Welcome!

CCI CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE® PHASE PREVENTING HEART ATTACKS & STROKES EVERY DAY

KAISER PERMANENTE® TC3 TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Type your first and last name, organization name

4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be at the top of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#)
- The following message should briefly pop-up: "You are now using your audio for your meeting"

Final Virtual Convening

Inspiration, Celebration, Appreciation: Our Work for Heart Healthy Communities

March 23, 2021

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Housekeeping Reminders

Mute

Please mute when not speaking. Please don't put the call on hold!

Chat Box

Use the chat box to ask questions and participate in activities

Tech Issues

Private chat Meaghan for assistance

Heads up!

CCI team is adding your breakout group # to your zoom name – don't be alarmed when you see it change!

Our Program Team

Juliane Tomlin
Senior Manager

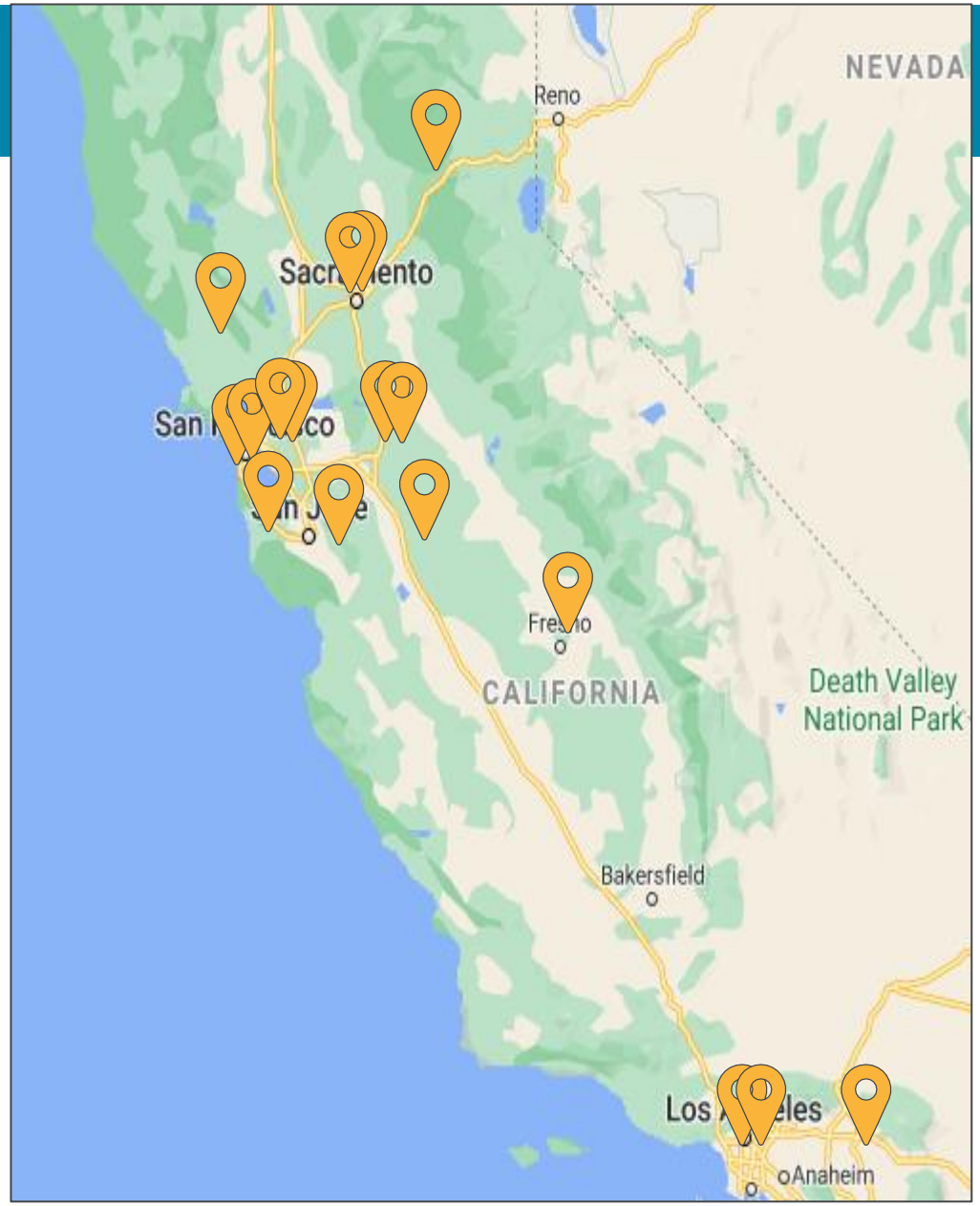
Meaghan Copeland
Senior Program Coordinator

Denise Armstorff
PHASE + TC3 Coach

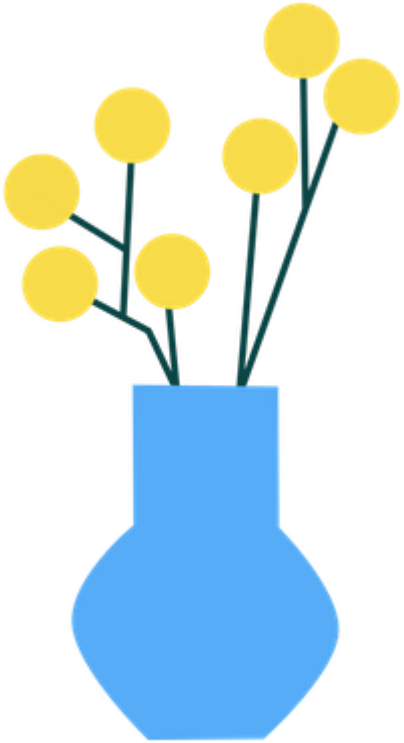
Welcome PHASE & TC3

- Preventing Heart Attacks and Strokes Everyday (PHASE) and Transforming Cardiovascular Care in Our Communities (TC3) both focus on caring for patients with or at risk for cardiovascular disease.

- Participants consist of: 14 PHASE teams and 3 TC3 teams:
  - 5 clinic consortia
  - 6 hospitals/hospital systems
  - 6 community health centers



Convening Objectives



- Showcase and celebrate accomplishments of PHASE & TC3 program and participating teams to improve care for patients with and at risk for cardiovascular disease
- Outline plans for sustainability with organizational leadership
- Acknowledge the people who have contributed to the success of PHASE and TC3 and inspire work moving forward

Agenda

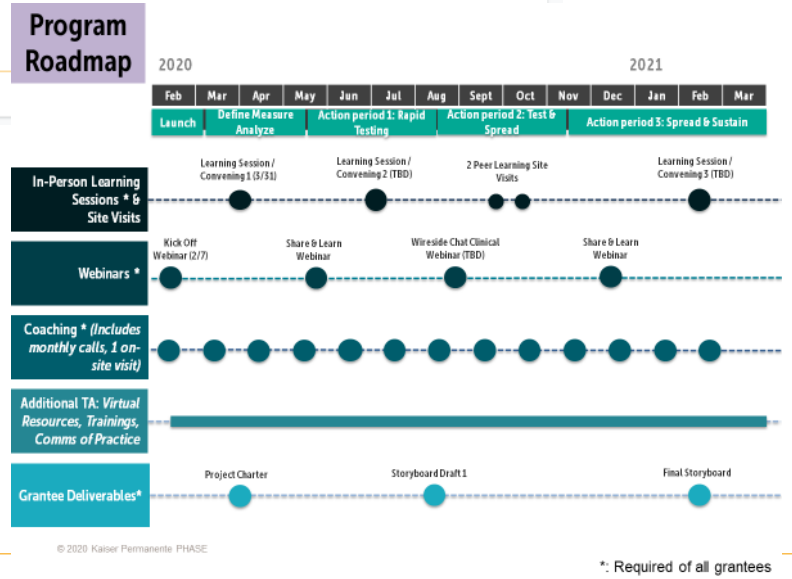
9:00		**Welcome and Introduction**
9:10		**Keynote: "Our Journey to Heart Healthy Communities"** ***Dr. Marc Jaffe*** *Guideline Director, Kaiser Permanente Northern California Region | Chief of Endocrinology, San Francisco Medical Center*
9:40		**Telling Your Story: Team Pitches to Leadership** ***Breakouts***
10:45		**Break!**
10:55		**Keynote: "Stepping Forward into a New Era of Population Health"** ***Dr. Timothy Ho*** *Regional Assistant Medical Director for Quality & Complete Care Southern California Permanente Medical Group*
11:25		**Reflections & Appreciation**
11:50		**Next Steps and Closing**

Where we started in 2020…

PHASE 2020

Goals for PHASE 2020

1. Manage chronic conditions of high-risk populations to decrease their risk of cardiovascular disease (CVD) and/or cardiovascular events.
2. Improve ability to screen for key CVD risk factors as well as the ability to follow-up with patients who have those risk factors.
3. Advance health equity by achieving high performance for all populations on measures impacting cardiovascular health.



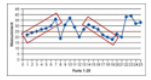
*: Required of all grantees

TC3 2019-2020

TC3 Initiative Goals

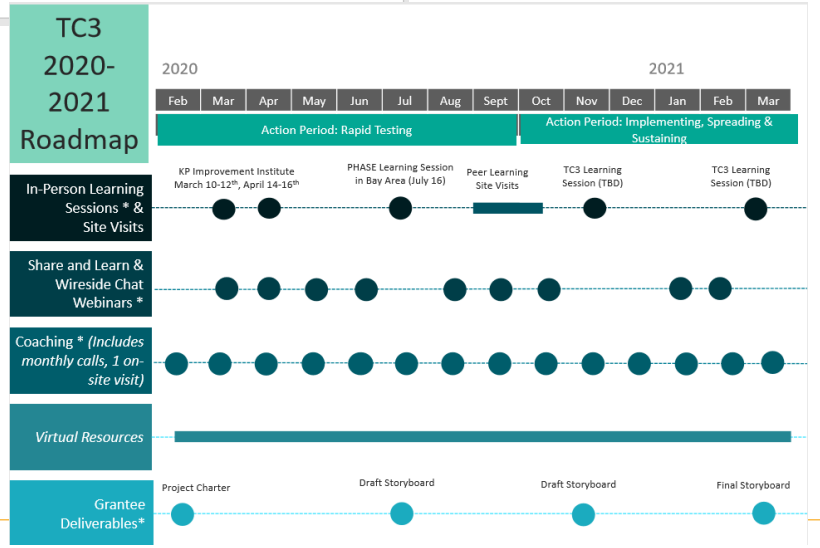
↑ adoption strategies that ↓ CVD risk for safety net patients

Strengthen capabilities of safety net organizations



Improve ability to report & use data to drive performance

Improve the capacity to support population health management



...how things changed

Community Health Center Network

Santa Rosa Community Health

Los Angeles County Department of Health Services

LifeLong Medical Care

Los Angeles County Department of Health Services

Words from Kaiser Permanente, Northern California Region

Jean Nudelman

Senior Director, Community Health

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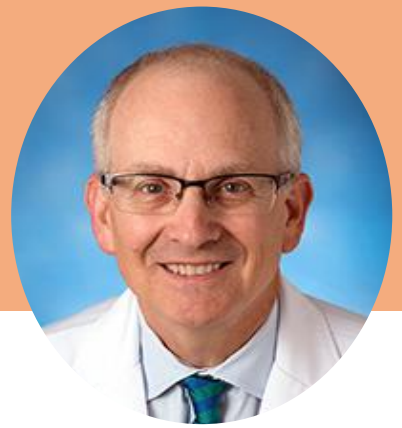
Our Journey to Heart Healthy Communities



Marc Jaffe, MD

The Permanente Medical Group, Northern California
Chief of Endocrinology, *Kaiser San Francisco Medical Center*

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Our Journey to Heart Healthy Communities

Presenter:

Marc G. Jaffe, MD
The Permanente Medical Group, Northern California
Chief of Endocrinology
Kaiser San Francisco Medical Center

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Outline for Today..

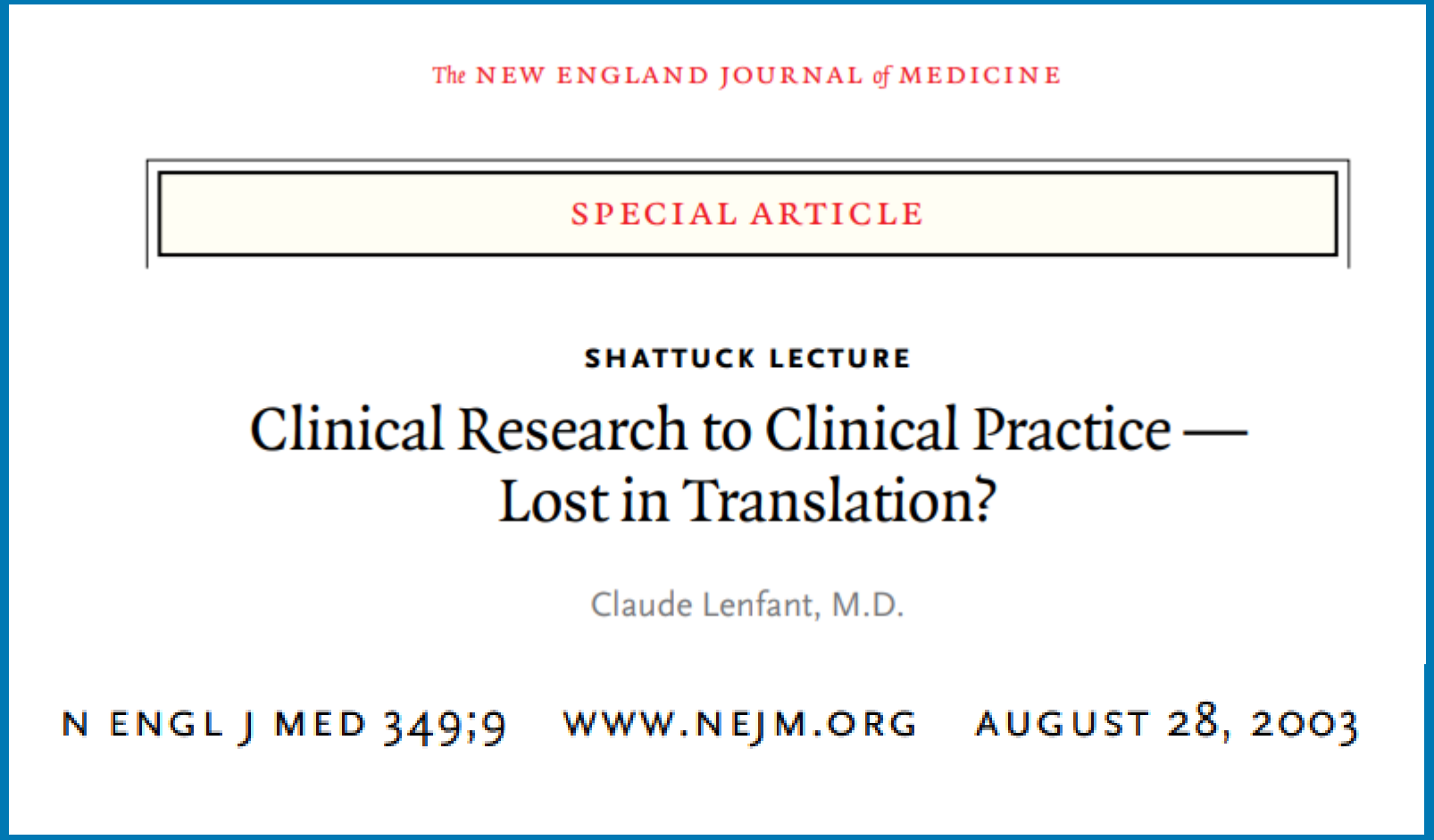
1. The Past
2. The Present
3. The Future

The Past

"Heart disease and stroke are the leading causes of death in the United States. Although most cardiovascular disease (CVD) is preventable, proven prevention approaches are not being adequately applied in clinical practice."

– Elias Zerhouni, MD, Director, National Institutes of Health
April 2004

The Past



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

SHATTUCK LECTURE

Clinical Research to Clinical Practice — Lost in Translation?

Claude Lenfant, M.D.

N ENGL J MED 349;9 WWW.NEJM.ORG AUGUST 28, 2003

Director of the National Heart Lung Blood Institute (NHLBI)
Branch of the National Institute of Health (NIH)

Quote from the most respected CV Implementor on the planet

"The [cardiovascular risk reduction] practices no longer require research to demonstrate efficacy and effectiveness; as a practical matter, everything that needs to be known is already known. …Yet their application in the real world is not what it should be, and we need to find out why and to try new approaches to change this situation."

Lenfant C. Shattuck Lecture: clinical research to clinical practice -- lost in translation? N Engl J Med 2003;349:868-874

The Past (“How health systems used to provide cardiovascular care”)

- Fragmented delivery of care
- Consensus guidelines
- Reactive care
- Lack of reliable metrics for quality assessment
- Compensation for services but not outcomes/quality
- MD-centered approach

Key Components of USA-Based Successful Hypertension Programs

Organization	Identified Key Components				
Kaiser Permanente NCal	Patient registry	Med. assistant BP checks	Performance feedback	Evidence-based drug protocol	Single pill drug combination
Finger Lakes, Upstate NY	Development of registries	Community collaborative	Performance data sharing	Underserved engagement	Practice imp. assistance
San Francisco Safety Net	Patient registry and reports	Pharmacist and nurse support	Performance metrics by race	Standardized BP measurement	Evidence-based drug protocol
Veterans Administration	EHR and reminders	Team care with RN, PA, Pharm	Free home BP monitors	Frequent follow up until control	“Very little” cost for services
Greenville, SC Health System		Partnering with patients	Monthly data on performance	Training for BP measurement	

Jaffe MG, Young JD. J Clin Hypertens 2016; 18: 260-1
Fortuna RJ, Rocco TA, Freeman J, et al. J Clin Hypertens. 2019;21:196–203
Fontil V, Bibbins-Domingo K, et al. Circ Cardiovasc Qual Outcomes. 2018; 11:e004386
Fletcher RD, Amdur RL, Kolodner R, et al. Circulation. 2012 May 22;125(20):2462-8
Egan BM, Sutherland SE, Rakotz M, et al. Hypertension. 2018;72(6):1320-1327

Key Components of Global Hypertension Program Technical Packages

Organization	Identified Key Components					
WHO Global Hearts Package	Healthy lifestyle counseling	Evidence-based protocols	Access to meds and technology	Risk-based CVD management	Team-based care	Systems for monitoring
Million Hearts Control Package	Making hypertension a priority	Equipping care teams	Population health management	Individual patient support		
Resolve To Save Lives Package	Simple, proven protocols	Community care and task sharing	Ensure supply of medications	Patient centered care	Information systems	

https://www.who.int/cardiovascular_diseases/hearts/en/
https://millionhearts.hhs.gov/tools-protocols/action-guides/htn-change-package/index.html
https://resolvetosavelives.org/cardiovascular-health/hypertension

The Present (roughly 2003 through the end of this presentation in 15 minutes)

- Organized delivery of care
- Evidence Based and Simple Guidelines
- Proactive care
- Access to reliable metrics for quality assessment
- Compensation for quality outcomes
- Team based approach

What does “now” look like for cardiovascular care?

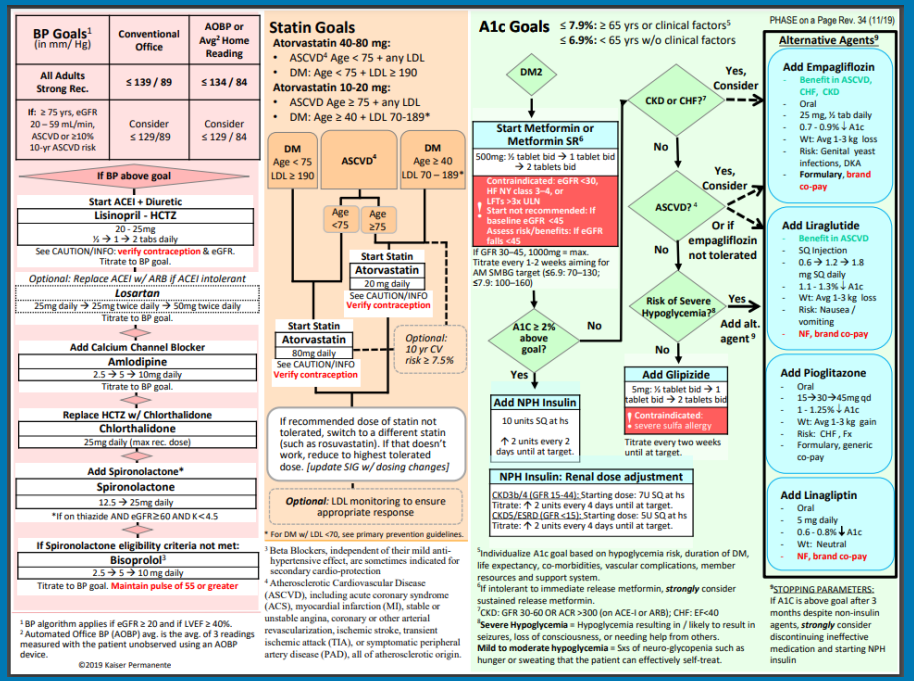
Organized Delivery of Care

- Collaboration
- Integration
- Transparency
- Prioritization

PHASE Grantee convening circa 2017

What does “now” look like for cardiovascular care?

Evidence-Based and Simple Guidelines



- Drug and dose specific
- Simplified and standardized
- Practical instead of perfect
- Designed by primary care for primary care
- Specialists can contribute but must be outnumbered!

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What does “now” look like for cardiovascular care?

Proactive Care

- Lists of people with unmet health needs (registries)
- Outreach overtakes inreach
- Focus on broad reaching low intensity strategies
- Builds relationship and trust between patients-providers
- Practical instead of perfect

Access to Reliable Metrics for Quality Assessment

- Data is Power: what matters gets measured
- Metrics used for Honor and not Shame
- Complaints about the data to be expected and welcomed!
- What’s the best metric? One that you can get quickly, reliably, and broadly

Compensation for Quality Outcomes

- Prepayment/capitation drives innovation
- Necessitates internal process metrics
- Drives population care public health perspective
- Can result in innovative team approaches

What does “now” look like for cardiovascular care?

Team-Based Approach

- Requires that people practice at the top of their scope
- Expands skill sets
- Can create environment for professional growth
- If done carefully can be cost neutral and improve quality

What does “now” look like for cardiovascular care in 2019-2020?

As of Q4 2019, efforts by participants in PHASE resulted in:

- 120,000 people with hypertension had BP at goal
- 89,000 people with diabetes had BP at goal
- 81,000 people with diabetes blood sugar not in poor control

As of Q4 2019, efforts by participants in TC3 resulted in:

- 37,000 people with hypertension had BP at goal
- 28,000 people with diabetes had BP at goal
- 28,000 people with diabetes had blood sugar not in poor control

Courtesy of Center for Community Health and Evaluation, March 2021

What does “the future” look like for cardiovascular care?

The Future is Now*

*well actually in about 5 minutes when I finish the presentation

What does “the future” look like for cardiovascular care?

Same Protocol (?), different venue…

Same Protocol (?), different team roles…

Same Protocol (?), different funding source…

Same Protocol (?), more equitable execution!

These are my best guesses…

Thank you for 15 years of devotion to improving the heart health of our community!

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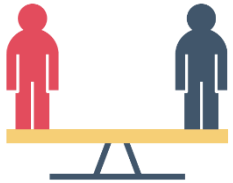
Telling Your Story:
Team Pitches to Leadership

PHASE & TC3 Teams

Why develop a "pitch"?

Articulates a vision and the desired future state

Describes the achievements to build on and roadblocks to break down



Starts an advocacy process with leadership and includes a direct ask

Provides the opportunity to gather feedback from leaders and peers

Identifies action steps to refine plans, spread changes and sustain momentum

As a Presenter...

- Share/advance your own slides
- Keep track of time!
- Receive feedback offered
- Respond to important clarifying questions, but focus more on listening to feedback.

As a Listener...

- Write down feedback in "I like, I wish, I wonder" format on stickies or paper:
  - "I liked/loved..." – What did you enjoy about the presentation?
  - "I wish..." - What felt missing? What do you wish had been included that wasn't?
  - "I wonder..." – What questions do you still have for the team? What needs further refining or clarifying in the presentation?
- After each presentation, there will be 5-8 minutes to share feedback verbally. The facilitator will invite the team's leader(s) to share first. Others type in I Like, I Wish, I Wonder into chatbox.

Breakout Groups

55 min

Group 1:

- Community Health Partnership
- Redwood Community Health Coalition
- San Francisco Community Clinic Consortium

Maggie Jones

Group 2:

- Community Health Center Network
- Community Clinic Association of Los Angeles County

Carly Levitz

Group 3:

- Riverside University Health System
- San Joaquin General Hospital
- San Mateo Medical Center

Dr. Michael Mulligan

SA Kushinka

Group 4:

- Alameda Health System
- L.A. County Dept. of Health Services
- San Francisco Health Network

Juliane Tomlin

Group 5:

- Chapa-De Indian Health
- Community Medical Centers, Inc.
- One Community Health

Denise Armstorff

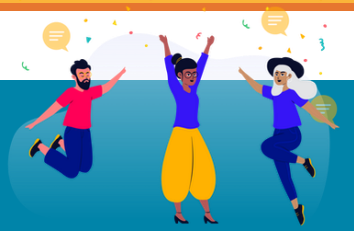
Group 6:

- Elica Health Center
- Golden Valley Health Centers
- Valley Health Team

Dr. Eric Henley

Crystal Dinh

Waterfall Chat



Type in the chat your response, but DO NOT PRESS “SEND / ENTER” until we prompt you to do so:

What one idea did you hear in your breakout that excited you?

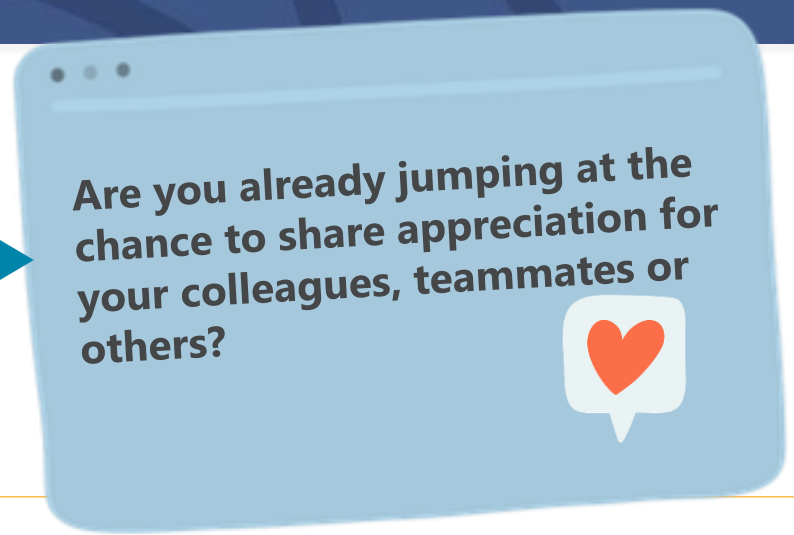
Thank You Teams, Leaders, and Facilitators!

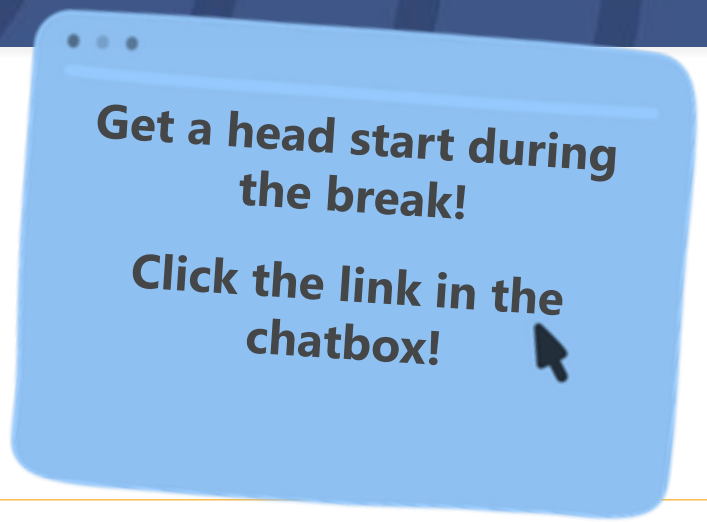
Coming Up After the Break

10:55 / Dr. Timothy Ho – "Stepping Forward into a New Era of Population Health"

11:25 / Reflections & Appreciation – A video, coach reflection, and post-it activity

11:50 / Next Steps & Closing – Evaluation activities and resources





Take a Break

We'll resume at 10:55 am

Stepping Forward into a New Era of Population Health

Timothy Ho, MD

Regional Assistant Medical Director for Quality and Complete Care
Southern California Permanente Medical Group

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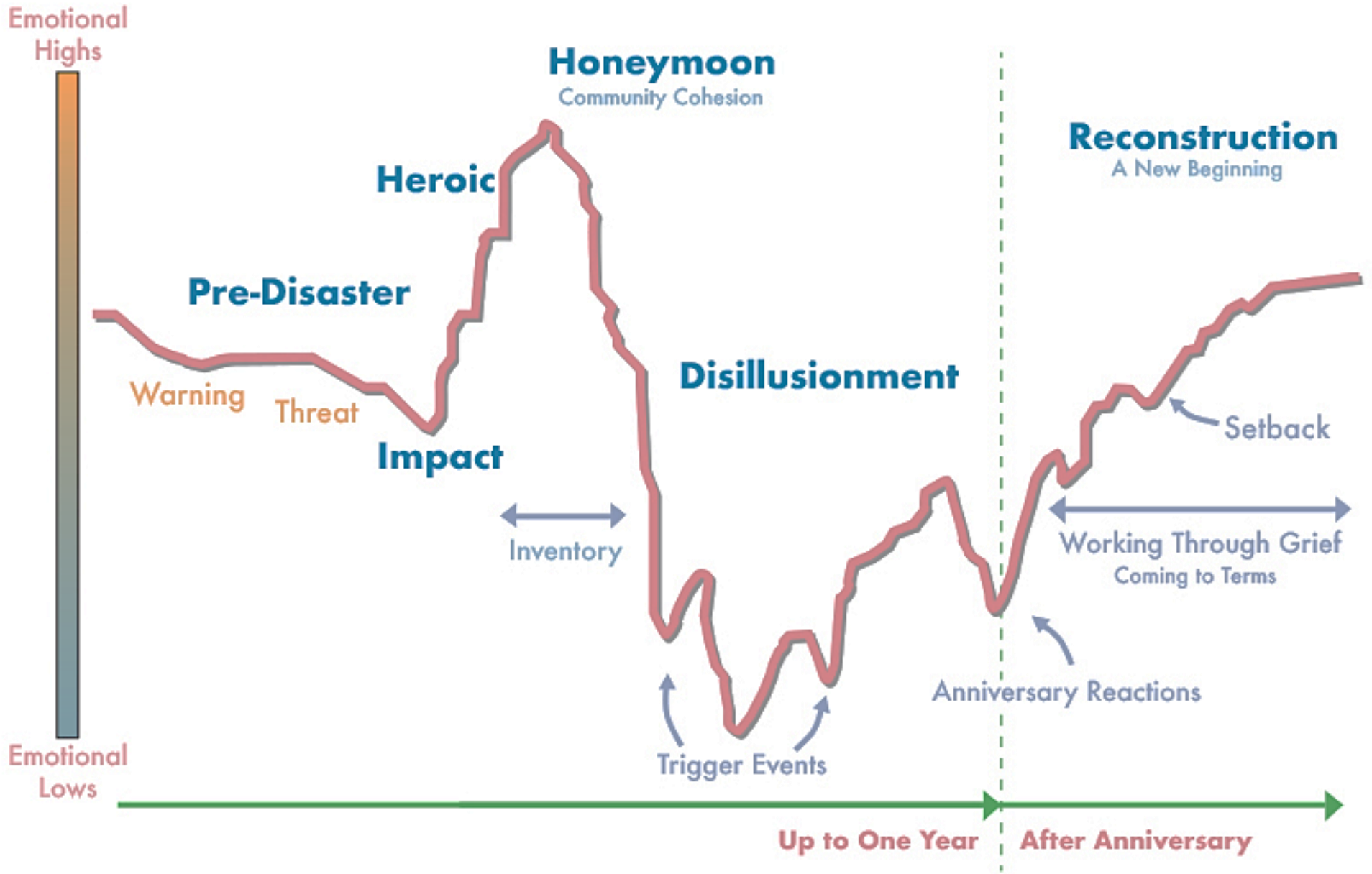
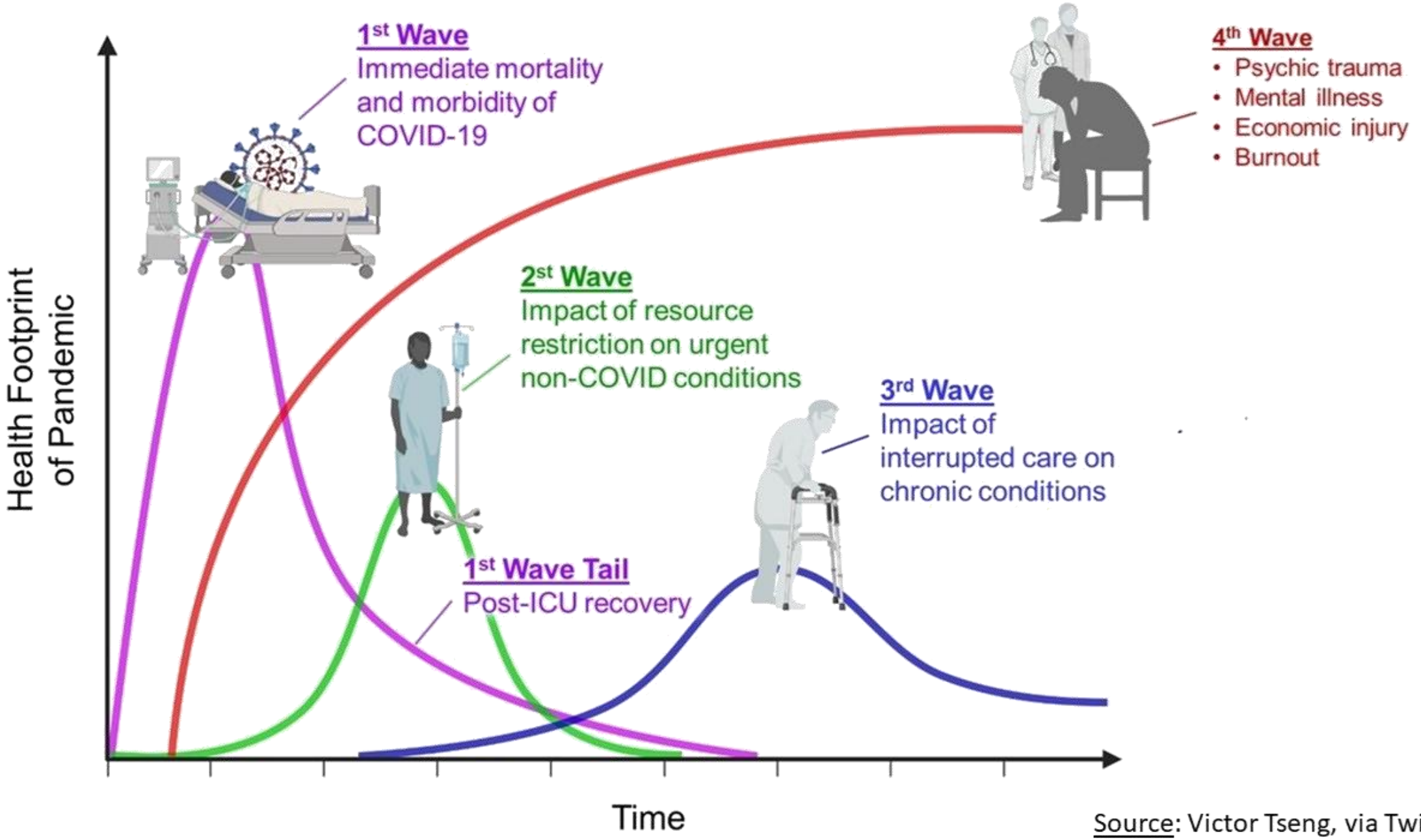


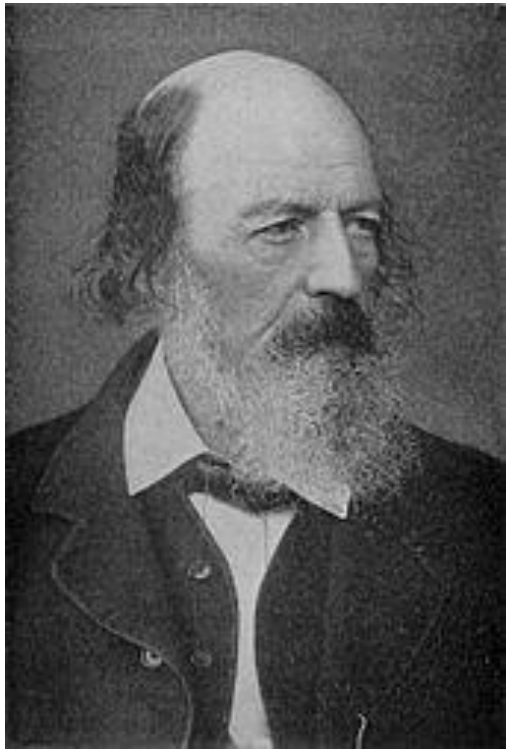
Adapted from Zunin & Myers as cited in DeWolfe, D. J., 2000. Training manual for mental health and human service workers in major disasters (2nd ed., HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.



Source: Victor Tseng, via Twitter

Pause and reflect: what has your experience been?

Where do we go from here?



We are not now that strength which in old days
Moved earth and heaven; that which we are, we are;
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield.

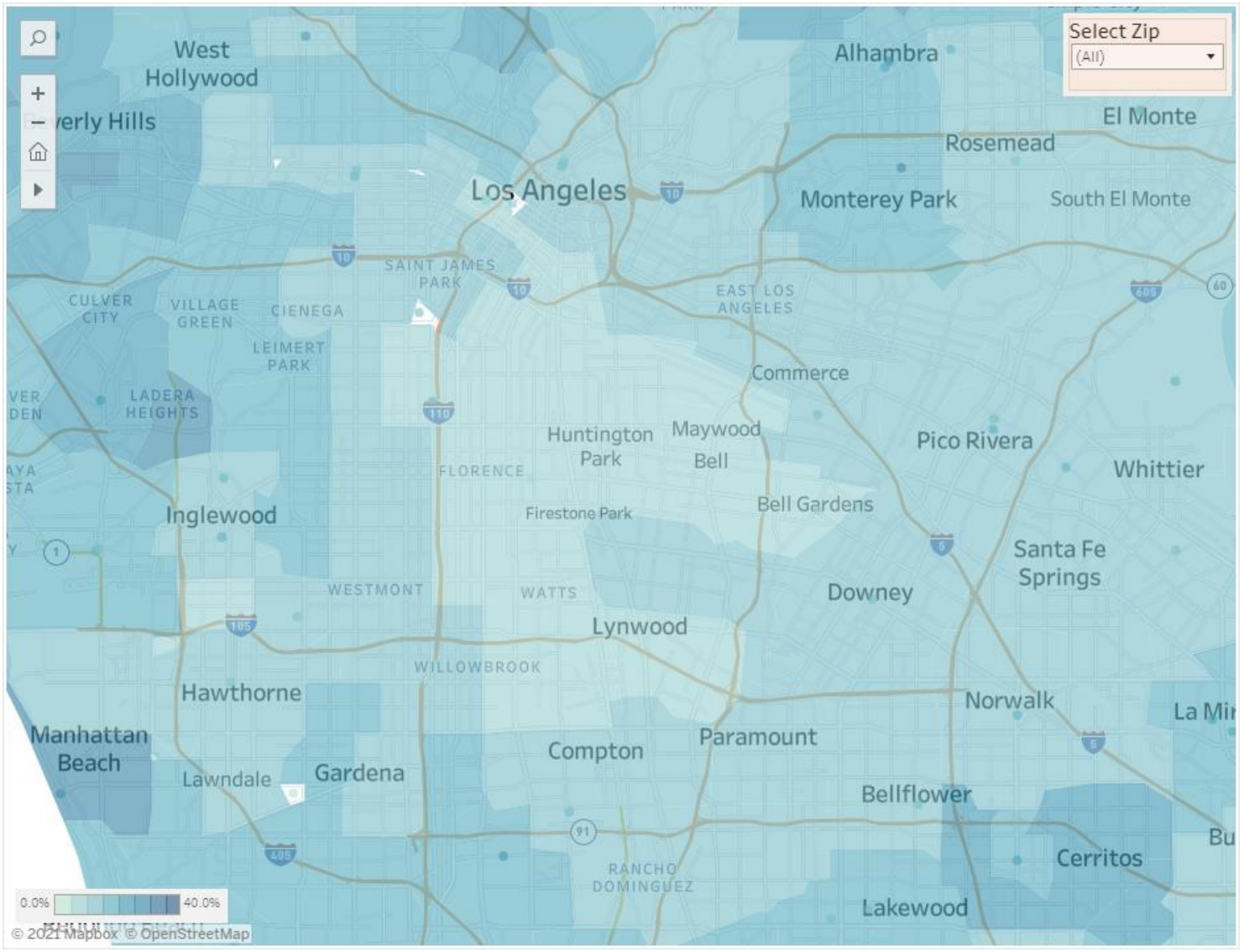
Alfred, Lord Tennyson, *Ulysses*

Sources:
Photo: Wikipedia
Text: Poetry Foundation

To *finally* strive, to *finally* seek, to *finally* find…

- Traction on telehealth and remote monitoring
- Timeliness and utilization of data
- Consideration & incorporation of social health and social determinants of health
- Others
  - Closed loop systems
  - Outreach
  - Life Care Planning

An example…


Select Zip
(All)
West Hollywood
Alhambra
El Monte
Rosemead
Los Angeles
Monterey Park
South El Monte
SAINT JAMES PARK
CULVER CITY
VILLAGE GREEN
CIENEGA
LEIMERT PARK
EAST LOS ANGELES
Commerce
LADERA HEIGHTS
Huntington Park
Maywood
Bell
Pico Rivera
Whittier
FLORENCE
Firestone Park
Bell Gardens
Inglewood
Santa Fe Springs
WESTMONT
WATTS
Downey
Lynwood
WILLOWBROOK
Hawthorne
Norwalk
Manhattan Beach
Paramount
Compton
Lawndale
Gardena
Bellflower
Cerritos
RANCHO DOMINGUEZ
Lakewood
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Reflections and questions?

Reflections & Appreciation

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Next Steps and Closing

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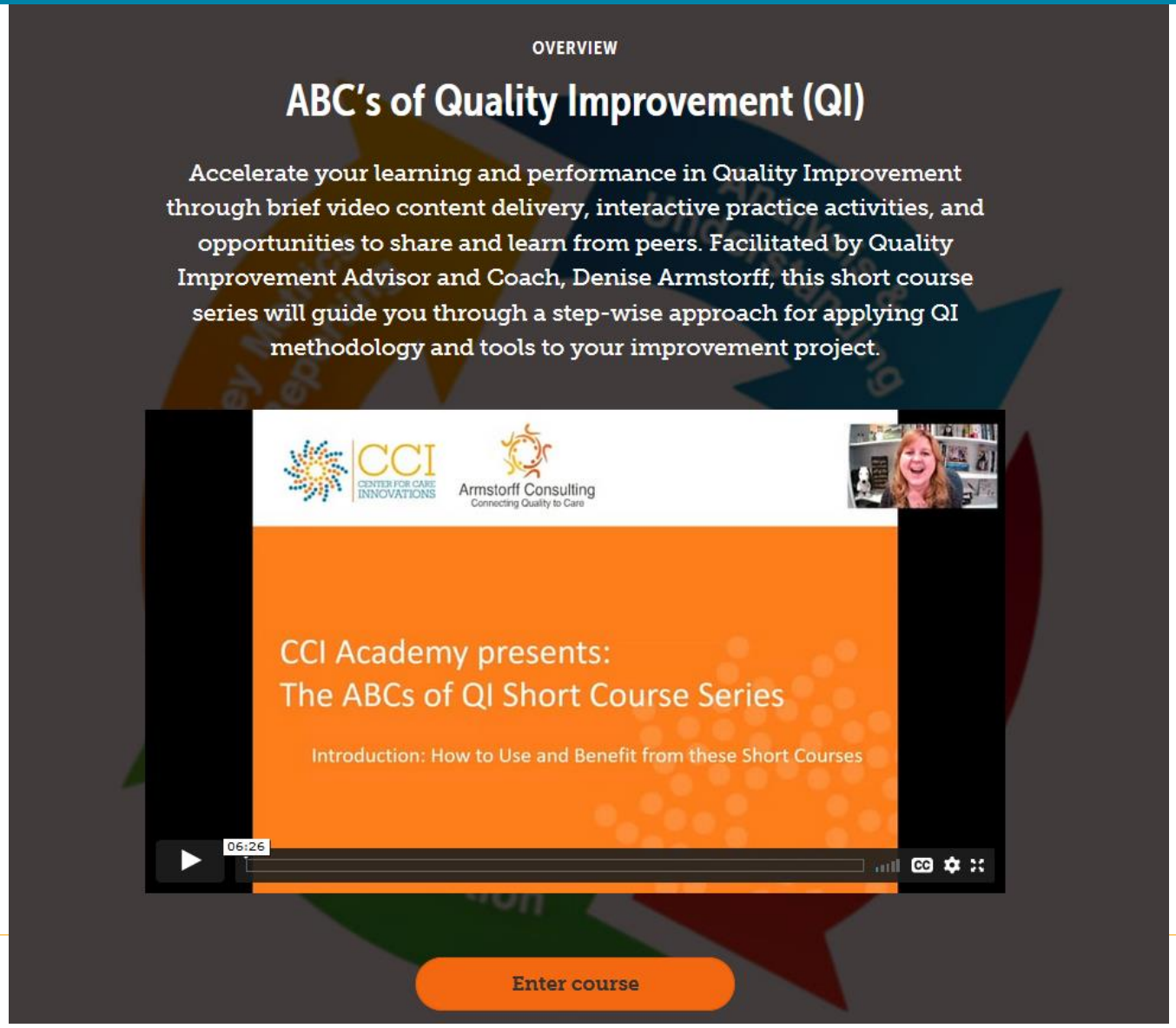
Final Evaluation Activities

NO final data report	The final data report is no longer required.
Interviews	One-hour team interview to talk about your work this year and how the program supported you.
Survey	Two team members will receive a link to complete this, which complements the interview.

Questions? Contact Crystal Dinh Crystal.X.Dinh@kp.org

ABC's of QI Video Course

https://academy.careinnovations.org/courses/abcs-of-quality-improvement/



Welcome!

THIS COURSE FEATURES:

Seven virtual short courses made up of 2 to 5 modules each.
Each module includes –

- A brief video (5 to 20 minutes in length) of facilitated QI curriculum
- Interactive activities with worksheets, tools, and templates for applying QI methodology
- Access to an on-line vehicle for engaging with peers

WHO MIGHT BENEFIT FROM THIS CURRICULUM?

Individuals from all facets of healthcare who are engaged in improvement work –

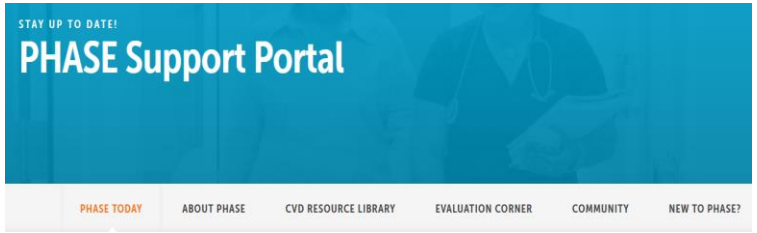
- Organizational leaders, providers, front-line staff, data analysts
- Newcomers to Quality Improvement
- Those seeking help/support regarding specific topics/tools
- CCI program participants

HOW MIGHT THIS CURRICULUM BE USED IN MY ORGANIZATION?

- To build QI capacity and capability for individuals and teams
- To improve the effectiveness and efficiency of CCI program facilitation and coaching activities
- To accelerate learning through connections to peer sharing
- As a resource library for QI tools and templates
- As a step-wise approach to developing, managing, and implementing an improvement project
- As a refresher training for individual quality improvement elements

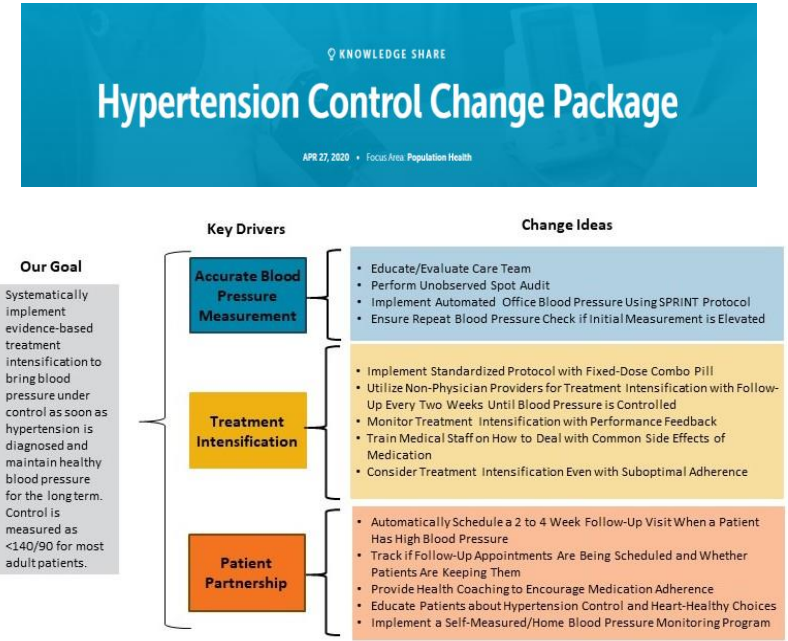
Resources

https://www.careinnovations.org/tc3support/



https://www.careinnovations.org/phasesupport/

You can continue to access webinar recordings, past event pages and other resources from the programs.



https://www.careinnovations.org/resources/hypertension-change-package/

https://www.careinnovations.org/resources/cardiovascular-disease-prevention-treatment-resource-library/

Virtual Care Innovation Network

It's not too late to join us! Sign up for the Learning Hub!
Hub members can access online courses, interactive forums for peer learning, and other online resources.

https://www.careinnovations.org/programs/virtual-care-innovation-network/#learn

And now, a thank you to our program partners

Kaiser Permanente, Northern California Community Health

Jean Nudelman
Michael Cox

Kaiser Permanente, Southern California Community Health

Mehrnaz Davoudi
Cody Ruedaflores
Livy Holguin

Center for Community Health and Evaluation

Maggie Jones

Carly Levitz

Crystal Dinh

Coach
Denise Armstorff

Safety Net Faculty

Dr. Eric Henley

Dr. Michael Mulligan

Kaiser Permanente Faculty

Dr. Jeffrey Brettler

Dr. Timothy Ho

Dr. Marc Jaffe

SA Kushinka

All the partners and CCI staff over these many years

And to our program participants!!

Alameda Health System
Chapa-De Indian Health
Community Clinic Association of L.A. County
Community Health Center Network
Community Health Partnership
Community Medical Centers, Inc.
Elica Health Centers
Golden Valley Health Centers
Los Angeles County Dept. of Health Services
One Community Health
Redwood Community Health Coalition
Riverside University Health System
San Francisco Community Clinic Consortium
San Francisco Health Network
San Joaquin General Hospital
San Mateo Medical Center
Valley Health Team

Thank you all for these years of partnership!

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