

Measure Up/Pressure Down™ response to release of **2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)**

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<http://jama.jamanetwork.com/article.aspx?articleid=1791497>

Significant recommendations that may impact Measure Up/Pressure Down™

Recommendation 1

In the general population aged ≥ 60 years, initiate pharmacologic treatment to lower blood pressure (BP) at systolic blood pressure (SBP) ≥ 150 mm Hg or diastolic blood pressure (DBP) ≥ 90 mm Hg and treat to a goal SBP < 150 mm Hg and goal DBP < 90 mm Hg. (Strong Recommendation – Grade A)

Corollary Recommendation

In the general population aged ≥ 60 years, if pharmacologic treatment for high BP results in lower achieved SBP (e.g., < 140 mm Hg) and treatment is well tolerated and without adverse effects on health or quality of life, treatment does not need to be adjusted. (Expert Opinion – Grade E)

Recommendation 4

In the population aged ≥ 18 years with chronic kidney disease (CKD), initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg and treat to goal SBP < 140 mm Hg and goal DBP < 90 mm Hg. (Expert Opinion – Grade E)

Recommendation 5

In the population aged ≥ 18 years with diabetes, initiate pharmacologic treatment to lower BP at SBP ≥ 140 mm Hg or DBP ≥ 90 mm Hg and treat to a goal SBP < 140 mm Hg and goal DBP < 90 mm Hg. (Expert Opinion – Grade E)

Implications for Measure Up/Pressure Down™

1. **Campaign Goal** – Measure Up/Pressure Down™ uses NQF 0018 as the basis for setting the overall campaign goal of 80% of patients with blood pressure in control. NQF 0018 includes as the denominator all patients aged 18–85 with hypertension who have an E&M visit within the 12-month measurement period, and control is defined as BP less than 140/90. Thus, if the campaign goal were to remain unchanged, it might become more challenging for Measure Up/Pressure Down to achieve its goal, as patients aged ≥ 60 who do not have diabetes or CKD may be treated under the new guidelines to < 150 and deemed not in control. (See below for Anceta data showing the impact of the 2014 Evidence-Based Guideline on current BP control rates.)

2. **Measurement Specifications** – Participating medical groups have been provided measurement specifications for reporting that are based on NQF 0018, which will remain unchanged at least for HEDIS performance year 2014. Changing the campaign reporting specs now to align with the new recommendations would entail additional cost and IT burden for participating groups, since these would involve BP thresholds that are not currently part of other reporting programs. However, participating groups may not want to report their control rates according to NQF 0018 for patients aged 60–85, since these rates will be lower than they would be under the new guideline.
3. **Patient Messaging** – Measure Up/Pressure Down has developed and has been provided patient-facing materials that do not incorporate the new recommendations. These materials, which are on the www.measureuppressuredown.com web site and included in social media outreach, are available to the general public and may need to be altered to align with new guidelines.
4. **Provider messaging** – Measure Up/Pressure Down has developed a Provider Toolkit that participating organizations have used to guide their improvement efforts. These materials and tools do not reflect the new guidelines and may need to be altered to align with the new recommendations.

Other recent guidelines

NICE (UK) – Recommends < 140/90 for all patients with hypertension, except <150/90 for age ≥80 (August 2011).

ADA – Changed from <130/80 to <140/80 for patients with diabetes, in January 2013, except “lower systolic targets, such as <130, may be appropriate for certain individuals, such as younger patients, if it can be achieved without undue treatment burden.”

ESH/ESC – Recommends <140/90 for “uncomplicated” patients, <150 systolic for age >80, <140/85 for patients with diabetes, <130 systolic if proteinuria (June 2013).

Discussions with other organizations

CDC – Conversations with CDC indicate that CDC and the Million Hearts Initiative© may not alter their current goals. Their focus will remain on patients who are out of control under any guideline, with an understanding that control rates may be lower for patients aged ≥60 due to the recommendations of the **2014 Evidence-Based Guideline**. They want physicians and patients not to lose focus on the key message that blood pressure control is important. CDC also indicated they would likely wait for AHA/ACC guidelines before making any changes to their goals.

NCQA – NCQA is the measure steward for NQF 0018. The measure is used in HEDIS, and blood pressure control is also part of diabetes and cardiovascular measures. NCQA’s cardiovascular measurement

advisory panel and committee on performance measurement both met in January, and they may release a modified version of NQF 0018 for public comment. (The public comment period runs from February 19 to March 18.) The cardiovascular measurement advisory panel will reconvene in April and the committee on performance measurement in May. A decision for the next HEDIS cycle, measurement year 2015, would need to be finalized by July. Also noted was that NQF has a separate process to change approved measures; NQF generally follows changes made by measure stewards, but it is a separate process, which would begin after NCQA makes its decisions.

American Heart Association – American Heart Association has posted a statement that “based on the current research available, the American Heart Association recommends that healthcare providers continue to follow existing guidelines for treating high blood pressure.”

Phone call with Rose Marie Robertson, MD, chief scientific officer of American Heart Association, indicated that AHA considers JNC-7 still in effect. They do not recognize the document released by the JNC-8 committee members as official guidelines, and they point out that AHA/ACC were sanctioned by NHLBI to write the official guidelines. She expects them to be released in 2015. She indicated that there would be additional literature review, with a focus on the benefit of stroke prevention in the elderly, as this may not have received full consideration in the literature review done for the JNC-8 expert panel. She is quite concerned that there is a risk that if we ease up on performance goals, the public may be harmed. Felt there is no good evidence that changing our current goals would be a good thing. Recommends that Measure Up/Pressure down not alter our goals, measurement specifications, or messaging.

Minority Report from JNC-8

Evidence Supporting a Systolic Blood Pressure Goal of Less Than 150 mm Hg in Patients Aged 60 Years or Older: The Minority View Jackson T. Wright Jr., MD, PhD; Lawrence J. Fine, MD, DrPH; Daniel T. Lackland, PhD; Gbenga Ogedegbe, MD, MPH, MS; and Cheryl R. Dennison Himmelfarb, PhD, RN, ANP

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This minority report, including several prominent members of the JNC-8 committee, emphasized the potential risks of raising the target blood pressure for patients aged ≥ 60 .

First, increasing the target will probably reduce the intensity of antihypertensive treatment in a large population at high risk for cardiovascular disease. (CVD) The higher SBP goal would apply to some of the groups at highest cardiovascular risk, such as African Americans, hypertensive patients with multiple CVD risk factors other than DM or CKD, and those with clinical CVD. Second, the evidence supporting increasing the SBP target from 140 to 150 mm Hg in persons aged 60 years or older was insufficient and inconsistent with the evidence supporting the panel’s recommendations for an SBP target of less than 140 mm Hg in persons younger than 60 years and those aged 60 years or older with DM or CKD. Third,

the higher SBP goal in individuals aged 60 years or older may reverse the decades-long decline in CVD, especially stroke mortality. In the absence of definitive evidence defining the optimum SBP target, observational studies and RCT data that the panel did not systematically review more strongly support the SBP goal of less than 140 mm Hg, especially in high-risk individuals. Other recent guideline groups reviewing similar evidence have recommended a goal of less than 140 mm Hg, particularly in persons aged 80 years or younger.

Measure up/Pressure Down™ Scientific Advisory Council (SAC)

Three members of the SAC met on January 9, 2014, to discuss the **2014 Evidence-Based Guideline**.

Key points of consensus

- Process has been difficult, with many clinicians and patients experiencing guideline overload, with multiple entities issuing differing guidelines.
- Need to maintain focus on the large proportion of patients in poor control by even the most lenient recommendations (the new 2014 Evidence-Based Guideline):
 - age 18–59 or ≥60 with diabetes or CKD and BP ≥140/90, or
 - age ≥60 without diabetes or CKD and BP ≥150/90
- The patient group affected by the new recommendations is relatively small, only those ≥60 who do not have CKD or DM and have systolic BP in the range $140 \leq \text{SBP} < 150$. This amounts to 4% of all patients with hypertension in the Anceta data (range 3 – 6% across groups).
- There may be harm in treating older patients too aggressively. The **2014 Evidence-Based Guideline** places particular emphasis on avoiding harm in the pursuit of a blood pressure goal that is not strongly supported by evidence.
- The new recommendations are generally consistent with UK and European guidelines (NICE, ESH/ESC), although ADA recommends a lower diastolic pressure goal for patients with diabetes.
- At the same time, there is concern about “treatment drift or tolerance for even higher blood pressures, if the targets are raised. Although a more lenient treatment goal is now recommended, it must be taken seriously.
- Liked idea of age-banding the current MU/PD measurement specs (18–59, 60–85), which is only a minor adjustment to the current age banding (18–64, 65–85).
- Consider altering MU/PD campaign goal to align with new recommendations, or establish a BP goal only for patients 18–59.
- Consider adding information about the new recommendations in materials for providers and patients (similar to the US Preventive Services Task Force statement about mammogram recommendations.)

Measure Up/Pressure Down™ National Steering Committee

The National Steering Committee met on February 3, 2014, and additional conversations were held with two members who could not participate on the call.

- All expressed opposition to altering the goals of the campaign to exclude those ≥ 60 years old. They indicated this might give the message of reduced importance of this population. They also wanted the campaign to remain in alignment with other national measurements, including HEDIS, PQRS, and Million Hearts.
- Many preferred an option of reporting in alignment with the **2014 Evidence-Based Guideline**, yet understood the constraint of the reporting burden upon the participating groups.
- Many also expressed the concern of patient harm, especially for older patients already on three anti-hypertensive agents and not under control at ≤ 140 systolic. They specifically identified the risks of orthostatic hypotension and side effects of medications.
- They recognized the need for a strategic response from the campaign, understanding that there was no perfect solution.
- They emphasized the need for the campaign to communicate a positive message, relating back to the original reasons for the national campaign.
- Uniform agreement on keeping campaign goal aligned with NQF 0018 for now and the proposed age banding reporting. Also agreed with carefully worded provider and patient messaging, emphasizing the evolving guideline landscape.

Measure Up/Pressure Down™ Decisions

It is important for the participating groups, providers, and patients to receive guidance from the Measure Up/Pressure Down campaign. The **2014 Evidence-Based Guidelines** are based on comprehensive, systematic review of the scientific evidence, and there is a lack of evidence from randomized clinical trials for a treatment goal of $\leq 150/90$ in patients ≥ 60 years old. There is also a risk of causing harm in treating older patients too aggressively in pursuit of a treatment goal of $\leq 150/90$. Thus, the campaign does not want to communicate a message that endorses specific treatment goals for patients ≥ 60 years. Measure Up/Pressure Down™ will emphasize that achievement of campaign goal of 80% should not result in patient harm, and that treatment goals for individual patients should be based on the scientific evidence and patient–physician review of risk and benefit.

Understanding that patients age ≥ 60 certainly need blood pressure control, Measure Up/Pressure Down™ would continue measurement, patient messaging, and provider messaging for this patient population. 60% of patients with hypertension are ≥ 60 years old, and it would seem unreasonable to have no campaign goal for this large group. Continuation of the current goal would maintain focus on the entire population of patients with hypertension while treatment guidelines continue to evolve. In the coming months, participating groups may adopt all or some of the recommendations of the **2014 Evidence-Based Guideline**, yet the overall campaign goal of 80% control would still be achievable. A population measure should not be viewed as a treatment goal for each individual patient, although some providers interpret goals this way. The campaign goal is 80% blood pressure control, not 100%, which allows for flexibility for the patients ≥ 60 years old without DM or CKD.

It is important to recognize that there is broad agreement between the **2014 Evidence-Based Guideline** and the existing campaign goal for most patients with hypertension—only about 4% of all patients with hypertension are affected by the new recommendations from the **2014 Evidence Based- Guideline**. Other campaign partners, including CDC, American Heart Association, and NCQA will likely not change treatment targets or measurements until 2015. In addition, there would be a substantial reporting burden for the participating groups to report blood pressure control for various combinations of control levels and age bands.

Age-banding will be requested from the participating medical groups. This proposed change in age banding is only a minor adjustment to the current age banding (18–64, 65–85). Age banding would require only minor adjustment and IT resources from the participating medical groups, yet allow medical groups to segment their population in an environment of evolving guidelines. This would also maintain medical group reporting for Measure Up/Pressure Down™ consistent with existing national measurement requirements.

Measure Up/Pressure Down™ will attempt to correctly assess and prioritize an evolving landscape in the treatment of hypertension. We do not want physicians and patients to lose focus on the key message that blood pressure control is important, especially the large proportion of patients who are not in control by even the most lenient recommendations. We will provide ongoing updates on dedicated webpages for patients and providers.

Measure Up/Pressure Down™ Decisions

- 1. Keep Measure up/Pressure Down™ campaign goal at 80% blood pressure control (<140/90) for patients 18–85.**
- 2. Continue Measure Up/Pressure Down™ measurement specifications in current form, but alter age-banding ranges (18–59, 60–69, 70-79, 80-85),**
- 3. Prominently display additional information along with the patient and provider materials that indicate the 2014 Evidence-Based Guideline recommendations, and the recommendations from other guidelines.**
- 4. Host town hall webinars of participating groups to explain these decisions and solicit feedback.**