KAISER PERMANENTE PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

CCI CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE TC3
TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

Hypertension Management
San Joaquin County Clinics
March 15, 2021

Team Members: Erin Dizon and Rohini Mehta

WHAT WERE WE TRYING TO ACCOMPLISH?

Problem Statement

- The most current data (PRIME/UDS 2019) identified an ongoing challenge regarding blood pressure control among the general population of patients diagnosed with hypertension at San Joaquin County Clinics (SJCC). Controlled blood pressure is reported among only 65% of SJCC patients compared to the 90th percentile of 73% (HEDIS2019). The data also shows a disparity in only 55% of African Americans having controlled blood pressure control compared to 65% of the general population.
- While SJCC saw a tremendous increase in blood pressure control rates around midyear 2019, this trend was not sustained. Among the factors that contributed to this were inconsistent application of established workflows, COVID pandemic, and staffing changes from organizational restructuring. Notable, however, is the success of physician champions and adherence to the PHASE protocol.

Aim Statement

Health Equity Aim Statement

Revised (04/20/2020): Due to the current ongoing COVID-19 pandemic, SJCC revised its aim statement as of Q1-Q2 period and may not be reflective of its true level of performance on these measures.

By **July 31, 2021**, SJCC will maintain the health of its hypertensive patients by reflecting data to pre-covid as evidenced by:

- Increasing % of patients with controlled hypertension from 61% to 65%
- Increasing % of African American patients with controlled hypertension from 47% to 55%

By **March 31, 2022**, SJCC will improve the health of its hypertensive patients as evidenced by:

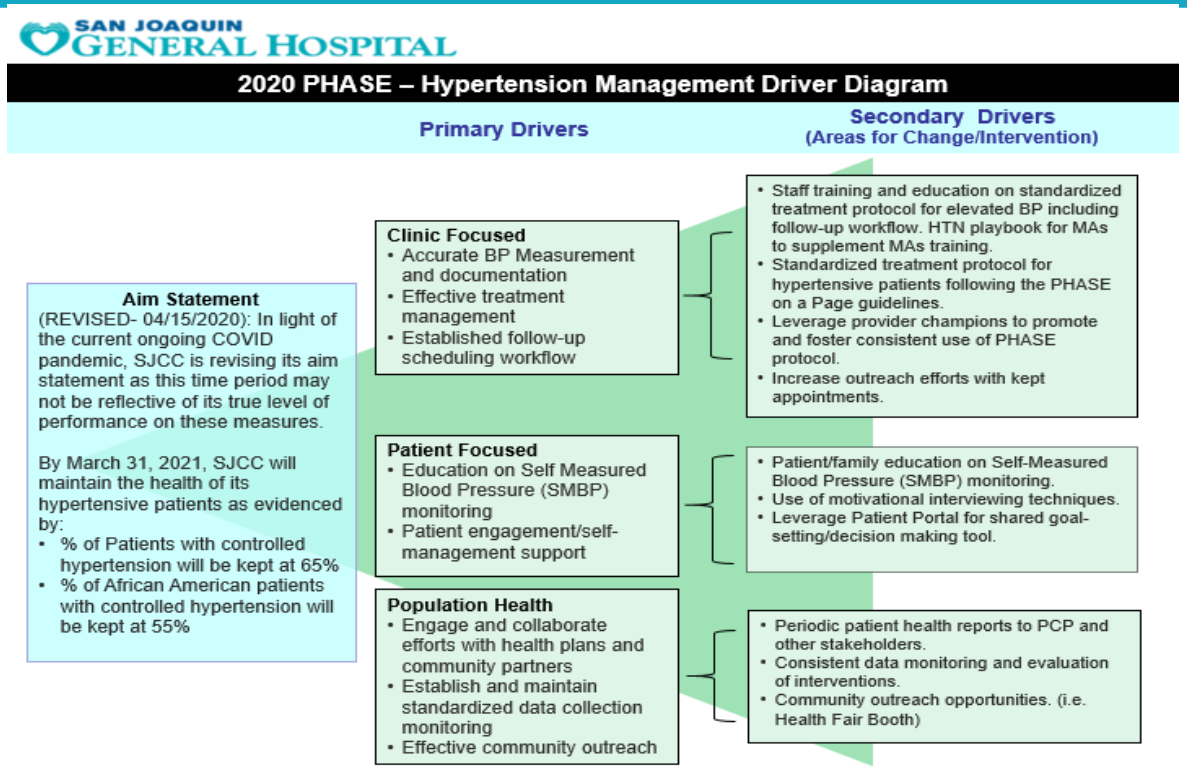
- Increasing % of patients with controlled hypertension from 61% (current) to 71%
- Increasing % of African American patients with controlled hypertension from 47% (current) to 61%

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

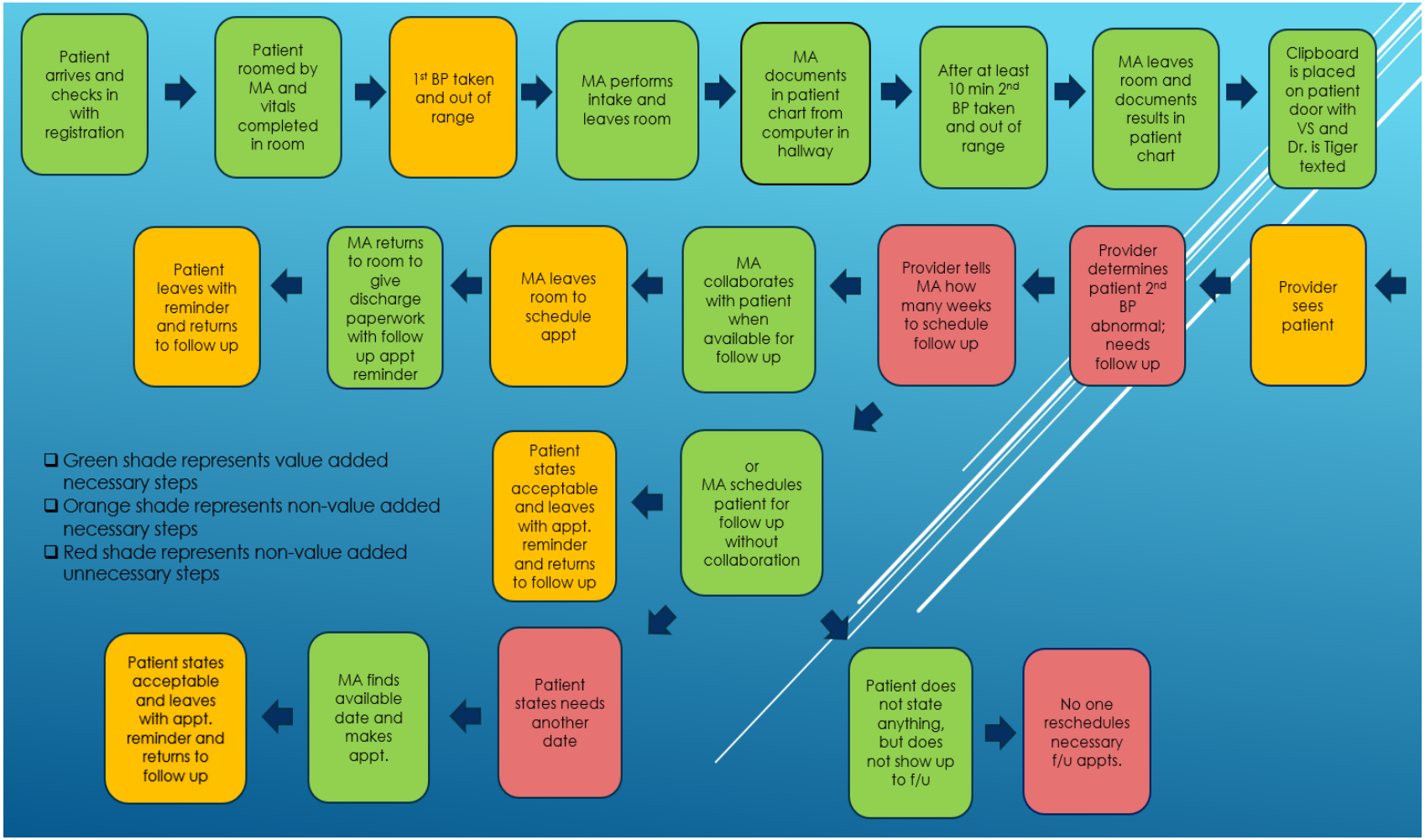
Our Theories for Change: How We Learned About Our Process

Through various chart audits it was determined there was a lack of methodical technique in measuring, documenting, and initiating follow-up of hypertensive patients within SJCC. In the same effort we determined it was necessary to bridge the gap in care of our hypertensive African American patients.

Organizational Driver Diagram

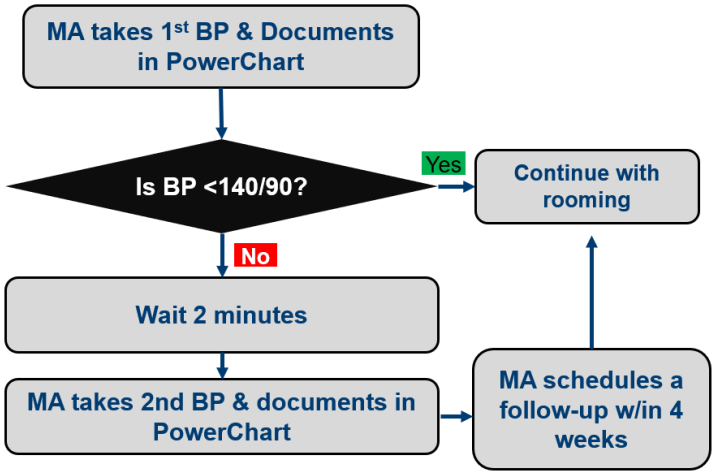


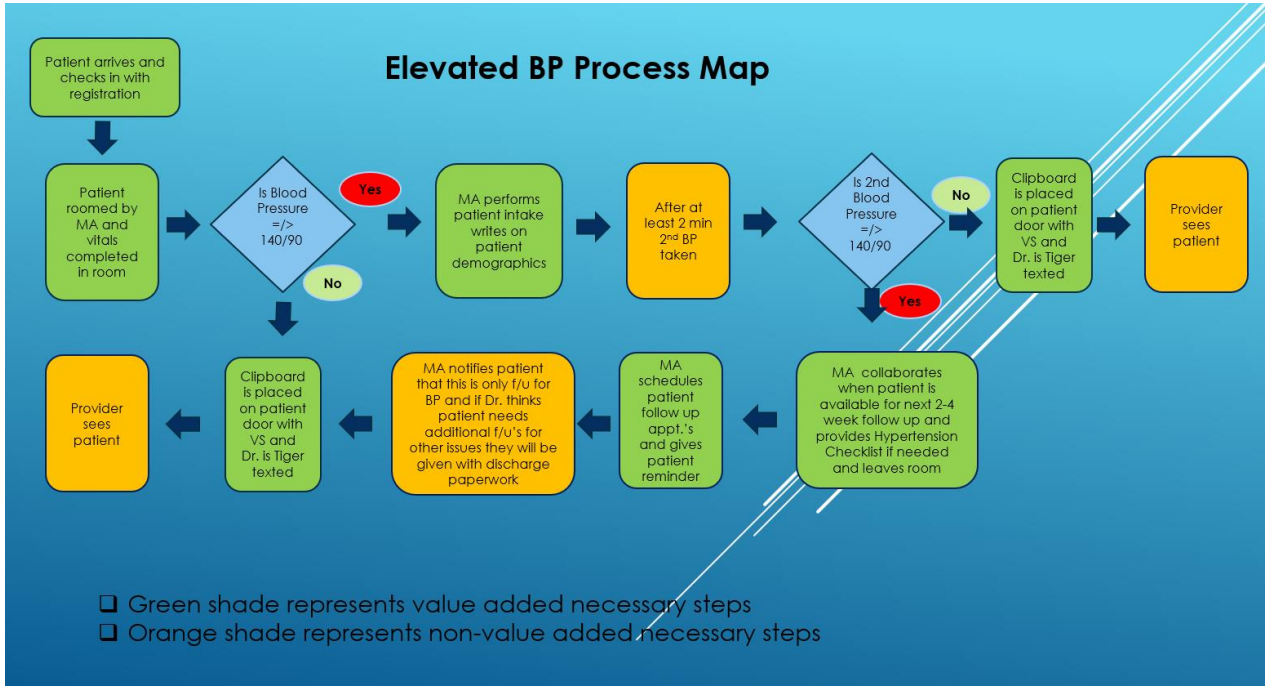
Process Observations



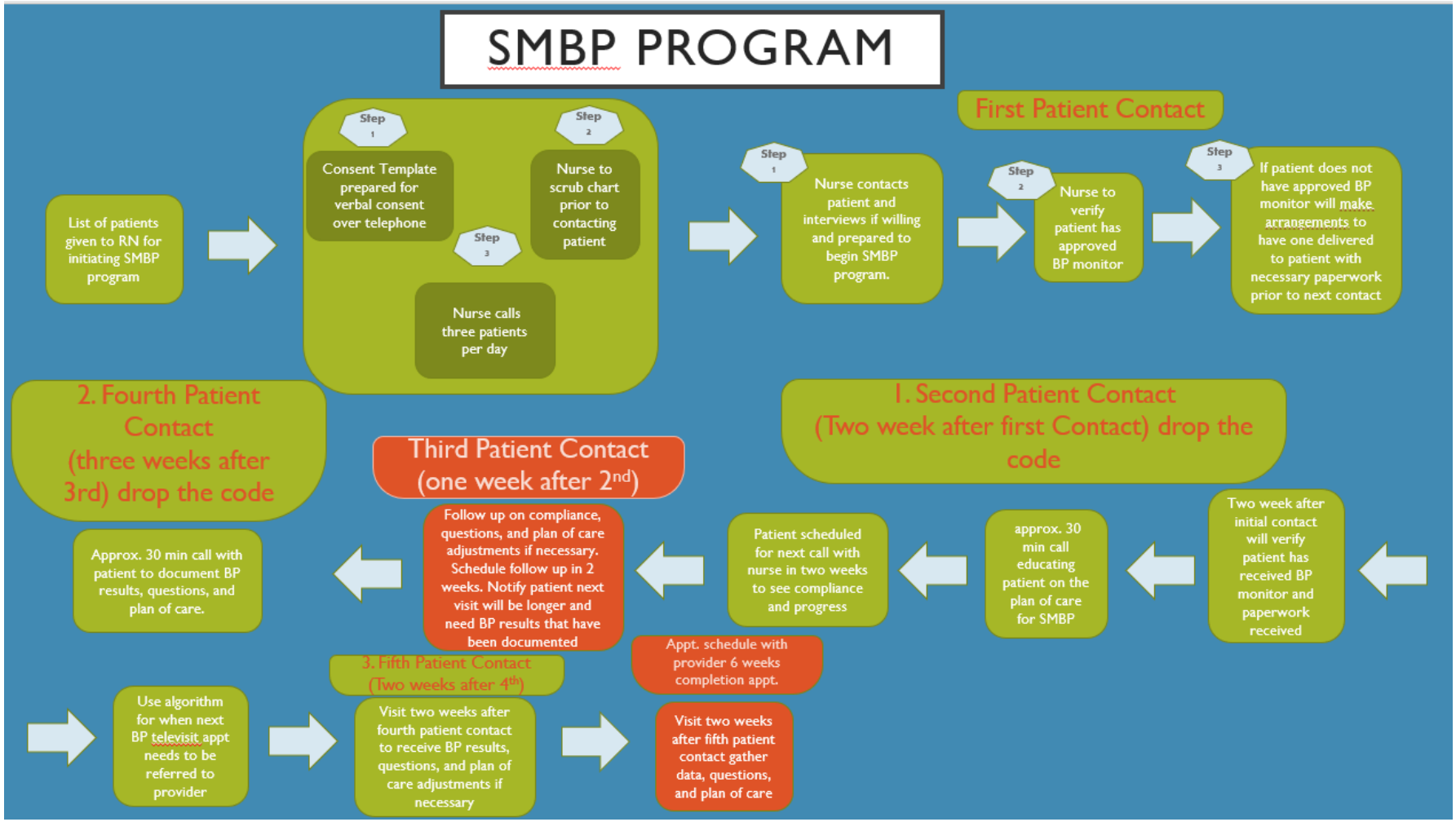
Process Flow Map

Elevated 1st BP Process Flow Map



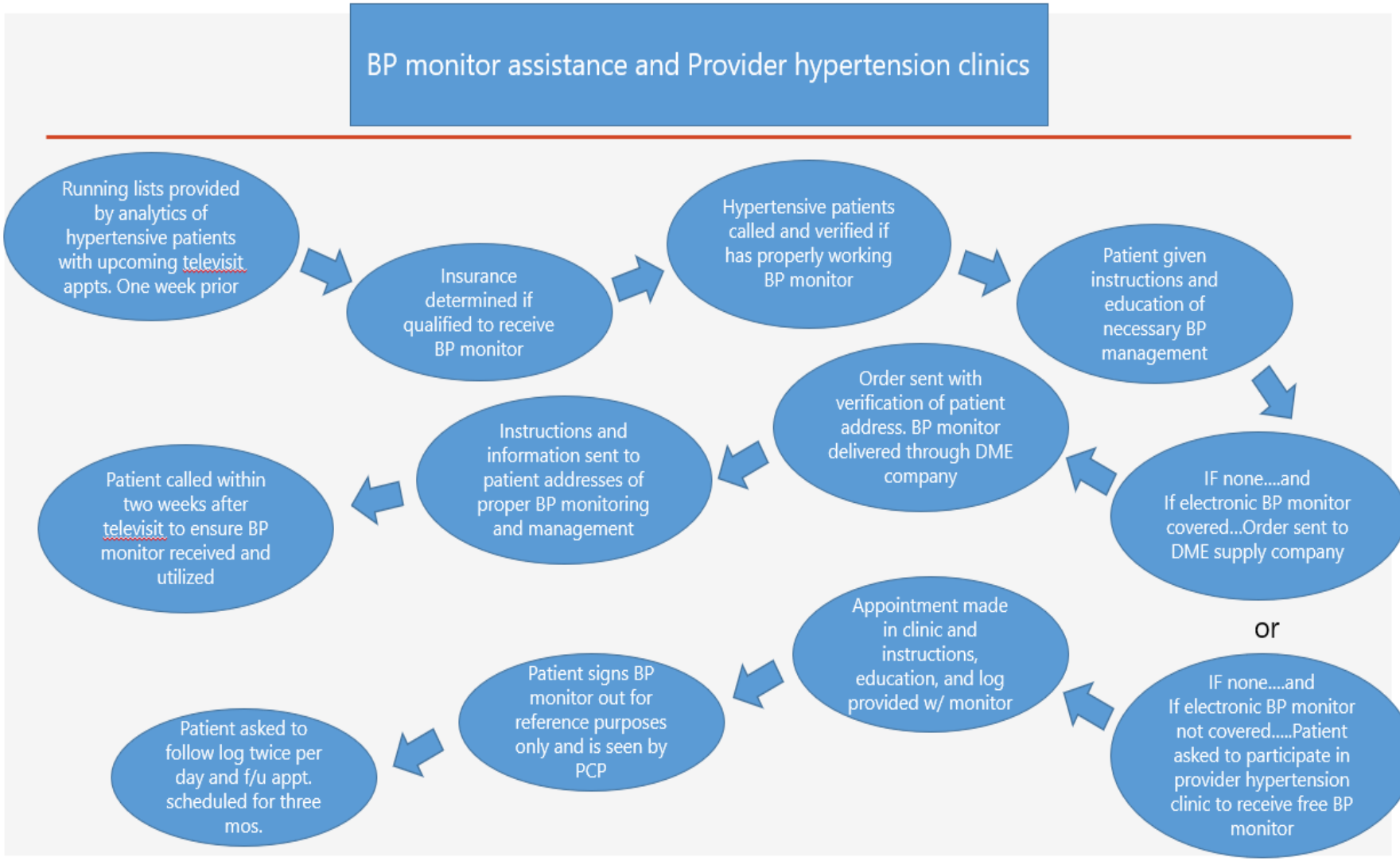


Process Flow Map for SMBP



Process Flow Map for Drive Thru Clinic

Process Flow Map for BP monitor assistance
And
Provider hypertesnsion clinic



WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Process for Selecting Test Ideas

How We Engaged the Patient
"Voice of the Customer"

We used patient surveys and chart audits to determine patient needs, experiences, considerations, priorities, and collaborative methods to achieve goals.

"We definitely needed some type of monitoring program within our community. This program reminds me to be accountable for my health."

How We Engaged Leaders, Providers, and Staff

We made a conscious effort to provide a Hypertension Manual for MA reference, utilized Healthy registries adaptation, developed workflows, made informational letters for providers and staff, produced posters, and provided continued education to staff.

"Developing a consistent and uniformed process amongst staff is necessary moving forward."

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?
PDSA #1 • Accurate BP readings	• Developed current state process flow map • Observed staff • Identified issues regarding accurate BP; provided playbook/in-service for BP and 2nd BP's • Collected data on 2nd BP	Adapted • Interrupted by COVID
• In addition to PDSA #1	• Ensure F/U appts. were scheduled for patients with elevated 2nd BP readings prior to provider instruction	Adapted • Interrupted by COVID
PDSA #2 • SMBP Nurse televisit program	• Developed workflow • Utilized gap in care lists • 12 week program with nurse televisits • Tested on 4 patients • Half of patients continued with program • Total of 10 patients enrolled in entire program	Adapted • Iterations have been made to change workflow and retest

Change Idea Tested	Summary of PDSAs	Adopted, Adapted, Abandon?
Cont. PDSA #2	Retested • Modified to 6 week program with prescheduled provider visit at completion • Patient population has been difficult to continue to engage • Many patients have not responded to calls or left messages	
PDSA #3 • BP monitor assistance and ordering	• Developed workflow for educating on BP monitor use • Collaborated with BI team to produce list of patients with future telephone appt's scheduled • Contacted patients on a weekly basis • Provided BP monitors or verified existence • Reminded patients of upcoming provider televisits and necessary hypertension management	Adopted • Assistance to limited staffing • Iterations to include mailed letters to patients
PDSA #4 • Hypertension Clinic	• Provider champion established • Healthy registries utilized for lists of patients • Face-to-face appt.'s scheduled • BP monitors provided in clinic if not covered by insurances • Patients no show to appt.'s • Patients do not participate or feel comfortable with face-to-face appts.'s w/o verbalizing concern	Adapted • New PDSA developed going through modification process

Change Idea Tested	Summary of PDSAs	Adopted, Adapted, Abandon?
PDSA #5 • Nurse Lead Drive Thru Clinic on 3/9th	• Care focused on established Hypertensive and Diabetic patients • Patients referred by providers • List obtained through utilization of Healthy Registries • List obtained through Gaps in care list provided by health plans • Patients contacted and appt. scheduled • Patients information scrubbed to capture other measures that can be done via drive thru (ex. A1C, depression screen, tobacco screen, SBIRT) • Patient comes to drive thru clinic and care provided • Patient asked whether has BP monitor at home regardless of BP values. • Depending on insurance coverage BP monitor to be ordered and delivered by DME supply company • If BP monitor not covered patient given free BP monitor along with educational materials, log, and instructions. • Patient referred to provider if BP on 2nd attempt >or=140/90. • Provider contacted on day of visit if BP>180/110 or symptomatic. • 16 out of 19 patients scheduled showed up to appt. • Able to capture all necessary measures and provide BP monitors on day of visit	Adapted • Due to management. Modifications in working progress

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):			
Controlled hypertension w/in SJCC patients	% of SJCC patients w/ BP <140/90	61%	71%
Controlled hypertension among African American SJCC patients	% of African American SJCC patients w/BP <140/90	47%	61%
Process (Steps to achieve outcome):			
Measure documentation of 2nd BP values taken	Monthly reporting of MA's that document 2nd BP values	about 20%	75%
Measure f/u appt.'s made	Monthly reporting of uncontrolled hypertensive patients with kept f/u appt.'s	about 32%	75%
Measure of SMBP patients who successfully complete program	Measurement of SMBP patients who successfully keep last provider visit (6 wks later)	New process measure	50%

How Did We Know the Changes Were An Improvement Continued?

What We Measured

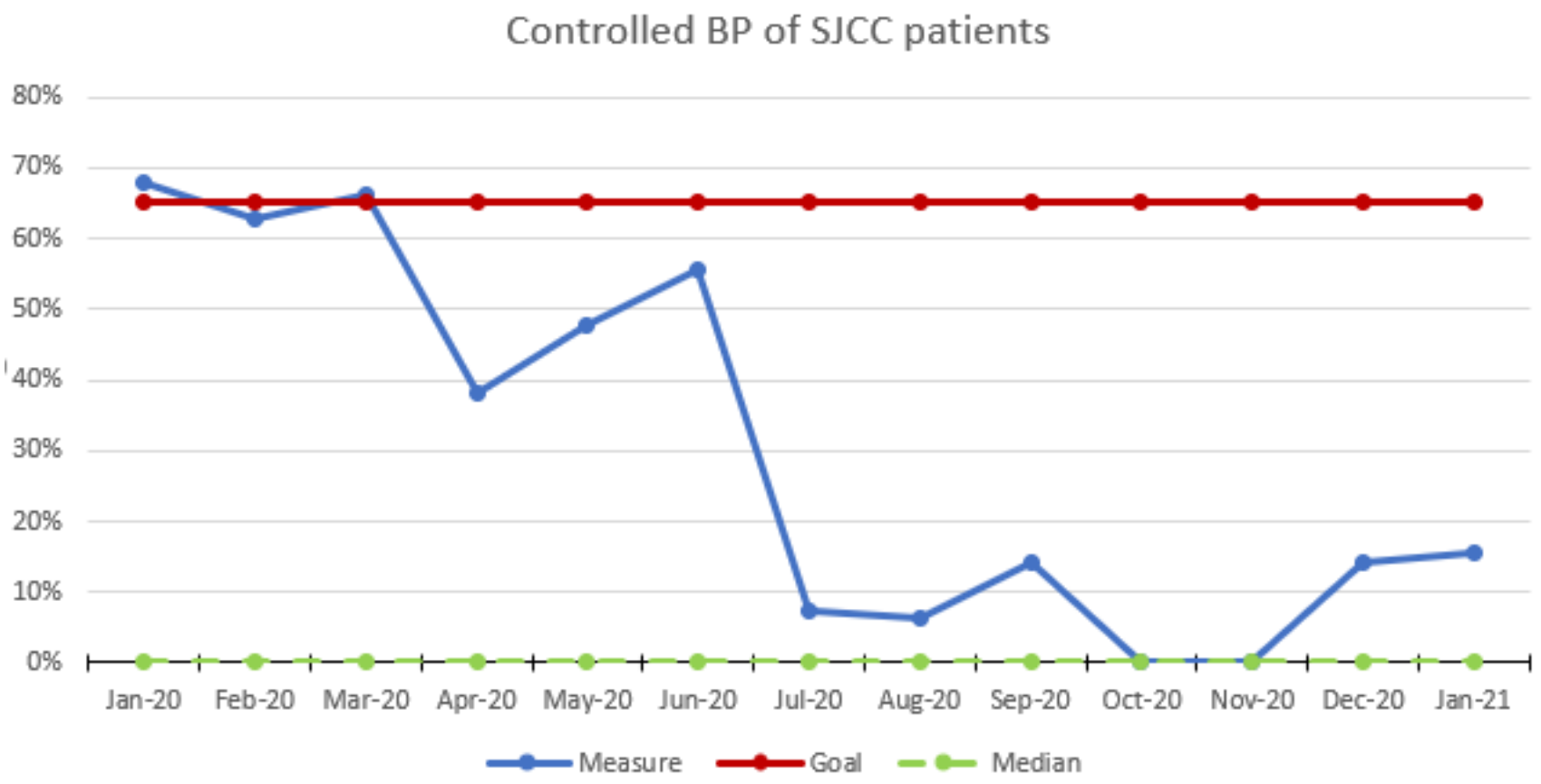
Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
Process (Steps to achieve outcome):			
Measure % of patients who have documented BP value on televisit appt.	Measures the amount of SJCC hypertensive patients w/ BP monitors at home	New process measure	71%
Measure % of patients who come to drive thru clinic, modified appt.'s, or hypertension appt.'s	Measures the amount of hypertensive patients who accomplish necessary hypertension management services	New process measure	75%
Measure % of hypertensive African American patients enrolled in management programs	Measures the amount of hypertensive African American patients who participate in BP management services compared to the rest of population	New process measure	61%
Balancing (Unintended impact/consequence):			
Increased patient satisfaction	Patient verbalized appreciation and increased trust w/ healthcare personnel	50%	80%
Increased amount of BP monitors given to hypertensive patients	Ensuring all hypertensive patients receive the opportunity to manage their BP regularly	New process measure	75%

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Outcome

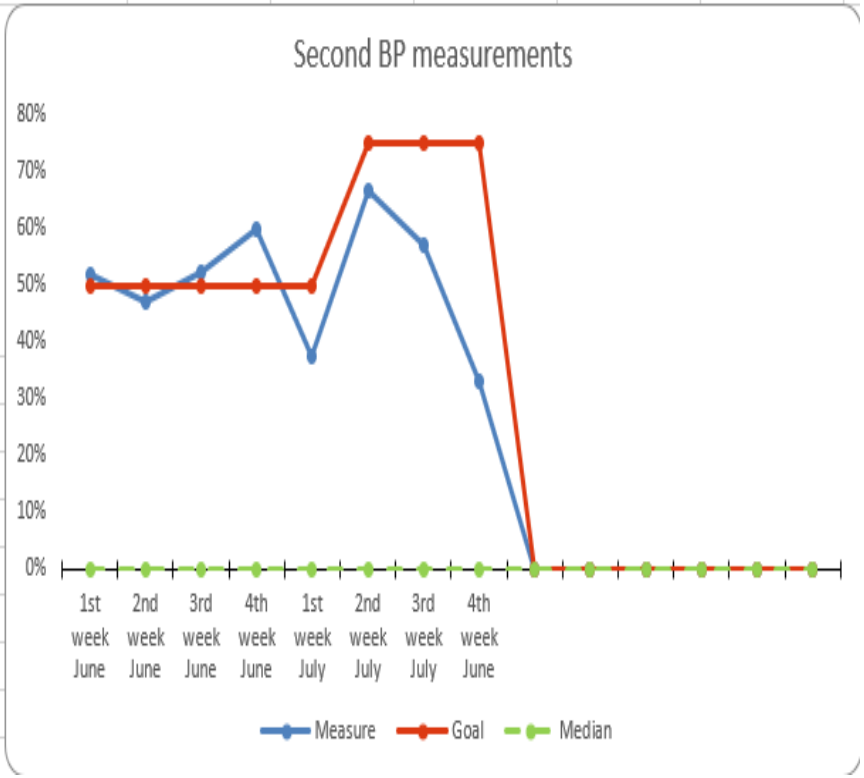


How Did We Know the Changes Were An Improvement?

Results: Run Charts

PROCESS MEASURE: Measuring 2nd BP performed by Two MA's

Week of	Denominator:	Numerator:	Measure	Goal	Median
1st week June	27	14	52%	50%	
2nd week June	70	33	47%	50%	
3rd week June	59	31	53%	50%	
4th week June	50	30	60%	50%	
1st week July	16	6	38%	50%	
2nd week July	6	4	67%	75%	
3rd week July	7	4	57%	75%	
4th week June	12	4	33%	75%	



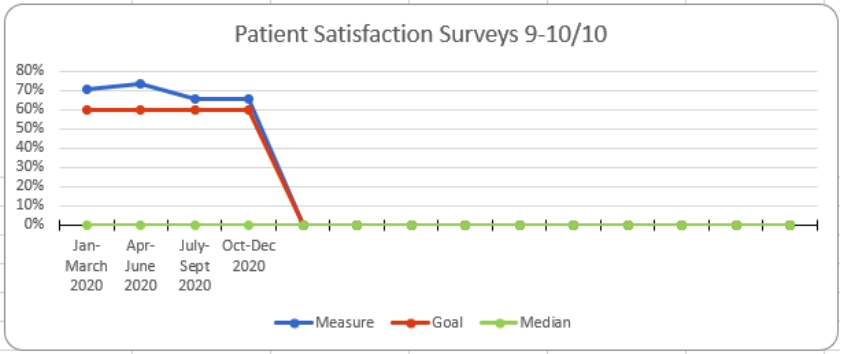
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing

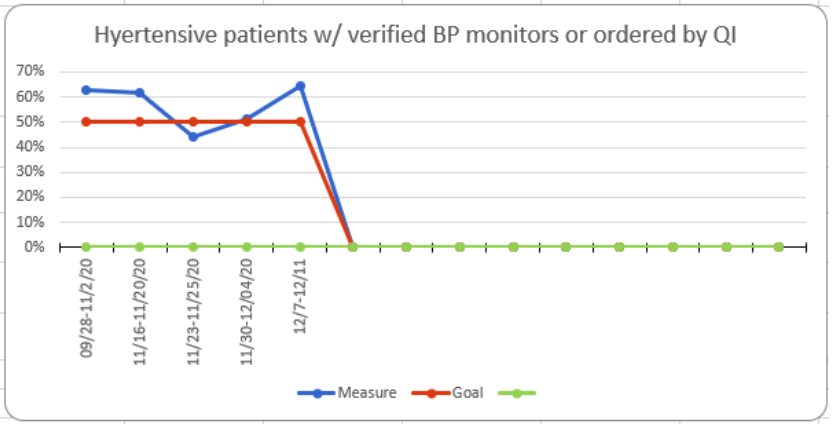
BALANCING MEASURE: Three month Patient Satisfaction Surveys (Scores 9 or 10/10)

MONTH	Denominator	Numerator	Measure	Goal	Median
Jan-March 2020	309	218	71%	60%	
Apr-June 2020	313	231	74%	60%	
July-Sept 2020	324	212	65%	60%	
Oct-Dec 2020	267	175	66%	60%	



PROCESS MEASURE: Hypertensive patients w/ verified BP monitors or ordered by QI

Week of	Denominator:	Numerator:	Measure	Goal	
09/28-11/2/20	312	196	63%	50%	
11/16-11/20/20	55	34	62%	50%	
11/23-11/25/20	34	15	44%	50%	
11/30-12/04/20	37	19	51%	50%	
12/7-12/11	34	22	65%	50%	



How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

- Patient appreciations
- Patient health improvements
- Provider and Staff collaborative efforts for goal attainment
- Providers and Staff have had to learn to adapt to many changes
- Staff that shine the brightest
- Staff that learn their capabilities
- Staff that go above and beyond to help the patients
- The common purpose of all staff to help the patients

Patient Quote: "I appreciate all the work you do to help me. I feel like I am not alone in this process."

Patient Quote: "I have been dealing with personal issues in my life. Thank you for reminding me to take care of myself."

Patient Quote: "I didn't realize I had been measuring my blood pressure wrong all this time. Thanks for the information."

How Did We Know the Changes Were An Improvement?

Here's What We Learned

The Challenge of the COVID-19 Pandemic

- Patient lack of resources → Learned to accommodate for patients.
- Decrease in-person visits → Learned to utilize televisits and develop new workflows
- Lack of Staff due to staff relocation; sicknesses; layoffs; resignations → Learn to work with our means and the art of patience

Overall Challenges

Improving staff culture:

- Change doesn't equal bad
- Our department is here to help
- Our goals are all the same

Challenge	How We Overcame/Resolution
Staffing deficiencies	Assisted with developing workflows that are time efficient
Decrease in-person visits	Included televisits in capturing BP measurements
Staff culture	Engage staff in understanding of importance of work
Resources/Supplies	Seek resources for patients to obtain BP monitors for televisit use

What's Next for PHASE/TC3?

Here's How We Will Continue the Work

New Aim Statement and Focus Areas for Change

By **July 31, 2021**, our system will implement the 7 key changes of our new care model for all integrated primary care teams at 3 adult clinic sites in relation to hypertension management.

The key changes:

1. Enroll patients with diagnosed uncontrolled blood pressure in SMBP
2. Patient letter reminders for SMBP practices and upcoming televisit appt. reminders
3. Schedule patients in Hypertension clinic provider appt.'s
4. Establish regular outreach of patients with 2 recorded uncontrolled BP values within the past 12 months.
5. Leverage electronic healthcare system to allow ease of workflow in documenting and managing BP.
6. Provide consistent, effective, and routine education with weekly unencumbered time
7. Utilize healthy registries data to improve hypertension management compliance

SPREAD

By **March 31, 2022**, our system will spread the 7 key changes of our new care model for all Integrated primary care teams for our 3 adult clinics by ….

The key changes:

- Schedule a meeting in March with MA's, Nurses, and providers
- Develop work teams in each location that test the change theories
- Create a scheduled bi-monthly meeting to go over challenges with theory tests
- Introduce the change theories to other clinics and use continued process
- Give each location team one month to complete the tests
- Present to managers/team leads the standardized and agreed upon changes

SUSTAINABILITY

Our system will continue sustainability of the 7 key changes of our new care model for All integrated primary care teams for our adult clinics by….

The key changes:

- Establishing bi-monthly QI organizational info meetings for providers and staff
- Regular monthly monitoring and measuring of practices and change implementations
- Establishing in person auditing within the organization
- Creating an educational platform that is accessible for staff