Together2Goal
AMGA Foundation
National Diabetes Campaign
Monthly Campaign Webinar
October 20, 2016
• **Together 2 Goal® Updates**
  – Webinar Reminders
  – Goal Post October Newsletter Highlights
  – National Day of Action

• **Embed Point-of-Care Tools**
  – Scott Hines, MD, Crystal Run Healthcare

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

• Webinar will be recorded today and available the week of October 24th
  – 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
Institute for Quality Leadership

• **Monday, November 14**
  – Pre-Conference Session (Interactive CORE Program)

• **Tuesday, November 15**
  – Quality Improvement Leadership Council Meeting
  - Improving Care Delivery: Assessing and Addressing CVD Risk
  - Team-Based Approach to Diabetes Care

• **Wednesday, November 16**
  – Peer-to-Peer Breakout Session
  - New Approach to Improving Diabetes Care with In-Person Professional Education Training Model
NATIONAL DAY OF ACTION: NOVEMBER 3

• **Online Pledge**
  – “Pledge” an action for diabetes!
  – Individuals and organizations can choose from sample actions or create your own!
  – Pledge form available at www.Together2Goal.org

• **Twitter Chat**
  – Chat about diabetes with patients, influencers, and others working to advance diabetes management
  – Chat scheduled for Nov. 3 from 2-3 p.m. EDT
  – Hashtag: #T2Gchat
TODAY’S SPEAKER

Scott Hines, MD
Chief Quality Officer
Crystal Run Healthcare
Point of Care Tools for Diabetes Management

Scott Hines, MD
Chief Quality Officer
Crystal Run Healthcare
October 20, 2016
Outline

• Introduction to Crystal Run Healthcare
• Point of Care Tools
  – Checklists
  – Gaps In Care Sheets
  – Point of Care Retinal Cameras
  – Best Practice Guidelines
• Patient Registries
• Outcomes
Outline

• Introduction to Crystal Run Healthcare

• Point of Care Tools
  – Checklists
  – Gaps In Care Sheets
  – Point of Care Retinal Cameras
  – Best Practice Guidelines

• Patient Registries

• Outcomes
Crystal Run Healthcare

- Physician owned MSG in NY State, founded 1996
- 350+ providers, >30 locations, 47 specialties
- Joint Venture ASC, Urgent Care, Diagnostic Imaging, Sleep Center, High Complexity Lab, Pathology
- Early adopter EHR (NextGen®) since 1999
- Care Managers since 2004
- Accredited by Joint Commission since 2006
- Level 3 NCQA PCMH Recognition 2009, 2012
Crystal Run Healthcare ACO

- Single entity ACO
- MSSP participant (since April 2012)
- NCQA ACO Accreditation (December 2012)
- 30,000 commercial lives at risk
- Medicare Shared Savings Program (MSSP)
  - 15,000 attributed beneficiaries
Outline

• Introduction to Crystal Run Healthcare

• Point of Care Tools
  – Checklists
  – Gaps In Care Sheets
  – Point of Care Retinal Cameras
  – Best Practice Guidelines

• Patient Registries

• Outcomes
Point of Care Tools
Measures, Measures Everywhere...

• Glycemic control (A1c >9, A1c <8, A1c <7)
• Screening for nephropathy
• Annual diabetic eye exam
• Blood pressure control
• Presence of a statin
• Immunizations (Pneumonia, flu, HBV)
• Comprehensive foot exam
• Aspirin prescription
• Tobacco cessation
Point of Care Tools

Checklists

• Pre-visit planning (primary care, endocrinology)
• Tracks 8 different performance measures
• Given to patient at end of visit
**Patient Scorecard: Diabetes**

At Crystal Run, we want you healthy! We are committed to working with you to manage your diabetes. We want you to enjoy the best possible quality of life for yourself. This scorecard shows what is important to take a look at when managing your diabetes. Meeting these goals will help you to reduce the problems related to your diabetes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Your Score/Date</th>
<th>Your Score/Date</th>
<th>Your Score/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average blood sugar test (A1c)</td>
<td>Less than 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Lower than 130 and lower than 90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>LDL less than 100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet and Exercise</td>
<td>30 minutes 5 times a week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Once a year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Exam</td>
<td>Once a year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Pneumonia vaccine only one time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine once each year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening for Kidney Disease</td>
<td>Once a year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

845-703-6999  CrystalRunHealthcare.com
Point of Care Tools
Gaps in Care Sheets

• Replaced checklists in primary care, soon endocrinology
• Nightly automated process
• Identifies applicable clinical care measures based on demographics, chronic conditions
• Includes last performed, next due
• Includes HCC opportunities
## Gaps in Care

<table>
<thead>
<tr>
<th>Related Measure</th>
<th>Recommended Action</th>
<th>Last Done</th>
<th>Next Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC)-Eye Exam</td>
<td>Eye Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NY State HIV Screening Law</td>
<td>HIV Screening</td>
<td>5/28/2013</td>
<td>05/27/2016</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC)-Nephropathy</td>
<td>Nephropathy Assessment</td>
<td>6/15/2016</td>
<td>06/15/2017</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC)-HgA1c &gt; 9</td>
<td>Most Recent HgA1c</td>
<td>9/10/2016</td>
<td>09/10/2017</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on ACE or ARB (MPM)</td>
<td>Medication Monitoring - ACE/ARB</td>
<td>9/21/2016</td>
<td>09/21/2017</td>
</tr>
<tr>
<td>Influenza Immunizations Current Season (Payer)</td>
<td>Most Recent Flu Vaccine</td>
<td>9/21/2016</td>
<td>Completed</td>
</tr>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td>Most Recent Screening</td>
<td>12/31/2014</td>
<td>12/30/2017</td>
</tr>
<tr>
<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
<td>Most Recent Counseling</td>
<td>9/27/2016</td>
<td>09/27/2018</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>Colon Cancer Screen - Colonoscopy</td>
<td>9/14/2015</td>
<td>09/11/2025</td>
</tr>
</tbody>
</table>
## Point of Care Tools
### Gaps in Care Sheets

**HCC/HHS Opportunities**

<table>
<thead>
<tr>
<th>HCC-HHS</th>
<th>icd10</th>
<th>ICD-10 Description</th>
<th>Last Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>E11.65</td>
<td>Type 2 diabetes mellitus with hyperglycemia</td>
<td>Completed 2016</td>
</tr>
<tr>
<td>20</td>
<td>E11.69</td>
<td>Type 2 diabetes mellitus with other specified complication</td>
<td>Completed 2016</td>
</tr>
<tr>
<td>21</td>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
<td>Completed 2016</td>
</tr>
<tr>
<td>21</td>
<td>E13.9</td>
<td>Other specified diabetes mellitus without complications</td>
<td>Completed 2016</td>
</tr>
</tbody>
</table>
Point of Care Tools
Point of Care Retinal Cameras

• **Barriers**
  – Need for dilation
  – Need for another appointment
  – Difficulty obtaining outside records

• **Solutions**
  – Point of care retinal cameras
  – Tracker forms
Point of Care Tools
Point of Care Retinal Cameras
Point of Care Tools
Point of Care Retinal Cameras

Referring Physician: Scott T. Hines, MD
Referring Clinic: Crystal Run Healthcare

Retinal Image Assessment and Management Plan

Fundus Photograph of Left Eye (OS):
Diagnosis for Left Eye (OS):
No diabetic retinopathy

Fundus Photograph of Right Eye (OD):
Diagnosis for Right Eye (OD):
No diabetic retinopathy

ICD-10 Diagnosis Codes:
E11.9 Type 2 diabetes mellitus without complications

Recommendation and Management Plan:
Follow up photographs in 12 months.
Point of Care Tools
Tracker Forms

The above-named patient is under the care of Crystal Run Healthcare. I hereby authorize the below provider to disclose my protected health information (information pertaining to my medical record) as indicated below:

(Fill in name and complete address of medical provider from whom information is being requested)

Physician and/or Provider: __________________________
Street Address: ____________________________________
City, State, Zip: ___________________________________
Phone and/or Fax: Phone ( ) - Fax ( ) -

THIS INFORMATION IS TO BE DISCLOSED TO: Attention Doctor: Scott Hine MD
Crystal Run Healthcare
HIM Department - QI
155 Crystal Run Road
Middletown, NY 10941
FAX: 845-703-6271

PLEASE RELEASE THE FOLLOWING INFORMATION:
□ Mammogram Report  □ Colonoscopy Report including Pathology Report
□ Diabetic Eye Exam  □ Pneumonia/Influenza Vaccine  □ Pap Smear
□ Lipid Profile  □ Hgbal c  □ Urine Microalbumin  □ Immunizations

Include (Indicate by initialing): ______ Alcohol/Drug Treatment ______ HIV Related Info and test results ______ Mental Health Information

TO BE READ AND SIGNED BY PATIENT: [Signature]
Point of Care Tools
Point of Care Retinal Cameras
Point of Care Tools
Best Practice Guidelines

• **Variation Reduction**
  - A cost control measure which seeks to **standardize care** according to clinical guidelines and **eliminate waste** amongst those not adhering to national or local practice standards.
Point of Care Tools
Best Practice Guidelines

• Variation Reduction – Process
  – Step 1: Analyze Utilization
  – Step 2: Compare utilization between physicians
  – Step 3: Analyze the variation
Point of Care Tools
Best Practice Guidelines

• Step 1: Analyze Utilization
  • Determine total cost per diabetic per physician
  • Cost includes professional, lab, imaging and procedure charges
Point of Care Tools
Best Practice Guidelines

• Step 1: Analyze Utilization

• Step 2: Compare utilization between physicians
Point of Care Tools
Best Practice Guidelines
Point of Care Tools
Best Practice Guidelines

• Step 1: Analyze Utilization

• Step 2: Compare utilization between physicians

• Step 3: Analyze the variation
  • What is the source of variation?
Point of Care Tools
Best Practice Guidelines

• What is the source of variation?
  • “My patients are sicker”
  • “My quality is better”
• Are best practice guidelines being followed?
Point of Care Tools
Best Practice Guidelines

• ADA guidelines for diabetes
• Lessons learned
  • Frequency of lab tests
  • Frequency of office visits
  • Accuracy of coding
  • Use of consultants
  • Brief discussion on medications
Point of Care Tools
Best Practice Guidelines

• Fast forward 6 months
• Compare Q3-Q4 2010 vs. Q3-Q4 2011
  • Provider charges per patient reduced by 7%
  • Lab charges per patient reduced by 15%
  • Radiology charges per patient reduced by 53%
  • Total charges per patient reduced by 9%
Point of Care Tools
Best Practice Guidelines

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Charges/patient</td>
<td>$670</td>
<td>$596</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>$228</td>
<td>$155</td>
</tr>
<tr>
<td>Coefficient of Variation</td>
<td>0.34</td>
<td>0.26</td>
</tr>
</tbody>
</table>

Graph showing comparison of charges per provider between 2010 and 2012.
Point of Care Tools
Best Practice Guidelines
Point of Care Tools
Best Practice Guidelines

Strategic Plan

The current strategic plan of Crystal Run Healthcare has been developed to optimally meet the challenges of the current healthcare system and advance our mission. All employees will understand the pillars of this plan and their role in helping the practice achieve its goals.

The pillars are as follows:

• Superior Quality of Care and Access to Care
• Financial Stability
• Leadership in Health Care Reform
• Leadership Development

Dashboards

» Provider’s Dashboard

» Meeting Attendance Record

» Leadership Development Measures - Physician Matrix

» Provider Quality Scorecard

» Committee Structure - 2014

Disclaimer: These questions and answers (FAQs) are intended to provide general guidance only. All medical care at Crystal Run Healthcare LLP is appropriately tailored to each individual patient, including without limitation, such patient’s history and medical condition.
Clinical Practice Guidelines

- Asthma
- Asthma, Pediatric
- Breast Cancer Treatment
- Cancer Screening
- Epicondylitis, Lateral
- Diabetes
- Gestational Diabetes
- Pre-Diabetes
- Hepatitis C Screening
# Point of Care Tools

## Best Practice Guidelines

### History and Exam

### Laboratory and Diagnostic Testing

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>HGB A1c</td>
<td>CONTROLLED (A1c &lt;7; no med change) – EVERY 6 MONTHS</td>
<td>ADA 2011 GUIDELINES (S19, S42)</td>
</tr>
<tr>
<td></td>
<td>UNCONTROLLED (A1c &gt;7; med changes) – EVERY 3 MONTHS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GOALS</td>
<td></td>
</tr>
<tr>
<td>Lipids</td>
<td>Testing [link]</td>
<td>ADA 2011 Guidelines (S29)</td>
</tr>
<tr>
<td></td>
<td>Treatment [link]</td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td>DM1 - Yearly (Start 5Y after Diagnosis)</td>
<td>ADA 2011 Guidelines (S33)</td>
</tr>
<tr>
<td>Microalbumin</td>
<td>DM2 - Yearly (Start at Diagnosis)</td>
<td></td>
</tr>
</tbody>
</table>

*Disclaimer: This Best Practice Guideline is presented as a model only by way of illustration and all medical care at Crystal Run Healthcare*
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Patient Registries
Care Optimization Team

• Four non-clinical staff led by nurse
• Utilize internal and payer derived registries
• Phone calls and letters to patients with gaps in care (diabetes measures, immunizations, well child visits)
• Direct phone line
<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>First Name</th>
<th>ID #</th>
<th>DOB</th>
<th>Date last</th>
<th>COT Notes</th>
<th>Date 1st call</th>
<th>Date 2nd call</th>
<th>Date letter</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td></td>
<td></td>
<td></td>
<td>3/31/2016</td>
<td>COT Scheduled 9/06</td>
<td>8/15/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no labs</td>
<td></td>
<td></td>
<td></td>
<td>8/1/2015</td>
<td></td>
<td>7/29/2016</td>
<td></td>
<td>8/15/2016</td>
</tr>
</tbody>
</table>
## Patient Registries
### Care Optimization Team

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>72.6% (Below threshold)</td>
<td>82.9% (maximum)</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>37.3% (Below threshold)</td>
<td>64.95% (maximum)</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>65.4% (Below threshold)</td>
<td>82.23% (maximum)</td>
</tr>
<tr>
<td>Diabetic Control (A1c &lt;7)</td>
<td>Unknown</td>
<td>51.00% (maximum)</td>
</tr>
<tr>
<td>Diabetic Nephropathy</td>
<td>75.5% (Below threshold)</td>
<td>95.42% (maximum)</td>
</tr>
</tbody>
</table>
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Outcomes

Hgb A1c < 7
Outcomes
Hgb A1c >9
Outcomes
Nephropathy Screen
Outcomes

BP Control

PCMH Performance Metrics

Percentage

0.00% 20.00% 40.00% 60.00% 80.00% 100.00%

Outcomes
Diabetic Eye Exam

PCMH Performance Metrics

Percentage

Time

0.00% 1/31/16 2/29/16 4/30/16 5/31/16 6/30/16 7/31/16 8/31/16 9/30/16

40.00% 60.00%
Conclusions

• Point of care tools to improve diabetes care are a necessity given the number of diabetes related clinical quality measures
• Build point of care tools with input from practicing providers
• Proper utilization of point of care tools can improve quality performance