

Million Hearts
Promising Practices for Blood Pressure Control in Clinical Settings Webinar
Thursday, December 4th, 2012, 3:00 pm – 4:30 pm EST
Audio Transcript

OPERATOR: Good day, ladies and gentlemen, and welcome to the Powerful Enough to Make a Difference, Promising Practices for Blood Pressure Control in Clinical Settings webinar sponsored by Million Hearts. The full presentation, slides and audio content will be available via the Million Hearts website following the webinar at www.millionhearts.hhs.gov. If you do not have computer speakers or prefer to listen via phone, please call the following phone number, 888-392-4587.

A few housekeeping items to remember before we get started. All participant lines are in a listen-only mode throughout the presentation. To reach an operator at any time, please press star, zero on your telephone keypad. We will have a live Q and A after the final presentation has concluded. Press 01 to queue up to ask your question. The operator will un-mute your line for you to ask your question and then will re-mute your line when you are finished. When you ask your question, please state your name and your organization.

You may submit questions via the chat feature at any time, but preference will be given to the live questions. In the field below the general chat you may type in your question and hit “send.” Your question will only be visible to the moderators. As there will be many more questions than we have allotted time for, we will be answering only a few select questions. With that, I would like to turn it over to today’s moderator, Judy Hannan, Deputy Director of the Division for Heart Disease and Stroke Prevention in the National Center for Chronic Disease Prevention and Health Promotion at CDC. Thank you.

JUDY HANNAN: Thank you, Olivia. And as I was introduced, I am Judy Hannan, the Senior Advisor for Million Hearts at CDC, and will serve as the moderator for today’s webinar. I trust that you’ll walk away from this webinar with an understanding of a national initiative to prevent a million heart attacks and strokes. You’ll learn how three separate practices have made great improvements in the hypertension control of their patients. And there will be plenty of time for questions and answers at the end, hopefully to leave you with sound advice about how to overcome some of the common challenges to achieving better blood pressure control.

To start us off, it’s my pleasure to introduce Dr. Janet Wright, the Executive Director of the Million Hearts initiative. Janet will provide a brief overview of the Million Hearts initiative, specifically focusing on the challenges and opportunities that are in front of us as a nation regarding control of hypertension. Janet is board certified in internal medicine and cardiology with over 20 years’ experience as a practicing cardiologist. Prior to becoming the Executive Director for the Million Hearts initiative, Janet served as Senior Vice President for Science and Quality at the American College of Cardiology and served on numerous national boards involved in improving quality of care. For those of us in the Million Hearts initiative, Janet is an indefatigable force with an unwavering optimism about what can be accomplished. Janet.

DR. JANET WRIGHT: Thank you, Judy. Let me just make sure if I am heard. Can you all hear me?

JESSICA WEHLE: Yes, we can.

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DR. JANET WRIGHT: Oh, great. All right. So it's a delightful opportunity today to share with you an overview of Million Hearts, but my job is really to quickly share with you the frame or the framework and to get out of the way for the individuals we've gathered today to share with you their real-life experience and expertise in preventing heart attack and stroke. So to set that frame, we'll start here with the overall goal of Million Hearts. As many of you know, it has a very specific goal and timeline because that's how we get things done. The goal is to prevent a million heart attacks and strokes in five years. The five-year period started January 1 of this year, 2012, and will end December 31st of 2016.

It is a national initiative launched by the Department of Health and Human Services and co-led by CDC and CMS. The purpose of that co-leadership is to combine the clinical and powerful payment policy levers at CMS with the scientific community and population health expertise that exists at CDC, really bringing public health and clinical practice together. The initiative is actually executed well beyond the federal doors into the states and into many private sector partners. We'll go over a few of those with you today.

On the second slide, you will see why the federal government would come together focusing tremendous effort on a specific condition like cardiovascular disease. You know that it's the number one killer. It kills both genders. It actually affects some of our population indiscriminately. African-Americans for example losing 14 months of their life expectancy to cardiovascular disease. An additional reason to focus on a number one killer like this is because of our under-performance frankly.

We know what works in preventing heart attack and stroke and yet this slide showing the status of the ABCs describes at the population level how we're performing. You see that we're not hitting 50 percent performance on any of these very basic and very well-evidenced areas of focus. So aspirin for example, only 47 percent of the people who need it who are at high risk for a cardiovascular event are taking a daily aspirin despite it being relatively inexpensive and available. The scariest because it can go on, for me at least, is the one on the slide related to smoking because the denominator here is those people who already decided to stop. And only 23 percent of them are being offered the pharmacotherapy and the counseling that have been shown to help them quit. So we have lots of opportunity here for improvement.

I'll share with you the basic framework. As I mentioned earlier, there are clinical or health system-focused efforts and efforts related to the population or to community. On the community side, we're working on eliminating tobacco smoke and smoke from other causes in the air. Secondly, reducing sodium content in the food and eliminating trans-fat. On the clinical side, we are working with providers and the systems in which they work to get excellence in the ABCs. And you're going to see some real-life examples of that in today's presentation.

We believe that you will all need to deploy health information technology to get excellence and we also want to take advantage of all the new models of care that are being developed and launched, the health homes and accountable care organizations and bundled payments as examples. Bridging the

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clinical and community areas though, we see a real focus on minority health. We have a minority health team now at Million Hearts led by Dr. Erica Taylor, who helped organize this webinar. And we are working really standing on the shoulders of the work that has been done to date, very specific activities improving the cardiovascular health for minority populations.

On our next slide you see where we are starting now, that baseline column. And the columns to the right entitled Target and Clinical Target are where we want to land by December 31st of 2016. These are ambitious targets to reach over the remaining four years of the initiative. And in true focus form, we are focusing first on blood pressure control, attempting to move the population control from 46 percent to at least 65 percent. And to the right of that, for folks who are already in health care systems, we have a higher target.

Here's the current knowledge about hypertension control in the country. You see that we have 67 million Americans over the age of 18 with hypertension and more are uncontrolled than controlled. The definition of control for this framework is less than 140 over 90.

On the next slide we look at the 36 million people who are not under control. Out of that 36 million, 14 million are not even aware that they have high blood pressure. That's a very frightening statistic. Sixteen million of that 36 million know that they have it. They're actually on treatment, but they are not under control. And in my mind, that's almost the worst experience because they are buying medicine, we hope they're taking medicine, but they are still not protecting themselves from heart attack and stroke. Lots of opportunity here for improvement.

You might think that those 36 million uncontrolled folks are not accessing care, that they don't have a regular physician or nurse. This slide shows you that it is not true. Out of the 36 million uncontrolled, 32 million have a usual source of care and 30 million have health insurance. In fact, 14 million of those have Medicare. And you also see that many of those, the great majority of those, have accessed that care twice in the previous 12 months. So we are missing some opportunities to improve blood pressure control and to prevent heart attack and stroke.

You see on this slide that it doesn't take much. Even five millimeters reduction in that top number has a major impact on that individual's risk of stroke, of heart attack, and of death. There are additional things that can come through a focus on medication adherence. On this slide as medication adherence to blood pressure and cholesterol medicine increases across the horizontal axis, you see that the risk of going in the hospital for any cause dropped. All cause hospitalization risk. The same framework is used in the following slide. Increasing medication adherence to blood pressure and cholesterol medicine across the horizontal axis and health care costs, total health care costs, all costs are diminished with increasing adherence.

So I'll just quickly review the state – really the state of the nation and the things that are driving this important focus on blood pressure control and reduction of heart attack and stroke. We know we have millions of people with uncontrolled high blood pressure. There are more coming. Because of

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the obesity and diabetes epidemics and the correlation between those and high blood pressure, we can anticipate many, many more people with hypertension. It's time to focus on this as a nation.

Secondly, we have newly insured folks, thank goodness, coming into the health care system, but we have no real increase in the short-term or even in the mid-term in the workforce, physician and nurse workforce. So we have to come up with a new way to manage blood pressure so we get more people safely under control. The EHRs blessedly have been adopted, but they were not really designed for quality. They're being adapted for quality now, and you'll see great examples of that on today's presentation. But we want to improve their use as a quality improvement tool. Employers looking for value in their health care purchases, they are shifting the cost to employees making all of us who are employees more attentive to our health care issues.

Next is the accountability for cost across settings, these new models of care, accountable care organizations and hospital systems that are enveloping communities around them. They are now all responsible for looking at cost and outcomes, clinical as well. We've got exploding in-health or mobile health technologies. All of them are looking for a market. How can we harness these and use them for blood pressure control? And then finally, we're all learning a lot about incentives and behavior change and we are very interested in that at Million Hearts in learning from what you all know.

So here quickly is the blood pressure control attack plan for Million Hearts. We have five objectives. They're listed here. We need to do a better job of detection that will get us to 14 million people, a better job of moving those who are treated to controlled. That's the 16 million. And then we have much larger populations to reach as we improve and facilitate self-management; we improve our ability to measure and report; and then we reduce the sodium intake of the population really affecting the entire population of the country. We know that these elements are the essential ones for high-performing teams. And again, I'm going to get out of the way here so you can hear it from the sources themselves.

But looking, what we've seen is that high performers execute care in teams, always involving the patient and the family. Technology is used to provide actionable data to connect people across settings of care and to provide those timely reminders. Self-management, as I mentioned before; more frequent contact with individuals who are managing their condition; better adherence to meds; and then a business model or a payment that works in two ways. One to cover the cost of the approaches that you see above it and the second one to convert to a safer control system rather than a pay for treatment and testing.

We have lots of resources available both on our website and the sources that you see here. And it is just delightful to me to be part of this initiative and to actually sit back and listen to these three presentations ahead of you. So Judy, I'll turn it back over to you.

JUDY HANNAN: Thank you, Janet. And if you had questions about the Million Hearts initiative or have questions, please write them down. At the end we should have time to address those also. But it's

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now my pleasure to introduce you to Dr. Merenich. Dr. John Merenich is Medical Director of Clinical Informatics and Decision Support and Medical Director of the Clinical Pharmacy, Cardiac Risk Service in Kaiser Permanente Colorado. He serves as Chairman of the Colorado State Cardiovascular and Stroke Prevention Guidelines Committee, is Clinical Lead of the National Kaiser Permanente Integrated Cardiovascular Disease Effort. For the past ten years he has also led clinical registry and panel support application development efforts for the Colorado Permanente Medical Group.

Kaiser Permanente Colorado is one of just two health care providers in the country to be recognized as the 2012 hypertension control champion. And I look forward to hearing from you, Dr. Merenich, about how you all got to your results.

DR. JOHN MERENICH: Well, thank you very much. I appreciate that nice welcome, including the promotion to National Integrated Cardiovascular Health. I actually am the Chairman of our Cardiovascular Health Program in Colorado and I am on the national Kaiser team. I'm actually joined by one of my colleagues, Stephanie Snyder, who's been with the integrated cardiovascular health effort in Colorado for the last six years and Anna and Ann Wells, my physician colleagues especially taking care of our blood pressure population, are actually attending a Colorado state symposium and workshop so they can't join us today.

So for those of you not familiar with Kaiser Permanents, in Colorado one of the regions where we take care of patients in the Kaiser system, we have 530,000 members. We presently have 24 medical offices and about 300 primary care physicians caring for those patients. While one in four of our adults has a diagnosis of hypertension as shown here in the slide, that's about 95,000 members. And we have another 3,000 or so that have elevated blood pressure that don't have a diagnosis. We're working on them. The total number of patients between the age of 18 and 85 with hypertension adds up to 89,500. And as Janet discussed in her opening statement, this adds up to a lot of potential events and we're very interested in making sure that these patients are cared for.

We were long involved in hypertension control, but for about three or four years in the mid-2000s through about 2008 we were stuck at about 60 percent. And so in January of 2008 we said we have to shake the tree a bit and we wanted to see what we could do to increase those numbers. We were just not happy with that low percentage of patients. And as you can see in this graph, over the last three years we have been able to increase our hypertension control rate up to about 82 percent.

The key to our success, and Janet mentioned this in her introduction as well, we can summarize in this slide. And these really are generalization statements. It's all about the people, the process, and the technology. There's nothing that we do in Kaiser that we don't have a patient at the center of our attention. In fact, a recommendation we would have is that patients join all of your governance boards and some of the planning implementation boards. We find that very helpful because it brings the patient perspective to the table right at the very beginning.

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We are always looking to make the right thing easier to do. If you can do something in two steps instead of three or four steps, then by all means do so. There's so much work to be done out there we just can't be – we have to be more efficient and we want to do the things as quickly as possible. And we do that also by making sure that the right person on the team does the right job.

As you'll see, hypertension control in Colorado and other places is a team sport and so we've brought a lot of people to the table. This can't be solely the job of a primary care physician. We're big into process. We constantly look at our metrics, always attending to evidence-based guidelines and protocols, updating them and sharing them with all of our providers and with our patients. And we spend a lot of time on integrating the care that our teams provide. We are very big on technology and I'll show you a couple examples of the way we use technology and that it's helped us to achieve our results.

I can't stress this next slide enough and that is back in 2008 when we started our new efforts, we really sought and got the buy-in from key sponsors in our medical group and in our health plan at the highest level. Our quality director and the director, executive medical director of our medical group bought on and signed on to the plans that we had in place as did the vice president of quality on our KP health plan. And without this kind of sponsorship, it's virtually impossible, especially when it's one that's trying to break down the silos that are often in the way of caring for our patients with hypertension.

We also had a dedicated physician. I have .2 of my time dedicated to all cardiovascular efforts and my two physician colleagues also were able to spend 20 percent of their time exclusively dedicated to hypertension control. And Stephanie, who joins me in the room today, is a full-time health plan employee who really is the glue and keeps all of our efforts together.

And finally, it's very important as we move forward to have vision. And I wanted to spend some time on the ABCDEs. Although we're concentrating on hypertension today, really we have no discussions about blood pressure control without considering all the cardiovascular risk factors and we've expanded on the ABCs from what Janet described to the ABCDEs where we talked about diet and some people use diabetes with the D as well and exercise. And we've showed you here the actual endpoints in these proxy surrogates of exercise of 150 minutes a week. And not only are you a smoker, but have you been advised and maybe you've been given the resources to help you quit. So these are very important metrics.

And then another slide. This is difficult to see and you could expand it on your own view on your browser, but we really do approach all of our patients from an integrated cardiovascular health approach, not just looking at the hypertension but the whole picture. On the left-hand side of this diagram for those of you interested in population management, we are able to actually break down our entire population into those people with heart disease. Those with heart disease see the equivalence such as diabetes, stroke, and peripheral arterial disease.

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And then those that have been risked with the classic Framingham Risk Calculator that have high, moderate, and low risk. And then finally the some 100,000 in our population that have not been risked. So we're able to actually then break down these patients into buckets and make sure that the right person is on the job trying to outreach to them.

So, back to hypertension proper and the people, again, we say this is a team sport. Our primary care providers help us and approve of treatment plans and help all of the team members when a patient is especially difficult to manage. But we have divided up the hypertension control largely now under the purview of our nursing teams from the RN and the nurse practitioners down to the medical assistants who have been trained on how to obtain blood pressures.

And we have a very important partner in our blood pressure control in Colorado and that's the clinical pharmacy specialists. Those of you who don't have or don't utilize pharmacy specialists in your blood pressure outreach programs; we suggest that this is a great member of the team. They can help with treatment plans as they do in Colorado and actually can help the nurses as they see the patients and have a kind of a treatment plan to start off a session. And that's very helpful.

We also have reached out over the last couple of years to specialty medicine departments so that when someone shows up and they have an optometrist visit, the specialty department goes in and gets a blood pressure. And if the blood pressure is elevated, they refer to the physician or in some cases special departments actually take on designing a treatment plan. So again, we take advantage of every opportunity, every visit, every in-reach that occurs in Kaiser to address the blood pressure issue and problem.

As we mentioned, we are very attentive to patient engagement. We provide wallet cards. We have DVDs online on our KP.org site. We provide DVDs. We have a lot of programs that we can provide to our patients at the office site when they're in the office so that they can actually take home materials with them. We spend time with our patients to make sure that they could also measure a blood pressure correctly. And actually we also provide blood pressure monitors at cost to all of our patients, encouraging them to check their blood pressure and to email, phone, or mail us when there are abnormal blood pressure results at home.

This next slide is a demonstration – is actually a poster that is in every office in Colorado in KP and that reminds our patients and our providers that this is their correct blood pressure technique. We have all of our patients rest for five minutes before the blood pressure is obtained, make sure that their feet are flat on the floor and back is supported. And I won't read the rest of them, but both our patients and our providers see this in the exam rooms and they kind of check on each other and make sure the blood pressures are done correctly.

I can't stress enough how important this is. For those of you who have not seen this type of slide, you can see that some of these correct blood pressure monitoring techniques go a long way in getting a

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true blood pressure and have been largely responsible or a large component of why we've been successful on getting blood pressure in control, getting the right blood pressure measurement.

We also have tried to remove as many barriers as possible for all the patients taking care of – with blood pressure. We removed a blood pressure co-payment for all of our BP visits about two years ago so that a patient who has hypertension and is being monitored and being titrated can walk into a clinic at any time, scheduled or unscheduled, and get their blood pressure checked at no cost. As I've already mentioned, we provided blood pressure monitors at no cost. So they're encouraged to use those.

And then for the LPNs and the nurses in the exam rooms, we made sure that there was the proper equipment in every exam room, four or five size cuffs so that a nurse doesn't have to run from office to office to find the right equipment to obtain the right blood pressure. We removed all of the work stations so that we kind of took away the risk and the temptation to try to get a blood pressure while you're getting the weight while the patient is standing right after they got in the exam room after driving in for example. So making sure that the blood pressure is obtained in the offices as we deem appropriate.

I mentioned CME here only to bring up that most of our CME is actually done at the office and in the clinics by Stephanie and our physician colleagues. We find that that onsite CME is much better than the formal presentation, and also I use this opportunity to say that we share our best practices with other Kaiser regions. And once every couple months all of our regions get together and share some of the successes that we've had in the other regions. So constantly sharing best practices and learning from each other.

For the doctors I mentioned that – I'll use this slide just to mention that one of the things that we found was very important to eliminate the titration barrier for those people with hypertension whose starting blood pressure is greater than 20 over 10 over goal was to start with combination therapy recognizing that some 75 to 90 percent of patients with blood pressure elevated to this degree wound up on more than one blood pressure medication anyway. And again, it allows for a reduction of the number of steps that are required to achieve goal.

Going on to technology, and I'll finish with technology. Just giving you some examples. This is actually in our electronic medical record. Whenever a blood pressure is obtained and it's abnormal, this alert is fired to remind the staff that they should recheck the blood pressure after waiting a minute and making sure that the blood pressure correct procedure is being observed. For those of you who are interested, in the Journal of Clinical Hypertension even this month our own Dr. Joel Handler has published on the efficacy of this kind of an approach and demonstrating that the second blood pressure value is often normal and really helps with our blood pressure control efforts.

I've talked numerous times about our metrics. You change what you measure and you measure what you change. And we have a process improvement mentality such that all of our clinics are asked to

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constantly re-address their processes and procedures. And in this list we have some of the kinds of things that we look to, action lists for instance for patients who have had a blood pressure elevated and had a recent blood pressure titration; anyone that has gone beyond nine weeks and not had a follow-up blood pressure is in a list. And where we worked those lists, we also make sure those patients who have had medications ordered and not picked up. So it's one thing to order, but it's another to actually have it sold. And so the patients who are in that category are made available to all the providers so that we can follow up and ask what the issue might be with a particular patient.

I'm showing here also some of the technology used with our population support systems. This is just an example that with all of these hyperlinks that are listed in this slide, you could drill down into patients who have not met a particular goal. In this case a blood pressure of less than 140 over 90 in the last few years. You could actually link on those people not at goal, click on it, and actually get the patient HRNs. So this actually greatly facilitates outreach efforts.

Dashboards – I can't emphasize enough how important it is for primary care providers. We provide a list of all their paneled patients, those meeting goal and those not at goal. And then we also provide for the docs something very important that we found helpful and that is the number of patients that need to be treated, the number needed to treat to prevent another heart attack or stroke. So that makes their work when they're working these patients a little bit – brings it closer to home.

For the nursing teams we also provide metrics, including such things as the number of patients who have not had their second blood pressure done during a routine office visit. And finally, I wanted to show you some examples of the kinds of dashboards and metrics that we use. This is our integrated cardiovascular health score card. In the upper left-hand side in particular that green line in that first upper left-hand panel actually represents the number of patients with major coronary event rates since 2000, and you can see that's trending down over the last ten years. And there's about a 40 percent reduction from its peak in 2000.

So we've been at this for quite some time and one of my messages to you would be keep it up, be persistent, and your efforts will pay off. The rest of the metrics that are shown in this panel refer to the number of patients screened and then the blood pressure control and our lipid measures, smoking, diabetes, and exercise is a vital sign in the last panel. Again, I'm just showing that these are the kinds of graphs that we would supply to both physicians and to the team so that they can do their work.

Last slide I wanted to share with you all is some of our barriers, obviously competing priorities. We have to provide a lot of different kinds of services, but we are keeping blood pressure center and really encouraging people not to shortcut in this important control metric. We are challenged always with time to do all these things in an in-reach visit. So we're increasingly going to outpatient mechanisms so that we could do a lot of this outside of the exam room. We are trying to make sure that our patients make the most use of their visits and making sure that they have the right co-payment type and constantly stressing the importance of blood pressure control so as to help maintain adherence with our patients that are on blood pressure meds.

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And then finally as we had mentioned several times, you always keep in mind that the main reason we're doing this is to prevent heart attacks and strokes and that these efforts go a long way into doing so as shown in our summary slide of the last ten years. And that's all I have. We'll answer questions at the end as well.

JUDY HANNAN: Thank you very much, John. And we'll encourage people, you can put your questions in the general chat and that will help start the conversation at the end or feel free to write them down and at the end get in the queue with the operator. With that, I'd like to now introduce you to Dr. Sarah Woolsey. She currently serves as a Medical Director for HealthInsight, a Utah Beacon Community working to assist local physician offices to improve care for diabetes patients through health information technology.

She is also one of 73 individuals from 27 states and the District of Columbia participating in the Innovation Advisor's Program launched by the CMS Innovation Center. The Innovation Advisor's Program is a new initiative designed to engage health care leaders to refine, apply, and sustain managerial and technical skills to drive delivery system reform for the benefit of Medicare, Medicaid, and CHIP.

Dr. Woolsey is working with the Innovation Center to test new models of care delivery and payment in the Utah Beacon Community and we will learn lots about the electronic health record and the technology that can help us all in hypertension control. Dr. Woolsey.

DR. SARAH WOOLSEY: All right. Can everyone hear me?

FEMALE SPEAKER: Yes, we can.

DR. SARAH WOOLSEY: Okay. So this is... I just want to thank everybody for the opportunity to share some of the local successes we're gaining in the Utah Beacon Project and specifically in the health center where I practice. And I just want to thank everyone for their interest in chronic care delivery and impacting hypertension control in the country. So thank you for having me.

This is a presentation about our health centers and improvement we have done with the Beacon Communities Projects. We are four urban sites. We are federally qualified health centers. We have 26 providers serving about 28,000 patients last year, underserved community, a high percentage of patients that are of Hispanic descent and monolingual Spanish. Like I said, we participated in the Beacon Communities Project, which is demonstrating that health information technology can impact patient health and outcomes. And we implemented the electronic health record ECW, in 2010.

I want to give a shout out to my team members. As the gentleman before me said, nobody can do it without a team and I've been lucky to have a great team and to have a team that's willing to try new things in our setting. I also want to thank our community leader, Dr. Barry Stults, a hypertension expert at the University of Utah, who provided lectures and information through the Beacon Communities Program that spurred much of our improvement.

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So as they said in the beginning, I do work with a quality organization and it always starts with an aim in the quality organization. So our aim working with the Beacon Community was to decrease our diabetes patients with uncontrolled blood pressure or to increase our diabetes patients with controlled blood pressure by five percent by March 1st, 2012. When we started, we weren't sure how this was going to go. We hadn't taken on blood pressure to this extent yet, but we were ready with the support of the Beacon Community. We actually after some initial successes said, "Let's do ten percent." And this impacts our 2,000 adults with type 2 diabetes across our centers.

And I won't make you wait 'til the end to see if we made it. We did. You'll see our data in the green. You'll see our ten percent goal that we actually hit by October. We hit our five percent target with no difficulty. And we're also very proud of the fact that we're approaching and probably about to hit the community benchmark of our three-county Beacon Communities that are working on the same measure for their outpatients. So we're hanging with the big boys now in terms of our delivery of quality health care to our patients. So we can demonstrate that.

This slide shows our barriers. Our barriers are not unique. Most folks dealing with chronic disease or chronic hypertension deal with the same barriers. How we address them is on the right. You can take a look at that list and I'll go through each one as I talk. Our barriers aren't unique. How we solve them though is a little bit unique for us and I hope some of our lessons can be applied to your setting or modified to your setting. Steal, borrow, re-process, and make it better for your patients.

Our theme for improvement and what I want to say about this particular project is there are three things. One is actionable data at the patient level at the time you get that blood pressure and then at the quality level so you can impact your providers just like the gentleman from Kaiser talked about. Next thing is education for everybody. And third, as we talked about, develop processes that remove barriers for everybody. Identify them and then get creative about removing the barriers.

So, first thing for us, we're in an information technology project. We set this goal of improving the control for our diabetes patients and their blood pressures. We needed an accurate blood pressure control baseline. We're pursuing meaningful use. We're working hard to have our electronic record work for us. But when we ran our first numbers, we realized our patients with diabetes appeared to not even be getting blood pressures.

We found system-wide recording errors and this is common in the Beacon Community clinics that I'm working with. So we went back with our regional extension center support, with e-clinical work support. We figured out what we were doing wrong and we retained our whole system. We had to retain our MAs and providers to put the blood pressure in the right place the right way. It seemed very simple, but if you don't have the right data, you cannot then action it.

What that's done for us, it's built trust in our monthly data pulls. We know that improvement's really an improvement. And when we look at our patient lists of patients who are not at goal for hypertension, we trust them. We don't have to go rework the data and see if that patient really has

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high blood pressure and it's out of control and needs our care or if she's really just got the wrong data entered. So that helped clean up things and made it go forward faster.

Education for providers. Providers have a lot of things to learn, a lot of things to think about. How do we get their attention on what we're talking about? So we picked one of our favorite pharmacists and someone that respects our providers, has fun lectures, and she updated us on current best practices. We made that meeting mandatory, gave people time to attend. We also provided hypertension guidelines from our state and shared those as a resource tool they could take home. We shared our aims, our project. We took their input as to what they think would help make this process improve and went to work on that. We did the same thing as we rolled out our self-management intervention.

Training on blood pressure. I don't think anyone's going to stress this enough. You'll see the quote at the bottom. That is one of my favorites from Dr. Barry Stults. Blood pressure reading does not seem to be done correctly. It seems simple, but it's actually not. This was important. We took a look in the mirror and realized we weren't as standardized or as careful as we wanted to be so we took that on.

The key to accurate diagnosis and therapy decisions is a good blood pressure. Again, actionable data at the point of care. This helps two things. Number one, providers trust a good measurement. They don't go in and check it again. They don't practice therapeutic inertia and avoid titrating a patient's medications because they know that blood pressure they're looking at is a good one. Number two, it avoids overdiagnosis of patients and over treating, which can lead to adverse drug event experiences for patients and negative experiences taking their meds. Like I said, it seems easy, but it's not. Stressing correct cuff size, having correct cuffs available for MAs to use at all times making that no barrier for a correct measurement has been key for us as well. And finally, it requires reminders and regular re-training.

We elected to also purchase automatic in-clinic blood pressure machines. We had talked about this for years and had not made that commitment because it's expensive and our system is low-resource, but we found that using a centralized machine on a roller, making sure it was calibrated regularly, training everyone on the use, we took the attention off that and now we pay attention to how the patient's sitting, the timing of the measurement, and we're focused on different parts of taking an excellent blood pressure. That's been one of our best interventions. Our cost was \$2,500 per machine. We have found it to be worth it.

So self-management, how many people that are listening would send a patient with diabetes out into the world without even talking about the option or prescribing a home glucose monitoring regimen? How many of us would titrate insulin or medications and hypoglycemic medications without a monitor? We probably wouldn't do that. But how many of our patients do we send out into the world without access to measuring their own blood pressures and self-managing themselves? So we took this on again. Dr. Stults is a big advocate for self-management and good self-management. So we took this to heart and decided we'd implement a program in our setting.

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The first thing we did was choose an approved home monitor. These are links to resources where you can find choices. We picked one that we felt was a good price point. It was accessible in our local pharmacy. We could train ourself to use it and train patients to use it. We also standardized that order in our electronic health record to reduce barriers of forgetting the monitor or taking time to order it and we put in the large cuff for patients that would need that.

Ideally, our process was that the patient would get their blood pressure cuff and return for training with our health educator who does an excellent job with patients. She's our expert, but we found a barrier. She's not there every day. She rotates between our clinics. So we developed an MA training system. Using the excellent training they had received on our own rolling machine, we said, "Let's train you on the home monitor. If a patient comes in, here's a checklist of success. You can do it with patients when they come in."

Continuing, we got patient education tools that we liked in the languages we wanted. We loaded them in our electronic health record so they were easy to find. We translated a home blood pressure monitoring log into Spanish so we had that available. We haven't gone highly technical. We don't yet have patient portal access. So we are on paper. But it's been working fine and when patients bring those in, that information is excellent.

We also reduce a barrier, just like the Kaiser system, to getting the blood pressure checked. We said to our patients this is important. Come in. We'll take your blood pressure and even if you don't have a home monitor, we'll come in and we'll track for you. We'll let your provider know those results and they can help you make some decisions on titrations. And that can allow medication titrations to happen as quickly as every two weeks with good information. We also developed what our MA should do if they got abnormal numbers either high or low so the medical assistants felt safe with those patients when they walked in. Here's just a quick shot of our Spanish documentation sheet. It's on paper. It works well.

Finally, the three R's: ongoing registry, review, and recall. Really important for any chronic population management and as again, my former speaker – I keep forgetting his name – as he said, providing patient lists to providers really hits home. Giving a provider an individualized report as to the impact of their care on their patient or their lack of care to the standard we hold, it really hits home. Those names make a difference. Also, you can do behind-the-scenes management with a good electronic health record. You can call patients in for self-management, refer them for education. Keeping that going is critical to what we hope to be ongoing success.

So that's our story. That's how we got where we got. We want to continue to improve, hit, and go past our community benchmark for our patients. We're next going to be looking at our sodium education and implementing that in an excellent way expanding that more patients get cuffs and finding some funding to cover those home cuffs or home monitors. And just for us, actionable data has made a difference. Education across the board has made a difference. And developing processes to remove barriers and continue to remove barriers is how we want to go.

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Well, that's a repeat. And then just I want to show some tools. We are borrowing and stealing from all kinds of organizations. This slide is a hypertension fault tree. This is from my organization, HealthInsight, looking at why a patient might not have controlled blood pressure and looks at the high impact areas for population. So this is a resource to educate clinical systems, even a clinic about hey, where are you going to find the best results to impact your hypertension rates.

This is from Welch Allyn, how to take a good blood pressure. It has graphics. It's something that could be posted on a wall or a reminder for I like patients and staff. This is a link to how to take a blood pressure at home from the Canadian Health System and also home blood pressure written instructions. This is another graphic on how to measure blood pressure and why it's so important to do it well. We love this slide and refer to this slide in our trainings.

If you haven't heard of heart age, check out this link. It communicates lipidemia, smoking, and hypertension reduction risks for patients. Hypertension is sometimes hard for people to understand how's it going to impact me, but when you tell them, "Hey, based on your data, your heart right now is 20 years older than you," it can actually help improve adherence. It's been shown to improve adherence in lipids and we think it communicates well for hypertension as well.

Adherence assessment. As we discussed, we haven't done this yet, but we're planning to put these adherence questions from the Public Health System of New York into our electronic record for intakes. Educating patients on what's important about home blood pressure taking and of course sodium from My Plate and then the basics. What is high blood pressure? Going back to basics as we educate ourselves and our patients. Thank you. My contact information is there and available for slides and we'll take questions at the end.

JUDY HANNAN: Thank you very much, Sarah. You've now heard from John Merenich and Kaiser Permanente about a health care system large overhaul. You heard from Sarah as far as a Beacon Community and what some leading technical assistance to providers across the state can look like and the things that they are finding within their practices.

It's now my pleasure to introduce you to our final speaker, Dr. Chris Tashjian. Dr. Tashjian is a family practice physician and a founding and current member of the Board of Directors at Western Wisconsin Medical Associates. He practices in River Falls and Ellsworth, Wisconsin and serves as President of the River Falls, Ellsworth, and Spring Valley Medical Clinics. He is a board certified member of the American Academy of Family Physicians and specializes in rural medicine, caring for patients ranging from pre-birth to great-grandparents. The Ellsworth clinic is the second practice that was honored as a Million Hearts Hypertension Control Champion in 2012. He is passionate about the ability of every practice to be able to make substantial improvements in hypertension control. Dr. Tashjian.

DR. CHRIS TASHJIAN: Thanks very much for that great introduction and I appreciate it. I'm going to give you a different point of view than our first two speakers in that I practice in a town of 15 hundred and like some of those first speakers that said if we can do this, then so can you. And that's really our –

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one of my goals today is to show you that if a small town rural practice with two docs, a PA and MAs without any nursing, you know, a registered nurse or LPNs, can do this, then we think everybody can and we're going to go – I'm going to go over a couple of things we did and I'm going to go ahead and emphasize some of the points that were already emphasized in the first two talks.

So if we could move to the next slide please. Okay. We're going to start out with what I would call our low-tech solution. And I'm going to start out here is the low-tech requires some education and requires making our staff understand the importance of taking blood pressure. And we talk about it in the standpoint of patients' lives. The blood pressure, while they're numbers, the numbers actually mean things to people.

And being in a small town, we see each other all the time, whether it's in the grocery store or at the office or you name it, the gas station. So there's a real integration of people's lives and what it means if this person has a stroke and what it means to their family if they have a stroke or a heart attack. And so it makes it real for our staff and our medical assistants who do most of the intake, most of the initial blood pressures.

The other thing that it shows is that – or that I want to say here is we have for many years now, at least ten, created a community awareness of blood pressure. And while access to home blood pressure machines may not have been as accessible as they are today, what we've done is we set up a system where it's between the nursing home and the pharmacy and the ambulance hall and our clinic that anybody can walk into any one of these four areas and get their blood pressure checked without... Can we move that back please? But can get this checked without any appointment. They don't need any – it doesn't cost anything. There's no co-pay. It doesn't get reported to their insurance companies or anything like that. So again, we think access to good data is vitally important.

So what you're seeing here is our really, really low-end tech. We spent, you know, five cents on a piece of red paper. We printed, "Recheck blood pressure" on it and we put a, you know, we laminated it and put a magnet on it. This is something my MA controls for all of our providers, the other doc and the PA in our clinic. And she'll go in ahead and take the blood pressure according to the rules that we've set up. And if the blood pressure's above 130 over 80, she'll do something very simple. She'll just take this red magnet that's on the inside of the door and she'll put it on the outside of the door.

By doing that she does a couple of things, is that she brings it, you know, it means that she's paying attention to what she's doing and she has real importance in the whole system and in the care of our patients. And she has the ability to bring it to my attention without taking a lot of time or a lot of effort to say, "Hey, doc, when you go in that room and you see that red magnet on the door, you know, it means I want you to pay close attention to their blood pressure because it's not under as good of control as we'd like it to be." It cues me to either recheck the blood pressure as it says and it also gives me an opportunity to remind the patient, even if they're there for something else, if they're there for a cough or a sore throat or something else, to basically have a brief conversation about blood pressure, which I think is, you know, vitally important to hear the same message every time. And

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that's done a great job at getting the patients engaged, which again, I think is one of the more important things that we do. So that's our low-tech solution.

We'll move to the next page. In 2010 we implemented an electronic medical record. And again, we're a small clinic so our electronic record actually resides in Kansas City. We have none of those records on our computers in our room. We have an IT Department, but what we do have is we have a fundamental philosophy that every patient who gets seen gets a blood pressure and the blood pressure gets entered in a discreet value in our EHR so that we can look at it.

So the first thing we do, you know, and one of the reasons we looked at blood pressure is because blood pressure is so vital to many chronic diseases. So we monitor our diabetics. We monitor our coronary artery disease or ischemic vascular disease patients. We monitor our hypertension patients. And so blood pressure is at the root of all of that. So that's one of the things we mine our EMR for in our reports and we actually pull out the actual data from our EHR and throw it into an Excel spreadsheet where we can then manipulate it and use it.

And what you notice here is this is page two or three of a report. You can see all the yellow. The yellow is the computer telling us these patients aren't at goal for some reason. Now, again, this is a diabetic patient so it has A1C and it has direct LDL as well as aspirin and tobacco, but blood pressure is on there as well. And if their blood pressure is elevated, it's highlighted in yellow and it draws it to our care coordinator's attention so that when we have these monthly meetings with our care coordinators, that we know exactly who we need to treat and how we need to address it and it brings it to the forefront.

So again, the idea is for us is the EHR is more than just a place to throw the blood pressures. We actually want to use it to help manage it and to actually stop being reactive, which is, you know, I've been in practice, you know, over 25 years now. The bulk of my practice has been reacting to patients coming in and we're really making a step forward now with this data to be proactive, to reach out to patients and say, "Hey," you know, "we're aware that your last couple blood pressures have not been where we want them. Please come in. Let's recheck it. If they're still elevated, let's deal with it."

So if we could move to the next slide please. Okay. So then what we develop is again out of our record and out of this database we make a registry and we develop patient scorecards. We do as much as we practice advance practice, advance scheduling, which is a nice way of saying is the bulk majority of our visits are same-day even for our chronic disease patients. So roughly a quarter of my schedule is prescheduled during the day and three-quarters of my schedule is scheduled same day. And so what these scorecards do is they give my nursing assistant or medical assistant a chance to at least pull up some data on the patient when they call in the same day.

And you can see, the computer again, does the work for us. It highlights the fields that either aren't done like you can see the field at the bottom or the field that's out of our parameter that's more towards the middle of the field. And so again, it points us in the right direction that says no matter

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what reason this patient is coming in, we should be looking at these values on this patient and making sure that we address it, you know, at the visit whether the visit is related to that or not.

So if we could move to the next slide please. And if we can have patient scorecards, you can bet we can have provider scorecards. And my colleagues also talked about this. This is physicians – now I blocked out the names for obvious reasons, but every one of the names, there's two of us and then we have what we call the mother clinic. Its 15 miles north with another 15 docs, you know. And we publish this on a monthly basis as to where people are. And we publish it by individual doc. We publish it by site because again, we're a firm believer that yes, we need to be accountable, but anybody that walks through the clinic walls that I practice in is my responsibility.

So even if it is my partner's patient or the PA had been seeing them, if they're in there and their blood pressure's not controlled, the patient doesn't really care whose patient they are. What they really need is to have their blood pressure controlled so they don't have the stroke and heart attack. So we focus both on the individual provider, but we also focus on the site and we make it clear to all of our providers that we're all responsible and that if you see somebody's blood pressure that's elevated and you can say well, that's so-and-so's patient so I'll let them address it at the next visit, but that's just not acceptable, that we're not, you know, that that doesn't serve our patients best and that it isn't going to give us the results we want.

And again, we push over and over again that we're not treating numbers to treat numbers. We're treating numbers so that grandparents can play with their grandchildren. We're treating numbers so that, you know, a 50-year old doesn't have a stroke and completely upset the entire family unit of that family and the community.

So if we could move to the next one please. So these are our results. And the results – again, this is a small rural clinic in the middle of what some people would call flyover country. We would call it God's country. But again, we improved our hypertension control from 73 percent to 97 percent and we could not have done this if we didn't involve our MAs, if we didn't make sure that the people at the front said, "If you need to come in, come in today. We'll be happy to see you."

Again, our blood pressure control for people with cardiovascular disease is 90 percent. And if we look at all patients, so all of our patients who have hypertension for any reason, whether it's diabetes hypertension or ischemic vascular disease, whatnot, in our clinic we're above 90 percent now and our most recent number we've – that was as of August and September and October, the numbers remained above 90 percent. And again, we celebrate these, you know, every month they come out, but we're always looking for new ways to see if we could bump it up because again as the higher you go, the more chance to go down and the harder it is to improve on it.

One of the things we're talking about to improve patient compliance is having our care coordinators in the room with the physician so that again the patient can share this constant message. But again, one

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of the things we realize is that we can't sit still. We can't just say, "These numbers are great. Now we can just kind of coast back." We really want to continue the improvement.

So the next please. Go on to the next slide. So this is an important message that we have a number of places in our clinic. And this is that, you know, sometimes we talk about taking baby steps, but really when we talk about crossing the quality chasm and really trying to make a difference in people's lives is we can't really take two small steps. We can't say, "Well, we're going to try a little bit here and a little bit there and we'll, you know." We went whole hog. We did both the low-tech and the high-tech solution. We took that big leap because we felt it was indicated for our patients.

And that's – it's been very fulfilling and it's been very transformative to see that we now are not a practice that's reacting to patients as they walk through the door, but we're actually proactive reaching out to our patients. It's more fun to practice. It's more fun for our staff. And, of course, our patients, you know, like getting that kind of care.

So we can move to the next slide. I think this should be it. And again, feel free to contact me if you have any questions. We'll be on the line to answer any questions at the end of this presentation. Thanks for your time.

JUDY HANNAN: Thank you so much, Chris. That was excellent. Now we're at the portion that involves all of you on the phone. It's the time for questions and answers. I will turn it over to Olivia right now to give you all instructions for submitting your questions.

OPERATOR: Thank you. At this time we will begin the question and answer session. To ask your question, please press zero followed by a one on your touchtone phone or you may submit your question via the general chat feature at the bottom of your screen. Again, if you would like to ask a live question, please press zero followed by a one now. If at any time you wish to withdraw your question, simply dial zero, one again to remove yourself from the question queue. Please hold for a moment as our system compiles your responses.

JUDY HANNAN: And while we're holding, I've got a question that I'd like to direct to John. As you were going over your blood pressure improvement rates in your third slide, you showed the blood pressure control going from 60 to just about 80 percent. I noticed a couple big bumps in improvement in January '09 and January of '10. Do you have some thoughts about what led to those larger bumps in improvement?

DR. JOHN MERENICH: Sure. I think the initial bump was clearly related to just a general shift from a general metric to specific patient and physician-level panel metrics. So starting in that month in 2009 we provided our primary care providers, all 280 or so of them, their individual panels with their blood pressure results with number needed to treat. They in turn shared that with their team members. So we got, you know, if you will, 280 individual experiments going on at the same time.

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In addition, we made system-wide changes that I think safe to say that during the first part – the last part of 2009 and early 2010 were just about complete. And those were explicitly around removing work stations from all the clinic offices and making sure that all of the MAs received proper blood pressure technique and were certified. And we also started in late 2009 our blood pressure alert that we shared with you so that second blood pressures are always obtained. And very specifically, we asked the nurses to do those second blood pressures, not the docs. The blood pressure alerts, by the way, about right now about 40 percent of blood pressures that were obtained required that second BP being done.

JUDY HANNAN: Great. Thank you. Operator, are there questions?

OPERATOR: Yes. We do have one current question in queue. Michelle, please introduce yourself. And Michelle, please go ahead.

MICHELLE: Hi. My question is in terms of recommendations for general public resources for the Department of Health website as well as information for our partners. I love that heart rate age risk calculator. Will that information, the link to how I can take a look at that, be available anytime soon? I mean I think that that's... We did something for diabetes awareness here with the – a quick diabetes quiz and this would be similar. And I think this is fantastic just in terms of general public awareness and public education. Is this something that I could put up on my heart disease and stroke prevention webpage and have an interactive setup for the general public and our partners?

DR. SARAH WOOLSEY: This is Sarah Woolsey. I believe you mean the heart age link?

MICHELLE: Yes. You mentioned the heart age risk calculator.

DR. SARAH WOOLSEY: Yeah. So that just takes the Framingham cardiovascular data and puts it in a more fun format. That link I believe will be mailed out with our slides and you can click on it or if you were fast enough to write it down, you can click on it. It's a publically available link and a website with lots of cardiovascular tools.

MICHELLE: Yeah. I mean even in the good – the picture diagram for BP I don't have anything quite like that and that would be excellent just in terms of, you know, having it even on our website. So I will take a look at that Framingham data site.

DR. SARAH WOOLSEY: Yes. And I believe we'll be sharing slides. At least I know I'll be sharing mine after this completes. I believe there's a mechanism for that. Thanks for your interest.

MICHELLE: Very good. Thanks a lot.

JUDY HANNAN: And this is Judy. We have a couple of questions in the chat area. I've got one for you, Chris. Who provides the care coordinator for your patients?

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DR. CHRIS TASHJIAN: We provide it ourselves, but I think one of the important things to remember about our care coordinator is that it actually is one of our MAs who we trained ourselves. And it has several advantages. First of all is needless to say she costs less than say somebody with a more advanced degree, but I think we get – we let her work to the fullest extent. And the second thing is when she calls, people know her because she's in our clinic and she's in our office and they see her. It's not somebody from Pennsylvania or a nurse call line or something. It's Roseanne who calls and so I think she's much more effective than I think the average care coordinator and that's one of the reasons why our numbers are so good. Thanks.

JUDY HANNAN: Thank you, Chris. Another question I have that would be for all three of the speakers, what types of provider resistance do you encounter in implementing these interventions? And how do you overcome them? And, John, maybe I'll start first with you.

DR. JOHN MERENICH: Well, I think our blood pressure efforts are greatly appreciated by our primary care physicians. They trust in our system. They welcome the team becoming involved, generating care plans, making sure that things don't fall through the cracks. The chief challenge is always time. It's the time factor in a busy day of just on the outreach side. And on the in-reach side I know there are a couple questions on the chat room just regarding it does change workflow a little bit. And so for people that were used to just coming in and getting a quick blood pressure at the very beginning and then having the doctor check it later on, it, you know, just challenged that workflow. But most of our doctors have adopted and just greatly appreciate the help.

JUDY HANNAN: Thanks, John. Sarah, what kind of resistance have you seen to some of the changes that are asked for of the providers?

DR. SARAH WOOLSEY: Yeah. So just a couple things. Number one, whenever providers are measured, they were all usually "A" students. So they don't like to have to not be "A" students. So initially when you measure or show them data, it will get them to improve because they want to "look better," but initially there's some, "I don't trust the data. Is that patient really out of control?" you know, et cetera. So one thing is just a barrier to showing them results.

Number two would be the similar workflow, getting interruptions at times for elevated blood pressures on patients who walk in is just something we helped mitigate with developing an MA protocol to deal with it.

And number three, I'm going to say that providers still aren't as comfortable as they could be with patient self-management data and making titration changes for example on the phone with a patient they know well. I personally am very comfortable with that, over time have looked at. It's so easy and quick with good information to help the patient make changes, but not everyone's used to that. They're much more used to the usual visit.

So it takes time to break down the workflow change that you may just call a patient and make a change without an actual face-to-face visit. Trusting that does take time for some providers. But again, you

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need to make sure your protocols are airtight, evidence-based, and that the information they're using to make decisions is excellent, and that the patients have access to communication if something doesn't go right.

JUDY HANNAN: Great. Thanks, Sarah. Operator, do we have any questions in the queue?

OPERATOR: We do have an additional question at this time. And that question is coming from Miss Wendy Goodwin. Please go ahead and introduce yourself.

WENDY GOODWIN: Yes. This is Wendy Goodwin and I'm from Well Care and actually the question that you just answered before was the exact question I was going to ask.

JUDY HANNAN: So aren't we good then? Let me try another one. This is Judy. So I've got another question of how do you engage if you did, either the public health community, local health departments, or the general community as partners in these interventions? And I think that could be open to all three of our speakers.

DR. CHRIS TASHJIAN: I'll start out with it. We started it a little bit. As I said, when we encouraged or we engaged our nursing home, the ambulance service, the local pharmacy so that all of them would help participate. And again, we found that very helpful. And then the other thing that it did is it created again another common message that they heard from multiple areas.

DR. JOHN MERENICH: This is John Merenich. We, to add to that, also are working with employers at the worksite and find that going to the patients at the worksite, getting the biometrics, and doing some training there is helpful as well.

DR. SARAH WOOLSEY: Hey, this is Sarah. So mostly for us it would be that if patients get a blood pressure checked for example at the Women, Infants, Children's Center or at a screening clinic, that those locations know there's not a barrier to come back and have their primary care setting recheck that and assess that. So we get a lot of walk-ins for that for example.

OPERATOR: Thank you. And, Miss Hannan, at this time there are no further questions in the audio queue.

JUDY HANNAN: There's a few more in the chat that I will go with. One of the questions, since many insurances do not pay for home blood pressure monitoring, how have you found success and adherence to the program? And I think that might have been directed towards John and Kaiser, but if others have some thoughts about how they've been able to pay for home blood pressure monitoring, I'm sure that would be welcome.

DR. JOHN MERENICH: Yeah. So this is Merenich. CMS still does not pay for an ambulatory blood pressure monitor blood pressure result, but that doesn't stop you from working with patients and doing titering with the ambulatory blood pressure monitors with – driven by protocol. In fact, we have

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published very encouraging results where pharmacy specialists with physician oversight actually manage and titer blood pressure medications using ambulatory blood pressure readings and then encouraging them to come in for their official walk-in or their routine visit.

We're working, and Janet certainly can speak to this as well, we are working here in Colorado and nationally. We see someday that an ambulatory blood pressure result might actually be counted in the – by CMS, but until that time, you know, just getting everything done and having the patient walk in for their, you know, official blood pressure and having it be normal is certainly a good step in the right direction.

DR. SARAH WOOLSEY: Hey, this is Sarah Woolsey. So we have a lot of patients that don't have health insurance. If you are a federally qualified health center and have 403(b) pricing for some medical equipment, you may get a discount. We did not find as good a discount there so we actually have a relationship with a pharmacy in our neighborhood to stock and cut a deal on the particular cuffs that we chose. So we worked with our local pharmacy to do that. We also priced the same cuffs that we have chosen as our preferred monitor so that we know how to train on it and it didn't go past \$60 at Walgreens on sale sometimes. So we will just also refer patients to look for sales. That's the two ways we've done it.

JUDY HANNAN: Thank you very much. And I would like to add my own follow-up question on patients with home blood pressure monitors, and I'll start with you, Sarah. For patients who are monitoring their blood pressure at home, do you have any suggestions or advice for the best way for them to be able to give that feedback back to the doctor? Sorry, Sarah. Let me try to repeat that question. When people... The question is that being when you send people home with a home blood pressure monitor, the most effective way for them to be able to bring the information back for the physician to be able to take it into account?

DR. SARAH WOOLSEY: Okay. Yeah. Can you hear me?

JUDY HANNAN: Yes.

DR. SARAH WOOLSEY: Okay. Yeah. So I'm going to say that if you have portals or ways it can be directly put into the electronic health record, that's awesome. I literally have patients bring me folded up grids. I have patients with very low literacy that with training, we fill out the grid. I have a gentleman who brings that same grid to me and won't let me keep it because he takes it to his cardiologist. You know, we do have patients walk them in. We can also have them report on the phone so just literally list off all their blood pressures. And we do two weeks periods of time so they can also just list the blood pressures and take a phone message. That happens sometimes. And then obviously hopefully one day we're going to have a portal or a better way. They also can bring their machine in and we can look at it. So there's various ways you can get that information depending on your patient's interest.

My patients do like the fact they don't pay a visit and now don't have to pay in order to still get support with their control. So it's an incentive to bring that information in. They get a call from me

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after I review their grids and we talk about changing things and then decide if they need to be seen in a month or two weeks, et cetera. Does that make sense?

JUDY HANNAN: Yes, it does and it leads right to another question that had come in the queue earlier that I'll start with you and, John or Chris, if you have answers also. And I think it came, John, from your presentation. When a patient comes in for a blood pressure check, and you talked about the walk-in, and its elevated does the patient then see a provider? And if so, then are they charged for the co-pay? So to me the question ends up being one. All of you have talked about some systems where somebody can be seen or be attended to by the doctor without necessarily a charge. And then if it's found out that they are having some challenges right now and need to see a provider, do they then have to pay?

DR. JOHN MERENICH: This is Stephanie Snyder who actually worked the blood pressure co-pay issue in Colorado. So I'll let her answer this.

STEPHANIE SNYDER: So thanks, everyone. What we do here in Colorado is we have the patient come back in and they walk in. If they are stage one and without symptoms and there's some questions that are quality-check questions, then the patient is discharged home and the provider will review the blood pressures and then titrate medications accordingly or leave things as such. If the patient is symptomatic at all, they're triaged by the registered nurse and then they are seen by the provider and there is a co-payment.

But for patients who are stage two or higher, with the guidance from the clinical pharmacy specialist, a treatment plan that's approved by the physicians, those patients are seen by the registered nurse who are also – these visits are also no co-payments. And so then the patient can be actively titrated and brought back. Those again are no co-pay visits unless the patient is symptomatic, at which time there is a co-charge.

JUDY HANNAN: Great. Thank you very much. I think at this point I'd like to close the questions and answers. I'd like to thank our four speakers for sharing their expertise, their experience, and their time with us today. I'd also like to thank Dr. Erica Taylor from CMS for organizing the webinar and I know she had assistance from Dr. Marsha Davenport and AIR Associates. But most importantly, I'd like to thank those of you that took the time to listen to today's webinar.

I hope that you were able to pick up some practical tips that will help you and your patients get better blood pressure control. Hopefully you can see what a key role you can play in preventing a million heart attacks and strokes over the next five years. And please, if we could get a few more minutes of your time to take a short survey, I'd like to ask the operator to give us all instructions about that now.

OPERATOR: Thank you. Before logging out of the webinar, please remember to take a minute to complete the short evaluation survey that is currently on your screen. Thank you for attending and have a great day.

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