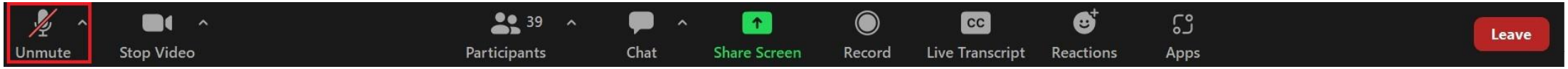
HEART HEALTHY OHIO INITIATIVE

HHOI Webinar #2 (Wave 2 Sites)

December 9th, 2022

Welcome and Logistics

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



HEART HEALTHY OHIO INITIATIVE

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	QIP clinics Aleece Caron, PhD
12:40 PM	Outreach	Shari Bolen MD, MPH
12:55 PM	Next Steps/Wrap Up	Stephanie Kanuch, MEd

HEART HEALTHY OHIO INITIATIVE

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

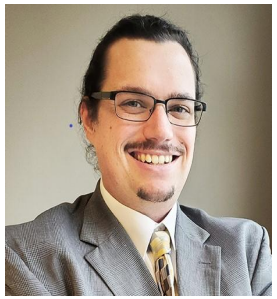
The Ohio State University

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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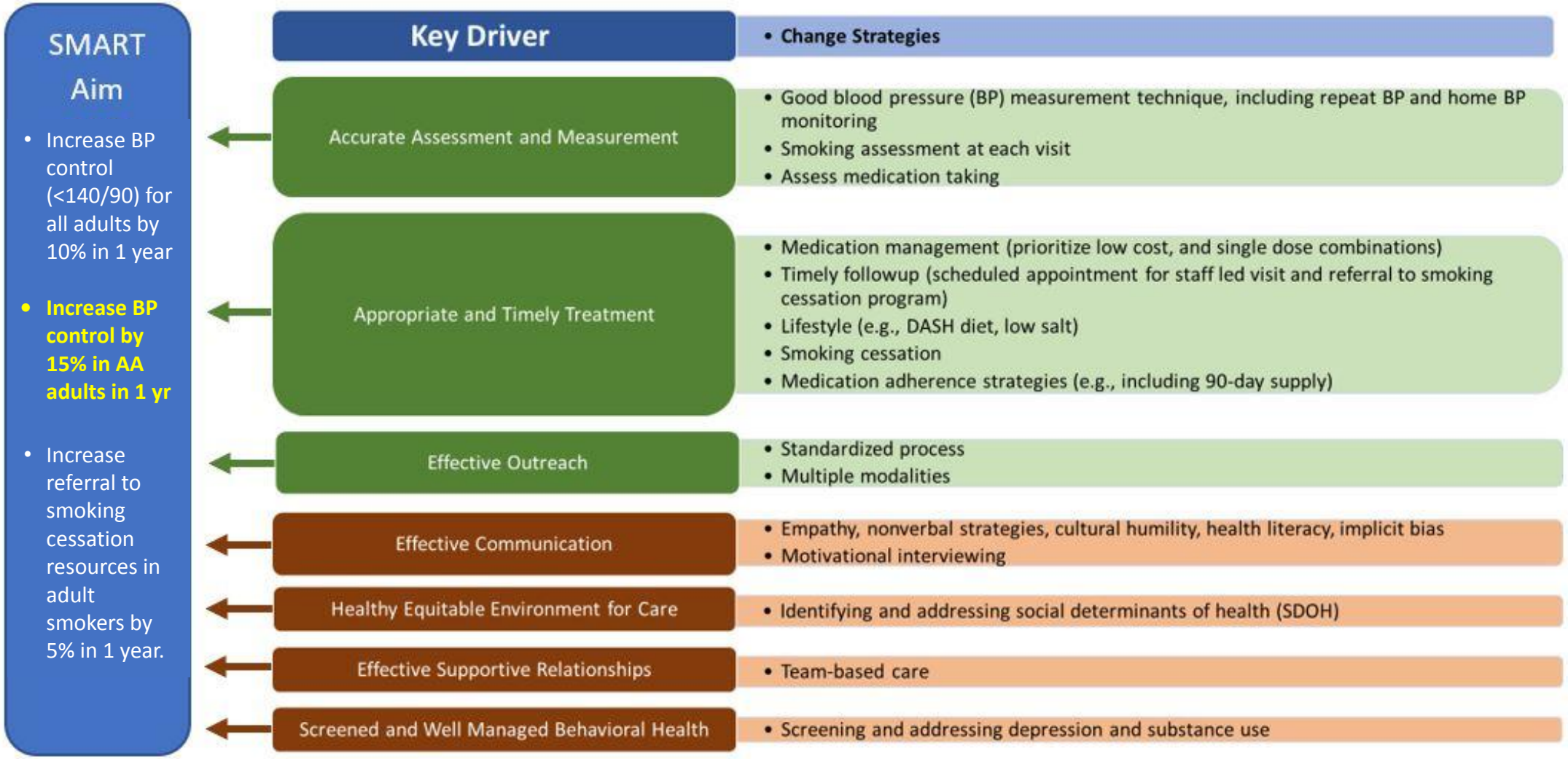
Key Driver Diagram and SMART AIM



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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

https://hearthealthyohio.org/addressing-disparities-and-toolkit-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

https://hearthealthyohio.org/healthy-equitable-environment-for-care

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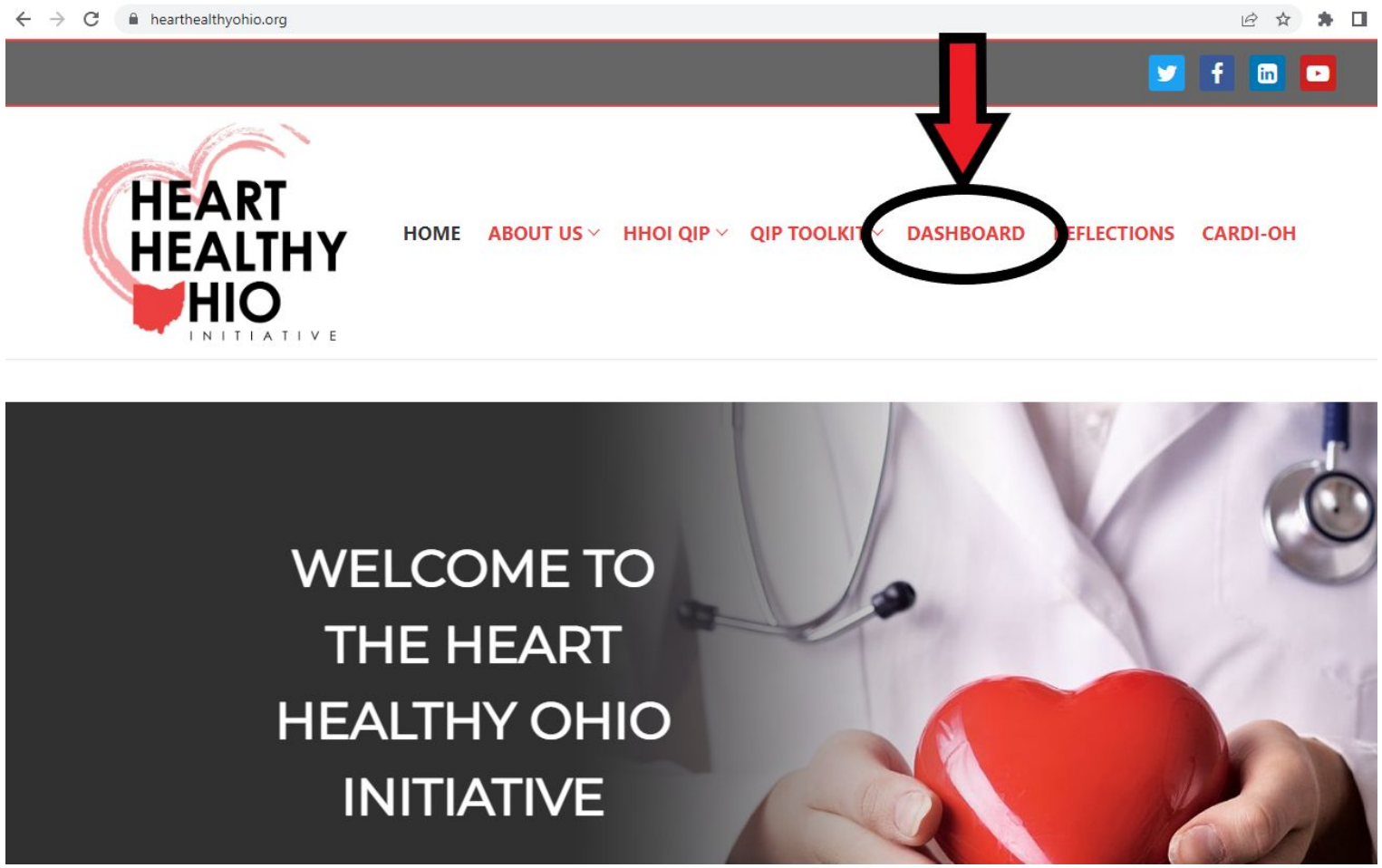
HHOI Data Dashboard

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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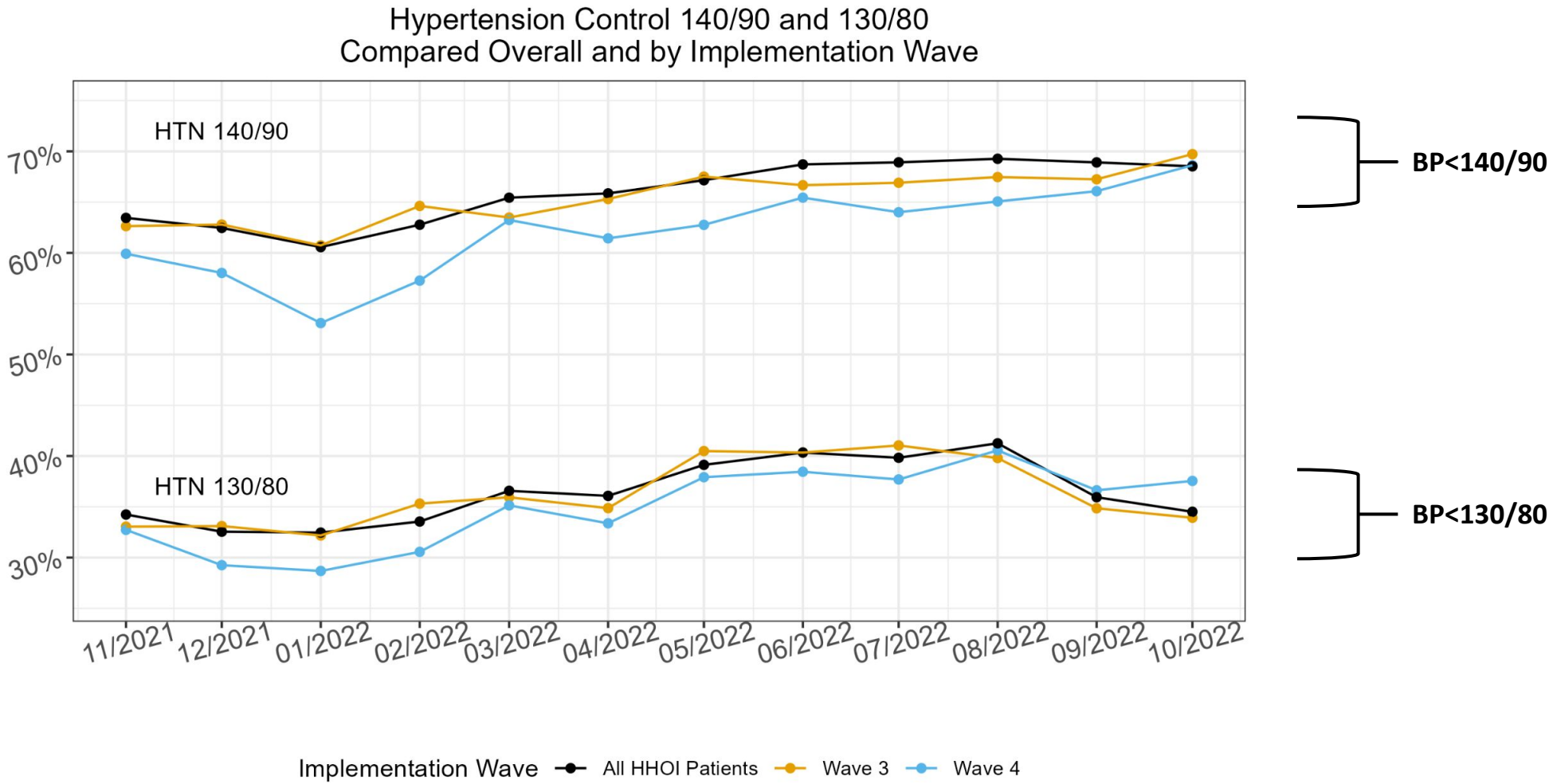
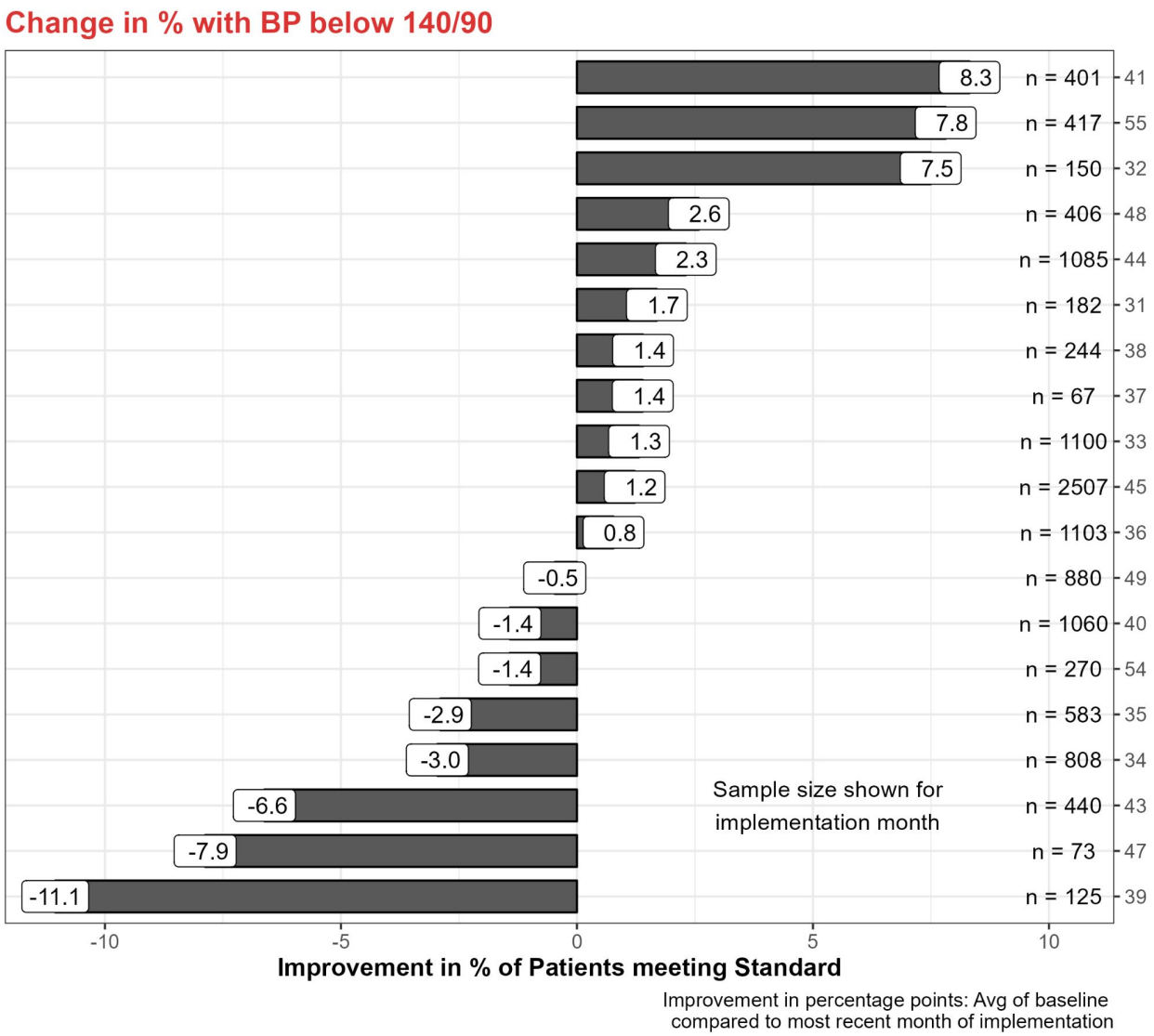
Percent of hypertensive adults under BP control by BP level



Improvement in BP Control by Site



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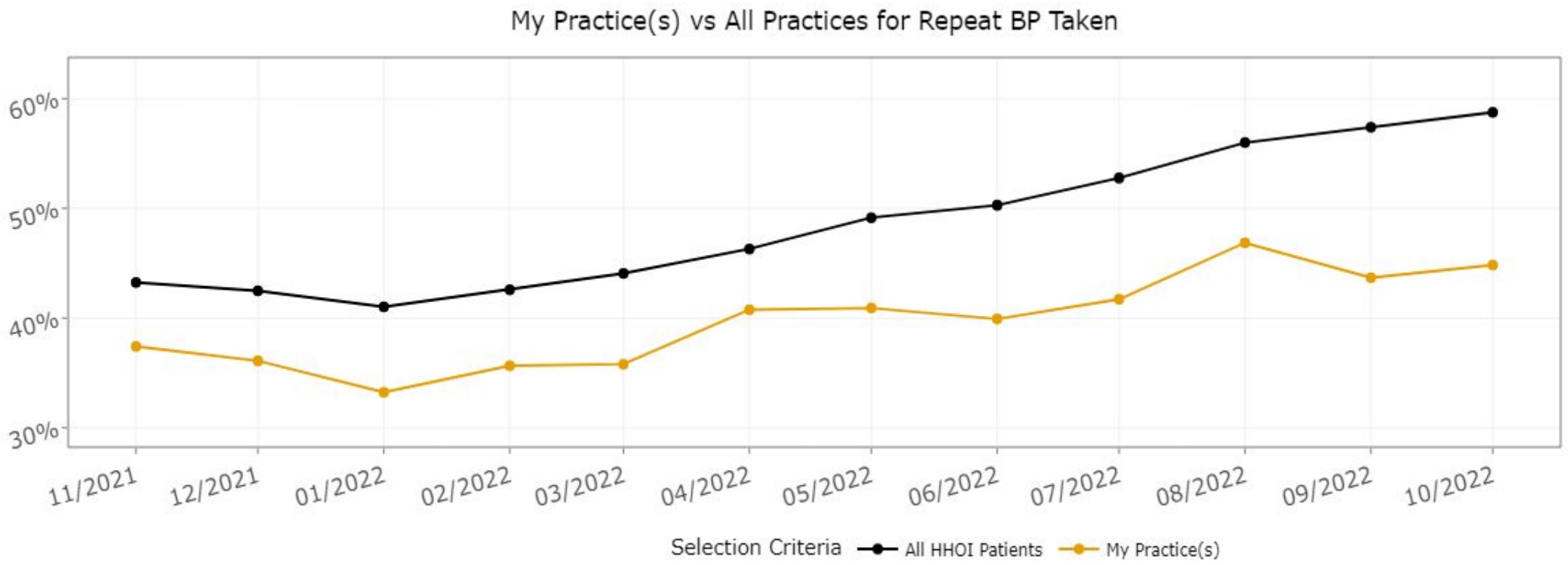
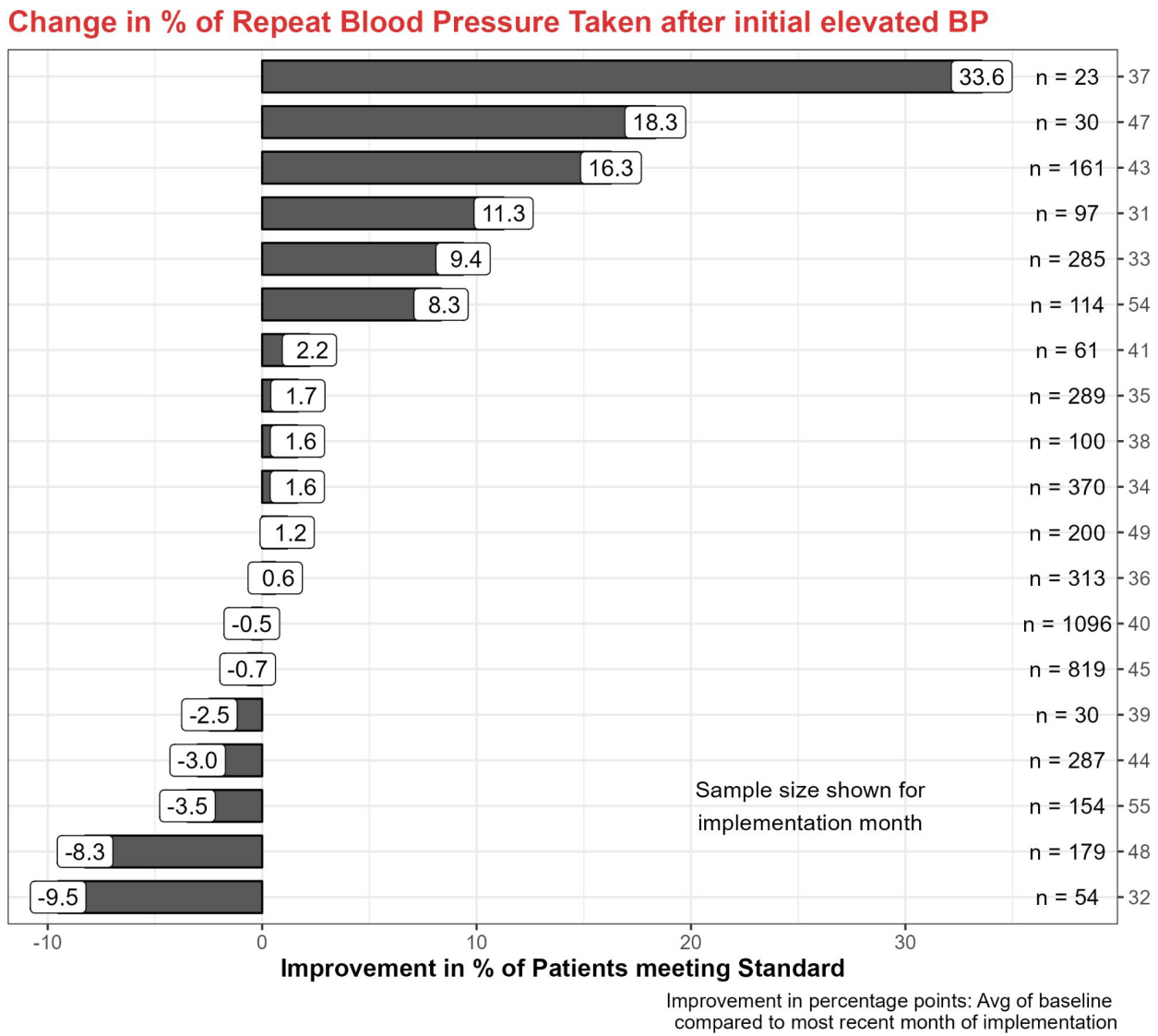
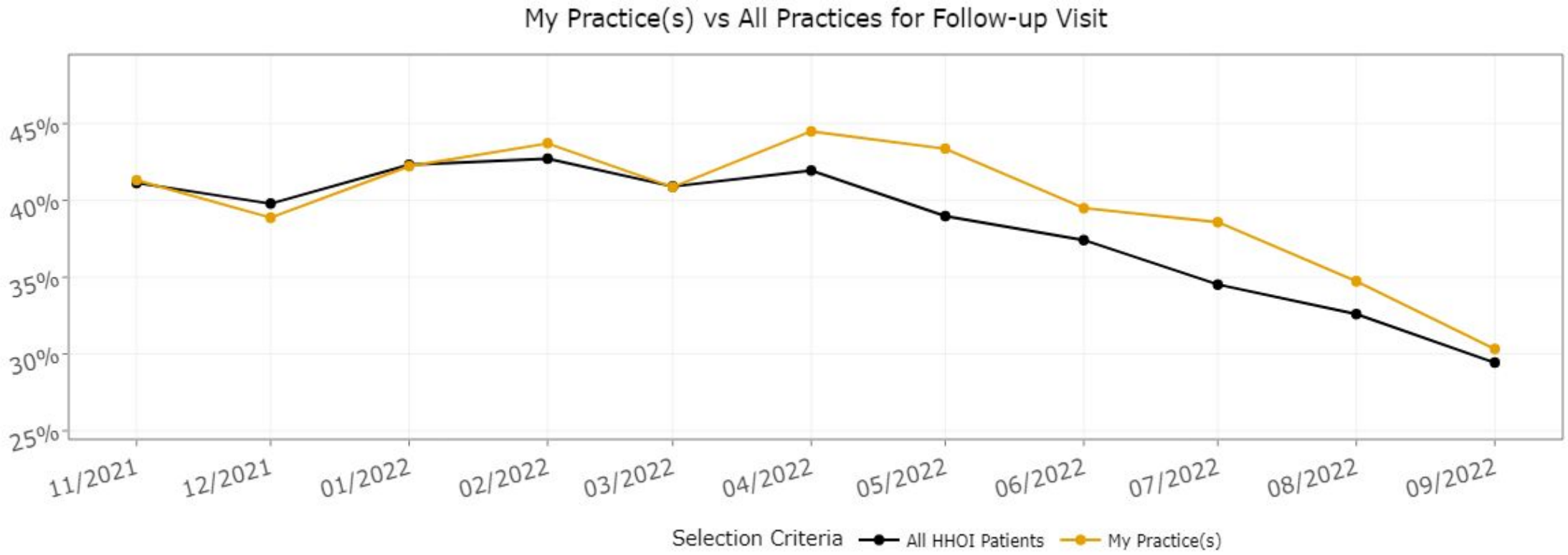
Percent of hypertensive adults with repeat BP if 1st BP elevated



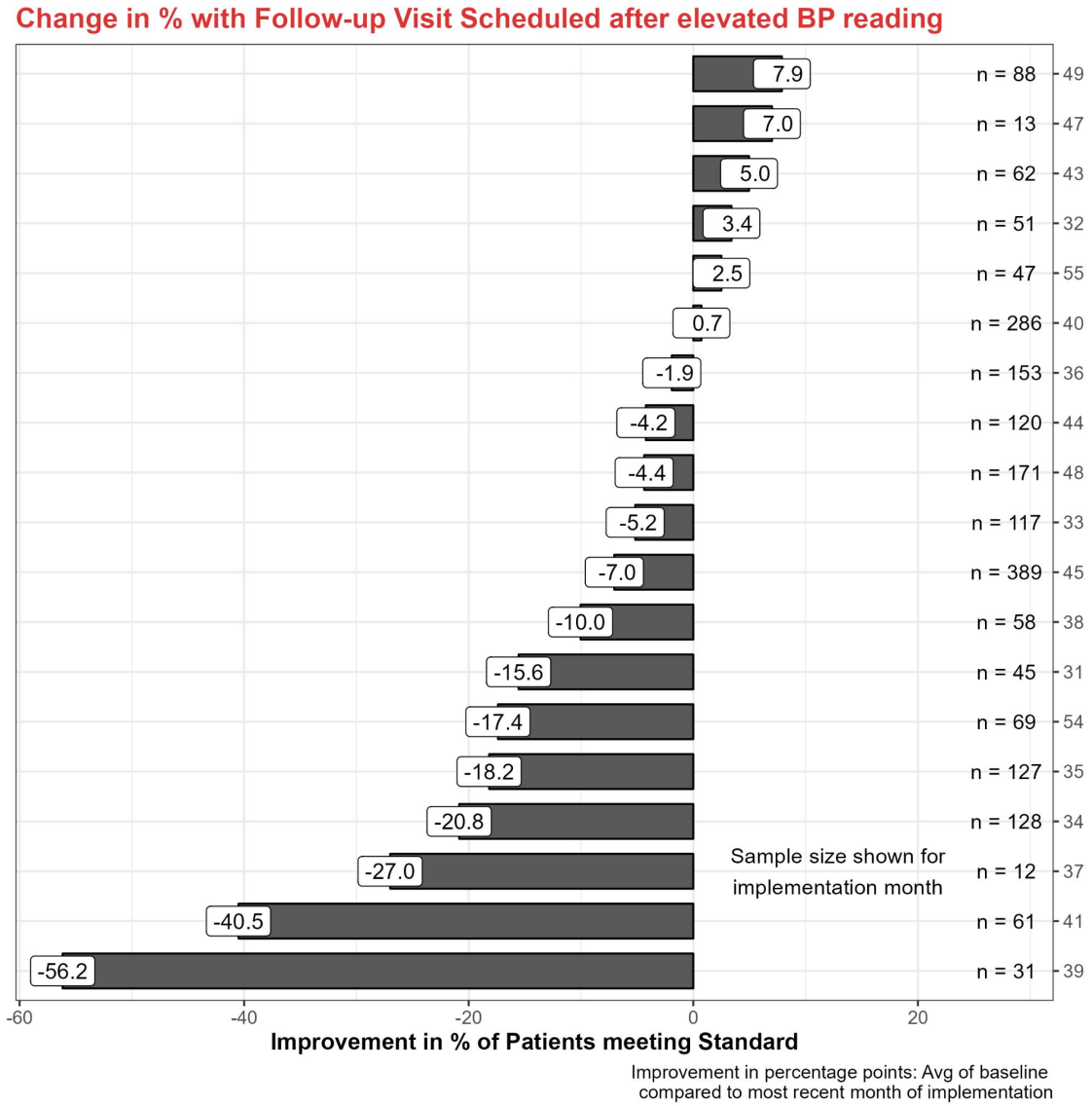
Improvements in Repeat BP by Site



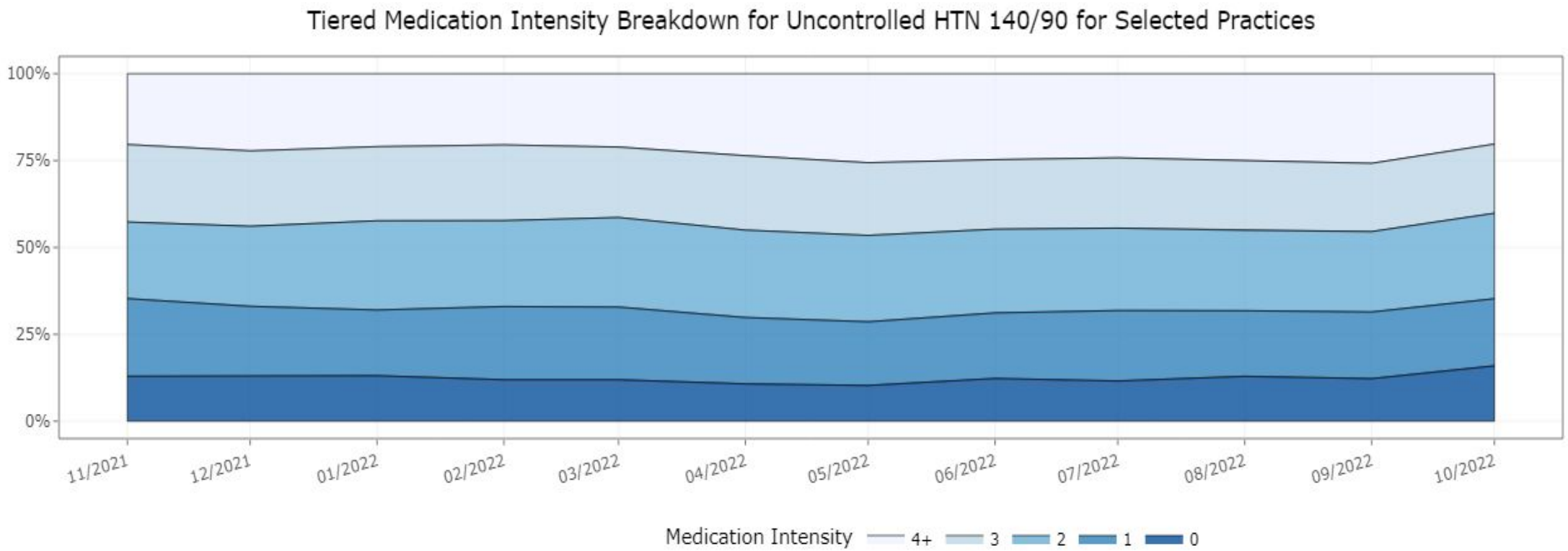
Percent of hypertensive adults with scheduled follow-up within 1 month



Improvements in Timely Follow-Up by Site



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



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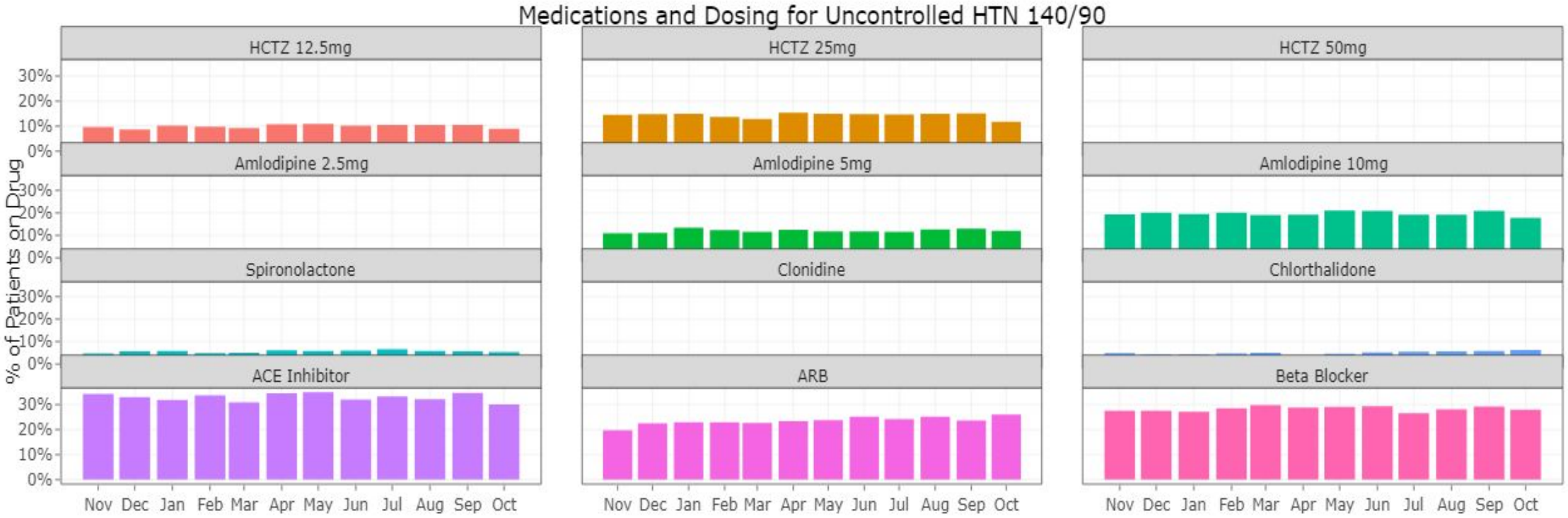
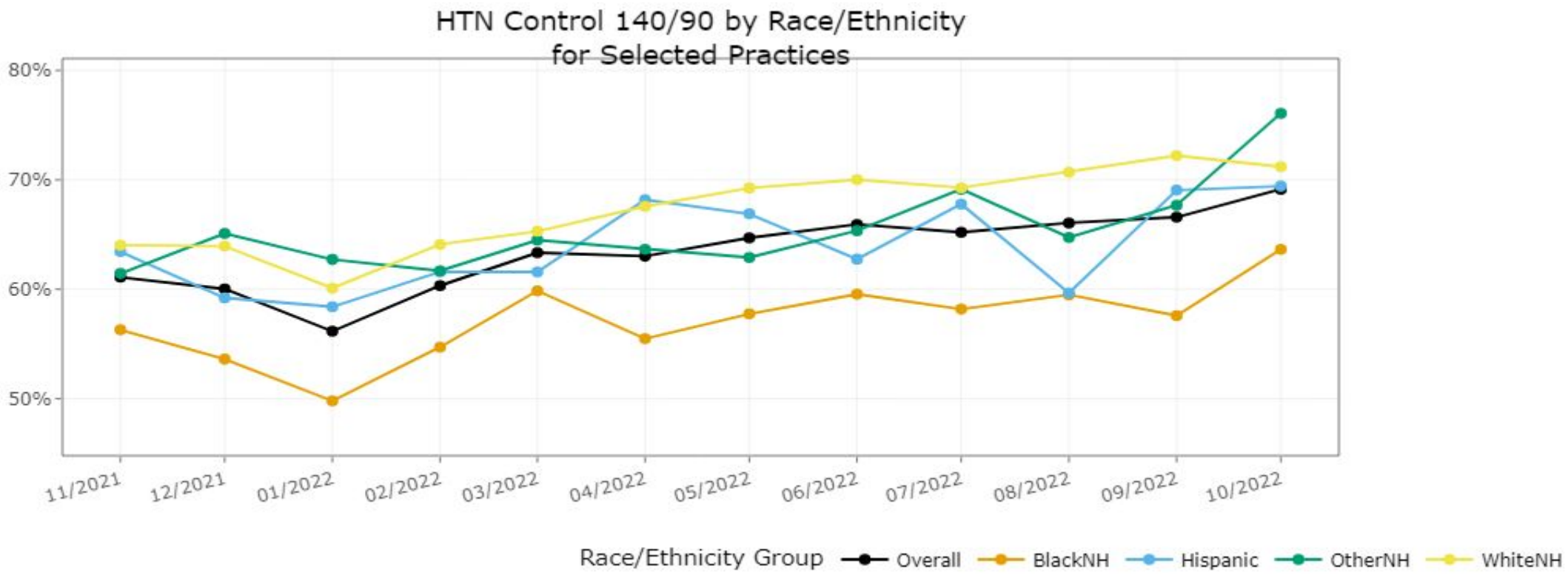
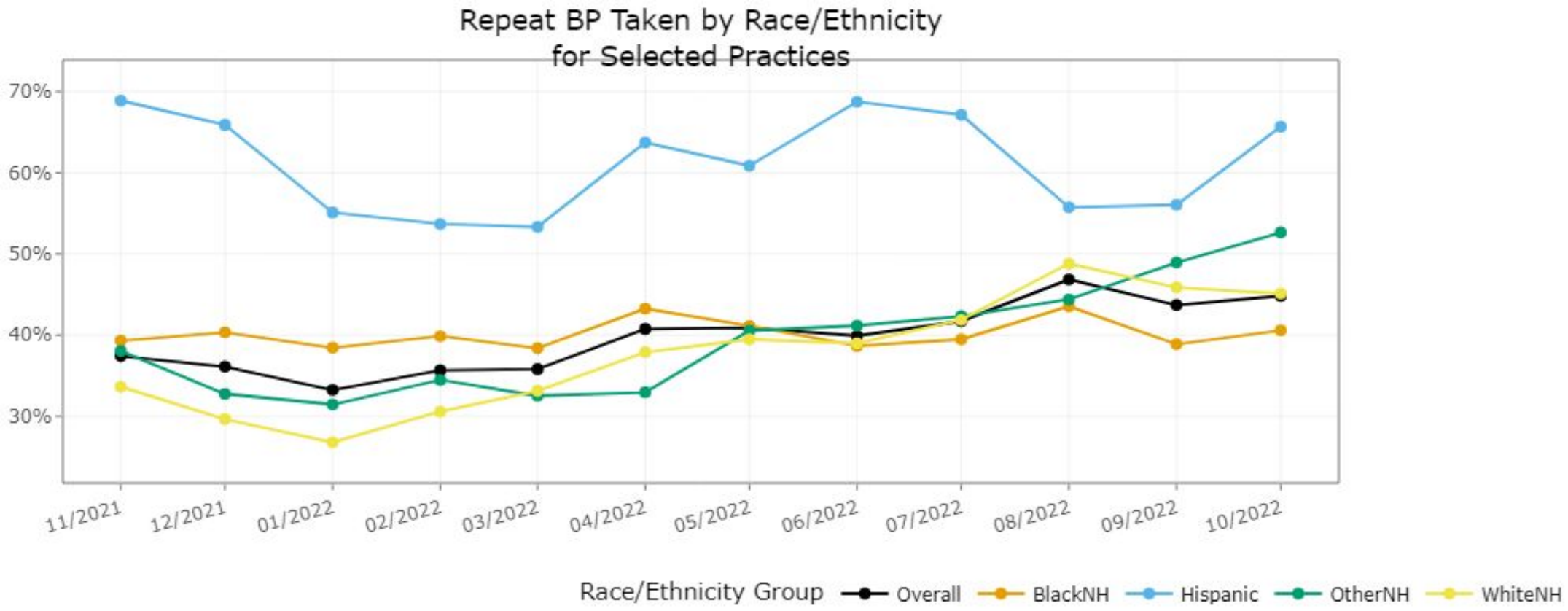
Percent of hypertensive adults with elevated BP on specific medications



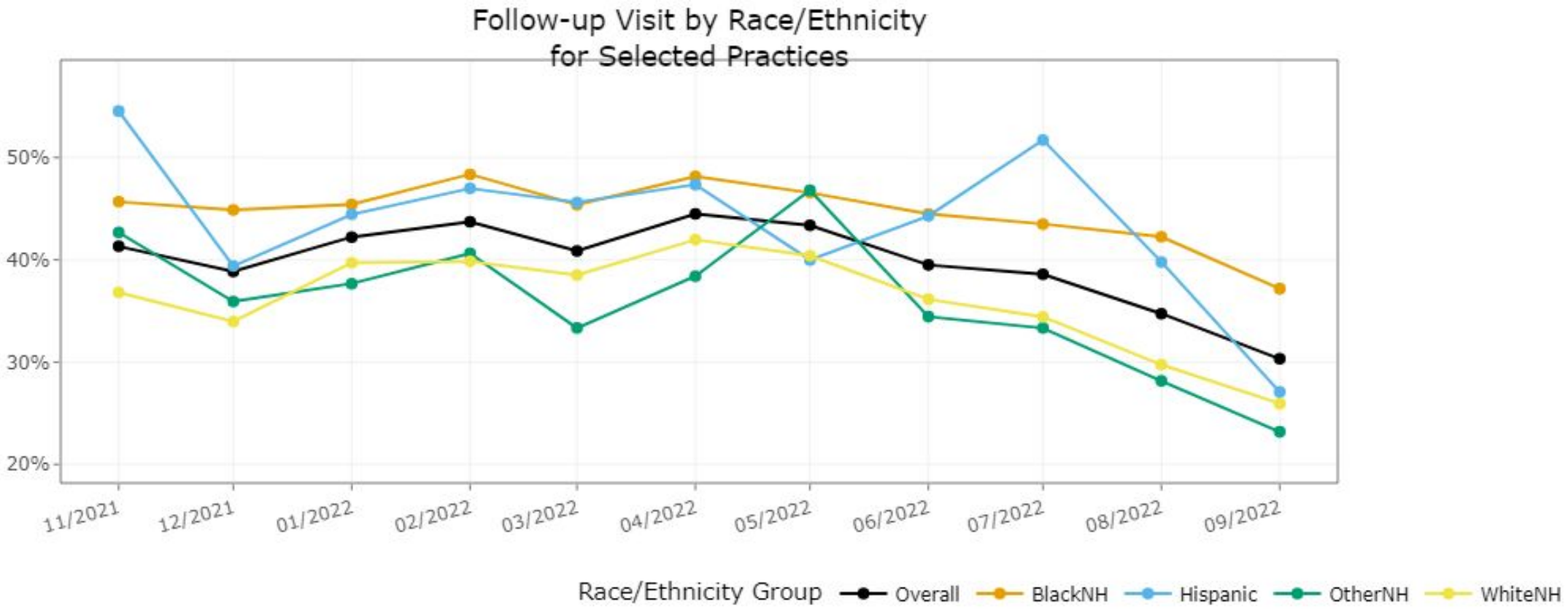
BP control by race and ethnicity



Repeat BP by race/ethnicity



Timely Follow-Up by Race/Ethnicity



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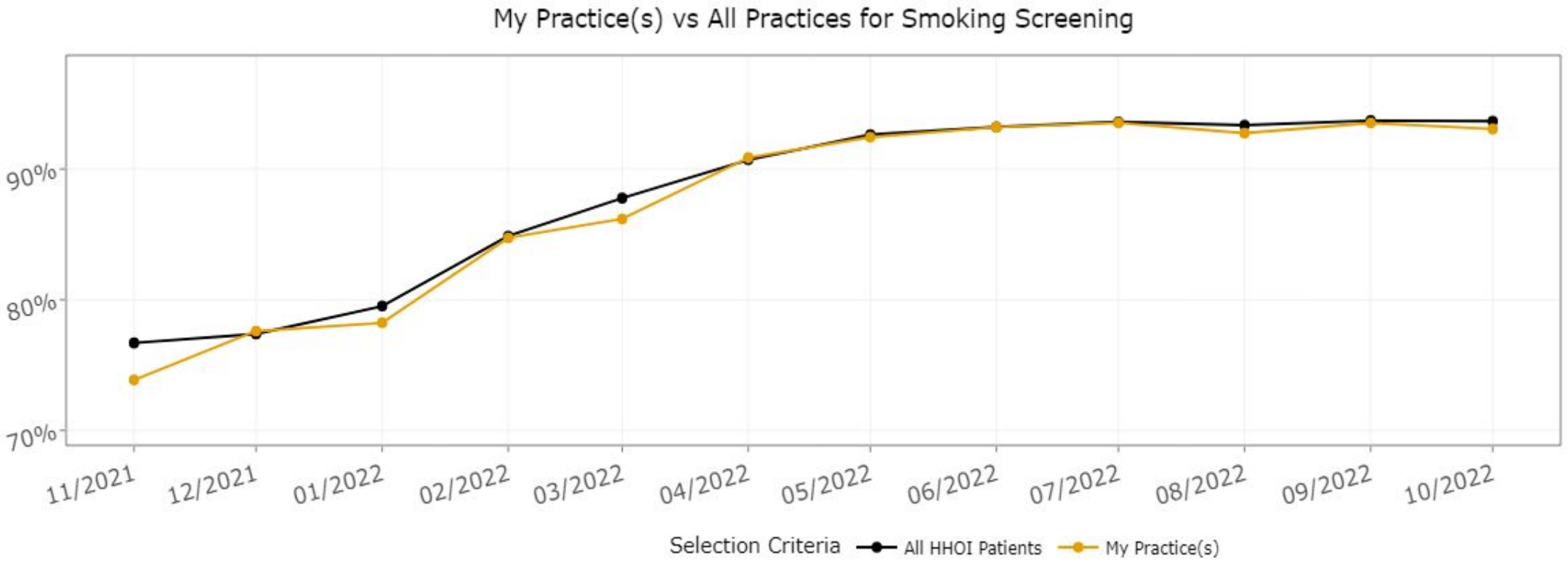
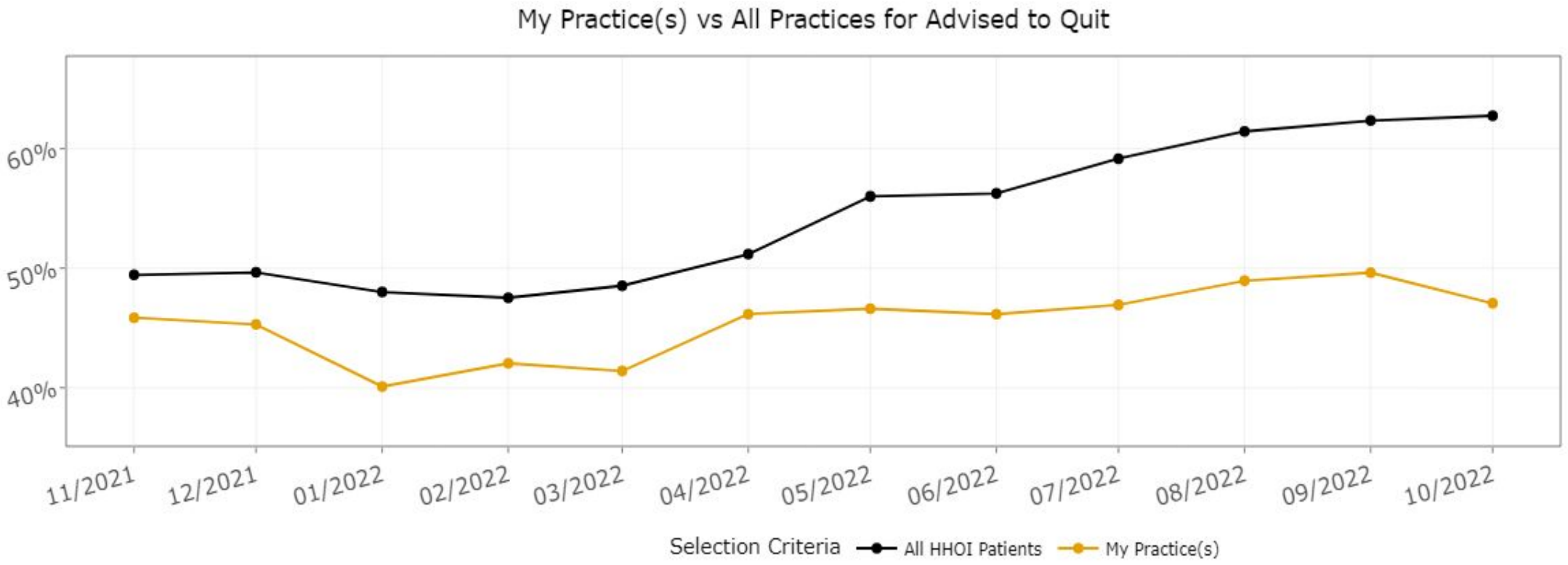
Percent of adults assessed for smoking in the last year



Percent of patient smokers advised to quit



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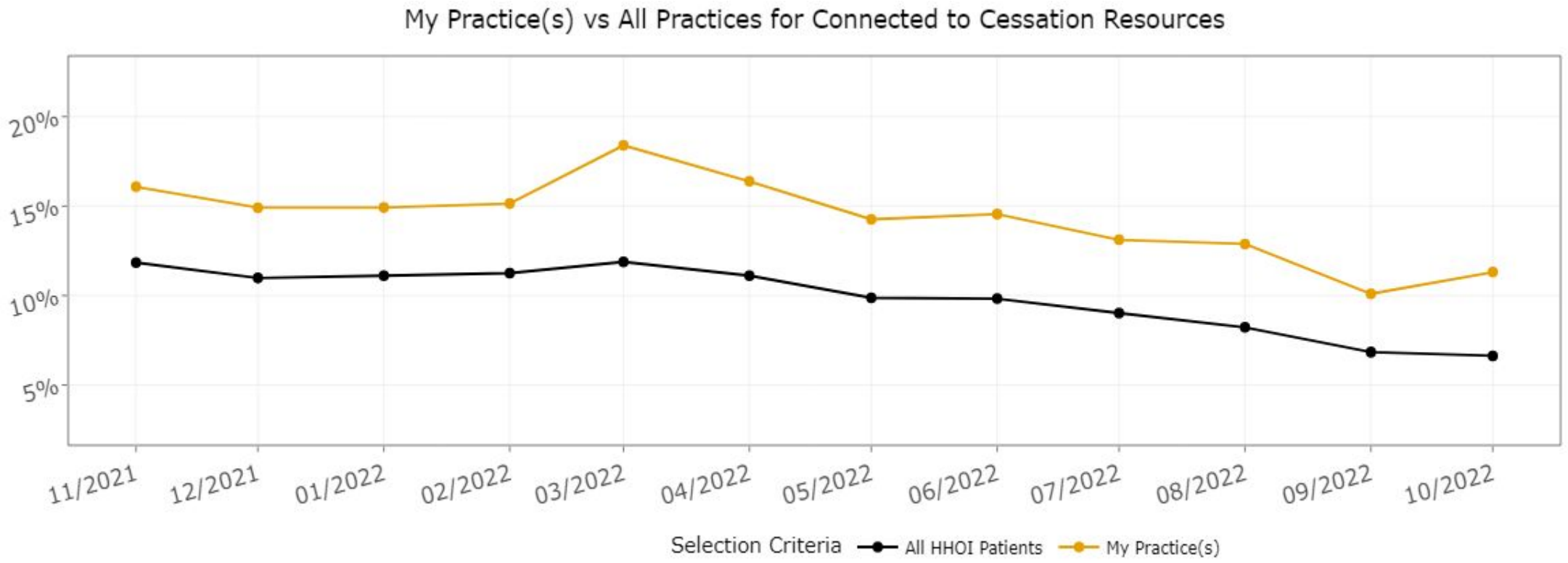
Percent of smokers connected to resources for smoking cessation



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Summary

- Beginning to see some improvements in BP control and smoking assessment 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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Teams in Action

Aleece Caron, PhD

QIP clinics

The Centers for Families and Children

THE CENTERS FOR FAMILIES AND CHILDREN

Project Goal: Reduce hypertension in Centers for Families and Children patients

Aim Statement: Improve quartile ratings for the percentage of patients 18 years or older with a diagnosis of hypertension whose most recent blood pressure reading was 140/90 mm/Hg from quartile 4 to quartile 2 by 12/31/2022

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THE CENTERS FOR FAMILIES AND CHILDREN

PDSA CYCLE

- **Plan:**
  - Hypertension work group developed
  - Healthy Heart Ohio baseline data reviewed
- **Do:**
  - List of Centers patients with a recent blood pressure screening of 160/90 currently on 0-1 medications was distributed to providers
  - Providers reached out to patients to schedule appointments for BP check and medication assessment
- **Study**
  - Reviewed Healthy Heart Ohio data one month after list was distributed
- **Act**
  - Begin cycle 2: Patients with a recent blood pressure screening of 140/90 or higher on 0 to 1 blood pressure medications

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THE CENTERS FOR FAMILIES AND CHILDREN

SUCCESSES AND CHALLENGES

Successes:

- Data driven change
- Able to troubleshoot data collection
- Collaboration in hypertension work group
- 5% overall increase in hypertension control from May to end of November
- Patients with screening of 160/90 or higher: 24% patients with completed appointment within the next month
  - 50% increased number of blood pressure medications
  - 60% had a decreased blood pressure screening

Challenges:

- Staff turnover in hypertension work group
- Challenges working with remote blood pressure vendor

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THE CENTERS FOR FAMILIES AND CHILDREN

Smoking Cessation in Internal Medicine – Provider and Resident Clinics

Cristina Sanders, APRN-CNP

Core Team Members

Internal Medicine

- ✔ **Jayne Barr, MD –** Site Champion
- ✔ **Vikas Gampa, MD –** Site Champion
- ✔ **Cristina Sanders, MSN, APRN-CNP** – Site Champion
- ✔ Lauren Chism, MD – Chief Resident
- ✔ Deni Drenic, MD – Resident
- ✔ Omnia Hamid, MD – Resident
- ✔ Stephanie Jackson, MD - Resident
- ✔ Alexander White-Cotsmire, MD - Resident
- ✔ Sheila Atkins, MSN, RN, NE-BC – Nurse Manager
- ✔ Laura Kusmik, RN, AMB-BC – Nurse Lead
- ✔ Brett Wade – MA Lead
- ✔ Katherine Liang – Informatics fellow

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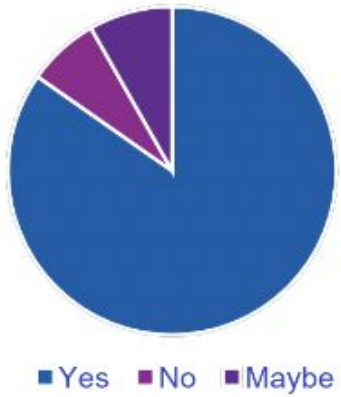
Establishing a baseline knowledge

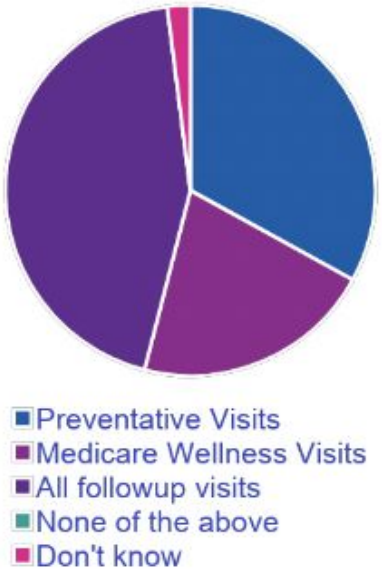
IM clinic Presurvey – Faculty/Resident Providers

Is there a smoking SmartSet

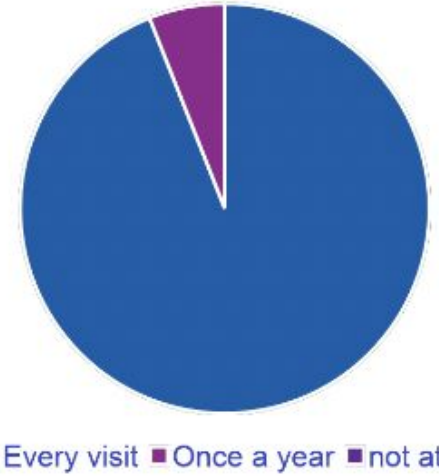
Would you use a smoking cessation SmartSet?



Which visits do you ask about smoking use? Check all that apply



How often do you ask about vaping? Check all that apply



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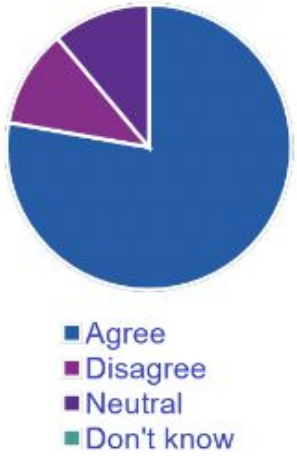
Establishing a baseline knowledge

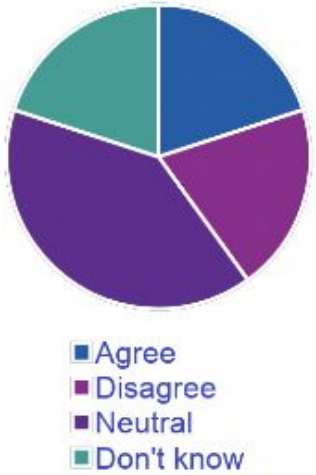
IM clinic Presurvey – RNs, MAs

I know where to find the tobacco screening survey

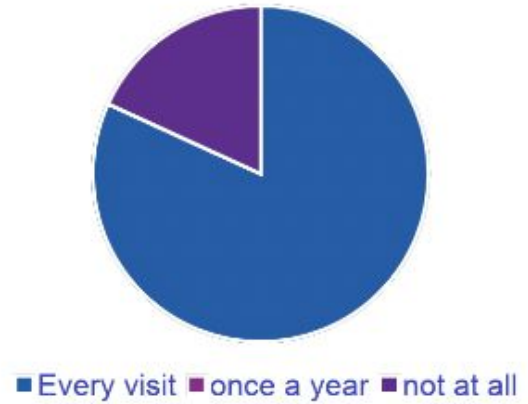
It is easy to document tobacco use history



Every patient is screened for tobacco use yearly



How often do you discuss smoking cessation with the patient



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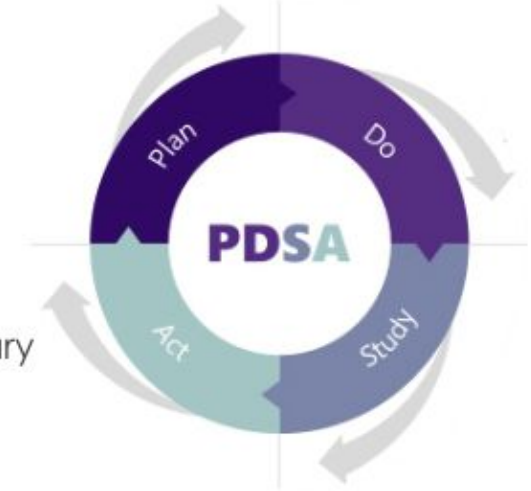
AIM, Objective and Plan



AIM

To improve cardiovascular health by implementing outpatient smoking cessation measures to 80% of active smokers between August 2022 and April 2023. Secondary measures will be aimed at decrease smoking in 50% of these patients

Plan

Objective:

Implement a standardized approach to identify and connect Interested smokers with Smoking Cessation Services.

Tests:

1. Use of visual prompts to Increase Smoking Cessation Screening
2. Utilize an electronic learning module to increase provider awareness for smoking cessation referrals and medications.
3. Implement an icon on EHR to help increase providers ability to find and update tobacco use history
4. Increase utilization of Smoking Cessation SmartSet

Data tracking/measure:

With use of EPIC (EHR) and Heart Healthy of Ohio Dashboard

- Track referrals to services aiding with Smoking Cessation
  - Tobacco QuitLine, Smoking Cessation Care Navigator, Integrated Behavioral Health, Pharmacist, Smoking Cessation Group Clinic, Smoking Clinic, Nurse Education
- Track attendance of visits
- Document attendance

Prediction of Test Outcomes:

1. Screening for Tobacco Use will increase
2. Referrals to Smoking Cessation Services will increase
3. Smoking Cessation will increase

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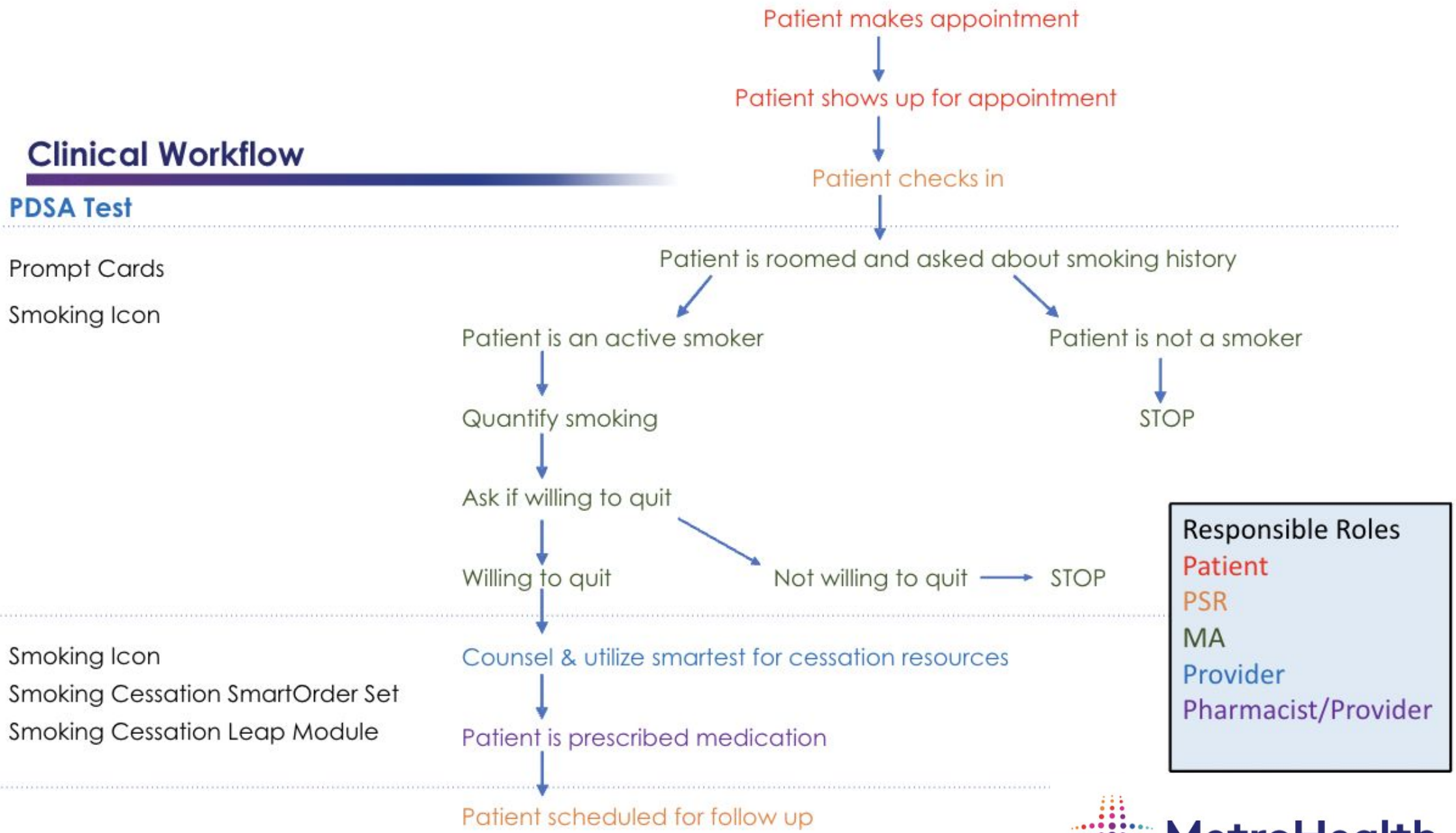
Clinical Workflow

PDSA Test



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PDSA #1: Smoking Cessation Prompt Cards

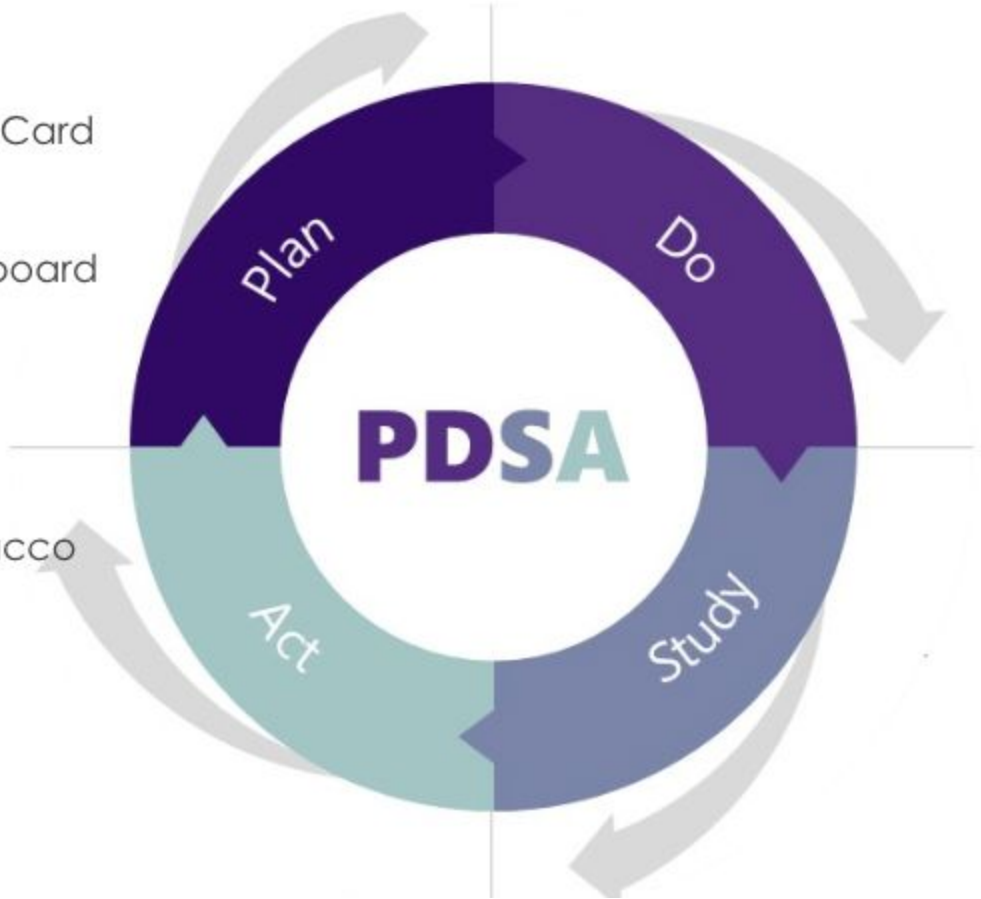
Specific AIM: Increase awareness of patients who are current smokers and are interested in smoking cessation by 10% by 07/2023

Plan

Test:
Smoking Cessation Prompt Card

Track:
EPIC (EHR) and HHOI Dashboard
- ASK
- ADVISE
- Refer

Predict:
Improve screening for tobacco use



Do

Create Card	Stephanie
Modify Card	Core Team
Print Card	Dr. Barr/Cristina
Distribute Card	Brett

Test Start Date: 12/1/2022

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1. **ASK** every patient at every visit if they are actively smoking

"Have you used tobacco or nicotine products including vaping in the past 30 days"?

If answer "yes", provide brief advice – *"As a member of your healthcare team, I strongly recommend that you quit."*

2. **ASSESS** readiness to quit smoking

"Are you thinking about quitting in the next 30 days?"

3. **CONNECT** with smoking cessation resources

If ready to quit – *"Can I connect you with the Ohio Quit line counselors to help you with quitting?' or "Can I connect you with our behavioral health counselors or pharmacist to help you with quitting?"*
→ PLACE ORDER

"Is it OK to have someone from the office check in with you in a month or so to see how it is going and check if you need additional assistance with quitting?"

If not ready to quit – *"OK, we are here to help you when you are ready"*

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PDSA #2: Smoking Cessation Icon

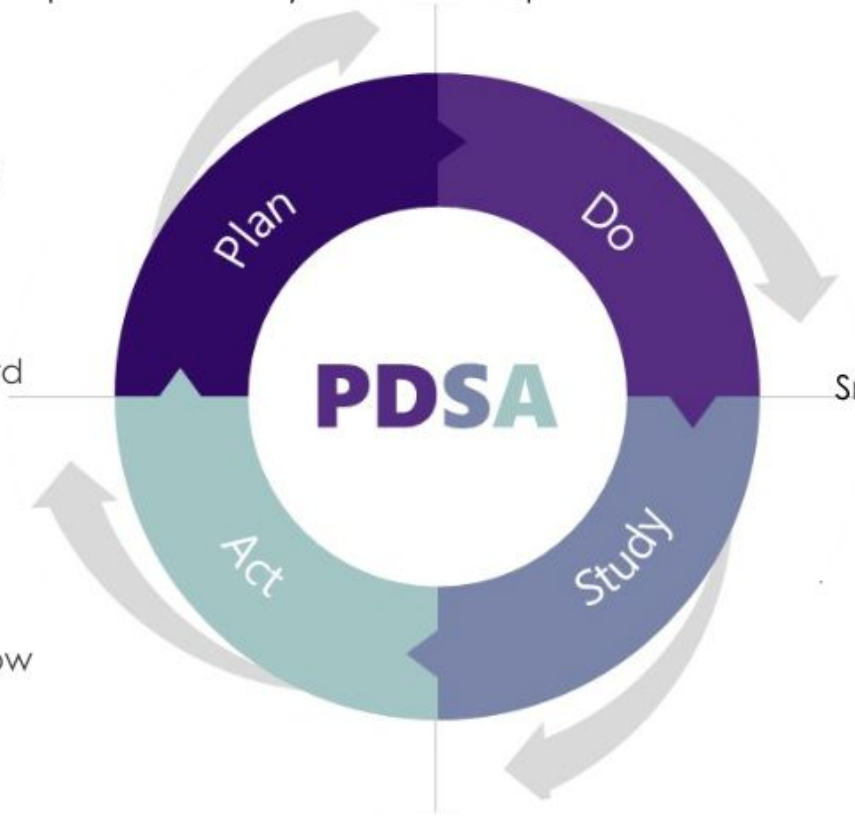
Specific AIM: Increase providers ability to find and update tobacco use history by 20% by June 2023.

Plan

Test:
Smoking Cessation Icon
Streamlined access to smoking history

Track:
Pre and post survey
EPIC (EHR) and HHOI Dashboard
- ADVISE
- Refer

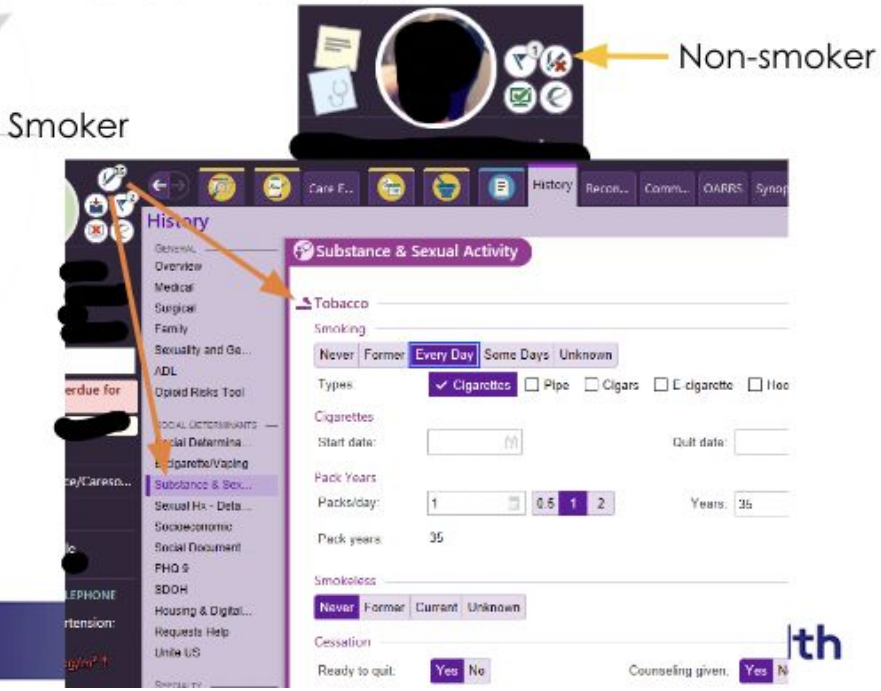
Predict:
Increase in confidence of providers in knowing where to find the Smoking history and how to edit it.



Do

Icon visible to amb care	IS/Katherine
Inform Providers	Alex
Send out Post-Survey	Dr. Barr

Test Start Date: 12/6/2022



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PDSA #3: Smoking Cessation SmartSet

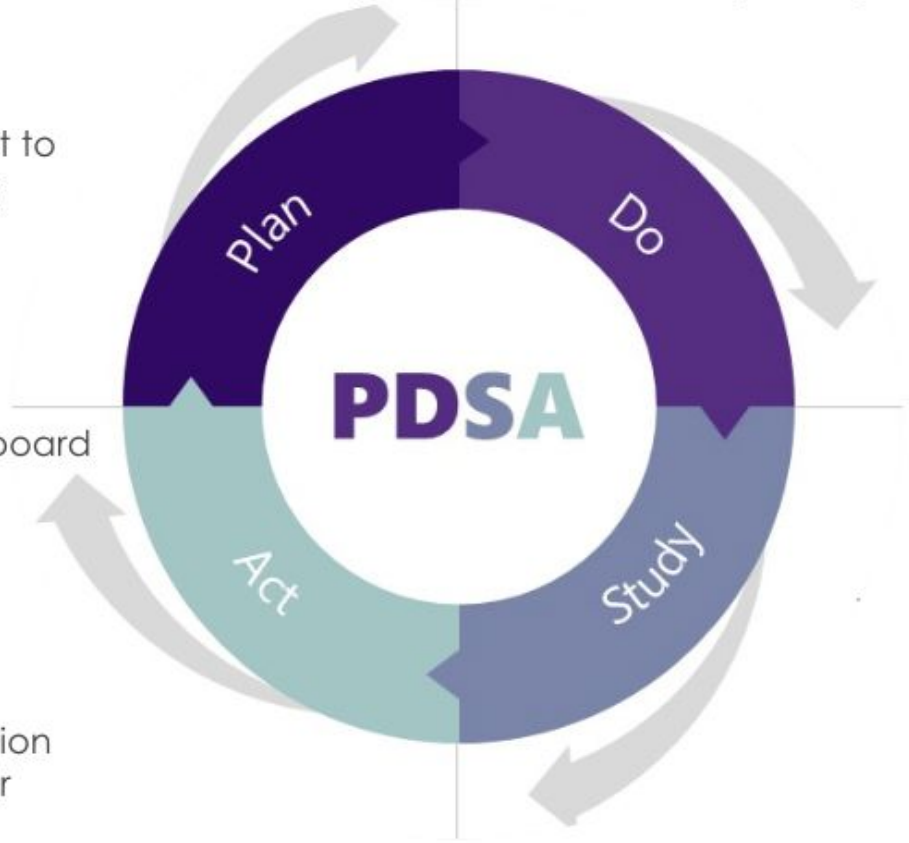
Specific AIM: Increase referral for smoking cessation services by 20% by June 2023.

Plan

Test:
Standardize use of SmartSet to improve access to smoking cessation services.
- MA led
- Informatics fellow

Track:
EPIC (EHR) and HHOI Dashboard
- ADISE
- Refer

Predict:
Increase in screening
Increase in referrals
Increase in Smoking Cessation
Improve documentation for billing



Do

Update SmartSet	Collaborate w IS
ID current Process	Laura, Brett
ID process change	Resident, Brett
Educate Staff	Laura, Brett
Educate Providers	Resident

Test Start Date: 12/6/2022

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PDSA #4: Smoking Cessation LEAP Module

Specific AIM: Increase knowledge and usage of SmartSet by 20% by June 2023.

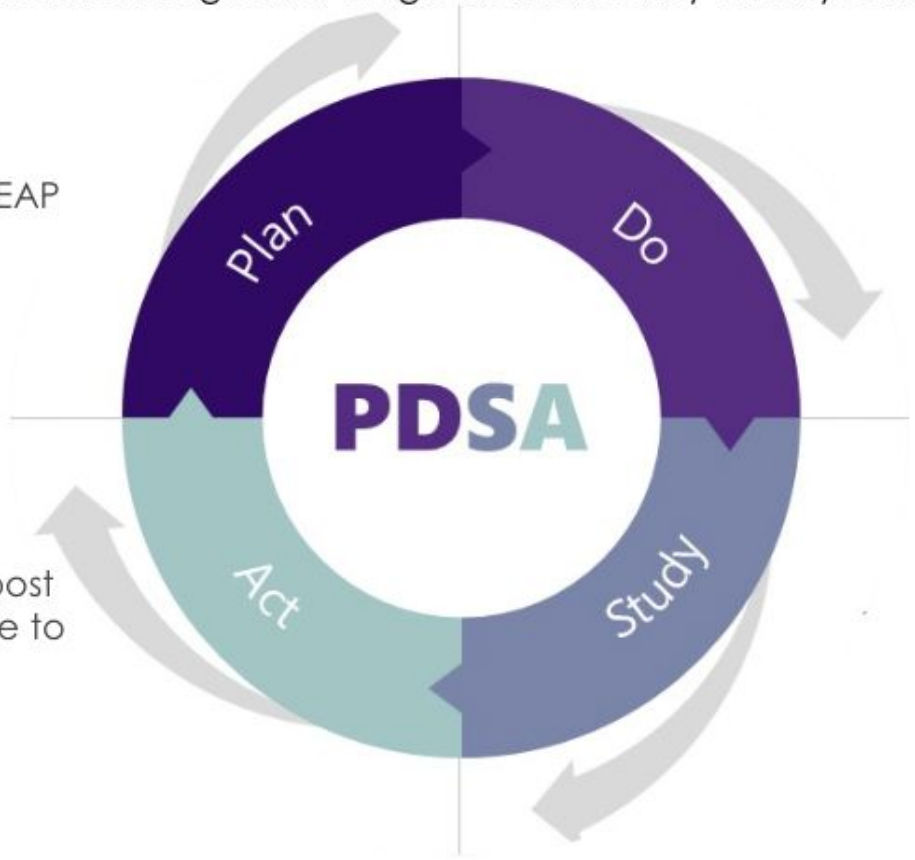
Plan

Test:
Integration and Completion of LEAP module by clinic staff
- 10 min or less

Track:
EPIC (EHR) and HHOI Dashboard
- ADISE
- Refer

Post-survey: compare pre and post survey responses (i.e. know where to find screening survey)

Predict:
Increase in screening
Increase in referrals
Increase in Smoking Cessation



Do

LEAP module creation	Eileen Seeholzer MD
LEAP module release	Eileen Seeholzer MD
Update SmartSet	Collaborate w IS
ID current Process	Laura, Brett
ID process change	Resident, Brett
Educate Staff	Laura, Brett
Educate Providers	Resident

Test Start Date: TBA

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Questions??

Cristina Sanders, MSN, APRN-CNP

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Jayne Barr, MD

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Vikas Gampa, MD

vgampa@metrohealth.org

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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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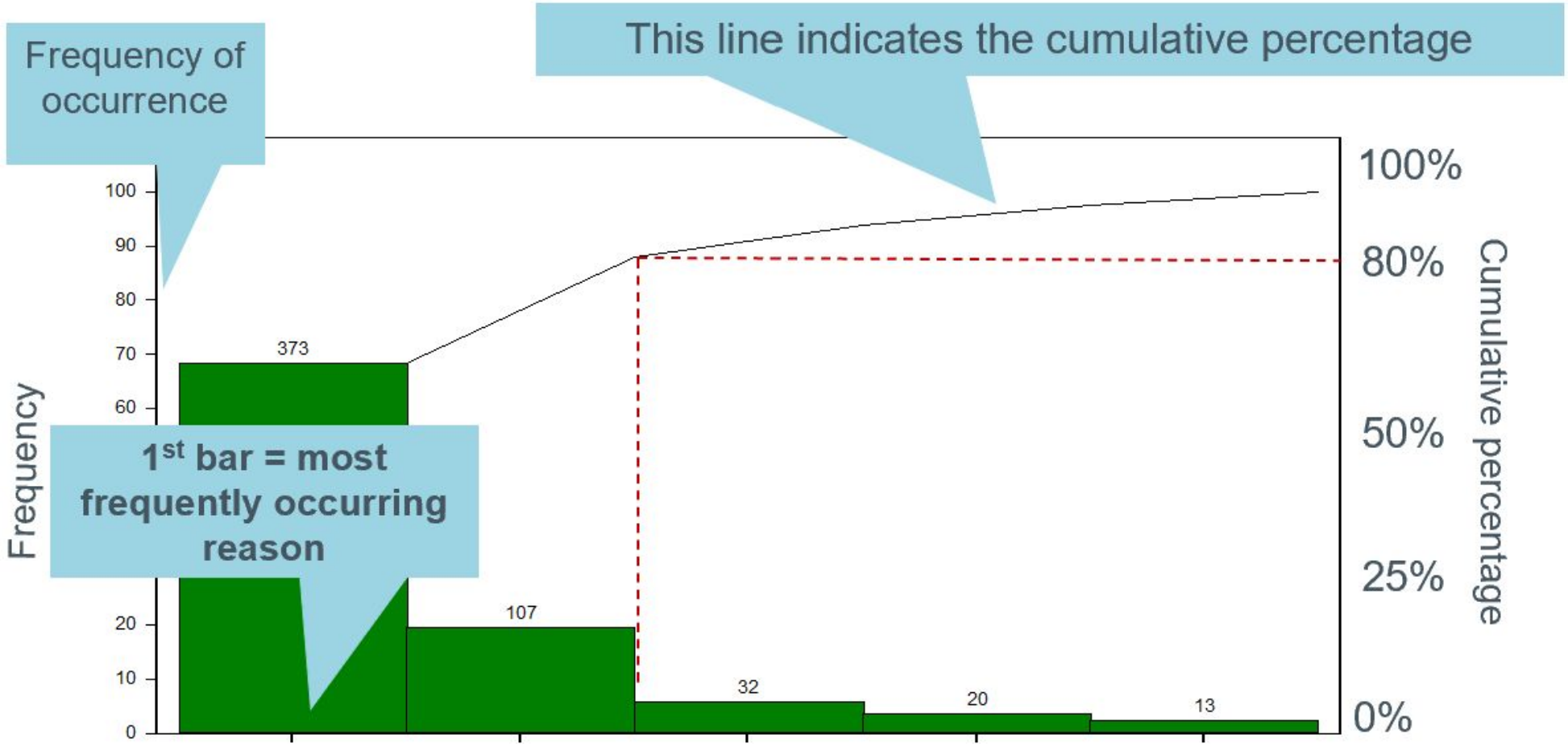
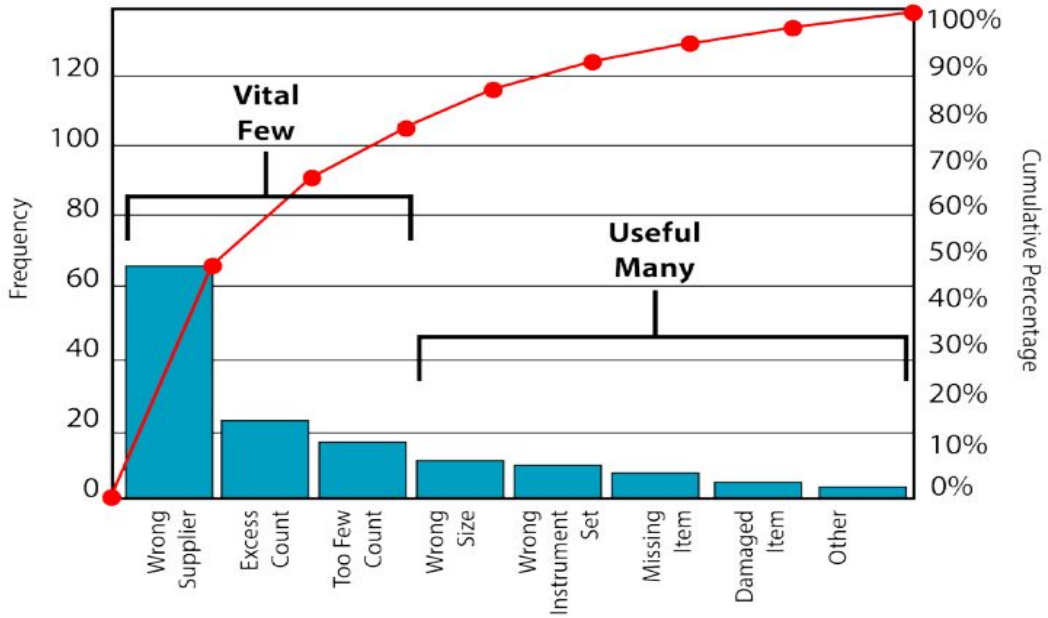
Reading a Pareto chart



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	



https://hearthealthyohio.org/pareto-charts

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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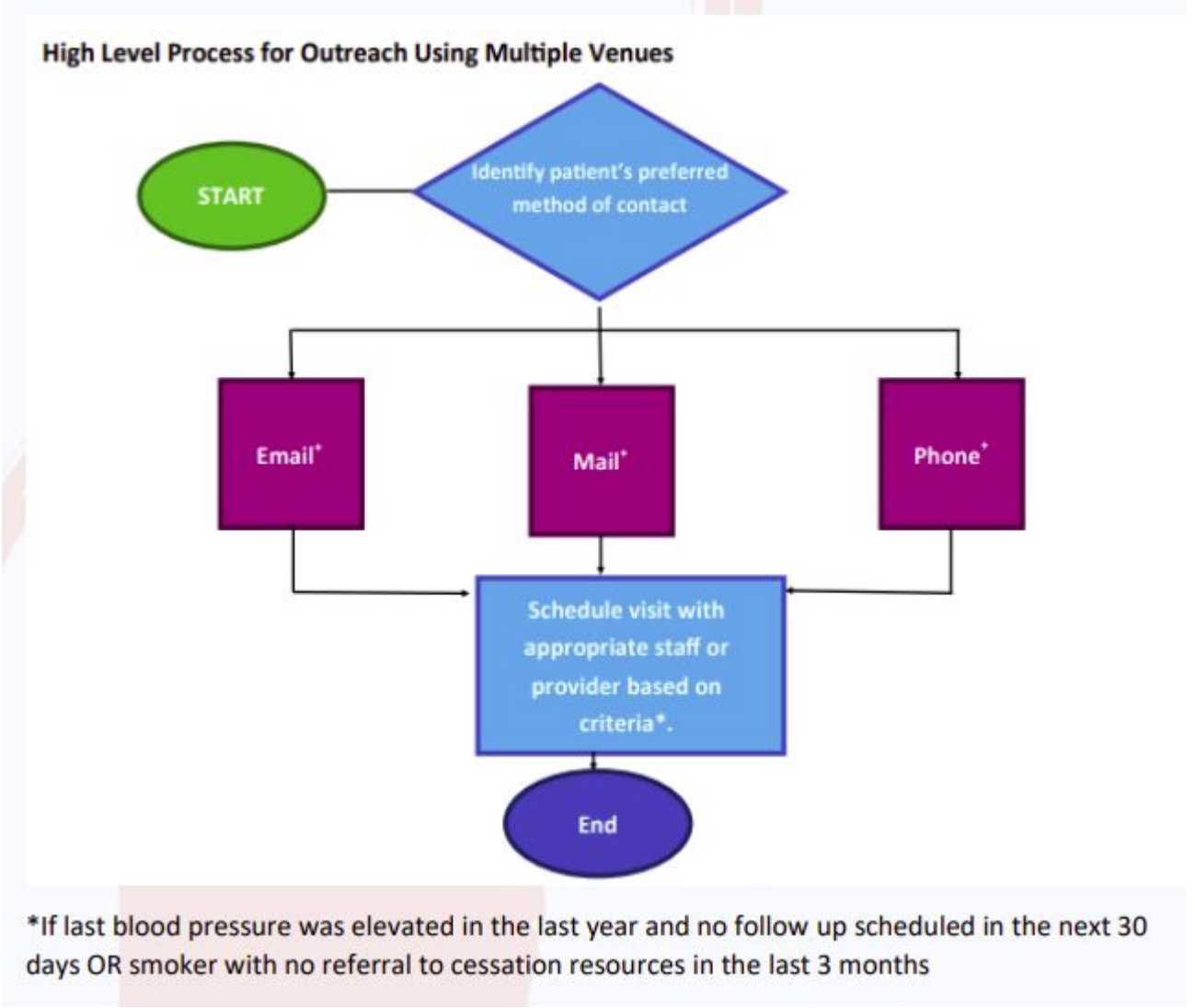
Poll Question(s)

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

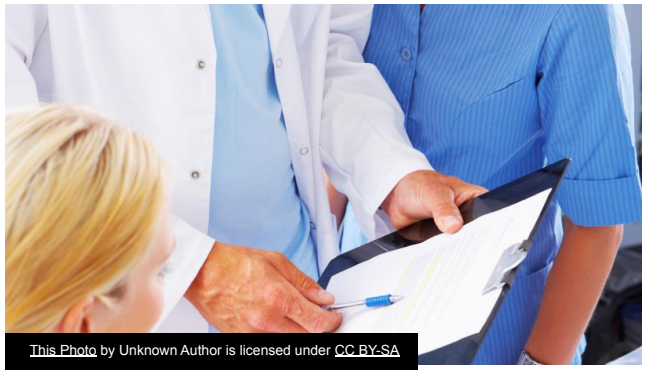
2. If yes to #1, please chat in what your clinic or health system does and at what intervals?

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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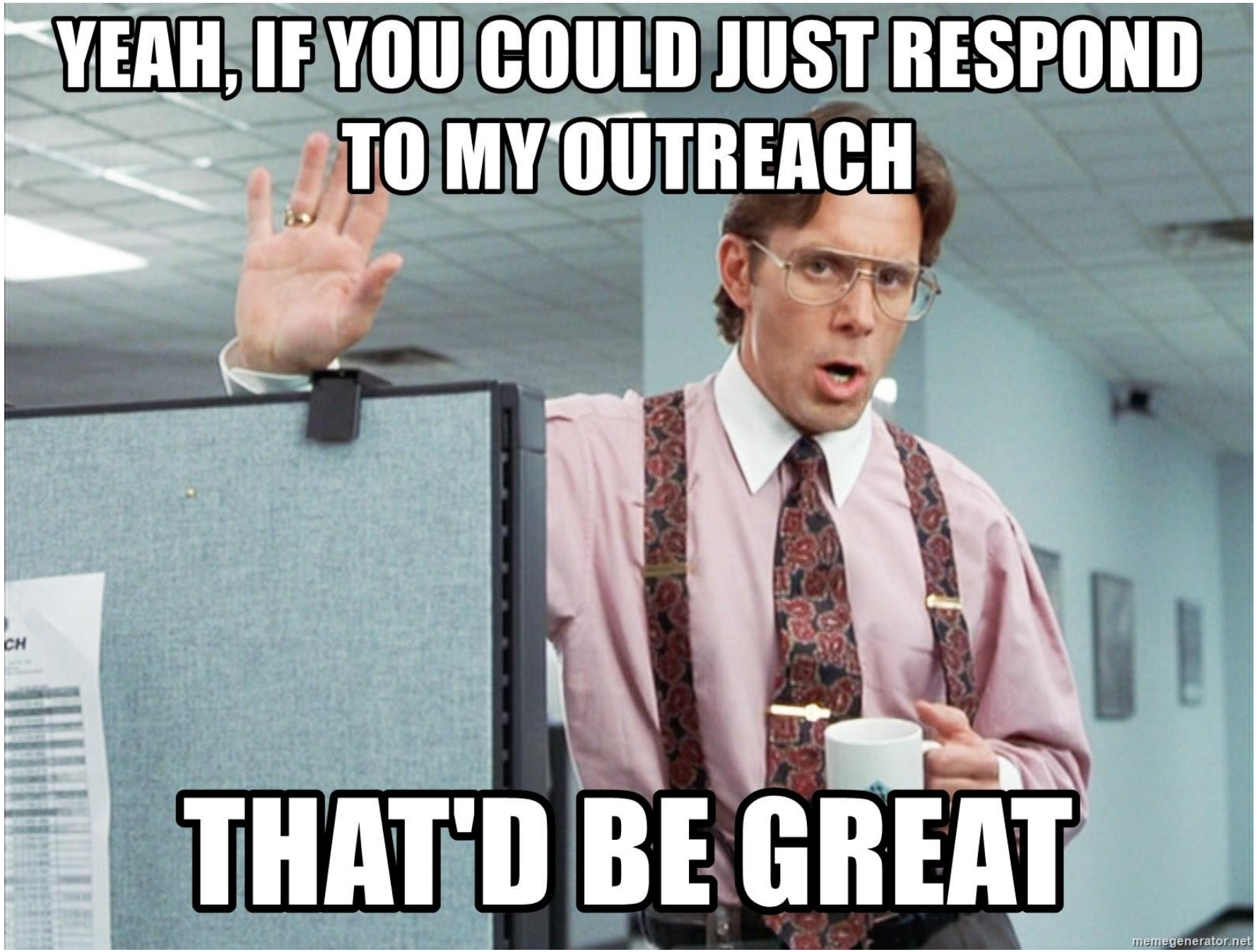

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Effectiveness

- 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

https://hearthealthyohio.org/effective-outreach

Quality Improvement Humor

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Next Steps

- Continue to submit EHR data monthly (1st Monday of the month; next due January 3rd)
- Review and modify the treatment algorithm and cardiovascular visit template when beginning the timely follow up process
- Continue to meet with your QI coach monthly
  - Develop a disparities SMART Aim for your site
- Payer collaborations - next meeting January 26, 12-1pm. Main focus: ease of obtaining home BP monitors
- Remember to engage a patient and obtain their feedback
- Next quarterly webinar March 10

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

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