Hypertension Best Practices Symposium

Improving Hypertension Control

ThedaCare Physicians
Appleton, WI

THEDACARE™

ORGANIZATION PROFILE

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. The group's 132 physicians and 69 mid-levels provide primary care (family practice, internal medicine and pediatrics) at 23 clinics. Approximately 420,000 office visits are conducted each year. ThedaCare is an early adopter of electronic medical records and has a completely paperless system.

PROJECT SUMMARY

The ThedaCare Physicians program utilizes a multifaceted approach to assist providers in caring for patients with uncomplicated HTN who are not at goal, bringing them into compliance, and maintaining compliance.

GOALS AND OBJECTIVES

The main goal of the project was to increase the percentage of patients with HTN whose BP is at a target of < 140/90. At project initiation in 2007, 72% of ThedaCare patients with uncomplicated HTN were at goal, and the aim was to increase that number to 80% or higher. The project targeted providers' processes with new tools and resources to help improve care and monitoring.

HTN POPULATION

The target population includes all active patients aged 18-85 with the diagnosis of uncomplicated HTN. An "active" patient has had two office visits in the past 24 months, with one of those visits in the past 12 months.

Patients with uncomplicated HTN: n = 14,000

Demographics:

- 18-39 yrs: 5%
- 40-59 yrs: 43%
- 60+ yrs: 52%
- Rural: 44%
- (Sub) urban: 66%
- Female: 55%
- Male: 45%
- On no meds: 25%
- On 3+ meds: 7.5%

IMPROVEMENT MODEL

Hypertension is the number-one diagnosis in the ThedaCare system, with more than 14,000 patients affected. The organization began its work to improve hypertension control in 1997, through its health plan. Even though ThedaCare no longer owns a health plan, hypertension continues to be an important initiative due to its continued clinical significance and high volume. However, the focus has changed from health plan-driven measurements to quality measures that are publicly reported; specifically, as part of the Wisconsin Collaborative for Healthcare Quality (WCHQ).

STRATEGIES

- Create a committee structure (Clinical Care Steering and Clinical Oversight committees)
- Obtain leadership support
- Develop a hypertension guideline reflecting evidence-based practice and integrate with the EMR
- Communicate the HTN project to all providers
- Operationalize the HTN project within all clinics
- Develop patient self-management and communication tools

COMMUNICATIONS

The project utilized a number of communication channels. Providers were informed via the medical director's newsletter, pharmacist presentations, and other educational activities at physician meetings. Also, the HTN protocol was made available within the EMR. Clinical Care Steering Committee members were responsible for communication with their own clinic sites. Finally, letters were sent to patients offering the Under Pressure program.

LEADERSHIP SUPPORT

Senior leadership support is critical to the success of this project. There is involvement from the highest levels of the organization. The Quality Committee of the board of directors considers HTN one of its top five priorities, and monthly reviews the rates. The senior executive team supports the HTN initiative and approves the expenditure of dollars to maintain and expand registry capabilities and functionality. The Health Information medical director is instrumental in supporting HTN project needs for the EMR.

PHYSICIAN INCENTIVES

When the health plan was sold, the organization's leadership considered the pros and cons of continuing a physician pay-for-performance program for meeting goals on certain quality measures. Due to the program's success, the leadership team decided to continue it, though with a modified payment structure and a reduced number of measures. Quality-based compensation is based on WCHQ reported measures.

It is a tiered system that determines dollar amounts of compensation:

Tier 1: the provider is within 4 percentage points below goal

Tier 2: the provider meets the goal

Tier 3: the provider exceeds the goal

PROCESS IMPROVEMENTS FOR PROVIDERS

Among the challenges facing the HTN project initially were lack of provider knowledge of the HTN evidence-based guideline, and difficulty reaching geographically dispersed clinics where busy physicians and staff have little time for educational programs.

To provide guidelines and tools to help providers improve HTN management, the Clinical Care Steering Committee reviews evidence-based guidelines and develops protocols and standards related to HTN management, and works with the Template Committee to weave guideline-based care into the daily work in the clinics.

- **Computerized tools and templates:** The HTN protocol is accessible from the EMR for the provider to reference. Templates in the EMR allow providers to document HTN care in a standard, guideline-based format and avoid omissions regarding a hypertension-focused visit. Templates also minimize variation in HTN care from one patient to another or from visit to visit.

- **Workflow:** BP is taken at every patient visit and recorded in the Vitals section of the EMR. The blood pressures may then be viewed on a flowsheet within the EMR for trends. If BP is elevated, it is rechecked. If the second reading is also elevated, the patient must speak to his/her physician before leaving the clinic. Previously, patients might leave without a discussion with the physician. With this new process, the doctor must take action.

- **Medication refills:** If a patient requests a refill for HTN medication, only a few months' supply is provided; this acts as a prompt to return to the office for a recheck.

- **Reports:** Monthly, an automated e-mail is sent to all physicians showing HTN results by clinic site and individual provider. The data are unblinded so clinics and providers can see how they stand in comparison to their peers. Physi-

cians can see details down to the individual patient level so they can target patients not at goal. Medical assistants and nurses contact patients who are in need of a repeat BP, or schedule patients who are in need of office visits.

PHYSICIAN EDUCATION

Because medication compliance is a major issue in HTN control, a health system pharmacist gave presentations at physician meetings about how to help patients overcome cost barriers and other challenges. The pharmacist discussed the use of generics and other strategies for "getting the biggest bang for the buck" from prescriptions. These presentations were very popular with physicians.

STAFF TRAINING

Due to variation in BP measurement techniques across clinics, the clinical educator developed a competency training and testing program for clinic staff. This competency must be completed upon hire and yearly. A BP simulation arm allows staff to practice correct technique and more importantly, allows the instructor to listen for systolic and diastolic measurements at the same time as the student.

PATIENT EDUCATION

Physicians do the primary teaching, but are supported by dietitians and nurses who call patients and provide information and guidance. In addition, the group offers free calibration of home BP monitors.

ThedaCare implemented the Under Pressure self-management program from Daiichi Sankyo to promote patient compliance through education. This was a one-time, opt-in program. Invitations were sent to 885 patients. A group of 106 patients over 60 years old chose to participate. This age group was chosen due to feedback from another medical group that used the Under Pressure program—this was the most engaged age group in the program. At inception, none of the participants had BP at goal, but by the end of the program, 70% were at target.

Participating patients received a DVD and other incentives along the way to help them manage their BP. The main incentive was the opportunity to receive a free home BP monitor if they completed all the steps (watching the DVD, returning questionnaires). Feedback from patients was quite positive.

The most motivating elements of the program, as reported by the patients, were:

1. Diet suggestions
2. Information on health problems associated with high BP
3. Nutritional information
4. Weight loss tips
5. Info on exercise
6. BP medication information
7. Smoking cessation

OUTCOMES

The HTN project showed steady improvement from implementation to the present.

ThedaCare WCHQ (publicly reported) rates for patients with uncomplicated HTN (<140/90) at goal:

- Year end 2007 = 72 %
- October 2008 = 77 %
- October 2009 = 80 %
- August 2010 = 81 %

OVERCOMING BARRIERS

The two main roadblocks facing ThedaCare Physicians were communicating the program's goals and providing training to multiple providers across multiple sites, and resolving conflicting priorities. The team relied upon diverse approaches to find the ones that would resonate with each provider and site, obtained leadership support from the medical director, focused attention on lower-performing sites, and publicized successes to encourage awareness and sustained improvement.

LESSONS LEARNED

- Leadership support is crucial
- Provider champion/leader is also critical to success
- Provide data which points to improvement and measure the successive improvement
- Standard competency (in blood pressure measurement) should not be assumed; provide education
- Engage office staff in the improvement efforts
- Celebrate successes

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One Prince Street, Alexandria, Virginia 22314-3318
Tel: (703) 838-0033 Fax: (703) 548-1890 www.amga.org