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2008-2009 Best Practices in Managing Hypertension

Sponsored by AMGA and Daiichi Sankyo.

Wrap-Up Meeting
November 18-20, 2009
San Diego, CA

AMGA
American Medical Group Association

Edmonds Family Medicine Clinic

Controlling Hypertension with lifestyle changes

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A Brief Project Overview

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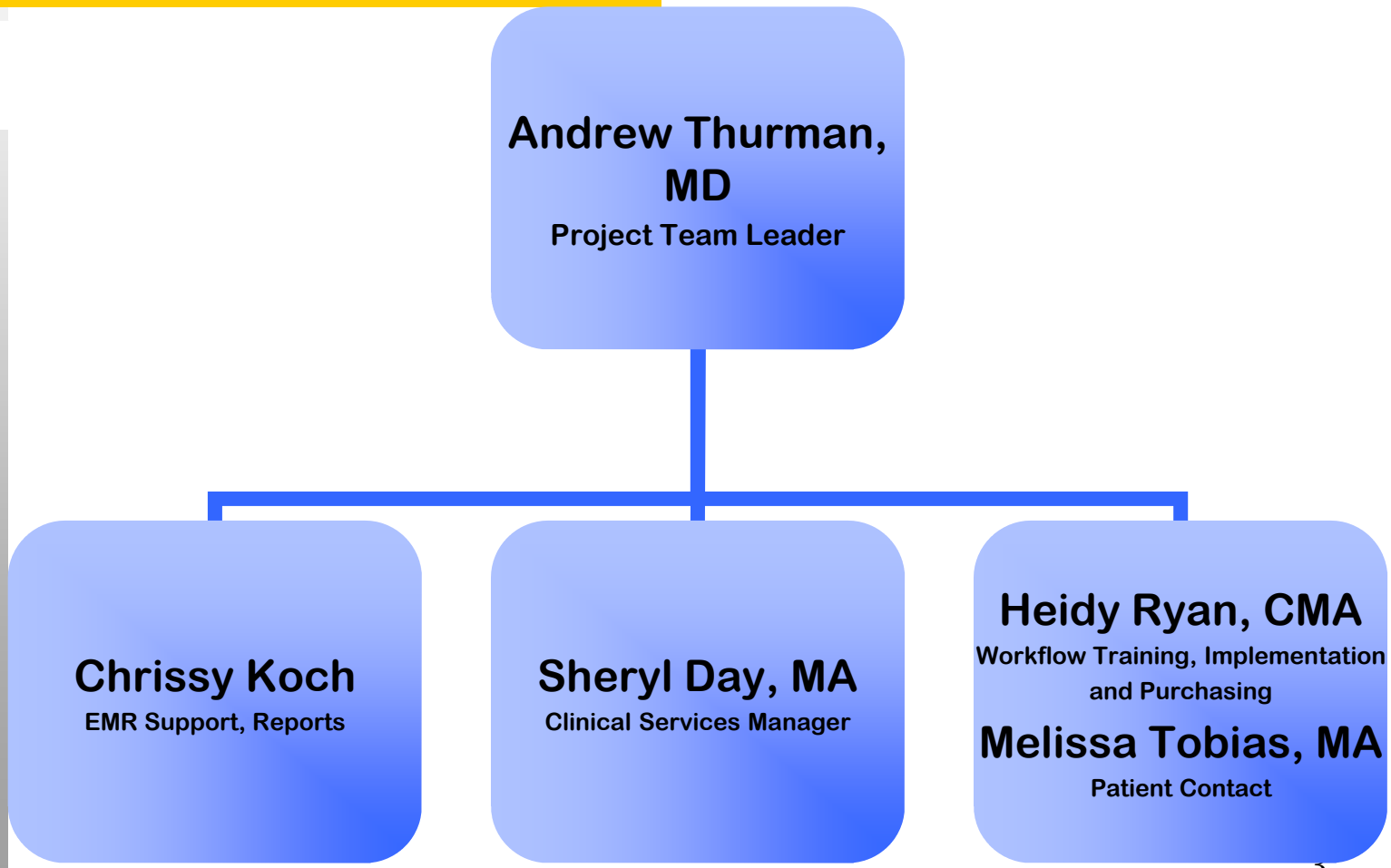
Our goals were to:

- **Encourage hypertensive patients to take an active role in their treatment by providing them with support, information, tangible tools, and the knowledge needed to make successful lifestyle changes.**
  - Enrolled patients were given blood pressure monitors, pedometers and DASH eating plan.
- **To provide educational opportunities for our physicians and nursing staff.**
  - CME opportunities were provided for the providers.
  - One of our RN's re-trained the medical assisting staff on proper technique for taking blood pressures.

We wanted to provide enrolled patients with a variety of tools including:

- **Telephone or Secure Email support**
  - A member of the medical assisting staff called enrolled patients to discuss their home blood pressures and answer questions. Only 28 patients enrolled for this service and 6 of those patients later asked to be removed. Our Secure Email met resistance from the providers and is on hold for now.
- **Nutrition education through Stevens Hospital**
  - Stevens Hospital did not have the funding to provide nutritional services for our patients. Most insurance will not cover nutritional counseling for hypertension.
- **Blood pressure cuff for home monitoring**
  - Enrolled patients were provided with a home blood pressure cuff.
- **Pedometer**
  - Enrolled patients were provided with a pedometer.
- **Gym membership trial**
  - Patients were encouraged to start a regular exercise program if able.
- **Guide to the DASH Eating Plan**
  - Enrolled patients were provided with the DASH Eating Plan.
- **Smoking cessation classes**
  - All hypertension patients were given smoking cessation information and smoking cessation classes were offered within our clinic.

Team Composition



Modifications/Enhancements

Was it necessary to modify approaches to our plan during our project?

Yes

Our original approach was to have the providers refer patients to our program and we would give those patients “Care Packages” at that time. This approach lacked participation and follow through. Some patients were given these care packages without the knowledge of the person that was monitoring this part of the project. As a result we had unaccounted for supplies and patients given blood pressure cuffs that did not fit properly and with no instruction.

Other modifications were the introduction of ICG testing in our clinic. We did purchase an ICG machine and offered training to the providers and a CME. Our challenges with the ICG are that many health plans do not recognize the importance of ICG testing. Due to lack of insurance support only a few providers are currently ordering ICG testing for their patients.

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Measuring Success

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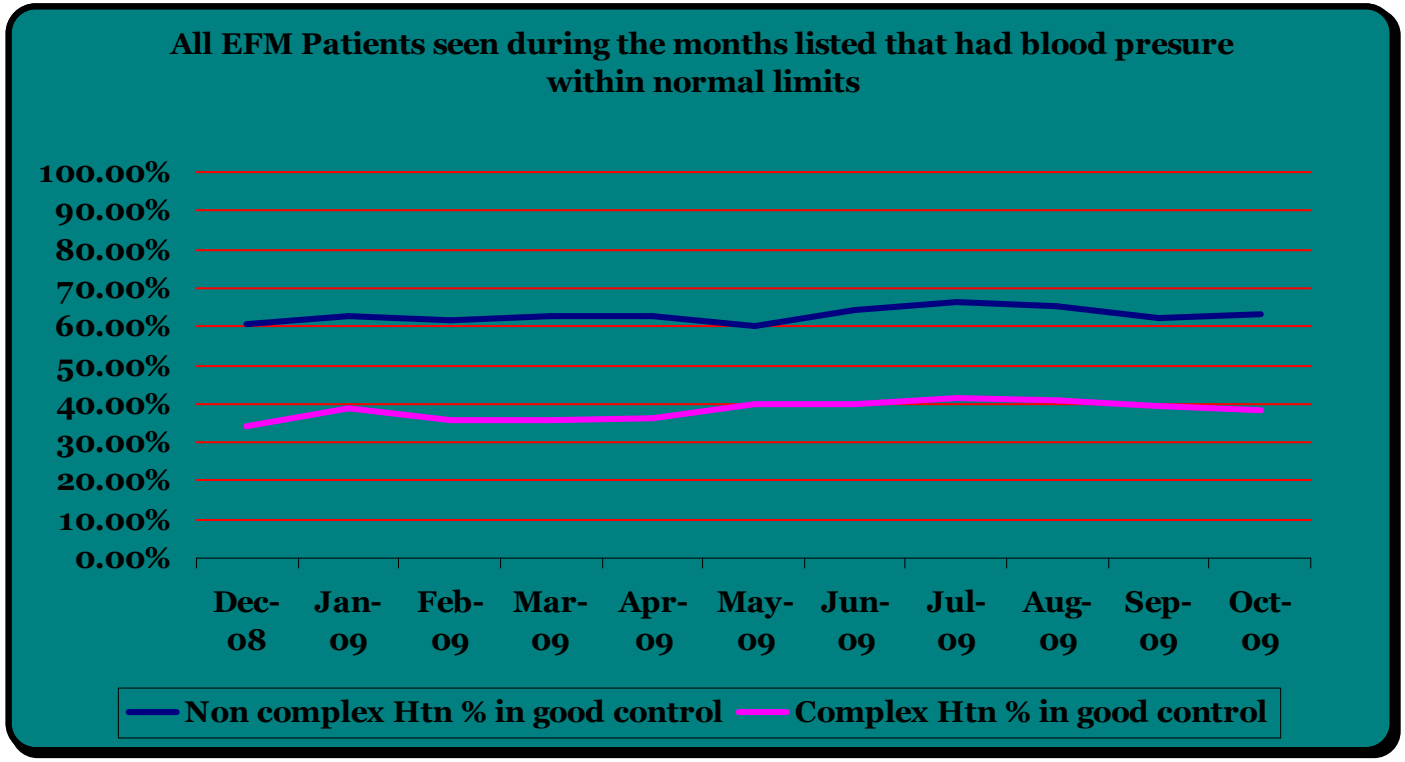

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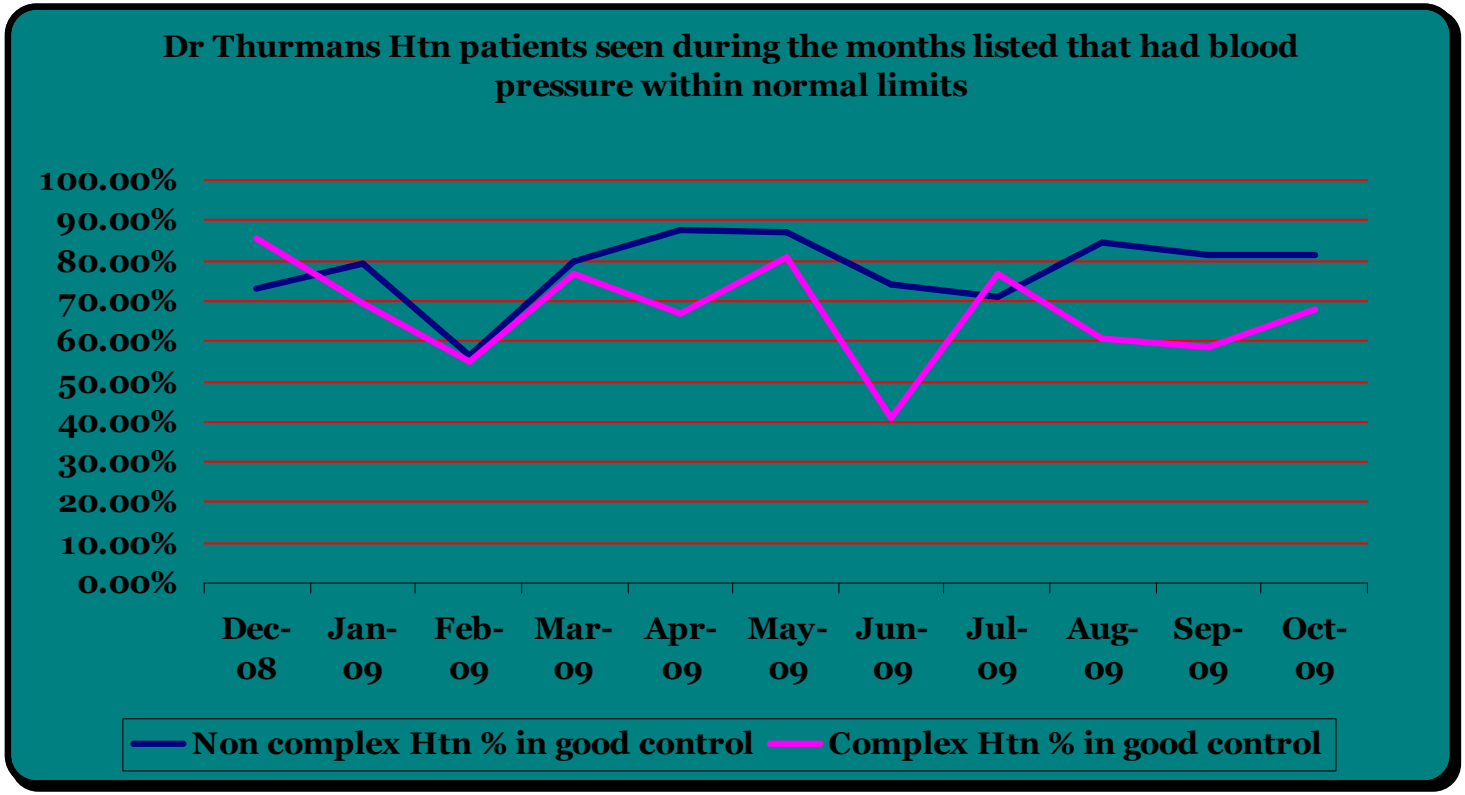

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Challenges?

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What were the most significant challenges or barriers we faced during our project?

Provider inertia. We found it difficult to motivate our providers to tighten the control of our hypertensive patients and to be more aggressive with our high risk population of hypertensive patients (diabetes).

Staffing changes such as having to pull staff assigned to help on this project to do other tasks.

How did we overcome these barriers?

We have been looking for ways to be more active in our community and raise awareness. Whenever possible we are doing community outreach involving blood pressure checks within our local community. Recently we participated in a health fair at the local community college, a Healthy Kids day at a local elementary school and The Taste of Edmonds which is an annual family festival in our area.

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Future Steps

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Continue to offer learning opportunities to providers particularly about tighter control of blood pressure for diabetic patients and to develop strategies at being more aggressive with patients who are not under control.

Continue our community outreach programs.

Work with health plans to change policies so that they recognize ICG testing as an important tool in the management of high blood pressure.

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Lessons Learned

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Lessons we have learned:

We needed at least one full time staff member that worked only on this project.

We should have started small, worked with a smaller group of providers to perfect our strategies.

The study design may have been better had we added a control group. Also, if we were able to get the data into the system and run averages instead of placing the home readings in a phone note we could have analyzed the data more thoroughly.

Questions for the Group

Do you have an specific questions you'd like to pose to the group?