Together2Goal®
AMGA Foundation
National Diabetes Campaign
Monthly Campaign Webinar
July 20, 2017
• **Together 2 Goal® Updates**
  – Webinar Reminders
  – August 2017 Monthly Webinar
  – Goal Post July Newsletter Highlights

• **Innovative Technology in Diabetes Care**
  – Dr. Philip Oravetz of Ochsner Health System

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

• Webinar will be recorded today and available the week of July 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
• **Date/Time:** Thursday, August 17, 2-3pm Eastern

• **Topic:** The Role of Community Pharmacists in Diabetes Care

• **Presenter:** Jennifer Humeniuk, Pharm.D., of Ralphs Grocery Company
Welcome to our July issue of our monthly newsletter highlighting Together 2 Goal® and the latest campaign news and updates.

Don’t miss the Together 2 Goal® Diabetes Symposium in Indianapolis! We designed the this special campaign meeting just for you and it’s an all day event on September 11 with a networking reception the evening before (September 10).

In collaboration with the American Diabetes Association, AMGA is holding the Together 2 Goal® Diabetes Symposium, featuring recent innovations and best practices to improve care and outcomes. The event will feature presentations from leading experts in diabetes care and management, as well as interactive workshops and networking opportunities with fellow diabetes advocates from across the nation.

Our symposium speakers include:

- Dr. David Reaven, MD, DVM, Tufts Medical Center, Boston, MA
- Dr. Robert Yarnell, MD, MPH, American Diabetes Association, Washington, DC
- Dr. Mary R. Trafton, MD, Mayo Clinic, Rochester, MN
- Dr. Mark B. Friedman, MD, Montefiore Medical Center, Bronx, NY
- Dr. William F. Cefalu, MD, University of Florida College of Medicine, Gainesville, FL
- Dr. David S. Ludwig, MD, PhD, Massachusetts General Hospital, Boston, MA

For more information about the symposium and registration details, visit our website. To receive the early bird rate, register by July 20.

Check out Together 2 Goal®. Please reach out to your Regional Liaison or email info@together2goal.org.

Upcoming Dates

- July 30: Identity campaign launch (US, Canada, Europe, Latin America)
- August 8: Background campaign launch (US, Canada, Europe, Latin America)
- September 10-11: Together 2 Goal® Diabetes Symposium, Indianapolis, IN

Campaign Spotlight: 

The initial program launch in September 2017 yielded positive outcomes, including a 3% increase in the number of people registering for the program. In the United States, Together 2 Goal® has partnered with philanthropic organizations to promote healthy living and disease management.

Resource of the Month:

The American Diabetes Association is collaborating with Together 2 Goal® to provide resources and workshops for healthcare providers and patients. The program offers Together 2 Goal® to eligible patients, providing them with personalized support and resources.

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Upcoming Dates

- **July 28:** Together 2 Goal® Diabetes Symposium early bird deadline

- **August 17:** Monthly Campaign webinar on The Role of the Community Pharmacists in Diabetes Care

- **September 12-13:** Together 2 Goal® Diabetes Symposium in Indianapolis, IN
GOAL POST NEWSLETTER:
JULY CAMPAIGN SPOTLIGHT

July 2017 Edition

Welcome to GOAL POST, our monthly newsletter highlighting “Together 2 Goal®” and the latest campaign news and updates.

As we continue to promote our campaign, we want to share the latest news and updates with you. In this issue, we will be focusing on the importance of diabetes management and prevention.

In cooperation with the American Diabetes Association, AMGA is hosting the “Together 2 Goal®” symposium on diabetes management and prevention. The symposium will take place on September 15th and will provide attendees with valuable information and resources on how to manage diabetes effectively.

Our symposium will feature expert speakers from various fields, including healthcare providers, researchers, and patient advocates. The focus of the symposium will be on diabetes prevention and management, and we are excited to share this information with you.

For more information about the symposium, please visit our website. We look forward to seeing you there.

Campaign Spotlight

The Baton Rouge Clinic, AMC

Keeping an Eye on the Prize with GLR Alerts

Challenge

As a part of the Diabetes: Together 2 Goal campaign, the Baton Rouge Clinic is making a difference in the lives of patients with type 2 diabetes. The clinic offers various programs and resources to help patients manage their diabetes effectively.

Team Stats

- The Baton Rouge Clinic is one of the largest diabetes clinics in the United States.
- The clinic offers a variety of programs, including diabetes education, nutrition counseling, and medication management.
- The clinic has a team of dedicated healthcare professionals, including physicians, nurses, and dietitians.
- The clinic has helped hundreds of patients achieve better diabetes control.

Goal Getter!

- Keeping an eye on the prize with GLR Alerts
- The Baton Rouge Clinic is committed to providing the best possible care for their patients.
- The clinic offers regular check-ups and personalized treatment plans for each patient.
- The clinic is dedicated to helping patients achieve their diabetes control goals.

Upcoming Dates

- July 30: Strategies for Managing Type 2 Diabetes (Register: 3050)
- July 31: “Together 2 Goal” Diabetes Symposium (Register: 3051)
- August 1: “Together 2 Goal” Diabetes Symposium (Register: 3052)

Follow us on Facebook and Twitter for more updates and resources related to diabetes management and prevention.

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GOAL POST NEWSLETTER:
JULY RESOURCE OF THE MONTH

Resource of the Month

Welcome to GOAL POST, our monthly newsletter highlighting Together 2 Goal® and the latest campaign news and updates.

Each month, the Together 2 Goal® Diabetes Symposium in Indianapolis, the premier event focusing on the management and treatment of diabetes, takes place. This year's symposium will feature sessions on the latest research and innovative strategies for improving outcomes in diabetes care.

In collaboration with the American Diabetes Association, AMGA is featuring the Together 2 Goal® Resource of the Month, a collection of practical information and resources for primary care practitioners to help their patients manage their diabetes.

Our Resource of the Month includes:
- "Clinical Diabetes: A Practical Guide to Care" by the American Diabetes Association
- "Managing Diabetes: A Guide for Healthcare Providers" by the American Diabetes Association
- "Diabetes: A Key to Improved Health" by the American Diabetes Association
- "Diabetes and Your Heart: A Guide for Healthcare Providers" by the American Diabetes Association
- "Diabetes and Your Feet: A Guide for Healthcare Providers" by the American Diabetes Association

For more information and to access the resources, visit our website. To receive the email and newsletter, subscribe by July 20.

Questions about Together 2 Goal®? Please reach out to your Regional Director or email Together2Goal@amga.org.

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Philip Oravetz, M.D., M.P.H., M.B.A.

Ochsner Health System
Innovative Technologies in Diabetes Care

Philip M Oravetz, MD, MPH, MBA
Medical Director, Accountable Care

Susan Montz, BSN, MBA
Director, ACO Performance Improvement

July 20, 2017
Ochsner Health System
New Orleans, LA
Who We Are:

• Louisiana’s largest non-profit, academic, health care system
• 25 owned, managed and affiliated hospitals, 1200+ group practice physicians in an integrated delivery system
• State-wide Clinical Integration network
• Significant value based portfolio
• First health system in the US to use Apple Watch for Chronic Disease Management
Taking responsibility for the health and well-being of a population as defined by:

**IMPROVED QUALITY**
- Safety
- Disease Management/Clinical Programming
- Medication Management
- Behavioral Health
- Wellness/Prevention

**REDUCED COST**
- Care Transitions/Post-Discharge Intervention
  - *ED, Admission/Readmission Avoidance*
- Complex Care Management
- Standardized Care Pathways
- Referral Management
- Community Partnerships/SNF

**BETTER PATIENT EXPERIENCE**
- Access
- Care Coordination (Ochsner On Call, LPN-CCC)
- Patient Activation/Satisfaction
  - *HCAHPS, CGCAHPS*
- Team-based Care
- Palliative Care

**ENVIRONMENTAL**
- Increasing health care expenditures
- Suboptimal quality
- Cost-shifting to consumers
- Clinical and cost variation
- Increased price & quality transparency
- Explosion of information
- Employer aggregation/force

**HEALTH POLICY**
- Shift to value-based care
- MACRA legislation/APMs
- Bundled payments
- MSSP & commercial shared savings
- Cost-shifting/HDHPs
- Health exchanges
- New reporting requirements

**FACILITATING CAPABILITIES**
- Governance • Leadership Commitment & Priority • Transparency • Advanced Analytics (Clinical + Financial) • Connectivity
- Coding/Documentation Excellence • Panel Management • Aligned Incentives/Comp Model • Resource Optimization
- Training & Development • Culture of Performance Improvement
Population Health Framework
Wellness and Prevention

Leadership

- Population Health Committee
- Primary Care Council
- Other (POV, IT, CCC, etc)

IT Functionality (EPIC)

- Health Maintenance
- Healthy Planet
- Patient Portal
- Kaboodle
- Dashboards
Population Health Framework
Wellness and Prevention

- The Population Health Cycle
- LPN-Clinical Care Coordinators (CCC) Program
- Written Order Guidelines
- Care Touch (call center)
- My Panel Dashboards (registry driven)
- Physician Compensation (Value-based)
# EPIC Healthy Planet Registry List

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Asthma</td>
</tr>
<tr>
<td>2.</td>
<td>ACO</td>
</tr>
<tr>
<td>3.</td>
<td>All Wellness (Adult)</td>
</tr>
<tr>
<td>4.</td>
<td>ALS</td>
</tr>
<tr>
<td>5.</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>6.</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>7.</td>
<td>CKD</td>
</tr>
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<td>8.</td>
<td>Hep C</td>
</tr>
<tr>
<td>9.</td>
<td>COPD</td>
</tr>
<tr>
<td>10.</td>
<td>Colorectal Cancer Screening</td>
</tr>
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<td>11.</td>
<td>CJR</td>
</tr>
<tr>
<td>12.</td>
<td>CHF</td>
</tr>
<tr>
<td>13.</td>
<td>Diabetes</td>
</tr>
<tr>
<td>14.</td>
<td>Headache</td>
</tr>
<tr>
<td>15.</td>
<td>HIV</td>
</tr>
<tr>
<td>16.</td>
<td>HTN</td>
</tr>
<tr>
<td>17.</td>
<td>IBD</td>
</tr>
<tr>
<td>18.</td>
<td>Lung Cancer</td>
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<td>19.</td>
<td>MS</td>
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<td>20.</td>
<td>Obesity</td>
</tr>
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<td>21.</td>
<td>Opioid</td>
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<td>22.</td>
<td>OPCM</td>
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<td>23.</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>24.</td>
<td>Readmissions</td>
</tr>
<tr>
<td>25.</td>
<td>Tobacco</td>
</tr>
<tr>
<td>26.</td>
<td>All Wellness (Peds)</td>
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</table>

Updated: 12/2016
## Population Health Registries

### Bulk Orders and Bulk Outreach

<table>
<thead>
<tr>
<th>Patients</th>
<th>Bulk Orders</th>
<th>Outreach</th>
<th>Outreach Type</th>
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<tr>
<td>DM Registry</td>
<td>71,854</td>
<td>Weekly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Mammo</td>
<td>50,000</td>
<td>Weekly</td>
<td>Monthly</td>
</tr>
<tr>
<td>DM Disease Mgt Program</td>
<td>604</td>
<td>Weekly</td>
<td>Weekly</td>
</tr>
<tr>
<td>CKD</td>
<td>26,623</td>
<td>Weekly</td>
<td>Weekly</td>
</tr>
<tr>
<td>CRS</td>
<td>50,000</td>
<td>Fit/Kit</td>
<td>Monthly</td>
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<tr>
<td>CCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLD</td>
<td>150,000</td>
<td>Twice</td>
<td>Once</td>
</tr>
<tr>
<td>HTN</td>
<td>193,302</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>252,540</td>
<td></td>
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</table>
Evolution of Primary Care at Ochsner
Population Health Cycle

Pre Visit Work

Orders placed using the Primary Care Written Order Guidelines

Predict Visit Work

Visit Work

Close care gaps

Registry work – place bulk orders and patient notifications
Diabetic Registry
Diabetic Registry: Inclusion Criteria

**Ochsner’s Diabetes Registry Inclusion Logic**

**Patient Status**
Patient is Alive

**AND**

**Medications**
Patient has one or more Active Diabetic Medications with a last order date in the current or last calendar year

**Lab Data**
Patient’s Last Lab Value for Hemoglobin A1c >= 7 in the last two years

**Visit Data (Outpatient)**
Patient has at least two encounters with a diagnosis of Diabetes Mellitus in the calendar year or the previous calendar year

**Visit Data (Inpatient)**
Patient has at least one ‘Hospital Encounter’ encounter type with a diagnosis of Diabetes Mellitus in the calendar year or the previous calendar year
Diabetic Registry Metrics

- Hemoglobin A1C testing
- Hemoglobin A1C control <8
- LDL testing
- LDL control < 100
- BP control <140/90
- Nephrology screening
- Retinal Eye Exam
- Foot Exam
- Statin Medication*

* Adding this to registry and Health Maintenance
Diabetes Registry: My Panel Metrics

- This metric calculates the percentage of patients 18 to 75 years of age in the registry who had a hemoglobin A1c (HbA1c) testing done within the last 12 months. This metric references specific lab values and health maintenance activity for the last testing date.

- Data is update/refreshed daily

- Metrics are a rolling 12 months
Healthy Planet Registries: Screenshot
## Physician Scorecard: DM Registry

### Healthy Planet - ST TAMMANY WEST REGION YTD October 19 2016

<table>
<thead>
<tr>
<th>DIABETES M. MEASURES</th>
<th>Covington</th>
<th>Abita Springs</th>
<th>Mandeville</th>
<th>STW Region (AVG)</th>
<th>OHS</th>
<th>GOAL</th>
<th>5 Star</th>
<th>4 Star</th>
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<td>2541/15438</td>
<td>330/3428</td>
<td>303/2366</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Cut Points</td>
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<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>91%</td>
<td></td>
<td>88%</td>
<td>88-100</td>
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<tr>
<td>Hemoglobin A1C Testing</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>91%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1C control</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>97%</td>
<td>91%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid Profile</td>
<td>88%</td>
<td>94%</td>
<td>94%</td>
<td>91%</td>
<td>82%</td>
<td></td>
<td></td>
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<tr>
<td>LDL Control</td>
<td>50%</td>
<td>51%</td>
<td>51%</td>
<td>48%</td>
<td>47%</td>
<td></td>
<td></td>
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<tr>
<td>Nephropathy Screening</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>90%</td>
<td></td>
<td></td>
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<tr>
<td>Blood Pressure Control</td>
<td>66%</td>
<td>72%</td>
<td>80%</td>
<td>73%</td>
<td>66%</td>
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<tr>
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<td>55%</td>
<td>48%</td>
<td>42%</td>
<td>48%</td>
<td>48%</td>
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<tr>
<td>Foot Exam</td>
<td>72%</td>
<td>82%</td>
<td>62%</td>
<td>73%</td>
<td>66%</td>
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<tr>
<td>Covington</td>
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<tr>
<td>Orange</td>
<td>357/1826</td>
<td>189/1044</td>
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<tr>
<td>Brown</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
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<tr>
<td>Black</td>
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<td>73%</td>
<td>84%</td>
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<td>100%</td>
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<td>Red</td>
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<td>Yellow</td>
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<td>70%</td>
<td>84%</td>
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<td>Cov. TG (AVG)</td>
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<tr>
<td>GOAL</td>
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<tr>
<td>Hemoglobin A1C Testing</td>
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<td>189/1044</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1C control</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
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<tr>
<td>Lipid Profile</td>
<td>77%</td>
<td>73%</td>
<td>84%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>LDL Control</td>
<td>83%</td>
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<td>Nephropathy Screening</td>
<td>63%</td>
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<td>50%</td>
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<tr>
<td>Blood Pressure Control</td>
<td>66%</td>
<td>70%</td>
<td>84%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>357/1826</td>
<td>189/1044</td>
<td></td>
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<td></td>
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<tr>
<td>Foot Exam</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
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</tr>
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</table>

### St. Tammany West

- **Panel Size**: 394/2599
- **GOAL**: 97%
# Diabetic Registry Outreach Outcomes

## January – December 2016

<table>
<thead>
<tr>
<th>REGIONS</th>
<th>Registry # Patients</th>
<th>Outreach Count</th>
<th>Patients Receiving Outreach</th>
<th>Labs/Tests Completed</th>
<th>Unique # of Patients Completing Labs</th>
<th>Avg # of Labs/Tests Completed per Pt</th>
<th>% of Patients Completing Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist</td>
<td>2112</td>
<td>837</td>
<td>568</td>
<td>1600</td>
<td>452</td>
<td>3.54</td>
<td>79.6%</td>
</tr>
<tr>
<td>Baton Rouge</td>
<td>10683</td>
<td>6849</td>
<td>4158</td>
<td>14565</td>
<td>3499</td>
<td>4.16</td>
<td>84.2%</td>
</tr>
<tr>
<td>Bayou</td>
<td>2308</td>
<td>665</td>
<td>310</td>
<td>854</td>
<td>256</td>
<td>3.34</td>
<td>82.6%</td>
</tr>
<tr>
<td>Kenner</td>
<td>3331</td>
<td>1210</td>
<td>701</td>
<td>2034</td>
<td>578</td>
<td>3.52</td>
<td>82.5%</td>
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<tr>
<td>Main Campus</td>
<td>12449</td>
<td>4469</td>
<td>2791</td>
<td>8715</td>
<td>2372</td>
<td>3.67</td>
<td>85.0%</td>
</tr>
<tr>
<td>St T East</td>
<td>2687</td>
<td>2298</td>
<td>1397</td>
<td>5015</td>
<td>1215</td>
<td>4.13</td>
<td>87.0%</td>
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<tr>
<td>St T West</td>
<td>3964</td>
<td>7372</td>
<td>2855</td>
<td>11834</td>
<td>2691</td>
<td>4.40</td>
<td>94.3%</td>
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<tr>
<td>Westbank</td>
<td>6191</td>
<td>3945</td>
<td>2088</td>
<td>5854</td>
<td>1746</td>
<td>3.35</td>
<td>83.6%</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>43725</strong></td>
<td><strong>27645</strong></td>
<td><strong>14869</strong></td>
<td><strong>50471</strong></td>
<td><strong>12809</strong></td>
<td><strong>3.94</strong></td>
<td><strong>85.1%</strong></td>
</tr>
</tbody>
</table>

**Registry # Patients**

- Baptist
- Baton Rouge
- Bayou
- Kenner
- Main Campus
- St T East
- St T West
- Westbank

**Labs/Tests Completed**

- Baptist
- Baton Rouge
- Bayou
- Kenner
- Main Campus
- St T East
- St T West
- Westbank
Primary Care Providers: Incentive

Diabetes Metrics

- **HgA1c Control Rate**
  - Metric: percentage of patients aged 18-75 with a diagnosis of diabetes whose most recent HgA1c was ≤ 8

- **BP control in Diabetics**
  - Metric: percentage of patients aged 18-75 with a diagnosis of diabetes whose most recent BP reading was ≤140/90

- **Foot Exam rate in Diabetics**
  - Metric: percentage of patients aged 18-75 with a diagnosis of diabetes who had a foot exam within 12 months
Suggestions for success

• Get to know your LPN CCCs- they can help identify patients who need help controlling their diabetes
• Explore use of the Digital Health Program for patients with Hypertension- rolling out Q2 2016
• Look at your MyPanel Dashboard and compare your performance with your peers
• Use Diabetes Education as an entry point into diabetes management for patients having difficulty maintaining diabetes control
• Use Complex Case Management for patients with complicated medical and socioeconomic barriers
• Provide feedback to your leaders about which resources make the biggest impact on patient care
• Pharmacy Assistance Program offering support for patients having difficulty affording meds.
DM Disease Management Program
OHS Diabetes Care Management Program

Patient-centered, team-based program developed to combine best practice standards

*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.
Multi-Disciplinary Diabetes Care Team

- Provider; MD, DO, NP, PA
- Diabetes Program Manager, CDE
- Diabetes Educator, CDE, RD/RN
- Pharm D
- Complex Case Manager, RN, LCSW
- Health Coach, RN or RD
- Engagement Specialist
- LPN CCC

Patient
Fears, Values, Beliefs, Goals
Work Flow

Diabetes Registry

Welcome Packets

Risk Stratified

Low Risk

Monthly Outreach

Moderate Risk

LPN CCC Bulk Order to CDE

Engagement Specialist Schedule Appointment

CDE Assessment and Comprehensive Care Plan

High Risk

LPN CCC Bulk Order to CDE and OPCM

Engagement Specialist Schedule Appointment with CDE

CDE Assessment

OPCM Assessment
Patient Centered

• Drive change!
  **DSME/S Programs**
• Move away from Didactic...approach
• “One size fits all”

**Move Towards…**

**Patient with Diabetes**

• Take into consideration patient needs and Values
• Fears and life experience....

**Improved Outcomes and Quality of Life**

• Empower the patient to make informed decisions about their own self-care
• Motivational interviewing

Patient Identification

Methods:
- Encounter/Claims Data
- Epic Healthy Planet
- Pharmacy Data

Diabetes Registry
Risk Stratification

High Risk
- A1c > 10%

Moderate
- A1c >7%-- <= 10% age 18-74
- A1c >/= 8%--< = 10% >75

Low
- A1c <= 7%-- age 18-74
- A1c < 8%-- age > 75
**Interventions**

**High Risk**
- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal
- Bulk order to Diabetes Education
- Education appt scheduled by Centralized Engagement Specialist
- Diabetes Education CDE visit for assessment and navigation to urgent or long-term Endocrine (if needed) or Diabetes Empowerment Clinic
- Bulk Referral to Outpt Care Management
- RN and/or Social Worker complete assessment and longitudinal care plan.

**Moderate Risk**
- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal
- Bulk order placed for DM education
- Education appt Scheduled by Centralized Engagement Specialist
- Diabetes Education CDE visit for assessment and navigation to urgent or long-term Endocrine (if needed) or Diabetes Empowerment Clinic

**Low Risk**
- Yearly PCP Visit
- Monthly tips and information pushed out via Ochsner Blog, My Ochsner pt portal
Pilot Data

- 60.9% of 218 referred patients attended diabetes education

- Results to date on A1c control: n=62 pts with f/u A1c

<table>
<thead>
<tr>
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<th># Patients</th>
<th>Entry A1c</th>
<th>Post-pilot A1c (2-6 mo)</th>
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<tr>
<td>Total</td>
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<td>8.41%</td>
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<tr>
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<td>11.57%</td>
<td>8.29%</td>
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<tr>
<td>Mod Risk</td>
<td>50</td>
<td>7.7%</td>
<td>7.3%</td>
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- Increase: Slidell’s diabetes educator overall total unique patient volume

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>2015</td>
<td>178 Patients</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>496 patients</td>
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Leveraging Technology In Diabetes Care
Telemedicine: Delivery of Diabetes Education

“increasing patient touch”
Diabetes Education offered through Telemedicine Clinic

Key points of Operation:

• Patient attends diabetes education sessions through telemedicine in their usual primary care clinic

• Educator Set up:
  – Computer with two monitors and 1 camera
  – all education materials, demo pens, meters, etc… stored at the remote location, the remote location has clinical staff that can assist as needed during patient teaching.

• Remote Site Set up:
  – an exam room with one desk top computer and a camera, Clinic staff MA/LPN to weigh the patient, perform the diabetes distress scale with the patient and then starts the session via Jabber and checks the patient out when education is done.
What have learned so far…

• Diabetes Education visits were very easy and inexpensive to implement:

  • Through the web ochsner.org website https://www.ochsner.org/services/diabetes/, the educator is able to play videos and show resources during the session

  • CDE able to assist in arranging for other health screening visits such as eye exam and lab visits

  • Blood sugar logs and Bluetooth technology has allowed the educator to access blood sugar trends between visits

  • CDE and the PCP actively discuss BG trends with the Patient and adjustments in therapy are made quicker.
Word of mouth travels!

- Patients leave the office with a smile saying....
- “I had such a good time”
- “I can do this”
- “I can’t wait to go home and try what I have learned”
- “So glad that this is offered”
- “When can I see you again”
Options…

Patients and Providers have options as to how insulin is delivered, syringe, pumps, pens, V-GO etc… Shouldn’t they have options on the delivery of their Diabetes Education too……Telemed, Digital, Self-study, Traditional Classroom, or combination of all….

GOAL… expand telemed offerings to multiple clinics and eventually offer educational services in patient homes on via own laptop, smartphone, or tablet.
Professional Continuous Glucose Monitoring

**Average Glucose:** 184 mg/dL

**Time in Target:** 57%

**Estimated A1c:** 7.8%

---

*The FreeStyle Libre Pro System provides a complete glucose profile so you and your doctor can personalize your treatment plan.*

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*Ochsner Health System*
Continuous Glucose Monitors Systems (CGMS)

- Collect continuous data 24 hours on glucose trends (paired with food, activity, medication log)
- Readings are recorded every 5 minutes
- Glucose is measured by interstitial fluid with sometimes can be delayed from a finger stick--capillary sample.
- Very useful for trends and improving patient self-awareness
- Management and adjustment of the diabetes treatment plan should be based on glucose trends and not solely A1c.
Continuous Glucose Monitoring

Daily Patterns (with Ambulatory Glucose Profile)
September 7, 2015 – September 20, 2015 (14 days)

Estimated A1c 7.8%, or 62 mmol/mol

Ochsner Health System
CGMS Indications

- Hypoglycemia
- Variable glucose readings
- A1c not matching BG readings
- Uncontrolled diabetes
- Baseline information
- Non-adherence to self glucose monitoring
- Assistance with both changes and adjustment in treatment
Workflow

- CGMS Order= in Epic by patient’s Primary Care Provider
- Actual CGMS procedure= performed by the Endocrine Team
- Patient= wears the sensor for 7 days (records meals, activity, medications, and stress on a log)
- Completion= 7 days of the sensor data is uploaded in the office and interpreted by Endocrine staff physician or nurse practitioner
- Results= primary care provider will receive the results in their Epic in basket. PCP will get unread CGMS tracings and CGM interpretation with recommendations of the diabetes treatment plan to provide to their patient.
Workflow

• Endocrine Recommendations: based on the CGMS results there will be general recommendations and/or suggestions
  – Examples:
    ◦ Patient needs better dietary management, refer to Diabetes Educator
    ◦ Patient non adherent to therapy
    ◦ Patient will need more basal coverage with a list of meds that cover basal needs
    ◦ Patient will need more prandial coverage with a list of meds that cover basal needs
• Ordering provider can make changes based these recommendations
Ochsner’s O Bar

Serving up technology that helps keep patients engaged and out of the doctor’s office
Among the tens of thousands of health apps and numerous devices, how to do decide what’s effective?
• **Purpose of the O Bar?**
  • With over 100,000 health care related apps on the market today, we are clearing the noise for our patients and direct them to the best apps.

• **What happens during a patient visit to O Bar?**
  • Patients drop by before or after primary care appointments, where they are can speak to non-clinical, tech-savvy IT specialists, who are members of the primary care team, to have questions answered, walk through app tutorials, and are assisted with app downloads and technology integration.

• **Early Results?**
  • In the first six months, patients downloaded over 3,000 apps

• **What’s happening now?**
  • Technology based battle against chronic disease: Hypertensive Digital Medicine Program enables patients to use wireless cuffs at home and blood pressure readings are streamed directly to the EMR. Congestive heart failure patients’ weight can now be monitored remotely by medical professionals via a wireless bathroom scale via our Heart Failure Digital Medicine Program. Diabetes monitoring, COPD, specialized inhalers for asthma and vision monitoring for failing eyesight programs are in development.
A closer look at the O Bar: Semi-retail space

- Bluetooth blood glucose monitors
- Wireless blood pressure monitors
- Wireless scales
- Activity trackers such as Fitbit and Jawbone
- Hundreds of physician approved health apps
Ochsner Health System

O Bar Prescription

Ochsner Center for Primary Care and Wellness
1401 Jefferson Highway, New Orleans, LA 70121

Visit the O Bar to get your apps & devices today!

RX
Your Prescription for good health.

RX APPS
- Nutrition
- Fitness
- Women’s
- Oncology
- Diabetes
- Medication
- Smoking
- General Health

DEVICES
- Activity Monitor
- Blood Glucose Monitor with Bluetooth
- Wireless Scale
- Wireless Blood Pressure Monitor

Physician Signature

“Tell me and I forget. Teach me and I may remember. Involve me and I learn.”

-BEN FRANKLIN
Diabetes Digital Medicine Program
Outpatient Home Monitoring: Diabetes

- Metrics scrubbed thru condition specific algorithms
- Patients stratified by risk status
- Potential readmission avoided
- High risk patients intervened by medication adjustment and/or outpatient visit
Traditional Healthcare Model

- Patient with Chronic Disease(s)
- PCP in Brick and Mortar Setting
- Manage Patient through PCP-directed Team (Medical Home Model)
- Referral to Specialists

Digital Healthcare Model

- Patient with Chronic Disease(s)
- Self Monitoring
- Home Monitoring
- Frequent data points:
  - “continuous measurement”
  - patient activated
  - faster cycle times
  - quicker course corrections
- Analytics engine:
  - better or worse?
  - need intervention?
  - need encouragement?
  - need advice?
- Integrated Practice Unit:
  - tools tailored for each patient
  - behavior, communication, education, engagement

Social Network:
- Strengthen/develop
- Activate
- Educate

Ochsner Health System

Uniform Standards for Measurement and Ordering Strips
All reminders and ordering via smartphone
Patient Characterization

• Onboarding
• Dietary analysis
• Medication adherence
• Living circumstances
• Medication affordability
• Social network
• Caregiver support
• Sleep apnea screening

• Depression
• Patient activation measure
• Physical activity index
• Health literacy
• Transportation issues
• Access to care
• Diabetes distress
# Principles of Type 2 Diabetes Management

Lifestyle therapy including medically supervised weight loss, is key to managing type 2 diabetes.

Weight loss should be considered as a lifelong goal in overweight and obese patients.

The A1C target must be individualized.

Glycemic control targets include fasting and postprandial glucoses.

The choice of therapies must be individualized on basis of patient characteristics, impact of net cost to patient, formulary restrictions, personal preferences.

Minimizing risk of hypoglycemia is a priority.

Minimizing risk of weight gain is a priority.

Initial acquisition cost of medications is only a part of the total cost of care which include monitoring requirements, risk of hypoglycemia, weight gain, safety, etc.

This algorithm stratifies choice of therapies based on initial A1C.

Combination therapy is usually required and should involve agents with complimentary actions.

Comprehensive management includes lipid and blood pressure therapies and related comorbidities.

Therapy must be evaluated frequently until stable, then less often.

The therapeutic regimen should be as simple as possible to optimize adherence.

Health maintenance should include active monitoring for complications of diabetes (eyes, renal, etc.)
Lifestyle Therapy

Intensity stratified by burden of obesity and related complications

**Nutrition**
- Maintain optimal weight
- Caloric restriction if BMI increased
- Plant-based diet; high PUFA & monounsaturated fatty acids
- Avoid trans fatty acids; limit saturated fatty acids
- Structured counseling
- Meal replacement

**Physical Activity**
- 150 min/week moderate exertion
- Strength training
- Increase as tolerated
- Structured program
- Wearable technologies
- Medical evaluation/clearance
- Medical supervision

**Sleep**
- About 7 hours per night
- Basic sleep hygiene
- Screen OSA
- Home sleep study
- Referral to sleep lab

**Behavioral Support**
- Community engagement
- Alcohol moderation
- Discuss mood with HCP
- Formal behavioral therapy

**Smoking Cessation**
- No tobacco products
- Nicotine replacement therapy
- Referral to structured program
Hey Siri, can you show me the best way to draw up and inject insulin?
How are we able to achieve success?

- Instant Reports
  - Real-Time Data is central to iO’s Digital Medicine Programs

- Warning Signs
  - Apple’s Health-Kit integration with Epic allows for patient data, such as BG readings to be automatically shared with their care team.

- Treatment Adjustments
  - Completed more quickly thanks to the continuous loop of information
Lessons Learned

- Patient engagement improved
- Data integration is key
- Integration beats best in class at Ochsner
- Scalability to populations in process
- Transition in lock step with increased value-based contracts
Questions?