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Into Practice

Team-based care to improve control of hypertension in an inner city practice

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ABSTRACT

The purpose of this case study was to identify which intervention or interventions, if any, resulted in improved hypertension control in an intercity public practice.

Data includes interventions, graphed chronologically and the results in the form of percentage of patients with controlled hypertension.

Challenges to success included understaffing of the practice and significantly limited access to appointments. Also, the variety of patients' languages and cultures presented a challenge.

We reached our target of 60% of patients meeting criteria for control of hypertension. Although we instituted several interventions and all cumulatively contributed to the outcome, the two likely to be most effective were the establishment of hypertension-only appointments with either primary providers or with nurses. Both of these interventions resulted in an increased number of available appointments and improved access to timely follow up.

1. Background

In 2012 the Health and Hospitals Corporation (HHC), the safety-net public hospital system in NYC distributed hypertension (HTN) control data to its ambulatory care facilities. This data was entered into a user-friendly computerized registry, developed so that the corporation, departmental administrators and individual providers could assess HTN control. At Jacobi Medical Center about 37% of all HTN patients in the database were at the target control level with blood pressures less than 140/90 mm mercury. Because of uniformly suboptimal results at its facilities in comparison to national data[1]. HHC issued a challenge to improve control rates to 60 percent.

2. Organizational context

In a system that is chronically underfunded and understaffed, waiting time for appointments can be long. Appointment access is particularly problematic for new patients to the practice. In addition many of the patients in the system fall below the poverty level and a significant percentage do not speak English and/or have limited health literacy. Most patients have public insurance and are able to obtain their antihypertensive medications. However, copayments or lack of medication coverage are barriers to adherence in our population.

3. Personal content

The practice's HTN-control registry data was viewable in its entirety, and could also be viewed by type of provider (all training physicians, for example) as well as by each provider individually. Providers were taught how to access their HTN registry data which they could compare to the group data. The data of an individual provider could be seen only by the provider himself and his supervisors and higher level administrators of the practice and hospital, so Dr. A. could not compare himself directly to Dr. B., but could compare himself to his peer group.

Problem. How could we both create more access for HTN patients and also find cost-effective management strategies that could benefit our diverse patient population?

Barriers to optimal hypertension control could be categorized into the following specific areas: staffing, access to care and the traditional care model.

4. Staffing

Our practice appears to be more robustly staffed than it actually

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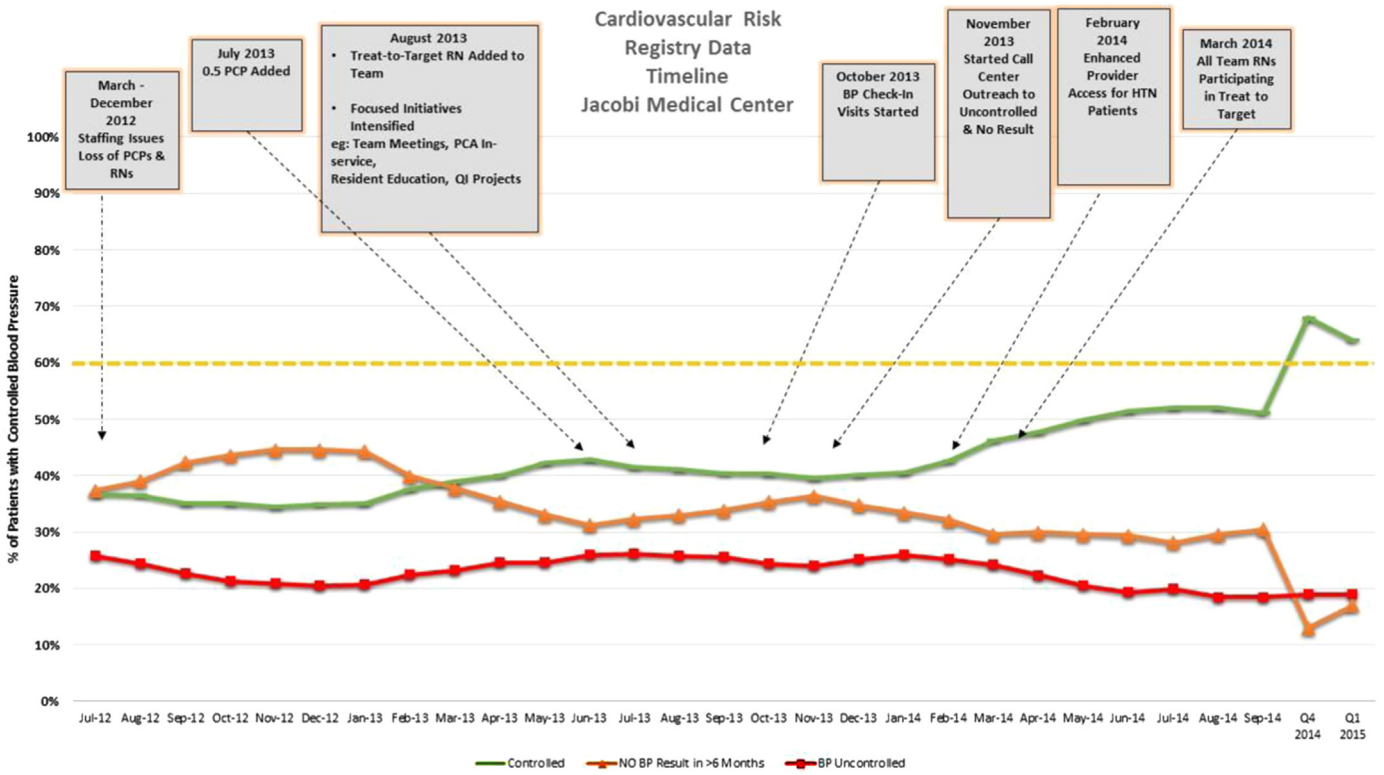

Fig. 1. Intervention timeline and % of patients with controlled blood pressure.

is. Of 15 physicians in the practice, half are part-time. Additionally, we have a large residency program, with about 110 residents, and are the primary teaching site for a required ambulatory medicine rotation for the medical school. Our attending physicians supervise in the practice, roughly as often as they see their own patients, but also provide other service to the hospital by functioning as in-patient service attendings and specialty service attendings. As medical school faculty, many devote significant time teaching in the classroom setting as well.

There are four nurse practitioners (NPs) in the practice. Like the physicians, they spend a significant amount of time away from seeing patients in the general medical practice because they review and follow up on all abnormal laboratory results from nearly all the medicine and medical specialty out-patient practices and participate in other practice settings as well. Because the patient-care staff is spread so thin and because of the less than optimal ability to recruit primary care providers, our “safety net” practice has more challenges with meeting the demand for appointments than ever before.

5. Access

Access to care is a daunting challenge for our practice. Our goal is to have same day appointments available at all times and a routine next available appointment with most providers within 14 days. We have not been able to achieve this goal. Primary care access is a national problem and as more people have become insured and with demographic changes and increasing numbers of patients with chronic disease – this is not likely to become any less challenging in the near future. Through a review of approximately 40 charts, we learned that patients with uncontrolled blood pressure who required quick follow up were often not able to obtain this required follow up in a timely manner. Providers may have suggested a follow up visit to check blood pressure in 2–4 weeks but due to lack of appointment availability, this often would not be scheduled in that timeframe and the patient may have left the practice without a return visit scheduled. This sent the wrong message to our patients – that their uncontrolled hypertension was not that important and it could wait. We also became aware that we needed to use population management strategies (database review, outreach and reminder calls, etc.) to be sure that we were getting the patients who most needed the follow up into the practice.

6. The care model

Given our needs and limited resources, we were challenged to design a program that would utilize other members of our team to see the patients back for quick follow up so that we would not block access for other patients needing care. Our registered nurses had not been in this type of role on a large scale before. With a multidisciplinary team including nurses, medical assistants or PCA's, attending physicians and practice administrators we designed our “Treat to Target” program.

Our traditional model, where the primary provider was responsible for all the patient education and management was time consuming. We had few printed educational resources for our patients and minimal resources in languages other than English. Teaching non-English speaking patients via telephone interpreter was also inefficient for the providers who were (and are) pressured to see more patients in less time.

7. Solution

The outpatient medical practice, already functioning as a patient-centered medical home, delegated planning for the HTN challenge to a team of staff members. The team concept has