HYPERTENSION BEST PRACTICES SYMPOSIUM

Hypertension Best Practices

MERCY CLINICS
DES MOINES, IA

Mercy Clinics, Inc.
A member of Mercy Medical Center–Des Moines

ORGANIZATION PROFILE

Established in 1983, Mercy Clinics, Inc., is based in Des Moines, Iowa and covers the greater metropolitan area. Mercy's 50 clinic locations provided 878,000 patient visits in 2010. The medical staff comprises 150 physicians in 10 specialties; 70% are in primary care. All physicians are paid using a home-grown virtual private practice (VPP) system that tracks all revenue and expenses to the physician level and pays them the difference. Reimbursement is 100% fee-for-service.

In 2008 Mercy Clinics was the recipient of the American Medical Group Association's Acclaim Award. The organization is currently in the process of rolling out the Allscripts ambulatory electronic health record solution.

PROJECT SUMMARY

The Mercy Clinics HTN program was an outgrowth of a major practice redesign effort that began in 2004. This initiative, which is based on Wagner's Care Model and the IOM's Six Dimensions of Quality, focuses on a whole-person orientation, team-based care, and patient registries. The organization began with diabetes patients. After setting up a Care Measures-hosted diabetes registry using state funding, Mercy Clinics adapted the registry to identify patients with hypertension. The HTN project began with a pilot at Mercy North and has expanded to 17 other locations.

GOALS AND OBJECTIVES

Mercy Clinics served as the pilot organization in Iowa for pay for performance (P4P) through its major insurance provider. When the insurer added hypertension to its list of P4P criteria and set a "stretch" goal of <140/90 for 75% of all patients, Mercy had an added incentive to focus on BP control.

The goals for HTN improvement were:

- 70% of patients with diabetes with BP of <140/90
- Use of the disease registry to track patients
- Self-management support for patients not at goal
- Measurement in a standardized fashion, with electronic BP cuffs preferred
- Office visits to discuss HTN at least twice a year and monthly if not controlled

HTN POPULATION

The HTN population in the registry increased sharply over the duration of the project:

Patients with HTN at beginning of project (April 2008)
n = 13,000

Patients with HTN at conclusion of project (December 2009)
n = 18,600

Age range: 18 years old and up

LEADERSHIP SUPPORT

Strong leadership has been critical to the success of the HTN project, particularly because the investment in the program (clinic health coaches) directly impacts each physician's compensation. At an organizational level, Mercy Clinics has provided significant personnel resources—a vice president and two Master's-educated RNs—to direct and oversee the initiative.

This leadership support stems from Mercy Clinics' commitment to improving processes and systems to achieve higher quality and also to prepare for the future of health care. Population-based care is a key aspect of the medical home and ACO models. By putting in place infrastructure, measurement systems, and a practice model that delegates care to team members other than the physician, Mercy's leadership is laying the foundation for accountable care.

COMMUNICATIONS

Because the health coaches are employed by and "embedded" in the clinics, cross-organizational communications has been one of the biggest challenges for the HTN project. The director of quality—one of the project leaders—meets twice monthly for two hours with all health coaches to exchange ideas and jointly solve problems. The director also meets with clinic managers on a regular basis.

The vice president of quality and IT, who directs the project, communicates with physicians through the medical director's meetings. Mercy Clinics is planning to institute clinic "huddles" as part of the Allscripts implementation, and these will be used to update the entire clinic staff about the HTN project.

CARE MANAGEMENT SYSTEM

The HTN program is based upon a hypertension practice guideline approved by the Quality Committee in accordance with JNC 7 guidelines. A cardiologist provided academic detailing to many of the family practice and internal medicine clinics, and a nurse educator from his clinic attended each session and engaged clinical staff in an in-service on standardized BP measurement.

Health Coaches

The program leveraged existing population health coaches that had been introduced as part of its practice redesign, and has expanded the number of coaches (currently 26 RNs, LPNs, and certified medical assistants serve 17 locations).

- 11 clinics have one health coach
- 3 clinics have 2 health coaches
- 3 clinics have 3 health coaches

The ultimate goal is to have a health coach for every full-time provider.

Originally, the coaches were focused on administration and data entry, but this job description has evolved to be more clinical, and the organization tries to use RNs as much as possible. All coaches attend a 30-hour certification class and are trained in self-management support.

The coaches' key responsibilities include:

Overseeing the registry

- They either enter data themselves or supervise a data entry person
- They proactively contact patients who are not at goal or who are overdue for a clinic visit
- They review performance reports

Conducting pre-visit chart reviews on every patient

Mercy Clinics saw instances where patients whose BP was not in control were missing opportunities for HTN care when they came to the clinic for another reason. Now, the coaches review the patient chart in advance and compare it to HTN standing orders to determine what procedures, tests, etc., should be conducted. In addition, the coaches look for preventive care needs such as immunizations. Labs and referrals are done before the patient is seen by the physician.

The HTN standing orders were developed by the Quality Committee using evidence-based practice guidelines. For example, patients not at goal for BP are seen monthly, and all patients receive a BMI, basic metabolic profile, and lipid profile yearly.

As a result, HTN care is administered promptly, even if the patient has come to the clinic for another condition. Also, this process helps the coach form a "big picture" of each patient.

Working with patients and their families on self-management

To support these efforts, Mercy Clinics developed improved patient education materials, including an HTN food diary, home BP monitoring log, and a display in waiting rooms. When the project began, no patients were routinely monitoring their BP at home, but now the coaches have persuaded many patients to take their BP and report it. Coaches systematically search the registry for patients who are not at goal and reach out to them between visits to encourage BP monitoring and lifestyle changes that can lower HTN.

The vast majority (90%) of patients respond positively when contacted by the coaches to schedule a visit or address noncompliance.

INTERVENTIONS

- HTN Algorithm: a simple flowchart that spells out care interventions, timing, and follow-up actions
- Standardized BP protocol: coaches are working with clinic staff to be sure a second BP reading is taken if the first is not at goal
- Use of electronic BP cuffs: this is currently optional and has only been adopted by one clinic; however, Mercy foresees that the Allscripts implementation will drive higher usage

OUTCOMES

From April 2008 through December 2009, the percentage of patients in the diabetes registry with BP at goal increased from 61.3% to 73.7%, even with a sharp increase of about 5,000 in the total population.

OVERCOMING BARRIERS

- Electronic BP cuffs have faced an uphill battle because they read "high" and physicians were concerned about losing P4P incentives if total results in BP compliance declined. However, the pilot site continues to champion electronic BP cuffs, and a second clinic subsequently adopted them in spite of a dip in number of patients in control.
- High patient numbers make it challenging to devote as much time as needed to help patients get to goal. The addition of more coaches is expected to help.
- Physicians have been reluctant in some cases to delegate to the health coaches, particularly regarding ordering lab tests. As the coaches have taken on more clinical duties and have become a familiar part of the care team, physician acceptance has increased at most clinics.
- Physicians perceived HTN control as an additional cost without accompanying revenue increases but pay for performance and the entire value the coaches bring to their patients has helped them become more open to utilizing health coaches.
- The new EHR does not have a registry built in, so it will be interfaced with the registry to allow data to be shared between the two systems.

LESSONS LEARNED

- A fundamental culture shift to population-based care is hard work—a change from reactive to proactive.
- Implementing Wagner's Care Model in a fee-for-service practice can generate enough revenue to cover the costs.
- Patients will respond positively to outreach about their care.
- System changes markedly improve chronic care delivery performance.

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