Monthly Campaign Webinar
February 21, 2019
Today’s Webinar

• Together 2 Goal® Updates
  – Webinar Reminders
  – AMGA Annual Conference
  – New Campaign Partnership
  – 2019 Million Hearts® Hypertension Control Challenge

• Clinical Inertia and Diabetes Care
  – Daniel McCall, M.D., M.S.P.H. of Hattiesburg Clinic

• Q&A
  – Use Q&A or chat feature
Webinar Reminders

• Webinar will be recorded today and available the week of February 25th
  – www.Together2Goal.org

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
2019 AMGA Annual Conference

March 27-30, 2019
National Harbor, MD

• New this year: AMGA will offer networking discussion groups by hot topic and by organizational type.
• Registration now open at amga.org/ac2019
• AMGA Foundation Celebration
  – Friday, March 29, 2019
    6:30 – 8:00 p.m. EST

Register by Friday, March 8 for the next lowest rate
New Partnership: National Minority Cardiovascular Alliance

The NMC Alliance is fielding a brief survey to understand the experiences and challenges faced by patients in managing their heart health.

The perspectives of minority patients and the physicians who treat them are particularly important to the alliance. The information collected will help us understand what issues and problems patients share in common and identify actionable solutions to address these.

Visit https://www.surveymonkey.com/r/2TMHKTQ to view the survey.
2019 Million Hearts®
Hypertension Control Challenge

• Health professionals, practices, and health systems that have achieved hypertension control rates of at least 80% are eligible to enter
• Submission deadline is April 1
• Visit https://millionhearts.hhs.gov for more information
Today’s Featured Presenter

Daniel McCall, M.D., M.S.P.H.

Clinical Endocrinologist
Associate Medical Director
Medicare and Commercial ACO Programs
Hattiesburg Clinic
Clinical Inertia and Diabetes

DAN MCCALL MD MSPH
Clinical Inertia and Diabetes

• Define clinical inertia
• Review the major causes of clinical inertia
• Review data detailing clinical inertia in diabetes care
• Case study in overcoming clinical inertia - hypertension control improvement at the Hattiesburg Clinic
• Lessons learned – how to avoid clinical inertia
Clinical Inertia – What is it?

Sir Isaac Newton's first two laws of physics:
A property of matter by which it continues in its’ existing state of rest or uniform motion in a straight line, unless that state is changed by an external force.

Lawrence S. Phillips in 2001 defined Clinical Inertia:
- Failure of health care providers to initiate or intensify therapy
- Problem of the health care profession and the health care system
- Separate from patient related issues of adherence and access to care

Clinical Inertia Lawrence S. Phillips, MD; William T. Branch Jr., MD; Curtiss B. Cook, MD; Joyce P. Doyle, MD; Imad M. El-Kebbi, MD; Daniel L. Gallina, MD; Christopher D. Miller, MD; David C. Ziemer, MD; and Catherine S. Barnes, PhD Ann Intern Med. 2001;135:825-834
Clinical Inertia – What is it?

• Advances in clinical understanding take approximately 5-10 years to translate into clinical practice

• Strong evidence for effective treatment of diabetes, hypertension, and hyperlipidemia can prevent or delay microvascular and macrovascular disease complications

• Management goals and effective therapies are well defined and available

• Healthcare providers often do not initiate or intensify therapy

Clinical Inertia Lawrence S. Phillips, MD, et. al Ann Intern Med. 2001;135:825-834
Three Major Causes of Clinical Inertia

• Overestimation of care provided and adherence to care guidelines

• Use of “soft” reasons to avoid intensification of therapy
  • Care “improving” despite time to achieve steady state
  • Delaying pharmacologic therapy due to “dietary nonadherence”

• Lack of education, training, and practice organization focused on achieving therapeutic goals
  • Prover lack of knowledge in need for dose escalation or need for multiple medications to achieve therapeutic goals

Clinical Inertia Lawrence S. Phillips, MD, et. al Ann Intern Med. 2001;135:825-834
Clinical Inertia in Type 2 Diabetes: Impact of Diabetes

Prevalence
  ◦ 30.3 million (9.4% population) in the US with diabetes

Morbidity
  ◦ Leading cause of vision loss, kidney failure, limb amputation
  ◦ 2x Heart disease and stroke risk – events occur at earlier age

Mortality
  ◦ 7\textsuperscript{th} Leading Cause of death although more recent data suggest 3\textsuperscript{rd} behind heart disease and malignancy

Cost
  ◦ $327 billion total cost in US in 2017
  ◦ Over 1 in every 4 healthcare dollars spent in US caring for people with diabetes
  ◦ Average medical expenditures 2.3 times higher than those without diabetes

Clinical Inertia in Type 2 Diabetes: Evidence and Clinical Guidelines

Evidence for intensive glycemic control:
United Kingdom Prospective Diabetes Study (1998) ¹
A1c 7% intensive group vs 7.9% conventional therapy
25% reduction in microvascular complications

Clinical Guidelines:
American Diabetes Association – Standards of Medical Care in Diabetes – 2019 Care Recommendations:

A reasonable A1C goal for many nonpregnant adults is <7%. Providers might reasonably suggest more stringent A1C goals (such as <6.5%) for selected individual patients if this can be achieved without significant hypoglycemia or other adverse effects of treatment (i.e., polypharmacy). Appropriate patients might include those with short duration of diabetes, type 2 diabetes treated with lifestyle or metformin only, long life expectancy, or no significant cardiovascular disease. ²

¹ Lancet 1998 Sep 12;352(9131):837-5
² Diabetes Care January 01 2019; volume 42 issue Supplement 1
Clinical Inertia in Type 2 Diabetes: Clinical Guidelines

ADA – Standards of Medical Care in Diabetes - 2019:

Diabetes Care January 01 2019; volume 42 issue Supplement 1
Clinical Inertia in Type 2 Diabetes: Glycemic Control Trends in the US 1999-2014

Despite more than 40 new Type 2 diabetes treatment options approved since 2005

Clinical Inertia in Type 2 Diabetes: Glycemic Control Trends in the US 1999-2014

Percentage of patients with A1c >9% is increasing

Clinical Inertia in Type 2 Diabetes: Treatment Intensification in Uncontrolled Patients

Retrospective cohort study of 11,525 adult patients with Type 2 diabetes in US insurance claims database

A1c ≥8% after ≥ 3 months of therapy including metformin with mean A1c 9.1%
- 37% patients had their treatment intensified <6 months
- 11% patients had their treatment intensified 6-12 months
- 52% patients did not have their treatment intensified <12 months

• Established in 1963 by 10 physicians and has since grown to one of the largest physician-owned multi-specialty clinics in the Southeast U.S.
  • 455 providers (285 physicians and 170 mid-level providers)
  • 50 specialties
  • 72 locations Service a market area of approximately 525K patients
  • Over 871,000 outpatient visits in 2018, excluding dialysis
  • Epic EMR since 2011
HBC’s Quality Initiatives

67 MILLION
American adults have high blood pressure
1 IN 3

High blood pressure contributes to
~1,000 DEATHS/DAY

1 in 3 adults with hypertension do not know they have this disease

ONLY ABOUT HALF
of people with high blood pressure have their condition under control
HBC’s Quality Initiatives

When your blood pressure is high:
- You are 4x more likely to die from a stroke
- You are 3x more likely to die from heart disease

- 69% of people who have a first heart attack...
- 77% of people who have a first stroke...
- 74% of people with chronic heart failure...

HAVE HIGH BLOOD PRESSURE

Annual estimated costs associated with high blood pressure:
- $51 BILLION
- $47.5 BILLION in direct medical expenses
HBC’s Quality Initiatives

Reducing average population systolic blood pressure by only 12–13 mmHg could reduce:

- **37%** Stroke
- **21%** Coronary heart disease
- **25%** Deaths from cardiovascular disease
- **13%** Deaths from all causes
The Good News ...

Association of systolic blood pressure with macrovascular and microvascular complications of type 2 diabetes (UKPDS 36): prospective observational study

*BMJ* 2000; 321

For every 10 mm Hg reduction in SBP:

- 12% Decrease in any end point related to diabetes
- 15% Reduction in risk of death related to diabetes
- 11% Decrease in MI
- 13% Decrease in microvascular complications
HBC’s Quality Initiatives
HBC’s Quality Initiatives

An evaluation of where the last 5,000 BP > 140/90 were recorded throughout the organization:

- Primary Care office: 34%
- Non-PC, non-main campus: 27%
- Non-PC, main clinic: 39%
HBC’s Quality Initiatives
HBC’s Quality Initiatives

Standardized Blood Pressure Measurement Process
HBC’s Quality Initiatives

Standardized blood pressure measurement process

Provider specific blood pressure management dashboards
Results?

74% of patients who were found to have an elevated blood pressure in a non-treating provider’s office were scheduled an appointment with a treating provider within 4 weeks.

Improvement in blood pressure control rate:

2%
All primary care providers have been given their “BP audits”

Data provided:
• MRNs and visit dates where BP high
• Overall control rate %
• Rank among all PCPs
• Meds changed when BP high %
• F/U scheduled within 4 wks %
• Number of meds prescribed
• Number of maxed out meds prescribed

Findings:
Control rate ranged from 42.6% to 74.6%
Higher performing providers were:
• 3x more likely to titrate meds when BP was high
• 4x more likely to schedule f/u within 4 wks when BP was high
• More likely to use more meds (2.7 vs 2.1)
Hypertension

Results?

74% of patients who were found to have an elevated blood pressure is an a non-treating provider’s office were scheduled an appointment with a treating provider within 4 weeks.

Improvement in blood pressure control rate: 16%
Lessons Learned - How to Avoid Clinical Inertia

Provider education – guidelines are necessary but not sufficient
- Education on benefits, costs, and side effects of treating to target
- Address the complexity of treating to target for different disorders (glycemic control, hypertension, and dyslipidemia)

Structure our care delivery systems to facilitate management of chronic diseases
- Utilize electronic medical record systems, best practice advisories, flowsheets, and disease registries
- Expand the care team
- Active outreach and planned visits to increase opportunities for “titratable moments”

Provide performance feedback
- Dashboards and audits – timely and specific
- Chart review with face-to-face peer feedback

Clinical Inertia Lawrence S. Phillips, MD, et. al Ann Intern Med. 2001;135:825-834
March Webinar

- **Date/Time**: March 21, 2019 from 2-3pm Eastern
- **Topic**: Overcoming Barriers to Diabetes Self-Management Education (DSME) Referrals
- **Presenters**:
  - Jodi Lavin-Tompkins, M.S.N., R.N., CDE, BC-ADM (American Association of Diabetes Educators)
  - Valerie Spier, M.P.H., R.D., CDE (Sutter Health)
Questions