Monthly Campaign Webinar
July 18, 2019
Today’s Webinar

• Together 2 Goal® Updates
  – Webinar Reminders

• Innovator Track Cardiovascular Disease Cohort Results
  – Erica Taylor and Cori Rattelman of AMGA

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

• Webinar will be recorded today and available the week of July 22\textsuperscript{nd} 
  – 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 Institute for Quality Leadership

Embracing Disruption
Delano Las Vegas
Las Vegas, NV

August 9: Early Bird Deadline to register with discounted rate
Today’s Featured Presenters

Erica Taylor
Senior Quality Improvement Project Manager,
National Health Campaigns
AMGA Foundation

Cori Rattelman
Senior Research Analyst
AMGA Analytics
The Heart of Progress: Updates and Insights from the Innovator Track CVD Cohort
Innovator Track Overview

Cardiovascular Disease Cohort

Eye Care Cohort
CVD Cohort

• Purpose: To identify best practices for the *prevention* and *management* of CVD in people with T2D
National Impact

T2D Patients: 166,000+
FTE Physicians: Nearly 4,000
Participant Expectations

**Daily**
Action Plan Implementation

**Bi-Monthly**
Webinar Participation

**Quarterly**
Data Reporting
CVD Cohort Advisory Committee

LEAD ADVISOR

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HealthPartners Medical Group
Director of Pharmacy Services
Summit Medical Group, P.A.
Cardiologist
Summit Medical Group

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Cohort Measures

- **1**: Non-Tobacco User
- **2a**: Daily aspirin for 2º prevention
- **2b**: Daily aspirin for 1º prevention
- **3a**: Any statin
- **3b**: High-intensity statin
- **3c**: Measured LDL < 70

Daily Aspirin or Anti-Platelet Agent

Lipid Management for Secondary Prevention
Cohort Timeline

March
• Groups Announced

May
• Kickoff Meeting

June
• Action Plans Submitted

January
• Report Outs

June
• Wrap-up Meeting
CVD Cohort Data: 2018Q1(Baseline) through 2019Q1

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## Collaborative Performance: Group Weight Averages

<table>
<thead>
<tr>
<th>Measures:</th>
<th>Collaborative Average Group Outcomes</th>
<th>Baseline</th>
<th>2019Q1</th>
<th>Absolute Δ</th>
<th>Relative Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco-free</td>
<td></td>
<td>86.0%</td>
<td>87.2%</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Secondary: Aspirin</td>
<td></td>
<td>83.4%</td>
<td>84.6%</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Primary: Aspirin</td>
<td></td>
<td>57.1%</td>
<td>58.2%</td>
<td>1.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Any Statin</td>
<td></td>
<td>86.7%</td>
<td>88.2%</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>H.L. Statin</td>
<td></td>
<td>44.9%</td>
<td>49.5%</td>
<td>4.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>LDL &lt; 70</td>
<td></td>
<td>32.6%</td>
<td>36.4%</td>
<td>3.8%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

- Collaborative touched more than 190,000 patients with type 2 diabetes (T2DM)
  - 26% with evidence of cardiovascular disease (CVD)
- Improvements seen in all measures
- Highest gains in lipid management measures (secondary CVD prevention)
Geographic Distribution of Cohort
2019Q1: T2G Type 2 Diabetes (T2DM) Cohort by Primary/Secondary Status

- **Primary**: w/ T2DM and no CVD history
- **Secondary**: w/ T2DM and CVD history

**Age < 50**

**Age ≥ 50**
<table>
<thead>
<tr>
<th>Tobacco Free</th>
<th>Aspirin (Secondary)</th>
<th>Aspirin (Primary)</th>
<th>Rx Any Statin (Secondary)</th>
<th>Rx High Intensity Statin (Secondary)</th>
<th>LDL &lt; 70 (Secondary)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>
Measure 1: Tobacco-Free

- Proportion of T2G cohort patients whose most recent tobacco status is determined to be “tobacco-free”
- Denominator: 190,200 patients with type 2 diabetes across 12 groups
  - 1.1% relative improvement among all patients
  - 8 groups saw improvement, 4 groups with ≥ 2% relative improvement
  - 1,700 additional patients with tobacco-free status
Measure 2: Aspirin or Anti-Platelet Therapy

- Daily aspirin or anti-platelet agent for secondary CVD prevention
- Denominator: 48,900 patients with type 2 DM and evidence of CVD across 12 groups
- Relatively flat for cohort as a whole but individual groups with improvements
  - 8 groups ≥ 85%, 5 groups ≥ 90% by 2019Q1
  - 6 groups with improvements including 3 with relative improvements of 4%, 7%, and 14%
  - 600 additional patients with documented aspirin therapy (secondary prevention)

Improvements made through better documentation and increased therapy
Measure 2: Aspirin or Anti-Platelet Therapy

Improvements made through better documentation and increased therapy

Aspirin (Secondary)  Aspirin (Primary)

- Daily aspirin or anti-platelet agent for primary CVD prevention
- Denominator: 103,000 patients with type 2 DM, no evidence of CVD, age ≥ 50 across 11 groups
- 2.1% relative improvement among all patients
- 1,000 additional patients with documented aspirin therapy (primary prevention)
  - 6 groups with improvements, 3 with relative improvements of 3%, 12%, and 14%
Measure 3: Lipid Management

- Proportion of patients on any statin for secondary CVD prevention
- Denominator: 47,400 patients with type 2 diabetes and evidence of CVD across 11 groups
- 1.6% relative improvement among all patients
- 775 additional patients with a Rx for any statin
  - 7 of 11 groups improved
  - Range: 1.4% to 5.8% relative improvement (average across 7 groups 2.7%)
With Statin Rx: 2019Q1 Core measure

- Each colored bar represents one group in the cohort

Compare to the T2G campaign Core Track Cohort?

<table>
<thead>
<tr>
<th>Group</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>25th Percentile</td>
<td>69.9%</td>
</tr>
<tr>
<td>50th Percentile</td>
<td>73.8%</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>80.5%</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>84.3%</td>
</tr>
</tbody>
</table>

*Group weighted average for 11 CVD innovator cohort groups
With Statin Rx: 2019Q1 Core and CVD Innovator measures

- Each set of colored bars represents one group in the cohort
  - Left bar in each set is proportion of patients with T2DM that have Rx for statin, right bar is proportion of patients with T2DM + CVD that have Rx for statin

*Group weighted average for CVD innovator cohort
Measure 3: Lipid Management (Secondary)

- Proportion of patients on high intensity statin for secondary CVD prevention
- Denominator: 47,400 patients with type 2 diabetes and evidence of CVD across 11 groups
- 1,900 additional patients with a Rx for high intensity statin
- 10 of 11 groups saw improvement
  - 8 with relative improvement ≥ 5%
  - 5 with relative improvements ≥ 9%
  - 1 with relative improvement of 68%
Any Statin Rx by Group (Secondary)

Note: Groups sorted in descending order by proportion of secondary prevention patients with Rx for any statin (2019Q1).
Statin Rx Breakdown by Group (Secondary Prevention)

Individual Groups

Note: Groups sorted in descending order by proportion of secondary prevention patients with Rx for any statin (2019Q1).
Statins (Secondary Prevention)

- No Med: 9%
- Right Statin/Wrong Dose or Wrong Statin: 55%
- Right Statin/Right Dose: 37%

**High intensity**

Daily dosage lowers LDL-C by approximately ≥ 50% on average
- Atorvastatin (Lipitor), 40† to 80 mg
- Rosuvastatin (Crestor), 20 (40) mg
Statins (Secondary Prevention)

1. Right Statin/Wrong Dose
   Or
   Wrong Statin

Right Statin/Right Dose

No Med

High intensity

Daily dosage lowers LDL-C by approximately
≥ 50% on average

Atorvastatin (Lipitor), 40† to 80 mg
Rosuvastatin (Crestor), 20 (40) mg
Statins (Secondary Prevention)

1. Right Statin/Wrong Dose
   Or
   Wrong Statin

   - Baseline: 55%
   - 2019Q1: 31%

   - No Med: 9%
   - Rx high intensity statin: 62%
   - Rx low or moderate statin: 31%
Statin Rx Breakdown by Group (Secondary Prevention)

Note: Groups sorted in descending order by proportion of patients with Rx for any statin (2019Q1).
Measure 3: Lipid Management

- Proportion of secondary-prevention patients with most recent LDL < 70 mg/dL
- Denominator: 48,900 patients with type 2 diabetes and evidence of CVD across 12 groups
  - 1,640 additional patients with LDL < 70 mg/dL
  - All 12 groups saw improvement, 8 had > 10% relative improvement
  - 3 groups with relative improvement between 19% and 48%

LDL not measured in last 12 months = non-compliance
Improvements can come from increased monitoring and/or better control

<table>
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<th>Rx High Intensity Statin (Secondary)</th>
<th>LDL &lt; 70 (Secondary)</th>
</tr>
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<tbody>
<tr>
<td>%</td>
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3.5% absolute improvement
11.7% relative improvement
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<tr>
<th>Measures:</th>
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<th>Additional Patients w/ positive outcome¹</th>
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¹. Increase in patients due to measure rate improvement from baseline (calculated as the sum of positive absolute improvement in rate times the denominator in final measurement period).
Participant Interventions

- Provider Education: 13%
- EHR Enhancements: 10%
- Care Redesign/Workflow Improvements: 21%
- Patient Outreach and Education: 21%
- Data/Documentation Improvements: 16%
- Elevate Emphasis within Leadership: 19%
Intervention Hot List – Top 5

• #5: Leveraging EHR to better identify or treat risk

Best Practice Alerts

Smart Phrases

Diabetes Order Sets
Intervention Hot List – Top 5

• #4: Integrating pharmacy team into DM/CVD efforts
Intervention Hot List – Top 5

• #3: Leverage data reports to identify patient gaps

Registry of DM Patients at Risk for CVD

List of High-Intensity Statin Candidates

Unblinded Provider Data re: Prescribing Statins, Evidence-Based CVOT Meds
Intervention Hot List – Top 5

• #2: Educate providers on relevant topics
Intervention Hot List – Top 5

• #1: EHR integration of ASCVD risk calculator
Lessons Learned – 1 of 4

• Educating and engaging all members of the care team is vital to success
  – Securing buy-in from leadership is crucial
  – Identifying a physician champion can amplify efforts
  – Educating providers on “why” helps to engage them; provider engagement enables organizational change
Lessons Learned – 2 of 4

• Targeted, data-driven communication can be effective for motivating both patients and providers
  – Evidence-based recommendations improve patient willingness to comply with provider guidance
  – Employing data-driven, face-to-face communication with providers can help overcome clinical inertia
  – Integrating evidence-based guidelines into provider tools (e.g., BPAs) can help clear up provider confusion
Lessons Learned – 3 of 4

• Data and technology can work for you and against you
  – Data review, validation, and monitoring can clarify needs and guide efforts more effectively
  – EHR challenges and deficiencies can be large roadblocks to quality improvement initiatives
  – Consider health IT factors (e.g., upcoming platform changes or integrations) and their implications when deciding on the feasibility and timing of initiatives
Lessons Learned – 4 of 4

• Quick wins are possible, but long-term change takes time and consistent effort
  – Embrace incremental improvements by targeting “low-hanging fruit” (e.g., right statin, wrong dose)
  – Learn from the efforts of others, but customize the approach based on your unique situation
  – Change will come, but only with time, patience, and consistency (in messaging, effort, and follow-up)
Stay Tuned for More!

2019

Case Studies (September)

2020

AMGA Annual Conference (March)
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AMGA Solutions Library
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The Boehringer Ingelheim and Lilly Diabetes Alliance
August Webinar

- **Date/Time**: August 15, 2019 from 2-3pm Eastern
- **Topic**: Embedded Pharmacists in Primary Care
- **Presenters**: Diane L. George, D.O. and James Kalus, Pharm.D. of Henry Ford Medical Group
Questions