TARGET: TYPE 2 DIABETES<sup>SM</sup>
AMBULATORY QUALITY PROGRAM

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Advanced Heart Failure and Transplant Cardiologist
Kaiser Permanente in Santa Clara, California

AHA Staff:
Katherine Overton, Senior Quality Systems Program Manager, Ambulatory
DISCLOSURES

Dana Weisshaar, MD FACC

• No Disclosures
TODAY’S AGENDA

1. Know Diabetes by Heart Overview
2. Science and Rationale of Know Diabetes by Heart and Target: Type 2 Diabetes
3. Introducing: Target: Type 2 Diabetes for Ambulatory Practices
4. Getting Started with Target: Type 2 Diabetes
5. Important timelines for recognition
6. Q&A
AHA, ADA and Industry Leaders Unite

Know Diabetes by Heart™

Founding Sponsors
Boehringer Ingelheim | Lilly | Novo Nordisk

National Sponsors
Sanofi | AstraZeneca | Bayer

Leading organizations collaborate on new initiative to combat growing diabetes and cardiovascular disease threat.
Reducing CV deaths, heart attacks, strokes and heart failure in people living with type 2 diabetes.
Shared Vision & Initiative Architecture

**Our Purpose:** To reduce cardiovascular deaths, heart attacks and strokes in people living with type 2 diabetes.

- **Bolster Science**
- **Clinical Quality Improvement**
- **Health Technology Solutions**
- **Professional Outreach**
- **Patient Support & Education**
- **Consumer Activation Campaign**
- **Policy Agenda**
- **Strategic Alliances**

**Community Engagement**

**Science Drives All Activities**
**Consumer Activation Campaign**
- New initiative with a full scale communications campaign
- Increase awareness and understanding of the link between CVD and type 2 diabetes
- Encourage people with diabetes to have a conversation with their doctor
- Initial Call-To-Action:
  - knowdiabetesbyheart.org
  - Take the quiz to learn about your risk
  - Download the discussion guide

**Patient Resources & Support**
- Know Diabetes By Heart Website
- Living with Type 2 Program
- Ask the Expert Q &A Series
- Patient Education and information
- Support Network: New social networking diabetes portal, content & blogs, survey
- Self-management tools for lifestyle and medication management

**Professional Resources & Education**
- Webinars & non-CME/CE training for Healthcare Providers, including a podcast series
- Tools and Resources to support adherence to guidelines
- AHA Guidelines-on-the Go App
- ADA Standards of Care App
- Providers Tracking Survey

**Quality & Systems Improvement**
- Target: Type 2 Diabetes
  - Ambulatory improvement and recognition program
  - Get With The Guidelines inpatient improvement and honor roll
- Diabetes INISIDE

**Center for Health Metrics and Evaluation**
- Baseline Market Research, Tracking Studies, Ongoing Program Evaluation
Introducing Know Diabetes by Heart™: A Spotlight on Type 2 Diabetes and Get With The Guidelines®

As part of the new Know Diabetes by Heart™ initiative, Dr. Gregg Fonarow, Co-Chief of the Division of Cardiology at UCLA, announced our Get With the Guidelines® efforts to better treat patients with type 2 diabetes (T2D) admitted for an acute cardiovascular event.

Register to view the Introducing Know Diabetes by Heart™ event. Event Password: knowdiabetesbyheart
Slides are available for download within the recorded event under the blue “Files” button.

Announcing Target: Type 2 Diabetes™ Honor Roll

A new Honor Roll recognition opportunity for Get With The Guidelines® – Heart Failure and Stroke participants.

Dr. Nancy Albert, a member of the American Heart Association Heart Failure Systems of Care Advisory Group, presented relevant science related to CVD and Type 2 Diabetes and detailed this exciting new honor roll opportunity.

Register to view the Honor Roll event.
Download the Honor Roll webinar slides.

https://knowdiabetesbyheart.org/quality
Science and Rationale
WHY THIS MATTERS

• Cardiovascular disease is the leading cause of death for people living with type 2 diabetes.¹,²

• People living with type 2 diabetes are twice as likely to develop and die from cardiovascular disease, such as heart attacks, strokes and heart failure, than people who do not have diabetes.³,⁴,⁵

• Only about half of people age 45 and older with type 2 diabetes understand their increased risk for developing heart disease or have discussed their risk with their health care provider, according to a recent online survey conducted by The Harris Poll.⁶
Diabetes and Survival

50-year-old with diabetes died, on average, 6 years earlier than those without diabetes (58% attributable to vascular, 9%, cancer, 30% other causes)
Reduction in life expectancy from long-term cigarette smoking ~10 years
“…data from 1998 to 2014 showed marked reductions in mortality (all cause and cardiovascular disease) among adults with type 2 diabetes”.

“There remains a substantial excess overall rate of all outcomes analyzed among persons with type 2 diabetes as compared with the general population.”
Kannel WB et al. Am J Cardiol 1974; 34:29-34

P<.001 for all values except *P<.05.
Heart Failure and Type 2 Diabetes Mellitus

22%, HFP EF
21%, HFM EF
57%, HFR EF

~ 25% of each type of HF
2017 U.S. Statistics:

- 1 in 11 Americans has diabetes.
- 1 of every two adults has diabetes or prediabetes
- Type 2 diabetes accounts for 90 to 95% of all diabetes cases in the U.S.

Deaths Due to Diabetes Complication Continue at Alarming Rate

IN THE US, DIABETES\(^a\) CONTRIBUTES TO, ON AVERAGE\(^1\):

- 1 stroke every 2 minutes
- 1 case of ischemic heart disease every 80 seconds
- 1 case of kidney failure every 10 minutes
- 1 lower limb amputation every 5 minutes

WORLDWIDE, 1 PERSON DIES EVERY 8 SECS. FROM DIABETES\(^a\) AND ITS COMPLICATIONS\(^2\)

That’s more than 11,000 people a day

OPIOID OVERDOSE CRISIS IN THE UNITED STATES, IN 2016, 1 PERSON DIES EVERY 52 MINS. FROM OPIOID OVERDOSE\(^3\)

That’s more than 46 people a day

\(^a\)Type 1 or Type 2 diabetes.

Prevalence of CV Risk Factor in US Adults
Heart Disease and Stroke Statistics 2018 At-a-Glance

- **HTN**: 45.60%
- **Prediabetes**: 33.90%
- **Diabetes**: 12.20%
- **High Cholesterol**: 39.70%

Age-Adjusted Prevalence of Diabetes Awareness, Treatment and Control in US Adults (20+ years): NHANES
Multiple Chronic Conditions (MCC)

> 1 in 4 Americans have 2+ concurrent chronic conditions including hypertension, diabetes, and heart disease
Prevalence of multiple chronic conditions among individuals increases with age.

As the number of chronic conditions ↑, the risks of the following outcomes also ↑:
• Mortality,
• Poor functional status; unnecessary hospitalizations
• Adverse drug events; duplicative tests; conflicting medical advice.

66% of total health care spending is directed toward care for the approximately 27% of Americans with MCC.

Individuals with MCC face financial challenges related to:
• Out-of-pocket costs of care, including:
  • Higher costs for prescription drugs and total out-of-pocket health care
Chronic Comorbidities –
US Medicare Population, 2005

Cardiovascular (CV) Risk Factor Targets and CV Disease Event Risk in Diabetes

POOLED ANALYSIS

- Atherosclerosis Risk in Communities (ARIC)
- Multi-Ethnic Study of Atherosclerosis (MESA)
- Jackson Heart Study (JHS)

2018 ADULTS AGES 28–86 WITH DIABETES AND NO CVD INITIALLY

Cardiovascular (CV) Risk Factor Targets and CV Disease Event Risk in Diabetes

*Percent at target level* among the 2018 persons with diabetes for each of the measures:

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>LDL-C</th>
<th>HBA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.8%</td>
<td>32.1%</td>
<td>41.9%</td>
</tr>
</tbody>
</table>

Percent at target levels for any one, two, or all three factors among the 2018 persons with diabetes:

<table>
<thead>
<tr>
<th>Any 1 of 3</th>
<th>Any 2 of 3</th>
<th>3 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.1%</td>
<td>26.5%</td>
<td>7.2%</td>
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</tbody>
</table>

Cardiovascular (CV) Risk Factor Targets and CV Disease Event Risk in Diabetes

**Percent CVD risk reduction** for being at target level among the 2018 persons with diabetes for each of the measures:

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>LDL-C</th>
<th>HBA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>17%</td>
<td>33%</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Percent lower adjusted risk of CVD events** with one, two, or three risk factors at target level:

<table>
<thead>
<tr>
<th>Any 1 of 3</th>
<th>Any 2 of 3</th>
<th>3 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>36%</td>
<td>52%</td>
<td>62%</td>
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</table>

Wong, et al. Diabetes Care 2016 May; 39(5) 668-676. Incident of CVD was defined as MI, CHD death, cardiac procedure (PCI, CABG, or coronary revascularization), stroke, or HF.
Number and percentage of outpatient chronic condition visits by physician type in the past year: 2008 National Ambulatory Medical Care Survey

### Causes of Death: USA (2016)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths</th>
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</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>635,260</td>
</tr>
<tr>
<td>Cancer</td>
<td>598,038</td>
</tr>
<tr>
<td>Accidents (unintentional injuries)</td>
<td>161,374</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>145,596</td>
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<tr>
<td><strong>Stroke (cerebrovascular diseases)</strong></td>
<td>142,142</td>
</tr>
<tr>
<td>Alzheimer's disease</td>
<td>116,103</td>
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<tr>
<td>Diabetes</td>
<td>80,058</td>
</tr>
<tr>
<td>Nephritis, nephrotic syndrome, and nephrosis</td>
<td>50,046</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>51,537</td>
</tr>
<tr>
<td>Intentional self-harm (suicide)</td>
<td>44,965</td>
</tr>
</tbody>
</table>

NEW CONSENSUS REPORT

Management of Hyperglycemia in Type 2 Diabetes, 2018. A Consensus Report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)

Melanie J. Davies,1,2 David A. D’Alessio,3 Judith Fradkin,4 Walter N. Kernan,5 Chantal Mathieu,6 Geltrude Mingrone,7,8 Peter Rossing,9,10 Apostolos Tsapas,11 Deborah J. Wexler,12,13 and John B. Buse14
DECISION CYCLE FOR PATIENT-CENTRED GLYCAEMIC MANAGEMENT IN TYPE 2 DIABETES

REVIEW AND AGREE ON MANAGEMENT PLAN
- Review management plan
- Mutual agreement on changes
- Ensure agreed modification of therapy is implemented in a timely fashion to avoid clinical inertia
- Decision cycle undertaken regularly (at least once/twice a year)

ONGOING MONITORING AND SUPPORT INCLUDING:
- Emotional well-being
- Check tolerability of medication
- Monitor glycaemic status
- Biofeedback including SMBG, weight, step count, HbA1c, BP, lipids

ASSESS KEY PATIENT CHARACTERISTICS
- Current lifestyle
- Comorbidities i.e. ASCVD, CKD, HF
- Clinical characteristics i.e. age, HbA1c, weight
- Issues such as motivation and depression
- Cultural and socio-economic context

GOALS OF CARE
- Prevent complications
- Optimise quality of life

CONSIDER SPECIFIC FACTORS WHICH IMPACT CHOICE OF TREATMENT
- Individualised HbA1c target
- Impact on weight and hypoglycaemia
- Side effect profile of medication
- Complexity of regimen i.e. frequency, mode of administration
- Choose regimen to optimise adherence and persistence
- Access, cost and availability of medication

IMPLEMENT MANAGEMENT PLAN
- Patients not meeting goals generally should be seen at least every 3 months as long as progress is being made; more frequent contact initially is often desirable for DSMES

SHARED DECISION-MAKING TO CREATE A MANAGEMENT PLAN
- Involves an educated and informed patient (and their family/caregiver)
- Seeks patient preferences
- Effective consultation includes motivational interviewing, goal setting and shared decision-making
- Empowers the patient
- Ensures access to DSMES

AGREE ON MANAGEMENT PLAN
- Specify SMART goals:
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time limited

ASCVD = Atherosclerotic Cardiovascular Disease
CKD = Chronic Kidney Disease
HF = Heart Failure
DSMES = Diabetes Self-Management Education and Support
SMBG = Self-Monitored Blood Glucose
Step 1: Assess cardiovascular disease

PRESENCE OF CARDIOVASCULAR DISEASE IS COMPELLING INDICATION

ASCVD predominates  HF or CKD predominates
GLUCOSE-LOWERING MEDICATION IN TYPE 2 DIABETES: OVERALL APPROACH

FIRST-LINE THERAPY IS METFORMIN AND COMPREHENSIVE LIFESTYLE (INCLUDING WEIGHT MANAGEMENT AND PHYSICAL ACTIVITY) IF HbA1c ABOVE TARGET PROCEED AS BELOW

ESTABLISHED ASCVD OR CKD

ASCVD PREDOMINATES

EITHER OR

SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs OR

GLP-1 RA with proven CVD benefit

HPF OR CKD PREDOMINATES

PREFERABLY

SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs

OR

If SGLT2i not tolerated or contraindicated or if eGFR less than adequate1 add GLP-1 RA with proven CVD benefit

COmPELLING NEED TO MINIMISE HYPOGLYCAEMIA

- Avoid TZD in the setting of HF
- Choose agents demonstrating CV safety
- Consider adding the other class with proven CVD benefit
- DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
- Basal insulin
- SU

SGLT2i OR TZD

COmPELLING NEED TO MINIsmise WEIGHT GAIN OR PROMOTE WEIGHT LOSS

IF HbA1c above target

- GLP-1 RA with good efficacy for weight loss

SGLT2i OR DPP-4i OR GLP-1 RA

WCOST IS A MAJOR ISSUE29

Either OR

SUb

SGLT2i

SU

TZeD

TZeD

IF HbA1c above target

- Insulin therapy basal insulin with lowest acquisition cost OR
- Consider DPP-4i OR SGLT2i with lowest acquisition cost29

IF HbA1c above target

- Consider the addition of SU OR basal insulin:
  - Choose later generation SU with lower risk of risk of hypoglycaemia
  - Consider basal insulin with lower risk of hypoglycaemia

IF HbA1c above target

- If triple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated use regimen with lowest risk of weight gain

PREFERABLY

DPP-4i IF not on GLP-1 RA based on weight neutrality

IF HbA1c above target

- If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:
  - SU
  - TZD
  - Basal insulin

1. Proven CVD benefit means it has label indication of reducing CVD events for GLP-1 RA; stronger evidence for lamlintide – saxagliptin – exenatide. For SGLT2i evidence mostly stronger for monogenic - sympathetics.
2. Be aware that DPP-4i vary by regimen and individual agent with regard to estimated rate of decrease in HbA1c and sustained use.
3. Both monogenic and sympathetics have lower rates of HF and reduction in CVD progression in CVOTs.
4. Dopamine or TRH agonists have demonstrated CV safety.
5. Liraglutide may be better tolerated though there has well studied for CV effects.
6. Choose later generation SU with lower risk of hypoglycaemia.
7. Syrup, pegylated GLP-1, liraglutide, degludec, long-acting insulin.
9. For specific cardiovascular i.e. revascularisation (CABG) or PCI, due to risk of hypoglycaemia and lower priority to avoid weight gain or in weight-related cardiometabolic.
10. Consider country- and regimen-specific cost of drugs, to some countries TZD relatively more expensive and DPP-4i relatively cheaper.
Consider the presence or absence of ASCVD, CKD and HF

Start with metformin if tolerated, then:

- In patients with ASCVD a GLP-1 RA or SGLT2-i is recommended
- In patients with ASCVD and HF SGLT2-i is recommended
- In patients with CKD, with or without ASCVD consider an SGLT2-i

agents with proven benefit are preferred

ASCVD, CKD and HF affects choice of additional glucose lowering medication

Diabetes Care https://doi.org/10.2337/dci18-0033
Key Points to Emphasize

• Update informed by evidence generated in the past 2 years
• Greater focus on lifestyle interventions, with increased emphasis on weight loss and obesity management, including metabolic surgery
• Greater focus on patient related issues and self-management which have a major impact on success of any pharmacological interventions
• Preferred choices of glucose-lowering agents driven by new evidence from CVOTs and consideration of areas of major clinical need (for example weight and risk of hypoglycaemia)
• GLP-1 RAs are preferred to insulin as first injectable
SUMMARY AND IMPLICATIONS

Beginning with the 2018 ADA Standards of Medical Care in Diabetes, the Standards document became a “living” document where notable updates are incorporated into the Standards.

Updates will be made in response to important events inclusive of, but not limited to:

• Approval of new treatments (medications or devices) with the potential to impact patient care;

• Publication of new findings that support a change to a recommendation and/or evidence level of a recommendation; or

• Publication of a consensus document endorsed by ADA that necessitates an update of the Standards to align content of the documents.

https://professional.diabetes.org/content-page/living-standards
TARGET: TYPE 2 DIABETES℠
QUALITY IMPROVEMENT AND RECOGNITION PROGRAM
WHAT IS TARGET: TYPE 2 DIABETES – AMBULATORY?

• Quality Improvement and annual recognition opportunity provided by the Know Diabetes by Heart Initiative and supported by the American Heart Association’s qualified regional staff.

• Target: Type 2 Diabetes leverages the Know Diabetes by Heart program resources and education combined with regional staff to support organizations who wish to tackle type 2 diabetes and CVD.

• The recognition is an output of an organization’s participation in Target: Type 2 Diabetes and should encourage and incentivize participants to register and improve.

• Organizations can sign on, submit data year to year, and engage with our program staff to improve and be recognized.
BENEFITS OF RECOGNITION

- An award certificate
- Digital award icons for use on your website and other materials
- Recognition Toolkit including a press release template, social media messaging, and other communication resources
- National recognition on the Recognition Program website
- Recognition mentions at American Heart Association’s annual Scientific Sessions meeting
RECOGNITION OVERVIEW

REGISTRATION + 2 STEP DATA SUBMISSION PROCESS

• Registration at www.knowsdiabetesbyheart.org/quality → ambulatory
• Annual Part 1: Organizational information and self-assessment
• Annual Part 2: Numerator/denominator aggregate measure submission

TWO AWARD LEVELS

Completes all parts of data submission process including aggregate measure information

Achieves participant award level and meets specified thresholds for each of the selected clinical measures

ELIGIBILITY

• U.S.-based healthcare organizations providing direct patient care can qualify for the Target: Type 2 Diabetes Ambulatory Recognition Program
REGISTRATION

NEW COMBINED REGISTRATION:

Available starting today: Register for 1, 2, or 3 programs

- Target: Type 2 Diabetes™
- Check. Change. Control. Cholesterol™
- Target: BP™

Already participating elsewhere? Add Target: Type 2 Diabetes and indicate you’re adding a new program to ensure all accounts are tied together

You’ll need to know:

1. Contact information
2. Total adult (18-85 years) patient population count
3. Total adult patients (18-85 years) that are a race other than white and/or identify as Hispanic or Latino ethnicity
4. Number of clinic locations in your health system.
5. Your organization’s characteristics, such as multi-specialty, Federally Qualified Health Center, etc.

Select YES for data platform access to submit for recognition
DATA SUBMISSION PART 1: INFORMING QI AND CLINICAL PRACTICES ASSESSMENT FOR ALL PARTICIPANTS

PARTICIPANT INFORMATION:

• Total Patients 18-75 years old, Race/Ethnicity, Payor Mix, Total # of Providers

SELF-ASSESSMENT:

1. Does your organization have a specific protocol to assess key characteristics of patients with type 2 diabetes? If yes, does this protocol include assessment of: (select all that apply)
   • Current Lifestyle, Comorbidities i.e. ASCVD, HF, CKD, Clinical characteristics associated with increased CVD risk (i.e. age, blood pressure, cholesterol, smoking, age, weight, etc.), Issues such as motivation and depression, Cultural and socioeconomic context, None of the above

2. Does your organization operationalize a specific treatment plan for managing patients with type 2 diabetes and related CVD co-morbidities and risk factors? If yes, does this treatment plan include: (select all that apply)
   • Comprehensive lifestyle modification recommendations, Diabetes Self-Management Education and Support, Guideline-based use of pharmacologic therapy inclusive of antihyperglycemic medications with proven CVD benefit, None of the above

3. How does your organization track patients with type 2 diabetes and associated CVD co-morbidities and risk factors? Select all that apply
   • Electronic health record (EHR) system, A population health management tool, A diabetes or CVD specific patient registry, None of the above

4. My organization is committed to continuously improving strategies for addressing CVD risk in patients with type 2 diabetes.
   • Yes response required for recognition
DATA SUBMISSION PART 2:
MEASURE SUBMISSION - FOR ALL PARTICIPANTS

**Participation (data submission required)**

Hemoglobin A1c Poor Control
MIPS #001 / NQF 0059

**AND**

Statin Treatment - MIPS 438

**OR**

Controlling BP measure
MIPS #236 / NQF 0018

**Gold (Meets Participation requirements and below thresholds)**

Hemoglobin A1c Poor Control
MIPS #001 / NQF 0059 \( \leq 25\% \)

**AND**

Statin Treatment - MIPS 438 \( \geq 70\% \)

**OR**

Controlling BP measure
MIPS #236 / NQF 0018 \( \geq 70\% \)

**Diabetes**

MIPS #001 / NQF 0059
Hemoglobin A1c (HbA1c) Poor Control (>9%)
Annual rate of 25% or less

**CVD Risk Management**

MIPS #438
Statin for the Prevention and Treatment of Cardiovascular Disease
Annual rate of 70% or greater

**OR**

MIPS #236 / NQF 0018
Controlling High Blood Pressure
Annual rate of 70% or greater
### MEASURE NUMBERS AND OTHER DETAILS

**2019 QUALITY MEASURES (QPP)**

#### DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (> 9%)

<table>
<thead>
<tr>
<th>Measure Numbers</th>
<th>NQS Domain</th>
<th>Specialty Measure Set</th>
<th>Primary Measure Steward</th>
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</thead>
<tbody>
<tr>
<td>CMS eCQM ID: CMS122v7</td>
<td>Effective Clinical Care</td>
<td>Family Medicine, Internal Medicine, Preventive Medicine, Nephrology</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NOF eCQM ID: None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOF: 0059</td>
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<tr>
<td>Quality ID: 001</td>
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</table>

#### CONTROLLING HIGH BLOOD PRESSURE

<table>
<thead>
<tr>
<th>Measure Numbers</th>
<th>NQS Domain</th>
<th>Specialty Measure Set</th>
<th>Primary Measure Steward</th>
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<tbody>
<tr>
<td>CMS eCQM ID: CMS165v7</td>
<td>Effective Clinical Care</td>
<td>Cardiology, Family Medicine, Internal Medicine, Obstetrics/Gynecology, Vascular Surgery, Rheumatology</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NOF eCQM ID: None</td>
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</table>

#### STATIN THERAPY FOR THE PREVENTION AND TREATMENT OF CARDIOVASCULAR DISEASE

<table>
<thead>
<tr>
<th>Measure Numbers</th>
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<tr>
<td>Quality ID: 438</td>
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UNDERSTANDING THE RECOGNITION MEASURES

WHY THESE MEASURES? FEEDBACK FROM AHA EXPERTS:

• Lack of measures targeting type 2 diabetes AND CVD specifically
• Nationally endorsed, widely available
  • Customized measure requirements for the program may be overly burdensome for many
  • Focus on quality improvement vs. novel data queries
• Combination of measures ensures the entire diabetes population is captured and CVD risk is addressed. Flexibility in selecting a “1 of 2” approach for CVD measures.

HOW SHOULD THEY BE CALCULATED?

• All measures should be calculated specifically to national reporting year specifications by the Primary Measure Steward, CMS, or National Quality Forum. eCQMs or registry specifications are acceptable.
RECOGNITION TIMELINE

Now

- Register for Target: Type 2 Diabetes
- Receive account setup information for new account holders
- Prepare for submission with upcoming worksheet

January - April

- Data submission begins 1/1/2020
  - All program data submission forms available
  - Data submission training
  - Submission support “office hours”
  - Know Diabetes by Heart education and AHA staff engagement ongoing

May – Ongoing

- Data submission ends May 29, 2020 11:59 EST (Friday)
- Summer – Awards are finalized
- September – Awards are announced
- Prepare for 2021 submission
Increase awareness and understanding of the connection between type 2 diabetes and cardiovascular disease.

A comprehensive portfolio of patient education, resources and self management tools.

Improve healthcare provider adherence to diabetes standards of care for management of CVD and CVD risk factors in patients with type 2 diabetes.

Implementing programs and activities to help health systems apply and practice the most up-to-date, evidence-based treatment guidelines for primary and secondary prevention of CVD and stroke events in patients with type 2 diabetes.
Health Care Professional Tools and Resources

- Guidelines pocket guide
- ASCVD calculator
- Podcast series
- Webinar series
- AHA and ADA scientific statements and guidelines
- Professional decks

Patient Education Materials (English and Spanish)

- Patient educational resources
- Discussion guides
- Monthly email series
- Monthly “Ask the Experts” events
- ADA’s “Living With Type 2” program

QI and Recognition Resources

- Recognition Fact Sheet
- Recognition FAQ
- Registration support document
- Initiative Overview “Fact Sheet”
- Ambulatory Clinical Change Guide
- Health System Roll-out & Implementation Guide
- By Jan 1, 2020: Data Submission Worksheet
- AHA staff support
A1CVD PRO

WHAT IS A1CVD PRO?

• Mobile app, competency-based medical education
• Aimed at clinicians in primary care, endocrinology, and cardiology
• Allows users to interact with real life case studies involving different situations reflecting an array of challenges in providing optimal care to people with type 2 diabetes and cardiovascular disease.
• Long-term patient simulation tailored to the immediate learning needs of health care professionals.
• Makes learning fun yet thought provoking: users learn as they go while experiencing successes and failures in treating patients to the latest practice guidelines
5 KEY TAKEAWAYS

1. Register now and stay connected at www.KnowDiabetesbyHeart.org/Quality > ambulatory Target: Type 2 Diabetes.

2. Existing AHA program participant? Expect a similar experience in registration and data submission.

3. Recognition requires summary “numerator/denominator” measure submission for a total of 2 measures; Diabetes + 1 of 2 CVD measures.

4. Recognition data submission begins Jan 1, 2020 and ends with a “snapshot” on May 29, 2020 at 11:59 EST. Edit your data any time!

5. Join our data platform trainings, office hours, and leverage your regional AHA staff person for assistance.
QUESTIONS?

www.knowdiabetesbyheart.org/quality
Regional contact: http://bit.ly/AQContactUs

TT2D@knowdiabetesbyheart.org
CITATIONS OF SLIDE 10


