Alameda Health System - Highland Hospital SMBP Pilot

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Pre-Pandemic SMBP in Primary Care at AHS

- Low usage (<10%) of SMBP
- No standardization:
  - Who? How? When?
- Provider dependent
- Inconsistent payer coverage of upper arm blood pressure monitoring devices
Alameda Health System’s 2020 Opportunity

- 90% In-person → 80-90% Telehealth
- Current climate: Financial, clinical, and ethical incentive for SMBP expansion

- Chronic Care Clinic
  - Multidisciplinary team embedded in Primary Care
    - Clinical Pharmacist
    - Registered Nurse
    - Medical Assistant

- Chronic Care provides DM and HTN medication management, education, and care coordination
- Well-positioned to impact vulnerable patients and test standardized process for SMBP
Epic workbench report identified patients active with Chronic Care (DM + Last BP >140/90)

Medical Assistant outreach (3 phone attempts)

Depending on payer – BP cuff ordering process initiated OR BP cuff provided

Telehealth or In-person visit scheduled (Visit #1) for BP cuff pick-up, teaching by LVN or RN
Visit #2 - BP review and Med Titration via telehealth in 1-2 weeks with RN or PharmD*

Visit #3 - BP review and Med Titration via telehealth in 1-2 weeks with RN or PharmD*

Visit #4 – Scheduled in-person with RN, PharmD, or PCP for BP validation and labs (as needed)

* If BP >180/100 mmHg then in-person visit scheduled
Patient and Staff Education

1) Patient materials
   • ‘Measure Your Blood Pressure’ – 1 page physical and electronic document
     • Link to AMA instructional video
     • SmartText created to embed content in visit notes

2) Standard Work Document for MA
   • Orientation/Tip sheet for Epic report
   • Scripting for outreach
   • Epic SmartPhrase for PCP notification
   • Instructions for scheduling

3) Standard Work Document for RN/PharmD
   • Overview of expected content for each visit
   • Reference Standardized Procedure for RN and Collaborative Practice Agreement for PharmD for HTN management
Highland Hospital SMBP Pilot Summary

• Pilot period: 5/1/20-10/31/20
• Report generated 91 patients:
  • Active Chronic Care Status + DM diagnosis + Last BP >140/90
• Highland Chronic Care team heavily involved with planning
  • Synergy with DM visits already occurring
  • Each part of the team owned a piece
• Reliance on in-person visits for initiating SMBP has the potential to widen disparities already present in HTN care at AHS
  • Race subgroup analysis for BP control and process metrics
Engagement Over Time - by race/ethnicity

Visit Guide
Visit #1 = Obtain cuff + education
Visit #2 = Telehealth BP readings + med titration
Visit #3 = Telehealth BP readings + med titration
Visit #4 = In-person BP recheck
Blood Pressure Control Over Time

Percent of Pts with BP at Goal
Patients with BP under Control

Visit 2
- Number pts: 50
- Number pts goal BP: 30

Visit 3
- Number pts: 44
- Number pts goal BP: 24

Visit 4
- Number pts: 40
- Number pts goal BP: 30
BP Control Over Time – Race/Ethnicity

Visit 0, Visit 2, Visit 3, Visit 4

Percent of Pts with BP at Goal

- Black/AA
- Latinx
- Other
- White
- Asian
Bright Spots

- Achieved a higher rate of BP control than expected
- Patients were grateful for receipt of BP Cuffs
- All members of the care team (MA, RN, PharmD, LVN) were responsible and successful in engaging the patient
- Re-emphasized the importance of BP review along with DM data by our chronic care staff
- Reinforced RN autonomy with BP medication titration
Challenges/Areas for Improvement

- Long delays getting blood pressure cuffs via insurance plans
- Patients often didn’t want to come in for an in-person appointment
- Differential effect on engagement and BP control by race/ethnicity
- DM management during appointment sometimes took precedence over SMBP education
• Work with Health Plans to stock BP cuffs in clinic
• Distribute BP cuffs to all patients presenting for an in-person RN BP check
• Narrow race/ethnicity effect gap noted during pilot
• Will provide education to all providers that reinforces patient use of self monitoring BP at home and in-between visits.