Improving Follow-up for Uncontrolled Hypertension in Humboldt County

Reality

Theoretical

Background

Hypertension contributes to preventable stroke, heart failure, kidney disease and early death

In rural primary care, elevated BP is often detected, but follow-up is inconsistent

Because hypertension is often silent, missed follow up can lead to preventable harm

Importance of Issue

Stroke mortality in Humboldt County is nearly **2x** higher than California average (65.6 vs 35.3 per 100,000) (California Health Care Foundation, 2020)

Even with 78.13% control rate, about 20% of diagnosed patients remain uncontrolled

Rural barriers may delay care and worsen inequities

Source: Texas Health Resources, n.d.

Framework

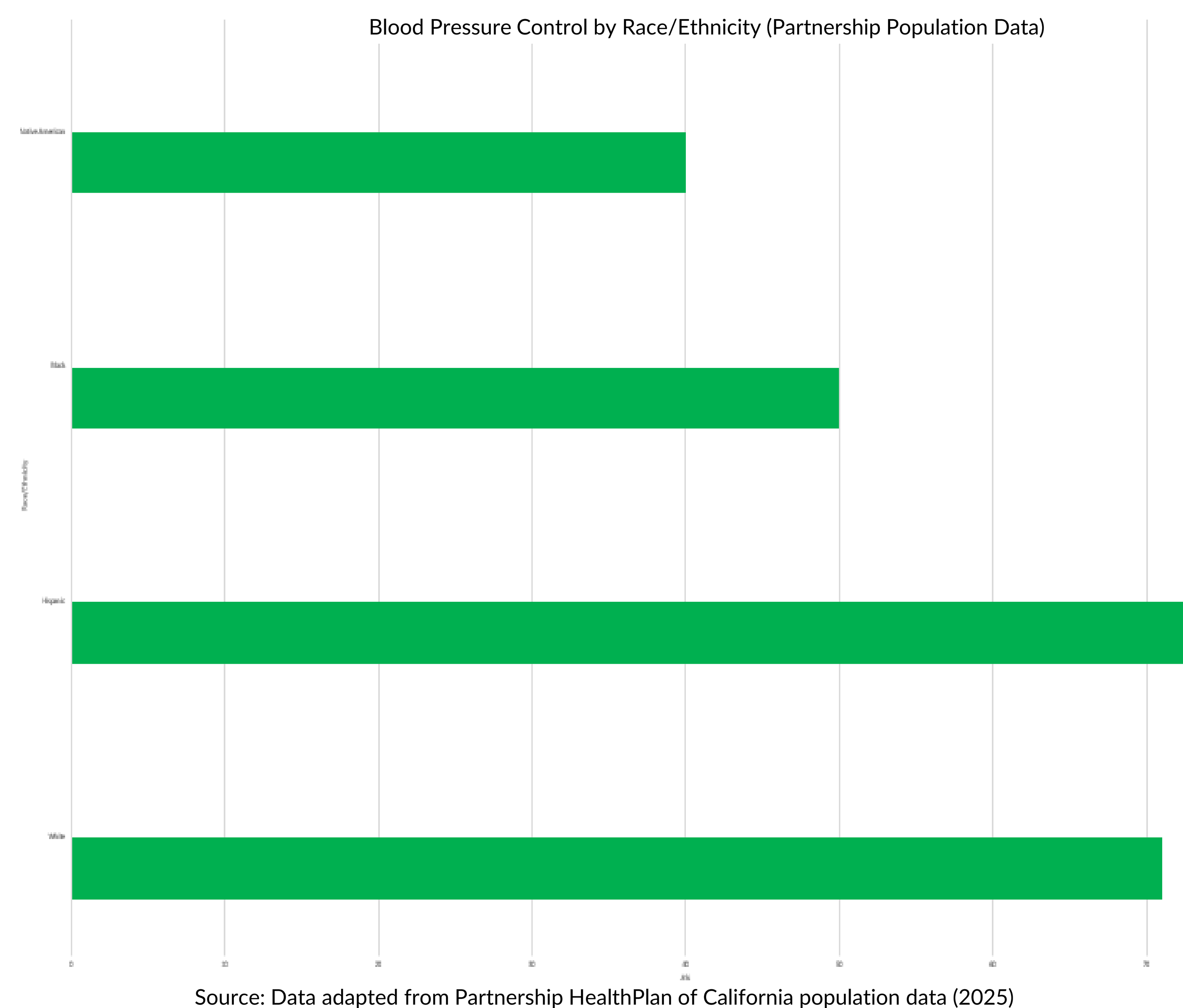
Plan-Do-Study-Act (PDSA)- used to test and refine standardized follow up process for elevated BP

Plan- Identify gap
Do- Implement RN follow-up
Study/Act- Measure and improve

Key Concepts & Outcomes

This project focuses on improving follow-up reliability after confirmed elevated BP and increasing BP control among Humboldt County patients with uncontrolled hypertension

SMART (Specific, measurable, attainable, realistic, time-bound) Goal: Increase HEDIS CBP rates by 5% in 12 months and reduce subgroup disparities by 20%



Source: Data adapted from Partnership HealthPlan of California population data (2025)

Interventions & Solutions

Individual: Home BP monitoring and RN check-ins

Unit: RN follow-up/flip visit with reassessment and closed loop scheduling

Policy: Standardized follow-up protocol, clear escalation criteria, and documentation template

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Key Players

Patient population is adults in Humboldt County with uncontrolled hypertension

Patients, their families, RNs, providers, MAs, LVNs, clinic leadership, QI/data teams and EHR support staff all play a role in improving reliable follow-up and equitable care. Community partners help address the barriers to care (transportation, health literacy, access, and others).

Evaluation

Success will be evaluated through QI and data tracking looking for improved BP control rates (HEDIS <140/90), faster/more reliable follow-up after high BP, reduced disparities in control rates

Process measures: Follow-up completions, documented plans, home BP submissions, and time to reassessment

Impact measures: BP reduction, improved HEDIS control rates, and reduced subgroup disparities

References

- California Health Care Foundation. (2020). *Regional market almanac: Humboldt and Del Norte counties.* https://www.chcf.org/wpcontent/uploads/2020/10/RegionalMarketAlmanac2020 HumboldtDelNorte.pdf
- Ito, M., Tajika, A., Toyomoto, R., Imai, H., Sakata, M., Honda, Y., Kishimoto, S., Fukuda, M., Horinouchi, N., Sahker, E., & Furukawa, T. A. (2024). The short- and long-term efficacy of nurse-led interventions for improving blood pressure control in people with hypertension in primary care settings: A systematic review and meta-analysis. *BMC Primary Care, 25*(1), 143. https://doi.org/10.1186/s12875-024-02380-x