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Together 2 Goal

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Together 2 Goal®
Innovator Track
Cardiovascular
Disease Cohort

Case Study

Hattiesburg Clinic

Organizational Profile

Founded in 1963 with 10 physicians, Hattiesburg Clinic (hattiesburgclinic.com) is now the largest physician-owned, multispecialty group in Mississippi. Powered by more than 2,400 employees, including more than 400 physicians and mid-level providers, Hattiesburg Clinic offers services in more than 45 specialties. The organization serves 19 counties in South Mississippi through 27 primary care clinics, five immediate care facilities, and 16 dialysis units.

Its physician-owned ambulatory outpatient facility features two ambulatory service centers, with 270 physician-level providers as well as 155 physician assistants, nurse practitioners, physical therapists, and certified registered nurse anesthetists. Around 35% of these providers are primary care.

As of 2016, Hattiesburg Clinic served around 525,000 patients who logged more than 815,000 outpatient visits.

Executive Summary

According to the *2017 National Diabetes Statistics Report* from the Centers for Disease Control and Prevention (CDC), an estimated 30.3 million Americans had diabetes. Approximately 5% had Type 1 diabetes and the remaining 95% had Type 2 diabetes. Over the last 20 years, the number of adults with diabetes has more than tripled, and the total direct and indirect estimated cost of diagnosed diabetes in the United States in 2012 was $245 billion.[1]

Due to factors such as high blood sugar, high blood pressure, and obesity, cardiovascular disease (CVD) is the leading cause of death for people with diabetes. The American Heart Association considers diabetes to be one of the seven major controllable risk factors for CVD. However, statistics indicate that people with diabetes are two to four times more likely to die from heart disease than people without diabetes. At least 68% of people age 65 or older with diabetes die from some form of heart disease; and 16% die of stroke.[2]

Hattiesburg Clinic participated in AMGA's Together 2 Goal® (T2G) Innovator Track Cardiovascular Disease Cohort (CVD Cohort) to explore how to better identify and manage cardiovascular risk among their patients with Type 2 diabetes.

During the CVD Cohort, Hattiesburg Clinic primarily focused on electronic health record (EHR) enhancements to help providers address patient risk, gaps, and treatment more effectively. The clinic also focused on educating providers and patients about CVD risk and reduction strategies.

Hattiesburg Clinic improved in five of the six selected measures, highlighted by improvements in statin therapy for secondary prevention of 2.25% for any statin and 3.5% for high-intensity statin.

Program Goals and Measures of Success

The primary goal of the CVD Cohort was to improve cardiovascular management in patients with Type 2 diabetes. Measures of success (see Appendix) were set forth by the AMGA Foundation based on industry-standard measures including: NCQA-HEDIS; United States Preventive Services Task Force; 2013 American College of Cardiology/American Heart Association (ACC/AHA) Prevention Guidelines; and 2018 American Diabetes Association (ADA) Standards of Care.

As an organization, Hattiesburg Clinic's main goal was to give providers accurate and up-to-date patient information in real time to allow those providers to review therapies and modify as appropriate. In order to accomplish this, the clinic expanded the care team and utilized a team approach.

Existing Diabetes Population and Care Structure

Hattiesburg Clinic serves its nearly 13,000 Type 2 diabetes patients across 29 sites. More than one in three of these patients (36%, or 4,633) have atherosclerotic CVD (ASCVD).

To manage these patients, Hattiesburg Clinic uses the Epic EHR platform. When patients have a diagnosis such as diabetes or ASCVD, disease-based registries populate in the EHR and activate Hattiesburg Clinic's EHR tools.

Through dashboards in the EHR, Hattiesburg Clinic can identify diabetes patients with gaps, such as those who

are overdue for their hemoglobin A1c (A1c) measurement, those who are candidates for statin therapy but not on statin medication, or those who are current tobacco users but haven't received tobacco cessation counseling for the year. Case managers from the Quality Management Department are embedded in primary care offices to ensure that overdue health maintenance measures are addressed.

The clinic alerts providers to patients with gaps through a personal EHR dashboard, letters to physicians, and best practice alerts (BPAs). Of note is that the clinic's BPAs populate across the entire system, so providers seeing patients during an urgent care visit will be alerted to the patient's need for a measured A1c.

Hattiesburg Clinic also makes efforts to alert patients to their gaps through a call reminder system, texting system, patient portal, and direct phone outreach.

Interventions

During the CVD Cohort, Hattiesburg Clinic primarily focused on EHR enhancements to help providers address patient risk, gaps, and treatment more effectively. The clinic also focused on educating providers and patients about CVD risk and reduction strategies.

To help providers identify diabetes patients at higher risk for CVD, Hattiesburg Clinic embedded the ASCVD 10-year risk calculator into its EHR. The calculator produces color-coded results that easily identify high-risk patients. Results are utilized in BPAs, linked to progress notes, listed in patient registries, and on providers' daily schedules.

The Quality Management Department also created a "hot list" for primary care providers (PCPs)—including the names of patients not on aspirin or appropriate statin therapy—and engaged nurse care managers to assist with gap closure efforts.

To aid providers in making treatment decisions based on risk, Hattiesburg Clinic embedded quality improvement (QuIP) treatment workflows into the EHR based on ASCVD risk reduction guidelines. The clinic also built smart order sets and BPAs to notify the physician during the visit if the patient is a candidate for statin therapy or anti-platelet therapy or if the patient is overdue for an A1c assessment or a lipid screening.

To aid providers in navigating statin therapy conversations with patients, the clinic also integrated the Mayo Clinic Statin Choice decision aid into the EHR. Data show that patients who begin statins after conversations guided by the decision aid are more likely to still be taking the statin two years later.

To amplify these efforts, Hattiesburg Clinic educated providers and others at all levels of the organization about ASCVD risk reduction guidelines. The team shared information with clinic managers in their monthly "Healthy Planet Managers' Meeting," a meeting to keep managers updated on active quality initiatives. They also educated providers on CVD risk and the QuIP workflow changes during Primary Care Department meetings and resident clinical conferences.

Hattiesburg Clinic also worked to educate patients about various aspects of CVD risk. After each office visit, diabetes patients received an after-visit summary that includes educational information on how to reduce CVD risk, statin therapy, tobacco use, and setup instructions for the Quitter's Circle app to assist in stopping tobacco use.

The team at Hattiesburg Clinic also worked to integrate its CVD Cohort efforts with another of the clinic's existing quality programs: the Million Hearts® CVD Risk Reduction Model (Million Hearts program), a CMS initiative that aims to prevent one million heart attacks and strokes from 2017 through 2021. The clinic was selected to participate in the intervention group of the Million Hearts program, which means that Hattiesburg Clinic patients who are considered high risk based on stratification criteria are entered into the program. For the five-year duration of the Million Hearts program, the clinic follows specific office visit timetables and tracks specific data to share with CMS. Integrating the efforts of both the CVD Cohort and the Million Hearts program helped Hattiesburg Clinic place a clear focus on cardiovascular risk, emphasize to providers the importance of risk reduction, and ultimately help patients through unified messaging and intensive efforts.

Outcomes and Results

Performance data was reported on a quarterly basis during the 12-month duration. Hattiesburg Clinic improved in five of six CVD Cohort measures (see Appendix).

The clinic's most notable improvements were related to statin therapy, as the number of diabetes patients on any statin

increased by 2.25% during the 12-month initiative, and the number of patients on a high-intensity statin improved by 3.5%. Hattiesburg Clinic anticipated improvements in this area, as the team invested significant effort into identifying appropriate candidates for initial statin therapy and appropriate intensity statin therapy.

The clinic also achieved an 1.25% increase in the tobacco-free population, which the team attributed to efforts to promote the Quitter's Circle app among eligible audiences. The team felt that the observed 0.9% increase in aspirin/antiplatelet therapy for secondary prevention was the result of the focused efforts to identify for primary care providers patients who were candidates for aspirin/antiplatelet therapy.

Lessons Learned and Ongoing Activities

Through participation in the CVD Cohort, Hattiesburg Clinic learned how important it is to leverage the information in the EHR. EHRs can allow organizations to easily identify patient gaps and provide care teams with the information needed to close those gaps.

The team at the clinic also learned the importance of engaging and maintaining involvement from administrators, management, physicians, and clinical staff. They felt that getting these key audiences on board was crucial to achieving results for their diabetes patient population. One strategy the clinic used to engage these audiences despite the busyness of clinic schedules was to remind providers about why Hattiesburg Clinic was participating in this quality initiative. Emphasizing the CVD risk that diabetes patients face and updating providers on progress in the selected measures was important to both engaging providers and maintaining their involvement.

Patient engagement is another area of importance to Hattiesburg Clinic. The team at the clinic feels that providers must have or develop skills to engage patients in shared decision making. Allowing the patient to take ownership in their health and treatment decisions can prompt greater adherence to the treatment plan.

Hattiesburg Clinic's main challenge was overcoming "quality initiative overload." The clinic has many quality improvement initiatives currently taking place, so motivating providers to become invested in these simultaneous initiatives is difficult. The clinic has attempted to overcome this challenge by expanding the care team so that the team takes on the tasks related to quality initiatives and the providers can focus on patient care.

The next steps for Hattiesburg Clinic will be to continue to focus on cardiovascular risk reduction efforts among patients with diabetes. The clinic plans to continue efforts with case managers (i.e., nurses from the Quality Management Department) embedded in primary care clinics to work collaboratively in identifying at-risk patients and recommending appropriate therapy for them based on diabetes and ASCVD QuIP treatment workflows. The clinic also plans to focus on long-term medication adherence by leveraging internal EHR reports based on claims data.

References

1. Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed October 10, 2019.

2. Cardiovascular Disease and Diabetes. American Heart Association website. heart.org/en/health-topics/diabetes/why-diabetes-matters/cardiovascular-disease--diabetes. Updated August 30, 2015. Accessed October 10, 2019.

Appendix

Measures of Success for Cohort

	Measure	Measure Description
1	Non-tobacco user	Proportion of T2G patients whose most recent tobacco status is determined to be "tobacco-free".
2a	Daily aspirin or antiplatelet in patients age ≥ 50, secondary prevention	Proportion of T2G patients eligible for secondary prevention with documentation of daily aspirin or another antiplatelet, or documented exception or contraindication during the measurement period.
2b	Daily aspirin or antiplatelet in patients age ≥ 50, primary prevention	Proportion of T2G patients eligible for primary prevention with documentation of daily aspirin or another antiplatelet, or documented exception or contraindication during the measurement period.
3a	Any statin, secondary prevention	Proportion of T2G patients eligible for secondary prevention on a statin during the measurement period.
3b	High-intensity statin, secondary prevention	Proportion of T2G patients eligible for secondary prevention on a high-intensity statin during the measurement period.
3c	LDL cholesterol < 70 mg/dL, secondary prevention	Proportion of T2G patients eligible for secondary prevention with a measured LDL < 70mg/dL.

CVD Cohort Results by Measure

Measure	Results
Non-tobacco user	Baseline Q1 2018 result 79% increased to 80.25% in Q4 2018
Daily aspirin or antiplatelet in patients age ≥ 50, secondary prevention	Baseline Q1 2018 result 88.7% increased to 89.6% in Q4 2018
Any statin, secondary prevention	Baseline Q1 2018 89.75% increased to 91.75% in Q4 2018
High-intensity statin, secondary prevention	Baseline Q1 2018 38.5% increased to 42.0% in Q4 2018
LDL < 70 mg/dL, secondary prevention	Baseline Q1 2018 88.7% increased to 89.6% in Q4 2018

Project Team

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