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Clinicians' Evolving Role in Hypertension Care

Evolving Role Of Clinicians In Hypertension Care.

The Internet plays such an integral role in so many aspects of our lives; it is only natural to consider expanding its role in medicine. This process is underway with the first large scale randomized clinical trial probing web-based hypertension interventions. How can we as clinicians adapt a new digital mechanisms for providing care.

You are listening to ReachMD XM 157, the channel for medical professionals. Welcome to the clinicians roundtable. I am your host, Dr. Mark Nolan Hill, Professor of Surgery and practicing general surgeon. Our guest is Dr. Beverly Green from the Group Health Center for Health Studies in Seattle. Dr. Green is the lead investigator of research published in JAMA, an innovative web-based interventions for patients with uncontrolled hypertension.

DR. MARK NOLAN HILL:

Welcome Dr. Green.

DR. BEVERLY GREEN

Hello.

DR. MARK NOLAN HILL:

We are discussing the evolving role of clinicians in hypertension care. Dr. Green, tell us the role that the pharmacist play in your research?

DR. BEVERLY GREEN

The pharmacist is an important part of the success of intervention. The pharmacist provided both proactive and reactive care for uncontrolled hypertension over the web.

DR. MARK NOLAN HILL:

Are we putting the pharmacist in a position that is really like the physician's position?

DR. BEVERLY GREEN

Well, one thing you must remember that this intervention was done in an integrated healthcare system that had a shared electronic medical record throughout and the pharmacist and the physicians shared this record. So, we considered the pharmacist to be a team member and not something peripheral to the practice.

DR. MARK NOLAN HILL:

So, simply stated when the pharmacist reviewed the blood pressures from the patients, what would the pharmacist do, will they actually write the prescriptions themselves or would they discuss it with the physicians, what would they do?

DR. BEVERLY GREEN

They would use their protocol and make changes and it was all done electronically because we do not write prescriptions anymore and so they could actually order the medications on the protocol themselves without consulting with the physician. The state of Washington has prescriptive authority that means that if you write up a specific protocol for medications that most people would agree with are the proper medications and dosage for conditions and you apply to your state board, you can get authority for the pharmacist to use those medications according to the protocol.

DR. MARK NOLAN HILL:

And these do not have to be signed off by the physician.

DR. BEVERLY GREEN

That is correct.

DR. MARK NOLAN HILL:

Well, the question I am sure coming to all of the listeners is where the liability is.

DR. BEVERLY GREEN

In our organization, it is the organizational liability and of course this was researched, so we have the data safety monitoring board, but we did not find any safety concerns, but we were very careful in supervising our pharmacist. Actually, the pharmacists were supervised by myself and I am somewhat of a hypertension expert and by other physicians and we made it very clear that their care was supposed to relate to the hypertension protocol and not involve any clinical care.

DR. MARK NOLAN HILL:

And what did you find in terms of the results with respect to the pharmacist's involvement.

DR. BEVERLY GREEN

The patients that were randomized to the pharmacy group were almost 2 times as likely to have their blood pressure in control at the end of 12 months.

DR. MARK NOLAN HILL:

Why do you think that is?

DR. BEVERLY GREEN

I think that the pharmacists were gluing on lot of good things that were already happening in our organization. Well, I do not know if you have heard of the Chronic Care Model.

DR. MARK NOLAN HILL:

No, please.

DR. BEVERLY GREEN

The Chronic Care Model is a new model developed by Ed Wagner actually at our institution to describe the processes that might be required to improve healthcare and it has been tested and shown to improve the healthcare outcomes for conditions such as diabetes and congestive heart failure and depression, but it has never been tested before our study on hypertension. The Chronic Care Model has several basic domains and 1 domain is evidence-based guidelines and decision support, so that you have evidence-based care for those conditions that you are addressing. The second domain is the healthcare team and how it is designed and how you deliver that care for the conditions. The third domain is information system, so you can connect those systems together, and the fourth domain is the patient and self management and the tools that you provide for your patients to help them assist in their your care of their conditions because most of the care that they need occurs at home outside of office visit and the last is the system itself, the healthcare systems, and things it does to encourage good healthcare like heed the measurements and feedback and providing coverage for certain conditions that are favorable and community resources that might assist in patients in their own self-care.

DR. MARK NOLAN HILL:

When if at all did the pharmacists directly speak to the patient's physicians about any medication changes or any protocols that they change?

DR. BEVERLY GREEN

The pharmacist would speak to the physicians if there was change that was needed that was not on the protocol.

DR. MARK NOLAN HILL:

And what have the pharmacists thought about this whole new process of having them take a proactive stance?

DR. BEVERLY GREEN

The pharmacists were experienced clinical pharmacists, that they really enjoyed this study. I think we got response from each of them that this was the best experience that they have had during their career.

DR. MARK NOLAN HILL:

Why?

DR. BEVERLY GREEN

I think because they were given a specific role, for one it was research, two - they had a specific role that they could focus on and they were able to interact with patients directly and not just count pills. They had an ongoing relationship with the patients and could also boost the patient's relationship with their physician. They found that focus time and the ability to really improve care in one area was very rewarding.

If you have joined us, you are listening to the clinicians' roundtable on ReachMD XM 157. I am your host, Dr. Mark Nolan Hill and our guest is Dr. Beverly Green from the Group Health Center for Health Studies in Seattle. We are discussing the evolving role of clinicians in hypertension care.

DR. MARK NOLAN HILL:

Dr. Green, does the pharmacists' involvement bring any additional cost to the program?

DR. BEVERLY GREEN

We have not done our cost effectiveness analysis yet. We are planning to do them. We did not find any changes in utilization. So, having the pharmacists for this intervention did not lead to less office visits and it also did not increase hospital or decreased hospital visits. There were some increases in specialty visits in the usual care group compared to the pharmacists group. We do not know for sure why that was. Our study was not designed really to maximize in cost effectiveness because I think what you might want to do if you were to look that you would have to directly compare it to equal attention by a physician and see which was most cost effective.

DR. MARK NOLAN HILL:

Did the patients enjoy dealing with the pharmacists?

DR. BEVERLY GREEN

Well, we know that web communication significantly increased in both groups, the home blood pressure monitoring and web training group only and the pharmacists group even more so compared to both the controls and the monitor and web training only group. However, also the patient initiated e-

mails significantly and dramatically increased particularly in the pharmacists group. So not just the ones that the pharmacists were sending to the patients, but the ones the patients started to thread themselves.

DR. MARK NOLAN HILL:

While considering the results of your study, do you think that this might distance the patient from the physician in terms of their relationship?

DR. BEVERLY GREEN

We are very careful to assure the patient that the pharmacist was working with their physician and that any clinical concerns were handled by the physician. We referred to the physicians specifically at the beginning of the intervention and any concerns that were outside of the protocol were addressed with the physician. The pharmacists were sensitive to what the physician might recommend or suggest and was watching for those things and sometimes asked for advice from our expert group when there were concerns about the physician advising things that were not in the protocol. We helped them work with the physicians closely. So, the patient physician-relationship was always kept strong.

DR. MARK NOLAN HILL:

Such a common complaint by patients is that the typical doctor-patient relationship is eroding. Do maneuvers like this where using electronic systems, the internet, by using pharmacists, and just plethora of other ways to treat diseases, do you think that we are going for the more impersonal relationship?

DR. BEVERLY GREEN

I think with the cost of healthcare and the amount of resources we have, I think that physicians are pretty much kept dry and physicians, the point of resistance is that the physician should do everything and the physician cannot do everything, and a lot of what happens in healthcare does not happen at the actual visit, it happens before or it happens after and the way doctors are compensated is based on visits alone. So they do not have time for the pre and aftercare and then if we want to maximize all the training that the physicians have gotten, we have got to figure out how to use teams to make the physicians more effective. So, I do not see it as decreasing the role of the physician. I see it as allowing them to do what they are best at and having other people help them do their things that they really do not need to do.

DR. MARK NOLAN HILL:

Now you brought up the idea of compensation and remuneration, how does this concept measure with the idea of fee-for-service payment plan?

DR. BEVERLY GREEN

Not very well, because currently physicians are compensated for actual time with patients and diagnostic codes for those that time. Telephone encounters do not receive any special compensation by most methods including Medicare and there is no current mechanism to be compensated for sending a secure message to your patient.

DR. MARK NOLAN HILL:

How does the web intervention correlate with the use of electronic medical records?

DR. BEVERLY GREEN

There is a push to have more practices use electronic medical records because it allows for improved safety, improved communications, and it is believed that it will be cost saving in the long run and the patient's shared medical record is one step beyond that and not very many organizations that already have electronic medical records have that capacity, but there are a few large major players that do like Harvard, Pilgrim, Kaizer, and other progressive organizations that are doing exactly the same things as Group Health and encouraging patients to share in their care and are finding that the results are very positive.

DR. MARK NOLAN HILL:

Clearly this research reflects a wonderful collaboration among great number of medical professionals. Do you expect that this would be expanded to other ancillary care providers as well?

DR. BEVERLY GREEN

I do not see any reason why it could not be. I see this just as an integrated approach, so it probably depends on the condition that you are trying to focus on or in general allowing physicians in certain instances to provide care more often this way because we thing it will be beneficial for that as well. In this case, for hypertension, it just so happens that we have good evidence, we have good guidelines and the care is not that complicated, but I think providing web-care in general is going to improve healthcare.

DR. MARK NOLAN HILL:

I want to thank our guest, Dr. Beverly Green. We have been discussing the evolving role of clinicians and hypertension care. I am Dr. Mark Nolan Hill and you have been listening to the clinicians' roundtable on ReachMD XM 157, the channel for medical professionals. Be sure to visit our website at reachmd.com featuring on-demand podcast of our entire library. For comments and questions, please call us toll-free at 888 MD XM 157 and thank you for listening.

This is Dr. Aaron Carroll, Director of The Center of Health Policy and Professionalism Research in Indianapolis, Indiana and you are listening to ReachMD XM 157, the channel for medical professionals.