Together 2 Goal®

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 22nd
  - www.Together2Goal.org
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

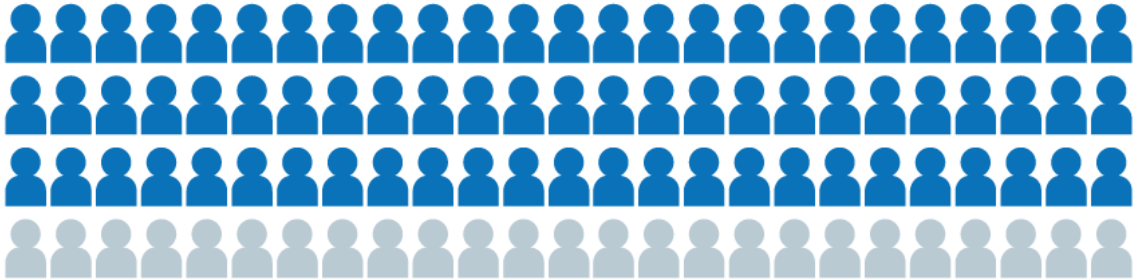
Campaign Extension into 2021

Together 2 Goal® Impact

Improved care for more than

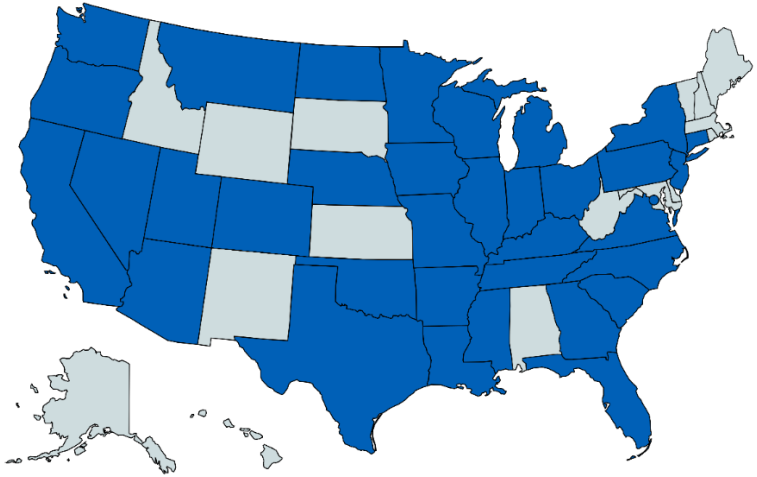
750,000 people

with Type 2 diabetes



Together 2 Goal® Reach

- 150 groups in 36 states
- 61,000 FTE physicians
- 2.0 million patients with Type 2 diabetes

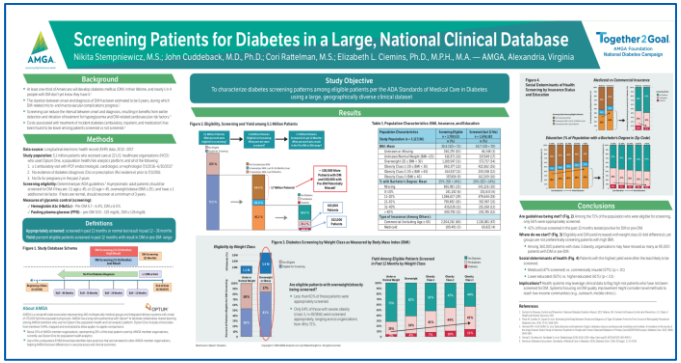


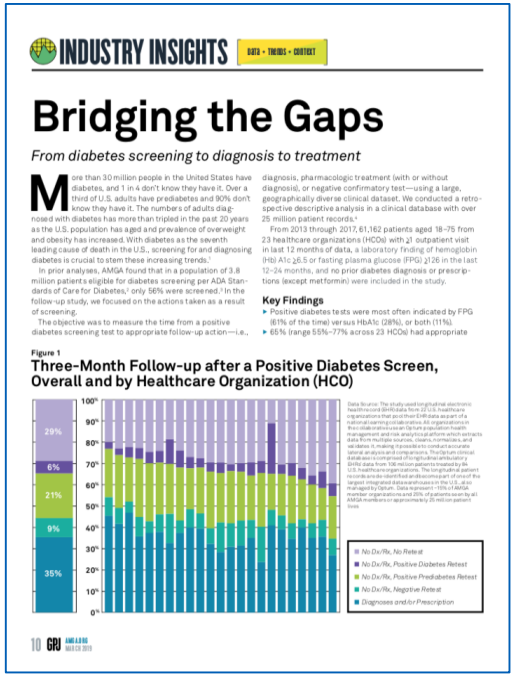
Together 2 Goal® Momentum

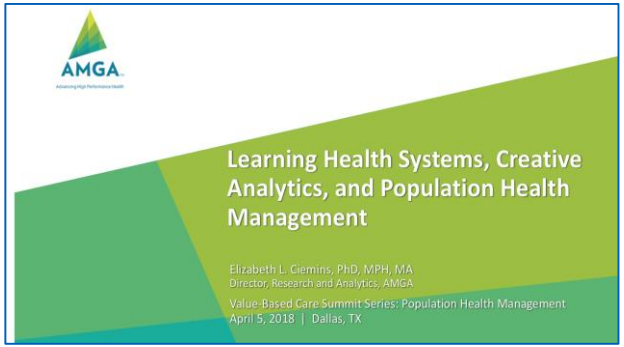
14 new groups with over 2,500 FTE physicians

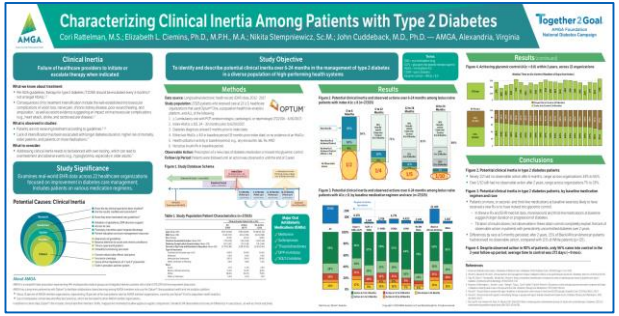
New Research

Publications & Presentations from AMGA Analytics









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 22 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 outbound claim or electronic health record (EHR) problem list at least 6 months prior to index A1c. A subset of 47,693 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."

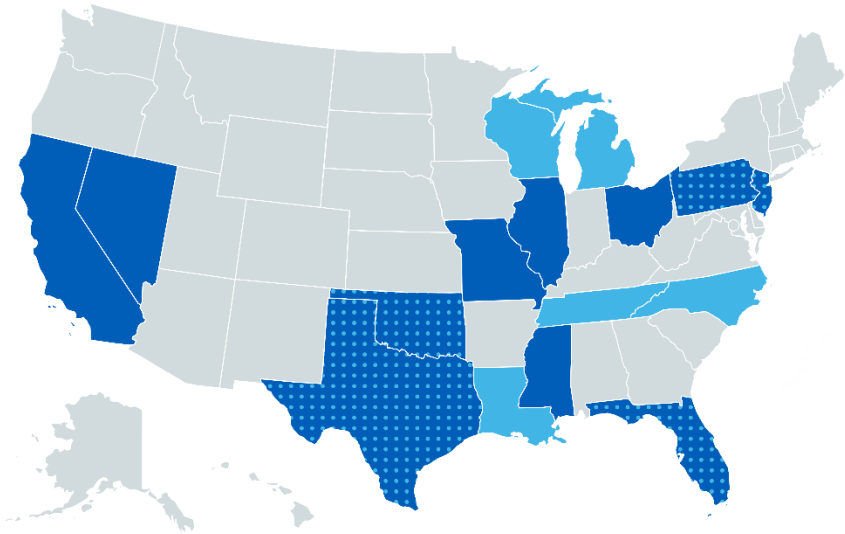
Principal Findings: Six months following an index A1c≥8, 55% of patients received no observable clinical action ranging from 45–65% across HCOs and 18–96% across individual providers. A new diabetes prescription was observed in 35% of patients (7.5% moved into glycemic control, i.e., A1c<8) and 10% moved into glycemic control without a new prescription. Within 24 months, clinical inertia was reduced to 19%, ranging from 13–28% 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.

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

Together 2 Goal®

Kendra Dorsey

Senior Director
National Health Campaigns

How to Remain in the Campaign

…No need to re-enroll!

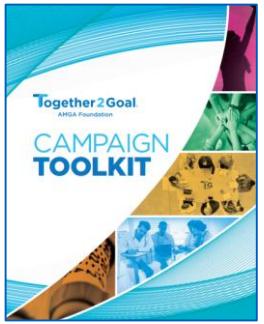
All you need to do is:

- 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

AMGA Communities

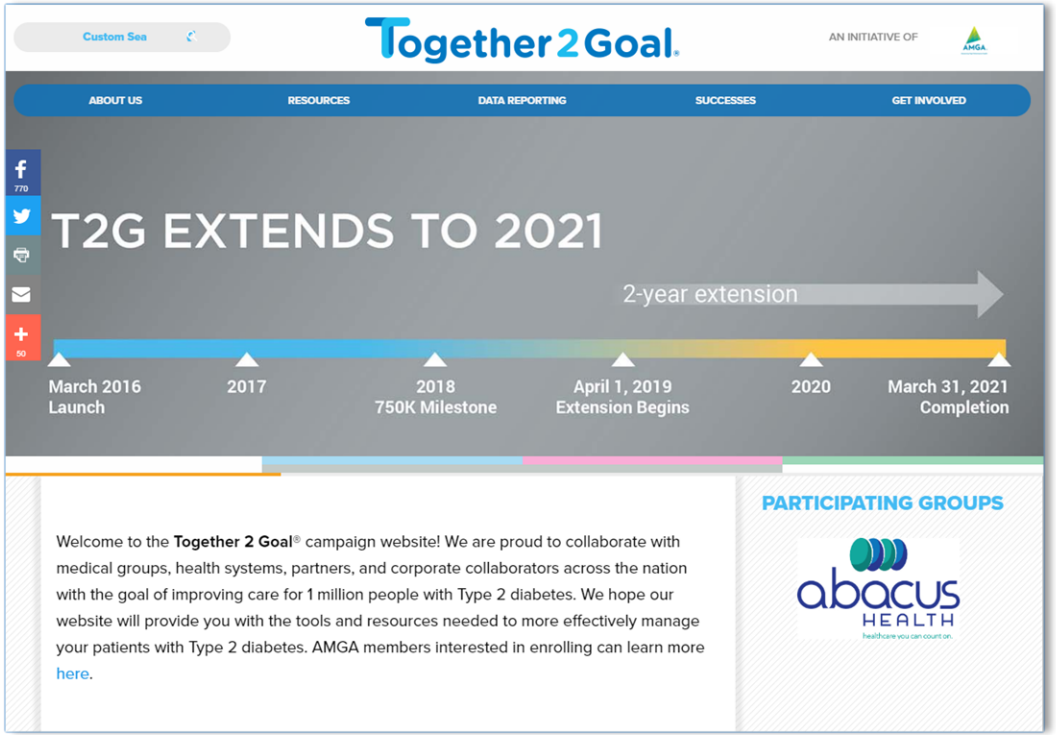


TOGETHER 2 GOAL® 2019 WEBINAR SCHEDULE

WEBINARS WILL BE HELD FROM 2-3PM EASTERN

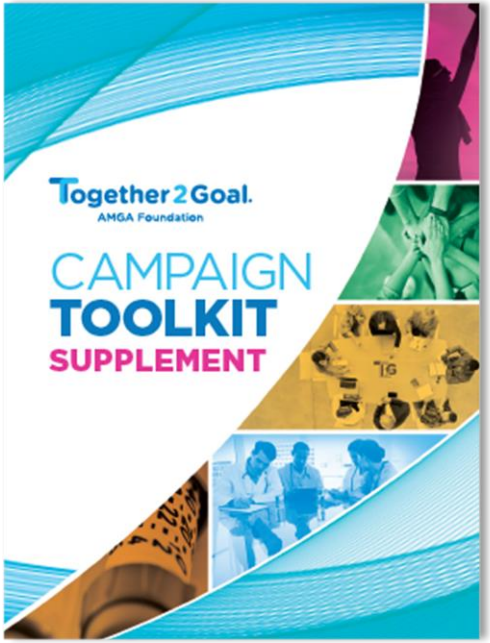
Date	Topic	Presenter(s)
Jan. 17, 2019	**American Diabetes Association 2019 Standards of Care**	Nisa Maruthur, M.D., M.H.S. (Johns Hopkins University)
Feb. 21, 2019	**Clinical Inertia and Diabetes Care**	Daniel McCall, M.D. (Hattiesburg Clinic)
March 21, 2019	**Overcoming Barriers to Diabetes Self-Management 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 (Sutter Health)
April 18, 2019	**T2G Campaign Extension**	AMGA
May 16, 2019	**Mental Health Integration and Diabetes Management**	Brenda Reiss-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 (Mercy Health)
Nov. 21, 2019	**Culinary Medicine as an Emerging Population Health Intervention**	Timothy Harlan, M.D., FACP, CCMS and Leah Sarris, R.D., LDN, CCMS (Tulane University School of Medicine)
Dec. 19, 2019	**T2G Diabetes Bundle Collaborative Results**	T2G Diabetes Bundle Participants

New Offering: Revamped Website

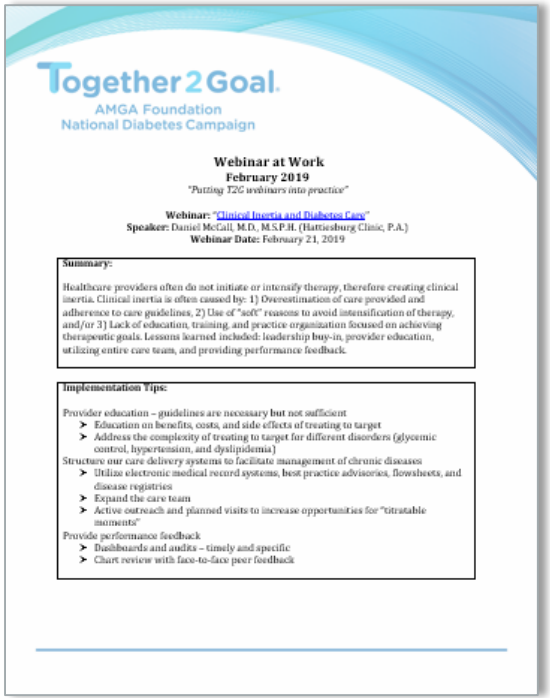


New Offering: Email Signature Badge

New Offering: Toolkit Supplement



New Offering: “Webinars at Work”



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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. (Hattiesburg Clinic, P.A.)
Webinar Date: February 21, 2019

Summary:

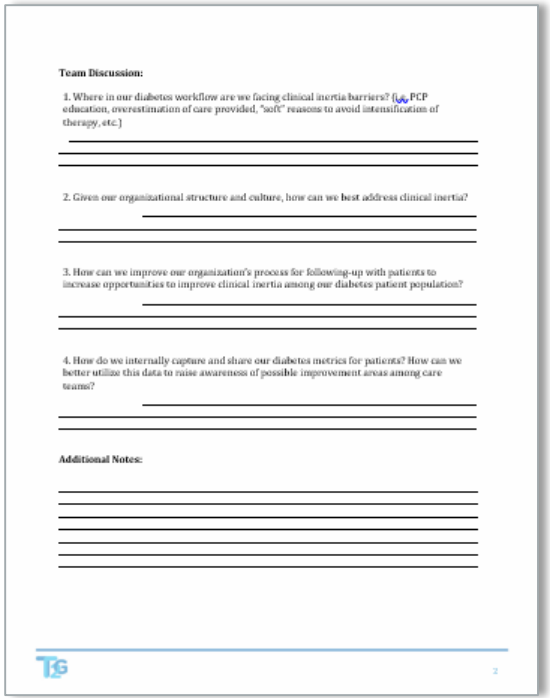
Healthcare providers often do not initiate or intensify therapy, therefore creating clinical inertia. Clinical inertia is often caused by: 1) Overestimation of care provided and adherence to care guidelines, 2) Use of "soft" reasons to avoid intensification of therapy, and/or 3) Lack of education, training, 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 "titratable 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.)

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

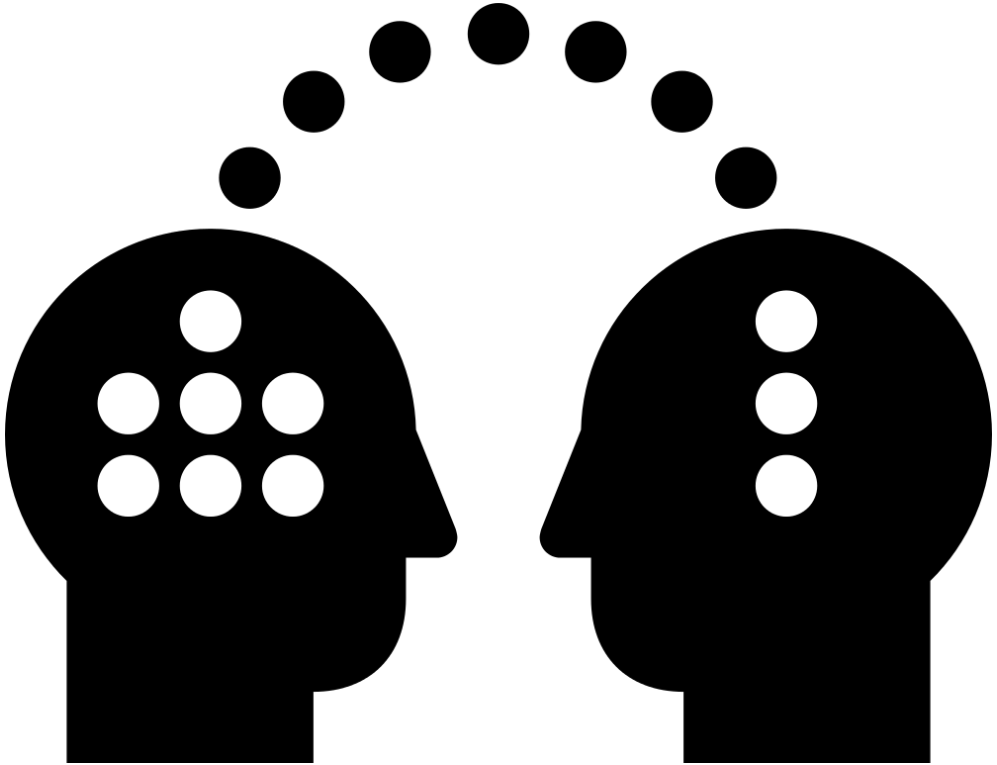
3. How can we improve our organization's process for following-up with patients to increase opportunities to improve clinical inertia among our diabetes patient population?

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?

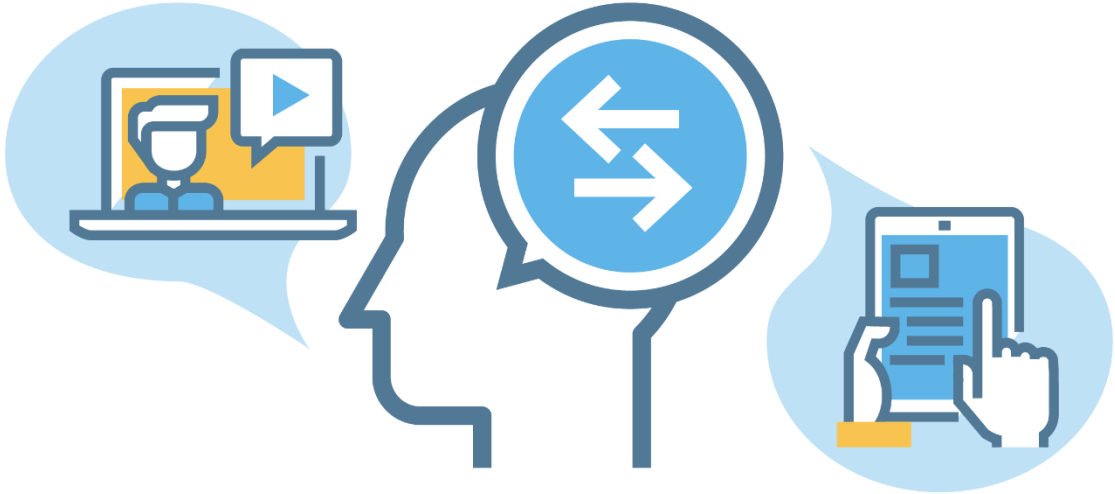
Additional Notes:

New Offering: Interactive Campaign Planks

New Offering: Plank Mentors



New Offering: Best Practices Compendium



Together 2 Goal® 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

Data Reporting Deadlines

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

New Reporting Template

Together 2 Goal® Core (Bundle)
Reporting Template

Please enter the requested data in the cells shaded blue.

Organization Name

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.

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.

			Core (Bundle) Track												
Phase	Ending Quarter	Measurement Period	Active Patients[1]	Patients with Type 2 Diabetes[1, 2]	Prevelance of Type 2 Diabetes	Patients with last HbA1C < 8%[2]	HbA1C control	Patients with last ambulatory in-office BP < 140/90[2]	BP control	Patients with medical attention for nephropathy[2]	Medical attention for nephropathy	Patients with statin prescribed or reason not to receive statin[2]	Lipid management	Patients compliant in all four measures (T2G Bundle)[2, 3]	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 Year4	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													

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	2018 Q4	01/01/2018-12/31/2018													
	2019 Q1	04/01/2018-03/31/2019													
T2G Year4	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													

T2G Year4	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

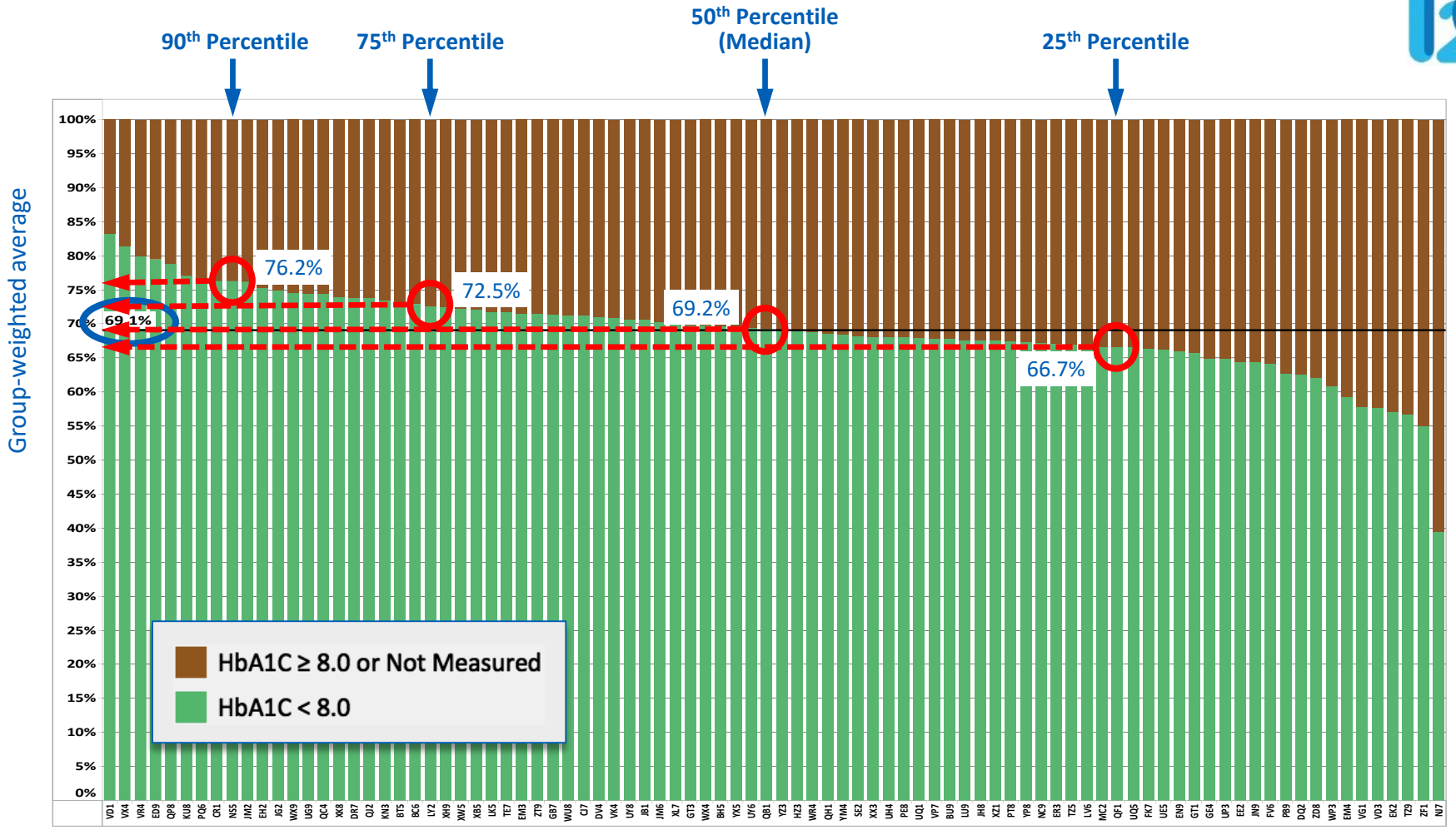
Campaign Measures

	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



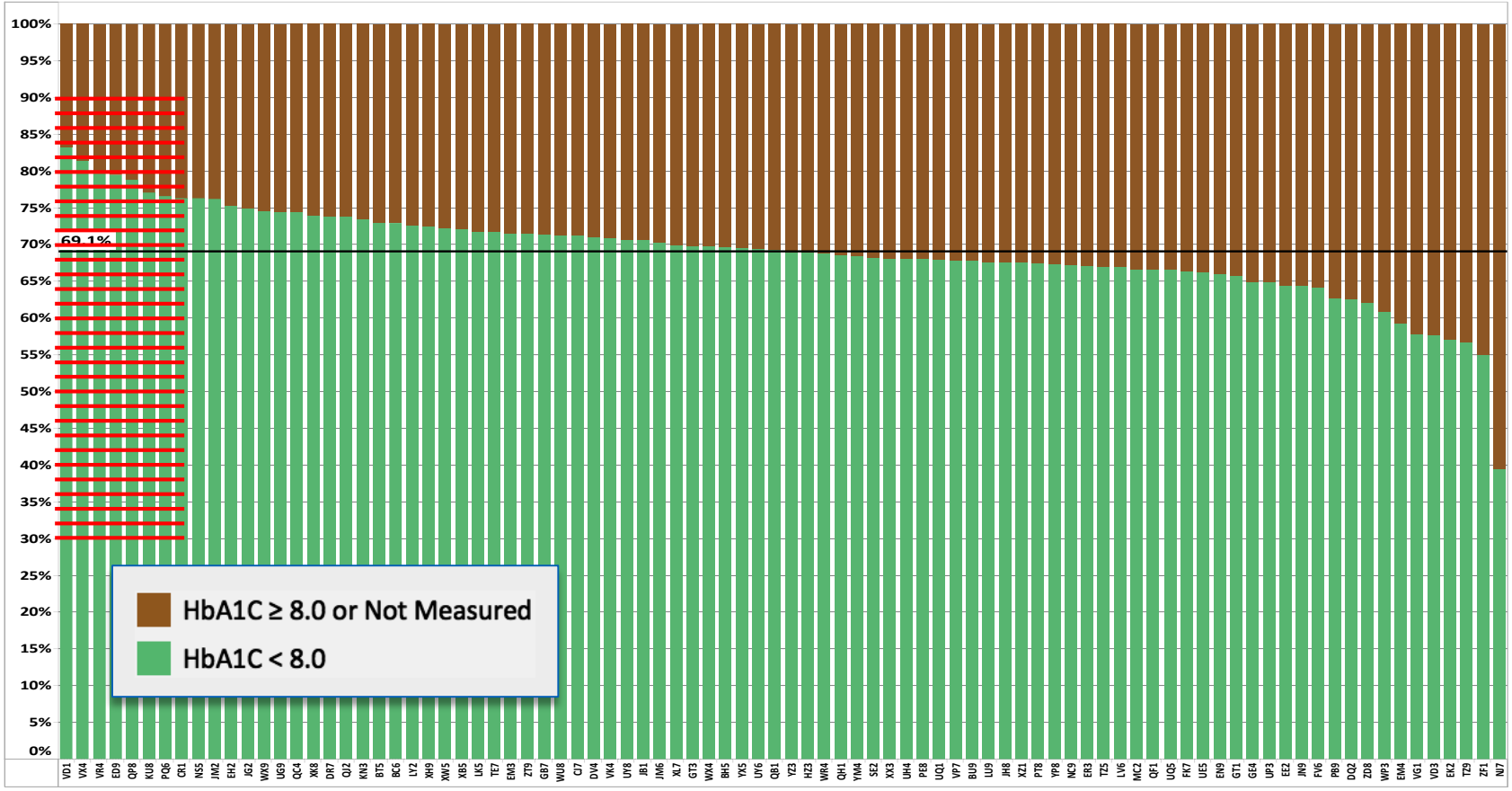
Updated Reports

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

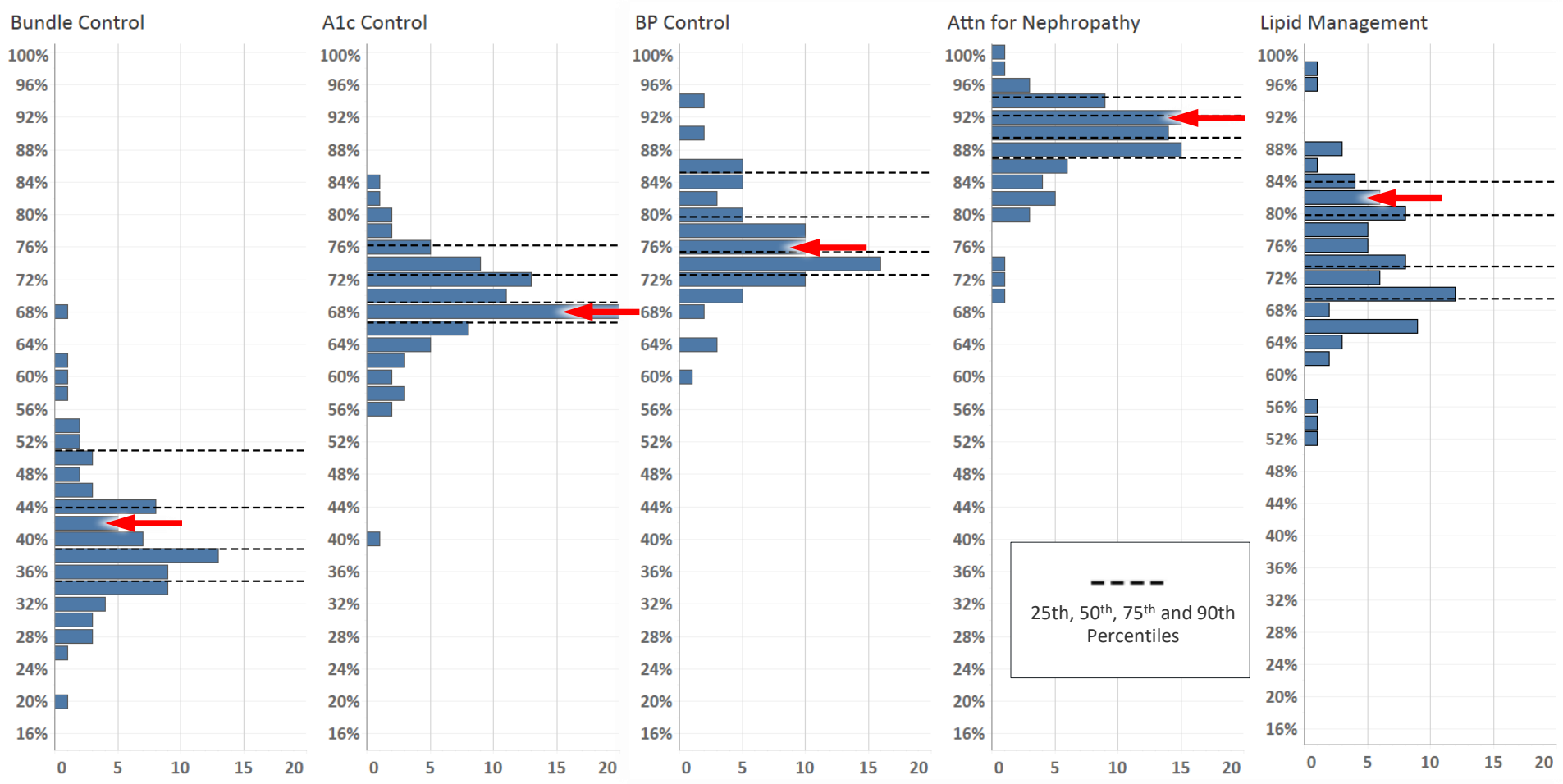
Summary Statistics (T2G 2018 Q4)	Prevalence of Type 2 Diabetes	HbA1c Control	BP Control	Medical Attention for Nephropathy	Lipid Management	Diabetes Care Bundle
Patient Weighted Average	13.3%	67.4%	76.1%	88.3%	73.4%	38.9%
Group Weighted Average	14.3%	69.1%	76.4%	88.7%	74.2%	40.1%
25th Percentile	11.5%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



Distribution of Measure Performance Rate



Number of Health Care Organizations (Reporting for 2018Q4)

Tracking Achievement

Population Measures

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

Patients Improved

- 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

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	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

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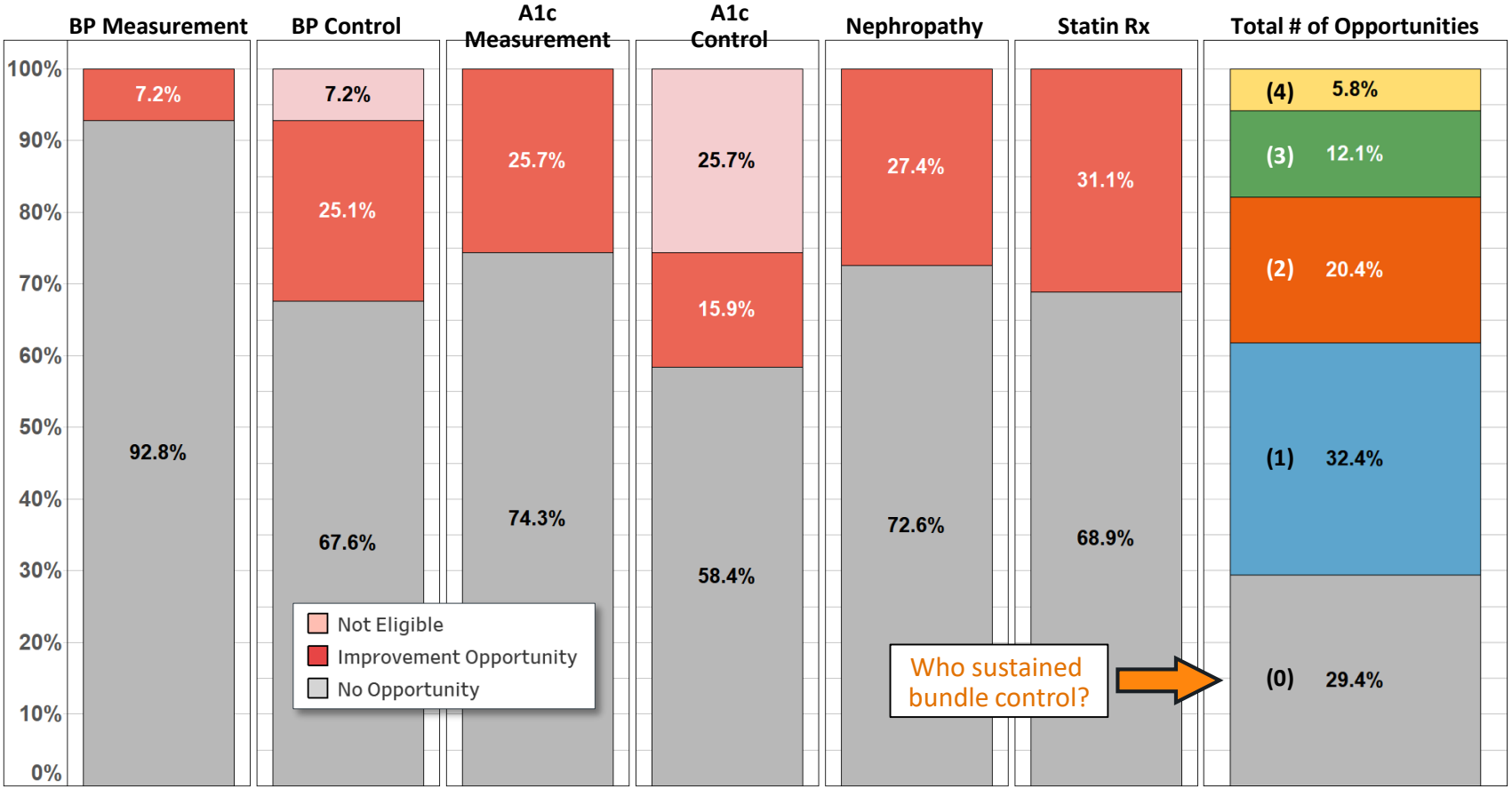
- Patients with no prior diagnosis of type 2 diabetes (on problem list or billing claim)
  - New diagnosis for T2DM (on claim* or problem list)
    - Practice-based screening
    - Review clinical data for existing evidence that's diagnostic or strongly suggestive of type 2 diabetes
- Patients with a diagnosis of type 2 diabetes
  - If A1c is not measured (during measurement period), measure A1c
  - If A1c ≥ 8.0, bring A1c into control
  - if BP is not measured, measure BP
  - If BP ≥ 140/90, bring BP into control
  - If no statin prescribed and LDL ≥ 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: Opportunities for Improvement

Campaign baseline data (2016 Q1): Broader population, i.e., patients age 18 – 75 with ≥ 1 visit (instead of ≥ 2 visits required in T2G)



Have Dx: Improvement Calculation

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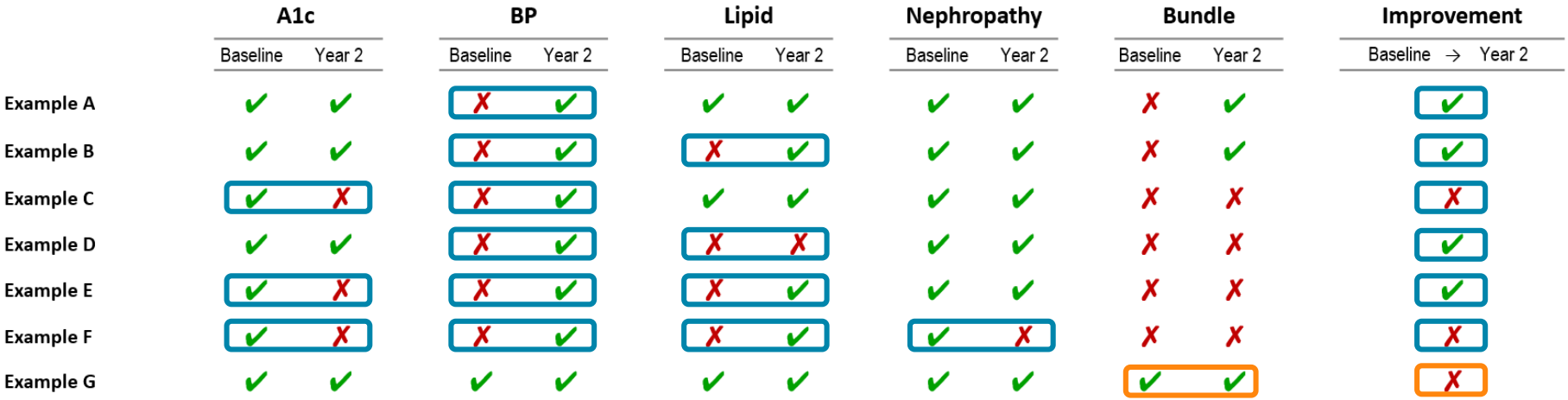


Improvement is assessed for each patient, then summarized for all patients in the T2G denominator

- Example A – Moving from out-of-control (✗) 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

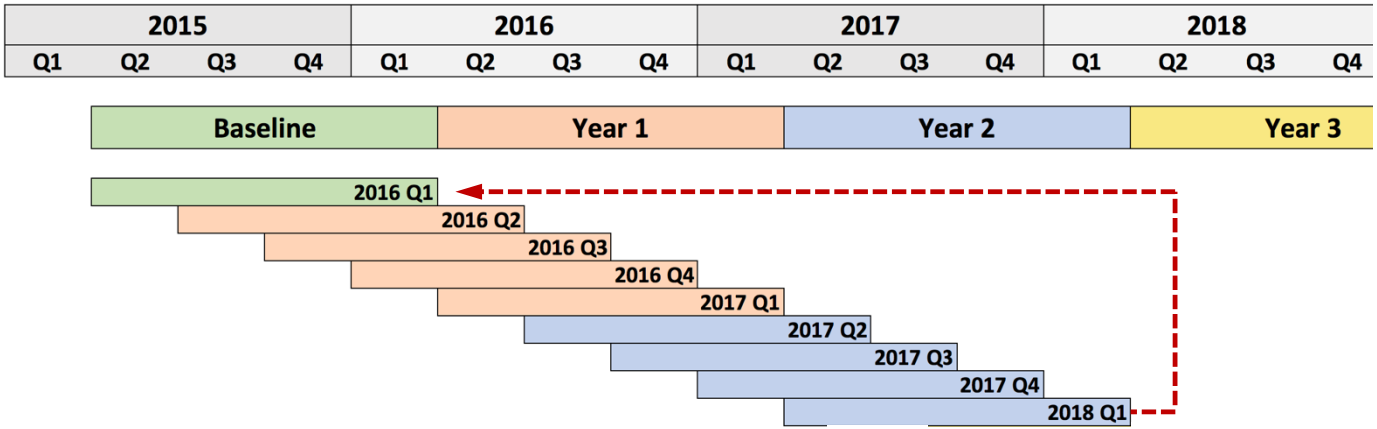
Improvement Calculation

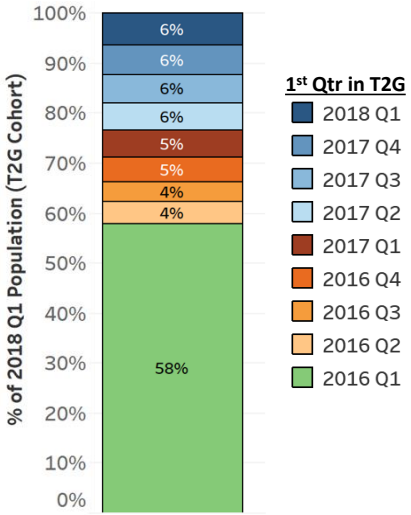
- For T2G, AMGA members self-report numerators and denominators for each measures, which does not provide the longitudinal, patient-level data needed to calculate improvements
  - In the self-reported data below, HbA1c control improved by +4%, and BP control also improved by +4%, but we do not know which 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	Prevelance 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





Improvement Calculation

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- 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 ≥ 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 ≥ 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

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AMGA Foundation
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- 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 ≥ 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 ≥ 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 ≥ 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

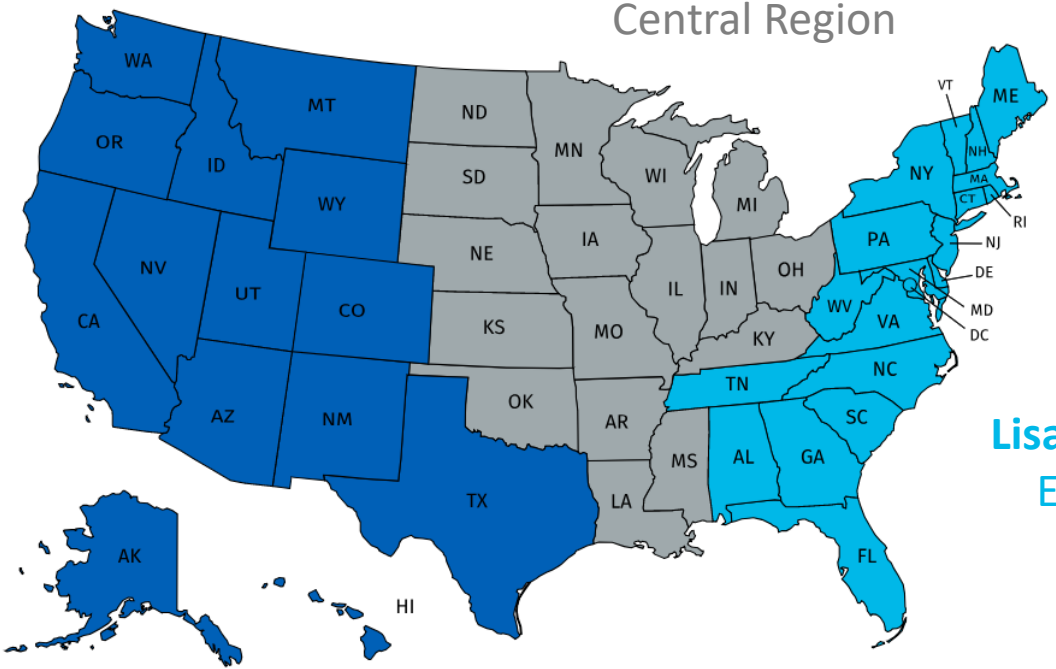
- **Date/Time**: May 16, 2019 from 2-3pm Eastern
- **Topic**: Mental Health Integration and Diabetes Management
- **Presenters**:
  - Brenda Reiss-Brennan, Ph.D., APRN (Intermountain Healthcare)
  - Mark Greenwood, M.D. (Intermountain Healthcare)

Questions?

Send inquiries to together2goal@amga.org

Carolyn McPhee
Central Region

Mallory Temple
West Region



Lisa Cornbrooks
East Region