Hypertension Best Practices Symposium

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Sharp Rees-Stealy Medical Group
San Diego, CA



ORGANIZATION PROFILE

Founded in 1923, Sharp Rees-Stealy Medical Group (SRSMG) is San Diego's oldest multispecialty medical group, nationally recognized for superior clinical practices and the recipient of numerous awards and recognition. With 1,850 employees and more than 400 physicians representing 27 specialties, SRSMG provides more than 1 million outpatient visits annually at 19 locations throughout the region. In 2006, the group implemented the Allscripts Touchworks electronic medical record system to manage and connect patient care across clinic sites, urgent care centers, and affiliated hospitals.

The medical group received the Malcolm Baldrige National Quality Award in 2007 (with Sharp Healthcare) and has been recognized as one of the highest-quality medical groups in California by the Integrated Healthcare Association.

PROJECT SUMMARY

The SRSMG program focused on improving blood pressure control in patients with diabetes, who were part of the group's existing diabetes registry. A key driver for the program was alignment with California's Perfect Care pay-for-performance program, which emphasizes measurement of BP and other quality factors in patients with diabetes. SRSMG had already implemented a blood glucose control process for its diabetes population and wanted to build on that success.

GOALS AND OBJECTIVES

SRSMG had been looking forward to using its new electronic medical record to improve quality efforts. In late 2006, after the EMR was rolled out system-wide, the Quality Department and clinical leadership team established goals for the HTN project for patients with diabetes:

1. Integrate EMR BP readings into the data warehouse for the diabetes registry
2. Use reporting capabilities to improve BP control in patients with diabetes

The goal for HTN improvement in diabetes patients was BP of < 129/79 (JNC 6 guidelines).

HTN POPULATION

Patients with diabetes: n = 13, 471

Inclusion criteria:

- Aged 18-75
- HbA1c > 6.5, or 2 codes of DM on separate dates of service, or one inpatient/ED code of DM, or one fill of DM med (except metformin), *and*
- One code of DM, and
- In diabetes registry for at least 1 year.

Demographics

Age 18-35	951
Age 36-55	5,359
Age 56-75	7,161
Female	7,141
Male	6,330

Major ethnic groups: white, Latino, Filipino, black

IMPROVEMENT MODEL

Using a Six Sigma tool and an Ishikawa fishbone diagram, a multidisciplinary team mapped out and planned the process for the pilot program at 1 of SRSMG's 12 primary care sites (Rancho Bernardo). The cross-sectional team—which comprised physician, nursing, and operational champions, a data analyst, a medical assistant, a diabetes department representative, and a quality expert—was selected with the goal of influencing staff at all levels of the practice.

The improvement process for the pilot comprised four steps:

1. Updated nursing blood pressure skills competency/ standardized rooming
2. Clinical guidelines for BP management in patients with diabetes
3. Patient education/participation handout
4. Monthly reports to physicians

COMMUNICATIONS

The program's launch and key successes were communicated to primary care providers (family practice and internal medicine) regularly at monthly all-physician meetings. For the pilot at Rancho Bernardo, the three champions (physician, nursing and operational), all members of the project team, held a kick-off meeting and trained the staff. When the project was expanded to the other sites, three champions were chosen for each location. The project team trained these champions (using the "train the trainer" approach), who then worked with their own staff to implement the four steps. At each site, the physician champion trained the other physicians and the nursing and operational champions trained all of the clinical staff.

LEADERSHIP SUPPORT

The board of directors of SRSMG sets entity goals each year. With the aim of strengthening diabetes management, the board made BP control in patients with diabetes an entity goal for the organization. The medical director for continuum of care was the leader in charge of this effort; he selected the family practice physician at Rancho Bernardo as the physician champion for the project team. The support of the board and the involvement of these key physician leaders were critical to the success of the pilot and its subsequent expansion across the medical group.

1. Nursing Competency

An important success factor for the SRSMG HTN pilot program was to ensure nursing competency in BP measurement before rolling the program out to primary care physicians. This was done to anticipate a frequent complaint by physicians that nurses were not taking BP accurately or consistently.

When a primary care nurse is hired by SRSMG, he or she receives competency training in vital signs. The existing materials for BP competency training were reviewed and updated by the group's cardiologists, primary care leaders, and an educational specialist who supervises the competencies. Using the revised material, nurse managers trained each primary care nurse in the updated BP technique.

2. Clinical Guidelines

The multidisciplinary team worked with the chair of the clinical guidelines committee to produce a simple, easy-to-follow BP guideline for diabetes patients for use by primary care physicians. This one-page flow diagram lists medication suggestions. Key points include adding appropriate BP medications and seeing patients every two weeks until BP is controlled.

3. Patient Education/Engagement

The team developed a two-sided education and participation handout for patients. Supplies of the handout are kept in every primary care exam room. If a patient's BP is not controlled, the physician writes down the BP reading on the front side (which also contains educational information about BP and diabetes). The reverse side is a list of steps the patient can take to improve BP control. The physician asks

the patient to choose one intervention to pursue during the two weeks until the next office visit. This approach is effective because:

- It prompts the doctor to have a discussion of risk factors with the patient
- It asks the patient to commit to just one action—of the patient's own choice
- It provides a short timeframe between visits until BP is controlled, helping the physician monitor the situation closely

4. Physician Reports

Each month, a report is generated from the EMR and sent to each primary care physician. Each doctor's patients are listed in order of systolic BP, from highest to lowest, making it easy to identify and work on the highest-risk individuals first. Also included are BP readings from the last three dates of service so the doctor can see trends, as well as the most recent HbA1c reading, the most recent LDL cholesterol level, and the most recent and scheduled appointments with the primary physician, endocrinologist, and/or diabetes educator.

Some physicians choose to contact these patients themselves, while others ask their nursing staff to conduct the outreach.

The HTN project team also provides monthly, unblinded reports to each site showing all primary care providers and their current percentage of patients with diabetes measures (including BP) at goal. These reports are designed to give simple feedback and accountability, stimulating friendly competition and physician participation in this quality effort.

PHYSICIAN INCENTIVES

In addition to professional satisfaction and peer recognition of performance on quality, SRSMG primary care physicians receive an end-of-the-year bonus that is partly based on each doctor's performance in quality measures.

OUTCOMES

Just 4 months after implementing the 4-step plan at its Rancho Bernardo location, SRSMG saw a dramatic improvement of 34% (from 41% to 55% of patients at goal). Out of 12 groups in the national AMGA collaborative it participated in, the medical group was honored with the most improved performance. Notably, the group's intervention was also the simplest.

Results were announced at the all-physician staff meeting, and the team successfully made its case for a system-wide roll-out. Training for the remaining 11 sites began in February 2010 and concluded in July 2010.

As of September 2010, compliance stood at 50.7%, a 32% improvement across the organization. In that month, the medical director for continuum of care and the physician champion for the project team accepted an award for SRSMG as a "top performer" in California's P4P program.

An unexpected but welcome result of the program has been its impact on BP at goal for patients with uncomplicated HTN, which improved from 61% in December 2008 to 70% in May 2010. This "halo" effect appears to be the result of a cultural change among physicians and staff regarding quality efforts.

OVERCOMING BARRIERS

A significant challenge that the group faced was a change in BP target levels midway through the system-wide roll-out. The ACCORD blood pressure trial (*New England Journal of Medicine*, March 2010) raised questions about the safety of the JNC 7 recommended BP target of <130/80 in patients with diabetes.

To resolve this, the project team physician and medical director for continuum of care convened a "Hypertension Summit" consisting of well-respected primary and specialty physicians, board members, diabetes educators, executive nurses, and a pharmacist. After reviewing several research studies, the group came to a consensus to change the BP goal in patients with diabetes from <130/80 to <140/80. This decision was explained to all physicians.

This change caused extra work for the project team but it established a culture of integrity in the group's quality efforts, increasing the trust and engagement of physicians system-wide.

LESSONS LEARNED

- Hardwire quality goals for disease management into the culture
- Train nurses and clinical staff before physicians
- Select physician, nursing, and operational champions for each site
- Incentivize quality performance
- Update project goals if/when new research becomes available

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