



*ASTHO Million Hearts State Learning
Collaborative on Hypertension:
Douglas County Experience*

June 4, 2015



Agenda for Presentation

- Introduce the Learning Collaborative Team
- Background on the Million Hearts Initiative
- Hypertension in Kansas
- Background on the ASTHO Hypertension State Learning Collaborative
- Kansas aim statement and goals
- Team Experiences
- Summary of Outcomes & Successes
- Next Steps
- Questions

Panel Members

- **Virginia Barnes**, MPH, Community-Clinical Linkages Section Director, Bureau of Health Promotion, Kansas Department of Health and Environment
- **Chris Tilden**, PhD, Community Health Promotion Director, Lawrence-Douglas County Health Department
- **Jonna Hackathorn**, RN, Nurse Manager, Heartland Community Health Center
- **Lanaya Henry**, Quality Assurance Coordinator, Heartland Community Health Center
- **Eric Cook-Wiens**, MPH, Data and Measures Manager, Kansas Healthcare Collaborative
- **Mary Monasmith**, RHIC, PCMH CCE, HIT Practice Consultant, Synovim Healthcare Solutions



Million Hearts Initiative

- Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes by 2017.



Million Hearts® aims to prevent heart disease and stroke by:

- Improving access to effective care.
- Improving the quality of care for the ABCS.
- Focusing clinical attention on the prevention of heart attack and stroke.
- Activating the public to lead a heart-healthy lifestyle.
- Improving the prescription and adherence to appropriate medications for the ABCS.

2011 Status of ABCS

A spirin	People at increased risk of cardiovascular disease who are taking aspirin	47%
B lood pressure	People with hypertension who have adequately controlled blood pressure	46%
C holesterol	People with high cholesterol who have adequately managed hyperlipidemia	33%
S moking	People trying to quit smoking who get help	23%

Source: MMWR: Million Hearts: Strategies to Reduce the Prevalence of Leading Cardiovascular Disease Risk Factors --- United States, 2011, Early Release, Vol. 60






Million Hearts® Targets

Changing the Environment

Reduce smoking 

By 2017...

The number of American smokers has declined from 26% to 24%

Reduce sodium intake 

Americans consume less than 2,900 milligrams of sodium each day

Eliminate trans fat intake 

Americans do not consume any artificial trans fat

Optimizing Care in the Clinical Setting

Focus on the ABCS 

Use health tools and technology 

Innovate in care delivery 

Aspirin use when appropriate

Of the people who have had a heart attack or stroke, 70% are taking aspirin

Blood pressure control

Of the people who have hypertension, 70% have adequately controlled blood pressure

Cholesterol management

Of the people who have high levels of bad cholesterol, 70% are managing it effectively

Smoking cessation treatment

Of current smokers, 70% get counseling and/or medications to help them quit

Stay Connected

-  http://millionhearts.hhs.gov/be_one_mh.html
-  facebook.com/MillionHearts
-  twitter.com/@MillionHeartsUS
-  millionhearts@cdc.gov

Million Hearts® promotes clinical and population-wide targets for the ABCS. The 70% values shown here are clinical targets for people engaged in the health care system. For the U.S. population as a whole, the target is 65% for the ABCS.

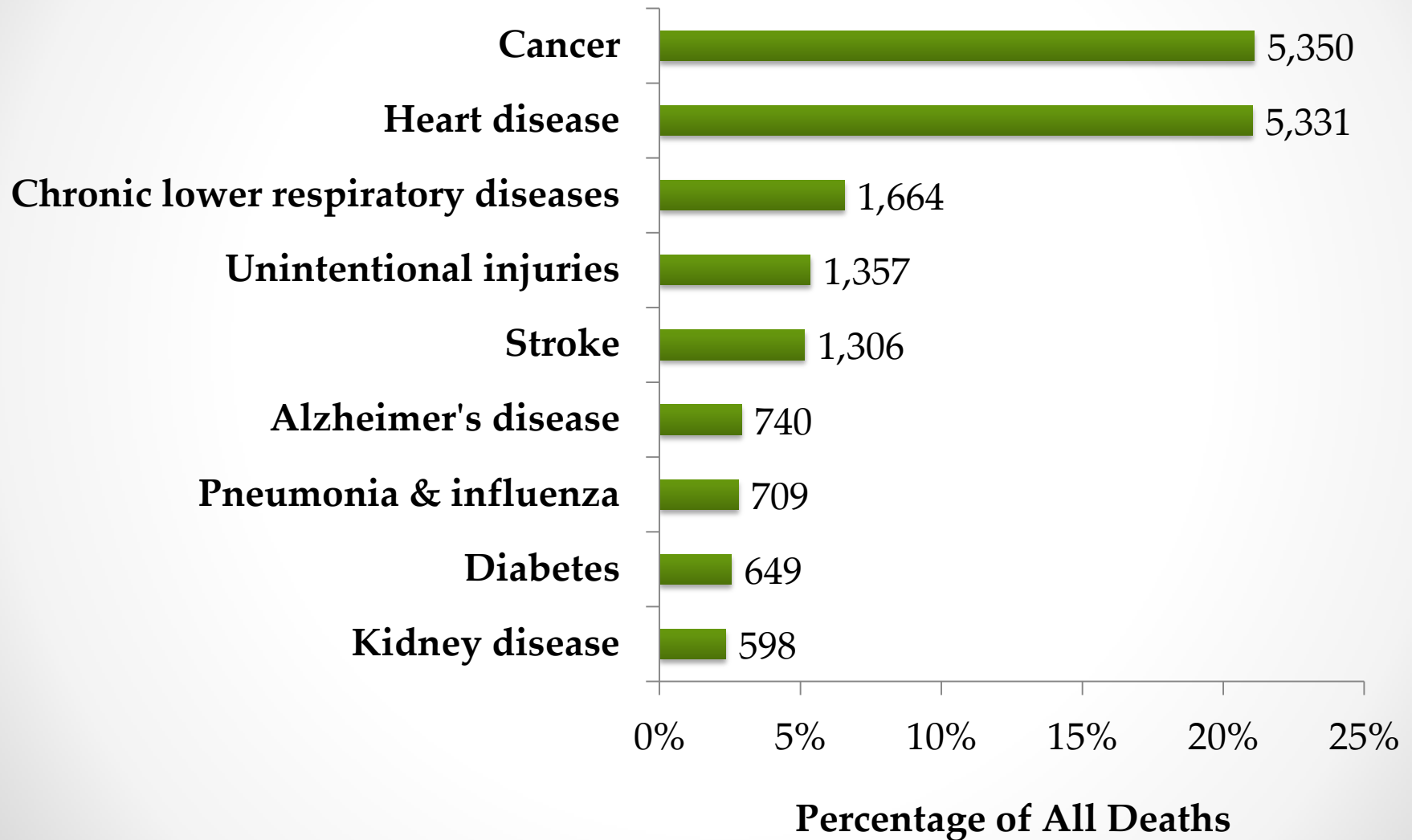
Why Blood Pressure?

High blood pressure is a common condition in which the force of the blood against your artery walls is high enough that it may eventually cause health problems.

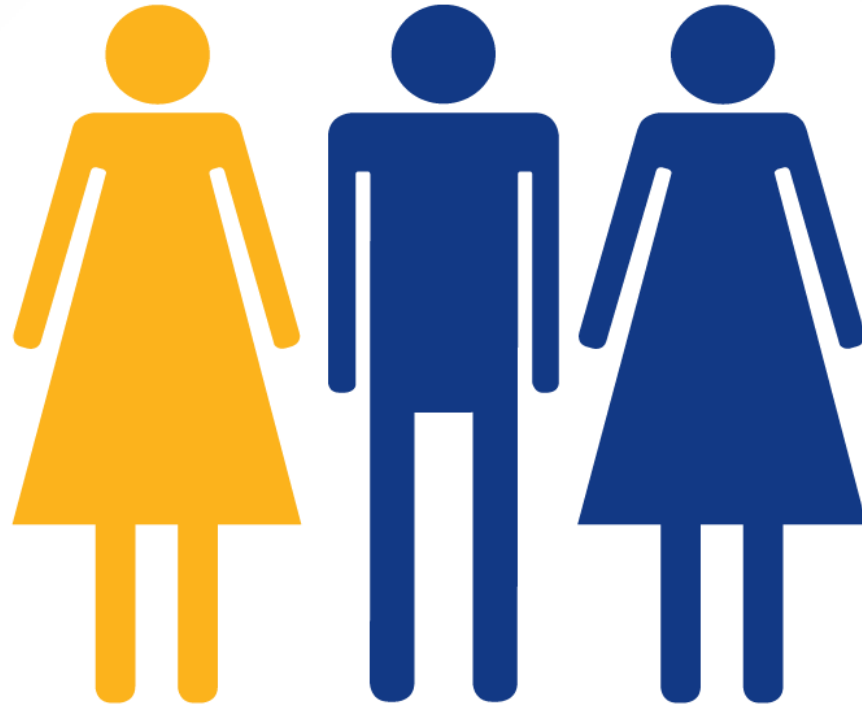
Hypertension is defined as having a systolic blood pressure of 140 or above, or a diastolic blood pressure of 90 or above, or currently taking medication to lower blood pressure.

- The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy.
- Hypertension is a very significant health issue in the United States. Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur.
- In clinical trials, antihypertensive therapy has been associated with reducing the incidence of stroke up to 40 percent, heart attack up to 25 percent and heart failure more than 50 percent.
- The United States Preventive Services Task Force recommends that clinicians screen adults age 18 and older for high blood pressure.

Leading Causes of Death in Kansas



Prevalence of Hypertension

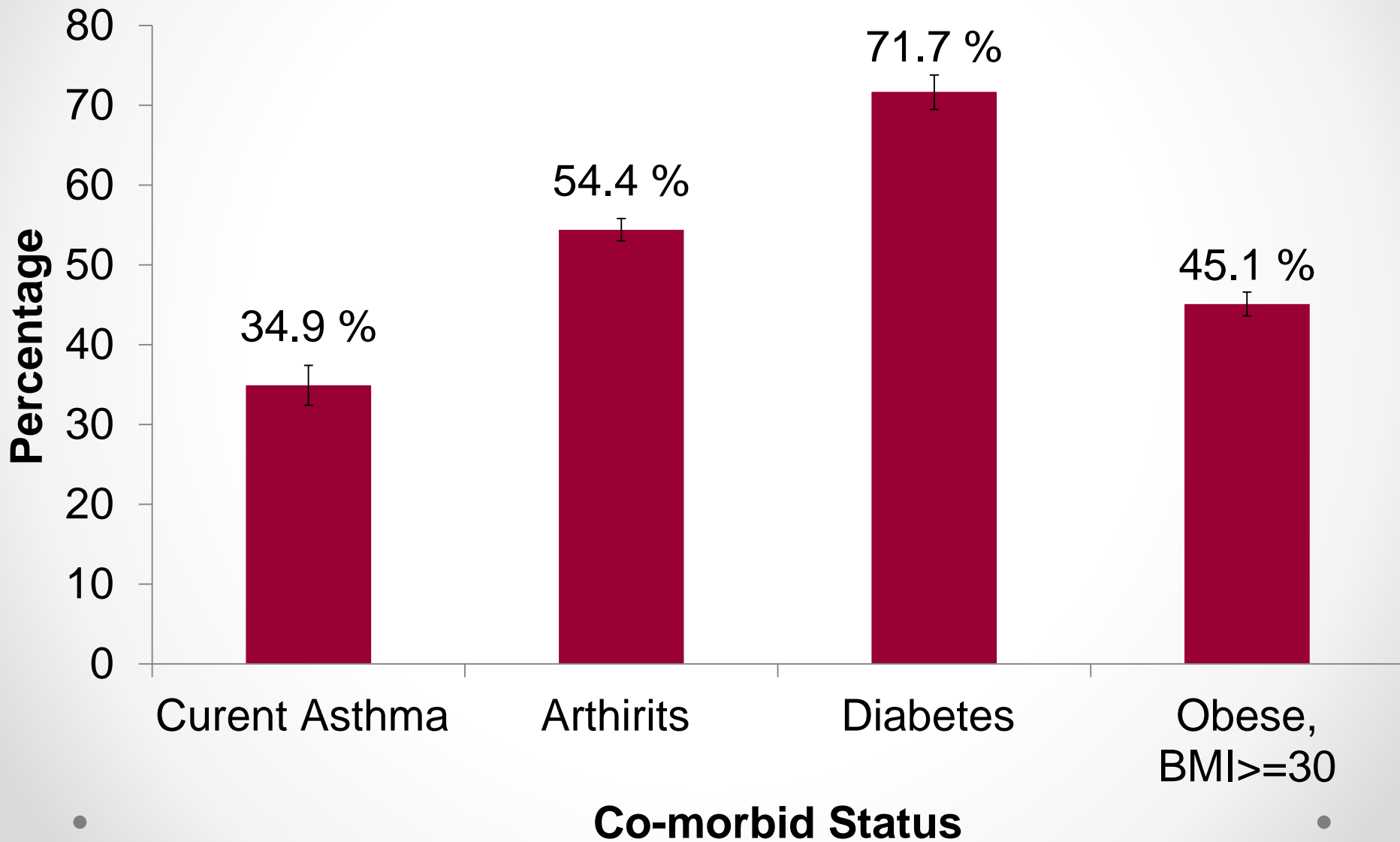


1 in 3 Kansas adults have ever been diagnosed with hypertension (2013 KS BRFSS)

Percent of Kansas adults ever diagnosed with **hypertension** significantly higher among:

Males	compared with females
Older adults	compared with younger adults
Non-Hispanic African-Americans	compared with all other race/ethnicity groups (age-adjusted)
High school graduates or adults with a GED	compared with adults with some college and college graduates
Adults with an annual household income of \$49,999 or less	compared with adults with an annual household income of \$50,000 or more
Adults living with a disability	compared with adults living without a disability
Adults with health insurance	compared with adults without health insurance

Percentage of Adults 18 Years Old and Older with Diagnosed Hypertension by Co-morbid Conditions, KS BRFSS 2013



ASTHO Million Heart State Learning Collaborative: Focus on Hypertension Identification, Control and Improvement

Purpose: Support states in utilizing a Quality Improvement process to partner across sectors including clinical, community, and public health partners to implement best practices and evidence based policies to identify, control, and improve blood pressure with the aim of achieving the goal of preventing 1 million heart attacks and strokes by 2017.



Timeline

- Second round RFP released in July 2014
- KDHE submitted our proposal September 4, 2014
- Accepted in September 2014 (6 states selected)
- Project period Sept. 22, 2014 through June 30, 2015
- Partner site visits/kickoff: October 27-28, 2014
- Washington D.C. Learning Session: December 10-11, 2014
- Virtual Learning Sessions: Feb. 26, 2015 & June 4, 2015



Kansas Aim Statement

“By June 30, 2015, improve HTN control rates by 10% among participating Douglas County providers by improving HTN diagnosis and management, while developing partnerships and systems to support eventual spread across Kansas.”

Goal: Use aggregated NQF18 data to improve population health outcomes by providing feedback to providers, health systems and communities;

Objective 1: By June 2015, engage the local health department, two FQHC and two health system clinics to standardize the way NQF 18 is collected in their respective EHRs;

Objective 2: By June 2015, engage the local health department, two FQHC and two health system clinics to standardize the way NQF 18 reports from their EHRs to create a community-level map of hypertension;

Objective 3: By June 2015, engage the local health department and local community coalition to target education and blood pressure screening to areas in the community identified as having more patients with hypertension.

Goal: Use Health Information Technology to manage patient panels and identify higher risk patients (racial/ethnic minorities; low socio-economic groups; low education; geographic areas with high risk patients)

Objective 1: By June 2015, engage the local health department, two FQHC and two health system clinics to standardize protocols for the way undiagnosed hypertension is identified in their respective EHRs;

Objective 2: By June 2015, engage the local health department, two FQHC and two health system clinics to aggregate data from EHR reports to create a community-level map of undiagnosed hypertension;

Objective 3: By June 2015, engage the local health department, FQHCs and local community coalition to target education and blood pressure screening to areas in the community identified as having more patients with undiagnosed hypertension.

National Quality Forum Measure 18

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Details of NQF 18

Numerator Statement:

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator Statement:

Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Note Exclusions:

1. Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.
2. Exclude all patients with a diagnosis of pregnancy during the measurement year
3. Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

Learning Collaborative Partner Experiences ...

Lawrence-Douglas County Health Department



Chris Tilden



Heartland Community Health Center



Jonna Hackathorn and Lanaya Henry

Health Care Access



Presented by Virginia Barnes



Synovim Healthcare Solutions



Mary Monasmith



Kansas Healthcare Collaborative



Eric Cook-Wiens



Outcomes & Successes

- Relationships established or strengthened
- Developed and piloted EHR Assessment tool
- Clinics able to run NQF 18 and undiagnosed HTN reports for quality of care
- Referral protocol for patients with high blood pressure implemented at LDCHD
- Referral protocol to Wellness Program
- Shared community resource information and blood pressure cards



Outcomes & Successes

- Implemented blood pressure protocol
 - Formal AMA screening guidelines for blood pressure technique with slight variation agreed upon by all participants.
- Staff education conducted to ensure readings taken correctly
- Blood pressure equipment calibrated in clinics
- Hypertensive patients identified and offered smoking cessation opportunities
- Protocols established for follow up with hypertensive patients at 6 months using EHR reports
- Protocols for tracking patients with elevated blood pressure established for improved monitoring
- Clinic report increased engagement in health management among Hispanic patients identified as hypertensive or offered additional management options during project period

Next Steps

- ASTHO extended and enhanced funding through June 30, 2016 for the learning collaborative to continue to expand the work in Douglas County
- Expand through KDHE's CDC funded work on health systems
 - Community of Practice on hypertension (NQF18) & diabetes (NQF59)
 - Stay Tuned! We will be inviting providers to participate starting in Fall 2015!
- Submitted additional application to expand work on NQF18 data aggregation through KHIN and to bring in additional health system partners

Questions??

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Questions for the Audience:

- Do you use EHR tracking reports for hypertension or other chronic diseases?
- What advantages do you see in participating in this type of collaborative?
- What challenges do you see in participating in this type of collaborative?
- Are you interested in comparative reports for your work?
- Do you refer patients to or partner with community programs for hypertension?



Thank You to Our Collaborators!



Health Care Access

Clinic | Serving the Uninsured

For Additional Information

<http://millionhearts.hhs.gov/index.html>

<http://www.astho.org/Million-Hearts/>

<http://www.astho.org/Million-Hearts/State-Learning-Collaborative-to-Improve-Blood-Pressure-Control/>