



Advancing High Performance Health

AMGA Foundation

Chronic Care Roundtable

Prevention, Screening, Diagnosis, and Treatment: Combating Clinical Inertia in CKD and Other Cardiometabolic Conditions

November 9, 2021

Meeting Summary





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Despite the heroic efforts of healthcare providers, the COVID-19 pandemic has strained resources at health systems and medical groups, exhausted the teams delivering care, and left patients disconnected, both physically and mentally. One result has been clinical inertia—burnout, fatigue, disassociation, and a lack of motivation—which plays out in a failure to establish appropriate targets, escalate treatment, and initiate or intensify therapy. Clinical inertia is particularly detrimental and costly in the cases of cardiometabolic conditions like chronic kidney disease (CKD).

On November 9, 2021, Chronic Care Roundtable participants, including industry partners and leaders from health systems and medical groups across the country, convened in Washington, DC, to evaluate the impact of the COVID-19 pandemic on primary care models that advance the prevention, screening, diagnosis, and treatment of cardiometabolic diseases and complications.

Following an introduction and welcome by John W. Kennedy, M.D., chief medical officer at AMGA and president of AMGA Foundation, the meeting examined clinical inertia and cardiometabolic disease from multiple angles, including challenges and opportunities in CKD population health, opportunities to improve kidney care in patients with type 2 diabetes, and the impact of influenza vaccination on cardiovascular outcomes.

In presentations, breakout sessions, and ongoing conversations, participants shared stories and statistics about the current state of health and care, plus ideas for overcoming clinical inertia for the benefit of patients, providers, and health systems and medical groups as the nation continues to battle COVID-19 and its many related challenges.

KEYNOTE

CKD Population Health: Challenges and Opportunities

Joseph Vassalotti, M.D., *Chief Medical Officer, National Kidney Foundation*

Recent years have brought many promising developments to CKD. Medicare beneficiaries with end-stage kidney disease became eligible for Medicare Advantage, and three drugs with powerful potential for reducing kidney failure and cardiovascular disease received U.S. Food and Drug Administration (FDA) approval: canagliflozin (Invokana[®]) and finerenone (Kerendia[®]) for kidney indication in adults with type 2 diabetes and CKD, and dapagliflozin (Farxiga[®]) for kidney indication in adults with CKD with and without type 2 diabetes.

Meanwhile, public awareness and efforts around CKD have intensified. The U.S. Department of Health and Human Services (HHS) launched the Advancing American Kidney Health initiative with a goal to reduce the incidence of kidney failure by 25% by 2030, and the National Kidney Foundation introduced its “Are you the 33%?” campaign, centered around the fact that 1 in 3 adults in America are at risk of life-threatening kidney disease and many don’t know it.



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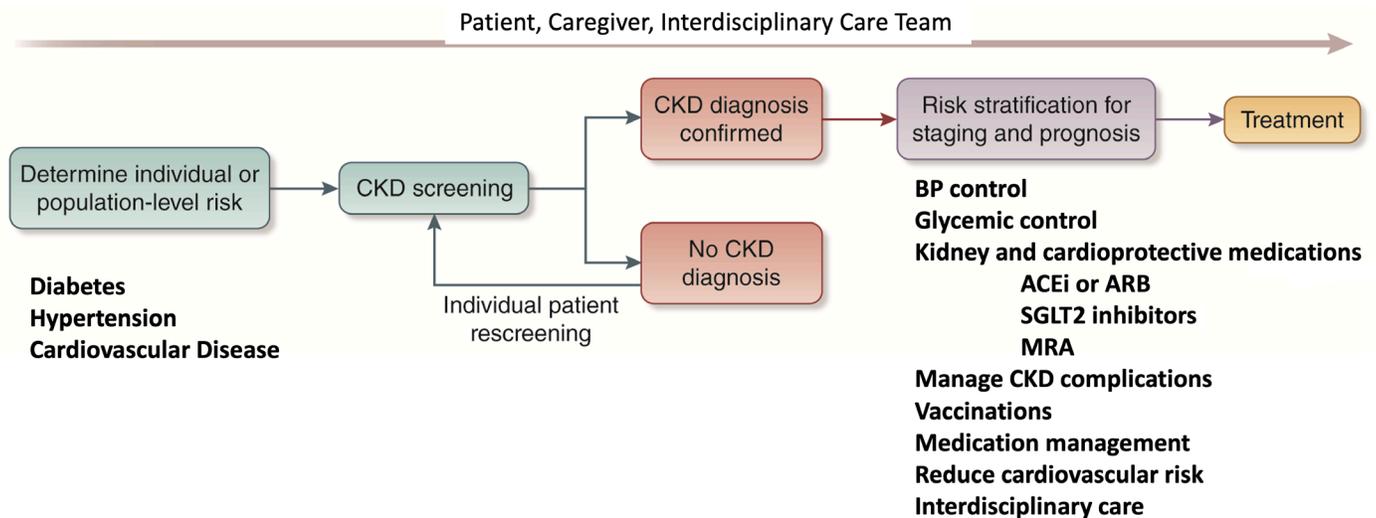
Yet the COVID-19 pandemic paralleled these advancements, increasing the risk of hospitalization and mortality for CKD patients while highlighting care inequities and gaps across the community. Even with telehealth, the pandemic put much innovation and care on hold, and the journey isn't over, Vassalotti cautioned.

Vassalotti shared recent research on screening, diagnosis, and treatment, (see Figure 1), as well as provided recommendations for improving rates and outcomes.

Expand CKD testing for patients with type 2 diabetes, evaluating kidney health at least once a year with both estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine (uACR) tests.

“Most patients just get the eGFR and not the uACR. Clinicians need to think more about low eGFR and albuminuria and how they predict kidney failure and mortality,” Vassalotti said. He noted that the current testing rate of more than 40% “should be 100% with people who have diabetes and combined diabetes/hypertension.”

Figure 1: Evaluating Risk of CKD Progression



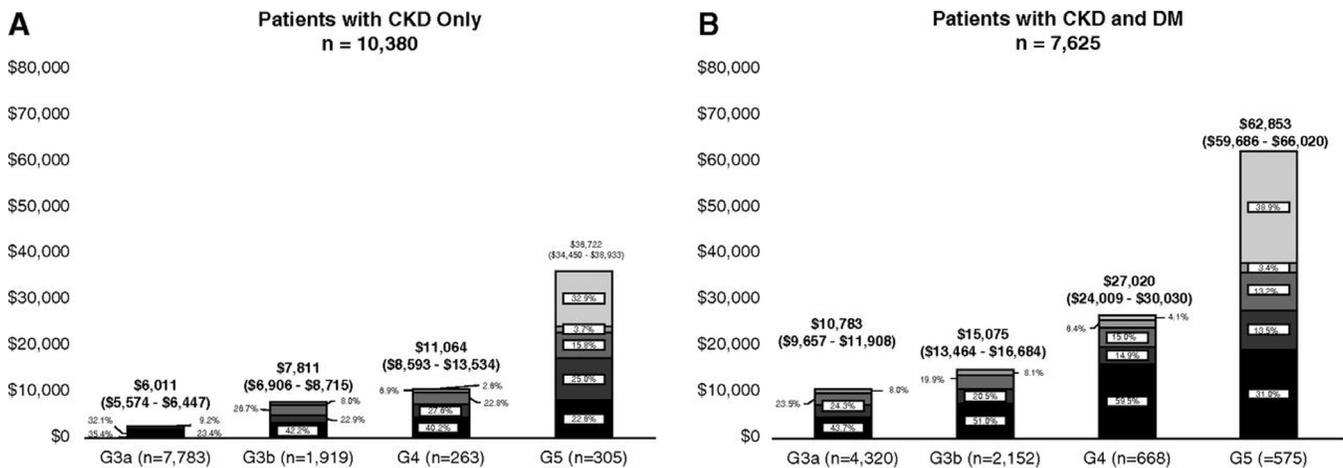
Kidney Int. 2021;99(1):34-47.



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For patients, low eGFR and albuminuria can be powerful predictors of kidney failure, heart failure, and mortality. For healthcare organizations, reducing comorbidities such as type 2 diabetes, cardiovascular disease, and heart failure in CKD patients can be an effective tool for managing costs (see Figure 2).

Figure 2: As eGFR Falls, Costs Multiply: Population Medical Costs by CKD G Stage



Annualized mean medical costs in total (95% CIs) and by resource adjusted for age, sex, and race/ethnicity for patients with CKD and (A) no comorbidities and (B) diabetes dramatically with declining kidney function. Similar patterns for (C) cardiovascular disease and heart failure (D) are not shown. The comorbidity groups are not mutually exclusive.

Gregory A. Nichols et al. *JASN* 2020;31:1594-1601

Expand evidence-based vaccinations for CKD patients to include annual influenza shots, as well as pneumococcal and COVID-19 vaccines. By helping to reduce hospitalizations, “vaccines are our secret sauce,” Vassalotti declared. He noted that monoclonal antibodies have also been shown to reduce COVID-19-associated hospitalizations and deaths by 70% and that home dialysis CKD patients suffered fewer infections than those who had to travel to clinics for treatment.

Rethinking the path forward to health equity. Vassalotti explained how the use of an African American coefficient to measure how well the kidneys filter blood is shifting to one coefficient for everyone, with immediate implementation of the CKD-EPI creatinine equation refit, without the race variable, supported by a broader discussion of social determinants, family history, and genetics.

“Nephrology is the first medical specialty to address and eliminate a commonly used race-based calculation, and we will work with other professions to do this,” Vassalotti said.



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Take an interdisciplinary approach to kidney care, with risk stratification upon confirmation of a CKD diagnosis followed by monitoring and medication management via a multifaceted team: primary care, pharmacist, dietitian or diabetes educator, endocrinologist, cardiologist, and nephrologist. Numerous resources offer support, including the eGFR calculator on kidney.org and virtual patient monitoring and pharmacy management tools such as Mt. Sinai Health Partners Care Management Program.

Q&A

Who should be in charge of patients? Nephrologists, cardiologists, or primary care?

All three need to work together, participants agreed. Too often, primary care physicians dominate care until patients need dialysis instead of serving as gatekeepers for understanding overall patient health, coordinating care such as medications, and charting patient progression toward a need for nephrology. For example, patients with an estimated glomerular filtration rate of less than 30 should see a nephrologist. Econsults can help care teams discuss each party's scope of practice.

How does this coordination extend into medication management?

Because kidney disease impacts all of a patient's medications, care teams must address medication management in a systematic way. This includes training and education to counter the perception that all over-the-counter drugs are safe, as some may be toxic for CKD patients. Participants also discussed extending care teams to include cardiologists, psychiatrists, and hospitals, where hypoglycemia poses a significant risk to CKD patients.

Opportunities for Improved Kidney Care Among Patients with Type 2 Diabetes

Nikita Stempniewicz, M.Sc., *Director, Research and Analytics, AMGA*

In the United States today, one out of three (33%) people with type 2 diabetes also have chronic kidney disease (CKD)—and most don't know it. How are clinical guidelines impacting testing patterns? How often are patients detected to have elevated albuminuria classified as being at risk of CKD? How does testing vary within and across health organizations and by patient characteristics?

AMGA—in cooperation with Johns Hopkins University, Geisinger, Janssen Pharmaceuticals, and AD Healthcare—published a study exploring these questions and more.

Chronic Kidney Disease Testing Among Primary Care Patients with Type 2 Diabetes Across 24 U.S. Health Care Organizations examined over half a million (513,165) adults across a wide age group (18–85 years). This study focused on patients who had been diagnosed with type 2 diabetes in the past two years and had not experienced



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hospice care, stage 5 CKD, or end-stage kidney disease in the past two years or pregnancy in the past year. The study used electronic health record data, including outbound billing claims, from 24 healthcare organizations and 1,164 clinical practice sites. Stempniewicz shared the following highlights from the study.

Kidney disease testing lags behind current American Diabetes Association (ADA) guidelines. The ADA recommends testing patients with type 2 diabetes at least once a year for estimated glomerular filtration rate (eGFR) to see how well their kidneys are working and urine albumin-to-creatinine ratio (uACR) for kidney damage. While the study revealed high eGFR testing rates, uACR testing was performed among only 50% of patients within one year and 75% within three years.

Among all patients with type 2 diabetes, the average prevalence of detected elevated albuminuria increased linearly with uACR testing (see Figure 3).

In the study, half of patients with CKD had elevated uACR without decreased eGFRs—underscoring the importance of using both tests.

Figure 3: uACR and eGFR Testing Rates

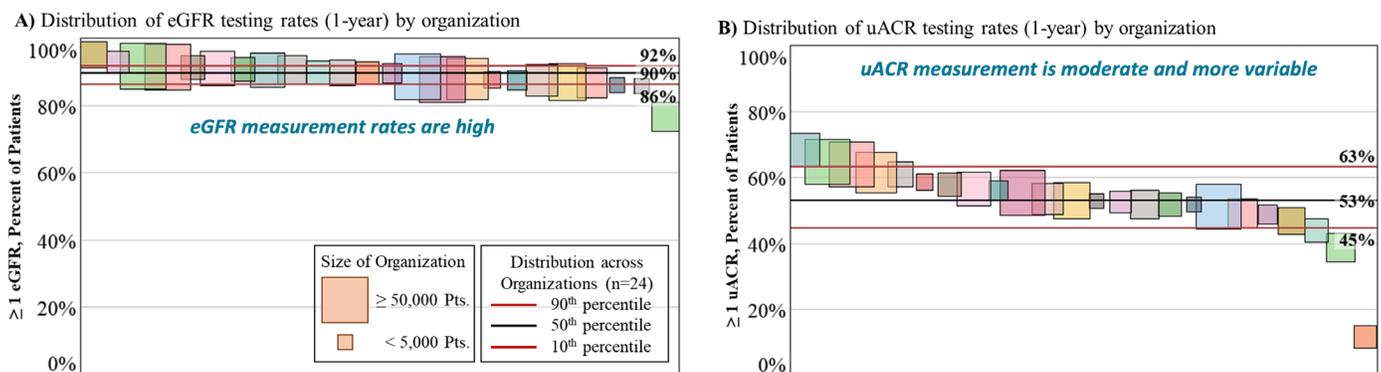


Figure 1: eGFR (panels: A, C) and uACR (panels: B, D) 1 year measurement rates by HCO (panels: A, B) and sites of care within HCOs (panels: C, D)

- Many organizations have at least one site among the **lowest-** and **highest-** performing sites across all organizations

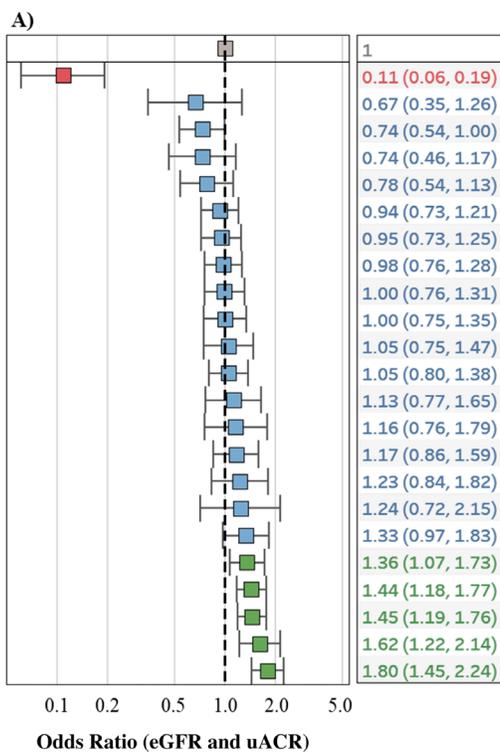
Each square reflects a different healthcare organization (HCO) which are ranked (horizontally) in descending order based on measurement rates. Each set of colored circles reflects the sites of care within the respective HCO with the same color above.



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Testing varied across and within healthcare organizations. “We saw dramatic testing variation among clinical practice sites within every organization, with some of the highest-performing organizations for eGFR testing being some of the lowest-performing for uACR testing,” Stempniewicz said. Overall, he noted: “Most organizations had sites with high testing rates from whom to learn, and sites with low testing rates that need improvement.” (See Figure 4.)

Figure 4: Differences in Testing (1-year) Across Healthcare Organizations



- After adjusting for differences in patient and clinical characteristics, odds ratio across healthcare organizations ranged from 0.11 to 1.80

Odds ratios were calculated using logistic regression with robust standard errors clustered by clinical practice site (error bars show 95% confidence intervals). Adjusted for age, sex, race, ethnicity, insurance, rural urban commuting area, median household income, smoking, comorbid conditions (ASCVD, CKD, diabetic retinopathy, heart failure, hypertension) diabetes complication severity index, utilization (visits with any provider, with nephrologists, with endocrinologist, and for education), medications prescribed (ACE-I/ARB, GLP-1 RA, SGLT2 inhibitor, statin), HbA1c control (< 8.0%), and BP control (< 140/90 mmHg). Odds ratio > 1.0 indicate increased odds of testing.

Testing varied based on several patient characteristics. Rates for both eGFR and uACR testing were higher for older patients and patients with a higher median household income, while female Medicare and Medicaid patients from rural areas saw lower eGFR and uACR testing rates.

Prescribing lags ADA guidelines. ADA-recommended medications for patients with CKD, type 2 diabetes, and hypertension include angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin receptor blockers (ARB) for lowering blood pressure and sodium glucose transport protein (SGLT2) inhibitors for preventing the reabsorption of glucose from blood filtered through the kidneys. SGLT2 inhibitors are recommended for reducing CKD progression and addressing cardiovascular disease. Glucagon-like peptide receptor-1 antagonists (GLP-1 RAs) have been noted to reduce albuminuria and its progression and reduce cardiovascular events.



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“GLP1 and SGLT2 prescriptions increased in recent years, yet no evidence exists that patients with CKD, heart failure, or ASCVD [atherosclerotic cardiovascular disease] are more likely to receive an SGLT2 or GLP1,” Stempniewicz noted.

Enlisting endocrinologists in the prescription process is one way to turn this trend around. Among cardiologists, family practitioners, general internists, and nephrologists, endocrinologists tend to be most familiar with ADA guidelines.

Q&A

What factors underlie this lack of testing?

Participants discussed a combination of factors: workflow issues, a lack of education, and a lack of a quality measurement until recently.

Did the study look at testing trends by line of business?

Yes. Medicare/Medicaid patients had lower testing rates than those covered by commercial insurance. Patients had at least one visit with a primary care physician.

How did COVID-19 impact eGFR and uACR testing?

Tests per month began decreasing in March 2020, with uACR seeing a slightly larger decrease. Testing quickly recovered in June and stabilized in August and September.

Opportunities to Improve Kidney Care in Patients with Type 2 Diabetes

- **Increase uACR testing**
- **Increase confirmatory testing and CKD diagnosis among patients with lab evidence of CKD**
- **Adopt new kidney-related quality measures**
- **Prescribe more guideline-recommended medications to appropriate patients**

Influenza Vaccination Impacts on Cardiovascular Outcomes

John W. Kennedy, M.D., *President, AMGA Foundation, and Chief Medical Officer, AMGA*

Influenza impacts multiple organ systems and can make patients more susceptible to secondary bacterial infections, cardiovascular events such as acute myocardial infarctions (MI) or stroke, functional decline, and loss of independence. Influenza can also exacerbate conditions like diabetes mellitus, renal disease, and chronic obstructive pulmonary disease (COPD). More than 9 out of 10 (90%) adults hospitalized for influenza had at least one chronic medical condition (CMC).

Influenza immunization is a critical part of the HHS Healthy People 2030 initiative, with a goal to have 70% of Americans immunized by the end of this decade.



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Unfortunately, COVID-19 has Americans lagging behind that goal. For the 2019-2020 flu season, only 63.8% of children over six months, and only 48.4% of adults were immunized.

Kennedy shared recent research reinforcing the connection between influenza and CMCs—and the urgency of vaccinations. A study in Scotland looked at adults over 40 years of age with a first-time myocardial infarction from 2004 to 2014. It found a tenfold increase in myocardial infarctions within three days of influenza infection, and an eightfold increase in stroke. A 2010-2016 study in Denmark similarly found increased incidence rate of first MI and stroke after developing influenza.

Kennedy also discussed the vaccination gap in at-risk groups. According to the Centers for Disease Control and Prevention's (CDC's) 2012-2013 National Health Interview Survey, more than 90% of unvaccinated adults under age 65 had at least one visit with a healthcare professional where they could have been vaccinated, and a similar gap existed among cardiovascular disease patients. Nearly one-third of people over 40 years old with ASCVD are not vaccinated against influenza.

Those especially likely to fall into this vaccination gap are age 40-64, non-Hispanic Black or Hispanic, low-income, and uninsured. They tend to have a high school or less level of education and lack a usual source of care. Adults with two of these high-risk characteristics have a 2.5-fold increase in their odds of lacking flu vaccination.

Vaccinations are powerful tools for increasing health and health equity. Kennedy cited four randomized trials and 12 studies of patients with established cardiovascular disease (CVD) that demonstrated vaccination was associated with a 25% drop in total mortality and an 18% drop in cardiovascular mortality. Influenza vaccinations have also been shown to decrease MI chances by 15% to 45%. This puts influenza vaccinations in the same league as smoking cessation, statins, and anti-hypertensives for reducing the chance of an MI.



Rise to Immunize: 25 Million Vaccines by 2025

Just as MeasureUp/PressureDown® and Together 2 Goal® rallied health systems against heart disease and diabetes, respectively, the AMGA Foundation's national Rise to Immunize™ campaign aims to move the needle on routine adult vaccinations, specifically influenza, pneumococcal, Zoster, Tdap, and bundled vaccinations.

The campaign operates across five domains—provider and staff education, clinical support, IT/documentation, patient education, and financial management—and engages groups at three levels of readiness. Participants are supported with blinded data reports and a range of resources, including a campaign toolkit, community listserv, monthly webinars, a newsletter, mentorship, and tools for patients and providers.

**Learn more about Rise to Immunize™ at
amga.org/rise-to-immunize.**



PANEL SESSION

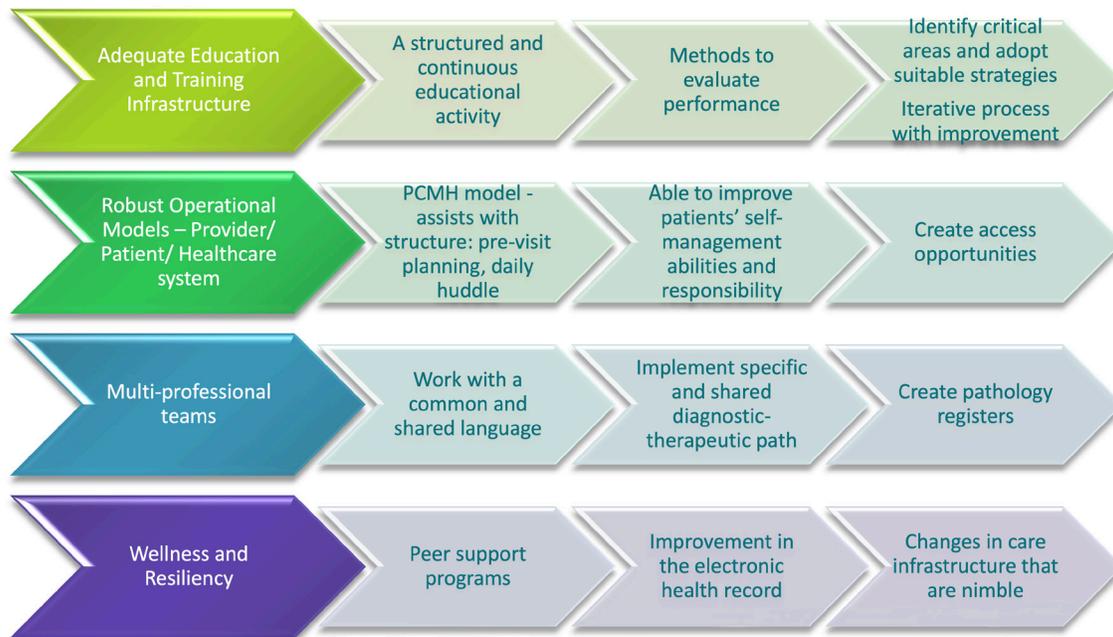
Moderated by **Francis Colangelo M.D., M.S.-HQs, FACP**

Screening, Diagnosis, and Treatment—Combating Clinical Inertia in CKD and other Cardiometabolic Diseases

Suelyn Boucree, M.D., M.B.A., FACP, *Medical Director, Quality, Hackensack Meridian Health*

Burnout among healthcare professionals is not new, but the problem has intensified during the COVID-19 pandemic. Boucree shared results from a local survey of 5,220 clinical and non-clinical team members: Nearly 8 out of 10 (79%) reported anxiety or depression, with 43% indicating “moderate to severe” levels, and nearly half (49%) reported burnout.

Figure 5: The Approach





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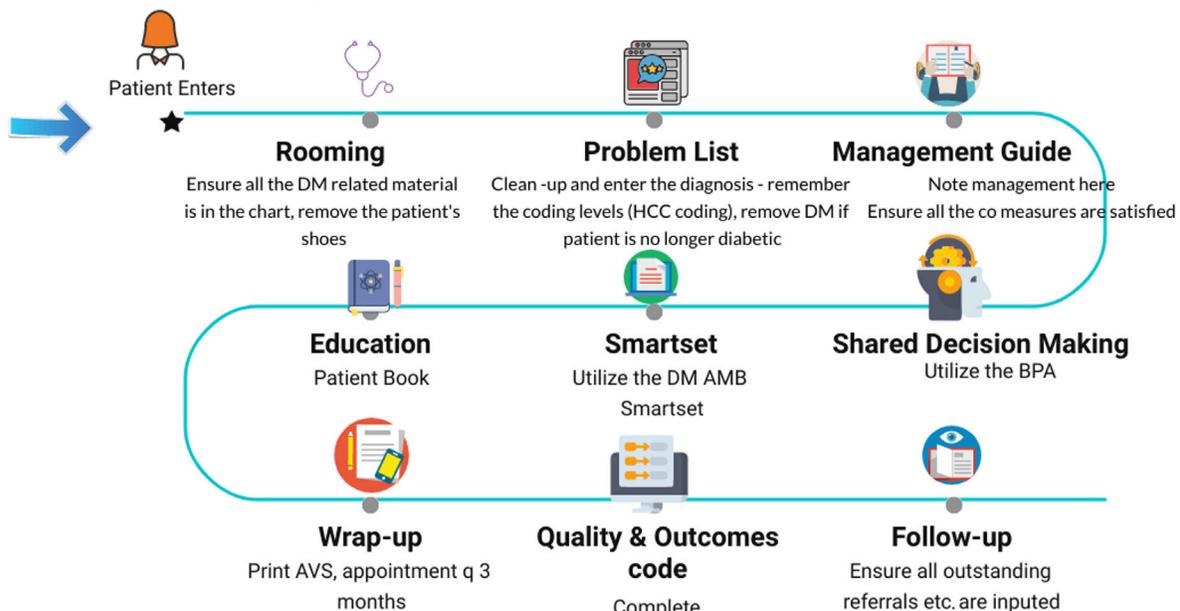
The resulting clinical inertia plays out across the healthcare ecosystem:

- **Healthcare professionals** may experience apathy toward escalating care and feel less accountable overall. They take more vacation days and switch jobs more frequently. They spend less time on patient education, and clinical encounters are incomplete.
- **Patients** are demotivated and have an increasingly fatalistic view of their treatment. They feel tired of hearing the same things at every visit (such as conversations about weight management) and are discouraged when they see no improvement in targets. Patients who are fearful of contracting COVID-19 may avoid the clinic setting altogether, exacerbating gaps in care.
- **Healthcare systems**, struggling “to keep the lights on” amid shortages in staffing and financial resources, are ill-equipped to grapple with these and other challenges.

Combating clinical inertia requires action on multiple fronts, Boucree declared. Multi-professional teams need to work with a common language across shared diagnostic and therapeutic paths, supported by pathology registers. They require peer support programs for wellness and resilience and adequate infrastructure for education and training, including methods for evaluating performance and making iterative improvements. Any changes in care infrastructure should be nimble (see Figure 5).

To maintain momentum across patients, providers, and the health system, Boucree suggested that organizations use robust operational models like the Patient-Centered Medical Home (which include activities such as pre-visit planning and daily huddles) to add structure, improve patients’ self-management abilities, and create opportunities for access. At an individual patient level, team workflows can help ensure comprehensive care at every stage: before, during, and after the visit (see Figure 6).

Figure 6: Meeting the Measure (HbA1c Poor Control)



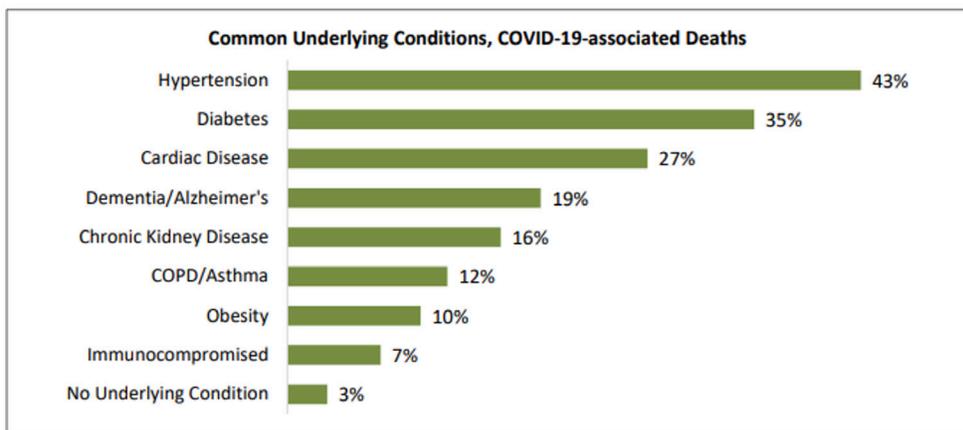


Combating Clinical Inertia in Cardiovascular Disease

Trung “Andy” Dang, M.D., *Medical Director, Quality and Population Health, Sharp Rees-Stealy Medical Group, Inc.*

Cardiovascular disease is the leading cause of death in the United States, and flu infections, hospitalizations, and comorbidities including hypertension and diabetes increase a patient’s risk even more. For example, the risk of a heart attack is six times higher within a week of a confirmed flu infection, and serious heart complications occurred in 12% of patients hospitalized with the flu (see Figure 7).

Figure 7: COVID Data: Common Comorbidities Associated with In-Hospital Mortality



Persons may have more than one underlying condition. These data are abstracted from death certificates and available medical records and may not reflect a complete list of underlying conditions for each person.

Reference: Rosenthal, N et al. Risk Factors Associated with In-Hospital Mortality in a US National Sample of Patients With COVID-19. *JAMA Network Open*.2020;3(12):e2029058. [doi:10.1001/jamanetworkopen.2020.29058](https://doi.org/10.1001/jamanetworkopen.2020.29058)[external icon](#)

Vaccinations and disease management are powerful tools for turning such outcomes in a positive direction. In fact, patients who are not fully vaccinated have a 34 times higher rate of hospitalization than those who are fully vaccinated. Yet the COVID-19 pandemic has hindered these efforts through reduced in-person visits, staff shortages, and burnout throughout the healthcare profession.



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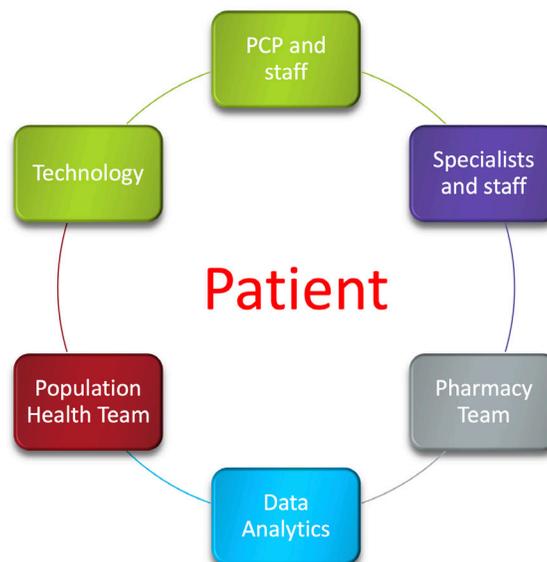
Organizations can resume their momentum through teamwork and technology. Dang cited tools such as electronic alerts for ordering a flu vaccine, data transparency for sites and physicians, and healthy competitions like Sharp Rees-Stealy's Stanley Cup Award, which is hand-delivered like the time-honored professional hockey trophy to clinics with improved scores.

Dang also suggested:

- **Leveraging multiple channels for vaccine outreach:** text messages, patient portals, phone calls, and beyond
- **Making care—primary care and beyond—easy to access** through convenient times at a variety of locations, such as primary care facilities, specialty clinics, vaccine sites, and population health nurse clinics
- **Helping patients manage comorbidities** through resources like statins for hypertension and initiatives like the CDC's National Diabetes Prevention Program

Throughout, tell a story, Dang advised. Screenings save lives, and quality measures drive good patient care. Engage the full care team from specialists to pharmacists to population health groups (see Figure 8).

Figure 8: Team-Based Approach to CVD



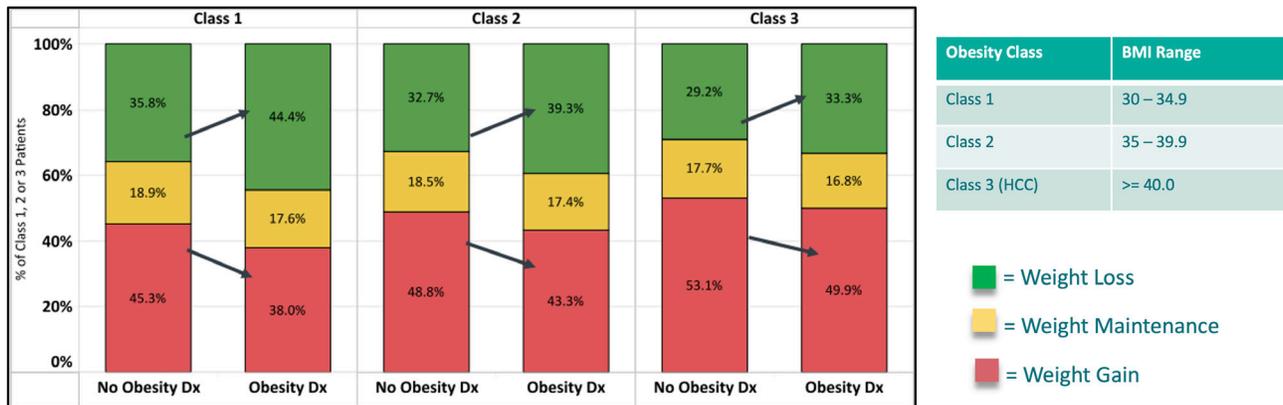


Clinical Inertia: Iowa Clinic Learnings on Moving the Needle

Barbara Hodne, D.O., Chief Quality Officer, The Iowa Clinic

Obesity is a hierarchical condition category (HCC) with a weighting of nearly three times that of diabetes without complications, so it is critical for care teams to code and assess. Yet a number of factors hinder effective obesity management, including a lack of provider education and knowledge, a need for support for understanding disease management tools, and provider discomfort with patient conversations around obesity (see Figure 9).

Figure 9: Importance of Coding and Assessing Obesity



*Source: AMGA Obesity Collaborative

Hodne shared tactics from Iowa Clinic’s “toolbox”: resources embedded in the organization’s electronic medical record (EMR), diagnoses and chart reviews before the patient visit, and education for providers and staff.

“If you deliver the news like it’s a character flaw, the result will be poor,” she said. “But when you put obesity in as a medical condition and have a conversation with the patient, the BMI improves.”

Iowa Clinic has been seeing progress with capturing HCC diagnoses and plans to monitor the impact of this on BMI reduction.

“It’s not a claim until a provider uses it,” Hodne said of the HCC code. “We need to make sure we have the right resources to help patients.”



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Panel Breakout Questions

Panelists and participants discussed their greatest challenges addressing CKD and other cardiometabolic conditions during the pandemic.

How can care teams help patients overcome vaccine hesitancy?

Factors from healthcare inequities to difficulties accessing care during the pandemic have resulted in a lack of trust—and a diverse group of vaccine-hesitant patients. Solutions are centered around communication and culture. One participant suggested encouraging a vaccinated loved one to speak to a hesitant family member or friend. “Having someone they trust can help them overcome their hesitation.”

In another example, a provider who recommended vaccinations during regular office visits—e.g., “It’s time for your vaccination today”—saw vaccination rates increase by around 40%. The provider would also talk to the patient, drawing out any concerns and then sharing relevant research.

How can teams build vaccine confidence?

With medical conditions like polio, participants remarked, the value of vaccination is more obvious. Today, by contrast, some patients may argue, “We don’t get the flu—why do we need a flu shot?” Other consumers may suspect vaccinations to be motivated by a “pharma boom” rather than population health. Meanwhile, misinformation campaigns online have created a “major trust issue.”

Participants emphasized the need for new messaging and scripting, with recognition of cultural differences. One organization partnered with local community groups to share the vaccination message in a “culturally sufficient” way.

How do health systems and medical groups overcome clinical inertia?

Clinical inertia isn’t new to the pandemic—it’s just been amplified over the past two years by systemic barriers, overloaded care teams, time constraints, EMR frustrations, and more.

Participants cited obstacles such as:

- Medication costs and pre-authorization. “The patient becomes overwhelmed and/or can’t afford it.”
- A remaining backlog of visits, with some patients still hesitant to stop by a clinic in person.
- Change management in general. Some patients insist on treatment from a physician, not support staff. Some care team members resist trying new things, even after receiving education on the reason why. “How do you change the way you process?”

Recommendations for overcoming inertia spanned the three “buckets” of care: the provider, the patient, and the system. One organization made albumin testing a standard, reinforced by alerts. Another enlisted a team wellness officer to provide support and evaluate progress system-wide.



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Risk stratification was discussed in many aspects, as were new ideas for resource utilization: enlisting care coordinators for patient outreach, allocating resources based on geography and zip code, and more. Pandemic-driven communication methods, such as videoconferencing and phone calls, helped care teams improve access and address social disparities.

How do providers overcome challenges to treating obesity?

Obesity management is critical to the management of CKD comorbidities like type 2 diabetes, but developing effective processes and outcome measures is easier said than done.

“It’s such a hard conversation to have, and one conversation doesn’t fix it,” a participant noted. In fact, one organization remarked that they weren’t able to pull patient records using obesity as a criteria because providers and patients weren’t having enough conversations on the subject.

“How do you approach it? It is not easy because it can be related to culture, food, and mental health. And it requires a long-term approach—it’s not one and done.”

Despite growing recognition of contributing factors such as nerve transmitters, hormone levels, and psychosocial influences, “we’re still on the discovery part of obesity,” one participant noted. Others discussed the difficulty in getting the right tools to the right patients, especially when interventions such as bariatric surgery come with a high price tag.

Suggested solutions ran the gamut, including:

- Removing barriers to medication adherence—for instance, revamping refill processes and protocols
- Teaching younger clinicians to understand obesity in a different way
- Helping patients tap their own motivation with goal-setting and encouragement. “Sustaining a BMI is hard work and should be considered a positive.”
- Strengthening alignment between pharmaceutical and patient goals, with better communications about the effectiveness of weight loss

Overall, one participant emphasized, it’s vital to understand where obesity falls in the care continuum, increase awareness that this care is available, and address any reluctance among providers and in the care delivery system.



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ROTATING BREAKOUT GROUPS

Session 1: Diet and Obesity

Moderated by **Robert Brenner, M.D., M.M.M.**, *President, Clinical Integration and Physician Enterprise, Valley Health System*

This group joined Hodne to discuss solutions related to patients' diet and obesity. Participants saw value in having a variety of options available, from health apps to pre-packaged meal plans.

Physicians should be trained in ways to approach obesity, such as interviewing patients in a motivational way, and feel comfortable discussing the importance of and plans for physical activity.

Genetic testing will be an important tool in the future, and insurance companies have a role to play in approving obesity medications.

Session 2: Combating Clinical Inertia

Moderated by **Stephanie Copeland, M.D., M.B.A., FAAP, CPHQ**, *Senior Medical Director, Quality DFW Market, WellMed Medical Group (TX)*

This group joined Boucree to discuss ways of combating clinical inertia in patients, physicians, and health systems in an integrated rather than "bucketed" fashion.

COVID-19 has been both a challenge and an opportunity for physicians, as the necessity of virtual meetings yielded many positives—like the long-term benefits of reaching out to patients with a simple phone call. When a patient knows a doctor will see them and interact with them, they have added incentive to manage their own health.

The pandemic further underscored the importance of making the best use of their limited resources and helping those in most need. When stratifying patients, providers should factor in disparities like transportation, medical costs, and experience with technology. Many elderly people struggle with remote appointments, for example.

Patients have been dealing with considerable stress as well. Many patients view hospitals as places of death, and many struggle with fear and loneliness. Even some health alerts, though intended to help, may increase patient stress levels. There are ways to help patients manage their conditions without making them anxious. Participants discussed glucose monitoring as one example. Patients move from being unsure to being actively involved in their own health and care.

On the provider side, insufficient emotional intelligence and lack of responsiveness from leadership to address concerns can exacerbate stress. Weekly talks can make care teams feel valued and can foster better working relationships.



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Session 3: Access to Care

Moderated by **Leon Jerrels, M.B.A., M.H.A., RN, CPHQ**, *Director, Quality Improvement, Kelsey-Seybold Clinic*

This group joined Dang to discuss access to care. COVID-19 has amplified shortages of providers and staff, making it difficult to provide patients with what they need for health and well-being. Although telehealth meetings have benefits, they can also be complicated. It may be difficult to hear what a patient is saying via a remote connection, for example.

Vaccine hesitancy complicates this further. Misinformation is common, so it is vital that care teams work to earn a patient's trust. It is important to listen carefully to a patient, ask them how they are doing, and address whatever reservations they may have about vaccination. Focus on vaccine competency and be mindful of health disparities.

Care teams should be mindful of culture and language differences and that each patient receives the necessary information in a way that is tailored to them. When a story is told by someone who looks like them and acts like them, they are more likely to listen and accept it. On a population health level, messaging delivered via trusted settings and channels, like barbershops and churches, can help. Providers can enlist marketing teams in these outreach and education efforts.

Closing

"I've never felt more strongly that what we do matters than during the pandemic. I feel we also are more connected to others," Vassalotti said in summary of his keynote presentation.

Chronic Care Roundtable participants will meet again on March 10, 2022, to discuss and find solutions for an evidence-based and equitable approach to secondary prevention, diagnosis, and treatment of cardiovascular disease.



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Thank you to our Chronic Care Roundtable
Corporate Partners



Mission:

AMGA Foundation enables medical groups and other organized systems of care to consistently improve health and health care.

Vision:

AMGA Foundation serves as a catalyst, connector, and collaborator for translating the evidence of what works best in improving health and health care in everyday practice.



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