Measure Up Pressure Down®

American Medical Group Foundation

November 2015 Campaign Updates

AMGA
American Medical Group Association®

Campaign Updates

1. Q3 2015 Data Reporting Deadline
2. 2016 Campaign Activities
3. Diabetes: Together 2 Goal® Campaign
   - Overview
   - Enrollment Details
   - AMGA Members Enrolled to Date

Questions? Contact **mupdcampaign@amga.org**.

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Q3 2015 Data Reporting

DEADLINE: FRIDAY, DECEMBER 4, 2015

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2016 Campaign Activities

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2016 Campaign Activities

- Data reporting
- Website & resource access
- National Day of Action (May 5, 2016)
- Best Practices Compendium
- Award recognition

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AMGF's Second Chronic Care Challenge Campaign

Together2Goal®

American Medical Group Foundation
National Diabetes Campaign

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CAMPAIGN GOAL

Improved care for 1 million people with type 2 diabetes

Together2Goal™

GOAL: Improve care for 1 million people with type 2 diabetes

EMPOWER PATIENTS

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

IMPROVE CARE DELIVERY

- Adopt Treatment Algorithm
- Measure HbA_{1C} Every 3-6 months
- Assess & Address Risk of Cardiovascular Disease
- Contact Patients Not at Goal & with Therapy Change within 30 Days
- Conduct Practice-Based Screening

LEVERAGE INFORMATION TECHNOLOGY

- Embed Point-of-Care Tools
- Use a Patient Registry
- Publish Transparent Internal Reports

DATA REPORTING TRACKS

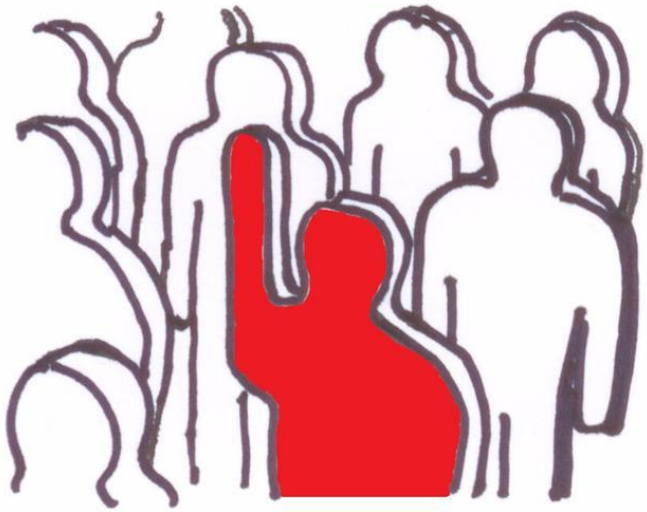
	Basic	Core (Bundle)	Innovator*
HbA1C control < 8 percent	Optional	√	√
BP control < 140/90 mmHg		√	√
Lipid management		√ Statin prescribed	√ Statin adherence
Medical attention for nephropathy		√	√
Non-smoking status			Potential
Body mass index			Potential
Foot exam performed			Potential
Eye exam performed			Potential
Other (e.g., patient engagement, functional outcomes, quality of life, overuse measurement)			Potential

Together2Goal™

*Note: Innovator track measures will be determined by AMGF and medical group/health system participants.

ENROLL TODAY!

- **How to enroll?**
  - Visit www.together2goal.org and complete the online enrollment form
- **Questions?**
  - Visit www.together2goal.org to view our campaign brochure, planks, data reporting tracks & FAQs
  - Email together2goal@amga.org to contact staff



Together2Goal™

PARTICIPATING AMGA MEMBERS

AS OF NOVEMBER 18, 2015

- AHS Oklahoma Physician Group, LLC dba Utica Park Clinic
- Austin Diagnostic Clinic, P.A.
- Austin Regional Clinic, P.A.
- Baptist Medical Group
- Boice-Willis Clinic, P.A.
- Colorado Springs Health Partners, P.C.
- Community Physicians of Indiana
- Cornerstone Health Care, P.A.
- Esse Health
- Essentia Health - Central Region
- Essentia Health - East Region
- Essentia Health - West Region
- Essentia Health System
- Harbin Clinic, LLC
- Hattiesburg Clinic, P.A.
- Henry Ford Health System
- Henry Ford Medical Group
- Kelsey-Seybold Clinic
- Lexington Clinic, P.S.C.
- Mercy Clinic-East Communities
- Mount Kisco Medical Group
- Mountain View Medical Group, P.C.
- Olmsted Medical Center
- Premier Medical Associates, P.C.
- Prevea Health Services
- PriMed Physicians
- Quincy Medical Group
- Riverside Health System
- Riverside Medical Group
- Saint Francis Health System / Warren Clinic
- Scripps Clinic Medical Group
- Scripps Coastal Medical Group
- Southeastern Integrated Medical
- Springfield Clinic
- SSM Health (including Dean Health Plan)
- Summit Medical Group, P.A.
- Sutter Health
- SwedishAmerican Health System
- The Iowa Clinic, P.C.
- The Polyclinic
- Union Associated Physicians Clinic, LLC
- UnityPoint Clinic
- University of Utah Community Clinics
- USMD Health System
- Watson Clinic, LLP
- Weill Cornell Physician Organization
- Wellmont Medical Associates
- Western Montana Clinic
- WESTMED Medical Group, P.C.

Together2Goal™

Today's Speaker

- John Kennedy, MD
- Endocrinology Department Director
- Geisinger Health Systems

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American Medical Group Foundation

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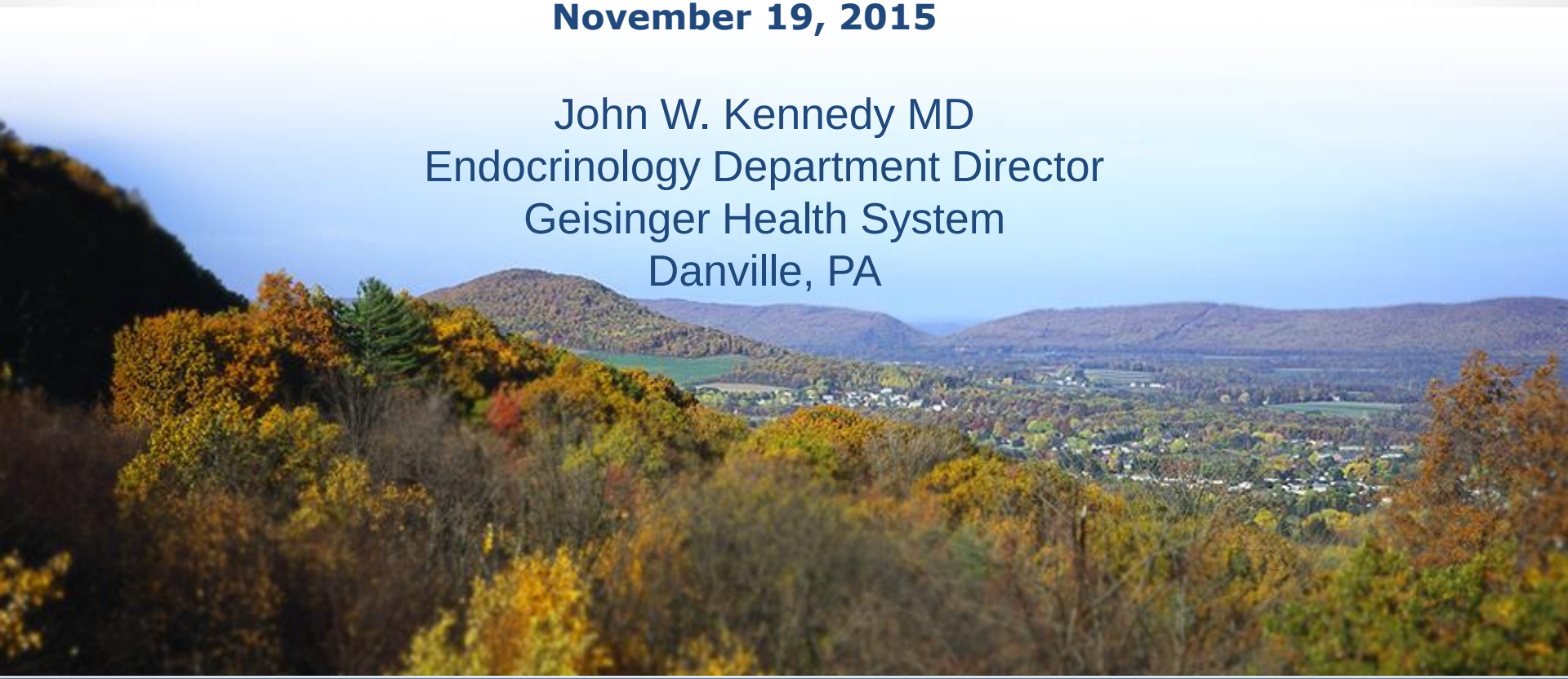
Diabetes & Hypertension Geisinger System of Care

AMGF Webinar
November 19, 2015

John W. Kennedy MD
Endocrinology Department Director
Geisinger Health System
Danville, PA



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Geisinger's Core Value since 1915
Patient Care Delivery

- Abigail Geisinger

- "Make my hospital right; make it the best…"

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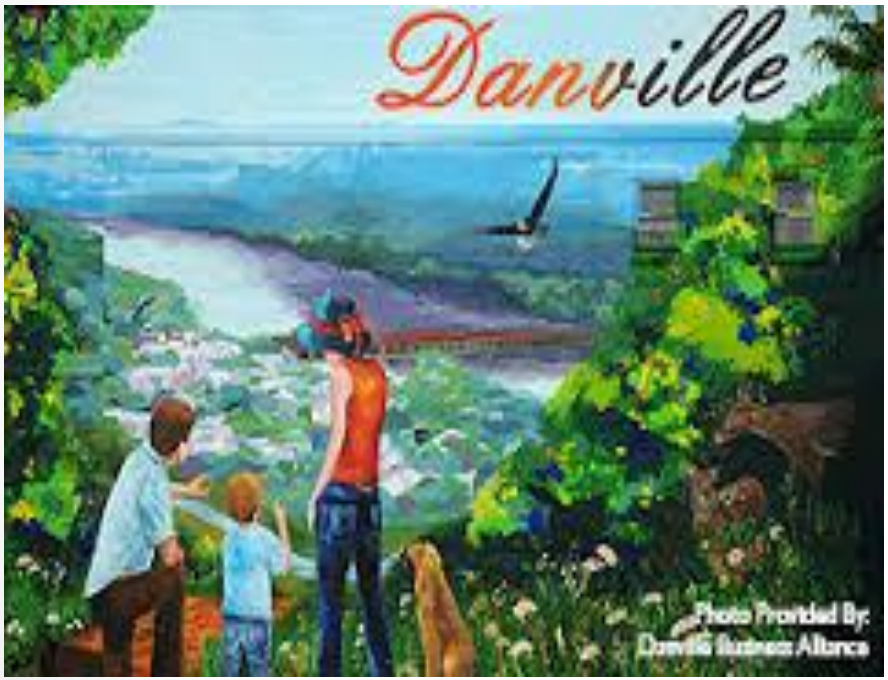
Integrated Health Services



- Geisinger Multispecialty Group Practice
- Geisinger Hospitals
- Geisinger Health Insurance Plan

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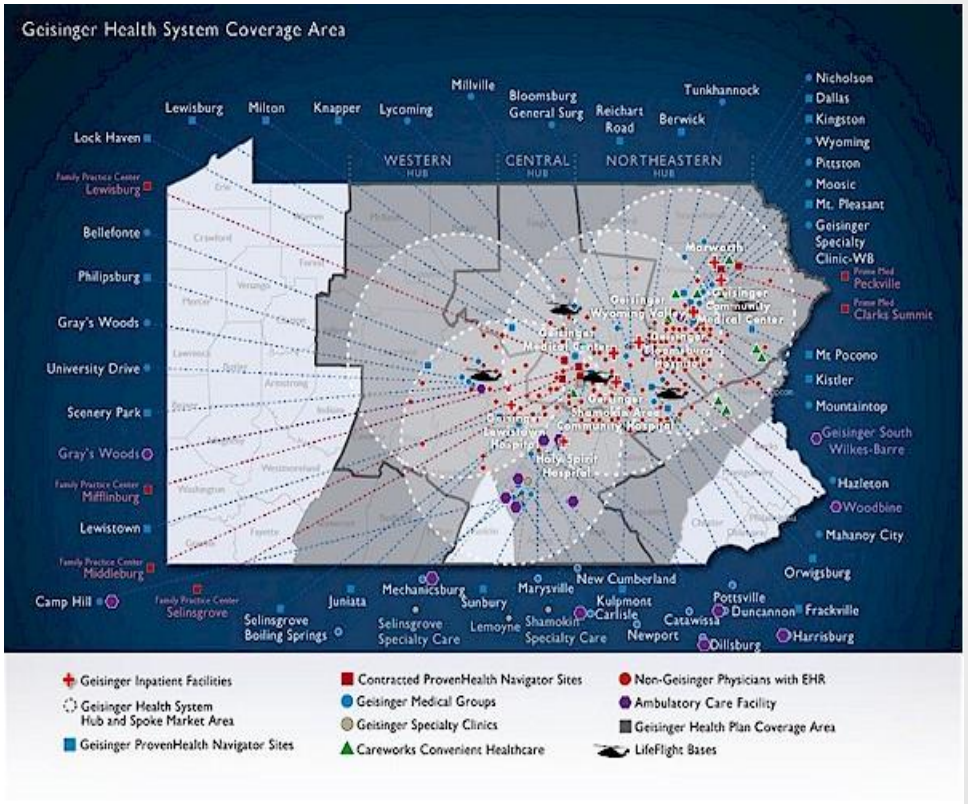
- Geisinger Health System is an integrated health services organization utilizing an electronic health record for inpatient and outpatient care
- As one of the nation's largest rural health services organizations, Geisinger serves more than 3 million residents throughout 48 counties in central, south-central and northeast Pennsylvania
- The physician-led system is comprised of approximately 23,500 employees, including a 1,200-member multi-specialty group practice, nine hospital campuses, two research centers and a 467,000-member health plan
- Estimated $7.7 billion positive impact on the Pennsylvania economy



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Who, What, Where, When

Geisinger Diabetes & HTN System of Care

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Diabetes Patient Inclusion Primary Care standards

- 18 years of age and older
- One or more of the completed office visits within the past year
- Patient has a diagnosis of Diabetes on their problem list.

OR

- Patients with four or more complete office visits with Diabetes encounter diagnosis within the past two years, or one unresolved Diabetic entry on Problem List
  - (Primary Care Office Visits in Fam Prac, Peds, GIM, Endocrinology encounters only).

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Diabetes Patient Exclusion [ICD-9 Code]

Primary Care Standards

- Deceased or Dismissed patients
- Nursing home active diagnosis on the problem list [E849.7]
- Palliative Care patients with active diagnosis on the problem list [V66.7 or V66.9]
- Symptomatic Care Patient diagnosis on problem list [V66.7]
- Do not Resuscitate patients with an active diagnosis on the problem list [V49.86]
- Patients residing outside PA or NJ
- Patients without a GHS Adult Primary Care Provider
- Resolved or deleted diabetes diagnosis from the problem list
- Patients with diabetes type 1 or type 2 Goal: symptoms mgmt
- Patients with health maintenance modifiers to permanently discontinue Diabetes Screens
- Test patients or Clinical Trial Patients

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Blood Pressure Technique Provider Training

- Sitting feet flat on floor, back supported
- Rest for 5 minutes, no caffeine or tobacco
- Correct cuff, correct position, bare skin
- Patient not talking or engaged in active listening….
- CHAMPIONS
  - Family Practice, General Internal Med
  - Endocrinology, Cardiology, Nephrology
  - Nursing

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Blood Pressure Measurements

Blood Pressure at Goal

(Based on Blood pressure Goal Diagnosis from Problem List)

- Last documented blood pressure is at the goal based on the blood pressure goal diagnosis on the patient's problem list.
  - In absence of provider-defined goal, measure is for <140/90.
- Blood Pressure taken from any encounter within the patient's record, uses the most recent, documented blood pressure (exclusive of Emergency Room/ Urgent Care Visit)

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Play nicely in the Sandbox

Cartoon by Steve Berry
https://www.ems1.com/ems-products/education/articles/532484-The-Sandbox-Parent-Child-Relationships-in-EMS/

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I argued that with the rapid advances being made by medical science it had become impossible for any one physician to master more than a relatively small segment of his art. Consequently a number of individuals had to share the responsibility once faced by the family doctor. Just as co-operative endeavor had become a requirement in arts and arms, business and science, finance and commerce, I reasoned that so had it become necessary in medicine, particularly in medicine practiced in a modern medical center such as we envisioned.

HL Foss, MD

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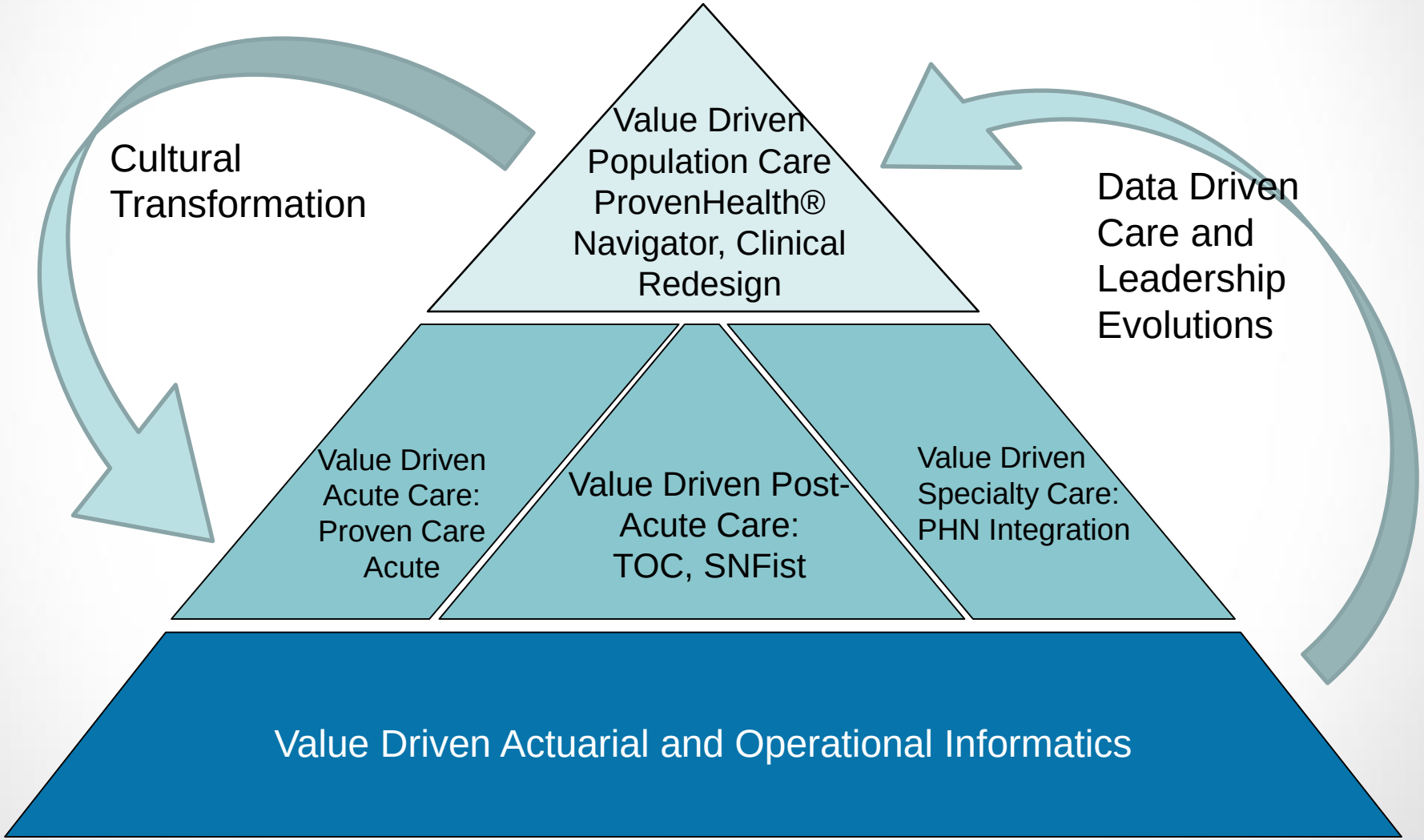
The Functional Components of Population Health



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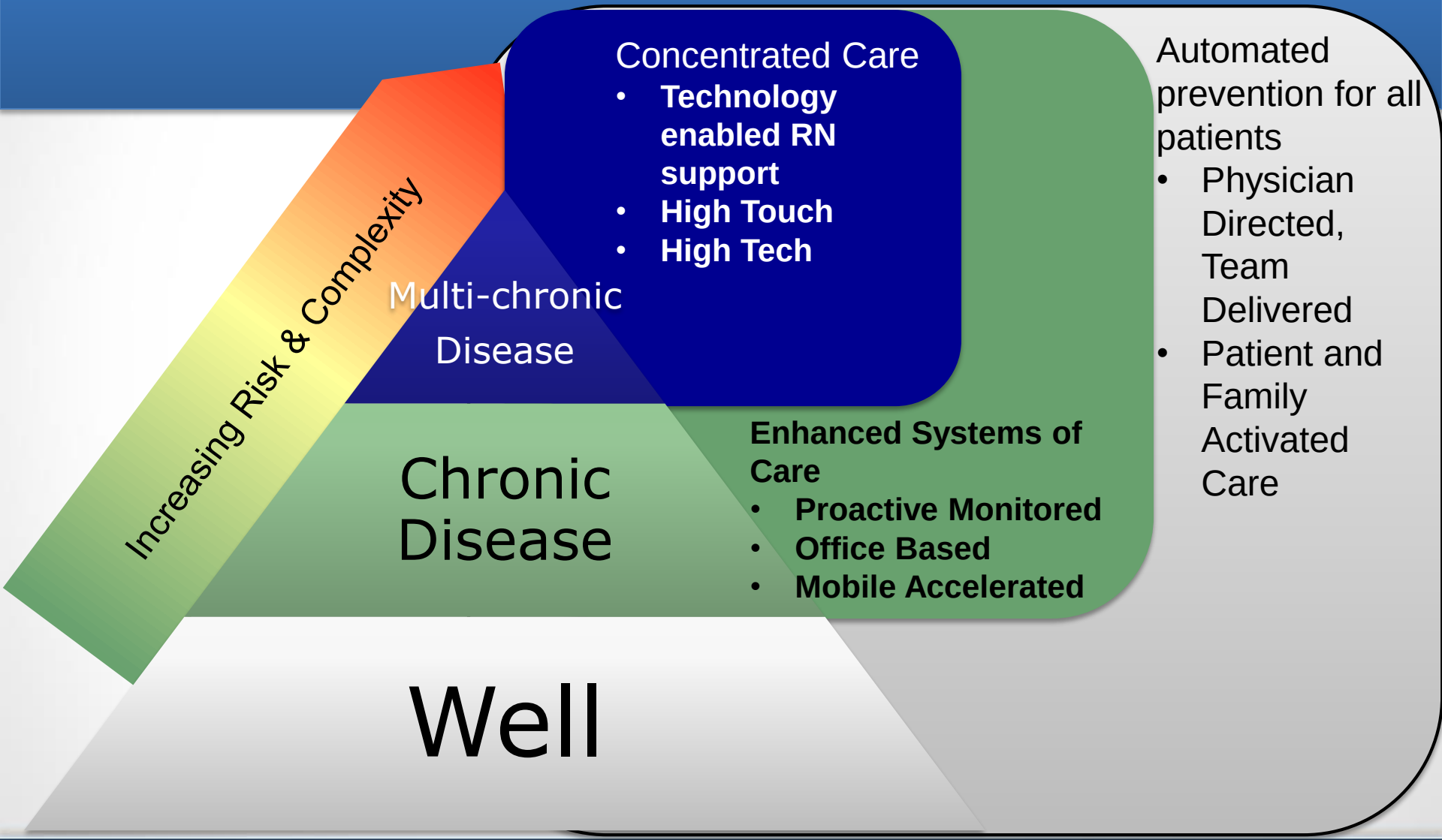
Clinical Foci for Population Care



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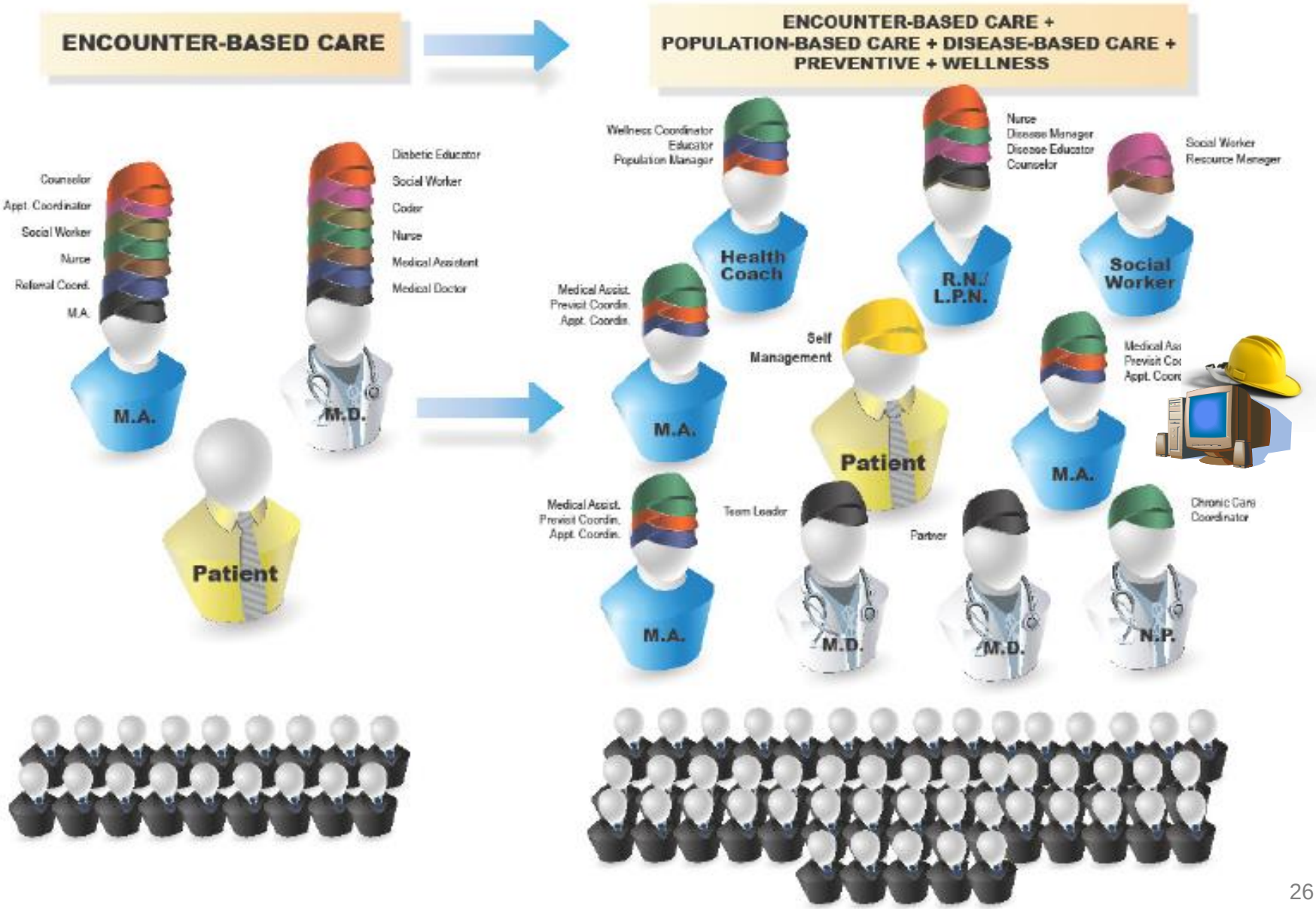
ENCOUNTER-BASED CARE
ENCOUNTER-BASED CARE +
POPULATION-BASED CARE + DISEASE-BASED CARE +
PREVENTIVE + WELLNESS
Counselor
Appt. Coordinator
Social Worker
Nurse
Referral Coord.
M.A.
M.A.
Diabetic Educator
Social Worker
Coder
Nurse
Medical Assistant
Medical Doctor
M.D.
Patient
Wellness Coordinator
Educator
Population Manager
Health Coach
Nurse
Disease Manager
Disease Educator
Counselor
R.N./ L.P.N.
Social Worker
Resource Manager
Social Worker
Medical Assist.
Previsit Coordin.
Appt. Coordin.
M.A.
Self Management
Patient
M.A.
Medical Assist.
Previsit Coordin.
Appt. Coordin.
M.A.
Team Leader
M.D.
Partner
M.D.
Chronic Care Coordinator
N.P.

Workflow Redesign

1. **Eliminate** non-value added work
2. **Automate** work that can be done by a computer or done outside an office encounter
3. **Delegate** work that is done at an office visit to trained non-physician staff when possible
4. **Incorporate** new workflows into the provider practice - "Hardwire" with reminders and EHR tools to enhance the reliability and efficiency of care
5. **Activate** the patient with EHR assistance when possible

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Process Redesign

Automate manual work	**EHR**	
		• Reminder letters— Care Gaps Outreach • Pre-visit planning
Delegate to trained, non-physician staff	**Clerical**	
		• Schedule flu/pneumococcal, follow-up
	Clinical Nurse	
		• Immunizations, lab testing, foot exam
	Case Manager	
		• High-intensity coordination/education
Incorporate new workflows into provider practice	**Nurses**	
		• Rooming process - Evidence-based Alerts
	Providers	
		• Evidence-based alerts and reminders for complex decisions
Activate	**Patients and Providers**	
		• Patient portal, patient report cards

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Geisinger Patient-Centered Clinical Continuum of Care

Population Health and Care Management

Achieved through integrated care delivery

Community-Based Care

Specialty Outreach ("Face-to-face" & Telemedicine)

Ambulatory Care & Surgery Center

Multi-Specialty Clinic

Urgent Care Center

Specialty Center, e.g. Cancer or Sleep

After-Hours Care Center

Community Practice Site

E-Visit MyGeisinger

Retail Clinic

Imaging Center

Wellness

Retail Pharmacy

Lab Outreach Site

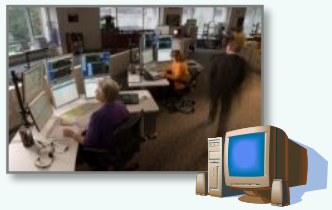
Work Site Clinic

Acute Care

Tertiary/Quaternary Medical Center

Destination Medicine

eICU



Post-Acute & Transitional Care

Inpatient Rehab

Skilled Nursing/ LTACH

Outpatient Rehab

Adult Health Program & Day Center

Home Care

LIFE Geisinger

Hospice

ProvenHealth Navigator®

Last updated June 28, 2011; Rev. September 10, 2013

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Diabetes & Hypertension Geisinger Results

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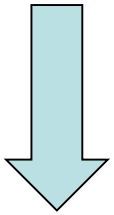
Endocrinology Specialty Diabetes Bundle June 2015



PROV / DEPT	# DIABETES PTS	% W/ PNEUMONIA VACC	% W/A1C ORDER PST 6 MOS	% W/A1C at Goal	% W/ LDL ORDER	% W/ LDL < 100 or < 70 IF CAD DX ALSO	% W/ MICROALB RESULT PST YR	% DOCUMENTED NON-SMOKER	% BP at goal	% COMPLIANT w/ ALL CPSL MEASURES	% W/RETINAL EXAM	% W/ DIABETIC FOOT EXAM	% W/ INFLUENZA VACC
08/1/2013 - 07/31/2014	2,864	74%	84%	40%	91%	63%	76%	87%	76%	15%	47%	76%	69%
09/1/2013 - 08/31/2014	2,856	74%	84%	42%	90%	63%	75%	87%	76%	15%	48%	76%	69%
10/1/2013 - 09/30/2014	2,870	73%	84%	42%	91%	63%	75%	87%	75%	15%	49%	77%	69%
11/1/2013 - 10/31/2014	2,790	74%	84%	42%	91%	62%	75%	87%	75%	14%	49%	77%	68%
12/1/2013 - 11/30/2014	2,806	74%	83%	42%	90%	62%	75%	87%	74%	15%	51%	77%	68%
01/1/2014 - 12/31/2014	2,834	74%	83%	42%	90%	63%	76%	87%	74%	15%	52%	77%	57%
02/1/2014 - 1/31/2015	2,847	73%	83%	41%	90%	62%	75%	87%	75%	15%	51%	78%	59%
03/1/2014 - 2/28/2015	2,834	73%	82%	41%	89%	63%	75%	88%	75%	15%	52%	78%	61%
04/1/2014 - 3/31/2015	2,858	73%	83%	40%	90%	62%	75%	88%	75%	14%	51%	78%	63%
05/1/2014 - 4/30/2015	2,840	73%	83%	41%	90%	61%	75%	88%	76%	14%	51%	77%	63%
06/1/2014 - 5/31/2015	2,821	73%	84%	42%	90%	62%	75%	88%	77%	15%	52%	78%	64%
07/1/2014 - 6/30/2015	2,880	72%	84%	43%	90%	61%	75%	88%	77%	15%	51%	77%	65%

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Improving CAD Care for 17,227 Patients

	9/06	3/07	4/14
CAD Bundle Percentage	8%	11%	26%
% LDL <100 or <70 if High Risk	38%	37%	62%
% ACE/ARB in LVSD,DM, HTN	65%	66%	79%
% BMI measured	79%	86%	99%
% BP < 140/90	74%	74%	79%
% Antiplatelet Therapy	89%	91%	95%
% Beta Blocker use S/P MI	97%	97%	97%
% Documented Non-Smokers	86%	86%	86%
% Pneumococcal Vaccination	80%	80%	81%
% Influenza Vaccination	60%	74%	79%

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Improving Diabetes Care for 27,788 Patients

	3/06	3/07	2/14
Diabetes Bundle Percentage	2.4%	7.2%	14.2%
% Influenza Vaccination	57%	73%	75%
% Pneumococcal Vaccination	59%	83%	79%
% Microalbumin Result	58%	87%	78%
% HgbA1c at Goal	33%	37%	46%
% LDL at Goal	50%	52%	60%
% BP < 140/80	39%	44%	65%
% Documented Non-Smokers	74%	84%	85%

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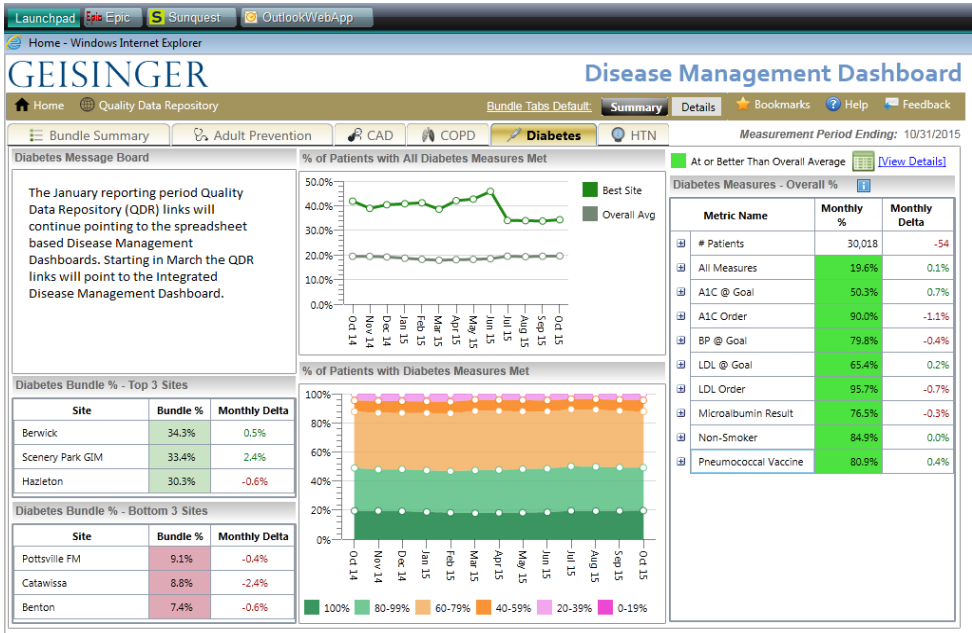
Geisinger Community Practice Diabetes Bundle Oct 2015



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GHP 2013 HEDIS Performance

Geisinger Clinic Rate much better than the Panel Provider Rate

Measure/Submeasure	Overall GHP Rate	Geisinger Clinic Rate	Panel Provider Rate	Difference
Adolescents Immun(1)	85.27%	90.32%	82.63%	7.70%
Adolescent Well Care Visits	58.89%	66.67%	57.33%	9.30%
Adult BMI Assessment	88.83%	98.12%	83.57%	14.50%
Childhood Immun Status (3)	86.68%	90.70%	83.44%	7.30%
Cholest Mgmt/LDL-C < 100	66.93%	73.62%	62.18%	11.40%
Comp Diab/BP < 140/80	58.65%	69.78%	51.24%	18.50%
Comp Diab/Eye Exam	69.88%	81.17%	61.96%	19.20%
Comp Diab/HbA1c <7	43.60%	48.19%	39.62%	8.60%
Comp Diab HbA1c <8	71.10%	73.58%	69.02%	4.60%
Comp Diab/HbA1c Poor Control	16.23%	11.11%	19.62%	-8.50%
Comp Diab/LDL-C < 100	58.81%	66.94%	52.89%	14.10%
Comp Diab/LDL-C Screening	90.74%	94.31%	88.18%	6.10%
Comp Diab/Monitor Nephropathy	89.20%	94.72%	85.33%	9.40%
Controlling HBP	73.02%	79.21%	69.49%	9.70%
Lead Screening in Children	35.94%	63.16%	31.19%	32.00%

Measure/Submeasure	Overall GHP Rate	Geisinger Clinic Rate	Panel Provider Rate	Difference
Antidepressant Mgmt Acute Phase	74.36%	78.76%	71.10%	7.70%
Antidepressant Mgmt Cont Phase	63.32%	71.43%	56.38%	15.00%
App Test for Children with Pharyn	79.25%	87.60%	74.97%	12.60%
App Tx for Children w URI	90.28%	92.59%	86.83%	5.80%
Avoidance of AB Treatment for Bronchitis	22.68%	25.47%	19.79%	5.70%
Breast Cancer Screening	75.35%	80.54%	70.42%	10.10%
Cervical Cancer Screening (CM)	78.99%	82.15%	75.39%	6.80%
Chlamydia Screening in Women	41.25%	47.67%	34.11%	13.60%
Colorectal Cancer Screening (HED)	72.01%	79.32%	66.67%	12.70%
Engage of AOD Dep Tx Total	15.52%	21.24%	11.85%	9.40%
Glaucoma Screening	76.85%	82.26%	72.43%	9.80%
Childhood Immunization Status-Hepatitis A	86.53%	93.82%	80.63%	13.2%
HPV Vaccine Female Adolescents	19.37%	24.27%	15.51%	8.80%
Childhood Immunization Status-Influenza	73.53%	81.40%	67.19%	14.2%
Osteoporosis Management in Women	59.20%	68.20%	53.29%	14.9%

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Why?
Leap of Faith…

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Patient Centered Outcome Improvements

AM J Manag Care. 2014; 20(6); e 175-e 182

•Microvascular

- Retinopathy
  - Less than three years
  - Number needed to treat to avoid one case: 151
- Intention to treat type analysis, e.g. does the patient's physician employ a system of care or not, regardless of patient adherence to the system of care (bundle score)

•Macrovascular

- Heart Attack
  - Less than three years
  - Number needed to treat to avoid one heart attack: 82
- Stroke
  - Less than three years
  - Number needed to treat to avoid one stroke: 178

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How

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Geisinger Soup

- Multi-specialty Medical group practice including PCP & Specialists
- Fully integrated Electronic Health record
  - Best Practice Alerts
  - Health Maintenance
- Data warehouse integrate disparate data sources to enable reporting
- ADA DSMT Program
  - 50+ outpt sites
  - Inpatient Diabetes Ed
- GHP Case Managers
  - Embedded in PCP office
- Pharmacists MTM
  - Polypharm, Med Recon
  - Coumadin Clinic
  - HTN, DM, Lipid
- Loyal patients who trust Geisinger brand
  - Sweet Spot

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REDEFINING BOUNDARIES

Lessons Learned

- The role of automation
- The role compensation
- The role of structure
- The role of funding
- The role of leadership
- The role of feedback
- The role of culture
- The role of the patient

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"Let us bear in mind that the most important individual after all is the patient. Our paramount thought must be to provide him means by which he can have skilled diagnostic and therapeutic service in as complete form as may be indicated in a given case, in the shortest possible time consistent with thoroughness, and at the least cost to him." *HL Foss, MD 11/4/1950*

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Geisinger Strives to Achieve The Triple Aim…

- Higher Quality
  - Diabetes Bundle
  - Reduced Complications
- Better Patient Experience
- Lower Total Cost of Care
  - Medical Home

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Geisinger 1915- 2015

A century of Transformation and Innovation

- Last 100 Years: Creating Systems to *change provider behavior* with a goal to improve both the *quantity and quality* of care delivered to patients

- Next decade: Creating Systems to *empower patient access* to the highest *quality of care* delivered at *reduced cost* while providing a world class *patient experience*

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Geisinger Technology

Engaging patients in a Rural Health Care Environment

- Telemedicine
  - eICU,
  - Inpatient Consults, Outpatient visits
- *My Geisinger* Web Portal 250,000 patients
  - Directly email your physician
  - All Laboratory and Radiology Reports
  - *Open Notes* Physician Progress Notes for patients
  - *Ask A Doc* Electronic Curbside Consults
- Text messaging
  - Appointment reminders & Preventive Health
  - Weight Management & Diabetes Education
- *My Code* Genetics Collaborative w/ Regeneron
  - 100,000 Whole Exome Sequences

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• Alistair Erskine, MD	CIO
• David Feinberg, MD, MBA	CMO and CEO

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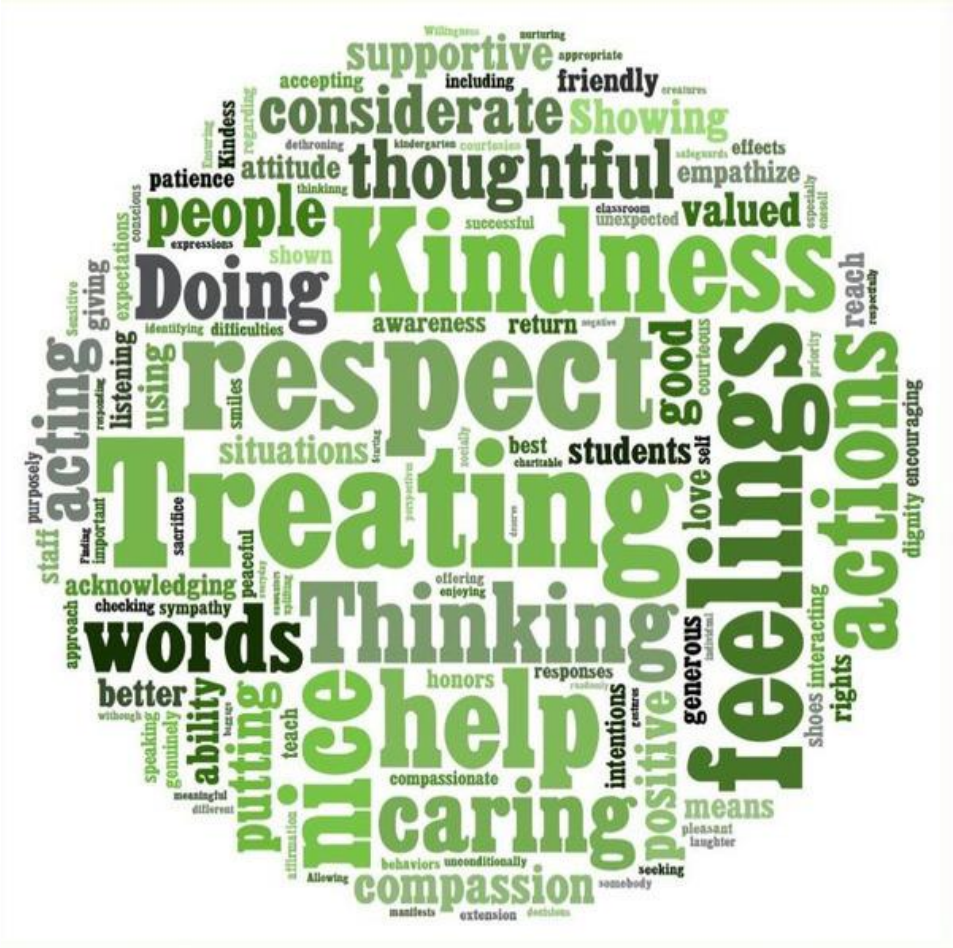
Geisinger *Proven Experience*

"People Caring for People"

100% Satisfaction Guaranteed



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AMGF Diabetes Campaigns: MUPD =>Together 2 Goal

- Abigail Geisinger

- Make this campaign right; make it the best…
- Improve care for 1 million patients with Type 2 Diabetes
- What's your role?
- Let's begin !

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