



Together2Goal[®]
AMGA Foundation

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



Watson Clinic LLP

Organizational Profile

Established in 1941, Watson Clinic (watsonclinic.com) is an independent, physician-owned organization with nearly 1,600 employees serving the greater Lakeland (FL) area. Watson Clinic has nearly 300 physicians and 216 full-time equivalent (FTE) physicians; nearly 20% of the clinic's providers are primary care providers. With 40 specialties that operate in 13 state-of-the-art locations across three counties, Watson Clinic conducts more than one million outpatient visits per year.

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 (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 with diabetes age 65 or older die from some form of heart disease, and 16% die of stroke.²

Since Watson Clinic strives to provide the best care possible to patients, they joined the Together 2 Goal® (T2G) Innovator Track Cardiovascular Disease Cohort (CVD Cohort) to address this growing epidemic among their patient population.

During the 12-month CVD Cohort, Watson Clinic focused on raising awareness among key audiences and leveraging technology to better identify and treat the patient population. The project team met with the Cardiology Department, clinical directors, and the Clinical Informatics (CI) Department to raise awareness about the link between diabetes and CVD and to strategize ways to enhance the current approach to focus on CVD risk. By leveraging their existing analytics tool, Watson

Clinic also created registries that helped providers better identify and care for their diabetes patients at greater risk for CVD.

Watson Clinic saw improvements in all measures during the CVD Cohort. Highlights were a 48% relative improvement on measured LDL cholesterol less than 70 mg/dL and a 15.8% relative improvement in patients on a high-intensity statin for secondary prevention, as those were areas of particular interest to the team.

Given the team's experience during the CVD Cohort, Watson Clinic concluded that early identification and engagement of a physician champion may amplify results. The team also determined that creating detailed project plans with clear action items and timelines is helpful to achieving results. Finally, Watson Clinic noted the important role that knowing and understanding data and reporting capabilities can have on deadlines and results.

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, Watson Clinic worked to align collaborative measures with organizational goals as well as to assess existing workflows and protocols and update them to focus on CVD risk. Watson Clinic's organizational aims were to:

- Engage physicians to take a more coordinated approach in managing and treating their patients
- Improve care team huddles to review scheduled patients who meet the designated criteria
- Improve electronic health record (EHR) functionality to incorporate a CVD risk calculator and defined diabetes order sets

Existing Diabetes Population and Care Structure

Watson Clinic serves more than 11,000 patients with diabetes. Watson Clinic's primary care physicians, endocrinologists, and cardiologists collaborate to provide diabetes patients with the best possible care. Providers develop the best treatment plan for each individual patient—to include pharmacologic treatment when appropriate—by reviewing the patient assessment, vital signs, and all laboratory values. Providers use individual smart phrases within their office note templates that pull in A1c, LDL, and obesity information, along with the ability to create goals. When necessary, they make internal referrals to the Cardiology Department and the Diabetes Education Department for additional support (e.g., educational classes).

To manage its fast-paced practice, Watson Clinic converted to Epic for its EHR in April of 2017. Watson Clinic has diabetes protocols in place and education materials embedded in the EHR that were utilized before and during the collaborative.

During the collaborative, Watson Clinic used the EHR—in addition to Optum® One—to monitor and report the selected CVD Cohort measures. Optum® One created variables using underlying data from a variety of data sources which included prescription tables, prescription history/patient reports, CPT/G codes, health maintenance tables, and ICD codes. Custom reports were created by the Optum® Analytics data team. These reporting templates were used to retrieve data needed for AMGA reporting and to identify populations for Watson Clinic interventions.

When identifying patients with evidence of CVD, Watson Clinic looked for patients who had evidence by diagnosis, event, or procedure, including: myocardial Infarction; coronary artery bypass grafting; stent placement; angioplasty or artherectomy; coronary artery disease; peripheral vascular disease; and cerebrovascular disease. The EHR was utilized for the reporting of high intensity statins since this variable was not available in Optum® One.

These methods identified that around 9,500 of Watson Clinic's diabetes patients met the criteria specific to the CVD Cohort. These patients are cared for by more than 60 physicians across five sites.

Interventions

Watson Clinic's primary interventions focused on raising awareness among key audiences and leveraging technology to better identify and treat the patient population.

Initial efforts to raise awareness included meeting with Watson Clinic's Cardiology Department—including the clinical director, clinical coordinator, physicians, and advanced practice registered nurses (APRNs)—to discuss CVD Cohort measures and share baseline data. From this discussion, the project team identified three CVD Cohort objectives that aligned with the existing cardiology practice: identifying patients not on a statin, increasing high-intensity statin use, and monitoring LDL.

Project team members also raised awareness about the project goals by meeting with clinical directors and the Quality Improvement committee on a regular basis to share information about the project and provide data updates after each measurement period.

Watson Clinic also identified the need to enhance the EHR to identify and manage diabetes and CVD. Although the project team wanted to implement the CVD risk calculator in Epic, they were unable to do so given an Epic upgrade in October 2018 and low engagement from physicians. Due to the increased focus on CVD risk in diabetes patients, however, providers successfully continued to utilize smart phrases within the EHR to help set goals, and manage and monitor diabetes patients.

While Watson Clinic did not disseminate new educational materials or implement new EHR tools, the team did see improvement in several measures based on providing education, training, and feedback.

Outcomes and Results

Watson Clinic saw improvements in all measures during the CVD Cohort (see Appendix).

Watson Clinic placed particular focus on the high-intensity statin and LDL measures, as they were areas of emphasis for the organization.

Watson Clinic saw a 15.8% improvement in patients on a high-intensity statin during the CVD Cohort (i.e., Measure 3b), from 36.3% of patients at baseline to 42.1% of patients at the conclusion. The team was pleased to see some movement in the high-intensity statin measure and hopes for continued improvement in this area.

The organization saw a 48 % relative improvement in measured LDL less than 70 mg/dL (i.e., Measure 3c), from 24.8% at baseline to 36.8% at the conclusion. This represents an improvement in more than 500 patients. Watson believes this increase was due in large part to the increased awareness and the engagement of the Cardiology Department.

While Watson Clinic did not focus on the tobacco-free measure (i.e., Measure 1) given that the baseline measure was 88%, the team did develop a registry in Optum One to identify whether patients have necessary EHR documentation for smoking cessation.

Watson Clinic also did not focus on aspirin for primary prevention (i.e., Measure 2b), as some providers were concerned about the risk of gastrointestinal bleeds outweighing the benefits given recent research.

Lessons Learned and Ongoing Activities

During the CVD Cohort, Watson Clinic made significant strides, but still has areas in which it hopes to improve. The team feels that part of its success was due to constant communication with leadership and providers and constant data and information sharing with key internal audiences.

One lesson Watson Clinic learned from the CVD Cohort is the importance of detailed project plans and timelines. In retrospect, Watson Clinic would handle things differently by developing a more comprehensive project plan and incorporating clear timelines.

The team also determined that identifying and engaging appropriate leadership such as a physician champion is important to project success. The project team noted that engaging team members from the CI Department is important, as they can lead information technology initiatives such as additions within the EHR.

Watson Clinic experienced a few challenges throughout this collaborative. Optum One was unable to report which patients were on a high-intensity statin. This added an extra step and additional validation for the quality team, which in turn delayed this data by about a week when it came time to report. There was also some resistance to notifying cardiology care teams of scheduled diabetes patients with missing LDL values or patients not on a high-intensity statin and without contraindications. Reasons given were high office volume and claims that it could not be incorporated into current workflow. Finally, Watson Clinic was unable to implement the CVD risk calculator during this collaborative due to an Epic upgrade in October 2018 and other time-sensitive projects.

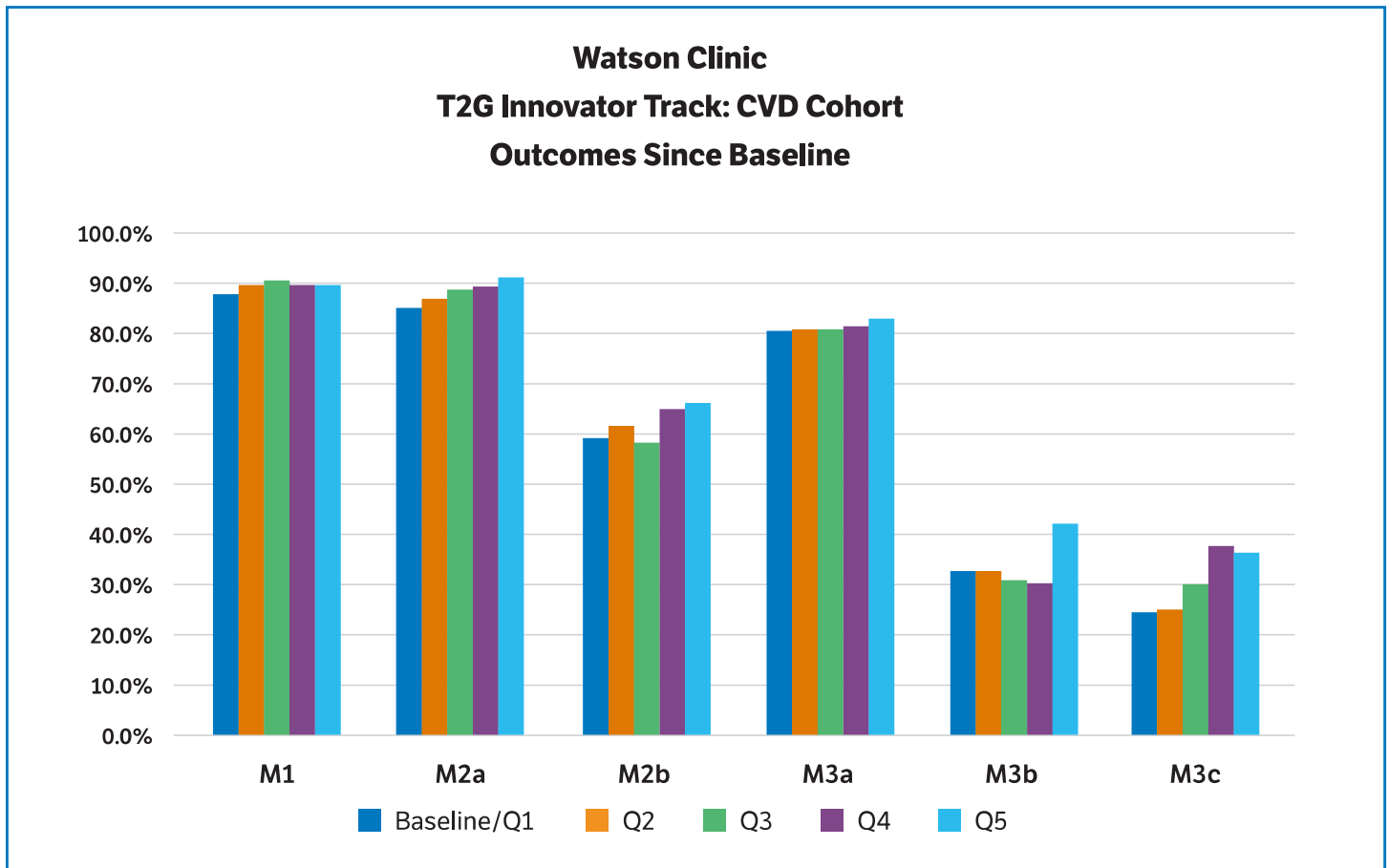
Watson Clinic will continue tracking all measures included in this collaborative. In the future, the team plans to filter results by provider in order to have more focused group discussions with providers. They also plan to pilot a process to notify cardiology APRNs of scheduled patients who meet certain lipid management criteria (i.e., patients who have an LDL greater than 70mg/dL; who are missing a recent LDL; who are not on a statin with no clinically supported rationale; and who are not on a high-intensity statin). To assist with future efforts, the project team is also working on identifying a physician support champion in cardiology and family practice/internal medicine. Watson Clinic plans to continue its work with the CI team on implementing the CVD risk calculator and diabetes order set in their EHR. The ultimate goal is to celebrate and share provider and care team successes.

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 ≥ 50 years, secondary prevention

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

M3a: Any statin, secondary prevention

M3b: High-intensity statin, secondary prevention

M3c: LDL < 70 mg/dL, secondary prevention

Project Team

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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.



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