CARDI-OH COLLABORATIVE
A STATEWIDE INITIATIVE ADDRESSING HYPERTENSION CONTROL IN OHIO

Million Hearts® in Action

[Strategies for Achieving Million Hearts® Goals]

The Ohio Cardiovascular and Diabetes Health Collaborative (Cardi-OH) is a statewide initiative of health care professionals working to improve patient health outcomes and eliminate health disparities among the state's Medicaid population. The initiative is led by Case Western Reserve University School of Medicine and collaborates with partners from all of Ohio's medical schools including Ohio University, University of Toledo, Northeast Ohio Medical University, University of Cincinnati, Wright State University and The Ohio State University. The group works to connect primary care teams with experts and colleagues facing similar challenges. Together, they identify, produce and disseminate evidence-based cardiovascular and diabetes best practices through peer-to-peer information exchanges, virtual trainings, Project ECHO® teleECHO clinics, monthly newsletters, podcasts, and other resources posted on their website at cardi-oh.org. Specific focus areas of the Collaborative include hypertension and diabetes management, lifestyle modification and addressing social determinants of health.

[Fast Facts]

- 21 of Ohioans have healthcare coverage through Medicaid and/or CHIP[1]
- 2017, Ohio had the 13th highest heart disease death rate in the nation[2]
- One third of adults in Ohio have hypertension[3]

[Focus on the Fundamentals]

Members of Cardi-OH partnered with the Ohio Department of Medicaid (ODM) and the Ohio Medicaid Managed Care Plans to develop and implement the Hypertension Quality Improvement Project (QIP) Change Package. The first wave of the Ohio Hypertension QIP included eight practices serving high-volume disadvantaged and Medicaid eligible populations statewide. Information and best practices were shared in monthly interactive webinars named Action Period calls attended by practice teams, payers, and clinical and Quality Improvement (QI) experts. With coaching from quality improvement guides, the practices implemented evidence-based best clinical practices such as:

- Accurate blood pressure measurement, including obtaining more than one blood pressure reading
- Streamlined treatment algorithm using effective, low-cost blood pressure medications taken once daily
- Monthly follow-up in staff-led visits until blood pressure is controlled
- Coordinated outreach to patients with elevated blood pressure
- Enhanced communication with patients

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[1]Kaiser Family Foundation US and State Medicaid Fact Sheets, 2017. https://www.kff.org/interactive/medicaid-state-fact-sheets/

[2]American Heart Association. Heart Disease and Stroke Statistics: 2019 Update. A Report from the American Heart Association. Circulation. https://doi.org/10.1161/CIR.0000000000000659 139:e56–e528

[3]Ohio Department of Health. 2018. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Heart-Disease/high-blood-pressure. Accessed August 2020

Each clinic formed a QI team and engaged a primary care champion to build support for the effort. They also leveraged the Electronic Health Record (EHR) to standardize protocols and track progress over time. Clinics worked to engage and educate all members of the primary care teams (e.g., nurses, pharmacists and Medical Assistants) to ensure project success. The Five Rivers Health Centers were among the initial participating clinics. Dr. Mamle Anim, Chief Medical Officer, led the implementation of the QIP Change Package. Dr. Anim found the Cardio OH process and the toolkit materials to be very helpful in that it provided the fundamentals and visual learning tools for each and every step. "The quality improvement process and the toolkit reminded me to focus on the fundamentals at every step, that is when QI works the best."

In addition, all six of the ODM contracted managed care plans used quality improvement science tools to test payer-based strategies for improving hypertension control, such as facilitation of medication adherence and home blood pressure monitoring.

[Improved Control in Eight Practices]

The project, which began in November 2017, aims to increase the percentage of patients seen with controlled hypertension by 15%, and to increase the percentage of African American patients seen with controlled hypertension by 20% in participating practices. Project outcomes are tracked through EHR data submitted and analyzed twice a month to provide a feedback mechanism for participating clinical teams and payers to view the success of their plan, do, study, act (PDSA) testing cycles. Across the eight practices, blood pressure control improved by 15.7%. Among non-Hispanic black patients with hypertension, blood pressure control improved by 13.5%. ODM's managed care plans combine these data with claims data to track their success in providing 90-day prescriptions and facilitating access to home blood pressure monitors.

[Overcoming Challenges with Communications and Consistency]

Clinic teams had to overcome challenges when implementing the Hypertension QIP. For example, engaging staff and providers in the project posed a challenge in some settings due to staff turnover and competing demands on staff time. In the Five Rivers Health Centers, the team intentionally went slowly to engage key staff, to train and retrain staff, and to track data closely. The Five Rivers clinic team utilized the toolkit posters and other resources for patient education which led to patients "pointing out when they were not seated the same as the example they saw in the poster, and we loved that." While Five Rivers patient engagement improved, there were hurdles for their Federally Qualified Health Center (FQHC) and others in the program related to medication adherence, lifestyle changes, low health literacy, and lack of voicemail to communicate effectively with patients. Patients also transition to other health systems, making it hard to follow improvement in control. Finally, access to home blood pressure monitors limited success in some settings.

In addition to preparing for challenges, clinic teams must also build upon facilitators for success. Specific facilitators included:

- Aligning outcome measures with value-based initiatives
- Providing monthly and biweekly EHR data feedback to test the impact of improvement efforts on selected performance measures and blood pressure
- Sharing project data to foster competition among clinics
- Collaborating with Medicaid Managed Care Plans
- Providing physical reminders to follow protocols (e.g., laminated hearts on door to remind staff and providers to recheck blood pressure, address medication adherence and ensure timely follow up)

Dr. Anim and the Five Rivers Health Centers team shared this simple and sound advice: "When we focus on the fundamentals every time and all the time, it works. It yields improved patient education and outcomes we all desire. It was our mantra: every time and all the time."

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