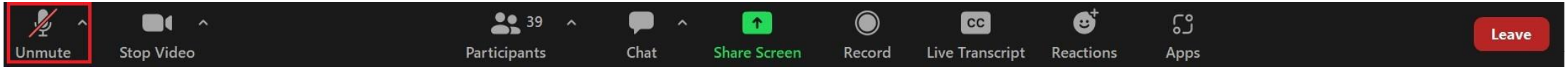
HEART HEALTHY OHIO INITIATIVE

HHOI Webinar #2 (Wave 1 Sites)

October 14th, 2022

Welcome and Logistics

- Welcome
- Please mute yourself when not talking
- Turn on video (if able)
- Chat in your name, organization, and role



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Agenda

Time	Item	Presenter
12:00 PM	Welcome and Logistics	Stephanie Kanuch, MEd
12:04 PM	Review Key Driver Diagram and SMART AIM	Aleece Caron, PhD
12:08 PM	HHOI Dashboard Data	Jordan Fiegl, MS
12:20 PM	Teams in Action	QI coaches QIP clinics Aleece Caron, PhD
12:35 PM	Pareto Charts	Aleece Caron, PhD
12:40 PM	Outreach	Shari Bolen MD, MPH
12:55 PM	Next Steps/Wrap Up	Stephanie Kanuch, MEd

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Select Project Team Members

Case Western Reserve University at The MetroHealth System

PI: Shari Bolen, MD, MPH

PI: Aleece Caron, PhD

University of Cincinnati

PI: Saundra Regan, PhD

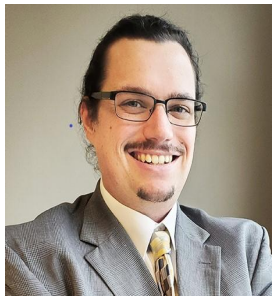
The Ohio State University

PI: Randy Wexler, MD, MPH

Quality Improvement Coaches

Caroline Carter, MS, LSW, BCC

Marty Williams, MHSA



Data Scientist

Jordan Fiegl, MS

Case Western Reserve University Project Management Leads

Stephanie Kanuch, MEd

Cathy Sullivan, MS, RD

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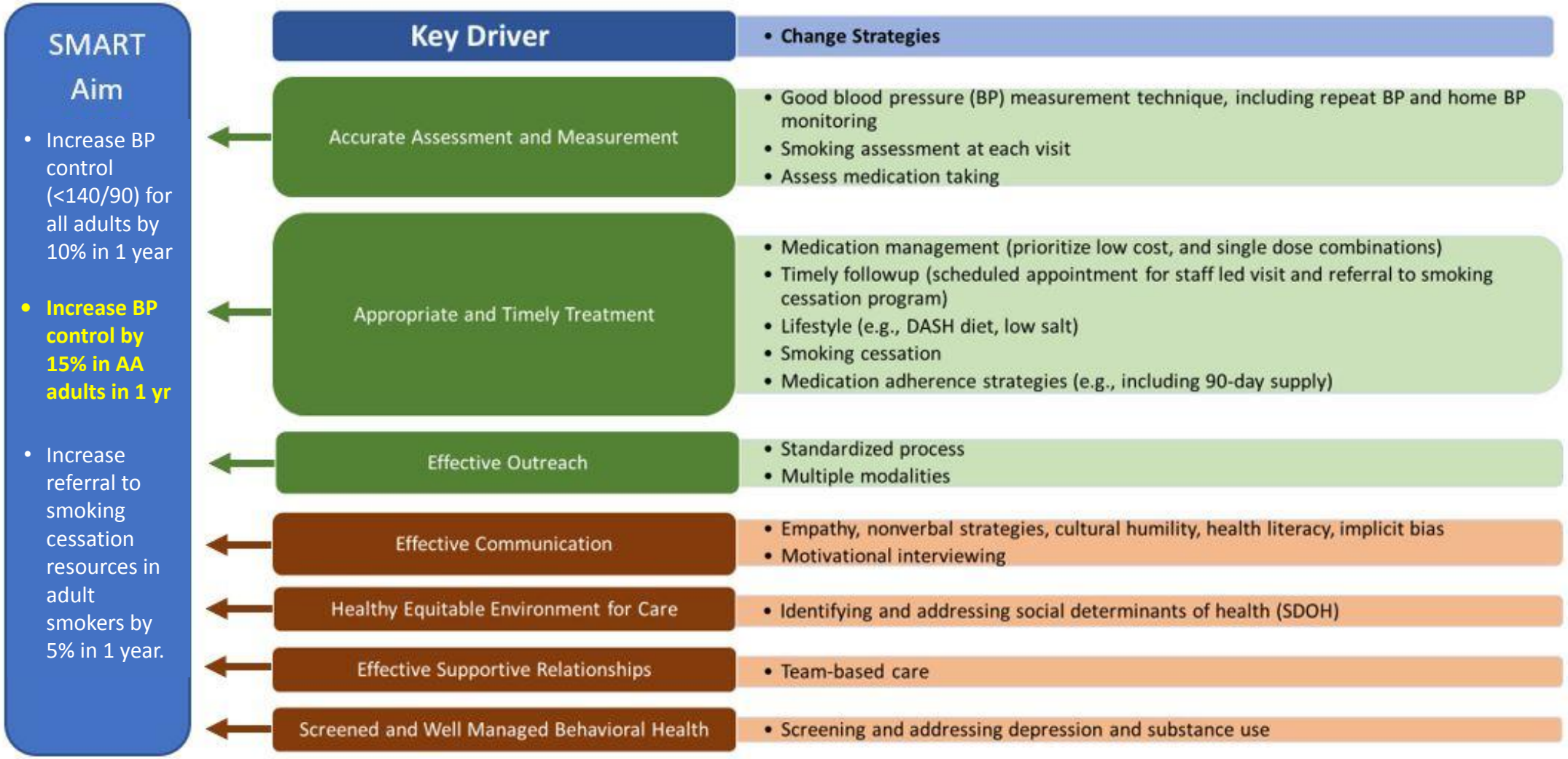
Key Driver Diagram and SMART AIM



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Addressing Disparities in our Toolkit

- Standardized office procedures reduces risk of implicit bias
- Treatment algorithms which prioritize low cost once daily medications
- Consistently identifying and addressing adherence (e.g., 90-day prescriptions, multiple follow-up modalities such as staff-led visits, CHW, and telehealth)
- Tailored outreach to patients, focused on those with care gaps
- Home BP monitoring to address transportation barriers/access
- Communication skill-building resources
- Identifying and addressing SDOH and racism resources

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Ohio Community Pathways HUBs

•Connecting Patients with Social Needs to Community Health Workers to Assist in Addressing these Needs

Member HUB Referral Information

Better Health Pathways HUB: Cleveland
jlever@metrohealth.org

Bridges to Wellness HUB: Tuscarawas County
sarah@accesstusc.org

Central Ohio Pathways HUB: Columbus
http://www.hcgc.org/hub-referrals.html

Community Action Pathways HUB: Canton
https://eform.pandadoc.com/?eform=c15f4cb9-4b93-4206-a635-4488c7c80195

Community Health Access Project: Mansfield
director@chaphub.org

Health Care Access Now: Cincinnati
https://www.surveymonkey.com/r/HCANReferral

Mahoning Valley Pathways HUB: Youngstown
medison@mahoninghealth.org

Northwest Ohio Pathways HUB: Toledo
csalamone@hcno.org

Pathways HUB Community Action: Akron
https://www.ca-akron.org/hub/contact

Stark County THRIVE: Canton
https://www.cantonhealth.org/thrive/?pg=548

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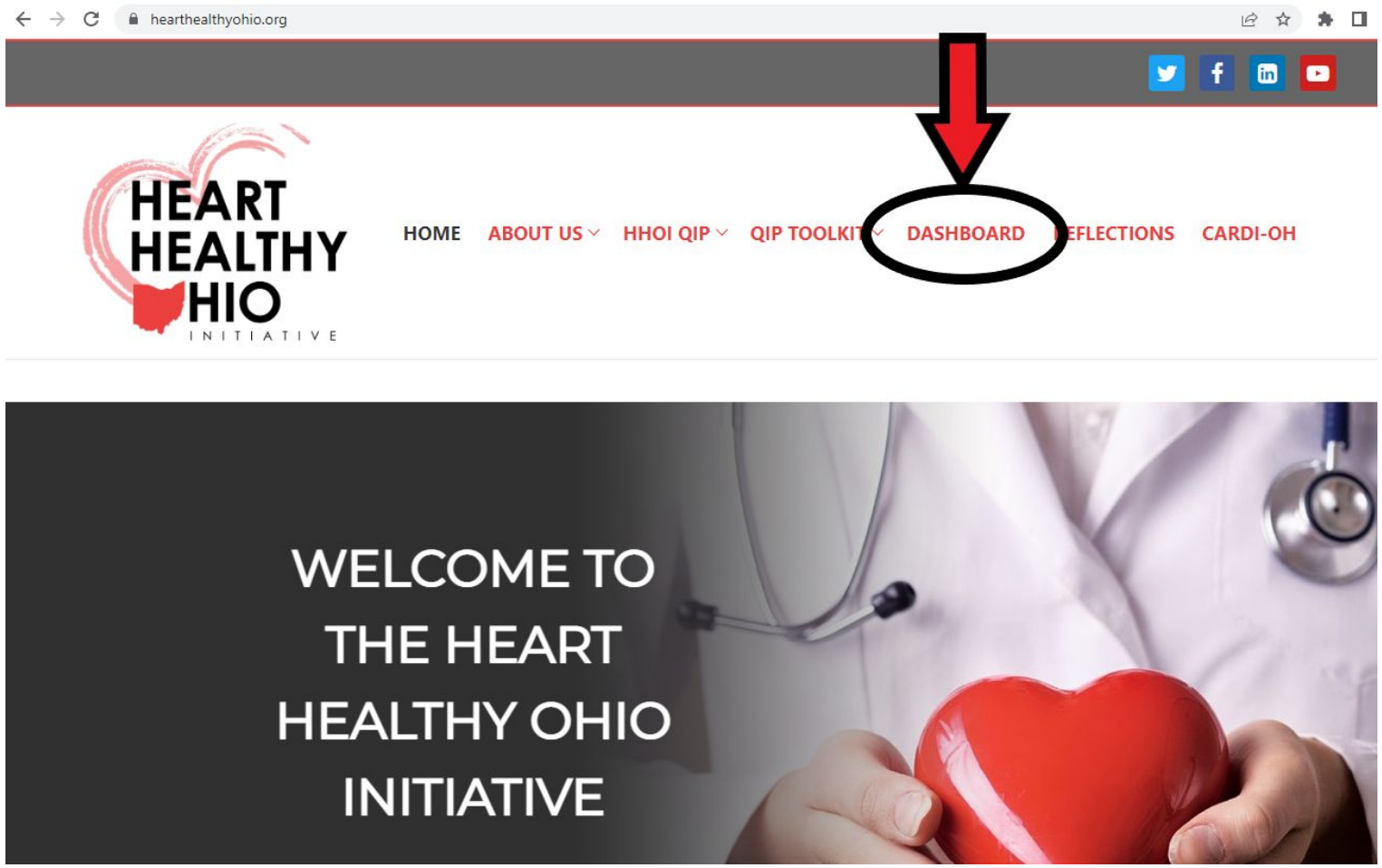
HHOI Data Dashboard

Jordan Fiegl, MS

Logistics of accessing your data

- Website: https://hearthealthyohio.org/



Logistics of accessing your data

- If you do not see your practice in the slides, there are several possible reasons for this:
  - Still waiting on initial submissions
  - Baseline data has been received, but waiting on subsequent submissions
  - Processing complications on our side

- Please reach out to us through email if you are unsure of which reason you are not seeing your practice!

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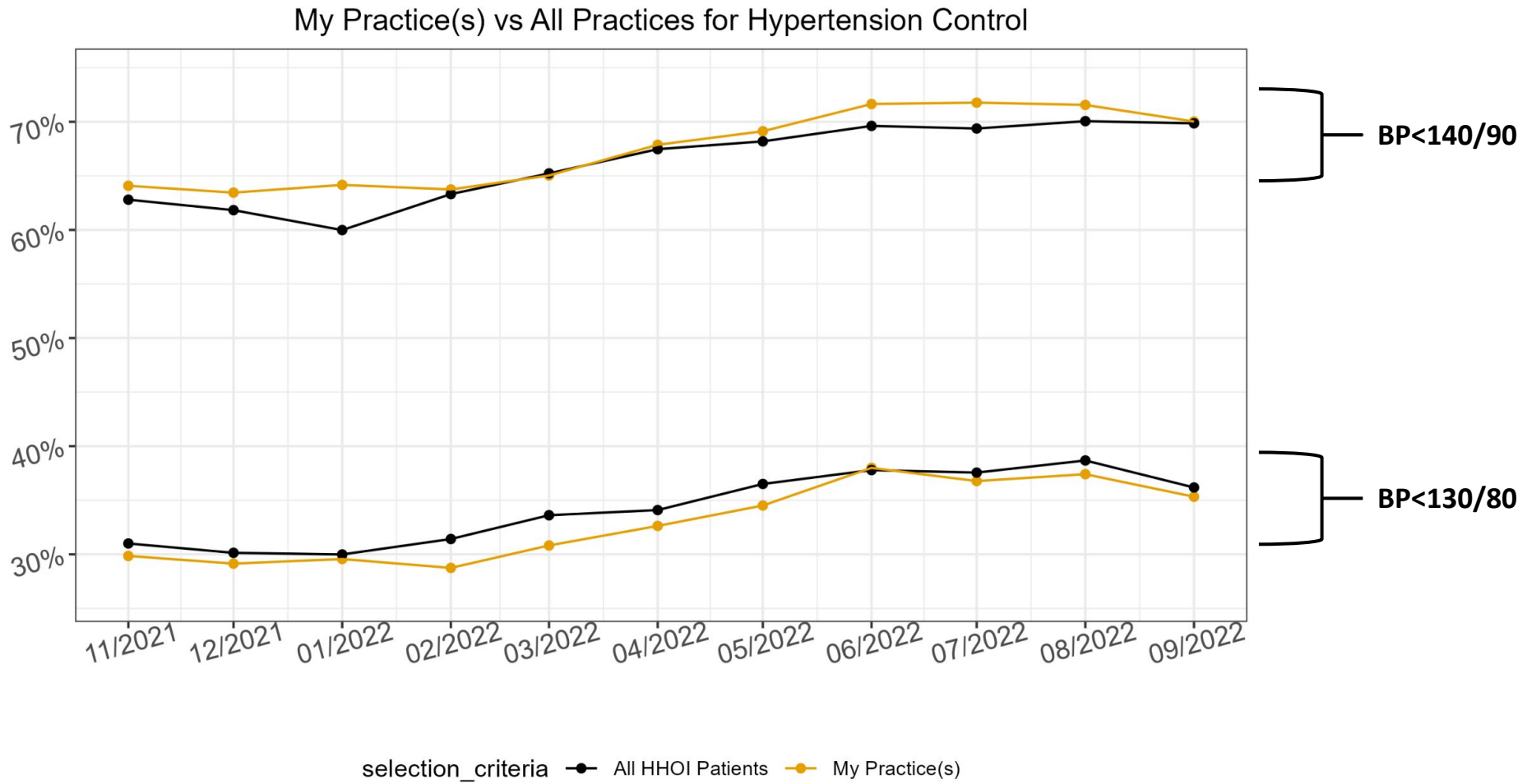
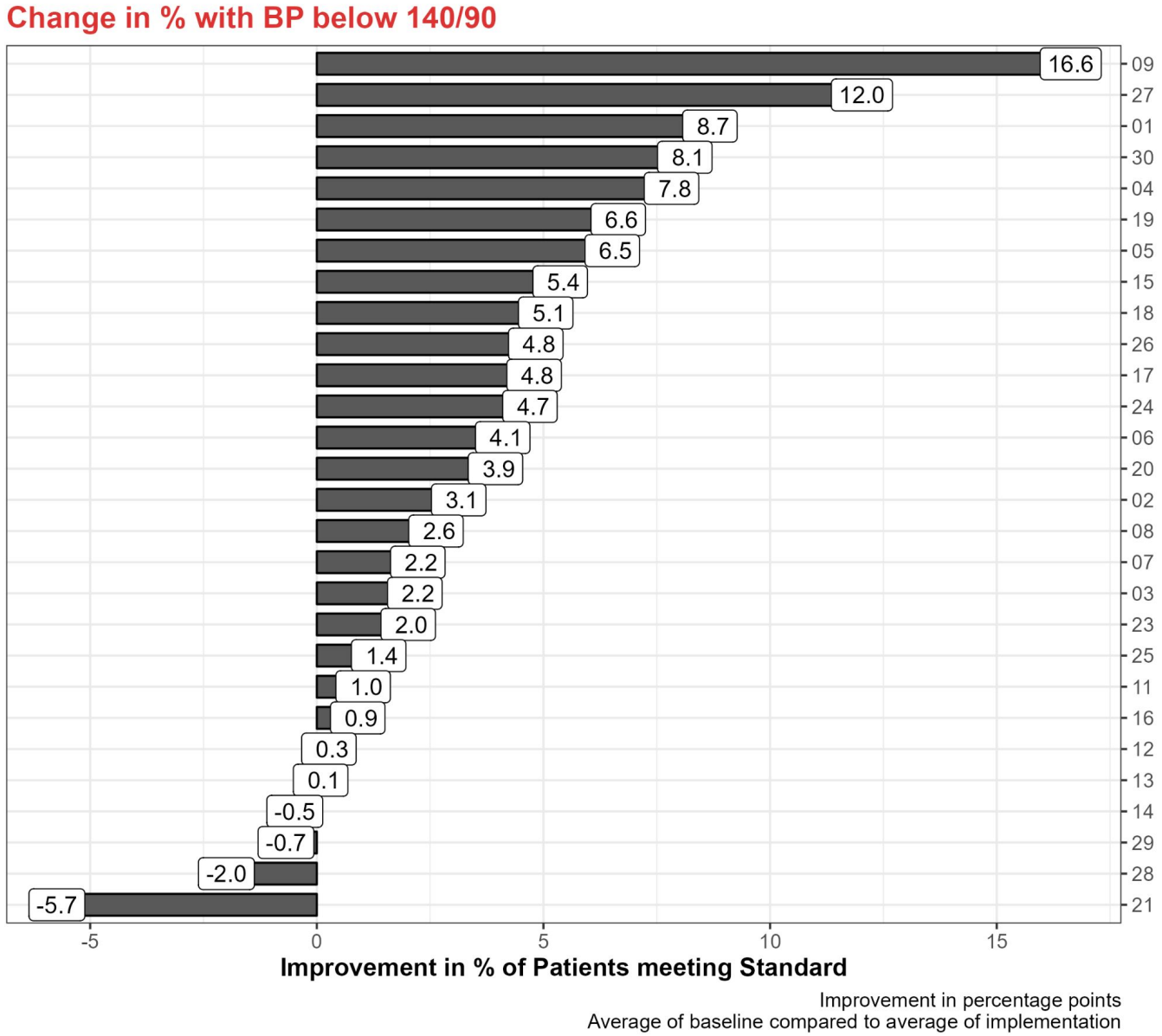
Percent of hypertensive adults under BP control by BP level



Improvement in BP Control by Site



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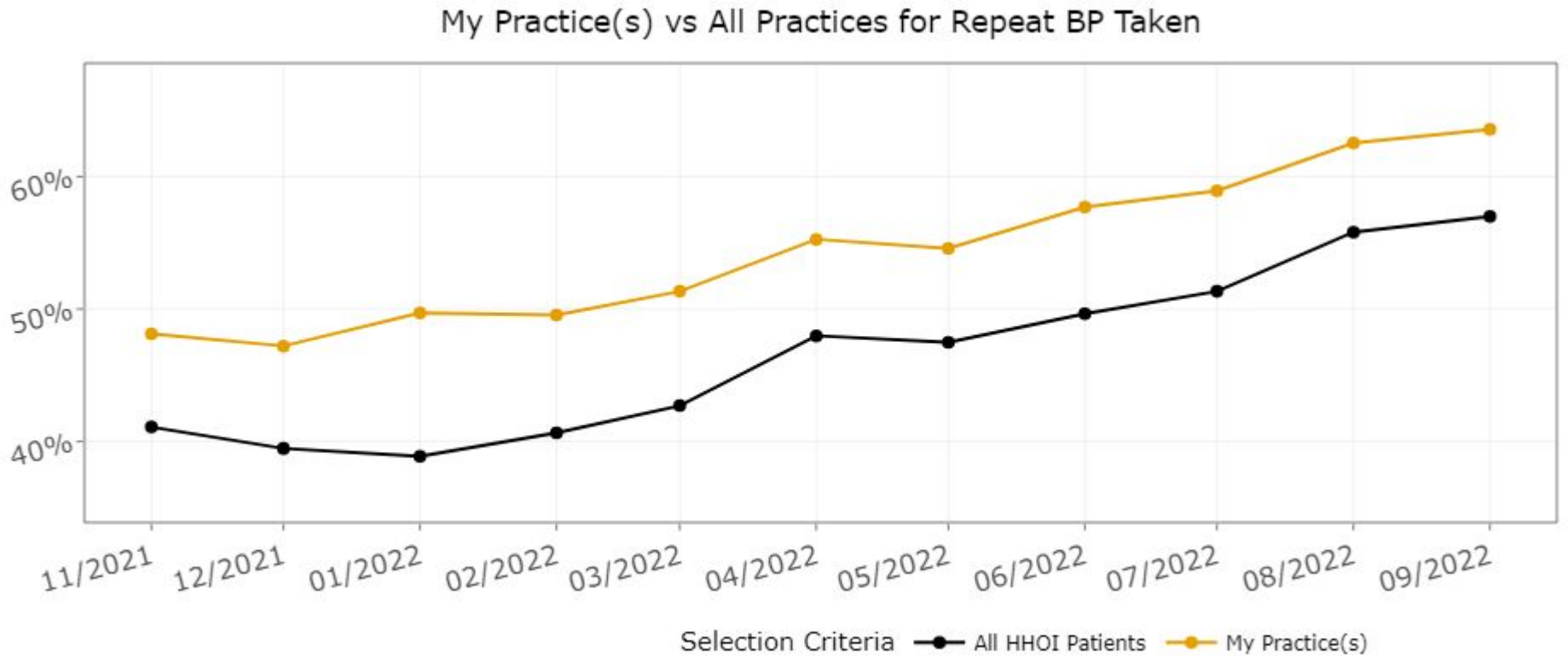
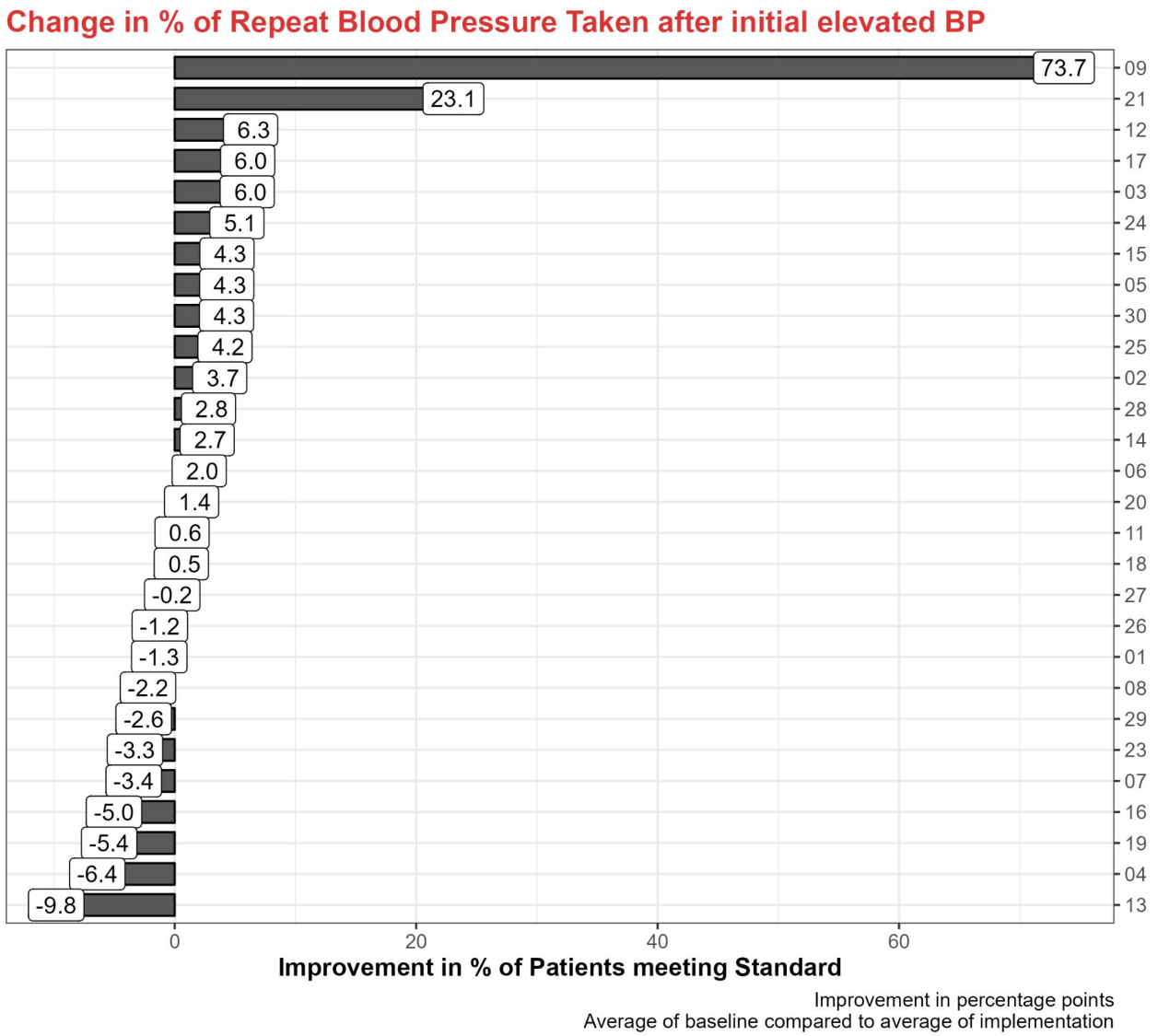
Percent of hypertensive adults with repeat BP if 1st BP elevated



Improvements in Repeat BP by Site



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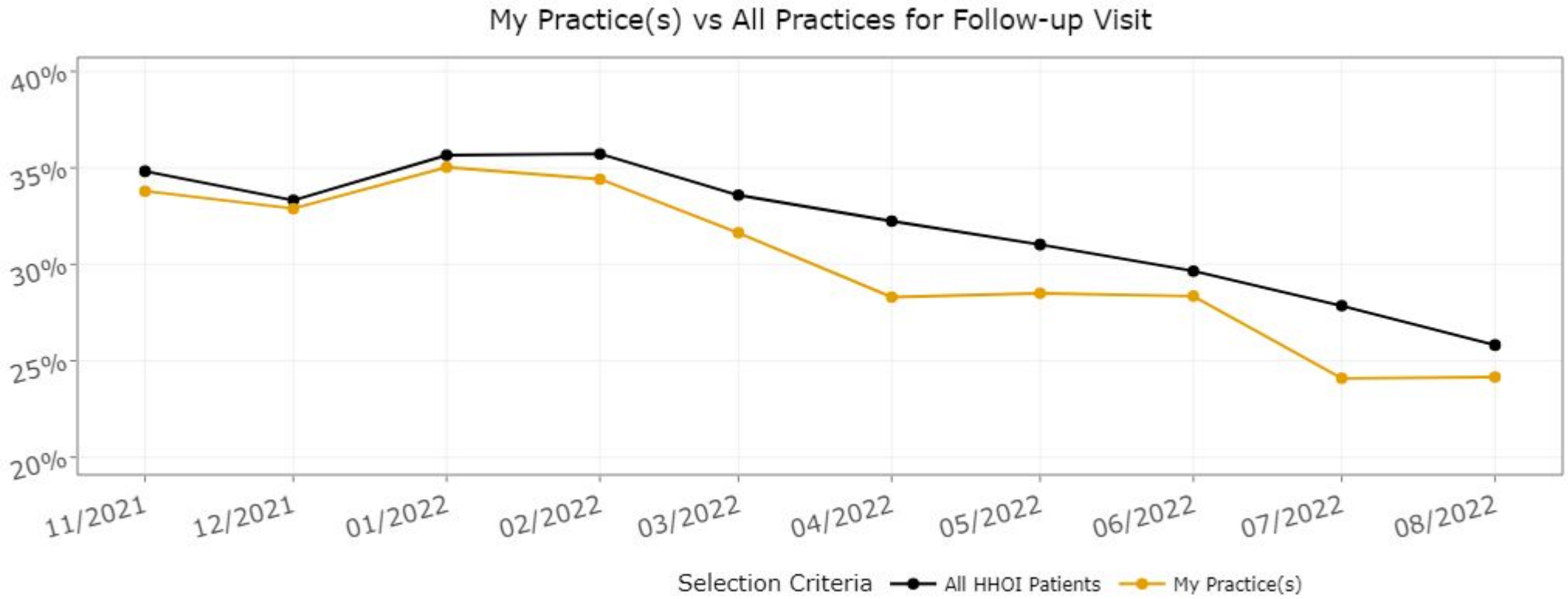
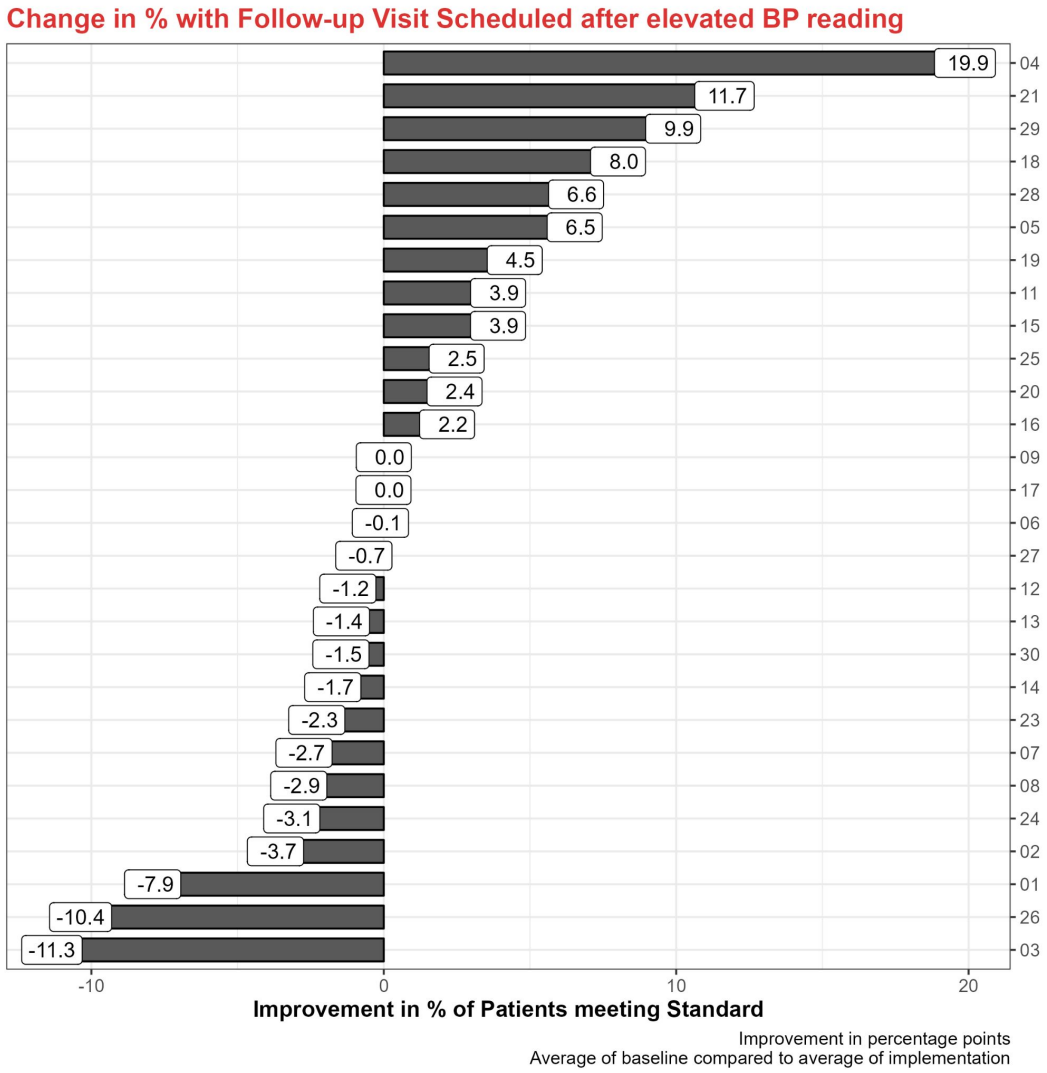
Percent of hypertensive adults with scheduled follow-up within 1 month



Improvements in Timely Follow-Up by Site



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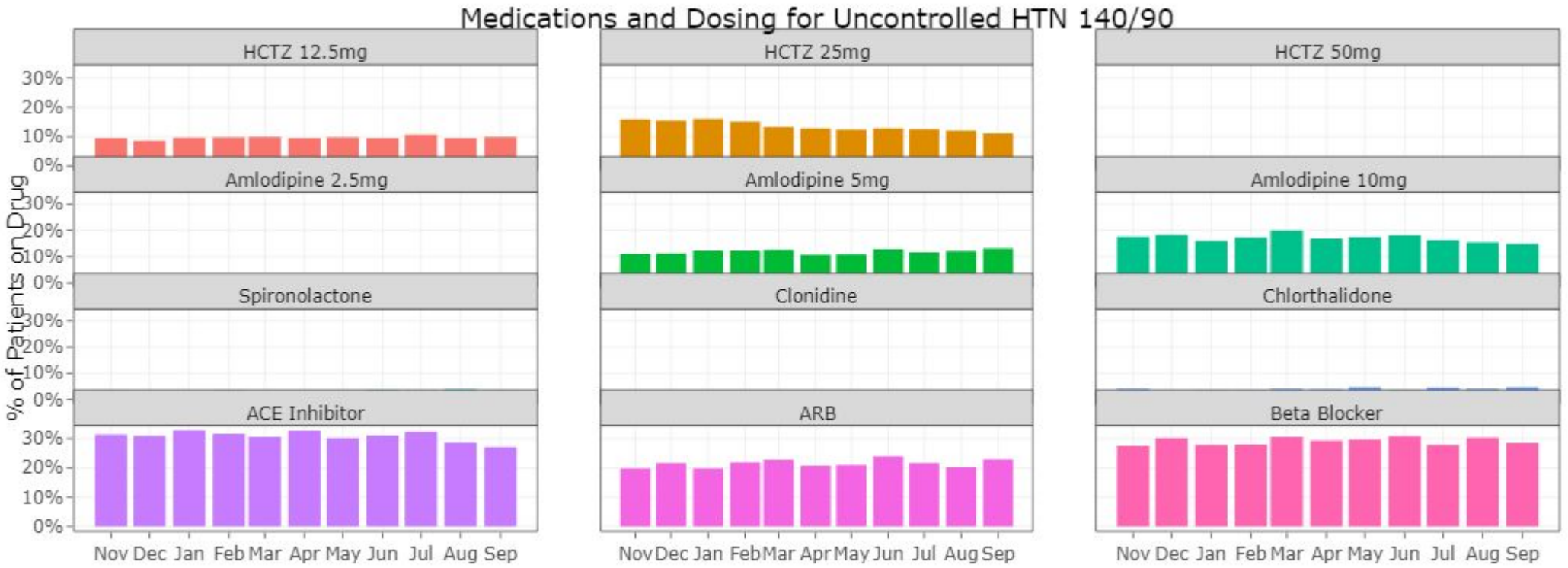
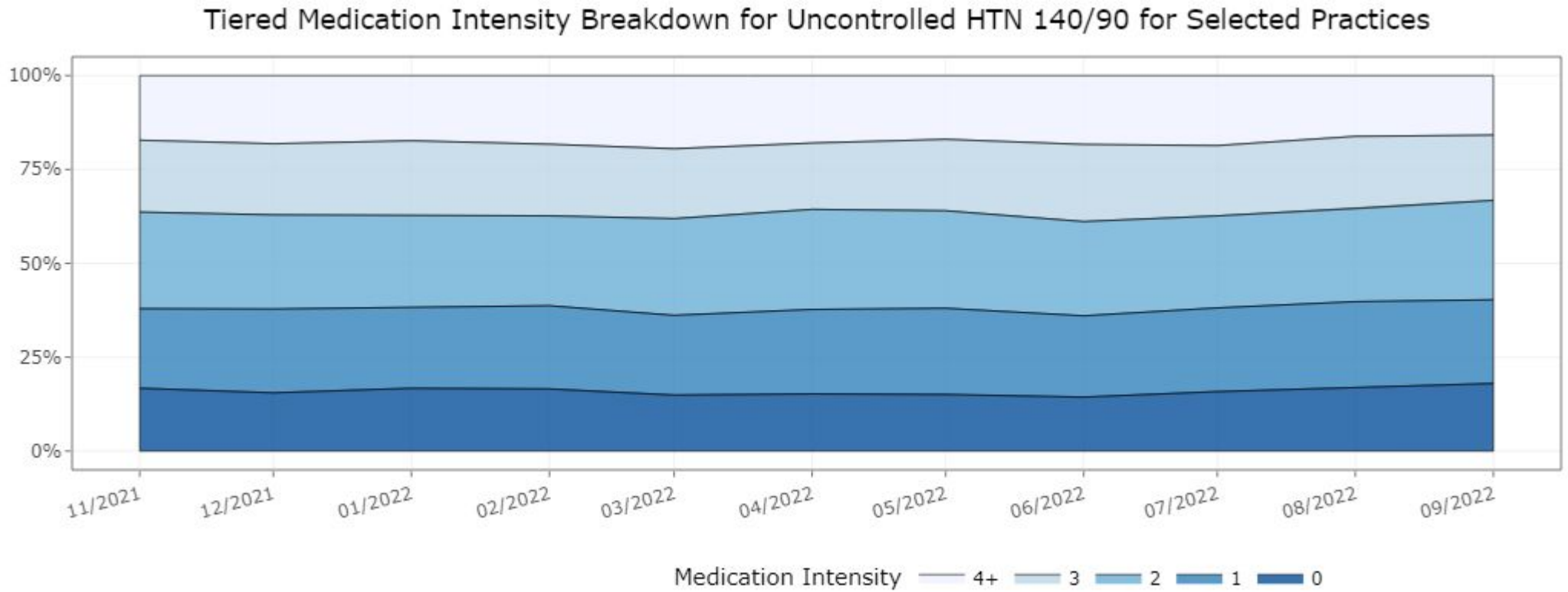
Percent of hypertensive adults with elevated BP on specific medications



Percent of hypertensive adults with elevated BP on specific numbers of medications



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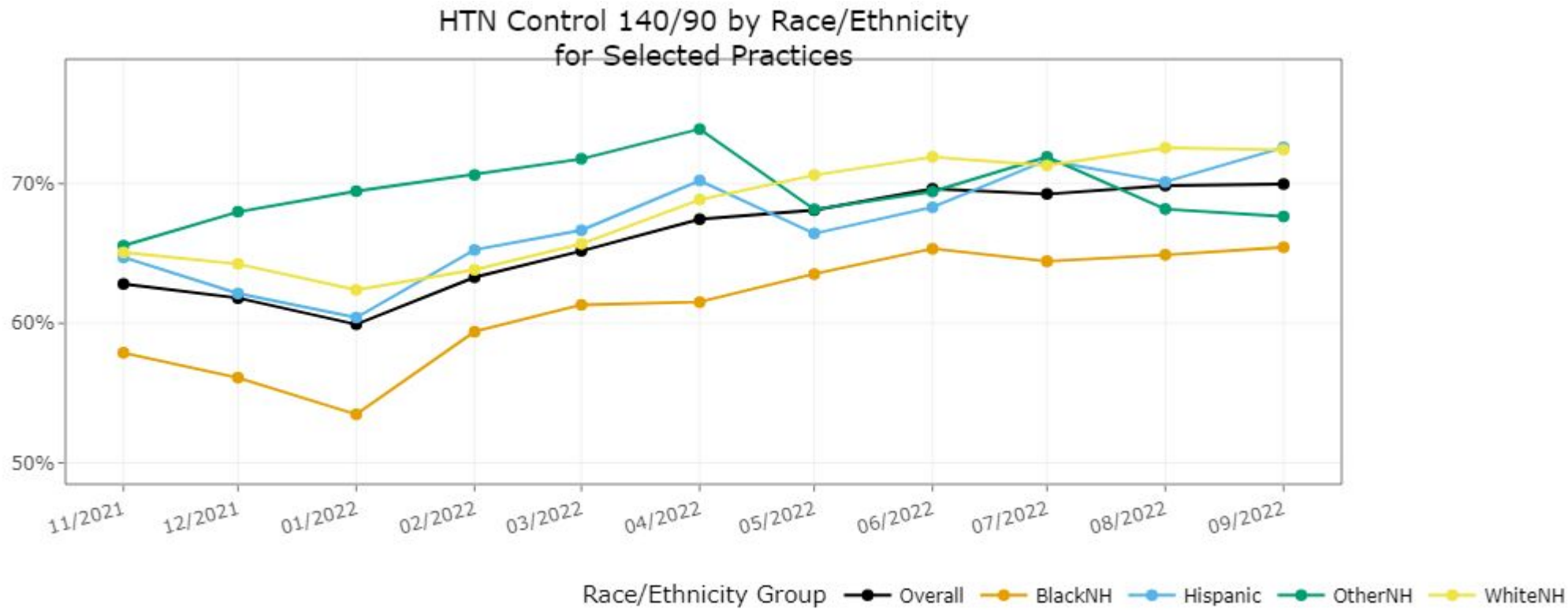
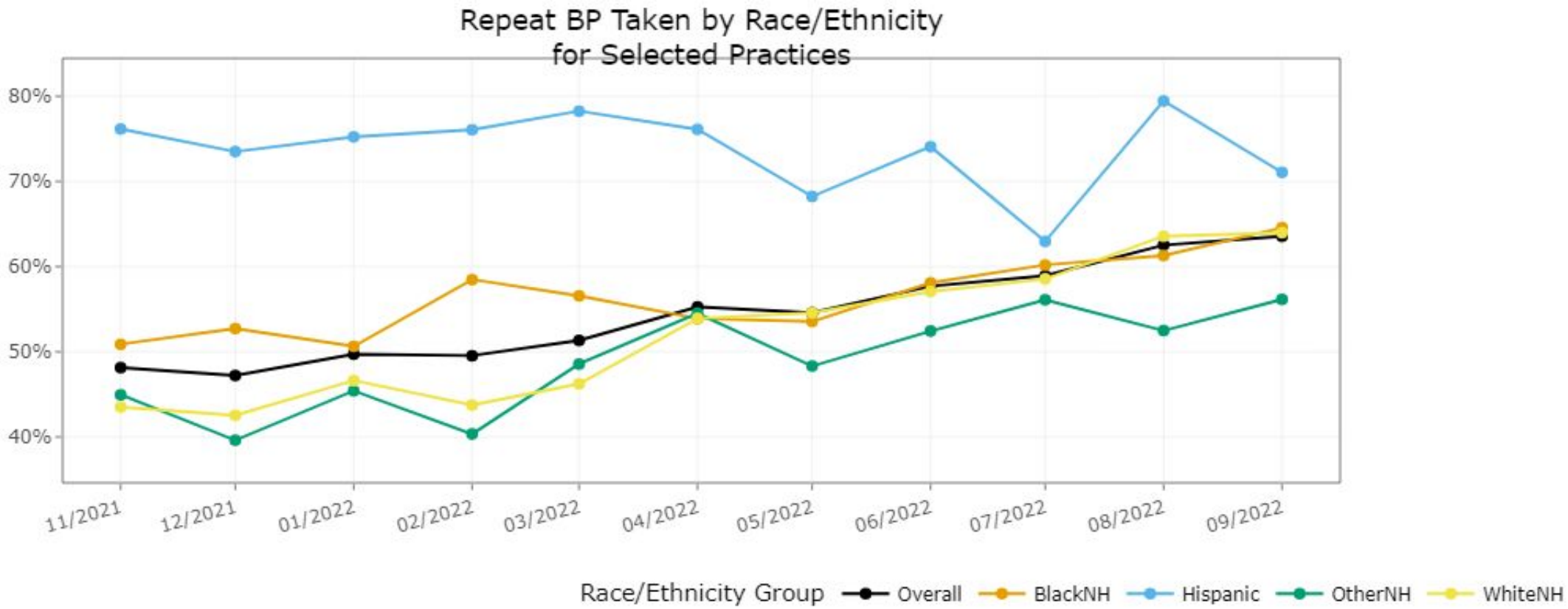
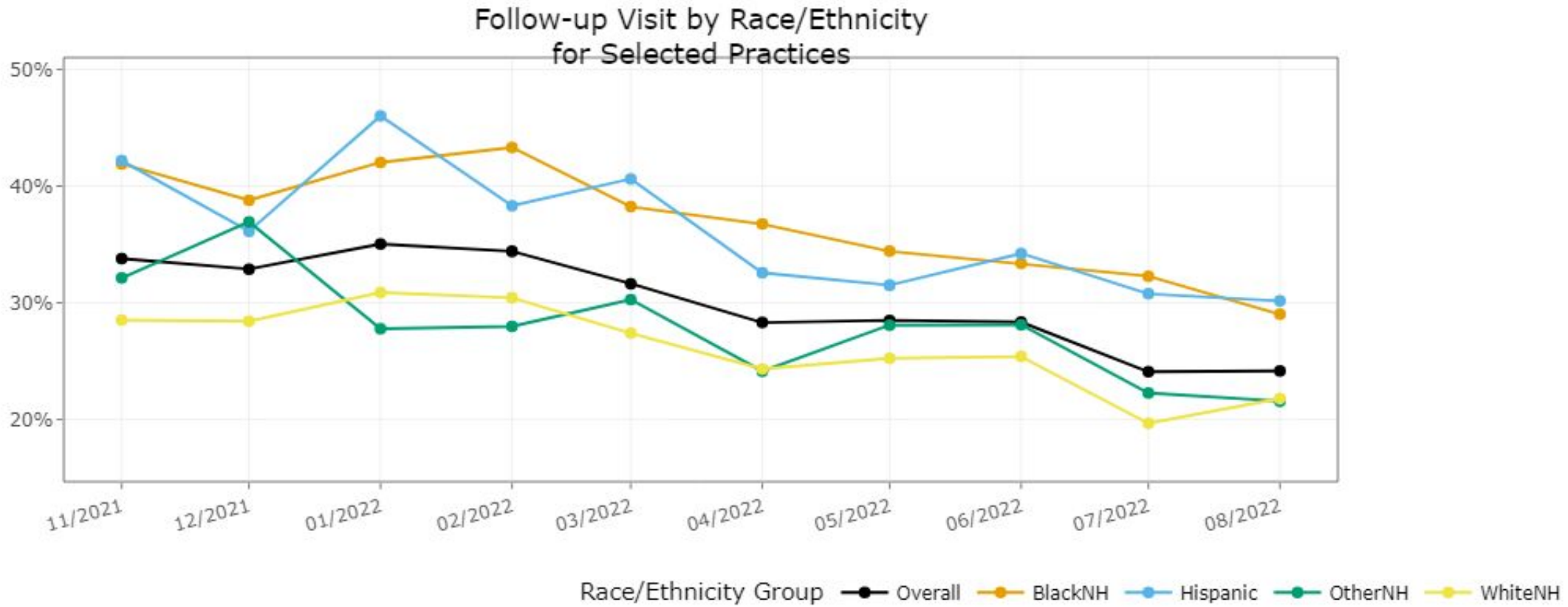
BP control by race and ethnicity



Repeat BP by race/ethnicity



Timely Follow-Up by Race/Ethnicity



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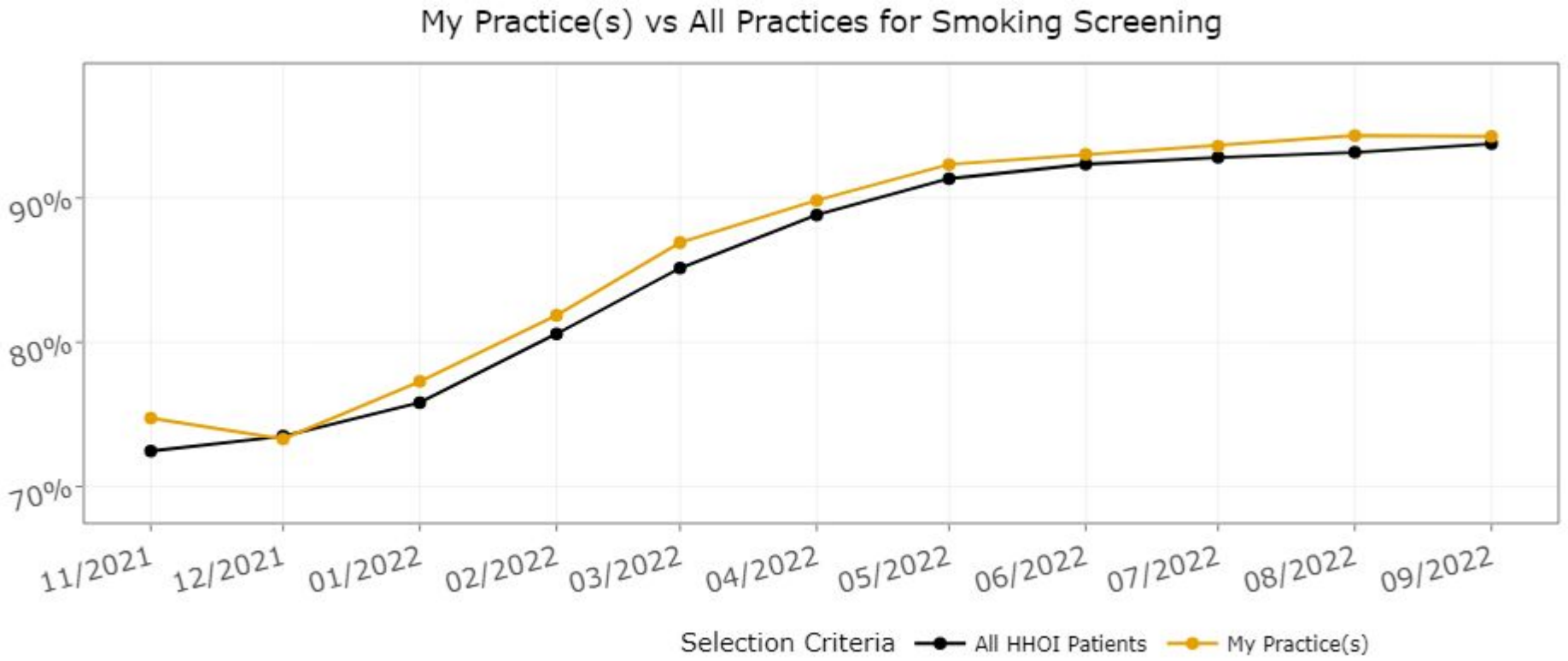
Percent of adults assessed for smoking in the last year



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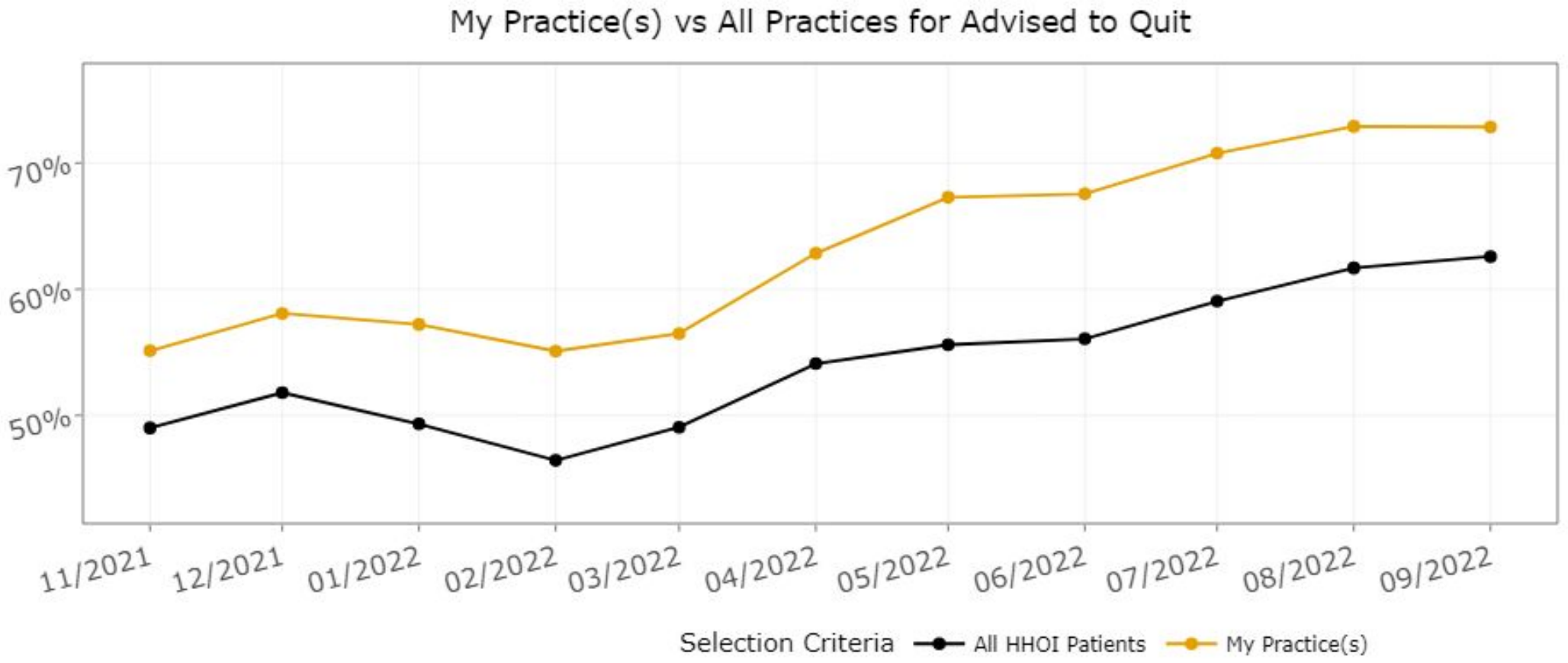
Percent of patient smokers advised to quit



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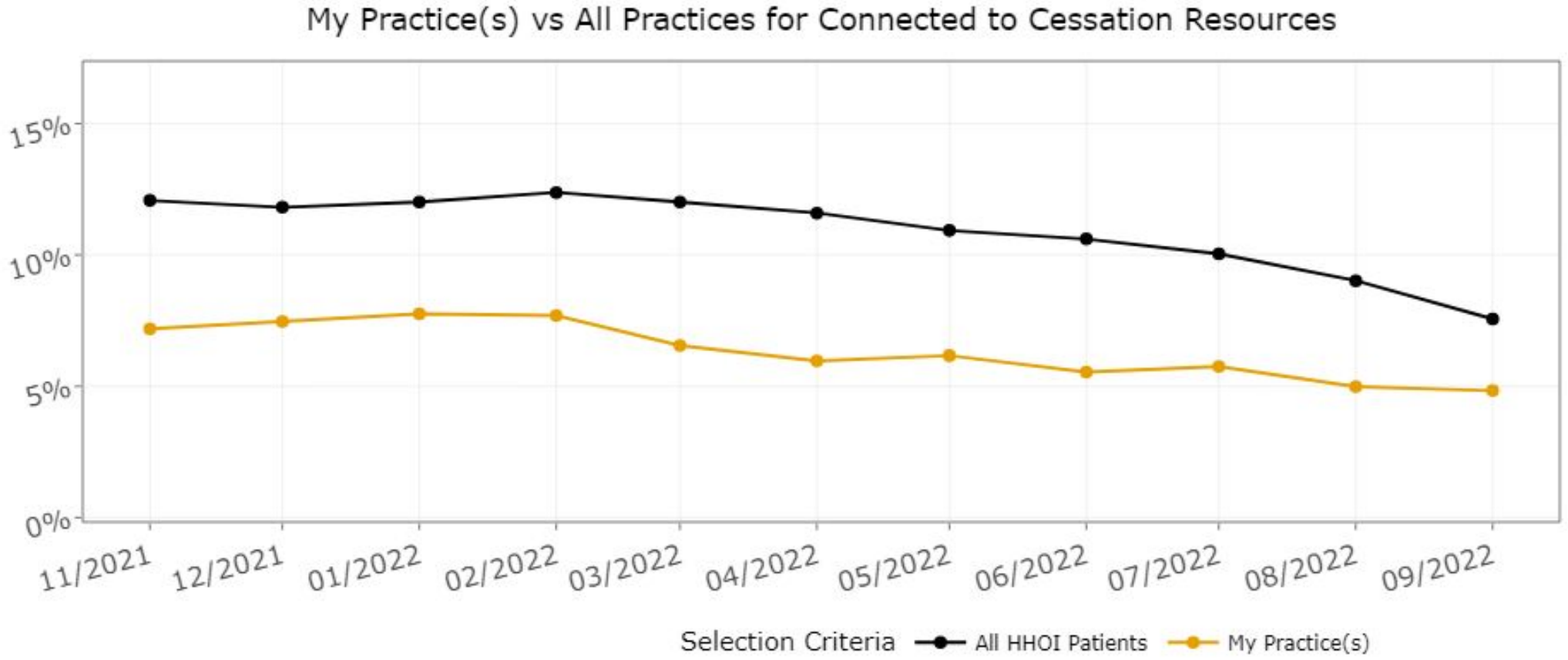
Percent of smokers connected to resources for smoking cessation



Summary

- Beginning to see some improvements in several BP and smoking measures
- Continued opportunities around accurate BP measurement, timely followup, medication intensification, and connection to smoking cessation resources
- Disparities exist in BP control by race/ethnicity but not in repeat BP or scheduled follow-up
- Review disparity data for your site and develop a SMART Aim for your practice around site level disparities with your coach

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Pareto Chart Overview

Aleece Caron, PhD

Pareto analysis (aka Pareto Principle)

- A graphical display of the most important factors contributing to a problem
  - Bar chart arranged in order from the largest to the smallest contribution to the problem
- Pareto principle: 80% of the effects come from 20% of the causes
- Informs your improvement efforts so you focus on tackling the 'vital few'
- Developed by Vilfredo Pareto from his socio-economic research: 80% of the wealth, is owned by 20% of the population

Vilfredo Pareto 1848 -1923

Source: IHI Improvement Coach Professional Development Program

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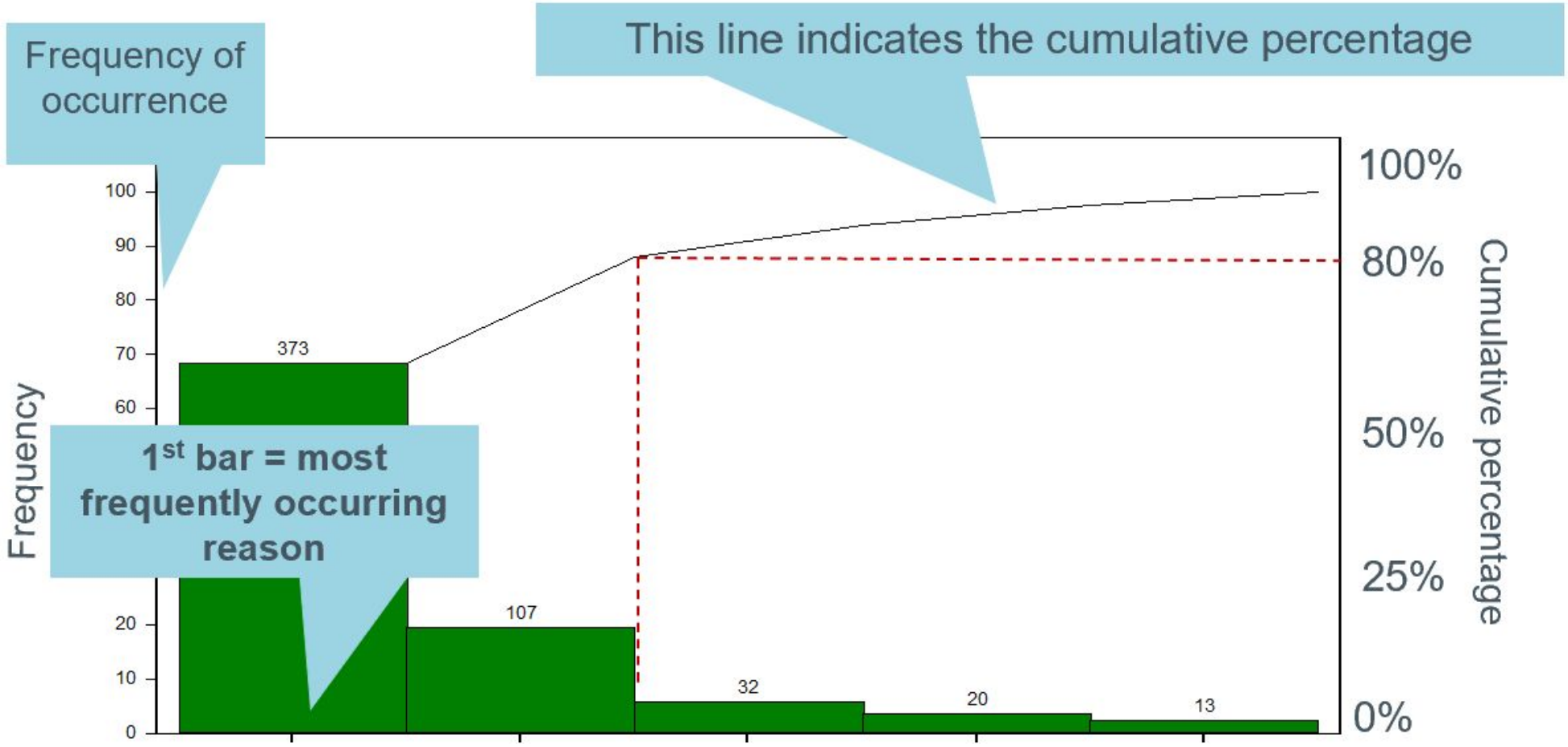
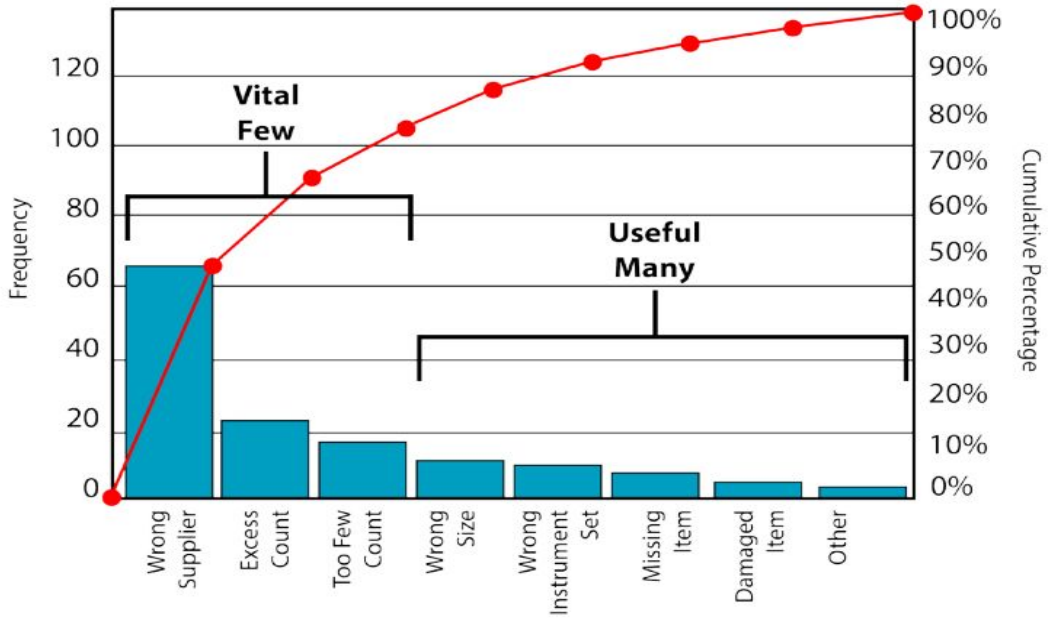
Reading a Pareto chart



Source: IHI QI Essential Toolkit

Examples – Errors during surgical set up

Error Type	Frequency	Percent	Cumulative %
Wrong Supplier	67	46.5	46.5
Excess Count	24	16.7	63.2
Too Few Count	17	11.8	75
Wrong Size	10	6.9	81.9
Wrong Sterile Instrument Set	10	6.9	88.8
Missing Item	8	5.6	94.4
Damaged Item	6	4.2	98.6
Other	2	1.4	100
TOTAL	144	100	



Source: IHI QI Essential Tool Kit

Outreach

Shari Bolen, MD, MPH

Outreach

- *What*? An activity of providing *services* to any populations who might not otherwise have access to those *services*
- *Why?* To better engage patients in care and improve health outcomes

Image by unknown author at https://commons.wikimedia.org/wiki/File:US_Navy_050826-N-9407V-003_Hospital_Corpsman_2nd_Class_Larosa_A._Watson,_assigned_to_the_amphibious_assault_ship_USS_Boxer_(LHD_4),_gives_a_Marshallese_student_an_immunization_during_a_community_health_fair_in_Majuro,_Marshall.jpg

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Population Health Management Perspective

- Trying to address care gaps outside of the typical office visit setting
- Often done by phone as part of care management and often requires the patient to come in for labs, visits, or screening tests
- Can sometimes be done by other mechanisms (e.g. health coaching, mailed FIT tests for colon cancer screening, or home visits)

Image by Tunstall Telehealth at https://www.flickr.com/photos/tunstalltelehealthcare/6850760963

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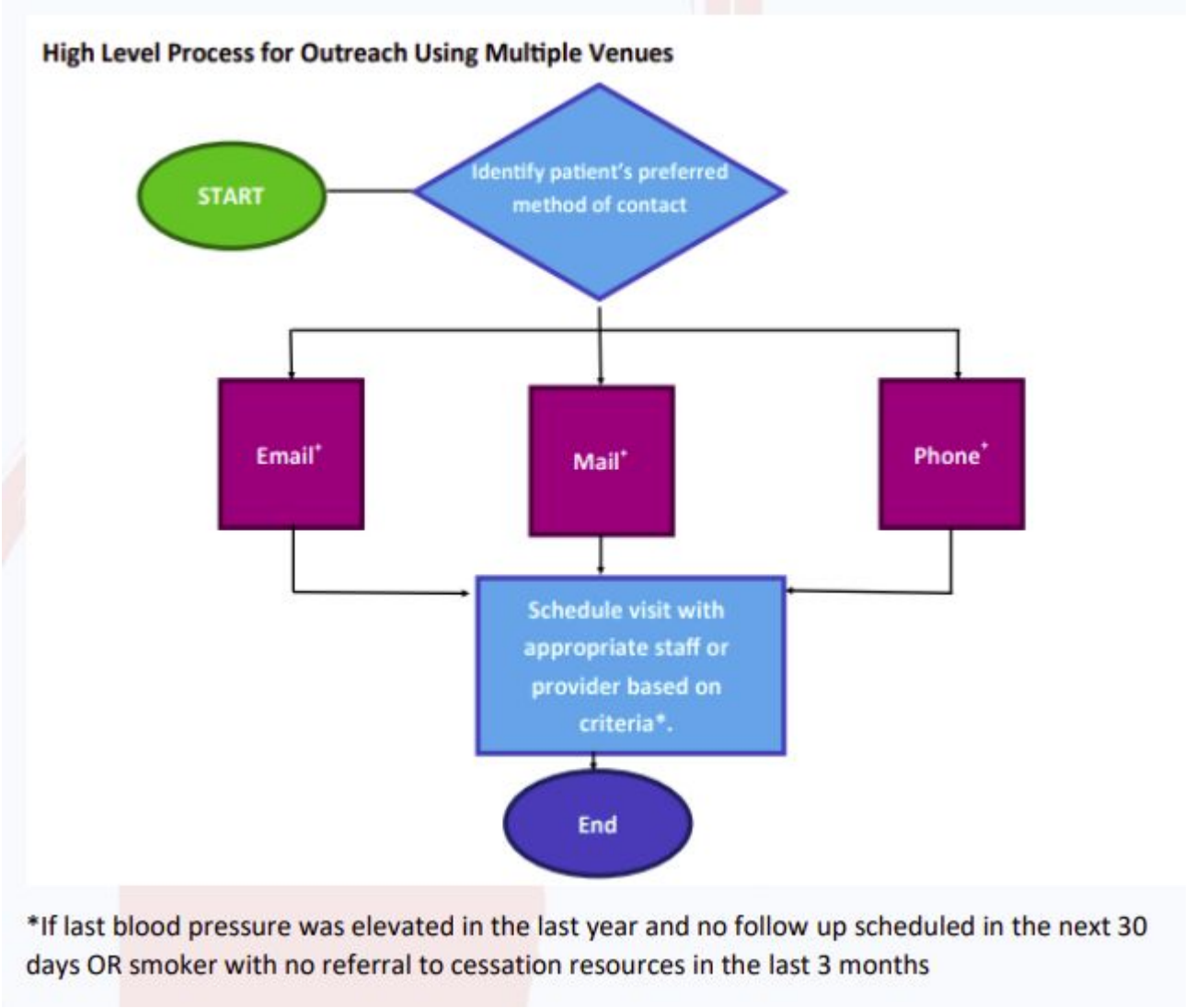
Poll Question(s)

1. Does your health system do any standardized approaches to outreach for patients with hypertension or who smoke?
   A. Yes
   B. No
   C. Not sure
   D. NA

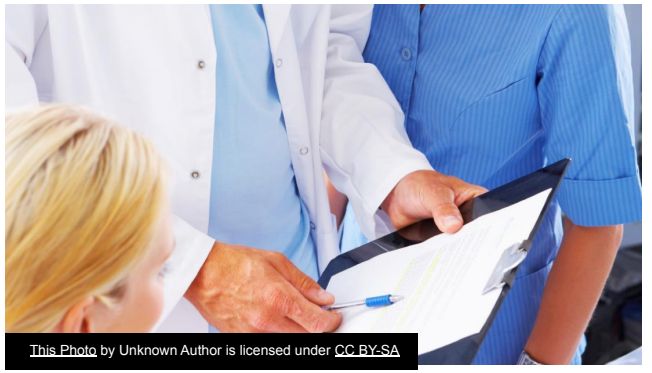
2. If yes to #1, please chat in what your clinic or health system does and at what intervals?

Outreach Process Map



Registry Outreach - Kaiser Model

- We had them see a nurse if seen by provider within the last 6 months
- We had them see the provider if seen within the 6 months to 2-year window
- Care coordinators called selected patients with moderately elevated BP



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Outreach Messaging – 3 Key Components

1. Reason for outreach
2. Importance of controlling a particular condition
3. A call to action

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Example Outreach Message for Hypertension

Dear Ms. Valdez,

Our records show that your last blood pressure was high (>=130/80). As you know, high blood pressure can lead to headaches, heart attack, kidney damage, and/or stroke. Please call us at xxx-xxxx to schedule a phone or in person NURSE blood pressure visit in the next 30 days.

Let's work together to protect your health.

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Example Outreach Message for Smokers

Dear Mr. Valdez,

Our records show you reported using tobacco at your last visit. Quitting tobacco is one of the most important things you can do for your health. Please call our office at xxx-xxx-xxxx to schedule a clinical pharmacist visit to discuss resources you can use to support quitting.

Let’s work together to protect your health.

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How Often Should You Reach Out?

- At least annually
- If doing this 1-2 times a year, Kaiser Permanente and others have used the approach of sending up to 3 reminders about 2 weeks apart if no response to the initial outreach attempt
- If you have a lot of patients on the outreach list, take 15% of that number as the ones that will likely be calling back
- Then, determine whether you need to stagger the outreach to ensure sufficient access when people start calling back

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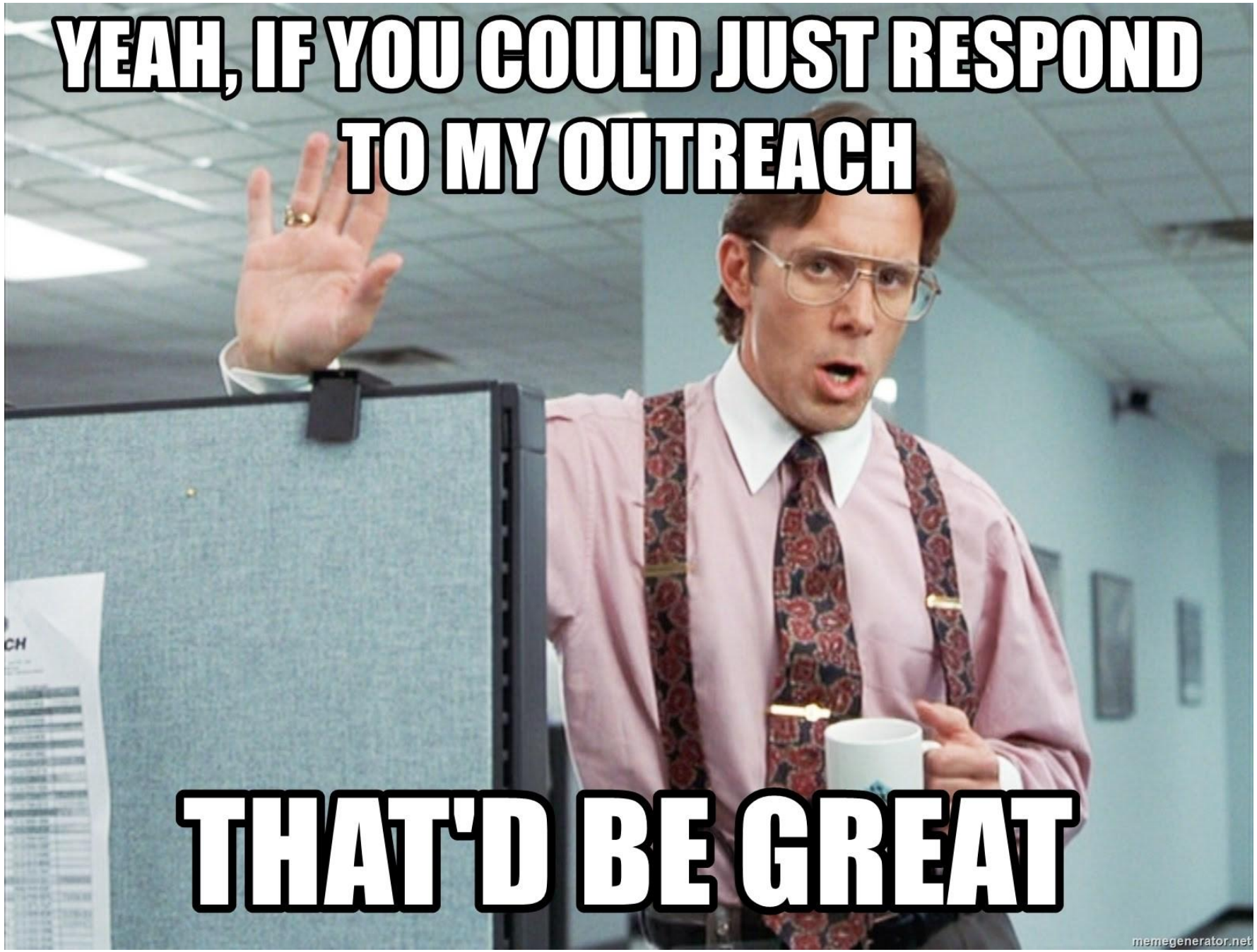

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Effectiveness

- In safety net clinics, uptake of these outreach efforts ranged from 10-25%

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What is the Cost to the Health System?

- The cost to the health system for automated outreach is typically made up for by patient volume and billing as well as value based payments for quality metrics.
- In our health system for adolescent immunizations, average visits generated $204 gross reimbursement for $1.77 in messaging expenses per vaccine given.
- The cost is higher if hiring a care coordinator or community health worker for live in person calls or outreach.
- Using care coordinator billing codes and receipt of value-based payments for higher quality metrics will help offset this cost.

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How Does Timely Follow-up and Outreach Improve BP Control and Smoking Cessation?

Enhancing the opportunity for high quality care for hypertension management include:

- Medication intensification
- Medication adherence
- Lifestyle and behavior change (DASH/low salt diet and home BP monitoring to reduce clinical inertia)

For smokers, it allows the opportunity to check in with smokers to see if you can provide additional supports for quitting

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Next Steps

- Continue to submit EHR data monthly (1st Monday of the month; next due November 7th)
- Review and modify the treatment algorithm and cardiovascular visit template when beginning the timely followup process
  - Optional webinars available Nov. 15th 12-1 pm and Nov. 17th 7-8 am to discuss **your** treatment algorithms and visit templates.
  - Same content at each webinar - offering 2 times to accommodate schedules
  - Please send us your algorithms and visit templates by Nov. 4th
- Continue to meet with your QI coach monthly
- Payer collaborations - working internally and planning a followup meeting
- Remember to engage a patient and obtain their feedback
- Next quarterly webinar January 20

Learn more & access resources at https://hearthealthyohio.org/

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Quality Improvement Humor

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