Monthly Campaign Webinar
April 18, 2019
Today’s Webinar

• Together 2 Goal® Updates
  – Webinar Reminders
  – Extension Announcement
  – How to Remain in the Campaign
  – Extension Offerings
  – New Data Reporting Components

• AMGA Analytics
  – John Cuddeback, M.D., Ph.D.

• Questions
Webinar Reminders

• Webinar will be recorded today and available the week of April 22nd
  – www.Together2Goal.org

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
Campaign Extension into 2021

T2G EXTENDS TO 2021

- March 2016 Launch
- 2017
- 2018 750K Milestone
- April 1, 2019 Extension Begins
- 2020
- March 31, 2021 Completion
Together 2 Goal® Impact

Improved care for more than 750,000 people with Type 2 diabetes
Together 2 Goal® Reach

- 150 groups in 36 states
- 61,000 FTE physicians
- 2.0 million patients with Type 2 diabetes
Together 2 Goal® Momentum

14 new groups with over 2,500 FTE physicians
New Research

Publications & Presentations from AMGA Analytics

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**Bridging the Gaps**

From diabetes screening to diagnosis to treatment

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**Industry Insights**

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**Learning Health Systems, Creative Analytics, and Population Health Management**

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**Characterizing Clinical Inertia Among Patients with Type 2 Diabetes**

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New Project: Innovator Track Progress Report

- Concludes in 2019
- Case studies to be shared with T2G participants
New Project: T2G Diabetes Bundle Best Practices Learning Collaborative
Together 2 Goal®

Kendra Dorsey

Senior Director
National Health Campaigns
How to Remain in the Campaign

All you need to do is:

• Continue implementing plank(s)
  – Or adopt new ones
• Continue submitting data
  – Or consider advancing tracks
• Use existing and new resources to get to goal

How do I re-enroll in the campaign?

...No need to re-enroll!
Continuing Campaign Offerings

- 1 Campaign Toolkit
- 3 National Days of Action
- 3 Data reporting tracks
- 6 Goal-Getters
- 11 quarterly blinded comparative data reports
- 31 Monthly Webinars
- 36 Goal Post resources
New Offering: Revamped Website

Welcome to the Together 2 Goal® campaign website! We are proud to collaborate with medical groups, health systems, partners, and corporate collaborators across the nation with the goal of improving care for 1 million people with Type 2 diabetes. We hope our website will provide you with the tools and resources needed to more effectively manage your patients with Type 2 diabetes. AMGA members interested in enrolling can learn more here.
New Offering: Email Signature Badge

Together, improving diabetes care for 1 million people
New Offering: Toolkit Supplement
New Offering: “Webinars at Work”

Webinar at Work
February 2019
“Putting T2G in healthcare practice”

Webinar: “Putting T2G in healthcare practice”
Speakers: Dr. B.M. B.C.P.P (Bartolook, D., P.A.)
Webinar Date: February 23, 2019

Abstract:
Healthcare providers often find it difficult to engage patients in diabetes education. Consequently, the effectiveness of diabetes education programs is questioned. To overcome this, we have a new approach to diabetes education that is designed to be more effective.

Implementation Tips:

- Provide education — guidance alone is not sufficient
- Address the complexity of diabetes treatment for different individuals (gene therapy, surgery, and insulin therapies)
- Develop case studies to facilitate management of diabetes
- Utilize a variety of educational methods to facilitate learning (videos, lectures, and interactive sessions)
- Expand the patient base
- Actively encourage and plan to increase opportunities for “tangible feedback”

Team discussion:

1. What is the clinical goal when providing clinical care to patients with diabetes?
2. How can we improve our patients’ adherence to treatment?
3. How can we improve our patients’ adherence to treatment?
4. How can we improve our patients’ adherence to treatment?

Additional Notes:

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New Offering: Interactive Campaign Planks

**Campaign Planks**

**Empower Patients**
- Build an Accountable Diabetes Team
- Integrate Emotional & Behavioral Support
- Refer to Diabetes Self-Management Education & Support Programs

**Improve Care Delivery**
- Conduct Practice-Based Screening
- Adopt Treatment Algorithm
- Measure HbA1c Every 3-6 months
- Assess & Address Risk of Cardiovascular Disease
- Contact Patients Not at Goal & with Therapy Change within 30 Days

**Leverage Information Technology**
- Use a Patient Registry
- Embed Point-of-Care Tools
- Publish Transparent Internal Reports

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New Offering: Plank Mentors
New Offering: Best Practices Compendium
Together 2 Goal® Extension Corporate Collaborators

Presenting Corporate Collaborator

Founding Corporate Collaborator

Innovator Track Corporate Collaborator

Distinguished Data and Analytics Corporate Collaborator

Contributing Corporate Collaborator
Together 2 Goal® Non-Profit Partners & Supporting Organizations
## Data Reporting Deadlines

<table>
<thead>
<tr>
<th>T2G Year 4:</th>
<th>Measurement Periods (Quarters)</th>
<th>Measurement Periods (Months and Days)</th>
<th>Reporting Deadline</th>
<th>Report Sent to Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 Q2</td>
<td>2018 Q3 – 2019 Q2</td>
<td>2019 Q2</td>
<td>September 2, 2019</td>
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<tr>
<td>2019 Q3</td>
<td>2018 Q4 – 2019 Q3</td>
<td>2019 Q3</td>
<td>December 2, 2019</td>
<td>December 20, 2019</td>
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<tr>
<td>2020 Q1</td>
<td>2019 Q2 – 2020 Q1</td>
<td>2020 Q1</td>
<td>June 1, 2020</td>
<td>June 26, 2020</td>
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</table>

<table>
<thead>
<tr>
<th>T2G Year 5:</th>
<th>Measurement Periods (Quarters)</th>
<th>Measurement Periods (Months and Days)</th>
<th>Reporting Deadline</th>
<th>Report Sent to Groups</th>
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<tbody>
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<td>2019 Q3 – 2020 Q2</td>
<td>2020 Q2</td>
<td>September 1, 2020</td>
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<td>March 1, 2021</td>
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<td>2021 Q1</td>
<td>June 1, 2021</td>
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</tbody>
</table>
**New Reporting Template**

*Together 2 Goal® Core (Bundle)*

**Reporting Template**

Please enter the requested data in the cells shaded blue.

Organization Name

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**Core (Bundle) Track**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Ending Quarter</th>
<th>Measurement Period</th>
<th>Active Patients&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Patients with Type 2 Diabetes&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Prevalence of Type 2 Diabetes</th>
<th>Patients with last HbA1C &lt; 8%&lt;sup&gt;2&lt;/sup&gt;</th>
<th>HbA1C control</th>
<th>Patients with last ambulatory in-office BP &lt; 140/90&lt;sup&gt;2&lt;/sup&gt;</th>
<th>BP control</th>
<th>Patients with medical attention for nephropathy&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Medical attention for nephropathy</th>
<th>Patients with statin prescribed or reason not to receive statin&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Lipid management</th>
<th>Patients compliant in all four measures (Together 2 BUNDLE)&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Diabetes care bundle</th>
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</thead>
<tbody>
<tr>
<td>Baseline</td>
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</table>

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Note: To use this updated template to track your T2G core data from the beginning of the campaign (2016 Q1 or your first reported measurement period), copy and paste your historical data into the appropriate light blue cells.

You are not required to include your historical data in order to submit to the portal. All prior data submission have been recorded and saved in the portal data base.
# New Reporting Template

## Together 2 Goal® Core (Bundle) Reporting Template

Please enter the requested data in the cells shaded blue.

### Organization Name

<table>
<thead>
<tr>
<th>Phase</th>
<th>Ending Quarter</th>
<th>Measurement Period</th>
<th>Active Patients</th>
<th>Active Patients with Type 2 Diabetes</th>
<th>Patients with Type 2 Diabetes Prevalence</th>
<th>Diabetes Care Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
<td>04/01/2015-03/31/2016</td>
<td></td>
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<tr>
<td>T2G Year 1</td>
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<tr>
<td>T2G Year 2</td>
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<td>T2G Year 3</td>
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<tr>
<td>T2G Year 4</td>
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</tr>
</tbody>
</table>

### Core (Bundle) Track

**T2G Year 4**

- **2019 Q2**: 07/01/2018-06/30/2019
- **2019 Q3**: 10/01/2018-09/30/2019
- **2019 Q4**: 01/01/2019-12/31/2019
- **2020 Q1**: 04/01/2019-03/31/2020

**T2G Year 5**

- **2020 Q2**: 07/01/2019-06/30/2020
- **2020 Q3**: 10/01/2019-09/30/2020
- **2020 Q4**: 01/01/2020-12/31/2020
- **2021 Q1**: 04/01/2020-03/31/2021

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AMGA Analytics

John Cuddeback, M.D., Ph.D.

Chief Medical Informatics Officer
AMGA
# Campaign Measures

<table>
<thead>
<tr>
<th></th>
<th>Basic</th>
<th>Core (Bundle)</th>
<th>Innovator</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c control &lt; 8.0 percent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>BP control &lt; 140/90 mmHg</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lipid management (statin prescribed)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical attention for nephropathy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>T2G Bundle</td>
<td>✓</td>
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<tr>
<td>CVD prevention measures</td>
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</tr>
<tr>
<td>Eye exam measures</td>
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<td>✓</td>
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</tbody>
</table>
Updated Measure Specifications (Version 3.0)

• Option to count telehealth encounters (HEDIS 2019)
  – One of the 2+ visits required to qualify for the Active Initial Population can be a telehealth encounter
  – Diagnosis of type 2 diabetes on an eligible telehealth encounter can be used to meet the inclusion criteria for the T2G cohort

• Updated ACEi/ARB reference table for Attention to Nephropathy measure
  – Amlodipine-perindopril and Sacubitril-valsartan have now been added

• Updated T2G value sets (HEDIS 2019)

• Updated table of reporting periods, deadlines, and reporting dates
  – Available in the specifications and on the website
Each bar shows A1c Control for One Member Organization – 2018 Q4

- 90th Percentile
- 75th Percentile
- 50th Percentile (Median)
- 25th Percentile

- Group-weighted average

- 69.1%
- 76.2%
- 72.5%
- 69.2%
- 66.7%
Updated Reports

- Quarterly blinded comparative summary reports will now include additional summary statistics

<table>
<thead>
<tr>
<th>Summary Statistics (T2G 2018 Q4)</th>
<th>Prevalence of Type 2 Diabetes</th>
<th>HbA1c Control</th>
<th>BP Control</th>
<th>Medical Attention for Nephropathy</th>
<th>Lipid Management</th>
<th>Diabetes Care Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Weighted Average</td>
<td>13.3%</td>
<td>67.4%</td>
<td>76.1%</td>
<td>88.3%</td>
<td>73.4%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Group Weighted Average</td>
<td>14.3%</td>
<td>69.1%</td>
<td>76.4%</td>
<td>88.7%</td>
<td>74.2%</td>
<td>40.1%</td>
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<tr>
<td>25th Percentile</td>
<td>11.5%</td>
<td>66.7%</td>
<td>72.5%</td>
<td>87.0%</td>
<td>69.8%</td>
<td>34.9%</td>
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<tr>
<td>50th Percentile</td>
<td>14.1%</td>
<td>69.2%</td>
<td>75.3%</td>
<td>89.4%</td>
<td>73.9%</td>
<td>38.9%</td>
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<tr>
<td>75th Percentile</td>
<td>17.2%</td>
<td>72.5%</td>
<td>79.7%</td>
<td>92.2%</td>
<td>79.7%</td>
<td>43.9%</td>
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<tr>
<td>90th Percentile</td>
<td>20.1%</td>
<td>76.2%</td>
<td>85.7%</td>
<td>94.5%</td>
<td>83.8%</td>
<td>50.8%</td>
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<tr>
<td>Minimum</td>
<td>3.4%</td>
<td>39.5%</td>
<td>60.6%</td>
<td>71.0%</td>
<td>52.9%</td>
<td>20.1%</td>
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<tr>
<td>Maximum</td>
<td>24.3%</td>
<td>83.3%</td>
<td>94.1%</td>
<td>99.6%</td>
<td>99.0%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

- New report: Distribution of group performance (by measure)
Each bar shows A1c Control for One Member Organization – 2018 Q4
Distribution of Measure Performance Rate

Number of Health Care Organizations (Reporting for 2018Q4)

Bundle Control  A1c Control  BP Control  Attn for Nephropathy  Lipid Management

25th, 50th, 75th and 90th Percentiles
Tracking Achievement

Population Measures

- Proportion of patients in control (%)
  - A1c < 8.0
  - BP < 140/90
  - Statin Rx
  - Nephropathy
  - Bundle

- Cross-sectional
- Reported quarterly

Patients Improved

- Number of patients with sustained improvement
  - New diagnosis of type 2 diabetes
  - Improve on at least one measure

- Longitudinal
- Reported annually
  - Year 2 concluded 2018 Q1

- Number of patients with sustained control on bundle measure
<table>
<thead>
<tr>
<th>Measure</th>
<th>2016 Q1</th>
<th>2017 Q1</th>
<th>2018 Q1</th>
<th>Δ Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td>14.0%</td>
<td>13.9%</td>
<td>14.1%</td>
<td>--</td>
</tr>
<tr>
<td>A1c &lt; 8.0</td>
<td>66.0%</td>
<td>66.6%</td>
<td>68.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>BP &lt; 140/90</td>
<td>72.7%</td>
<td>73.8%</td>
<td>75.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Nephropathy</td>
<td>85.6%</td>
<td>87.1%</td>
<td>88.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Statin Rx</td>
<td>68.6%</td>
<td>69.0%</td>
<td>71.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Bundle</td>
<td>33.2%</td>
<td>34.6%</td>
<td>37.3%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

74 AMGA member organizations in all 3 quarters: Baseline, Year 1, and Year 2
Opportunities for Improvement

• Patients with no prior diagnosis of type 2 diabetes (on problem list or billing claim)
  – New diagnosis for T2DM (on claim* or problem list)
    • Practice-based screening
    • Review clinical data for existing evidence that’s diagnostic or strongly suggestive of type 2 diabetes

• Patients with a diagnosis of type 2 diabetes
  – If A1c is not measured (during measurement period), measure A1c
  – If A1c ≥ 8.0, bring A1c into control
  – If BP is not measured, measure BP
  – If BP ≥ 140/90, bring BP into control
  – If no statin prescribed and LDL ≥ 70 mg/dL, prescribe (or re-try) a statin
  – If no medical attention to nephropathy, screen/diagnose, prescribe an ACEi/ARB, or refer to a nephrologist

* We require Dx codes on claims to be associated with an encounter with a provider, to ensure we don’t pick up a code for diabetes that’s used in a “rule out” sense, on a claim for a lab test intended as screening for diabetes. This use of the code is technically not correct, but it’s a common error.
Have Dx: Opportunities for Improvement

Campaign baseline data (2016 Q1): Broader population, i.e., patients age 18 – 75 with ≥ 1 visit (instead of ≥ 2 visits required in T2G)
### Have Dx: Improvement Calculation

<table>
<thead>
<tr>
<th>A1c</th>
<th>BP</th>
<th>Lipid</th>
<th>Nephropathy</th>
<th>Bundle</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Year 2</td>
<td>Baseline</td>
<td>Year 2</td>
<td>Baseline</td>
<td>Year 2</td>
</tr>
<tr>
<td>Example A</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example B</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example C</td>
<td>✔ ✗ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example D</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example E</td>
<td>✔ ✗ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example F</td>
<td>✔ ✗ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Example G</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
<td>✗ ✔</td>
<td>✔ ✔</td>
</tr>
</tbody>
</table>

**Improvement is assessed for each patient, then summarized for all patients in the T2G denominator**

- Example A – Moving from out-of-control (✗) to in-control (✔) on any measure counts as improvement, provided it is not offset by movement from in-control to out-of-control on another measure (see Example D)
- Example B – Moving from out-of-control to in-control on multiple measures improves performance, but it counts the same as a single measure toward improvement
- Example C – Moving from out-of-control to in-control does not count as improvement if it is “offset” by regression (moving from in-control to out-of-control) on another measure
- Example D – Remaining out-of-control diminishes performance on the respective measure, but it does not offset improvement on another measure
- Examples E and F – Improvement on two measures is not offset by regression on one other measure, but it is offset by regression on two other measures
- Example G – Remaining in-control (✔) maintains performance on the respective measure, but it does not count as improvement for the campaign
For T2G, AMGA members self-report numerators and denominators for each measures, which does not provide the longitudinal, patient-level data needed to calculate improvements

- In the self-reported data below, HbA1c control improved by +4%, and BP control also improved by +4%, but we do not know which patients improved in one or both measures, which is needed to prevent double counting toward our 1 million patient goal

We can use longitudinal EHR data from AMGA members using an Optum population health analytics tool

- 20 organizations participating in AMGA’s Analytics for Improvement (A4i) Collaborative and Together 2 Goal Campaign
- Extrapolate from A4i groups to self-reporting groups—A4i groups account for 35% of active initial population, 37% of T2G cohort
  - Similar prevalence and similar performance on each measure, similar range of organization size and geographic distribution

<table>
<thead>
<tr>
<th>Phase</th>
<th>Ending Quarter</th>
<th>Measurement Period</th>
<th>Active Patients</th>
<th>Patients with Type 2 Diabetes</th>
<th>Prevalence of Type 2 Diabetes</th>
<th>Patients with last HbA1C &lt; 8%</th>
<th>HbA1C control</th>
<th>Patients with last ambulatory in-office BP &lt; 140/90</th>
<th>BP control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>2016 Q1</td>
<td>04/01/2015-03/31/2016</td>
<td>208,483</td>
<td>17,720</td>
<td>8%</td>
<td>9,747</td>
<td>55%</td>
<td>13,090</td>
<td>74%</td>
</tr>
<tr>
<td>T2G Year 1</td>
<td>2016 Q2</td>
<td>07/01/2015-06/30/2016</td>
<td>212,430</td>
<td>18,174</td>
<td>9%</td>
<td>10,053</td>
<td>55%</td>
<td>13,561</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>2016 Q3</td>
<td>10/01/2015-09/30/2016</td>
<td>215,354</td>
<td>18,482</td>
<td>9%</td>
<td>10,423</td>
<td>56%</td>
<td>13,821</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>2016 Q4</td>
<td>01/01/2016-12/31/2016</td>
<td>218,435</td>
<td>18,724</td>
<td>9%</td>
<td>10,540</td>
<td>56%</td>
<td>14,030</td>
<td>75%</td>
</tr>
<tr>
<td>T2G Year 2</td>
<td>2017 Q1</td>
<td>04/01/2016-03/31/2017</td>
<td>223,016</td>
<td>19,238</td>
<td>9%</td>
<td>10,621</td>
<td>55%</td>
<td>14,555</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>2017 Q2</td>
<td>07/01/2016-06/30/2017</td>
<td>225,943</td>
<td>19,488</td>
<td>9%</td>
<td>11,037</td>
<td>57%</td>
<td>15,202</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>2017 Q3</td>
<td>10/01/2016-09/30/2017</td>
<td>227,414</td>
<td>19,805</td>
<td>9%</td>
<td>11,397</td>
<td>58%</td>
<td>15,528</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>2017 Q4</td>
<td>01/01/2017-12/31/2017</td>
<td>229,516</td>
<td>20,074</td>
<td>9%</td>
<td>11,785</td>
<td>59%</td>
<td>15,490</td>
<td>77%</td>
</tr>
<tr>
<td>2018 Q1</td>
<td>04/01/2017-03/31/2018</td>
<td>235,895</td>
<td>20,634</td>
<td>9%</td>
<td>12,105</td>
<td>59%</td>
<td>16,090</td>
<td>78%</td>
<td></td>
</tr>
</tbody>
</table>
• Compare data from Year 2 (2018 Q1) to Baseline (2016 Q1)
• Look backward, to ensure that any improvements are sustained through end of measurement period
  – 58% of patients in T2G Cohort in 2018 Q1 were in T2G Cohort at Baseline (2016 Q1)
• Evaluate these patients for improvement in measures, from Baseline to Year 2
Improvement Calculation

• For remaining current T2G Cohort patients, evaluate quarterly—check how they entered the T2G Cohort
  – Patient new in T2G Cohort but Active in a prior quarter → established patient, newly diagnosed
    (diagnosis counts as improvement)
  – Patient new in T2G Cohort and in Active Population → new patient, already diagnosed
    (diagnosis does not count as improvement)
    • Evaluate these patients for improvement in measures, from cohort entry to current

• Consider patients who were active during the campaign, but not in the most recent quarter
  – Include improvements among patients who were active in ≥ 2 quarterly reporting periods but not the most recent quarter
    • Evaluate these patients for improvement in measures, from cohort entry to exit

• For 8 self-reporting groups who entered T2G after 2016 Q1 or left before 2018 Q1 but were active for > 2 quarters
  – Extrapolate using improvement figures specific to the length of their participation

• For all self-reporting groups, extrapolate from age 18–75 (control rates) to age 18–89 (improvement)
Sustained Bundle Control

• For patients with bundle in control at cohort entry or baseline, check to see if they sustained bundle control
  – These patients are not eligible for any improvements, so they don’t count toward the campaign goal
  – For patients who were not in the campaign from Baseline through the end of Year 2, count only if bundle control was sustained for ≥ 1 year

Together 2 Goal Bundle Measure

• A1c < 8.0 percent
• BP < 140/90 mm Hg
• Lipid management—statin prescribed
• Medical attention for nephropathy
Patients with Improved Care

- Among **1,440,000** patients with type 2 diabetes, age 18–75, in the 2018 Q1 population
  - **536,000** patients with improved care, through the end of Year 2 of the campaign (2018 Q1) – 37.2% of patients
  - **227,000** additional patients with sustained bundle control for ≥ 1 year
    - These patients had all measures in control at baseline, so they were not eligible for any improvements—no overlap with the 536,000 patients above

- Among **2,350,000** patients with type 2 diabetes, age 18–89, included in the 2018 Q1 population or in ≥ 2 quarterly reporting periods during campaign
  - **763,000** patients with improved care, through the end of Year 2 of the campaign (2018 Q1) – 32.5% of patients
  - **319,000** additional patients with sustained bundle control for ≥ 1 year

- Type of improvement:
  - About 1/3 of improvements are in people who have a new diagnosis of type 2 diabetes
  - 2/3 are patients who already had a diagnosis and achieved a net improvement in control, among the four measures that make up the T2G bundle
May Webinar

- **Date/Time**: May 16, 2019 from 2-3pm Eastern
- **Topic**: Mental Health Integration and Diabetes Management
- **Presenters**:
  - Brenda Reiss-Brennan, Ph.D., APRN (Intermountain Healthcare)
  - Mark Greenwood, M.D. (Intermountain Healthcare)
Questions?
Send inquiries to together2goal@amga.org

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