Hypertension Control Change Package: An Overview for State and Local Health Departments

Hilary K. Wall, MPH
Million Hearts® Science Lead
Division for Heart Disease and Stroke Prevention
U.S. Centers for Disease Control and Prevention

NACDD Webinar
August 19, 2015
Financial and/or Commercial Disclosures

None

The opinions expressed by authors contributing to this project do not necessarily reflect the opinions of the US Department of Health and Human Services, the Public Health Service, the Centers for Disease Control and Prevention, or the authors’ affiliated institutions. Use of trade names is for identification only and does not imply endorsement by any of the groups named below.
Presentation Outline

- Million Hearts® overview
- Hypertension in the U.S.
- Continuous Quality Improvement
- Million Hearts® Hypertension Control Change Package
Million Hearts®

Goal: Prevent one million heart attacks and strokes by 2017

• US Department of Health and Human Services initiative, co-led by:
  – Centers for Disease Control and Prevention (CDC)
  – Centers for Medicare & Medicaid Services (CMS)

• Partners across federal and state agencies and private organizations
Key Components of Million Hearts®

Keeping Us Healthy
Changing the environment

Focus on the ABCS
Optimizing care

Health Disparities

Aspirin when appropriate
Blood pressure control
Cholesterol management
Smoking cessation

Health information technology
Innovations in care delivery

millionshearts.hhs.gov
# Targets for the ABCS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin when appropriate</td>
<td>53.8%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>52.4%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Cholesterol management</td>
<td>33.0%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>22.2%</td>
<td>65%</td>
<td>70%</td>
</tr>
</tbody>
</table>

National Ambulatory Medical Care Survey, National Health and Nutrition Examination Survey
70 Million Adults with Hypertension (29.1%)

Controlled 52%

Uncontrolled 48%

34M Adults With Uncontrolled Hypertension By Awareness And Treatment Status

Source: 2009-2010 National Health and Nutrition Examination Survey
Data may not add due to rounding.
Uncontrolled Hypertension and Access to Care


Barriers to Achieving Hypertension Control

- Patient resistance to treatment
- Patient non-adherence to medications and lifestyle changes
- Multiple medication choices and dosages
- Up-titration and follow-up timelines
- Therapeutic inertia
- White-coat hypertension and resistant hypertension

Persell SD. Hypertension. 2011;57:1076–80
MOVING THE DIAL
What is Continuous Quality Improvement?

- A quality management process that encourages all health care team members to continuously ask:
  - How are we doing?
  - Can we do better?
- Culture of improvement for the patient, the practice, and the population in general
- Structured planning approach to evaluate the current practice processes and improve systems to achieve improvement
- Enables team members to assess and improve health care delivery and services

Continuous Quality Improvement (CQI) Strategies to Optimize your Practice: Primer, 2013
“It is not necessary to change. Survival is not mandatory.”
– W. Edwards Deming
The Model for Improvement

- Developed by Associates in Process Improvement
- Used by the Institute for Healthcare Improvement (IHI)
- The IHI Improvement Project Planning Form
What are we trying to accomplish?

- Based on:
  - Staff perceptions/insights of needed improvements
  - Patient surveys
  - Chart reviews
  - Ambulatory Health IT-enabled Quality Improvement Worksheet ([http://bit.ly/1KB3Xny](http://bit.ly/1KB3Xny))

- Start small, narrow focus
  - One clinical area
  - Authority and resources to make changes
Establish SMART Aims

- Specific, Measurable, Achievable, Realistic, Timebound

- Examples
  - Increase the number of patients with hypertension who receive reminders for follow-up visits from 25% to 100% today.
  - Increase the hypertension control rate for diagnosed hypertensive patients from 33% to 48% in 6 months.
How will we know that a change is an improvement?

- Determine data source
  - Chart reviews on samples of patients
  - Patient registries
  - EHR data
  - Patient surveys

- Share results
What changes can we make that will result in improvement?

- “All improvement requires change but not all changes result in improvement.”

- Sources for ideas for change:
  - Creative problem solving
  - Insights of those who work in the system
  - Scientific literature
  - Borrowing from others who have successfully improved
Plan-Do-Study-Act (PDSA) Cycles

- Rapid tests of change
- Way to test an idea in a real-life work setting
- The Institute for Healthcare Improvement (IHI) PDSA Worksheet for Testing Change
  http://bit.ly/1KMP7rq
Repeating PDSA

1. **Change Idea**: Pilot the change with a small group of patients and refine it.
2. **Data**: Modify the change and use it with other patients.
3. **Wide-scale tests of change**: Modify the change as needed and make it standard practice.
4. **Changes to the system resulting in improvement**: Repeating PDSA
Selecting Changes

- Source for ideas for change: Borrowing from others who have successfully improved
- A “change package” is an evidence-based set of changes that are critical to the improvement of an identified care process.

Improving Chronic Illness Care, 2014
Hypertension Control Change Package

Table 1. Hypertension Control Change Package—Key Foundations (continued)

<table>
<thead>
<tr>
<th>Change Concepts</th>
<th>Change Ideas</th>
<th>Tools and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop HTN control policy and procedures</td>
<td>• American Medical Group Association, Provider Toolkit to Improve Hypertension Control: BP Addressed for Every Hypertension Patient at Every Primary Care/Office Visit: [Link]</td>
<td>[Link]</td>
</tr>
<tr>
<td>Leverage local Patient Contained Medical Home (PCMH) activities to help drive comprehensive approach to HTN management</td>
<td>• Washington State Department of Health, Improving the Screening, Prevention, and Management of Hypertension—An Implementation Tool for Local Practice Teams, PAMII Change Concepts, Tools, and Resources [(pg. 18-35)]</td>
<td>[Link]</td>
</tr>
<tr>
<td>Develop a Routine for How Hypertension Patients will be Proactively Tracked and Managed</td>
<td>• Health Resources and Services Administration, Implementation: HHS Health Information Technology Integration: [Link]</td>
<td>[Link]</td>
</tr>
</tbody>
</table>

Table 2. Hypertension Control Change Package—Population Health Management

<table>
<thead>
<tr>
<th>Change Concepts</th>
<th>Change Ideas</th>
<th>Tools and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve a clinic registry</td>
<td>• American Medical Group Association, Registry Used to Track Hypertension Patients: [Link]</td>
<td>[Link]</td>
</tr>
<tr>
<td>Identify patients with elevated BP and without a HTN diagnostic diagnosis HTN to appropriate</td>
<td>• Health Center Network of New York, Undiagnosed Hypertension Registry: [Link]</td>
<td>[Link]</td>
</tr>
<tr>
<td>Use a Registry to Identify, Track, and Manage Patients with HTN</td>
<td>• Redwood Community Health Coalition, Hypertension Recall Instructions: See Appendix A</td>
<td>[Link]</td>
</tr>
<tr>
<td>Use a default process for outreach e.g., via phone, mail, email, text message to patients with uncontrolled HTN and those otherwise meeting follow up</td>
<td>• The Office of the National Coordinator for Health Information Technology, Quality Improvement in a Primary Care Practice: [Link]</td>
<td>[Link]</td>
</tr>
<tr>
<td>Access adherence to proper BP measurement technique</td>
<td>• Atevon Heart Association: HeartView in Online Tool for Patients to Track and Manage Their Heart Health and Share Information: [Link]</td>
<td>[Link]</td>
</tr>
</tbody>
</table>

Access the Change Package at:
Change Concept

• General notions that are useful in the development of more specific ideas for changes that lead to improvement

Change Idea

• Actionable, specific ideas for changing a process

Tools & Resources

• Can be adapted by or adopted in a health care setting
Hypertension Control Change Package
Focus Areas

1. Key foundations
2. Population health management
3. Individual patient supports

→ Hypertension control case studies
Key Foundations

- **Change Concepts:**
  - Make hypertension control a practice priority
  - Implement a policy to address blood pressure for every patient with hypertension at every visit
  - Train and evaluate direct care staff on accurate blood pressure measurement and recording
  - Systematically use evidence-based hypertension guidelines and treatment protocols
  - Equip direct care staff to facilitate patient self-management
Train and Evaluate Direct Care Staff on Accurate Blood Pressure Measurement and Recording

1. Provide Guidance On Measuring BP Accurately
2. Assess Adherence To Proper BP Measurement Technique

Change Concept
Change Ideas
Tools & Resources
Population Health Management

- **Change Concepts:**
  - Use a registry to identify, track, and manage patients with hypertension
  - Use clinician-managed protocols for medication adjustment and lifestyle recommendations
  - Use practice data to drive improvement
Use Practice Data To Drive Improvement

1. Determine HTN Control Metrics For The Practice

2. Regularly Provide A Dashboard With BP Goals, Metrics, And Performance

Change Concept

Change Ideas

Tools & Resources
Individual Patient Supports

- **Change Concepts:**
  - Support patients in hypertension self-management during their routine daily activities
  - Prepare patients and care team beforehand for effective hypertension management during office visits
  - Use opportunities during each patient visit phase to optimize blood pressure management
    - Intake
    - Provider Encounter
    - Encounter Closing
  - Follow up after visits to monitor and reinforce blood pressure management plans
### Use Each Patient Visit Phase to Optimize HTN Management: Intake (e.g., check-in, waiting, rooming)

1. **Provide patients with educational materials to help them understand HTN and its implications**

2. **Provide patient with tools to support their visit agenda and goal setting**

3. **Measure, document and repeat BP correctly as indicated; flag abnormal readings**

4. **Reconcile medications patient is actually taking with the record’s medication list**

---

**Tools & Resources**

- [Image of medication reconciliation form]

---

**Change Concept**

- Change Ideas

---

**Tools & Resources**

- [Image of patient chart]

---

Be one in a Million Hearts®
millionhearts.hhs.gov
Department of Health Role - DISTRIBUTE

• Share with clinicians and health care systems who are undertaking QI efforts
• Distribute to clinical organizations who are positioned to encourage change among their membership (e.g. state medical associations, state primary care associations)
Department of Health Role - IMPLEMENT

- DOH staff with QI expertise can use the change package for technical assistance
- Encourage TA-providing partners to use as source material (e.g. RECs, QIN/QIOs)
- Use the change package as a basis for intervention in QI collaboratives
- Include QI strategies in RFPs/sub-awards
Practice Facilitation

• A supportive service provided to a PC practice by a trained individual or team, using a range of QI approaches to build the internal capacity of a practice to improve over time

• [https://www.pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf](https://www.pcmh.ahrq.gov/sites/default/files/attachments/Developing_and_Running_a_Primary_Care_Practice_Facilitation_Program.pdf)

• Audience
  – State or local departments of health
  – Quality improvement organizations (QIOs)
  – Area health education centers (AHECs)
  – HITECH regional extension centers (RECs)
  – Practice-based research networks (PBRNs)
  – Primary care associations (PCAs)
  – Accountable care organizations (ACOs)
Special Thanks

- Rikita Merai – CDC
- Jerry Osheroff – TMIT Consulting
- Brita Roy – Yale University

- American Medical Group Foundation
- Clinical Decision Support Collaborative for Performance Improvement
- Health Center Network of New York
- Institute for Healthcare Improvement
- Kaiser Permanente Northern California
- New York City Department of Health and Mental Hygiene Primary Care Information Project
- Redwood Community Health Coalition
- Washington State Department of Health
Questions?

Hilary Wall – hwall@cdc.gov
HCCP Value and Continued Use: 9 QI Leads Surveyed

- **Value**
  - 33% very valuable, 56% somewhat valuable

- **Ongoing Use (Optional Comments; Quotes)**
  - Will continue to use
  - Current plan is [to continue using] the package after the initiative is over.
  - Will continue to use in our clinic/practice settings.
  - Apply activities to other chronic diseases.
THT QI Project: Other Legacy

Insights
- High value/motivation by starting w/’current state analysis’
- Hard for practices to find time to analyze and select HCCP tools – needed hand-holding
- People/process issues must be addressed first – can’t just drop in a tool
- HCCP tools provide good starting point for modification (e.g., pre-visit call scripts for decreasing no-shows)

Disseminating/Spreading Tools and Approach
- Proposal to CMS to help 10,000 clinicians transform care
- NJ DOH looking at project implications for spread
- Serving as a model for other projects, e.g., BP control in community health centers across several states
Core Principles for CDS/QI Success

Improving care delivery and outcomes requires meticulous attention to:

- People (engagement, capacity)
- Processes (for care and QI)
- Products (e.g., HIT)
Successful QI Projects Are Win–Win–Wins

- Efficient care, Better health, Lower costs
- Efficient workflow/information flow, Better clinical results
- Better clinical and business results, Scalable QI approaches
Escalating Value as Projects Unfold

Value grows as each group is engaged

1. Departments of Health
   - Inform, convene, inspire, fund, scale, spread

2. CDS/QI SME
   - CDS/QI Expertise
   - In the trenches insight & care delivery

3. Lead Organization
   - Overarching Insight & Project management
   - CDO specific insight, local enhancements; care management

4. CDO Leads & Sponsors
   - CDO specific insight, local enhancements; care management

5. CDO Staff
   - Patients [Decision/Actions Key to Goal]

© 2015 TMIT Consulting, LLC
Polling Question #2!
Questions and Answers

Please type your questions into the chat box!
Polling Question #3!
Thank you!

Today’s webinar will be posted to the NACDD website in a few days! Please check out: http://www.chronicdisease.org/?page=CVHWebinars

For more information about NACDD’s work to support Million Hearts, please visit us at: https://chronicdisease.site-ym.com/general/custom.asp?page=MHIInit