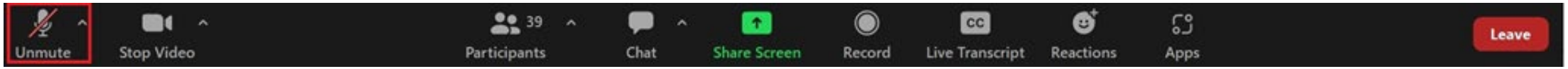
HEART HEALTHY OHIO INITIATIVE

HHOI Final Webinar (Wave 1 Sites)

April 28, 2023

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	Shari Bolen, MD, MPH
12:04 PM	Review Key Driver Diagram and SMART AIM	Aleece Caron, PhD
12:05 PM	HHOI Data Review	Shari Bolen, MD, MPH
12:10 PM	Storyboard Presentations	QI coaches QIP clinics Aleece Caron, PhD
12:50 PM	Next Steps/Wrap Up	Aleece Caron, PhD Shari Bolen, MD, MPH

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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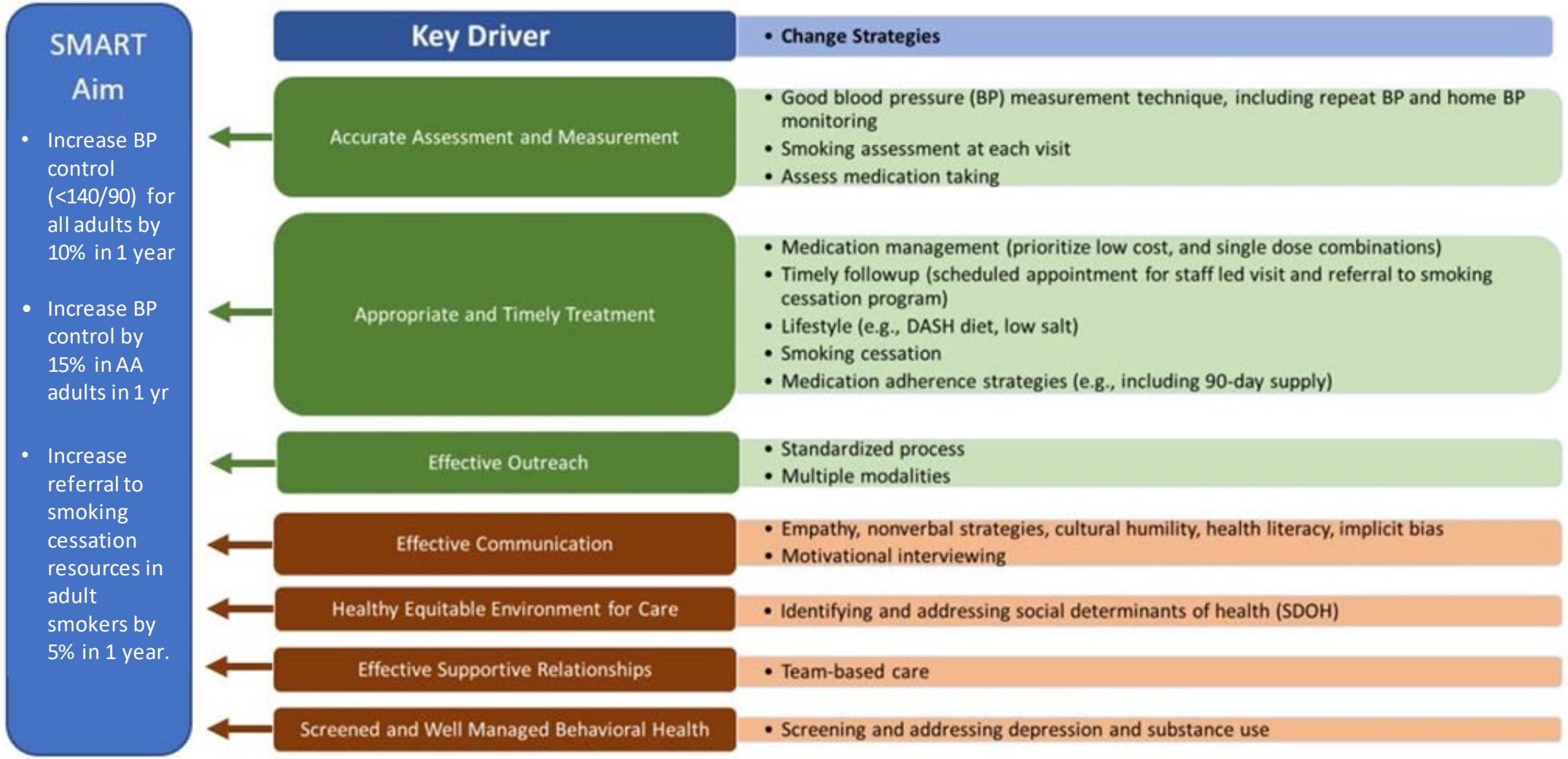
Key Driver Diagram and SMART AIM



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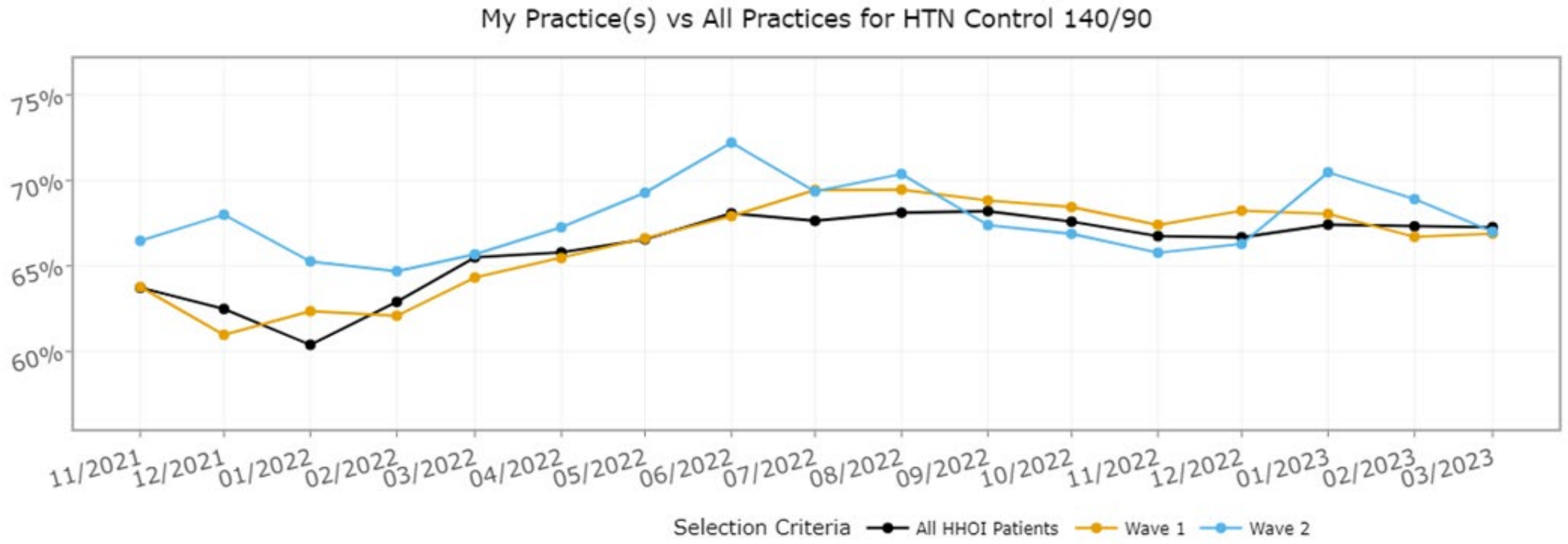
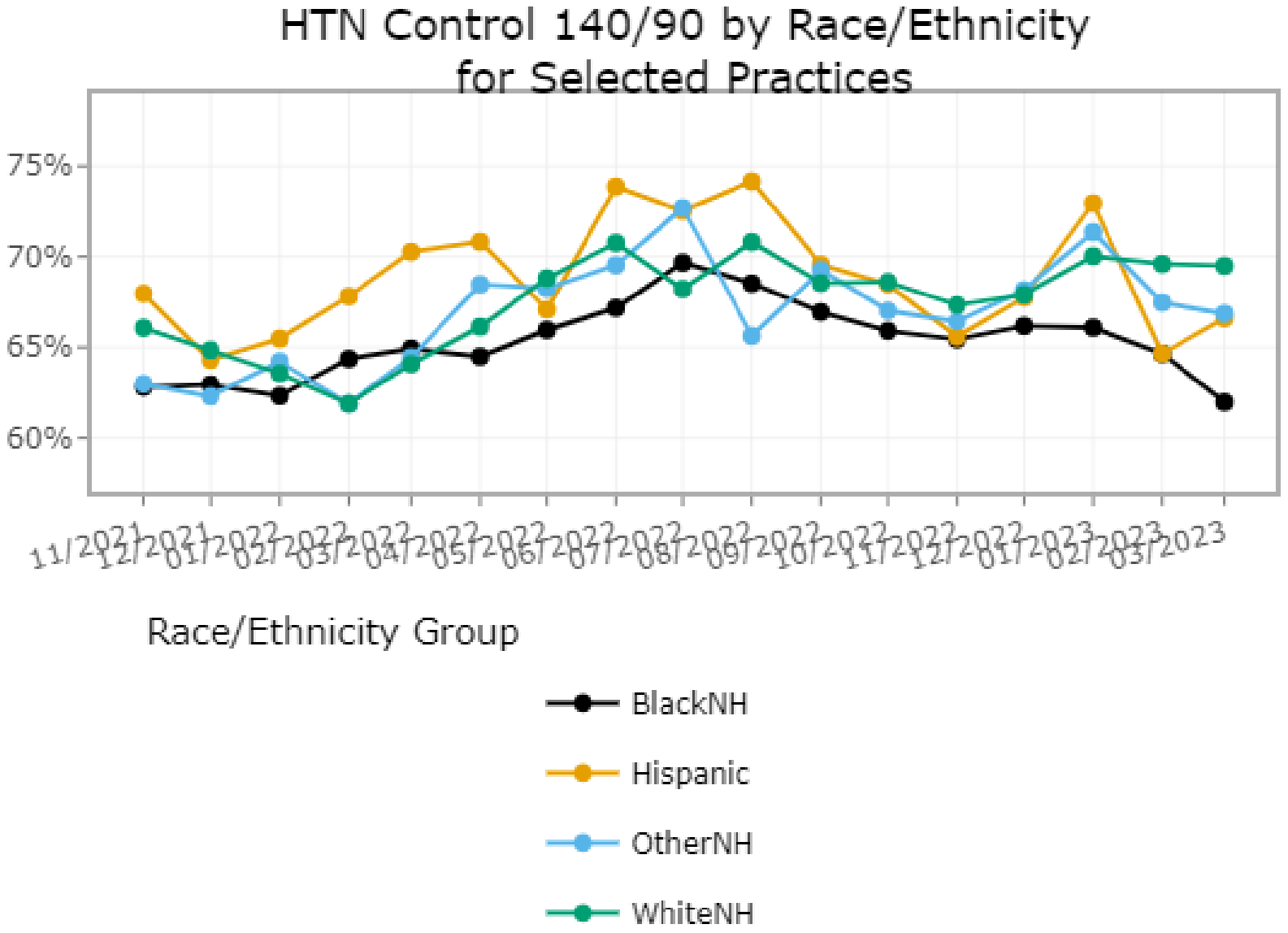
HHOI Data Review

Shari Bolen, MD, MPH

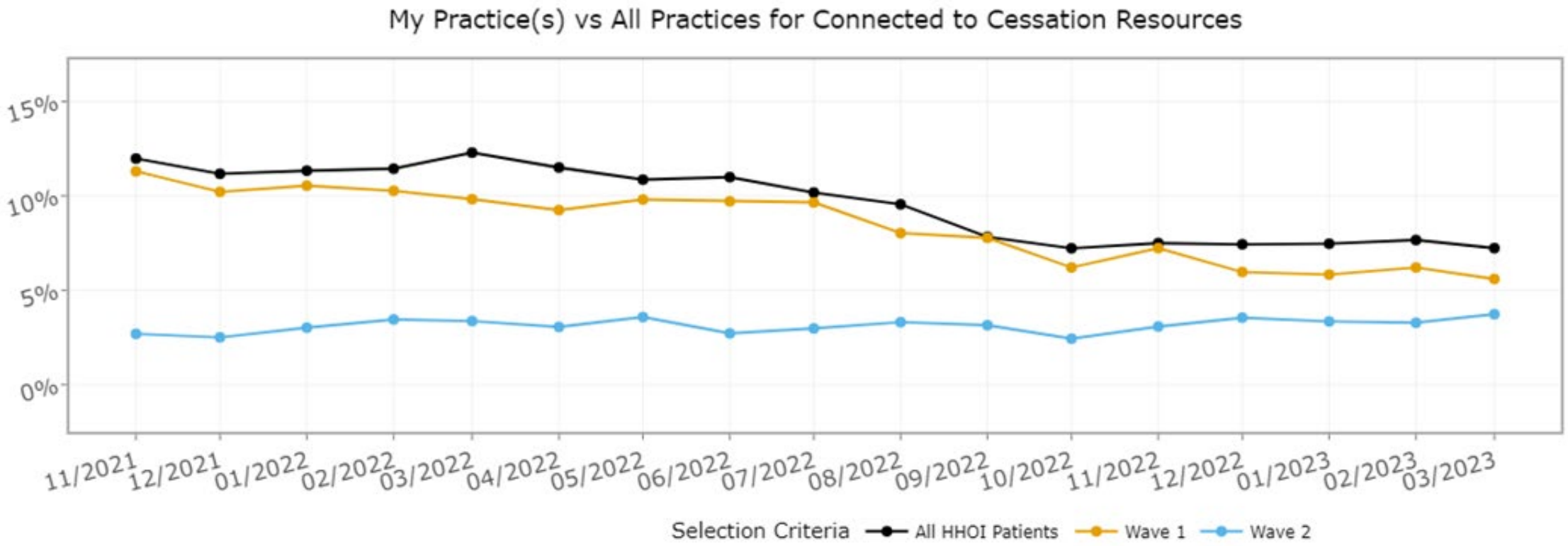
Percent of hypertensive adults under BP control



BP control by race and ethnicity



Percent of smokers connected to resources for smoking cessation



Storyboard Presentations

Aleece Caron, PhD

Caroline Carter, MS, LSW, BCC

Marty Williams, MHSA

Breakout Room Assignments

room	facilitator	practice	practice	practice
1	Marty Williams	Adams County (combined)	OSU Hilliard	Genesis Primary Care (combined)
2	Caroline Carter	East Liverpool VA	Canton VA	Lorain VA
3	Joe Daprano	UC Tri-County	Tri-Health Family Medicine Residency	Equitas (combined)
4	Deb Cohen	CCF Akron Hospital	CVS (Canfield and Niles)	Sandusky VA
5	Shalina Nair	MH Ohio City	Physicians CareConnection	New Philadelphia VA
6	Soni Regan	Youngstown VA	MH Cleveland Heights	Parma VA

If you are not assigned to a room you may choose any room

ACRMC Family Medicine Winchester & West Union

Team Members

- **<u>WINCHESTER STAFF MEMBERS:</u>**
  - Amber Severn, NP
  - Sunshine Piatt, NP
  - Vanessa Kirker, MA

- **<u>WEST UNION STAFF MEMBERS:</u>**
  - Dr. Hannah Hopkins
  - Amber Thiel, NP
  - Tina Gifford, NP
  - Mika Fain, MA
  - Mark Maddy, MA
  - Becca Rabold, MA
  - Cynthia Spencer, MA
  - Shelby Ralston, MA

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Learning from testing

- Most interesting test of change/PDSA that you have run since start of QIP
    - Most interesting test we have had to change is instructing the staff that we need to wait 5 minutes before taking the patient blood pressure.

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Which Process Measures were most effective?

- Share one slide for hypertension process and/or one for smoking from dashboard

Resource 2: How to Appropriately Measure Blood Pressure in a Practice Setting Video

Resource 4: Blood Pressure Training Checklist

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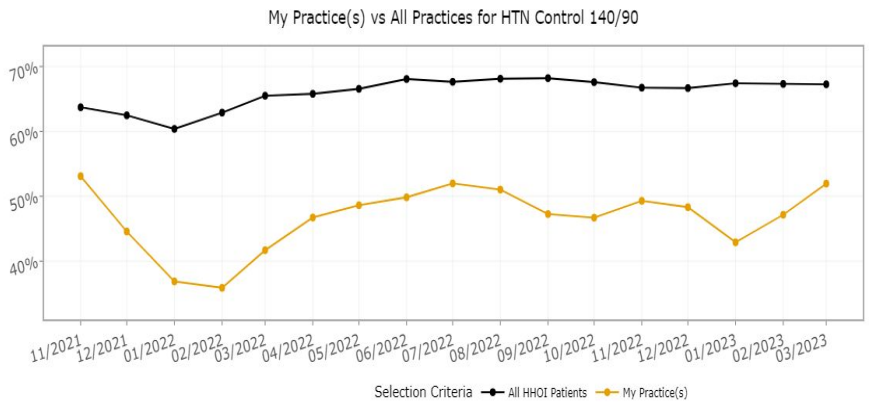
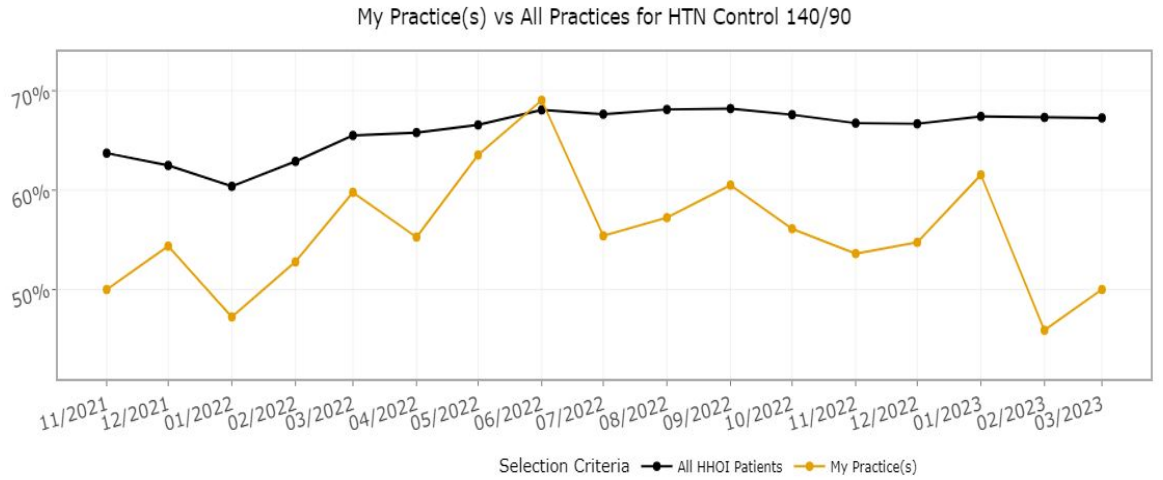
Outcome Data

- Share one slide for hypertension control (140/90) and/or one for smoking (connected to resources)

West Union



Winchester



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Keys to success at your site

- Hands on training completed by each provider with every staff member
- Reviewed all equipment in the offices for appropriate cuff sizes
- Received new nurse on stick at our Winchester location to allow the device to fit in the exam room for blood pressure management to be collected appropriately
- Repeating blood pressure measurement with abnormal readings (140/90) and documenting repeat blood pressure in our EMR correctly

HEART HEALTHY OHIO INITIATIVE

What were some of your Challenges? And are they still barriers?

- Nurse on stick wouldn't fit in our exam rooms at Winchester, so we had to order a smaller one
- Supply chain – making sure all of our offices had the correct cuff sizes
- Training all staff on how to properly take a manual blood pressure

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How are you planning to continue and sustain your QI efforts?

Implementing a new hire checklist that will include hands on blood pressure measurement training with staff and providers

While implementing the new hire checklist making sure all staff and providers are aware that if blood pressure reading is greater than 140/90 that we are rechecking a manual blood pressure and documenting the result in the correct spot in our EMR system

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OSU
Internal Medicine & Pediatrics

Hilliard, Ohio

Team Members

Shannon Stevenson, DO
Allyson Duffy, PharmD

HEART HEALTHY OHIO INITIATIVE

Learning from testing

- Most interesting test of change/PDSA that you have run since start of QIP

Blood pressure measurement accuracy with manual BP cuff

Next up: BP measurement with automatic with high BP manual recheck by MA and measurement of all BP by provider

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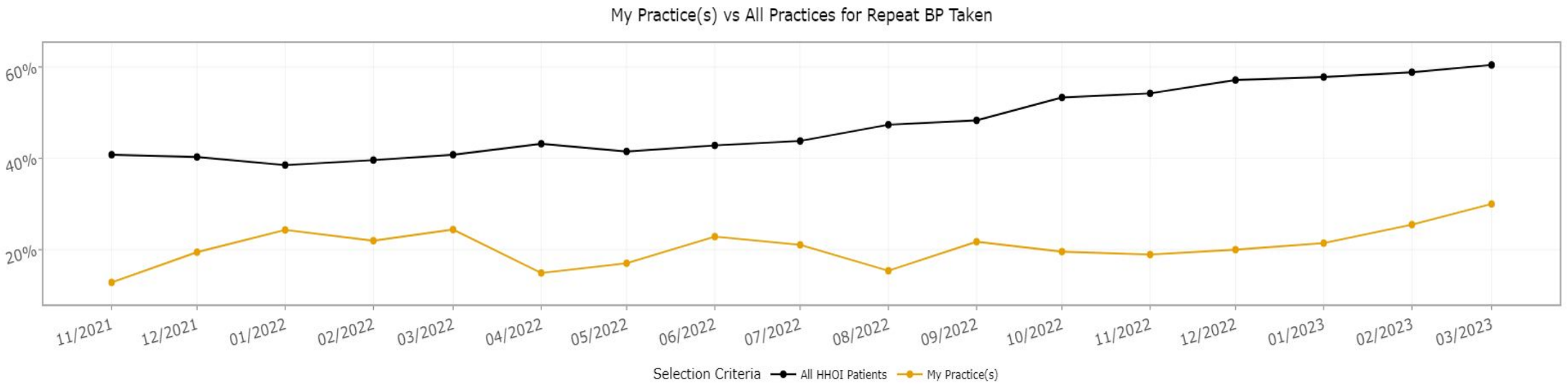
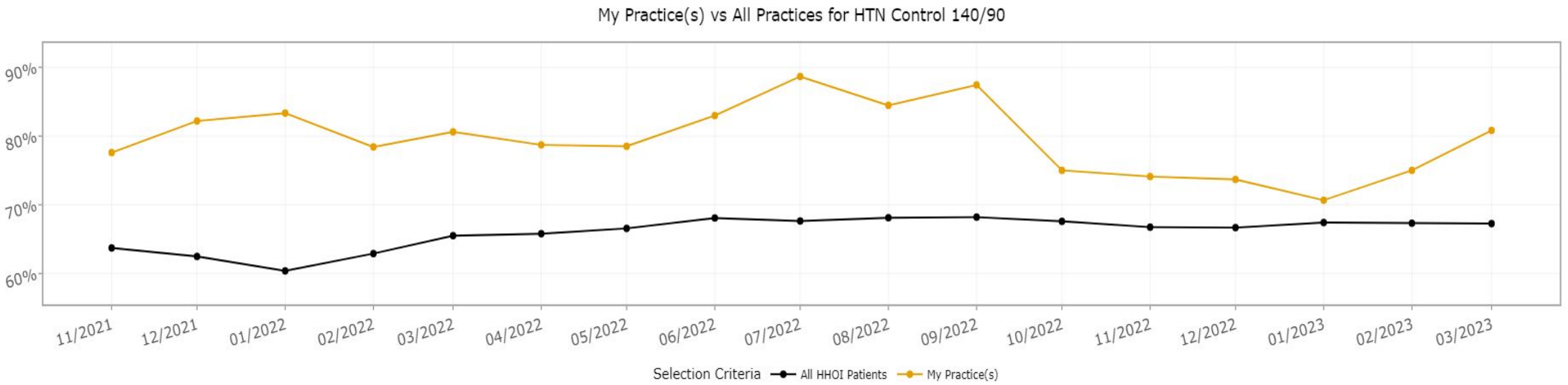
Which Process Measures were most effective?



Outcome Data



Keys to success at your site

- "Buy in" from the providers and medical assistants/LPNs
- A motivated team/team member
- Enthusiasm for the topic (passionate about BP control or smoking cessation as paths to health)

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What were some of your Challenges? And are they still barriers?

- Turnover
- Nursing support
- Medical Assistant support
- Providers as the only team members – too busy
- Limitations on vendors for supplies & login issues

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How are you planning to continue and sustain your QI efforts?

We have a new tobacco cessation QI in effect, including outreach from the pharmacy team with brief invitation to discuss smoking cessation at upcoming appointment (within 2 weeks).

I think this will be successful as it is in a time window to allow reflection and engagement from the patient at an appointment with the provider.

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Genesis Primary Care: Somerset and Junction City

"Where the art of medicine is loved, there is also love for humanity" Hippocrates.

Team Members

Kevin Frank, MD- Physican Lead

Renee Riley, LPN- Practice Manager

McKenzie Fitch, BSN,RN- Clinical Education Consultant

Dawn Reichley, LPN- Clinical Coordinator

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Learning from testing

- Inconsistent blood pressures taken by staff members (human error)
- Educated staff on proper technique on taking blood pressures.
- Once staff educated properly, and then we added 2-week nurse follow up.
- We then added the automated blood pressure machines and intervals.

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Which Process Measures were most effective?

- Blood pressures were taken after patient's chart was reviewed during check in with Nurse.
- If blood pressure was above 140/90 during triage, intervals were set on the vitals machine to recheck in 1 minute x 3 times. Which discards the first reading and average the second and third readings.
- Provider made aware of elevated blood pressure and patient was scheduled for a Nurse Call in 2 weeks to reassess blood pressures at home.
- When Provider checks blood pressure is WNL after intervals, Nurse appointment not needed.
- 2 week follow up call with Patient made and blood pressure sent to Providers.
- If a change in medications were made if needed. We can implement a change sooner. If still elevated, we scheduled for an additional Nurse call in 2 weeks.

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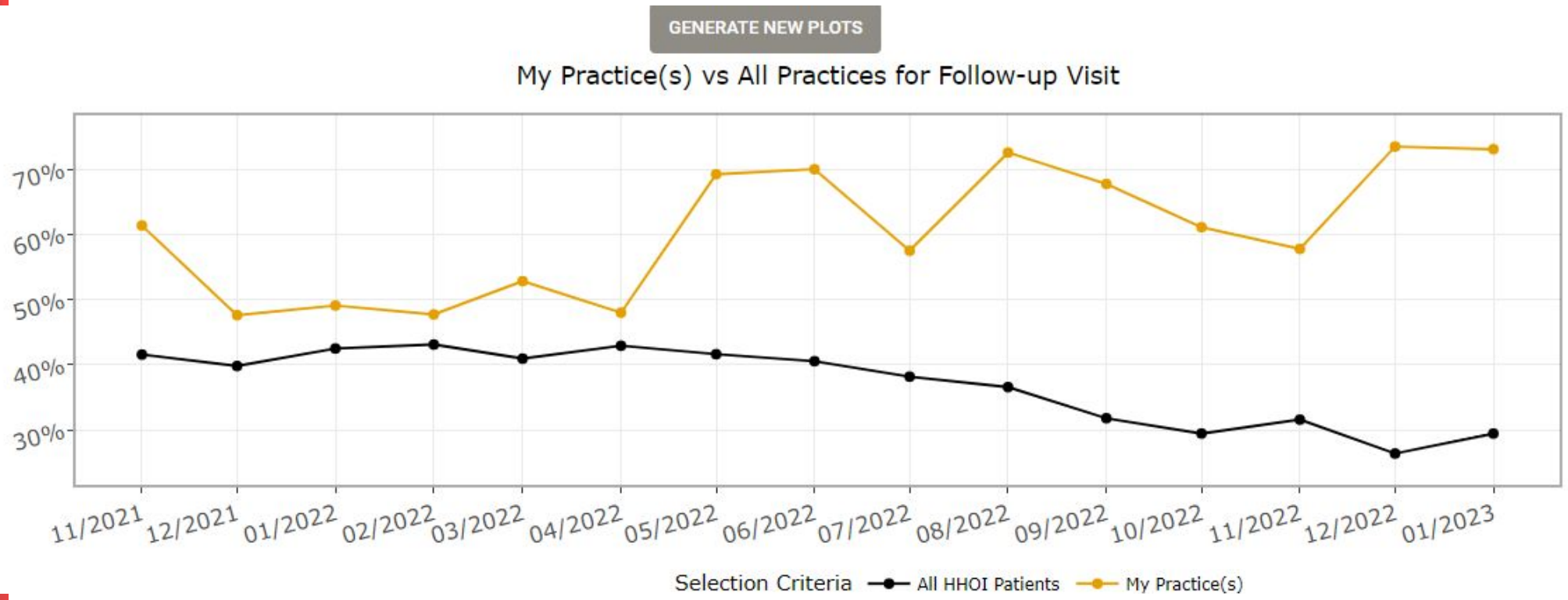

- Scheduling Patients for a 2-week follow up after the elevated blood pressure after triage.

Keys to success at your site

- Consistency with automated blood pressure cuffs.
- Staff education on how to properly take blood pressures.
- Patient education on how to properly take blood pressures at home.
- Calling patients at home for a 2 week follow up with Nurse, blood pressures at home were lower than at office.

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What were some of your Challenges? And are they still barriers?

- Patient's not answering when we call them for the Nurse blood pressure follow up.
- Patient's that do not have a blood pressure machine at home, making them return into the office for the recheck.

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How are you planning to continue and sustain your QI efforts?

- We will continue to check patient's blood pressure at end of triage, and if elevated about 140/90 we will schedule them for a 2-week Nurse blood pressure check.
- Formulating a plan to begin Remote Patient Monitoring (RPM) for our patients

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What did you like?
What would you steal?

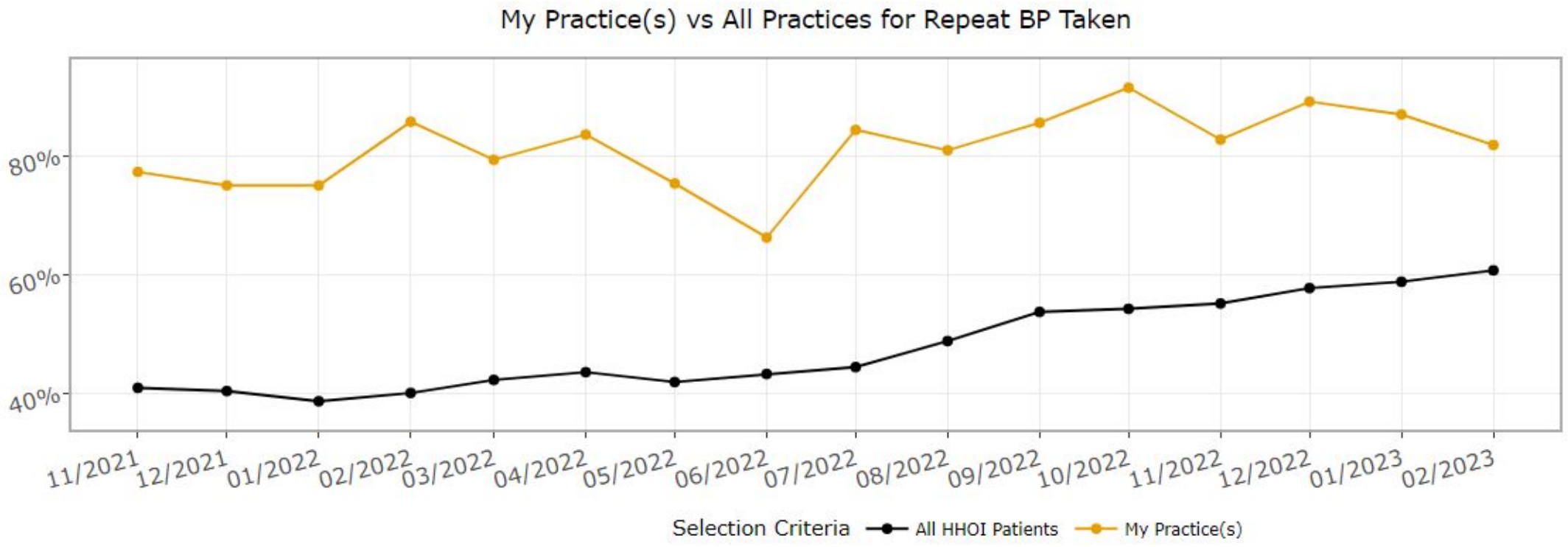
Questions or Comments

Canton CBOC

1st PDSA Cycle

- Started with looking at repeat blood pressures for any of them over 140/90. During intake, BP repeated if elevated.
- Removed manual BP checks by intake nurses
- Intake nurses to tag RN if both BP's >140/90
- Case Manager to follow up with veteran on elevated BP
- Monthly list of elevated BP's given to RN for case management follow up
- Started at 77% being repeated at start of project went up to 91% at end of 2022

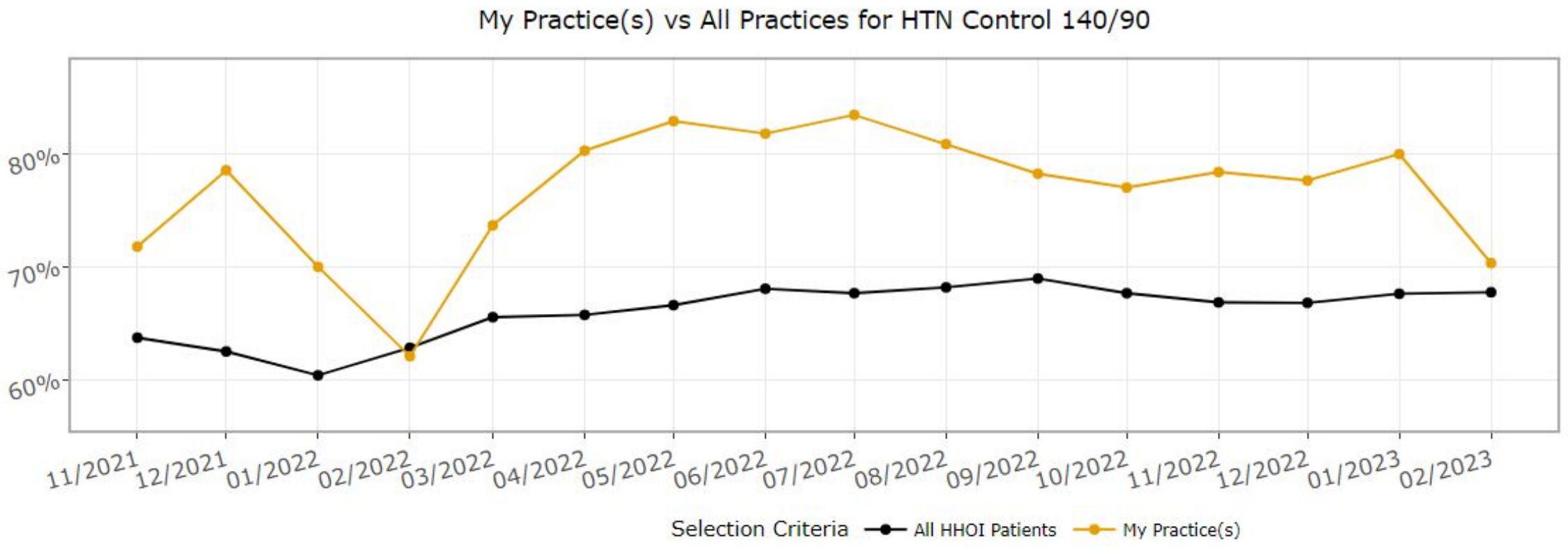
Repeat Blood Pressure Taken



2nd PDSA cycle

- Renew training for taking a proper blood pressure
- Had a few clinic meetings talking about the education, made sure signs were up in every PCP room regarding proper BP checking
- Attempted to create a checkoff for the BP
- Stopped by the education department as they said they would like to complete this part

Canton Clinic Numbers



Smoking Cessation

- CPRS has reminders that every veteran is asked on a timed schedule about smoking at every PCP visit
- Created billboard for lobby talking about smoking and how to quit. Had the resources available from our clinic on there.

Smoking Cessation

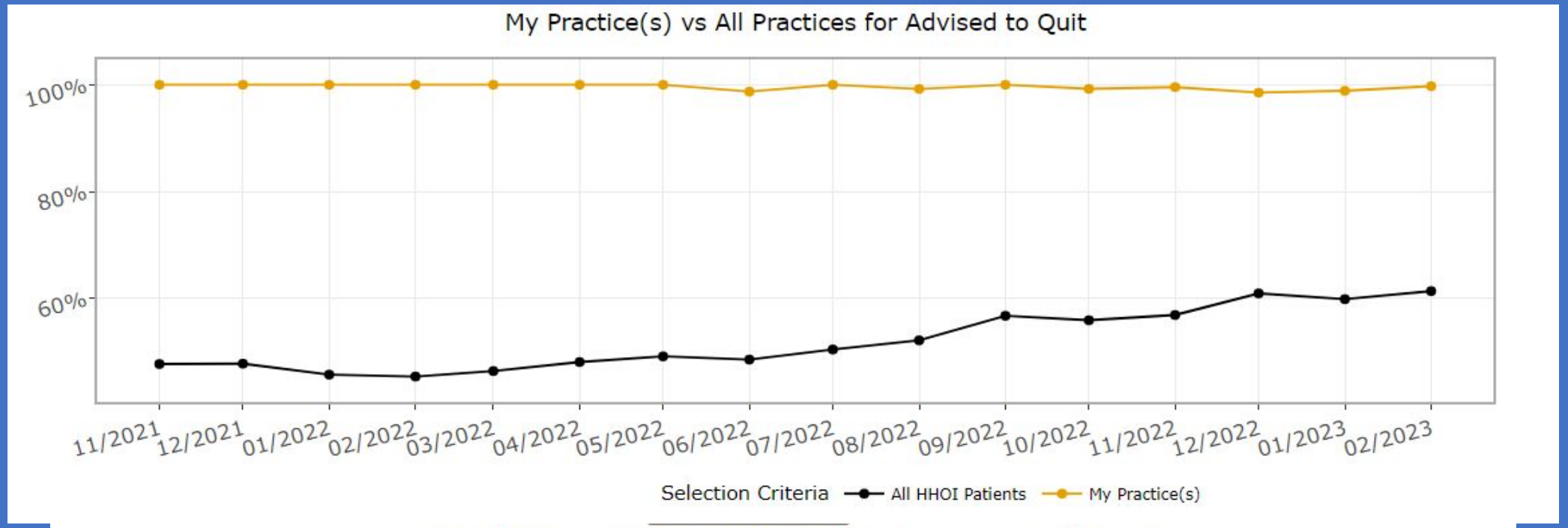
Canton clinic does not use MH/Smoking consults so numbers always low.

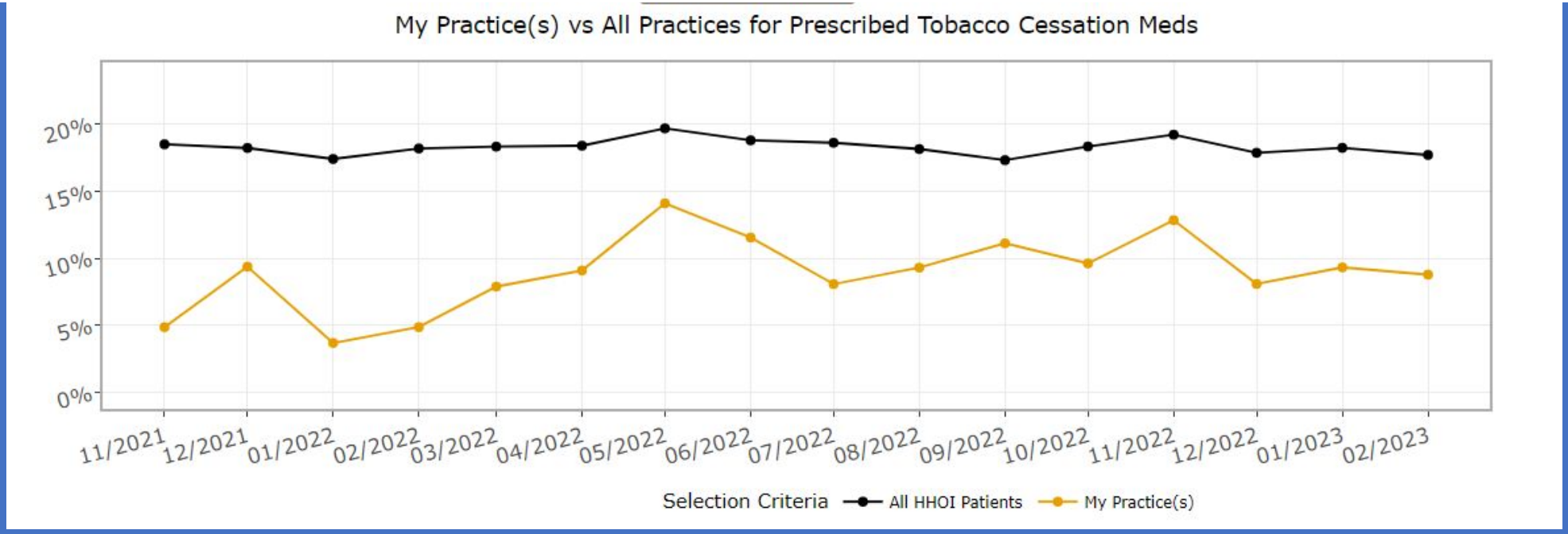
Veteran can sign up for Smoking Cessation Counseling at MH window, no consult needed.

Offer weekly follow up by MH RN as well, alert him to the note or team him.

Prior to this project, MH RN had around 3 people he called on. Now he is over 25 and has multiple success stories of veterans quitting smoking.

MH RN started 4 week program on the phone individually with his veterans that he follows, uses the same program outline that Akron Clinic used for their smoking cessation group classes.


My Practice(s) vs All Practices for Advised to Quit
100%
80%
60%
11/2021
12/2021
01/2022
02/2022
03/2022
04/2022
05/2022
06/2022
07/2022
08/2022
09/2022
10/2022
11/2022
12/2022
01/2023
02/2023
Selection Criteria
All HHOI Patients
My Practice(s)


My Practice(s) vs All Practices for Prescribed Tobacco Cessation Meds
20%
15%
10%
5%
0%
11/2021
12/2021
01/2022
02/2022
03/2022
04/2022
05/2022
06/2022
07/2022
08/2022
09/2022
10/2022
11/2022
12/2022
01/2023
02/2023
Selection Criteria
All HHOI Patients
My Practice(s)

IN THE WORKS

- Canton Clinic starting a group smoking cessation class with in-class offerings.
- Sending out letters/MHV emails regarding smoking cessation offerings to veterans that are listed as smoking currently in CPRS

What did you like?
What would you steal?

Questions or Comments

VA East Liverpool Outpatient Clinic

Team Members

- Marisa Longwell- LEAD
- Anna Citino- PCP
- Amanda Golubski- Pharm
- Robin See- Mental Health
- Jessica Garver- LPN
- Jordyn Charlier- Care Manager

Learning from testing

PATIENTS ACTUALLY ENJOY BEING CALLED

A LOT OF PATIENTS DEMONSTRATE RESISTANCE

FOLLOW UP CALLS MATTER

Effective Processes

STAFF EDUCATION

INTAKE SCREENINGS WITH RN NOTIFICATION

RN FOLLOW-UP

Process data: Prescribed Tobacco Cessation Medication

0% June 2022

12% Mar 2023

Keys to Success

Buy In

Managing expectations

Data Tracking

Challenges and Barriers

- Data Analysis
- Participation
- Time management

Sustainability

- Updating internal markers
- Including more staff
- Group sessions in clinic when approved

What did you like?
What would you steal?

Questions or Comments

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Lorain VA Outpatient Clinic

Team Members

Julie Baron, PharmD | Clinical Pharmacy Specialist

Ashley Kenzik, PharmD | Clinical Pharmacy Specialist

Johnny Hughes, RN | Nurse Manager

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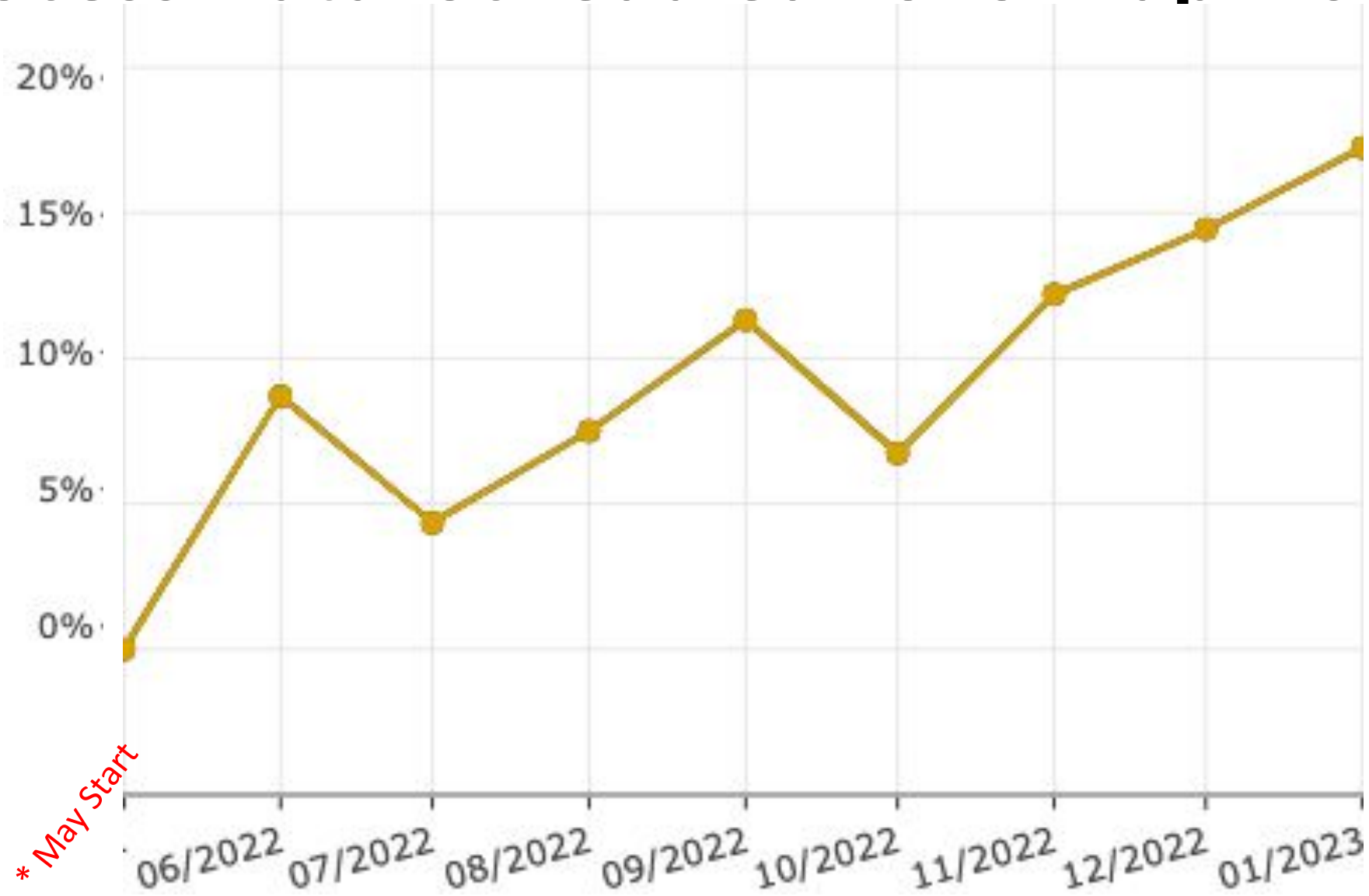
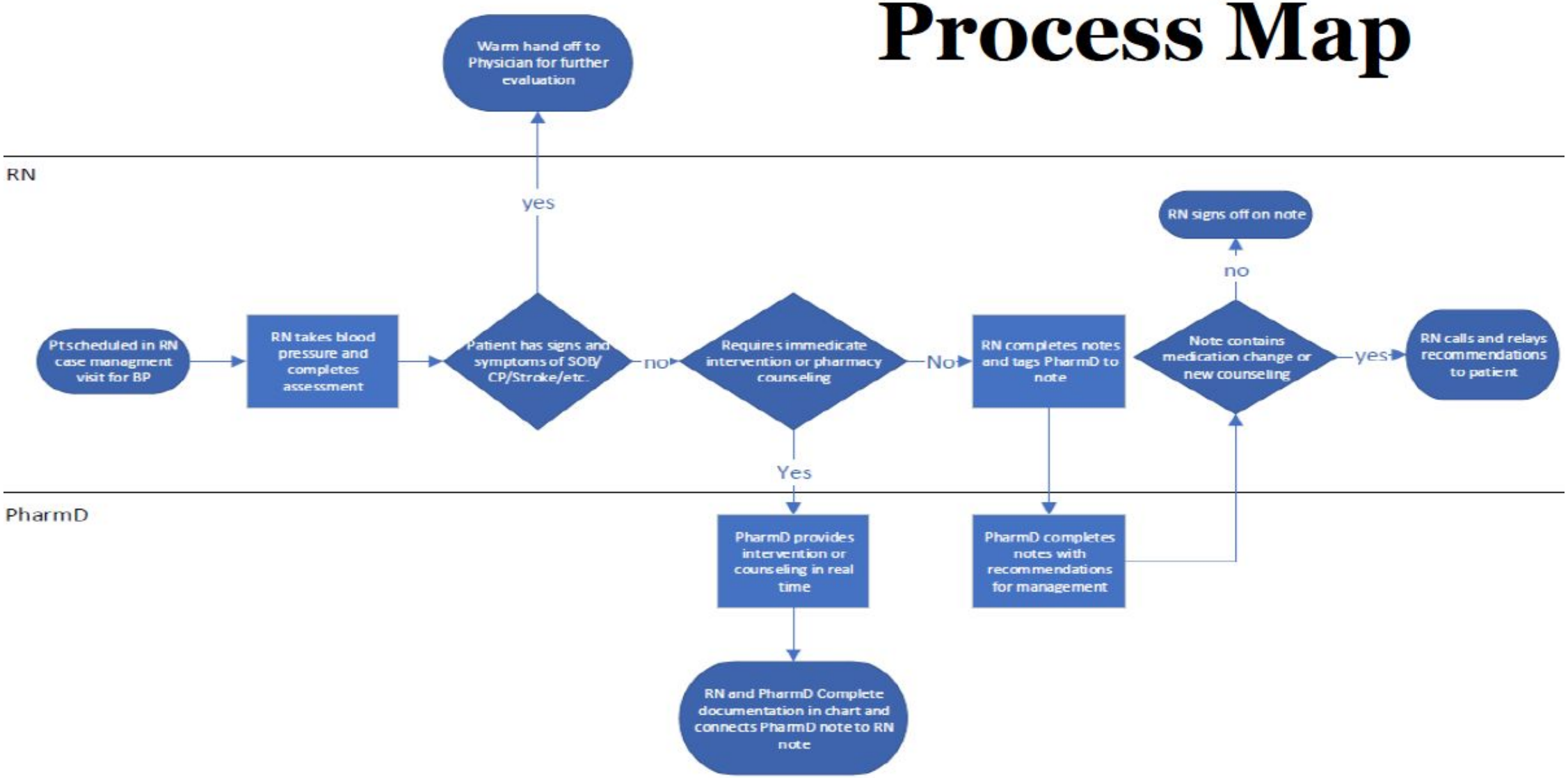
Process Data: Scheduled Follow-up Visit

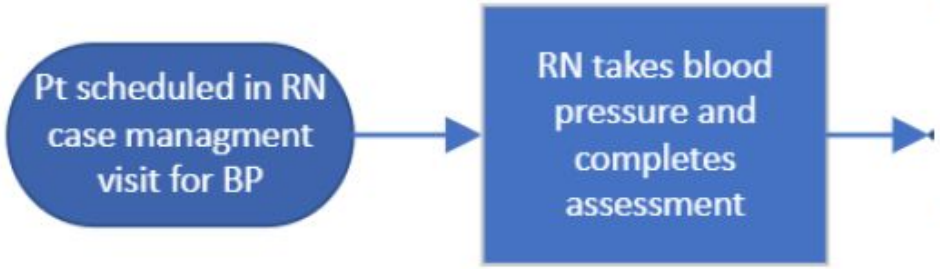


HEART HEALTHY OHIO INITIATIVE

Process Map


Provider
Warm hand off to Physician for further evaluation
RN
yes
RN signs off on note
no
Pt scheduled in RN case managment visit for BP
RN takes blood pressure and completes assessment
Patient has signs and symptoms of SOB/ CP/Stroke/etc.
no
Requires immedicate intervention or pharmacy counseling
No
RN completes notes and tags PharmD to note
Note contains medication change or new counseling
yes
RN calls and relays recommendations to patient
Yes
PharmD
PharmD provides intervention or counseling in real time
PharmD completes notes with recommendations for management
RN and PharmD Complete documentation in chart and connects PharmD note to RN note

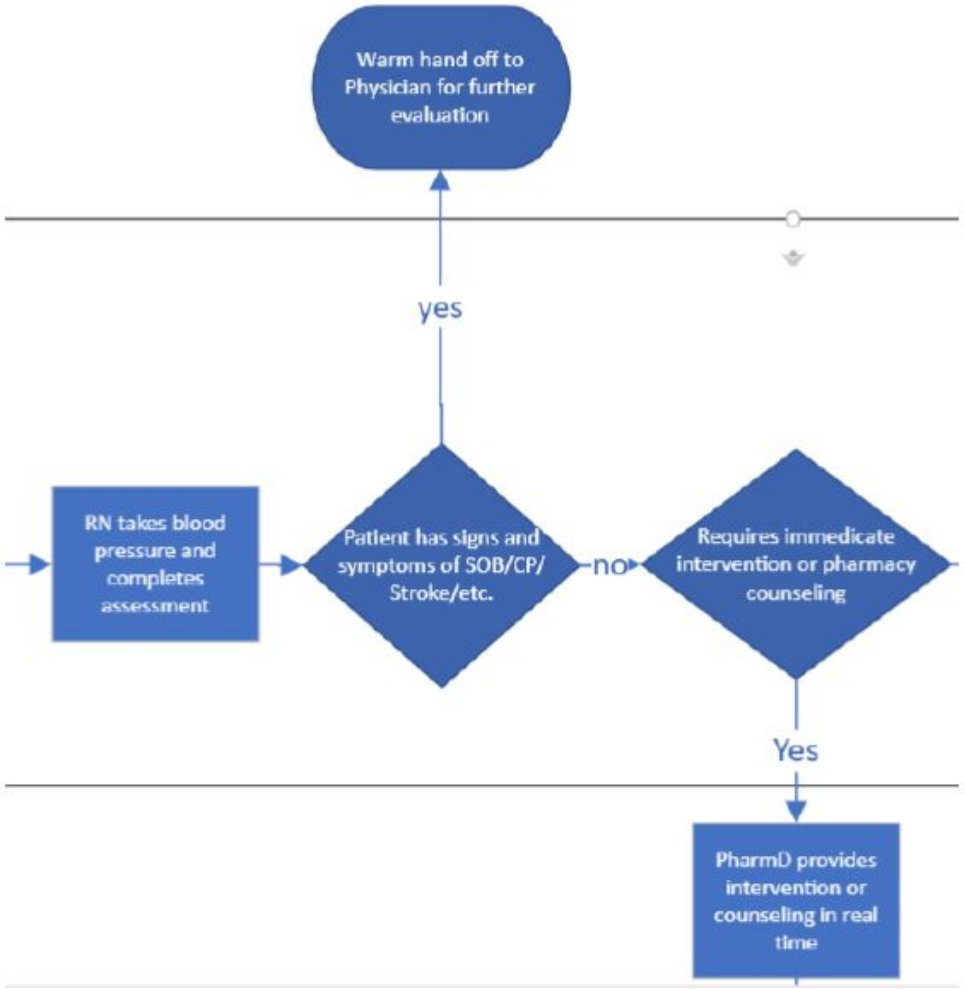
Process



Patient with blood pressure (BP) above 140/90

- Return to clinic order placed for RN Care Management visit for BP check
- At face to face RN appointment:
  - Vitals taken by RN (BP and HR)
    - If elevated above 130/80 or below 100/60 then repeat vitals
  - BP assessment completed by RN
    - Lifestyle assessment: Tobacco, ETOH, caffeine, hydration, etc.
    - Adherence: is patient taking medications as prescribed?

HEART HEALTHY OHIO INITIATIVE



Process

Patient to be triaged for follow-up with the following:

Patient is symptomatic:

BP >140/90 with symptoms (chest pain, SOB, blurred vision, etc) then warm hand off to PACT provider or POD (provider of the day).

BP <100/60 with symptoms of hypotension (i.e. dizziness) then warm handoff to PharmD if available or PACT provider or POD

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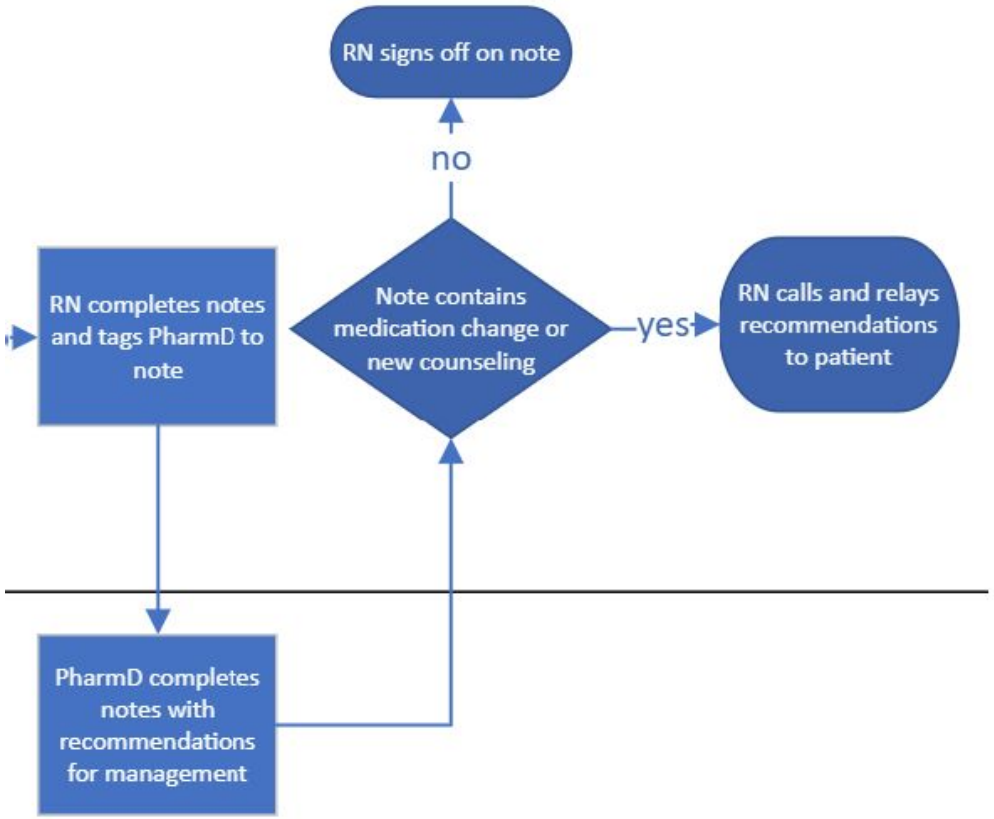

Process

After assessment by RN

- Nurse provides nonpharmacologic counseling as indicated
- Nurse completes note and tags PACT PharmD as indicated
- PACT PharmD reviews RN assessment and enters note to RN with interventions
  - If no medication adjustment made then RN to sign off note and encounter is complete
  - If medication adjustment then RN to contact pt by phone with changes and PharmD will update orders

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Learning from Testing

PDSA: PharmD/RN Collaboration:

- The value of having a work group create a recommended process to help implement RN/PharmD collaboration across sites
- Presentation provided to nursing staff on use of PharmDs to assist with medication management for uncontrolled HTN
- Incorporating into weekly workflow
- Using Data Warehouse tools to identify patients for clinic follow-up

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Keys to Success

- Renewed focus on HTN through HHOI participation
- Each Team member understands goals and performs duties well
- Having both RN's and Pharm D embedded in the clinic to help with disease management

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What were some of your challenges/barriers?

- Staffing challenges
- Many of our veterans have primary care providers outside the VA and prefer their PCP to manage their HTN
- Getting our veterans to return to clinic for blood pressure checks

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How are you planning to continue and sustain your QI efforts?

- Continue to use Data Warehouse Tools to identify patients for clinic follow-up
- Stay focused on the RN/PharmD collaboration
- Continue to educate patients on the importance of BP control to decrease cardiovascular disease
- Spread RN/PharmD collaborative across all PACT teams
- Continue reviewing monthly data for progress

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What did you like?
What might you steal?

Questions or Comments

HEART HEALTHY OHIO

INITIATIVE

UC Health Primary Care Tri County

Primary PDSA Team

Erin Moushey, M.D.
Jennifer Gambrell - CMA
Fern Adams - PSR
Ruthie Hogan – Practice Manager

Orson Austin, M.D.
Mark Hoelzle, M.D.
Beth Erin Smith, M.D.
Michelle Zamudio, CNMW
Raven Thomas – MA
Laura Dunham – CMA
Amy Wuebbling – CMA

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Learning from testing

- PDSA was done to try to increase the percentage of patients with BP >140/90 schedule their BP follow up appointment.

  - Patients with a repeat BP >140/90 were given a red card at the time of discharge as a reminder to schedule a BP follow up appointment prior to leaving the office.
  - Patients turned in their cards to the front office staff and appointment was scheduled.
  - At the end of the day all cards received in the front office were returned to the clinical staff.

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Which Process Measures were most effective?

- Repeating the blood pressure after sitting for 5 minutes
- Proper technique
- Utilization of cards stating to stop at the front desk to schedule follow up appointment

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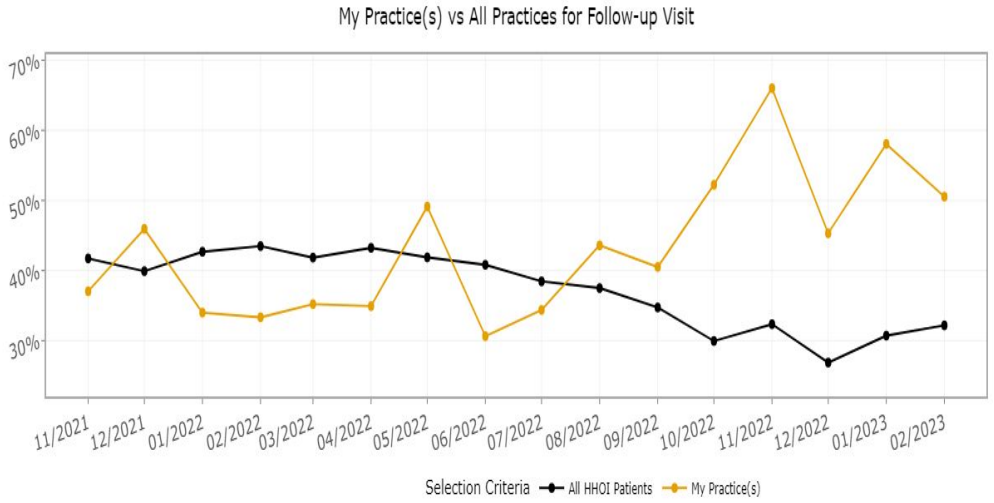
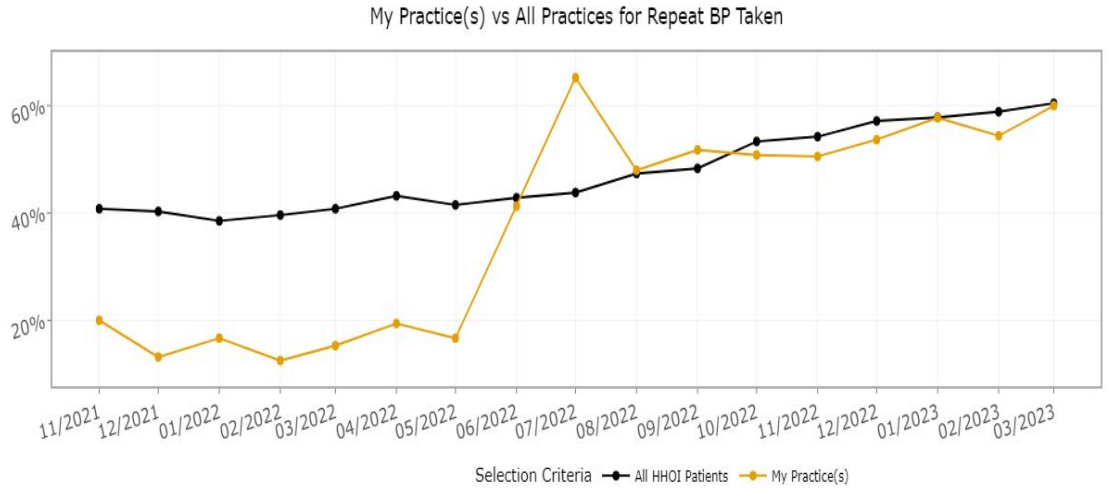
Outcome Data





- 2 weeks prior 75% of the patients with uncontrolled BP scheduled their f/u visits. (29% of the patients seen during this timeframe had uncontrolled BP)
- During the 2 weeks PDSA period, 89% pf the patients with uncontrolled BP scheduled their f/u visits. (27% of the patients seen during this timeframe had uncontrolled BP)

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Keys to success at your site

- Having a doctor and MA dedicated to assuring a repeat BP was done and patients were given the cards when needed.
- Involving the front office staff in discussions regarding the PDSA helped with buy-in their dedication to looking out for the cards and assuring the appointments were scheduled.
- Communication with patients regarding the importance of managing their BP helped patients to more willing to follow process.
- MAs being willing to schedule follow up appointments during discharge if needed and time allowed.
- Reviewing the data was motivating and sobering.

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What were some of your Challenges? And are they still barriers?

- Disposition was not always listed
- Being short staff in the front office
- Staff education of the importance of the need for repeat BP as well as proper technique for taking a patient's BP
- Competing priorities

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How are you planning to continue and sustain your QI efforts?

- Additional cards have been created to add another doctor to the PDSA
- We will continue to the current process and would also work to use the card system to assure follow up visits are scheduled for other conditions such as diabetes
- Frequent review the data

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HEART HEALTHY OHIO INITIATIVE

Bethesda Family Practice

Cincinnati, OH

Team Members

Faculty Advisor: Stephen Zitelli MD

HTN Project: Chad Thiemann DO PGY3

Smoking Cessation: Subhra Jana DO PGY2

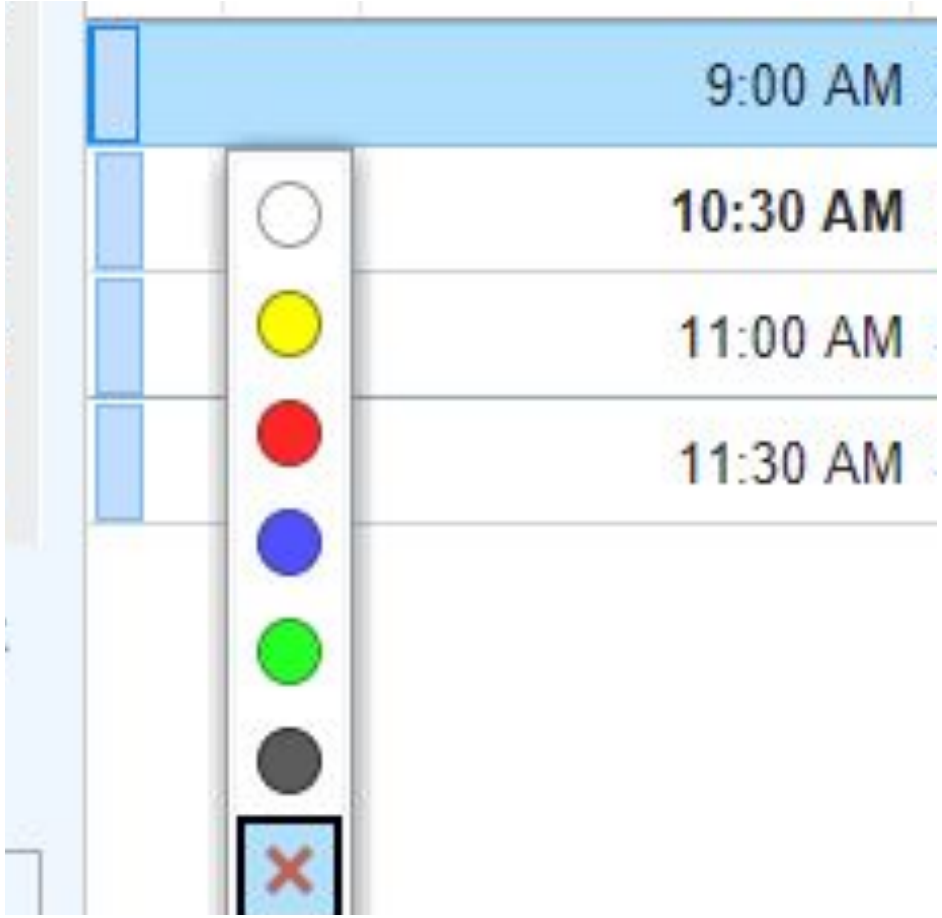
HEART HEALTHY OHIO INITIATIVE

Project Overview

- Hypertension QI Project
  - Ensuring proper training of staff to collect accurate blood pressure measurements
  - Implementing in office protocol to notify physicians that initial blood pressure recording was elevated during rooming of patients
  - Clarifying that physicians were responsible to repeat blood pressure recording if found to be >140/90 to help with management and follow up for HTN management
  - Providing a smart phrase to use on patient after visit summaries to communicate the need for follow up and management of hypertension
  - Increase close (4 week target) follow up and scheduling for hypertensive patients

HEART HEALTHY OHIO INITIATIVE

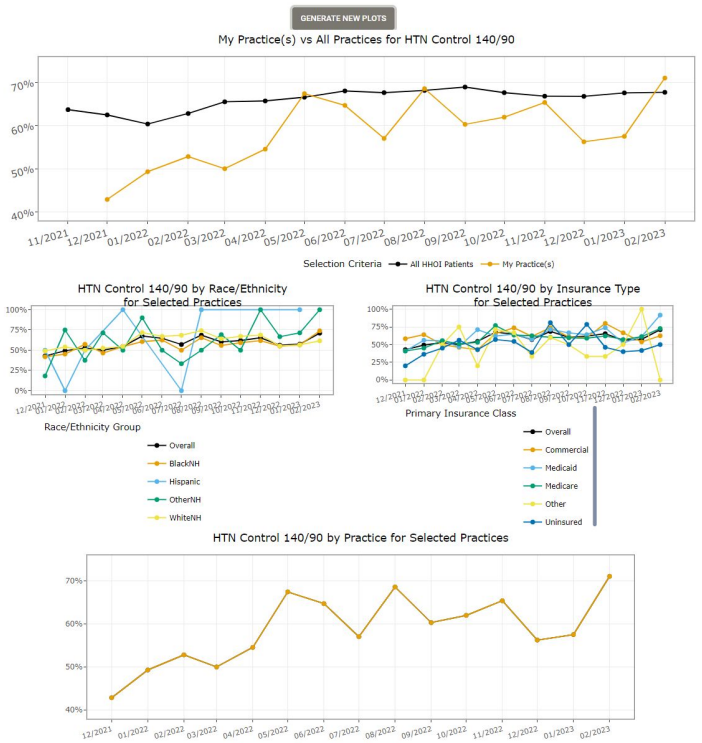
Which Process Measures were most effective?



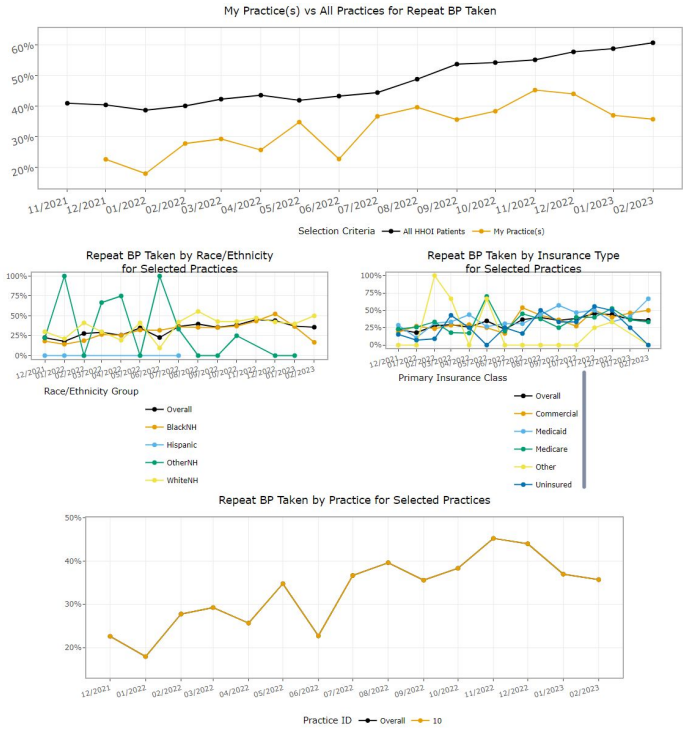
- MAs participated in "Dot" system where if initial blood pressure >140/90 they would put yellow color dot to notify to physician that the patient was ready to be seen and that they were found to have elevated BP

Outcome Data

- We had myriad data collection and integrity issues however overall BP control improved and repeats of initially elevated BP appeared to increase



BP Control



BP Repeats

Outcome Data

- Self Audit of repeat blood pressures in our office from clinic days in February, March, April
  - Total # of pt encounters: 244
  - Total # of adult visits with vitals recorded: 114 (Pts < age 18, nurse visits, no shows, sports medicine, telemedicine encounters excluded)
  - Total pts with BP >140/90 : 24
    - 7/24 (29%) of these patients had blood pressure rechecked per new office protocol
    - This may mask people who erased the initial BP and replaced it with a repeat

HEART HEALTHY OHIO INITIATIVE

Keys to success at your site

- Staff cooperation in utilizing "dot" system during rooming process to notify physicians that patient had initial elevated blood pressure reading
  - Suggestion for workflow came from a medical assistant
- Resident cooperation in repeating blood pressures that were initially elevated and charting as a second vital reading and not erasing the first

HEART HEALTHY OHIO INITIATIVE

What were some of your Challenges? And are they still barriers?

- Time to repeat patient's blood pressure and address the problem during a visit has and will remain a barrier dependent on nature of the visit
- Lag with data processing and integrity limited continuous assessment of efficacy
- Scheduling follow up appointments in 2-4 weeks for repeat blood pressure checks to see if management has been effective
  - This has posed a challenge in our clinic as often residents future clinic schedules are not always yet available, and per our scheduling protocol that tries to keep continuity of patients with providers

HEART HEALTHY OHIO INITIATIVE

How are you planning to continue and sustain your QI efforts?

- Implementing call back list to help schedule follow up for our patients who were found to have elevated blood pressures during their appointment
- Referral system for patients to ambulatory home blood pressure monitoring program

HEART HEALTHY OHIO INITIATIVE

Project Overview

- Smoking Cessation project
  - Identify current practices regarding smoking cessation counseling and management
  - Ensuring smoking cessation gets addressed at more visits
  - Identifying patients who may benefit from the smoking cessation Quit Line
  - Building a new electronic referral to Quit Line with IT
  - Following up with patients to determine effectiveness of Quit Line referral, and whether it helped patient quit smoking
  - Monitoring long term effectiveness

HEART HEALTHY OHIO INITIATIVE

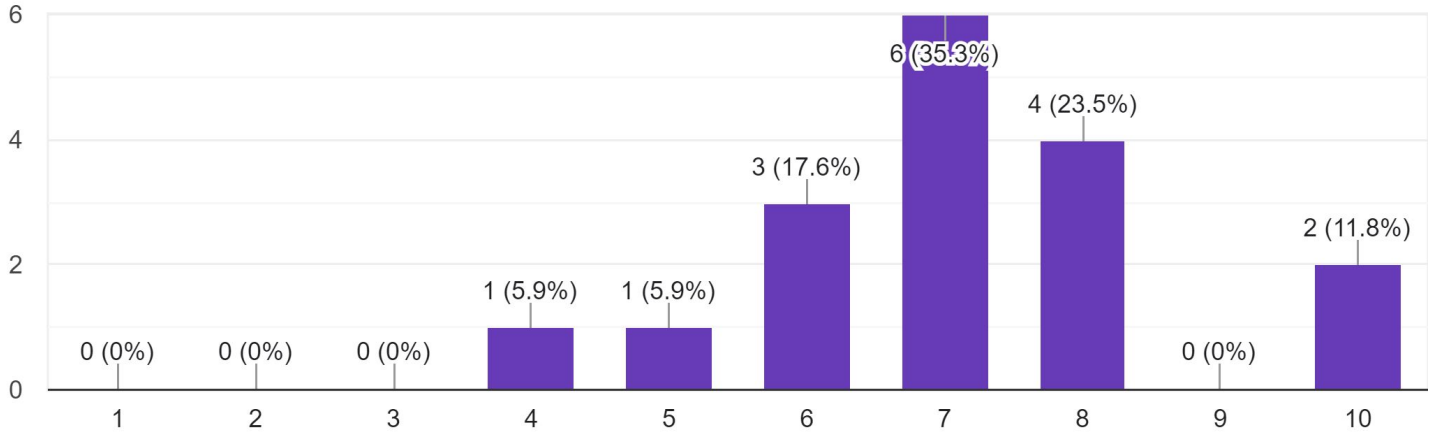
Smoking Cessation Pre-Survey

- Surveyed Bethesda Family Practice residents on emphasis on smoking cessation, time spent discussing, and treatment options during an office visit

HEART HEALTHY OHIO INITIATIVE

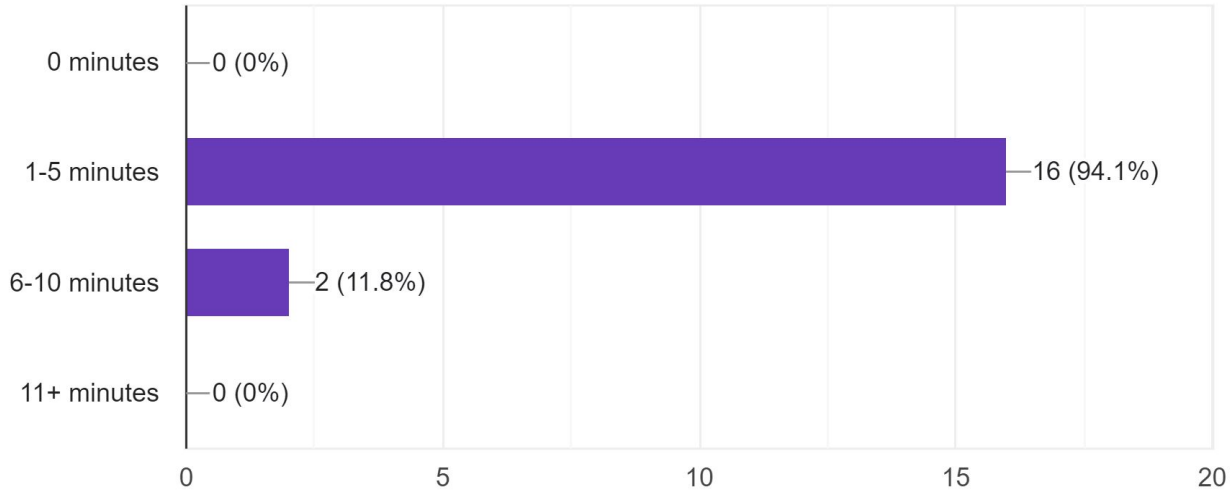
On a scale of 1-10, how much of an emphasis do you give to smoking cessation during an office visit?

17 responses



On average, how long do you spend discussing smoking cessation with patients?

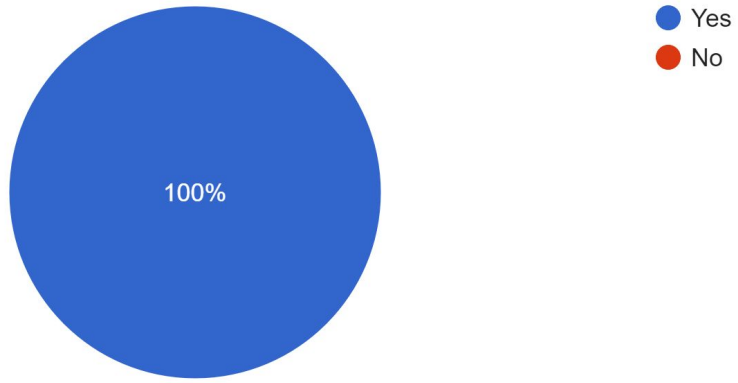
17 responses



HEART HEALTHY OHIO INITIATIVE

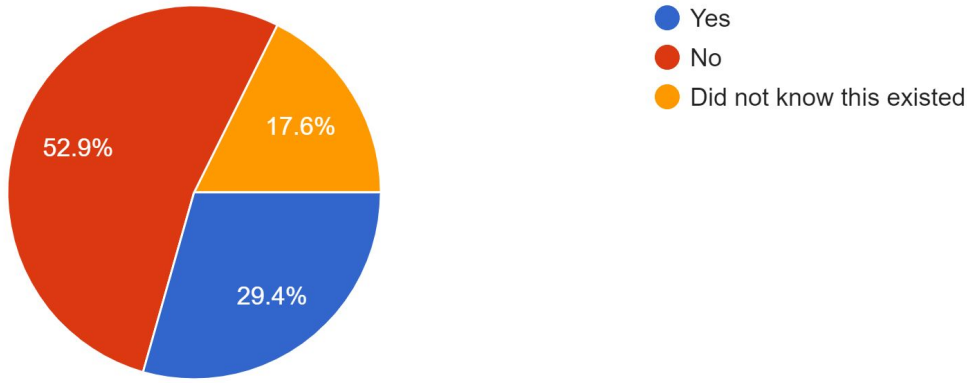
Have you prescribed nicotine replacement therapy (NRT)?

17 responses



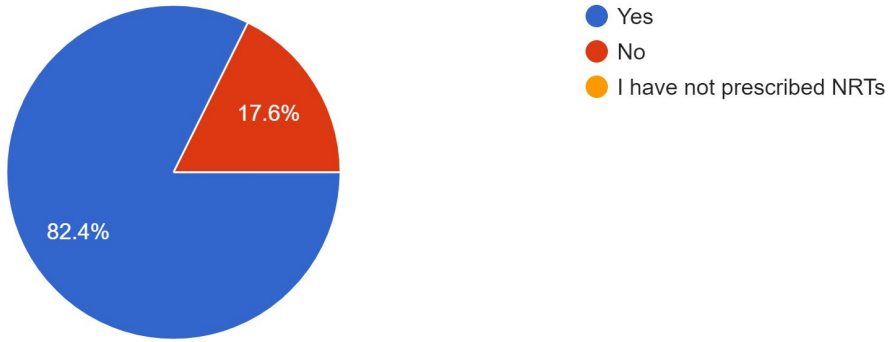
Have you ever discussed or referred to the smoking quit line?

17 responses



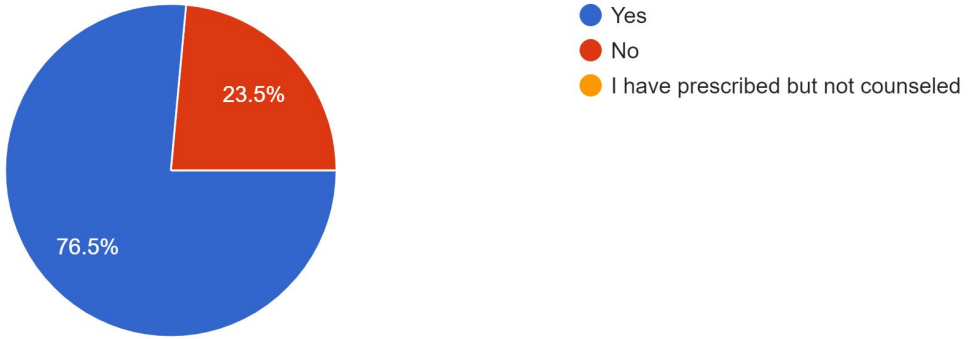
If you prescribed NRT, did you counsel on how to use it?

17 responses



Have you prescribed and counseled Varenicline or Buproprion for smoking cessation?

17 responses



HEART HEALTHY OHIO INITIATIVE

Barriers to Addressing Smoking Cessation

- Patient readiness
- desire to quit, education, years of addiction, medication side effects
- Time, not interested in quitting
- Time, patient not yet ready to quit or discuss, patient has tried other methods that haven’t worked and feel discouraged about continuing the discussion
- Not high on patient's priority list
- I need to see more patients before I can throughly answer this question
- Time
- Patient resistance
- Usually most people don’t want to, or are in the contemplative stage so the biggest barrier is usually themselves. Sometimes price of medication/availability.
- Patient Willingness to quit, medication availability

Outcome Data

- Currently 12 known electronic referrals placed since initiation of project as of early April 2023
  - 4 patient received follow up phone calls about the quitline
- Of the 4 follow ups:
  - 3 reported they felt "supported to continue smoking cessation", and it was a positive impact on their journey to stop smoking
  - 1 reported "too many phone calls" from the quitline, and it was a negative impact
- Remaining 8 patients have a one month follow up phone call pending

HEART HEALTHY OHIO INITIATIVE

Keys to Success at your site

- Getting electronic referral made and in production
- Continuing to work to make referral fully electronic, successfully securing grant funding to pay $9,000 connection fee
- Making everyone more aware the referral is another way to help patients
- Scheduling follow up calls to monitor effectiveness

HEART HEALTHY OHIO INITIATIVE

What were some of your Challenges? And are they still barriers?

- During office visits, may still not have enough time to properly address smoking cessation
- Patients are sometimes hesitant to talk to another person about cessation, would rather address themselves
- May feel overwhelmed by "multimodal" approach to smoking cessation

HEART HEALTHY OHIO INITIATIVE

How are you planning to continue and sustain your QI efforts?

- Continue making referrals to the Quit Line
- Making residents more aware that such a referral is a great way to continue care
- Following up with patients about effectiveness and better approaches to ensure adherence
- Possibly setting up smoking cessation counseling as its own office visit or telehealth call
- Have more patient data for analysis

HEART HEALTHY OHIO INITIATIVE

Equitas Health

Team Members

Jill Anderson, LISW-S Manager of Population Health

Adriana Castellanos, RN Population Health Care Coordinator- King Lincoln Clinic, Columbus

DanaRenee Langevin, RN Population Health Care Coordinator- Short North Clinic, Columbus

Brittany Baird, LPN Population Health Care Coordinator- Dayton Clinic

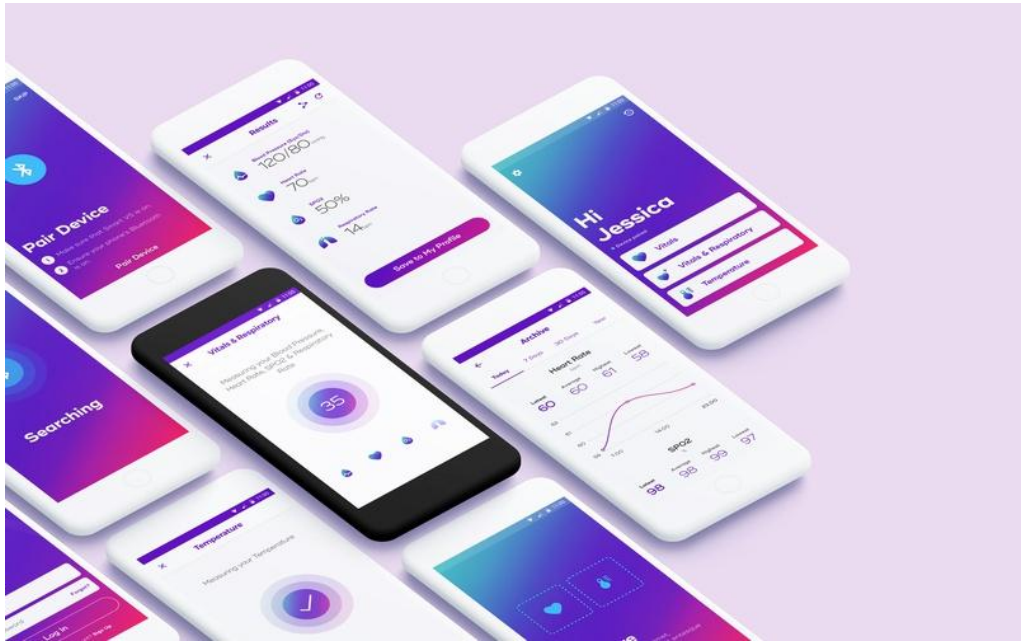
Kyle Smith, RN Population Health Care Coordinator- Cincinnati Clinic
(Cincinnati Clinic was not a part of this initiative but is involved in implementation)

Taylor Hart Continuous Quality Improvement Specialist and Data Team Lead

HEART HEALTHY OHIO INITIATIVE

Learning from testing

Alternative reporting/Tracking methods



HEART HEALTHY OHIO INITIATIVE

Which Process Measures were most effective?

- ***Communication around the project saw an increase in referrals to the program.***

Outcome Data

Patients Enrolled as of 3/30/2023

- King Lincoln- 11
  - Success Story
- Dayton- 7
  - Success Story
- SN- 3
  - Success Story

HEART HEALTHY OHIO INITIATIVE

Keys to success at your site

HEART HEALTHY OHIO INITIATIVE

What were some of your Challenges? And are they still barriers?

- The biggest challenge has been the interface with EPIC not working properly and it continues to be a barrier

HEART HEALTHY OHIO INITIATIVE

How are you planning to continue and sustain your QI efforts?

- Interface: Plan is to get that up and working

- Reports: We currently focus on referrals from providers but will also run reports around uncontrolled hypertension to reach out to folks not referred by providers

HEART HEALTHY OHIO INITIATIVE

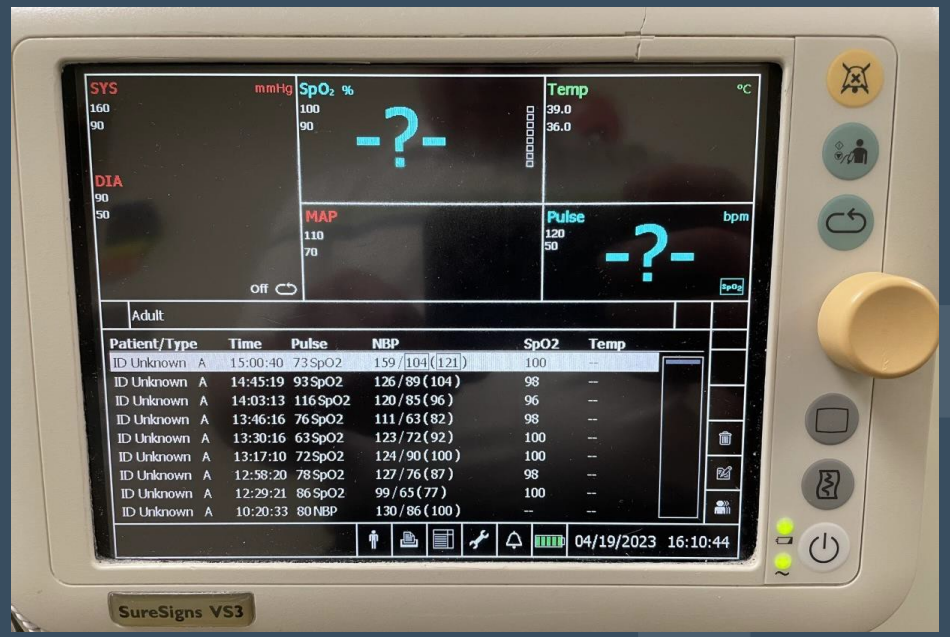
Center for Family Medicine

Cleveland Clinic
Akron General

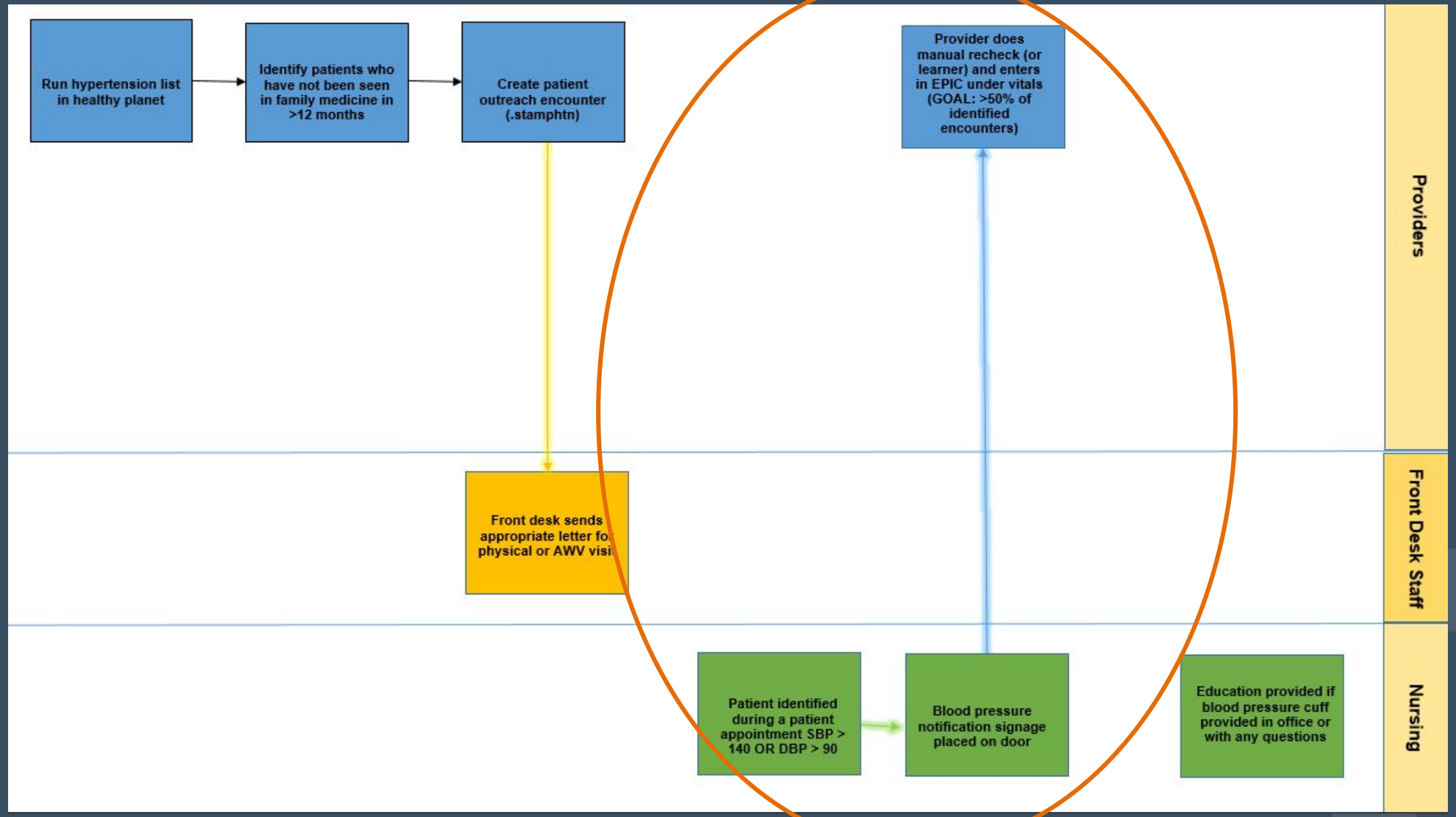
Team Members

Learning from testing

- Who should be responsible for the repeat BP?
- When should repeat BP occur?
- Automated vs Manual?



Which process measures were most effective?



Which process measures were most effective?

Nursing Staff

- ✓ Write "↑BP" on white board and/or place "Repeat Blood Pressure" reminder sheet on patient door.

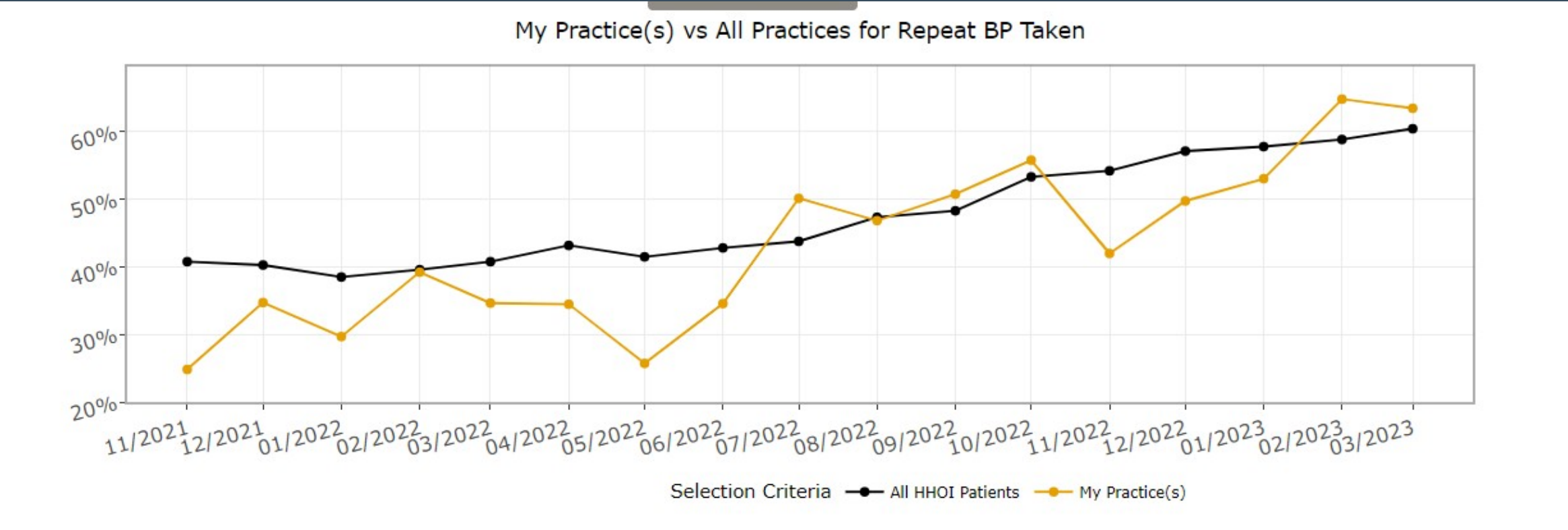
Provider

- ✓ **Re-measure and record** BPs ≥140/90 in **vitals section**. If it is still elevated, next steps should include:
  - Medication review & reconciliation.
  - Assessing barriers to medication adherence & BP control.
  - Education on lifestyle modifications.
  - Adding patient instructions to AVS **(.pihtn)**
  - Instructing patients to measure BP at home.

    Order home BP cuff for patients who need it (.cfmbpmonitor)

Outcome Data

Repeat Blood Pressure Taken



Keys to success

- STAMP (Strengthening Teams in the Advanced Management of Populations) i.e. Teamwork
- Repetition/Reminders
- Home BP monitors (hypertension control)

Barriers

- Role clarification (lack of)
- Time

Sustainability

- STAMP Executive team – front of mind
- Cleveland Clinic World Class Care

Heart Healthy Ohio QI Project: MinuteClinic, CVS Health

2022-2023

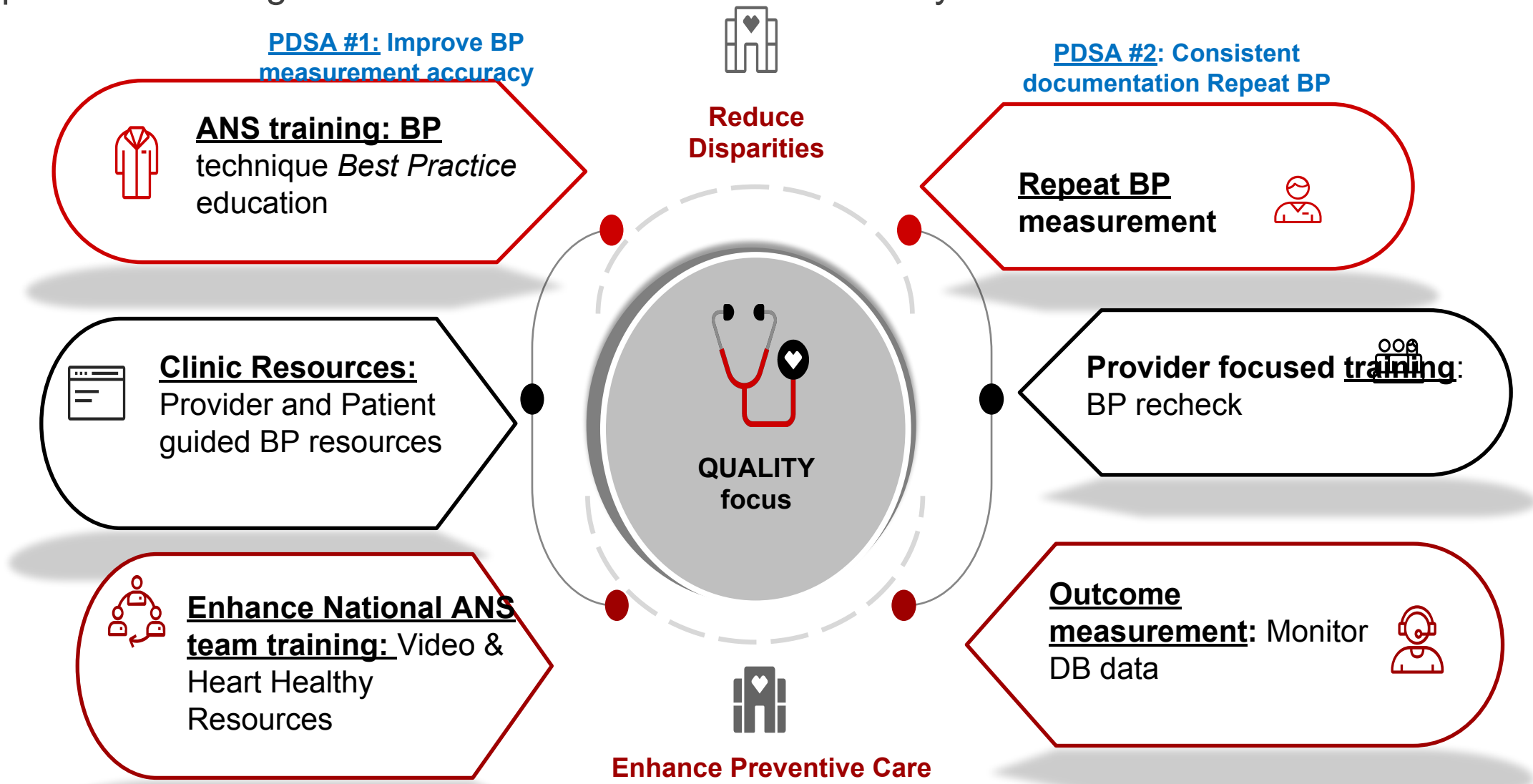
Version March 2023

Heart Healthy Ohio Quality Improvement Team Members

- **QI Coach:** Caroline Carter
- **MinuteClinic/CVS Executive Sponsors:** Angela Patterson, CNPO & Mary Czymbor, Medical Director Clinical Quality
- **Project Coordinator:** Tammy Todd, CRNP, Senior Manager of Quality
- **QI Team Leader:** Autumn Jones, CRNP
- **QI Clinic Practice implementation team:**
  - Julia Newman, CRNP, Senior Practice Manager
  - Nicole Prox, CRNP, RQL, CVS Provider
  - Erika Carrol, CRNP, CVS Provider

Quality Interventions: PDSA

- **Overarching goals**: Identify "best practice" strategies to augment Chronic Care management, incorporate QI strategies at the clinic level to advance Quality



Heart Healthy Ohio QI Plan-Do-Study-Act Outcomes

PDSA #1: (5/4/22-7/31/22)
AIM: Improve BP technique accuracy for Provide & Nurse with education

- Provider and Nurse team for all 3 HHOI clinics completed HHO Video on proper BP measurement technique.
- Added in-clinic visual cues, A & B clinic rooms
- Post video training evaluation completed, validated accurate technique and accuracy of BP.
- Positive feedback noted – Video added to Provider and Nurse new hire orientation
- Project team felt this was a valuable reminder on

PDSA #2: (9/1/22-9/30/22) AIM: Improve documentation of 2nd BP readings to 100% of all abnormal initial BPs.

- Reinforced education on "best practice" workflow to check & document 2nd BP when abnormal
- Baseline data captured to measure impact of intervention
- Results of repeat BP for abnormal BP reading for participating clinics: ****All clinic metrics showed improvement**
  - **Canfield Clinic:** 2nd BP documented, from 90% to 100%
  - **Niles Clinic:** 2nd BP documented, from 48% to 52%

PDSA #3:(10/1/22 -12/31/22)
AIM: Improve BP accuracy with the use of an automatic BP cuff to obtain readings for all patients.

- Provider & Nurse staff trained on Automatic BP cuff, proper technique, package insert review
- Gathered provider and patient feedback
- Part of MC Pilot to measure effectiveness of automatic BP use in new Care team model approach
- Pulse Survey findings reveal overall positive feedback with Automatic BP device, noting improved efficiency and patient satisfaction.

PDSA #4: (1/1/23-1/31/23)
AIM: Ensure all staff feel comfortable obtaining patient BPs with the automatic cuff.

- Data validation exercise to ensure accuracy of manual and automatic BP readings
- Performed case studies to verify accuracy of automatic BP cuff readings with manual cuff readings. (Results were considered valid if within 10mm/Hg of difference).
- Reviewed these results with the 3 clinics. Confirmed and validated accuracy of Automatic BP cuffs.

Focused review of Automatic BP cuff PDSA

Plan-Do-Study-Act Worksheet

CVS Health

Overall project aim: Improved BP Control for all patients

Test start date: 10/1/2022

Objective of test: Improve BP accuracy with use of automatic BP cuff to obtain readings for all patients for all provider role types

Test end date 12/31/2022

Plan:

What is the test? **All provider role types (NP/PA and ANS team members) use an automatic BP cuff to obtain blood pressure readings for all patients.**

How will data/ measure be tracked? **Encourage frequent provider and patient feedback through close communication.**

What is the prediction for the test outcome?
All BP readings will be obtained by using the automatic BP cuff (thus increasing provider and patient satisfaction from using automatic BP cuff vs manual BP readings). *This project is part of MC Pilot to measure effectiveness and provider satisfaction of BP devices to support potential national expansion of this device.*

Tasks needed to complete the test	Person responsible	Details/ How
Work with Clinic Ops to identify BP Device, place order through appropriate Cost Center	Tammy	**Completed 8.19.22** Pending final confirmation of order and delivery to clinics (2 BP devices per clinic = 6 devices total)
Train ALL NP/PA and ANS team members on proper use of automatic BP devices .	Autumn by 10.24.22	Email communication to all providers/ANS team members, reinforce via phone calls.
Encourage frequent feedback and communication regarding patient and staff satisfaction using the automatic BP cuffs.	Autumn by 10.24.22	Email; 1:1 communication, create post-survey to evaluate impact of BP cuff (Autumn work with Tammy/Janelle Rastad to create FORMS survey)

Do:

What the test carried out as planned?
Yes / No

Test data/ observations:
Positive feedback from participants about using the automatic BP cuff. The automatic BP effectively obtains patient's blood pressures.

Unexpected events/ observations:
Balancing measures: additional time or staff resources>?
N/A

Study:

Did the results match predictions?
Yes / No

How are the results different than past tests/ previous system?
Providers prefer using the automatic blood pressure cuff to help obtain accurate patient blood pressures.

New learning from the test:
Providers recommend rolling out the automatic blood pressures to Minute Clinics nationwide .

Act:

ADAPT: Improve / edit the intervention and continue testing
Plan: Continue using the automatic blood pressure cuff

ADOPT: **Select changes for larger test or implementation: Propose to expand the use of the automatic cuffs to clinics nationwide**

ABANDON: Discard this change and try a different idea

PDSA: Evaluating Automatic BP cuff use

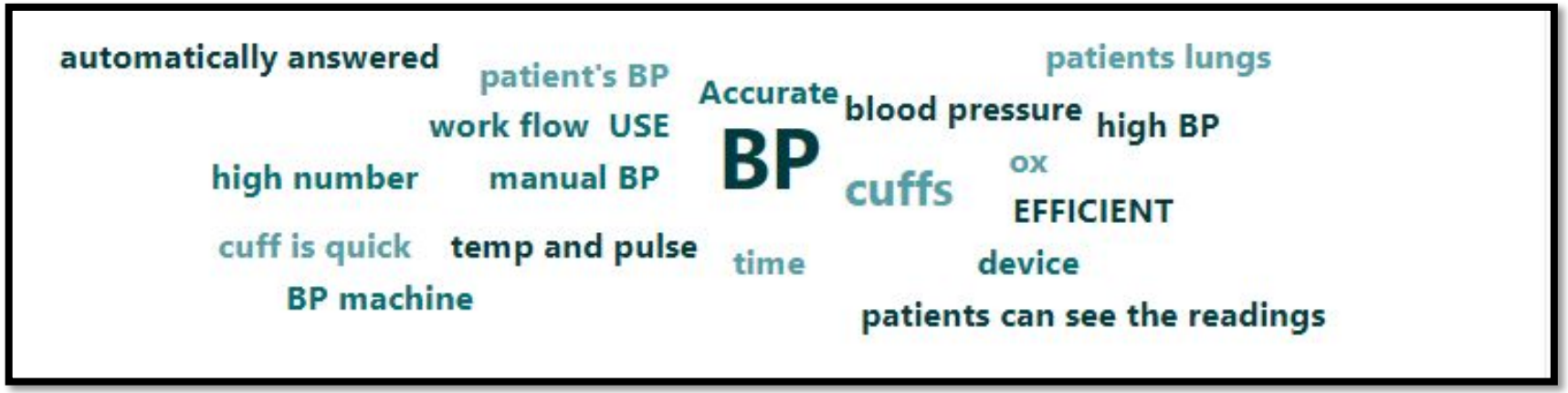
- Step one: **Purchase automatic BP cuff** for each Clinic (A/B)
- **All provider & nurse team training** completed & encouraged to use automatic BP cuff for all BP readings and repeat Elevated BP readings
- **Direct feedback** received via HHO team meetings
- **Validation exercise completed** - analysis confirmed + validation of automatic BP cuff vs. manual
- **Microsoft Forms provider & nurse survey** completed
- **Evaluated surveys:** Positive feedback and outcomes noted
- **Evidence Based Practice** findings support use of automatic BP cuffs in clinical setting
- **Next steps:** Propose expansion of automatic BP cuff use nationally across all practice locations & service areas, ROI analysis
- Collaborate with internal partners for uniform

Heart Healthy Ohio Pulse Survey:

- **Participants Surveyed:** All participating HHO Ohio clinic provider and nurse HHO team (Canfield, Niles, Boardman)
- **Total** = 13 respondents
- **Outcomes:** Overall positive feedback with use of Automatic BP cuffs

- **Total of 2 questions (Likert Scale):**
  - 86% offered an overall high rating for Automatic BP cuff use
  - 79% of staff thought the automatic BP cuff improved clinic workflow and efficiency
  - 65% felt that the automatic BP cuff was accurate
  - 86% rated the patient experience as being high with the automatic BP cuff
  - **72% of said yes, we should roll out the automatic BP cuff to Minute Clinic nationwide**

- Free text comments:
  - * "Makes workflow more efficient" (NP) * "Useful in improving workflow" (LPN) * "Accurate BP readings that are more efficiently obtained" * "I like that my patients can see the readings, this is an easy way to open up discussions about BP" * "The cuff is quick" * "Streamlines taking vital signs"



Automatic BP cuff Business Proposal

Patient Volume Projections	
# of patients seen per day	30
# of times BP is captured on each patient during visit	1
Annual # of blood pressures taken	7800

Time to Collect Blood Pressure Per Patient (In Seconds)	
Manual*	58.6
Automated*	29.3

Average Nurse & Medical Assistant Labor Costs	
Nurse & Medical Assistant's time per hour (Salary & Benefits)**	$ 25.00

Annual Savings Summary & ROI	
Time	**Hours**
Manual time acquiring BP	127
Automated time acquiring BP	63
Annual time savings by moving to AOBP	63
Labor	**$**
Manual cost to acquire BP	$ 3,174
Automated cost to acquire BP	$ 1,587
Annual labor savings by moving to AOBP**	$ 1,587

By switching to automated blood pressure, your practice could reduce your measurement time by 50% and pay for the device(s) in 2.8 years due to efficiency gains. Additional efficiency and savings could be realized if the automated devices were connected to an EMR.

CVSHealth

Automatic BP cuff project timeline 2023

2023 → 2024

Proposal Planning

February-April

- Identify key project owners: HHO project leads, CPS, Quality, SLC
- Gain vendor insight
- EBP literature review
- Finalize HHO Pulse Survey
- Create proposal

Proposal Kick Off

May 2023

- Present collective proposal @ May CPS
- Topic review @ May CEC
- Gain additional feedback SLC partners
- CPS partnership to identify next steps

Project Work Group

May-August

- Finalize business proposal, approval & funding
- Work with Clinical Operations team to secure equipment
- Establish provider training/educational needs

Project Launch

Q4 2023 or Q1 2024

- Dependency on Go Live with budget approval

Sandusky VA Clinic

Clinic

U.S. Department of Veterans Affairs

Veterans Health Administration

VA Northeast Ohio Healthcare System

Team Members

- Primary Care Providers
- Patient Aligned Care Team (PACT) Nurses
- PACT Clinical Pharmacy Specialists

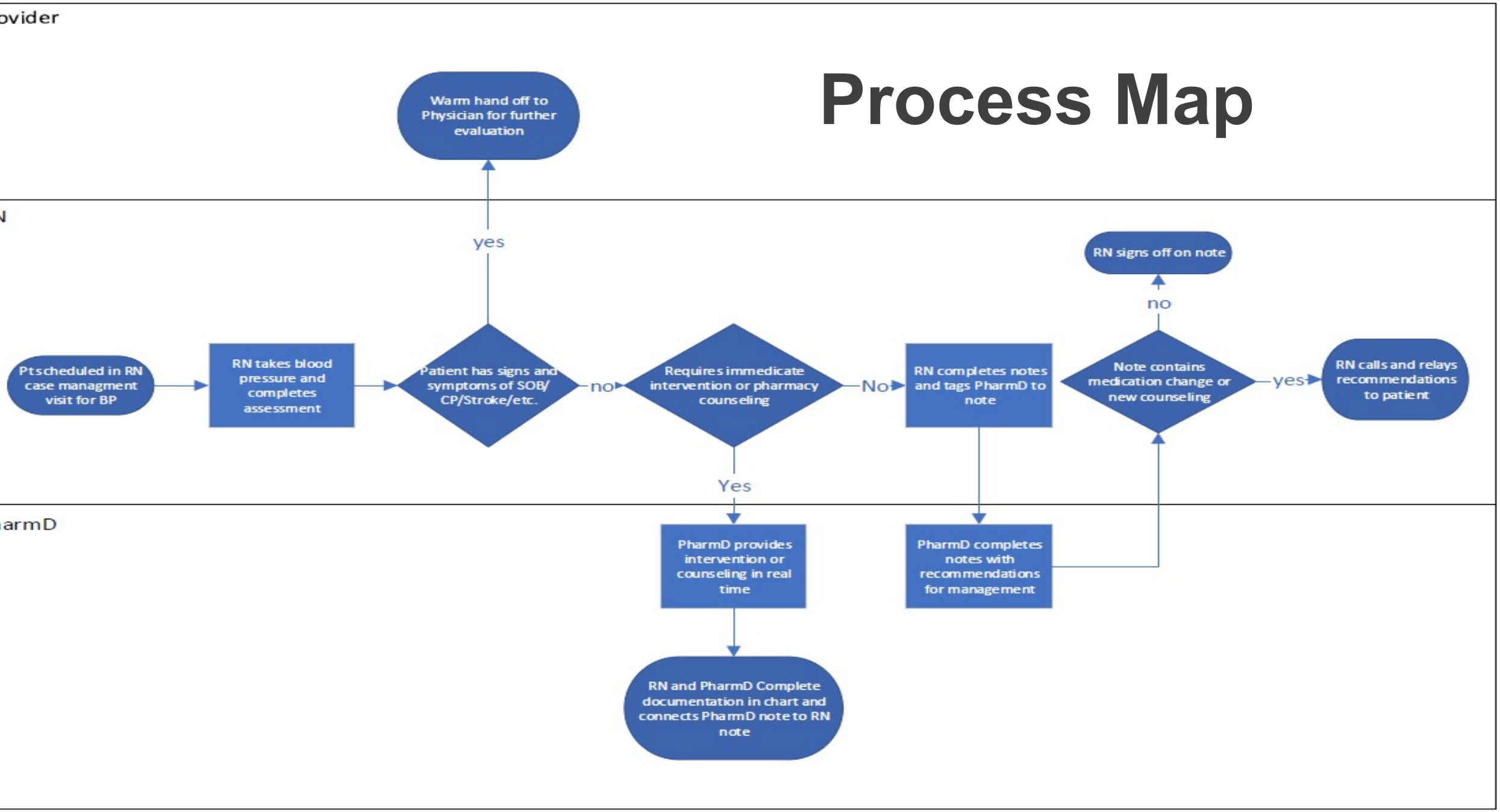
Learning from Testing

- Most interesting test of change/PDSA that you have run since start of QIP
- Challenges
  - Implementing across all PACT Teams and at different VA sites
    - Work group created a recommended process to help implement RN/PharmD collaboration across sites
    - Presentation provided to nursing staff on use of PharmDs to assist with medication management for uncontrolled HTN
  - Incorporating into weekly workflow
    - Using Data Warehouse tools to identify patients for clinic follow-up

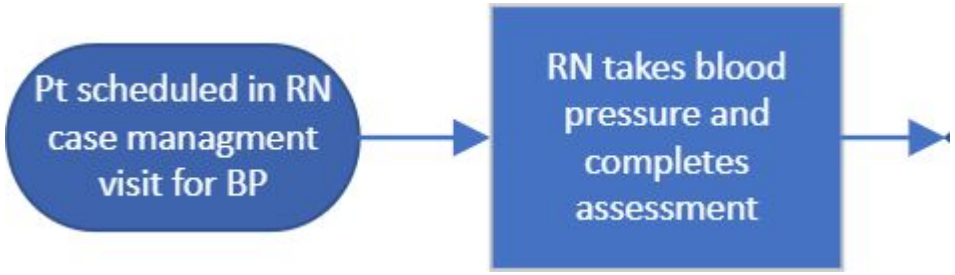
Most Effective Process Measures

- Clinical reminders
  - Tobacco Use Screening
    - Due every 1 year for all ages
      - Monthly Smoking Cessation Class available through Akron VA Clinic
      - Referral to Mental Health or PACT PharmD available to implement smoking cessation treatment
  - HTN Assess for Elevated BP >= 140/90
    - Due every 6 months for ages 85 and younger
- RN/PharmD Collaboration (see process map on next slide)
  - RN Care Manager appointments for HTN generated by
    - PCPs
    - PharmDs
    - RN population management

Process Map

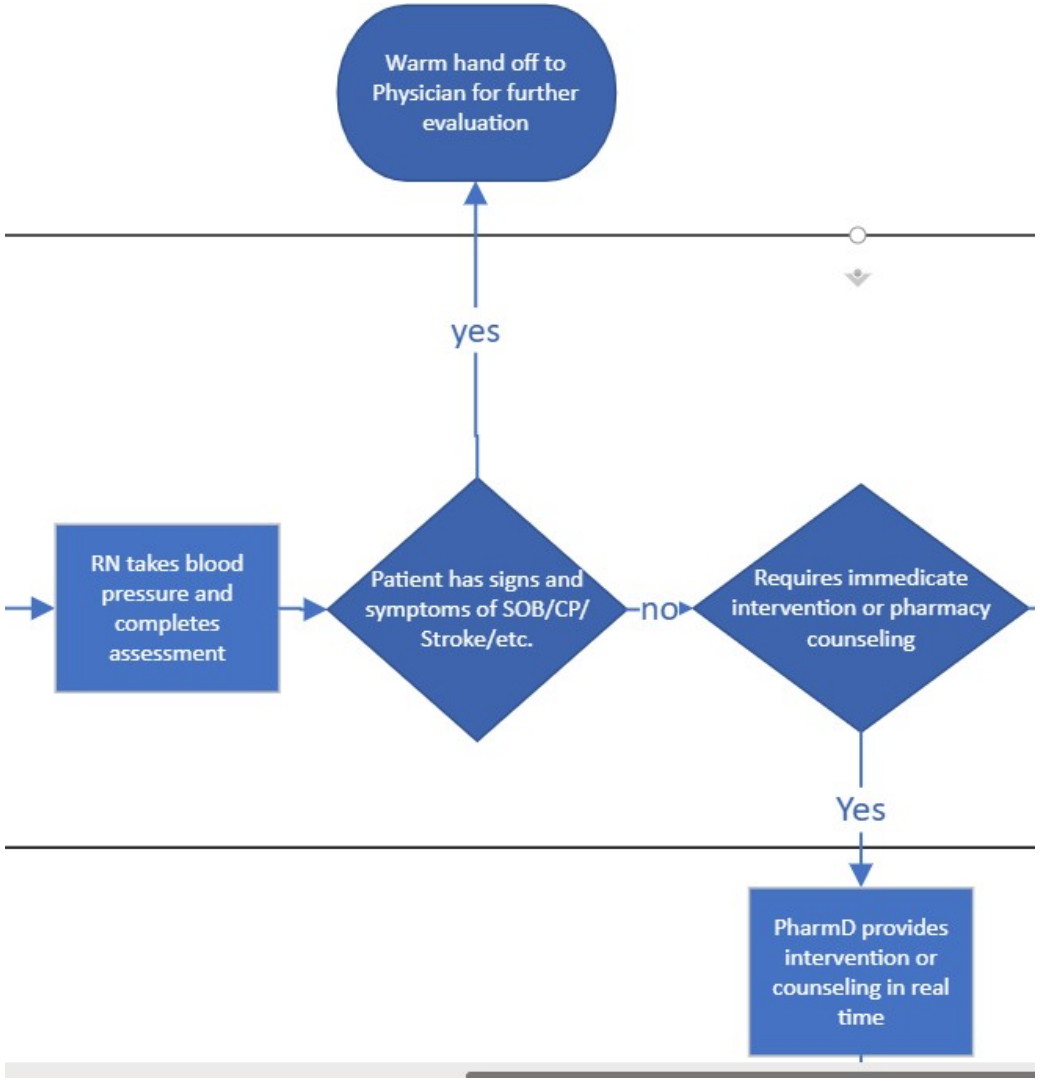

Provider
RN
PharmD
Warm hand off to Physician for further evaluation
yes
Pt scheduled in RN case managment visit for BP
RN takes blood pressure and completes assessment
Patient has signs and symptoms of SOB/ CP/Stroke/etc.
no
Requires immedicate intervention or pharmacy counseling
No
RN completes notes and tags PharmD to note
RN signs off on note
no
Note contains medication change or new counseling
yes
RN calls and relays recommendations to patient
Yes
PharmD provides intervention or counseling in real time
PharmD completes notes with recommendations for management
RN and PharmD Complete documentation in chart and connects PharmD note to RN note

Process



Patient with blood pressure (BP) above 140/90

- Return to clinic order placed for RN Care Management visit for BP check
- At in-person RN appointment:
  - Vitals taken by RN (BP and HR)
    - If elevated above 130/80 or below 100/60 then repeat vitals
  - BP assessment completed by RN
    - Lifestyle assessment: Tobacco, ETOH, caffeine, hydration, etc.
    - Adherence: is patient taking medications as prescribed?



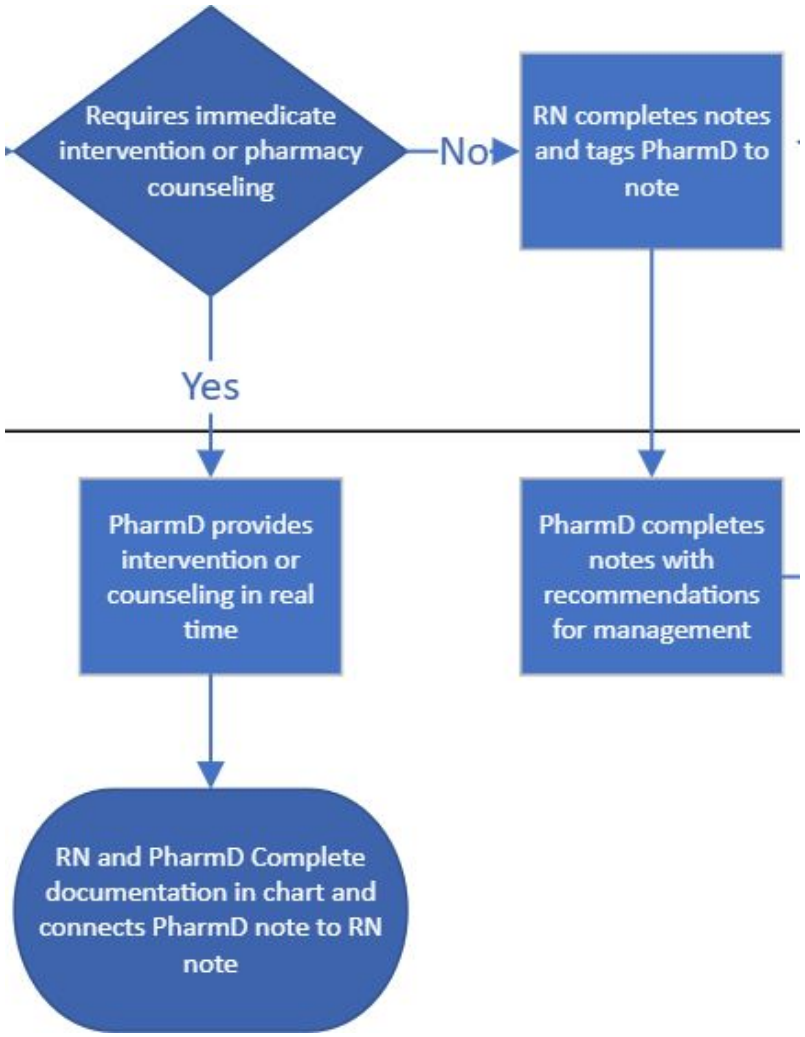
Process

Patient to be triaged for follow-up with the following:

Patient is symptomatic:

BP >140/90 with symptoms (chest pain, SOB, blurred vision, etc) then warm hand off to PACT provider or POD (provider of the day).

BP <100/60 with symptoms of hypotension (i.e. dizziness) then warm handoff to PharmD if available or PACT provider or POD



Process

Patient to be triaged for follow-up for the following

Patient is asymptomatic:

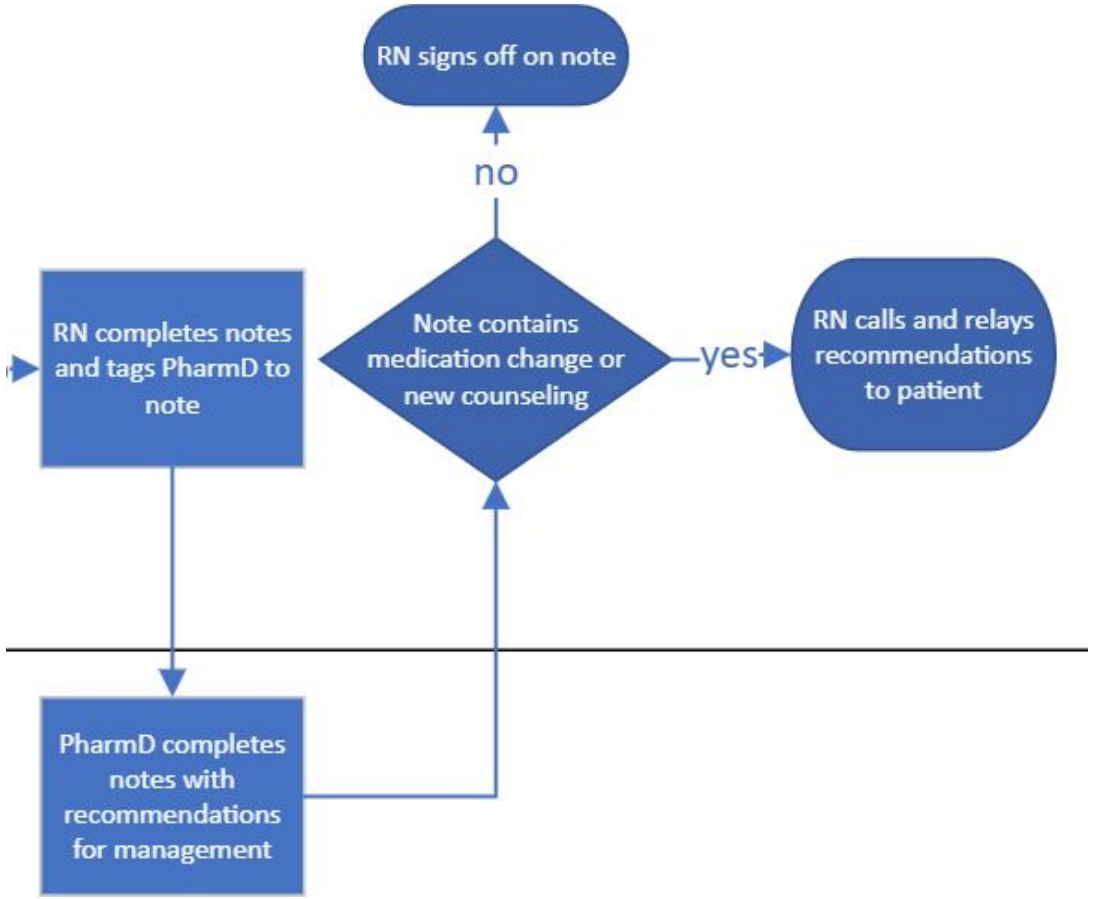
BP > 140/90 and <160/90 with no symptoms then

<u>nurse to complete note and tag PharmD</u>

BP > 160/90 with no symptoms and no clear reason for elevated BP then <u>warm hand off to PharmD if available</u>

(i.e. did not take meds that day, home BPs within normal limits).

Process



After assessment by RN

- **Nurse provides nonpharmacologic counseling as indicated**
- **Nurse completes note and tags PACT PharmD as indicated**
- **PACT PharmD reviews RN assessment and enters note to RN with interventions**
  - If no medication adjustment made then RN to sign off note and encounter is complete
  - If medication adjustment then RN to contact pt by phone with changes and PharmD will update orders

Outcome Data

Mr L. is a 79 year old with long smoking history. Had failed to quit with help of Wellbutrin SR and Chantix in the past. His BP had been uncontrolled on lisinopril 20 mg for several years and he was resistant to increase BP meds.

Readings in the 150s-160s/80s were common.

While he has not completely quit smoking, he is down to 2 cigarettes a day and his blood pressure readings are now 130s/60s-70s, last reading was 131/64

VA
U.S. Department of Veterans Affairs
Veterans Health Administration
VA Northeast Ohio Healthcare System

Keys to Success at Your Site

We are fortunate to have both RNs and a Pharm D embedded in the clinic To help with disease management.

The VA is also lucky to have BP cuffs on site to give to veterans to help monitor Blood pressures.

Challenges and Barriers

In the past without a definite plan, blood pressures were difficult to get controlled. We also have a large amount of veterans who have primary care providers outside the VA and get medications only from the VA. These people are difficult to manage as the veteran will want the civilian provider to adjust meds.

It also has been difficult to have veterans return for blood pressure checks if they are not accustomed to coming in sooner.

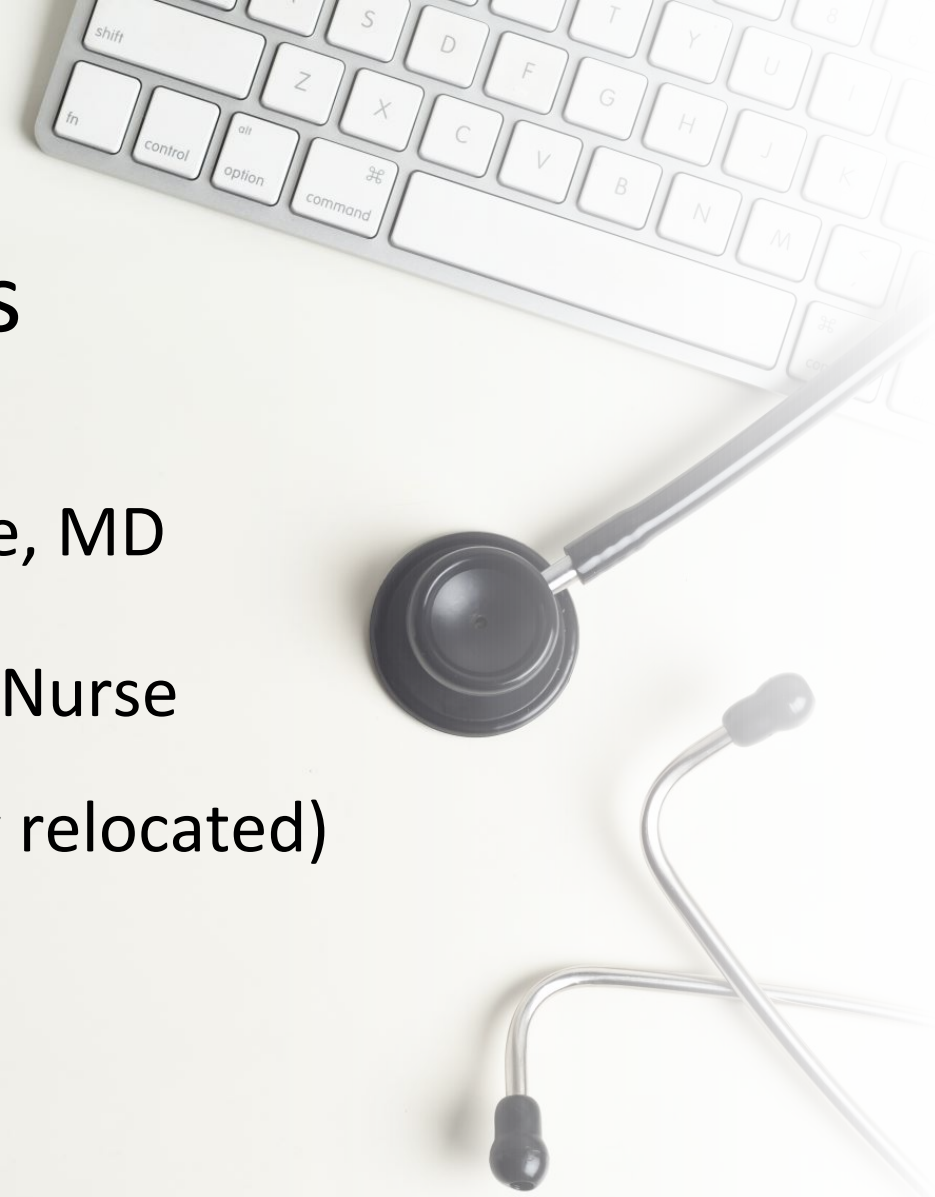
Plan for Continuation:

Our process developed with continue with the RNs and Pharm D being educated on the process.

Ohio City Health Center
4757 Lorain Rd
Cleveland, OH

Team Members

- Christopher Gillespie, MD
- Rochelle Smith, RN, Nurse Manager – (recently relocated)
- Jean Font, RN



Learning from testing

Learned that BP technique was inconsistent across the practice.

Trained all MTA's on proper technique for measuring blood pressure.

We are now confident that blood pressure readings are accurate.

Which Process Measures were most effective?

BLOOD PRESSURES INITIALLY IMPROVED AFTER TRAINING OF MTA'S

STAFF TURNOVER AND STAFFING SHORTAGES HAVE SINCE NEGATED THOSE GAINS

Outcome Data: HTN Control 140/90

KEYS TO SUCCESS

- Excellent clinical staff dedicated to our patient population
- Familiarity with PDSA’s

PERSISTANT CHALLENGES

RECENT LARGE TURNOVER OF MTA'S

PERSISTENT STAFF SHORTAGES

CURRENTLY WITHOUT A NURSE MANAGER

LIMITED TIME TO WORK ON QI

SUSTAINABILITY

CONTINUE TO MONITOR ACCURACY IN BLOOD PRESSURE READINGS; MONITOR CONSISTENT REPEATED BP'S; AND ENSURE FOLLOW-UP APPOINTMENTS ARE MADE.

REVIEW MEDICATION MANAGEMENT. REFINE AS NECESSARY.

CONTINUE ACCESS TO MONTHLY PROCESS OUTCOME DATA.

Physicians CareConnection

An affiliate of the Columbus Medical Association

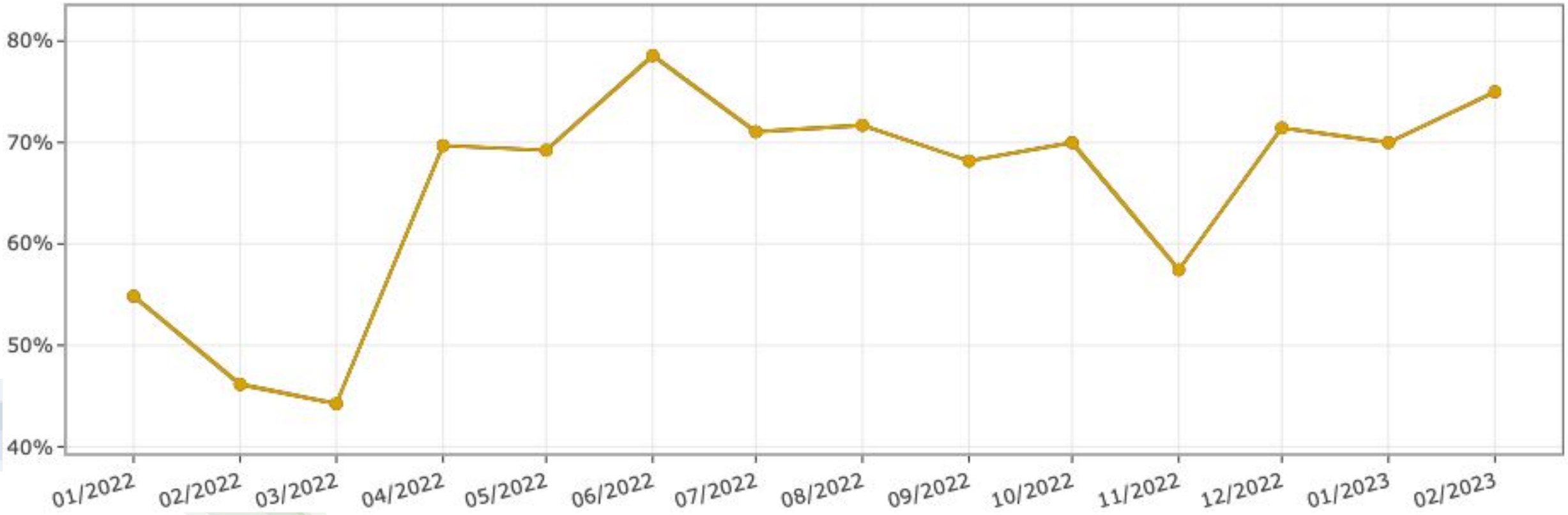
Team Members

- Isi Green, PCC President
- Yemi Akingbola, RN(clinic lead)
- Kathy Walston, RN
- Medical student coordinators
- Tori, CHW

Learning from testing

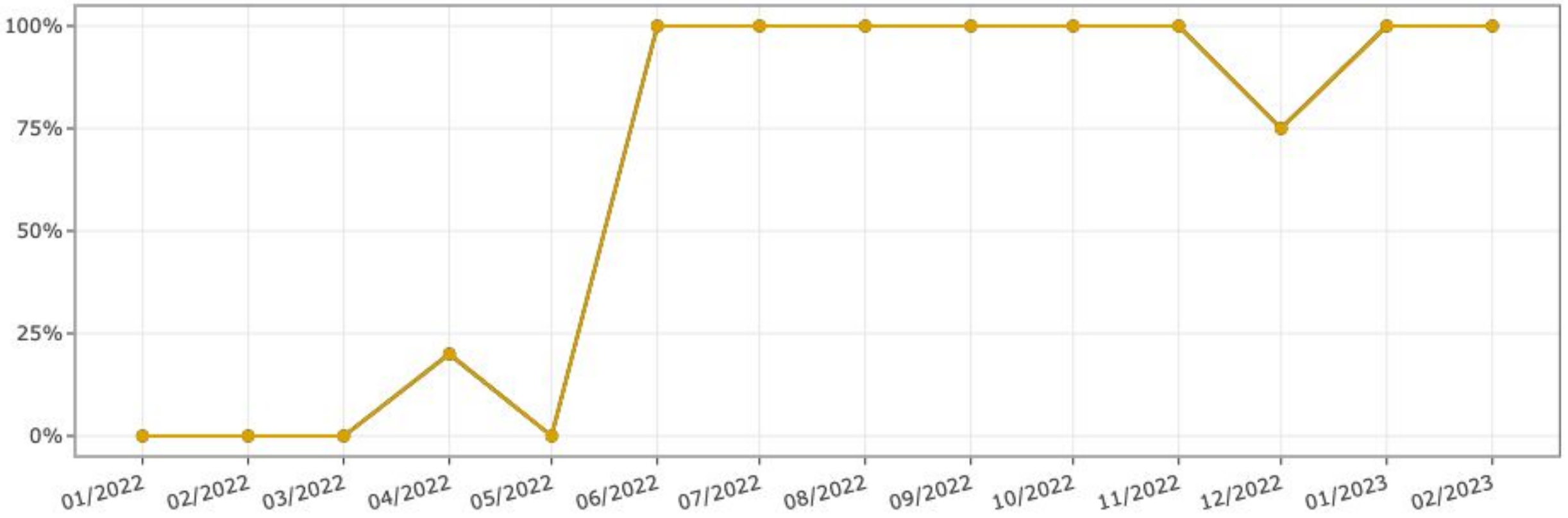
We learned to carry out one PDSA at a time. This allowed us see results and know where we were successful.

OUTCOME DATA: HTN Control 140/90



- Jan 2022 HTN Control 55%
- Feb 2023 HTN Control 75%

Effective Process Measure: Repeat BP Taken



Keys to success

- Everyone who took vitals at clinic learned to take accurate BP and do repeat BP's. Now, regardless of who takes a patient's BP, the readings are statistically equal.
- Our whole intake process has been re-tooled/re-worked while implementing this quality improvement initiative. This has allowed for more streamlined and accurate clinic processes.

What were some of your Challenges?

Challenge: Patients not returning for follow up BP appointments.

Solutions:

1. Home Blood Pressure monitoring
   - Patients are provided with home BP machines to check and record BP.
   - Logs are presented to the nurse who relays the information to the provider.
   - Provider assesses if patient's medications need adjustments.
2. Offering nurse visits on a non-clinic day

Persistent barrier

Barrier: Patients who identify as smokers not following up with resources provided.

Solution:

We haven’t identified a solution - yet.

This is our next PDSA opportunity!

Our plan to continue and sustain our QI efforts

- Continue to train and monitor anyone taking vitals to ensure it is done the right way. Include it intentionally in onboarding new staff
- Providing nurse visits on clinic and non-clinic days to ensure patients BP numbers are effectively monitored so appropriate medication regime is prescribed.
- Providing home BP machines.
- Education on how to accurately take BP at home and how to upload their numbers to their portals.

New Philadelphia VA Clinic

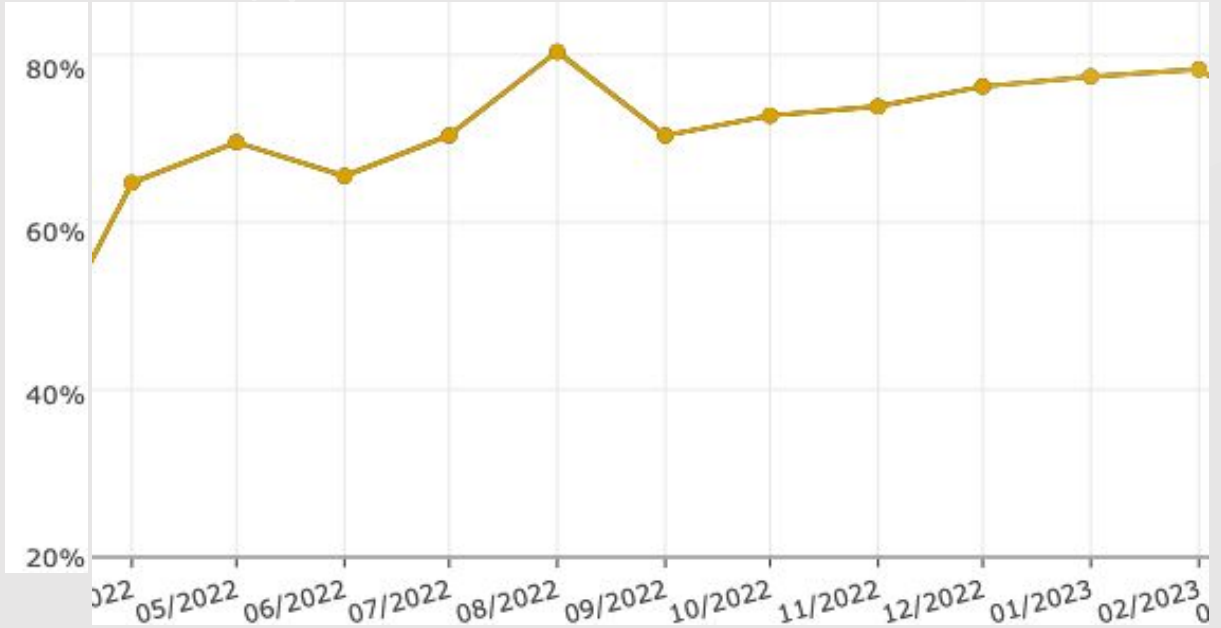
Heart Healthy Ohio Initiative

2022-2023

Team Members

- Tiffany Adkins, Nurse Practitioner
- Kevin Stack, Clinical Pharmacy Specialist
- Carrie Gammeter, RN

Outcome Data: HTN Control 140/90



Learning from testing

Needed to do outreach to patients that didn’t attend their scheduled follow-up visit to understand why.

Provider was alerted when BP higher than goal and made changes to meds when veteran agreeable.

Some of these changes were made at the pcp visit which helped get them to goal

We looked at the data and looked at workflow and we were consistent with the process

Which Process Measures were most effective?

- Blood pressure RN follow-up visit and PharmD collaboration has been most effective.
- Our Pact team improved to 93.94%. We are working on the entire clinic now.

Process Data: Scheduled Follow-Up Visits

Keys to success

- RN’s doing more care management
- Provider entering the orders for the vet to come back to the clinic for follow at their check out from visit so they get scheduled before leaving the clinic.
- Alerting the provider and calling the vet for follow up on blood pressures at home

Persistent Challenges

- No shows to follow up visits
- Staffing issues
- Some veterans are followed by outside providers for blood pressure control

Sustainability plans

- RN’s are now collaborating with PharmD to help with controlling BP
- RN’s for the pact teams will continue to case manage and review for elevated blood pressures and do outreach for follow-up
- Providers will enter order for a blood pressure follow up appt to get scheduled before the veteran leaves the clinic

Carl Nunziato VA Clinic

Youngstown, Ohio

Team Members

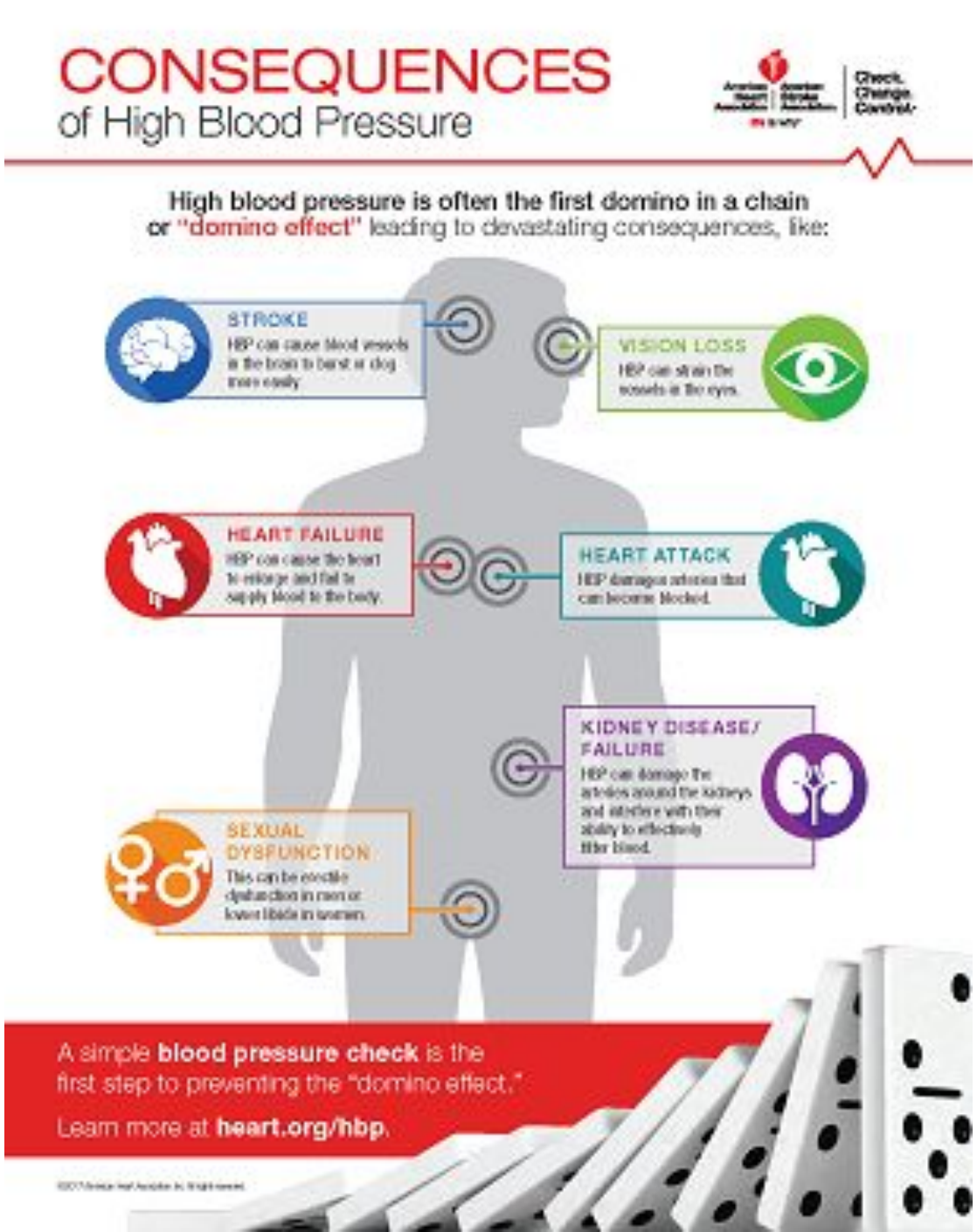
- Karen Dill RN, Care Manager
- Dr. Robert Angelo
- Darice Somple-Jay RN, Nurse Manager
- Cristina Warrick RN, Assistant Nurse Manager
- Dr. Jennifer Troyer, Pharm D
- Dr. Jillian Quitiquit, Pharm D
- Aeren Endicott, LPN
- Rocco Core RN, Care Manager
- Amy Pollock RN, Care Manager

Learning from testing

The most interesting test of change is the use of the National Clinical Reminder to document blood pressures

A reminder is triggered when an elevated blood pressure is entered prompting the provider to take action

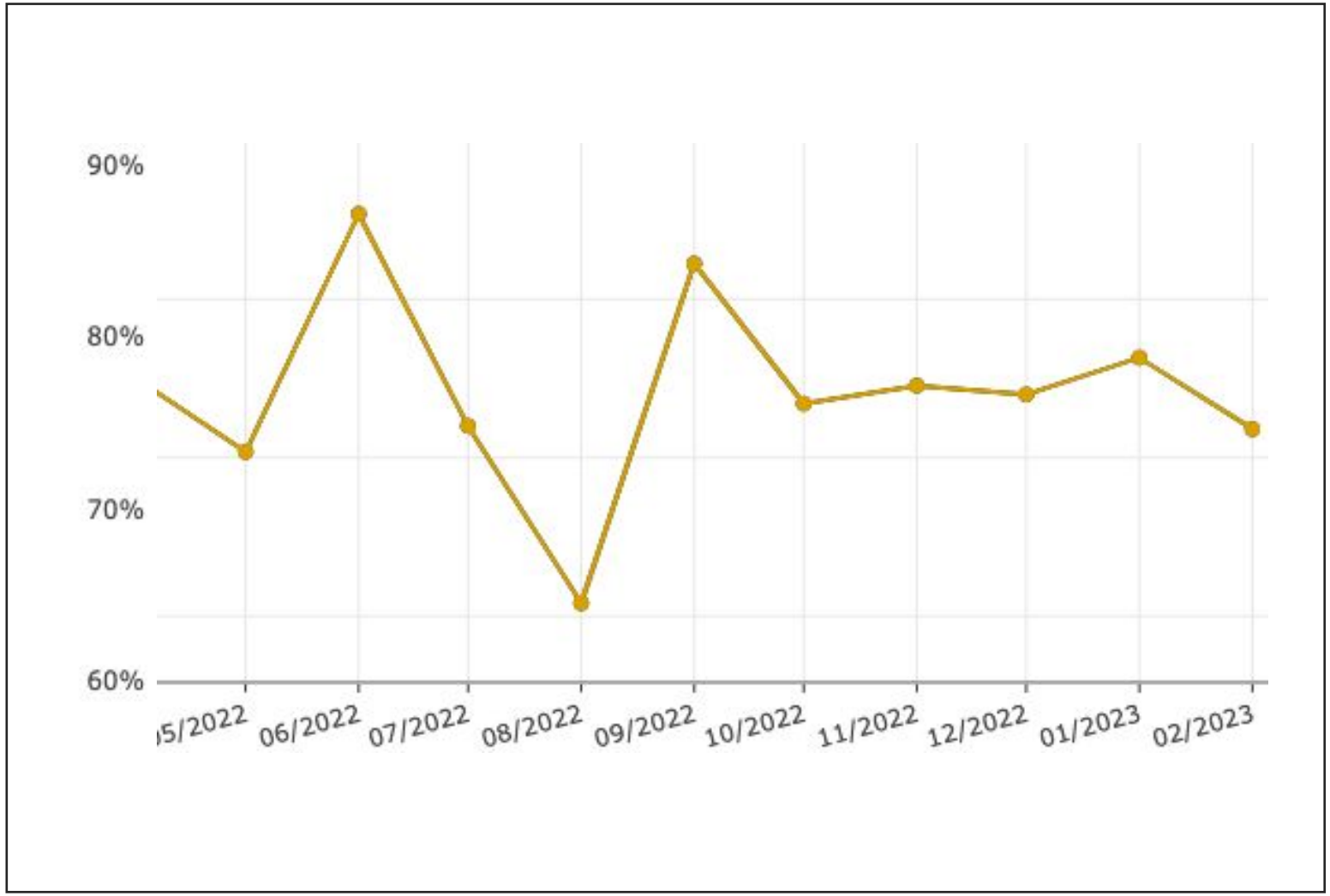
This graphic has been useful in driving home the importance of getting blood pressure under control. Generally, the veteran is familiar with a couple of consequences but not of them all.



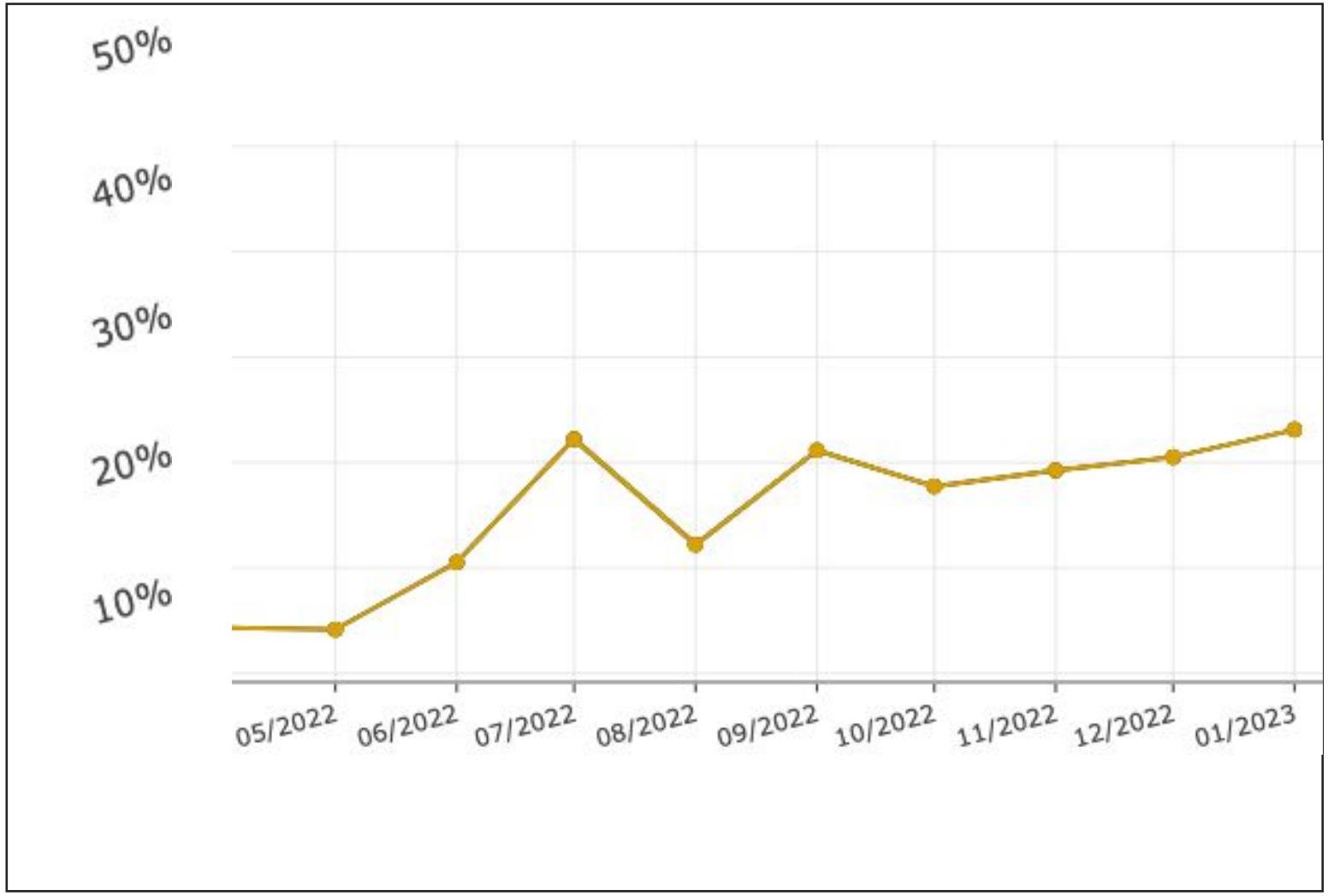
Most effective process measures

- Effective communication of outlier readings among Care Team members
- Strict adherence to proper techniques
- Provision of sphygmomanometer for veteran use at home and the return demonstration by veteran

Outcome Data: HTN Control 140/90



Process Data: Scheduled follow-up visit



- 4% May 2022
- 23% Jan 2023

Keys to our success

- Using the posted sign with instructions on accurate cuff sizes
- Using the reference table (next slide) for best practices in obtaining blood pressure readings.
- Educating the veteran on the purpose/value of HTN care management.
- Ensuring that the veteran has a Home BP monitor.
- Instruct or review with the veteran on the proper use of home BP monitor
- Following our CBOC nursing protocol for hypertension

PLEASE USE TABLE BELOW FOR ACCURATE CUFF SIZING AND REFERENCE TABLE ON RIGHT FOR BEST PRACTICES IN OBTAINING BLOOD PRESSURE READINGS

Recommended Cuff Sizes for accurate measurement of Blood Pressure

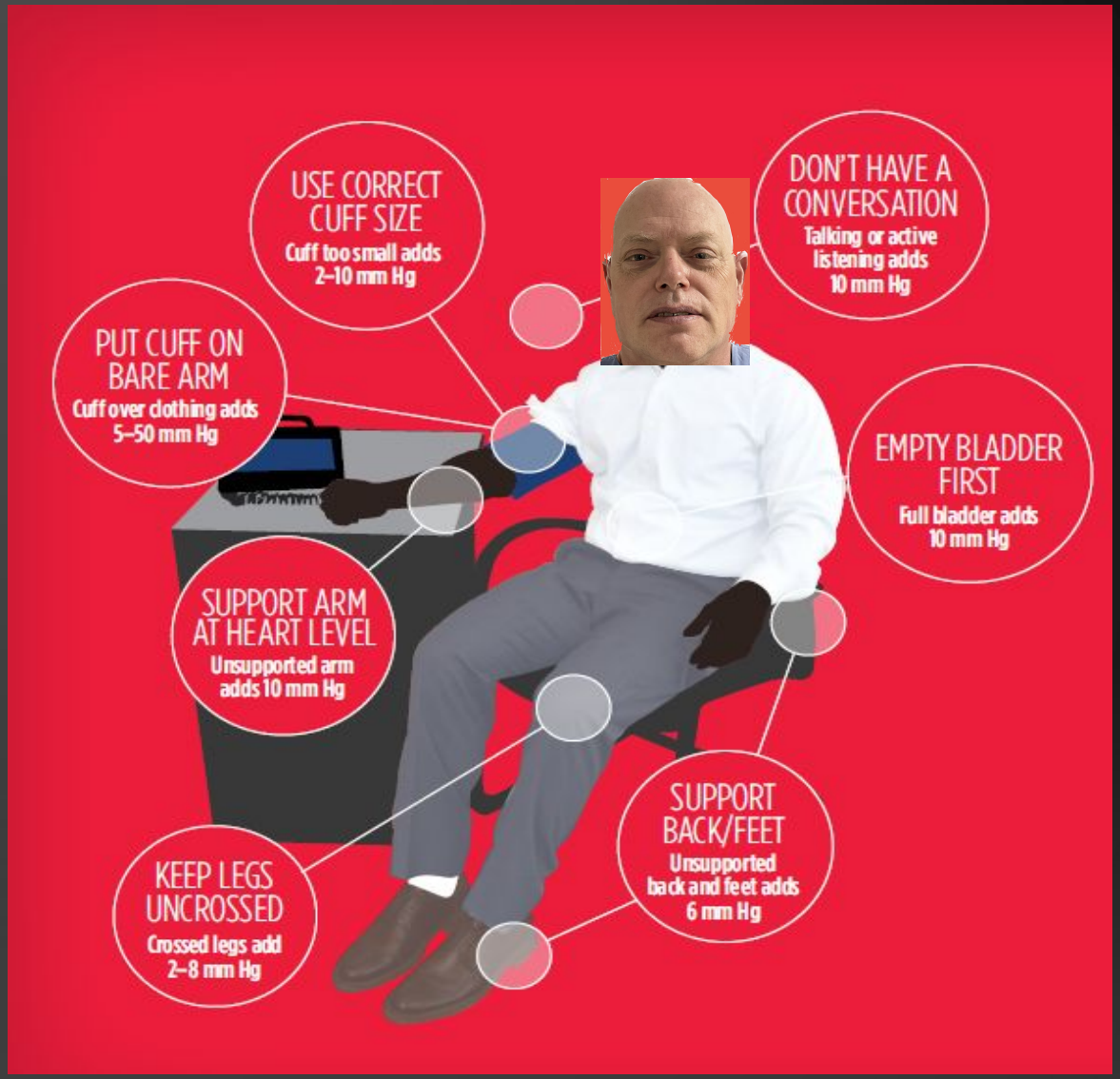
22-26 cm (small adult)

27-34 cm (adult)

35-44 cm (large adult)

45-52 cm (adult thigh)

Source: Pickering TG, Hall JE, Appel LJ, Falkner BE, Graves J, Hill MN, et al.; Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research. Recommendations for blood pressure measurement in humans and experimental animals. Part 1: blood pressure measurement in humans. Hypertension 2005;45:142–61.



Source: J Am Coll Cardiol. Forthcoming 2017. Online ahead of print. American Medical Association. 2017 Sep.

Challenges and Barriers

- Patient’s compliance with regime
- Patients not understanding their medications, or not carrying a current medication list
- Getting accurate data in reference to follow up appointments- understanding how the data is obtained

Plan to continue and sustain our QI efforts

- Ongoing veteran education and adherence to established algorithm for treatment and follow up
- Quarterly review of our HTN process with staff for changes
- Review of our HTN process with all new hires
- Process to increase smoking cessation

MetroHealth Cleveland Heights

Suburban practice

10 providers

30% Medicaid, 30% Medicare, 30% Private

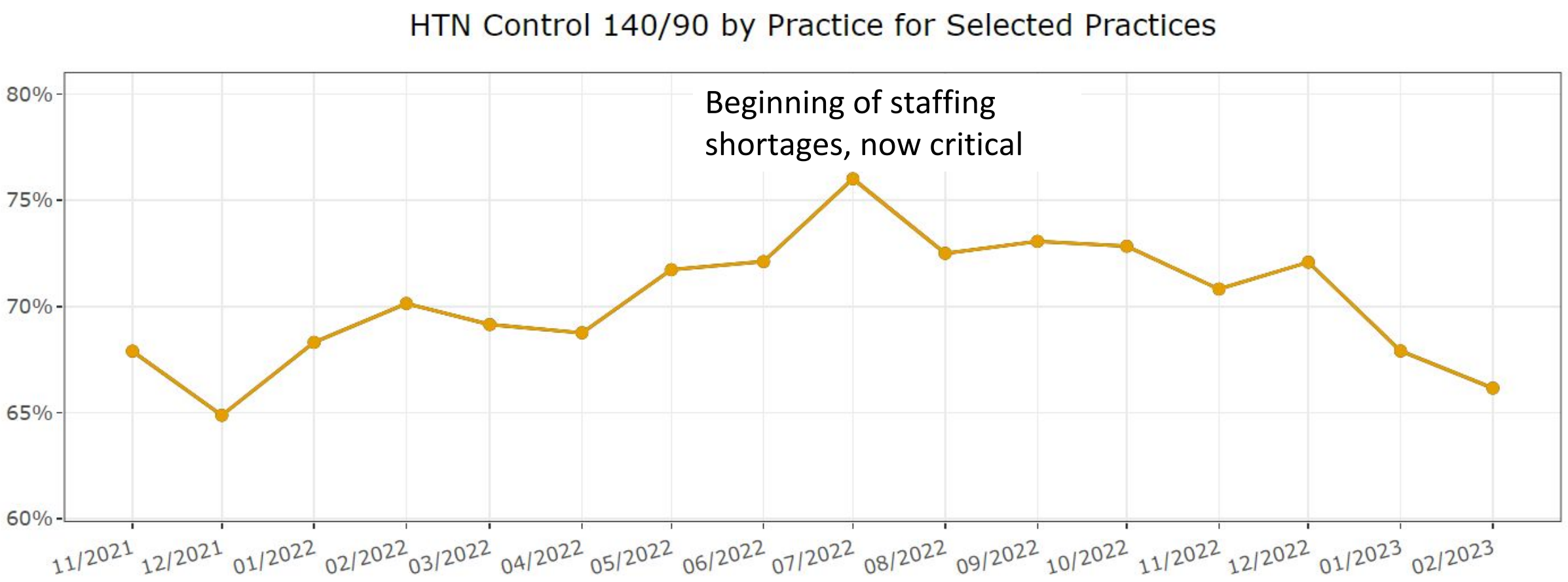
Team Members

- Mary Ryan, MD
- Kirsten Hendon, RN, MSN
- Nora Barnes, RN, BSN

Biggest Challenges

- Staff turnover and shortages
  - Varying personnel, sometimes day to day
  - Role “free-for-all” (e.g. providers rooming patients, discharge without scheduling appropriate follow-up, etc.)
  - Decrease in availability in RN BP check appointments, often cancelled on short notice

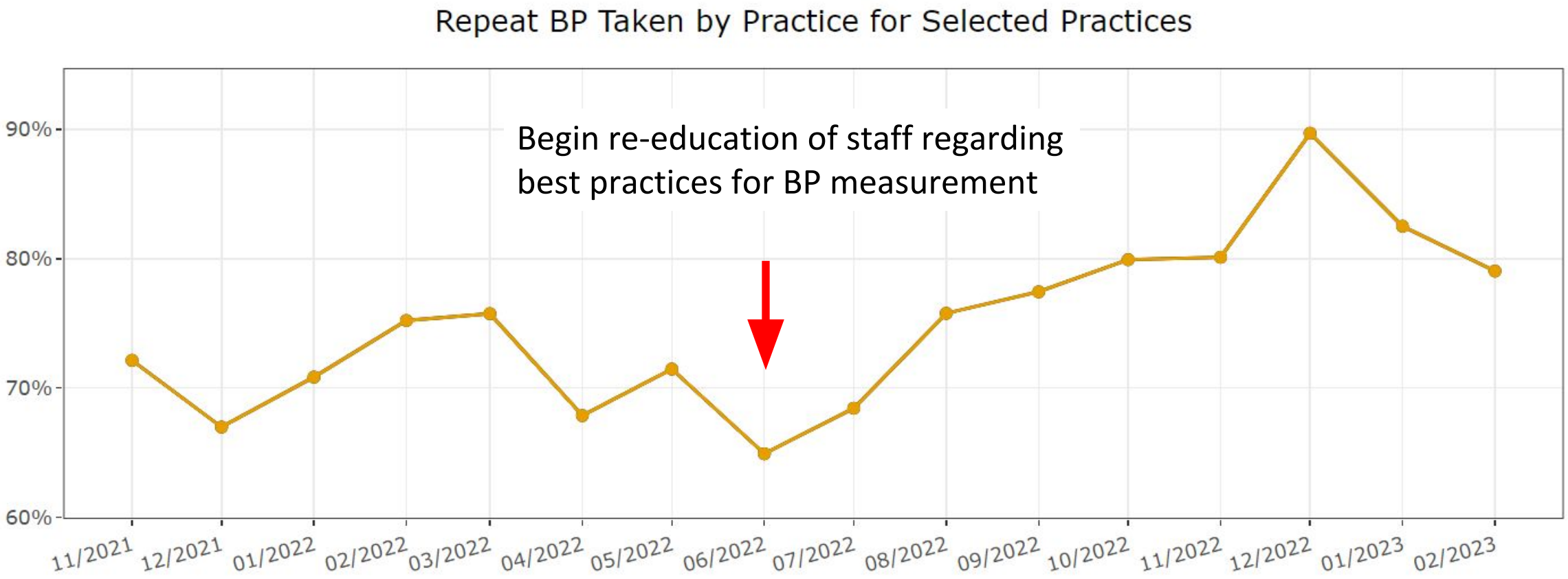
Outcome Measure: HTN Control 140/90



Biggest Successes

- Completed review training for staff with frequent reminders regarding proper technique
- Had 6 consecutive months of improved Repeat BP
  - Alas ….

Process Measure: Repeat BP Taken



Sustainability

- Maintain monthly data for accountability
- Frequent reminders for staff
  - Use data visuals such as run charts as motivator/reminder
  - Reminders during staff meetings/huddles etc.

Parma VA Outpatient Clinic
17 PACT teams (Primary care provider, RN, LPN, and AMSA)
4 Pharm D providers
Veteran population

Team Members

Stephanie Licata, PharmD, BCACP, CDCES | Clinical Pharmacy Specialist
Katelyn McMillan, PharmD, BCACP | Clinical Pharmacy Specialist
Natasha Conley, PharmD, BCACP | Clinical Pharmacy Specialist
Dave McCluskey, RN, BSN | Assistant Nurse Manager
Donna Rosin, RN, BSN | Nurse lead
Allison Rogish, DO| Clinician lead

HEART HEALTHY OHIO INITIATIVE

Outcome Data: HTN Control 140/90

HEART HEALTHY OHIO INITIATIVE

PDSA #1: Accurate Blood Pressure Measurement

- Targeted education to Pact LPNs by RN and physician lead

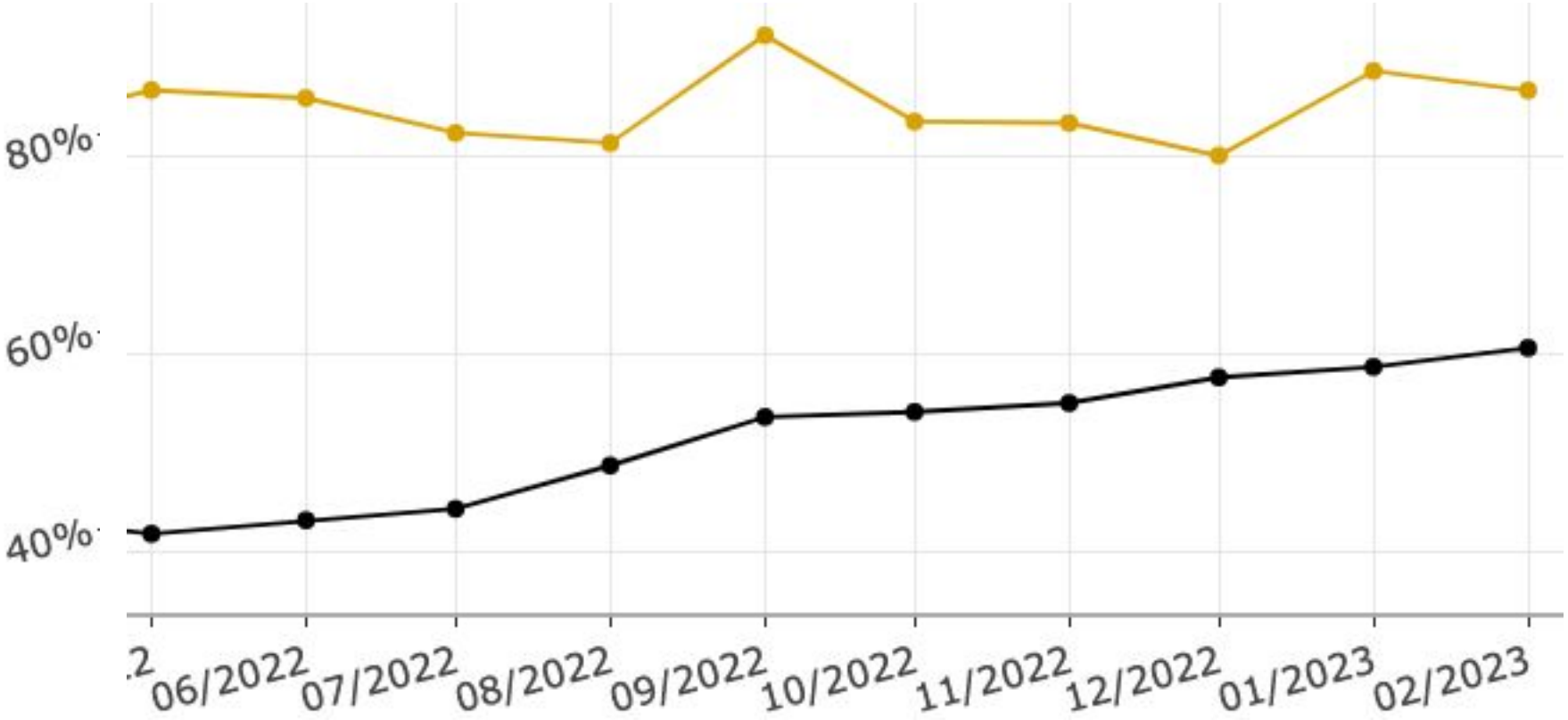
PDSA #2: Repeat Blood Pressure Measurement

- Ensured repeat BP's were taken
- Ensured accurate documentation-LPNs were instructed to repeat BP manually if initial reading was >140/90.
- Observation-BP's were being rechecked according to protocol by LPN. Exception is lack of time (i.e. patient late-then LPN would notify primary care provider to recheck BP).

PDSA #3: Timely scheduled follow-up visits

HEART HEALTHY OHIO INITIATIVE

Process Measure, PDSA #2: Repeat BP Taken



Learning from Testing

- We have learned that reviewing our technique is so very important for consistent results

- Start small – recognized going clinic wide would be futile – so selected 1 pod (6 PACT teams) to pilot

HEART HEALTHY OHIO INITIATIVE

Effective Process Measures/ Keys to Success:

- Renewed focus on HTN through HHOI participation.
- Each Team member understands goals and performs duties well.
- Getting staff buy-in.
- Having a Hypertension Champion- keeps an eye on data in real time.
- Project Lead helped to keep project on task and data visible to all stakeholders.

HEART HEALTHY OHIO INITIATIVE

What were some of your challenges/barriers?

- Significant staffing challenges
  - Staff turnover
  - Short staffed
  - New staff training

- Limitations to data interpretation
  - Capturing all data/visits (video visits)

- Easy access to data
  - Difficult to obtain data specific to PACT teams used for interventions

HEART HEALTHY OHIO INITIATIVE

How are you planning to continue and sustain your QI efforts?

- Continue to evaluate BP reports quarterly.
- Continue education and evaluate effectiveness of techniques quarterly.
- Educating patients on importance of BP control to decrease cardiovascular disease.
- Implement process for patient reminder calls for HTN nurse visit to decrease no-show rates.
- Maximize opportunities in RN visits with initiation of PharmD/RN collaboration.

HEART HEALTHY OHIO INITIATIVE

End of Storyboard Presentations

CERTIFICATE

OF PARTICIPATION

THE HEART HEALTHY OHIO INITIATIVE RECOGNIZES

Wave 1 Practices

for participation in the Heart Healthy Ohio Quality Improvement Project.

2022 - 2023

HEART HEALTHY OHIO INITIATIVE

HEART HEALTHY OHIO INITIATIVE

Chat Activity

What is one thing you heard during the storyboard rounds that you might test in your practice?

Data Sustainability

- Please continue to submit data monthly through **February 2024 (last data submission March 4, 2024)**
- After March 2024, no new data will be uploaded to the dashboard and data submission requests will end
- The dashboard may be unavailable after Dec 2024, so please **download any data or graphs you want prior to Dec 2024**
- Please work with your individual site level IT or vendors to support any continued data reporting needs to ensure sustainability of your work
  - You would need to let them know what you would like to continue to see moving forward and see if they can assist you
  - Our data team can join a call with your vendors or IT to assist with this transition

HEART HEALTHY OHIO INITIATIVE

MOC

- For those wanting to claim both MOC and CME credit through OAFP for the **American Board of Family Medicine**, please review the instruction sheet and complete the Credit Attestation Form
- For those wanting to claim MOC credit through Health Impact Ohio/Columbus Medical Association for the **American Board of Medical Specialties (ABMS)**, please complete the Credit Attestation Form
- **Please share this opportunity with eligible clinicians at your clinic.**
- **Instructions will be sent with the slides after today's webinar**

HEART HEALTHY OHIO INITIATIVE

Next Steps

- Continue to submit EHR data monthly (1st Monday of the month; next due May 1)
- Continue to submit data through February 2024 (submission date March 4, 2024)
- Please look out for a final survey to be sent out by email in July 2023

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