Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

June 16, 2016

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - Goal Post June Newsletter
  - Bonus Webinar
  - Data Submission & Survey Responses
- Build an Accountable Diabetes Team
  - Beth Averbeck, MD (HealthPartners Medical Group)
- Q&A
  - Use Q&A or chat feature

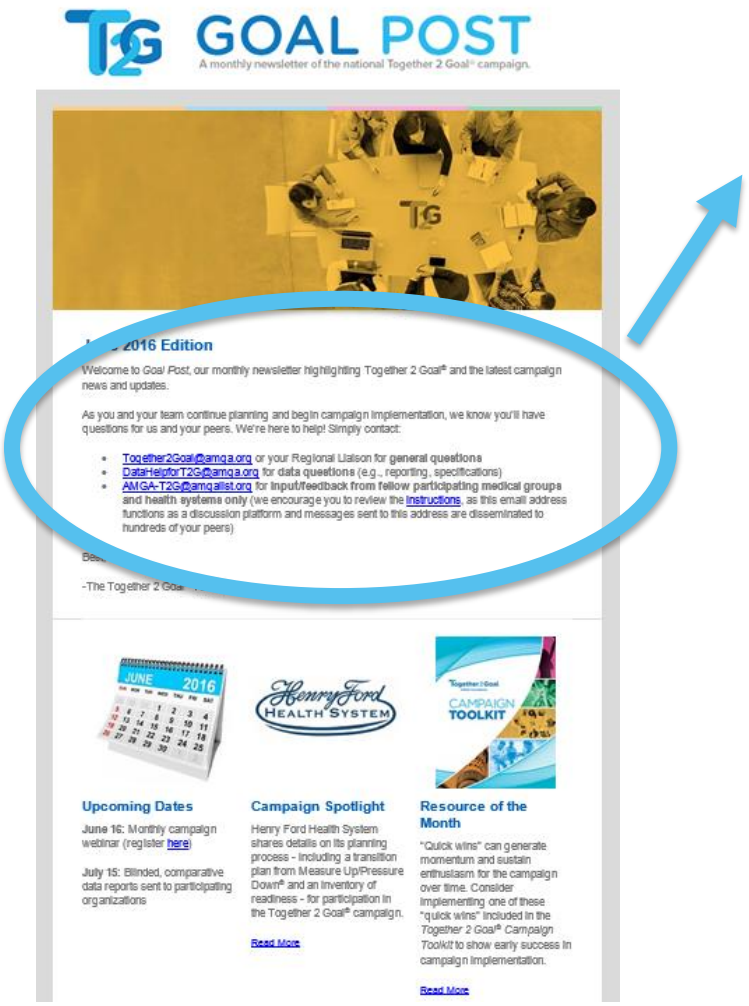
Together 2 Goal®

WEBINAR REMINDERS

- Webinar will be recorded today and available the week of June 20th
  - 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®

GOAL POST JUNE NEWSLETTER HIGHLIGHTS


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

2016 Edition

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

As you and your team continue planning and begin campaign implementation, we know you'll have questions for us and your peers. We're here to help! Simply contact:

- Together2Goal@amga.org or your Regional Liaison for **general questions**
- DataHelpforT2G@amga.org for **data questions** (e.g., reporting, specifications)
- AMGA-T2G@amgalist.org for **input/feedback from fellow participating medical groups and health systems only** (we encourage you to review the instructions, as this email address functions as a discussion platform and messages sent to this address are disseminated to hundreds of your peers)

-The Together 2 Goal

JUNE 2016

Henry Ford Health System

CAMPAIGN TOOLKIT

Upcoming Dates

June 16: Monthly campaign webinar (register here)

July 15: Blinded, comparative data reports sent to participating organizations

Campaign Spotlight

Henry Ford Health System shares details on its planning process - including a transition plan from Measure Up/Pressure Down® and an inventory of readiness - for participation in the Together 2 Goal® campaign.

Read More

Resource of the Month

"Quick wins" can generate momentum and sustain enthusiasm for the campaign over time. Consider implementing one of these "quick wins" included in the *Together 2 Goal® Campaign Toolkit* to show early success in campaign implementation.

Read More

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Together 2 Goal®

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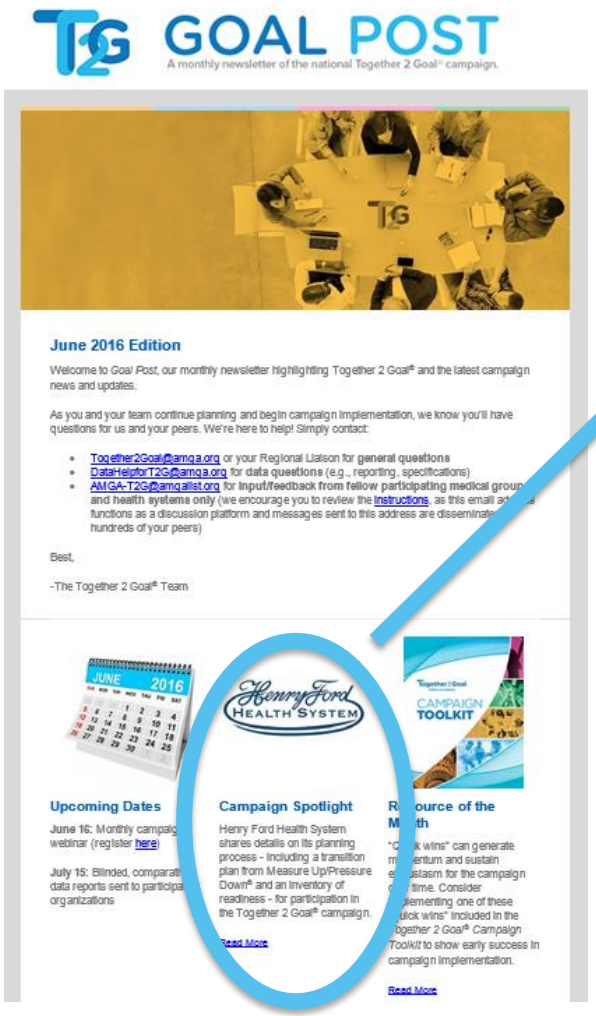

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Best,

-The Together 2 Goal® Team

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Henry Ford Health System

Together2Goal®

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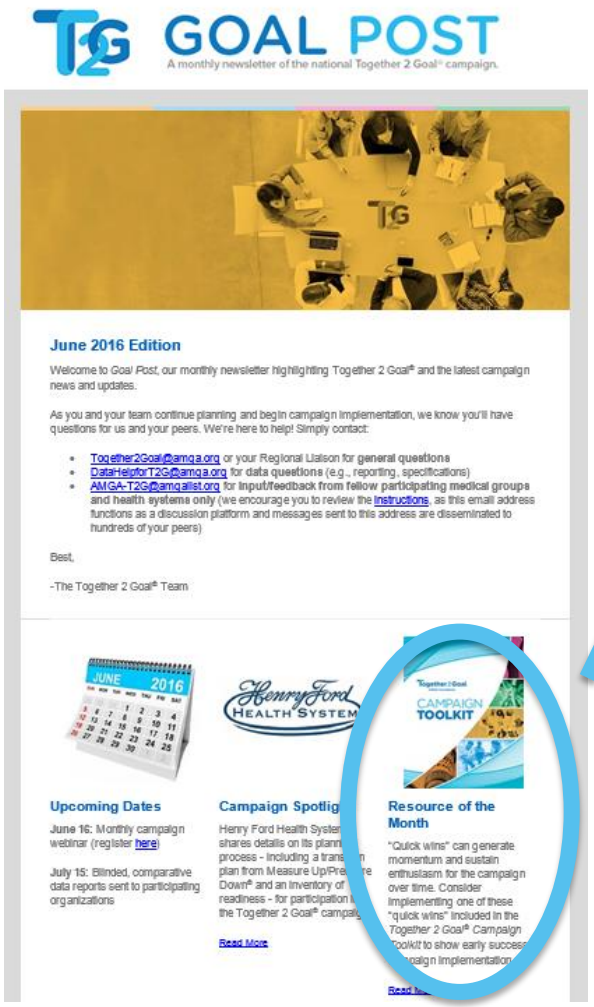

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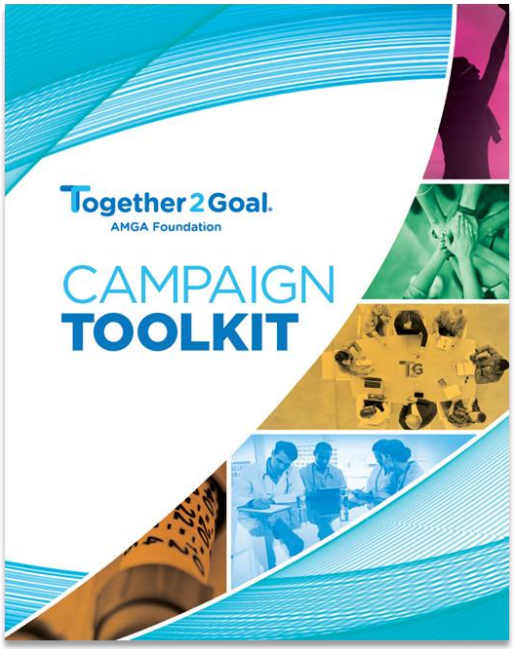

Together2Goal®

GOAL POST NEWSLETTER

- If you did not receive the Goal Post newsletter and would like to:
  - Check your spam folder
  - Email your Regional Liaison or Together2Goal@amga.org
- If you have ideas for future Campaign Spotlights or Resources of the Month, email Together2Goal@amga.org
  - Can include self-nominations

BONUS WEBINAR: AUGUST 4 AT 2 P.M. EASTERN

- **Topic:** Care4Today™
- **When:** Thursday, August 4 from 2-3 p.m. Eastern
- **Who:** Principal Corporate Collaborator Johnson and Johnson Family of Diabetes Companies and AMGA member Sharp Community Medical Group

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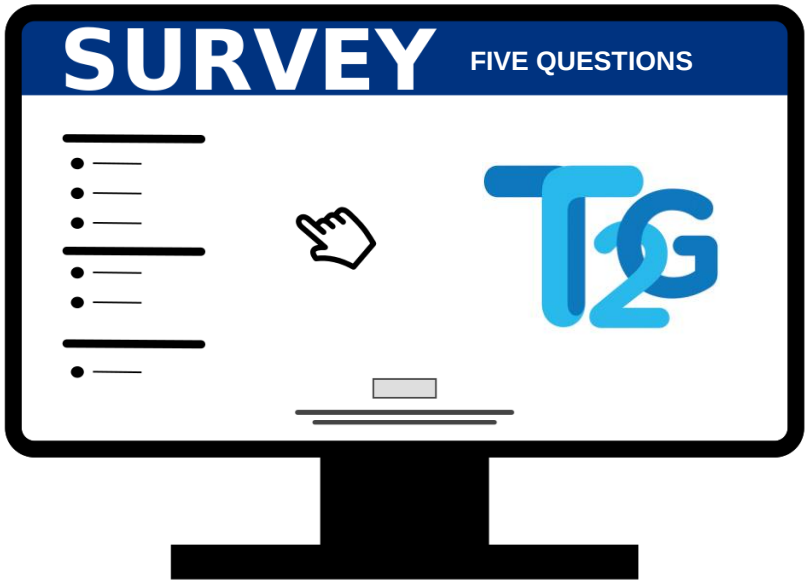
THANK YOU!

Next steps:

- **July 15** – Blinded, comparative data reports sent to participating organizations
- **July 21** – Review baseline data on monthly campaign webinar
- **August 18** – Review survey results on monthly campaign webinar

REPORTING TIMELINE:

	Measurement Periods (Defined by Quarters)	Measurement Periods (Defined by Months and Days)	Reporting Deadline
T2G Baseline:	2016 Q1 (2015 Q2 - 2016 Q1)	2016 Q1 (2015 Apr 1 - 2016 Mar 31)	June 1, 2016



Together2Goal®

TODAY'S SPEAKER: DR. BETH AVERBECK

- Senior Medical Director, Primary Care for HealthPartners Medical Group
- Practicing internist with over 15 years of leadership experience in clinic and hospital operations and in quality improvement

Together2Goal®

HealthPartners®

Team-Based Approach to Diabetes Care

Beth Averbeck, MD – Senior Medical Director, Primary Care

6/16/2016

Overview

- Care team roles and responsibilities
  - For all patients
  - Specific to patients with diabetes
- Role of specialist
- Optimal Diabetes
  - Definition
  - Measure
- Results
  - Accountability/improvement
- Customization example
  - Disparities work

HealthPartners®

- Consumer-governed, non-profit
- Integrated health and financing
  - Clinics and hospitals
  - Health plan
- Twin Cities & surrounding communities (MN & Western WI)

Patient with diabetes vs. "diabetic"

John Smith, Patient History

- Hyperlipidemia
- DM Type2
- Pain Low Back
- Obstructive Sleep Apnea Hypopnea
- Schizophrenia NOS
- Depression Major NOS
- Hemorrhoids Internal NOS
- Gastroesophageal Reflux Disease
- Obesity Morbid
- Other
- Atypical chest pain

Medication List

45 total medications:

- 4 hypertension
- 2 lipid
- Aspirin
- 2 glycemic
- 5 mental health
- 7 topical

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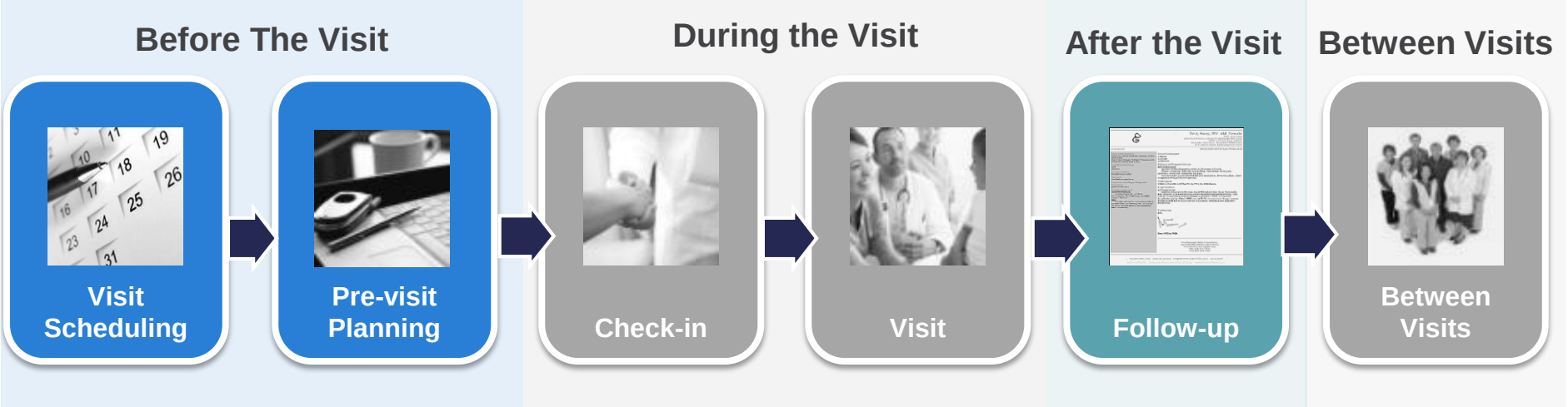
Approach to Diabetes Care

- Teamwork is a key skill
  - Specific roles and responsibilities
  - Delegate and trust
  - Proactively identify patients using a registry
  - Reach out to patients who need to come in for a visit or need support between visits
- Increasing use of technology
  - e.visits/tele-health
- Engage patients in healthy lifestyle choices (‘health coaching’)
- Standing orders for pharmacists and diabetes nurse specialists

Care Model Process

Standardize to science, customize to patient

Includes diabetes care



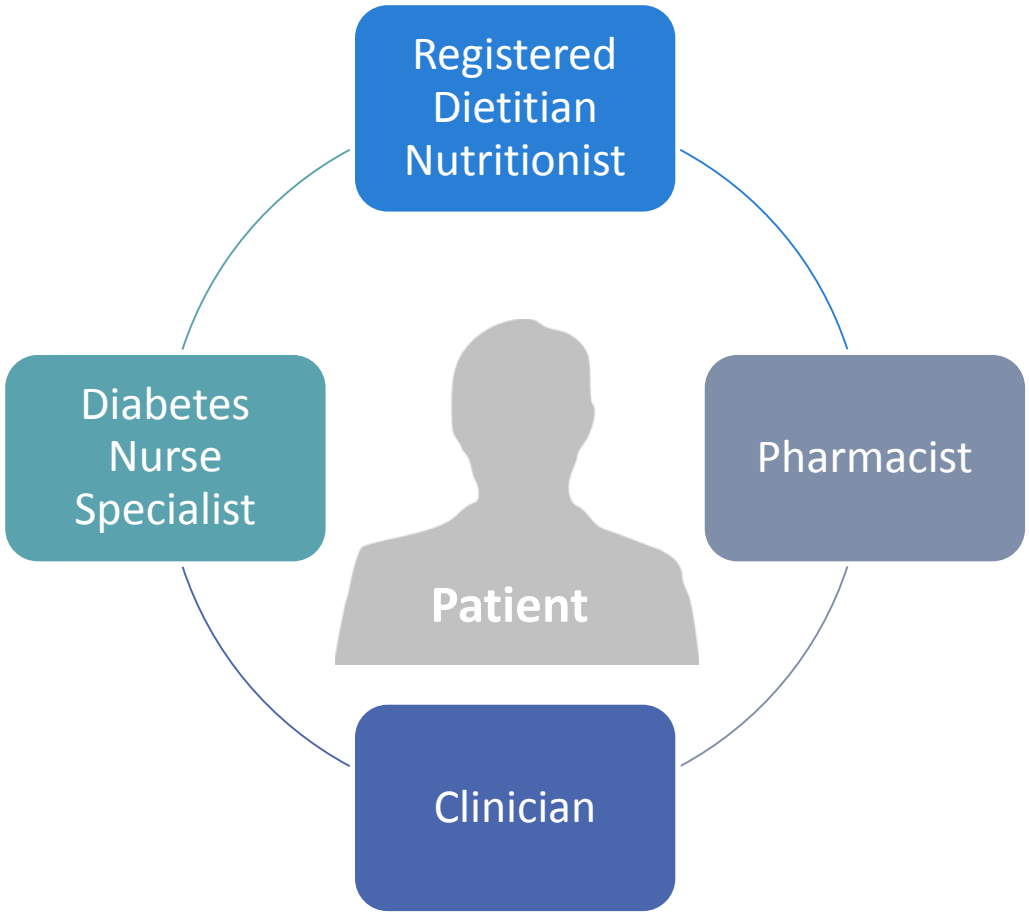
Reception
- Insurance verification
- Check-in
- Scheduling
- Message triage
- Forms

CMA/RMA/LPN
- Registry
- Message triage
- LPN standing orders
- Test results
- Immunization
- Preventive services
- Collaborative documentation

RN's
- Phone triage
- Protocol driven care
- Medication refill
- Abnormal test triage
- Care Coordination
- Action Plan
- Health coaching

Clinician
- Leader of care team
- Diagnosis and treatment
- Engaging patients in their care
- Directing members of care team
- Care plans

Diabetes "Neighborhood" Care Team



System support: Lab standing orders & EHR decision support

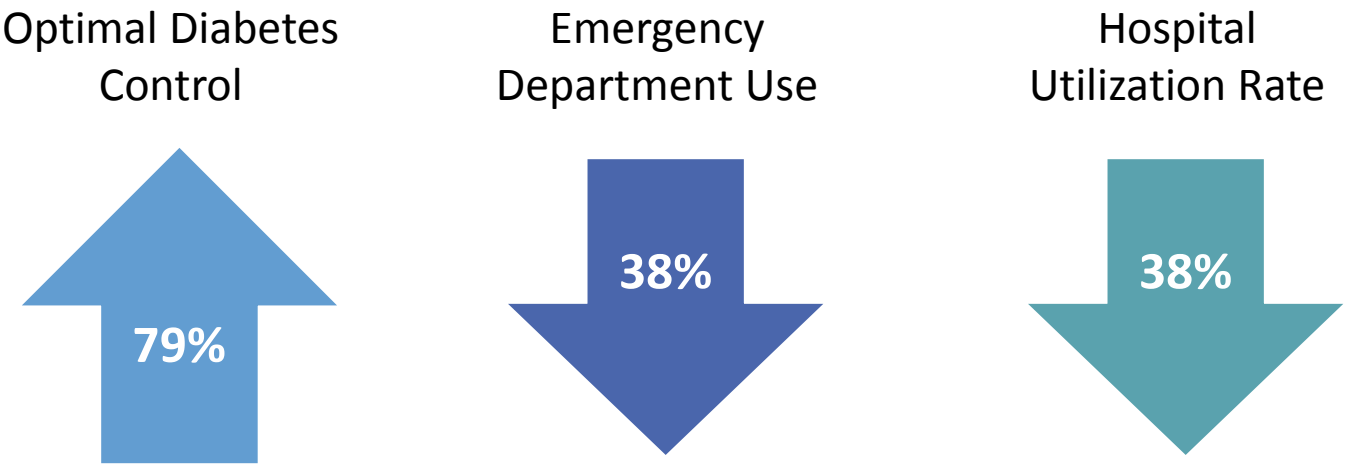
*Diabetes Nurse Specialists and Dietitian Nutritionists can both be **Certified Diabetes Educators**

Medication Therapy Management

Diabetes Pilot

- One employer
- 296 out of 666 invited members
- Participants received waived copays for medications

Results:



Care Team Roles

- **Diabetes Nurse Specialist**
  - Matching meter to coverage
  - Medication adjustment
  - Help with registries
  - Support behavior change
- **Registered Dietitian Nutritionist**
  - Balancing eating and activity with medication and monitoring
  - Support culturally specific diet

Role of Specialist

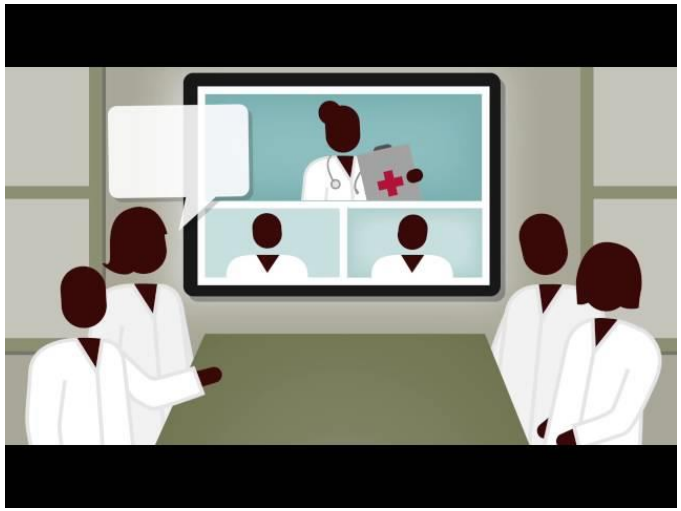
- Referrals
  - Glycemic control
- Primary management of patients with Type I
- Co-management
- Population consultant
- Endocrine Hotline (for clinicians/staff only)
- Content expert

Population Consultant

Moving knowledge and information, not patients

A new approach to diabetes care in Endocrinology:

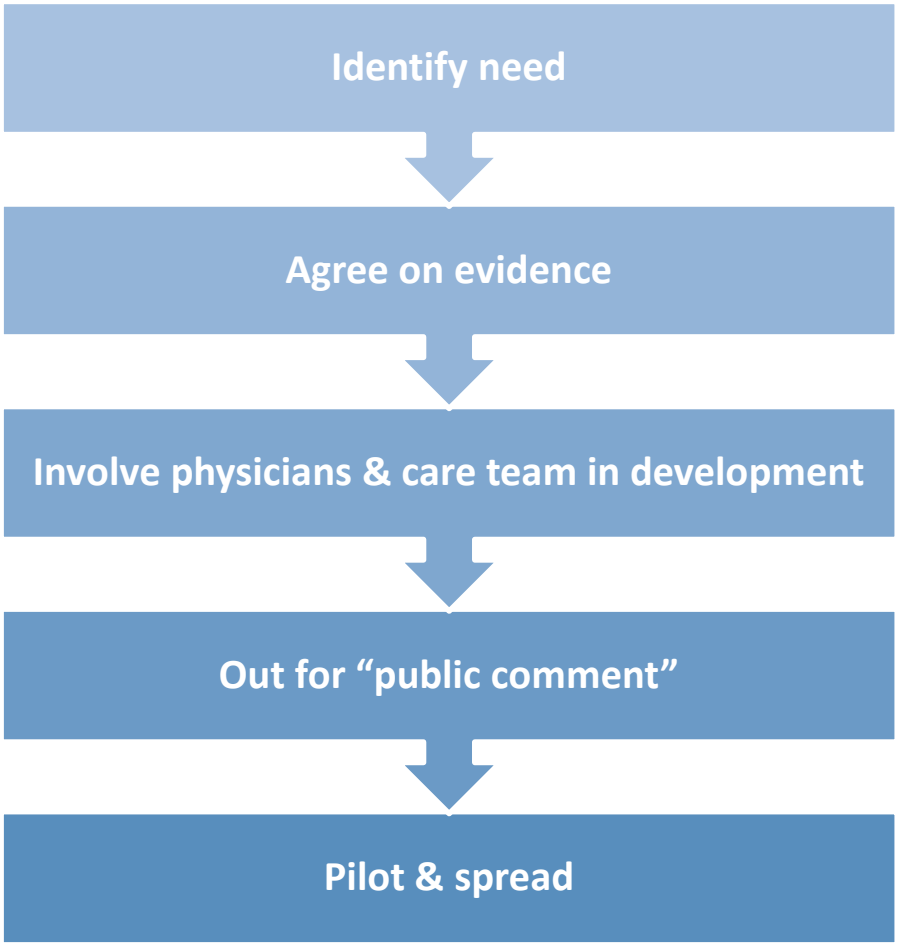
- Share knowledge and best practices through the use of tele-video
- Discuss difficult diabetes cases with experts and other providers
- Build relationships with colleagues



UNM SCHOOL of MEDICINE | Project ECHO®

*Modeled after Project ECHO

Standing Orders Process



Standing orders

- Conversion of supplies
- Hyperglycemia
- Hypoglycemia
- Initiation of insulin
- Adjustment of insulin
- Medication refill
- Hypertension
- Lipids

Optimal Diabetes Care Measure

(Ages 18-75)

Measure: Optimal Diabetes Care - % of patients with diabetes who have the following:

- Statin on current medication list or LDL < 70 for patients > 40
- A1c with a value less than 8.0
- Blood pressure less than 140/90
- Documented non-tobacco user
- Aspirin on current medication list (vascular disease)

MN Community Measurement
Measure Up To Better Health

HealthPartners

Overview

- Care team roles and responsibilities
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2015 Minnesota Community Measurement (MNCM): Optimal Diabetes Care

Medical Group Name (△= Endocrinology)	Rate (Actual)	Lower Bound of 95% CI	Upper Bound of 95% CI	N	Total Population Or Sample	Rate (Expected)	Actual to Expected Ratio	Rating
STATEWIDE AVERAGE	53.5%	53.3%	53.7%	245,241				
Catalyst Medical Clinic	71.7%	59.2%	81.5%	60	Sample	54.4%	1.3	Top
Richard Schoewe MD	68.9%	54.3%	80.5%	45	Total Population	57.4%	1.2	Expected
Edina Sports Health & Wellness	65.6%	56.9%	73.4%	125	Total Population	57.0%	1.2	Expected
Allina Health Clinics	62.9%	62.4%	63.4%	33776	Total Population	54.0%	1.2	Top
Park Nicollet Health Services	62.5%	61.8%	63.2%	18116	Total Population	53.2%	1.2	Top
Entira Family Clinics	61.9%	60.6%	63.2%	5358	Total Population	55.8%	1.1	Top
France Avenue Family Physicians - Minnesota Healthcare Network	61.3%	56.3%	66.0%	385	Total Population	55.6%	1.1	Expected
Stillwater Medical Group	60.7%	58.7%	62.8%	2219	Total Population	56.1%	1.1	Above
Apple Valley Medical Clinic	60.3%	57.5%	63.1%	1150	Total Population	55.2%	1.1	Top
Vibrant Health Family Clinics and Minnesota Health Network	59.0%	55.7%	62.3%	852	Total Population	56.8%	1.0	Expected
Gundersen Health System	58.7%	50.8%	66.2%	155	Total Population	56.9%	1.0	Expected
Mankato Clinic, Ltd.	57.8%	55.7%	59.8%	2243	Total Population	54.7%	1.1	Above
Family Practice Medical Center of Willmar	57.5%	53.5%	61.3%	623	Total Population	54.7%	1.0	Expected
AALFA Family Clinic	57.2%	48.9%	65.2%	138	Total Population	55.0%	1.0	Expected
North Memorial	56.8%	55.4%	58.3%	4467	Total Population	55.5%	1.0	Expected
Burnsville Family Physicians	56.3%	50.7%	61.8%	302	Total Population	57.1%	1.0	Expected
Affiliated Community Medical Centers	56.3%	54.7%	57.8%	4072	Total Population	54.2%	1.0	Above
HealthPartners Clinics	55.7%	54.9%	56.5%	15421	Total Population	53.0%	1.1	Above
[illegible]	55.4%	54.4%	56.3%	10164	Total Population	54.3%	1.0	Expected
Allina Health Specialties	55.2%	52.9%	57.5%	1815	Total Population	55.7%	1.0	Expected
Sanford Health - Fargo Region	55.2%	54.3%	56.1%	12665	Total Population	54.7%	1.0	Expected
Fairview Health Services	55.2%	54.5%	55.9%	18343	Total Population	53.5%	1.0	Above
CentraCare Health								
Lake City Family Physicians PC								
Essentia Health - East Region								
Mayo Clinic Health System								
Essentia Health - Central Region								
HealthPartners Central Minnesota C								
Essentia Health - St. Mary's								
Multicare Associates								
Essentia Health - West								
Ortonville Area Health Services-Nor								
Richfield Medical Group								
HealthEast Clinics	52.7%	51.5%	54.0%	6326	Total Population	53.5%	1.0	Expected
Hudson Physicians - Minnesota Healthcare Network	52.0%	49.0%	55.1%	1003	Total Population	55.2%	0.9	Expected
FirstLight Health System	51.7%	48.6%	54.9%	955	Total Population	53.4%	1.0	Expected
Cuyuna Regional Medical Center	51.7%	44.1%	59.2%	165	Mixed	55.0%	0.9	Expected
Integrity Health Network	51.2%	49.7%	52.7%	4417	Total Population	54.9%	0.9	Below
Unity Family Healthcare, Family Medical Center	51.2%	47.6%	54.7%	760	Total Population	53.5%	1.0	Expected
Chippewa County Montevideo Hospital & Medical Clinic	50.9%	46.3%	55.5%	452	Total Population	54.1%	0.9	Expected
Albany Medical Center	50.6%	42.9%	58.3%	158	Total Population	55.4%	0.9	Expected
Glencoe Regional Health Services	50.5%	46.9%	54.0%	751	Total Population	55.0%	0.9	Expected

TABLE 11: STATEWIDE RATE FOR OPTIMAL DIABETES CARE

	Statewide Average (Weighted)	95% CI	Numerator (Patients who met treatment goals)	Denominator (Patients sampled)	Total Eligible
Optimal Diabetes Care	53.5%	53.3%-53.7%	131,847	245,241	249,878

HealthPartners

MNCM by Clinic

MINNESOTA HealthScores
When Health Care Improves, Everyone Wins.

CLINICS	PATIENT EXPERIENCE MORE INFORMATION	DIABETES: ADULTS MORE INFORMATION	VASCULAR CARE MORE INFORMATION
Sort	Sort	High to Low Performer	Sort
Entira Family Clinics- Shoreview (formerly Family HealthServices Minnesota- Shoreview) SHOREVIEW, MN (1.44 MILES)	ABOVE AVERAGE 88 %	ABOVE AVERAGE 69 %	ABOVE AVERAGE 81 %
Allina Health- Shoreview SHOREVIEW, MN (0.77 MILES)	ABOVE AVERAGE 83 %	ABOVE AVERAGE 68 %	AVERAGE 79 %
HealthPartners- Arden Hills ARDEN HILLS, MN (1.37 MILES)	ABOVE AVERAGE 85 %	ABOVE AVERAGE 68 %	AVERAGE 73 %
HealthPartners- Roseville ROSEVILLE, MN (3.77 MILES)	AVERAGE 81 %	ABOVE AVERAGE 67 %	ABOVE AVERAGE 82 %

HealthPartners

Clinic/Clinician Results

HealthPartners Medical Group
Optimal Diabetes Care
March 2016 Summary Report

Top 10 Clinics

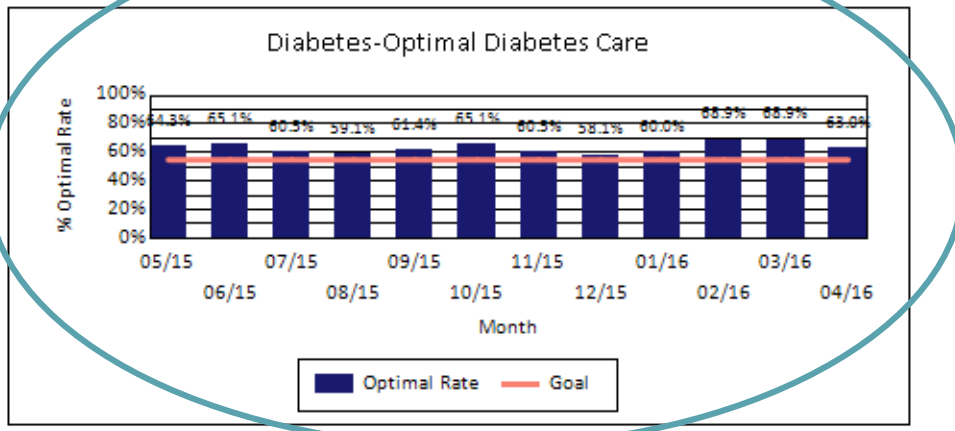
Primary Care Clinic	# Eligible Patients	% Met Criteria
Arden Hills	584	64.73%
Hlth Ctr for Women	311	58.52%
Coon Rapids	788	58.50%
Woodbury	1,268	58.20%
Roseville	486	58.02%
Elk River	458	56.33%
SMG Curve Crest	2,221	56.28%
Andover	583	54.89%
Riverside	629	54.69%
Ctr International Hlth	354	54.52%

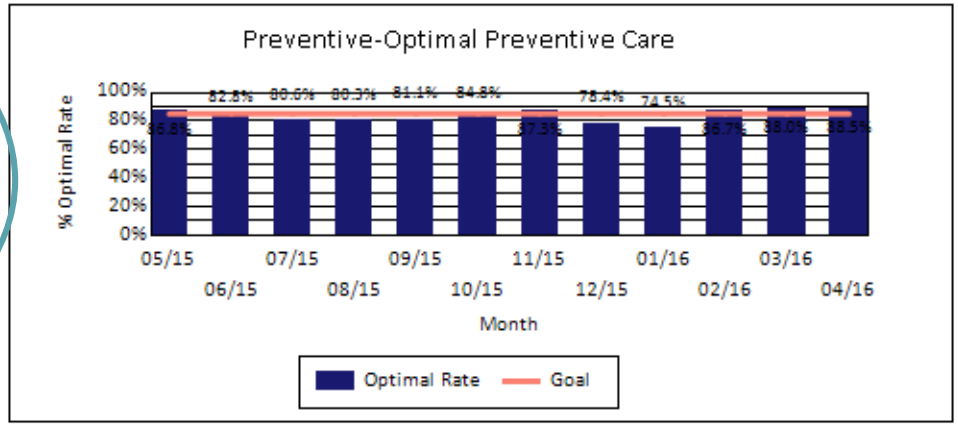
Top 20 Clinicians

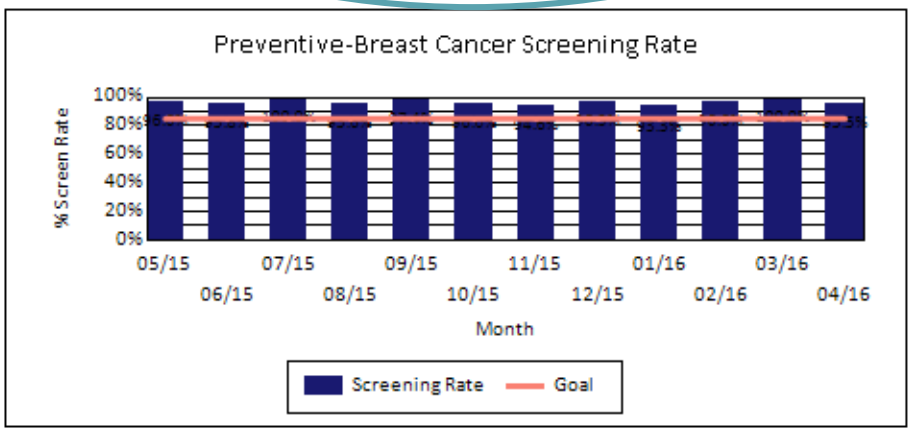
Clinician	Eligible Patients	% Met ODC	Location
[redacted]	102	76.47%	HPMG
	80	73.75%	HPMG
	22	72.73%	HPMG
	76	72.37%	HPMG
	47	72.34%	SMG
	99	69.70%	HPMG
	46	69.57%	HPMG
	16	68.75%	HPMG
	67	68.66%	HPMG
	82	68.29%	SMG
	61	67.21%	HPMG
	161	67.08%	HPMG
	78	66.67%	HPMG
	51	66.67%	SMG
	33	66.67%	HPMG
	123	65.85%	HPMG
	26	65.38%	HPMG
	134	64.93%	HPMG
	88	64.77%	SMG
	217	64.52%	HPMG

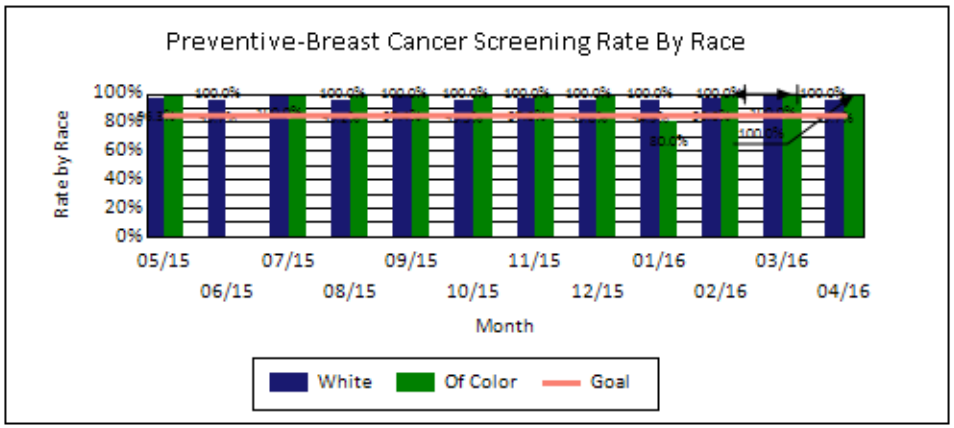
HPMG Primary Care -- Care Team Scorecard

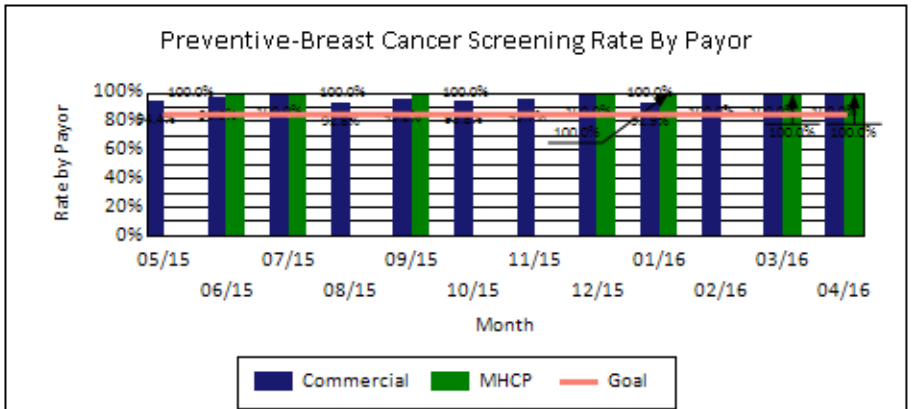
[redacted] --Care Team -- HP COMO CLINIC

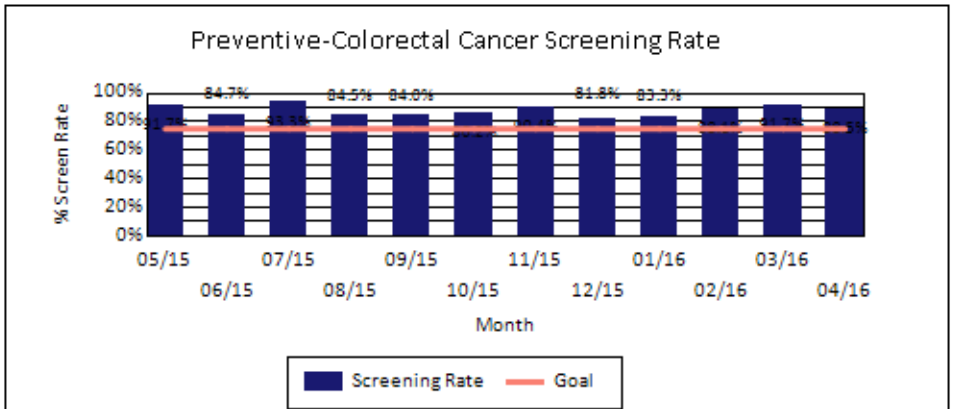












Care Team Scorecard Meetings

Structure

- Meet every 90 days with site leadership
- Physician/Clinician, LPN/CMA, RN

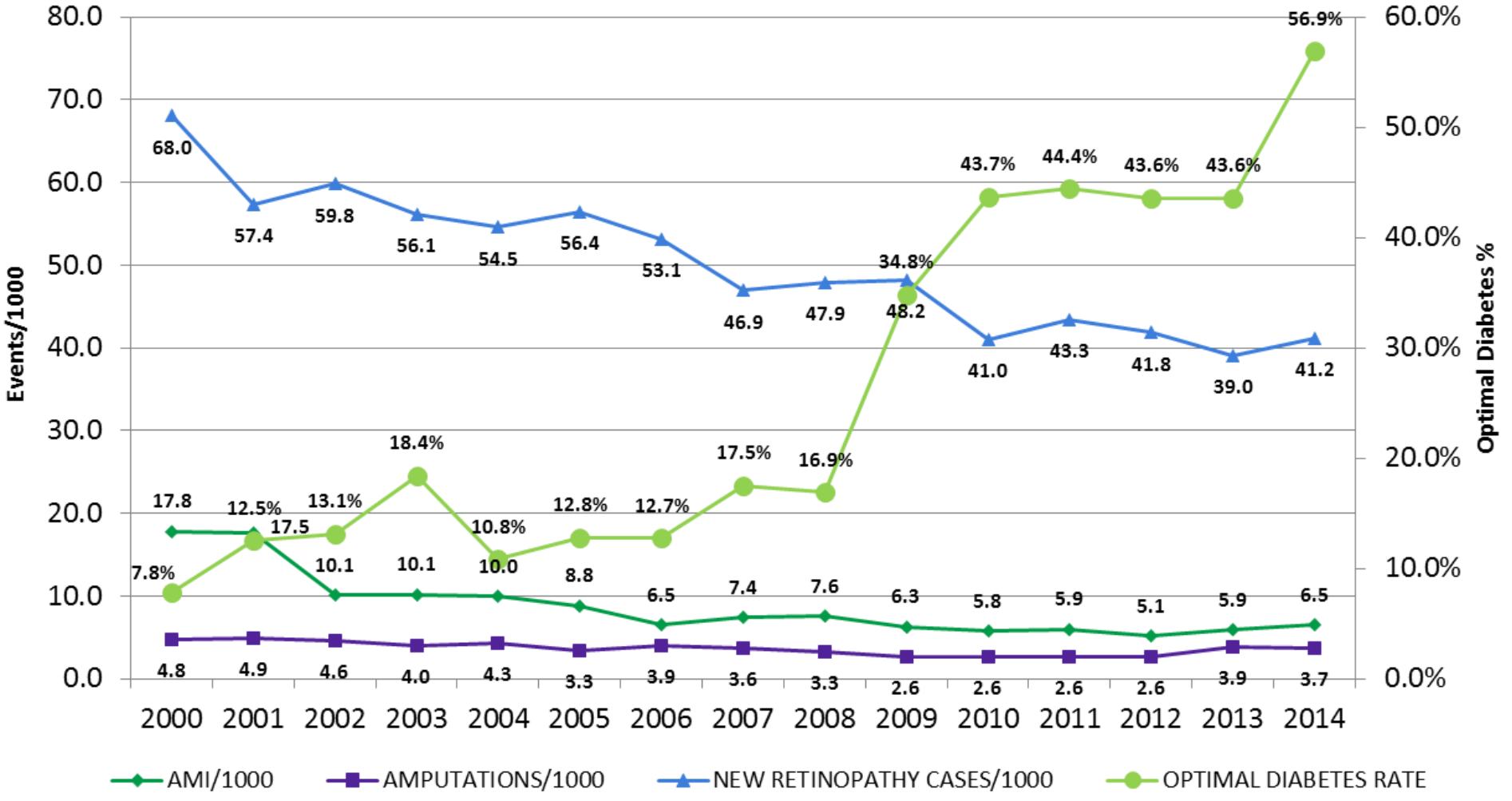
Process

- Celebrate & share
- Identify opportunities and learn
- Test improvements: care teams and leaders partner

Site Leaders send plans to division leaders

- Identify best practices
- Reward and recognize
- Share with others

Saves 403 hearts, 40 legs & 760 pairs of eyes each year



HealthPartners' 35,646 members with diabetes in 2014 suffered 403 fewer heart attacks, 40 fewer leg amputations and 760 people did not experience eye complications compared to what would have happened to the same 35,646 plus members in 2000.

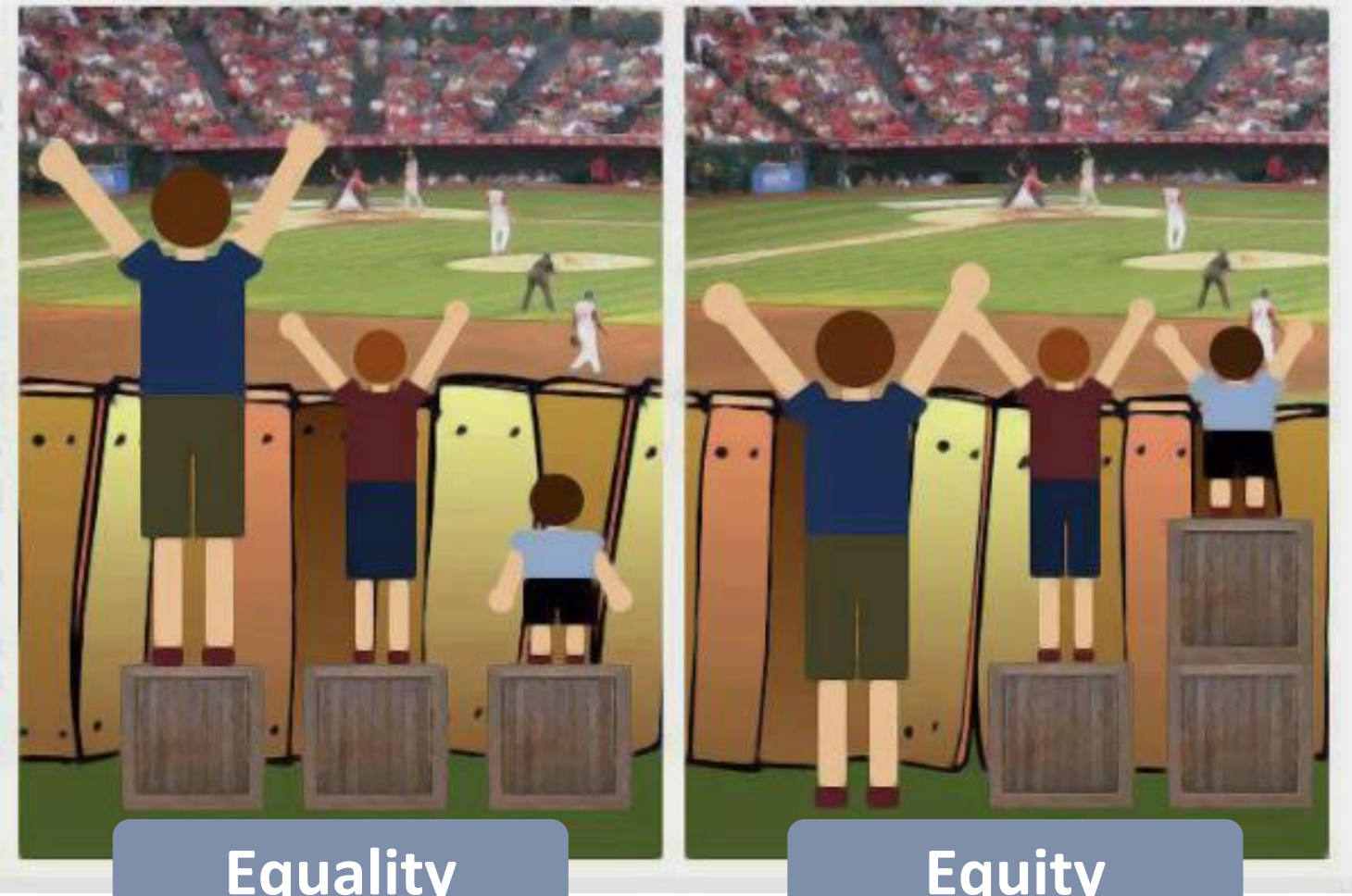
HealthPartners

Overview

- Care team roles and responsibilities
  - For all patients
  - Specific to patients with diabetes
- Role of specialist
- Optimal Diabetes
  - Definition
  - Measure
- Results
  - Accountability/improvement
- Customization example
  - Disparities work

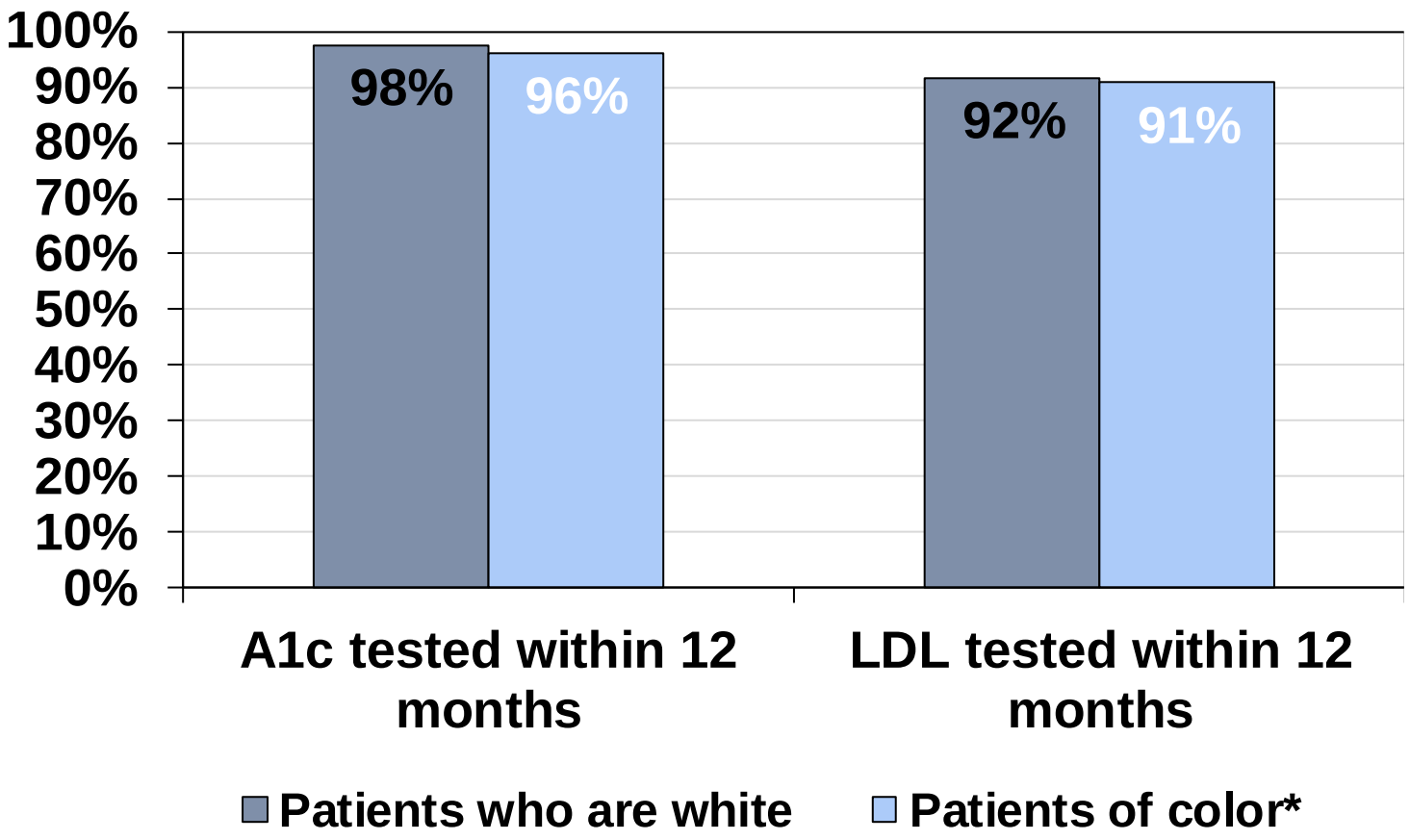
Customize

Care that meets the needs of the person



Optimal Diabetes Process Measure

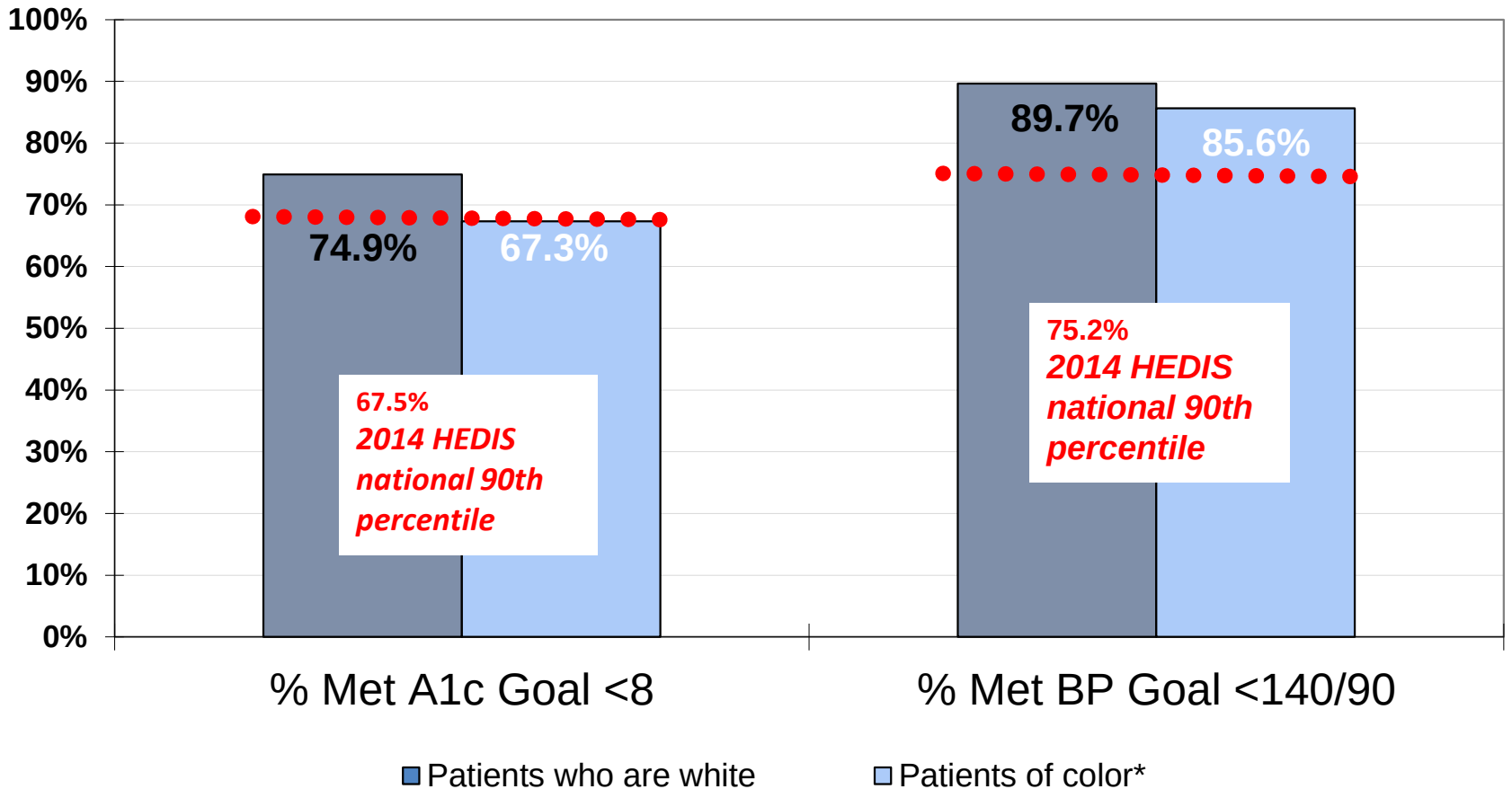
2014 Data



*Patients of color: includes patients whose self-identified race is either American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino, Some other race, and patients with more than one race documented (Multiple race)

Diabetes Outcomes by Race

2014 Data



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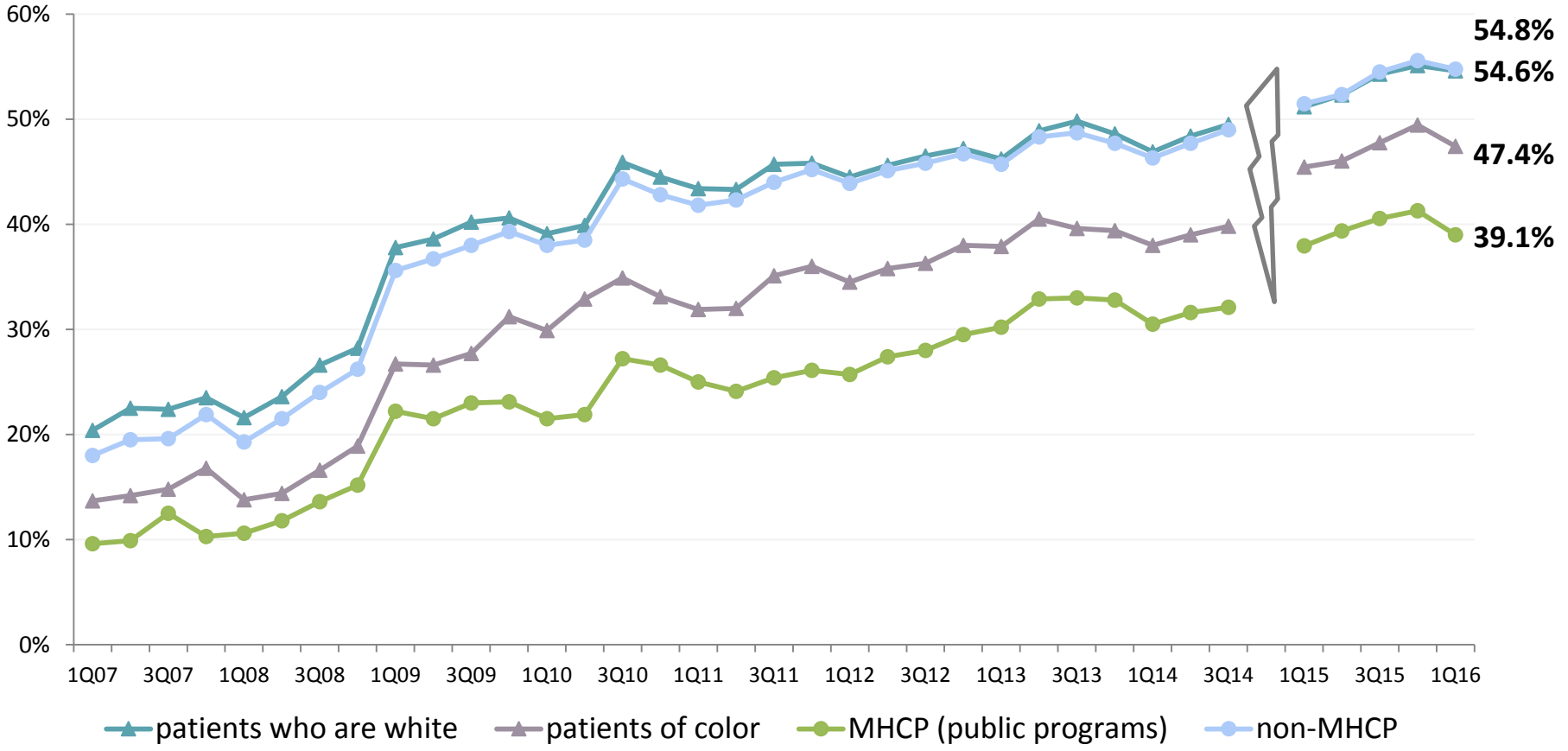
Standardization Improves Care

Optimal Diabetes Care



***Measure**: % of HPMG patients with diabetes have statin on current medication list (or LDL <70 for patients >40), have had an A1c in the last 12 months with a value <8.0, last recorded blood pressure <140 and <90, documented non-tobacco user and documented regular aspirin user.*

Partnerships to Improve Care

- Managing Diabetes Care During Ramadan
  1. Identify when Ramadan begins each year
  2. While reviewing diabetes registry, identify patients who may fast during Ramadan 4-6 weeks before Ramadan begins
  3. Schedule diabetes visits before patients begin to fast
  4. Use problem-oriented charting to document that a patient observes Ramadan and whether s/he chooses to fast
- 3D: Defeating Diabetes Disparities
  - 5 teams focused on improvements for African American and East African patients with Diabetes
  - 30 patients and community advisors helped guide our efforts

Minted Veggie Pita Pockets

Ingredients (serves 4):
1 can garbanzo beans, rinsed and drained
2/3 cup plain yogurt
¼ cup red pepper, chopped
2 Tbsp fresh mint, finely chopped
1 garlic clove, minced
½ teaspoon ground cumin
1/8 teaspoon cayenne pepper
4 standard pita breads
Torn romaine leaves
2/3 cup crumbled feta or goat cheese
Green scallions

Directions:
Mash garbanzo beans in small bowl with fork until somewhat pasty.
Combine yogurt, red pepper, green onion, mint, garlic, cumin, and cayenne with beans.
Cover and chill mixture for at least 2 hours to blend flavors.
Bring to room temperature before serving.
Cut pitas in half vertically to form pockets.
Line the pita halves with torn romaine leaves and sprinkle with feta cheese.
Spoon mixture into pitas & serve.

Nutrition per serving: 330 calories; 8 g total fat (4.5 g saturated, 0 g trans); 0 mg cholesterol; 670 mg sodium; 52 g carbohydrates; 8 g fiber; 6 g sugars; 16 g protein.

Care Team Picks

AADE Diabetes Goal Tracker – Diabetes Man...
American Association of Di...

Glucose Buddy - Diabetes Logbook Manager w/syn...
Azumio Inc.
★★★★½ (1,821)

CalorieKing Food Search
CalorieKing
★★★★☆ (36)

Calorie Counter & Diet Tracker by MyFitnessPal
MyFitnessPal.com
★★★★☆ (183)

D-Life Diabetes NSW... 4+
GiveEasy ›

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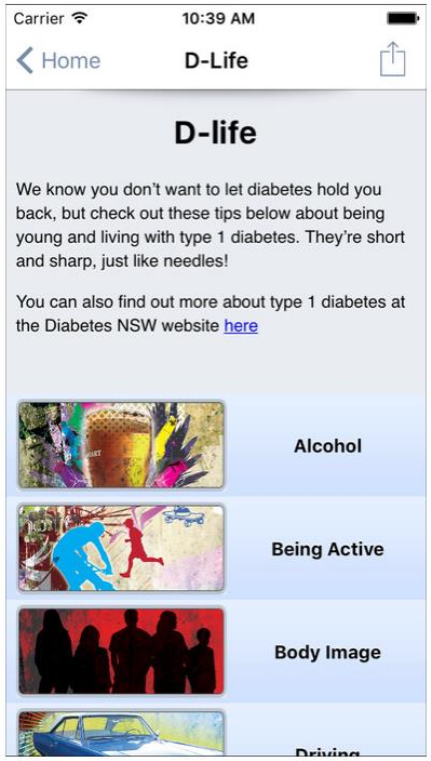

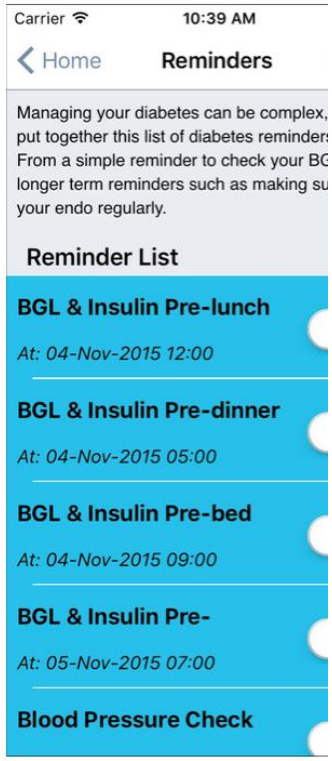

HealthPartners

Additional Resources

- Social networking
  - www.tudiabetes.org/
  - www.patientslikeme.com/
  - www.diabetescommunity.com/
- Online resources
  - www.cdc.gov/diabetes/home/index.html
  - www.diabetes.org/
  - http://wellshareinternational.org/resources-tools/english/diabetes-ramadan-english/
- Yumpower
  - www.healthpartners.com/yumpower/my-kitchen

Next Steps

- Hypertension standing order for RN's
- Supporting behavior change
- Leveraging technology
- Community linkages

Questions?