CHRONIC DISEASE PREVENTION & HEALTH PROMOTION

WEBINAR SERIES

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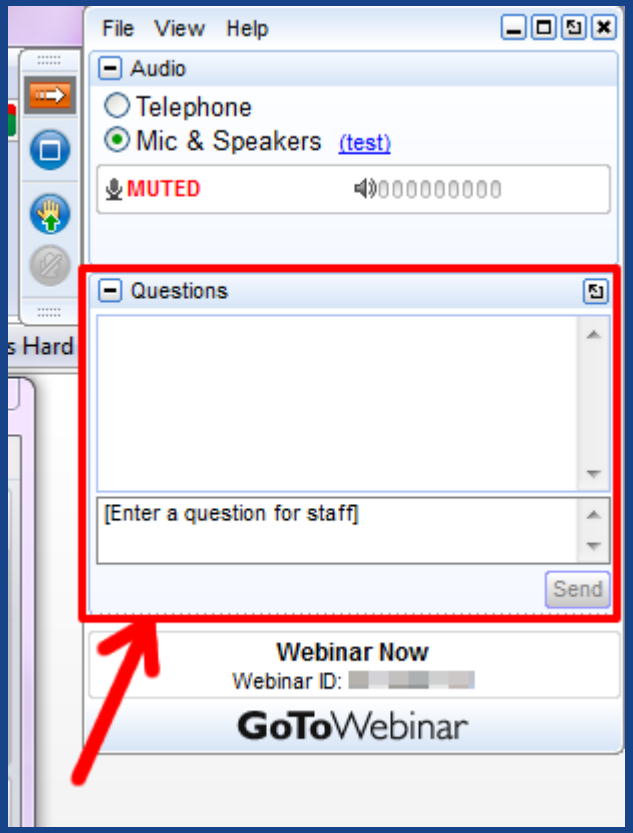

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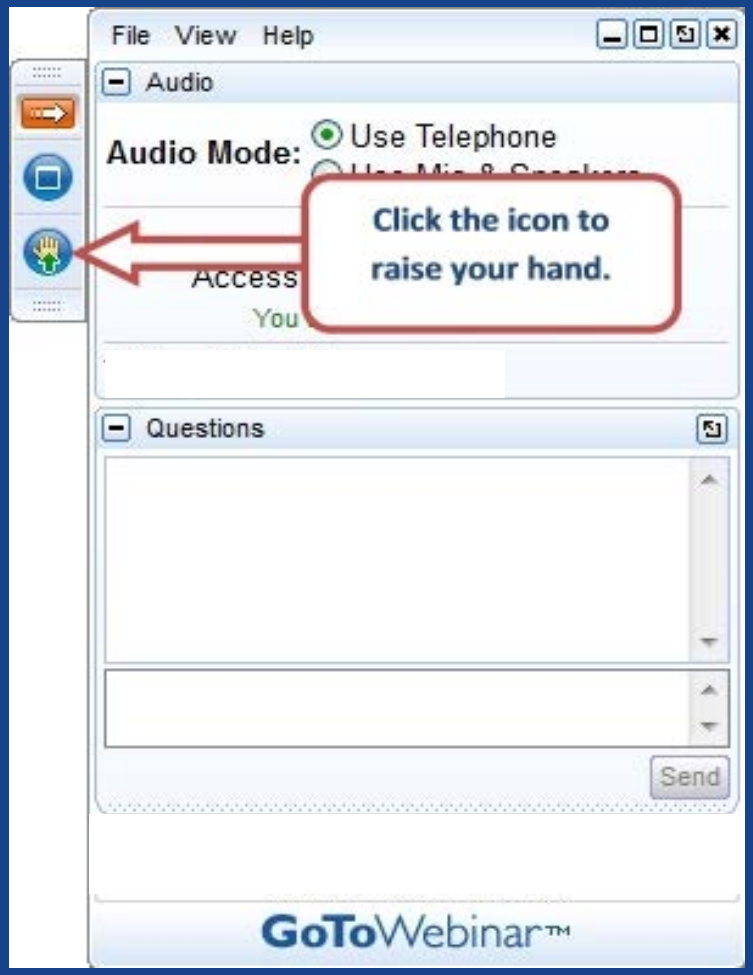

Eastern Aleutian Tribes Hypertension Control Project

State, Tribal and Community Partnerships to Identify and Control Hypertension

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Section of Chronic Disease Prevention and Health Promotion, DPH, DHSS

15 May 2018

Photo: Cold Bay

Objectives

- Provide an overview of the project
- Review of Alaska hypertension data
- Provide an overview of the systems-focused QI coaching framework
- Review the initial AIM statements and team strategies
- Describe successes and challenges


Photo: King Cove

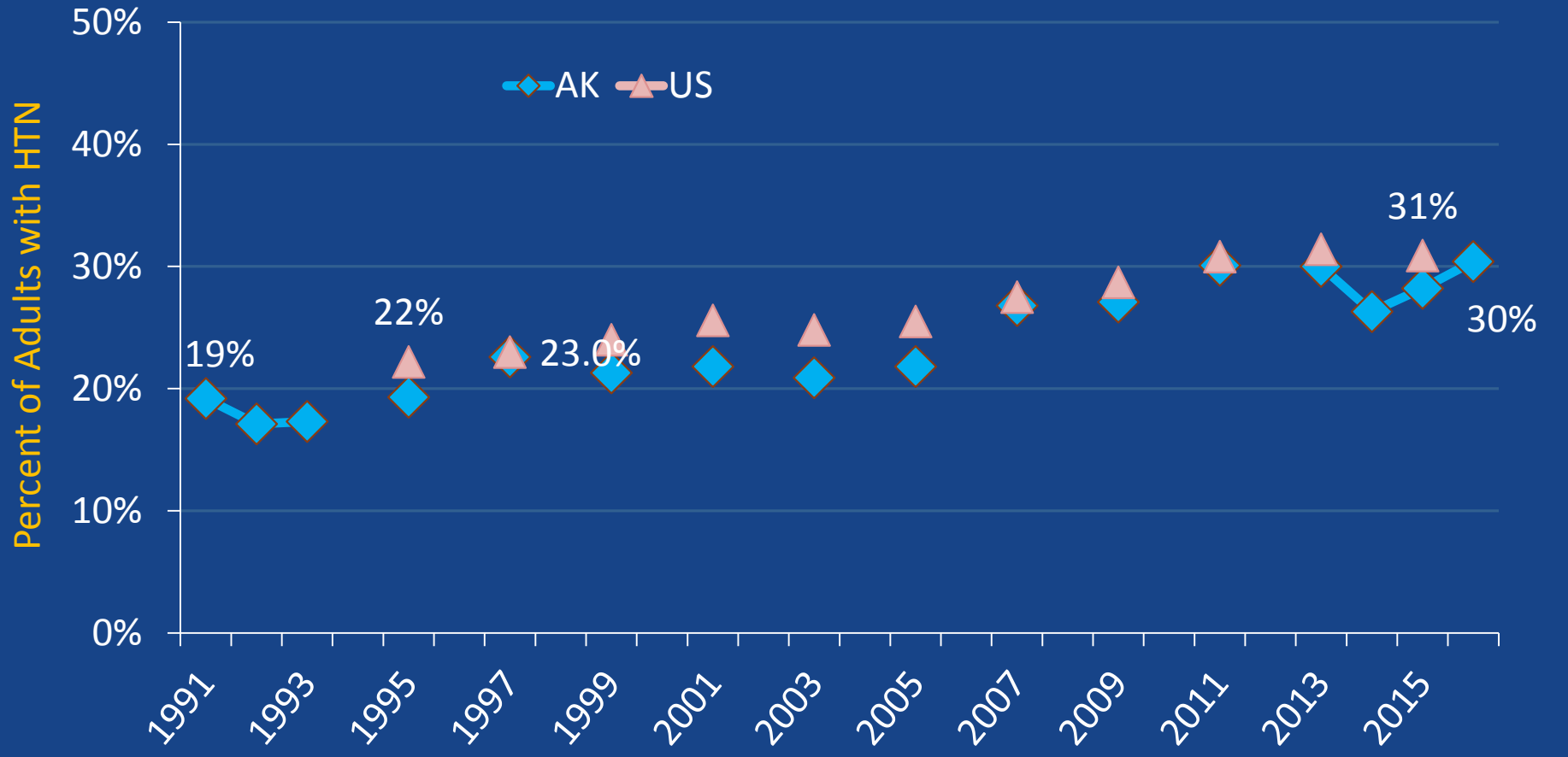
Eastern Aleutian Tribes Hypertension Control Project

EASTERN ALEUTIAN TRIBES

CLINIC SITES

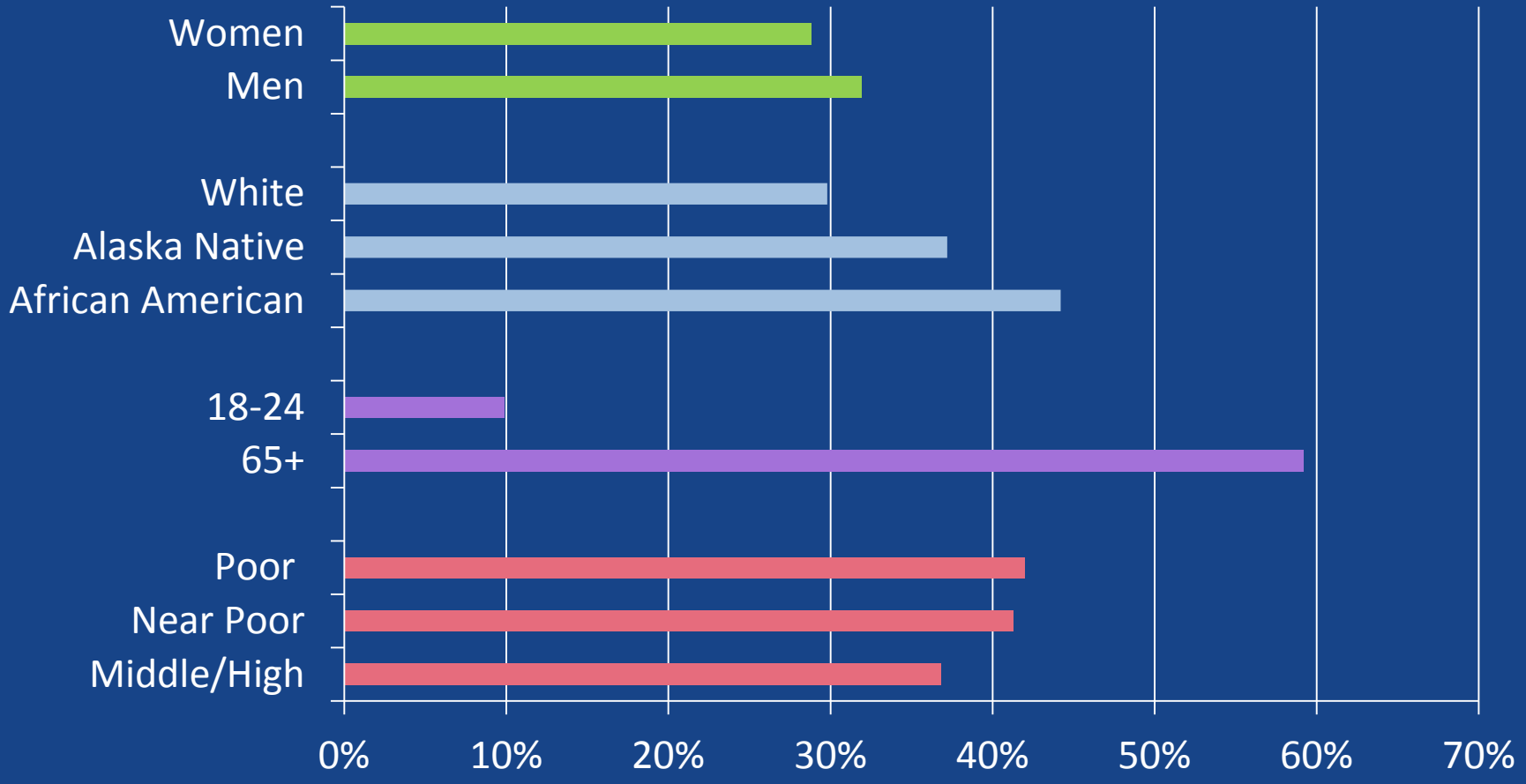
1. Adak
2. Akutan
3. False Pass
4. Cold Bay
5. King Cove
6. Nelson Lagoon
7. Sand Point
8. Whittier

Hypertension Prevalence among Adults: Alaska and US, 1991-2016 (BRFSS)



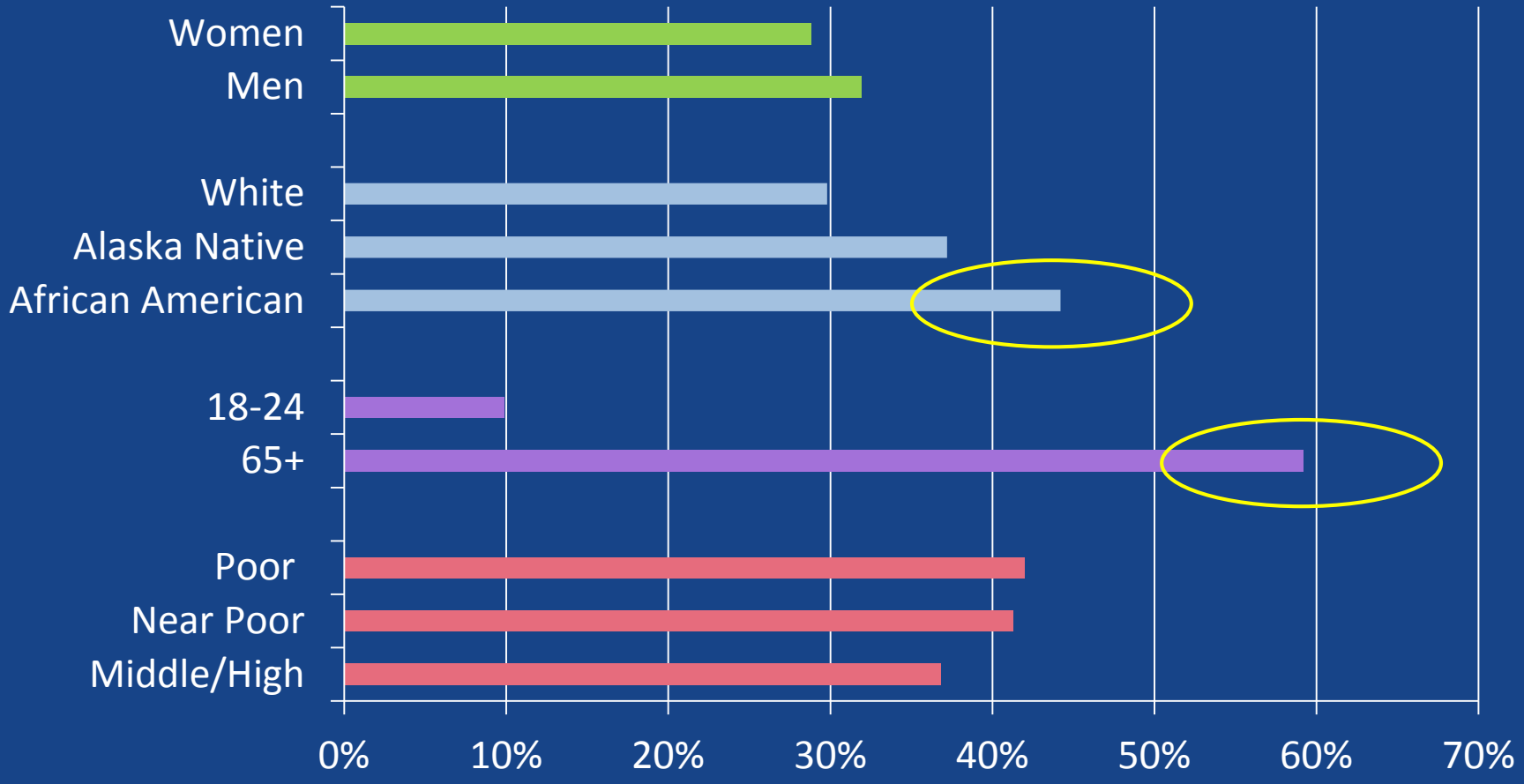
Source: Alaska BRFSS
"Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?"

Adult Hypertension Prevalence: Alaska, Select Groups, 2016 (BRFSS)



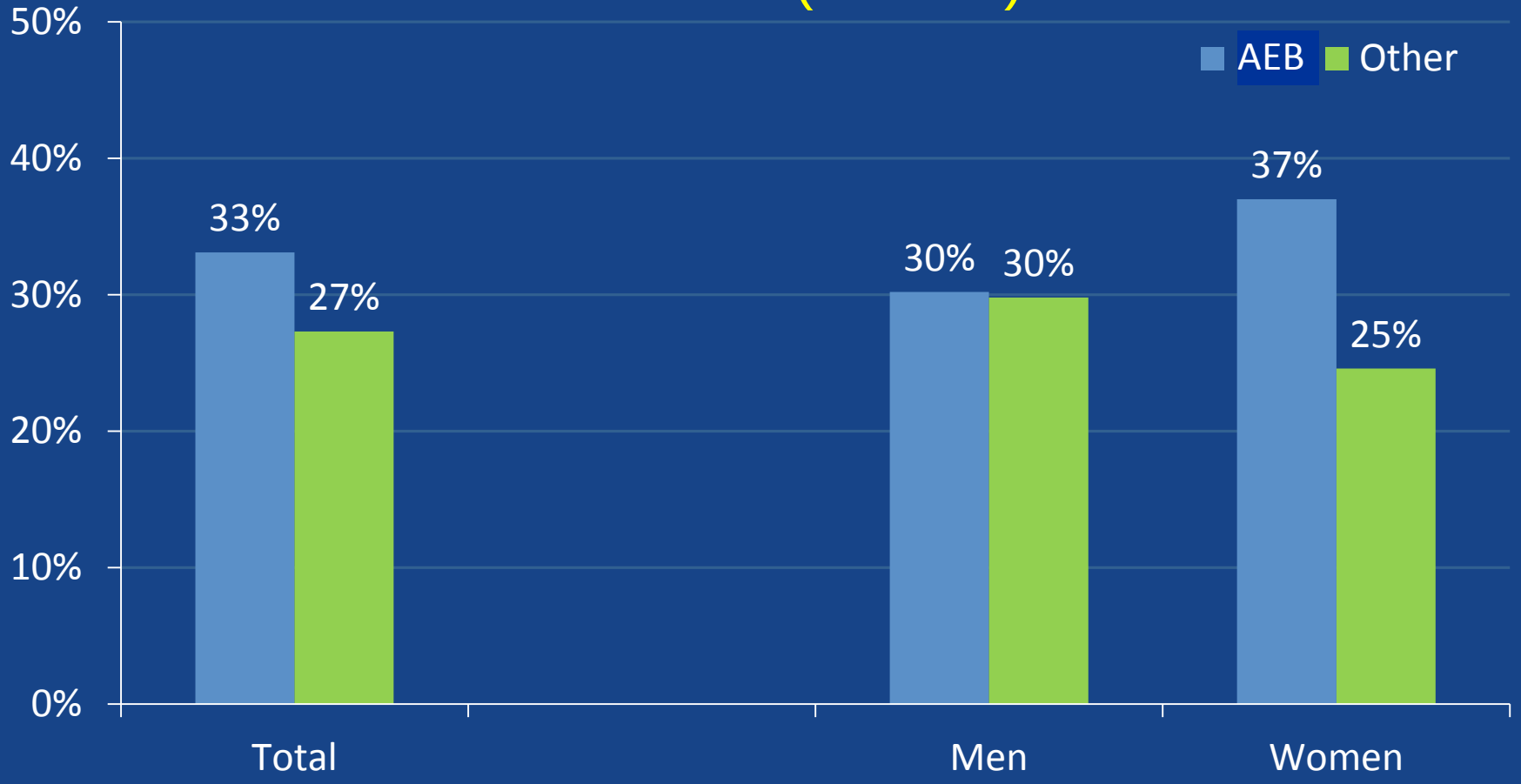
BRFSS – Behavioral Risk Factor Surveillance System

Adult Hypertension Prevalence: Alaska, Select Groups, 2016 (BRFSS)



BRFSS – Behavioral Risk Factor Surveillance System

Adult Hypertension Prevalence: Aleutians East Borough vs. Other Regions of Alaska, 2005-2015 (BRFSS)



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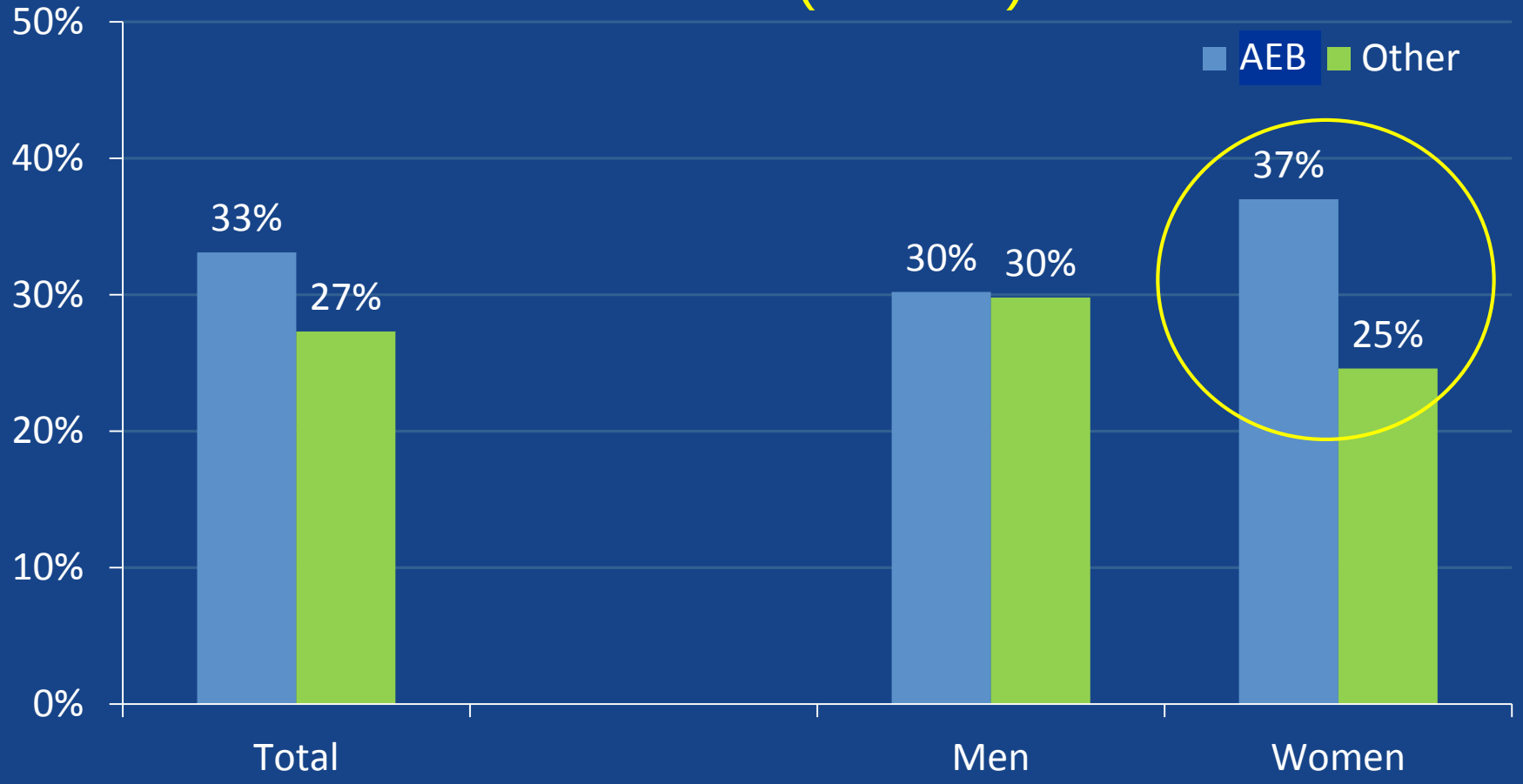

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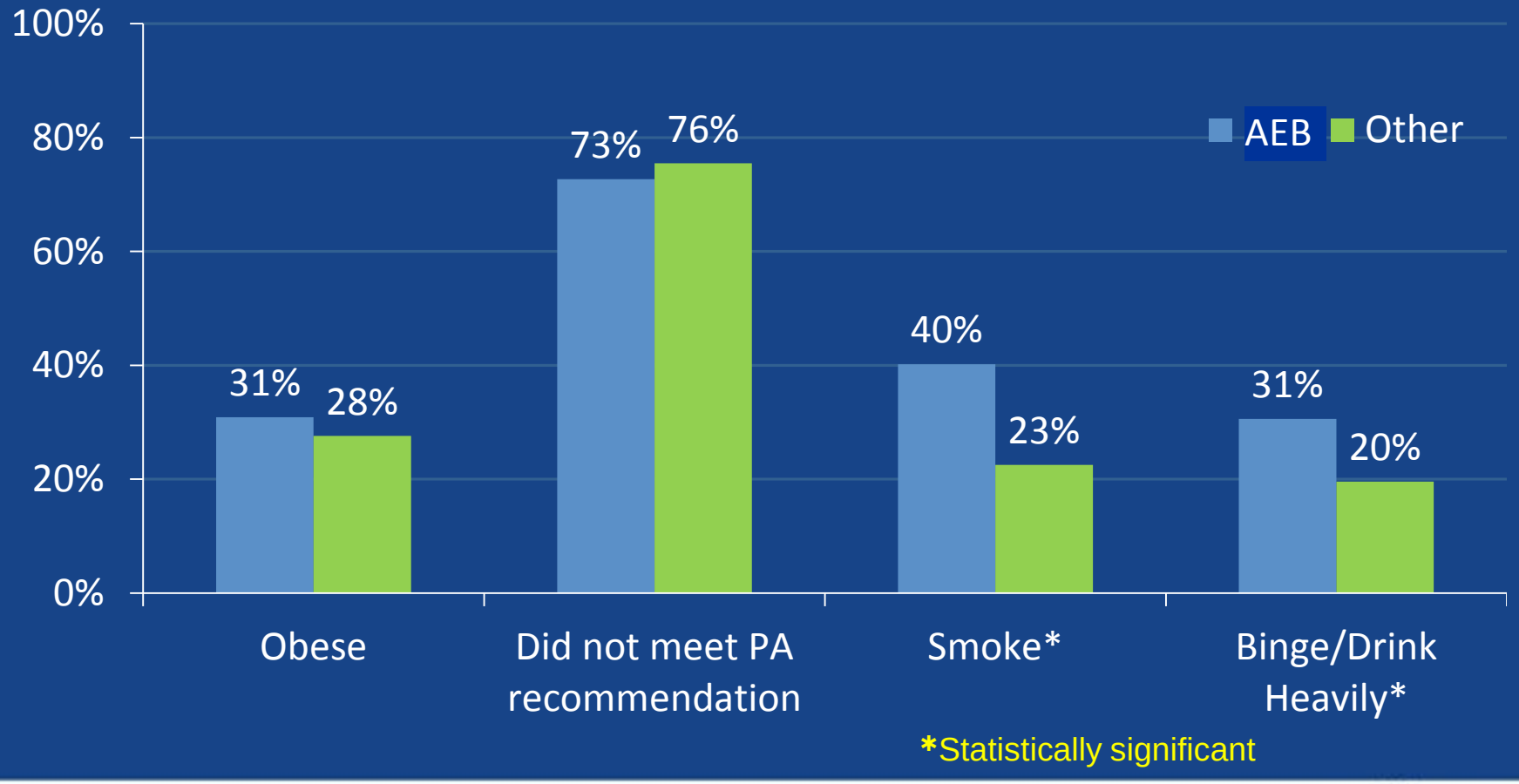
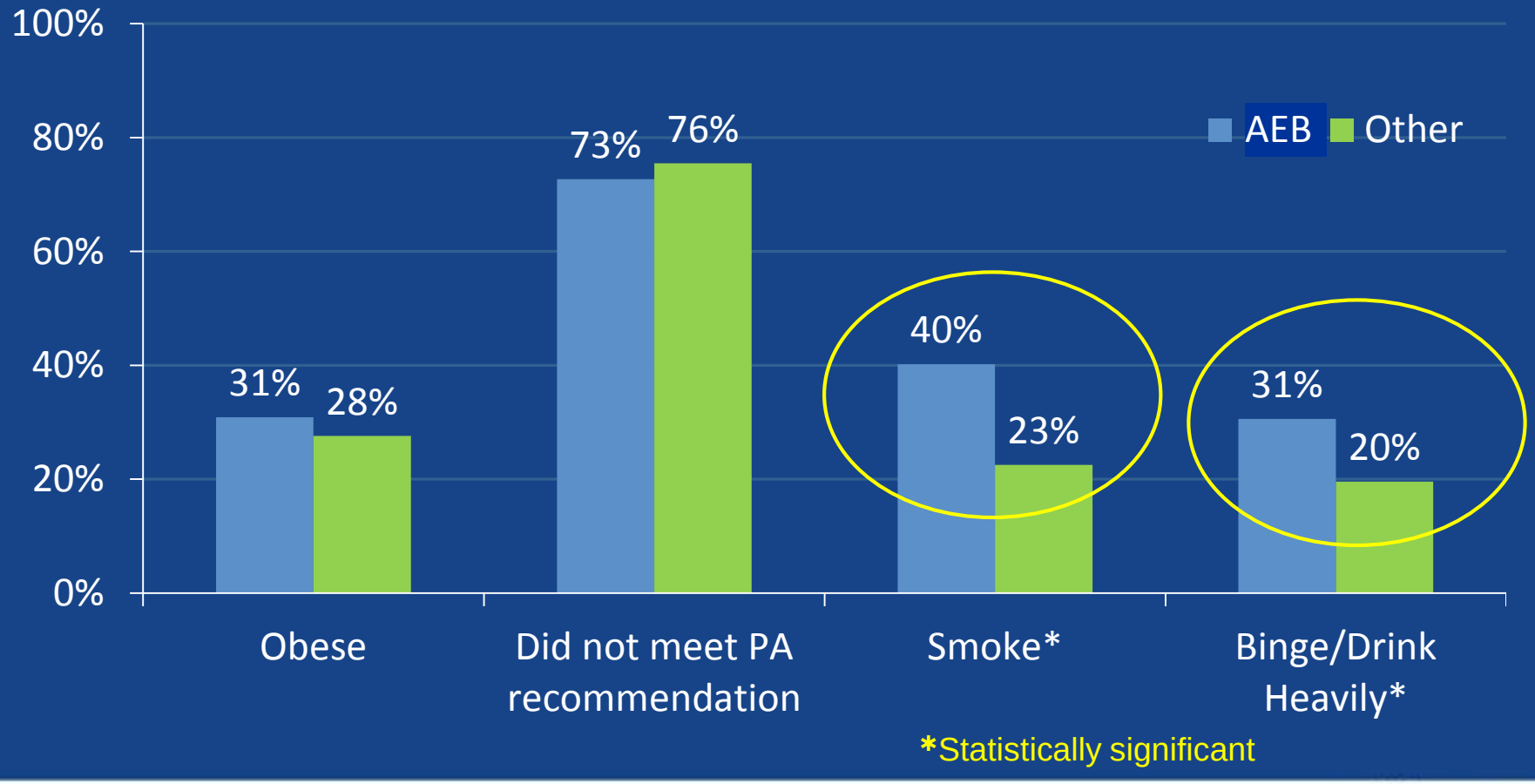


*Statistically significant

PA – Physical Activity

Adult Hypertension Risk Factor Prevalence: Aleutians East Borough vs. Other Regions of AK, 2005-2015 (BRFSS)



*Statistically significant

PA – Physical Activity

ASTHO Hypertension Control Project Partners

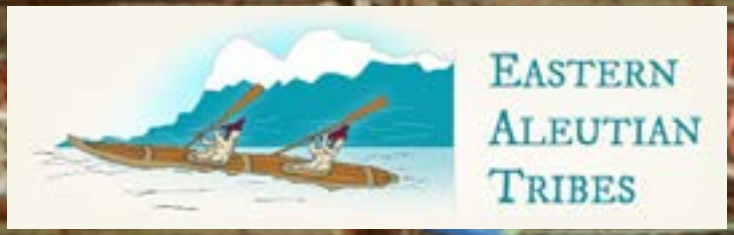


Photo: King Cove

Learning Collaborative Goals

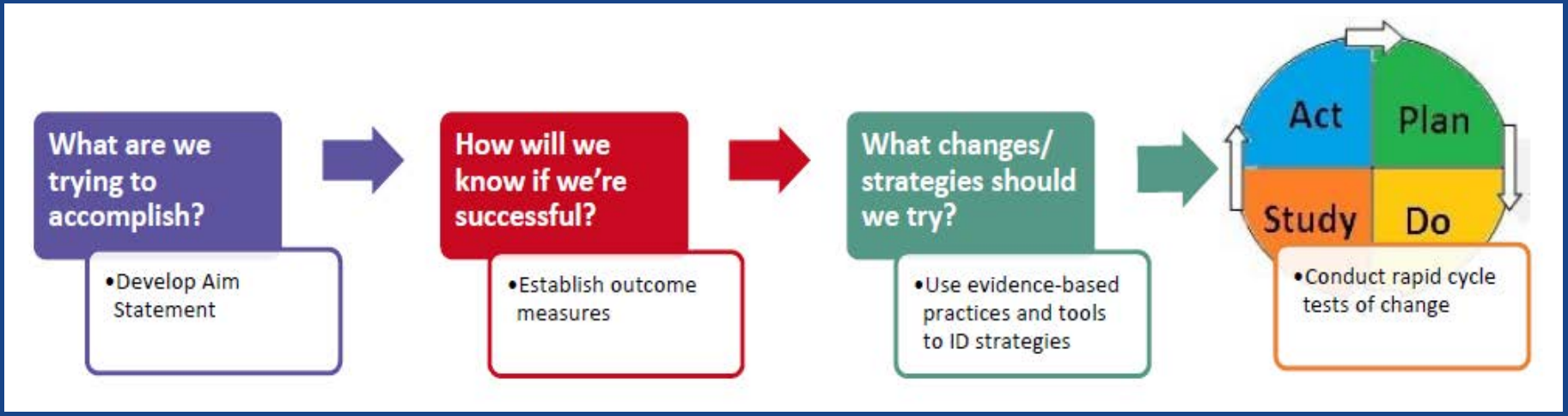
- Improve hypertension control and prevention and achieve the national Million Hearts goal
- Increase the percentage of patients 18–85 years of age who had a hypertension diagnosis and whose blood pressure was adequately controlled during the measurement year
- Identify and build networks and cross-sector partnerships to control hypertension
- Test models for collaboration between public health, healthcare, and community partners
- Deploy a quality improvement process to affect practice and policy at all levels of the system

Six Key Themes To Lasting Success

1. Build partnerships across public health, healthcare, and communities.
2. Use data to identify patients and drive quality improvement.
3. Standardize practices and protocols for treatment, workflows and referrals.
4. Gain support from leadership, payers, and policymakers.
5. Incorporate successful strategies in state strategic plans.
6. Leverage other statewide initiatives and chronic disease prevention efforts.

ASTHO Framework for Systems-focused Quality Improvement

Based on the Institute for Healthcare Improvement Breakthrough Series



Alaska/East Aleutian Tribe's AIM Statements

Patient-focused AIM Statement:

- By June 30, 2018, among active patients 18-85 years old in EAT clinics, improve the % of patients whose hypertension is in control and reduce the % of patients with elevated blood pressure who have not been diagnosed with hypertension by 10% each through improved medication and BP monitoring access and team-based care.

Systems-level AIM Statement:

- By June 30, 2018, improve access to affordable medications for rural and remote Alaskans through partnerships.

Project Teams

- Eastern Aleutian Tribes Clinical Team
- Eastern Aleutian Tribes Billing/Administrative Team
- Alaska Primary Care Association Team
- State of Alaska Division of Public Health Team

EAT Initial Clinical Team Strategies

- Create a universal protocol for hypertension management for all EAT clinics
- Enroll all patients seen for outreach clinics (flu, etc.) to get the patients in the system to allow for follow-up
- Include BP checks for all patients seen in outreach clinics
- Map patient flow in all of the 8 clinics
- Train all clinic staff members to take blood pressures to allow all staff members to work to their fullest ability and allow for better follow-up during the visit
- Include BP monitor in clinic waiting rooms

EAT Clinical Successes

- Two HTN protocols are being created for use in all 8 EAT clinics – one for new and one for chronic HTN patients
- New HTN registries were created in 3 of the EAT clinics
- All clinic visits now include BP checks at critical points in pt flow
- Created a process to enroll all patients seen in outreach clinics in the EAT EHR
- All outreach clinics now include BP checks for all patients
- Patient flow was mapped in all 8 EAT clinics and 5 improvement points were identified in each clinic

EAT Clinical Successes

- Trained all clinic staff members to take BPs
- BP monitors are being added to some clinic waiting rooms
- Seeking funding to purchase BP monitors for community locations
- Medicaid provides funding for covered individuals to purchase home BP monitors
- Learning management system was purchased and information was loaded for tracking and providing training.

EAT Clinical Activities Still in Progress

- Complete final versions of new and chronic HTN protocols
- Create HTN registries for 5 additional EAT clinics
- Secure funding to purchase BP monitors for community locations
- Expand the use of the Learning Management system
- Institutionalize accurate BP measurement training into ongoing training system

EAT Initial Billing/Admin Strategies

- For total population of EAT and by clinic, create reports that include patients 18-85 with:
  - diagnosed hypertension
  - controlled hypertension
  - uncontrolled hypertension
  - elevated blood pressure and no diagnosis of hypertension

EAT Billing/Admin Progress

- Provided clinic-specific data for all 8 Eastern Aleutian Tribes clinics throughout the project
- Partnered with ANTHC to create EHR reports – currently finalizing the accuracy of the reports
- Reports will be available in all EAT clinic sites
- Creating Dynamic Work List in all EAT clinics

APCA Initial Strategies

- Identify content for team-based care QI facilitation training; content aligned with PCMH content
- Develop algorithm in collaboration with EAT and SOA
- Develop training for:
  - Onsite, in-person
  - Virtual (requires test of platform)
  - Community Health Worker apprentices, including roles and responsibilities
- Develop training schedule for EAT clinic sites
- Identify and develop measures and goals for EAT system, individual EAT clinics, APCA
- Deliver and evaluate training
- Research options for pharmacies/improving access to medications

APCA Successes

- Identified and developed measures and goals for EAT system and individual EAT clinics
- Created, delivered, and evaluated team-based care, PCMH, and QI training for all 8 EAT clinics
- Training was developed for:
  - Onsite, in-person
  - Virtual (required test of new learning platform)
  - Community Health Worker apprentices, including roles and responsibilities

APCA Successes

- Enhanced huddles – include more staff members, have patient information available of who's coming in and why
- Able to use clinic-specific data to show progress
- Developing HTN algorithm in collaboration with EAT and SOA
- Research options for pharmacies/improving access to medications

SOA Division Of Public Health Initial Strategies

- Explore how the 340B program can support improved access to medication
- Explore options with private pharmacies
- Determine what supports or barriers exist within Medicaid regarding medication access
- Convene stakeholders to address certification and reimbursement for Community Health Workers
- Identify other root causes related to medication access and adherence

SOA Division Of Public Health Activities

- Medication access/payment research:
  - Federal 340B program – determined that this was not a viable option for many of the FQHCs
  - Medicaid – discovered that most antihypertensive meds are available with 90-day refills, home BP monitors are covered
- Community Health Workers - certification and reimbursement
  - No viable payment/reimbursement mechanism was identified
  - No certification mechanism was identified
- Mail delivery barriers were identified in some rural areas

EAT Hypertension Data

Data collected by EAT IT staff members manually searching each patient record:

Date	Percent of EAT Patients with HTN Controlled (BP <140/90)
Dec 15, 2016	8%
June 21, 2017	17%
Feb 26, 2018	57%

King Cove Clinic: Data collected by EHR (Cerner) clinical data report

Number of patients identified as hypertensive with reduced blood pressure			
Dates	Pts Seen with Elevated BP (>140/90)	Number Improved	Percent Improved
Aug 1-Sept 30, 2017	167	10	24%
Mar 1-Apr 30-2018	143	15	35%

Alaska Team Members

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- Patty Linduska
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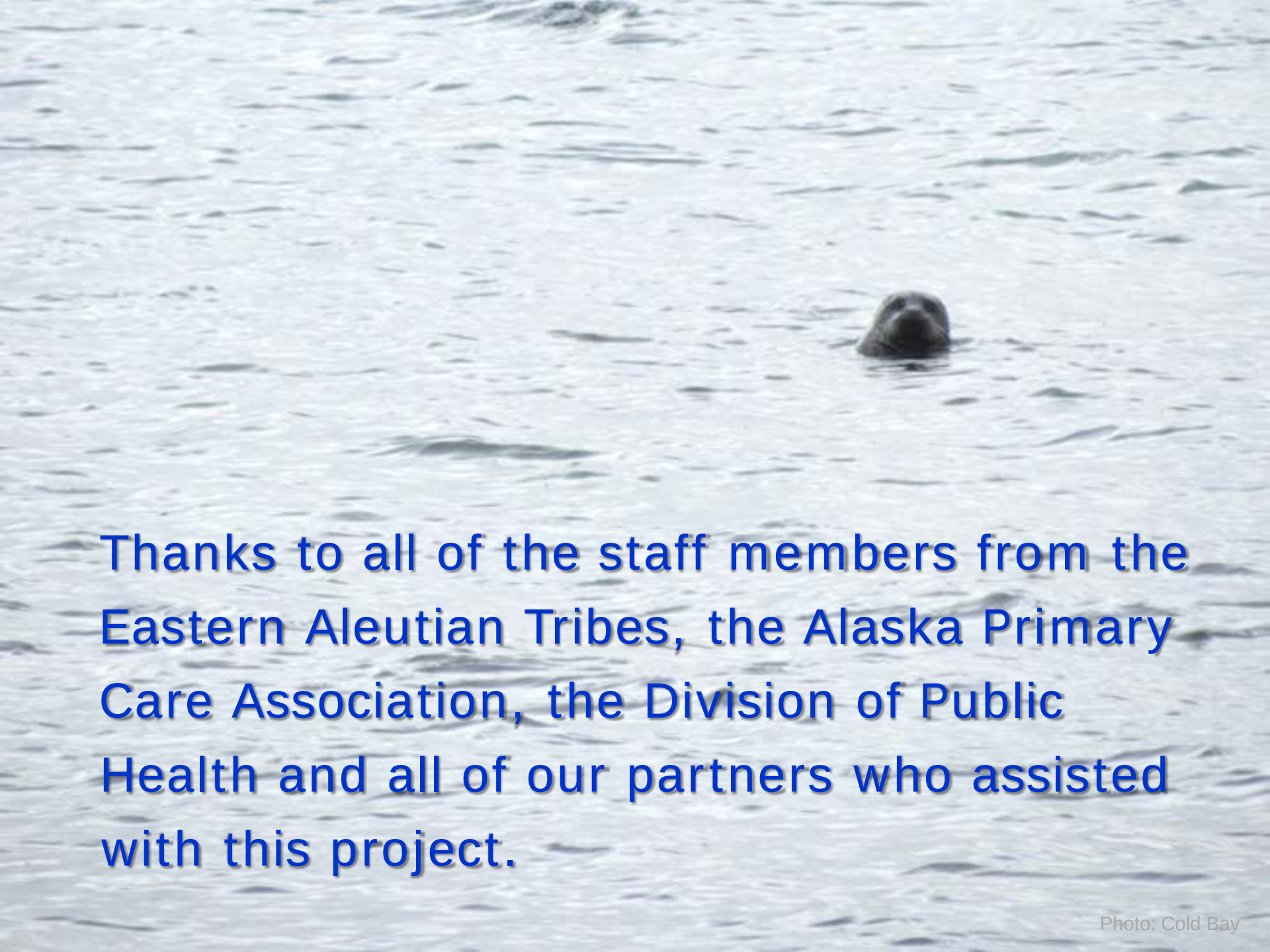

Thanks to all of the staff members from the Eastern Aleutian Tribes, the Alaska Primary Care Association, the Division of Public Health and all of our partners who assisted with this project.

Photo: Cold Bay

Thank You!

Questions?

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Photo: King Cove