The Central Role of Physician Leadership for Driving Change in Value-Based Care Environments

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ABSTRACT

BACKGROUND: In 2013, it was reported that about 1 of every 3 U.S. adults has hypertension. Of these 70 million individuals, approximately 50% have their blood pressure under control. Achieving hypertension control, especially in at-risk populations, requires a multipronged approach that includes lifestyle modifications and pharmacological treatment. As provider groups, hospital systems, and integrated delivery networks optimize their care processes to promote population health activities in support of the accountable care organization (ACO) model of care, managing hypertension and other chronic diseases will be essential to their success. A critical aspect of managing populations in an ACO environment is optimization of care processes among providers to increase care efficiency and improve patient outcomes.

PROGRAM DESCRIPTION: Launched in 2013, Measure Up/Pressure Down is a 3-year campaign developed by the American Medical Group Foundation (AMGF) to reduce the burden of high blood pressure. The goal of the campaign is for participating medical groups, health systems, and other organized systems of care to achieve hypertension control for 80% of their patients with high blood pressure by 2016, according to national standards. The role of physician leadership at Cornerstone Health Care (CHC) and Summit Medical Group (SMG) in facilitating organizational change to improve hypertension management through the implementation of the Measure Up/Pressure Down national hypertension campaign is examined.

OBSERVATIONS: Using patient stratification via its electronic health record, SMG identified 16,000 patients with hypertension. The baseline percentage of hypertension control for this patient population was 66%. Within 7 months, SMG was able to meet the 80% goal set forth by the AMGF's Measure Up/Pressure Down campaign. CHC diagnosed 25,312 patients with hypertension. The baseline percentage of hypertension control for this subgroup of patients was 51.5% when the initiative was first implemented. To date, the organization has achieved 72% hypertension control for at-risk patients and continues work towards the 80% campaign goal. The implementation of the Measure Up/Pressure Down campaign by CHC and SMG provides some valuable lessons. To further explore important aspects of successfully implementing the Measure Up/Pressure Down campaign in real-world settings, 6 key themes were identified that drove quality improvement and may be helpful to other organizations that implement similar quality improvement initiatives: (1) transitioning to value-based payments, (2) creating an environment for success, (3) leveraging program champions, (4) sharing quality data, (5) promoting care team collaboration, and (6) leveraging health information technology.

IMPLICATIONS: The strategies employed by SMG and CHC, such as leveraging data analysis to identify at-risk patients and comparing physician performance, as well as identifying leaders to institute change, can be replicated by an ACO or a managed care organization (MCO). An MCO can provide data analysis services, sparing the provider groups the analytic burden and helping the MCO build a more meaningful relationship with their providers.

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What is already known about this subject

- Achieving hypertension control, especially in at-risk populations, requires a multipronged approach that includes lifestyle modifications and pharmacological treatment.
- A critical aspect of managing populations in a value-based care environment is the optimization of care processes among providers to increase care efficiency and improve patient outcomes.

What this study adds

- Insights are shared from Cornerstone Health Care and Summit Medical Group's implementation of the American Medical Group Foundation's Measure Up/Pressure Down initiative, which seeks to achieve hypertension control for 80% of the participating provider groups' patients with high blood pressure by 2016.
- Cornerstone Health Care and Summit Medical Group have seen improvements in hypertension control for their at-risk patients and have identified key aspects of the initiative's success that may be helpful to other providers that are adapting to value-based care environments.

In 2013, it was reported that about 1 of every 3 U.S. adults has hypertension. Of these 70 million individuals, approximately 50% have their blood pressure under control.¹ Achieving hypertension control, especially in at-risk populations, requires a multipronged approach that includes lifestyle modifications and pharmacological treatment.² Medication therapy plays a critical role in preventing the long-term morbidity associated with uncontrolled hypertension.³ As provider groups, hospital systems, and integrated delivery networks optimize their care processes to promote population health activities in support of the accountable care organization (ACO) model of care, managing hypertension and other chronic diseases will be essential to their success.

Beginning with the Centers for Medicare & Medicaid Services (CMS) launch of the Pioneer ACO Model and Medicare Shared Savings Program (MSSP) in 2012, ACOs have been heralded as one of the more promising alternative payment models to incentivize improved care and reduced costs.⁴⁻⁶ Quality of care in the MSSP is measured by 33 quality metrics. Not only is controlling hypertension for at-risk patients specifically measured (ACO #28) in the ACO program, but the ability of

FIGURE 1 Measure Up/Pressure Down Campaign Planks

©American Medical Group Foundation (AMGF), Measure Up/Pressure Down, Provider Toolkit. AMGF; 2013 (http://www.measureuppressuredown.com/HCPProffind/provtoolkit_find.asp).

BP = blood pressure; Rx = prescription.

providers to deliver quality care for this patient population can have positive downstream effects on other metrics measured in the MSSP.⁷ In addition, with CMS penalizing hospitals for the readmission of patients diagnosed with acute myocardial infarction and heart failure, the financial ramifications of not effectively controlling a patient population's hypertension are greater than ever in the area of value-based payments.⁸

A critical aspect of managing populations in an ACO environment is optimization of care processes among providers to increase care efficiency and improve patient outcomes. Medication therapy, as a core component of care, plays an important role in patients' health. Previous research has highlighted the role of medications in ACOs and the processes associated with effective medication management and has provided examples of how ACOs are leveraging medication, technology, and pharmacists to achieve success.⁹⁻¹² It is well established that pharmacists and collaborative care teams are able to effectively deliver hypertension interventions.^{13,14} To further explore the role of all care providers in delivering a multifaceted hypertension intervention, the authors specifically highlight the role of physician leadership. This article builds on previous work by examining the role of physician leadership at Cornerstone Health Care (CHC) and Summit Medical Group (SMG) in facilitating organizational change to improve hypertension management through the implementation of the

American Medical Group Foundation's (AMGF) Measure Up/Pressure Down national hypertension campaign.^{11,12} Measure Up/Pressure Down is a hallmark example of driving quality improvement in a value-based environment, and many aspects of the program can be applied to other chronic conditions.

Program Description

The 2 organizations profiled in this article are committed to delivering value-based care, which gives them a strong incentive to implement programs such as Measure Up/Pressure Down. SMG is a physician-run, multispecialty group with locations throughout northern and central New Jersey. Consisting of 550 physicians and more than 2,000 employees at 73 locations, the organization serves 440,000 patients, with approximately 180,000 of those patients in various shared savings contracts. CHC is a physician-owned, multispecialty group located throughout central North Carolina. With over 375 physicians, pharmacists, and advanced practice providers, Cornerstone serves approximately 250,000 patients, all of whom are covered by some form of value-based contracting.

The Measure Up/Pressure Down Campaign

Launched in 2013, Measure Up/Pressure Down is a 3-year campaign to reduce the burden of high blood pressure.¹⁵ The goal of the initiative is for participating medical groups,

health systems, and other organized systems of care to achieve hypertension control for 80% of their patients with high blood pressure by 2016, according to national standards.² This is being accomplished by mobilizing participating organizations to improve blood pressure prevention, detection, and control by using effective care processes (“campaign planks”) identified during AMGF’s 2 Best Practices Collaboratives that focused on hypertension and in consultation with the campaign’s National Steering Committee and Scientific Advisory Council (Figure 1).

Each participating group in the Measure Up/Pressure Down program voluntarily agrees to 3 requirements: (1) to aim for 80% blood pressure control in their attributed population; (2) to adopt at least 1 of the evidence-based practices recommended by the campaign; and (3) to report quarterly data back to the campaign. Each group can tailor the clinical interventions to their organizations, thus affording flexibility in approach and resource requirements. Some care process changes are easier for many organizations, such as adoption of a hypertension treatment guideline. Others are more challenging, such as ensuring that specialists take blood pressure readings at all visits. Over time, successful organizations have adopted more of the recommended new processes.

Campaign Results

Using patient stratification through its electronic health record (EHR), SMG identified 16,000 patients with hypertension. The baseline percentage of hypertension control for this patient population was 66%. Within 7 months, SMG was able to meet the 80% goal set by AMGF and the Measure Up/Pressure Down campaign. SMG was able to achieve this goal through direct engagement with providers, quality reporting, and tying payments to outcomes. In addition, hypertension control was one of the metrics for primary care providers on their dashboards and was imbedded in the bonus calculation.

CHC diagnosed 25,312 patients with hypertension. The baseline percentage of hypertension control for this subgroup of patients was 51.5% when the Measure Up/Pressure Down initiative was first implemented. To date, the organization has achieved 72% hypertension control for at-risk patients and continues work towards the 80% campaign goal.

Nationally, 447,764 patients at participating provider groups have improved hypertension detection or control since the launch of Measure Up/Pressure Down. Control rates improved from 68.8% in the first quarter of 2013 to 70.0% in the first quarter of 2015, a relative improvement of 1.7%. In addition, 5 groups have improved control rates by at least 10%, and all 91 participating groups reporting data to Measure Up/Pressure Down have control rates above the national average of 47%.¹⁶

Observations

Throughout the past 3 decades, the promise of evidence-based medicine (EBM) has been widely touted as the mechanism to reduce practice variation and improve patient outcomes.¹⁷

However, translating and implementing EBM processes at an institutional level has proven difficult for many health care providers.¹⁸ Value-based payments can be a way to incentivize implementation through standardized measurement of quality and payments that reward better outcomes. To further explore important aspects of successfully implementing the Measure Up/Pressure Down campaign in real-world settings, 6 key themes were identified that drove quality improvement and may be helpful to other organizations implementing similar programs: (1) transitioning to value-based payments, (2) creating an environment for success, (3) leveraging program champions, (4) sharing quality data, (5) promoting care team collaboration, and (6) leveraging health information technology. These themes are discussed in the following sections.

Transitioning to Value-Based Payments

Physician leadership and support is critical for a successful transition to value-based payments to ensure that providers are adequately prepared for this new environment. In order to overcome providers’ initial concerns about shifting to value-based payments, CHC established a 2-year, guaranteed minimum salary based on physicians’ historical productivity. This strategic decision allowed CHC to retain a significant portion of its high-volume physicians who may have left the organization if it were not for the minimum salary guarantee. Further demonstrating the organization’s commitment to value-based payments, the minimum salary guarantee was funded primarily through debt financing. This approach was promoted by physician leaders in the organization. As former clinicians, physician executives understood the importance of providing financial reassurance to providers during times of transition.

SMG approached the issue in a different manner, since all providers are part owners, so they already have financial buy-in to transition to value-based payments. SMG’s experience is unique since all of the providers benefit from the organization’s success in value-based payment models. Therefore, all of the providers, regardless of their specific patient panel, had incentives to achieve the Triple Aim. In addition to the organization’s incentives to improve care and reduce costs for the whole practice, value-based payments were incorporated into the bonus pool that was distributed to providers based on their individual performances. The organization found that the provider-level incentive has been an effective mechanism to achieve organizational buy-in.

Creating an Environment for Success

The introduction of new processes, such as those in Measure Up/Pressure Down, is often met with resistance.¹⁹ Health care provider groups and systems have continually struggled with how to best achieve large-scale change.²⁰ Understanding and adapting newly introduced processes to fit organizational culture is critical for implementation success.²¹ Instituting organizational change can be supported and championed by

physician leadership. Like many other health care providers, CHC and SMG had to implement and adapt evidence-based practices to their organizations' culture. SMG established evidence-based practices through a multidisciplinary group, which featured presentations from frontline providers as opposed to administrators. These individuals were some of the most respected clinicians in the organization, and their influence was helpful in gaining widespread approval and adoption of the new practices.

In order to engage physicians, nurses, pharmacists, and other support staff, SMG developed a task force in which all clinical staff could have input in the guidelines that would influence the Measure Up/Pressure Down initiative's implementation. Physician leaders were able to act as intermediaries between their clinical staff and executive leadership to ensure that the transition went smoothly. This early engagement with all clinical staff was been critical to the initiative's initial success.

Leveraging Program Champions

The CEO of CHC is its most prominent champion of the Measure Up/Pressure Down and other value-based initiatives. With vision and guidance from the highest level of the organization, physicians have been willing to implement the program in a systematic fashion. CHC also used a dedicated licensed practical nurse who focused solely on training lower-level clinical staff, such as physician assistants, on the Measure Up/Pressure Down campaign planks (Figure 1 and Appendix, available in online article). CHC communicated with its clinical staff that the campaign was not about changing the way each individual provider practices; rather, it was a systemwide change where value-based incentives were aligned with achieving blood pressure control.

As a provider-owned, multispecialty practice, SMG benefited from champions in each respective practice and specialty to ensure that buy-in was achieved in all facets of the organization. The medical directors of population health and of quality were involved, in addition to countless physician leaders. SMG also involved its pharmacy leader from the launch of the initiative, and this individual was highly influential in the organization's development of care processes related to medication to improve hypertension control for SMG's high-risk population. Having the involvement of multiple levels of leadership creates a snowball effect throughout an organization and is a significant contributor to Measure Up/Pressure Down's success. Also, in order to establish awareness of the initiative, SMG directed resources to marketing materials that targeted patients and providers

Sharing Quality Data

SMG and CHC found that physicians were especially motivated to improve patients' hypertension control after seeing the results of peers. To instill accountability, physician leaders determined that sharing performance data would be a key

driver to quality improvement. For example, CHC initially furnished blinded individual reports to providers for the first 3-4 months before sharing reports of all their peers. No provider wants to be at the bottom of the quality list, and this drives providers to seek additional guidance from quality staff as to how they can improve their patients' hypertension control.

SMG first approached report sharing in a blinded manner with the caveat that the reports would be unblinded after providers gained experience. While there was some initial resistance, it eventually faded. All of the providers improved except for a few, and these individuals were provided opportunities to engage with either of the 2 medical directors (quality or population health) involved or a pharmacist to help improve their results. This approach allowed for all providers to understand how their peers were doing, and the atmosphere of transparency resonated throughout the whole organization.

Providing patient care data to providers is perhaps the most important contributor in getting them to change their behaviors. Not only are these data informative for each provider, but they can also serve as a catalyst for system-level dialogues. Reviewing patient care data allows practices to identify which providers are succeeding in their quality metrics, and organizations can seek out these physician leaders to identify learning opportunities for other care teams. Since medication therapy is an important component of blood pressure control, data sharing can serve as a starting point for discussion among providers and care teams on how medication regimens achieved optimal patient outcomes and, ultimately, improved providers' quality scores.

Promoting Care Team Collaboration

Effective physician leadership recognizes the value that pharmacists, nurse practitioners, and physician assistants bring to the care team. In line with Measure Up/Pressure Down's campaign planks, each member of the care team plays an integral role in controlling patients' hypertension. All team members are trained in accurate blood pressure measurement and made aware of the importance of blood pressure management and target blood pressures for each patient. Pharmacists provide valuable insight into patients' medication management interventions. Tasks led by pharmacists with appropriate physician oversight include medication reconciliation, adjusting medication dosages, and checking for drug-drug interactions. All of the team members' efforts are to ensure optimal therapy and to promote patient adherence.

Pharmacists, nurses, and medical assistants employed with CHC and SMG contributed to their successful implementation of Measure Up/Pressure Down and value-based care agreements. The informatics tools used by CHC and SMG leveraged EHR and claims data to detect and stratify patients with hypertension according to severity and control. For patients who met

FIGURE 2 Cornerstone Health Care Hypertension Pathway

Used by permission from Cornerstone Health Care.

ACE=angiotensin-converting enzyme; ARB=angiotensin II receptor blocker; BP=blood pressure; CKD=chronic kidney disease; DM=diabetes mellitus; dx=diagnosis; eGFR=epidermal growth factor receptor; HCTZ=hydrochlorothiazide; HF=heart failure.

the high severity criteria and were not already on the clinical pathway were prioritized for clinical review by a pharmacist as a centralized “hub” location. During the review process, the clinical pharmacist looked for potential drug therapy problems, including drug interactions, inappropriate medications, inappropriate dosage, and patient compliance. Based on the review, the pharmacist completed a patient specific medication action plan designed to optimize therapeutic outcomes. The action plan was then shared with the patient’s clinical team for additional patient follow-up. To promote care continuity, CHC leveraged nurse navigators to ensure that patients were adhering to

the treatment plan and that appropriate follow-up appointments were scheduled so that hypertension control was maintained.

SMG engaged pharmacists upon implementation of the national campaign. Pharmacy leadership sought consensus among physicians to develop tailor-made protocols that determined when pharmacists should refer to an internist and what medications to use in certain clinical situations. The experiences of both organizations highlight the importance of empowering all care providers when introducing new care processes in a value-based care environment.

Leveraging Health Information Technology

As the primary users and gatekeepers of patient data, physician leaders followed guidance from Measure Up/Pressure Down to leverage the use of hypertension patient registries in order to note comorbid conditions, track goals, and identify gaps in care. Since medication therapy is an important component of blood pressure control, the use of these data can help guide treatment decisions and spur dialogue among providers as to which medication regimens have been successful with specific patient types.

In order to streamline workflow, CHC integrated clinical pathways for hypertension into their Allscripts EHR care guide. The organization also built care guides, based on published best practices and in accordance with Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, in which the clinical pathway was embedded. Recognizing that just providing additional information may not result in the data being effectively used, CHC empowered its care managers to open the care guide for additional documentation. CHC's overall vision was to make the right care processes easier than not using them (Figure 2).

Focusing on patient identification, SMG leveraged their patient registry to identify and track at-risk patients with hypertension. Through the registry, the medical director of quality analyzed the data to identify success factors that are associated with greater hypertension control. For example, SMG specifically looked at what medications are most commonly prescribed and which are most successful in assisting patients to achieve hypertension control. Although this is not directly integrated into the clinical decision support software, providers are able to easily access the hypertension protocols with minimal click-throughs. Finally, the additional data shared with both organizations from AMGF provided valuable insight as to how they can better improve their care processes. AMGF also provides quarterly reports to participating groups with benchmarks so they can compare their performances with their peers and to encourage sharing of best practices among medical groups.

Implications

Although the real-world experiences shared in this article are from the perspective of provider groups, many aspects of the intervention and lessons learned are applicable to other ACO settings.

The strategies employed by SMG and CMC, such as leveraging data analysis to identify at-risk patients and compare physician performance, as well as identifying leaders to institute change, can be replicated by an ACO or a managed care organization (MCO). An MCO can provide data analysis services, sparing the provider groups the analytic burden and helping the MCO build a more meaningful relationship with its providers. MCO analytics may include risk stratification that can be incorporated into quality programs at the group level. However, this may be challenging for MCOs that do not have access to EHR data.

MCOs can provide additional insight into the services that a patient receives outside of a single provider's care setting, which would be helpful in reducing duplicative care. In addition, MCOs can leverage their larger provider networks to compare physician groups as a whole rather than only on the provider level. This type of analysis can help MCOs develop value-based referral networks and establish incentive payments for providers who are following best practices in hypertension care.

As provider groups and health systems rely more on value-based payments rather than traditional fee-for-service payments, physician leadership will play an important role in care team transformation to meet quality and financial metrics associated with value-based contracting. With CMS encouraging providers to accept more risk via MSSP Track 3, the next generation ACO model, and the recently announced Comprehensive Care for Joint Replacement Model, providers and MCOs should think proactively about how they can standardize care to help achieve the Triple Aim. Although the Measure Up/Pressure Down campaign focused on patients with or at-risk for hypertension, the lessons learned can be applied to other clinical areas in which defined protocols have been established that are ripe for optimizing medication therapy and care processes in an effort to achieve higher quality care and better patient outcomes.

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Study concept and design were contributed by Lustig, Penso, Westrich, and Dubois. Lustig, Ogden, Brenner, and Penso collected the data, and data interpretation was performed by all authors. The manuscript was written primarily by Lustig, along with the other authors, and revised by Lustig, Penso, Westrich, and Dubois, assisted by Ogden and Brenner.

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APPENDIX Detailed Description of Measure Up/Pressure Down Campaign Planks

Plank	Description
Direct Care Staff Trained in Accurate BP Measurement	All team members involved in direct patient care should be trained in taking blood pressures according to a standard process. An annual evaluation/certification should involve both the ability to follow the process and blood pressure measurement accuracy. The entire on-site team should, through training, be aware of the importance of hypertension management and target blood pressures. Team members should be encouraged to comment to patients on their progress especially when not at goal.
Hypertension Guideline Used and Adherence Monitored	Each organization will adopt and deploy a process or algorithm to guide therapy in accordance with JNC 7 Guidelines. In addition, the ADA and NCQA goal for diabetic patients (140/90) should be included in the algorithm.
BP Addressed for Every Hypertension Patient at Every Primary Care or Cardiology Visit	This will occur without exception, and processes are in place to monitor adherence.
All Patients Not at Goal or with New Hypertension Rx Seen within 30 Days	When patients are not at goal or have had a new Rx or change in Rx, they should be scheduled for a return visit with primary care within 30 days. Visit reminders may be useful in ensuring that patients keep their appointments.
Prevention, Engagement and Self-Management Program in Place	There is a program to educate patients on lifestyle, diet, exercise, and the importance of taking antihypertension medications. The program emphasizes patient engagement in their care and teaches self-management skills.
Hypertension Registry Used to Track Patients	A method is in place to identify all hypertension patients before each visit and to note whether they have comorbid conditions that could affect their BP control, whether they are at goal, and whether there are gaps in care.
All Team Members Trained in Importance of BP Goals and Metrics	The entire on-site team should, through training, be aware of the importance of hypertension management and blood pressure goals. Team members should be encouraged to comment to patients on their progress and on the importance of medications, especially when patients are not at goal.
All Specialties Intervene with Patients Not in Control	All specialty departments should routinely take blood pressures of adult patients and refer the not-at-goal patients to primary care. When possible, a primary care appointment should be made before the patient leaves the specialty appointment.

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ADA=American Diabetes Association; BP=blood pressure; JNC 7=Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; NCQA=National Committee for Quality Assurance; Rx=prescription.