Together 2 Goal®
AMGA Foundation
National Diabetes Campaign

1. Are the baseline data due by June 1, or is there any flexibility in this date? (Typical reason for asking: This population differs from the diabetes population we currently track internally, so we will need to do some work to select just the patients with Type 2 diabetes.)

   The data submission due dates are set to allow us time to process data for the campaign's quarterly reports. Timely submission is necessary to be certain that your group will be represented in the initial version of each quarter's report. Depending on when we get your data, we may have to include it in the next quarterly report cycle.

   Additionally, you can also go back at any time and revise data for prior quarters, and any revisions will be taken into account as we compute improvement for subsequent quarterly reports.

2. Being in the Basic Track, is only the number of patients with HbA1c < 8.0% needed, or does our submission need to also include Active Initial Population and Active Initial Population with Type 2 Diabetes?

   Even if you're reporting only one measure, in the Basic Track, we request three patient counts for each measurement period:
   - (1) Active Initial Population,
   - (2) Patients in Active Initial Population who have Type 2 diabetes (T2G cohort, the denominator), and
   - (3) Patients in T2G cohort (denominator, i.e., Patients in Active Initial Population who have

Type 2 diabetes) whose last A1c in the measurement period was < 8.0%.
The first two counts allow us to compute the prevalence of Type 2 diabetes within the Active Initial Population. This is not an official campaign measure, but the blinded campaign reports will give you a sense of how your prevalence compares to that of other AMGA members participating in T2G. This may be helpful in monitoring the impact of screening, if you choose to implement that campaign plank. (Prevalence = number of patients in Active Initial Population who have Type 2 diabetes ÷ Total number of patients in Active Initial Population.)

If you cannot report the number of patients in your Active Initial Population, we will simply omit prevalence from your campaign report.

However, we do need the other two patient counts, even for the Basic Track. For each campaign measure, we need a numerator and a denominator. The denominator is the same for all campaign measures: the "T2G cohort," or the number of patients in the Active Initial Population who have Type 2 diabetes (on their problem list or on a claim for a face-to-face visit in an ambulatory setting). The numerator for the HbA1c control measure that is reported in the Basic Track is the number of patients in the T2G cohort whose last HbA1c in the measurement period is < 8.0%. (Note that patients who did not have an A1c measured during the measurement period are considered *not* numerator compliant.)

Thus we do need the patient counts labeled (2) and (3) above, to be able to calculate the HbA1c control measure for the Basic Track.

3. Can we choose a subset of metrics to submit data for, and then add additional metrics later in the project cycle?

You may change campaign reporting tracks and/or update prior reported data at any time. If you are unable to submit data for all four measures and the bundle (the Core Track) then you can choose to start with the Basic Track option, which requires only the HbA1c control measure (see preceding question). We encourage members to change to the Core Track once all the metrics are available. Just make sure you reach out to your Together 2 Goal® regional contact (or email together2goal@amga.org) and let us know you are changing tracks. We will update your registration. You may report the additional measures just going forward, or you may report the full measure set for prior quarters as well.

4. Patient Level or Summary Level Data: Would we be submitting this data to you by patient to calculate those rates, or are you only collecting our summary data for Type 2 diabetics for the specific measures listed (for example, numerator and denominator for HbA1c > 8%, not the actual HbA1c values for each patient)?

We are not requesting patient-level data, only patient counts:
   (1) Active Initial Population,
   (2) Patients in Active Initial Population who have Type 2 diabetes (T2G cohort, the denominator), and
   (3) Patients in T2G cohort (denominator, i.e., Patients in Active Initial Population who have Type 2 diabetes) for each of the four Core Track measures, plus the bundle measure.
       • For the Basic Track, this is just one patient count: those in the T2G cohort who are numerator-positive HbA1c < 8.0%.

- For the Core Track, this is five patient counts: those who are numerator-positive for each of the four Core Track measures, plus those who are numerator-positive the bundle measure (i.e., numerator-positive for all four Core Track measures).

5. In the Together 2 Goal® Campaign Measurement Specifications document, it mentions an accompanying Excel workbook, HEDIS Value Sets for T2G Measures v1.0.xlsx. Could you forward us this document?

   The campaign measurement specs document and the referenced HEDIS Value Sets are available for download on the Together 2 Goal® website:

   http://www.together2goal.org/Improve/dataReporting_improve.html

6. I have a question about the Measurement Period (MP): Reading through the specification, I noticed sometimes it refers to a 12-month MP, other times it refers to 12-month MP plus the prior 6 months (18 months total). My understanding is that we are to use 18-month MP to get the Active Initial Population and the denominator (aka the T2G Cohort), but use 12-month MP to capture the numerator for each measurement, is that correct?

   That is correct. The 18-month time period is defined for (a) the two face-to-face ambulatory encounters required to be in the Active Initial Population, (b) the associated exclusions, and for (c) the evidence of Type 2 diabetes that is required to be in the denominator (T2G cohort). The numerators for the measures are almost exclusively calculated using the 12-month measurement period, except for just one aspect of the lipid management (statin prescribed) measure: some of the reasons for not having a statin are calculated based on an 18-month period.

7. I have a question related to the T2G lipid management measure. "active liver disease" is listed as a possible reason for a patient not receiving a statin, but I don't see a HEDIS Value Set for this criterion. What is the definition/spec for active liver disease (e.g., hepatitis)? Will you be providing the spec for this, such as diagnosis codes, CPT codes, lab result values (how elevated), etc?

   We do not have a value set for active liver disease. As with most of the **optional** exclusions (or in the case of this measure, "free pass"—see below) for T2G measures, the intent was that organizations who have been using these exclusions internally have the option to use them in their reporting for T2G, as well. We want to minimize the burden of T2G reporting and to mirror your internal reports as closely as possible.

   We analyzed longitudinal EHR and outbound claims data from AMGA members who are using the Optum One population health analytics platform, and we found that among patients meeting the criteria for the T2G cohort, only 3% had a documented reason for not receiving a statin (in vitro fertilization or a prescription for clomiphene; end-stage renal disease, or cirrhosis; muscle pain, inflammation, or rhabdomyolysis; or age < 40 with no cardiovascular risk factors or overt cardiovascular disease). These patients should be considered compliant for the lipid management measure ("free pass"). Across organizations, this proportion ranged from 1 to 6%. Therefore, we expect the number of patients not receiving a statin due to active liver disease will be small and thus will have very little impact on the lipid management measure reported by most organizations.

Regardless, if your organization is not currently using a method for tracking patients with Type 2 diabetes and active liver disease, and you would like to use the optional "free pass" logic, you may use any reasonable criteria to identify patients in the T2G cohort with active liver disease. We recommend methods that are limited to diagnosis codes on a claim or problem list rather than specific lab values. Please contact us if you would like further guidance (DataHelpForT2G@amga.org). We can share some lists of codes that other organizations have used.

Just to explain the "free pass" concept: If we were considering this measure in isolation, it would make sense to exclude (remove from the denominator) patients with a reason not to receive a statin. But since this is part of a bundle measure, we need to keep the denominators consistent in order to avoid a lot of complexity in calculating the bundle measure. So we consider patients with a reason not to receive a statin to be numerator-compliant for this measure.

8. Identifying people with Type 2 vs. Type 1 Diabetes: The database from which we pull quality reports does not distinguish between Type 1 and Type 2 diabetes, in all cases. How should we handle patients for whom we cannot determine diabetes type? (Our quality improvement committee is working to improve the specificity of the coding, and we expect it will improve as ICD-10 becomes more prevalent.)

Together 2 Goal® is focused on patients with Type 2 diabetes, so for comparability, we ask that you include only patients who are known to have Type 2 diabetes.

As part of the T2G campaign, organizations are encouraged to identify patients who have evidence for diabetes in the EHR (for example, elevated HbA1c or fasting glucose, or medications for glycemic control in the absence of other indications for those meds) and to place a diagnosis on their problem list and relevant claims. But these patients do not enter the T2G cohort until the diagnosis of Type 2 diabetes is recorded.

9. We already track similar metrics and/or collect measures that are defined slightly different from T2G. Can we use those?

It depends. In some cases, when an organization has made thoughtful choices and has come to a different decision/definition, we may be able to accommodate them. These are the cases where, based on the analysis we conducted in developing the specs, we know that those slight variations do not significantly affect performance rates. Still, we need to track and document these differences for the quarterly reports.

Examples of *when we have been able to accommodate* differences include: variations in visit codes used to define an eligible encounter and differences in the time period for determining inclusion in the active cohort. Many measures are defined for health plans, whose accountability for a patient is determined by an explicit enrollment process. Since provider organizations don't have formal enrollment, the visit type, specialty, and time-frame requirements for T2G are an attempt to define a cohort of patients with Type 2 diabetes for whom the organization is likely to "feel" accountable for providing their diabetes care. As long as the choices made by the organization don't significantly bias their results, and they feel comfortable with the population captured, we have attempted to accommodate.

If the differences are likely to be very small, we will simply include their results in the blinded campaign reports without notation. If the differences could be more substantial but are still consistent with the intent of the campaign definitions, we will include their results with a footnote indicating the nature of the differences.

However, there are *some variations that cannot be accommodated,* because the results would simply not be comparable to those defined by the campaign measures. For example:

- Active population with diabetes: We currently pull T1 and T2 together...

  The T2G campaign is focused specifically on patients with Type 2 diabetes, with an emphasis on primary care for this patient population. *Therefore, patients with Type 1 diabetes cannot be included in the measures, nor can patients known to have diabetes but the type is unknown.*

- T2G bundle: We have a 5 component bundle which also pulls tobacco free...

  In order to be comparable, the bundle must include all four of the T2G cCre track measures (A1c control, BP control, medical attention for nephropathy, and lipid management) and only those four. If an organization is unable to report the bundle in this way, they can opt for the Basic Track. Campaign participants can switch tracks and update their data at any time.

If you are unable to determine if your measure variation would *not be acceptable* for the campaign, contact us (DataHelpForT2G@amga.org). We will discuss whether your difference can still accomplish the intent of the measure without seriously biasing the results.

10. Identifying people with Diabetes—Problem List vs. Claims: For internal quality reports, we use only the EHR problem list to identify patients with diabetes. In the past, we used (outbound) claims data to identify diabetes, but when converting our registry, we found that 95% of patients with diabetes who were identified through claims were also identified by the problem list alone. May we use our problem list to identify patients with diabetes, or does the campaign require we use claims data as well?

    In general, organizations should contact us and let us know if they would like to use only one data source, either claims or problem list (DataHelpForT2G@amga.org). We recommend looking at the combination of claims and problem lists, because of what we see in the longitudinal EHR and outbound claims data from AMGA members who are using the Optum One population health analytics platform. Among patients 18–75 with Type 2 diabetes (based on *either* a problem list entry or a claim for a face-to-face ambulatory encounter), 4% had the diagnosis only on the problem list, 40% had the diagnosis only on a claim (for a qualifying encounter), and 56% had both. Across organizations, the proportion of patients with the diagnosis on both ranged from 34 to 91%.

    It's great to hear that your organization is maintaining problem lists so well! At the same time, we are concerned that if 5% of your patients who have Type 2 diabetes do not have a problem list entry, and your clinical decision support is driven from the problem list, then reminders about care gaps might not be triggered for these patients, and performance on one or more of the measures may be different. In this situation, we would include your results in the campaign report, with a footnote indicating this difference in how patients with Type 2 diabetes are identified.

We want to create minimum additional reporting burden for organizations participating in T2G, consistent with obtaining meaningful performance data that accurately reflect your success in improving care for people with Type 2 diabetes. If you have any questions at all, please contact us at DataHelpForT2G@amga.org.