

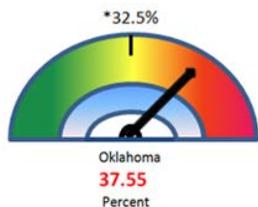


PLAN: Reduce uncontrolled hypertension (high blood pressure) and its associated economic burden in targeted populations

1. Getting Started

In the United States, about 67 million (1 out of every 3) adults have high blood pressure. In Oklahoma, 37.5% of adults have been told they have high blood pressure by a healthcare professional.

In 2012, heart disease was the leading cause of death among Oklahomans, accounting for 9,173 deaths. There were 41,553 hospital stays for heart disease, accounting for over \$2 billion in hospital charges.



High blood pressure is a common and dangerous condition, and is called the "silent killer" as it often has no warning signs or symptoms, and many people do not know they have it. Having high blood pressure increases your risk of heart attack, heart failure, stroke, and kidney disease.

Leadership from the Oklahoma Health Care Authority (OHCA) and the Oklahoma State Department Health (OSDH) decided to join forces to create a Hypertension Quality Improvement Workgroup (Workgroup) to help individuals better manage their blood pressure and realize their healthiest potential.

2. Assemble the Team

Oklahoma State Department of Health

- Chronic Disease Service | Center for Health Innovation & Effectiveness

Oklahoma Health Care Authority

- Population Care Management | Health Policy | Strategic Planning & Reform | Reporting & Statistics

3. Examine the Current Approach

For the past six years, OHCA has worked with Telligen, Inc. (clinical and technical expertise consultants) to reduce hypertension through the use of nurse care management. These efforts include: practice facilitation; provider education via quarterly mailings; monthly collaborative sessions with practice facilitation providers; and incentive payments.

OSDH has a dedicated program area, Chronic Disease Service (CDS), which continually pursues opportunities to integrate population health promotion, preventive health services, and the management of chronic disease. CDS is currently working with the Centers for Disease Control and Prevention (CDC) and the Million

Hearts Initiative to reduce hypertension among Oklahomans in targeted communities.

4. Identify Potential Solutions

The two agencies decided to leverage each other's expertise and tools around the Million Hearts initiative in a concerted effort to improve care coordination and promote appropriate clinical practice for those with hypertension.

5. Develop an Improvement Theory

Aim Statement: Increase the number of Heartland OK (Million Hearts) patient referrals made by participating Medicaid providers in a 5-county target area from seven to 150, by December 31, 2014.

DO: Reduce uncontrolled hypertension in identified SoonerCare members through participation in the Million Hearts initiative

6. Test the Theory

The Workgroup utilized the National Quality Foundation measure of NQF 18, Controlling High Blood Pressure, which seeks to improve the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. The Workgroup leveraged the following three key tools:

- Public health surveillance data, which enabled a hot spot analysis to single out five counties with high rates of hypertension (Atoka, Coal, Latimer, Pittsburg, and Pontotoc).



- Predictive modeling software, which identified certain at-risk Medicaid beneficiaries who could benefit from the care coordination model.
- Provider relationships, which capitalized on OHCA's unique relationship with providers by sending an interagency letter to at-risk beneficiaries' providers, urging them to refer their patients to the care coordination model.

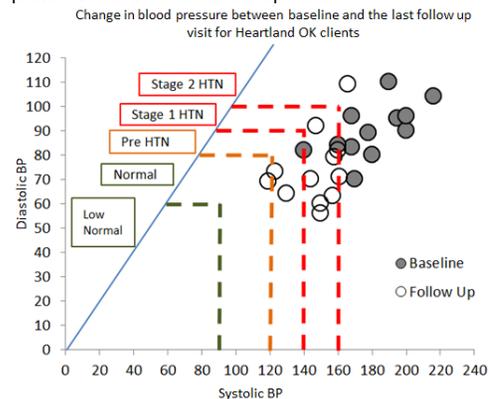
CHECK: Use data to check the results

7. Check the Results

The Workgroup was able to achieve an increase to 24 patient referrals by Medicaid providers in the targeted areas, but did not realize the goal of 150 referrals in the Year 1 rapid response cycle. Some of the concerns cited for the shortfall in referrals were: apprehension on the part of provider of disclosing information on their practice; the length of the patient referral form; and reluctance of patients to participate due to confidentiality concerns.

Year One successes were identified in the health outcomes of patients who did benefit from a provider referral. Between baseline and the final follow up visits, diastolic BP decreased by 18.5% from a baseline average of 90 to an average measurement at the last follow-up visit of 74.

During this same timeframe, a 17.8% reduction was revealed in systolic BP from a baseline average of 180 to an average final follow-up measurement of 147 (just short of the systolic goal for NQF 18). Of the clients seen through Heartland OK, 25% achieved controlled blood pressure at their final follow-up visit.



ACT: Standardize the improvement and establish future plans

8. Standardize Improvement or Develop New Theory

As there were challenges to achieving the high rate of referrals in the AIM statement, the Workgroup will look at other opportunities to reduce uncontrolled hypertension in SoonerCare members.

9. Establish Future Plans

CDS was recently awarded additional grant funding to extend and expand the Heartland OK initiative in order to implement prevention strategies targeting adult populations statewide who experience a disproportionate burden of obesity, diabetes, heart disease, stroke, and corresponding risk factors.