



# Together2Goal<sup>®</sup>

AMGA Foundation  
National Diabetes Campaign



# Monthly Campaign Webinar

## April 18, 2019

# Today's Webinar

- Together 2 Goal® Updates
  - Webinar Reminders
  - Extension Announcement
  - How to Remain in the Campaign
  - Extension Offerings
  - New Data Reporting Components
- AMGA Analytics
  - John Cuddeback, M.D., Ph.D.
- Questions



# Webinar Reminders



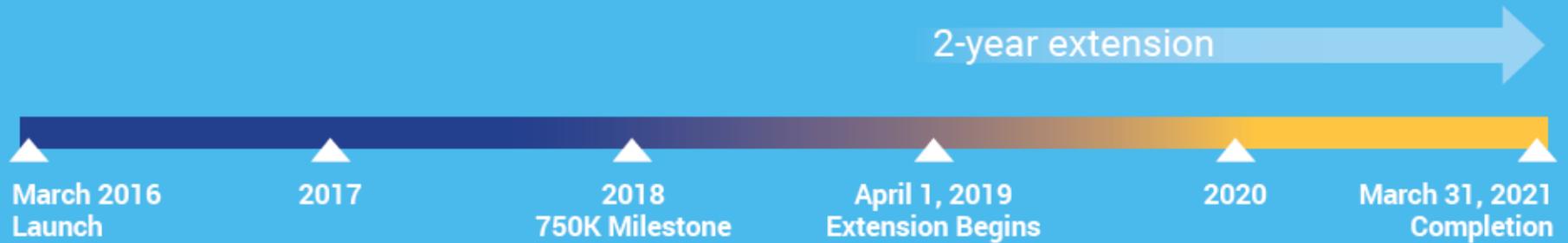
- Webinar will be recorded today and available the week of April 22<sup>nd</sup>
  - [www.Together2Goal.org](http://www.Together2Goal.org)
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen



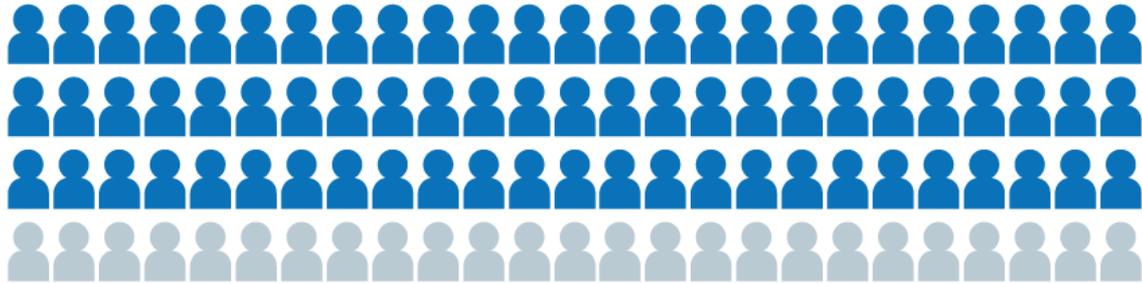
# Campaign Extension into 2021



## T2G EXTENDS TO 2021



Improved care for more than  
**750,000** people  
with Type 2 diabetes





# Together 2 Goal<sup>®</sup> Momentum



**14 new groups with over 2,500 FTE physicians**

# New Research Publications & Presentations from AMGA Analytics

## Screening Patients for Diabetes in a Large, National Clinical Database

Nikita Stempniewicz, M.S., John Cuddeback, M.D., Ph.D., Cori Rabiner, M.S., Elizabeth L. Ciemins, Ph.D., M.P.H., M.A. — AMGA, Alexandria, Virginia

**Background**  
 1. Diabetes is a leading cause of death and disability in the United States.  
 2. The ADA Standards of Medical Care in Diabetes suggest that all adults aged 18 years and older should be screened for diabetes.  
 3. The ADA Standards of Medical Care in Diabetes suggest that all adults aged 18 years and older should be screened for diabetes.

**Study Objective**  
 To measure diabetes screening patterns (including patient and ADA Standards of Medical Care in Diabetes) using large, geographically diverse clinical database.

**Results**  
 Figure 1: Diabetes Screening and Follow-up in 23 Health Care Organizations (HCOs)

**Methods**  
 Retrospective descriptive analysis of 22 million patient records across 23 HCOs from 2012 to 2017. Data was analyzed using Optum's data science platform.

**Definitions**  
 Type 2 Diabetes Mellitus: ICD-9-CM 250.00-250.99  
 Fasting Plasma Glucose (FPG): ICD-9-CM 86.00-86.09  
 Hemoglobin A1c (HbA1c): ICD-9-CM 86.10-86.19  
 Diabetes Medication: ICD-9-CM 272.00-272.99

**Conclusion**  
 1. 18% of patients were screened for diabetes.  
 2. 65% of screened patients received a diagnosis or prescription.  
 3. 35% of patients with a diagnosis or prescription had a follow-up visit within 6 months.

**Research Objective:** To characterize clinical inertia in the treatment of type 2 diabetes using a large, national, geographically diverse clinical data repository.

**Study Design:** A retrospective descriptive analysis was conducted in a clinical database containing 22 million patient records across 23 health care organizations (HCOs).

**Population Studied:** A total of 281,000 patients aged 18–75 were included during the 5.5-year study period (1/2012–6/2017). Patients had at least one outpatient visit in the last 12 months of the study period, an HbA1c in the last 24–30 months (index A1c), and a diagnosis of type 2 diabetes on an outpatient claim or electronic health record (EHR) problem list at least 6 months prior to index A1c. A subset of 47,893 patients with an index A1c ≥8 and a prior A1c <8 or lack thereof, was observed for four 6-month follow-up periods for actions including a new class of diabetes medication prescribed or an A1c <8. The absence of observable action following the index A1c suggests potential “clinical inertia.”

**Principal Findings:** Six months following an index A1c ≥8, 55% of patients received no observable clinical action ranging from 45–65% across HCOs and 18–96% across individual providers. A new diabetes prescription was observed in 35% of patients (7.5% moved into glycemic control, i.e., A1c <8) and 10% moved into clinical control without a new prescription. Within 24 months, clinical inertia was reduced to 19%, ranging from 13–26% across HCOs. Patient characteristics associated with increased clinical inertia, i.e., no observable action, during the 6- and 24-month follow-up periods included black race, low-income insurance, normal body mass index, and being on bolus insulin (all P < .01).

**Conclusions:** Lack of clinical action in the 6 months following an A1c ≥8 suggests clinical inertia in relation to adherence to ADA guidelines. The decline in clinical inertia within 24 months further indicates either actions not seen in the data, or later interventions that were ultimately effective.

**Implications for Policy or Practice:** Greater rates of clinical inertia in low-income insurance and race/ethnic minority adults suggests potential populations to target to ensure adequate treatment for diabetes as well as the need for further investigation into the source of inertia, i.e., provider or patient. Findings suggest that social determinants of health may have been contributing factors. The decline in clinical inertia from 6 months to 24 months warrants further exploration into clinical practice patterns around diabetes treatment and management.

## INDUSTRY INSIGHTS DATA - TRENDS - CONTEXT

# Bridging the Gaps

### From diabetes screening to diagnosis to treatment

More than 30 million people in the United States have diabetes, and 1 in 4 don't know they have it. Over a third of U.S. adults have prediabetes and 80% don't know they have it. The number of adults diagnosed with diabetes has more than tripled in the past 20 years as the U.S. population has aged and prevalence of overweight and obesity has increased. With diabetes as the second leading cause of death in the U.S., screening for and diagnosing diabetes is crucial to stem these increasing trends.

In prior analyses, AMGA found that in a population of 3.8 million patients eligible for diabetes screening per ADA Standards of Care for Diabetes, only 86% were screened. In the follow-up study, we focused on the actions taken as a result of screening.

The objective was to measure the time from a positive diabetes screening test to appropriate follow-up action—i.e.,

**Key Findings**

- Positive diabetes tests were most often indicated by FPG (81% of the time) versus HbA1c (28%), or both (11%).
- 65% (range 55%–77% across 23 HCOs) had appropriate

**diagnosis, pharmacologic treatment (with or without diagnosis), or negative confirmatory test—using a large, geographically diverse clinical database. We conducted a retrospective descriptive analysis in a clinical database with over 25 million patient records.**

From 2013 through 2017, 61,162 patients aged 18–75 from 23 healthcare organizations (HCOs) with ≥1 outpatient visit in last 12 months of data, a laboratory finding of hemoglobin (Hb) A1c ≥6.5 or fasting plasma glucose (FPG) ≥126 in the last 12–24 months, and no prior diabetes diagnosis or prescription (except metformin) were included in the study.

**Figure 1**  
**Three-Month Follow-up after a Positive Diabetes Screen, Overall and by Healthcare Organization (HCO)**

**Study Objective**  
 To measure the time from a positive diabetes screening test to appropriate follow-up action—i.e., diagnosis, pharmacologic treatment (with or without diagnosis), or negative confirmatory test—using a large, geographically diverse clinical database.

**Methods**  
 Retrospective descriptive analysis of 22 million patient records across 23 HCOs from 2012 to 2017. Data was analyzed using Optum's data science platform.

**Results**  
 1. 18% of patients were screened for diabetes.  
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## Learning Health Systems, Creative Analytics, and Population Health Management

Elizabeth L. Ciemins, PhD, MPH, MA  
 Director, Research and Analytics, AMGA

Value-Based Care Summit Series: Population Health Management  
 April 5, 2018 | Dallas, TX

## Characterizing Clinical Inertia Among Patients with Type 2 Diabetes

Cori Rabiner, M.S., Elizabeth L. Ciemins, Ph.D., M.P.H., M.A., Nikita Stempniewicz, Sc.M., John Cuddeback, M.D., Ph.D. — AMGA, Alexandria, Virginia

**Clinical Inertia**  
 Failure of a healthcare provider to initiate or adjust therapy when indicated.

**Study Objective**  
 To identify and describe potential clinical inertia in the management of type 2 diabetes in a large, geographically diverse clinical database.

**Methods**  
 Retrospective descriptive analysis of 22 million patient records across 23 HCOs from 2012 to 2017. Data was analyzed using Optum's data science platform.

**Results**  
 1. 18% of patients were screened for diabetes.  
 2. 65% of screened patients received a diagnosis or prescription.  
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**Conclusion**  
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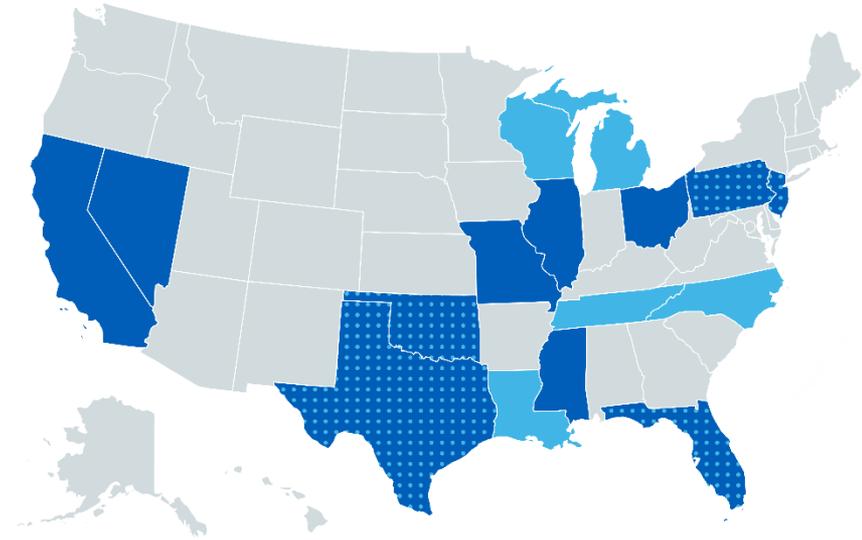
**Study Significance**  
 Diabetes is a leading cause of death and disability in the United States. The ADA Standards of Medical Care in Diabetes suggest that all adults aged 18 years and older should be screened for diabetes.

**Potential Causes of Clinical Inertia**  
 1. Lack of awareness of the patient's condition.  
 2. Lack of knowledge of the patient's condition.  
 3. Lack of resources to manage the patient's condition.  
 4. Lack of time to manage the patient's condition.  
 5. Lack of patient motivation to manage the condition.

# New Project: Innovator Track Progress Report



- Concludes in 2019
- Case studies to be shared with T2G participants



# New Project: T2G Diabetes Bundle Best Practices Learning Collaborative



Kendra Dorsey



Senior Director  
National Health Campaigns

# How to Remain in the Campaign

**How do I re-enroll in the campaign?**

**...No need to re-enroll!**

All you need to do is:

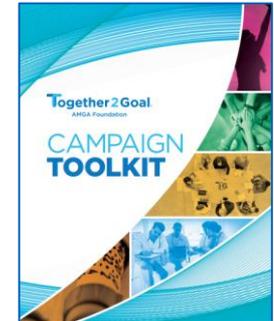
- Continue implementing plank(s)
  - Or adopt new ones
- Continue submitting data
  - Or consider advancing tracks
- Use existing and new resources to get to goal

# Continuing Campaign Offerings

- 1 Campaign Toolkit
- 3 National Days of Action
- 3 Data reporting tracks
- *6 Goal-Getters*
- 11 quarterly blinded comparative data reports
- 31 Monthly Webinars
- *36 Goal Post* resources



## Communities



| TOGETHER 2 GOAL® 2019 WEBINAR SCHEDULE    |  |  |
|---|--|--|
| WEBINARS WILL BE HELD FROM 2:30PM EASTERN |  |  |
| Date                                      | Topic  | Presenter(s)   |
| Jan. 17, 2019                             | American Diabetes Association 2019 Standards of Care                       | Nisa Maruthi, M.D., M.H.S. (Johns Hopkins University)  |
| Feb. 21, 2019                             | Clinical Inertia and Diabetes Care   | Daniel McCall, M.D. (Hattiesburg Clinic)   |
| March 21, 2019                            | Overcoming Barriers to Diabetes Self-Management Education (DSME) Referrals | Jodi Lavin-Tompkins, M.S.N., R.N., CDE, BC-ADM (American Association of Diabetes Educators) and Valerie Spier, M.P.H., R.D., CDE (Butter Health) |
| April 18, 2019                            | T2G Campaign Extension   | AMGA   |
| May 16, 2019                              | Mental Health Integration and Diabetes Management                          | Brenda Aiso-Brennan, Ph.D., APRN and Mark Greenwood, M.D. (Intermountain Healthcare)   |
| June 20, 2019                             | T.B.D.   | T.B.D.   |
| July 18, 2019                             | Innovator Track Cardiovascular Disease Cohort Results                      | Innovator Track Cardiovascular Disease Cohort Participants   |
| Aug. 15, 2019                             | Embedded Pharmacists in Primary Care                                       | Diane L. George, D.O. and James Kalus, Pharm.D. (Henry Ford Medical Group)   |
| Sept. 19, 2019                            | Innovator Track Eye Care Cohort Results                                    | Innovator Track Eye Care Cohort Participants   |
| Oct. 17, 2019                             | Billing and Code for Diabetes Care   | Debra Barnhart (Meriv Health)  |
| Nov. 21, 2019                             | Culinary Medicine as an Emerging Population Health Intervention            | Timothy Harlan, M.D., FACO, CCMS and Leah Sarris, R.D., LDN, CCMS (Tuane University School of Medicine)  |
| Dec. 10, 2019                             | T2G Diabetes Bundle Collaborative Results                                  | T2G Diabetes Bundle Participants   |

# New Offering: Revamped Website



The screenshot shows the Together2Goal website interface. At the top, there is a navigation bar with the logo 'Together2Goal.' and 'AN INITIATIVE OF AMGA'. Below the navigation bar, there are social media icons for Facebook (770), Twitter, Print, Email, and a plus sign (50). The main content area features a large heading 'T2G EXTENDS TO 2021' and a timeline graphic. The timeline is a horizontal bar with a color gradient from blue to yellow, marked with key dates: March 2016 Launch, 2017, 2018 750K Milestone, April 1, 2019 Extension Begins, 2020, and March 31, 2021 Completion. A grey arrow labeled '2-year extension' points from the 2019 mark to the 2021 mark. Below the timeline, there is a text block on the left and a 'PARTICIPATING GROUPS' section on the right featuring the Abacus Health logo.

Custom Sea

Together2Goal.

AN INITIATIVE OF AMGA

ABOUT US RESOURCES DATA REPORTING SUCCESSES GET INVOLVED

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T2G EXTENDS TO 2021

2-year extension

March 2016 Launch 2017 2018 750K Milestone April 1, 2019 Extension Begins 2020 March 31, 2021 Completion

Welcome to the **Together 2 Goal**® campaign website! We are proud to collaborate with medical groups, health systems, partners, and corporate collaborators across the nation with the goal of improving care for 1 million people with Type 2 diabetes. We hope our website will provide you with the tools and resources needed to more effectively manage your patients with Type 2 diabetes. AMGA members interested in enrolling can learn more [here](#).

PARTICIPATING GROUPS

abacus HEALTH  
healthcare you can count on.

# New Offering: Email Signature Badge



**Together, improving diabetes  
care for 1 million people**

# New Offering: Toolkit Supplement



# New Offering: “Webinars at Work”

**Together2Goal.**  
 AMGA Foundation  
 National Diabetes Campaign

**Webinar at Work**  
**February 2019**  
*“Putting T2G webinars into practice”*

**Webinar: “Clinical Inertia and Diabetes Care”**  
**Speaker:** Daniel McCall, M.D., M.S.P.H. (Hattisburg Clinic, P.A.)  
**Webinar Date:** February 21, 2019

**Summary:**  
 Healthcare providers often do not initiate or intensify therapy, therefore creating clinical inertia. Clinical inertia is often caused by: 1) Overestimation of care provided and adherence to care guidelines, 2) Use of “soft” reasons to avoid intensification of therapy, and/or 3) Lack of education, training, and practice organization focused on achieving therapeutic goals. Lessons learned included: leadership buy-in, provider education, utilizing entire care team, and providing performance feedback.

**Implementation Tips:**

Provider education – guidelines are necessary but not sufficient

- Education on benefits, costs, and side effects of treating to target
- Address the complexity of treating to target for different disorders (glycemic control, hypertension, and dyslipidemia)

Structure our care delivery systems to facilitate management of chronic diseases

- Utilize electronic medical record systems, best practice advisories, flowsheets, and disease registries
- Expand the care team
- Active outreach and planned visits to increase opportunities for “treatable moments”

Provide performance feedback

- Dashboards and audits – timely and specific
- Chart review with face-to-face peer feedback

**Team Discussion:**

1. Where in our diabetes workflow are we facing clinical inertia barriers? (e.g. PCP education, overestimation of care provided, “soft” reasons to avoid intensification of therapy, etc.)

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2. Given our organizational structure and culture, how can we best address clinical inertia?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. How can we improve our organization’s process for following-up with patients to increase opportunities to improve clinical inertia among our diabetes patient population?

\_\_\_\_\_

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4. How do we internally capture and share our diabetes metrics for patients? How can we better utilize this data to raise awareness of possible improvement areas among care teams?

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**Additional Notes:**

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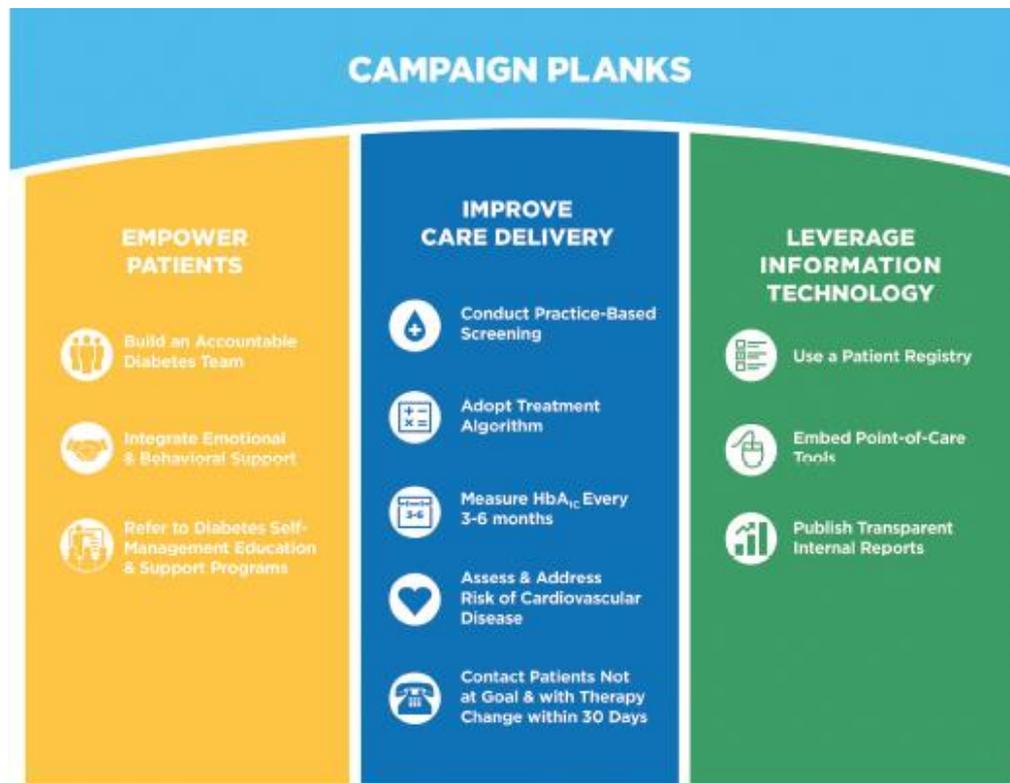
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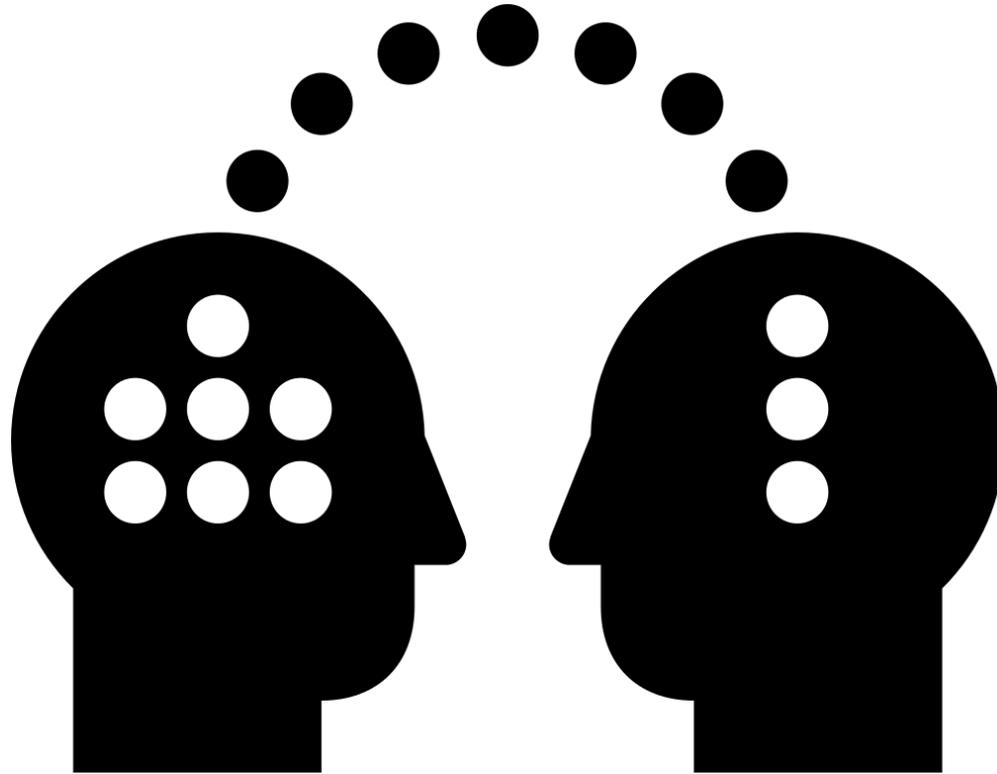
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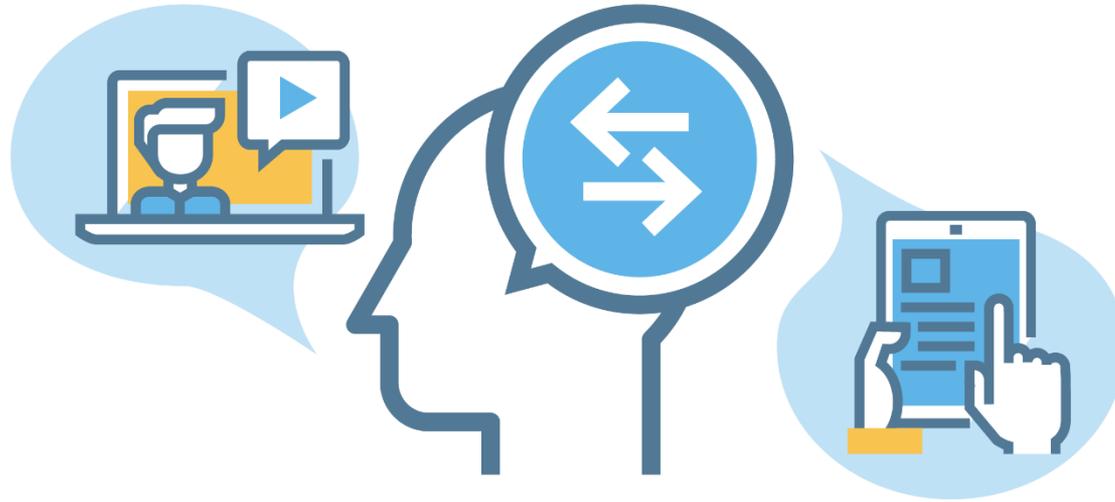
# New Offering: Interactive Campaign Planks



# New Offering: Plank Mentors



# New Offering: Best Practices Compendium



# Together 2 Goal<sup>®</sup> Extension Corporate Collaborators



Presenting Corporate Collaborator



Founding Corporate Collaborator



Distinguished Data and Analytics  
Corporate Collaborator



Innovator Track Corporate Collaborator



Contributing Corporate Collaborator

# Together 2 Goal® Non-Profit Partners & Supporting Organizations



American Association  
of Diabetes Educators



*Diabetes Sisters*



# Data Reporting Deadlines



|                        | Measurement Periods<br>(Quarters)     | Measurement Periods<br>(Months and Days)     | Reporting Deadline | Report Sent to<br>Groups |
|------------------------|---------------------------------------|--|--------------------|--------------------------|
| <b>T2G<br/>Year 4:</b> | <b>2019 Q2</b><br>(2018 Q3 – 2019 Q2) | <b>2019 Q2</b><br>(2018 Jul 1 – 2019 Jun 30) | September 2, 2019  | September 27, 2019       |
|                        | <b>2019 Q3</b><br>(2018 Q4 – 2019 Q3) | <b>2019 Q3</b><br>(2018 Oct 1 – 2019 Sep 30) | December 2, 2019   | December 20, 2019        |
|                        | <b>2019 Q4</b><br>(2019 Q1 – 2019 Q4) | <b>2019 Q4</b><br>(2019 Jan 1 – 2019 Dec 31) | March 2, 2020      | March 20, 2020           |
|                        | <b>2020 Q1</b><br>(2019 Q2 – 2020 Q1) | <b>2020 Q1</b><br>(2019 Apr 1 – 2020 Mar 31) | June 1, 2020       | June 26, 2020            |
| <b>T2G<br/>Year 5:</b> | <b>2020 Q2</b><br>(2019 Q3 – 2020 Q2) | <b>2020 Q2</b><br>(2019 Jul 1 – 2020 Jun 30) | September 1, 2020  | September 25, 2020       |
|                        | <b>2020 Q3</b><br>(2019 Q4 – 2020 Q3) | <b>2020 Q3</b><br>(2019 Oct 1 – 2020 Sep 30) | December 1, 2020   | December 22, 2020        |
|                        | <b>2020 Q4</b><br>(2020 Q1 – 2020 Q4) | <b>2020 Q4</b><br>(2020 Jan 1 – 2020 Dec 31) | March 1, 2021      | March 26, 2021           |
|                        | <b>2021 Q1</b><br>(2020 Q2 – 2021 Q1) | <b>2021 Q1</b><br>(2020 Apr 1 – 2021 Mar 31) | June 1, 2021       | June 25, 2021            |

# New Reporting Template



| Together 2 Goal® Core (Bundle) Reporting Template         |                |                       | <p>Note: To use this updated template to track your T2G core data from the beginning of the campaign (2016 Q1 or your first reported measurement period), copy and paste your historical data into the appropriate light blue cells.</p> <p>You are not required to include your historical data in order to submit to the portal. All prior data submission have been recorded and saved in the portal data base.</p> |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|---|----------------|-----------------------|--|---|-------------------------------|--|---------------|--|------------|--|-----------------------------------|--|------------------|--|----------------------|
| Please enter the requested data in the cells shaded blue. |                |                       |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| Organization Name   |                |                       |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| Core (Bundle) Track                                       |                |                       |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| Phase   | Ending Quarter | Measurement Period    | Active Patients <sup>1</sup>   | Patients with Type 2 Diabetes <sup>1, 2</sup> | Prevalence of Type 2 Diabetes | Patients with last HbA1C < 8% <sup>2</sup> | HbA1C control | Patients with last ambulatory in-office BP < 140/90 <sup>2</sup> | BP control | Patients with medical attention for nephropathy <sup>2</sup> | Medical attention for nephropathy | Patients with statin prescribed or reason not to receive statin <sup>2</sup> | Lipid management | Patients compliant in all four measures (T2G Bundle) <sup>2, 3</sup> | Diabetes care bundle |
| Baseline  | 2016 Q1        | 04/01/2015-03/31/2016 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| T2G Year 1  | 2016 Q2        | 07/01/2015-06/30/2016 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2016 Q3        | 10/01/2015-09/30/2016 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2016 Q4        | 01/01/2016-12/31/2016 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2017 Q1        | 04/01/2016-03/31/2017 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| T2G Year 2  | 2017 Q2        | 07/01/2016-06/30/2017 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2017 Q3        | 10/01/2016-09/30/2017 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2017 Q4        | 01/01/2017-12/31/2017 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2018 Q1        | 04/01/2017-03/31/2018 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| T2G Year 3  | 2018 Q2        | 07/01/2017-06/30/2018 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2018 Q3        | 10/01/2017-09/30/2018 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2018 Q4        | 01/01/2018-12/31/2018 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2019 Q1        | 04/01/2018-03/31/2019 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| T2G Year 4  | 2019 Q2        | 07/01/2018-06/30/2019 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2019 Q3        | 10/01/2018-09/30/2019 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2019 Q4        | 01/01/2019-12/31/2019 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2020 Q1        | 04/01/2019-03/31/2020 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
| T2G Year 5  | 2020 Q2        | 07/01/2019-06/30/2020 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2020 Q3        | 10/01/2019-09/30/2020 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2020 Q4        | 01/01/2020-12/31/2020 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |
|   | 2021 Q1        | 04/01/2020-03/31/2021 |  |   |                               |  |               |  |            |  |                                   |  |                  |  |                      |



# AMGA Analytics



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



Chief Medical Informatics Officer  
AMGA

# Campaign Measures

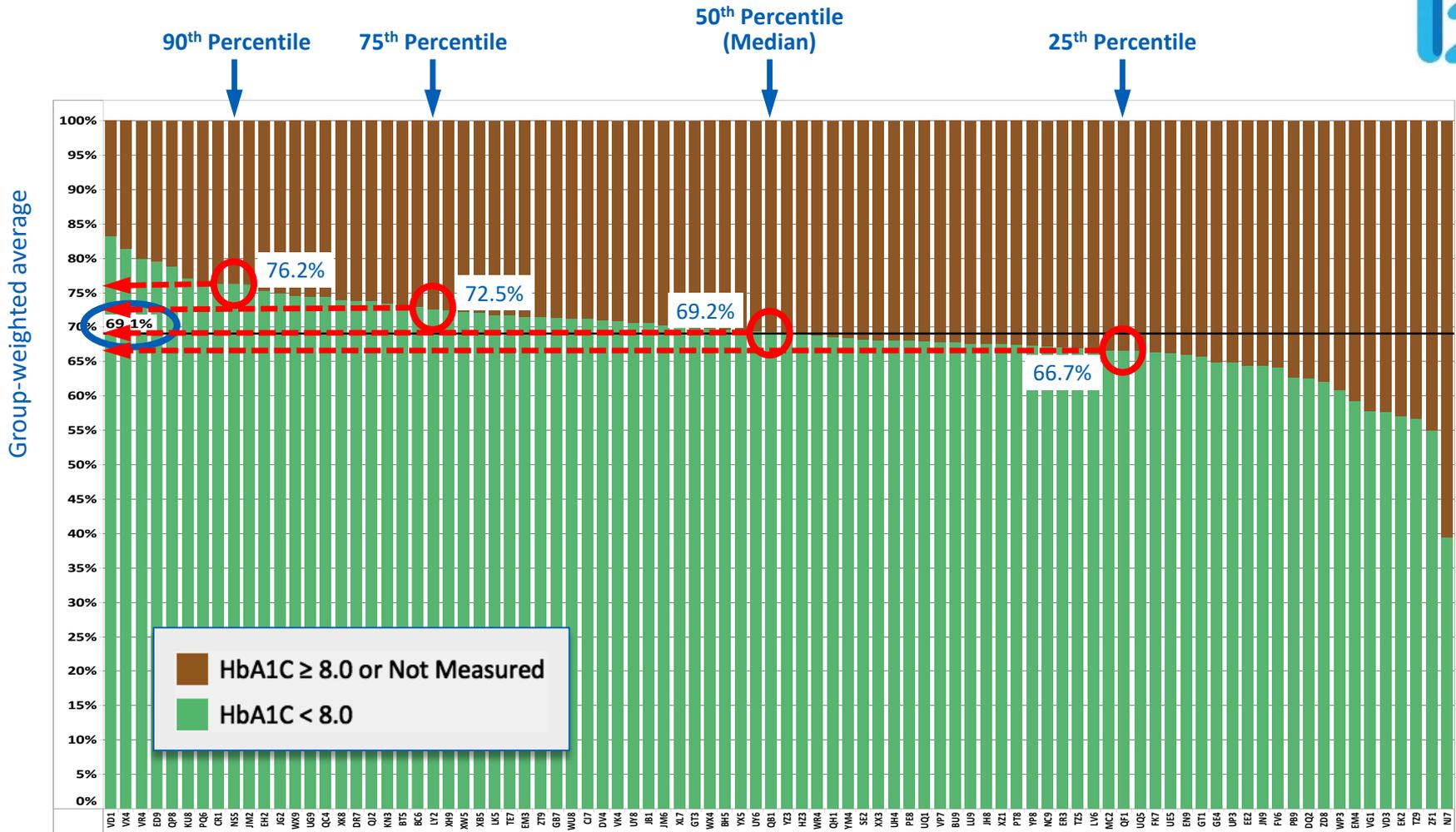
|                                      | Basic | Core (Bundle) | Innovator |
|--------------------------------------|-------|---------------|-----------|
| HbA1c control < 8.0 percent          | ✓     | ✓             | ✓         |
| BP control < 140/90 mmHg             |       | ✓             | ✓         |
| Lipid management (statin prescribed) |       | ✓             | ✓         |
| Medical attention for nephropathy    |       | ✓             | ✓         |
| T2G Bundle                           |       | ✓             | ✓         |
| CVD prevention measures              |       |               | ✓         |
| Eye exam measures                    |       |               | ✓         |



# Updated Measure Specifications (Version 3.0)

- Option to count telehealth encounters (HEDIS 2019)
  - One of the 2+ visits required to qualify for the Active Initial Population can be a telehealth encounter
  - Diagnosis of type 2 diabetes on an eligible telehealth encounter can be used to meet the inclusion criteria for the T2G cohort
- Updated ACEi/ARB reference table for Attention to Nephropathy measure
  - Amlodipine-perindopril and Sacubitril-valsartan have now been added
- Updated T2G value sets (HEDIS 2019)
- Updated table of reporting periods, deadlines, and reporting dates
  - Available in the specifications and on the website

# Each bar shows A1c Control for One Member Organization – 2018 Q4



# Updated Reports

- Quarterly blinded comparative summary reports will now include additional summary statistics

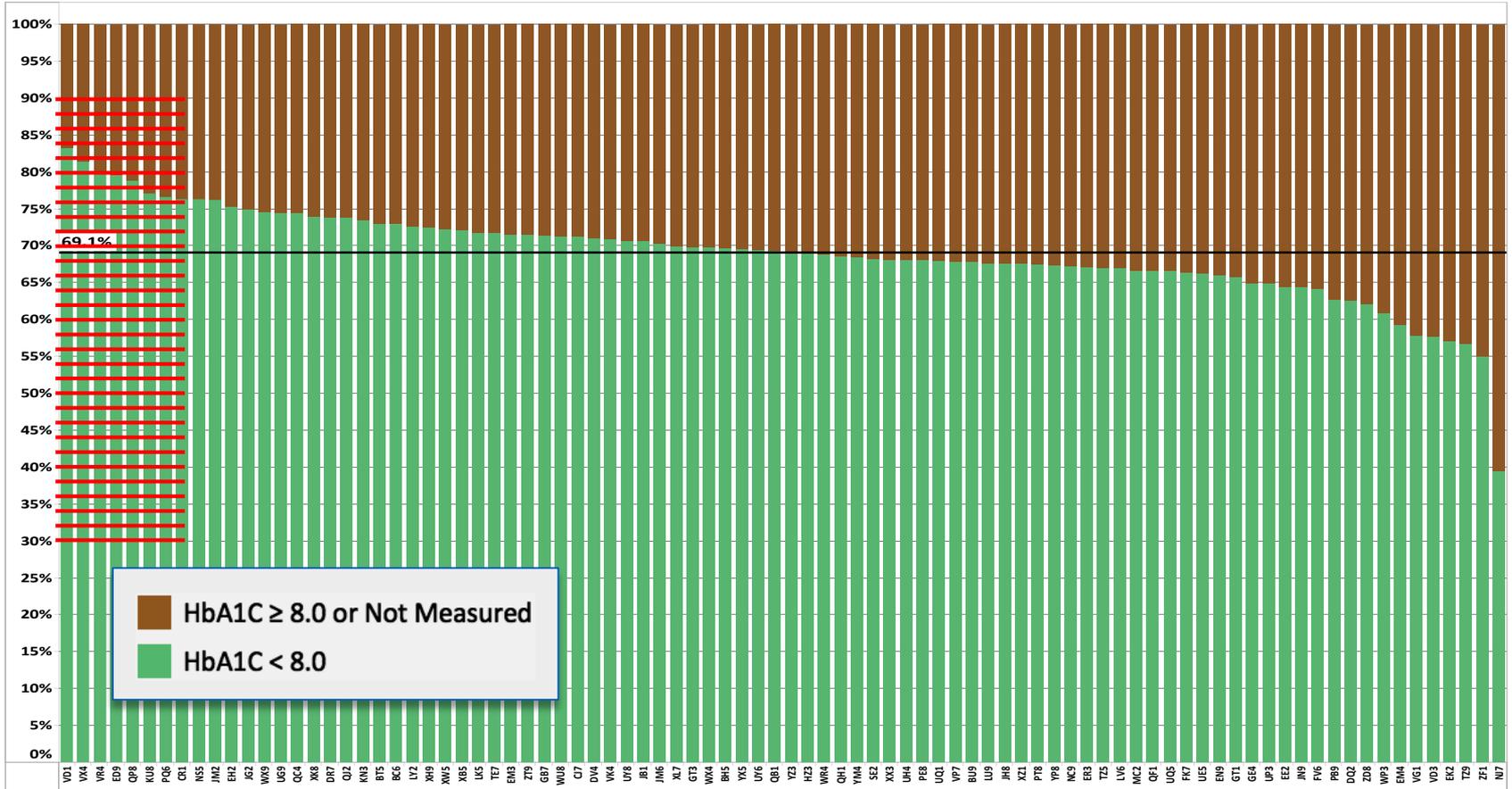
| Summary Statistics (T2G 2018 Q4) | Prevalence of Type 2 Diabetes | HbA1c Control | BP Control | Medical Attention for Nephropathy | Lipid Management | Diabetes Care Bundle |
|----------------------------------|-------------------------------|---------------|------------|-----------------------------------|------------------|----------------------|
| <b>Patient Weighted Average</b>  | 13.3%                         | 67.4%         | 76.1%      | 88.3%                             | 73.4%            | 38.9%                |
| <b>Group Weighted Average</b>    | 14.3%                         | 69.1%         | 76.4%      | 88.7%                             | 74.2%            | 40.1%                |
| <b>25th Percentile</b>           | 11.5%                         | 66.7%         | 72.5%      | 87.0%                             | 69.8%            | 34.9%                |
| <b>50th Percentile</b>           | 14.1%                         | 69.2%         | 75.3%      | 89.4%                             | 73.9%            | 38.9%                |
| <b>75th Percentile</b>           | 17.2%                         | 72.5%         | 79.7%      | 92.2%                             | 79.7%            | 43.9%                |
| <b>90th Percentile</b>           | 20.1%                         | 76.2%         | 85.2%      | 94.5%                             | 83.8%            | 50.8%                |
| <b>Minimum</b>                   | 3.4%                          | 39.5%         | 60.6%      | 71.0%                             | 52.9%            | 20.1%                |
| <b>Maximum</b>                   | 24.3%                         | 83.3%         | 94.1%      | 99.6%                             | 99.0%            | 68.5%                |

- New report: Distribution of group performance (by measure)

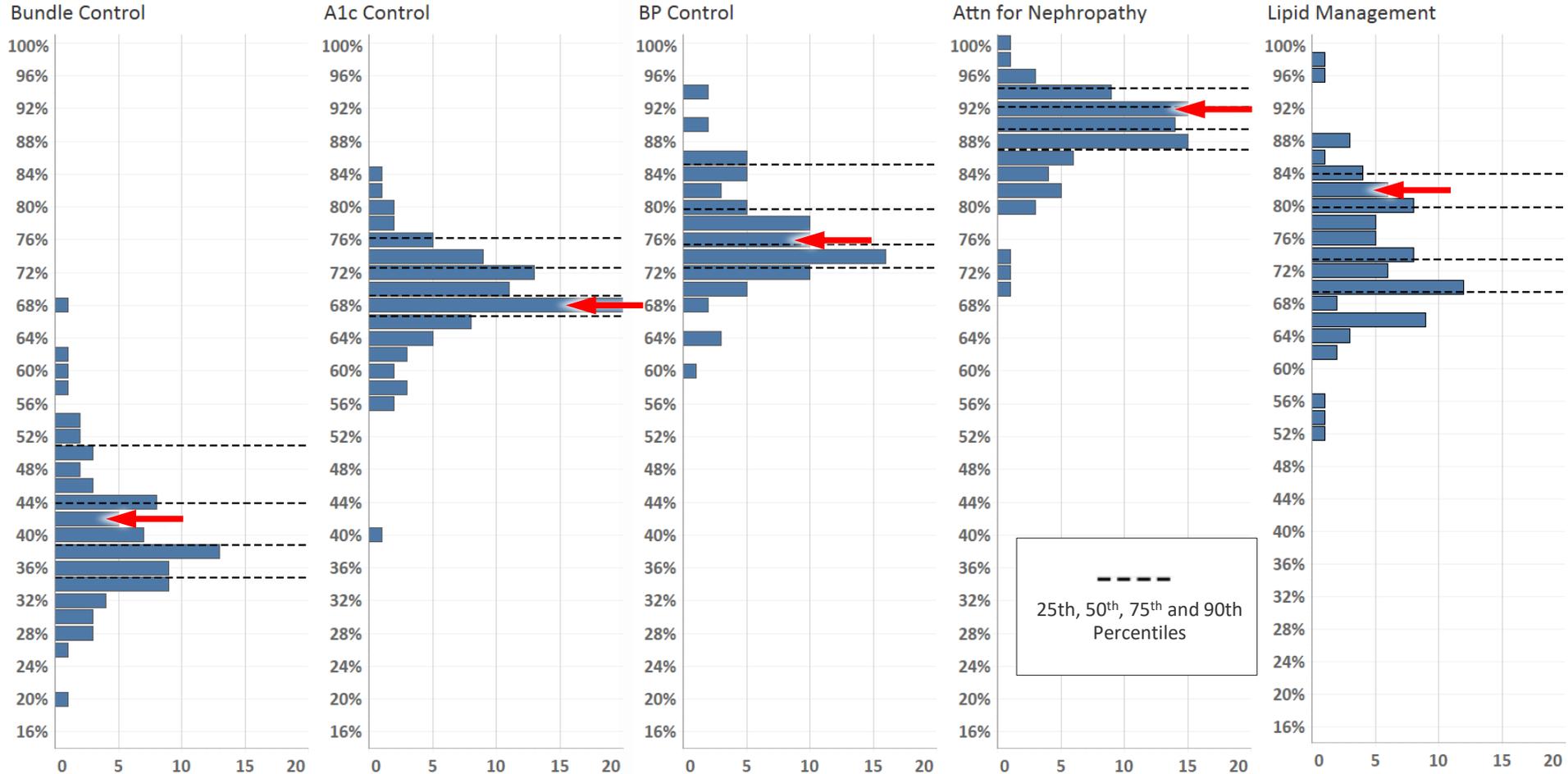
# Each bar shows A1c Control for One Member Organization – 2018 Q4



Group-weighted average



# Distribution of Measure Performance Rate



Number of Health Care Organizations (Reporting for 2018Q4)

# Tracking Achievement

## Population Measures

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- Proportion of patients in control (%)
  - A1c < 8.0
  - BP < 140/90
  - Statin Rx
  - Nephropathy
  - Bundle
- Cross-sectional
- Reported quarterly

## Patients Improved

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- Number of patients with sustained improvement
  - New diagnosis of type 2 diabetes
  - Improve on at least one measure
- Longitudinal
- Reported annually
  - Year 2 concluded 2018 Q1
- Number of patients with sustained control on bundle measure

# Population Measures: 2016 Q1 → 2018 Q1

|             | 2016 Q1 | 2017 Q1 | 2018 Q1 | Δ Year 2 |
|-------------|---------|---------|---------|----------|
| Prevalence  | 14.0%   | 13.9%   | 14.1%   | --       |
| A1c < 8.0   | 66.0%   | 66.6%   | 68.0%   | 2.0%     |
| BP < 140/90 | 72.7%   | 73.8%   | 75.4%   | 2.7%     |
| Nephropathy | 85.6%   | 87.1%   | 88.0%   | 2.4%     |
| Statin Rx   | 68.6%   | 69.0%   | 71.0%   | 2.4%     |
| Bundle      | 33.2%   | 34.6%   | 37.3%   | 4.1%     |

74 AMGA member organizations in all 3 quarters: Baseline, Year 1, and Year 2

# Opportunities for Improvement

- Patients with no prior diagnosis of type 2 diabetes (on problem list or billing claim)
  - New diagnosis for T2DM (on claim\* or problem list)
    - Practice-based screening
    - Review clinical data for existing evidence that's diagnostic or strongly suggestive of type 2 diabetes
- Patients with a diagnosis of type 2 diabetes
  - If A1c is not measured (during measurement period), measure A1c
  - If A1c  $\geq 8.0$ , bring A1c into control
  - if BP is not measured, measure BP
  - If BP  $\geq 140/90$ , bring BP into control
  - If no statin prescribed and LDL  $\geq 70$  mg/dL, prescribe (or re-try) a statin
  - If no medical attention to nephropathy, screen/diagnose, prescribe an ACEi/ARB, or refer to a nephrologist

\* We require Dx codes on claims to be associated with an encounter with a provider, to ensure we don't pick up a code for diabetes that's used in a "rule out" sense, on a claim for a lab test intended as screening for diabetes. This use of the code is technically not correct, but it's a common error.



# Have Dx: Improvement Calculation

|           | A1c      |        | BP       |        | Lipid    |        | Nephropathy |        | Bundle   |        | Improvement |        |
|-----------|----------|--------|----------|--------|----------|--------|-------------|--------|----------|--------|-------------|--------|
|           | Baseline | Year 2 | Baseline | Year 2 | Baseline | Year 2 | Baseline    | Year 2 | Baseline | Year 2 | Baseline    | Year 2 |
| Example A | ✓        | ✓      | X        | ✓      | ✓        | ✓      | ✓           | ✓      | X        | ✓      | ✓           | ✓      |
| Example B | ✓        | ✓      | X        | ✓      | X        | ✓      | ✓           | ✓      | X        | ✓      | ✓           | ✓      |
| Example C | ✓        | X      | X        | ✓      | ✓        | ✓      | ✓           | ✓      | X        | X      | X           | X      |
| Example D | ✓        | ✓      | X        | ✓      | X        | X      | ✓           | ✓      | X        | X      | ✓           | ✓      |
| Example E | ✓        | X      | X        | ✓      | X        | ✓      | ✓           | ✓      | X        | X      | ✓           | ✓      |
| Example F | ✓        | X      | X        | ✓      | X        | ✓      | ✓           | X      | X        | X      | X           | X      |
| Example G | ✓        | ✓      | ✓        | ✓      | ✓        | ✓      | ✓           | ✓      | ✓        | ✓      | X           | X      |

## Improvement is assessed for each patient, then summarized for all patients in the T2G denominator

- Example A – Moving from out-of-control (X) to in-control (✓) on any measure counts as improvement, provided it is not offset by movement from in-control to out-of-control on another measure (see Example D)
- Example B – Moving from out-of-control to in-control on multiple measures improves performance, but it counts the same as a single measure toward improvement
- Example C – Moving from out-of-control to in-control does not count as improvement if it is “offset” by regression (moving from in-control to out-of-control) on another measure
- Example D – Remaining out-of-control diminishes performance on the respective measure, but it does not offset improvement on another measure
- Examples E and F – Improvement on two measures is not offset by regression on one other measure, but it is offset by regression on two other measures
- Example G – Remaining in-control (✓) maintains performance on the respective measure, but it does not count as improvement for the campaign

# Improvement Calculation



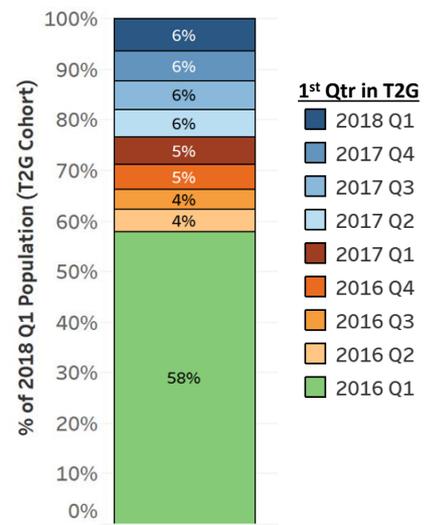
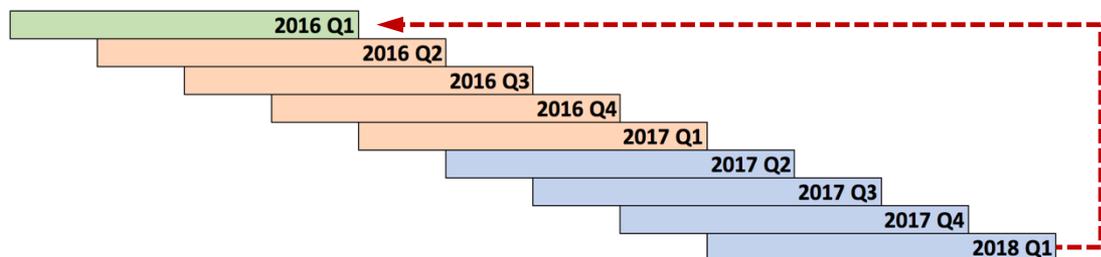
- For T2G, AMGA members self-report numerators and denominators for each measure, which does not provide the longitudinal, patient-level data needed to calculate improvements
  - In the self-reported data below, HbA1c control improved by +4%, and BP control also improved by +4%, but we do not know which patients improved in one or both measures, which is needed to prevent double counting toward our 1 million patient goal
- We can use longitudinal EHR data from AMGA members using an Optum population health analytics tool
  - **20** organizations participating in AMGA’s Analytics for Improvement (A4i) Collaborative and Together 2 Goal Campaign
  - Extrapolate from A4i groups to self-reporting groups—A4i groups account for 35% of active initial population, 37% of T2G cohort
    - Similar prevalence and similar performance on each measure, similar range of organization size and geographic distribution

| Phase      | Ending Quarter | Measurement Period    | Active Patients | Patients with Type 2 Diabetes | Prevalence of Type 2 Diabetes | Patients with last HbA1C < 8% | HbA1C control | Patients with last ambulatory in-office BP < 140/90 | BP control |
|------------|----------------|-----------------------|-----------------|-------------------------------|-------------------------------|-------------------------------|---------------|---|------------|
| Baseline   | 2016 Q1        | 04/01/2015-03/31/2016 | 208,483         | 17,720                        | 8%                            | 9,747                         | 55%           | 13,090  | 74%        |
| T2G Year 1 | 2016 Q2        | 07/01/2015-06/30/2016 | 212,430         | 18,174                        | 9%                            | 10,053                        | 55%           | 13,561  | 75%        |
|            | 2016 Q3        | 10/01/2015-09/30/2016 | 215,354         | 18,482                        | 9%                            | 10,423                        | 56%           | 13,821  | 75%        |
|            | 2016 Q4        | 01/01/2016-12/31/2016 | 218,435         | 18,724                        | 9%                            | 10,540                        | 56%           | 14,030  | 75%        |
|            | 2017 Q1        | 04/01/2016-03/31/2017 | 223,016         | 19,238                        | 9%                            | 10,621                        | 55%           | 14,555  | 76%        |
| T2G Year 2 | 2017 Q2        | 07/01/2016-06/30/2017 | 225,943         | 19,488                        | 9%                            | 11,037                        | 57%           | 15,202  | 78%        |
|            | 2017 Q3        | 10/01/2016-09/30/2017 | 227,414         | 19,805                        | 9%                            | 11,397                        | 58%           | 15,528  | 78%        |
|            | 2017 Q4        | 01/01/2017-12/31/2017 | 229,516         | 20,074                        | 9%                            | 11,785                        | 59%           | 15,490  | 77%        |
|            | 2018 Q1        | 04/01/2017-03/31/2018 | 235,895         | 20,634                        | 9%                            | 12,109                        | 59%           | 16,090  | 78%        |

# Improvement Calculation

- Compare data from Year 2 (2018 Q1) to Baseline (2016 Q1)
- Look backward, to ensure that any improvements are sustained through end of measurement period
  - 58% of patients in T2G Cohort in 2018 Q1 were in T2G Cohort at Baseline (2016 Q1)
- Evaluate these patients for improvement in measures, from Baseline to Year 2

| 2015 |    |    |    | 2016 |    |    |    | 2017 |    |    |    | 2018 |    |    |    |
|------|----|----|----|------|----|----|----|------|----|----|----|------|----|----|----|
| Q1   | Q2 | Q3 | Q4 |



# Improvement Calculation

- For remaining current T2G Cohort patients, evaluate quarterly—check how they entered the T2G Cohort
  - Patient new in T2G Cohort but Active in a prior quarter → established patient, newly diagnosed (diagnosis counts as improvement)
  - Patient new in T2G Cohort and in Active Population → new patient, already diagnosed (diagnosis does not count as improvement)
    - Evaluate these patients for improvement in measures, from cohort entry to current
- Consider patients who were active during the campaign, but not in the most recent quarter
  - Include improvements among patients who were active in  $\geq 2$  quarterly reporting periods but not the most recent quarter
    - Evaluate these patients for improvement in measures, from cohort entry to exit
- For 8 self-reporting groups who entered T2G after 2016 Q1 or left before 2018 Q1 but were active for  $> 2$  quarters
  - Extrapolate using improvement figures specific to the length of their participation
- For all self-reporting groups, extrapolate from age 18–75 (control rates) to age 18–89 (improvement)

# Sustained Bundle Control

- For patients with bundle in control at cohort entry or baseline, check to see if they sustained bundle control
  - These patients are not eligible for any improvements, so they don't count toward the campaign goal
  - For patients who were not in the campaign from Baseline through the end of Year 2, count only if bundle control was sustained for  $\geq 1$  year

## Together 2 Goal Bundle Measure

- A1c < 8.0 percent
- BP < 140/90 mm Hg
- Lipid management—statin prescribed
- Medical attention for nephropathy

# Patients with Improved Care

- Among **1,440,000** patients with type 2 diabetes, age 18–75, in the 2018 Q1 population
  - **536,000** patients with improved care, through the end of Year 2 of the campaign (2018 Q1) – 37.2% of patients
  - **227,000** additional patients with sustained bundle control for  $\geq 1$  year
    - These patients had all measures in control at baseline, so they were not eligible for any improvements—no overlap with the 536,000 patients above
- Among **2,350,000** patients with type 2 diabetes, age 18–89, included in the 2018 Q1 population or in  $\geq 2$  quarterly reporting periods during campaign
  - **763,000** patients with improved care, through the end of Year 2 of the campaign (2018 Q1) – 32.5% of patients
  - **319,000** additional patients with sustained bundle control for  $\geq 1$  year
- Type of improvement:
  - About 1/3 of improvements are in people who have a new diagnosis of type 2 diabetes
  - 2/3 are patients who already had a diagnosis and achieved a net improvement in control, among the four measures that make up the T2G bundle

# May Webinar

- **Date/Time:** May 16, 2019 from 2-3pm Eastern
- **Topic:** Mental Health Integration and Diabetes Management
- **Presenters:**
  - Brenda Reiss-Brennan, Ph.D., APRN (Intermountain Healthcare)
  - Mark Greenwood, M.D. (Intermountain Healthcare)



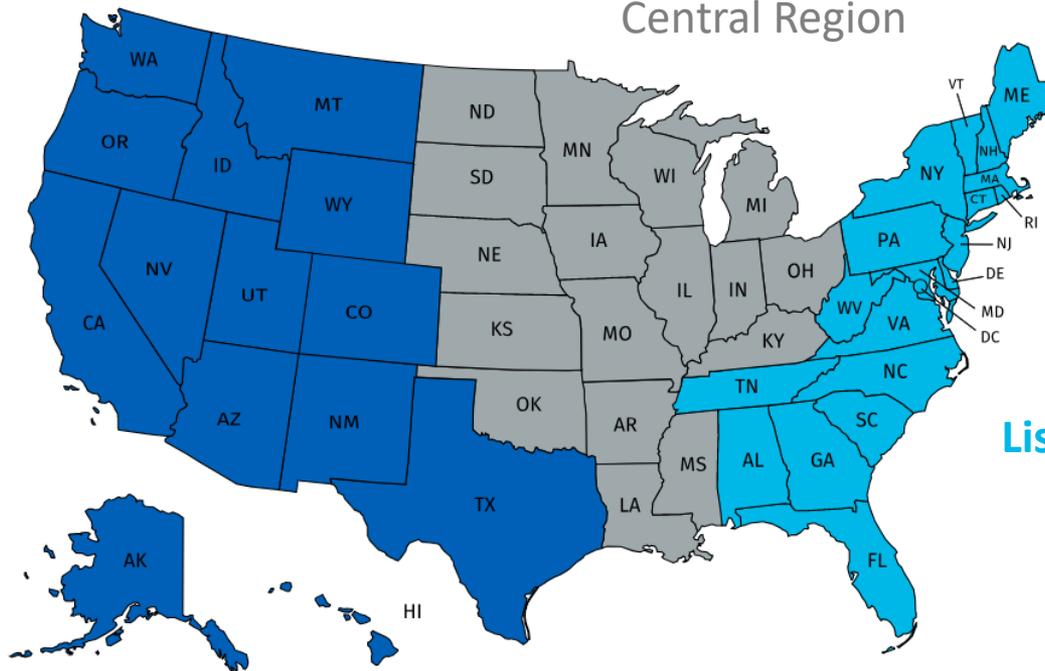
# Questions?



Send inquiries to [together2goal@amga.org](mailto:together2goal@amga.org)

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