Activity Title: Collaborative Approach to Improve the Cardiovascular Health of Patients With Rheumatoid Arthritis.

Partner(s): National Jewish Health

Activity Dates: September, 2014 – February, 2017

Proof of accreditation, unbiased, and/or evidence-based medical education: National Jewish Health is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. *Each participating physician received 20 AMA PRA Category 1 Credits and ABIM MOC Part IV points.*

Why this activity merits the award: Collaboration

PROGRAM DETAILS:

In 2014, National Jewish Health (NJH) implemented a novel rheumatology-focused cardiology consultation service and intervention program for rheumatoid arthritis (RA) patients with increased risk for cardiovascular disease (CVD). The initiative aligned with newly introduced standards of care from the European League Against Rheumatism (EULAR), specifically that rheumatologists engage in assessing CVD risks in RA patients, as well as gaps in patient care identified by our rheumatology and cardiology teams related to RA patients who had modifiable cardiovascular risk factors. A 28-month collaborative PI-CME initiative was developed to create a streamlined way to educate and evaluate RA patients about their CVD risks. Through an independent educational grant, the Office of Professional Education at National Jewish Health engaged the Divisions of Rheumatology, Cardiology, Biostatistics, Pulmonary Rehabilitation, the Center for Health Promotion and Health Initiatives – including the smoking cessation and weight management teams in the design and implementation of this project.

Prior to 2015, there was not a standard or systems-based approach for screening, documenting or tracking CV risk factors at NJH. A baseline EMR audit indicated that out of 784 RA patients seen in 2014, 597 (76%) had additional CV risk factors among many other modifiable risk factors. Throughout the initiative, we, as a project team from the Office of Professional Education frequently met with all of the providers and specialty programs to plan, implement and help improve workflow issues or concerns related to any aspect of the program. For their participation, each participating physician received 20 *AMA PRA Category 1 Credits* and ABIM MOC Part IV points (practice assessment).

The process improvement activity was implemented as follows:

1) The providers were tracked based on a series of pre-determined metrics. The Office of Professional Education analyzed and reported the data at six time points. This data was shared with each provider as a means of tracking their progress on the metrics which included best practice assessments and referrals to patient resources.
2) Another goal was to assess the awareness of RA patients on their CVD risks and whether they had discussed these risks with their providers in the past. It was determined that a pre- and post-treatment phone interview conducted by our dedicated Patient Navigator was the ideal avenue to conduct this research. The patients were asked a variety of questions on BMI awareness, health risks associated with smoking and obesity, what modifiable risk factors are, as well as the overall relationship between RA and CVD. This process showed there was a positive correlation between provider education to the patient and increased health outcomes.

3) While the performance over time for all data shows that within both divisions, there was a rapid acceptance of the program initiatives, a further aim of this project was to implement sustainable change. After the conclusion of the formal tracking of these data, we conclude that the changes to assess and address patient CVD risk will be sustainable long term. By building frameworks in our existing EMR, both the Rheumatology and Cardiology divisions have the proper tools and new processes to continue these new treatment plans long term.

OUTCOMES MEASUREMENT AND ANALYSIS:

1) From initiative implementation to conclusion (2015 to 2016), there was a 91% increase in referral of RA patients for CVD risk assessment.
2) Referrals to QuitLogix, NJH's smoking cessation group, went from 2% to 50%. 56% of the total smoking patient population were referred to QuitLogix.
3) Referrals to FitLogix, or other identified weight management programs at NJH went from 11% at baseline to 69% in Q4 of 2016.
4) 82% of Rheumatology patients had a MDHAQ entered into newly created fields of the EMR. This disease activity tracking tool is now a standard of care in that division and allows for a formal tracking process of disease progression.
5) 47% of patients with a BMI ≥25 were provided a weight loss intervention by their provider while 46% of the total patient population in that category also received a referral to FitLogix.
6) 80% of the post-survey group agreed that they have a better understanding of the tie between cardiovascular health and RA, up from 26% during the pre-surveying.
7) One patient was diagnosed with diabetes by a rheumatologist as result of the new screenings implemented in this project.
8) At the conclusion of the project, 100% of the providers reported the process changes are "sustainable" to "somewhat sustainable". Sustainability was then measured in January, 2018. Two key takeaways showing the project's successes were 270, or 74% of the total patient population received tobacco cessation messaging and education from their clinician as well as an electronic referral to the Quitline for tobacco cessation coaching. Also, 94, or 70% of rheumatoid arthritis patients received a MDHAQ disease activity score. Both of these metrics were piloted and implemented as a result of this project.

IMPACT RATIONALE:

Prior to this activity, there was limited collaboration between the respective divisions, although working within the same institution. This activity created sustainable awareness for not only patients, but also their care team relating to the correlation between cardiovascular health and rheumatoid arthritis. Referral processes to our QuitLogix and FitLogix services were created, along with prompts to use them for both rheumatologists and cardiologists within our EMR. These replaced our outdated and infrequently used fax versions as well as educated NJH providers on all that is available to their patients in those programs.

A 90-day membership to the fitness center in our Pulmonary Rehabilitation Department was created, which provided two one- on-one sessions with physical therapists where they developed a workout plan to counteract previously identified co-morbidities. It was determined while conducting mid-project patient surveys that patients thought a follow-up office visit was not enough time to learn about their disease activity and options for further treatment. The project team designed a RA Patient Education Day which included presentations from a physician in National Jewish Health's Division of

Cardiology, a tobacco cessation coach from the Quitlogix Department, The project's RN Patient Case Manager and the Director of Pulmonary Rehabilitation. Following the presentations, there was an opportunity for attendees and their families or caretakers to have individual conversations with any of the program's presenters.

Initial feedback from the 13 physicians from the Divisions of Rheumatology and Cardiology was that they did not have time to address weight and smoking cessation in their already busy patient visits. The Director of National Jewish Health's Center for Health Promotion provided interventions to the providers of both divisions teaching them how to have those conversations in less than one minute. Following that, the rate of referrals to smoking cessation and/or weight management programs increased.

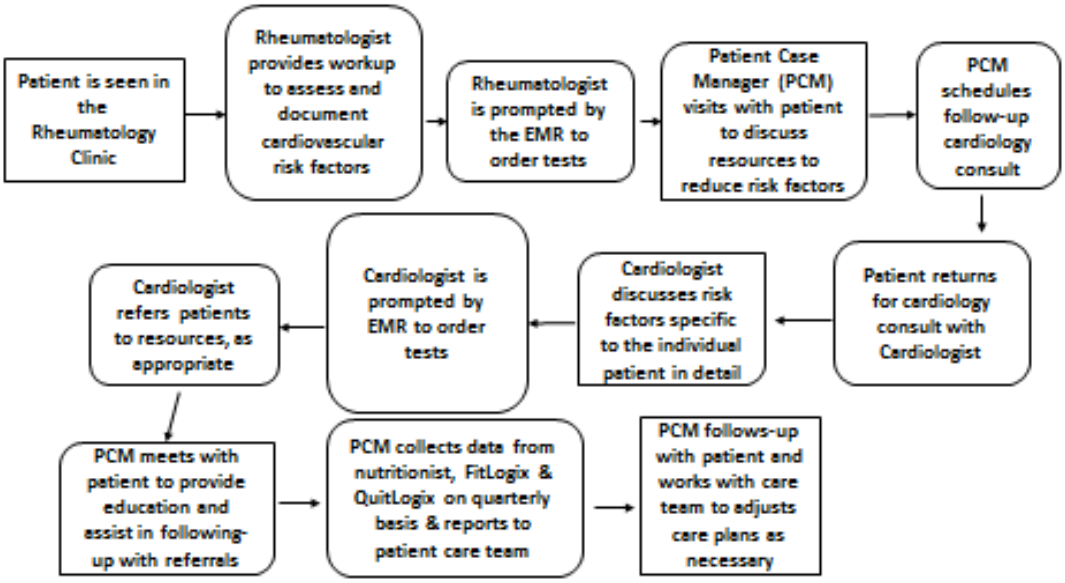
A total of 371 patients were identified as potential candidates for referral and were considered the subjects of this study, without our efforts, these patients' modifiable risk factors likely would have gone untreated and their providers would not have systematically screened and treated their cardiovascular risk.

SUPPORTING DETAILS:

Interventions and Qualitative Achievements:

- Grand Rounds presentation to increase project and clinical process improvement awareness
- Standing meetings and revised clinic workflow in two divisions (Cardiology and Rheumatology) for improved assessment, documentation impacting best patient care
- Provider and patient education about system resources; Processes and available materials sustained
- EMR Order sets for best practice approach to RA patients
- EMR referral to Quitline tobacco cessation program
- Posters prompting weight management discussion developed for clinic rooms
- Med Facts or National Jewish Health's educational materials documents added to aid weight management discussions
- Developed six-month physical therapy membership program targeted to RA patients
- New weight intervention prompt administered by Medical Assistants – weight loss goals and action plans were added
- Abstracts accepted and posters presented: ACEhp 2016, ACR, and EULAR Annual Conferences

Patient Care Process Flow:



Measured Program Metrics:

METRIC	Q1/Q2 2015 (Program Begins)	Q4 2016 (Final Measurements)
Hemoglobin A1c Ordered	36%	63%
Lipid Panel Ordered	16%	45%
Quitline Referral	2%	50%
Weight Loss Intervention	16%	69%
ASCVD Lifetime Assessment	6%	9%
ASCVD 10-Year Assessment	7%	26%
MDHAQ/RPAID3 Assessment	58%	70%
RA Patient Referral for CVD Risk Assessment	22%	42%