Welcome to the PHASE Learning Community!
Webinar Housekeeping

1. Lines are muted.

2. Chat in questions or unmute your line by pressing *7 to ask a question (*6 to re-mute).

3. Webinar is being recorded and will be posted on the PHASE Support site. A link will be sent via email.

4. Please fill out our feedback survey at the end of the webinar
THREE-PART SERIES:
Nurse-Run Hypertension Care
Facilitated By

KATE COLWELL, MD
POLL

At your organization, do you have ongoing skills evaluations in measuring blood pressure?
NURSE-RUN SERIES REVIEW

PART 1: MAKING THE CASE

WHY: QUADRUPLE AIM
WHAT: MODELS RANGE FROM STANDING ORDERS TO STANDARDIZED PROCEDURES

PART 2: DEVELOPING THE PROGRAM

HOW TO DEVELOP A PROGRAM: GUIDELINES, SCOPE OF PRACTICE, APPROVAL, AND BUY-IN

PART 3: MOVING TO ACTION

TODAY: YOU HAVE A GOOD PROGRAM - HOW DO YOU MAKE THIS WORK? TRAINING & IMPLEMENTATION
DETAILS FOR A SUCCESSFUL IMPLEMENTATION

- RIGHT PATIENTS
- RIGHT BP
- COMPREHENSIVE TRAINING
- DECISION SUPPORT & EHR INTEGRATION
- ONGOING SUPPORT FOR THE NURSES
- ROLL OUT, PROCTORING, & TROUBLESHOOTING
FINDING THE RIGHT PATIENTS

- Criteria and workflow for referral to RN visit
- Criteria for discharge and return to clinician
- Is the blood pressure correct?
ALAMEDA HEALTH SYSTEM'S INCLUSION / EXCLUSION CRITERIA

1. Uncomplicated hypertension and hypertension with stage 1-3 chronic kidney disease, diabetes mellitus, stroke, or transient ischemic attack
2. Adult, aged 18 and older
3. May be on other anti-hypertensive medications other than those listed which will not be titrated.
4. Referring provider is responsible for initiating Hydrochlorothiazide, Lisinopril, Lisinopril/Hydrochlorothiazide, or Amlodipine.
5. Referring provider is responsible for ordering serum sodium, potassium and serum creatinine within 2 weeks of starting an ACEI or thiazide.
6. Exclusion criteria: Coronary artery disease, stage 4 or 5 chronic kidney disease, heart failure, or pregnancy.
IS THE BP CORRECT?

- Patient: Relaxed not talking
- Arm: Supported at level of heart
- Equipment functioning. Automatic preferred
- Average of two readings if high
- Take other measures if elevated

Image Credit: https://targetbp.org/tools_downloads/how-to-accurately-measure-blood-pressure-2/
COMPREHENSIVE RN TRAINING

ALAMEDA HEALTH SYSTEM

ERIC MAHONE, PHARMD
Clinical Pharmacy Manager - Ambulatory Care

- **Model**: PCP referral to nurse paired with PharmD in each clinic. Nursing notes sent to PCP.
- **Scheduled with RN**: Yes
- **Face-to-Face?**: Warm hand-off + scheduled face-to-face or phone
- **Adjust Meds**: Yes
- **Visits/Week**: Uncertain - RNs see multiple patient types
- **Billable**: No, unless visit coincides with provider visit.
- **Empanelled**: No
- **EHR**: NextGen
AHS: RN Training Overview

- Review medication classes utilized in the Standardized Procedure:
  - Dosing
  - Mechanism of Action
  - Advantages and disadvantages
  - Side effects and monitoring
ACEi

- **Advantages:**
  - Multiple indications (CKD, DM, CHF, CVA)
  - Low cost
  - Once daily dosing

- **Limitations:**
  - Hyperkalemia
  - Cough (~19%)
  - Angioedema
  - Contraindicated in pregnancy
  - Bilateral renal artery stenosis

**Monitoring:**
- BP
- BMP
- Pregnancy test
- Albumin/Creatinine
AHS: RN Training Overview

- Walk through the Standardized Procedure Document
- Discuss requirements for implementation
  - HTN competency
  - Proctoring 10 cases
  - Physician Mentor sign-off
- Case studies in implementation of the Standardized Procedure
Case #1

- WA - 58 yo female here for 4 week follow up HTN appointment
  - PMH = HTN, CVA (2011), chronic pain, tobacco use (10 cigarettes/day), obesity
- PCP started lisinopril/HCTZ at last visit:
  - Rx = 10/12.5mg daily #30
- Completed BMP/Chem 7 yesterday
  - K+ = 4.3
  - SCr = 1.0 (unchanged)
- Blood Pressure = 162/91 (R) 165/88 (L)
Case #1 Questions

- What additional information may you want to collect from the patient?
  - New cough?, Dizziness?, Adherence evaluation

- Education items to cover?
  - Smoking cessation, physical activity, salt intake

- Assessment and Plan?
  - BP above goal <140/90
  - Increase lisinopril/HCTZ 10/12.5mg - 2 tabs daily

- Follow up?
  - BMP/Chem 7 in 2 weeks
  - Message PCP for new Rx – Lisinopril/HCTZ 20/25mg 1 tab daily
RN COMMUNICATION TRAINING

San Francisco Health Network

JUDITH SANSONE, RN, MS
Director of Nursing, Primary Care

- **Model:** Standard work for RNs. Some co-visits with Pharm D. MD or pharmacists sign off to alter meds.
- **Scheduled with RN:** Yes
- **Face-to-Face?** Yes
- **Adjust Meds:** Yes
- **Visits/Week:** Varies & decided by clinics
- **Billable:** No, unless visit coincides with provider visit.
- **Empanelled:** No
- **EHR:** eCW
Q&A: TRAINING
INTEGRATION WITH EHR:

RCHC’s EMR Tools to Support RN Protocol for PHASE

DANIELLE ORYN, DO, MPH
Chief Medical Informatics Officer
Make the Protocol Available
Reflect the Protocol in Documentation

Template

**HPI:**

Endocrine

- DIABETES _____.
- HYPOGLYCEMIA (Low Blood Sugar): _____.
- BLOOD SUGAR REVIEW: _____.
- ASSOCIATED SYMPTOMS _____.
- DENIES _____.

Cardiovascular

- HYPERLIPIDEMIA _____.
- HYPERTENSION _____.
- HOME BP MONITORING _____.
- MEDICATION ADHERANCE _____.
- ASSOCIATED SYMPTOMS _____.
- DENIES _____.

Hypertension Goal <140/90.

**Treatment Plan/Self Management**

- LAST SELF MANAGEMENT GOAL: see last note for details.
- SELF MANAGEMENT GOAL: Documented in Preventive Medicine.
- BARRIERS: _____.

**Current Medication:**
Reflect the Protocol in Documentation

Template

Assessment:

- PHASE Med Management - Z71.89
- "USE PHASE ORDER SET"
- "IF pregnancy potential address contraceptive issues and consider starting on HCTZ without ACE/ARB"

The PCP co-signature on this note indicates supervision and approval of the treatment plan above due to medical necessity.

Plan:

- Treatment:
- Procedures:
- Immunizations:
- Therapeutic Injections:
- Diagnostic Imaging:
- Lab Reports:
- Procedure Orders:
- Preventive Medicine:
- Counseling:
  - SELF MANAGEMENT GOAL
    - Goal Set: (Meta)
  - CARE GOAL FOLLOW UP PLAN
    - BMI Management Provided

Disposition & Communication:

Next Appointment:
Reflect the Protocol in Order Set
Reflect the Protocol in Order Set

Assessment:

**Assessment:**
- PHASE Med Management - Z71.89
- ***USE PHASE ORDER SET***
- ***IF pregnancy potential address contraceptive issues and consider starting on HCTZ without ACE/ARB***

The PCP co-signature on this note indicates supervision and approval of the treatment plan above due to medical necessity.

Plan:

**Treatment:**

**Procedures:**

**Immunizations:**

**Therapeutic Injections:**

**Diagnostic Imaging:**

**Lab Reports:**

**Procedure Orders:**

**Procedure:**Patient Navigator

**Preventive Medicine:**

- Counseling:
  - SELF MANAGEMENT GOAL
  - Goal Set: (Meta).
  - CARE GOAL FOLLOW UP PLAN
  - BMI Management Provided Yes

**Disposition & Communication:**

**Next Appointment:**
# RN Tracking Reports

<table>
<thead>
<tr>
<th>Name</th>
<th>Owner</th>
<th>Last edited</th>
<th>Published</th>
<th>Execution count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHASE: Diabetic Patients - Last A1C: 7 - 8.9</td>
<td>Kelli Ewing</td>
<td>6 days ago</td>
<td>yes</td>
<td>6</td>
</tr>
<tr>
<td>PHASE: Diabetic Patients - Last A1C: &gt;= 9</td>
<td>Kelli Ewing</td>
<td>6 days ago</td>
<td>yes</td>
<td>9</td>
</tr>
<tr>
<td>PHASE: Diabetic Patients - Last A1C &lt; 7</td>
<td>Kelli Ewing</td>
<td>6 days ago</td>
<td>yes</td>
<td>7</td>
</tr>
<tr>
<td>PHASE: Non-Diabetic Patients</td>
<td>Kelli Ewing</td>
<td>6 days ago</td>
<td>yes</td>
<td>5</td>
</tr>
<tr>
<td>PHASE Patients</td>
<td>Kelli Ewing</td>
<td>12 days ago</td>
<td>yes</td>
<td>11</td>
</tr>
<tr>
<td>Phase Appts</td>
<td>Kelli Ewing</td>
<td>7 months ago</td>
<td>yes</td>
<td>13</td>
</tr>
</tbody>
</table>
# RN Tracking Reports

**Description**
List of PHASE Patients, including: Risk Score, Last A1C, Last BP, Last Appt, Next Appt

**Query parameters**
- **Team**: Petaluma Team 3
- **Provider**: Danielle Oryn

**Run Report**

---

**Query Time**: 72.743 sec.
**Displaying 30 of 64 results**

<table>
<thead>
<tr>
<th>Acctno</th>
<th>Patient</th>
<th>Provider</th>
<th>Team</th>
<th>Risk Score</th>
<th>Last Bp</th>
<th>Last Bp Value</th>
<th>Last A 1 C</th>
<th>Last A 1 C Value</th>
<th>Next Appt</th>
<th>Last Appt</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>Patient1</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>4.0</td>
<td>05/03/2018</td>
<td>142/68</td>
<td>04/12/2018</td>
<td>8.7</td>
<td>05/01/2018</td>
<td>05/03/2018</td>
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<td>67890</td>
<td>Patient2</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>4.0</td>
<td>10/01/2017</td>
<td>135/66</td>
<td>10/31/2017</td>
<td>8.4</td>
<td>05/17/2018</td>
<td>10/31/2017</td>
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<td>45678</td>
<td>Patient3</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>5.0</td>
<td>05/01/2018</td>
<td>96/66</td>
<td>02/06/2018</td>
<td>7.4</td>
<td>05/31/2018</td>
<td>05/01/2018</td>
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<tr>
<td>87654</td>
<td>Patient4</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>7.0</td>
<td>10/21/2013</td>
<td>132/74</td>
<td>09/06/2013</td>
<td>7.6</td>
<td>None</td>
<td>10/21/2013</td>
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<tr>
<td>98765</td>
<td>Patient5</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>4.5</td>
<td>10/05/2017</td>
<td>136/85</td>
<td>10/05/2018</td>
<td>None</td>
<td>10/05/2018</td>
<td>None</td>
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<td>54321</td>
<td>Patient6</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>8.5</td>
<td>05/07/2018</td>
<td>142/62</td>
<td>03/21/2018</td>
<td>8.6</td>
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<td>05/07/2018</td>
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<tr>
<td>21345</td>
<td>Patient7</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>2.0</td>
<td>05/01/2018</td>
<td>129/66</td>
<td>05/01/2018</td>
<td>6.8</td>
<td>None</td>
<td>05/01/2018</td>
</tr>
<tr>
<td>74521</td>
<td>Patient8</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>4.0</td>
<td>01/15/2018</td>
<td>125/54</td>
<td>11/02/2017</td>
<td>6.3</td>
<td>05/17/2018</td>
<td>01/15/2018</td>
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<tr>
<td>43215</td>
<td>Patient9</td>
<td>Danielle Oryn</td>
<td>Petaluma Team 3</td>
<td>2.5</td>
<td>12/20/2016</td>
<td>112/75</td>
<td>04/10/2014</td>
<td>6.5</td>
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<td>12/20/2016</td>
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<td>Measure</td>
<td>Description</td>
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<td>Actual 1</td>
<td>Actual 2</td>
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<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Diabetes Blood Pressure Control</td>
<td>Diabetic patients with last BP under 140/90</td>
<td>80%</td>
<td>1,186</td>
<td>1,479</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetics on ACE/ARB and Statin for Diabetics age 55-75</td>
<td>Percent of diabetic patients who are on an ACE or ARB AND a statin</td>
<td>68%</td>
<td>716</td>
<td>1,060</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>INCENTIVE - Diabetes: Blood Sugar Control</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c ≤ 5.9% during the measurement period</td>
<td>73%</td>
<td>1,062</td>
<td>1,460</td>
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<tr>
<td>INCENTIVE - Hypertension Control</td>
<td>Percentage of patients 18-89 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (≤140/90 mmHg) during the measurement period</td>
<td>75%</td>
<td>2,182</td>
<td>2,913</td>
<td></td>
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</tr>
<tr>
<td>NURSING - PHASE Patients on Appropriate Medications</td>
<td>Percentage of PHASE Eligible Patients on an Antihypertensive, an ACE/ARB AND a Statin</td>
<td>48%</td>
<td>1,063</td>
<td>2,186</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Preventive Care and Screening: BMI Screening And Follow-Up Plan (UDS 2017 Table 8B)</td>
<td>Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous six months to that visit and, when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of that visit</td>
<td>93%</td>
<td>17,907</td>
<td>18,183</td>
<td></td>
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<tr>
<td>Preventive Care and Screening: Screening for Depression and Follow Up Plan (UDS 2017 Table 8B)</td>
<td>Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the positive screen</td>
<td>74%</td>
<td>13,100</td>
<td>17,743</td>
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<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation intervention (UDS 2017 Table 8B)</td>
<td>Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if defined as a tobacco user</td>
<td>93%</td>
<td>12,568</td>
<td>13,538</td>
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</tbody>
</table>
Performance Tracking

Diabetics on ACE/ARB and Statin for Diabetics age 55-75

Compliance: 68%

Target: 1 Compliance is 1 percentage point above the organization’s target of 67%.

Filters: No Store selected

Compliance trend

Compliance by Provider Team

Compliance by Provider

Leighton, Lynette: 100%, 100%
Nagin, Cheryl: 100%, 100%
William, Lauren: 100%, 100%
Banerjee, Amrita: 100%, 100%
Chan, Lulu: 100%, 100%
Moore, Jessica: 100%, 100%
Hofst, Jane: 100%, 100%
Katz, Fime: 100%, 100%
Bennett, Lee: 100%, 100%
Cline, Jonathan: 100%, 100%
Payton, Victor: 100%, 100%
Harland, Faith: 100%, 100%
Pendleton, John: 100%, 100%
Noble, Annie: 100%, 100%
Ashworth, Andrew: 100%, 100%
Limi, Nand: 100%, 100%
Limper Keene: 100%, 100%
Rowell, Hilary: 100%, 100%
Upton, Sean: 100%, 100%
Kamataku, Justin: 100%, 100%
Levine, Natasha: 100%, 100%
Olyn, Donald: 100%, 100%
Williams, Victoria: 100%, 100%

Measurement period: June 1, 2017—May 31, 2018
Recalls
# CDS Package

## RCHC Diabetes - Clinical Decision Support Package V1.0

### Version Changes

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>4/30/2018</td>
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</tbody>
</table>

### Contents

- RCHC DM Guidelines
- Data Elements - CMS122V2
- Data Elements - CMS134V5
- Data Elements - CMS131V5
- BridgeIT Reporting Instructions
- Relevant Reporting Queries
- Template Data
- Order Set Data
- Alert Data
- Relevant Care Gap Queries
- Recall Data

### Associated Documents

- Provider Education PDFs
- Patient Education PDFs
- eCW Screenshots - Template/OS/Alerts/Recalls (password required)
- NextGen Screenshots - Template/OS/Alerts/Recalls (password required)
- RN Standardized Procedure Template for Diabetes
- Full BridgeIT reporting instructions

### Instructional Videos

- How to use clinical decision support packages to create standard templates
- How to use clinical decision support packages to create standard order sets
- How to use clinical decision support packages to create standard alerts
- BridgeIT basics
- Data Validation
- How to run recalls using eCW
- Tips for maintaining your clinical decision support tools
Thanks!
ONGOING SUPPORT & CONTACT FOR RNS:
RCHC PHASE Case Conference Webinar Series

REBECCA MUNGER, RN, CNM, MPH
Clinical Program Director

- **Goal:** prepare & support RNs co-managing patients under standardized procedures
- **Focus:** cardiovascular health in community health centers - PHASE algorithm, hypertension, diabetes care
- **Logistics:** began Fall 2016, one session q month over 15 months
- **Format:** didactic presentation with PowerPoint, case review, Q&A
Ongoing Support for RNS

2017 Fall Webinar Series PHASE
Back to Basics with Dr. Jerry Minkoff

3 Thursdays 12-1:30pm
November 2nd Introduction to PHASE
November 16th Hypertension control
December 7 Diabetes control

Sample Objectives:
- Identify and assess patients with elevated blood pressure;
- Describe medications used for hypertension control, their contraindications, side effects and patient follow-up;
- Work within a care team to manage adult hypertension using standardized procedures;
- Identify contraindications for treating a patient with combination pharmacotherapy;
- Outline a plan to titrate medications to achieve blood pressure goals;
- Evaluate a patient for possible medication non-adherence;
- Manage common side effects of antihypertensive medications.

Join Meeting: https://rhec.zoom.us/j/547673635
Or Telephone: (646) 558 8656
Meeting ID: 547 673 635

Simply join! - No registration * CEUs are NOT provided
Case-based discussion with Q&A during last half hour

Supported by Kaiser Permanente Northern California Community Benefit Program
ROLL OUT, PROCTORING & TROUBLESHOOTING
TROUBLESHOOTING: PATIENT BUY-IN

San Francisco Health Network

JUDITH SANSONE, RN, MS
Director of Nursing, Primary Care

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- **EHR**: eCW
NURSE-RUN HYPERTENSION CARE

- Improved Population Health
- Satisfied Patients
- Reduced Care Cost

- Evidence-Based Guideline
- Agreed upon by clinical staff
- Protocols & procedures based on legal scope of practice
- Approved by appropriate authorities
- Defined workflow
- Accepted by Stakeholders
- New Team-Based Care Process
Today, presenters will be answering questions about how they implemented their program, including training, support, rollout, and troubleshooting.
Final Thoughts

Thank you!

Questions? Contact:

SA Kushinka
Program Director
sa@careinnovations.org

Angela Liu
Program Coordinator
angela@careinnovations.org

Please remember to fill out the post webinar brief survey!!
Save the date!
In-Person PHASE Convening

Tuesday, June 5 | DoubleTree, Berkeley Marina
ACCESSING RESOURCES DISCUSSED IN THIS SERIES

- RCHC’s RN Standardized Procedures Templates: https://www.rchc.net/POPULATION-HEALTH/EVIDENCE-BASED-CARE/

- AHS RN Standardized Procedure for Medication Titration
  https://phasesupport.files.wordpress.com/2017/12/standardized-procedure-_htn.pdf

- AHS Nursing Standardized Procedure Training
  https://phasesupport.files.wordpress.com/2017/12/nursing-standardized-procedure-training-htn.pptx

Or, go to PHASEsupport.org Resource Hub > Protocols & Change Packages:
https://www.careinnovations.org/phasesupport/resources/#protocols
References

• Mike Rakotz Webinar: https://www.careinnovations.org/resources/practical-considerations-new-hypertension-guidelines/