Additional Q&A from Webinar

Participants posed the following questions to presenters during the webinar. View the webinar recording here.

New Hampshire Specific Questions

- Is the patient hypertension registry a state registry or a registry within the Primary Care and Public Health (PCPH) Collaborative? How was this funded?

  The registry is not a state registry. Cheshire Medical Center/Dartmouth-Hitchcock Keene developed their own registry through funding from their community benefit program. The registries developed for Manchester and Nashua for Million Hearts was funded through the ASTHO Million Hearts Learning Collaborative, supported by CDC. Both health centers are members of the Community Health Access Network (CHAN) which assists with EHR data warehousing and report development. Now that CHAN has created the registry, it will be available to other CHAN members.

- This is great, but what is happening outside of the registry in the clinic? What is the healthcare team doing? Improved accuracy in measurement? Improved medication adherence? Others?

  The registry management process includes regular contact between patient data coordinators (PDC) and providers to discuss treatment planning. The registry is more than just a report, it is a tool to guide these discussions. Clinics have also implemented the blood pressure competency and equipment calibration training, instituted wallet cards, and are beginning to implement triaging and medication algorithms.

- Speak to the challenges of suggesting and implementing a hypertension registry? Including challenges in communicating to stakeholders why this might be desirable?

  Challenges include building the report functionality to live within the EHR as well as the cost associated with it. Further, training staff to become PDCs and attaining provider engagement in the process can be challenging. Developing a center-specific work flow is needed and there can be barriers to this change. The registry does not live on its own. There is a provider dashboard piece as well. Providers are able to use the registries to see how their patient pool is doing, but the dashboard shows providers how they compare to each other, promoting a bit of competition.

New York Specific Questions

- How have states engaged with health plans? And Medicaid MCOs in particular? Have there been any change to the MCO contracts or quality measures used to evaluate the plans?

  We involved the MCOs 3 counties where we are working with county health departments and the FQHCs. They’ve been part of the discussion and workgroup there. We have not changed the MCOs at this point. The Medicaid MCO contracts include a public health component that governs issues such as paying for services that county health departments would provide (e.g., TB testing). We are 10 months into the process and are hopeful we will see improvements in this area.
This collaborative created a forum for the conversations between the health centers, the providers, and the health plans to identify areas where there are opportunities to work together to improve population level care and identify areas they can explore together. To that end, the practice identified a complete list of patients that were identified according to their primary care provider so being able to look more broadly across their panel of patients, versus just patients that come into their health center for care. Are there any opportunities to work with the health plans to do outreach to those who are assigned to the FQHC but are not coming into care? How can they work together to bring those patients in? The other example was how to get information about Medicaid fill rates, which is difficult at the practice level. With the plans and our Medicaid partners we have our pilot test looking around Medicaid data to see if we can create a method for giving fill rate data back to the FQHCs. These are very specific examples that came out of that forum and that opportunity will continue as we move forward.

**Oklahoma Specific Questions**

- Can Oklahoma share the standardized blood pressure measure protocol? What type of care coordination policy needed to be accomplished?

Click [here](#) for the standardized blood pressure measure protocol

To support and encourage the use of a care coordination team for the care and treatment of high blood pressure, a care coordination policy template was developed which calls for the collaboration of primary care, pharmacy, community-based services, and the local health department as team members. The policy is currently focused for use in hospitals, large medical clinics, or large specialty services. The intent is to position the care coordination model when treating high blood pressure as a routine population based intervention. The policy and template are under review by the regional medical hospital and a large community based medical clinic. Once edits have been received and finalized we will make the policy template available.

- Can you elaborate on the healthcare compensation component provided by Blue Cross Blue Shield?

Current healthcare delivery paradigms compensate clinicians using a fee for service strategy. This strategy relies upon continued visits by patients for treatment of illness rather than visits to monitor and maintain health. Strategies for advancing health rather than treatment of illness have been shown to reduce preventable hospitalizations, reduce morbidity and mortality and result in engaged and empowered patients. To achieve a shift in the focus of healthcare compensation systems, a new paradigm will require cooperation between clinicians and private and public compensation systems. In pursuit of a new compensation paradigm, Oklahoma proposed a model designed to pay providers for performance. Specifically a global payment to the care coordination team will occur when a patient’s blood pressure goal is achieved based upon nationally adopted treatment and management protocols. This pilot project allows for the study of care coordination focused on the control of high blood pressure in actual clinical settings with active participation between providers, provider systems, and public and private compensation systems. The opportunity to identify issues between care delivery and payment structures in a “controlled” environment offers an opportunity to learn before implementing the model on a larger scale.
Partnerships developed as a result of establishing the Heartland OK Leadership Team allowed for dialogue between clinicians in McAlester and public and private compensation systems in Oklahoma. That dialogue led to a request by Blue Cross Blue Shield of Oklahoma to pursue the development of a value-based care coordination allocation logic model with the long term outcome of achieving a decline in preventable heart disease deaths. The Heartland OK Paying for Performance logic model was developed which outlines four primary influencers associated with achieving patient-centered controlled blood pressure and includes activities connected to clinicians, county health departments, pharmacists, and providers of community-based services. Recognizing the need for “buy-in,” a meeting was held with representatives from each of the four influencers in McAlester, and a separate meeting was held with representatives of Blue Cross Blue Shield of Oklahoma. This approach was used to allow open conversation and to not unduly influence decisions. Discussion focused on identifying outputs that have value connected to achieving short and intermediate outcomes. Inherent in both of these outcomes is the need to place responsibility on the patient and on the community where the patient lives and their care delivery system. Outcomes of the meeting with clinicians in McAlester resulted in establishment of an allocation model reflecting a global payment to the hypertension management team based upon percentages agreed to by all meeting participants. Innovative to this model is the agreement to not receive the global payment if the patient does not achieve NQF 18 or a medically accepted blood pressure goal. The adoption of such an approach signals a movement toward payment for performance where maintaining health is more highly valued than monitoring illness. Global payments are made to the care coordination team via contractual agreement between the Oklahoma State Department of Health, and care coordination team members.

Vermont Specific Questions

- You mentioned an FQHC doing very thorough work with panel management, would you expound?

What we in public health call panel management is referred to by some clinicians as “population management” for their patient populations. This particular FQHC has queries they use on a scheduled basis that address specific combinations of conditions known to be costly or challenging to control for their clinic (and probably for primary care sites in general). For example, they regularly check “patients with HTN and no documented LDL in the past year”, and then they will further refine their search for “LDLs > 130 in the past”, to hone down their lists to the most important patients for follow-up. They have a schedule by quarter that maps out what reports they run, and they have a weekly meeting with key staff for 1.5 hours to discuss the ongoing results of these queries regarding the actions they’ve taken with the patients.

One strategy suggested to practices: “develop or steal a data-based case identification strategy and use it”. Case-by-case care management wastes a lot of time from excessive case loads. If the practice just starts with a standard query that was useful to another practice, it will eventually lead to useful queries for that practice. One suggestion that would hone in on patients needing attention = BP > 140/90, LDL over 130, A1C > 8.5 (and if PHQ for depression was used, adding in those with depression).

- What is the funding source for the BP monitors you are using?
ASTHO’s Million Hearts Learning Collaborative grant, supported by CDC, was our funding source, and I’m hoping that CDC will allow 1422 funds to also allow this expense. 1305 did not allow it; WISEWOMAN did allow it. There is inconsistency within CDC about considering BP monitors as “equipment” versus “supplies”. I think that these should be considered supplies and allowed in limited amounts when tied to clinical care. They are needed to test system improvements.

Questions for All States

Q: Did states use any of their HIE to aggregate data to community clusters, not just practices?

- VT: I’m not sure but I believe that our Blueprint for Health team (who have done the most with data) is NOT using our HIE, but rather is using a contractor that can manipulate data within our all payers claims database to attribute claims to practice, to provider, and to health service areas. This contractor is also examining outcomes data through a state registry to see if it’s “clean” enough to include in the “practice profiles” they are generating that are currently now just based on claims data. At the health department we are using a different version of our all payers claims database for the analysis that we are doing.

- NY: The HIE data will be by zip code for Albany County in NY and will capture hypertension prevalence, rates of hypertension control and undiagnosed patients with hypertension. We are currently analyzing the data.

- OK: No. Initial analysis for determining locations to place Heartland OK was made using BRFSS data.

Q: What worked best to engage the private practices/groups to buy into MH?

- OK: We put in some financial incentives that was really important to send the message that their time is valuable and well spent being engaged in this particular collaborative. It allowed us to have an entry point to get our foot in the door as we heard from providers over and over about unfunded mandates, too many demands on physicians and healthcare providers. It gave us some credibility that we’re serious about this in terms of putting our money where our mouth is and putting some money behind that to incentivize that. The other piece that we believe will become more apparent is that it’s a win for everyone. It helps the physicians better manage patients that they haven’t necessarily been as successful in managing in the past. As those data start to come back, we believe we will create that quality improvement cycle with the quick feedback for the providers so they can see the benefits of engagement. But I think it really took a realignment of the incentive system for that initial engagement.

- NH: We have not really used the payment incentive. We partnered with the medical society to get a dissemination of this approach and have a partnership group of the medical society between public health and the clinical community working specifically on this project. The medical society put money to hire an intern to go around the practices in a particular region to try and proselytize about the approach. We understand by showing the small cards and engage in the general providers is the first step in the wider engagement of private practices that we would love to do basically through the main insurer in NH. They are willing to work with us. It has been an issue of timing and funding which we are trying to work through.
Q: Have you received any feedback from clinicians on the value of receiving info on Medicaid patients' fill data?

- VT: My answer to this is more complex as I am also struggling to sort out terms and who is poised to use these data, who is not, where should data come from, and what it really means. We want to avoid having our payer partners spend lots of time pulling data that is not useful, and we are getting mixed messages about how useful it is. Comments have included “no time to do the chart audits that these data necessitate”, “data is old; PCPs already addressed with corrections before I did the chart audit”, and “this was helpful to show us that the poor medication possession ratios (MPRs) were for reasons unrelated to care management.” I wonder if a clinic like the “population-managing” FQHC could provide Medicaid a list of patients with poor BP control, and then Medicaid could run MPRs just for those patients, would it help both clinic and payer in saving time. My latest info from the BCBSVT pharmacy leader recently also helped clarify terms. Prescription fill rates are related to the percentage of written prescriptions that are actually filled. Since health plans (payers) only know when a prescription is filled and not when it’s written, they won’t measure prescription fill rates but rather they measure MPRs. But for some FQHCs like the one I’ve been referencing, their patients may also use a pharmacy on site. And by considering the prescription fill rates and the MPRs for patients showing poor control, will that help with this group’s population management?

- NY: The request for this information came from the providers participating in the collaborative. The data is still being analyzed, providers have not received a report on the findings as of today. The plan is to share with them once the analysis is complete.

- OK: The Medicaid reverse notification project is currently being reviewed by providers in Heartland OK target counties. We have not received feedback to date on refill data. Once obtained we will pass along.

Q: I have found that there are few materials explaining the ABCS of heart disease and stroke prevention written for low health literacy populations. Have any of the participating states developed new patient materials to foster patient engagement in their own health specifically around heart health?

- NH: The wallet cards contain information on the basics of a healthy lifestyle and how making proper choices can positively impact health. The cards are available in English, Spanish, and Portuguese, and an Arabic version is coming.

- VT: VT has been in touch with the NH Dept of Health and got permission to share their lower literacy, black and white versions of the DASH diet developed independently of the DASH resource we referenced in our slides. The black and white version was intended to be used within some of the state’s EHRs.

- NY: NY State has an extensive chronic disease self-management network, our collaborative has promoted the referral by providers to these evidence based programs. NY State has also developed a low literacy manual for patients on how to take a home blood pressure measurement for a specific model of home BP monitor, see attached.

- OK: Agree. We are discussing health literacy with internal partners focusing on health equity. To partially address this concern, physical activity and nutrition staff located in the five targeted county health departments who are part of the Heartland OK care coordination model developed the attachment for use with Heartland OK patients. The design of the material is for use by the patient alone and through the care coordination team. None of the materials are new but adapted to
address literacy issues in the target area.

Supporting Documents

- [OK Blood Pressure Measurement Procedure](#)
- [OK Heartland Revised CHD Patient Education Packet](#)
- [NY Blood Pressure Booklet](#)
- [NH-VT DASH to Health for Medical Record](#)