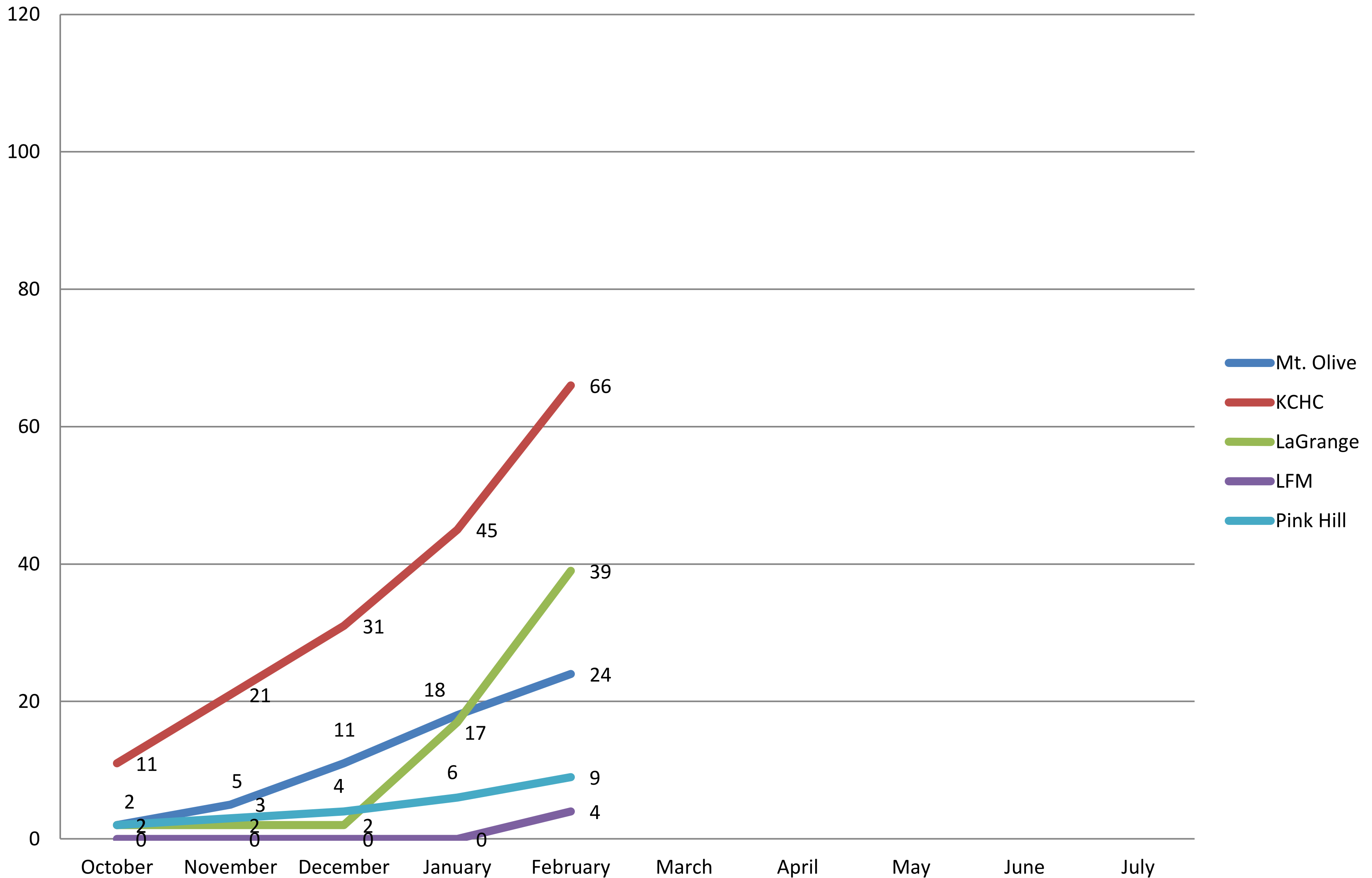
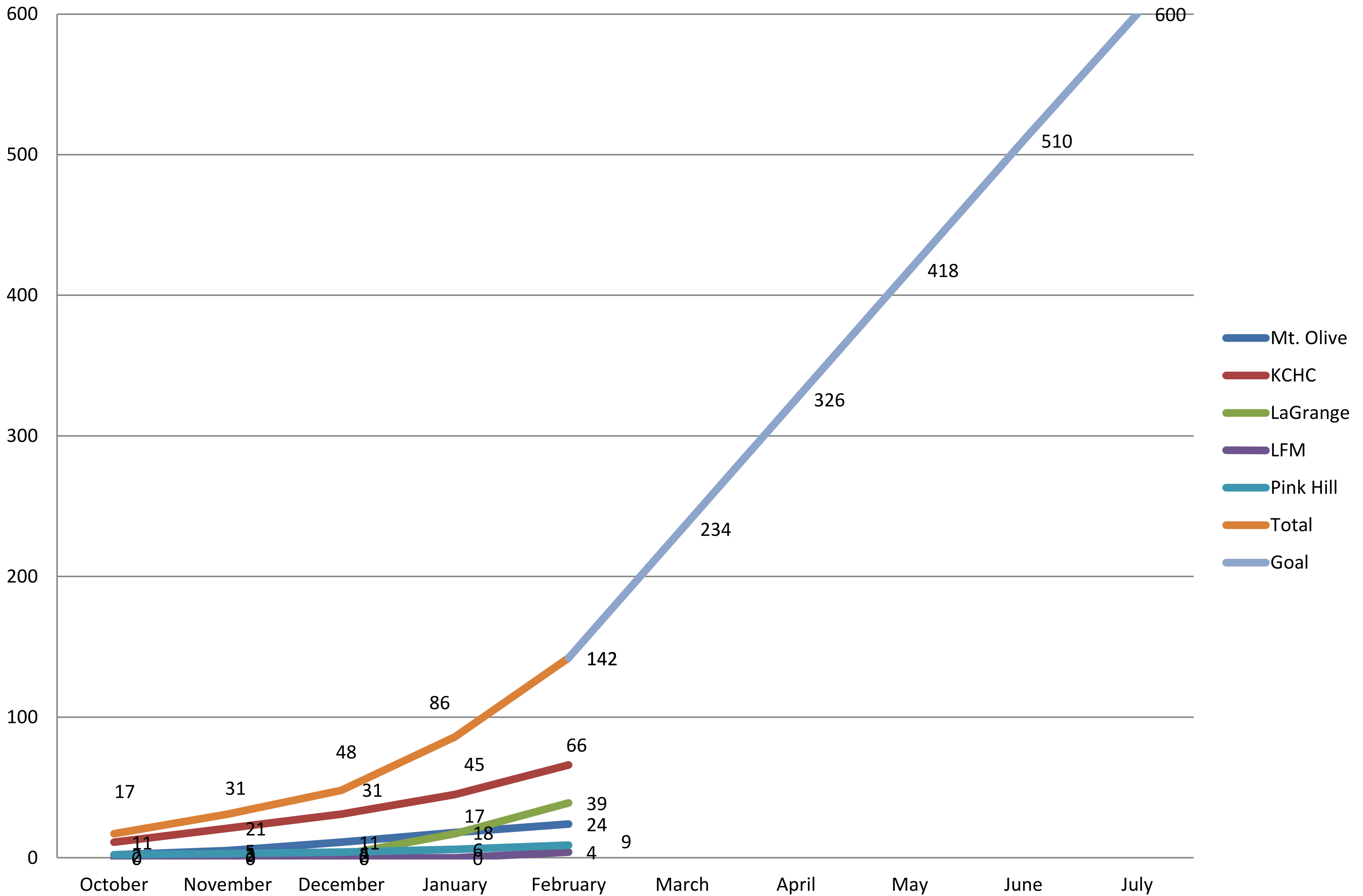
Recruitment & Enrollment

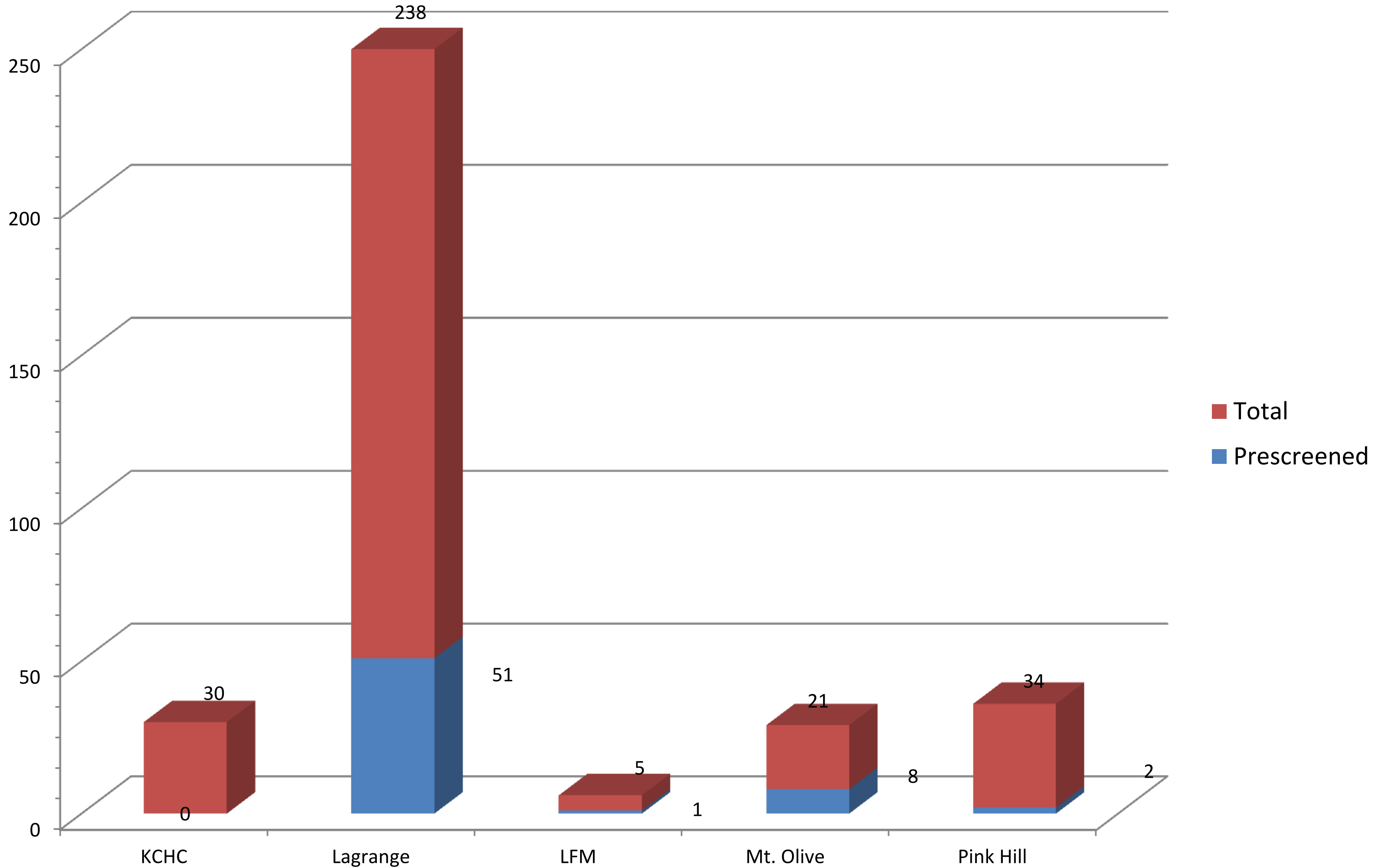
Participant Enrollment

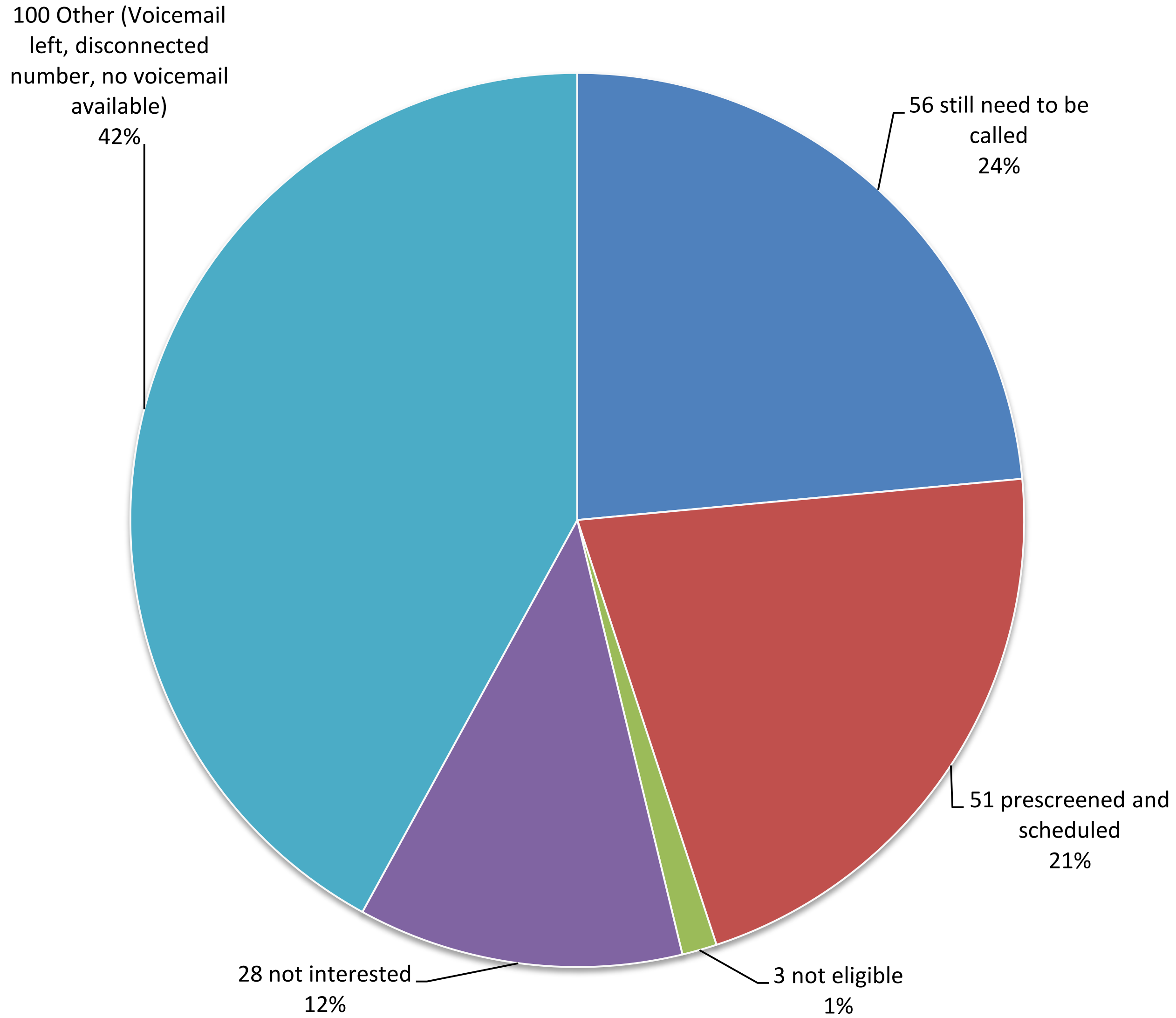


Participant Enrollment



Fax and Enrollment Summary




La Grange Fax Data
100 Other (Voicemail left, disconnected number, no voicemail available)
42%
56 still need to be called
24%
51 prescreened and scheduled
21%
3 not eligible
1%
28 not interested
12%

Controversies in Hypertension Care

Case Studies

1. How to set blood pressure goals in patients with multiple comorbidities?
   - Is a higher BP goal ok with stage 4 Chronic Kidney Disease, or in the elderly where medication side effects become a problem?

Case Studies

2. Amlodipine vs Felodipine – is one more effective than the other?

Case Studies

3. Difficult patient:
    - 60 years old
    - Has HTN, CAD, CKD stage 3, tobacco abuse.
    - Medications currently on:
        - Metoprolol 100mg bid
        - Imdur sr 60mg qd
        - Lasix 40mg bid
        - Hydralazine 100mg tid
        - Clonidine .1mg bid
- Home & office BP readings - 170s/90s.
- Next step?

Case Studies

4. Difficult patient:
   - Patient with HTN and diabetes (so needs renal protection)
   - Got hyperkalemia on ACE or ARB
   - What else could help?
   - What if they develop pedal edema with a CCB?

Hypertension Practice Measures:
The Importance of Data Driving Outcomes

Objectives

- Rationale for looking at practice data
- What will it look like
- Expectations and timeline

Overarching Framework

- Reduce blood pressure levels among patients with poorly controlled hypertension
- Reduce disparities in blood pressure
- Create systems to sustain these improvements

Why are data important?

- Important way to study progress at the practice level
- Help drive interventions to improve outcomes
- Compare with national guidelines

Measurement for Improvement

- IS:
  - Designed to help your team and other teams learn
  - Like a growth curve: it's not where you are, but where you are going
- IS NOT:
  - Designed for criticism or punishment
  - Supposed to end (it should be sustainable)

Key Office System Drivers of Improvement

- **Registries**
- Templates for Care
- Protocols for Care
- Self- Management

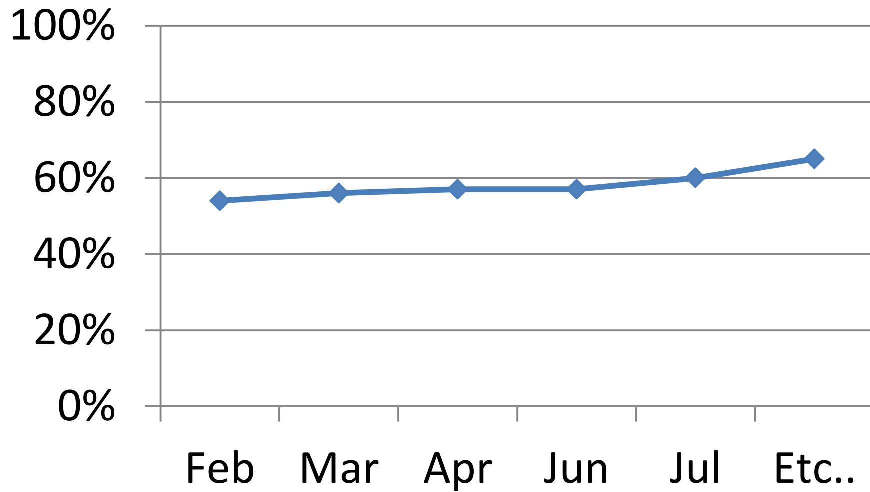
Choosing Measures

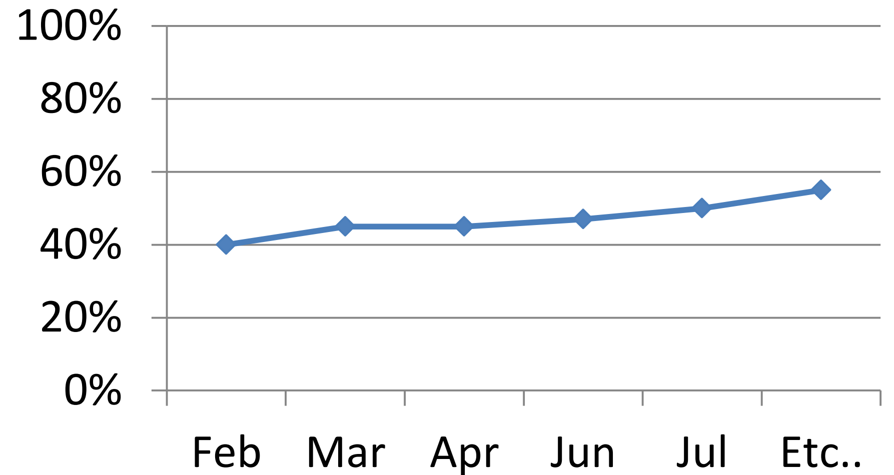
- Everyone has an opinion about quality measures
- Measures are designed for a certain purpose
- All have limitations

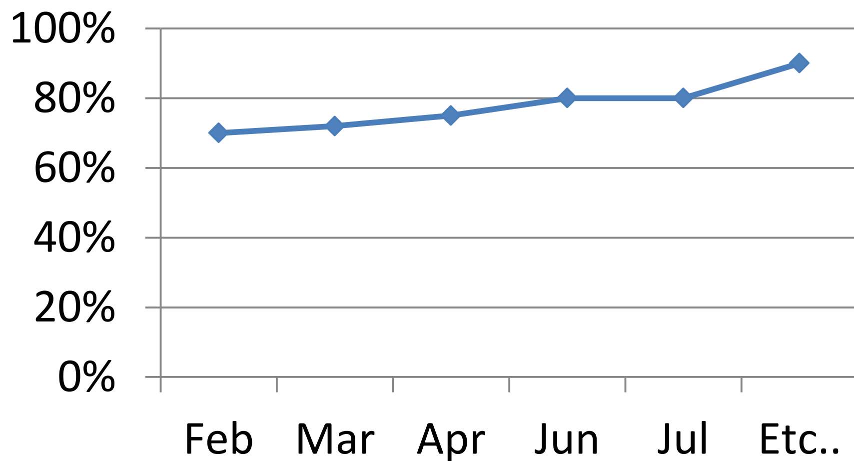
- **Practice Measure for Hypertension**
  - **% of adult patients with a diagnosis of hypertension and with a Blood Pressure <140/90***

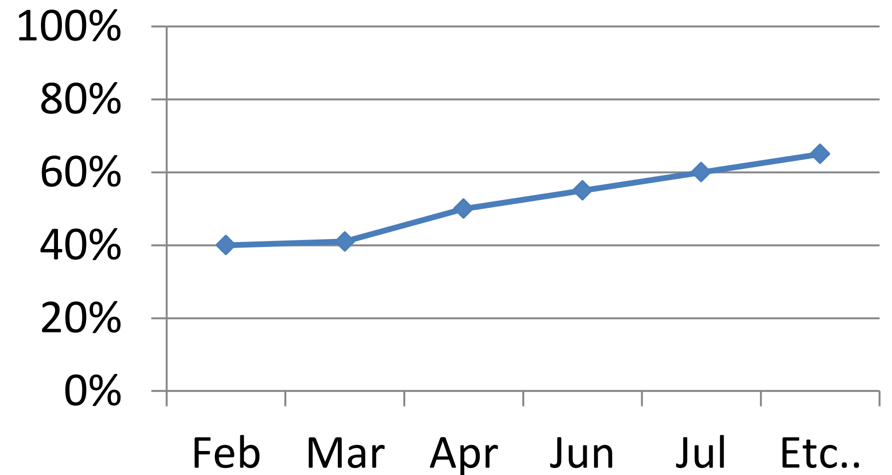
*National and State groups using this measure: CMS-Centers for Medicare & Medicaid Services, NCQA- National Committee for Quality Assurance, PC- Physicians Consortium, IPIP-Improving Performance in Practice, DPH-North Carolina Division of Public Health

THIS IS HOW IT WILL LOOK…


Practice 1: BP <140/90
100%
80%
60%
40%
20%
0%
Feb
Mar
Apr
Jun
Jul
Etc..

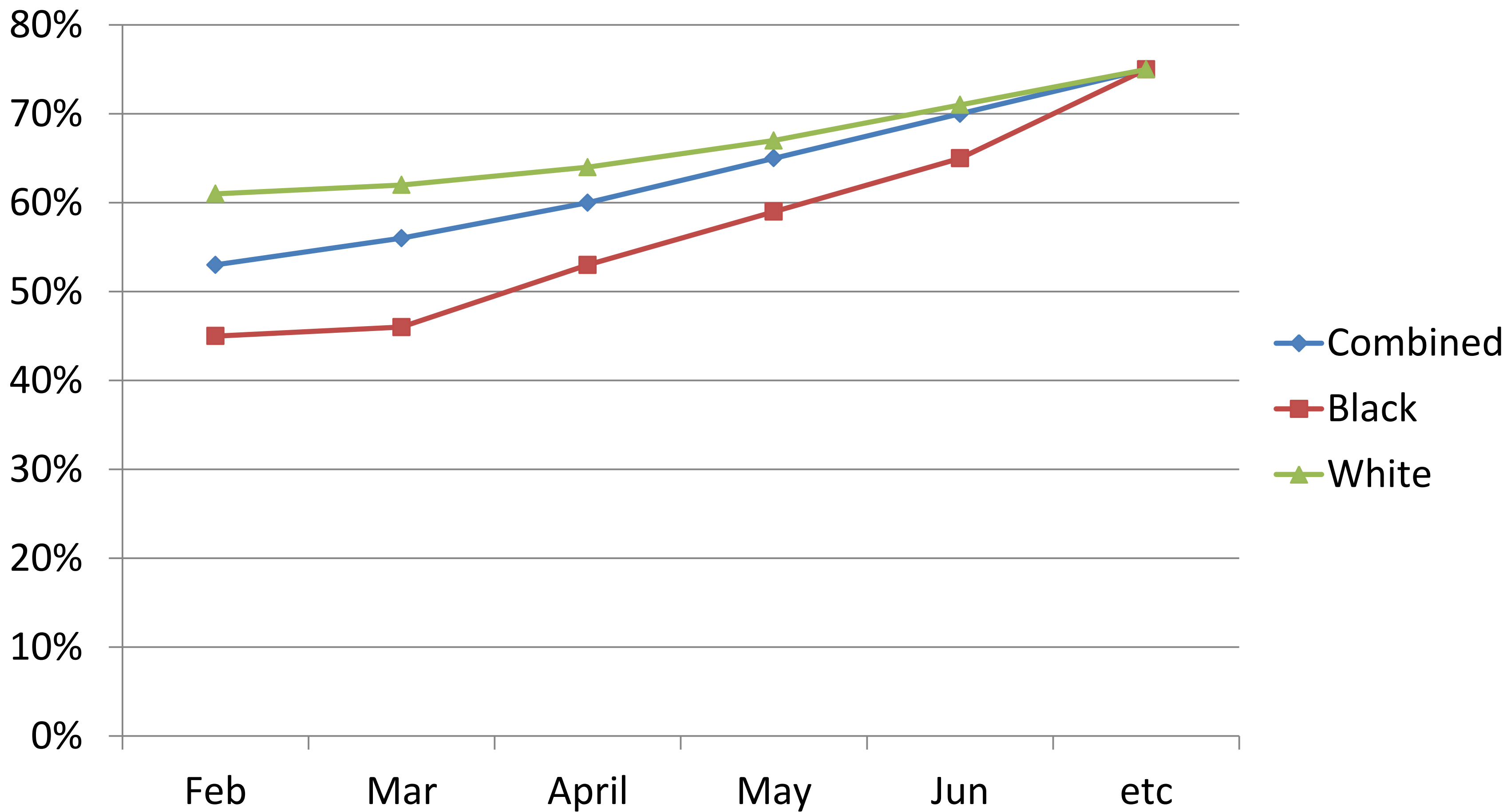

Practice 3: BP <140/90
100%
80%
60%
40%
20%
0%
Feb
Mar
Apr
Jun
Jul
Etc..


Practice 2: BP <140/90
100%
80%
60%
40%
20%
0%
Feb
Mar
Apr
Jun
Jul
Etc..


Practice x: BP <140/90
100%
80%
60%
40%
20%
0%
Feb
Mar
Apr
Jun
Jul
Etc..

ALSO TRACK DATA TO IMPROVE DISPARITIES…

Example Practice X- BP<140/90



Current Baseline Data

BP < 140/90

90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

46.0%
48.1%
0.0%
78.2%
76.9%

Practice 1
Practice 2
Practice 3
Practice 4
Practice 5

BP < 140/90

What we need

- Baseline blood pressure measure pull (population pull)
  - % of adult pts with HTN with a BP < 140/90-in past year*
  - % of adult pts with HTN with a BP < 140/90-in past year, by race
- Monthly pull
  - % of adult pts with HTN with a BP <140/90 in past month
  - % of adult pts with HTN with a BP < 140/90-in past month, by race
- Repeat population pull every 6 months

*Baseline pull could be a 3 month pull if unable to pull 1 year measure yet

Logistics-Numerators& Denominators

	Baseline, June, December	**Monthly (by 7th)**
# of pts with HTN seen in past year with BP < 140/90	X	
# of pts with HTN seen in past year	X	
# of pts with HTN seen in past year with BP < 140/90, by race	X	
# of pts with HTN seen in past year, by race	X	
# of pts with HTN seen in past month with BP < 140/90		X
# of pts with HTN seen in past month		X
# of pts with HTN seen in past month with BP < 140/90, by race		X
# of pts with HTN seen in past month, by race		X

Next steps

- Submit your data by the 10th of each month
- We will present at each dinner meeting
- Thoughts and questions?

Use of Visit Planner

Visit Planner

Please attach this sheet to every patient with a diagnosis of high blood pressure

Staff or Provider: Awareness of BP and consequences of uncontrolled BP

Patient Initials: _________ **Date:** _________________

Patient's BP today:_______/_______ **(please enter office BP)**

Please check appropriate box

	Yes	No	NA
Did patient bring in home BP information?			
Did you review previous BP's with the patient today?			
Did the patient know their goal BP?			
Did you remind them why we worry about high blood pressure? (Heart failure/heart attacks, stroke, kidney disease/vision loss/other)			

Provider:

Please check appropriate box

	Yes	No	NA
Did you review nurse/staff actions or cover some of the above items during your visit with the patient ("Awareness" items above)**?**			
Is home Systolic BP >135?			
Is clinic Systolic BP >140?			
Is patient at goal?			
Did you take make any medication or treatment changes?			

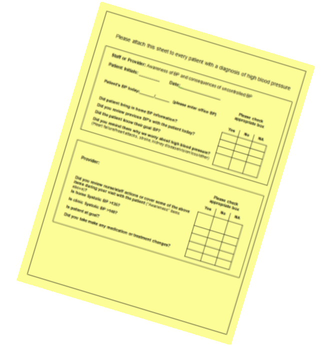
Why implement a Visit Planner?

- Q I studies suggest that using an organized system of regular review of BP information when linked with medication titration improve BP control.
- It prompts the team to be steadfast in addressing high blood pressure at **every visit** and helps patients reach their BP goals.

Process to date

- Evidence review
- Interviews with practice staff members and providers
- Trial runs in a few HHL practices
- Discussions with the study “Design Team” via conference calls

Items on the HHL VP?



- Address BP knowledge
- Address BP goal values
- Reinforce the impact of uncontrolled hypertension
- Find out if home BP values are influencing decision making

How to fill out the visit planner…..

Staff or Provider: Awareness of BP and consequences of uncontrolled BP

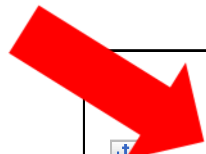
Patient Initials: JH **Date:** 4.2.12

Patient's BP today: 154 / 92 **(please enter office BP)**

Please check appropriate box

	Yes	No	NA
Did patient bring in home BP information?	✓		
Did you review previous BP's with the patient today?	✓		
Did the patient know their goal BP?		✓	
Did you remind them why we worry about high blood pressure? (Heart failure/heart attacks, stroke, kidney disease/vision loss/other)	✓		

How to fill out the visit planner…..



Provider:

	Please check appropriate box		
	Yes	**No**	**NA**
Did you review nurse/staff actions or cover some of the above items during your visit with the patient ("Awareness" items above)**?**	✓		
Is home Systolic BP >135?	✓		
Is clinic Systolic BP >140?	✓		
Is patient at goal?		✓	
Did you take make any medication or treatment changes?	✓		

Collect the Visit Planners

Implementation

1. Identify each patient with hypertension that is scheduled for an office visit.
2. Attach the paper copy of the “Visit Planner” to each chart .
3. Rooming staff fill out “Staff or Provider” portion provider-patient visit.
4. Use the “not applicable” choice when appropriate.

Implementation

5. Provider reviews the team’s items and then addresses the “provider” items.
6. Drop each of the individual Visit Planners in a Box labeled “HHL Visit Planner” at the end of each visit or each day.
7. HHL team collects the VP’s and provides feedback to practice.

***NOTE this also helps us determine how much time it takes to fill out VP’s which has $$ implications.*

Phone Coaching

- Participants will receive phone calls from trained phone coach every 1-2 months for 24 months (6-12 calls total).
- Each phone call will last approximately 10-20 minutes.
- Phone coach will use automated computer program that prompts & adds follow-up questions based on participant’s answers.

Phone Coaching Sessions

Encounter:	Module:
1st and 7th	Medication module Literacy Side effects Memory
2nd and 8th	Medication module Literacy Hypertension knowledge Decision making Side effects
3rd and 9th	Diet Weight Medication module Literacy Side effects
4th and 10th	Exercise Memory Social & medical barriers Medication module Literacy Side effects
5th and 11th	Stress Alcohol Medication module Literacy Side effects
6th and 12th	Medication module Literacy Side effects Memory
Any month	Patient initiated

Before you leave!

- Please make sure you have signed in – we will use this to send you your CME completion certificate

- Please complete the CME evaluation form