Maximize the value of hypertension population management programs with advanced analytics
STEP ONE:
Analyze your patient population

Bend the cost curve: Learning more about your patients can lead to higher-quality care
As providers increasingly assume more risk, population health management (PHM) is being looked to as a way to improve the quality and delivery of health care and control costs. As part of this strategy, providers are expanding their chronic disease management programs into their communities and proactively monitoring and interacting with the populations they serve.
Underlying the success of these programs is the effective use of advanced analytics. With the help of sophisticated tools that scrutinize longitudinal claims and clinical data, for instance, providers are getting a more robust view of their patients with hypertension. They are identifying patients who haven’t been seen regularly, or who have undiagnosed comorbidities, and are finding ways to more intensively manage them.

Foster change leadership and a culture of data before launching initiatives
Population health management starts with building a coalition of leaders to lead PHM initiatives. Such leaders may include a steering committee and the engagement of a range of disciplines spanning areas that are critical to success.
For example, before tackling hypertension, Cornerstone Health Care — a multi-specialty clinic in the Piedmont Triad region of North Carolina — convened workgroups to design processes and define measures. They focused on an automated system for outreach and patient engagement. The physician-led group began by educating and aligning its entire staff on the same clinical pathway.
For population health management to succeed, organizations need to do more than lead from the top down. They also need to cultivate a bottom-up cultural change by encouraging trust in their data. The Mayo Clinic Health System, for instance, has engendered trust among physicians by offering training for those who use data to improve decision making. The integrated system has also established governance mechanisms to ensure that priorities are aligned with capabilities and that data are used properly.

With the help of sophisticated tools that scrutinize longitudinal claims and clinical data, providers are:
• Getting a more robust view of their hypertensive population
• Identifying patients who haven’t been seen regularly
• Identifying patients whose health metrics are outside acceptable limits
• Finding ways to more intensely manage these metrics
Better managing patients with hypertension means having a fuller picture of their health — including predicting their risk for future complications and more accurately targeting interventions.

One in three U.S. adults has hypertension and is at increased risk for heart disease and stroke. Annual costs are estimated at $156 billion in health care services, medications and missed work days. Among all patients, hypertension is the leading cause of visits to the doctor. But much of the cost and harm to quality of life caused by hypertension can be prevented. Organizations can work to control costs and prevent bad outcomes by applying advanced analytics to gain a deeper understanding of patients with hypertension. Armed with more understanding, they can implement a plan for concerted intervention.

Advanced analytics enable organizations to sort patients with hypertension by risk. Applying advanced analytics to a broad database of longitudinal data, for instance, helped Cornerstone Health Clinic segment patients with Stage 1 and 2 hypertension who had not been seen by a provider for six months or longer. This allowed Cornerstone to create its registry of patients given priority for early intervention.

Nine months after instituting its hypertension management program, Cornerstone’s overall HTN control rate improved to 66.2 percent from 64.2 percent — a step forward to its goal of 80 percent.

In addition to identifying and acting on gaps in care, organizations can use longitudinal data to track clinical, operational and financial performance. Dashboard reports, for instance, can provide valuable insight into clinical performance, laying the groundwork for initiatives designed to promote physician behavior and drive improvements in quality, safety and efficiency. Gaining access to comprehensive longitudinal data can also help providers benchmark their practices against other practices across the country.

**STEP TWO:**
Predict the future. Are your patients at risk of being hospitalized?

1 IN 3 U.S. ADULTS HAS HYPERTENSION

$156 BILLION

Organizations can use longitudinal data to:

IDENTIFY AND ACT ON GAPS IN CARE

TRACK CLINICAL, OPERATIONAL AND FINANCIAL PERFORMANCE

BENCHMARK THEIR PRACTICES AGAINST OTHER PRACTICES ACROSS THE COUNTRY

ANNUAL COSTS OF HYPERTENSION

HEALTH CARE SERVICES

MEDICATIONS

MISSED DAYS OF WORK
STEP THREE:
Stratify patients by risk to more effectively coordinate care

Segmenting a patient population lays the groundwork for devising effective care management and patient engagement programs. Many organizations have retooled their care management approach from a reactive model to one that is driven by predictive, proactive intervention and care.

Billings Clinic in Montana, for example, implemented a scalable approach to identify and track patients with hypertension. By applying analytics to its data, the clinic was easily able to find patients with hypertension based on clinical findings such as blood pressure readings. It was also able to stratify patients with hypertension into clinically relevant cohorts based on clinical findings, such as those consistent with kidney disease or diabetes. Billings was then able to further analyze these groups by clinical acuity, medication patterns or other process measures. Billings went on to monitor the impact of its hypertension interventions over time and track their patients’ control longitudinally. Physicians were also provided with reports that compared their results to their peers locally and at other leading practices throughout the U.S.

San Francisco Bay Area group Brown & Toland Physicians — whose initial population health improvement focus was on hypertension, diabetes and preventive care — has used its data to create a working registry that in-house care coordinators use to target outreach to high-risk patients. Thirty to 40 percent of each day’s schedule is held for same-day or next-day appointments so that patients identified as having gaps in care can be seen quickly. Patients with uncomplicated problems can be seen in 10-minute “quick sick” appointments. As a result, wait times for patients have dramatically improved.

Providers who use PHM principles to manage their patients with hypertension will be ahead of the curve as the industry continues its march toward value-based reimbursement. Leveraging advanced analytics to create more comprehensive risk profiles for patients will better position providers to make the transition from treating illness to managing health.

BILLINGS CLINIC
• Serves patients in Montana, Wyoming and the Western Dakotas
• Hypertension and cardiovascular health is a high priority
• Approximately 36% of Billings Clinic patients with hypertension are uncontrolled

BROWN & TOLAND HEALTH SERVICES
• One of the first medical groups in the U.S. to deploy integrated EHR in a private practice setting
• Selected as a Pioneer Accountable Care Organization (ACO) in 2011
• Leading primary care transformation through its PCMH

PREDICT PATIENT RISK TO PREVENT HIGH-COST CARE AND COMPLICATIONS
Use population analytics to separate those in need of intervention from those whose chronic illness is well-managed.

Segment by Clinical Risk
- HIGH 5%
- MEDIUM 40%
- LOW 55%

leveraging advanced analytics
TREATING ILLNESS
MANAGING HEALTH