National Rural Health Day Webinar: Rural Clinics’ Role in Hypertension and Diabetes Management: A Webinar and Peer Discussion for Primary Care Offices

Association of State and Territorial Health Officials (ASTHO)
November 16, 2016

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National Rural Health Day Webinar: Rural Clinics’ Role in Hypertension and Diabetes Management
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New Hampshire State Health Improvement Plan

2013-2020

Charting a Course to Improve the Health of New Hampshire
State Health Improvement Plan

- Tobacco
- Obesity/Diabetes
- Infectious Diseases
- Cancer Prevention
- Cardiovascular Disease
- Healthy Mothers and Babies
- Misuse of alcohol and drugs
- Asthma
- Injury Prevention

Promote Health
Protect Communities
Prevent Disease

Surveillance & Epidemiology
Emergency Preparedness
Rural New Hampshire by Public Health Region
Baby Steps

- Small State Office of Rural Health (SORH) with limited funding so Rural Health Clinic (RHC) TA started off as offering stipends for attendance at the National Rural Health Association RHC Conference and ad-hoc requests for information around CMS guidelines, required shortage designations, and receiving automatic designations.

- Created and had approved Governor Designated Secretary Certified Rural Health Clinic Designation Policy
Bigger Steps

- Worked with the National Organization of State Offices of Rural Health (NOSORH) to perform needs assessment of all NH Rural Health Clinics to determine future planning for TA network.
- Identified internal partners (in Public Health) that may have programmatic goals of reaching rural providers.
- Began working with the Chronic Disease Section on joint Request for Proposals for Rural Health Clinic TA Network. TA Network would cover basic RHC needs but also need to include a clinical QI component.
Funding

- Health Resources and Services Administration - State Office of Rural Health Grant $30,000/year which covers the basic infrastructure and webinars.

- Centers for Disease Control - State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health 1305 Grant $80,000/year for first two years, $65,000/year for next two years.
Partnerships

- JSI Research & Training, Inc. (JSI)
- The Institute for Health Policy and Practice (IHPP) – University of New Hampshire
- Rudolph Fedrizzi, MD
  - Cheshire Medical Center/Dartmouth-Hitchcock Keene
4,084 RHCs Nationally

Rural Health Clinics (RHCs)

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; April 2015.
Note: Alaska and Hawaii not shown to scale
Antrim Medical Group
Cottage Hospital Internal Medicine
Dartmouth Hitchcock – Plymouth
Newfound Family Practice
Newport Rural Health Clinic
North Country Primary Care
Plymouth OB/GYN
Saco River Medical Group
Speare Primary Care
Weeks Medical Center – Stratford
Weeks Medical Center – Groveton
Weeks Medical Center – Lancaster
Weeks Medical Center – Whitefield
Westside Health Care
NH RHC TA Network

**Goal:** To provide support to Rural Health Clinics based on determined needs.

**Strategy:** Develop an ongoing Technical Assistance (TA) Network targeting all certified NH Rural Health Clinics (RHC) for communication, learning and assessment.

**Overview:**
- Needs Assessment
- Technical Assistance Webinars
- Collection of Clinical Measures Data (Hypertension/Diabetes)
- Action Learning Collaboratives (Hypertension/Diabetes)
Needs Assessment
Services of NH RHCs

- Primary Care
  - Family Practice, Internal Medicine, and Pediatrics
- Obstetrics/Gynecology
- Behavioral Health
- General Surgery
- Diagnostic Orthopedics
- Podiatry
RHC Provider Types

- NP
- FP
- PA
- Ob/Gyn
- IM
- Podiatry
- Pedi
- Psych
- Surgery
## NH RHC Payor Mix

<table>
<thead>
<tr>
<th>Payor Type</th>
<th>Average %</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>24.92%</td>
<td>10 - 60%</td>
</tr>
<tr>
<td>Medicare</td>
<td>30.24%</td>
<td>5 - 50%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>41.6%</td>
<td>35 - 57%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.24%</td>
<td>0 - 6%</td>
</tr>
</tbody>
</table>
Technical Assistance Needs

- Clinical Integration: 62%
- QI: 62%
- Practice Management: 54%
- Billing: 46%
- MU: 46%
- CQM: 38%
- Data collection/reporting: 31%
- HIE: 31%
- Financial reporting: 23%
Technical Assistance Webinars

- Introduction to Rural Health Clinics
- RHC Recertification
- Recruitment and Retention
- Conducting a Practice Operational Assessment
Collection of Hypertension Data

- NH Accountable Care Project EMR Web Reporting Portal
  - Quarterly reports
  - Comparisons to state RHCs median and all providers participating in the Accountable Care Project
- Assistance to RHCs for proper data collection and accurate reporting
Action-Learning Collaborative Objectives

• Promote/help develop collaboration within and across RHC clinical practices and communities.

• Teach teams how to evaluate their clinical practice cultures and patterns within the context of desired outcomes.

• Support RHC teams in their application of action-based learning techniques and improvement science to facilitate practice changes that result in improvement.

• Apply *The Ten Steps for Improving Blood Pressure Control in New Hampshire* as a guide to unlock leadership skills, and promote change in practice.
Learning Collaborative Process

- Pre-Work
- Problem Identification
- Intervention Planning
- Coaching Support
- Reflection
YOU ARE HERE

Pre-work

Call #1
Kick-off Webinar

2015
Sep Oct Nov Dec Jan Feb Mar Apr May June 2016

Action Period
Intervention Implementation

Problem Identification & Intervention Planning
January 11, in-person meeting: Kick-Off

In person meeting:
Reflection
Pre Work
GLOBAL AIM: We aim to improve hypertension control in our practice or team. The process begins with establishing our baseline (% of patients with BP < 140/90) and ends with achieving 85% of our patient population’s BP in control for 3 months.
Global Aim

1. GLOBAL AIM: We aim to improve hypertension control in our practice or team.

2. The process begins with establishing our baseline (% of patients with BP < 140/90) and ends with achieving 85% of our patient population’s BP in control for 3 months.

3. Aim is based on population data (Million Hearts® & local competition)
Engaging Providers and Staff: Survey

Most practitioners:
- Set goals with patients
- Encourage use of self management tools (logging blood pressure)
- Make lifestyle recommendations

Fewer practitioners:
- Follow-up patients without appointments
- Refer to nurse clinic
- Provide printed educational materials
RHC Name:

5 P’ Assessment

**PURPOSE: What are we trying to accomplish?**

TO IMPROVE EMR REPORTING ABILITIES TO BETTER IDENTIFY PATIENTS WHO ARE IN CONTROL IN ORDER TO TARGET THOSE WHO ARE NOT IN CONTROL

**PEOPLE: Who will project serve?**

PATIENTS

PROVIDERS

EMERGENCY DEPT

NUTRITIONIST

PATIENT FAMILIES

**PROCESS: How do we do our work?**

Patient Checks-in to clinic at reg.
Nursing staff weighs patient
Nursing staff brings pt to exam rm & reviews history
Blood pressure taken last prior to nurse exiting room
Provider – reviews vitals, labs, if elevated BP PCP takes BP

**PERSONNEL: Who is involved in Hypertension Management?**

<table>
<thead>
<tr>
<th>Front Desk</th>
<th>Laboratory</th>
<th>ER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Nursing/ Medical Asst.</td>
<td>PCP</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>Cardiac Rehab</td>
<td>Patient</td>
</tr>
<tr>
<td>Fitness Centers</td>
<td>Local Grocery Stores</td>
<td>Food Bank</td>
</tr>
</tbody>
</table>

**PATTERNS**

What is working well?

All new BP equipment in 9/2015
BP taken at every visit for all pt’s.
Short wait times
Provider availability/same day appt

Where are the opportunities for improvement?

Better EMR Reporting
Have 2nd RHC employee CDSMP certified
Schedule CDSMP in early 2016
Patient Engagement to make 1 change
Gain access to more community resource
In-Person Learning Session
- Coaching in Action -
Problem Identification & Intervention Planning

January 11, in-person meeting: Kick-Off

In person meeting: Reflection
Teams Present to Each Other & Identify Common Enablers and Barriers

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ED relationships</td>
<td>• EHR reporting</td>
</tr>
<tr>
<td>• Reminders-appointments</td>
<td>• Lack of resources, people/time</td>
</tr>
<tr>
<td>• Front Desk-good check in</td>
<td>• Rapid growth/staff</td>
</tr>
<tr>
<td>process</td>
<td>• Multiple roles</td>
</tr>
<tr>
<td>• New BP equipment</td>
<td>• Need more community linkages</td>
</tr>
<tr>
<td>• BP measure each visit</td>
<td>• Cost of meds/co-pays</td>
</tr>
<tr>
<td>• Short wait times</td>
<td>• Transportation</td>
</tr>
<tr>
<td>• Community, relationships</td>
<td>• Low literacy, high poverty</td>
</tr>
<tr>
<td></td>
<td>• Lack of community</td>
</tr>
</tbody>
</table>
Evidence Informs Change Ideas

10 Change Ideas for Improving Blood Pressure Control
- Engaging Providers and Staff
- Shared Vision
- Workflow
- Accuracy of Measurement
- Sharing Data
- Registries
- Communication
- Engaging Patients
- Algorithms for Hypertension Care
- Community – Clinical Collaboration

GLOBAL AIM: We aim to improve hypertension control in our practice or team. The process begins with establishing our baseline (% of patients with BP < 140/90) and ends with achieving 85% of our patient population’s BP in control for 3 months.
Learn About the Evidence

Available for free by download:

Prioritizing Factors: Sphere of Influence

10 Change Ideas for Improving Blood Pressure Control
- Engaging Providers and Staff
- Shared Vision
- Workflow
- Accuracy of Measurement
- Sharing Data Registries
- Communication
- Engaging Patients
- Algorithms for Hypertension Care
- Community – Clinical Collaboration

Things over which we have control
Things we can influence but not control
Things outside our control and influence
Written and Specific Aims and Plan-Do-Study-Act

QUALITY IMPROVEMENT WORKSHEET

Team: 

Project: 

GLOBAL AIM
Create an aim statement that will keep your focus clear and your work productive. What are we trying to accomplish?
What is the overarching goal?
We aim to improve __________________________ (name the process) in __________________________ (clinical/administrative location). The process begins with __________________________ (where/when the process begins) and the process ends with __________________________ (where/when the process ends).

SPECIFIC AIM
Use numerical goals, specific dates, and specific measures. What is the area of focus?
By / / 20 (enter date), we aim to: __________________________ (e.g., increase/decrease/etc.) (name of measure)
from __________________________ to __________________________.

MEASURES
How will we know that a change is an improvement? List measures to track for project.

PDSA
PLAN (How should we PLAN the pilot? Who? Does what? By when? What baseline data do we track?)

Common Measurement Reinforce Operational and Strategic Objectives National & External Measures
Coaching
Coaching Role

Assists the practice teams to:

- Understand the practice and environment
- Establish a team
- Limit reliance on additional resources
- Examine processes
- Identify data
- Commit to ongoing efforts
- Track and share data over time (in and across organizations)
- Recognize the importance of community involvement
Help Teams to Acknowledge Challenges & Opportunities

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff changes</td>
<td>Reinforce strategic and operational priorities</td>
</tr>
<tr>
<td>Time</td>
<td>Start small</td>
</tr>
<tr>
<td>Small Teams</td>
<td>Share information</td>
</tr>
<tr>
<td>EHR upgrades/changes</td>
<td>Decrease redundancy</td>
</tr>
<tr>
<td>Data extraction</td>
<td>Harness what you do have</td>
</tr>
</tbody>
</table>
Map Current Process of Care: Flow Chart Example
Stick to Aim and Provide Tools

- Community, practice, patient
- Reinforce the evidence
- Track, trend and evaluate data
**Evidence-supported wallet cards in English, Spanish and Portuguese supported by the NH Medical Society**

**6 Steps to a Normal Blood Pressure**

1. Maintain a normal weight
2. Get at least 30 minutes of physical activity most days
3. Drink alcohol in moderation
4. Eat more fresh fruits and vegetables
5. Avoid tobacco
6. Reduce salt
   - Buy fresh, frozen or canned vegetables with "no salt added"
   - Use herbs, spices and salt-free seasonings
   - Eat home-cooked meals
   - Reduce food labels and buy low-sodium or low-sodium added versions
   - Eat fresh poultry, fish or lean meat
   - Not canned or processed varieties

**Questions to Ask Your Health Provider**

- Is my Blood Pressure good? What’s my goal?
- What would be a healthy weight for me? Do you have some suggestions to help me achieve and maintain a healthy weight?
- Do you have suggestions for a healthier eating plan that I could follow?
- Am I getting enough physical activity? How can I get more in a safe, enjoyable way?

**Dining Out the Healthy Way...**

- Decent, don’t splurge.
- Ask for dressings, gravies and sauces on the side.
- Skip away from fried and butter and cheese-basted, grilled, and breaded instead.
- Order water rather than soda.
- Share your entrée with a friend.
- Read nutritional labels on menus.
- Choose healthy heart selections.

**Know Your Numbers!**

<table>
<thead>
<tr>
<th>Ideal</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>&lt;120/80</td>
<td>&lt;120/80</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>&lt;80 BPM</td>
<td>&lt;80 BPM</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>&lt;200 mg/dL</td>
<td>&lt;200 mg/dL</td>
</tr>
<tr>
<td>HDL (Good) Cholesterol</td>
<td>&gt;40 mg/dL</td>
<td>&gt;40 mg/dL</td>
</tr>
<tr>
<td>LDL (Bad) Cholesterol</td>
<td>&lt;100 mg/dL</td>
<td>&lt;100 mg/dL</td>
</tr>
<tr>
<td>Weight</td>
<td>155-159</td>
<td>155-159</td>
</tr>
<tr>
<td>Waist Size</td>
<td>&lt;35</td>
<td>&lt;35</td>
</tr>
</tbody>
</table>

**Know Your Numbers!**

When it comes to **Blood Pressure**, you need to know your numbers!

What is **High Blood Pressure** and can it affect me?

- Systolic (the pressure when the heart pumps) = the top number
- Diastolic (the pressure when the heart relaxes) = the bottom number

**Sparks of Evidence**

- Systolic MD or above or Diastolic 90 or above
- Systolic 120 or less and Diastolic 80 or less

**Para Controlar Su Presión Arterial Alta y Que Puede Hacer al Respecto?**

- Sistólica (la presión cuando el corazón está bombeando) — el número de arriba debería ser menor de 140
- Diastólica (la presión cuando el corazón está en medio de latidos) — el número de abajo debería ser menor de 90

**A Healthy Heart needs 30 minutes or more of physical activity a day, at least 5 days each week**

- Take a brisk walk before breakfast or after dinner, or both!
- Wait the dog or walk with a friend
- Take the stairs
- Park farther from work or store
- Plan family outings and vacations that include physical activity — biking, hiking, swimming, dancing, etc.
- Draw a one-mile circle around your house on a map and commit to traveling everywhere within it by walking or bicycling

**Sodium Chart**

- Natural Cooking
- 77%
- 12%
- 8%
- 3%
- 2%
- 1%
- 2%
Education Tool Example

**DASH Eating Plan**

Dietary Approaches to Stop Hypertension

Eating nutritious foods will help you control your hypertension. The DASH diet emphasizes fruits, vegetables, low fat milk products, and whole grains. It is a Mediterranean diet full of nutrients that are good for you and your health. This eating plan is for 1,800 calories per day. The sample menu on the following page is based on this plan.

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Servings</th>
<th>Serving Size</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vegetables</td>
<td>4-5 per day</td>
<td>1 cup raw leafy green</td>
<td>Lettuce/kale/spinach, broccoli, green beans, squash, sweet potato, tomatoes, low sodium veggie juice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>½ cup chopped raw or cooked veggies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>½ cup vegetable juice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 medium fruit</td>
<td></td>
</tr>
<tr>
<td>Fruits</td>
<td>4 per day</td>
<td>½ cup cut fresh, frozen, or canned fruit</td>
<td>Apples, bananas, berries, oranges, pineapple, peaches, pears, grapes, melons, raisins, dried apricots.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>½ cup dried fruit</td>
<td>Limit juice to 1 serving/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>½ cup 100% fruit juice</td>
<td></td>
</tr>
<tr>
<td>Grains</td>
<td>6-7 per day</td>
<td>1 slice of bread</td>
<td>Whole wheat bread and pasta, English muffin, pita, oatmeal, popcorn, unsalted pretzels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¼ - 1 cup dry cereal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>½ cup cooked rice, pasta, grain</td>
<td></td>
</tr>
<tr>
<td>1% Fat or Non-Fat Dairy</td>
<td>2-3 per day</td>
<td>1 cup milk or yogurt</td>
<td>Reduce fat milk or cheese, fat free or low fat regular or frozen yogurt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 ½ ounce cheese</td>
<td>Choose lean meat and trim visible fat</td>
</tr>
<tr>
<td>Poultry Fish, Lean Meats</td>
<td>4-6 oz per</td>
<td>1 ounce cooked meat, poultry, or</td>
<td></td>
</tr>
</tbody>
</table>
Education Tool Example

Artificially Increased Blood

Several factors contribute to blood pressure levels and can raise them artificially, giving you a false blood pressure reading. Make sure you account for the factors below:

<table>
<thead>
<tr>
<th>When the patient has:</th>
<th>Blood Pressure can be increased by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A small cuff on</td>
<td>10—40 mmHg</td>
</tr>
<tr>
<td>Cuff over clothing</td>
<td>10—50 mmHg</td>
</tr>
<tr>
<td>An unsupported arm</td>
<td>10 mmHg</td>
</tr>
<tr>
<td>An unsupported back</td>
<td>6 mmHg</td>
</tr>
<tr>
<td>Unsupported feet</td>
<td>2—8 mmHg</td>
</tr>
<tr>
<td>A conversation going on or is talking</td>
<td>10—15 mmHg</td>
</tr>
<tr>
<td>A full bladder</td>
<td>10—15 mmHg</td>
</tr>
<tr>
<td>Arm lower than heart</td>
<td>2 mmHg for each inch lower than heart</td>
</tr>
<tr>
<td>Not been resting for at least 5 minutes</td>
<td>10—20 mmHg</td>
</tr>
</tbody>
</table>
Help Teams Share and Track Measures
Help Teams Share and Track Measures

Patients 18-85 years of age with HTN who have a BP <140/90 within the past year

Comparison of providers at different practice sites:
- Provider at Practice Site A: 62.1 in 2015 Q4, 86.6 in Q1 2016
- Provider at Practice Site B: 68.5 in 2015 Q4, 86.0 in Q1 2016
Hypertension Action-Learning Collaborative Practice

**Specific Aims:** Improve HTN by achieving control for 85% of patients with diagnosis of HTN.

**Run Chart, Data Measures (Outcomes):** 50% of patients received HTN handout cards, patient education and DASH diet.

Practice wide % increase (5 FP providers started 6 weeks after 1st provider)

Provider reached 85% control an increase of 17% during HALC

Practice from X to X %

**Workflow Before:** BP possibly being taken over clothing, with improper seating, without rest after walking to exam room. Rechecking BP was difficult – charge vs no charge.

**Workflow After:** Staff fully trained on proper technique with proper equipment. Patient education including cards-tracking, DASH diet and patient education posters. BP rechecks provided free of charge with handouts regarding availability of services.

**Patient/Community:** Patient awareness increased with display of things that effect BP readings.

**Educational Tools:** Use of the HTN cards, DASH diet

**Key Lessons from PDSAs:** Patient and staff buy in to change is essential. Free rechecks of the BP enabled better control. Having a systematic approach to the aim is also essential. Hard work pays off. Posting progress for all staff important. Progress reports to the providers urges them on. Meetings with staff groups throughout the office. Development of workflows both procedural and clinical.
Spread and Sustainability

- Diabetes
- Behavioral Health
- Pediatrics
- Geriatrics
- Women’s Health
- Cancer

Expand QI efforts based on population and practice data
Prework:
- Establish Team
- Conduct Baseline Assessment
- Develop Charter

Problem Identification & Intervention Planning
In person meeting: Kick-Off

Action Period
Intervention Implementation

In person meeting:
Reflection
Key Elements

- MOU – clearly defined roles
- ListServ
- Incentives
- In-person visits and frequent follow up via telephone
  - Assessment
  - Collect data
  - Inform of upcoming webinars
  - Learning collaborative
  - Survey
  - Response to individual questions/issues
Contact Information

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THANK YOU!

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