

When you leave your family to go buy groceries and toilet paper.

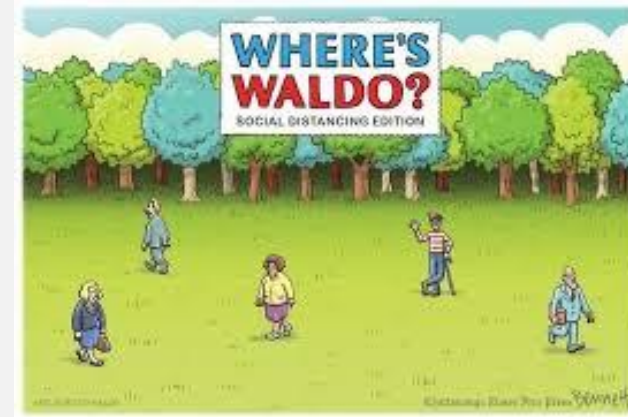


Fencing: the perfect COVID-19 Sport

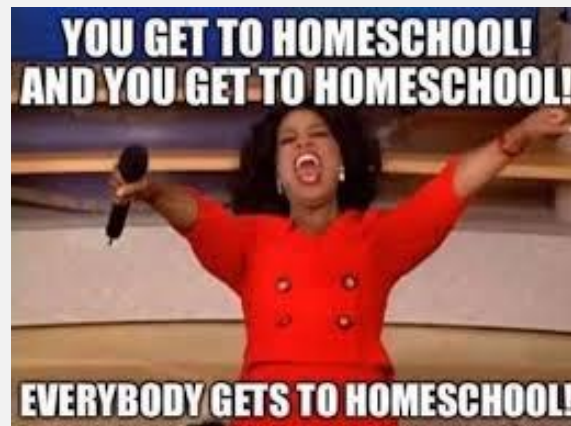
1. Masks
2. Gloves
3. If anybody gets closer than 6 feet to you, you stab them.

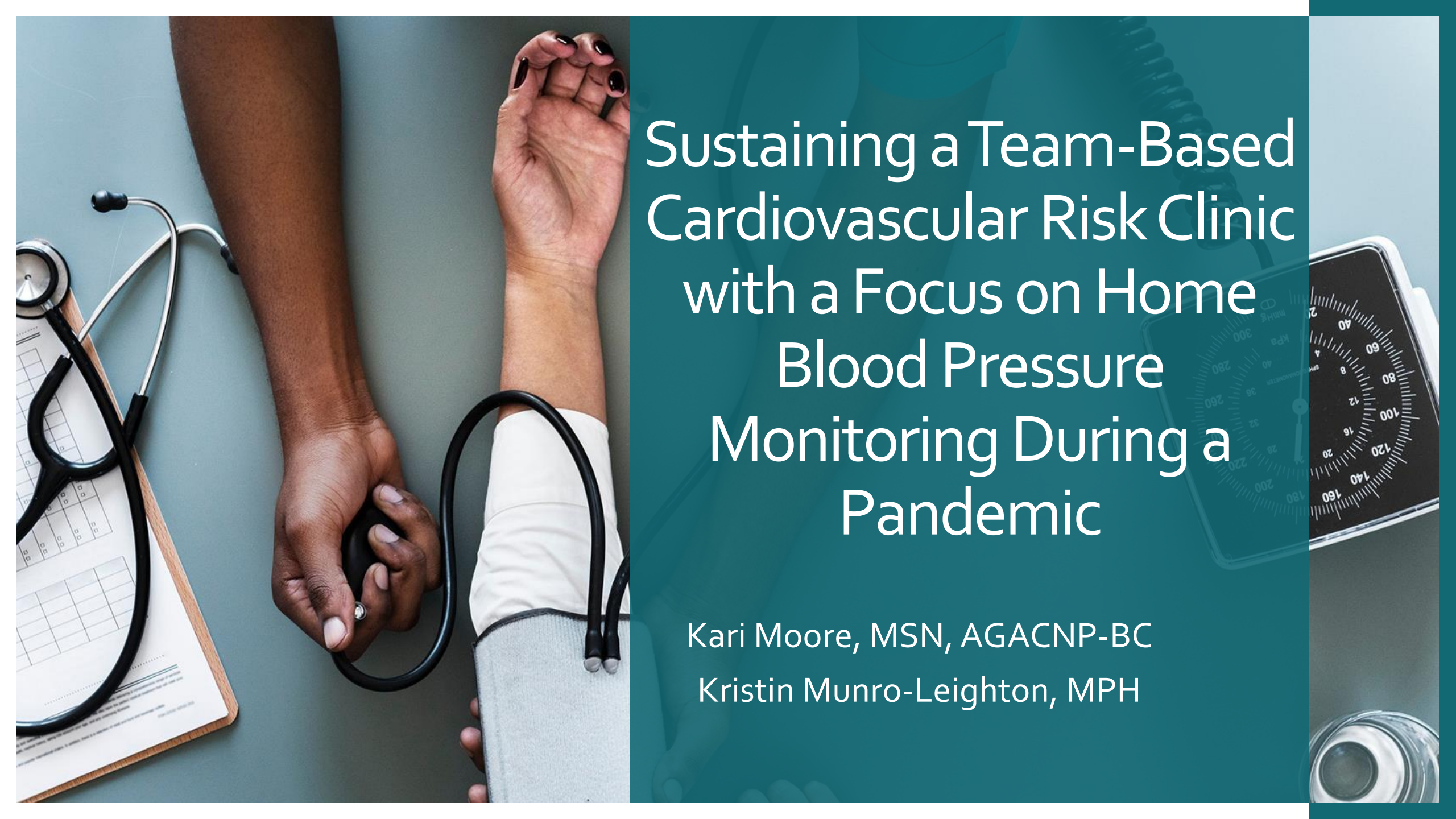


TOILET PAPER SEEDS
.25 EACH



Not sure what the cat needs but it knows how to follow rules





Sustaining a Team-Based Cardiovascular Risk Clinic with a Focus on Home Blood Pressure Monitoring During a Pandemic

Kari Moore, MSN, AGACNP-BC
Kristin Munro-Leighton, MPH

Objectives

We will discuss:

- Team-based care as a key component of blood pressure monitoring and control programs
- Implementation, barriers/solutions, initial data, and sustainability of a pilot team-based care SMBP program
- Adapting a pilot team-based care SMBP program during an unexpected pandemic



US Hypertension Statistics

Table 8-1. HBP in the United States

Population group	Prevalence, 2015–2018, age ≥20 y	Mortality,* 2018, all ages	Hospital discharges,† 2016, all ages	Estimated cost, 2016–2017
Both sexes	121 500 000 (47.3%) (95% CI, 45.4%–49.2%)	95 876	486 000	\$52.4 Billion
Males	63 100 000 (51.7%)	46 124 (48.1%)‡	246 000	...
Females	58 400 000 (42.8%)	49 752 (51.9%)‡	240 000	...
NH White males	51.0%	31 094	...	...
NH White females	40.5%	35 763	...	...
NH Black males	58.3%	9249	...	...
NH Black females	57.6%	8546	...	...
Hispanic males	50.6%	3764	...	...
Hispanic females	40.8%	3373	...	...
NH Asian males	51.0%	1389§	...	...
NH Asian females	42.1%	1629§	...	...
NH American Indian/Alaska Native	...	671	...	...

Table 8-2. Hypertension Awareness, Treatment, and Control: NHANES 1999 to 2002, 2007 to 2010, and 2015 to 2018 Age-Adjusted Percent With Hypertension in US Adults by Sex and Race/Ethnicity

	Awareness, %			Treatment, %			Control, %		
	1999–2002	2007–2010	2015–2018	1999–2002	2007–2010	2015–2018	1999–2002	2007–2010	2015–2018
Overall	48.9	61.2	61.2	37.7	52.5	50.4	12.0	24.1	21.6
NH White males	42.7	58.0	60.3	31.4	48.7	45.9	10.9	22.2	20.2
NH White females	56.7	66.1	64.8	45.9	59.2	57.7	14.8	28.7	25.4
NH Black males	46.0	60.5	63.1	33.0	47.6	48.7	9.1	18.2	15.8
NH Black females	67.7	73.5	70.1	54.9	64.3	60.9	16.4	28.2	22.8
Mexican American males*	25.9	40.6	41.9	14.0	30.5	30.3	4.1	12.7	13.3
Mexican American females*	50.4	55.6	55.8	35.4	49.3	47.8	10.4	21.2	20.7



US Cardiovascular Risk Factors

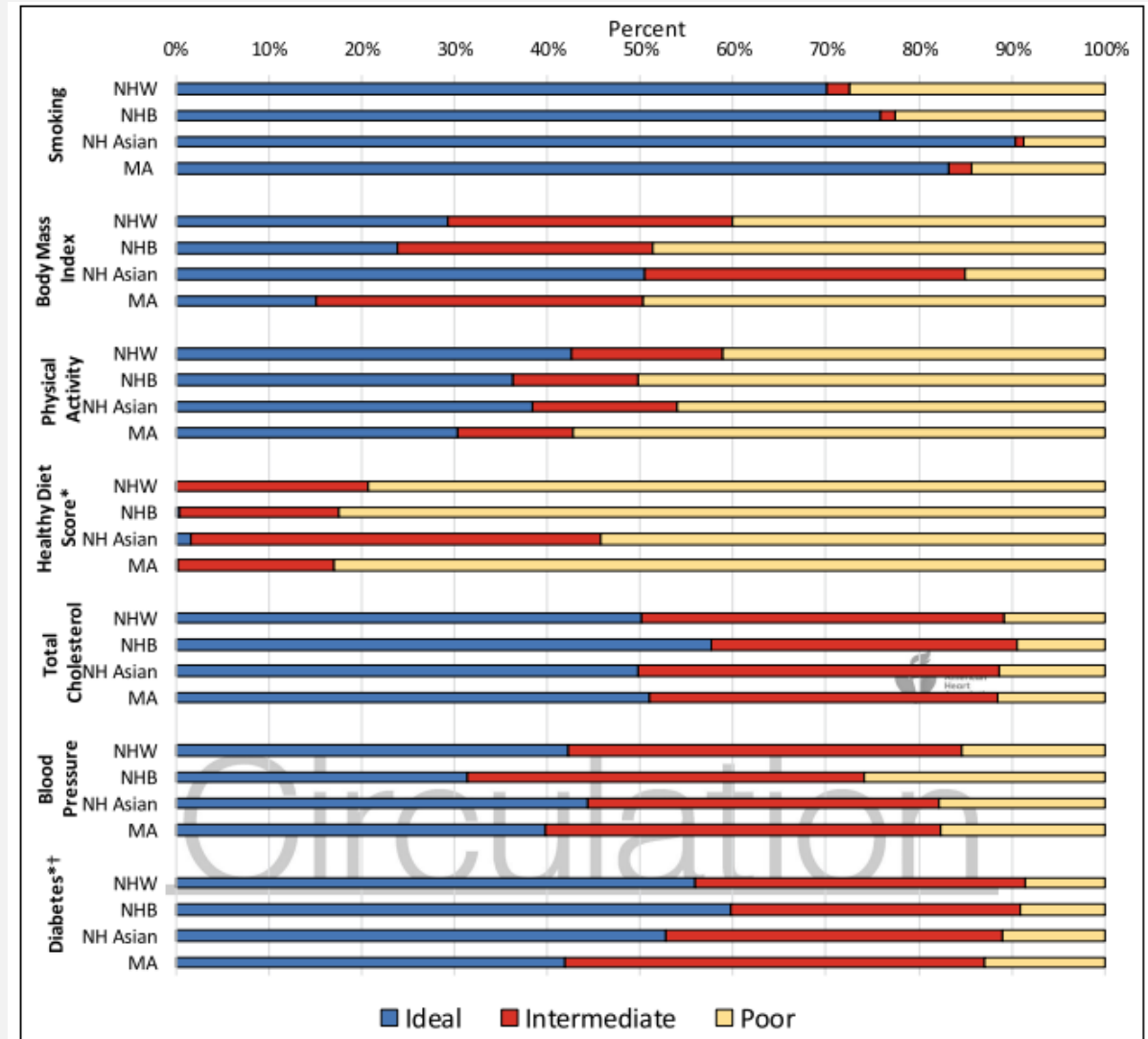


Chart 2-3. Age-adjusted prevalence estimates of poor, intermediate, and ideal cardiovascular health (CVH) for each component of CVH by race/ethnicity among US adults ≥20 years of age, 2015 to 2016 and 2017 to 2018.

MA indicates Mexican American; NH, non-Hispanic; NHB, non-Hispanic Black; and NHW, non-Hispanic White.

*Data from 2015 to 2016. All other data are from 2017 to 2018.

†Categories defined by either fasting plasma glucose or hemoglobin A_{1c} on the basis of data availability.

Source: Unpublished American Heart Association tabulation using National Health and Nutrition Examination Survey, 2015 to 2016 and 2017 to 2018.³⁴

Kentucky Hypertension Statistics (BRFS)

Question: Have you ever been told by a doctor, nurse or other health professional that you have High Blood Pressure?

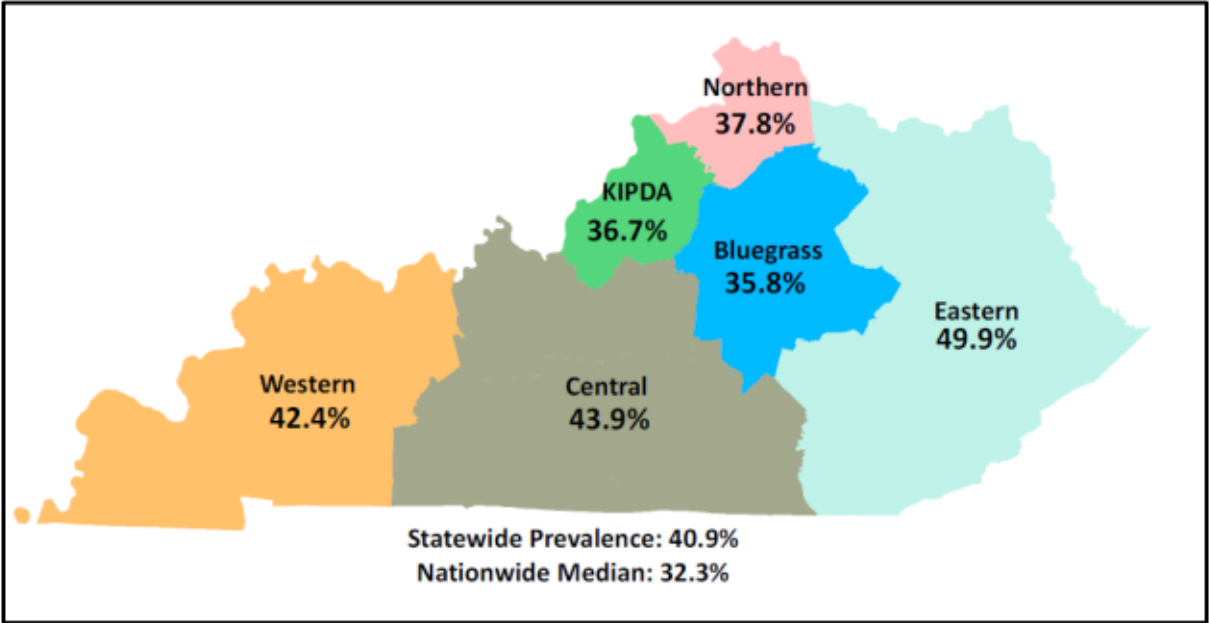
At Risk: Adults who answered ‘Yes’ are considered at risk.

Those who were borderline hypertensive and women who had high blood pressure only during pregnancy are excluded

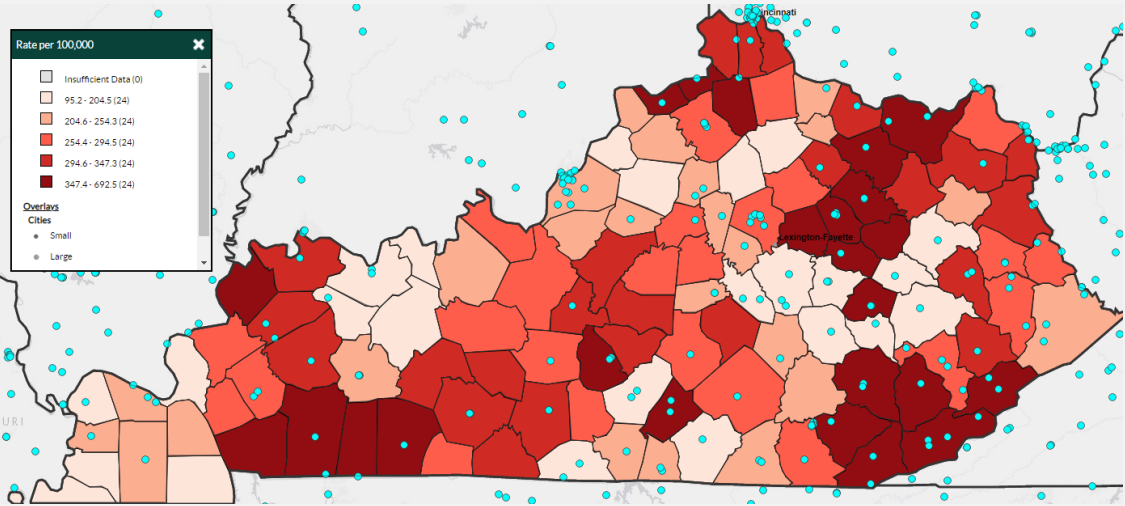
Prevalence of High Blood Pressure Among Kentucky Adults 2019 KyBRFS		
Characteristics	%	95% CI
Overall	40.9	(39.2 – 42.6)
Sex		
Male	42.7	(40.1 – 45.2)
Female	39.2	(37.0 – 41.5)
Race/Ethnicity		
White	41.8	(40.0 – 43.6)
Black	44.9	(37.2 – 52.6)
Age		
18 – 34	16.4	(13.6 – 19.2)
35 – 49	32.0	(28.3 – 35.6)
50 - 64	53.3	(50.0 – 56.5)
65 +	67.7	(65.0 – 70.5)
Education		
<High School	54.2	(48.3 – 60.1)
H.S Grad	42.0	(39.1 – 44.8)
Some post H.S.	38.5	(35.4 – 41.4)
College Grad	34.0	(31.2 – 36.9)
Income		
<\$25,000	52.1	(47.6 – 56.6)
\$25,000 to <\$49,999	41.3	(37.2 – 45.5)
\$50,000 or more	34.7	(31.9 – 37.5)

Source: 2019 KyBRFS

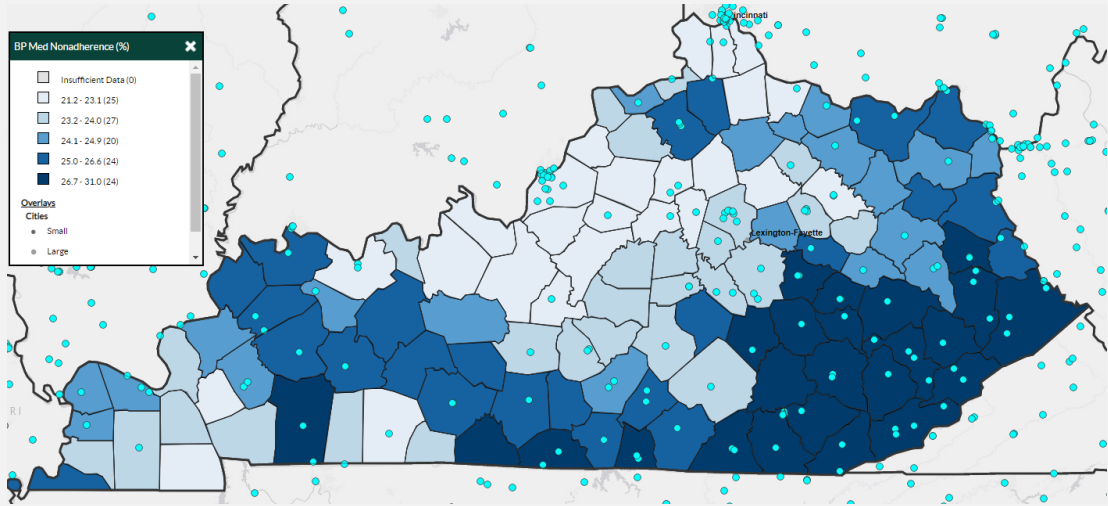
Prevalence of Hypertension by Regions		
Regions	%	95% CI
Western (Purchase, Pennyrite, Green River)	42.4	(39.4 – 45.3)
CENTRAL (Barren River, Lincoln Trail, Lake Cumberland)	43.9	(40.9 – 47.0)
KIPDA	36.7	(32.2 – 41.2)
NORTHTERN KY	37.8	(32.7 – 42.8)
EASTERN KY (Buffalo Trace, Gateway, FIVCO, Big Sandy, Kentucky River, Cumberland Valley)	49.9	(47.0 – 52.8)
BLUEGRASS	35.8	(31.0 – 40.5)



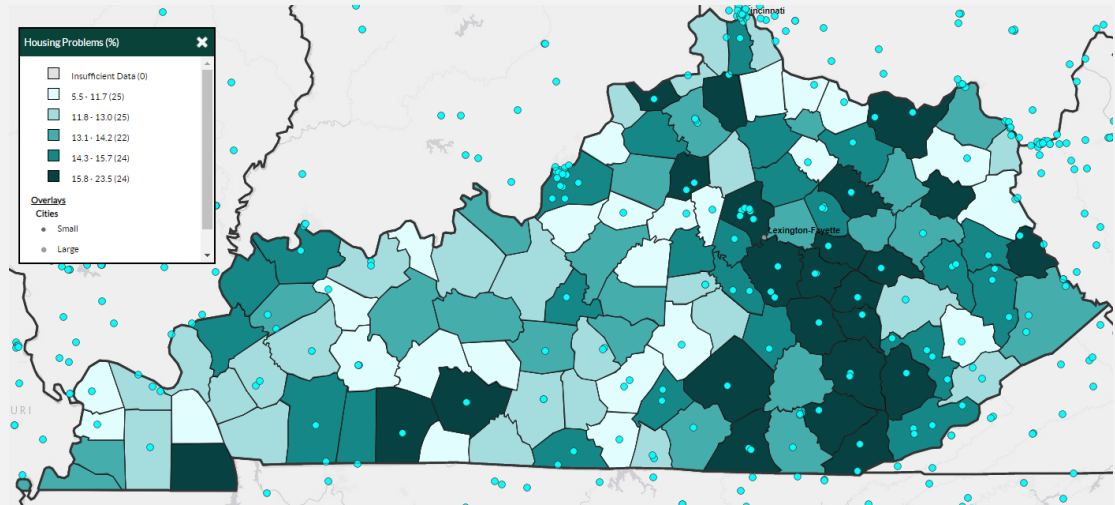
2016-2018 HTN Deaths, All genders, All Races
Age 35+



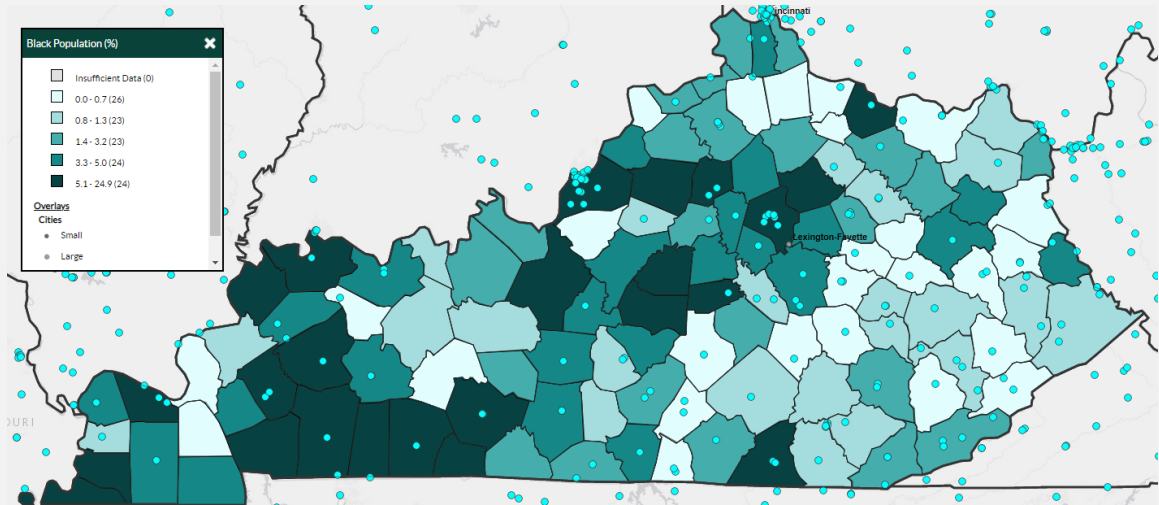
% Non-adherence to BP Medication



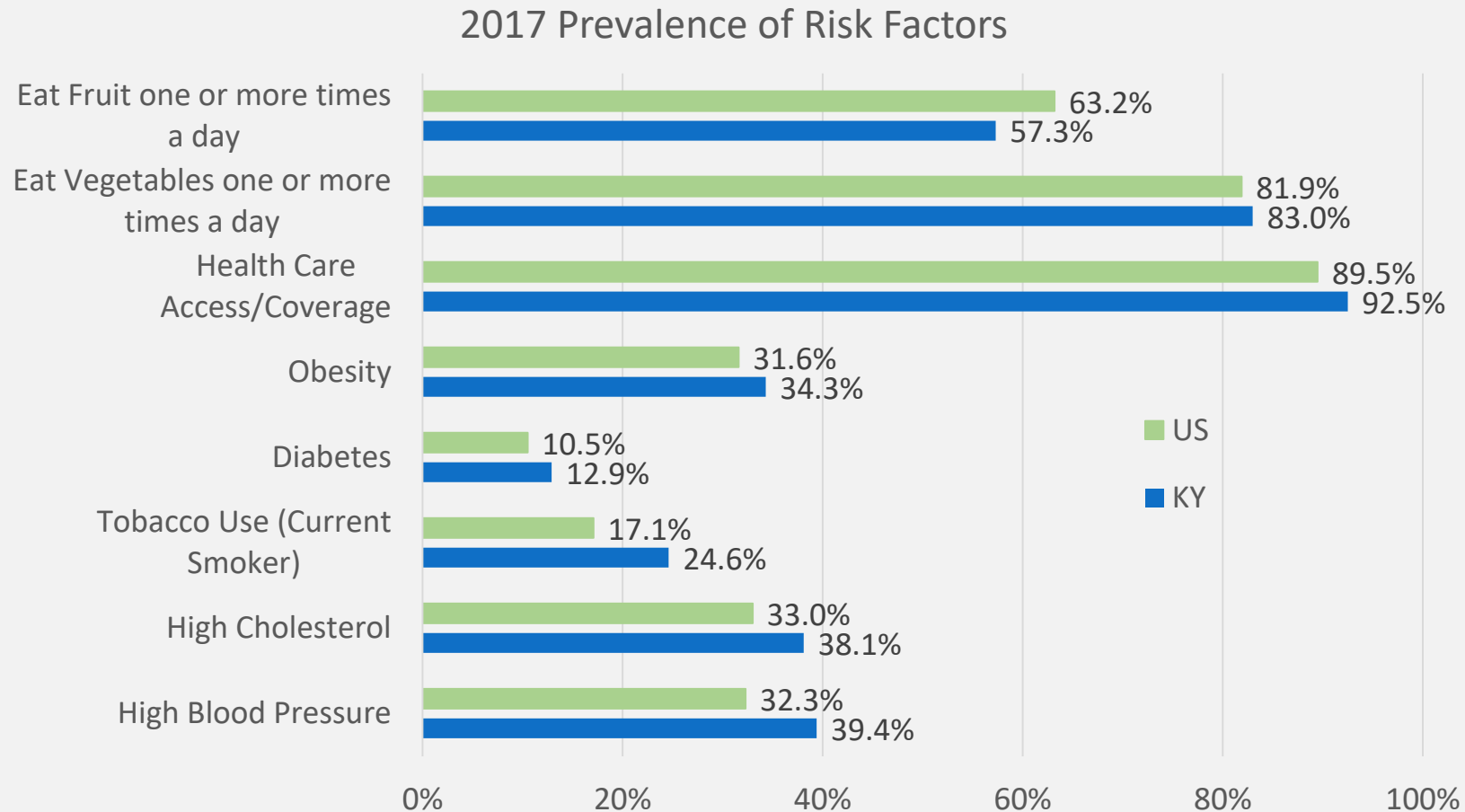
% Severe Housing Problems



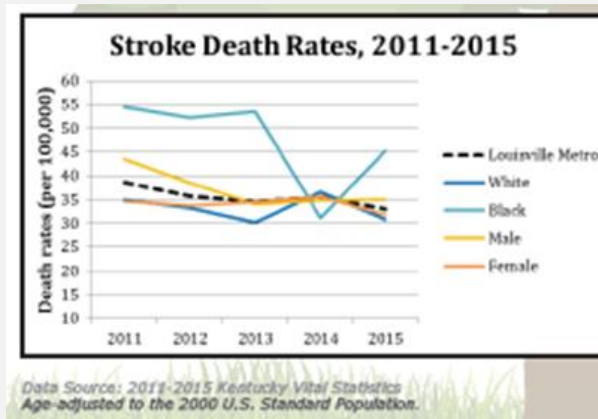
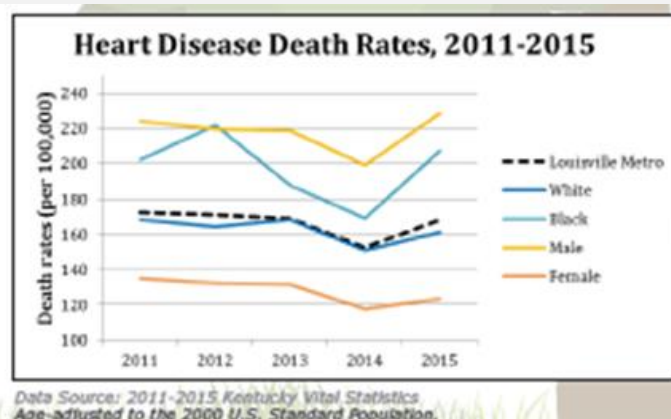
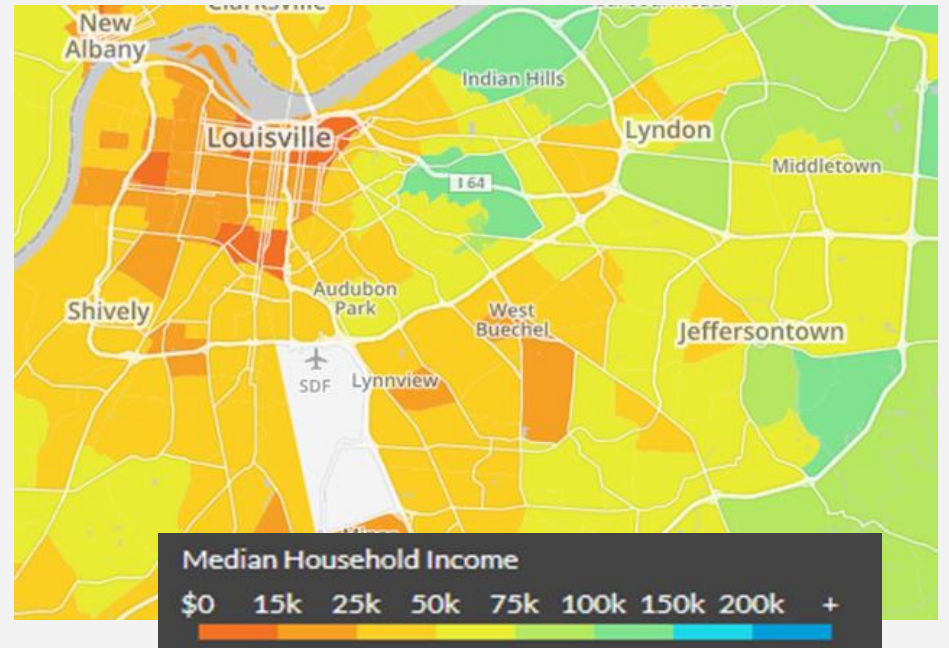
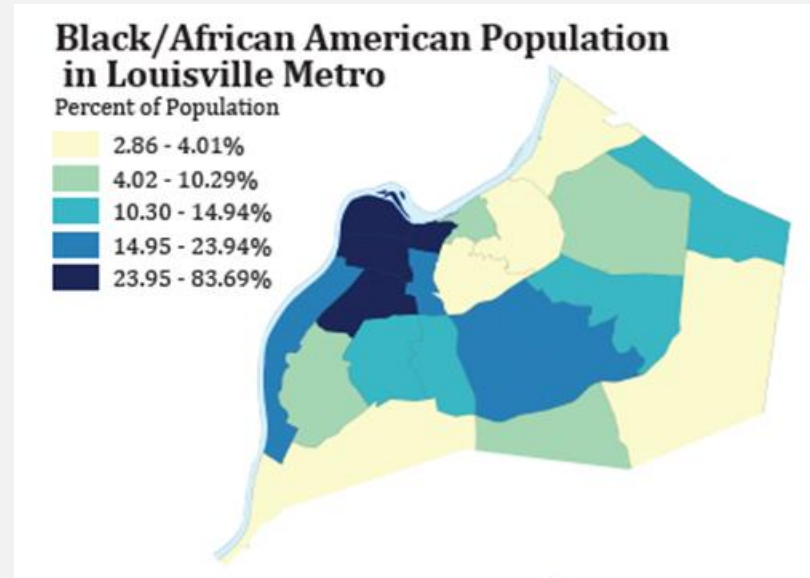
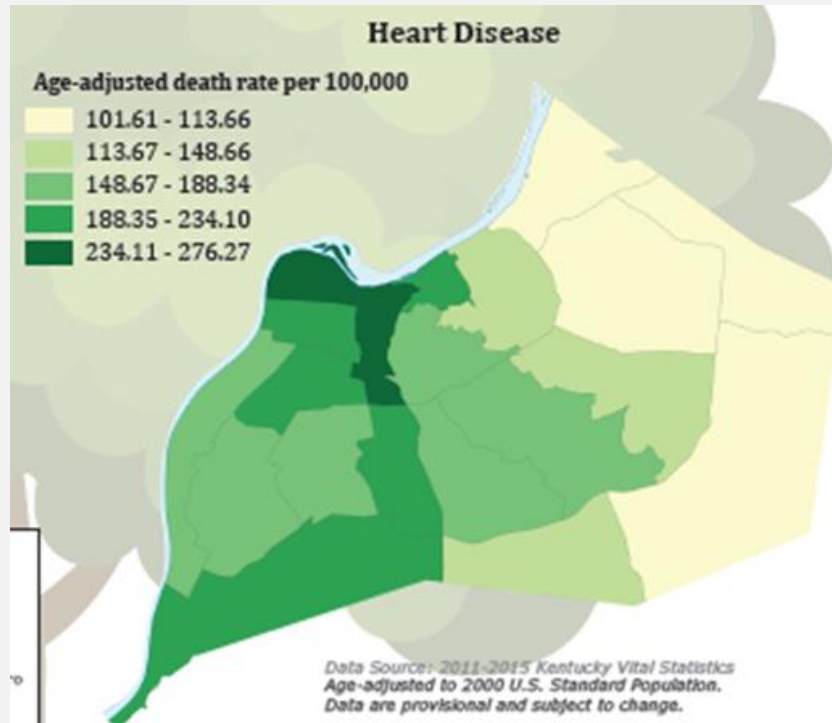
% Black Population



US and KY Cardiovascular Risk Factors



Louisville Statistics



Blood Pressure Reduction and Decreased Cardiovascular Event Risk

- Cardiovascular incidence and mortality increase with BP higher than 115/75 mm Hg
- Optimal BP in general population < 120/80 mm Hg

Age	SBP Blood Pressure Reduced by 10 mm Hg = Decreased Stroke Risk
< 60	54%
60-69	36%
≥ 70	25%

Stroke, 2017

Impact on Mortality - SBP			
Reduction in SBP	Stroke	CHD	Total Mortality
2 mm Hg	-6%	-4%	-3%
3 mm Hg	-8%	-5%	-4%
5 mm Hg	-14%	-9%	-7%

JAMA, 2002

DBP Reduction	Decreased Stroke Risk
5 mm Hg	34%
7.5 mm Hg	46%
10 mm Hg	56%

Lancet, 1990

- BP > 115/75 mmHg associated with higher mortality in stroke patients
- Decrease in 20 mm Hg SBP and 10 mm Hg DBP associated with > 2-fold decrease in stroke mortality

Lancet, 2002

Self Measured Blood Pressure Monitoring (SMBP) with Clinical Support



- Regular monitoring of blood pressure by the patient outside the clinical setting
- Can reduce disability or death due to high blood pressure
- Alternative to in office care
- More convenient and accessible to a larger patient population
- Endorsed by Professional Organizations and Public Health Agencies
 - American Heart Association
 - Centers for Disease Control
 - American Society of Hypertension
 - Preventive Cardiovascular Nurses Association
 - World Health Organization



SMBP Team Based Care

What is a healthcare team?

- Two or more health care professionals who work collaboratively with patients and their caregivers to accomplish shared goals
- Strives to meet patient needs and preferences by engaging patients as full participants in their care

Evidence for team-based care

- Associated with better performance measures and healthcare quality
- FFS Reimbursement - > Value based payment models
- Can be more expensive, but still cost-effective
- Supported by AHRQ

Keys to success for high functioning healthcare teams

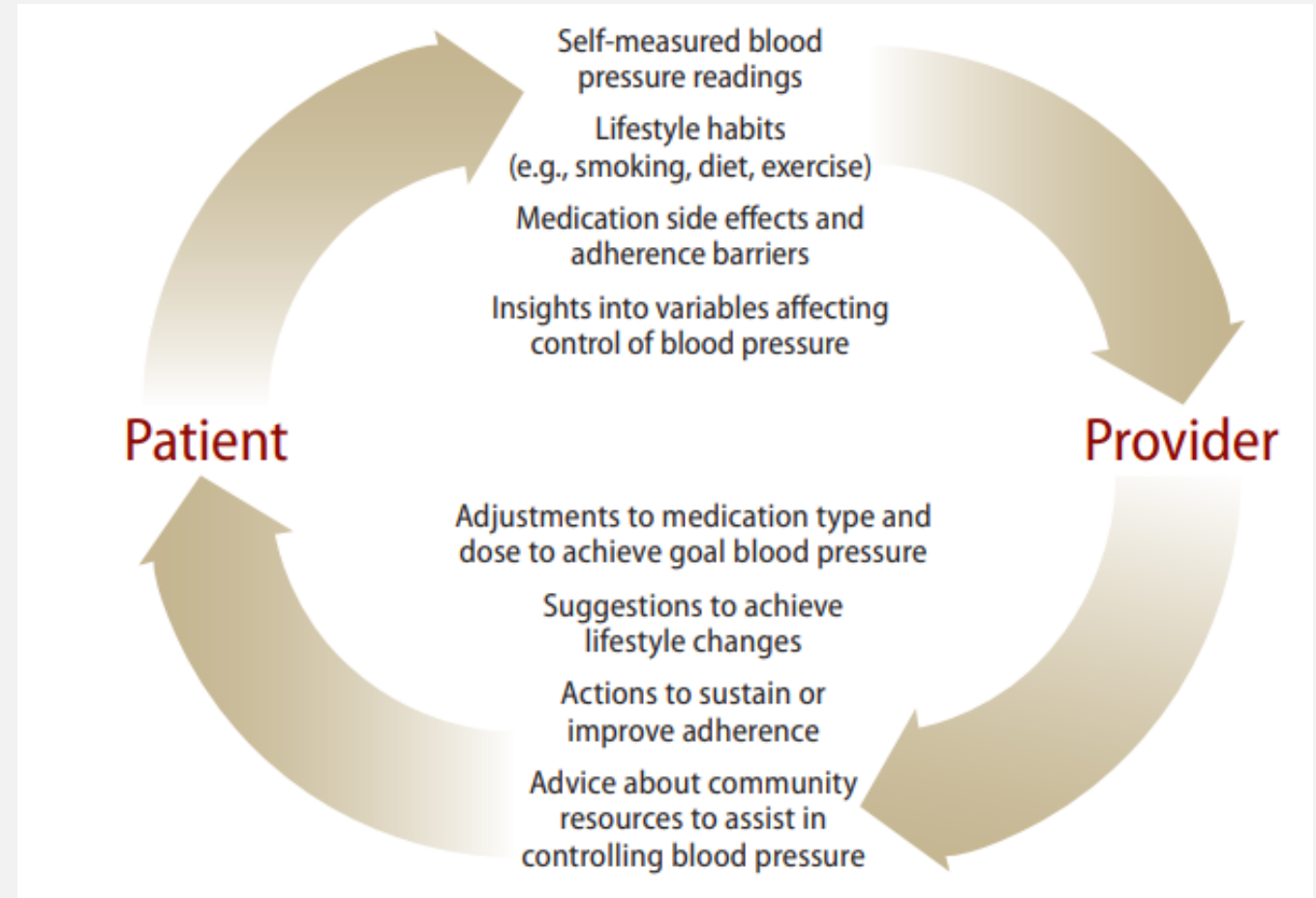
- Shared team identity, values, and goals
- Leadership and team coordination
- Regular meetings
- Adequate staffing
- Open communication and mutual respect
- Constructive conflict resolution
- Effective help among team members
- Task sharing and shifting



SMBP Team Based Care

Formats

- One-on-one Counseling
- Web-based or telephonic telehealth
- Educational Classes
- Use of testing, secure messaging, other technology



Cardiovascular, Assessment, Risk Reduction, and Education (CARE) Collaborative

- Kentucky's Heart Disease and Stroke Prevention Program's primary statewide health change strategy
- Funded by CDC's Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke 1815 grant
 - Heart Attack and Stroke Signs and Symptoms
 - Smoking Cessation
 - Blood Cholesterol
 - Blood Pressure
 - Sodium Reduction
 - Body Mass Index
 - Hemoglobin A1c

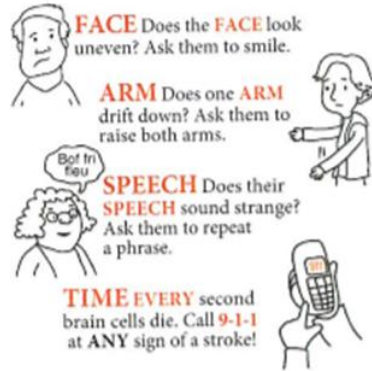


CARE Collaborative Tool

BLOOD PRESSURE LOG

[illegible]

**IS IT A STROKE?
CHECK THESE SIGNS **FAST****



STROKE IS AN EMERGENCY!

Call 911 immediately if you see or have any of these symptoms. Every minute counts!

BLOOD PRESSURE RECORD CARD

Name



In partnership with:
CARE Collaborative
www.stelizabeth.com/services/nkycare

MEDICAL HISTORY

Please check all that apply:

- ☐ Asthma
 - ☐ Cancer
 - ☐ Diabetes
 - ☐ Heart Disease
 - ☐ High Cholesterol
 - ☐ High Blood Pressure
 - ☐ Other
 - ☐ Peripheral Vascular Disease (*poor circulation*)
 - ☐ Kidney Disease
 - ☐ Tobacco Use
- KY Tobacco Quit Line:**
1 (800) QUIT-NOW
1 (800) 784-8669

Recent Surgeries/Hospitalizations
(include month/year and location)

Your Self-Management Goals

Pharmacy Name, Location and Phone Number
Emergency Contact Name and Phone Number
Health Care Provider and Office Phone Number
Allergies (Food and Medication)

SIGNS AND SYMPTOMS OF A HEART ATTACK

- Chest discomfort lasting more than a few minutes; pressure, squeezing, fullness or pain.
- Discomfort in one or both arms, the back, neck, jaw or stomach.
- Shortness of breath with or without chest discomfort.
- Cold sweat, nausea or light headedness.
- Women most often experience chest pain or discomfort, but may be more likely than men to experience shortness of breath, nausea/vomiting, and back or jaw pain.

If you or someone you are with has any of these symptoms, call 911 immediately.
HEART ATTACK IS AN EMERGENCY!
Every minute counts!



Please list all medications you take, including over-the-counter medications (for example antacids, vitamins, pain relievers). Review and update this list at every visit to your primary care provider, specialist, emergency room and/or hospital.

NAME OF MEDICATION	DOSE	HOW MANY	HOW OFTEN/PURPOSE	KNOW YOUR NUMBERS			
(Brand or generic name)	(mg, units, puffs, drops)	(Number of tablets, puffs, drops)	(Number of times taken per day, evenings? at mealtime? mornings?) (Why do you take this medication?)		Healthy Goal	Actual	Actual
				Total Cholesterol	<200 mg/dL		
				LDL (bad) Cholesterol	<100 mg/dL		
				HDL (good) Cholesterol	>50 mg/dL		
				Triglycerides	<150 mg/dL		
				Fasting Glucose	<100 mg/dL		
				Hemoglobin A1C (without Diabetes)	<5.7		
				BMI	<25		
				Waist Circumference	<35		
			90	Provided to you by:	Date Recorded		

Collaborative Partnership



University of Louisville Signature Partnership

- Launched in 2007
- In collaboration with community partners, enhance quality of life for residents in west Louisville by improving the overall educational attainment levels to equal those of Metro Louisville in general, through the integrated enhancement of health, social and human services, and economic viability of the community.

In the past decade, UofL has garnered over **\$30 million** in grants & contracts for service and research projects that directly benefit west Louisville residents.



21,000+

Instances of student engagement in service and outreach in curricular and co-curricular activities



4,200+

Instances of faculty & staff engagement with community projects in west Louisville



250,000+

UofL have engaged in over 250,000 hours of service related to the Signature Partnership Initiative



200+

Community partner organizations working with UofL and the residents of west Louisville

These numbers represent instances of service and may reflect a duplicated head count for faculty, staff and students; but does not represent a duplication of service.

--- Icons made by Freepik from flaticon.com licensed under Creative Commons



Family Health Centers, Inc.

Overview

- 8 locations in medically underserved areas of Louisville
 - Portland, East Broadway, Iroquois, Fairdale, Southwest, West Market
 - Phoenix (Health Care for the Homeless), Americana (Refugee Health Assessments)
- 40,000+ patients; 130,000+ visits annually
- Sliding Fee Scale
 - Income
 - Family size
- Open to all

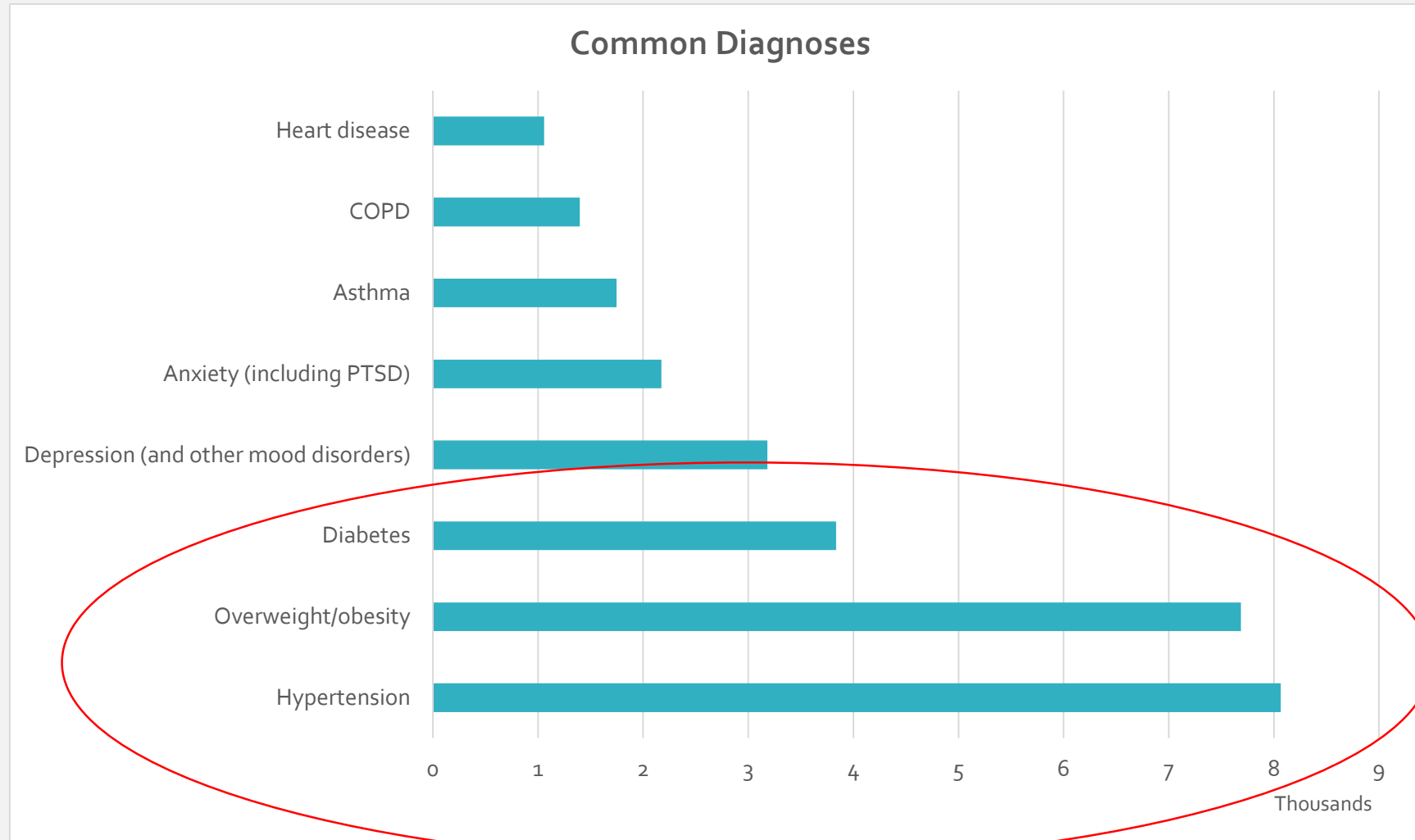


Services

- Medical care
 - Adult primary care, pediatric primary care
 - Women's health, prenatal care
- Lab, Radiology, Pharmacy, Dental
- Behavioral Health, Substance Abuse
- Social Services, Health insurance application assistance, Interpreter services, Housing assistance
- Health Education, Clinical Pharmacy



Patient Diagnoses



Establishing a Multidisciplinary SMBP HTN Clinic

Multidisciplinary Team



Cassy
Hobbs
Clinical Pharmacist



Kari
Moore
Nurse Practitioner



Judy
Bullard
CARE Coach



Lindsey
Bramlett
Health Educator



Kristin
Munro-
Leighton
Health Educator



Priscilla
Ewing
Community Health
Worker



Nana
Bullock
Program Assistant



Ruolan
Liu
Data Analysis
Epidemiologist

Signature Project History



Year 1: July 2015 to June 2016

- Monthly program
- Class format, enroll in September or October
- 2 locations; 39 patients enrolled
 - Receive automatic BP cuff
 - CARE Collaborative
 - My Life Check
 - Individual counseling with nurse practitioner, clinical pharmacist, or dietician
 - Educational presentation (healthy eating, physical activity, diabetes management)
 - Reporting to Primary Care Provider

Year 2: July 2016 to June 2017

- Monthly program (similar to above)
- 2 locations; 43 patients enrolled

Signature Project History



Year 3: July 2017 to June 2018

CARE Collaborative

- 7 locations; all patients age 18+ (non-OB)
- Conducted by Medical Assistants during BP check
- Integrated with Electronic Health Record system

Blood Pressure CARE Collaborative

Green=Normal <120/80

Yellow=Caution 120-139/80-89

Red=High > or = 140/90

☐ Y ☐ N New CARE collaborative participant

☐ Y Gave blood pressure record card to patient

☐ Y Patient correctly identified current blood pressure zone

☐ Y If BP improved from previous - did pt start BP meds?

☐ Y If BP improved from previous - did pt make lifestyle changes?

Use free text for specific lifestyle changes
(Improve diet, exercise? Reduce smoking,
stress?)

Signature Project History



Year 3: July 2017 to June 2018

Hypertension Management Clinic

- By appointment, continuous enrollment
- 1 location: 119 patients enrolled
 - Receive automatic BP cuff
 - CARE collaborative
 - Individual counseling with Nurse Practitioner or Clinical Pharmacist, plus Health Educator (medication, goals, education, referrals)
 - Reporting to Primary Care Provider

Year 3 RESULTS: all participants (N=120)

	1 st visit	Last visit	Change
Systolic BP (average)	138.9	134.2	-4.8
Diastolic BP (average)	84.5	82.2	-0.6

- 40% dropped systolic BP by 5 mmHg
- 32% dropped systolic BP by 10 mmHg

Year 3 RESULTS: initial BP 140/90 and 2+ visits (N=49)

	1 st visit	Last visit	Change
Systolic BP (average)	150.0	136.7	-14.1
Diastolic BP (average)	88.8	84.3	-4.5

- 76% dropped systolic BP by 5 mmHg
- 61% dropped systolic BP by 10 mmHg
- 47% dropped systolic BP by 15 mmHg

Reducing Cardiovascular Disparities Through Community-Engaged Implementation Research

A National Heart, Lung, and Blood Institute Workshop Report

George A. Mensah, Richard S. Cooper, Anna Maria Siega-Riz, Lisa A. Cooper, Justin D. Smith, C. Hendricks Brown, John M. Westfall, Elizabeth O. Ofili, LeShawndra N. Price, Sonia Arteaga, Melissa C. Green Parker, Cheryl R. Nelson, Bradley J. Newsome, Nicole Redmond, Rebecca A. Roper, Bettina M. Beech, Jada L. Brooks, Debra Furr-Holden, Samson Y. Gebreab, Wayne H. Giles, Regina Smith James, Tené T. Lewis, Ali H. Mokdad, Kari D. Moore, Joseph E. Ravenell, Al Richmond, Nancy E. Schoenberg, Mario Sims, Gopal K. Singh, Anne E. Sumner, Roberto P. Treviño, Karriem S. Watson, M. Larissa Avilés-Santa, Jared P. Reis, Charlotte A. Pratt, Michael M. Engelgau, David C. Goff Jr, Eliseo J. Pérez-Stable

Year 4: July 2018 to June 2019
Year 5: July 2019 to June 2020
HTN Clinic Model



P &T
Med Exec Approval

Year 5: July 2019 to June 2020 RESULTS

284 Encounters

- 98 participants
- 64 new patients (65.3%)
- 74 returning patients (75.5%, including 40 new patients)
- Average visits per patient = 2.9 (284/98)

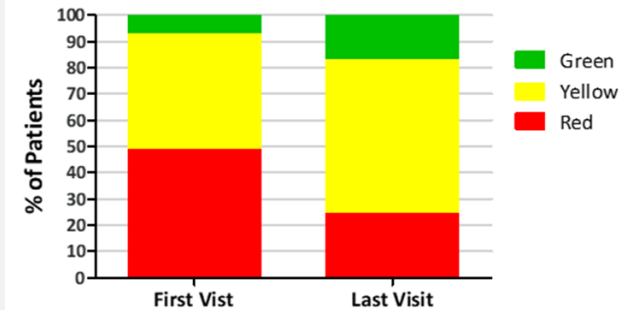
Participation Demographics (n = 98, first visit)

Age (year)		Gender (#, %)		Race (#, %)		Poverty Level (#, %)	
Mean	57	Female	63 (64.3%)	Black	79 (80.6%)	Mean	84.3
Median	58	Male	35 (35.7%)	White	17 (17.3%)	Range	0-422
Range	33-85			Unreported	2 (2.0%)	≤ 150% of FPL	83 (84.7%)
Age subgroups (#, %)		Language (#, %)		Ethnicity (#, %)			
< 45 yrs.	14 (14.3%)	English	94 (95.9%)	Hispanic	4 (4.1%)	≤ 100% of FPL	67 (68.4%)
45-65 yrs.	61 (62.2%)	Spanish	3 (3.1%)	No Hispanic	93 (94.9%)	≤ 50% of FPL	38 (38.8%)
> 65 yrs.	23 (23.5%)	Arabic	1 (1.0%)	Unreported	1 (1.0%)		

Risk Factors	Patients (#, %)	
Hypertension	98	100%
Diabetes	27	27.6%
Hyperlipidemia	59	60.2%
Atrial Fibrillation	3	3.1%
Myocardial Infarction	7	7.1%
Stroke	6	6.1%
Obesity	45	45.9%
Use Tobacco	34	34.7%
Depression	21	21.4%
Congestive Heart Failure	8	8.2%
Chronic Kidney	7	7.1%

(reported as mean ± SE)	First Visit	Last Visit	Change	p-value ^A
<u>Diastolic BP</u> (mmHg)	83.2 ± 1.2	79.4 ± 1.1	-3.8	0.003**
<u>Systolic BP</u> (mmHg)	137.7 ± 1.8	129.8 ± 1.4	-7.9	<0.001***
BMI (kg/m ²)	34.5 ± 1.3	34.0 ± 1.2	-0.5	0.778
Weight (lbs. Oz)	201.5 ± 8.0	200.6 ± 7.3	-0.9	0.941
^A P-value: Paired t test				

BP in Color Zones (July 2019 - June 2020)



BP Color Zone	First Visit	Last Visit
Green	5 (7.1%)	12 (17.1%)
Yellow	31 (44.3%)	41 (58.6%)
Red	34 (48.6%)	17 (24.3%)
Chi-squar test for trend		
p-value = 0.002**		

Year 5: July 2019 to June 2020 ADDITIONAL OUTCOMES



- 60.2% also had HLD, 45.9% obese
- Average visits per patient: 2.9 (range 1-12)
- 139 referrals for additional services
- 217 lifestyle changes made (2.21 per patient)
- 84.4% of patient's adherent to antihypertensive medication
- Of 98 patients:
 - 25 graduated
 - 21 continued in FY21
 - 51 lost to follow up (2 later improved to green zone, 6 to yellow zone, 15 improved BP)

2020 Pandemic

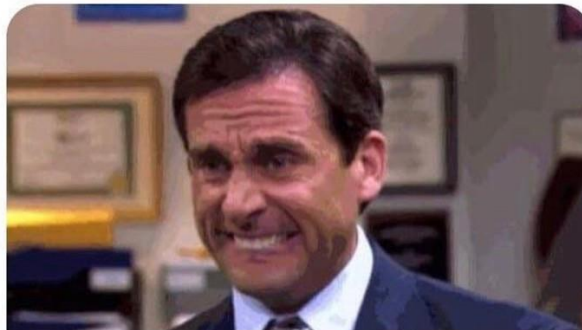
If 2020 was a Slide



Time traveler: What year is it?

Me: 2020

Time traveler:



Hypertension and COVID - 19

Hospitalizations were **6** times higher and deaths **12** times higher for COVID-19 patients with reported underlying conditions*

MOST FREQUENTLY REPORTED UNDERLYING CONDITIONS

CARDIOVASCULAR DISEASE



DIABETES



CHRONIC LUNG DISEASE



*compared to those with no reported underlying health conditions

CDC.GOV

bit.ly/MMWR61520

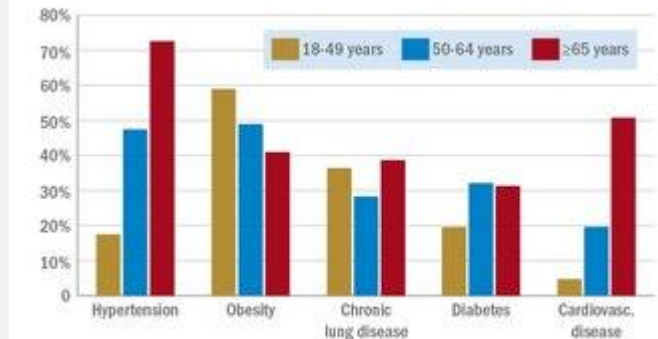
MMWR

Comorbidities

Increasing Risk of Infection and Severity of Lung Injury

- Hypertension (30%)
- Diabetes (19%)
- Coronary Heart Disease (8%)

Underlying conditions among adults hospitalized with COVID-19



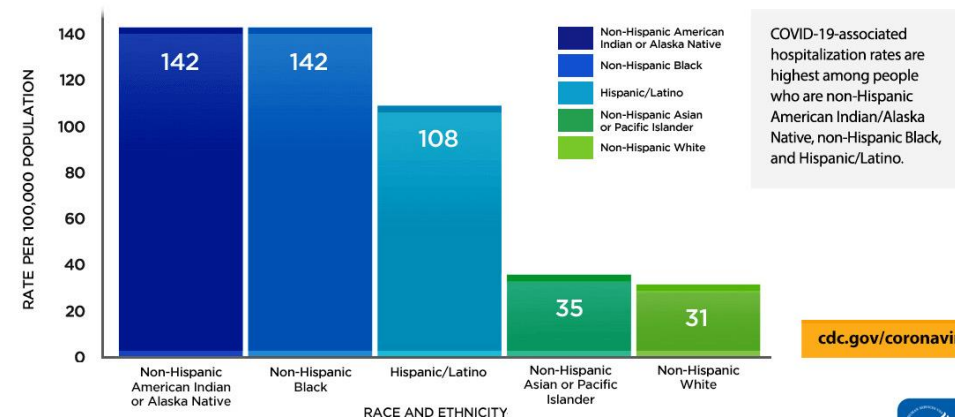
Note: Based on data from the COVID-19-Associated Hospitalization Surveillance Network for patients hospitalized in 99 counties in 14 states from March 1-30, 2020.

Source: MMWR. 2020 Apr 8;69(early release):1-7

Features		Hazard Ratio (95%CI)	P Value
Type of comorbidities			
COPD		2.681 (1.424-5.048)	0.002
Diabetes		1.586 (1.028-2.449)	0.037
Hypertension		1.575 (1.069-2.322)	0.022
Malignant tumor		3.501 (1.604-7.643)	0.002
Number of comorbidities			
1		1.789 (1.155-2.772)	0.009
2 or more		2.592 (1.611-4.171)	<0.001

Age-adjusted COVID-19-associated hospitalization rates by race and ethnicity

COVID-NET, MARCH 1 - MAY 23, 2020



cdc.gov/coronavirus



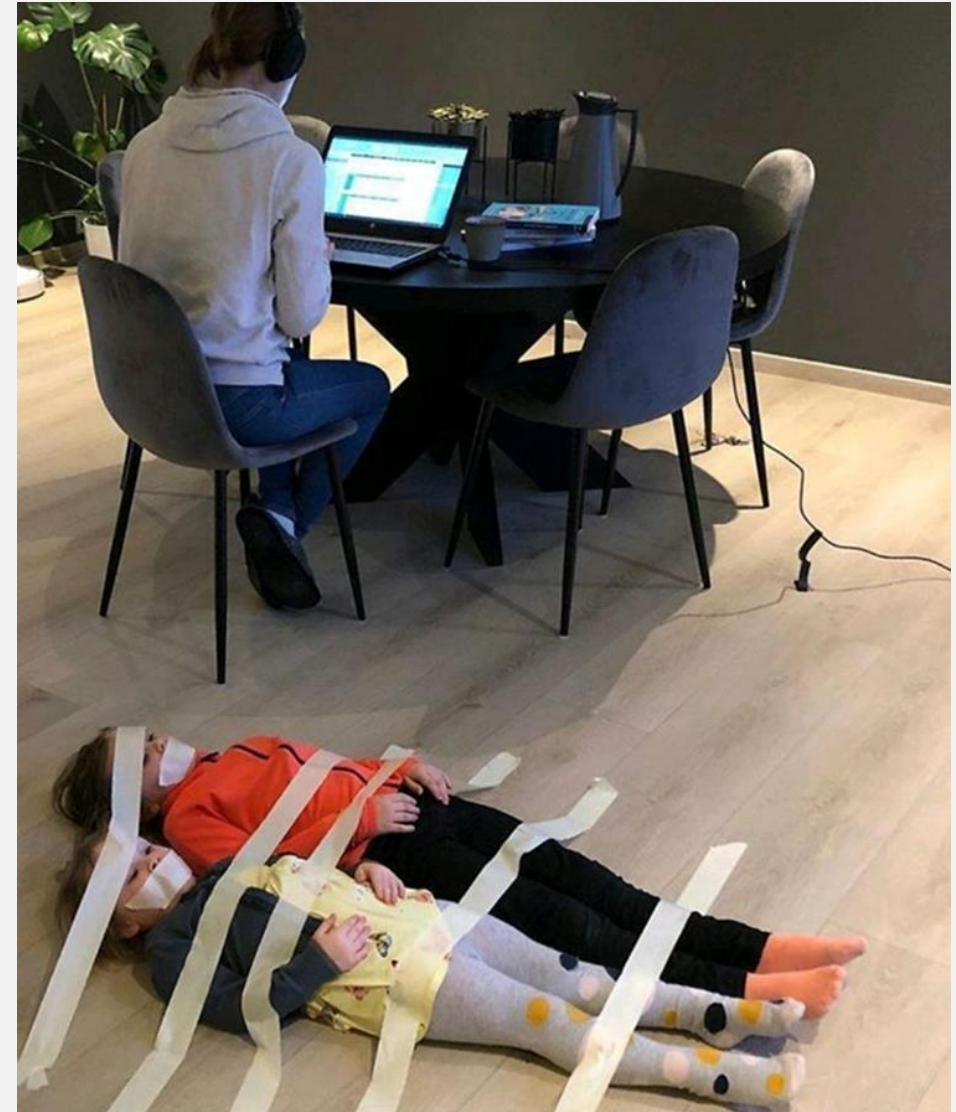
Rates are statistically adjusted to account for differences in age distributions within race and ethnicity strata in the COVID-NET catchment area. Rates are based on available race and ethnicity data which is now complete in 83% of cases from COVID-NET sites. COVID-19-associated hospitalization rates for American Indian and Alaska Natives (AI/AN) may be impacted by recent outbreaks among specific communities within this population and the small numbers of AI/AN cases included in COVID-NET.

Barriers to Sustaining the HTN Clinic During the Pandemic

Staff Barriers (Kari's World)



Staff Barriers (Kristin's World)



Staff Barriers



- Multiple organizations = multiple pandemic guidelines
- Team-based care = 5+ people in 1 office with constant rotation between multiple exam rooms
- Working from Home
 - Child Care / Online school
- Technology
 - Computers, internet, cameras, headphones, printer/fax/scanner
- Telehealth Platform
 - HIPAA Compliant
 - Allows multiple providers into appointment, varying levels of access
- Access to EHR
- Scheduling for maximum productivity
 - Ability to serve Limited English Proficiency patients
- Team member roles
 - Pharmacy Student involvement
- Patient Intake process
 - Consent and other paperwork
 - Blood Pressure Cuff and Incentive Distribution

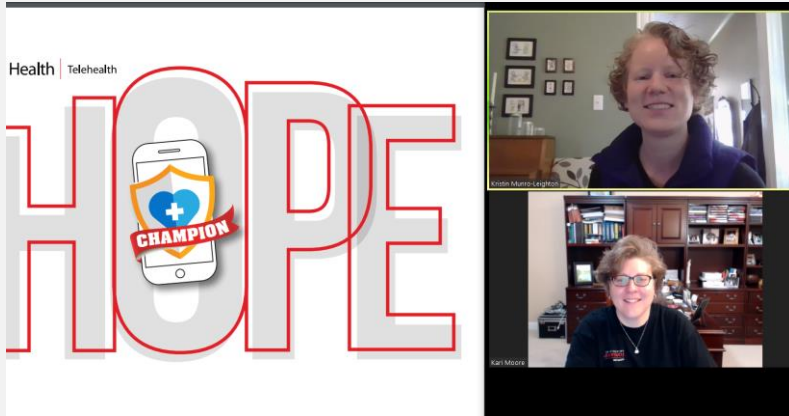
Barriers to Sustaining the HTN Clinic During the Pandemic

Patient Barriers

- Technology availability/literacy
- Internet availability
- Increased Stress
 - Basic needs – housing, food, health insurance
 - Job loss
- Health literacy
- Exposure to COVID-19
- Social distancing requirements
 - Increase in sedentary lifestyle
 - Increase in isolation and depression
 - Decreased access to health care
 - Routine Doctor's appointments
 - Specialists
 - Decreased access to community resources
 - YMCA, gyms, health Education Classes
 - Transportation



SOLUTIONS to Sustaining the HTN Clinic During the Pandemic



Telehealth Champions

- Manage exposure to COVID-19
 - Clinic precautions, PPE
 - Some staff onsite, some at home – seamless experience for patient
- Use supply budget to purchase equipment for staff
- Purchase and learn Telehealth Platform (Mend)
 - Duplicate scheduling systems
 - Managing pre-visit tech testing with patients, glitches, patients who need to call in
- Access to EHR via VPN

SOLUTIONS to Sustaining the HTN Clinic During the Pandemic



- Develop workflows for multiple appointment options and adapt to COVID risk in community and agency/state/federal guidelines
 - In person vs. telehealth vs. hybrid
 - Team-based care requires communication during visit = TEXT thread
- Team member roles
 - Warm hand-offs within the telehealth visit
 - Pre-rounding by Pharmacy Students
- Patient Intake process
 - Mailing cuff, paperwork, incentives to patient or patient picks up at clinic
- Scheduling
 - Fewer appt. slots, less productive, issues when patients take more time

Year 6: October 2020 to December 2020 PARTIAL RESULTS

72 Encounters in EHR data

- 41 Unique patients (56.9%)
- 12 New patients (16.7%)
- Average visits per patient = 5.71



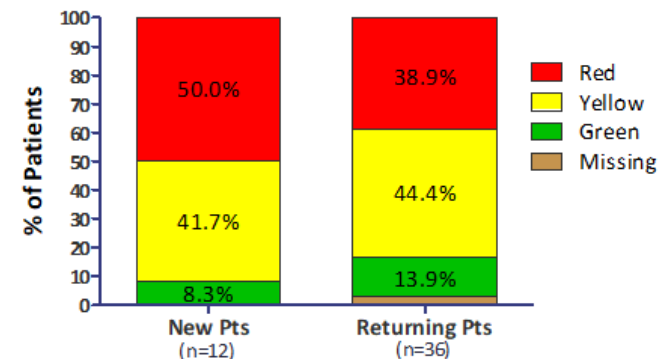
CARE Collaborative Report

All Participants		Returning Participants	
Total Education Encounters (#)	72	Total Returning Participants (#, %)	36 87.8%
New Participants (#, %)	12 38.1%	Monitoring BP at Home (#, %)	35 97.2%
BP in Green Zone (#, %)	7 10.1%	Brought in BP Log (#, %)	32 88.9%
BP in Yellow Zone (#, %)	29 42.0%	Total Lifestyle Changes Made (#)	88
BP in Red Zone (#, %)	33 47.8%	Participants made Lifestyle Changes (#, %)	32 88.9%
Identify BP Zone (#, %)	62 86.1%	Improved to Green (#, %)	5 13.9%
		Improved to Yellow (#, %)	10 27.7%
		Improved BP (#, %)	28 77.8%

* 2 encounter: BP record was missing

** 7 new patients: also were returning Pt during this time period

BP in Color Zones (Oct-Dec 2020)



Future -- > Sustainability

Year 6 (2020-21)

- Continue to manage changing landscape of COVID-19
- Assess new telehealth vendors
- Implement text and automated education messaging
- Incorporate FHCs new HRSA HTN grant
- Prepare for new EHR in 2022
- Review and determine sustainability of current data collection and analysis

Year 7 (2021-22)

- Utilize and enhance telehealth platform
- Adapt to new EHR and data collection
- Consider remote BP monitoring pilot that communicates with EHR and assists those with health literacy concerns
- Create SMBP toolkit curriculum
- Start HTN clinic for Spanish-speaking patients

Year 8 (2022-23)

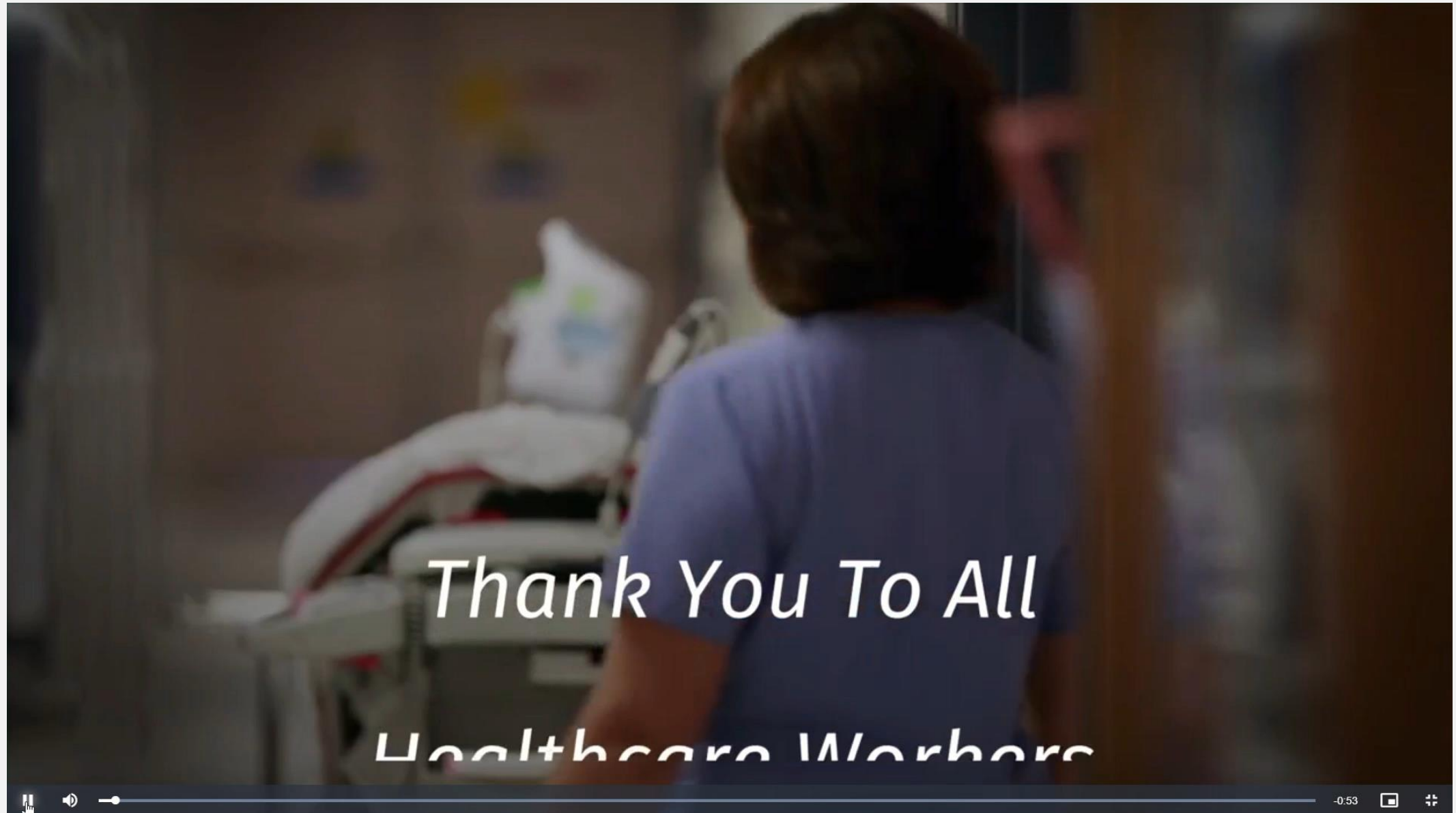
- Expand telehealth sites across the Commonwealth outside of FHC
- Secure funding source
- Identify opportunities to include other non-English speaking patients

- Cardiovascular risk factors in Kentucky are uncontrolled
 - Disparate populations are at the highest risk
- Team Based SMBP programs have proven to be effective
- The FHC HTN clinic has:
 - Increased utilization of home BP monitoring
 - Helped patients implement lifestyle changes
 - Helped patients improve and achieve blood pressure control
 - Increased communication with PCPs
 - Increased referrals to health education classes
 - Succeeded due to HTN clinic team members, FHC staff, HDSP support, and patient flexibility
- Regular team meetings and discussion regarding strengths, weaknesses, and processes are key to program sustainability

A photograph of a medical stethoscope with a teal tube and silver chest piece, resting on a white medical chart with horizontal lines. The word "Summary" is written in a large, white, sans-serif font in the bottom right corner of the image.

Summary

Thank You



Commonwealth Journal, Somerset, KY