KAISER PERMANENTE PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

CCI CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE TC3
TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

One Community Health
Healthy Together.

1/4/2021

Team Members: Diana Guzman, Simone Asare, Senely Navarrete, Tracy Sisemore, Jillian Marks, Muninder Dhaliwal

WHAT WERE WE TRYING TO ACCOMPLISH?

Problem Statement

Without a focused effort on hypertension control, our patients will continue to be at risk for and suffer the effects of heart disease.

Reducing uncontrolled hypertension is a natural progression and growth of our OneHeart project, which was the focus of our previous PHASE workplan. OneHeart showed success in a small cohort of patients. In this project, we wanted to spread this to our larger patient population.

Aim Statement

We will increase the percentage of the hypertensive population with controlled blood pressure from 52% (1,433 patients) to 63% (1,706 patients) by March 31, 2021. This represents an additional 303 patients to get to controlled status.

Health Equity Aim Statement

Reduce the % of African American, female patients with at least two medical encounters in Midtown Medical or Arden Medical in the last 12 months with BP readings ≥140 mmHg SBP or ≥90 mmHg DSP at two separate medical visits, including the most recent visit, who do not have a hypertension diagnosis on the Problem List.

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Our Theories for Change: How We Learned About Our Process

1. If we provide our Hypertension Committee with the training and tools in QI, they will be in a better position to brainstorm, plan and implement their improvement work
2. If we conduct patient interviews, we will better understand the true needs and values of the patients we serve
3. If we observe the current process for measuring blood pressure and informing the provider of the result, we will better understand what refinements to this workflow need to happen
4. If we build a report to help us identify previous BP history, BP measurement and race/ethnicity, we will know where we need to target efforts
5. If we observe and follow a set of patients from the time they're ordered a BP monitor to the time they receive it, we will better understand and address inefficiencies in the process
6. If we include other care team partners, such as Dental team and Psych team, then we will have additional opportunity to identify patients with uncontrolled blood pressure and connect them to care

Hypertension Team

Undiagnosed Hypertension
Lead: Dr. Asare

Current Focus: Hiding in Plain Sight

Objective: Identify patients with undiagnosed hypertension and discover why documentation/treatment are being missed

Members:
- **Natalie Pandher**
- **Yvette De La Torre**
- **Kim Vue**
- **Dr. Simone Asare**

Accurate BP at Every Appointment
Lead: Jillian/Tracy

Current Focus: Reminder Icons on Exam Room Computer

Objective: Ensure care hypertension diagnosis is appropriate and care is provided

Members:
- **Brandee Walker**
- **Veronica Taylor**
- **Christina Lehigh**

Dental Hypertension
Lead: Senely

Current Focus: Develop process/protocol for BP at every appointment

Objective: Develop and test workflows to ensure accurate BPs are completed at every visit and proper links are made to PCP for necessary f/up care

Members:
- Lisa Conover
- Dr. Victor Fong
- Tatyana Jidkova
- Senely Navarrete

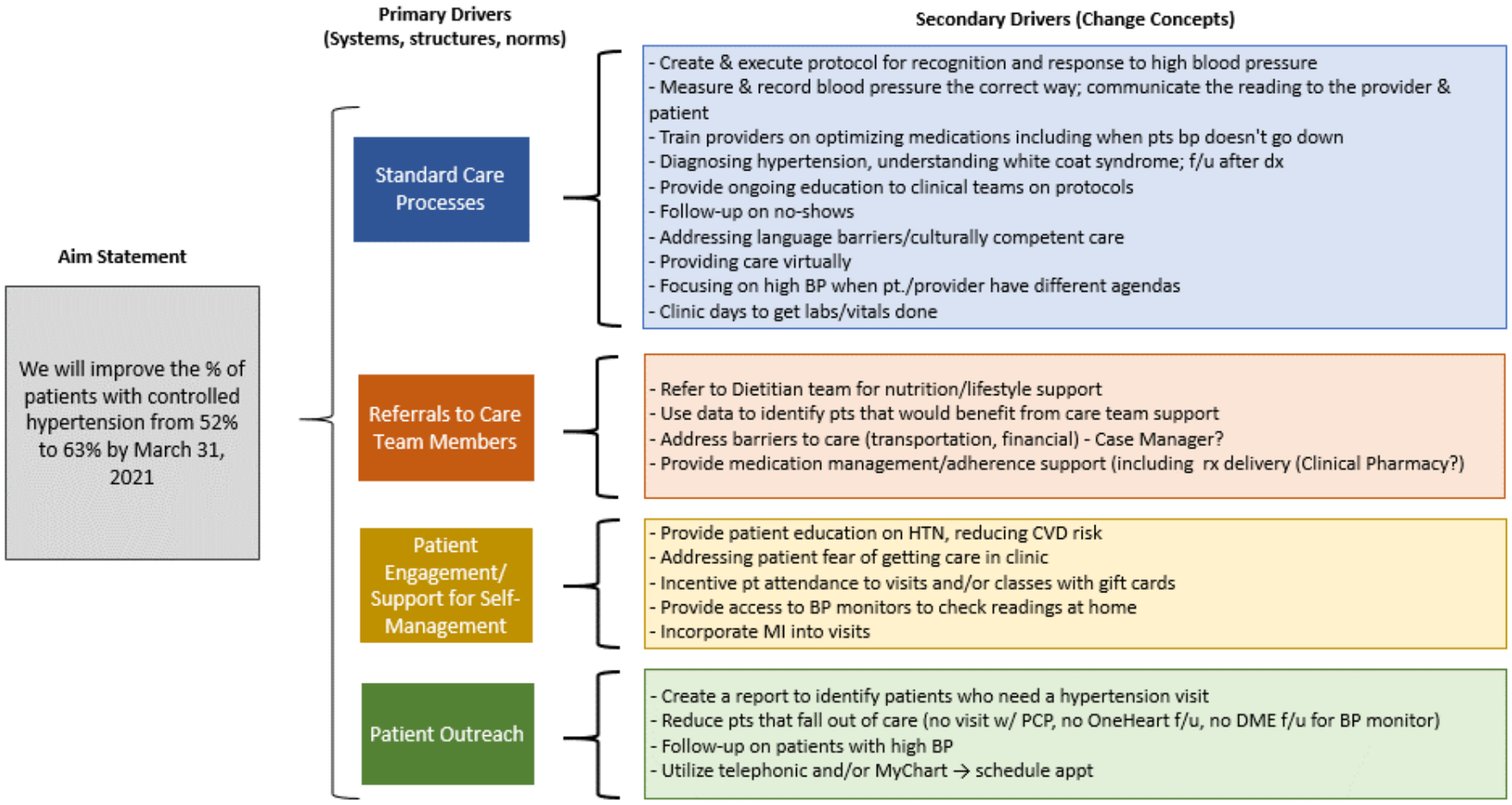
SMBP
Lead: Nin

Current Focus: Establish/support patient self-monitoring

Objective: Provide patients with BP devices and establish workflows for patient hypertension self-management

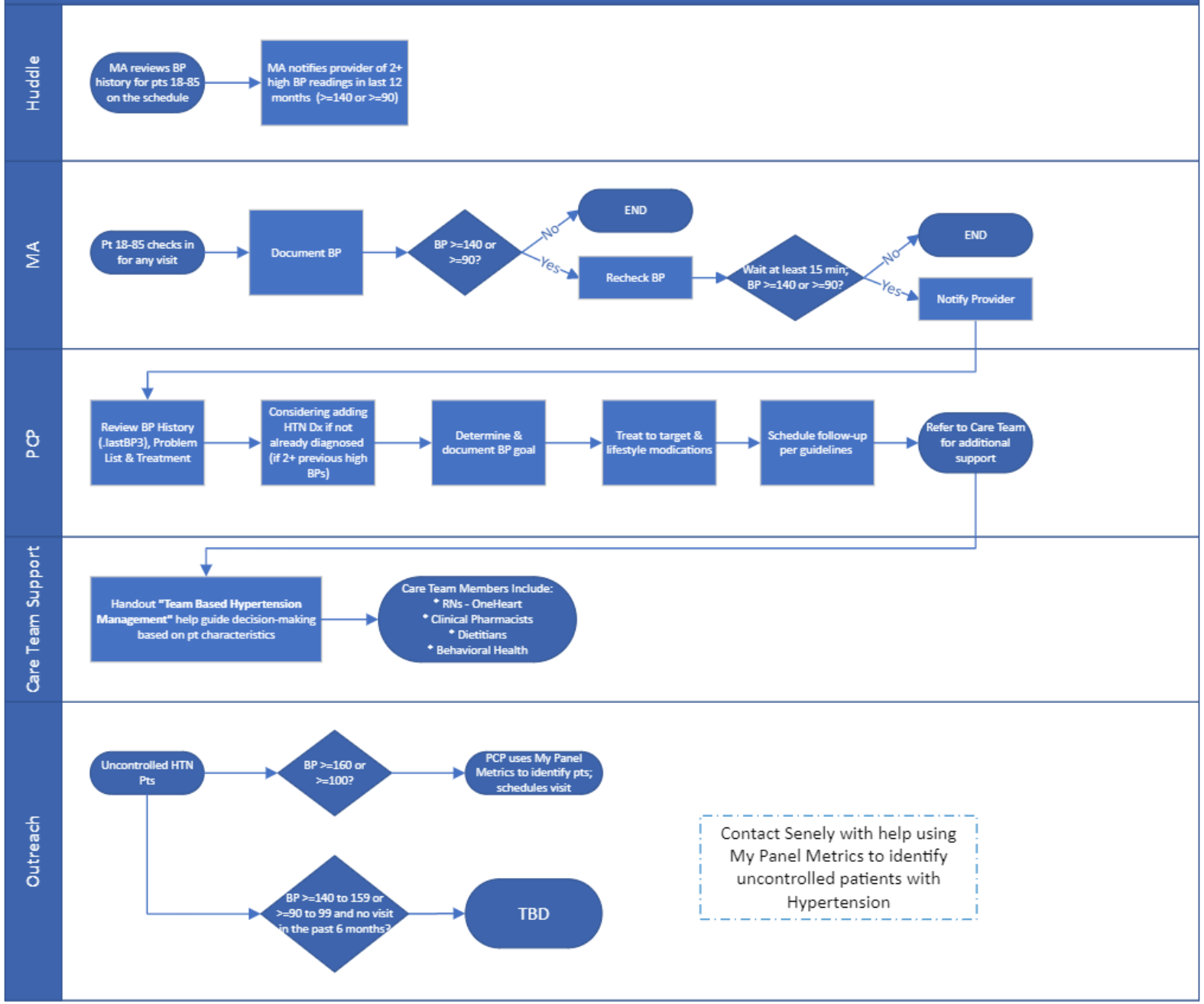
Members:
- Muninder Dhaliwal
- Brian Rasmussen
- Jane Valentine
- Diana Guzman

Hypertension Team Driver Diagram



Hypertension Care Pathway

Last updated 9/24/20



WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Process for Selecting Test Ideas

How We Engaged the Patient
"Voice of the Customer"

Patient Interview Project:

- Pulled lists of patients seen by Dr. Asare with recent past high bp readings (some were assigned to her and some weren't); Dr. Asare, Jillian and a OneHeart RN contacted the patients to ask them our 3 primary questions.
- Patients expressed great appreciation that we were interested in their thoughts/feedback.

How We Engaged Leaders, Providers, and Staff

- Created Driver Diagram using Mural during HTN committee and assigned as "homework" after meeting. Voted on change ideas committee felt were most impactful.
- HTN Committee is a multidisciplinary team of front line staff
- Use of Microsoft Teams chats for information sharing and coordination. Example: BP monitors as DME
- Training on treatment algorithm by Clinical Pharmacy, RNs and LVNs
- PDSA Worksheets – completed with subcommittee leads and their participants
- Staff investigated how to get patients access to BP chcks during covid: BP monitors, and insurance coverage
- Provider leadership – approved blocked time for provider committee member participation in patient interview project and follow-up

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?
Outreach	Outreach to AA/F pts with high BP (call-based)	Adapted
Outreach/ Precharting	Outreach & pre-charting for all pts with hx of high BP regardless of race/sex	Adapted
MA/Provider Communication	MA communicated elevated BP to provider using 'sticky'; 2nd iteration was a bright paper on the door	Adapted
Patient Feedback	Conducted patient interviews	Adapted
QI Staff Training	QI training for Hypertension Committee	Adapted
Outreach – registry based	High blood pressure outreach by Quality Coordinator → reduced staffing levels in QI, providers notified and provided with training materials to manage their own uncontrolled hypertension lists using EHR tools	Abandoned →Adapted
EHR	Hypertension smartphrase development for use during hypertension- focused visit; underwent several drafts and made improvements in keeping with tools from Kaiser	Adapted

How Did We Know the Changes Were An Improvement?

What We Measured

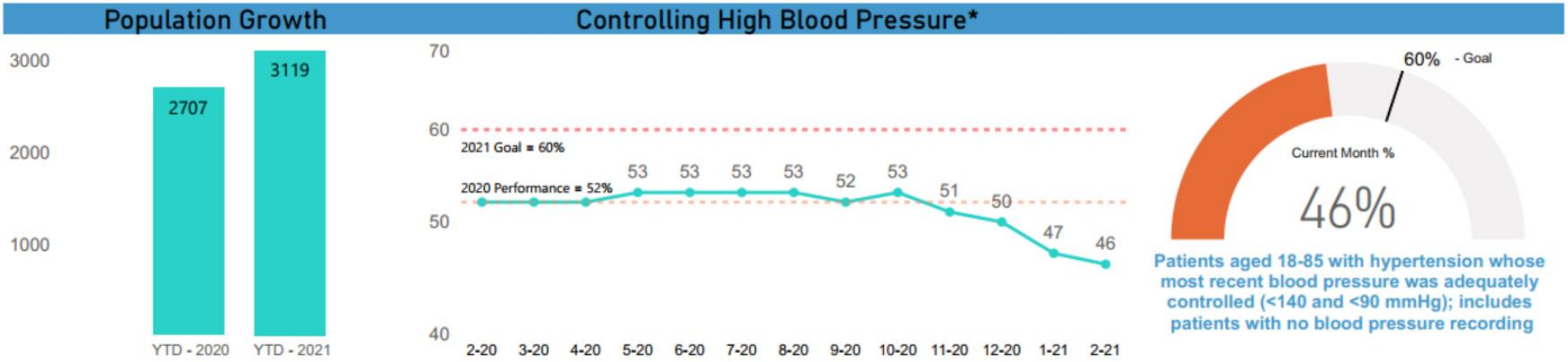
Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
Outcome (Directly related to the aim):			
Outcome	% of patients with controlled blood pressure	52%	46%
Outcome	% of AA/F pts with undiagnosed HTN (lower is better)	100% of sample pop	88% of sample pop
Process (Steps to achieve outcome):			
Process	Pre-charting to identify high bp	No baseline	No target
Process	Notifying provider of high BP	No baseline	No target
Process	Acquiring BP monitors for pts	No baseline	No target
Process	Provider ed on protocol	No baseline	No target
Balancing (Unintended impact/consequence):			
n/a			

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Outcome



After initially holding steady on BP control, our performance has dipped as the number of community members we've seen for covid testing and vaccines has increased. We have had a sizeable jump in our denominator from December (2,707) to end of February (3,119)

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Metric	Initial	End
Identifying high BP on the schedule and notifying the provider	3 of Dr. Asare's AA/F pts at Arden	All of Dr. Asare's pts at Arden, + 1 addtl provider
Acquiring BP monitors for pts	3 pts at Arden who were ordered a BP monitor	Still reviewing the process with a total of 9 pts
Training/education on the PHASE protocol	15 providers	All providers received a HTN toolkit with the PHASE Protocol and other resources; Currently assigning Dr. Brettler's video as part of required training in our LMS
Identifying undiagnosed AA/F pts with upcoming visits (followed the same women)	40 pts	Of 34 pts (6 excluded due to high BP during pregnancy or outside PCP), 4 pts were diagnosed w/ HTN
Notifying providers of high BP via visual cues	7 pts via 'sticker' that was velcroed on PC	9 via bright paper kept at workstation, then 16 kept in room, now expanding to OB and ID

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing

No balancing measure

How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

- Hypertension Committee engaged in a much more meaningful way – there is excitement about the work among committee members.
- A member of the committee, a scribe and an MA as front-line staff, has bubbled to the top as a natural leader, championing the project and engaging others.
- Able to continue this work in the midst of COVID. Our performance is relatively stable.
- Committee's creativity to create change; engaging our community and making change – propelled us to think outside the box.
- We need to make projects smaller and collect more data to determine functions of change.

How Did We Know the Changes Were An Improvement?

Here's What We Learned

The Challenge of the COVID-19 Pandemic

- Getting pts access to check their own bp at home
- Unstable staffing levels – staff getting pulled to help each other out to care for pts
- How do we keep everyone (staff and patients) safe when providing in-person care?
- Where to enter BP data collected during a phone or video visit
- How do we take our everyday workflows and adjust to a remote/telephonic/virtual visit and achieve the same quality of care?

Overall Challenges (not covid specific)

Challenge	How We Overcame/Resolution
Outreach for uncontrolled pts	Text/MyChart/Letter based outreach
Poor adoption of protocols	Hypertension Resource Toolkit with links to JNC-8, PHASE and a variety of other HTN resources, including unblinded performance
Helping pts acquire monitors	Following the DME workflow for ordering from start to finish
Nurses getting comfortable implementing protocol	Re-training on protocol

What's Next for PHASE/TC3?

Here's How We Will Continue the Work

SPREAD

- MAs will use a visual cue to inform the provider when 2nd BPs remain elevated
- Last 3 BP readings will be added to the schedule view for primary care patients and they will be discussed at huddle
- Enroll patients with uncontrolled hypertension in our SMBP program (also, identify patients who will be good candidates for the HRSA HTN Initiative (bluetooth/wireless enabled devices)

SUSTAINABILITY

- Continue to have a provider champion to both spread and sustain the work
- Performance measures will be built into peer review
- Staff will be trained in new workflows, which will also be included as part of annual competency & onboarding.
- Build reports to help us measure how well the steps in the workflow are being met - this will help us assess whether staff are following workflows
- Share successes often via team meetings, OneHealth, Quality Boards & Teams chats
- Build tools in Epic to help staff do the "right thing" with the patient at the "right time" (like using BPAs (best practice advisory's)

THE DESIRED FUTURE

- What is the desired future for PHASE/TC3 (new Aim Statement)
  - By December 31, 2021 we achieve a 10 percent improvement in the percentage of patients with controlled hypertension.
- We will achieve this through a focus on protocol adoption and implementation, using our registry to identify and find uncontrolled patients and connect them to care, and potentially adding additional FTE in the form of care managers that can coordinate care for our highest-risk, comorbid patients.