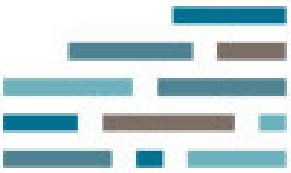
Innovation Report



Washington Association for Community Health
Community Health Centers Advancing Quality Care for All



Improving Blood Pressure with Team-Based Care

North Olympic Healthcare Network collaboration with the American Heart Association on the Target BP™ initiative empowered their care teams to achieve better hypertension outcomes.

Background

In 2023, North Olympic Healthcare Network (NOHN) saw an opportunity to implement a clinic-wide strategy to improve hypertension outcomes by participating in American Heart Association's (AHA) Target BP: Initiative™.

NOHN initially launched a Self-Measured Blood Pressure (SMBP) program in July 2023, aiming to improve control rates by leveraging community health workers (CHWs). AHA trained NOHN CHWs on hypertension and the SMBP model. The program brings care beyond clinical walls, tackling both disease management and non-medical needs that impact health. NOHN utilized their Chronic Care Management (CCM) roster to identify patients who had poorly controlled hypertension and who were likely to engage with the SMBP program upon enrollment.

In November 2024, with the intention to enhance patient care and improve hypertension management, NOHN implemented an updated intake process. This streamlined approach focuses on early intervention, social support, and structured provider engagement. The updated steps include:

- **Education and Care Plan Overview**: Patients receive personalized education about hypertension and a tailored care plan to support self-management from the outset.
- **Patient Needs Screening and CHW Referral**: Patients are screened for non-medical factors that impact health, such as housing and food insecurity. When appropriate, referrals are made to CHWs for further support and resource navigation.
- **Scheduled Follow-Up Appointments**: Patients are scheduled for three monthly follow-up visits with their Primary Care Provider (PCP) to monitor progress and adjust care plans as needed.
- **Structured Provider Engagement**: Clinical input is integrated into the workflow, ensuring timely provider engagement and continuity of care throughout the program.



North Olympic Healthcare Network

- **Rural FQHC that has been in operation for over 40 years**
- **18,500 active patients**
- **Over 58,000 patient visits in 2023 including medical, dental, & mental health**



Staffing Roles

The success of the Target: BP™ hypertension management program is deeply rooted in a multidisciplinary approach that leverages the unique strengths of each team member. Clearly defined roles and targeted training ensure effective implementation, patient engagement, and continuous quality improvement across the program.

- CHWs serve as the foundation of the hypertension program, taking on multiple critical roles. They act as program coordinators, managing day-to-day activities and tracking patient progress. As SMBP leads, they educate patients on accurate blood pressure monitoring practices and help interpret trends.

- As patient advocates, CHWs provide social and emotional support, helping patients navigate both health care and community systems. They also serve as liaisons to the care teams, ensuring that information is communicated effectively between patients and clinical staff.

- Care Managers serve as a clinical bridge between the CHWs and PCPs. This role ensures seamless communication and coordination of care. Care Managers provide clinical support to CHWs, help interpret blood pressure data and ensure a timely escalation of issues requiring medical intervention. Their role is vital in maintaining clinical oversight without duplicating efforts.

- PCPs hold the primary responsibility for clinical decision-making in the program. They oversee individualized care plans, adjust antihypertensive medications as needed, and provide medical guidance based on the patient's progress. Their consistent involvement ensures that clinical care remains aligned with best practices and evolving patient needs.



Training Framework

Known barriers to self-management for patients:

- **Unable to purchase a home BP machine**
- **Improper home BP measurements**
- **Health Literacy**
- **Other Health Conditions**

CHW Training
CHWs are trained by the Outreach and Navigation Manager using curriculum and resources provided by AHA. This ensures alignment with national standards and reinforces evidence-based practices in hypertension management.

Blood Pressure Cuff Training
To promote accurate home monitoring, the NOHN nursing team provides hands-on training to all staff—including CHWs and care managers—on the proper use of blood pressure cuffs.

Ongoing Coaching and Development
CHWs receive ongoing coaching aimed at improving their communication, engagement strategies, and problem-solving skills.

Lessons Learned

One of the most significant lessons from this program is the recognition that hypertension must be treated as a continuous, core focus of primary care—not merely addressed during annual or biannual screenings. By integrating hypertension management into regular care processes, clinics are better equipped to intervene early, monitor trends, and prevent long-term complications. The SMBP model has proven to be a powerful tool in shifting care from reactive to proactive. By equipping patients with knowledge and tools to monitor their own blood pressure, the program promotes self-efficacy and accountability. Simultaneously, providers receive more timely and accurate data, allowing them to make better-informed treatment decisions and adjustments in real time.

Another important outcome is the successful integration of CHWs into the clinical care team, demonstrating that with proper training and role clarity, CHWs can enhance care coordination, improve patient follow-through, and extend the reach of the primary care team. Routine interaction with patients through CHWs and SMBP follow-ups provides valuable insight into patient needs and community-level trends. This deeper understanding allows care teams to tailor interventions more precisely, identify emerging health needs, and address upstream barriers to effective hypertension management. Trust is foundational to health outcomes, and this program has shown that consistent CHW engagement builds long-term trust with patients. Above all, a notable success factor has been the collaboration between CHWs, providers, and outreach staff. This cross-functional teamwork breaks down silos and enables more seamless care delivery. The program illustrates how coordinated communication, and shared goals can enhance both patient experience and clinical effectiveness.

Early Wins: Encouraging Indicators of Progress
Early program data highlights several encouraging outcomes:

- **Patient Enrollment: More than 35 patients enrolled since program launch in August 2023**
- **Patient Engagement: Approximately 66% of participants have demonstrated sustained engagement, submitting consistent BP readings over time**
- **BP Control Achieved: Roughly 10% of participants have achieved blood pressure control within the program period, within a population of patients with historically difficult to control hypertension.**
- **Improved Collaboration: There has been a notable improvement in communication between providers and CHWs, fostering more cohesive care coordination**
- **Patient Enthusiasm: Feedback reflects strong interest and willingness to participate, underscoring the program's relevance and accessibility**

Challenges & Solutions

As the Target: BP™ program continues to evolve, several operational and engagement-related challenges have emerged. In response, targeted solutions are being developed and implemented to strengthen the program's sustainability, effectiveness, and scalability.

- **CHW Turnover:** To improve retention, NOHN is collaborating closely with human resources and organizational leadership.

- **Patient Engagement:** NOHN is currently exploring community-based incentives and recognition strategies to motivate ongoing participation.

- **Cuff Logistics and Availability:** NOHN is diversifying their suppliers to include options that meet varied size and quality standards, ensuring equitable access to all patients.

- **Return and Calibration of Cuffs:** A structured tracking and reassignment workflow has been implemented, ensuring that cuffs are systematically collected at program completion and calibrated and assessed for quality.

Next Steps and Vision

As NOHN continues to evolve and refine their hypertension management program, they are currently rolling out Version 2.0, incorporating both lessons learned and structural improvements.

Although comprehensive outcome data is still forthcoming, NOHN has established clear goals to guide the success of this next program phase:

- Patient Enrollment: Enroll at least 30 patients with uncontrolled hypertension (BP ≥140/90 mmHg) into the Self-Measured Blood Pressure (SMBP) program
- BP Control among SMBP Participants: Achieve blood pressure control (<130/80 mmHg) in 55% of enrolled SMBP patients
- Overall Hypertension Management: Ensure 70% of all hypertensive patients at NOHN maintain blood pressure control under the clinical threshold of <140/90 mmHg

As NOHN moves forward with the next phase of the Target: BP™ hypertension management program, their focus is not only on refining their operational model but also on deepening their understanding of the systemic challenges affecting blood pressure control in their community. With the rollout of Version 2.0 now underway, they are aligning immediate actions and long-term strategies to ensure meaningful, data-driven impact. Their long-term vision is to utilize self-measured blood pressure data as a tool for community needs assessment.



Washington Association for Community Health

The Association's innovation reports aim to support community health centers in leading innovation by identifying successful promising practices and communicating them to the statewide network.

Does your CHC have an innovation to share? Let us know!

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