PERCs as Cross-Pollinators:
How the H2N Project has prompted practices to work together

HEALTHY HEARTS NORTHWEST
An EvidenceNOW Project

Healthy Hearts Northwest (H2N) is part of EvidenceNOW, a national initiative funded by the Agency for Healthcare Research and Quality (AHRQ). H2N was established to help primary care practices improve the cardiovascular care they provide to patients. H2N focuses primarily on the "ABCS" measures of cardiovascular care: **A**spirin use by high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation.

Six of ORPRN's nine Practice Enhancement Research Coordinators (PERCs) provide at-the-elbow H2N facilitation in 89 practices across Oregon. Each practice has developed an H2N team to focus on the ABCS measures and develop new strategies for improving the cardiovascular care provided to patients. A PERC's role on these teams is to aggregate resources, disseminate evidence, and circulate new systems surrounding the ABCS measures with a particular view toward implementing quality improvement (QI) strategies. PERCs often act as cross-pollinators, taking innovative ideas from certain teams and suggesting these concepts to others. They act as sounding boards for ideas with the practice teams, thinking aloud about new ways of delivering best practices, with the understanding that the practice teams are experts on these care processes. In this way, the PERCs act as a bridge and span boundaries so that practices across Oregon share "best practices". This article highlights specific ways PERCs act as cross-pollinators.

Sharing Resources

Davies Clinic's Blood Pressure Checklist
by Cullen Conway, MPH

A recent successful innovation occurred at the Davies Clinic, with the development of a Blood Pressure (BP) Checklist. The Davies Clinic has developed, implemented, and sustained a robust outreach and recall structure, but the clinical champion on this team was interested in finding an effective way of identifying and addressing elevated BP at the point of care. This team went through an iterative process of refining their BP Checklist to a point that worked optimally in their workflow. The finished checklist includes information on BP goals, the benefits of keeping BP down, as well as tips and advice on how to maintain a healthy BP. Additionally, this checklist includes a BP log for patients to monitor their BP between visits and focus on self-management. If a patient has an initial BP reading of 140/90 or above, an MA pulls out the checklist and places it next to the patient. When a clinician comes into the room and sees the checklist, they go straight to taking a second reading and providing counseling by walking through the checklist with the patient. The clinical champion has found this new process effective in helping to identify those patients in need of additional support around their BP. Additionally, patients have found this checklist to be extremely beneficial in understanding the importance of their BP, different strategies to maintain their BP, as well as an effective means of monitoring progress between visits. This form has been so effective that the clinic is in the process of developing a similar checklist to be used with their diabetic patients. Now that the BP checklist is functioning as desired, practice facilitators plan to share this document across other clinics and care teams to see if it would function similarly across these other teams.

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Family Medical Group North East's "Tobacco Free Readiness Assessment"
by Beth Sommers, MPH

As part of H2N, Family Medical Group North East (FMGNE) focused on identifying patients who use tobacco products and assessing their readiness to quit. The group developed a structured form, called the Tobacco Free Readiness Assessment (TFRA), to gather patient details around tobacco use and patients' interest in becoming tobacco-free as a means to target cessation conversations and intervention activities based on patients' self-identified stage of change readiness. The TFRA also gathers information from patients on their perceived barriers and motivations to becoming tobacco-free, gauges their awareness of resources available to help them quit, and asks whether patients are interested in receiving active support from their care team in becoming tobacco-free. The group codified into structured electronic medical record (EMR) data the stages of readiness in order to track individual and population changes over time. FMGNE developed the form and the associated workflow using the Plan-Do-Study-ACT (PDSA) method, an iterative process of testing changes, incorporating feedback, and testing some more. Over six months, the practice:

- Piloted use of the form with two clinicians on one care team. Findings: patients were open and interested in using the form. Information from the form led to deeper, tailored conversations between clinicians and patients.
- Reviewed the form with their patient and family-advisory council (PFAC) for feedback and suggestions. Findings: the PFAC confirmed the concept and liked that the form was a single page. They also liked the barriers section on the form – as it will give the clinicians insight into how to help patients.
- Held all-staff meetings to share progress and gain clinician and staff input. Findings: at a recent meeting the MAs reviewed the form and suggested the dummy codes associated with the stages of readiness be removed from the document. They felt it would make their patients afraid of "being tracked."

- Fully implemented the TFRA workflow across the practice. Findings: Sept.-Nov. 25, 2016,

18% of smokers marked they were ready to quit.

The TFRA has been shared with several other practices who are interested in leveraging their health coaches to administer the form and follow up with patients.

Winding Waters Clinic's "Your Heart Health Guide"
by Angela Combe, MS

One of the most widely spread H2N resources has been the Winding Waters Clinic's "Your Heart Health Guide." This tool has been shared with over 10 H2N practices. In "Lasting Imact", an article on page 7, Winding Water Clinic's Nurse Care Manager, Randi Movich, RN describes how the guide was created following a collaborative and iterative process during the Implementing Networks Self-Management Tools Through Engaging Patients and Practices (INSTTEPP) Boot Camp in 2014.

While enrolled in H2N, the clinic has undertaken many quality improvement activities. Specifically, focus has been to review, update and test the inclusion of "Your Heart Health Guide" into hypertension workflows using the PDSA method and incorporating patient feedback. The clinic plans to continue monitoring their performance rates and is hopeful that "Your Heart Health Guide" will help improve cardiovascular outcomes. Across Oregon, the tool has been well received and tested for use in hypertension workflows and other quality improvement strategies. One of Cullen Conway's practices has been effectively using "Your Heart Health Guide" as a guiding document for their visits with patients not meeting the blood pressure measure. The front desk does outreach noting the patient's name and appointment on the tool for the Medical Assistant (MA) to fill in the information from the prior visit. The clinician then reviews and updates the tool with the patient extending the conversation for more complete understanding. The patient then leaves with the tool and schedules a follow-up if necessary. The spread of this tool statewide has been incredible, supporting peer-to-peer learning, highlighting innovations and use of best practices.

Collaborative Learning Sessions

Clinics on eCW: sharing, then planting, a seed
by Kristin Chatfield, MPP

When a small practice in Central Oregon joined H2N, not only had they never worked with OHSU or ORPRN, they have never before looked at their data. In fact, they decided it was more cost effective to pay penalties than report to the clinician Quality Report System (PQRS) or Meaningful Use. Still, they knew they were providing great care and were ready to learn how to prove it, starting with the ABCS measures.

The solo clinician diligently and effectively documents visits in eClinicalWorks, but how to make the EMR work for them at the panel level? The Health Information Technology (HIT) facilitator and H2N PERC met with the MA and office manager, the clinician's spouse, who also happens to have an IT background. After plenty of clicking and head scratching, the HIT facilitator suggested we reach out to a practice in the Healthy Hearts New York City (NYC) Cooperative to see if they might share some instructions. NYC sent back some basics for navigating the reporting system eClinicalWorks, which the office manager implemented for their clinic in Central Oregon. The office manager then developed clean, stream-lined instructions which we have distributed to multiple eClinicalWorks practices across the H2N cooperative! These instructions are easy to read and replicate, proving that with a little technical assistance primary care clinics are poised to learn from one another.

If you are wondering, yes, the ABCS data did show that this provider provides great care, surpassing the Million Hearts clinical targets! They got so good at using data, their first PDSA cycle involved cross referencing those who did not meet the ABCS measures with those who have high Body Mass Indexes (BMIs) and flagging them for special care.

Primary care clinics are poised to learn from one another.

Choosing an EMR: Dr. Walker's Clinic & Deschutes Rim
by Emily Chirnside, BS

With data extraction and ease of electronic documentation being on the forefront of primary care practices, big and small, I offered a small rural primary care clinic an opportunity of connection to aid them in a very big decision.

Deschutes Rim Health Clinic in Maupin, OR began entertaining the idea of transitioning to a new EMR system in the summer of 2016. Within a month they were narrowing in on their top two vendors. They had been "courted" by each vendor and had hosted demonstrations on how each system would work, for providers, for billing, etc. Both sounding too good to be true, I encouraged this clinic to think about speaking with other clinics that were already using the particular systems "in real life" to assist in a tie breaker.

With the substantial financial commitment tied to making a switch like this, the clinic enthusiastically entertained the idea of being connected with another H2N clinic to speak with. The H2N HIT facilitators and I worked quickly to identify the clinics using the Athena Health EMR system (the EMR Deschutes Rim was most interested in). We then narrowed it down by finding a clinic in relative distance from Maupin and by size of the practice. We connected with Dr. Kent Walker's clinic, which is the exact same panel size. Myself and co-PERC Angela Combe facilitated and primed the virtual introduction and connection between the two sites and within days the two clinics had worked out a date in late September for a half day visit. On this day, the entire Deschutes Rim staff visited with Dr. Kent Walker's office manager Darla Linker. Darla ran with this opportunity and created a valuable experience for the entire group. She walked everyone through the functions of the EMR, adding her tips and tricks along the way. The visit was so successful that Deschutes Rim immediately selected and enrolled in Athena Health, rolling it out in their clinic in early November. I foresee this facilitated connection lasting and growing as Deschutes Rim becomes more familiar with their new EMR. I could see the two clinics using one another in the future to exchange workflows, ideas, timely IT support and beyond.