Improving Measure Outcomes: Managing Chronic Disease Strategies for Blood Pressure and Diabetes Control

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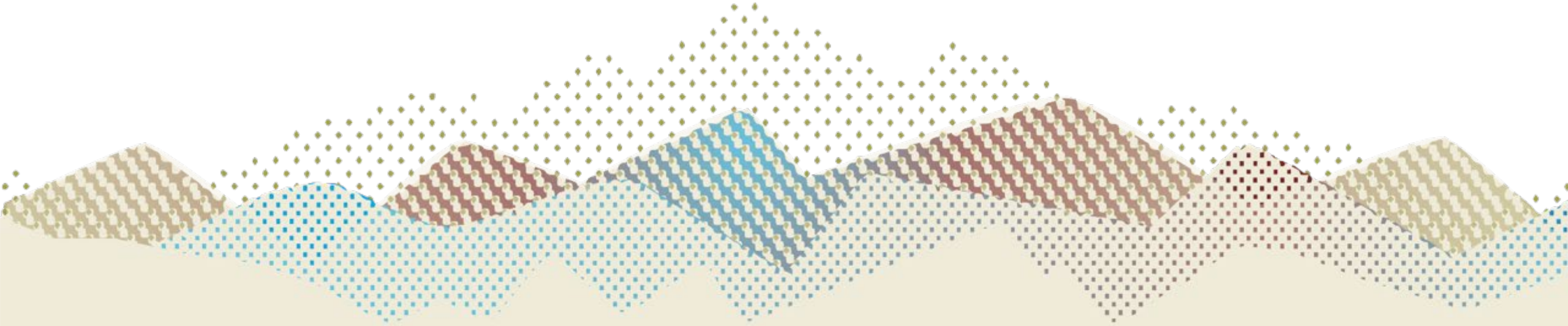


Learning Objectives

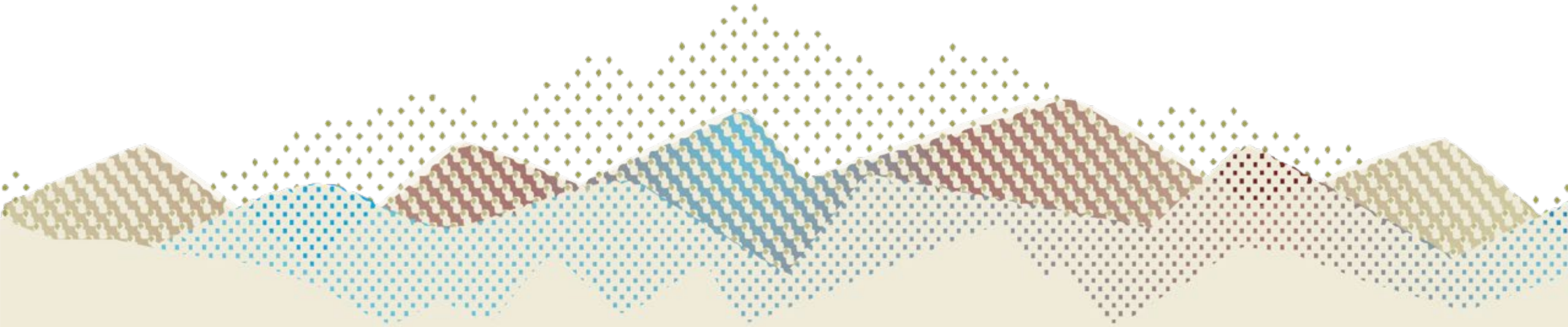
- Understand the clinical background, quality measure specifications, and performance 2026 thresholds for the Provider Quality Incentive Program measures:
  - ***Controlling High Blood Pressure***
  - ***Blood Pressure Control for Patients with Diabetes***
  - ***Comprehensive Diabetes Management – HbA1c Good Control***
  - ***Diabetes Retinal Exam***
  - ***Kidney Health Evaluation for Patients with Diabetes***
- Apply quality measure specifications to improve adherence and performance across chronic disease measures in controlling high blood pressure and comprehensive diabetes management while understanding the role of Partnership's programs and resources in supporting sites in closing care gaps.

Learning Objectives

- Evaluate the prevalence, risk factors, and health inequities associated with high blood pressure, managing diabetes including evaluation of kidney health, risk factors for diabetes mellitus and related diabetic conditions and associated health inequities prevalent in their diagnosis and treatment.
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications and controlling high blood pressure.
- Examine how cultural and lifestyle factors, such as diet, access to care, and historical marginalization contribute to disproportionate rates of chronic disease and screening gaps.

Improving Measure Outcomes: Managing Chronic Disease Strategies Hypertension

Matthew Morris, MD, Regional Medical Director



History of Hypertension

https://www.britannica.com/topic/Huangdi

- Awareness of blood pressure dates back to the Chinese Yellow Emperor's Classic of Internal Medicine (2600 BCE).
- Original treatments included acupuncture, blood letting, and leeches.
- Hypertension remains one of the most commonly treated conditions.

Bakris GL, Weber MA. Overview of the evolution of hypertension: from ancient Chinese emperors to today. *Hypertension*. 2024;81(4):717-726.

Hypertension Fast Facts

Hypertension affects approximately one-half 48.1% of U.S. adults.

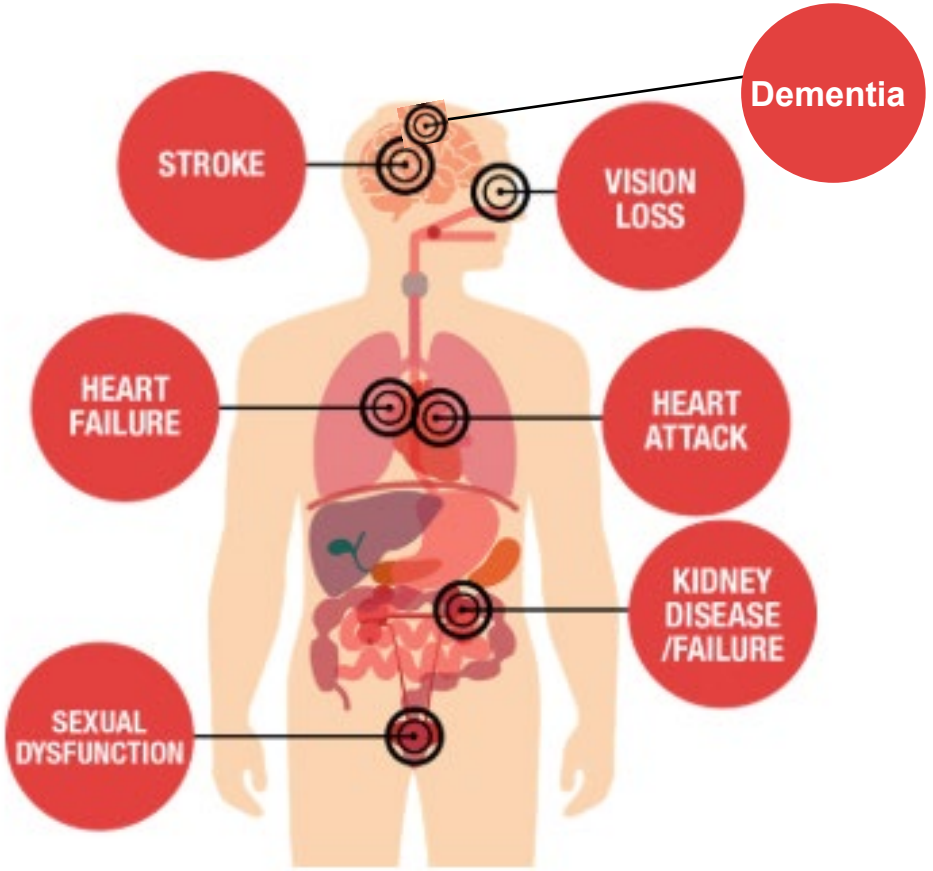
Of those with hypertension, 77.4% are uncontrolled.(1)

Primary hypertension risk factors include advancing age, obesity, family history, nutrition, physical inactivity, insufficient sleep, and history of gestational hypertension or preeclampsia.

Common causes of *secondary hypertension* include obstructive sleep apnea, kidney disease, alcohol, and certain medications (i.e., NSAIDs, oral contraceptives, steroids).

Centers for Disease Control and Prevention (CDC). Hypertension cascade: hypertension prevalence, treatment and control estimates among US adults aged 18 years and older: applying the criteria from the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2017–2020. May 12, 2023. Accessed August 2, 2024.

Clinical Importance



Source: American Heart Association

Definitions

Blood Pressure Levels			
The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 2003/2014 Guideline)		*The American College of Cardiology/American Heart Association Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (ACC/AHA 2025 Guideline)*	
Normal	< 120/80 mm Hg	Normal	< 120/80 mm Hg
Elevated	≥ 120/80 mm Hg	Elevated	≥ 120/80 mm Hg
Stage 1 Hypertension*	≥ 140/90 mm Hg	Stage 1 Hypertension*	≥ 130/80 mm Hg

Making the Diagnosis

1. Patient to avoid caffeine, exercise, and smoking 30 minutes before measurement and ensure patient has emptied their bladder.
2. Use a validated device and correct cuff size, over a bare arm.
3. Arm should be supported at heart level.
4. Have patient relaxed, sitting in chair with feet on the floor and back supported, for more than five minutes.
5. Neither the patient or clinician should be talking, and the patient should not be on their phone.

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Making the Diagnosis

- Use of ≥ 2 BP readings on ≥ 2 occasion should be used to diagnosis hypertension.[1]
- Office blood pressure measurements consistent with hypertension, should be confirmed with home or 24-hour ambulatory measurements whenever possible.[2]

1. Krist AH, Davidson KW, Mangione CM, et al. Screening for hypertension in adults: US Preventive Services Task Force reaffirmation recommendation statement. *JAMA.* 2021;325(16):1650-1656.
2. Kronish IM, Hughes C, Quispe K, et al. Implementing ambulatory blood pressure monitoring in primary care practice. *Fam Pract Manag.* 2020;27(3):19-25.

Hypertension Treatment

- Lifestyle Interventions:
  - If overweight or obese (based on BMI) target an initial goal of ≥5% weight loss.
  - Encourage heart healthy nutrition DASH or Mediterranean Diet.
  - Encourage physical activity.
  - Limit alcohol intake to ≤1 drink per day for women and ≤2 drinks per day for men.
  - Stop tobacco use.

Hypertension Treatment

Table 6: Lifestyle Modifications and Associated Blood Pressure Reduction in Patients With Hypertension

Intervention*	Approximate Mean Reduction in Systolic Blood Pressure**
Weight Loss	1 mm Hg per 1 kg of weight loss
Sodium Restriction	6-8 mm Hg
DASH Diet	5-8 mm Hg
Reduced Alcohol Consumption	4-6 mm Hg
Aerobic Exercise	4-8 mm Hg
Stress Reduction	5-7 mm Hg

Abbreviation: DASH, Dietary Approaches to Stop Hypertension.

* Blood pressure effects are for interventions which follow the general parameters defined by professional organizations. Blood pressure response will vary depending on the patient's adherence and level of commitment to each intervention of interest.

** Eligible patient populations vary across interventions, so the comparative efficacy of the mean blood pressure reductions should be interpreted with caution.

References - Circulation 2025 Aug 14, Eur Heart J 2024 Oct 7;45(38):3912.

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Hypertension Treatment

- Medication Management:
  - Thiazide-type diuretic
  - ACE inhibitors
  - ARB's
  - Dihydropyridine calcium channel blocker

*Beta-blockers are not a first line treatment in patients without other indications.

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

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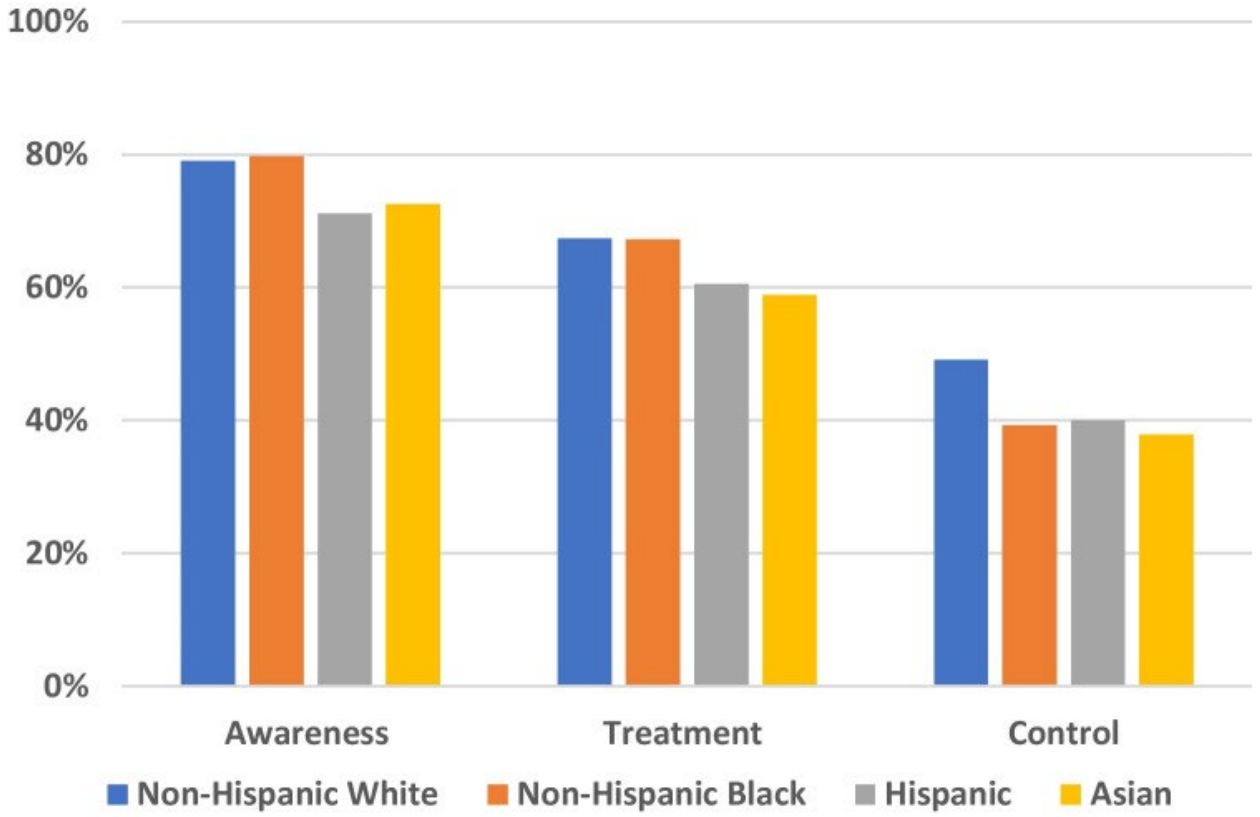
Self-Measured Blood Pressure Monitoring (SMBPM)

- Can reduce high blood pressure, improve patient knowledge, and enhance medication adherence.
- Associated with empowerment, autonomy, and self efficiency.
- Can improve adherence to lifestyle changes.

https://hdsbpc.cdc.gov/s/article/Evidence-of-Impact-for-Self-Measured-Blood-Pressure-Monitoring-With-Clinical-Support

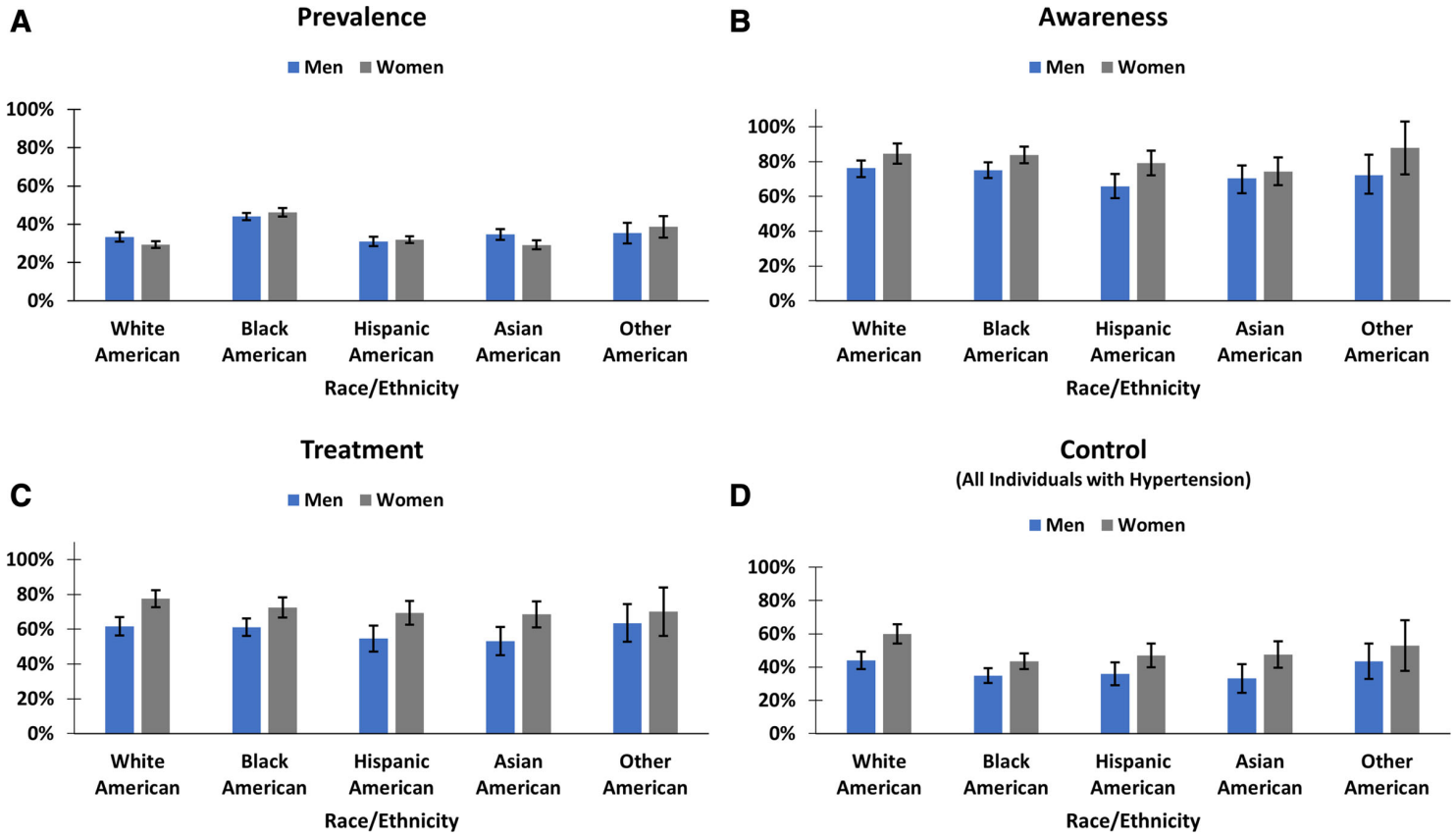
Health Disparities

- Blood pressure control rates have worsened in the U.S. over the last decade, with significantly lower rates of control among minority groups.



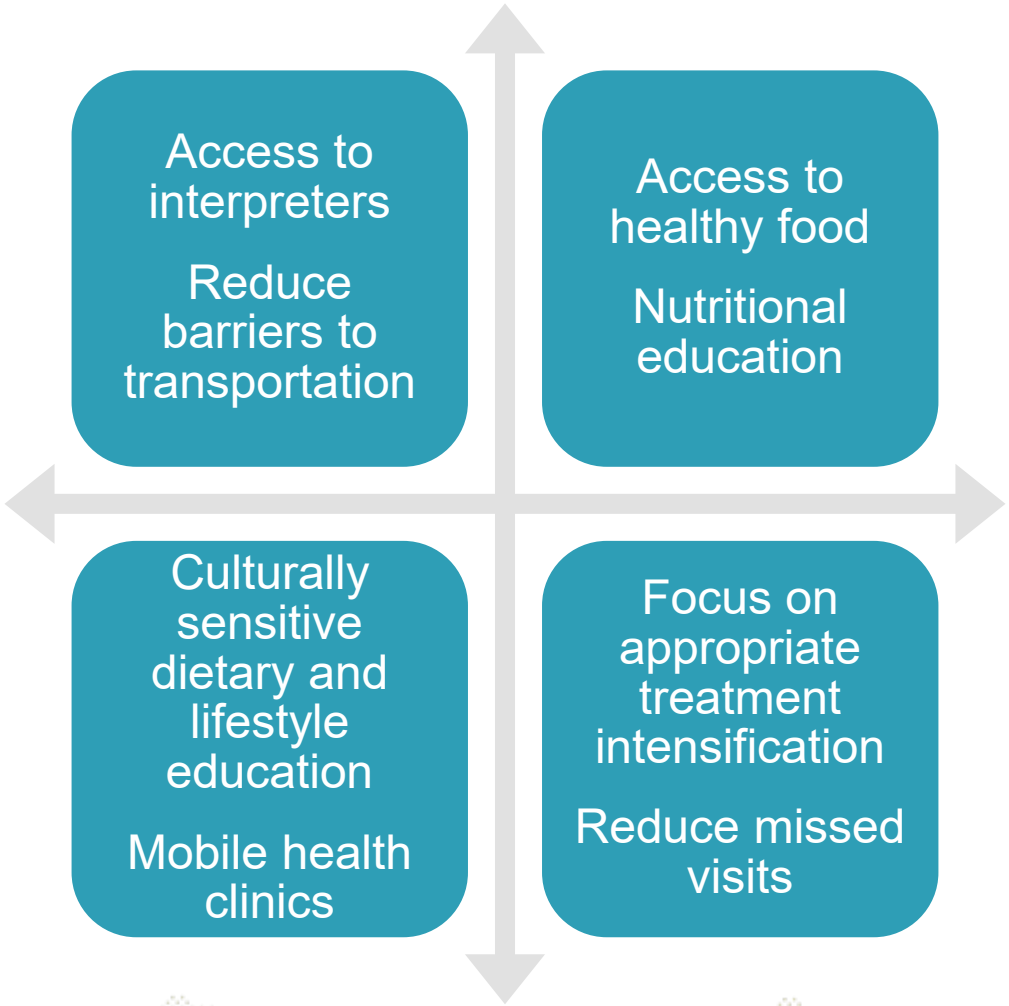
Abrahamowicz AA, Ebinger J, Whelton SP, Commodore-Mensah Y, Yang E. Racial and Ethnic Disparities in Hypertension: Barriers and Opportunities to Improve Blood Pressure Control. Curr Cardiol Rep. 2023 Jan;25(1):17-27. doi: 10.1007/s11886-022-01826-x. Epub 2023 Jan 9. PMID: 36622491; PMCID: PMC9838393

Health Disparities



Aggarwal R, Chiu N, Wadhera RK, Moran AE, Raber I, Shen C, Yeh RW, Kazi DS: Racial/Ethnic Disparities in Hypertension Prevalence, Awareness, Treatment, and Control in the United States, 2013 to 2018. Hypertension 2021, 78:1719–1726.

Potential Drivers of Disparities



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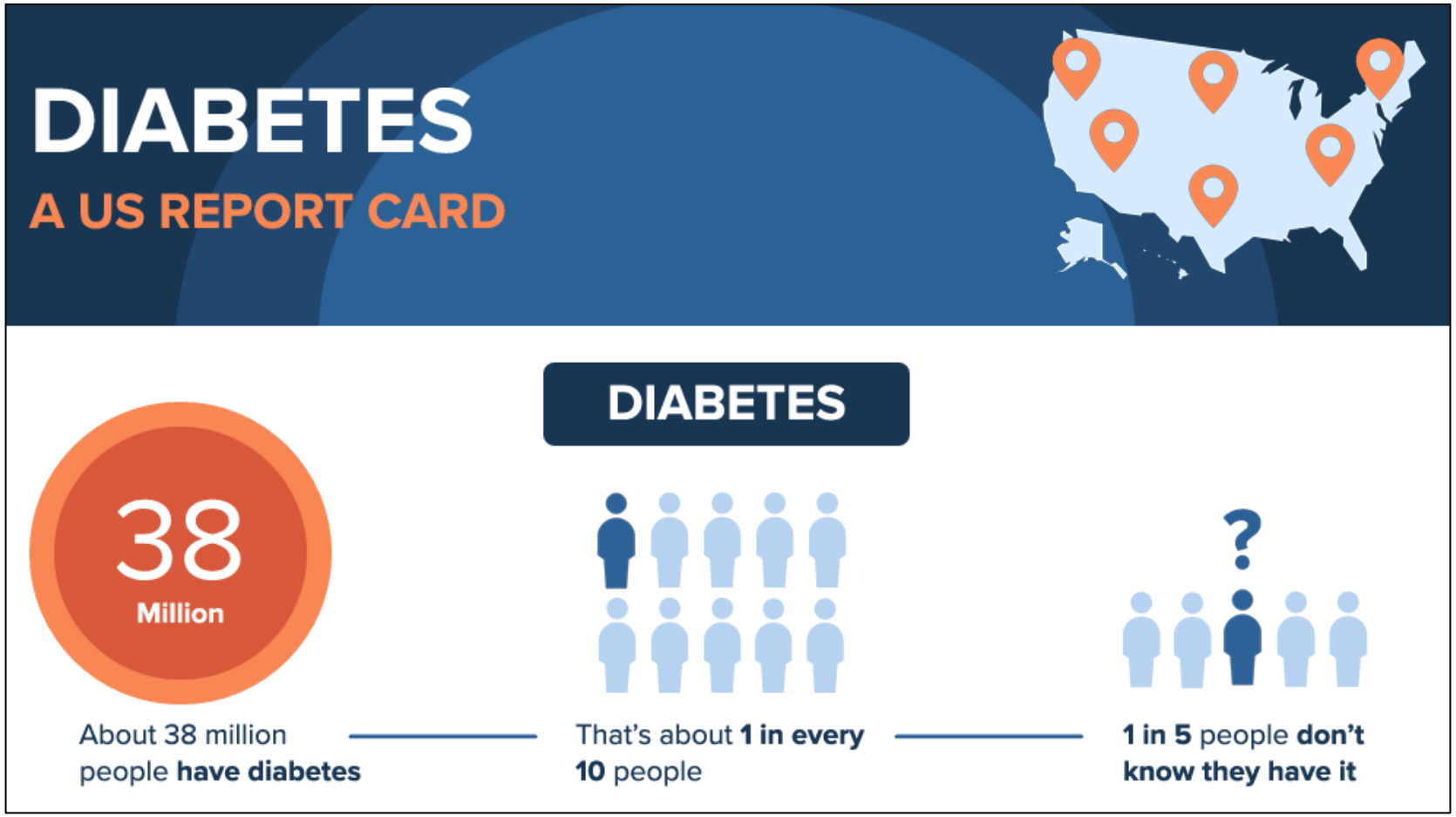
Overview of Clinical Guidelines for Comprehensive Diabetes Management

Prevalence of Diabetes in the U.S.



https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html

Risk Factors for Diabetes

Obesity, body fat distribution	Western diet, sugar-sweetened beverages	History of diabetes in pregnancy, family history of diabetes
Heart disease	Metabolic syndrome, polycystic ovarian syndrome	Certain medications / steroids, like prednisone

Fast Facts

- **Diagnosis**
  - Blood tests that show blood sugar is consistently elevated
    - Blood Sugar
      - ≥ 126 mg/dL fasting
      - ≥ 200 mg/dL 2 hr OGT
    - HbA1C ≥ 6.5% Measures glycosylated hemoglobin
- **Components of Treatment**
  - Nutrition and activity changes
  - Oral medications
  - Injectable medications
- **Impacts of Poorly Controlled Diabetes**
  - Fatigue, low energy
  - Retinopathy / blindness
  - Kidney disease
  - Neuropathy
  - Heart disease
  - Stroke and dementia
  - Poor wound healing
  - Infection

HbA1C Good Control

Individualizing treatment based on specific patient factors is essential.

An A1C goal for many non-pregnant adults of <7% without significant hypoglycemia is appropriate.

Higher A1C goals (such as <8%) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits.

American Diabetes Association Clinical Care Guidelines 2023

https://doi.org/10.2337/cd23-as01

Diabetic Retinopathy

- Screenings:
  - *Type 1 Diabetes*: annual screenings beginning five years after diagnosis onset
  - *Type 2 Diabetes*: annual screenings beginning immediately

- Patient education about the connection between glucose and blood pressure control is essential to decrease the risk of retinopathy or progression.

- Preferred screening method is digital retinal photography.

Kidney Health Evaluation for Patients with Diabetes

Follow Up	Educate On	Controlling	Take	Offer	Limit	Coordinate
Follow up with patients to discuss and educate on lab results.	Educate on how diabetes can affect the kidneys and offer tips to your patients on preventing damage to their kidneys. Use the National Kidney Foundation educational flyer.	Controlling their blood pressure, blood sugars, and cholesterol.	Take medications as prescribed that can protect kidney function (ACE inhibitors or ARBs).	Offer education on medications that could be harmful to the kidneys (NSAIDs such as naproxen or ibuprofen).	Limit protein intake and salt in diet. Consider specialized diet options: DASH and Mediterranean diets for better heart and metabolic health.	Coordinate care with specialists, such as an endocrinologist or nephrologist, as needed.

https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/health-care-performance-measures/hedis/kidney-health-evaluation-patients-diabetes

Health Disparities and Inequities

Why Collect Demographics Data

- Capturing demographics data like language, race, ethnicity at the organization / clinic level may assist with:
  - Identifying race / ethnicity related disparities
  - Enhancing availability of interpreters and translated, health-education member-facing materials
  - Adaptation of existing services to better meet the cultural and health needs of members
  - Improve community relations
  - Improve member-clinician communication
  - Improve member satisfaction

Disparities in Diabetes Rates and Complications

Diabetes Statistics by Race / Ethnicity – National	Black / African American (2021)	Native American / Alaskan Native (2018)	Hispanic (2018)	Non-Hispanic White (2021)
DM Diagnosis (percent of adult population)	12.7	23.5	13.2	7.0
Death Rate due to DM (per 100K)	38.8	43.7	24.6	19.1
Visual Impairment	18.4	Not Reported	31.6	16
End Stage Kidney Disease (per million)	437.2	274.9	267.7	111.8

CDC 2022. National Diabetes Surveillance System and 2021.
Summary Health Statistics: National Health Interview Survey
https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html#

Health Disparities – Potential Drivers

- Barriers to diabetic care include:
  - Access to healthy food options impact inequities in management and control
  - Limited health care access
  - Poor control seen in those without a PCP visit >1 year
  - Dietary patterns by race and ethnicity
  - Implicit bias, racism
  - Culturally congruent care (providers reflect culture)
  - Concerns with language and immigration status
  - Poverty, unequal access to health care
  - Lack of education
  - Lack of transportation
  - Difficulty to take time off work for care – financial stressors (transportation associated costs, reduction in pay)
  - Competing priorities, including caring for other children, school schedules, and caregiver's own medical needs

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Overview of Measures:
QIP Specifications, Tools, and Resources

Measure Specification – HbA1c Good Control

- Importance
  - Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death (National Diabetic Statistics Report, 2020).
  - **Denominator:** The number of continuously enrolled assigned members 18 – 75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1951, and December 31, 2008).
  - **Numerator:** The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1c ≤ 9.0% during the measurement year.
- Partnership's Clinical Practice Guidelines for diabetes mellitus: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Measure Specification – Retinal Eye Exam

- Importance
  - Left unmanaged, diabetes can lead to serious complications, including blindness (National Diabetic Statistics Report, 2020).
  - **Denominator:** The number of continuously enrolled Medi-Cal members 18 – 75 years of age (DOB between January 1, 1951, and December 31, 2008) with diabetes identified as of December 31 of the measurement year.
  - **Numerator:** An eye screening for diabetic retinal disease as identified by administrative data.
- Partnership's Clinical Practice Guidelines for diabetes mellitus: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Measure Specification – Kidney Health Evaluation

- Importance
  - KED measure is critical because diabetes is the leading cause of Chronic Kidney Disease (CKD), affecting 20 – 40% of diabetics. Annual KED evaluations (combined eGFR and uACR tests) enable early detection of kidney damage to prevent or delay progression to kidney failure, heart disease, or stroke.
  - **Denominator:** The percentage of members 18 – 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.
  - **Numerator:** There are two ways to identify members with diabetes: by claim / encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Measure Specification – Controlling High Blood Pressure

- Eligible Readings Include:
  - Outpatient visits, telephone visits, virtual check-ins, or remote monitoring taken by **any digital device**.
  - Multiple readings for a singe date: use the lowest systolic and diastolic BP.
    - Example: BP readings on 5/30/23 were 140/**80**, 138/90, and **130**/87.
      - Use 130/87

Comprehensive Diabetes Control: PCP QIP Measure Exclusions

- Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2024 – December 31, 2025) and who meet either of the following criteria:
  - Members receiving palliative care during the measurement year
  - Members who had an encounter for palliative care any time during the measurement year
  - Members aged 66 and older by the end of the measurement period, with frailty and advanced illness

Primary Care Provider Quality Improvement Program

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2026 PCP QIP

Webinars

PCP QIP Webinars

Upcoming Webinars and Trainings

On Demand Courses

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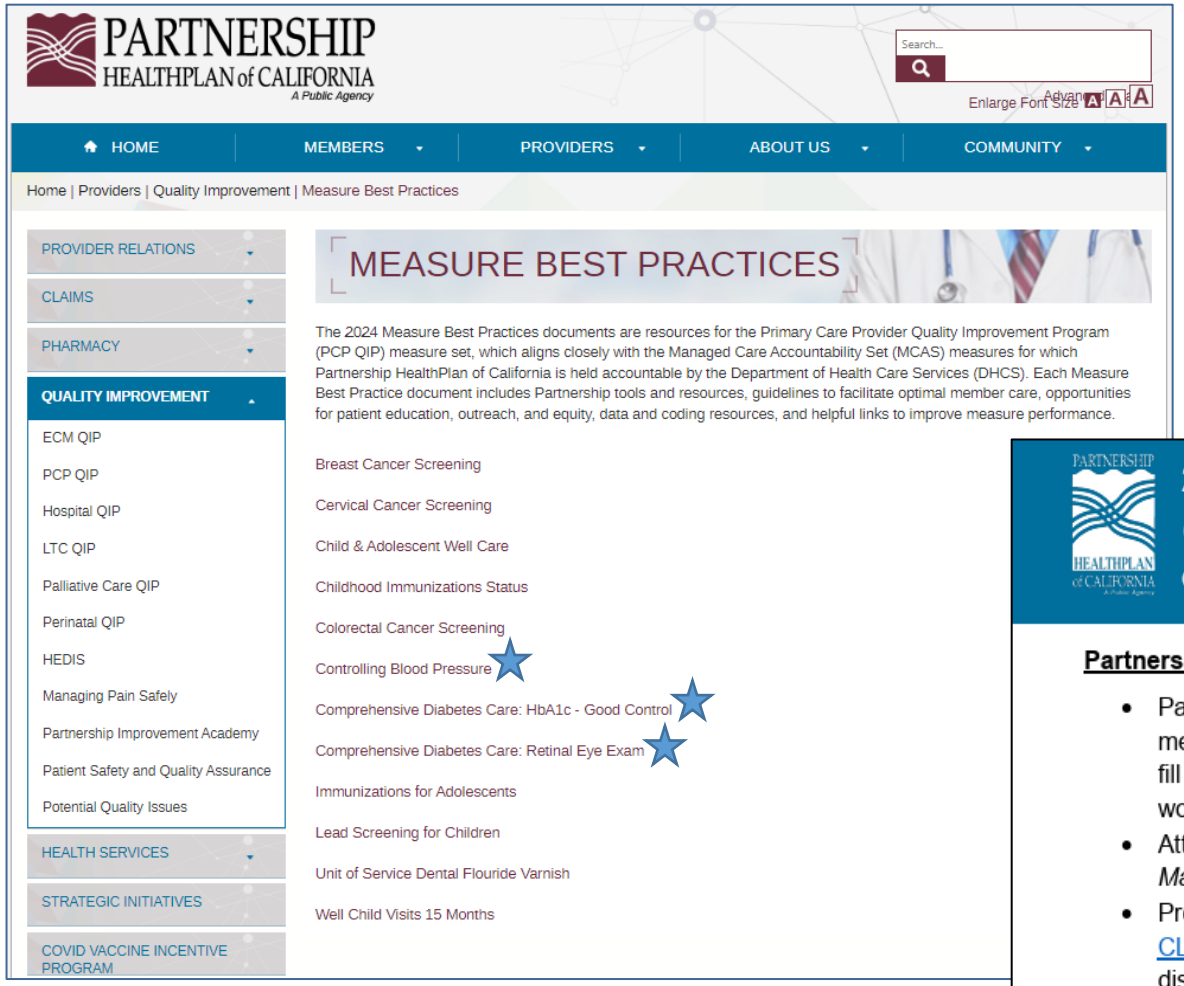
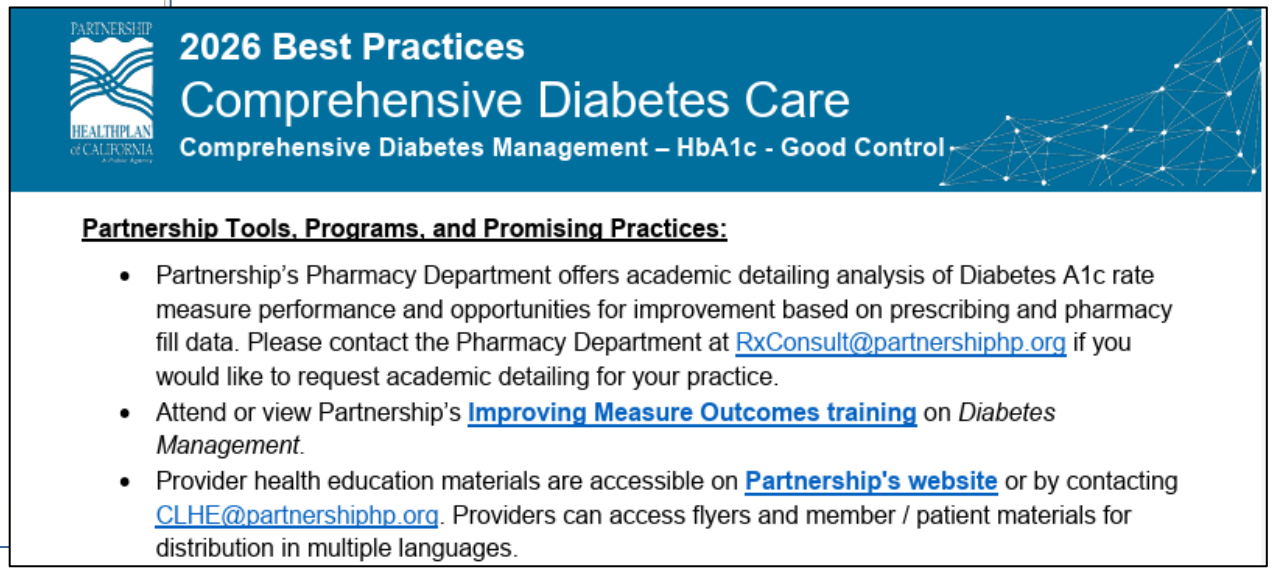
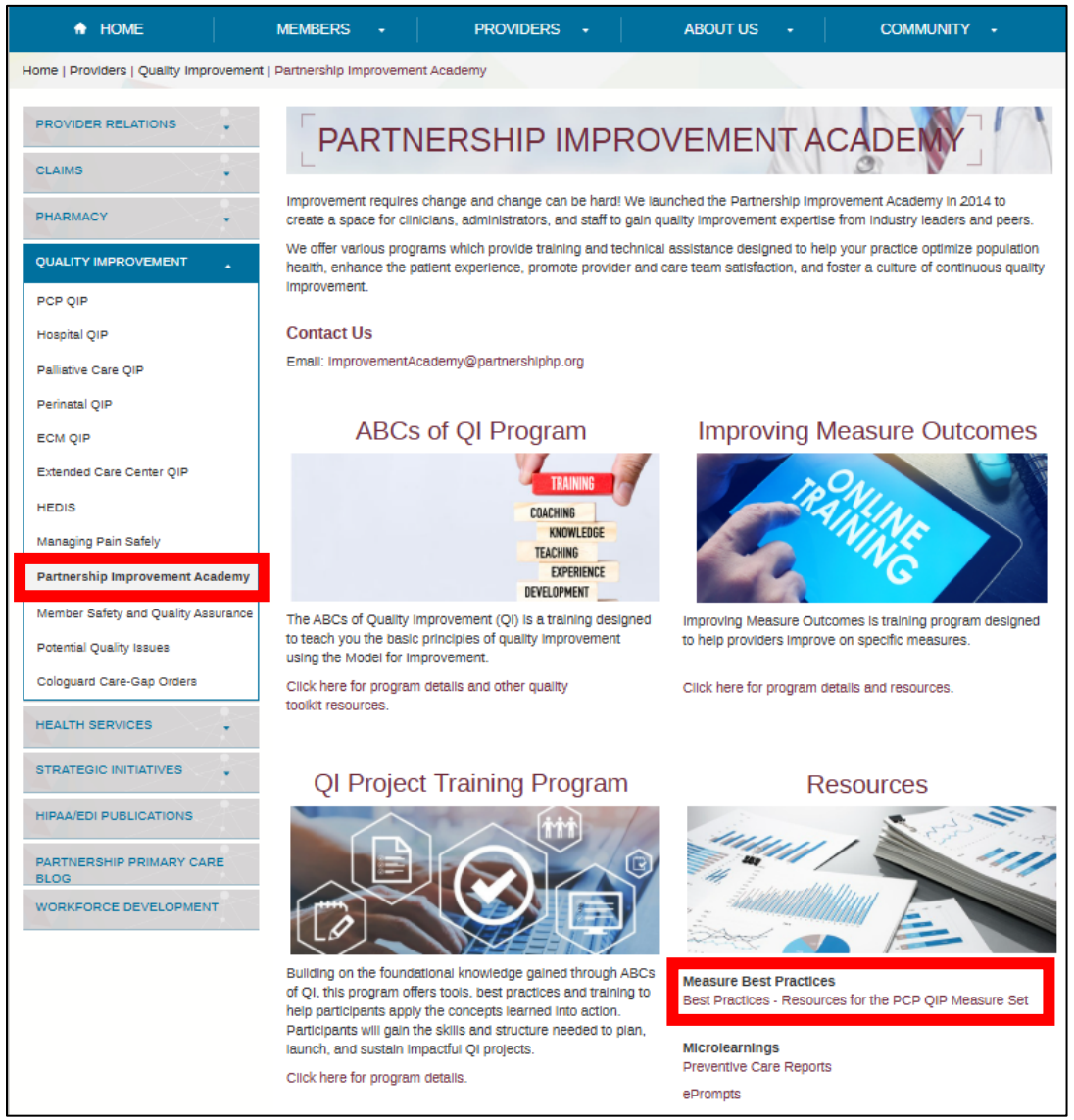
Putting Quality Into Practice

Measure Best Practices





Partnership Improvement Academy Landing Page



To visit this page and access the Measure Best Practices section, click here.

Care Gap Identification by Staff

- Best practice for pre-visit and/or check-in processes is to identify needed care gaps within the PCP QIP. This can be done two ways:
  - **eReports > Member Search**
    - Provide staff involved in these processes with access to eReports. They can conduct a member search and will display the care gaps from the PCP QIP
    - Access to eReports can be given by your organization's designated eAdmin
  - **Provider Online Services > ePrompts**
    - Ensure staff involved with insurance verification knows about and utilizes ePrompts within the Provider Online Services
    - Access to Provider Online Services is provided by your Provider Relations Representative
    - Not all PCP QIP clinical measures transmit to ePrompts
    - **Short Video Training** (6 minutes)

Measure Best Practices – Diabetes Management

Outreach

- Designate a team member to contact patients due for testing (phone call, post card, letter signed by provider, text).
- Call patients within a week to reschedule missed in-house blood draws.

Patient Education

- Reinforce medication use and physical activity.
- Refer to nutrition education, in-house, or via telehealth.
- Reinforce the importance of self-testing and self-management.
- Inform member/patient that all services included in comprehensive diabetic care, including vision, diabetic footwear, medical nutrition therapy and approved monitoring devices including continuous glucose monitors and insulin pumps, are covered benefits under Medi-Cal.

Measure Best Practices: Short-Term Strategies

- Take blood pressures at every visit, multiple times if out of normal range.
- Provide blood pressure clinics with MAs.
- Create EMR alerts and flags for patients with hypertension.
- Work your gap lists to outreach; follow-up on no-shows.
- Upload data beginning in October.
- Confirm health information, medication management, and next steps for those who screen high.
- Re-assess blood pressure every three months if target is achieved.

Measure Best Practices: Long-Term Strategies

- Use a remote monitoring blood-pressure cuff program.
- Offer telehealth for management visits as appropriate.
- Collaborate with multidisciplinary teams for management (RN, RD, and Pharmacy).
- Enroll in Chronic Case Management.
- Reinforce patient education with diet, smoking cessation, physical activity, and medication management.
- Promoting Academic Detailing around blood pressure management.

Measure Best Practices – Health Equity Focus

- Address transportation barriers.
- Continue to educate about preventive services and dispel myths.
- Review measure adherence rates by race, ethnicity, location (zip code), and preferred language to address potential barriers.
- Consider how member information is presented.
- Partner with community organizations that share your goals.
- Address access issues.

Additional Resources

- To contact the PCP QIP Team, email QIP@partnershiphp.org.
  - eReports access
  - Measure specification questions
- For coaching resources related to improving measure performance, email the Performance Improvement Team at pit@partnershiphp.org.
  - Coaching, measure best practices, sounding board, project planning guidance, facilitation
- Partnership Quality Dashboard (PQD) User Guide
- PCP QIP Webinars Page: 2026 Kick-Off Webinar recordings are now available for PCP QIP and eReports

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Voices of the Field

Mountain Valley Health Centers

CONTROLLING
High Blood Pressure Project

QUALITY IMPROVEMENT PROJECT
TULELAKE HEALTH CENTER

Mountain Valleys
HEALTH CENTERS

Project Aim

- By December 30, 2025, improve blood pressure control among clinic patients
- Increase percentage of patients with BP <140/90 from 54% to 72%
- Focus on consistent workflows and staff engagement

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Measures

- Outcome Measure: Percentage of patients with BP under good control (<140/90)
- Process Measure: Percentage of BP rechecks performed when initial BP ≥140/90
- Process Measure: Percentage of staff following the 10-minute recheck process

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Improving BP control required

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1. STANDARDIZED WORKFLOWS
2. ONGOING STAFF AND PATIENT EDUCATION IS ESSENTIAL
3. CONSISTENT PROVIDER ENGAGEMENT SUPPORTS SUSTAINED IMPROVEMENT

Changes Tested

- Purchased dedicated staff timers for BP rechecks
- Implemented 10-minute wait before BP recheck for readings ≥140/90
- Ensured consistent documentation of rechecks

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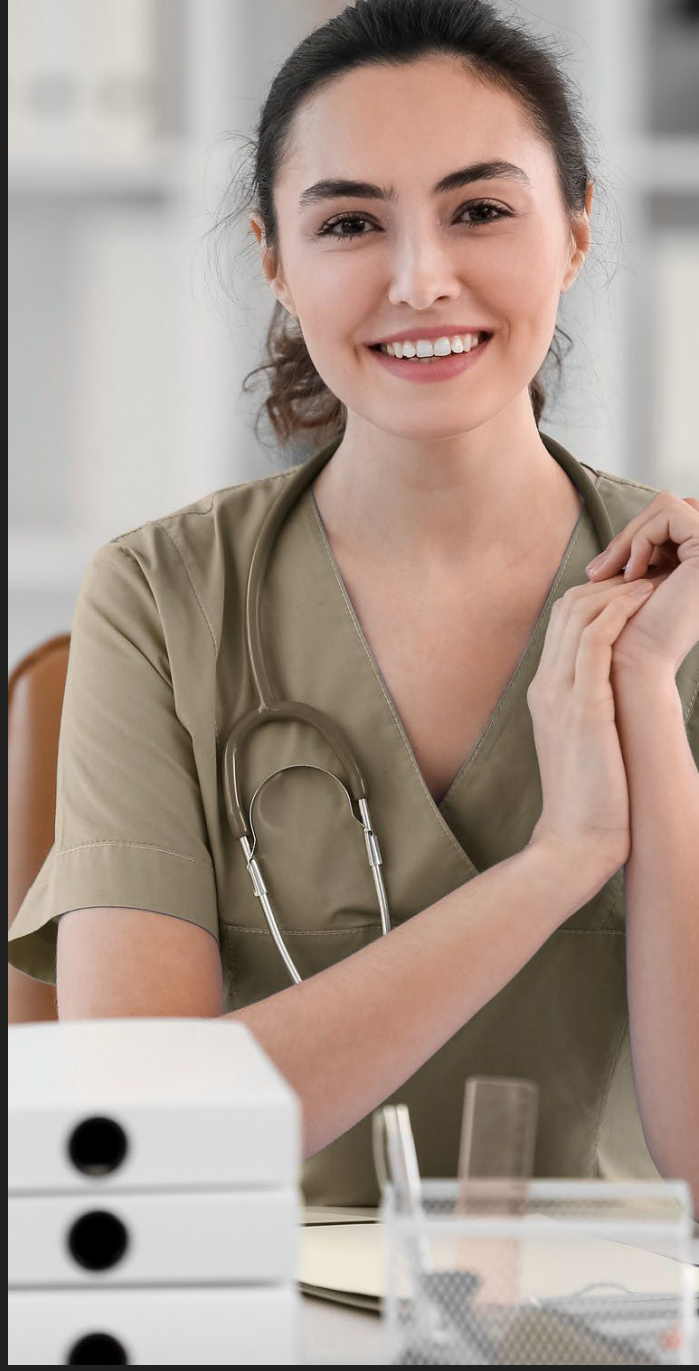

Provider Notification Workflow

- 10-second huddle immediately after initial BP is obtained
- Provider notified of elevated BP reading
- Provider informed that BP will be rechecked in 10 minutes
- Staff re-enters exam room during visit to complete recheck

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Visual Cues

- Door hangers used to alert providers that a BP recheck is needed
- Door hanger placed inside exam room door
- Serves as reminder for both provider and patient

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Results

- February–April: BP control improved by 20%
- Increase from 17.14% to 42.86%
- Improvement continued through September
- Achieved 72.09%, exceeding QIP goal ahead of schedule

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What We *Learned*

- Extensive staff training improved BP measurement accuracy
- Identified posture and cuff size issues requiring correction
- Staff defaulted to incorrect cuff sizes when unavailable
- Administrative team confirmed availability of full cuff size ranges
- Providers reminded to obtain second BP readings for consistency

Audit & Feedback Process

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1. Quality team conducted audits every two weeks
2. Audit results shared transparently with staff
3. Balanced feedback: addressed gaps while highlighting successes
4. Used positive reinforcement and 'pats on the back' to maintain momentum

Troubleshooting & Provider Buy-In

- Identified provider hesitation with borderline elevated readings (e.g., 142/90)
- Reinforced that even mildly elevated readings require rechecks
- Engaged CMO to reinforce clinical importance and project expectations
- Achieved provider buy-in after consistent reinforcement over several months

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DATA SHARING & *Sustainability Lessons*

- Observed decline in second BP readings when audit data was not shared
- Confirmed that regular feedback is essential for sustained improvement
- Established need for monthly audit reporting moving forward
- Audit results used as both accountability and coaching tools

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Future Plans

- Continue reinforcing BP recheck workflow during huddles and meetings
- Implement MA training on proper blood pressure measurement technique
- Assign the Nurse Manager to monitor, track, and ensure competency validation
- Conduct direct observation of blood pressure measurement to identify workflow gaps and technique inconsistencies
- Use observation findings to inform targeted process improvements and guide next-phase interventions

Thankyou

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Upcoming Trainings

Improving Measure Outcomes Webinar Series

The Improving Measure Outcomes learning series is designed to help quality improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes

2026 Webinar Schedule

All webinars are held from noon to 1 p.m.

April 8, 2026 – Sexual and Reproductive Health
April 22, 2026 – Improving Perinatal Outcomes

**Continuing education credits available.*

For details and registration, visit Improvement Academy's event page.
Questions? Email improvementacademy@partnershiphp.org

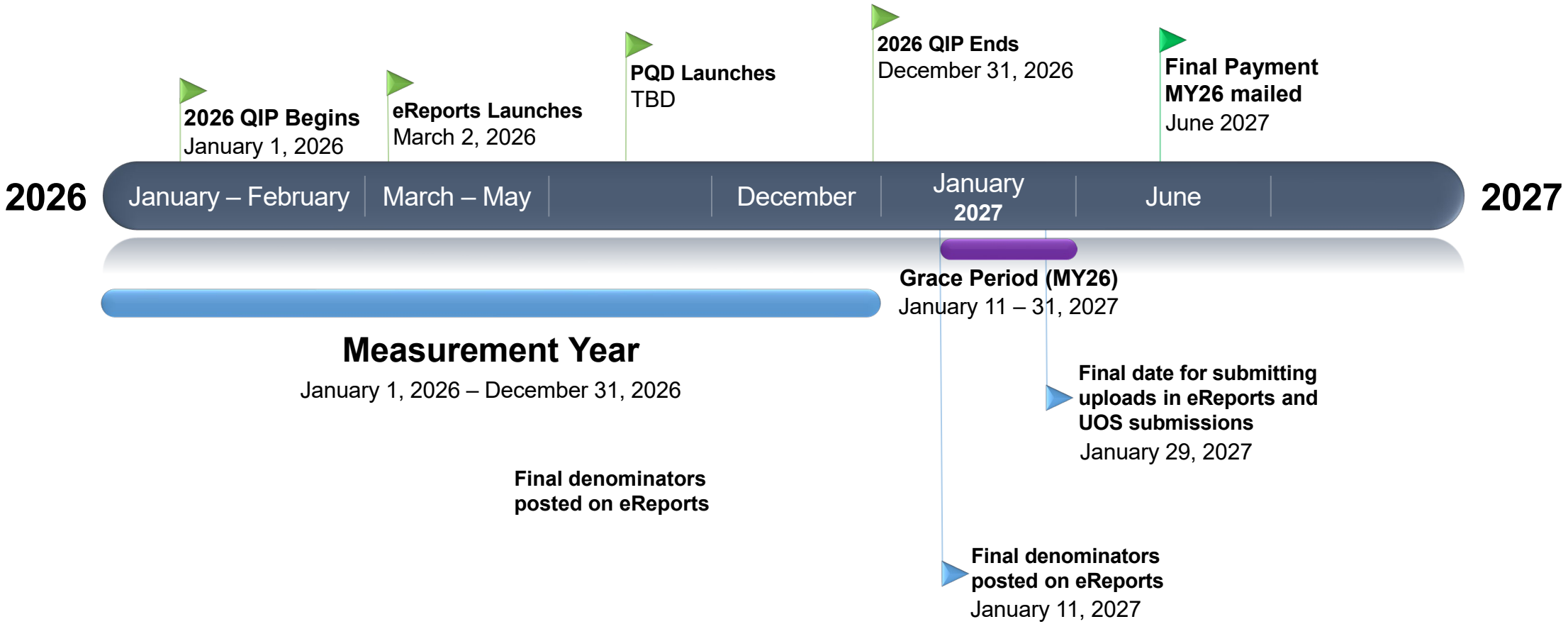
ABCs of Quality Improvement

- An in-person training designed to introduce participants to key Quality Improvement (QI) methodologies, with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings.

Thursday, May 14, 2026
8 a.m. – 4 p.m.
Auburn

REGISTER HERE

PCP QIP Timeline



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- Performance Improvement Team
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- Quality Incentive Program
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Evaluation

Your feedback is important to us!