



## Quarterly Data Report: Q1 2018

### 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 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 your individual dashboard with you quarterly and how that relates to the initiative overall helps use to ensure that we understand the 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.

Prepared by the Center for Community Health and Evaluation /// May 2018

*Questions about clinical data definitions?*

*Please contact Carly Levitz*

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*Questions about the PHASE evaluation?*

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Reach of the PHASE initiative in Q1 2018



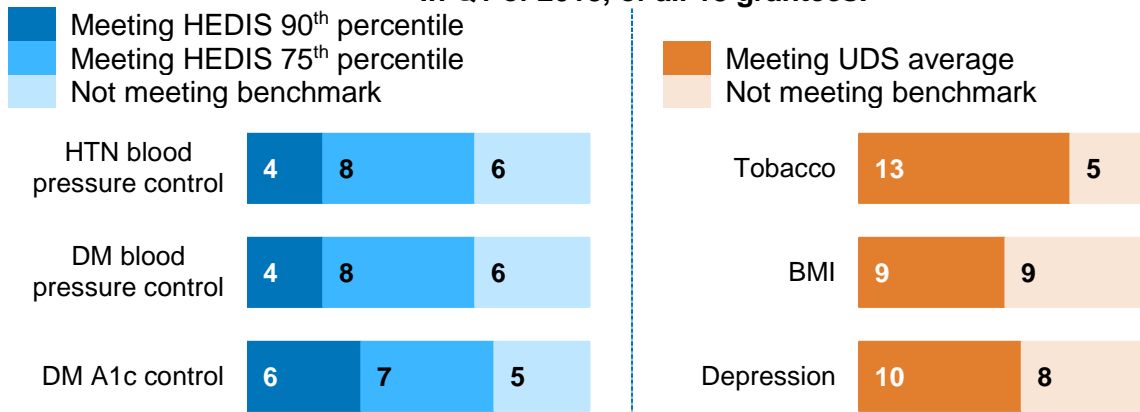
Key Outcomes



72.6% of patients with diabetes (DM) are prescribed a statin

87.8% of patients with hypertension (HTN) are prescribed an anti-hypertensive

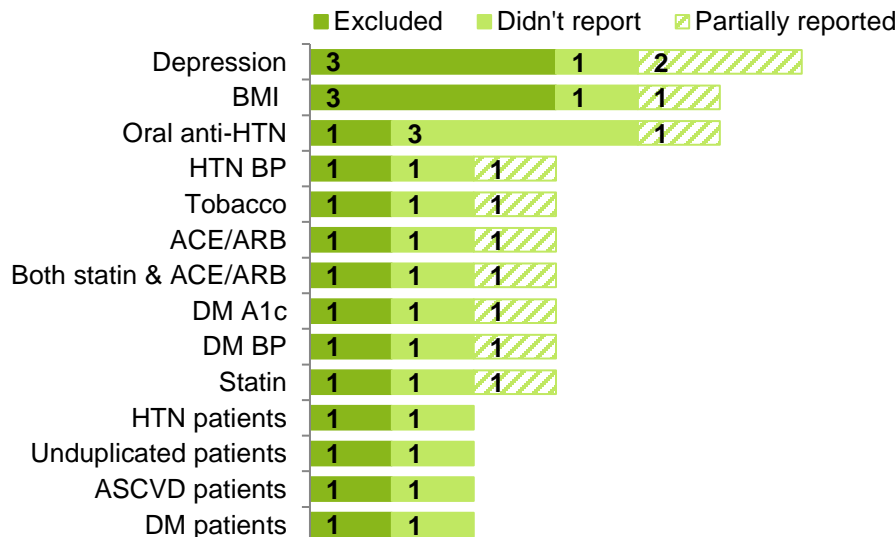
In Q1 of 2018, of all 18 grantees:



If a grantee did not report or have a reliable value for the measure, they are considered “not meeting benchmark.” Benchmarks were updated to reflect the most recent data available. See “interpretation notes” on the next page.

Availability & Quality

Not all of the 18 grantees currently report all of the measures, though complete reporting has been increasing. Partial reporting is when a consortium or hospital reports the measure for only some clinics. Due to lack of a full year of data in new EHRs, 1 grantee’s data were excluded from the initiative aggregation. Two grantees’ BMI and depression data were excluded due to only reporting screening as opposed to screening and follow-up. One grantee has not yet reported any data for this quarter.





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**Interpretation  
notes**

**Updated benchmarks:** HEDIS & UDS benchmarks were updated to the most recent year available to look at PHASE performance compared to national trends. For HEDIS, this was updating the Medicaid percentiles from 2016 to those from 2017. For UDS, the 2015 averages were updated to the 2016 averages. The new benchmarks are reflected in time trends such that all of 2017 has the previous benchmarks, and the new benchmarks begin in 2018.

**Spread to new sites:** 4 health center grantees and 1 consortium grantee increased the number of sites reporting data during this quarter. This reflects that grantees are implementing PHASE processes at new sites. In some cases, this spread negatively impacted trend data (e.g. diabetes blood pressure control) as new sites are brought onboard, while in other metrics performance remained stable even with substantial spread.

**Data quality:** In cases where grantees feel that a specific site's data are not reliable for a specific quarter, those sites are excluded from aggregations of that quarter. There are a few outstanding questions related to data quality that impact trend data, such as one consortium's member health center that saw more than a drop of an absolute 30% across multiple measures. Issues like these are not widespread, and we talk with grantees to better understand what might be going on at specific sites. Once we understand the issue, we temporarily exclude that site's data for that quarter if we don't receive updated data or exclude it permanently.

**Blinded/un-identified data:** In grantee-specific graphs, only top performers for each measure are called out by name. Other grantees are shown in order of performance; the letter for a grantee can change with each chart. Top performing grantees approved being called out by name.

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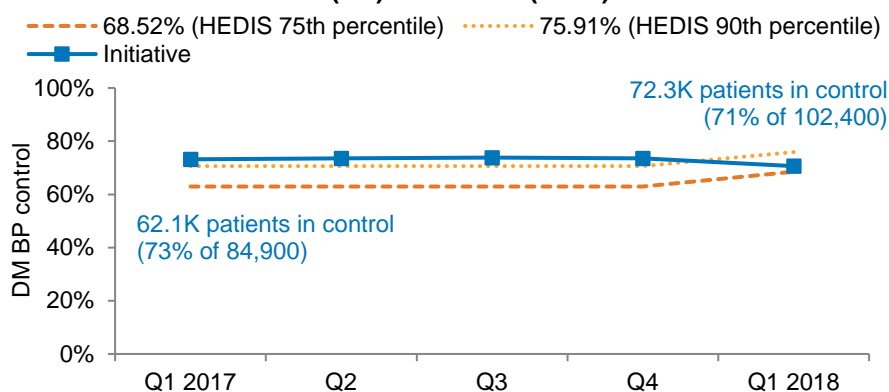
## Initiative results – clinical data outcomes

Kaiser Permanente Northern California Community Benefit 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.

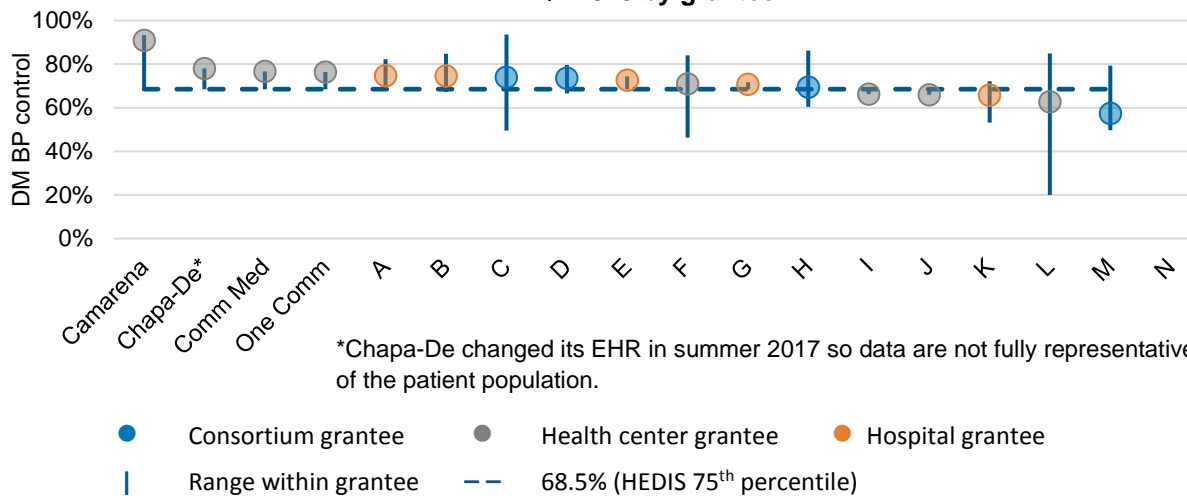
### Key outcomes

Across PHASE grantees, **71% of patients with diabetes have their blood pressure in control**. With the update of the benchmarks, the initiative average lies between the HEDIS 75<sup>th</sup> and 90<sup>th</sup> percentile. The decline in the average from last quarter to Q1 2018 is predominantly driven by declines at two participating health centers—one of which spread substantially in the last quarter. While the rate of control has decreased slightly, the number of patients with blood pressure in control has increased (62k at baseline, 72k in the most recent quarter). . The variation across grantee type (health center, consortium, hospital) is minimal, though in previous quarters, health center grantees were performing better than others.

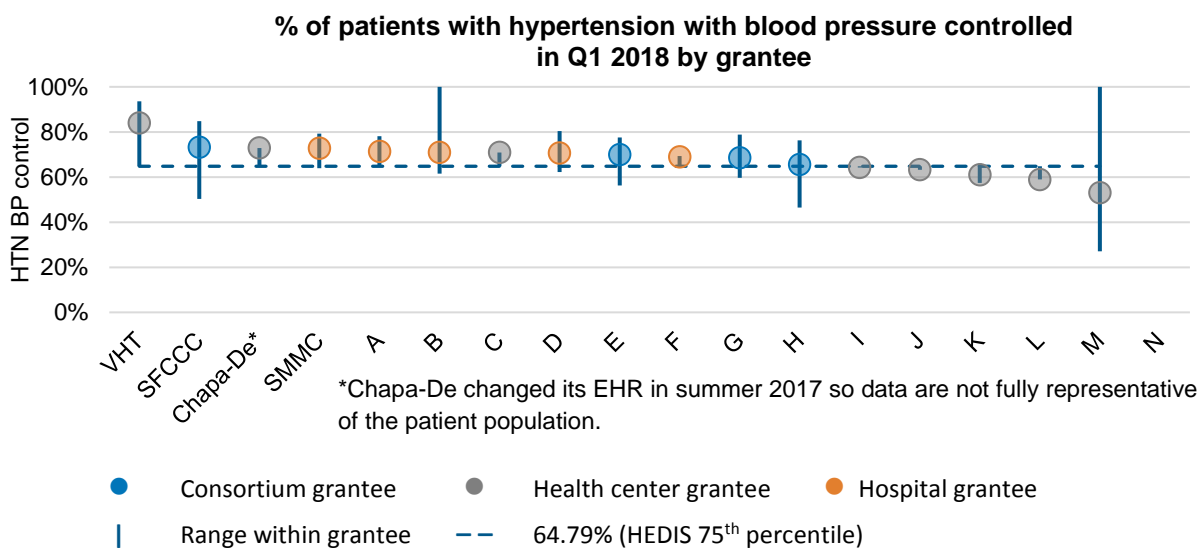
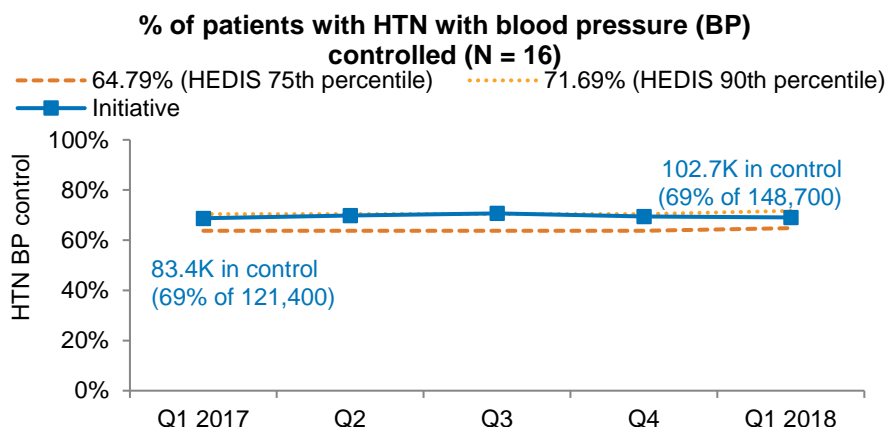
**% of patients with diabetes (DM) with blood pressure (BP) controlled (N=16)**



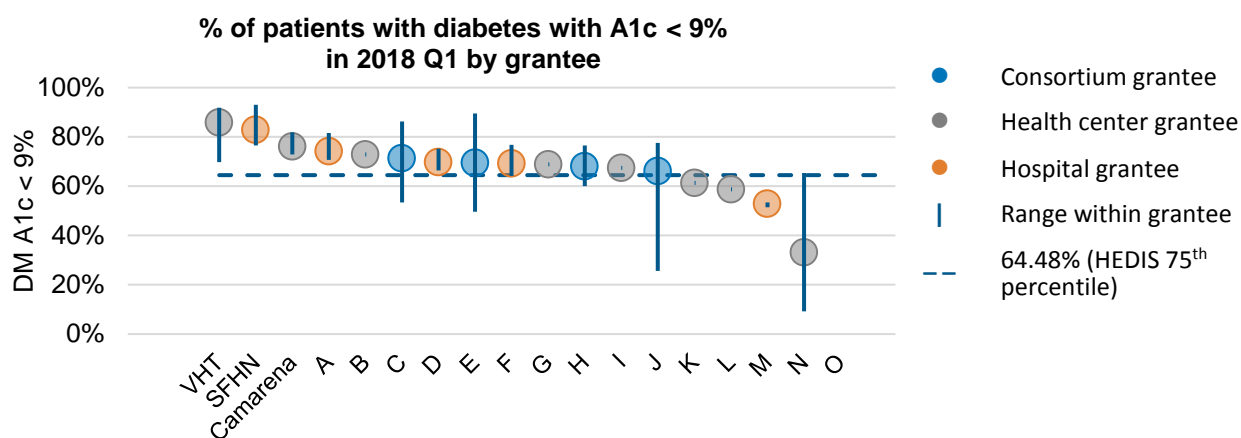
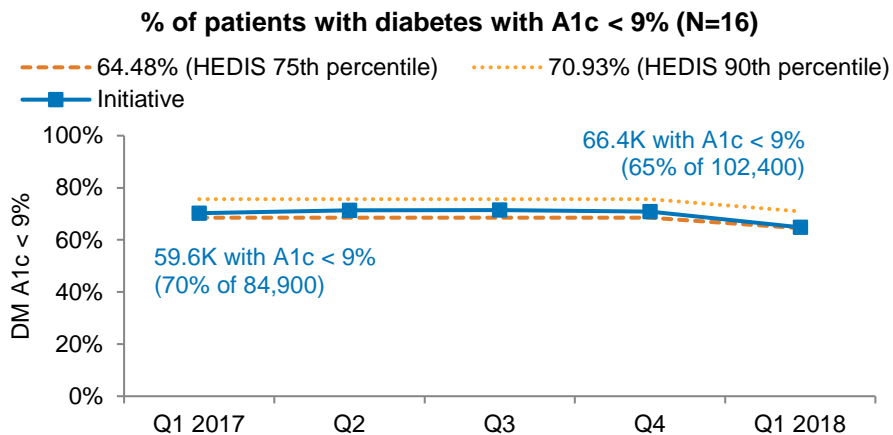
**% of patients with diabetes with blood pressure controlled in Q1 2018 by grantee**



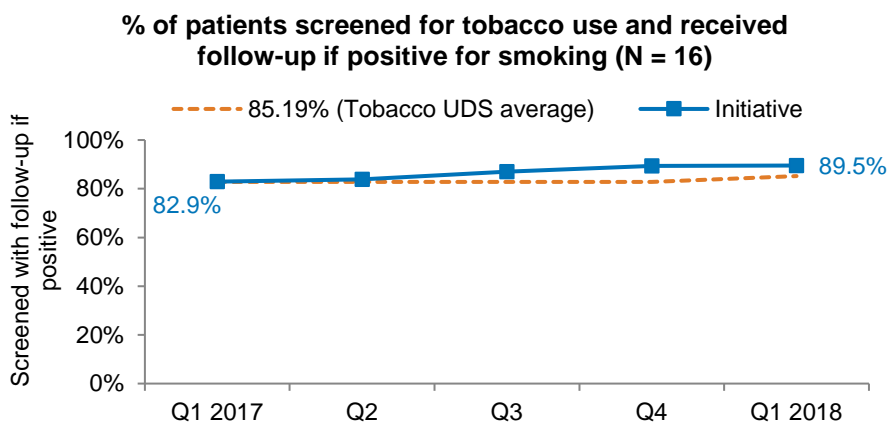
Across the initiative, there is an average of **69% of patients with hypertension with their blood pressure in control, which means 102,700 patients have their blood pressure in control**. The initiative average has remained above the HEDIS 75<sup>th</sup> percentile for blood pressure control for those with hypertension, and is nearing the 90<sup>th</sup> percentile (71.69%). There is less variation across grantee types in this measure than in the blood pressure control for those with diabetes.

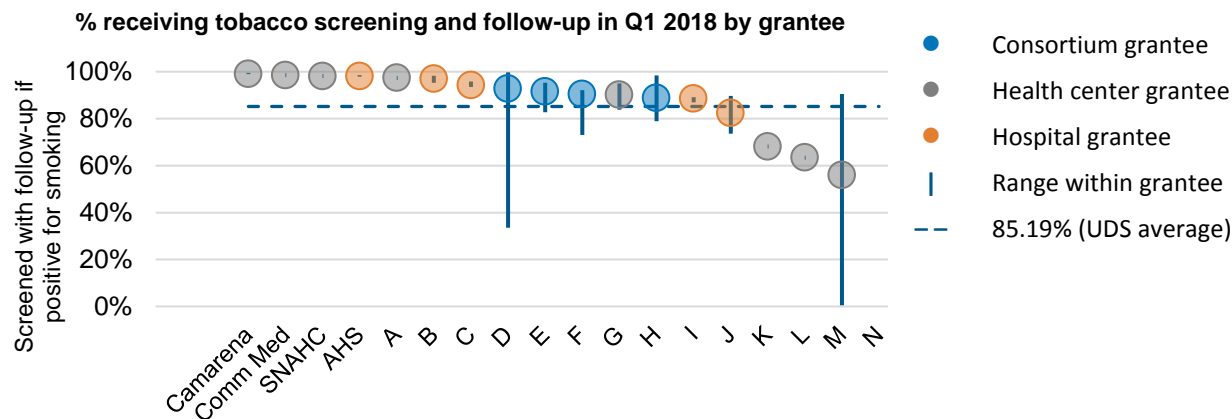


**Of patients with diabetes, 65% have their A1c < 9%.** This is just above the HEDIS 75<sup>th</sup> percentile for control of A1c, which is 64.48%. PHASE data and the national data, as indicated by the trend lines of the HEDIS 75<sup>th</sup> and 90<sup>th</sup> percentiles, both show a decline in this measure. While the rate of control has decreased for PHASE, there has been an increase in the absolute number of patients who have A1c < 9% since baseline (see next page).



Tobacco use is a significant risk factor for cardiac events. **The grantees have reached 90% for the rate of patients who have received tobacco screening and follow-up**, surpassing the UDS average of 85.19%. All grantee types are meeting the benchmark of the UDS average. The difference between grantee types has narrowed over time, mostly due to large improvements made by the consortia.

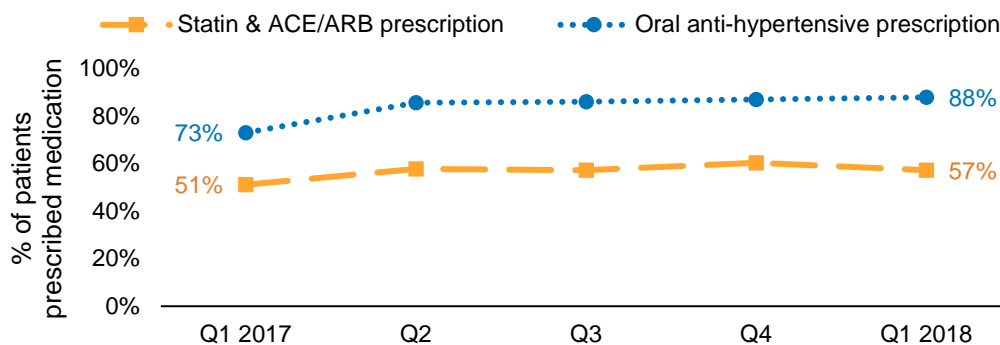




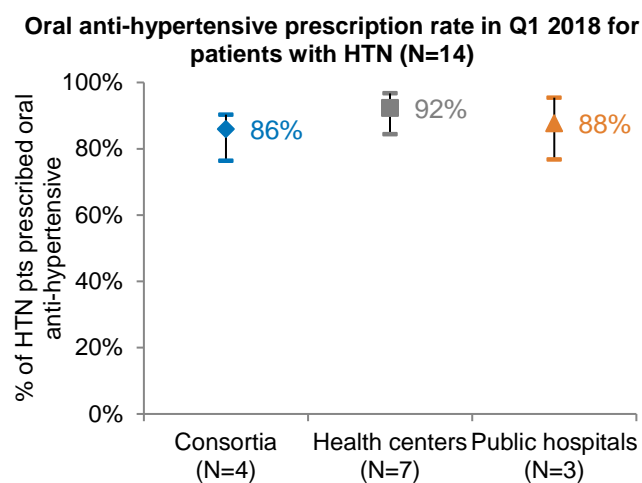
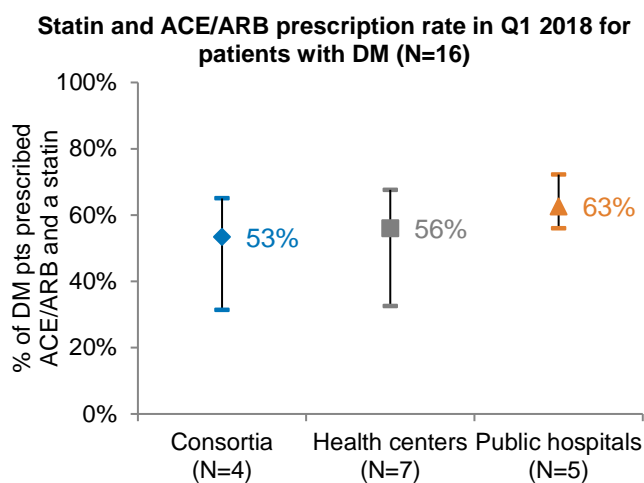
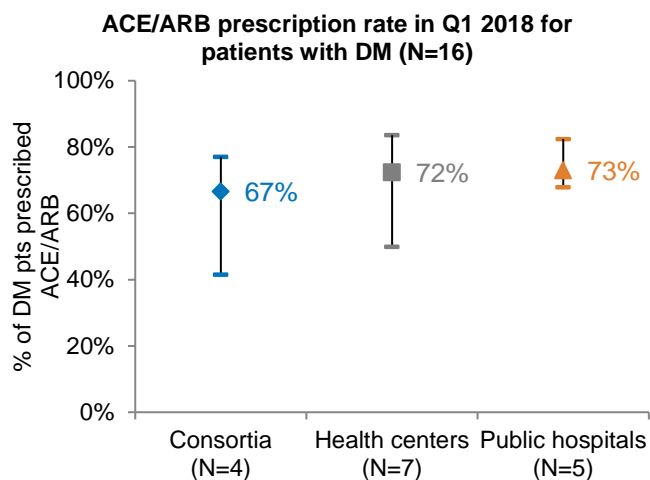
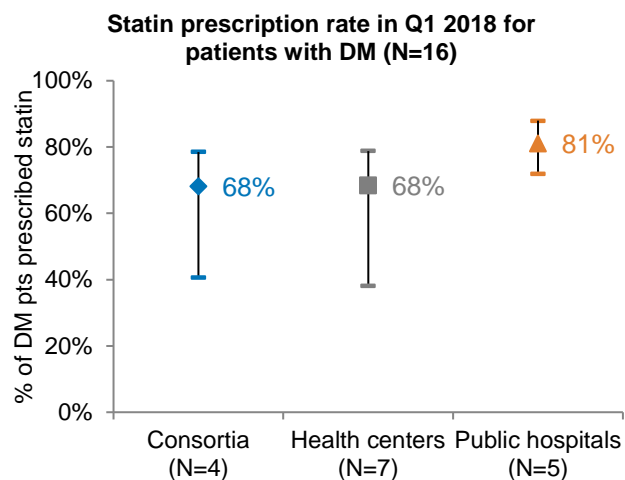
**Additional outcomes**

In addition to the outcomes that were 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, and 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.

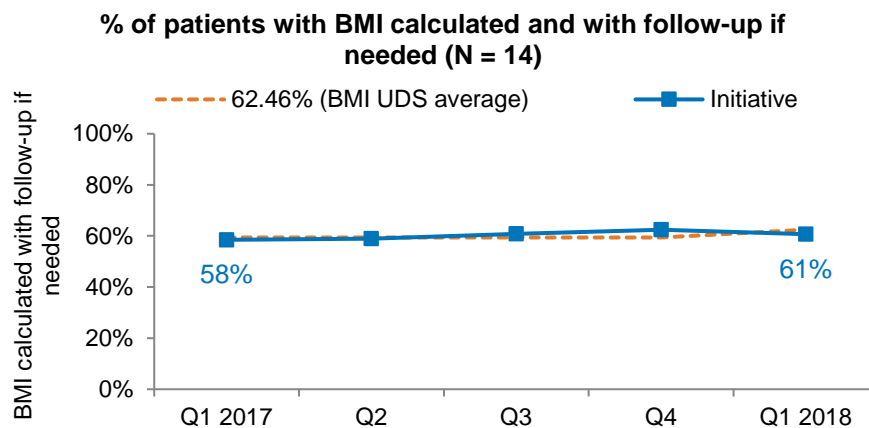
There has been an increase in prescription rates of these medications, which is seen across all cohorts. Almost 90% of the hypertensive patient population has been prescribed an oral anti-hypertensive. Of the patient population with diabetes, 57% have been prescribed both a statin and an ACE or ARB.



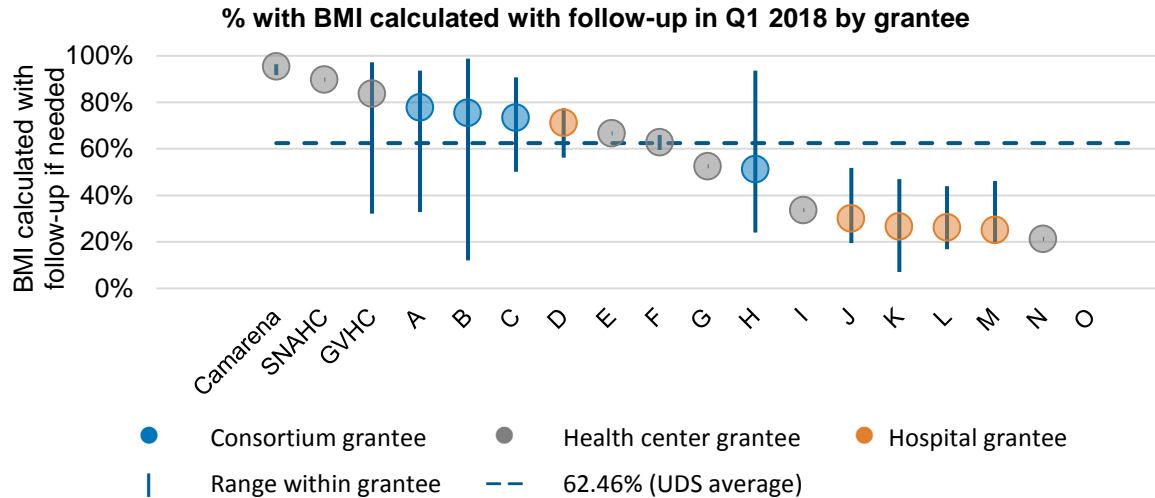
There is a wide range of prescription rates for each of the key cardio-protective medications across grantees. The hospitals have the highest rates of prescriptions for three of the measures, and the health centers have the highest rate for prescription of oral anti-hypertensives. As noted on page 1, three grantees did not submit this measure: two of which are not yet able to report on oral anti-hypertensive prescription rates, and the third being the one that did not submit any data for this quarter.



Initiative-wide, **61% of patients received BMI screening and follow-up if needed.** The initiative has not yet surpassed the 2016 UDS average of 62.46%, but remains above the 2015 average. Most grantees made slight improvements in this measure since the start of the grant.







Grantee performance on **depression screening with follow-up if positive is at 52% of patients**. The average has increased slightly over time, remaining above the past benchmark of the 2015 UDS average (50.6%), but not above the 2016 UDS average of 60.34%. Some grantees have indicated that lower performance on this measure may be due to a reluctance to screen for depression when they do not have the resources or ability to provide the follow-up care needed if the patient screens positive. The majority of grantees have improved on this measure since baseline.

