

## Adult QI Panel Management Activity, Wednesday, 7/10/19

### PHASE MEETS RELEVANT

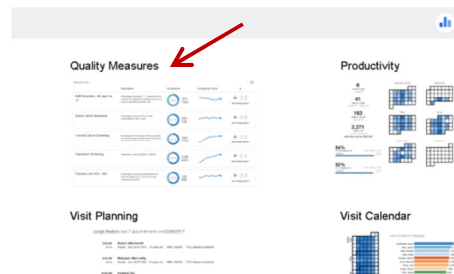
This month we will practice using a new feature in Relevant called Population Explorer to work on Panel Management for our PHASE patients. We know and love PHASE as the program that helps keep our patients who are most vulnerable to cardiovascular disease safe from harm. Please see the **attached algorithms that have recently been approved as the official PHASE guidelines by Redwood Community Health Coalition (RCHC)**. As a reminder, these are the main PHASE and UDS metrics that we track and act on to help prevent heart attacks and strokes in our patients with diabetes, hypertension and a history of previous cardiovascular disease:

- A1C<9 in patients 18-75 yo with DM
- BP <140/90 for patients with DM
- BP <140/90 for patients 18-85 yo with HTN diagnosis (providers may choose to adhere to JNC-8 criteria)
- Statin Use in patients 18+ yo with known CAD
- Aspirin Use in patients 18+ yo with known ischemic vascular disease
- Statin Use in patient with DM 40-75yo

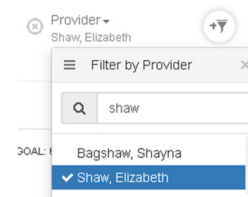
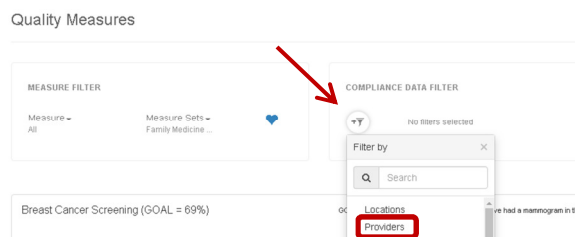
#### TODAY'S ACTIVITY:

#### 1. Review your PHASE Performance in Relevant

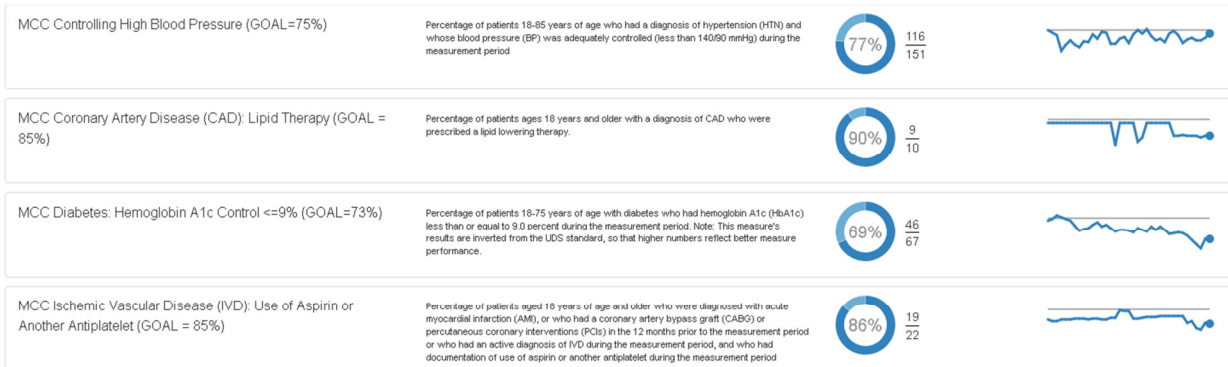
- a. Login to Relevant
- b. From the home screen, click on the Quality Measures module (upper left corner)



- c. In the Quality Measures module, click on the funnel icon to Add Filter and select Providers. From the provider drop down, select yourself.




- d. Scroll down to review your performance on the following four PHASE-related measures. Note the goal for the measure next to the title.



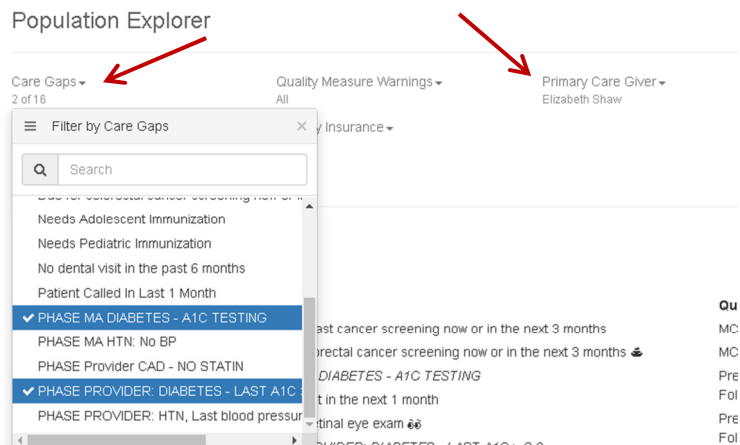
2. Choose one measure to focus on today based on *your* performance relative to the goal. (In the example above, Diabetes Hemoglobin A1C Control <=9% would be a good choice.)

3. Review your non-compliant patient list for the measure you select using the Population Explorer feature in Relevant.

- a. Return to the home screen by clicking on  the icon at the top of the screen
- b. Click into the *Population Explorer* module. This module will allow you to filter lists of your patients by outstanding needs that correspond with Quality Measures.



- c. Once in the Population Explorer module, *select yourself as the Primary Care Giver*. Then select the *Care Gap(s)* that correspond to the Quality Measure you selected in step 1. \*\*Notice that for some measures, there are MA and Provider Care Gaps that apply. *For example*, related to DM control, MAs can focus on ordering A1Cs for patients with no result while providers can look at management changes.



- d. Review your list of patients with the selected Care Gap(s). Note that *only patients with at least one of the Care Gaps you select are listed, but all of the Care Gaps for those patients are displayed*. Also, patients are listed by number of Care Gaps.

Displaying 25 of 31 results Export ▾

<p>PCG: Elizabeth Shaw Provider Team: South Novato Home Phone: Preferred Phone: Primary Language: English</p>	<p><b>Care Gaps</b> Due for breast cancer screening now or in the next 3 months Due for colorectal cancer screening now or in the next 3 months ⚡ <i>PHASE MA DIABETES - A1C TESTING</i> Appointment in the next 1 month Due for a retinal eye exam 👁️ <i>PHASE PROVIDER: DIABETES - LAST A1C &gt; 9.0</i> <i>PHASE PROVIDER: HTN, Last blood pressure &gt;= 140/90</i></p>	<p><b>Quality Measure Warnings</b> MCC Diabetes: Hemoglobin A1c Control &lt;=9% (GOAL=73%) MCC Controlling High Blood Pressure (GOAL=75%) Preventive Care and Screening: Body Mass Index (BMI) Screening And Follow-Up Plan (UDS 2018 Table 6B) Preventive Care and Screening: Body Mass Index (BMI) Screening And Follow-Up Plan (UDS 2018 Table 6B) - YTD Diabetes Management - Retinal Eye Exam (Duplicate) Controlling High Blood Pressure (UDS 2018 Table 7) Colorectal Cancer Screening (UDS 2018 Table 6B) Diabetes: Hemoglobin A1c Control (&lt;=9%) (UDS 2018 Table 7, Inverted) Breast Cancer Screening (GOAL = 69%) Diabetes Management - Retinal Eye Exam (GOAL = 70%) MCC Colorectal Cancer Screening (GOAL = 71%) Annual Monitoring of Patients on Persistent Medications (QIP 2018) MCC Preventive Care and Screening: Body Mass Index (BMI) Screening And Follow-Up Plan (GOAL = 65%)</p>	<p><b>**Please ignore the Quality Measure Warnings. These are out-of-the box Relevant items that are less useful than the Care Gaps</b></p>
<p>Preferred Phone: Primary Language: English</p>	<p><b>Care Gaps</b> Due for a retinal eye exam 👁️ <i>PHASE MA DIABETES - A1C TESTING</i> Due for colorectal cancer screening now or in the next 3 months ⚡ Due for cervical cancer screening now or in the next 3 months Due for breast cancer screening now or in the next 3 months <i>PHASE PROVIDER: DIABETES - LAST A1C &gt; 9.0</i></p>	<p><b>Quality Measure Warnings</b></p>	
<p>PCG: Elizabeth Shaw Provider Team: South Novato</p>	<p><b>Care Gaps</b> Due for breast cancer screening now or in the next 3 months Due for colorectal cancer screening now or in the next 3 months ⚡ <i>PHASE MA DIABETES - A1C TESTING</i> <i>PHASE MA HTN: No BP</i></p>	<p><b>Quality Measure Warnings</b> Annual Monitoring of Patients on Persistent Medications (QIP 2018)</p>	

## PHASE PANEL MANAGEMENT BEST PRACTICES:

- **Diabetes Control:**
  - Targeting patients who need A1C testing is an easy way to increase your control rate. Many patients who need testing are controlled, but don't count for the measure if their A1C is out of date!
  - Consider referring patients to Diabetes groups or nutrition for lifestyle support
  - Review the attached algorithm for DM management and consider adding GLP-1, SGLT-2 and DPP-4 agents as adjuvant treatment options in uncontrolled patients.
- **HTN Control:**
  - Consider having RNs call patients for whom you have medication adherence concerns
  - Refer patients to nutrition/health ed for lifestyle support
- **ASA/Statins:**
  - Documents contraindications or allergies to medications or medication classes in the chronic problem list and allergy module if appropriate

Questions/comments? Email [quality@marinclinic.org](mailto:quality@marinclinic.org)