

**Million Hearts® and Controlling Hypertension in Adults
Guidance for the Use of Protocols
August 26, 2014
3:00-4:00 pm ET**

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode throughout the duration of today's conference. And today's call is being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn over the meeting to John Clymer, Executive Director, National Forum for Heart Disease and Stroke Prevention.

John Clymer: Thank you, (Angela). Good afternoon. As (Angela) said, I'm John Clymer, Executive Director of the National Forum for Heart Disease and Stroke Prevention based in Washington DC. Today's webinar Millions Hearts and controlling hypertension in adult guidance for the use of protocols is presented jointly by the American Heart Association and the National Forum.

Before we begin, I'd like to cover a couple of housekeeping matters within my meetings. First, you can review and download slides and handouts that are being shared during this meeting. To do so, please go to the top right-hand corner of your screen where you will see an image that looks like 3 pieces of paper. It's next to a yellow thing that looks like a pad of paper.

Click on the icon that looks like the 3 pieces of paper and you can download the presentation and the handouts there. For questions and the answers which

will be covered later in the webinar, you may submit questions online. So to do that, please go to the Q&A tab that is in the upper left-hand quadrant of the screen and type in your questions. We'll be answering the questions at the end of the presentation.

We are very pleased and honored today to have joining me as a presenter, Dr. Mary Ann Bauman, who is the Medical Director for Women's Health and Community Relations for INTEGRIS Health in Oklahoma City. Mary Ann is the chair of the American Stroke Association Advisory Committee, chair of the Guideline Advantage Steering Committee and a national spokesperson for Go Red for Women. Dr. Bauman is a contributing writer to several American Heart Association publications most recently for an effective approach to high blood pressure control, a science advisory from the AHA, the American College of Cardiology and the CDC.

I could read on her bio which is very impressive is posted online and rather than taking away from the presentation Q&A time, I'll simply refer you to her bio and move ahead to the objectives for today's presentation which appear on screen right now.

We want you to be able at the end of the webinar to identify how protocols may be part of a system or systems approach to improving blood pressure control rate, to be able to summarize the recommended elements of effective hypertension protocols for the use for successful adoption to identify why blood pressure control protocols and algorithms may be useful and to utilize Million Hearts tools and resources.

You'll see we have a full agenda today so we will move ahead and we'll begin with an overview of the Million Hearts initiative for those who may not be familiar with it or who may benefit from a brief refresher. Million Hearts is a

national initiative that was launched in January 2012 by the US Department of Health and Human Services. It's co-led by the Center for Disease Control and Prevention and Centers for Medicare and Medicaid services and it focuses the efforts of federal agencies, states, regions, communities and individuals on a common goal which is preventing 1 million heart attacks and strokes in five years or by 2017.

This goal is audacious and it's achievable only with the collective efforts of each of us as individuals and as members and leaders of our communities, work places and organizations. The table that is on screen now provides an overview of the Million Hearts population health goals and clinical targets for the ABCs of clinical care where; A, stands for aspirin use where in appropriate; B, stands for blood pressure control; C, stands for cholesterol management; and S, stands for smoking assessment and cessation treatment.

The table on the targets can be used by clinicians and public health practitioners to describe the Million Hearts ABCs and the most current values, population goals and clinical targets for each measure. In conjunction with other Million Hearts efforts by meeting the population goals for this evidence-based interventions, the US could experience more than 1 million fewer heart attacks, strokes and other related events during the five year period of the Million Hearts initiative. Each ABCs measure is described in more detail than subsequent figures.

The population goal represents the minimum value desired for the entire US populations described within each ABCs measure. The clinical target refers to the minimum value desired for healthcare systems and clinics as they treat their patient population described within each measure. So the example that I've highlighted is the population goal for all US adults for age 18 or older

who have hypertension or that is to say high blood pressure and to have blood pressure control of at least 65%.

I've already described how devastating cardiovascular disease for the nation so now let's look at how much of the devastation is preventable. To do so, we'll take a closer look at hypertension which is one of the risk factors for having a heart attack or stroke. Nearly, one in three or about 72 million adults in the United States have hypertension or high blood pressure.

Of those American with high blood pressure about half are not yet under control, control being defined as systolic blood pressure less than a 140 and diastolic less than 90. So 35 million adults or about 48% of the population have uncontrolled blood pressure. Of the approximately 35 million with uncontrolled blood pressure 13 million do not know that they have high blood pressure.

Seventeen million are aware that they have it and they're being treated with medication but they still don't have it under control and there is an additional 5 million are aware of their high blood pressure but they're not taking medication for it. But the bar graph that's on the screen now shows that the vast majority of these adults with uncontrolled high blood pressure or hypertension have health insurance and a usual care provider and most of them have received healthcare in the past year.

So what can be done if so many people already have access to care? I'd now like to outline the proven community and clinical strategies that we know will prevent heart attack and stroke. We know that it is feasible for many healthcare systems to dramatically improve their hypertension control rates. Hopefully, you remember the earlier slide that showed the declining smoking rates. Well that was from a different presentation but I want to show you right

now a visual that looks at the clinical side and how we can achieve increased blood pressure control rates.

This is taken from Kaiser Permanente in Northern California which developed a large scale program that improved blood pressure control from 44% in 2001 to 87% in 2011, virtually doubling their rate of control. They started with the development at system wide hypertension control registry. In 2001, they generated hypertension control reports every one to three months for quality improvements and performance measures and develop an evidence-based high blood pressure control protocol.

In 2007, all Kaiser Permanente in Northern California medical centers developed a medical assistance followup visit for followup measurement. There are numerous stories like this from the Million Hearts hypertension control champions. If you're not familiar with those champions, I commend your attention to the Million Hearts Web site where you will be able to find them. These are great success stories of clinical settings of various sizes and in various locations, various types of locations with different types of patients panels who have all been very successful in bringing about much greater blood pressure control among their patients populations.

With a focus on improving hypertension and using the HRs and care protocols that allow everyone on the team to know how they can intervene and frequent provider feedback, we're seeing individual providers and large provider systems substantially improving their control to in some cases over 80% as with the examples that's on screen right now.

The full deployment of meaningful EHR technology, electronic health records, allows for use of clinical quality measures to track the quality of care that's being delivered. Million Hearts is acutely aware of the measurement

burden being placed on clinicians at this time and as result, a Million Hearts has been working hard with numerous public and private partners to align the clinical quality measures use to assess the ABCs.

This is an overview an I won't take time to run through line by line but it's an overview of the clinical quality measures associated with the ABCs and you can see if you look at the left hand column, the A, B, C or S designation where; A, relates to preventive use of aspirin; B, relates to blood pressure control; C, relates to cholesterol control; and S, relates to smoking cessation.

At this point, I'd like to hand the baton to Dr. Bauman who will take us forward from this point.

Mary Ann Bauman: Thank you, John. I appreciate that. And I'm excited to be here and talk with you because we really do have some good information for you about ways that you can help your organizations to achieve the type of blood pressure control that we need. And first off, I wanted to share American Heart Association's roadmap for achieving our goal and that's to improve millions, 13.4 million to blood pressure control in 2020 or by 2020.

Our plan is comprehensive seeks to attack the issue of hypertension from multiple angles and influence as you can see on this slide. First of all, equipping providers. Much of this work is around the standardization of protocols and we'll spend our time talking about some of that today. We'll also be working through direct to consumer channels to motivate individuals to take their hypertension seriously. People do not take it seriously.

We want to connect them with the resources and tools to help them to develop the habits like self-monitoring which makes a big difference and making

important lifestyle changes like decreasing sodium in a diet. We Americans love our salt and it makes our blood pressure go up.

In communities, we're seeking to reach the underserved populations. We're working with stakeholders at churches, community centers, clinics, housing, to support individuals and helping them to make the changes they need to get their blood pressure under control -- in other words helping to take away those barriers to blood pressure control.

And finally, we're looking at systems of care and we'll be talking more about that today. How can the systems be set up to make hypertension management targeted and easier for healthcare providers so that we really pay attention to this?

So what is an effective approach to blood pressure? It's really team work is the key to controlling it. In November 2013, the American Heart Association, American College of Cardiology and the Center for Disease Control came together -- and John mentioned this -- to publish the new science advisory that urged doctors, healthcare providers and hospitals to collaborate on programs that will help patients control their blood pressure and we all know that blood pressure is continuing to rise despite the fact that we have had proven treatments for the last 50 years.

I had the pleasure of serving on this writing group, Dr. Alan Go is Kaiser Permanente in Northern California and they have achieved the results that you saw in an earlier slide by using this teamwork approach that we will be discussing. So blood pressure management is multi-factorial. You have to have everyone involved with this.

We have to expand the patient and healthcare provider. We have to give appropriate lifestyle modifications. People have to have access to care. We need evidence-based treatment, a high level of medication adherence which is a big issue. Study show that 24% of people do not feel their cardiac medications within seven days of discharge for a cardiac hospitalization. That's huge and we have to have adequate followup.

So recognizing this urgent need to address the inadequate control that you saw from John's slide, the American Heart Association has made hypertension a primary focus for our 2014 to 2017 strategic plan because we want to improve the cardiovascular health of all Americans by 20% and reduce the death rate from cardiovascular disease and stroke by 20% by 2020. So we've had three-year plan along the way and this is hypertension is one of the major parts of our 2014 to 2017 plan.

Also working with Million Hearts which John has already discussed with you is extremely important because they also are focusing on hypertension so, you know, we have a synergy there which makes us both much more able to achieve the successes that we need. We believe that identifying best practices and John mentioned a couple of those, evidence-based management algorithms that lead to standardization of treatment is critical if we're going to be successful because really what we're trying to do is we are trying to improve the care on the whole population level.

So let's talk about system level approaches in hypertension. Again, despite strong evidence and consensus regarding treatment and control, success has not been great at both the individual patient level and more importantly at the population level. It's a major challenge. So to reduce the prevalence of hypertension in the US, the system level approach will be needed.

Hypertension needs to be addressed with the multiple factors in a coordinated manner so what do we need to do? We need to identify the patient's eligible. We need to monitor them at both the practice and the population level, increase patient and provider awareness, effective diagnosis and treatment, followup, extremely important for initiation but also the intensification of therapy. You can't wait three months or six months when they come in again to change their medication regimen.

Clarifying the roles of healthcare providers to implement that team approach especially in today's healthcare environment where financial concerns are an issue too. Developing that team and how you can do it within your framework is an issue that we all need to address then reducing the barriers for patients to receive and adhere to medications and as well as getting them to make the lifestyle modifications which we all know are very difficult for people to do and then using the electronic medical records. That's part of the reason why we can do this population level now because we do have the electronic medical records in so many of the practices so we're able to do that.

Onto my next slide here. Continuing then, we want the algorithms to be with the best available science and that's why I was excited to participate in the review that we just did with the algorithm because we know that we are using the best science there. It must be formatted to be simple. It must be formatted to be simple implementation. There must be a patient version. Patients need to be partners in this and they need to understand and it needs to be so they can understand it.

We have to look at cost of diagnosis, monitoring and treatment. The format has to be used with the team and it has to be easy to remember so you're not trying to think of 50 different things and it has to be incorporated into the

electronic medical record so that you can use it but also this - and this is an important one this last one.

The algorithm can't take away the healthcare providers best clinical judgment so it isn't just - this is what you do every single time. You do need to use your judgment on this as well. So continuing with the recommended elements; it needs to be simple, clear, needs to involve lifestyle modification, needs to treat by stages of the hypertension. There must be a limited time interval to titration and reassessment.

You must use low cost first line treatments and that often includes combination pills so that patient only has to purchase one and we have to know what the exclusions and suggestions for medications based on other medical conditions because as all of you know, many people have more than 1 condition going on. They may have hypertension, they may have diabetes along with it, they may have heart disease, obesity, other things going on with it.

And then, I want everybody to really remember that everything is not essential hypertension that there are secondary causes for hypertension such as renal vascular and we have to pay attention to that as well. As I mentioned, fix those or combination drugs. Back when I was in residency, we never wanted to use combinations because you wouldn't be sure which would had the side effect but now with some of this that we're recommending in combination, they are medications that have been around for a long time and I think we can use them safely.

We need to know when to refer to a hypertensive specialist. I'm a primary care internist so I want to know when is the right time to do that. We need to know the number needed to treat to avoid a clinical event so that we know that this

is cost effective therapy as well and you want to be able to look at the supporting references so you trust that the science is accurate.

So now I want to present to you what is this AHA, ACC and CDC hypertension treatment algorithm. And you can see that it is pretty simple in terms of being a one pager that you can think about. We look at the systolic blood pressure so the 140 to 159 and diastolic is 90 to 99 and then we look at it above. All right.

You start considering adding the thiazide and I'm not going to go through the whole thing but just kind of to show you and then you recheck and review in three months for those people who are at the stage 1 hypertension. For those who are higher, you'll start perhaps two medications on them and then you review in two to four weeks. That is something we need to pay attention that you don't let them go for long periods of time.

If their blood pressure is at goal then fine, we want them to self-monitor, we want to continue on their meds, we want to them call the office and if they have problems and we want to see them in the office. If no, then we want to add more medications or titrate them higher. Again, we recheck and review in two weeks. If they're at goal, we go on. If they're not, then we want to add medications perhaps for this.

We want to talk about adherence. We want to talk to self-monitoring. Maybe request readings from home. Consider secondary causes and if we're not getting them to goal, then we need to consider referral to the hypertensive specialist. I like this also because you can see on the side and this is best research from AHA and ACC, reducing weight, look what it will bring down their blood pressure.

Adopting the DASH eating plan which is diet of rich in fruits, vegetables, low fat, dairy, less saturated and total fat, lowering the intake. That could bring it down two to eight millimeters of mercury, physical activities four to nine, moderate alcohol two to four -- or moderation of alcohol I should say -- so we all want to encourage the alcohol -- moderation of alcohol.

And if you look at this, this is helpful information to be able to tell your patients. This is how you bring it down and combination of this can do very well. So you can see that the algorithm is easy to follow and can be used in a team approach. So how do you get people to adopt a protocol? What do you do to adopt it?

So first of all, you identify a key influencer. Who will be the champion? Somebody who is in charge who will be effectively pushing everybody to use it, somebody is who respected. You want to identify mentor so that they can help people with consultation because physicians and healthcare providers are very busy when they're seeing patients so if they need a question answered, they need to be able to get it answered. They need to understand how to do it.

You want to get the baseline data and then you want to set a goal such as increasing by 10%, the number under control but you want to make it a reasonable goal to start. Hopefully, you have an electronic registry. You can use paper if you need to but then you can identify the patients and allow you to track them over time. Using the electronic health record to collate and analyze clinical information is key, timely feedback on performance to the entire healthcare team so they know that they're reaching goal and where they can do better.

And you'll be surprised every member of your team can offer you help with how to streamline and make it better and then make the performance data

transparent, it doesn't need to be - I'm always a believer in giving everybody's name and how they're doing. I think we're all competitive people so if we see someone else's is doing so much better, we might ask them why and how can we do better with that? You got to celebrate the early wins.

So your stakeholders in this are you protocol owners, your key organizations, your healthcare providers who have successfully used the protocols and this document by the way with this audit and feedback insight from key stakeholders I have should have mentioned that the Million Hearts convened a group of stakeholders to try to come up with the ways, these ways that will help you to be successful with it and those stakeholders are the ones that were the protocols owners key organizations and healthcare providers.

I got so excited about telling about the elements that I didn't attribute to that properly to whom it should be but that came from some of our Million Hearts group which were great. And then, again, these are from the key stakeholders, team-based care. Hypertensions got to become a priority. Everybody from the top down has to say we're going to do this.

You must use the expertise and scope of practice to every member of the healthcare team so that every member feels that they are a contributing factor. Patient and family, key members of the team. Community resources, know about them and recommend them to your patients. Pre-visit planning is something we're starting to do in our offices to try to make the most of the encounter. Get everything back, all the data back so you have time to talk with them.

Get their home blood pressure readings in. Know the questions and concerns of the patient ahead of time. It will make the appointment go much more efficiently. And then, look for the opportunities to check in with the patients

between visits. You know, we are needing that portal to talk with patients for meaningful use so have a member of the care team. Check, how is blood pressure going? Get the answers back again so that you can adjust the medication dosages as needed for the patient.

And then again, professional and patient education. You know, you need to know that the evidence is there of adopting and using protocols that healthcare team needs to be trained on how to use a protocol, how to measure blood pressure accurately. The equipment does need to be calibrated and inspected so that we make sure it's correct and again, we are seeing more and more articles in the literature about home blood pressure monitoring and the importance of it.

Coaching and self-management because once you're patients know that this is important to you, important enough that you're calling them and checking on them and having them call in to you, they will be more involved in their care as well.

Now the next thing I want to mention is something that I'm really excited about. I am the chair of the Guideline Advantage Steering Committee and I want to bring this up because it fits so well and some of you may be interested in using the Guideline Advantage to help you to be able to reach your hypertension goals.

This is a combination program that is American Cancer Society, American Diabetes Association and American Heart Association and what we did is we came together with all three organizations because we're all telling people the same things -- lose weight, exercise, watch your diet, eat fruits and vegetables and you will help with all of these diseases.

And so what happens is -- and you can see on this slide -- the providers can use their own technology so your own computer system and then from that, the practices submit the clinical data to the forward health group for the Guideline Advantage so Forward Health Group is a data aggregator that takes it from your electronic medical record. You don't have to do something differently and that is process, analyze and back to the practice via practice portal.

So then you have the information both at the individual level, the group level, and your whole system level to look at how your practice is doing and your patients are doing so that you can help to get better blood pressure control, better diabetes control, the other things that we are looking at as well. So basically what happens with this is you have one click access to your patient list, okay.

And you can see your own patients and you can see where you are and how you compare with best practice. Then we could - your look at the population and you can, again, as I mentioned here you can see your comparison for your measures of what you're doing, can data aggregated at the system level so your whole group can see how well they are doing and comparing and then again the clinic view, the whole clinic can see what they are doing.

And you can bring this down and it's a great patient education tool as well because in your own office if you're working on your either your tablet or your computer with the patient there, you can show them through red and green where there - wherever is green, they're good, wherever it's red, they're bad and they can see that visual immediately.

So it helps with the patient education aspects of it that we need. It is also connected with our Heart360 which is where the patients add their

information so it is available for meaningful use as well. All right. So, again, the Guideline Advantage I mentioned is aligned with Million Hearts, the uniform data system, the Bridges to Excellence which is a program that help the programs reach goals and actually has some financial involvement as well and the unified data systems are used by the community health systems and very qualified health systems.

So this can be very helpful. If you are interested, you can go to guidelineadvantage.org and get information about the program and how you might be able to participate because we're going to do is this - we're accumulating this into a registry. We have five million records currently and we will be able to determine best practice for primary care for this type of preventive health measures so that all of us will be able to benefit and again have that evidence based to know what works and what doesn't.

Now, let me see. My next slide shows where you can get some of the information on what we've talked about here -- the heart and stroke statistics so that you have that. The advisory that I mentioned that we wrote for 2013 tool kits including the algorithm and education for your patient visits and a customizable template for your organization and you can see some additional algorithm example like the Kaiser one. The VA also has one as well so you can look at those as you try to make your decisions about what you are going to do to achieve blood pressure control in your organization.

So John, I will now turn it back over to you.

John Clymer: Well, thank you for Dr. Bauman. That was a great presentation and I'm pleased that we were able to get through the introduction and your comments and explanation in time to have ample time for questions and answers. I encourage people who are participating in the webinar to go to the Q&A tab at

the top of your screen upper left quadrant and enter your questions there so that Dr. Bauman and I can answer them live during the webinar and they will by the way be available after the webinar. We'll need a little bit of time to get everything correlated and spell checked and so forth and then posted but it will be posted to the internet afterward.

In the meantime, I want to remind everyone that you can access and download the slide deck in the many resources that have been referred to during the webinar so far by going to the upper right quadrant of your screen where there's an icon that looks like it has three sheets of paper, click on that and that will give you a menu you can use to download the slide deck.

If you haven't already done that, I encourage you to do so now so that you will have it available for reference. I also want to draw your attention to a host of resources that are on the slide that appears on screen right now. There are a number of hot links that are included on screen and so you can get a number of different tools and resources there. I will call your attention in particular to one that's about 2/3 of the way down the screen titled 2013 Hypertension Control Champions.

This is a great resource because it enables you to read success stories about different practices and different types of locations serving different types of populations with different sorts of practices all of which had been successful, highly successful, in bringing their patient population's blood pressure under control. So great success stories. If you go to the Million Hearts Web site to which that hyperlink will lead you, then you'll be able to not only read those success stories but they're suitable for download and printing so that you can share them with colleagues in your practice and elsewhere.

If you are in public health as opposed to clinical practice, it's a great resource for you to share with clinical practitioners in your area with whom you want to collaborate and who you want to bring into collaboration with you to achieve these goals for your community. If you aren't able to download the slide deck, then you can go directly to the Million Hearts Web site to access the hypertension control champion success stories and that's available at millionhearts.hhs.gov. Again millionhearts.hhs.gov.

I see we have questions coming in and I encourage you if you haven't already submitted one to do so now. I'm pleased to let everybody know that we have over 100 people participating in today's webinar so that's terrific. I think it says a lot about your interest about people's commitment to controlling blood pressure, one of the most important things that can be done to improve both longevity and quality of life.

And our first question comes from (Debra) who asked does it cost to join the Guideline Advantage? Dr. Bauman, can you answer that?

Mary Ann Bauman: Yes, I can answer that. There are some costs -- licensing cost -- for the Guideline Advantage, there are different aspects of the program depending on what your needs are. We had some people who are - or some groups that are using the entire program to get the feedback back because it helps with their meaningful use and also with the patient portal aspect of it helps for meeting meaningful use.

And there are fees associated with that and then for those who already had a robust quality program of their own but want to see how they compare with the national benchmarking, then we also have some programs that simply have a different licensing fee for that.

So I encourage you to go to guidelineadvantage.org if you have an interest in this and we can get you all of the data and the information because it is an incredible program that we've already had an article accepted for publication about the Million Hearts initiatives and the aspirin use and we expect that those of you who are familiar with get with the guidelines and all of the publications that have come from that, that have moved the needle on cardiovascular care and stroke care inpatient that we feel we can do the same thing with this outpatient across the wider area of also including diabetes control and cancer-reducing aspects of it.

John Clymer: Great. Thank you, Dr. Bauman. And thank you, (Debra Bailey), for that question. The next question which also is for Dr. Bauman comes from (Fayad Sayed). I apologize if I mispronounced your name. The question is would you please talk about the meaningful use requirement for hypertension monitoring?

Mary Ann Bauman: Well, there - meaningful use does have a requirement before patient's involved and inputting information and having information with their doctors and the hypertension aspect of that allows us with the - our programs of Check Change Control to have -- and Heart360 -- to have people input that information that then goes to their provider and so meets the meaningful use needs for that.

John Clymer: Great. Thank you, Dr. Bauman. Our next question comes from (Judy Nowicki) who asks when looking for metrics during the measurement period, which blood pressure should be used? That is to say an average of self-reported blood pressures that have been submitted, today's blood pressure or the last BP during the measurement period?

Mary Ann Bauman: That's a really good question. And that has in part then a moving target. Certainly, we now feel fairly confident that that blood pressure we measured in the doctor's office is probably not the best way to do it because either you've got white-coat hypertension or you may have masked hypertension where it's lower in the office than it is otherwise. There are more and more studies suggesting that the patient's blood pressures that they take are the best.

Now, usual best case recommendations are that patients do five blood pressures 1 minute apart and the second and third are usually considered to be the most accurate. You're not getting everybody to do that. I know among my patient population, if I can get them check one blood pressure, I'm really happy with that but those are goals that we can work towards.

And then I don't know that there's a specific definitive of how if you average or what you do but I believe most general practices are then taking the average or the median or mean that is on the blood pressure machine and using that when they input it in for the patient's own blood pressure readings. I just reviewed a recent article that also talked about patient's blood pressures and having them self-titrate so there is interest in doing that as well.

John Clymer: Okay. Terrific. The next question, Mary Ann, comes from (Mitchell Gittelman) who says I currently participate in the IHO BP program with the AMA. Our office is able to send data to Forward Health Group because we house the EMR on our own server. However, how does Forward Health Group mine data from Cloud-based EMR systems for other PCP offices and who will pay that cost?

Mary Ann Bauman: Well, I have to tell you you're asking me technology questions and I am rather technologically impaired. So I don't know the specific answer to that. I do know at guidelineadvantage.org, we have the techie people who can

answer that question about the Cloud-based versus not. I also know as a general overview, Forward Health is able to gather the information from any EHR that somebody is using. We've been successful with all different ones that we have tried to use. So they are able to grab that information from whichever electronic medical record is being used.

John Clymer: Great. Thanks, Dr. Bauman. Again, if you have questions for Dr. Bauman or myself, you may go to the Q&A tab that's on the upper left of your computer screen and enter your question there and we will do our best to get to it. Our next question is again for Dr. Bauman and its if you're using a team-based approach and I think many of us have learned in the last year or so that team-based care has been shown to be highly effective in moving the needle on blood pressure control and is now a recommendation included in the community guide.

So if you do use a team-based approach, how do you ensure that health literacy is addressed?

Mary Ann Bauman: This is another good question and I think the team-based approach is the way we are moving in the future and many of our best practices are already doing that and so you have a number of different ways that you can do it. If you have clinic educators already, they are great persons to have groups. We've been doing some groups with people with diabetes and you can do the same thing with hypertension.

Also, as I mentioned with the Guideline Advantage on the individual patient level, you have the opportunity to show them in the office where they are in the green range and where they are in the red range which then gives them a very nice visual to help them to see where they need to go. In the Kaiser model that we saw the significant increases in blood pressure control that they

use medical assistance to contact the patients at two to four weeks so as that we're not under good control.

They brought them in for a visit did not charge them for that visit, brought them in for the visit and helped them to adjust and then did adjust their blood pressure and they also used pharmacist to actually titrate the medications up and down according to the set protocols that they had. So there are a number of different ways to do this and I know especially with some primary care practices for those of you who are out there, a lot of the members of the team and maybe and expense that you can't always afford easily.

And so really what you need to try to do is have your educators might be your nurse who would - but they have to be trained in knowing exactly how to speak with the patients and how to handle these particular issues. So I think the teams are going to vary depending on the situations of various clinics. If you're in a system, several clinics may pull together with their resources. We've done that with care coordinators so they'll spend a couple of days at each clinic. And then, we refer all of our patients during that time.

So I think there are a number of ways to do it. The key is that you want to involve the patient with more than here. Here's the prescription. Take it and take this pill and come back and see me in three months. That just is not getting us blood pressure control.

John Clymer: Great. Well thank you very much. Our next question comes from (Tasha Moore) and she says, "I work in a community setting. What is your recommendation for following up with patients between doctor visits? Do you make phone calls to patients providing nutrition counseling or exercise? How do you do that?"

Mary Ann Bauman: I think that - again, I think it's variable. I think phone calls are very helpful. I know that when patients know you're thinking about them, that makes a difference. However, I think if you really wanted - a phone call is great to call in and say, "How are you doing and are you taking your medications, et cetera," as reminders. But I do think bringing patients back for a visit and ideally if it can be done at no cost to the patient because as we know, cost is a barrier for hypertension control for many patients but bringing them back face to face again lets them know how important to think their blood pressure control is.

So I would say that a combination would work very well. On your patients who are under control as we've seen from our algorithm, you can go three months with them although I think a phone call in the middle or an email or something would be very motivating to the patient but for those who are not under control, that's where you want to focus and you want to be following them every two to four weeks to make sure that they're doing what you've advised them to do, if not, why are they not doing it. It isn't always because they don't care -- so looking at those barriers.

One of the things that American Heart Association is now looking at are the social determinants of health because so many people have barriers to doing these things we're talking about even with generic \$4 medications. It comes to a choice between getting that medication and taking care of your family or getting your kids their immunization or whatever it happens to be. So I do think it is important for us to consider the barriers and work on those aspects as well.

John Clymer: Great. Thanks, Dr. Bauman, and (Tasha), thank you for that question. The next question is what are ways that we can engage with Million Hearts? And there are lots of different ways that one can engage with Million Hearts

depending on where you sit whether you're in a clinical setting or a public health agency or a community-based organization or another setting.

So one way to get guidance on that is to access the Million Hearts Engagement Guide which can be found on the National Forum Web site so to get that, go to nationalforum.org/millionhearts and there, you'll see a hot link to the Million Hearts Engagement Guide. Click on that and it will provide guidance to you. If you're looking for additional guidance, you can contact either the American Heart Association or the National Forum and their - our links on the National Forum Web site for doing so and - so you can get more information and assistance in becoming engaged with Million Hearts.

We are able to accept a few more questions. We have another one right now from (Genie Gallogly). Again, I apologize if I mispronounced your name. (Genie)'s question is do you feel there is a difference in compliance with the recent changes and recommendations for target blood pressures in older populations? Have these changes modified any approaches perhaps with different results?

Mary Ann Bauman: The American Heart Association has not changed the recommendations for blood pressure control and that is under 140/90 up to age 80. Now, I know that JAMA published recommendations that liberalized that but we are convinced that the data supports very definitely the less than 140/90 blood pressure and so, the answer is no. There - certainly, I know that this raised a lot of a discussion but there are some articles now coming out that are suggesting that there is an increased risk of cardiovascular disease and stroke by letting those blood pressures drift to the higher level.

So 140/90 is still where we believe the science takes us and the recommendations stand.

John Clymer: Thank you, Mary Ann. Our next question refers back to the example that I gave from Kaiser Permanente in Northern California and you referred to it in your presentation as well. The question is I understand that Kaiser used medical assistance to follow up on blood pressure checks. Can you share how this work and what was the frequency of those follow ups?

Mary Ann Bauman: Yes. I think they felt in their article that was published in JAMA that they felt that using the medical assistance to do this was an excellent use of their time and using those medical assistance to the level of their expertise so I think that they were very pleased with that and the followup by the medical assistance when people were not reaching goal was every two to four weeks and they brought those patients in.

And as I mentioned and I will mention again, I think one of the key benefits that they did not charge the patients to co-pay so there was not that barrier the patient saying, "I don't want to come in as frequently as you want me to because it cost me money each time." So I think they found the use of medical assistance very advantageous for this particular function.

John Clymer: Great. Okay. And I realized as you're giving that answer and we're referring to team-based care that when I referred to team-based care earlier being a recommendation that's included in the community guide, I didn't give the location for that information. It's easy to access. You can get not only that evidence-based practice recommendation but many others that are related to the ABCs by going to www.thecommunityguide.org. Again, that's thecommunityguide.org.

And you can get there as well by doing a number of clicks through CDC's Web site but the most expeditious way to access that information is

thecommunityguide.org. We have some additional questions. Thank you. This one is from (Ellen Hasmanic). Will the Q&As be available at a later time? And yes, (Ellen). I believe they will be so thank you for asking that question. They won't be available instantly.

As I mentioned before, we'll have to edit them, get them transcribed, and clean them up a bit but then we will be posting them online. They should be readily accessible on both the American Heart Association and National Forum Web sites and I would expect pretty easy to find via Google as well. So if you were able to download the slide deck and you have the title of today's webinar handy that way, then you'll be able to google those. Thank you.

We received a nice attaboy or attagirl from another participant who says the presentation was useful and we need more like this. So, thank you very much. We appreciate that. And we're able to take a couple of more questions if you have them. In the meantime again, I want to call your attention to the ability to download the resources. I encourage you to do so.

Dr. Bauman presented a tremendous amount of information in a very short period of time and it may be handy to have her slides to refer back to as you're trying to recall exactly what she said and find some of the resources to which she referred so that you can carry out some of these practices in your own setting.

And now, I want to remind everyone that today's webinar was presented by the American Heart Association and the National Forum for Heart Disease and Stroke Prevention. We encourage you to join us in supporting and carrying out the Million Hearts initiative and working together to prevent a million heart attacks and strokes across the country.

As we've discussed today, there are a number of practices, programs and strategies that we know work to reduce and to control high blood pressure and some of the other risk factors for heart attacks and strokes. We encourage, we ask, we implore that you join us so we can all work together to collectively achieve the goal of preventing one million heart attacks and strokes in five years.

Thank you again to Dr. Mary Ann Bauman from INTEGRIS in Oklahoma City and thank you as a participant for joining us today. We hope that you're able to put this information that we presented to good use.

Coordinator: And thank you for your participation in today's conference. Please disconnect at this time.

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