KENTUCKIANA HEALTH COLLABORATIVE

June 7, 2022

AGENDA

- Describe Hypertension Quality Measure
- Using EHR and HIT to identify undiagnosed hypertension and patients with uncontrolled hypertension
- How to establish proactive identification and monitoring (running EHR reports)
- Tips for gaining provider engagement to use their EHRs in this way
- Up next discussion of monitoring through clinically supported SMBP

BASELINE DATA FOR HYPERTENSION

Determine your Measurement Period

Methods to Calculating Your Current Rate

- NQF
- UDS

Helps to see where you are and assist to set an achievable goal

Measure Consistently with the same measure type

- Examples: NQF/ UDS/ HEDIS reports

QUALITY ID#236/NQF0018: CONTROLLING HIGH BLOOD PRESSURE NUMERATOR

Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140mmHg and diastolic blood pressure < 90mmHg) during the measurement period

Don't include BP readings:

1) Taken during an acute inpatient stay or an ED visit
2) Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. BP readings taken on the same day that the member receives a common low-intensity or preventive procedure are eligible for use.
3) Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope

- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

QUALITY ID#236/NQF0018 DENOMINATOR

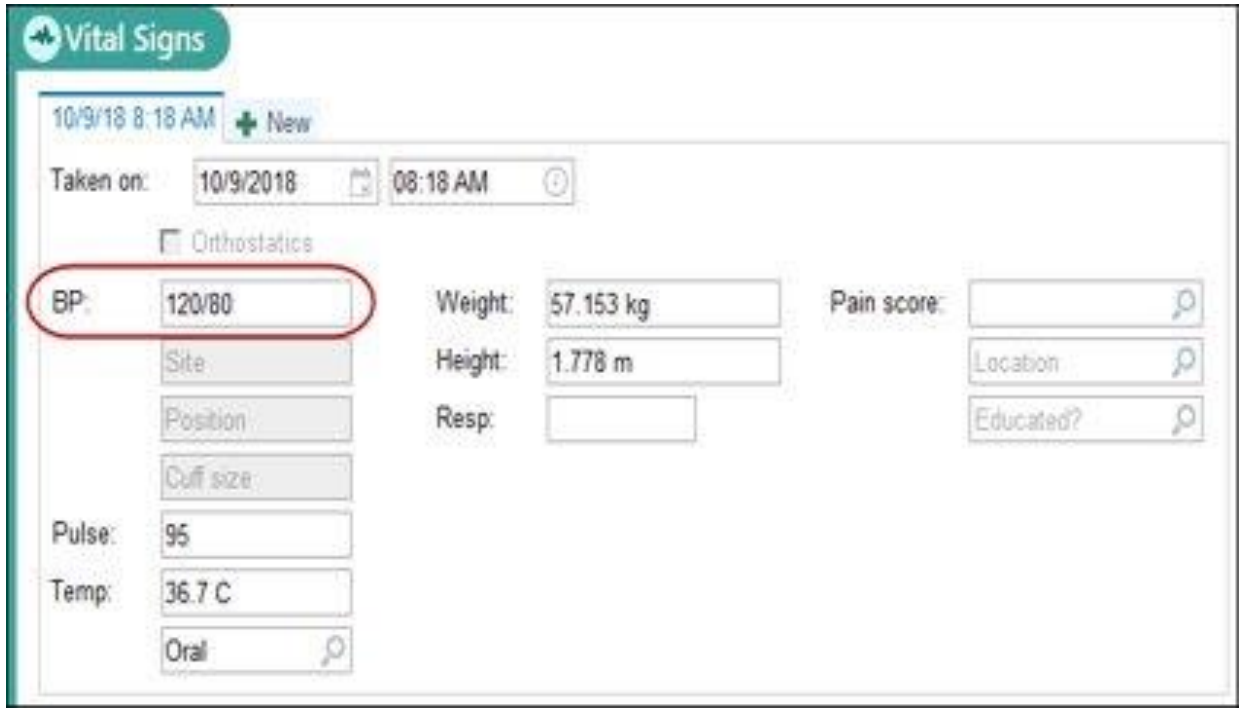
Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

1. Age 18-85 year of age on date of encounter
2. Diagnosis for hypertension
3. Patient encounter during the performance period

Exclusions:

- Hospice
- Palliative Care
- End Stage Renal Disease
- Long Term Care

RECORD BLOOD PRESSURE (SUPPORT STAFF)



In the **Rooming** activity, go the **Vital Signs** section.

In the **BP** field, enter the patient's blood pressure.

NOTE: Remember to repeat blood pressure if reading above 140/90 at first reading and record

DOCUMENT HYPERTENSION (PROVIDER)

In the **Plan** activity, go the **Problem List** section.

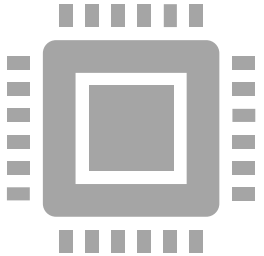
Add or confirm diagnosis of hypertension.

Importance of Validating Data

Verification

Are you pulling the correct report?

Are you using the correct measurement period?



Validation

Is your EHR pulling the correct information into the Numerator/Denominator?

Are the fields within your EHR tracking to give you credit?

Is everyone on your team trained to enter data in the appropriate field?

MONTHLY DATA

Consistant

- Continue to use the same method each month
  - NQF vs UDS

Reports

- Run report by 15th of each month
  - Year To Date or Rolling Calendar Year

Navigation

- Use of Navigation data
  - Tracked manually each month

Tools to Track Data

- Line Charts
  - Trend is 5 or more data points that change in either direction
- PDSA Tracking Sheets
  - Plan spread
- Share Data Throughout Organization
  - Helps team to understand the overall goal and where they stand

Tips for gaining providers engagement to use their EHRs in this way

Value-based care vs. fee-for-service

How does value based care differ from fee-for-service?

- In contrast to fee-for-service, **value-based reimbursement models compensate providers not for the quantity of procedures performed, but rather for the quality of the care they provide, measured by patient health outcomes**.

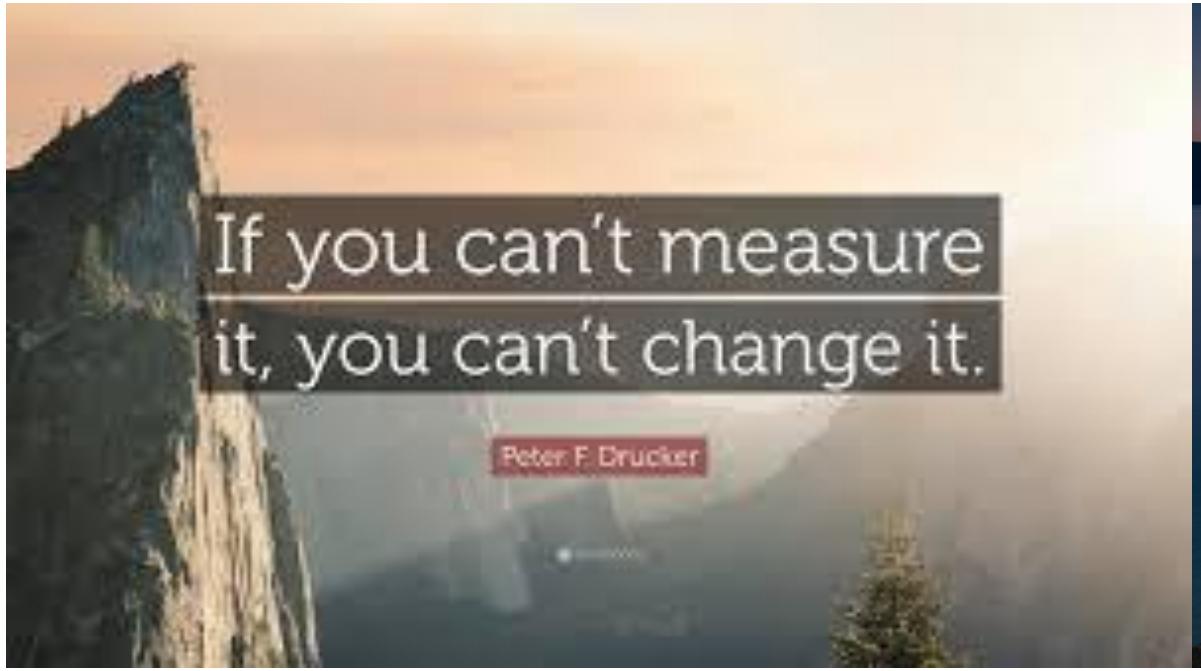
Data Validation Results

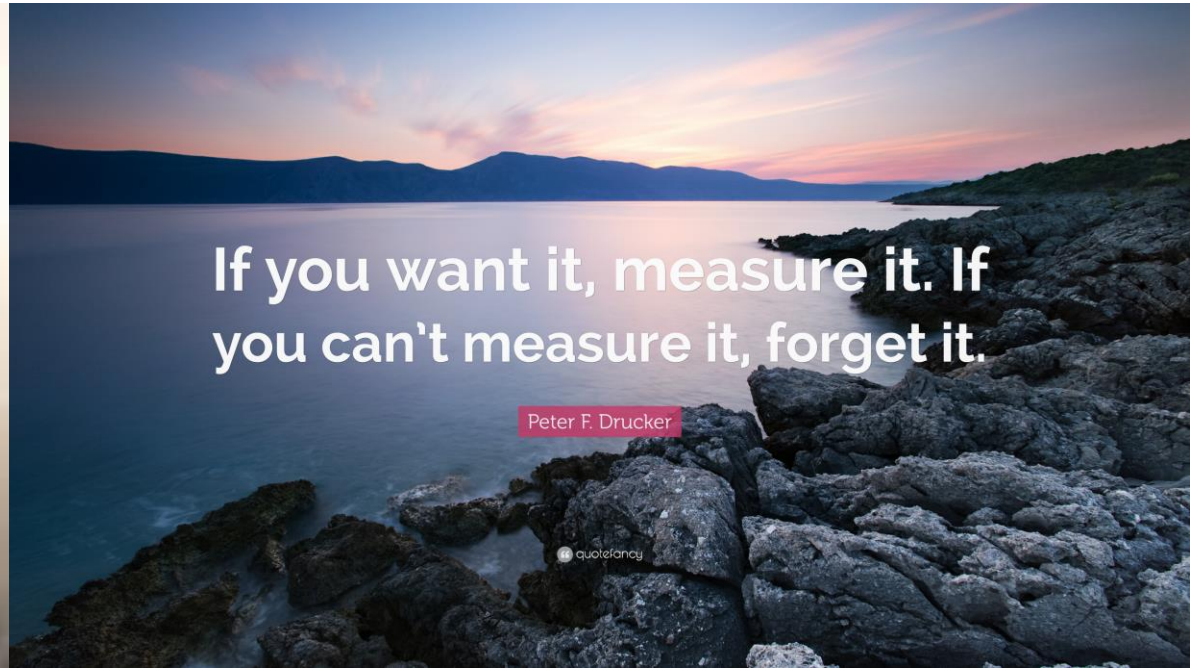
	Numerator	Denominator	Exclusions	Screening Rate	Audit Error Rate	Audit Other Issues Found
Provider 1	65	260	21	27.20%	20%	5
Provider 2	132	437	23	31.80%	30%	3
Provider 3	177	586	52	33.10%	20%	3
Provider 4	147	511	20	29.90%	20%	4
Provider 5	80	267	17	32%	10%	2
Provider 6	229	945	40	25.30%	10%	5
Totals	**830**	**3006**	**173**	**29.30%**	**18.30%**	**22**

Tracking Outcomes-Share Findings

- PDSA cycles forms
  - Plan, Do, Study, Act
  - Small scale
  - Identify positive and negative outcomes
- Negative outcomes tell us as much as positive outcomes
- Spread positive changes throughout your organization
- Positive outcomes will provide sustainability

WHAT GETS MEASURED, GETS MANAGED: PETER DRUCKER





OTHER ACTIONABLE IDEAS FOR STAKEHOLDER ENGAGEMENT

1. Link Clinical Measures and Outcomes to the Strategic Plan
   - EX: Will increase QI measure performance by XX% each year; will gain gold/silver/bronze HRSA QI medallion

2. Gain the Senior Leader's interest with reports and feedback

3. Involve Senior Leadership with the team's work

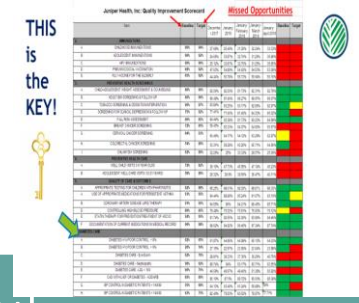
4. Have Senior Leadership regularly report QI work to the BOD/Leadership team

5. Place storyboards in visible places

6. Distribute or post QI reports/graphs so staff can review MONTHLY (at least quarterly!) if possible (Org Level, Clinic Level, Provider Level)

7. QI staff need to be constantly running internal reports to check data accuracy; work constantly with vendor to improve reports

GAIN THE SENIOR LEADER'S & PROVIDERS INTEREST WITH REPORTS AND FEEDBACK

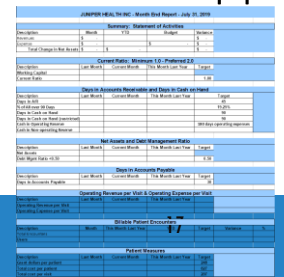


The reports and feedback ABSOLUTELY MUST be accurate, concise and meaningful

- Physicians are scientists and they will scrutinize data very closely, especially if it seems to show their outcomes are not what they thought
- CEOs are very worried about keeping the lights on and paying employees so they will scrutinize data to the $1
- One or two "inaccurate reports" will cause leadership to lose faith in the process
- SO…….validate, validate, validate

Leaders can lose track of "people" so always remember to tie reports back to patient stories!

- Tell the stories of how patient's hypertension was caught early
- Remind leaders about how population health monitoring also began to look at social determinants of health and the organization was able to assist with transportation or with getting someone affordable DM supplies
- Our Dir. Of BH's monthly report always included a short paragraph "success story"



CONVENE HUDDLES-MAKE IT QUICK AND EASY

Daily Huddles

- Include patient's that will be seen that day

10 minutes or less

- Standing is best

Use Visual Boards

- Helps to identify what you are trying to accomplish

SAMPLE OUTREACH STRATEGIES

Compile a list of patient concerns, prioritize them with patient and address them in order

Use registry to proactively contact patients for follow-up

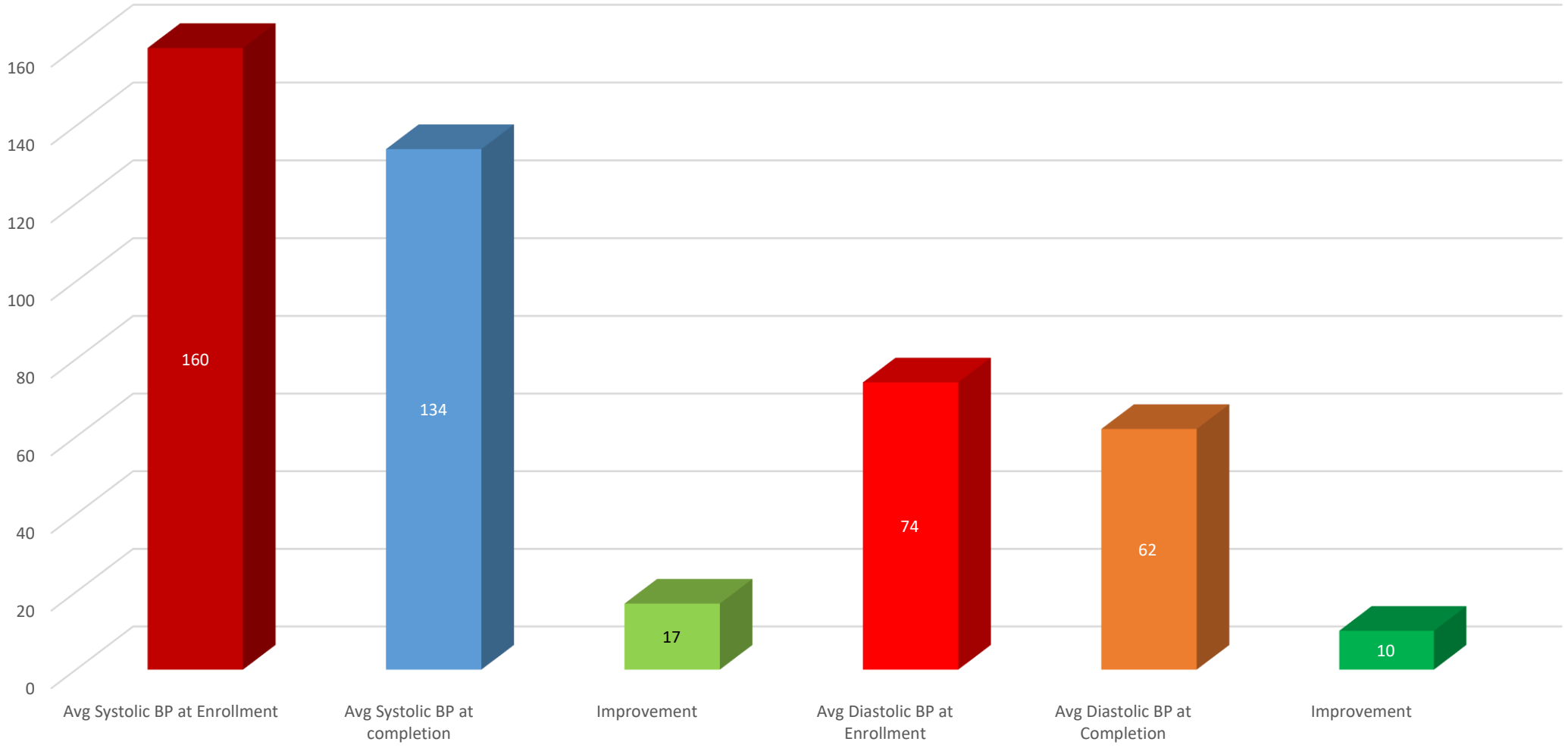
Assign specific person to review registry for patients in need of care

Pre-arrange telephone or e-mail follow-up at a face-to-face visit

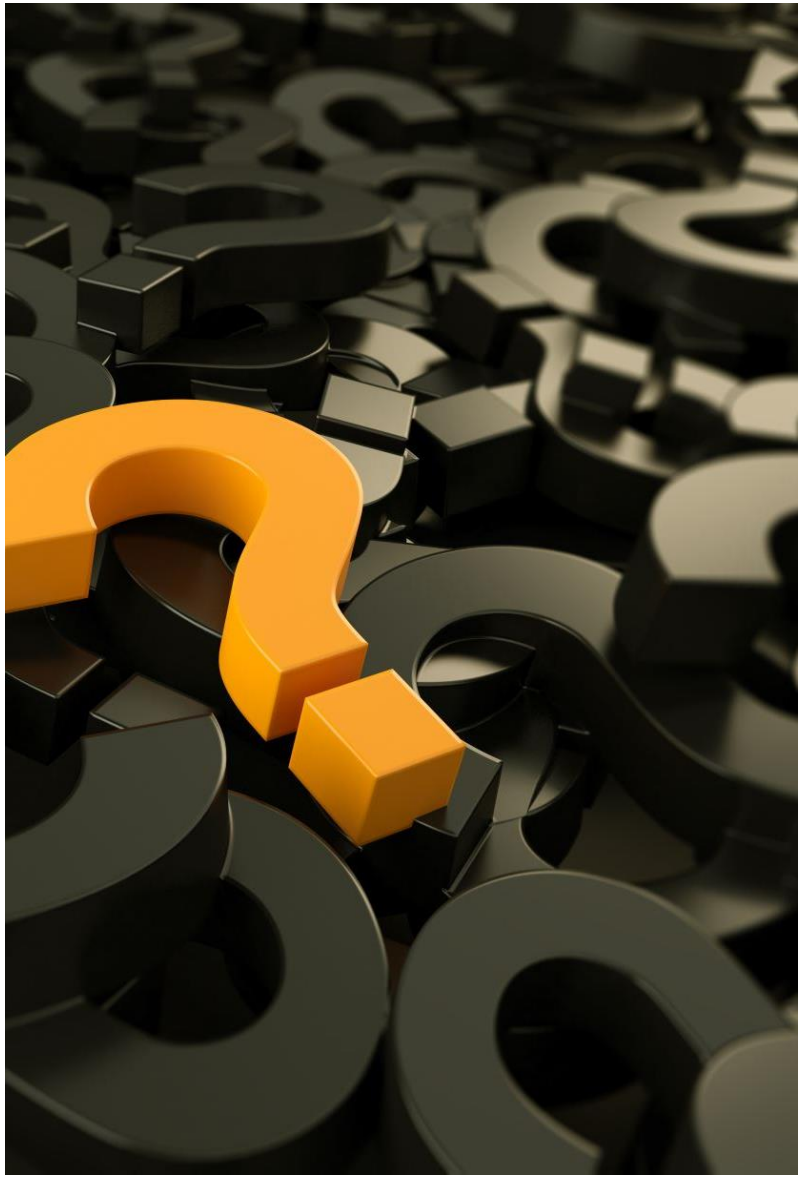
PATIENT OUTCOMES WHEN REFERRED TO SELF-MEASURED BLOOD PRESSURE MONITORING

QUARTERLY PILOT DATA

MARCH 31, 2022



ANY QUESTIONS?



WANT TO WORK ON CLINIC HYPERTENSION RATES?

HYPERTENSION LEARNING COLLABORATIVE
JULY 1, 2022 — JUNE 30, 2023

- ❑ Receive monthly technical assistance, monthly webinars and quarterly Learning Sessions, regular reporting
- ❑ Educate patients on options for blood pressure screening, refer interested patients to Self-Measured Blood Pressure Monitoring at Local Health Department
- ❑ Conduct small tests of change using quality improvement methodology
- ❑ Financial Support: $1500 quarterly

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