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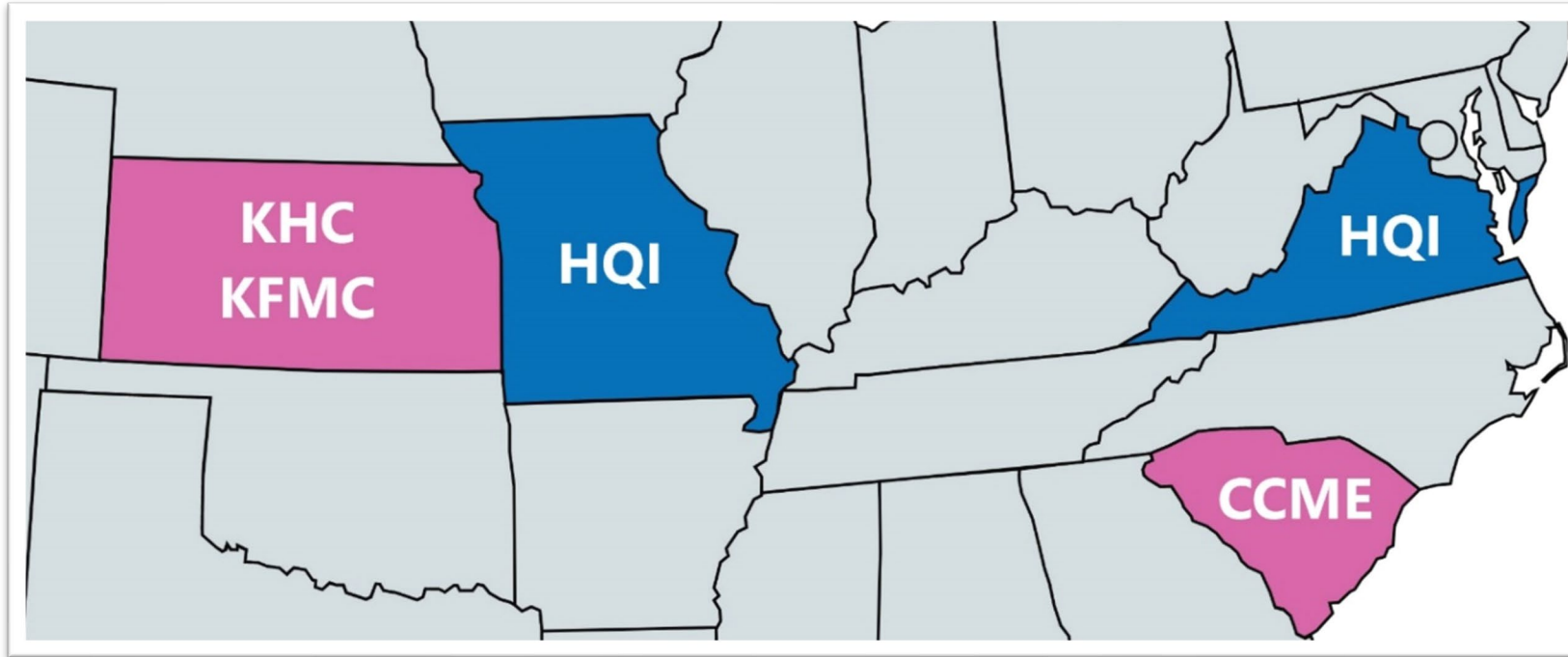


Health Quality Innovation Network

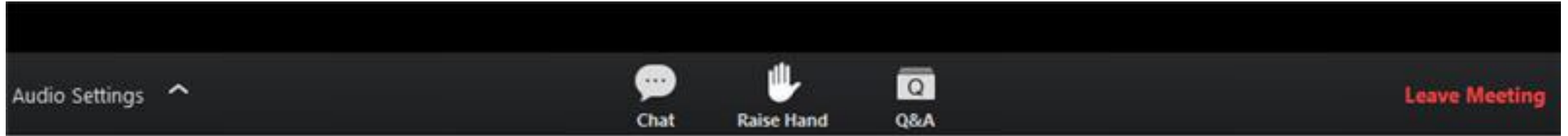
HEARTS in America Program Update 2024: Improving Hypertension Control

February 21, 2024

Health Quality Innovation Network



Logistics – Zoom Meeting



To ask a question during the presentation, please use **Chat**.

Raise your hand if you want to verbally ask a question.

Links from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.



The HQIN **HEARTS in America** series was delivered by **HEARTS** subject matter experts. They introduced the pillars of the [HEARTS Technical Package](#) while beginning the conversation about HEARTS in America and addressing critical topics associated with Hypertension.

Objectives

1

Review the Global HEARTS Initiative and HEARTS in the Americas Program: Pillars, technical package, implementation, and progress to date to improve hypertension control.

2

Recognize the importance of the development of a primary care, population-based approach using a standardized pharmacologic protocol in the treatment of hypertension.

3

Identify and address the key barriers and clinical drivers to improve hypertension control.

4

Improve outcomes by integrating the diagnosis, management and recognition of hypertension, diabetes mellitus, and chronic kidney disease,

Polling Question

How familiar are you with HEARTS in America?

- a. I am not familiar with it.
- b. I've heard of it.
- c. I'm familiar with HEARTS and its components
- d. I am using HEARTS



***PROGRESS OF THE HEARTS IN THE AMERICAS
PROGRAM 2024:
IMPORTANCE TO INCREASING HYPERTENSION
CONTROL***



***DONALD J. DIPETTE MD FACP FAHA
DISTINGUISHED HEALTH SCIENCES PROFESSOR
UNIVERSITY OF SOUTH CAROLINA
UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE
COLUMBIA, SOUTH CAROLINA***

HQIN PRESENTATION FEBRUARY 21, 2024

Process for Successful Change: Kotter

Establish a “sense of urgency/burning platform”

- Form a powerful coalition/allies
- Create a vision for change
- Communicate the vision
- Empower others to act on the vision/remove obstacles
- Build on the change/create short-term wins
- Consolidate improvements producing more change
- Anchor the change/institutionalize the new approaches

Change: “Sense of Urgency/Burning Platform”

- Cardiovascular disease (CVD) is the leading cause of morbidity and mortality globally, in the nation. **Hypertension is the leading risk factor for CVD.**
- **The control rate of hypertension (<140/90 mmHg) in the U.S. is a dismal 45%. Globally the control rate of hypertension is 20%.**
- Safe, effective, and affordable pharmacologic treatment for hypertension is available.
- Start discussions regarding the efficacy of current practices.
- Examine opportunities to increase the control rate of hypertension.



Recent NHANES Data:

U.S. Population Results: A call to action! (JAMA 2020)

- Hypertension control rates (using $<140/90$ mmHg) continued to increase to 53.8% in the 2013-2014 survey
- However, hypertension control rates (**using $<140/90$ mmHg**) have significantly **decreased to 43.7%** in the last 2017-2018 survey and have continued to the present
- Using the ACC-AHA **criteria of $<130/80$ mmHg**, the hypertension control rate is **19%** in the 2017-2018 survey
- This decrease in control rate parallels the recent increase in CVD-related morbidity and mortality!

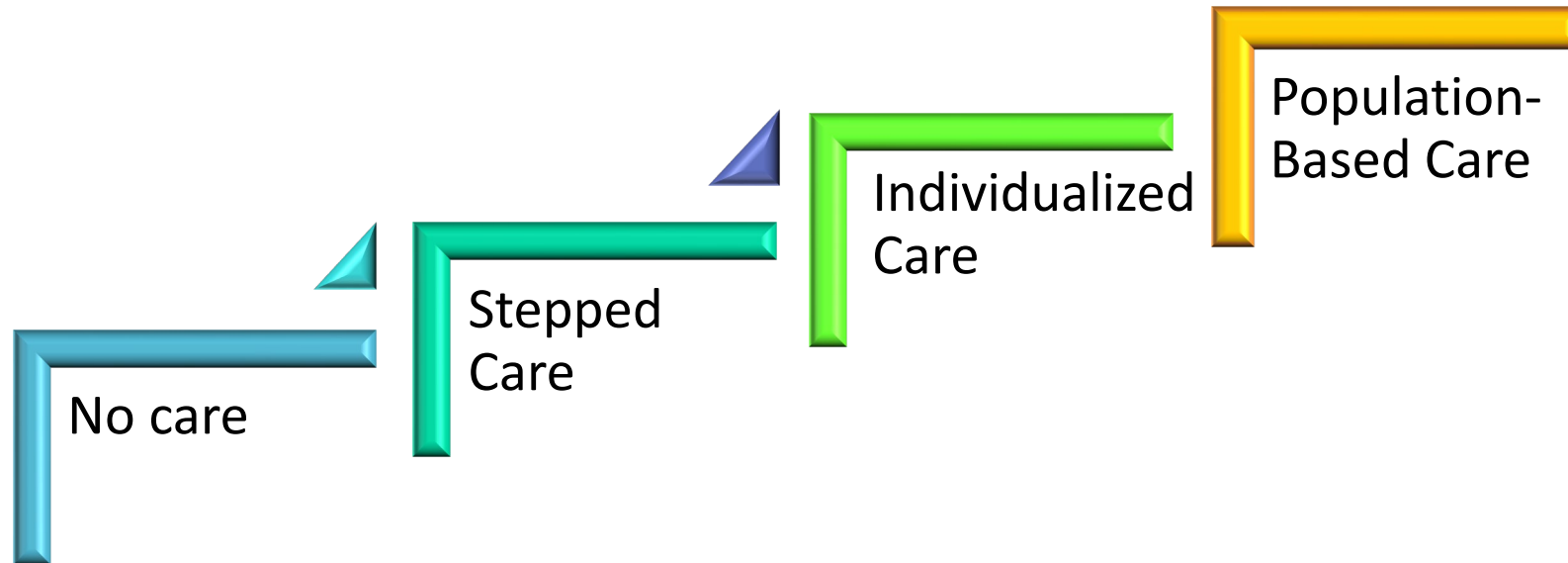


Declining HTN Control Rates: The U.S. Surgeon General's Call to Action to Control Hypertension-2020

Overall Goal: “To avert the negative health effects of hypertension across the U.S. by identifying interventions that can be implemented, adapted, and expanded across diverse settings”

- **Goal 1.** Make hypertension control a national priority.
- **Goal 2.** Ensure that the places where people live, learn, work, and play support hypertension control.
- **Goal 3. Optimize patient care for hypertension control.**
 - **Strategy A. Advance the use of standardized treatment approaches and guideline recommended care including a hypertension formulary and treatment protocol**

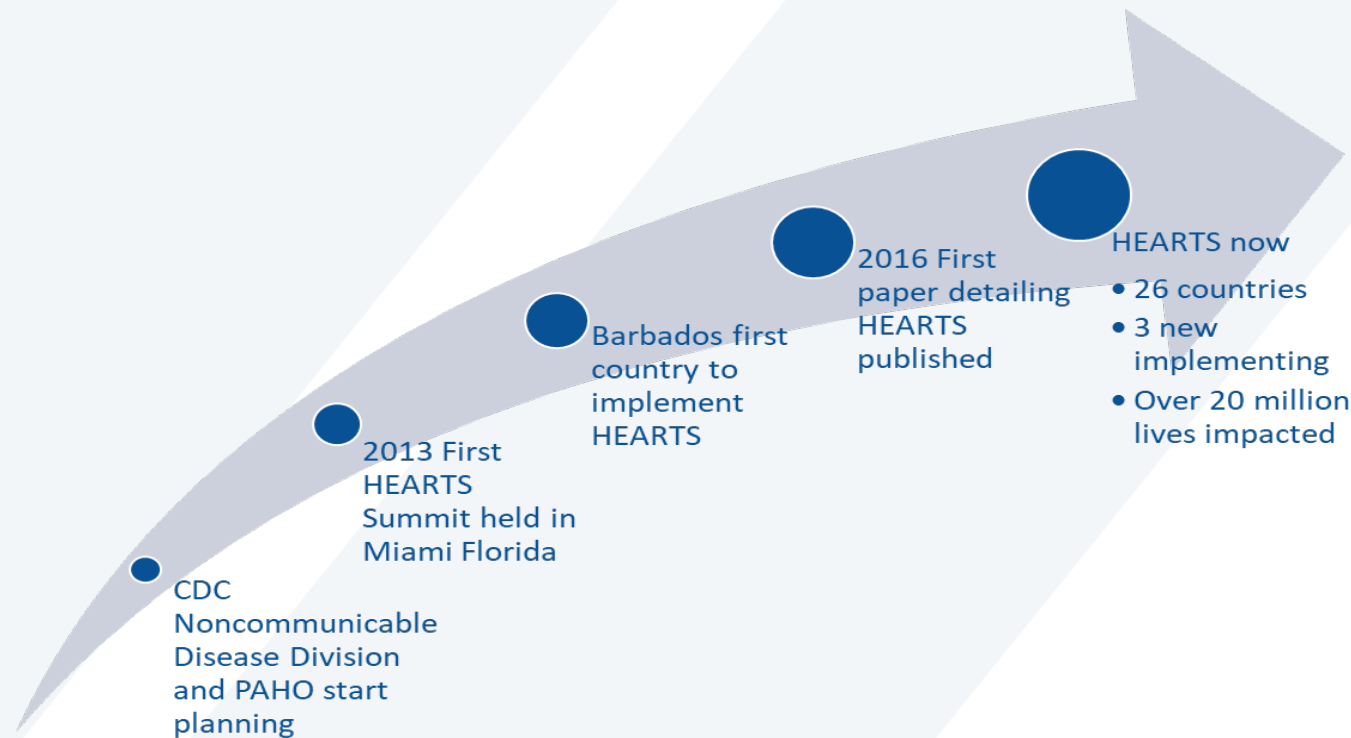
Approaches to Care in the Pharmacologic Treatment of Hypertension



DiPette, Ridley 2020

Skeete, Connell, Ordunez, DiPette. Integrated

Where HEARTS in the Americas Began



Healthy-lifestyle counselling

Information on the four behavioural risk factors for CVD is provided. Brief interventions are described as an approach to providing counselling on risk factors and encouraging people to have healthy lifestyles.



Evidence-based treatment protocols

A collection of protocols to standardize a clinical approach to the management of hypertension and diabetes.



Access to essential medicines and technology

Information on CVD medicine and technology procurement, quantification, distribution, management and handling of supplies at facility level.



Risk-based CVD management

Information on a total risk approach to the assessment and management of CVD, including country-specific risk charts.



Team-based care

Guidance and examples on team-based care and task shifting related to the care of CVD. Some training materials are also provided.



Systems for monitoring

Information on how to monitor and report on the prevention and management of CVD. Contains standardized indicators and data-collection tools.

HEARTS

IN THE AMERICAS

GUIDE AND ESSENTIALS FOR IMPLEMENTATION



Global Hearts Initiative



Population approach

Health Services/Clinical approach

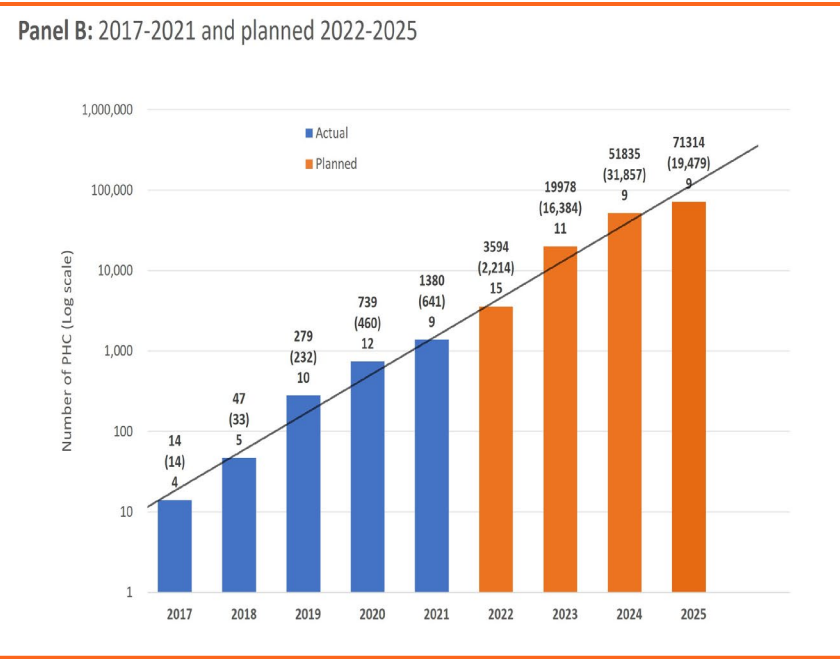
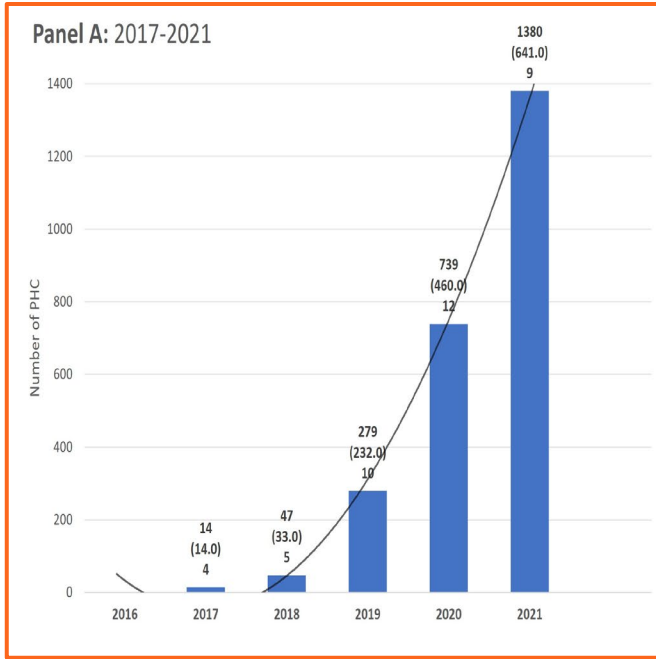
<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Healthy-lifestyle counselling</p>	<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Evidence-based treatment protocols</p>	<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Access to essential medicines and technology</p>	<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Risk-based management</p>	<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Team-based care</p>	<p>HEARTS</p> <p>Technical package for cardiovascular disease management in primary health care</p> <p>Systems for monitoring</p>
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Chronic Care Model

HEARTS in the Americas



- 33 countries implementing HEARTS.
- More than 1300 PHC.
- More than 5 million people covered.

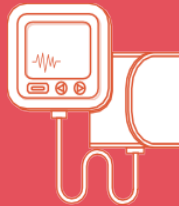


HEARTS in the Americas Technical Pillars

VISION: HEARTS will be the institutionalized model of care for cardiovascular risk management, with special emphasis on the control of hypertension and secondary prevention in primary health care in the Americas by 2025.



Standardized treatment protocols and medications



Blood pressure measurement:
Regulations and validated BP devices



Training and education



Data standardization and innovation in data utilization



Implementation research and program evaluation



Innovation in organization of care and team-based care

MODULES OF THE HEARTS TECHNICAL PACKAGE

Module	What does it include?	Who are the target users?		
		National	Subnational	Primary care
H ealthy-lifestyle counselling	Information on the four behavioural risk factors for CVD is provided. Brief interventions are described as an approach to providing counselling on risk factors and encouraging people to have healthy lifestyles.		✓	✓
E vidence-based protocols	A collection of protocols to standardize a clinical approach to the management of hypertension and diabetes.	✓	✓	✓
A ccess to essential medicines and technology	Information on CVD medicine and technology procurement, quantification, distribution, management and handling of supplies at facility level.	✓	✓	✓
R isk-based CVD management	Information on a total risk approach to the assessment and management of CVD, including country-specific risk charts.		✓	✓
T eam-based care	Guidance and examples on team-based care and task shifting related to the care of CVD. Some training materials are also provided.		✓	✓
S ystems for monitoring	Information on how to monitor and report on the prevention and management of CVD. Contains standardized indicators and data-collection tools.	✓	✓	✓

HEARTS in the Americas – Guiding Principles

Ownership

HEARTS is led by the Ministries of Health, with the participation of other stakeholders and PAHO's technical cooperation.

Simple and practical

The Initiative provides pragmatic, cost-effective, and feasible solutions to primary healthcare systems (PHC)

Evidence-based

HEARTS promotes the adoption of best practices in preventing and controlling CVD and improving health services organization.

Accountability

HEARTS is a data-driven initiative.

Continuous learning

Continuous learning cycles, peer-led teaching, dissemination of effective innovations, and lessons learned during implementation.

Long-term sustainability

Integrating elements into the existing PHC.

Increasing the PHC capacity

Recruiting more PHC facilities and increasing the speed of model institutionalization.

Traditional Model vs. HEARTS Model

Level of care	Specialty-based	Primary care-based
Provider model	Physician-centered	Team-based care with task shifting
Training and education	Not standardized and centered on specialist	Standardized and focused on the primary health care team
Decision making	Individualized and based on complex clinical guidelines	Standardized clinical pathway with a specific treatment protocol
BP measurement	Non-standardized technique. BPMDs may not be clinically validated and BP accuracy is not guaranteed	Adoption of standardized technique and regular training. Exclusive use of automated BPMDs clinically validated
Therapeutic approach	Physician preferences and complex medication-based pharmacologic formularies	Standardized, simple, directive treatment algorithm using FDC and specific, timely follow-up intervals.
CVD risk evaluation	Discretionary	Integrated into the standardized clinical pathway and focus on CVD secondary prevention, including diabetes

Characteristics of High Performing Health Systems

In addition to focusing on outcome measures:

- Identify key drivers
- Translate key drivers into process measures
- Performance feedback to front-line clinicians and clinics



IN THE AMERICAS

Key Drivers Identified

Domain	Key Driver	Recommendations
Diagnosis	BP measurement accuracy	Training, standardized protocol, validated monitors
	CVD risk assessment	Assess in all patients; statins and ASA as appropriate
Treatment	Standardized treatment protocol	Specific medication with doses, use of FDC
	Treatment intensification	Initiate treatment after diagnosis; titrate when BP above goal
Continuity of care and follow-up	Continuity of care and follow-up	F/u within 4 weeks if uncontrolled; 3-6 months if controlled
Delivery system	Team-based care and task shifting	BP measurement, f/u BP visit, medication titration
	Medication refill frequency	3-month refills
System for performance evaluation	System for performance evaluation with feedback	Monthly performance feedback

Hypertension Clinical Pathway

1. BP measurement accuracy

2. CVD risk assessment

3. Standardized Treatment Protocol

4. Treatment intensification

5. Continuity of care and follow-up

6. Team-based care and task-shifting

7. Medication refill frequency

8. System for performance evaluation with feedback

A ACCURATE BLOOD PRESSURE MEASUREMENT

MEASURE BLOOD PRESSURE IN ALL ADULTS AND AT ALL VISITS

- 1 Don't have a conversation
- 2 Support arm at heart level
- 3 Put the cuff on bare arm
- 4 Use correct cuff size
- 5 Support feet
- 6 Keep legs uncrossed
- 7 Empty bladder first
- 8 Support back

Whenever available, use validated automatic devices for the arm.

B CARDIOVASCULAR RISK

KNOW YOUR RISK OF CARDIOVASCULAR DISEASE AND HOW TO MODIFY IT

CARDIOVASCULAR RISK CALCULATOR

Use the HEARTS App to assess your cardiovascular risk

Scan code to access the cardiovascular risk calculator

This App does not replace clinical judgment.

C TREATMENT PROTOCOL

START TREATMENT IMMEDIATELY AFTER CONFIRMING HYPERTENSION

Blood Pressure $\geq 140/90$ mmHg in all HYPERTENSIVES.
 Systolic Blood Pressure ≥ 130 mmHg in HIGH-RISK HYPERTENSIVES
 (Established cardiovascular disease, Diabetes, Chronic Kidney Disease, Risk score $\geq 10\%$)

Cardiovascular risk	All Hypertensives	HIGH-RISK Hypertensives	
		WITH established cardiovascular disease	WITHOUT established cardiovascular disease
Blood Pressure TARGET $<140/90$ mmHg	✓		
Systolic Blood Pressure TARGET <130 mmHg		✓	✓
ASPIRIN 100 mg/daily		✓	
High-dose statins: ATORVASTATIN 40 mg/daily		✓	
Moderate-dose statins: ATORVASTATIN 20 mg/daily			✓

Avoid alcohol consumption

Body mass index between 18.5 and 24.9

Avoid foods high in sodium

- 1 1 Tablet of Telmisartan/Amlodipine 40/5 mg 1 MONTH
- 2 Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10 mg 1 MONTH
- 3 Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10 mg + 1/2 Tablet of Chlorthalidone 25 mg 1 MONTH
- 4 Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10 mg + 1 Tablet of Chlorthalidone 25 mg 1 MONTH

Patient above target:
Refer to the next level of care

Do 30 minutes of physical activity daily

Keep a healthy diet

No smoking

Patients under control	Minimum 6-MONTH follow-up	Minimum 3-MONTH follow-up	Supply medicines for 3 MONTHS	Vaccination		
				Influenza	Pneumococcus	COVID
All Hypertensives	✓		✓			✓
HIGH-RISK Hypertensives		✓	✓	✓	✓	✓

Country Name

Entity name

ASSESS TREATMENT ADHERENCE AT EACH VISIT

TAKE ALL MEDICATIONS AT THE SAME TIME EVERY DAY

This protocol is NOT INDICATED in WOMEN of CHILDBEARING AGE

Hypertension Clinical Pathway

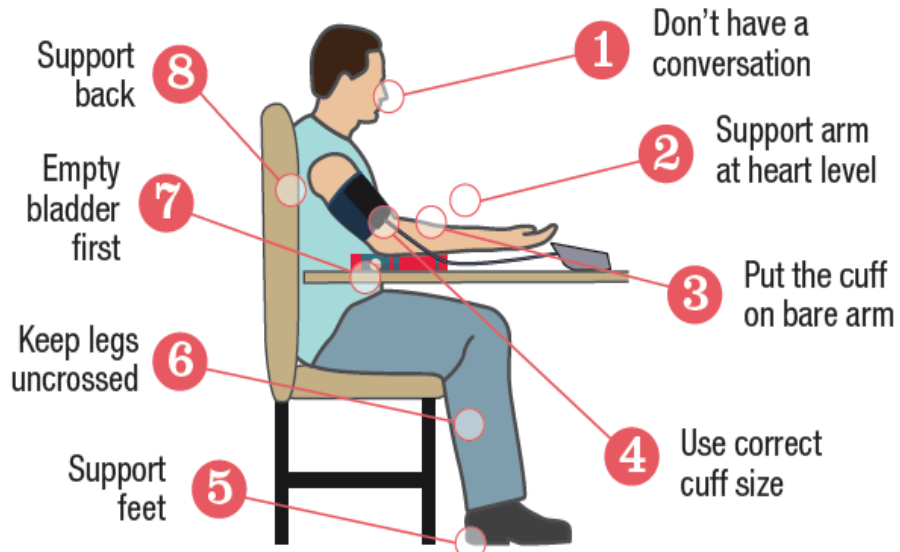
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ACCURATE BLOOD PRESSURE MEASUREMENT

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CARDIOVASCULAR RISK

KNOW YOUR RISK OF CARDIOVASCULAR DISEASE AND HOW TO MODIFY IT

CARDIOVASCULAR RISK CALCULATOR

Use the **HEARTS** App to assess your cardiovascular risk



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Driver - Accurate BP Measurement

Recommendation: Repeat BP when initial BP elevated.

Evidence: Reliability of single office BP measurement:

- 34% of initially elevated BPs normalized with recheck
- In 24%, SBP dropped more than 10 mm.¹

Opportunity: BP repeated only 23% of time when initial reading elevated²

Support: ACC/AHA 2017, ESC/ESH 2018, ISH 2020, AHA Scientific Statement Measurement of BP in Humans 2019

- ¹Burkhard et al, *Heart* 2018 Jul 104 (14)
- ²Cooper-DeHoff et al, *J Am Heart Assoc.* 2021: 10:e022224

CVD Risk Assessment

- SPRINT clinical trial: benefit of more intensive treatment in high risk
- Meta-analysis of individual participant data from 11 trials and 48K participants: CVD risk strategy avoided more CV events than BP strategy alone*
- WHO 2021: target SBP < 130 in high-risk patients (CVD, DM, CKD)
- *Karmali et al, PLOS Medicine 2018; 15(3)



C

TREATMENT PROTOCOL

START TREATMENT IMMEDIATELY AFTER CONFIRMING HYPERTENSION

Blood Pressure $\geq 140/90$ mmHg in **all HYPERTENSIVES**.

Systolic Blood Pressure ≥ 130 mmHg in **HIGH-RISK HYPERTENSIVES**
(Established cardiovascular disease, Diabetes, Chronic Kidney Disease, Risk score $\geq 10\%$)

Cardiovascular risk

	All Hypertensives	HIGH-RISK Hypertensives	
		WITH established cardiovascular disease	WITHOUT established cardiovascular disease
Blood Pressure TARGET $<140/90$ mmHg	✓		
Systolic Blood Pressure TARGET <130 mmHg		✓	✓
ASPIRIN 100 mg/daily		✓	
High-dose statins: ATORVASTATIN 40 mg/daily		✓	
Moderate-dose statins: ATORVASTATIN 20 mg/daily			✓



Avoid alcohol consumption



Body mass index between 18.5 and 24.9



Avoid foods high in sodium

1

1 Tablet of Telmisartan/Amlodipine 40/5 mg

2

Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10 mg

3

Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10 mg
+ 1/2 Tablet of Chlorthalidone 25 mg

4

Patient above target after repeat measurement
1 Tablet of Telmisartan/Amlodipine 80/10mg
+ 1 Tablet of Chlorthalidone 25 mg

1 MONTH

1 MONTH

1 MONTH

1 MONTH

**Patient above target:
Refer to the next level of care**



Do 30 minutes of physical activity daily



Keep a healthy diet



No smoking

- Most eventually need multiple drugs
- Greater efficacy (additive or synergistic)-improves blood pressure control rates
- Allows lower dosages of each of the 2 drugs
 - More effective than a higher dose of either single drug
 - Reduced side effects
- Simplified treatment regimen: better adherence
- Reduces clinical inertia
- When complementary drug classes are chosen, lowers BP equally across diverse demographic groups
- Economic benefits
 - Lower health care costs and fewer office visits

Driver – Standardized Treatment Protocol

Recommendation: Use established protocol with FDC

Evidence:

- Most patients require more than one medication.¹
- FDCs improve adherence, control, and decrease length of time to achieve control.²

Opportunity: FDCs used in only 19% of patients in the US 2013-2016.³

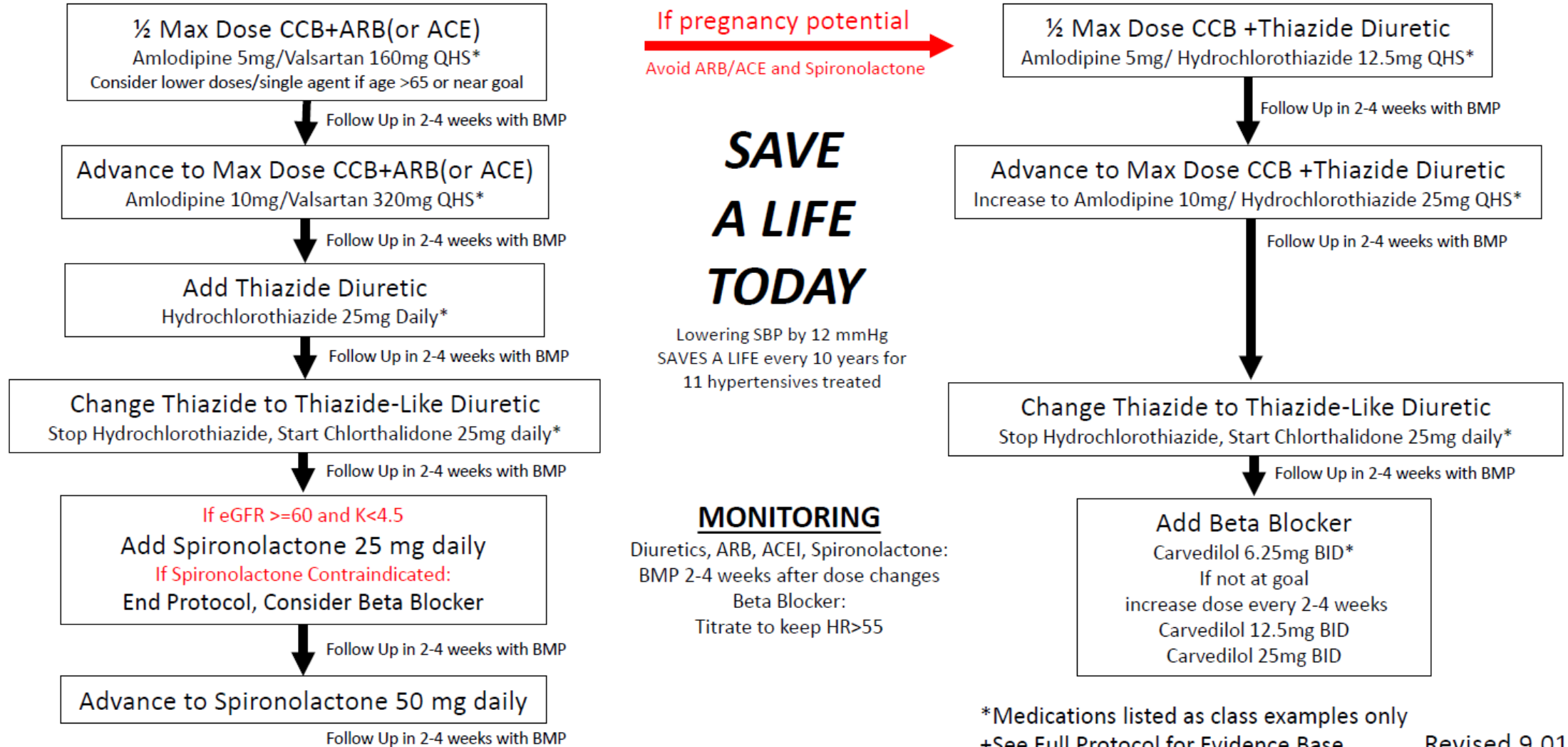
Support: WHO 2021 HTN guideline, ISH 2020, ESC/ECH 2018, ACC/AHA 2017

- ¹Whelton et al, *JACC* 2018; 71 (19)
- ²Derrington et al, *J Hum Hypertension* 2020; 34 (9)
- ³Derrington et al, *Hypertension* 2020; 75 (4)

PRISMA HEALTH PRIMARY CARE ADULT HYPERTENSION INITIAL PHARMACOTHERAPY ALGORITHM+

Intensify Regimen Every 2-4 Weeks As Indicated

Blood Pressure Goal $\leq 139/89$ or ≤ 129 Systolic with CAD, DM, CKD or ASCVD $>10\%$



If pregnancy potential
Avoid ARB/ACE and Spironolactone

**SAVE
A LIFE
TODAY**

Lowering SBP by 12 mmHg
SAVES A LIFE every 10 years for
11 hypertensives treated

MONITORING

Diuretics, ARB, ACEI, Spironolactone:
BMP 2-4 weeks after dose changes
Beta Blocker:
Titrate to keep HR>55

*Medications listed as class examples only
*See Full Protocol for Evidence Base

Treatment Intensification Driver

- In a recent study of 25 US health systems, when medication was added for uncontrolled BP:
- SBP decreased by 15 mm Hg
- Cooper-DeHoff et al, J Am Heart Assoc. 2021;10:e022224



Patients under control	Minimum 6-MONTH follow-up	Minimum 3-MONTH follow-up	Supply medicines for 3 MONTHS	Vaccination		
				Influenza	Pneumococcus	COVID
All Hypertensives	✓		✓			✓
HIGH-RISK Hypertensives		✓	✓	✓	✓	✓

Country name

Entity name



ASSESS TREATMENT ADHERENCE AT EACH VISIT

TAKE ALL MEDICATIONS AT THE SAME TIME EVERY DAY

This protocol is
NOT INDICATED
 in **WOMEN** of
CHILDBEARING
AGE

The Hypertension Clinical Pathway is the fundamental tool for the HEARTS implementation, catalyzing the recommendations of the new WHO CPG and the Drivers for Hypertension Control.

Utilizing the Electronic Health Record (EHR)

- A New Hypertension Smart Set was created within EHR to guide providers
- Incorporates new hypertension algorithm for primary care
- Follow-up options include a 2-week nurse follow-up for BP check
- Secondary work-up is easy to order and guides toward proper tests

AMB Hypertension ⌵

- ▼ Reference & Information
 - ▼ Hypertension Reminders
 - Target BP less than 140/90 for most patients, with a systolic goal less than 130 mmHg for patients with Diabetes, CKD, ASCVD or at high risk for ASCVD.
 - Consider combination therapy, ideally as a fixed dose combination pill, for all patients requiring pharmacotherapy to reduce side effects and increase efficacy.
 - Appropriate antihypertensive drug choice is dependent upon the presence of comorbid conditions.
- ▼ Lab
 - For patients taking a diuretic or an ARB or ACE inhibitor, obtain a serum potassium, and either a serum creatinine or a BUN at least annually
 - ▶ Hematology & Coagulation
 - ▶ Chemistry
 - ▶ Urine
- ▼ Other Diagnostics
 - ▶ ECG 12 Lead
 - ▼ Secondary Workup
 - Vascular ultrasound renal artery complete ■
Routine, Ancillary Performed
 - Echocardiogram Complete (Initiate Ultrasound Enhancing Agent and Bubble Study Protocol for Echocardiogram in Adults) ■
Routine, Ancillary Performed
 - Home Sleep Testing ■
 - Aldosterone Renin Ratio ■
- ▶ Prescriptions
- ▼ Consults & Referrals
 - ▶ Referrals
- ▼ Disposition & Discharge
 - ▼ Follow-up
 - appointment in 2 weeks for nurse visit
 - appointment in 1 month
 - appointment in 3 months
 - appointment in 4 months
 - appointment in 6 months

Special report

Integrating hypertension and diabetes management in primary health care settings: HEARTS as a tool

David Flood^{1}, Elizabeth W. Edwards^{2*}, David Giovannini³, Emily Ridley³, Andres Rosende⁴, William H. Herman¹, Marc G. Jaffe⁶ and Donald J. DiPette²*

Suggested citation Flood D, Edwards EW, Giovannini D, Ridley E, Rosende A, Herman WH et al. Integrating hypertension and diabetes management in primary health care settings: HEARTS as a tool. Rev Panam Salud Publica. 2022;46:e150. <https://doi.org/10.26633/RPSP.2022.150>

Integrated Management of Diabetes and Hypertension: Critical Role of HEARTS

Primary Pathophysiology



Prevention/Treatment

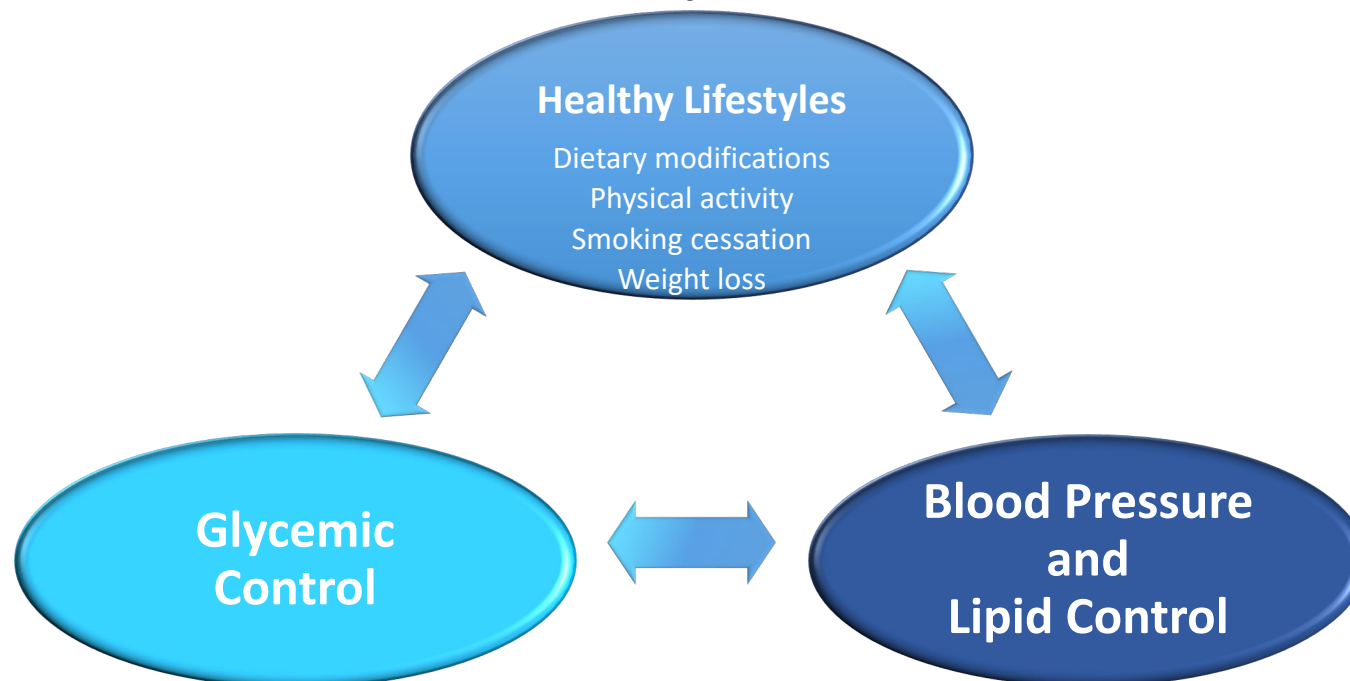


FIGURE 1. Overlapping risk factors and management of hypertension and diabetes

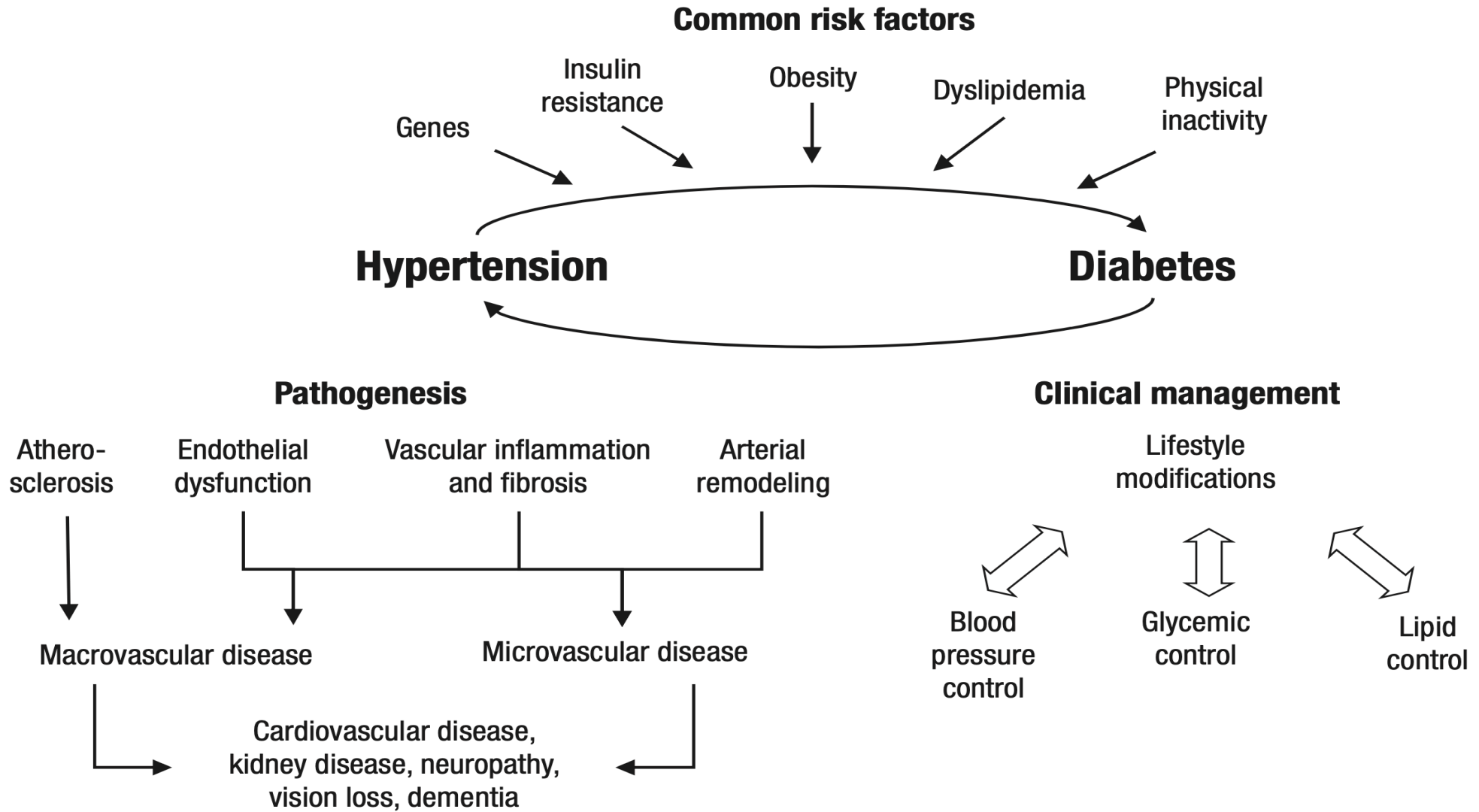


TABLE 1. Deaths attributable to modifiable risk factors in the Americas

Leading risks 1990		Percentage of deaths 1990	Leading risks 2019		Percentage of deaths 2019	Total deaths 2019 (thousands)
1	Tobacco	18.8	1	High systolic blood pressure	16.9	1 230
2	High systolic blood pressure	18.0	2	High fasting plasma glucose	14.7	1 064
3	Dietary risks	14.5	3	Tobacco	14.4	1 043
4	High LDL cholesterol	10.9	4	High body-mass index	13.0	940
5	High fasting plasma glucose	10.4	5	Dietary risks	12.6	916
6	High body-mass index	8.9	6	Kidney dysfunction	7.6	550
7	Child and maternal malnutrition	7.9	7	High LDL cholesterol	7.3	528
8	Air pollution	7.0	8	Alcohol use	5.1	370
9	Kidney dysfunction	5.2	9	Air pollution	4.1	298
10	Alcohol use	4.5	10	Non-optimal temperature	3.1	225

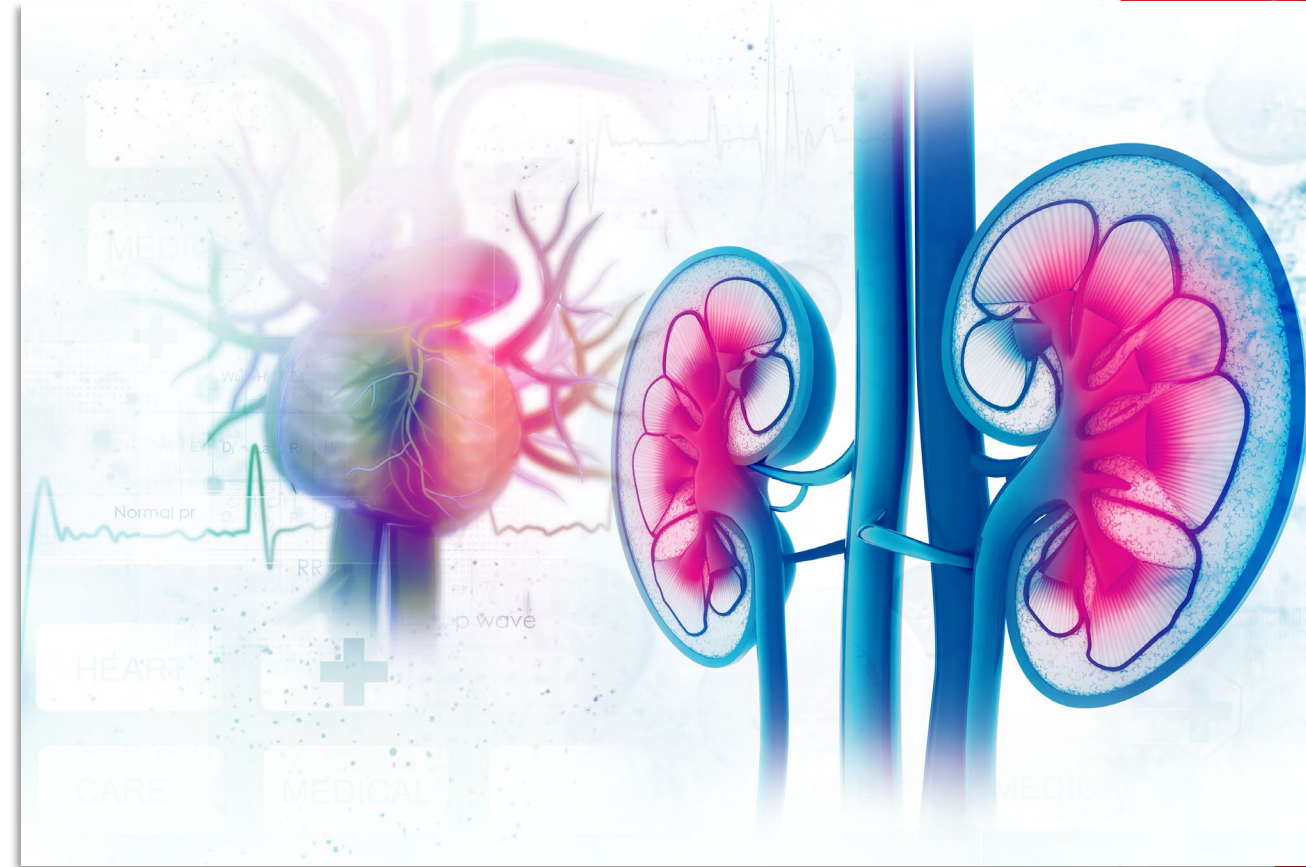
Source: Prepared by the authors using estimates from the Global Burden of Disease study (1).

Note: The arrows refer to changes in order ranking for high systolic blood pressure and high fasting plasma glucose from 1990 to 2019.

Definition of CKM Syndrome Simplified

Cardiovascular-kidney-metabolic (CKM) syndrome

is a health disorder due to connections among heart disease, kidney disease, diabetes, and obesity leading to poor health outcomes.



Scientific Understanding of CKM Syndrome

CKM syndrome results in **excess morbidity and mortality** beyond the sum of its parts.

Metabolic risk factors **cause end-organ damage in the heart, kidneys, and vasculature.**

Mechanisms of end-organ injury are **hemodynamic, metabolic, inflammatory, and fibrotic.**

Abbreviations: CKM indicates Cardiovascular-Kidney-Metabolic.

Scientific Understanding of CKM Syndrome

Chronic Kidney Disease as an Amplifier of Cardiovascular Risk



Low glomerular filtration rate and albuminuria independently increase the risk of MACE and CV death



Pro-inflammatory state which potentiates CVD risk



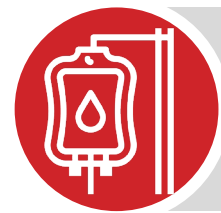
CKD and diabetes precipitate peripheral artery disease below the knee



Development of heart failure and/or progressive CKD can increase bidirectional organ damage, in tandem with neurohormonal activation and inflammation



Vascular calcification is common in CKD and increases CVD risk



Anemia is common in CKD and exacerbates CVD

Abbreviations: CKD indicates chronic kidney disease; CKM, Cardiovascular-Kidney-Metabolic; CV, cardiovascular; CVD, cardiovascular disease; and MACE, major adverse cardiovascular events.

Progress of the HEARTS in the Americas Program: Closing Thoughts

“START WITH THE END IN MIND”: INCREASING HYPERTENSION CONTROL

- Comprehensive, evidence, population and primary care-based, aligned with current major hypertension guidelines, and proven success
- Stresses the importance of appropriate measurement of blood pressure, cardiovascular risk factor assessment, and the use of a standardized pharmacologic treatment algorithm
- Importance of timely patient follow-up, rapid medication titration, and vaccinations
- Details the hypertension clinical pathway and critical clinical drivers to achieve rapid hypertension control
- Moves toward the integration of the management and treatment of hypertension, diabetes, and kidney



Thank You



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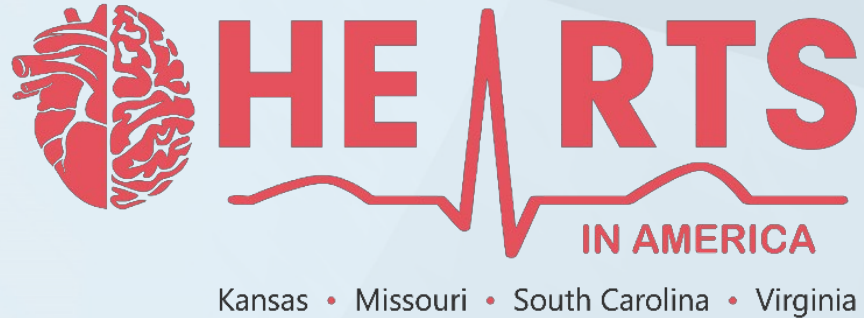


Polling Question

Based on today's session, which of the following actions will you take?

- a. Review HEARTS materials.
- b. Share information with colleagues.
- c. Reach out to HQIN Advisor to discuss further.
- d. Review our current hypertension practices





Contact Us

South Carolina – Katherine Plunkett kplunkett@constellationqh.org

Virginia – Jim Bugg jbugg@hqi.solutions

Missouri – Mary Ann Kimbel, mkimbel@hqi.solutions

Kansas – Mandy Johnson, mjohnson@khconline.org



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