Improving chronic care: It takes a team

CREATING A NATIONAL CAMPAIGN TO IMPROVE HYPERTENSION CONTROL

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As chief medical and quality officer for AMGA, Dr. Penso leads best-practices learning collaboratives for the 400-plus member groups, research and benchmarking programs, and AMGA's national hypertension campaign. Prior to joining AMGA, Dr. Penso served as medical director, continuum of care for Sharp Rees-Stealy Medical Group (SRSMG) in San Diego. When Dr. Penso coordinated pay-for-performance initiatives and chronic disease management at SRSMG, it was recognized as a top performer in California's pay-for performance program every year, beginning in 2005. Dr. Penso has served on the Integrated Healthcare Association's board of directors, the California Cooperative Healthcare Reporting Initiative Executive Committee, and the board of directors of the Behavioral Diabetes Institute, as well as chairing the Technical Quality Committee for California's pay-for-performance initiative.

There is a growing imperative for medical groups and healthcare delivery systems to improve clinical quality. Many payors include ambulatory quality measures in performance-based contracts, such as value-based purchasing or accountable care, with financial incentives linked to clinical outcomes. Public reporting of quality performance is also increasingly common, compounding the pressure to create a sustainable quality infrastructure.

In addition, many payment models now reward the successful management of designated populations. Since a large percentage of healthcare costs are associated with patients who have one or more chronic conditions, many organizations have developed programs to address preventive and chronic disease needs to reduce the total cost of care.

Groups beginning their quality journey face a strategic challenge. They must find a target area that will result in improved outcomes and lower costs, while simultaneously engaging and motivating their physicians, employees and patients. For our purposes, an appropriate chronic condition to target is one that is common, costly, can be improved and has proven evidence-based care processes.

To help groups determine the appropriate chronic condition to target for their respective populations and develop treatment programs, the American Medical Group Foundation (AMGF), the philanthropic arm of the American Medical Group Association (AMGA), created a series of learning collaboratives that targeted specific diseases, such as chronic obstructive pulmonary disease (COPD), diabetes and hypertension. In these collaboratives, teams of physicians, nurses, administrators and quality improvement staff work together and with other teams around the country over the course of a year.

The two collaboratives focused on managing hypertension were remarkably successful. In many teams, more than 80 percent of patients were able to control their high blood pressure. These groups learned that the key to improvement was engaging the entire care team and creating standardized processes that were implemented throughout the organization. They had to move away from the more typical practice of medicine that resulted in unwanted variation in outcomes and toward a more systematic, team-based approach. Borrowing from Lean manufacturing methodologies, the groups learned how to efficiently and consistently produce better results.

Impressed by the results, the AMGF board decided to take the program to another level by creating a national campaign centered on the knowledge gained from the 30 groups that participated in the two hypertension collaboratives. *Measure Up/Pressure Down* is a three-year national campaign to improve care and reduce high blood pressure. It currently includes nearly 150 medical groups and health systems caring for approximately 45 million patients, as well as national partners such as the U.S. Department of Health and Human Services' (HHS) Million Hearts™ initiative. The goal of the campaign is to have 80 percent of high blood pressure patients in control of their condition by 2016.

Improving hypertension control

Even though patients have their blood pressure checked at a physician's office, pharmacy or community screenings, national data indicate that only one-half of American adults have their blood

pressure under control. Why has blood pressure, with good medications and treatment available for more than 50 years, been so hard to manage? And, more importantly, what can we do as healthcare providers to produce better quality outcomes for our patients?

According to the Centers for Disease Control and Prevention, an astonishing 68 million American adults have high blood pressure.[1] Approximately 30 million, or 45 percent, are not maintaining good control of their high blood pressure and are currently being treated in the healthcare system, indicating that something is lacking in the healthcare delivery or education process. High blood pressure was listed as a primary or contributing cause of death for about 348,000 Americans in 2008, or nearly 1,000 deaths per day. And the annual cost of high blood pressure is estimated at $131 billion in healthcare services, medications and missed days of work.[2]

Measure Up/Pressure Down was developed to improve high blood pressure prevention and control to reduce the burden of this chronic condition and lift the standard of care for patients nationwide.

Creating the campaign

The committee identified three elements necessary to make a national campaign for blood pressure control a reality, including the need for:

- A concrete, time-limited goal;
- Defined, easily understood and adopted care processes; and
- An evaluation process to track progress throughout the campaign and confirm the goal had been reached.

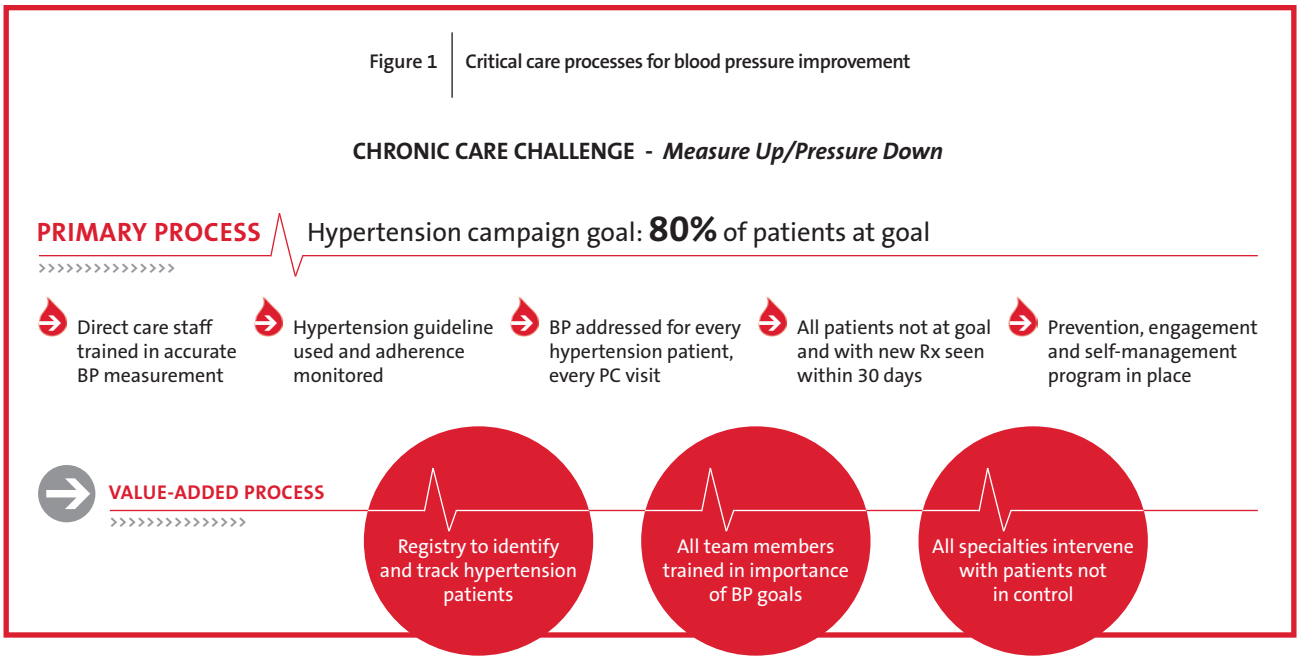
Step 1: Pick an ambitious but achievable goal.

It was critical to select a goal that would motivate all participants and create excitement around the campaign. The goal needed to be specific; vague, undefined goals would not sustain efforts. The steering committee reviewed medical literature, national quality results in hypertension and results of the previous AMGF collaboratives. The goal of 80 percent control within three years was identified as a stretch goal, yet one that was reachable. Many of the provider groups in the earlier collaboratives had achieved this result, and national Healthcare Effectiveness Data and Information Set (HEDIS) quality data indicated that 80 percent was doable.[3]

Step 2: Determine the care processes that would lead to proposed outcomes.

Eight critical care processes were chosen as the framework for blood pressure improvement (see Figure 1). The care processes were selected by practical considerations including likelihood of success, ease of adoption, involvement of entire care team, cost concerns, and patient engagement. The committee also decided that medical groups joining the campaign could choose the processes or "campaign planks" that made sense for their local environments. It was not an all-or-none package, which could have kept many groups from joining.

Figure 1 | Critical care processes for blood pressure improvement



Step 3: Create an evaluation plan.

Standardized measurement is key to quality improvement. If each group measured blood pressure control rates differently, we would never know if the campaign's goal was reached. So standard measurements were determined, and groups joining the campaign agreed to provide aggregate data to AMGF for evaluation by external researchers. In addition, information was compared to AMGA's data warehouse, which compiled data from 25 medical groups. Detailed information about participants' performance – including prescribing patterns, physician performance, visit frequency and demographic factors affecting blood pressure control – provided additional insights for the campaign.

Launching the campaign

After almost a year of planning, *Measure Up/Pressure Down* officially launched in November 2012, and additional functions were developed in the first half of 2013. These included monthly webinars focused on individual campaign planks and presented by leading medical experts in implementing hypertension improvement strategies; a website (www.measureuppressure-down.com) that provides resources for both health professionals and patients; and a provider toolkit that serves as a "how to" handbook for participating teams.

While improving patient care is not easy, it is essential if we are going to enhance the experience of care, improve the health of populations and reduce per capita costs. As the American population ages, more and more patients will be living with at least one chronic condition such as high blood pressure, increasing the total cost of healthcare. To meet these challenges, we must learn to do things differently, work collaboratively and apply best practices from other organizations.

Improving hypertension control at ThedaCare

Located in northeastern Wisconsin, ThedaCare Physicians is part of a community health system that encompasses four hospitals, home health, senior services, behavioral health and employee wellness. ThedaCare noted that hypertension was the number one diagnosis in its system, with more than 14,000 patients affected. In 2007, ThedaCare Physicians initiated an improvement program that used a multifaceted approach to help providers in caring for patients with uncomplicated hypertension.

Some key innovations adopted by ThedaCare included:

- Templates in the EHR that allowed providers to document high blood pressure care in a consistent format and avoid omissions;
- Standardized workflows that required patients with elevated blood pressures to speak to a physician before leaving the clinic;
- Adjusted refill protocols to prompt office visits for patients with poor control;
- Monthly automated emails sent to all physicians showing high blood pressure results by clinic site and individual provider in an unblinded, transparent report;
- Competency training and testing for staff to reduce variation in blood pressure measurement techniques across clinics; and
- Other patient incentives, including an educational DVD and a free home blood pressure monitor.

Within three years, 81 percent of ThedaCare's patients had their blood pressure under control, according to statewide publicly reported data.

References
1. "High Blood Pressure," CDC, last modified May 2, 2013, http://www.cdc.gov/bloodpressure/.
2. U.S. Department of Health and Human Services (May 2, 2012). HHS Secretary Sebelius statement on National High Blood Pressure Education Month [press release], http://www.hhs.gov/news/press/2012pres/05/20120502a.html.
3. "Continuous Improvement and the Expansion of Quality Measurement: The State of Health Care Quality 2011," The National Committee for Quality Assurance 2011, http://www.ncqa.org/Portals/0/SOHC-web1.pdf.

Improving primary care management of high blood pressure at Riverside Medical Group

Based in Newport News, VA, Riverside Medical Group (RMG) is one of the largest multispecialty group practices in the state, with 150 physician practices staffed by 450 providers in 28 specialties. In 2009, RMG's quality committee decided to make high blood pressure a priority for the practice and assembled a team that focused first on patients with uncomplicated high blood pressure. Some of the interventions included:

- Educational sessions on hypertension guidelines;
- Automated telephone reminders to patients for appointment scheduling;
- A nurse leader who traveled to the practice locations to evaluate hypertension management;
- Monthly scorecards that provided blood pressure control rates by practice, provider, and patient;
- Testing of clinical staff in blood pressure measurement competency by teams of nurses;
- Development of a highly secure, Web-based communications tool that enabled patients to communicate with their physician team 24 hours a day;
- Hypertension management reports sent to physicians and office managers each month listing all high blood pressure patients, their most recent appointments, next scheduled appointment, and whether they were at goal for BP; and
- Hypertension outcomes included in a formula for physician compensation.

Starting with a 57 percent blood pressure control rate in 41,408 patients, RMG was able to improve its control rate to 71 percent in two years.

Using nurse health coaches to improve high blood pressure control at Mercy Clinics

Established in 1983, Mercy Clinics Inc. covers the greater metropolitan area of Des Moines, IA. There were 878,000 patient visits to Mercy Clinics in 2010, and the medical staff includes 150 physicians in 10 specialties.

The Mercy Clinics high blood pressure program was an outgrowth of a major practice redesign that featured embedded nurse health coaches, who were required to attend a 30-hour certification class, within primary care practices. The program began by working with more than 13,000 diabetic patients. Nurse health coaches provided:

- Registry management, including verification of complete data;
- Chart reviews with assessment of patient needs and evidence-based practice guidelines to determine future tests and procedures;
- Outreach to patients with poor blood pressure control;
- Educational materials, a food diary, home blood pressure monitoring log and one-on-one motivational coaching to support patient self-management; and
- Performance monitoring for each practice to improve outcomes.

Although there was some initial physician reluctance to delegate duties to the nurse health coaches, as the nurses became a familiar part of the care team, physician acceptance increased. From April 2008 through December 2009, the percentage of patients with diabetes with blood pressure at goal increased from 61.3 percent to 73.7 percent.