Driving Hypertension Control

Data-Driven Strategies for Sustainable Improvement

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Today's Speakers

Thomas Weir, FNP

Chief Nursing Officer

Bedford Stuyvesant Family Health Center

Evan Splan, RPh

Clinical Pathways Pharmacist

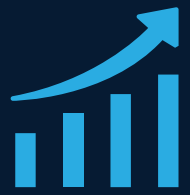
Health Partners of Western Ohio

Samuel Hall

Patient Access Analytics Advisor

Health Partners of Western Ohio

Today's Agenda



Improving Hypertension Management Using the AMA MAP™ Framework

Bedford Stuyvesant Family Health Center

Data-Driven Strategies for Sustainable Hypertension Improvement

Health Partners of Western Ohio

Wrap-Up and Questions

Improving Hypertension Management Using the AMA MAP™ Framework

Bedford Stuyvesant Family Health Center

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Bedford Stuyvesant Family Health Center

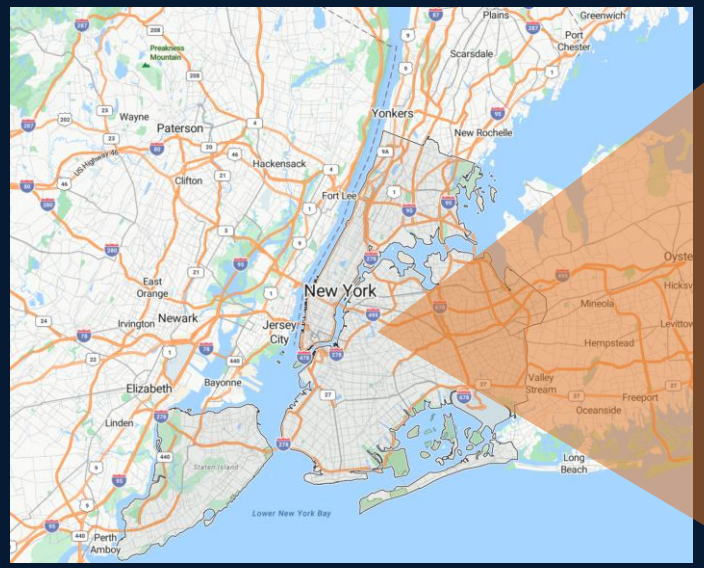
Who We Are: FQHC with four locations located in the heart of Brooklyn, NY.

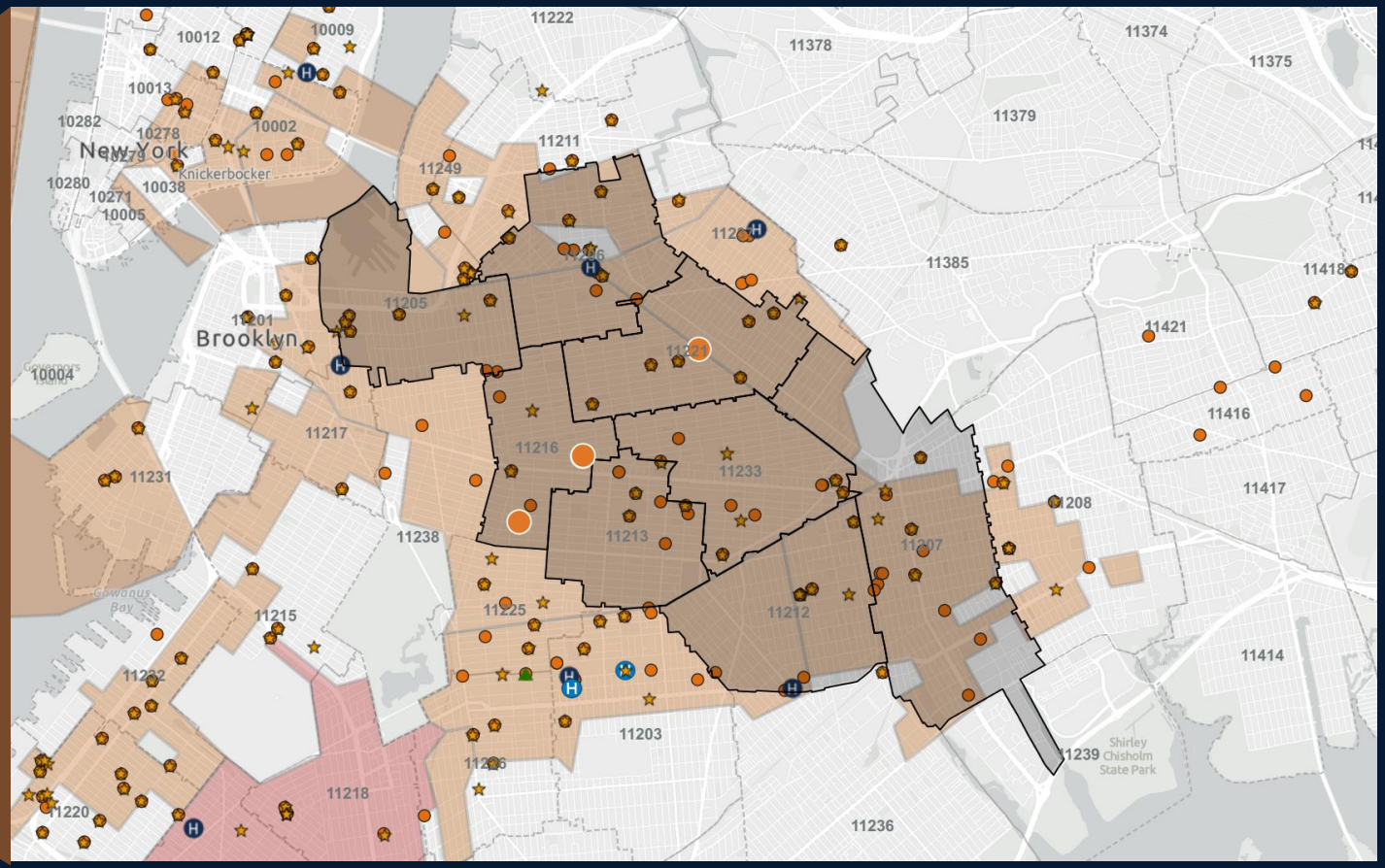
What We Do: 47 years of experience primary and specialty care to over 16,000 unique patients and 70,000 visits annually.

Our Mission: provide the most professional, courteous, and highest quality healthcare, with dignity, to those we serve, especially the underserved population, without regard for their ability to pay.

Our Vision: to become the model of excellence for community-based primary care, and to act as a catalyst to promote health, prevent disease and address socioeconomic factors that adversely affect health, as an integral member of the community.

Service Area

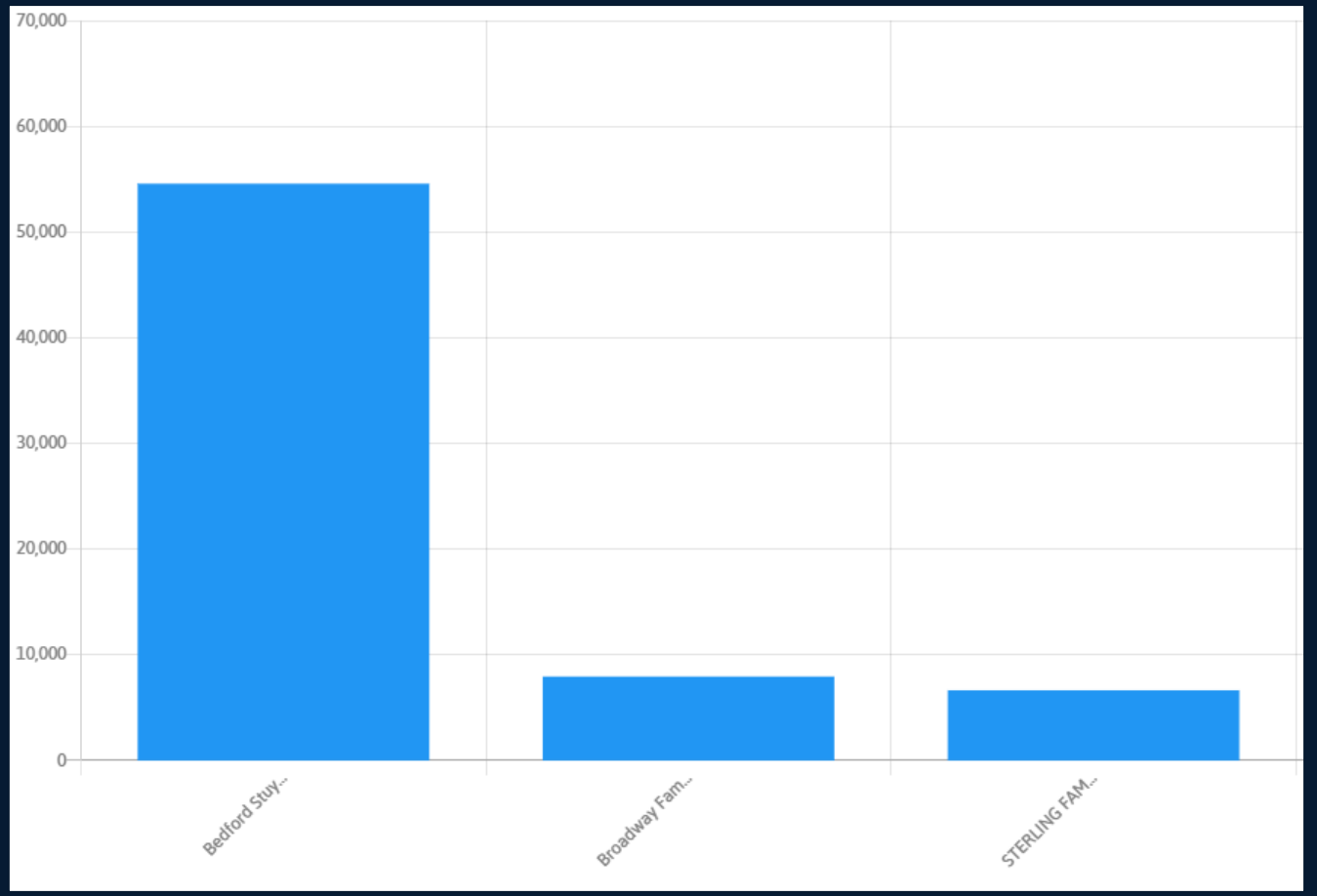




Bedford Stuyvesant Family Health Center

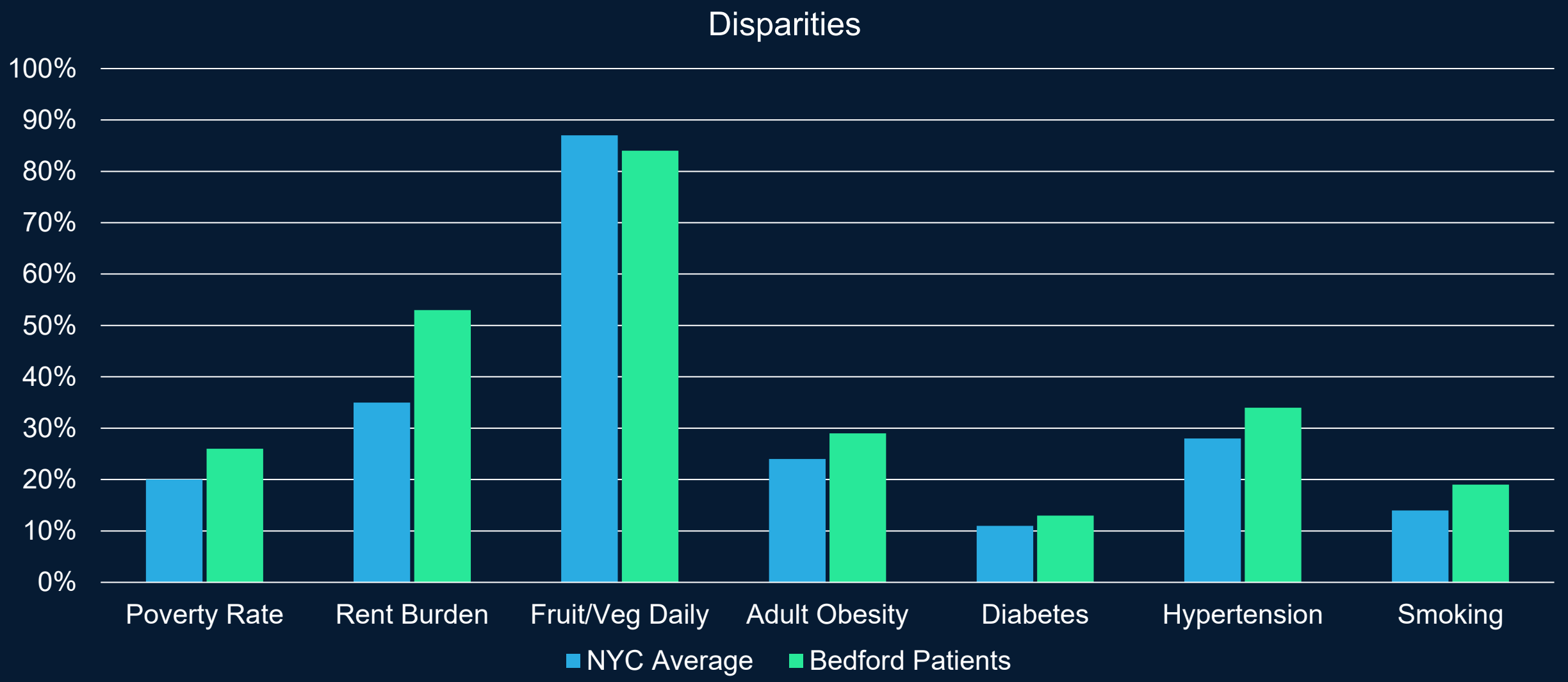
16,421
Unique Patients
2025

69,239
Patient Visits
2025

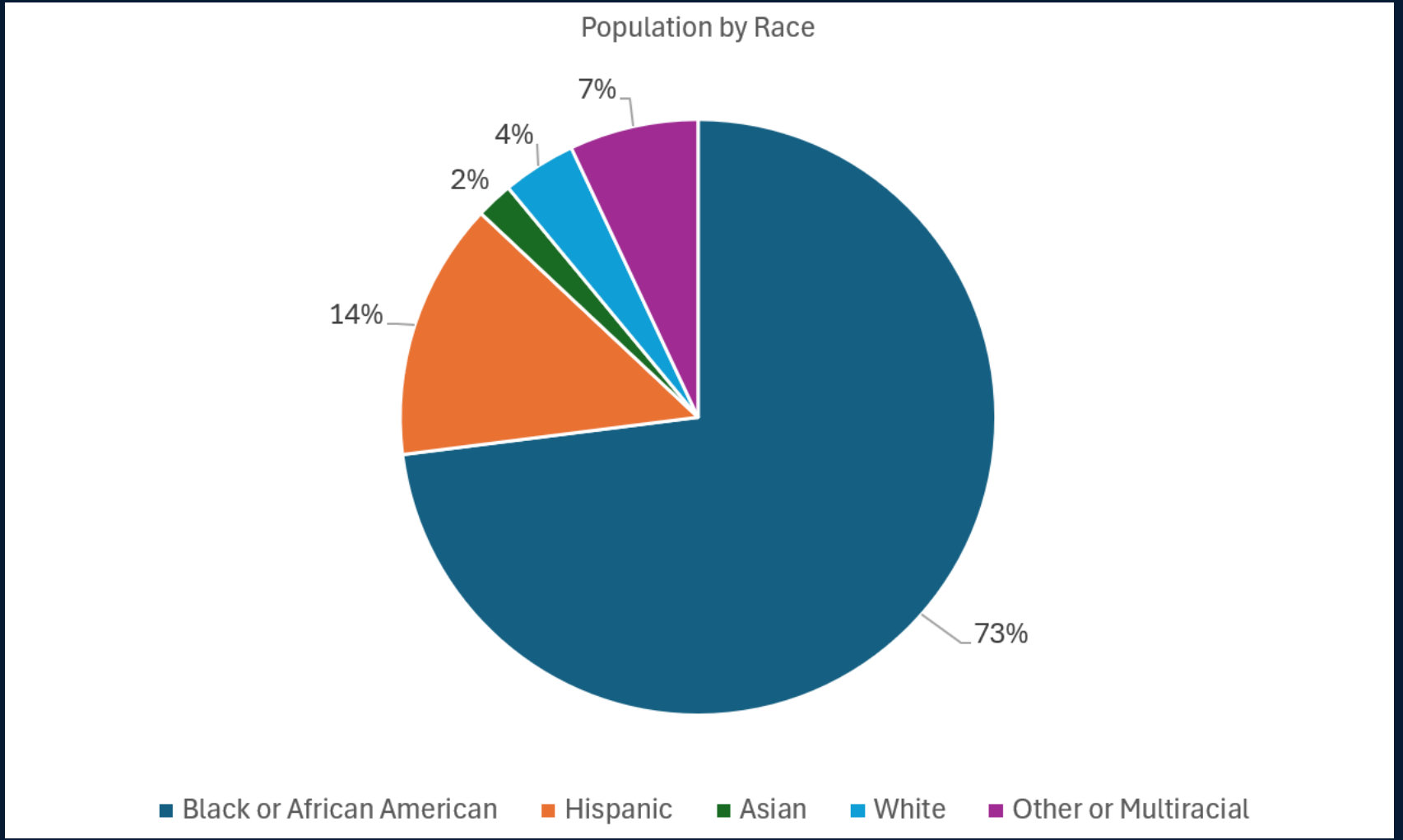


Our Patient Population

Demographic Data



Demographic Data



Demographics in DRVS

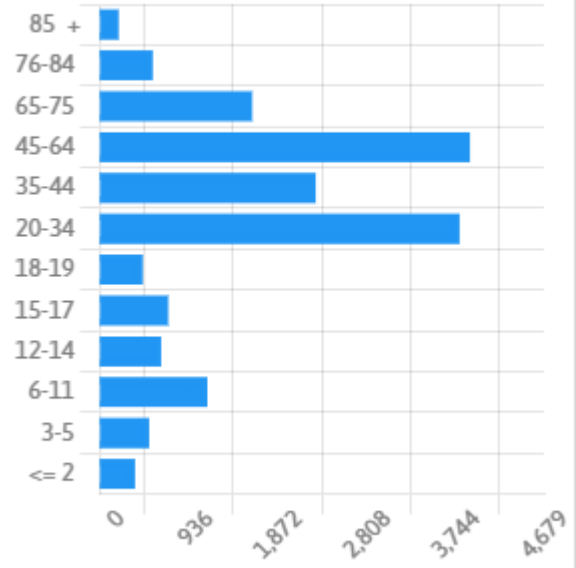
Race Selections

RACES	NUM
White	754
Unreported/Choose Not to Disclose Race	977
Unmapped	1
Other Pacific Islander	81
Other Asian	229
Native Hawaiian	6
More than One Race	1,202
Korean	11
Japanese	3
Filipino	6
Chinese	12
Black/African American	12,693
Asian Indian	32
American Indian/Alaska Native	108

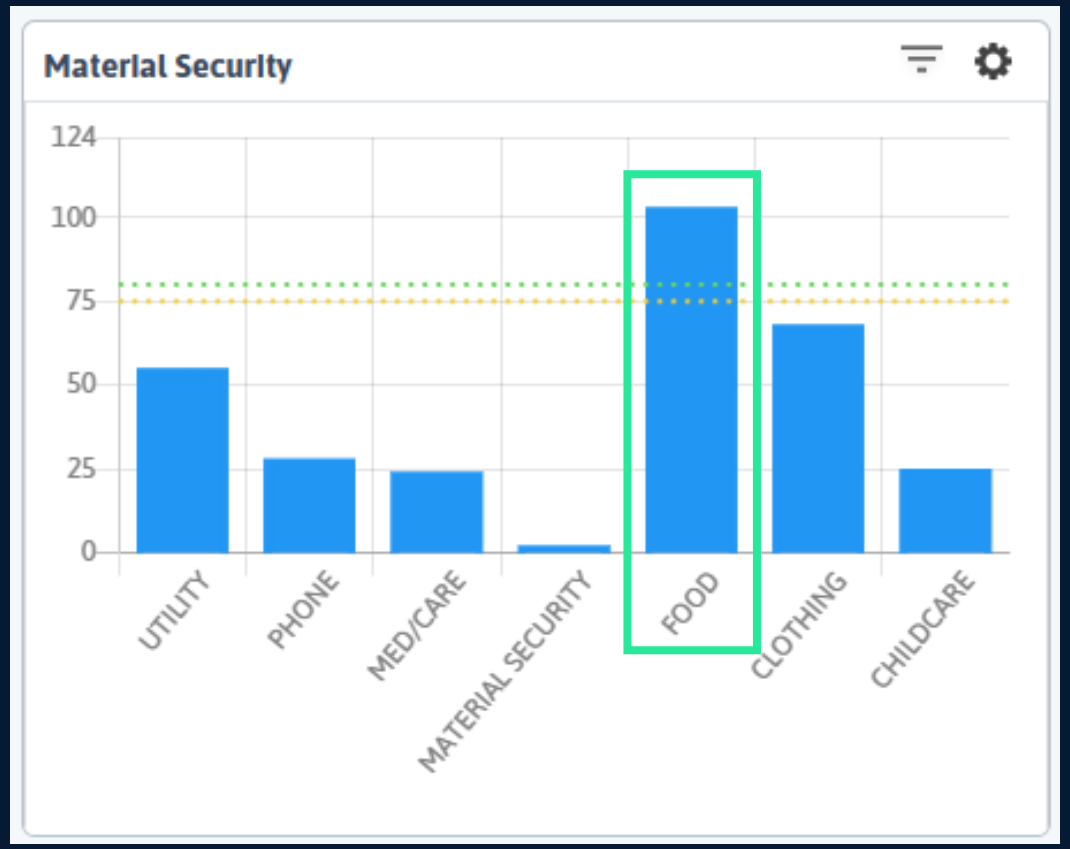
Sex at Birth

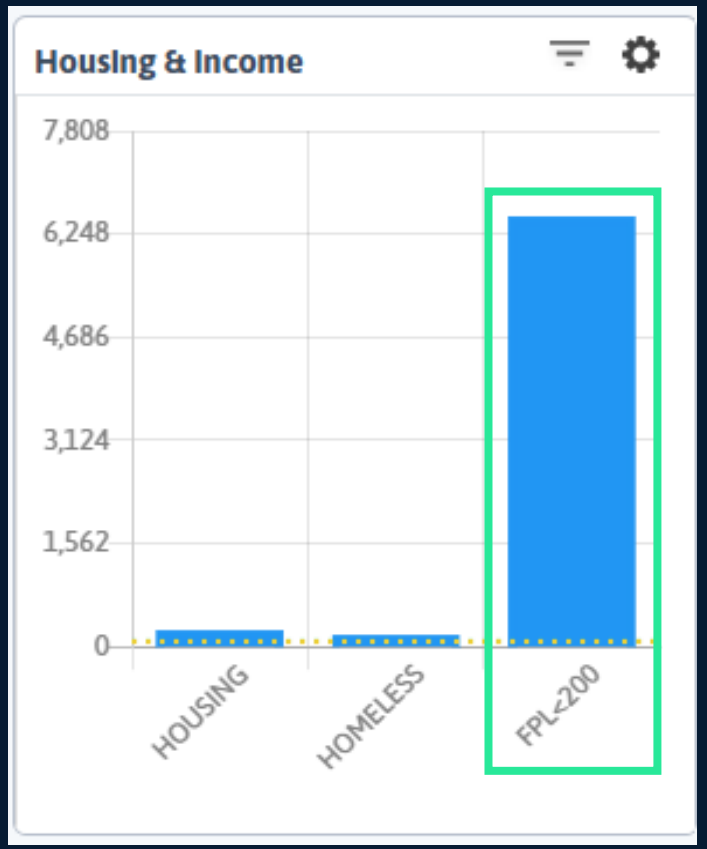
SEXES AT BIRTH	NUM	% TOTAL
F	9,957	61.8%
M	6,157	38.2%
U	1	0.0%
Totals	**16,115**	

Age Groups



Demographic in DRVS





Why a Focus on Hypertension?

About **58% of Black adults** in the United States have **high blood pressure.**

Black adults also have **higher rates of more severe high blood pressure** than other racial or ethnic groups and it can develop earlier in life.

Historical and **systemic factors** play a major role in these numbers.

Black adults face **higher rates of obesity and diabetes**. Higher rates of these conditions increase the risk for high blood pressure and heart disease.

Health **statistics for our area show a population at higher risk** and a population with higher Hypertension rates vs. Other New York City areas.

Previous Improvement Efforts and Outcomes

15

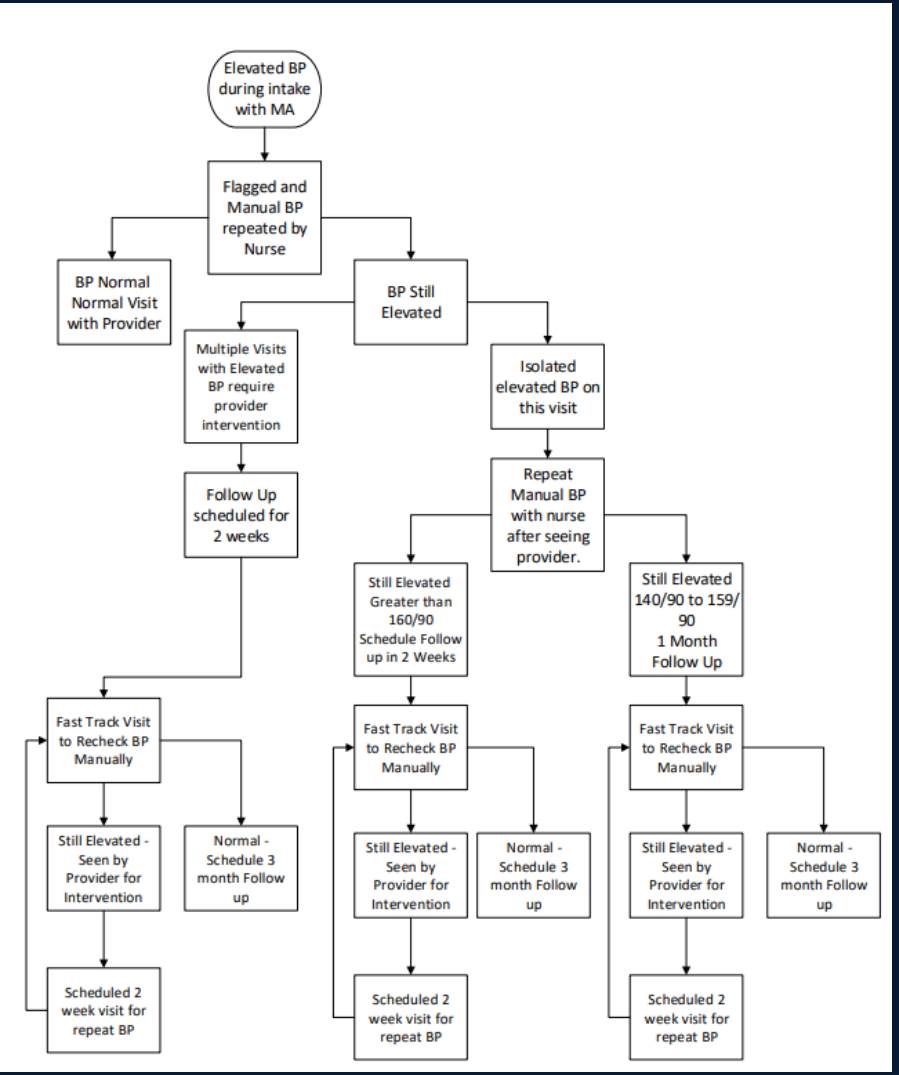
Improvement Efforts

- Updated technology
- Nurse led quick BP check visit
- QI team outreach
- Incorporating HTN education into DM education classes
- Added an "At Home" BP field
- Increased efforts to prescribe at home BP monitors

Outcomes

- We would have improvements in numbers, but they were not sustained
- Restart cycle each end of year when we were focusing on numbers

Original Follow Up Visit Workflow



Key Collaborations

Key Collaborations & Infrastructure

Population Health & Data Solutions

Customized Care Processes & Clinical Workflows

Cardiovascular Disease Prevention, Quality Improvement & Coaching & Training Expertise

AMA MAP™ Framework

Measure Accurately

Obtain actionable blood pressure (BP) measurements to diagnose hypertension and assess BP control.

Act Rapidly

Initiate and intensify treatment when indicated.

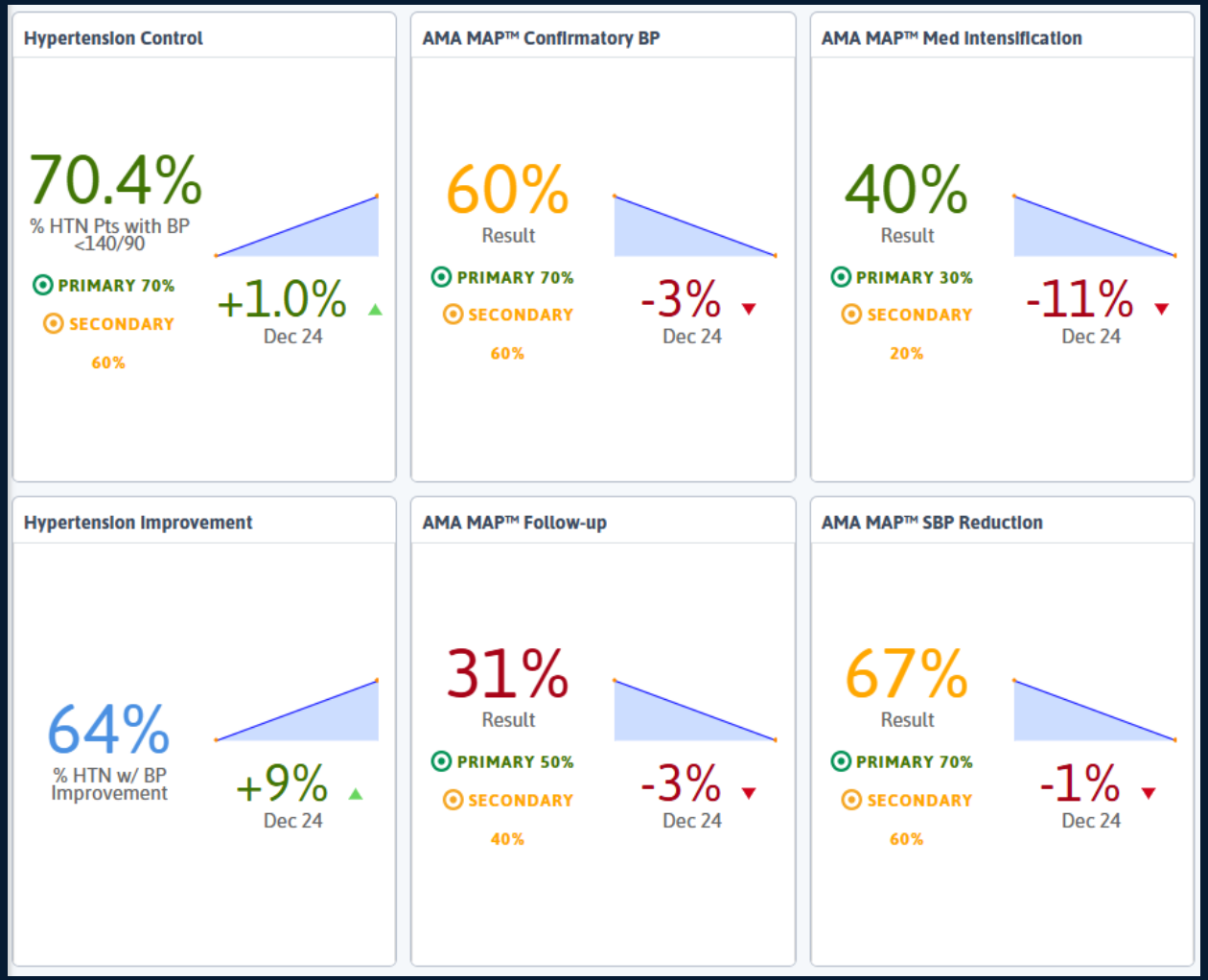
Partner with Patients

Support patient activation for self-management, assess and improve adherence to treatment.

Baseline Data

Baseline Data

Launched AMA MAP™ HTN on Jan 28, 2025 > Feb 2025



AMA MAP™ Hypertension Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
HTN Controlling High BP (CMS 165v13)	70.4%	795	1,129	71	334	109
Improvement in Blood Pressure	64.3%	180	280	13	100	
AMA MAP Confirm BP	60.2%	350	581	0	231	
AMA MAP Med Intens.	39.8%	140	352	20	212	
AMA MAP Follow-up	31.2%	132	423	39	291	
AMA MAP SBP Reduction	66.7%	6	9	0	3	

Hypertension Prescribing Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Adult HTN Guideline Recommended Therapy	66.4%	817	1,231	68	414	
Uncontrolled HTN Guideline Recommended Therapy	68.5%	226	330	25	104	
HTN >=140/90 and No Medication	21.5%	71	330	25	71	
HTN >=140/90 on Monotherapy	27.9%	92	330	25	92	
AMA MAP SBP Reduction	66.7%	6	9	0	3	
AMA MAP Follow-up	31.2%	132	423	39	291	

Baseline Information

Measure Accurately

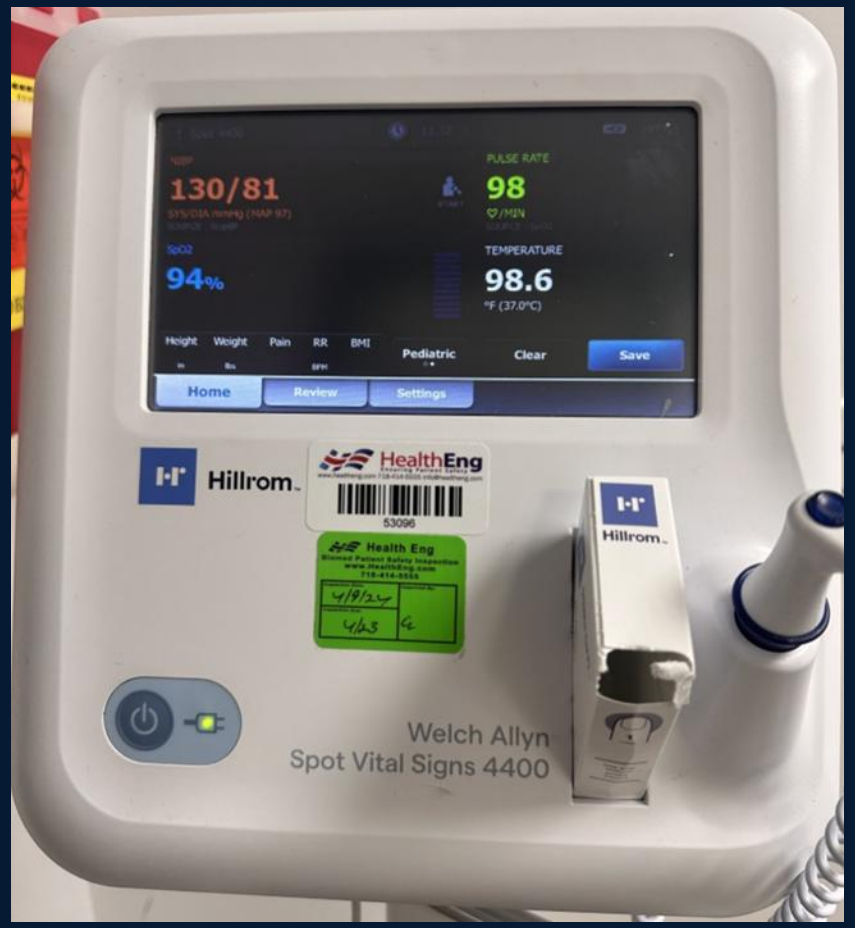
- Had Welch Allyn 4400 but were not using AOBP functionality
  - Repeat BPs were being done manually
- Providers had observed lack of wait period before BP measurement and use of incorrect cuff sizing so they did not trust readings or chose to do measurements themselves

Act Rapidly

- 2017 AHA tx protocol was being used

Leveraging Data to Drive Improvements

- Sharing only BP control rates with team



Infrastructure & Interventions

Program Adopters and Team Infrastructure

System Champions

Executive Sponsor & Physician Leader
Dr. Chukwudi Ozo | Cozoonyali@bsfhc.org

Project Manager
Neikisha Charles | NCharles@bsfhc.org

Clinical Education Lead	Clinical Operations Lead	EHR / Data Technical Lead	Quality Improvement Lead	Pharmacist Lead
Thomas Weir | Tweir@bsfhc.org	Thomas Weir | Tweir@bsfhc.org	Neikisha Charles | NCharles@bsfhc.org	Neikisha Charles |NCharles@bsfhc.org	None on staff – potential for non-staff pharmacist

Site Champions

SITE 1

Broadway Family Health Center
1238 Broadway Brooklyn, NY 11221

Physician/Provider Champion:
Nkwenti, Guedem, NP GNkwenti@bsfhc.org

Nurse/MA Champion:
Lisa Alexis, LPN LAlexis@bsfhc.org

SITE 2

Sterling Family Health & Wellness Center
803 Sterling Pl, Brooklyn NY 11216

Physician/Provider Champion:
Hilma Hill Lawrence, DNP HHillLawrence@bsfhc.org

Nurse/MA Champion:
Timothy Gardner, LPN TGardner@bsfhc.org

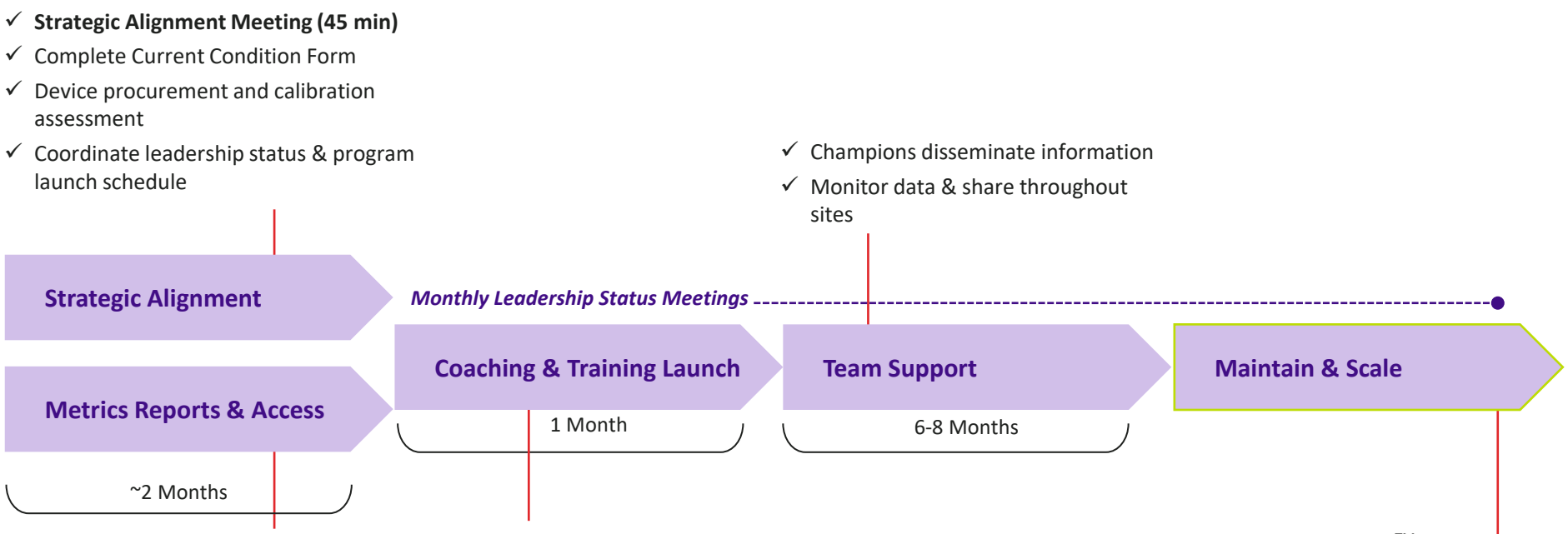
SITE 3

Bedford Stuyvesant Family HC (Fulton)
1456 Fulton Street, Brooklyn NY 12116

Physician/Provider Champion:
Ngozi Oji, MD | NOji@bsfhc.org

Nurse/MA Champion:
Angela Finch, RN Afinch@bsfhc.org

AMA MAP™ Hypertension Operational Roadmap

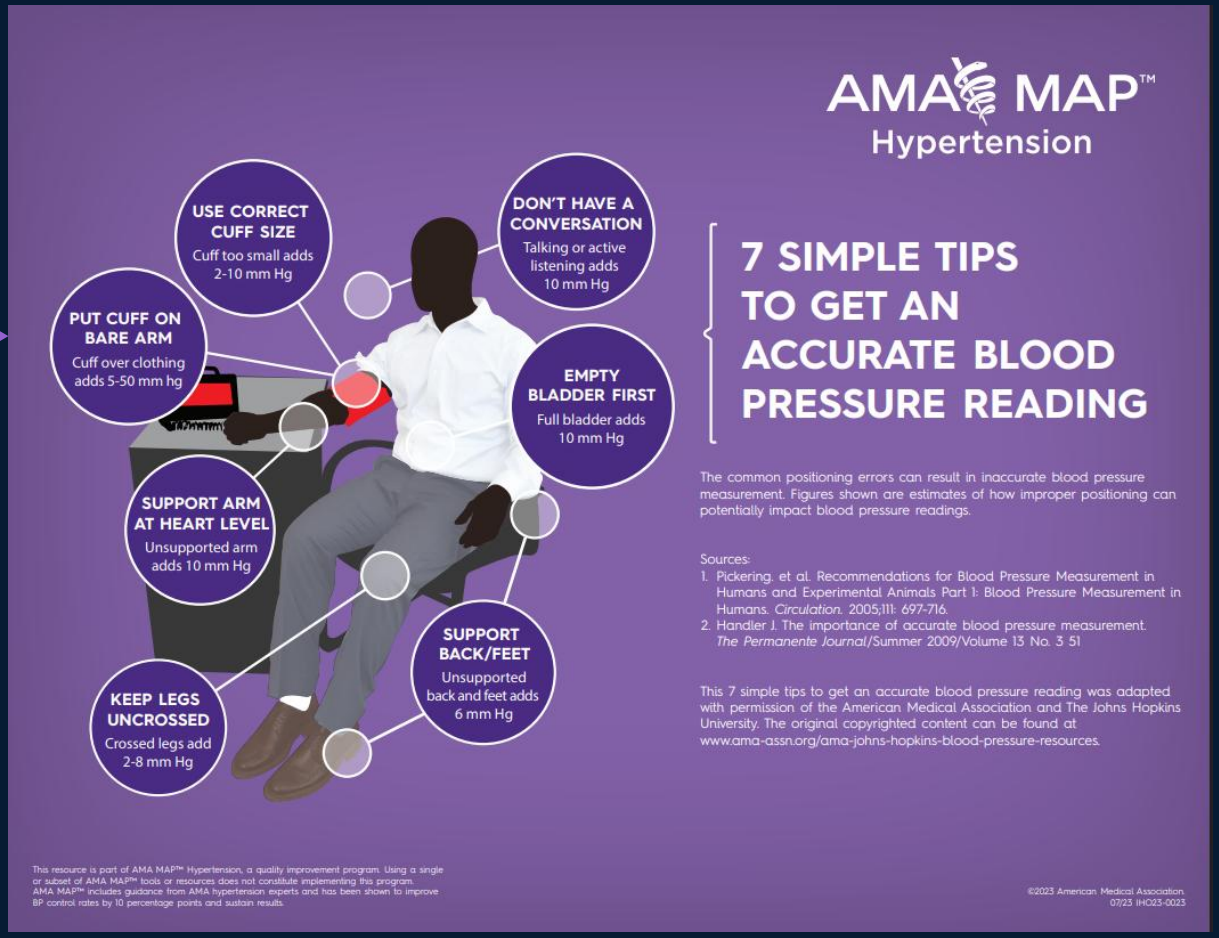


Bold text indicates virtual meeting

Interventions

Measure Accurately

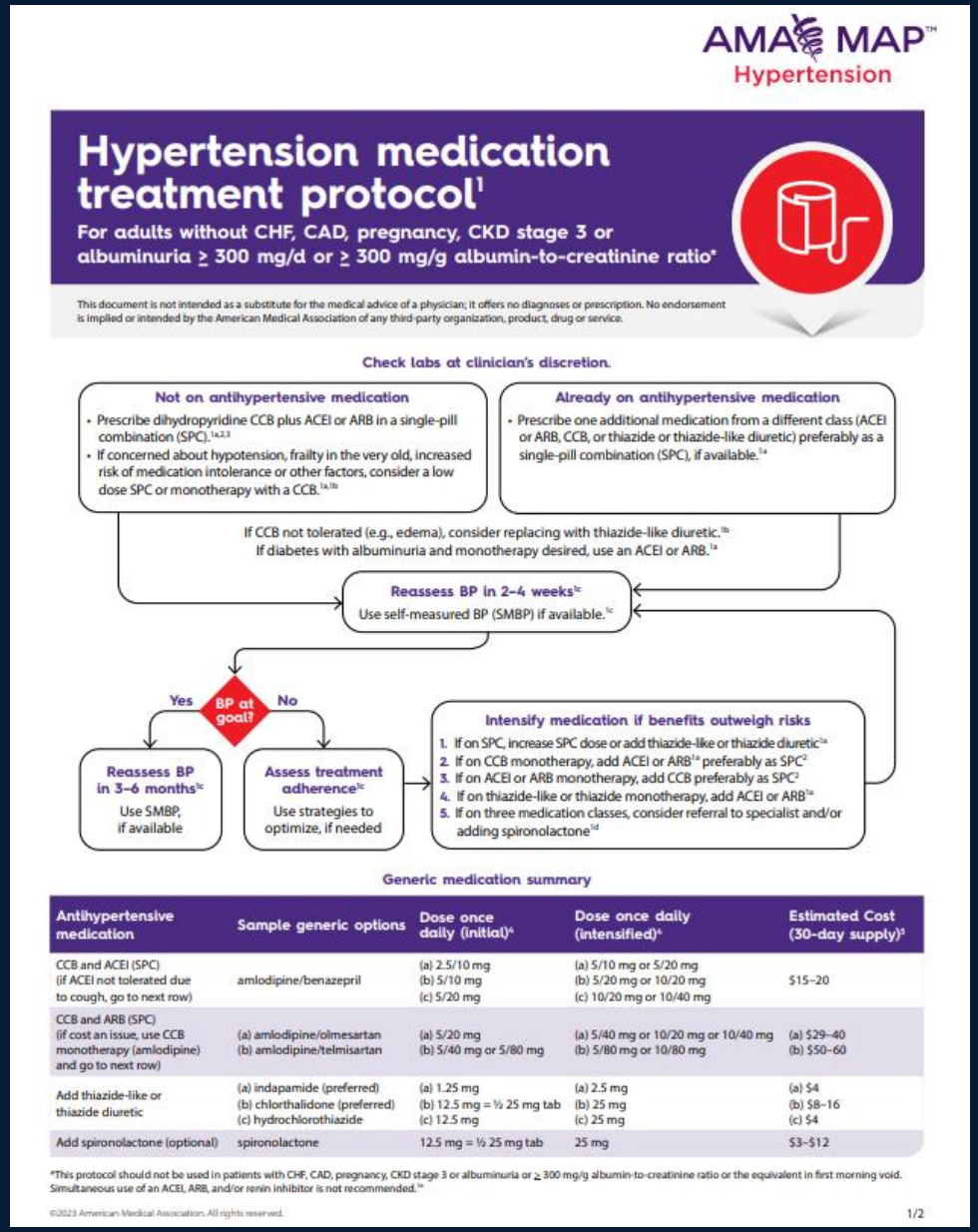
- Started utilizing AOBP functionality
  - Timers used to help implementation
- Accurate positioning infographic hung in all exam rooms
- Re-education on Measure Accurately conducted
- Informed providers of BP measurement workflow to increase trust in readings



Interventions

Act Rapidly

- Updated treatment protocol to include single pill combination (SPC).
- Physician champion (Dr. Ozo) on the floor providing elbow to elbow coaching to other providers
- Provider level data reviewed and discussed
- Recruited a Cardiologist to speak at provider meetings regarding HTN treatment and med intensification



AMA MAP™ Hypertension

Hypertension medication treatment protocol[1]

For adults without CHF, CAD, pregnancy, CKD stage 3 or albuminuria ≥ 300 mg/d or ≥ 300 mg/g albumin-to-creatinine ratio*

This document is not intended as a substitute for the medical advice of a physician; it offers no diagnoses or prescription. No endorsement is implied or intended by the American Medical Association of any third-party organization, product, drug or service.

Check labs at clinician's discretion.

Not on antihypertensive medication
- Prescribe dihydropyridine CCB plus ACEI or ARB in a single-pill combination (SPC).[1a,2,3]
- If concerned about hypotension, frailty in the very old, increased risk of medication intolerance or other factors, consider a low dose SPC or monotherapy with a CCB.[1a,1b]

Already on antihypertensive medication
- Prescribe one additional medication from a different class (ACEI or ARB, CCB, or thiazide or thiazide-like diuretic) preferably as a single-pill combination (SPC), if available.[1a]

If CCB not tolerated (e.g., edema), consider replacing with thiazide-like diuretic.[1b]
If diabetes with albuminuria and monotherapy desired, use an ACEI or ARB.[1a]

Reassess BP in 2–4 weeks[1c]
Use self-measured BP (SMBP) if available.[1c]

BP at goal? Yes / No

Reassess BP in 3–6 months[1c]
Use SMBP, if available

Assess treatment adherence[1c]
Use strategies to optimize, if needed

Intensify medication if benefits outweigh risks
1. If on SPC, increase SPC dose or add thiazide-like or thiazide diuretic[1a]
2. If on CCB monotherapy, add ACEI or ARB[1a] preferably as SPC[2]
3. If on ACEI or ARB monotherapy, add CCB preferably as SPC[2]
4. If on thiazide-like or thiazide monotherapy, add ACEI or ARB[1a]
5. If on three medication classes, consider referral to specialist and/or adding spironolactone[1d]

Generic medication summary

Antihypertensive medication	Sample generic options	Dose once daily (initial)[4]	Dose once daily (intensified)[4]	Estimated Cost (30-day supply)[5]
CCB and ACEI (SPC) (if ACEI not tolerated due to cough, go to next row)	amlodipine/benazepril	(a) 2.5/10 mg (b) 5/10 mg (c) 5/20 mg	(a) 5/10 mg or 5/20 mg (b) 5/20 mg or 10/20 mg (c) 10/20 mg or 10/40 mg	$15–20
CCB and ARB (SPC) (if cost an issue, use CCB monotherapy (amlodipine) and go to next row)	(a) amlodipine/olmesartan (b) amlodipine/telmisartan	(a) 5/20 mg (b) 5/40 mg or 5/80 mg	(a) 5/40 mg or 10/20 mg or 10/40 mg (b) 5/80 mg or 10/80 mg	(a) $29–40 (b) $50–60
Add thiazide-like or thiazide diuretic	(a) indapamide (preferred) (b) chlorthalidone (preferred) (c) hydrochlorothiazide	(a) 1.25 mg (b) 12.5 mg = ½ 25 mg tab (c) 12.5 mg	(a) 2.5 mg (b) 25 mg (c) 25 mg	(a) $4 (b) $8–16 (c) $4
Add spironolactone (optional)	spironolactone	12.5 mg = ½ 25 mg tab	25 mg	$3–$12

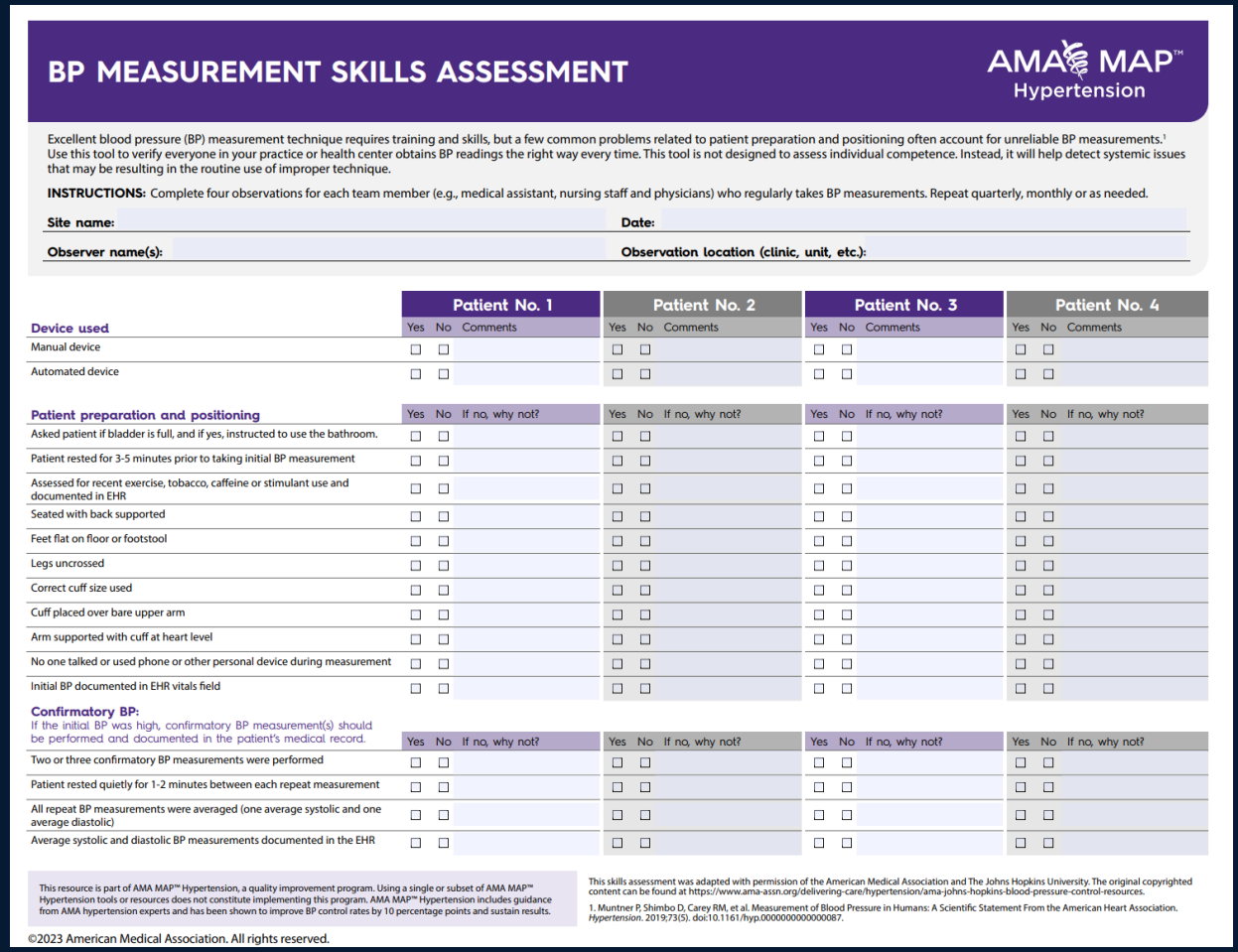
*This protocol should not be used in patients with CHF, CAD, pregnancy, CKD stage 3 or albuminuria or ≥ 300 mg/g albumin-to-creatinine ratio or the equivalent in first morning void. Simultaneous use of an ACEI, ARB, and/or renin inhibitor is not recommended.[1e]

1/2

Interventions

Partner with Patients – Support Self-Management and Improve Adherence

- Platform used to notify patients of upcoming refills
- Reinforced using 90-day prescriptions
- Reeducation and Competency of Medical Assistant Staff from AMA Education
- Education and Coaching from each staff member patient had contact with.
- Coaching on how to set up medication reminders
- Ensuring patients had home BP Monitors.



BP MEASUREMENT SKILLS ASSESSMENT

AMA MAP™ Hypertension

Excellent blood pressure (BP) measurement technique requires training and skills, but a few common problems related to patient preparation and positioning often account for unreliable BP measurements.[1] Use this tool to verify everyone in your practice or health center obtains BP readings the right way every time. This tool is not designed to assess individual competence. Instead, it will help detect systemic issues that may be resulting in the routine use of improper technique.

INSTRUCTIONS: Complete four observations for each team member (e.g., medical assistant, nursing staff and physicians) who regularly takes BP measurements. Repeat quarterly, monthly or as needed.

Site name: **Date:**

Observer name(s): **Observation location (clinic, unit, etc.):**

	Patient No. 1			Patient No. 2			Patient No. 3			Patient No. 4		
Device used	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments	Yes	No	Comments
Manual device	☐	☐		☐	☐		☐	☐		☐	☐	
Automated device	☐	☐		☐	☐		☐	☐		☐	☐	
Patient preparation and positioning	Yes	No	If no, why not?	Yes	No	If no, why not?	Yes	No	If no, why not?	Yes	No	If no, why not?
Asked patient if bladder is full, and if yes, instructed to use the bathroom.	☐	☐		☐	☐		☐	☐		☐	☐	
Patient rested for 3-5 minutes prior to taking initial BP measurement	☐	☐		☐	☐		☐	☐		☐	☐	
Assessed for recent exercise, tobacco, caffeine or stimulant use and documented in EHR	☐	☐		☐	☐		☐	☐		☐	☐	
Seated with back supported	☐	☐		☐	☐		☐	☐		☐	☐	
Feet flat on floor or footstool	☐	☐		☐	☐		☐	☐		☐	☐	
Legs uncrossed	☐	☐		☐	☐		☐	☐		☐	☐	
Correct cuff size used	☐	☐		☐	☐		☐	☐		☐	☐	
Cuff placed over bare upper arm	☐	☐		☐	☐		☐	☐		☐	☐	
Arm supported with cuff at heart level	☐	☐		☐	☐		☐	☐		☐	☐	
No one talked or used phone or other personal device during measurement	☐	☐		☐	☐		☐	☐		☐	☐	
Initial BP documented in EHR vitals field	☐	☐		☐	☐		☐	☐		☐	☐	
Confirmatory BP: If the initial BP was high, confirmatory BP measurement(s) should be performed and documented in the patient's medical record.	Yes	No	If no, why not?	Yes	No	If no, why not?	Yes	No	If no, why not?	Yes	No	If no, why not?
Two or three confirmatory BP measurements were performed	☐	☐		☐	☐		☐	☐		☐	☐	
Patient rested quietly for 1-2 minutes between each repeat measurement	☐	☐		☐	☐		☐	☐		☐	☐	
All repeat BP measurements were averaged (one average systolic and one average diastolic)	☐	☐		☐	☐		☐	☐		☐	☐	
Average systolic and diastolic BP measurements documented in the EHR	☐	☐		☐	☐		☐	☐		☐	☐	

This resource is part of AMA MAP™ Hypertension, a quality improvement program. Using a single or subset of AMA MAP™ Hypertension tools or resources does not constitute implementing this program. AMA MAP™ Hypertension includes guidance from AMA hypertension experts and has been shown to improve BP control rates by 10 percentage points and sustain results.

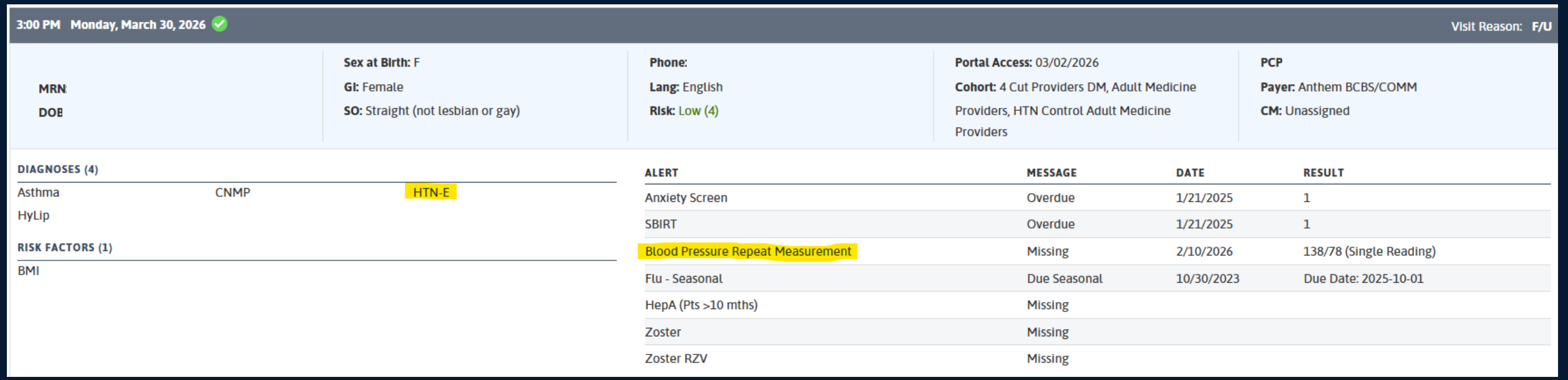
This skills assessment was adapted with permission of the American Medical Association and The Johns Hopkins University. The original copyrighted content can be found at https://www.ama-assn.org/delivering-care/hypertension/ama-johns-hopkins-blood-pressure-control-resources.

1. Muntner P, Shimbo D, Carey RM, et al. Measurement of Blood Pressure in Humans: A Scientific Statement From the American Heart Association. *Hypertension*. 2019;73(5). doi:10.1161/hyp.0000000000000087.

Interventions

Leveraging data to drive improvements

- Use of the Pre Visit Planning Reports and huddles to identify patients.
- Utilizing reports for f/u on Measures and re-education to staff
- Used prescribing reports to identify patients with uncontrolled HTN on 0 or 1 med
- Drilling down data to find areas or staff members that needed attention.



3:00 PM Monday, March 30, 2026 Visit Reason: F/U

MRN
DOB

Sex at Birth: F
GI: Female
SO: Straight (not lesbian or gay)

Phone:
Lang: English
Risk: Low (4)

Portal Access: 03/02/2026
Cohort: 4 Cut Providers DM, Adult Medicine Providers, HTN Control Adult Medicine Providers

PCP
Payer: Anthem BCBS/COMM
CM: Unassigned

DIAGNOSES (4)

Asthma	CNMP	HTN-E
HyLip		

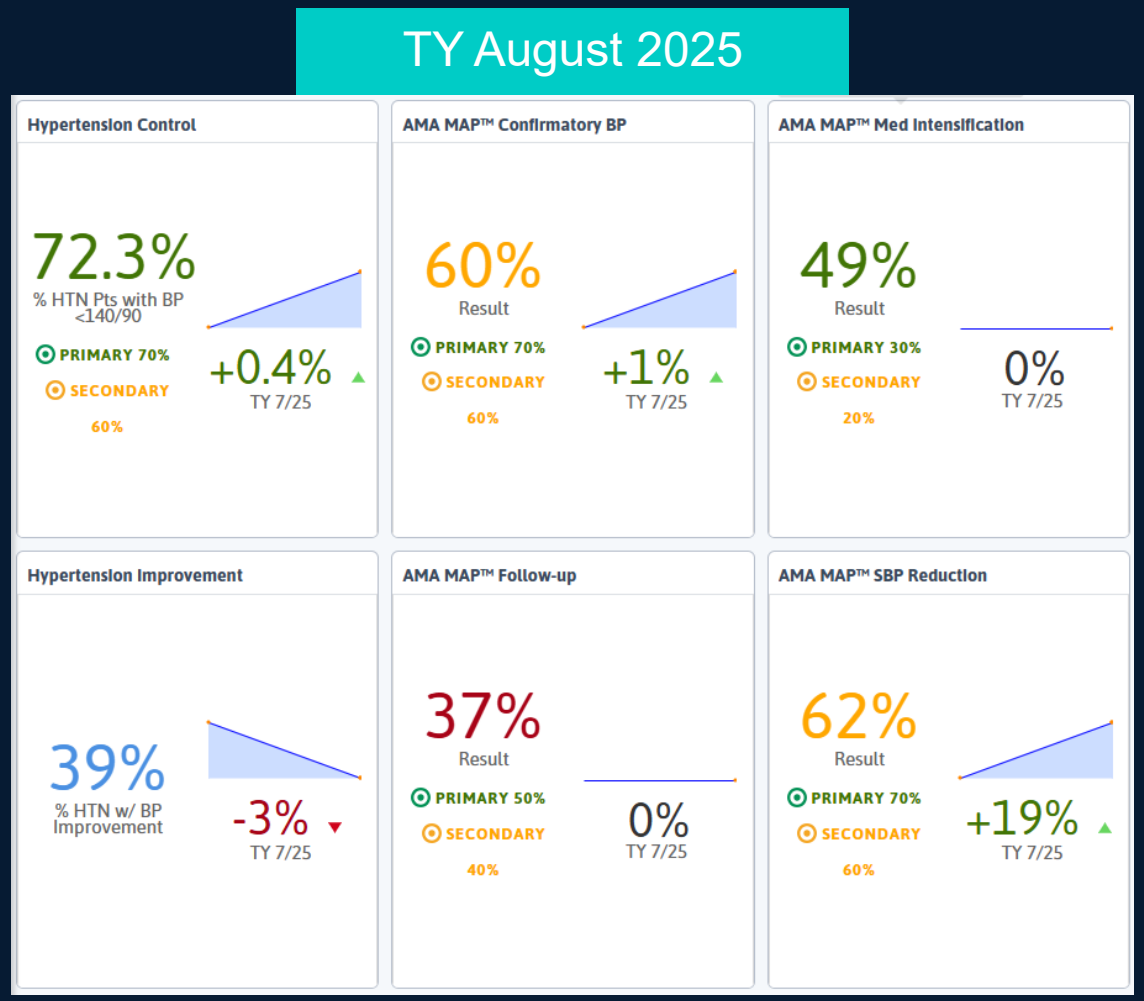
RISK FACTORS (1)

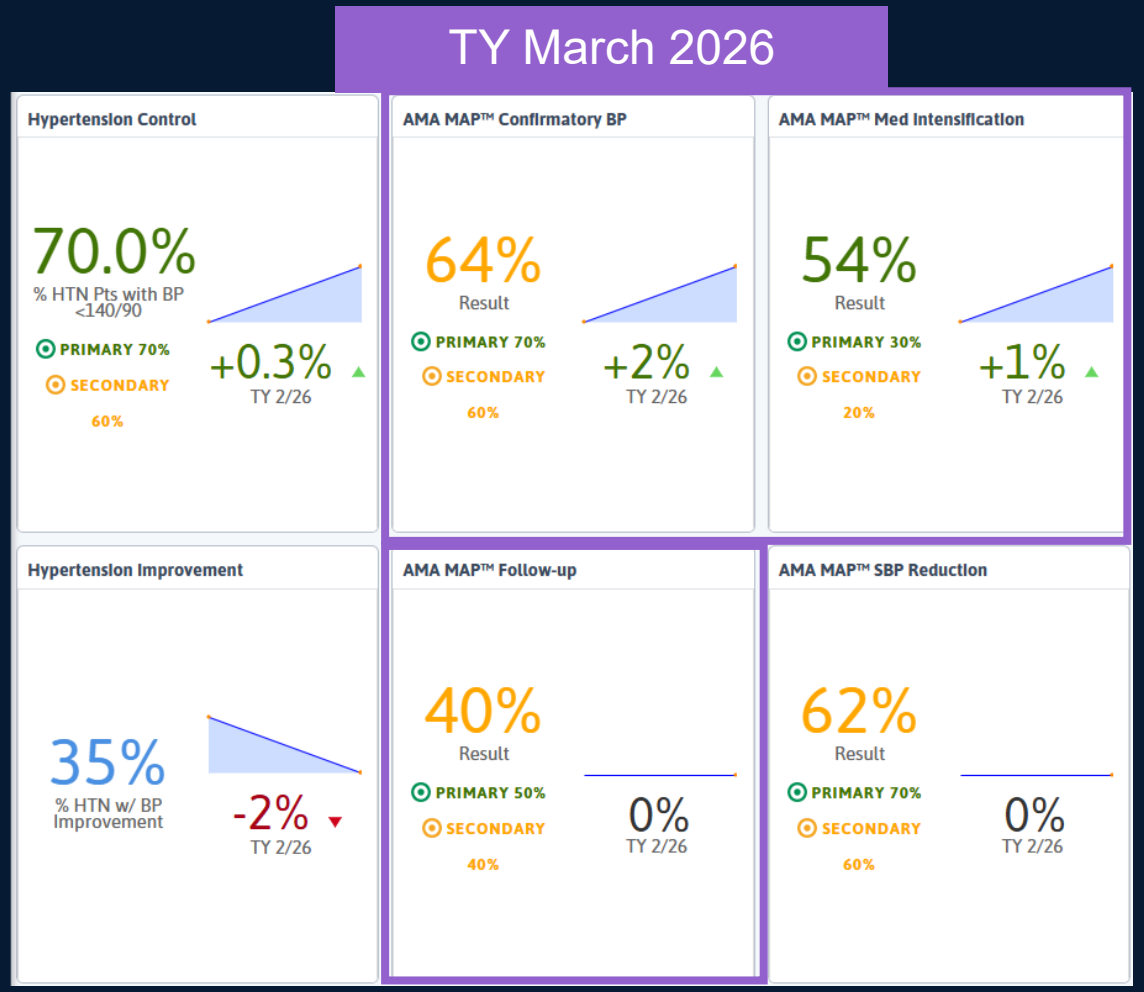
BMI

ALERT	MESSAGE	DATE	RESULT
Anxiety Screen	Overdue	1/21/2025	1
SBIRT	Overdue	1/21/2025	1
Blood Pressure Repeat Measurement	Missing	2/10/2026	138/78 (Single Reading)
Flu - Seasonal	Due Seasonal	10/30/2023	Due Date: 2025-10-01
HepA (Pts >10 mths)	Missing		
Zoster	Missing		
Zoster RZV	Missing		

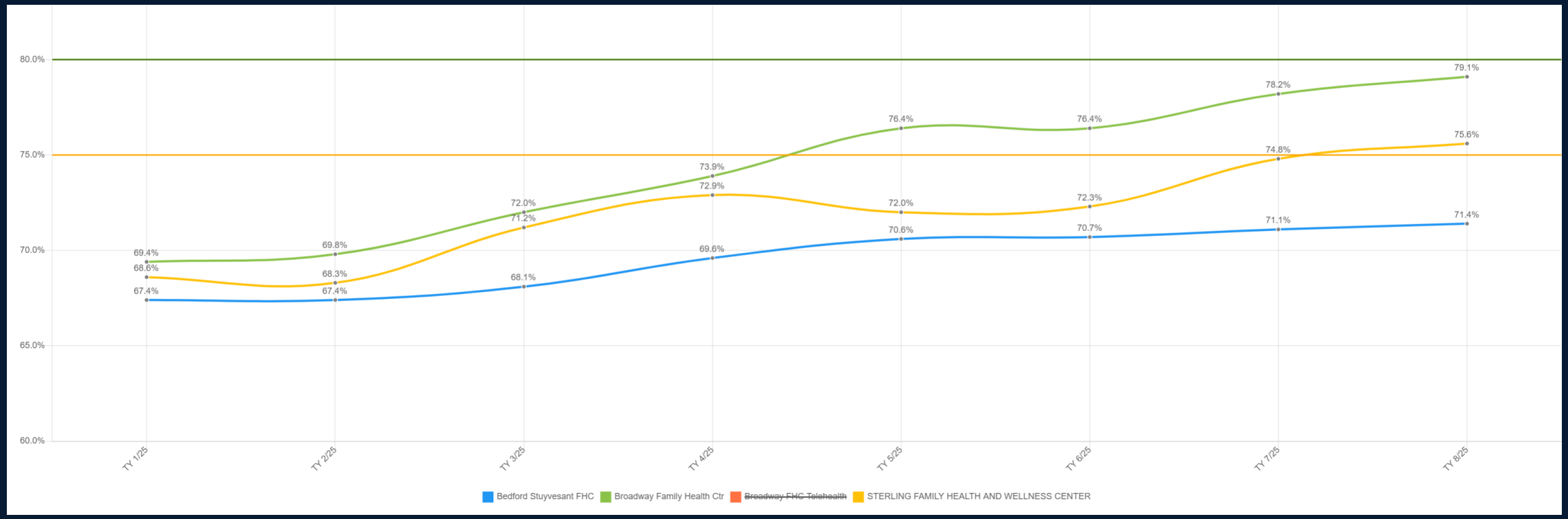
Results

AMA MAP™ Hypertension Dashboard

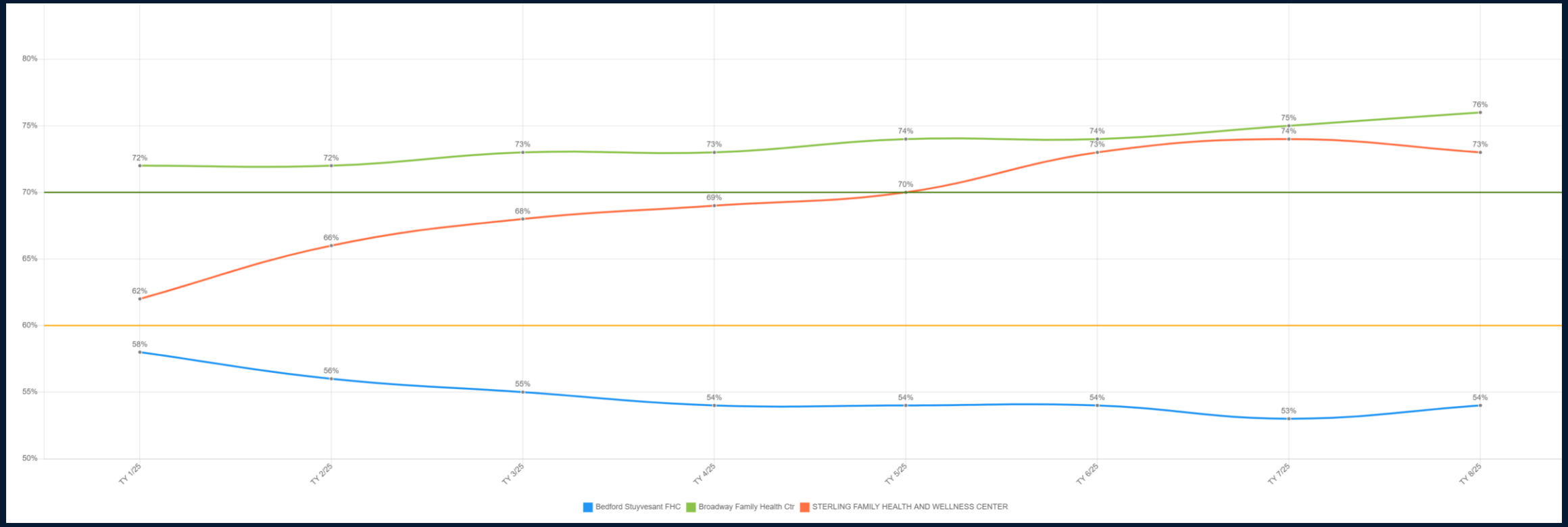




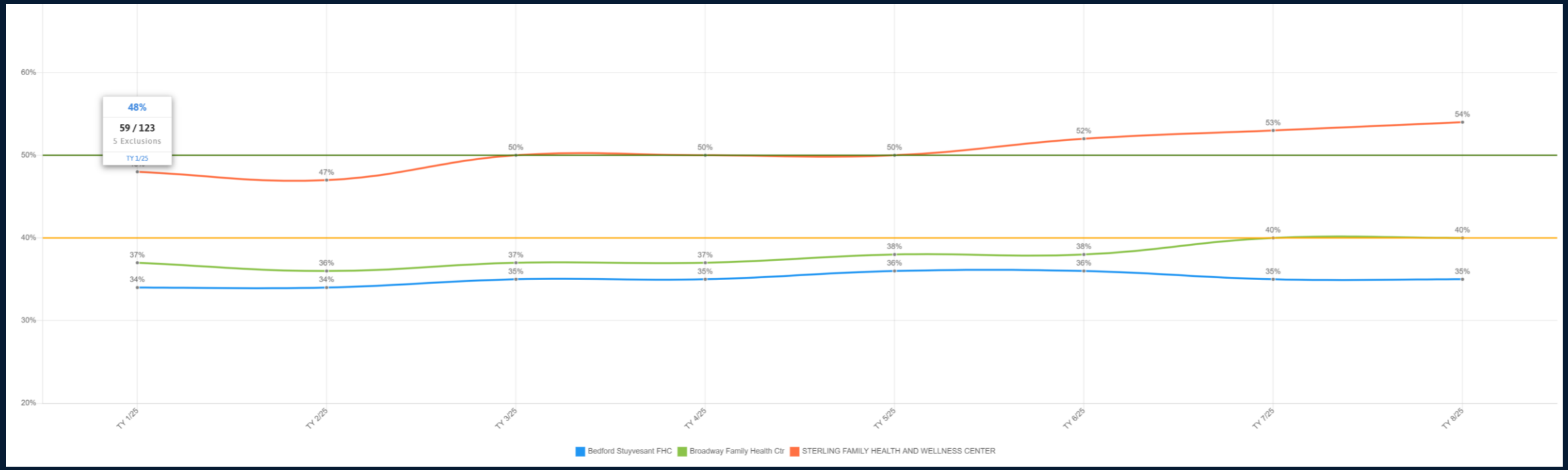
Hypertension Control by Center



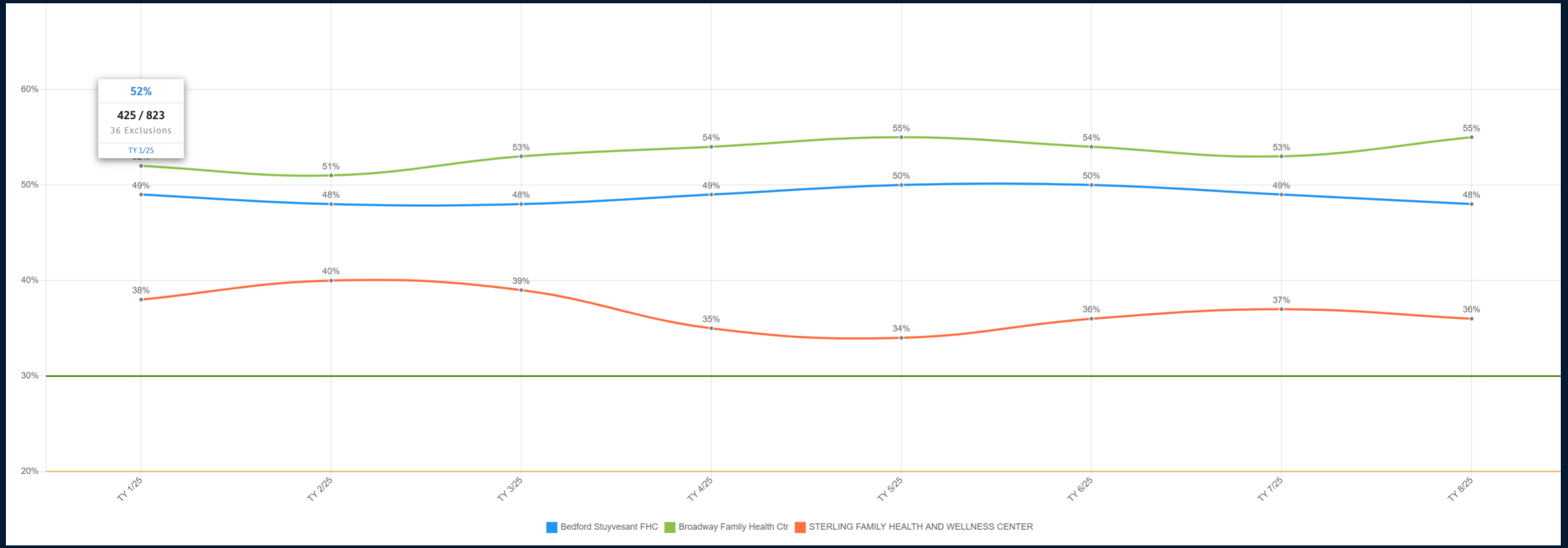
Confirmatory BP Measurement In-Clinic



Follow-Up for SBP >140 or DBP >90



Med Intensification for Uncontrolled HTN



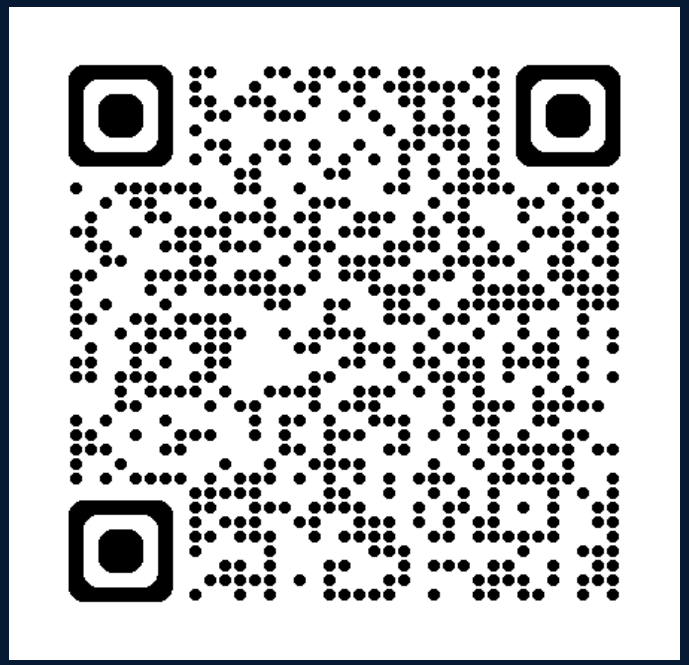
Key Learnings

Structure and Sustained Results	Provider Buy-In	Education	Sharing Data	Staff Turnover
• Strong foundation • Champions • Living System rather than static	• Joined from the start • Accurate Data	• Infographics, videos, and competencies • Strengthened our staff ability to educate patients and feel comfortable doing so.	• Issues getting it to the team • Standard part of provider, support staff, and QI meetings.	• Will make the AMA training the standard and include in the new MA training manual

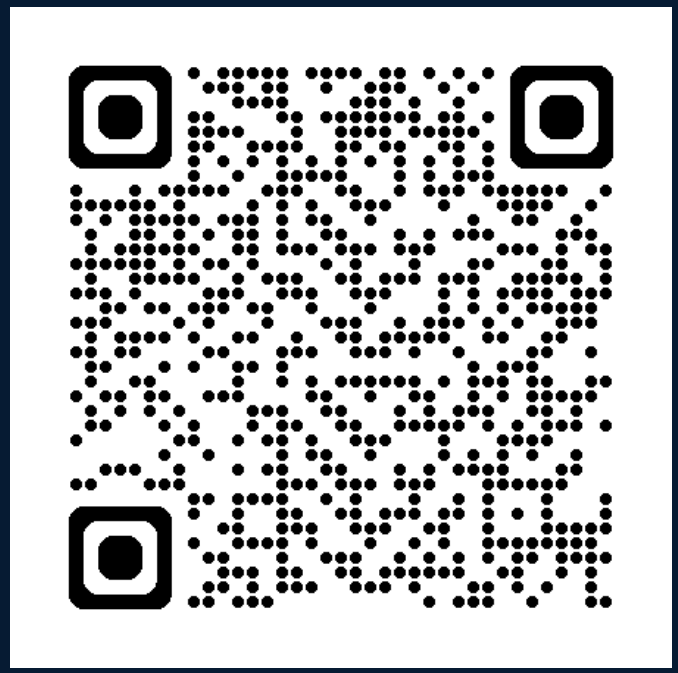
Next Steps

Looking Forward

1. Continuous **reinforcement of measures and expectations** and ensuring we continue to share data on a regular basis
2. Will focus on our main sites
3. Include the training and videos as part of **Medical Assistant onboarding**
4. Work to **regain improvement lost** during end of year during holiday season
5. Plan to **extend the training to our OB department**
6. Continue to align with our UDS and HEDIS Measures priorities
7. Discussing creating a Hypertension Education Class similar to the Diabetes Education Classes offered



BEDFORD-STUYVESANT
FAMILY HEALTH CENTER



AMA MAP™

Data-Driven Strategies for Sustainable Hypertension Improvement

Health Partners of Western Ohio

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Learning Objectives

Data in Action

Utilize Azara DRVS & AMA MAP™ Dashboards to Identify Gaps

Care Models

Evaluate and Apply Pharmacist-Led Hypertension Managements

Measurement Accuracy

Standardize Blood Pressure Measurement Workflows and Automated Averaging

Health Partners of Western Ohio

Integrated Model of Comprehensive Primary Care

In 2025, HPWO Cared for:

64,216
Patients

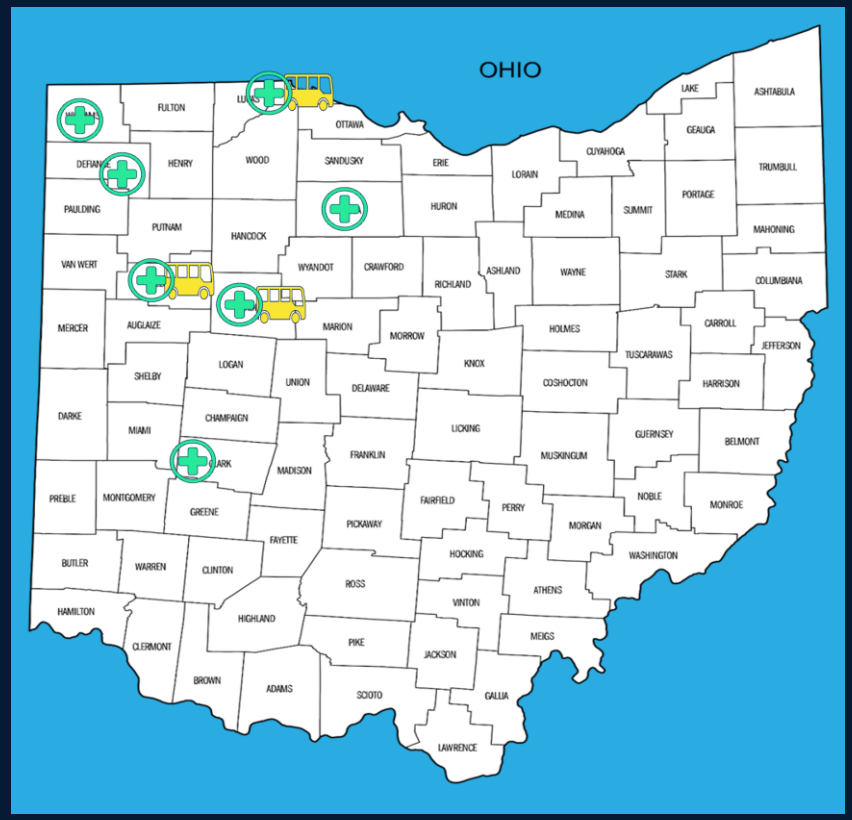
253,066
Visits

114,925
Medical

67,357
Dental

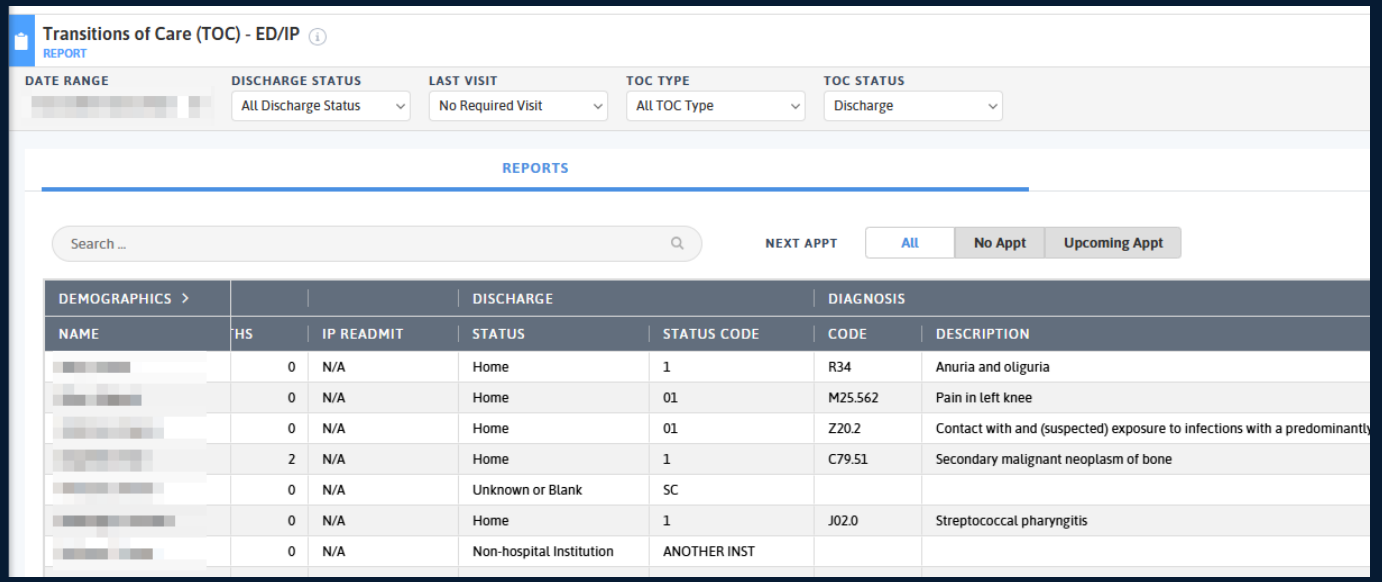
58,685
Behavioral Health

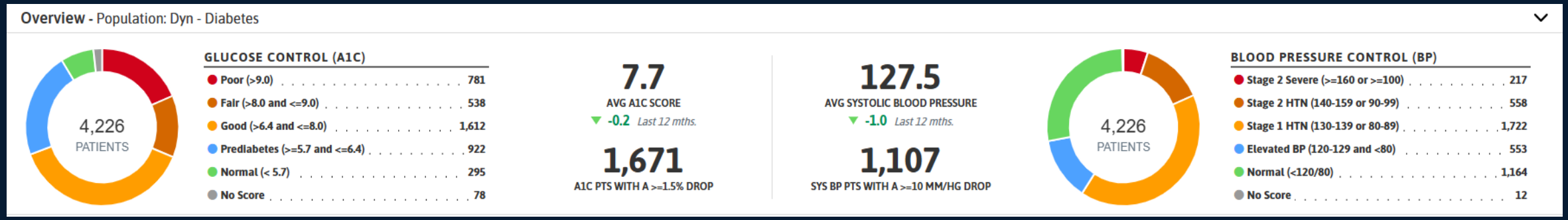
6,471
Vision



Azara Utilization at HPWO

- PVP
- Alerts (Stock and Custom)
- Transitions of Care Module
- UDS Scorecard & Tables
- Stock and Custom Registries
- Cohorts
- Care Effectiveness Reports





Hypertension in Ohio

37.1%
of Adults in Ohio

Diagnosed with Hypertension

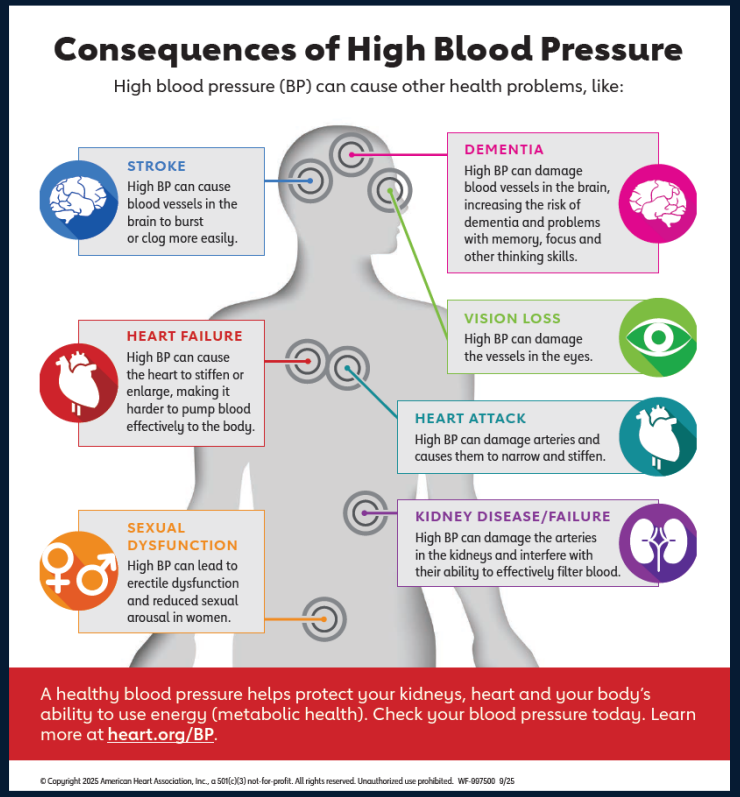
1 in 3
Adults w/ HTN

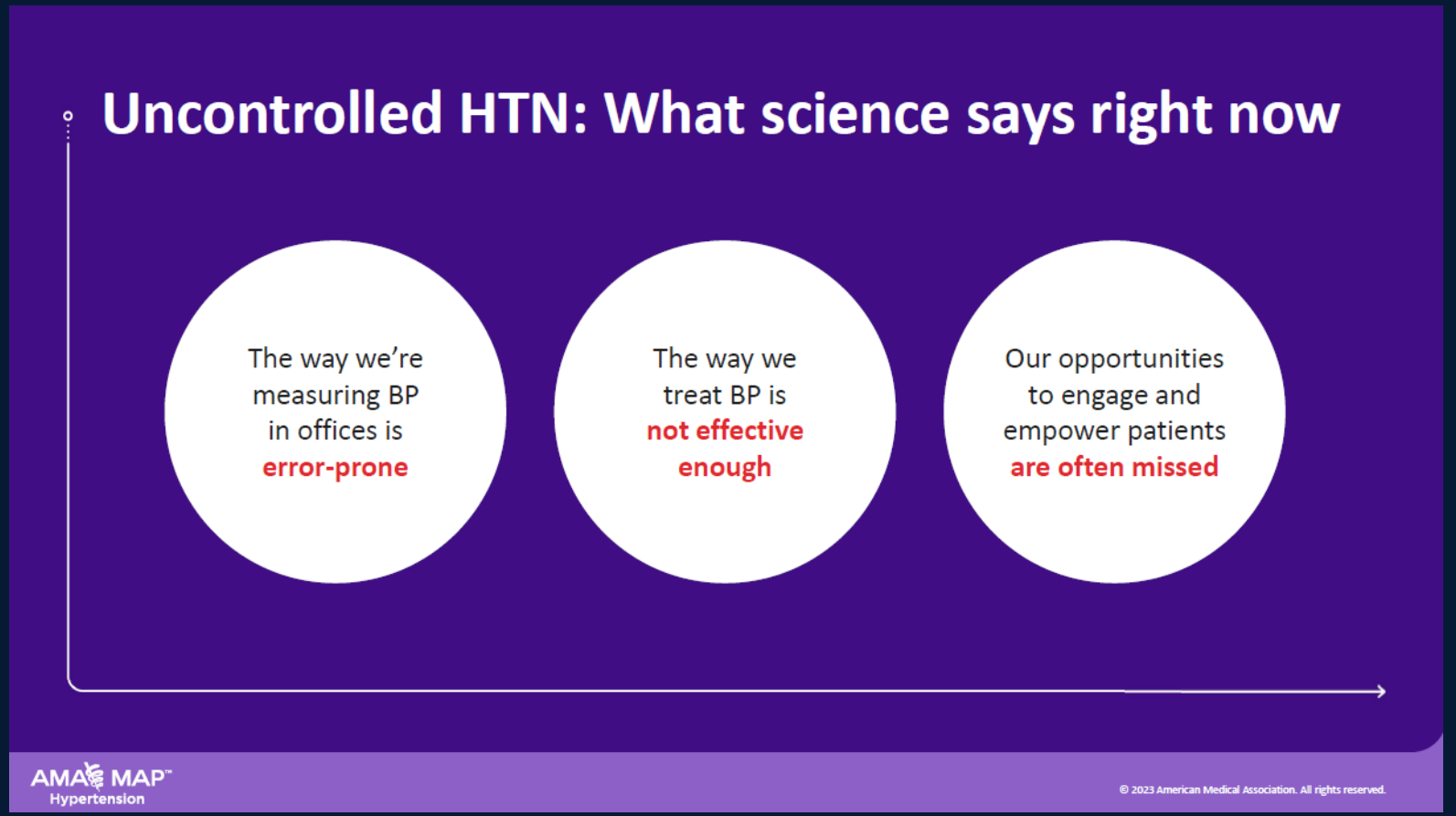
Remain Undiagnosed

50%
of Adults in Ohio

Likely have Hypertension

The Impact of Uncontrolled Blood Pressure

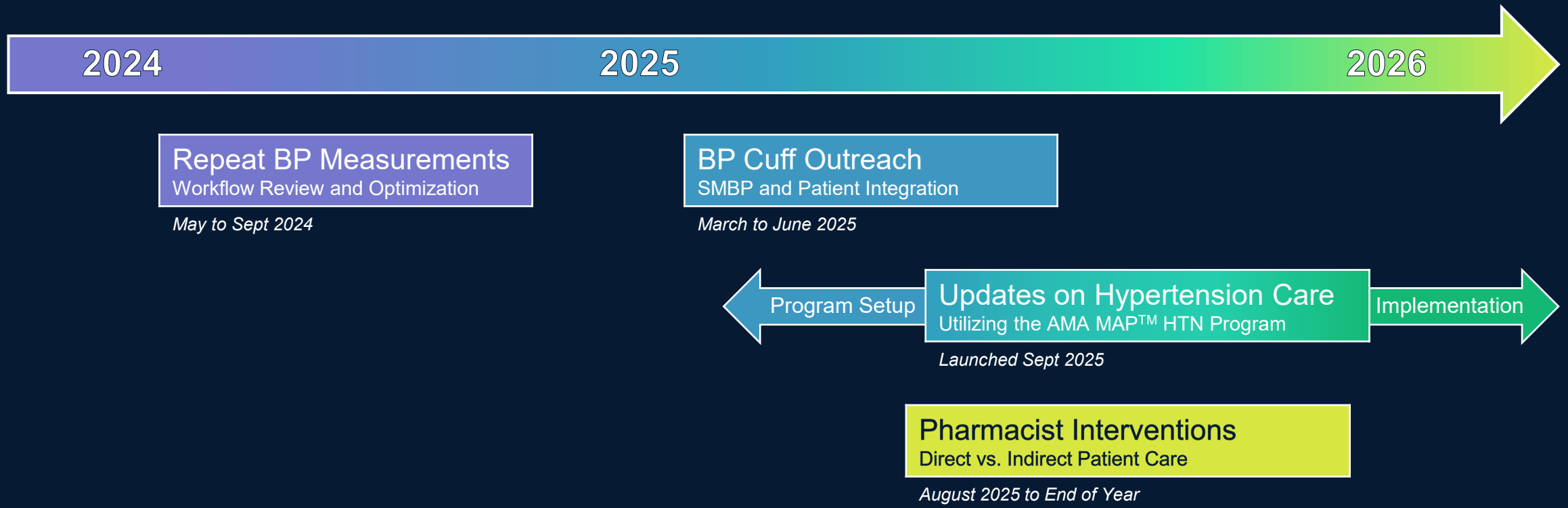




Barriers Seen at Health Partners

Workflows	• Varied BP Measurement Techniques • Awareness of Structured Clinical Pathways and Guideline Updates
Patient-Based	• Inadequate Understanding of Hypertension • Medication Non-Adherence • Comorbidities and Contributing Factors
Provider-Based	• Triage of Comprehensive Care • Clinical Inertia and Intensification • Ensuring Patient Engagement

Ongoing Timeline for Hypertension Control Efforts



Improving Blood Pressure Measurement Accuracy

Standardizing Blood Pressure Measurements and Repeat Workflows

Evaluating Our Measurement Technique

Opportunities

Inconsistent Repeat BPs

Variation in Workflows

Risk of Inaccurate HTN Control

Objectives

Improve Measurement Accuracy

Align with AHA & WHO Standards

Evaluation

Location

Dr. Gene Wright CHC

Goals

- 100% Repeat BP Collections
- Improve HTN Control ≥10%

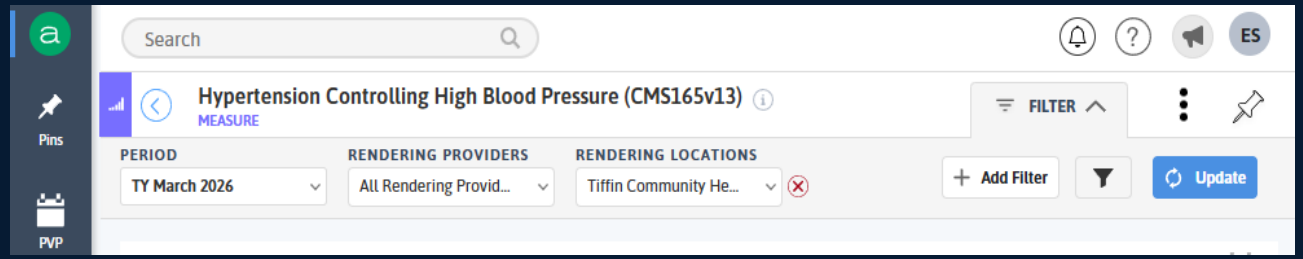
Actions

- Three Med Teams
- Utilize Automated Averaging

Hypertension Controlling High Blood Pressure (CMS165v13)

Drives UDS Performance

Track Population HTN Control



Welch Allyn Spot Vital Signs 4400

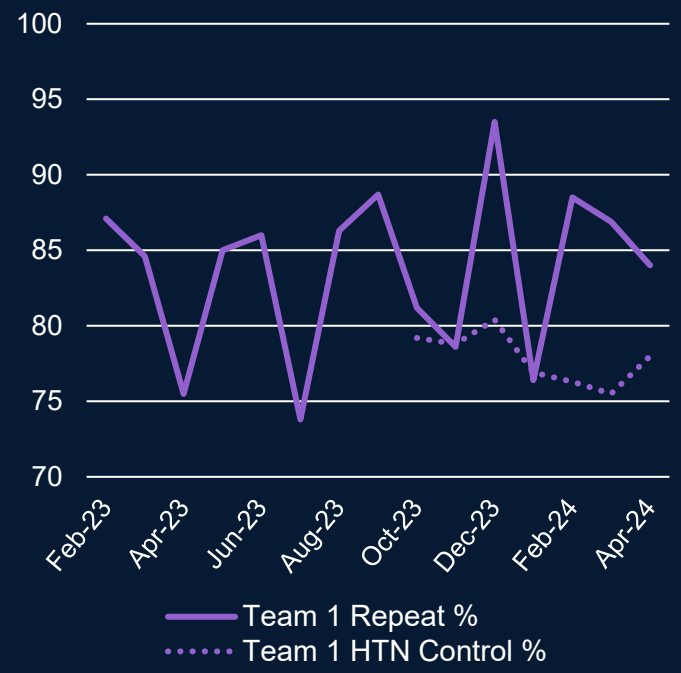
Automated Vitals Device Function for Repeat BP

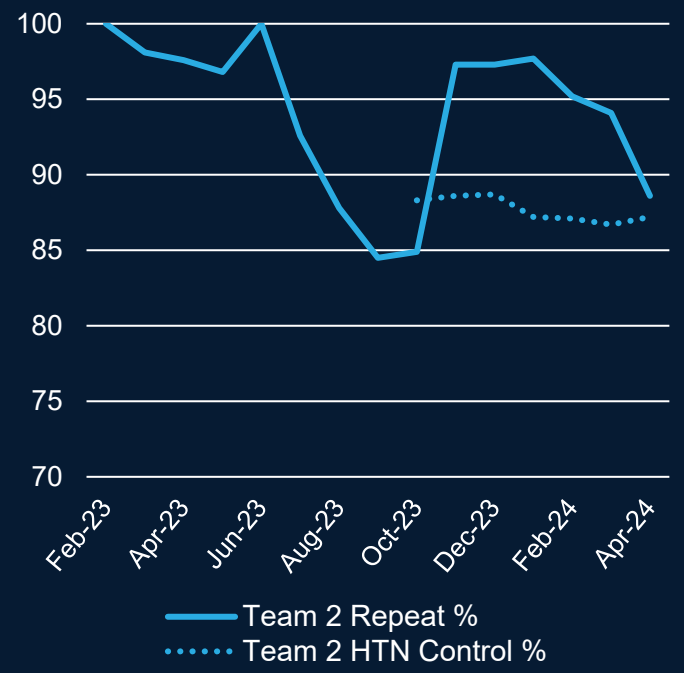
Historical Data

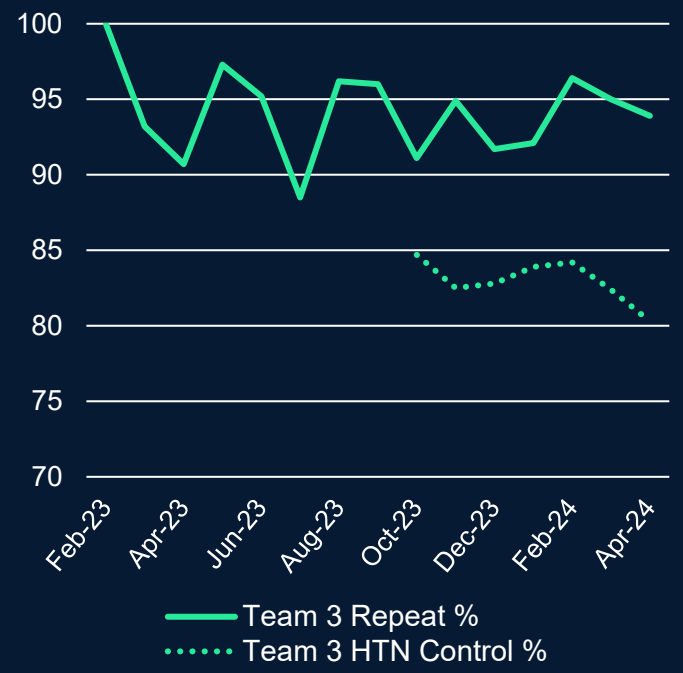
Repeat BP Protocol in Place January 2023

Manual Readings Permitted

No Controls or Further Structure







Identifying Measurement Intervals

Establish

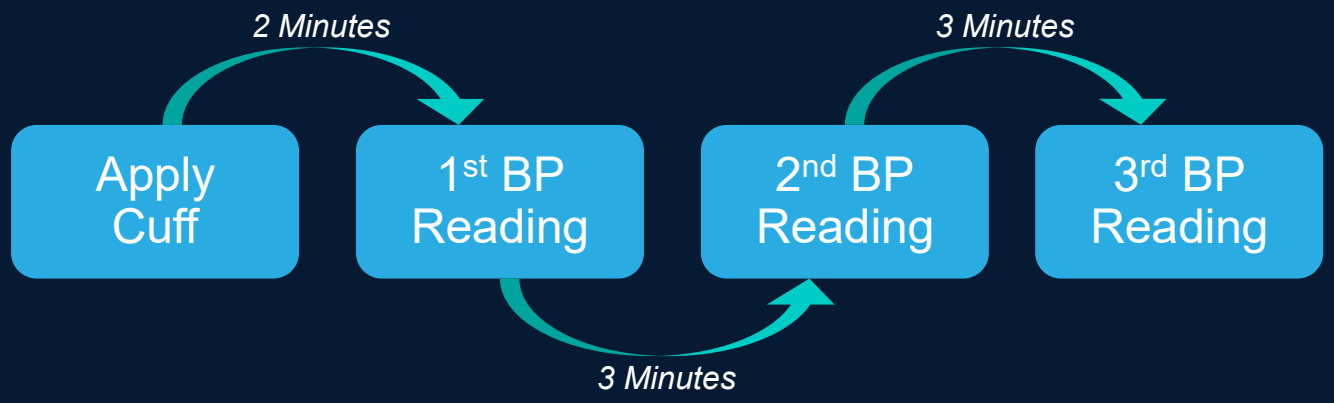
Baseline Performance
Workflow Feasibility

Limited Training Provided to Support Staff

Vitals Machine Operation

Informing Patients on Process

Completing BP During Intake



Staff Workflow Observations

		Workflows	Findings
Cycle 1	Support Staff 1	Intake & 1st Reading Leave Room Complete 2nd & 3rd Readings	Variances Seen Between Teams' HTN Control Support Staff 1 – Varied Support Staff 2 - Consistent
	Support Staff 2	Intake & All Three Readings In Room for All Readings	
Cycle 2	Both Members	***Complete Intake Inform Patient of Process Place Cuff, Leave Room Return & Document***	Staff Differences Still Seen Added Controls Slightly Variances not Reduced

Results of PDSA Cycles 1 & 2

47%

of Patients

HTN Control After 2nd Reading

11%

Controlled at 2nd Reading

Still Controlled at 3rd Reading

Establish

Baseline Performance ?

Workflow Feasibility ☑

Third BP Measurement Did Not Provide Additional Value

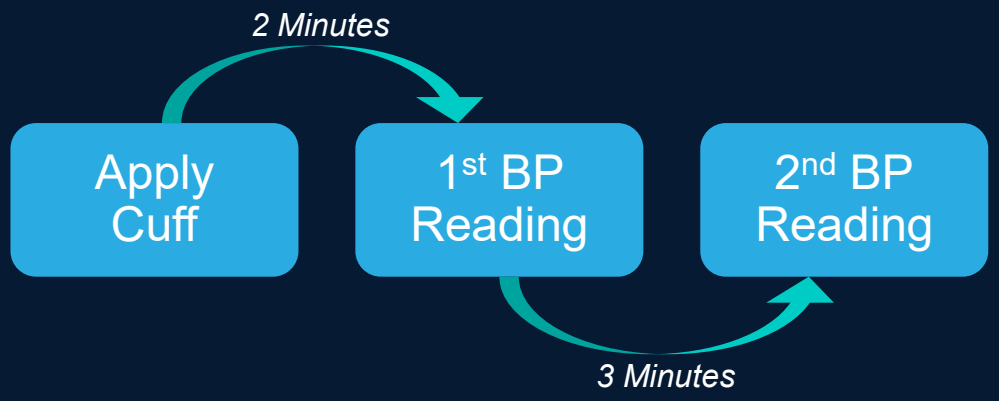
Variations Addressed, Inconclusive if Patient or Staff-Based

Next Steps

Remove 3rd Reading from Protocol

Test with Experienced Team

Assessing Staff Variations



No Controls Set to Mimic Natural Practices
Both Staff Performed Same Intake
Variations in BP Still Apparent

35%

of Patients with

PDSA HTN Control

2nd Reading <140/90mmHg After High 1st Reading

↓

Results were Compared to Recent UDS HTN Control

Most Recent Lowest SBP & DBP <140/90mmHg

↓

Significant Increase in HTN Control Noted

↓

Concern for Confirmation Bias

Manual BPs Performed on Uncontrolled Patients (Non-Testing Days)

↓

Next Steps

Repeat Process with Different Team
Monitor Collections for Entire Month
Align Trials with Monthly HTN Reporting

Linking Workflows with Patient Outcomes

Setup Same as Cycle 3
No Workflow Controls
2 BP Readings Taken

Trial for Full Month
Connecting to Monthly BP Reporting

Shift Focus to Measurement Accuracy

Will we Reduce Missed Repeats?

Will Automation Increase Likelihood of Controlled Reading?

January to August	
Repeat %	HTN Control*
94%	54%

**BP Control Defined as:*
Most Recent Lowest SBP & DBP <140/90mmHg

September	
Repeat %	PDSA Control*
100%	47%

**BP Control Defined as:*
2nd Reading <140/90mmHg After High 1st Reading

Impact of Data Integrity

Repeat Completion Improved

HTN Control Decreased

Automation Reflected Blood Pressure More Accurately

Improved Measurement Accuracy → Improved Patient Care

Communication of Findings

HPWO implements an electronic method of BP collection across the organization to align with current literature supporting automated, non-invasive BP devices for hypertension monitoring.

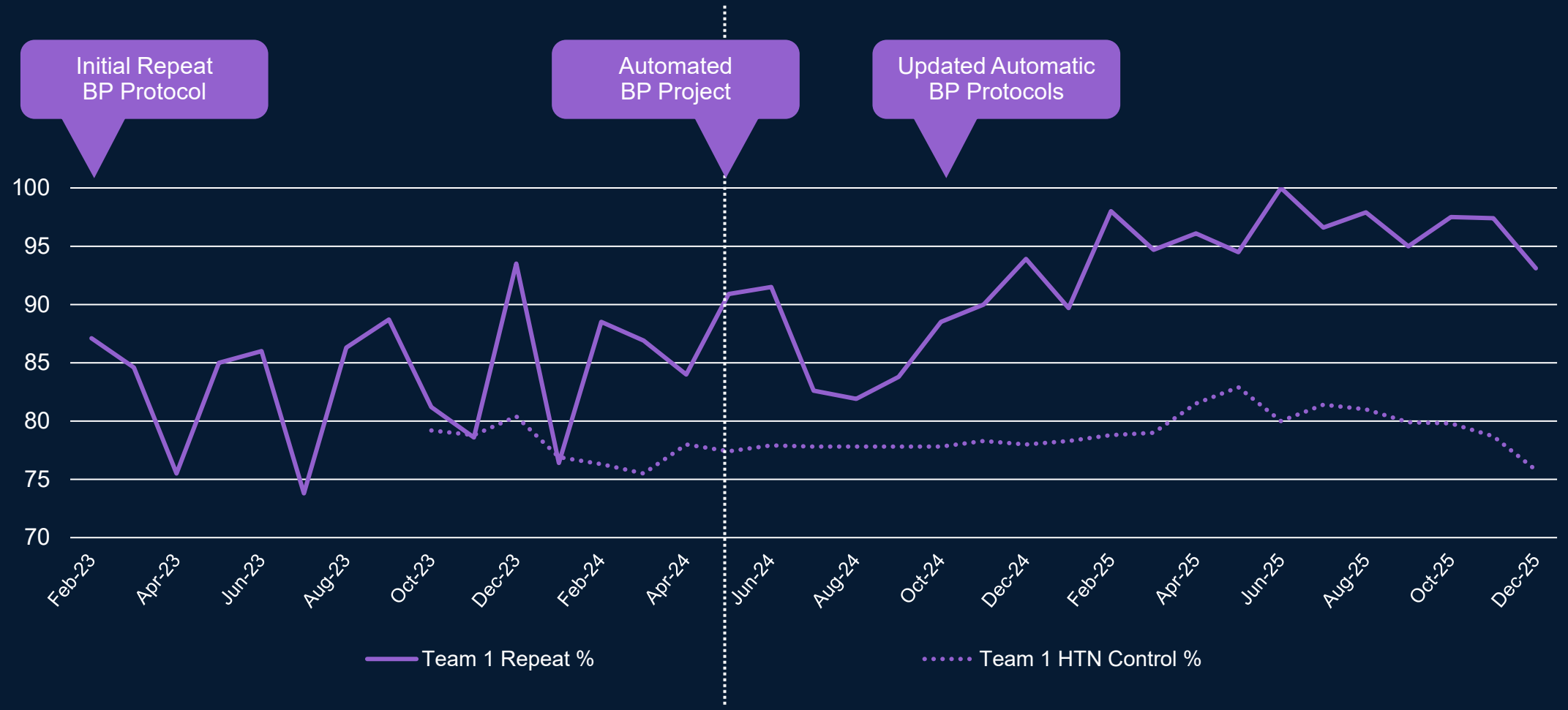
The Chief Nursing Officer and Assistant Directors of Nursing are formally briefed to ensure consistent leadership support during implementation.

Frontline staff are informed through brief, scheduled meetings, with reinforcement and additional training provided during monthly Assistant Director site visits.

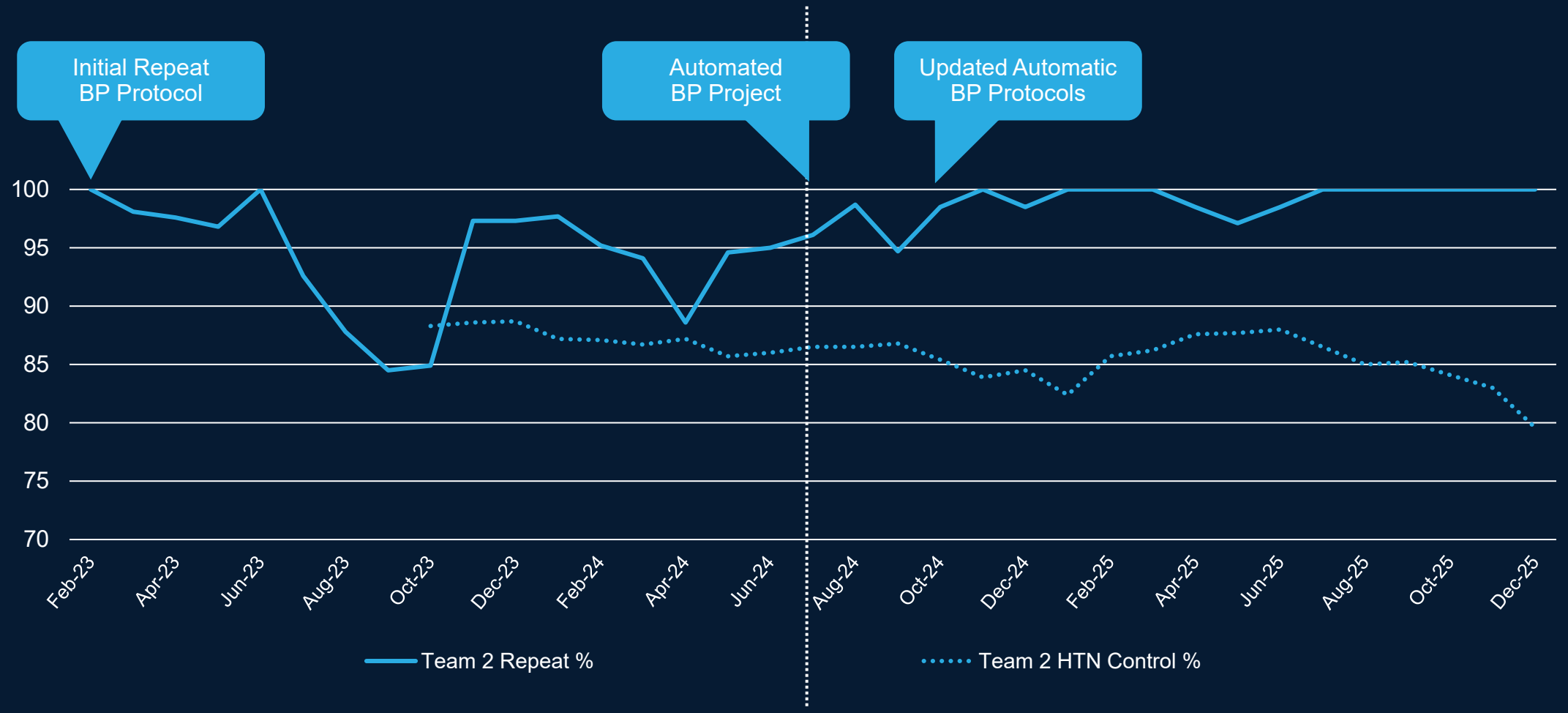
Hypertension data are collected and reviewed monthly, with concerns addressed in site-level quality meetings to support ongoing adherence and performance improvement.

Data Pulled January 2024		Blood Pressure Score Card				
Location	Provider	Patients Needing Rechecked	Repeat BP Percentage	Follow-up 1 Month Scheduled	Hyptertension Control	Percent Now Controlled After Rechec
Perry		0	No Elevated BPs	No Elevated BPs	88.9%	No Repeats Needed
Old West End		100	92.0%	51.9%	78.2%	80.4%
Gene Wright		44	97.7%	85.0%	87.2%	58.1%
Gene Wright		0	No Elevated BPs	85.0%	No adult patients	No Repeats Needed
Woodward		5	20.0%	60.0%	73.3%	No Repeats Needed
Quick Care		50	92.0%	34.6%	79.6%	65.2%
North Lima		40	95.0%	38.1%	79.4%	55.3%

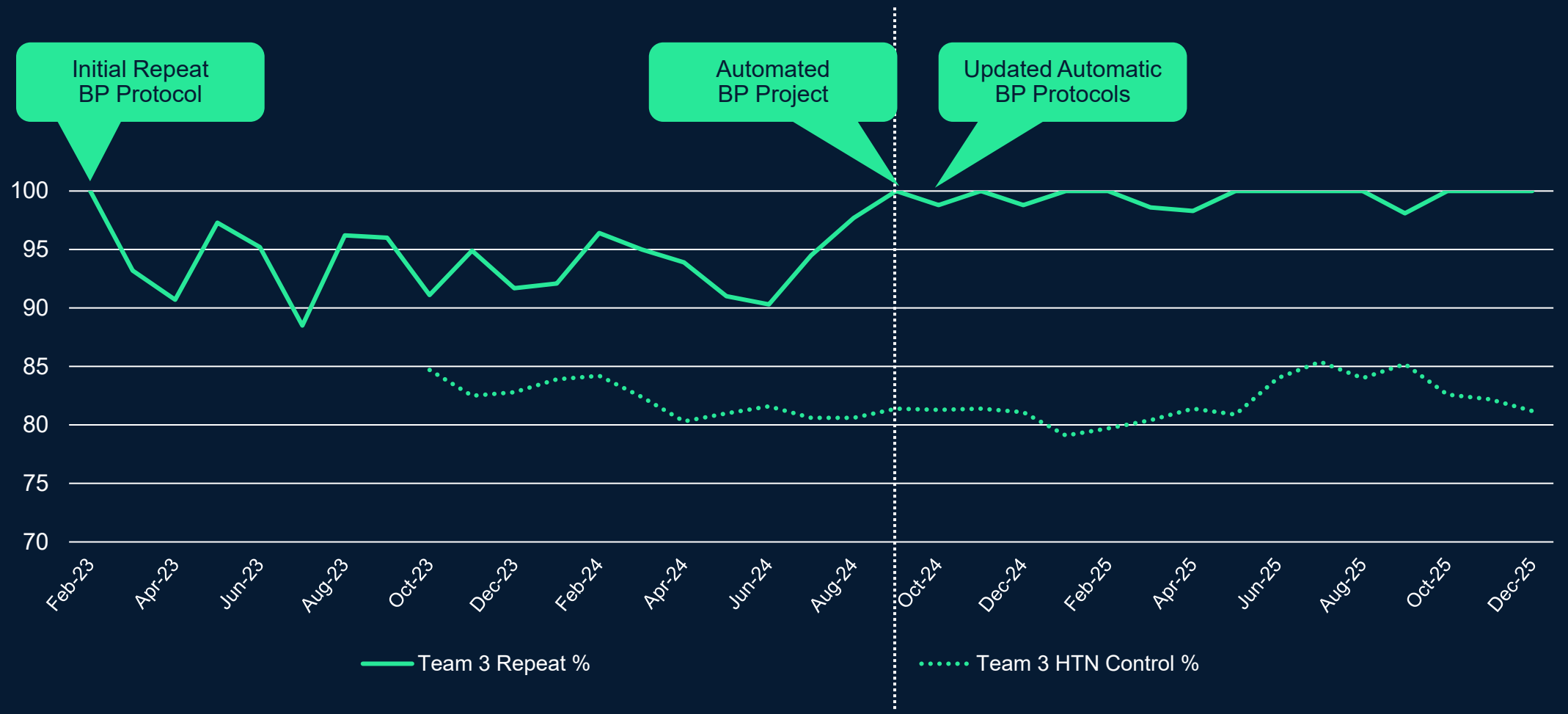
Continuing our Success from Cycles 1 & 2



Continuing our Success from Cycle 3



Continuing our Success from Cycle 4



Enhancing Patient Involvement

Supplying Automated Blood Pressure Cuffs and Utilizing Self-Measured Blood Pressure Readings

Utilization of SMBP

Study Setting

Old West End Community Health Center
March to June 2025

Goals

Evaluate Patient Interest

Test Cuff Distribution

Determine Feasibility of SMBP at our Sites

Patient Outreach

Hypertension Controlling High Blood Pressure
Added Filter for Anxiety

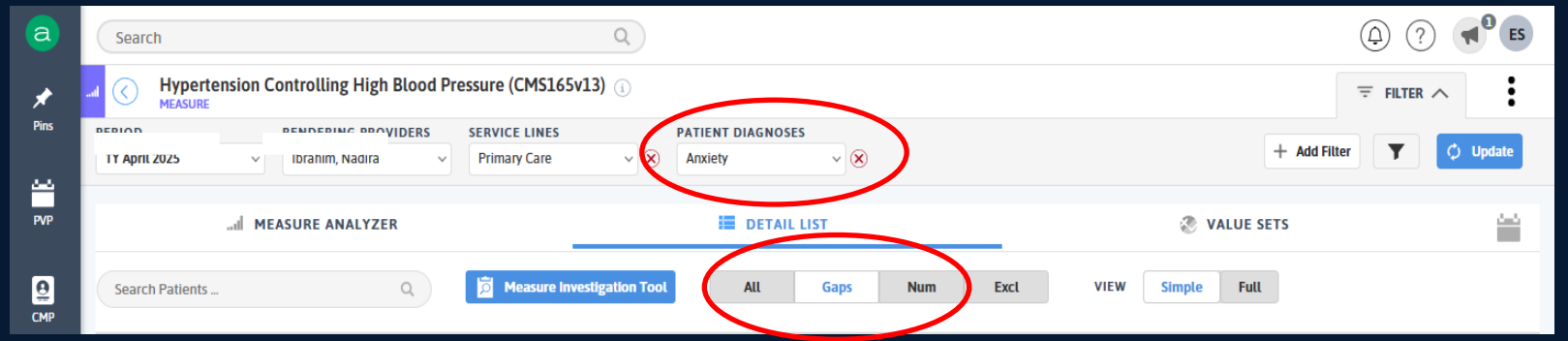
Randomized Patients were Contacted via Phone Calls

Interventions

Automated BP Cuff Provided
No Charge for Patient

In-person training

Weekly Reporting



Patient Resources for SMBP

How to measure your blood pressure at home

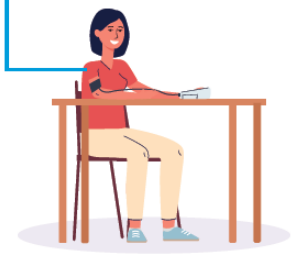
Follow these steps to get an accurate blood pressure measurement:

1. Prepare

- Avoid these things for 30 minutes:
  - Eating
  - Smoking
  - Exercise
  - Caffeine, such as coffee and some teas and sodas
- Measure your blood pressure before taking your morning medicine
- Use the bathroom to empty your bladder, if needed
- Find a quiet space to sit with no distractions

2. Position

- Sit in a chair that supports your back
- Sit next to a flat surface, like a desk or table
- Put the cuff above your elbow on your upper arm, on your skin and not over clothing
- Rest your arm on the flat surface at mid-chest or heart level with your palm up
- Keep both feet flat on the floor with your legs uncrossed



3. Measure

- Rest quietly for 5 minutes in your seated position
- Keep your arm and body relaxed
- Sit quietly without:
  - Talking or conversations
  - TV, phone, or other electronic devices
- Take 2 measurements, waiting 1 minute in between. Do this twice a day, once in the morning and once at night, for 7 days.
- Write down each of your measurements as instructed by your doctor or care team
- Share your measurements with your doctor or care team as instructed

Note: If you are using a wrist cuff, talk to your doctor or care team about how to position your arm.

AMA MAP™ Hypertension

7-day blood pressure recording log

1. For 7 days, measure your blood pressure 2 times in the morning, and 2 times in the evening. Wait 1 minute in between measurements.
2. Fill in your blood pressure and pulse numbers for each day and time you measure – "SYS" is the top number, and "DIA" is the bottom number.
3. Return your log after 7 days to your doctor's office by:

☐ Appointment ☐ Phone ☐ Email ☐ Patient portal ☐ Other

Important! Call your doctor's office if:

- Your blood pressure is above _____ SYS or _____DIA
- Your blood pressure is below _____ SYS or _____ DIA
- You're worried about your symptoms
- You have any questions

Blood pressure arm: ○ Left ○ Right

Day 1 (Date)	Day 2 (Date)	Day 3 (Date)	Day 4 (Date)	Day 5 (Date)	Day 6 (Date)	Day 7 (Date)
Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE	Morning 1 SYS / DIA / PULSE
Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute
Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE	Morning 2 SYS / DIA / PULSE
Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE	Evening 1 SYS / DIA / PULSE
Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute	Wait 1 minute
Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE	Evening 2 SYS / DIA / PULSE
Notes	Notes	Notes	Notes	Notes	Notes	Notes

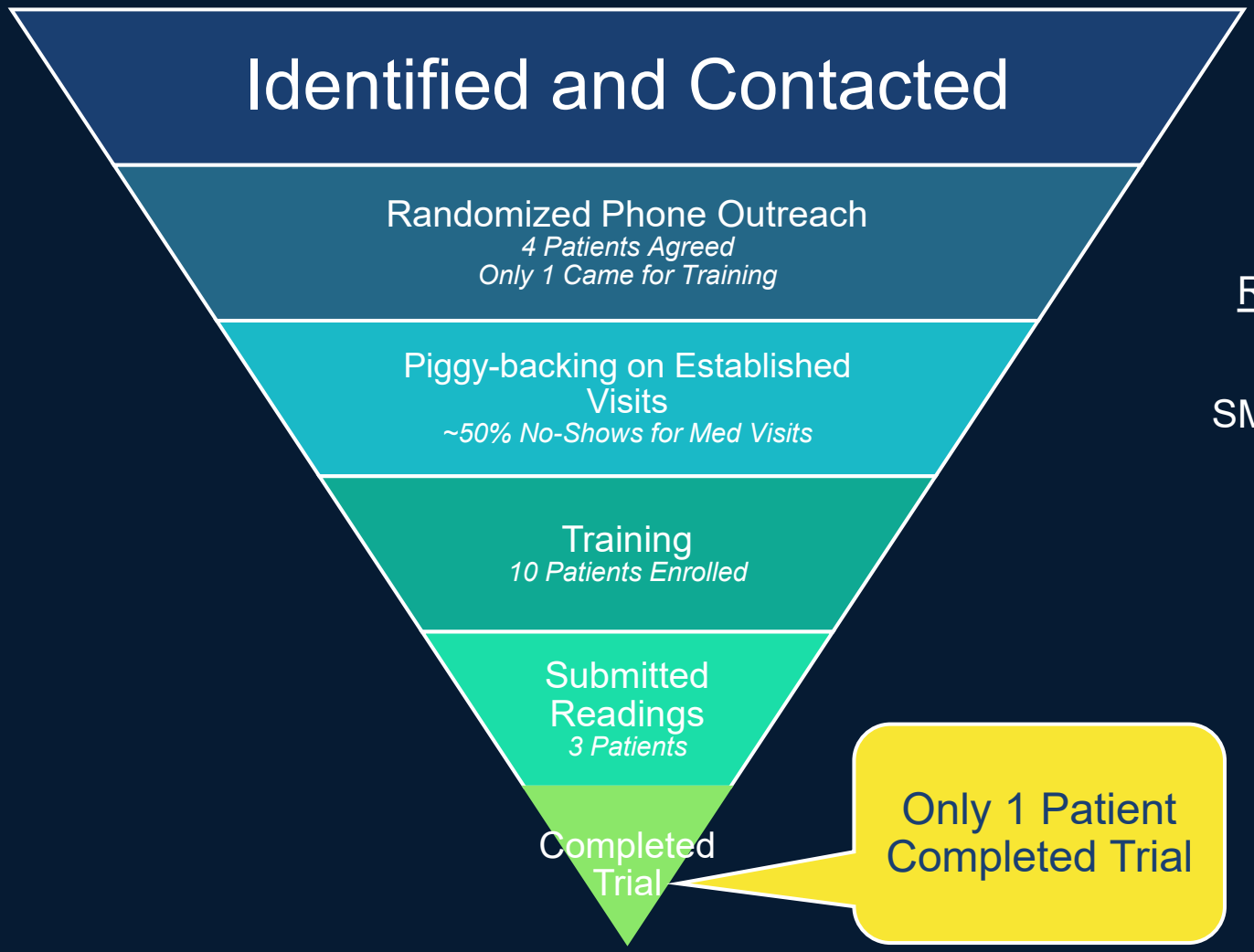
For office use only:

Patient name:_____ Patient ID:_____ PCP:_____

SMBP average: _____SYS / _____DIA

AMA MAP™ Hypertension

Patient Participation



Key Lessons

Randomized Outreach → **Very Low Engagement**

Participation Dwindled at Every Step

SMBP Likely Best for **Motivated/Referred Patients**

Ongoing Efforts

Focus on Patient-Initiated Interest

Integrate SMBP into Existing Visits

Use Targeted Populations

Leveraging Clinical Resources with the AMA MAP™ Hypertension Program

Identifying Improvement Opportunities in Collaboration with AMA Experts

AMA MAP™ Hypertension

M **Measure Accurately**

Obtain Actionable BP Measurements for Diagnosis and Assessment

A **Act Rapidly**

Initiate and Intensify Treatment when Indicated

P **Partner with Patients**

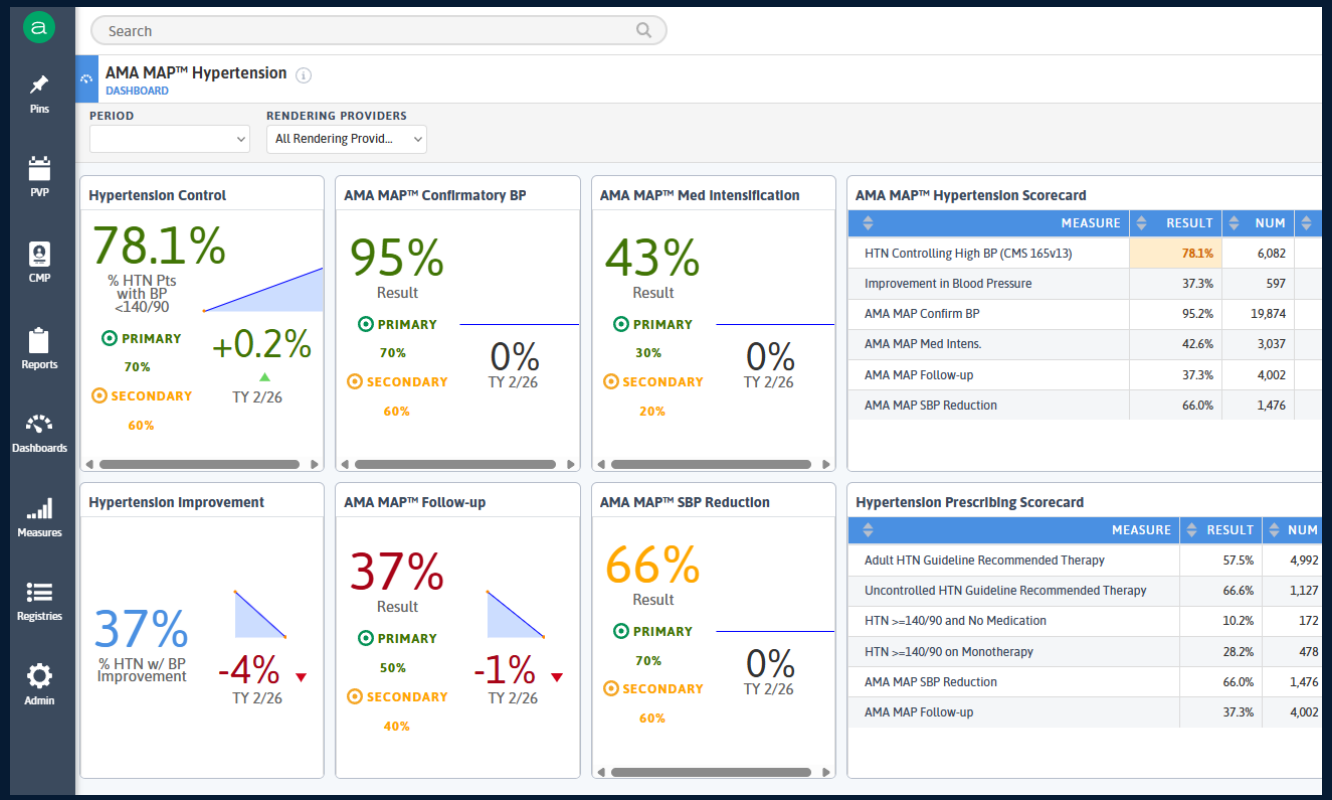
Support Patient Activation Assess & Improve Adherence

AMA MAP™ Hypertension

Each MAP Component Incorporates:

- Evidence-Based Strategy and Action Steps
- Supporting Tools and Resources
- Quality improvement Coaching
- Performance Metrics, Reports & Visualization

Monthly Support and Analysis



AMA MAP™ HTN Dashboard in Azara DRVS

- Utilized to Track Progress and Identify Gaps
- Baseline and Monthly Data Submitted
  - *Reviewed at Each Monthly Call*

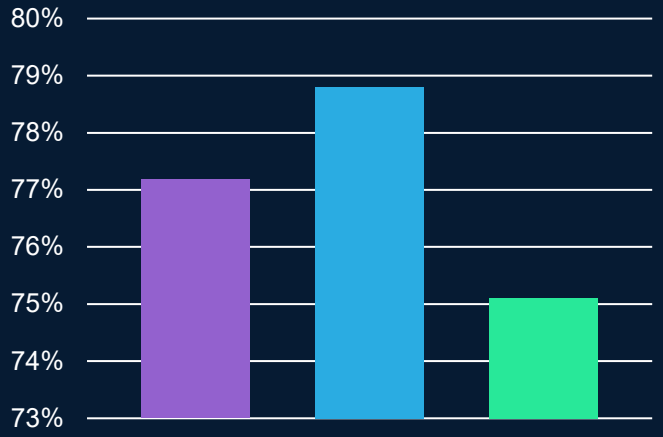
Participation

- Data Submitted for Three CHCs
- HPWO Structure Well-Established for Systematic Updates
  - Plan to Disseminate Info for All Sites

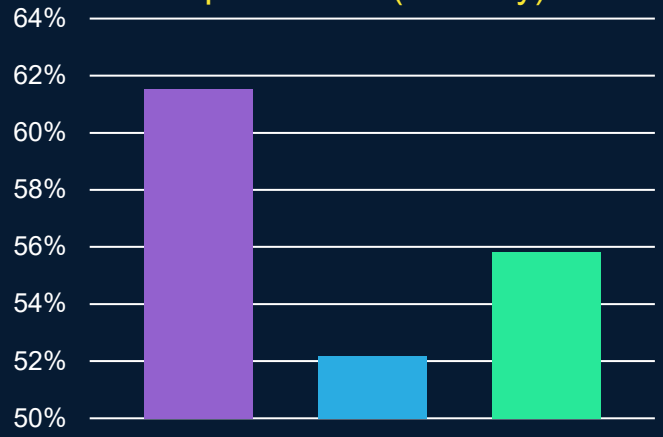
Baseline Hypertension Control

OWE Riverside Tiffin

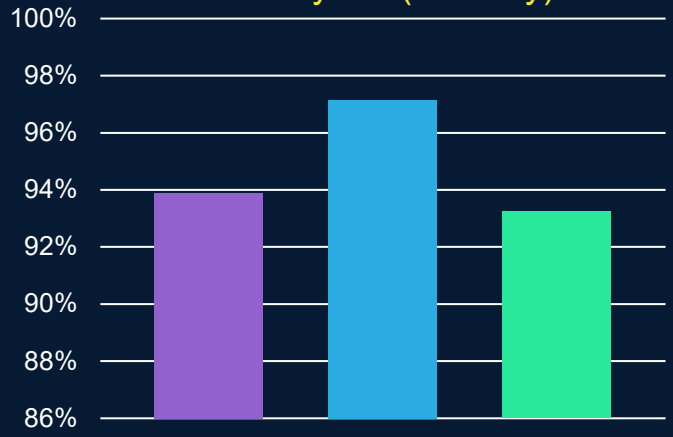
BP Control Rate (Trailing Year)



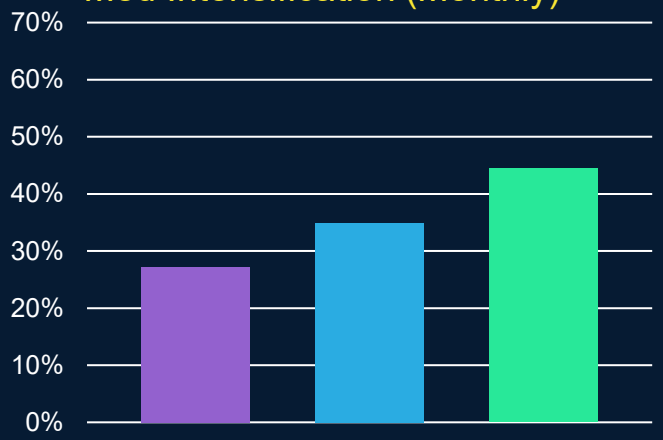
BP Improvement (Monthly)



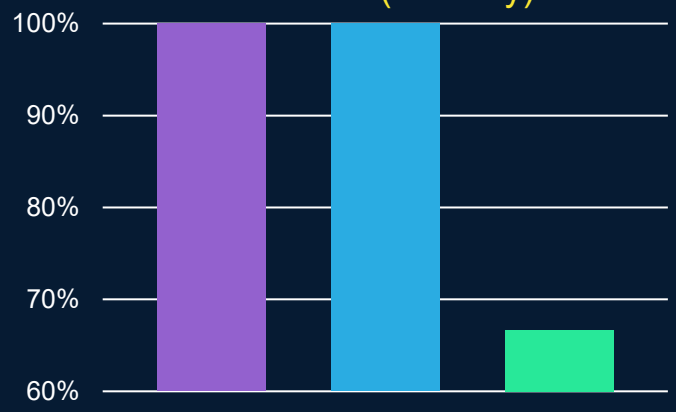
Confirmatory BP (Monthly)



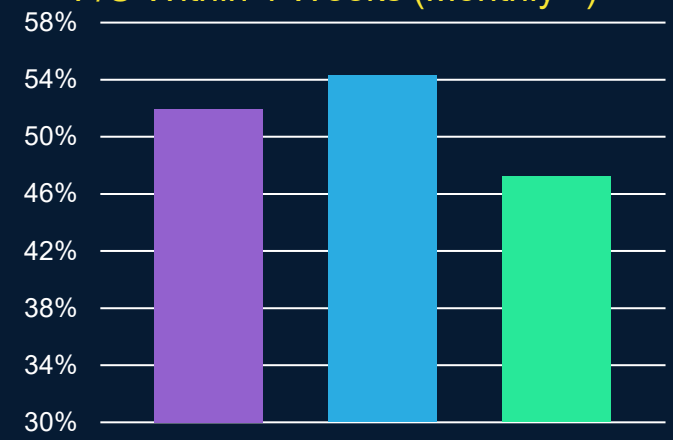
Med Intensification (Monthly)



SBP Reduction After Med Intensification (Monthly)



F/U Within 4 Weeks (Monthly**)



Collaboration with AMA MAP™

Through Monthly Reviews and Coaching
HPWO Focused on…..

Clinical Best Practice Updates

- Incorporating Updated HTN Guidelines
- Educating Providers
  - Ensuring Adherence Through Follow-up
  - Developing HTN Crash Course for Onboarding Providers

Workflow and Reporting Improvements

- Standardizing SMBP Documentation
- Expanding HTN Performance Reports
  - Tracking Follow-up Intervals for Uncontrolled BP
  - Monitoring Medication Intensification

Education & Implementation

2025 → 2026

Planning & Initiation
Establishing Framework
Participating Sites
Submitting Data

March to July

Baseline Data

August

Updates to AMA MAP™ Hypertension Measures and Reports

August

Updated 2025 AHA/ACC High Blood Pressure Guidelines Released

August 14th

Program Launch
"M" Training Session
"A" & "P" Training Session

September

Implementation
Action Planning & Guidance
Barriers to Change
Data Application & Analysis

November

Current Efforts

Post-Launch 3 Month Assessment

December 2025

Post-Launch 6 Month Assessment

March 2026

Pharmacist Interventions
Direct vs. Indirect Patient Care

August 2025 to End of Year

Interdisciplinary Approaches for Patient Care

Comparing Various Efforts of Pharmacist-Led Interventions

Traditional Interventions at HPWO

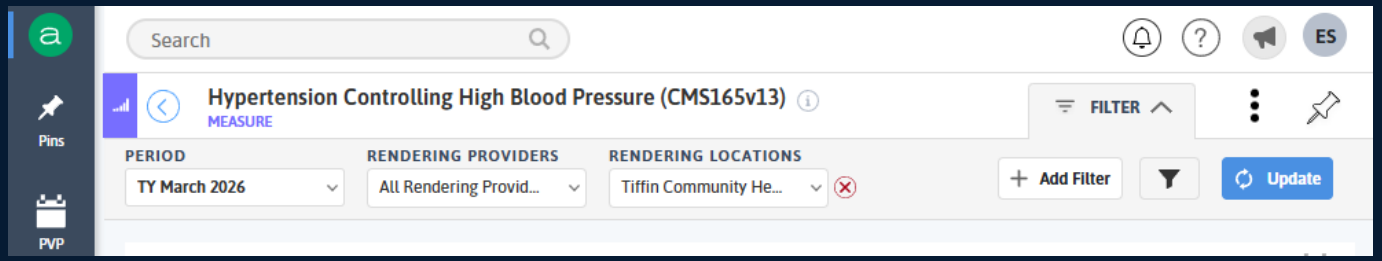
Clinical Pathways Pharmacist

- Gap List Reviews & Chart Audits
- Targeted Provider Education
- Workflow and Follow-up Optimization

Hypertension Controlling High Blood Pressure (CMS165v13)

Drives UDS Performance

Track Population HTN Control



Initial BP Study

Tiffin, Ohio
Feb to June 2021

Baseline HTN Control

Data extracted from Azara DRVS
Assessment from UDS Measure CMS165v13
51.5% (TY Feb 2021)

Pharmacist Intervention

Focus of Chart Audits and Timely Follow-Up

Filtered Data Collection

Looking Specifically at Project Timeframe
52.8% (Q1 2021) to **73.0%** (Q2 2021)

The Medication Experts

Pharmacist-Led Care Consistently Improves

Clinical Outcomes	• Improved BP Control
	  • 43% Uncontrolled Patients Achieved Control
	  • Average Change SBP ↓ 7.6mmHg & DBP ↓ 3.9mmHg
	• A1c Reduction of 6%

Quality and Preventative Care	• Statin Optimization: 77% → 80% • Yearly Diabetic Eye Exams: 58% → 73% • Improving CMS Adherence Measures to 4 or 5 Stars

Access and Care Coordination	• Med Problem Identified at 43% Visits
	  • 98.6% Recommendations Accepted
	• Collaborative Models Benefit Greater than PCP Alone
	  • Readmissions Following Discharge: 3.9% vs. 6.2%
	  • Collective Diabetic Measures Met: 27% vs. 7%

Pharmacist-Led Interventions

How Can we Utilize Pharmacists Further?

Direct Patient Care

Old West End – *Toledo, OH*

Dedicated Pharmacist Clinic Day

Medication Review and Counseling

Targeted Patient Involvement

Patient Follow-up & Continued Care

Traditional Interventions

Tiffin CHC – *Tiffin, OH*

Provider Support Meetings

Guideline Educations

Chart Audits & Case Discussions

Gap List Trend Review

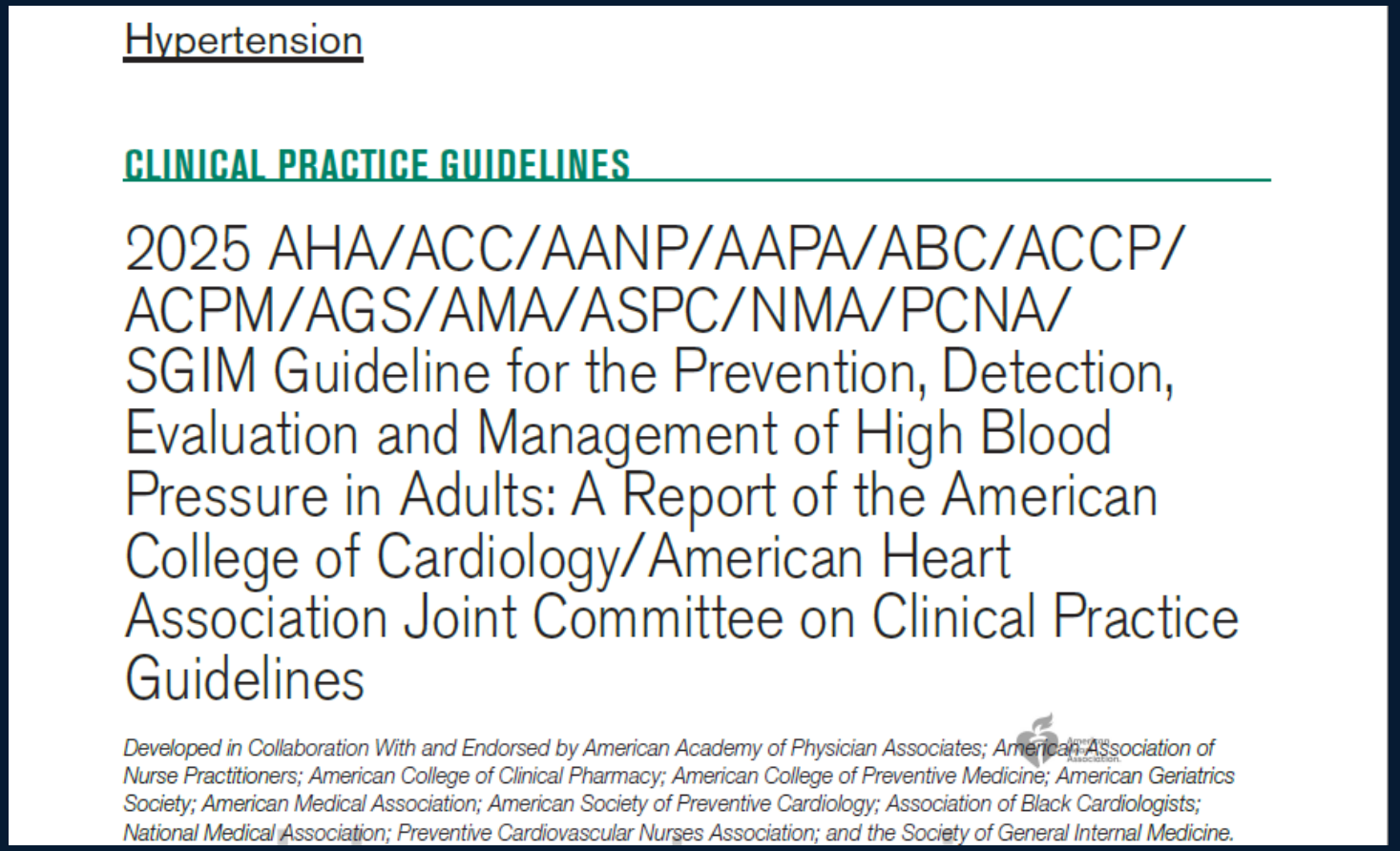
2025 Hypertension Guideline Updates

BP Goal < 130/80mmHg
for Most Patients

Earlier Medication Initiation

Single-pill Combinations Still
Strongly Encouraged

Emphasis on Multidisciplinary
Care and SMBP



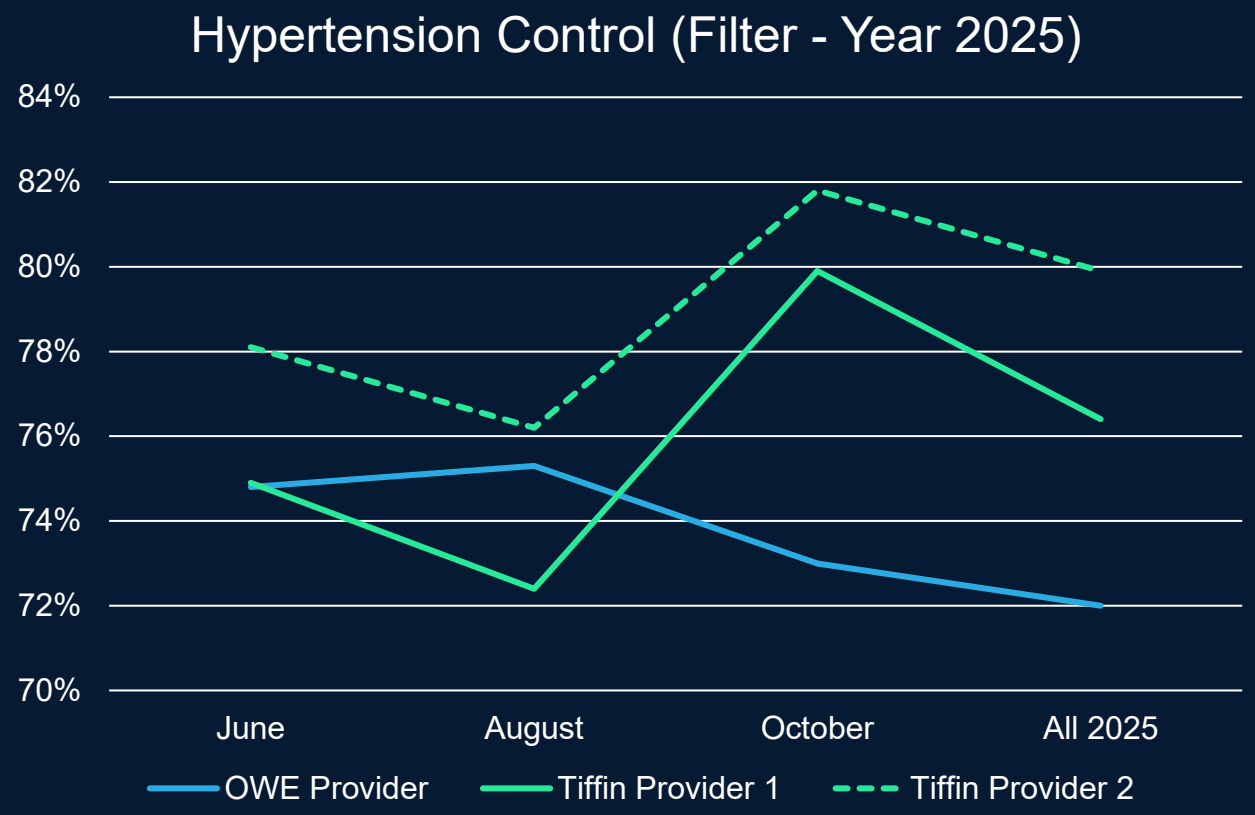
Hypertension

CLINICAL PRACTICE GUIDELINES

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Developed in Collaboration With and Endorsed by American Academy of Physician Associates; American Association of Nurse Practitioners; American College of Clinical Pharmacy; American College of Preventive Medicine; American Geriatrics Society; American Medical Association; American Society of Preventive Cardiology; Association of Black Cardiologists; National Medical Association; Preventive Cardiovascular Nurses Association; and the Society of General Internal Medicine.

Comparisons of Interventions



Direct Patient Care

Old West End – *Toledo, OH*

Clinic Days ran October through December 2025

- Targeted Patient Education and Follow-up
- Strong Outcomes for Engaged Patients
- Recruitment was Lacking
- Limited Time to Establish Practice

Traditional Interventions

Tiffin CHC – *Tiffin, OH*

Provider Discussions ran June through December 2025

- Provider-Focused Workflow Support
- Faster Systemic Improvement
- Providers Quickly Adopted Changes
- Enthusiasm led to Provider Successes

Summary of Findings & Next Steps

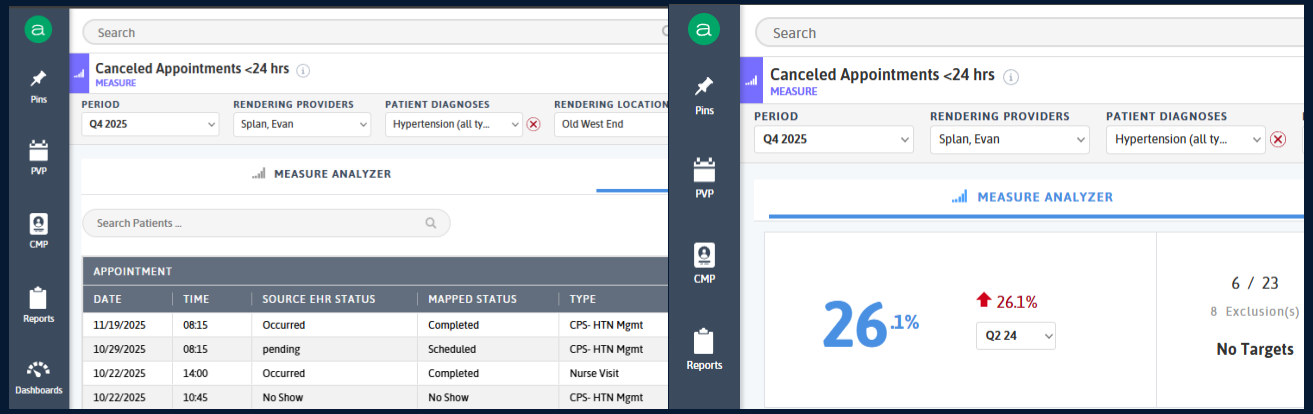
Key Finding

Established Provider Relationships and Workflows Allowed Traditional Interventions to Show Earlier Impact

Visits at OWE	Completed	Rescheduled	No Show Cancel
All Providers	52.8%	22.2%	25.0%
DM RPh	51.3%	19.2%	29.5%
HTN RPh	***34.4%***	***15.6%***	***50.0%***

Ongoing Efforts

- Continue Pharmacist-Provider Collaboration
- Explore Pharmacist Clinical Services
- Use Azara Data to Target Improvement Opportunities
  - UDS HTN Control Measure
  - Custom Hypertension Registries
  - AMA MAP™ Hypertension Dashboards



Organizing our Ongoing Hypertension Care

Combining Years of Hypertension Care Trials

What is the impact of treatment?

If the probability of intensifying treatment was **2 out of 3 visits**

If visit frequency was increased to **every 1 week**

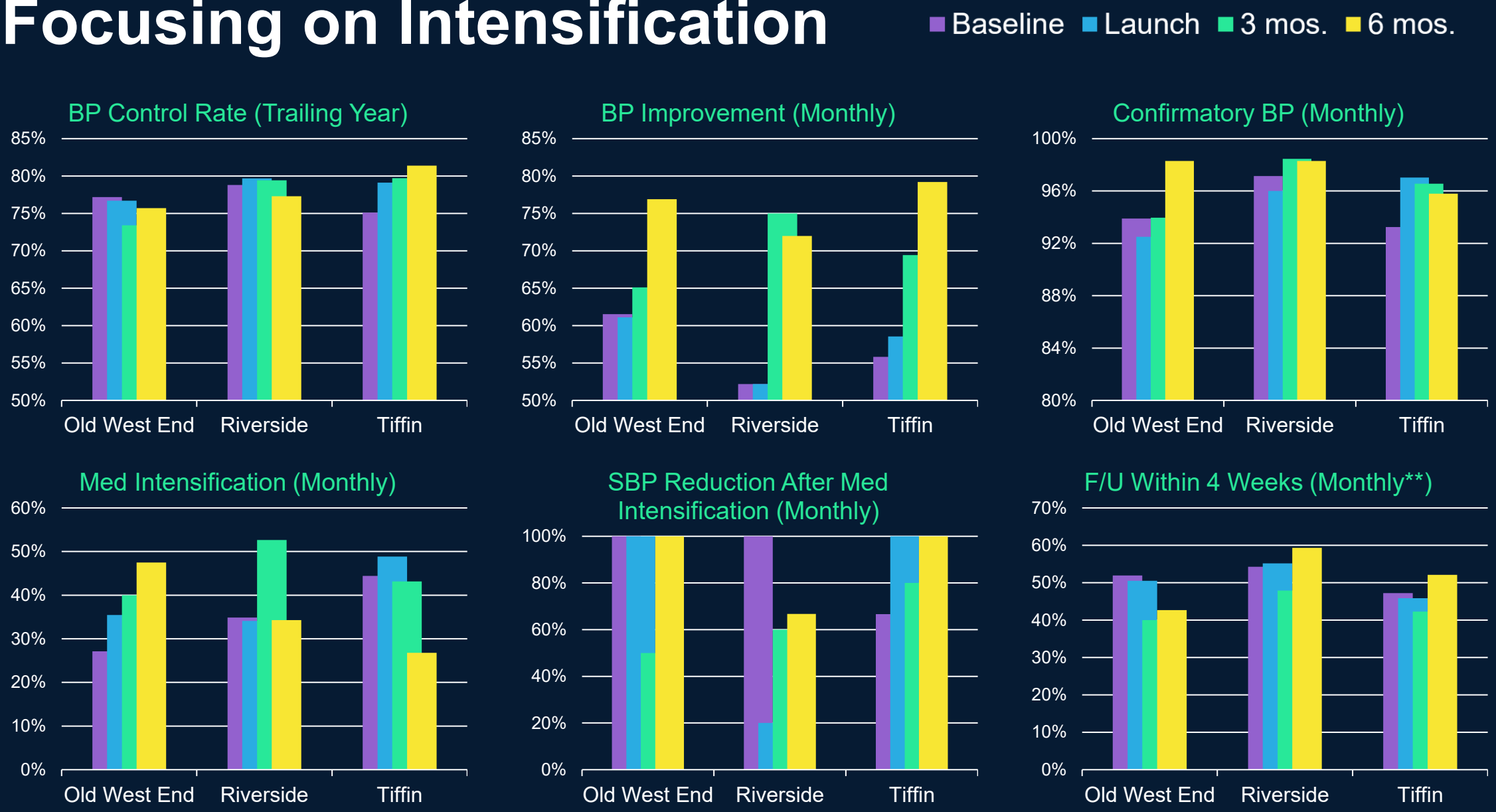
If adherence to antihypertensive medication at 1 year **improved to 100%**

80%
or higher

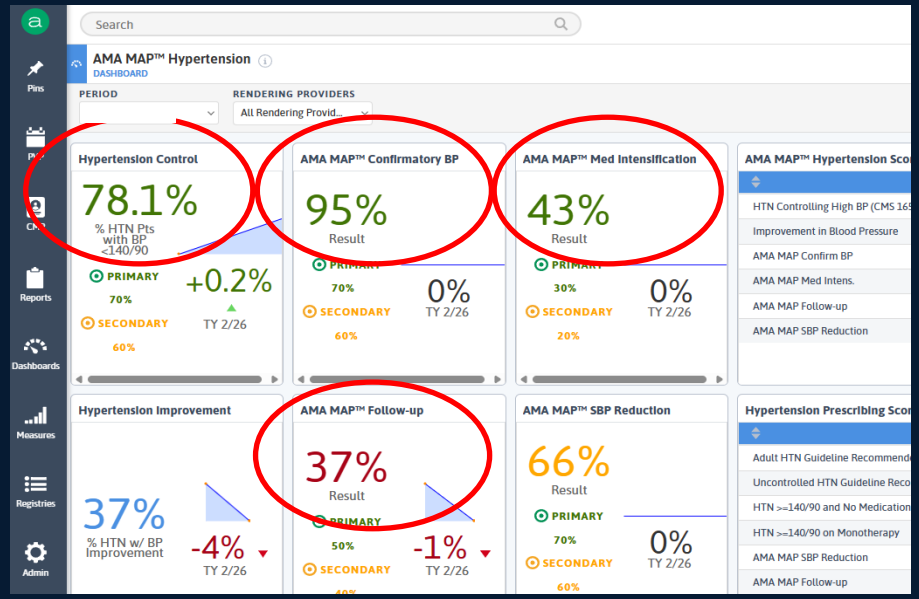
Assuming BP control rate of **46%**

Bellows BK, Ruiz-Negrón N, Bibbins-Domingo K, King JB, Pletcher MJ, Moran AE, Fontil V. Clinic-based strategies to reach United States million hearts 2022 blood pressure control goals. Circ Cardiovasc Qual Outcomes. 2019;12:e005624. DOI: 10.1161/CIRCOUTCOMES.118.005624

Focusing on Intensification



Updates for Data Collection



Azara Alerts	Enabled?	Configurable?
ASCVD Missing	N	N
BP	**Y**	**Y**
BP Stage 1 Repeat	N	N
CKD Screening – HTN	N	Y
Elevated BP	N	N
Elevated BP Stage 1 or 2	**Y**	**N**
HTN Med Intensification	N	N

Data Pulled January 2024

Blood Pressure Score Card

Location	Provider	Patients Needing Rechecked	Repeat BP Percentage	Follow-up 1 Month Scheduled	Hyptertension Control	Percent Now Controlled After Recheck
Perry		0	No Elevated BPs	No Elevated BPs	88.9%	No Repeats Needed
Old West End		100	92.0%	51.9%	78.2%	80.4%
Gene Wright		44	97.7%	85.0%	87.2%	58.1%
Gene Wright		0	No Elevated BPs	85.0%	No adult patients	No Repeats Needed
Woodward		5	20.0%	60.0%	73.3%	No Repeats Needed
Quick Care		50	92.0%	34.6%	79.6%	65.2%
North Lima		40	95.0%	38.1%	79.4%	55.3%

Blood Pressure Score Card

Patients with High BP Needing Rechecked (December 2025)

Azara HTN Measures

Number of Patients 1st BP Elevated	Percent with Repeated BP at Visit	Percent Now Controlled After Recheck	Percent Uncontrolled with 1 Month Follow Up Scheduled	Average Follow Up Duration (Days) After Uncontrolled Visit	Medication Intensification (December 2025) Num	Denom	Result	Hyptertension Control (TY Dec 2025)
4	75.0%	100.0%	100.0%	12.0	No Patients in Measure		N/A	80.0%
65	89.2%	58.6%	41.9%	33.2	7	21	33.3%	72.8%
55	100.0%	63.6%	65.0%	41.8	7	17	41.2%	79.6%
1	100.0%	100.0%	No Uncontrolled Pts!	N/A	No Patients in Measure		N/A	N/A
13	100.0%	46.2%	14.3%	115.4	2	3	66.7%	62.5%
26	92.3%	45.8%	20.0%	26.6	0	6	0.0%	76.0%
27	96.3%	46.2%	40.0%	33.2	8	12	66.7%	76.6%

Updates for Data Collection

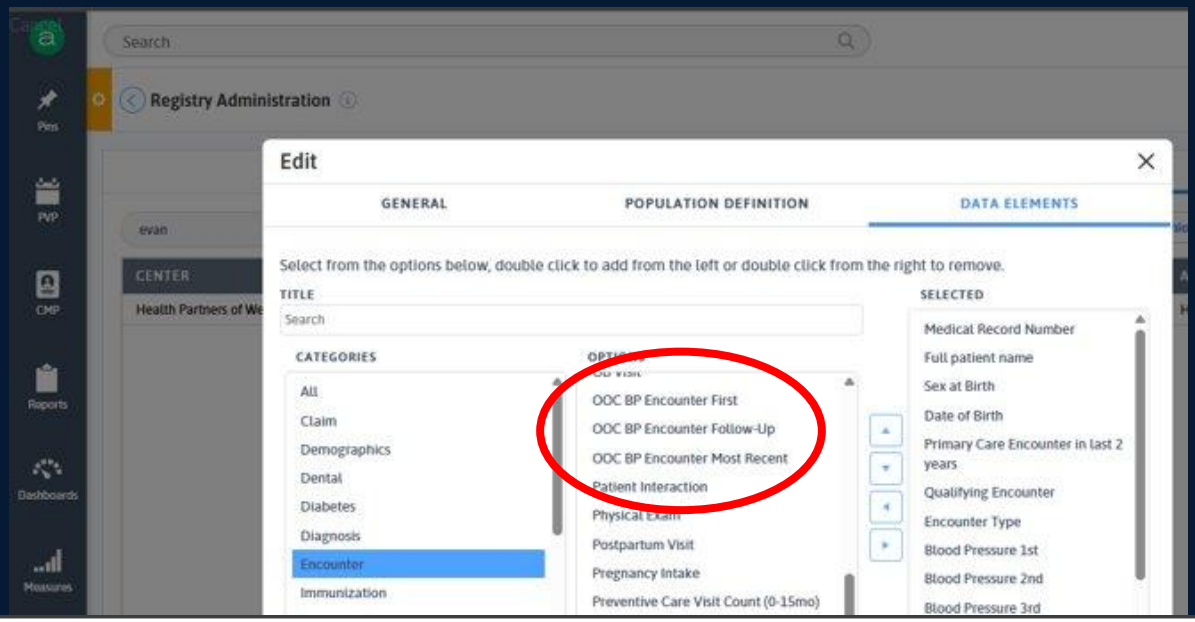
Act Rapidly Interventions

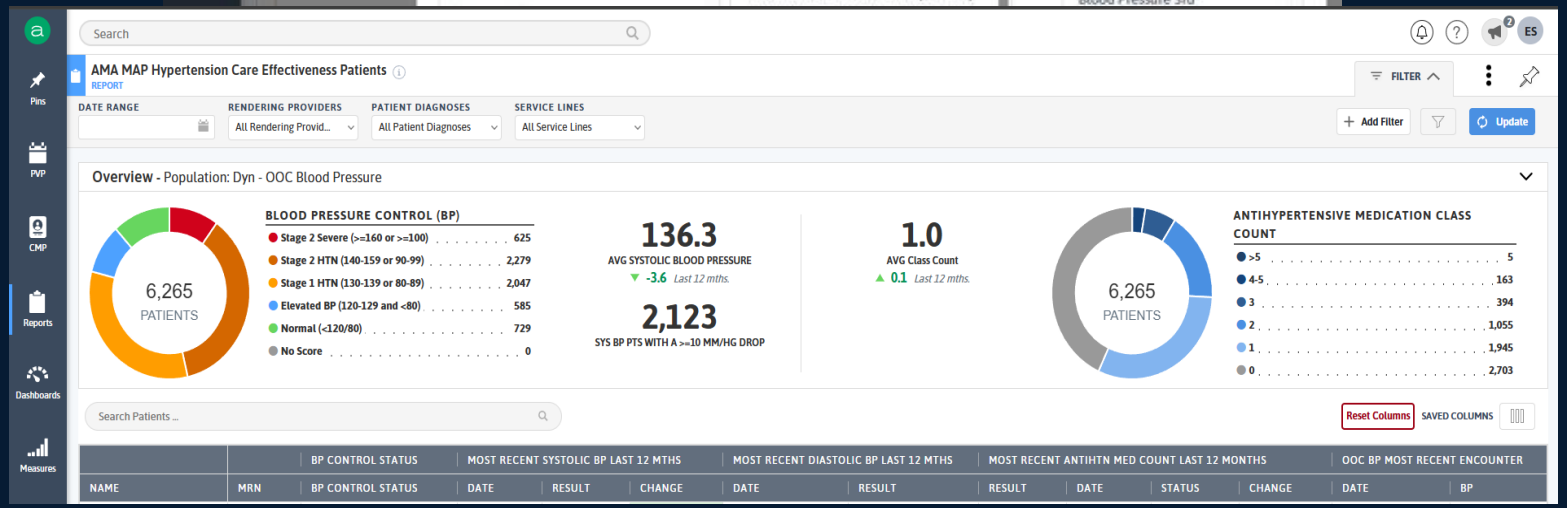
Act Rapidly: Use combination therapy and a medica		
Intervention	**Lead(s)**	**Due**
Conduct a deep dive into patients with uncontrolled HTN. Consider number of medications used in this group of patients and other patients' characteristics that could drive selection of impactful interventions		
Develop/adopt a treatment protocol. Determine how to make it easy to use at point of care.		
Determine SPCs on formulary and make information available to prescribers		
Utilize single pill combinations		
Educate all prescribers on treatment protocol, combination therapy and single pill combinations		
Share success stories across teams		
Consider if there are opportunities to partner with other members of the team to drive evidence-based prescribing and manage HTN (ex: pharmacists)		

Partner with Patients

Partner with Patients: Follow up		
Intervention	**Lead(s)**	**Due Date**
Schedule follow-up appointment before patient leave		
Determine process to identify patients with uncontrolled HTN who need follow up and develop outreach process		
Consider various members of the team that could support patient follow-up (nurses, pharmacists, etc)		
Consider using SMBP as a form of follow-up		
Partner with Patients: Use collaborative communicatio		
Intervention	**Lead(s)**	**Due Date**
Train team members on collaborative communication strategies and encourage use		
Partner with Patients: Address medication adherence		
Intervention	**Lead(s)**	**Due Date**
Evaluate medication reconciliation process to confirm clear roles/responsibilities and opportunities for improvement		
Ensure adherence issues are communicated across the team		
Determine other members the care team that can support patient barriers to adherence		
Educate patients on their medications		

AMA MAP





Sustaining HTN Improvement

Despite Years of QI Work, Maintaining BP Control Proves Difficult

Key Areas of Focus for 2026

Improve Clinical Assessment *Further Evaluating:*	
Patient Adherence	Medication Barriers
Comorbidities	Contributing Factors

Ensure Accurate Measurement	
Verify Proper BP Measurements	Reinforce Staff Measurement Practices

Act Rapidly for Uncontrolled HTN	
Earlier Med Initiation	Indicated Med Intensification
Consistent, Timely Follow-up	Utilization of Preferred SPCs

Develop SMBP Programs	
Verify EHR Documentation	Establish Inclusion Protocols
Increase Patient Engagement	Reduce Follow-up Barriers

Health Partners of Western Ohio

Thank You!

Celebrating 15 Years of Partnership & Progress

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Questions?

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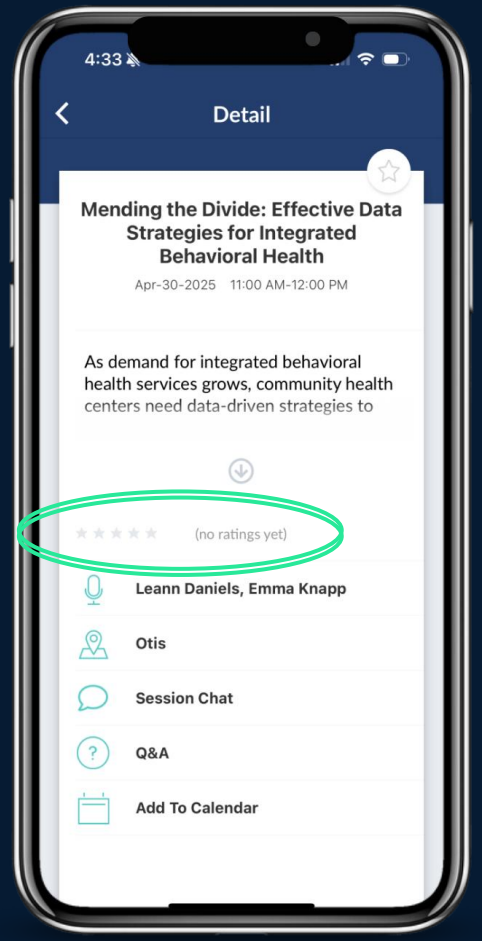
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

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Thanks for attending!