NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Integrating Social Risk Factors into Hypertension Care and Prevention

Wednesday, February 7th, 2024

11:00am-12:00pm Eastern / 8:00am-9:00am Pacific

At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome. If there is anything said in our program that makes you feel uncomfortable, please let us know via email at nca@chc1.com

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National Training and Technical Assistance Partnership

Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

Team-Based Care

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

Training the Next Generation

- Postgraduate Residency and Fellowship Training
- Health Professions Training

Emerging Issue

- HIV Prevention

Advancing Health Equity

Preparedness for Emergencies and Environmental Impacts on Health

Speaker

- **Mary Blankson, DNP, APRN, FNP-C, FAAN**
  - Chief Nursing Officer, Community Health Center, Inc.

Objectives

- Explain how social determinants of health affect patient outcomes, focusing on key factors impacting individuals with hypertension.
- Utilize the care team to address patients' social needs and use knowledge of social risk factors to create personalized hypertension care plans.
- Assess the impact of integrating social risk factors on hypertension prevention by evaluating approaches for combining medical and dental care.

What is High-Quality Primary Care?

- High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. (National Academies of Sciences, Engineering, and Medicine, 2021)
- High-quality primary care is best provided by a team of clinicians and others who are organized, supported, and accountable to meet the needs of the people and the communities they serve. (National Academies of Sciences, Engineering, and Medicine, 2021)

National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

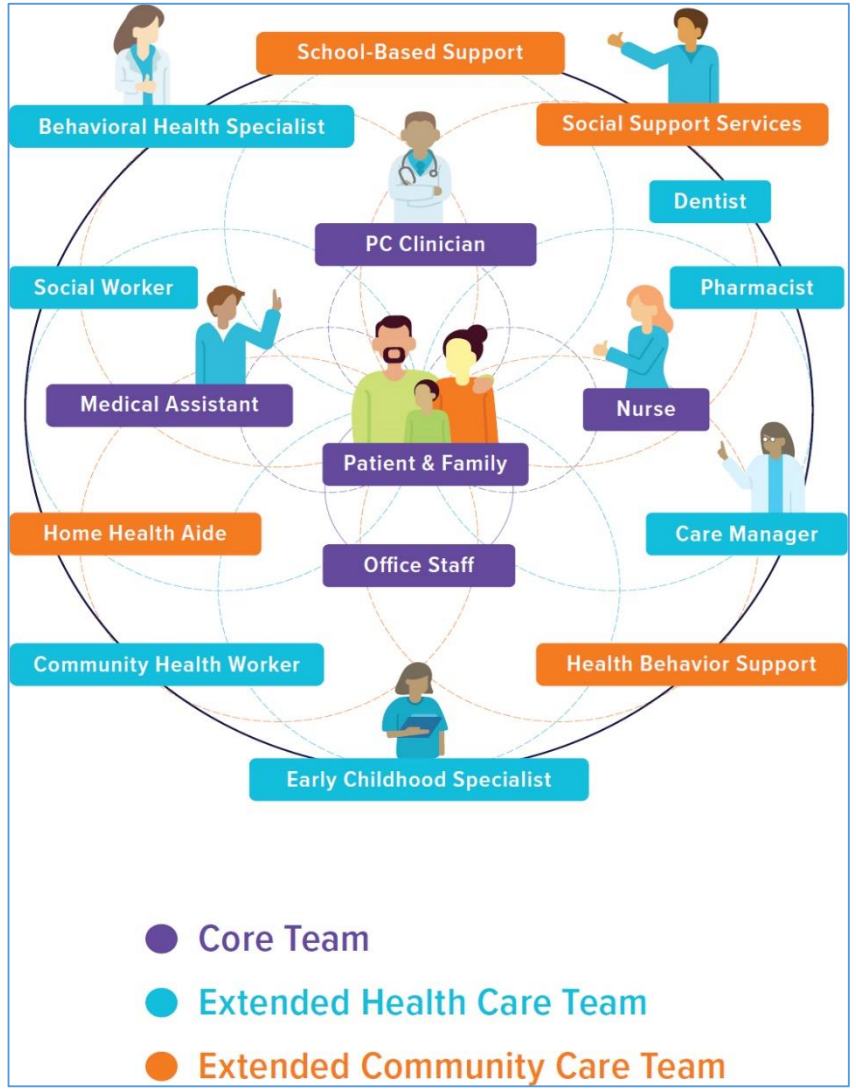
Team-Based Care

- Team-based care is “the provision of health services to individuals, families, [and] their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care. (Mitchell et al., 2012, Okun et al., 2014):
- Advanced models of team-based care provide:
  - Increased access to care and services with a consistent care team
  - Improved quality, safety, and reliability of care
  - Enhanced health and functioning in those who have chronic condition; and
  - More cost-effective care (Hupke, 2014)

Hupke, C. (2014). Team-based care: Optimizing primary care for patients and providers. Institute for Healthcare Improvement.
Okun, S., S. Schoenbaum, D. Andrews, P. Chidambaran, V. Chollette, J. Gruman, S. Leal, B. A. Bown, P. H. Mitchel, C. Parry, W. Prins, R. Ricciardi, M. A. Simon, R. Stock, D. C. Strasser, C. E. Webb, M. K. Wynia, and D. Henderson. 2014. Patients and health care teams forging effective partnerships. NAM Perspectives. Discussion Paper, National Academy of Medicine
Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C. E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC

Interprofessional Care Teams

- Facilitators of high-quality primary care include the interprofessional care teams
  - *Interprofessional care teams* - Care provided by teams of clinicians and other professionals fit to the needs of communities, working to the top of their skills, and in coordination leads to better health (National Academies of Sciences, Engineering, and Medicine, 2021)
- Figure on the right demonstrates the composition of interprofessional primary care. (National Academies of Sciences, Engineering, and Medicine, 2021)



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Provider Role in Team Based Care

- **Model Behavior**
  - Embody “shared care”
  - Support accountability
- **Communicate**
  - Talk about the practice transformation work
  - Connect the work to improved patient care
- **Follow-Up and Support**
  - Check in with team members (MA, Nurses, others)
  - Address gaps and concerns in implementation
- **Collaborate**
  - Collaborative with team on challenges and successes

Hypertension

- HTN is increases risks of heart disease and stroke, which are leading causes of death in the US[1]
- In 2021, HTN was a primary contributing factor to almost 700,000 deaths in the US[1]
- Nearly **HALF** of adults have HTN (defined as systolic >130, diastolic >80, or are on medications for HTN)[2]
- Only about 1 in 4 adults have their HTN in control[2]
- High Blood Pressure costs the US $131 Billion each year[3]
- Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic white adults (32%) than in non-Hispanic black adults (25%), non-Hispanic Asian adults (19%), or Hispanic adults (25%).[2]

1) National Center for Health Statistics. Multiple Cause of Death 2018–2021 on CDC WONDER Database. Accessed February 2, 2023.
2) Centers for Disease Control and Prevention. Hypertension Cascade: Hypertension Prevalence, Treatment and Control Estimates Among U.S. Adults Aged 18 Years and Older Applying the Criteria from the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2017–2020. Atlanta, GA: May 12, 2023. Accessed July 6, 2023.
3) Kirkland EB, Heincelman M, Bishu KG, et. al. Trends in healthcare expenditures among US adults with hypertension: national estimates, 2003-2014. *J Am Heart Assoc*. 2018;7:e008731.

Social Determinants of Health

- Defining and assessing homelessness and housing instability
- Identifying food insecurity and strategies to improve nutrition
- Health literacy
- Transportation
- Access to pharmacy services
- Partnering with community organizations to increase access to resources

Screening Tools and Strategies for Assessing Patient Social Risk Factors

- PRAPARE or other tools
- Collection Mechanisms:
  - MA while rooming patients
  - Telephonic collection during registration
  - Asynchronous survey sent to patient on portal or other tech platform
- Importance of Coding to track risk
  - ICD-10s added to the problem list
  - Population Health data analysis

Housing and HTN

- Examples of potential impact to HTN rates:
  - Impacts of temperature stability
  - Lower anxiety and impacts related to other SDOH when housing is stable (food, med storage, etc.)
  - Better sleep/ability to store use devices (like CPAP) while sleeping
- Workflows to address this:
  - Support for filling out housing applications
  - W.Y.A support/mobile units
  - Formulary of combination medications to reduce pill burden

Food Insecurity and HTN

- Examples of potential impact to HTN rates:
  - Impacts of salty of prepared foods
  - Lower impact of stress/anxiety to eating habits
- Workflows to address this:
  - Coordinate with community programming to improve food choices (soup kitchens, pantries, add partnerships with local farms, etc.)
  - Culturally appropriate nutrition counseling, meal planning, test kitchens, etc.
  - CHWs to assist with patients at the grocery store
  - Implement goal setting templates (this also supports PCMH implementation!)

Transportation and HTN

- Examples of potential impact to HTN rates:
  - Getting to the grocery store, pharmacy, medical appts, parks or other recreational sites, etc.
- Workflows to address this:
  - Medical transportation for appts
  - E-Consults with specialty services (could be synchronous or asynchronous)
  - Delivery pharmacy/Integrated pharmacy programming
  - Specific education for ideas to exercise at home

Access to Pharmacy and HTN

- Examples of potential impact to HTN rates:
  - Low medication adherence rates (either by not filling, or filling late)
  - High pill burden or non-evidence-based regimens
- Workflows to address this:
  - 90-day rx standard for chronic, non-controlled meds
  - HTN Formulary designed around less-expensive combination drugs
  - Implementing evidence-based standard data dashboards (address no therapy, single therapy, etc.)
  - Create standing orders regarding HTN for ancillary care team members (more to come on this!)

HTN & Health Literacy

- Literacy vs. Health Literacy
- Examples of potential impact to HTN rates:
  - Med non-adherence
  - Disease progression
- Impacts of numeracy?
- Workflows to address this:
  - Health Literacy assessment (HTN knowledge, demo of SMBP, self-efficacy, etc.)
  - Incremental education planning
  - Culturally appropriate patient education
  - CHW or other community based groups/partnerships

A Word About Harm Reduction

- What is Harm Reduction
- Why is it important?
- How does it apply to HTN?
- Managing challenging behaviors of patients with chronic diseases:
  - Lying/Poor Insight – ask open ended questions; probe with curiosity
  - Unrealistic goal setting – assist with ensuring incremental goals that are S.M.A.R.T. goals
  - Low motivation – Educate/Deliver MI, and then set checkpoints
- Which comes first: medication or lifestyle modification?
  - BOTH!

Strategies for Nurse Management of Hypertension: Medication titration

- Nurses may titrate blood pressure medication as prescribed by the PCP according to patient-specific goals-defined by the PCP under delegation
- This requires a patient specific order at CHC, however, some organizations do have algorithms that nurses or pharmacists can use!
- The nurse shall send refills according to **The Nurse Management of Medication Refills** standing order policy
- Nurses should ensure medication reconciliation is done with the patient at any visit where medications are refilled or modified; This is also important to confirm medication adherence before implementing any medication changes (even if changes are not initiated by the nurse!)
- **Proactive scripting** for support team members: ask the provider for exactly what is needed!

Strategies for Nurse Management of Hypertension: Care Management

- The nurse will schedule follow up with the patient two weeks after the initiation of SMBP cuff.
  - Nurses may engage in management of hypertension at an in-person nurse visit for patients for whom the PCP has already initiated medications.
  - Nurse visits may occur through provider-referral, nutritionist or CDCES referral, patient self-referral, and proactive nurse identification.
  - Although in-office visits are preferred, telephonic or video nurse visits may be conducted for patients who have reliable measurement in the community – including a skilled homecare nurse or SMBP cuff that has been calibrated by a CHC Nurse
  - Potential patients may be identified during panel management or from population health lists of uncontrolled HTN patients that are sent to care teams for review
  - RPM Programming

Strategies for Nurse Management of Hypertension: Care Management

- Complex Care Management
  - Identify poorly controlled patients via the Care Management Dashboard such as those who have been in the emergency department or hospitalized and outreach to patients for both PCP appointment and Hypertension Nursing Visit appointment.
  - Collaborate with insurance case managers for patients who are seeking emergency department or inpatient care on a frequent basis.
  - Coordinate referrals to medical specialists such as Cardiology/Nephrology as needed and directed by the patient's provider.
  - Ensure that referrals ordered by the PCP have been executed, that patient is aware of upcoming appointments, and facilitates the scheduling and rebooking of appointments in collaboration with the Referral Coordinator.
  - Coordinate with pharmacy and other home care services to including home delivery and pillboxes, and convey medication changes to any homecare service providers.
  - Include family members/care takers in the patient's care plan, as desired by the patient.
  - Delegate appropriate care to other CHC team members as appropriate per their expertise/role on the care team

Integrating Medical and Dental Care for Improved Patient Outcomes

- Conducting oral exams and dental screenings in medical settings for those with cardiovascular risk/diabetes
- Checking vitals and monitoring chronic conditions in dental offices
  - Blood pressure before dental care
    - However, some may have dental anxiety, so be prepared to assess (think job tool!)
  - Discuss healthy eating and other health promotion items

Connecting Patients to Community Services and Resources

- External Referral platforms
- 211
- Agency OneNote
- Patient-led support groups
- Other ideas?

Clinical Strategies to Help Patients with "Stubborn" HTN

- Aggressive medication titration with pharmacy tracking
- Homecare evaluation to get a sense of the actual care scenario
- E-consult to Cardiology or Nephrology, depending on patient scenario
- Integrated care rounds
- "All Hands on Deck" approach

Accountability with Program Implementation

- HTN control rates are a team measure
  - Break down team roles and hold staff accountable on yearly appraisals
  - Incentivize team care
  - Make time
  - Celebrate success and lessons learned—QI is about failing a bunch of times before you get to the best practice

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Questions?

Wrap-Up

Comprehensive and Team-Based Care Learning Collaborative

- Free eight-month participatory experience designed to provide knowledge, tools, and coaching support to help health centers and look-alikes implement advanced models of team-based care.
- In this Collaborative, teams will learn how to:
  - Use quality improvement concepts and skills to facilitate their implementation of a model of high-performing team-based care
  - Conduct self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- Outcomes of the learning collaborative:
  - Identified a clinical team to work on a quality improvement project
  - Implemented pre-visit planning and morning huddles
  - Integrated behavioral health with warm welcomes/handoffs
  - Increase UDS measures, such as hyptertension, cancer screenings, etc.
- Apply Here! For more information/questions, please reach out to Meaghan Angers (angersm@mwhs1.com)

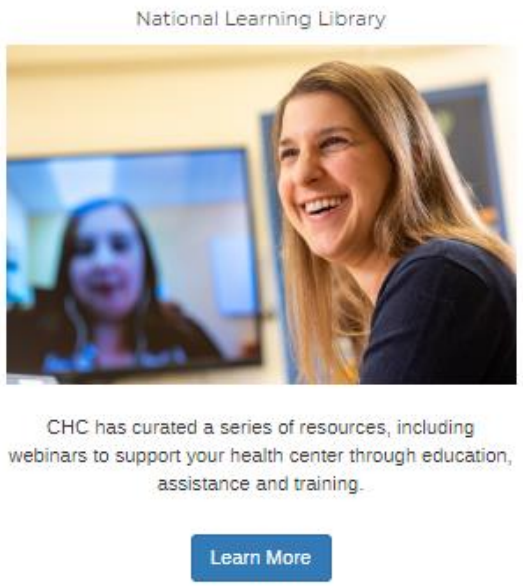
Team-Based Care

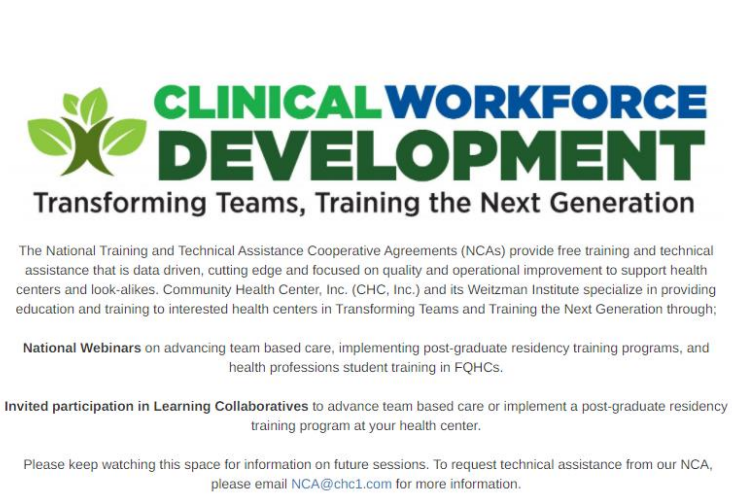
- **Fundamentals of Comprehensive Care**
- **Advancing Team-Based Care**

Our NTTAP also offers learning collaborative opportunities in Postgraduate NP Residency Programs, Health Professions Student Training, and HIV Prevention!

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development





https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca