Obesity: Where Do We Go From Here?

PRESENTATION TO THE
AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS
NOW AND THE FUTURE

What must we do now?

What must we do for the future?
Improving Health Outcomes

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Initial IHO Goals

**Prevent**
heart disease, stroke and type 2 diabetes
and
**Improve Outcomes**
for
those with disease
Risk factors for heart disease, stroke, and type 2 diabetes include

- High blood pressure
- High blood glucose
- Overweight and Obesity

Therefore, AMA initial focus is on helping physicians, care teams and patients

- Control blood pressure
- Prevent diabetes
Why These Clinical Topics

• Every physician in every specialty in every practice type in every geographic location sees patients with hypertension and prediabetes

• We have an evidence base for treating both conditions but evidence not applied everywhere

• The combined costs of type 2 diabetes and cardiovascular disease exceeds $500 billion each year

• These diseases place a heavy toll on patients and families
#1 risk factor worldwide for death and disability

SECTION I

Why hypertension is a major public health issue

The Lancet,
Global Burden of Disease
December 12, 2012
67 million American adults have high blood pressure

That’s 1 in every 3

Source: CDC
Patients with hypertension and receiving care but not at goal—more than 30 million

Hypertension†
66.9 million (30.4%)

Controlled
31.1 million (46.5%)

Uncontrolled
35.8 million (53.5%)

Unaware
14.1 million (39.4%)

Aware but untreated
5.7 million (15.8%)

Aware and treated
16.0 million (44.8%)

† = ≥ 140MM Hg or ≥ 90MM Hg or current use of Rx

MMWR/Sept 7, 2012/Vol. 61/No. 35
Hypertension

- 30 million Americans with source of care and HTN but not controlled
- Significant disparities in care
- Solid evidence base
- National focus - Million Hearts® initiative
26 million Americans have diabetes

79 million Americans have prediabetes

Source: CDC
79 million Americans have prediabetes

1 in 3 adults will have diabetes by 2050 if we do not do something significant

Source: (Boyle JP et al, Pop Health Metrics, 2010)
Prediabetes

- 89% of adults with prediabetes don’t know they have it
- Significant disparities in care
- Solid evidence base to prevent diabetes
- National focus – CDC National Diabetes Prevention Program
Widespread, Profession-led Quality Improvement Successes

Door-to-balloon time
300,000 patients at 900 hospitals
Median time reduced from 96 to 64 minutes
Harlan Krumholz, et al;
  *Circulation.* 2011;124:1038-1045

CLABSIs
1,100 hospital ICUs, 44 states
40% reduction in rates
Peter Pronovost—Johns Hopkins Armstrong Institute for Patient Safety and Quality
*AHRQ Publication* No: 12-0087-EF, October 2012
“If clinicians believe, results will follow.”

Peter Pronovost, MD, PhD
Journal of Oncology Practice, 2013
Strategy

partner with others to strengthen clinical-community linkages
Hypertension

Collaborator: Johns Hopkins Medicine (JHM)
Armstrong Institute for Patient Safety
Center to Eliminate Cardiovascular Health Disparities

• Help to meet and exceed Million Hearts goal: 10 million more adults have their high BP controlled
• Focus on those in care
• Pilot practices
  – 5 sites in Illinois, 5 sites in Maryland
  – Represent cross-section of how ambulatory care is practiced in the US
• Think big—Start small—Learn fast—Spread
Measure accurately
Without credible BP measurements, clinicians cannot make wise therapeutic decisions

Act rapidly
Therapeutic inertia is often the primary reason for uncontrolled hypertension when BP control rates are low

Partner with patients to promote self-management
Evidence-based ways for supporting patients’ ability to adhere to and self-manage their care are under-utilized
IHO: BP Initiative Phases

Phase 1: Prototyping
- AMA and JHM
- Physician champions, innovators
- Hypertension improvement checklists

Phase 2: Local Spread
- Illinois and Maryland
- Clinical practice sites
- Clinical-Community integration
- Communities of practice focused on hypertension

Phase 3: National Spread
- Large-scale improvement in hypertension control
Prediabetes

Collaborator: YMCA of the USA

• YMCA offers CDC Diabetes Prevention Program (DPP)
  – Largest provider of DPP: in 40 states
  – One-year lifestyle intervention, evidence-based and effective
    • NIH research has shown that programs like the YMCA’s Diabetes Prevention Program reduce the number of new cases of diabetes by 58% overall and by 71% in individuals over age 60.
  – Has CMMI grant to increase number of Medicare beneficiaries in the DPP

• AMA pilot practices in Delaware, Indianapolis and Minneapolis/St. Paul

• Think big—Start small—Learn fast—Spread
AMA in Collaboration with Y-USA (CMMI Award)

DPP Physician Practice Guide

1. Screen patients for prediabetes
2. Refer to DPP in your community
3. Integrate feedback from Y-DPP into physician-patient care plan
YMCA DPP CMMI Communities

ARIZONA: Phoenix; Tucson

DELAWARE: State of Delaware

FLORIDA: Clearwater; St. Petersburg; Tampa; Venice

INDIANA: Indianapolis

MINNESOTA: Minneapolis/St. Paul

NEW YORK: New York City

OHIO: Cincinnati; Cleveland; Columbus; Dayton

TEXAS: Arlington; Dallas; Fort Worth
National Diabetes Prevention Program Sites
National Diabetes Prevention Program Sites
Clinical-Community Linkages: Diabetes prevention

- Physician champions, Innovators
  - (1) Create physician referral process
- AMA & YMCA
- Pilot practices & local Ys
  - Expand to more Ys and other DPP providers
  - (2) Establish physician-YMCA communication
- Diabetes Prevention Programs
- Increase payor coverage of DPP
- Widespread participation in DPP programs for all eligible adults
Future Strategy…

- Patient and Community Interventions
- Public Health Interventions
- Research and Innovation
- Employer and Insurer Interventions
- Provider Interventions (including retail pharmacies)

Healthy BP & Glucose