6 Ways to Improve Hypertension Control

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6 best practices for managing hypertension under population health models

Healthcare organizations are seeking new approaches to manage patient health and control the cost of care across their patient populations. In order to truly reduce costs, enhance care and improve outcomes, these organizations must take a coordinated, multi-step approach involving their practice, their providers and their patients.

Coordinated care among systems and payers is particularly important for chronic disease — including extremely prevalent and costly conditions such as hypertension, heart disease, stroke, diabetes and arthritis. Imagine the patient with five chronic conditions, who averages 15 physician visits and more than 50 prescription fills annually. Or picture the average Medicare beneficiary, who sees seven different physicians and fills more than 20 prescriptions in a year.[1]

The American Medical Group Association and its member groups and health systems — including some of the nation's largest, most prestigious integrated delivery systems, such as Cleveland Clinic, Geisinger Health System, Kaiser Permanente and Mayo Clinic — understand firsthand this need for fully integrated, efficient and patient-centered care.

Utilizing its research and knowledge around chronic disease, the American Medical Group Foundation, AMGA's nonprofit arm, launched a multi-year initiative called the Chronic Care Challenge. This program leverages best practices in disease management and population health. Measure Up/Pressure Down®, the program's first campaign, brings together nearly 150 organized systems of care to achieve a goal of 80 percent of patients in control of their blood pressure by 2016. Groups across the nation implement eight evidence-based care processes to achieve this aim.

Why hypertension? Medical professionals have known about the risks of poorly controlled hypertension for over a century, and effective treatments have been available for more than 50 years. Yet according to the Centers for Disease Control and Prevention, less than half of the 68 million American adults with hypertension have their condition under control, and nearly 20 percent are unaware they have it. The disease accounts for an estimated $156 billion in healthcare services, lost productivity to illness and premature death.[2] Due to the strain hypertension puts on the heart, it is also a major risk factor for other chronic conditions, including stroke and heart disease.

6 ways to get started

The following key steps will help systems of any shape and size immediately start to move the needle in blood pressure control in their patients with little to no burden on the group's infrastructure or staff bandwidth:

1. Distribute and share best practices with staff

Many organizations are demonstrating how significant strides in disease control can be achieved and are sharing the best practices behind these control rates. There are materials available for distribution to physicians and staff at your organization to show how a high level of achievement is possible through practical steps:

- Over the course of a decade, the efforts of Kaiser Permanente Northern California nearly doubled the percentage of its patients in control of hypertension (to 87 percent) through implementation of standardized approaches, including a formal process for physicians to be updated on their patients' control, free blood pressure readings with medical assistants and the use of cheaper and easier-to-take medications. Authored by Kaiser Permanente, this free article ("Improved Blood Pressure Control Associated with a Large-Scale Hypertension Program") in the *Journal of the American Medical Association* showcases the program, its best practices and successes.

- To support participating campaign medical groups and health systems, AMGF launched the Measure Up/Pressure Down® Provider Toolkit in May 2013. Organized around the eight campaign care processes, the free toolkit provides useful tools, tips and resources based on best practices from AMGF hypertension collaboratives and campaign participants.

2. Disseminate monthly physician reports

Transparent, timely feedback is crucial to increasing physician and staff engagement in performance improvement. Use electronic health record data to pull provider and site performance reports. Letting physicians know where they are relative to their peers and the goal motivates everyone on the care team to adopt the required changes in process.

For example, Summit Medical Group, a physician-owned multispecialty practice in New Jersey, distributes unblinded physician-level hypertension control data and patient lists on a monthly basis for primary care, endocrinology, nephrology and cardiology. Physicians and staff reach out to patients with prehypertension or hypertension on these lists to schedule screenings and appointments. As patients receive one-on-one communications, they are reengaged in their own care and are able to make lifestyle modifications and use medication to improve blood pressure control.

3. Engage staff, physicians and patients in proper blood pressure technique

Studies show that every day, hundreds of patients with hypertension visit their doctor's office and leave without having the disease diagnosed or addressed. Why? Increasingly, physicians have limited time with patients and must choose which health concerns to addresses, particularly for patients with multiple chronic conditions or those that need acute care. In addition, hypertension can only be accurately diagnosed if a patient's blood pressure is taken correctly.

Direct care staff must be trained and certified on an annual basis in accurate blood pressure measurements, including proper patient positioning, selection of cuff size, obtaining a valid blood pressure measurement, recording it accurately and reporting abnormal results.

Patients should also be engaged in proper blood pressure measurement. Two groups, Colorado Springs Health Partners and University of Utah Health Care, display posters next to exam room blood pressure cuffs that showcase accurate measurement techniques. These signs help patients understand the rationale for staff requests (e.g., if a patient doesn't remove a jacket as requested, the blood pressure measurement will fluctuate by 10-40 mmHg), remind staff of the importance of accurate measurements and empower patients to take an active role in their own health.

4. Create a two week follow-up process

Rapid re-measurement and titration of medications, when indicated, is an essential element to overcome clinical inertia. Create an easy process for hypertensive patients to have blood pressure measured every two weeks, such as scheduling nurse or medical assistant appointments. This will accelerate control achievement and further improve patient engagement and adherence.

San Diego-based Arch Health Partners incorporates a pharmacist into the care team for hypertensive patients. The pharmacist, working in an internal medicine practice, sees patients outside of normal visits, starts medications using internal treatment protocol and schedules patients to return within two weeks. This rapid-cycle pilot resulted in 7 percent improvement in control rates over six weeks. At Sacramento Family Medical Clinics, hypertensive patients are scheduled and seen within two weeks by medical assistants who conduct blood pressure re-checks and address any gaps needing to be filled under protocol. After 15 months, this approach saw a nearly 20 percent improvement in blood pressure control. EHR technology assists The Baton Rouge Clinic in scheduling follow-up appointments for hypertensive patients. Automated pop-ups in the EHR prompt nurses and physicians at this multispecialty clinic to schedule follow-ups in two or four weeks.

5. Adopt and promote hypertension protocols

Treatment guidelines serve to facilitate a systematic approach to the management of hypertension. Developing, disseminating and implementing an effective hypertension treatment algorithm aids clinical decision-making and creates conversations around your organization's best practices.

While many medical groups or healthcare systems create a guidelines committee to evaluate and make recommendations for the organization, a number of treatment processes and algorithms are available from leading organizations for use or customization. For instance, the Measure Up/Pressure Down® Provider Toolkit provides algorithms and guidelines from Kaiser Permanente and Sharp Rees-Stealy Medical Group. Million Hearts® has also developed a template to create a hypertension treatment protocol and provides examples from the Veterans Affairs/Department of Defense, Institute for Clinical Systems Improvement and New York City Health and Hospitals Corp.

6. Utilize patient engagement tools

Patient behaviors — including maintaining a healthy diet, adhering to medication and treatment programs, keeping medical appointments and exercising regularly — are key to blood pressure management. Patients should be encouraged to be active participants in their own health and do what they can to more effectively manage their blood pressure. Groups can engage patients through:

- ***Home blood pressure monitoring.*** ThedaCare Physicians, a community health system in Wisconsin, equips patients with free home blood pressure monitors. Patients learn tips for accurate readings, measure and record blood pressure on a regular basis and share results with their provider for medication adjustments or lifestyle changes.
- ***Health coaches.*** In Iowa, Mercy Clinics, Inc. embedded health nurses into the system to work with diabetic patients, many of whom had hypertension. Guided by patient data and chart review, coaches reached out to those with poor hypertension control and helped them manage their conditions with food diaries and one-on-one motivational coaching.
- ***Educational materials.*** Many participating groups provide patients with free materials to help them understand the disease and recommended lifestyle adjustments. Groups produce their own resources, or use the Measure Up/Pressure Down® Circulation Nation: Your Roadmap to Managing High Blood Pressure patient booklet or similar materials.
- ***Mobile apps***. Marshfield Clinic Research Foundation, a division of AMGA member Marshfield Clinic, has developed the Heart Health Mobile app. This app provides a quick heart health check, motivates users to obtain a more accurate assessment with blood pressure and cholesterol values and directs users to nearby locations offering affordable, convenient blood pressure screenings.

All tools mentioned are available in the free Measure Up/Pressure Down® Provider Toolkit. Additional success stories from participating medical groups and health systems are also available here.

Jerry Penso, MD, MBA is Chief Quality and Medical Officer at the American Medical Group Association. In his role, Dr. Penso oversees quality initiatives through the American Medical Group Foundation, a 501(c)3 nonprofit, including best practices in care collaboratives and the Chronic Care Challenge. Follow the campaign at @MUPDcampaign.

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[1] Partnership for Solutions. *Chronic Conditions – Making the Case for Ongoing Care: September 2004 Update.* Available at: http://www.partnershipforsolutions.org/DMS/files/chronicbook2002.pdf.

[2] U.S. Department of Health and Human Services. *HHS Secretary Sebelius Statement on National High Blood Pressure Education Month.* Available at: http://www.hhs.gov/news/press/2012pres/05/20120502a.html.