AMGA

Advancing High Performance Health

AMGA Foundation

Chronic Care Roundtable

September 11, 2017 • Indianapolis, Indiana

Meeting Summary

AMGA Foundation

Chronic Care Roundtable

On September 11-12, 2017, AMGA Foundation hosted its fourth annual Chronic Care Roundtable, a forum created to equip health systems to address the needs of those with chronic conditions.

This year's event explored ways to improve medication adherence and ways to strengthen patient and care team communications. Three out of four Americans do not take medications as directed; in fact, one out of three doesn't even get their prescriptions filled. Poor medication adherence costs the United States approximately $290 billion per year and is believed to be the cause of 33-69% of hospitalizations.

Presenters, panelists, and participants examined these issues with a focus on diabetes and shared their challenges, lessons learned, and recommendations for the Together 2 Goal® (T2G) campaign.

Welcome

Welcoming remarks were delivered by Kevin McCune, M.D., chief medical officer of Advocate Medical Group, senior medical director of Advocate at Home, and Chair of the AMGA Foundation Board, and Jerry Penso, M.D., M.B.A., President and Chief Executive Officer, AMGA (Dr. Penso was president, AMGA Foundation, and chief medical and quality officer for AMGA at the time of the meeting).

Together 2 Goal® Updates

Through a framework for improving care, a measurement system to assess outcomes, and key tools and resources, T2G, AMGA Foundation's second Chronic Care Challenge campaign, aims to improve care for 1 million people with Type 2 diabetes by 2019.

Launched in 2016 with an event featuring world champion boxer Sugar Ray Leonard and more than 700 AMGA members and supporters, T2G engages 150 groups in 35 states through a toolkit of resources, monthly campaign webinars on diabetes management, and quarterly data reporting, as well as a National Day of Action reaching 2 million Americans. Participants have noted improvements in baseline reporting in A1c control, blood pressure control, medical attention for nephropathy, lipid management, and a bundle of those four measures.

2017 Goal-Getter Success Stories

Read about achievements of some of T2G's most successful groups at **together2goal.org/Improve/goalGetters_improve.html**.

- **The Baton Rouge Clinic:** Keeping Eyes on the Prize with EHR Alerts
- **Geisinger Health System:** Scoring Big with EHR Point-of-Care Tools
- **Pinnacle Health System:** It Takes a Team to Improve Outpatient Diabetes Control
- **Premier Medical Associates:** Enhancing Performance by Going Head to Head with Cardiovascular Disease Risk

Campaign Highlights

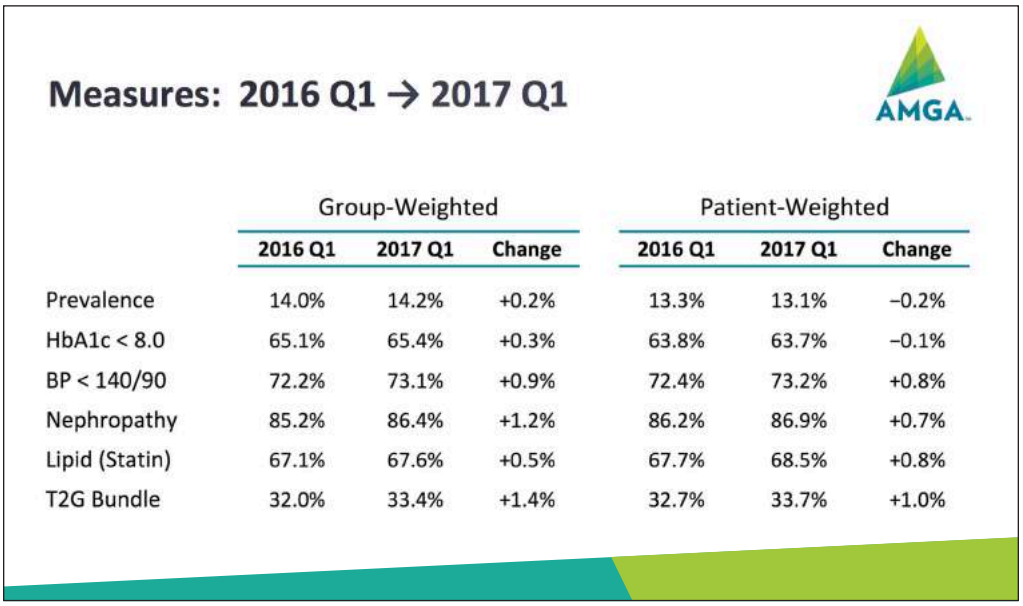
Kendra Dorsey, director of national health campaigns for AMGA, shared campaign highlights for 2017, including:

- The September 12-13 Diabetes Symposium in Indianapolis, where participants discussed the adoption of a treatment algorithm, assessment of cardiovascular disease risk, and the integration of emotional and behavioral support into treatment
- An article in *Group Practice Journal (GPJ)* that highlighted T2G's partnership with the American Diabetes Association (ADA)
- An 18-month Innovator Track that gives participants the opportunity to explore topics including cardiovascular disease and eye care for patients with diabetes
- The November 9, 2017, National Day of Action, with activities co-hosted by ADA
- The November 7 release of results from the Year 2 survey
- A video for provider education, "Six Tips to Fine-Tune Your Diabetes Office Visits"

Attendees viewed a video for T2G providers: "Six Tips to Fine-Tune Your Diabetes Office Visits"

Measuring Outcomes

John Cuddeback, M.D., Ph.D., chief medical informatics officer at AMGA, updated attendees on T2G data, with a spotlight on Q1 2017 measurements. For 1.1 million patients with Type 2 diabetes, across 97 AMGA member organizations, several key measures improved from the Q1 2016 baseline.



Measures: 2016 Q1 → 2017 Q1

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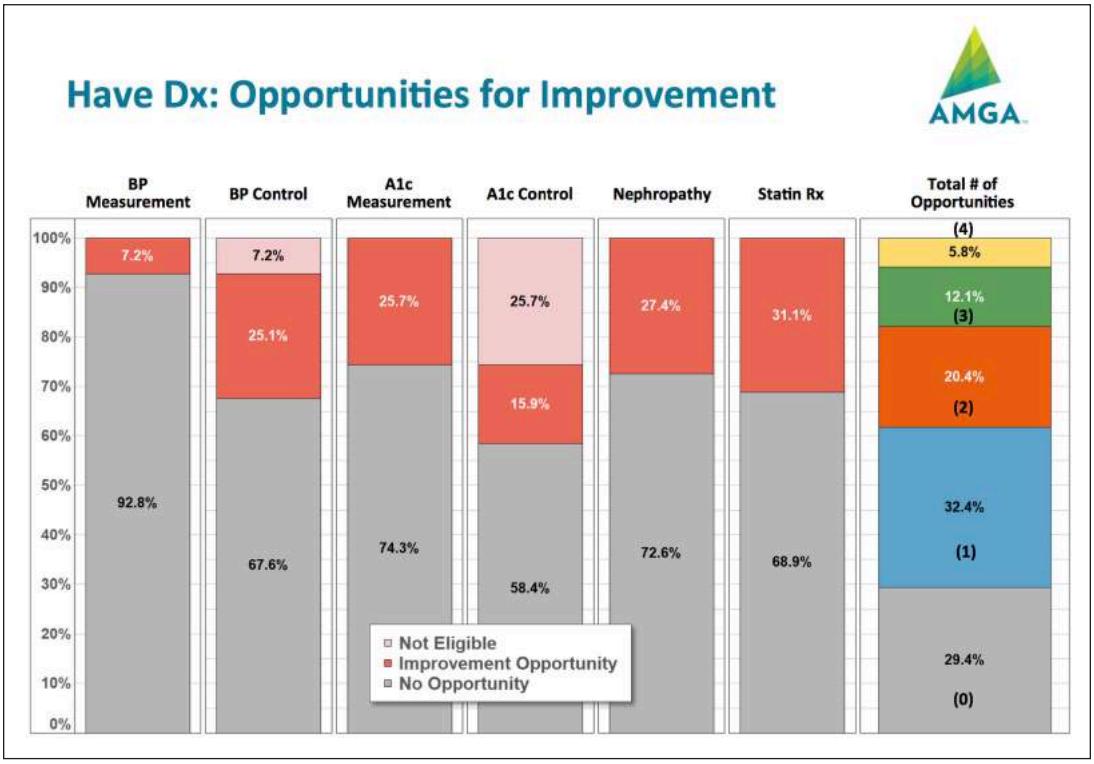
	Group-Weighted			Patient-Weighted		
	2016 Q1	2017 Q1	Change	2016 Q1	2017 Q1	Change
Prevalence	14.0%	14.2%	+0.2%	13.3%	13.1%	−0.2%
HbA1c < 8.0	65.1%	65.4%	+0.3%	63.8%	63.7%	−0.1%
BP < 140/90	72.2%	73.1%	+0.9%	72.4%	73.2%	+0.8%
Nephropathy	85.2%	86.4%	+1.2%	86.2%	86.9%	+0.7%
Lipid (Statin)	67.1%	67.6%	+0.5%	67.7%	68.5%	+0.8%
T2G Bundle	32.0%	33.4%	+1.4%	32.7%	33.7%	+1.0%

Dr. Cuddeback walked through the calculations and logic behind these findings, including:

- A look backward, to ensure that any improvements are sustained through end of current measurement period
- Evaluation of newly diagnosed patients and new patients already diagnosed with diabetes
- Extrapolation of data from A4i groups (AMGA's Analytics for Improvement Collaborative) to self-reporting and non-reporting groups

Dr. Cuddeback then suggested the following screening guidelines for patients with a diagnosis of Type 2 diabetes.

- If A1c has not been measured, measure it. If it's ≥ 8.0, bring it into control.
- If blood pressure has not been measured, measure it. If it's ≥ 140/90, bring it into control.
- If no medical attention has yet been paid to nephropathy, screen/diagnose for it or refer the patient to a nephrologist.
- If no statin has been prescribed and the LDL ≥ 70 mg/dL, prescribe (or re-try) a statin.
- For patients with no prior diagnosis on claims or problems lists, review clinical data for evidence that may suggest Type 2 diabetes.



Session I:
Pharmacy Panel - Adherence

Moderated by Mitchel C. Rothholz, R.Ph., M.B.A., Chief Strategy Officer, American Pharmacists Association

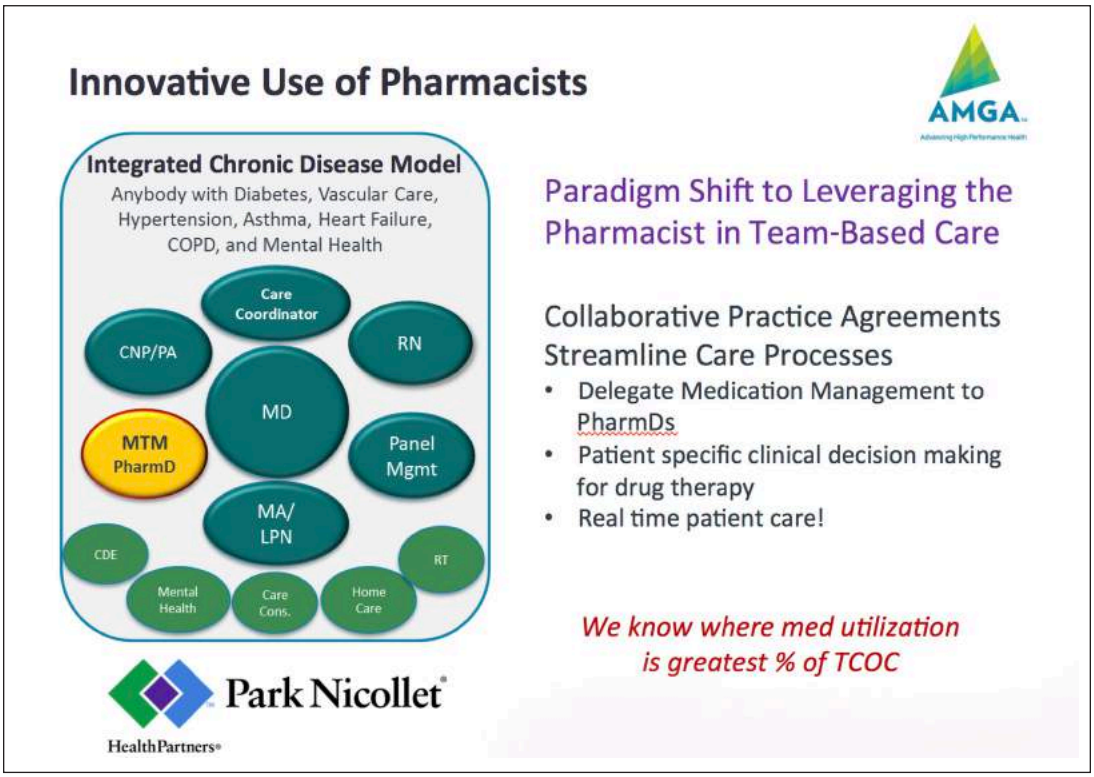
Panelist: Molly Ekstrand, R.Ph., BCACP, AE-C
Medication Management Program Lead, Park Nicollet HealthPartners Care Group

With a budget of $1.7 million and just over a dozen full-time pharmacy professionals, Park Nicollet HealthPartners resolved 87% of more than 15,000 medication-related problems. The secret to this success: Strong relationships and a holistic view.

"You can't look at adherence in a silo," Ekstrand said. For patients, consider medications in the context of daily life. For example, many patients with diabetes have other chronic conditions, so their diet for diabetes may interact with other drugs or foods like leafy greens. Medication costs can be a huge burden for patients with high deductibles, and many don't understand rebates.

Sometimes care teams are so focused on guidelines that they can miss the patient's perspective. Align care priorities with patient priorities.

Then support these priorities with team-based care. At Park Nicollet HealthPartners, Ekstrand's team leveraged pharmacists as medication specialists and used collaborative practice agreements to give them authority over medications for multiple chronic conditions, such as diabetes, vascular care, hypertension, asthma, and heart failure.

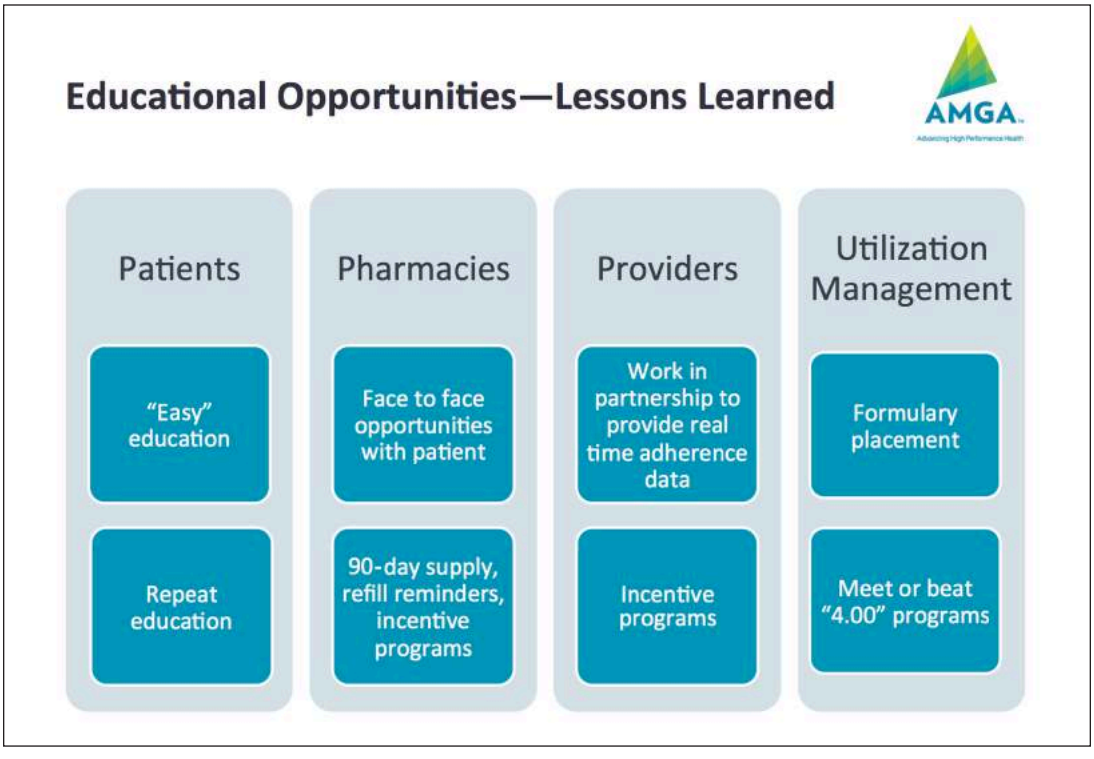


Panelist: Mitzi Wasik, Pharm.D., BCPS
Medicare Stars, Business Lead, Aetna

Medicare Stars supports 20 national Medicare Supplement Part H contracts for over a million members across a range of contract sizes. The program has seen year-over-year improvements in medication adherence for patients with diabetes, and with substantial money on the line (rebates depend on high star ratings), there's incentive to get even better.

Wasik shared her recommendations:

- Keep tactics simple, such as adherence "scorecards" that serve up the most pertinent information. Providers are already overwhelmed by communications from multiple business lines, companies, and payors.
- Extend this simplicity to patient education. Instead of assigning patients "homework," aim to weave guidance into conversations and follow-up, and focus on the long-term journey.
- Engage and incentivize pharmacists and quality nurse managers, to move some of the adherence burden from busy doctors.
- Expand this team approach to include caregivers, community resources, and retail pharmacies, which some patients may prefer to visit over getting medications in the mail.
- Look at readmissions as a possible indicator of issues like gaps in therapy or duplicate therapies.
- Engage patients—but trust data as a true measure of progress. Aetna shares real-time adherence data with providers to help them better understand their patients.



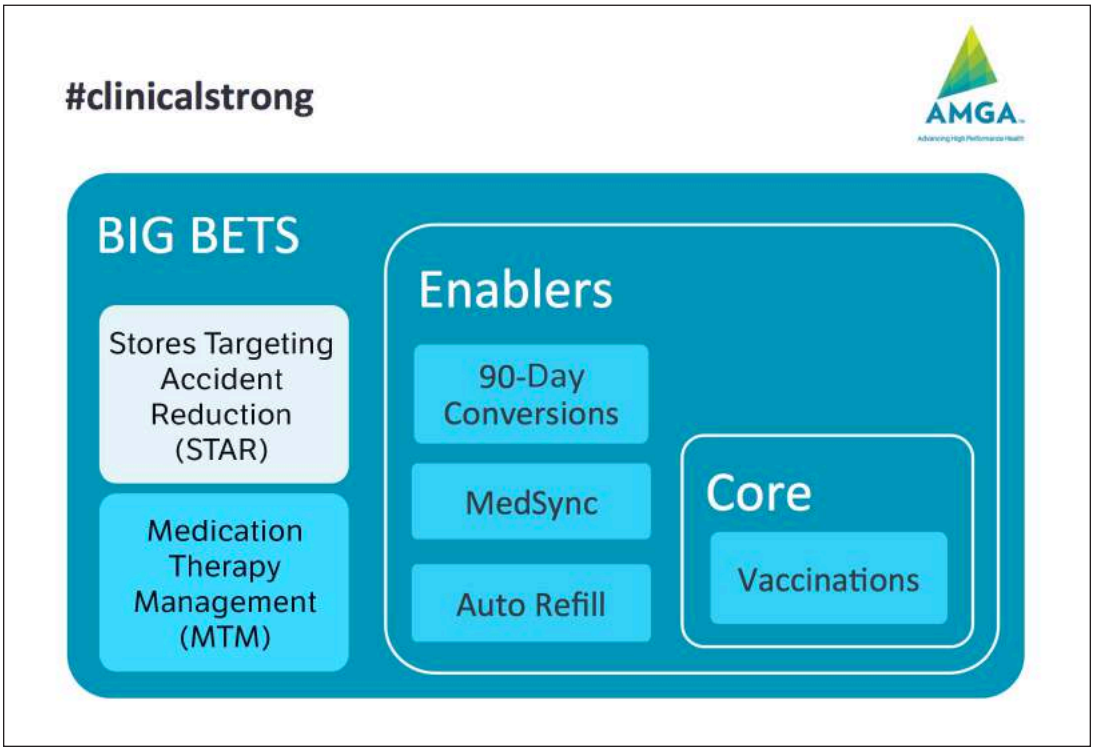
Panelist: Jim Kirby, Pharm.D., BCPS, CDE
Senior Director, Pharmacy Services, The Kroger Co.

Filling 185 million prescriptions annually through more than 2,200 pharmacies and 7,000 pharmacists, The Kroger Co. is in a position to improve medication adherence nationwide. Kirby shared highlights from its #ClinicalStrong program.

"At the beginning of the year, adherence is higher, but as the year goes on, the ratings performance declines," he said. Kroger aims to improve this picture through minimizing reporting for pharmacists and empowering patients with programs like MedSync, which enables the same-day pick-up of refills. Pharmacists are encouraged to communicate "consistently and persistently" with patients and employ therapy management in a way that is both comprehensive and targeted.

"But just talking to patients or using MedSync is not enough," he said. Kirby stressed the need for data—and putting this data to use. "We need to examine: What does a successful intervention look like? Do the improvements last over time?"

To help pharmacy teams track their progress—and incentivize them to achieve even more—Kroger created a dashboard linking STAR criteria to other metrics, like CMS requirements. One store with a rating of less than three stars became a five-star store in under 20 months. Pharmacies that achieve a certain level of performance on specified quality measures can earn rebates on their DIR fees (which pharmacies participating in Medicare Part D pay to reduce patient premiums and out-of-pocket spending).



Questions for the Panel

What programs worked best?
Panelists cited MedSync and auto-refill initiatives, as well as refill bundling (in states with mail-order or retail Medicare prescription refills) to bypass a call to the doctor. Local pharmacies may offer convenience by being able to fill some 90-day prescriptions, yet program availability can vary, especially in rural areas. Panelists also reported success with team-based care, large-dollar contracts, and quality initiatives, but cautioned that these interventions can be difficult because there's little fee-for-service revenue for pharmacists.

How can manufacturers help?
They can partner with associations like American Pharmacists Association (APhA) and support practice-based research to help fill the need for more publications and funding in the area.

What else can providers try?
Panelists suggested looking at adherence through a broader scope with tactics like counseling through diabetes health coaches, diet-focused initiatives, and collaborative partnerships with grocery stores.

Any thoughts on oral versus injectable training (for patients who have experienced no improvements with lifestyle changes)?
Do you have resources for it in your system? Are patients comfortable with injectables, and is your organization comfortable training care teams on them? Although data support success for some offerings, like MedSync, no definitive answers exist yet on overall effectiveness.

Roundtable Recommendations

- Align with patient and system priorities.
- Start small and focused to show quick wins.
- Address adherence in context of medication optimization.
- Drive team performance through the appropriate use of quality measures.
- Leverage pharmacists as knowledgeable and capable team members.

Adherence Breakout Discussions

Allocating resources. Implementing the right processes, tools, and evaluation measures. Finding the correct regime and getting everyone to opt in, from insurers to healthcare teams to patients. Medication adherence is vital to managing chronic diseases like diabetes, yet health systems face many challenges. How do you identify the low-hanging fruit? How do you get the right information to the right people, and leverage this data for more efficient, effective operations and improved patient outcomes?

In three group discussions, participants shared their challenges, recommendations, and suggestions on improving adherence for T2G.

Facilitator: Deloris Berrien-Jones, M.D., FACP, *Internal Medicine, Physician Champion Diabetes Initiative, Henry Ford Medical Group/Henry Ford Health System*

Participants cited their own experiences with predictive modeling, medication management, registries, and point-of-care tools. But these resources were only part of the story. "Adherence isn't important if medication isn't proper," one participant emphasized, ushering in a discussion on the need for standard screening tools and medication reviews at each doctor's visit. Providers also need to support non-adherent patients with resources (but no homework!), coaching, and guidance on the lowest copays to prevent nonmedical medication switching.

Roundtable Recommendations

- Use videos and presentations to share data about specific interventions and best practices.
- Measure the impact of interventions against a control group. Align data with metrics and other guidelines to help providers identify the most actionable opportunities.
- Stratify risk and narrow focus to a specific geographic area or patient population.
- Keep adherence simple for patients. Study how they take their medications at home and get their feedback through partnerships with providers and pharmacists.
- Support patients via channels like a community website that enables discussions on cost.
- Develop an affordability guide to help patients manage out-of-pocket costs and a cost marketing guide for pharmacies.
- Capture scripts to study primary non-adherence, and examine adherence interventions in a standardized way through multi-site studies.

Facilitator: Kevin McCune, M.D., *Chief Medical Officer of Advocate Medical Group, Senior Medical Director of Advocate at Home, Chair, AMGA Foundation Board*

Participants cited adherence tactics from their own practices, including the patient-based resources, provider scorecards, partnerships with technology providers, and training/materials for CDEs and RNs. They've been streamlining performance measures, working with payors to identify members, using data to target areas of opportunity, and leveraging pharmacists, embedding them in primary care practices and engaging them in collaborative care management and practice agreements.

Roundtable Recommendations

- Engage stakeholders across the industry, including other health organizations, to develop a more holistic community pharmacy strategy. Then be as flexible and collaborative as legal and regulatory barriers allow.
- Coordinate efforts to avoid duplication.
- Place the pharmacist at the center of the care team to help identify the patients with the highest noncompliance risk.
- Use predictive analytics for identifying likely noncompliance. Then develop an adherence score for all patients, not just certain payors.

Facilitator: Theresa Frei, R.N., M.B.A., *Chief Executive Officer, Sutter Medical Foundation/Sutter Physician Alliance*

Improved medication adherence requires an understanding of patient behavior (especially the physical, mental, and emotional toll of diabetes), data, patient education, focus, and ongoing communication, participants reported from their own experiences. They've found success with prevention efforts, Lean processes, vouchers/savings cards, and continuous glucose monitoring.

Roundtable Recommendations

- Encourage simple solutions (e.g., health apps for education in the waiting room).
- Educate providers and medical school programs on diabetes, devices, coverage policies, and reimbursement. Share decision-making and allow clinicians to be problem-solvers.
- Employ patient-centered tactics (e.g., focus groups to better understand adherence issues, simple screening tools to understand medication use and interactions, and long-term coaching for encouragement and increased health literacy).
- Identify local and cultural resources that can help patients make lifestyle changes.

Session II:
Medical Group Panel – Patient and Provider Communications

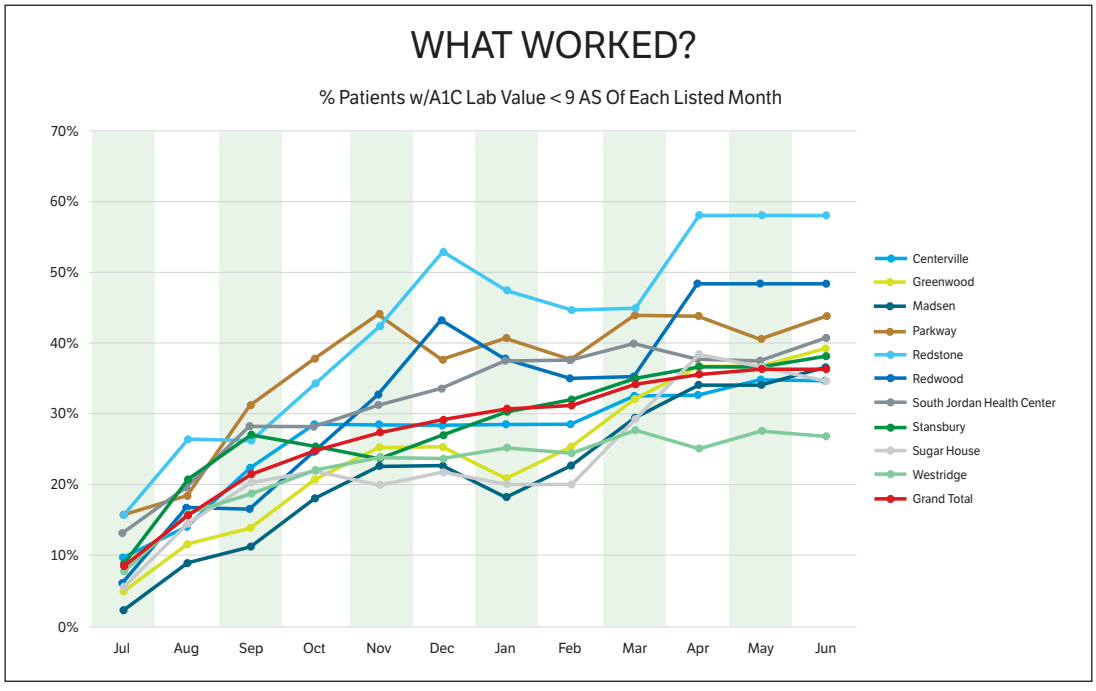
***Moderated by John W. Kennedy, M.D.**, Chief Medical Officer, AMGA, and President, AMGA Foundation (at the time of the meeting, Dr. Kennedy was Endocrinology Department Director, Geisinger)*

Panelist: Julie Day, M.D.
Medical Director, University Community Physician Group, University of Utah

Without strong communication and coordination, patients with diabetes (especially those with comorbidities) might end up seeing several people in a health system, according to Dr. Day. Combatting this trend requires technology, process improvement, and cultural change.

Her team identifies gaps in care through a centralized care navigation center that feeds information into a diabetes registry. Patients in this registry who aren't in control within 30 days must check in with a clinical pharmacist or primary care provider. Longitudinal care plans are incorporated in a patient's electronic record to ensure care continuity and are administered through an expanded team. Social workers look at barriers impeding patients from their goals, coding for this time under "mental health" and "diabetes" to offset costs. Clinical pharmacists engage patients weekly and participate in pre-visit planning. Throughout, care team members focus on warm hand-offs and share information at care conferences.

To provide ongoing support for process improvements, four quality improvement specialists work onsite within the 11 community clinics. Meanwhile, a care manager is developing an algorithm to help overwhelmed providers make decisions about diabetes resources.



Panelist: Theresa Frei, R.N., M.B.A.
Chief Executive Officer, Sutter Medical Foundation/Sutter Physician Alliance

Busy healthcare practitioners can immediately forget what patients tell them – sometimes over 80% of the information provided, Frei told attendees. To address this situation at Sutter, her team used a grant from AstraZeneca to pilot a program based on the OpenNotes movement (opennotes.org), which encourages transparency through opening up care team notes for patients to read.

Sutter's OpenNotes application gave patients the opportunity to choose what area of risk they wanted to focus on, such as heart attack or amputation. The goal: Bring knowledge together though a single source for the patient and the healthcare provider and foster a partnership of sustained engagement.

The application decreased clicks in Epic and reduced the average time of an encounter by 20%, and patients loved it. "Delivering real data in real time leads to a higher quality relationship," Frei said.

"Patients are able to take ownership of their health and communicate their thoughts. They feel more informed and able to see what physicians are thinking," she said.

Panelist: Tony Hampton, M.D., M.B.A., CPE
Medical Director, Advocate Operating System, Advocate Health Care

Advocate's diabetes prevention program operates through increasing the use of evidence-based services and connecting patients to services outside of the clinical setting and community resources. Even though it's easy to implement, Dr. Hampton said, the program was underutilized.

His team increased participation by communicating at every stage. Advocate marketed the program to patients through local churches, grocery stores, and YMCA branches, and did research in the community to make its outreach relatable.

In the program, coaches (purposefully selected not to be physicians for greater approachability) guided patients throughout, backed by the support of interdisciplinary teams of pharmacists, nurses, care managers, behavioral health specialists, and more. Program participants signed commitment forms and found support through population health summits, which delivered education on healthy foods, medications, smoking cessation, and more outside of clinical settings.

So far, the program has helped Advocate experience a 100% reduction in Emergency Department (ED) visits and generate a projected $39,500 in cost savings.

Questions for the Panel

How effective have pharmacists been in preventing doctor burnout?
Panelists reported good early outcomes embedding pharmacists in care teams where they were welcomed and valued. Virtual pharmacists knowledgeable in patient management, who can offer prepared recommendations, have allowed doctors to spend more time with patients and focus on other issues. Such pharmacy programs can incur costs in the first year, but can save money later if operationalized well.

How do you replicate community practices?
"Pilot, cascade, and make it happen," panelists advised. They solicited front-line feedback, embedded team members in care conferences, and held process improvement meetings with highly focused agendas. They prioritized the understanding of team roles, bridging gaps, and working together. Another strong recommendation: patient engagement. "When patients take adherence seriously, it will be a disruptive force."

What about culture?
Although the current focus has been on quality measures, panelists stressed the importance of team cohesiveness. Do teams use huddles to engage and share improvements? Has a culture of "no" and fear been removed from the system? Ideally, people should feel like they're a part of decision-making, or at least that decisions are made locally. Culture is hard to measure, but organizations can start with surveys for gathering insights.

Patient and Provider Communications Breakout Discussions

As they grapple with the complexities of chronic conditions, organizations are challenged to define roles and responsibilities, partner with payors and industry, manage data, and engage patients throughout the care experience. Meanwhile, issues with coding, culture, knowledge transfer, and more hinder the ability to execute as a team.

How can providers align efforts to achieve patient "moments of truth" and improved health outcomes? How can organizations keep communications simple and efficient for all? Through three discussion groups, roundtable attendees explored answers.

Facilitator: John W. Kennedy, M.D., *Chief Medical Officer, AMGA and President, AMGA Foundation*

Working together emerged as an overarching theme for improving patient and care team communications, from engaging pharmacists as patient coaches to empowering non-physician team members. Participants cited a Diabetes Advocacy Alliance, programs like Cornerstones4Care, and strategic partnerships with groups like AMGA as ways to collaborate, activate, and educate around diabetes issues. They cited extended clinic days and hours, metrics-sharing huddles, and digital health apps as beneficial and effective tactics.

Roundtable Recommendations

- Engage an interdisciplinary team (involving a panel manager, population health, etc.), with members empowered to initiate team-based care resources.
- Educate primary care providers on simple prevention and care management strategies. Improve and clarify these strategies as necessary.
- Gain patient perspectives through Kaizen-type councils and events, and use digital health interfaces and social media to facilitate communication between patients and care teams.
- Integrate diabetes activities with screening. Share this data with clinicians.
- Reward and promote "walking the walk" through recognition activities.
- Keep things simple and focused externally on the patient rather than internally on the organization.
- Take a visionary leadership role and dream big!

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Facilitator: Kevin McCune, M.D., *Chief Medical Officer, Advocate Medical Group and Senior Medical Director, Advocate at Home; Chair, AMGA Foundation Board*

This group cited education tactics as key to improved patient and care team communications: behavioral messaging guided by market research, resources co-developed with partners for specific patient populations, risk assessments to drive patient communications, and downloadable health literacy tools (including the T2G toolkit and no-branded resources).

Partnerships are also pivotal, between health providers and payors on patient self-management programs, and across organizations to highlight best practices. Throughout, the patient remains at the center of a multidisciplinary care team, with clear roles for extended care providers and a case manager for bringing out patient concerns.

Roundtable Recommendations

- Use data and core insights to develop an action plan for today and tomorrow (including multi-year product development). Consistently track cultural evaluation measures. Make sure all team members understand care goals.
- Standardize processes and resources (e.g., use a uniform payor template for sending data to providers). Look for synergies.
- Break down silos. Engage provider and pharmacist organizations in care coordination.
- Plan more strategically around intervention sites—with integrated delivery networks and patient touchpoints, for example.
- Be an advocate and voice for patients through tactics like patient advisory committees and care teams training on how to communicate about motivation, goals, risk, and clinical trials.

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Facilitator: Theresa Frei, R.N., M.B.A., *Chief Executive Officer, Sutter Medical Foundation/Sutter Physician Alliance*

These participants reported success in leveraging digital tools (for creating conversations, supporting care management, and conducting automatic outreach), using patient-centered medical homes, incorporating social health determinants in care, and closing care gaps. Teamwork is key at every step, from aligning care coordination and patient touch points to creating accountability, getting feedback, and engaging the right team members at the right time.

Roundtable Recommendations

- Leverage coaching and huddles to harvest front-line ideas. Share IP across organizations.
- Mind the "3 Cs": coaching, culture, coordination.
- Engage patients as part of the care team and help them set goals and prioritize. Let their needs, not policy, dictate their care team point of contact.
- Educate patients on care team roles. But keep things simple—with no homework!
- Extend the care team to include community pharmacists and engage with community organizations like payor networks and state pharmacy organizations.
- Include patients and caregivers in leadership roles and care design (NCQA model).
- Identify care gaps for diabetes prescriptions. Use patient satisfaction metrics to inform data. Organize population health data into cohorts to improve care.
- Equip providers with a standard needs assessment checklist to understand behavioral drivers and needs. But let them prioritize their most important issues.

In Conclusion: Moving Forward Even Stronger

To achieve even greater success in the remaining year of T2G and in future collaboratives, roundtable participants emphasized continued—and strengthened—focus on the patient.

"Move to where the patient lives" through success stories, blogs, focus groups, patient advisory committees, and more, including a tool kit based on data collected so far. Ask them how they want to receive communications. And recruit them to the care team. "We spend so little time with the patient. They need to be part of the team."

Thank you to our Chronic Care Roundtable Corporate Members

(as of September 2017)

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