Clinic Characteristics

<table>
<thead>
<tr>
<th>Type of Clinic</th>
<th>Hypertension Prevalence</th>
<th>Hypertension Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCs</td>
<td>38%</td>
<td>18%</td>
</tr>
<tr>
<td>UIC</td>
<td>28%</td>
<td>25%</td>
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Strategies

Improve coordination/communication
- Implement referral systems with feedback documentation
- Create a "whole person" plan addressed at each appointment
- Implement hypertension (HTN) treatment protocol for those not at target
- Conduct daily huddles in all departments
- Increase medical/nursing staff awareness of team-based care (TBC) approaches
- Establish clinical roles so everyone knows what they need to do
- Standardize BP/Chol patient education materials
- Create a concise care plan for patients to take home
- Improve coordination between provider and Management Service RN

Add New Team Member(s) or Expand role of an existing team member

Clinical and Behavioral Health Coordinator, Community Health Improvement Manager, PT, Chronic Care Navigator (CCN), Behavioral Health Improvement Specialist

Maximize Scope of Practice

Nurses, RN - design training for MAs, provide patient care coordination and care management
Clinical Coach - provide care management Pharmacists - evaluate patient characteristics and prescribed medications with appropriate follow up
Dietitian - help implement and manage the lifestyle change program
Medical Assistants - enter orders on patient based on the protocol, provide outreach support
Care Coordinators - review patient records to identify HTN and high blood cholesterol (HChol) to proactively address conditions
Provider - develop workflow and adopt "elevated BP" to visit diagnosis

Refer to healthy lifestyle or community programs
- Wellness Center, Lifestyle Change Program, Food Fairway, Behavioral Health, Chronic Care Management

Warm hand-offs to a health professional
- Health professionals - CCN, Behavioral Health Specialists, RD

Facilitators

Organizational support
Access to lifestyle change program
Information technology
Team support for referrals
Determine roles and parameters of huddles

Results

Warm hand-offs

Implementation strategies
- Increased awareness of other providers & services available
- Provided written referrals and electronic health record documentation
- Identified patients needing additional assistance

# of warm hand-offs
- Clinical Pharmacist = 4
- Dietitian = 18
- Behavioral Health = 105

Impacted by TBC to address
- BP control: 11,080 patients (31% of patient population 18-85 years)
- Chol control: 1,784 patients (Years 2 and 3)

New Team Members

- Community Pharmacist
- Lifestyle Coordinator
- Dietitian

Impacted of referrals made to new member = 113

Sustainability Activities

- Offer additional classes with RD and PT
- Change workflow
- Gather benchmark data
- Expand TBC
- Make referrals
- Increase nursing buy-in
- Establish Collaborative Practice Agreements with Clinical Pharmacists

- Continue improving the process
- Improve BP and cardiovascular disease management
- Continue focus on BP and HChol
- Provide chart prep and screening
- Hold team huddles

Team-Based Care

1815 Grant Years 1-3

Project Goal: Support engagement of all team members in hypertension AND cholesterol management in clinical settings.