Achieving the Triple Aim

Michael J. Dolan, MD, FACP
Internal Medicine
Medical Vice President
Gundersen Health System
Learning Objectives...

• Be able to locate La Crosse, WI on a map of the United States

• Remember that Gundersen is spelled with an “e” at the end and not an “o”
“Jane”

• Seen in PCP office for “pre-op” prior to cataract surgery (12/4/2014)
  – BP 166/88  no action taken

• Seen by Anesthesia day of surgery (12/11/2014)
  – BP 170/73  no action taken

• Seen by new PCP for 2nd “pre-op” (12/15/2014)
  – BP 150/80  no action taken

• Admitted 1/10/2015 for left-sided weakness, left facial droop and slurred speech
Rising to the Challenge

RESULTS FROM A SCORECARD ON LOCAL HEALTH SYSTEM PERFORMANCE

2012

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

MARCH 2012
La Crosse, WI

2012 Rank

7
(out of 306)
• St. Paul, MN (#1)
• Dubuque, IA (#2)
• Rochester, MN (#3)
• Minneapolis, MN (#4)
• Appleton, WI (#5)
• Santa Rosa, CA (#6)
• La Crosse, WI (#7)
The road to West Union...
Case Study
Organized Health Care Delivery System • August 2009

Gundersen Lutheran Health System: Performance Improvement Through Partnership

Sarah Klein and Douglas McCarthy
Issues Research, Inc.
Exhibit 1. Six Attributes of an Ideal Health Care Delivery System

- **Information Continuity**  Patients’ clinically relevant information is available to all providers at the point of care and to patients through electronic health record (EHR) systems.

- **Care Coordination and Transitions**  Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.

- **System Accountability**  There is clear accountability for the total care of patients. (We have grouped this attribute with care coordination, since one supports the other.)

- **Peer Review and Teamwork for High-Value Care**  Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other’s work, and collaborate to reliably deliver high-quality, high-value care.

- **Continuous Innovation**  The system is continuously innovating and learning in order to improve the quality, value, and patients’ experiences of health care delivery.

- **Easy Access to Appropriate Care**  Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsive to patients’ needs.
Disease Management at Gundersen Health System

Disease Management is an evidence-based approach to care for patients who either have a chronic disease or are at risk of developing a chronic disease (pre-disease). It is a proactive, multidimensional, collaborative partnership with each patient.

Gundersen Health System's Goals are:

- Reduce the variability in care delivery
- Supply providers with tools to assist in identification and care of patients with chronic diseases
- Standardize information given to patients
- Provide the best care for each patient

Video Resources:

COPD Provider Education This hyperlink will direct you to a taping of the noon conference on 12/8/2014. Dr. Dolan and Dr. Pratt presented an overview of COPD guidelines and an introduction to the new COPD Registry coming to EPIC in January of 2015.

Bulk Order and Bulk Communication Demo * Created August 2014-This 3 minute video was produced by Dr. Gerrig.

Quick Links:

2015 Disease Management Updates January 2015

Coming Soon Up-dated Disease Management Registries Resource

Disease Management Process Guide
### Hypertension

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### Diabetes

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### Chronic Kidney Disease Stage 1, 2, 3

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### Chronic Kidney Disease Stage 4, 5

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<td>75</td>
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</table>
Colorectal Cancer Screening

The results below represent **858,903** men and women who should have had a colorectal cancer screening. Read More About This Measure

### Reporting Period: Q1 2013 - Q4 2013

<table>
<thead>
<tr>
<th>Clinic</th>
<th>N</th>
<th>Percentage</th>
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<td>Agnesian Healthcare</td>
<td>22807</td>
<td>60.99%</td>
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<tr>
<td>Aurora Advanced Healthcare</td>
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<td>Aurora Medical Group</td>
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<td>Aurora UW Medical Group</td>
<td>6753</td>
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<td>Bellin Medical Group</td>
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Diabetes: All-or-One Process Measure (Optimal Testing)

The results below represent **168,767** patients with Diabetes.

The All-Or-One method is a more complete way of reporting the diabetes measure and has three goals. All three goals must be reached by each patient in order to meet the measure. For more information about how this method is different from reporting individual measures please click: [Read More About This Measure](#)

<table>
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<tr>
<th>Community</th>
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<th>Percentage</th>
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<tr>
<td>Columbia St. Mary's Community</td>
<td>N=8188</td>
<td>68.75 %</td>
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<tr>
<td>Dean Clinic</td>
<td>N=6255</td>
<td>76.73 %</td>
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<tr>
<td>Froedtert &amp; The Medical College of Wisconsin</td>
<td>N=9141</td>
<td>65.69 %</td>
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<tr>
<td>Gunderson Clinic, Ltd</td>
<td>N=7783</td>
<td>60.15 %</td>
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<tr>
<td>Marshfield Clinic</td>
<td>N=13858</td>
<td>59.34 %</td>
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<tr>
<td>Mayo Clinic Health System - Franciscan Healthcare</td>
<td>N=999</td>
<td>67.72 %</td>
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What percentage of US adults with hypertension are under good control?

A. 40%
B. 50%
C. 60%
D. 70%
E. 80%
UNCOMPICLATED HYPERTENSION: BLOOD PRESSURE CONTROL
All WCHQ Patients, All WCHQ Reporting Members

This measure assesses the percentage of patients 18-85 years old who have a diagnosis of uncomplicated essential hypertension, and whose blood pressure was adequately controlled (less than 140/90 mm Hg).

N: Total patient population measured (not a sample)
Gundersen Management System

- Physician leaders at every level
- Physician development
- Dyad structure
- Morning rounds
- A3 process
- Activity boards
- Recognition event
Hypertension-related diseases account for what percentage of all deaths in the US (2013 data)?

A. 6%
B. 15%
C. 25%
D. 38%
E. 50%
2013 US Deaths

- Ischemic heart disease: 15%
- Cerebrovascular disease: 5%
- CHF: 2%
- HTN: 3%
- All other: 75%
2013 Deaths from Selected Causes, ages 25-64

- Homicide: 9,981
- HIV: 6,075
- Hypertensive Heart Disease: 13,516
- Coronary Disease: 74,844
- Essential HTN: 5,179
- Cerebrovascular Disease: 18,984
- Renal Failure: 7,715
Hypertension Deaths per 100,000

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<th>Age Group</th>
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<th>2013</th>
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<td>35-44</td>
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<td>8.0</td>
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<td>65-74</td>
<td>15.2</td>
<td>17.3</td>
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<tr>
<td>75-84</td>
<td>43.6</td>
<td>53.7</td>
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<tr>
<td>&gt;85</td>
<td>152.1</td>
<td>231.6</td>
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Percentage of Hypertensive Patients at Target

- 61.45% in 2007
- 64.49% in 2008
- 65.69% in 2009
- 70.1% in 2010
- 74.67% in 2011
- 78.07% in 2012
- 79.09% in 2013
- 80.42% in 2014

% controlled
### LET 2015

<table>
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<th>Current</th>
<th>Target</th>
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<tr>
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<td>Diabetes Optimal Therapy - WCHQ</td>
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<tr>
<td>Chronic Kidney Disease - Screening for CKD - WCHQ</td>
<td>87.94</td>
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<td>Falls Mod+ Harm for Clinic</td>
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<td>Falls Mod+ Harm for Hospital Inpatient</td>
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<td>Falls Mod+ Harm for Procedural Outpatient</td>
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<td>Hand Hygiene</td>
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<td>IMM-2 Inpatient Influenza Immunization</td>
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<td>Event Always Reported - Survey EPS</td>
<td>66.58</td>
<td>84</td>
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<tr>
<td>Feedback about Changes Based on Events - Survey EPS</td>
<td>71.28</td>
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Treating Hypertension...

- Reduces risk of first stroke by 30%
- Reduces risk of CHF by 50%
- Reduces risk of MI by 20%
- Reduces incidence of ESRD & death by 38%

A – Antihypertensive and
L – Lipid
L – Lowering Treatment to Prevent
H – Heart
A – Attack
T - Trial
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)
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, DrPH; Gbenga Ogedegbe, MD, MPH, MS; and Cheryl R. Dennison Himmelfarb, PhD, RN, ANP

The “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)” recommends several major changes from the JNC 7 report (1, 2). The 2014 guideline is based on a systematic review of randomized, controlled trials (RCTs) by a multidisciplinary panel using a process informed by Institute of Medicine recommendations for guideline development (3). Although there was almost unanimous agreement on nearly all recommendations, a minority of the panel (the authors of this commentary) disagreed with the recommendation to increase the target systolic blood pressure (SBP) from 140 to 150 mm Hg in persons aged 60 years or older without diabetes mellitus (DM) or chronic kidney disease (CKD). This target guides both the initiation of therapy and treatment goals.

Online groups reviewing similar evidence have recommended a goal of less than 140 mm Hg, particularly in persons aged 80 years or younger (5–9).

Persons Aged 60 Years or Older With Hypertension and SBP Controlled to 140 mm Hg or Lower

More than half of the 72 million persons with hypertension in the United States are aged 60 years or older (10, 11). Among these individuals, the 2014 guideline recommends the SBP goal of 140 mm Hg or lower only for those with DM and those younger than 70 years with CKD (2). Although the prevalence of hypertension in this age group (65% to 67%) did not change between 1999 and 2010, the percentage with adequate blood pressure control increased from 27% (2000–2002) to 40.5% (2011–2014).
Miller School Study Finds Lower Systolic Blood Pressure Reduces Risk of Stroke

People 60 or older, especially minorities and women, have a lower risk of stroke if the top number (systolic) in their blood pressure is below 140 millimeters of mercury (mm Hg), according to a study conducted by a team of neurologists at the University of Miami Miller School of Medicine and Columbia University.


The JAMA report advised doctors to aim for blood pressure readings of less than 150/90 mm Hg when treating patients 60 or older who do not have diabetes or chronic kidney disease. That raised the standard for systolic blood pressure by 10 points from previous guidance, stirring controversy among healthcare providers, agencies and professional groups.

The 2014 report relied on evidence from clinical trials, but did not consider data from various other studies that support a systolic blood pressure goal of less than 140 for these patients, said Chuanhui Dong, Ph.D., lead author of the new study and research associate professor at the Miller School.

The new study involved 1,706 people older than 60 (average age 72) in the Northern Manhattan Study in New York City, funded by the National Institute of Neurological Disorders and Stroke at the National Institutes of Health. None of the participants had a previous stroke, diabetes or kidney disease. After adjustment for age, sex, race/ethnicity and use of blood pressure medications, stroke risk was 70 percent higher for people with systolic pressure in the 140-149 range, compared with those whose readings fell below 140.

The results support what some health experts had feared, Dong said. “Raising the treatment bar could lead to more strokes.”
Wisconsin

California
Prevalence* of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2013

*Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.
ICE CREAM COUNTRY
The Cities and States That Eat the Most Ice Cream in America

Ben & Jerry's: Headquartered in South Burlington, Vermont, 430 U.S. locations, Cherry Garcia is the most popular flavor.

Yogurt: Headquartered in Salt Lake City, Utah, 390 U.S. locations, stands for The Country's Best Yogurt, formerly This Can't Be Yogurt.

Cold Stone Creamery: Headquartered in Scottsdale, AZ, 1,400 U.S. locations, name comes from the cold stone used to mix the ice cream.

Marble Slab: Headquartered in Houston, TX, 349 U.S. locations, name comes from the marble slab used to mix the ice cream.

Baskin Robbins: Headquartered in Canton, MA, has 2,400 U.S. locations, originally 31 flavors and now there are more than 1,000.

Applies to Cities and States:
- 60% above average
- 51-65% above average
- 36-50% above average
- 1-25% above average
- U.S. average
- 1-20% below average
- 21-30% below average
- 51-75% below average
Sources: Institute for Health Metrics and Evaluation

Note: County figures are estimated, based on modeled federal survey data.
How can I convince my patients to take medication for something they don’t even feel?

Which medicine do I choose (from well over 100)?

I have my patient on 3 meds and still not under control, now what?
Which of the following should be followed to obtain a proper blood pressure measurement?

A. Patient should be seated on exam table comfortably with legs off the floor
B. Bladder should be empty
C. 1 or 2 step method can be used
D. Exercise 15 minutes before measurement
E. A, B, and C are correct
“We are treating your high blood pressure to prevent strokes, heart attacks and kidney failure.”
Myth #1

“Lifestyle modification doesn’t work.”
"I was able to get in one last lecture about diet and exercise."
I’m not Lazy...
I’m Addicted to Inertia

\[ I = \int r^2 \, dm \]
We’ll see you back in 6 months.

We need to start a new medication.
Myth #2

“Hypertension management is complicated.”
All of the following are reasonable choices for initial therapy of hypertension except (pick one):

A. Angiotensin receptor blocker
B. Calcium-channel blocker
C. Thiazide diuretic
D. ACE inhibitor
E. Alpha blocker
Hypertension Management Flowsheet

(Representative medications are listed in parentheses)

---

**Blood Pressure Goals**
- <140/90 if less than age 80;
- <150/90 if age 80 or greater

**Initial Tests**
- Na, K, Creatinine, UA, Calcium, TSH, Hgb, Glucose, Fasting lipids, EKG

---

**Step 1:**
- ACE-I (Lisinopril 10 mg daily)
  - Preorder Na, K, Creatinine for 2-4 week follow-up
  - If not at goal, increase ACE-I (Lisinopril 20 mg daily)
    - Change to ARB if cough develops.

**Step 2:**
- Add Thiazide Diuretic (Chlorthalidone 25 mg daily) OR (HCTZ 25 mg daily)
  - Preorder Na, K, Creatinine for 2-4 week follow-up
  - If not at goal, go to Step 3.

**Step 3:**
- Add Dihydropyridine Calcium Channel Blocker (CCB) (Amlodipine 5 mg daily)
  - If not at goal, increase CCB (Amlodipine 10 mg daily)
  - 2-4 week follow-up

**Step 4:**
- Add Mineralocorticoid Receptor Antagonist (Spironolactone 25 mg daily – caution if GFR <30, Max 50 mg daily if on high dose ACE-I/ARB)
  - May combine steps 5 and 6 by using alpha/beta blocker (Carvedilol 6.25 mg twice daily) OR (Labetolol 100 mg twice daily)
  - Preorder Na, K, Creatinine for 2-4 week follow-up
  - If not at goal, increase alpha blocker.
    - (Doxazosin 4 mg in evening)
  - Titrate by doubling dose every 2-4 weeks until BP controlled or K is mid-upper 4 range.

**Step 5:**
- Add Beta Blocker (Metoprolol succinate 25 mg in evening)
  - If anti-androgenic effects occur, change to eplerenone – increase to maximum of 50 mg twice daily. If not at goal, go to step 5.

**Step 6:**
- Add Alpha Blocker (Doxazosin 1 mg in evening)
  - If not at goal, increase alpha blocker.
    - (Doxazosin 2 mg in evening)
  - Titrate by doubling dose every 2-4 weeks until BP controlled or pulse is around 60.

- If anti-androgenic effects occur, change to eplerenone – increase to maximum of 50 mg twice daily.
- If not at goal, go to step 5.

---

This algorithm is for non-pregnant, non-breastfeeding patients age 18 or older.
- Black patients without CKD should use ACE-I/ARB as second-line therapy.
- Adapted from several national and international guidelines, randomized studies, and review articles.

(Gundersen Health System in July, 2014)
Compelling Indications for Initial Treatment

- Diabetic patients
  - ACE/ARB
- Chronic kidney disease
  - ACE/ARB
- Black patients
  - Thiazide or CCB
Hypertension
Management Flowsheet

(Representative medications are listed in parentheses)

**Blood Pressure Goals**
- <140/90 if less than age 80;
- <150/90 if age 80 or greater

**Initial Tests**
- Na, K, Creatinine, UA, Calcium, TSH, Hgb, Glucose, Fasting lipids, EKG

---

**Step 1:**
**ACE-I**
(Lisinopril 10 mg daily)

- Preorder K, Creatinine for 2–4 week follow-up

- If not at goal, increase ACE-I.
  (Lisinopril 20 mg daily)
  Change to ARB if cough develops.

- Preorder K, Creatinine for 2–4 week follow-up

- If not at goal, increase ACE-I.
  (Lisinopril 40 mg daily)
  An increase in creatinine up to 30% is acceptable.

- Preorder K, Creatinine for 2–4 week follow-up

- If not at goal, go to Step 2.

---

**GUNDERSEN HEALTH SYSTEM**
Myth #3

“Blood pressure medications are expensive”
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<th>Drug Name</th>
<th>30-day</th>
<th>90-day</th>
</tr>
</thead>
<tbody>
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<td>30</td>
<td>90</td>
</tr>
<tr>
<td>Enalapril 5mg tab.</td>
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</tr>
<tr>
<td>Enalapril 10mg tab*</td>
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<tr>
<td>Enalapril 20mg tab*</td>
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</tr>
<tr>
<td>Furosemide 20mg tab</td>
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<tr>
<td>Furosemide 40mg tab</td>
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<tr>
<td>Furosemide 80mg tab</td>
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<td>Guanfacine 1mg tab</td>
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<tr>
<td>Hydralazine 10mg tab</td>
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<tr>
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<tr>
<td>Hydrochlorothiazide (HCTZ) 12.5mg cap*</td>
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<tr>
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<tr>
<td>Isosorbide Mononitrate 60mg ER tab</td>
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<tr>
<td>Lisinopril-HCTZ 10mg-12.5mg tab</td>
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<tr>
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<td>Lisinopril-HCTZ 20mg-25mg tab*</td>
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<tr>
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<td>Methyldopa 250mg tab*</td>
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<tr>
<td>Metoprolol Tartrate 25mg tab</td>
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<tr>
<td>Metoprolol Tartrate 100mg tab*</td>
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**Heart Health & Blood Pressure**

- **Atenolol-Chlorthalidone 100mg.** | 30 | 90 |
- **Atenolol 25mg tab**               | 30 | 90 |
- **Atenolol 50mg tab**               | 30 | 90 |
- **Atenolol 100mg tab**              | 30 | 90 |
- **Benazepril 5mg tab.**             | 30 | 90 |
- **Benazepril 10mg tab**             | 30 | 90 |
- **Benazepril 20mg tab**             | 30 | 90 |
- **Benazepril 40mg tab**             | 30 | 90 |
- **Bisoprolol-HCTZ 2.5mg-6.25mg tab.** | 30 | 90 |
- **Bisoprolol-HCTZ 5mg-6.25mg tab.**  | 30 | 90 |
- **Bisoprolol-HCTZ 10mg-6.25mg tab.** | 30 | 90 |
- **Bumetanide 0.5mg tab.**           | 30 | 90 |
- **Bumetanide 1mg tab.**             | 30 | 90 |
- **Carvedilol 3.125mg tab**          | 60 | 180 |
- **Carvedilol 6.25mg tab**           | 60 | 180 |
- **Carvedilol 12.5mg tab**           | 60 | 180 |
- **Carvedilol 25mg tab**             | 60 | 180 |
- **Clonidine 0.1mg tab.**            | 30 | 90 |
- **Clonidine 0.2mg tab.**            | 30 | 90 |
- **Enalapril-HCTZ 5mg-12.5mg tab**   | 30 | 90 |
Keys to Our Success

Set aspirational goals – Aim to be the best
Exploit your EMR
Simplify
Educate clinicians to do the right thing
Measure and be transparent
Team-based care – Maximize the value of the visit by standardizing