Welcome to the TC3 In-Person Learning Session!

As you get settled, please:

- Find your table number on your nametag
- Help yourself to breakfast
Transforming Cardiovascular Care in Our Communities

November 5, 2019 | City of Industry, CA
Snowflake Handshake

• Introduce yourself to as many people as you can, who you do not already know, in 5 minutes

• With each new friend:
  • Share your name and organization
  • Collaborate to create a unique handshake (e.g. elbows, high-fives, bows)

• We will share the best inventions!
TC3 Evaluation

We support continuous learning by providing insights into progress, successes, and challenges.

**Evaluation questions**

- **What practices are implemented** as part of TC3? How are they sustained & spread?
- To what extent do clinics **improve in clinical metrics**?
- To what extent do clinics improve their **capacity to do population health management**?
- What **technical assistance** is provided? How does it contribute to success?
- What **challenges and enabling factors** influence progress and success?
- How can TC3 be **improved**?

**Evaluation components**

- Complete the Building Block Assessment at baseline and end of grant
- Submit quarterly clinical data
- Discuss clinical data as part of coaching calls (quarterly)
- Bi-annual reflective conversations
- Annual survey

**Evaluation team**

Maggie Jones, Jennie Schoeppe, and Carly Levitz
Center for Community Health and Evaluation
Today’s Ideal Results

• New ideas and connections
• Specific aims, driver diagram, testing plan
• Plan for engaging colleagues you need for success
RECORD IDEAS ON A “STICKY” NOTE AND PLACE ON THIS SHEET FOR A LATER ACTIVITY
Chat and Chows with Physician Leaders
11:55 am - 12:40 pm

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<td>Dr. Brettler &amp; Dr. Ong-Su</td>
<td>Inside the Clinic Walls and Day-of-Visit Hypertension Care</td>
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<td>Dr. Ho, Helen Chin, PharmD, &amp; Amanda Benedict, PharmD</td>
<td>Outside the Clinic Walls Care Management</td>
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<td>Dr. Mulligan</td>
<td>How to build an effective team and run effective meetings for world class quality improvement</td>
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<td>Dr. Henley</td>
<td>How to secure leadership investment in QI in a safety net organization</td>
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Practical Improvement Skills

- Clear aims
- Clear driver diagram
- Initial testing ideas
### Stakeholder Types & Strategies

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<th>Stakeholder Type</th>
<th>Characteristics</th>
<th>Strategies (Say &amp; Do)</th>
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| Enthusiastic Adopters    | • Invested in the new way  
  • See the positives  
  • Feel pride as an adopter     | • Communicate to them  
  • Invest in them  
  • Give key tasks  
  • Enable to share stories |
| The Big Middle           | • See pros and cons of new way  
  • Unsure about need for change  
  • Unsure can be successful with new  
  • Unclear about your picture | • Engage Adopters to influence Shadow/see results of high performers  
  • Involve them in later testing to provide you feedback |
| Concerned Resisters      | • Protect core values/traditions  
  • Focus on negatives of new way  
  • Don’t see success for themselves in new world | • Listen for key fixable issues  
  • Focus on those who are influential  
  • Find a victory with changeables  
  • Find narrow agreements with unmovables |
Learning from Kaiser Permanente

Blood Pressure Measurement and Care Management

Timothy Ho, MD
Angeline Ong-Su, MD
Jeffrey Brettler, MD

Terri Ma, MHIS, RHIA
Helen Chin, PharmD
Liliana Santos, LVN
Amanda Benedict, PharmD, BCPS
Blood Pressure Measurement and Care Management at Kaiser Permanente

November 5, 2019
Transforming Cardiovascular Care in our Communities
Jeff Brettler, MD, SCAL Kaiser HTN Co-Lead
Angeline Ong-Su, MD, SCAL Kaiser HTN Co-Lead
Southern California Permanente Medical Group (SCPMG)/Kaiser Permanente Southern California

SCPMG: Who we are in 2019

- 4.5 million members
- 74,290 employees
- 7,421 physicians
- 21,167 nurses
- 15 hospitals
- 230 medical offices
- 319,000 hospital discharges
- 42,500 babies delivered
- 23.2 million outpatient visits
- 29 million prescriptions filled
- 2.3 million BP checks/month
- 869,943 members with HTN
Figure 2. Kaiser Permanente Southern California population overview.
BP Trended Performance
HEDIS 2018 Controlling BP Results
All – Administrative Data

[Bar chart showing percentages for each region: WA, NCAL, SCAL, GA, MA, CO, HI, NW, KP, with All at the top. The percentages range from 84% to 90%.]
Black/African American HTN Control
Racial and Ethnic Disparities among Enrollees in Medicare Advantage Plans

John Z. Ayanian, M.D., M.P.P., Bruce E. Landon, M.D., M.B.A., Joseph P. Newhouse, Ph.D., and Alan M. Zaslavsky, Ph.D.

ABSTRACT

BACKGROUND
Differences in the control of blood pressure, cholesterol, and glucose among the various racial and ethnic groups of Medicare enrollees may contribute to persistent disparities in health outcomes.
In stratified analyses of Kaiser and other health plans in the West, significant disparities between black enrollees and white enrollees in the frequency of blood-pressure control were not evident in Kaiser health plans in 2006 (67% vs. 73%, P=0.18) or 2011 (89% vs. 85%, P=0.41), but there were significant disparities between the two groups in other health plans in 2006 (52% vs. 57%, P=0.04) and in 2011 (58% vs. 66%, P<0.001).

Ayanian J. NEJM 2014; 371:2288-2297
Sex-Specific Trends in Acute Myocardial Infarction Hospitalization, 2000 to 2014

Stephanie R. Reading, PhD, MPH; Kristi Reynolds, PhD, MPH; Bonnie H. Li, MS; Lei X. Cian, PhD; Denison S. Ryan, MPH; Teresa N. Harrison, SM; Ronald D. Scott, MD; Jeffrey J. Cavendish, MD; Steven J. Jacobsen, MD, PhD; Michael H. Kantor, MD

Age-Specific Incidence Rates of Acute Myocardial Infarction

**MEN (AMI)**

- 35-54
- 55-74
- 75+

**WOMEN (AMI)**

- 35-54
- 55-74
- 75+

Circulation: Cardiovascular Quality and Outcomes.
2017;10:A061
Figure 2. Age-adjusted mortality rates for each of the top 6 causes of death in Kaiser Permanente Southern California (KPSC), the US, and CA, 2001-2016.
Key Elements of a Successful HTN Program

- Comprehensive and accurate registry
- Simple and clear guidelines
- Treatment algorithm using combination pill
- Performance feedback
- Team based care
- Therapeutic inertia and medication adherence
- Credibility of BP measurement
- EMR/decision support
- Patient empowerment
Health System-Wide Hypertension Registry

- Hypertension Registry developed in 2000
- Elements used for identification:
  - Outpatient Diagnostic Codes
  - Pharmaceutical Utilization Data
  - Hospitalization Records
- Chart review audits of random samples of identified members were conducted
Hypertension Registry

2 outpatient visits within 365 days of each other with a diagnosis code for hypertension

1 outpatient visit with a diagnosis code for hypertension and 1 hospital discharge with a diagnosis code for hypertension within 365 days of each other

1 antihypertensive dispensing in the past 6 months and 1 outpatient visit with a hypertension diagnosis code within 365 days of the dispense date

1 outpatient visit with a code for hypertension AND a member of one of the following populations: Heart Failure, CAD, Diabetes, CKD, CVA (excluding subarachnoid, subdural and cardioembolic)
Guidelines

Kaiser Permanente National
CLINICAL PRACTICE GUIDELINES

Adult Blood Pressure
Clinician Guide

Introduction  This Clinician Guide is based on the 2018 KP National Blood Pressure (BP) Guidelines. It was developed to assist primary care physicians and other health care professionals in the outpatient setting with screening and treatment of elevated BP in non-pregnant adults aged ≥ 18 years. The KP National BP Guideline is revised after review of the 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners.
**FIGURE 1: MANAGEMENT OF ADULT BLOOD PRESSURE (BP)**

**BP GOALS**
- Treat adults with confirmed hypertension to a goal BP < 140/90 mm Hg.
- In adults with ASCVD, CKD, age ≥ 75 years, or 10-year ASCVD risk ≥ 10%, consider treating to a goal SBP < 130 mm Hg. (Exclude adults with eGFR < 20 from this lower target.)

**ACE Inhibitor** ¹/ Thiazide Diuretic
- Lisinopril / HCTZ (advanced as needed)
  - 20/25 mg x 1/2 daily
  - 20/25 mg x 1 daily
  - 20/25 mg x 2 daily

**Thiazide Diuretic**²
- HCTZ 25 mg ⇒ 50 mg OR Chlorthalidone 12.5 mg ⇒ 25 mg

For ACEI intolerance due to cough, use ARB²
- Add losartan 25 mg daily
  ⇒ 50 mg daily ⇒ 100 mg daily
- Do not combine ACEI and ARB.
- Pregnancy potential: avoid ARBs³

**Calcium Channel Blocker (CCB)**
- Add amlodipine 2.5 mg daily ⇒ 5 mg daily ⇒ 10 mg daily

**Spironolactone**⁴ - Aldosterone Receptor Antagonist (ARA)
- Spironolactone 12.5 mg ⇒ 25 mg daily
  *If on thiazide AND eGFR ≥ 60 mL/min/1.73 m² AND potassium < 4.5 mmol/L

If spironolactone eligibility criteria not met:
- bisoprolol 2.5 mg ⇒ 5 mg daily ⇒ 10 mg daily
  - Titrade BP; maintain pulse of > 55

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¹ Pregnancy potential: avoid ACE inhibitors
² For ACEI intolerance due to cough, use ARB
³ Pregnancy potential: avoid ARBs
⁴
**Guidelines**

- Consider medication non-adherence.
- Consider interfering agents (e.g., NSAIDs, excess alcohol).
- Consider white-coat effect. Consider BP checks by medical assistant, AOBP, or outside the office.
- Consider discontinuing lisinopril/HCTZ and changing to chlorthalidone 25 mg plus lisinopril 40 mg daily.
- Consider additional agents (hydralazine, terazosin, minoxidil).
- Consider stopping beta blocker and adding diltiazem to amlodipine, maintaining heart rate > 55.
- Avoid using clonidine, verapamil, or diltiazem with a beta blocker. These heart rate-slowing drug combinations may cause symptomatic bradycardia over time.
- In adults with eGFR < 30-40 mL/min/1.73², change thiazide diuretic to furosemide twice daily or torsemide daily.
- When bisoprolol is used in adults with eGFR < 40 mL/min/1.73², start bisoprolol at 2.5 mg and advance cautiously.
- Consider secondary etiologies.
- Consider consultation with a hypertension specialist.
Combination pill use and BP control

**Figure 4.** Combination pill use and hypertension control at Kaiser Permanente Southern California. Since 2005, when the combination of lisinopril/HCTZ was advocated, hypertension control rates have steadily increased, paralleling the proportion of those prescribed the lisinopril/HCTZ combination pill. HCTZ, hydrochlorothiazide; HTN, hypertension.
Performance Feedback

- Unblinded data with clear targets
- Monthly reporting
- Data drilled down to medical center, clinic, team, individual physician and nurse. Facilitates best practice identification and spread at all levels.
- Overall control as well as process measures
Figure 1: Standard deviation of hypertension control among 13 medical centers in Southern California Permanente Medical Group (SCPMG) compared to overall hypertension control < 140/90. Blue line represents hypertension control; purple line represents standard deviation of hypertension control.

Handler J, Lackland DT. JASH 2011; 5: 197-207
HEDIS Controlling High BP Measure
September 2018
## Provider Level Feedback

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Process Measures

Outreach – BP measurement needed every year

BP measurement: repeat if elevated, standing in older patients

Specialty measurement

Treatment intensification, adherence

Follow-up
2nd BP Report

2nd BP Performance - September 2019

WLA: 96%
ANA: 96%
BPK: 95%
SUN: 95%
RIV: 94%
DOW: 94%
REGION: 94%
PAN: 94%
SD: 93%
BAK: 93%
FON: 93%
WOD: 91%
AV: 91%
SB: 90%
No BP - September 2019

[Bar chart showing percentages for various locations: BAK, BEL, FON, ANA, BPK, WLA, AV, HAR, RIV, SD, WOD, PAN, SUN, REGION. The percentages range from 3% to 9%.]
Specialty BP Report

BP Excellence + Efficiency = Value: Results by Medical Center Area – September 2019 (2019 75% Weighted LOS Composite)

Maximize Prompted BPs
Minimize Unprompted BPs
Drive Line of Sight BP Composite

Response to the KP HealthConnect Proactive Care Tab prompt for a BP entry at Specialty office visits when there is no recent, normal BP on file.
Unprompted Pre-Op & Consult visits with patients who have a known recent, normal BP in KPSC are excluded from these data.

Data Source: KP HealthConnect/Clarity
Merry Meyers: Business Systems & Reporting

KAISER PERMANENTE®
Team Based Care

MA/LVN BP checks every 2 weeks – automatic process from either primary or specialty care

Real-time titration by non-MD providers: RNs under protocol, NPs, pharmacists
# Treatment Intensification Score
April 2019

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### Treatment Intensification Report

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<td>CWMU</td>
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<td>INGU</td>
<td>1.46</td>
<td>1.18</td>
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<td>PLVU</td>
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<td>0.99</td>
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<td></td>
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<td></td>
<td>VENU</td>
<td>1.06</td>
<td>0.82</td>
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<td></td>
<td></td>
<td></td>
<td>WILAU</td>
<td>1.50</td>
<td>1.26</td>
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<td></td>
<td></td>
<td>WLMM</td>
<td>1.53</td>
<td>0.06</td>
<td>1.59</td>
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<tr>
<td>Grand Total</td>
<td></td>
<td></td>
<td></td>
<td>1.31</td>
<td>1.06</td>
<td>2.37</td>
</tr>
</tbody>
</table>
Therapeutic Intensity Score

- **TIS**: prescribed daily dose for each medication is set as numerator; corresponding max FDA approved daily dose set as denominator.

- Example: patient on 3 BP meds, each at 25% max dose: \( TIS = 0.75 \).

- Example: patient on Lisinopril-HCTZ 20-25, 2 tabs + amlodipine 5 mg daily: \( TIS = 2.5 \).

- **Systolic BP decreased by a significant 14-16 mm for every 1 point increase in TIS.** Levy, PD. JASH 2016. Prospective study in AA uncontrolled patients.
Treatment

Intensification

Probably the most important intervention to improve BP control

Consider dedicated model – provider is only treating BP and not other conditions.

Ideal for non-physician provider – pharmacist, NP, RN under protocol

Provider specific data
Standardized Templates

**HTN Real Time Titration Opportunity**

@LASTBP3@  
@LASTPULSE(3)@

@TAKINGMED@ ***Delete meds if not taking  
@MRAR@***Delete if not HTN meds

Allergies/intolerances: ***

Did pt take meds today? {26850::"Yes","No","Unsure"}

Pt states @HE@ takes meds as directed: {26850::"All the time","Sometimes","Rarely"}

Have you consumed any caffeine drinks (coffee) or smoked in the past 30 minutes? {26850::"Yes","No"}

Does patient have symptoms? {26850::"Yes","No"}

Does the patient need a refill? {26850::"Yes","No"}

@LASTNA@  
@LASTCR@  
@LASTK@  
@LASTGFR@

**PROACTIVE CARE ACTIONS**

Proactive Office Encounter Actions: {65444}

AVS given, reviewed with patient, no further questions at this time.
# Medication Adherence

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dispense Date</th>
<th>Refill</th>
<th>MRAR</th>
<th>DSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atorvastatin (LIPITOR) 40 mg Oral Tab</td>
<td>07/21/2019</td>
<td></td>
<td>99.0</td>
<td>85</td>
</tr>
<tr>
<td>Allopurinol (ZYLOPRIM) 300 mg Oral Tab</td>
<td>07/22/2019</td>
<td></td>
<td>93.1</td>
<td>115</td>
</tr>
<tr>
<td>Lisinopril (PRINIVIL/ZESTRIL) 20 mg Oral Tab</td>
<td>07/23/2019</td>
<td></td>
<td>93.1</td>
<td>115</td>
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<tr>
<td>VITAMIN B-12 500 MCG ORAL TAB</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carvedilol (COREG) 12.5 mg Oral Tab</td>
<td>07/21/2019</td>
<td></td>
<td>93.4</td>
<td>114</td>
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<tr>
<td>Spironolactone-Hydrochlorothiazide (ALDACTAZIDE) 25-25 mg Oral Tab</td>
<td>06/21/2019</td>
<td></td>
<td>100</td>
<td>194</td>
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<tr>
<td><em>WARFARIN 2 MG ORAL TAB</em></td>
<td></td>
<td></td>
<td>86.2</td>
<td>0.23</td>
</tr>
</tbody>
</table>
Blood Pressure Technique Competency

Education of MAs, LVNs, RNs

Audits: observed vs unobserved

AOBP: SPRINT protocol - mandates 5 minute rest and multiple measurements

Nurse specific data
# Annual Skills Validation

## Taking a Blood Pressure with an Automatic Digital Monitor

### Skills Validation Tool

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>MET</th>
<th>NOT MET</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verifies patient identity with 2 identifiers: name, MR #, date of birth, or other personal data; have patient state their name and DOB, or name and MR # on armband (if used)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Explains procedure to patient taking into account age, education level, physical and mental condition, language, and cultural background</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Selects appropriate cuff size (reseats equipment from prior patient if needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Palpates brachial artery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Removes all clothing covering the patient’s upper arm, as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Properly places cuff on bare arm with arrow over brachial artery. Wraps cuff smoothly and snugly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ensures patient’s arm is fully supported on furniture (i.e. Mayo stand, arm of chair) at heart level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Instructs patient to sit still with back supported, feet flat on floor, and legs uncrossed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Instructs patient to relax and sit calmly without talking for at least 5 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Sets the auto-inflation on the monitor. Turns the power ON. Takes the recommend battery charge or that the monitor is plugged in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. The cuff will auto-inflate. Instructs the patient not to move or talk during blood pressure measurement. Digital monitors measure blood pressure by detecting small movements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Does not speak to patient during blood pressure measurement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. After the cuff auto-deflates, note the monitor readings. The top number on the monitor is the systolic pressure and the bottom number is the diastolic pressure reading. The last number is the pulse</td>
<td></td>
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</table>
# Blood Pressure Spot Checks

<table>
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<tr>
<th>Criteria</th>
<th>Total # Yes</th>
<th>Total # No</th>
<th>% Correct</th>
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<tbody>
<tr>
<td>Bare Arm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct BP Cuff Size</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Arm Support at Heart Level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Talking During BP</td>
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</tr>
</tbody>
</table>
## Repeat BP Report

### SCBPA0001c - High Blood Pressure Best Practice Alert Report with User MA Detail - Summary

**High Blood Pressure Best Practice Alerts: Fired Alerts With 2nd BP Reading**

Blood Pressure readings are limited to those recorded in Flowsheet row 9005

Contact Date Range from: 7/1/2019 to 7/31/2019

Medical Center Location: All

<table>
<thead>
<tr>
<th>Med Center / Location / Specialty / User/MA</th>
<th>Total Encounters with High BP BPA: User/MA</th>
<th>2nd BP Reading</th>
<th>2nd BP Reading</th>
<th>Percentage of Encounters With 2nd BP Reading</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>User/MA</td>
<td>Specialty/ Location/</td>
<td>User/MA</td>
<td>Specialty/ Location/</td>
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<tr>
<td>WEST LA MEDICAL CENTER AREA</td>
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<tr>
<td>Internal Medicine</td>
<td></td>
<td></td>
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<tr>
<td>KEYHEA, DEVON - X841856</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>WILLIAMS, STEPHANIE - X552961</td>
<td>6</td>
<td>6</td>
<td>6</td>
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<tr>
<td>ZUNIGA, PEARL - K245533</td>
<td>5</td>
<td>5</td>
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<td>100%</td>
</tr>
<tr>
<td>CANDLER, RONEISHA - H818330</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>100%</td>
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<tr>
<td>GARDOCE, MARICEL - W964937</td>
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<td>6</td>
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<td>100%</td>
</tr>
<tr>
<td>BROWN, ALICIA - K222474</td>
<td>9</td>
<td>9</td>
<td>9</td>
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<tr>
<td>HERNANDEZ, CHRISTOPHER - M681989</td>
<td>15</td>
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<tr>
<td>RODRIGUEZ, ROXANNA - K254772</td>
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<td>12</td>
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<tr>
<td>SIEGEL, JEFFREY - P301459</td>
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<td>0</td>
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<tr>
<td>KWON, KAREN - W059395</td>
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<td>12</td>
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<tr>
<td>ACOUSTA, MARIA - I571153</td>
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<td>11</td>
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<tr>
<td>ANGUANO, DANIEL - C663196</td>
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<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>CAIN, LEATRICE - K391982</td>
<td>3</td>
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<tr>
<td>JOHNSON, CHERYL - K237488</td>
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<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>CHEN, ALLAN - P160781</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
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</tbody>
</table>

**Specialty Total**: 109  106  97%
AOBP – Automated Office Blood Pressure

- Automated
- Multiple
- Alone

SPRINT: 5 minute rest, BP measurement, 1 minute rest, BP measurement, 1 minute rest, BP measurement; average of 3 readings
Follow-up of Elevated BPs

2-4 week follow-up is key, but 2 is more effective

Automate: follow-up appointment can be booked before provider sees patient

Need to measure and report monthly - clinic and nurse level data
Elevated BP Follow-up - Sep 2019

Elevated Follow Up

- **Primary Care**: 79%Booked, 58%Kept
- **Specialty Care**: 53%Booked, 41%Kept
- **Urgent Care**: 56%Booked, 42%Kept
- **All**: 66%Booked, 49%Kept
Home BP Protocol

- Check your BP 3 mornings between 6 am and 10 am and 3 evenings between 6 pm and 10 pm, over one week.
- Morning BP readings are taken within 1 hour of waking up and before morning medications and breakfast.
- Evening BP readings are taken prior to medications and at least 1 hour after eating.
- Please take 2 or 3 BP readings each time you measure your BP. Each should be at least 1 minute apart.
Home BP Smart Phrase

How to Take Your Blood Pressure at Home

Buy an accurate blood pressure monitor.
- You can buy one from a Kaiser Permanente pharmacy or Healthy Living store.
- Wrist and finger tip devices are not accurate and should not be used.

If you have your own blood pressure machine, bring it to an appointment. Ask staff to check your blood pressure with your device and with the office device to compare readings and validate your machine.

Prepare yourself to get an accurate reading:

DO:
- Sit in a chair with your back supported and both feet resting on the ground.
- Make sure your arm is at heart level and rest it on a flat table or other surface for support.
- Put the cuff in direct contact with the skin of your arm.
- Sit in a quiet room.

DON’T:
- Do not smoke, have caffeinated drinks, or exercise within 10 minutes before taking your blood pressure.

How many readings should be taken?
Take 3 sets of morning and 3 sets of evening readings for best results. Each set should include 2 to 3 readings.

How to Take Your Blood Pressure Results Log to record blood pressure readings:

- Check your blood pressure 3 mornings during the week between 6 a.m. and 10 a.m. and 3 evenings between 6 p.m. and 10 p.m.
- Rest for 5 minutes before taking the first reading.
- Your morning and evening readings can be done on the same day or on separate days.
- Wait 1 minute after the first reading, and then take the second reading.
- Take 1 to 3 readings each time you take your blood pressure. Each should be at least 1 minute apart.
- Wait 1 minute again, and then take the third reading.
- Write all 2 to 3 readings down. Be sure to note the date and time.

Sunday/Date: Monday/Date:

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon/AM</th>
<th>Mon/PM</th>
</tr>
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<tbody>
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</table>

Tuesday/Date: Wednesday/Date:

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<th>Time</th>
<th>Wed/AM</th>
<th>Wed/PM</th>
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Thursday/Date: Friday/Date:

<table>
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<tr>
<th>Time</th>
<th>Fri/AM</th>
<th>Fri/PM</th>
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<tr>
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Saturday/Date: Sunday/Date:

<table>
<thead>
<tr>
<th>Time</th>
<th>Sun/AM</th>
<th>Sun/PM</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Kaiser Permanente. thrive
Home BP Smart Phrase (Short)

Taking Your Blood Pressure at Home
- Over the course of one week, you should take your blood pressure at least 3 mornings and 3 evenings.
- Your blood pressure should be checked in the seated position after resting for several minutes, with both legs on the floor, back supported, and your arm at heart level.
- Each time you measure your blood pressure, you should take 2-3 readings, about one minute apart.
- The morning reading should be taken between 6 am and 10 am before your morning medication and before breakfast.
- The evening reading should be taken between 6 pm and 10 pm before your evening medication and at least one hour after dinner.
- The average of these readings should be < 135/85
How to Take Your Blood Pressure at Home

Buy an accurate blood pressure monitor.

- You can buy one from a Kaiser Permanente Pharmacy or Healthy Living store.
- Wrist and finger tip devices are not accurate and should not be used.

If you have your own blood pressure machine, bring it to an appointment. Ask staff to check your blood pressure with your device and with the office device to compare readings and validate your machine.

Prepare yourself to get an accurate reading.

**DO**

- Use the bathroom before you measure your blood pressure so that you are comfortable.
- Sit in a chair with your back supported and both feet resting on the ground.
- Have your arm at the elbow and rest it on a flat table top or other surface for support.
- Put the cuff in direct contact with the skin of your arm.
- Sit in a quiet room.

**DON’T**

- Do not cross your legs.
- Do not position the cuff over clothing.
- Do not talk when you take your reading.
- Do not smoke, have caffeine, drinks, or exercise within 30 minutes before taking your blood pressure.

What are the best times to measure blood pressure?

- Early morning: Measure within 1 hour of waking and before taking any morning medicines.
- Evening: Measure 1 hour or more after eating dinner but before taking any evening medicines.

Note: Morning readings are higher than evening readings for many people. Because of this, it is important that at least half of your readings are morning readings.

How many readings should be taken?

Take 3 sets of morning and 3 sets of evening readings for best results. Each set should include 2 to 3 readings.

Use the Home Blood Pressure Results Log on the back of this page to record blood pressure readings.

---

**Home Blood Pressure Results Log**

1. Rest for 5 minutes before taking the first reading.
2. Wait 1 minute after the first reading, and then take the second reading.
3. Wait 1 minute again and then take the third reading.
4. Write all 2 to 3 readings down. Be sure to note the date and times.

<table>
<thead>
<tr>
<th>Sunday/Date:</th>
<th>Monday/Date:</th>
<th>Tuesday/Date:</th>
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<tbody>
<tr>
<td>Time</td>
<td>Time</td>
<td>Time</td>
</tr>
<tr>
<td>a.m.</td>
<td>a.m.</td>
<td>a.m.</td>
</tr>
<tr>
<td>a.m.</td>
<td>a.m.</td>
<td>a.m.</td>
</tr>
<tr>
<td>p.m.</td>
<td>p.m.</td>
<td>p.m.</td>
</tr>
<tr>
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<table>
<thead>
<tr>
<th>Wednesday/Date:</th>
<th>Thursday/Date:</th>
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<td>Time</td>
<td>Time</td>
<td>Time</td>
</tr>
<tr>
<td>a.m.</td>
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</tr>
<tr>
<td>a.m.</td>
<td>a.m.</td>
<td>a.m.</td>
</tr>
<tr>
<td>p.m.</td>
<td>p.m.</td>
<td>p.m.</td>
</tr>
<tr>
<td>p.m.</td>
<td>p.m.</td>
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</tr>
</tbody>
</table>

**Notes:**

---


The information is not intended to diagnose or take the place of medical advice or care you receive from your physician or other health care provider. If you have additional questions, please consult with your physician.

---

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Center for Healthy Living
(southern california)
Cómo tomar la presión de la sangre en la casa

Compre un monitor de la presión de la sangre de precisión.

- Puede comprarlo en una farmacia o en tienda Vela Sana de Kaiser Permanente.
- Las dosis de medicamentos y de duda no son precisos y no se deben usar.

Si tiene un propio aparato para tomar la presión de la sangre, tráigalo a una cita. Pida al personal que le tome la presión de la sangre con su aparato. Comparta los lecturas y valide su aparato.

Cómo prepararse para una lectura de presión.

¿QUÉ DEBE HACER

- Para estar cómodo, use el baño antes de tomar la presión de la sangre.
- Sienta en una silla con respaldo y los dos pies apoyados en el suelo.
- Flexione el brazo a la altura del codo y apriete sobre una mesa o una superficie plana.
- Coloque el brazaletes en contacto directo con la piel del brazo.
- Tome la presión de la sangre en un cuarto tranquilo.

¿QUÉ NO DEBE HACER

- No encegue la pierna.
- No ponga el brazalete sobre la ropa.
- No habla mientras se está tomando la presión de la sangre.
- No fume, consume bebidas con cafeína ni haga ejercicio por lo menos durante las 30 minutos antes de tomar la presión de la sangre.

¿Cuáles son los mejores momentos para tomar la presión de la sangre?

- Tómelo por la mañana. Mida la presión de la sangre darse 1 hora que no despierte y antes de tomar medicamentos que debe tomar por la mañana.
- Por la noche. Mida la presión de la sangre 1 hora o más después de la cena, pero antes de tomar las medicinas que debe tomar por la noche.

Nota: Para muchas personas, las lecturas de la mañana son más altas que las lecturas de la noche. Por este motivo, es importante que al menos la mitad de las lecturas de la presión de la sangre se hagan por la mañana.

¿Cuántas lecturas se deben hacer?

Para los mejores resultados, tomen 3 veces por la mañana y 3 veces por la noche. En cada grupo de tomar debe incluir entre 2 a 5 lecturas.

Use la Guía de registro de la presión de la sangre en la casa que se encuentra en el reverso de esta página para anotar las lecturas de la presión de la sangre.

<table>
<thead>
<tr>
<th>Lunes/Pérdida</th>
<th>Mora</th>
<th>Sistólica/Clástica</th>
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</thead>
<tbody>
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<tr>
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<tr>
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Key Drivers for BP Control

- Blood pressure competency
- Treatment intensification
- Elevated BP follow-up
Thank you!
Hypertension Population Management

Kaiser Permanente Downey Medical Center

- Terri Ma, MHIS, RHIA, Department Administrator, Complete Care
- Helen Chin, PharmD, Supervisor, Ambulatory Care Pharmacy Services
- Liliana Santos, LVN, Ambulatory Clinical Supervisor, Complete Care
- Amanda Benedict, PharmD, BCPS, Clinical Pharmacist

Transforming Cardiovascular Care in Our Communities (TC3)
November 5, 2019
Presentation Outline

Hypertension (HTN) Population Overview

Strategy #1: Large Scale Health Fairs

Strategy #2: Primary Care Department Workflow

Strategy #3: Specialty Department Workflow
Hypertension Population

- Kaiser Permanente Southern CA = 514,063
- Kaiser Permanente Downey Medical Center = 43,028
  - Ages 18-85
  - Latino = 22,018 (51.2%)
  - African American = 3,538 (8.2%)
  - Non-African American = 17,472 (40.6%)

HTN Control Rates

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>Kaiser Permanente Southern CA*</th>
<th>Kaiser Permanente Downey*</th>
</tr>
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<tbody>
<tr>
<td>HTN Control Rates</td>
<td>48.3%</td>
<td>84.7%</td>
<td>86.2%</td>
</tr>
</tbody>
</table>


*Complete Care Population ages 18-85
Complete Care

• A method of panel management or population management or care management
  ▪ A proactive approach to ensuring that all patients receive preventive care, not just those who come in for appointments
  ▪ Different from “case” management

• Provides evidence-based, person-focused care addressing a large set of protocol-based health needs for every individual during every encounter within the health care system

Downey Complete Care Core Teams
Why Panel Management?

- Low Risk
- Moderate Risk
- High Risk
- Palliative Care

Case Management

Care & Panel Management
The Type of Care We Provide

<table>
<thead>
<tr>
<th>High</th>
<th>Low</th>
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</thead>
<tbody>
<tr>
<td>Panel Management</td>
<td>Care Management</td>
</tr>
</tbody>
</table>

Duration of Patient Interaction

Frequency
Complete Care at Kaiser Permanente

- Team-based care in all settings
  - Primary care
  - Specialty care
  - Centralized outreach
- More details:
Three Strategies

• With our unique patient population, we have implemented HTN population care through three main strategies:

1. Large scale health fairs
2. Primary Care department Workflow
3. Specialty department workflow
Clinical Practice Guidelines

• Practice is aligned with:
  ✓ 2017 ACC/AHA Blood Pressure Guidelines
  ✓ Kaiser Permanente National Clinical Practice Guidelines

• Physicians and Population Care Management follow the same clinical practice and the same formulary medication options
Keys to Success

• Each strategy features opportunities for:
  ▪ Real-time medication titrations
  ▪ Direct scheduling for follow-up appointments
  ▪ Practice alignment to clinical guidelines
Large Scale Health Fairs
Saturday Health Fairs

- Large-scale events
  - 4 events per year
  - Each event is 4 hours
- ~300-400 members
  - General population
  - Commercial population
  - African American population

Join us for a FIESTA!

Blood Pressure & Diabetes Health Fair
Saturday, November 16, 2019
8am to 12pm
Garden Medical Offices, 1st Floor

Take Care of Your Heart
- Schedule a no-charge blood pressure check. Having high blood pressure can lead to problems such as heart disease, heart attack, heart failure, and stroke.

Take Care of Your Blood Sugar
- If you have uncontrolled diabetes, schedule a no-charge Saturday appointment with a Pharmacist Care Manager who specializes in treating diabetes.

Services available for Kaiser Permanente members:
- Diabetes appointment
- Blood pressure check
- Flu vaccine
- Diabetic foot exam
- Diabetic eye exam
- Medication review
- Breast cancer screening (mammogram)
- Colon cancer screening (colonoscopy)
- Nutritional cooking demonstration
- Snacks

To schedule an appointment or for more information, please contact your Downey Complete Care Team at (562) 622-4330.

kp.org/downey
Patient’s Health Fair Worksheet

**MY BLOOD PRESSURE WORKSHEET**

Appt Time: _____ Age: _____

**HTN Diagnosis:** Yes or No (If NO, and BP above goal, see RN)

**Screenings Due:**
- 🦔 Foot Exam
- 🎈 Retinal Exam
- ⚽ A1c Lab
- 🍼 Mammogram
- 🫀 Pap Smear
- 🧔 Colorectal
- ⏰ Medication Reminder: Take your medications as directed
- 🗓 Other _______
- 📈 Flu Vaccine
- 🍯 Pneumonia Vaccine

**Today’s Blood Pressure:**

- Pulse: ________
- Standing: Yes or No

**My Blood Pressure Goal:**

< 140/ < 90

**Medication Plan:**

**CHANGES:**

**CONTINUE:**

**Action Plan:**

Follow up appt needed? YES NO

Next Appt Date: ________ Time: ________

Location: ________ Provider: ________

Laboratory Tests Due Date: ________

- Do NOT Fast (Non-Fasting)
- Fast 12 Hours Before Blood Draw
“Have you completed the diabetes class series yet?”

“Have you had your mammogram screening done yet?”

“Have you had your flu shot yet?”

“Have you had your PAP exam yet?”

“Have you had your diabetic retinal screening completed yet?”

“Have you completed your repeat A1c blood test?”

“Did you turn in your iFOBT kit yet? If not, would you consider scheduling a colonoscopy instead?”

“Have you had your Pneumovax shot yet?”
Direct book any follow up appointments as needed
Attendance & Results

• Saturday, August 24, 2019
  • 315 Total Attendees
    • 291 Total HTN Members
    • 24 Total DM/HTN
  • Care Managers titrated Medications for:
    • 116 uncontrolled HTN Members
    • 24 uncontrolled DM/HTN Members

• Additional Services completed:
  • 16 Mammograms
  • 24 Foot Exams
  • 56 Medication Adherence addressed
  • 16 Members enrolled in KP.org
  • 20 A1c labs ordered
  • 63 Flu shots given
  • 15 Center for Healthy Living - online education ordered
  • 20 Members referred for colonoscopy

Total Care gaps addressed: 217
Health Fairs

• Advantages:

  ▪ **Opportunities for patients to learn about other aspects of preventive care**
    • e.g. health education classes, stroke prevention, advance directive, options for weight management, cancer screenings, immunizations
  ▪ **Access for patients who are unavailable during regular business hours**
  ▪ **Real-time medication titration**
  ▪ **Direct scheduling for follow-up**
    • Primary care BP workflow
    • PCP appointment (if overdue)
BP Workflow

• Located within primary care clinics (Internal & Family Medicine)
• Scheduled and walk-in appointments
• Interdisciplinary workflow
  ▪ Care Managers embedded within the primary care clinic
    • Available by telephone
• Opportunities
  ▪ Real-time medication titration
  ▪ Direct scheduling for follow up
Multidisciplinary Primary Care Team

PCP

The Patient

Care Managers

Support Staff

Nurses and Medical Assistants
- Support staff outreach to patients 18-85 years old with uncontrolled HTN:
  - Book BP visit
  - Or book PCP visit if no PCP visit within last 10 months
Alternatively, the PCP can direct book BP visits for follow up after a medication titration.
- At BP visit, nurse/medical assistant checks BP
- If BP elevated and patient has HTN diagnosis, Care Manager provides real-time medication titration
- Nurse books a 1-2 week BP visit for follow up
OR...

- If patient is symptomatic, no HTN diagnosis, or Care Manager is unavailable, then case is escalated to doctor-on-duty or PCP

- Nurse books a 1-2 week BP visit for follow up
Other Scenarios

- Symptomatic BP
- Low BP
- BP elevated above 180/110
Specialty Department Workflow
 Specialty Departments

- Using a “BP High Pool” in electronic medical record
- If a patient has an elevated BP measured while at Specialty Department:
  - Chart is routed to “BP High Pool”
  - Complete Care outreach team contacts patient and schedules BP visit
  - Re-integrates patient back into Primary Care BP workflow
Hypertension Population Care Management

• Using a panel management model of care

• Employing three targeted strategies for real-time HTN medication titration and direct-scheduling:
  1. Large-scale health fairs
  2. Primary Care department workflow
  3. Specialty department workflow
Questions?
Chat and Chows with Physician Leaders
11:55 am-12:40 pm

<table>
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<th>Content Details</th>
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<tr>
<td>Dr. Brettler &amp; Dr. Ong-Su</td>
<td>Inside the Clinic Walls and Day-of-Visit Hypertension Care</td>
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<tr>
<td>Dr. Ho, Helen Chin, PharmD, &amp; Amanda Benedict, PharmD</td>
<td>Outside the Clinic Walls Care Management</td>
</tr>
<tr>
<td>Dr. Mulligan</td>
<td>How to build an effective team and run effective meetings for world class quality improvement</td>
</tr>
<tr>
<td>Dr. Henley</td>
<td>How to secure leadership investment in QI in a safety net organization</td>
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LUNCH

Back at 12:40PM
Quality Improvement Development

Establishing a Foundation for Improvement

Juliane Tomlin, MA, Senior Manager, Practice Transformation
Denise Armstorff, Master Improvement Coach
My Recent Experience . . .

• “The care provided to me (or to my family member) was of the highest quality”

  o Strongly agree
  o Agree
  o Neutral
  o Disagree
  o Strongly disagree
Quality Improvement Defined

“Quality improvement consists of systematic and continuous actions that lead to measurable improvement”

Health Resources and Services Administration
Elements of Quality Improvement?

- Theory or hypothesis
- Regular, ongoing assessment and measurement
- System focused
- Reduction in variability
Why is Quality Improvement Important?

“Improving quality is about making healthcare more safe, effective, patient-centered, timely, efficient and equitable.”

From “Quality Improvement Made Simple” : The Health Foundation Inspiring Improvement
What is Quality Improvement REALLY about?
How Do We Improve Quality?

• Setting aims
• Establishing/tracking measures
• Developing theories about the current system/process
• Generating/testing change ideas
Building a Team Charter

Defining the Problem

Aim Statement

Driver Diagram
Building a Team Charter

- Defining the Problem
- Aim Statement
- Driver Diagram
Defining the Problem
What’s Wrong and Why Should We Do this Now?

• How is this problem preventing us from achieving greater organizational goals?
• What is the **better** future that the change will accomplish?
• What are the consequences of **not** doing this **now**?
Messaging for Change

• People must see:
  • A need for change (dissatisfaction)
  • A better future (desire)
  • Consequences of avoiding the change

Building a Team Charter

- Defining the Problem
- Aim Statement
- Driver Diagram
Why Are Aim Statements Important?
Developing an Aim Statement
“What are we trying to accomplish?”

COLLECTIVE/COLLABORATIVE EFFORT

APPROPRIATE SCOPE

SMART CHARACTERISTICS
SMART Characteristics

- Specific
- Measurable
- Achievable Ambitious
- Relevant
- Time-bound
Aim Statement Template

Will improve _____________________________
(High-level broad focus area, e.g., health of our patients, operational efficiency, patient experience, etc.)

By ____________________________________________
(Reducing/decreasing or raising/increasing, etc.)

(Specific area of focus or patient population, e.g., diabetes management, breast cancer screening, etc.)

From ____________________ to _________________________
(Baseline) (Target goal)

By _______________________________________________
(Target date – specify exact date)
Could this Aim Statement Be SMARTer?

• Good Health Clinic will better manage diabetes by December 2020.

  • **Specific**
  • **Measurable**
  • **Achievable**
  • **Ambitious**
  • **Relevant**
  • **Time-bound**
A SMARTer Version

• Good Health Clinic will improve the health of its diabetic patients by increasing the rate of annual A1c screenings completed from 25% (38 diabetic patients) to 75% (112 diabetic patients) by December 31, 2020

• Specific
• Measurable
• Achievable
• Ambitious
• Relevant
• Time-bound
Could this Aim Statement Be SMARTer?

• Northstar Medical Center will decrease the number of patients with uncontrolled hypertension.

- **Specific**
- **Measurable**
- **Achievable**
- **Ambitious**
- **Relevant**
- **Time-bound**
A SMARTer Version

• Northstar Medical Center will decrease the number of patients with uncontrolled hypertension from 68% to 20% by December 31, 2020.

- **Specific**
- **Measurable**
- **Achievable**
- **Ambitious**
- **Relevant**
- **Time-bound**
Evaluate Your Aim Statement

• In your organizational teams,
  • Review and revise your problem definition and aim statement
  • Record new versions on the template provided
  • Post updates on your storyboard

Take 15 Minutes
Pair and Share

• Pair up with another organizational team and meet at your Storyboard
  • Teams take turns sharing problem definition and aim statement
    • As the sharing team:
      • What did you update today and why?
    • As the receiving team, provide feedback:
      • I really like . . .
      • I wonder if . . .

Take 15 Minutes
Building a Team Charter

Defining the Problem

Aim Statement

Driver Diagram
Driver Diagrams

Purpose: Making Your Theory for Change Explicit

TRANSLATES A HIGH-LEVEL IMPROVEMENT GOAL INTO SUB-PROJECTS

HELPS ORGANIZE CHANGE CONCEPTS AND IDEAS

TESTS THEORIES ABOUT CAUSE AND EFFECT

SERVES AS A COMMUNICATION TOOL
ABC Clinic will improve the health of its diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9) from 92% [121 patients] to 50% [60 patients] by August 31, 2020.

**Aim Statement**

**Primary Drivers (Systems Elements)**

- Electronic Health Records Utilization
- Team-based Care
- Patient Engagement

**Secondary Drivers (Areas for Change/Intervention)**

- System alerts regarding care gaps
- Appointment reminders
- Report generation and analysis
- Pre-visit planning activities
- Outreach to Patients
- Standing orders
- Team huddles
- Group Appointments
- Shared Agenda-planning
- Case Management
Developing a Driver Diagram

Gather
Gather team members (subject matter experts)

Brainstorm
Brainstorm by asking “what do we need to improve to achieve our goal?”

Cluster
Cluster “like” ideas and identify “themes”

Add
Add any new ideas that have surfaced during clustering

Develop
Develop diagram – Primary/Secondary Drivers
Let’s Build One Together
Step 1 – Gather Experts
Step 2 - Brainstorm
The Value of Brainstorming

• Generates ideas quickly
• Expands the portfolio of alternatives
• Gets people unstuck
• Injects insights from a broader group
• Builds enthusiasm

IDEO U https://www.ideou.com/pages/brainstorming
Guidelines for Brainstorming

- Defer judgment
- Encourage wild ideas
- Build on the ideas of others
- Stay focused on the topic
- One conversation at a time
- Be visual
- Go for quantity

IDEO U https://www.ideou.com/pages/brainstorming
Silent Brainstorming

• Each person has a stack of “sticky notes”
• Set a timer (no more than 2 minutes)
• Facilitator poses a question for brainstorming
• Individuals *silently* write as many ideas as they can think of

1 IDEA PER STICKY NOTE
Let’s Try It!

• Each person needs a stack of “sticky notes”
• I’ll set the timer for 2 minutes
• Write as many ideas as possible – 1 IDEA PER STICKY NOTE
• Topic for brainstorming is the following Aim Statement:

  ABC Clinic will improve the health of its hypertensive patients by decreasing the % of patients with uncontrolled hypertension from 50% [150 patients] to 10% [30 patients] by December 31, 2020.

  “Why aren’t we currently meeting the target?”
Step 3 – Cluster Similar Ideas to Find “Themes”
Step 4 – Add Any New Ideas that Surfaced During Clustering
Step 5: Develop Driver Diagram
Aim Statement

ABC Clinic will improve the health of its hypertensive patients by decreasing the % of patients with uncontrolled hypertension from 50% [150 patients to 10% [30 patients] by December 31, 2020.

Primary Drivers
(Systems, structures, norms)

Information/data Systems

Planned Care Delivery/Team-Based Care

Patient Engagement and Self-Management Support

Community Partnerships

Secondary Drivers (Change Concepts)

- Panel assignment
- Panel data/registry to document, review care and plan visits for hypertensive patients, regardless of reason for visit
- Systems to identify/alert staff regarding overdue preventive care needs
- Ability to generate reports to identify/analyze care opportunities (gaps)
- Appointment/access management

- Establish workflows and standardized care processes (appointment reminder calls, chart scrubbing, huddles, pre-visit planning, outreach, in-reach, etc.)
- Use of standing orders
- Pre-visit planning and follow-up/case management
- Medication reconciliation

- Shared agenda-planning tool
- Shared goal-setting/decision-making tools
- Patient education classes/materials
- Telephone check-ins between visits
- Patient satisfaction surveys

- Linkages with organizations to develop support programs and policies for patients
- Encourage participation in community education classes and support groups
- Link patients to social needs resources (State programs, local agencies, schools, faith organizations, businesses, and clubs)
Things to Remember About Driver Diagrams:

• Use the Activity for Engagement
  • Include those who know the work best
  • Allow your team’s ideas to surface AND record them all!

• Two ways to start:
  • Primary drivers can be stated – brainstorm each primary driver
  • If primary drivers are less evident – brainstorm the secondary drivers (working backwards)

• No right or wrong
Develop a Driver Diagram

• In your organizational teams,
  • Build your Driver Diagram on the chart pad provided next to your storyboard

Take 10 Minutes
ABC Clinic will improve the health of its diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9) from 92% [121 patients] to 50% [60 patients] by August 31, 2020.
Selecting and Prioritizing Focus Areas for Change

• Establish criteria
  • Which idea would most address . . .
    • Clinical quality?
    • Waste reduction?
    • Finances?
    • Patient/family care experience?

• Which idea is . . .
  • Easy to try?
  • Important to staff?
  • Important to leadership?
  • Most likely to get attention if it’s successful?
## Uncontrolled Diabetes Example

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<td>EHR Alerts for patients with scheduled appointments</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>13</td>
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<td>Team Huddles</td>
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<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Case Management</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>12</td>
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**Instructions:**
1. Score each item 1-3 (1 is lowest, 3 is highest)
2. Total scores across all categories
3. What is your #1 highest ranked area to focus on?
ABC Clinic will improve the health of its diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9) from 92% [121 patients] to 50% [60 patients] by August 31, 2020.
Brainstorming for Ideas to Test

**Aim Statement**
ABC Clinic will improve the health of its diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9) from 92% [121 patients] to 50% [60 patients] by August 31, 2020

**Primary Drivers (Systems Elements)**
- Electronic Health Records Utilization
- Team-based Care
- Patient Engagement

**Secondary Drivers (Areas for Change/Intervention)**
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- Pre-visit planning activities
- Outreach to Patients
- Standing orders
- Team huddles
- Group Appointments
- Shared Agenda-planning
- Case Management

**Change Ideas**
Let’s Practice . . .

- Return one last time to your Storyboards
  - Review your secondary drivers and identify priorities via DOT VOTING
  - For one of the identified priorities, **brainstorm at least 2 ideas** that you would like to try within the next month
  - Record these ideas on your Storyboard
Share Your Plan

• What area will you focus on first?
• What 2 change ideas will plan to test in the next month?
Questions and/or Comments
BREAK

15 minutes

2:30 - 2:45 PM
Leading Change

Build your team and your influence

Michael Mulligan, MD
Eric Henley, MD, MPH
Agenda

1. Set the stage (15 minutes)
   • Chapa-de Journey of Change
   • Influential leadership model

2. Develop your stakeholder influence plan
   • Teams assess stakeholders and build influence plan
   • Teams pair and share with another team
A Journey of Change

Chapa-de Indian Health
QUESTION

• We asked, “Are we situated to survive and thrive in a value-based care environment”?
• Answer: NO !!!!!

• Field trip

• Identify gaps
GOALS

• Aligned incentives
• Focus on Quality
• Culture of Learning/Improvement
• Develop Empowered Teams
• Embrace change
Aligned Incentives

• The “changes” need to be aligned with overall organizational goals

• Buy-in from the top necessary to allow freedom to innovate below
FOCUS ON QUALITY

• Highly aligned to internal processes

• Highly aligned to external partners

• $$$
Culture of Learning

• Process Improvement

• PDSA’s
Develop Empowered Teams

• Flatten hierarchy - Deming

• PODS as functional units

• Value everyone
Embrace Change

• Naturally followed from prior steps

• A value add that comes from participating in initiatives such as this

• Fun !!!
Focus on your Site

• Big picture
  • Culture of Learning/Improvement
  • Embrace change

• Strategies
  • Develop Empowered Teams
  • Flatten hierarchy
  • Value everyone
Challenges with Change

• People often worry about ‘what’s going to happen to me’
• You can’t mandate the behavior change you want
Responses to Change Efforts

- Recognize different groups
  - **Enthusiastic adopters**: they focus on the positives and have arguments for the negatives
  - **The Big Middle**: they see pros and cons; listen to both, reinforce positives, consider responses for the negatives
  - **Resisters, concerned**: they focus on the negatives; listen to them as they may have issues that need to be addressed. They may also be wrong; don’t let them hold you back

- Responses and strategies may be things you say and things you do
## Stakeholder Types & Strategies

<table>
<thead>
<tr>
<th>Stakeholder Type</th>
<th>Characteristics</th>
<th>Strategies (Say &amp; Do)</th>
</tr>
</thead>
</table>
| Enthusiastic Adopters    | • Invested in the new way  
                          • See the positives  
                          • Feel pride as an adopter                                                  | • **Communicate** to them  
                          • **Invest** in them  
                          • Give **key tasks**  
                          • Enable to **share stories**                                                  |
| The Big Middle            | • See pros and cons of new way  
                          • Unsure about need for change  
                          • Unsure can be successful with new  
                          • Unclear about your picture                                                  | • **Engage Adopters** to influence  
                          • **Shadow/see results** of high performers  
                          • Involve them in later testing to provide you feedback                      |
| Concerned Resisters      | • Protect core values/traditions  
                          • Focus on negatives of new way  
                          • Don’t see success for themselves in new world                               | • Listen for key **fixable issues**  
                          • Focus on those who are **influential**  
                          • Find a victory with **changeables**  
                          • Find narrow agreements with **unmovables**                                 |
Engaging Site Staff

• Articulate need, vision, goals
• Multi-disciplinary site-based core group
  • Make sure those lower in the hierarchy get heard
• Democratize leadership
• Look for natural leaders, not necessarily those with higher status based on title or role
Leadership

• Leader – willing to take stands, good communicator; not the best at everything; knowledgeable/smart in practical way

• Involves many

• Recognizes individual strengths

• Listens well and takes suggestions

• Recognizes and acknowledges achievements publicly

• Makes everyone feel a part of the effort
THE TIMELESS CLASSIC NOVEL
OF EXILE, COURAGE AND SURVIVAL

“Astonishing...
Everyone who can read
English should read it.”
St. Louis Post-Dispatch

Watership Down
Richard Adams
author of Tales From Watership Down
Team Time (30 minutes)

• Facilitator identifies scribe & time-keeper (1 min.)

• Discussion questions (29 minutes)
  • Which staff will be in the different stakeholder groups? (could be disciplines or individual people, i.e. MAs, nurses or individuals)
    • Imagine the positive and negative responses to your proposed changes. How will you respond? What could you say and do?

• Suggested process
  • (5) Team silent brainstorms stakeholders on stickies
  • (7) Facilitator collects & groups stickies (round robin)
  • (3) Dot vote 2-3 most important
  • (5) Brainstorm (silent or as group) strategies for top 1-3
  • (10) Dot vote top strategies for each of top stakeholders
Sharing in Pairs (20 minutes)

• Use same pairs as the last session
• Team 1 shares top stakeholders and strategies for 5 minutes
  • Team 2 captures “I like,” “I wish,” “I wonder” stickies
• Team 2 shares feedback for 5 minutes
• Team 2 shares for 5 minutes
  • Team 1 captures feedback on stickies
• Team 1 shares feedback for 5 minutes
Closing

Next Steps, Upcoming Opportunities, and Learning Session Evaluation Survey

Alexis Wielunski, MPH, Program Manager
Next Steps for TC3 Core Teams

• November coaching call with Denise
  • Review updated Charter
    • Focus on forming the improvement team at the site
    • Developing a measure set
  • Develop plans for testing the change ideas identified today

• December coaching call with Denise, Carly, and Jennie from the evaluation team
  • Discuss your latest evaluation data submission
Peer Learning Site Visit: December 3

On December 3rd, TC3 grantees can visit one of two sites that exemplify innovative population health management practices:

- **Livingston, CA**
  - 6 primary care sites
  - 4,000 patients with hypertension, diabetes and/or ASCVD
  - Patient Self-Measured BP
  - Data Analytics and Data Governance

- **Stockton, CA**
  - 20 primary care sites
  - 15,000 patients with hypertension, diabetes and/or ASCVD
  - Quality Improvement Processes
  - Diabetes Group Visits

*Registration survey has been sent to TC3 team leads and is due by Tuesday, November 19.*
Motivational Interviewing Community of Practice – January – April 2020

In partnership with Elizabeth Morrison Consulting, CCI is launching a Motivational Interviewing (MI) Community of Practice. MI is effective in improving patient health outcomes, patient experience, and job satisfaction.

The MI CoP consists of monthly 6-hour in person training sessions for 4 months, with participants engaging in homework and practice workshops at their organization between sessions.

Space for 2 or 3 participants from about 5 grantees participating in TC3 and PHASE.

Applications due Dec. 2\textsuperscript{nd}

Optional Informational Webinar: November 13\textsuperscript{th} at 12pm
Learn how to use “Design Thinking” to solve community health problems!

This year will focus on social factors contributing to health. Program offers training, coaching, peer learning community, virtual resources, and a travel stipend and runs January 16 to June 18, 2020.

Applications due November 22nd

The CCI Academy

An online learning community with new content published each month to help you achieve your goals in improving health and wellness in your community:
• short courses
• peer workshops
• community calls
• discussion forum
Get virtual resources & program updates with the TC3 Newsletter & Program Portal!

- Monthly newsletter: 3rd Thursday of the month
- Program portal: https://www.careinnovations.org/tc3support/
Thank you for spending the day with us!

*Please complete an evaluation survey before you leave.