**PROMISING PRACTICE OVERVIEW**

Coastal Health Alliance's 2017 practice focus area for the PHASE program is Diabetes: Blood Pressure under 140 systolic mmHg and 90 diastolic mmHg. This measure was considered under the umbrella of the larger measure for Hypertension: Blood Pressure Good Control.

**RESULTS**

- CHA results for January, 2017: 59.0%
- Implementation of Nurse PHASE Case Management: January through March, of 2017
- CHA results for October, 2017: 68.9%
- 10 month percent improvement: 9.9%

**BACKGROUND**

CHA's Clinical Operations Team decided that a very directive approach was needed to improve Blood Pressure results for all patients with HTN and PHASE patients specifically. The nurse team was chartered to develop an approach that could be managed and tracked on a case by case basis as well as for CHA as a whole. The nurse team observed the following:

- Adherence to medication recommendations is an issue for the homeless population
- Financial capability is a barrier to repeat visits needed for medication adjustments
- Patients prefer to come in rather than have a phone visit because they feel more supported in a person to person interaction
- Up to 3 visits may be required to adjust dosage correctly

**AIM**

Improve BP control for patients with Diabetes to Blood Pressure under 140/90 mmHg so that goal of 65% is met by the end of 2017

**MEASURE**

*Measure:* Patients with Diabetes meet goal of BP under 140/90 mmHg

*Secondary Measure:* CHA patients with Essential Hypertension meet goal of BP under 140/90 mmHg

*Numerator:* Patients for whom the last BP reading is under 140 systolic mmHg and 90 diastolic mmHg

*Denominator:* Patients between 18 and 75 years of age who have an active diagnosis code of Diabetes on their Problem List. (or HTN or Secondary Measure)

**PHASE Nurse BP Visit Set up in eCW.**

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<th>Resources</th>
<th>TUE 1/3/17</th>
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**RESULTS TO DATE**

CHA’s results for January, 2017 of 59.0% Good Control for patients with Diabetes were increased to 68.9% BP of less than 140/90 mmHg in October, 2017 yielding a 10 month percent improvement of 9.9%

**WORKFLOW**

1. Provider holds the initial visit with the patient to establish a medication plan according to the PHASE algorithm and the individual patient needs.
2. Provider makes medication adjustment and notes for follow-up in 2 weeks with an RN
3. RN reviews notes and next steps and always confirms with provider if there are any questions
4. Two-week follow-up occurs, preferably with the same RN (see eCW note) until the patient’s BP is in good control
5. RN supports the patient with specific lifestyle goals (e.g. walking 3 times a week)

**LESSONS LEARNED**

- Patients preferred an established relationship with one nurse so we scheduled visits to accommodate that preference
- The financial commitment to unpaid nurse visits was a key success factor to the program
- Provider commitment to the flip visit when the nurse decides provider review is needed is essential
- Leadership commitment to implement and expand the nurse visit program is critical
- Requirement for individual follow-up with patients on the self management goals is more effectively managed by the nurses than the providers