SNAPSHOT OF SUCCESS

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Quality Improvement Coaching to Improve Blood Pressure Control in Alaska

Public Health Issue

- High blood pressure, or hypertension, is a major risk factor for cardiovascular disease. Uncontrolled hypertension leads to many serious health problems including stroke, heart attack, heart failure, kidney disease, vision loss, and dementia.
- These consequences of high blood pressure decrease life expectancy, increase U.S. health care costs and decrease productivity.
- Focusing public health resources on controlling high blood pressure can help prevent the serious effects of high blood pressure.
- Nearly 30% of Alaskans report having high blood pressure. Alaska Native and black Alaskans are more likely to report having high blood pressure than the Alaska population as a whole. Alaska priority populations also include lower socio-economic status and those living and/or working in rural areas.

Program Action

- The State of Alaska Department of Health and Social Services/Division of Public Health is partnering with the Alaska Primary Care Association on a quality improvement project in FQHCs which serve a large population of Alaska Natives, those of lower socioeconomic status, and those in rural locations.
- This project was designed in part using the Agency for Healthcare Research and Quality Primary Care Practice Facilitation strategies.
- Health care practice quality improvement teams travel to community health centers to provide training, facilitation, and coaching for health care providers, clinic staff, and administrators on how to improve the care of patients with high blood pressure.
- The teams use quality improvement processes modeled on the Institute for Healthcare Improvement Model for Improvement, provide evidenced-based resources on how to improve blood pressure control, and provide training on team-based, coordinated care.
- FQHCs participating in this project were chosen because they have reliable blood pressure control data, they have rural locations throughout Alaska, and they can benefit from these quality improvement resources.
- Six clinics that have the lowest percentage of hypertensive patients with controlled blood pressure are invited to participate as a cohort each year.

Impact

- Each of the six Cohort 1 clinics improved their percentage of patients with adequately controlled blood pressure. Between 2013 and 2015, improvement ranged from 2.6 to 37.6 percentage points. Cohort 2 clinics have not been evaluated yet.
- In one year, clinics made 13 clinical system changes which affected 3,635 adult patients with hypertension.
- Clinics implemented hypertension registries with patient referral and tracking capabilities within their electronic health records.
- Successful processes and lessons learned were spread to other clinics in some of the FQHCs with multiple clinic sites.
- Clinics improved their patient flow and the effective use of electronic health records.
- Staff and patient engagement in closer management of hypertension and diabetes improved.
- Lessons learned are being applied to diabetes and cancer focused process improvement work.

Janice Gray
Alaska Department of Health and Social Services, Division of Public Health
907-465-8670 · janice.gray@alaska.gov

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Project Objectives

The following are the objectives of the Alaska Division of Public Health Federally Qualified Health Center (FQHC) quality improvement facilitator coaching project:

1. To increase the percentage of patients 18-85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90)
2. To establish a facilitated peer network of FQHC/Community Health Center clinic staff and providers as a platform for sharing best practices and methods among the 29 Alaska FQHCs
3. To increase the number of referrals to diabetes self-management education programs for patients with diabetes

Data/Other Information Collected

Monthly data reports from the Alaska Primary Care Association quality improvement facilitators to the state include:

- List of new or ongoing quality improvement projects in each of the clinics
- List of system changes made in each of the clinics
- Number of site visits, team meetings, and Plan-Do-Study-Act cycles completed
- The percentage of patients ages 18-85 with a diagnosis of hypertension and the number whose blood pressure was adequately controlled (<140/90)
- Number of webinars/teleconferences, and trainings provided
- Number of clinics that have spread system changes within their clinic and/or shared practices with other clinics
- Number of adult patients with hypertension with access to health care systems/policies implemented by this project
- Number of sites that have met clinical quality goals
- Number of sites that have a hypertension registry and/or a diabetes registry
- Number of sites designated as patient-centered medical homes

Challenges

- Electronic health record functionality problems
- Ineffectiveness of training staff members from many clinics at a large meeting led to adjusting training sessions to become clinic-specific and on-site at clinics.
- Lack of interest or buy-in from some clinic staff
- Staff turnover
- Need for staff training on the importance of hypertension control
- Loss of interest by one clinic (due to staff turnover) which led them to quit the project

Lessons Learned

- Paying attention to hypertension at daily meetings helped medical providers and staff stay focused on clinic blood pressure goals
- On-site training and engagement of clinic staff, health care providers, and administration in the quality improvement process can increase the number of patients with hypertension whose blood pressure is in control (<140/90) when the training is augmented by the effective use of evidence-based protocols and electronic health records, by ongoing coaching and facilitation, and is supported through a peer network.

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Alaska Department of Health and Social Services, Division of Public Health
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