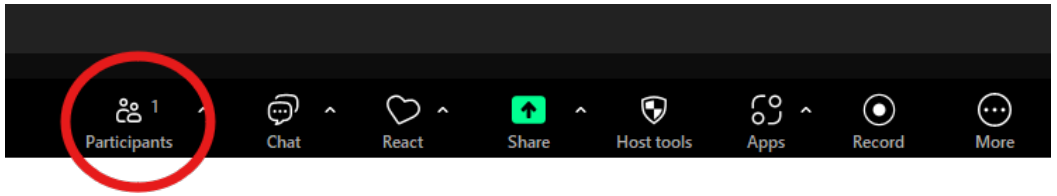
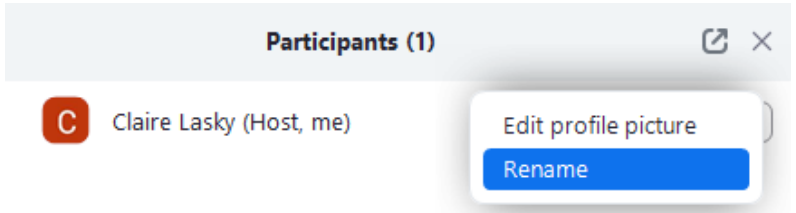
HealthChoices PCMH Learning Network Housekeeping

For introductions and breakout room assignment based on intervention of interest, please rename yourself to include the following:

Full name, Organization, either 1. BP or 2. Asthma





Blood Pressure & Asthma Sprint Learning Session #1

February 18, 2025

HealthChoices PCMH Learning Network

SUZANNE COHEN, SENIOR DIRECTOR OF POPULATION HEALTH, HEALTH FEDERATION OF PHILADELPHIA

Continuing Education Information

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and The Jewish Healthcare Foundation. The University of Pittsburgh is jointly accredited by the **Accreditation Council for Continuing Medical Education (ACCME)** and the **American Nurses Credentialing Center (ANCC)**, to provide continuing education for the healthcare team. **1.5 hours are approved for this course.**

As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the **Association of Social Work Boards (ASWB)** Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive **1.5 continuing education credits**.

Disclosures

No members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity **have relevant financial relationships** with any entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients **to disclose**.

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The PCMH Learning Network

Designed to support the PCMHs and MCOs in:

- ✓Achieving the shared aims of the HealthChoices PCMH Program
- ✓Identifying and acting on strategies in response to opportunities for improvement
- ✓Developing an internal capacity to continuously learn, adapt, and improve

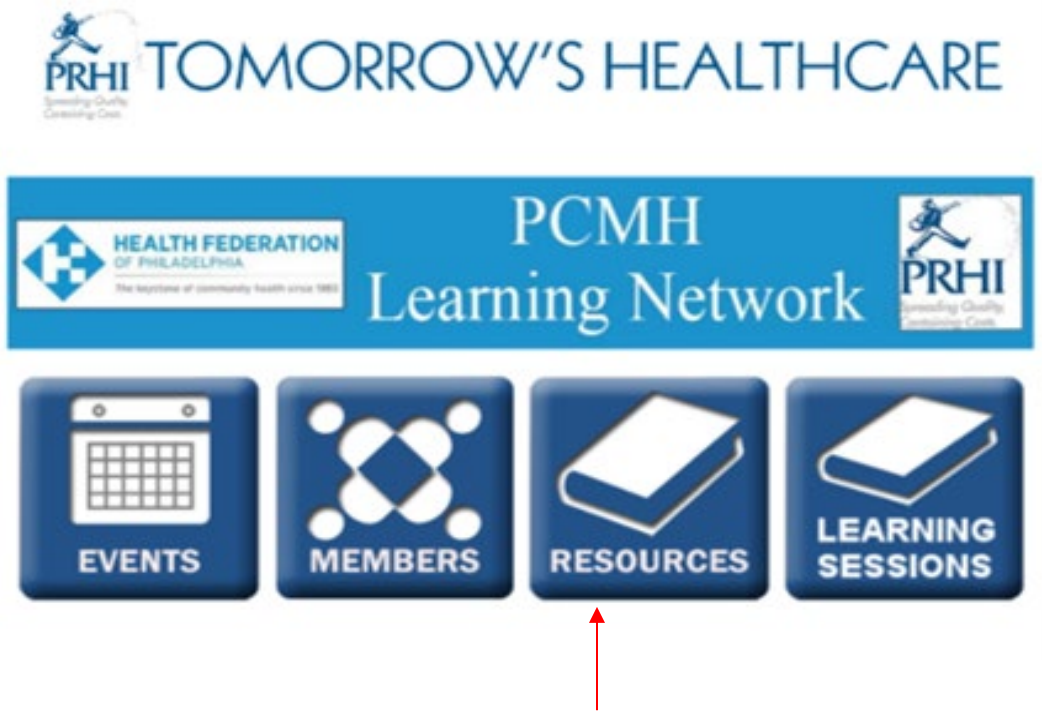
Access today's slides online

GO TO: www.tomorrowshealthcare.org

Your Login: The email address you RSVP'd with
Your Password: Welcome

To get assistance or access for your colleagues:
email Lisa at ***boyd@jhf.org***

PCMH Online Community



Keep track of upcoming sessions in "Events"

Access session materials in "Learning Sessions" Including slides and webinar recording

Look for guides and tools in "Resources"

Learning Objectives for Today

- ✓ Establish a shared understanding of the 2025 PCMH Sprint goals and framework for addressing blood pressure control and/or asthma medication ratio
- ✓ Define a key intervention each PCMH is addressing and next steps for making progress towards it
- ✓ Identify the root cause(s) to address as part of respective key intervention
- ✓ Describe practices that enhance the current approach to managing hypertension.

Agenda

1:00 – 1:10 p.m.	Welcome & Presentation of 2025 Sprint	Suzanne Cohen, Health Federation of Philadelphia
1:10 – 1:20 p.m.	Q&A	Suzanne Cohen, Health Federation of Philadelphia
1:20 – 1:40 p.m.	Peer to Peer Sharing	Break Out Rooms
1:40 – 1:50 p.m.	Group Report Outs	
1:50 – 2:20 p.m.	Hypertension Control Change Package + Q&A	Debra McGrath, DPM Healthcare Consulting
2:20 – 2:30 p.m.	Sprint Timeline, Next Steps & Evaluation	Suzanne Cohen, Health Federation of Philadelphia

Sprint Structure

SUZANNE COHEN, SENIOR DIRECTOR OF POPULATION HEALTH, HEALTH FEDERATION OF PHILADELPHIA

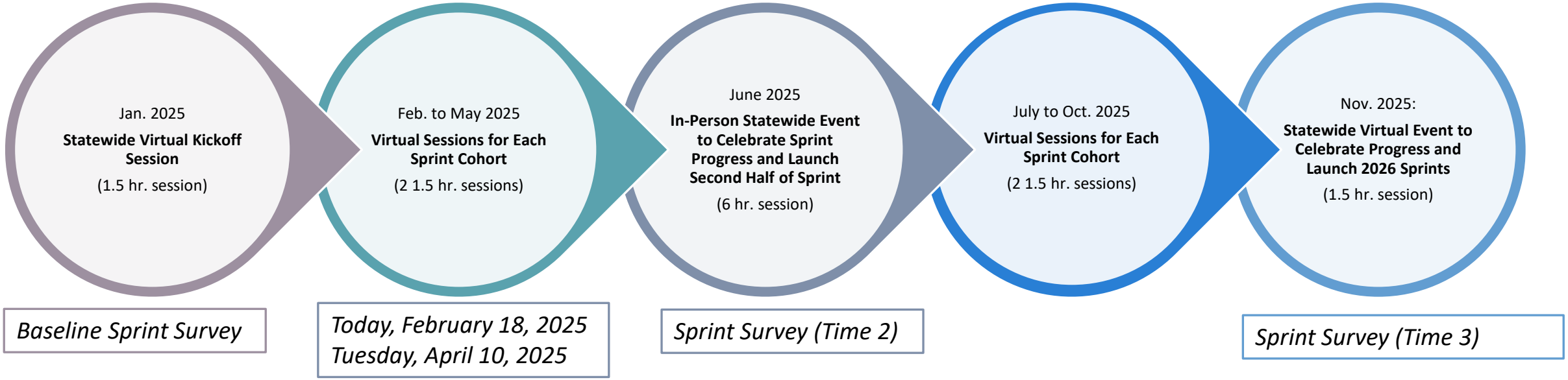
Blood Pressure Control & Asthma Medication Ratio Sprint Participating Practices

- Allegheny Health Network (Physician Partners of Western PA LLC)
- ChesPenn Health Services
- Community Health and Dental
- Delaware Valley Community Health, Inc.
- Evangelical
- Fair Hill Community Physicians
- Family First Health
- Geisinger Health System
- Laurel Health Center
- Mazzoni Center Family and Community Center
- Penn State Health
- Primary Health Network
- Family Practice & Counseling Network)
- Scranton Primary Health Care Center Inc
- Temple University Health System (incl. Temple Physicians Inc & Temple Faculty Practice Plan)
- Tower Health - Reading Hospital Medical Group
- UPMC Susquehanna
- Valley Health Partners Community Health Center

Goals and Intent of 2025 PCMH LN Structure

- Promote further engagement from and learning across PCMHs
- Increase awareness and alignment around key PCMH focus areas and best practices (within and across organizations)
- Apply best practices and lessons learned from other statewide learning networks (e.g., PA PQC, etc.)
- Demonstrate measurable impact
- Create a learning structure around these goals with the same number of learning hours for PCMHs (recognizing healthcare workforce shortages)

2025 PCMH Learning Network



Optional Case-Based Learning Sessions on Clinical Topics Offered throughout the Year

HEDIS Metrics: BP Control and Asthma Medication Ratio

HEDIS Measure: Controlling BP

"Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period"

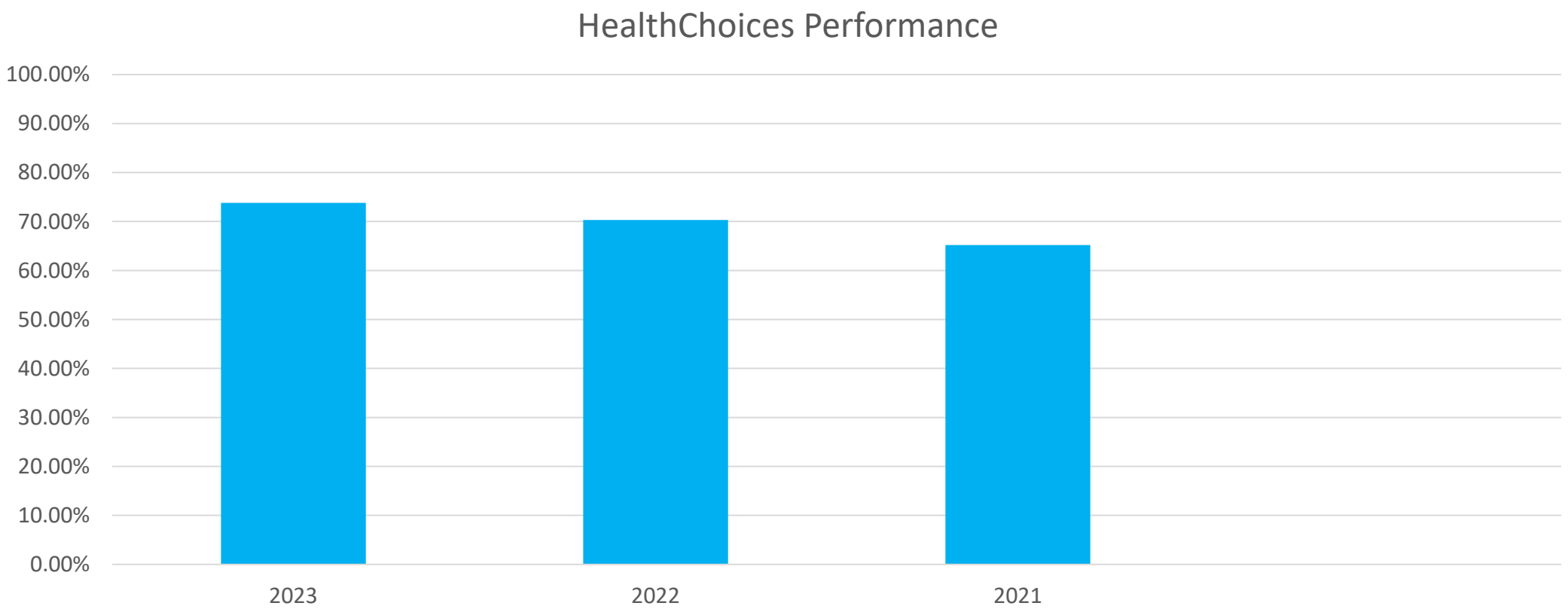
Measurement

- In reference to the numerator element, only blood pressure readings performed by a clinician or an automated blood pressure monitor or device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by an automated blood pressure monitor or device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the automated blood pressure monitor or device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record.
- Do not include BP readings taken during an acute inpatient stay or an emergency department (ED) visit.
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled".

BP Control: Measurement and reporting challenges

- Blood pressure is a clinical data element – only goes across on a claim if CPT II coding is used.
- Payers may be missing many BP measurements that are in the EHR without a supplemental data feed.
- Can be challenging to get an accurate BP measurement in an office setting.
- SMBP programs have technology, cost and staffing challenges.

Recent trends in BP Control



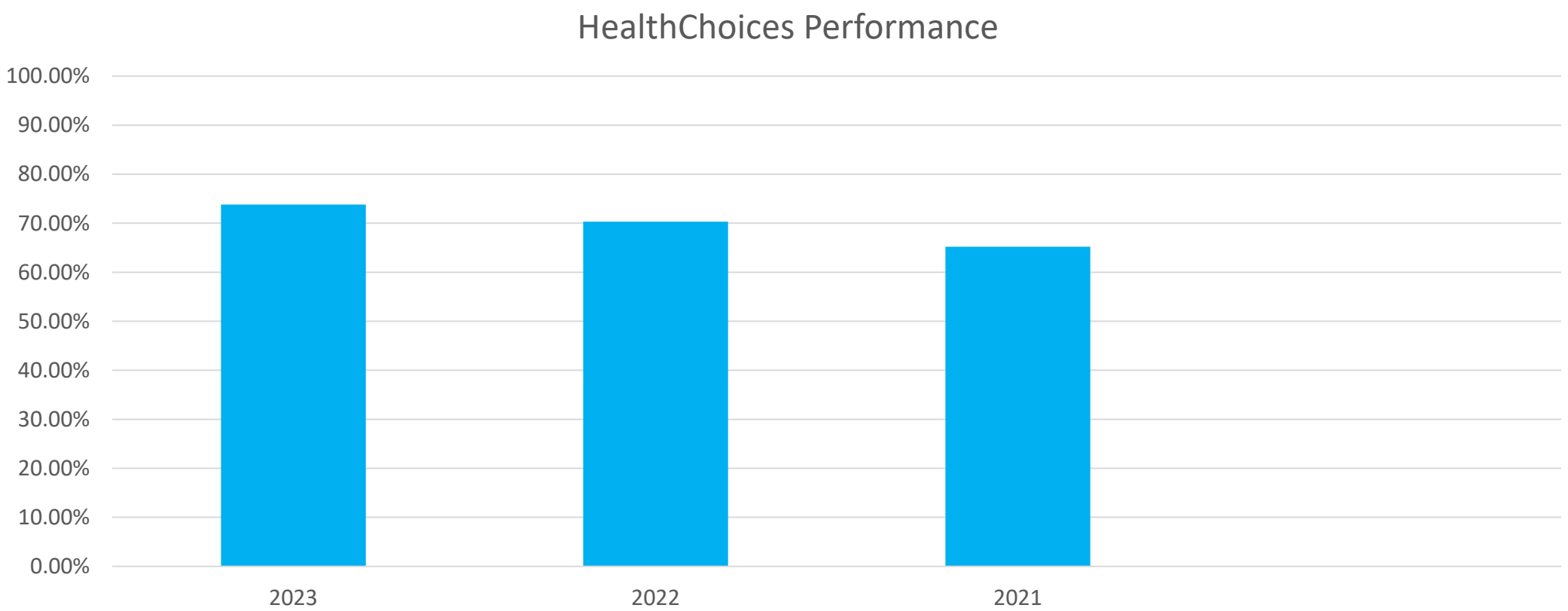
Asthma Medication Ratio

"The percentage of adults and children ages 5-64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year"

Asthma Medication Ratio: Measurement and Reporting Challenges

- Correct diagnosis of persistent asthma determines the denominator
- Difficult for providers to track and manage since the calculation is based on pharmacy claims
- Others?

Recent trends in AMR



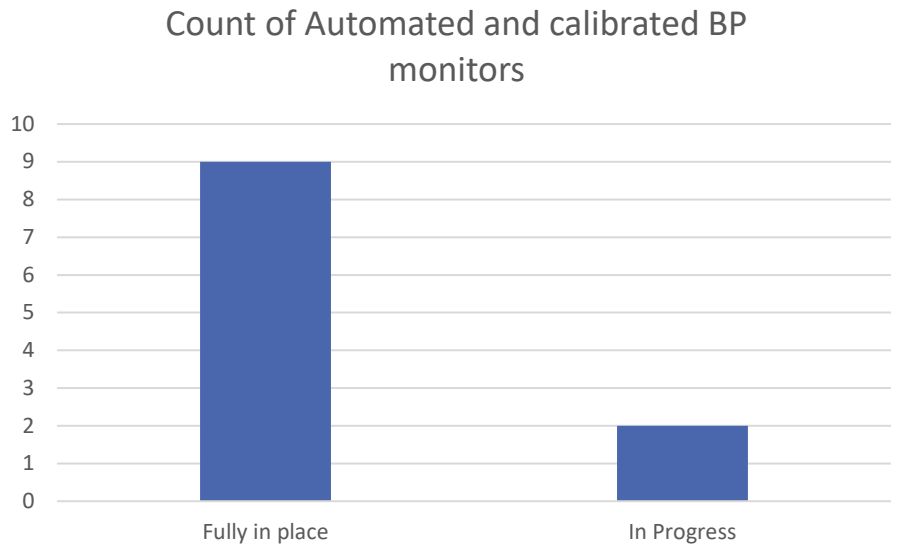
Key Interventions and PCMH Survey Responses

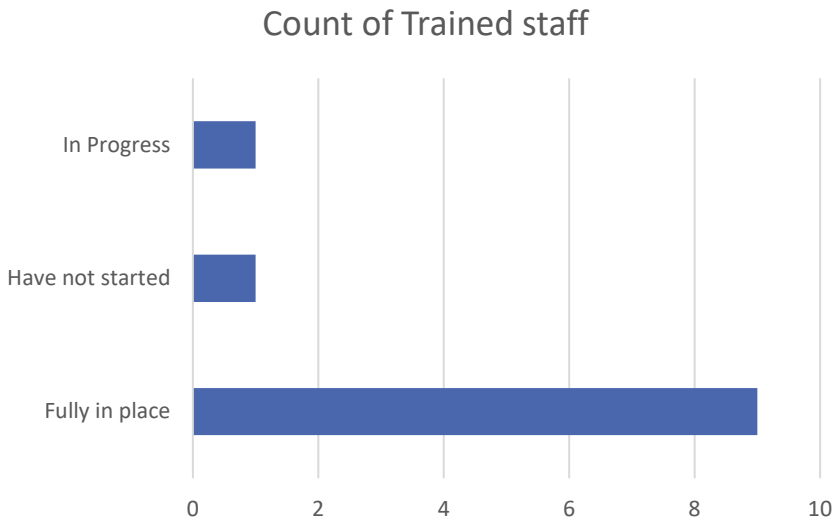
Blood Pressure: Key Interventions

- Consistent accurate in-office BP screenings
  - automated, calibrated BP monitors, trained staff, correct room set-up, taking BPs after patients have rested for a few minutes
- Use SMBP (Self Monitoring Blood Pressure) - validated cuffs, sending average BP in electronically for review and action by clinical teams
- Treatment algorithm - include both lifestyle change and medication - eliminate lags in treatment
  - Address both medication initiation and titration of the initial plan
  - Use of combination medications and reducing the number of medications
- Team based care - pharmacists, nurses, health educators, CHWs
- Address comorbidities
- Address disparities in the BP measure

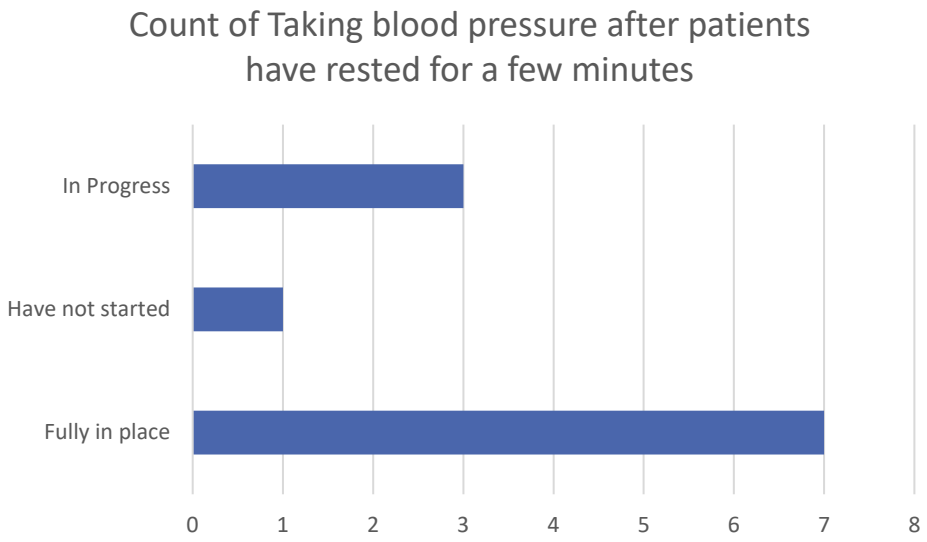
Key Interventions from Surveys: Blood Pressure

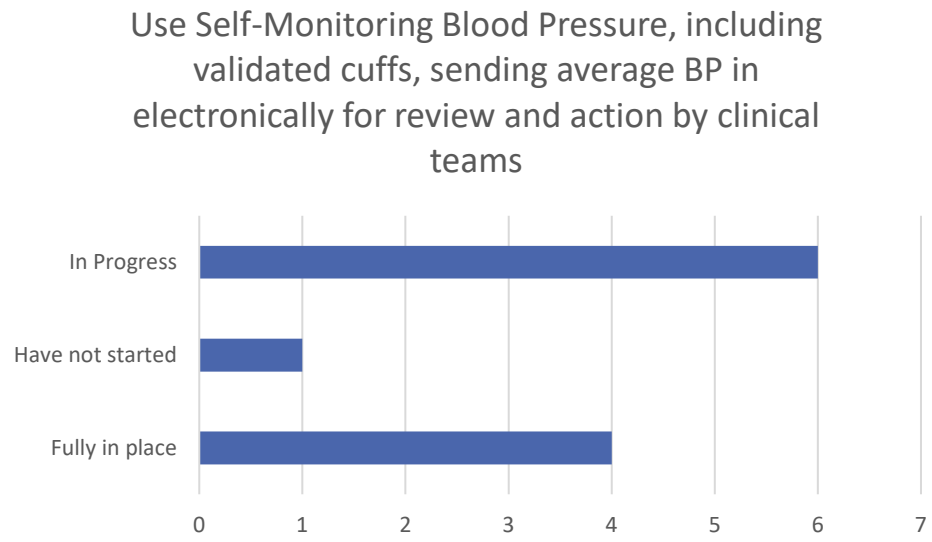
Implement processes and team roles for consistent, accurate in-office BP screening, including:





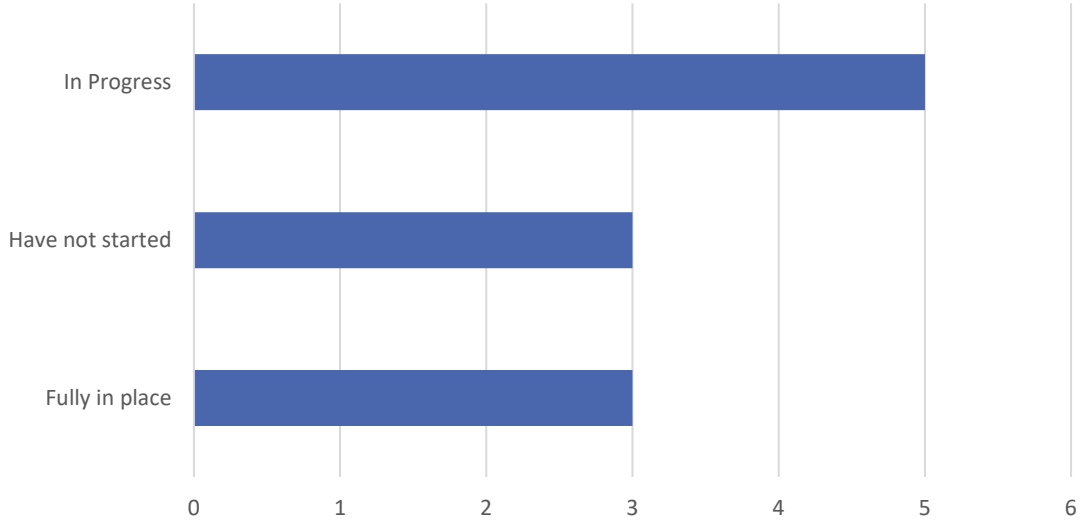
Key Interventions from Surveys: Blood Pressure



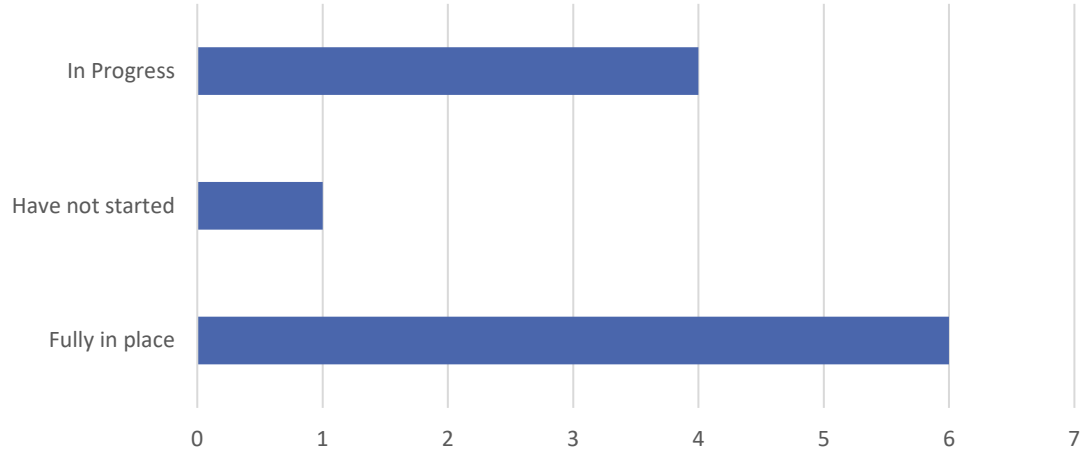


Interventions from Surveys: Blood Pressure

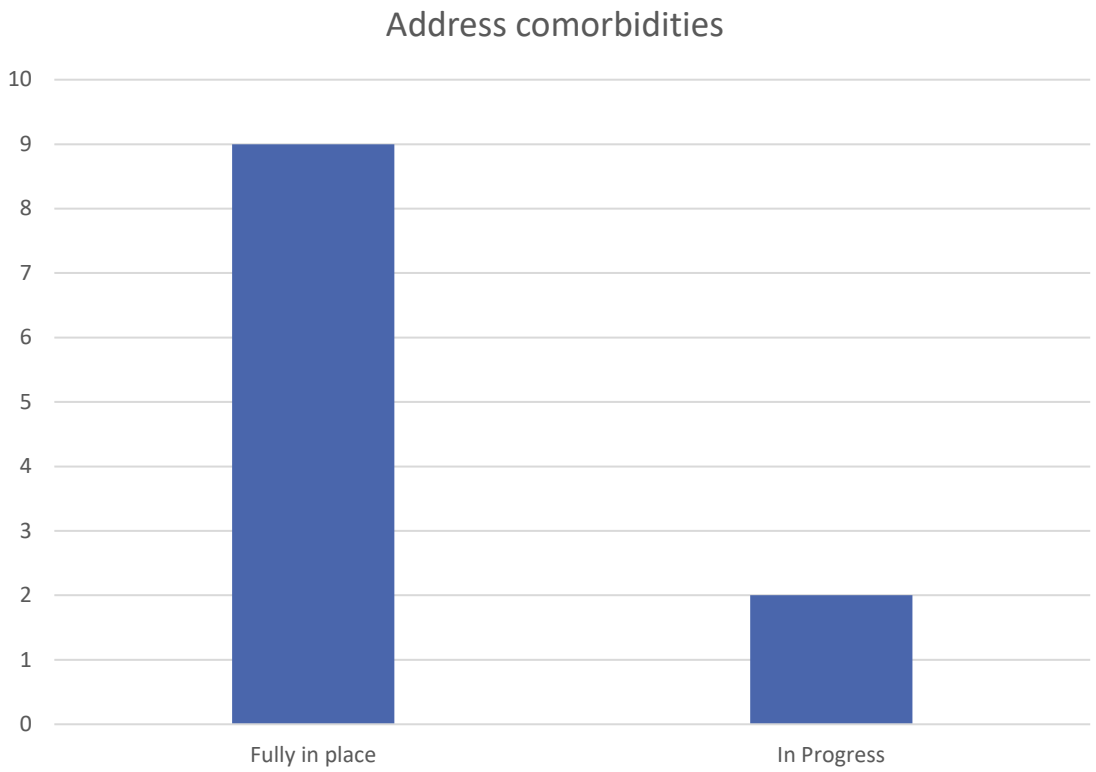
Develop and use treatment algorithms with lifestyle changes and medications initiation and titration to eliminate lags in treatment and reduce the number of unnecessary medications

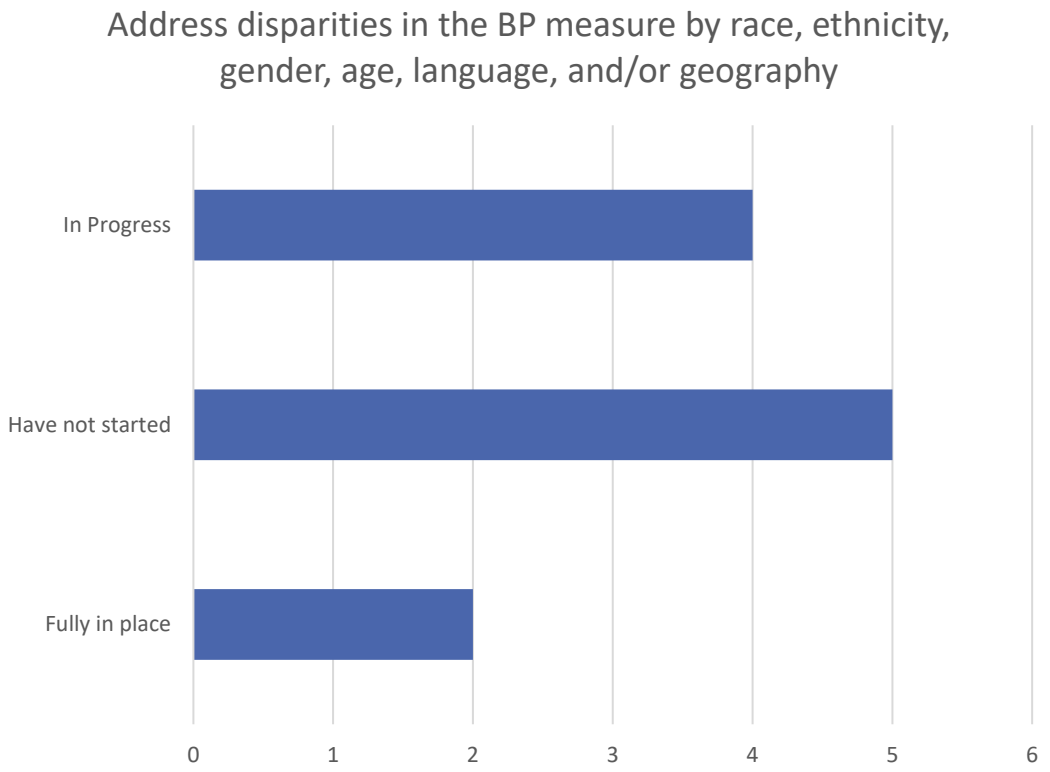


Develop a multi-disiplinary team with disciplines, such as pharmacists, nurses, health educators, and community health workers (CHWs)



Interventions from Surveys: Blood Pressure



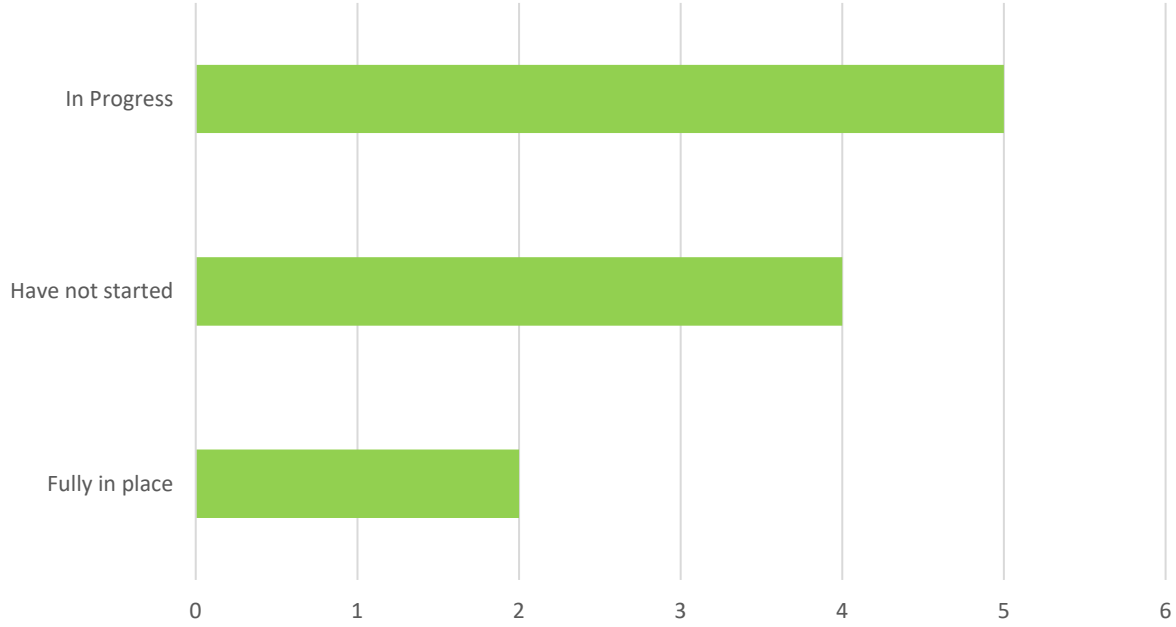


Asthma: Key Interventions

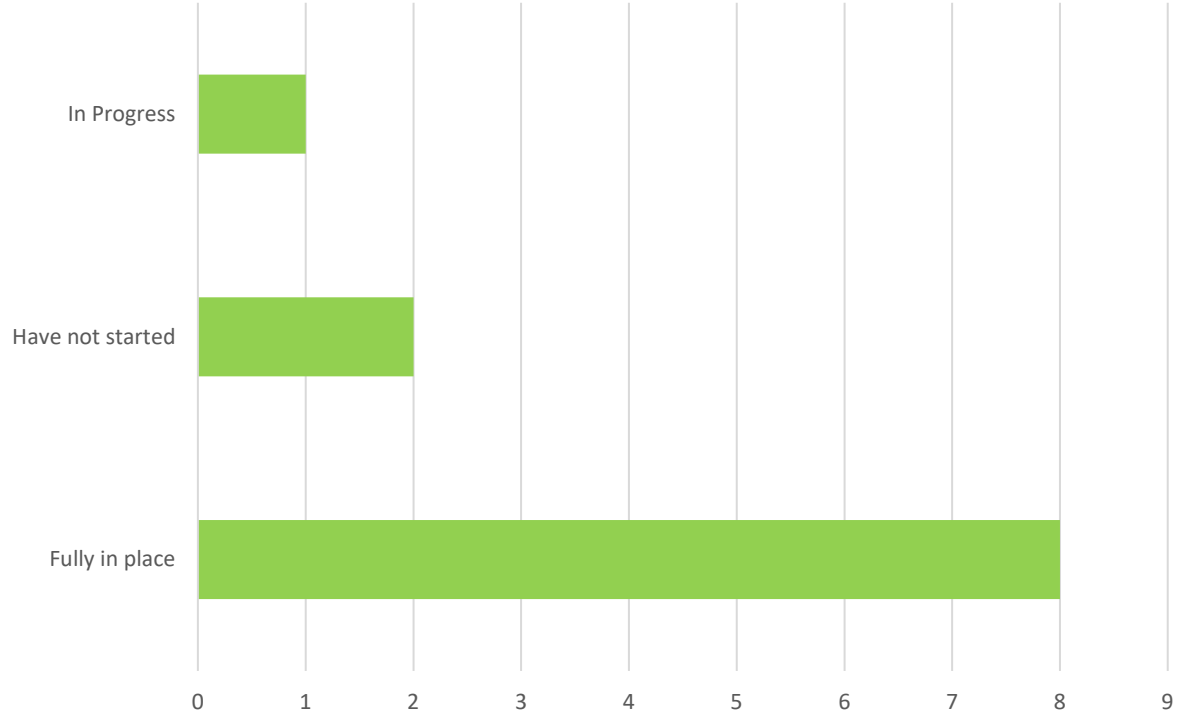
- Engage pharmacists, nurses and other team members in medication education and supporting ideal prescribing practices.
- Routine vaccination (including flu, etc.)
- Develop and implement a medication algorithm, defining ideal prescribing behavior for specific circumstances and incorporating Medicaid formulary restrictions
- Ensure correct diagnoses
- Evaluate and remediate environmental issues (home visits)
- Develop an asthma action plan jointly with patients

Interventions from Surveys: Asthma

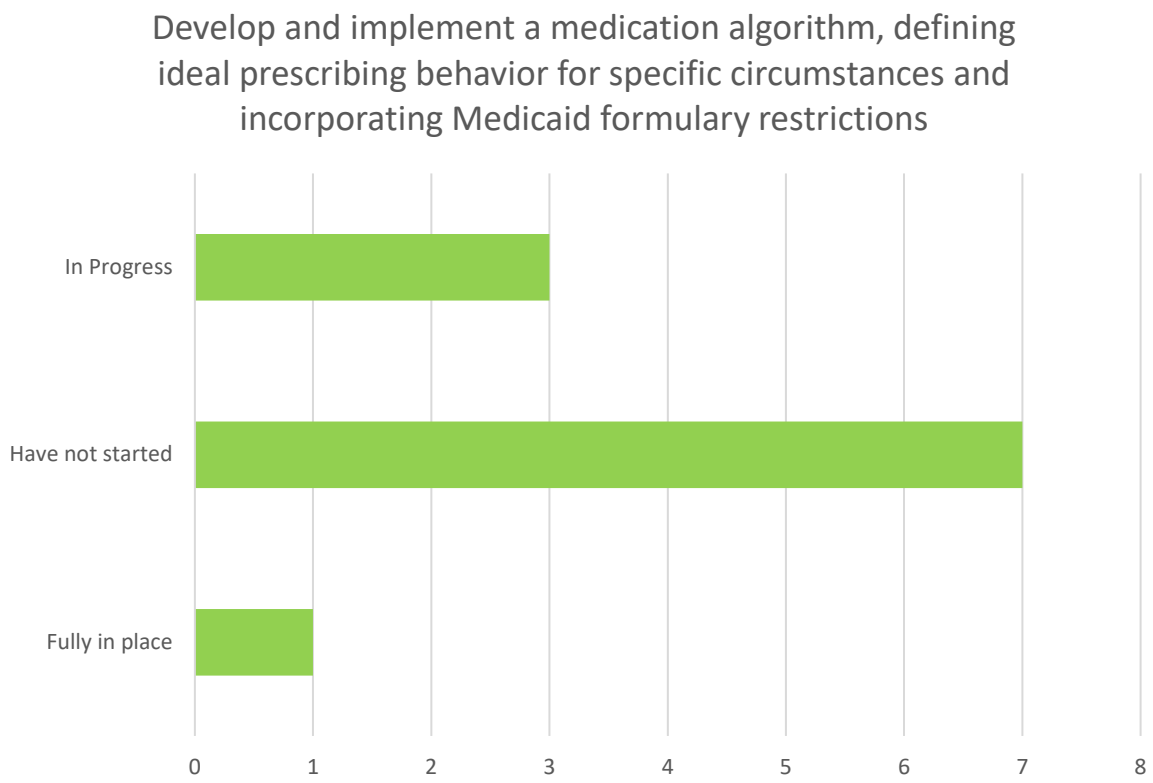
Engage pharmacists, nurses and other team members in medication education and supporting ideal prescribing practices

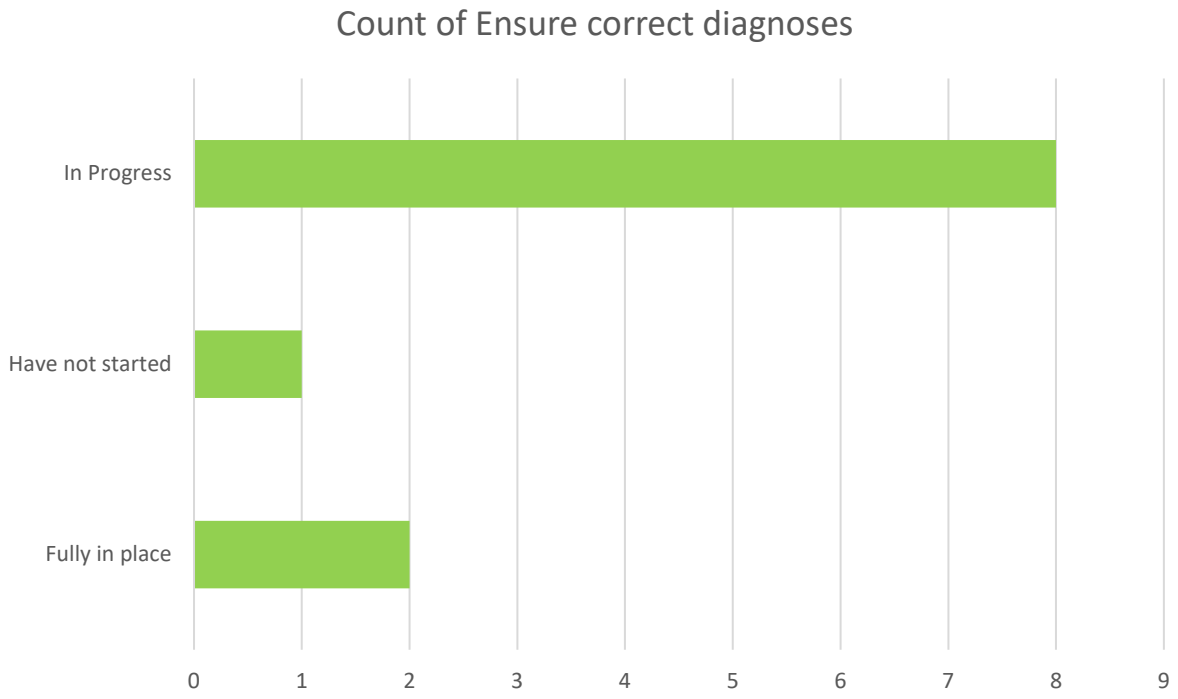


Implement processes for routine vaccinations

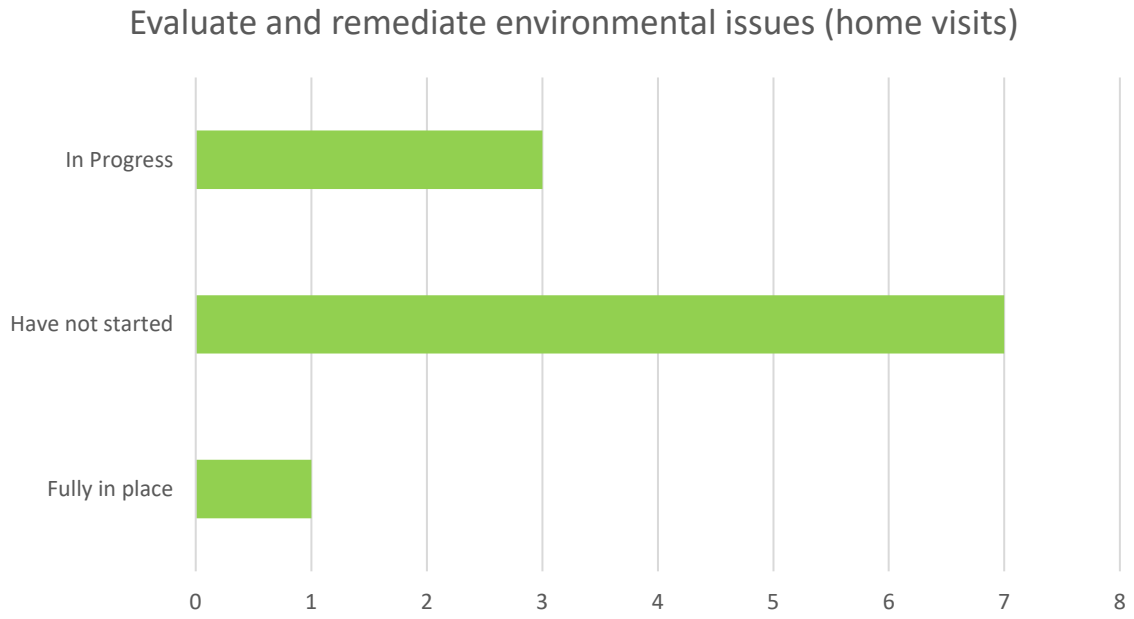


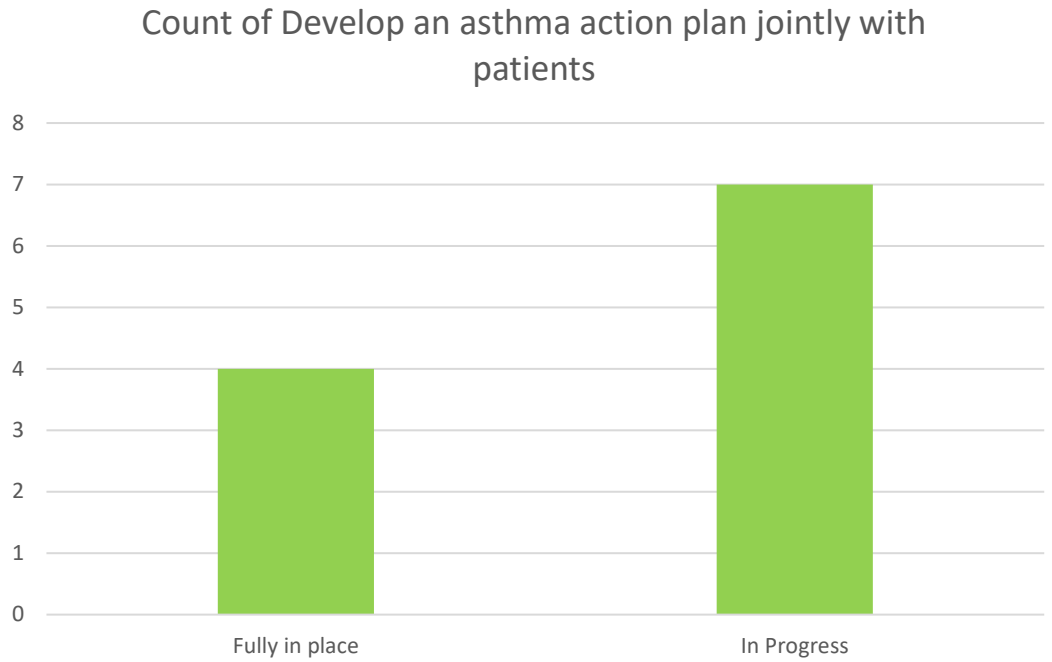
Interventions from Surveys: Asthma



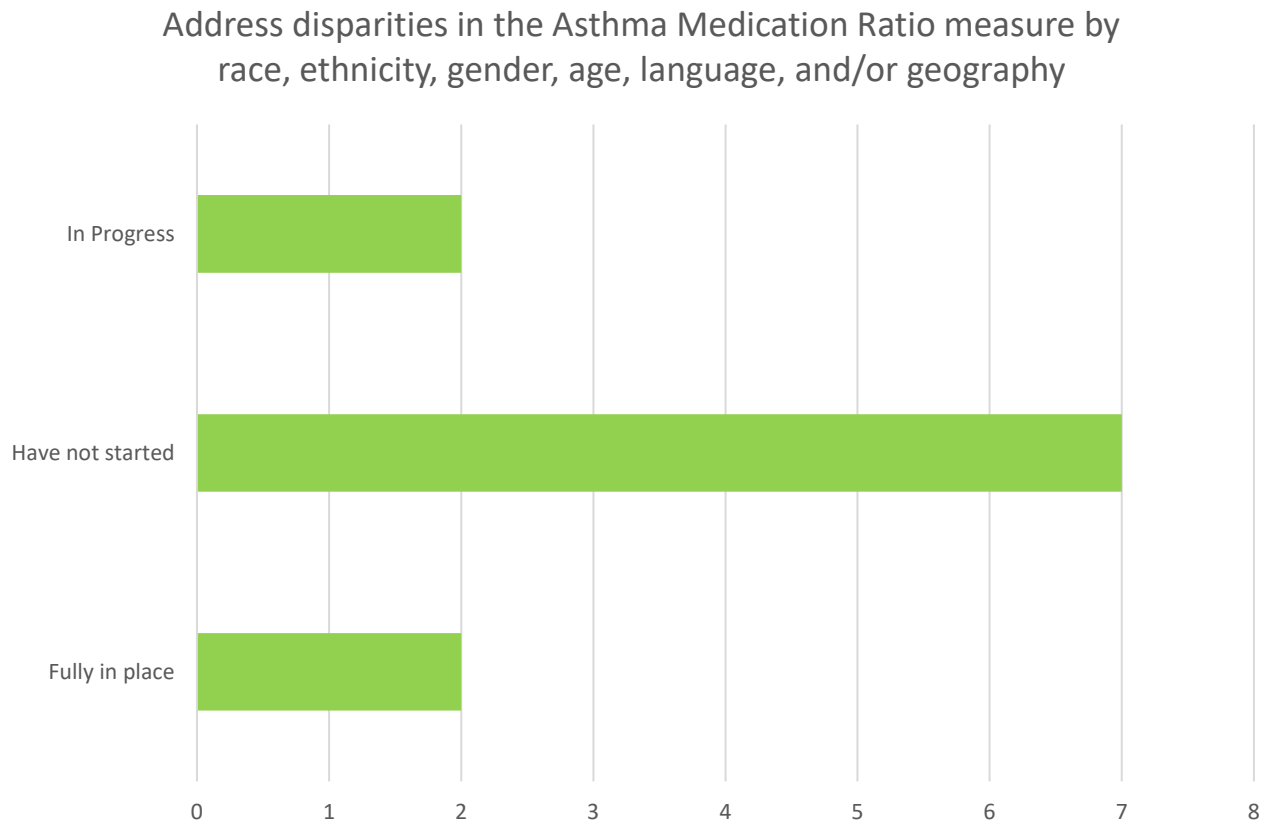


Interventions from Surveys: Asthma





Interventions from Surveys: Asthma



Q & A

Peer to Peer Sharing

Breakout Rooms

Hypertension Control Change Package

Debra McGrath, MSN, FNP, President, DPM Healthcare Consulting

Hypertension Control Change Package with Q&A

PCMH Learning Collaborative

Hypertension Sprint

February 18, 2025

Debra McGrath, MSN, FNP
President, DPM Healthcare Consulting

DPM Healthcare Consulting
Improving the Health of Healthcare

Learning Objective

Describe practices to enhance the current approach to managing hypertension.

Hypertension by the Numbers

- 47.7% of the US population was diagnosed with hypertension between August 2021 and August 2023
- 50.2% were aware of their condition; 20.7% achieved control
- Uncontrolled blood pressure is a leading cause of heart attack, stroke, heart failure, dementia, and kidney disease.
- Hypertension disorders of pregnancy are increasing in prevalence, raise a woman's lifetime risk of cardiovascular disease, and are associated with poor birth outcomes

Figure 2. Comparison of Blood Pressure Classification Thresholds, JNC 7,[5] and the 2017 ACC/AHA Guideline[4]

Systolic Blood Pressure, mmHg		Diastolic Blood Pressure, mmHg	Classification	
			JNC 7	2017 ACC/AHA
<120	and	<80	Normal BP	Normal BP
120–129	and	<80	Prehypertension	Elevated BP
130–139	or	80–89	Prehypertension	Stage 1 Hypertension
140–159	or	90–99	Stage 1 Hypertension	Stage 2 Hypertension
≥160	or	≥100	Stage 2 Hypertension	Stage 2 Hypertension

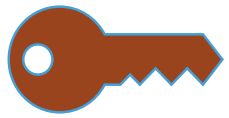
Improving hypertension control has a profound impact on cardiovascular health

Hypertension Control Change Package – What is it?

- A list of process improvements designed for implementation in outpatient clinical settings
- Composed of change concepts and ideas and practice-based tools and resources
- Intended as a blueprint for healthcare practices to implement systems to care for patients with hypertension more efficiently and effectively.

Improving blood pressure control rates depends on how each practice, care team, and provider thinks about and actively addresses hypertension diagnosis and management.

HCCP Focus Areas



Key Foundations ***Make hypertension control a practice priority***

- Designate a hypertension champion
- Redesign office space to support proper blood pressure measurement technique
- Implement a policy to address blood pressure at every patient visit
- Deploy hypertension treatment protocols and medication algorithms
- Develop and implement a process for tracking patients with hypertension

HCCP Focus Areas

Equip Care Teams:* *Evaluate and Train Direct Care Staff

- Accurate BP measurement
- Facilitate patient self-management
- Establish a self-measured blood pressure monitoring service
- Prepare care teams for effective hypertension management during office visits (e.g., team huddles, pre-visit planning, using treatment protocols and algorithms)

HCCP Focus Areas

Population Health Management:* *Evaluate quality improvement tools

- Identify patients with undiagnosed hypertension
- Identify patients with potentially undiagnosed Chronic Kidney Disease
- Establish a registry to track and follow patients with hypertension
- Use clinician-managed protocols for medication adjustment and lifestyle recommendations, e.g., improved diet and exercise and smoking cessation
- Use and distribute practice data to drive improvement and adjust protocols.

HCCP Focus Areas

Individual Patient Supports: ***Adopt a patient-centric approach***

- Prepare patients ahead of an office visit
- Optimize intake processes e.g. check-in, waiting, rooming
- Optimize patient-clinician encounter e.g. documentation templates, standing orders, order sets
- Support patient self-management e.g. medication adherence, SMBP monitoring, improved diet and exercise, smoking cessation, education about hypertension and cardiovascular risk
- Follow up between office visits

How to use HCCP Scenario #1

Your practice has reviewed clinical quality measures and realized that 32% of patients with hypertension have achieved a blood pressure of under 140/90.

Key Foundation:

Implement a policy to address HTN at every visit

Equip the Care Team:

Promote taking multiple BP readings in the office using the proper technique

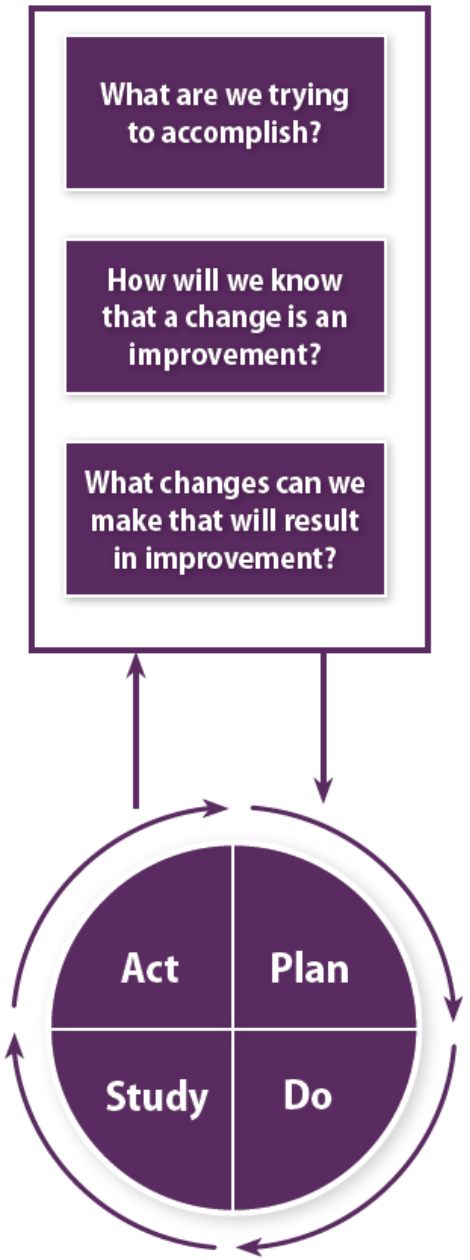
Population Health Management:

Establish a registry to track and follow patients with hypertension

Individual Patient Support:

Use the patient portal to disseminate patient education related to cardiovascular health.

Figure 3. Institute for Healthcare Improvement (IHI) Model for Improvement[6]



How to use HCCP Scenario #2

After assessing the skills of care teams, blood pressure measurement accuracy is unreliable

Key Foundation:

Redesign office space to support proper blood pressure measurement technique

Equip the Care Team:

Assess training of the care team on accurate BP measurement

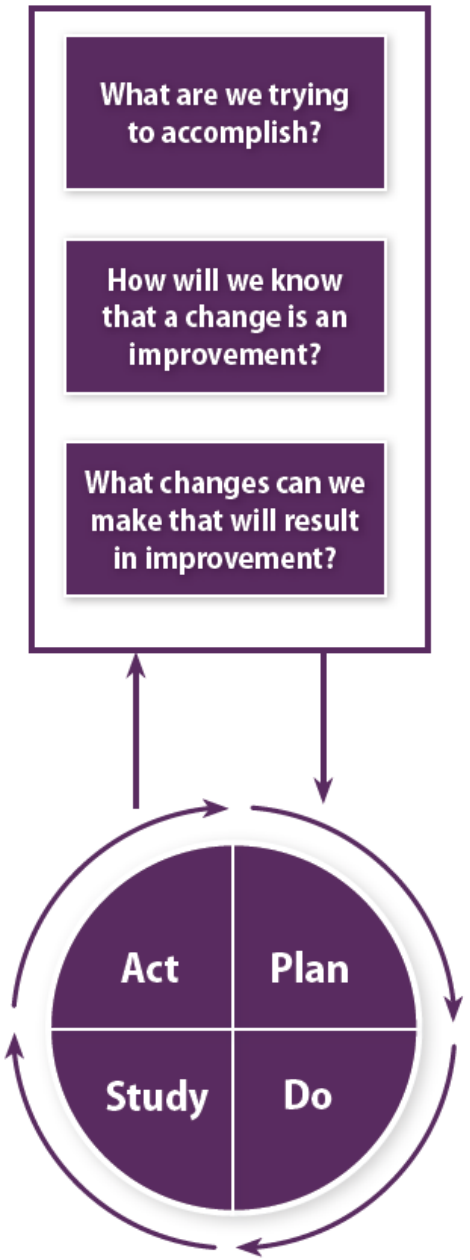
Population Health Management:

Share process data with the care team related to measuring accurately

Individual Patient Support:

Support and promote SMBP.

Figure 3. Institute for Healthcare Improvement (IHI) Model for Improvement[6]



Resources

- Centers for Disease Control and Prevention. *Hypertension Control Change Package* (2nd ed.). Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2020. https://millionhearts.hhs.gov/tools-protocols/action-guides/htn-change-package/index.html
- Self-measured Blood Pressure Implementation Toolkit https://www.nachc.org/resource/smbp-toolkit_final-2/
- NACHC Heart Health Hub https://www.nachc.org/resource/heart-health-hub/
- Articles:
    - Bellows, B.K. et al. Clinic-based strategies to reach US Million Hearts blood pressure control goals https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.118.005624
    - Debra McGrath, Margaret Meador, Hilary K Wall, Raj S Padwal, Self-Measured Blood Pressure Telemonitoring Programs: A Pragmatic How-to Guide, *American Journal of Hypertension*, Volume 36, Issue 8, August 2023, Pages 417–427, https://doi.org/10.1093/ajh/hpad040https://academic.oup.com/ajh/article/36/8/417/7151540

Thank You!

Contact Debra McGrath

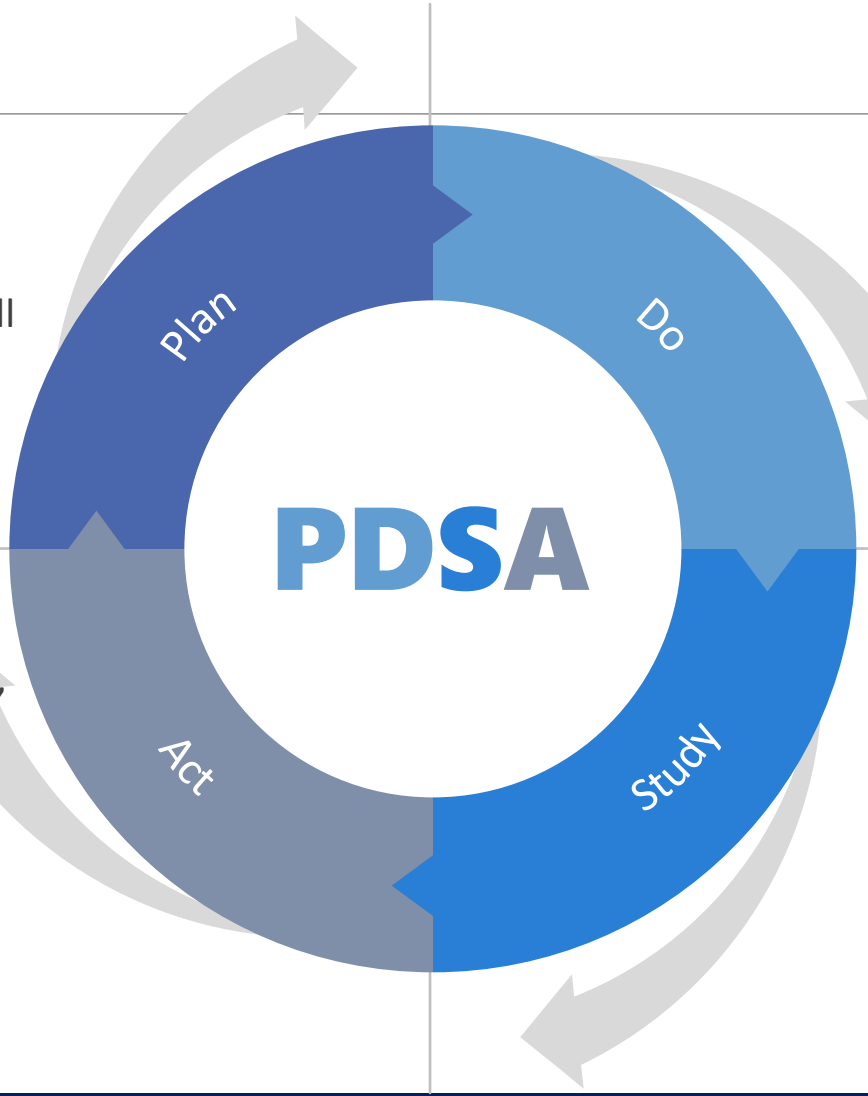
dmcgrathnp@gmail.com
Mobile phone: 206-940-7464

Suggested Next Step:
Start a(or document an already existing) PDSA Cycle

PDSA Cycle

Plan: Plan the test, including a plan for collecting data.

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change.
  - (Who? What? When? Where?)
- Identify what data you will need to collect.



Do: Run the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.

Act: Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

Study: Analyze the results and compare them to your predictions.

- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

IHI QI Essential Toolkit: PDSA 2017

Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: PDSA Worksheet

Objective:

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

-
-

Who, what, where, when:

Plan for collecting data:

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

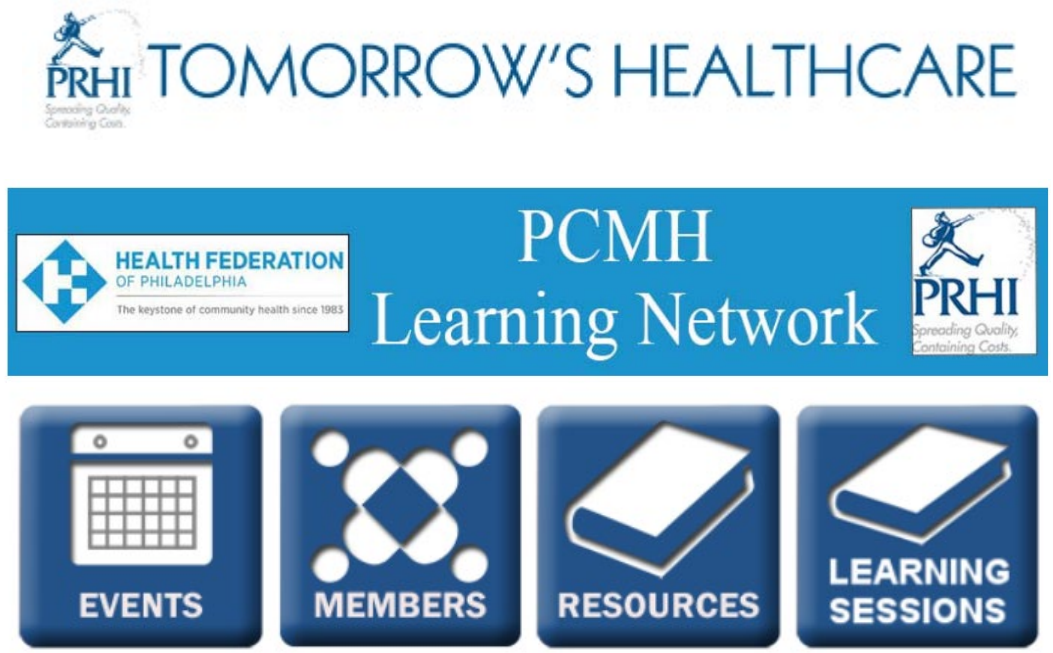
IHI QI Essential Toolkit: PDSA 2017

Wrap Up & Session Evaluation

PCMH Online Community

https://www.tomorrowshealthcare.org/

Members of your PCMH's multi-disciplinary learning team will receive log-ins



- Access the session materials in "Learning Sessions"
- Look for guides and tools in "Resources"

CEU Process

You will receive a follow up email with links to:

Complete the survey at: https://www.surveymonkey.com/r/GWTY2MY by **2/26/2025**

1. Please be sure to designate which CEU credits you are requesting **CME, CNE, Social Worker or Certificate of Attendance**. If you already have an account with the UPMC Center for Continuing Education, please be sure the email you enter on the survey matches the UPMC CCE account email that you create.

2. The UPMC Center for Continuing Education will follow up with you via email after **2/26/2025** with instructions on how to claim your credits.
   - ❑ To prepare, we recommend you create an account with UPMC CCE via this website https://cce.upmc.com.

Upcoming Sessions

Next Sprint Virtual Session:
April 10, 2025
9:00 am – 10:30 am

In-person Statewide Session:
June 25, 2025
Location: Hilton Harrisburg
1 N. Second St., Harrisburg, PA 17101

Thank You!