



PREVENTING HEART ATTACKS
& STROKES EVERY DAY



PHASE 2020 - 2021

Golden Valley Health Center

16 March 2021

Team Members:

Associate Chief Medical Officer, Director of QI, Director of Operations, Director of Clinical Education and Outreach, QI Project Manager, QI Specialists, Call Center Staff, Community Health Workers

WHAT WERE WE TRYING TO ACCOMPLISH?

Problem Statement

Patients with chronic conditions such as hypertension are more vulnerable to adverse health outcomes including heart disease and strokes. Moreover, hypertension and other associated risk factors for cardiovascular disease simultaneously put patients at greater vulnerability to COVID19 complications and death. As a result, improving our ability to manage chronic conditions amongst our patients as well as our ability to screen and provide follow up services for key risk factors is vital to the health of these patients.

Aim Statement

By March 31, 2021 GVHC will maintain HEDIS 75th percentile for blood pressure control amongst patients with hypertension by coordinating access to care and resources.

Health Equity Aim Statement

By March 31 2021, GVHC will improve blood pressure control amongst African American patients with hypertension from 57.8% to 60%

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Our Theories for Change: How We Learned About Our Process

Aim Statement

By March 31, 2020 GVHC will maintain HEDIS 75th percentile for blood pressure control amongst patients with hypertension through 2020 by coordinating access to care and resources.

Documentation

- Difficulties of documenting BP readings with telephonic appointments.
- HIT Technology



- Workflow modification Capture self-reporting BP in telephonic calls.
- Optimize telemedicine encounters to facilitate improved HTN

Treatment

- Health Educators unavailable to provide education to patients regarding their treatment.
- Increase follow up appointments to identify effectiveness of BP medication.



- Health education program including education on diet, exercise, blood pressure monitoring.
- LVN/RN's are available for BP education such as how to use BP monitors.

Patient Engagement

- Contact patient to offer appointments with provider.
- Interview patients to request feedback.
- Send text messages with open ended questions.



- Use registries to outreach to patients via telephone.
- Text message and phone follow up.

Self Management

- Patient education
- Lifestyle changes
- Medication affordability
- BP monitor for in home use.



- Develop care message program.
- Observe workflow and identify barriers for accessibility of receiving a BP monitor.

Health Equity

- Identify, track, and prioritize disparities for high risk populations.
- Utilize outreach teams.
- Create workflows within the organization to further identify interventions for Black/African American patients with uncontrolled BP.



- Utilize internal reports such as NextGen/EPIC and SQL and Azara to identify patients.
- Collaborate with community outreach team to increase patient engagement and compliance.

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Process for Selecting Test Ideas

How We Engaged the Patient “Voice of the Customer”

What we did to facilitate input/feedback regarding what is most important to the patient AND what might be contributing to current performance

- Patient Feedback to Members of the Clinical Team
- Evaluation Questions
- Receipt of Feedback via Text or Phone

How We Engaged Leaders, Providers, and Staff

What we did to facilitate input/feedback regarding selecting testing change ideas? What we did to address what matters most to those who do the work?

- Clinical Quality Committee
- Leadership Meetings
- (Bi)weekly team meetings

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Changes We Tested

What Worked and What Didn't Work

Change Idea Tested	Summary of PDSAs	Adopted, Adapted, Abandon?
Patient Engagement Strategies	Developed and utilized patient registries to facilitate patient outreach, different approaches were utilized including modality (phone vs. text), Staffing (CHWs vs. QI Specialists), strategy and prioritization.	Adapted
Integrated HE HTN Program	Enrolled patient cohort in a 20 week virtual HE program. Observations and lessons learned include importance of staff training, troubleshooting and vetting resources within the system, patient feedback monitoring etc. Future utilization of programming to be expanded to more patients through automatic integration and adapted to include different types of programming	Adapted
HIT Workflows	Quick conversion to telephonic encounters, resulted in need to adjust rapidly including scheduling guidelines, documentation needs (self reported BP), training materials, etc. Began exploring use of video encounters and optimizing workflows.	Adapted
Self Monitoring Blood Pressure	Interviewed African American patients to better understand their lived experiences as it relates to HTN control. Based on interview feedback, in combination with telephonic and video initiatives, initial research on SMBP programs and possibilities began to be explored. Tested accessibility through Medi-cal coverage and identified potential opportunities through current process	Adapted

How Did We Know the Changes Were An Improvement?

What We Measured

Measures Set

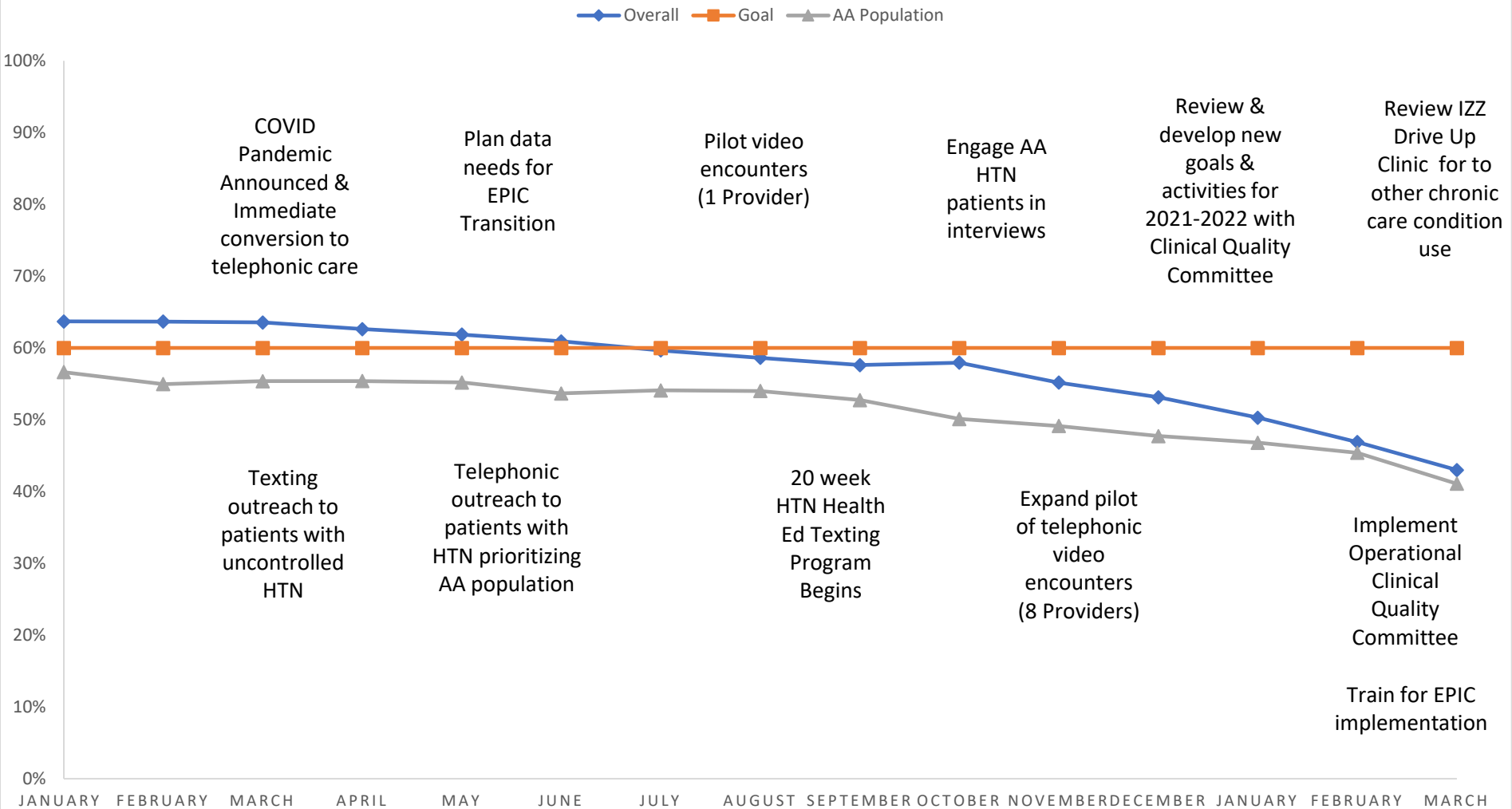
Measure Type/Name	Description/ Specifications	Baseline %	Target %
Outcome (Directly related to the aim):			
Blood Pressure Control Amongst PT's with HTN	<p>Denominator: Patients 18-85 years of age who had an active diagnosis of essential hypertension during the measurement period.</p> <p>Numerator: Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period</p>	64%	60%
BP control amongst African American patients with HTN	<p>Denominator: African American patients 18-85 years of age who had an active diagnosis of essential hypertension during the measurement period.</p> <p>Numerator: African American patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period</p>	57%	60%
Process (Steps to achieve outcome):			
Response Rates to text messages	<p>Denominator: The number of text messages/phone calls made to patients by staff</p> <p>Numerator: The # of patients who scheduled an appointment</p>	0%	5%
# of PT's enrolled in care message & Response Rates	<p>Denominator: The number of patients enrolled in care message as of July 2020.</p> <p>Numerator: The number of patients who participate in care message outreach program.</p>	0%	15%
Balancing (Unintended impact/consequence):			
Controlled HTN amongst HE Program Participants	<p>Denominator: The number of patients enrolled in HTN program (uncontrolled HTN)</p> <p>Numerator: The number of patients enrolled in HTN program whose BP was controlled at the last visit</p>	0%	5%

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Outcome

BLOOD PRESSURE CONTROL AMONGST HYPERTENSIVE PATIENTS MARCH 2021 TRAILING YEAR



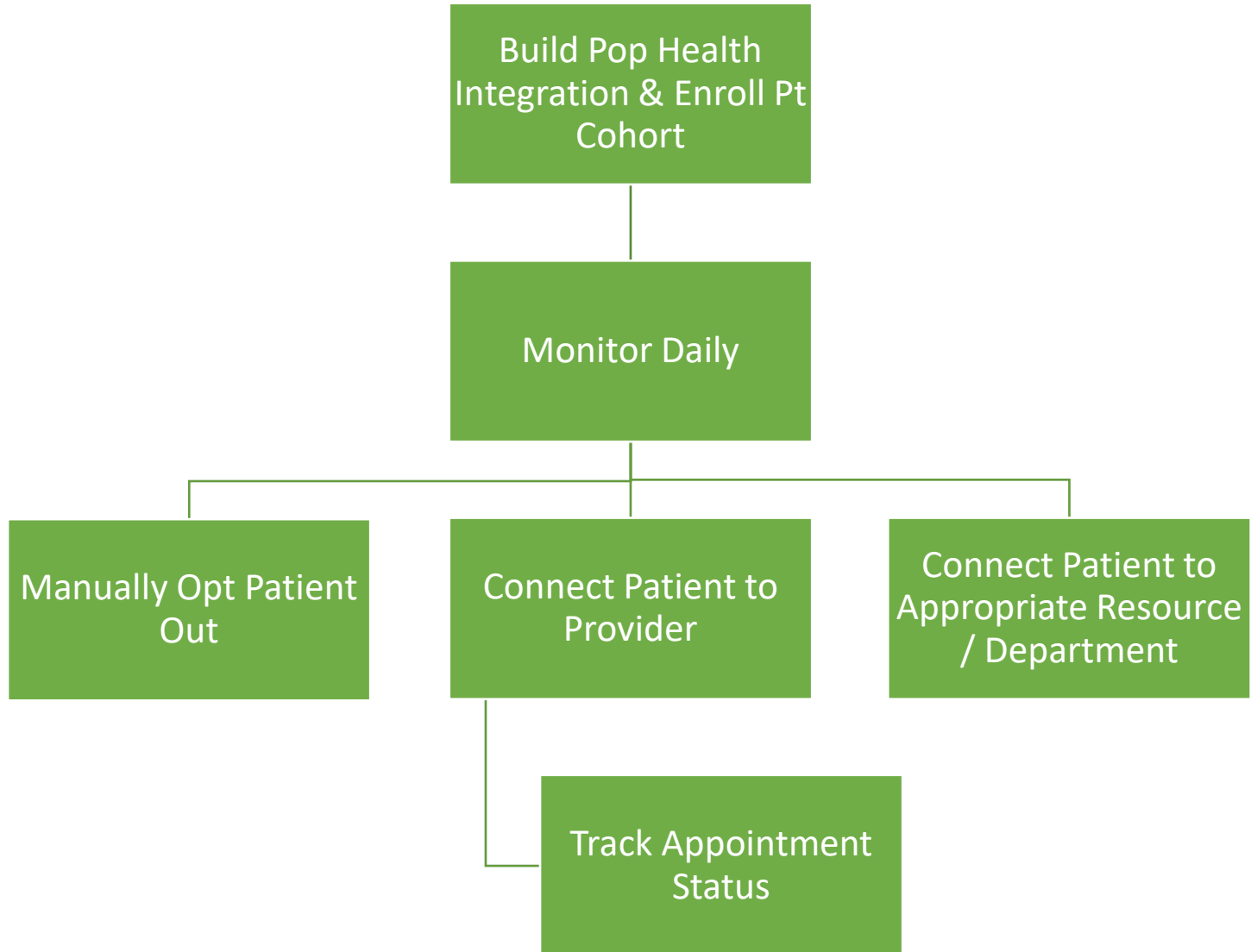
WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

HTN Health Education Background

- Integrated Texting Platform with Population Health Management Tool
 - Automatic Enrollment Option Available
- 20 Week: Semi-structured HE messaging
 - All messages mapped
 - Reviewed & approved by Clinical Leadership
- Piloted Program Utilizing Point In Time Cohort
 - Inclusion Criteria: Hypertensive Patients seen in the last year and BP was >140/90
 - Daily Monitoring for Patient Feedback / Inquires, Opt Out Requests, Provider Connection
- Lessons Learned
 - Patient Engagement on more than just HTN (Billing, Recipe Requests, Rx)
 - Limitations in reversing accidental program opt out
 - Ensure Resources and links are Active
 - Positive Experience for Patients

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

HTN Campaign

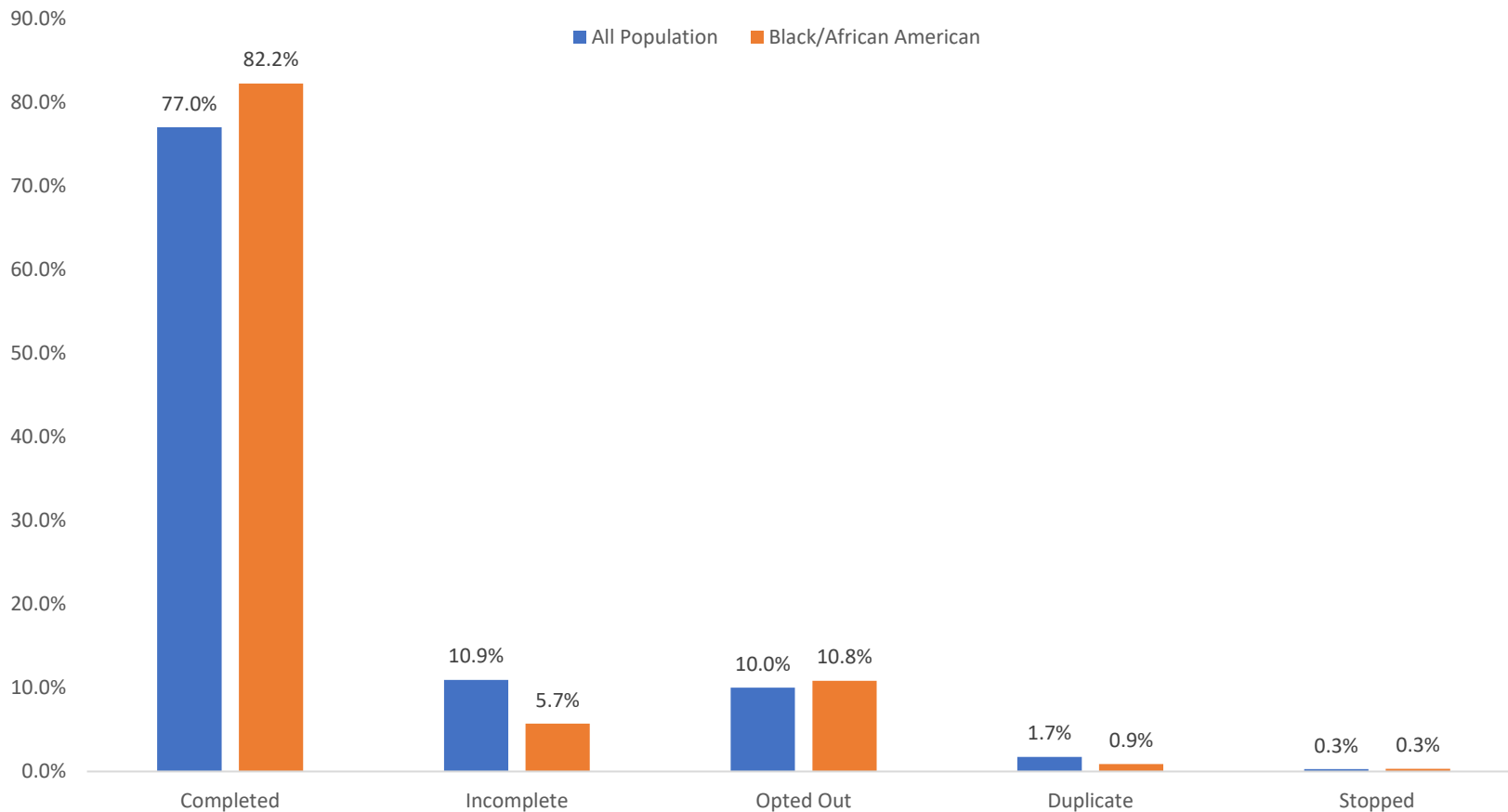


How Did We Know the Changes Were An Improvement?

Results: Run Charts

Process

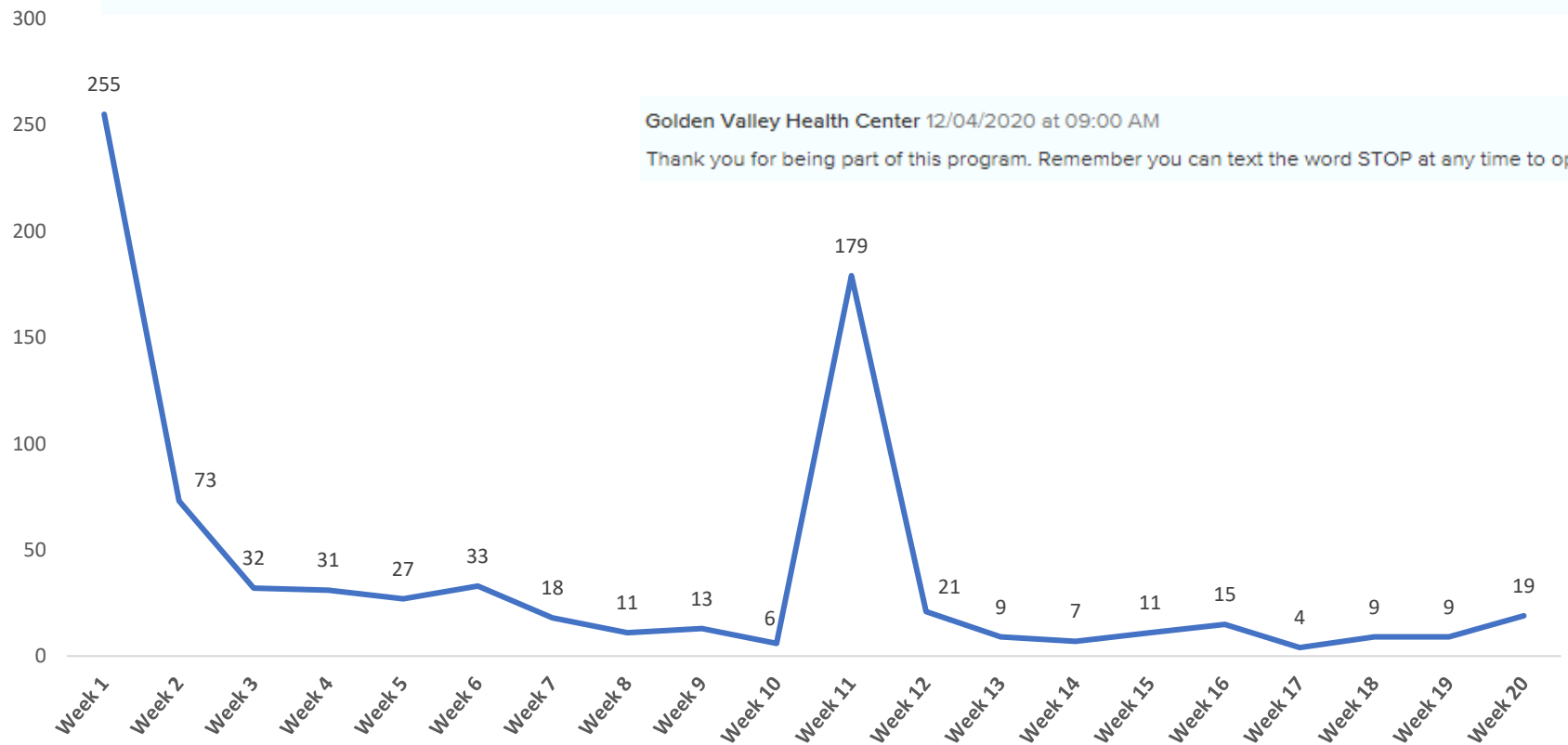
Percentage of Patients Completed Virtual HTN HE Program



Weekly Opt-out Count

Golden Valley Health Center 09/21/2020 at 09:01 AM

Welcome to the Golden Valley Health Center high blood pressure program! We will send a few messages per week. Text STOP at any time to stop receiving messages.

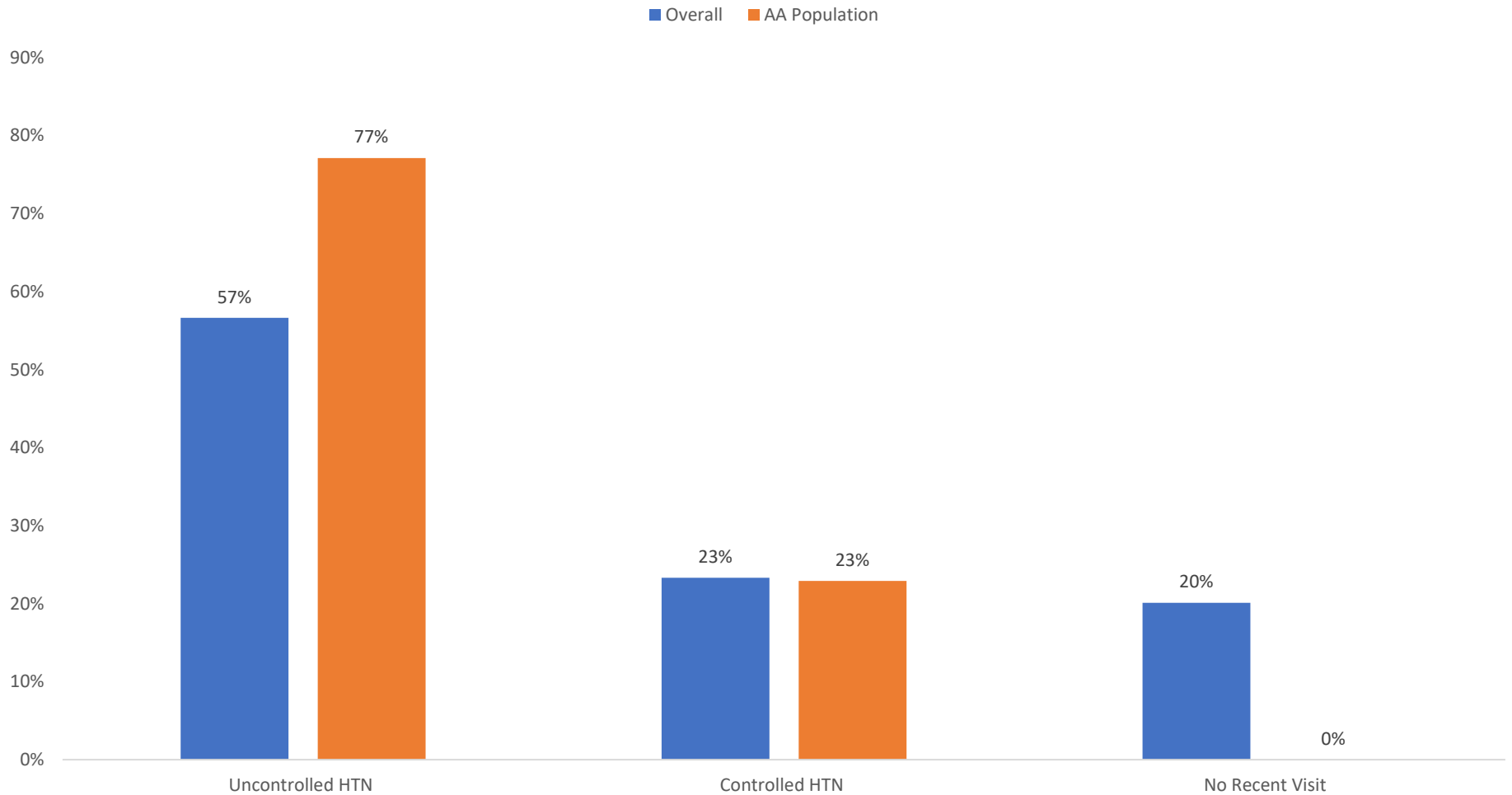


How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing Measures

HTN Status Amongst Patients Post Participation in Virtual HE Program



Program Evaluation – Patient Feedback

Immediate: I would recommend these text messages to a friend with high blood pressure. From 1 to 5, text 1)Strongly Agree 2)Agree 3)Not Sure 4)Disagree 5)Strongly Disagree



88.4%
Response Rate

5.9%
Population Received

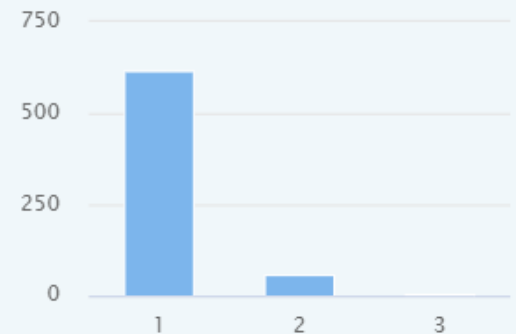
Immediate: I learned useful information from the text messages. From 1 to 5, Text 1)Strongly Agree 2)Agree 3)Not Sure 4)Disagree 5)Strongly Disagree



90.4%
Response Rate

5.2%
Population Received

Immediate: How important is managing your blood pressure to you? 1)Very important 2)Somewhat important 3)Not important



89.1%
Response Rate

9.8%
Population Received

How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

What stands out most about the work of PHASE/TC3 2020-2021

What are you most proud of?

We are proud of the collaboration that took place this last year to develop new innovative workflows and engagement strategies despite the challenges posed throughout the COVID pandemic. For example, we were able to implement new innovative program and design patient outreach scripting and follow up. Patients have continued to inform us that they have benefited from being enrolled in care message to improve their lifestyles and have made healthier choices to aid in controlling their blood pressure.

What surprised you?

Patients actively and positively engaged in virtual HE programming. Patients respond to us with an open dialogue to express how the tips that we send them have been successful. Additionally, they voluntarily provide us with details on additional actions that they take to live a healthier lifestyle.

What did you learn about the process of change?

Small & quick incremental changes are key

What did you learn about your team?

We're resilient & passionate!



[Redacted] 10/28/2020 at 05:00 PM

gracias continua enviándome pasos saludables



[Redacted] 10/30/2020 at 11:56 AM

Los mensajes son muy informativos y de mucha ayuda para mi gracias

How Did We Know the Changes Were An Improvement?

Here's What We Learned

The Challenge of the COVID-19 Pandemic

Challenge	How We Overcame/Resolution
Staffing	<ul style="list-style-type: none">• Increased float pool• Reviewed roles and responsibilities and developed new innovative approaches to improve efficiency• Collaborative Approach
Technology	<ul style="list-style-type: none">• Immediate and overnight redesign of clinical workflows & documentation• Updated Reporting Mechanisms• Planned for EPIC Transition• Utilized simple/easy to understand verbiage regarding health education via care message app while avoiding complex medical terminology so that it is easy for patient to understand.
Time	<ul style="list-style-type: none">• Identified Opportunities & Streamlined processes• Utilized technology to assist in improving efficiencies• Communication

What's Next for PHASE/TC3?

Here's How We Will Continue the Work

New Aim Statement and Focus Areas for Change

By December 31, 2022 GVHC aims to improve blood pressure control amongst patients with diabetes from 53% to 58% (550pts)

Additionally, throughout the same time period, GVHC would like to decrease inequities experienced by black patients by prioritizing improvement efforts that result in a change from 50% to 58% (30pts)

Focus Areas

- Epic Transition – Data Collection, Reporting, Registries, Risk Stratification,
- Team Base Care – Virtual Innovations, Roles & Responsibilities, Telehealth, Patient & Clinician Engagement

SPREAD

- Utilization of CareMessage Health Education Programming for specific detail types of programming and expansion of cohorts
- Telehealth video encounters

SUSTAINABILITY

- Clinical care team support
- CQC and Operational committee