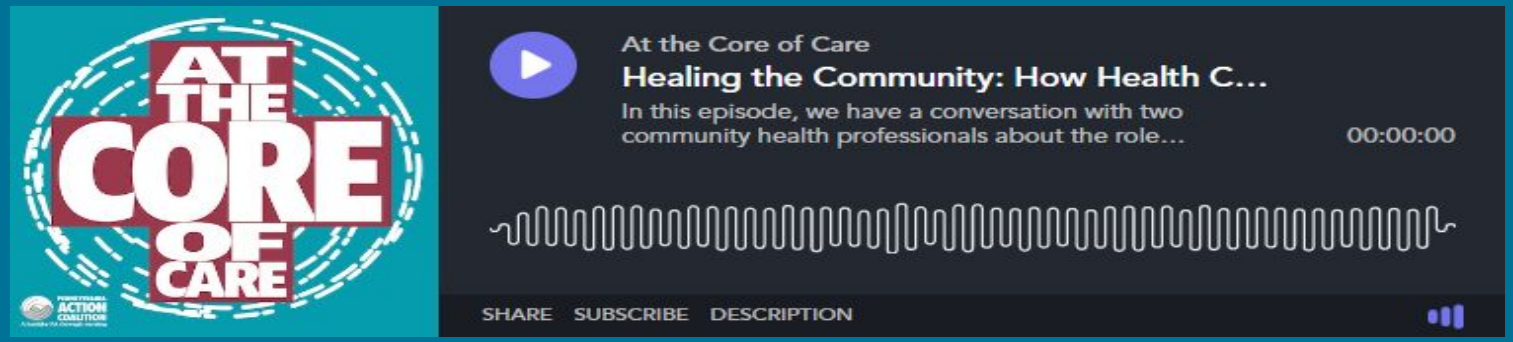
Optimize your Care Team to Improve Chronic Hypertensive Disease Management

December 5, 2023



HEALTH CENTER RESOURCE CLEARINGHOUSE

Housekeeping

1 Captions

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Live Transcript

2 Questions

Please add your questions for the speaker and comments for the group into the Chat box.

Chat

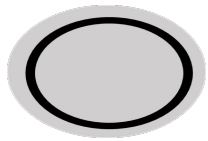
3 Technical Issues

Please raise your hand to let us know or message us in the chat.

Raise Hand

4 Recording

This session will be recorded and available to view on Vimeo



Recording

NNCC/ANCC Disclosures

Accreditation Statement: The National Nurse-Led Care Consortium is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Success Completion Requirements: Nurses completing the entire activity and the evaluation tool may be awarded a maximum of **1.0 contact hours** of nursing continuing professional development (NCPD). **To obtain nursing continuing professional development contact hours, you must participate in the entire activity, participate in audience polling and/or Q&A sessions, and complete the evaluation.**

Relevant Financial Relationships: It is the policy of the National Nurse-Led Care Consortium to require nursing continuing professional development program faculty and planning committee members to disclose any financial relationship with companies providing funding or manufacturers of any commercial products discussed in the educational activity. The program faculty and the planning committee members report they do not have financial relationships with any manufacturer of any commercial products discussed in the activity.

The National Nurse-Led Care Consortium (NNCC) is a nonprofit public health organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care.

We do this through

- -training and technical assistance
- -public health programing
- -consultation
- -direct care

https://nurseledcare.phmc.org/

NNCC NTTAP Team

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Junie Mertus
Program Intern

Introduction/Welcome
- 5 minutes

Didactic
- 40 -45 minutes

Questions & Wrap-Up
- 10-15 Minutes

Today’s Agenda

Meet our speakers:

Ingrid Andersson, RN, BSN

Director of Care Coordination
Mary's Center

Caitlin Young, RN, BSN

Clinical Nurse Coordinator II
Mary's Center

Katherine de Juan, BSN, EMT

Telephone Triage Nurse
Mary's Center

Optimize Your Care Team to Improve Chronic Hypertensive Disease Management

Mary's Center

Ingrid Andersson, RN, BSN
Director of Care Coordination

Caitlin Young Cameron, RN, BSN
Assistant Nurse Manager

Katherine DeJuan, RN, BSN
Triage Nurse Supervisor

Objectives:

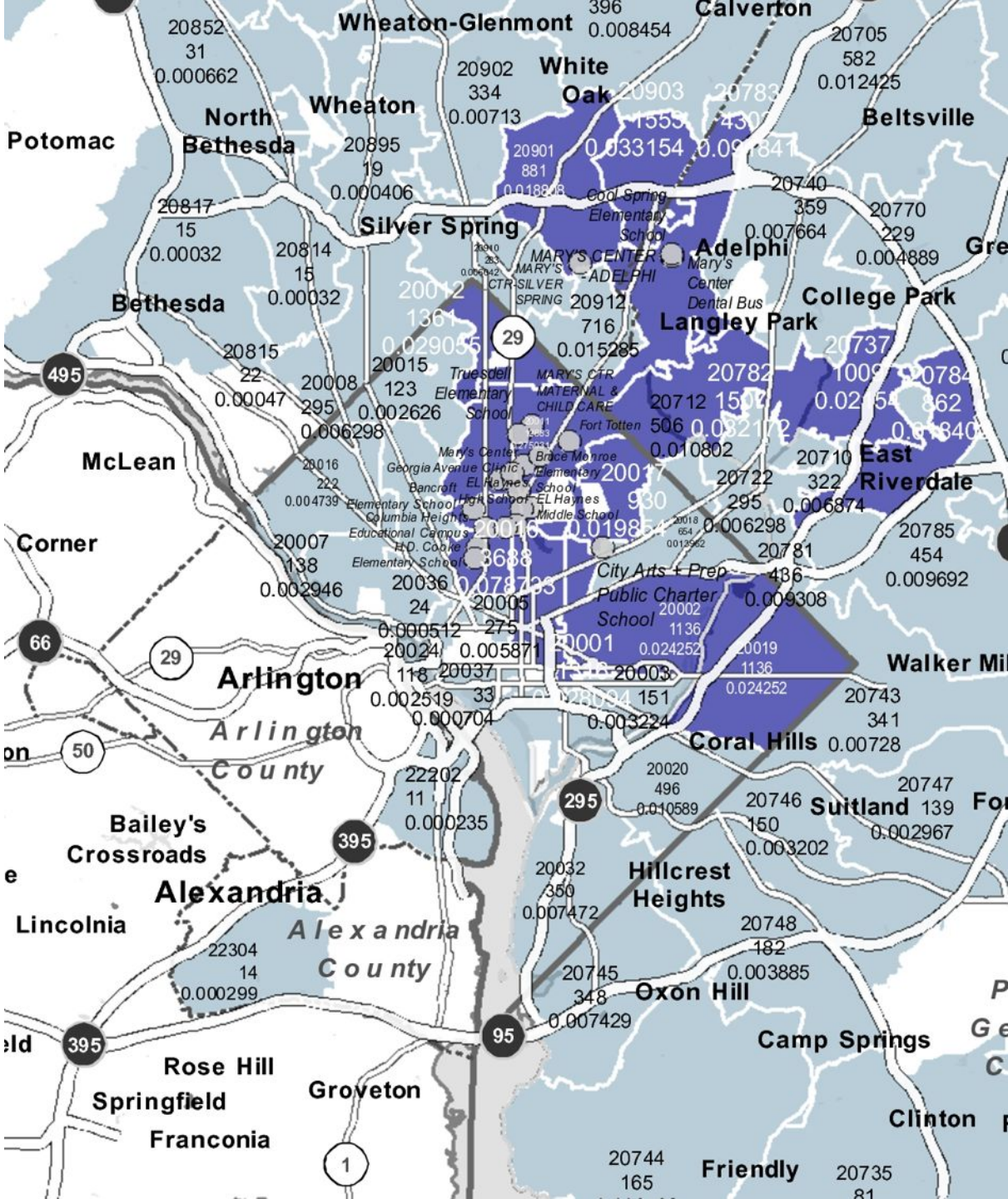
1. Understand the fundamental principles and values that drive effective care team optimization

2. Define the advantages of care team optimization, discerning its impact on enhancing patient outcomes related to hypertension.

3. Identify how certain roles on the team could work more autonomously with empaneled patients to control hypertension and lead to improved hypertension outcomes.

Mary's Center

- Federally Qualified Health Center (FQHC)
- Established in 1988
- Over 65,000 participants from 50+ countries
- 5 full-service community health centers
- 26 School-based mental health programs
- 2 Senior Wellness Centers



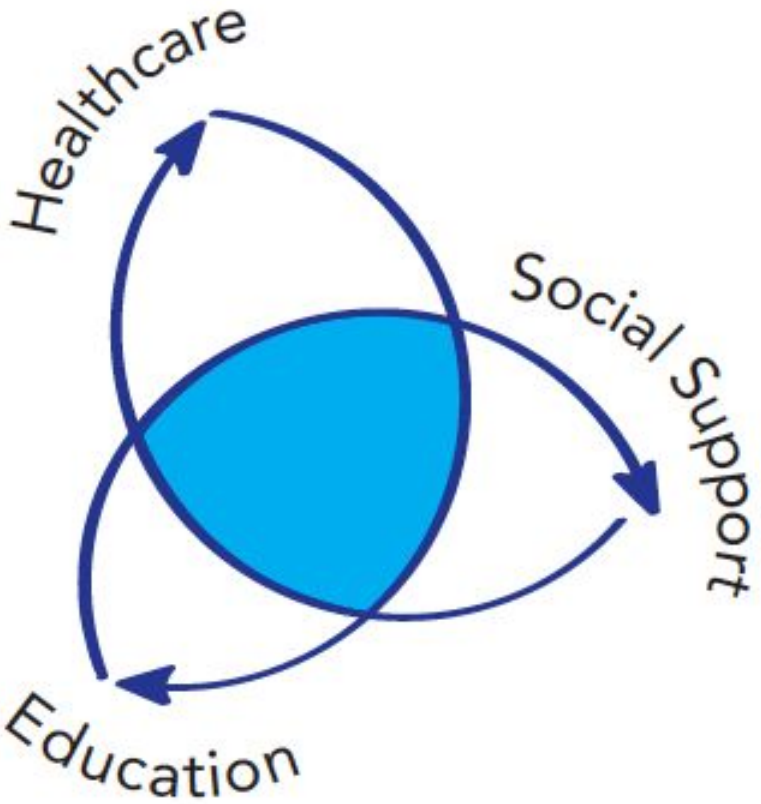
Our Mission

Mary's Center embraces all communities and provides high-quality healthcare, education, and social services to build better futures.

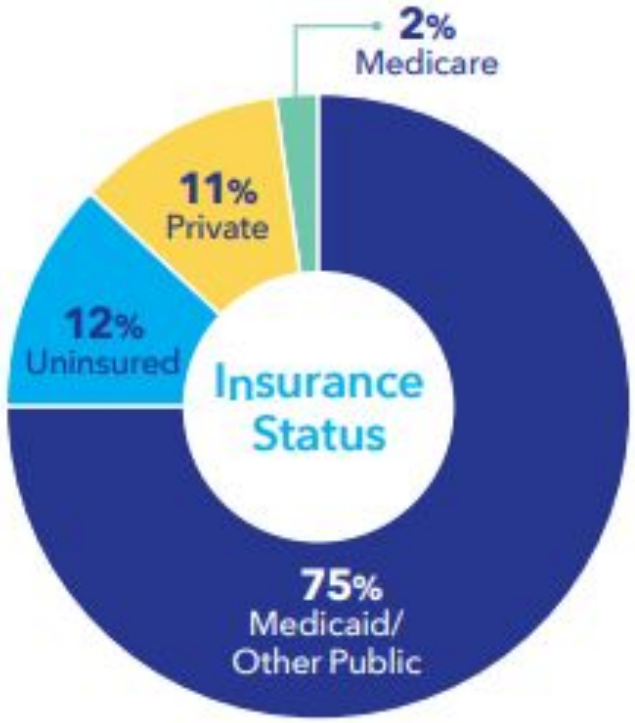
Our Social Change Model:

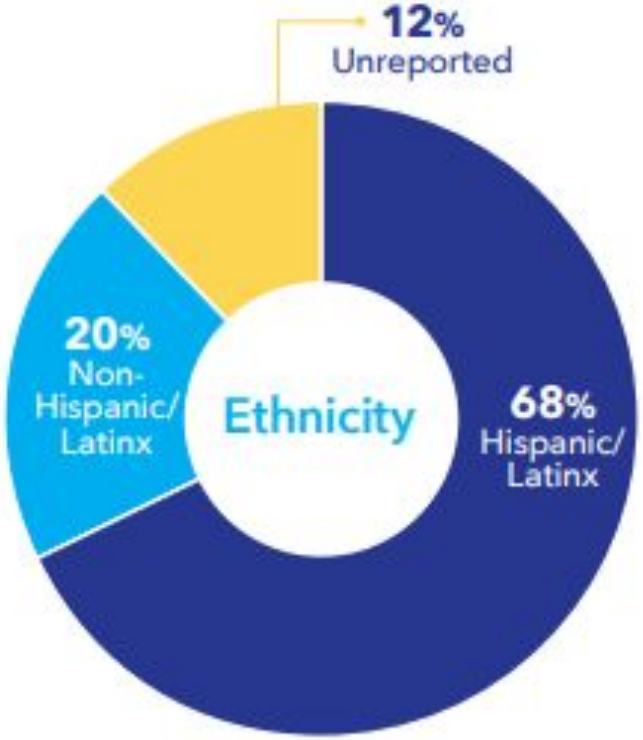
Strive to address aspects of wellbeing that can impact quality of life and advancement

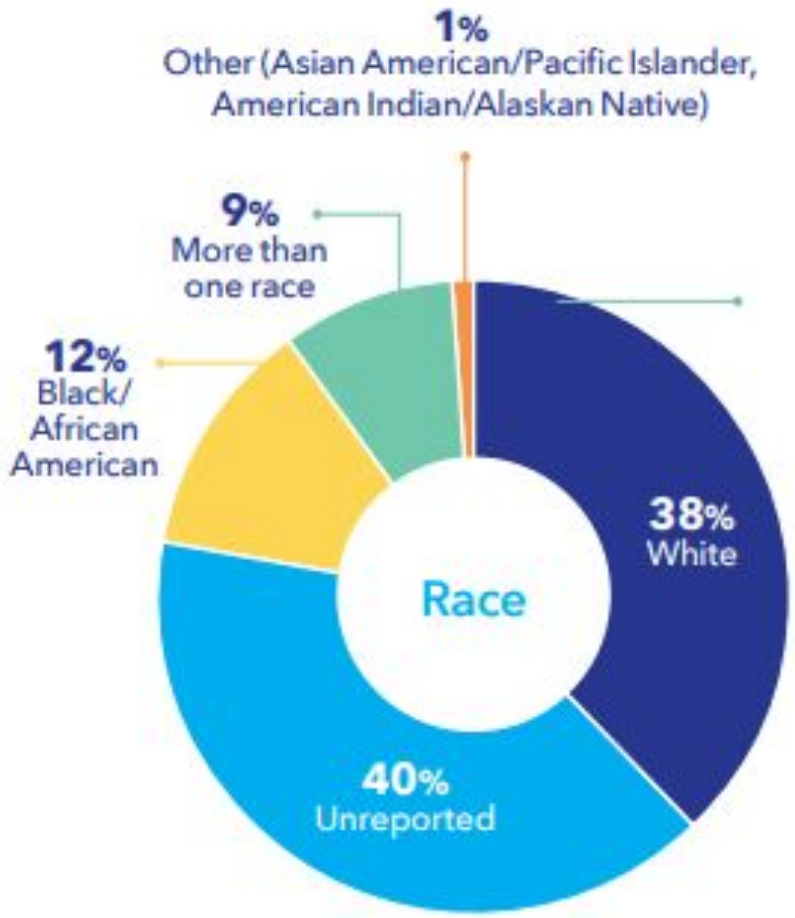
- Comprehensive health care
- Dual-generation education
- Social services



Who we see:







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Care Teams

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"the primary goal of medical teamwork is to optimize the timely and effective use of information, skills, and resources by teams of health care professionals for the purpose of enhancing the quality and safety of patient care"

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Agency for Healthcare Research and Quality. 2014. *TeamSTEPPS long-term care implementation guide.* Available at: https://www.ahrq.gov/teamstepps/longtermcare/implement/implguide.html (accessed November 27, 2023).

- What is a care team?
  - Multidisciplinary group with shared goals, explicit roles, clear communication, respect, and a positive attitude.

- Why use care teams?
  - Outcomes
  - Staff Satisfaction
  - Patient Satisfaction

Mary's Center

Harrington C. (2022). Composition of An Ideal Medical Care Team. *Delaware journal of public health*, *8*(5), 150–153. https://doi.org/10.32481/djph.2022.12.033

The Mary's Center Care Team:

- Providers: MD/DO, PA, NP, CNM
- RNs: EVPN, Directors, Nurse Managers, Clininca Nurse Coordinators, Care Coordination RN, Triage RNs, Nurse Home Visitors
- MAs: clinic MAs, Population Health MAs, Facilitated Telemedicine MAs
- Patient Care Navigators: Front desk, referrals, medical records
- Health Educators/Navigators: Cancer, long COVID, Pediatric Obesity, HIV risk/PReP, HIV, Obstetric Care, Integrated Recovery Program/Medication Assisted Therapy for Substance Use Disorder,
- Social Service Support: Family Support Workers, Domestic Violence Advocates, Insurance navigators, WIC (Women Infant Children Program), Senior Centers, Teen Program
- Behavioral Health Support: Integrated, Behavioral Health Counselling and Treatment
- Pharmacist
- Lab Technicians
- Briya PCS

Care Team Optimization – the role of the RN:

- ANA, 2016: “The effective engagement of nursing is key to patient safety and care quality improvement”
- In applying the core principles for true collaboration, team members’ values must align
- honesty, discipline, humility, creativity, and curiosity
- these values are interwoven through the principles of the care team: shared goals, clear roles, mutual trust, effective communication, which lead to improved outcomes.

https://www.nursingworld.org/~4af159/globalassets/docs/ana/ethics/issue-brief_patient-centered-team-based-health-care_2016.pdf

RNs as part of the care team to improve hypertension outcomes:

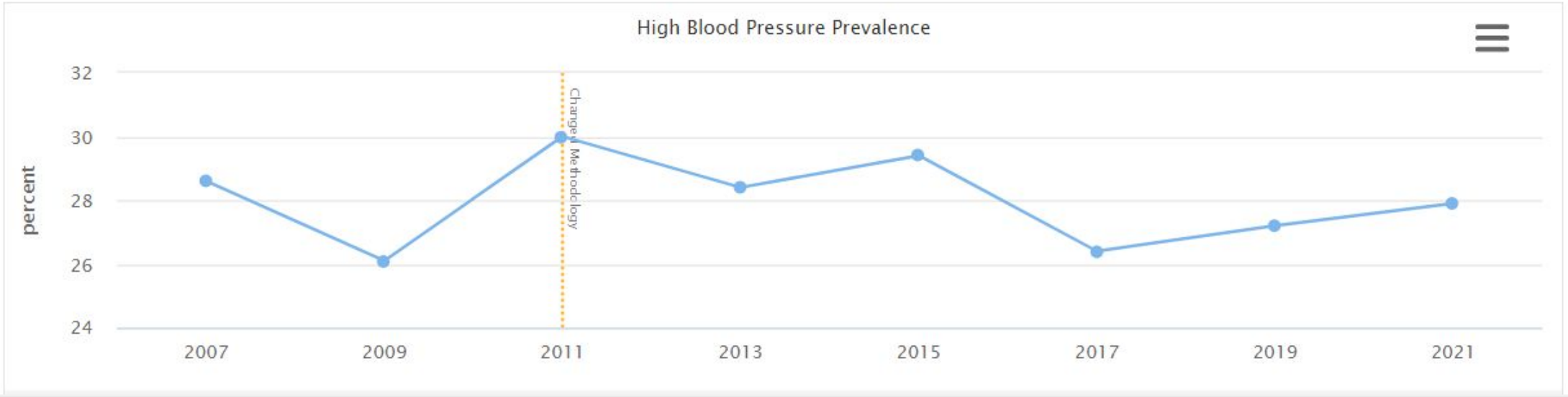
Hypertension prevalence, DC:

COMPARED TO

U.S. States	US Value (32.4%)	Prior Value (27.2%)	Trend	HP 2030 Target (42.6%)

City: District of Columbia

27.9%



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https://www.dchealthmatters.org

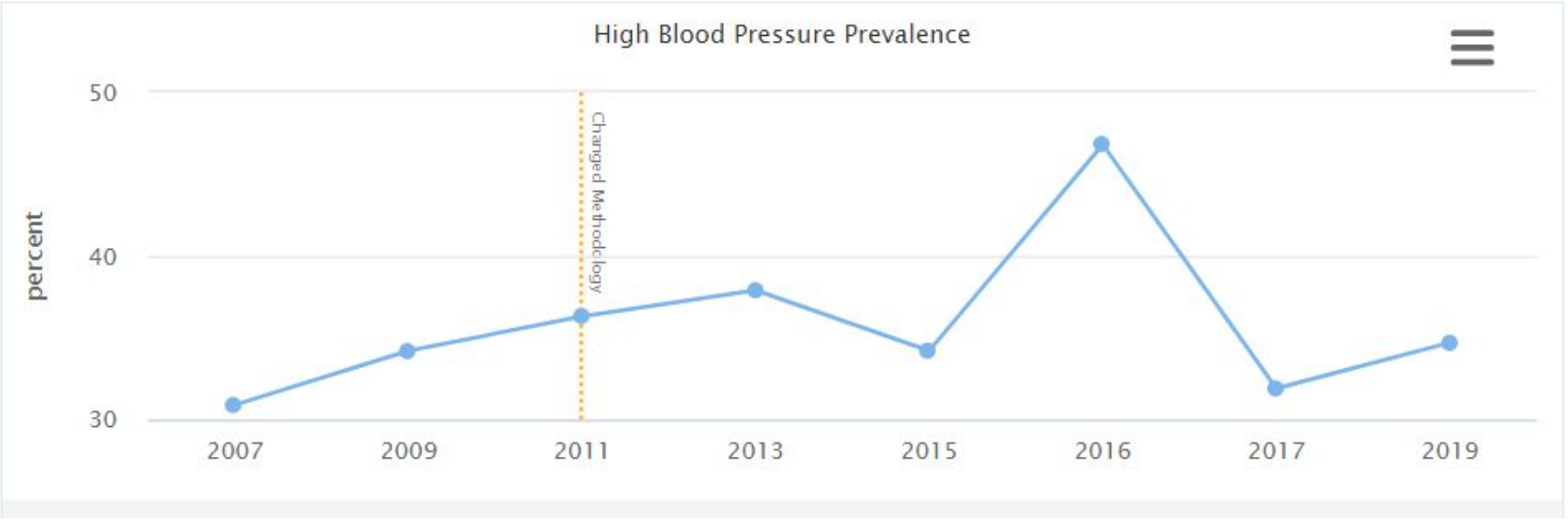
Hypertension prevalence, Prince Georges County,

COMPARED TO

MD Counties	MD Value	US Value	Prior Value	Trend	HP 2030 Target
	(32.2%)	(32.3%)	(31.9%)		(42.6%)

County: Prince George's

34.7%

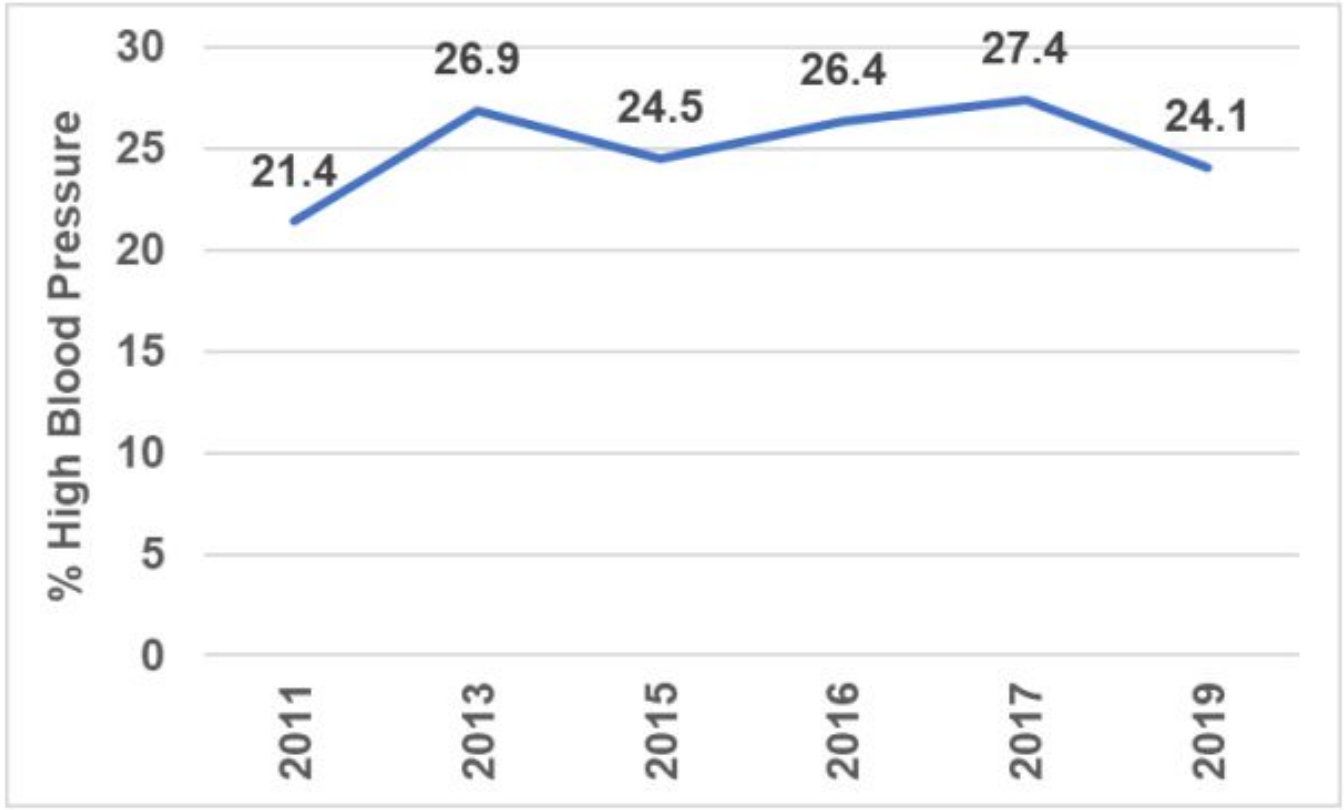


https://www.pgchealthzone.org

Healthy Montgomery Core Measures Data Summary

High Blood Pressure Prevalence

Percent of Adults with High Blood Pressure, Montgomery County, 2011-2019



Healthy Montgomery 2023
32.4

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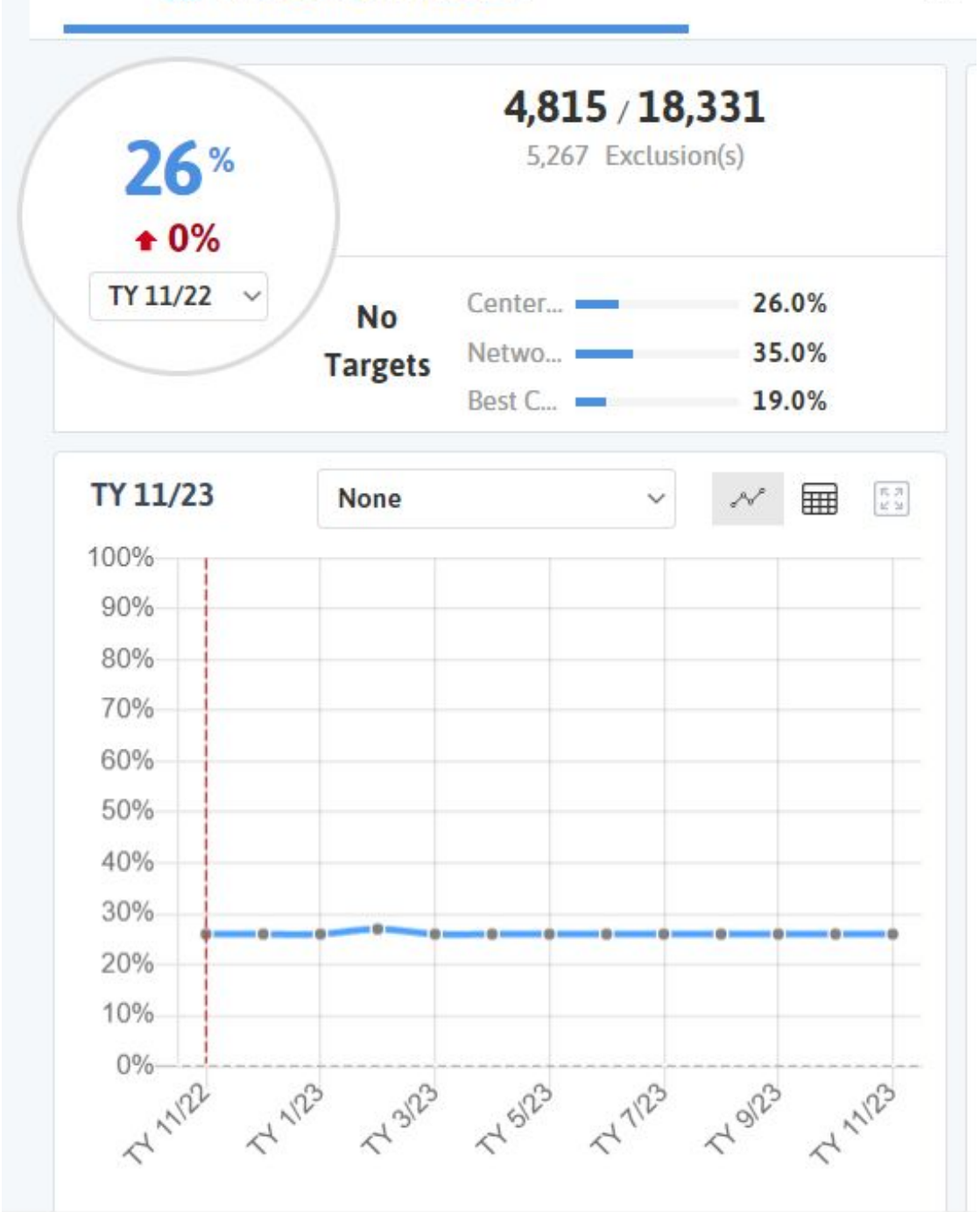
Hypertension prevalence, Adult medical participants at Mary's Center:



Healthy People 2020:

Objective Description	Baseline Value (Year)	Midcourse Value (Year)	Target
HDS-25 Physician office visits by adults with hypertension whose blood pressure is controlled (percent, 18+ years)[4]	58.1% (2006–2007)	62.9% (2009–2010)	63.9%

Numerator: Number of ambulatory care visits by patients aged 18 years and over, excluding visits by pregnant women, with hypertension whose mean systolic blood pressure is less than 140 mm Hg and mean diastolic blood pressure is less than 90 mm Hg

Denominator: Number of ambulatory care visits by adults aged 18 years and over with high blood pressure/hypertension, excluding visits by pregnant women

https://wayback.archive-it.org/5774/20211120164643/https://www.healthypeople.gov/node/11019/data_details

Healthy People 2030:

Increase control of high blood pressure in adults — HDS-05

Status: Baseline only

Learn more about our data release schedule

Most Recent Data:
16.1 percent (2017-20) *

Target:
18.9 percent [1] *

Desired Direction:
Increase desired

Baseline:
16.1 percent of adults aged 18 years and over with high blood pressure/hypertension had it under control in 2017-20 [2] *

* Age adjusted to the year 2000 standard population.

Numerator: Number of adults aged 18 years and over, excluding pregnant women, with hypertension whose mean systolic blood pressure is less than 130 mm Hg and mean diastolic blood pressure is less than 80 mm Hg.

Denominator: Number of adults with high blood pressure/hypertension aged 18 years and over, excluding pregnant women.

https://health.gov/healthypeople/objectives-and-data

Mary's Center Data – Unified Data System (UDS):

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Controlling High Blood Pressure (Columns 2a-2c), CMS165v11			
January 1 to December 31, 2021	Numerator	Denominator	Percentage
	1,546	3,504	**44.12%**
January 1 to December 31, 2022	Numerator	Denominator	Percentage
	2,103	4,004	**52.52%**
January 1 to October 31, 2023	Numerator	Denominator	Percentage
	2,552	4,249	**60.06%**

Mary's Center Data – UDS:

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Figure 7 Data Table: Rate of Controlled Hypertension, 2020-2022

Clinical Quality Measure	2020	2021	2022
HEDIS Hypertension Control (<140/90 mmHg)	58.60%	58.60%	58.60%
Health Center Hypertension Control (<140/90 mmHg)	57.98%	60.15%	63.40%

Health centers improved clinical quality for hypertension and diabetes between 2021 and 2022, exceeding the comparable Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks in 2022. The HEDIS benchmarks are national averages based on data from patients with Medicaid insurance across the United States. Nearly two-thirds **(63%)** of health center patients diagnosed with hypertension had controlled blood pressure, exceeding the HEDIS benchmark of **59%** (Figure 7).

https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-trends-data-brief.pdf

Mary's Center

Nursing perspectives – RNs at Mary's Center:

-Clinic based team and hypertension control (Caitlin)

-Telephonic nurse triage and hypertension control (Katherine)

-Care Coordination Programs and hypertension control (Ingrid)

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Managing Hypertension in the Clinic Setting

- How does Mary's Center manage Hypertension in the clinic?
  - Provider visits
  - Nurse visits

- What happens during a provider visit?
  - Check BP
  - Evaluate symptoms
  - Discuss medication
  - Patient education
  - Follow up
  - Goal setting
  - Care teams
  - Referrals

Mary's Center

How is Nursing Involved?

- Nurse visits
  - Blood pressure checks
  - Hypertension education
  - WHOs
  - Co-visits

- What happens during an appt?
  - Check BP
  - Triage symptoms
  - Troubleshoot barriers
  - Educations
  - Discuss goals
  - Follow up

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Evidenced Based Triage

1. Schedulers book routine Patient visits and escalate patients to the remote triage RN.
2. Triage nurses:
    - Assessment using evidence based clinical tools
        - Barton/Schmitt protocol: ClearTriage
        - Management of Emergencies
        - Afterhours nursing support for emergencies
    - Standing orders for refills
        - Troubleshooting medical supplies refills
        - Prior Authorizations
    - Healthcare Navigation
    - Patient Education
        - Signs and symptoms
        - Medication Management
        - Supporting Lifestyle changes

ClearTriage

Mary's Center

Motivational Interviewing

- Motivational interviewing is
  - client-centered counselling style for behavior change
  - Helps clients to explore and resolve ambivalence.
  - Facilitative style for interpersonal relationship.
- MI is an evidence-based tool shown to enhance treatment adherence.
- Recommended in the public Health setting.
- Referrals to care team and care coordination
  - Nurse led assessment
  - patient led engagement in care.

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Care Coordination Programs to support hypertension control:

- Socios de Salud
  - Provider referral
  - MA/RN contact patient between provider visits
  - Patient activation via communication/education
  - Medication titration
- MyHealthGPS
  - Insurance Specific (DC Medicaid)
  - Health Home Program
  - Patient activation via communication/care coordination

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Facilitated Telemedicine:

- Based on provider referral or outreach
- Addresses SDOH transportation and mobility barriers
- Patient activation via education and care coordination.
- May address white coat hypertension and other causes of elevated readings

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Organizational Activities that support hypertension control:

- SDOH screening
- Staff education and training
- Working with insurers/city to understand resources/benefits
- Telemedicine follow-up
- Grant funding for programs and supplies
- CQI Committee/multidisciplinary subgroup

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Next steps/what we are working on:

- HTN follow-up care workflows
- Patient empanelment/care teams – redirecting back to PCP
- Staffing
  - Leadership development
  - Ratios
- Billing optimization for sustainable funding of programs
- Improved communication with participants

Mary's Center

Resources:

Agency for Healthcare Research and Quality. 2014. TeamSTEPPS long-term care implementation guide. Available at: https://www.ahrq.gov/teamstepps/longtermcare/implement/implguide.html (accessed November 27, 2023)

Harrington C. (2022). Composition of An Ideal Medical Care Team. Delaware journal of public health, 8(5), 150–153. https://doi.org/10.32481/djph.2022.12.033

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Ma, C., Zhou, Y., Zhou, W., & Huang, C. (2014). Evaluation of the effect of motivational interviewing counselling on hypertension care. Patient Education and Counseling, 95(2), 231-237.

https://www.dchealthmatters.org/indicators/index/view?indicatorId=253&localeId=130951&localeChartIdxs=1%7C4

https://www.pgchealthzone.org/indicators/index/view?indicatorId=253&localeId=1260&comparisonId=6721

https://www.montgomerycountymd.gov/healthymontgomery/Resources/Files/Reports/Healthy%20Montgomery%20Core%20Measures%20Data%20Summary.pdf

https://wayback.archive-it.org/5774/20211120164643/https://www.healthypeople.gov/node/11019/data_details

https://health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke/increase-control-high-blood-pressure-adults-hds-05/data-methodology

https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-trends-data-brief.pdf

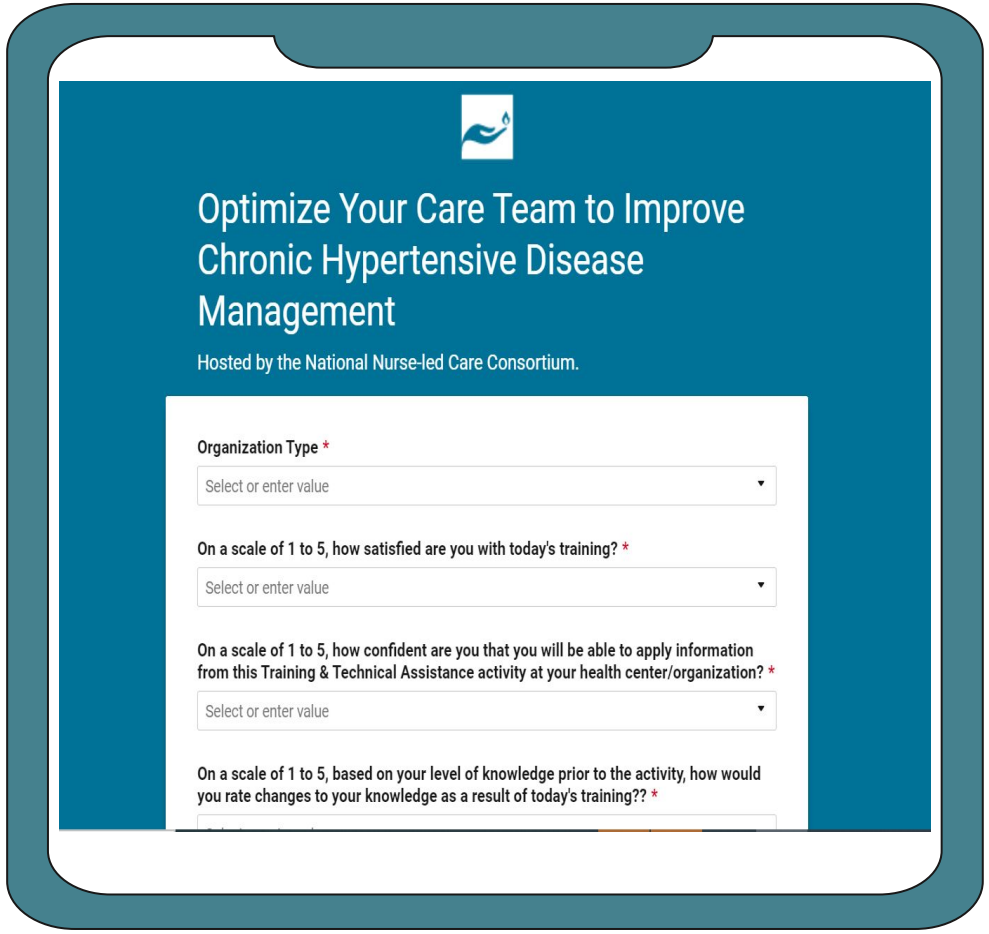
Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23(4), 325-334.

DISCUSSION

QUESTIONS

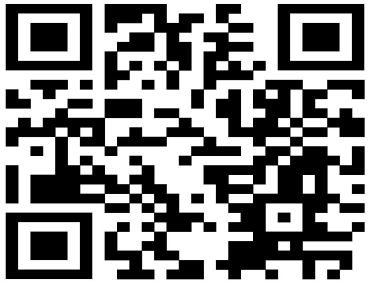
COMMENTS

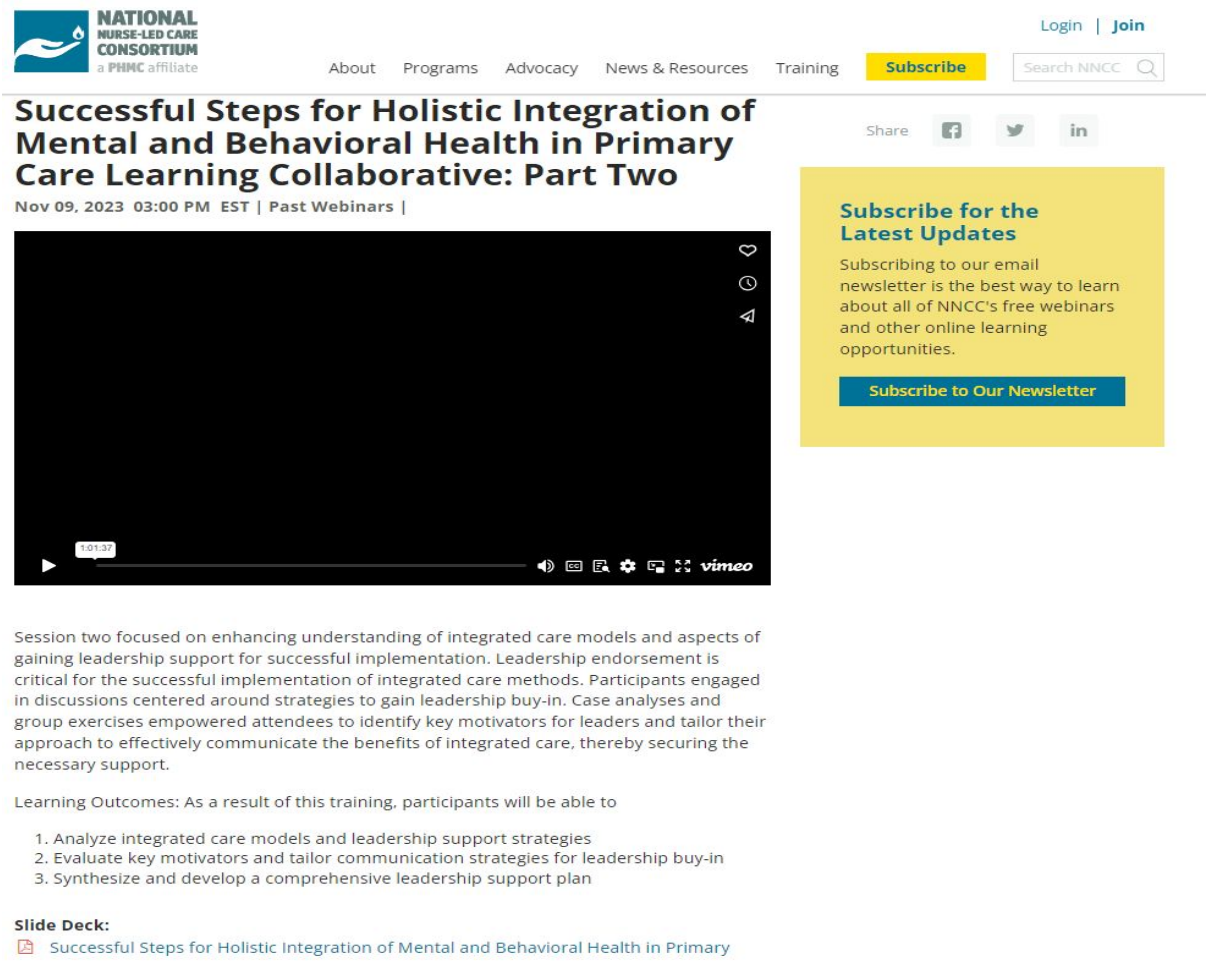
Evaluation Survey



Access T/TA Resources

HEALTH CENTER RESOURCE CLEARINGHOUSE





Upcoming Trainings

Future Trainings

- **Stratifying Quality Measures by Housing Status/Location-Dec 7th @ 2 PM EST**
  NNCC and the Primary Care Development Corporation are partnering to conduct a webinar that will guide health centers serving public housing residents and other special groups on how to use UDS data for QI, care coordination, and care model design. Discover how to stratify UDS data by location and understand SDOH factors that impact health outcomes. We will also cover how to use PREPARE data to drive quality improvement and provide examples of successful interventions for sub-populations. Join us to explore challenges and enablers related to leveraging SDOH to inform quality improvement.

  Registration: https://us02web.zoom.us/webinar/register/WN_Sa-mTgAMTYKywmQERUq7yQ

Thank You!

If you have any further questions or concerns please reach out to Fatima Smith fasmith@phmc.org or Matt Beierschmitt at mbeierschmitt@phmc.org