Hypertension Control
Adapting to Remote Chronic Care Management

San Francisco Health Network
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Our Desired Future for PHASE

A hypertension control strategy that is well-adapted to remote care and that maximizes telehealth visits for chronic care management where...

- All patients with uncontrolled HTN have access to MyChart
- All patients with HTN have access to MyChart
- All patients with uncontrolled HTN have BP cuffs at home
- All patients with uncontrolled HTN receive a pre-telehealth visit call to collect blood pressure vitals, to check-in on medications, and offer lifestyle education and health coaching
- Blood pressure vital is recorded at all telehealth and in-person PCP visits and patient has ability to regularly upload BP vitals
- Care Teams conduct regular outreach to patients with uncontrolled HTN
Our Desired Future for PHASE
Key Changes & Priority Process Measures

By December 31, 2021, our network will implement 3 key changes to our hypertension control strategy at all our primary care clinic sites to achieve our goal.

The key changes & process measures are:

• All HTN patients have a blood pressure monitor at home
  • 10% relative improvement in the percent of HTN patients with at least one self-measured blood pressure recorded

• Self-measured blood pressure is documented for every PCP telehealth visit
  • 10% improvement in missed opportunity rate for telehealth BP since February baseline for all clinics

• Outreach to B/AA patients with uncontrolled HTN is conducted regularly
  • 10% relative improvement in rate of B/AA patients with HTN who have not had a PCP visit in more than 6 months having an outreach encounter documented within the last 3 months
Why It’s Not Possible Now

- **Limited staff capacity** as many of our nurses and MEAs have been deployed for citywide COVID-19 response

- **Limited leadership capacity** and reduced QI infrastructure due to COVID-19 restrictions
Why It’s Not Possible Now

• Lack of synchronous, coordinated approach to remote chronic care management
Learnings that Inform Our Desired Future

• Prioritizing B/AA patients for outreach helped maintain BP control while overall rates declined
• Inclusion of patient-reported BP improved HTN control rate
Hypertension Blood Pressure Control
Richard Fine People's Clinic (Test Clinic)
September through December 2020

B/AA patient outreach
- Phone outreach
- Schedule in-person clinic visits

6-8 weeks into patient outreach
- In-person clinic visits
- BP checks & A1c labs

Outreach paused
- Coronavirus surge
- Reduced in-clinic capacity

Overall percentage trends:
- Sept: 59%
- Oct: 58%
- Nov: 57%
- Dec: 55%

Patients in B/AA:
- Sept: 53%
- Oct: 52%
- Nov: 54%
- Dec: 52%
Hypertension Blood Pressure Control with Self-Measured BP (SMBP)
at Ocean Park Health Center
June 2020-March 2021

% of Controlled BP
% of Controlled BP with SMBP

- Build data tools in Epic for SMBP
- Track patient reported BP in Epic
- Pre-telehealth visit calls

24% change
Activities we will keep doing based on what we’ve learned

• Maintain efforts to provide **home BP cuffs** to all HTN patients who do not have one
• Conduct **pre-telehealth visit calls**
• Document **patient-reported BP vitals** in Epic
• **Outreach** to B/AA patients with uncontrolled HTN
What Else Can Contribute to Our Desired Future?

Team based care

- Primary Care Providers
- RNs
- Health Workers
- MEAs
- Pharmacists
- Behavioral Health Clinicians
- Food Pharmacy

Patient

Remote RN hypertension visits
Benefits of Achieving Desired Future

• Home blood pressure monitoring will help patients with hypertension control their blood pressure

• Pre-telehealth workflows will improve both patient and provider experience with remote care

• Prioritized outreach will improve hypertension control for B/AA patients

• Quality Incentive Program (QIP) and financial metric performance

“The pandemic has made it more difficult for me to manage my blood pressure.”
~Clinic Patient

“My doctor keeps me on my toes and gets me to come in and get my BP checked.”
~Clinic Patient
Challenges if We Don’t Move Forward with Solution

• Lack of comprehensive remote care will lead to poor quality healthcare
• Limited patient access
• Poor staff and provider morale if they feel like they can’t provide high quality remote care
• Our network will fall behind and potentially lose patients to other clinics that are better equipped for remote care
• Risk losing pay for performance dollars
What We Need from Our Leaders to Make it Happen

• Prioritize quality improvement funds for purchasing home BP monitors
• Advocate to payors to reimburse home monitoring devices including BP monitors
• Dedicate resources for MyChart sign-up including staff, tablets and electronics (e.g., camera, microphone, monitors)
• Include telehealth workflows as part of centralized onboarding and training for MEAs
• Hold clinic leadership accountable to spotlight quality improvement initiatives for remote chronic care management
• Prioritize team-based quality improvement for remote chronic care management by ensuring dedicated time for panel management for nurses and pharmacists and chronic care visits
• Hire 5 FTE health workers as part of a central outreach team
Thank you for your time!

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