



Advancing High Performance Health

Together2Goal.
AMGA Foundation

**Together 2 Goal®
Innovator Track
Cardiovascular
Disease Cohort
Case Study**



Southwest Medical Associates

Organizational Profile

Southwest Medical Associates (SMA, smalv.com/en), part of OptumCare, is a subsidiary of UnitedHealth Group. Established in 1972, the organization has a large footprint in the southern Nevada (Las Vegas) area and is a recognized Patient-Centered Medical Home (PCMH) and also a patient-centered specialty practice.

Powered by 345 medical providers—including 168 physicians and 177 advanced practice clinicians—SMA offers 10 specialties across 21 practice sites. Primary care accounts for about half of SMA's provider population, as 170 of SMA's providers are primary care clinicians. These clinicians see more than 308,000 patients who logged nearly one million arrived visits in 2018.

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 (AHA) 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

SMA elected to participate in the AMGA Together 2 Goal® (T2G) Innovator Track CVD Cohort (CVD Cohort) to better identify and manage CVD risk in Type 2 diabetes patients. As part of the CVD Cohort, the organization implemented new initiatives and guidelines, including:

- Embedding an atherosclerotic CVD (ASCVD) risk calculator in the organization's electronic health record (EHR) to calculate the identified patient's risk of developing heart disease or stroke
- Formation of a CVD Risk Reduction Subcommittee which meets monthly and aims to provide guidelines and management to the identified patient population
- Education of providers and patients aimed at changing the mindset of the organization's providers, e.g., appropriately prescribing high-intensity statins and patient resistance to perceived issues with statin use

Adopting these interventions led to an increase in compliance during the measurement period for most of the measures that align with management of ASCVD and ASCVD risk, including lipid management for secondary prevention.

Existing Diabetes Population and Care Structure

SMA serves 20,000 patients with Type 2 diabetes, and roughly 32% (6,400) of them have a history of ASCVD. To better manage these patients, SMA links all practice sites and specialties through the information in Allscripts, the organization's EHR.

Individual patients are assigned to a care team led by a primary care provider (PCP) that manages his or her primary medical needs. Following the PCMH approach to healthcare, the PCP/care team coordinates and collaborates with the in-house endocrinology and cardiology specialists to manage the referred patient's diabetes and any associated CVD.

Enrolled patients are referred to the in-house specialty—endocrinology for diabetes management and cardiology for ASCVD—via an application in the shared EHR following organizational protocol using evidence-based guidelines. Once accepted, the referring provider is notified via an “EHR task” of the patient's upcoming appointment and also of the availability of the post-visit consultation note, which includes any updates and plan of care in the shared EHR (see Task Process in Appendix).

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.

During the CVD Cohort, SMA aimed as an organization to:

- Assess the ASCVD risk for SMA's patient population with Type 2 diabetes
- Achieve improved communication and treatment planning between diabetes patients and provider care teams to address CVD risk and risk reduction
- Standardize care by using national guidelines in the management of at-risk patients
- Integrate a comprehensive Diabetes Management Care Guide in the EHR, allowing for point-of-care collaboration between patient and the treating provider that is driven both by evidence-based guidelines and by patient needs and preferences

Interventions

To achieve Cohort and organizational goals, SMA implemented numerous interventions during the year-long initiative focused in the areas of provider and patient education, information technology, and clinical support.

Provider and Staff Education

Prior to the CVD Cohort, SMA had in place a monthly PCP meeting (i.e., internal medicine, family practice) and monthly lunch-and-learns for providers and staff. The management of diabetes and ASCVD are often topics of discussion at these meetings, and specialty providers (e.g., endocrinology and cardiology) are invited to give updates on the latest guidelines for management of both diabetes and CVD. Each year, the organization also allots providers a generous allowance for continuing medical education (CME), where they can partake

in conferences geared toward the management of diabetes and ASCVD.

To bolster these existing efforts, during the CVD Cohort, SMA created an ASCVD Risk Reduction Subcommittee comprised of PCPs, cardiology and endocrinology specialty providers, and clinic operations personnel. The subcommittee meets monthly to discuss and set guidelines to improve the management of the diabetes patient population.

Patient Education

Prior to the CVD Cohort, SMA offered free classes to patients, called Healthy Interactions and Health Education and Wellness classes. These are specific offerings aimed at diabetes management and prevention and also classes geared towards addressing ASCVD risk and management. Patients are referred to these classes by their attending provider or have the option of self-referral.

During the CVD Cohort, SMA made additional efforts to reach patients by placing patient-facing posters and brochures in waiting and exam rooms aimed at fostering dialogue between provider and patient during the appointment around diabetes and the associated CVD risk (see Appendix).

Health Information Technology (HIT)

Prior to the CVD Cohort, SMA did not have a defined process in place to identify at the point-of-care diabetes patients at risk for CVD at the point of care. As a result, the organization prioritized the implementation of an ASCVD risk calculator in the organization's EHR to better identify and assess patient risk.

Another HIT initiative was updating the Care Guide in the EHR to improve management of diabetes and ASCVD by using the latest ADA guidelines. This was done as part of a pilot program with the Healthy Interactions platform. When using this tool, providers are guided through the management of the identified patient population (via alert in the EHR), including medication/lab management and lifestyle modifications.

SMA implemented an initiative to close gaps that existed within the at-risk population by asking its robust Health Informatics Department to add the ability to produce a "chase list" that identified patients with ASCVD or were at risk for ASCVD who are missing labs or have other gaps. An assigned

team is then charged with contacting the identified patients to encourage a provider visit so deficiencies can be addressed and missing labs can be ordered to achieve compliance.

Clinical Support

Prior to the CVD Cohort, SMA did not have a standardized treatment guideline at the point-of-care level to assist providers in managing patients diagnosed with chronic medical conditions (e.g., diabetes) who are now at risk for the development of ASCVD or who have already been diagnosed with ASCVD.

As a result of the CVD Cohort, SMA added a definitive protocol for evaluating and managing patients who have been diagnosed with or are at risk of developing ASCVD (see Appendix for protocol). This is now part of the standard operating procedure for all PCPs at the organization.

Outcomes and Results

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

Daily Aspirin/Antiplatelet Therapy (primary prevention)

SMA observed a 3% increase in patients without a history of ASCVD who were prescribed daily aspirin/antiplatelet therapy.

Tobacco Free

SMA noted a 2% improvement in the number of patients who were tobacco free, which means that 400 more patients moved to a tobacco-free status during the yearlong period.

Lipid Management for Secondary Prevention (any statin)

Among the approximately 6,000 patients with a documented history of ASCVD, SMA saw a 2.8% increase in those who have a documented use of statins.

Lipid Management for Secondary Prevention (high-intensity statin)

Among the approximately 6,000 patients with a documented history of ASCVD, SMA saw a 3.7% increase in patients prescribed a high-intensity statin.

Lipid Management (measured LDL less than 70 mg/dL)

During the CVD Cohort, SMA observed a 6% increase in patients whose LDL cholesterol measured less than 70mg/dL.

Along with the five measures, SMA also tracked daily aspirin or antiplatelet therapy for secondary prevention and observed a 1% decrease in this measure. Potential reasons for the decrease could be a decline in documentation within the EHR or steady performance during the yearlong period with an increase in the total patient population.

Lessons Learned and Ongoing Activities

SMA learned several lessons during the course of the CVD Cohort, including the following:

- The addition of the ASCVD risk calculator in the EHR proved to be one of the most worthwhile interventions in management of the Type 2 diabetes and CVD risk. Providers are now able to accurately identify the at-risk patient and intervene in timely fashion
- Another approach that showed great promise was the update to the Diabetes Care Guide, which was embedded in the EHR. The guide, which serves as a blueprint for the provider, allows for the utilization of evidence-based guidelines (ADA guidelines) in the comprehensive management of the patient population with diabetes
- The patient-facing posters developed as part of this initiative have proven to be a valuable resource, as they encourage more patient-centric dialogue aimed at addressing diabetes and ASCVD

Challenges

As is common during the implementation of new processes, there were some challenges—predominately related to the disruption of the status quo—including difficulty changing the mindset of providers regarding the appropriate prescription of high-intensity statins; patient resistance to statins and perceived issues with their use; and standardization of the documentation on aspirin in the EHR.

Next Steps

To address the challenges and continue improving the management of ASCVD risk among the diabetes population, SMA plans to take the following steps:

- Train and re-train providers and staff in the management of diabetes via mandatory training sessions (e.g., lunch-and-learns, PCP meetings).
- Develop additional patient education materials (e.g., brochures and pamphlets) centered on diabetes and its proper management, with the goal being to change attitudes and beliefs based on evidence-based guidelines. SMA will also use its social media platforms (Facebook and Twitter) and referral-based diabetes classes to address the topic.
- Update organizational guidelines to allow for the proper documentation of over-the-counter medications (aspirin). The function is now part of the pre-visit rooming process and is documented in a structured format allowing for accurate measuring.

SMA will continue with these initiatives, addressing any challenges that may arise. The organization recognizes that the process takes time, adhering to the mantra that “quality improvement is a process, not a destination.”

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.

Task Process

Consultation Reports Notification Task

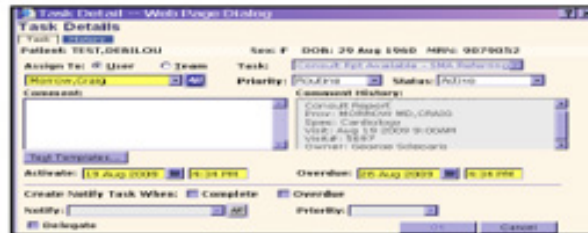
To comply with Medicare requirements to notify referring providers of consultation reports, effective, September 10, 2009, the new automated TW Consultation report process will begin.

Two separate processes were created for SMA referring providers as well as Network referring providers.

SMA Referring Providers:

Task titled **"Consult Rpt Available – SMA Refer Prov"** is created

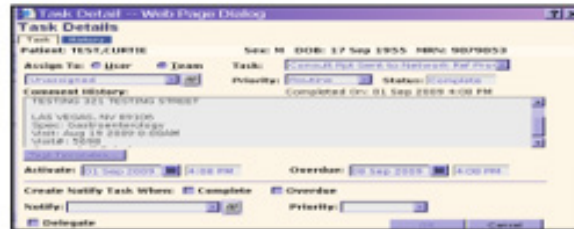
- When the SMA Specialist has finalized the initial consult, the SMA provider will receive notification through a system generated TW "Consult Rpt Available – SMA Refer Prov" task.
- The task will be assigned to the SMA referring provider and will be viewable through the "My Active Tasks" view.
- The consult note is now ready for review through the ChartViewer
- The task can be completed as needed.



Network Referring Providers

Task titled **"Consult Rpt Sent to Network Refer Prov"** is created

- A system generated task will be created as unassigned and will auto-completed.
- The finalized consult and subsequent follow up visits reports will be sent via US mail.



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 < 70 mg/dL.

Patient-Facing Posters and Brochures

OPTUMCare

Know Your Score. Know Your Risk.

Get Your Cardiovascular Disease (CVD) Risk Score Today.
A CVD Risk Score over 7.5% puts you at increased risk of heart attack or stroke in the next 10 years.

Major Risk Factors Include:

- High Cholesterol
- Family History of CVD
- Diabetes
- Smoking
- High Blood Pressure

Other Risk Factors include:

- Overweight
- Sedentary Lifestyle
- Chronic Kidney Disease

Take your medications as prescribed to reduce your risk of heart attack or stroke. Ask your provider how to reduce your cardiovascular disease risk.

PROTECT YOUR HEART

Along with a healthy diet and exercise, statins can be an important part of good health.

STATINS HELP PATIENTS WITH HEART DISEASE, DIABETES, AND BLOOD CLOTS

STATINS DO NOT DAMAGE YOUR HEART

STATINS RARELY CAUSE MUSCLE ACHES

STATINS LOWER BLOOD CHOLESTEROL

STATINS REDUCE RISK OF HEART ATTACK AND STROKE

STATINS DO NOT CAUSE DEMENTIA

Talk to your doctor to find the right statin for you.

OPTUMCare


Statins are drugs used to lower cholesterol in the blood, making them one of the treatments available to people with diabetes and heart conditions. You may have heard conflicting reports about statin safety and effectiveness. Let's clear up some misunderstandings about these life-saving medicines.

Will statins hurt my heart?
While statins can cause muscle ache in some patients, research overwhelmingly shows that they don't damage heart muscle. If you experience ache or severe muscle pain or weakness, even after exercise, you should talk to your doctor.

Will they cause dementia?
Studies have shown the opposite—that long-term statin use could actually protect against cognitive dysfunction and dementia.

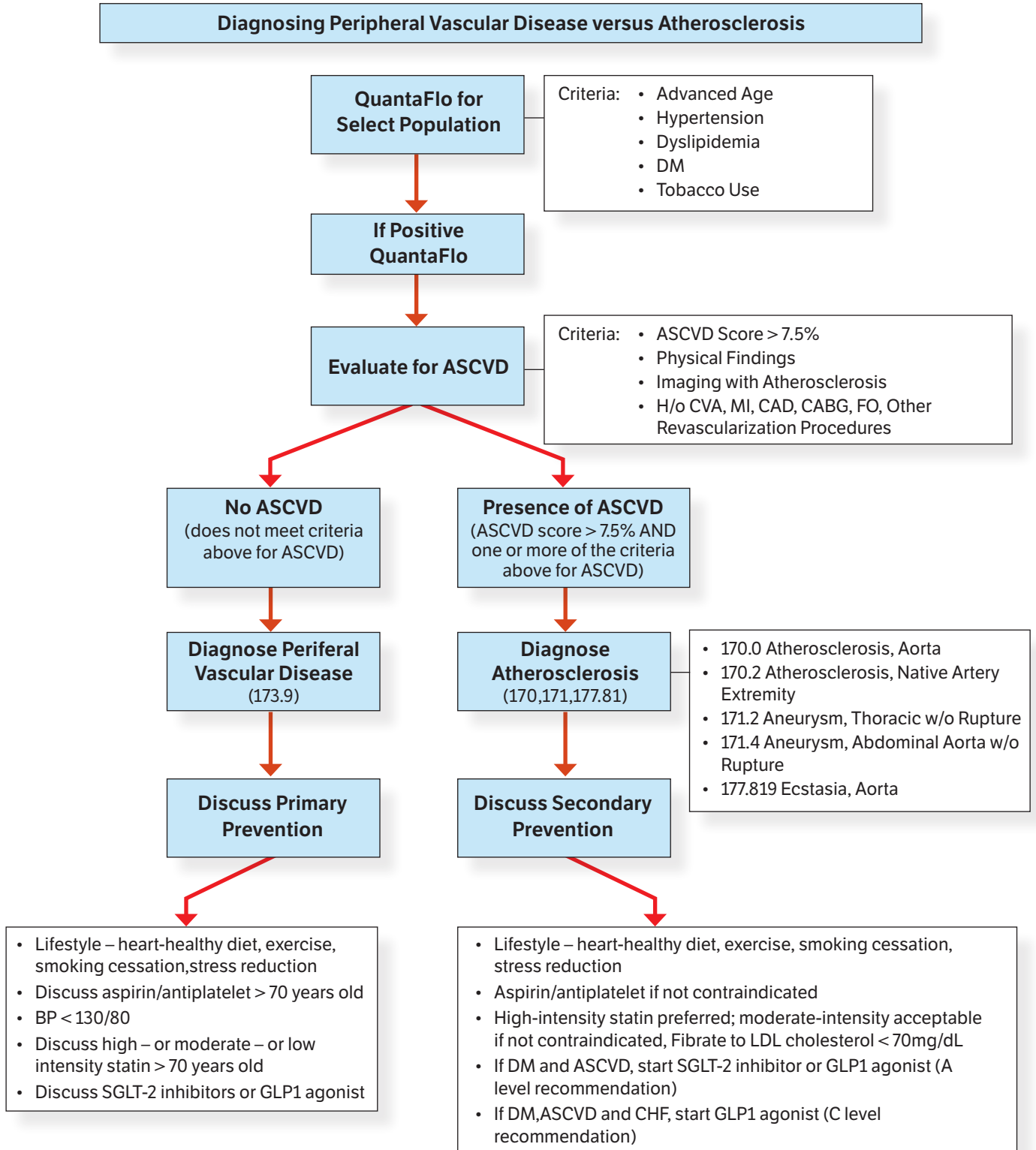
Aren't natural supplements better than statins?
Doctors don't recommend red yeast or other rumored natural treatments because there are no controlled or reliable studies demonstrating their effectiveness. Remember—just because the label says "natural," that doesn't mean it's safe.

Information provided by wwwpcpi.org and clearandcenter.org

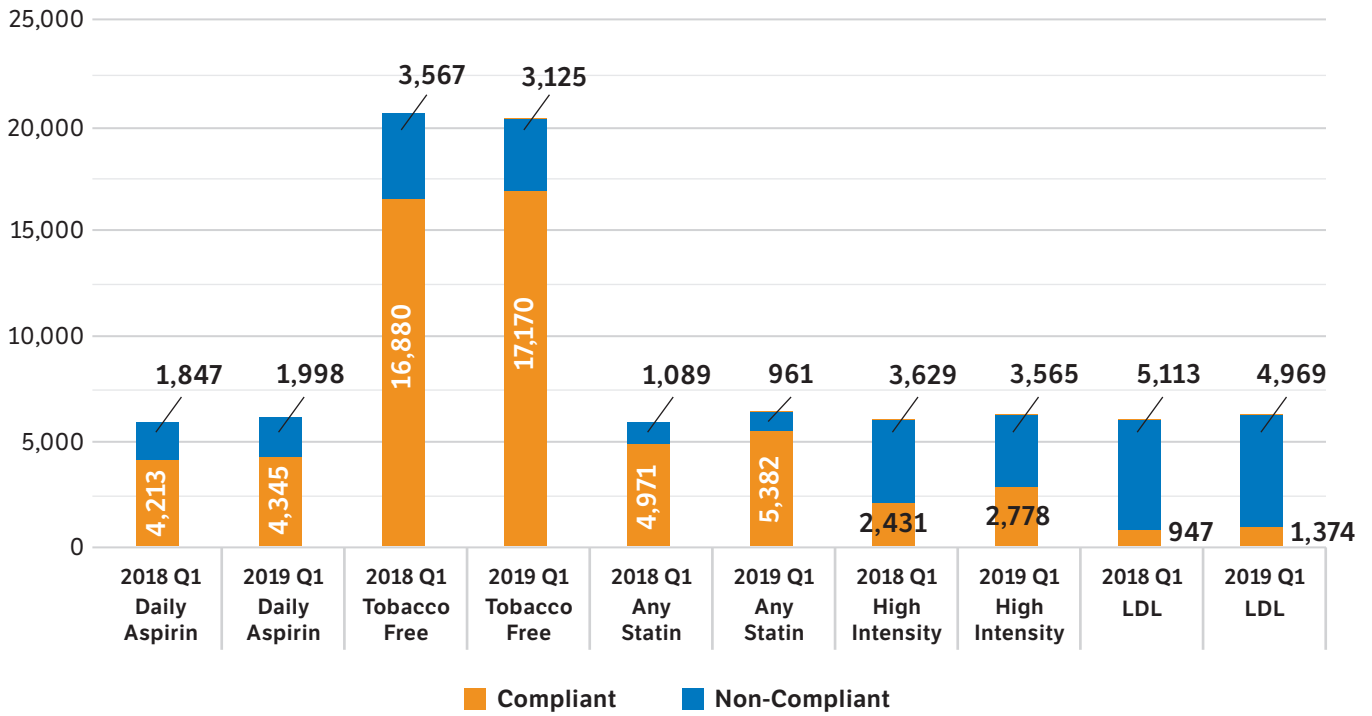


Should everyone take statins?
The short answer: only if you need them. They benefit those with diabetes, high cholesterol, heart disease and blood clot issues. They also benefit older adults. Statins are part of a life plan to manage health. There are many different types of statins, so finding the right one could take time. With diet, exercise, and good dialogue with your doctor, statin therapy could benefit you.

ASCVD Assessment and Management Protocol



Southwest Medical Associates Outcomes CVD Cohort Reporting



Project Team

Andrew Fraser, M.D., M.P.H.

Cheryl Lake, M.S.N., RN

Samuel Bauzon, M.D., M.M.M., CPE





AMGA Foundation

One Prince Street
Alexandria, VA 22314-3318

amga.org/foundation

The Together 2 Goal[®] Innovator Track CVD Cohort was sponsored by the Boehringer Ingelheim and Lilly USA Diabetes Alliance. BI and Lilly were not involved in the development of content for this publication.

