



ADDRESSING HEALTH DISPARITIES

EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

MILLION HEARTS® 2014 HYPERTENSION CONTROL CHAMPIONS: ADDRESSING HEALTH DISPARITIES

In 2014 Million Hearts® recognized 30 health care organizations and practices as 2014 Hypertension Control Champions for controlling the blood pressure of at least 70% of their hypertensive patients. Five of these Champions—Kelsey-Seybold Clinic in Houston, Texas; Green Spring Internal Medicine in Lutherville, Maryland; Denver Health Community Health Services; Kaiser Permanente Southern California; and Northlake Family Medical Practice in Columbia, South Carolina—also have many patients from racial and ethnic minority groups who have a higher risk for hypertension (high blood pressure) or who are less likely to receive treatment.

African Americans have a much higher risk of having high blood pressure. About 33% of all adults have hypertension, but about 45% of African Americans do. Hispanics do not have higher rates of hypertension, but Hispanic men who are hypertensive are less likely to take blood pressure medication.

SUPPORT FROM THE TOP

“The best thing a health care organization can do to control hypertension is to have a physician champion and to have support from the top.”

—Jackie Evans, MBA
Supervisor of Quality Improvement
Kelsey-Seybold Clinic

Kelsey-Seybold has locations across Houston and a patient population that is about 19% African American, 15% Hispanic, and 6% Asian, Native Hawaiian, or Pacific Islander.

As part of providing the best care and reducing health disparities, the clinic has a Spanish-language

website and doctors and staff who are bilingual in English and Spanish. The clinic also has a language line available to meet the language needs of non-English speakers when a staff member is unavailable.

The clinic also has a physician who is a hypertension specialist and a strong advocate for the hypertension control effort across the clinics. Among other steps, the hypertension specialist has emphasized the importance of proper techniques for measuring blood pressure through education and training.

A SYMPTOM OF STRESS

“We are very passionate about eliminating health disparities.”

—Holly R. Dahlman, MD
Green Spring Internal Medicine

Hypertension is a medical problem, and stress may lead to temporary increases in blood pressure. Holly R. Dahlman, MD, takes the time to talk with her patients about why they are having difficulty controlling their hypertension and acknowledges the source of the patient’s stress and the role stress can play in the patient’s health.





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COMMUNITY ENGAGEMENT



“Partnering with community programs has helped our patients adopt healthier lifestyles.”

—Raymond Estacio, MD
Associate Medical Director for Quality and Research
Denver Health Community Health Services

At Denver Health, 78% of their patients are racial or ethnic minorities, including 33% whose primary language is not English. Denver Health uses community-based prevention programs to reach minority groups, including a community health worker (promotora)-led prevention program for Latino patients. Denver Health also runs the [Just Check It](#) blood pressure control program in collaboration with the Center for African American Health.

EQUITABLE CARE



“Patient demographics matter in our treatment approach. We call it equitable care.”

—Joel Handler, MD
Hypertension Lead Physician
Kaiser Permanente Southern California

Kaiser found that their medication protocol was not strong enough for many of their African-American patients. When they doubled the dose for those patients, they were able to reduce the blood pressure to safe levels. Those steps, and others, have helped to achieve more equitable outcomes in controlling the blood pressure of their African-American patients.

LIFESTYLE IS THE KEY

“When people know you care about them as individuals, they tend to be your partners in health care.”

—Reginald Parker, MD
Northlake Family Medical Practice

At Northlake, 96% of patients are African American, a population that is at [greater risk for hypertension](#). Reginald Parker, MD, a solo practitioner, advises his patients to follow the [DASH](#) eating plan, which encourages lower sodium consumption and emphasizes fresh fruits and vegetables.

To help his patients really understand hypertension, Dr. Parker uses educational resources such as visuals of the heart and blood vessels, and he reinforces his advice with informational flyers.



These five providers have made control for every single patient their goal in the face of health disparities that put some populations at greater risk. These, and other practices, show it is possible to maintain high rates of hypertension control among their patients.

Learn more about all of the [2014 Hypertension Control Champions](#).



BUILDING COMMUNITY, SAVING LIVES

INTERNATIONAL COMMUNITY HEALTH SERVICES

CHAMPIONS HYPERTENSION CONTROL

Million Hearts®—Success in Blood Pressure Control

Keeping blood pressure under control helps prevent heart attacks and strokes and saves lives. Million Hearts® launched the Hypertension Control Challenge in 2012 to recognize clinicians and health systems who make blood pressure control their goal. The Hypertension Control Champions use evidence-based strategies to achieve blood pressure control rates in their practices at or above the Million Hearts® goal of 70% of adult patients. As of 2015, CDC has recognized 59 clinicians, health care practices, and health systems as Million Hearts® Hypertension Control Champions.



THE CHALLENGE

International Community Health Services (ICHS) is a federally qualified health center (FQHC) serving a largely Asian and Pacific Islander patient population at seven locations around the greater Seattle, Washington, area. Interim Medical Director Dr. Lucy Sutphen explained that people in this cultural group traditionally have healthy diets. Exercise, from walking to tai chi, is a regular part of life in this community. “That sort of gives us a head start on the interventions that we look to do,” she said.

But ICHS faces other challenges in controlling hypertension in its patient population. These include treating an aging population, encouraging medication adherence in patients whose primary language is not English, and combatting the tendency of patients from immigrant communities to adopt a less healthy American diet and lifestyle. It took a combination of multidisciplinary approaches for ICHS to achieve a hypertension control rate of 70%.

WHAT THEY DID

- **Gained trust from the community.** ICHS began as a small storefront clinic in Seattle’s International District in 1973. The neighborhood still serves as ICHS’s main site.

“We are literally in the midst of the community...Many of our patients know and respect ICHS as being part of the community.”

—Dr. Lucy Sutphen,
Interim Medical Director, ICHS

“We are literally in the midst of the community,” said Dr. Sutphen. Over the decades, ICHS has engaged community leaders in its efforts and employed staff from the community.

“Many of our patients know and respect ICHS as being part of the community,” Dr. Sutphen said. That respect trickles down to more trust between patients and the health care team, allowing for better hypertension control results.

Altogether, ICHS’s patients speak close to 50 languages, and for almost two thirds, English is not their preferred language. ICHS uses trained medical interpreters to communicate with its patients about hypertension, including medication adherence, diet, and exercise.

“The interpreters not only literally translate words, but they also understand the cultural context. Maybe there’s a term that’s more commonly used in

Cantonese that doesn't translate exactly from English. The interpreters know how to get that message across," said Dr. Sutphen.

- **Used multidisciplinary health teams and quality measures.** ICHS uses a team approach to caring for patients, which includes doctors, physician assistants, nurses, nurse practitioners, medical assistants, and, in many cases, dietitians, clinical pharmacists, and health educators. Members of the team review patient charts and brainstorm ways to better control hypertension. This helps identify patients who might need an interpreter, preventive services, or other support.

Many patients need help learning how to adhere to their medicines. Dr. Sutphen noted that a patient may be less likely to continue taking a medicine if its positive effects are not as easily noticed by the patient as its negative side effects are. Each team member, from the prescribing doctor to the pharmacist handing the patient medicine, talks to the patient about the importance of regularly taking his or her antihypertensive medication.

Each month, ICHS provides health care teams and departments with score cards that show where the teams stand in terms of patient blood pressure control. Members of the teams can receive financial incentives for demonstrating excellence in hypertension control.

"[Score cards] are a great way to provide feedback," Dr. Sutphen said. "We try to do it in a timely manner, because that's the best way to get improvements in performance."



- **Delivered individualized and culturally appropriate care.** ICHS recognizes that controlling high blood pressure requires different approaches for each patient. For some patients, that means discussing diet changes with a nutritionist.

"Sometimes we encourage the patient to bring in whoever is the cook, whoever buys the food, and have a family discussion about healthy eating. That's been very successful," said Dr. Sutphen.

It helps that many of ICHS's staff come from the communities they serve. "Our dietitians may know, for example, a specific grocery store in the neighborhood," Dr. Sutphen said. "They understand some of the specific foods that are commonly used in different cultures, and they will cater their recommendations to the cultural background of a patient or family."

Other patients, especially those coming from other countries, might need support from health educators to understand the health care system in the United States. "It's not only about a patient's own individual health, but [also] helping them navigate health care insurance and services," said Dr. Sutphen.

Dr. Sutphen pointed out that nearly 20% of ICHS patients are age 65 or older. ICHS works with patients in assisted living facilities and adult day cares in the neighborhood to find ways to better control hypertension in those settings. Older patients likely take multiple medications, so pharmacists pay close attention to potential drug interactions.

ADVICE FOR OTHERS

Although ICHS serves specific communities in the Seattle area, Dr. Sutphen believes its multidisciplinary, community-based, and individualized approach is translatable to health organizations across the country.

"You really have to [meet] patients where they are, whether that's cultural, whether that has to do with language, or whether that has to do with willingness to change a lifestyle," said Dr. Sutphen. "We go a long way toward the patient, and they come toward us, and we meet in the middle."



CARING FOR UNDERSERVED POPULATIONS

LORAIN COUNTY HEALTH & DENTISTRY-NORTH HUDSON
COMMUNITY ACTION CORPORATION

CHAMPIONS IN HYPERTENSION CONTROL

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THE OPPORTUNITY

Federally Qualified Health Centers (FQHCs) are community-based organizations that are critical components of the health care landscape. They provide preventive and primary care services to people of all ages, regardless of ability to pay. Often, this means FQHCs treat people who are uninsured, underinsured, or underserved and who are most at risk for chronic diseases, such as high blood pressure.

Lorain County Health & Dentistry is an FQHC based in north-central Ohio that serves about 14,000 patients annually. Nearly two thirds of its patients are members of a racial or ethnic minority, and almost all are at or below 200% of the federal poverty line. **North Hudson Community Action Corporation** is the largest FQHC in New Jersey, with 10 locations in three counties. In 2017, it served more than 71,000 patients, about 70% of whom are not native English speakers. Nearly half of North Hudson's patients are uninsured.

Successfully managing chronic conditions such as high blood pressure in these underserved populations can be a challenge. Language barriers, constantly changing phone numbers and addresses, and lack of transportation access are all issues that can hinder clinicians' ability to successfully treat patients.

But Lorain County and North Hudson learned that using a special model of care that focuses on a team-based



"Most people relate hypertension to older person's disease, and this isn't the case in our world."

—Jennifer Casey, M.D.,
Chief Medical Officer for Lorain County Health & Dentistry

approach and creates patient ownership was the best way to help their communities control high blood pressure. "I think that's been a key part of our ability to work within the patient population... [It's] not just, 'Here's medicine and go on your way,'" said Jennifer Casey, M.D., chief medical officer at Lorain County.

WHAT THEY DID

In 2017, Lorain County's blood pressure control rate was more than 83%; North Hudson's rate was 77%. To reach these impressive targets, the FQHCs

- **Adopted a "patient-centered medical home" model of care.** Lorain County and North Hudson are certified to provide care under

the patient-centered medical home (PCMH) model, which uses a coordinated, team-based approach to deliver comprehensive care across a variety of providers. For example, Lorain County is a multidisciplinary health center, offering services in women's health, optometry, podiatry, primary care, pediatrics, and dentistry. Within each discipline, the health care team checks patients' blood pressure, helping ensure no cases of hypertension are left hiding in plain sight.

The PCMH model ensures that the health care team performs a routine set of tasks designed to improve quality and outcomes. At North Hudson and Lorain County, each day begins with a morning "huddle" to discuss patients, schedules, and workflows. New patients complete a detailed intake form and answer questions about their behaviors, medical history, and more. If a patient's blood pressure reading is high, a nurse will check again during that visit to make sure the reading is accurate. Any patient with a chronic disease, such as high blood pressure, must schedule a follow-up appointment before leaving the office.

- **Created patient ownership.** Lorain County and North Hudson believe that patients must take responsibility for their health. The FQHCs encourage



“Because we’re an FQHC, we’re the safety net, and we see a lot of sick patients. They’re coming in with multiple medical challenges and no prior care.”

—Flordeliz Panem, M.D.,
Chief Medical Officer, North Hudson
Community Action Corporation

this by empowering patients to set self-management goals. These goals may include losing weight before the next appointment, incorporating more low sodium foods into their diet, or reaching lower blood pressure numbers. At each visit, a member of the health care team reviews the patient's goals and progress, discusses barriers, and provides education.

ADVICE FOR OTHERS

For other health care practices and systems that want to provide better blood pressure control for underserved populations, Lorain County and North Hudson recommend a few tips:

- **Work with staff to maximize everyone's abilities.** For example, “Patients feel more comfortable working with medical assistants” than with physicians, said Flordeliz Panem, M.D., chief medical officer at North Hudson.
Dr. Casey echoes that every member of the team should be involved in patient care, regardless of who they are or what they do. “Our billers and accountants are as familiar with our quality numbers and goals as anyone,” she said. “Everyone needs to have ownership in care for the patient.”
- **Educate patients and focus on their lifestyle goals.** For example, North Hudson gives patients a printed list of their medicines and a summary of their visits. Nurses, counselors, or dietitians in both groups reinforce and track patients' goals at each visit.
- **Partner with other community organizations to ensure uninsured patients have access to all needed care.** For example, North Hudson partners with a local ophthalmologist who can provide vision care. Lorain County partners with the local YMCA, which has a blood pressure monitoring program and can provide patients with home blood pressure monitors.



FEDERALLY QUALIFIED HEALTH CENTERS

EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

2014 MILLION HEARTS® HYPERTENSION CONTROL CHAMPIONS: FEDERALLY QUALIFIED HEALTH CENTERS

Million Hearts® has recognized 30 health care providers and organizations for their success in controlling the blood pressure of at least 70% of their hypertensive patients. This year, the following seven Federally Qualified Health Centers (FQHCs) were recognized as 2014 Hypertension Control Champions:

- Denver Health Community Health Services, Denver, CO
- East Jordan Family Health Center, Jordan, MI
- Family Health Centers of San Diego, San Diego, CA
- Peninsula Community Health Services, Bremerton, WA
- Roane County Family Health Care, Spencer, WV
- Southwest Montana Community Health Center, Butte, MT
- WinMed Health Services, Cincinnati, OH

FQHCs serve a unique role of providing preventive and primary care services in communities of need, regardless of an individual's ability to pay. The Centers for Disease Control and Prevention spoke with some of the FQHC Champions to gather insights and best practices for hypertension control within their communities.

Many of the patients served at Denver Health, Family Health Centers of San Diego, and WinMed are African American, a population at greater risk for high blood pressure. These health centers have taken steps to address populations at risk of high blood pressure through a variety of tactics. For example, Denver Health has partnered with the Center for African American Health's [Just Check It](#) program to provide self-management support and health education to African Americans. Family Health Centers of San Diego and WinMed have

maintained their vigilance to control blood pressure among African American patients through free blood pressure checks and patient appointment reminders.

TRUSTING THE DATA

"My advice to improve quality metrics is first to have data that providers understand and believe is valid."

—Charles Smoot, MD
Assistant Medical Director for Clinical Outcomes
Family Health Centers of San Diego

Family Health Centers of San Diego increased its overall control rate for high blood pressure, also known as hypertension, by 3 percentage points in just 1 year. Staff achieved this milestone by building their own electronic health record (EHR) system that tracks multiple care quality indicators, contains 55 treatment reminders, and offers information and decision aids on demand. Providers can customize their own EHRs and see data in real time.

Family Health Centers of San Diego also took the following steps:

- Establishing a clinical quality department to analyze data and drive improvements.
- Measuring 21 clinical outcomes and focusing more attention on those that fell below the national average.
- Sharing hypertension metrics with providers to encourage progress.

A GROWING POPULATION

"The main thing is to always be vigilant."

—Raymond Estacio, MD
Associate Medical Director for Quality and Research
Denver Health Community Health Services

FQHCs nationwide have risen to the challenge of caring for more new patients as a result of wider health care coverage under the Patient Protection and Affordable Care Act (ACA). Denver Health has



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enrolled 15,000 new patients since the ACA took effect and anticipates adding 10,000 more in 2015. While going through tremendous growth, Denver staff continued to improve their hypertension control by taking the following steps:

- Establishing a hypertension clinic for patients with uncontrolled blood pressure, where patients can meet with a nurse practitioner or pharmacist.
- Promoting self-measured blood pressure monitoring and feedback for patients who have complex conditions.
- Forming partnerships with community groups, including the Center for African American Health, to engage them in preventive health programs.

BUILDING A RELATIONSHIP

“Our patients see us as their medical home.”

—Carroll Christiansen, MD
Medical Director
Roane County Family Health Care

Roane increased its hypertension control rate by 4 percentage points in just 1 year by starting a data-driven program with clear provider goals. Staff know that medication adherence is key to blood pressure control, so they address unpleasant side effects and help patients find access to medicines at low or no cost. Roane’s rural location and comprehensive health service enable staff to form strong relationships with patients.

Among the other steps that Roane has taken to achieve control are the following:

- Establishing clear protocols for treating patients with hypertension and training staff.
- Measuring blood pressure properly and repeating the measurement when the reading is high.

- Hiring a care coordinator to contact patients who are overdue for a check-up.

THE PATIENT AT THE CENTER

“We make sure patients have their medications and come in regularly, even though it is labor intensive.”

—Yvette Casey-Hunter, MD
Chief Medical Officer
WinMed Health Services

WinMed increased its hypertension control rate by 7 percentage points in just 1 year. WinMed notes one of the keys to controlling hypertension is to ensure patients come in for regular care and blood pressure screenings. The health center has implemented a team-based approach for treating patients composed of physicians, pharmacists, staff, and behavioral and dental experts to ensure the patient is cared for across the continuum of care.

WinMed also takes the following steps to achieve hypertension control:

- Reinforcing community ties, emphasizing patient education, and ensuring cultural competence to build trust with patients.
- Including specialists such as pharmacists and patient assistants on the health care team.
- Confirming regular appointments and sufficient medication for between visits.

These 2014 Million Hearts® Hypertension Control Champions know that blood pressure control is challenging, but it can be achieved by building trust, using health information technology, tracking quality, and working as a team. Together, these Champions have made control the goal to prevent heart attacks and strokes.

Learn more about all of the [2014 Hypertension Control Champions](#).



IMPROVING MEDICATION ADHERENCE THROUGH COORDINATED HEALTH CARE TEAMS

SHARP REES-STEALY MEDICAL GROUP-SOUTHWEST
ORLANDO FAMILY MEDICINE
CHAMPIONS IN HYPERTENSION CONTROL

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THE OPPORTUNITY

When it comes to managing high blood pressure, many health care professionals know that medication adherence—taking medicines as directed—can be a major hurdle on the way to success. But two health care teams discovered ways to inspire patients to take their blood pressure medicines on time and in the right amount while improving overall care in the process.

Sharp Rees-Stealy, founded in 1923, is one of the oldest medical groups in San Diego, California. It serves more than 330,000 people in San Diego County and is part of the Sharp HealthCare System, which operates seven hospitals and 22 clinics. **Southwest Orlando Family Medicine (SWOFM)**, operating regionally for 28 years, is an independently owned family practice that serves nearly 20,000 people at two locations in Orlando, Florida.

Though they operate on vastly different scales on opposite sides of the country, both care groups learned that they could succeed in patient blood pressure control with creative, team-based approaches that focus on patients not just as numbers or targets but as people with complex motivations and needs.

WHAT THEY DID

To achieve better patient blood pressure control, the two medical groups took similar key steps:

- **Established a chronic care management team.** Both groups began by organizing their administrative processes, including aligning team members around



“Remember to listen to the patient, because they’re trying to tell you a story. It’s not just about ‘This is a new pill you need to get to that target.’ It’s about understanding why the patients aren’t doing what you’re saying.”

—Bryan Roy, ARNP, FNP-BC, Chief Operating Officer,
Southwest Orlando Family Medicine

common goals, adopting simplified treatment and medication guidelines, and establishing and analyzing patient registries to show clinicians which patients were not taking their medicines.

Sharp Rees-Stealy has a dedicated population health department that collaborates with physicians, nurse practitioners, medical assistants, health coaches, pharmacists, and other staff to adopt and tailor best practices for controlling patient hypertension. That process has included adopting a standardized hypertension protocol and evidence-based practices for heart attack and

stroke prevention and sharing learning among peers from other organizations.

SWOFM has a dedicated analyst to evaluate and report data such as medication adherence and blood pressure control. These efforts increased awareness and helped shape new models of patient care. For example, data showed that patients with uncontrolled high blood pressure had fewer regular office visits. This led to the birth of SWOFM's chronic care management team, a collaborative of doctors, nurses, medical assistants, coaches, and others who share responsibility for working with patients on medication adherence and other preventive care goals.

"If you're not looking at the data, you just assume you're doing good, because you feel good about each patient that you deal with. But when you aggregate that information at a registry level, it starts to tell a different story," said Bryan Roy. In 2017, SWOFM reached a hypertension control rate of nearly 83%.

- **Focused on the patient.** SWOFM encourages patients to bring their pill bottles to each office visit. This gives the care team insights into whether the patient is taking the medicine as directed. Via annual or biannual patient surveys, SWOFM also uses a special adherence risk estimator to determine whether someone is not likely to adhere, based on whether the patient values the treatment plan. This survey allows the team to learn answers to more unique, subjective questions that often don't come up during office visits.

Sharp Rees-Stealy also regularly assesses patients to find out what medicines they take, whether they're adhering (and if not, why), and their goals for success. This step is crucial to understanding why a patient is not adherent and allows the care team to try different approaches to improving adherence. For example, if the patient isn't taking the medicine because of side effects, the physician or pharmacist can work with the patient to find a different medicine or work with a health coach to incorporate lifestyle changes that enhance other treatments. Sharp Rees-Stealy also uses multiple ways of reaching out to patients to support medication adherence, including text messaging and home blood pressure monitoring programs. In 2017, the group reached a hypertension control rate of 82%.



"Medication adherence is truly a partnership between the patient and the clinical team."

—Parag Agnihotri, M.D., Medical Director, Population Health and Post-Acute care, Sharp Rees-Stealy Medical Group

"Medication adherence is truly a partnership between the patient and the clinical team," said Parag Agnihotri, M.D., population health and post-acute care medical director for Sharp Rees-Stealy. "It means helping each other to understand the values and the socioeconomic impacts related to managing high blood pressure." Dr. Agnihotri also stressed the importance of making patient and staff education an ongoing part of the hypertension control process.

ADVICE FOR OTHERS

For other health care practices and systems that want to improve patients' medication adherence and overall hypertension, Sharp Rees-Stealy and SWOFM have a few tips:

- Make sure everyone on the care management team understands and supports the program's goals and guidelines.
- Reach a consensus about what you want to achieve. Set clear, measurable targets.
- Have a diverse care team, including health coaches, medical assistants, and other support staff. This helps prevent physician fatigue. It also helps patients feel more connected, supported, and involved in managing their own care.
- Educate your care team and patients on the seriousness of hypertension and the consequences of not taking needed medicines.
- Invest in data analytics and population health outreach.



LARGE HEALTH SYSTEMS EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

2014 MILLION HEARTS® HYPERTENSION CONTROL CHAMPIONS: LARGE HEALTH SYSTEMS

For their success in keeping patients' blood pressure under control, Million Hearts® has recognized 30 health care providers, practices, and systems as 2014 Hypertension Control Champions. Among them are three large health care organizations: Presbyterian Healthcare Services in Albuquerque, New Mexico; Kaiser Permanente Southern California; and Essentia Health in Duluth, Minnesota. These large health systems, which together serve more than 4 million patients, have helped at least 70% of their hypertensive patients achieve a safe blood pressure level of 120/80 mmHg or below.

RAPID IMPROVEMENT IN HYPERTENSION CONTROL

“Creating change in a large health system can be quite challenging—and rewarding.”

—Fauzia Malik, MPAS, MS
Evidence-based Programs Manager
Presbyterian Healthcare Services



In 2012, Presbyterian Healthcare decided to take action and revamp its hypertension protocols to further help patients with blood pressure control. The health system staff created a step-by-step, evidence-based “care pathway” to outline patient-specific interventions and the role of each care team member in hypertension control.

By September 2014, Presbyterian increased its hypertension control rate by 18 percentage points. The rapid improvement brought many more people's blood pressure into control, preventing heart attacks, strokes, and kidney and heart failure. Buoyed by their own success, the medical and nursing directors who help guide the new program set a new goal to achieve an additional control rate by 5 percentage points by the end of 2015. To get there, Presbyterian will use proven strategies that include the following:

- Engaging all staff, from appointment schedulers to providers, as part of the care team, including a registered nurse who specializes in population health as the team manager to educate patients and staff.
- Creating opportunities for conversations between patients and care team members about hypertension and the importance of managing the condition, including easy appointment scheduling and no-cost walk-in blood pressure checks.

PREVENTION FOR ALL



“Preventive care is a mantra at Kaiser.”

—Joel Handler, MD
Hypertension Lead Physician
Kaiser Permanente
Southern California

African Americans develop high blood pressure more often and at earlier ages than whites. Over the past couple of years, Kaiser has improved the hypertension control rate of all its patients while also reducing the gap between blood pressure control rates of African Americans and whites from 6% to 3.8%.



LARGE HEALTH SYSTEMS

EXCELLENCE IN BLOOD PRESSURE CONTROL

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To help achieve its success, Kaiser focused on the following methods:

- Harnessing the power of electronic health records to create a hypertension registry, based on diagnosis and procedure codes, with treatment and testing reminders and patient reports.
- Tapping medical assistants to take walk-in, 10-minute blood pressure checks, of which there are about 30,000 every month.
- Prescribing a simple drug regimen that patients can follow, with automated reminders for prescription refills and checkups.
- Using an evidence-based protocol to guide treatment.

INCENTIVES FOR CONTROL



“We make quality performance data available to all 13,000 employees.”

— Patrick Twomey, MD
Chief Medical and
Chief Quality Officer
Essentia Health

Transparency has been a powerful tool for blood pressure control at Essentia, where 3% of physicians' compensation is tied to performance across 28 quality measures, including hypertension control. In 2013, the organization began sharing these performance data, broken down by region, clinic, and individual provider. This transparency encouraged friendly competition and prompted discussions among providers about how to help more patients control their blood pressure.

Essentia also expanded hypertension monitoring to specialty areas such as orthopedics. Staff in these specialties alert patients' primary care providers to elevated blood pressure readings and encourage patients to schedule a follow-up primary care appointment before they leave the specialists' office.

Essentia has also taken the following evidence-based steps:

- Training all care team members to use proper technique to measure blood pressure accurately.
- Providing designated nurses to manage patients with complex health issues who need additional support to achieve blood pressure control.
- Encouraging select patients to meet with a pharmacist to help manage their medications and improve adherence.

These 2014 Million Hearts® Hypertension Control Champions know that blood pressure control is challenging, but it can be achieved through the use of team-based care, health information technology, performance tracking, and even friendly competition. These strategies take time and dedication to put into action, but lead to fewer heart attacks and strokes and healthier patients.

Learn more about all of the [2014 Hypertension Control Champions](#).



RELIANT MEDICAL GROUP STRATEGIZES FOR THE ROAD TO SUCCESS

EMPOWERING PATIENTS TO CONTROL HYPERTENSION

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Dr. Lawrence Garber,
Reliant Medical Group

THE CHALLENGE

Reliant Medical Group, a multi-specialty group practice, cares for over 300,000 patients across more than 20 locations in central Massachusetts. In 2010, Reliant launched an effort to better control high blood pressure among its patients. Identifying which patients were truly hypertensive proved to be a significant challenge.

Reliant Medical Group used a Harvard Pilgrim Health Care grant to study how blood pressure was being recorded across its numerous locations. The data showed that the frequency of patients' blood pressure readings tended to spike on multiples of 10, such as 120, 130, or 140. The team discovered that roughly half of blood pressure readings were being rounded up or down to the nearest 10, casting doubt on the accuracy of readings.

WHAT THEY DID

- **Used evidence-based strategies.** In response, Reliant created standard operating procedures for accurately measuring blood pressure and distributed digital blood pressure monitors to all of its primary care sites. Reliant hypothesized that digital monitors would make it easier for the health care team to record accurate readings. The team continued to collect and graph data on blood pressure readings. Soon, Reliant began to see dramatic results.

"After we got the digital cuffs, we evened [blood pressure measurements] out much more so that [staff] weren't rounding to the nearest 10," said Dr. Lawrence Garber, medical director for informatics at Reliant. "It's very striking."

- **Leveraged health information technology to provide better, more cost-effective care.** After this initial success, the Reliant team tackled the challenge of controlling patients' high blood pressure. In a pilot study funded by the Agency for Healthcare Research and Quality, Reliant gave digital home blood pressure monitors to 200 of its prediabetic and diabetic patients. Several times a week, patients measured and uploaded their blood pressure readings into their electronic health record (EHR). Nurses regularly reviewed patients' data and adjusted the amount of blood pressure medicine based on a protocol. If a patient's medicine did not seem to be working, the nurse would talk with a physician about switching to a different medication.

SIGNS OF SUCCESS

Reliant found that mildly hypertensive patients with home digital cuffs were more likely to get their blood pressure under control than similar patients without home monitoring. This was especially true for hypertensive patients with a systolic pressure of 160 mmHg or lower.

Dr. Garber said that this group can easily be overlooked if they see a doctor only once every 6 months.

“If a person comes into my office and their blood pressure is 152 and we talk about it and [they say] they hit traffic on the way...I might write it off,” said Dr. Garber.

But with more frequent readings, nurses and doctors can see that someone consistently has high blood pressure, even when they are in a relaxed setting at home, he said: “It’s a lot more obvious when someone has slightly elevated blood pressure and thus we were treating them more appropriately.”

Reliant found that home monitors not only helped identify patients with uncontrolled hypertension, but the digital cuffs can also help patients control their blood pressure more quickly than patients without home monitoring can.

“The patient can get several medication [adjustments] between the time I see them initially and when I see them at a 6-month follow-up,” said Dr. Ken Kronlund, Quality Chief of adult primary care at Reliant. “It’s so much smoother and more aggressive [as a medication

“Engaging patients and letting them become empowered to participate in their blood pressure monitoring has been a very positive thing.”

— Dr. Ken Kronlund,
Quality Chief of Adult Primary Care, Reliant Medical Group



Dr. Diego Illanes of Reliant Medical Group confers with a patient about her blood pressure. Credit: Mark Seel/Reliant Medical Group

adjustment] process than we had 10 years ago. [Before,] you might spend years trying to treat someone with modestly elevated blood pressure.”

Now, anyone at Reliant who is diagnosed with hypertension is linked to a nurse right away.

“In days of old, it would be, ‘Your blood pressure is high; see me in 6 months,’ and now it’s, ‘Your blood pressure is high; talk to the nurse three to six times before I see you next,’” said Dr. Kronlund. Patients can either purchase or borrow a home monitor to track their blood pressure as their medication is adjusted.

WHAT THEY ACCOMPLISHED

Through a combination of accurate measuring, home monitoring, and nurse, clinical pharmacist, and health coach feedback and support, Reliant transformed blood pressure care and control in its patient population. Reliant now has a hypertension control rate of 79% in its adult population and is consistently in the top 90% of blood pressure control rates compared with other health care systems across the country.

ADVICE FOR OTHERS

A key part of the program was allowing patients to visit the practice without a copay. The health care team answered questions about medicines, discussed diet and exercise, and counseled patients on how to adhere to their medicines.

“This has to be convenient for the patient, and doctors can’t become the bottleneck in moving patients forward in their treatment,” said Dr. Garber. In order to facilitate this process, Reliant developed medication protocols that are available to all 250 physicians in their medical group.

And how do the patients feel about tracking their health?

“They gleefully bring in more data than I ever wanted—blood pressure readings at multiple times a day,” said Dr. Kronlund. “Engaging patients and letting them become empowered to participate in their blood pressure monitoring has been a very positive thing.”



SOLO PROVIDERS

EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

2014 MILLION HEARTS® HYPERTENSION CONTROL CHAMPIONS: SOLO PROVIDERS

Million Hearts® recognizes 30 health care providers and organizations as 2014 Hypertension Control Champions for their success in controlling the blood pressure of at least 70% of their hypertensive patients. Two of these Champions are private practice providers: Holly R. Dahlman, MD, of Green Spring Internal Medicine, Lutherville, Maryland, and Mark Backus, MD, of Cascade Internal Medicine Specialists, Bend, Oregon. Dr. Dahlman is a solo practitioner, and Dr. Backus is part of a two-physician office.

Providers in small or solo physician practices are pulled in many directions. These Champions successfully implemented processes to monitor and track patients' blood pressure while simultaneously forming partnerships with patients to help them keep their blood pressure at a healthy level

TRUSTING THE DATA

“We engage our patients in self-monitoring their blood pressure. In doing so, patients are able to identify the factors that affect blood pressure and target those factors. Our patients bring readings to visits for our review.”

—Holly R. Dahlman, MD
Green Spring Internal Medicine

In 2011, Dr. Dahlman counted the number of her patients with high blood pressure and was surprised to learn that many did not have their blood pressure under control.

“Clearly that was something we needed to improve,” said Dr. Dahlman. To efficiently and effectively treat patients, Dr. Dahlman uses the registry feature in her electronic health record (EHR) to identify

and monitor high-risk patients. The feature allows her to sort patients at risk for high blood pressure to monitor when they are due for a follow-up appointment. Patients can also self-monitor their blood pressure and record the results in a daily log.

Dr. Dahlman and the nurse practitioner at Green Spring work with patients to identify barriers to controlling blood pressure and strategies to overcome those barriers. She individualizes her approach for each patient to ensure the blood pressure management plan matches the patient's cultural attitudes toward their disease and aligns with the individual's goals.

Encouraging a healthy lifestyle is a priority. Dr. Dahlman recommends the [DASH](#) eating plan (Dietary Approaches to Stop Hypertension). DASH encourages patients to eat heart-healthy foods low in sodium and trans and saturated fat. Many of Dr. Dahlman's patients follow the diet because they want to control their blood pressure without medication.

When each patient leaves the office, Dr. Dahlman gives the patient the notes generated by the EHR, as well as additional resources, such as information about DASH, so patients can refer back to the resources later.





SOLO PROVIDERS

EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

PROVIDER TEAM EFFORT

“Most doctors and clinics are aware of blood pressure goals, but you have to have a system that gets it done. It takes a team approach.”

—Mark Backus, MD
Cascade Internal Medicine Specialists

At Cascade Internal Medicine Specialists, a medical assistant takes the patient’s blood pressure. If the pressure is high, the assistant waits 5 minutes before retaking the pressure. If the pressure continues to be high, the assistant informs Dr. Backus.

“All of that happens without me having to think about it, which is really nice,” Dr. Backus said. He credits his hypertension control rate to a system



that has internal checks to prevent patients from falling through the cracks, as well as a team that follows the system closely. Those internal checks ensure all patients will be monitored, even on unusually busy days or when the serious illness of another patient is occupying the doctor’s time.

“The demands on providers in small practice settings make it hard to focus on blood pressure over time, so you need a system to get it done,” Dr. Backus said. He continues staff training by reviewing procedures or teaching staff new skills, such as how to take pressure in elderly patients who have only a faint pulse.

“You can’t achieve blood pressure control right away, but the longer you work on it, the better control you get,” Dr. Backus said. Many of his patients have been with him for 15 years, giving him and his patients time to find the strategies that work best for each individual. His patients are happy when they get their blood pressure down.

Dr. Dahlman and Dr. Backus have engaged their patients and staff, put time-saving system changes in place, and focused on patient relationships, all of which have helped these small practices become Million Hearts® Hypertension Control Champions—one heart at a time.

Learn more about all of the [2014 Hypertension Control Champions](#).



TENNESSEE

EXCELLENCE IN BLOOD PRESSURE CONTROL

Million Hearts®—Success in Blood Pressure Control

2014 MILLION HEARTS® HYPERTENSION CONTROL CHAMPIONS: TENNESSEE

Methodist Primary Care Group, Memphis



Arsalan Shirwany
MD, FACC



Daniel Otten
MD, FACC



Holger Salazar
MD, FACC



Jennifer Morrow
MD, FACC

Many health care providers, practices, and systems across Tennessee and the nation are focusing on blood pressure control. This challenging effort requires engagement from patients and family members or caregivers as well as teamwork from doctors, nurses, physician assistants, pharmacists, community health workers, and other professionals.

High blood pressure, also called hypertension, is a major risk factor for heart disease and stroke, the first and fifth leading causes of death in the United States. Every day, hypertension contributes to nearly 1,000 American deaths. In Tennessee, the rate of hypertension-related deaths is even higher than the national average, especially for African Americans.

The Centers for Disease Control and Prevention (CDC) launched the Million Hearts® Hypertension Control Challenge to encourage more clinical focus on controlling patients' blood pressure. Million Hearts® is a national initiative of the US Department of Health and Human Services to prevent 1 million heart attacks and strokes by 2017, and blood pressure control is crucial to achieving that ambitious goal. The Challenge recognizes doctors and health practices that achieved blood pressure control rates in at least 70% of their adult patients.

CDC and Million Hearts® are recognizing 30 providers, health care practices and systems—including 5 in Tennessee—as 2014 Hypertension Control Champions.

SUCCESSFUL STRATEGIES FOR BLOOD PRESSURE CONTROL: TENNESSEE

The five Tennessee Champions used the following evidence-based strategies to help their patients achieve blood pressure control:

- **Take the time.** Spend time with patients to measure their blood pressure and explain hypertension risks, building trust and engagement. Educate patients about lifestyle factors like a healthy diet, exercise, and not smoking, and provide materials patients can take with them for reference.
- **Measure, measure, measure.** Use proper blood pressure measurement technique, and educate patients about how to check their own blood pressure properly at home. Encourage patients to keep a record of their blood pressure readings and bring this “homework” to follow-up visits.
- **Address medication adherence.** Work with patients to develop a treatment plan that fits their health goals and addresses barriers to taking medicines as directed, including medication cost and side effects. Emphasize the importance of following the plan and discussing any challenges with the health care team.
- **Use health information technology.** Track patient progress using standardized hypertension treatment protocols and electronic health records, with alerts for missed steps or gaps in follow-up and a dashboard, a tool to track and compare hypertension rates, to quickly visualize trends over time.

“We try to be more interactive with the patient. We give them ‘homework,’ that they bring with them to office visits.”

—Jennifer Morrow, MD, FACC,
Stern Cardiovascular Foundation





USING PERFORMANCE INCENTIVES TO OPTIMIZE PATIENT CARE

NEW WEST PHYSICIANS–RUSH UNIVERSITY MEDICAL GROUP
CHAMPIONS HYPERTENSION CONTROL

Million Hearts®—Success in Blood Pressure Control

Keeping blood pressure under control helps prevent heart attacks and strokes and saves lives. The Hypertension Control Challenge recognizes clinicians and health systems that have excelled at controlling blood pressure. The Hypertension Control Champions use evidence-based strategies to achieve exemplary blood pressure control rates. As of 2017, CDC has recognized 83 clinicians, health care practices, and health systems as Million Hearts® Hypertension Control Champions for achieving blood pressure control rates of at least 70%.

THE OPPORTUNITY

Many health care teams participate in value-based performance reimbursement programs. These programs can reward health care organizations for improved performance and patient outcomes. These programs have the greatest impact when health systems not only distribute resources to clinicians but also invest in assets that sustain and advance improvements on critical performance measures, such as cardiovascular events. By aligning financial incentives with quality care, health systems can enable the teams, technology, and processes that ensure optimal outcomes for patients.

Rush University Medical Group serves a primarily urban population of about 300,000 people on the southwest side of Chicago, Illinois. The group operates three hospitals and more than 20 clinical sites. **New West Physicians** has 135 clinicians in 18 locations in a suburb of Denver, Colorado. It serves about 200,000 patients annually.

Though they operate a thousand miles apart, both Rush University Medical Group and New West Physicians recognize that prioritizing hypertension control would boost patient health and their bottom lines.

“There is a concrete reality to improving outcomes through hypertension control,” said Ken Cohen, M.D., FACP, chief medical officer of New West Physicians.



“Tying incentives to individual physicians’ performance is a successful strategy for gaining physician buy-in.”

—Ken Cohen, M.D.,
New West Physicians

WHAT THEY DID

To achieve better patient blood pressure control, both medical groups took similar key steps.

- **Tied performance to financial incentives.** Rush University Medical Group recently started a quality improvement program partly focused on hypertension control. Clinicians who are more successful at helping patients manage blood pressure receive more incentive dollars and bonus payments. Michael Hanak, M.D., assistant professor in family medicine at Rush University, said the first year of the incentive program taught the team an important lesson.

“The problem we ran into was that the dollars that were being received by meeting performance measures were not going to the individual clinicians. They were going to the system and funding other parts of the system,” Dr. Hanak said.

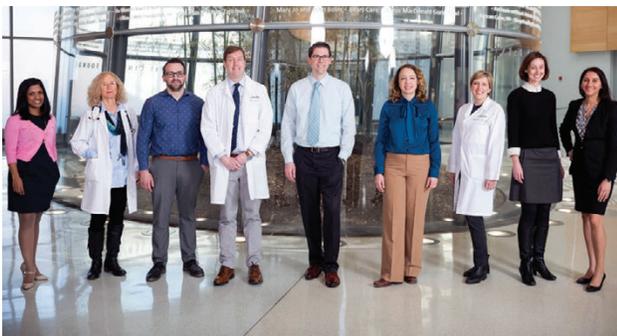
The next year, Dr. Hanak’s team set more aggressive targets for blood pressure control and made sure that more incentive dollars went directly to the clinicians.

“That really, I think, turned the tables, and people were paying much closer attention to how they performed,” Dr. Hanak said. Rush University Medical Group reached a hypertension control rate of 84%.

For New West Physicians more than one-third of its physicians’ salaries are tied to how each clinician performs, based on both quality and utilization metrics. For example, Dr. Cohen said, physicians are compensated in part based on their patients’ hypertension control (rather than on New West’s control rate as a whole).

“Tying incentives to individual physicians’ performance is a successful strategy for gaining physician buy-in,” Dr. Cohen said. New West Physicians reached a blood pressure control rate of nearly 81%.

- **Shared physicians’ data with each other.** Rush University Medical Group and New West Physicians decided to share data as transparently as possible among their medical teams. At Rush University Medical Group, this clued physicians in to the reality of their patients’ hypertension.



“The day-to-day chaos of seeing patients all day long, you forget about things...When we presented [doctors] with their data, they were really compelled to take action,” Dr. Hanak said.

Soon, better hypertension control became a priority for the entire Rush system, which drove further quality improvements, including working with medical assistants to optimize workflows and make plans for reaching hypertensive patients.

At New West, data sharing motivated competition as well as improvements. Knowing one another’s statistics drove doctors to perform better. “Nobody wants to be at the bottom of those reports,” Dr. Cohen said.

ADVICE FOR OTHERS

For other health care practices and systems that are engaged in value-based reimbursement programs, Rush University Medical Group and New West Physicians recommend a few tips.

- As much as possible, transition to value-based care. “Until physicians engage in models where they’re financially responsible for their outcomes of care, you won’t see huge changes in behaviors,” Dr. Cohen said.
- Expand the team by bringing in additional patient supports, such as social workers or community health workers and people with expertise or time to help with processes such as workflows. This can improve performance and increase staff satisfaction.
- Make data accessible and transparent. This helps physicians see patients’ data objectively and identifies targets for higher achievement.
- Manage the comprehensive health of the patient population. Both Rush and New West tackle other chronic conditions, such as diabetes, and unhealthy behaviors, such as not taking medicines as directed. This is a natural way to engage patients in care across the continuum, not just with blood pressure, Dr. Hanak said.
- Ensure rewards go directly to the care team, not only the larger group or system. This creates physician buy-in, motivates competition, and allows practices to expand their team where needed most.



ZUFALL HEALTH MEETS THE CHALLENGE LIKE A CHAMPION

TEAM EFFORT HELPS TAME HYPERTENSION

Million Hearts®—Success in Blood Pressure Control

Keeping blood pressure under control helps prevent heart attacks and strokes and saves lives. Million Hearts® launched the Hypertension Control Challenge in 2012 to recognize clinicians and health systems who make blood pressure control their goal. The Hypertension Control Champions use evidence-based strategies to achieve blood pressure control rates in their practices at or above the Million Hearts® goal of 70% of adult patients. As of 2015, CDC has recognized 59 clinicians, health care practices, and health systems as Million Hearts® Hypertension Control Champions.



Dr. Rina Ramirez,
Zufall Health

THE CHALLENGE

In 1990, Dr. Robert Zufall and his wife, Kathryn, founded a free clinic to provide medical treatment to northwest New Jersey's working poor, uninsured, and underserved populations. Today, Zufall Health has nine locations in northwest New Jersey.

“Our providers have really embraced the guidelines and the importance of controlling high blood pressure.”

— Dr. Rina Ramirez,
Chief Medical Officer, Zufall Health

Among Zufall Health's 30,000 patients, 92% are at least 200% below the poverty level and 49% are uninsured. Three in four patients are Latino/Hispanic, and half of these patients are non-native English speakers. Some patients have low literacy levels even in their native language.

When a patient population faces so many challenges, Zufall Health has to go the extra mile to help patients control their blood pressure.

“Our providers have really embraced the guidelines and the importance of controlling high blood pressure,” said Rina Ramirez, M.D., Zufall Health's Chief Medical Officer.

WHAT THEY DID

Controlling hypertension begins by forming trusting relationships with patients, conveying to them the seriousness of hypertension, and giving them the means to control their blood pressure. When patients experience Zufall clinicians putting so much emphasis on blood pressure control, they embrace the importance of it.

- **Forming relationships and building trust.** Zufall's medical van visits soup kitchens during the day to serve homeless individuals and encourage them to receive medical services.

One homeless patient visited the medical van with an initial blood pressure reading of 210/140 mmHg. Over the next 9 months, the clinician worked with the patient and encouraged regular follow-up visits to the center, waived the copays, reinforced and simplified the medication regimen, and assisted the patient in making lifestyle changes. Ultimately, the patient stopped drinking alcohol and cut back on smoking. The patient's latest blood pressure reading was 137/82 mmHg.

The van also visits migrant farm workers' housing in the evenings to accommodate their schedules.

When workers need to visit the clinic or get medication, an outreach worker drives them to the clinic.

“The most important thing is establishing trust.”

— Dr. Elif Ozdener,
Clinical Pharmacist, Zufall Health

Zufall clinical pharmacist Elif Ozdener meets one-on-one with high-risk patients and those who are having difficulty controlling their blood pressure. She emphasizes the seriousness of high blood pressure and the importance of medications and lifestyle modifications to control it.

“The most important thing is establishing trust,” Dr. Ozdener said. “They may feel embarrassed that they can’t afford the medication, but if we have their trust, they can say, ‘I can’t afford this.’”

Zufall Health helps patients obtain affordable medications with the Federal 340B Drug Pricing Program and by prescribing from a list of affordable medicines. Zufall Health is also able to provide free medications to a limited number of patients who cannot afford them.

- **Taking steps for success.** The steps that Zufall takes to improve patients’ blood pressure include:
 - Training medical assistants in proper pressure-taking techniques, including having patients settle in before taking blood pressure and retaking it later if the reading is high. Medical assistants perform blood pressure competency testing at least once a year.



- Reviewing blood pressure guidelines with staff during clinical staff meetings and quarterly grand rounds.
- Monitoring for hypertensive effects from other medications the patient is taking, such as drugs for pain, and adjusting the regimen accordingly.
- Teaching patients the skills to manage their own health. Zufall offers wellness programs, including healthy cooking and nutrition, yoga, and adult and children’s exercise classes.
- Discussing hypertension with patients and giving positive reinforcement when they take steps to reduce their blood pressure.
- Celebrating small successes or, if a patient does not have a success to celebrate, encouraging them to continue trying.
- Working as a team. Clinicians communicate with patients and pass along important information or success strategies to other health care team members.
- Tracking the blood pressure control rate of health care teams and disseminating it among them, harnessing friendly competition to improve control.
- Using patient navigators to help patients obtain health insurance and other services.
- Publishing a monthly newsletter to inform and motivate patients to make healthy choices. An announcement about Zufall’s Million Hearts® Champion designation lets patients know that their efforts to control their blood pressure make a difference.

ADVICE FOR OTHERS

Zufall’s patient-focused approach to blood pressure control can benefit health care practices of all sizes. Building personal relationships and trust, providing a caring team approach and positive reinforcement, and tracking quality metrics help and support patients who face many challenges controlling their blood pressure, taking their medications, and living a healthier life.

“One of the main tenets of the practice is to give people the information that they need, the skills they need, to manage themselves,” Dr. Ramirez said.