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APR 29–MAY 1
BOSTON, MA
2025

Stronger Hearts, Smarter Strategies

Advancing Hypertension Management

Today's Speakers

Dodey Roughton
Senior Director, Health System Transformation

Alabama Primary Health Care Association

Kara Vernatter
Quality Manager

Southern West Virginia Health System

Michelle Swanson
Nursing Manager

Southern West Virginia Health System

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Stronger Hearts, Smarter Strategies: Advancing Hypertension Management

Dodey Roughton
Alabama Primary Health Care Association

Objectives

APHCA Hypertension Improvement

Detail hypertension improvement efforts from a network perspective.

Leveraging DRVS

Understand use case for role-based dashboards related to quality improvement (QI) efforts for patients at risk of cardiovascular disease leveraging the AMA MAP™ Framework.

Facing Challenges

Review diagnoses related challenges as well as challenges faced at the network level.

APHCA – Quality Connect Network

21 Health Center Organizations across 2 states

206 care delivery sites

Representing over 450,000 patient lives

APHCA PCA / HCCN Members

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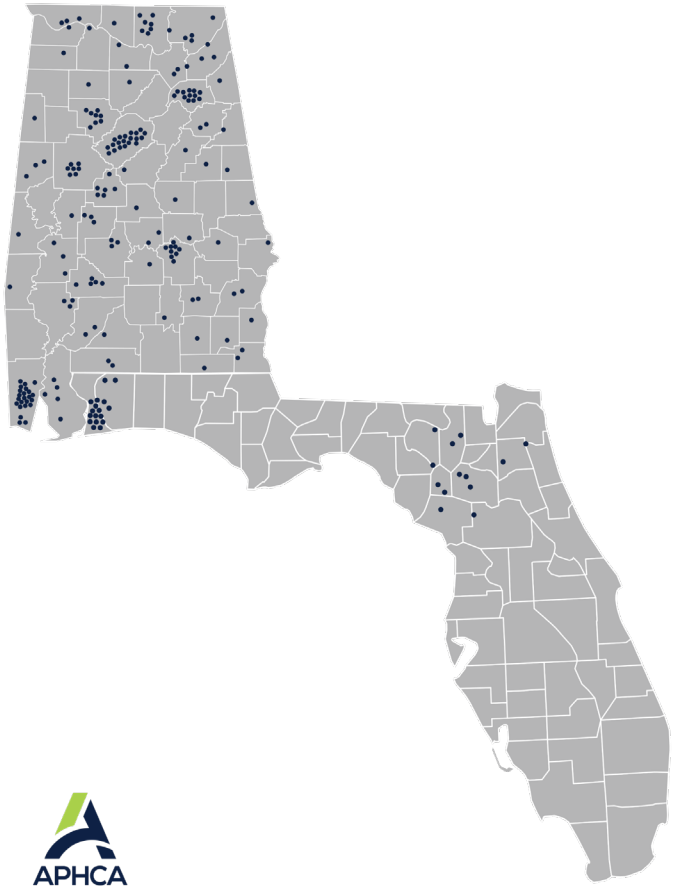


APHCA

- Alabama Regional Medical Services
- Aletheia House
- AltaPointe Health Systems
- Bayou La Batre Area Health Development Board
- Cahaba Medical Care
- Capstone Rural Health Center
- Central North Alabama Health Services
- Christ Health Center
- Community Health Northwest Florida
- Family Health/MCHD
- Franklin Primary Health Center
- HAPPI Health
- Health Services
- Northeast Alabama Health Services
- Physicians Care of Clarke
- Quality of Life Health Services
- Rural Health Medical Program
- Southeast Alabama Rural Health Associates
- Thrive Alabama
- Trenton Medical Center
- Whatley Health Services

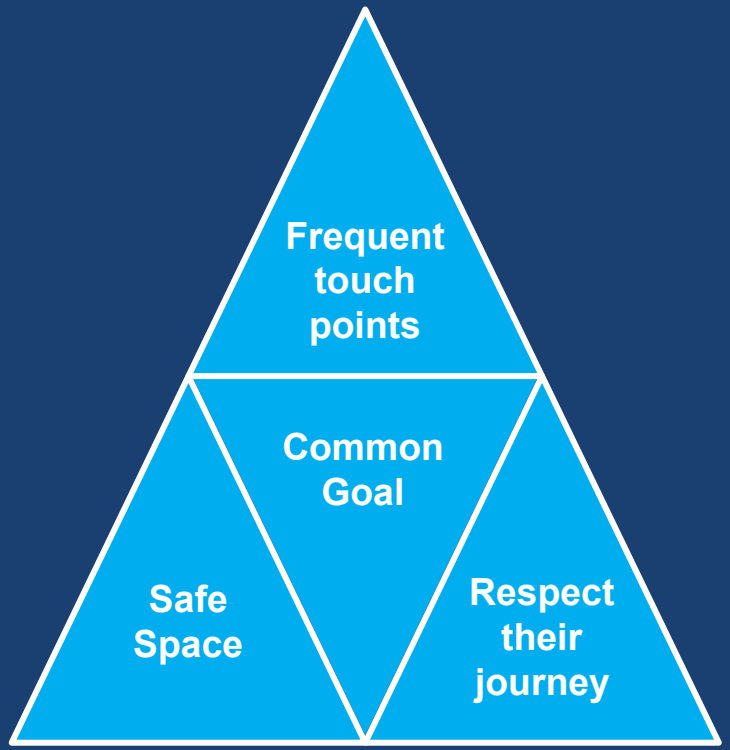
APHCA – Quality Connect of Alabama

Relationship Building:

Quality Connect meetings

User Groups

CLIMB



Quality Connect Meetings

Monthly at consistent time
- Quality Staff
- Data/IT Staff
- Clinical Staff (including CMO for some centers)

Review workplan activities

Identify QI projects for center

Time to request/offer assistance in various area

Participation rate monthly in excess of 85%

T/TA needs identified include:
- Azara Training
- Practice Facilitation needs
- Policy/Compliance questions
- PCMH needs

Alabama Health Outcomes

3rd Poorest health outcomes in the country

2nd Lowest life expectancy in the country

1st Highest level of mortality related CV disease & stroke

Highest level of mortality related CV disease & Stroke

- Highest mortality for heart disease
- Stroke is the fifth leading cause of death

HCCN Disease Burden

51.2% of patients are obese

42% of people with high blood pressure are uncontrolled

Over 20,667 have heart disease (other than HTN)

11.4% have diabetes

1 in 5 adults have been diagnosed with anxiety and/or depression

Cardiovascular Health

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Collaborations

CDC + ALABAMA PUBLIC HEALTH + AMA MAP™ Hypertension

Strategies		
Track/monitor clinical & social services and support needs measures with a focus on HTN & high cholesterol	Implement team-based care to prevent/reduce CVD risk with a focus on HTN & high cholesterol prevention, detection, control, & management through the mitigation of social support barriers	Link community resources & clinical services that support bidirectional referrals, self-management, and lifestyle change to address health related social risks that put priority populations at increased risk for CVD with a focus on HTN & high cholesterol

Commitment

Participate fully in PDSA cycles

Allow staff to meet with Practice Facilitator on site and virtually

Assign practice champions (MA & provider) at each clinic location

Allow reporting of data to ADPH

Complete surveys as necessary

AMA MAP™

Hypertension

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Strategies and Action Steps

M Measure Accurately

Obtain actionable BPs to diagnose hypertension and assess BP control

- Use automated, validated upper arm measurement devices
- Use proper patient preparation and positioning and correct measurement technique
- Implement a standardized BP measurement protocol; take confirmatory measurements

A Act Rapidly

Initiate and intensify using evidence-based treatment

- Use an evidence-based treatment protocol
- Use single-pill combinations
- Follow up frequently until BP control is achieved

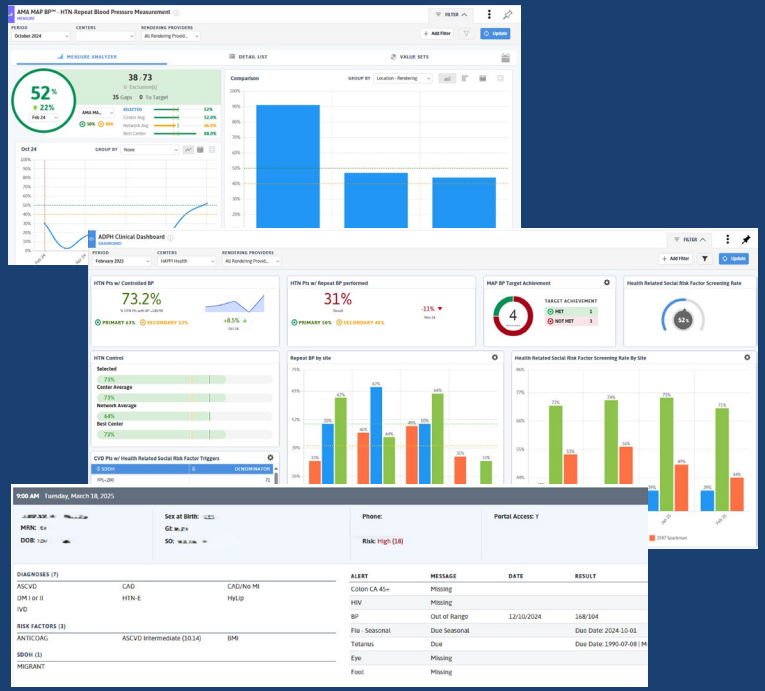
P Partner with Patients

To support patient activation and improve adherence to treatment

- Assess and address non-adherence to treatment
- Use collaborative communication
- Use proven non-pharmacological interventions
- Incorporate self-measured blood pressure (SMBP)


"JUST DON'T TAKE THESE
ON AN EMPTY STOMACH"

Azara as a Tool

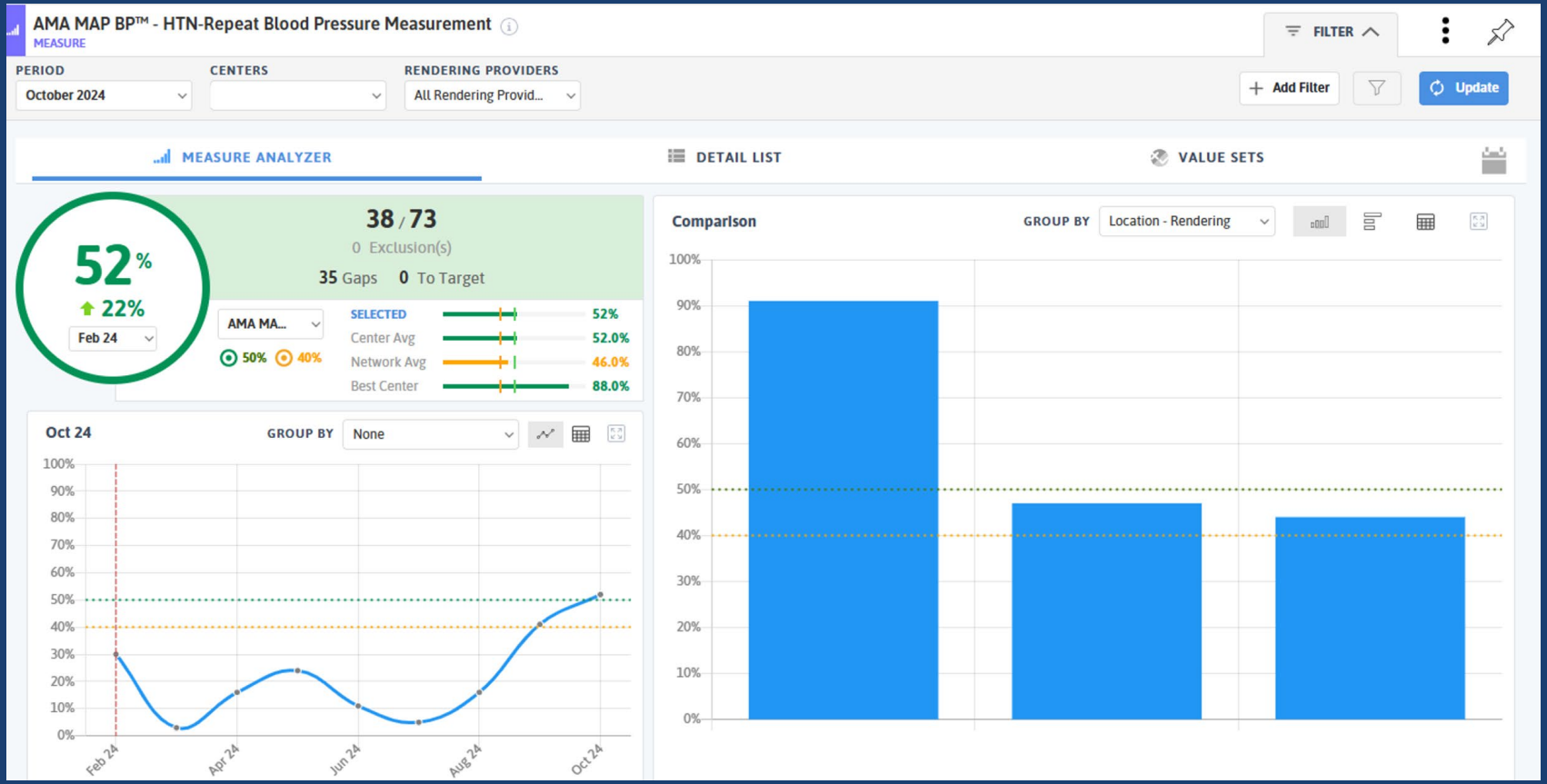


- Huddle management – **PVP** alerts, **CMP**
- **Dashboards** – CQM, Role-Based
- Provider **Registry**
- **Measures** – include:
  - UDS tables
  - Health Related Social Needs data tracking
  - AMA MAP™ Hypertension Metrics

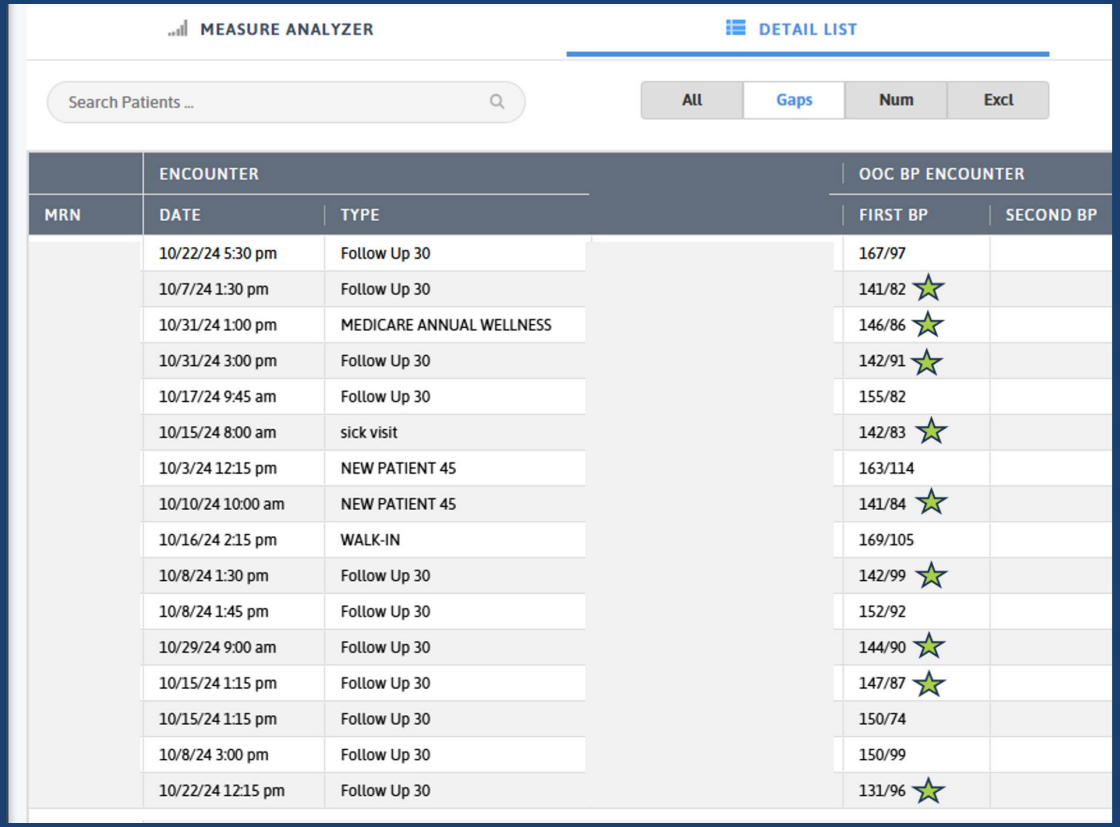
Measure Accurately

- Provider Education
- Workflow Discussion
  - Huddles
- Provider Dashboard
- Provider Registry

Repeat Blood Pressures



Repeat Blood Pressures – Gaps



	ENCOUNTER		OOC BP ENCOUNTER	
MRN	DATE	TYPE	FIRST BP	SECOND BP
	10/22/24 5:30 pm	Follow Up 30	167/97	
	10/7/24 1:30 pm	Follow Up 30	141/82	
	10/31/24 1:00 pm	MEDICARE ANNUAL WELLNESS	146/86	
	10/31/24 3:00 pm	Follow Up 30	142/91	
	10/17/24 9:45 am	Follow Up 30	155/82	
	10/15/24 8:00 am	sick visit	142/83	
	10/3/24 12:15 pm	NEW PATIENT 45	163/114	
	10/10/24 10:00 am	NEW PATIENT 45	141/84	
	10/16/24 2:15 pm	WALK-IN	169/105	
	10/8/24 1:30 pm	Follow Up 30	142/99	
	10/8/24 1:45 pm	Follow Up 30	152/92	
	10/29/24 9:00 am	Follow Up 30	144/90	
	10/15/24 1:15 pm	Follow Up 30	147/87	
	10/15/24 1:15 pm	Follow Up 30	150/74	
	10/8/24 3:00 pm	Follow Up 30	150/99	
	10/22/24 12:15 pm	Follow Up 30	131/96	

Repeat Blood Pressures - Opportunities

Encourage staff that their efforts have the power to impact positive change!

October Control = **154** / 269 = 57.2%

57 / 94 patients were within 10 points of control

Potential Control num = **154** + **57** = 211 / 269 = 78.4%

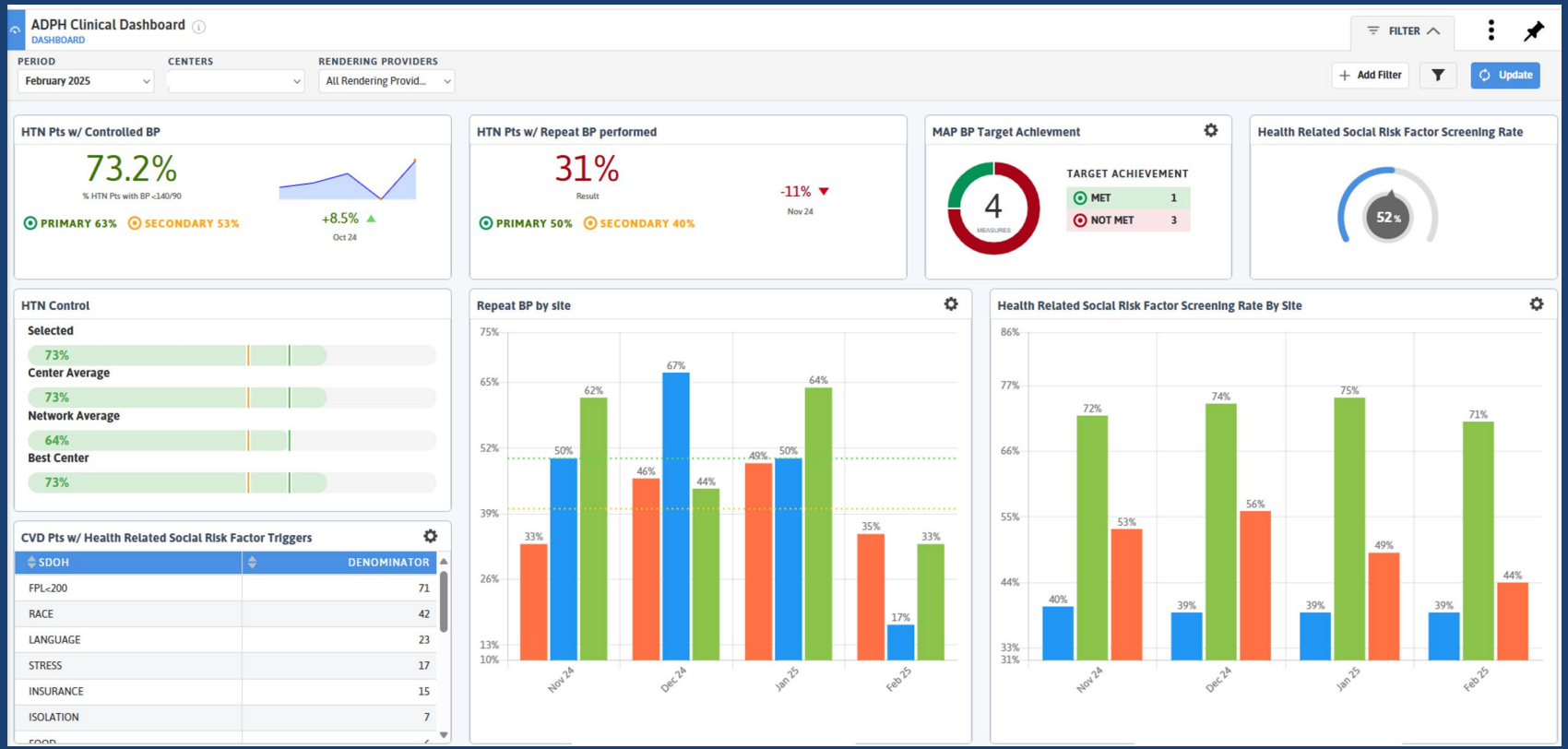
If you are able to get ½ of those **57** patients to < 140/90 → 154 + 28 = 182 / 269 = 67.6%

Clinical staff often are unsure of how to use data.

APHCA is teaching them to translate that into what they do every day.

Reminder that these numbers / percentages / gaps are people.

Clinical Dashboard



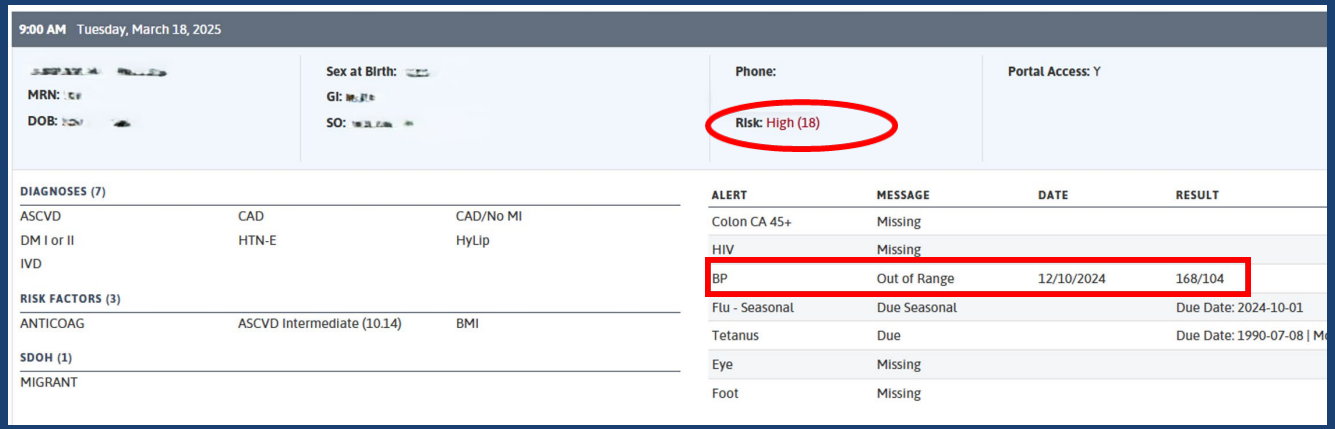
Repeat BP Improvements

Center	July	August	September	October	Overall Increase
Center 1	7%	27%	46%	47%	**40%**
Center 2	0%	20%	75%	91%	**91%**
Center 3	5%	11%	28%	44%	**39%**

Act Rapidly

- Provider Education
- Workflow Discussion
  - Huddles
- Provider Dashboard
- Provider Registry

Huddles – PVP



9:00 AM Tuesday, March 18, 2025

MRN:

DOB:

Sex at Birth:

GI:

SO:

Phone:

Risk: High (18)

Portal Access: Y

DIAGNOSES (7)

ASCVD	CAD	CAD/No MI
DM I or II	HTN-E	HyLip
IVD		

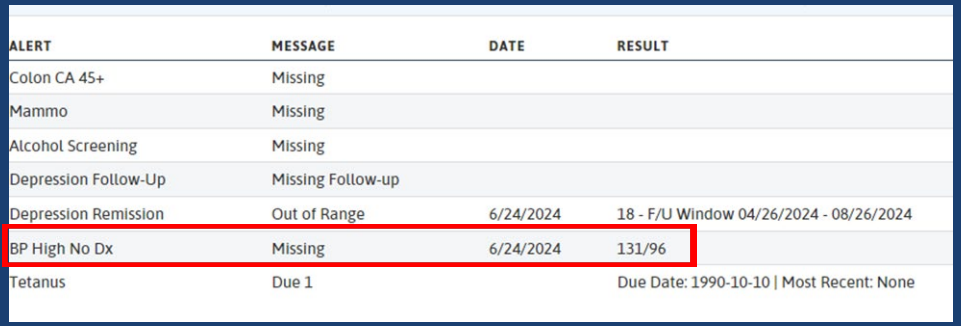
RISK FACTORS (3)

ANTICOAG	ASCVD Intermediate (10.14)	BMI

SDOH (1)

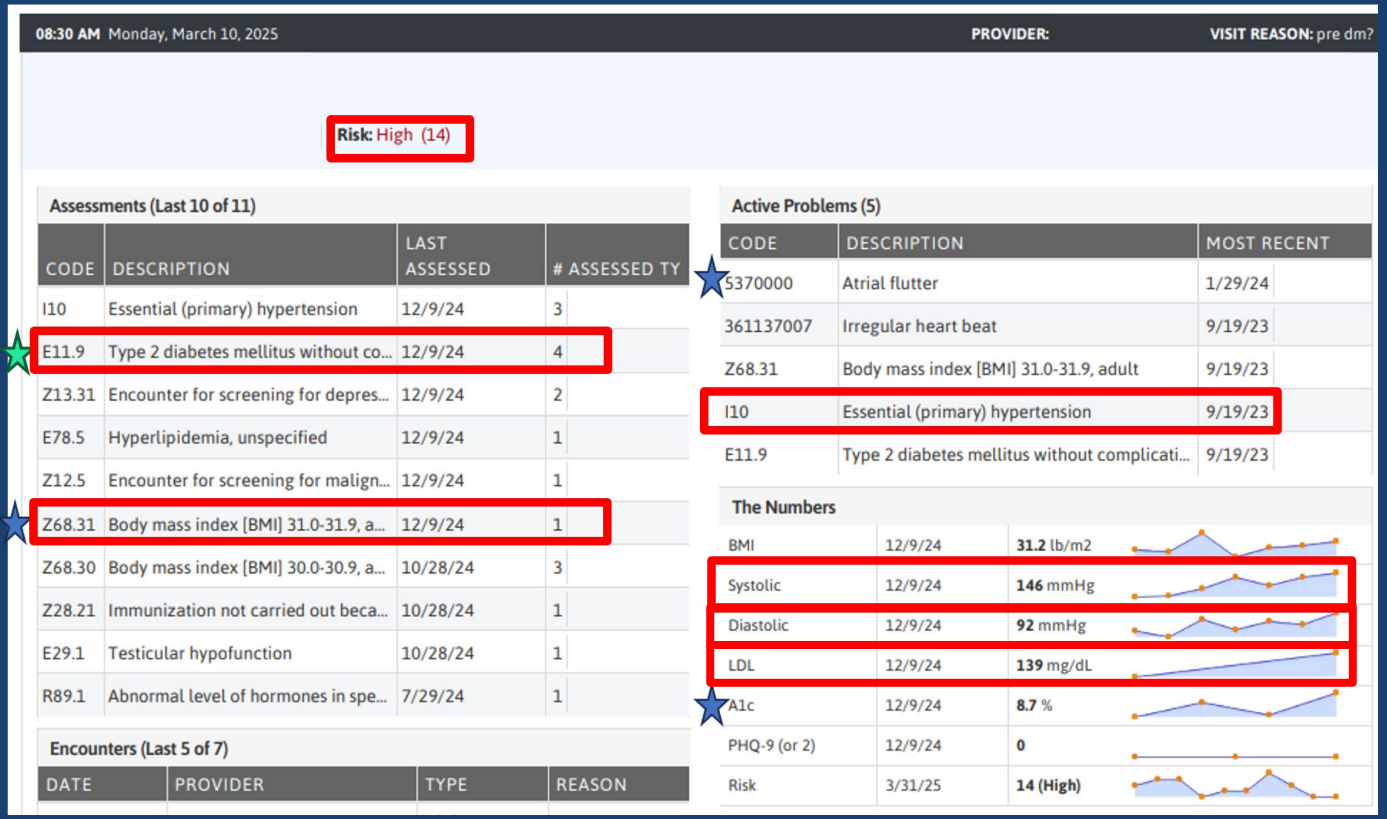
MIGRANT

ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Missing		
HIV	Missing		
BP	Out of Range	12/10/2024	168/104
Flu - Seasonal	Due Seasonal		Due Date: 2024-10-01
Tetanus	Due		Due Date: 1990-07-08 | M
Eye	Missing		
Foot	Missing		



ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Missing		
Mammo	Missing		
Alcohol Screening	Missing		
Depression Follow-Up	Missing Follow-up		
Depression Remission	Out of Range	6/24/2024	18 - F/U Window 04/26/2024 - 08/26/2024
BP High No Dx	Missing	6/24/2024	131/96
Tetanus	Due 1		Due Date: 1990-10-10 | Most Recent: None

Huddles – CMP



08:30 AM Monday, March 10, 2025 PROVIDER: VISIT REASON: pre dm?

Risk: High (14)

Assessments (Last 10 of 11)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
I10	Essential (primary) hypertension	12/9/24	3
E11.9	Type 2 diabetes mellitus without co...	12/9/24	4
Z13.31	Encounter for screening for depres...	12/9/24	2
E78.5	Hyperlipidemia, unspecified	12/9/24	1
Z12.5	Encounter for screening for malign...	12/9/24	1
Z68.31	Body mass index [BMI] 31.0-31.9, a...	12/9/24	1
Z68.30	Body mass index [BMI] 30.0-30.9, a...	10/28/24	3
Z28.21	Immunization not carried out beca...	10/28/24	1
E29.1	Testicular hypofunction	10/28/24	1
R89.1	Abnormal level of hormones in spe...	7/29/24	1

Encounters (Last 5 of 7)

DATE	PROVIDER	TYPE	REASON

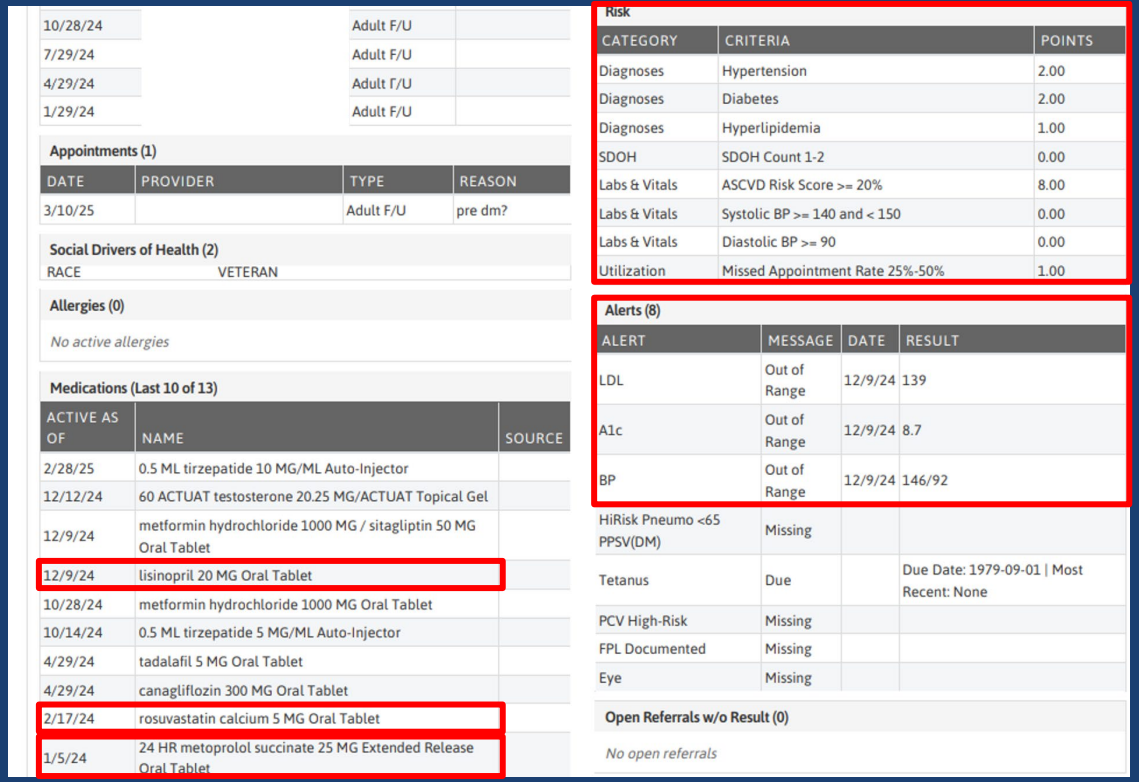
Active Problems (5)

CODE	DESCRIPTION	MOST RECENT
5370000	Atrial flutter	1/29/24
361137007	Irregular heart beat	9/19/23
Z68.31	Body mass index [BMI] 31.0-31.9, adult	9/19/23
I10	Essential (primary) hypertension	9/19/23
E11.9	Type 2 diabetes mellitus without complicati...	9/19/23

The Numbers

BMI	12/9/24	**31.2** lb/m2
Systolic	12/9/24	**146** mmHg
Diastolic	12/9/24	**92** mmHg
LDL	12/9/24	**139** mg/dL
A1c	12/9/24	**8.7** %
PHQ-9 (or 2)	12/9/24	**0**
Risk	3/31/25	**14 (High)**

Huddles – CMP



10/28/24		Adult F/U	
7/29/24		Adult F/U	
4/29/24		Adult F/U	
1/29/24		Adult F/U	

Appointments (1)

DATE	PROVIDER	TYPE	REASON
3/10/25		Adult F/U	pre dm?

Social Drivers of Health (2)

RACE	VETERAN

Allergies (0)

No active allergies

Medications (Last 10 of 13)

ACTIVE AS OF	NAME	SOURCE
2/28/25	0.5 ML tirzepatide 10 MG/ML Auto-Injector	
12/12/24	60 ACTUAT testosterone 20.25 MG/ACTUAT Topical Gel	
12/9/24	metformin hydrochloride 1000 MG / sitagliptin 50 MG Oral Tablet	
12/9/24	lisinopril 20 MG Oral Tablet	
10/28/24	metformin hydrochloride 1000 MG Oral Tablet	
10/14/24	0.5 ML tirzepatide 5 MG/ML Auto-Injector	
4/29/24	tadalafil 5 MG Oral Tablet	
4/29/24	canagliflozin 300 MG Oral Tablet	
2/17/24	rosuvastatin calcium 5 MG Oral Tablet	
1/5/24	24 HR metoprolol succinate 25 MG Extended Release Oral Tablet	

Risk

CATEGORY	CRITERIA	POINTS
Diagnoses	Hypertension	2.00
Diagnoses	Diabetes	2.00
Diagnoses	Hyperlipidemia	1.00
SDOH	SDOH Count 1-2	0.00
Labs & Vitals	ASCVD Risk Score >= 20%	8.00
Labs & Vitals	Systolic BP >= 140 and < 150	0.00
Labs & Vitals	Diastolic BP >= 90	0.00
Utilization	Missed Appointment Rate 25%-50%	1.00

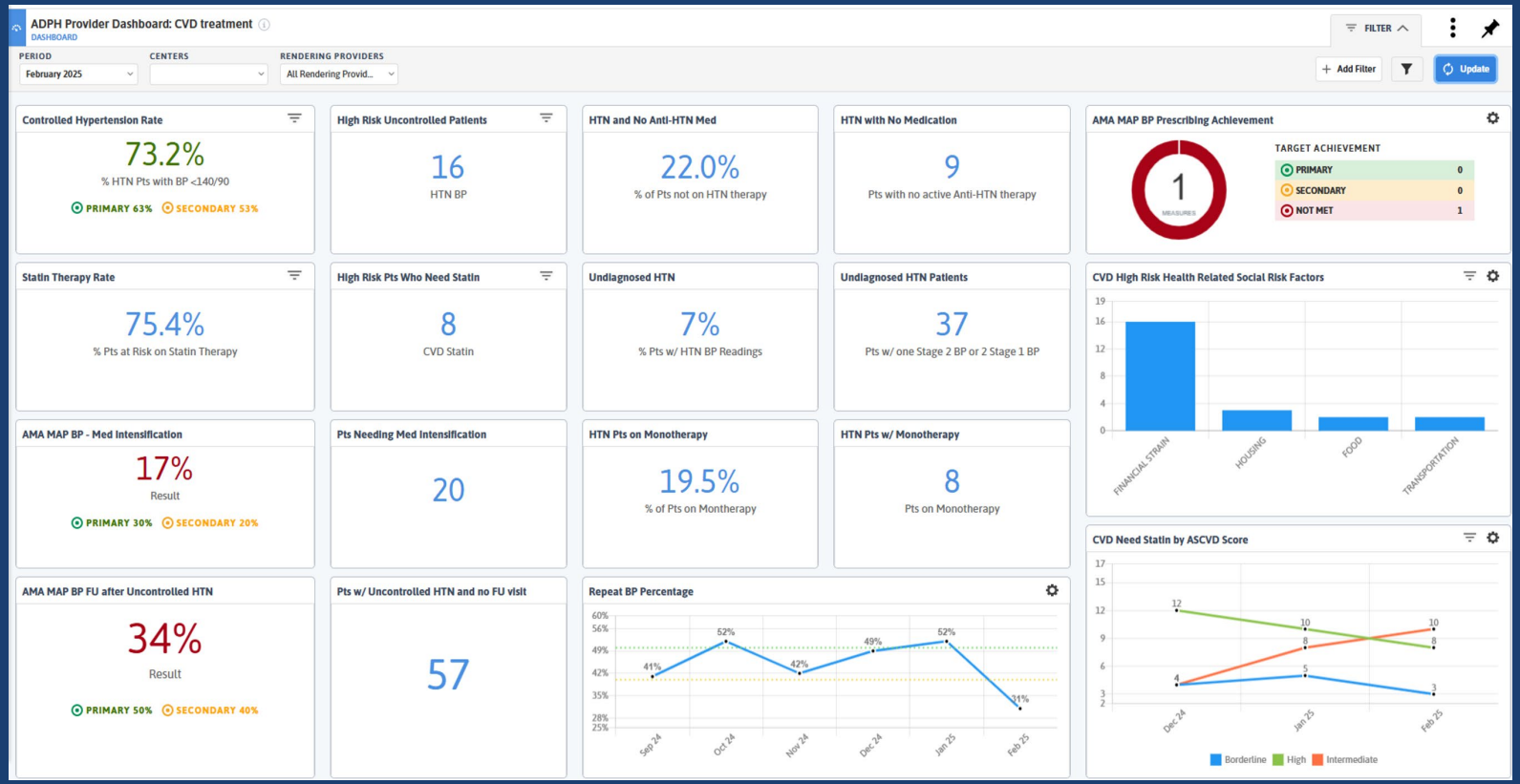
Alerts (8)

ALERT	MESSAGE	DATE	RESULT
LDL	Out of Range	12/9/24	139
A1c	Out of Range	12/9/24	8.7
BP	Out of Range	12/9/24	146/92
HiRisk Pneumo <65 PPSV(DM)	Missing		
Tetanus	Due		Due Date: 1979-09-01 | Most Recent: None
PCV High-Risk	Missing		
FPL Documented	Missing		
Eye	Missing		

Open Referrals w/o Result (0)

No open referrals

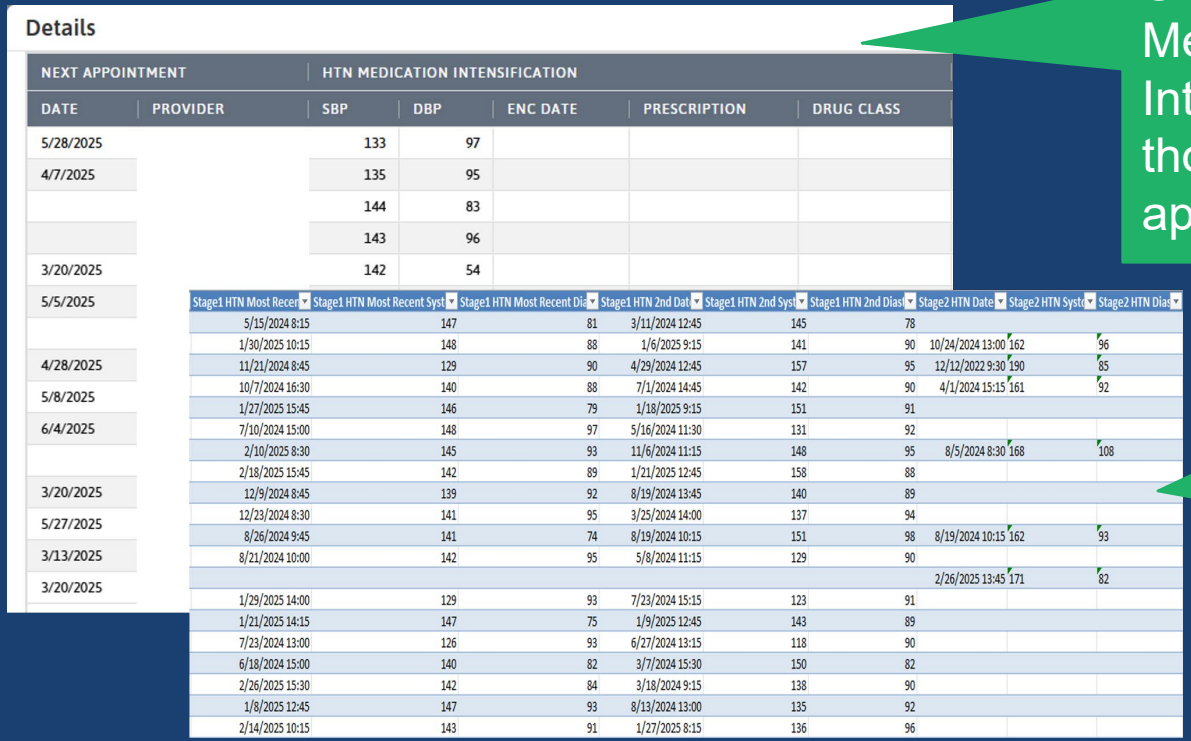
Provider Dashboard



Undiagnosed HTN & Needs Med Intensification

Use Details list of Medication Intensification to see those with upcoming appointments

Download details for Undiagnosed to see trend of BP values



Details

NEXT APPOINTMENT		HTN MEDICATION INTENSIFICATION				
DATE	PROVIDER	SBP	DBP	ENC DATE	PRESCRIPTION	DRUG CLASS
5/28/2025		133	97			
4/7/2025		135	95			
		144	83			
		143	96			
3/20/2025		142	54			
5/5/2025						
4/28/2025						
5/8/2025						
6/4/2025						
3/20/2025						
5/27/2025						
3/13/2025						
3/20/2025						

Stage1 HTN Most Recen	Stage1 HTN Most Recent Syst	Stage1 HTN Most Recent Dia	Stage1 HTN 2nd Dat	Stage1 HTN 2nd Syst	Stage1 HTN 2nd Diast	Stage2 HTN Date	Stage2 HTN Syste	Stage2 HTN Dias
5/15/2024 8:15	147	81	3/11/2024 12:45	145	78			
1/30/2025 10:15	148	88	1/6/2025 9:15	141	90	10/24/2024 13:00	162	96
11/21/2024 8:45	129	90	4/29/2024 12:45	157	95	12/12/2022 9:30	190	85
10/7/2024 16:30	140	88	7/1/2024 14:45	142	90	4/1/2024 15:15	161	92
1/27/2025 15:45	146	79	1/18/2025 9:15	151	91			
7/10/2024 15:00	148	97	5/16/2024 11:30	131	92			
2/10/2025 8:30	145	93	11/6/2024 11:15	148	95	8/5/2024 8:30	168	108
2/18/2025 15:45	142	89	1/21/2025 12:45	158	88			
12/9/2024 8:45	139	92	8/19/2024 13:45	140	89			
12/23/2024 8:30	141	95	3/25/2024 14:00	137	94			
8/26/2024 9:45	141	74	8/19/2024 10:15	151	98	8/19/2024 10:15	162	93
8/21/2024 10:00	142	95	5/8/2024 11:15	129	90			
						2/26/2025 13:45	171	82
1/29/2025 14:00	129	93	7/23/2024 15:15	123	91			
1/21/2025 14:15	147	75	1/9/2025 12:45	143	89			
7/23/2024 13:00	126	93	6/27/2024 13:15	118	90			
6/18/2024 15:00	140	82	3/7/2024 15:30	150	82			
2/26/2025 15:30	142	84	3/18/2024 9:15	138	90			
1/8/2025 12:45	147	93	8/13/2024 13:00	135	92			
2/14/2025 10:15	143	91	1/27/2025 8:15	136	96			

Provider Registry

Risk Level

Next Appointment

- Date
- Provider
- Location

HTN Diagnosis

DM Diagnosis

ASCVD Risk Score

Blood Pressure

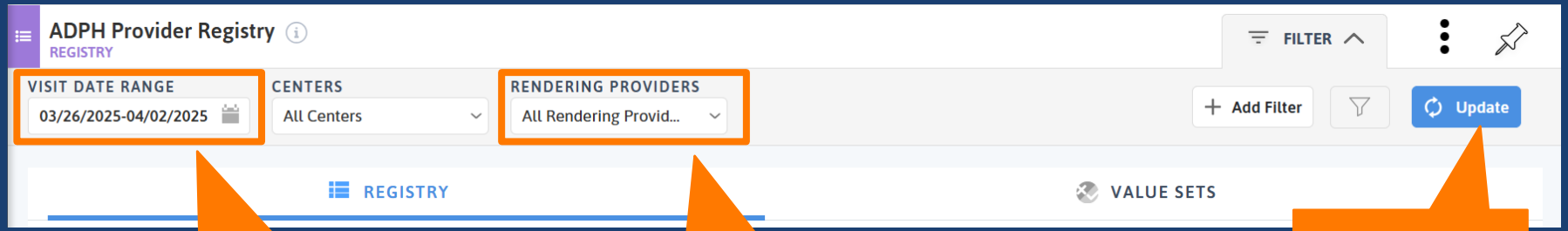
- Date
- Value

Anti-HTN Med

Statin Med

ACE / ARB

Patients with Upcoming Appointments Needing Statin &/or HTN Meds

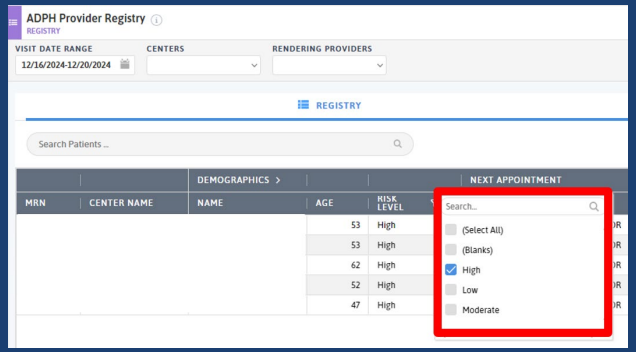


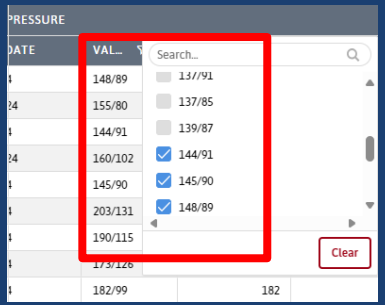
Date Range – future – next week

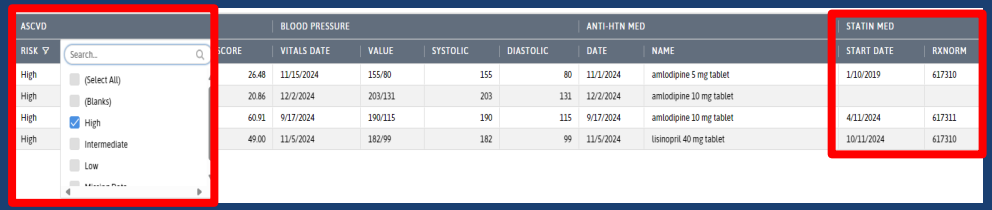
Chose yourself as a provider from the list of Rendering Providers dropdown

Click Update

Patients with Upcoming Appointments Needing Statin &/or HTN Meds





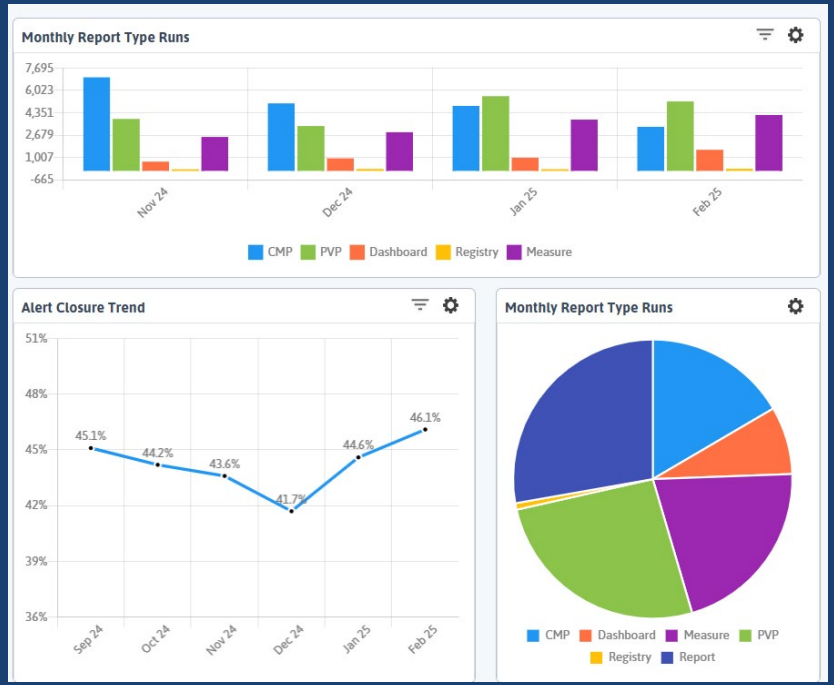


Use Filters:

- Risk Score High
- Find Uncontrolled HTN
- Find Missing Statin Med

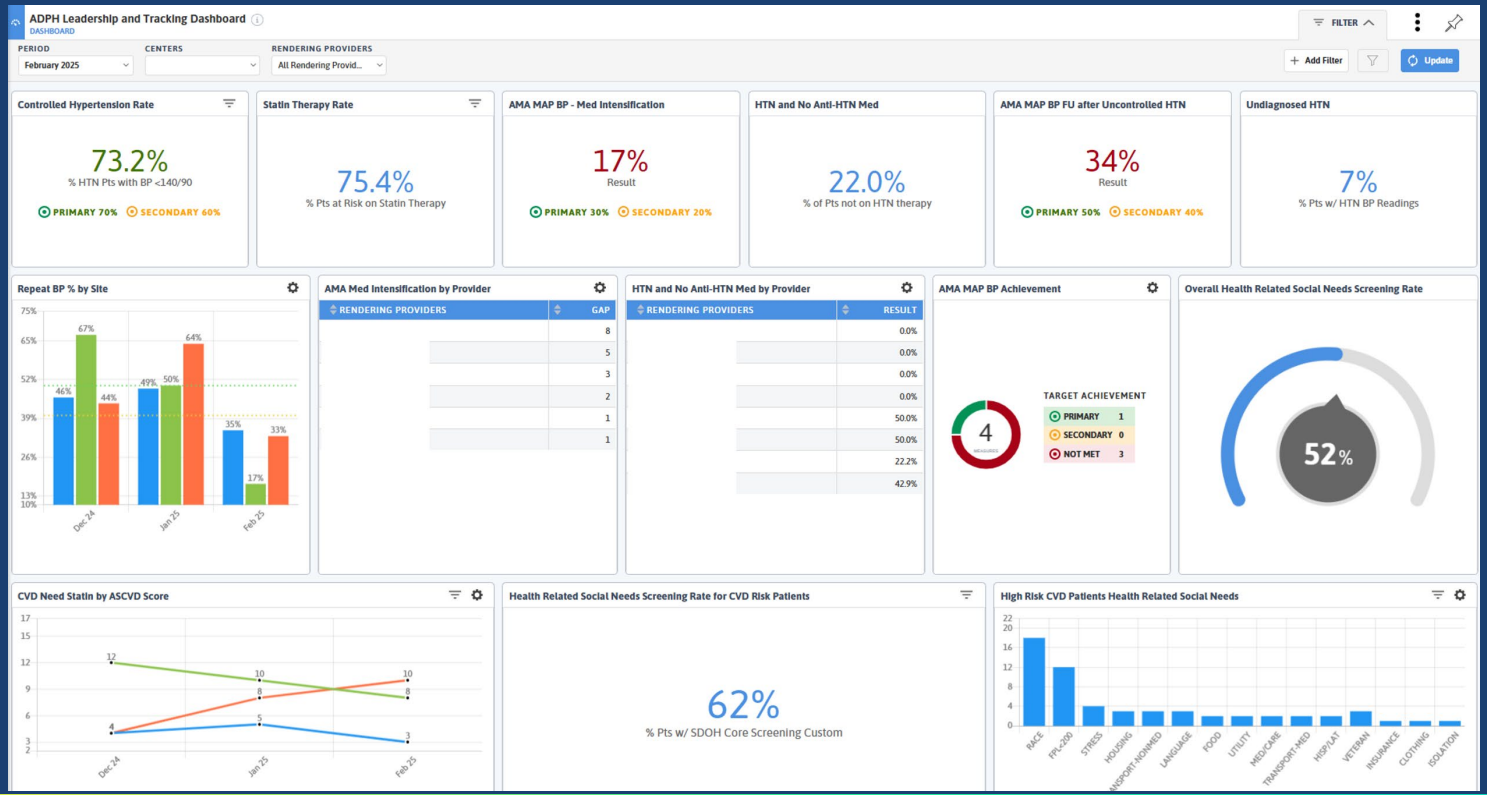
Improvements in Engagement

- Provider engagement has been a challenge
- Small, incremental steps
  - Begin with provider specific data
  - Make it actionable
  - Training may take several times
- Where we are seeing wins:
  - More Azara users
  - More dashboards and specific measures being used
  - Alert closure rates climbing
  - More clinical staff engaged with idea that data can lead you to action



Leadership Dashboard

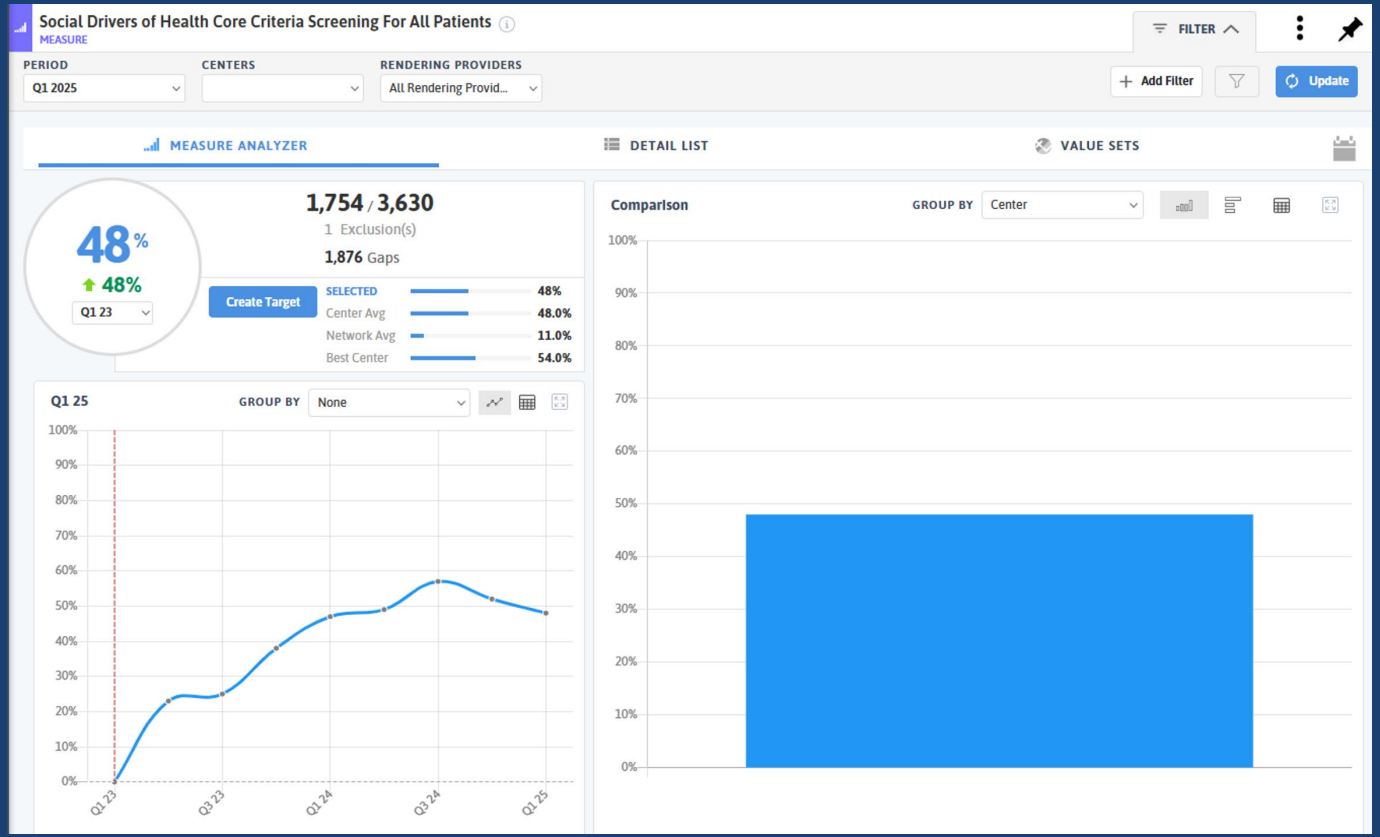
CEO
CMO
Nursing Admin



Partner with Patients

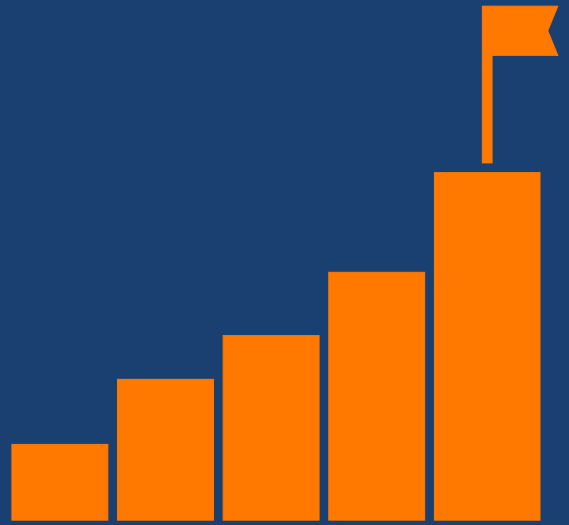
- Self-Management Goals & Health Related Social Need Referrals
  - Non-adherence
  - Non-pharmacological interventions
- Self-Measured Blood Pressure (SMBP)
- Remote Patient Monitoring (RPM)

Health Related Social Risks



Challenges

- Diagnosis Related
  - Patient compliance with treatment regimen
    - Lifestyle
    - Health Related Social Risks
  - Clinical inertia
- Organizational
  - Staff turnover
  - Competing priorities
  - Organizational preferences / workflows



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2025

Continuous Improvement

“Perfection is not attainable, but if we chase perfection, we can catch excellence.”

Vince Lombardi

We Are

A P H C A

CONTACT US

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Southern West Virginia Health System

Stronger Hearts, Smarter Strategies: Advancing Hypertension Management

Michelle Swanson, BSN,RN (Regional Nurse Manager)

Kara Vernatter, BSN, RN, RT(R), (Quality Improvement Manager)

Who are we?

Mission Statement:
Southern West Virginia Health System provides quality care and serves as a leader in improving the health of our communities.

1975 Opened the first clinic as Lincoln County Primary Care Center in Hamlin, West Virginia, Southern West Virginia Health System has been dedicated to delivering high quality, accessible healthcare services to the residents of our local communities.

1977 LPCC was recognized as the nation's first designated Rural Health Clinic (RHC).

2002 LPCC became a Federally Funded Section 330 center under the Health Resources Services Administration in 2002.

2025 With the addition of three new clinics in 2025, our total now reaches 26 locations. This includes both community-based centers and school-based health clinics, further expanding our reach and services.

Southern West Virginia Health System

Hypertension in West Virginia

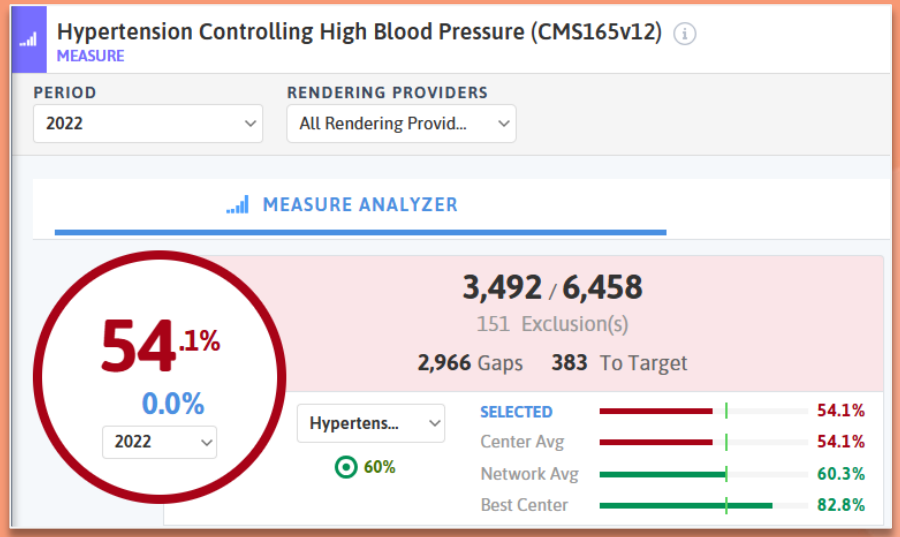
Over **1 in 3 adults in West Virginia are diagnosed with hypertension**, representing approximately 43.4% of the population.

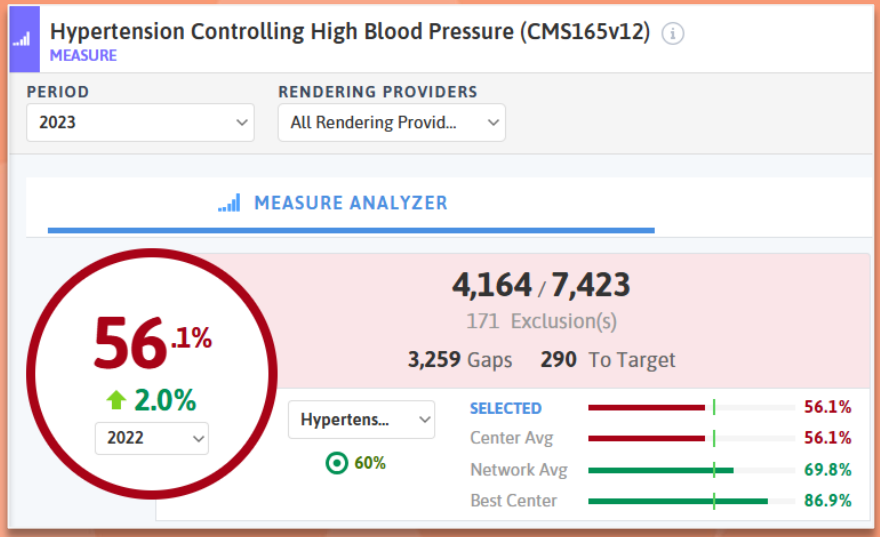
Hypertension is a **leading risk factor for heart disease and stroke**, both of which are major causes of death in the state.

Many counties, particularly those in our service area, rank high for hypertension rates, highlighting the need for targeted interventions and improved care.

Southern West Virginia Health System

Baseline





Southern West Virginia Health System

Recognizing The Need for Change

- Establishment of a Collaborative Committee
- Creation of Target Educational Programs for staff
- Launch of Continuous Quality Improvement Initiatives (utilizing Azara DRVS Hypertension Controlling High Blood Pressure Detail List)
- Ongoing training for Nursing staff through annual skills day
- Leverage of educational resources for staff and patients

Southern West Virginia Health System

Overview of Implementation

- Adopted the **Aledade Hypertension Management Workflow** (Red Door Hanger)
- Utilized data (PVP) to **prioritize patients with hypertension**, optimizing clinical efficiency and **improving patient outcomes** during each visit
- **Staff education** through signage, posters, and visual aids
- Mandated participation in **skills day** for manual blood pressure techniques
- Procurement of **new supplies** including manual cuffs and digital vital sign machines

Southern West Virginia Health System

Barriers to Improving Hypertension Control

- Transportation limitations
- Inconsistent staff engagement (nurses and providers)
- Low patient adherence to treatment plans
- Insufficient at-home monitoring equipment
- Lack of education on the serious risks of hypertension

Overcoming Challenges

Collaborated with our Community Health Manager to compile a comprehensive list of transportation resources

Posted Signage displaying local bus schedules for easy access

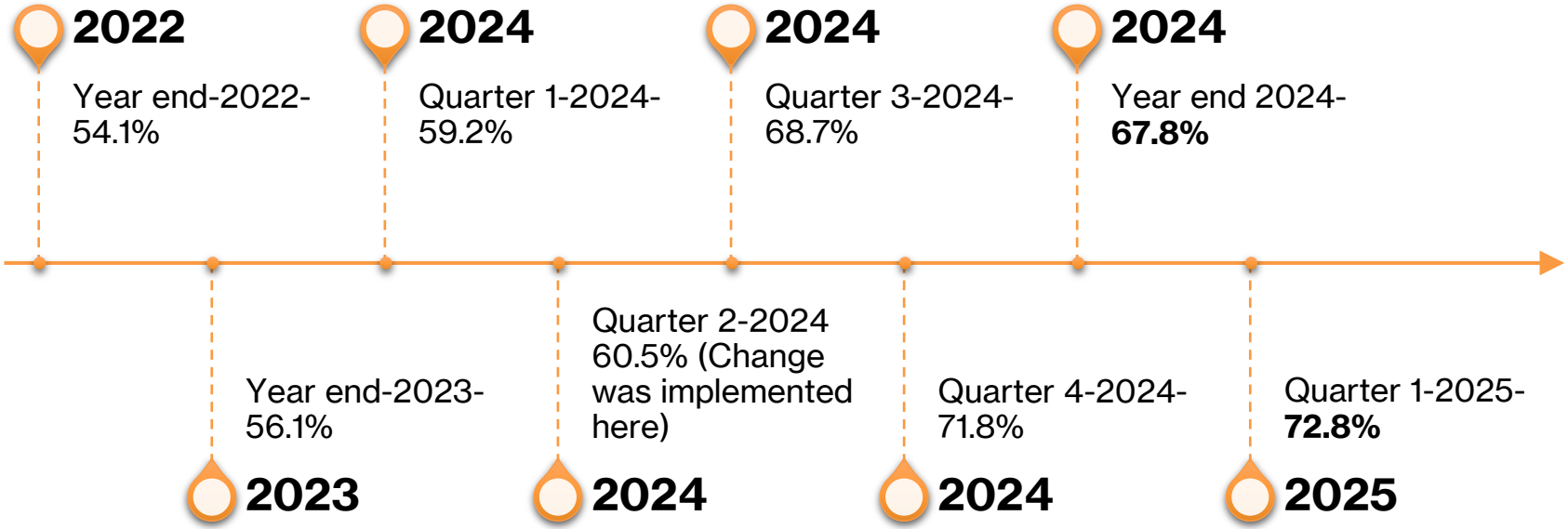
Monitored Staff Performance to ensure quality care and compliance

Community Health Manager and CHWs launched a project to acquire necessary equipment for patients

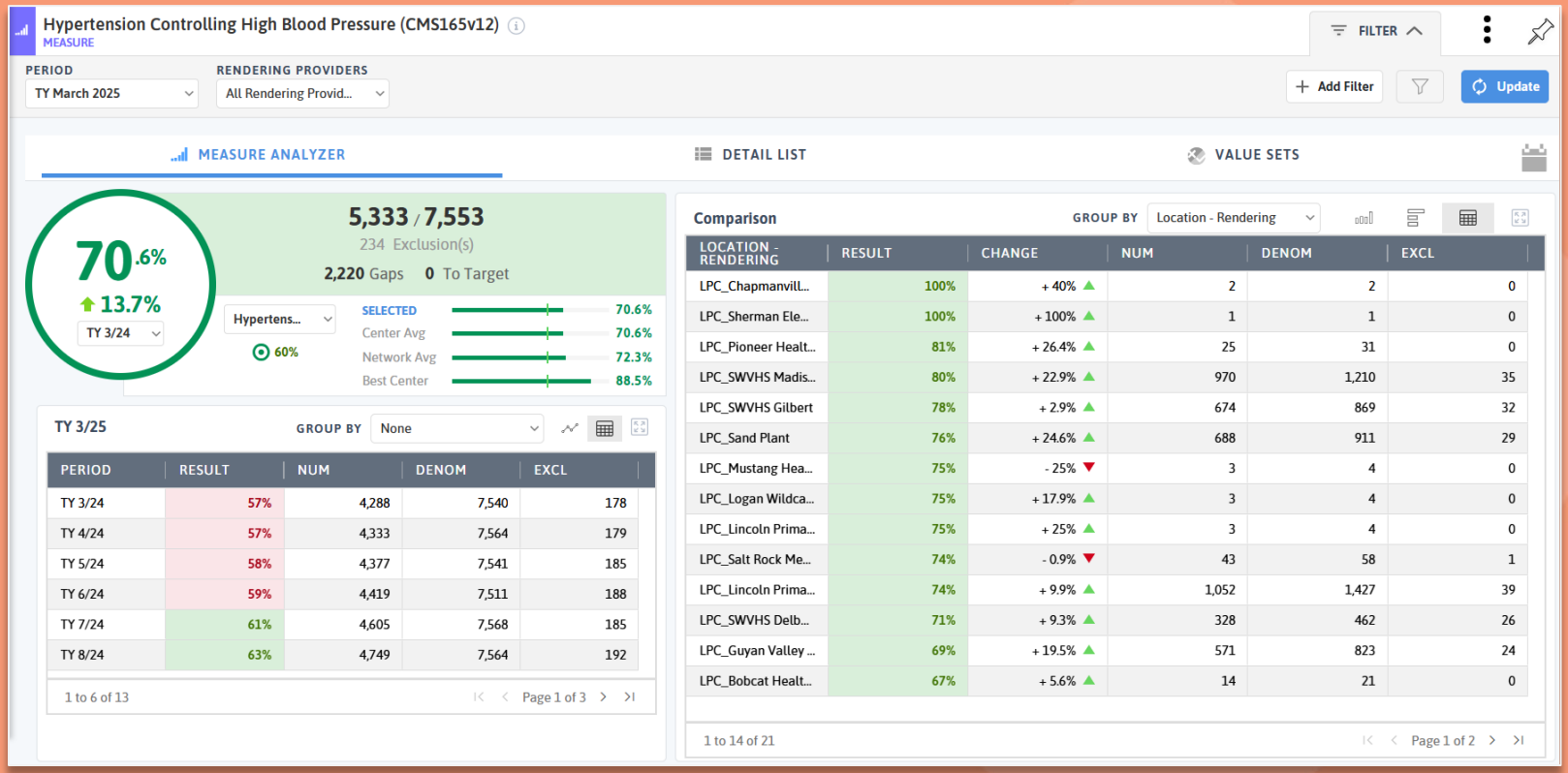
Enhanced Education by Clinical Staff on home monitoring and reporting procedures

Scheduled More Frequent Patient Visits to improve follow-up care and management

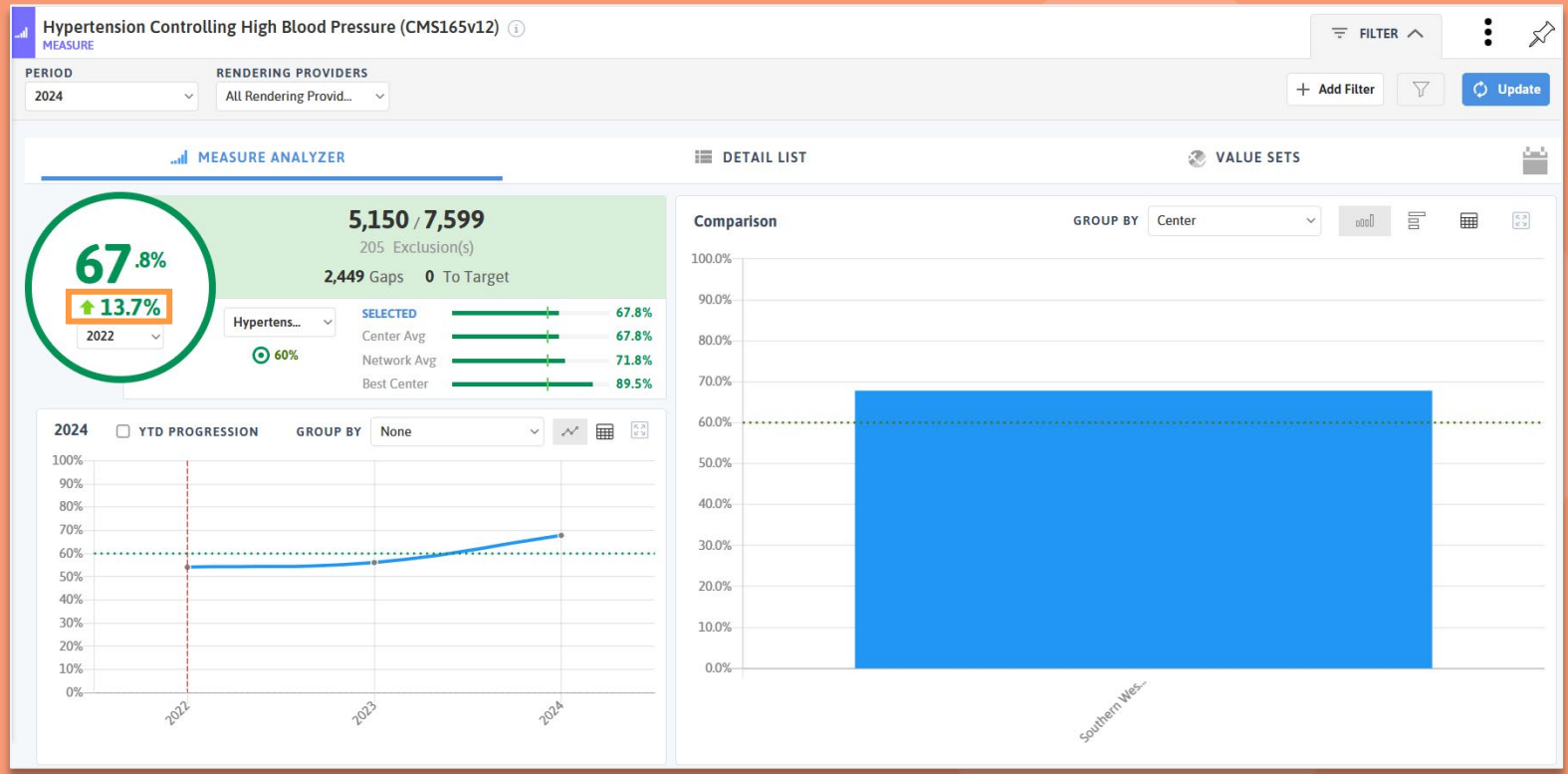
Hypertension Controlling High Blood Pressure Measure



Current Reporting



Current Reporting



Current Status

Successfully implemented key initiatives to improve hypertension management and patient care.

Actively utilizing the **Hypertension Controlling High Blood Pressure Detail List** for real-time reporting and data-driven decisions.

Enhanced staff education and training are in place, with a focus on home monitoring and patient compliance.

Strengthened community resources, including transportation support and access to necessary equipment.

More frequent patient visits are being scheduled to ensure continuous monitoring and care.

Seeing progress in addressing the challenges of hypertension within our service areas, but there's still work to be done to further reduce the impact of this condition.

Sources

High Blood pressure. High blood pressure. (n.d.). https://dhhr.wv.gov/hpcd/FocusAreas/HBP/Pages/hbp.aspx

CDC. (2020, May 19). *West Virginia*. Www.cdc.gov. https://www.cdc.gov/nchs/pressroom/states/westvirginia/wv.htm

Blood pressure toolkit.Physician-led Accountable Care Organization (ACO). (n.d.). Aledade. https://aledade.com/

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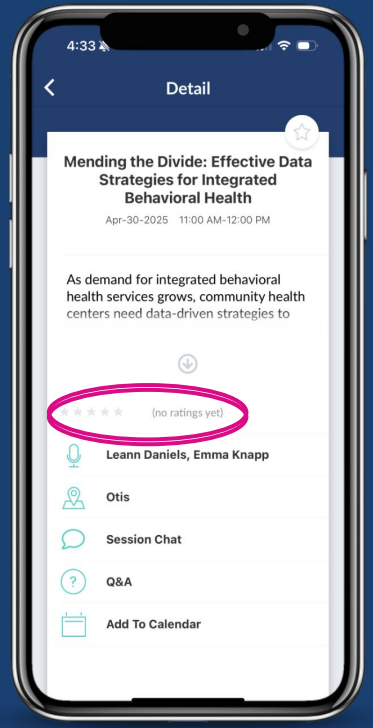

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