Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

December 14, 2017

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - January 2018 Monthly Webinar
  - Goal Post December Newsletter Highlights
- Diabetes Management at ProHealth Physicians
  - Rich Guerriere, M.D.
  - Rob Wenick, M.D.
  - Suzanne Florczyk, Pharm.D.
  - Jen Sabo, M.S., RD, CDN
- Q&A
  - Use Q&A or chat feature

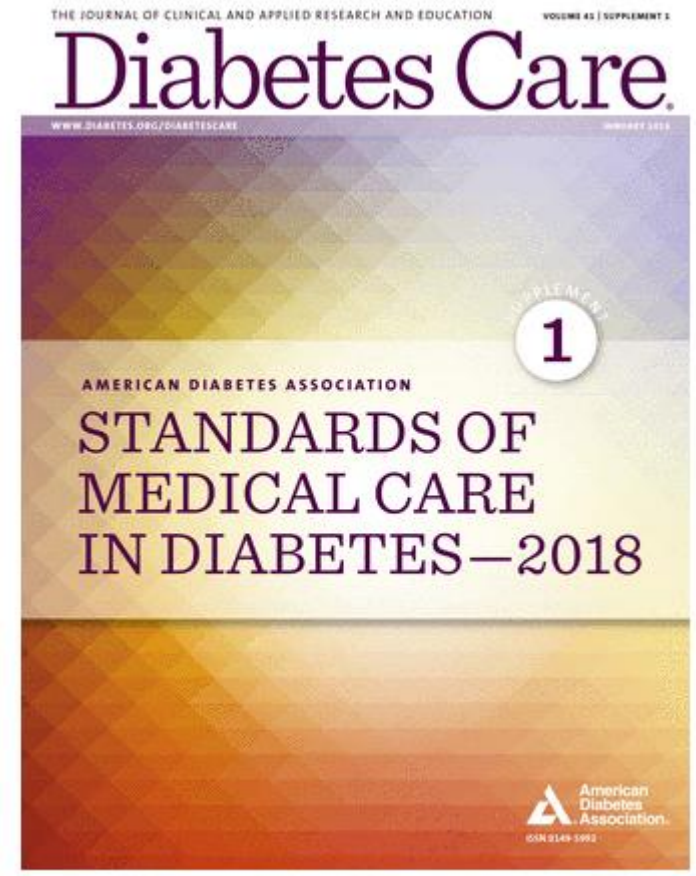
Together2Goal®

WEBINAR REMINDERS

- Webinar will be recorded today and available the week of December 18th
  - 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®

JANUARY WEBINAR: ADA 2018 STANDARDS OF CARE UPDATE



Thursday, January 18, 2018
2:00-3:00 p.m. ET

Featured Presenter:

- Andrea L. Cherrington, M.D., M.P.H.
- Associate Professor, Nutrition Obesity Research Center, Division of Preventive Medicine
- University of Alabama Birmingham

Together2Goal®

APPLY FOR THE CORE TRAINING PROGRAM

- Free all-day diabetes training for up to 40 staff at your organization
- Application is on the T2G website under the "Improve Patient Outcomes" tab and is due January 31, 2018

Together2Goal®

GOAL POST NEWSLETTER: DECEMBER HIGHLIGHTS


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

December 2017 Edition

Are you looking for tips about building or improving a dedicated diabetes care team at your organization? Check out our two newest *Goal-Getters*:

- HealthPartners Medical Group: Read how a patient taking 45 medications inspired HealthPartners to reorganize their care teams to better support patients with chronic conditions.
- Pinnacle Health System: Learn how Pinnacle's team-wide focus on patients with A1c levels higher than 9.0 paid off.

These *Goal-Getters* present strategies and tactics that can be used to overcome barriers to team building. They also include contact information for the "head coach" at each organization if you have additional questions. If you haven't seen all of our *Goal-Getters*, you can download all archived editions from our website.

...our organization having great success on a certain campaign measure? Are you doing ...thing unique to drive measureable results for your patients with Type 2 diabetes? If so, ...Goal-Getter! Let us know and help us share best practices with your colleagues nation... by ...pleting the online form.

Questi... ...ut Together 2 Goal®? Email us at together2goal@amga.org

DECEMBER 31

CONTROL CHAMPIONS

Mercy

Upcoming Dates

December 14: Monthly campaign webinar on Advancing Diabetes Management at ProHealth Physicians (register)

December 22: Blinded comparative reports sent to participating groups

January 8: Deadline for abstracts for ADA's Scientific Sessions (learn more)

January 18: Monthly campaign webinar on the ADA 2018 Standards of Care (register)

Campaign Spotlight

Congratulations to the four AMGA members who were honored by the CDC as Million Hearts® 2017 Hypertension Control Champions: New West Physicians, OhioHealth Primary Care Physicians, Sanford Health Clinics, and Sharp Rees-Stealy Medical Group. We are proud of their efforts to bring more than 70% of their patients under blood pressure control, an achievement that is key to improving diabetes management.

Read more

Resource of the Month

Download Mercy's one-page handout, "Top Ten Tips to Start Managing your Diabetes," and share it with your patients. This is a great tip sheet for newly diagnosed patients, as well as those who may need a refresher for the holiday season.

Read more

Congrats to our newest *Goal-Getters*:

- HealthPartners Medical Group
- Pinnacle Health System

Learn how to build a world-class diabetes team!

Visit Together2Goal.org to view all our *Goal-Getters.*

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- **January 18:** Monthly campaign webinar on the ADA 2018 Standards of Care
- **January 19**: Early bird registration deadline for AMGA's Annual Conference

Together 2 Goal®

Join AMGA March 7-10 in Phoenix!

Shared Learning

Real-world case studies and insights, led by AMGA member groups

Inspiring Keynotes

Featuring burnout expert Abraham Verghese, disruption guru Jonah Berger, former Congresswoman Gabby Giffords, and astronaut Mark Kelly

Networking

15+ hours of free-flowing conversations and structured networking events

Learn more about our annual conference and register at: amga.org/ac18

TOGETHER 2 GOAL® 2018 WEBINAR SCHEDULE

WEBINARS WILL BE HELD FROM 2-3 P.M. EASTERN

Date	Topic	Presenter(s)
Jan. 18, 2018	**American Diabetes Association (ADA) 2018 Standards of Care**	Andrea L. Cherrington, M.D., M.P.H. (University of Alabama, Birmingham)
Feb. 15, 2018	**An Rx for Good Health: Geisinger's Fresh Food Pharmacy**	Andrea Feinberg, M.D. (Geisinger)
March 15, 2018	**Addressing Health Disparities in Latino Populations with Diabetes**	David Marrero, Ph.D. (University of Arizona)
April 19, 2018	**The Role of the Nurse in Diabetes Care**	Sentara Medical Group
May 17, 2018	**Succeeding in the Together 2 Goal® Bundle**	AMGA Analytics
June 21, 2018	**Blood Pressure Control for Patients with Diabetes**	Robert Matthews (PriMed Physicians)
July 19, 2018	**Shared Medical Appointments for Diabetes Care**	Marianne Sumego, M.D. (Cleveland Clinic)
Aug. 16, 2018	**Diabetes and Obesity**	Timothy Garvey, M.D. (University of Alabama, Birmingham)
Sept. 20, 2018	**Removing Patient Barriers to Medication Adherence**	Molly Ekstrand, RPh, BCACP, AE-C (Park Nicollet HealthPartners Care Group)
Oct. 18, 2018	**Diabetes and Mental Health**	Joanne Rinker, M.S. (American Associate of Diabetes Educators) and Jasmine D. Gonzalvo, PharmD (Purdue University, Eskenazi Health)
Nov. 15, 2018	**How to Succeed in Your Diabetes Prevention Program (DPP)**	Tony Hampton, M.D. (Advocate Medical Group)
Dec. 13, 2018	**The Together 2 Goal® Innovator Track**	Together 2 Goal® Innovator Track Participants

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Read more

Resource of the Month

Mercy

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Campaign Spotlight

- New West Physicians
- OhioHealth Primary Care Physicians
- Sanford Health Clinics
- Sharp Rees-Stealy Medical Group

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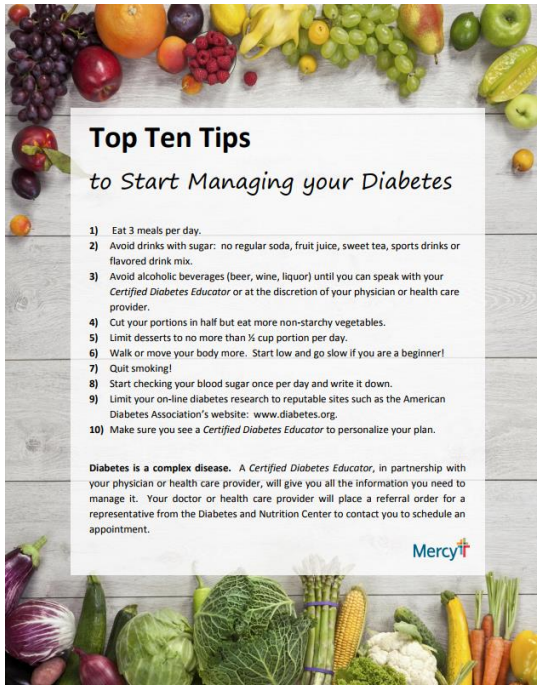

Mercy's handout, "Top Ten Tips to Start Managing your Diabetes"

Together 2 Goal®

TODAY'S SPEAKERS

ProHealth Physicians

Richard P. Guerriere, M.D.

Chief Medical Officer

Robert Wenick, M.D.

Medical Director for OptumCare Network of CT IPA

Jennifer Sabo, M.S., RD, CDN

Healthy Me Program Manager

Suzanne Florczyk, Pharm.D.

Clinical Pharmacist

Together2Goal®

ProHealth™ PHYSICIANS
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Together 2 Goal: 20 Years of Success

Richard P. Guerriere, MD
Chief Medical Officer

Presentation Outline

- About ProHealth Physicians
- ProHealth's Clinical Performance Journey
- Success Drivers:
  - Clinical Performance Tools
  - Provider Incentives
  - Leadership and Staff Support
- Our Results
- Lessons Learned & Key Takeaways
- Q&A

ProHealth™ PHYSICIANS
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About ProHealth Physicians

ProHealth Physicians Key Statistics

- Primary care-driven multi-specialty medical group
- Company formed in June 1997
- Joined Optum in December 2015
- 78 practices across 87 locations (all 8 counties of Connecticut)
- Our Providers
  - 238 Physicians
  - 156 Advanced Practitioners
- Our Patients
  - 350K active patients
  - 750K patient records
  - 937K annual patient encounters (2016)
- Our Technology
  - Common EHR and PM across enterprise

Clinical Specialties

Specialty	# of Physicians
Family Practice	73
Internal Medicine	68
Pediatrics	85
Specialties:	
Ear, Nose & Throat	6
Gastroenterology	2
Neurology	2
Pathology	1
Plastic Surgery	2
Pulmonology	1
Sleep Medicine	1

Other Programs:

- Healthy Me nutrition program – Helping Families Eat Well and Be Active!
- All primary care locations recognized as Level III Patient-Centered Medical Homes since 2011.
- Clinical Performance and Medical Management.
- ADHD Center
- Extended Hours Centers
- Nurse Call Line

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ProHealth's Clinical Performance Journey

Our Clinical Performance Journey

Since 2003, ProHealth's clinical performance team has implemented a broad array of quality improvement initiatives that help our physicians provide the best possible care to our patients.

Programs are designed to identify opportunities for improving clinical outcomes in key quality areas such as diabetes, cardiovascular conditions, asthma, immunization against disease, and overall preventive care.

ProHealth launched its first version of physician performance reports more than a decade ago.

In each subsequent year, we have made significant improvements to the reports, based on the feedback of our providers.

ProHealth manages its own comprehensive data warehouse that incorporates information from multiple electronic sources, including our electronic health record, practice management system, laboratory information system, and credentialing database.

Clinical Performance/Medical Management

- Strategic and operational focus on:
  - Population health
  - Building capabilities to accept risk from public and private payers
  - Conversion of ACO contracts to risk
- Strong historical results under pay-for-performance contracts
  – Commercial and Medicare Advantage shared savings contracts
  – Savings based upon achievement of quality goals and utilization targets
  – Partnership includes transitions in care and collaboration on care management
- Medicare Shared Savings Program ACO since 2013
  – Consistent performance on quality metrics
    - 99th percentile for Quality in 2015, 98th percentile for Quality in 2016
  – Saved $12M in 2016 resulting in ProHealth obtaining $5.9M in SS
- Learnings from these programs to be adopted in our medical management strategies under global risk arrangements

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Clinical Performance Tools

Clinical Performance Tools

- The Clinical Performance Drilldown Tool enables providers, practice managers, staff, and medical management leadership to view quality metric performance at multiple levels:
  - Organization wide
  - Across regions
  - Across practices
  - For individual providers
- The tool is refreshed nightly so that it is as close to “real time” as possible
- In addition to displaying current performance, the tool enables staff to produce lists of patients eligible for each measure, along with their current compliance status
- Practice staff produce outreach lists to schedule visits for patients who are due or overdue for a particular service
- ProCORE provides point-of-care alerts that identify quality gaps that can be resolved during the patient’s scheduled visit
- ProCORE reports are also used for pre-visit planning & huddling

Clinical Performance Drilldown Snapshots

Measure	Compliant % Rolling Year	Target %	Compliant % Calendar Year	ProHealt Rate
ADHD	100.0	95.0	100.0	90.5
Adolescent Immunization	86.7	81.0	86.7	95.0
* Adult Pneumococcal	86.5	90.0	86.5	86.9
* Adult Weight Screening	57.0	90.0	55.2	70.7
Adult Wellness / Adult Well Visits	74.2	50.0	74.2	74.8
Annual K, Cr/BUN testing with ACE, ARB	86.8	92.0	86.8	87.8
Annual K, Cr/BUN testing with Digoxin	100.0	92.0	100.0	91.8
Annual K, Cr/BUN testing with diuretic	88.1	92.0	88.1	88.2
Asthma / Controller	86.5	90.0	86.5	92.1
Baby Well Visits	100.0	94.0	100.0	99.9
* Breast Cancer Screening	79.8	90.0	76.1	76.4
Childhood Imm / DTaP	88.9	96.0	88.9	98.9
Childhood Imm / Hepatitis B	95.2	96.0	95.2	99.6
Childhood Imm / HIB	94.4	96.0	94.4	99.1
Childhood Imm / IPV	94.4	96.0	94.4	99.1
Childhood Imm / MMR	83.3	97.0	83.3	97.8
Childhood Imm / VZV	88.9	97.0	88.9	96.9
Chlamydia Screening	14.8	50.0	14.0	38.6
* Clinical Depression Screen/Plan	61.9	51.8	58.4	69.4
* Colorectal Cancer Screening	75.0	90.0	75.0	76.7
Congestive Heart Failure or Renal Disease	85.5	65.0	80.6	87.0
CVC BP <140/90	84.6	75.0	84.6	80.2
Depression Remission	0.0	0.0	0.0	14.7

Measure	Non-Compliant Reason	Last Test Date	Test Result	Due Date	Treatment Plan
Influenza Vaccination	Patient has no record of receiving influenza immunization between August 1 2016 and March 31 2017.			OVERDUE	Administer immunization, document patient refusal or add date of external immunization if one is available w ithin the EHRor patient records.
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Adolescent Well Visits	No well visit this year.	8/11/2015		OVERDUE	Complete well visit by the end of the year.
Clinical Depression Screening	Patient has not received a screening for depression in the current measurement year, OR patient has been screened in the current measurement year and has a score above 15, BUT does not have a follow -up plan documented.			OVERDUE	Perform depression screening if one has not been peformed w ithin the measurement year ; if score is >15, document a follow -up plan that includes one or more of the follow ing: 1) depression follow -up visit 2) suicide risk assessment; 3) referral to behavioral health provider; 4) depression medication; 5) other depression inter ventions and treatments.

Partial scorecard for a family practice group
Includes measure, 12-month rolling compliance rate, target, calendar year compliance rate and specialty average rate of compliance

Patient outreach list for family practitioner
Includes measure name, reason for non-compliance, last date and result, due date, and recommended action plan to resolve the gap

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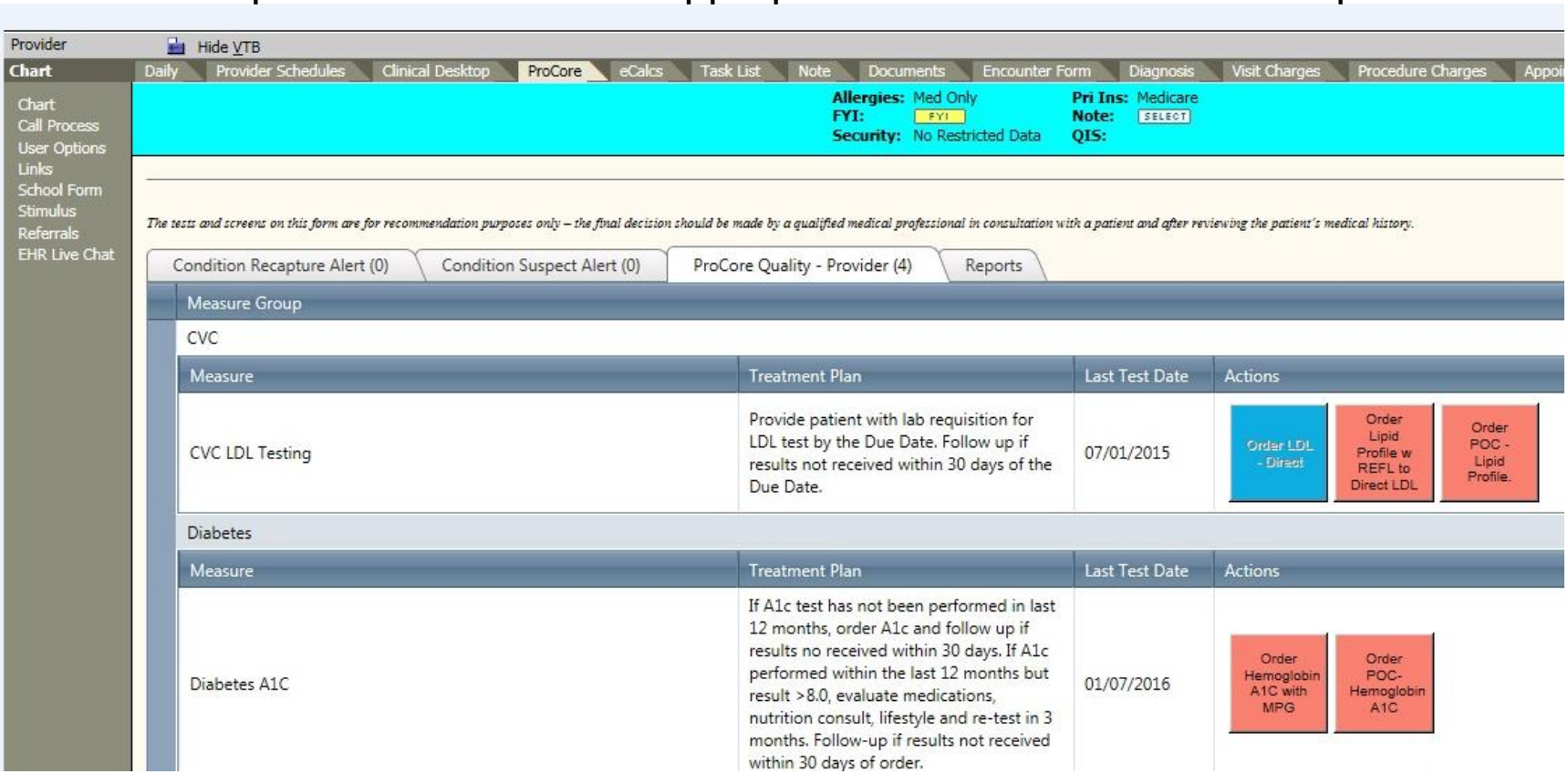
ProCORE Patient Snapshot

- ProCORE tab is embedded into the patient's electronic health record to identify quality measures that require attention during the patient's visit.
- Enables providers to take the appropriate action to address the open alert.



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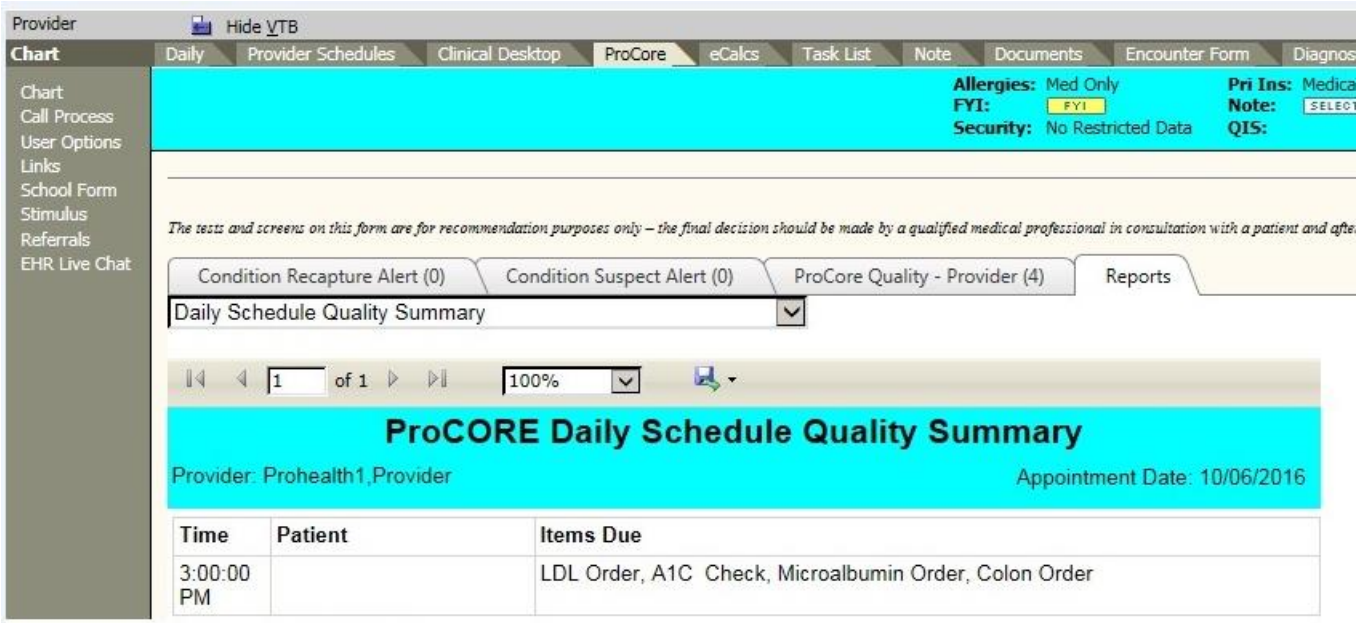
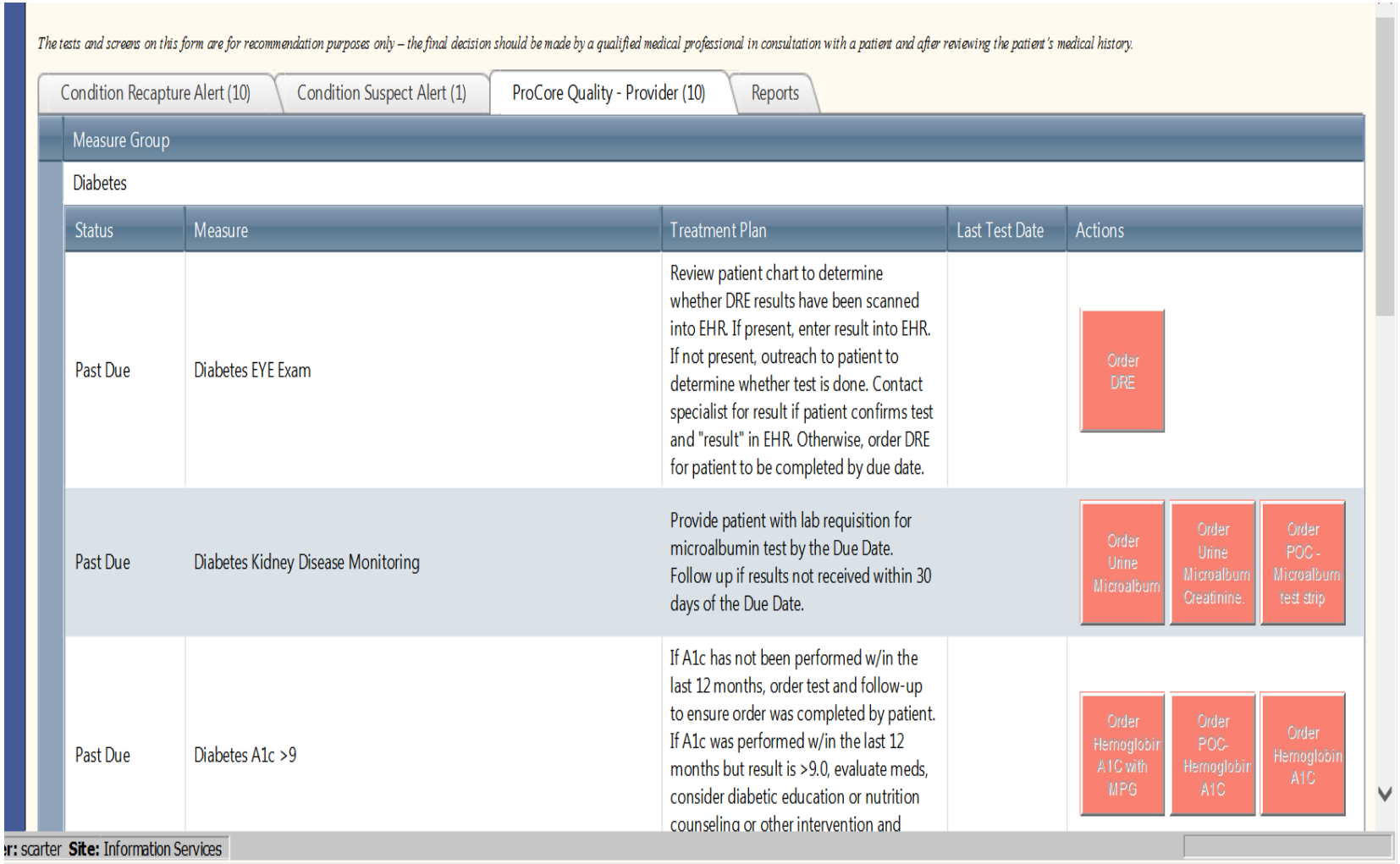
ProCORE Reporting Snapshot

- ProCORE reports enable the team to identify gaps for all patients on the daily schedule
- These are used for pre-visit planning and in daily huddles to optimize the efficiency and effectiveness of the visit



ProCORE: Point-of-Care Diabetes Gap Alerts



The tests and screens on this form are for recommendation purposes only – the final decision should be made by a qualified medical professional in consultation with a patient and after reviewing the patient's medical history.

Condition Recapture Alert (10) | Condition Suspect Alert (1) | ProCore Quality - Provider (10) | Reports

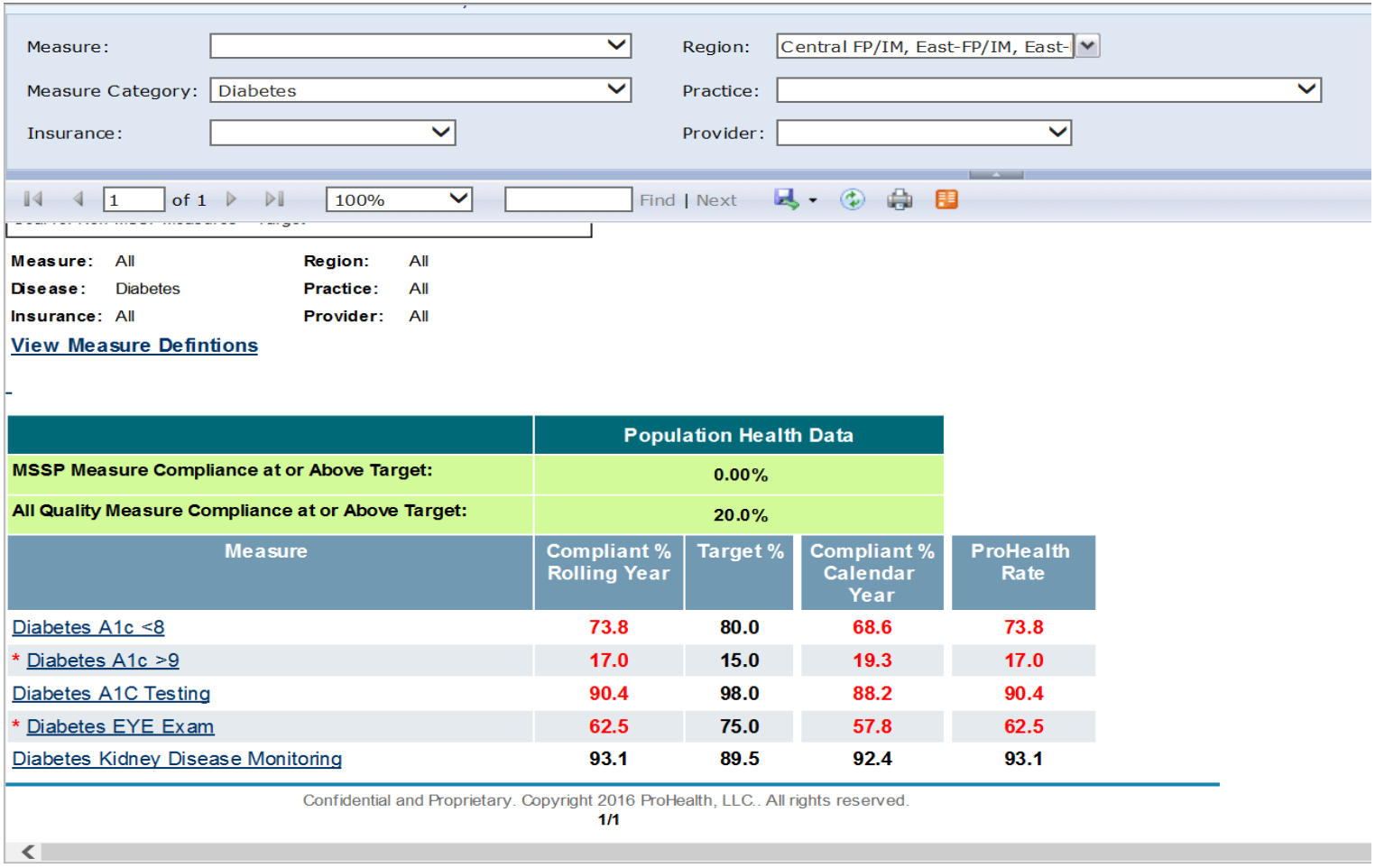
Measure Group: Diabetes

Status	Measure	Treatment Plan	Last Test Date	Actions
Past Due	Diabetes EYE Exam	Review patient chart to determine whether DRE results have been scanned into EHR. If present, enter result into EHR. If not present, outreach to patient to determine whether test is done. Contact specialist for result if patient confirms test and "result" in EHR. Otherwise, order DRE for patient to be completed by due date.		Order DRE
Past Due	Diabetes Kidney Disease Monitoring	Provide patient with lab requisition for microalbumin test by the Due Date. Follow up if results not received within 30 days of the Due Date.		Order Urine Microalbum; Order Urine Microalbum Creatinine; Order POC - Microalbum test strip
Past Due	Diabetes A1c >9	If A1c has not been performed w/in the last 12 months, order test and follow-up to ensure order was completed by patient. If A1c was performed w/in the last 12 months but result is >9.0, evaluate meds, consider diabetic education or nutrition counseling or other intervention and		Order Hemoglobin A1C with MPG; Order POC-Hemoglobin A1C; Order Hemoglobin A1C

r: scarter **Site:** Information Services

ProHealth™ PHYSICIANS Part of OptumCare®

Clinical Performance Drilldown: Diabetes Measures



Measure: | Region: Central FP/IM, East-FP/IM, East-
Measure Category: Diabetes | Practice:
Insurance: | Provider:

1 of 1 | 100% | Find | Next

Measure: All **Region:** All
Disease: Diabetes **Practice:** All
Insurance: All **Provider:** All

View Measure Defintions

	Population Health Data
MSSP Measure Compliance at or Above Target:	**0.00%**
All Quality Measure Compliance at or Above Target:	**20.0%**

Measure	Compliant % Rolling Year	Target %	Compliant % Calendar Year	ProHealth Rate
Diabetes A1c <8	73.8	80.0	68.6	73.8
* Diabetes A1c >9	17.0	15.0	19.3	17.0
Diabetes A1C Testing	90.4	98.0	88.2	90.4
* Diabetes EYE Exam	62.5	75.0	57.8	62.5
Diabetes Kidney Disease Monitoring	93.1	89.5	92.4	93.1

1/1

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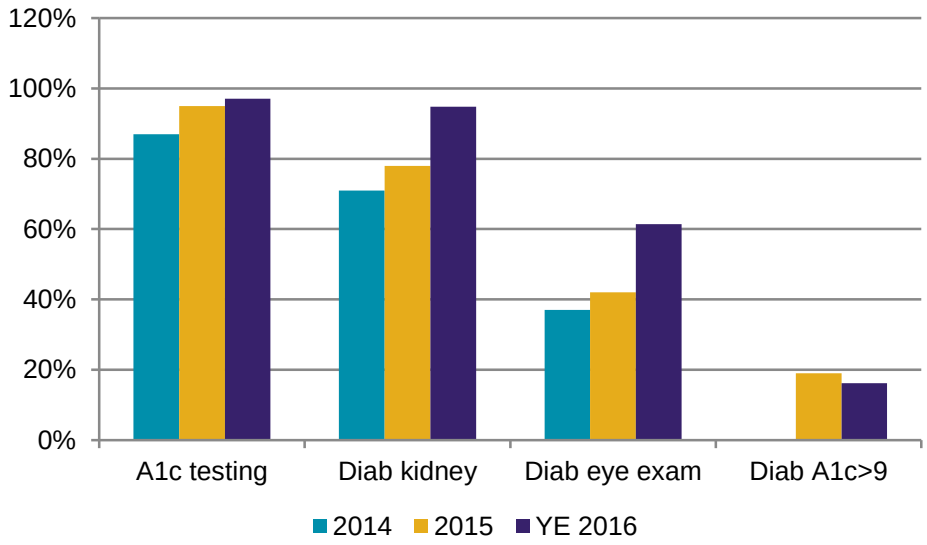
Clinical Performance Results

- Based on HEDIS/Stars definitions
- Success = % of our patients who are “at goal” for their condition based on standard industry-approved clinical guidelines such as the American Diabetes Association, U.S. Preventive Services Task Force, National Heart, Lung, and Blood Institute, etc.
- At the end of each year, we review our year-end actual results and apply a standard improvement formula to establish the targeted improvement level and goal for the following year.
- Consistent improvement



ProHealth™ PHYSICIANS Part of OptumCare®

ProHealth Compensation Model – Aligning our Incentives

- Historical compensation model was almost entirely FFS
  - Net clinical performance dollars obtained by the entire group credited to individual practice financials based on personal performance
  - Historically very difficult for providers to gauge how to prioritize their efforts
- In P4P, total dollars distributed to the physicians in 2003, were under $500K but grew to ~$5M prior to the recent conversion to Shared Savings Contracts
- In 2018, ProHealth will change its compensation model and benchmark to the market
  - 20% of Total Cash Compensation will be aligned to incentives
  - 30% of those incentives aligned to the performance in Quality Metrics
  - The model is revenue neutral in that the dollars forfeited by the lower-performing providers will additionally reward the higher-performing providers

Primary Care Clinical Quality Metrics

IM/FP	Measure and associated targets for 2018	Target
1	Breast Cancer Screening	90%
2	Adult Weight Screening	90%
3	Adult Wellness / Adult Well Visits	50%
4	Colorectal Cancer Screening	74%
5	Diabetes A1c <8	80%
6	Diabetes A1c >9	13%
7	Diabetes A1C Testing	98%
8	Diabetes EYE Exam	75%
9	Diabetes Kidney Disease Monitoring	90%
10	Hypertension / Controlling Blood Pressure	83%
11	Statin Therapy	25%
12	Adult immunizations: pneumonia	90%
13	CHF/Renal Disease: BMP, CMP, Renal Panel	65%
14	Asthma / Controller	90%
15	Clinical Depression Screen/Plan	52%

Peds	Measure and associated targets for 2018	Target
1	Asthma / Controller	90%
2	Clinical Depression Screen/Plan	52%
3	Childhood Imm / DTaP	96%
4	Childhood Imm / Hepatitis B	96%
5	Childhood Imm / HIB	96%
6	Childhood Imm / IPV	96%
7	Childhood Imm / MMR	97%
8	Childhood Imm / VZV	97%
9	Chlamydia Screening	50%
10	Pediatric Depression	90%
11	Pediatric Obesity	70%
12	Wellness / Adolescent Well Visits	89%
13	Wellness / Childhood Well Visits	93%
14	Pediatric Development (MCHAT)	90%
15	Adolescent immunization: Meningococcal and Tdap	81%

Patient Experience, Clinical Quality and Affordability Incentive Details

Categories, Historical Distributions and Resulting Bonus

Performance Category	Distribution	Incentive Value	Plan Bonus
Outstanding	10%	100%	2 shares/FTEs
Effective	23%	100%	1 share/FTEs
Acceptable	33%	100%	none
Needs Improvement	18%	50%	none
Poor	15%	0%	none

These are self funding incentives, differentiated by performance.

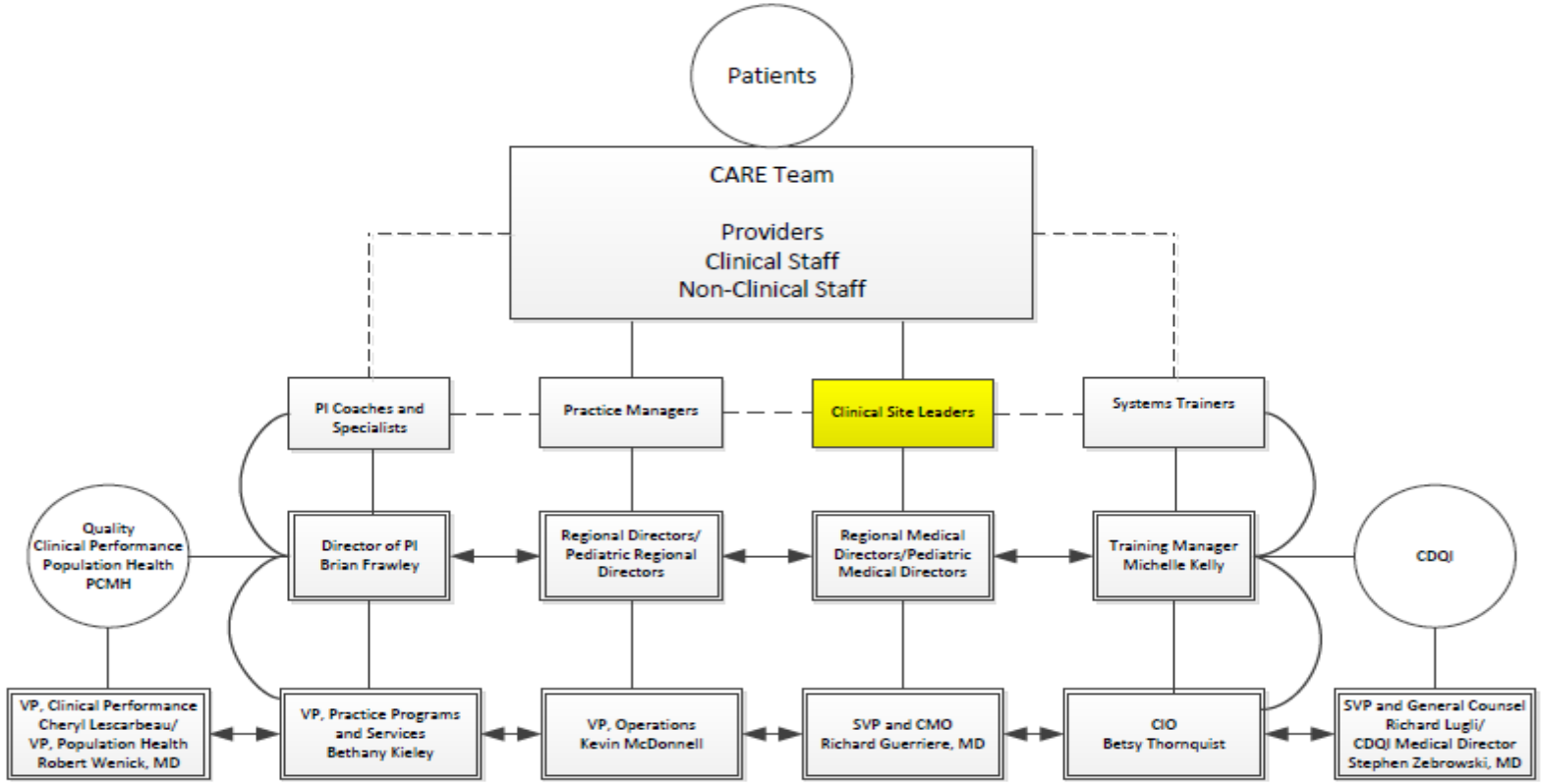
2018 Category Thresholds by Incentive

Performance Category	Patient Experience Score	Adult Clinical Quality Score	Ped. Clinical Quality Score	Affordability Score
Outstanding	>=89%	12,13,14,15	14,15	>=96%
Effective	>= 85% and < 89%	10,11	12,13	>= 91% and < 96%
Acceptable	>= 79% and < 85%	7,8,9	10,11	>= 85% and < 91%
Needs Improvement	>= 75% and <79%	5,6	9	>= 79% and < 85%
Poor	< 75%	0-4	0-8	< 79%

Regional Medical Directors and Practice Support

- **Regional Medical Directors, Regional Practice Directors, Process Improvement Specialists, and EHR Trainers** visit practices every two months
  - Meet with Practice Managers and all providers to discuss strategies and workflows at the individual practice to improve performance in: Quality Metrics, HCC coding, Patient Satisfaction and Gaps in Care
  - Process Improvement works with practice to design and implement best practices
  - EHR education and training upon provider request
  - Identifies and solutions for barriers to performance
- This role of the Regional Medical Director is a 0.3 FTE (11 hours/week)
  - Provides bidirectional flow of information for providers' issues, concerns, and barriers
  - Practicing physicians have "street cred"; 70% of their role is still clinical
  - Monthly planning meetings to review approach to the organization and to prioritize practices that need additional support

Practice Support Organizational Chart



2018: ProHealth and IPA Care Coordination and Medical Management Programs…At-a-Glance

Current Program	Current Description	As of 1/1/2018	Practice Impact
TIC and ER Outreach Calls Program limited to hospitals that provide access to discharge data	Central office nurses make TIC and ER outreach calls within 2 days of notification of the patient's discharge	• Central office nurses will continue to perform TIC & ER follow-up for commercial and Medicare Advantage patients as required under PH's contractual obligations	• Practices should continue to perform TIC and ER follow-up for MSSP and Medicaid patients. Standard templates are utilized by all personnel who conduct TIC and ER calls; training is available on the ProHealth Learning Center titled, "PH New Discharge EHR Note Form TIC and ER Care Coordination. • Send "all" Case Management referrals through EHR Order; the Central Referral Coordinator will coordinate with the appropriate Health Plan
Quality Gap Closure	Central Office nursing and Pharm-D staff assist with payer aligned gap closure for Commercial and Medicare Advantage Shared Savings Contracts	• Central Office nursing staff focus on quality gap opportunities and conduct outreach calls to patients and/or practice staff • Pharm D collaborates with Health Plans re medication adherence and other Rx measures	• Practices should continue to monitor clinical performance reports and ProCore • Outreach to patients in need of AWV • Address gaps at morning huddle

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Our Results

ProHealth's Population Data Trends

- Active Patient Population and Patients with Type 2 Diabetes
  - Both populations are trending up but ProHealth's prevalence of Type 2 DM is increasing from 8.4% to 10.4%
  - Resumption of practice acquisitions into ProHealth after the Optum transaction
  - Provider Drilldown tool enabled in August of 2015 for Quality Gap closure and Patient Outreach uses a 3 year active patient panel
  - More patients are being called in for well visits, follow-up visits, and diagnostic tests
  - ProCORE tool enabled in August of 2016 to address HCC and Quality gaps in care resulting in greater diagnostic specificity of more patients

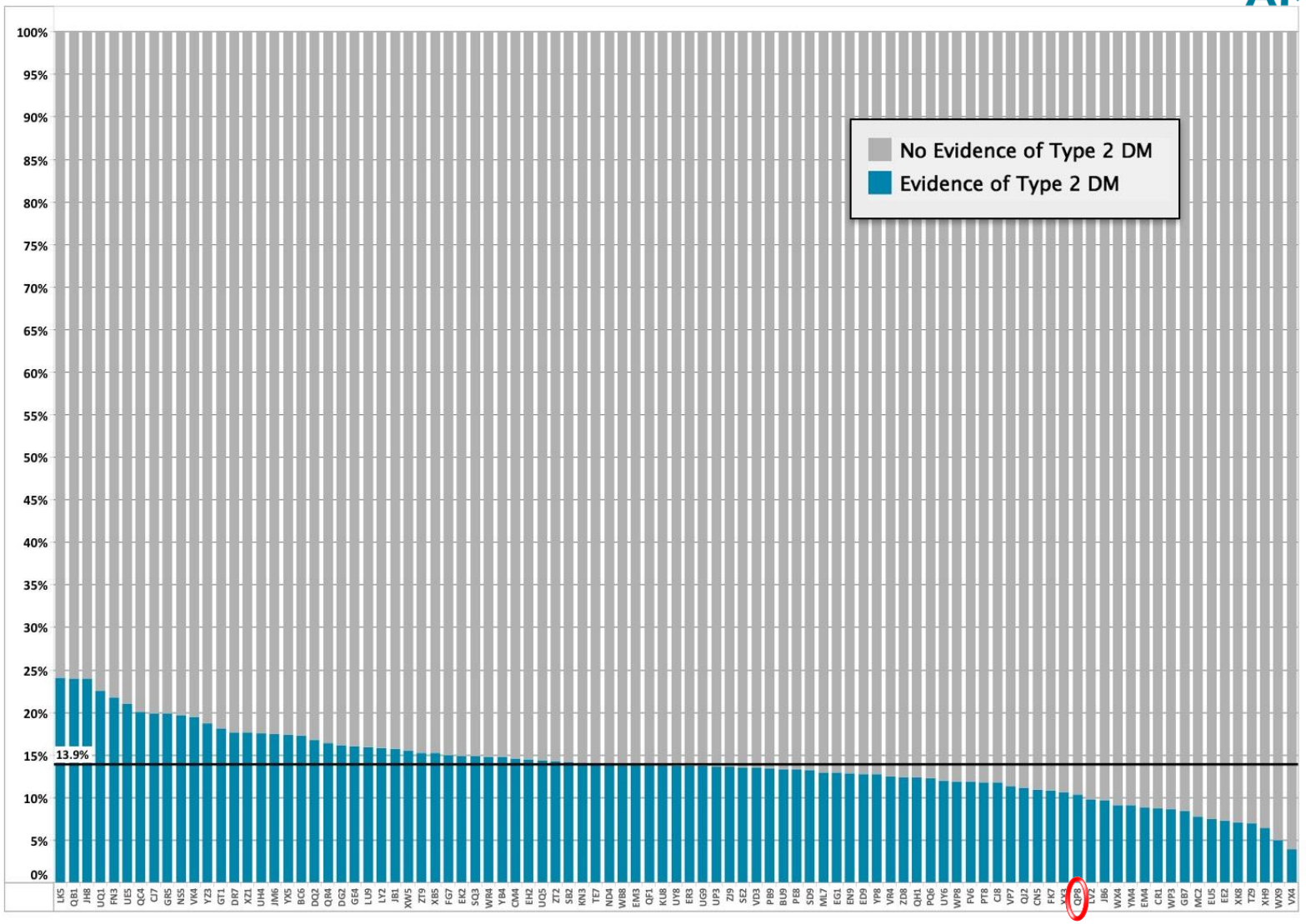
T2G Data Reported – Group QP8

Ending Quarter/Measurement Period	Core (Bundle) Track												
	Active Patients	Patients with Type 2 Diabetes	Prevelance of Type 2 Diabetes	Patients with last HbA1C < 8%	HbA1c Control	Patients with last ambulatory in-office BP < 140/90	BP Control	Patients with statin prescribed or reason not to receive statin	Lipid Management (Statin Rx)	Patients with medical attention for nephropathy	Medical Attention for Nephropathy	Patients compliant in all four measures (T2G Bundle)	T2G Diabetes Care Bundle
2016 Q1 (04/01/2015-03/31/2016)	157,075	13,147	8.4%	10,590	80.6%	12,447	94.7%	9,046	68.8%	12,079	91.9%	6,808	51.8%
2016 Q2 (07/01/2015-06/30/2016)	156,727	14,937	9.5%	12,057	80.7%	14,100	94.4%	9,602	64.3%	13,536	90.6%	7,176	48.0%
2016 Q3 (10/01/2015-09/30/2016)	158,724	15,849	10.0%	12,725	80.3%	14,925	94.2%	10,652	67.2%	14,571	91.9%	8,079	51.0%
2016 Q4 (01/01/2016-12/31/2016)	157,001	16,222	10.3%	13,004	80.2%	15,182	93.6%	10,788	66.5%	15,067	92.9%	8,240	50.8%
2017 Q1 (04/01/2016-03/31/2017)	159,487	16,219	10.2%	12,726	78.5%	15,086	93.0%	10,338	63.7%	14,489	89.3%	7,654	47.2%
2017 Q2 (07/01/2016-06/30/2017)	158,247	16,384	10.4%	12,732	77.7%	15,208	92.8%	10,250	62.6%	14,669	89.5%	7,469	45.6%

Prevalence of Type 2 Diabetes

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)

1.27 million people with type 2 diabetes • 98 AMGA members reporting



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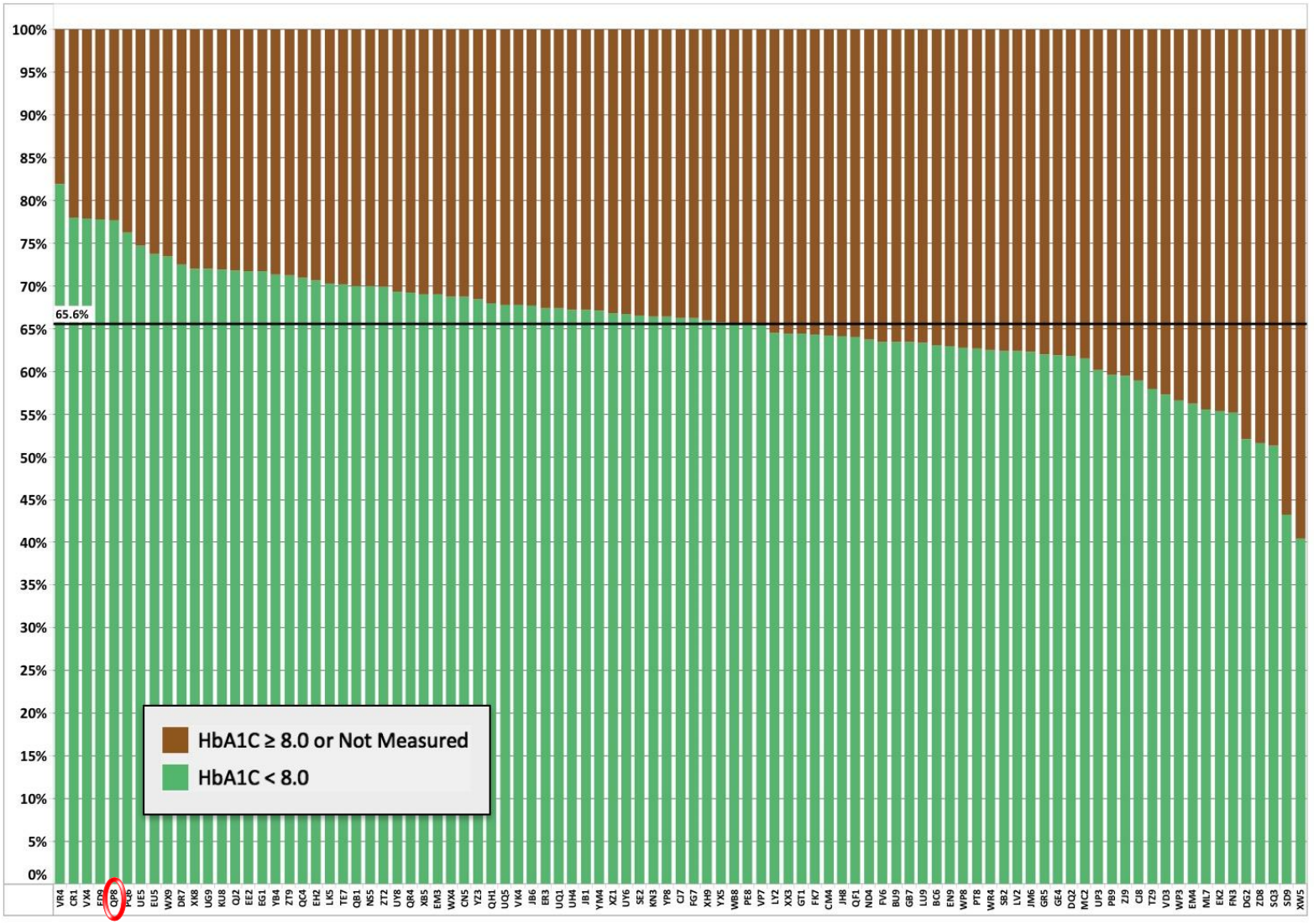
ProHealth's Core Bundle Data Trends

- ProHealth's results in the Together 2 Goal Core Track show an upward trend in the number of patients getting to:
  - HgA1c <8%
  - Last Ambulatory BP <140/90
  - Number of Diabetics with a statin prescribed/documented reason for refusal
  - Number of Diabetics that received medical attention for nephropathy
- But…there was a downward trend in the percentage of our diabetics achieving those goals
- The T2G Bundle Measure shows an initial upward trend followed by a downward trend in the both the number and percentage of diabetic patients compliant with all four measures
- Despite the downward trend in the T2G Bundle percentage, ProHealth Physicians, CT finished 8th out of 87 AMGA members reporting

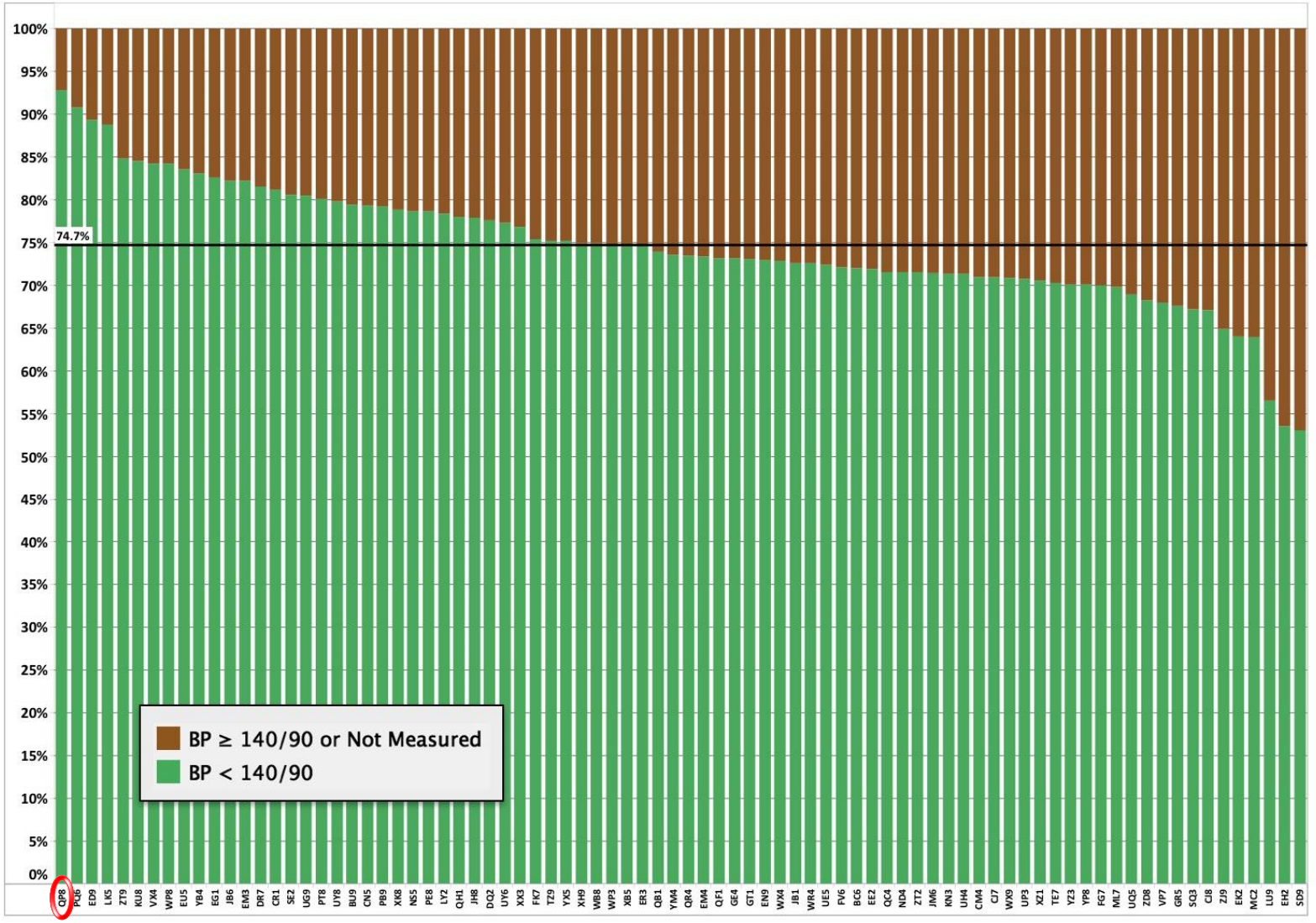
Glycemic Control

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)
1.27 million people with type 2 diabetes • 98 AMGA members reporting



Blood Pressure Control

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)
1.14 million people with type 2 diabetes • 87 AMGA members reporting



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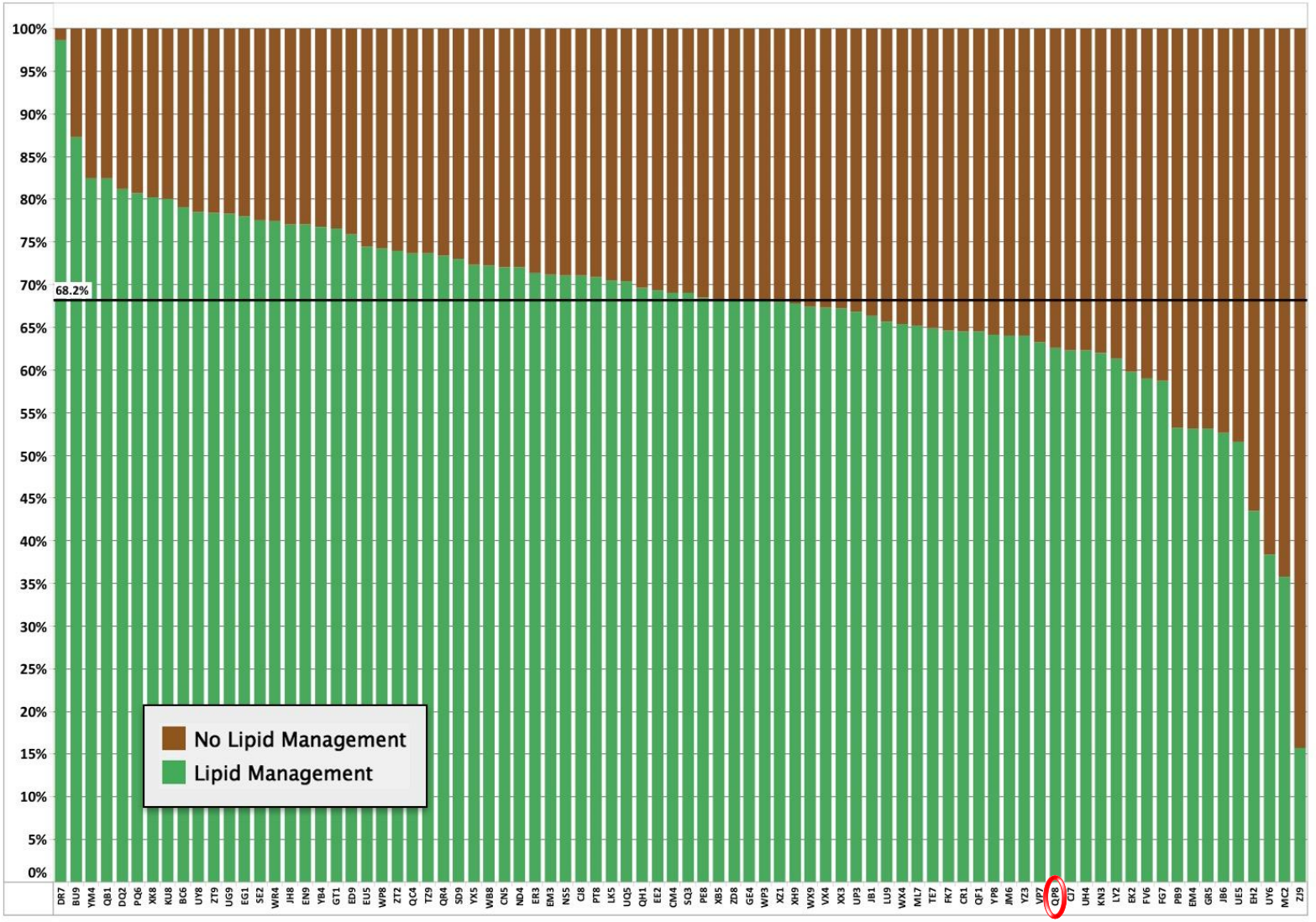
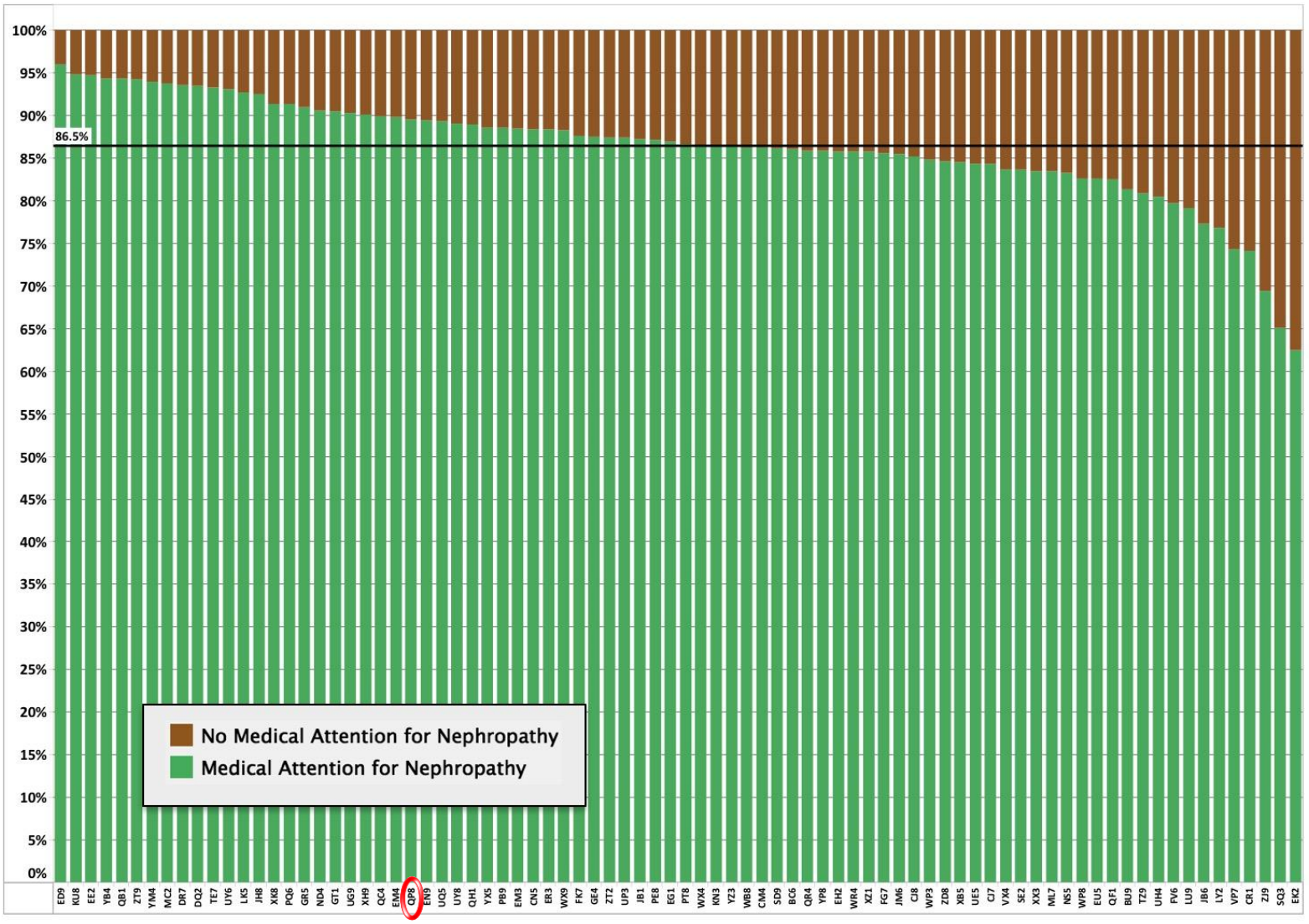
Lipid Management (Statin Rx)

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)
1.14 million people with type 2 diabetes • 87 AMGA members reporting



Medical Attention for Nephropathy

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)
1.14 million people with type 2 diabetes • 87 AMGA members reporting



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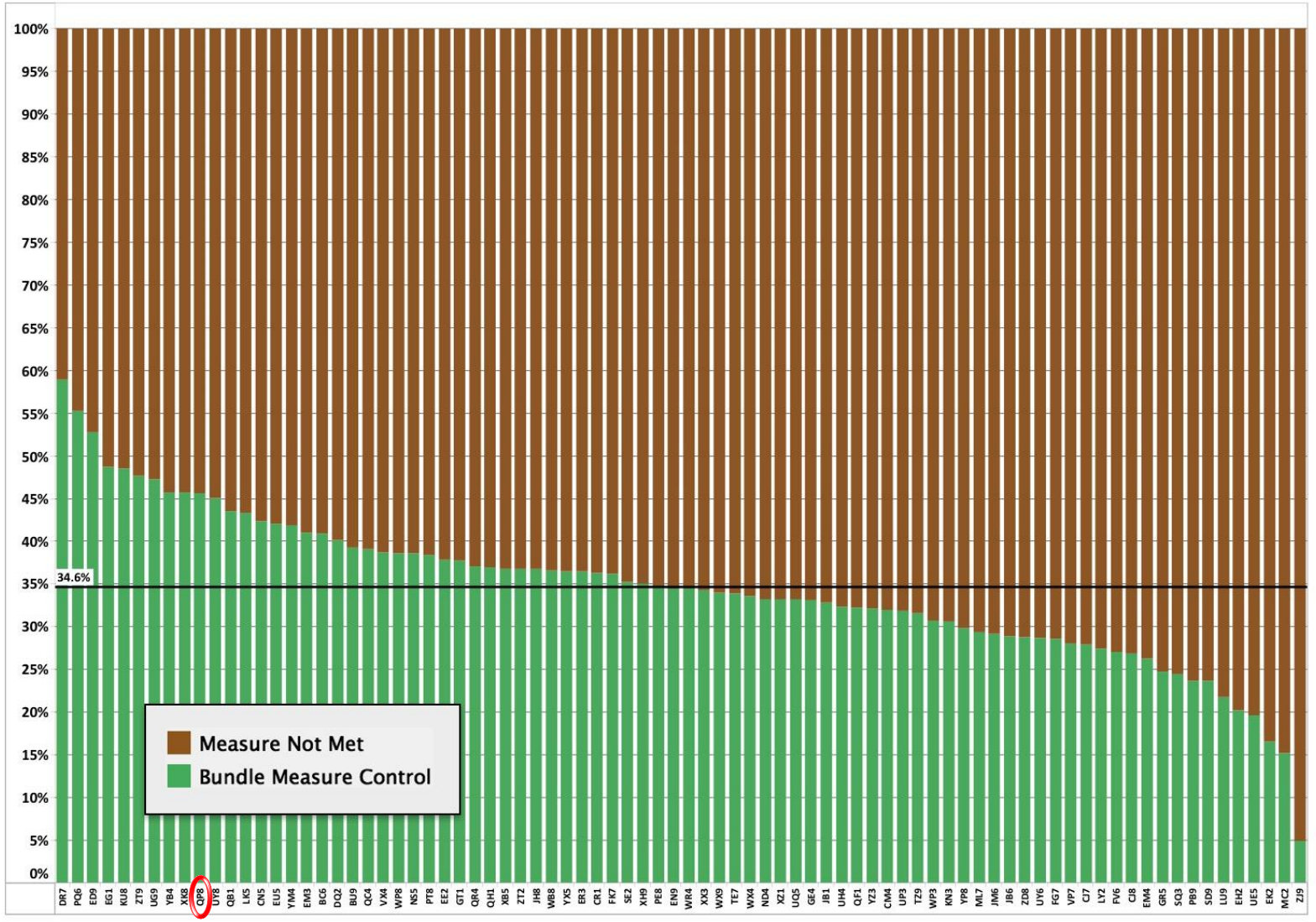
Together 2 Goal Bundle Measure

AMGA Foundation Together 2 Goal® Campaign • 2017 Q2 (7/2016 – 6/2017)
1.14 million people with type 2 diabetes • 87 AMGA members reporting



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Lessons Learned & Key Takeaways

Lessons Learned

- The strategy of target setting for quality metrics
  - ProHealth's internal target for statins was set at a 25% threshold
  - ProHealth also missed this measure in MSSP as part of our quality score
  - Rewarding providers within the organization may sacrifice overall performance

- Reconciling payer provided member data
  - Lack of alignment between payer-defined attributed members and provider-defined patient population
    - Ex. Patients that payer delineates as attributed, but no office visits in 3 years (or ever)
  - Reconciliation requires philosophical discussion, delineation of what makes someone a ProHealth "patient"
  - Resources required to outreach to newly identified, non-engaged eligible members

Key Takeaways

- ProHealth's overall success in clinical performance is largely the result of a longitudinal effort to deliver quality care to our diabetic population and beyond
  - Provider Education
  - Clinical Performance Reports
  - Clinical tools to provide outreach and point-of-care support to the providers
  - Compensation incentives
  - Supportive clinical leadership structure
- ProHealth will encounter challenges as a FFS organization if it does not continue to evolve its care delivery model
  - Our work in Quality uses the same tool (ProCORE) as our HCC Coding initiative
  - Providers are doing significantly more "Total Gap Closures" at the point of care over this period, and our present clinical model in FFS presents capacity limitations
  - 2018 Model Clinic pilot concept in the planning stages to support ProHealth's transition to value-based care

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Thank you and questions

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