

# Together 2 Goal<sup>®</sup>

AMGA Foundation  
National Diabetes Campaign

Monthly Campaign Webinar

*September 15, 2016*

# TODAY'S WEBINAR

- Together 2 Goal<sup>®</sup> 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



# WEBINAR REMINDERS

- Webinar will be recorded today and available the week of September 19<sup>th</sup>
  - 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



# INPUT REQUESTED: 2017 WEBINAR TOPICS



- Beginning planning for 2017 monthly webinars
- Email topic and/or speaker recommendations to [together2goal@amga.org](mailto:together2goal@amga.org)
- Self-nominations accepted

# 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!

# GOAL POST SEPT. NEWSLETTER HIGHLIGHTS



## Campaign Spotlight:



## Resource of the Month



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



## **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](http://www.amga.org/IQL2016)

# TOGETHER 2 GOAL<sup>®</sup> AT AMGA'S INSTITUTE FOR QUALITY LEADERSHIP (IQL)

DiABETES



- **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

# 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, FFAO

Sameera Ahmed, MS, RHIA, CHDA

# Today's Discussion

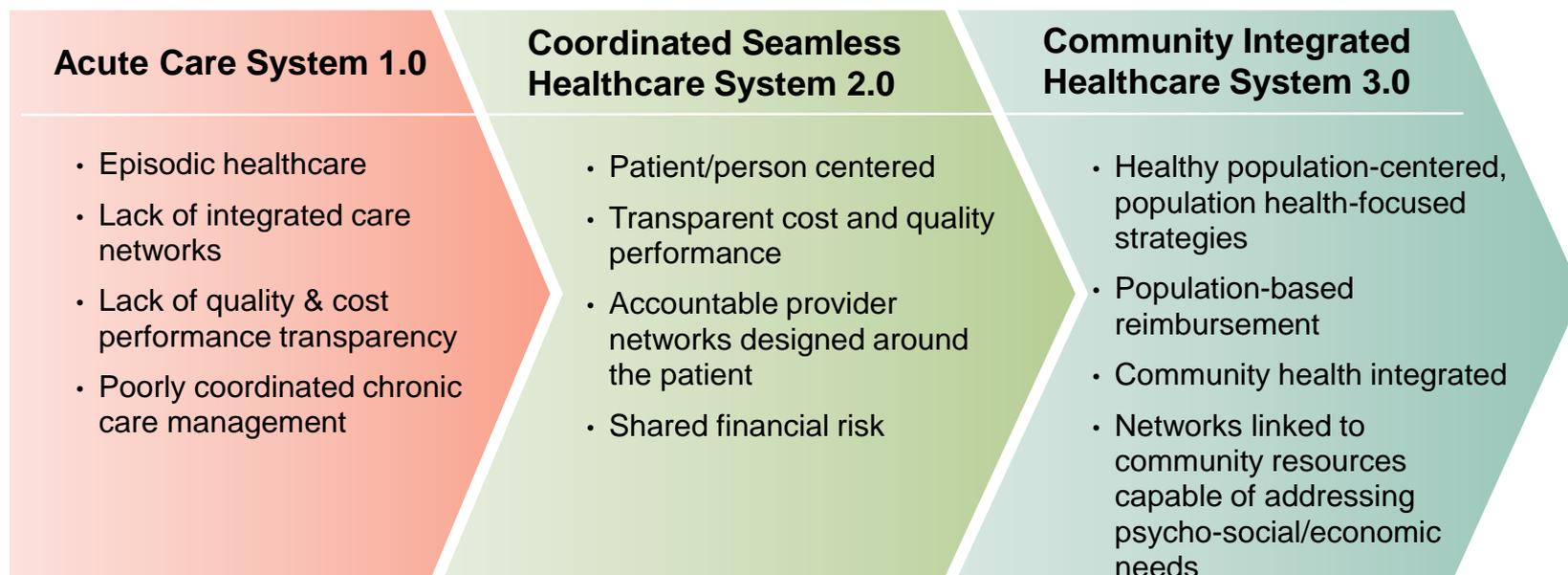
- Introduction
- LVHN's population health management strategy
- Development and deployment of patient registries using Optum One

# 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



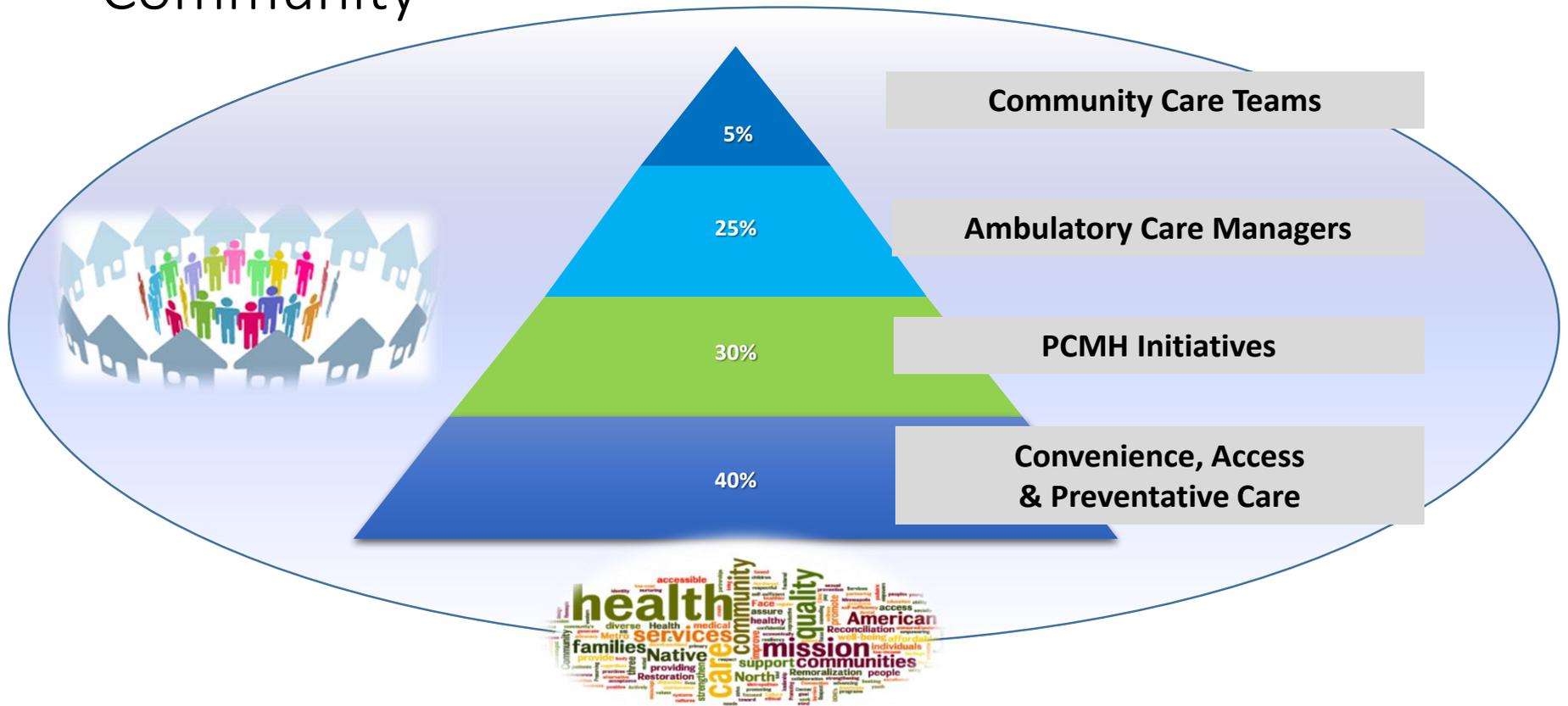
\*Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. Health Affairs 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

# 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



# 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)

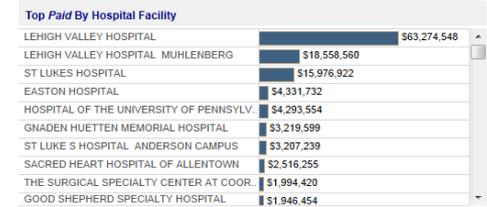
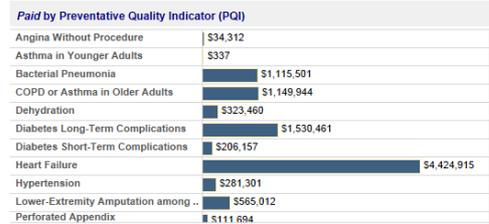
## Diabetes Patients

Attributed ACA patients with >= 1 episode of diabetes with claims paid in period 2/1/2015 - 1/31/2016



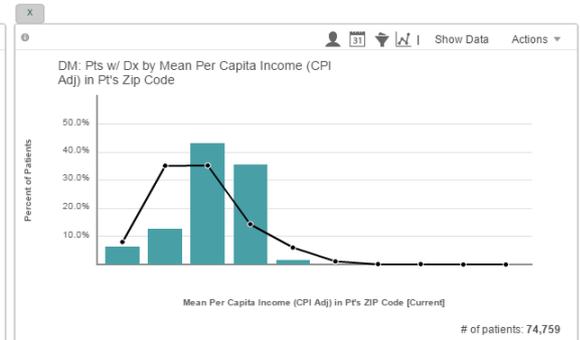
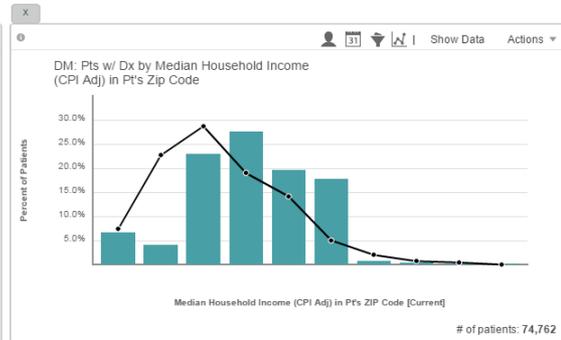
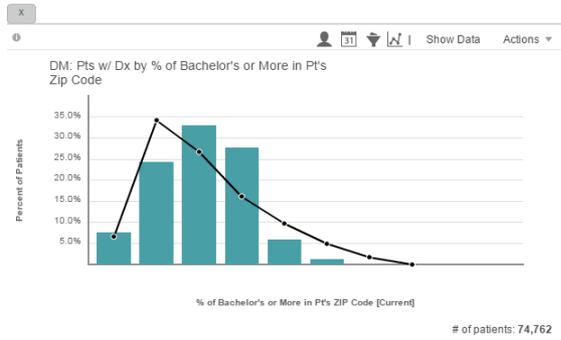
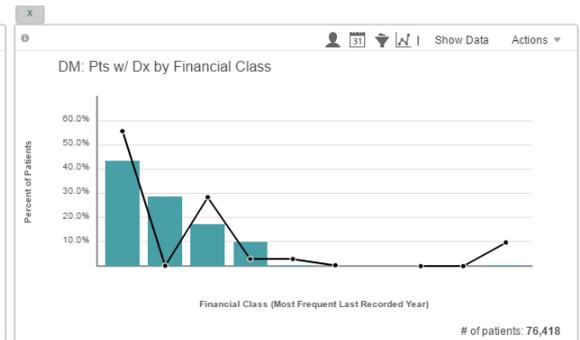
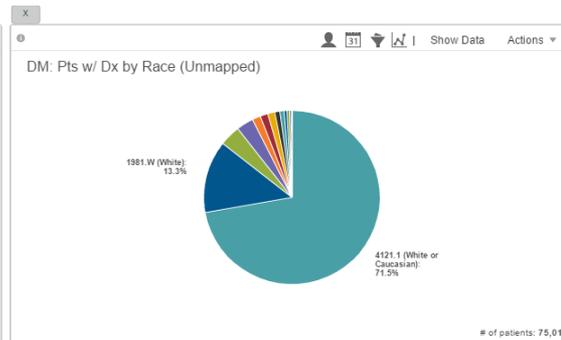
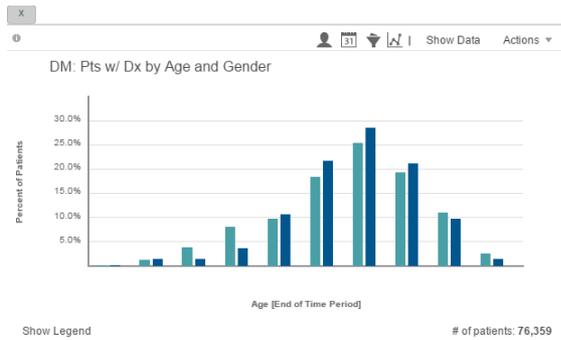
Choose Calculation: Paid  
 Member Month Type: Cohort Member Months  
 Filters: Payer: (All), Active Member: (All) [No/Yes], PCP Continuity: (All) [No PCP/PCP], IP Admits Group: (All), ER Visit Group: (All), Clinical Category: (All), Condition Detail: (All), Member Cost: (All)

Clinical Category: Paid		Population Overview		Selected
Endocrinology	Diabetes	\$19,762,901	Members	17,814
Nephrology	Chronic renal failure	\$19,672,076	Member Months	211,220
Cardiology	Ischemic heart disease	\$19,540,149	PMPM	\$1,338.67
Cardiology	Congestive heart failure	\$9,998,698	Total \$	\$282,753,426
Neurology	Cerebral vascular disease	\$9,296,051	Admits	13,581
Infectious diseases	Septicemia	\$8,603,933	Days	158,777
Cardiology	Hypertension	\$7,057,160	ER Visits	20,206
Orthopedics & rheumatology	Joint degeneration, localized - back	\$6,308,550	Episodes	301,495
Orthopedics & rheumatology	Joint degeneration, localized - knee & lower leg	\$5,968,907	Admits/K	771.6
Pulmonology	COPD	\$5,485,636	Days/K	9,020.6
			ER Visits/K	1,148.0
			Episodes/K	17,128.8
			ALOS	11.69
			Readmit Rate	43.32%
			Readmits	5,883



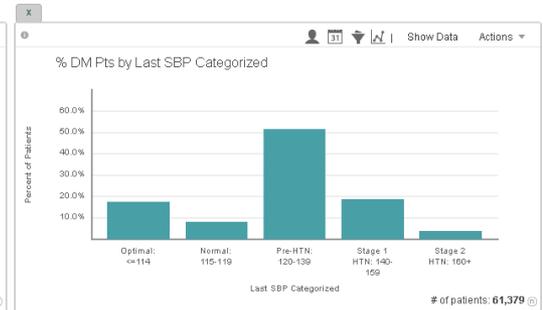
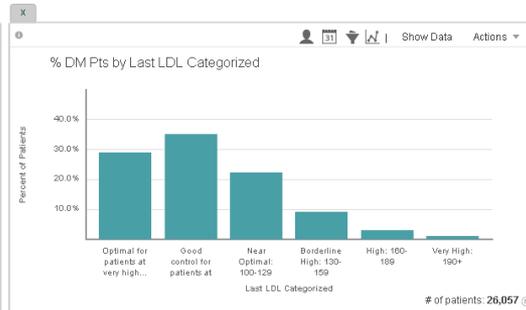
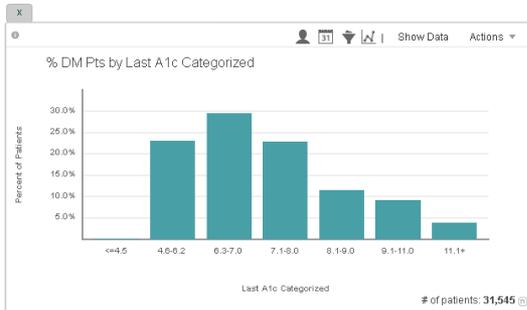
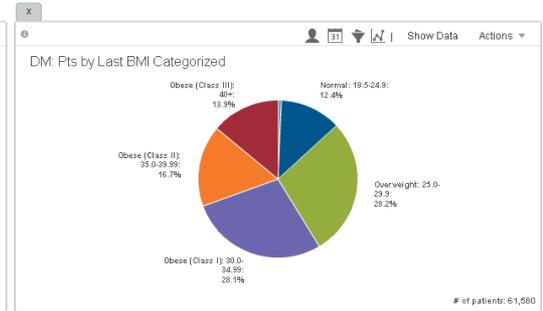
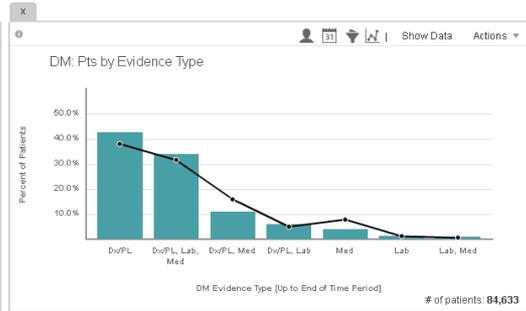
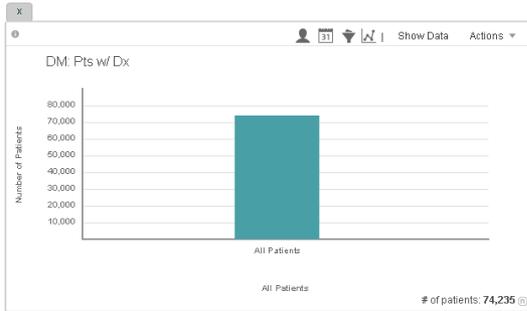
# Using Clinical Data to Stimulate Discussion

- DM Cohort Demographic Profile



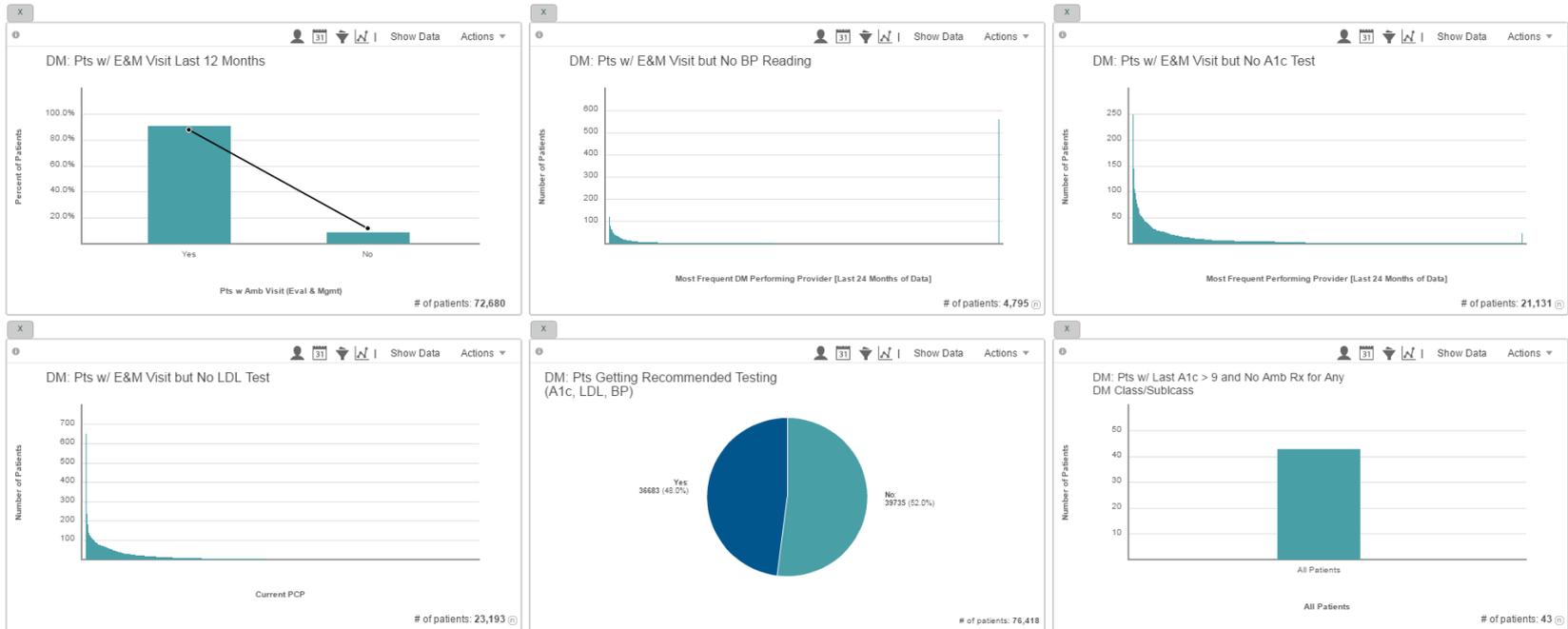
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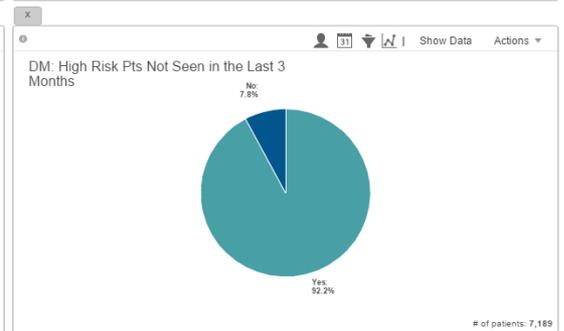
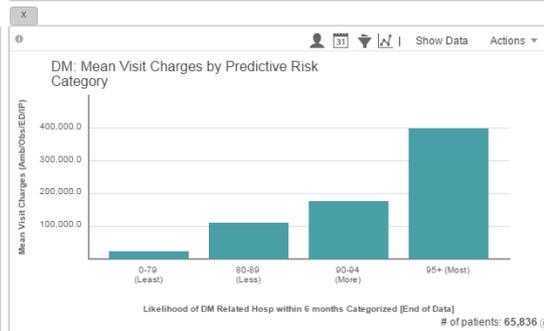
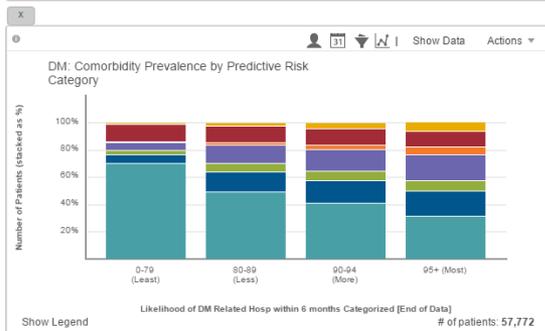
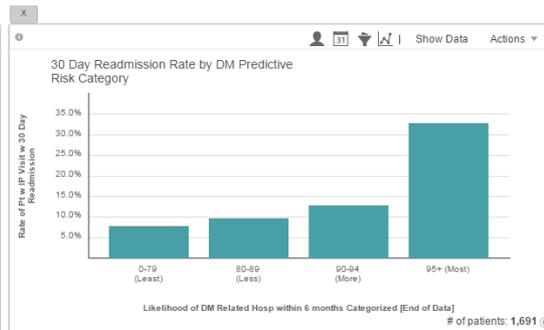
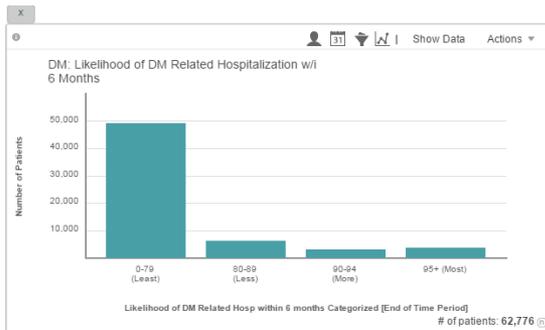
# Using Clinical Data to Stimulate Discussion

- DM Care Gap Overview



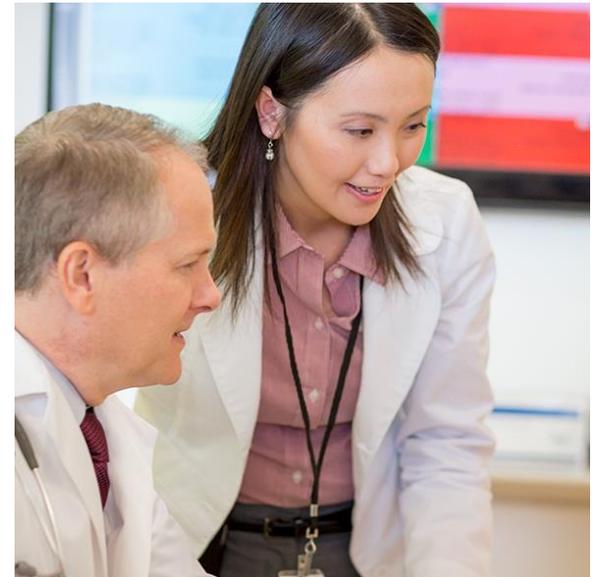
# Using Clinical Data to Stimulate Discussion

- DM Predictive Risk Overview



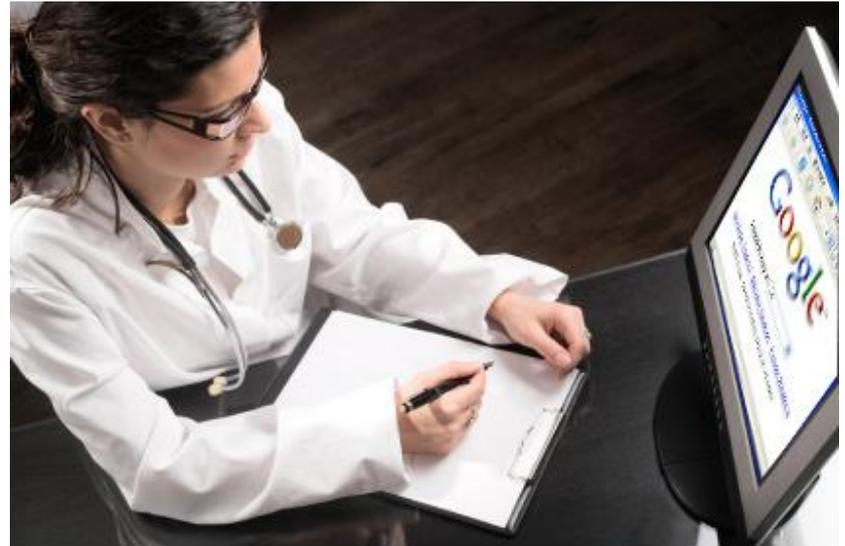
# Turning Data into Actionable Information

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



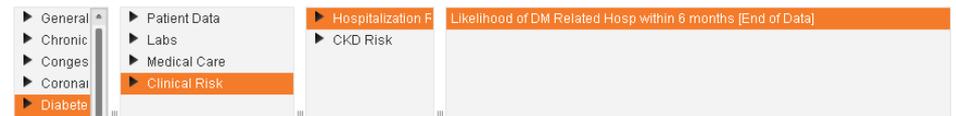
# Practice Team Information Needs

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



# Predictive Analytics

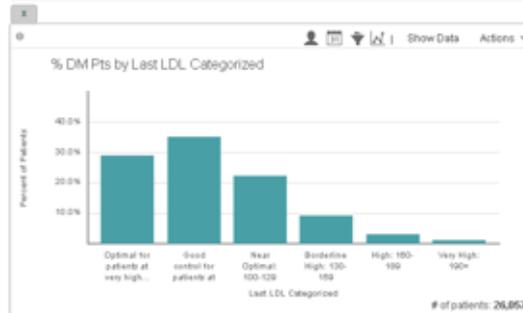
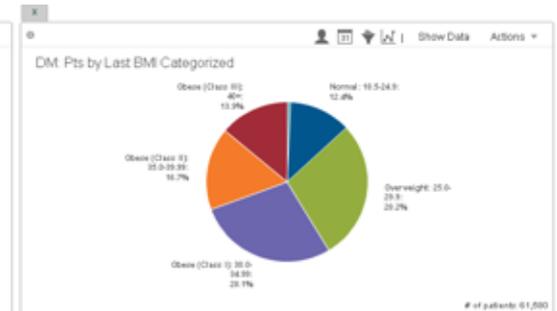
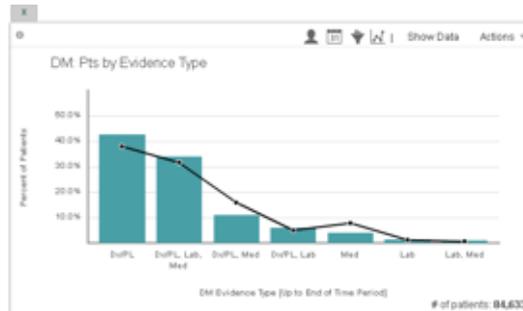
- Prompts proactive outreach
- Predictive models assessing the likelihood of chronic-disease related admission and disease progression
  - DM
  - DM to CKD



# 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

The image displays four screenshots of a patient data interface, each showing a different set of filters and metrics. The interface is organized into columns and rows, with orange highlights indicating the active filters.

**Screenshot 1:** Shows filters for Patient Data, Clinical Observations, Labs, and Medical Care. The active filter is Medical Care. Metrics include # of ED Visits, # of ED Visits Missing 7 Day Amb Follow-up, Pt Has Had ED admission within 3 Days, and Pt Has Had ED admission within 7 Days.

**Screenshot 2:** Shows filters for Patient Data, Clinical Observations, Labs, and Medical Care. The active filter is Medical Care. Metrics include # of Hosp Admits and Longest time to Follow-up between IP and Amb visit.

**Screenshot 3:** Shows filters for Patient Data, Clinical Observations, Labs, and Medical Care. The active filter is Medical Care. Metrics include # of IP Visits w 30 Readmission, # of IP Visits w 7 Day Readmission, Pt w IP Visit w 30 Day Readmission, and Pts w IP Visit w 7 Day Readmission.

**Screenshot 4:** Shows filters for Patient, Clinical, Labs, and Medical. The active filter is High Risk. Metrics include Pts w Depression, Pts w Depression [Ever], Pts w Dx of Major Depression, and Pts w Dx of Major Depression [Ever].

# 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  $\geq$  80%
- High Utilizers
  - ED Visits  $\geq$  2, Hosp Admits  $\geq$  3 in 12 months
- High Risk, Low Spend
  - HCC-RAF in high risk range, Total Charges  $\leq$  \$15,000

Quick Filters ➤

- Last Rx for Chol Lowering Med (09/01/2015 - 09/...
- Last Rx for for Any Oral DM Med Class/Subclass ...
- Last Rx for insulin (09/01/2015 - 09/11/2016)
- Likelihood of DM Related Hosp within 6 months [ ... is greater than or equal to 80 ✎
- Most Frequent Endocrinology Provider (Last 12 ...
- Patient Status
- Patients known to be deceased [Current]
- Pt w Dx of Type 1 DM (09/01/2015 - 09/11/2016)
- Pt w Dx of Type 2 DM (09/01/2015 - 09/11/2016)
- Pt w IP Visit w 30 Day Readmission (09/01/2015 - ...
- Pts w Chronic Kidney Disease: CCS (09/01/2015 - ...
- Pts w Depression (09/01/2015 - 09/11/2016)
- Pts w Diabetic Retinopathy (09/01/2015 - 09/11/2...
- Pts w Dialysis (09/01/2015 - 09/11/2016)
- Pts w DM with Neurological Complications (09/0...
- Pts w DM with Renal Complications (09/01/2015 ...
- Pts w Eye Exam - PQRI (09/01/2015 - 09/11/2016)
- Pts w Foot Exam - PQRI (09/01/2015 - 09/11/2016)
- Pts w Rx for ACEI/ARB (09/01/2015 - 09/11/2016)
- Pts w Rx for Any Depression Med Class (09/01/2...
- Pts w Rx for Any DM Med Class/Subclass (09/01/...
- Pts w Rx for Any Oral DM Med Class/Subclass (0...
- Pts w Rx for Aspirin (09/01/2015 - 09/11/2016)
- Pts w Rx for Chol Lowering Med (09/01/2015 - 09...
- Pts w Rx for Insulin (09/01/2015 - 09/11/2016)
- Total Charges (09/01/2015 - 07/31/2016)

# 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?**

