

Together2Goal®

AMGA Foundation
National Diabetes Campaign

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

AMGA Foundation's national diabetes campaign aims to improve care for 1 million people with Type 2 diabetes. The framework to achieve this goal consists of 11 evidence-based care processes ("campaign planks") spanning three domains: Empowering Patients, Improving Care Delivery, and Leveraging Information Technology. At the onset, each participating organization is expected to implement at least one campaign plank. Over time, we anticipate participants will adopt multiple planks to achieve our shared goal.

EMPOWER PATIENTS

Build an Accountable Diabetes Team: The organization creates a diabetes team that accepts accountability for overall performance and achievement of goals. The team consists of engaged, multi-disciplinary participants who will address all aspects of diabetes care. Team composition is flexible and adapted to each organization and its culture.

Integrate Emotional and Behavioral Support: A critical component of managing and treating patients with Type 2 diabetes is emotional and behavioral support, addressing patient motivation as well as diabetes-related distress (i.e., emotional responses related to the disease). This support includes intervention strategies to promote patient engagement and self-management. Patients are offered resources and/or referrals for behavioral health support.

Refer to Diabetes Self-Management Education (DSME) and Support Programs: Patients are referred to an American Diabetes Association (ADA) Education Recognition Program (ERP) or an American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program (DEAP). The program emphasizes collaboration with patients to develop their own educational plan to promote self-management skills that facilitate behavior change. The program also offers resources and/or referrals for community services.

IMPROVE CARE DELIVERY

Conduct Practice-Based Screening: A process is in place to identify patients seen in the practice who are at high risk for diabetes, according to ADA recommendations for testing for diabetes or prediabetes in asymptomatic adults. Screening occurs at primary care, endocrinology, cardiology, nephrology, and other specialty visits (as determined by the group), and appropriate follow-up is provided. The EHR is used to identify patients who already meet the clinical criteria for Type 2 diabetes but lack a diagnosis or problem list entry.

Adopt Treatment Algorithm: The organization develops and consistently uses a treatment algorithm for patients with Type 2 diabetes that is consistent with evidence-based guidelines. Care teams and patients determine mutually agreed-upon treatment plans and goals that are individualized to each patient's needs and circumstances. Adherence to the treatment algorithm is monitored.

Measure HbA1c Every 3-6 Months: HbA1C is measured every 3-6 months for each patient with Type 2 diabetes, according to ADA guidelines. Processes are in place to monitor system performance and conduct outreach to patients who are overdue for testing.

Assess and Address Risk of Cardiovascular Disease: Care teams systematically evaluate each patient's risk for cardiovascular disease, using a trusted risk assessment tool. For patients at risk, treatment plans include primary and secondary prevention in accordance with ADA recommendations for lifestyle, lipid-lowering and antihypertensive medications, and aspirin.

Contact Patients Not at Goal and with Therapy Change within 30 Days: All patients not at goal and with either a new prescription or a change in therapy receive proactive clinical contact within 30 days to assess progress. An appropriate member of the care team initiates clinical interaction(s) in the form of an office or home visit, medication therapeutic management, telephone outreach, contact via the patient portal, virtual visit, or e-messaging. Treatment is intensified as appropriate.

LEVERAGE INFORMATION TECHNOLOGY

Use a Patient Registry: The organization uses a registry to identify and track all patients with Type 2 diabetes. Outreach is performed to patients who miss scheduled appointments, have gaps in care, require scheduled follow-up, and/or have additional care needs.

Embed Point-of-Care Tools: Clinical decision support tools are embedded in workflow to ensure that all members of the care team are aware of the patient's status on diabetes management and preventive measures, even if the current visit is for an unrelated problem. Protocols assist the care team in addressing patient needs.

Publish Transparent Internal Reports: Unblinded performance reports are generated and distributed at least quarterly to providers and care teams, as well as administrative leadership. Action plans establish targets for improvement and address performance. There is a process to recognize and spread best practices.