Chronic Disease Improvement Collaborative (CDIC2)

WEBINAR:

Understanding Current Guidelines for Hypertension and Using a Team-Based Approach to Improve Care for Patients

February 25, 2016, noon-1 pm

For Audio, please call: 1.866.740.1260, Access Code: 1120970#

Funding for this work is provided under US CDC grant award DP 13-1305 through Maine CDC.
QC Staff is Working to Improve the Health of Everyone in Maine
QC Brings Together the People Who Give, Get and Pay for Health Care to Address Shared Priorities
Join Us!
Become a Maine Quality Counts Member

Visit mainequitycounts.org & click “Membership”

- Networking events
- Webinars with national experts
- Discounted registration for QC 2016
Register Today! Early Bird Rates Expire March 4th
mainequalitycounts.org/qc2016

Wednesday, April 6th
Connect With Us

email list:
mainequalitycounts.org

blog:
blog.mainequalitycounts.org
Today’s Webinar Agenda:

12:00 pm  Welcome & Introductions
12:05 pm  Review of Standards of Care and How Primary Care Teams Can Improve Care for Patients with Hypertension
          Dr. Emery
12:40 pm  Practice Report Out on Success and Challenges
12:50 pm  QI Coaches Corner and Quick Data Review
12:55 pm  Prepping for the Learning Session and Health Literacy Materials
1:00 pm   Adjourn
Webinar Logistics:

To minimize background noise, all lines will be muted until the presentation begins

• To unmute your line, press *7
• To mute your line, press *6

To ask questions or share comments, use one of two ways:

1. Raise Your Hand button (press *7 to unmute your line)
2. Type in chat box on the lower left-hand side of the screen

Please state your name and organization before asking your question or sharing your comment.
Who is Maine Quality Counts?

- Independent, multi-stakeholder alliance in Maine working to transform health and health care by leading, collaborating, and aligning improvement efforts

- Only organization working to improve quality of care for all Maine people

- Members include consumers, doctors, nurses, hospitals, health systems, payers, employers, government, policy makers, and others working to improve health and healthcare
Speaker Disclosure

None of the speakers today have any relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.
Peter Emery is an internal medicine provider at InterMed in Portland, Maine. He attended Boston University and completed medical school at Dartmouth. He did his internship at Beth Israel Deaconess Medical Center. He is board-certified by the American Board of Internal Medicine. He recently spoke at the 2014 Maine Cardiovascular Health Council Annual Summit on November 13, 2014, on the topic of Hypertension Management: Current Guidelines and Recommendations.
Increase in Percent of Patients with Controlled Hypertension

Kaiser Permanente Northern California hypertension control rates*

*NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; KPNC: Kaiser Permanente Northern California

Source: Jaffe MG, et al. Improved blood pressure control associated with a large-scale hypertension program. JAMA August 21, 2013, Vol 310, No. 7
Standards of Care: Office BP Measurement

- Manual or automated sphygmomanometer
- Average of (at least) 2 readings
- If not done, readings will be inaccurate
  - Patient seated, back supported, feet on the floor
  - Resting for 5 minutes
  - Appropriately-sized cuff
  - Over bare arm
  - Arm raised and resting at the level of the RA
  - Estimate the systolic BP by palpating the radial artery with manual cuff (if using manual technique)
Standards of Care: Office BP Measurement

- Various short-term factors affect BP
  - Emotions
  - Stress
  - Pain
  - Physical activity
  - Caffeine
  - Nicotine
  - Full bladder

- 15-30% of people have lower BPs outside of the office
Standards of Care: Screening for Hypertension

• Properly measured office BP is the standard of care for screening

• Disadvantages
  • Errors
  • Limited number of readings
  • “White Coat” Hypertension
Standards of Care: Screening for Hypertension

- **USPSTF: Screening Intervals**
  - Screen for high blood pressure in adults 18 years or older
    - Annually for high risk
      - age >40
      - overweight
      - African American
      - high-normal BP (130-139/85-89)
    - 3-5 years for all others
USPSTF Guideline
Screening for Hypertension

- Obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment
  - Ambulatory Blood Pressure Monitor (ABPM)
  - Home Blood Pressure Monitor (HBPM)
    - Possible alternative
USPSTF Guideline
Screening For Hypertension

- ABMP is for confirmation of the diagnosis of hypertension (when available)
- HBPM is an alternative
  - Evidence is not as strong as for ABMP
  - Need a valid machine
    - Association for the Advancement of Medical Instrumentation
  - Patient education in proper use
Interpretation of ABPM

- 24 hour average >135/85
- Daytime >140/90
- Nighttime > 125/75
  - Nighttime BP better predictor of total mortality (CV and non-CV) vs daytime
- “Dipping”
  - 15% lower than daytime levels is normal
  - Failure to “dip” by at least 10% = “non-dipper”
  - “non-dippers” at increased risk for LVH, CHF, progression of kidney disease in diabetics
2014 Guidelines
Treatment: Guidelines

- Medication initiation and titration strategies
- Follow up time intervals
- Emphasis on lifestyle modification
- Allow practices to standardize care
Million Hearts Algorithm

- Based on AHA/ACC guideline
- Similar to JNC 7
  - Familiar
- Follow up time intervals
- Easy to follow
- Gives prescribers choice
  - Seems less like “cookbook medicine”
- Does not have different BP targets for different populations
  - Seems to be supported by SPRINT
SPRINT

- Age 50 and older with BP > 130 and at least one other CV risk factor (diabetics excluded)
  - SBP target of < 120 vs < 140
    - reduced MI, stroke, CHF, death
  - Takes about 3 meds to get most people to < 120

## Lifestyle Modifications to Manage Hypertension†

<table>
<thead>
<tr>
<th>Modification</th>
<th>Recommendation</th>
<th>Approximate SBP Reduction (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight reduction</td>
<td>Maintain normal body weight (body mass index 18.5–24.9 kg/m²).</td>
<td>5–20 mm Hg/10 kg weight loss²</td>
</tr>
<tr>
<td>Adopt DASH eating plan</td>
<td>Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat.</td>
<td>8–14 mm Hg²⁴</td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).</td>
<td>2–8 mm Hg¹⁶</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week).</td>
<td>4–9 mm Hg²⁷</td>
</tr>
<tr>
<td>Moderation of alcohol consumption</td>
<td>Limit consumption to no more than 2 drinks (1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men and to no more than 1 drink per day in women and lighter weight persons.</td>
<td>2–4 mm Hg²</td>
</tr>
</tbody>
</table>

DASH, Dietary Approaches to Stop Hypertension.

* For overall cardiovascular risk reduction, stop smoking.
† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.
Medication Titration

- Most people with initial BP >160/100 and many people with BP 140-159/90-99 will require more than one agent to get to goal

- The Kaiser Permanente Guideline
  - Initiating with lisinopril/HCTZ is the preferred strategy for all patients
Intermed Hypertension Improvement Program

- Using Clinical Microsystems Tools
  - Patient Education
    - Patient Education Materials
  - Community Integration and Resources
    - Pharmacy, Nutritionist, Exercise instruction
  - Provider and Clinical Staff Education
    - BP technique with manual cuffs
    - Workflow in the office, timing
  - “Know Your Numbers”
    - Card, patient portal
Intermed Hypertension Improvement Program

- Adopted the Million Hearts Algorithm
- EHR Registry of Hypertensive patients
- Provider control rates
  - Reported every 2 weeks
- Specialized on line training for NP/PA
  - American Society of Hypertension
Intermed Hypertension Improvement Program

- Team Structure: Everyone plays a role
  - Clinical Microsystems
  - Patient and Family
    - Seeking feedback, engagement
      - Home BP monitoring, “know your numbers”
  - Front Desk
    - Pre-visit planning
  - Medical Records
    - Medication refill protocol
  - Clinical Staff
    - Docs, NP/PAs
  - Managers
    - Workflow, equipment
Intermed

• Challenges
  • Time-consuming
    • Team-building, morale-building
  • Education and training
  • Getting providers use the tools
    • Transparency
  • Sustaining successful practices
    • Staff turnover, “clinical intertia”
Intermed

- Success
  - Team Building
  - Evidence-based standards of care
  - Standardization
    - Everyone is on the same page
- EHR registry
  - Reporting
AHA/JCC
Hypertension: The Public Health Perspective

• “High-quality blood pressure management is multifactorial and requires engagement of patients, families, providers, healthcare delivery systems, and communities.”

• Science Advisory from AHA/ACC, CDC

• *J Am Coll Cardiol.* April 1, 2014, 63(12)
CDIC Blood Pressure Trainings at the Practices

Ellsworth Family Practice  (two trainings)
• **March 8**\(^{th}\) and **April 12**\(^{th}\)  7-10 am
• Will be held at Maine Coast Memorial 50 Union St Ellsworth, ME 04605 in the Boardroom, which is located within the Medical Office Building.
• Anticipating 15 people (RN’s, LPN’s, and MA’s)

Nasson Health Care
• **March 17**\(^{th}\) 1-4 pm
• Will be held at Nasson Health Care, Community Action Corporation, 15 Oak Street Springvale, ME 04083
• Anticipating 6 people (MA’s)

York Family Practice
• **April 6**\(^{th}\) 7-10 am
• Will be held at York Family Practice 17 Long Sands Road York, ME
• Anticipating 5 people (RNs and MAs)

• **Lincoln Medical Partners** has a master trainer through MaineHealth
QI Corner: Practice Report Out

One Success and One Challenge

- Ellsworth Internal Medicine
- Lincoln Medical Partners Family Medicine
- Nasson Health Care Center
- York Family Practice
Model for Improvement

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

From: Associates in Process Improvement
- Median performance 62.5%
- Reliable
- Target of 75%

- Median performance 60.85%
- Wider variation
- Target of 75%
- Median performance 37.7%
- 2 more points down, unfavorable trend
- Target of 75%
- Data definition?

- Median performance 45%
- Reliable
- Target of 75%
Story in the Data

• Performing reliably
  – Performance predictable if nothing further changed

• Operational definition of the self care plan for patients living with diabetes clear for all?

• Continued room for improvement
  – Opportunity to practice with self care plans—up next😊
Health Literacy – Ending the Confusion

Patient Goal Setting Tools

My Action Plan

Name: ___________________________ Date: ___________________________

[ ] I have worked with another provider to set a goal.

1. What I Will Do

Choose One:
- Improve my physical activity.
- Take my medications.
- Improve my food choices.
- Reduce my stress.
- Change my tobacco use.
- Other: ___________________________

Specifically I will: (Example: Walk more.) ___________________________

Why? ___________________________

2. How Much/How Often

How much: (Example: 20 minutes) ___________________________

How often: (Example: Three times a week.) ___________________________

When: (Example: Monday, Wednesday, Friday) ___________________________

3. Confidence

How confident are you that you will be able to do the activity? (Circle one. Choose an activity where you would be a 7 or above.)

0 1 2 3 4 5 6 7 8 9 10

Not sure at all Somewhat sure Very sure

My signature: ___________________________

Healthcare provider signature: ___________________________
My Self-Care Plan

Name: ___________________________ Date: ___________________________

☐ I have worked with another provider to set a goal.

1.

What I Will Do

Choose One Goal:
I will ____________________________
(Examples: increase my physical activity; take my medications; make healthier food choices; reduce my stress; reduce my tobacco use)

Choose One Action:
I will ____________________________
(Examples: walk more; eat more fruits and vegetables)

2.

How Much/How Often

How much: ____________________________
(Example: 20 minutes)

How often: ____________________________
(Example: three times a week on Monday, Wednesday, and Friday)

3.

Confidence

Circle a number to show how sure you are about doing the activity. Try to choose an activity that you are a 7 or above.

0 1 2 3 4 5 6 7 8 9 10

Not sure at all Somewhat sure Very sure

My signature ___________________________ Healthcare Provider signature ___________________________
Key Facts About Health Literacy

- Nearly half of American adults lack adequate literacy skills
- More than half lack adequate numeracy skills

- Literacy: The ability to read, write, compute, understand and use written information. Even adults with adequate literacy skill may struggle with health literacy

- Health Literacy: The ability to use complex literacy skills in health-related circumstances and environments to help prevent, manage and treat health conditions

Evidence supports 2 major solutions – Teach-back & plain language

- Teach-back
- Plain Language

Watch the AMA Health Literacy & Patient Safety: Help Patients Understand Video
Short version: https://www.youtube.com/watch?v=ubPkdpgHWAQ
Save the Dates!

- **Blood Pressure Trainings:**
  - Ellsworth FP: **March 8th** and **April 12th** 7-10 am
  - Nasson Health Care: **March 17th** 1-4 pm
  - York Family Practice: **April 6th** 7-10 am

- **Submit monthly chart review and PDSA:** **March 15th**

- **Second Learning Session:** **March 17th** from 8:30 – 3:00 at Maple Hill Farm in Hallowell- If you are able, please bring five community partners

- **Final webinar:** **April 21st** from 12-1 pm, “Hiding in Plain Site (Patients with High BP): Hilary K. Wall, MPH, Senior Health Scientist, CDC Division for Heart Disease and Stroke Prevention.

- **Final Learning Session:** **June 16th** from 8:30 – 3:00 at Maple Hill Farm in Hallowell
Chronic Disease Improvement Collaborative 2

We welcome your comments and questions!

CDIC website:
www.mainequalitycounts.org/CDIC
Contact Information: 620-8526

Megan Stiles, Sr. Project Manager
mstiles@mainequalitycount.org, ext. 1033

Kimberly Jablon, Administrative Coordinator
kjablon@mainequalitycounts.org, ext. 1004

Sue Butts-Dion, Quality Improvement Advisor,
sbutts@maine.rr.com, 283-1560