KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS
& STROKES EVERY DAY

Using your Analytics Ecosystem to Manage PHASE Patients

Loretta Khangura, MPH, BSN, RN, CHTS-CP, PCMH CCE

Webinar Housekeeping

1. Lines are **unmuted**, please chat in questions!
2. To listen to the audio for this webinar, please call 408-638-0968, ID: 415 561 7817.
3. Webinar is being recorded and will be posted on PHASEsupport.org and a link will be sent via email.
4. Please fill out our **feedback survey** at the end of the webinar

Webinar Agenda

Welcome & Intro

5 Minutes

Using Your Analytics Ecosystem to Manage PHASE Patients

40 Minutes

Discussion and Q&A

10 Minutes

What's next?

5 Minutes

KAISER PERMANENTE®
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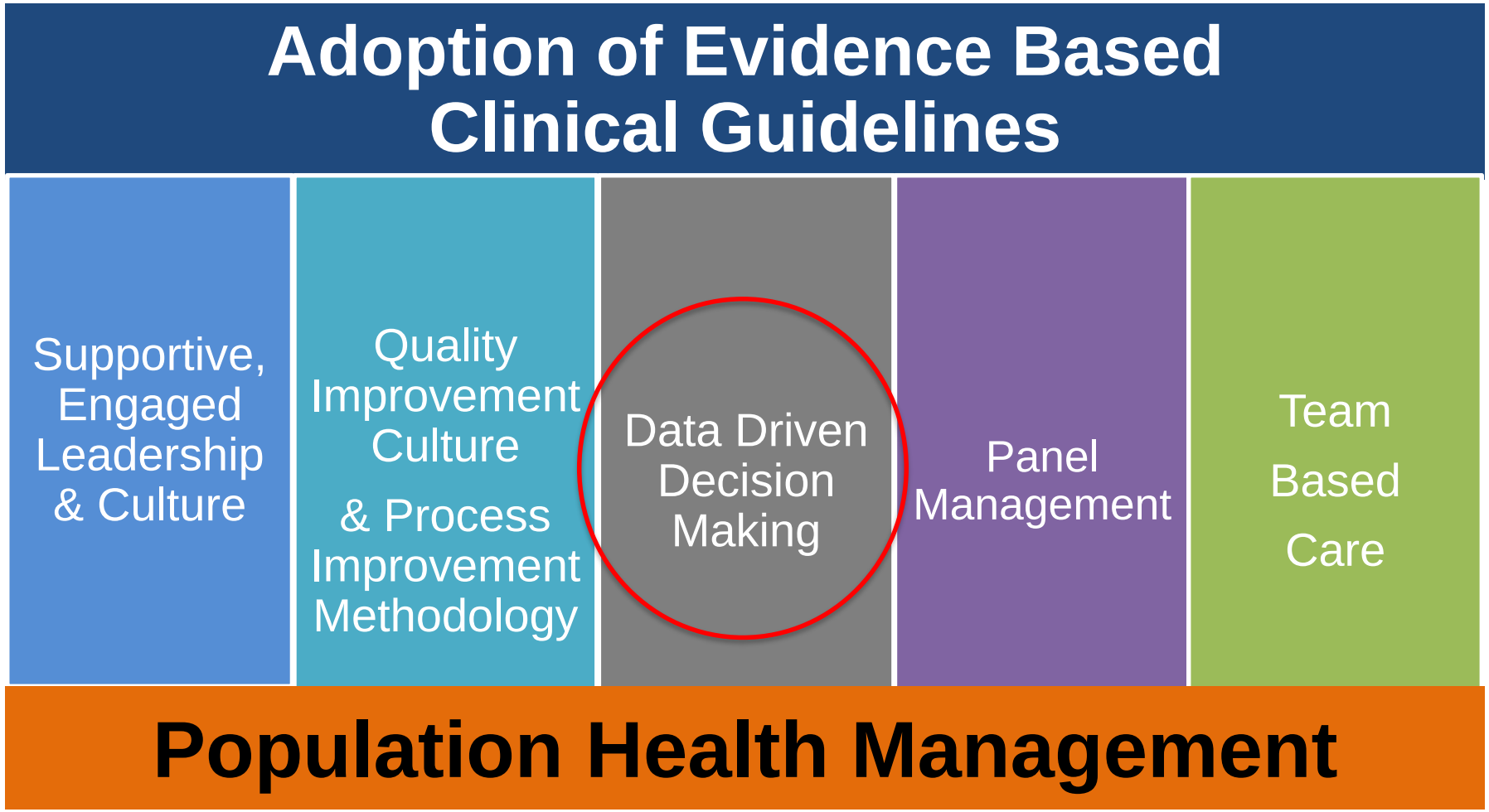
PREVENTING HEART ATTACKS & STROKES EVERY DAY

Building Blocks



Using your Analytics Ecosystem

TO MANAGE PHASE PATIENTS

CCI
CENTER FOR CARE INNOVATIONS

Prepared for Center for Care Innovations

PHASE Grant Participants

December 14, 2017

Loretta Khangura, MPH, BSN, RN, CHTS-CP, PCMH CCE

VP Data Translation and Practice Transformation
Health Initiatives Consulting

Nurse and "data poet," works with clinical organizations across the country to improve processes and outcomes.

Facilitated by Dr. Jerry Osheroff

PHASE "Master Coach" and improvement advisor.

Health Initiatives Consulting

Objectives

By the end of this webinar, you will be able to:

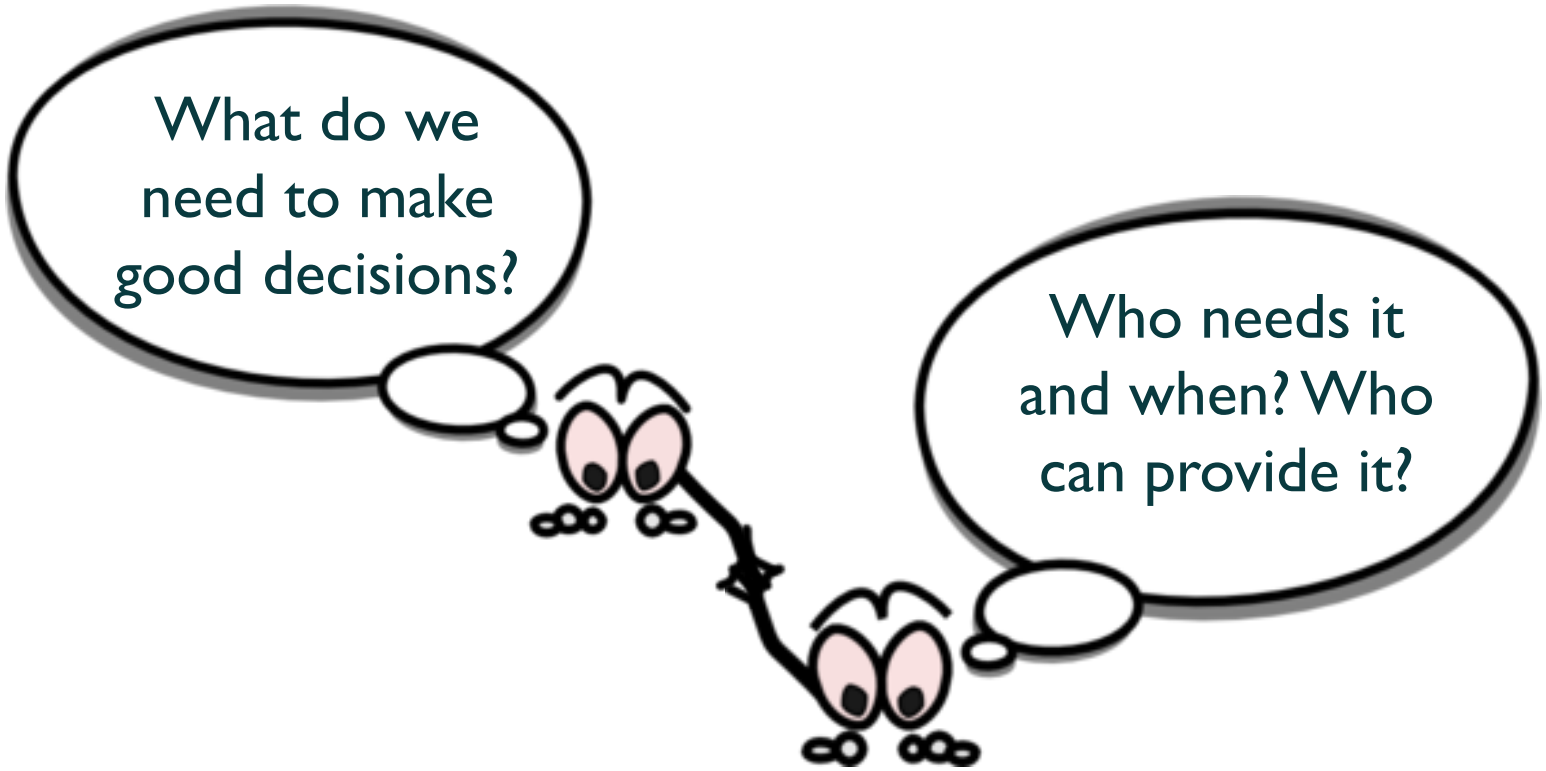
Optimize your use of analytics to regularly assess clinical performance and accelerate QI efforts.

Better understand **which** patients do not have their blood pressure in control and **why**.

Leverage analytics to **prioritize** patient outreach and support care during visits (e.g., by using data in pre-visit planning)

Health Initiatives Consulting

Be thinking about…



Health Initiatives Consulting

Poll #1

How often does your PHASE team review your performance on hypertension control and other PHASE measures?

- **Quarterly**
- **Monthly**
- **Weekly**
- **More Often**

Health Initiatives Consulting

Proactive, Iterative Analytics

Built on a firm foundation

Health Initiatives Consulting

Proactive, Iterative Analytics

Built on a firm foundation

Health Initiatives Consulting

PHASE Metrics Include:

- Medical visits
- Hypertension visits
- Hypertension
- Blood pressure
- Rx Antihypertensive
- Tobacco Use and Cessation Intervention
- Depression Screening and Follow-up
- BMI and Follow-up if out of range
- Diabetes and level of control
- Rx ACE/ARB and Statin use in diabetes

PHASE Patient Population Measures		
A. All Patients With Medical Visit in Reporting Period	80751	100%
B. Number of Patients with a diagnosis of Diabetes Type 1 or 2 age 18-75	6079	8%
C. Number of Patients with a diagnosis of clinical ASCVD any age	1242	2%
D. Number of patients with a diagnosis of Hypertension age 18-85	11927	15%
E. Number of Unduplicated Patients who meet at least one of the above criteria	14246	18%
PHASE Prescription Measures		
A. Number of Diabetic Patients age 55-75	3372	100%
1. % of patients prescribed a Statin	2569	76%
2. % of patients prescribed an ACE or ARB	2835	84%
3. % of patients prescribed a Statin and an ACE or ARB	2223	66%
B. Number of patients with a diagnosis of Hypertension age 18-85	11927	100%
1. % of patients prescribed an oral drug in the anti-hypertensive class	11034	93%

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A. All Patients With Medical Visit in Reporting Period	80751	100%
B. Number of Patients with a diagnosis of Diabetes Type 1 or 2 a		
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D. Number of patients with a diagnosis of Hypertension age 18-8		
E. Number of Unduplicated Patients who meet at least one of the		
PHASE Prescription Measures		
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3. % of patients prescribed a Statin and an ACE or ARB		
B. Number of patients with a diagnosis of Hypertension age 18-8		
1. % of patients prescribed an oral drug in the anti-hyperter		

PHASE Screening and Follow Up Measures		
Tobacco Screening and Follow Up		
1. Patients 18+ wtith 2 medical visits or 1 preventive visit in the last year	34240	100%
a. Screened for Tobacco Use and if Positive, had Intervention	33837	99%
BMI Screening and Follow Up		
1. Patients 18+ and not pregnant	50088	100%
a. 18 and older with BMI calculated during the RP with follow up plan if outside normal parameters	22461	45%
Depression Screening and Follow Up		
1. Patients age 12+ without Major Mood Disorders	54601	100%
a. Screened for Depression and if Positive, have a documented Follow Up Plan on the date of the Positive Screening	32300	59%
Clinical Quality Measures (HEDIS)		
Controlled BP for Diabetic Patients age 18-75		
1. Denominator	6695	100%
a. BP less than 140/90	5029	75%
Controlled A1c for Diabetic Patients age 18-75		
1. Denominator	6695	100%
a. A1c Less than 9%	4111	61%
Controlled BP for Hypertensive Patients age 18-85		
1. Denominator	11927	100%
a. Controlled BP Stratified by Age and Diabetes Comorbidity	8376	70%

PHASE B/P Control Challenges

Location:	17		75		22		70	
BP Control Challenges Patient 18-85 w/HTN	Value	%	Value	%	Value	%	Value	%
Denominator	486	100%	621	100%	479	100%	690	100%
Controlled BP Stratified by Age and Diabetes Comorbidity	310	64%	378	61%	226	47%	316	46%
BP Uncontrolled	176	36%	243	39%	253	53%	374	54%
Opportunity: Antihypertensive	14	8%	13	5%	21	8%	35	9%
Minimum 2 visits in past year, at least 5 months apart	75	43%	73	30%	65	26%	201	54%
Minimum 4 visits in past year, at least 2 months apart	4	2%	6	2%	9	4%	49	13%
Co-Morbid Diabetes	61	35%	83	34%	53	21%	130	35%
A. A1c >= 9	16	26%	17	20%	16	30%	24	18%
Co-Morbid Major Mood Disorders	31	18%	92	38%	68	27%	73	20%
A. Rx Antidepressant	30	97%	86	93%	62	91%	72	99%
Smokers	32	18%	52	21%	34	13%	46	12%
A. Cessation Intervention in Past Year	32	100%	52	100%	34	100%	45	98%
B. Rx Tobacco Cessation	10	31%	24	46%	7	21%	16	35%
BMI >=30	105	60%	153	63%	178	70%	221	59%
A. BMI Follow-Up Plan	49	47%	56	37%	101	57%	188	85%
B. Physical Activity Education	26	25%	101	66%	31	17%	58	26%
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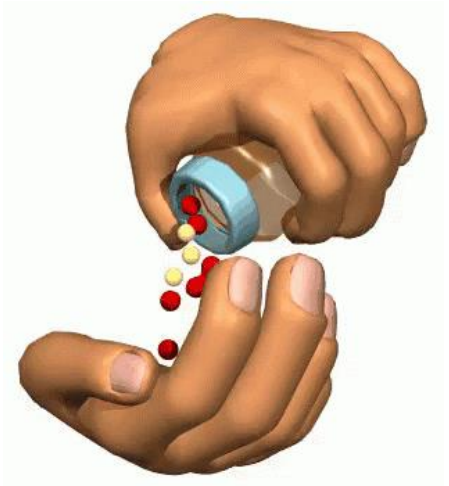

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Controlled BP	310	64%	378	61%	226	47%	316	46%
Average # Medical Visits/patient in report period	4.92		5.51		4.47		4.65	
BP Uncontrolled	176	36%	243	39%	253	53%	374	54%
Average # Medical Visits/patient in report period	4.93		4.44		3.69		4.22	
Co-Morbid Diabetes	61	35%	83	34%	53	21%	130	35%
A. A1c >= 9	16	26%	17	20%	16	30%	24	18%
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Average # Medical Visits/patient in report period	4.92		5.51		4.47		4.65	
Average # HTN Visits/patient in report period	2	41%	1.54	28%	1.63	36%	2.76	59%
BP Uncontrolled	176	36%	243	39%	253	53%	374	54%
Average # Medical Visits/patient in report period	4.93		4.44		3.69		4.22	
Average # HTN Visits/patient in report period	2.23	45%	1.84	41%	1.79	49%	2.75	65%
A. BMI Follow-Up Plan	11	34%	19	39%	45	62%	54	84%
B. Physical Activity Education	7	22%	36	73%	14	19%	20	31%
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Health Initiatives Consulting

Poll #2

What are the obstacles in your organization for getting more comprehensive or more frequent reports?

- **Analyst capability/creativity**
- **Analyst time**
- **Access to data**
- **Data quality**
- **Other – specify in chat**

Strategies

Analyst	• Relationships • Communicate intent, not content • Draw pictures • Develop priorities with leadership
Data Access	• Self-service reporting • Vendor relations • Order Sets • Data Stewardship and Governance
Data Quality	• Data validation strategies • Order sets • Data Stewardship and Governance

Blood Pressure Control in Patients 18-85 w/ Essential Hypertension	Uncontrolled		Controlled	
HTN Control Denominator	3514	30%	8287	70%
Opportunity: Antihypertensive	249	7%	657	8%
Minimum 2 visits in past year, at least 5 months apart	1024	29%	2739	33%
Minimum 4 visits in past year, at least 2 months apart	166	5%	440	5%
Co-Morbid Diabetes	1320	38%	3042	37%
A1c >= 9	360	27%	651	21%
Co-Morbid Major Mood Disorders	689	20%	1845	22%
Rx Antidepressant	529	77%	1491	81%
Smokers	1209	34%	2688	32%
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Physical Activity Education	86	17%	243	22%
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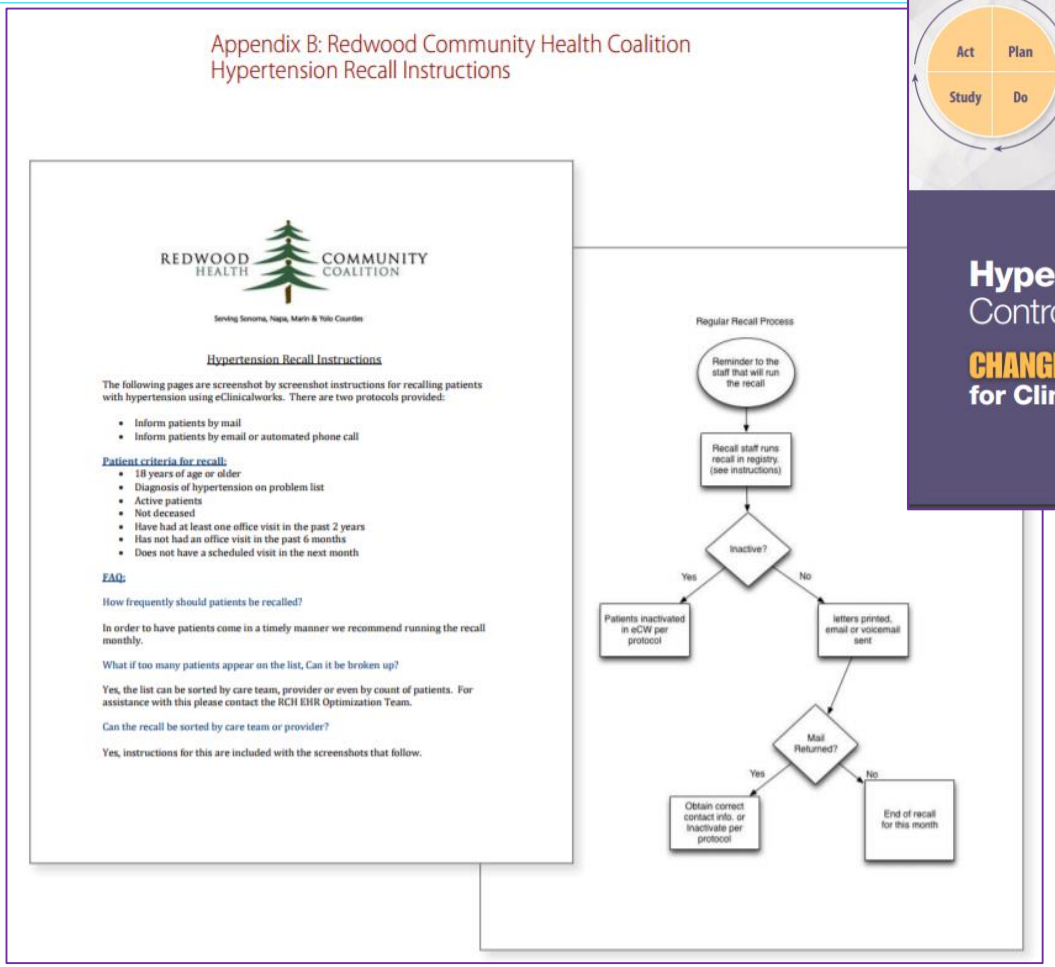
Poll #3

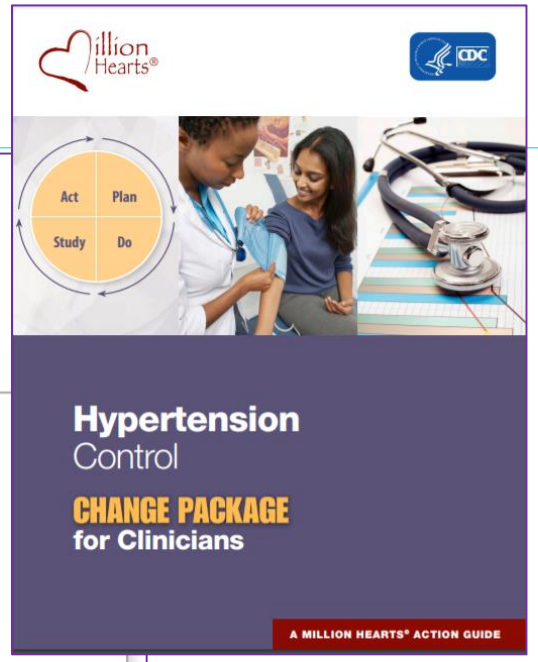
If your analysis was similar ours, what would be your next logical step(s) to improve blood pressure control in the population with poor control?

1. **Outreach** to patients out of control who have not had a recent visit and don't have an upcoming appointment
2. Leverage **integrated behavioral health** to address tobacco use and mood disorders
3. **Strengthen relationships** with professionals and programs that address obesity
4. All of the above

Outreach Tools & Techniques

- Portal
- Email
- Text
- Phone
- Snail Mail





https://www.rchc.net/wp-content/uploads/2017/09/RCHC-Hypertension-CDS-Package-v.1.xlsx

Identifying Opportunities

- Pre-Visit Planning
- Highlighting elevated blood pressures
- Highlighting contributing factors
- Engaging Behavioral Health
- Lining up referrals
- Between visit interventions

Make the right thing to do, the easy thing to do.

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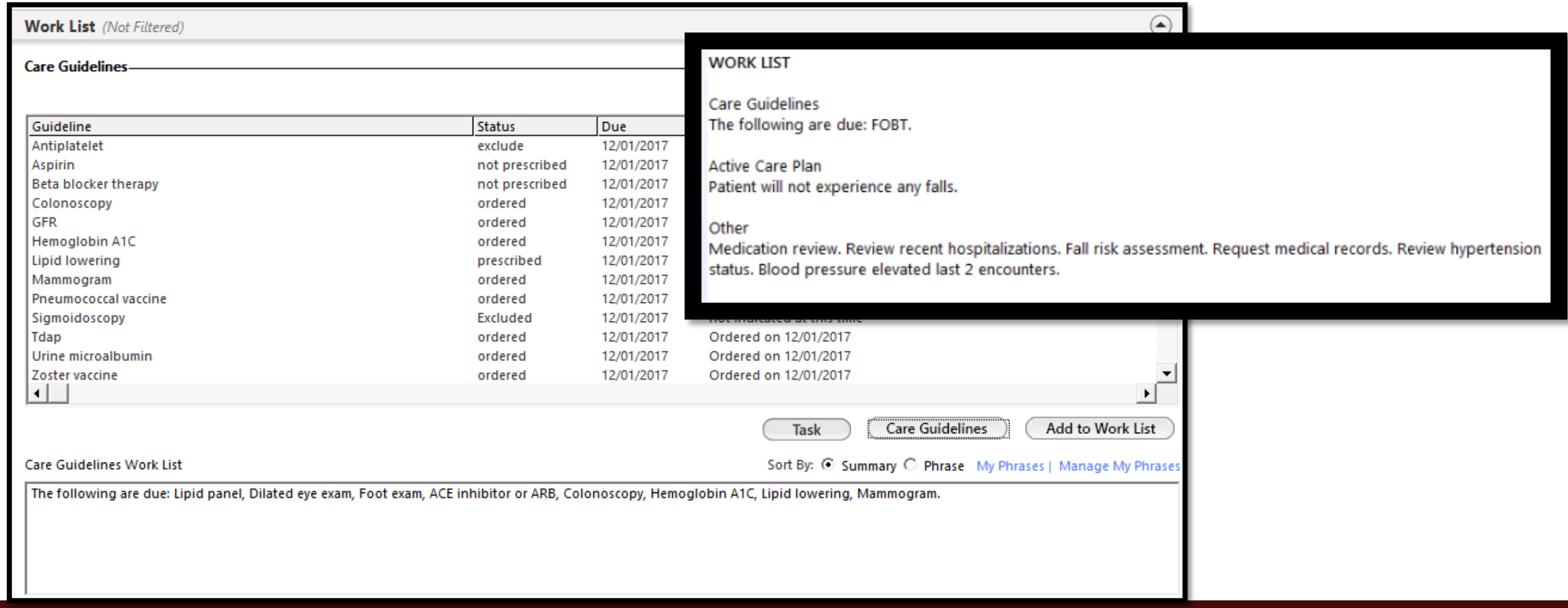

Health Initiatives Consulting

They're Here, Now What?

- **Who** does it?
  - Care Team
  - Clinician
  - Patient
- **Team work** and **point-of-care tools** that make the right thing to do, the easy thing to do:
  - Order sets
  - Templates
  - Protocols

Health Initiatives Consulting

Next Steps

- Create an i2iTracks Toolkit (3-Part Webinar Series)
  - Personalizing the Population Analytics Report content and frequency
  - Creating Outreach Campaigns based on results
  - Point-of-Care Tools and pre-visit planning
- Implement strategies to increase frequency, depth and breadth of analysis
- Data-driven focus on improvement efforts

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Trusted Advisors For High-Value Business Transformation Impact

Health Initiatives Consulting

Discussion & Questions

What one part of this presentation got you thinking about something you could do differently?

KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Health Initiatives Consulting

3-Part, Hands on Webinar Training Series on a new **i2iTracks** PHASE Toolkit

Jan. 25
10-11 am

Feb. 15
10-11 am

Mar. 8
10-11 am

Health Initiatives Consulting

Please respond to the evaluation poll!

1. On a scale of 1 to 5, how would you would rate this webinar?
2. Was this webinar a good use of your time? Yes or No?
3. **In Chat**: Please share at least one takeaway or piece of information that you plan to share with your team, or use in your organization.

Thank you!