American Heart Association: Quality and Systems Improvement

5/23/18

American Heart Association | American Stroke Association

life is why

Disclosures

- No disclosures

2017 Hypertension Guideline Update

- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults

- Published November 13, 2017
  - Available at: *Hypertension and Journal of the American College of Cardiology*
  - http://hyper.ahajournals.org/content/early/2017/11/10/HYP.0000000000000065

So What's New?

- Changes in prevalence:
  - 46% of adults (up from 32%)
  - 56% of black women
  - 59% of black men
  - 30% of men 20 to 44 years of age
  - 19% of women under 45 years of age
  - 80% of adults with atrial fibrillation
  - 80% of adults with diabetes mellitus
  - 20% of patients follow treatment plan

- Left untreated, systolic BP higher than 180 mm Hg or diastolic BP higher than 120 mm Hg has an average survival rate of 10 months (80% die within 1 year)

Change in BP Classification

BP Category	Systolic BP		Diastolic BP	Treatment or Follow-up
Normal	<120 mm Hg	**and**	<80 mm Hg	Evaluate yearly; encourage healthy lifestyle changes to maintain normal BP
Elevated	120-129 mm Hg	**and**	<80 mm Hg	Recommend healthy lifestyle changes and reassess in 3-6 months
Hypertension: stage 1	130-139 mm Hg	**or**	80-89 mm Hg	Assess the 10-year risk for heart disease and stroke using the atherosclerotic cardiovascular disease (ASCVD) risk calculator • If risk is less than 10%, start with healthy lifestyle recommendations and reassess in 3-6 months • If risk is greater than 10% or the patient has known clinical cardiovascular disease (CVD), diabetes mellitus, or chronic kidney disease, recommend lifestyle changes and BP-lowering medication (1 medication); reassess in 1 month for effectiveness of medication therapy – If goal is met after 1 month, reassess in 3-6 months – If goal is not met after 1 month, consider different medication or titration – Continue monthly follow-up until control is achieved
Hypertension: stage 2	≥140 mm Hg	**or**	≥90 mm Hg	Recommend healthy lifestyle changes and BP-lowering medication (2 medications of different classes); reassess in 1 month for effectiveness • If goal is met after 1 month, reassess in 3-6 months • If goal is not met after 1 month, consider different medications or titration • Continue monthly follow-up until control is achieved

Hypertensive Crises	Systolic BP		Diastolic BP	Treatment or Follow-up
Hypertensive urgency	>180 mm Hg	**and/ or**	>120 mm Hg	Many of these patients are noncompliant with antihypertensive therapy and do not have clinical or laboratory evidence of new or worsening target organ damage; reinstitute or intensify antihypertensive drug therapy, and treat anxiety as applicable
Hypertensive emergency	>180 mm Hg + target organ damage	**and/ or**	>120 mm Hg + target organ damage	Admit patient to an intensive care unit for continuous monitoring of BP and parenteral administration of an appropriate agent in those with new/ progressive or worsening target organ damage (see Tables 19 and 20 in the 2017 Hypertension Guideline)

Hypertensive Crises: Emergencies and Urgencies

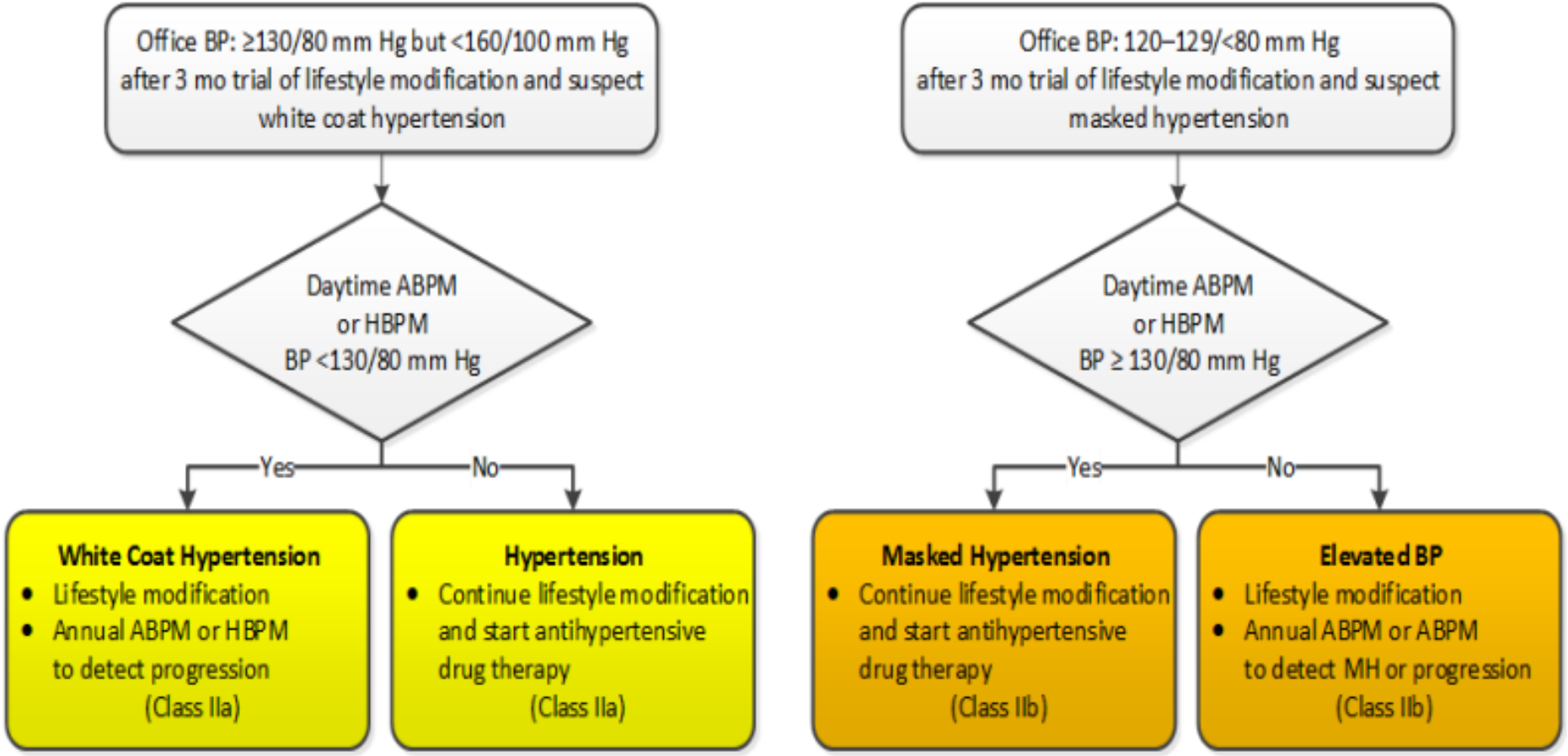
Section 11.2 of 2017 Hypertension Guideline

Accurate Measurement of BP

Step	Key Instructions
1. Prepare the patient	• Have the patient relax, sitting in a chair (feet on floor, back supported) for >5 min. • Make sure the patient avoids caffeine, exercise, and smoking for at least 30 min before the measurement.
2. Use the proper technique for BP measurements	• Support the patient's arm (eg, resting on a desk). • Using the correct cuff size, position the middle of the cuff on the patient's upper arm at the midpoint of the sternum.
3. Take measurements needed for diagnosis and treatment	• At the first visit, record BP in both arms, and use the arm with the higher reading. • Use a palpated estimate of radial pulse obliteration pressure for systolic BP and inflate the cuff 20-30 mm Hg above this level to determine the BP level. • Deflate the cuff pressure 2 mm Hg per second and listen for Korotkoff sounds.
4. Document accurate BP readings	• Record systolic BP at the onset of the first Korotkoff sound and diastolic BP at the disappearance of all Korotkoff sounds, using the nearest even number.
5. Average the readings	• Use an average based on ≥2 readings obtained on ≥2 occasions to estimate the individual's level of BP.
6. Provide BP readings to patient	• Provide patients the systolic/diastolic BP readings both verbally and in writing.

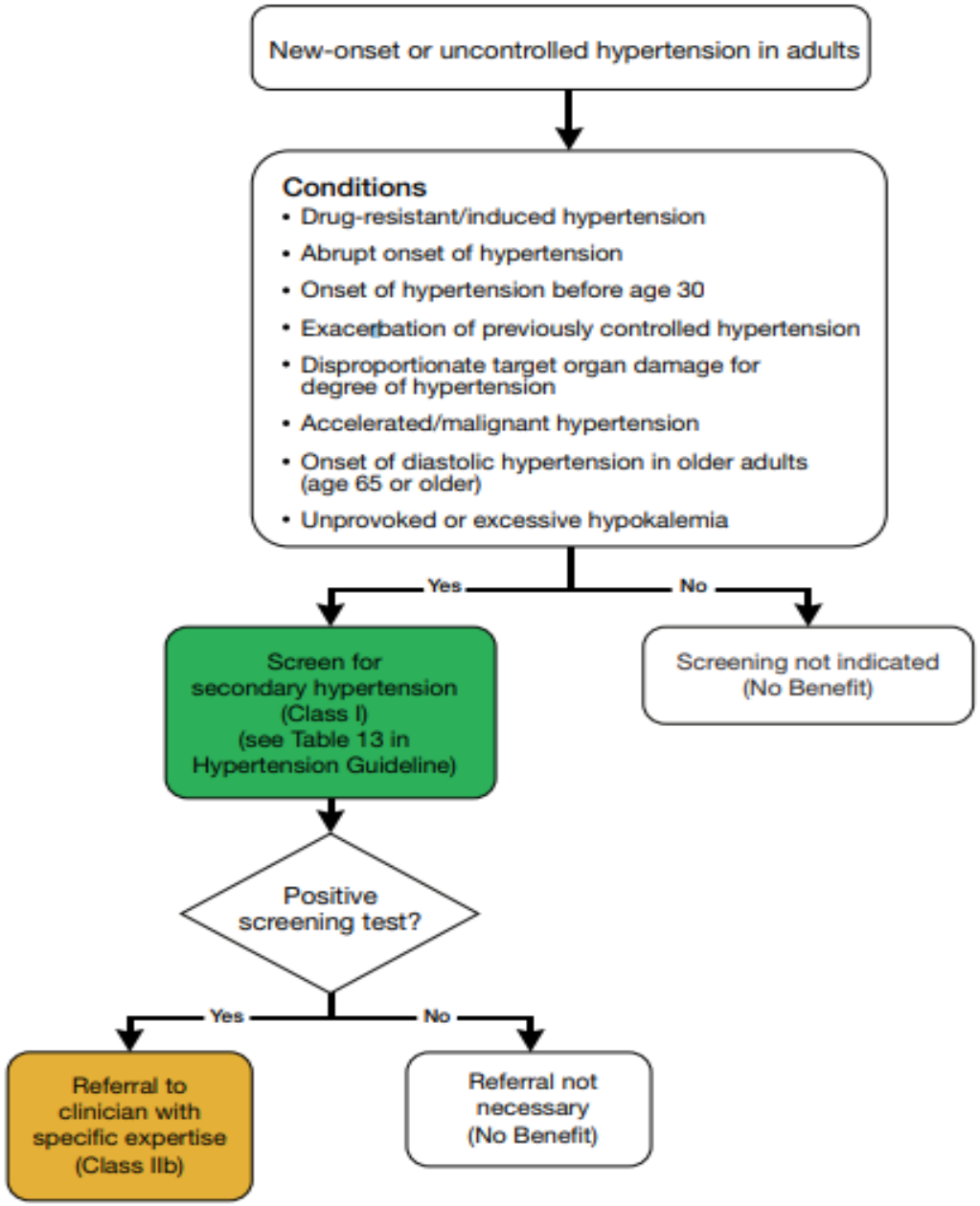
See Table 8 of the 2017 Hypertension Guideline for more information.
Adapted with permission from Mancia et al,[21] Pickering et al,[22] and Weir et al.[23]

Masked and White Coat Hypertension



Colors correspond to Class of Recommendation in Table 1.
ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; and HBPM, home blood pressure monitoring.

Secondary Forms of Hypertension



Causes of Secondary Hypertension with Clinical Indications

Common causes
Renal parenchymal disease
Renovascular disease
Primary aldosteronism
Obstructive sleep apnea
Drug or alcohol induced
Uncommon causes
Pheochromocytoma/paraganglioma
Cushing's syndrome
Hypothyroidism
Hyperthyroidism
Aortic coarctation (undiagnosed or repaired)
Primary hyperparathyroidism
Congenital adrenal hyperplasia
Mineralocorticoid excess syndromes other than primary aldosteronism
Acromegaly

Nonpharmacological Management of High BP

Drug Management of Hypertension

- BP-lowering medication for stage 1 hypertension with clinical CVD or 10-year risk of ASCVD 10% or more

- BP-lowering medication for stage 2 hypertension
  - 2 BP-lowering medications
  - Healthy lifestyle changes

- Target BP is 130 mm Hg/80 mm Hg

- Full list of medications – Table 18 in the 2017 Hypertension Guideline

Choice of Antihypertensive Medication

- Four drug classes recommended in adults (without managing other illness)
  - Thiazide diuretics
  - Calcium channel blockers
  - Angiotensin converting enzyme inhibitors
  - Angiotensin receptor blockers

- Most adults require more than one agent

- Specific combinations of antihypertensive medication have been shown most likely to be effective

- Simultaneous use of an ACE Inhibitor, ARB, and/or renin inhibitor is potentially harmful and is not recommended

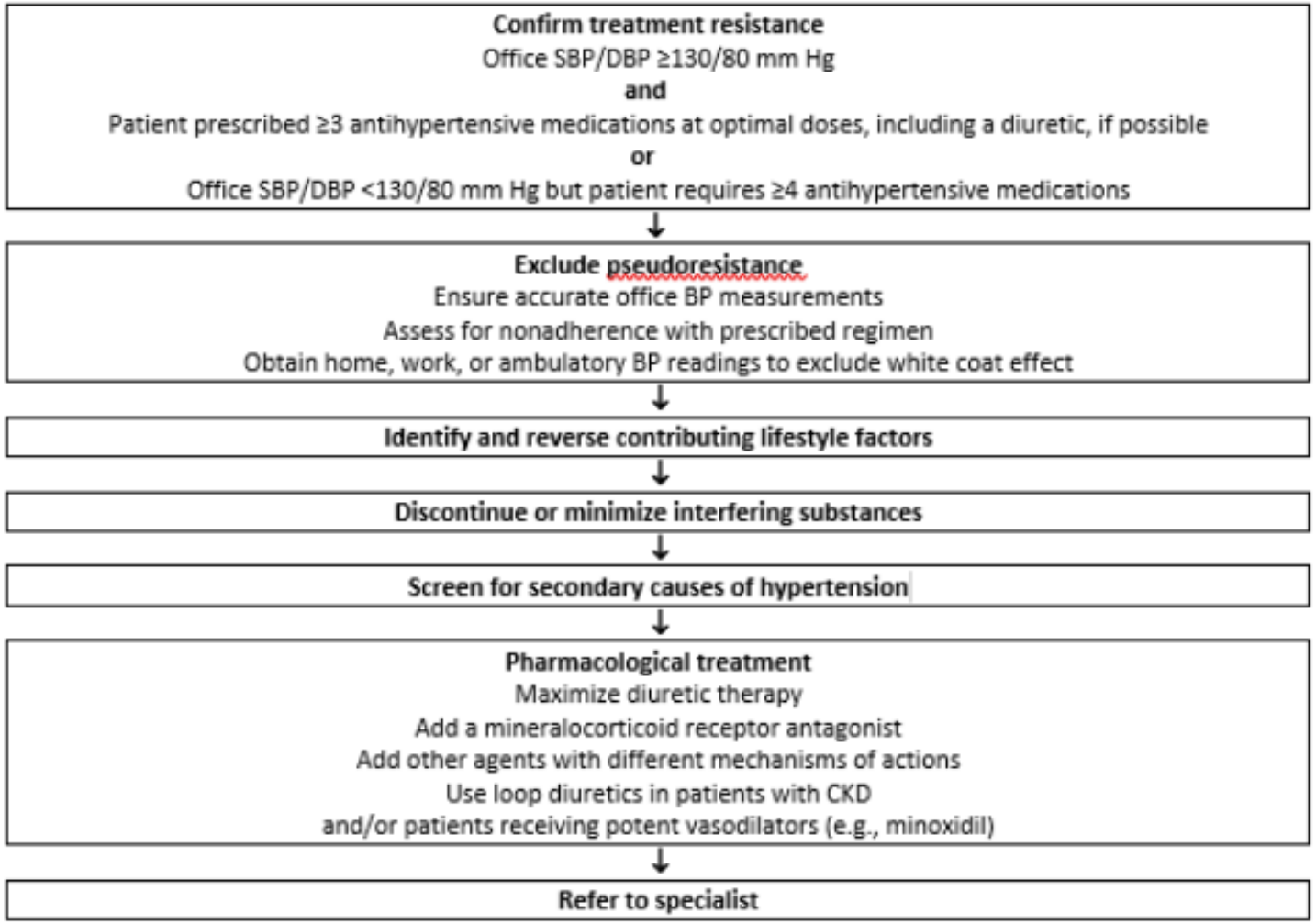
Management of Special Patient Groups

- Screen for and manage other modifiable CVD risk factors in adults with hypertension

- Thiazide-type diuretic or calcium channel blocker for black patients (without HF or chronic kidney disease)
  - 2 or more medications recommended

- Women with hypertension that become pregnant
  - No ACE Inhibitors, ARBs, or direct renin inhibitors
  - Transition to Methyldopa, nifedipine, and/or Labetalol

Other Considerations



Improving Treatment and Control

- Team-based care approach
- Utilize the EHR
- Improve quality of care
- Financial incentives
- Health literacy
- Access to health insurance and medication assistance plans
- Social and community services

AHA Target BP and CCC Programs

Target BP- Improvement Program

Measure Act Partner

Target: BP Improvement Program

The Target: BP Improvement Program leverages the latest clinical evidence to make it easier for physicians and care teams to more effectively manage their patients with high blood pressure. The BP Improvement Program has three main parts, which can be remembered using the acronym M.A.P.: Measure accurately; Act rapidly; and Partner with patients, families and communities.

***M* is for MEASURE blood pressure accurately every time**

Proper measurement is critical to controlling blood pressure. Each practice should build a protocol to ensure accuracy of blood pressure readings.

***A* is for ACT rapidly to address high blood pressure readings**

This step requires rapid action during a patient visit and prioritizes follow-up appointments and a clear treatment plan to help patients achieve blood pressure control.

***P* is for PARTNER with patients, families and communities to promote self-management**

Real change comes when patients take ownership of their health. Physician engagement with patients, their families and communities helps to promote sustainable lifestyle change, thus supporting the improvement of overall health.

The BP Improvement Program uses a team-based care approach where data drives improvement. Clinicians utilize hypertension quality-improvement metrics to monitor the impact of their efforts. Furthermore, it encourages practices to outreach to uncontrolled patients who need to return to the office for follow-up. Typically, within a six-month period, a practice that implements the BP Improvement Program can expect to see lower blood pressure and improved control rates in patients with hypertension.

Improvement Program Overview – Measure Accurately

Click a circle below to view detailed information

Measure | Act | Partner

Measure accurately

Accurately measuring blood pressure provides clinicians with a higher degree of certainty when making a hypertension diagnosis or adjusting treatment. An important part of measuring blood pressure accurately is ensuring the patient is properly prepared and positioned when taking a blood pressure reading. It is highly recommended that patients with a potential new hypertension diagnosis have out-of-office confirmation of their elevated blood pressure before a diagnosis is made.

The process of having patients measure their blood pressure outside of the clinical setting is referred to as self-measured blood pressure (SMBP). A condition known as "white coat hypertension" occurs when people have elevated in-office blood pressure but normal blood pressure at home. Those with white coat hypertension don't actually have hypertension and don't need medication for treatment. As a result, treatment with medication is not only potentially harmful, it creates unnecessary costs.

Physician Resources – Recognition Plaque

Practice-building visibility

To further display the commitment of Target: BP™ to lowering high blood pressure, a program plaque will be given to the practice when they've joined and uploaded data in their first year. Each year, following analysis of uploaded patient data, practices will receive a commemorative medallion aligning to their level of achievement (Participant or Gold in 2017), which can be inserted into the plaque. Over the years the practice can accumulate achievement medallions to show their longstanding commitment to helping their patients achieve blood pressure control. **Plaques will be available for distribution in mid-November.**

Practices can build additional visibility through promotion using social media messages, digital seals and banners, and a press release that will be emailed to Target: BP participants. You can view the entire list of recognition items here.

Recognition—Data Overview

Data submission

The data submission process occurs annually, beginning in the first quarter of each year. All Target: BP™ registrants will be notified of the opening of the submission window via the Target: BP Newsletter.

Sites will need to submit data for the prior calendar year to calculate the blood pressure control rate measure based on NQF #0018/PQRS #236/ACO #28.*

Participating sites will receive a message if the data they submit has errors. Data will be saved as a draft with errors to allow the practice to review and resolve the issue(s).

*NQF #0018 is endorsed by the National Quality Forum (NQF). In CMS programs, it's designated as "PQRS #236." It's also used for quality benchmarking and reported as ACO #28 for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program.

Physician Resources- Website

Easy access to innovative resources:

https://targetbp.org/

Target: BP Patient Resources

User-friendly learning and discovery

Patients seeking additional information about high blood pressure can learn about having an open conversation with their physician at **LowerYourHBP.org**. The website also has a number of valuable tools and resources that can be reviewed and downloaded as patients prepare to re-engage with high blood pressure management.

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Check. Change. *Control.*® Tracker

Easy to use tracking tool for participants and volunteers. There is an admin site with real time reporting on participant enrollment and blood pressure improvement. Unique campaign codes can be created for each site to use for enrolling participants.

heart.org/ccc

AHA Updates

Stroke Guidelines

- The AHA/ASA has rescinded aka published a correction of the recently released stroke guidelines
- This was based on recent feedback from the clinical stroke community
- Large sections of the guideline have been deleted and clarifying work is in progress
- This is temporary and as always clinicians are recommended to use good clinical decision making

Stroke Guidelines - Deletions

- The following sections have been deleted from the guidelines:
  - Section 1.3: EMS Systems Recommendation 4
  - Section 1.4: Hospital Stroke Capabilities Recommendation 1
  - Section 1.6: Telemedicine Recommendation 3
  - Section 2.2: Brain Imaging Recommendation 11
  - Section 3.2: Blood Pressure Recommendation 3
  - Section 4.3: Blood Pressure Recommendation 2
  - Section 6.0: All subsections

Advocacy Emerging Issues Summit

- Focuses on discussion about policy related to stroke and STEMI systems of care
- Sessions are designed to educate attendees and gain feedback and ideas from experts

Questions?

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Thank you!