Be There San Diego
Preventing Heart Attacks & Strokes

Medical Director Panel
Hiding in Plain Sight:

Dealing with Undiagnosed Hypertension in the Community Health Center and in Your Practice

Medical Director Panel
BeThere San Diego
July 31, 2017

Jim Schultz, MD, MBA, FAAFP, DiMM
Chief Medical Officer
Neighborhood Healthcare
Hiding in Plain Sight (HIPS)

- CDC HTN Prevalence estimator tool
- [https://nccd.cdc.gov/MillionHearts/Estimator/](https://nccd.cdc.gov/MillionHearts/Estimator/)

<table>
<thead>
<tr>
<th>Result</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>23146</td>
</tr>
<tr>
<td>Expected hypertension prevalence</td>
<td>22.8%</td>
</tr>
<tr>
<td>95% confidence interval range (low)</td>
<td>22.5%</td>
</tr>
<tr>
<td>95% confidence interval range (high)</td>
<td>23.0%</td>
</tr>
<tr>
<td>Actual NHCare Prevalence</td>
<td>27.52%</td>
</tr>
</tbody>
</table>

### Validation

![Expected Hypertension Prevalence Chart](chart.png)
**Hiding in Plain Sight (HIPS) - NHC Results**

**NHC HIPS percentage (N= 27,675 adult pts with >=1 visit)**

- **2.9%**
- **2.4%**

**HIPS- NHC Results- Why HIPS % so low?**
HIPS at Neighborhood Healthcare

Clinical Dashboard

- CRC: 62 % (Goal: 55 %)
- AIC: 75 % (Goal: 71 %)
- DM ALL: 54 % (Goal: 80 %)
- DIGOXIN: 43 % (Goal: 61 %)
- PNEUMO: 74 % (Goal: 50 %)

- BREAST CA: 70 % (Goal: 72 %)
- HTN: 80 % (Goal: 64 %)
- DIURETIC: 84 % (Goal: 91 %)
- PEDS IMM: 78 % (Goal: 70 %)

- CERVICAL CA: 75 % (Goal: 77 %)
- DM BP: 81 % (Goal: 60 %)
- ACEARB: 85 % (Goal: 92 %)
- ANTI-PSY GLC: 76 % (Goal: 50 %)

NOTES:
- To get NHC org average, unselect all facility
- Refreshed weekly
HIPS at Neighborhood Healthcare

Steps to Take - Summary

- Refine and Standardize BP Measurement
- Establish a real time point-of-care alert
- Find and recall your potential HIPS patients
  - Think outside of the parameters of a usual office visit
- Establish and use treatment pathways to minimize clinical inertia and maximize follow up
- Measure and report results down to the individual provider and team level
Parag Agnihotri, MD
Medical Director, Continuum of Care
Sharp Rees-Stealy
Self-Measured Blood Pressure Monitoring
Improving Hypertension Performance:
SCPMG
July 31 2017

Todd Martin, MD - Physician Director of Complete Care Medicine

Complete Care Management
Direct Patient Care Staff Process

• All patients’ blood pressures are checked with a standardized process at check-in to primary care and most specialties
  • All staff have been trained on proper blood pressure taking technique
  • Initial elevated blood pressures are repeated immediately
  • If second blood pressure is elevated, “elevated blood pressure” is entered as a chief complaint.
  • Follow up instructions are placed in the After Visit Summary to ensure a 3rd BP is taken at the end of the visit, and follow up is arranged if still elevated
  • Specialty Departments: Patients with elevated BP are directed to the nurse’s clinic for follow up and chart cc’d to the PCP to ensure follow up
Nurse/MA Follow Up

• Nurses/MAs: Nurse-only visits for blood pressure check
  • Patients with elevated blood pressures are scheduled for a follow up nurse/MA visit called MABP10
  • Repeated elevated blood pressures are offered “just in time” management by the PCP to adjust medications. Follow up is repeated in 1 week
  • Normal blood pressures are documented
POINT / CSG Performance
From 2012 - 2017
Barriers/Lessons

• Barriers
  • Consistency in Back Office Staff arranging proper follow up
  • Physician barriers in doing just-in-time medication intensification
  • Following up with patients who do not return for scheduled follow up

• Lessons
  • Control rates fall when outreach efforts are redirected to other tasks
  • Training and staff accountability are crucial
Rakesh Patel, MD, FAAFP, CPE
Medical Director of Operations
Our Challenge

- 67,000 total patients
- 5,694 Pre-diabetics in 2016
- 5,932 Active Diabetics
- 98% of our patients < 200% FPL
- 8-10% unfunded
- 50% non-English speaking (Spanish/Arabic)
## Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 40 to 70 years who are overweight or obese</td>
<td>The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</td>
<td>B</td>
</tr>
</tbody>
</table>
A1C: Patient has diagnosis of Diabetes, CVD (Cardiovascular Disease), HTN. Or Age between 40-70 and BMI >=25
Omada Overview

Prevent®

Prevent is an online health program. We surround you with support and tools you need to lose weight and reduce your risk of getting diabetes.

WEEKLY LESSONS
Learn new ways to eat healthy and become more active.

WIRELESS SCALE & Pedometer
A wireless weight scale and more, mailed to your home.

CARING HEALTH COACH
Who will guide you and answer your questions.

ONLINE GROUP SUPPORT
A small peer group for extra support.

If you qualify, the Prevent program is available at no cost to you, thanks to Neighborhood Healthcare.

YOU CAN JOIN PREVENT
2. Fill out the application
3. Check your email in 1-2 days for next steps on how to get started

GET STARTED TODAY
preventnow.com/nhc2016

Or Call (888) 409-8687
Monday through Friday, 8am-6pm Pacific
Results

• 638 individuals identified as being at risk for type 2 diabetes or heart disease

• 88% of emails delivered

• Enrolled 6% of emailed members within 2 weeks
Outcomes

• 86% of those who started the program, completed it

• 36% met or surpassed their goal

• Over 1 in 3 graduates lost at least 4% of their body weight by week 16.
Pharmacist as Part of the Care Team

Dan Dworsky, MD
What Did We Do?

- Within CMMI grant we co-located a pharmacist with 17 IM providers with the goal of getting high risk CVD patients on the recommended medication bundle
- 1/4\textsuperscript{th} of those patients required BP control
- 96\% of those patients achieved control within 3.9 contacts (1 face to face visit, 2.9 telephonically)
- The above lead to expanding pharmacist as part of the care team for HTN control
Organizational and Patient Benefits

- More rapid titration of patients to goal BP
- Improved physician access for new or more complex patients
- Lower cost per patient titrated to goal BP
- Complete medication reconciliation within EMR
- Improved patient life style modification counseling by using pharmacist
- Improved patient medication compliance via generic substitution, use of combined meds, once a day meds and review for medication interactions
- High patient acceptance and satisfaction
Barriers and Counter Measures

- Physician’s attitudes and fears
  - “That’s my job”
  - Fear that they may harm their patient by using pharmacist
  - Fear that process may create more work physician not less
  - Need to learn new process to refer patient to pharmacist
  - Fear of lost income

- Counter Measures
  - Showed them data from other organizations and studies
  - Showed them that their patient access was poor
  - Designed are positive communication feedback loop from pharmacist to PCP thru EMR for their patients
  - Co-located pharmacist on site to create positive relationships between MD and pharmacist
  - Engaged physician’s staff in identifying patients for referral to pharmacist program
  - Created reports for pharmacists to identify HTN patients and outreach to MD for referral
Next steps and recommendations

- **Next step:** Move to opt out vs opt in referral process
  - Make referral to pharmacist easier to do than not referring to a pharmacist
    - Create standing orders so no need for MD to take positive action for referral
    - Have pharmacist get daily report to do outreach to any patient who left the office with a second BP ≥140/90

- **Recommendations**
  - Co-locate pharmacist: It is all about relationships
  - Create positive communication feedback loop: It is all about feelings of control
  - Insure there are more positives to using program for MD than just patient BP control