Improving Million Hearts Measures: High Blood Pressure

*Dr. Jones has an electronic health record system that meets the requirements of Meaningful Use and consistently gets the same denominator with accurate reports. Dr. Jones is concerned about patients that may be at risk for a heart attack or stroke, and his patient dashboard discovers the percentage of patients in his practice with controlled high blood pressure (NQF #0018) (CMS165v1) is much lower than he’d like. Dr. Jones’ REC representative works with IT staff and his vendor to review his system’s functionality, repeat the reports, and confirm they are accurate. Knowing these patients are at very high risk of major coronary or vascular events, Dr. Jones wants to learn about systematic ways to improve. First, the REC advises Dr. Jones to identify a care team of both clinical and administrative staff that can reach out to patients. The care team starts by using the patient list function to identify the names and phone numbers of all patients with uncontrolled hypertension that have not been seen in the last 3 months. As a team, the practice then engages in the following activities:*

Engage at Risk Patients

* Schedule individual office visits purely dedicated to cardiovascular care;
* During visit systematically review patient history for exclusions, (e.g. renal failure or pregnancy);
* Discuss any barriers to adherence (e.g. fear of the medicine, price issues, side effects); and
* Once adherence is determined, the practice could consider evidence based protocols to intensify medical therapy using nursing visit or home blood pressure measurements. These protocols could be administered electronically or by phone by an office nurse.

Use EHRs to Engage Patients

* Use **clinical decision support interventions** to:
* Highlight missing preventive cardiovascular services at every visit;
* Suggest the need for appropriate medication; and
* Survey problem list for contra-indications / exclusions.
* Use the **e-prescribing** system to:
* Obtain prescription and refill history if recommended or required;
* The care team should perform a medication reconciliation;
* The care team should perform an adherence analysis, either electronically or through patient discussion; and
* For medication use, review progress notes or medication list.
* Use **patient education** function
* Use print-outs, websites, and/or kiosks specified for a low-health literacy audience; and
* The care team can use educational materials to assess patient knowledge and use teach-back at subsequent visits.

Implement a Workflow that Supports Quality Improvement

* Start this change cycle and workflow with one provider:
* Perfect the mechanics and team roles;
* Repeat process measures to see if process is consistent;
* Repeat measurement and assess if improvement has occurred; and
* Employ a “team huddle” before each of these clinic sessions:
* Review the patients who have had difficulty with adherence from the entire care team’s perspective;
* Use hypothetical cases to ensure that the team understands the protocols well;
* Ensure that appropriate lab work is gathered and / or ordered;
* Divide important educational tasks.
* Spread to other providers and set up staff meetings to give provider-specific feedback:
* If the feedback is public in a peer group, the incentive to adhere to the workflow and achieve improvement is intensified.