The Silent Forgotten Killer: Blood Pressure Control Eliminating Disparities by 2020

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Problem Statement

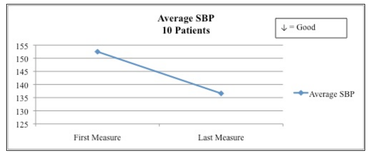
Cardiovascular death related to hypertension is the #1 cause of death in the USA. The greatest health inequity, premature death, kills Black/African American (BAA) patients 13 years before Asian Americans in our county. Typical performance improvement (PI) work can worsen disparities.

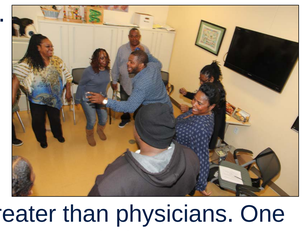
Discovery

1. Through interviewing 50 staff and patients across our safety net system of 11 federally qualified health centers, we co-designed a team-based blood pressure control program. It included universal nursing education with auditing, quarterly provider metric sharing with tips to improve & titration clinics with different staffing models.

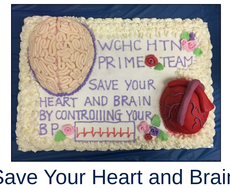
2. Initial phone-outreach to BAA patients failed. A culturally informed approach with African American Health Conductors (community health worker navigators) with lived experience like our patients, was more successful. Church collaboration is challenging.

3. Group interventions had a better no-show rate than individual visits and engaged the BAA community more. A clinical team of all People of Color was appreciated by patients and staff. Our BAA Group Medical Visit for Blood Pressure **"How Low Can You Go?"** lowered SBP (systolic blood pressure).

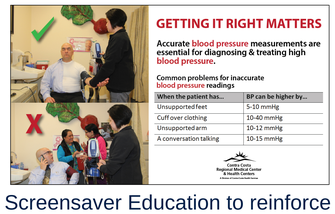




4. Nursing's impact on patients proved greater than physicians. One clinic's pilot taught us proper blood pressure technique was an essential starting point.



"Save Your Heart and Brain" Cake to celebrate nursing campaign



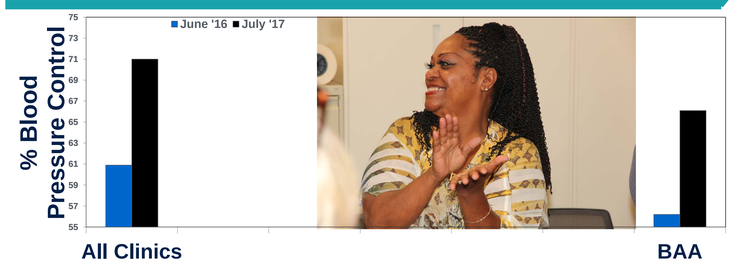
Screensaver Education to reinforce required competency

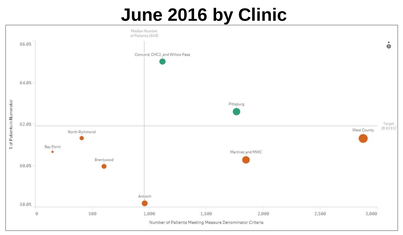
Goals and Objectives

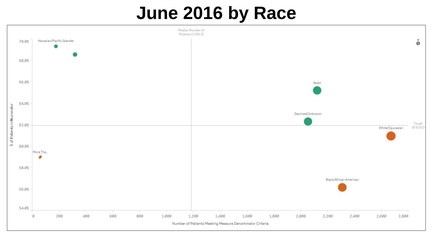
Goal: Improve blood pressure (BP) control and eliminate disparities through a team-based blood pressure control program.

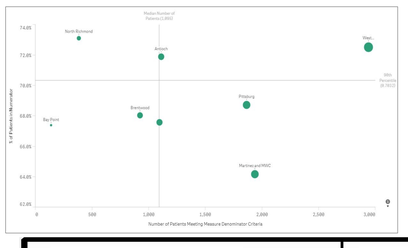
Outcome-oriented Objective: Improve blood pressure control from 60% to 65% (~600 patients) while also improving control amongst BAA from 56% to 65% from June 2016 – June 2017.

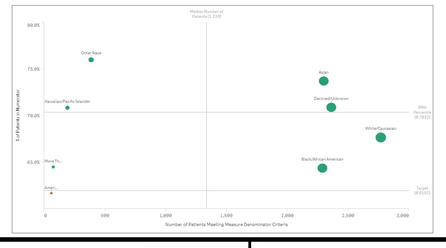
Results











Lessons Learned

- As a leader I engaged front-line staff and patients later than I could have and should have. Early authentic engagement is worthwhile.
- Broad coalition team-based interventions can address geographic and racial health disparities.
- Linking to institutional priorities like the strategic plan and Medical Waiver pay for performance created executive buy-in & resources.
- Embedding equity into PI is necessary but not sufficient.
- Low-hanging fruit interventions can exacerbate disparities if hard to reach populations are left behind. Customized co-designed interventions can overcome inequities.
- Widening stakeholder engagement to all potential workforces involved could minimize union contract battles.

Next Steps:

- Sustain: We achieved spread to all 11 clinics. Now we must monitor standard work monthly to sustain our improvements.
- Monthly Disparity Dashboard Examination: Evolve interventions to leave no population or region behind.

Mission Model Canvas

Key Partners

Nursing (Educators, Managers, Frontline Staff)

Providers (MD's/NP's)

PRIME Executive Team

Ambulatory Care Redesign Team

Information Technology and Data Analytics Team

Health Plan (add BP as a disease priority to complement diabetes and pediatric obesity)

Health Services & Public Health

American Heart Association

Key Activities

Pilot BP Titration Clinic with Different Staffing Models

Pilot BAA Group Medical Visits

Update Providers Quarterly with comparative metrics and tips

Expand RN Patient Education with phone based follow-up

Key Resources

Executive Sponsorship

Staff: overcoming turnover with cross-training & several champions

Space: clinic rooms

Equipment: home & clinic BP cuffs

Value Propositions

Gains:
Access beyond MD face to face

Home Monitoring of BP is convenient and promotes self-management of disease

Less Pains:
Transportation: Phone based follow-up with home BP cuffs

Waiting for provider averted at Group Medical Visits

Maintaining BP at goal saves hearts and brains decreasing disability from stroke and death from heart attacks

Buy-in & Support

Get Buy-In: Culturally informed registry outreach with PCP support.

Keep Buy-In: Share successes with data and stories. Invite patients and frontline staff to weekly meetings.

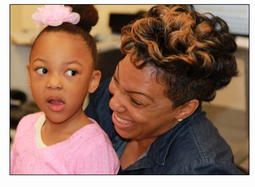
Grow Buy-In: Scale and Sustain with champions and auditing.

Deployment

- Phone Calls
- Texting
- Mailings with Health Plan
- Patient EHR Portal
- Staff Meetings
- Screensavers

Beneficiaries

Patients and Families



Nurses (feel good, get BP right)

Providers (healthy competition)

Mission Budget/Cost

Used existing workforce, no new FTE's. Key was shared mission.

Time and effort from all parties to restructure existing resources especially data analytics and nursing education.

Mission Achievement/Impact Factors

Keep $1.2 million dollars of PRIME Medical Waiver pay for performance money. Increase billable visits through well-attended Group Medical Visits.

Support our system's vision of "becoming the healthiest community in the nation by 2020" through a specific focus on BAA disparity elimination.