TODAY’S WEBINAR

• Together 2 Goal® Updates
  – Webinar Reminders
  – Goal Post June Newsletter
  – Bonus Webinar
  – Data Submission & Survey Responses

• Build an Accountable Diabetes Team
  – Beth Averbeck, MD (HealthPartners Medical Group)

• Q&A
  – Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of June 20th
  – 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
Questions? Contact:

- **Together2Goal@amga.org** or your Regional Liaison for **general questions**
- **DataHelpforT2G@amga.org** for **data questions** (e.g., reporting, specifications)
- **AMGA-T2G@amgalist.org** for input/feedback from fellow participating medical groups and health systems only
Campaign Spotlight:

Henry Ford Health System

Upcoming Dates
June 16: Monthly campaign webinar (Register here)
June 21: Missing, completed, data reports and district contacts sent to participating organizations

Campaign Spotlight
Henry Ford Health System awards districts for the planning process, including a form from MeasureMap, tracking progress and an inventory of successes for the district. For information on the "Together2Goal" campaign, contact your district contacts.

Read More

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Resource of the Month:
• If you did not receive the Goal Post newsletter and would like to:
  – Check your spam folder
  – Email your Regional Liaison or Together2Goal@amga.org

• If you have ideas for future Campaign Spotlights or Resources of the Month, email Together2Goal@amga.org
  – Can include self-nominations
**Topic:** Care4Today™

**When:** Thursday, August 4 from 2-3 p.m. Eastern

**Who:** Principal Corporate Collaborator Johnson and Johnson Family of Diabetes Companies and AMGA member Sharp Community Medical Group
Next steps:

- **July 15** – Blinded, comparative data reports sent to participating organizations
- **July 21** – Review baseline data on monthly campaign webinar
- **August 18** – Review survey results on monthly campaign webinar
TODAY’S SPEAKER: DR. BETH AVERBECK

• Senior Medical Director, Primary Care for HealthPartners Medical Group
• Practicing internist with over 15 years of leadership experience in clinic and hospital operations and in quality improvement
Team-Based Approach to Diabetes Care

Beth Averbeck, MD – Senior Medical Director, Primary Care
6/16/2016
Overview

• Care team roles and responsibilities
  – For all patients
  – Specific to patients with diabetes
• Role of specialist
• Optimal Diabetes
  – Definition
  – Measure
• Results
  – Accountability/improvement
• Customization example
  – Disparities work
HealthPartners®

- Consumer-governed, non-profit
- Integrated health and financing
  - Clinics and hospitals
  - Health plan
- Twin Cities & surrounding communities (MN & Western WI)
Patient with diabetes vs. “diabetic”

Medication List

45 total medications:
• 4 hypertension
• 2 lipid
• Aspirin
• 2 glycemic
• 5 mental health
• 7 topical

John Smith, Patient History

• Hyperlipidemia
• DM Type2
• Pain Low Back
• Obstructive Sleep Apnea Hypopnea
• Schizophrenia NOS
• Depression Major NOS
• Hemorrhoids Internal NOS
• Gastroesophageal Reflux Disease
• Obesity Morbid
• Other
• Atypical chest pain
Overview

• Care team roles and responsibilities
  – For all patients
  – Specific to patients with diabetes
• Role of specialist
• Optimal Diabetes
  – Definition
  – Measure
• Results
  – Accountability/improvement
• Customization example
  – Disparities work
Approach to Diabetes Care

• Teamwork is a key skill
  – Specific roles and responsibilities
  – Delegate and trust
  – Proactively identify patients using a registry
  – Reach out to patients who need to come in for a visit or need support between visits

• Increasing use of technology
  – e.visits/tele-health

• Engage patients in healthy lifestyle choices (‘health coaching’)

• Standing orders for pharmacists and diabetes nurse specialists
Care Model Process
Standardize to science, customize to patient
Includes diabetes care

Before The Visit
- Visit Scheduling
- Pre-visit Planning

During the Visit
- Check-in
- Visit

After the Visit
- Follow-up

Between Visits

Reception
- Insurance verification
- Check-in
- Scheduling
- Message triage
- Forms

CMA/RMA/LPN
- Registry
- Message triage
- LPN standing orders
- Test results
- Immunization
- Preventive services
- Collaborative documentation

RN’s
- Phone triage
- Protocol driven care
- Medication refill
- Abnormal test triage
- Care Coordination
- Action Plan
- Health coaching

Clinician
- Leader of care team
- Diagnosis and treatment
- Engaging patients in their care
- Directing members of care team
- Care plans
Diabetes “Neighborhood” Care Team

System support: Lab standing orders & EHR decision support

*Diabetes Nurse Specialists and Dietitian Nutritionists can both be Certified Diabetes Educators*
Medication Therapy Management
Diabetes Pilot

• One employer
• 296 out of 666 invited members
• Participants received waived copays for medications

Results:

- Optimal Diabetes Control: 79%
- Emergency Department Use: 38%
- Hospital Utilization Rate: 38%
Care Team Roles

• **Diabetes Nurse Specialist**
  - Matching meter to coverage
  - Medication adjustment
  - Help with registries
  - Support behavior change

• **Registered Dietitian Nutritionist**
  - Balancing eating and activity with medication and monitoring
  - Support culturally specific diet
Role of Specialist

• Referrals
  – Glycemic control

• Primary management of patients with Type I

• Co-management

• Population consultant

• Endocrine Hotline (for clinicians/staff only)

• Content expert
Population Consultant
Moving knowledge and information, not patients

A new approach to diabetes care in Endocrinology:

- Share knowledge and best practices through the use of tele-video
- Discuss difficult diabetes cases with experts and other providers
- Build relationships with colleagues

*Modeled after Project ECHO
Standing Orders Process

1. Identify need
2. Agree on evidence
3. Involve physicians & care team in development
4. Out for “public comment”
5. Pilot & spread

Standing orders
- Conversion of supplies
- Hyperglycemia
- Hypoglycemia
- Initiation of insulin
- Adjustment of insulin
- Medication refill
- Hypertension
- Lipids
Optimal Diabetes Care Measure (Ages 18-75)

**Measure:** Optimal Diabetes Care - % of patients with diabetes who have the following:

- Statin on current medication list or LDL < 70 for patients > 40
- A1c with a value less than 8.0
- Blood pressure less than 140/90
- Documented non-tobacco user
- Aspirin on current medication list (vascular disease)
Overview

• Care team roles and responsibilities
  – For all patients
  – Specific to patients with diabetes
• Role of specialist
• Optimal Diabetes
  – Definition
  – Measure
• Results
  – Accountability/improvement
• Customization example
  – Disparities work
# 2015 Minnesota Community Measurement (MNCM): Optimal Diabetes Care

### Table: Optimal Diabetes Care

<table>
<thead>
<tr>
<th>Medical Group Name</th>
<th>Rate (Actual)</th>
<th>Lower Bound of 95% CI</th>
<th>Upper Bound of 95% CI</th>
<th>N</th>
<th>Total Population Or Sample</th>
<th>Rate (Expected)</th>
<th>Actual to Expected Ratio</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td><strong>STATEWIDE AVERAGE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Catalyst Medical Clinic</td>
<td>71.7%</td>
<td>59.2%</td>
<td>81.5%</td>
<td>60</td>
<td>Sample</td>
<td>54.4%</td>
<td>1.3</td>
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<td>Richard Schowee MD</td>
<td>68.9%</td>
<td>54.3%</td>
<td>80.5%</td>
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<td>Expected</td>
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<td>Edina Sports Health &amp; Wellness</td>
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<td>56.9%</td>
<td>73.4%</td>
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<td>Expected</td>
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<tr>
<td>Allina Health Clinics</td>
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<td>62.4%</td>
<td>63.4%</td>
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<td>1.2</td>
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<td>Park Nicollet Health Services</td>
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<td>61.8%</td>
<td>63.2%</td>
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<td>1.2</td>
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<td>Entira Family Clinics</td>
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<td>60.6%</td>
<td>63.2%</td>
<td>5358</td>
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<td>55.8%</td>
<td>1.1</td>
<td>Top</td>
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<tr>
<td>France Avenue Family Physicians - Minnesota Healthcare Network</td>
<td>61.3%</td>
<td>56.3%</td>
<td>66.0%</td>
<td>385</td>
<td>Total Population</td>
<td>55.6%</td>
<td>1.1</td>
<td>Expected</td>
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<tr>
<td>Stillwater Medical Group</td>
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<td>58.7%</td>
<td>62.8%</td>
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<td>Total Population</td>
<td>56.1%</td>
<td>1.1</td>
<td>Above</td>
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<td>Apple Valley Medical Clinic</td>
<td>60.3%</td>
<td>57.5%</td>
<td>63.1%</td>
<td>1150</td>
<td>Total Population</td>
<td>55.2%</td>
<td>1.1</td>
<td>Top</td>
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<tr>
<td>Vibrant Health Family Clinics and Minnesota Health Network</td>
<td>59.0%</td>
<td>55.7%</td>
<td>62.3%</td>
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<td>Gundersen Health System</td>
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<td>66.2%</td>
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<td>Mankato Clinic, Ltd.</td>
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<td>55.7%</td>
<td>59.8%</td>
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<td>1.1</td>
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<td>53.5%</td>
<td>61.3%</td>
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<td>AALFA Family Clinic</td>
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<td>48.9%</td>
<td>65.2%</td>
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<td>58.3%</td>
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<td>Total Population</td>
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<td>61.8%</td>
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<td>Total Population</td>
<td>57.1%</td>
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<td>Expected</td>
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<td>Affiliated Community Medical Centers</td>
<td>56.3%</td>
<td>54.7%</td>
<td>57.8%</td>
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<tr>
<td><strong>HealthPartners Clinics</strong></td>
<td>55.7%</td>
<td>54.9%</td>
<td>56.5%</td>
<td>15421</td>
<td>Total Population</td>
<td>53.0%</td>
<td>1.1</td>
<td>Above</td>
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</tbody>
</table>

**Note:** The table above highlights the Statewide Rate for Optimal Diabetes Care. The Statewide Average is 53.5%, with a 95% CI of 53.3%-53.7%. The numerator represents patients who met treatment goals (131,847), while the denominator represents patients sampled (245,241), with a total eligible of 249,878.
# MNCM by Clinic

<table>
<thead>
<tr>
<th>CLINICS</th>
<th>PATIENT EXPERIENCE</th>
<th>DIABETES: ADULTS</th>
<th>VASCULAR CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entira Family Clinics-Shoreview (formerly Family HealthServices Minnesota-Shoreview)</td>
<td>□</td>
<td>ABOVE AVERAGE 88 %</td>
<td>ABOVE AVERAGE 69 %</td>
</tr>
<tr>
<td>SHOREVIEW, MN (1.44 MILES)</td>
<td>□</td>
<td>ABOVE AVERAGE 83 %</td>
<td>ABOVE AVERAGE 68 %</td>
</tr>
<tr>
<td>Allina Health- Shoreview</td>
<td>□</td>
<td>ABOVE AVERAGE 85 %</td>
<td>ABOVE AVERAGE 68 %</td>
</tr>
<tr>
<td>SHOREVIEW, MN (0.77 MILES)</td>
<td>□</td>
<td>ABOVE AVERAGE 81 %</td>
<td>ABOVE AVERAGE 67 %</td>
</tr>
<tr>
<td>HealthPartners- Arden Hills</td>
<td>□</td>
<td>ABOVE AVERAGE 81 %</td>
<td>ABOVE AVERAGE 67 %</td>
</tr>
<tr>
<td>ARDEN HILLS, MN (1.37 MILES)</td>
<td>□</td>
<td>ABOVE AVERAGE 81 %</td>
<td>ABOVE AVERAGE 67 %</td>
</tr>
<tr>
<td>HealthPartners- Roseville</td>
<td>□</td>
<td>ABOVE AVERAGE 81 %</td>
<td>ABOVE AVERAGE 67 %</td>
</tr>
<tr>
<td>ROSEVILLE, MN (3.77 MILES)</td>
<td>□</td>
<td>ABOVE AVERAGE 81 %</td>
<td>ABOVE AVERAGE 67 %</td>
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</tbody>
</table>
Clinic/Clinician Results

HealthPartners Medical Group
Optimal Diabetes Care
March 2016 Summary Report

Top 10 Clinics

<table>
<thead>
<tr>
<th>Primary Care Clinic</th>
<th># Eligible Patients</th>
<th>% Met Criteria</th>
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<tbody>
<tr>
<td>Arden Hills</td>
<td>584</td>
<td>64.73%</td>
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<tr>
<td>Hlth Ctr for Women</td>
<td>311</td>
<td>58.52%</td>
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<tr>
<td>Coon Rapids</td>
<td>788</td>
<td>58.50%</td>
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<tr>
<td>Woodbury</td>
<td>1,268</td>
<td>58.20%</td>
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<tr>
<td>Roseville</td>
<td>486</td>
<td>58.02%</td>
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<tr>
<td>Elk River</td>
<td>458</td>
<td>56.33%</td>
</tr>
<tr>
<td>SMG Curve Crest</td>
<td>2,221</td>
<td>56.28%</td>
</tr>
<tr>
<td>Andover</td>
<td>583</td>
<td>54.89%</td>
</tr>
<tr>
<td>Riverside</td>
<td>629</td>
<td>54.69%</td>
</tr>
<tr>
<td>Ctr International Hlth</td>
<td>354</td>
<td>54.52%</td>
</tr>
</tbody>
</table>

Top 20 Clinicians

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Eligible Patients</th>
<th>% Met ODC</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>102</td>
<td>764.47%</td>
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<td>HPMG</td>
</tr>
<tr>
<td>80</td>
<td>73.75%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>22</td>
<td>72.73%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>76</td>
<td>72.37%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>47</td>
<td>72.34%</td>
<td></td>
<td>SMG</td>
</tr>
<tr>
<td>99</td>
<td>69.70%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>46</td>
<td>69.57%</td>
<td></td>
<td>HPMG</td>
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<tr>
<td>16</td>
<td>68.75%</td>
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<tr>
<td>67</td>
<td>68.66%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>82</td>
<td>68.29%</td>
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<td>SMG</td>
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<tr>
<td>61</td>
<td>67.21%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>161</td>
<td>67.08%</td>
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<tr>
<td>78</td>
<td>66.67%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>51</td>
<td>66.67%</td>
<td></td>
<td>SMG</td>
</tr>
<tr>
<td>33</td>
<td>66.67%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>123</td>
<td>65.85%</td>
<td></td>
<td>HPMG</td>
</tr>
<tr>
<td>26</td>
<td>65.38%</td>
<td></td>
<td>HPMG</td>
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<tr>
<td>134</td>
<td>64.93%</td>
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<td>HPMG</td>
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<tr>
<td>88</td>
<td>64.77%</td>
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<td>SMG</td>
</tr>
<tr>
<td>217</td>
<td>64.52%</td>
<td></td>
<td>HPMG</td>
</tr>
</tbody>
</table>
Care Team Scorecard Meetings

**Structure**
- Meet every 90 days with site leadership
- Physician/Clinician, LPN/CMA, RN

**Process**
- Celebrate & share
- Identify opportunities and learn
- Test improvements: care teams and leaders partner

**Site Leaders send plans to division leaders**
- Identify best practices
- Reward and recognize
- Share with others
HealthPartners’ 35,646 members with diabetes in 2014 suffered 403 fewer heart attacks, 40 fewer leg amputations and 760 people did not experience eye complications compared to what would have happened to the same 35,646 plus members in 2000.
Overview

• Care team roles and responsibilities
  – For all patients
  – Specific to patients with diabetes
• Role of specialist
• Optimal Diabetes
  – Definition
  – Measure
• Results
  – Accountability/improvement
• Customization example
  – Disparities work
Customize
Care that meets the needs of the person

Equality

Equity
Optimal Diabetes Process Measure

2014 Data

- **A1c tested within 12 months**
  - 98% (Patients who are white)
  - 96% (Patients of color*)
- **LDL tested within 12 months**
  - 92% (Patients who are white)
  - 91% (Patients of color*)

*Patients of color: includes patients whose self-identified race is either American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino, Some other race, and patients with more than one race documented (Multiple race)
Diabetes Outcomes by Race

2014 Data

% Met A1c Goal <8

- Patients who are white: 74.9%
- Patients of color*: 67.3%

67.5%
2014 HEDIS national 90th percentile

% Met BP Goal <140/90

- Patients who are white: 89.7%
- Patients of color*: 85.6%

75.2%
2014 HEDIS national 90th percentile

*Patients of color: includes patients whose self-identified race is either American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino, Some other race, and patients with more than one race documented (Multiple race)
Standardization Improves Care
Optimal Diabetes Care

Measure: % of HPMG patients with diabetes have statin on current medication list (or LDL <70 for patients >40), have had an A1c in the last 12 months with a value <8.0, last recorded blood pressure <140 and <90, documented non-tobacco user and documented regular aspirin user.
Partnerships to Improve Care

• Managing Diabetes Care During Ramadan
  1. Identify when Ramadan begins each year
  2. While reviewing diabetes registry, identify patients who may fast during Ramadan 4-6 weeks before Ramadan begins
  3. Schedule diabetes visits before patients begin to fast
  4. Use problem-oriented charting to document that a patient observes Ramadan and whether s/he chooses to fast

• 3D: Defeating Diabetes Disparities
  • 5 teams focused on improvements for African American and East African patients with Diabetes
  • 30 patients and community advisors helped guide our efforts
Minted Veggie Pita Pockets

**Ingredients (serves 4):**
- 1 can garbanzo beans, rinsed and drained
- 2/3 cup plain yogurt
- ¼ cup red pepper, chopped
- 2 Tbsp fresh mint, finely chopped
- 1 garlic clove, minced
- ½ teaspoon ground cumin
- 1/8 teaspoon cayenne pepper
- 4 standard pita breads
- Torn romaine leaves
- 2/3 cup crumbled feta or goat cheese
- Green scallions

**Directions:**
Mash garbanzo beans in small bowl with fork until somewhat pasty.
Combine yogurt, red pepper, green onion, mint, garlic, cumin, and cayenne with beans.
Cover and chill mixture for at least 2 hours to blend flavors.
Bring to room temperature before serving.
Cut pitas in half vertically to form pockets.
Line the pita halves with torn romaine leaves and sprinkle with feta cheese.
Spoon mixture into pitas & serve.

**Nutrition per serving:** 330 calories; 8 g total fat (4.5 g saturated, 0 g trans); 0 mg cholesterol; 670 mg sodium; 52 g carbohydrates; 8 g fiber; 6 g sugars; 16 g protein.
Care Team Picks

AADE Diabetes Goal Tracker – Diabetes Manager...
American Association of Di...

Glucose Buddy - Diabetes Logbook Manager w/sync...
Azumio Inc.
★★★★☆ (1,821)

CalorieKing Food Search
CalorieKing
★★★★☆ (36)

Calorie Counter & Diet Tracker by MyFitnessPal
MyFitnessPal.com
★★★★☆ (183)
Additional Resources

• Social networking
  – www.tudiabetes.org/
  – www.patientslikeme.com/
  – www.diabetescommunity.com/

• Online resources
  – www.diabetes.org/

• Yumpower
  – www.healthpartners.com/yumpower/my-kitchen
Next Steps

• Hypertension standing order for RN’s
• Supporting behavior change
• Leveraging technology
• Community linkages
Questions?