KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

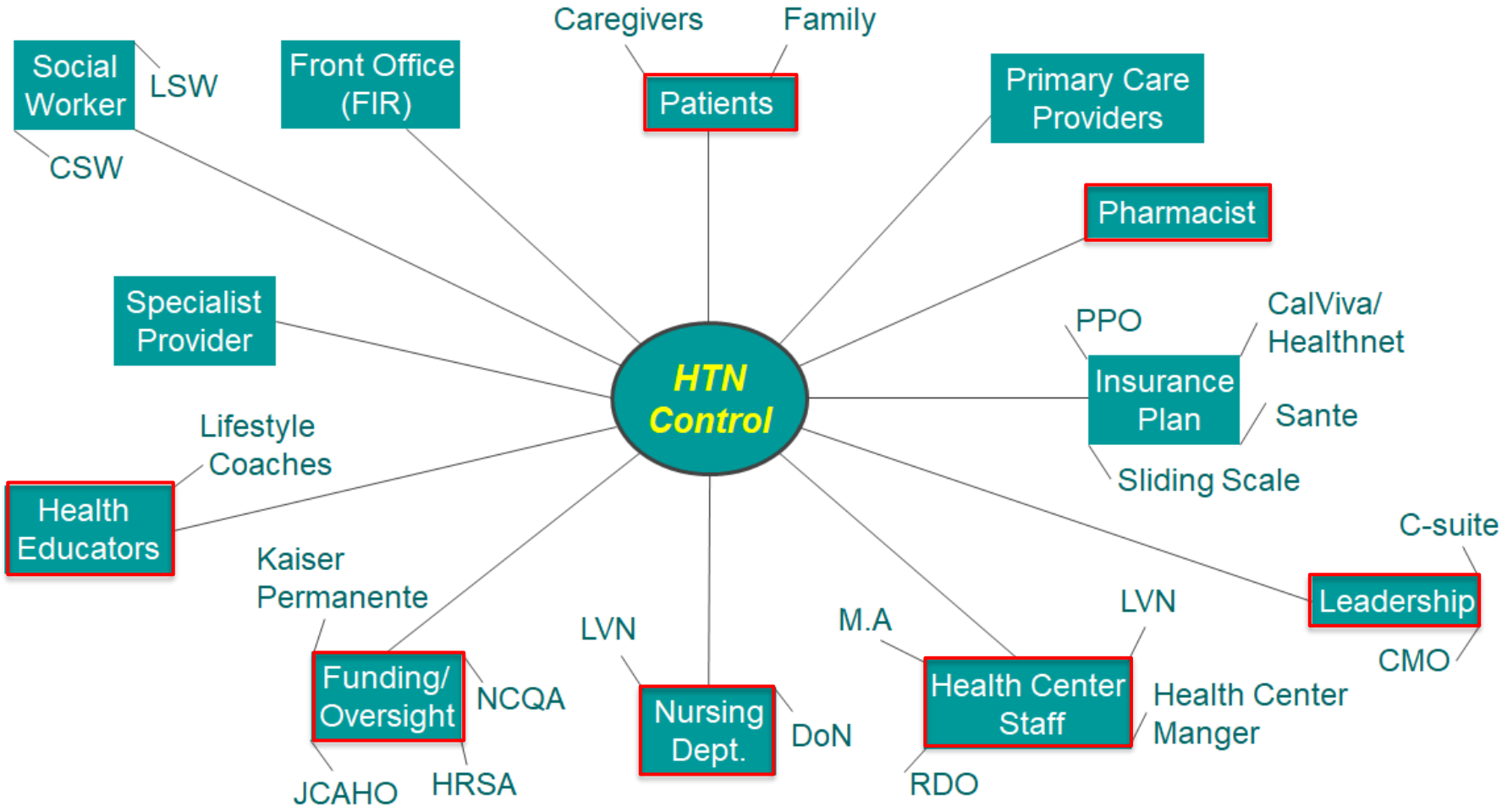
CCI
CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE®
TC3
TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

Valley Health Team Inc.
11/18/2020

Team Members: Dr. Ronald Dominguez, MD; Lisa DeGraff, RN; Sunny Gill, CQO; Noemi Sweidy, QI Coordinator

Stakeholder Analysis - HTN



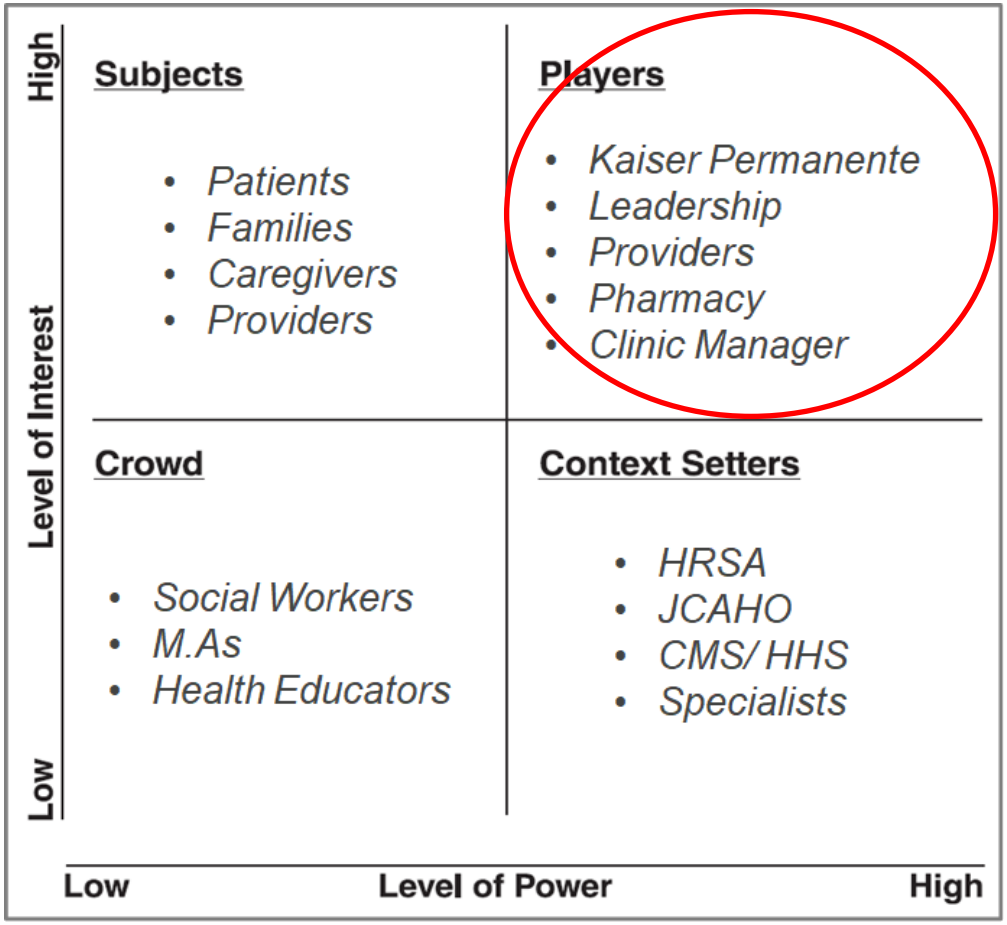
Power vs. Interest Grid (HTN Control)

Identify Entities/ people:

- High Level of Interest
- High Level of Control

Entities Identified & Engaged:

- Leadership – C Suite (CQO)
- Clinical Leadership (CMO)
- Nursing Director
- Pharmacist
- Clinical Staff
- QI Staff



WHAT WERE WE TRYING TO ACCOMPLISH?

Problem Statement

Due to the COVID-19 pandemic, many of our patients are sheltering at home in order to prevent the spread of the virus. VHT has had to conduct appointments by telephone and/or video in order to meet our patient's healthcare needs.

Existing care team tools aren't being used effectively to address gaps in care.

Aim Statement

Increase the statin prescription rates for our Clovis patients with a high risk of cardio vascular events from 47.7% to 52.7% by March 31, 2021.

Health Equity Aim Statement

Decrease the rate of uncontrolled blood pressure rates for our Clovis homeless patients from 25% to 20% by March 31, 2021.

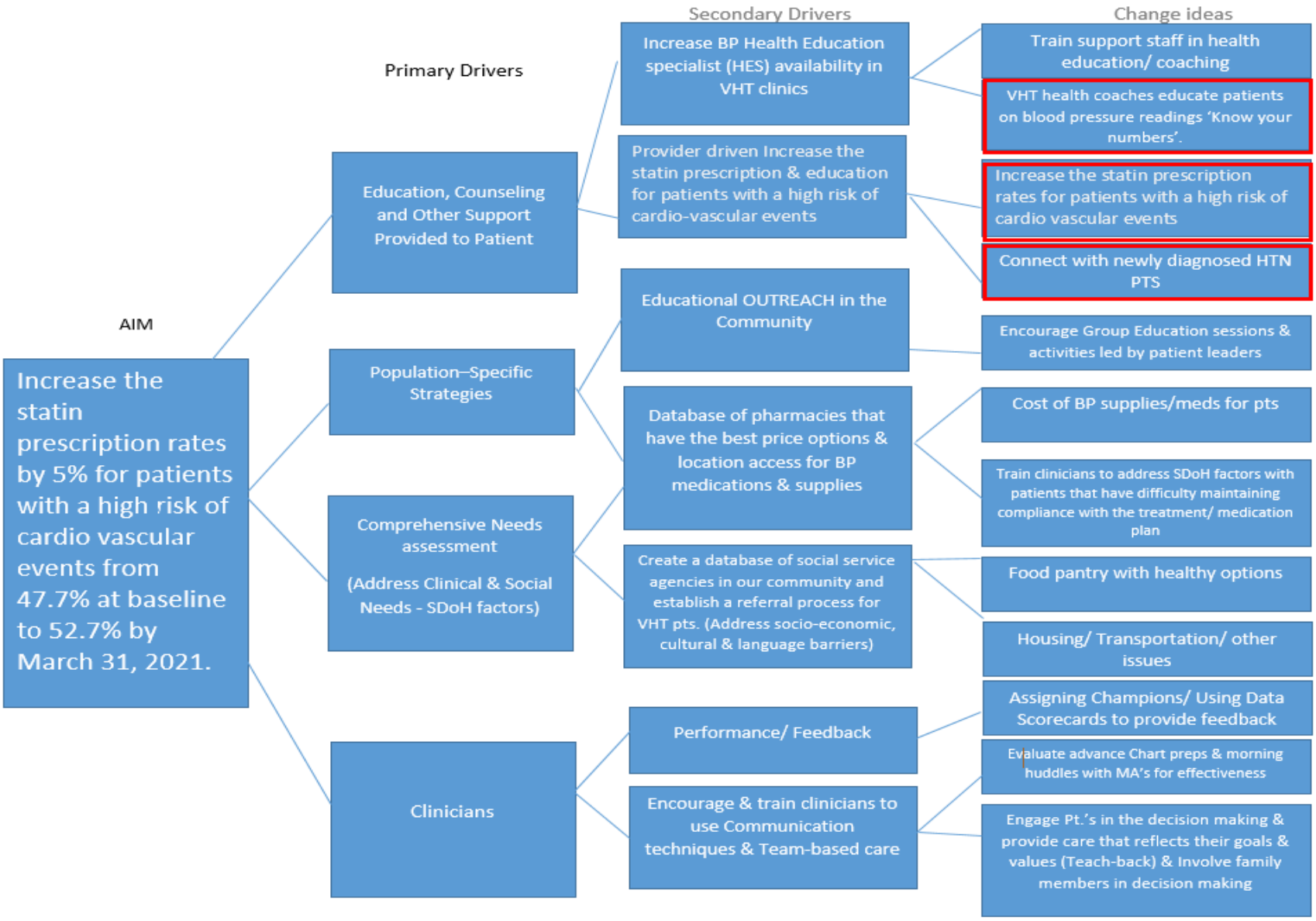
Background

- Hypertension is common among people over the age of 50 years that affects ~30% of adults in the US and is one of the largest contributors to morbidity and mortality.
- Hypertension is associated with higher risks of numerous diseases including atherosclerotic cardiovascular disease, stroke, chronic kidney disease, and vascular dementia.
- Effective management greatly reduces the risk of these diseases, only ~50% of patients with hypertension are effectively managed.
- Moreover, recent studies have reported an association between hypertension and higher rates of mortality from coronavirus disease (COVID-19) which has accounted for 500,000 deaths in the US so far.
- The problem of hypertension has taken on added importance during this pandemic as hypertension is shown to be a major risk factor for mortality due to COVID-19.

GOAL: To improve blood pressure control for VHT patients to keep our patients healthy and safe (reduce mortality) especially during the SARS-CoV-2 pandemic.

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Organizational Driver Diagram



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 was to:

- Each team member called 2-4 patients to interview by 12/2/2020.
- Most respondents - "tried different medications until the right one worked well"
- Some respondents - "my doctor has taken really great care of me with medication and have been managing it well"
- What surprised us- "I wish there was someone I could call all the time when I have questions, rather than having to wait for the doctor or nurse to call me back"

How We Engaged Leaders, Providers, and Staff

Our Medical Associate Director, Director of Nursing, and our Chief Quality and Informatics Officer interviewed the patients.

Medical assistants and health center manager reached out to patients with a new high blood pressure medication and ensured they understand how to properly take their medications and answer any question they may have with Pharm on the line.

"I like that we made a change in our patients life, help them understand about their disease process."
- Medical Assistant

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?
To reach out to patient with a new high blood pressure medication and ensure they understand how to properly take their medications and answer any question they may have with Pharm and/or provider on the line.	Newly diagnosed patients were contacted, 41% of patient did not respond after 2 attempts. 17% had no concerns, 15% resulted in new health education referral's, 17% are taking meds and feeling well, and 9% are not taking meds (maintain diet/exercise). Barriers: Pts not answering, high volume calls, staff shortages, COVID vaccine clinic	Adapt
Provide the health educators/ health coaches with a PHASE patient list to for providing education Blood Pressure readings "know your numbers".	Due to the Shelter-in-place order, many of our patients were afraid to come into the clinic, thus the telehealth visits were introduced. Health education visits were also conducted via telehealth. The health educators mailed out HTN materials ("know your numbers", how to read nutrition labels, weekly food log, consequences for not managing BP, etc.)	Adopt
To develop a PHASE case management program to improve Blood pressure control for patients with hypertension	New PDSA idea to consider	

How Did We Know the Changes Were An Improvement?

What We Measured

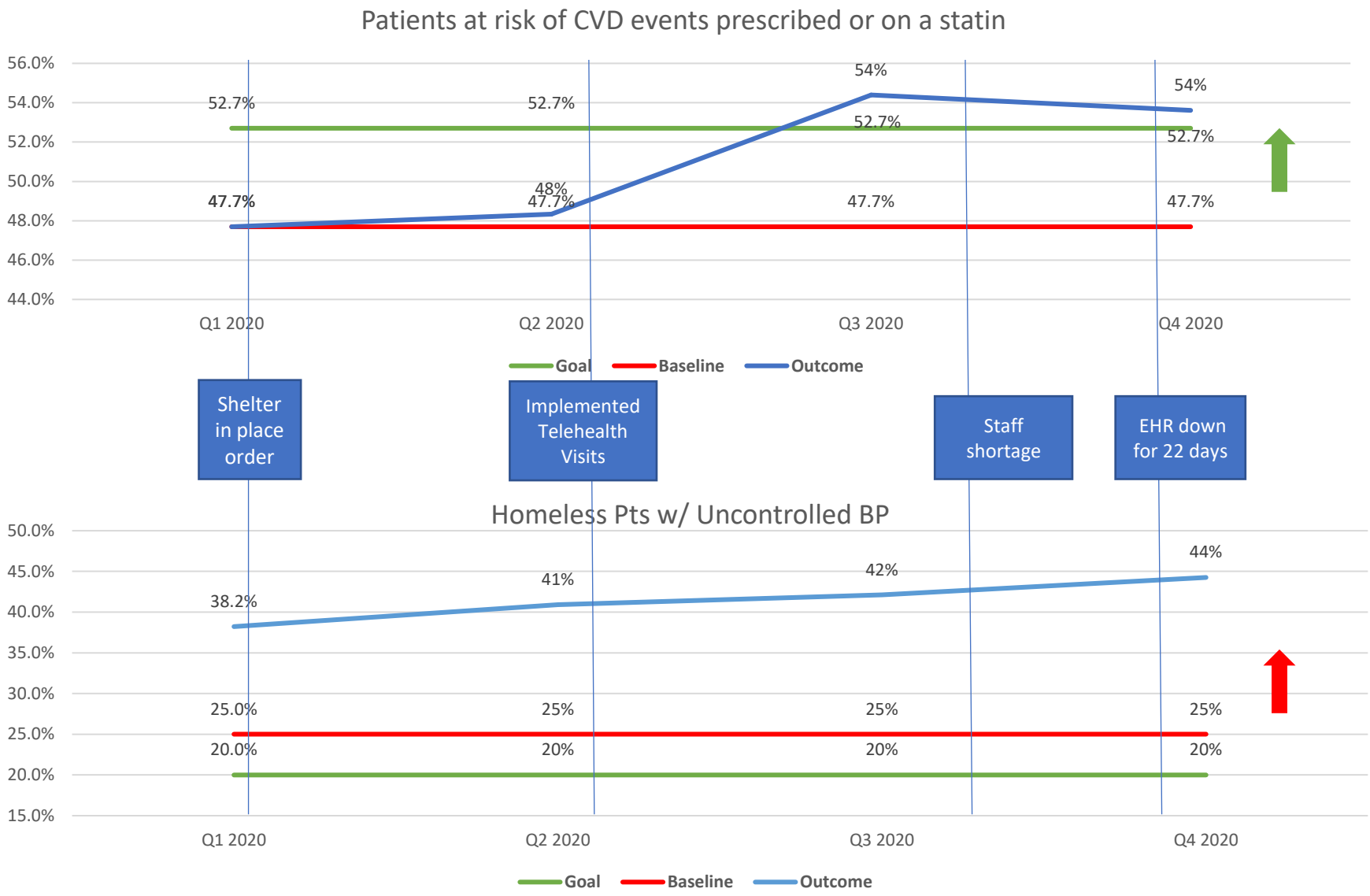
Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
Outcome (Directly related to the aim):			
Statin Management	Statin prescription ordered for patients with high risk of cardio vascular events	47.7%	52.7%
BP Management	Number of HTN patients with BP pressure of 140/90 or less	25%	20%
Process (Steps to achieve outcome):			
Statin Management	Provider/patient education in regards to statin medication.		
BP Management	Train clinical staff to teach homeless patients in the importance of medication adherence and engage in self management.	1%	5%
Balancing (Unintended impact/consequence):			
Statin Management	Elevated liver enzymes	7.6%	5.6%
BP Management	Hypotension Electrolyte imbalance (BMP/CMP)	4.1%	2.1%

How Did We Know the Changes Were An Improvement?

Results: Run Charts

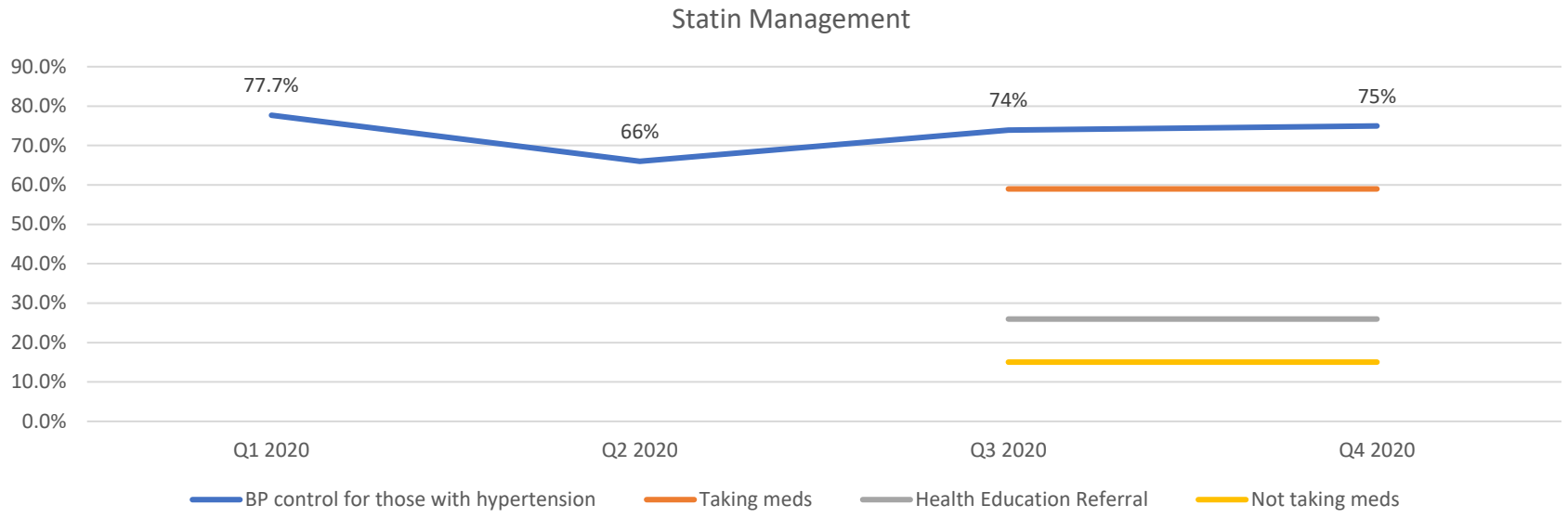
Outcome

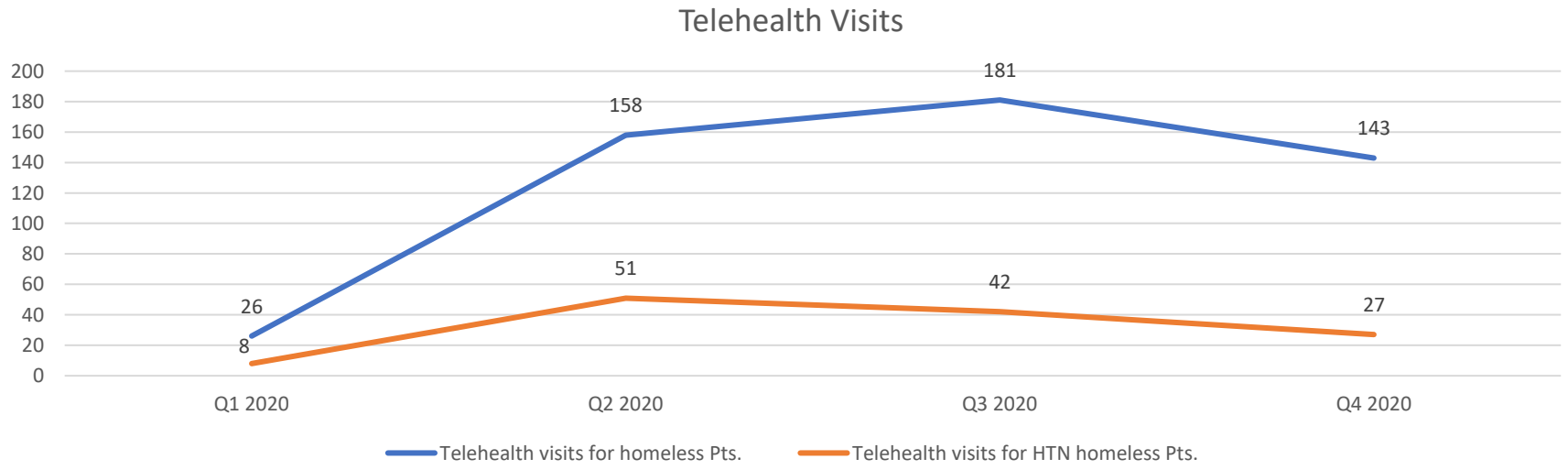


How Did We Know the Changes Were An Improvement?

Results: Run Charts

Process

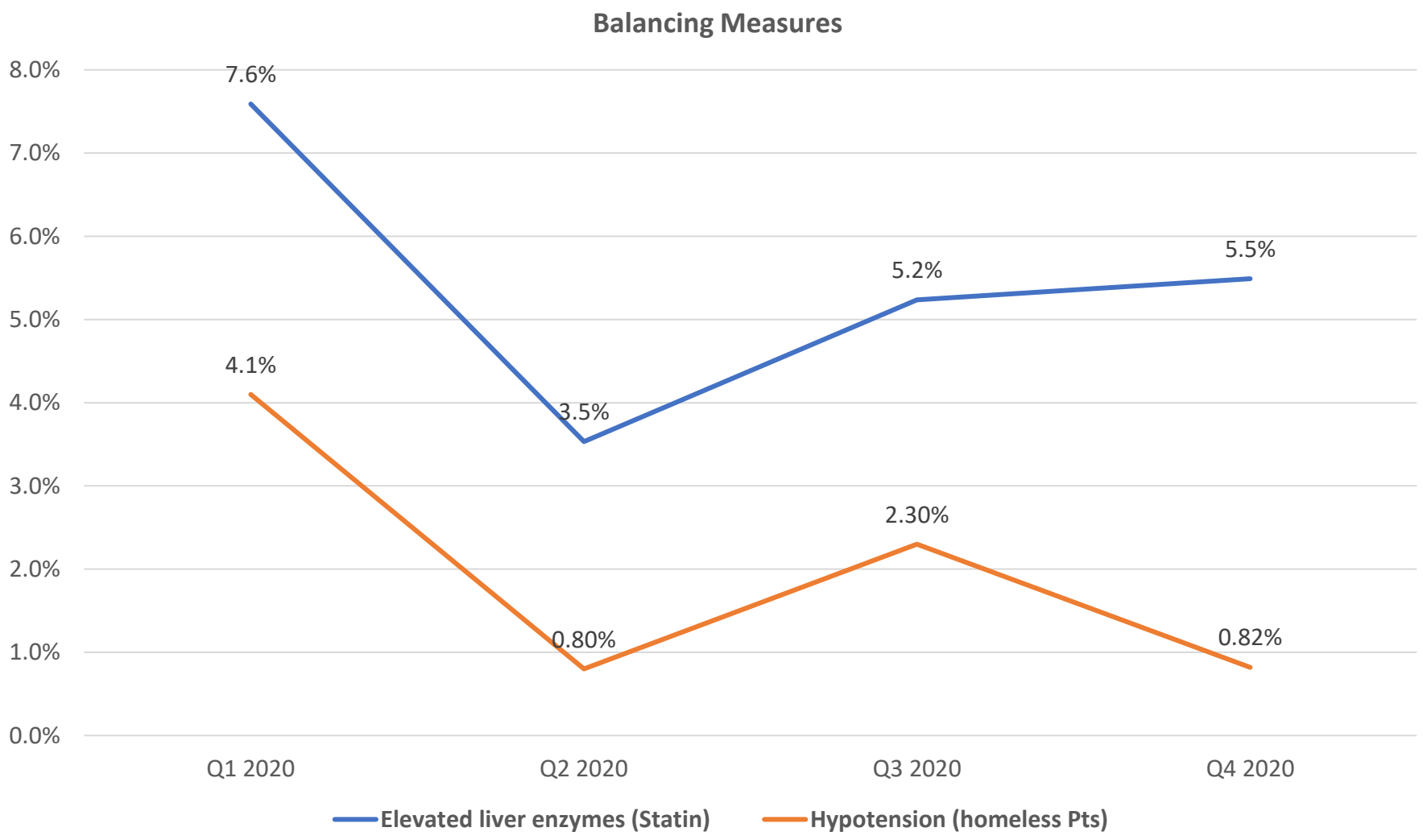




How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing



How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

We learned:

1) Patient care can be provided in multiple ways, tele-health, phone, outside, in the car, on-site.
2) How to maintain quality while providing services in these new ways.
3) How to manage a crisis.
4) How to protect ourselves and the patients with PPE.
5) How to provide the same level of care with much fewer staff.

"I like that we made a change in our patients life, help them understand about their disease process."- Medical Assistant

" I didn't really think I needed medication, I don't like taking medicine, but Dr. Pinto was really sure that I did." "I got on line and tried to find out as much as I could about high blood pressure, and now I'm glad he made me start taking it." – Patient

"My doctor has taken really great care of me with medication and have been managing it well"- Patient

How Did We Know the Changes Were An Improvement?

Here's What We Learned

The Challenge of the COVID-19 Pandemic

VHT is required to comply with directives and orders from the United States, California and local government officials regarding quarantines, sheltering-in-place, patient care and the use of its resources. We have adjusted to new ways of caring for our patients though steadfast determination and patience. We have learned that patient care can be provided in multiple ways: tele-health, outside in the car and on-site. We have learned how to maintain quality while providing services in new ways, manage crisis, how to protect ourselves with PPE in masses, and provide same level of care with much fewer staff.

Overall Challenges

Challenge	How We Overcame/Resolution
Shelter in place	Activated our Emergency Preparedness Plan. Implemented virtual and telephone visits for medical, dental and behavioral health visits.
COVID-19 testing	Lack of supplies for testing, lab results had long wait times= longer quarantine times. VHT contracted with new lab A to Z Diagnostic, to alleviate some burden on LabCorp.
Shortage of all staff	Staff members contracting the virus, or were quarantine for exposure. Some staff recovery times can be longer than others. VHT implemented bi-weekly testing for all staff. (Shortage of staff is STILL a BIG challenge)
VHT's Systems outage	Our EHR was down for 20 days in December, all of our visits went to paper. Once the system was back up and running it took a lot of human power to scan documents into patient's medical records.
COVID-19 Vaccinations	VHT is experiencing a shortage for vaccines for our patients in need, still pending resolution. The vaccine paperwork is not translated to Spanish or Punjabi, so staff are spending lots of time reviewing the paperwork and answering many questions that patient's are having.

What's Next for PHASE/TC3?

Here's How We Will Continue the Work

SPREAD

By June 1, 2021 our system will implement 5 changes of our new care model for 8 of our clinical sites.
The key changes:

- The DON will train nurses at all sites to case manage chronic patients with a focus on homeless disparity
- Nurses are to meet with new case managed patients (telehealth) once a month
- Health coaches are to mail out educational materials to patients regarding controlling A1c and Blood Pressure readings "know your numbers"
- Clinical pharmacist and team can communicate with (non-compliant) patients (if needed) on the importance of medication compliance/BP control utilizing Medication Management Therapies (MMT)
- The Quality Improvement team will provide site specific dashboards to care teams in order to identify PHASE patients and monitor measures

SUSTAINABILITY

VHT will create site specific dashboards to measure, monitor and communicate the progress to all clinical staff, operations, and leadership. Each site will receive their dashboard report bi-weekly and then monthly. The dashboard will display (1) PHASE patient and disparity population, (2)prescription measures (statins, ACE/ARBs, Anti-hypertensive meds), and (3) clinical quality measures (HTN pts with controlled BP, DM pts with controlled A1c, DM pts with controlled BP. Sites that measure below expectations, will be required to submit an action plan of improvement.

What's Next for PHASE/TC3?

THE DESIRED FUTURE

- (new Aim Statement) Increase the statin prescription rates for all VHT patients with a high risk of cardiovascular events from 58% to 68% by March 31, 2022.
    - (health equity focus area) Decrease the rate of uncontrolled blood pressure rates for all VHT homeless patients from 37.% to 32% by March 31, 2022.
- (New problem statement) Due to the COVID-19 pandemic VHT implemented telehealth services to better serve of patients during the shelter-in-place order. With fewer face to face visits, the sites were unable able to collect vitals and/or labs.

What have you learned from your PHASE/TC3 focus this year that may serve you in achieving the desired future?

- Access to patient care can be bridged using multiple methods for (e.g. tele-health, extension of clinics services to outdoor/remote venues, in the car, on-site).
- Engaging VHT's emergency pandemic response
- How to address vulnerable populations care needs during a pandemic

What, specifically, are you already doing and would like to *keep* doing to support achieving the desired future?

- To continue with telehealth services, health coaching and medications compliance utilizing Medication Management Therapies (MMT).
    - Existing care team tools and workflows are being reviewed/revised to incorporate remote patient monitoring and telehealth case management to effectively to address gaps in care.
        - What needs to happen to ensure that these activities continue to occur? The PHASE dashboard will be added as an additional reporting item to be reviewed during Quarterly QI meetings, medical provider meetings, and leadership meetings, and posting the reports at all sites.
    - What needs to happen for these new possibilities to be considered, tested, and implemented? Transparency of the data, clinical and operational buy-ins (reason why), engaging care team to goals by using PDSA methodology. Recognizing and celebrating improvement to drive change.
    - What will you *stop* doing? The traditional model of seeing patient's face-to-face in a clinical setting.
    - What are the consequences of *not* doing the above to achieve the desired future? Reduced patient outcomes & adherence to care plans & screenings. Additional patient barriers to access primary/specialty care

What, specifically, do you need from your leaders to support achieving the desired future?

- Continue to focus on care disparities utilizing social determinants of health (PREPARE)
- Support ongoing improvement activities to assist with clinical interventions & outreach efforts
- Increase technical resources for staff & patients, for incorporation of remote monitoring