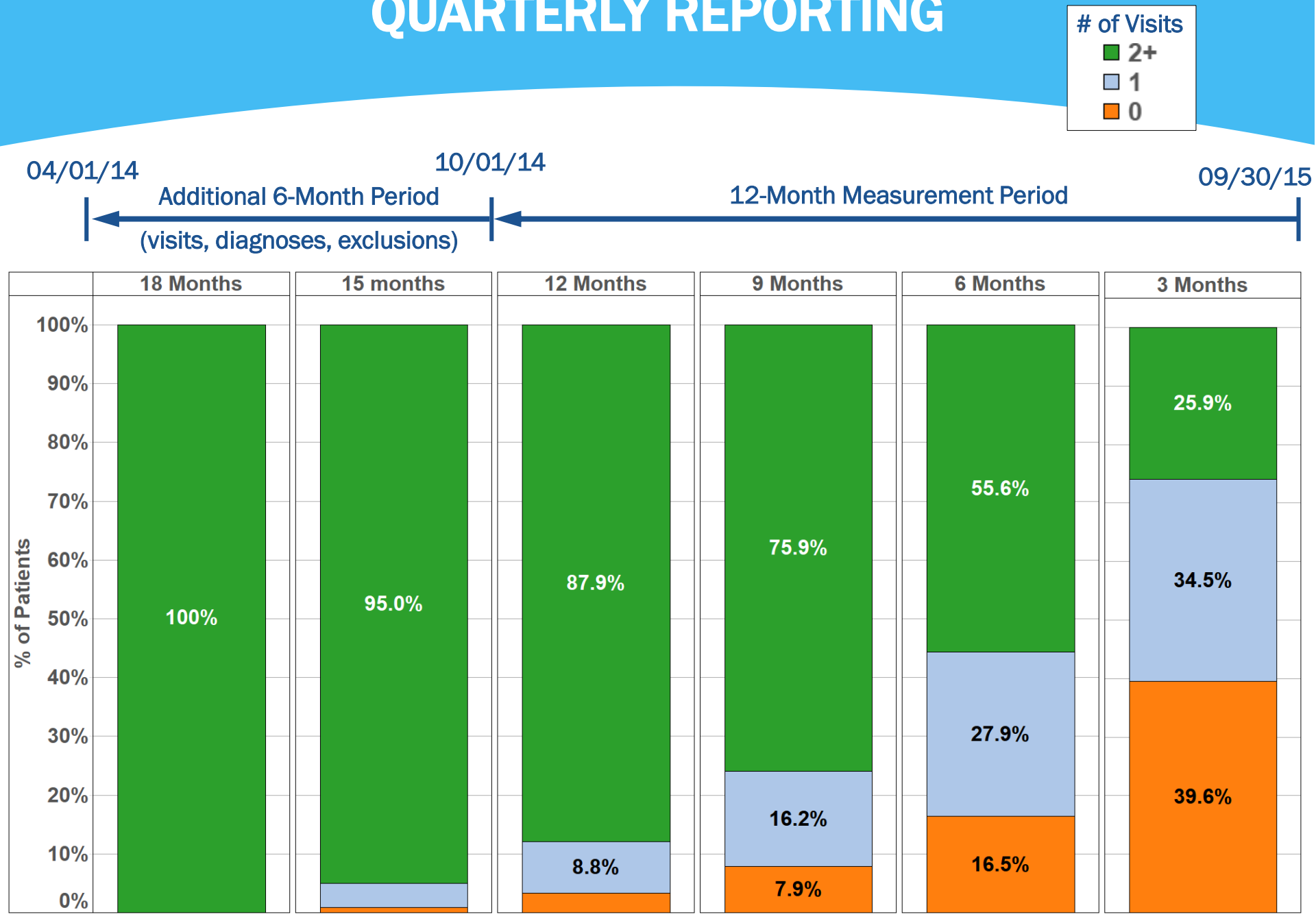
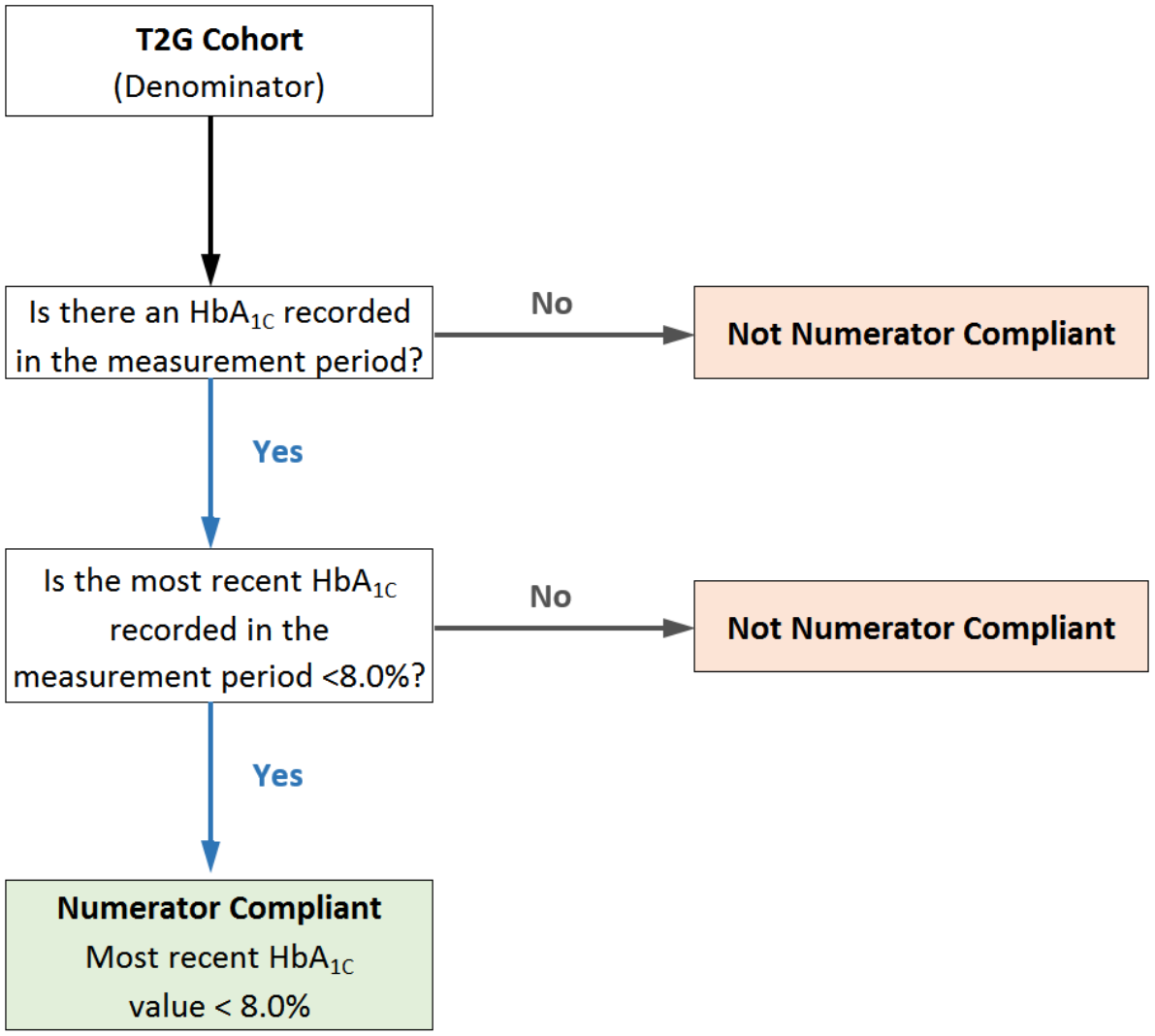
QUARTERLY REPORTING



MEASURE #1 – HbA_{1C} CONTROL

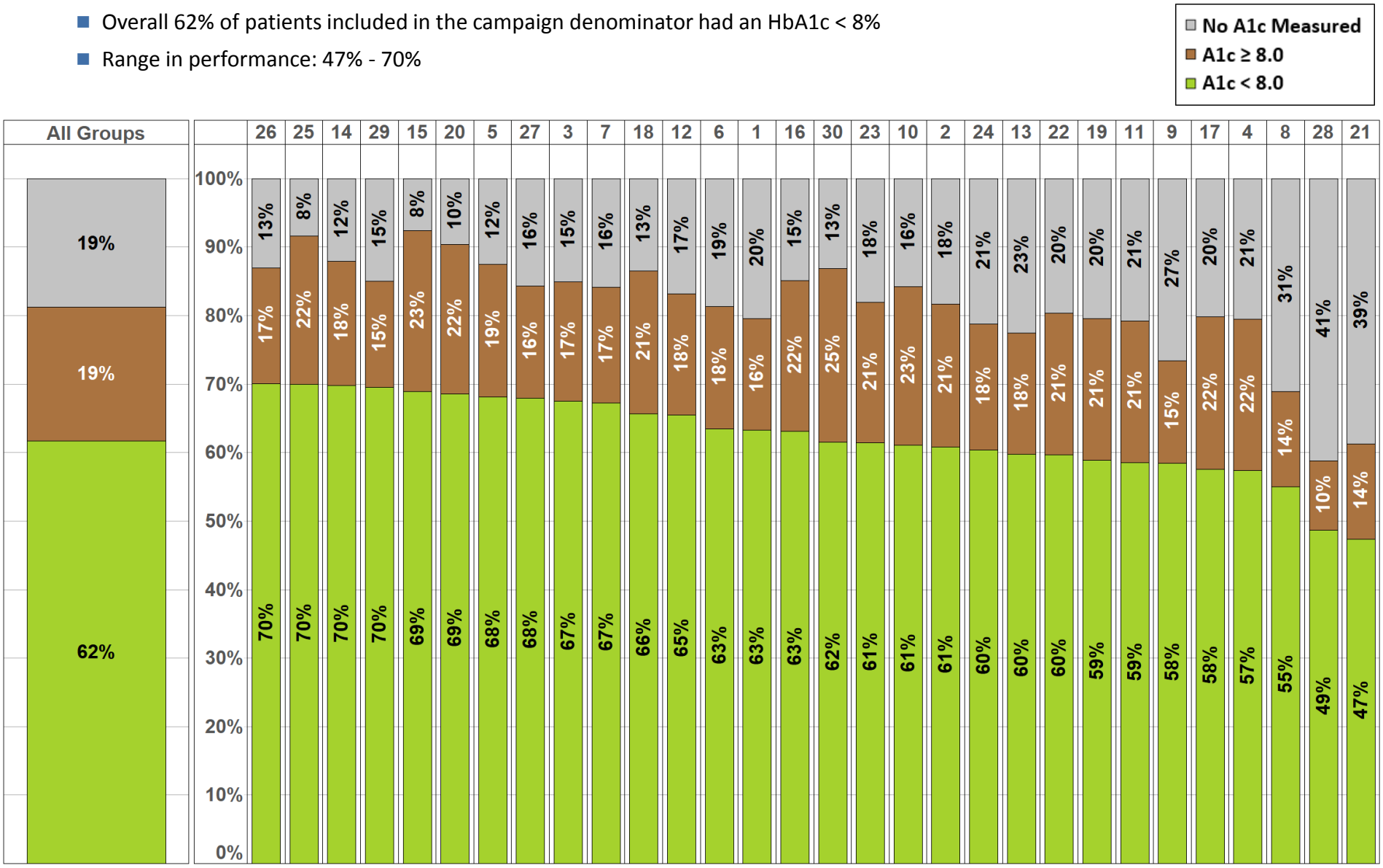
- Number of denominator patients whose most recent HbA_{1C} in the 12-month measurement period (MP) is < 8.0%
  - this is a population threshold—the target for each patient should be individualized
- Use last HbA_{1C} result in the measurement period, regardless of setting (ambulatory, urgent care, ER, inpatient, etc.)
- Patients with no HbA_{1C} measurement during the measurement period are considered to be out of control

Measure #1- HbA_{1C} Control

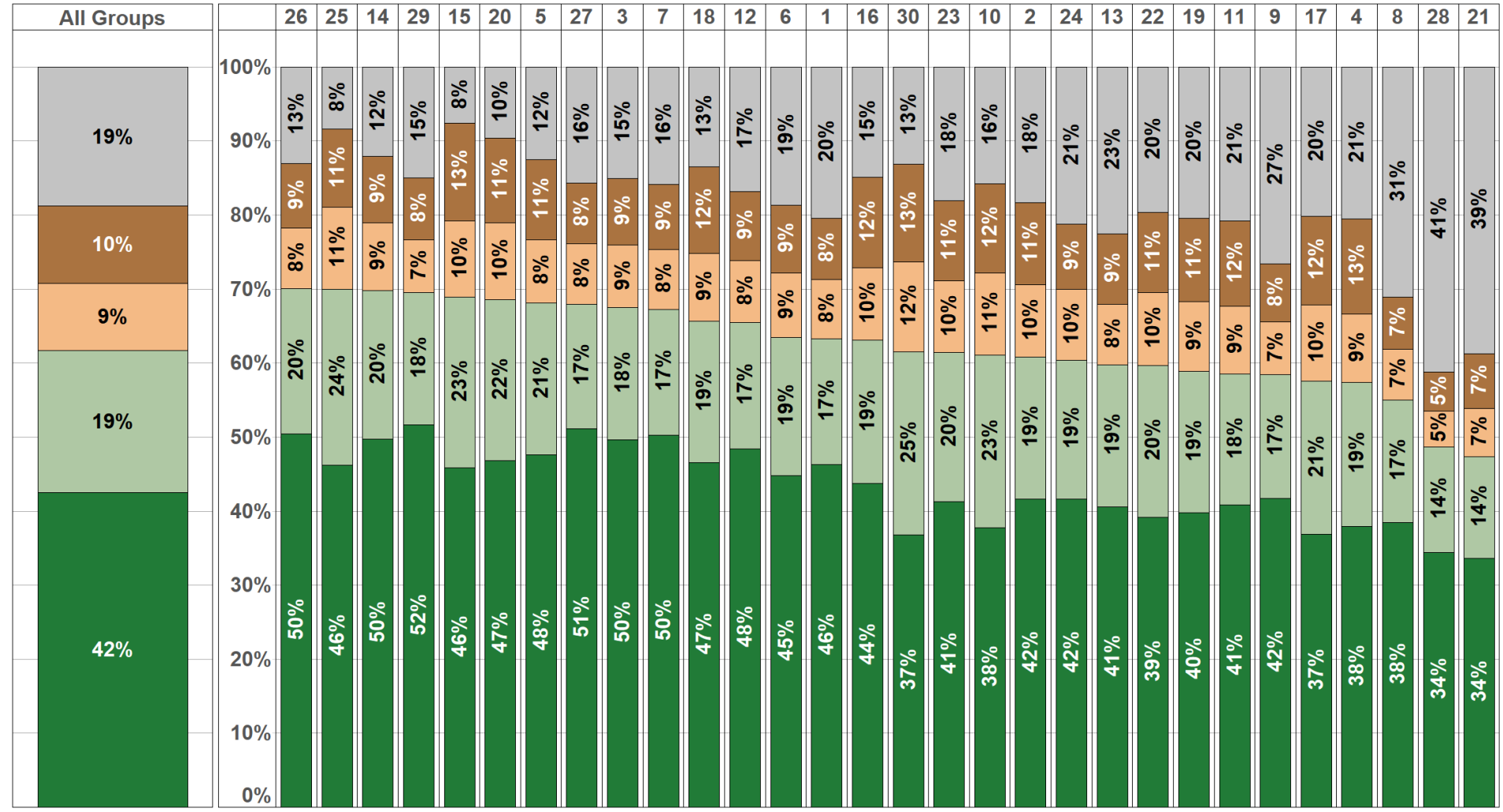


HbA_{1c} CONTROL

- 700,000 patients, aged 18–75, across 30 medical groups, included in campaign denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 62% of patients included in the campaign denominator had an HbA1c < 8%
- Range in performance: 47% - 70%



HBA_{1C} < 7.0 VS. 8.0 VS. 9.0

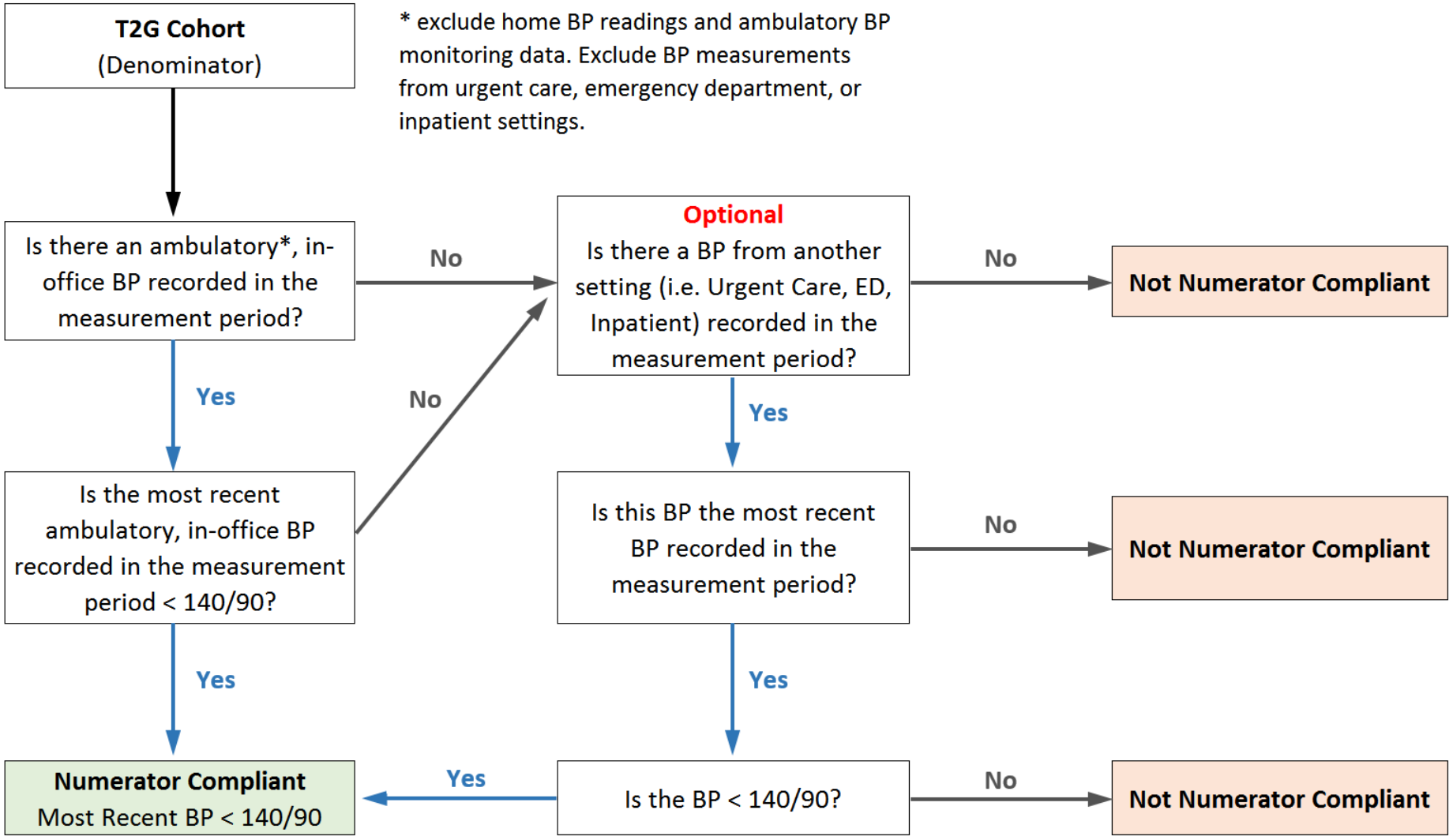


- 700,000 patients, aged 18–75, across 30 medical groups, included in denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 19% of patients included in the campaign denominator had an HbA1c ≥ 7.0% and < 8.0%
  - 9% of patients had an HbA1c ≥ 8.0% and < 9.0%, and 10% had an HbA1c ≥ 9.0%

MEASURE #2 – BP CONTROL

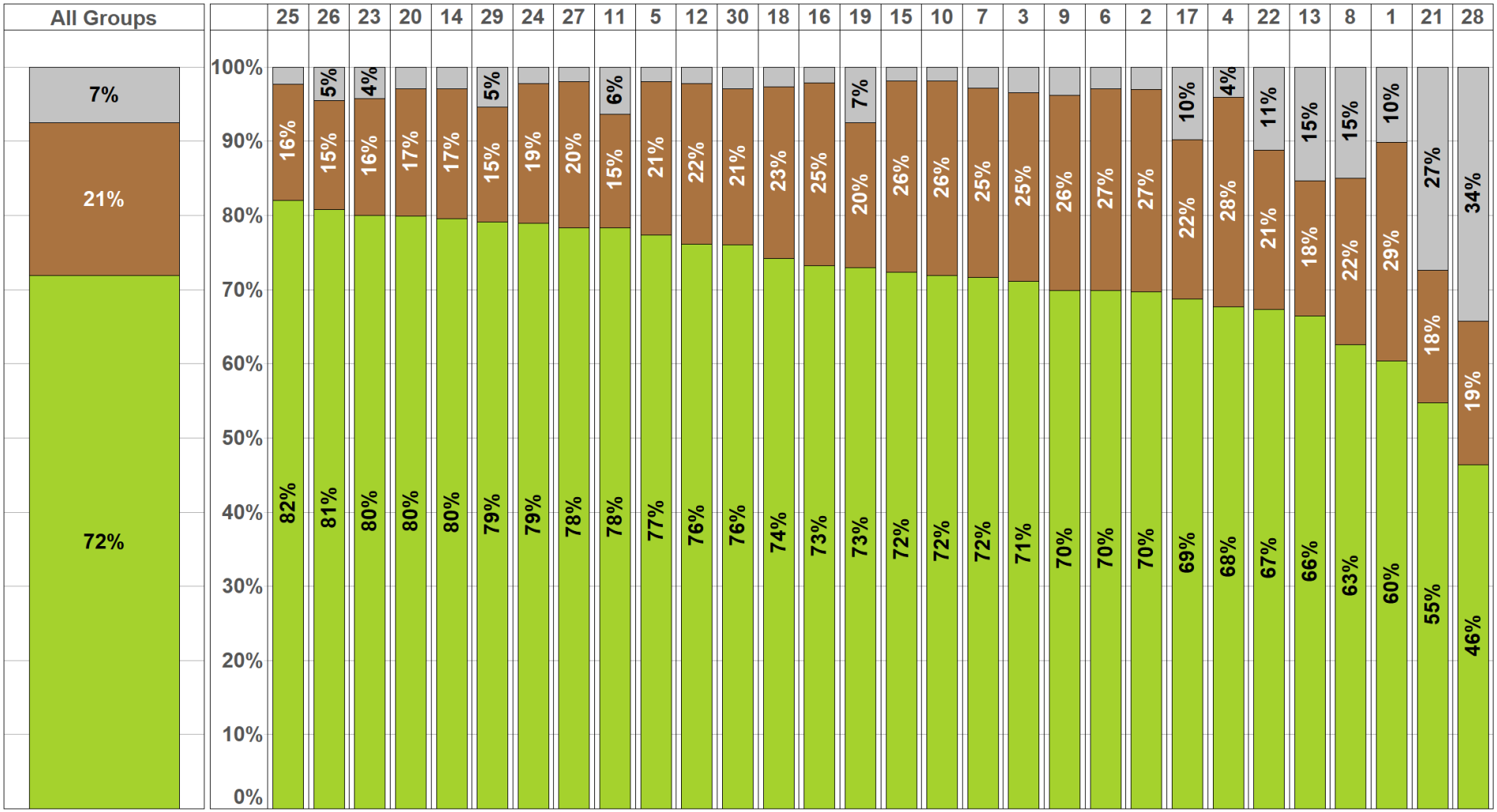
- Number of denominator patients whose most recent ambulatory, in-office blood pressure reading in the 12-month measurement period (MP) is < 140/90 mm Hg
  - A BP measurement from an urgent care, ED, or inpatient setting may optionally be considered, but only if it is the most recent recorded BP and is < 140/90
  - exclude home BP readings and ambulatory BP monitoring data
  - patients with no blood pressure recorded during the measurement period are considered to be out of control

Measure #2- BP Control



BP CONTROL

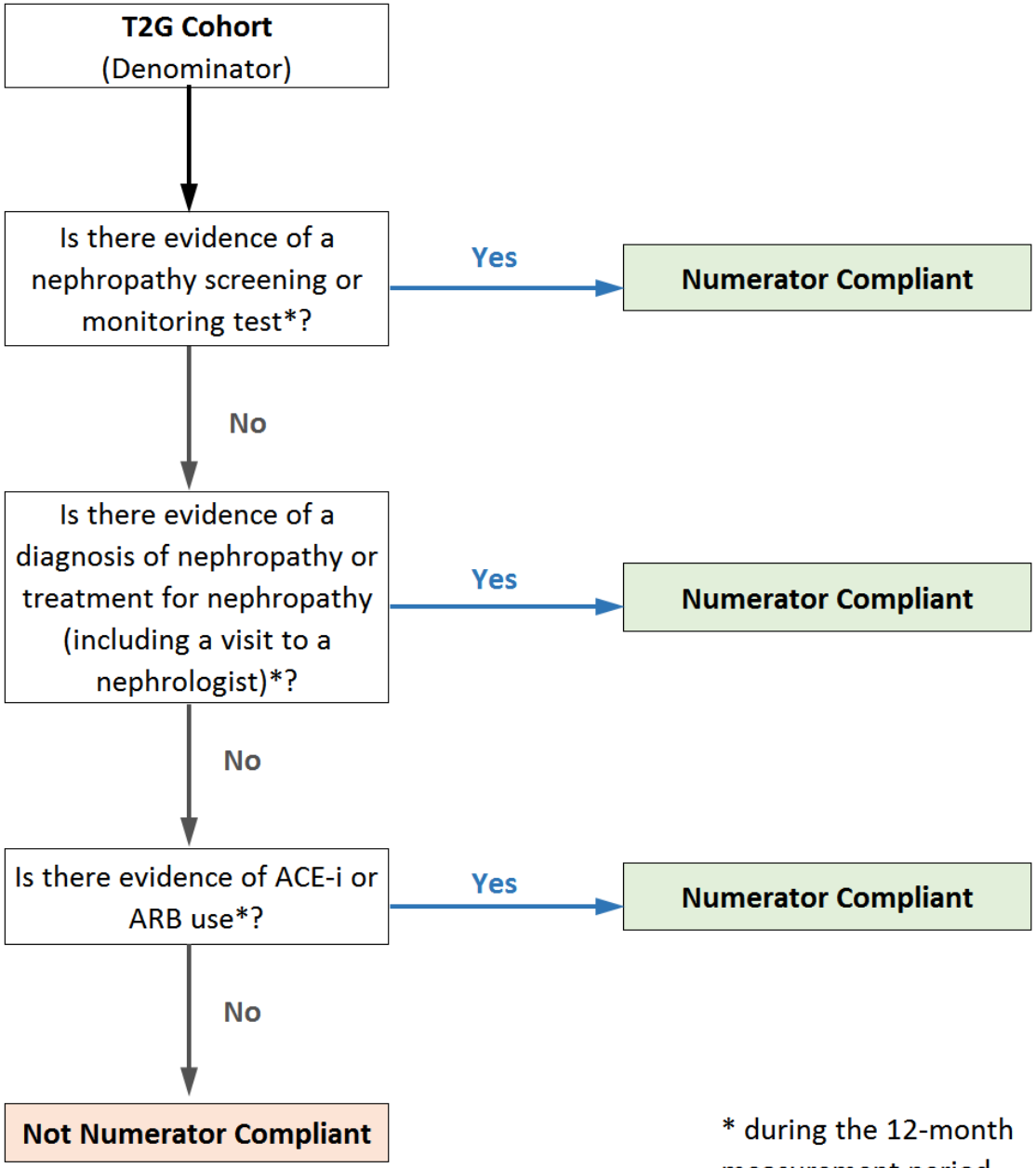
- 700,000 patients, aged 18–75, across 30 medical groups, included in denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 72% of patients included in the campaign denominator had BP< 140/90 mm Hg
- Range in performance: 46% - 82%



MEASURE #3 – MEDICAL ATTENTION FOR NEPHROPATHY

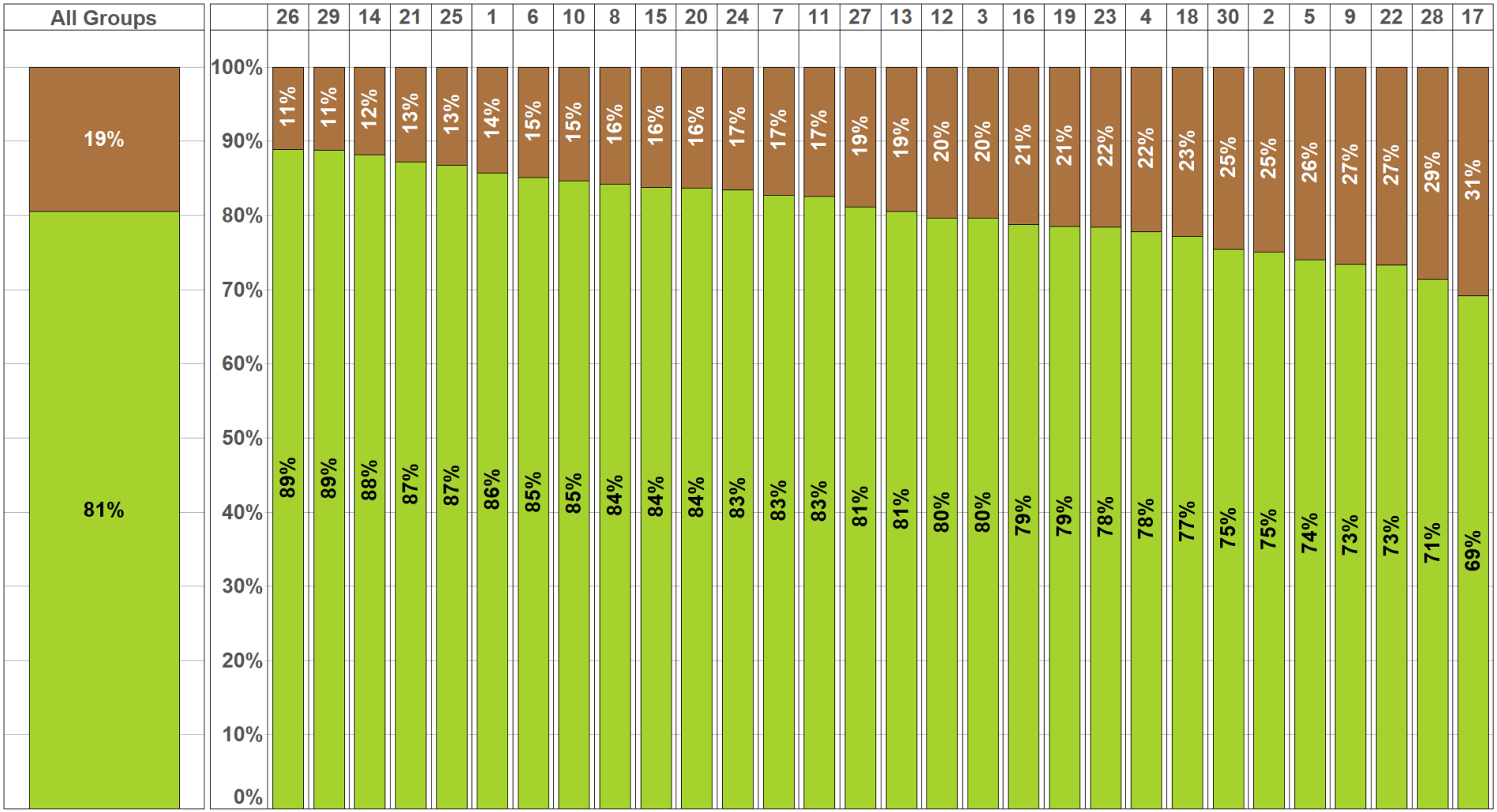
- Number of denominator patients who had evidence of medical attention for nephropathy during the 12-month measurement period
- Evidence for medical attention for nephropathy includes
  - nephropathy screening or monitoring tests (e.g., urine protein tests)
  - diagnosis of nephropathy or treatment for nephropathy
    - diagnosis on a claim or problem list for nephropathy or a related condition (e.g., chronic kidney disease, end stage renal disease)
    - visit with a nephrologist
  - use of an angiotensin-converting-enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB)
    - e-Prescribing transaction or active on the patient's medication list in the EHR

Measure #3- Medical Attention for Nephropathy



MEDICAL ATTENTION FOR NEPHROPATHY

- 700,000 patients, aged 18–75, across 30 medical groups, included in denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 81% of patients included in the campaign denominator had medical attention for nephropathy
- Range in performance: 69% - 89%



MEASURE #4 – LIPID MANAGEMENT

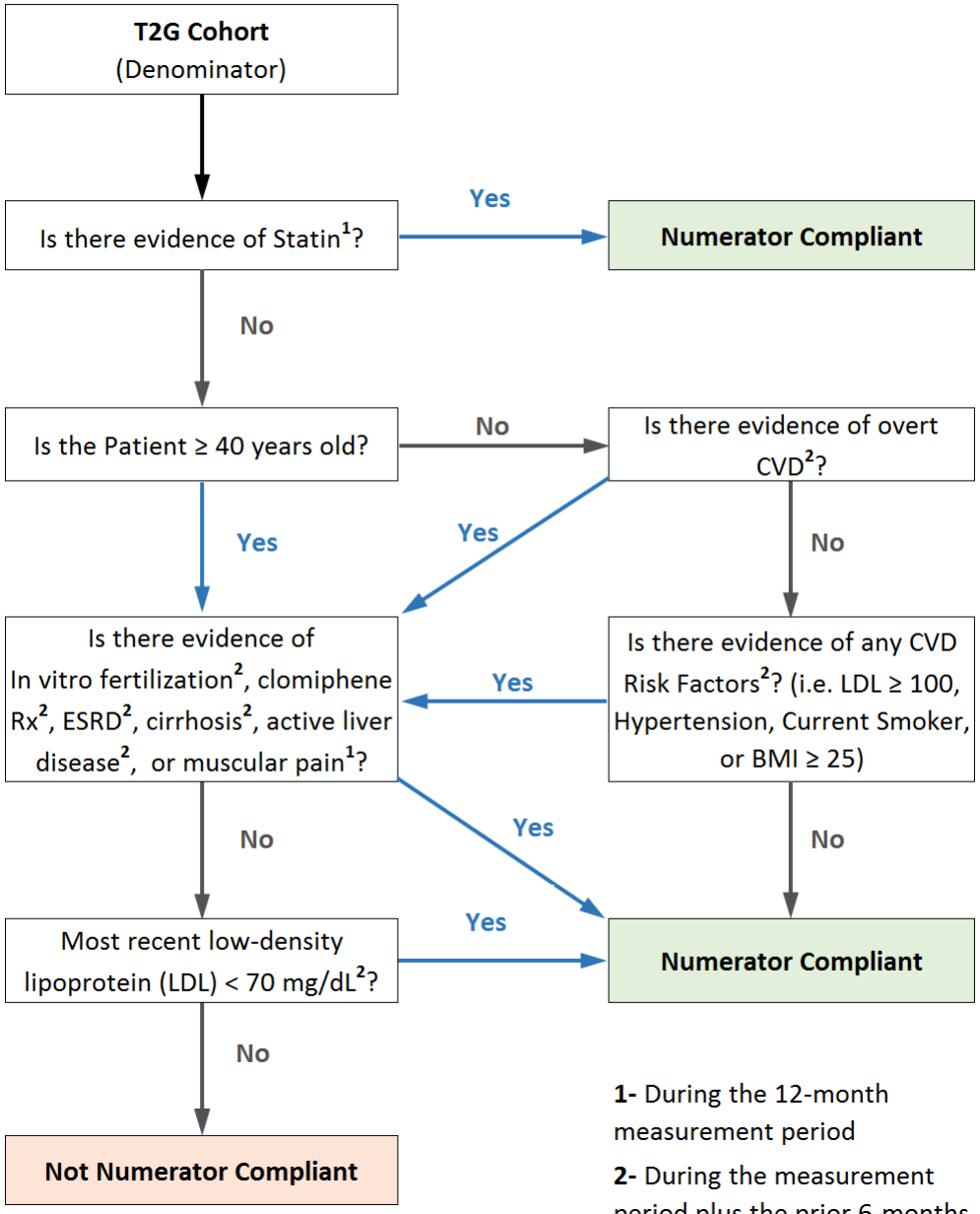
- Number of denominator patients who had a statin prescribed or had documentation of a reason not to receive a statin
- Statin use can be identified on e-Prescribing transaction during the 12-month measurement period or on the patients medication list
  - we accept evidence of any statin use and do not require organizations to assess the dose (different from ACC/AHA guidelines)

Prescription	
• Atorvastatin	• Atorvastatin-amlodipine
• Fluvastatin	• Atorvastatin-ezetimibe
• Fluvastatin XL	• Lovastatin-niacin
• Lovastatin	• Pravastatin-aspirin
• Pitavastatin	• Simvastatin-ezetimibe
• Pravastatin	• Simvastatin-niacin
• Rosuvastatin	• Simvastatin-sitagliptin
• Simvastatin	

MEASURE #4 – LIPID MANAGEMENT

- Documented reasons for not receiving a statin include
  - In vitro fertilization, prescription for clomiphene (Clomid), cirrhosis, or ESRD
  - Muscular pain (i.e. myalgia, myositis, myopathy, or rhabdomyolysis)
  - Most recent low-density lipoprotein (LDL) < 70 (optional)
  - active liver disease (e.g. hepatitis) (optional)
  - Age < 40 and no overt cardiovascular disease (CVD) or CVD risk factors (i.e., LDL > 100, hypertension, current smoker, obese) (optional)
- Patients with a documented reason not to receive a statin are considered numerator compliant
  - while it would be logical to exclude them from the denominator for the statin measure, we want to maintain the same denominator as the other three measure for the bundle measure

Measure #4- Lipid Management

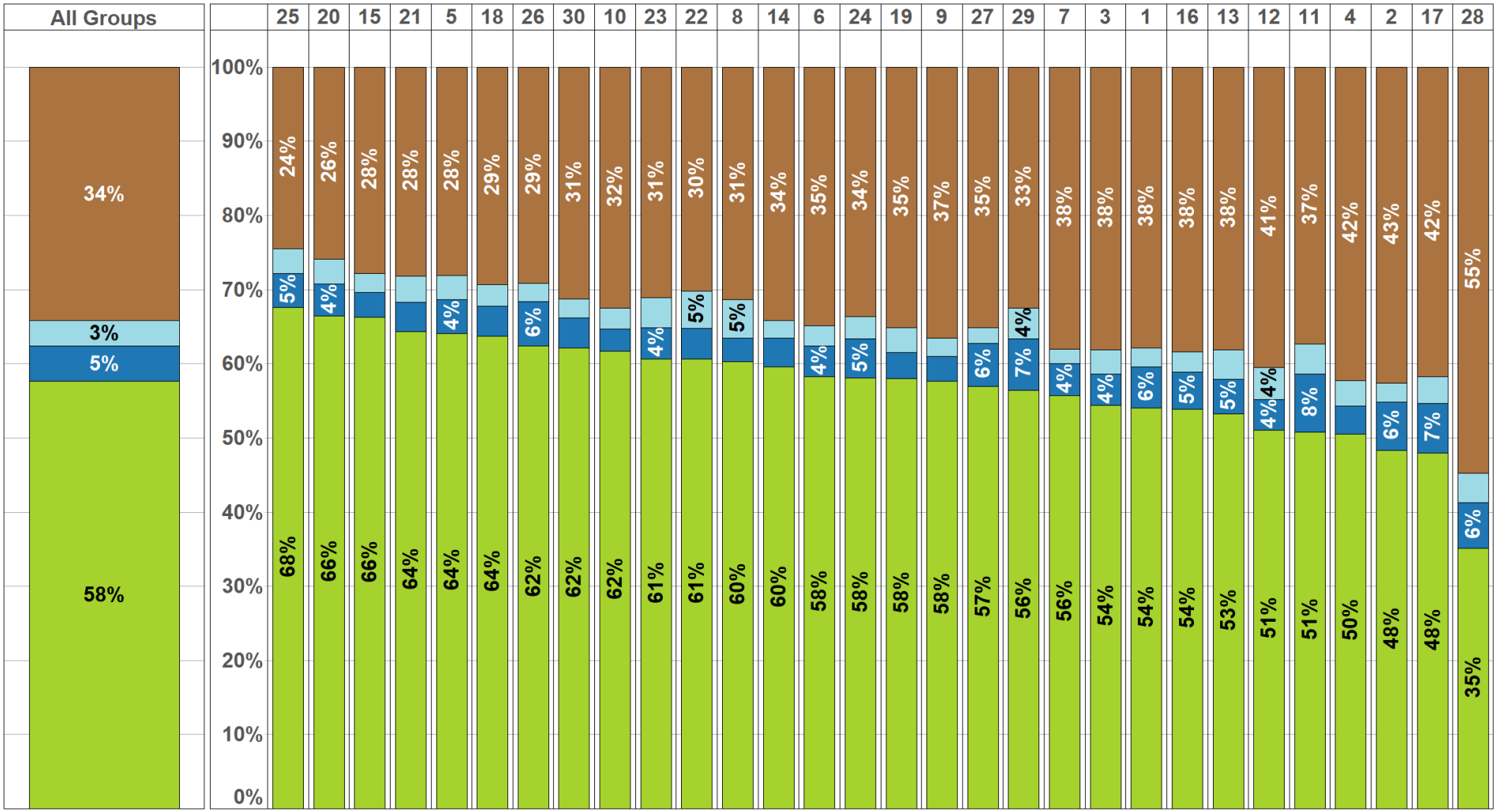


1- During the 12-month measurement period

2- During the measurement period plus the prior 6-months

LIPID MANAGEMENT

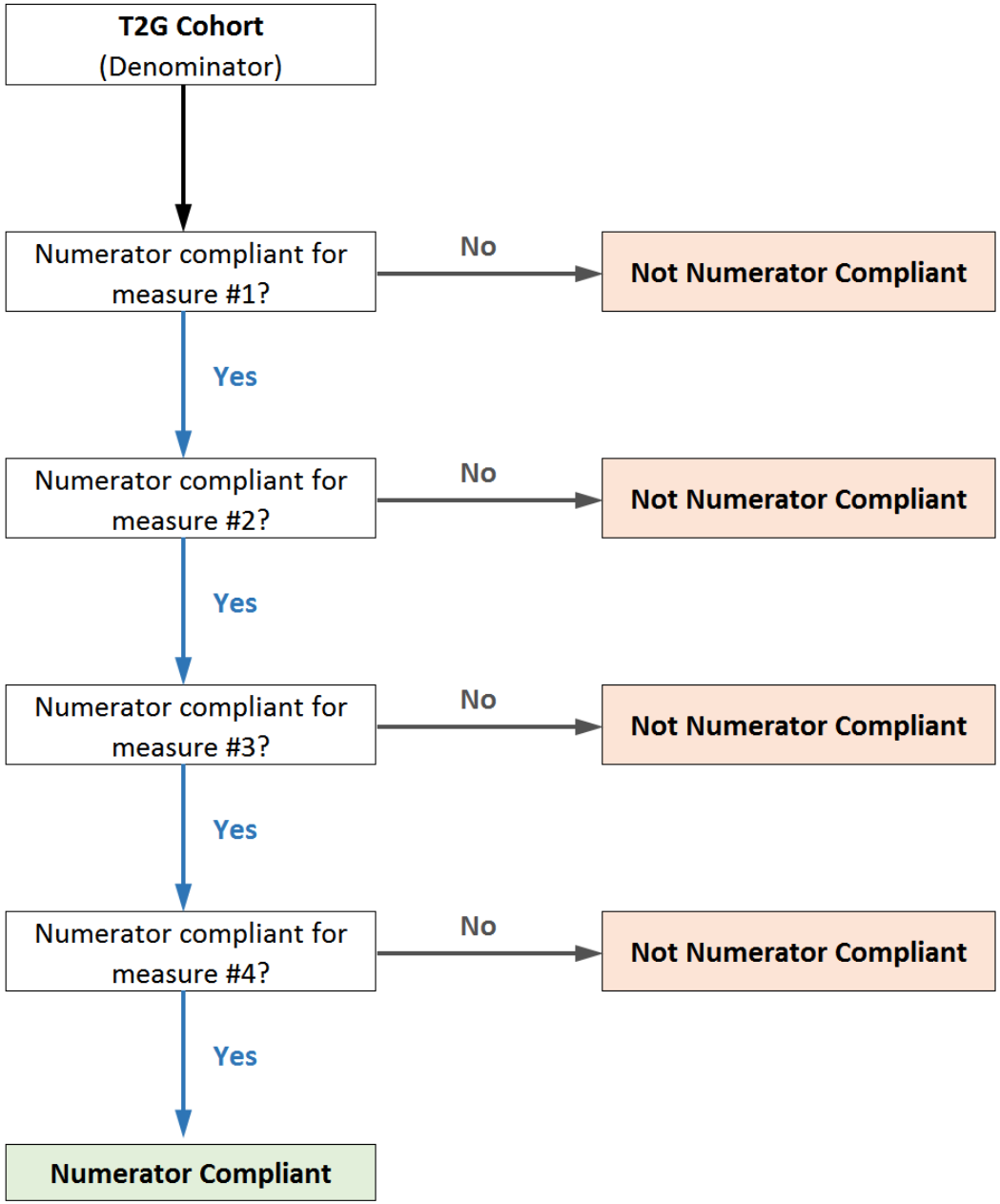
- 700,000 patients, aged 18–75, across 30 medical groups, included in denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 58% of patients included in the campaign denominator had evidence of statin use, 5% had no evidence of statin use but had an LDL < 70, 3% had no evidence of statin use but had a documented reason for not receiving a statin
- Range in performance for Lipid Management: 45% - 76%



MEASURE #5 – BUNDLE

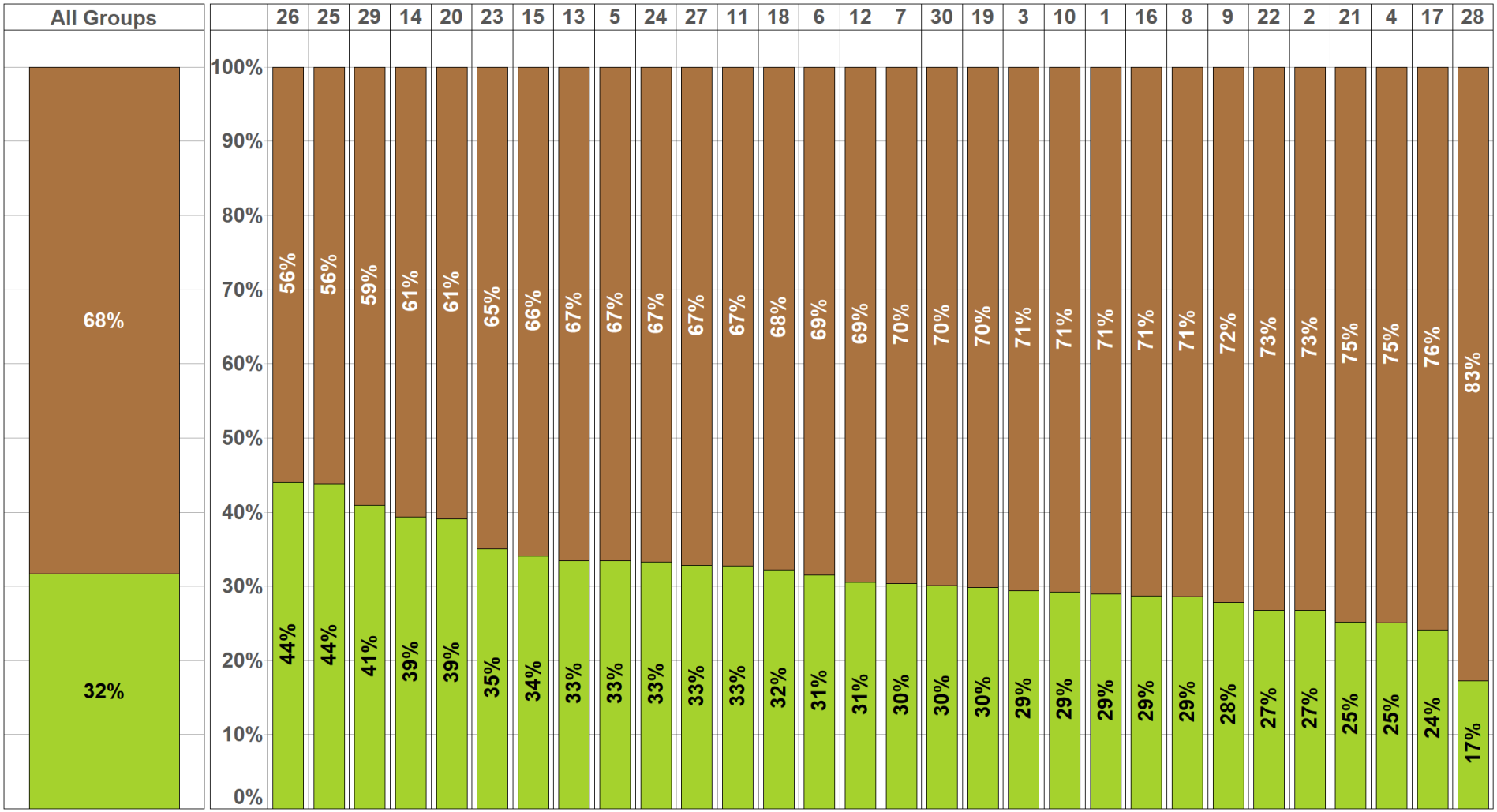
- Number of patients who were numerator-compliant for all four measures.
  - Most recent HbA_{1C} < 8% (measure #1)
  - Most recent BP < 140/90 (measure #2)
  - Received medical attention for nephropathy (measure #3)
  - Statin prescribed or documented reason not to prescribe a statin (measure #4)
- All-or-none, or "bundle," measure best reflects the patient's perspective, and it encourages organizations to think of each patient as a whole and to take a system-oriented approach to improvement.

Measure #5- Bundled Measure



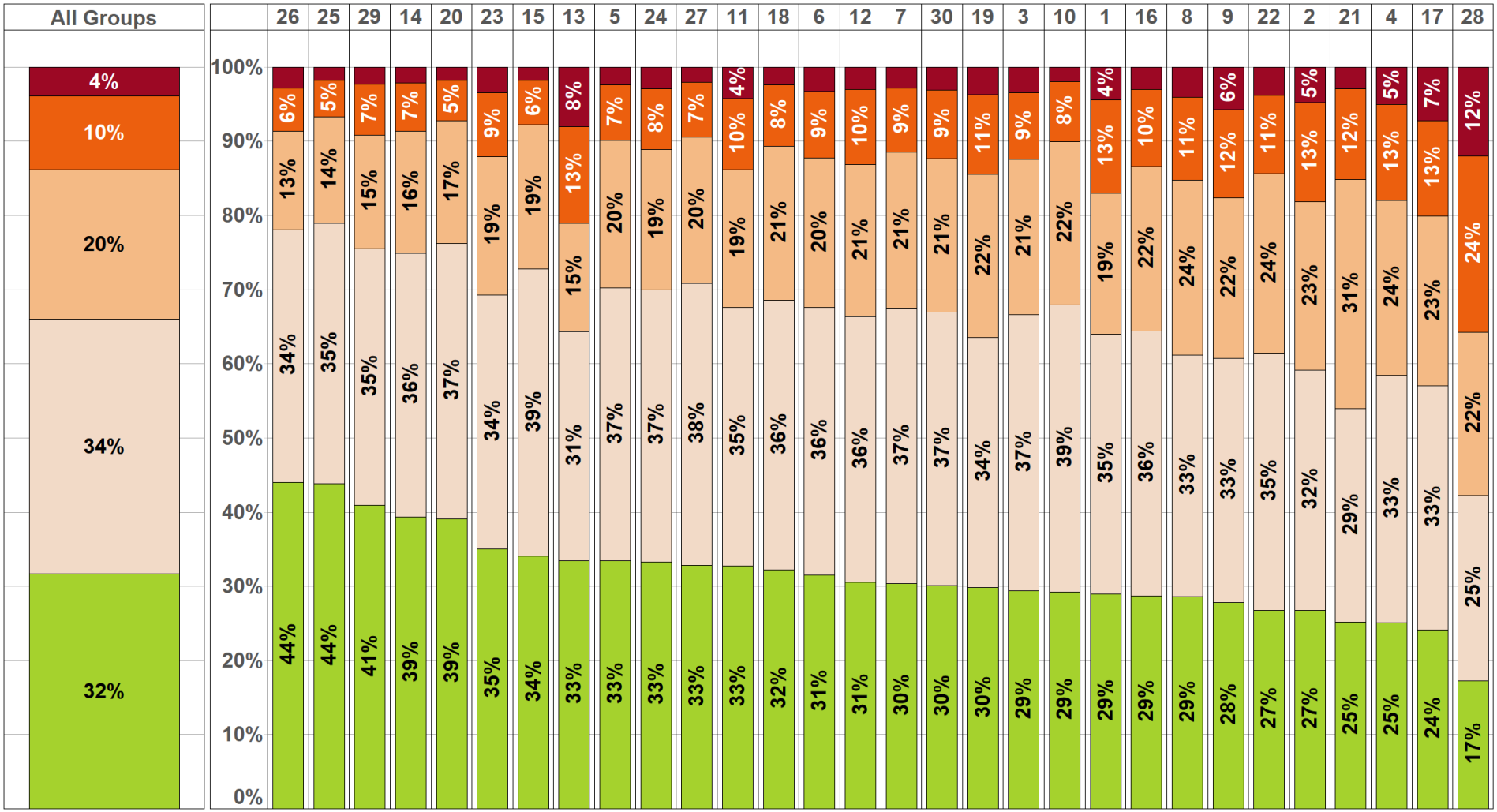
BUNDLE MEASURE

- 700,000 patients, aged 18–75, across 30 medical groups, included in denominator (i.e., 2 visits, no exclusions, T2DM)
- Overall 32% were numerator compliant for the bundle measure
- Range in performance in statin use: 17% - 44%



BUNDLE MEASURE (2)

- Overall 34% of patients are not compliant in only 1 of the 4 measures, 20% are not compliant in 2, 10% in 3, and 4% are not compliant for all 4 measures
- All patients who improved in one or more of the measures would count once towards the campaign goal of 1 million patients with improved care. Only the patients in green do not have an opportunity for improvement.



DATA SUBMISSION OPTIONS

1. Edit and email Excel template to DataForT2G@amga.org
2. Use the campaign's data collection portal https://Data.Together2Goal.org to enter or upload the data directly into a reporting interface

- Both methods require the participating organization and user(s) submitting data to be properly registered in the campaign database
  - AMGF campaign staff (your regional liaisons) will facilitate the registration process
- Data submission can be accomplished using email or the web portal interchangeably throughout the duration of the campaign

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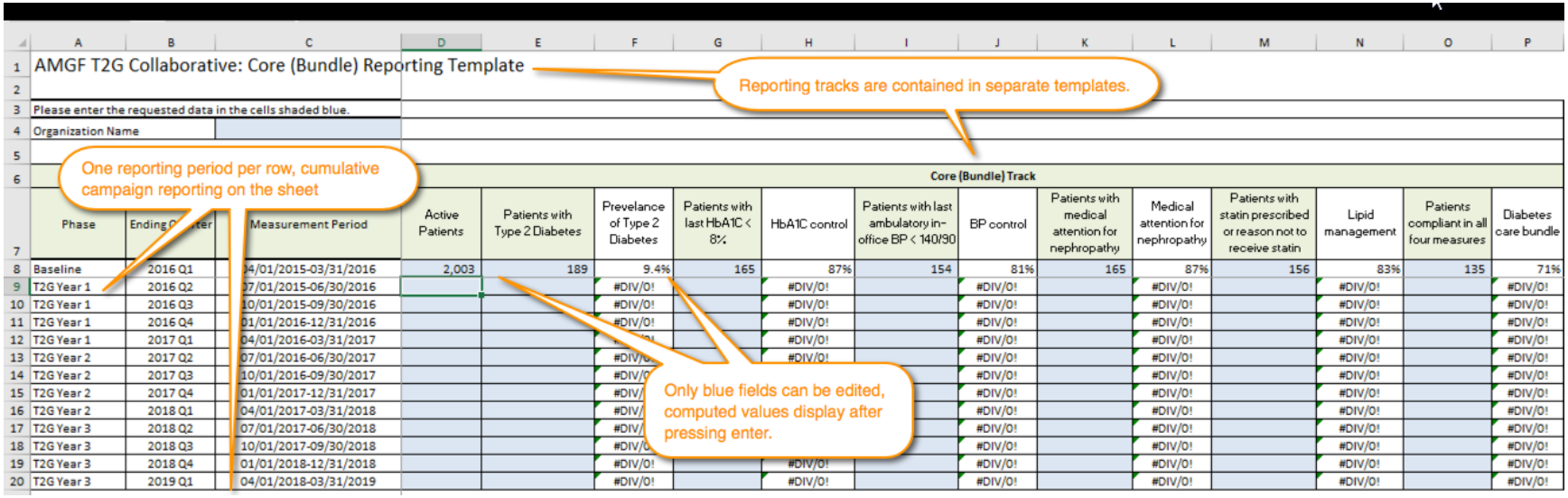
DATA SUBMISSION USING EMAIL

- Data for the measures can be entered into a excel template and attached to an email sent to DataForT2G@amga.org
  - Templates appropriate to participants level of participation (Basic, Core, Innovator) will be provided to the organization or can be downloaded from the campaign portal. Participating groups will only have access to the template for their selected data reporting track.
  - Templates are cumulative, spanning all reporting periods of the campaign timeline; to amend a submission simply edit the prior reporting period data and submit normally, the system will retain the last submission
- Email submissions must come directly from users registered with the campaign to be properly loaded into the campaign database. Please do not email data submissions to campaign staff.
- User will receive an acknowledgement confirming a successful submission or in the case of issues, a error or warning indicator
- Users can login to the portal to view/edit emailed submissions

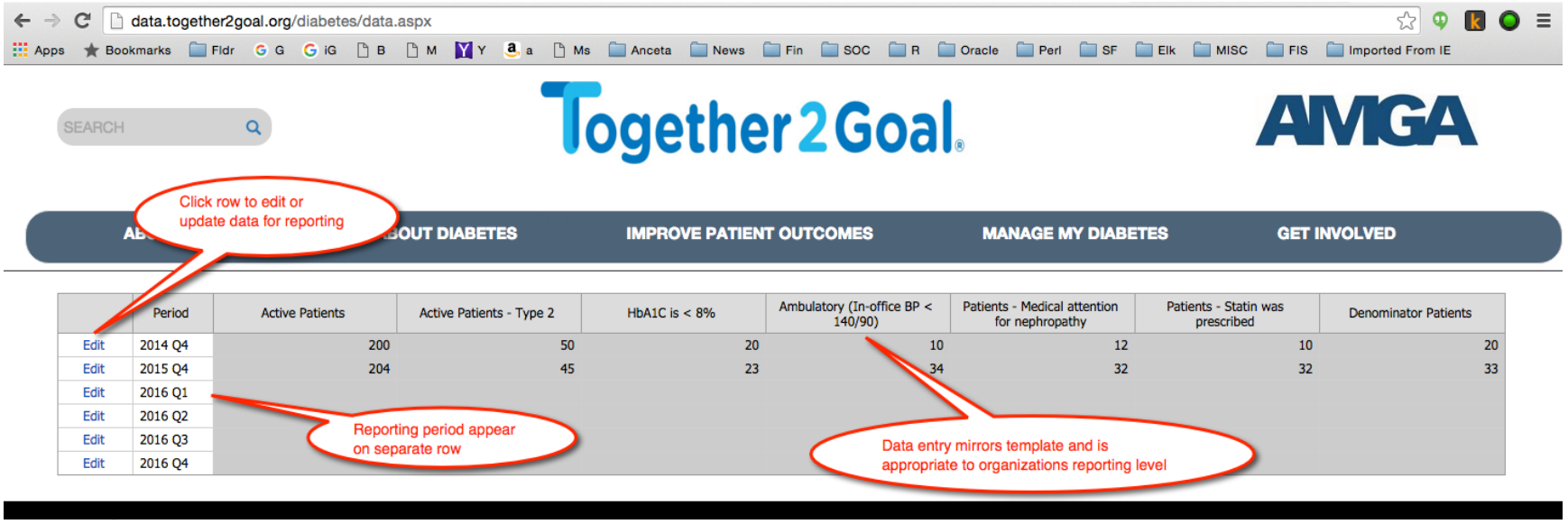
USING THE TEMPLATE

- Use the template appropriate to your organizations reporting level (Basic, Core, Innovator)
- Template is locked permitting edits to blue fields only, all other fields are computed
- Template provide for cumulative data submission, no need to delete prior reporting periods, submit revisions by editing prior periods and resubmitting via email, or directly edit on the portal



DATA SUBMISSION USING DATA PORTAL

- Use AMGA's data collection portal https:\\Data.Together2Goal.org and enter the data directly into a reporting interface.
  - AMGF campaign staff will email you with credentials to access the site
  - View/revise data previously emailed for the campaign
  - Enter/upload data directly on the portal.



	Period	Active Patients	Active Patients - Type 2	HbA1C is < 8%	Ambulatory (In-office BP < 140/90)	Patients - Medical attention for nephropathy	Patients - Statin was prescribed	Denominator Patients
Edit	2014 Q4	200	50	20	10	12	10	20
Edit	2015 Q4	204	45	23	34	32	32	33
Edit	2016 Q1							
Edit	2016 Q2							
Edit	2016 Q3							
Edit	2016 Q4							