CARDIOVASCULAR HEALTH IN PRIMARY CARE: PHASE 3
IMPLEMENTATION TOOLKIT FOR COMMUNITY PARTNERS

Evidence-based strategies for disease management in high-risk and affected populations

Last Updated: January 30, 2018
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HOW TO USE THIS IMPLEMENTATION TOOLKIT

Developed by OneCity Health to assist partners in project oversight and performance, this toolkit is intended for use by primary care partners/sites participating in the Delivery System Reform Incentive Payment (DSRIP) project for Evidence-Based Strategies for Disease Management in High Risk/Affected Populations.

SYMBOL KEY
Important implementation consideration

ONECITY HEALTH SUPPORT DESK
If you have any questions, please contact the OneCity Health support desk:

Phone Number:
646-694-7090

Email ochsupportdesk@nychhc.org,
with the subject line “Cardiovascular Project”

Hours of Operation:
Monday through Friday from 9am to 5pm ET
IMPLEMENTATION GOALS CHECKLIST

IMPLEMENTATION GOALS

• Provide opportunities for follow-up blood pressure checks without a co-payment or advanced appointment

• Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit

• Implement clinical pathways that support guidelines-based use of aspirin to prevent cardiovascular events

• Implement protocols to increase influenza vaccination rates within the primary care population

• Document patient driven self-management goals in the medical record and review with patients at each visit

• Offer group visits and/or partner with community-based organizations to support self-management for patients with cardiovascular risk or cardiovascular disease; follow up with referrals to community-based organizations
PROJECT OBJECTIVES
Cardiovascular disease is a major source of suffering and early death in all populations and disease control is a key to helping patients and communities be healthier. The objective of the Cardiovascular Project is to support primary care excellence in cardiovascular health in alignment with the Million Hearts Campaign, a national initiative led by the Centers for Medicare and Medicaid Services (CMS) and by the Centers for Disease Control and Prevention (CDC). The Million Hearts campaign addresses blood pressure control, cholesterol management, smoking cessation, and aspirin use as key factors in promoting cardiovascular health.

The Cardiovascular Disease Management project furthers the goals of the Million Hearts Campaign through a variety of strategies:

- Support primary care excellence in cardiovascular health:
  - Aspirin use
  - Blood pressure control
  - Cholesterol management
  - Smoking cessation
- Support patient self-management of cardiovascular health
- Promote integrated care delivery, including partnerships with community-based organizations

IMPLEMENTATION OF THE CARDIOVASCULAR PROJECT IN PRIMARY CARE
The toolkit “Cardiovascular Health in Primary Care: Phases 1 & 2” provided resources for a variety of key activities, including:

- Create a cardiovascular health workgroup
- Select an implementation leader to oversee implementation activities
- Identify a clinical champion to engage, educate and lead others
- Implement guidelines for management of hypertension
- Provide appropriate training and equipment for blood pressure measurement
- Standardize documentation of self-management plans
- Evaluate Resource Gaps for Cardiovascular Disease Management

This Cardiovascular Health in Primary Care Phase 3 toolkit guides organizations to build on and strengthen quality improvement activities for cardiovascular disease management in primary care, beyond those activities accomplished in Phases 1 & 2.

This toolkit describes multiple approaches to improving the cardiovascular health of a primary care patient panel. Partners are expected to review the strategies described in this toolkit and prioritize work based on the organization’s existing resources and population health needs. Partners may choose to strengthen existing areas of work and/or address new areas of work in their efforts to improve the cardiovascular health of their patient populations.
CARDIOVASCULAR DISEASE MANAGEMENT: NEXT STEPS

All primary care organizations participating in this project are required to:

• Demonstrate implementation of and report progress on quality improvement activity to increase Statin use amongst applicable patient population QI_004 Metric.

Organizations participating in this project are recommended to review the activities described in this toolkit and to prioritize those activities that are the most appropriate next steps in improving health outcomes related to cardiovascular disease.

DEMONSTRATE IMPLEMENTATION OF QUALITY IMPROVEMENT ACTIVITY TO INCREASE STATIN USE

The Quality Improvement activity is designed to:

• Assist each facility in understanding its current work in cardiovascular disease management

• Allow the OneCity Health team to understand baseline work in cardiovascular disease management at each facility

• Provide physicians and nurses an opportunity to improve in managing their patients with CVD risk to LDL-cholesterol goals according to the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in Adults.

The QI_004 metric will be available in the OneCity Health Partner Portal. Instructions on completion and associated due dates will be provided in the OneCity Health Partner Reporting Manual.

Provide opportunities for blood pressure checks without a co-payment or advanced appointment

Blood pressure monitoring is important to successful hypertension control and can be supported in a variety of ways, including home blood pressure monitoring. For patients who cannot monitor their blood pressure at home, hypertension management can be supported by providing other opportunities to check blood pressure between physician visits.

A workflow that enables patients to obtain follow-up blood pressure checks without a co-payment or advanced appointment is one way of supporting successful hypertension management.

Hypertension Control Package for Clinicians

Guideline/Protocol on Walk-In Blood Pressure Checks
Identify patients with undiagnosed hypertension

In a primary care patient population, some patients may have hypertension that is undiagnosed. Patients who have multiple instances of elevated blood pressure readings, but do not have a diagnosis of hypertension, need to be evaluated for this diagnosis.

A protocol to identify patients with elevated blood pressure and without a diagnosis of hypertension, and to conduct outreach to follow up with them, will require considerations including the following:

• Process and criteria to identify patients with multiple elevated blood pressure readings.
• Staff member to conduct outreach to patients and schedule visits
• Documentation of outreach activities
• Monitoring and evaluation of protocol implementation by clinical and/or administrative leadership

1.0 IDENTIFY PATIENTS WITH UNDIAGNOSED HYPERTENSION PROTOCOL

While existing protocols and evidence-based guidelines are in place to improve blood pressure control, some patients are at risk for undiagnosed hypertension. These “at-risk” patients are seen regularly, often multiple times, and had multiple high blood pressure readings documented, but they had not been diagnosed as having hypertension.

Patients who have multiple instances of elevated blood pressure readings, but do not have a diagnosis of hypertension, need to be evaluated for this diagnosis. A protocol to identify patients with elevated blood pressure without a diagnosis of hypertension, and conduct outreach will require considerations including the following:

• Process and criteria to identify patients with multiple elevated blood pressure readings
• Staff member to conduct outreach to patients and schedule visits
• Documentation of outreach activities
• Monitoring and evaluation of protocol implementation by clinical and/or administrative leadership

1.1 PROCESS AND CRITERIA TO IDENTIFY PATIENTS WITH MULTIPLE ELEVATED BLOOD PRESSURE READINGS.

Using health information technology to identify patients with undiagnosed hypertension, (1) establish clinical criteria for potential undiagnosed hypertension, (2) search the electronic health record (EHR) data for patients that met the clinical criteria, and (3) determining a plan for addressing the identified population.

For assistance with developing a registry or data collection and quality assurance, use the enclosed resource “Registries for Evaluating Patient Outcomes: A User’s Guide” to establish and maintain a registry of patients with undiagnosed hypertension.

1.2 STAFF MEMBER TO CONDUCT OUTREACH TO PATIENTS AND SCHEDULE VISITS

Identify health care professionals who can perform outreach for patients in their practices whose hypertension has not been diagnosed. Using practice data after querying and compiling an EHR registry, practices should select current evidence-based criteria to establish clinical guidelines for treatment. The identified staff member, using the registry, can conduct outreach to schedule patients for blood pressure follow-up appointments.
1.3 DOCUMENTATION OF OUTREACH ACTIVITIES

Interactions with patients, including blood pressure readings captured outside of the practice should be documented in the EHR within an area accessible to all members of the care team. Communication and coordination are vital to outreach and should be documented, regardless of successful or unsuccessful contact. Ensure a mechanism exists for communication between clinical providers and outreach staff to share progress on engaged patients.

1.4 MONITORING AND EVALUATION OF PROTOCOL IMPLEMENTATION BY CLINICAL AND/OR ADMINISTRATIVE LEADERSHIP

Adopt a systematic approach to assess patients identified as potentially having hypertension. Design care pathways that direct patients at risk to appropriate confirmatory studies and timely follow-up with the treating clinician. For patients confirmed to have hypertension, institute standardized treatment algorithms and at least monthly feedback to the clinical care team to help patients achieve and maintain blood pressure control.

For assistance with monitoring, evaluation or identification of patients using a registry/evidence based guideline, use these resources:

Million Hearts – Undiagnosed Hypertension

Hypertension Control Package for Clinicians

Undiagnosed Hypertension Registry

Follow evidence-based guidelines for aspirin use

Guideline-based management means that everyone in the primary care team has agreed to follow the same standard goals of treatment and the same standard treatment algorithm to achieve those goals.

While guidelines do not replace individualized evaluations and treatment plan, they do enable an organization to:

- Promote consistent and timely evidence-based care for all patients
- Facilitate a team-based approach to identifying and managing patients’ needs
- Conduct quality improvement activities

Aspirin use can prevent cardiovascular events, such as heart attacks and strokes, in patients who are at increased risk. National guidelines for aspirin use include those disseminated by the United States Preventive Services Task Force:


In implementing a guideline with your primary care teams, consider the following steps:

- Step One: Review national guidelines on aspirin use to prevent cardiovascular events, and engage clinical staff in agreeing to implement this guideline as a team
- Step Two: Support use of guidelines with primary care team.
  » Strategies to support the use of guidelines may include providing patient education materials on aspirin use; posting clinical guidelines in treatment areas or on desktop computers; sending reminders to providers by email or during staff meetings; and encouraging providers to pursue Continuing Medical Education opportunities on this topic.
- Step Three: Embed guidelines in team-based care
  » Consider how different primary care team members can contribute to identifying patients who would benefit from aspirin use and to reinforcing patient education on medication adherence. Steps in this process may include mapping patient workflows, including points of contact with different team members; identifying opportunities for health education and self-management support; and planning how health literacy and other barriers to adherence can be addressed.
- Step Four: Conduct quality improvement (QI) reviews on a sample of charts for each clinical provider
  » Quality improvement reviews allow the primary care team to assess providers’ adherence to guidelines-based care, to encourage appropriate adherence to guidelines, and to identify and address barriers. Rapid-cycle improvements in care can be supported effectively even with relatively small amounts of data, such as 5-10 charts for a provider. For example, providers can review their own charts, can review each other’s charts in pairs, or can receive the results of chart reviews done by a nurse. Reporting back on QI results on a monthly basis to the primary care team brings attention to the group’s ongoing work.
Increase influenza vaccination rates
The Centers for Disease Control (CDC) recommends a yearly flu vaccine for everyone 6 months and older.

Seasonal Influenza: Flu Basics

Prevention and Control of Seasonal Influenza with Vaccines

Use of Standing Orders Programs to Increase Adult Vaccination Rates

Promote patient self-management
Self-management plans document recommendations by the clinical team that the patient can follow to improve his or her own health. These include medication adherence as well as lifestyle changes.

Consistent documentation of self-management plans allow different members of the primary care team to reinforce and add to the plan. It also allows the patient to be provided with the self-management plan in a way that reflects this continuity of care.

American Medical Association’s Motivating Patients to Change Behavior

Department of Health and Human Services’ Self-Management Support

Techniques for Effective Patient Self-Management
This 33 minute CHCF video provides strategies and tools based on the principles of motivational interviewing that busy clinicians can use to help patients adopt healthy behaviors. Must register to gain access.

Coaching Patients for Successful Self-Management
A 14 minute video by CHCF. Video includes: Using the action planning process to support healthy behavior change, Ensuring patients are taking their medications appropriately.

The Planned Care Visit Video Series

Offer group visits within clinical setting to support patient self-management
Patient education and self-management support can be promoted in a variety of ways, including group visits within the clinical setting.

Group experiences provides a venue for patients to give and share information, practice skills and test perception against reality of management principles. A beneficial aspect of group experiences is the patient’s ability to learn self-acceptance through accepting others and in turn, being accepted. As these concepts are explored in the group setting, patients realize others have had a similar or exact situation and will learn new skills to handle varying situations. Groups build a sense of camaraderie, high morale and empowerment to become responsible for their personal well-being.

To incorporate these approaches into your primary care setting, consider the following:

• Is there sufficient staff and space within the clinical setting to carry out group visits?
• Does the clinical staff have the expertise, or are they willing to obtain training, to provide high-quality group visits in support patient self-management?
• What community-based organizations provide services that are conveniently located for your patients, are linguistically appropriate, and address cardiovascular and other health needs of your population?
• How can you strengthen relationships with community-based organizations whose services can help your patients?
• What processes will help clinical teams to appropriately identify and refer patients to self-management support programs?

Group Visit Starter Kit

Putting Group Visits into Practice

Integrating Evidence-Based Clinical and Community Strategies to Improve Health
Partner with and make referrals to community-based organizations

Social and behavioral factors are key determinants of patients’ health outcomes. Clinical teams should partner with community-based organizations to link patients to community-based services and supports that address these social determinants of health.

Clinical teams can work with local community-based organizations to develop protocols for referral and communication that are feasible for both entities. Clinical teams are better able to coordinate care if they can determine if the referral was completed and obtain information on the result of the community-based intervention.

OneCity Health is currently rolling out a software platform, called NowPow, that can support making and tracking referrals to community-based programs. There are two levels of the NowPow platform, which are being made available to partners: NowRx and PowRx.

In NowRx users can:

a. Find and navigate patients to community-based services by:
   - Conducting screenings and providing matched resource recommendations
   - Adding custom screeners (e.g. food insecurity, PHQ-9, social determinants of health assessment) directly into the NowPow.
   - Mapping screener outcomes and scores (e.g. 15 on the PHQ-9) to specific community resource recommendations (e.g. individual counseling, group counseling).
   - Leverage knowledge into action by providing patient education and referrals immediately upon screener completion.

b. Gain insight into your community’s health and social service network by:
   - Generating monthly reports that include a summary of soft referrals made and the supply and demand of resources across a patient population
   - Customizing reports based on providers’ specifications

PowRx includes all of the same features as NowRx, plus a closed-loop referral functionality and access to client utilization data.

To learn more about how to get access to NowPow, please refer to the Phase III Integrated Delivery System Toolkit (IDS).
APPENDIX A: QUALITY IMPROVEMENT RESOURCES

Plan, Do, Study, Act (PDSA) Cycles

The Plan-Do-Study-Act (PDSA) cycle is part of the Institute for Healthcare Improvement Model for Improvement, a simple yet powerful tool for accelerating quality improvement. Once a team has set an aim, established its membership, and developed measures to determine whether a change leads to an improvement, the next step is to test a change in the real work setting. The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning.

The steps in the PDSA cycle are:

**Step 1:** Plan—Plan the test or observation, including a plan for collecting data

**Step 2:** Do—Try out the test on a small scale

**Step 3:** Study—Set aside time to analyze the data and study the results

**Step 4:** Act—Refine the change, based on what was learned from the test

For more information click here.

## AIM

PDSA Cycle # 1

(All Aim will require multiple small tests of change)  

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<tr>
<th>Person(s) Responsible</th>
<th>When to complete</th>
<th>Where to complete</th>
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<td>Describe your test of change:</td>
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## PLAN

List the tasks needed to set up this test of change  

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Predict what will happen when the test is carried out  

| Indicator to measure if prediction succeeds | |

## DO

Describe what actually happened when you ran the test.

## STUDY

Describe the measured results and how they compared to the predictions.

## ACT

Describe what modifications to the plan will be made for the next cycle from what you learned.
Guideline for the management of cholesterol

In 2013, the American College of Cardiology (ACC) and the American Heart Association (AHA) released new clinical guidelines on the treatment of Blood Cholesterol to reduce Atherosclerotic Cardiovascular Disease (ASCVD) risk in adults.

Qualification: “The guideline uses a CVD risk assessment tool that has not been validated and may overestimate risk. The risk cut-off of 7.5%, rather than 10%, will significantly increase the number individuals on statins.” (American Academy of Family Physicians)


American Academy of Family Physicians
APPENDIX C: NEW YORK STATE MILESTONE FOR COMPLETION OF THE CARDIOVASCULAR DISEASE MANAGEMENT PROJECT

Milestones – General:

• Engage a majority (at least 80%) of primary care providers in this project.

• Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.

• Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.

Milestones – Hypertension, Aspirin use, Cholesterol, Smoking:

• Adopt strategies from the Million Hearts Campaign.

• Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.

• Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

• Develop and implement protocols for home blood pressure monitoring with follow up support.

• Ensure that all staff involved in measuring and recording blood pressure is using correct measurement techniques and equipment.

• Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.

• Identify patients who have repeated elevated BP readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.

• Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.

• Use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange) or AAR (Ask, Advise, Refer).

• Facilitate referrals to NYS Smoker’s Quitline.

Milestones – Specific strategies:

• Document patient driven self-management goals in the medical record and review with patients at each visit.

• Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.

• Follow up with referrals to community based programs to document participation and behavioral and health status changes.

• Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population; perform group visits, and implementation of the Stanford Model for chronic diseases.

Milestones – Structural:

• Use EHRs or other technical platforms to track all patients engaged in this project.

• Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging); alerts and patient record look up, by the end of DY 3.

• Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.