Monthly Campaign Webinar

August 20, 2020

Today's Webinar

- Together 2 Goal® Updates
  - Webinar Reminders
  - AMGA's 2020 IQL Virtual Conference
  - Obesity Care Model Collaborative Case Studies
- T2G Diabetes Bundle Best Practices Learning Collaborative Results
  - AMGA
- Q&A
  - Use Q&A or chat feature

Webinar Reminders

- Webinar will be recorded today and available the week of August 24th
  - www.Together2Goal.org

- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

IQL20 *Virtual*

Transformation and Innovation Post COVID-19

September 17-18, 2020

Register today at **amga.org/IQL20**

Obesity Care Model Collaborative Case Studies

OCMC Case Studies are available at AMGA.org

Today's Featured Presenters

Danielle Casanova, M.B.A.

Senior Director, Population Health Initiatives
AMGA

Earlean Chambers, R.N., M.S., CPHQ

Director of Clinical and Quality, Population Health Initiatives
AMGA

Cori Rattelman

Senior Research Analyst
AMGA Analytics

T2G Diabetes Bundle Best Practices Learning Collaborative

Program Overview

T2G Diabetes Best Practices Learning Collaborative

Improve performance on the T2G Core Track bundle measure:

- HbA1c control (< 8.0)
- Blood pressure control (< 140/90)
- Lipid management (statin Rx)
- Medical attention for nephropathy

National Advisors

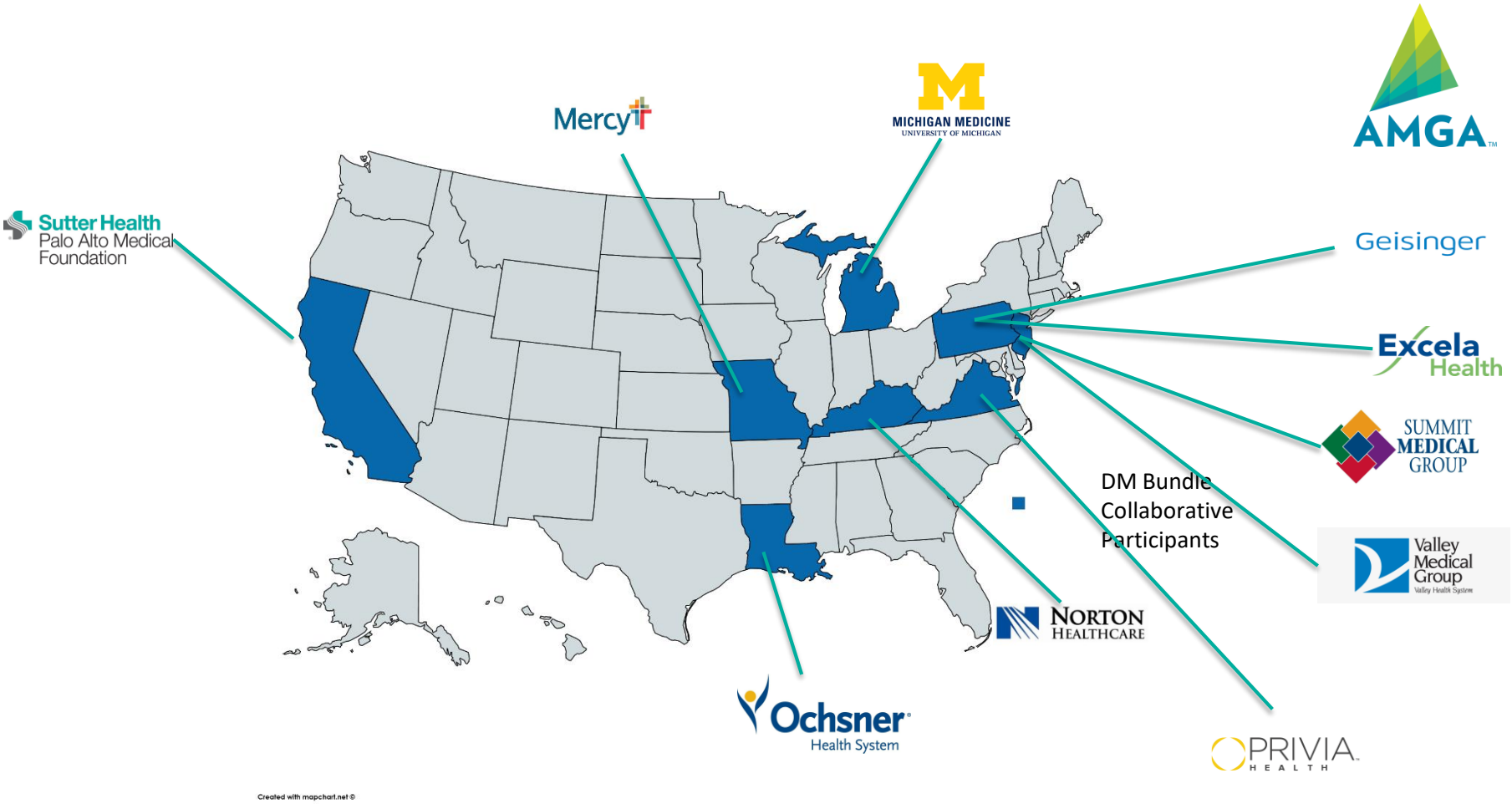
Francis Colangelo, MD, MS-HQS, FACP
Chief Quality Officer, Premier Medical Associates

Megan Dorrell, PharmD, BCACP
Clinical Director, Ambulatory Pharmacy Services, Community Health Network

Tony Hampton, MD, MBA, ABOM, CPE, Regional Medical Director Advocate Trinity Service Area, Advocate Aurora Healthcare

Jamie L. Reedy, MD, MPH
Chief of Population Health, Summit Health Management

Gretchen Shull, MD
Endocrinologist, Vice President of Diabetes Care, Mercy



Diabetes Bundle Collaborative Process

Development Phase

- Program planning
- National Advisors
- Measure development
- Organization recruitment
- Application vetting & selection
- On-boarding Organizations

Implementation Phase

12 months

- Quality improvement & data reporting
- Site visits/Clinical outreach
- Regular education webinars
- In-person/Virtual meetings

Final Analysis & Dissemination Phase

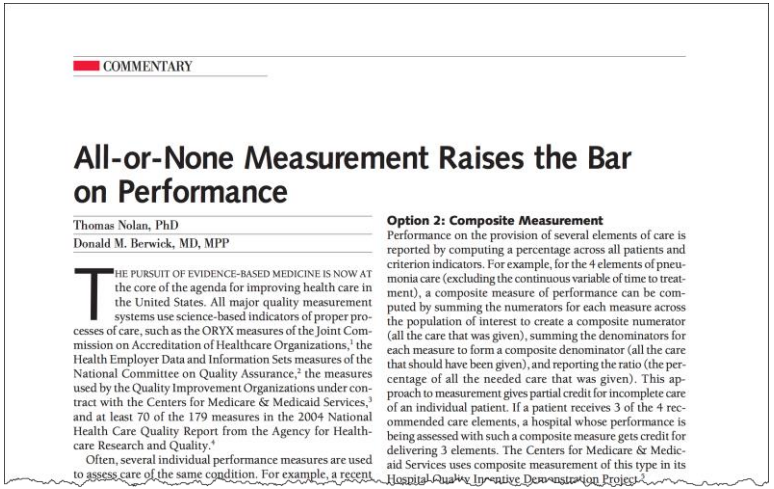
- Compile findings
- Data analysis
- Qualitative analysis
- Publication

SHARED LEARNING

Summary Data Report: T2G Bundle Measure

Why a Bundle Measure?

- Reflects the patient's perspective—holistic view
  - Address multiple 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



COMMENTARY

All-or-None Measurement Raises the Bar on Performance

Thomas Nolan, PhD
Donald M. Berwick, MD, MPP

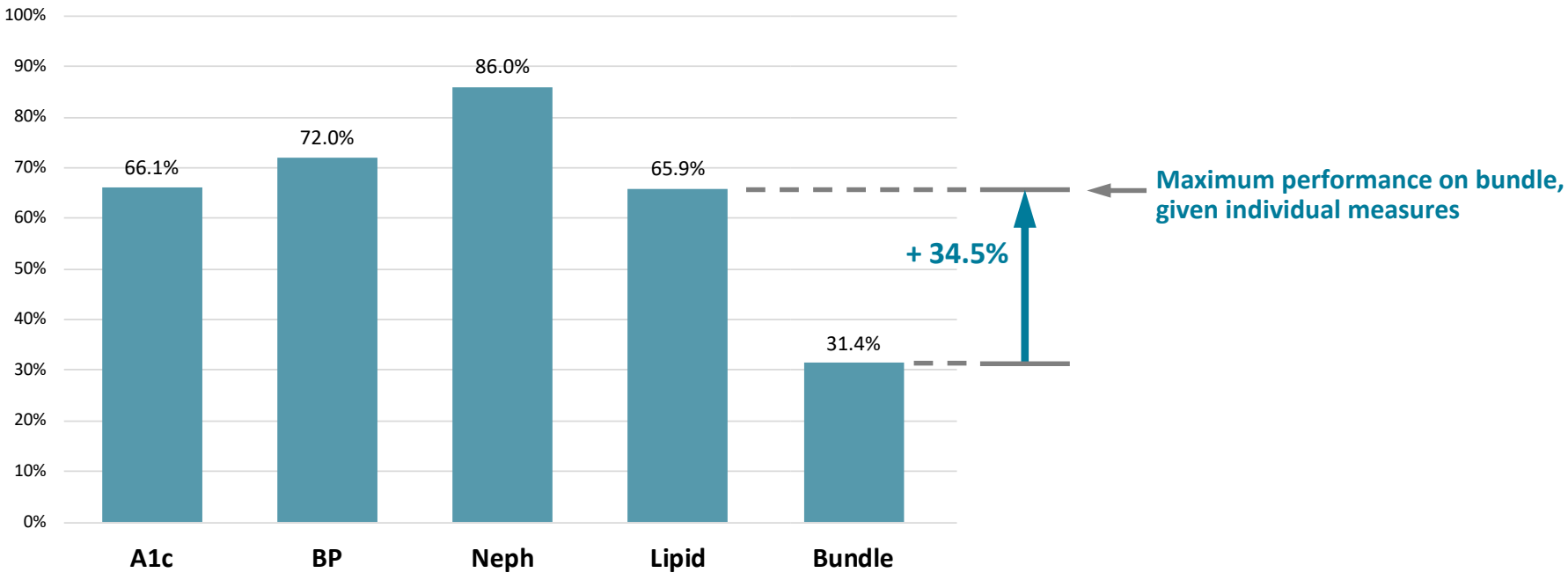
THE PURSUIT OF EVIDENCE-BASED MEDICINE IS NOW AT the core of the agenda for improving health care in the United States. All major quality measurement systems use science-based indicators of proper processes of care, such as the ORYX measures of the Joint Commission on Accreditation of Healthcare Organizations,[1] the Health Employer Data and Information Sets measures of the National Committee on Quality Assurance,[2] the measures used by the Quality Improvement Organizations under contract with the Centers for Medicare & Medicaid Services,[3] and at least 70 of the 179 measures in the 2004 National Health Care Quality Report from the Agency for Healthcare Research and Quality.[4]

Often, several individual performance measures are used to assess care of the same condition. For example, a recent

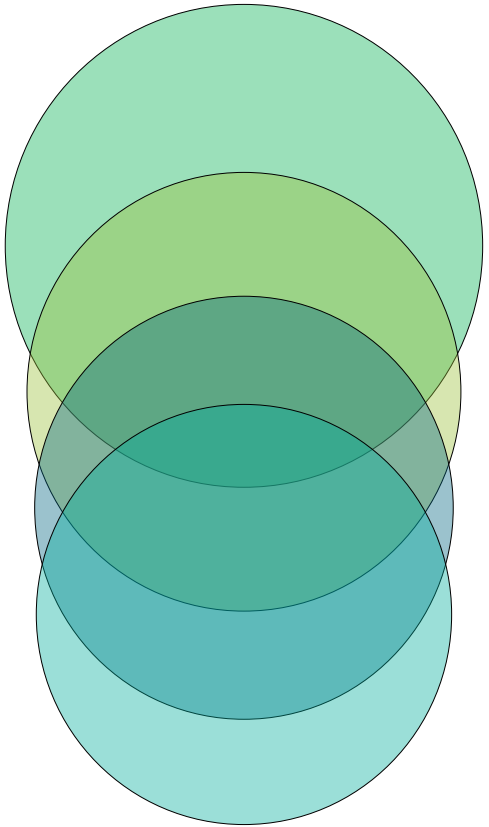
Option 2: Composite Measurement

Performance on the provision of several elements of care is reported by computing a percentage across all patients and criterion indicators. For example, for the 4 elements of pneumonia care (excluding the continuous variable of time to treatment), a composite measure of performance can be computed by summing the numerators for each measure across the population of interest to create a composite numerator (all the care that was given), summing the denominators for each measure to form a composite denominator (all the care that should have been given), and reporting the ratio (the percentage of all the needed care that was given). This approach to measurement gives partial credit for incomplete care of an individual patient. If a patient receives 3 of the 4 recommended care elements, a hospital whose performance is being assessed with such a composite measure gets credit for delivering 3 elements. The Centers for Medicare & Medicaid Services uses composite measurement of this type in its Hospital Quality Incentive Demonstration Project.[5]

Bundle Measure → Frustration!



Bundle Measure Arithmetic

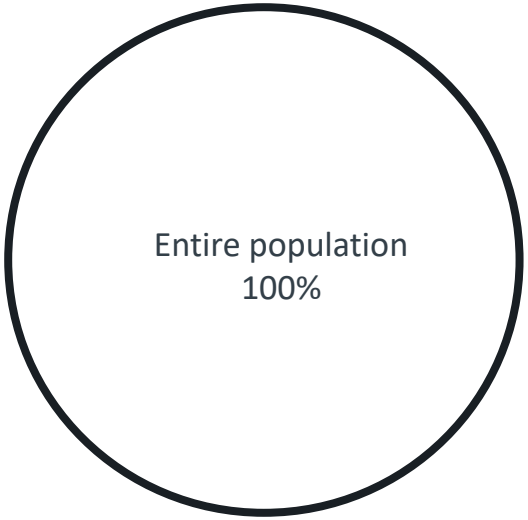


Neph 86.0%

BP 72.0%

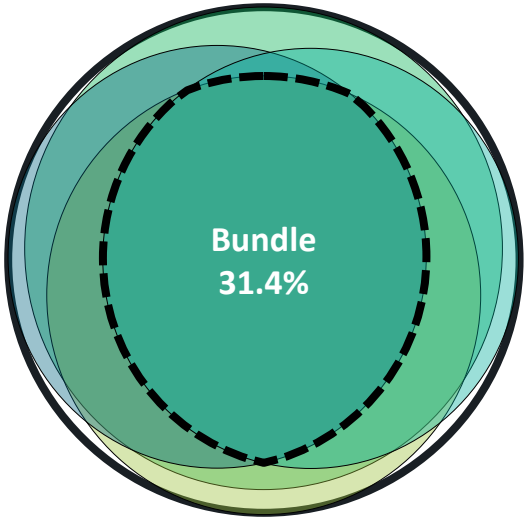
A1c 66.1%

Lipid 65.9%



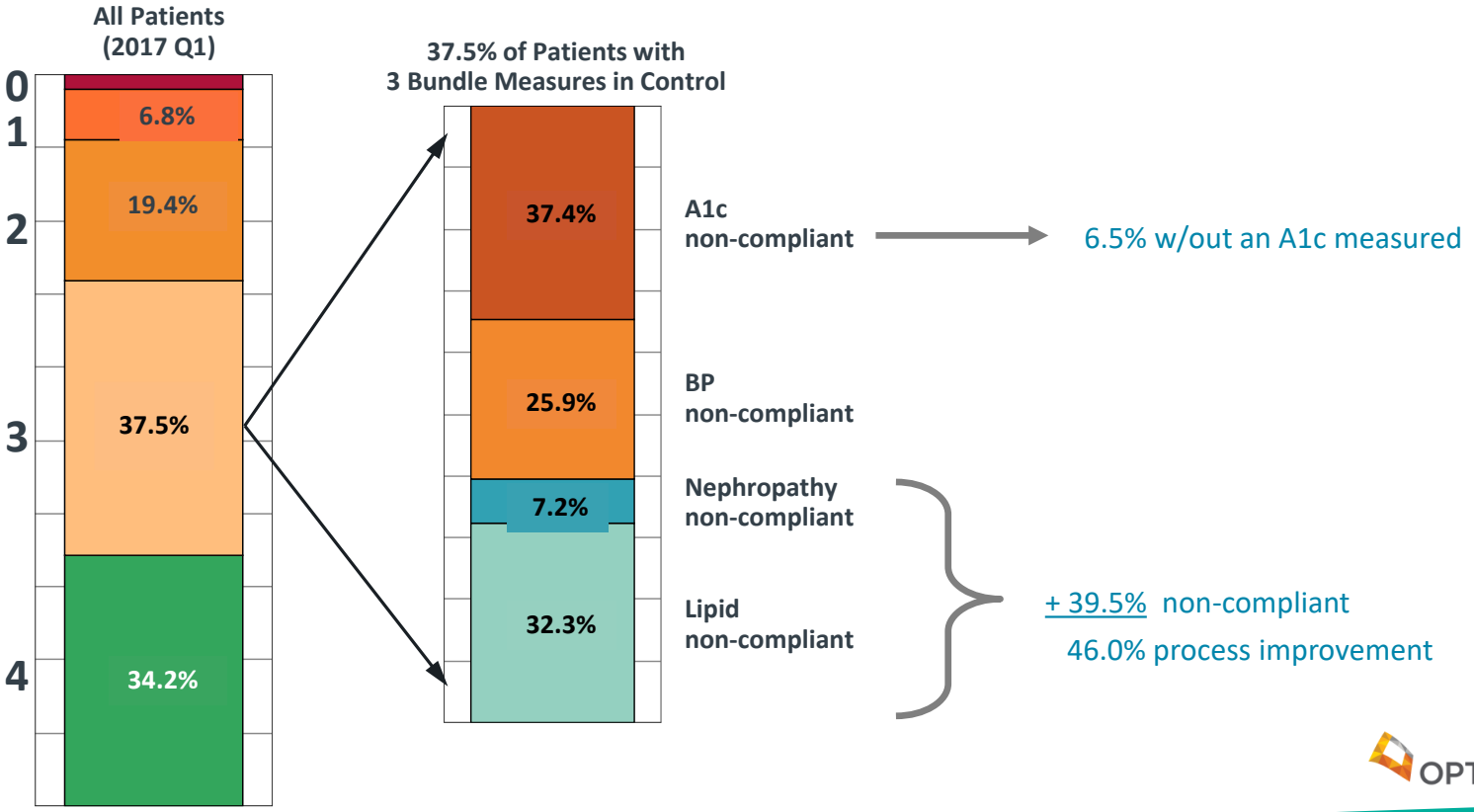
Bundle Measure Arithmetic

Neph	86.0%
BP	72.0%
A1c	66.1%
Lipid	65.9%

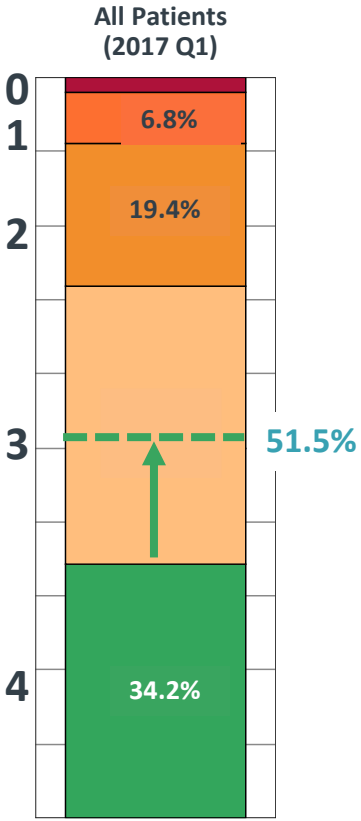


T2G Bundle: Distribution of Patients by Number of Measures in Control

T2G Patients by Number of Measures in Control



T2G Patients by Number of Measures in Control



Data Timing

Data Timeline

	Measurement period
Baseline period	2018 Jan 1 - 2018 Dec 31
Pre-intervention period 1	2018 Feb 1 - 2019 Jan 31
Pre-intervention period 2	2018 Mar 1 - 2019 Feb 28
Pre-intervention period 3	2018 Apr 1 - 2019 Mar 31
Intervention Phase:	
Intervention period 1	2018 May 1 - 2019 Apr 30
Intervention period 2	2018 Jun 1 - 2019 May 31
Intervention period 3	2018 Jul 1 - 2019 Jun 30
Intervention period 4	2018 Aug 1 - 2019 Jul 31
Intervention period 5	2018 Sep 1 - 2019 Aug 31
Intervention period 6	2018 Oct 1 - 2019 Sep 30
Intervention period 7	2018 Nov 1 - 2019 Oct 31
Intervention period 8	2018 Dec 1 - 2019 Nov 30
Intervention period 9	2019 Jan 1 - 2019 Dec 31
Intervention period 10	2019 Feb 1 - 2020 Jan 31
Intervention period 11	2019 Mar 1 - 2020 Feb 29
Intervention period 12	2019 Apr 1 - 2020 Mar 31

2018 Q4 (BL)

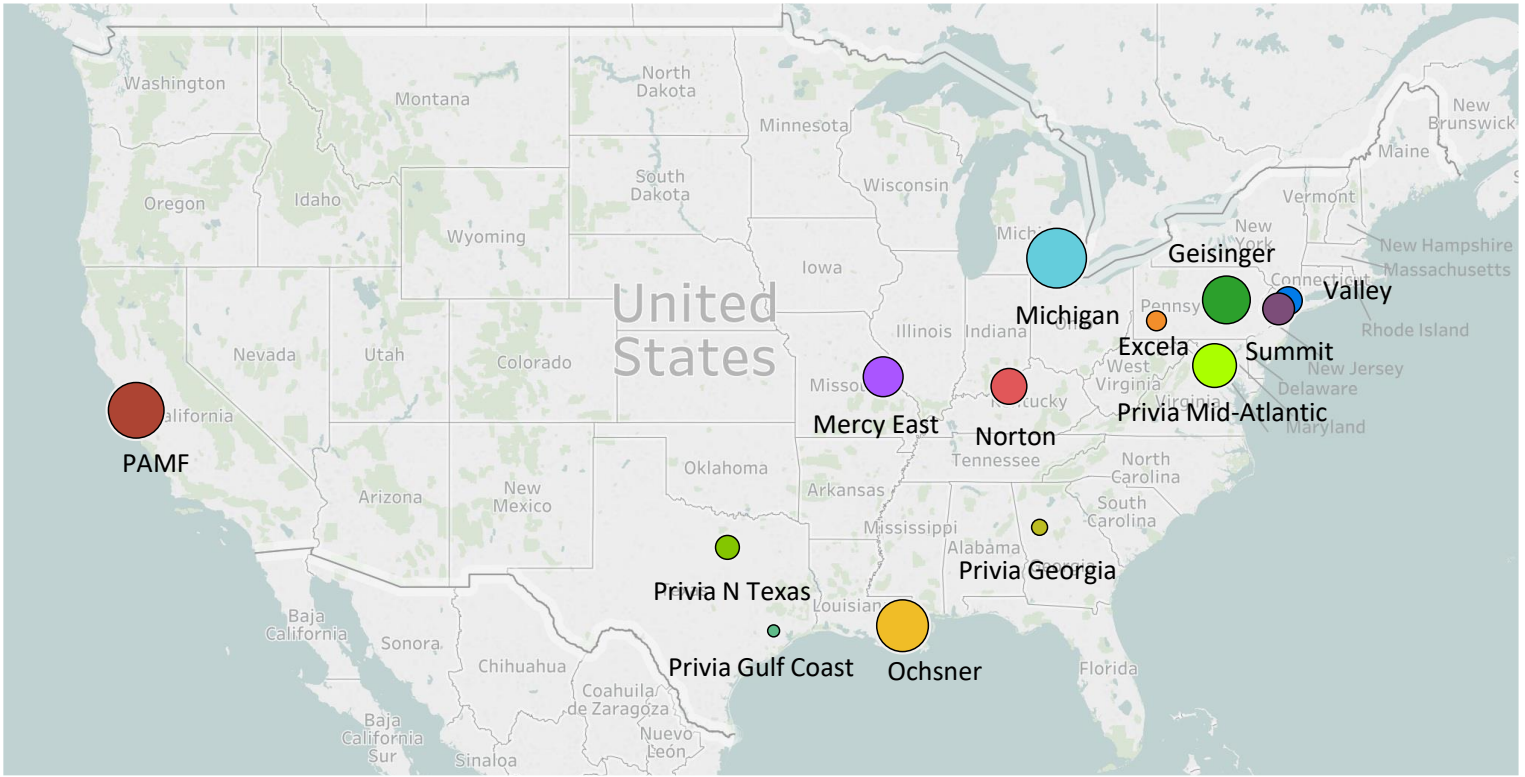
1st in-person meeting

Final MP for comparison to campaign (2019 Q4)

Final MP for collaborative improvements (Jan '20)

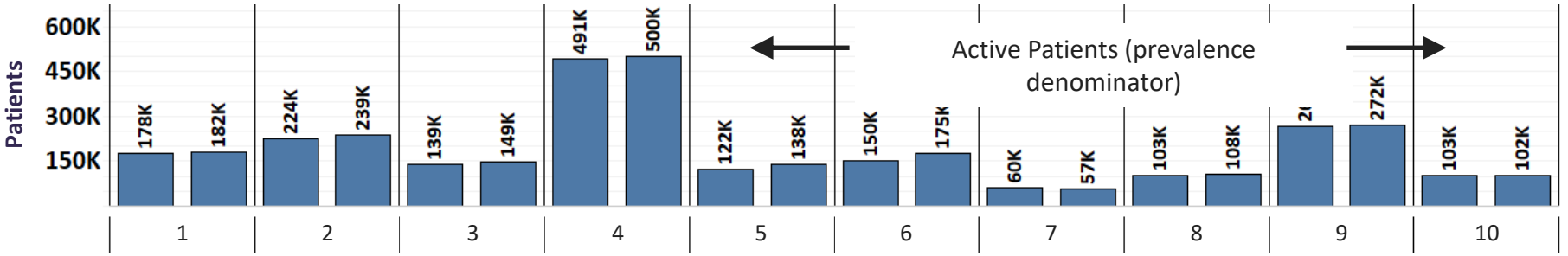
The Collaborative Cohort

Bundle Collaborative Participants



Patient population:

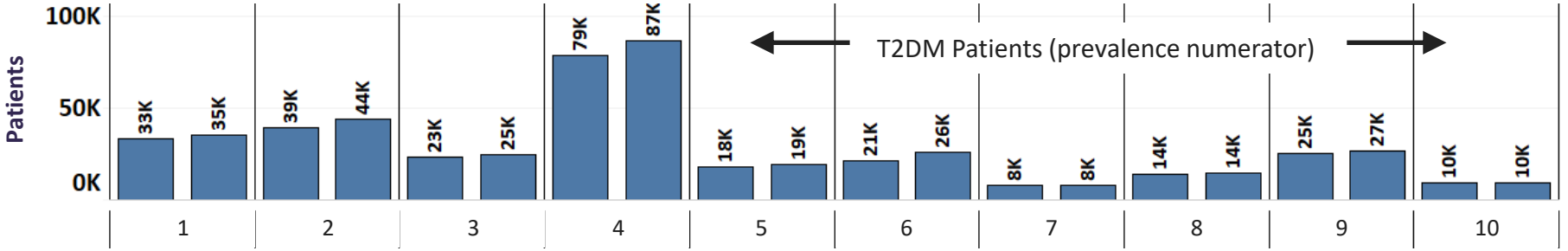
- Active Patient population increased by 4.6% (1.8M to 1.9M)



* Includes 4 geographic regions: Georgia, Gulf Coast, Mid-Atlantic, N Texas

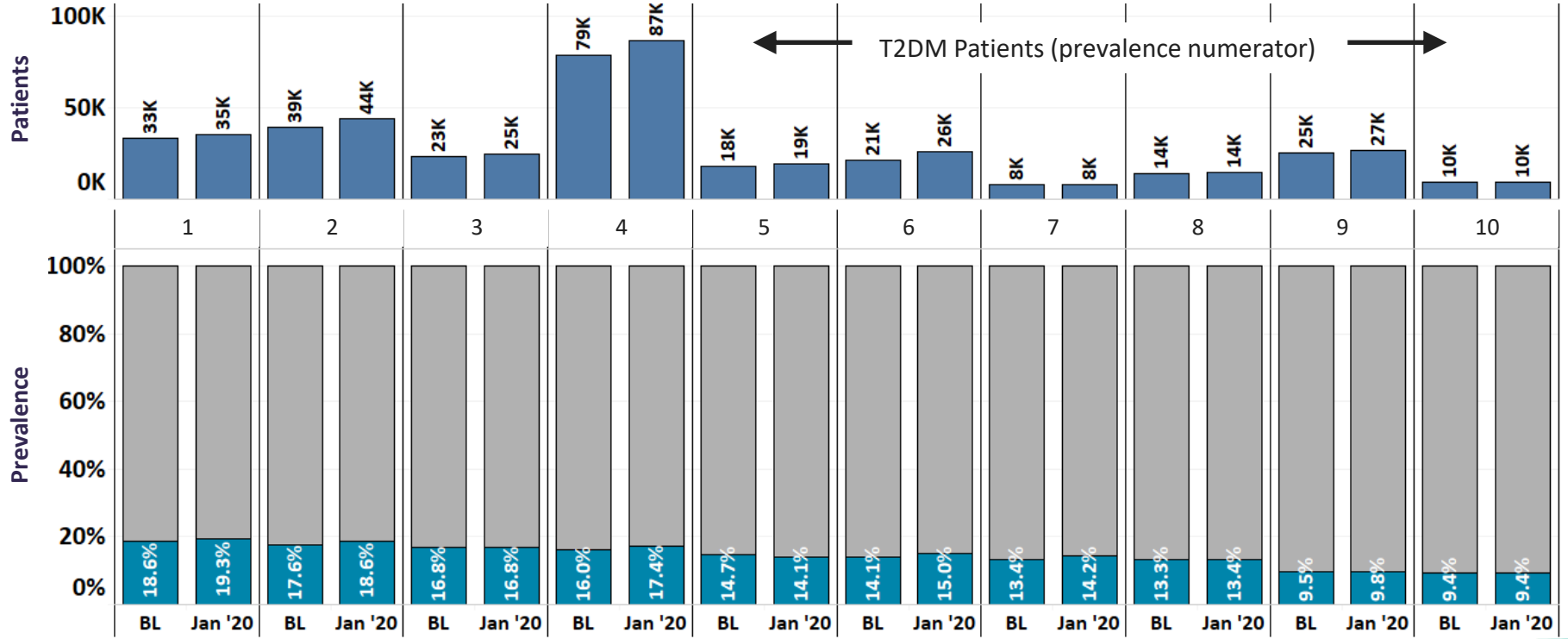
Patient population:

- Active Patient population increased by 4.6% (1.8M to 1.9M)
- T2G cohort (active patients w/ T2DM) increased by 9.4% (271K to 296K)



Prevalence: Type 2 diabetes (T2DM)

- Active Patient population increased by 4.6% (1.8M to 1.9M)
- T2G cohort (active patients w/ T2DM) increased by 9.4% (271K to 296K)
- Patient weighted average prevalence increased from 14.7% to 15.4%



Collaborative Performance

Collaborative Performance: Group Weighted Averages

Measures:	Collaborative Average Group Outcomes[1]			
	Baseline (Dec 2018)	Jan 2020	Absolute Δ	Relative Δ
A1c < 8.0	67.3%	68.5%	1.2%	1.8%
BP < 140/90	76.5%	78.6%	2.0%	2.7%
Attention for Nephropathy	90.7%	91.3%	0.6%	0.6%
Lipid Management	77.3%	79.2%	1.9%	2.5%
T2G Bundle	40.2%	42.9%	2.7%	6.7%

[1] Columns may not add due to rounding.

- Collaborative touched more than 296,000 patients with type 2 diabetes
- Improvements across all measures

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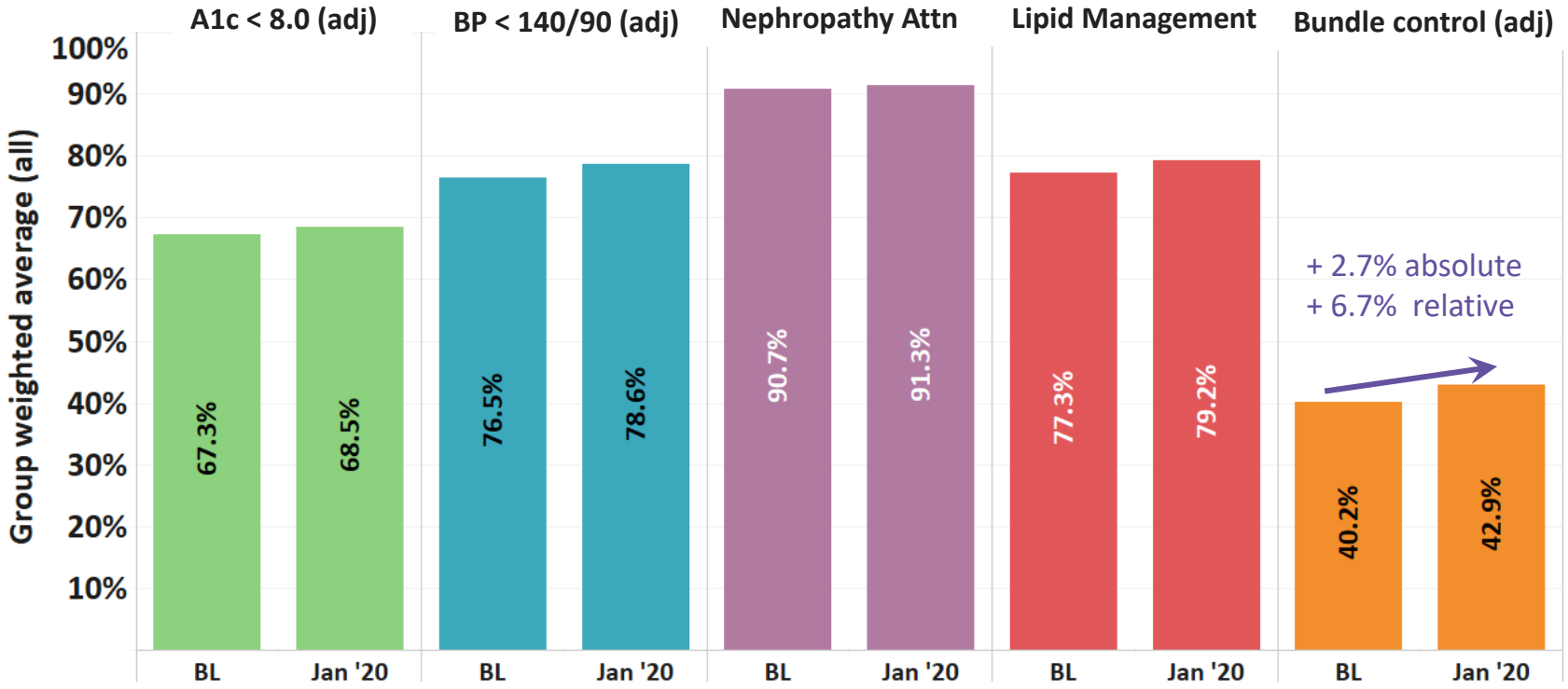
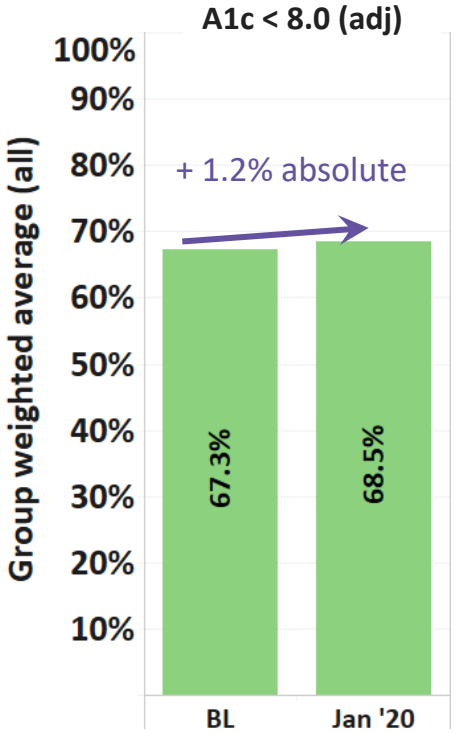
- Collaborative touched more than 296,000 patients with type 2 diabetes
- Improvements across all measures
- Highest gains in T2G Bundle control

T2G Measures (adjusted)

- Seasonally adjusted A1c, BP, and bundle measures



Patients with A1c control (A1c < 8.0)
Adjusted for seasonality



- 1.8% relative improvement among all patients
- Over 2 x improvement seen by campaign (as of 2019Q4)
- **3,100 additional patients** with A1c measured and < 8.0
  - ✓ 2.0% relative improvement → 363 patients
  - ✓ 2.4% relative improvement → 449 patients
  - ✓ 3.7% relative improvement → 1007 patients
  - ✓ 6.9% relative improvement → 450 patients

Patients with BP control (BP < 140/90)
Adjusted for seasonality

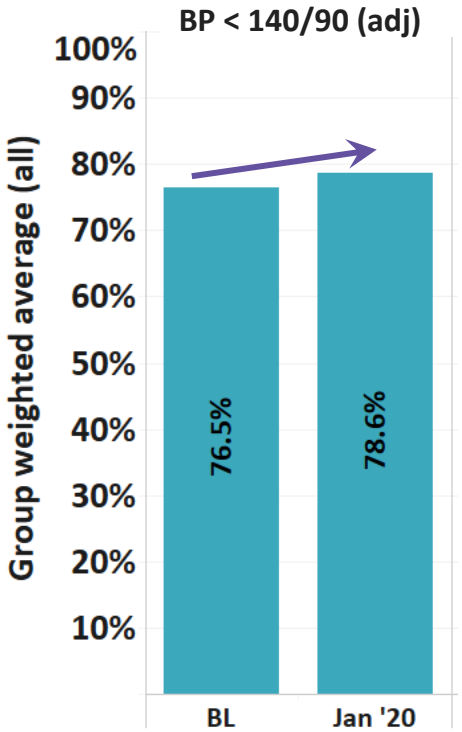
+ 2.0% absolute
+ 2.7% relative

OR

If you think of available improvement:

100 – 76.5 = 23.5% without BP control

Cohort captured 8.6% of the available improvement



- 3 organizations above 80% control (MUPD)
- **5,900 additional patients** with BP measured and < 140/90
  - ✓ 2.8% relative improvement → 435 patients
  - ✓ 2.9% relative improvement → 752 patients
  - ✓ 3.2% relative improvement → 642 patients
  - ✓ 3.4% relative improvement → 2,186 patients
  - ✓ 5.7% relative improvement → 371 patients

Patients with BP control (BP < 140/90)
Adjusted for seasonality

+ 2.0% absolute
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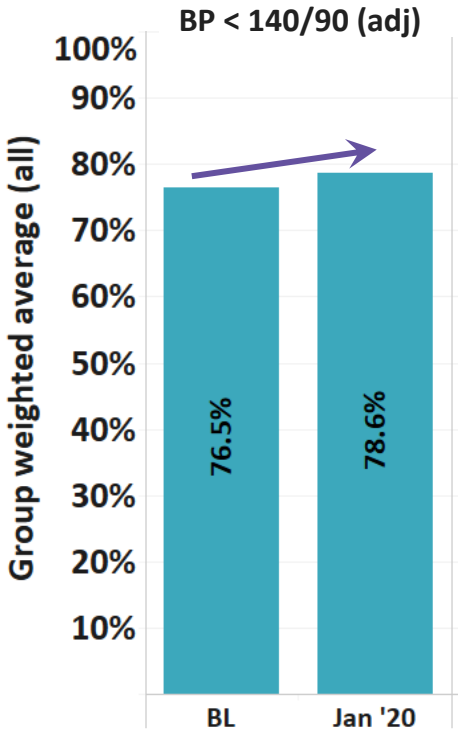

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  - ✓ 5.7% relative im[illegible] patients

80% to 84.5%

Patients with BP control (BP < 140/90)
Adjusted for seasonality

+ 2.0% absolute
+ 2.7% relative

OR

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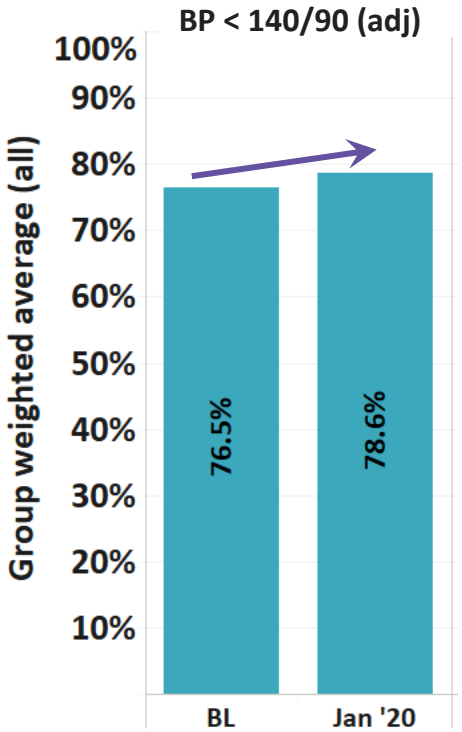

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  - ✓ 3.4% relative improve[illegible] patients
  - ✓ 5.7% relative im[illegible] patients

23% of available improvement

Patients with medical attention for nephropathy

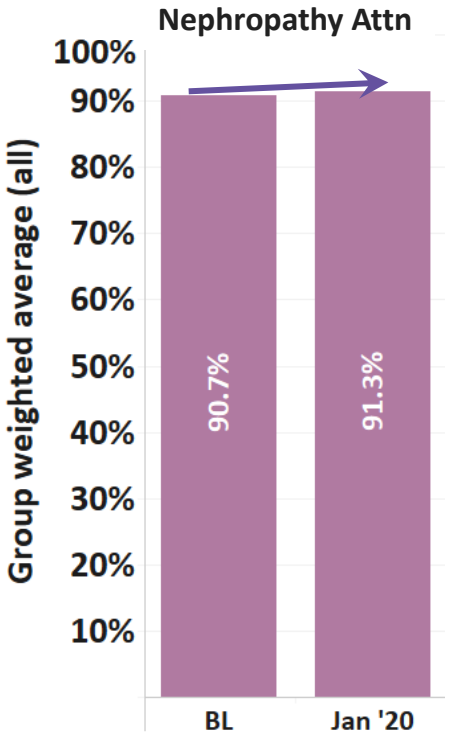
+ 0.6% absolute improvement
+ 0.6% relative improvement

OR

If you think of available improvement:

100 – 90.7 = 9.3% without attention for nephropathy

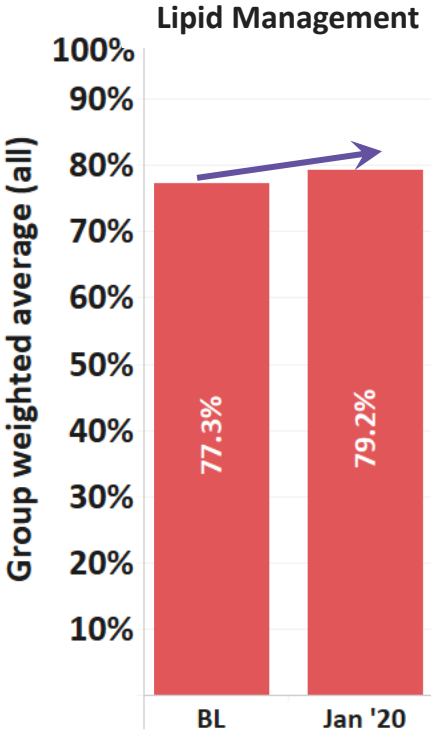
Cohort captured 6.4% of that available improvement



- 2 organizations started at over 93% control and still made gains
- **1,500 additional patients** with attention to nephropathy
  - ✓ 1.2% absolute increase, capturing 13.9% of available improvement → 100 patients
  - ✓ 1.5% absolute increase, capturing 16.4% of available improvement → 362 patients

Patients with lipid management (with statin prescription or documented reason not to have a statin)

- **6,000 additional patients** with lipid management
- 9 of 10 groups saw improvement
  - ✓ 2.5% relative improvement → 214 patients
  - ✓ 3.0% relative improvement → 2,038 patients
  - ✓ 3.2% relative improvement → 664 pts
  - ✓ 3.4% relative improvement → 805 patients
  - ✓ 7.3% relative improvement → 1,294 patients
- 5 groups captured > 10% of their available opportunity



+ 1.9% absolute
+ 2.5% relative

OR

If you think of available improvement:

100 – 77.3 = 22.7% without lipid management

Cohort captured 8.4% of the available improvement

Patients with lipid management (with statin prescription or documented reason not to have a statin)

- **6,000 additional patients** w[illegible] lipid management
- 9 of 10 groups saw in[illegible]
  - ✓ 2.5% relative i[illegible] atients
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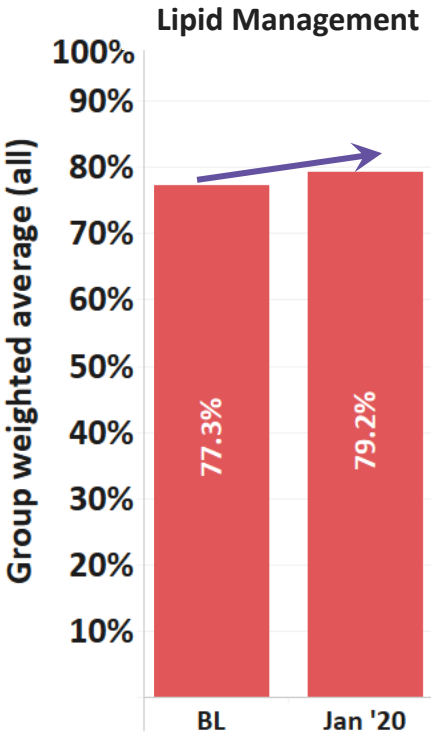
- 5 groups captured > 10% of their available opportunity

87.5% to 89.7%



+ 1.9% absolute
+ 2.5% relative

OR

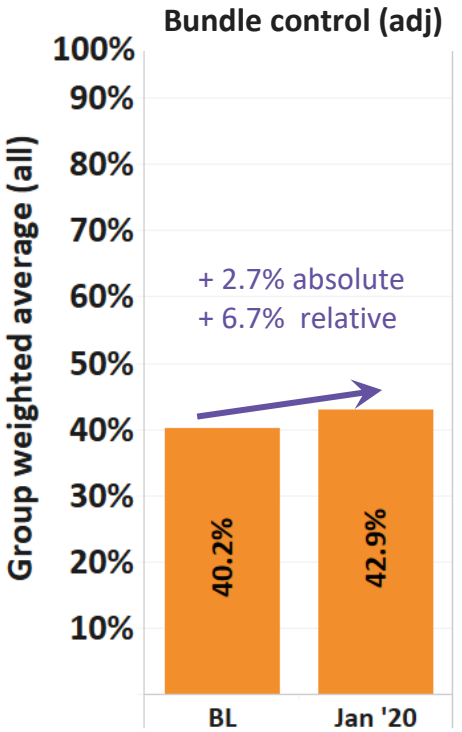
If you think of available improvement:

100 – 77.3 = 22.7% without lipid management

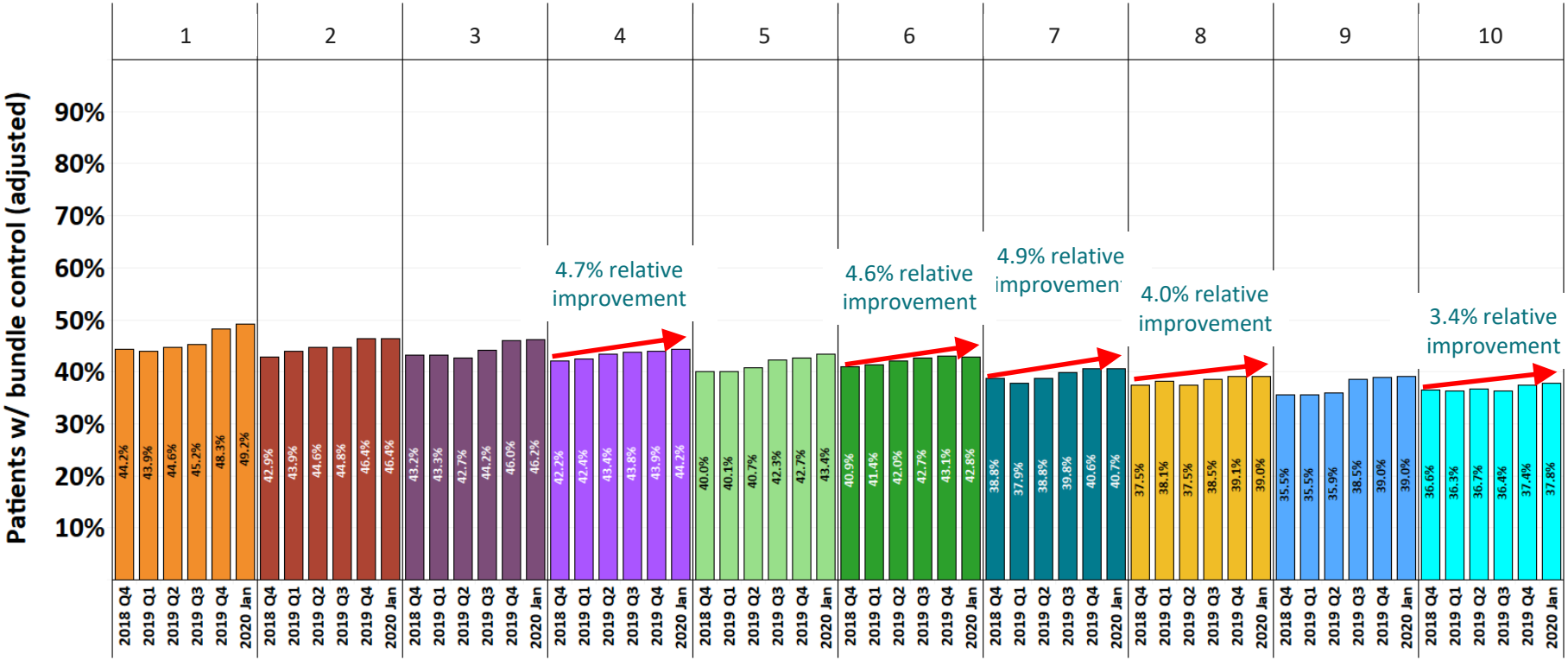
Cohort captured 8.4% of the available improvement

Patients with bundle control
Adjusted for seasonality

- All 10 groups saw improvement

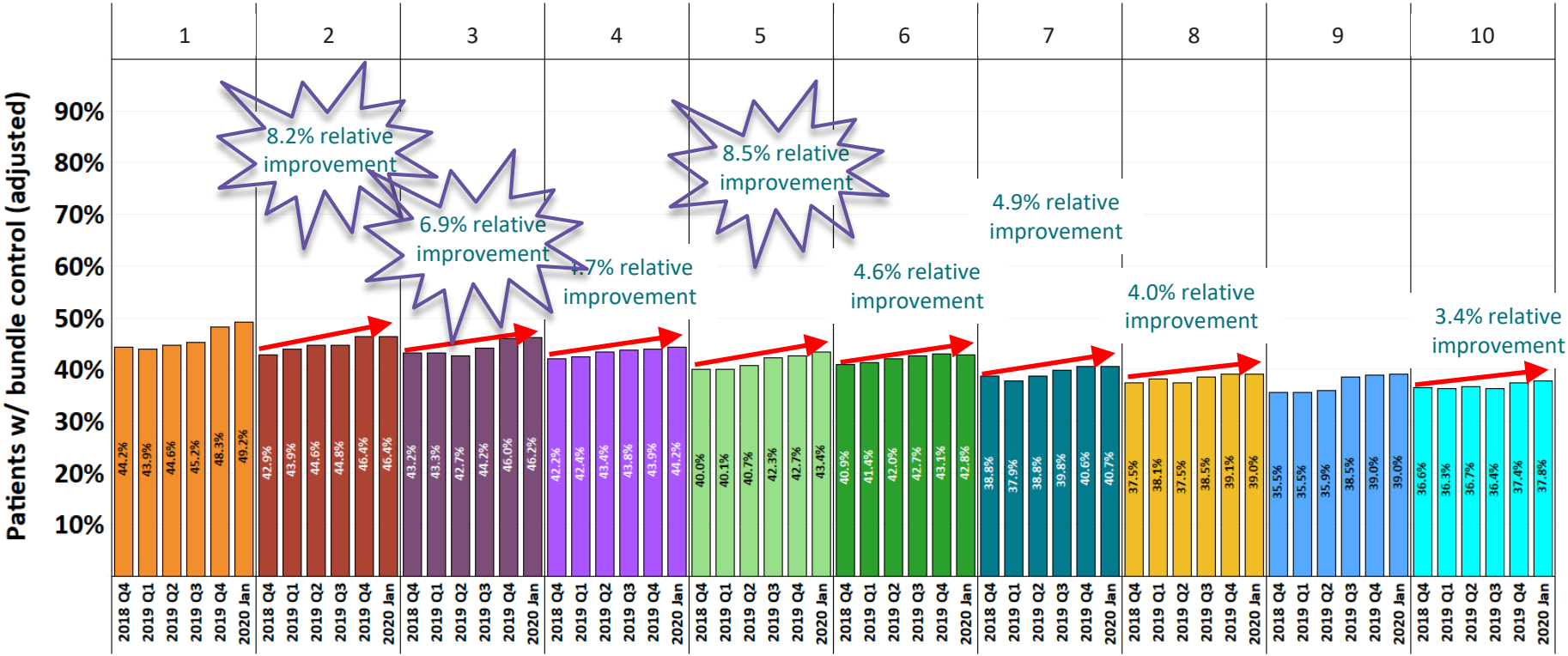


Patients with bundle control*
Adjusted for seasonality



* Sorted by measure rate in last reporting period (descending)

Patients with bundle control*
Adjusted for seasonality



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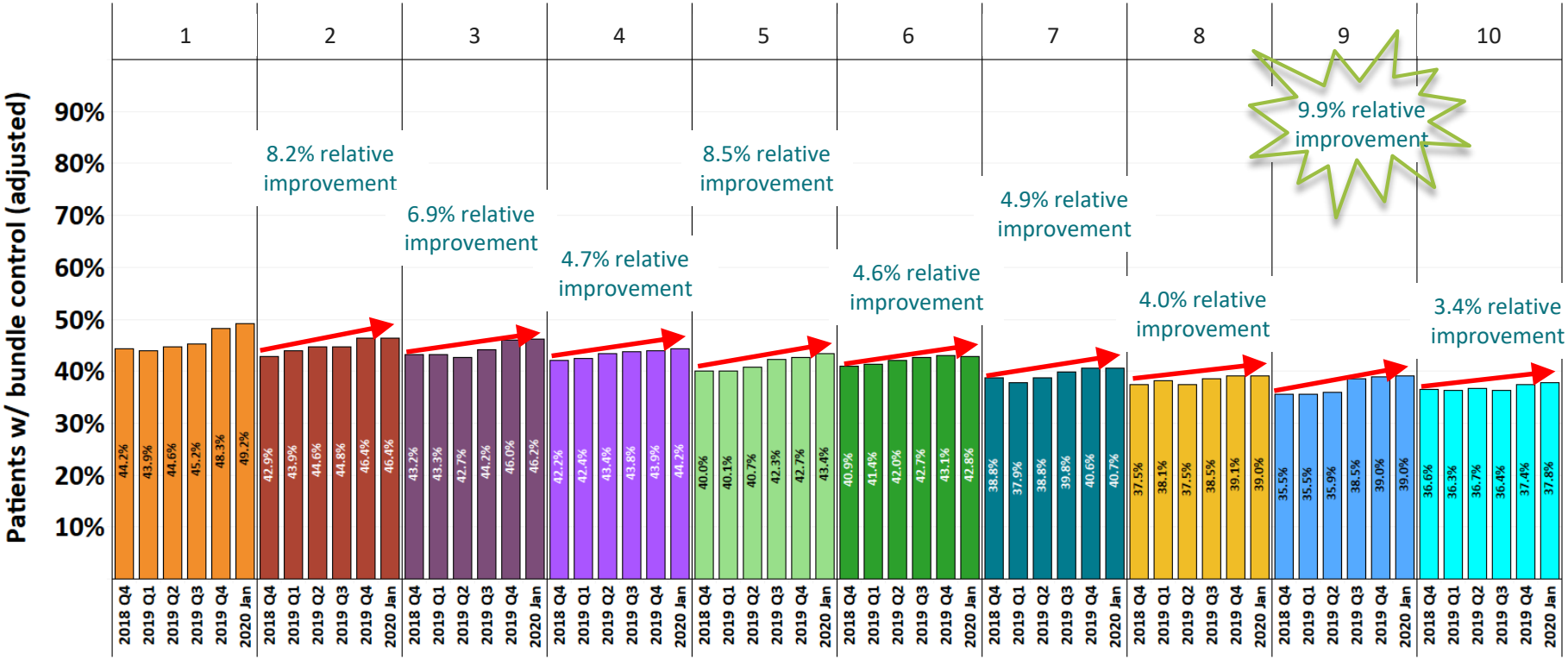
Patients with bundle control*
Adjusted for seasonality



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Patients with bundle control*
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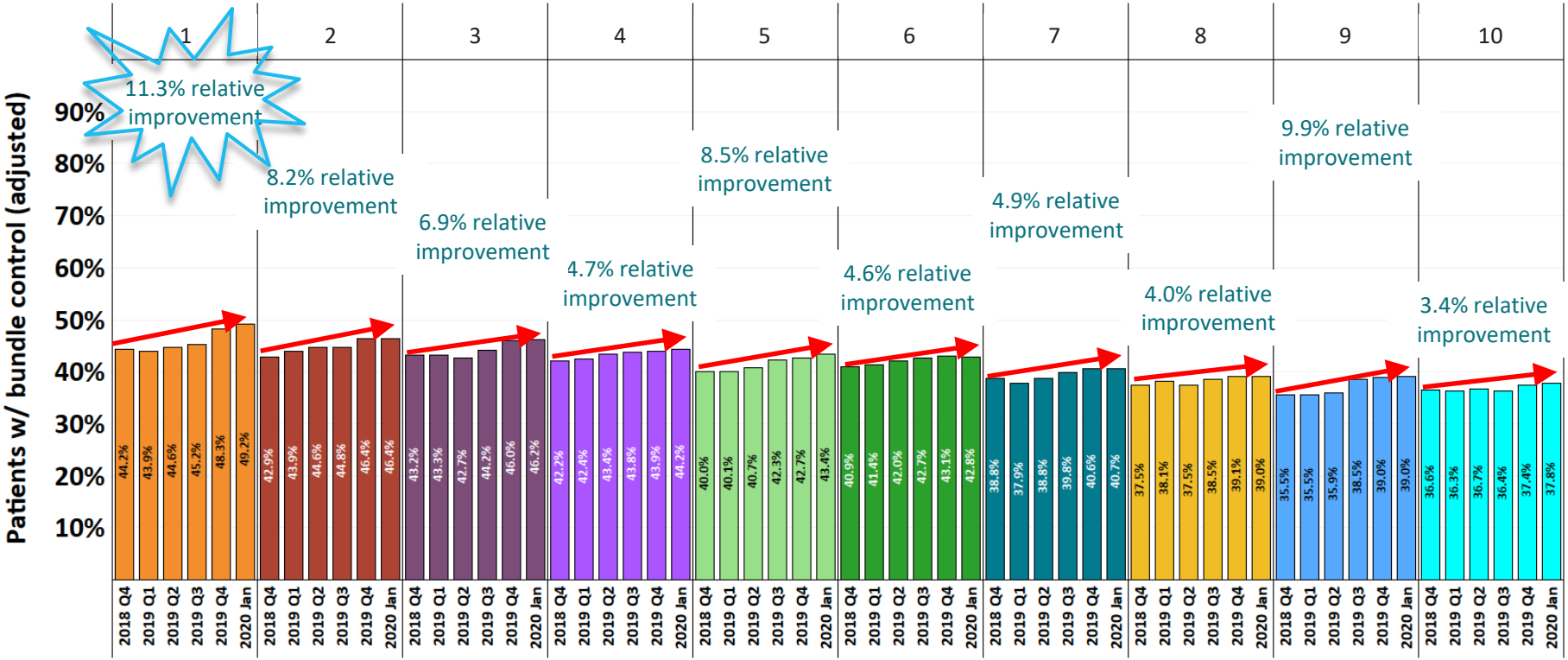
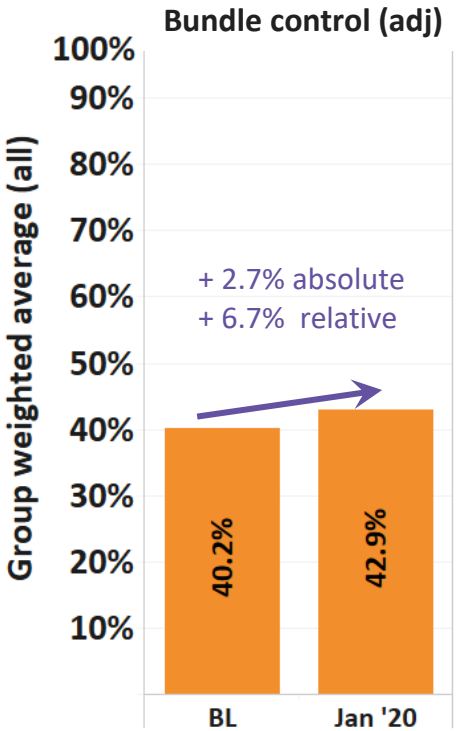


* Sorted by measure rate in last reporting period (descending)

Patients with bundle control
Adjusted for seasonality

8,000 additional **patients** with bundle control

- All 10 groups saw improvement
  - ✓ 3.4% relative improvement → 181 patients
  - ✓ 4.0% relative improvement → 531 patients
  - ✓ 4.7% relative improvement → 847 patients
  - ✓ 4.9% relative improvement → 367 patients
  - ✓ 4.9% relative improvement → 543 patients
  - ✓ 7.9% relative improvement → 243 patients
  - ✓ 8.1% relative improvement → 861 patients
  - ✓ 8.5% relative improvement → 2,961 patients
  - ✓ 9.9% relative improvement → 941 patients
  - ✓ 11.2% relative improvement → 480 patients



Comparison to Campaign Cohort

Comparison of Collaborative Improvement to Campaign: T2G Patients with bundle control

Seasonally adjusted group weighted average[1]: T2G Bundle

	Baseline (2018Q4)	2019Q4	Δ BL to 2019Q4	
			Absolute	Relative
Campaign[2]	40.4%	41.8%	1.4%	3.4%
Collaborative[3]	40.2%	42.6%	2.5%	6.1%

Relative improvement for collaborative 1.8x that seen by the campaign.

Comparison of Collaborative Improvement to Campaign: All T2G Core Measures

Measures:	Relative Δ 2018 Q4 (BL) to 2019 Q4[1]		Rel. Improvement: collaborative vs campaign (BL to 2019Q4)
	Collaborative[2]	Campaign[3]	
A1c < 8.0	1.7%	0.8%	2.2 x
BP < 140/90	2.4%	1.4%	1.6 x
Attention for Nephropathy	0.8%	0.5%	1.8 x
Lipid Management	2.4%	2.0%	1.2 x
T2G Bundle	6.1%	3.4%	1.8 x

[1] Note that these Δs are measured from the bundle baseline to December 2019, the last bundle measurement period to coincide with a T2G campaign measurment period (2019Q4) prior to when health systems began to see an impact due to COVID-19 pandemic. For the collaborative, January 2021 was considered the end of the intervention period with regard to calculating collaborative improvements.

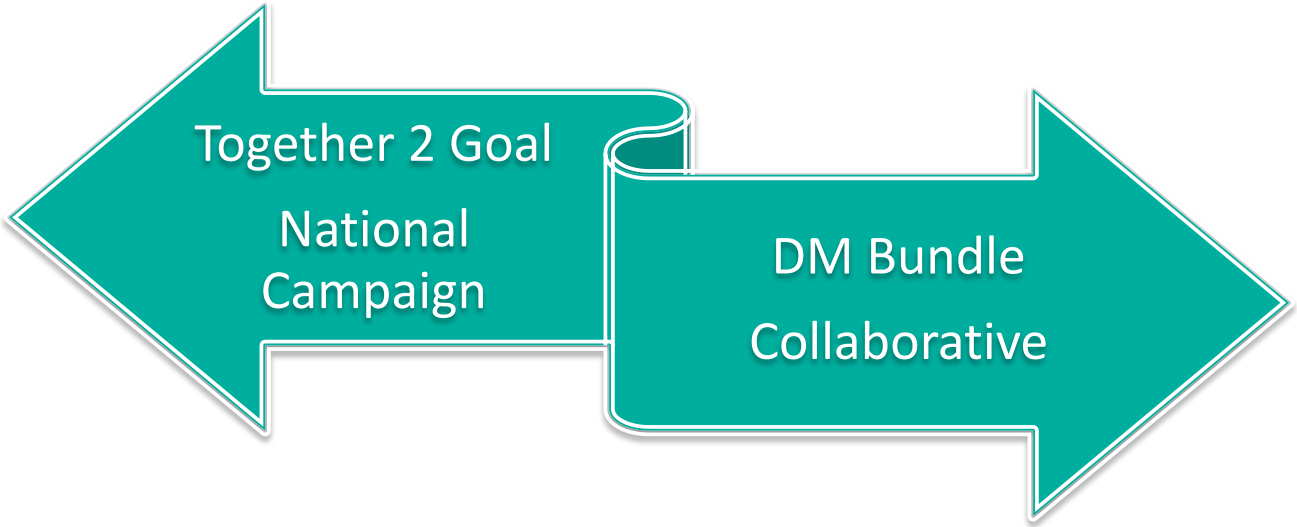
[2] Campaign includes 51 health care systems that reported to the T2G campaign in both 2018Q4 (BL) and 2019Q4, excluding collaborative participants.

[3] Collaborative includes the 10 health care systems participating in the T2G bundle collaborative.

In 13 months…

- Cohort improved in each of the bundle components
  - A1c control: + 3,100 patients, 2.2 x campaign
  - BP control: + 5,900 patients, 1.6 x campaign
  - Nephropathy: + 1,500 patients, 1.8 x campaign
  - Lipid mngt: + 6,000 patients, 1.2 x campaign
- Cohort achieved a 6.7% relative improvement in bundle control
  - All 10 organizations improved (range: 3.4% to 11.3%)
- 8,000 additional patients with bundle control
- 1.8 x the bundle improvement achieved by campaign

Quality Improvement Activities



Teamwork

Daily Huddles

Amplified Huddles

Diabetes Operations Group and Task Force

Diabetes Mellitus Care Model Program

Education

Provider

Staff

Patient

Provider Education

- Department meetings
- Insulin trouble shooting guide
- Peer to peer assistance on performance
- Collaboration with Cardiology Department
- Grand Rounds on diabetes medication
- CME seminar "Diabetes Clinical Updates"

Provider Education cont.

- Treatment algorithm
- Diabetes Super BPA
- Health Maintenance updates for Diabetes Standards of Care
- Monthly Provider Diabetes transparent reports
- Gap Reports

Staff Education

- Motivational interviewing training
- Scripting
- Annual competencies
- Novo Nordisk training course
- POC A1C machine training
- Chart Review and Documentation
- Standing Orders

Patient Education

- Patient waiting area and exam room
- Virtual visits including diabetes education
- Increase referrals to Diabetes Specialist
- Statin education material mailed to patients

A1C Control - Nephropathy

- POC A1C machines
- Pre-visit lab work
- Digital Medicine Diabetes Program
- Automated outreach for gaps in care

- Bulk messaging to patient with missing nephropathy test
- Urine screening at POC
- Automated outreach for gaps in care

Blood Pressure Control

- Outreach to patients with elevated BP
- Repeat Blood pressure checks
- Getting back to basics among staff
- Alignment of hypertension metrics across value based contracts

Lipid Management

- Pharmacy Engagement
- Grand Rounds on diabetes medication
- Statin focused education for providers and patients
- Patient engagement algorithm for statins
- Provider-talking point on the demystification of statins for patients
- 30 day prescription to 90 day prescriptions

Patient Outreach

Measures

- Missing, Due or Uncontrolled Measures

Methods of Outreach

- Patient portal
- Mail
- Phone calls (automated/manual)

Care Coordinators/ Medical Assistants

- Communication with patients
- Schedule a provider appointment
- Follow up for needed lab work
- Schedule Diabetes specialist appointments and programs

Quality Measures

- DB measures align with organization quality measures
- Bundle measure added to organizations quality measures
- Part of value based contracts
- 100 Day Value Goals Push for BP control, A1C Poor Control, DM Bundle to improve care and close gaps
- Provider incentives

Lessons Learned

- Improvement is a slow process
- Improvement needs to occur as a system wide approach
- Adopt standard care guidelines and address deviation
- Dedicated and trained staff to conduct patient outreach works
- Providing tools to increase efficiency does not equal immediate adoption
- Laboratory relationship and cooperation is essential
- Communication is key
- Celebrate Accomplishments

September Webinar

- **Date/Time**: September 17, 2020 from 2-3pm Eastern
- **Topic**: Addressing Social Determinants of Health: Community Partnerships and Health Equity Strategies
- **Presenter**: Kristen M. Kopski, M.D., Ph.D of HealthPartners Care Group

Questions