Seeking to Improve HTN in Young Adults Within Two Family Medicine Clinics... During a Pandemic

Milwaukee, Wisconsin

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INTRODUCTION

- Hypertension (HTN) is a chronic disease impacting 1/3 of U.S. adults.
- Primary care physicians typically are the 1st to identify & treat HTN.
- Two family medicine residency clinics analysis of HTN patients:
  - Younger adult population (age 18-49) had high rates of uncontrolled HTN per system quality metrics (> race / gender)
  - Controlling HTN in younger patients has significant long-term health impacts
- Successful models for treating HTN use an interprofessional collaborative team approach including regular huddles.

AIMS

AURORA AIM
- Apply tested interventions to facilitate a safer environment for patients and clinicians

FAMILY MEDICINE PROJECT AIMS & OBJECTIVES
- ORIGINAL: Reduce age disparity gap between our younger patients (age 18-49) vs our older patients (age > 50) who have controlled hypertension by 5%
  - Baseline < 70% are controlled in age 18-49 vs 80% in age 50+
  - Ultimately seek to cut the age disparity in half
- PVaID AIMs (COVID-19)
  - Increase patient awareness of hypertension-related sequelae
  - Standardize clinician response to elevated BP virtual/ in person
  - Develop creative solutions to push toward achieving these aims despite pandemic restrictions/disruptions

METHODS: Interventions

PHASE 1: EDUCATION OF CLINICIANS AND CLINIC STAFF

A. BASELINE SURVEY OF CLINIC PHYSICIANS & RESIDENTS REVEALED:

- Clinicians felt comfortable prescribing HTN medications for patients with average age of 27 yrs = current JNC 8 guidelines
- Clinical Inertia – Unlikely to prescribe HTN medications to younger adults (various reasons noted)

B. EDUCATION

- RESIDENTS: Didactics on HTN and appropriate management (applicable to all ages with emphasis on young adults)
- RES/FAC ANNUAL EDUC MEETING: Review data & strategies to improve HTN including Motivational Interviewing
- CLINIC HUDDLES: Introduction and reiteration of HTN goal and residency-wide initiative; delineate roles

PHASE 2: PATIENT EDUCATION & WORKFLOW

- Create laminated BP card
- MAs circle BP risk on BP card
- Physicians or MA’s recheck BP
- Discuss JNC 8 management options

PHASE 3: IMPLEMENT & SUSTAIN MOMENTUM

- Identify MA & Nurse champions (role specificity)
- Monitor quality metrics and adjust
- Monthly Res/Fac meeting discussion on progress | strategies

PHASE 4: PATIENT OUTREACH

- Identify mechanisms for “COVID” outreach via online patient portal “MyAurora” during pandemic to check on high risk patients | offer appointments (virtual, phone, F2F in clinic)
- Secured foundation funds to purchase home BP cuffs to give to uncontrolled BP patients per priorities
  - In targeted age group, Returning Citizens project
  - Patient doesn’t want to come to clinic, white coat HTN

RESULTS

<table>
<thead>
<tr>
<th>ALL CLINICS</th>
<th>JANUARY 2020</th>
<th>AUGUST 2020</th>
<th>December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Un Controlled</td>
<td>% Control</td>
</tr>
<tr>
<td>Age 18-49</td>
<td>206</td>
<td>89</td>
<td>69.8%</td>
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<td>Age 50+</td>
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<td>229</td>
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DISCUSSION

KEY FINDINGS
- Pandemic’s impact on patient & team’s engagement with its “starts”, “stops” and “pivots” make data interpretation difficult
- Initial success in decreasing age disparity, offset by increase
- Younger HTN patients more likely to have activated MyAurora

LIMITATIONS
- Fluctuation in number of HTN patients via system QI data cumulative data makes it difficult to tease out variables impacting scores
- Redeployment | resident rotations changes
- One clinic relocated from easily accessible outpatient building to more difficult hospital-based setting in Sept 2020

PHASE 5: SUSTAINABILITY

- Secured funding for home BP monitors & cuffs
- Successfully recruited medical student to the team (in medical school track on training for urban /underserved patients)

What is Blood Pressure?

Blood Pressure Categories

What Do These Numbers Mean?

"Hypertension is a chronic disease impacting 1/3 of U.S. adults."

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