Together2Goal
AMGA Foundation
National Diabetes Campaign
Monthly Campaign Webinar
December 15, 2016
TODAY’S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - Goal Post Dec. Newsletter Highlights
  - AMGA Opportunities
    - 2017 AMGA Annual Conference
    - MIPS Learning Collaborative

- Contact Patients Not at Goal & With Therapy Change within 30 Days
  - John Kennedy, MD, Endocrinology Department Director, Geisinger Health System

- Q&A
  - Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of December 19th
  – 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
Campaign Spotlight

• Bonus Webinar
  – January 11, 12-1pm Eastern
  – ADA Standards of Care Updates
  – Featuring William Herman, M.D., M.P.H., co-chair of ADA's Professional Practice Committee
Resource of the Month

- **Johnson & Johnson CORE Program**
  - Complimentary, on-site, interactive CORE Program training
  - Applications due by January 31
  - Questions or need application? Email together2goal@amga.org
2017 AMGA ANNUAL CONFERENCE

- Agenda includes
  - Leadership Council meetings
  - Pre-conference immersion sessions
  - General session speakers
  - Peer-to-peer breakout sessions
  - Networking opportunities
  - And more!

- Together 2 Goal® Breakout Sessions
  - Improving Care Delivery: Assessing and Addressing the Risk of Cardiovascular Disease for Patients with Diabetes (Premier Medical Associates)
  - Partnering for Improved Health: Excela Health’s Implementation Journey (Excela Health Medical Group)
Timeline: February 2017 – July 2018
  - Includes orientation webinar (February 2017), in-person meeting (March 2017), monthly program webinars (April 2017-June 2018), in-person meeting (July 2017), and in-person meeting (July 2018)

Tuition: $19,000 per organization (AMGA member rate)
  - Covers all program materials for up to three in-person meetings for two attendees (travel expenses not included), program webinars, and dedicated website and listserv for participant

More information and application available at:
http://www.amga.org/MIPS
John Kennedy, MD
Endocrinology Department Director
Geisinger Health System
CONTACT PATIENTS NOT AT GOAL & WITH THERAPY CHANGE WITHIN 30 DAYS

Together 2 Goal Webinar  December 15, 2016

John W. Kennedy MD
Endocrinology Department Director
Geisinger Health System
Together 2 Goal

TOGETHER 2 GOAL® PREMIERE EVENT

"When I heard about Together 2 Goal®, it resonated with me. It's a major task but it's doable - and it's going to happen."

-Sugar Ray Leonard

Improve the lives of 1 million Adults in the United States with Type 2 Diabetes within 3 years
Contact Patient with Results & Change Rx within 30 days

5 Audience Response Questions
- Specialty Access
- Diabetes Education
- Registries & Reports
- Patient Activation
- Together 2 Goal

Geisinger Experience

Open Forum & Questions
The average wait time for a Diabetes patient to receive a face to face visit with an Endocrinology Specialty Provider (MD, DO, NP or PA) in my area is

A. Same Day or Next Day  
B. 1 week or less  
C. 1 month or less  
D. 1 to 3 months  
E. More than 3 months. It’s really a long wait.
Geisinger Specialty Access: initiate contact → Rx change

**PROBLEM:**
- Primary Care Providers (PCP’s) may lack knowledge or resources or experience or time to escalate care in diabetes patients not at goal
- PCP’s & patients prefer a referral to a Board Certified Sub Specialty Provider
- Endocrinology Access is severely restricted in many Geographies in US

**SOLUTIONS**
- Shared NP/PA with Physician Initial Visit
- ASK a DOC Electronic Curbside Consult
  - Option at time of referral. Response Time Specified by PCP
  - Arrives as a Telephone encounter & page to Specialist
  - Documented in EHR with recommendations

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GMC Endocrinology Wait List -- News

![GMC Endocrinology Wait List Chart](chart.png)
## Ask A Doc - Electronic Curbside Consult — Eric Newman MD

<table>
<thead>
<tr>
<th>Responding Specialty</th>
<th>Count</th>
<th>% Of Total</th>
<th># Done Correctly</th>
<th>% Done Correctly</th>
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<td>307</td>
<td>14%</td>
<td>261</td>
<td>85%</td>
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<tr>
<td>Endocrinology</td>
<td>532</td>
<td>24%</td>
<td>498</td>
<td>94%</td>
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<tr>
<td>Hematology</td>
<td>104</td>
<td>5%</td>
<td>82</td>
<td>79%</td>
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<td>Infectious Disease</td>
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<td>Nephrology</td>
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<tr>
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<tr>
<td>Rheumatology</td>
<td>204</td>
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<td>200</td>
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<tr>
<td>Thoracic Surgery</td>
<td>44</td>
<td>2%</td>
<td>42</td>
<td>95%</td>
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<td><strong>Total</strong></td>
<td><strong>2,253</strong></td>
<td><strong>2,051</strong></td>
<td></td>
<td><strong>91%</strong></td>
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</table>
Question #2: Diabetes Educators

My medical group practice or health care organization currently employs the following diabetes educators for face to face patient encounters (individual or group):

A. **Outpatient** Diabetes Nurse or Dietitian Certified Diabetes Educators (CDE)
B. Hospital based **Inpatient** Nurse or Dietitian CDE
C. Pharmacist Diabetes Educators or Med Therapy Manage (MTM)
D. Any 2 of the above
E. All of the Above
F. None of the above. I have plenty of Endocrinologists to care for all our diabetes patients.

Geisinger
Improving Contact Time and Time to Rx utilizing Diabetes Educators in Collaborative practice agreements with Specialty & Primary Care Providers.

Starting with a single ADA Diabetes Self Management Training site

ADA / NCQA Accredited Program—Mary Johnson, RD CDE BCADM

Individual Diabetes Self Management Training of every Diabetes patient

- Diet
- Monitoring
- Counseling, Support
- Oral Medication, Insulin & GLP-1
- Sick Day Rules
- Eye Screening, Foot Screening
GHS ADA Program size 2016  Slide provided by Stacy Coolbaugh

- 27 Educators billing for DSMT
- 58 locations
  - 27 under Endocrinology Danville
  - 18 under Northeast Endocrinology
  - 13 under Pediatric Endocrinology,
- Program growth:
  - 8 Educators in training
  - Scranton
  - Wilkes Barre
  - State College
  - Lewistown
  - Harrisburg
Outpatient Diabetes Education: ADA Diabetes Self Management Training

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<td>Nutrition</td>
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<td>335</td>
<td>264</td>
<td>854</td>
<td>827</td>
<td>316</td>
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<td>Total</td>
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<td>2,574</td>
<td>3,314</td>
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ADA DSMT Program Stats by Unique MRN
Inpatient Diabetes Education -- Diabetes Survival Skills

Monthly Adult Diabetes Education
InPatient Consult

Geisinger
Pharmacist Diabetes Educator: Medication Therapeutic Management

MTM Pharmacist embedded in Primary Care Practices
- Polypharmacy
- Coag Clinic
- Hypertension
- Lipid management

MTM Pharmacist Diabetes Care Impact—early access, rapid results.
- CDE
- BC ADM
- Pump Certified
Question #3: Registries & Reports

My medical practice or health care organization currently utilizes the following PROVIDER TOOLS to identify & close Diabetes Care Gaps:

A. Medication Reconciliation at patient visits
B. Diabetes Carepath or Bundle Checklists (paper or electronic)
C. Diabetes patient registries and reports (T2G excluded—sorry 😊)
D. 2 of the above
E. ALL of the ABOVE
F. NONE of the ABOVE. We have no Diabetes Care Gaps.
## Endocrinology Specialty Diabetes Bundle
### Registries & Reports: Target Measure to Contact & Change

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<tr>
<th>PROV / DEPT</th>
<th># DIABETES PTS</th>
<th>% W/ PNEUMONIA VACC</th>
<th>% W/A1C ORDER PST 6 MOS</th>
<th>% W/A1C at Goal</th>
<th>% W/ LDL ORDER</th>
<th>% W/ LDL &lt; 100 or &lt; 70 IF CAD DX ALSO</th>
<th>% W/ MICROALB RESULT PST YR</th>
<th>DOCUMENTED NON-SMOKER</th>
<th>% BP at goal</th>
<th>% COMPLIANT w/ ALL CPSL MEASURES</th>
<th>% W/ RETINAL EXAM</th>
<th>% W/ DIABETIC FOOT EXAM</th>
<th>% W/ INFLUENZA VACC</th>
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<td>82%</td>
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<td>89%</td>
<td>61%</td>
<td>75%</td>
<td>88%</td>
<td>81%</td>
<td>15%</td>
<td>52%</td>
<td>75%</td>
<td>63%</td>
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<tr>
<td>09/1/2014 - 8/31/2015</td>
<td>2,855</td>
<td>71%</td>
<td>84%</td>
<td>42%</td>
<td>90%</td>
<td>62%</td>
<td>75%</td>
<td>87%</td>
<td>82%</td>
<td>15%</td>
<td>52%</td>
<td>78%</td>
<td>64%</td>
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<tr>
<td>10/1/2014 - 9/30/2015</td>
<td>2,848</td>
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<td>43%</td>
<td>89%</td>
<td>63%</td>
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<td>81%</td>
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<td>82%</td>
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<td>88%</td>
<td>80%</td>
<td>16%</td>
<td>51%</td>
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<td>12/01/2014 - 11/30/2015</td>
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<td>88%</td>
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<td>16%</td>
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<td>73%</td>
<td>86%</td>
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<td>49%</td>
<td>77%</td>
<td>58%</td>
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<td>73%</td>
<td>88%</td>
<td>78%</td>
<td>14%</td>
<td>50%</td>
<td>76%</td>
<td>60%</td>
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<td>61%</td>
<td>72%</td>
<td>87%</td>
<td>78%</td>
<td>14%</td>
<td>49%</td>
<td>74%</td>
<td>60%</td>
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<tr>
<td>06/01/2015 - 5/31/2016</td>
<td>2,855</td>
<td>70%</td>
<td>83%</td>
<td>42%</td>
<td>87%</td>
<td>62%</td>
<td>72%</td>
<td>88%</td>
<td>77%</td>
<td>13%</td>
<td>48%</td>
<td>74%</td>
<td>60%</td>
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<tr>
<td>07/01/2015 - 6/30/2016</td>
<td>2,929</td>
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<td>84%</td>
<td>43%</td>
<td>87%</td>
<td>62%</td>
<td>72%</td>
<td>88%</td>
<td>77%</td>
<td>15%</td>
<td>50%</td>
<td>72%</td>
<td>61%</td>
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</tbody>
</table>
CONCLUSIONS AND RELEVANCE  Telemedicine increased the percentage of diabetic retinopathy screening examinations, most participants did not require referral to an eye care professional, and diabetic retinopathy levels were generally stable during the study period. This finding suggests that primary care clinics can use telemedicine to screen for diabetic retinopathy and monitor for disease worsening over a long period.
Digital Retinal Imaging
Non-Mydriatic Process v1

Best Practice Alert Fires

Nurse acknowledges BPA and places order

Ordering Provider co-signs order

Tech takes image

Tech attaches image

Tech creates staff message

Tech enters Smart Phrase

Tech enters documentation

Tech sends staff message

Ophthalm phys reviews staff message

Ophthalm phys reviews image

Ophthalm phys creates results encounter

Ophthalm phys documents results in encounter

Ophthalm phys signs note

Ophthalm phys sends communication to ordering provider

Ordering provider reviews results

Follow-up with patient

Who follows up? Need to design measure

Abnormal = Eye Clinic Referral

Normal = Letter to patient

Uninterpretable

= Measurement

July 22, 2016

Contact @ PCP or Endocrine Office Visit → Telemed Ophtho
Non Mydriatic Telemedicine Retina Screening Program: 20% Abnormal
*Rapid Return of Results without delay of scheduling Ophtho Appointment*
Question #4: Patient Activation

My Medical Group Practice or Healthcare organization currently utilizes the following PATIENT ENGAGEMENT techniques to close Diabetes Care Gaps:

A. Home visit, Mail and/or Telephone
B. Email, Web based or Patient Portal
C. Mobile, Text or Social Media
D. 2 of the above
E. All of the above
F. None of the above. What’s all the hub bub about Social Media anyway?
T2G: Contact Patient → Change Rx

A case study of rapid cycle quality improvement
## Together 2 Goal Reporting Tracks

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<th></th>
<th>Basic</th>
<th>Core (Bundle)</th>
<th>Innovator</th>
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<td><strong>HbA₁c control &lt; 8 percent</strong></td>
<td>Optional</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td><strong>BP control &lt; 140/90 mmHg</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Lipid management</strong></td>
<td></td>
<td>✓ Statin prescribed</td>
<td>✓ Statin adherence</td>
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<tr>
<td><strong>Medical attention for nephropathy</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
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<tr>
<td><strong>Non-smoking status</strong></td>
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<tr>
<td><strong>Body mass index</strong></td>
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<td></td>
<td>?</td>
</tr>
<tr>
<td><strong>Foot exam performed</strong></td>
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<td></td>
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<tr>
<td><strong>Eye exam performed</strong></td>
<td></td>
<td></td>
<td>?</td>
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<tr>
<td><strong>Other (e.g., patient engagement, functional outcomes, quality of life, overuse measurement)</strong></td>
<td></td>
<td></td>
<td>✓</td>
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</table>
Together 2 Goal Summary

• Q1 2016 Measurement Period

• April 2015-March 2016

• **N = 33,000 patients at Geisinger Health System**

• Adult Type 2 DM active in Primary Care, Cards, Nephro or Endocrinology

• Geisinger System Code DQ2-- Core Track
## Geisinger Baseline T2G Core Track Data vs National Average

### Core Track

<table>
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<tr>
<th></th>
<th>Geisinger Code DQ2</th>
<th>Average T2G Groups</th>
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<tbody>
<tr>
<td>Prevalence of Type 2 DM</td>
<td>16.9%</td>
<td>14%</td>
</tr>
<tr>
<td>HbA1c Control</td>
<td>63.7%</td>
<td>66.1%</td>
</tr>
<tr>
<td>BP Control</td>
<td>76.8%</td>
<td>67.2%</td>
</tr>
<tr>
<td>* Med Attention Nephropathy</td>
<td>80.9%</td>
<td>84%</td>
</tr>
<tr>
<td>Lipid Management</td>
<td>80.8%</td>
<td>65.7%</td>
</tr>
<tr>
<td>Diabetes Care Bundle</td>
<td>34.9%</td>
<td>30.2%</td>
</tr>
</tbody>
</table>
T2G Lipid Management March 2016

* 80.8 (mean 65.7%)
T2G Medical Attention to Nephropathy March 2016

*80.9% (mean 84%)
T2G--MEDICAL ATTENTION FOR NEPHROPATHY

• Number of denominator patients who had evidence of medical attention for nephropathy during the 12-month measurement period
  
• Evidence for medical attention for nephropathy includes
  – nephropathy screening or monitoring tests (e.g., urine protein tests)
  – diagnosis of nephropathy or treatment for nephropathy

• diagnosis on a claim or problem list for nephropathy or a related condition (e.g., chronic kidney disease, end stage renal disease)

• visit with a nephrologist
  – use of an angiotensin-converting-enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB)

• e-Prescribing transaction or active on the patient’s medication list in the EHR

Source: T2G Data Orientation Webinar February 16, 2016 Nikita Stempniewicz, John Cuddeback, Rich Stempniewicz, and Cori Rattelman
Urine Microalbumin  EHR Best Practice Alert 2016
Matthew Hackenberg, Institute for Advanced Applications

Missed Opportunity (Gap Remains Open) 24,184
- No Alert, Gap Not Addressed 6,623
- Alert Fired, Not Seen 106
- Not Drawn 5,111
- Unable to Void 512
- Defer (Cost) 30
- Done Elsewhere 174
- Patient Declined 3,702
- Future Lab Apt 818
- Alert Seen, Not Acknowledged 5,248

Total Opportunity 36,456
- Alert Did Not Fire 8,454

Opportunity Addressed Gap Closed 12,272
- Gap Closed Despite no alert 1,871
- Gap Closed Despite alert not seen by provider 102
- Completed 9,395
- Acknowledgement but still closed 904

Alert Seen?
- Yes
- No

Alert Acknowledged?
- Yes
- No
T2G Medical Attention to Nephropathy:  
*Patient Activation as a component of Continuous Quality Improvement*

**Accountable Care Team**—Diabetes Care Improvement Project (DCIP)  
- Endocrinology, Primary Care, Population Health, Pharmacy, EHR IT, Health Plan, Nutrition

**Registry & Reports**—Identified 21,000 patients with over 30,000 total Care Gaps  
- HgbA1c%, Urine Microalbumin, Diabetes Retinal Eye Exam

*Patient Activation*  
- MyG **patient portal email** & **letters**—21,000 patients contacted over 4 weeks (50% mail, 50% portal)  
- **Text Message** Lab & Office visit Appointment reminders  
- **Open Notes**—patients receive all progress notes from all Geisinger Physicians on the portal

**Physician & Staff Education**  
- Best Practice Alert Acknowledgement & Correct Lab order Workflow Re-Education  
- Protein/Cr Ratio in CKD 3 or CKD 4 patients
Geisinger Medical Attention to Nephropathy Q2 2016

94% (Mean 84%)
## TOGETHER TO GOAL 2016 Q2 DATA → Room to improve…

**Measurement Period:** Year 1 2016 Q2 (Jul 1, 2015 - Jun 30, 2016)

**Generated on:** 8/10/2016 at 10:55:20AM

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<tr>
<th>Active Patient MRN</th>
<th>T2G Cohort YN</th>
<th>Cohort - HBA1C Control YN</th>
<th>Cohort - BP Control YN</th>
<th>Cohort - Med Attention Nephropathy YN</th>
<th>Cohort - Lipid Cohort - Bundle Management YN</th>
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</thead>
<tbody>
<tr>
<td>202,163</td>
<td>34,116</td>
<td>21,550</td>
<td>26,509</td>
<td>31,962</td>
<td>27,476</td>
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<tr>
<td>17%</td>
<td>63%</td>
<td>78%</td>
<td>94%</td>
<td>81%</td>
<td>40%</td>
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</tbody>
</table>
My medical group practice or health care organization is making positive change to improve care for our patients with diabetes since joining the AMGA Foundation Together 2 Goal Campaign

A. Yes! 😊

B. I’m making a New Year’s Resolution to improve in 2017

C. We’re already at 100% on our 4 out of 4 T2G Core Track Bundle

* Please let Jerry know you’ll be leading the next Webinar
Together 2 Goal

Improve the lives of 1 million Adults in the United States with Type 2 Diabetes within 3 years...
Together 2 Goal

Improve the lives of 1 million Adults in the United States with Type 2 Diabetes within 3 years...
Acknowledgements: Diabetes Care Improvement Project

Deb Templeton: Population Health, Committee Co-Chair
Mike Evans Pharm D: Pharmacy & Care Support Services
Matt Hackenberg: Institute for Advanced Applications
Renee Winter Bertsch RD: Nutrition Director
Jordon Olsen MD : Lab Medicine
Stacey Coolbaugh RD : ADA Diabetes Education Program Director
Diane Francis : T2G Data
Kris Mc Gann: T2G & Endocrinology Operations
Jessica Sheriff: T2G Marketing
George Godlewski: T2G Quality