Quality Improvement Measure: Hypertension

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Measure Description
Percentage of patients 18 to 85 years of age with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
### Hypertension Control

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Patients from the denominator with last blood pressure measurement with systolic blood pressure less than 140 mm Hg and diastolic blood pressure less than 90 mm Hg.</td>
<td>▶ All patients 18 to 85 years of age with a diagnosis of hypertension (HTN) during the measurement year.</td>
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### Characteristics for Success

- Set goals
- Set expectations of staff related to improvement strategies
- Compile improvement strategies
- Commitment from leadership
- Tools & resources
- Audit timelines; make immediate corrections
- Celebrate Successes
Setting Goals

Define the clinical protocol your organization will use for Hypertension

- Seventh Report of the Joint Committee on Prevention, Detection, Evaluation, & Treatment of High BP (JNC7) & Measure Up, Pressure Down from AMA
- Provider handouts: JNC7 quick reference card, TennCare preferred drugs, Walmart drug list with pricing
- Define patient handouts: EMR & non-EMR literature, BP logs, etc.

Goals

1. 
2. 
3. 

Setting Goals continued....... 

Do training with clinical staff on taking a manual BP & use of spot vitals machine

- Skills evaluation
- Cuff size importance & training on use

Conduct pre-visit planning

Include patient as an essential member of the team

Educate staff to teach the patient about lifestyle modifications and the need for lab testing
Train the trainer

Clinical Support staff will be trained to educate the patient on lifestyle modifications. Patients will be provided with educational handouts.

### HYPERTENSION LIFESTYLE MODIFICATIONS

<table>
<thead>
<tr>
<th>Modification</th>
<th>Recommendation</th>
<th>Approximate Systolic BP Reduction (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Reduction</td>
<td>Maintain normal body weight (BMI 18.5-24.9 kg/m²)</td>
<td>5-20 mm Hg/10k</td>
</tr>
<tr>
<td>Adopt DASH eating plan</td>
<td>Consume a diet rich in fruits, vegetables, and low-fat dairy products with reduced content of saturated and total fat</td>
<td>8-14 mm Hg</td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 100 mmol per day (2.4 sodium or 6 g sodium chloride)</td>
<td>2-8 mm Hg</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Engage in regular physical activity such as brisk walking at least 30 min. per day, most days of the week which may be broken into shorter time intervals such as 10 minutes each of moderate or vigorous effort</td>
<td>4-9 mm Hg</td>
</tr>
<tr>
<td>Moderation of alcohol consumption</td>
<td>Limit consumption to no more than 2 drinks (e.g. 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men, and to no more than 1 drink per day in women and lighter weight persons</td>
<td>2-4 mm Hg</td>
</tr>
</tbody>
</table>

Setting Staff expectations

Define responsibilities

**Clinical Support Staff**

If BP is equal to or greater than 140/90 clinical support staff should take a 2nd reading in opposite arm (white coat syndrome).

Notify provider if BP continues to be elevated and based on discretion, take a 3rd reading.

Provide patient with information on hypertension

Provide patient with BP log & ask them to keep daily log & bring to all visits

If patient is a smoker provide cessation literature (Quit literature)

IF BMI is 25 or greater provide DASH diet & exercise materials

Educate patient on lifestyle changes & the need for lab tests

Document in chart all actions

Notify provider of all actions (communication is vital) Discuss in huddle if doing them.
Setting Staff expectations

Provider Staff
Follow adopted clinical practice protocols
- Consider medication non-compliance & address barriers
- Consider other medications (prescribed & OTC) and items which could effect BP (energy shots, alcohol, cough syrup, etc.)
Review and document any risk factors with patient (comorbidities, etc.)
Review & Stress with the patient importance of lifestyle changes, then
Set & document goals; take small, attainable steps to set pt. up for success
Define next steps with patient (follow-up visit, lab tests required etc.)
Provide patient with patient plan (includes goals, expectations for return visit, etc.)
Refer patient to cardiology or other specialists as appropriate

Commitment from Leadership

- It is imperative that any protocol be evidence based.
- The Chief Medical Officer should discuss the clinical protocol with all providers and have them “buy in” and adopt that protocol. They need to understand their responsibilities as providers but also know what is expected of their nurse (team approach).
- QI Team needs to be fully involved in all actions. Document in QI Meeting minutes all actions. They need to be instrumental in any improvement initiatives and help to celebrate successes.
- Executive Mgmt. needs to be informed of the actions around the measure and help to celebrate successes.
- Report to Board of Directors.
QI Improvement Plan

Set performance goals
- Set improvement goals for each quarter
- Audit monthly vs. quarterly (report quarterly)
- Audit down to responsible party (clinical support staff & provider).
- Define corrective actions & implement immediately. (based on monthly audit findings) (provide details of findings to staff)

What prohibited our success in meeting goals?
Frequent auditing (monthly) will help you to:
- See if BP was not in range
- Identify nurse & provider
- Did nurse hand out literature?
- Document pt. education, lifestyle changes
- Did provider follow clinical protocol?
- Identify non-compliant patients & reason (No money for BP medication? Forgot to take meds? Under stress? Simply doesn’t care to make changes?)

Be armed with data when presenting to staff!
Performance Action Plan

Performance Improvement Action Plan:

- Document what corrective action needs to occur
- Take small steps (example: would a 3rd reading have helped, does re-training with a specific nurse need to occur, does the patient need reminders about their appointment or a call from the nurse to check on progress toward goals)
- Were clinical protocols met?
- Was adequate pt. education provided?
- Were risks & barriers addressed?
- Does Medical Director need to discuss case with provider? Peer review?
- Medication non-compliance: Patient assistance needed?
- If we sent patient to ER, did they return within 2 weeks for follow-up appt.?
- Is consult with cardiology or other specialist appropriate? Do we need rule out renal artery stenosis? Does patient have addiction issues; are they depressed, are they obese? Do they have other un-controlled co-morbidities?

Sharing Success

Staff rewards for performance improvement
Consider:

- Broadcast e-mails (boost moral and keep goal focused)
- Recognition of individuals at staff meeting for meeting performance goals
- Cake or cupcakes, gift card for lunch, etc.
- Recognition: Ribbons, pins, certificates, postings at time clock, etc.
CREATE A CAMPAIGN

Provide staff all the tools they need to be successful!

Provide continued education and reinforcement!

Celebrate success!

DOCUMENT, DOCUMENT, DOCUMENT!

EXAMPLE: 1st BP reading was 142/74; 2nd reading was within range at 110/68
Note: after 3rd reading BP was within range.

Tools & Resources

- Protocol links:
  - Measure Up, Pressure Down toolkit: [http://www.measureup pressuredown.com/HCProf/Find/provToolkit_find.asp](http://www.measureup pressuredown.com/HCProf/Find/provToolkit_find.asp)
  - Million Hearts (resources, templates, etc.) [http://millionhearts.hhs.gov/index.html](http://millionhearts.hhs.gov/index.html)
- BP logs
- EMR literature
  - Examples from our EMR (Next Gen) include topics such as:
    - High BP (Essential Hypertension)
    - High BP (Secondary Hypertension)
    - High Blood Pressure Medications
    - High Blood Pressure: Weight Control
    - High Blood Pressure: Low-Sodium Diet
    - Dietary Approaches to Stop Hypertension (DASH Diet)
    - Quit Smoking Hot line & associated literature (local Health Dept.)
- Provider case discussion
- Peer review