Welcome!

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”
Inspiration, Celebration, Appreciation: Our Work for Heart Healthy Communities
March 23, 2021
Heads up!
CCI team is adding your breakout group # to your zoom name – don’t be alarmed when you see it change!

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
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
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>Welcome and Introduction</td>
</tr>
<tr>
<td>9:10</td>
<td><strong>Keynote: “Our Journey to Heart Healthy Communities”</strong></td>
</tr>
<tr>
<td></td>
<td>Dr. Marc Jaffe</td>
</tr>
<tr>
<td></td>
<td>Guideline Director, Kaiser Permanente Northern California Region</td>
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<tr>
<td></td>
<td>Chief of Endocrinology, San Francisco Medical Center</td>
</tr>
<tr>
<td>9:40</td>
<td><strong>Telling Your Story: Team Pitches to Leadership</strong></td>
</tr>
<tr>
<td></td>
<td><em>Breakouts</em></td>
</tr>
<tr>
<td>10:45</td>
<td><strong>Break!</strong></td>
</tr>
<tr>
<td>10:55</td>
<td><strong>Keynote: “Stepping Forward into a New Era of Population Health”</strong></td>
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<tr>
<td></td>
<td>Dr. Timothy Ho</td>
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<td>Regional Assistant Medical Director for Quality &amp; Complete Care</td>
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<td></td>
<td>Southern California Permanente Medical Group</td>
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<tr>
<td>11:25</td>
<td><strong>Reflections &amp; Appreciation</strong></td>
</tr>
<tr>
<td>11:50</td>
<td><strong>Next Steps and Closing</strong></td>
</tr>
</tbody>
</table>
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.

**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
Words from Kaiser Permanente, Northern California Region

Jean Nudelman
Senior Director, Community Health
Our Journey to Heart Healthy Communities

Marc Jaffe, MD

The Permanente Medical Group, Northern California
Chief of Endocrinology, Kaiser San Francisco Medical Center
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
Outline for Today..

1. The Past

2. The Present

3. The Future

Wiresside Chat with Dr. Marc Jaffe – Clinical Review of PHASE Protocol

June 17, 2015
“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
Clinical Research to Clinical Practice — Lost in Translation?

Claude Lenfant, M.D.

The New England Journal of Medicine
SPECIAL ARTICLE

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

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

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

Jaffe MG, Young JD. J Clin Hypertens 2016; 18: 260-1
### Key Components of Global Hypertension Program Technical Packages

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

https://www.who.int/cardiovascular_diseases/hearts/en/
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!
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
What does “now” look like for cardiovascular care?

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
What does “now” look like for cardiovascular care?

**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!
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

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

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
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

Are you already jumping at the chance to share appreciation for your colleagues, teammates or others?

Get a head start during the break!
Click the link in the chatbox!
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
Agenda

**1st Wave**
Immediate mortality and morbidity of COVID-19

**2nd Wave**
Impact of resource restriction on urgent non-COVID conditions

**3rd Wave**
Impact of interrupted care on chronic conditions

**4th Wave**
- Psychic trauma
- Mental illness
- Economic injury
- Burnout

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:
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...
Reflections and questions?
Reflections & Appreciation
Next Steps and Closing
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
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

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

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

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

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

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

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.

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 Ruedafl ores
Liv y Holgu in
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!