# Quarterly Data Report: Q3 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 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?*
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*For additional information, please see the PHASE Mid-Initiative Evaluation Report.*

**Reach of PHASE in Q3 2018**


**Key outcomes**

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 of such events.

Of patients with diabetes (DM),

- 76.9% are prescribed a statin
- 60.1% are prescribed a statin and an ACE/ARB

Of patients with hypertension (HTN),

- 88.7% are prescribed an oral anti-hypertensive

Three HEDIS performance measures are monitored:

**16** of 18 grantees are meeting the HEDIS 75th percentile for at least one of the two blood pressure control measures

**11** are meeting the HEDIS 90th percentile for at least one of these measures

**13** of 18 grantees are meeting the HEDIS 75th percentile for the proportion of patients with A1c ≤ 9%

**7** are meeting the HEDIS 90th percentile for this measure

The following three UDS measures take into account screening and follow-up:

Tobacco:

**13** of 18 grantees are meeting the UDS average

BMI:

**7** of 18 grantees are meeting the UDS average

Depression:

**10** of 18 grantees are meeting the UDS average

**Data quality & availability**

All grantees submitted their data for this quarter. Three grantees who had previously been excluded from aggregation due to data quality issues after EHR implementation are now included in aggregation. Data reporting issues that we're monitoring include:

- Two grantees submitted partial data, missing data for at least one participating health center or clinic
- One grantee did not submit any of the UDS measures
- Two grantees did not submit prescription of oral anti-hypertensives
- One grantee's BMI & depression data are excluded from aggregation because they only reported screening, instead of screening and follow-up

## 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

For the three HEDIS measures (blood pressure control for two different populations and A1c control[1]), the PHASE grantees as a cohort have consistently exceeded the HEDIS 75th percentile values. Across the initiative, there is an average of **71.0% of patients with hypertension with their blood pressure in control, which means 108,100 patients have their blood pressure in control**. The BP control rate is higher for the patient population with diabetes, though the population is smaller: **75.7% of patients with diabetes have their blood pressure in control, for a total of 82,700 patients in control**. For the same patient population with diabetes, **67.2% of these patients (or 73,400) have their A1c ≤ 9%**.

There have not been significant changes over time when looking at the initiative trend; however, the increasing number of patients for whom grantees are reporting means that while the rates remain similar over time, there is an increased number of patients who are "in control."

When looking at individual grantee performance, many grantees are performing well against the HEDIS 75th and 90th percentile values. Grantees have also made improvements over time.[2] 16 of the 18 grantees have made improvements on one or both measures of blood pressure control.

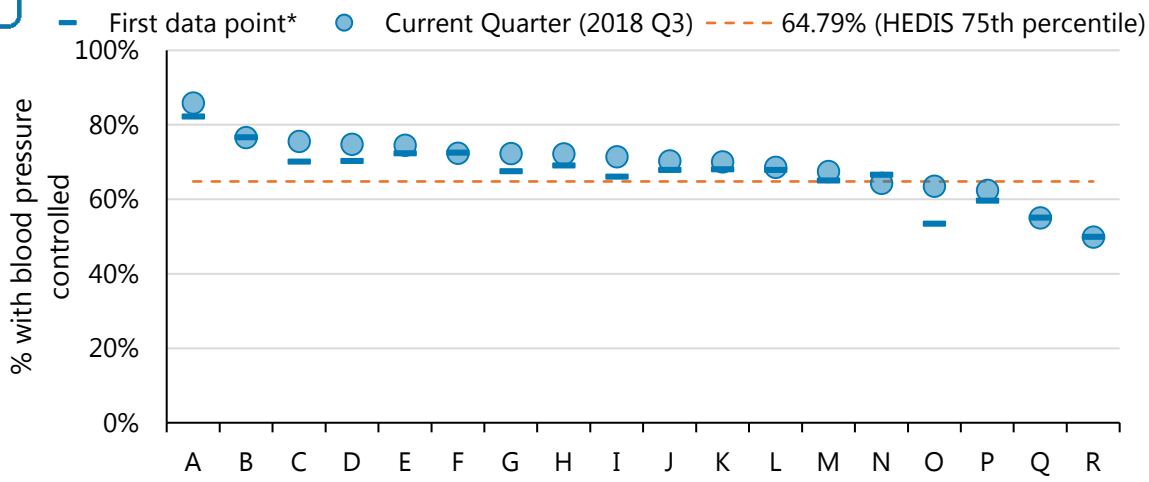
| | Number of grantees meeting: | | Number of grantees who improved since baseline |
|---|---|---|---|
| | 75th percentile value | 90th percentile value | |
| Blood pressure control for patients with HTN | 13 | 8 | 13 |
| Blood pressure control for patients with diabetes | 15 | 9 | 11 |
| A1c ≤ 9% | 13 | 7 | 8 |

The following figures depict grantee level performance on the three HEDIS measures. The first data point shown for each grantee is the earliest quarter in which the grantee's data were of high enough quality to be compared to subsequent quarters. The letters that represent grantees do not signify the same organization in each figure; they are sorted in order of performance. When time allows, high performers will be called out after they've approved us to do so.

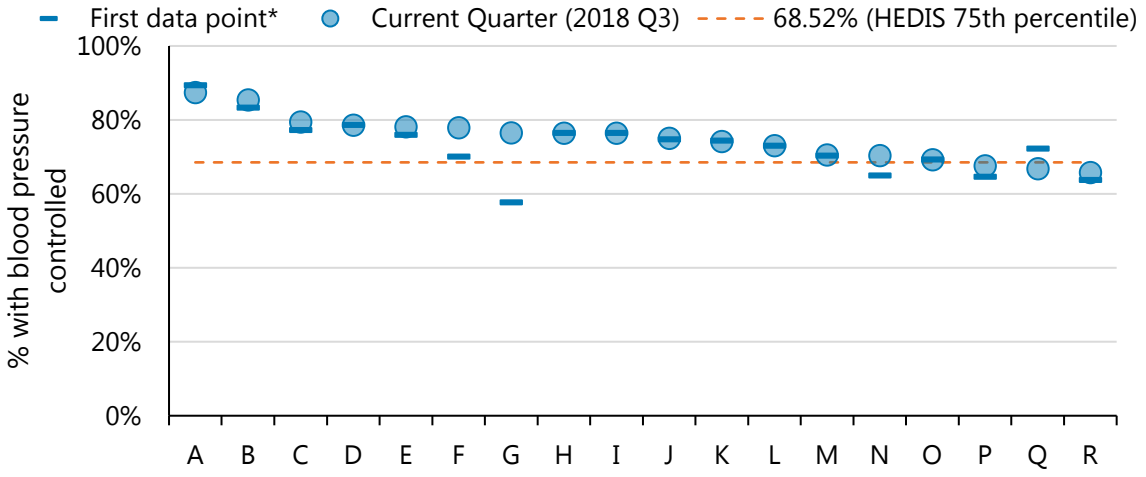
[1] Clinically, A1c control is often viewed as A1c < 8%. In this case, A1c control is A1c ≤ 9% to match the HEDIS definition (https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/).

[2] The period that represents grantees' baseline data point may differ depending on the grantees' data quality over time.

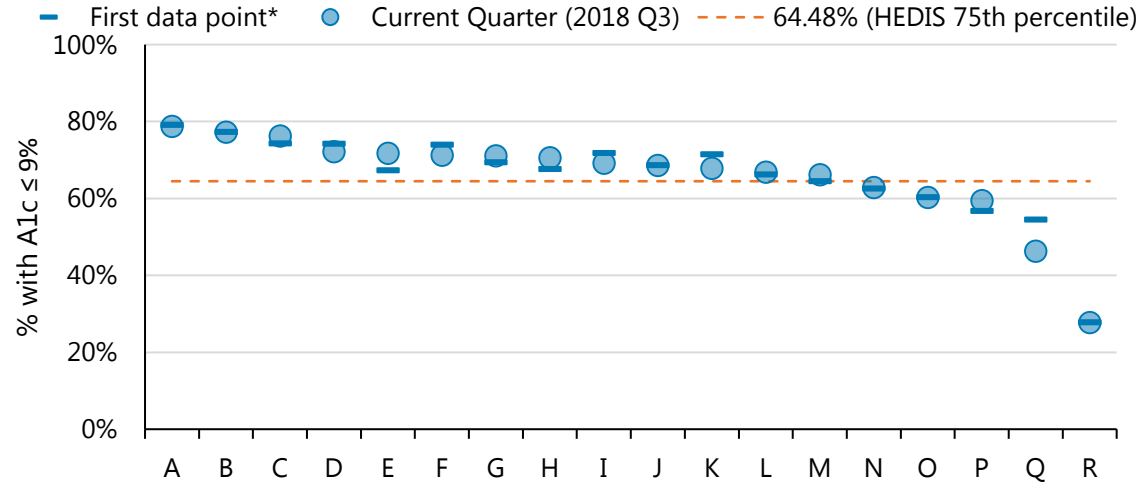
## % of patients with hypertension who have their blood pressure controlled (N = 18)




## % of patients with diabetes who have their blood pressure controlled (N = 18)

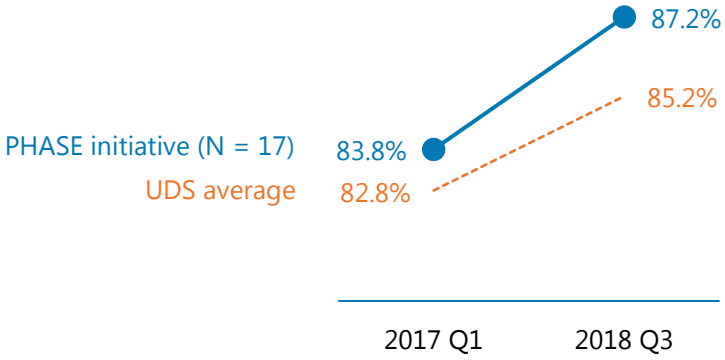



## % of patients with diabetes who have their A1c ≤ 9 (N = 18)



The fourth key outcome is around tobacco use, which is a significant risk factor for cardiovascular events. The initiative has seen improvement in the rate of tobacco screening and follow-up if patients use tobacco. **87.2% of patients are screened for tobacco, and if they use tobacco, receive follow-up for tobacco cessation**. Six grantees have improved their rates over time, but those that haven't are all still above the UDS average (85.19%). There has been a slight decline in the past quarter; more investigation with grantees is needed to understand this. This decline is relatively small for the grantees with a decline (all have a relative change between -0.5% and -2.2% except for one grantee), so it does not yet indicate the need for concern. All but two grantees are above 80% on this measure, with one grantee at 78.9% and another at 60.5%.

**% of patients screened for tobacco use and received follow-up if positive for smoking (N = 17)**

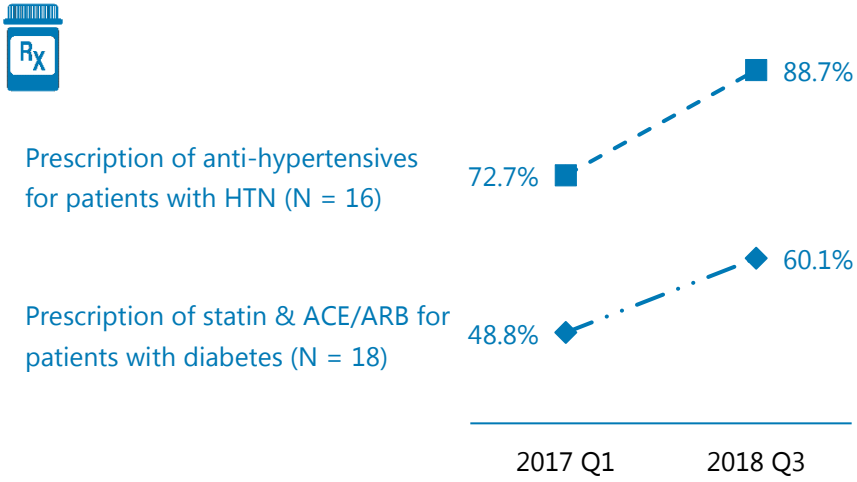



## Additional outcomes

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.

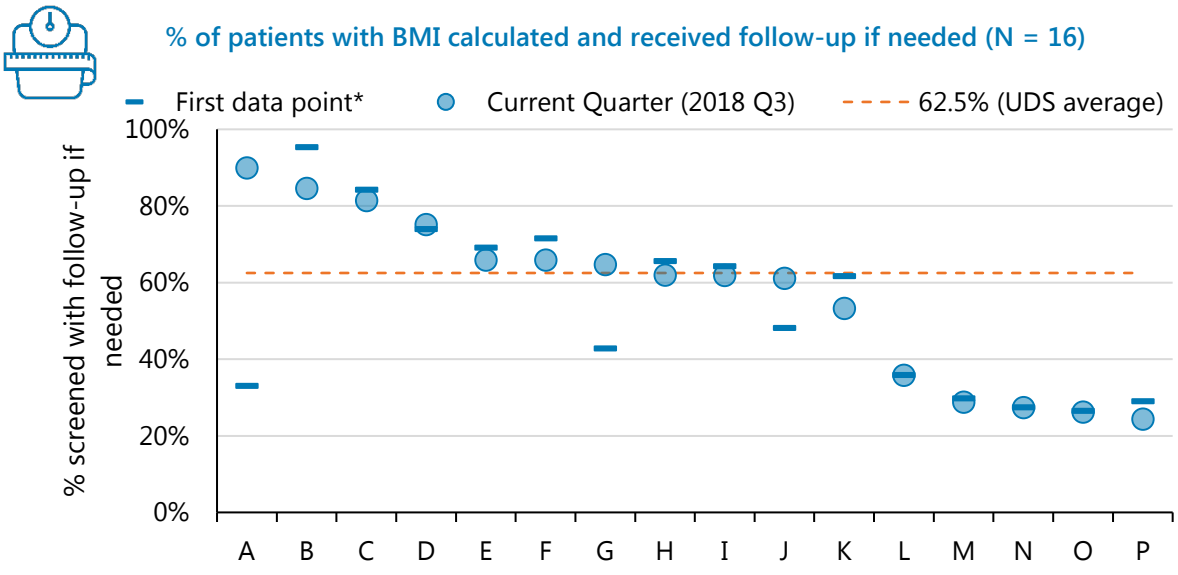
There has been an increase in prescription rates of these medications, which is seen across all cohorts (see below figure). **Almost 90% of the hypertensive patient population has been prescribed an oral anti-hypertensive**. Of the patient population with diabetes, 60.1% have been prescribed both a statin and an ACE or ARB. There are no benchmarks for these medication

measures because there are many reasons why individual patients would or would not be on these medications compared to other available medications.

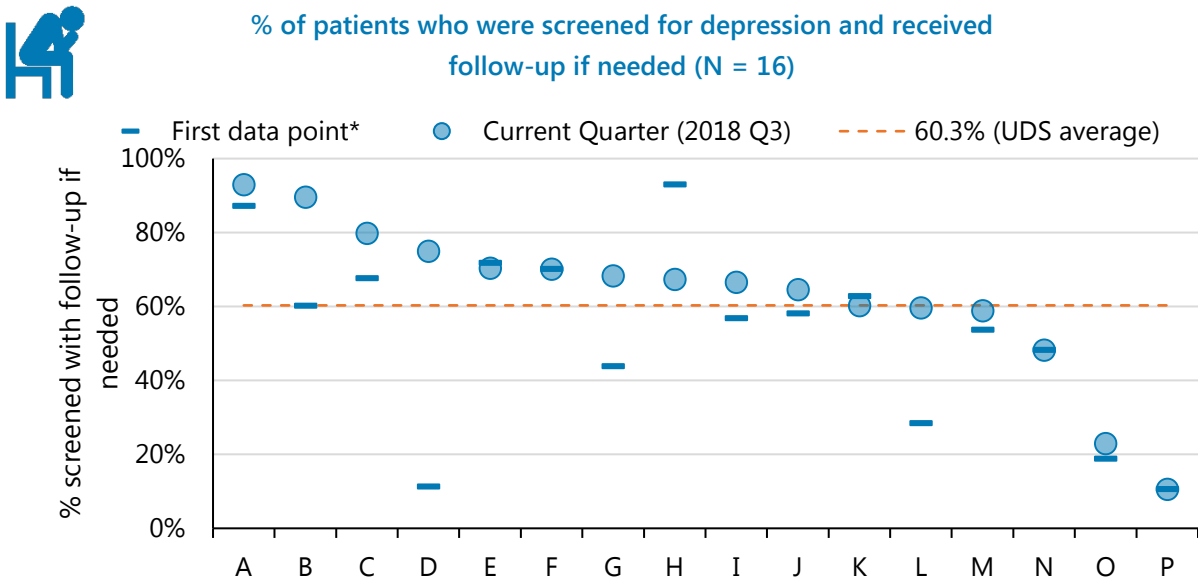



The **rates of BMI screening & follow-up and of depression screening & follow-up have increased only slightly over time across the initiative; they are hovering just below the UDS averages**. Due to an increased reach of the grantees, though, there are more patients who are considered in the denominator and thus the numerator. For example, in the first quarter of 2017, 205,600 patients were screened for depression and received follow-up if needed; in this quarter, it was 358,400 patients.

As of 2018 Q3, **60.8% of patients have had their BMI calculated and received follow-up if needed**, which is below the UDS average of 62.5%. Four grantees have improved in this measure over time, three of which have made substantial progress in this measure, as depicted in the below graph (Grantees A, D, & G). In the below two graphs, the first data point* shown for each grantee is from the earliest quarter in which the grantee's data were of high enough quality to be compared to subsequent quarters.



Across the initiative, **57.2% of patients receive depression screening and follow-up if needed**, which is still less than the UDS average of 60.3%. Over half of grantees have improved their rates of depression screening and follow-up, five of which have had statistically significant changes over time. As a reminder, the letters representing each grantee can change from figure to figure.




## For more detailed information

If you'd like to learn more about strategies grantees are using to make progress on these clinical outcomes, changes in grantees' capacities in the PHASE Building Blocks, or on the technical assistance provided as part of PHASE, please see the PHASE Mid-Initiative Evaluation Report.