CPCPracticeSpotlight48

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Million Hearts® 'Champion' Practice Honed Performance in Hypertension Control through Multiple Tests of Change

Upper Valley Family Care, Troy and Piqua, Ohio; independent; 5 physicians, 2 NPs, 1 PA; 12,500 patients

June 22, 2015

CPC Change Driver 1: Comprehensive Primary Care Functions

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Caregiver Engagement

Change Driver 2: Enhanced Accountable Payment

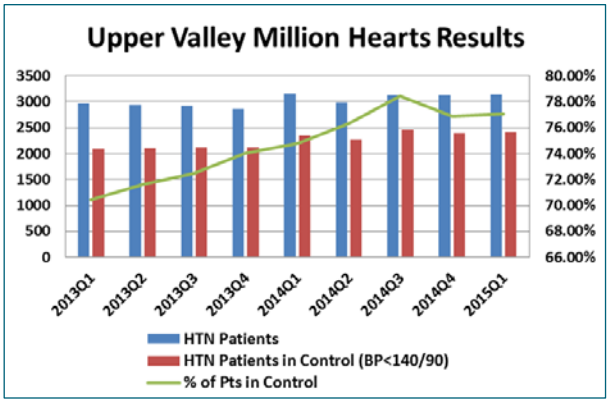
- 2.2: Analytic Capability

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: In February 2015, the U.S. Department of Health and Human Services' Million Hearts® initiative recognized **Upper Valley Family Care** as one of 30 "Hypertension Control Champions" in the U.S. for its success in helping patients control their high blood pressure.



Strategy: Upper Valley's strategies for improvement originate with "transformation teams," made up of physicians and clinicians from both sites along with the business manager and the nursing supervisor. The teams' diverse expertise expedites decision making, plans for training, resource procurement as well as data analysis. To monitor their progress, the team followed the Million Hearts® reporting parameters and developed rolling 12-month reports. Upper Valley notes that engaged, consistent physician leadership is the bedrock for improvement work and cohesive teams. When physician leaders express confidence in their teams' critical thinking and assessment skills, this encourages every team member to proactively participate in quality improvement and patient care.

These teams leveraged multiple tests of change to hone workflow, techniques and care management follow-up to improve on strong baseline hypertension (HTN) control among patients with high blood pressure (<140/90).

Timeline Highlights:

2013 Q1 – Transformation teams met to create workflows for initial blood pressure (BP) measurements, follow-up steps in the office (and subsequent visits), as well as ongoing care management for patients working toward HTN control.

2013 Q2 – Began procuring patient education materials and testing workflows, including identifying where in the workflow to take the patient's initial BP reading and manual versus electronic measurement (manual technique was not only more accurate, but patients preferred it over the electronic cuff, which some patients found uncomfortable). An evaluation of loaner wrist and arm cuffs for patients to use at home found that wrist cuffs were less accurate, but they were kept in use due to their value in engaging patients in tracking their own BP readings.

2013 Q3 – Both sites implemented the tested workflows and techniques. As care managers and health coaches worked with patients to improve their HTN control through individualized care plans, they used motivational interviewing to shape plans that reflect the patient's abilities and priorities. As a result, they realized that patients needed materials to support their changes in diet and exercise. The coaches created packets of targeted information (for example, exercise tips for beginners, beginning strength training, goal-focused regimens, etc.), encouraged patients to drop in anytime during regular office hours for blood pressure checks and loaned patients an automated cuff to take at-home readings and send updates through the patient portal. Patients seeking to make healthy eating a priority can meet with the staff registered dietitian.

2013 Q4 – It was observed that measurement techniques varied among staff and was affecting consistency. This was addressed with a refresher training session for clinicians using videos from Million Hearts.® The refresher training then opened a discussion about allowing the patient to rest before taking the reading, which lead to additional PDSAs.

2014 Q2 and Q3 – Teams tested taking measurements before and after intake, ultimately finding that readings taken after intake resulted in fewer false positives for HTN. This change in the order of steps led to equipping all exam rooms with cuffs, which was completed in 2014 Q3.

Outcomes and Ongoing Improvement: Over seven quarters, Upper Valley showed continuous improvement in control rates, moving from a baseline of 70.4% to 78.5% by 2014 Q3. Engaged physician leadership and teamwork have helped drive this improvement. The transformation teams are now creating visuals to post in each office to promote sustainability and friendly competition between the sites.

TMF Health Quality Institute

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