

## 3.b.i

# Evidence-Based Strategies for Disease Management in High Risk/Affected Populations: Cardiovascular



## Project goal

**Immediate:** Integrate evidenced-based strategies and clinical guidelines and patient education material; document at least 1 self-management goal identified by the patient and review at each visit.

**Long-term:** Improve access and management of hypertension and hypercholesterolemia in Suffolk County as demonstrated by: decreasing the admission rate for patients with a principal diagnosis of hypertension (PQI 7) and heart failure (PQI 8); adequately controlled blood pressure for patients with a diagnosis of hypertension. For high risk/affected population increase percentage of patients: with discussion of risks/benefits of aspirin use; use of aspirin; LDL-C testing; management for patients with cardiovascular conditions and LDL-C > 100 mg/dl; advised to quit smoking and were recommended cessation medications and cessation strategies; received flu shots; improve health literacy (measured by CAHPS-QHL 13,14,16).

## Interventions

Cardiovascular disease is a significant issue and the 3rd leading cause of avoidable admissions in Suffolk County. The Million Hearts Campaign is a national initiative to prevent one million heart attacks and strokes by 2017. The goal of the campaign is to enhance cardiovascular disease prevention by focusing on blood pressure control, cholesterol management, smoking cessation, and aspirin use for people at risk. The project focuses mostly on PCPs but also requires adoption of the policies and procedures by non-PCPs and behavioral health providers and a commitment to adhere to them in clinical practice. Home blood pressure monitoring with appropriate support and facilitating access to blood pressure checks without copayment or advanced appointment in the office are outlined interventions. Patients who have repeated elevated blood pressure readings but no diagnosis of hypertension should be identified and scheduled for a hypertension visit. Care management will play an integral role in meeting project requirements through follow up and coordination of care. The 5 A's of tobacco control should be used, optimally embedding prompts in the EMR to support its use, and referral to the NYS Quitline when appropriate. At least one self-management goal identified by the patient must be documented in the medical record and reviewed at each visit.

The Stanford Chronic Disease Self-Management Program is an educational program aimed at empowering patients with cardiovascular disease to achieve self-management practices and lifestyle change. This program will be utilized by PPS partners and offered in areas with the highest burden of illness.

## Patient Engagement Metric

The number of patients (age 18 and older) with a principal or secondary diagnosis code of hypertension or hypercholesterolemia with documented self-management goals in the medical record reviewed at each visit.

## Clinical Metrics

- **Controlling High Blood Pressure** - The number of people, who have hypertension, and whose blood pressure was adequately controlled as follows: below 140/90 if age 18-59; below 140/90 if age 60 to 85 with diabetes diagnosis; or below 150/90 if age 60 to 85 without a diagnosis of diabetes.
- **Flu Shots for Adults Age 18-64 (CAHPS Survey)** - The number of respondents, age 18 to 64, who have had a flu shot.
- **Health Literacy (CAHPS Survey - QHL 13, 14 16)** - The number of respondents who answered that they saw their provider for an illness or condition and were given instructions that were "Usually" or "Always" easy to understand, described how the instruction would be followed and were told what to do if the illness/condition got worse or came back.
- **Medical Assistance with Smoking and Tobacco Use Cessation - Advised to Quit (CAHPS Survey)** - The number of respondents, age 18 and older, who smoke or use tobacco some days or every day and were advised to quit.

(Continued on reverse)



## Clinical Metrics (continued)

- **Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication (CAHPS Survey)** - The number of respondents, age 18 years and older, who smoke or use tobacco and discussed or were recommended cessation medication.
- **Medication Assistance with Smoking and Tobacco use Cessation - Discussed Cessation Strategies (CAHPS Survey)** - The number of respondents, age 18 and older, who smoke or use tobacco some days or every day and discussed or were provided with cessation methods or strategies.
- **Prevention Quality Indicator #8 (Heart Failure)** - The number of people, age 18 and older, with an admissions with a principal diagnosis of heart failure.
- **Prevention Quality Indicator #7 (Hypertension)** - The number of people, age 18 and older, with an admission with a principal diagnosis of hypertension.
- **Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy** - The number of males age 21 to 75 or females age 40 to 75, who were dispensed at least one high or moderate intensity statin medication.
- **Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%** - The number of males age 21 to 75 or females age 40 to 75, who achieved a proportion of days covered of 80% for the treatment period.

**Tools to be employed:** 5 A's of Tobacco Control; Stanford Chronic Disease Self-Management Program

## References/Guidelines

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7. Whelton PK, et al. (2017). 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: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension*. Retrieved from <http://hyper.ahajournals.org/content/early/2017/11/10/HYP.000000000000065>
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