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Closing Gaps in Hypertension Control: A Quality-Driven Approach at West County Health Centers

Aliados Health
Promising Practice

PROMISING PRACTICE OVERVIEW

From 2023 to 2024, West County Health Centers (WCHC) experienced a consistent increase in blood pressure control rates among hypertensive patients, rising from 69.4% at the start of 2023 to 77.8% by the end of 2024. West County Health Centers utilized its Population Health Team to conduct outreach, schedule patient visits, and provide support across its three primary care sites. They effectively addressed care gaps by facilitating access to home blood pressure monitors and ensuring follow-ups through a new quality measure implemented via Relevant. Additionally, annual staff training was conducted to promote accurate blood pressure readings. WCHC also enhanced access by adding extra provider shifts and scheduling blocks in its Quality Clinics. These combined efforts resulted in a steady improvement in blood pressure management.

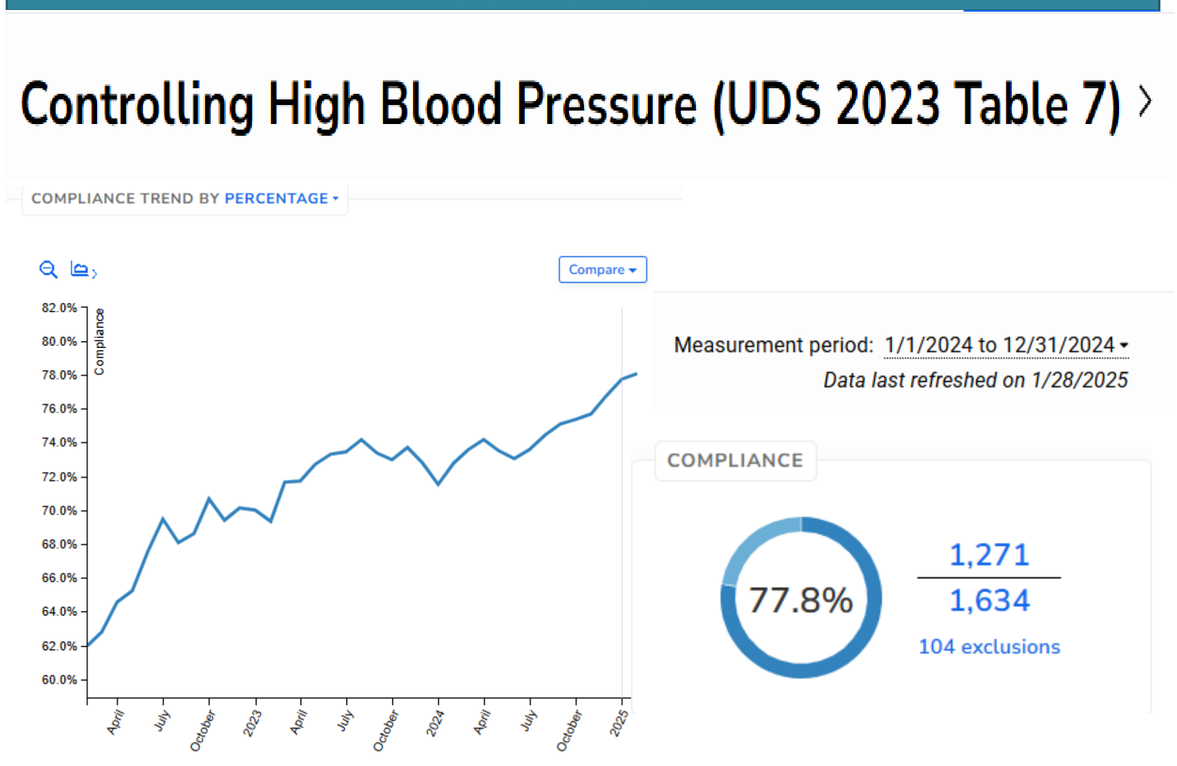
AIM

West County Health Centers set out to improve blood pressure control in their hypertensive patients.

MEASURES

Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period

RESULTS TO DATE



LESSONS LEARNED

Team-Driven Success: Mobilizing front-line staff, such as the Population Health Team, improved compliance across all West County Health Center's sites.
Continuous Training: High staff turnover in health centers highlights the need for ongoing competency assessments. Annual retraining ensures consistent skills across the team, maintaining a high standard of care.

ACTIONS TAKEN

Quality Clinics:
- ✓ In 2023, West County Health Centers (WCHC) began testing Quality Clinic Shifts to create scheduling access for preventative care items.
- ✓ The Population Health Team (3 MAs and 1 front office) are responsible for scheduling and rooming for these clinics.
- ✓ Site Management matched providers that have expressed interest in picking up an extra shift with room availability. Their schedule is then blocked for the Pop Team to schedule.
- ✓ If a Quality Clinic's schedule is not full, the block for that day is removed, and same-day walk-ins are accepted
- ✓ WCHC tested maintaining the block while engaging providers to conduct outreach calls that turn into visits. Providers are encouraged to complete 10 visits during those shifts.
- ✓ In 2025, Quality Clinics Shifts were built into the primary care schedules across the sites with set providers and set dates (i.e. 1st Monday AM shift at one site, 2nd Monday PM shift at the other)

QIP Focus:
- ✓ Midway through the year, WCHC shifts its focus to QIP patients. Relevant QIP Due Lists are created and updated weekly using QIP eReports data and data from eCW.
- ✓ These comprehensive reports display all QIP patients and all their QIP metrics and status.
- ✓ These lists includes a column for tracking outreach progress notes which get populated and imported back into Relevant when the data refreshes the following week. This allows WCHC to analyze and ensure compliance and status of outreach efforts with all QIP measures.

Needs Home BP Cuff Care Gap:
- ✓ This Care Gap was built to display hypertensive patients who do not have access to at-home blood pressure monitors. West County Health Center staff then assist the patient in getting an at-home monitor and then documents this in the EHR.

Annual MA BP Competency Training
- ✓ West County Health Centers updated and retrained Medical Assistants, by implementing annual competency assessments.
- ✓ These trainings ensure that MAs maintain proficiency in accurately taking and recording blood pressure readings.

Quality Measure For Repeat Blood Pressure:
- ✓ A quality measure was introduced and customized in early 2024 to track high blood pressure readings and whether follow-up retakes were performed.

$$Quality\ Measure\ (\%) = \left(\frac{Number\ of\ High\ Blood\ Pressure\ Readings\ Retaken}{Total\ number\ of\ High\ Blood\ Pressure\ Readings}\right) x100$$

- ✓ **Numerator:** The number of visits where a blood pressure reading was retaken after an initial reading is 140/90 or greater.
- ✓ **Denominator:** The total number of visits where the initial blood pressure reading was 140/90 or greater.

Repeat Blood Pressure Reading

Measurement period: 3/1/2024 to 2/28/2025

Data last refreshed on 2/3/2025

Patients ages 18 and over with an abnormal blood pressure reading during a visit in the measurement period who received a repeat blood pressure reading on the same day.

Notes:
Compliance by Provider = Compliance by *Visit* Provider (NOT PCG)
Compliance by Location = Compliance by *Visit* Location (NOT Primary Location)

Use this process measure alongside the HTN Blood Pressure Control outcome measure to analyze whether an effort to always repeat BPs may help to improve compliance for Blood Pressure Control.

Required Mappings: Data Element: `blood_pressure_readings.visit_id`

Denominator:
Patients ages 18 and over with an abnormal blood pressure reading (systolic blood pressure greater than or equal to 140 mmHg OR diastolic blood pressure greater than or equal to 90 mmHg) during the measurement period. If a patient has multiple abnormal blood pressure readings, we will assess the most recent reading.

Numerator:
Patients with an abnormal blood pressure reading and the blood pressure was repeated during the same visit.

Exclusions:
None.

Measure type: process

Measure developer: Relevant Healthcare

Reporting Risk Model: none selected

Measure SQL and configuration

Denominator Minimums

Age groups	0
Ethnicities	0
Genders	0
Locations	0
Payers	0
Payer groups	0
Populations	0
Providers	0
Provider teams	0
Races	0
Risk model 1 risk levels	0
Risk model 2 risk levels	0
Risk model 3 risk levels	0
Risk model 4 risk levels	0

Repeat Blood Pressure Reading

Measurement period: 3/1/2024 to 2/28/2025

Data last refreshed on 2/3/2025

COMPLIANCE

481
2,478
0 exclusions

TARGET

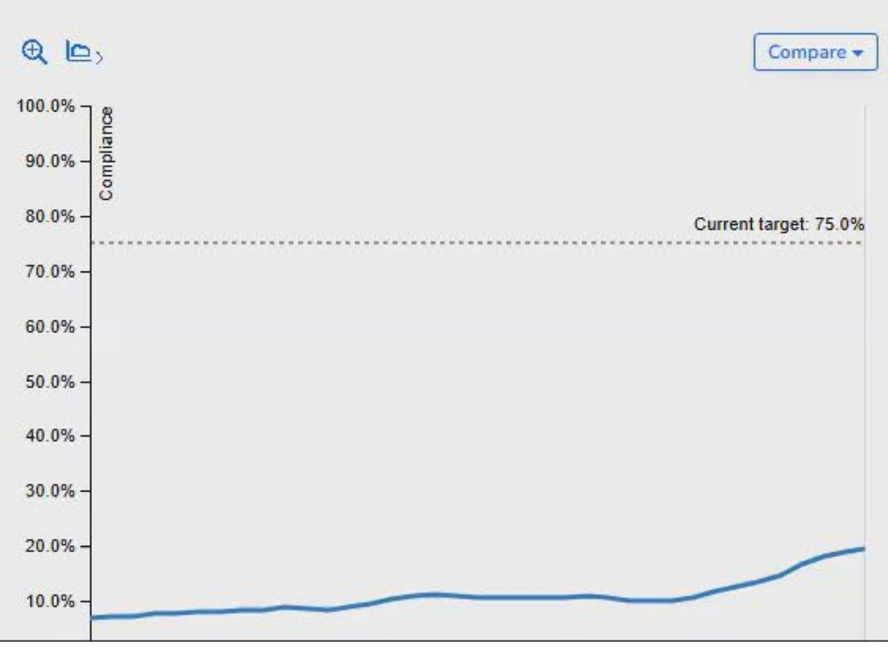
Below target

75.0%	-55.6	-1,378
Compliance target	Percentage points	Patients

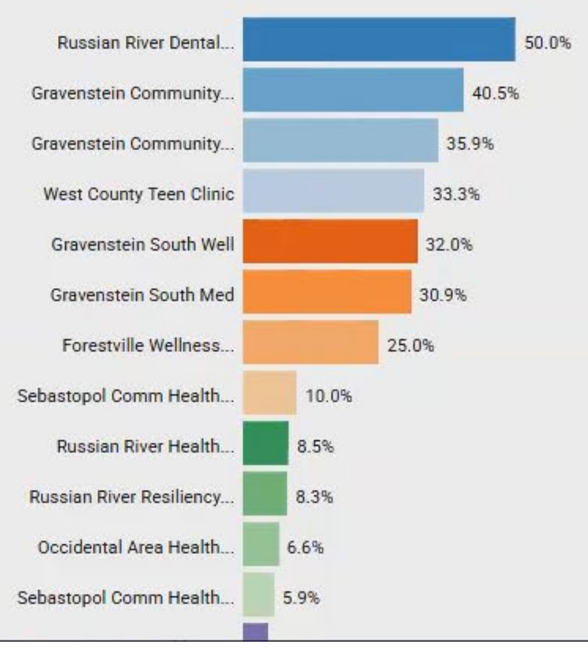
FILTERS

+ Add filter

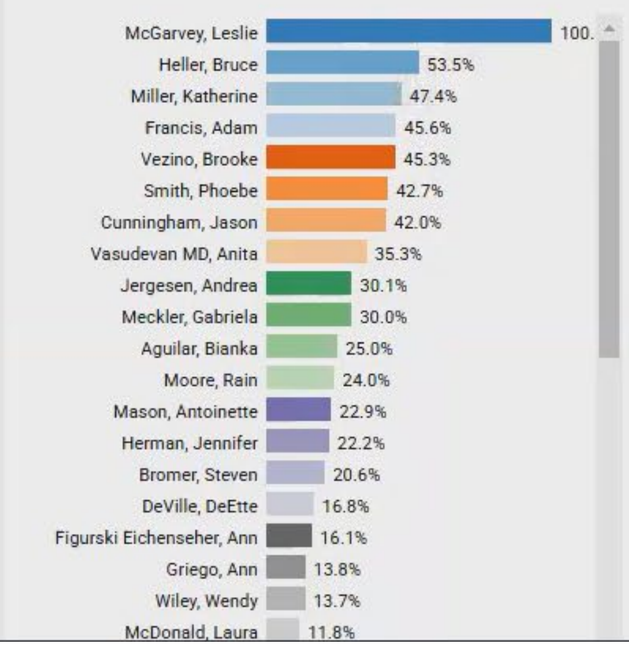
COMPLIANCE TREND BY PERCENTAGE



COMPLIANCE BY LOCATION



COMPLIANCE BY PROVIDER



Relevant Report: 2024 QIP Due List

This report displays the patients on the eReports export by metric and is separated out by Adult, Child and New Patient tabs. This report will be used by staff and pop team for targeted outreach.

Patients that display include patients that were matched in eCW and new patients that were unable to be matched.

Drill down to include:

- eCW acct number (will be blank if not in eCW)
- CIN
- Member first name
- Member last name
- Tracking Notes
- Status
- Incentive
- AGE
- PHP Assigned location
- Rendering Provider (from eCW)
- Default facility (from eCW)
- HCH Population (True/False)
- **School Populations**
- Colo (num/den/blank)
- A1C
- A1C corrected
- Eye
- HTN
- HTN corrected
- Mammo
- Mammo corrected
- Pap
- Child WCE
- Child WCE Corrected
- 15 month WCE
- 15 month WCE Corrected
- Lead
- CIS
- IZs Adolescents
- Child report
- Adult report
- New patient report (patients unable to be matched in eCW)

QIP Due list exports

This report should be exported each Monday and saved in the above folder. Outreach notes are to be populated on the spreadsheet.