



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



Building Blocks

Adoption of Evidence Based Clinical Guidelines

Supportive,
Engaged
Leadership
& Culture

Quality
Improvement
Culture
& Process
Improvement
Methodology

Data Driven
Decision
Making

Panel
Management

Team
Based
Care

Population Health Management



Using your Analytics Ecosystem

TO MANAGE PHASE PATIENTS



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.

Objectives

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

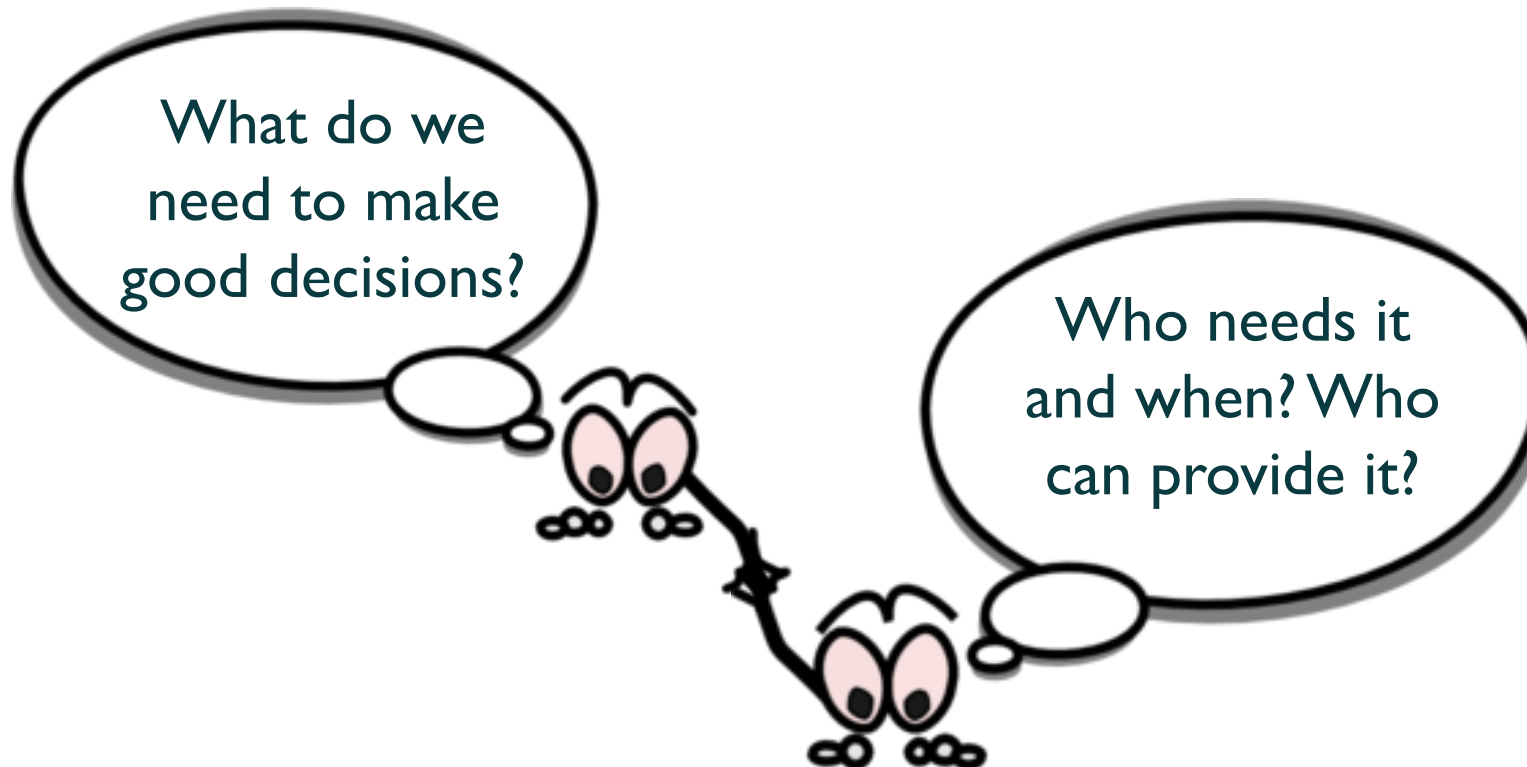
Optimize your use of analytics to regularly assess clinical performance and accelerate QI efforts.

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)



Be thinking about...





Poll #1

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

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



Proactive, Iterative
Analytics



Built on a firm
foundation



Proactive, Iterative
Analytics



Built on a firm
foundation



PHASE Metrics Include:

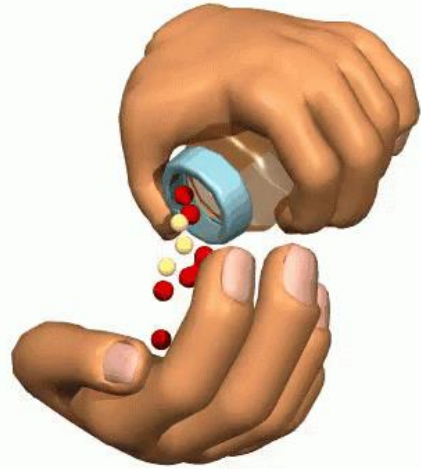
- ❖ Medical visits
- ❖ Hypertension visits
- ❖ Hypertension
- ❖ Blood pressure
- ❖ Rx Antihypertensive
- ❖ Tobacco Use and Cessation Intervention
- ❖ Depression Screening and Follow-up
- ❖ BMI and Follow-up if out of range
- ❖ Diabetes and level of control
- ❖ Rx ACE/ARB and Statin use in diabetes

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%

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	PHASE Screening and Follow Up Measures			
C. Number of Patients with a diagnosis of clinical ASCVD any age	Tobacco Screening and Follow Up			
D. Number of patients with a diagnosis of Hypertension age 18-84	1. Patients 18+ with 2 medical visits or 1 preventive visit in the last year	34240	100%	
E. Number of Unduplicated Patients who meet at least one of the above	a. Screened for Tobacco Use and if Positive, had Intervention	33837	99%	
PHASE Prescription Measures		BMI Screening and Follow Up		
A. Number of Diabetic Patients age 55-75	1. Patients 18+ and not pregnant	50088	100%	
1. % of patients prescribed a Statin	a. 18 and older with BMI calculated during the RP with follow up plan if outside normal parameters	22461	45%	
2. % of patients prescribed an ACE or ARB	Depression Screening and Follow Up			
3. % of patients prescribed a Statin and an ACE or ARB	1. Patients age 12+ without Major Mood Disorders	54601	100%	
B. Number of patients with a diagnosis of Hypertension age 18-84	a. Screened for Depression and if Positive, have a documented Follow Up Plan on the date of the Positive Screening	32300	59%	
1. % of patients prescribed an oral drug in the anti-hypertensive class	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%
C. Nutrition Education				92	88%	149	97%	162	91%	202	91%
BMI ≥ 40				32	18%	49	20%	73	29%	64	17%
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%
C. Nutrition Education				26	81%	48	98%	65	89%	60	94%



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B. Physical Activity Education			26	25%	101	66%	31	17%	58	26%
C. Nutrition Education			92	88%	149	97%	162	91%	202	91%
BMI >=40			32	18%	49	20%	73	29%	64	17%
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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Co-Morbid Diabetes

A. A1c ≥ 9

61	35%	83	34%	53	21%	130	35%
16	26%	17	20%	16	30%	24	18%

Co-Morbid Diabetes

A. A1c ≥ 9

Co-Morbid Major Mood Disorders

A. Rx Antidepressant

61	35%	83	34%	53	21%	130	35%
16	26%	17	20%	16	30%	24	18%
31	18%	92	38%	68	27%	73	20%
30	97%	86	93%	62	91%	72	99%

Co-Morbid Major Mood Disorders

A. Rx Antidepressant

31	18%	92	38%	68	27%	73	20%
30	97%	86	93%	62	91%	72	99%

A. BMI Follow-Up Plan

B. Physical Activity Education

C. Nutrition Education

BMI ≥ 40

A. BMI Follow-Up Plan

B. Physical Activity Education

C. Nutrition Education

45	47%	58	57%	101	51%	188	85%
26	25%	101	66%	31	17%	58	26%
92	88%	149	97%	162	91%	202	91%
32	18%	49	20%	73	29%	64	17%
11	34%	19	39%	45	62%	54	84%
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BMI >=40	32	18%	49	20%	73	29%	64	17%
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B. Physical Activity Education	7	22%	36	73%	14	19%	20	31%
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Denominator	486	100%	621	100%	479	100%	690	100%

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%
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%
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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	
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%
C. Nutrition Education	26	81%	48	98%	65	89%	60	94%



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%
	Cessation Intervention in Past Year		1179	98%	2622	98%
	Rx Tobacco Cessation		207	17%	471	18%
	BMI ≥ 30		1995	57%	4380	53%
	BMI Follow-Up Plan		333	17%	988	23%
	Physical Activity Education		333	17%	988	23%
	Nutrition Education		471	24%	1377	31%
	BMI ≥ 40		503	14%	1096	13%
	BMI Follow-Up Plan		86	17%	243	22%
	Physical Activity Education		86	17%	243	22%
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BMI Follow-Up Plan			86	17%	243	22%
Physical Activity Education			86	17%	243	22%
Nutrition Education			138	27%	391	36%



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

Appendix B: Redwood Community Health Coalition Hypertension Recall Instructions



Hypertension Recall Instructions

The following pages are screenshot by screenshot instructions for recalling patients with hypertension using eClinicalworks. There are two protocols provided:

- Inform patients by mail
- Inform patients by email or automated phone call

Patient criteria for recall:

- 18 years of age or older
- Diagnosis of hypertension on problem list
- Active patients
- Not deceased
- Have had at least one office visit in the past 2 years
- Has not had an office visit in the past 6 months
- Does not have a scheduled visit in the next month

FAQ:

How frequently should patients be recalled?

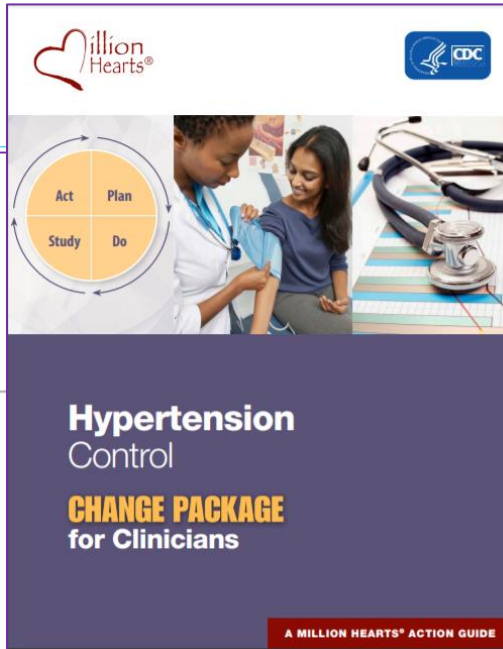
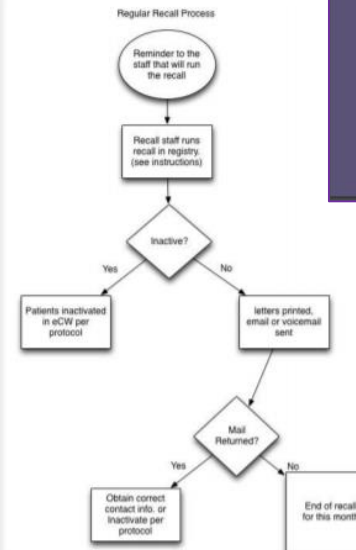
In order to have patients come in a timely manner we recommend running the recall monthly.

What if too many patients appear on the list, Can it be broken up?

Yes, the list can be sorted by care team, provider or even by count of patients. For assistance with this please contact the RCH EHR Optimization Team.

Can the recall be sorted by care team or provider?

Yes, instructions for this are included with the screenshots that follow.



<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.

Work List (Not Filtered)

Care Guidelines

Guideline	Status	Due
Antiplatelet	exclude	12/01/2017
Aspirin	not prescribed	12/01/2017
Beta blocker therapy	not prescribed	12/01/2017
Colonoscopy	ordered	12/01/2017
GFR	ordered	12/01/2017
Hemoglobin A1C	ordered	12/01/2017
Lipid lowering	prescribed	12/01/2017
Mammogram	ordered	12/01/2017
Pneumococcal vaccine	ordered	12/01/2017
Sigmoidoscopy	Excluded	12/01/2017
Tdap	ordered	12/01/2017
Urine microalbumin	ordered	12/01/2017
Zoster vaccine	ordered	12/01/2017

WORK LIST

Care Guidelines
The following are due: FOBT.

Active Care Plan
Patient will not experience any falls.

Other
Medication review. Review recent hospitalizations. Fall risk assessment. Request medical records. Review hypertension status. Blood pressure elevated last 2 encounters.

Not indicated at this time

Ordered on 12/01/2017

Ordered on 12/01/2017

Ordered on 12/01/2017

Task

Care Guidelines

Add to Work List

Care Guidelines Work List

The following are due: Lipid panel, Dilated eye exam, Foot exam, ACE inhibitor or ARB, Colonoscopy, Hemoglobin A1C, Lipid lowering, Mammogram.



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





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



Loretta Khangura
lorettak@hiccare.net
Office: 803-816-5001
Mobile: 209-201-1850
www.hiccare.net



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Transformation Impact



Discussion & Questions

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



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

save
the
date

Jan. 25
10-11 am

Feb. 15
10-11 am

Mar. 8
10-11 am



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!