

John Clymer: Hi, my name is John Clymer and I'm Executive Director at the National Forum for Heart Disease and Stroke Prevention (National Forum). The National Forum is working in collaboration with the Association of State and Territorial Health Officials (ASTHO) to promote the Million Hearts initiative, the goal of which is to prevent a million heart attacks and strokes in a five-year period ending in 2017. This podcast to which you're listening was developed to inform state and local public health department chronic disease program staff and clinicians on the use of successful strategies to improve diagnosis, treatment and control of high blood pressure. At the end of the session you should be able to describe the problem of hypertension control in a clinical base setting population, describe the planning process to identify hypertension control strategies, describe key successes and challenges to implement strategies for hypertension control, and describe the results achieved through the implementation of strategies.

We are pleased today to have an expert in hypertension control in a primary care practice, Dr. Craig Gilbertson, who is a family practice physician with the P. S. Rudie Medical Clinic in Duluth, Minnesota. Dr. Gilbertson, welcome.

Dr. Craig Gilbertson: Thank you for this invitation to participate in this podcast, and again, greetings from Duluth, Minnesota, and the westernmost port on the Great Lakes at the head of Lake Superior. I've been in practice as I think John said at P.S. Rudie since August 1985 and will be celebrating 30 years this coming August. P.S. Rudie is a small family medicine clinic in downtown Duluth, a city of about 80,000.

John Clymer: And Dr. Gilbertson, about how many practitioners do you have in your practice?

Dr. Craig Gilbertson: We have nine providers, seven physicians, and two physician extenders, a nurse practitioner and a physician assistant.

John Clymer: Okay, terrific. And your practice, the P. S. Rudie clinic, was recognized by the CDC and Centers for Medicare and Medicaid Services as a Million Hearts Hypertension Control Champion because you had very successfully moved the needle in a positive direction on hypertension control among your patients, so congratulations on that.

Dr. Craig Gilbertson: Thank you very much.

John Clymer: We know that you raised your hypertension control rates, Dr. Gilbertson, from about 73% up to 86%, and you did so using the resources and capacity available to you in a relatively small clinic, and I believe you did that in collaboration with some other entities – the local health agency and the state Department of Health. Can you describe that a little bit?

Dr. Craig Gilbertson: Sure. So, John, maybe what I'd like to do is first respond to the question of what is the current reality of hypertension diagnosis treatment and control in our population. As a way of background, St. Louis County, which is our county, is a county that includes our city of Duluth and is in the State of Minnesota. The County of St. Louis County has a hypertension prevalence rate of about 25 percent. P. S. Rudie has a hypertension prevalence rate of about 23 percent. Our hypertension control rate at P. S. Rudie started fairly high at the beginning of this grant, namely 73.1 percent. The State of Minnesota averaged 75 percent. Our clinic control at the end of the grant was 85.5 percent. At the end of this last November it was 83.7 percent, and at the end of May this year the control rate was 84.4 percent. So we've been fairly persistent and/or consistent with maintaining that rate and very happy about that.

John Clymer: Congratulations.

Dr. Craig Gilbertson: Thank you. Given that background information, the next question is, well, how did we achieve these hypertensive control rates. And I'd like to address the question with somewhat of a multi-faceted response. I put together what I consider to be a 10 point list of thoughts on what we believe may be contributing to a higher rate of hypertensive control.

First, number one, P. S. Rudie has been an established small group family medicine practice for 70 to 80 years. We were an independent practice until 2007 when we joined the St. Luke's multi-specialty healthcare system. We've always prided ourselves with providing patient and family oriented care, and, frankly, continuity of care as family physicians. We strongly believe that that type of relationship and care model builds trust, compliancy and accountability. We recently also gained the status of medical home and are attempting to use that model as well to its best effect.

Number two, we've always felt very strongly about a team approach to the care of the patient. All in this clinic are valued, from reception to physician. All have a vested interest in the patient and their care, thus contributing to success.

Number three, we have a very loyal patient population, as you can imagine with the longevity that we have, and that perhaps, and because of that perhaps more people are compliant with treatment and follow up. Loyalty has been a foundation in the first two points mentioned earlier.

Number four, our clinic has been fortunate to have an environment promoting wellness with many years experience and quality improvement initiatives. And most recently we were also invited to be part of a wellness grant called Healthy Northland, which was specifically aimed at addressing obesity and tobacco abuse. That grant was spearheaded by our local quad county community health board. Obviously, or perhaps not so obviously to some, having such initiatives as these in the Million Heart hypertensive control challenge bring the issue at hand to a higher level of awareness with providers and staff. This awareness then stimulates a higher level of vigilance and formulation of strategies for better care.

Well, that's a lot to say. All that being said, I distinctly believe that our involvement with our local community health board grant, and about the same time, the million hearts hypertensive control challenge, did indeed stimulate an increased awareness and increased our control rates perhaps even further.

Finally, we must admit that in the middle of this grant, the JNC 8 came out, which changed the treatment parameters somewhat, allowing for a slightly higher blood pressure, especially in those over 65, which may have improved some of our percentage numbers, and this is stated just to be in all honesty. Yet, despite that, we've been able to maintain those high hypertensive control numbers.

So now I'd like to speak to some more day-to-day strategies that we've employed to aid in hypertensive control.

So number five, sharing an understanding of the goals of treatment, especially as providers, and then taking the time to discuss the problem of hypertension with our patients, or educating our patients, and equally important, engaging their participation.

Number six, monitoring prescription refills is a way to look at compliance and also follow up, and, I might add with somewhat of a groan, reading notices from insurance companies about patient's needs or compliance. Those are indeed helps and should be looked upon as helps.

Number seven, being sure that follow up appointments are scheduled at the time of the visit. Being very careful to make sure that the patient has scheduled follow up, that they're not lost to follow up.

Number eight, reviewing the accurate measurement of blood pressure with staff. Actually being sure that staff are certified, have knowledge in the appropriate way of doing blood pressure measurement. We've also flagged blood pressure measurements, once the staff does a blood pressure, being sure that that's flagged either in the computer by lighting up in red as an abnormal blood pressure reading, or simply using a magnetic door, little chip that we put on the door that indicates this patient has an abnormal blood pressure and needs follow up.

Number nine, as part of our strategy, supplied blood pressure cuffs to patients for monitoring blood pressure out of the office. And as we all know as healthcare providers we often see the white coat hypertension that results in higher blood pressure here in the office, which may not be a true reading, and in fact may indeed be detrimental in treating elderly patients with higher blood pressures when out of the office they have lower blood pressures and may succumb to the treatment protocol or medicine that's being prescribed to them and have orthostatic or abnormally low blood pressure. So that's also an important key.

And finally, number ten, and I think this kind of wraps up my comments here, is again simply caring. Simply caring, being involved as you reflect on my earlier points. Being involved and being conscientious and vigilant in the care of patients. We found over the years that people respond to people that care. So if you have a distinct caring attitude with people they'll respond, and I believe very firmly compliancy will increase.

So those are the comments that I have. John, do you have questions?

John Clymer:

I do. That was a great concise and brisk rundown of a number of things that you did that I think are very helpful to our listeners. Dr. Gilbertson, you talked about things that you did to increase compliance and about receiving, analyzing and using data that you got from health plans and insurers, and about paying more attention to data within the practice. Did you have to go out and acquire new systems or were you able to utilize existing resources

in a different or more focused way to do that? What did it take to accomplish what you just described?

Dr. Craig Gilbertson: Well I think kind of given that background, that historical background, John, as I think about this and as I think about success in controlling blood pressures, there has to be a medical home. There has to be a place for patients to be comfortable, to come and go, trust in their doctor and their delivery system and faith that what's being done is reasonable and cost effective. So no, we did not go out and procure any elaborate model or any elaborate equipment. As I mentioned, we did purchase some blood pressure cuffs. Actually, blood pressure cuffs were supplied as part of the grant. We used part of the grant money to buy more blood pressure cuffs, and we issued those to patients and have utilized that data. We did sit as a group and kind of go over the JNC 7 guideline to say "are you doing this, have you been educated, is this what you're doing" and so forth, and then reviewed the JNC 8 as well as that came out. So we did not have a distinct kind of custom protocol. We copied what's been nationally recommended and continue to try to do that.

Higher level of awareness with staff again about appropriate blood pressure measurement, about appropriate follow up. The electronic record has been helpful. Some people criticize electronic records as not being helpful, but in this case being helpful in flagging our blood pressures as being abnormal. Nothing sticks out more in a typed graphic than red lettering that says this blood pressure is out of control, you need to follow this, you need to check it. So we try to pay attention to that as well. I hope that answers your question.

John Clymer: It does. And in addition to the utilization of the electronic health records and embracing them rather than resisting and using some of the indicators that come from them, which is great, I love the fact that you used magnets on the door. And something that simple and that low tech was a component of what you did to improve your patients' health and improve outcomes. So I think that's a great reminder for people who are listening and people who are in other practices that it doesn't take a huge investment, it doesn't always require new or additional technology to move the needle, that sometimes it's, as we said at the outset, practicing the fundamentals.

You talked, Dr. Gilbertson, in one of your points, about team care, and not only the physicians and the advanced practice nurses, but also about office staff. So can you expand just a little bit on that?

What were the different roles within your practice and who played them and how did you bring about that kind of cohesive but multi-player approach?

Dr. Craig Gilbertson: Well, I think that again it's valuing staff. It's saying no job is mundane or tedious or has limits. So we've said your role in being a provider of healthcare is no less important than the physician or the provider who writes the prescription. Making sure that patients are comfortable, that they're cared for, that they have been looked after I think is kind of the point that I would like to make. There was not a distinct systematic discussion of this or that or the other thing. We do occasionally have meetings to talk about planning and care of patients. I would like to wish that they were more common and frequent than they actually are, but that helps too. I kind of think to build camaraderie, to have people focused on people's cares and people's needs and the value of staff in providing that. I can't work as a physician, I can't do my job as a physician unless I have staff that comes together and behind me and before me and sometimes after me to clean up the mess. But to support what I'm doing, and likewise I hope to support them. So, John, no, there's not a magical kind of formulation here, I think it's just again people caring for people and looking after the business of managing people's health and well being.

John Clymer: Great, that's very helpful. So a final question before we wrap up, Dr. Gilbertson. You mentioned collaborating or working in concert with the local board of health. Can you describe briefly what that looked like and how that came about?

Dr. Craig Gilbertson: Sure. We were invited by our local quad county, so it just isn't our local county of St. Louis County, it was several other counties that have come together to form a community health board. We were asked by this community health board to be part of a SHIP grant that looks at wellness, and we packaged that –

John Clymer: Excuse me, SHIP I should internet is State Health Improvement Program, is that right?

Dr. Craig Gilbertson: Right, it is. Yes. Thank you. And as part of that, looking at wellness and specifically about looking at obesity and tobacco use and strategies to try to provide care of patients who deal with those issues and try to certainly attain healthier weights and tobacco cessation.

So we came together to strategize on how to do that. We came together for some training. And I must admit we were one of

several clinics in the area that were asked to be part of this. We came together as a group, we shared information. We had informative lectures. And then we also had some training on motivational interviewing, and that was very helpful. I think again in equipping and tooling and motivating us and being vigilant about the care of those particular problems, in that case obesity and tobacco use, and as I said earlier, that was almost exactly at the same timing commensurate with the Million Hearts challenge as well. So we probably had a heightened sense of awareness in working with our community health board on their initiative and then following shortly thereafter in the Million Hearts challenge. So talking about systems and system improvement and education and so forth I think helped.

John Clymer:

Excellent, excellent. So you've talked about team-based care, which I think is essential to success, and there's guidance for team-based care in multiple places. It's an evidence-based recommendation. We know that it works. Dr. Gilbertson has just attested to that. There's more information about it available online at thecommunityguide.org. Dr. Gilbertson has talked about using data from electronic systems and about using simple measures such as magnets on office doors to indicate where attention to hypertension is needed to assist the patient. He covered the importance of compliance, of adherence, therapeutic adherence, and different types of approaches for practices taken to increase adherence and via that increased adherence achieve greater control of hypotension or high blood pressure among the patients. And about collaboration across sectors. So a private practice collaborating with public health agencies. So it's people within the practice working in concert, it's the practitioners and staff and patients working in concert, and then it's people across sectoral lines working in concert. It truly takes multiple players in order to achieve the goal of improving hypertension control. But as the P. S. Rudie Clinic has shown, it's doable, it's feasible and it can be accomplished.

So, Dr. Gilbertson, again, we appreciate your time today, we appreciate your sharing your formula for success. We congratulate you on being a hypertension control challenge champion, being recognized by the CDC for that, and we especially congratulate you and thank you on behalf of your patients.

Dr. Craig Gilbertson: Well, I want to say thank you very much for this time and for your attention. It's been my honor. It's been my honor and pleasure to be with you today, so thank you, John.

John Clymer: Great, well thank you very much.

Dr. Craig Gilbertson: You're welcome, have a good day.

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