KAISER PERMANENTE®

PHASE

PREVENTING HEART ATTACKS & STROKES EVERY DAY

Quarterly Data Report: Q1 2019

Purpose

This report is a snapshot of PHASE grantees' performance on clinical quality measures. It shows performance relative to national benchmarks and trends over time. It is meant to facilitate discussions about PHASE grantees' performance and progress in clinical measures.

CCHE reviews grantees' data quarterly to elevate areas of progress and areas for potential technical assistance. Additionally, CCHE explores the data with grantees and the PHASE Support Team to ask whether changes over time are due to changes in data quality or clinical practice.

These clinical measures do not follow patients over time; they are a point-in-time view of how each organization is managing its patient population. In discussions with grantees, CCHE does its best to understand nuances and limitations of each grantee's data.

Audience

- ### PHASE grantees:
  This initiative-wide look of the clinical data can put your data into perspective. Comparison of the initiative's time trends with yours provides context for how other grantees are progressing. Discussing the individual dashboard with your team quarterly helps us to understand your data and the contribution of PHASE to your efforts.
- ### Center for Care Innovations and technical assistance partners
  With this report, you will get an initiative-wide view of where grantees may be struggling and are excelling to inform technical assistance and promising practices/bright spots.
- ### Kaiser Permanente Northern California Community Benefit
  Quarterly snapshots provide opportunities to understand the impact of your investment in the community.

Questions about clinical data definitions?
Please contact Carly Levitz
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Questions about the PHASE evaluation?
Please contact Jennie Schoeppe
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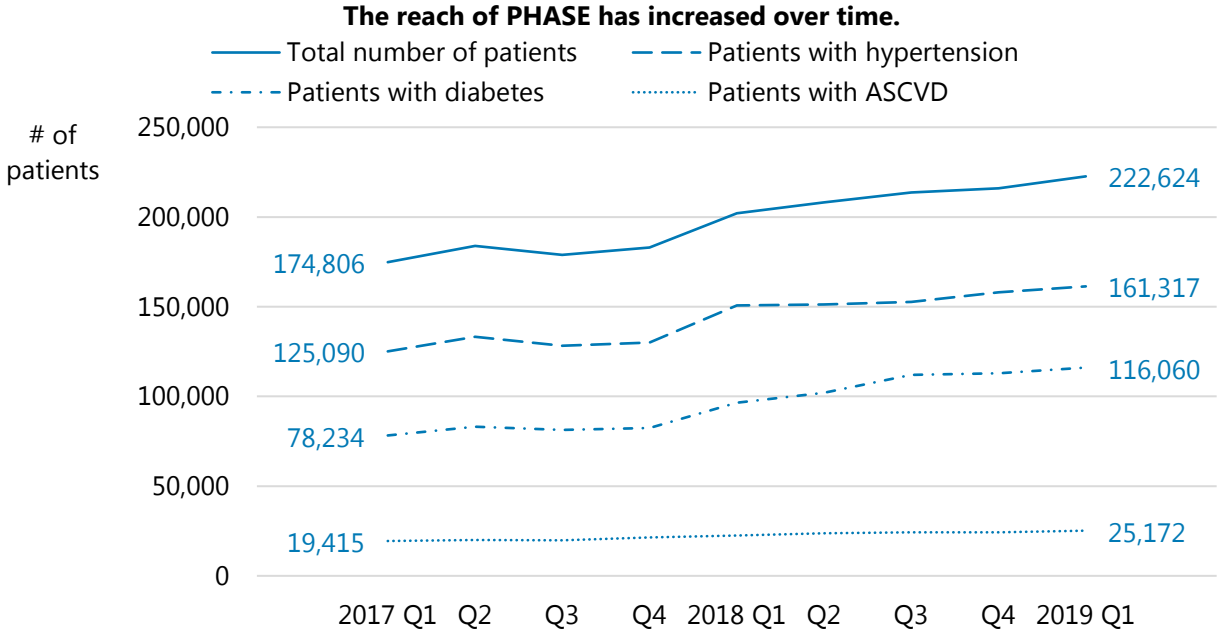
For additional information, please see the PHASE Mid-Initiative Evaluation Report.

Reach of PHASE



Data quality

All 18 grantees submitted their data within one week of the deadline. In any given quarter, there are exclusions due to unanticipated data quality issues and/or EHR changes leading to un-validated or incomplete data. Exclusions due to data quality have decreased over time as teams become more adept at identifying errors. However, there are still some cases of systemic issues; for example, grantees using multiple reporting tools for which specific measures do not match up. Additionally, as the Alameda County grantees have begun their transition to Epic, the anticipated data quality issues arose as they began extensive data mapping and validation. Data from two grantees were significantly affected by this, with an inability to report with confidence on certain measures given where they are in the data validation process.

Initiative results: clinical data outcomes

Kaiser Permanente Northern California Community Health program supports the PHASE initiative to prevent heart attacks and strokes in high-risk patient populations served by the safety net. The aspirational goal of the program is to eliminate preventable cardiovascular disease so that all people in our communities have controlled blood pressure, controlled Hemoglobin A1C levels, and are tobacco-free.

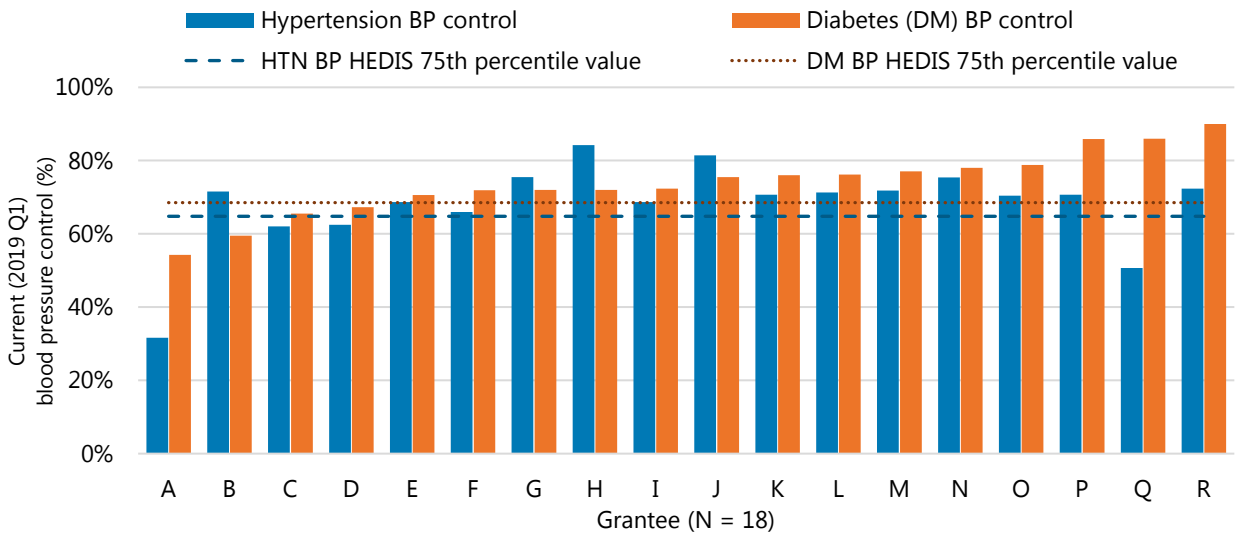
Key outcomes

The PHASE initiative has made progress on the proportion of patients with hypertension whose blood pressure is in control and has made statistically significant progress on that same measure for patients with diabetes.

Patients with hypertension		Patients with diabetes	
69.6% have controlled blood pressure (BP)	**88.7%** are prescribed oral anti-hypertensive	**75.6%** have controlled BP	**73.0%** are prescribed an ACE and/or ARB

Across the initiative, there is an average of **69.6% of patients with hypertension with blood pressure controlled**, which means 110,123 patients have their BP in control. The BP control rate is higher for patients with diabetes, though the population is smaller: **75.6% of patients with diabetes have their blood pressure in control**, for a total of 86,937 patients in control.

Fifteen of 18 grantees are surpassing the HEDIS 2018 Medicaid 75th percentile value for at least one of these BP measures; there are 13 grantees that are meeting that goal for both measures. Furthermore, there are 11 grantees that are meeting the HEDIS 90th percentile value for at least one of these measures. See figure below.[1] Sixteen grantees have improved on at least one of these measures over time. Ten grantees have improved on both measures.



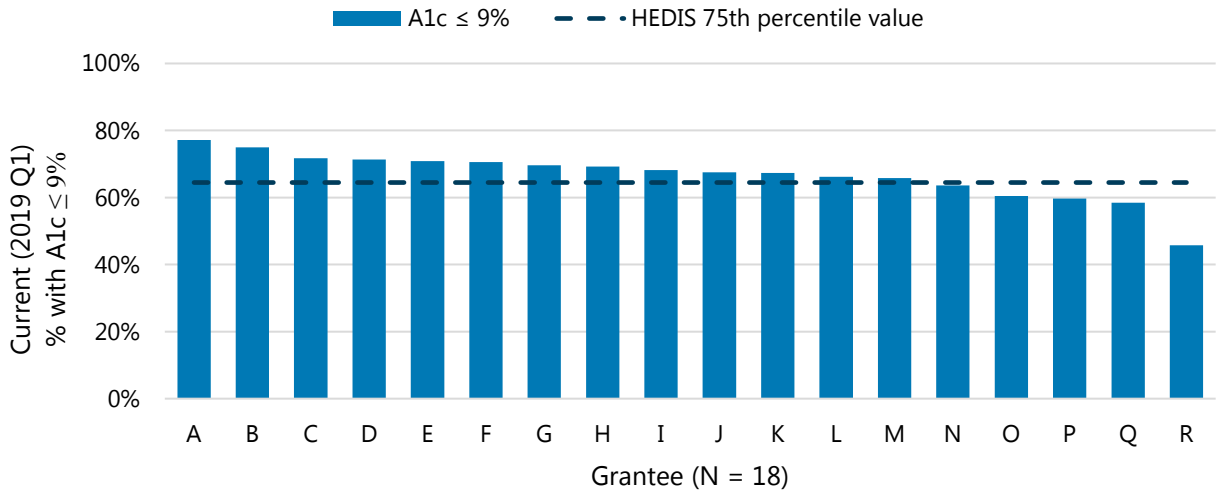
[1] Grantees are listed in ascending order by current value of diabetes BP control. "Grantee A" in this figure will not always be "Grantee A" in subsequent figures.

Clinic sites with higher percentages of patients with hypertension prescribed oral anti-hypertensives also have higher rates of controlled blood pressure for patients with hypertension.[2] A similar relationship is found between clinics with a higher prescription rate of ACE/ARB for those with diabetes and a higher proportion of patients with diabetes whose blood pressure is controlled.

There are two capacity indicators, as measured by the PHASE Building Blocks Assessment, that are related to blood pressure outcomes. The sites' baseline scores on these two questions are related to both baseline blood pressure control and to current level of blood pressure control, suggesting that these activities may improve a clinic's ability to effectively manage blood pressure control across their patient populations.

- Data-driven decision making: Registries on individual patients are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
- Team-based care: Non-physician practice team members perform key clinical service roles that match their abilities and credentials.

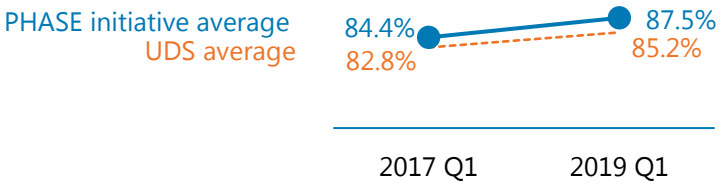
The initiative has seen a statistically significant decline in the proportion of patients with **diabetes with A1c in control (≤ 9%)**. Looking at national numbers (e.g., HEDIS 2018 Medicaid percentile values), we see a decline nationally as well. Nine grantees have seen declining rates of A1c control since baseline, but seven of those are still performing at a high level—i.e., meeting the HEDIS 75th percentile value (64.48%). An additional seven grantees are meeting the HEDIS 75th percentile and have improved over time. In this quarter, the average proportion of patients with diabetes with their A1c in control (≤ 9%) is 66.5%.



[2] Taking into account population size and excluding influential outliers.

The rate of **screening for tobacco use with follow-up for those that use tobacco** has been increasing over time, though the trend is not significant. Across the initiative, 87.5% of patients are screened for tobacco use and receive follow-up when needed. Eleven grantees have increased their rates over time, and 14 of 18 are surpassing the UDS average of 85.2%.

% of patients screened for tobacco use and received follow-up if positive (N = 18)



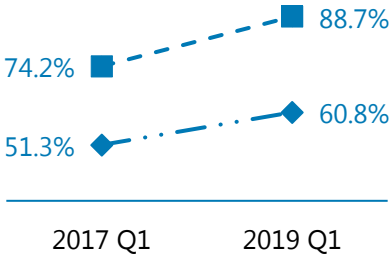
Additional outcomes

In addition to the outcomes identified in the initiative-wide goal, the evaluation is also tracking process measures that relate to reducing risk of CVD and managing chronic conditions. A key contribution of Kaiser Permanente to the safety net is PHASE-on-a-page—a medication algorithm that, when applied to patients at risk for cardiovascular events, reduces their risk. The medication algorithm includes statins, ACEs and ARBs, and anti-hypertensives, so the evaluation data captures prescription rates of these medications. Additionally, because high BMI is related to CVD risk, data on BMI calculation and follow-up if out of the healthy range is collected. Many individuals with chronic conditions also experience depression. Because of these co-occurring conditions, it is important to the management of these populations to also screen for and manage depression care, when needed.

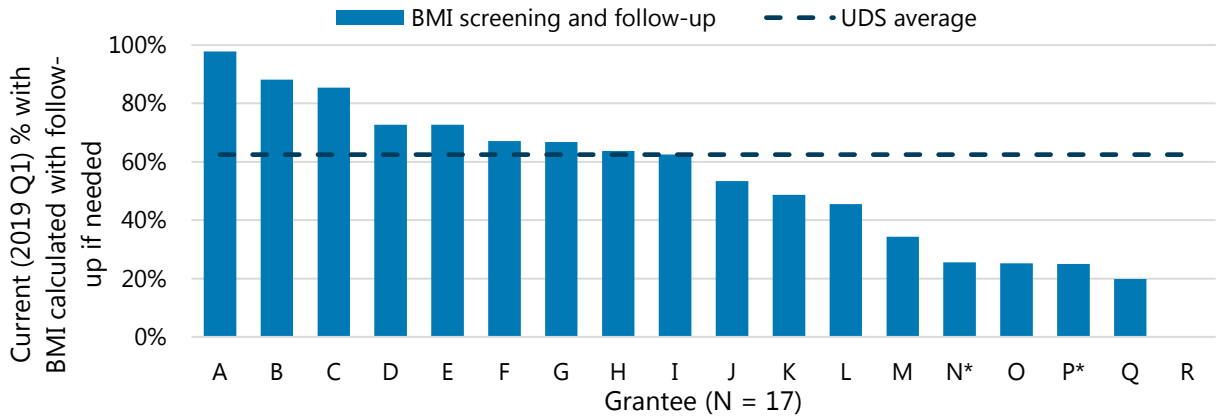
There has been a statistically significant increase in **prescription rates** of the medications pertinent to the medication algorithm, which is seen in the figure below. Almost 90% of patients with hypertension have been prescribed an oral anti-hypertensive. Of the patient population with diabetes, just over 60% have been prescribed both a statin and an ACE or ARB. There are many reasons why individual patients would or would not be on these medications compared to other available medications, so there are no benchmarks for these measures. See figure on page 6 for the trends over time.

■: % of patients with HTN an oral anti-hypertensive (N = 16)

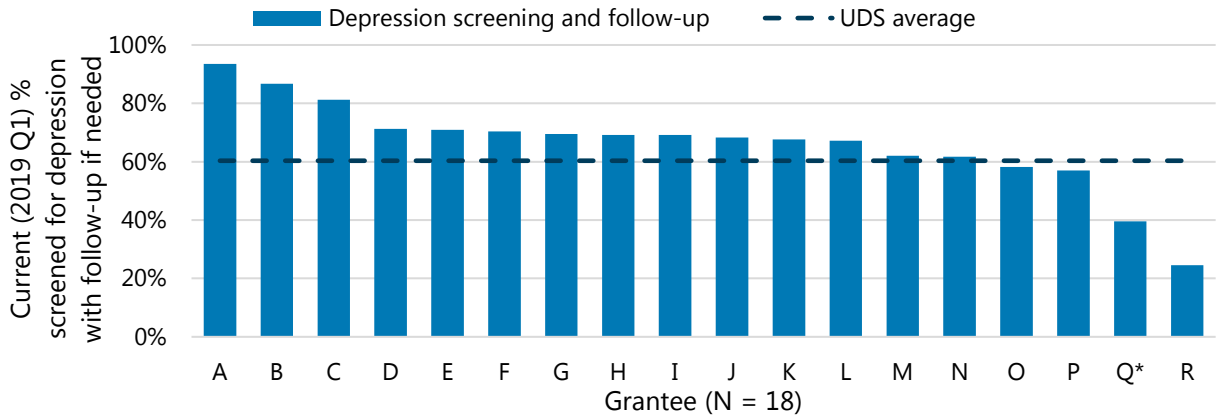
◆: % of patients with diabetes prescribed both a statin & ACE/ARB



There has been a statistically significant increase at initiative level of **BMI screening and follow-up** when needed. Nine grantees are meeting the UDS average (62.46%) and seven have seen improvement over time. Two grantees have made great strides – for example, one started at 33% and is now at 85%. On average, 67.6% of patients have had their BMI calculated and received follow-up if they were outside the normal range. Compared to consortia and health centers, hospitals have lower rates for BMI screening and follow-up. In the figure below, the two grantees marked with * are only reporting screening.



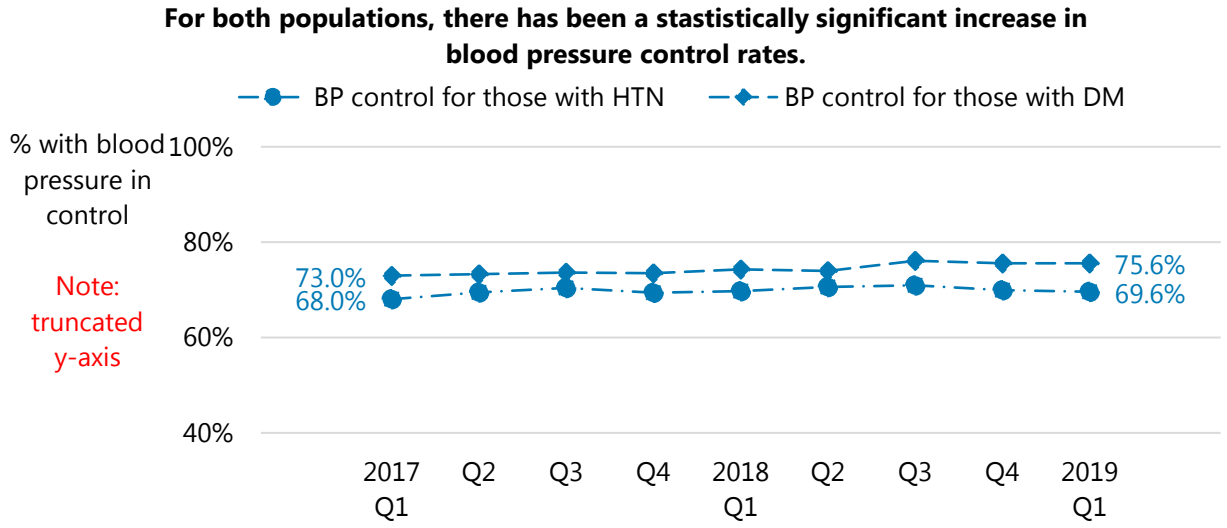
Depression screening and follow-up has statistically significantly increased over time at the initiative level. 15 of 18 grantees have made improvements in this measure over the past two years, and 14 are meeting the UDS average of 60.34%. The initiative as a whole has an average of 66.0% of patients that have received depression screening and follow-up. In the figure below, the grantee marked with * is only reporting screening.

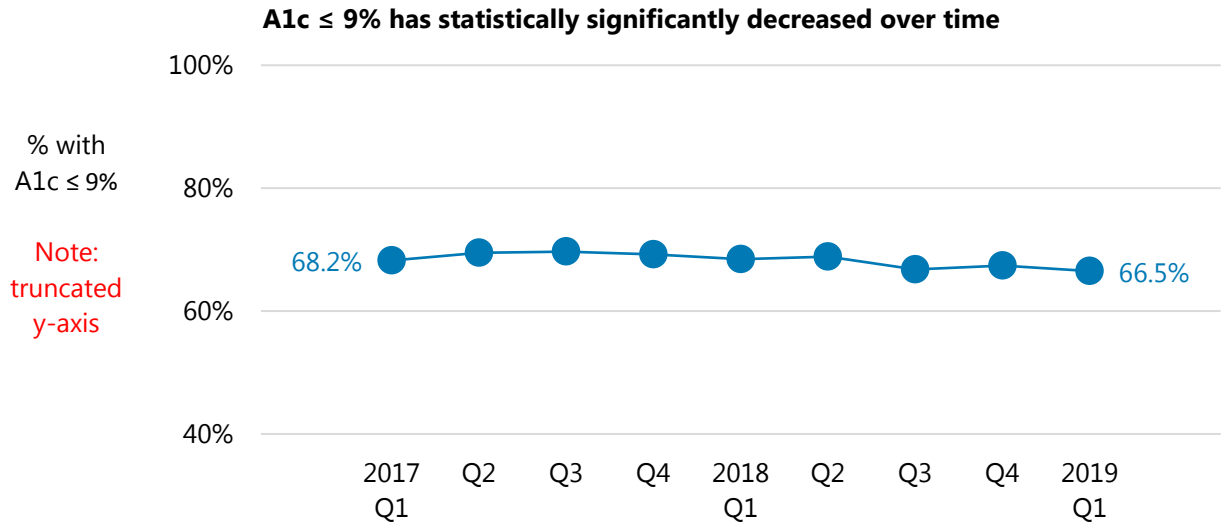


Methods

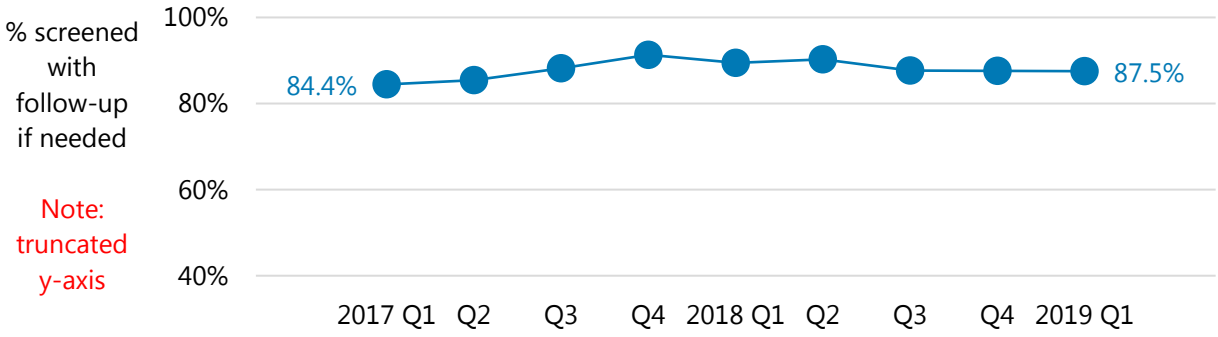
Each quarter, grantees submit clinical quality data that, to the extent they are able, align with existing reporting requirements (e.g., UDS, PRIME, HEDIS). These measures have not been certified by any organization. Benchmarks (e.g., UDS averages, HEDIS percentile values) are provided to compare grantee performance to national performance and trends. These data are used for internal QI processes at the grantee organizations and participating clinics. Grantee data are excluded from aggregation when errors are identified for a given measure or quarter. As data quality improves at grantee organizations, they can resubmit data so that the data most accurately represent the clinical care that they are providing for their patients.

Appendix

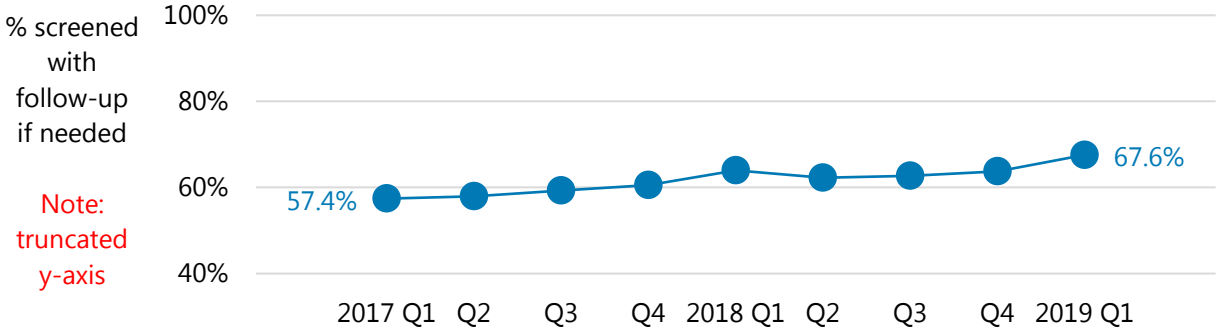




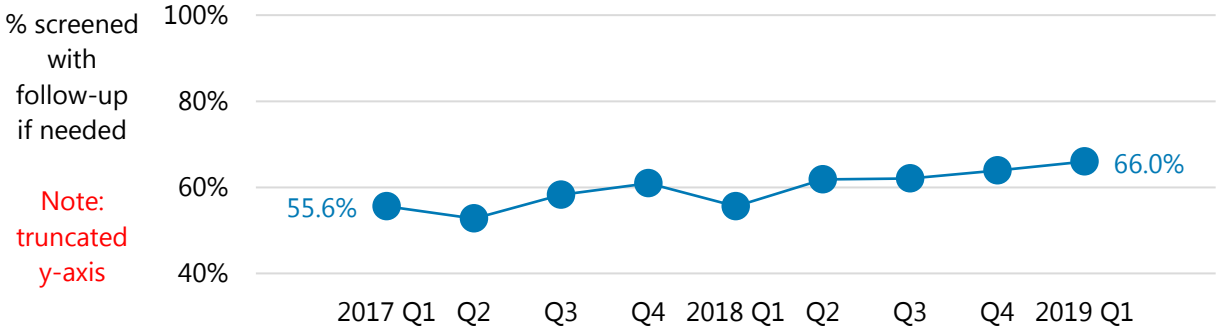
Tobacco screening with follow-up has remained statistically stable over time.



BMI screening with follow-up has statistically significantly increased.



Depression screening with follow-up has statistically significantly increased.



The rates of prescriptions have statistically significantly increased.