Reducing Disparities in Blood Pressure Control Rate for Hypertensive Patients at East Oakland, California

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Project Aim
To reduce health disparities by race/ethnicity and gender in patients with hypertension while supporting the Triple (or Quadruple) Aim beginning with one care team before scaling to two additional care teams at East Oakland by October 2017

Background
Lifelong Medical Care (LMC) is a Federally-Qualified Health Center based in Northern California. Our organization is invested in advancing the health and experience of all patients while reducing costs and burnout. LMC serves low-income communities of color who are either under Medicare, Medicaid, or uninsured. Patient demographics are predominantly Black, Hispanic and White. Since Blacks and Hispanics are at a higher risk than Whites, our aim is to reduce health disparities. Blacks develop high blood pressure more often, and at an earlier age, than Whites and Hispanics. Further, prevalence of controlled hypertension is higher among Whites than Blacks and Hispanics.

Project Design
LMC pursued a four-pronged approach on advancing health equity: improve population health, deliver team-based care, increase patient engagement, and develop an institutionalized framework. By identifying drivers to achieve the project’s aim, we determined change tests centered on data measurement and reporting, staff workflows, patient involvement and social determinants of health integration.

Changes Tested
Plan-Do-Study-Act (PDSA) cycles were conducted to make systems-level improvements at LMC’s East Oakland location. (1) Data was stratified by provider, race/ethnicity and gender. Clinical Care Assistant reported blood pressure control rates monthly to care teams via email, Quality Board, and All Staff meetings. (2) Front Desk Receptionists performed reminder calls to patients with hypertension, asking them to take and bring medications to upcoming visits. (3) If patients had an elevated blood pressure reading, Medical Assistants tested to see if blood pressure improved once measured a second time at the end of the visit. Additional change tests include outreach letters, medication adherence reporting, nurse-led hypertension clinics, and a 6-session hypertension shared medical visit.

Lessons Learned
In order to do improvement work, support from executive and site-level leadership is required. We learned that all levels of the care team must be involved throughout the process. Dedicated time must be available to discuss performance and to determine next steps. Data must not only be available, but also be timely, actionable and meaningful to the end-user. We learned that utilizing QI tools (e.g. charter, driver diagram, flowchart, PDSA, run chart, etc.) facilitates team-building and increases staff engagement. By focusing on localized efforts at a small scale, we were able to drive more rapid cycle improvements that generated a larger impact. Being an expert on technical skills is helpful, but not necessary to drive improvement. Rather, intellectual curiosity, proactive attitude and high emotional quotient are better indicators and drivers for success.

Next Steps
Given improvements in both blood pressure control and reduction in disparities (i.e. race/ethnicity and gender), we plan to share our practices with other LMC locations. For instance, improvement work is necessary at LMC’s Brookside San Pablo location. We also hope to establish site-level QI teams at Pinole, Ashby and East Oakland. Additionally, we need to continue building internal and external partnerships in order to achieve health equity. LMC is participating in IHI’s Virtual Expedition: Achieving Health Equity beginning October 2017. LMC was also rewarded a grant from the Center for Care Innovations (CCI) Fund of Tides Foundation, in partnership with Blue Shield of California Foundation. This 2017-18 Roles Outside of Traditional Systems (ROOTS) grant will help us address social determinants of health (SDOH), and integrate SDOH data into medical visits. By having both IHI and CCI as external partners, LMC will not only continue reducing disparities for communities of color, but also advance health equity for its most vulnerable populations.

If you would like more information, or to partner with us in achieving health equity, please contact:
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