AMGA™

Advancing High Performance Health

Together 2 Goal®

AMGA Foundation

Together 2 Goal® Innovator Track Cardiovascular Disease Cohort

Case Study

Utica Park Clinic

Organizational Profile

Utica Park Clinic (UPC, uticaparkclinic.com) is an expansive network of healthcare facilities that is part of Ardent Health Services and Hillcrest HealthCare System's physician group.

UPC's more than 220,000 patients log more than a half million outpatient visits each year to its 70+ local and rural clinic locations throughout northeast Oklahoma. UPC features 20 specialty groups that employ more than 230 physicians and advanced practice providers. Primary care is a significant part of UPC and accounts for approximately 60% of providers.

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 cardiovascular disease. 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]

UPC participated in the Together 2 Goal® (T2G) Innovator Track Cardiovascular Disease Cohort (CVD Cohort) to explore ways to better identify and manage cardiovascular risk for its patients with Type 2 diabetes. Led by two clinical champions, UPC worked to meet its goals by making relevant updates to the electronic health record (EHR) and educating patients and providers on CVD risk and approaches to risk reduction.

During the yearlong initiative, UPC improved in five of the six selected CVD Cohort measures, suggesting that efforts to increase clinical and patient awareness of cardiovascular risk factors and risk reduction strategies may have taken hold.

Lessons learned from the initiative include the importance of targeting "low hanging fruit," celebrating small wins, and engaging clinical staff by increasing overall awareness of CVD risk and statin use in patients with diabetes.

Program Goals and Measures of Success

The primary goal of the CVD Cohort was to improve cardiovascular management in patients with Type 2 diabetes (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.

UPC's organizational goals for the CVD Cohort were to increase the awareness of cardiovascular risk factors for patients with diabetes. The project team also wanted to improve risk identification processes as a first step in decreasing the overall cardiovascular risk for diabetes patients.

Existing Diabetes Population and Care Structure

Of the nearly 130,000 patients UPC saw for at least one office visit in 2018, nearly 14,000 of them were Type 2 diabetes patients who met the criteria for inclusion in the T2G population. At UPC, diabetes care is a collaborative effort between primary care, population health, and specialists. The Quality Department works with these groups to guide them in the management of CVD in people with diabetes. The majority of UPC's primary care providers have a compensation model built on both relative value unit (RVU) production and quality metrics.

To manage its patient population, UPC recently migrated to Epic for its EHR.

Interventions

During the CVD Cohort, UPC placed an emphasis on making relevant updates to the EHR and educating patients and providers on CVD risk and approaches to risk reduction. The main intervention employed by UPC was the implementation of an atherosclerotic CVD (ASCVD) risk calculator in the EHR. Ardent Health Systems implemented a new system-wide EHR shortly after the CVD Cohort began. After some challenges with the transition, the ASCVD risk calculator was integrated into the EHR in May 2019 along with other tools such as best practice alerts (BPAs), flag indicators, and an Epic Quick Guide.

By leveraging the ASCVD risk calculator to identify high-risk patients, UPC deployed an updated care coordination approach for those patients. This updated approach was the result of a collaborative effort—led by the provider champion and clinic champion—that brought together the quality improvement (QI) and population health teams. The QI team was comprised of QI project managers, care partners, and a pharmacy tech. The population health team consisted of embedded care managers, certified diabetes educators, data analysts, social workers, and transition-of-care nurses. The teams worked together to complete pre-visit planning, manage high-risk patients during discharge, and coordinate the transition to primary and specialty health care teams (including Oklahoma Heart) for continued health promotion, prevention, and chronic disease management.

To amplify these efforts, the project team also worked on a variety of provider and patient education tactics. The project team targeted providers with messages to encourage use of the ASCVD risk calculator and to increase clinical awareness about statin use for patients with diabetes; care coordination of high-risk patients; and documenting aspirin use during medication reconciliation. UPC leveraged several communication channels to deliver these messages, including a provider video about using the ASCVD tool, infographics developed as a result the CVD Cohort, "Friday Facts" distributions, direct outreach from the quality and care management teams, and a letter from the Chief Medical Officer to providers. The team worked to educate patients on CVD risks, the ASCVD risk assessment tool, and risk reduction strategies through social media posts on Facebook and Instagram and through focused email outreach.

Outcomes and Results

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

Throughout the CVD Cohort, UPC saw improvements in smoking cessation, documentation of aspirin therapy for secondary prevention, statin use—including high-intensity statin use—for secondary prevention, and measured LDL cholesterol less than 70 mg/dL. The highest gains were seen in daily aspirin or antiplatelet use for secondary prevention (8.1% improvement) and patients on any statin for secondary prevention (4.7% improvement).

Lessons Learned and Ongoing Activities

Two of the most important lessons UPC learned from its participation in the CVD Cohort were how crucial provider engagement is to any quality initiative that requires change and how important it is to provider engagement to equip providers with accurate data, easily accessible and usable evidence-based risk assessment tools, and knowledge about CVD risk and management strategies.

At the conclusion of the CVD Cohort, UPC determined that appointing more than one provider champion would have been helpful in determining provider engagement strategies. Since providers have different interpretations about communication technique and best practices, it might be advantageous to have multiple perspectives and insights about what could work to gain and keep provider attention and involvement.

UPC also learned that the ability to use data as a tool to identify high-risk patients improves quality of care by allowing care teams to provide appropriate health promotion resources, chronic disease management, medication education (e.g., medication compliance, statin therapy concerns), and diet and lifestyle modifications to patients.

Finally, UPC learned that communication and collaboration between facility staff, providers, and patients are key to a successful implementation of any program. And, successful implementation of program elements (e.g., improved care

coordination between primary care and specialty health care teams) can ultimately help improve patient outcomes and quality of life.

UPC had its fair share of challenges during the CVD Cohort. The project team was able to navigate most of the challenges it faced and learned that implementing changes requires time, consideration, diligence, and dedication.

References

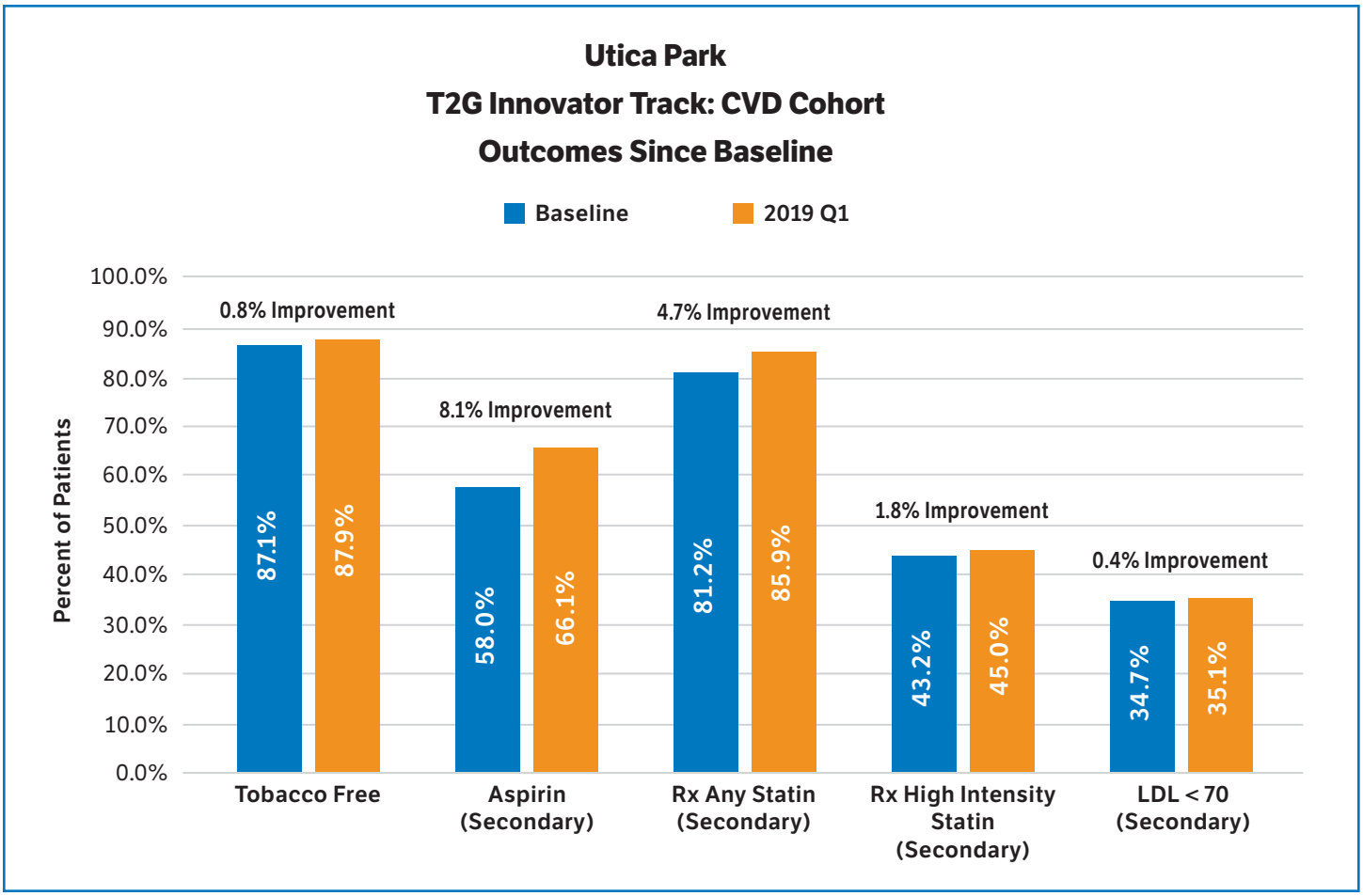
1. Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf. Accessed October 10, 2019.

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 < 70mg/dL.

Appendix


Utica Park
T2G Innovator Track: CVD Cohort
Outcomes Since Baseline
Baseline
2019 Q1
Percent of Patients
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.8% Improvement
87.1%
87.9%
Tobacco Free
8.1% Improvement
58.0%
66.1%
Aspirin (Secondary)
4.7% Improvement
81.2%
85.9%
Rx Any Statin (Secondary)
1.8% Improvement
43.2%
45.0%
Rx High Intensity Statin (Secondary)
0.4% Improvement
34.7%
35.1%
LDL < 70 (Secondary)

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