



Diabetes and Blood Pressure PIP Care Coordinator Toolkit

Provided by:



**BlueCross BlueShield
BluePlus
of Minnesota**
Independent licensees of the Blue Cross and Blue Shield Association



HealthPartners
Your health. Your partner.

MEDICA

METROPOLITAN
MHP
HEALTH PLAN

U *Care*

MSHO/MS C+/SNBC Community & Institutionalized Blood Pressure Control for Members with Diabetes 2010 Performance Improvement Project Care Coordinator Toolkit

Project Summary

This project is designed to increase the proportion of community and institutionalized members with diabetes who have blood pressure in control. Consensus statements from the American Diabetes Association and other authoritative groups recommend that blood pressure in individuals with diabetes who are 18 through 75 years of age be controlled at levels below 130/80 mmHg. Blood pressure goals for individuals 76 years and older will vary from one individual to another and need to be set through an individual's discussion with his or her practitioner. It should be noted that while the project's interventions will reach members 18 and older, the measure being used to track improvement is focused on members 18 through 75 because of the consistent goal for this age group. Using administrative claims and chart review data gathered for the HEDIS CDC 130/80 Blood Pressure measure, goals have been set as follows:

MSHO/MS C+ Population:

Sustain a 4-percentage-point increase in the proportion of members with blood pressure less than 130/80 mmHg over 3 measurement periods.

SNBC Population:

Goal rate to be determined based upon pending 2009 HEDIS results.

Project Intervention Goals

Interventions will focus on *outreach* (mailings to members and direct contact with care coordinators); *tools* (for members, practitioners and care coordinators) and *training* (for practitioners and care coordinators). Specific intervention and improvement strategies include:

1. Encourage and engage members in self-monitoring of blood pressure.
2. Encourage and engage members in improving medication management.
3. Provide a presentation and tools for staff in long term care facilities.
4. Promote customized quality improvement (QI) projects with subset of clinics.

Care Coordinator Role

The Diabetes BP PIP health plan collaborative would like to thank you for your active role with the MSHO, MS C+ and SNBC members. As you play an essential role in the health and well being of the members, we have listed the step-by-step activities for this project:

- Identify members with diabetes.
- Educate members with diabetes about the importance of blood pressure control as well as encourage them to track their blood pressure and take their results to their next practitioner visit.
- Encourage members with blood pressure $\geq 130/80$ mmHg to follow up with practitioner.
- Assist member in obtaining a home blood pressure monitor if prescribed by physician.
- Use risk lists supplied by health plans to work with members who are non-compliant with blood pressure medication.
- Provide tips for remembering to take their medications to members where appropriate.
- Document discussions about this topic in case notes, and document next steps for follow up on care plan.

Member and Provider Interventions

Bi-annual Member Activation Mailings^{1, 2}

Postcard 1: Focused upon self-management through blood pressure tracking.

Distribution: Sent in the mail during the first or early second quarter of each implementation year to all community members with diabetes.

Purpose: To encourage members to discuss with their practitioners what their optimal blood pressure should be (if no contraindications, will be 130/80 mmHg for members aged 75 years or less and will vary for those over 75 years) as a means to help them achieve their blood pressure goals through active tracking, including home blood pressure monitoring if prescribed by practitioner.

Postcard 2: Focused upon blood pressure medication management tools.

Distribution: Sent in the mail during the third or early fourth quarter of each implementation year to all community members with diabetes.

Purpose: To encourage members to comply with their blood pressure medication regimen and to initiate discussions with their pharmacist or practitioner about better ways to manage their blood pressure medications, including using Medication Therapy Management (MTM) services.

¹Mailings are pending DHS approval. Care Coordinators will receive copies of the postcards via email from their corresponding health plan prior to distribution to the member.

²Postcards will be reformatted into a flyer and translated into multiple languages for Care Coordinators to take to at-home visits.

Annual Communication to Eligible Members about MTM Services

Distribution: Sent in the mail during the first or early second quarter of each implementation year to eligible community members with diabetes.

Purpose: To encourage members with diabetes and on several medications to enroll in Medication Therapy Management (MTM) services.

Practitioner Internet-Based Training Series

Distribution: Sent to clinic staff via email by second quarter of implementation.

Purpose: To provide education and resources promoting the value of blood pressure self-monitoring (community and home monitoring). To supply techniques on how to have productive conversations with members about their self-monitored blood pressure results. To give population-specific information for practitioners working with members with disabilities and seniors.

Quality Improvement Toolkit for all Clinics

Distribution: Sent to clinic staff via email by third quarter of implementation.

Purpose: To encourage action that practitioners can take for better control of blood pressure in members with diabetes. The major focus areas of the QI toolkit will include the following:

- Support for member blood pressure self-monitoring
- Clinic process (rooming) changes to assure the most accurate blood pressure readings
- Institution of blood pressure monitoring and reporting processes
- Increased member referrals to Medication Therapy Management Services

Customized Quality Improvement Projects for Selected Clinics

Purpose: To work closely with selected clinics on improvement strategies through customized Quality Improvement projects.

Member and Provider Interventions (Continued)

Quality Improvement Presentation and Tools for Long Term Care Facilities

Distribution: Sent to long term care facility staff via email by the end of first quarter of implementation.

Purpose: To provide a presentation that long term care facilities can use to train staff on the importance of hypertension control for residents with diabetes.

Importance of Self-Monitoring Blood Pressure

Because several studies have shown that self-monitoring can help lower blood pressure (Cappucio et al, 2004; Fahey et al, 2006; McManus et al, 2005 and 2009; Pickering et al, 2008), self-monitoring will be recommended in this PIP. A cut-off card for tracking blood pressure readings at home or in the community will be part of the first member mailing. Members will be asked to complete the cut-off card and bring it to their next clinic appointment.

Members have many options for monitoring their own blood pressure. Some examples include: fire stations, grocery stores and drug stores. Many retail outlets offer free use of accurate devices requiring no training. Home blood pressure monitors are another possibility. They are prescribed at the discretion of practitioners. They are not appropriate for everyone. Any member who obtains one should be trained on proper techniques.

The first member mailing will encourage members to talk with their practitioners about whether they are a good candidate and – if their practitioner writes a prescription – to utilize their Durable Medical Equipment (DME) benefits to obtain a blood pressure monitor. Care coordinators can support this effort by discussing self-monitoring options and proper technique with members and by being familiar with the process of obtaining a home monitor (if prescribed) through a plan's DME vendor.

Importance of Activating/Motivating Members

There is wide agreement that patients who are informed and are active participants in their care (“activated”) have better outcomes, and that their health care is apt to cost less (Hibbard, 2004). Katz et al (2007) observed that patient activation has been shown to enhance patient satisfaction, perceived health, and adherence; decrease patients’ anxiety levels; and improve diabetes and hypertension management. Naik et al (2007) looked at factors to explain the significant gap between rates of blood pressure control resulting from routine diabetes care and those achieved in randomized controlled studies. The authors hypothesized that clinical inertia may be more common in practitioners’ interactions with passive patients, indicating that patients who take a more active role can impact how aggressively their practitioners treat their hypertension.

The health plan collaborative is urging care coordinators to use the information provided in this training to better inform members with diabetes about the importance of blood pressure control, and motivate them to participate more actively in their care.

ATTACHMENT A:
Blood Pressure Control for “Community” Members with Diabetes Talking Points:
A Guide for MSHO/MSC+/SNBC Care Coordinators

The following talking points may be helpful when consulting with clients about blood pressure self monitoring and medication adherence.

1. Include the following points when talking to ALL members with diabetes:

- If you have diabetes, you must pay close attention to your blood pressure. That is one of the best ways to keep from having serious problems. (As many as 2 out of 3 adults with diabetes have high blood pressure.)
- High blood pressure raises your risk for heart attack, stroke, eye problems, and kidney disease.
- Do you know your most recent blood pressure reading? You should have your blood pressure checked regularly. Do not miss any scheduled practitioner appointments.
- Do you keep track of your blood pressure readings? You will be receiving a blood pressure tracking card in the mail. This card is being sent to all of our members with diabetes because blood pressure management is very important for people with diabetes.
- Look for opportunities to have your blood pressure checked in the community - drug stores, health fairs, and even some churches offer blood pressure screenings. Record your results on the card.
- Remember to always share your recorded blood pressure readings with your practitioner.
- If you have diabetes and are between ages 18 and 75, controlling your blood pressure means keeping it under 130/80 mmHg. If you are 76 or older, talk with your practitioner about what your blood pressure goal should be.
- Know your blood pressure goal. Then do all you can to reach that goal.
- Eat healthy, be active and – if your practitioner has said you should take medicine – take your medicine every day.

2. Add the following talking points if your member has diabetes AND hypertension:

- Remember that high blood pressure, also called hypertension, is usually SILENT. You won't have symptoms unless it is dangerously high.
- Your best protection is to check your blood pressure often.
- Ask questions about your blood pressure when you visit your practitioner. (These questions and others: What is my blood pressure goal? What do I need to do to reach it? Why is it important for me to do this?)
- Discuss whether you should be monitoring your blood pressure yourself. If your practitioner thinks you should have a home blood pressure monitor, ask for a prescription.
- Some studies show that people who take their own blood pressure and pay attention to the numbers are more likely to keep their blood pressure under control.
- Be sure to take your medicines every day.

ATTACHMENT A (Continued):
Blood Pressure Control for “Community” Members with Diabetes Talking Points:
A Guide for MSHO/MSC+/SNBC Care Coordinators

3. If your member is identified as being at risk for medication noncompliance (RISK LIST MEMBERS), please inform their provider. (See suggested provider communication – Attachment B) Please be aware of any opportunities that you, the care coordinator/case manager, might have to enhance their current situation and promote medication compliance. Contact the member as soon as possible and include the following talking points:

- Do you ever have problems with getting or taking your medicines?
- Your medicines are VERY important. Talk to your practitioner about any problems you might have with taking your medicines. Call your practitioner’s office today if you are out of your medicines and not sure what to do next.
- Let me know if I can be of any assistance.
- Watch for a letter in the mail which talks about **Medication Therapy Management**. It is a new pharmacy service that can help you keep your medicines on the right track. At no charge to you, a pharmacist would talk to you about how and when you take your medicines. The letter will have a phone number to call for more information. I encourage you to think about signing up for this program.
- Have your blood pressure checked as soon as possible.
- Controlling your blood pressure can save your life.
- Taking your medicines correctly is one of the best ways to control your blood pressure.
- If you learn that a member is forgetting to take their medicine, here are some tips for remembering:
 - Take your medicine at the same time every day.
 - Take medicine along with meals or other daily events, like brushing your teeth.
 - Use a weekly pill box with separate compartments for each day or time of day.
 - As people close to you to remind you.
 - Use a medicine calendar near your medicine and make a note every time you take your dose.
 - Leave notes to remind yourself.
- Messages to address other barriers:
 - If you can’t afford your medicine, talk with your practitioner about options
 - If you can’t pick up your prescriptions, check to see if your pharmacy delivers, or if you can use a mail order service.

ATTACHMENT B:
Practitioner Communication
Suggested Wording for Care Coordinators

Provider Communication

For your RISK LIST members: Suggested notation to provider regarding a member identified at risk of medication noncompliance. This may be communicated via phone or included on any correspondence.

Your patient, _____, has the diagnosis of diabetes and hypertension. Based on a health plan review of pharmacy claims, it has been called to my attention that this member may not be taking their blood pressure medications as you have prescribed. Please address this issue of **potential medication noncompliance** with your patient and let me know if I can be of any assistance with this matter.

Thank you,
Your name
Your contact information.

ATTACHMENT C: ADA Fact Sheet

Link: <http://professional.diabetes.org/UserFiles/File/Make%20the%20Link%20Docs/CVD%20Toolkit/16-Treating-HBP.pdf>



Treating High Blood Pressure in People with Diabetes

Toolkit No. 16

An important part of taking care of yourself is keeping your blood pressure under control. High blood pressure—also called hypertension—raises your risk for heart attack, stroke, eye problems, and kidney disease. As many as 2 out of 3 adults with diabetes have high blood pressure.

Having your blood pressure checked regularly and taking action to reach your blood pressure target can prevent or delay diabetes problems.

What is high blood pressure?

Blood pressure is the force of blood flow inside your blood vessels. When your health care team checks your blood pressure, they record two numbers, such as 130/80 mmHg. You'll hear them say this as "130 over 80." Both numbers are important:

- The first number is the pressure as your heart beats and pushes blood through the blood vessels. Health care providers call this the "systolic" pressure.
- The second number is the pressure when the vessels relax between heartbeats. It's called the "diastolic" pressure.

When your blood moves through your vessels with too much force, you have high blood pressure. Your heart has to work harder when blood pressure is high, and your risk for diabetes problems goes up. High blood pressure is a problem that won't go away without treatment.

What is the recommended target for blood pressure?

Both diabetes and high blood pressure increase your risk of heart attack, stroke, and eye and kidney disease. Because of this, people with diabetes have a lower blood pressure target than the general public. The American Diabetes Association (ADA) and the National Institutes of Health recommend a target blood pressure of less than 130/80 mmHg for people with diabetes. When you keep your blood pressure below



Choosing foods wisely, being physically active, and taking medications are all part of treating high blood pressure.

130/80 mmHg, you'll be lowering your risk for diabetes problems.

How will I know if I have high blood pressure?

High blood pressure is a silent problem—you won't know you have it unless your health care provider checks your blood pressure. The ADA recommends that you have your blood pressure checked at every office visit, or at least two to four times a year. Keep track of your blood pressure by recording the results of your checkups here.

ADA blood pressure target: Below 130/80 mmHg		
Office Visit	My Results	My Target
Date:		
Date:		
Date:		
Date:		

What treatments are recommended?

Both lifestyle changes and medication help control blood pressure. Treatment differs from one person to the next. Work with your health care provider to find a treatment that's right for you.

Lifestyle changes

Lifestyle changes can help control your blood pressure as well as your blood glucose (sugar) and blood lipid (cholesterol and triglyceride) levels. Place a check mark next to steps you're willing to try.

Make wise food choices

- I'll eat a serving of fruit at each meal.
- I'll eat one or two servings of vegetables at lunch and at dinner.
- I'll switch to low-fat or fat-free dairy products (such as low-fat cheese and skim milk).
- I'll eat whole-grain breads (such as whole-wheat bread) and cereals.
- I'll eat nuts or peanut butter sometimes.
- I'll choose lean meats and meat substitutes (such as chicken without the skin, fish, lean beef such as flank steak or chuck roast, boiled ham, or pork tenderloin).
- I'll cook using low-fat methods such as baking, roasting, broiling, or grilling.
- I'll add little or no salt to my food at the table and during cooking.
- I'll try herbs and spices instead of salt.
- I'll check food labels and choose foods with less than 400 mg of sodium per serving.

Lose weight or take steps to prevent weight gain

- I'll cut down on calories and fat.
- I'll try to be more physically active than I am now.

Be physically active

- Before I start a new routine, I'll check with my doctor to find out which activities will be safe for me.
- I'll try to do a total of about 30 minutes of aerobic exercise, such as brisk walking, most days of the week. If I'm just starting out, I'll begin with 5 minutes a day and gradually add more time.

Be careful with alcohol

- I'll talk with my health care team about whether it's wise for me to have alcoholic beverages.
- If and when I drink alcoholic beverages, I'll limit myself to 1 serving a day (for women) or 2 servings a day (for men).

Quit smoking

- I'll talk with my health care team about methods that can help.

Medications

Several types of medications are available. Not everyone takes the same blood pressure medication, and many people take more than one kind. Which ones you take will depend on your blood pressure readings and other factors such as cost.

- **ACE inhibitors**—These medications lower blood pressure by keeping your blood vessels relaxed. ACE inhibitors prevent a hormone called angiotensin from forming in your body and narrowing your blood vessels. These medications also help protect your kidneys and reduce your risk of heart attack and stroke.
- **ARBs**—These medications keep the blood vessels open and relaxed to help lower blood pressure. Like ACE inhibitors, ARBs also protect your kidneys.
- **Beta blockers**—These medications help lower blood pressure and relax your heart by allowing it to beat slower and less forcefully. Beta blockers help prevent heart attack and stroke.
- **Calcium channel blockers**—These medications help the blood vessels relax by keeping calcium out of your blood vessels and heart.
- **Diuretics**—These medications, sometimes called “water pills,” help rid your body of extra water and sodium through urine.

