

Improving Blood Pressure Control for a Healthier Community



American
Heart
Association

American
Stroke
Association

life is why™

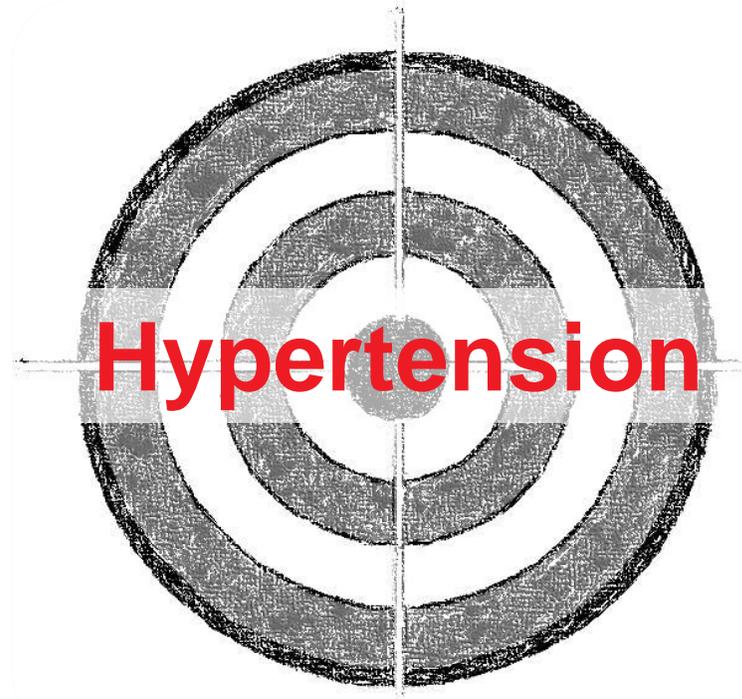
Hypertension in the United States

In 2010, hypertension was listed as the primary or secondary diagnosis in over 11 million hospital visits.

Heart Disease

Hypertension is an independent risk factor for heart disease, stroke, heart failure and renal failure.

Heart Failure



The cost of high blood pressure is estimated at \$46.4 billion in direct and indirect medical cost and \$25 billion in lost productivity

Stroke

Hypertension is listed as primary or contributing cause of death for 348K Americans per year

Renal Failure

Our Goal for Better Control



GOAL
- MOVE -
13.4M
PEOPLE
TO CONTROL
- BY 2020 -



From 2009 to 2012 among US adults with HBP



54.1%
HBP is
controlled



76.5%
currently
treated



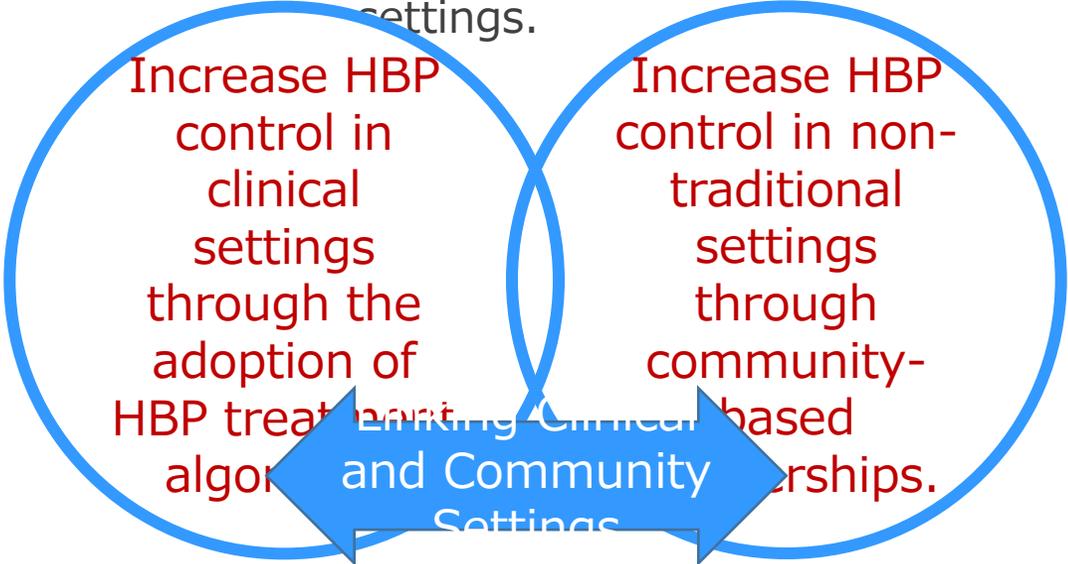
82.7%
are aware
they have HBP



17.3%
remain
undiagnosed

Key Health Impact Strategy

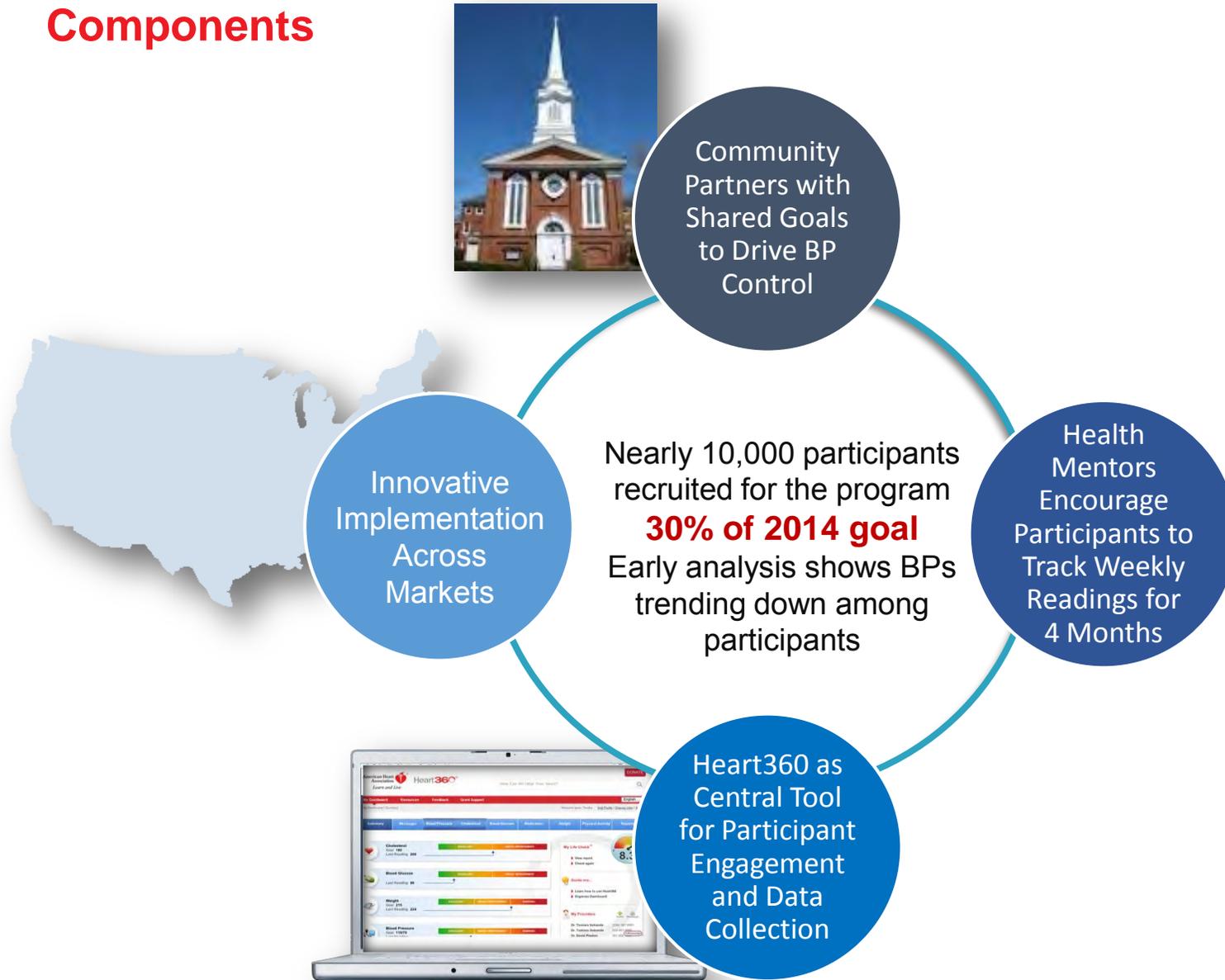
Improve blood pressure control in traditional and non-traditional settings.



Connecting Clinic to Community & Community to Clinic

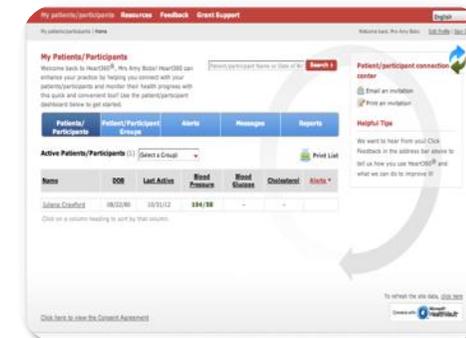
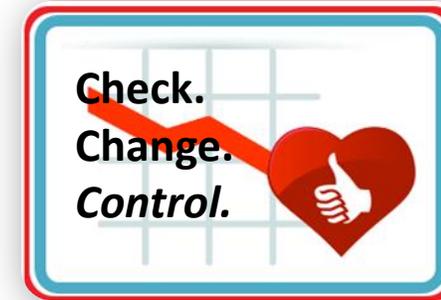


Program Components

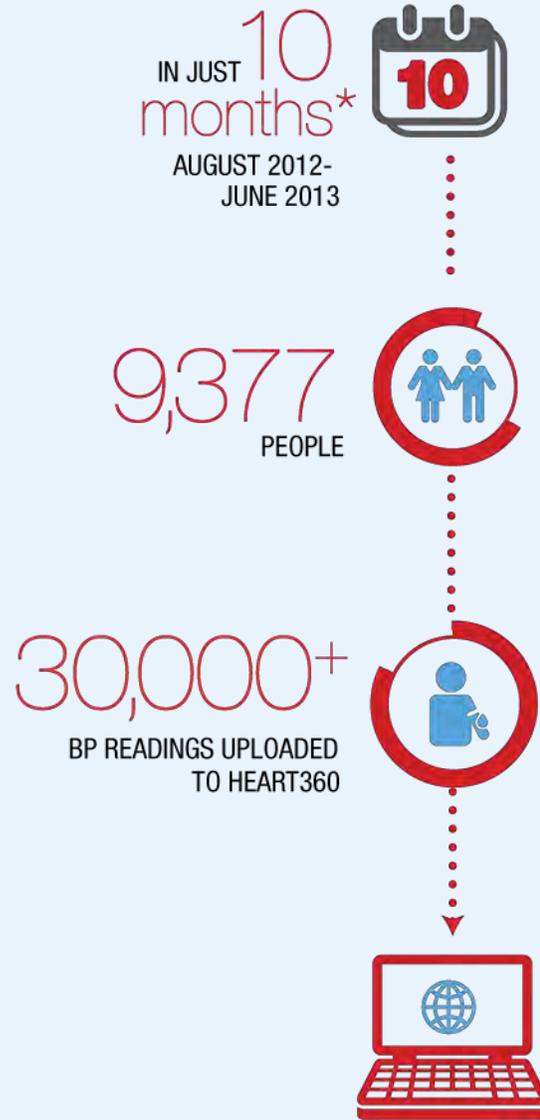


WHY IT WORKS: Key Evidence-Based Scientific Principles

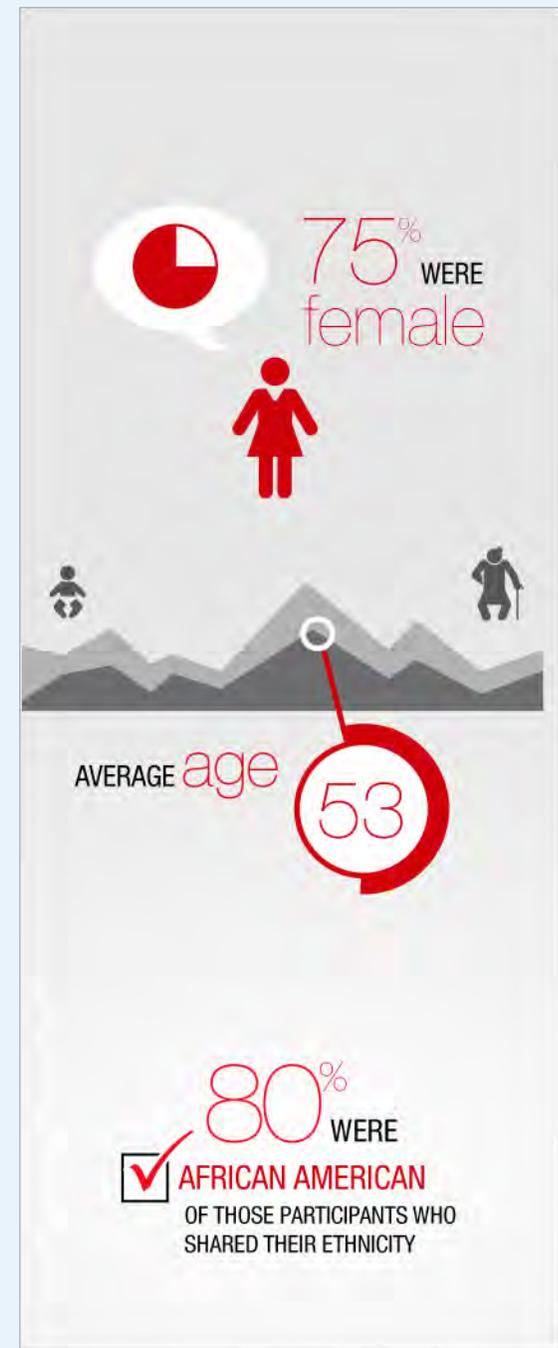
- **Self Monitoring Makes a Difference**
- **Proven track record for taking blood pressure readings** at home or outside of the healthcare provider office setting.
- **Use of digital self-monitoring and communication** (Heart360 which we explain later).
- **Charting & tracking improves self-management skills** related to blood pressure management.
- **Personal Interaction Makes a Difference**
- **Health mentors can motivate and encourage participants.**
- **Multicultural Program Investments Make a Difference**
Hypertension creates a health disparity for African-Americans.



Statistics on the 6-month pilot phase RESULTS

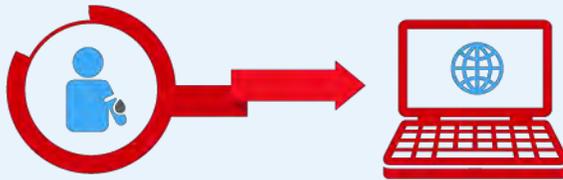


*APPROXIMATELY



Consistent Measurement Can Lead To Success

Participants* who met the retention criteria



Uploading readings:

- At least 2x's per month
- For 4 consecutive months

Avg drops in BP

SBP

DBP

11.2
mmHg

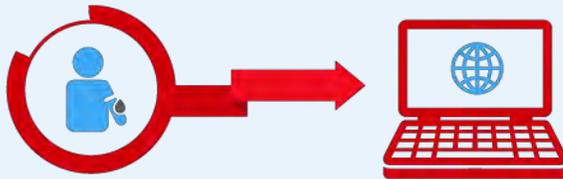
4.31
mmHg

*Total participant pop. represented is 854

Participants who started with high readings saw the greatest average reduction.
Effective for those with the greatest need.



Participants* who met the retention criteria



Uploading readings:

- At least 2x's per month
- For 4 consecutive months
- **And started the program with a BP > 140/90**

Avg drops in BP



*Total participant pop. represented is 374

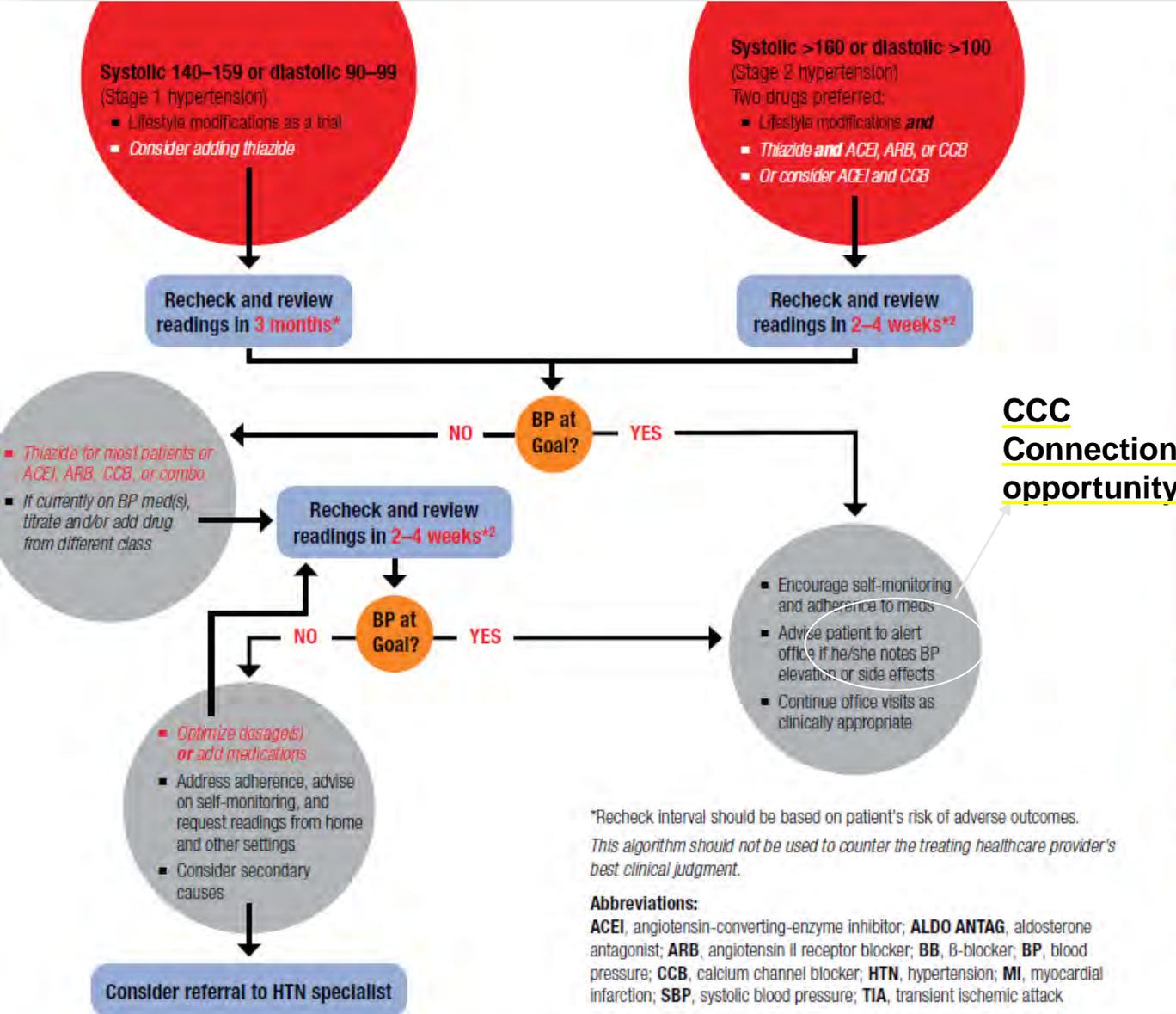
Participation can lower overall risk and decrease mortality



WHAT DO THESE RESULTS MEAN?



AHA/ACC/CDC Hypertension Treatment Algorithm



Modification	Recommendation	Approximate SBP Reduction (Range)**
Reduce weight	Maintain normal body weight (body mass index 18.5–24.9 kg/m ²)	5–20 mm Hg/10 kg
Adopt DASH^{4,5} eating plan	Consume a diet rich in fruits, vegetables, and low-fat dairy products with a reduced content of saturated and total fat	8–14 mm Hg
Lower sodium intake⁶	a. Consume no more than 2,400 mg of sodium/day; b. Further reduction of sodium intake to 1,500 mg/day is desirable, since it is associated with even greater reduction in BP; and c. Reduce sodium intake by at least 1,000 mg/day since that will lower BP, even if the desired daily sodium intake is not achieved	2–8 mm Hg
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week)	4–9 mm Hg
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men, and to no more than 1 drink per day in women and lighter weight persons	2–4 mm Hg

* DASH, dietary approaches to stop hypertension
** The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals

Elements Associated with Effective Adoption of Protocols

Team-Based Care:

- Make hypertension control a priority.
- Fully use the expertise and scope of practice of every member of the health care team.
- Include the patient and family as key members of the team.
- Learn about community resources and recommend them to patients.
- Conduct pre-visit planning to make the most of the care encounter.
- Look for opportunities to check in with patients between visits and adjust medication dose as needed.



Elements Associated with Effective Adoption of Protocols

Professional & Patient Education

- Use of evidence for adopting and using protocols.
- Train the health care team on how to use the protocol.
- Training on how to measure blood pressure accurately.
- Calibrate and inspect equipment at to ensure correct blood pressure measurement.
- Emphasize the value of home blood pressure monitoring.
- Incorporate coaching and self-management into patient education and follow-up.

