WEBINAR REMINDERS

• Webinar will be recorded today and available the week of May 23rd
  – Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  – Email distribution

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
For data assistance, contact DataHelpForT2G@amga.org.
April email included:
• Excel template
• Data portal
• User guide
• Reporting deadlines
• Measurement specs

*Note: As a benefit to Anceta participants, AMGA Analytics (Anceta) will automatically report data on your organization’s behalf according to the Core Track. Anceta will reach out in advance of the reporting deadline to review your data.
NOT RECEIVING OUR EMAILS?

To assist with delivery of campaign emails, please add the following addresses to your “Approved Senders” list:

• together2goal@amga.org
• messenger@webex.com
• amga-t2g@amgalist.org
• Domains ending in @amga.org
TODAY’S SPEAKER: DR. PARAG AGNIHOTRI

- Medical Director for Continuum of Care for Sharp Rees-Stealy Medical Group in San Diego
- Focuses on reforming the delivery of health care by building multidisciplinary teams to implement the ‘three part aim’ for improving the health of the population.
- Recognition
  - California Health Care Foundation Fellow
  - Center for Medicare and Medicaid Innovation Innovation Advisor
  - Board certified in Internal Medicine and Geriatric Medicine
Improving Care for the Population with Diabetes

“Measure HbA1c every 3-6 Months”

Parag Agnihotri, MD
Medical Director, Continuum of Care

Sharp Rees-Stealy Medical Group, San Diego
Agenda

How to promote team-based care

Address practice variation

How remote patient monitoring...

...creates patient engagement

Q&A

SHARP Rees-Stealy Medical Group
Success in Controlling Diabetes

Top 2 in California
Above national 90th percentile
Optimal Diabetes Care Bundle

90th Percentile Commercial

California 41%

Commercial Insurance 2015

52%
21,000 Patients with Diabetes: A1c<8%, LDL<100, Blood Pressure <140/90, and Nephropathy Screening

Added to Current Measures 2 A1cs and LDL>100 on Active Statin

Methodology: 12 month inclusion period
Datasource: Diabetes Datamart
How do you address this in a large multispecialty medical group with ...

1.3 million visits
250,000 assigned patients
500 Physicians & 60 NP/PA
2000 Clinic staff
22 Clinic locations

21,000 population with Diabetes
Diabetes Care Success: Three Simple Rules

1. Appointment every 4 weeks until achieve goal A1c
2. Laboratory every 4 weeks until at goal A1c
3. Titration of medication every 4 weeks until at goal A1c
Our Successful Methods

1. Align Stakeholders
2. Create Workflows
3. Build Teams
4. Use Technology
Diabetes Care Measures are on the Organization Scorecard

Staff
President
Physicians

CEO
Board
Senior VP
Our Successful Methods

Align Stakeholders
Create Workflows
Build Teams
Use Technology
Have a Common EHR Platform

Find us in Touchwork
The Registry: Shows all needed clinical components

<table>
<thead>
<tr>
<th>Last PCP</th>
<th>Last Endo</th>
<th>Last HA1c</th>
<th>HA1c Date</th>
<th>Last LDL</th>
<th>LDL Date</th>
<th>BP2</th>
<th>BP1</th>
<th>BP Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2014</td>
<td></td>
<td>5.8</td>
<td>7/7/2014</td>
<td>144</td>
<td>7/7/2014</td>
<td>92</td>
<td>62</td>
<td>9/9/2014</td>
</tr>
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<td>2/7/2014</td>
<td></td>
<td>6</td>
<td>8/7/2014</td>
<td>129</td>
<td>8/7/2014</td>
<td>126</td>
<td>84</td>
<td>2/7/2014</td>
</tr>
<tr>
<td>Last PCP</td>
<td>Last Endo</td>
<td>Last HA1c</td>
<td>HA1c Date</td>
<td>Last LDL</td>
<td>LDL Date</td>
<td>BP2</td>
<td>BP1</td>
<td>BP Date</td>
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<td>-----------</td>
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<tr>
<td>2/7/2014</td>
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<td>8/7/2014</td>
<td>129</td>
<td>8/7/2014</td>
<td>126</td>
<td>84</td>
<td>2/7/2014</td>
</tr>
</tbody>
</table>

- All necessary labs
- Color coded for out of range
- Current medication
- Last Appointment
- Next Appointment
Hot Spotting of HTN in San Diego Population

- 29% North & North Inland n=10,000
- 15% Central n=5,000
- SOUTH 22% n=7200
- 31% East n=11,000
List 1

Diabetes Disease Managers

1. A1c $\geq$ 8.5%

2. List of DM patients not seen in past year

**Workflow:**

- Manage the Diabetes care
- Schedule f/u appointments
List 2
Diabetes Nurses

1. LDL > 100 or
2. BP > 140/90
3. A1c 8% to 8.4%

**Workflow: Targeted Intervention**

- Manage LDL as per protocol.
- BP recheck appointments and
- No appointment within two months
1. Missing lab values
   – A1c, LDL, Microalbumin
2. No appointment with PCP 6 months

**Workflow**

– Automated Phone calls
– Web Portal messaging
– Care Specialist will schedule with PCP
Create Workflows with Automation

SR-HA1c>=9

Patients above 8.5% automatically go to Diabetes DM
Outreach in Multiple Ways

Outreach using *Follow My Health* web portal and Nuance telephonic outreach messages

Minimize the number of lists which go out to the Physicians and Clinic sites
Our Successful Methods

1. Align Stakeholders
2. Create Workflows
3. Build Teams
4. Use Technology
11 Diabetes Disease Managers  A1c> 8%

3 Dedicated RNs for Targeted DM Intervention
→ Call patients to make sure they are taking meds
  — Then ensure labs have been tested
  — Not taking meds -- Task physicians

2 Care Specialists obtain appointments
Engage the Patient: *Partner with me*

- Form personal connection
- Face to face interaction
- **Step-by-step wellness plan**
- Coordination of care across the system
- Patient specific education material
- Shared care plans
- Medication adherence reporting
- Use HIT to engage all patients not just present
### Questionnaire for Diabetes Patients

#### Self Efficacy

16) How well do you feel that you are currently able to manage your Diabetes?
- Fair

17) What is your biggest concern right now about your Diabetes?
- How am I going to do everything I need to do

18) Does your current cultural heritage or spiritual/personal beliefs conflict with your doctor's recommendations for treatment?
- No

19) I can prevent complications:
- Disagree

20) Feelings about health/diabetes:
- Frustrated
## Diabetes Care Goals

<table>
<thead>
<tr>
<th>Measurements</th>
<th>Goal</th>
<th>My Latest Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1C:</strong></td>
<td>A measure of the average blood sugar over the past 3 months.</td>
<td></td>
</tr>
<tr>
<td>HbA1c  7% = Avg BS 154</td>
<td>2 A1C measurements in past 12 months</td>
<td>□</td>
</tr>
<tr>
<td>HbA1c  8% = Avg BS 183</td>
<td>Latest A1C=7.0% or Less</td>
<td></td>
</tr>
<tr>
<td>HbA1c  9% = Avg BS 212</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td>139/89 or Less</td>
<td></td>
</tr>
<tr>
<td><strong>Taking Statin Medication to Lower LDL:</strong></td>
<td>LDL = The lower the better</td>
<td></td>
</tr>
<tr>
<td>LDL - Bad cholesterol that can increase the risk of heart disease and stroke.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urine Microalbumin</strong></td>
<td>Screening annually or taking an ACE or ARB medication</td>
<td>□</td>
</tr>
<tr>
<td>Annual screening for kidney disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 1. Contact the following Sharp Rees-Stealy programs:
- Diabetes Education and Training (858) 499-2700
- Healthier Living Class 1-800-82-SHARP (1-800-827-4277)
- Diabetes Texting Program (Text MYTEXT to 63141)
- Health Education Programs (619) 590-3300

### 2. If your A1C is 8.0% or greater, talk to your doctor about checking your A1C again in 4-8 weeks.
# Measure the Engagement Rate

## Sample Month Program Engagement Rates: Rolling 12 Months

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Overall Engagement</th>
<th>Previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>68.5%</td>
<td>65.1%</td>
</tr>
<tr>
<td>COPD</td>
<td>75.5%</td>
<td>75.3%</td>
</tr>
<tr>
<td>CHF</td>
<td>62.9%</td>
<td>62.4%</td>
</tr>
<tr>
<td>CKD</td>
<td>22.9%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Complex Case Management</td>
<td>31.1%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Chronic Care Nursing</td>
<td>78.8%</td>
<td>78.3%</td>
</tr>
<tr>
<td>Senior Enhanced Care Management</td>
<td>57.2%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>29.2%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Health Coaching</td>
<td>34.4%</td>
<td>26.6%</td>
</tr>
<tr>
<td><strong>Overall Engagement</strong></td>
<td><strong>52.1%</strong></td>
<td><strong>51.1%</strong></td>
</tr>
</tbody>
</table>
Graduation into Self-Management: Healthier Living Classes 2015 YTD

15 workshops
118 participants

63% completion rate
Physician Engagement Strategy

1. What do you want your Physicians to do?
2. Do they know how to do the work?
3. Do they have the resources to do the work?
4. Are physicians motivated to do the work?

Ralph Jacobson is founder and principal of The Leader’s Toolbox and author of "Leading for a Change: How to Master the Five Challenges Faced by Every Leader." He is also a faculty member of the Physician’s Leadership College. He can be reached at www.theleaderstoolbox.com
Diabetes Care Success: Three Simple Rules

1. Appointment every 4 weeks until achieve goal A1c
2. Laboratory every 4 weeks until at goal A1c
3. Titration of medication every 4 weeks until at goal A1c
Tools to help with Panel Management
Point of Care Tool via EHR

HCC Opportunity Report

Patient:  
Provider:  
Appointment Site/Date/Time:  LM - 04/11/2016 09:20

Codes Reported In Previous Years - Evaluate and Report if Appropriate:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>440.0</td>
<td>AORTIC ATHEROSCLEROSIS</td>
<td>6/19/2015</td>
</tr>
</tbody>
</table>

Clinical Considerations - Evaluate and Report if Appropriate:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.8X</td>
<td>Evaluate for diabetes with complications (CAD, CVA, dyslipidemia): Code 250.8X if present.</td>
</tr>
<tr>
<td>250.7X</td>
<td>Diabetis with PAD: Evaluate and code 250.7X if PAD due to DM.</td>
</tr>
</tbody>
</table>

Diabetes Advanced Perfect Care

Diabetes Data Effective Date: 04/03/2016

Patient:  
EMRN:  
DOB:  
SHC#:  
Actual Provider:  
Appointment Site/Date/Time:  LM - 04/13/2016 09:20

The Following Tests Are Over 12 Months Old:

Microalbumin: 01/23/2015

The Following Tests Do Not Meet Control:

BP >= 140/90: (176/94)
Diabetes Management Guidelines

SHARP REES-STEALY CLINICAL GUIDELINES COMMITTEE

Title: Diabetes Medication Management Guidelines for Patients w/A1c 7-8.9%

Original Date: 10/30/2012
Revision Date: 1/29/15

Disclaimer: Sharp Rees-Stealy clinical guidelines are designed to assist clinicians in the evaluation and treatment of the more common medical problem. They are not intended to replace clinical judgment or establish a protocol for all patients. The clinical approach described by this guideline will not fit all patients and will rarely establish the only appropriate approach to a problem.

SRS Diabetes Medication Management Algorithm for HbA1C 7-8.9%

A1c 7-8.9%

- Diabetes education and lifestyle modification

Is GFR > 45? *see footnote

- Yes
  - Start *Metformin ER and increase weekly as tolerated
  - Check A1c in 1 month

- No
  - Add Glimepiride (or other long-acting sulfonylurea) and increase every 1-2 weeks as tolerated

- Is A1c < 7%?
  - No
    - Check A1c in 1 month
  - Yes
    - Check A1c in 3-6 months
HbA1c is a weighted average of Blood Glucose levels during the preceding 120 days.

Defining the Relationship Between Plasma Glucose and HbA1c Analysis of glucose profiles and HbA1c in the Diabetes Control and Complications Trial Curt L. Rohlfing, BES, et al 0.2337/diacare.25.2.275 Diabetes Care February 2002 vol. 25 no. 2 275-278
Uncontrolled Diabetics need at least 5 A1c labs...every 2-3 months...

Optimal Frequency of A1c tests/year for Diabetic population whose baseline HgA1c result were \( \geq 9\% \)
Actionable Peer Review
Transparent reports based on disease registries

SHARP Rees-Stealy Medical Centers
Monthly Diabetes Graphs

Diabetes Advanced Perfect Care - April 2016
Percent of patients with A1cs, LDL, Nephropathy Screening, BP done in previous 12 months, and 2 A1cs, A1c < 8, LDL < 100 or on a Statin, and BP < 140/90

Dr. A panel  Dr. B  Dr. C.  Dr. D

0%  10%  20%  30%  40%  50%  60%  70%  80%  90%  100%
It is all about Teamwork!
Create Workflows

Align Stakeholders

Build Teams

Use Technology
Diabetes Texting Program

Has expanded Case Manager reach for moderate risk patients

Uncontrolled Diabetic Costs are $14,000 per year

myAgileLife: Q: What effect does unsweetened fruit juice have on blood glucose? Reply 17A=Lowers it, 17B=Raises it or 17C=Has no effect

myAgileLife: A: You got it right! Even unsweetened juices have lots of sugars and calories that raise blood sugar. Try drinking water instead.
Future Pilots
Wireless Glucometers
Increase Patient Caseload with Mobile Technology

Population Health Patient Caseload

25% Increase in Patient Caseloads Due to Mobile Technology

Caseload Without Mobile Technology | Caseload With Mobile Technology
Clinical Effectiveness

Population Identification

Population Management

Measurement of Clinical Effectiveness
Continuous Improvement Process

Optimal Diabetes Bundled Care

Diabetic patients with A1c < 8%, 2 A1c/yr., LDL <100 or active statin, BP<140/90

SR-APC Rate

All sites: 56% have perfect Diabetes care
Correlation between Diabetes Care and Overall Clinical Care

PO performance on the Optimal Diabetes Care measure is highly correlated with overall clinical achievement.
Effectiveness of Diabetes Care Interventions

<table>
<thead>
<tr>
<th>Diabetics in control</th>
<th>Prevented Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>1 MI</td>
</tr>
<tr>
<td>178</td>
<td>1 Stroke</td>
</tr>
<tr>
<td>151</td>
<td>1 Retinopathy</td>
</tr>
</tbody>
</table>

Average hospital admission cost for MI and Stroke is $20,000

Source: HCUP; Source: Geisinger Health System, [www.ajmc.com](http://www.ajmc.com)
Clinical Outcome Measures for Patients with Diabetes

Rate per 1,000 SRS Patients with Diabetes per Year

<table>
<thead>
<tr>
<th>Year</th>
<th>New ESRD on Dialysis</th>
<th>New Dx DM Retinopathy</th>
<th>New Dx Acute Myocardial Infarction</th>
<th>New Dx Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>40.6</td>
<td>34.8</td>
<td>9.1</td>
<td>21.4</td>
</tr>
<tr>
<td>2010</td>
<td>42.7</td>
<td>30.6</td>
<td>8.6</td>
<td>20.0</td>
</tr>
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<td>2011</td>
<td>34.8</td>
<td>29.3</td>
<td>6.4</td>
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<td>2012</td>
<td>31.0</td>
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<td>9.7</td>
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<td>2013</td>
<td>31.0</td>
<td>33.7</td>
<td>3.2</td>
<td>9.9</td>
</tr>
<tr>
<td>2014</td>
<td>20.0</td>
<td>21.4</td>
<td>3.5</td>
<td>10.9</td>
</tr>
<tr>
<td>2015</td>
<td>14.3</td>
<td>14.3</td>
<td>14.3</td>
<td>9.8</td>
</tr>
</tbody>
</table>

REduction in Admissions per 1,000: 1.20

Mean Cost of Stroke Hospitalization (HCUP): $20,000

Estimated Cost Savings for 2015: $487,584

Stroke Cost Savings in 2015

| CY 2014 per 1,000 Members per Year: | 13.30 |
| 2015 (Jan-Jun) per 1,000 Members per Year: | 12.10 |
| Reduction in Admissions per 1,000: | 1.20 |
| Mean Cost of Stroke Hospitalization (HCUP): | $20,000 |
The campaign to make San Diego a heart attack and stroke-free zone.

Heart Attack and Stroke are preventable. See your doctor today to find out your risk for heart disease and stroke and to get on the right treatments to reduce your risk for premature death.

Take charge of your health today and visit www.betheresandiego.org

The campaign to make San Diego a heart attack and stroke-free zone.
Friday Fun Facts

**Fun Fact**
Laughing regularly may lower your blood pressure by 5 mmHg

≤139/89
Our Successful Methods

- Align Stakeholders
- Create Workflows
- Build Teams
- Use Technology
Lessons Learned

Registry
- Common EHR

Physician Engagement
- Transparent peer review of data

Team Based Healthcare
- Keep core team centralized

Patient Engagement
- Measure effectiveness of Health Coaching

A1c testing
- A way to drive performance & engagement

Technology
- Leverage it

Change is hard
- Together 2 Goal collaborative
Diabetes Care Success: Three Simple Rules

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3. Titration of medication every 4 weeks until at goal A1c