

Together 2 Goal.®

AMGA Foundation National Diabetes Campaign

Monthly Campaign Webinar

May 17, 2018

TODAY'S WEBINAR

- **Together 2 Goal® Updates**
 - Webinar Reminders
 - Together 2 Goal® Innovator Track Eye Care Cohort
 - Innovator Track CVD Cohort Kickoff
 - Q1 2018 Data Reporting
 - Social Media Move
- **Quality Improvement and the Together 2 Goal® Bundle**
 - John Cuddeback, M.D., Ph.D. of AMGA Analytics
 - Jill Powelson, RN CPC, M.B.A., M.P.H. of AMGA Analytics
 - Jennifer Obenrader, Pharm.D., CDE of Premier Medical Associates
 - Frank Colangelo, M.D., M.S.-HQS, FACP of Premier Medical Associates
 - Tracy Godfrey, M.D. of Mercy Joplin
 - Rose Peacock, B.A. of Mercy Joplin
- **Q&A**
 - Use Q&A or chat feature

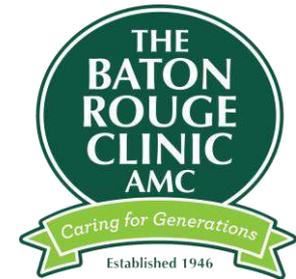


WEBINAR REMINDERS

- Webinar will be recorded today and available the week of May 21st
– www.Together2Goal.org
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen



TOGETHER 2 GOAL[®] INNOVATOR TRACK EYE CARE COHORT



INNOVATOR TRACK CVD COHORT KICKOFF



A snapshot of the patient panel sharing their experiences with the group

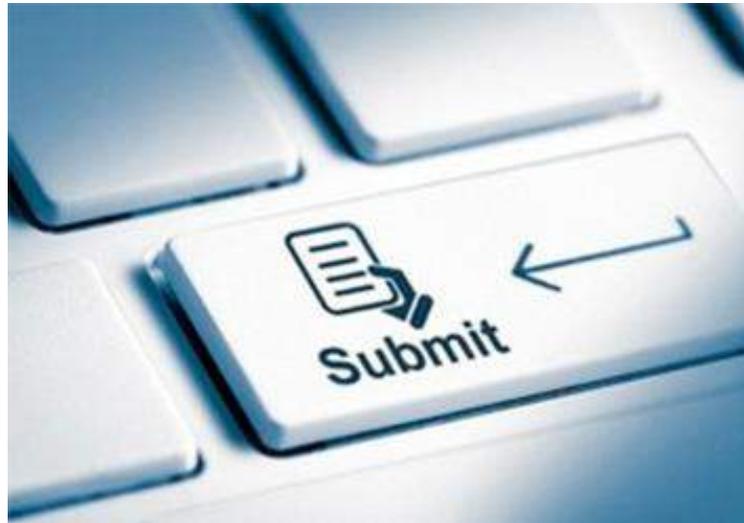
May 14-16, 2018

Our 12 participating groups:

- Discussed primary and secondary prevention of CVD in patients with Type 2 diabetes
- Heard insights from a patient panel
- Brainstormed and developed actions plans
- Left ready to begin implementation

Q1 2018 DATA REPORTING

Q1 2018 Data is due **June 1!**



SOCIAL MEDIA MOVE

- We no longer post on our AMGAFhealth accounts.
- Follow @theAMGA on Facebook and Twitter to stay connected with us!



AMGA™

AMGA

@theAMGA Follows you

AMGA supports its members in enhancing population health and care for patients through integrated systems of care.



TODAY'S FEATURED PRESENTERS

**John Cuddeback, M.D.,
Ph.D.**



**Chief Medical Informatics
Officer
AMGA Analytics**

**Jill Powelson, RN, CPC, M.B.A.,
M.P.H.**



**Director, Clinical Translation
AMGA Analytics**

TODAY'S FEATURED PRESENTERS

**Frank Colangelo,
M.D., M.S.-HQS, FACP**



Chief Quality Officer
Premier Medical
Associates

**Jennifer Obenrader,
Pharm.D., CDE**



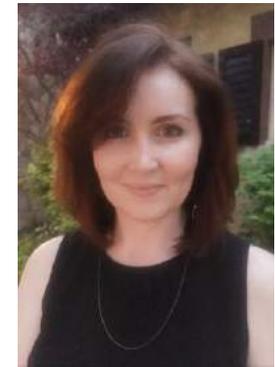
Clinical Pharmacist
Premier Medical
Associates

**Tracy Godfrey,
M.D.**



President, Mercy
Clinic Southwest
Missouri/Kansas
Mercy Joplin

**Rose Peacock,
B.A.**



Manager of Quality and
Service Improvement
Mercy Joplin



A4inFocus—
A mini-collaborative
focused on improving the
Together 2 Goal[®]
diabetes bundle measure

May 17, 2018

Analytics for Improvement (A4i) Collaborative

The Analytics for Improvement (A4i) Collaborative* is a forum for healthcare organizations to conduct meaningful, apples-to-apples comparative analyses and share knowledge, data-driven insights, and best practices. A4i is available exclusively to AMGA member organizations using Optum’s data and analytics platforms.



In-Person Meetings

Opportunity to network with peers at the spring and fall collaboratives

Webinars

“Virtual Collaborative meetings” between in-person meetings

A4i Community

- Convenient access to A4i Collaborative materials and reference documents
- Participants may post questions and easily engage in threaded discussions via email

Outreach and Consultation

- Assistance with data interpretation and supplemental analyses
- Best practices discovery, documentation, and translation

A4i Advisory Committee

- Provide direction for and feedback on analytical research with the objective of translating new research into practice

* Formerly known as Anceta

A4i = Analytics for Improvement, for AMGA members using Optum One

A4iinFocus = a learning collaborative focused on T2G diabetes bundle improvement

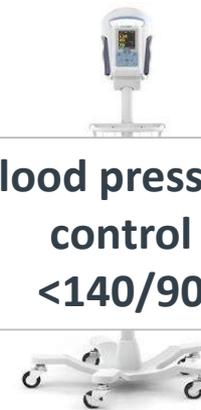
Together2Goal[®]



Bundle Measure

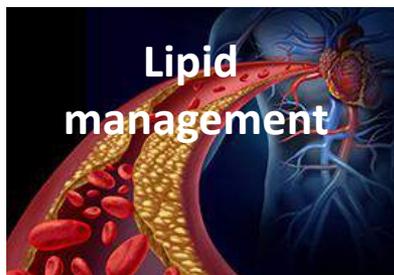


**A1c control
<8**



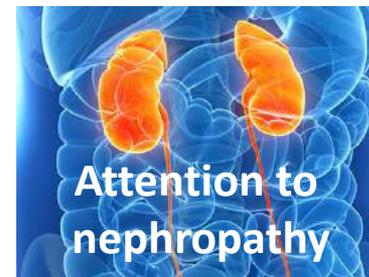
**Blood pressure
control
<140/90**

Photo credit: Welch Allyn/Medisave



**Lipid
management**

Photo credit: rsm.ac.uk



**Attention to
nephropathy**

Photo credit: NIDDK.nih.gov

Why a bundle measure?

- What would you want for yourself or your family member?
- Reflects the patient's perspective—holistic view
 - Address *all* key risk factors or care needs
- Encourages system perspective—no dropped balls
 - Are all contributors to the care process working together?
- More sensitive scale for assessing improvement
 - Amplifies variation in care process
 - Also amplifies errors in measurement

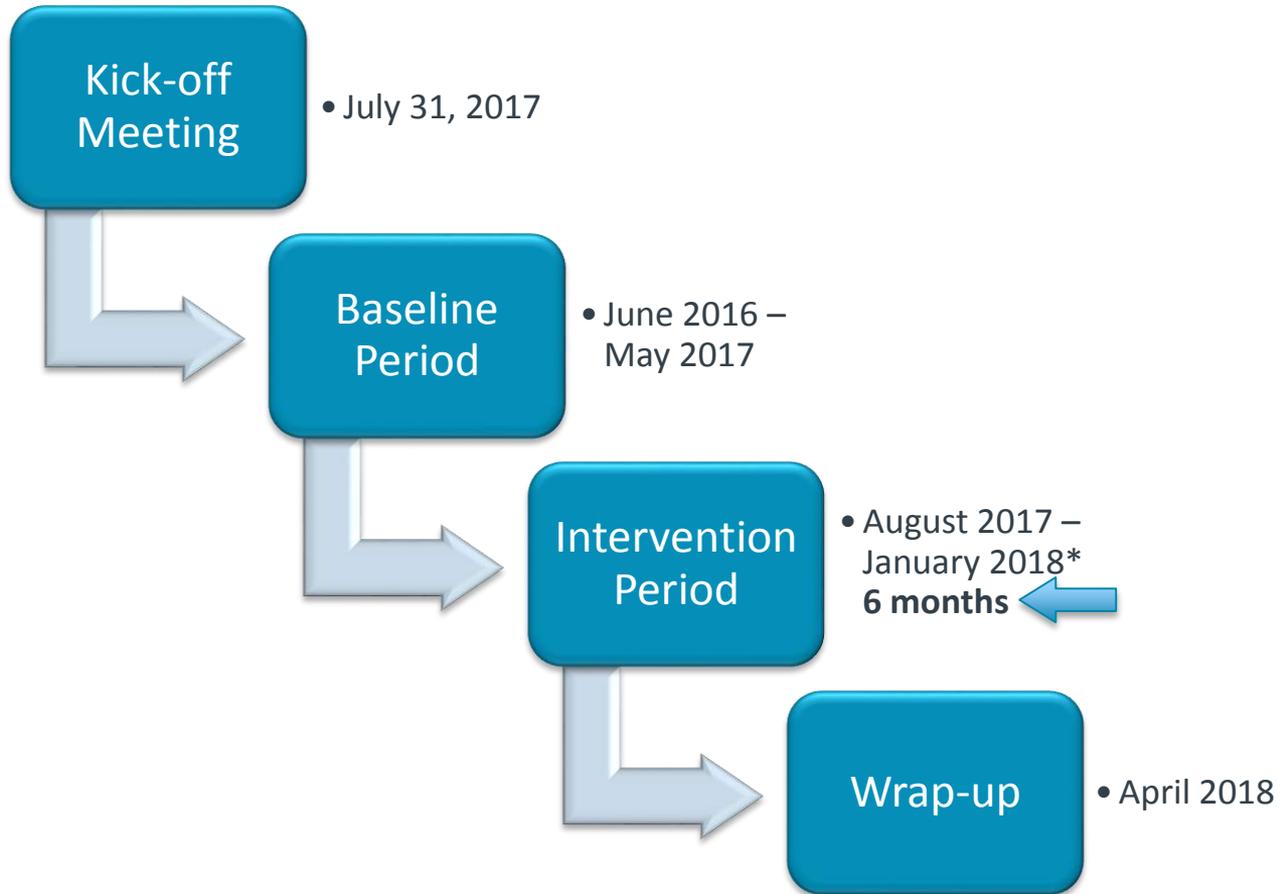
A4inFocus Learning Collaborative Framework



Optum[®] One Resources for Together 2 Goal[®]

| Performance Measurement/ Reporting | Identify Opportunities and Close Gaps | | | |
|---|---|--|---|---|
| | A1c | Blood Pressure | Nephropathy | Lipid Management |
| <p>Customizable Graph/Report Templates</p> <ul style="list-style-type: none"> • AMGA T2G Cohort Denominator • A1c Numerator • BP Numerator • Nephropathy Treatment Numerator • Lipid Management Numerator • Bundle Numerator <p>Self Guided Training/ User Manual</p> | <ul style="list-style-type: none"> • Identify high risk patients with “Leaky Bucket” rule of thumb queries • Leverage into registries | <ul style="list-style-type: none"> • BP “rounding” (precise measurement and recording of blood pressure) report | <ul style="list-style-type: none"> • Templates to identify intervention/ documentation opportunities • Leverage with registries | <ul style="list-style-type: none"> • Templates to identify intervention/ documentation opportunities • Leverage with registries |
| | Bundle Improvement Tools | | | |
| | Identify and learn from “positive deviants” (high-performing clinics/ sites of care in your organization) | | Identify and focus on patients who are “almost there” (i.e., meet 3 of 4 bundle component measures) | |

A4inFocus Timeline



*12 month periods ending August 2017, September, October, November, December and January 2018

A4inFocus

9 reporting organizations*



Mercy

Communities:

- East
- Forth Smith
- Joplin
- North Central
- West

Most Improved



PREMIER

MEDICAL ASSOCIATES

Highest Overall

SWEDISHAMERICAN

A DIVISION OF UW HEALTH



Lexington Clinic

* Six at Mercy (5 Communities + 1 additional pilot site), SwedishAmerican, Premier Medical Associates, Lexington Clinic

A4inFocus 6-month results (seasonally adjusted)

5 out of 9
improved



6 out of 9
improved



Blood pressure
control
<140/90

Image showing a white medical device on wheels, representing blood pressure control.

Photo credit: Welch Allyn/Medisave

9 out of 9
improved

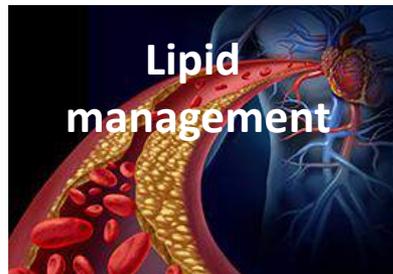


Photo credit: rsm.ac.uk

8 out of 9
improved

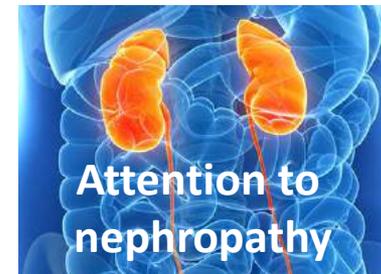


Photo credit: NIDDK.nih.gov

And **8** of the **9** improved
their **Bundle measure**
in just 6 months

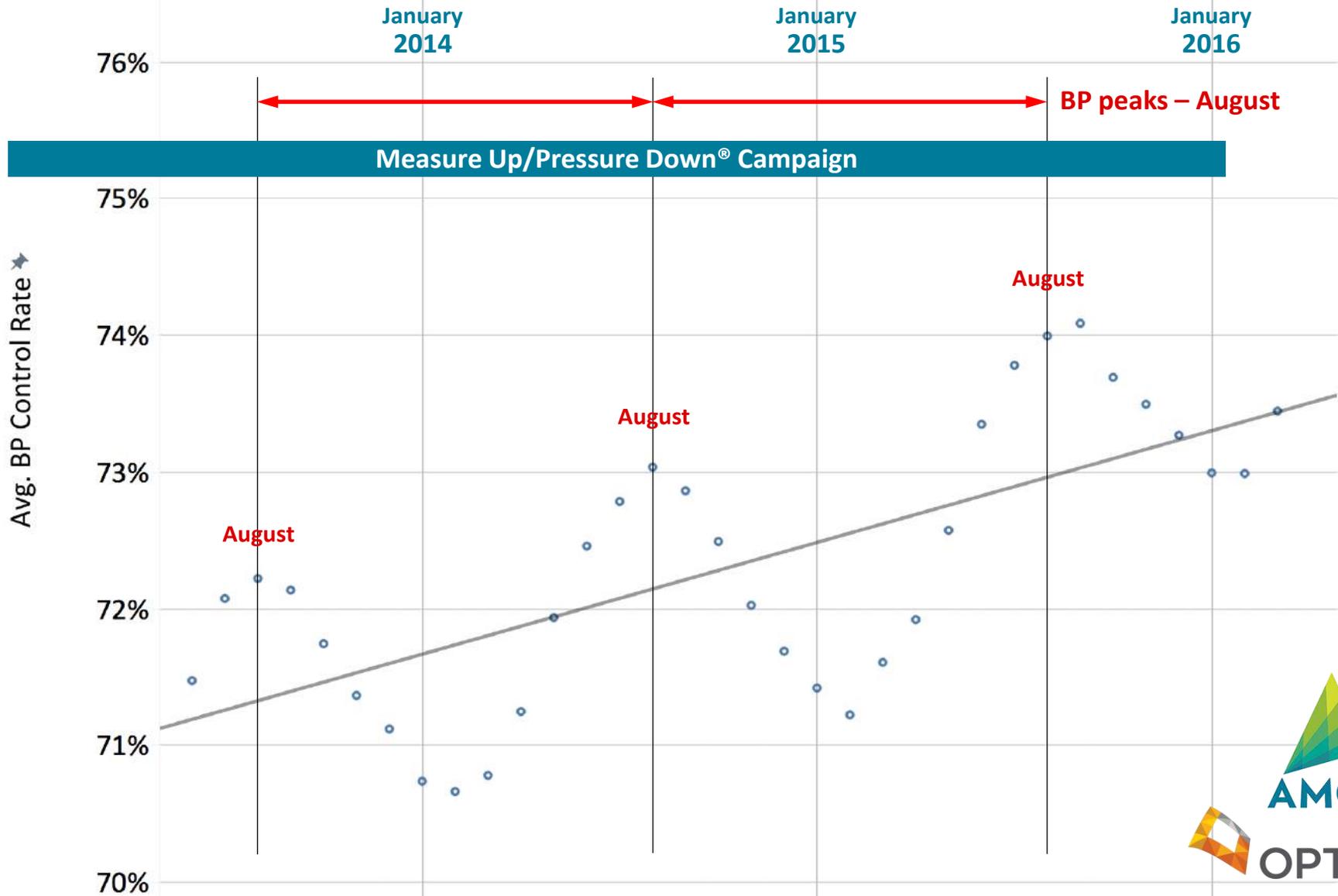


From 9 reporting organizations

Adjusting for Seasonal Variation

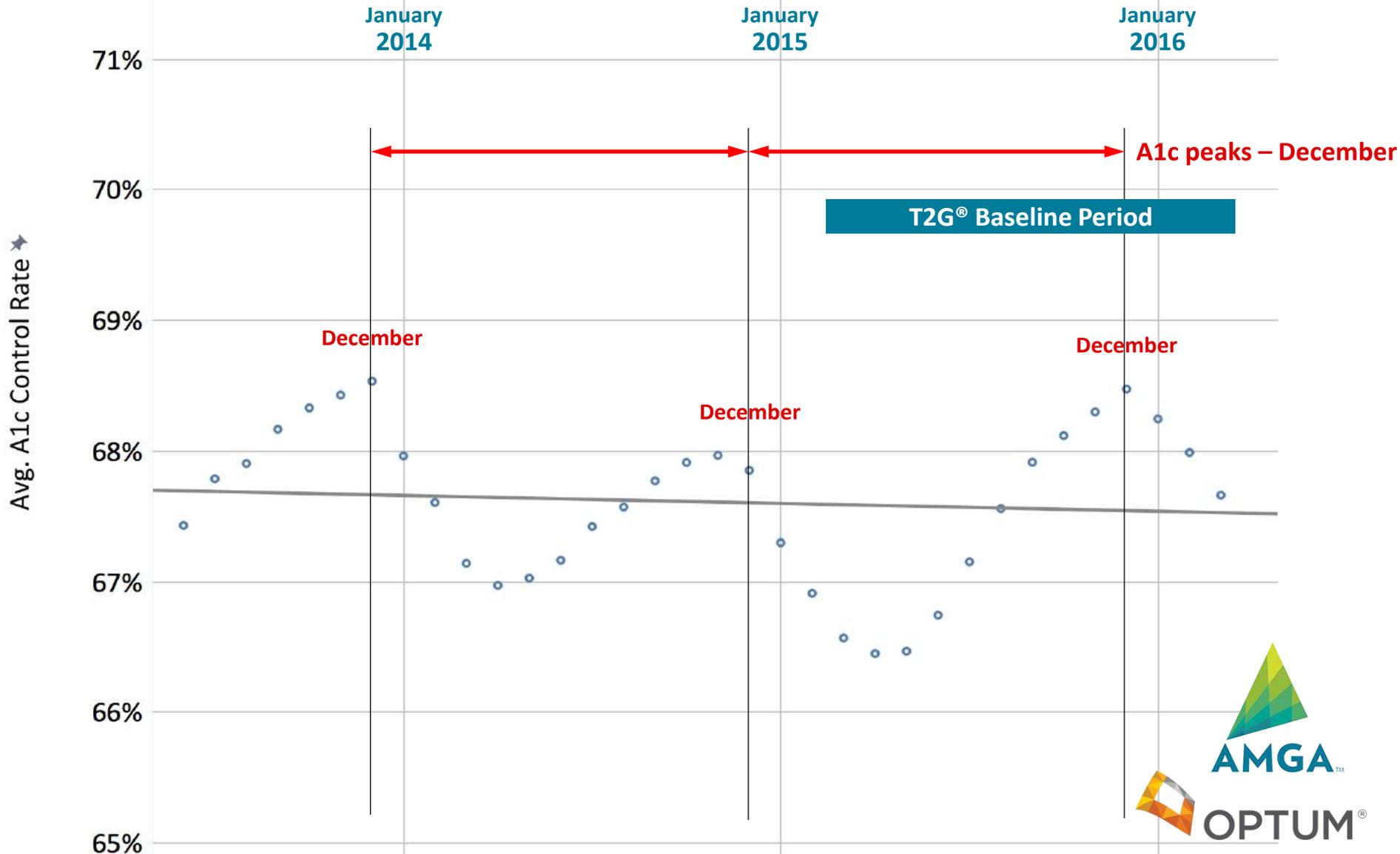
Variation in T2G BP Control Measure by Month: June 2013 – March 2016

1 million patients with type 2 diabetes across 29 AMGA member organizations using Optum One



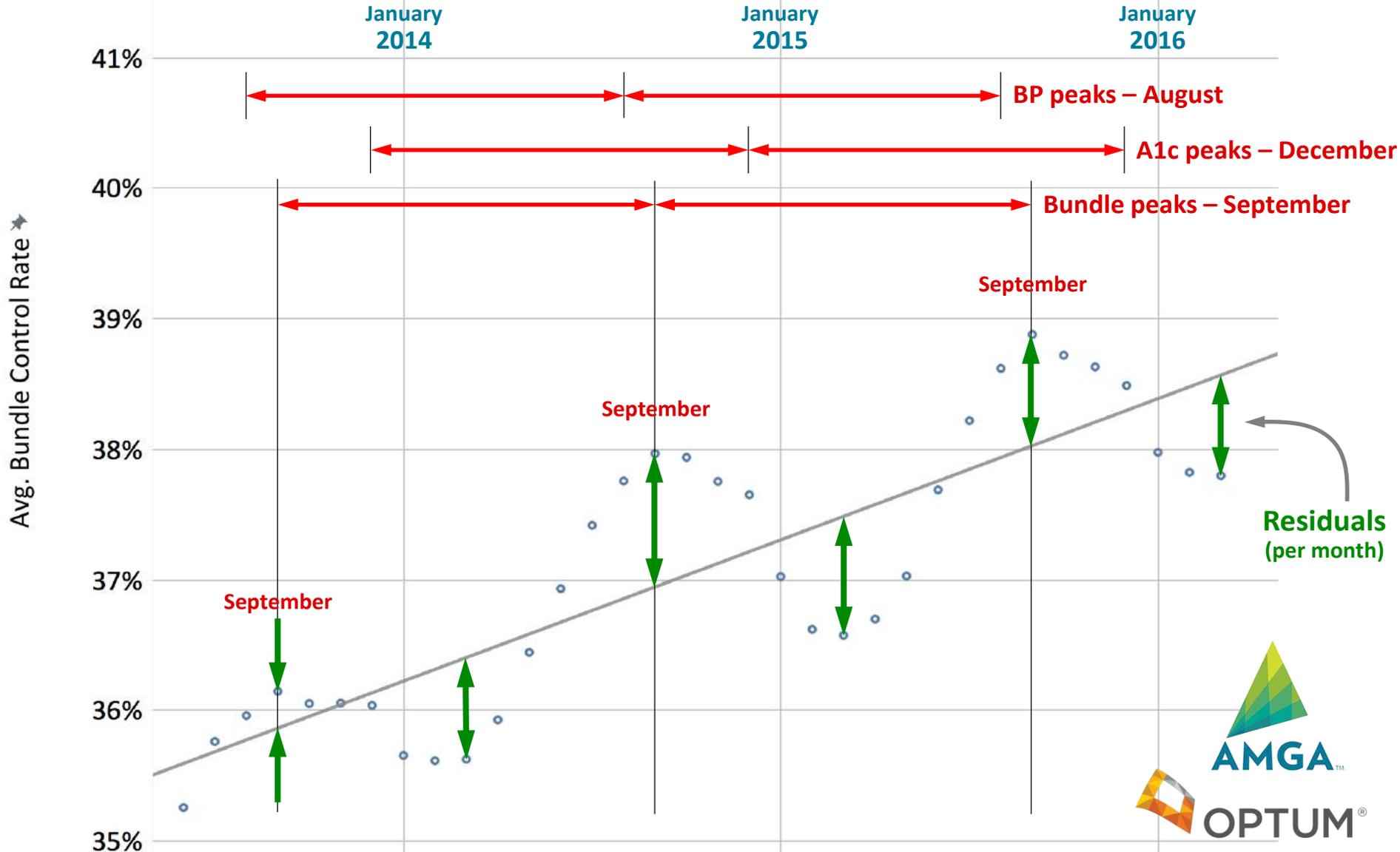
Variation in T2G A1c Control Measure by Month: June 2013 – March 2016

1 million patients with type 2 diabetes across 29 AMGA member organizations using Optum One

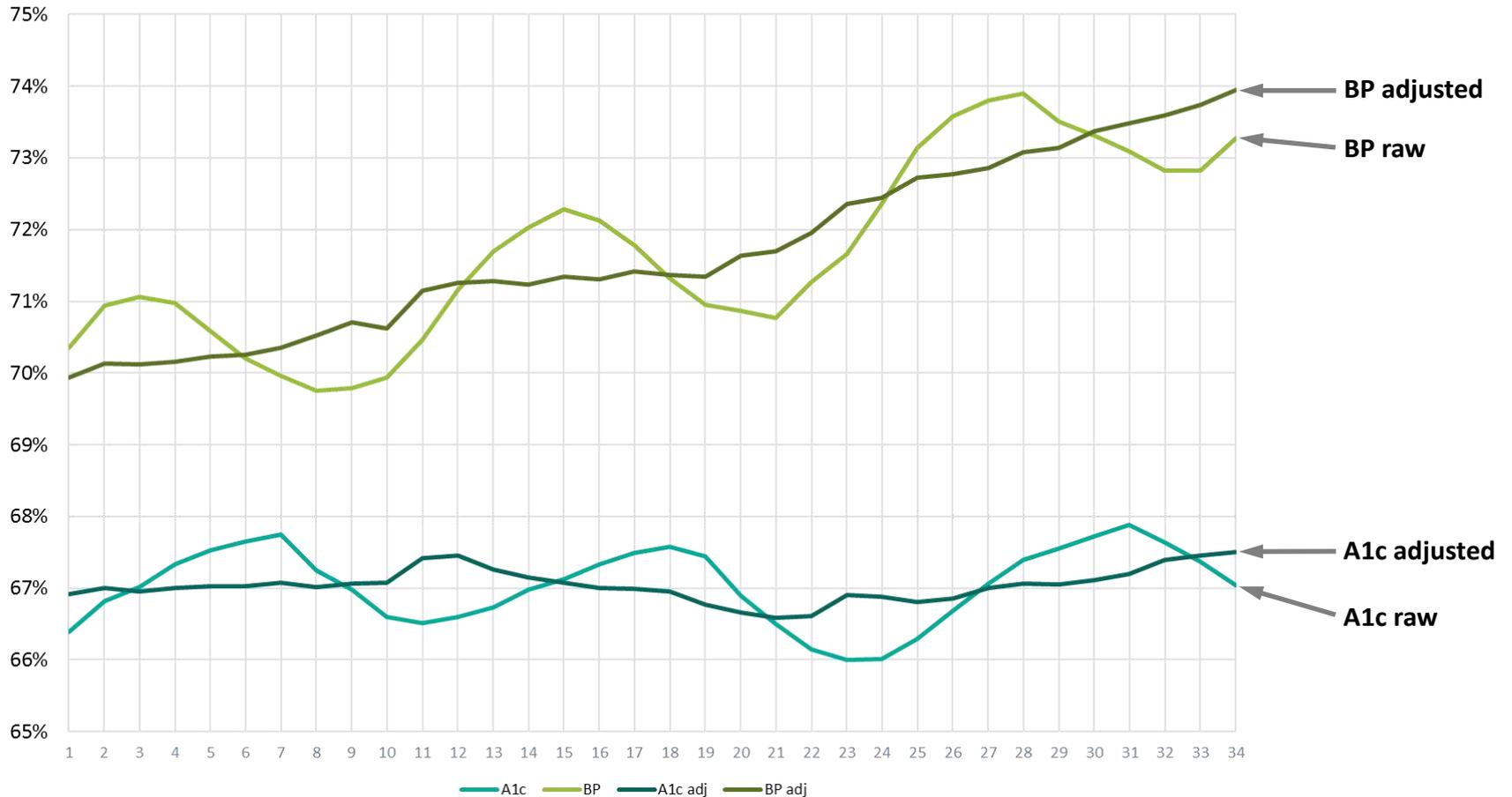


Variation in T2G Bundle Measure by Month: June 2013 – March 2016

1 million patients with type 2 diabetes across 29 AMGA member organizations using Optum One

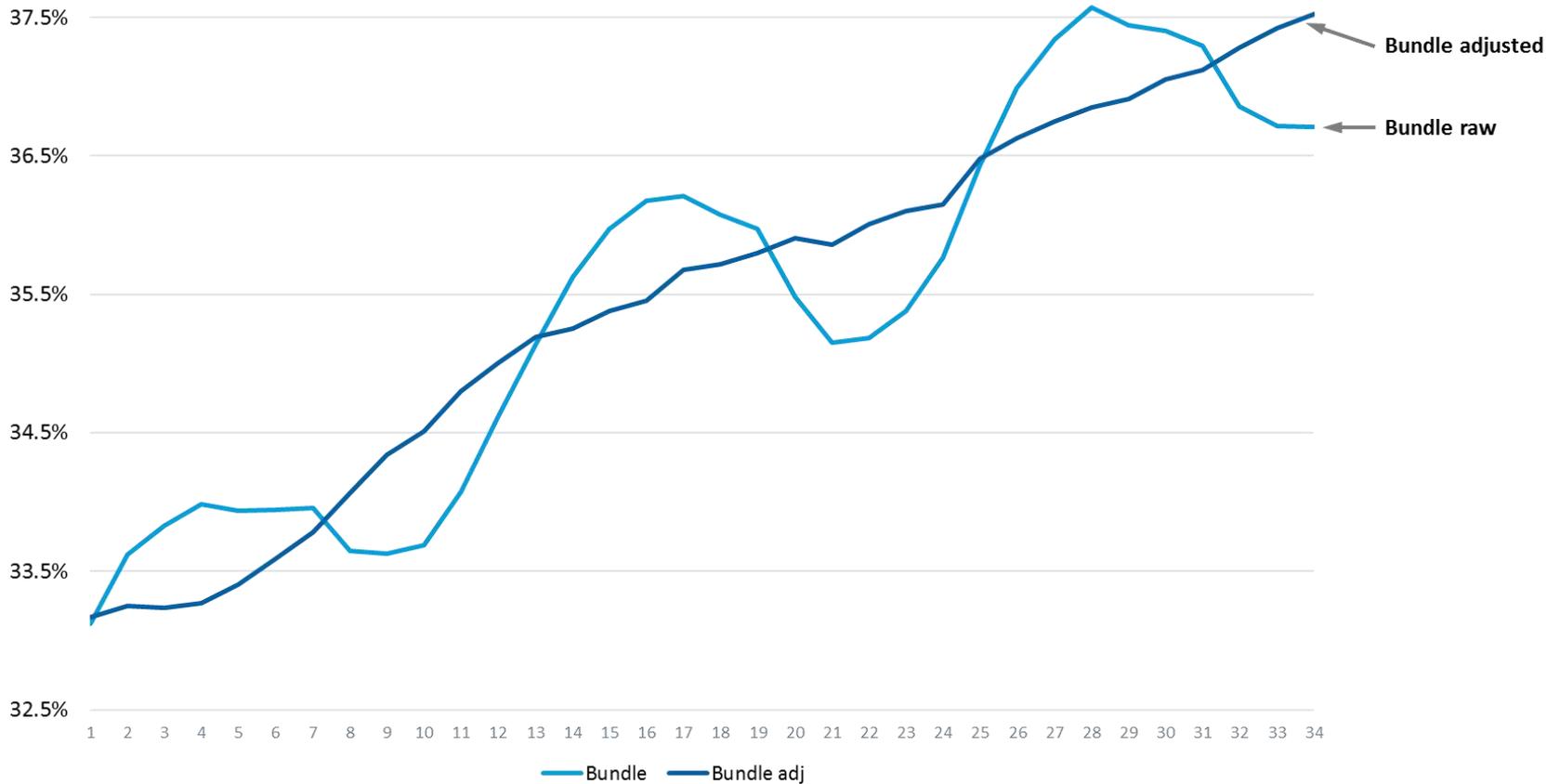


A1c and BP control – unadjusted (lighter colors) and adjusted (darker colors)
34 months prior to T2G (2013-06 through 2016-03)



Unadjusted vs. Adjusted Bundle

T2G Bundle control – unadjusted (lighter color) and adjusted (darker color)
34 months prior to T2G (2013-06 through 2016-03)



Change in T2G Measures: May 2017–January 2018

| A4inFocus Participants | Measure (Seasonally Adjusted) | | | | |
|----------------------------|-------------------------------|--------|--------|-------|--------------|
| | A1c | BP | Neph | Lipid | Bundle |
| Group 1 | 2.38% | 2.39% | 2.74% | 6.41% | 6.14% |
| Group 2 | 2.87% | 0.63% | 1.98% | 2.17% | 3.39% |
| Group 3 | -1.48% | 0.67% | 2.34% | 1.70% | 3.12% |
| Group 4 | 2.36% | 1.76% | 0.48% | 2.08% | 2.30% |
| Group 5 | 0.65% | 0.12% | 0.45% | 1.36% | 1.68% |
| Group 6 | -1.23% | 1.75% | 2.73% | 1.83% | 1.58% |
| Group 7 | -0.89% | -0.45% | -0.68% | 3.42% | 1.41% |
| Group 8 | 1.34% | -0.53% | 1.57% | 0.88% | 0.64% |
| Group 9 | -0.44% | -1.97% | 0.98% | 0.72% | -0.54% |
| A4inFocus Participants* | 0.62% | 0.49% | 1.40% | 2.29% | 2.19% |
| T2G Overall*† | 0.30% | -0.23% | 1.04% | 2.03% | 0.95% |
| Δ: A4inFocus – T2G Overall | 0.32% | 0.71% | 0.36% | 0.26% | 1.24% |

* Group-weighted average

† Based on quarterly data, 2017 Q2–Q4; excluding A4inFocus Participant Groups

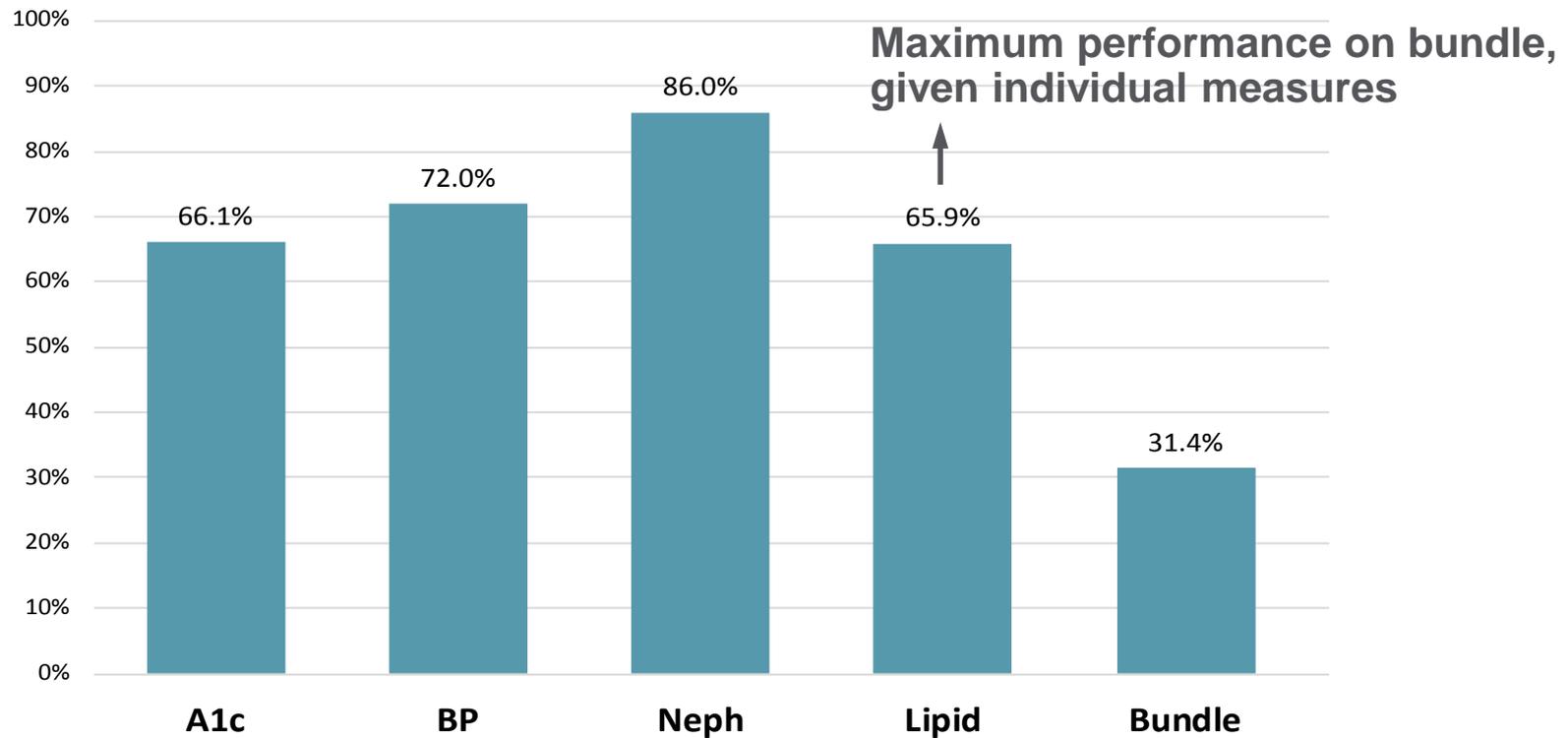
The Bottom Line

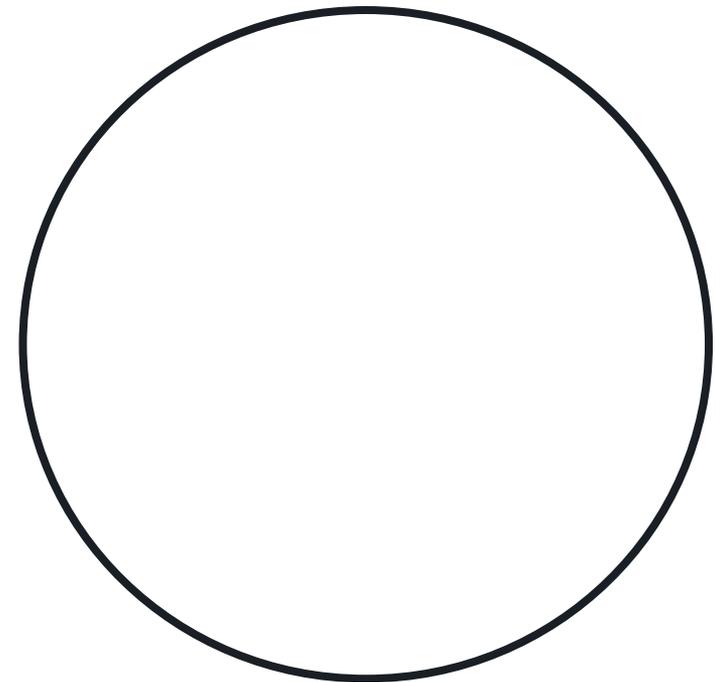
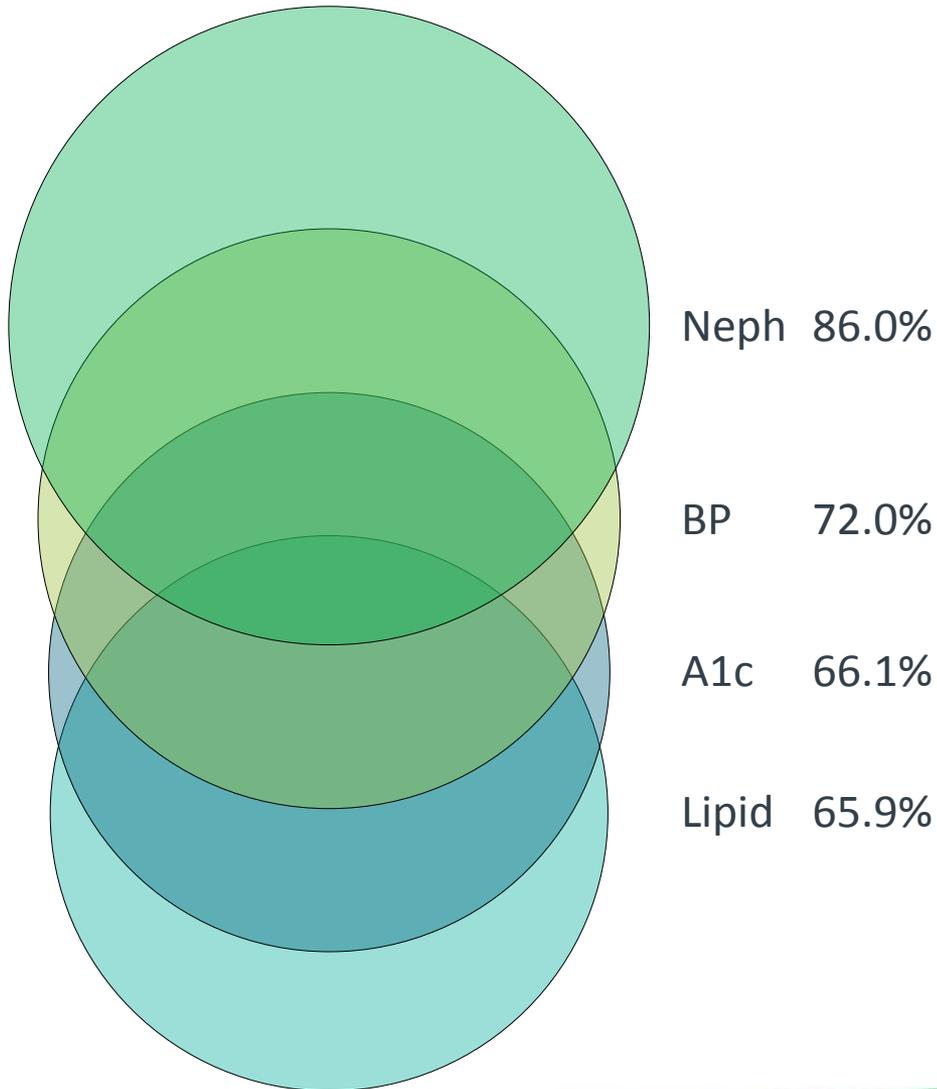
A4inFocus participants achieved **twice** the rate of Bundle measure improvement as other Together 2 Goal® participants.

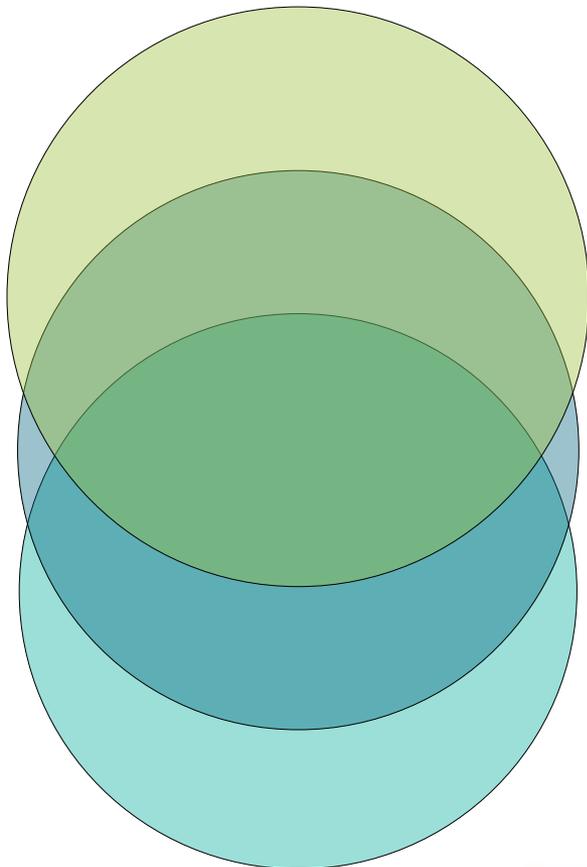
2,500 additional patients achieved Bundle completion in just 6 months.

Bundle Measure Arithmetic

Bundle Measure → Frustration!





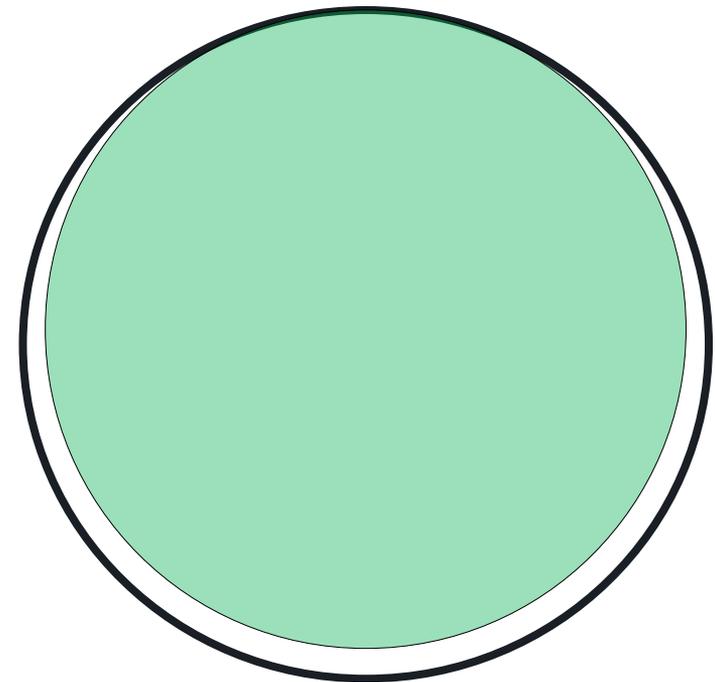


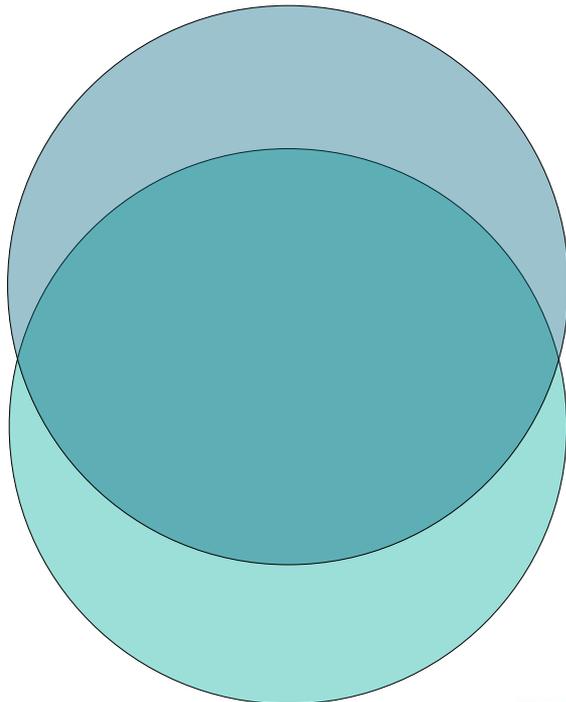
Neph 86.0%

BP 72.0%

A1c 66.1%

Lipid 65.9%



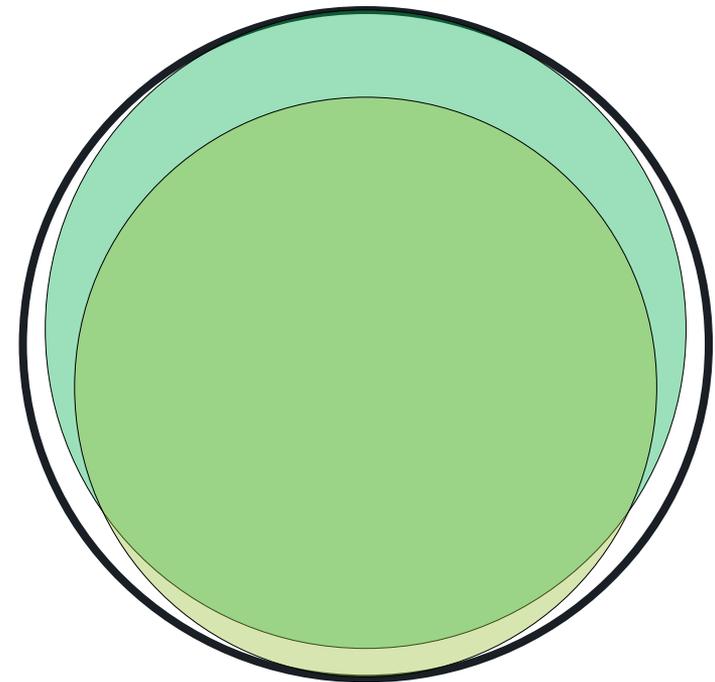


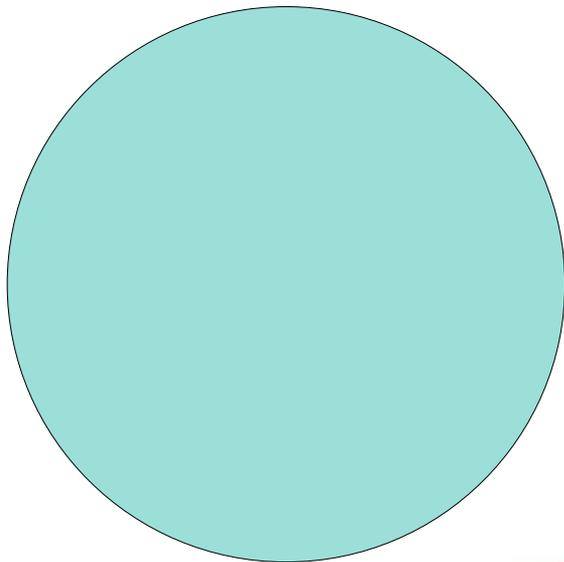
Neph 86.0%

BP 72.0%

A1c 66.1%

Lipid 65.9%



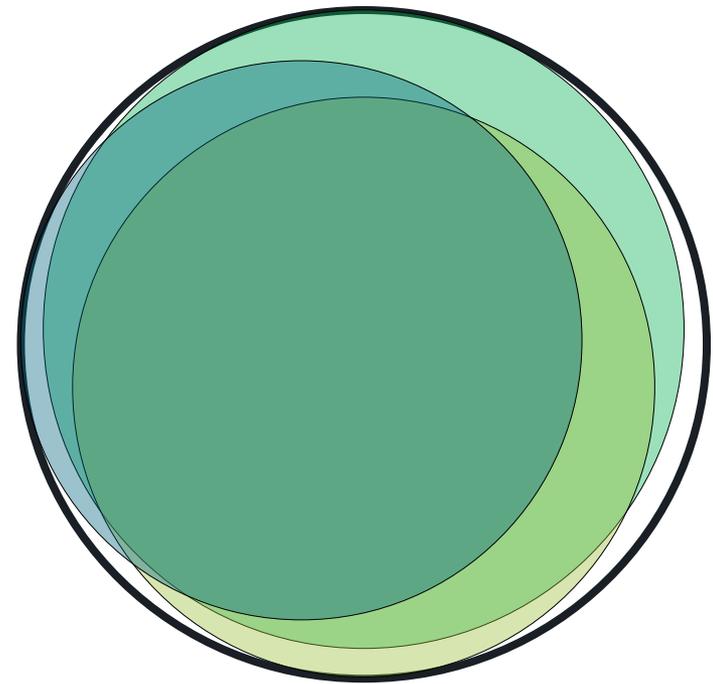


Neph 86.0%

BP 72.0%

A1c 66.1%

Lipid 65.9%

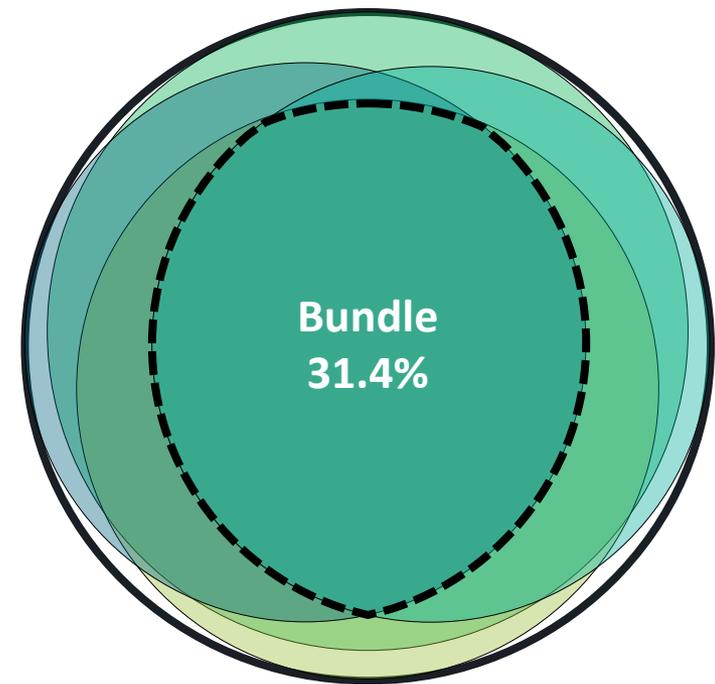


Neph 86.0%

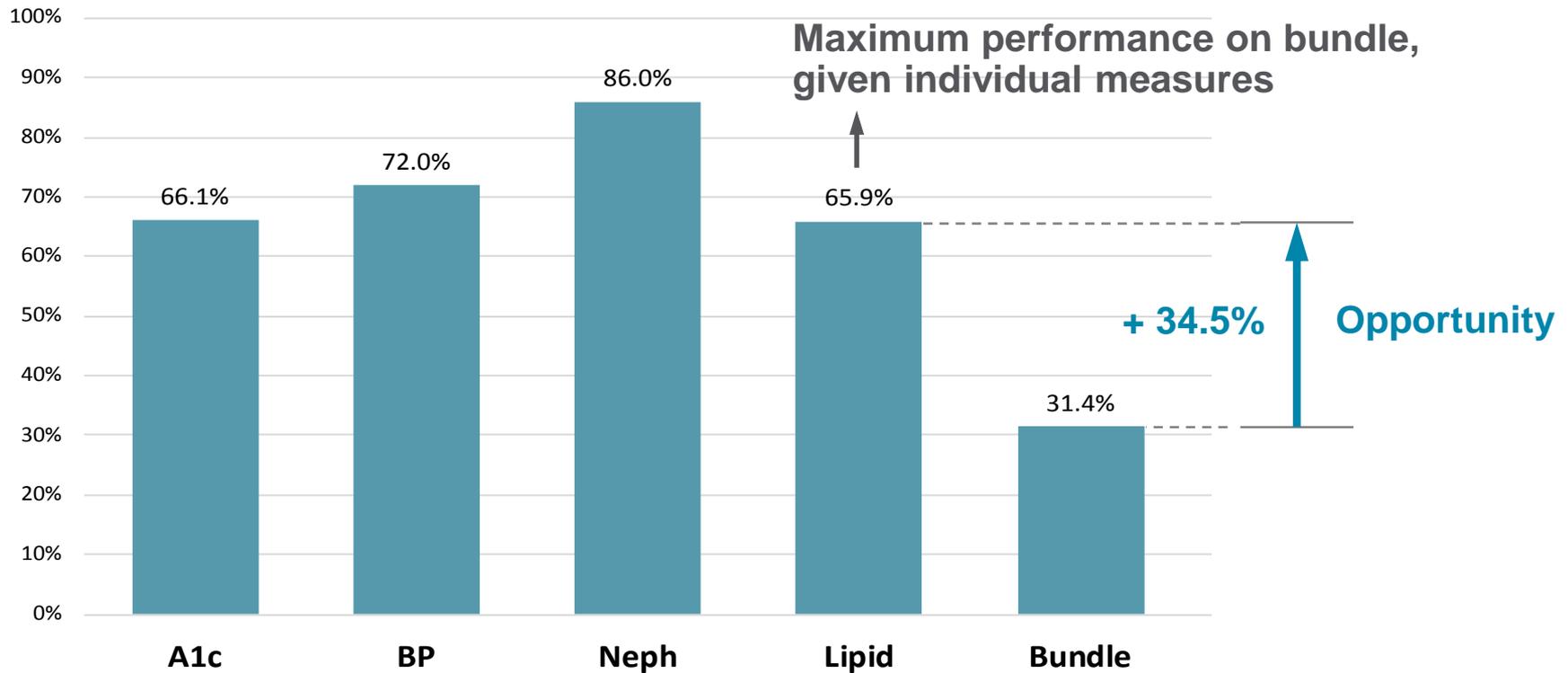
BP 72.0%

A1c 66.1%

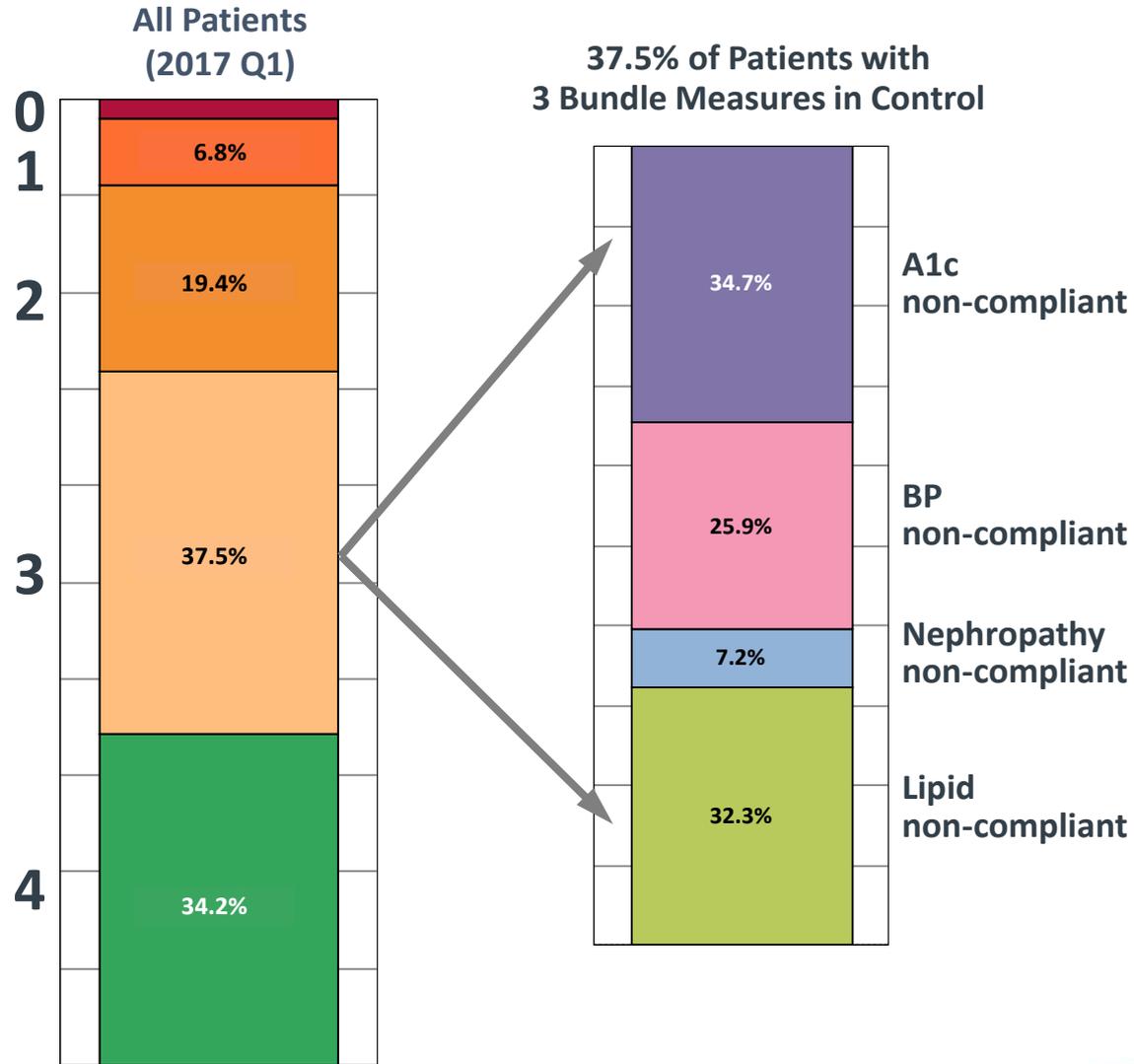
Lipid 65.9%



Bundle Measure → Opportunity

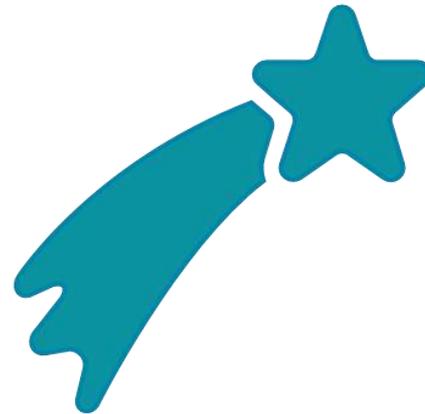


T2G Patients by Number of Measures in Control



- 0 measures in compliance
- 1 measure in compliance
- 2 measures in compliance
- 3 measures in compliance
- 4 measures in compliance

A4inFocus Most Improved: Mercy



A4inFocus Results

Dr. Tracy Godfrey
Rose Peacock

Mercy

May 17, 2018

About Mercy

Services & Locations

Headquartered in St. Louis with a multi-state footprint, Mercy is the 5th largest Catholic health system in the US.

1827
founded

44
hospitals

Outreach ministries in Arkansas, Louisiana, Mississippi and Texas.

350
outpatient facilities

3,000
integrated providers¹

Opened the first of its kind virtual care center.

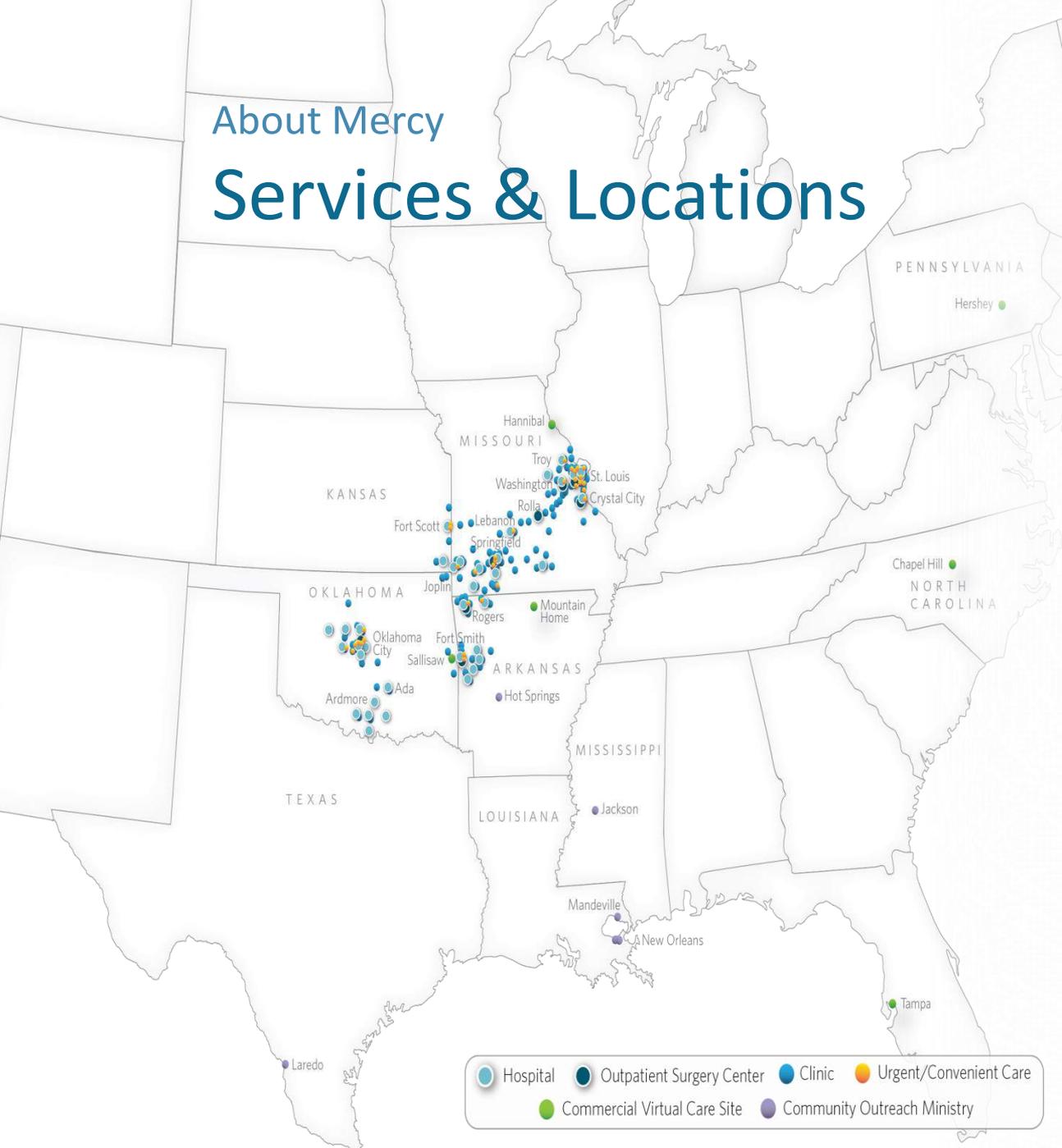
40,000
co-workers

Serving millions each year.

>\$5B
revenue

Top 5
consistent best performing large health system²

¹ Physicians & advanced practice clinicians
² Truven Health 15 Top Health System consecutive years: 2016 & 2017



- Hospital
- Outpatient Surgery Center
- Clinic
- Urgent/Convenient Care
- Commercial Virtual Care Site
- Community Outreach Ministry



A4inFocus Mercy DM Populations

| Communities | Count | Change 5/17 -1/18 |
|-------------|--------|----------------------|
| East | 25,457 | 41 |
| Springfield | 17,541 | 329 |
| West* | 12,956 | 2,230 |
| West-Pilot | 1,138 | 69 |
| Joplin | 2,777 | 496 |
| Fort Smith | 4,335 | 572 |

*apart from Pilot site

Focused Strategies – A1c Control

- Daily Visit Planner – point of care tool
- Existing DM Reports – outreach to patients with no A1c or A1c out of control
 - Accountability for operational leaders
- Primary care dashboards
- Diabetes ambassador program
- Diabetes care gaps SmartSet and BPA

Daily Visit Planner

| Preventive Care | | | | | | Hypertension - Treat to Below Goal | | | | | |
|--|----------------------|----------|----------|-----|--|--|---------|----------|-------|-----|--|
| Measure | Result | Date | Freq | Src | | Measure | Result | Date | Freq | Src | |
| Last Visit | -- | 2/27/18 | -- | E | | HTN 60-85 >= 150/90 | Above | 2/27/18 | Visit | E | |
| Medications Reviewed | -- | 2/17/18 | Visit | E | Coronary Artery Disease | | | | | | |
| Flu Vaccine | -- | 11/2/17 | 1 Yr | E | Antiplatelet Therapy | aspirin 81 mg tablet | | 2/17/18 | 1 Yr | E | |
| Pneumonia Vaccine | PREVNAR | 1/29/16 | Lifetime | E | Lipid Lowering Agent | simvastatin 40 mg tablet | | 2/17/18 | 1 Yr | E | |
| Tobacco Assessment | Quit | 2/27/18 | 2 Yrs | E | Prior MI | N | -- | -- | -- | -- | |
| Screening for Fall Risk | -- | 8/8/17 | 1 Yr | E | Beta Blocker | -- | -- | -- | -- | -- | |
| Body Mass Index | 24.97 | 2/27/18 | 1 Yr | E | ACEI/ARB Contra | Noted in Allergies | 2/16/18 | -- | -- | E | |
| Depression Screening | 1 | 8/8/17 | 1 Yr | E | Last LVEF<40% Or Recent LVEF | RECORD RESULT | 5/10/07 | Lifetime | -- | S | |
| Annual Wellness Visit | G0439 | 8/8/17 | 1 Yr | E | Congestive Heart Failure - Patient does not have this disease | | | | | | |
| Colorectal Screening | | | | | | Rheumatoid Arthritis - Patient does not have this disease | | | | | |
| FOBT/FIT | -- | DUE | 1 Yr | -- | Utilization | | | | | | |
| Flex Sig | -- | DUE | 5 Yrs | -- | # of ER Visits in the Last Year | -- | -- | -- | -- | -- | |
| Colonoscopy | -- | DUE | 10 Yrs | -- | Last ER Visit | -- | -- | -- | -- | -- | |
| Diabetes | | | | | | # of IP Discharges in the Last Year | -- | -- | -- | -- | |
| HbA1c | 7.8* | 12/14/17 | 1 Yr | E | Last IP Discharge | -- | -- | -- | -- | -- | |
| Urine Protein Test | -- | 11/8/17 | 1 Yr | C | Chronic Care Management | -- | -- | -- | -- | -- | |
| Dx of Nephropathy | Y | 4/10/18 | -- | E | | | | | | | |
| DM & HTN and On ACEI/ARB | -- | DUE | 1 Yr | -- | | | | | | | |
| Dilated Retinal Eye Exam | -- | 9/1/17 | 1 Yr | E | | | | | | | |
| Aspirin or Antiplatelet Therapy w/ DM & IVD | aspirin 81 mg tablet | 2/17/18 | 1 Yr | E | | | | | | | |
| COPD - Patient does not have this disease | | | | | | | | | | | |

Diabetes Ambassador Program

- Primary care advanced practitioners
- Intensive endocrinology training
- Diabetes management in home location

DM Care Gaps – “What”

- Diabetic testing
- Diabetic Intervention based on Mercy and ADA/ACE recommended treatment approach
- Diabetic Co-Morbidities
- Diabetic Patient Education Opportunities

DM Care Gaps – “Who”

- Providers (MD/DO, NP, PA) that provide Diabetic Care
- Encounter Types
- BPA section only

Mercy Diabetes Management Algorithm

- Treatment strategy is based on patient's individualized A1c goal
- Previous guidelines were not clinically helpful for guiding next steps after metformin
- Key clinical characteristics of drug therapy options are highlighted, including cardiovascular benefit
- Algorithm increases emphasis on value by incorporating estimated cost per point of A1c reduction
- Facilitates shared decision making between clinicians and patients based on clinical factors and patient-specific needs

| Diagnosis of Diabetes | A1c ≤ 1.0 over goal | A1c 1.1-2.0 over goal | A1c > 2.0 over goal | Failure to Achieve A1c Goal |
|--|---|--|--|---|
| Establish Patient-Specific A1c Goal | INITIATE MONOTHERAPY | INITIATE MONO- or DUAL THERAPY | INITIATE DUAL or TRIPLE THERAPY | INTENSIFY INSULIN or REFER TO ENDOCRINOLOGY |
| 1. Select Goal A1c 2. If lifestyle modification fails, then select therapeutic column corresponding to desired A1c reduction. 3. Initiate indicated therapy. 4. Follow remaining process steps below. | | | Add 3 rd line agent | If combination therapy including basal insulin fails to achieve goal, intensify with pre-meal insulin, and/or refer to Endocrinology. |
| | | Add 2 nd line agent | Maintain 2 nd line agent | |
| | Metformin (or other 1 st line agent) | Maintain Metformin (or other 1 st line agent) | Maintain Metformin (or other 1 st line agent) | |
| Lifestyle Modification | Lifestyle Modification | Lifestyle Modification | Lifestyle Modification | |
| | Titrate to Goal | Titrate to Goal | Titrate to Goal | Titrate to Goal |
| | Escalate if Failure | Escalate if Failure | Escalate if Failure | Escalate if Failure |
| | | | | Refer to Endocrinology |

Process Steps

- Modification:** Adjust diet and exercise to achieve positive outcomes, potentially delaying or avoiding drug therapy. If patient has maximized lifestyle modification or is unable or unwilling to make necessary modifications, proceed to next step.
- Initiation:** Start drug therapy based on patient's current A1c relative to individual goal.
- Titration:** Increase dose within each "tier" to the maximally tolerated dose or until goal is achieved.
- Escalation:** If A1c goal is still not achieved after dosage titration, escalate to the next tier and add another agent as needed.
- Intensification:** Once all tiers have been maximized, intensify insulin therapy with both basal and pre-meal insulins. Consider referral to Endocrinology.

| Reasonable HgbA1c Goals for T2DM | < 7.0 | < 7.5 | < 8.0 | < 8.5 |
|----------------------------------|----------------------|-----------|--|----------|
| | Uncomplicated Adults | Fit Older | Frail Older w/Co-morbidity, < 10 yrs life expectancy | Very Old |

Diabetes Drug Therapy Options

| Drug Class | Route | Hypoglyc. Risk | Weight Gain | CHF | CV Benefit | Typical A1c Change | Avg Cost /30 days | Cost per 1.0 A1c decr/yr |
|------------|-------|----------------|-------------|-----------------------|-----------------------|--------------------|-------------------|--------------------------|
| Metformin | Oral | Low | Slight Loss | Neutral | Neutral | 1.0-2.0 | \$7 | \$84 |
| GLP-1 RAs | Inj | Low | Loss | 1 st Pref* | 1 st Pref* | 0.5-1.0 | \$570 | \$9,120 |
| SGLT2i | Oral | Low | Loss | 1 st Pref | 1 st Pref* | 0.8-1.2 | \$360 | \$4,320 |
| DPP4i | Oral | Low | Neutral | Avoid | Neutral | 0.5-0.8 | \$350 | \$6,461 |
| TZD | Oral | Low | Gain | Avoid | Avoid | 0.5-1.4 | \$65 | \$821 |
| SU | Oral | High | Gain | Neutral | Neutral | 1.0-2.0 | \$8 | \$96 |
| Insulin | Inj | High | Gain | 2 nd Pref | 2 nd Pref | 1.5-3.5 | \$525 | \$2,520 |

GLP-1 RA = glucagon-like peptide 1 receptor agonists (e.g. Victoza, Byetta, Bydureon, Trulicity, Tanzeum, Ozempic)

SGLT2i = sodium glucose cotransporter 2 inhibitors (e.g. Invokana, Jardiance, Farxiga, Steglatro)

DPP4i = dipeptidyl peptidase-4 inhibitors (e.g. Januvia, Tradjenta, Onglyza, Nesina)

TZD = thiazolidinedione (e.g. Actos (pioglitazone), Avandia); SU = sulfonylurea (e.g. glipizide, glyburide, glimepiride)

*NOTE: Victoza is preferred GLP-1 RA for CHF and ASCVD; Jardiance is preferred SGLT2i for ASCVD per clinical trials and FDA labeling.

Diabetes Care Gaps Smartset & BPA

SmartSet Preview

SOM AMB DIABETES GAPS IN CARE [3131]

Identify gaps in diabetic care and provide solutions.

Diagnosis

DIABETES (Single Response)

- Diabetes mellitus Type II or unspecified type diabetes mellitus without mention of complication, not stated as uncontrolled

Diabetic Medication

| Component | Value | Date/Time |
|-----------|---------|---------------------|
| HGBA1C | 8.3 (A) | 08/01/2017 08:00 AM |

The patient's last A1c was above goal. Please consider either adjusting the dose of their current medication, or adding one or more of the options below to help improve their control.

[Type 2 Diabetes - Management of persistent hyperglycemia](#) **URL:** <https://www.uptodate.com/contents/management-of-persistent-hyperglycemia-in-type-2-diabetes-mellitus?search=diabetes%20treatment#graphicRef70606>

[Type 1 Diabetes - Management of blood glucose](#) **URL:** https://www.uptodate.com/contents/management-of-blood-glucose-in-adults-with-type-1-diabetes-mellitus?source=search_result&search=diabetes%20treatment%20type%201&selectedTitle=1~150

BIGUANIDES (Single Response)

- metformin 500 mg 60 Tablet, 5, E-Prescribe
- metformin SR 500 mg 30 Tablet, 5, E-Prescribe
- metformin 850 mg 60 Tablet, 5, E-Prescribe
- metformin 1000 mg 60 Tablet, 5, E-Prescribe

GLP-1 (Single Response)

- dulaglutide (TRULICITY) 0.75 mg/0.5 mL Pen Injector 4 Syringe, 5, E-Prescribe
- dulaglutide (TRULICITY) 1.5 mg/0.5 mL Pen Injector 4 Syringe, 5, E-Prescribe
- exenatide microspheres (BYDUREON) 2 mg/0.65 mL Pen Injector (CrCl >30 only) 4 Each, 5, E-Prescribe
- liraglutide (VICTOZA 3-PAK) 0.6 mg/0.1 mL (18 mg/3 mL) 15 mL, 5, E-Prescribe
- liraglutide (VICTOZA 3-PAK) 0.6 mg/0.1 mL (18 mg/3 mL) 15 mL, 5, E-Prescribe
- exenatide (BYETTA) 5 mcg/0.02 mL Pen Injector (CrCl >30 only) 15 mL, 5, E-Prescribe

SGLT-2 (Single Response)

Use with caution in patients with a history of frequent UTI, a history of yeast infections, and those at risk for dehydration.

- canagliflozin (INVOKANA) 100 mg 30 Tablet, 5, E-Prescribe
- canagliflozin (INVOKANA) 300 mg 30 Tablet, 5, E-Prescribe
- dapagliflozin (FARXIGA) 5 mg 30 Tablet, 5, E-Prescribe
- dapagliflozin (FARXIGA) 10 mg 30 Tablet, 5, E-Prescribe
- empagliflozin (JARDIANCE) 10 mg 30 Tablet, 5, E-Prescribe
- empagliflozin (JARDIANCE) 25 mg 30 Tablet, 5, E-Prescribe

DPP4 - GFR>50 (Single Response)

Use for patients with GFR >50

- empagliflozin (JARDIANCE) 25 mg 30 Tablet, 5, E-Prescribe

DPP4 - GFR>50 (Single Response)

Use for patients with GFR >50

- sitagliptin (JANUVIA) 100 mg 30 Tablet, 5, E-Prescribe
- saxagliptin (ONGLYZA) 5 mg 30 Tablet, 5, E-Prescribe
- linagliptin (TRADJENTA) 5 mg 30 Tablet, 5, E-Prescribe

BASAL INSULIN (Single Response)

- insulin detemir (LEVEMIR) FlexPEN 100 Unit/mL 15 mL, 5, E-Prescribe
- insulin glargine (LANTUS) FlexPEN 300 Unit/3mL 15 mL, 5, E-Prescribe
- insulin glargine (TOUJEO) 300 unit/mL, PEN 4.5 mL, 5, E-Prescribe
- insulin degludec (TRESIBA) 100 unit/mL pen syringe 15 mL, 5, E-Prescribe
- insulin degludec (TRESIBA) 200 unit/mL, PEN 15 mL, 5, E-Prescribe
- insulin glargine (BASAGLAR KWIKPEN) 100 unit/mL, PEN 15 mL, 5, E-Prescribe
- HUMULIN N, Vial 1 Bottle, 5, E-Prescribe
- HUMULIN N, PEN 5 Each, 5, E-Prescribe

SHORT ACTING INSULIN (Single Response)

- insulin aspart (NOVOLOG) 100 Unit/mL FlexPEN 15 mL, 5, E-Prescribe
- insulin lispro (HumaLOG) 100 unit/mL pen syringe 15 mL, 5, E-Prescribe
- insulin lispro (HumaLOG) 200 unit/mL pen syringe 15 mL, 5, E-Prescribe
- insulin glulisine (APIDRA) 100 unit/mL PEN 15 mL, 5, E-Prescribe
- HUMULIN R, Vial 1 Vial, 5, E-Prescribe

SULONYLUREA (Single Response)

- glimepiride 2 mg (AMARYL) 30 Tablet, 5, E-Prescribe
- glimepiride 4 mg (AMARYL) 30 Tablet, 5, E-Prescribe
- glipizide 5 mg (GLUCOTROL) 60 Tablet, 5, E-Prescribe
- glipizide 10 mg (GLUCOTROL) 60 Tablet, 5, E-Prescribe
- glipizide SR 5 mg (GLUCOTROL XL) 30 Tablet, 5, E-Prescribe
- glipizide SR 10 mg (GLUCOTROL XL) 30 Tablet, 5, E-Prescribe
- glyburide 2.5 mg (MICRONASE) 60 Tablet, 5, E-Prescribe
- glyburide 5 mg (MICRONASE) 60 Tablet, 5, E-Prescribe

ACE / ARB

BP Readings from Last 3 Encounters:

08/01/15 (!) 140/90

BP Goal = <140/90

| Component | Value | Date/Time |
|------------|----------|---------------------|
| MICRCREATR | 32.0 (A) | 08/01/2017 08:00 AM |

Microalbuminuria = 30 to 300 mg/g
Proteinuria = >300 mg/g

This patient's BP or microalbumin are elevated and they may benefit from either initiation or escalation of their current treatment. Consider rechecking BMP two weeks after initiation or dose escalation of ACE inhibitor or ARB.

Close

Focused Strategies on BP Control

- Measure Up Pressure Down – Mercy East  BP control
– Spread of best practices learned
A4inFocus
- Co-worker Education - Blood Pressure Measurement Education via MyEducation
- Blood pressure “basics”

Focused Strategies on Statin Prescribing

- Million Hearts Campaign – Mercy East
- Directed Messaging and “Heart Protection Package” – Mercy Oklahoma
- Statin Re-trial Algorithm and Education for Physicians and Providers
- Documentation of Statin Intolerance in EPIC Allergy

Focused Strategies on Attention to Nephropathy Measure

- Daily Visit Planner
- Exception Reports
- Standing Orders
- HCC coding alerts

A4inFocus Mercy Summary Impact

(seasonally unadjusted & adjusted)

| Bundle Measure | % Change 5/17-1/18 Unadjusted | % Change 5/17-1/18 Adjusted |
|----------------|----------------------------------|--|
| East | 1.65 | 1.68 |
| Springfield | 1.38 | 1.41 |
| West* | 2.27 | 2.30 |
| West-Pilot | 6.11 | 6.14  |
| Joplin | 3.36 | 3.39  |
| Fort Smith | 3.09 | 3.12  |

*apart from Pilot site

A4inFocus Mercy Joplin Next Steps

- Continue engaging primary care APC's for diabetes ambassador program
- Maintain/update diabetes care gaps SmartSet/BPA
- Implement standing order protocols
- Standardize co-worker education

A4inFocus Highest Overall: Premier Medical Associates



A4inFocus Results:
Improving Together 2 Goal[®] Bundle
Measure Performance

Francis R Colangelo MD, MS-HQS, FACP

Jennifer Obenrader, Pharm.D., CDE

Premier Medical Associates

May 17, 2018



Building
Better
Care

Premier Medical Associates

Specialties

| | |
|--------------------------|---------------------|
| Allergy & Immunology | Internal Medicine |
| Audiology | Laboratory Services |
| Behavioral Health | Neurology |
| Cardiology | Ophthalmology |
| Electrophysiology | Optometry |
| Dermatology | Pain Management |
| Ear, Nose & Throat | Pediatrics |
| Family Medicine | Pulmonology |
| Gastroenterology | Radiology |
| General & Breast Surgery | Rheumatology |
| Hospitalists | Sleep Medicine |
| Infectious Disease | |

- Formed 1993
- 100 providers
- 23 specialties
- 1:1 ratio PCP to specialists
- Part of Highmark Health
- Member of Allegheny Health Network
- Allscripts Enterprise

Together 2 Goal[®]: PMA Initial Experience

| Measure | As of 12/31/15 | Place in Campaign | As of 6/30/17 | Place in Campaign |
|-------------------------------------|----------------|-------------------|---------------|-------------------|
| A1c control rate | 70.6% | 20th | 72.0% | 12th |
| BP control rate | 78.8% | 17th | 80.5% | 17th |
| Medical attention to kidney disease | 88.6% | 26th | 90.3% | 20th |
| Statin prescribing rates | 68.9% | 35th | 78.3% | 12th |
| D4 Control bundle | 40.7% | 9th | 47.2% | 7th |

A4INFOCUS ACTION PLANS



Building
Better
Care

Focus on A1c Control

- EHR Registry
- Optum One



Leaky Bucket

Browse/Load in Workspace

My Files Shared Files Library Search

- alexcan
- catherm
 - AFIB
 - 3 of 4
 - AI-2
 - Development
 - T2G
 - Leaky Bucket
 - Leaky Bucket - All Groups
 - Leaky Bucket - Group 1 (Well Controlled)
 - Leaky Bucket - Group 2 (Moderately Well Controlled)
 - Lipid Management
 - Nephropathy
 - Validation
- daniel.r
- dlynn@j
- elyse.yo
- hkern@
- holli.wh
- lucy.pan
- rmack@

Delete Rename... New Folder... Show all files

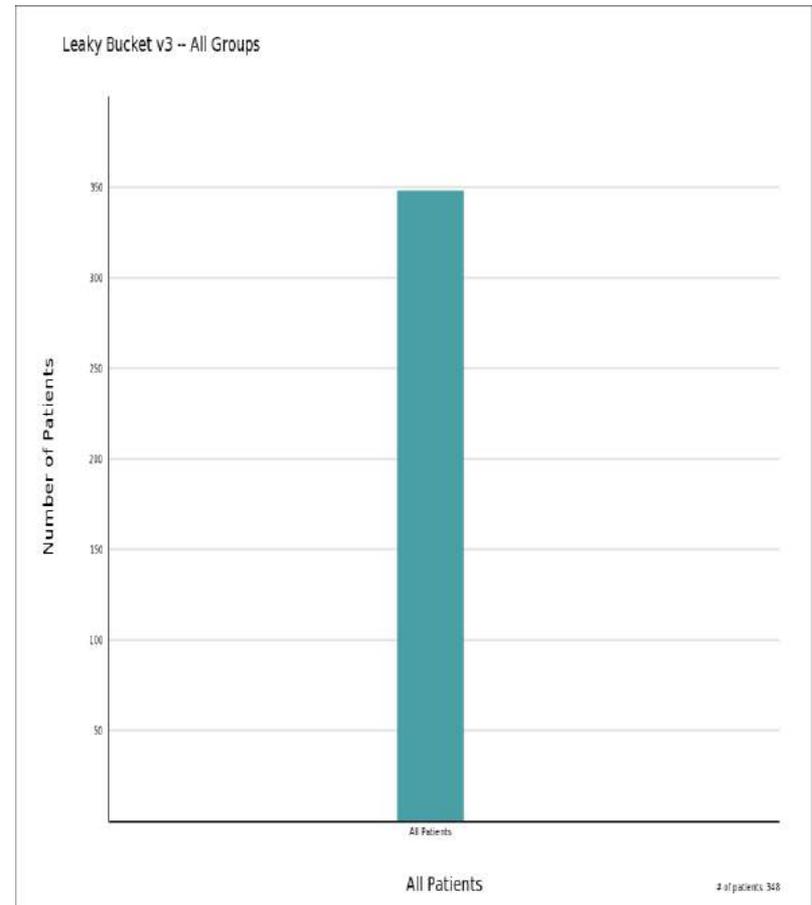
Details:

Shared > catherine.mullins@humedica.com > T2G > Leaky Bucket > Leaky Bucket - All Groups

Type: Graph
Availability: Shared
Saved on: 7/31/2017 14:28
Comments: None

Title: Leaky Bucket v3 -- All Groups
Variables: Patients by All Patients
Disease Cohort: Diabetes Mellitus

OK Cancel



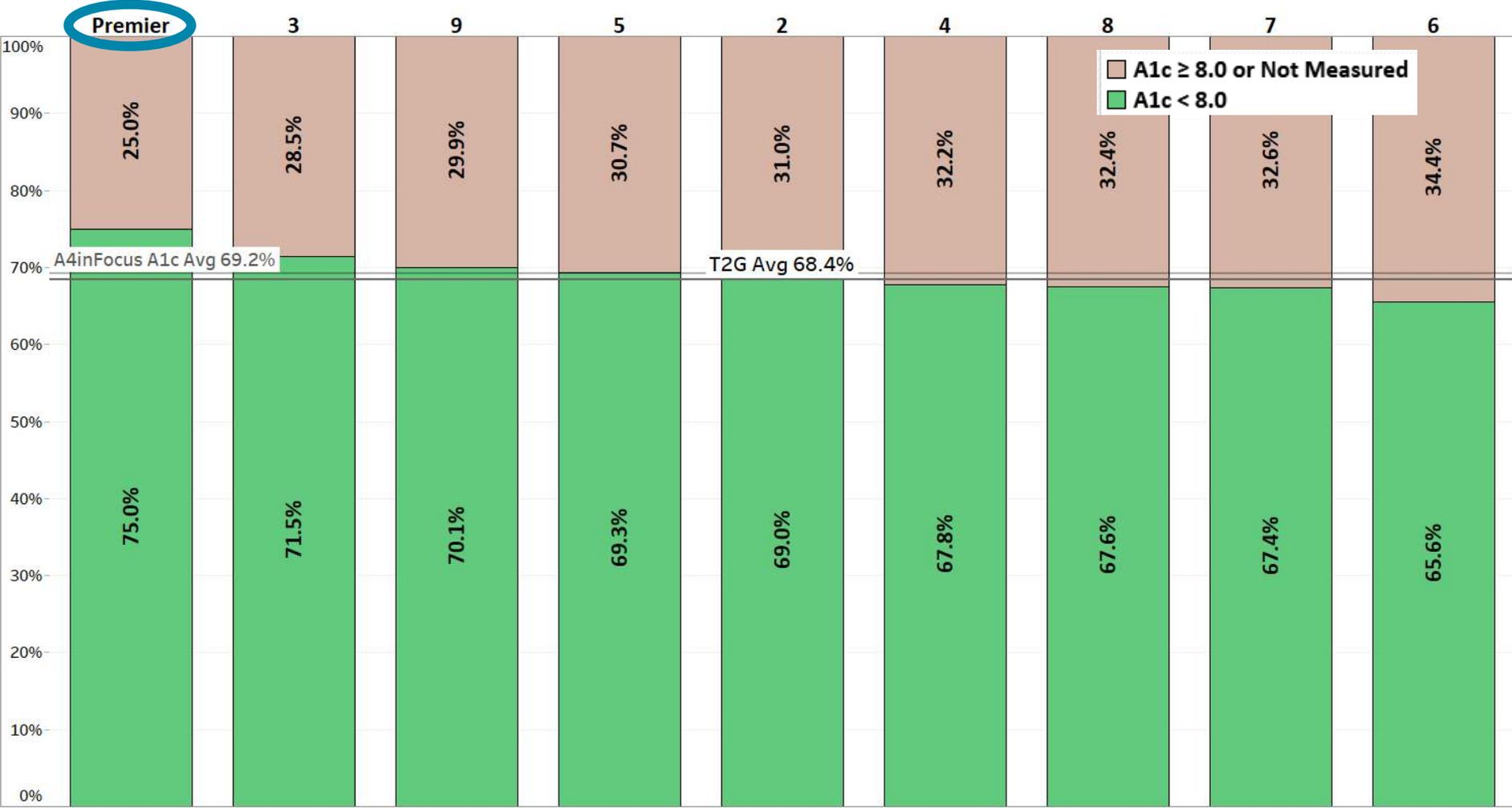
PREMIER
MEDICAL ASSOCIATES

**Building
Better
Care**

A4inFocus

A1c Control < 8 (seasonally adjusted)

2/1/17–1/31/18 (final monthly reporting period for A4inFocus)



Focus on BP Control

Measure Up
Pressure Down

PROVIDER TOOLKIT
TO IMPROVE HYPERTENSION CONTROL

American Medical Group Foundation
©2013

Rose, G. (1961). Seasonal variation in blood pressure in man.
Nature, 189(4760), 235.

Paper chromatography (*n*-butanol / pyridine / 0.1*N* hydrochloric acid, 5 : 3 : 2) showed that the two peaks contained the same component which was identified as *N*-glycolylneuraminic acid. Release of glycolic acid, after hydrolysis by *N* sulphuric acid, confirmed this result¹.

Although the human menopausal gonadotropin preparation was not pure, the following conclusions may be drawn from the experimental results: (a) human menopausal gonadotropin contains sialic residues which are accessible to neuraminidase; (b) enzymic release of the sialic acid residues reduces the biological activity of human menopausal gonadotropin by 80 per cent or more. Bound sialic acid is an essential part of the molecule.

RENÉ GOT
ROLAND BOURBILLON

Laboratoire de Biochimie,
Faculté de Médecine,
45 rue des Saints-Pères,
Paris 6.

- ¹ Whitten, W. K., *Austral. J. Sci. Res., Ser. B*, **1**, 258 (1948).
² Brosmier, E., and Walter, K., *Klin. Wochschr.*, **38**, 925 (1958).
³ Gotschalk, A., Whitten, W. K., and Graham, E. R. B., *Biochim. Biophys. Acta*, **38**, 324 (1960).
⁴ Gotschalk, A., *Biochim. Biophys. Acta*, **23**, 645 (1957).
⁵ Bourbillon, R., Got, R., and Marcy, R., *Actes*, **186**, 502 (1959).
⁶ Bourbillon, R., Got, R., and Marcy, R., *Actes Endocrinol.* (in press).
⁷ Werner, I., and Odén, L., *Acta Soc. Med. Upsaliena*, **57**, 230 (1952).
⁸ Swannholm, I., *Acta Soc. Med. Upsaliena*, **61**, 75 (1956).
⁹ Kleek, E., and Ullmerbruck, G., *Hoppe-Seyler's Z. physiol. Chem.*, **307**, 266 (1957).

Seasonal Variation in Blood Pressure in Man

SEVERAL of man's bodily functions, such as thyroid activity, are known to show a characteristic seasonal pattern; but in general such seasonal variations have received less attention in man than in many other animals. In particular, seasonal trends in blood pressure do not seem to have been measured hitherto.

The data presented here were derived from measurements on 56 middle-aged men who had been observed for 1-3 years at a clinic for ischaemic heart disease. Most had suffered cardiac infarction, but for all of them at least two months had elapsed since the acute illness and during the period of observation they were in a clinically stable state. There were three observers, but as a rule each subject's blood-pressure measurements had all been taken by the same observer. All measurements were made in a comfortably warm room after a period of rest and using standard instruments.

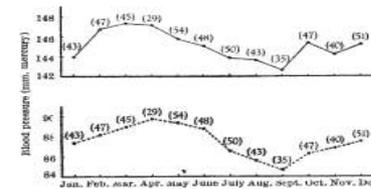


Fig. 1. Mean systolic (above) and diastolic (below) blood pressures, by months, of 56 men. (No. of observations are shown in brackets)

The results are shown in Fig. 1, where mean systolic and diastolic pressures have been plotted by months; the technique of grouped means has been followed; the value at each month represents the mean of the values for that and the two adjacent months. There is a clear seasonal trend, with a peak covering the spring and a trough in the late summer.

This pattern is quite different from that of ischaemic heart disease morbidity and mortality, which follow the reciprocal of air temperature, namely, a peak in January and February and a lower level throughout the late spring and summer.

GEOFFREY ROSE

Department of Epidemiology,
London School of Hygiene and Tropical Medicine,
Gower Street, London, W.C.1.

Relationship between Urinary Hyaluronidase and Diuresis

In a recent communication, Berlyne¹ states that he was unable to corroborate my results² on the relationship between the hyaluronidase activity of the urine and diuresis.

(1) Berlyne believes that my method is unsuitable for quantitative assay of urinary hyaluronidase, as I did not take into account the drop of substrate viscosity before the first reading. But the determination of enzyme activity by the method of Stryer and Emmes³, used by me, does not depend on the initial substrate viscosity. The modified method of McLean and Hale⁴, used by Berlyne, has no advantage over mine.

He thinks that my results are not precise enough because I did not take into account the electrolyte effect. But in practice I did take it into consideration, and some of my experiments were performed on samples of urine previously dialysed. On the removal of electrolytes, hyaluronidase activity somewhat increases. But the correction introduced by dialysis does not alter the main relationship and curves of dialysed urine, as well as of electrolyte-containing urine run in parallel⁵.

(2) Berlyne believes that I was wrong when giving the results as the fermentation activity of the urine in arbitrary units. In his opinion, the results should be expressed by the amount of the enzyme excreted per minute. I cannot agree with this.

The urinary hyaluronidase is produced by renal cell secretion under the action of antidiuretic hormone. The enzyme performs a specific function in the kidney. It depolymerizes hyaluronic structures of the tubules, and this provides the conditions for antidiuretic reaction. The appearance of hyaluronidase activity in urine should not be regarded as a process of excretion. This phenomenon is merely a side-effect of the antidiuretic hormone enabling one to verify the mechanism of the hormone action.

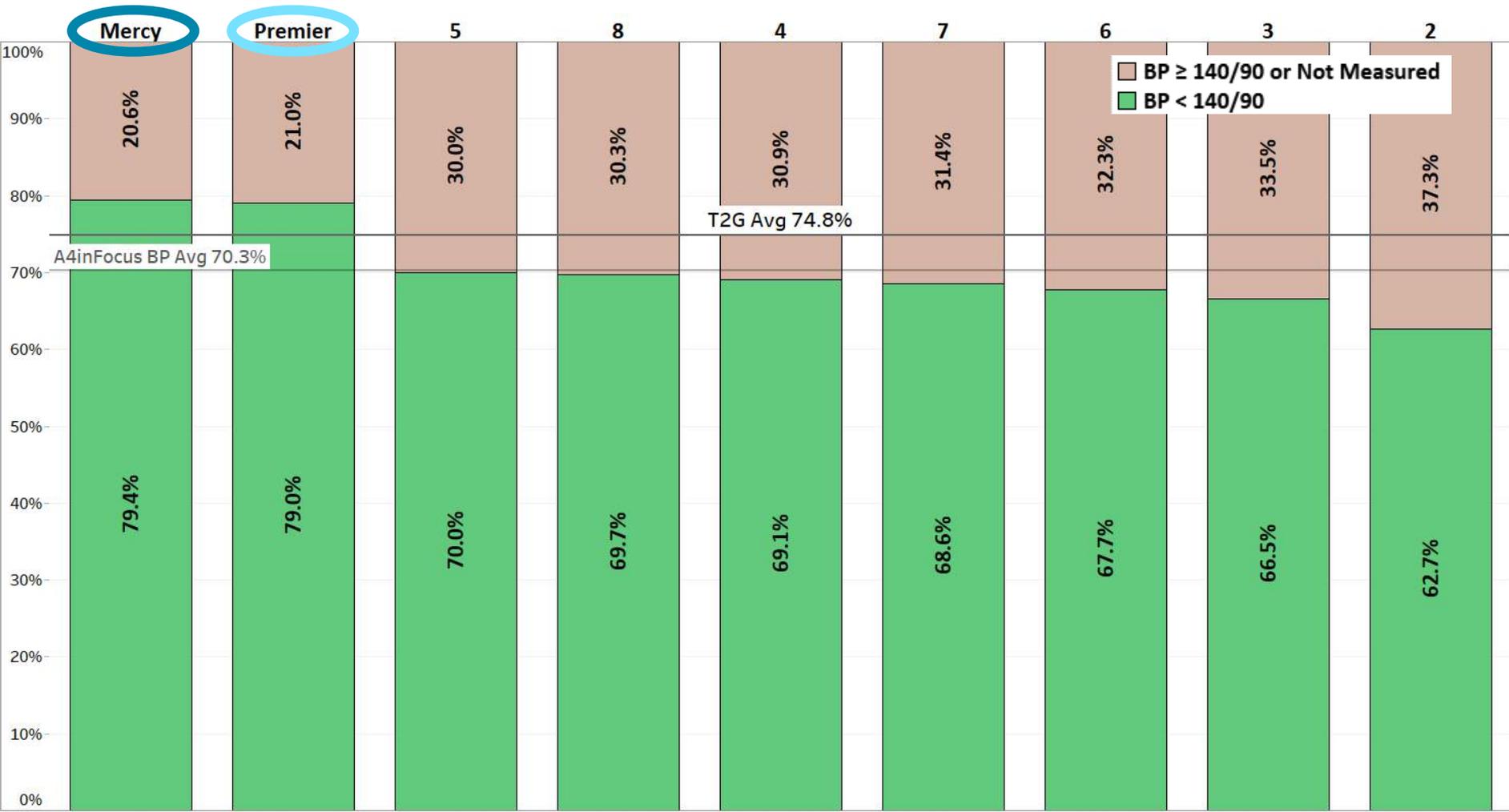
From the above point of view, there is no reason to express the results as the product of the enzyme concentration (irrespective of any units) by the volume of urine, as it is done for estimating the excretion of substances removed by the kidney. As this operation has no physiological meaning in this case, it becomes purely arithmetical and completely distorts the essence of the phenomenon under study.

(3) The probability of my physiological interpretation of the phenomenon in question was investigated in two series of experiments. In one (jointly



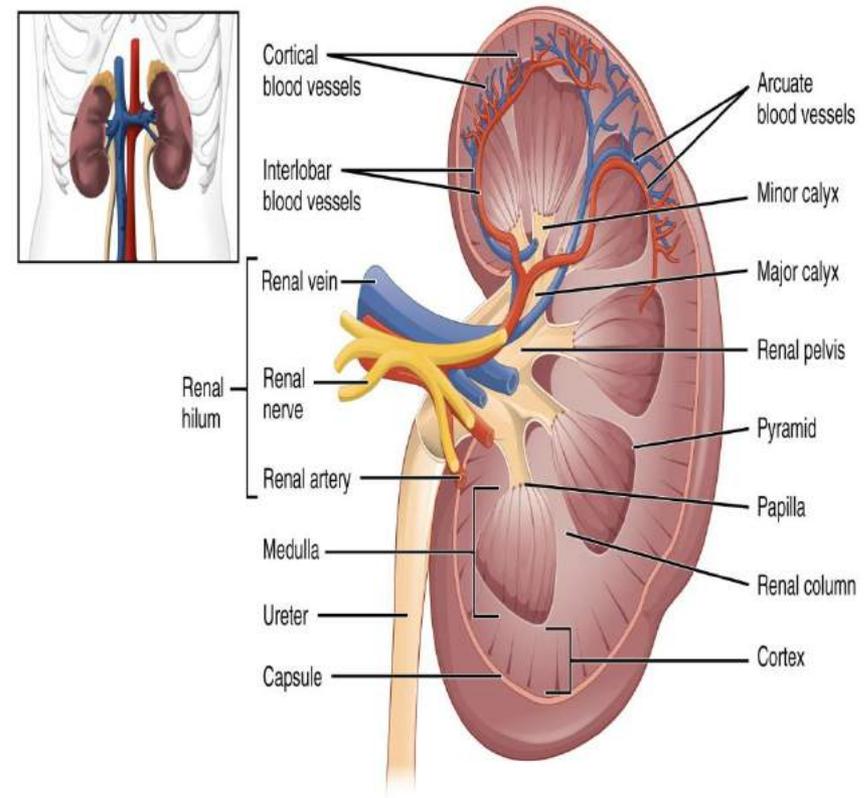
A4inFocus BP Control (seasonally adjusted)

2/1/17–1/31/18 (final monthly reporting period for A4inFocus)



Focus on Medical Attention to Nephropathy

- HCC coding
- Modified leaky bucket
- Barrier:
 - PMA cardiology patient with outside PCP



PREMIER
MEDICAL ASSOCIATES

**Building
Better
Care**

Focus on Medical Attention to Nephropathy

Load report

My Files Shared Files Library Favorites Search

- General
 - Ambulatory
 - ACO
 - AFIB
 - ASTH
 - CAD
 - CHF
 - COPD
 - Depression
 - DM
 - DYS
 - HTN
 - Care
 - Codin
 - Popul
 - Predi
 - Preve
 - Provi
 - Repor
 - Reso
 - Dashboard
 - User Grc

- DM: Care Management Outcomes Report
- DM: Care Overview
- DM: Coding Opportunity Analysis
- DM: D3 Bundle Opportunity Analysis
- DM: Gaps in Care
- DM: High Risk Patients
- DM: Patient Clinical Profile
- DM: Patient Demographic Profile
- DM: Population Utilization Review

Delete Rename... New Folder... Show all files

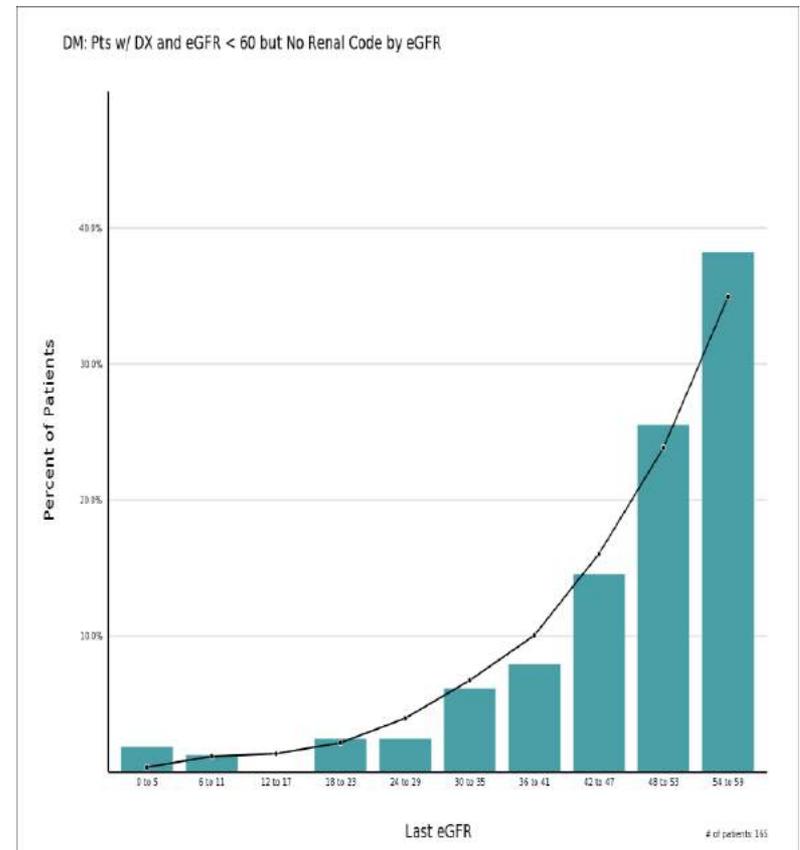
Details:

Library > Ambulatory Care > Reports by Disease State > DM > DM: Coding Opportunity Analysis

Type: Report
Availability: Shared
Saved on: 8/13/2013 12:52
Comments: None

Graph 1: DM: Clinical and Coded Evidence of DM
Graph 2: DM: Pts w/ DX and eGFR < 60 but No Renal Code
Graph 3: DM: Chronic Pts with Dropped Code by Site of Care

OK Cancel



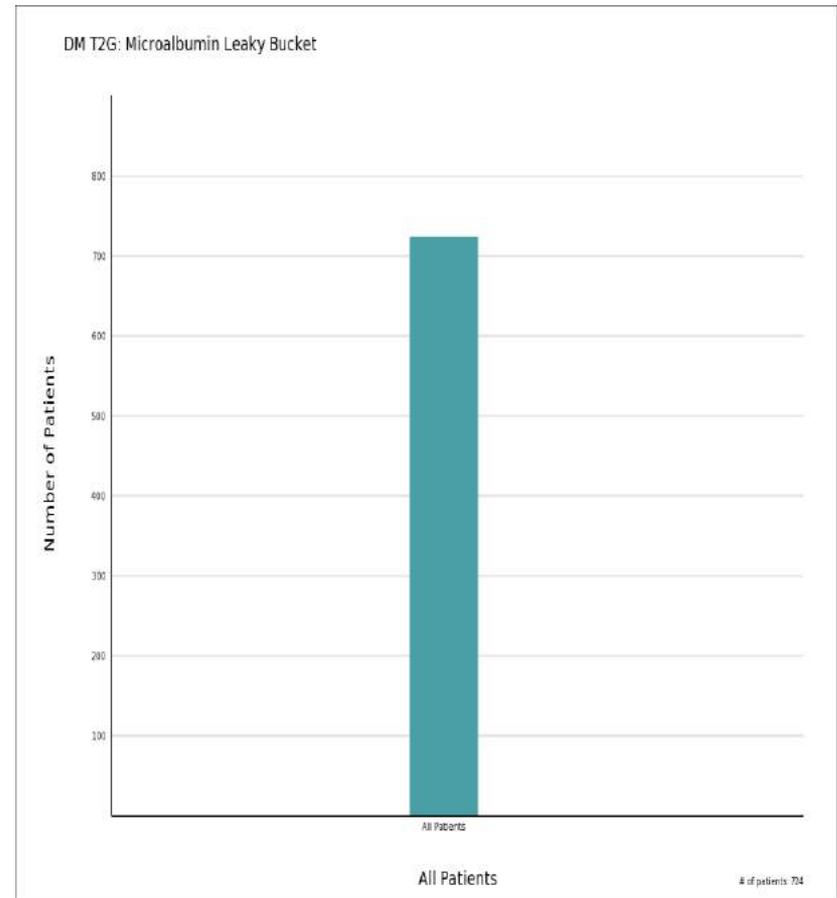
Focus on Medical Attention to Nephropathy

Filters (4)

AND

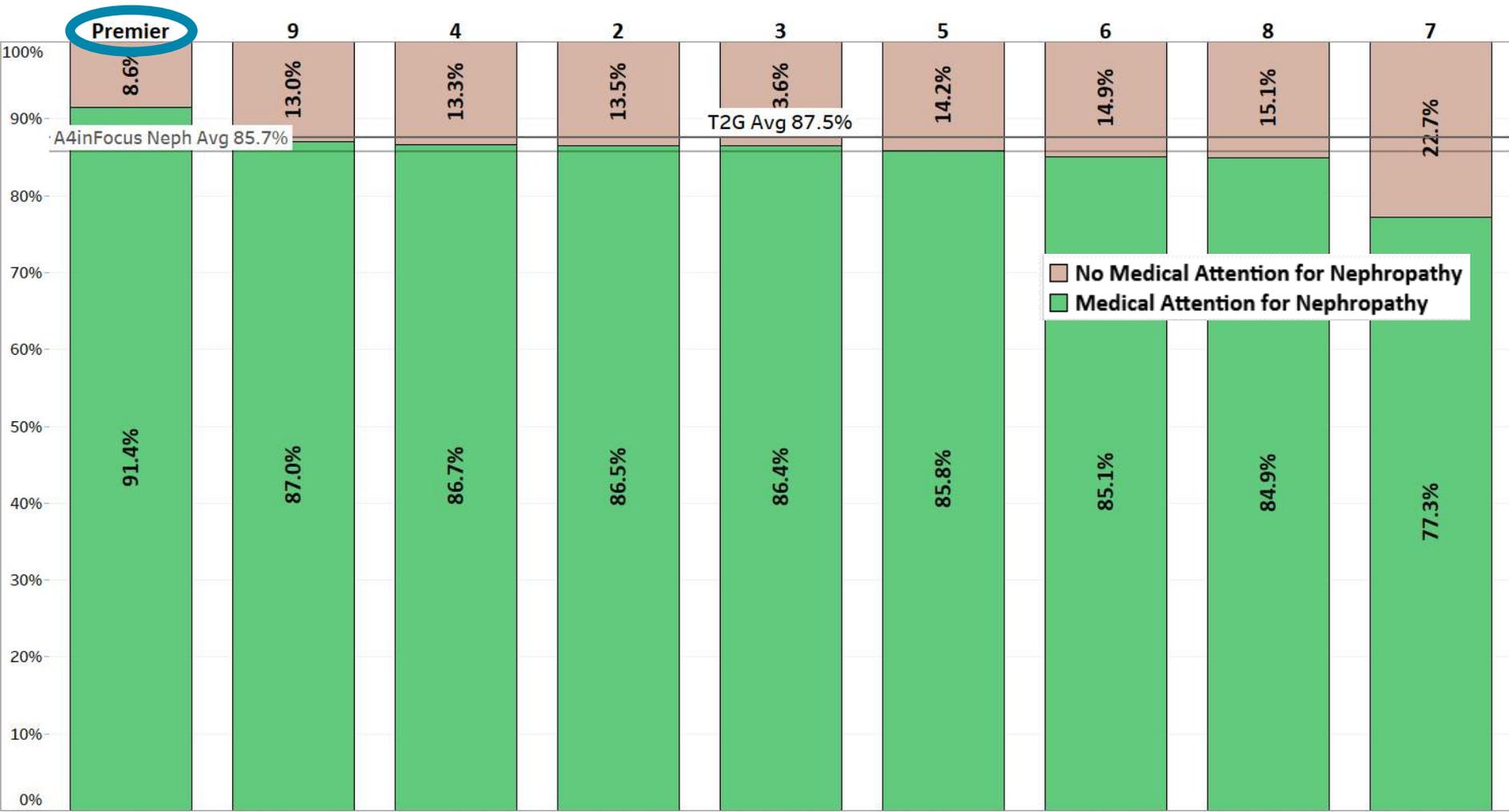
- Pts w Dx of DM Type 2 (AMGA)
Value: True
- Last eGFR
INCLUDE values ≥ 60
- Pts w Rx for ACEI/ARB
Value: False
- Pts Had Urine Albumin
Value: True

+ Add filter... Load... Clear all



A4inFocus Nephropathy Measure

2/1/17–1/31/18 (final monthly reporting period for A4inFocus)



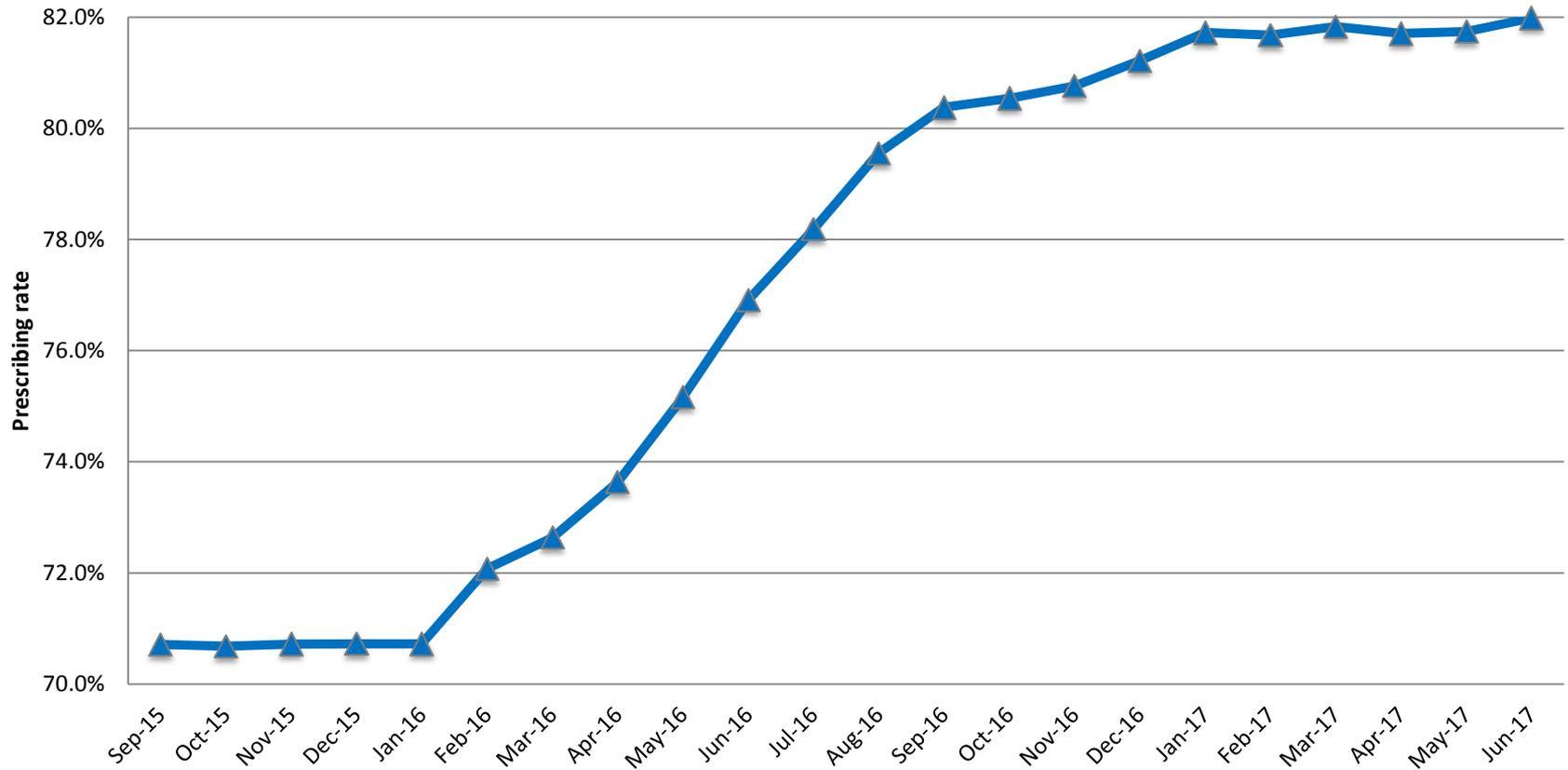
Focus on Statin Prescribing

- Included point of care alerts in EHR
- Educated clinicians and care team members about the importance of CVD risk assessment for patients with type 2 DM
- Used the ACC/AHA Risk Calculator for patients with type 2 DM over age 40
- Delegated use of the calculator to other team members
- Incorporated automated tools in the EHR to calculate risks



Focus on Statin Prescribing

Statin Use for Type 2 DM Patients

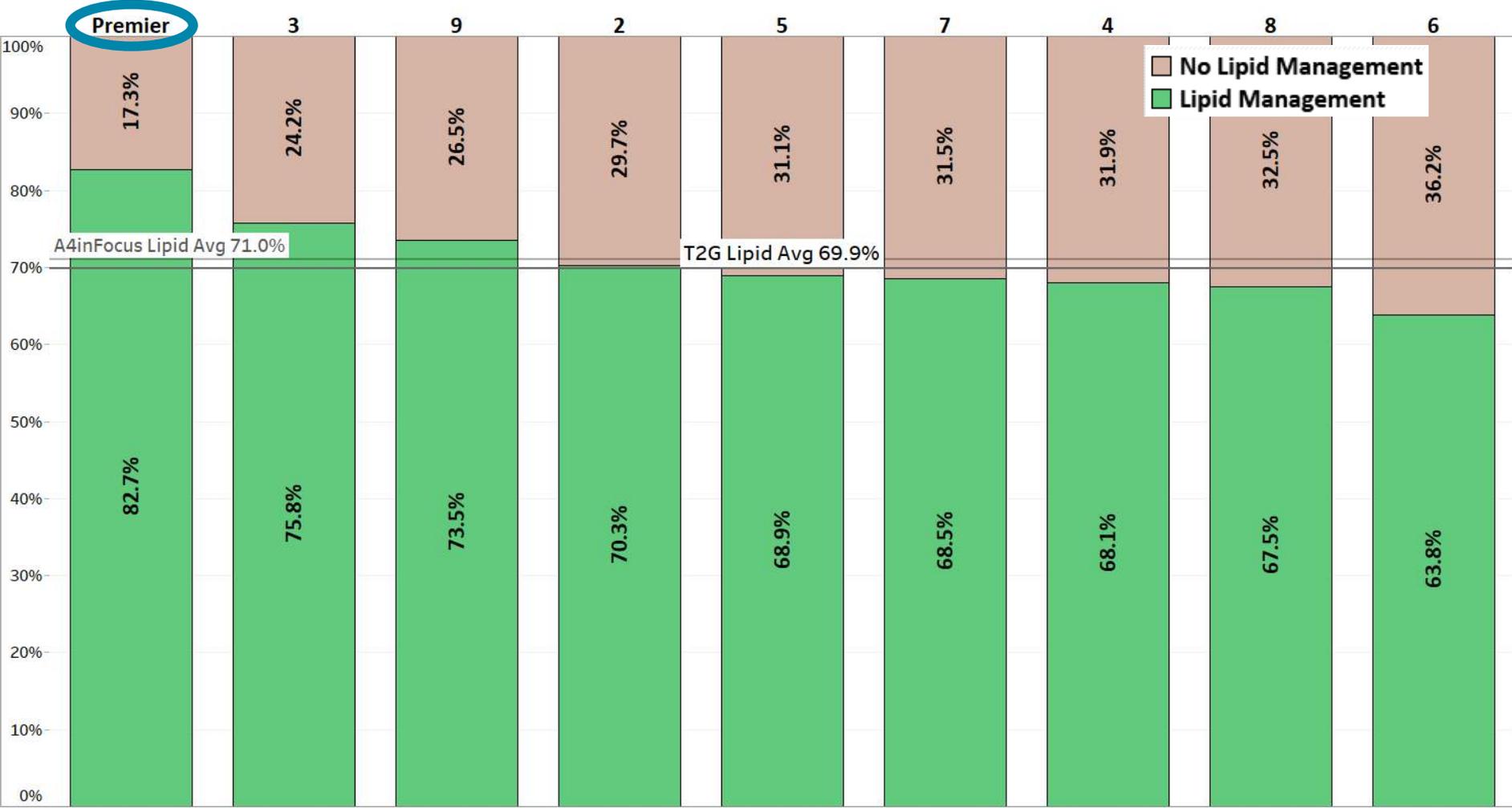


PREMIER
MEDICAL ASSOCIATES

Building
Better
Care

A4inFocus Lipid Measure

2/1/17–1/31/18 (final monthly reporting period for A4inFocus)



Focus on Bundle Improvement

MANAGERIAL

Value of Primary Care Diabetes Management: Long-Term Cost Impacts

Daniel D. Maeng, PhD; Xiaowei Yan, PhD; Thomas R. Graf, MD; and Glenn D. Steele, Jr, MD, PhD

- Need for provider buy in

Maeng, D. D., Yan, X., Graf, T. R., & Steele Jr, G. D. (2016). Value of primary care diabetes management: long-term cost impacts. *The American journal of managed care*, 22(3), e88-e94.

Despite the existence and availability of effective clinical guidelines for treating diabetes,^{1,3} wide variability in the treatment patterns of patients with diabetes remains,^{4,8} resulting in adverse health outcomes and incurring avoidable care and cost.^{9,10} Reducing unjustified and nonpatient-centered variations in care, therefore, via a comprehensively redesigned system of care tuned to deliver all of the care needed to every patient at every encounter, can lead to both improved patient health outcomes and avoid expensive “downstream” care.

An increased focus on standardization is likely to increase the reliability of care delivery. One such effort to standardize care is Geisinger’s diabetes system of care (DSC). Geisinger has redesigned its care system to allow physicians to focus on “physician work” (ie, complex medical decision making, and patient relationships and leading staff members functioning in a top-of-license team). This physician-directed, team-delivered care is facilitated and enhanced by hard-wired technology accelerators available in primary care clinics.¹¹ The care team is a standard office complement involving physicians, advanced practitioners, and front-office staff. Staffing ratios are approximately 2.25 nonproviders to 1 physician or advanced practitioner. This system of care allows the team to focus on an all-or-none bundle that consists of quantifiable measures of care based on commonly accepted clinical elements and intermediate outcome targets (summarized in Table 1) that can be easily implemented during routine primary care visits and are associated with improved outcomes for the patients.¹²⁻¹⁴

The DSC is a practice-level intervention that changes how care is delivered to all patients with diabetes treated within a primary care practice site. Thus, in this study, all primary care physicians and healthcare providers are employed by Geisinger, are practicing in one of the primary care sites owned by Geisinger, and are subject to the DSC. Operationally, the DSC specifies delegated accountable responsibilities for each team member, with the goal to develop work flows

ABSTRACT

Objectives: To estimate long-term cost savings associated with patients’ exposure to an all-or-none bundle of measures for primary care management of diabetes.

Study Design: In 2006, Geisinger’s primary care clinics implemented an all-or-none diabetes system of care (DSC). Claims data from Geisinger Health Plan were used to identify those who met Health-care Effectiveness Data and Information Set criteria for diabetes and had 2 or more diabetes-related encounters on different dates before 2006. A cohort of 1875 members exposed to the DSC was then compared against a propensity score matched non-DSC comparison cohort from January 1, 2006, through December 31, 2013.

Methods: A set of generalized linear models with log link and gamma distribution was estimated. The key explanatory variable was each member’s bundle exposure measured in months. The dependent variables were inpatient and outpatient facility costs, professional cost, and total medical cost excluding prescription drugs measured on a per-member-per-month basis.

Results: Over the study period, the total medical cost saving associated with DSC exposure was approximately 6.9% ($P < .05$). The main source of the saving was reductions in inpatient facility cost, which showed approximately 28.7% savings ($P < .01$) over the study period. During the first year of the DSC exposure, however, there were significant increases in outpatient (13%; $P < .05$) and professional (9.7%; $P < .05$) costs.

Conclusions: A system of care with an all-or-none bundled measure used in primary care for patients with diabetes may reduce long-term cost of care while improving health outcomes.

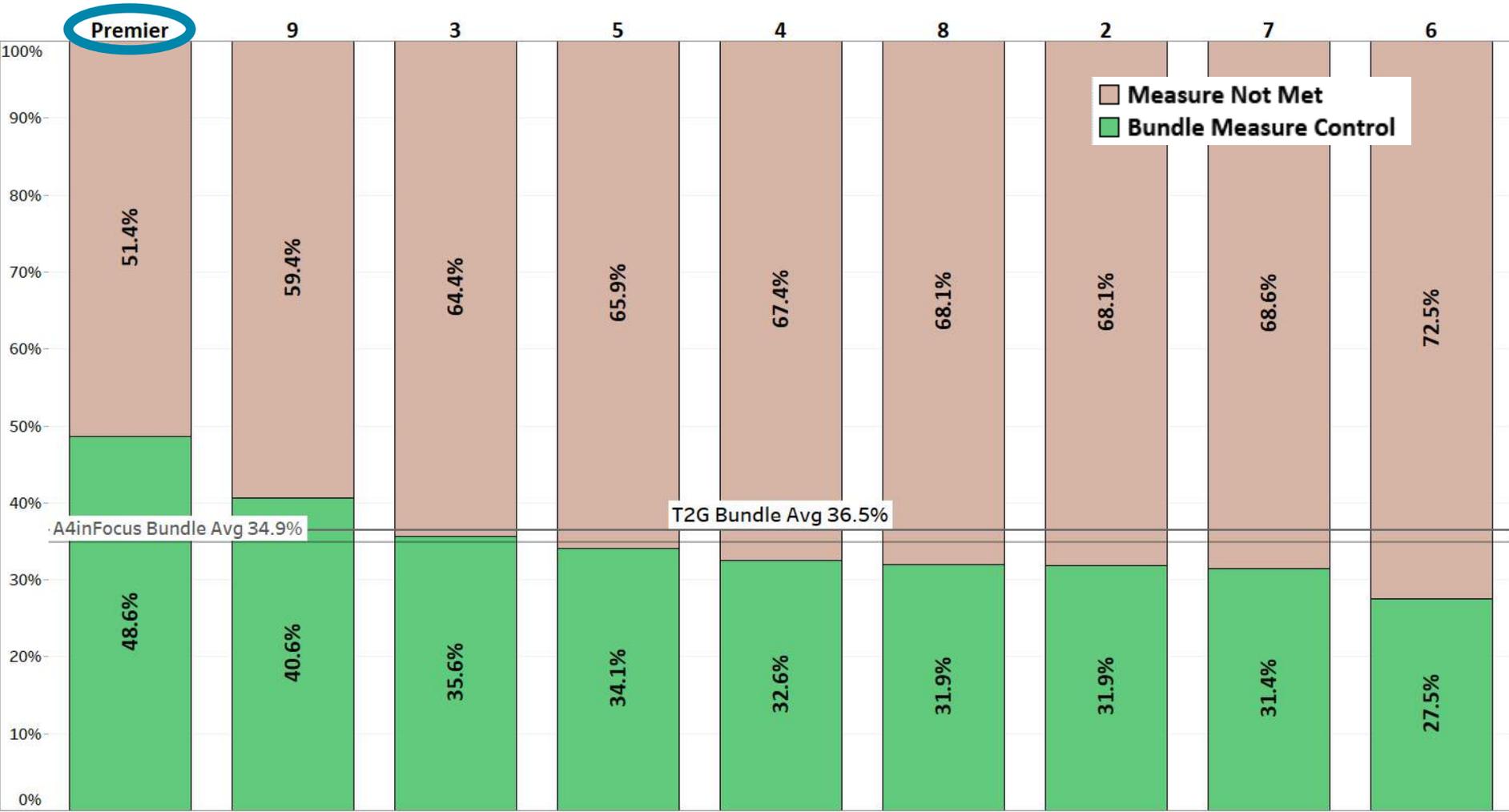
Am J Manag Care. 2016;22(3):e88-e94



Building
Better
Care

A4inFocus Bundle Measure (seasonally adjusted)

2/1/17-1/31/18 (final monthly reporting period for A4inFocus)



A4inFocus PMA Summary

(seasonally unadjusted & adjusted)

| Measure | Impact of A4inFocus Unadjusted | Impact of A4inFocus Adjusted |
|-------------------------------------|--------------------------------|------------------------------|
| A1c control rate | +2.4% | +1.3% |
| BP control rate | -1.2% | -0.5% |
| Medical attention to kidney disease | +1.6% | +1.6% |
| Lipid management | +0.9% | +0.9% |
| D4 Control bundle | +0.61% | +0.64% |

Up Next...

Browse/Load in Workspace

My Files Shared Files Library Search

- ▶ alexzan@
- ▶ **catherin**
- ▶ daniel.n
- ▶ dlynn@
- ▶ elyse.yo
- ▶ hkern@
- ▶ holli.whi
- ▶ lucy.par
- ▶ rmack@

- ▶ AFIB
- ▶ AI-2
- ▶ **T2G**

- ▶ **3 of 4**
- ▶ Development
- ▶ Leaky Bucket
- ▶ Lipid Management
- ▶ Nephropathy
- ▶ Validation

T2G: Patient Missing 1 of 4 Bundle Measures

Delete Rename... New Folder... Show all files

Details:

Shared > catherine.mullins@humedica.com > T2G > 3 of 4 > T2G: Patient Missing 1 of 4 Bundle Measures

Type: Graph
Availability: Shared
Saved on: 2/21/2018 12:42
Comments: None

Title: T2G: Patient Missing 1 of 4 Bundle Measures
Variables: Patients by Current PCP
Disease Cohort: Diabetes Mellitus

OK Cancel

Questions for the Panelists?



- Mercy Joplin
 - Dr. Tracy Godfrey, Tracy.Godfrey@Mercy.Net
 - Rose Peacock, Rose.Peacock@Mercy.Net
- Premier Medical Associates
 - Dr. Frank Colangelo, fcolangelo@pmamail.com
 - Jennifer Obenrader, jobenrader@pmamail.com
- AMGA
 - Dr. John Cuddeback, jcuddeback@amga.org
 - Jill Powelson, jpowelson@amga.org

JUNE 2018 MONTHLY WEBINAR

- **Date/Time:** Thursday, June 21, 2-3pm Eastern
- **Topic:** Blood Pressure Control for Patients with Diabetes
- **Presenter:** Robert Matthews of PriMed Physicians



AMGA/Optum Analytics June User Group

Topic:

**Self-reporting and bundle improvement for
T2G measures using Optum One**

When: **June 27th, 2:00pm ET**

Save the date! Registration will open soon.



Questions for the Panelists?



- Mercy Joplin
 - Dr. Tracy Godfrey, Tracy.Godfrey@Mercy.Net
 - Rose Peacock, Rose.Peacock@Mercy.Net
- Premier Medical Associates
 - Dr. Frank Colangelo, fcolangelo@pmamail.com
 - Jennifer Obenrader, jobenrader@pmamail.com
- AMGA
 - Dr. John Cuddeback, jcuddeback@amga.org
 - Jill Powelson, jpowelson@amga.org