



Advancing High Performance Health

Together2Goal.
AMGA Foundation

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



Summit Medical Group (NJ)

Organizational Profile

With a history dating back to 1919, Summit Medical Group of New Jersey (Summit, summitmedicalgroup.com) is an independent, multispecialty medical practice that provides comprehensive, integrated primary and specialty ambulatory care for nearly two million patients annually. Powered by more than 900 providers representing 80 specialties, Summit's footprint spans seven counties with six major medical campuses and more than 80 locations. In 2019, Summit had nearly 125,000 active patients on its roster.

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

Summit participated in the AMGA Foundation's Together 2 Goal® (T2G) Innovator Track Cardiovascular Disease Cohort (CVD Cohort) to raise awareness about CVD and drive CVD risk reduction in Summit's diabetes population. Led by a cardiologist and an endocrinologist champion who are recognized experts in CVD diagnosis and treatment, Summit implemented four concurrent interventions:

1. Establish a registry of Type 2 diabetes (diabetes) patients at risk for CVD
2. Implement the atherosclerotic CVD (ASCVD) calculator into the electronic health record (EHR)

3. Provide statin and aspirin education to providers and patients
4. Maintain high levels of achieved cessation in tobacco users

To achieve these interventions, Summit formed a multidisciplinary committee—consisting of clinicians, pharmacists, dietitians, and nurses as well as several administrators—to lead the project during its one-year duration and to take responsibility for patient outreach and in-office patient contact.

Summit improved its performance in four of the six selected CVD Cohort measures, including a 1.5% increase in high-intensity statin use among the high-risk patient population. Summit also maintained a very high level of tobacco non-use at 92.5%.

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.

Summit's first organizational aim was to identify individuals at risk for CVD and those already with CVD. Additional goals were to minimize care gaps, improve medication adherence and, ultimately, outcomes.

To better distinguish the target patient population, the team developed an algorithm to better identify patients who are high risk and/or have CVD or coronary artery disease. Further, Summit enhanced its treatment algorithm for people with diabetes to incorporate best practices that would improve patient CVD outcome measures.

Summit aimed to improve appropriate aspirin utilization, accurate documentation, and statin use; and to maintain cessation of former tobacco users. To facilitate tobacco

cessation maintenance, the team worked diligently to secure a reliable data source to identify patients in need of cessation counseling to ensure that they received appropriate follow up.

Existing Diabetes Population and Care Structure

Summit currently serves around 17,000 diabetes patients with expert, coordinated care provided by more than 180 providers—including 120 primary care physicians, 22 endocrinologists, and eight registered dietitians/certified diabetes educators—in more than 40 locations.

Since 2014, Summit has used athenahealth as the group's EHR platform. Summit will adopt a new data analytics platform in late 2019.

Interventions

Based on the CVD Cohort measures, Summit's goal was to identify diabetes patients at increased risk for CVD and implement interventions aimed at mitigating this risk. These interventions included expansion of the patient registry, addition of the ASCVD calculator into the EHR, educating providers and patients about statins and aspirin, and maintaining historic success with tobacco cessation.

Patient Registry

Since its registry of diabetes patients was established in 2008, Summit has benefited from being able to track and project outcome trends for this population. As part of the CVD Cohort, the Summit team expanded the registry to better identify diabetes patients at higher risk for CVD so that treatment approaches could be customized to their needs.

ASCVD Calculator EHR Implementation

Summit implemented the ASCVD calculator in the EHR in July 2018. This critical step raised awareness and enhanced treatment approaches patients at the point of care where treatment discussion and selection of the engaged patient based on their score was optimal.

Statin and Aspirin Education

Summit's clinical pharmacy team developed an education program for providers and patients focused on demystifying statins. Given the controversial 'fact vs. fiction' questions

surrounding this drug class, there was a clear need to empower providers and patients with evidence-based information to make well-informed decisions. The program was well received and has had a positive impact on patient buy-in to take their statin. With support from the Cardiologist Champion, the pharmacy team also addressed conflicting aspirin use for primary prevention guidance through helpful infographics from the ACC.

Tobacco Cessation Performance Maintenance

While Summit has had success with tobacco cessation measures prior to participating in this initiative, it has remained a priority to maintain high levels of achieved cessation for former tobacco users. This is also supported through partnership with the Marketing Department to provide patient education through social media channels on tobacco cessation.

Outcomes and Results

Summit reported performance data on a quarterly basis during the 12-month initiative. From baseline, Summit improved in four of the six CVD Cohort measures (see Appendix).

M1: Non-tobacco user

Summit tracked tobacco non-users to ensure that the already high group performance of 92.6% would be maintained. Promotion of smoking cessation continues to be a focus across the group and especially for high-risk patient populations. Summit successfully maintained its non-tobacco user rates, finishing the CVD Cohort with a rate of 92.7%.

M2a: Daily aspirin or antiplatelet in patients age ≥ 50, secondary prevention

The team noted an improvement from baseline for daily aspirin/antiplatelet agent for secondary prevention. Improvement in this metric was expected given the strong educational messages and updated treatment algorithm. Summit will continue to track and report this measure after the CVD Cohort concludes and will aim for the 92.6% benchmark established during the Cohort.

M2b: Daily aspirin or antiplatelet in patients age ≥ 50, primary prevention

Given the current controversy regarding daily aspirin/antiplatelet agent for primary prevention, Summit did not focus

nor expect improvement on this measure. Performance was simply maintained from baseline. Summit will continue to track and report this metric after the CVD Cohort concludes.

M3a: Any statin, secondary prevention

Summit focused on educational efforts that highlight the importance of statin use for patients at risk for CVD as secondary prevention of ASCVD. The team noted that patients in Summit's geographic area are reluctant to engage in statin therapy. As a result, performance was simply maintained from baseline. Summit will continue to track and report this metric, as well as continue educational efforts to dispel statin use myths.

M3b: High-intensity statin, secondary prevention

As noted above for overall statin therapy, Summit focused on educational efforts that highlight the importance of statin use for patients at risk for CVD for secondary prevention of ASCVD. For high-intensity statin use, performance improved by 1.5% from baseline with a continued positive trend towards the overall goal. This was expected as more guidance regarding indications for ordering statins was shared across the group. Summit will continue to track and report this metric as well as continue educational efforts.

M3c: LDL cholesterol < 70 mg/dL, secondary prevention

Although improvement from baseline was only 0.5%, a positive trend has been noted. As statin use increases, Summit expects to see this increase as well. Summit will continue to track and report the percentage of patients with an LDL cholesterol less than 70 mg/dL.

Lessons Learned and Ongoing Activities

During the CVD Cohort, Summit learned that small changes in practice can produce big results. Continued perseverance in improving patient and provider education and combatting clinical inertia is needed to reduce the burden of CVD in Summit's high-risk patients.

Summit's data revealed areas for statin treatment opportunities of which the team was previously unaware. Specifically, this data pointed to the need for additional provider and patient statin education. This education focused on how providers can influence concerned patients to buy into taking a statin and on demystifying the perceived adverse effects, such as muscle symptoms, liver effects, new onset diabetes, memory loss, and increased attention to medication interactions that impact statin levels.

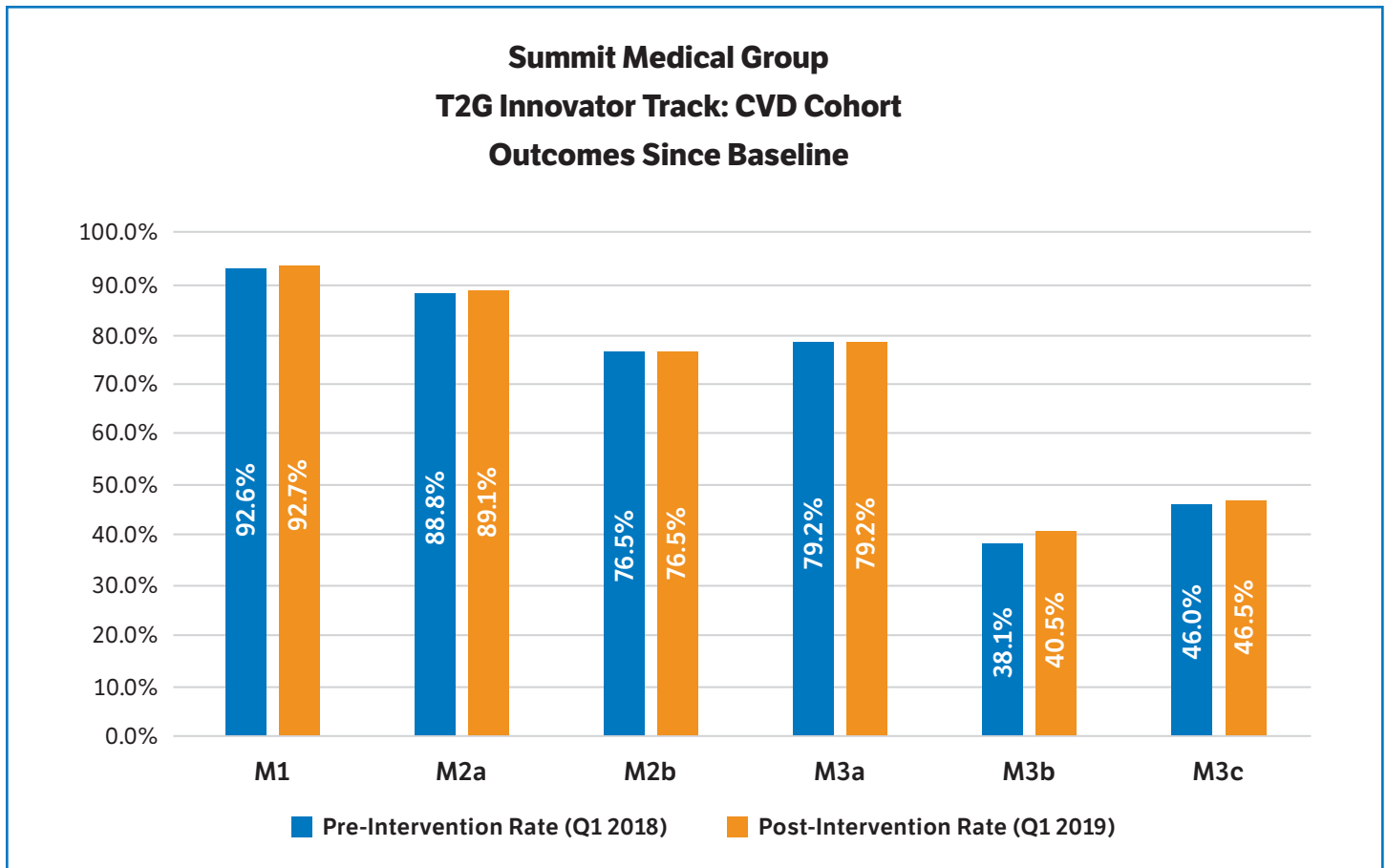
Summit's next steps include the adoption of a new data analytics tool that will identify patients being treated with a moderate-intensity statin that should be taking a high-intensity statin based on their ASCVD risk score. The Summit team will also address underutilization of medication classes that have been shown to have cardioprotective benefits (i.e., SGLT-2 inhibitors and GLP-1 agonists) by educating providers about the potential of these classes to reduce CVD risk. Other top priorities for Summit moving forward include provider education on the revised 2018 ACC/AHA Guideline on the Management of Blood Cholesterol Treatment Algorithm (see Appendix) and help navigating the conflicting guidance surrounding aspirin use for primary prevention of ASCVD.

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.

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. |



M1: Non-tobacco user

M2a: Daily aspirin or antiplatelet in patients age \geq 50 years, secondary prevention

M2b: Daily aspirin or antiplatelet in patients age \geq 50 years, primary prevention

M3a: Any statin, secondary prevention

M3b: High-intensity statin, secondary prevention

M3c: LDL < 70 mg/dL, secondary prevention

Cholesterol Treatment Algorithm



This algorithm is based on the 2018 ACC/AHA Guideline on the Management of Blood Cholesterol and the 2013 ACC/AHA Guideline on Lifestyle Management to Reduce Cardiovascular Risk.

CLINICAL ASCVD*

Clinical ASCVD is defined as one or more of the following:

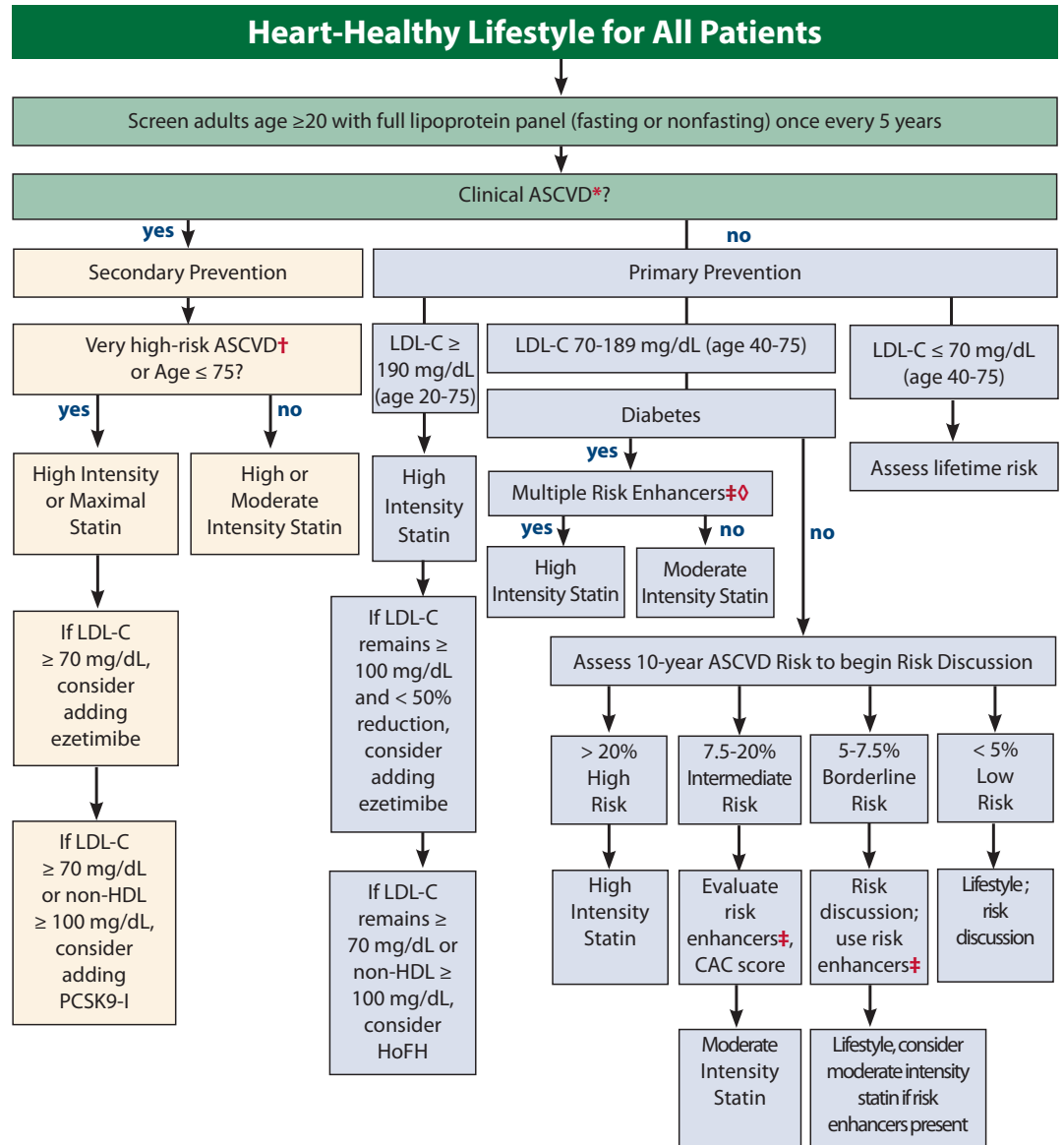
- Acute coronary syndromes
- History of MI
- Stable or unstable angina
- Coronary or other arterial revascularization
- Atherosclerotic stroke
- Atherosclerotic TIA
- Atherosclerotic peripheral artery disease
- Abdominal aortic aneurysm

VERY HIGH RISK ASCVD†

History of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions (≥ 65 YO, History of CABG or PCI outside major ASCVD event(s), HeFH, DM, HTN, CKD, CHF, current smoker, LDL-C ≥ 100 mg/dL despite maximally tolerated statin and ezetimibe)

TREATMENT FUNDAMENTALS FOR PATIENTS WITH CLINICAL ASCVD

- A — Assess risk, Aspirin/antiplatelet therapy, Atrial Fibrillation
- B — Blood pressure control
- C — Cholesterol control and Cigarette smoking cessation
- D — Diet and weight management, Diabetes and blood glucose control
- E — Exercise
- F — Heart Failure



Project Team

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